

diseases that did not permit to perform surgery under general anesthesia. Patients with no clinically involved axillary nodes, and nonmetastatic (N0M0) disease were eligible for this trial. The control group consisted of 141 patients received segmental resection with axillary dissection. Upward of 65% women were more than 60 years old, the average age of the group was 68.6 ± 2.1 years. Most of the patients had primary breast tumours less than 3 cm and median size of tumour was 2.4 ± 0.2 cm. As most of the patients were elderly persons, 64 (63.4%) of them suffered from different intercurrent diseases (uncontrolled hypertension, unstable angina, serious cardiac arrhythmia, chronic renal failure, cirrhosis, serious asthma and diabetes).

Results: Surgery was performed in 25 (24.7%) patients, surgery plus radiotherapy – in 26 (25.7%) patients, surgery plus chemo/hormonal therapy – in 23 (22.8%) patients, surgery plus radiotherapy and chemo/hormonal therapy – in 23 (22.8%) patients. Surgery was performed under local anesthesia. In the study we found that overall 3 years survival was 89.9%, 5 years survival – 81.9%. There was no statistical difference of these rates in all studied groups. That's why we may consider, that overall survival does not depend on the method of treatment. The results of survival rates in the control group were nearly the same – 3 and 5 years survival were 93.2% and 85.2%, respectively. Three patients developed an axillary recurrence. Seven patients later developed distant metastases. During the follow-up 29 patients (28.7%) died, 7 of them – because of cancer progression, 13 – because of intercurrent diseases. The reason of death of 9 patients is still not known.

Conclusion: Segmental resection without axillary dissection may be performed in selected cases of early breast cancer and doesn't influence on long-term survival.

5134

POSTER

Are Mammograms Reliable in Determining True Ductal Carcinoma In-situ (DCIS) Size?

N. Randhawa¹, K. McEvoy¹, H. Khan¹. ¹University Hospitals Coventry & Warwickshire Trust, Breast Surgery, Coventry, United Kingdom

Background: Ductal Carcinoma In-Situ (DCIS) is an increasingly common diagnosis due to the NHS Breast Screening Programmes. DCIS is usually impalpable, with excision margins often dictated by the extent of calcification identified on mammography. The aim of this study was to assess whether the mammographic size truly reflects the actual pathological size.

Materials and Methods: A retrospective case-note review study of all patients diagnosed with DCIS in a teaching hospital from 2007 to 2009 was carried out. Initial mammographic size was compared to final histological size. Size correlation was defined as within 10 mm (normal macroscopic clearance). DCIS type and grade were also recorded as were patient demographics.

Results: 100 patients' notes were reviewed. Mammographic size correlated with pathological size in 49 (49%). However in the remaining 51 patients, 27 were under estimated by mean 27 mm (330% of original mammographic size) whilst 24 were over estimated by mean 23 mm (56.5%). There is no DCIS type that predicted size correlation although; the greatest concordance between radiological and histological data was seen in the high grade group. The lowest concordance was seen with the intermediate grade group.

Conclusion: Mammograms do not appear to predict true size in half of the cases of DCIS reviewed. Under-estimating the size of the lesion may impact margin status and thus require further excision. Over-estimating the size may result in more extensive excision than necessary, resulting in a worse cosmetic outcome even mastectomy. Clinicians need to be aware of the limitations of using mammographic size alone to plan surgery and ensure that patients are appropriately counselled regarding this.

5135

POSTER

New Approaches Into Early-stage Breast Cancer Surgery in Older Patients

V. Rodionov¹, A. Midlenko¹, V. Muzyakov², E. Rakhmatullina², A. Suetin², M. Rodionova³. ¹Ulyanovsk State University, Medical Faculty, Ulyanovsk, Russian Federation; ²Ulyanovsk Regional Oncology Center, Breast Cancer Department, Ulyanovsk, Russian Federation; ³Russian National Cancer Research Center, Breast Cancer Department, Moscow, Russian Federation

Background: Axillary lymph node dissection has been considered to be a standard procedure due to better locoregional control and survival rates. However 48% of breast cancer patients are women aged 65 and older. And the question of performing axillary lymph node dissection in this group of patients is still controversial due to the lack of data, higher mortality rates from concomitant diseases and good response to endocrine therapy.

Materials and Methods: A retrospective study of 425 early breast cancer cases (stage T1 and T2, N0, M0) in women after 60 years old treated in the Ulyanovsk Regional Oncological Centre between July 1988 and December 2008 was conducted.

58.3% of patients underwent mastectomy + axillary lymph node dissection (group A), 21.8% – lumpectomy + axillary lymph node dissection (group B), 19.7% – lumpectomy only (group C). Most of them had 2 or more concomitant diseases.

Results: 5.2% of patients from the group C developed local recurrence: 1.1% – in the scar, 4.7% – in regional lymph nodes and ipsilateral breast. Distant metastases occurred in 7.1% of patients, mostly in lung and mediastinum lymph nodes. In Group B local recurrence occurred in 13.9% of patients: 7.5% – in the scar, 4.3% – in the ipsilateral breast, 2.1% – in axillary lymph nodes. Distant metastases were detected in 12.9% of patients. Disease progression was fixed in 11.2% of Group A patients, with local recurrence rate – 2.4%.

At the time of analysis (10/07/2010) 97 deaths (22.8%) in the study group were registered. Mortality structure was different in the studied groups, with the highest death rate from concomitant diseases in the group C.

A statistically significant increase in overall survival in group B than in group C (log rank test: $\chi^2 = 11.88353$, $df = 2$, $p = 0.00263$) was non-significant in comparison with those in group A. 3-year overall survival in groups A–C was 88.8 ± 2.3 , $89.4 \pm 3.4\%$ and $79.6 \pm 4.9\%$ respectively. Disease-free survival rates were $84.7 \pm 2.6\%$, $81.7 \pm 4.2\%$ and $75.1 \pm 5.2\%$ respectively in the three groups (log rank test: $\chi^2 = 5.578870$, $df = 2$, $p = 0.05047$).

Conclusions: Lumpectomy does not increase disease-related mortality and could be recommended for treatment of older patients with early-stage breast cancer.

Lumpectomy+axillary lymph node dissection does not significantly change overall and disease-free survival in comparison to radical mastectomy and can be preferred for surgical management of this group of patients.

5136

POSTER

Sentinel Node Biopsy Under Local Anesthesia in Patients With Breast Cancer – in Whom is It Indicated?

M.W.H. Leenders¹, M. Broeders¹, R. Mollema¹, A.M.F. Lopes Cardoso¹, W.H. Schreurs¹. ¹Medical Center Alkmaar, Surgery, Alkmaar, The Netherlands

The most important prognostic factor in breast cancer patients is the axillary nodal status. Preoperative axillary ultrasound with subsequent fine needle aspiration cytology (FNAC) in case of suspicious lymph nodes, is currently used to screen for axillary metastases. Before, we concluded that the percentage of false negative results of FNAC was very high. Therefore, in the present study we analyzed if certain patient or tumour factors cause an increased risk of false negative results of FNAC. In these patients, a sentinel node biopsy under local anesthesia might be indicated.

Retrospectively, we reviewed the data of 1151 breast cancer patients, that were evaluated and treated in our clinic between 2004 and 2009. Preoperative axillary ultrasound with subsequent FNAC in case of suspicious lymph nodes was performed in all patients. Pathological node status was used as the reference standard. The association between the incidence of axillary metastases and 11 clinical/pathological factors (age, side, histology, multifocality, size, grade, estrogen and progesterone receptor status, HER-2/neu, nuclear grade and radiologist) was analyzed by univariate and, when significant, by multivariate analysis. The association between these factors and the risk of false negative results of FNAC was analyzed as well.

427 of 1151 patients had metastatic disease on final histological analysis. Multivariate analysis identified 2 factors as independent predictors of axillary metastases: age ($p < 0.01$) and tumour size ($p < 0.01$). Likewise, multivariate analysis identified 3 factors as predictors for the risk of false negative results of FNAC: age ($p < 0.01$), tumour size ($p < 0.01$) and multifocality ($p = 0.04$).

Before, we concluded that sensitivity of FNAC was 24.4% (104/427). The lower the sensitivity [defined as true positives/(true positives + false negatives)], the higher the percentage of false negative results. Therefore, the possibility of a false negative result of FNAC increases, if the percentage of patients with axillary metastases increases. Hereby, we explain that age and tumour size are predictors of the risk of axillary metastases as well as predictors for the risk of a false negative result of FNAC.

Because of the increased risk of a false negative result of FNAC, we recommend a sentinel node biopsy under local anesthesia in patients with a large breast carcinoma or a multifocal tumour and in elderly patients.