11 courses of intravenous antibiotics, 24 courses of oral antibiotics and 115 inpatient days. The primary recommendation of this audit was to include primary prophylaxis with G-CSF in the FEC-D protocol.

The second audit identified 146 patients, their median age was 49. Primary prophylaxis was administered in 98% of cases. There were 17 episodes of FN, resulting in a FN rate of 11.6%. All of these cases had received prophylactic G-CSF. These episodes resulted in a total of 11 courses of intravenous antibiotics, 8 courses of oral antibiotics and 24 hospital admission days.

Conclusions: Near universal administration of primary G-CSF during FEC-D has been achieved resulting in a clear reduction in FN rate. Hospital admission days have also substantially reduced suggesting a possible financial benefit in addition to an improved patient experience.

References

[1] Ali Z, O'Reilly S, Zahoor T, Scholfield P, Malik Z. Experience of Febrile Neutropenia and secondary G-CSF Prophylaxis During FEC_D Chemotherapy in Merseyside and Chseshire Cancer Network. National Cancer Research Institute Cancer Conference 2008; Abstract B67

Friday, 23 March 2012   **12:45–14:00**

POSTER SESSION
Ductal and Lobular Carcinoma in Situ

450   Poster discussion
Is There a Different Prognosis Between Infiltrative Carcinoma of the Breast and Infiltrative Recurrences After Ductal Carcinoma in Situ of the Breast?

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Background: Local recurrence after breast-conserving treatment of Ductal Carcinoma In Situ (DCIS) occurs at around 8−20% and half of these local recurrences are invasive carcinoma.

The aim of this study was to compare the prognosis of these invasive recurrences after DCIS with prognosis after treatment of carcinomas that are invasive at diagnosis.

Material and Methods: From 1971 to 2003, we treated 1592 DCIS and 14450 invasive carcinomas (IC) at our institution. Overall, 111 recurrences were observed for DCIS patients, 61 (55%) of which were invasive (IR). We created two groups; the first based on all cases of IR and the second consisting of 2 IC matched to each IR on 3 criteria: age +/− 3 years, period of treatment (+/− 1 year) and cTNM. We compared survival outcomes between the two groups at 5 and 10 years after treatment and investigated prognostic differences.

Results: Clinical characteristics in terms of tumour grade, number of nodes affected and metastatic rates were similar across both groups. Clinical characteristics were similar in both groups as shown in Table 1.

Table 1. cTNM regarding each group

	T0	T1	T2	T3	T4	TX	N0	N>0	M+
IR, n = 61	34.4%	39.3%	13.1%	0.0%	1.6%	11.5%	72.1%	27.9%	13.1%
IC, n = 122	31.1%	41.8%	13.1%	0.8%	13.1%	0.0%	69.7%	29.5%	13.1%

Differences were observed in the types of treatment offered across groups: IR were more often treated by mastectomy (47.5% vs. 9.8%) and less frequently by radiotherapy than in the IC group (15% vs. 40% respectively). Chemotherapy was more systematically performed in the IC group than in the IR group (35.2% vs. 17%, p = 0.008).

There were no differences between overall survival rates across groups at 5 and 10 years (86.8% and 77.4% in the IR group vs. 89.7% and 76.6% in the IC group, p = 0.627).

Conclusions: Our results indicate that despite differences in treatment, such as twice the rate of chemotherapy for carcinoma that are invasive at diagnosis compared to invasive carcinoma occurring as recurrence after DCIS, both of these types of invasive carcinoma have the same outcomes in terms of survival.

451   Poster discussion
Underestimation Rate of Invasive Malignancy in Atypical Lobular Hyperplasia (ALH) and Lobular in Situ Carcinoma (LCIS)

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Background: The management of atypical lobular hyperplasia (ALH) and lobular in situ carcinoma (LCIS)discovered on breast biopsies is still controversial.

Some authors do not recommend surgical excision, and up to one third of the patients in the literature undergo radiological follow up.

The aim of this study was to assess the risk of invasive malignancy when ALH and LCIS are diagnosed on breast biopsy.

Methods: All cases of ALH and LCIS diagnosed by percutaneous biopsy at Saint-Louis hospital, (Paris, France), between January 2000 and January 2011 were identified from the computerized database of pathological reports.

Patients' characteristics, clinical, radiological patterns and subsequent management and outcome were collected from medical records.

Cases with an invasive lesion coexisting with ALH and LCIS and patients with missing pathological data after biopsy were excluded from the study.

Results: One hundred and seven pathological reports were identified, and 87 medical records were available for analysis, (ALH, n = 45, LCIS n = 46).

69 lesions were diagnosed by vacuum assisted biopsy (79.3%) and 18 by core needle biopsy (20.7%).

67 lesions (77%) (ALH n = 25 LCIS n = 42) were further managed by excision, either by lumpectomy (n = 53, 79%) or by mastectomy (n = 14, 21%). An invasive cancer (4 lobular, 3 ductal and 1 undetermined) was found in 8 of the 67 excision-based specimens, leading to an under-estimation rate of the biopsy of 11.9% for excised specimens (14.3% for CLIS and 8% for ALH).

Five patients were lost to follow-up. After a mean follow-up of 39 months, 2 additional ipsilateral (3.2%) and 3 controlateral (4.8%) invasive cancers were diagnosed.

20 lesions were managed by observation (ALH=18 and LCIS=2). After a mean follow-up of 40 months, 3 ipsilateral (15%) and 2 controlateral (10%) invasive malignancies were diagnosed.

Conclusion: Given the significant rate of under-estimation of invasive malignancy, we recommend to excise both atypical lobular hyperplasia and lobular in situ carcinoma when discovered on core biopsies.

Predictive factors of under-estimation should be investigated and validated before this attitude can give way to radiological follow-up.

Despite surgery, the risk of cancer remains high. The early diagnosis after biopsy suggests that multifocal or bilateral lesions pre-existed and that a meticulous local assessment is necessary.

MRI could be a useful tool regarding this issue.

452   Poster
Development and Validation of Nomogram to Predict Postoperative Invasive Component in Ductal Carcinoma in Situ at Core Needle Biopsy

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Background: This study was to develop and validate nomogram to predict underestimation of DCIS at breast core needle biopsy.

Material and Methods: We developed a nomogram using previous reported meta-analysis study about DCIS underestimation. The factors related DCIS underestimation was palpability (OR = 3.87), size more than 2 cm (OR = 2.28), mammographic mass (OR = 1.83), 14 g automated vs. 11 g vacuum assisted (OR = 1.85), histological high grade (OR = 1.79). We developed web-based nomogram using a linear regression model with intercept calibration. To validate the nomogram, we used a retrospective data from January 2003 to September 2011. The accuracy of the nomogram was validated by comparing expected value with observed value assuming Poisson distribution and Hosmer-Lemeshow test. The discrimination was validated by ROC curve analysis.

Results: The developed nomogram was posted at the website (http://user.dankook.ac.kr/~surgery/dcis/dcis-dku.htm). In the total sixty cases of DCIS diagnosed by core needle biopsy, twenty-nine cases (48.3%) were finally confirmed to have invasive component. The expected number of underestimation was not significantly different to the observed number according to the related factors. Also, the expected number was not significantly different to the observed number by the Hosmer-Lemeshow