

(LD) miniflap while modified radical mastectomy, skin sparing mastectomy and subcutaneous mastectomy were done in 2(5%), 4(10%) and 6(15%) patients respectively with complete reconstruction by extended(LD) flap. The complication rates were noted as follows: partial flap necrosis in 4 patients (10%), wound breakdown in 2 patients (5%), lymphorrhea in 2 patients (5%), seroma in 6 patients (15%), some of patients showed a minor deformity in the back which disappeared with time and most patients had temporary limitation of shoulder movements postoperatively but all recovered completely within few weeks. No patients underwent secondary nipple and areola reconstruction. No local recurrence or distant metastasis in any patient during the follow up period of our study. Evaluation of aesthetic results by patients revealed that 30 patients (75%) were deeply satisfied, 6 patients (15%) were satisfied and 4 patients (10%) were poorly satisfied. While, surgeon aesthetic evaluation was good in 28 patients (70%), satisfactory in 8 patients (20%) and fair in 4 patients (10%).

Conclusion: (LD) flap breast reconstruction is a very versatile, safe and satisfactory technique with a success rate of over 99% and is even suitable for high-risk patients. Donor site seroma is the most common complication and can be treated by repeated aspiration in outpatient clinic. Latissimus dorsi (LD) miniflap is the mainstay of breast reconstruction after partial mastectomy to repair defects in the lateral quadrants and the upper inner pole with low donor site morbidity and deep patient satisfaction.

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Do Surgeons See Benefit of Operating in Stage IV Breast Cancer?

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Introduction: Historically, patients with established Stage IV disease have been referred for primary palliative management with surgery usually limited to locoregional control. Survival with metastatic breast cancer has improved over the past few decades, but there is concern that resection of the breast primary could disrupt immunologic balance and propagate tumour seeding.

Method: A postal survey of 260 Consultant members of the Association of Breast Surgery (UK) aimed to define factors that influence the decision to surgically treat the breast primary with regards to tumour biology and metastatic variables. Opinions on factors they felt would influence tumour burden, immunosuppression leading to increased tumour burden and whether long term survival could be achieved with aggressive treatments was questioned.

Results: Eighty two (32%) responded. Units saw 100–800 new breast cancers and 5–200 metastatic cancers per year. Ninety percent of surgeons would consider surgery of the primary in Stage IV disease. The younger age group were favourable, with 75.6% treating age 20–50 years; 66% age 50–60 and 18.3% treating the 70–80 year olds with none considering patients aged more than 80 years. Diabetes and previous myocardial infarction negatively influenced surgeons 36.6% and 26.8% respectively as did 39% if patients had either previous chemotherapy or radiotherapy. No more than a third were influenced by tumour biology factors; 61% were positively influenced by the sole presence of bone metastases and 55% if only one distant site was affected.

The majority (86.6%) believe that duration of response to systemic therapy should influence the decision for surgery. Sixty percent did not know of any evidence relating to durable benefit of treating patients with metastatic disease and 36.6% believed that removing the primary tumour significantly eradicated a source of metastatic spread. More than two thirds (68.3%) didn't believe that removing tumour bulk had any impact in restoration of immunosuppressive factors. Nearly 50% believed that both debulking surgery increased efficacy of systemic therapy and that surgery and anaesthesia caused significant immunosuppression. Only 24.3% felt operative therapy can achieve complete remission and long-term survival.

Conclusion: Definitive answers in the absence of a large multicentre clinical trial, leave this issue controversial. Evidence to date suggests that an aggressive approach to surgery with curative intent in selected, physically fit patients with well-controlled metastatic disease with systemic therapy is at least a reasonable option for consideration. The oncology community remains divided and management of these patients warrants the perspectives of the multidisciplinary team.

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Sentinel Lymph Node Dissection in Breast Cancer Relapse After Previous Axillary Surgery

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Background: Use of sentinel lymph node biopsy (SLN) is still controversial in patients with ipsilateral breast cancer recurrence (IBTR) and a previous

axillary surgery (axillary lymph node dissection or SLN). Although previous reports have showed extra-axillary drainage in 40–60% of patients, the clinical significance of this drainage is unknown.

Material and Methods: Between 2008 and 2011, SLN was performed in 40 patients with IBTR and previous axillary surgery. The day before surgery ⁹⁹Tc nanocolloid was injected retroareolar in the affected breast and injected intratumorally when the recurrence was after a mastectomy. Lymphoscintigraphy and SPET-TC were obtained in all patients. During surgery, the sentinel node was identified using a gamma probe. Sentinel lymph node was excised at the discretion of the surgeon when considered technically feasible. In patients with previous SLN, an ALND was performed after the SLN. The study was approved by the IRB and all patients signed an informed consent.

Results: 40 patients were included in the study. In 31 (77%) the initial axillary surgery was an ALND and 9 (23%) patients has had a previous SLN. Median time between first surgery and local relapse was 108 months (range 15–276). In 3 (7%) patients, the recurrence was located in the mastectomy flap and in 37 the IBCR was after a lumpectomy, more frequently in the same quadrant that the initial lumpectomy (34 patients). The identification rate using SPECT-TC was 77% but only in 25 (62.5%) at least one sentinel node was removed. Extra-axillary drainage was recorded in 17 patients by the SPET-TC. In two cases the node wasn't found during surgery because low activity and in 6 cases the surgeon decided not to excise it. In 10 (25%) patients some hotspot was saw in the SPECT-TC but not removed. None of those patients had a relapse after a median follow-up of 12 months. In 5 patients (20%) the sentinel node was positive. Only one patient with previously SLN had a positive node in the second surgery and this was the only positive node. There were no false negative SLN in the patients who had a complete ALND.

Conclusions: Although rates of SLN excision in patients with previous axillary surgery and a local recurrence were low, 20% of patients had a positive SLN removed during the procedure that has an impact on the management of this patients.

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Nipple Sparing Subcutaneous Mastectomy (NSSM) as Dual-plane Prosthetic Reconstruction Using the Modified Wise Pattern Mastectomy, Fasciocutaneous Flap and Titan-Polypropylen-Mesh-Interpolation in Women with Macromastia

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Introduction: Ablative surgery of voluminous, ptotic breasts poses the problem of implant cover of the lower and lateral two thirds that are not covered by the lifted pectoral muscle. Based on reduction mammoplasty techniques we applied a method that utilizes the excess mammary skin in terms of vertical, lateral, and medial de-epithelialized fascio-cutaneous tissue columns that serve together with a mesh (TiLoop® Bra) as cover for the subpectoral implant.

Material and Methods: Between 06/2009 and 09/2011 we performed 10 nipple and skin sparing mastectomies with marked tissue reduction (defined as difference in weight between implant and resected tissue of more than 300 g) in 7 patients. Indications comprise primary and secondary prophylactic as well as 4 nipple sparing mastectomies after neoadjuvant chemotherapy.

Results: Mastectomy weights ranged between 325 and 1100 g; implant volumes ranged between 295 and 685 cm³. There occurred three partial necrosis of the nipple-areolar complex (NAC) and one partial skin necrosis at the margin of the vertical incision with inverted T cut. Two patients had to be operated on a second time for cosmetic reasons. The overall complication rate was very low.

Conclusions: The method described herein using the de-epithelialized excess mammary skin and the advantages of the titanized polypropylene mesh archives stable reconstructions and a safe vascularization of the NAC.

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Subpectoral Implants in Oncoplastic-reconstructive Breast Surgery – Habit or Necessity?

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Introduction: We perform nipple-sparing subcutaneous mastectomies since 2002. Herein we report on 302 cases, in 107 of which acellular dermis or meshes as tissue interponates were used.

The standard procedure of subpectoral implant positioning with or without caudo-lateral tissue interponates (acellular dermis or mesh) can lead to postoperative problems due to detachment of muscle. Against this