

lymphadenectomy was performed at the axillary level III with an average of 17 lymph nodes removed (SD 6.40) and 46% had positive lymph nodes. Most had advanced pathological stage (57% II and 23% III) and 86% were ductal carcinoma infiltrante. O adjuvant treatment with chemotherapy was performed in 59%, the adjuvant radiotherapy performed in 63% and adjuvant hormone therapy in 68%. Patients were followed for a median 61 months (1–94), 16% of deaths occurred in the period, with average survival time of 82 months (95% CI 81–84) (Figure 1). In Kaplan-Meier analysis, the variables that were statistically associated with better overall survival were initial staging ($p < 0.000$), negative lymph nodes ($p < 0.000$), tumor size ($p < 0.000$), number of lymph nodes removed ($p = 0.005$), adjuvant chemotherapy ($p = 0.013$) and neo-adjuvant ($p < 0.000$), adjuvant hormone therapy ($p = 0.001$), CDI ($p = 0.005$), conservative surgery ($p < 0.000$).

Conclusions: Overall survival is similar to data found in the literature for staging. The results suggest the need for early diagnosis and treatment.

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Poster

Breast Cancer Control in Iran: National Screening/specialized Breast Unit, Which One is the Urgent Priority?

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Background: Rapid correct diagnosis and treatment is the key point in breast cancer control worldwide. Screening decreases breast cancer mortality through detection of small non palpable lesions. Due to high cost, the need for enough imaging centers and radiologists actually it is not affordable for many health care systems in populated low resource countries.

Specialized Breast Unit is a cost effective program. While increasing the accuracy and the quality of care the total cost of diagnosis and treatment of breast disease is significantly decreased. More there is limitation of health budget more it is important to go through this program as an urgent act for breast cancer control according to international guidelines. In this study we try to show the actual problems of breast cancer in Iran and the efficacy of Specialized Breast Unit to solve them.

Material and Method: All published data about breast cancer in Iran are reviewed since 2001 to 2011 to list the problems. Then the workflow and outcome of our unit between 2003 to 2011 with total 52 114 visits are analyzed to show how does it help to solve these problems.

Results: Younger age of the patients, late presentation, delayed diagnosis and small number of non palpable lesions are the major features of breast cancer in Iran. Mastectomy and axillary dissection is the dominant approach. Cancer diagnosis is based on excisional/incisional biopsy or frozen section. Sentinel node biopsy, reconstruction and screening are offered in few centers.

Multidisciplinary team work in specialized breast unit provides rapid assessment of breast symptoms with correct pre-operative imaging. Trucut biopsy is done for all suspected palpable and non palpable lesions. This simple act has resulted in tailored surgery (conservative, mastectomy with or without immediate reconstruction) and sentinel node biopsy for all eligible cases and active participation of patients in treatment plan. All women are offered sporadic screening when indicated. Team work approach has decreased the number of visits and unnecessary surgeries.

Conclusion: Correct diagnosis and treatment of breast cancer as a life threatening disease is the duty of all health care systems regardless of their budget. If screening as the standard for early detection in asymptomatic women is considered as an option, **Specialized Breast Unit** is an obligation for correct diagnosis and treatment of both symptomatic and asymptomatic breast cancers. It is cost effective and helps to shift from dominant Halstead concept through international standards even in low resource countries. Without these referral units no attempt can be done for breast awareness programs, training and further screening.

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Poster

Radial Scar and Its Association with Malignancy: Retrospective Audit

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Background: Radial scar/complex sclerosing lesions (RS/CSL) arise in the breast tissue without any previous trauma/surgery. They are not 'scars' in

the true sense and the likely cause is either localised inflammatory reaction or ischaemia of the breast tissue. The incidence rate of radial scar has gone up significantly due to screening programme.

The reported prevalence in the screening programme is between 0.1 and 2.0 per 1000 mammograms.

We reviewed cases of RS/CSL treated in our hospital over a period of five years (2004–2009) in this retrospective audit.

Materials and Methods: We included all patients diagnosed with radial scar (on triple assessment) that had core biopsy followed by excision biopsy in this audit.

The case notes were obtained and studied for clinical, radiological and pathology details such as palpable abnormalities, mammographic and ultrasound appearance, micro calcification, size of the lesion on radiology and final pathology, and type of associated cancer. Correlation was made with Ultrasound, Mammography, core biopsy findings and final histology.

Results: 73 case notes were made available for the audit (59 screen detected, 14 symptomatic clinic).

27 (37%) patients had associated palpable abnormality (nodularity, lump, tenderness, thickening) on clinical examination.

The mammographic abnormalities reported were typically distortion of architecture (DOA: 57/73) or opacity (10/73). Six patients had associated microcalcification with DOA. Average size of the lesion on radiology was 14.6 mm.

R-Score analysis (R score refers to mammographic score: ranging from 1 to 5): Mean = 3.63, standard error = 0.1, Standard deviation = 0.81, Median = 4.00.

U Score analysis: (This is similar scoring to R score from 1 to 5) on Ultrasound. Mean = 3.39, standard error = 0.12, Standard deviation = 1.00, Median = 3.00.

All patients had Ultrasound/stereo wire guided excision biopsy. Final histology confirmed that 17/73 (23.2%) had associated ductal carcinoma in situ (DCIS) and/or invasive cancer (DCIS in 10/73 cases, tubular carcinoma 4/73 cases, 1/73 Invasive carcinoma grade 1, and two cases of DCIS with invasive and tubular carcinoma).

The invasive carcinoma associated was tubular variety or low grade (grade 1) cancer.

Four patients had lobular carcinoma in situ (LCIS) and one patient had small focus of atypical lobular hyperplasia.

There was no significant association between clinical abnormality, size of the scar or mammographic appearance and DCIS/invasive cancer.

Conclusion: In this series, 23.2% of cases with radial scar had associated DCIS or invasive cancer.

There was no significant correlation between clinically palpable abnormality, size of the radial scar or mammographic appearance and association with DCIS or Invasive cancer.

The associated invasive cancer with radial scar is low grade, mainly tubular cancer.

Based on these findings, those with a finding of radial scar should be advised to undergo excision due to the risk of associated disease.

Wednesday, 21 March 2012

12:00–13:15

POSTER SESSION

Pathology

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Poster

The Clinical Features and Prognosis of Tubular Breast Cancer

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Background: Compare the clinical features and prognosis of Tubular Breast Cancer with the rest of Breast Cancer Grade I.

Materials and Methods: Analyzed all Tubular breast cancer studied in Breast Diseases Committee during the period 1990–2009, comparing the clinical features and prognosis of Tubular breast cancer with the rest of breast cancer grade I, the free disease survival were analyzed with Kaplan Meier curves.

Results: Studied 170 cases, 41 (24.1%) Tubular Breast Cancer and 129 (75.9%) the rest of Breast Cancer Grade I. No differences in the average age of patients with Tubular Breast Cancer and Breast Cancer Grade I. (51.9 versus 52.7), family history, parity, fertility treatment, nulliparous, menopausal status, tumour size, and hormonal receptors. HER2 receptors are more frequent in Breast Cancer Grade I. Two cases of Tubular Breast Cancer (4.8%) less than 15 mm have nodal involvement. In Tubular