Conclusion. This international survey shows the ambiguity in axillary treatment of patients with clinically negative/sentinel node positive patients worldwide. Hopefully, both future trials and trials which are currently being conducted will lead to more international consensus on the optimal axillary treatment regimens in these patients.
Conflict of interest: No conflict of interest.

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COMPLETE PATHOLOGIC RESPONSE RECTAL CANCERS (CORSICA) EYSAC.1 STUDY

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Background. About 20% of rectal cancers who underwent neoadjuvant treatment achieve a pathological complete response in the surgical specimen (ypT0); however, about 10% of ypT0 present metastatic nodes (ypN+).
Material and methods. This international, retrospective, multicentre cohort study officially launched on December 2017 as a worldwide call, included all consecutive rectal cancers treated from 2012 to 2017 with total mesorectal (TME) or local excisions (LE) with a pathological diagnosis consistent with ypT0, independently from N status. Each center participated with a junior and a senior investigator. Patients were excluded from data analysis if follow-up was missing or less than 3 months or if presenting peri-operative mortality (Clavien 5). Outcome measures included overall (OS), disease free (DFS) and disease specific (DSS) survivals. This study was registered on ClinicalTrials.gov, number NCT03351959.
Results. Some 729 ypT0 rectal cancers from 45 European, Australian and South American centers were registered for the retrospective evaluation. 674 ypT0 patients were eligible for data analysis: 95% treated with TME and about 5% treated with LE. Among those who underwent TME, 7% were ypN+. Mean follow-up was of 31.0 months (median 26.0 months). About 58% of the patients did not complete post-operative adjuvant treatments. 46 patients (6.8%) experienced a relapse (37% local and 63% at a distant site). Mean time to relapse was of 21.1 months (media 17.5 months). Kaplan Meier survival curves comparing patients treated with LE vs TME did not document differences of statistical value for OS, DFS, DSS outcomes (Log rank test respectively p 0.7, p 0.92 and p 0.39). Opposite when survivals of patients who underwent TME were analyzed according to the nodal status, significant worse OS, DFS and DSS were documented in the ypN+ subgroup (Log rank test respectively p 0.007, p 0.05 and p 0.02).
Conclusion. Persistence of nodal metastasis in the surgical specimen is a worse prognostic factor also in ypT0 rectal cancers. However, also survivals curves following LE provided homogeneous results comparing TME. These findings support the conclusion that organ preservation with LE is a feasible and safe option for rectal cancers who underwent complete response, given the identification of factors predicting the absence of nodal metastases in the surgical specimen.
Conflict of interest: No conflict of interest.

Scientific Symposium
Tissue Regenerative Surgery and Oncological Safety of Fat Grafting

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REOPERATIONS DUE TO INADEQUATE SURGICAL MARGINS AND RISK OF LOCAL RECURRENCE IN BREAST CANCER: COMPARISON BETWEEN CONVENTIONAL AND ONCOPLASTIC BREAST CONSERVING SURGERY

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Background: This retrospective cohort study aims to evaluate insufficient surgical margins, re-operations and local recurrences after conventional or oncoplastic breast conserving surgery (BCS).
Material and methods: We reviewed 1805 consecutive patients with invasive breast cancer (N = 1712) or ductal carcinoma in situ (N = 93) who underwent BCS at our center between January 2010 and December 2012. The patients were categorized into two groups, conventional or oncoplastic BCS. Multiple oncoplastic techniques were used: racket mammoplasty (N = 184), round block (N = 171), rotation mammoplasty (N = 116), superior pedicle mammoplasty (N = 41), inferior pedicle mammoplasty (N = 10), S-mammoplasty (N = 21), J-mammoplasty (N = 20), wise-amputation (N = 7), mastopexy (N = 26) and batwing mammoplasty (N = 17).
Results: Conventional BCS was performed in 1192 patients (66.0%) and oncoplastic BCS in 617 (34.0%). Patients with oncoplastic BCS had more often multifocal ($p < 0.001$) and larger tumors ($p < 0.001$) with larger resection specimens ($p < 0.001$). The amount of resected tissue varied substantially depending on the oncoplastic technique. Patients treated with oncoplastic BCS were slightly younger ($p < 0.001$) and their tumors were more aggressive according to histological grade ($p < 0.001$) and lymph node status ($p < 0.001$). There was no difference in surgical margins ($p = 0.671$) or reoperation rates ($p = 0.471$), however. After oncoplastic BCS, reoperation was more often mastectomy (69.6%) compared to conventional BCS group (54.6%) but there was no statistically significant difference ($p = 0.068$). There was no difference in local recurrences ($p = 0.174$) or in overall survival ($p = 0.073$) during a median follow-up time of 74 months.
Conclusions: Oncoplastic BCS was used for larger, multifocal and more

		Conventional BCS N = 1192	Oncoplastic BCS N = 613	*p-value*
		Count (%)	*Count (%)*	
Tumor	Impalpable	750 (62.9%)	256 (41.8%)	<0.001
	Palpable	442 (37.1%)	357 (58.2%)	
Reoperation due to inadequate margins	No	1095 (91.9%)	557 (90.9%)	0.471
	Yes	97 (8.1%)	56 (9.1%)	
Reoperation	Re-excision	44 (45.4%)	17 (30.4%)	0.068
	Mastectomy	53 (54.6%)	39 (69.6%)	
Multifocal breast tumor	No	1068 (89.6%)	513 (83.7%)	<0.001
	Yes	124 (10.4%)	100 (16.3%)	
Histological grade	1	417 (35.0%)	176 (28.8%)	<0.001
	2	500 (42.0%)	238 (38.9%)	
	3	274 (23.0%)	198 (32.4%)	
Lymph node status	pN0i- or pN0i+	894 (75.0%)	416 (67.9%)	<0.001
	pN1mic	85 (7.1%)	36 (5.9%)	
	pN1-	213 (17.9%)	161 (26.3%)	
		Mean (SD)	*Mean (SD)*	
Age (years)		62 (9.85)	60 (9.47)	<0.001
Tumor size (mm)		13 (7.42)	18 (9.22)	<0.001
Specimen weight (g)		69 (48.74)	152 (235.45)	<0.001
Smallest lateral surgical margin (mm)		10.5 (5.98)	10.7 (7.27)	0.671