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DOES LYMPHOVASCULAR INVASION AFFECTS THE OUTCOME OF AXILLA DOWN STAGING IN NODE POSITIVE OPERABLE INVASIVE BREAST CANCER?

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Background: The role of surgery for node positive early breast cancer treatment became a dynamic process and is changing by time. The neoadjuvant chemotherapy (NAC) is regarded as part of the standard management of node positive early breast invasive carcinoma. The NAC potentially result in complete pathological response of the axillary diseases as well as the primary breast cancer. Many approaches has been suggested to deal with the axilla after NAC. One of the suggestions is to avoid unnecessary axillary surgery and decrease the morbidity associated with axillary node clearance (ANC). In patients with early invasive breast cancers suitable for neoadjuvant chemotherapy and surgery, a number of prognostic indicators have been investigated. The identification of a such prognostic factors and parameters predictive of responsiveness to specific treatment modalities represents a major challenge in breast cancer management. Inflammatory breast cancer, is known as the most aggressive form of breast cancer, is characterized by extensive lymphovascular invasion and poor prognosis. LVI shows a close relationship with poor prognostic indicators as tumour histological grade, and lymph nodes involvement. The question here is – presence of lympho-vascular invasion in node positive early breast cancer affects the outcome of axillary disease down staging the axilla after NAC?

Material and methods: A single institutional retrospective database review identified 54 patients with operable node positive early breast cancer. The node status has been confirmed by core biopsy or radio-colloid assisted sentinel lymph node biopsy. All underwent NAC in addition to trastuzumab if they are Her-2 positive. Subsequently they had therapeutic breast surgery (mastectomy or breast conservative surgery) as well as axillary node clearance (ANC). Post-operative patho-morphological analysis of the removed breast and axillary tissue has been performed.

Results: The age of study ranges between 32–72 years of age. The subgroup aged between 41–50 years formed the majority of cases (55%). All the 54 patients had a positive nodal disease prior to NAC, this has been confirmed in the core biopsy or sentinel lymph node biopsy. The lymphovascular invasion was detected in 72%. Complete pathological response seen in only 27% of the study group in total, all those patients are LVI negative. Incomplete response was seen in 72%, 40% of patients are LVI positive with incomplete response, where 30% are LVI negative with incomplete response.

Conclusion: After NAC, the nodal pathological response of the node positive disease early breast cancer is slightly superior in LVI negative patients. Complete pathological response in LVI positive patients was absent in our study group. However, the study is limited with the small sample

Conflict of interest: No conflict of interest.

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EXPERIENCE OF THE BREAST RECONSTRUCTION WITH LATISSIMUS DORSI FLAP

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Background: Analysis of the aesthetic results and complications rate after breast reconstruction using the latissimus dorsi (LD) flap.

Material and methods: The study was conducted in "Petrov's National Medical Research Center of Oncology" in the breast tumors department for the period 2016–2017. A feature of the breast reconstruction using the LD-flap was cutting of the muscles on anterior-axillary line, prior to closure of the breast tissue defect, but retaining thoracodorsal vascular bundle. Surgical treatment was performed to 83 patients with breast cancer,

including patients after neoadjuvant therapy.

Results: Immediate reconstruction with breast conserving surgery was performed in 12 (14.5%) patients, with mastectomy in 7 (8.4%), with mastectomy and implant-based reconstruction in 40 (48.2%) patients. Delayed reconstruction of the breast: the LD-flap in combination with implant-based reconstruction – 19 (22.9%); the LD-flap without an implant – 5 (6.0%) patients. Complications were observed in 8 (9.6%) patients.

Postoperative complications were observed in 16 (23%) patients, lymphorrhea – 10 (14%), hematoma of the postoperative region of the back – 1 (1.4%), LD – flap necrosis – 1 (1.4%) (patient had bullous epidermolysis bullosa; there was no vascular thrombosis), necrosis of skin flaps after mastectomy – 3 (4.4%) (after RT, without loss of implants), divergence of the edges of the back wound – 1 (1.4%) (against febrile neutropenia after chemotherapy). A higher incidence of complications was noted in the implant reconstruction group. In comparison with other types of operations, the number of complications was not higher than the average indicators for this pathology.

Conclusion: Reconstruction of the breast using the LD-flap is the method of choice and priority for patients who underwent radiation therapy, with a lack of own tissues to cover the implant. LD-flap is a "good" plastic material and it can be used for patients with breast defect after breast conserving surgery and mastectomy. The LD-flap breast reconstruction is characterized by low complications rates. The use of LD-flap does not worsen the rehabilitation of patients and does not shift the timing of adjuvant treatment.

Conflict of interest: No conflict of interest.

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NIPPLE SPARING MASTECTOMY IN BREAST CANCER: EXTENDED INDICATIONS. THE MIDDLE EAST INSTITUTE OF HEALTH EXPERIENCE

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Introduction: Nipple-sparing mastectomy (NSM) is offered as a surgical treatment for breast cancer. It preserves the skin overlying the breast and the nipple areola complex. In this study, we review our experience with NSM, performed for both early and advanced breast cancer patients.

Materials and Methods: This is a retrospective study from October 2004 till December 2017. It evaluates the outcomes of 187 patients who underwent 243 NSMs with both immediate and delayed prosthetic breast reconstruction. Sentinel lymph node biopsy was performed for 162 patients. The oncologic and cosmetic outcomes are presented.

Results: In our study group, 187 patients had 243 NSMs; 55 patients had bilateral and 133 had unilateral procedures. 90 patients had invasive breast cancer (locally advanced: 32); (Ductal carcinoma in situ (DCIS): 65). 11 patients had a history of breast cancer (invasive: 6; DCIS: 5) and presented with diffuse microcalcifications (5), atypical ductal hyperplasia (5) and typical ductal hyperplasia (1); 8 patients had a history of previous mastectomy; 12 patients were BRCA-1 positive. Sentinel lymph node was positive in 39 patients; 17/58 patients with invasive cancer, 2/65 patients with DCIS, 20/32 patients with locally advanced breast cancer (LABC) post neoadjuvant chemotherapy. They received axillary dissection. 52 patients received adjuvant chemotherapy, radiation, or both for their first breast cancer 2 to 7 years before their NSM (radiation to ipsilateral or contralateral breast: 10) post NSM, 14 patients received radiation therapy, 32 patients received adjuvant chemotherapy. The average tumor size; invasive cancer: 1.8 +/- 0.6 cm and locally advanced breast cancer: 4.5 +/- 1.7 cm. The age range was 22–81 years. Local recurrence: 4 patients, 11 patients had distant metastases.

Complications: 29 patients had wound infection and/or partial nipple necrosis that recovered on conservative therapy; nipple-areola complex necrosis with removal of the prosthesis: 12; contracture of the capsule: 4. Three patients had a positive retroareolar biopsy and NAC was removed. No patient had a breast implant associated -anaplastic large cell lymphoma