

23. LONG-TERM OUTCOMES OF BILATERAL THERAPEUTIC MAMMOPLASTY - CLINICAL CHARACTERISTICS AND QUALITY OF LIFE

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Introduction: Therapeutic mastopexy is the use of breast reduction techniques and radiotherapy to treat breast cancer. We have been performing therapeutic mastopexies and simultaneous contralateral reductions at the Edinburgh Breast Unit (EBU), and would like to share our indications, approach and technical refinements.

Methods: A database of all breast cancer patients at EBU from 2007–2017 was analysed. Case note analysis was performed for all patients who underwent therapeutic mastopexy and simultaneous contralateral reductions. BREAST-Q has been used to assess quality of life.

Results: 104 patients underwent therapeutic mastopexy and simultaneous contralateral reductions. All were discussed at the breast multidisciplinary team meeting, and deemed to have large breasts suitable for this technique. Oncological incomplete excision rate was 3% (n=3); local recurrence rate at 5 years was 3% (n=3) and 8% (n=8) developed cancer metastasis. On the cancer side, a variety of pedicles were used to reconstruct the volume deficit following cancer resection (a single pedicle [superior/superomedial/inferior/lateral], extended pedicle or a combination of a single and secondary pedicle). A simple algorithm will be presented. On the non-cancer side, all patients received wise pattern superomedial pedicle reductions (regardless of the pedicle used on the cancer side). 3% (n=3) subsequently requested revision surgery (2 scar revisions, 1 lipomodelling) to improve cosmesis.

Conclusion: Therapeutic mastopexy and simultaneous contralateral reduction is a suitable surgical option in select patients, with good oncological safety profile and favourable cosmesis. We hereby share our 10-year experience including PROMS.

24. WHAT'S BEST? TEAM-APPROACH BREAST CARE NURSING VERSUS 1-1 BREAST CARE NURSING – YOU DECIDE!

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National guidelines state that all breast cancer patients must have a keyworker but does not stipulate how this should be carried out. The theory behind the keyworker strategy is that communication will be improved and patients can build a relationship with that particular member of staff but what happens when this member of staff is away?

For this reason our Trust has implemented a team approach to breast care nursing but this approach has been challenged when we are assessed for quality assurance in relation to a perceived lack of continuity and a possible negative affect on patient care.

We therefore decided to ask patients to complete a patient questionnaire asking them about their opinion on whether they would prefer to have one keyworker or a team of keyworkers with the intention of reviewing practice if patients indicated it was necessary. Interestingly the majority of patients stated that they had no preference.

The breast care nursing team have robust systems in place to ensure excellent levels of communication and documentation and the team approach has enabled developments which have greatly improved patient care. It has also allowed patients to speak to a breast clinical nurse specialist at the time that they have the concern or question which in turn decreases their anxiety and actually helps build a rapport. The benefits and disadvantages for both methods of care will be discussed with the intention of commencing a thought-provoking debate which will lead to changes in practice.

25. THIS ABSTRACT HAS BEEN WITHDRAWN

26. SURGICAL MANAGEMENT OF DCIS DURING THE SLOANE PROJECT

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Introduction: The Sloane Project is a prospective cohort study, including 50% of UK screen detected DCIS (2003–2012).

Methods: Trends in type of breast surgery were compared with DCIS radiology, pathology and breast size.

Results: Of 10071 patients with complete data undergoing surgical excision, 2194 (21.8%) underwent mastectomy, of whom 1499 (68.3%) had simple mastectomy. Among 7877 undergoing breast conserving surgery (BCS), 83 (1%) had therapeutic mastopexy (TM). The 4:1 BCS:mastectomy ratio remained consistent over time.

Over the decade, DCIS excised at BCS was 19.3mm (mean), at TM was 32.4mm and at mastectomy was 39.8mm. The rates of simple mastectomy decreased from 76.5% to 64.7% while there was a small increase in TMS (from 0.2% (2 patients) [2003–4] to 2% (18 patients) [2011–12]).

There was a statistically (but small [8%] clinically) significant difference in mean breast volume for BCS compared to mastectomy patients (1068ml vs 988ml respectively, p<0.0001). Mean breast volume (determined from mammography measurements) increased by 16% over the 9 years (from 1005ml to 1166ml). Size of DCIS excised increased year on year from mean 21.4mm to 24.1mm. Despite increasing breast volume, extent of the DCIS excised by WLE remained constant over time while size of DCIS excised at mastectomy increased from 36.5mm to 45.6mm.

Conclusion: Breast size and pathological size of screen detected DCIS both increased between 2003 and 2012, but BCS rates remained constant. Interestingly breast size had no apparent influence on type of surgery, although the decrease in simple mastectomy suggests breast reconstruction increased over time.

27. MULTIFOCALITY IN BRCA-ASSOCIATED BREAST CANCER: A CROSS-SECTIONAL ANALYSIS

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Introduction: Multifocal breast cancer (BC) is reported in around 10% of BCs, although previous studies have not specifically addressed its incidence in BRCA mutation carriers. We hypothesised that multifocal disease may be more common in these patients, due to genomic instability resulting in widespread field changes within breast tissue. This study set out to investigate prevalence of multifocality in BRCA-association BC in Northern Ireland.

Methods: Clinical and pathological data was retrospectively collected from 211 women with BRCA-associated BC diagnosed over a 20 year period, following approval by the Trust Audit Department. Differences in tumour characteristics were explored using Chi-squared and t-tests; odd ratios for multifocality were calculated using logistic regression analysis.

Results: 43% of women had BRCA1 and 57% BRCA2 mutations. Mean age at diagnosis was 45 years. Overall prevalence of multifocality was 25% but prevalence amongst BRCA2 carriers was over double that of BRCA1 carriers.

		BRCA status	
		BRCA1 N (%)	BRCA2 N (%)
Tumour focality	Multifocal	12 (13.3)	40 (33.1)
	Unifocal	78 (86.7)	81 (66.9)