Principles of Breast Surgery
Oncoplastic Surgery

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Conflict of Interest Disclosure

• No financial relationships to disclose
Locorregional therapy for early breast cancer

- Conservative (BCT) vs Mastectomy
- Oncoplastic Surgery
- Delayed Reconstruction vs Immediate Reconstruction
- Total mastectomy vs Skin Sparing Mastectomy
- Surgery after primary systemic treatment (PST)
- Sentinel Node vs Axillary dissection
- Conservative (BCT) vs Mastectomy

- Breast cancer screening programs

- Increase mass awareness

- Patients with earlier stages presenting to clinic

- Better psycho-social Adjustment

- Better Quality of life
Conservative (BCT) vs Mastectomy

MRM vs BCT
Randomized trials
Meta-analysis

Comparable local control, Overall survival

Better cosmetic outcome
Conservative (BCT) vs Mastectomy

Fisher B. et al. (2002).
“Twenty-year follow-up of a randomized trial comparing total mastectomy, lumpectomy and lumpectomy plus irradiation for the treatment of invasive breast cancer.”

Veronesi U. et al. (2002).
“Twenty-year follow-up of a randomized study comparing breast-conserving surgery with radical mastectomy for early breast cancer.”

…..as long as a good aesthetic outcome is obtained
Conservative (BCT) vs Mastectomy

Still 30% of fair/poor results

### Conservative (BCT) vs Mastectomy

**Effect of Breast Conservation Therapy vs Mastectomy on Disease-Specific Survival for Early-Stage Breast Cancer**

Shailesh Agarwal, MD; Lisa Pappas, MS; Leigh Neumayer, MD; Kristine Kokeny, MD; Jayant Agarwal, MD

<table>
<thead>
<tr>
<th></th>
<th>BCT</th>
<th>Mastectomy</th>
<th>Mastectomy+RT</th>
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**CONCLUSIONS AND RELEVANCE** Patients who underwent BCT have a higher breast cancer-specific survival rate compared with those treated with mastectomy alone or mastectomy with radiation for early-stage invasive ductal carcinoma. Further investigation is warranted to understand what may be contributing to this effect.
Conservative (BCT) vs Mastectomy

http://medicalresearch.inescporto.pt/breastresearch

Towards an intelligent medical system for the aesthetic evaluation of breast cancer conservative treatment. Cardoso JS1, Cardoso MJ.
Conservative (BCT) vs Mastectomy

Contra-indications for BCT

In aggregate, in the following clinical situations the increased risk of breast relapse should be extensively discussed with the patient and breast conservation should be executed with caution:

- very young woman (<35 years),
- the presence of extensive DCIS (heralded by extensive microcalcifications) mounting up to one quarter of the breast,
- more than focally incomplete resection of an invasive or in situ cancer,
- and in the case that radiotherapy cannot be given.

In all other clinical situations breast conservation is a safe option, provided complete resections are achieved and good cosmetic outcome is secured.

Who should not undergo breast conservation?
Nijenhuis MV1, Rutgers EJ.

Curr Treat Options Oncol. 2015 Apr;16(4):16.
Breast cancer under age 40: a different approach.
Ribnikar D1, Ribeiro JM, Pinto D, Sousa B, Pinto AC, Gomes E, Moser EC, Cardoso MJ, Cardoso F.
**Conservative (BCT) vs Mastectomy**

Margins

The association of surgical margins and local recurrence in women with early-stage invasive breast cancer treated with breast-conserving therapy: a meta-analysis.
Houssami N1, Macaskill P, Marinovich ML, Morrow M.

Society of Surgical Oncology-American Society for Radiation Oncology consensus guideline on margins for breast-conserving surgery with whole-breast irradiation in stages I and II invasive breast cancer.
Ann Surg Oncol. 2014 Mar;21(3):704-16
J Clin Oncol. 2014 Feb 10
Conservative (BCT) vs Mastectomy

1. Positive margins
   A positive margin, defined as ink on invasive cancer or ductal carcinoma in situ (DCIS), is associated with at least a 2-fold increase in IBTR. This increased risk in IBTR is not nullified by:
   
   a) Delivery of a boost dose of radiation
   
   b) Delivery of systemic therapy (endocrine therapy, chemotherapy, or biologic therapy), or
   
   c) Favorable biology

2. Negative margin widths
   Negative margins (no ink on tumor) minimize the risk of IBTR. Wider margin widths do not significantly lower this risk. The routine practice to obtain negative margin widths wider than no ink on tumor is not indicated.

3. Systemic therapy
   The rates of IBTR are reduced with the use of systemic therapy. In the uncommon circumstance of a patient not receiving adjuvant systemic therapy, there is no evidence suggesting that margins wider than no ink on tumor are needed.

4. Biologic subtypes
   Margins wider than no ink on tumor are not indicated based on biologic subtype.
5. Radiation therapy delivery
The choice of WBRT delivery technique, fractionation, and boost dose should not be dependent on margin width.

6. Invasive lobular carcinoma and lobular carcinoma in situ
Wider negative margins than no ink on tumor are not indicated for invasive lobular carcinoma (ILC). Classic lobular carcinoma in situ (LCIS) at the margin is not an indication for re-excision. The significance of pleomorphic LCIS at the margin is uncertain.

7. Young age
Young age (≤40 years) is associated with both increased IBTR after BCT as well as increased local relapse on the chest wall after mastectomy, and is also more frequently associated with adverse biologic and pathologic features. There is no evidence that increased margin width nullifies the increased risk of IBTR in young patients.

8. Lobular carcinoma in situ
A lobular carcinoma in situ (EIC) identifies patients who may have a large residual DCIS burden after lumpectomy. There is no evidence of an association between increased risk of IBTR and EIC when margins are negative.
Conservative (BCT) vs Mastectomy

The margin status of invasive carcinoma did not influence IBTR, DM rate, or OS. Between 1980 and 2008, locoregional control after BCT remained stable with low IBTR rates, even in young patients.


Very low local recurrence rates after breast-conserving therapy: analysis of 8485 patients treated over a 28-year period.

- Conservative (BCT) vs Mastectomy

Still 30% of fair/poor results

Can we improve those results
Oncoplastic Surgery

When a resection of more than 20% of breast volume is planned, oncoplastic techniques are recommended and can prevent major deformities.

Oncoplastic Surgery

Oncoplastic surgery is **tumor specific immediate breast reconstruction**.

It represents the **integration of plastic surgery techniques into breast cancer surgery** in order to preserve aesthetical outcomes and quality of life of the patients, without compromising local control of disease.

It is based on three surgical principles: **ideal breast cancer surgery with free tumour margins, immediate breast reconstruction, and immediate symmetry with the other breast**.

Although the **word was originally coined by Werner Audrescht** in Germany in the 1990’s, plastic surgery techniques were transposed into breast-conserving therapy to avoid late unsatisfactory aesthetic results in the 1980’s France by Jean-Yves Petit (Institut Goustave- Roussy), Jean-Yves Bobin (Centre Leon-Berard) and Michel Abbes (Centre Lassagne).
Oncoplastic Surgery

Concept background

- At the beginning limited to conservative surgery
- Correction of previous defects
- Use of aesthetic concepts in cancer
Oncoplastic Surgery

Concept evolution

- correct oncological surgery
- local reconstruction to correct excision defects
- immediate or delayed reconstruction with access to all techniques
- asymmetry correction on both sides

Oncoplastic breast surgery--a guide to good practice.
On behalf of BASO, BAPRAS and TIGBS
Oncoplastic Surgery

Although oncoplastic surgery is considered to be a major technical improvement it is associated with larger scars, increased complications and an increasing need for contralateral breast surgery.
Viewpoints and Debate

Training in oncoplastic surgery: An international consensus. The 7th Portuguese Senology congress, Vilamoura, 2009

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The Breast xxx (2010) 1–3

Contents lists available at ScienceDirect

The Breast

journal homepage: www.elsevier.com/brst
- Oncoplastic Surgery

**Pros**
- Wider excisions - Better margins
- Less recurrences
- Overall better cosmetic outcomes

**Cons**
- Trained teams
- Higher cost
- Higher complication rate
- Possible delay of adjuvant treatments

Which technique to use for each case?
Oncoplastic Surgery

http://www.vph-picture.eu/
Oncoplastic Surgery

TABLE 1. Articles Included in Systematic Review

<table>
<thead>
<tr>
<th>Reference</th>
<th>Year</th>
<th>Patients/Cases</th>
<th>Mean/Median Follow-up, mo</th>
<th>Oncologic Outcomes Described</th>
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<td>Denewer et al24</td>
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Outcomes Following Oncoplastic Reduction Mammoplasty: A Systematic Review.
Piper ML, Esserman LJ, Sbitany H, Peled AW.
Ann Plast Surg. 2016 May;76 Suppl 3:S222
Reside Oncoplastic Surgery

<table>
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<tr>
<th>Reference</th>
<th>Patients/Cases</th>
<th>Mean/Median Follow-up, mo</th>
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*Studies that utilized intraoperative frozen section.

Outcomes Following Oncoplastic Reduction Mammoplasty: A Systematic Review.
Piper ML, Esserman LJ, Sbitany H, Peled AW.
Ann Plast Surg. 2016 May;76 Suppl 3:S222
Delayed Reconstruction vs Immediate Reconstruction

Is immediate autologous breast reconstruction with postoperative radiotherapy good practice?: a systematic review of the literature.
Schaverien MV, Macmillan RD, McCulley SJ.
Delayed Reconstruction vs Immediate Reconstruction
Delayed Reconstruction vs Immediate Reconstruction
- **Delayed Reconstruction vs Immediate Reconstruction**

- Reconstruction should be offered to all mastectomy patients and all techniques should be discussed even if not available locally.

- Immediate reconstruction can be performed in the majority of patients and does not reduce radiation efficacy.

- Patients who will probably need radiotherapy should be advised about the possibility of a poorer cosmetic outcome.
Total mastectomy vs Skin Sparing Mastectomy

Breast Reconstruction following Nipple-Sparing Mastectomy: Predictors of Complications, Reconstruction Outcomes, and 5-Year Trends.
Colwell AS, Tessler O, Lin AM et al.
Total mastectomy vs Skin Sparing Mastectomy
- Total mastectomy vs Skin Sparing Mastectomy
- Surgery after primary systemic treatment (PST)

.....without ever forgetting the importance of each discipline
Surgery after primary systemic treatment (PST)

- Primary systemic treatment (PST) is responsible for a greater percentage of BCT.

- All patients proposed to PST should have their tumor marked before initiating treatment.

- Candidates to PST are those whose tumor breast size ratio doesn’t allow conservative treatment with a favorable cosmetic outcome and those with locally advanced breast cancer (LABC).
- Surgery after primary systemic treatment (PST)
  - Initial work-up of locorregional disease
  - Monitoring response to treatment
  - Axillary approach
  - BCS after treatment
  - Reconstructive surgery
Surgery after primary systemic treatment (PST)

Pre-treatment work-up

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Meta-analysis of Magnetic Resonance Imaging in Detecting Residual Breast Cancer After Neoadjuvant Therapy.
- Surgery after primary systemic treatment (PST)

Tattooing
- Surgery after primary systemic treatment (PST)
- Surgery after primary systemic treatment (PST)
Surgery after primary systemic treatment (PST)

Surgery after primary systemic treatment (PST)

- For patients with operable BC who are candidates for PST, ultrasound of the axilla and FNA/CB of suspicious lymph nodes should be considered as part of the staging workup.
- SNB before PST does not offer particular clinical advantages and reduces the number of patients who could benefit from the down-staging effect of PST in the axillary nodes.
- SNB after PST is feasible and accurate with similar performance to SNB before PST (bigger samples). Neo-adjuvant protocol.
- By performing SNB after PST, up to 40 percent of patients who present with minimal involvement of axillary nodes may be spared from axillary dissection.
- Caution is however required for patients who present with clinically (or pathologically) involved nodes before PST (until further results of prospective trials are obtained).
Sentinel Node vs Axillary dissection

Sentinel node biopsy is actually considered standard of care in patients with clinically and ultrasound negative axillae

Sentinel Node vs Axillary dissection

Recommendations

- **Recommendation 1**: Clinicians should not recommend axillary lymph node dissection (ALND) for women with early-stage breast cancer who do not have nodal metastases. Type: evidence based; benefits outweigh harms. Evidence quality: high. Strength of recommendation: strong.

- **Recommendation 2.1**: Clinicians should not recommend ALND for women with early-stage breast cancer who have one or two sentinel lymph node metastases and will receive breast-conserving surgery (BCS) with conventionally fractionated whole-breast radiotherapy. Type: evidence based; benefits outweigh harms. Evidence quality: high. Strength of recommendation: strong.

- **Recommendation 2.2**: Clinicians may offer ALND for women with early-stage breast cancer with nodal metastases found on SNB who will receive mastectomy. Type: evidence based; benefits outweigh harms. Evidence quality: low. Strength of recommendation: weak.

- **Recommendation 3**: Clinicians may offer SNB for women who have operable breast cancer who have the following circumstances:
  - DCIS/mastectomy
  - Prior breast/axillary surgery
  - PST

- **Recommendation 4**: There are insufficient data to change the 2005 recommendation that clinicians should not perform SNB for women who have early-stage breast cancer and are in the following circumstances:
  - LABC / Inflammatory
  - DCIS in BCS
  - Pregnancy