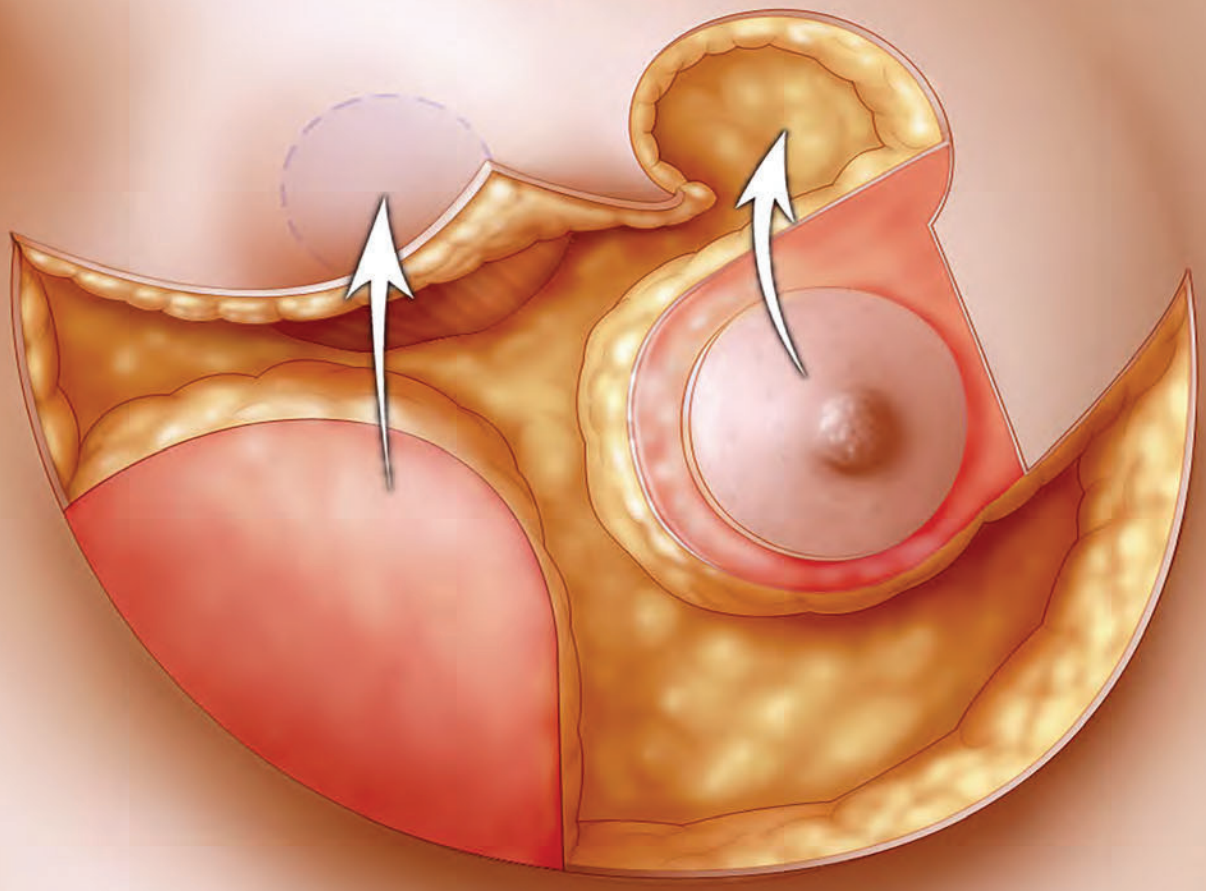
Partial Breast Reconstruction

Techniques in Oncoplastic Surgery

Second Edition



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34 Outcomes and Tumor Recurrence After Oncoplastic Surgery of the Breast: Eighteen-Year Follow-up

Cristina Garusi, Santos Soto

Oncoplastic surgery may allow more-extensive resections and good aesthetic outcomes in some patients, minimizing the deformity and expanding the indications for breast-conserving therapy (BCT).[1] Although numerous series have documented acceptable cosmetic outcomes using these techniques, the available data on local recurrence and distant metastasis following oncoplastic surgery are limited. Most series are small, with a relatively short follow-up.

In this chapter we first review our experience with 148 consecutive patients who underwent oncoplastic surgery consisting of BCT and concomitant bilateral plastic remodeling. We also present an updated follow-up of our cohort, 18 years after the original procedure. Local recurrence, metastases, and death rates are reported. Related complications and cosmetic outcomes are also discussed. All patients are reclassified according to the Revision of the American Joint Committee on Cancer staging system for breast cancer.[2]

SURGICAL APPROACH

The oncoplastic procedures were performed with the patients under general anesthesia. Using a two-team approach, oncologic and plastic surgeons worked on both breasts simultaneously.

The tumor resection included at least 1 cm of macroscopically safe margin.

If the lesion was close to the resection margins, further resection was performed. The deep and superficial surfaces of the remaining breast tissue were evaluated bimanually for occult lesions.[3,4] The mammaplasty techniques used to reconstruct the involved breast were superior pedicle (Lejour or Pitanguy techniques), inferior pedicle, round block, latissimus dorsi, or definitive silicone implants.[5-7] The contralateral mammaplasty was performed concomitantly in all cases of this series, with a technique similar to that used in the breast with the tumor to achieve the best symmetry. A complete axillary dissection or sentinel node biopsy was performed in all clinically indicated cases, independent of the oncoplastic technique. When the sentinel node was positive after an extensive frozen section analysis, a complete axillary dissection was performed according to our previously described protocol.[8]

HISTOPATHOLOGIC EXAMINATION

Specimens were weighed and well oriented in the operating room to allow the pathologist to evaluate the margins grossly or microscopically to determine the need for further treatment and eventual reexcision. The volume of each specimen was calculated by multiplying the length, width, and height.[9] They were inked and formalin fixed, and paraffin-embedded sections were stained with hematoxylin and eosin for routine examination.

For consistency with the literature, we used a 2 mm surgical margin as the cutoff point for negative margins.

Positive margins were defined as those with tumor cells at the cut edge of the specimen. *Close margins* were defined as those with tumor cells between the cut edge of the specimen and the boundary defined as negative (less than or equal to 2 mm).