antibiotic prophylaxis (AP) in patients at risk of wound infection occurrence undergoing breast cancer surgery.

Material and Methods: In the setting of breast cancer surgery, we compared the incidence of WI in two prospective cohorts of patients, respectively followed before (September 1996-April 1997) and after (May-July 2004) implementation of a preventive strategy that consisted in: (i) identification of patients at risk of wound infection (i.e., previous chemotherapy and breast reconstruction) and (ii) administration of antibiotic prophylaxis (i.e., cefuroxime) in those patients. The incidences of WI in the two groups were compared with Fisher exact test. The impact of the strategy was analyzed using a logistic regression model after adjustment on potential confounding variables. Confounding variables were defined as those variables who had a significantly different distribution in the two periods and were statistically associated to the WI occurrence.

Results: WI incidence was estimated at 19/542 (3.5% [95% CI, 1.9–5.05]) before the implementation of the preventive strategy compared to 2/247 (0.8% [95% CI 0–1.8]) after the implementation of that strategy (Crude Odd Ratio 0.22 [95% CI 0.05–0.97], p = 0.03). We identified three potential confounding variables: breast reconstruction, previous breast surgery, and duration of surgical procedure. After adjustment for these variables in the multivariate analysis, the preventive strategy implemented decreased the risk of WI by 81% (adjusted Odd Ratio 0.19 [95% CI 0.04–0.85], p = 0.03).

Conclusion: The present study illustrates the benefit of an antibioprophylaxis strategy targeting those patients at high risk of WI occurrence in breast cancer surgery.

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Image guided histological core needle biopsy of palpable breast lesions are significantly more accurate than palpation guided biopsy

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A histological core needle biopsy of a palpable breast lesion can be performed under image or palpation guidance. Image guidance is more expensive and may require additional equipement and expertise. The purpose of this study was to determine differences in diagnostic performance of the histological core needle biopsy of a palpable breast lesion obtained by image guidance (stereotactic or ultrasonographic) or by palpation guidance.

Methods: A group of consecutive patients with a palpable breast lesion who underwent a histological core needle biopsy was studied retrospectively. Between January 1999 and July 2002, 239 women with 267 palpable breast lesions underwent a histological core needle biopsy. Weather image guidance by the radiologist or palpation guidance by the surgeon was performed depended on logistic reasons and the waiting list of the image guidance biopsy at the department of radiology. The biopsy was performed on palpation in 58 cases and by image guidance in 209 cases (ultrasonography in 167 cases and stereotactic in 42 cases). The results of the histology of the core needle biopsy were compared with the findings at excision (216), or 12 months follow-up (51).

Results: Patients and lesions were comparable besides lesion size. The mean size of the palpable breast lesions biopted by palpation was significant larger than those biopted by image guidance. However compared to palpation guidance, biopsy by image guidance showed a better sensitivity (0.69 vs. 0.91, p < 0.001). Specificity showed no significant difference. After stratification for tumour size this difference still existed. Sensitivity for palpation guidance vs. image guidance was 0.57 vs. 0.92 for T1 tumours (p = 0.003) and 0.75 vs. 0.95 for T2 tumours (p = 0.014). Specificity for palpation guidance vs. image guidance was 0.69 vs. 0.98 for T1 tumours and 1.00 vs.0.94 for T2 tumours (p = 0.02!).

Conclusion: Image-guided histological core needle breast biopsies are significantly more accurate than palpation-guided biopsies. The smaller lesion size in the image-guided biopsy group suggests that clinicians choose to biopsy the larger lesions themselves and to refer smaller lesions to the radiologist. This selection bias reinforces the conclusion that image-guided biopsy is more accurate than a biopsy which is palpation-guided. We think the physician is lured by the size of the breast lesion to perform a diagnostic procedure, which he believes to yield a reliable result.

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Preoperative ultrasonography may decrease incidence of false negative sentinel node biopsy in clinically node negative, large-sized breast carcinoma

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Introduction: Sentinel node biopsy (SLNB) has become a standard of care for clinically node negative breast carcinoma patients with small-sized primary tumors limited to 2–3 cm. (Veronesi et al, 2003), (Ung, 2004). Egyptian patients population comprises tumours with relatively larger size and a high percent of heavy nodal invasion. Large tumor size increases the incidence of non-sentinel node infilteration up to 71% in T3 tumors *(Gervasoni et al., 2000)*. SLNB may lose its sensitivity with heavy infiltration due to total replacement of nodal tissue by the tumour. Ultrasonic visualization is particularly sensitive in this setting *(Bonnema et al,1997)*. We evaluated the accuracy of surgeon-performed, B-mode imaging alone in predicting final nodal status. This work may be further developed to suggest a management plan that maximize accuracy and cost-effectiveness of ultrasonography and sentinel node biopsy in T3 tumors.

Patients and Methods: 110 patients with breast carcinoma were examined. Ultrasonic-imaging of the axilla was done using 10 mHz linear transducer.

The whole area from the apex of the axilla above to the sixth rib below was scanned. Any imaged node was studied as regard its size, its contour, its internal echo. When feasible needle aspiration of the most suspicious node was performed.

Results: 110 patients with invasive breast carcinoma were included. Tumour size was T**1** in twelve cases, T**2** in 32 cases, T**3** in 22 cases and T**x** in 44 patients.

Pathologically, 80 axillae were infilterated. Using ultrasonography, sensitivity raised to 85% compared with 40% of clinical palpation alone. Low lying nodes visualized in relation to third to sixth rib or in the vicinity of axillary tail were more predictive of metastases (specificity of 80% while sensitivity was still around 81%) than isolated apical nodes. Multiplicity of visualized nodes was detected in 42 cases of the 80 visualized, metastatic nodes. Echoic pattern of the node and node contour were poorly correlated with histological findings. Also, sensitivity and specificity of ultrasonic examination was markedly decreased in the subgroup of axillae with one to three lymph nodes infilteration (76.4%, 66.6% respectivly).

Conclusion: Preoperative ultrasonography for clinically node negative breast carcinoma may select cases for either SLNB or full axillary dissection in clinical situation where a false negative SLNB is highly anticipated.

Thursday, 23 March 2006 16:00–16:45

POSTER SESSION

Adjuvant and neo-adjuvant therapy

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Effectiveness of Vinorelbine/Capecitabine (NX) versus Docetaxel/Doxorubicin/Cyclophosphamide (TAC) in patients non-responding to 2 cycles of neoadjuvant TAC chemotherapy: First Results of the phase III GEPARTRIO-Study by the German Breast Group

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Background: Breast cancer patients (pts) with no response to 2 cycles of neoadjuvant TAC experience a low pathologic complete remission (pCR) rate after further 4 cycles TAC (von Minckwitz et al, Ann Oncol 2005). These pts were randomized to continuation of TAC or to a non-cross resistant combination of NX.

Patients and Methods: Pts with operable (T 2 cm by palpation) or locally advanced (T4 or N3, M0) breast cancer (BC) were treated with 2 cycles TAC (75 mg/m / 50 mg/m / 500 mg/m day 1, q21, supported with