best practice based on evidence of both clinical and cost effectiveness. The scope of both guidelines is very broad and, given the time and resources available, it will only be possible to cover about 30 topics within each guideline. This means that topics of a high priority (either clinical or economic) will have to be chosen. We believe that it is important that this choice should not be based solely on the opinions of the guideline development groups but should be informed by the views of clinicians and patients.

Methods: A list of 140 potential topics covering the whole scope of both guidelines was developed in consultation with expert clinicians. This was sent out in questionnaire form to relevant patient organisations and also to breast cancer advisory groups in 32 locality-based cancer 'networks' across England and Wales, which are responsible for the organisation and quality of care in their area. They were asked to rate each topic on the basis of its clinical and cost impact priority. The results were aggregated and scored to generate a prioritised list.

Results: Results of this survey and prioritisation will be available for presentation at the conference.

85 Poster

Occult primary breast cancer

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Introduction: 'Axillary lymphadenopathy without clinically palpable primary' is a rare clinical presentation of breast cancer. However, when a women presents with axillary lymphadenopathy as the only clinical sign, breast cancer is far more likely cause than others like lung cancer or lymphoma. A retrospective study was done at our centre and we reviewed the data of patients presenting with occult breast primary and axillary lymphadenopathy.

Materials and Methods: The unit database of last 30 years was searched and patients presenting with axillary lymphadenopathy alone, were identified. The clinical notes and investigation reports of these patients were studied in retrospect; data collected and analysed, and compared with available world literature.

Results: 21 patients were identified from the database of 9605 patients (incidence: 0.21%). 16 of these patients were postmenopausal and five were pre-menopausal. 13 patients presented with left and 8 presented with right axillary lymphadenopathy. One patient had opposite breast cancer treated 11 years back and one patient had adenocarcinoma cervix treated 2 years back.

2 primary tumours were found in ipsi-lateral breast on mammography and one primary tumour was identified on MRI. None of the 21 patients had systemic metastases on investigations at primary presentation.

8 patients had mastectomy as treatment and 8 patients had radiotherapy to the breast following axillary clearance. One patient had axillary clearance followed by tamoxifen only (due to medical condition), one patient had axillary clearance alone, one had axillary clearance followed by radiotherapy and chemotherapy (patient's choice), one had axillary clearance followed by chemotherapy (due to uncertain nature of histopathology) and one patient had axillary clearance and wide local excision and radiotherapy (primary tumour found on mammography).

20 patients had adenocarcinoma consistent with breast primary as their final histopathology and one patient had poorly differentiated metastastatic carcinoma of uncertain origin. Primary tumor was identified in 3/8 mastectomy specimens, who had negative radiology.

2 patients developed loco regional recurrence, one patient developed contra- lateral breast cancer, and one patient had renal cell cancer after 26years. 5 patients developed systemic metastases and died of disease, 6 died of old age and 10 are still alive and on follow up. The overall 5 years survival was76.47%.

Conclusion: Occult breast cancer presenting as axillary lymphadenopathy is a rare presentation. But breast cancer is the most common cause of metastatic axillary disease in women. There was preponderance in postmenopausal women in our study. Prognosis in this situation is good. New investigation modalities like PET and MR scan might help in the future to detect clinically occult primary breast cancer.

86 Poster

Prophylactic mastectomy in women at high breast cancer risk. Are pathology results convincing?

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Objective: To evaluate the indications, techniques and pathologic findings of prophylactic mastectomy (pME).

Patients and Methods: Retrospective case note study of women with a strong familial breast/ovarian cancer risk undergoing a bilateral or contralateral pME during a 10 years' period at the University Hospitals Leuven, Belgium.

Results: We identified sixty patients. Almost half (n = 29) were mutation carriers for BRCA1 (n = 10), BRCA2 (n = 18) or HNPCC (n = 1). Thirty-one others with a strong familial breast/ovarian cancer risk either tested negative for the mutated genes (n = 20) or were not tested (n = 17). Several women (n = 39) had a personal history of breast cancer; 15 already underwent a therapeutic mastectomy.

The median time to decision for pME was 44 months. Mean age at pME was 43 years (range 29–64 years). Histopathology of the pME specimen revealed an invasive breast cancer in 2 patients whereas lobular and ductal carcinoma in situ were present in respectively 12 and 9 women. Other proliferative lesions like atypical ductal and lobular hyperplasia (ADH and ALH) and flat epithelial atypia (FEA) were found in 6 patients. Considering these different (pre-) invasive lesions together, they were present (solely or together) in a total of 21 patients (35%).

Conclusion: In our case series of 60 women with a strong familial breast/ovarian cancer risk and normal surveillance for breast cancer, pME revealed intra-epithelial neoplasia in 35% of the patients. Whether this procedure will affect survival of breast cancer is unknown but our data are helpful when counselling high risk women.

87 Poster

Long-term registration of prophylactic mastectomy (PM) in BRCA1/2 mutation carriers and women at increased breast cancer (BC) risk due to a family history at a single institution

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Introduction: Women from a hereditary breast(/ovarian) cancer family (HB(O)C), especially BRCA1/2 mutation carriers, have a highly increased risk of developing BC. PM, being one of the available options in high-risk women, results in the greatest BC risk reduction. Long-term data on PM are scarse.

Methods: The findings concerning (bi-/contralateral) PM in 357 high-risk women (233 BRCA1/2-mutation carriers, 124 women from HB(O)C families so called 'non-carriers'), performed between January 1, 1994 and December 31, 2004, were prospectively collected. Relevant data, including dates of birth, death, and PM; occurrence of BC in relation to PM; mutation status and preoperative imaging examination results were extracted from the medical records. Results were analyzed separately for women without (unaffected, n = 178) and with (affected, n = 179) a history of BC at PM.

Results: The median follow-up after PM was 4.5 yrs. The unaffected group mainly consisted of BRCA1/2 mutation carriers (81%), while the percentage carriers/non-carriers in the affected group was 49%/51% ($p < 0.001$). The mean age at PM was 38 and 44 yrs for unaffected/affected women ($p < 0.001$). The mean age at PM for carriers/non-carriers in the unaffected group was 38 and 40 yrs, respectively ($p = 0.29$), while this was 43 and 46 yrs in the affected group ($p = 0.03$). Unexpected malignant changes were found in the PM specimens in 5 unaffected (3 DCIS, 2 invasive BC, 3%) and in the contralateral breast in 5 affected women (4 DCIS, 1 invasive BC, 3%). One woman in the unaffected, and 16 women in the affected group died of BC after PM. In one unaffected woman, distant metastases of BC were detected almost 4 yrs after PM, suggesting the presence of an occult BC at PM (not found). In the total group, no primary BCs occurred after PM.

Conclusions: Women identified as a mutation carrier opt for PM at an earlier age as compared to non-carriers, while the percentage of carriers/non-carriers choosing for PM is significantly different between women with and without a history of BC. Further, we found that the risk