The mean duration of pain in naproxen group was 17.4 months versus 25.8 months in placebo group.

The mean of pain severity was 5.8 and 6.1 in naproxen and placebo group respectively at the presentation (day 0) while it was reduced to 3.9 ($P = 0.005$) and 3.7 ($P < 0.0001$) at the end of the study respectively.

Although the decrease in pain severity in each individual group was statistically significant but It was not significant when two groups compared with each other ($P = 0.64$).

Conclusion: We found that naproxen has no superiority to placebo in reducing non cyclic mastalgia.

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Risk management practices of Australasian BRCA1 And BRCA2 mutation carriers

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Limited data exist on the utilization of risk-reducing surgery, chemoprevention and screening by BRCA1 and BRCA2 mutation carriers. This study prospectively evaluated utilization of breast and ovarian cancer risk management strategies in a cohort of mutations carriers. Data was obtained using a self-report questionnaire mailed to unaffected female mutation carriers on average 38 months after their enrollment in the Kathleen Cuningham Foundation Consortium for Research into Familial Breast Cancer (kConFab) breast cancer family cohort study. Proportions of women who utilized each risk management strategy and who were in the appropriate age group were calculated. Linear regression was used to identify factors associated with uptake of screening and risk-reducing surgery. Of 206 carriers, 155 responded (75%). Thirteen were excluded (6 developed cancer during follow-up, 7 participated in a trial mandating regular screening), leaving 142 mutation carriers, 49% of whom knew their mutation status. Since baseline, only one woman had used chemoprevention outside a clinical trial, 5% of women had bilateral mastectomy, 16% had bilateral oophorectomy (BO), 78% performed regular breast self-examination (BSE), and 59%, 69%, 28%, and 0% had at least annual clinical breast examination (CBE), mammography, transvaginal ultrasound and CA125 respectively. A further 10%, 8%, 56%, and 87% respectively reported never having had these tests. Uptake of risk-reducing surgery and screening was associated with knowing one's mutation status (for all behaviors except BSE), age (for BO and CBE) and residing in a major city (for mammography). In this Australasian cohort, the minority of mutation carriers utilized risk-reducing surgery or chemoprevention and a substantial minority were not undergoing regular breast and ovarian cancer screening tests.

Wednesday, 22 March 2006 16:00–16:45

POSTER SESSION

Surgical management

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A randomised clinical trial evaluating the role of prophylactic antibiotics in patients undergoing non-reconstructive breast surgery

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It has been suggested that the administration of prophylactic antibiotics may prevent wound infections in patients undergoing non-reconstructive breast surgery. We conducted a single-institution clinical trial evaluating the ability of a single dose of two grams of flucloxacillin, administered intravenously immediately after the induction of anaesthesia, to prevent wound infection when compared with no prophylaxis.

The study involved 618 patients who underwent local excision (n = 490), mastectomy (n = 107), and microdochectomy (n = 21). Of these, 312 patients had a hookwire inserted under either ultrasound or mammographic control; 129 patients had a sentinel node biopsy; and 254 patients had an axillary node clearance. The masked randomisation process was based on random numbers. Patients were monitored for 42 days after surgery by a research nurse. The primary endpoints were the incidence of wound infection (defined as the presence of either pus or a serous discharge containing a pathogen) and wound morbidity (using our previously validated scoring system for breast wounds).

The groups were well matched for baseline characteristics and had a similar incidence of wound infection: Flucloxacillin Group 10/311 (3.2%) c.f. Control Group 14/307 (4.6%) – $X^2 = 0.75$, $p = 0.39$; Relative Risk = 0.71 (95%CI = 0.32–1.53). The mean time to presentation of wound infections was 16 days. Staphylococci were present in all but one of the 18 positive isolates. The groups also had similar numbers of patients with wound scores > 10 points: Flucloxacillin Group 42/311 (13.5%) c.f. Control Group 50/307 (16.3%) – $X^2 = 0.94$, $p = 0.33$; Relative Risk = 0.83 (95%CI = 0.57–1.21).

It is concluded that a single-dose of flucloxacillin did not reduce the incidence of wound infection after non-reconstructive breast surgery. It remains to be determined whether specific subgroups of patients at high risk of a wound infection would benefit from antibiotic prophylaxis.

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Mammoplasty for breast carcinoma gives more conservative treatments

A. Fitoussi, B. Couturaud, F. Laki, S. Alran, H. Charytanski, R. Salmon. *Institut Curie, Surgery, Paris, France*

Advantages of breast conservative treatments are well known. To get more conservative treatment for breast carcinoma, since 15 years we use mammoplasty techniques with a good local control.

Inverted T techniques were the first used, then vertical and peri-areolar approach came.

With the time we create new mammoplasty techniques for external, superior or internal tumour.

All these techniques give us better margins, good aesthetics results and easy radiotherapy treatment.

Our experience is with 225 women treated in Curie Institute since 15 years.

Main age was 53 year old, main tumour size was 32 mm and the main weight of the resection, was 132 grams. The same surgery was done for the other side in the same time or later.

The five years recurrence rate was 8% (same as traditional breast conservative treatment).The main survival rate was 93% at five years.

In conclusion, the mammoplasty techniques for breast carcinoma give use more conservative treatment with better margins, same recurrence rate and good aesthetic results in more than 85% of the cases.

Only 7% of the women were re operated because of unsafe margins and get mastectomy.

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4 year follow up of nipple-areola-skin sparing mastectomy in breast cancer patients

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Background: Skin-sparing mastectomies (SSM) with immediate reconstruction with permanent prosthesis are being used more frequently to treat many cases of breast cancer. But, because of concerns about probable neoplastic involvement of the nipple-areola complex (NAC) and local recurrence (LR), conventionally used SSM included resection of the NAC. Reported rates of neoplastic involvement of the NAC varied from 0% to 58%, but most of these were based on the retrospective pathological analysis of preserved mastectomy specimens. Nevertheless, little consideration has been given to the feasibility of nipple-areola-skin sparing mastectomy (NASSM) using intraoperative frozen-section assessment of NAC and the rate of LR after NASSM.

Materials and Methods: A total of 104 patients treated with SSM or NASSM and immediate reconstruction with implant from 1997 to 2003 were studied, including 84 NASSM and 20 SSM cases. During performing NASSM, frozen section analysis of the tissue beneath NAC was performed, and if there was evidence of neoplastic involvement, the NAC was resected. The medical reports were analyzed for tumor size, nodal status, tumor location, histology, grade and LR rate.

Results: The mean age of patients was 41.1 years (ranges: 23–64 years). Neoplastic NAC invasion were more common in centrally located tumors and larger tumors, but there were no statistical significance ($p > 0.05$). Primary tumor characteristics were not predictive for neoplastic NAC invasion. During the mean follow-up of 4 year, 8 (9.5%) of 84 patients developed LRs; 5 (6.0%) with NAC recurrences and 3 (3.5%) flap recurrences. No statistical difference in recurrence rate was demonstrated between NAC recurrence and flap recurrence patients ($p > 0.05$). Mean LR-free interval of NASSM patients was 31.9 months (ranges: 5 to 51). Two mastectomies and 6 wide excisions were done for the treatment of these