

104

Poster

Quality assurance in breast cancer surgery in France – Recommendations of the French Senologic Society (Société Française de Sénologie et de Pathologie Mammaire – SFSPM)

K. Clough, F. Laffargue, L. Piana, P. Bonnier, R. Villet, J. Lefranc, B. Gairard. *SFSPM, B. Gairard Clinique gynécologique et obstétricale, Strasbourg cedex, France*

In France, regional breast cancer screening programmes have been implemented since 1989 and a national protocol started in 1994. The national extension was effective in January 2004. During this period major improvements in terms of professional practice have been achieved. Quality control procedures were initially implemented for radiologists, thanks to the national breast cancer screening programme. Our first guidelines based on the "European guidelines for quality assurance in mammography screening" initially involved screening and diagnosis but surgery and breast cancer treatment were not yet considered. Being concerned by the quality of the whole process, from the diagnosis to the treatment, the SFSPM worked on quality assurance together with the national agency for accreditation to develop guidelines for the treatment of breast cancer with a particular effort on surgery.

In the vast majority of cases, surgery is the first treatment applied. Surgery also plays a decisive role in a patient's cure. An insufficient technical environment or inadequate individual care may lead to serious consequences for the future of the patient. We suggested that the experience of the surgeon is, amongst other factors, related to his/her activity (number of cases annually operated). This criterion has to be considered when choosing specialists for breast cancer surgery, but the present conditions of medical practice in France must also be taken into account. Considering the high number of breast cancer women (42,000 new cases per year) an abrupt stop of the activity of the surgeons who would not be immediately in accordance with the new guidelines could disrupt national senologic activity.

In France, breast surgery is performed in numerous public and private institutions by specialists coming from different specialities: mainly gynaecologists, general or visceral surgeons, surgical oncologists, or more rarely plastic surgeons with an oncologic specificity. Our goal was to ensure that all these surgeons would have a homogeneous approach, to ensure equal quality of care to breast cancer patients throughout the country.

Breast surgery requires a double multidisciplinary organisation: non palpable lesions require close collaboration with both the radiologists and the pathologists (this activity is growing with the national extension of mass screening). On the other hand, taking care and treating invasive lesions require a close collaboration with radiation oncologists and medical oncologists. For breast cancer care, each step of the ladder, from diagnosis to treatment, can be a subject for improvement: breast cancer surgery is one of those steps.

Quality assurance criteria for hospitals are based on:

- Adequate specific equipment.
 - Written procedures that must outline the organisation of every step required for the quality of the surgery (preoperative, the surgery itself, and postoperative care).
 - These procedures secure the care of the patient in the hospital from his/her admission to the moment they are allowed home.
 - The hospital has to be able to give the surgeon's activity to the authority's representatives.
 - The hospital has to sign a convention with a regional network for cancer treatment.
- Quality assurance criteria for the surgeon himself focus on:
- The training: surgical specialisation (gynaecologic surgery, general surgery) with a specific training in breast surgery.
 - Regular participation in a multidisciplinary breast cancer meeting. The surgeon has to personally present his/her patients records to a clearly identified team.
 - The surgeon has to be a member of a known regional network of oncology.
 - The patient's medical record has to contain all the data related to the surgery.
 - The time allowed between each step of the process has to be in accordance with national recommendations, particularly in case of invasive cancers.
 - The surgeon has to be able to demonstrate his/her annual activity in breast surgery in case the representatives of the national authority require it.
 - If a minimum level of surgical breast activity was to be considered as a quality criterion, the useful and acceptable level proposed would be between 20 and 30 breast cancer operations annually after 2 to 4 years of practice.

In 2006, these recommendations will be included in a national ministerial order and we hope that they will contribute to a more equal access for women to high quality breast cancer care

105

Poster

Outcomes of breast conserving surgery in early onset breast cancer: Omission vrs. delivery of adjuvant radiotherapy

D. Westbroek¹, A. Abdel-Rahman¹, S. Alavi¹, A. Athow¹, J. Gattuso¹, N. Perry², C. Wells¹, D. Ryan¹, R. Carpenter¹. ¹St Bartholomews Hospital, Breast surgery unit, London, United Kingdom; ²St Bartholomews Hospital, Radiology and screening service, London, United Kingdom

Introduction: Early onset breast cancer (stage I/II) is associated with good prognosis and low local recurrence rates. Breast conserving surgery plus adjuvant radiotherapy is accepted treatment for stage I/II disease. Evidence increasingly demonstrates the deleterious long-term consequences of radiotherapy. The purpose of this study is to investigate whether or not the omission of adjuvant radiotherapy in this specific cohort of (stage I/II) breast cancer patients has any measurable consequence on local recurrence rates, disease free survival and overall survival.

Method: Clinical case notes were reviewed retrospectively on 190 patients treated with breast conserving surgery (BCS) at a single institution from January 1990 to December 2004. The cohort was divided into two matched treatment groups: BCS with or without adjuvant radiotherapy. The groups were matched by age and date of presentation. Parameters recorded included: histo- pathological features, adjuvant therapy received, follow- up, local relapse rates, disease free and overall survival.

Results (provisional): In group I (with adjuvant radiotherapy) there were 112 women of median age 57 (38–80 years). The median tumour size was 9 mm (1–10 mm) and median follow-up was 74 (15–110) months. There were no local recurrences. In group II (without adjuvant radiotherapy) the median age at presentation was 59 (48–81) years. The median tumour size was 7 (9–10) mm and median follow-up was 47 (14–93) months. There were three non-breast cancer related deaths and three local recurrences (6%).

Conclusions: Following breast conservation surgery in these select groups of patients there was an annualised rate of recurrence of approximately 1.5%. There were no significant different outcomes between the two groups. This provides further evidence to suggest patients with small invasive breast cancers could be adequately managed without the use of adjuvant radiotherapy.

106

Poster

Multidisciplinary management of patients with BRCA1 and BRCA2 mutations in Institut Curie of Paris

A. Fitoussi¹, B. Coutraud¹, P. This¹, F. Laki¹, D. Stoppa-Lyonnet², A. Fourquet³, A. Tardivon⁴, R. Salmon¹. ¹Institut Curie, Surgery, Paris, France; ²Institut Curie, Genetics, Paris, France; ³Institut Curie, Radiation Oncology, Paris, France; ⁴Institut Curie, Radiology, Paris, France

Five per cent of breast cancers are associated with a genetic predisposition. BRCA1 and BRCA2 genes and their mutations associated to breast cancer, respectively located on chromosomes 17q and 13q, have been identified in 1994 and 1995. The inheritance of BRCA1 and BRCA2 mutations is autosomal dominant. Identification of a mutation in a family neither explored before, usually takes a long time (about 9 months) and is particularly difficult as a result of the large sizes of BRCA1 and 2 genes and of the wide range of the various mutations (800 for BRCA1 and 200 for BRCA2). On opposite when a mutation is identified within a family, its detection can be obtained in few days.

Management of patients with mutated BRCA genes is complex; requiring usual mammary imaging as well as MRI scan. Different concurrent consultations are advisable: with the oncogenetician, breast surgeon, gynaecologist, plastic surgeon and oncopneumologist. When the assessment is done the therapeutic schedule is decided by the medical team and the patient.

In summary 3 different situations can be encountered:

1. when no malignant breast lesion is present, a bilateral prophylactic mastectomy with areola ablation, skin cover preserving and breast reconstruction by implants is proposed. No axillary exploration of lymph nodes will be performed. On another hand, scientific pieces of information concerning the question of areola conservation are still lacking
2. when in situ carcinoma lesions are present, a mastectomy with areola ablation, skin cover preserving and immediate breast reconstruction is proposed an exploration of axillary lymph nodes either by sentinel lymph node procedure or limited axillary dissection will be performed. A contralateral prophylactic mastectomy will be concurrently proposed as described above. Similar procedures are proposed to patients with an