A total of 1242 patients were examined and lymphoedema found in 5 (0.04%). Of these 5, 3 had undergone axillary clearance, 1 ANS plus radiotherapy and only 1 had ANS alone.

A policy of ANS, with prophylactic treatment for lymph node positivity either by surgery or RT alone, gives a very low rate of lymphoedema.

O-42. COMPARISON OF MARGIN STATUS WITH VAN NUYS INDEX TO PREDICT RECURRENCE OF DUCTAL CARCINOMA IN SITU AFTER BREAST CONSERVING SURGERY

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Aims: Selection of patients for radiotherapy after breast conserving surgery (BCS) for uni-focal ductal carcinoma in situ (DCIS) is determined by recurrence risk. The Van Nuys prognostic index (VNPI combining tumour grade, size and resection margin width) has been claimed in the USA to predict recurrence, therefore we aimed to validate this and compared VNPI with a simpler measure of margin clearance to predict recurrence after BCS for DCIS.

Methods: Clinico-pathological data for 228 patients treated with BCS for DCIS were compared for risk factor of recurrence. Median age of patients was 56 years and the median follow up was 48 months. Patients were placed in 3 groups based on VNPI score. Data was analysed for proximity of margins (close < 1 mm or not) and by Van Nuys sub-groups.

Results: There were 36 ipsilateral recurrences (27 DCIS and 9 invasive cancer).

Variable		n	Recur	%Recur	P value
VNPI	3 & 4	33	0	0	
Groups	5	42	3	7.1	0.001
	6, 7 & 8	152	33	21.7	
Proximity	Close (<1 mm)	73	27	36.9	<0.001
of margin	Not close (>1 mm)	154	9	5.8	
Grade Van Nuys	I or II No necrosis (1)	53	3	5.6	
	I or II Necrosis (2)	31	5	16.1	0.048
	III (3)	144	28	19.4	

Conclusions: Logistical regression shows that close resection margins (<1 mm) is a better predictor than the Van Nuys prognostic index for DCIS recurrence.

O-43. WIDE LOCAL EXCISION WITH 10 MM CLEARANCE WITHOUT RADIOTHERAPY FOR DCIS

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In Breast Conserving Surgery (BCS) for DCIS there are no standard protocols for histopathological margin assessment width required, or for adjuvant radiotherapy. We have used a protocol including a mandatory 10 mm histologically clear margin without radiotherapy for 12 years. In addition to radial blocks, margin assessment was further refined 6 years ago to include shaved radial margins.

From 1988 to 1999, 126 women were treated by BCS. The age range was 31–70 years (mean 55); median follow-up is 86 months. 46 of these patients (34%) had re-excision to obtain a 10 mm clearance.

28 patients have developed local recurrence (LR), (10 DCIS, 9 as invasive with DCIS and 9 pure invasive), 1 patient has died from or with breast cancer, none are alive with distant metastatic disease, 3 have regional recurrence. All 4 previously had invasive LR. 3 patients have developed contralateral cancer.

24 of the LRs occurred in the 46 patients who had undergone re-excision to clear margins. Only 2 LRs (invasive) have occurred in 43 patients treated between 1995–1999 (median follow up 59 months), both had re-excision to clear margins.

The LR rate attributable to our current protocol is 1% per annum which is acceptable. Failure to achieve clear margins at first therapeutic operation may be an indication for mastectomy.

O-44. RECURRENCE AND OUTCOME AFTER TREATMENT OF DUCTAL CARCINOMA IN SITU

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Background: The optimal management of DCIS remains controversial. Local recurrence has been used as a marker of treatment failure. When this occurs it is demoralising and if invasive is a threat to life. The results of salvage surgery after recurrence may become a more important marker of outcome

Methods: A total of 575 patients treated for DCIS in Glasgow were identified from a prospective audit and their records and pathology reviewed.

Results:

	Mastectomy	WLE + DXT	WLE
No of patients	217	136	222
Recurrent DCIS	3	8	37
Invasive recurrence	4	4	17
Distant metastases	3	2	2
Breast cancer deaths	0	0	1
Median follow up (months)	70	76	65
Local disease free survival	98.7%	93%	83%
Distant disease free survival	99%	99%	99%
Breast cancer specific survival	100%	100%	100%

Conclusions: Our data indicate that even with careful selection, WLE alone in the management of DCIS is inadequate in achieving local control. However, irrespective of treatment, most patients treated for DCIS survive, even after invasive recurrence and that salvage surgery is successful in most patients.