ONCOLOGIC AND COSMETIC CHALLENGES DO NOT ROUTINELY OPPOSE BREAST CONSERVING SURGERY IN RETRO-AREOLA PRIMARY LESIONS

16TH UP CONTROVERSIES AND PROBLEMS IN SURGERY SYMPOSIUM

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All truth passes through three phases.

First, it is ridiculed.

Second it is violently opposed.

Third, it is accepted as being self-evident

*(Arthur Schopenhauer)*
INTRODUCTION

Goal of BCT

- Oncological treatment
- Good cosmetic outcome

Challenging

- Excision with clear margins
- Preserve aesthetic appearance
- Single, definitive surgical procedure
Contraindications to BCT
- Multicentricity
- Extensive DCIS
- Radiotherapy matters

Central tumours
- Mastectomy conventional treatment

What is the evidence?
CENTRAL QUADRANT LESIONS

- 5% - 20% breast cancers
- 2 scenarios
  - Entirely subareola
  - 1.5 – 2cm beyond areola edge
- BCT contraindicated
  - Oncological perspective
    - Higher incidence multicentricity/ multifocality and NAC infiltration
  - Cosmetic perspective
    - Resection NAC + central portion → loss of a defining feature and central projection
CENTRAL QUADRANT LESIONS

Incidence NAC infiltration

- Breast cancer at any site
  - 11% - 58%
    - 58% - 82% neoplastic involvement occult

- Higher
  - NAC involvement
  - 1° lesion superficial retroareola
    - 54% NAC involvement
  - Lesion within 2.5cm from nipple edge
    - 95% involved nipples
Predictors NAC involvement
- Tumour location: tumour-areola (<2cm)/ tumour-nipple (<4cm)
- Tumour size: ≥T2
- Clinical involvement: NAC or adjacent skin

Minimal requirement
- *En bloc* NAC, tumour excision + adequate margin

Limitations sBCS

Particular challenge
ONCOPLASTIC SURGERY

**Definition**
- Oncological principles + best principles PRS techniques =
  - ↑ cosmetic outcome
  - ↓ complications

**Indications**
- Medium to large breasts
- Volume excisions 20% - 50%
- Small lesions (<3.5cm) in unfavourable location

**Considerations**
- Specific training
OPS: CENTRAL QUADRANT LESIONS

- Central quadrant lesions → BCT

- Alternatives to mastectomy
  - Therapeutic mammoplasty
  - Myocutaneous (LD) or fasciocutaneous (ICAP) flaps

- Steps
  - NAC and skin over tumour excised
  - Full-thickness glandular excision to pectoralis fascia
  - Re-shaping without extensive glandular mobilization
  - Tumour bed clips
TH. MAMMOPLASTY: TECHNIQUE 1

Modified inverted-T mammoplasty

- Superior pedicle mammoplasty
- NAC resection
- NAC reconstruction
  - immediate or delayed
Modified vertical scar mammoplasty

- Modification by Lejour
- Site, volume excision identical
- Avoids submammary scar
Grisotti technique

- 2 reduction mammoplasty techniques
  - Strombeck
  - Regnault B-flap mammoplasty

- Reconstruct central quadrantectomy defect

- Immediate NAC reconstruction
  - Skin island on advancement flap
Grisotti technique

- NAC reconstruction
  - Areola: dermal tattooing
  - Nipple: flaps

- Few patients complete
  - Across spectrum
  - Breast mound preservation > nipple reconstruction

3 months post-surgery
FASCIOCUTANEOUS (ICAP) FLAP
FASCIOCUTANEOUS (ICAP) FLAP

1 YEAR POST-RADIOThERAPY
Common types
- Necrosis: skin, flap, glandular
- Hematoma, seroma

Glandular necrosis: 26%
- Risk factors
- Sequelae
  - SSI, abscess, wound dehiscence

Flap necrosis: 13%
- Superficial epidermolysis > full thickness
SAFETY OPS

- LRR and OS
  - 1996: Cothier-Savey
    - 5 years: LRR 9.4% and OS 86%
  - 2003: Clough
    - 5 years: LRR 8.5% and OS 95.7%
  - 2007: Rietjens
    - >6 years: LRR 3% and OS 92%
  - Central quadrant OPS: LRR 4.3% and OS 95.7% at 18 months

- Adjuvant therapy
  - Onset not delayed

- Radiographic surveillance
CONCLUSION

- Retroareola lesions particular challenge

- Concerns excluded BCT

- OPS → most BCT
  - Volume displacement techniques
  - Volume replacement techniques
    - Safe
    - Satisfactory outcomes

- Mastectomy select cases