

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.

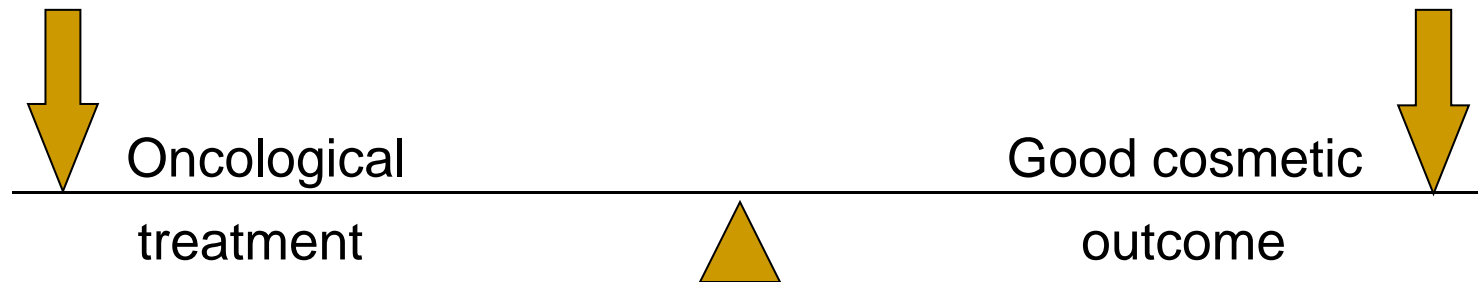
Third, it is accepted as
being self-evident

(Arthur Schopenhauer)



INTRODUCTION

■ Goal of BCT



■ Challenging

- ❑ Excision with clear margins
- ❑ Preserve aesthetic appearance
- ❑ Single, definitive surgical procedure

INTRODUCTION

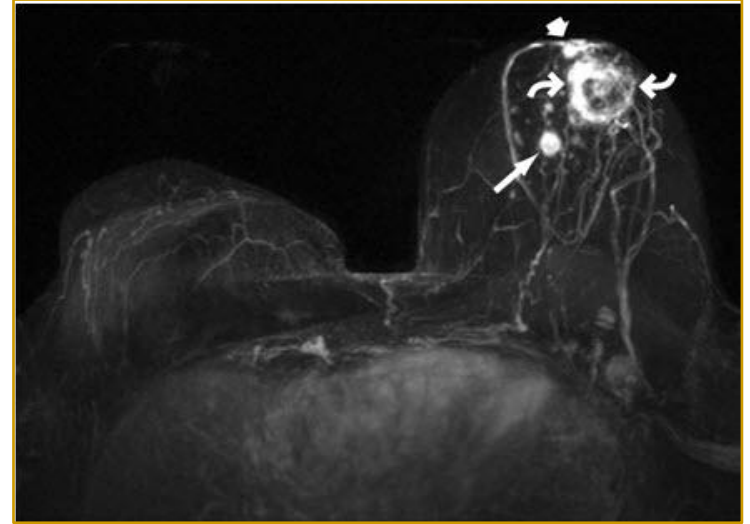
- Contraindications to BCT
 - ❑ Multicentricity
 - ❑ Extensive DCIS
 - ❑ Radiotherapy matters

- 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

CENTRAL QUADRANT LESIONS

- Predictors NAC involvement
 - Tumour location: tumour-areola (<2cm)/ tumour-nipple (<4cm)
 - Tumour size: $\geq T2$
 - 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



TH. MAMMOPLASTY: TECHNIQUE 2

Modified vertical scar mammoplasty

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



TH. MAMMOPLASTY: TECHNIQUE 3

Grisotti technique

- 2 reduction mammoplasty techniques
 - Strombeck
 - Regnault B-flap mammoplasty
- Reconstruct central quadrantectomy defect
- Immediate NAC reconstruction
 - Skin island on advancement flap



MARKINGS



DEFECT AND FLAP



ADVANCED FLAP



CLOSURE

TH. MAMMOPLASTY: TECHNIQUE 3

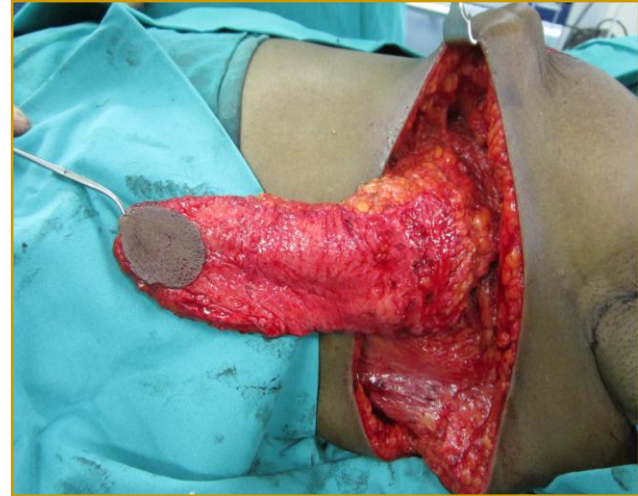
Grisotti technique

- NAC reconstruction
 - Areola: dermal tattooing
 - Nipple: flaps
- Few patients complete
 - Across spectrum
 - Breast mound preservation > nipple reconstruction

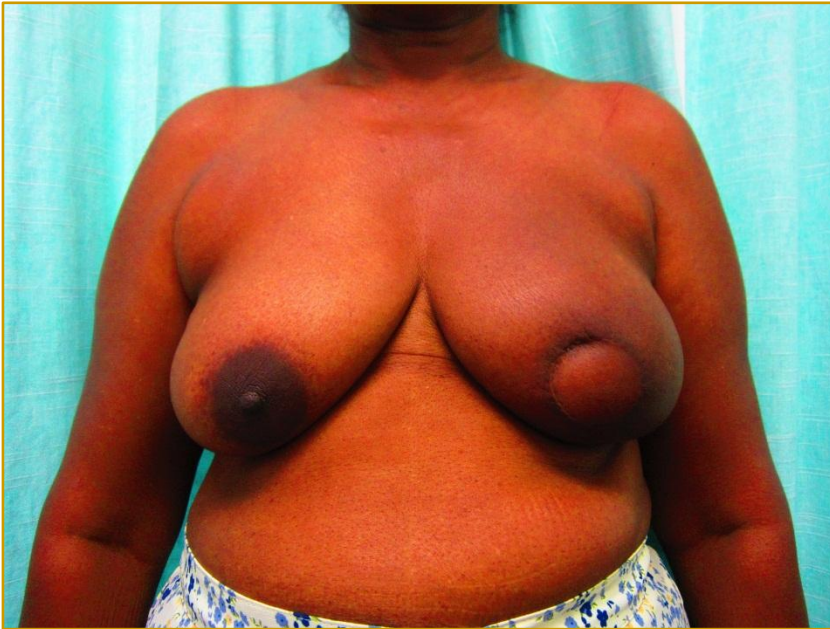


3 months post-surgery

FASCIOCUTANEOUS (ICAP) FLAP



FASCIOCUTANEOUS (ICAP) FLAP



1 YEAR POST-RADIOTHERAPY

COMPLICATIONS OPS

■ 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