1. BACKGROUND

Consensus on the axillary management in cT1+ breast cancer patients who convert to ypT0 after primary systemic treatment (PST) is still lacking. A survey was conducted to investigate the clinical practice in this setting.

2. MATERIALS AND METHODS

A web-based survey was developed by a multidisciplinary group on behalf of the European Breast Cancer Research Association of Surgical finalists (EUBREAST), and distributed to breast surgeons and radiation oncologists via breast cancer societies.

3. RESULTS

3.1 RESULTS: BREAST SURGERY SECTION

The preferred surgical approach to the axilla in cT1+ patients who convert to ypT0 is targeted axillary dissection (TAD) in 56%, sentinel lymph node biopsy (SLNB) in 21%, axillary lymphadenectomy (ALND) in 19%, other (15%) (when SLNB is performed, single and dual tracers are used in 62% and 38% of the centres, respectively; no minimum number of SLNs is required by 36% of the surgeons, while 48% suggest to remove at least 2 or 3 SLNs). For targeted lymph node biopsy (SLNB) or TAD, there is a wide heterogeneity with regards to localization techniques. In case of multiple suspicious nodes, 65% of the responders declare to mark only one node. 47% of responders routinely perform an additional preoperative localization of the TLN imaging modalities to assess the ycT1 status: ultrasound (67%), MRI (21%), others (12%). Before PST, in case of cT1+hamanatomics findings, ALND is suggested by 23% only after routine histologic confirmation of lymph node involvement, and by 48% without, 29% of the responders perform SLNB/TAD/TLNB without additional axillary surgery, 3% suggest different approaches. After PST, 66% of the breast surgeons recommend ALND in ycT1+ patients only after histologic confirmation, while 23% do not perform CNB/SLNB. 11% voted for TAD/SLNB/TLNB in this setting. 34% of the breast surgeons suggest ALND for patients with ypT1+ negative status after TAD/SLNB, 31% favour RT, 29% a combination and 12% suggest omission of further regional treatment.

3.2 RESULTS: RADIATION ONCOLOGY SECTION

The decision for post-operative regional irradiation is influenced by initial nodal lymph node status (61%) and by a combination of pre- and post-PST assessment (39%). 21% of the respondents never irradiate level II in patients with a ypT1+ status after ALND while 37% suggest selective use of RT and 42% favour RT in all patients. Target volumes for elective nodal irradiation are determined mainly based on EORTC (61%) and RTOG (38%) guidelines. In case of micrometastatic nodal disease (ypN1a/b) regional node irradiation is suggested by 39% of the radiation oncologists regardless of the number of involved nodes, 37% suggest RT in patients with more than 3 positive nodes, while 4% would never irradiate. After a positive TAD or SLNB radiation oncologists suggest ALND in 63% and RT in 37%. Similar results were obtained for spT1-2N+ and spT3N+. Remodelling fibrous scar tissues rarely affect regional treatment planning.

In patients with cT1+ and/or ycT1+ we provide an sentinel node biopsy (SNB) as an initial step to exclude micrometastasis. If SNB is negative, a TAD/SLNB/TLNB is considered. If SNB is positive or there is a lack of SNB, we perform a SLNB/TAD/TLNB. If SLNB/TAD/TLNB is positive, a ALND is recommended. If SLNB/TAD/TLNB is negative, a RT is recommended. If ALND is performed, a RT is recommended. If ALND is not performed, a RT is recommended.

4. CONCLUSIONS

The results of this EUBREAST survey highlight the wide heterogeneity in the approach to the axilla after PST, corroborate the need for further clinical research and provide the rationale for the AXSANA(EUBREAST) 3.

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