breast conservation using large resection volumes (OBCII; Clough level II/Tübingen 5–6) may improve local recurrence rates in biologically high risk breast cancer patients compared with conventional breast conservation (CBC; Tübingen 1–2) and low volume (OBCI; Clough level I/Tübingen 3–4).

**Methods:** Seventeen breast cancer centers from the Oncoplastic Breast Consortium (OPBC) network retrospectively included data from 3177 women consecutively undergoing breast conservation for high risk breast cancer between 1st January 2010 and 31st December 2013.

**Results:** Thirty percent were treated with OBC (OBCI n = 663; OBCII n = 297). The CBC/OBCI group had significantly more small tumors and more close resection margins compared with OBCII (pT1: 50% versus 37% p = 0.002; margin <1/X: 17% versus 6% p < 0.001). There were significant more second re-resections due to R1 (tumor on ink) after the first surgical attempt in the CBC/OBCI compared with OBCII (11% versus 7%; p = 0.049). More her2pos subtypes were seen in the CBC/OBCI group (41% versus 26% p < 0.001). Univariate as well as multivariable regression analysis adjusted for tumor biology, tumor size and systemic treatment as well as radiotherapy demonstrated no clinical relevant difference in local, regional nor distant recurrence free or overall survival between CBC/OBCI and OBCII.

**Conclusion(s):** Large resection volumes in oncoplastic surgery increases the distance from cancer cells to the margin of the specimen as well as reduces re-operation rates, however there is no oncologic influence on local, regional or distant recurrence free nor on overall survival using level II oncoplastic surgery in high risk breast cancer.

**Conflict of Interest:** No significant relationships.

---

**P136**

**Ductal carcinoma in situ (DCIS) and breast cancer-specific and all-cause mortality among postmenopausal women in the Women’s Health Initiative**


1The Lundquist Institute, Torrance, United States; 2City of Hope National Medical Center, Duarte, United States; 3Royal College of Surgeons in Ireland, Dublin, Ireland; 4Karmanos Cancer Center, Detroit, United States; 5Albert Einstein College of Medicine, Bronx, United States; 6University of Buffalo, Buffalo, United States; 7Stony Brook University, Stony Brook, United States; 8Harvard, Boston, United States; 9The L undquist Institute, Torrance, United States

**Goals:** A small proportion of women with DCIS die of breast cancer. The purpose of this analysis is to compare breast-cancer specific and all-cause mortality among women with DCIS to that of unaffected controls among participants in the Women’s Health Initiative (WHI).

**Methods:** The study population included 68,133 postmenopausal women aged 50 to 79 years who enrolled in a WHI clinical trial (Dietary Modification –DM, Hormone Therapy - HT or Calcium Vitamin D) from 1993–1998 at one of 40 US clinical centers. After study enrollment, there were 781 incident cases of DCIS identified who were matched to 781 controls by age at study entry and time since enrollment. Information collected at study entry included medical and family cancer history, demographics, lifestyle, as well as breast and cardiovascular disease risk factors. Screening mammography was mandated annually or bi-annually with high adherence. [MJE1] Incident DCIS cases were confirmed by central medical record review. Mortality data available through 2018, were enhanced by serial National Death Index queries. Adjusted Cox proportional hazard regression models were used to estimate hazard ratios (HRs) and 95% confidence intervals (CI) for breast cancer-[MJE2] specific and all-cause mortality for women with DCIS and controls. Kaplan Meier plots were used to assess 10-year mortality rates.

**Results:** Median follow-up was 20.3 years from enrolment and 13.2 years from DCIS diagnosis (or corresponding date of mammogram for matched controls). Compared to women without incident DCIS, women with incident DCIS had higher income, were more likely to have a family history of breast cancer, were less likely to be WHI HT trial participants but were more likely to be current HT users (all P < 0.01). There were 227 (29%) deaths among women with DCIS and 253 (32%) deaths among women without DCIS. In multi-variable adjusted analyses, compared to women without DCIS, breast cancer-specific mortality was statistically significantly higher for women with incident DCIS (HR: 2.95; 95% CI: 1.21–7.20). However, the absolute difference was small, with 10-year breast cancer-specific mortality 0.8% in women without DCIS and 1.5% in women with incident DCIS. There was no significant difference in all-cause mortality between the two groups (HR: 0.97; 95% CI: 0.80–1.16).

**Conclusion(s):** In postmenopausal women, a diagnosis of DCIS is [MJE1] associated with higher mortality due to breast cancer, but no relationship with all-cause mortality.

**Conflict of Interest:** Rowan Chlebowski is a consultant for Novartis, AstraZeneca, Genentech, Merck, Immunomedics, and Puma and received honorarium from Novartis and AstraZeneca. None of the other authors report any conflict of interest related to this study.

---

**P137**

**Autologous breast reconstruction with free flaps in patients with oligometastatic breast cancer: when to proceed and when not?**


**Goals:** Clinical decision making about autologous breast reconstruction (ABR) in the oligometastatic setting is challenging due to a lack of