breast conservation using large resection volumes (OBCI; 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).


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 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.

P135
Management of patients with residual microcalcifications and false-negative results after stereotactic vacuum – assisted biopsy of mammographic suspicious microcalcifications

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Goals: The aim of the present study is to determine the false negative rate of stereotactically vacuum-assisted breast biopsy (VABB) in patients with suspicious microcalcifications detected on screening mammography.

Methods: In our Department, from January 2015 to April 2020, 1280 patients underwent VABB. Data of patients with benign lesions in VABB were evaluated retrospectively during a median follow-up period of 16 months. In total, 242 VABBs were considered benign and follow-up was recommended. Of these 242 lesions, 118 were completely removed during the biopsy procedure.

Results: Follow-up data were available for 208 of 242 patients (86%) with intervals ranging from 6 to 54 months (median 16). Surgery or reintervention was needed in 7 of 208 patients (3.4%). Of these cases 3/208 (1.4%) turned out as false negatives. Two of these cases showed large areas of microcalcifications or several clusters, and only partial removal was possible due to the size of the lesions.

Conclusion(s): Although VABB has proven clinical value and is an accurate procedure for diagnosing nonpalpable breast lesions with a low cancer miss rate, we should consider the exclusion of malignancy in cases of extensive microcalcifications or several clusters as a limitation. The radiologic-histologic correlation in these cases is a challenge, especially in terms of residual microcalcifications. To avoid delayed cancer diagnosis, strict follow-up of benign lesions is necessary.

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

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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 cancer 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 honoraria 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?

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