Optimal Surgical Management of breast cancer

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EUSOMA Executive Committee
ESO Faculty member
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The Breast Editor
Conflict of Interest Disclosure

• No financial relationships to disclose
We acknowledge that most patients will not benefit from adjuvant therapies in terms of OS (the ultimate goal of adjuvant therapies) and many adjuvant treatments offered have a small to marginal impact. Patients should be informed about magnitude of benefit of interventions with small to marginal benefit and be offered no treatment as a reasonable alternative.
Surgery for breast cancer
Estimating the magnitude of Clinical benefit of local therapies in EBC (St Gallen 2019)

- Hereditary breast cancer
- DCIS
- Margins in conservative surgery
- Total mastectomy vs Skin Sparing Mastectomy
- Immediate vs Delayed Reconstruction
- No axillary approach vs Sentinel Node vs Axillary dissection
- Surgery after primary systemic treatment (PST) – Breast and axilla

ABC 4
- The role of Surgery of the Primary Tumour in ABC (Stage IV)
Hereditary breast cancer

- Strong family history
- Patients < 35 years
- Triple negative < 60 years
Hereditary breast cancer

Impact that Timing of Genetic Mutation Diagnosis has on Surgical Decision Making and Outcome for BRCA1/BRCA2 Mutation Carriers with Breast Cancer. Akiko Chiba et al 2016, Ann Surg Oncology
Hereditary breast cancer

- IBR – 1-2% year <7 Y
- IBR – doubles >7 Y
- CBC – 3% year BRCA1 - 2% year BRCA2

- IBR – 1-2% year
- CBC -0.5% year

NO OVERALL SURVIVAL DIFFERENCES
DCIS

Lopez-Garcia et al. Histopathology 2010
DCIS

- DCIS represents a spectrum of different situations, and should be approached accordingly

- BCS with selective use of whole breast radiotherapy is still the optimal treatment for the majority of women with DCIS.

- Sentinel node biopsy should not be performed in patients having BCS for DCIS.

- If margins ≥2 mm then surgery is complete. Given the limited amount of information in 1-2 mm margins, discuss before re-excision.

- Endocrine therapy reduces RR. Benefits/Risks. Consider BabyTam

- Stratification tools can help in risk quantification and optimizing treatment strategies
### DCIS Surveillance trials

<table>
<thead>
<tr>
<th>TRIAL</th>
<th>Inclusion</th>
<th>Recruit</th>
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<tr>
<td>The Low risk DCIS trial LORIS Trial UK</td>
<td>➢ 45, pure, non high grade DCIS (VACB or open surgical without margins)</td>
<td>Ongoing</td>
<td>932</td>
<td>Ipsilateral invasive BC within F-UP 10 years</td>
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<tr>
<td></td>
<td>➢ unifocal or multifocal,</td>
<td></td>
<td>(50)</td>
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</tr>
<tr>
<td></td>
<td>➢ uni or bilateral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Asymptomatic micros</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low risk DCIS trial LORD trial - NKI</td>
<td>➢ 45, pure low and intermediate grade DCIS (VACB)</td>
<td>Ongoing</td>
<td>1240</td>
<td>Ipsilateral invasive BC or higher grade (II-III) within F-UP 10 years</td>
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<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ unilateral</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>➢ Asymptomatic micros</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison of operative to monitoring and endocrine therapy for low-risk DCIS COMET trial USA</td>
<td>➢ 40, pure, non high grade DCIS (VACB)</td>
<td>Ongoing</td>
<td>1189</td>
<td>Ipsilateral invasive BC or higher grade (II-III) within F-UP 5 years</td>
</tr>
<tr>
<td></td>
<td>➢ unifocal or multifocal,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ uni or bilateral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ HR positive, Her2 negative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Asymptomatic micros</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Low and intermediate risk DCIS study LARRIKIN trial Australia</td>
<td>➢ 55, pure, non high grade DCIS (VACB open surgical biopsy)</td>
<td>Ongoing</td>
<td>550</td>
<td>Ipsilateral invasive BC or higher grade (II-III) within F-UP 5 years</td>
</tr>
<tr>
<td></td>
<td>➢ unifocal &lt; 2 cm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ uni or bilateral</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

VACB: vacuum assisted core biopsy; HR: hormone receptor; Her2: human epidermal growth factor 2.
Margins in conservative surgery

**Effect of Breast Conservation Therapy vs Mastectomy on Disease-Specific Survival for Early-Stage Breast Cancer**

Shailesh Agarwal, MD; Lisa Pappas, MS; Leigh Neumayer, MD; Kristine Kokeny, MD; Jayant Agarwal, MD

*JAMA Surgery*  March 2014  Volume 149, Number 3

<table>
<thead>
<tr>
<th></th>
<th>BCT</th>
<th>Mastectomy</th>
<th>Mastectomy+RT</th>
<th>p value</th>
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<tbody>
<tr>
<td>132 149</td>
<td>70%</td>
<td>27%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>5Y BCSSR</td>
<td>97%</td>
<td>94%</td>
<td>90%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>10Y BCSSR</td>
<td>94%</td>
<td>90%</td>
<td>83%</td>
<td>&lt;.001</td>
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</tbody>
</table>

**CONCLUSIONS AND RELEVANCE:** Patients who underwent BCT have a higher breast cancer-specific survival rate compared with those treated with mastectomy alone or mastectomy with radiation for early-stage invasive ductal carcinoma. Further investigation is warranted to understand what may be contributing to this effect.
Margins in conservative surgery

“Sometimes patients demand a mastectomy, driven by fear and the desire of getting rid of the disease while ignoring all this new information. It is important to inform them properly that, in most cases, breast cancer can be cured maybe even better without the need to be separated from of their breasts.”
Margins in conservative surgery

Contra-indications for BCT

In aggregate, in the following clinical situations the increased risk of breast relapse should be extensively discussed with the patient and breast conservation should be executed with caution:

- very young woman (<35 years),
- the presence of extensive DCIS (heralded by extensive microcalcifications) mounting up to one quarter of the breast,
- more than focally incomplete resection of an invasive or in situ cancer,
- Inflammatory Breast Cancer and LABC with poor response to PST
- and in the case that radiotherapy cannot be given.

In all other clinical situations breast conservation is a safe option, provided complete resections are achieved and good cosmetic outcome is secured.

(St Gallen 2017)

Who should not undergo breast conservation?
Nijenhuis MV1, Rutgers EJ.

Breast cancer under age 40: a different approach.
Ribnikar D1, Ribeiro JM, Pinto D, Sousa B, Pinto AC, Gomes E, Moser EC, Cardoso MJ, Cardoso F.
Margins in conservative surgery

- Margins/need to forgo 2nd surgeries/mastectomies in three settings:
  - Invasive breast cancer – no need for additional distance in Lobular Invasive, in extensive intraductal componente, or in multifocal/multicentric breast cancer
  - Does focally invasive margin < 4 mm require additional excision?
  - After neoadjuvant therapy – no tumour on inked margins, the same as in primary surgery.

The association of surgical margins and local recurrence in women with early-stage invasive breast cancer treated with breast-conserving therapy: a meta-analysis.

Society of Surgical Oncology-American Society for Radiation Oncology consensus guideline on margins for breast-conserving surgery with whole-breast irradiation in stages I and II invasive breast cancer.
Margins in conservative surgery

The margin status of invasive carcinoma did not influence IBTR, DM rate, or OS. Between 1980 and 2008, locoregional control after BCT remained stable with low IBTR rates, even in young patients.

Omitting re-excision for focally positive margins after breast-conserving surgery does not impair disease-free and overall survival. Vos EL, Siesling S, Baaijens MHA, Verhoef C, Jager A, Voogd AC, Koppert LB.
Margins in conservative surgery

Oncoplastic Surgery

When a resection of more than 20% of breast volume is planned oncoplastic techniques are recommended and can prevent major deformities.

Current approaches to managing partial breast defects: the role of conservative breast surgery reconstruction.

Margins in conservative surgery

Oncoplastic Surgery

Considered a major technical improvement
- larger scars,
- increased complications
- increasing need for contralateral breast surgery
Margins in conservative surgery

Oncoplastic Surgery

Pros
- Wider excisions - Better margins
- Less recurrences
- Overall better cosmetic outcomes

Cons
- Trained teams
- Higher cost
- Higher complication rate
- Possible delay of adjuvant treatments

Which technique to use for each case?
Margins in conservative surgery

Oncoplastic Surgery

BCCT PLAN (PORTUGAL 2020)

3D tool for planning breast conserving surgery in breast cancer
Margins in conservative surgery

Oncoplastic Surgery

BCCT PLAN (PORTUGAL 2020)

3D tool for planning breast conserving surgery in breast cancer
Total mastectomy vs Skin Sparing Mastectomy

Breast Reconstruction following Nipple-Sparing Mastectomy: Predictors of Complications, Reconstruction Outcomes, and 5-Year Trends.
Colwell AS, Tessler O, Lin AM et al.
Total mastectomy vs Skin Sparing Mastectomy

Preservation of the skin envelope in mastectomy indications (SSM)/(NSM)

- NOT in Inflammatory breast cancer even with clinical complete response to PST

Oncoplastic Breast Consortium consensus conference on nipple-sparing mastectomy.
Weber WP et Al
Breast Cancer Res Treat. 2018 Dec;172(3):523-537
Delayed Reconstruction vs Immediate Reconstruction

Delayed Reconstruction vs Immediate Reconstruction
Delayed Reconstruction vs Immediate Reconstruction
Delayed Reconstruction vs Immediate Reconstruction

- Reconstruction should be offered to all mastectomy patients and all techniques should be discussed even if not available locally.

- Immediate reconstruction can be performed in the majority of patients and does not reduce radiation efficacy.

- Patients who will probably need radiotherapy should be advised about the possibility of a poorer cosmetic outcome.
Optimal Surgical Management of Breast Cancer

Maria João Cardoso, MD, PhD
### Timing of Reconstruction—when?

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>RT first</th>
<th>Reconstruction first</th>
<th>Odds Ratio M-H, Fixed, 95% CI</th>
</tr>
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<tbody>
<tr>
<td><strong>1.8.1 Autologous</strong></td>
<td>189</td>
<td>0</td>
<td>Not estimable</td>
</tr>
<tr>
<td>Baumann (2011)</td>
<td>19</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Halvorsen (2004)</td>
<td>0</td>
<td>1</td>
<td>Not estimable</td>
</tr>
<tr>
<td>Mokh (2012)</td>
<td>100</td>
<td>0</td>
<td>Not estimable</td>
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<tr>
<td>Nahabedian (2008)</td>
<td>53</td>
<td>0</td>
<td>Not estimable</td>
</tr>
<tr>
<td>Temple (2005)</td>
<td>2</td>
<td>100</td>
<td>Not estimable</td>
</tr>
<tr>
<td>Tran (2001)</td>
<td>70</td>
<td>0</td>
<td>Not estimable</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td>512</td>
<td>68</td>
<td>1.00 [0.24, 4.23]</td>
</tr>
<tr>
<td><strong>Total events</strong></td>
<td>32</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Heterogeneity:</strong> Not applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Test for overall effect:</strong> Z = 0.00 (P = 1.00)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **1.8.2 Implant** | 0        | 0                    | Not estimable                 |
| **Subtotal (95% CI)** | 0        | 0                    |                               |
| **Total events**  | 0        | 0                    |                               |
| **Heterogeneity:** Not applicable |          |                      |                               |
| **Test for overall effect:** Not applicable |          |                      |                               |
| **Total (95% CI)** | 512      | 68                   | 1.00 [0.24, 4.23]             |
| **Total events**  | 32       | 5                    |                               |
| **Heterogeneity:** Not applicable |          |                      |                               |
| **Test for overall effect:** Z = 0.00 (P = 1.00) |          |                      |                               |

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Reconstruction: Before or after postmastectomy radiotherapy? A systematic review of the literature
Sentinel Node vs Axillary dissection

Sentinel node biopsy is actually considered standard of care in patients with clinically and ultrasound negative axillae.

Estimating the benefit of axillary surgery

In patients undergoing surgery before systemic treatment:

- Omitting SLND in low-risk invasive breast cancer – Luminal A T1>70, comorbidities
- Omitting ALND in patients with macrometastatic sentinel lymph nodes – 1-2 nodes – Z11 / AMAROS

- Can lead to lower rates of typical side effects such as lymphedema, dysesthesia, arm/shoulder morbidity
- These benefits need to be weighed against loco-regional recurrence risk

Sentinel Node vs Axillary dissection

Recommendations

- Recommendation 1: Clinicians should not recommend axillary lymph node dissection (ALND) for women with early-stage breast cancer who do not have nodal metastases.

- Recommendation 2.1: Clinicians should not recommend ALND for women with early-stage breast cancer who have one or two sentinel lymph node metastases and will receive breast-conserving surgery (BCS) with conventionally fractionated whole-breast radiotherapy.

- Recommendation 2.2: Clinicians may offer ALND for women with early-stage breast cancer with nodal metastases found on SNB who will receive mastectomy – RT NOT PLANNED

- Recommendation 3: Clinicians may offer SNB for women who have operable breast cancer who have the following circumstances:
  - DCIS/mastectomy
  - Prior breast/axillary surgery

- Recommendation 4: There are insufficient data to change the 2005 recommendation that clinicians should not perform SNB for women who have early-stage breast cancer and are in the following circumstances:
  - LABC / Inflammatory
  - DCIS in BCS
Surgery after primary systemic treatment (PST)

...without ever forgetting the importance of each discipline
Surgery after primary systemic treatment (PST)

- Initial work-up of locorregional disease
- Monitoring response to treatment
- Axillary approach
- BCS / Mastectomy after treatment
- New Trials

Pre-treatment work-up

<table>
<thead>
<tr>
<th>Comparative Accuracy Studies</th>
<th>Number Studies (2050 patients)</th>
<th>P value</th>
<th>AUC</th>
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</thead>
<tbody>
<tr>
<td>MRI Clinical</td>
<td>11</td>
<td>0.10</td>
<td>0.89 0.93</td>
</tr>
<tr>
<td>MRI Ultrasound</td>
<td>10</td>
<td>0.15</td>
<td>0.93 0.90</td>
</tr>
<tr>
<td>MRI Mammography</td>
<td>7</td>
<td>0.02</td>
<td>0.90 0.89</td>
</tr>
</tbody>
</table>

Meta-analysis of Magnetic Resonance Imaging in Detecting Residual Breast Cancer After Neoadjuvant Therapy.

Multimodality Imaging for Evaluating Response to Neoadjuvant Chemotherapy in Breast Cancer.
Timing SN in N0 axilla

SNB before NAC
+ reliable SNB
  identification rate accepted (97%)
  false negative rate accepted (SN-/N+; 9.8%)

SNB after NAC
+ no separate operation needed for SNB
+ downstaging of the axilla (23-42% in cN+)

Krag. Lancet Onc 2007
Boughey. JAMA 2013
Rouzier. JCO 2002
Approach to axillary surgery in patients undergoing primary systemic therapy

- Response can lead to lower axillary tumour burden.
- The benefits of less axillary local therapy need to be weighed against loco-regional recurrence risk and the risk of “understaging” and of overtreatment.
  - Indications for SLND
  - Indications for “SLNDplus” (e.g. >2 nodes, tailored axillary dissection)
  - Indications for ALND (e.g. in cN2 or resistance)
Current indications for axillary dissection
Post neoadjuvant therapy

- Clinically (US) node-positive patients confirmed by staging after NAC – IBC or Locally advanced inoperable (N2/N3)
- SLNB positive after NAC (burden of disease? – ITC/micro- NSABP – B-18)
- If postmastectomy radiation is not indicated by the positive SLN or does not include the regional nodes
Omission of ALND in clinically N+?

Initially positive axilla

- May be restaged after NACT
- Axilla still clinically positive → ALND (US findings*)
- Axilla clinically negative → SLN or ALND
- FNR >10% after NACT, can be reduced by documenting removal of clip, dual tracer, and removing >2 SLN
- Marking of nodes during biopsy with tattoo or clip

*Node positivity: Palpable lymph nodes; >1 cm in size; reduced fatty deposition; lateral cortical hypertrophy on ultrasonography.
Does Low-Volume SLN Disease Require ALND?
T.A. Moo et al. Ann Surg Oncol 2018

Low-volume SLN disease after NAC is not an indicator of a low risk of additional positive axillary nodes and remains an indication for ALND, even when not detected on intraoperative FS.
Axilla negative at presentation and NAC (except in LABC) – SNB Post NAC

Axilla positive pre-NAC and negative post NAC (at least 3 negative nodes, dual tracer/clip/tattoo)

Axilla positive pre-NAC and micro or minimal burden – ALND/RT

Beware of subtypes associated a higher FNR – Luminal/lobular
Criteria for mastectomy

- IBC /LABC not responding to PST (NO RECONSTRUCTION)
- Persistence of skin edema
- Residual tumor size (Oncoplastic Techniques) – Tumor/Breast ratio
- Presence of extensive suspicious microcalcifications - >mammography, MRI – (Bx confirmed)
- Evidence of multicentricity > MRI (Bx confirmed)
- Desire of the patient – INFORMATION
Meta-analysis of randomised trials evaluating pCR and surgical outcomes after neoad NST in patients EBC.
The primary outcome was breast-conserving surgery (BCT) rate.
Secondary outcomes were pCR rate and association to BCT.
BCT rate ranged 5-76% across arms with an average BCT of 57% (95% CI 52-62%).
In the subset of 14 multi-arm studies, no significant association was seen between the differences in pCR and BCT between treatment arms (p Z 0.27).
pCR does not increase BCT in patients receiving NST for EBC.
- **Surgery after primary systemic treatment (PST)**

  - Primary systemic treatment (PST) is responsible for a greater percentage of BCT.
  - All patients proposed to PST should have their tumor marked before initiating treatment.
  - Candidates to PST are those with locally advanced breast cancer (LABC) and those whose tumor breast size ratio doesn’t allow conservative treatment with a favorable cosmetic outcome.
  - Triple negative and Her2 positive benefit from PST
New trials
NO SURGERY AFTER COMPLETE RESPONSE

The role of Surgery in ABC

PROSPECTIVE TRIALS ON SURGERY IN STAGE IV BREAST CANCER AT PRESENTATION

<table>
<thead>
<tr>
<th>Country</th>
<th>CI Tri gov ID</th>
<th>Current Name</th>
<th>Accrual Period</th>
<th>N</th>
<th>Type</th>
<th>Initial Tr</th>
<th>Radiotherapy</th>
<th>Pr End Point</th>
<th>STATUS</th>
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<tr>
<td>India</td>
<td>NCT00193778</td>
<td>Tata Memorial</td>
<td>2005-2012</td>
<td>350</td>
<td>RCT</td>
<td>ST</td>
<td>If indicated</td>
<td>TTP</td>
<td>Completed</td>
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<tr>
<td>USA</td>
<td>NCT00941759</td>
<td>MSKCC</td>
<td>2009-2016</td>
<td>100</td>
<td>PO</td>
<td>ST/Surg</td>
<td>Not addressed</td>
<td>TTP</td>
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<tr>
<td>Netherlands</td>
<td>NCT01392586</td>
<td>SUBMIT</td>
<td>2011-2014</td>
<td>10</td>
<td>RCT</td>
<td>Surgery</td>
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<td>Survival</td>
<td>Terminated</td>
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<tr>
<td>Japan</td>
<td>JCOG1017</td>
<td>PRIM-BC</td>
<td>2011-2016</td>
<td>410</td>
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<td>ST</td>
<td>Not addressed</td>
<td>Survival</td>
<td>Ongoing</td>
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<tr>
<td>USA/Canada</td>
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<td>ECOG</td>
<td>2011-2025 (15)</td>
<td>880(368)</td>
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<td>ST</td>
<td>If indicated</td>
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<td>Ongoing</td>
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<tr>
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<td>Surgery</td>
<td>For BCT only</td>
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<td>Completed</td>
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<tr>
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<td>EOSYTIVE</td>
<td>2010-2019</td>
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<td>Surgery</td>
<td>If indicated</td>
<td>Survival</td>
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<tr>
<td>Turkey</td>
<td>NCT02125631</td>
<td>BOMET MF 14-01</td>
<td>2014-2017</td>
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<td>RCT</td>
<td>Surgery</td>
<td>Not addressed</td>
<td>Survival</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
A retrospective cohort study using data from the SEER program. Female patients stage IV ab initio breast cancer from 1988 to 2011 (not receive radiation as part first treatment) (N = 21 372).
The median survival increased from 20 months (1988-1991) to 26 months (2007-2011).
Receipt of surgery was associated with improved survival in multivariate analysis. Account for several bias.
**A large benefit for many women with stage IV breast cancer with surgery to the primary tumor is unlikely.**
More potent and targeted drugs may be able to provide better control/eradication of systemic disease. Systemic therapies cannot yet manage all macroscopic disease.
Until then, local therapy with surgery to the primary tumor may offer critical disease control for select patients and could be an essential component of prolonged survival.
The role of Surgery in ABC

Primary operation in synchronous metastasized invasive breast cancer patients: first oncologic outcomes of the prospective randomized phase III ABCSG 28 POSYITIVE trial

Fitzal, Bjelic, Steger, Singer, Marth, Hubalek, Schrenk, Balic, Knauer, Haid, Wette, Swoboda, Luisser, Fuegger, Greil, Soelkner, Tesl, Gnant on behalf of the ABCSG.

Results: 90 patients (45 with surgery, 45 with primary systemic therapy without surgery). The median survival in the surgery arm was 34.6 months versus 54.8 months in the no surgery arm without statistical significance (HR 0.691 CI 0.358 – 1.333; p=0.267). Time to distant progression was insignificantly longer in the no surgery arm (surgery arm 13.9 versus no surgery arm 29.0 months).

Conclusion: This first analysis of the prospective randomized phase III trial POSYITIVE-ABCSG-28 demonstrated no benefit in overall survival for immediate surgery of the primary in de novo stage IV breast cancer patients.
The role of Surgery in ABC

To date, the *removal of the primary tumor in patients with de novo stage IV breast cancer* has not been associated with prolongation of survival, with the possible exception of the subset of patients with bone only disease.

However, it can be considered in selected patients, particularly to improve quality of life, always taking into account the patient’s preferences. *(LoE/GoR: I/C) (70%)*

Of note, some studies suggest that surgery is only valuable if performed with the same attention to detail (e.g. complete removal of the disease) as in patients with early stage disease. *(LoE/GoR: II/B) (70%)*

Additional prospective clinical trials evaluating the value of this approach, the best candidates and best timing are currently ongoing.
Conclusions

- Surgery is suffering major de-escalation
- Broader indications for genetic testing – preventive strategies
- DCIS - wait and see in low/intermediate grade.
- Breast conservation is possible in the majority of cases.
- When mastectomy, NS with immediate reconstruction – except skin invasion and inflammatory cancer.
- Less surgery or no surgery after PST – Trials ongoing
- Axillary clearance vs minor axillary approach or none
- Primary tumor surgery in stage IV at presentation - only in controlled by systemic treatment and oligometastatic disease
The Breast and Best Team
ESO-ESMO EEBR Masterclass 2019

Advanced Breast Cancer

Fifth International Consensus Conference

14-16 November 2019
Lisbon, Portugal

Coordinating Chair: F. Cardoso, PT

RECEIVE UPDATES AT WWW.ABC-LISBON.ORG | #ABCLISBON

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