MASTER 2° LIVELLO

SENOLOGIA MULTIDISCIPLINARE

Direttore: Prof.ssa Chiara Benedetto

CHEMIOTERAPIA PREOPERATORIA (NEOADIUVANTE)

Ruolo dell'oncoplastica 1° livello, R.Bussone

Ospedale Cottolengo di Torino

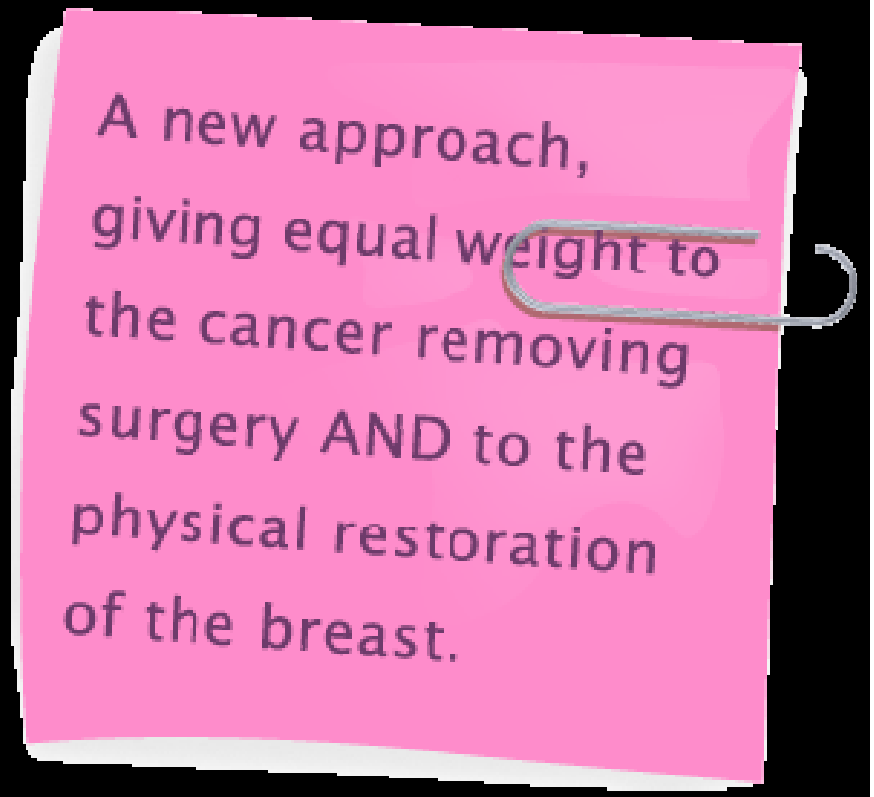
Breast Unit – Chirurgia Senologica

MARTEDÌ 26 SETTEMBRE 2017

AULA DELLEPIANE SANT'ANNA VIA VENTIMIGLIA, 3 - TORINO

Che cos'è l'oncoplastica?

- Descritta nel 1990 per la prima volta da Audretsch come un' integrazione di tecniche di chirurgia plastica utilizzate per la chirurgia conservativa della mammella volte a ridurre il difetto cosmetico derivante da tale procedura
- Estensione della chirurgia conservativa tradizionale
- Permette di effettuare resezioni maggiori senza la compromissione dell'outcome estetico



Goals

- 1) resezione con margini liberi e buon controllo locale
- 2) soddisfacente risultato estetico associato a soddisfazione del paziente ed ad una miglior qualità della vita

40% delle donne sottoposte a chirurgia conservativa ha uno scadente risultato estetico

Ansia
Depressione
Alterazione della percezione dell'immagine corporea
Disturbi sfera sessuale
Alterazione dell'autostima

Aumento dei costi della sanità pubblica

L’ Oncoplastica
è imprescindibile da una
Pianificazione dettagliata

- **SEDE DELLA LESIONE**
- **DIMENSIONE DELLA LESIONE**
- **CARATTERISTICHE ISTOLOGICHE DELLA LESIONE**
- **DIMENSIONE LESIONE / DIMENSIONE MAMMELLA**
- **PTOSI MAMMARIA**
- **PATOLOGIE ASSOCIATE**

Classificazioni

Improving Breast Cancer Surgery: A Classification and Quadrant per Quadrant Atlas for Oncoplastic Surgery

Krishna B. Clough, MD, Gabriel J. Kaufman, MD, Claude Nos, MD, Ines Buccimazza, MD, and Isabelle M. Sarfati, MD
Department of Surgery, The Paris Breast Center (L'Institut du Sein), Paris, France

Society of Surgical Oncology 2010

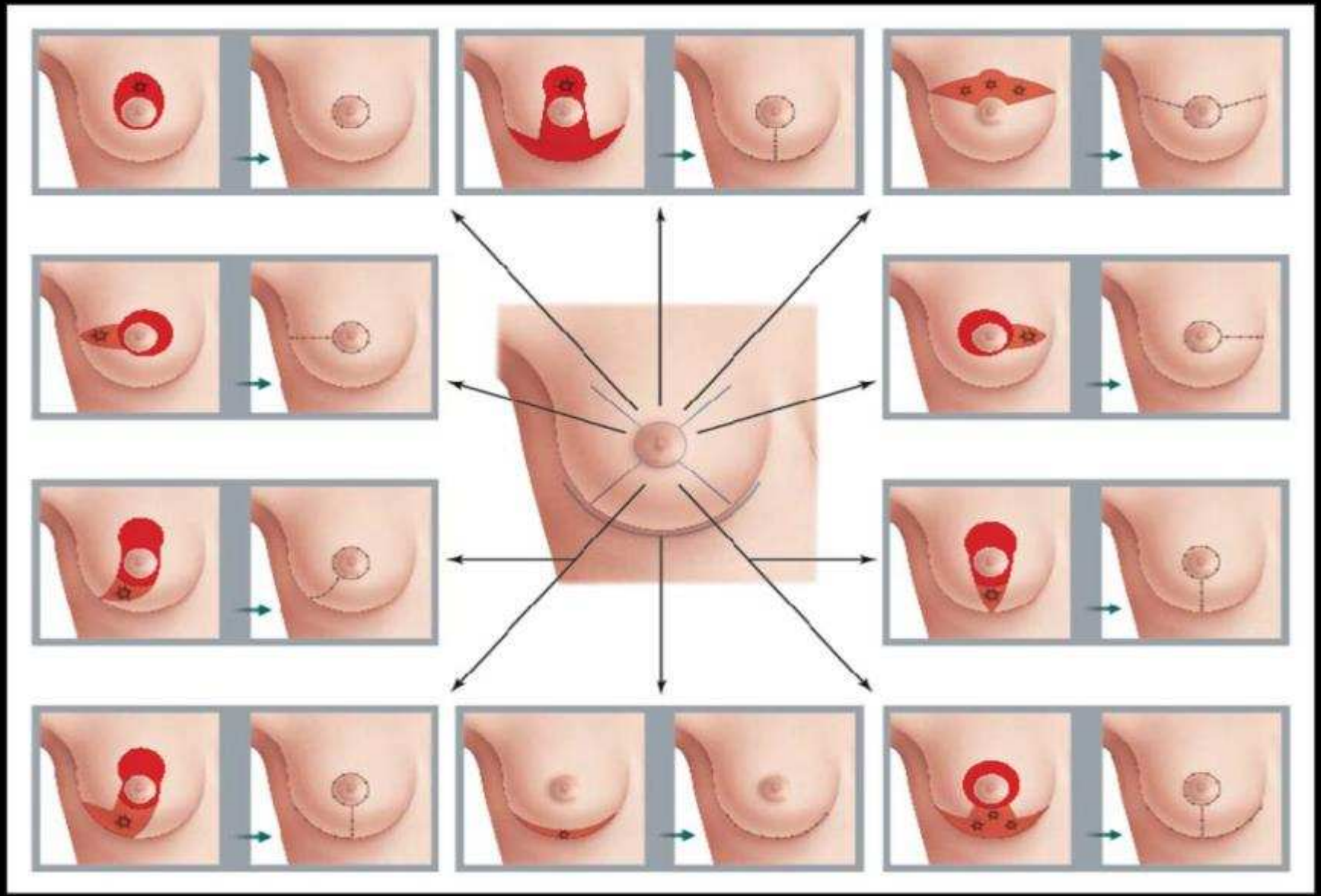
A level I approach is based on dual-plane undermining, including the nipple– areola complex (NAC), and NAC recentralization if nipple deviation is anticipated.
No skin excision is required.
Level II techniques allow major volume resection.
They encom- pass more complex procedures derived from breast reduction techniques. These ‘‘therapeutic mammoplasties’’ involve extensive skin excision and breast reshaping.

Primo livello

Non sono richieste tecniche di chirurgia plastica specialistiche

Escissioni < del 20 % del volume totale della ghiandola

DOVE POSIZIONO LA CICATRICE?



ONCOPLASTICA

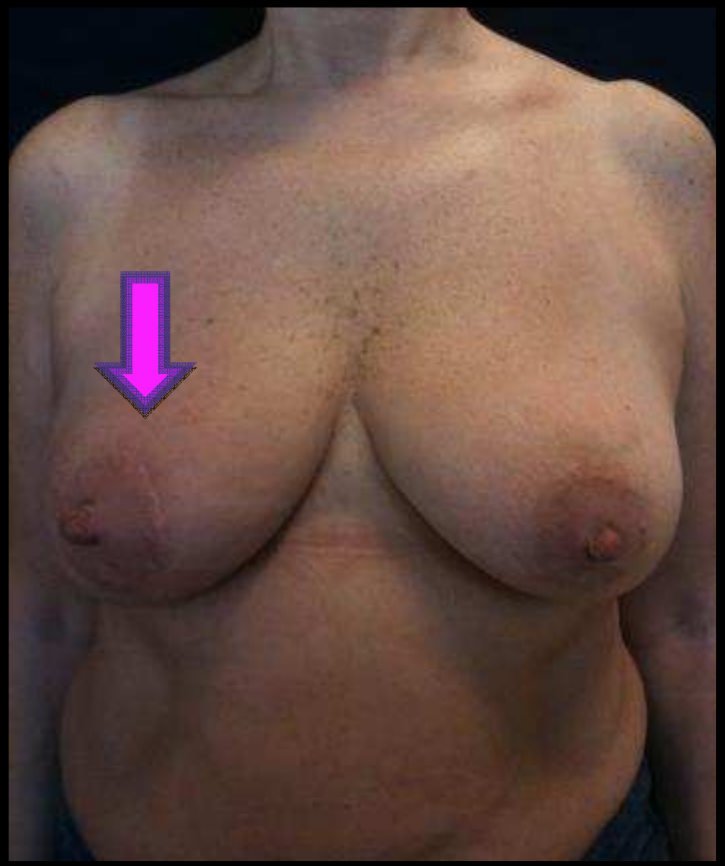
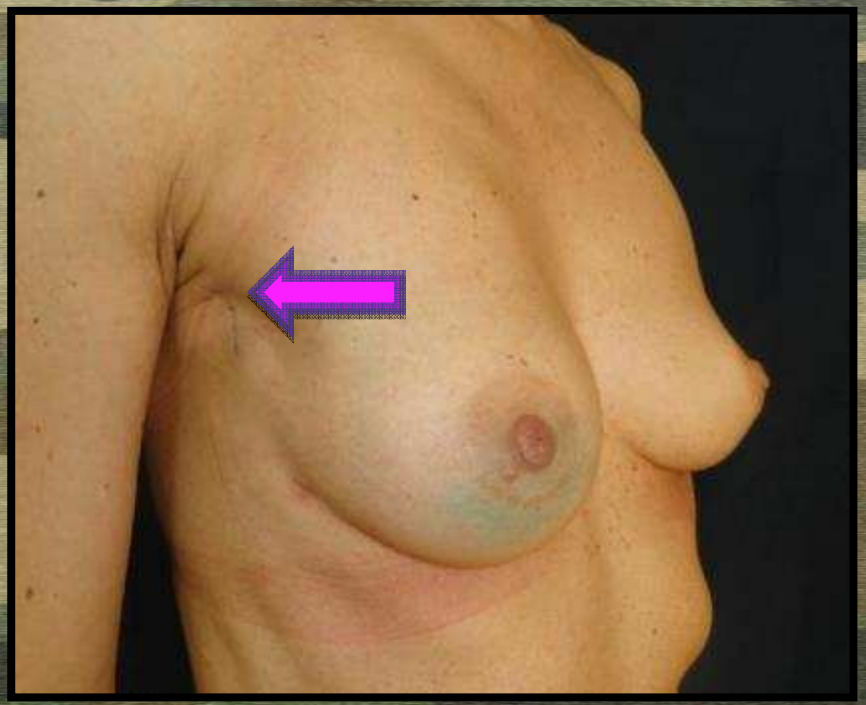


FOTO POST-OPERATORIE

Si cerca di posizionare la cicatrice in aree in cui sia facilmente mimetizzabile

ONCOPLASTICA



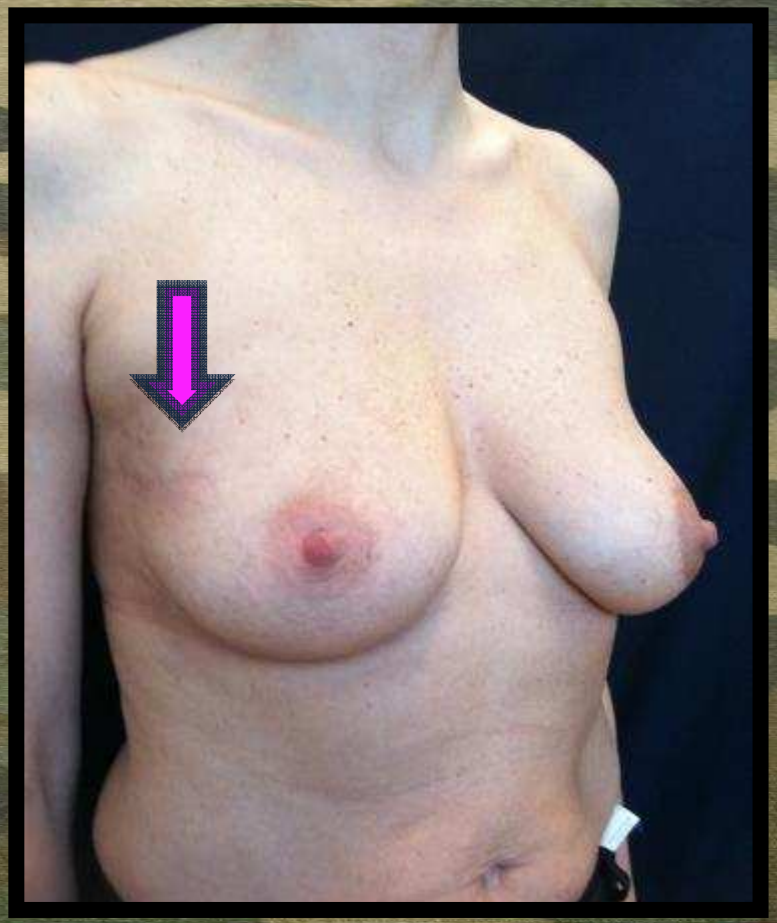


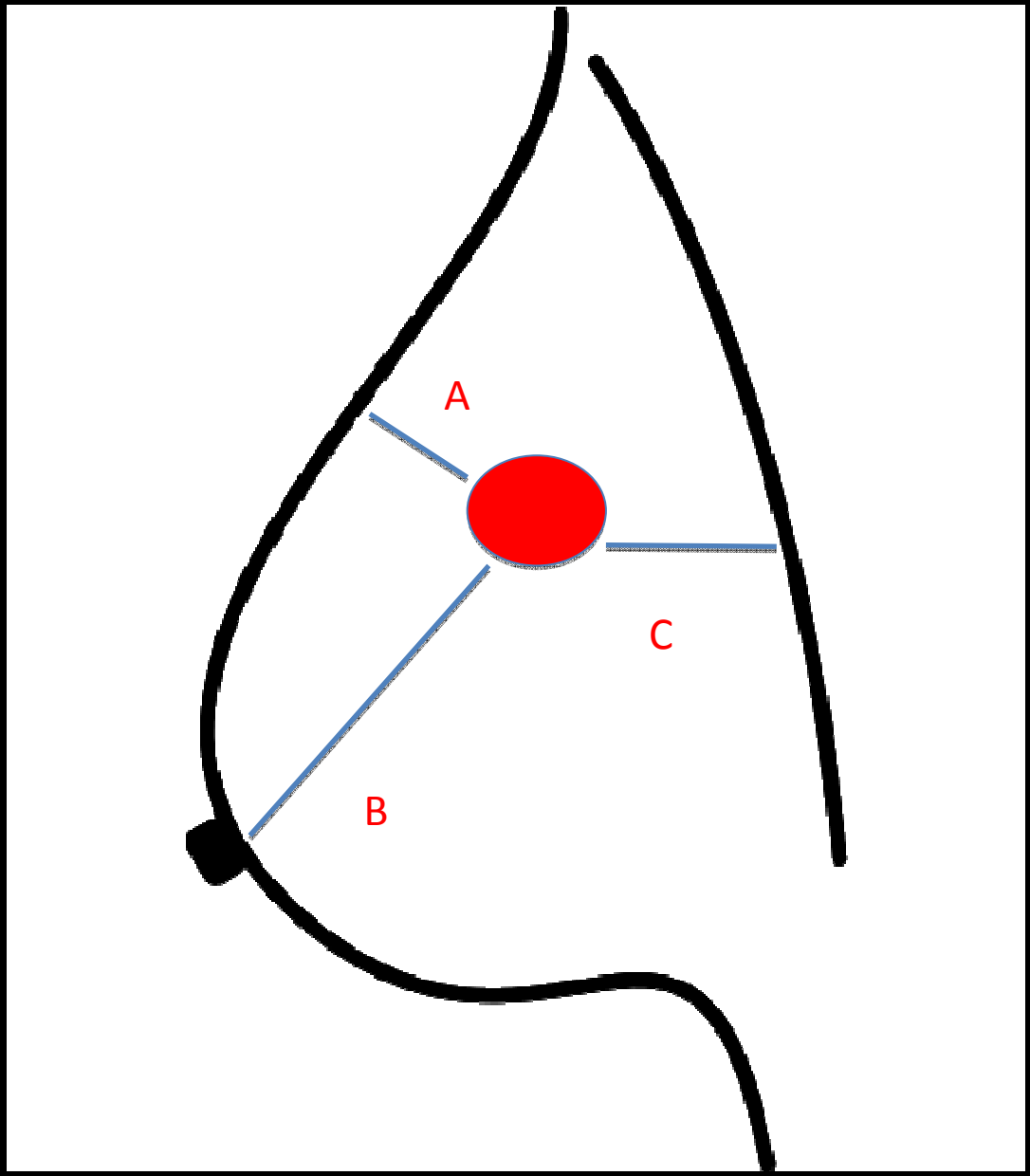
FOTO POST-OPERATORIE

Dati radiologici fondamentali

A: distanza lesione - cute

B: distanza lesione - capezzolo

C : distanza lesione - muscolo pettorale



Jeevan R, Cromwell DA, Trivella M, et al. Reoperation rates after breast conserving surgery for breast cancer among women in England: retrospective study of hospital episode statistics. *BMJ.* 2012;345:e4505.

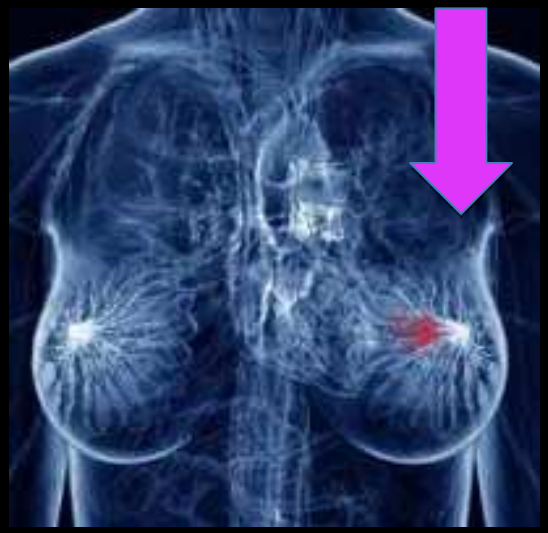
- Involved surgical margins occur in 20%–40% of all standard BCS and 1 in 5 BCS patients undergo a reoperation (including re-excision or completion mastectomy).

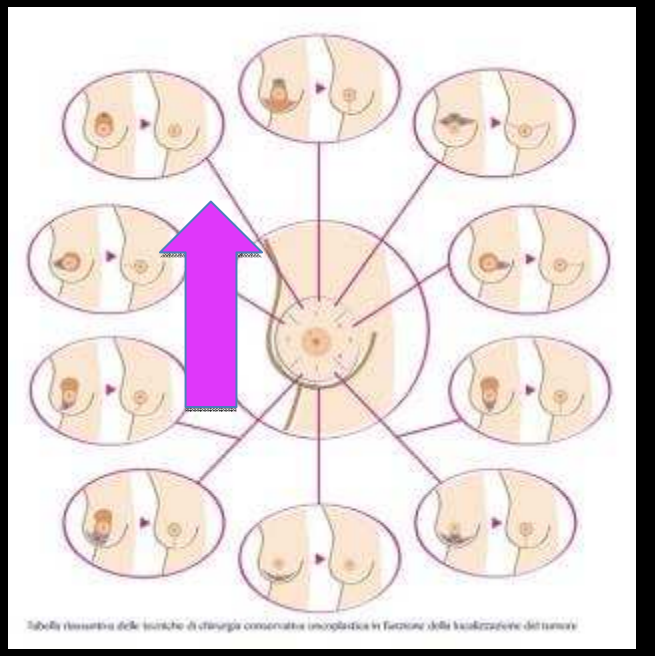
ONCOPLASTICA

Riduce la percentuale di margini coinvolti grazie a piu' ampie resezioni

Riduce i re-interventi , diminuendo il rischio di posticipare terapie adiuvanti

Chemioterapia neo adiuvante





De-escalating and escalating treatments for early-stage breast cancer: the St. Gallen International Expert Consensus Conference on the Primary Therapy of Early Breast Cancer 2017

BREAST SURGERY FOLLOWING NEOADJUVANT THERAPY

Neoadjuvant therapy serves two main goals. It provides effective systemic treatment (equivalent to adjuvant therapy) to prevent cancer recurrence, and allows de-escalating surgery for many women with larger tumors and/or axillary nodal involvement.

Should the entire area of the original primary be resected after neoadjuvant therapy or should the resection include only the residual area of tumor?

The Panel recommended that the extent of residual tumor guide the extent of breast surgery, and that full resection of the initial tumor bed was not necessary.

In general, the Panel favored the 'no ink on tumor' standard for surgical margins following neoadjuvant therapy.

However, in cases of multifocal residual disease and/or cases of 'scattered' residual disease, many panelists expressed an expert opinion to favor more 'generous' margins.

Carter SA, Lyons GR, Kuerer HM, et al. Operative and oncologic out- comes in 9861 patients with operable breast cancer: single-institution analysis of breast conservation with oncoplastic reconstruction. *Ann Surg Oncol.* 2016;23(10):3190–3198.

In terms of margin status, patients who underwent OBCS had significantly less positive or close margins (5.8%) compared with sBCS (8.3%, *P*=0.04)

La valutazione intraoperatoria dei margini deve essere

radiologica

o

anatomo patologica ???

Mansell J, Weiler-Mithoff E, Stallard S, Doughty JC, Mallon E, Romics L. Oncoplastic breast conservation surgery is oncologically safe when compared to wide local excision and mastectomy. *Breast.* 2017;32:179–185.

There was no statistical difference in 5-year local recurrence rates between the 3 groups

2% OBCS

3.4% sBCS,

2.6% Mx ± IR

In terms of distant recurrence, rates were signi cantly higher after Mx ± IR and OBCS

7.5% OBCS,

3.3% sBCS

13.1% Mx ± IR,

The higher rates of distant recurrence after OBCS, compared with sBCS, most likely reects the more advanced cancer pathology and biological aggressiveness in this group, and does not indicate that OBCS is unsafe oncologically

Risultati estetici

Haloua MH, Krekel NM, Winters HA, et al. A systematic review of oncoplastic breast-conserving surgery: current weaknesses and future prospects. *Ann Surg.* 2013;257(4):609–620.

Most studies report good cosmetic outcome after OBCS in nearly 90% of patients.

Variation in how cosmetic outcome was evaluated:

reporting with non-validated assessment tools

timing of evaluation for cosmetic outcome is heterogenous.

Evaluation of cosmetic outcome should be performed at least 2 years postoperatively to allow for long-term effects of radiation therapy.

Patients frequently report better scores than professionals

Carter SA, Lyons GR, Kuerer HM, et al. Operative and oncologic out- comes in 9861 patients with operable breast cancer: single-institution analysis of breast conservation with oncoplastic reconstruction. *Ann Surg Oncol.* 2016;23(10):3190–3198.

- A recent study from the MD Anderson Cancer Center in the USA demonstrated that OBCS had a nearly fourfold increase in the percentage of all breast cancer surgeries performed (from 4% to 15%) between 2007 and 2014.

Oncological safety and cosmetic outcomes in
oncoplastic breast conservation surgery, a review of the best level of evidence literature
Breast Cancer - Targets and terapy 2017:9 521-530

- The techniques of OBCS previously required either specialist oncoplastic training for breast surgeons or a combined approach by breast oncological surgeon and plastic surgeons. In the UK, at present, all general surgeons with a breast subspeciality interest require
  competency in mammoplasty techniques and involvement in pedicledaps for certicate of completion of training (CCT).

Breast. 2017 Aug;34:58-64. doi: 10.1016/j.breast.2017.04.010. Epub 2017 May 13.

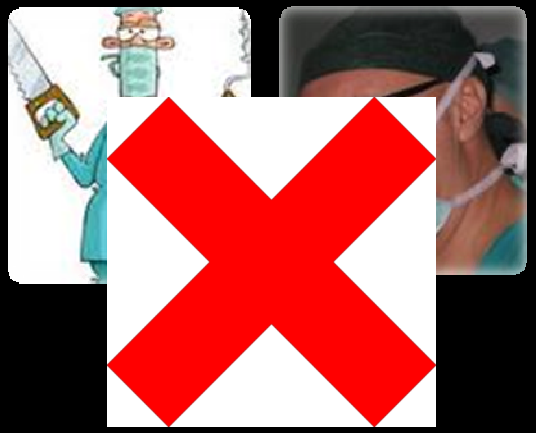
Oncoplastic techniques: Attitudes and changing practice amongst breast and plastic surgeons in Great Britain.

Challoner T1, Skillman J2, Wallis K3, Vourvachis M1, Whisker L4, Hardwicke J

- I chirurghi senologi devono includere nel proprio bagaglio le tecniche di chirurgia oncoplastica per poter offrire chirurgia conservativa in percentuale maggiore con migliori risultati estetici
- I chirurghi senologi devono effettuare dei training di chirurgia plastica e i chirurghi plastici dei training in oncologia

FORMAZIONE ONCOPLASTICA DI NUOVI CHIRURGHI SENOLOGI

CHIRURGIA ONCOLOGICA



CHIRURGIA PLASTICA