Material and Methods: We retrospectively reviewed the medical records and pathological reports of 143 patients that underwent BCS for BC between 2009 and 2017 in General Surgery Department from Mures Country Hospital. The postoperative evolution was evalueted by phone contact of the patients. The follow-up period was between 20 and 120 months. 46 patients could not be contacted, therefore, 97 patients were completely included in the study, and 46 were included only in determining the preoperative parameters associated with the positive resection margins. Statistical analysis were done using GraphPad Prism, Fisher exact's test, Chi square test and Kaplan Meier survival curves.

Results: Of the 143 patients included in this study, positive resection margins were identified in 11, representing 7.69%. The overall mortality is 16.66% for patients with positive resection margins (one patient out of 6) and 6.59% for patients with negative resection margins (6 patients out of 91). For the overall survival $p = 0.50$, and for the specific survival $p = 0.53$, statistically insignificant. No patient had local recurrence during the follow-up period. Positive margins were significantly associated with neoadjuvant chemotherapy ($p < 0.0001$) and the presence of DCIS ($p = 0.01$). Patient's age ($p = 0.2$), patient's BMI ($p = 0.54$), tumor diameter ($p = 0.75$), histological type ($p = 0.39$), grade ($p = 0.96$) and IHC profile of the primary tumor ($p = 0.31$), multifocale tumors ($p = 0.09$), the presence of microcalcifications ($p = 0.18$), lymphovascular embolous ($p = 0.29$), necrosis ($p = 0.14$) and inflammatory infiltrate ($p = 0.43$), axillary limph nodes status ($p = 1$), axilary surgery ($p = 1$) and oncoplastic surgery ($p = 1$) do not statistically influence the positivity of resection margins in our study.

Conclusions: In our series, 2 out 16 factors analysed are significantly asociated with positive resection margins in BCS. They should be considered when planning surgical management of early-stahe breast cancer.

No conflict of interest.

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Knowledge attitude and practice of surgeons for breast conserving surgery: Results from an Indian cohort

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Background: Breast conservation surgery (BCS) is now standard practice across the western world. However, in India numerous groups have attributed the low uptake of BCS to patient related factors. In India, breast cancer is treated by general surgeons and trained breast surgical oncologists. Making the choice between Mastectomy (MRM) and BCS is a complex process and surgeons play a vital role in that choice. We conducted a survey among treating surgeons to evaluate the knowledge, attitude and practice for BCS in India.

Methods: A structured questionnaire with 20 questions regarding various aspects of physician details and their impact on breast surgery was distributed to 100 surgeons who manage patients with breast cancer, including general surgeons, trained breast surgeons across India. The questionnaire was developed by a group of breast surgeons at a large tertiary cancer center in India and the results were analyzed using SPSS version21.

Results: Of the 100 surgeons invited to participated in the survey, 72 responded at the close of the survey in October 2019. Twenty-one (29.2%) respondents were from cancer centers, 25(34.7%) from medical colleges and 26(36.1%) in private practice, with 43(59.7%) having been in practice for more than 10 years and 33 (45.8%) from tier 1 cities. Of these 64 (88.9%) offer BCS to eligible patients with early breast cancer (EBC). Those that do not offer BCS in EBC cited reasons of patient compliance, fear of recurrence and inadequate training in breast surgery. Physician related factors that appeared to negatively impact the choice of BCS in EBC were, inadequate breast surgery training ($n = 17$, 17.2% opt for BCS vs 75% opt for mastectomy, $p = 0.002$), volume of cases (less than 5 cases a month, $n = 21$, 21.9% BCS vs 87.5% mastectomy = 0.001). There was no impact of gender, years in practice, type of practice, tier of city, multidisciplinary or individual decisions. When asked about BCS post neo-adjuvant chemotherapy (NACT), only 36/72 (50%) routinely performed BCS and 24(33.3%) performed in select cases. Of these 60, 33(55%) performed in all T size if feasible for BCS post-NACT, while 19 (31.6%) offered BCS post-NACT in women with pre-NACT T1-T3 lesions. The factors impacting choice of BCS post-NACT included training, volume of cases and access to mammography. However, there was a large variability in the understanding evidence for post-NACT BCS among surgeons, suggesting a need for clarity of the same, for the locally advanced cancers with heavy tumor burden seen in India.

Conclusion: The surgeons' training, availability of resources, volume of cases, affected the decision making between MRM and BCS. Fear of recurrence was responsible for making BCS less popular, and there was a large variability in the understanding of safety to post-NACT BCS.

No conflict of interest.

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Current clinical practice and determinants of the use of delayed breast reconstruction in the Netherlands

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Background: Delayed breast reconstruction (DBR) is a valid option for post-mastectomy breast cancer patients who did not receive immediate breast reconstruction (IBR) due to (oncological) contra-indications or personal preferences. The objective of this study was to investigate the clinical practice and determinants of the use of delayed breast reconstruction (DBR) in the Netherlands.

Materials and Methods: Early-stage breast cancer patients treated with mastectomy between January and March 2012 in the Netherlands were selected from the Netherlands Cancer Registry (NCR). Routinely collected patient, tumor, treatment and hospital characteristics were completed with data on DBR up to five years after diagnosis. Treatment groups (DBR, immediate breast reconstruction (IBR), and mastectomy only (MAST)) were compared using Pearson Chi-square tests. A multivariable logistic regression analysis was performed to determine which factors were independently associated with post-mastectomy DBR. To determine factors influencing the time between mastectomy and DBR, a Cox regression analysis was performed.

Results: In total, 1,415 patients underwent mastectomy of whom 10.2% underwent DBR, 13.7% IBR and 76.1% MAST. Treatment groups differed based on patient, tumor, treatment and hospital characteristics. The mean time between mastectomy and DBR was 2.4 years [range 1–6 years]. DBR patients more often received autologous reconstruction compared to IBR patients (37.5% versus 6.2%, $p < 0.001$). Age below 50 years (35–49 versus 50–75 years OR 4.3, 95%CI 2.9–6.3) and chemotherapy treatment (adjuvant or neoadjuvant versus no chemotherapy OR 2.99, 95%CI 1.84–4.85; OR 2.85, 95%CI 1.52–5.35, respectively) were predictive factors for use of DBR, but did not exclusively explain the use of DBR. Time between mastectomy and DBR was significantly shorter in when radiation therapy (HR 0.61, 95%CI 0.42–0.89, $p = 0.011$) or adjuvant chemotherapy (HR 0.53, 95%CI 0.30–0.93, $p = 0.028$) was not given.

Conclusions: Although treatment with radiation therapy and adjuvant chemotherapy could explain time between mastectomy and DBR, the use of DBR over mastectomy alone could not be fully explained by age below 50 years and chemotherapy treatment. More information on for instance patient preferences is needed to understand the use and timing of DBR.

No conflict of interest.

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Clinical, imaging and pathology factors related to residual axillary disease after neoadjuvant treatment

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Background: Performing a sentinel node (SN) after neoadjuvant treatment (NAT) is still controversial. The SN false-negative rate may be acceptable for cN0 tumours but too high for cN1 tumours. Defining which clinical, imaging and pathology factors modulate the risk of residual axillary disease after neoadjuvant treatment could be helpful to determine the patient's eligibility for post-chemotherapy SN.

Material and Methods: A retrospective review of prospectively entered data contained in our institutional Tumour Registry. Data on patients submitted to NAT between 2009 and 2018 were retrieved. Several clinical (age at diagnosis, diagnosis made by screening mammography or symptoms, chemotherapy scheme used), imaging (ultrasound axillary features previous to neoadjuvant treatment, axillary FNAC positivity previous to treatment, MRI axillary description after neoadjuvant treatment) and pathology factors (pathology type, breast pathology response to treatment, grade, oestrogen receptor status, progesterone receptor status, Her2Neu status, p53 status) were evaluated as possible predictors of post-treatment