Methods: All patients attending breast clinic between 1st January 2008 - 31st December 2010 with breast pain only, undergoing mammography, were assessed. Patients were then divided into the under 50 and over 50 age group for comparison.

Results: 315 patients were assessed, 168 (53%) were under 50 years old (mean 43). All had clinically normal breasts on examination. Six (3.5%) patients had indeterminate mammographic abnormalities in the under 50’s age group, versus eight (5%) in the over 50’s group. All had benign findings following further investigation. One (0.6%) patient in the under 50’s group had a malignant mammographic abnormality - this was on the asymptomatic side in a 48 year old. In those patients over 50 years, three (2%) had malignant abnormalities on mammography, of which two were confirmed malignancies.

Conclusions: Malignancy is rare in patients under the age of 50 presenting with pain only. In the setting of a normal clinical examination, routine mammography is not necessary, and may lead to further unnecessary investigations and anxiety.

0571: MAJOR BREAST AND AXILLARY SURGERY – FEASIBILITY OF A 23 HOUR PATHWAY

Rachel Clancy, Roger Watkins. Frenchay Hospital, Bristol, UK

Aims: Length of hospital stay for mastectomy patients has declined. Hospital Episode Statistics data for 2010-11 showed the average length of stay is still almost four days. Without compromising clinical care the aim of this study was to evaluate the feasibility and safety of a new pathway aimed at discharging patients within 24 hours of surgery.

Methods: From December 2008 suitable breast cancer patients requiring mastectomy and/or major axillary surgery were offered same day admis-
sion and discharge home within 24 hours.

Results: 126 patients (mean age:60; range27-86) were included from 2008-2011. 99 (79%) underwent mastectomy with either axillary node sampling (ANS) (10), sentinel lymph node biopsy (SNB)/99, axillary node clearance (ANC)(20) or no axillary procedure (10). 4 (3%) had bilateral mastectomy with either ANS(1), SNB(2) or no axillary procedure (1). (18%) patients underwent ANC with either wide local excision (4), repeat excision (1) or no breast procedure (18). 97 (77%) patients were discharged within 24 hours. 24 (19%) were discharged on second day and 4(3%) required a three night stay. One patient developed ventilatory problems post-operatively requiring transfer to ITU. None of the 97 patients required unplanned readmission.

Conclusions: Major breast and axillary surgery can be safely performed with a minimal length of post-operative stay in suitable patients.

0589: ONE-STAGE DELAYED BREAST RECONSTRUCTION USING STRATITICE AND PERMANENT IMPLANT

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Aim: This case series aims to determine the degree of patient satisfaction and complication rates associated with a novel method of one-stage delayed breast reconstruction. Method: Six patients underwent reconstruction, one of which was bilateral, over an eight-month period. StratiticeTM was used to create a subpectoral/allogenic graft pocket capa-
cious enough to accommodate a permanent implant, hence eliminating the need for further intervention following the index procedure. The creation of a neo-inframammary fold was essential to produce a natural appearance.

Conclusion: This case series has demonstrated that this new technique is an excellent option for patients wishing to undergo a less extensive form of delayed reconstruction. It is associated with less tissue disruption than other reconstructive procedures, hence reducing the length of recovery and complication rates whilst giving the reconstructed breast a natural appearance.

0600: GYNECOMASTIA: IS IT COST-EFFECTIVE TO INVESTIGATE ALL PATIENTS IN A FINANCIALLY RESTRAINED NHS?

Habib Tafazal, Hiren Chauhan, Mehboob Mirza. Sandwell General Hospital, Birmingham, UK

Aim: Gynecomastia is a common condition, with many men being referred to the already busy rapid access breast clinic. As surgery for gynecomastia is classed as non-essential, is it cost-effective to investigate all patients?

Method: Retrospective analysis of 97 patients referred from primary care. All patients were male, aged 17 to 89 years. The costs of the following investigations were calculated. Blood tests including LFTs, U&Es, TSH, FSH, LH, prolactin, testosterone, oestradiol, AFP, HCG and imaging in the form of mammography and ultrasound.

Results: The cost of a complete set of blood tests for each patient, including staffing and reagents, totals £35. Mammography and ultrasound cost £110 each. 87% of the patients were investigated with blood tests; the majority of which were normal. 43% had a mammogram, 52% had an ultrasound. Neither breast cancer nor endocrine pathology was detected in any cases. Total cost of the blood tests was £3000; mammography costs were over £4500.

Conclusions: Investigating all patients may not be cost effective but a selected combination of tests may be useful. We recommend that blood tests do not add value towards diagnosis and are an unnecessary additional cost to the already financially restrained NHS.

0649: A COMPLETE AUDIT CYCLE OF PREOPERATIVE SURGICAL SITE MARKING VERIFICATION CHECKLIST


Aims: Correct preoperative surgical site marking is a major patient safety issue. The aim of this audit was to examine the compliance with preoperative surgical site marking verification checklist (PMVC) used at this trust.

Methods: A prospective audit (101-patients) and a re-audit following staff education (125-patients) examined PMVC for correct written confirmation of: (a) side and procedure, (b) marking verification checks on ward (checks 1 and 2), and preoperatively in theatre (checks 3 and 4), (d) safety net signings if any of checks 1-4 were not completed (checks 5 and 6).

Results: All patients had correct side and operation description listed. Ward documentation for checks 1 and 2 were complete in 100% and 97% in initial-audit, and in 100% and 98% in re-audit period, respectively. In theatre documentation for checks 3 and 4 were complete in 70% and 48% in initial-audit, and in 80% and 74% in re-audit period. Further safety net checks 5 and 6 were not completed in either case (initial-audit–58%, re-audit–36%). No inadvertent side surgery error occurred in either cohort.

Conclusions: A significant improvement in practice was demonstrated following staff education and regular close audit is necessary to ensure compliance to PMVC which is pivotal in preventing error.

0664: IMPACT OF PROPHYLACTIC ANTIBIOTICS ON THE INCIDENCE OF POST-OPERATIVE WOUND INFECTION AND SUBSEQUENT DELAY IN ADJUVANT THERAPY FOR BREAST CANCER

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Introduction: Breast surgery is considered clean but studies have shown rates of infection to be 5% to 30%. Wound infection results in the delayed start of adjuvant breast cancer treatment. We therefore conducted an audit to analyse compliance with guidelines (SIGN guideline 84,104).

Methods: 68 patients undergoing radiotherapy following wide local excision for breast cancer across four units were analysed. Data was extracted from treatment sheets, operation notes and anaesthetic charts.

Results: Antibiotic prophylaxis was administered in 28 patients (41%) of which six (21%) developed wound infection. No antibiotics were given in 40 patients (59%) of which 20 (50%) developed wound infection. There was a delay in the initiation of radiotherapy in 31 patients. In two patients (7%) the delay was due to wound infection while in ten patients (32%) the delay was due to wound infection and adjuvant chemotherapy.

ABSTRACTS
Conclusion: Wound infection following breast cancer surgery can have severe consequences by delaying the start of adjuvant chemo-radiotherapy and affect the outcome of patient. This audit indicates that prophylactic antibiotics substantially reduce the risk of post-operative wound infections in breast surgery and thus avoid delay in start of adjuvant treatment or any additional operation required for definitive treatment.

0747: ULTRASOUND MARKING OF THE WIRE-TIP PRIOR TO WIRE GUIDED WIDE LOCAL EXCISION SHOWS PROMISE IN IMPROVING OUTCOME FOR IMPALPABLE BREAST Cancer

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Aim: We examined whether pre-operative ultrasound marking (PUM) of the wire-tip improved outcome for women undergoing wire-guided wide local excision (WLE) of impalpable breast cancer.

Methods: Between 01/2010 and 06/2011, 33 women underwent wire-guided WLE in our institution. Via a retrospective analysis of case-notes we identified patients who had undergone PUM of the wire-tip. Patient age, tumour characteristics, operating time, mass of specimen excised and further procedures (cavity-shave) were recorded.

Results: 12 women underwent PUM of the wire-tip (group a), 21 women did not (group b). Both groups were well matched for age, histological grade of tumour and tumour size. The median mass of specimen excised was 48.5g (range 24-92g) for group a and 57g (range 22-140g) for group b (p=0.14). Median operating time was 36.5mins (range 19-52mins) for group a compared to 41mins (range 24-103mins) for group b (p=0.001). None of the patients in group a (0%) required a further cavity-shave compared with 5 of the patients in group b (24%).

Conclusions: PUM of the wire-tip promises as an adjunct in wire-guided WLE of impalpable breast cancer, reducing the mass of specimen removed (with obvious aesthetic implications), the operating time, and the number of repeat procedures to which the patient is subjected.

0782: ANALYSIS OF SOCIAL STATUS AND BREAST CANCER PROGNOSIS USING WELSH INDEX OF MULTIPLE DEPRIVATION AND ACORN CLASSIFICATION: DOES A GAP EXIST?

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Introduction: There has always been an implied association between poor health and social deprivation. Our study assessed whether a gap in patient outcome for breast cancer exists between different strata of society within a geographical region in Wales.

Methods: A retrospective cohort of 745 breast cancer patients was recruited using cancer registry data from January 2008 to February 2011. Welsh Index of Multiple Deprivation (WIMD) along with 4 deprivation categories from the ACORN classification based on patient postcodes were used as a measure of deprivation. Nottingham Prognostic Index (NPI) was used as a marker of patient outcome.

Results: Analysis of WIMD demonstrated no correlation with NPI (coefficient: 0.042, p: 0.25). The incidence of breast cancer was highest (30%) in the least deprived category of patients (20%-26% for the remaining categories). The mean NPI score was 3.1 for the least deprived group (3.2 for other categories). 38% of the least deprived patients had an excellent prognostic outcome (32%-34% for other categories), 11% of the least deprived patients had a poor prognosis (9%-11% for other categories).

Conclusions: Our results show no statistically significant difference in either the incidence of breast cancer or outcome from treatment of the disease between different strata of society.

0858: WHAT DO PATIENTS UNDERSTAND ABOUT THE ROLE OF HOSPITAL STAFF AND INVESTIGATIONS IN BREAST CANCER SERVICES?

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Aims: Patients’ should be well-informed on the investigations they undergo and the roles of individual groups of healthcare professionals involved in their care. The aim of this study was to determine the level of knowledge in patients presenting to a breast unit.

Methods: A written questionnaire was given to new patients in the breast clinic. Questionnaires were reviewed by two independent assessors.

Results: 120 consecutive patients received the questionnaire; 7 declined or were unable to complete it. Mean age was 46.8 years, 97% (n=110) were female and 89% (n=101) spoke English as their first language. 88% defined ‘surgeon’ correctly whereas ‘radiographer’ and ‘radiologist’ were correctly defined by only 19% and 29% respectively. 26% correctly defined ‘pathologist’ and 41% ‘oncologist’. Only 39% of patients could define ‘mammogram’ and 8% ‘ultrasound’. 21% had an understanding of a ‘multi-disciplinary team meeting’. Younger patients (age<50 years) had a worse overall understanding than older patients (36% v 41% correct, p=0.017).

Conclusions: The majority of breast clinic patients have a poor understanding of the investigations they undergo and the role of medical staff involved in cancer care. Early education is essential, especially in this group of patients who may require multiple visits and investigations.

0882: THE ROLE OF AXILLARY ULTRASOUND IN EARLY INVASIVE BREAST CANCER

Liam Convie, Claire Jones, Carrie Moffitt, Mike Reilly, Janne Bingham. Altnagelvin Hospital, Londonderry, UK

Aim: Axillary node metastases influence the management of women with invasive breast cancer. Guidelines recommend axillary ultrasound for all patients, with fine needle aspiration (FNA) if abnormal. The study aim was to assess axillary ultrasound accuracy in a specialist breast centre.

Methods: All cancer patients with early invasive breast cancer, from August 2010 to August 2011 inclusively, were identified. Patient demographics, axillary ultrasound and histology results were obtained. Mann Whitney U and Fishers Exact tests were used, with a p value of <0.05 considered significant.

Results: 197 patients were identified; 9 were excluded due to incomplete data. All had axillary ultrasound; 31% were abnormal. 64% of abnormal lesions were malignant histologically. Ultrasound sensitivity and specificity were 60.9% and 82.5% respectively. Positive and negative predictive values were 65.0% and 78.8% respectively. Overall accuracy was 75.0%. The median IQR proportion of involved nodes was higher in those with a positive pre-operative ultrasound (50.0%(14.3-85.7%); vs.17.5%(8.2-42.5%); p=0.02), although harvested nodes was similar (17.0(11.0-23.0) vs.14.0(2.7-30.3); p=0.22). A lower proportion of patients with micrometastatic disease (35.7%) had a positive ultrasound compared to macroscopic nodal disease (85.7%; p=0.004).

Conclusions: Ultrasound accurately assesses axillary lymph node status. Routine ultrasound should help avoid excessive axillary surgery.

0897: PREDICTING RESPONSE – THE USE OF NEOADJUVANT CHEMOTHERAPY IN BREAST CANCER A 5 YEAR REVIEW

Eamon Francis, Aoife Lowery, Giueseppe Gullo, John Crown, James Geraghty, Denis Evey, Ennda W McDermott. St Vincents University Hospital, Dublin, Ireland

This study aimed to determine the rate of pCR following neoadjuvant chemotherapy, identify clinicopathologic factors associated with pCR and validate the efficacy of a published nomogram (Neoadjuvant) (1) in predicting pCR.

Data was collected on patients with breast cancer treated with neo-adjuvant chemotherapy at SVUH from July 2006 to July 2011. Patient demographics, tumour clinicopathologic parameters and chemotherapeutic regimens were recorded. Response to neoadjuvant chemotherapy was assessed radiologically and pathologically. Where sufficient data was available the Neoadjuvant nomogram was used to calculate the probability of pCR. Predictive accuracy was assessed by calculating the area under the receiver operating characteristic (ROC).

89 patients were treated with neoadjuvant chemotherapy during the study period. pCR was observed in 14%. Estrogen receptor (ER) negativity and HER2/neu receptor positivity were significantly associated with pCR (p<0.05). All tumours exhibiting a pCR were invasive ductal carcinomas. No invasive lobular carcinoma exhibited a pCR to neoadjuvant chemotherapy. The ROC of the validated nomogram in our breast cancer population revealed a value of 0.87.