

for the left and right cases are statistically significant for the ML beam.

EP-1319

Application ACOSOG Z0011: no axillary dissection in women with invasive breast cancer and sentinel node metastasis

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Purpose/Objective:

Introduction: Following the publication of the randomized clinical trial 'Axillary Dissection vs No Axillary Dissection in Women With Invasive Breast Cancer and Sentinel Node Metastasis' by Dr. Armando E. Giuliano et al. and taking into account the experience of our hospital in selective sentinel node dissection SLND (we performed SLND in our institution for 13 years to 1490 patients, 20% of the cases resulted metastatic sentinel node and only 8% of this cases had involvement of other nodes in the lymphadenectomy), The Breast Cancer Committee of our hospital approved the implementation of the protocol ACOSOG Z0011.

Aim: The primary end point was to determine disease free survival, defined as the time from diagnosis to the first documented recurrence of breast cancer. Breast cancer recurrence was categorized as locoregional disease (tumor in the breast or ipsilateral supraclavicular, subclavicular, internal mammary, or axillary nodes) or distant metastases. These morbidities have been reported

Materials and Methods: Inclusion criteria: adult women with histologically confirmed breast carcinoma, tumor size 5 cm or less (T1-T2), no palpable adenopathy, negative axilla evaluated by ultrasound, and SLN positive for metastatic breast cancer documented by or hematoxylin-eosin staining on permanent section. Women were ineligible if they had 3 or more positive SLNs (they received axillary lymph node dissection in the second time) and patients candidates to mastectomy. All women received whole-breast opposing tangential-field radiation therapy and Axillary radiotherapy included levels I and II. Radiation therapy not include supraclavicular fossa and level III. The use of adjuvant systemic treatment was applied at the discretion of the treating multidisciplinary team.

Results: From February 2011 to June 2014, 88 patients met the inclusion criteria and were selected for analysis. All patients had invasive breast carcinoma and 1 or 2 sentinel node metastasis. Median follow-up was 24 months (5 - 39 months). The average tumor size was 1.81 cm (0.6 to 3.7 cm). Median excised lymph nodes was 2 and the median sentinel node with metastasis was 1. Breast cancer subtype

was: Luminal A 42,2%, luminal B her2 - 35,6%, luminal B her2 + 8,9% Triple negative 8,9%, Her2 + no luminal: 4,4% At a median follow-up of 2 years disease-free survival was 93.2%.

Conclusions: In patients with limited SLN metastasis, breast cancer treatment with breast conservation, systemic therapy and radiation therapy, the use of SLND alone, avoiding the lymphadenectomy, provides good local control.

Although, the results of this study are limited by the short follow up, we report our experience and working procedures to establish the ACOSOG Z0011 protocol in our center.

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Feasibility and efficacy of stereotactic radiotherapy in lymph-node metastases

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Purpose/Objective: Malignant tumors typically metastasize to lymph-nodes. These localizations can arise with associated symptoms or can be, in most cases, asymptomatic. Often node metastases can be the only site of active disease. It is reasonable to treat local metastasis with ablative therapies. Some evidence show that local ablative treatment can achieve a good response and an optimal local-disease control (LC). The aim of this study was to evaluate the feasibility, local control and the potential impact on survivals of stereotactic body radiotherapy in lymph-node metastases in oligometastatic patients.

Materials and Methods: Fifty-eight patients with 66 lymph-node metastases (32 male, 26 female) were treated with SBRT between 2009 and 2014. Site of node metastases were as follows: 38 (57,5%) intra-thoracic metastases, 28 (42,5%) abdominal/pelvic metastases. The most common primary site of tumor was lung 22 (38%), followed d by colon-rectum 7 (12%) prostate 6 (10%), stomach 5 (9%), uterus 4 (7%), ovary 4 (7%), breast 2 (3%), melanoma 2 (3%), and others (2%). Single fraction of 30Gy (24%) or 23Gy (26%) was used in 33 lymph nodes. Fractionated schedule was used for the other 33 lymph node metastases. Variables was evaluates as prognostic factors.

Results: Of the 66 pathological nodes response was achieved as follows: 37 nodes achieved complete response (56.2%), and 17 nodes achieved partial response (25.6%), while 10 lesions had stable disease (15.2%). The progressive disease was observed for only 2 lesions (3%) after SBRT. The observed local control was 93% at 2-years. Disease-free survival was 42.5% at 1-year and 30% at 2-years. The 1-year and 2-years overall survival was 80% and 65.8%, respectively. The PTV volume (<20 cc) was significantly associated with better DFS (p=0.043) and OS (p=0.001), respectively. For the other variables no impact on survivals was calculated.

Conclusions: Stereotactic body therapy is feasible and safe for the treatment of metastatic lymph-nodes inside the thorax or the abdominal-pelvic area. Also, this treatment is efficient in a selected population of patients presenting oligometastatic disease. SBRT can be administered even in patients receiving systemic therapies without increasing toxicity rates.