

THE

# ASBD Advisor



Newsletter of the American Society of Breast Disease

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[www.asbd.org](http://www.asbd.org)

## New Directions in Breast Surgery

The American Society of Breast Disease’s Board of Directors has over the past 18 months endorsed multiple initiatives related to oncoplastic surgery. The Board adopted this new service direction in response to member interest and perceived education needs. This rapidly evolving subspecialty area of breast surgery has, at its core, integration of essential interdisciplinary principles of surgical oncology and aesthetic and reconstructive surgery.

According to Society president **Julio Ibarra, MD**, “the interplay of specialties involved in the effective application of oncoplastic surgery is consistent with the Society’s commitment to interdisciplinary teams. As a result,” he emphasizes, “our education programs in this arena will uniquely incorporate specialty-specific content within a multidisciplinary context.”

These programs support patient needs, in light of the decreasing numbers of traditional plastic surgeons working with cancer patients. According to a recent article in the Wall Street Journal (July 1, 2009), “the number of breast-reconstruction surgeries declined 29% to 57,100 last year from 2000, a development the American Society of Plastic Surgeons attributes in part to poor insurance reimbursement for these procedures.”

The article continues, “Making plans for breast reconstruction at the same time as cancer surgery can speed a woman on the path of psychological, as well as physical, recovery. And by combining procedures to reduce the number of operations, it also reduces the risk of complications from successive surgeries.”

This report provides members with information on two current Society initiatives related to the area of oncoplastic breast surgery.

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## LETTER FROM THE PRESIDENT

Your Board of Directors met immediately following the Society's provocative and educational Symposium in San Diego this past April. The Symposium offered an amazing breadth and depth of presentations and discussions that ranged from genetics and screening to late-breaking news on clinical trials to an emotionally charged presentation on the history of the Breast Cancer Stamp, which in July celebrated its tenth anniversary. Our congratulations and thanks to **Balazs Bodai, MD**, for his wonderful presentation and to the worldwide success in raising research funds of the stamp whose creation and implementation he spearheaded.

During our meeting, the Board reviewed the challenges facing Society's like ours in a rapidly changing environment in which we must continually assess our services to ensure that we maintain our relevance to you, our members.

To respond to member educational needs, we are again actively involved in the development and programming of the multi-sponsored Breast Cancer Symposium managed so very well by our friends at the American Society of Clinical Oncology. The program for our second School of Oncoplastic Surgery is in place, and registration for this weekend, very hands-on program, is now open through our web site.

The Program Committee for the Society's 33rd Annual Symposium, to be held April 2 to 4, 2009, at The Drake Hotel, Chicago, has convened and will shortly provide you with a full outline of the program. Program Committee chair **Aman Buzdar, MD**, has advised me that this year's Poster Abstract Review Committee, chaired by **Anees Chagpar, MD**, will provide expanded opportunity for oral presentations from submitted posters (see Call for Abstracts in this issue). So please plan to submit a poster, particularly our resident and fellow members. It is a wonderful opportunity.

I hope that by now you may have had read our latest issue of the ASBD Breast Healthcare Update – Systemic Chemotherapy for Breast Cancer: Issues in Preoperative and Adjuvant Treatment. This excellent newsletter, with introduction by Board member **Clifford Hudis, MD**, and highlights articles by **Patrick Morris, MD**, effectively summarizes two major sessions at our April Symposium.

As you will have noted in that newsletter and in this issue of the ASBD Advisor, the ASBD is going "green." A goal established by the Board of Directors at our April meeting is to migrate most, if not all, Society publications and communications to online delivery. Of course, this transition will support reduction of our Society's carbon footprint by reduced used of paper, printing, and mailings. It will also significantly increase our capacity to provide relevant

summary and, as appropriate, in-depth information quickly and efficiently. As **Kathy Diehl, MD**, chair of the ASBD Advisor Editorial Board will report in a future issue, even more change is coming in 2009.

By transferring our services to online delivery, the Board of Directors believes that the Society can extend its reach to more diverse and distant audiences. This past year the Membership Committee, using World Bank guidelines, adopted a variable membership fee structure to enable healthcare professionals around the world to more actively participate in the Society's online services. We look forward to a borderless Society in which we can more broadly advance our core multidisciplinary mission.

We hope that you find the ASBD increasingly relevant and useful in your daily practice. However, if you have needs that are not being met, let us know. If you see opportunities to extend our services and reach, please e-mail us. You can contact me directly at [president@asbd.org](mailto:president@asbd.org). I look forward to hearing from you.

■ **JULIO IBARRA, MD**



## FROM THE EXECUTIVE DIRECTOR

A basic goal of any membership organization should be to work toward satisfying member needs and interests. To that end, the ASBD maintains a voluntary advisory structure of standing and ad hoc committees that meet throughout the year to review on-going activities and to consider new ones. Relevance to the membership is an essential component of committee deliberations. Since the Society's committees include representatives from the ASBD's multidisciplinary constituency, we believe that the outcomes of these discussions lead to programs and initiatives of benefit and value to its members.

This issue of the ASBD Advisor documents several initiatives undertaken recently as a result of these membership discussions. The Board of Directors' endorsement of multiple projects related to oncoplastic surgery reflects increasing interest and communications from the nearly 60% of members who are practicing breast surgeons. The high level of interest exhibited by guests at our booth at this past spring's meeting of the American Society of Breast Surgeons further reinforced the need for programming in this area. To ensure that educational events reflect the Society's core commitments, the Education Program Committee, chaired by **Aman Buzdar, MD**, reviews program content to confirm that it incorporates the Society's multidisciplinary base through diverse faculty

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## **Mary Kay Ash Advanced Training Program in Breast Oncoplastic Surgery**

In July, the American Society of Breast Disease announced the creation of the Mary Kay Ash Advanced Training Program in Oncoplastic Breast Surgery. The Addison-based Mary Kay Ash Charitable Foundation – a leading philanthropic organization in the field of cancers affecting women – approved a two-year \$225,000 grant to support this innovative program to train breast surgeons in the emerging field of oncoplastic surgery.

The Mary Kay Ash Charitable Foundation recognized that the Society, as the nation's only professional organization serving all healthcare professionals involved in breast cancer and disease diagnosis, treatment, and research, is the appropriate entity to administer the program. ASBD president-elect **Gail Lebovic, MD**, Director, Women's Health, Cooper Clinic, Dallas, Texas, will serve as the Program Director.

"This grant is a natural extension of the Foundation's long history of supporting research involving women's cancers," said Anne Crews, a board member of the Mary Kay Ash Charitable Foundation. "One of the missions of the Foundation is to eliminate cancers affecting women by supporting top medical scientists. We are proud to provide funding for this innovative training as well."

The Mary Kay Ash Charitable Foundation was created in 1996 and its mission is two-fold: to fund research of cancers affecting women and help prevent domestic violence while raising awareness of the issue. Since the Foundation's inception, it has awarded more than \$14 million to shelters and programs addressing domestic violence and \$10.8 million to cancer researchers and related causes throughout the United States.

The support of the Mary Kay Ash Charitable Foundation will enable the American Society of Breast Disease to announce the appointment of the program's first trainee in fall, 2008.

"The objective of oncoplastic breast surgery is to improve aesthetic outcomes after the surgical removal of benign or malignant tumors, and to address any other concerns the patient may have regarding size, shape, and/or symmetry of the breasts," said Dr. Lebovic. "As a result, patients benefit from careful and complete preoperative assessment that uses an interdisciplinary approach to help define a comprehensive surgical plan."

Dr. Lebovic emphasizes that "the principles of oncoplastic surgery apply to the treatment of benign and malignant breast

conditions. In some settings, breast surgeons may, in collaboration with plastic surgeons, provide aspects of oncoplastic surgical treatment. Current multidisciplinary breast fellowship programs address some of these elements, but do not provide sufficient training to enable graduates of these programs to comfortably practice as trained oncoplastic surgeons."

The Advanced Training Program has been designed to build on the core educational objectives established jointly by the American Society of Breast Disease, American Society of Breast Surgeons, and Society of Surgical Oncology. The ASBD hopes to bring these groups together, along with the plastic surgeons, in order to work effectively towards a common goal in the future - improving breast surgery for patients.

This multidisciplinary curriculum incorporates, but is not limited to, concepts in oncoplastic surgery such as preoperative workup of patients with breast conditions including breast cancer, or high risk history of breast cancer, implant problems, macromastia, hypomastia, reconstruction or failed reconstruction. In order to evaluate patients and develop the necessary surgical skills to provide care in each of these areas, surgeons will focus on comprehensive physical exam, integration of radiologic and pathologic findings, while taking into account the patients' needs and desires. Surgeons will be trained to perform diagnostic and treatment procedures such as core needle biopsy with and without imaging; reduction mammoplasty, mastoplasty with and without implants skin sparing mastectomy with immediate reconstruction as well as numerous other important breast surgical procedures.

The initial site for training will be the Cooper Clinic at Craig Ranch in North Dallas, Texas, with selected surgical procedures performed at the nearby Baylor/Frisco Hospital. Dr. Lebovic notes that "this intensive year of training following a multidisciplinary fellowship focuses on development of minimally invasive and oncoplastic techniques. It is structured to allow for integrated research (25%) and clinical activities (75%), if possible, similar to those offered in actual academic practice."

Participants will perform initial clinical consultation, initiate management decisions, conduct operative interventions, and provide post-operative care; participate in formal didactic training to include weekly meetings and regular participation in multidisciplinary breast care conferences; develop and participate in community service and outreach activities; develop and present at least one research project during the year. Full information and qualifications are available through the ASBD's Career Center ([www.asbd.org](http://www.asbd.org)).

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# Case of the Quarter

The following case was presented for review and comment in July 2008. Expert commentaries provide surgical and diagnostic radiological perspectives on the case. The data analyses and occasional comments reflect input from 118 breast healthcare professionals in the United States and around the world. These self-reported data should be viewed as anecdotal only.

## Presentation

A 59-year-old post-menopausal Caucasian female (M.T.) presented to the breast surgeon after a routine screening mammogram revealed a new spiculated density in her lower left breast. Her history of breast problems includes only a right breast biopsy for a fibroadenoma. This occurred over ten years ago. Her gynecological history began at age 13 with menarche, and she has never been pregnant. The patient went through natural menopause approximately eight years ago. M.T. has no history of hormone medications. Her past medical history is unremarkable, and the patient has no history of tobacco use. Her family history is significant for a sister who was diagnosed with breast cancer at age 65, a maternal cousin who had breast cancer at age 27, and her mother who had ovarian cancer at age 81.

A suspicious, spiculated density in the left breast at the 6:00 position was detected on bilateral screening mammogram. This mass was also present on ultrasound examination. On clinical examination, skin dimpling was noted, and a fairly ill-defined 2-3 cm mass in the lower left breast at 6-7:00 was palpable. Shotty adenopathy was also palpated in the left axilla, and the right breast was normal. An ultrasound-guided core needle biopsy was performed which revealed an infiltrating lobular carcinoma, nuclear grade 2. Markers were ER positive, PR positive, HER2 negative (FISH).

## QUESTIONS TO CONSIDER

**Should M.T. be offered breast-conserving surgery and should she receive an MRI?**

TABLE 1. BREAST-CONSERVING SURGERY OPTION

Should M.T. receive breast-conserving surgery?	Response Percent
Yes	38.6%
Yes, but only after genetic counseling and testing	35.1%
No	8.8%
Unsure	9.6%
Other	7.9%

Respondents from outside the United States were more likely to offer breast conservation (50% non-U.S. vs 32.1% U.S).

Surgeons at breast centers or comprehensive breast centers are more likely to offer breast-conserving surgery than surgeons in other practice settings. In fact, based on the survey responses, women like M.T. are more than twice as likely to be offered breast-conserving surgery by surgeons at breast centers than by surgeons in private practice.

TABLE 2. INFLUENCE OF PRACTICE SETTING ON OFFERS OF BREAST-CONSERVING SURGERY

Practice Setting	Yes	Yes, but only after genetic counseling and testing	No	Unsure
Breast Center	60.0%	20.0%	10.0%	10.0%
Comprehensive Breast Center	60.0%	20.0%	20.0%	0.0%
Cancer Center	40.0%	40.0%	0.0%	0.0%
Hospital	37.5%	37.5%	12.5%	12.5%
Teaching Hospital	37.5%	12.5%	37.5%	0.0%
University	33.3%	66.7%	0.0%	0.0%
Private Practice	26.9%	50.0%	3.8%	15.4%

## Use of MRI of the Breast

Of all respondents, 72.8% would recommend an MRI. Of these, 50% indicated that all breast cancer patients should have an MRI and 50% indicated that they would request an MRI for M.T. because it is a lobular cancer. Again practice setting appears to influence practice. Breast surgeons in private practice and those affiliated with breast centers were more than three times as likely to recommend an MRI than individuals in general hospital settings.

TABLE 3. INFLUENCE OF PRACTICE SETTING ON MRI USE

Practice Setting	% recommending MRI
Private Practice	81.0%
Breast Center	80.0%
University	66.7%
Comprehensive Breast Center	66.7%
Cancer Center	60.0%
Teaching Hospital	50.0%
Hospital	25.0%

Reasons varied among those breast surgeons who would order an MRI. 70% of those at breast centers would request an MRI because it is a lobular cancer whereas nearly 50 % (46.2%) of those in private practice report that all breast cancer patients should have MRIs.

The patient was then referred for contrast-enhanced breast magnetic resonance imaging (MRI). Her left breast had a 1.7 cm x 1.1 cm x 0.8 cm spiculated, persistently enhancing mass at the inferior aspect of the breast. The spiculation extended to the skin surface where there was associated skin thickening along the inferior lateral aspect of the breast. There were also a few small adjacent satellite lesions. Some prominent axillary lymph nodes were seen.

## Neoadjuvant Therapy

### QUESTIONS TO CONSIDER

**Should M.T. be referred for chemotherapy or hormonal therapy (in an ACOSOG clinical trial or off-study)? Should she receive a USN and USN FNA of suspicious nodes?**

72% of survey respondents would refer M.T. to either chemotherapy or hormonal therapy as follows.

TABLE 4. RECOMMENDED USE OF NEOADJUVANT THERAPIES

Neoadjuvant Chemotherapy	Neoadjuvant Hormonal Therapy ACOSOG Z-1031	Neoadjuvant Hormonal Therapy Off-Study
60.80%	31.10%	8.10%

Overwhelmingly, 82.4% of respondents reported that M.T. would receive a USN and USN FNA of suspicious nodes.

Respondents were also asked when a sentinel lymph node biopsy should be performed. No clear consensus emerged in the responses.

TABLE 5. TIMING OF SENTINEL LYMPH NODE BIOPSY

A sentinel lymph node biopsy should be done	Response %
If the axillary USN FNA was negative	39.0%
Prior to initiating neoadjuvant therapy	14.3%
After neoadjuvant therapy at definitive surgery	30.5%
Prior to neoadjuvant therapy, and if its is positive, after neoadjuvant therapy in order to make a decision regarding the need for ALND	4.8%
Prior to neoadjuvant therapy, and if its positive, after neoadjuvant therapy, but I would still do the ALND	11.4%

After a consultation with her medical oncologist, M.T. was offered pre-operative hormonal therapy on protocol with letrozole and bevacizumab. She was thought to be a good candidate for preoperative endocrine therapy given the size of tumor, tumor biology, and the patient’s desire for breast conservation rather than mastectomy.

M.T. declined the preoperative hormonal therapy, but did receive dose-dense preoperative chemotherapy doxorubicin and cyclophosphamide for four cycles. Prior to starting the chemotherapy protocol, the patient underwent left sentinel lymph node biopsy (SLNB), which revealed two lymph nodes that were negative for carcinoma.

At the time of the SLNB, the patient also had left breast tattooing. In this method, the edges of the tumor are tattooed prior to chemotherapy, thereby allowing all tissue initially involved with tumor to be resected following the chemotherapy. 95% of survey respondents would have used a clip to mark the tumor.

The patient completed her course of pre-operative chemotherapy. On physical examination, the mass was softer and much less apparent. Her follow-up MRI, however, still revealed the 1.8 cm tumor in addition to satellite lesions. It appeared that the original 3 cm diameter was still involved with tumor.

### QUESTION TO CONSIDER

**Given her response to neoadjuvant chemotherapy should she be offered breast conservation? Again, no clear consensus exists.**

TABLE 6. NEOADJUVANT THERAPY OUTCOMES AND BREAST CONSERVATION

Given her response to neoadjuvant chemotherapy, should she be offered breast conservation?	Response Percent
Yes	36.6%
Yes, depending on the results of genetic counseling and testing	38.7%
No	24.7%

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When asked whether the second MRI results influenced their decision to offer breast conservation, nearly 50% of respondents noted that it did. The majority of breast surgeons located in breast centers and comprehensive breast centers reported that they were not influenced by the second MRI results whereas those in cancer centers, teaching hospitals, and universities were.

TABLE 7. MRI RESULTS AND BREAST CONSERVATION

Influence of second MRI results	Response Percent
Yes	33.3%
Only if the residual contrast enhancement is biopsy proven to be residual cancer	16.2%
No	38.4%
No, since I always use oncoplasty techniques	12.1%

## SURGICAL MANAGEMENT DECISIONS

The decision as to where to locate the incision for M.T. showed no clear consensus. Although practice setting clearly influences the location of the incision, there is also a lack of consensus within practice settings as to the most appropriate approach to surgical management of this patient.

TABLE 8. INCISION LOCATION DECISIONS

Incision location decisions	Response %
Circumareolar	1.2%
Over lesion, horizontal within Langer lines of breast	15.7%
Radial	24.1%
Modified reduction mastopexy incision, in conjunction with a plastic surgeon	32.5%
Modified reduction mastopexy incision	26.5%
Other	8.4%

Given the patient's small breast size and the relatively large tumor size, it was explained to her that breast conservation surgery might leave her with an unacceptable cosmetic result. Despite this, she elected to have a left breast partial mastectomy. This was performed through a modified reduction mastopexy incision. A roughly 3 cm, horizontal incision was made in the center of the inframammary groove. Next, an inferior vertical, elliptical incision was made extending from the base of the nipple to the midpoint of the horizontal, inframammary incision. Oncoplastic techniques were applied in performing the full-thickness resection and breast-flap advancement. By referencing the previously placed tattoo markings, the original tumor bed was excised.

TABLE 9. PRACTICE SETTING AND LOCATION OF INCISIONS

Practice Setting	Circumareolar	Over the lesion	Radial	Modified reduction mastopexy w/ plastic surgeon	Modified reduction mastopexy	Other
Breast Center	0.0%	10.0%	20.0%	60.0%	10.0%	0.0%
Comprehensive Breast Center	0.0%	25.0%	25.0%	50.0%	0.0%	0.0%
Cancer Center	0.0%	0.0%	40.0%	0.0%	60.0%	0.0%
Hospital	0.0%	25.0%	12.5%	25.0%	0.0%	0.0%
Private Practice	4.0%	8.0%	28.0%	28.0%	24.0%	8.0%
Teaching Hospital	0.0%	33.3%	50.0%	16.7%	0.0%	0.0%
University	0.0%	0.0%	33.3%	66.7%	0.0%	0.0%

On final pathology, the specimen measured 5.9 cm x 4.7 cm x 3.3 cm. The tumor measured 2.6 cm and was an infiltrating carcinoma with mixed ductal and lobular features. It was well-differentiated, and lymphovascular invasion was not identified. Final margins were negative. She received whole breast radiotherapy and is on anastrozole.

There is no evidence of local, regional or systemic disease at one year of follow-up. The cosmetic outcome in terms of scarring, breast shape and breast symmetry has been evaluated in serial visits and is favorable according to the patient, surgeon, and nurse practitioner and physician's assistant.

## QUESTION TO CONSIDER

**If the lumpectomy margins had been positive which should she be offered?**

TABLE 10. SURGICAL OPTIONS FOR POSITIVE LUMPECTOMY MARGINS

Surgical options for positive lumpectomy margins	Response %
Re-excision	26.6%
Mastectomy	73.4%

Significantly, practice setting appears to impact surgical options for this patient if her lumpectomy margins are positive. It is highly probable that she will be offered a re-excision if she is receiving her medical care in a breast center or comprehensive breast center facility. If indicated by breast surgeons

responding from hospital, private practice, teaching hospitals, and university settings, M.T. would receive a mastectomy.

TABLE 11. PRACTICE SETTINGS AND SURGICAL OPTIONS

Practice Setting	Re-excision	Mastectomy	Other
Breast Center	60.0%	30.0%	10.0%
Cancer Center	40.0%	60.0%	0.0%
Comprehensive Breast Center	40.0%	20.0%	20.0%
Hospital	0.0%	100.0%	0.0%
Private Practice	8.7%	78.3%	13.0%
Teaching Hospital	16.7%	66.7%	16.7%
University	0.0%	100.0%	0%

## Expert Commentaries

### FROM THE SURGICAL PERSPECTIVE

**MICHAEL J. CROSS MD, FACS**  
Surgical Oncologist of the Breast  
Fayetteville, Arkansas

This patient should certainly be offered breast conservation, but genetic testing and counseling should be conducted early on as a full workup is performed. In our practice setting, we believe that all breast cancer patients should undergo bilateral breast MRI. An MRI is needed to properly stage the affected breast and assess for occult disease in the opposite breast. It is useful in determining extent of disease in the affected breast as well as identifying any axillary or internal mammary lymph nodes that may be involved. 3.1 percent of the time a synchronous cancer is found in the opposite breast (The New England Journal of Medicine, Volume 365, Number 13, Page 1295-1303, March 2007).

Following her MRI we would proceed with neoadjuvant therapy while awaiting genetic testing results, which may take 3-4 weeks. Response to neoadjuvant therapy may provide surgical advantages by decreasing tumor vascularity and volume, which would increase procurement of safe surgical margins.

This particular patient would be eligible for the randomized hormonal adjuvant trial ACOSOG Z-1031. The limiting factor would be that the tumor must be palpable and measure at least 2 cm by caliper measurement in at least one dimension. She could also be a candidate for neoadjuvant hormonal therapy off-study if a preexisting condition existed that precluded safe surgical removal or neoadjuvant chemotherapy.

One should always evaluate the axilla with ultrasound as part of the workup, followed by image-directed needle sampling of suspicious nodes to stage the axilla. A positive axillary node precludes a sentinel node biopsy.

As to when a sentinel node biopsy should be done, one could easily argue for performing sentinel lymph node biopsy before or after neoadjuvant chemotherapy. I prefer to do the sentinel node biopsy post-neoadjuvant therapy, if the axilla was negative on ultrasound on pre-chemo evaluation. If chemotherapy is initiated prior to full surgical wound recovery, the patient may experience delayed healed, infection, and possible wound dehiscence. Also, future surgery in the axilla is compromised by scarring if the axillary tissue has previously been dissected.

Marking the tumor for localization after neoadjuvant therapy is probably one of the most important principles associated with the treatment of breast cancer. If I perform an ultrasound-guided breast or axillary node biopsy I place a clip in each location. There are several reasons for placing a marker, or clip, after biopsy, including locating the tumor site post chemotherapy in the event that there is complete pathologic response. Sometimes a mastectomy may be the primary thought process on original assessment, but downstaging can occur, thereby converting the surgery to a breast conservation approach. If a clip is present, then all options are still available. If there is no clip then accurate surgical removal of the cancer is severely compromised.

Surgical borders are managed by the use of bracketing wires in conjunction with a surgical marker, i.e., clip that has been placed during initial tumor diagnosis.

This patient's response to chemotherapy is partial at best considering the fact that the tumor size is essentially unchanged. If the patient's genetic testing results did indeed come back negative then one could still offer attempted breast-conservation although downsizing by neoadjuvant therapy was unsuccessful.

In our practice, we obtain a post-chemo MRI to restage the cancer and judge treatment effects. In this instance the MRI would help us take a more aggressive surgical approach to ensure clean margins since the tumor size was unchanged.

There are several factors to consider regarding placement of the incision for this lesion. Small-breasted women with larger tumor-to-breast tissue ratio are more effectively treated with skin-sparing mastectomy and reconstruction, especially when genetic testing is positive. One would have to know advanced oncologic techniques to successfully resect a tumor of this size. I would definitely use the advanced oncologic technique of a reduction-type mastopexy incision. As a result, the scar is

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not necessarily shorter but strategically placed allowing for a more aesthetically pleasing outcome, i.e., less deformity of the nipple and reduced ptosis of the breast.

If clean margins are unattainable then a mastectomy can still be performed using the same reduction mastopexy incision without sacrificing skin and cosmesis.

Our personal protocol requires a post-biopsy mammogram verifying the clip deployment and placement in the correct location. This would be followed with a post-neoadjuvant therapy mammogram to reidentify clip location and assist in bracketed wire localization for lumpectomy.

If the lumpectomy margins had been positive, a mastectomy could be performed through an inverted-T mastopexy reduction incision, followed by tissue expander placement and nipple reconstruction.

The key to using successful oncoplastic surgical approaches is being able to accurately predict the location of the nipple areolar complex for final cosmetic symmetry.

## FROM THE BREAST IMAGING PERSPECTIVE

**BRIAN S. ENGLANDER, M.D.**

**Director of Imaging, Integrated Breast Center  
Clinical Assistant Professor of Radiology  
Pennsylvania Hospital, University of Pennsylvania  
Health System. Philadelphia, PA**

Based upon the initial findings, this patient should be offered breast conservation unless the patient elects to undergo mastectomy. A carefully planned surgical approach would allow breast conservation with a lumpectomy, as well as a sentinel lymph node biopsy without pre-surgical proof of metastatic lymphadenopathy.

Based upon current Society recommendations and anecdotal experience, bilateral breast MRI should be performed prior to definitive surgery. All breast cancer patients, including those with DCIS, should undergo bilateral breast MRI to exclude multifocal, multicentric, and contralateral disease. Although lobular cancer can be difficult to evaluate with any radiologic modality, given the known diagnosis and its MRI appearance, careful MRI interpretation should be performed. Also, evaluation for chest wall invasion or extension to the skin, as well as evaluation of the axilla, should be performed.

Given the size of the cancer and the dermal involvement, the patient should be offered both neoadjuvant chemotherapy and hormonal therapy. Following the appropriate course, repeat bilateral MRI should be performed to evaluate for response to

therapy and extent or residual disease prior to surgery.

There should absolutely be an axillary USN and USN FNA of any suspicious nodes. Pre-operative ultrasound-guided fine needle aspiration or ultrasound-guided core biopsy should be performed if there is sonographic evidence of abnormal lymph nodes during ultrasound evaluation of the axilla. At our institution, we are routinely performing ultrasound-guided core biopsy with and without vacuum assistance of morphologically abnormal or enlarged lymph nodes or other axillary masses rather than fine needle aspiration. We have found fewer false-negative results with more information provided (secondary to an improved tissue specimen) without an increase in the rate of complications.

As we know, there remains much debate concerning the timing of sentinel lymph node biopsies when neoadjuvant therapy is anticipated. However, I would argue that if we attempt ultrasound-guided core biopsy of the axilla, then pre-operative sentinel lymph node biopsy may not be necessary. Radiologic and clinically evident lymphadenopathy is different than micrometastatic disease. As we improve our detection of abnormal lymph nodes radiographically, ultrasound-guided or MRI-guided core biopsy of presumed involved lymph nodes may be appropriate. A negative lymph node after neoadjuvant therapy will be treated whether or not the lymph node had been positive prior to neoadjuvant therapy.

The tumor should be marked with a clip at the time of biopsy with the clip placed in the center of the mass/architectural distortion. We have not been using the tattooing method as we are not able to definitely demonstrate a correlation of the tattoo before and after neoadjuvant therapy especially if the mass is deep within the breast.

Given her response to neoadjuvant chemotherapy should she be offered breast conservation? The patient can still be offered breast conservation, particularly if there is an oncoplastic approach to the surgery, although the patient should be advised that the cosmetic outcome, given the size of the cancer and the dermal involvement, may be better with mastectomy and reconstruction. However, there remain a large subset of patients who are adverse to mastectomy as an initial surgical approach, and breast conservation may be an excellent option for this patient with radiation therapy.

In this case, the results of the second MRI did not influence the breast conservation decision since there was little change in the MRI appearance of the cancer. However, there was no increase in size, and follow-up MRI can be performed using these pre-operative MRIs for comparison.

If lumpectomy margins had been positive, the patient should

*Case of the Quarter, continued from page 8*

be counseled to undergo mastectomy with the assumption that the cosmetic outcome of re-excision would not be ideal.

Continued attempt to pre-operatively identify and biopsy lymph nodes within the axilla, particularly the sentinel lymph node, may reduce the controversy concerning pre-therapy sentinel lymph node biopsy. In addition, MRI of the breast, although it does not change the treatment of this patient, should become a part of all pre-operative evaluations and pre- and post-neoadjuvant therapy evaluation. ■

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## School of Oncoplastic Surgery

The American Society of Breast Disease's second annual School of Oncoplastic Surgery (SOS) will provide practicing breast surgeons an opportunity to focus on the basic principles and techniques essential to integrating oncoplastic surgery into their current practice. This will include integration of the multidisciplinary approach and will provide lectures in breast imaging, pathology, high risk assessment, etc. In this manner, the course will assist the surgeon in bringing state-of-the-art surgical management of breast disease to their community.

The December 5-7, 2009, course at the Westin Stonebriar Resort, North Dallas, Texas, will expand upon the hands-on, experience introduced at the Society's first SOS in 2008. This includes nearly of full day of programming on surgical planning with live models and an intensive training session in the cadaver lab. The limited enrollment at the School will allow participants extended time for this unique aspect of the program.

The course will include:

- Achieving complete oncologic tumor resection with the best aesthetic outcome
- Hands-on exposure to minimally invasive biopsy techniques
- Introduction to various breast implants, including expanders
- Interactive assessment with live models focused on skin marking and practical surgical techniques

Because it is an ASBD course, participants will gain insight into issues in the interdisciplinary management of patients through presentations and discussion of:

- Mammography, MRI, and US
- Pathology and Recurrence Risk
- Managing High-Risk Patients
- Delivering Radiation Therapy

Additional information and a list of faculty can be found on page 10. The full program schedule and online registration is available at [www.asbd.org](http://www.asbd.org).

## ASBD Career Center Offers Free Training Listings

Early in 2008, the Society conducted an online membership survey to assess interest in a variety of new services. As a result, among the first of several new initiatives, in mid-July, the Society announced the opening of a career center to link breast healthcare professionals across all specialties with employers and educational opportunities. The new feature at the Society's web site at [www.asbd.org](http://www.asbd.org) provides free listings of fellowships, residencies, as well as international and domestic volunteer opportunities.

In addition to listing these educational and volunteer opportunities, the site provides easy-to-post resume and professional job listing services for all disciplines. Organizations and individuals posting positions will be able to easily manage postings online, receive activity reports, search resumes, and receive automatic e-mail notices when new resumes arrive that match search criteria.

Individuals looking for positions in breast healthcare can post their resumes for free enabling employers or recruiters to contact them directly, receive automatic notification of new postings that match their criteria, and post up to three documents, e.g., CVs, to simplify application processing.

Contact the Society at [info@asbd.org](mailto:info@asbd.org) for step-by-step support in posting complimentary educational and volunteer listings.

*From the Executive Director, continued from page 2*

and presentations, even though a program like the December School of Oncoplastic Surgery is intended for surgeons.

The current case of the quarter summarized with expert comments from members **Michael Cross, MD**, and **Brian Englander, MD**, representing surgical and diagnostic radiological perspectives also includes results of a recent member survey that coincidentally reflects this same interest in oncoplastic breast surgery. The survey findings confirm areas of professional consensus and point to areas in which practice settings appear to influence practice significantly.

This issue of the ASBD Advisor also provides a brief article on our new online Career Center. This and other new services to be introduced in the coming year all respond to input from members as to ways in which the Society can provide better service. As always, please let us know if you want to participate actively on one of the Society's committees, or simply e-mail us your ideas at [membership@asbd.org](mailto:membership@asbd.org).

■ BROOKE BRESLOW



www.asbd.org

# American Society of Breast Disease

*Advancing Multidisciplinary Breast Healthcare*

## ■ 2008 School of Oncoplastic Surgery Essentials for the Breast Surgeon

December 5-7, 2008 • Westin Stonebriar Hotel • Dallas, Texas

A CME Program jointly sponsored by St. Luke's & Roosevelt Hospitals and the American Society of Breast Disease

### FACULTY

**BENJAMIN O. ANDERSON, MD**  
University of Washington, Seattle

**JOEL ARONOWITZ, MD**  
Cedars-Sinai Medical Center  
Los Angeles

**KENNETH COOPER, MD, FOUNDER**  
The Cooper Clinic, Dallas

**MICHAEL J. CROSS, MD**  
Breast Treatment Associates,  
Fayetteville

**JENNIFER ENGELS, MD**  
The Cooper Clinic, Dallas

**STEPHEN FEIG, MD**  
Director of Breast Imaging,  
University of California, Irvine

**STEVE HARMS, MD**  
Breast Center of Northwest  
Arkansas, Fayetteville

**DARRYL HOFFMAN, MD**  
Stanford University, Stanford

**JULIO IBARRA, MD**  
Memorial Care Medical Center,  
Fountain Valley

**CARY S. KAUFMAN, MD**  
Bellingham Breast Center  
Bellingham

**ROBERT KUSKE, MD**  
AZ Oncology, Scottsdale

**GAIL LEBOVIC, MD**  
The Cooper Clinic, Dallas

**BARBARA RABINOWITZ, PhD**  
Meridian Health, Brick

### LEARNING OBJECTIVES

Following this course, participants will be able to:

- Apply basic principles and techniques for planning and performing oncoplastic surgical management of breast disease
- Evaluate and plan minimally invasive biopsy techniques
- Assess augmentation, reduction, and mastopexy management issues in breast conserving surgery
- Explain techniques to correct breast asymmetry
- Consider breast and nipple reconstruction options
- Discuss with patients of aesthetic approaches to breast cancer management
- Evaluate and manage women with silicone breast implants
- Discuss timing and impact of neoadjuvant and adjuvant chemotherapies for patients electing oncoplastic surgical management of breast disease

*For full program and registration – visit [www.asbd.org](http://www.asbd.org)*

## ■ ASBD Breast Healthcare Update

### Systemic Chemotherapy in Breast Cancer - Issues in Preoperative and Adjuvant Treatment

#### Preoperative Systemic Therapy in Breast Cancer

- Indications for Preoperative Systemic Therapy
- Can Preoperative Chemotherapy Be Tailored Based on Clinical Response?
- Surgical Issues After Preoperative Chemotherapy
- Radiotherapy After Preoperative Chemotherapy
- Pathologic Analysis After Preoperative Chemotherapy

#### Update on Systemic Postoperative Therapy in Breast Cancer

- Hormonal Therapy
- Chemotherapy
- Individualizing Therapy With Predictive Markers
- Future Directions in Targeted Therapy: HER2
- Future Directions in Targeted Therapy: VEGF

*To download this issue, visit [www.asbd.org](http://www.asbd.org)*



www.asbd.org

# American Society of Breast Disease

*Advancing Multidisciplinary Breast Healthcare*

## 33rd Annual Symposium

APRIL 2-4, 2009 • THE DRAKE HOTEL • CHICAGO, ILLINOIS

## Call for Poster Abstracts

SUBMISSION DEADLINE: FRIDAY, JANUARY 9, 2009 (5 PM ET)

The Poster Abstract Review Committee of the 33rd Annual Symposium of the American Society of Breast Disease invites abstract submissions for Poster Sessions to be included in the Symposium schedule.

Individuals submitting abstracts for Poster Sessions should consider the ASBD's core message of the benefits of an interdisciplinary standard for breast disease prevention, detection, treatment and research in developing their submissions.

The ASBD Annual Symposium will be attended by breast specialists from throughout the world representing the multiple specialties involved in breast cancer management.

The Committee particularly encourages the active involvement of residents, fellows, and allied professionals in providing information on clinical practice, small studies, case reports, and research related to breast disease.

Accepted posters will be eligible for three tiers of recognition to be determined by the Review Committee:

### ■ Poster Session

Poster exhibits will allow Poster Presenters the opportunity to discuss their Posters informally with Symposium participants and to answer questions about their presentation. Therefore, at least one author must be present at the Symposium session or the poster will be withdrawn.

### ■ Poster Discussion Session

Presenters will present an oral session by their poster in a moderated format.

### ■ Oral Presentations during Symposium plenary sessions

A special recognition Committee will designate three outstanding abstract submissions to receive *The Breast Journal* Award for 2009, to be invited to provide oral presentation during the Symposium, and to submit an article for expedited publication in *The Breast Journal*.

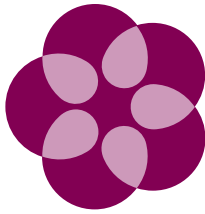
This year, the ASBD will also issue a "Distinguished Medical Student/Resident Award" for trainees who submit outstanding abstracts.

### ABSTRACTS MAY BE SUBMITTED THREE WAYS:

1. Online at [www.asbd.org](http://www.asbd.org)
2. Fax to 214-368-5719
3. Mail to ASBD Symposium 2009, PO Box 140186, Dallas, TX 75214

*Download the submission form at [www.asbd.org](http://www.asbd.org)*

All submissions must be received by Friday, January 9, 2009 (5 pm ET). Submitters will receive notification of Committee decisions no later than February 2, 2009.



## American Society of Breast Disease

PO Box 140186, Dallas, TX 75214

## Advancing Multidisciplinary Breast Healthcare

Visit us on the web at [www.asbd.org](http://www.asbd.org)

# CONFERENCE CALENDAR

## September

- 11-13** International Symposium of Oncological, Aesthetic, and Reconstructive Breast Surgery, Rio de Janeiro, Brazil - [www.isbs08.com](http://www.isbs08.com) – an ASBD co-sponsored education program
- 21-25** American Society for Therapeutic Radiology and Oncology, Boston, MA – [www.astro.org](http://www.astro.org)
- 23-26** Lynn Sage Breast Cancer Symposium, Chicago, IL [www.lynnsagebreastcancer.org](http://www.lynnsagebreastcancer.org)
- 25-28** College of American Pathologists, San Diego, CA [www.cap.org](http://www.cap.org)
- 25-28** Oncology Congress (breast-specific sessions - September 26), San Francisco, CA [www.OncologyCongress.com](http://www.OncologyCongress.com)

## October

- 12-16** American College of Surgeons, San Francisco, CA [www.facs.org](http://www.facs.org)
- 16-18** 7th Annual Symposium on Advances in Breast MRI, Las Vegas, NV – <http://radiologycme.stanford.edu/2008bmri/>
- 29 – Nov 2** SWOG, Atlanta, GA – [www.swog.org](http://www.swog.org)



**T**HE 2008 BREAST CANCER SYMPOSIUM expanded this year to a two-and-a-half-day multidisciplinary symposium in order to provide more feature presentations on the latest multidisciplinary research from selected theme-based translational, and clinical abstracts, as well as related educational sessions. This symposium offered an opportunity for

clinically relevant, in-depth discussions of how and when to translate new findings into patient care and how to be more selective about breast cancer therapy.

ASBD planning representatives for the Symposium program included **Steven E. Harms, MD, Ann D. Thor, MD, and Debu Tripathy, MD.** The broad-ranging program incorporated sessions on risk, screening, and prevention; angiogenesis and insulin-like growth factor receptor; radiation basics; early stage, locally advanced, and metastatic disease tumor boards; triple-negative breast cancer; controversies in pathology; self-seeding; challenges in survivorship; locally advanced breast cancer; healthcare in developing countries; and multidisciplinary implications of preoperative therapy.

# THE ASBD Advisor

Newsletter of the American Society of Breast Disease