How can surgeons help the Radiation Oncologists ?

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fall breast cancer update

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Outline

- Introduction

- OR reports

- Marking of surgical cavities

- Scar and drain placement

- How axillary radiation may be affected by lack of ALND in patients with a positive SNB

- Summary of key points

Introduction

- Rates of ipsilateral breast tumour recurrence are now very low and appear to be falling over time

- this is multi-factorial
- Important factor is the emergence of
  - surgical oncology
  - breast surgical subspecialists
  - multidisciplinary care and guidelines

- There is a large volume of early breast cancer and close collaboration between surgeons and Rad Oncs is necessary for optimal results

OR Reports - margins

- We rely on them and read them <u>in detail</u>

- Information about margins is especially useful

  - mention areas where no further breast tissue can be taken
  - eg down to pectoralis fascia, right up to skin, close to nipple, or at an extreme margin of the breast

- Describing how a re-excision is done
  - Eg complete (in how many specimens) or partial

OR Reports - clips

- Placement of clips around the surgical cavity can be very useful for planning of partial breast radiation and for boost planning

- Boosts are given to a large number of patients – 25-30% (close margins and age)

- Orientation of clips helpful to know and if any are placed at a distance from the main surgical cavity
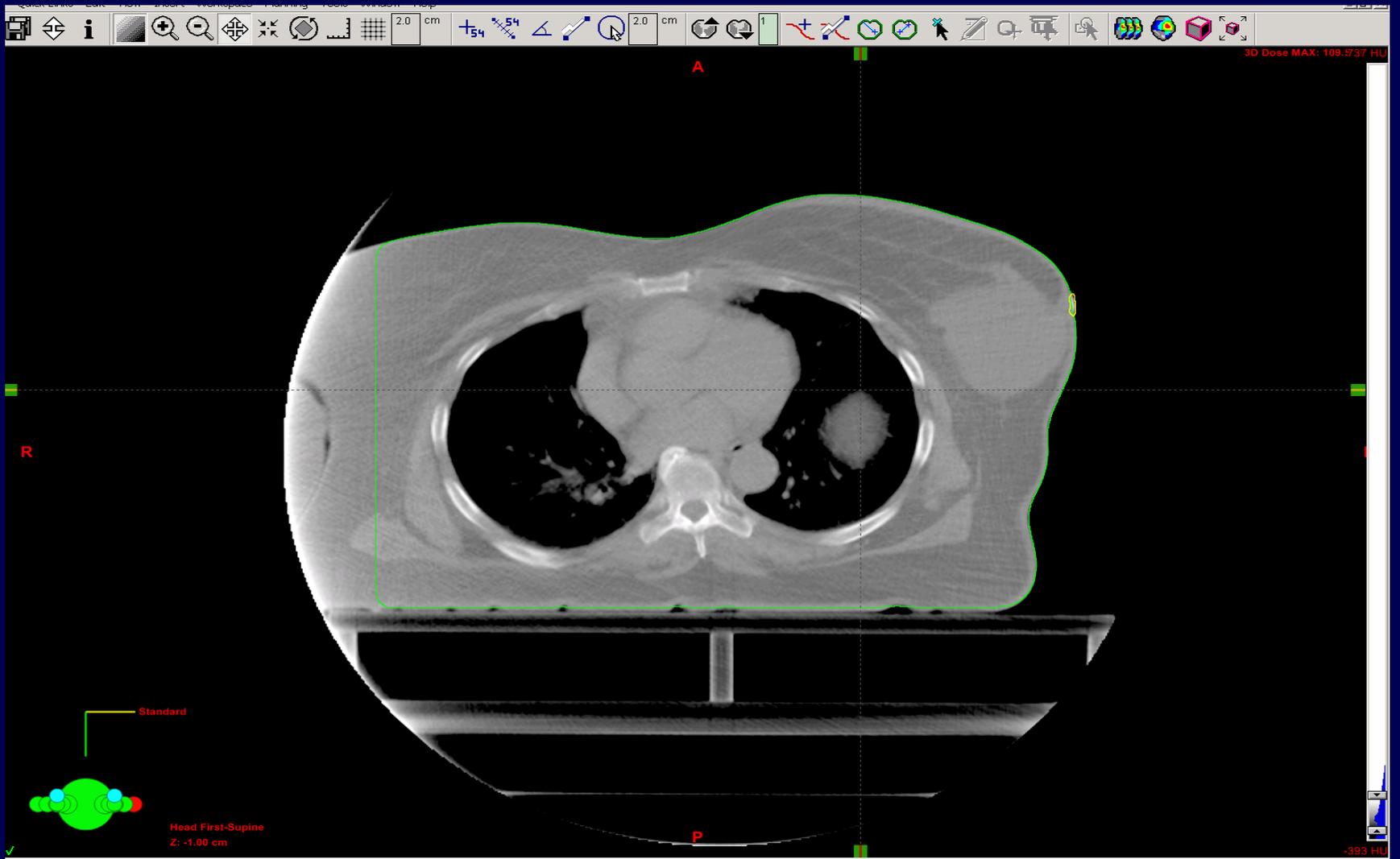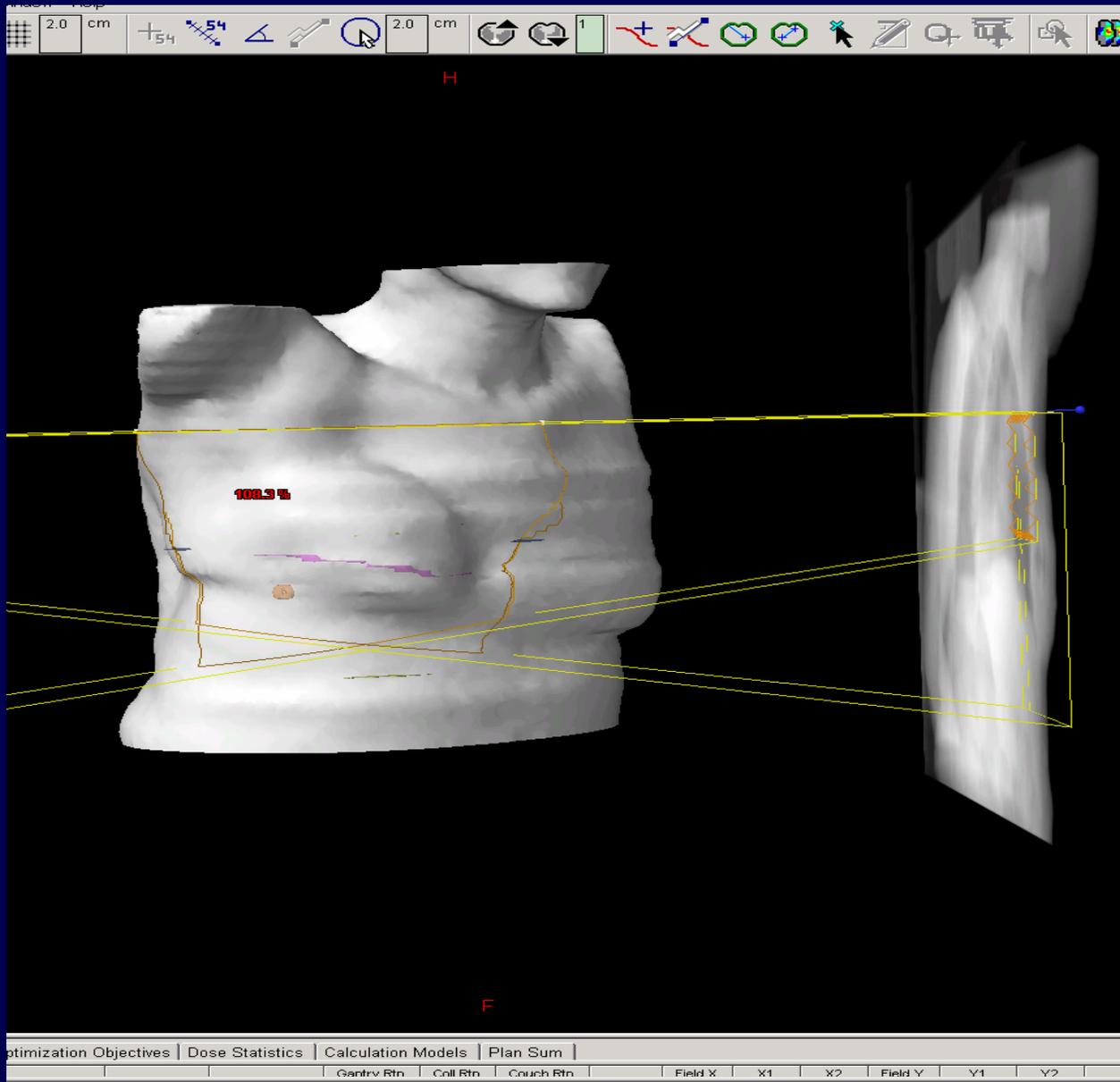
Scar and drain placement

- This can sometimes affect the radiation fields and the technical quality of the radiation

- generally drain scars placed close to the mastectomy scar are easier to cover

- Avoid single UOQ and axilla scars even if they are close together
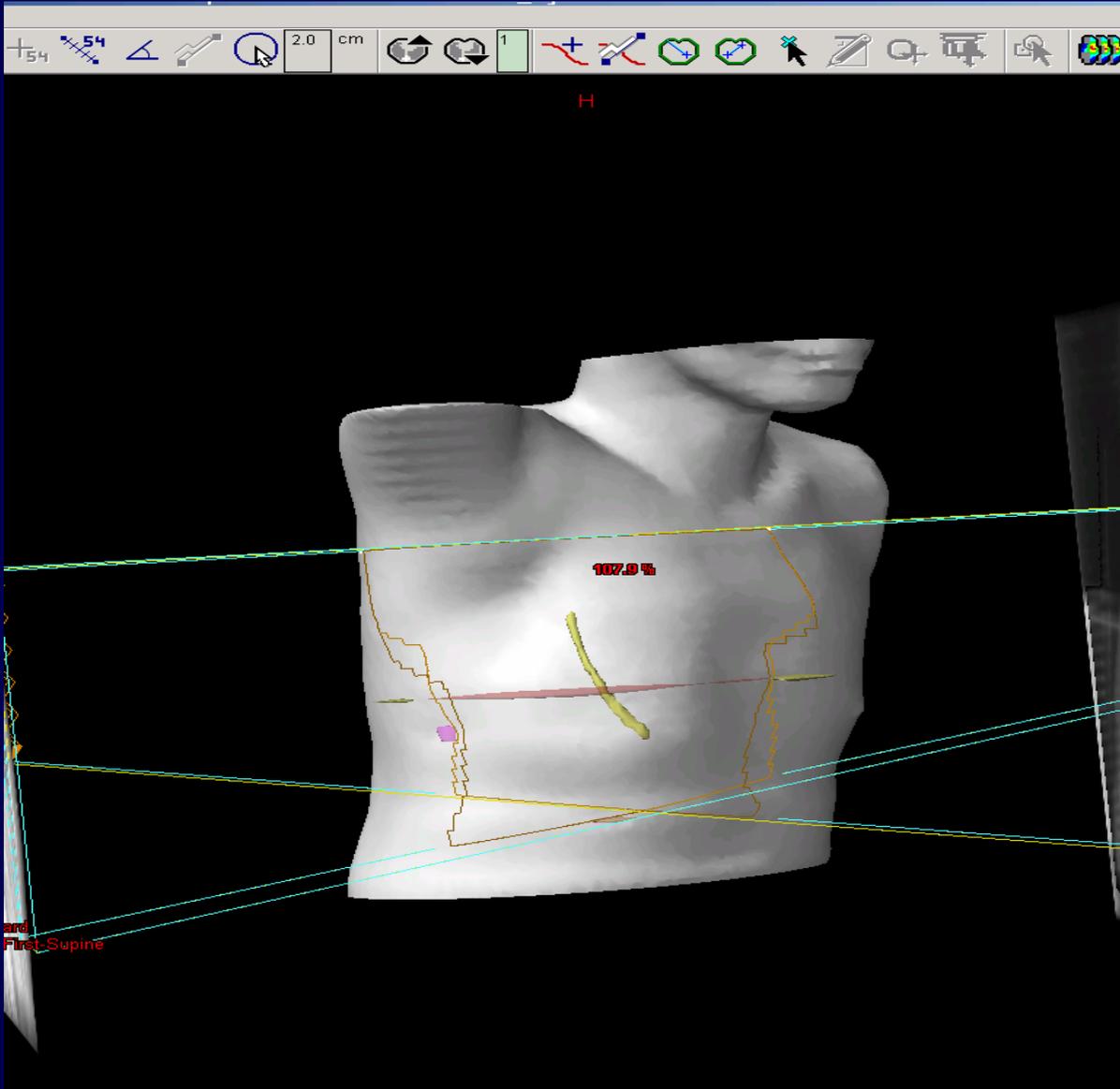
+SNB, ALND and axillary radiation

- This is an evolving area

- Solid evidence based recommendations will not be available until we have longer FU of current patients and results of randomized trials

- In the meantime, we will try to devise some general approaches

- Generally patients with a low risk (eg 5%) of further positive nodes may have ALND omitted

- Also, patients who have other indications for nodal radiation may not go back

- It is very helpful if the surgeon has explained the potential need for a completion ALND

Key points

– Breast cancer local recurrence rates are falling. Contributing to this is the increased attention to margins and the good collaboration between surgeons and oncologists

– OR reports which contain details about margins are very helpful to the Rad Oncs
  - we like to know when there areas where no further breast tissue can be taken
  - for example, if the dissection was taken down to the pectoralis fascia, right up to skin, very close to the nipple, or to an extreme margin of the breast such as medial, superior or inferior breast

– Marking of the surgical cavity with clips is very helpful for planning patients for partial breast RT and RT boost planning.

– noting in the OR report how the clips are placed and if there are any clips placed at a distance from the main surgical cavity is very useful information

Key points

- Scar and drain placement can affect the radiation fields and the technical quality of radiation.
  - drain scars placed close to the mastectomy scar (if technically feasible) are generally easier to cover with RT fields
  - avoid single UOQ lumpectomy and axillary scars, even if the 2 are going to be quite close together

- Axillary radiation may be affected by lack of ALND in patients with a positive SNB – this is an evolving field and requires more study.
- more follow-up of current practices and the results of trials will be required before evidence based policies are created.
- Currently, patients considered at low risk for additional positive nodes can often be spared further axillary surgery and radiation to the axilla may be an option.
- It is very helpful if the surgeon has explained the recommendation for a completion axillary dissection to the patient prior to the SNB

END