

Table 1

Types of reconstruction with breakdown of specialties performing procedures

Type of reconstruction	Numbers of patients receiving reconstruction	Percentage performed by plastic surgeons	Percentage performed by breast surgeons
DIEP	28	100%	0%
LD flap	4	0%	100%
Implant only	5	0%	100%

Conclusion: Charing Cross Hospital rates for immediate reconstruction are slightly higher than those across London, possibly reflecting the difference in services for on-site breast reconstruction offered across London hospital trusts. However, errors in coding may account for under reporting of procedures by HES.

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P155. Reoperation rates for cavity shaves following breast conserving surgery

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Background: Traditionally local recurrence (LR) rates have been linked to adequate surgical margins. NICE guideline has not defined the optimum clear margin; hence the substantial difference in the reoperation rates among the English NHS Trusts. However, a meta-analysis in 2010 did not show any significant difference in LR associated with margins of >1, >2, or >5mm. Following this publication, the updated North Trent Breast Cancer Group guidelines (2012) recommend a margin of 1mm for invasive cancer and 2mm for DCIS.

Aim: The aim of this study was to identify the rate and trend of reoperations for cavity shaves following breast conserving surgery (BCS) in Sheffield Teaching Hospitals (STH) before and after the change in regional guidelines.

Methods: The electronic list of all breast operations and reoperations performed between 2008 and 2013 at STH was retrieved. Non-breast conserving surgeries, operations for benign diseases, pure cosmetic/reconstruction operations and cavity shaves done during the first operation were excluded.

Results: There was an increase in the proportion of cavity shaves up until 2011 – from 11% (26/236) in 2008 to 20% (52/259) in 2011. This has sharply and significantly reduced in the subsequent two years, reaching 7.2% (18/250) in 2013 (Chi-square: 19.79, df: 5, $p=0.001$).

Conclusions: This study demonstrates a significant reversal in the trend towards increasing re-excision for margins in BCS following the introduction of new network guidelines in 2012. This may have an impact on cosmetic outcome and treatment cost whilst LR rates will need to be monitored to ensure adequate disease control.

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P156. Therapeutic mammoplasty with rotation advancement dermoglandular flap – A simple and effective technique

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Introduction: Breast conserving surgery is used for local control of breast cancer in preference to mastectomy wherever applicable. Various techniques of Therapeutic Mammoplasty (TM) are used to allow breast

conserving surgery to be performed with better aesthetic and possibly better oncological outcomes.

Aim: We review our Rotation Advancement Dermoglandular Flap (RADF) as simple Therapeutic Mammoplasty technique.

Method: We studied 93 consecutive cases of Therapeutic Mammoplasty performed by a single surgeon over a period of 5 years. The commonest technique used was RADF in 56 cases. The rest included wise pattern technique, Grissotti flap, Bat wing mammoplasty and combination of reduction mammoplasty techniques with or without use of a secondary parenchymal or dermoglandular flap. The study focuses on 56 cases of Therapeutic Mammoplasty with RADF. The technique used is based on simple plastic surgical principle of creating full thickness flap from skin to pre-pectoral fascia after planned resection of the cancer and rotating it to meet the other dermoglandular pillar to reconstitute the breast. The breast sizes varied from A to G cup (Median C cup). The commonest quadrant where the technique was employed was LIQ (24 cases, 46%) followed by LOQ (12 cases, 23%), UOQ (9 cases, 17%), UIQ (7 cases, 13%). The nipple was relocated by de-epithelialisation in 45 cases (86%). 6 patients (11.5%) had DCIS only who did not have any axillary procedures and of the remaining 46 patients 41 had Sentinel node biopsy and 7 Axillary Lymph node dissection. Post-operative outcomes including complications, surgical margins, re-excision rate, cosmetic result and patient satisfaction were examined.

Results: The mean clinical size of the tumour was 21mm (range 8-40mm). The mean histological size of the tumour was 26mm (range 13-51mm) and the mean and median closest radial margins were 6mm and 5mm (range 2.5- 15mm). Mean specimen weight was 58gms (range 32-146gms). Mean operating time was 42 minutes. No haemorrhagic complications were recorded. 3 patients (5.7%) required re-operation (1 further excision and 2 completion mastectomy). 2 patients were treated with antibiotics but no cases of fat necrosis were recorded and there were no cases of local recurrence over a mean follow up period of 28 months. High patient satisfaction and good to excellent cosmetic results were reported by 50 out of 54 patients (96%).

Conclusion: Therapeutic Mammoplasty with Rotation Advancement Dermoglandular flap is a safe technique and can achieve good oncological and cosmetic outcomes with low complication and re-operation rates in the author's experience.

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P157. The role of breast conserving surgery in the treatment of multiple ipsilateral breast cancer: A systematic review

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Introduction: The true incidence of multiple ipsilateral breast cancer (MIBC) may be as high as 30%. The traditional surgical treatment is a mastectomy although some now advocate breast conserving surgery (BCS). The aim of this study was to evaluate and critically appraise the evidence that supported BCS in this context.

Methods: A comprehensive electronic database search was performed to identify complete papers published between May 1998 and May 2013 that reported outcomes of BCS for patients with MIBC. Papers were assessed using a modified Cochrane risk of bias tool.

Results: 19 papers, 12 retrospective studies (RS) and 7 case series (CS) were identified. 4 RS compared BCS in MIBC to BCS in unifocal cancers, 2 RS compared BCS to mastectomy in MIBC and 6 compared both. All 7 case series included MIBC patients undergoing BCS. A total of 1817 patients were included in the 19 papers with a median sample size of 36 (range 7-476). Median local recurrence was 5% (range 0-40%) with a median follow up period of 70 months (range 20-120). No study reported statistically significant differences in recurrence following mastectomy or BCS although 30% (3/10) reported statistically significant differences in