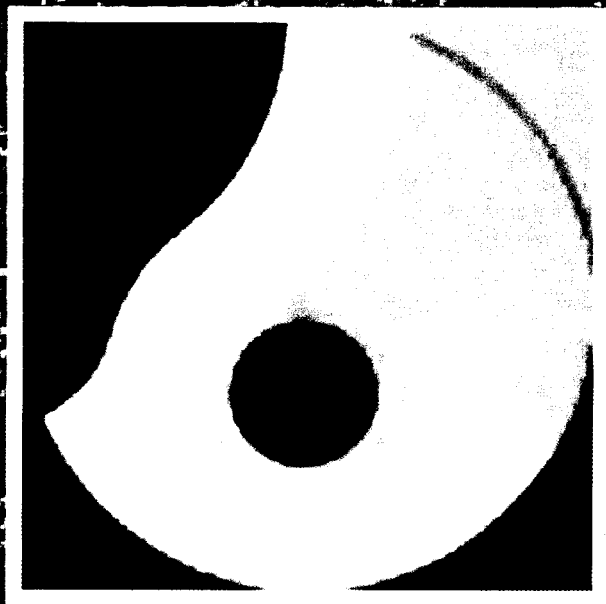


SENOLOGY



INTERNATIONAL PROCEEDINGS DIVISION

Treatment of T₀N₁ tumors. What type of surgery?

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A very rare pathology in the practice of mastology, between 0.5 and 1% of the breast cancers, in most of the short series published (1). Since Halsted, who published the first three patients in 1907, the most numerous series were those of the 70's and 80's. Its frequency logically fell as diagnosis methods for breast pathology were developed and perfected.

As regards axillary adenopathy, the metastasis of a breast carcinoma without a clinical or mammographic diagnosis of the lesion, it is natural that it was more frequent in the premammographic period or in its first stages. Nowadays we think that many of them are going to be included in the ever-increasing section of non-palpable breast lesions, aimed, from the surgical point of view of its diagnosis and treatment, towards the carrying out on the breast of a radiosurgical biopsy (2). In these cases, although the initial symptom of the disease is the presence of an axillary adenopathy which is identified most of the times by the patient herself, the clinical-diagnostic study of the patient will inevitably and almost in the first place lead us to a mammographic study which in many cases confirms the existence of radiological damage. This, even if not palpable, will present no doubts as regards its positive diagnosis. The patient will be shown under 'non-palpable breast carcinoma' instead of as 'occult carcinoma'.

It is curious to see how in some of the series published as occult breast carcinomas there are some cases with positive mammographies (3, 4, 5). Logically, a suspicious mammogram is present in almost all of them. However, we believe that all the positive ones should nowadays be shown not as occult carcinomas but

as non-palpable lesions. The cases with suspicious mammograms could largely disappear in the future of this series because that suspicion will be confirmed either with more advanced high-quality mammography techniques or with other already published methods such as the colour Doppler pulse (6) or with RNM. In the latter there are already false positives and false negatives, but the possibilities reach around 75-100% (7, 8). On the other hand, as regards surgical operations, that suspicion is going to condition the treatment to follow, for it will need confirmation with surgical removal of that area in most cases. As everyone, even ourselves, will have experienced, the surveillance of these areas of radiological suspicion mostly ends up being clearly positive in a short time (9).

The protocol for the treatment of occult carcinomas always starts with a surgical process which is the axillary biopsy with a removal of the problematic adenopathy. The presence of an axillary adenopathy can be due to several benign or malignant causes. All kinds of infections, lymphomas, and multiple metastases, such as those of melanoma, breast, lung, thyroid, gastro-intestinal tract, ovary, etc. The histologic diagnosis of adenocarcinoma metastasis will focus the problem towards techniques which may confirm the origin of the process in the breast. Techniques of selective staining of mucicarmine, etc. There is also the important aid of immunohistochemical procedures which will help to identify cytokeratin, the membrane antigen, S-100 protein, milk albumen and, in our experience, the C-erb B-2 oncogene, the hormone receptors and the P-53 oncoprotein.

We believe that it is once the possible breast origin of the tumour is found that it is necessary to move deeper into the radiological study of the breast. Confronted with an initially negative mammography, every area which could be suspicious will need to be examined. Enlarged, compressed and focalised mammographies will make area study clearer. Also useful at times, although to a lesser degree, will be thermographies and echographies. As we commented before, an MNR with a staining of gadolinium can be useful, and in the experience of the New York Memorial they show 75% positivity (9 out of 12 patients) where small focal masses or regional highlighted areas were detected (7).

Within our protocol it is also time to carry out an extension study. As in all N1 patients, apart from the general study already done, we also asked for a marker study, a bone gammagraph and an abdominal echography or CAT. Other studies are shown not to have been worthwhile for eliminating various possible origins of the tumour (4, 10, 11).

Once this diagnosis study is completed, two different situations are found regarding the treatment to follow. Firstly, that the carcinoma is really occult and there are no suspicions about its presence in the breast or, secondly, there is really a suspicious area in one of the techniques carried out. The surgical treatment has, as in all types of breast cancer, two different fields of action: the breast and the axilla. The regional affectionation is clear in these patients, and in this sense we are nowadays completely radical and a removal of the ganglionic lymph node of the three Berg levels is carried out. The advantages are those of any axillary cleaning, increased here by the already tested security of its affectionation.

In the literature, very different levels of affectivity can be found in these patients, but, as can be logically deduced, when the diagnosis is for a not small, clinically palpable adenopathy most of the patients have an important axillary affectionation. Out of 151 patients reviewed in the various series from where these data are gathered, only 32.2% had a single affected ganglion, and up to 48.7% of them had 4 or more metastatic ganglions. (Table 1)(3, 4, 5, 10 to 15). The only reviewed series which talks about levels is that of Ashikari of the New York Memorial in 1971. In its small group of patients (28) only 6 (21.4%) had an affectionation of the first exterior Berg level, 46.4% had affectionation in both the first and second levels and up to 32.1% had metastasis of the three axillary levels (16).

With all these data it is easy to understand our preference for a complete

Table 1 **Tumours T₀ N₁**
Axillary affectation: number of metastatic adenopathies.

Adenopathies	1	2-3	4	Average
Kemeni (11)	2	2	7	12.7
Westbrook (3)	2	2	6	7.9
Ellerbrock (12)				6.6
Rosen (5)	12	7	20	11
Iglehart (13)	5			
Merson (14)	13	10	23	
Fitts (10)	7	2	3	
Bhatia (15)	0	3	7	8.2
Patel (4)	11	4	11	
TOTAL	32.2%	18.9%	48.7%	

axillary cleaning which can give us a complete diagnosis of the axilla, can eliminate in many cases the need for radiotherapy on the axilla (which increases its morbidity), will eliminate axillary recidivists, which have a complicated treatment, and the greater number of affected adenopathies, when checked, will condition the quality and quantity of adjuvant chemotherapy or the inclusion of some patients in intensifying protocols (17).

If we are radical in the regional treatment we are quite conservative in the treatment of the breast. The history of the development of the patients with this pathology produces, in our view, enough data to support this criterion.

Several arguments which have been taken from previous studies support a more conservative criterion than the normal mastectomy which is used as local treatment in the older series. In the first place, it is important to show the great percentage of patients who did not develop a tumour after surgery. The figures move between 0% and 85.6%, with a total average of 35.7% (table 2). And, even though these big differences show varying degrees of detail in the study of the parts, it is true that in most of them there is an important number of patients where no tumour was found and, moreover, even through long periods of post-surgery control, a tumour never developed, even though the patient died of the disease.

If we accept, as we should, that the main parameter for a conservative treatment is the size of the tumour, we are faced with a kind of breast cancer where the size of the tumour is usually very small, microscopic in many cases or of a few millimetres in size. Only in some cases, a minority of them, would the great tumoral or intraductal size justify a mastectomy.

The size of 107 occult carcinomas has been gathered from the reviewed or

Table 2. **Tumours T₀ N₁**

Breast tumour not found.	Surgery on the breast		Absence of tumour	
Kemeni (11)	11		6	54.5%
Ashikari (16)	34		11	32.3%
Westbrook (3)	12		6	50%
Barón (18)	35		11	31.4%
Ellerbrock (12)	42		36	85.6%
Rosen (5)	45		9	25%
Merson (14)	27		6	22.2%
Bhatia (15)	11		0	0
Patel (4)	29		13	44.8%
TOTAL	246		98	35.7%

Table 3. Tumours T₀ N₁

Tumour size	Microscopic	T ₁		T ₂	T ₃
		0-1 cm	1-2 cm		
Ashikori (16)		8	8	7	
Rosen (5)			18	3	1
Iglehart (13)		3	2		
Merson (14)		9	6	5	
Fitts (10)	4	1	5		1
Bhatia (15)	2	2	3	1	1+2 ext. cid.
Patel (4)	10		5	1	
TOTAL	16-15%		69-65%	17	3+2

published series. Out of these, 16 (15%) are mentioned as being microscopic or too small to be measured, and the sum of all the T₁ (tumours of less than 2 centimetres which, being palpable, would be in the strictest conservative protocol criterion) is a total of 85 patients, nearly 80% (table 3).

On the other hand the results also speak in favour of conservation or observation, and in the more modern series where these treatments have been carried out the results in comparison with mastectomies do not establish significant differences. This can be seen in the works by Barón (18), from the New York Memorial (1990), by Ellerbroek (12), from the Anderson Centre in Houston (1990) or by Merson (1991), of the Tumour Institute in Milan (14).

If in palpable tumours, which are even big at times, a conservative treatment is being used without worse results (19), how can the need for a mastectomy in many small or microscopic cases be justified? Is it because a recidivist or a tumour which was occult at the start is going to appear later, even though it does not always happen that way? (1) We should wait until that happens to make the most convenient decision then, which could even be that of following the conservative criterion with a tumourectomy or a segmentectomy.

It is true that, in some series, as in a case we experienced in FEMA (1), there is the appearance in the course of the disease of a tumour with inflammatory characteristics of fatal prognosis (14, 15). However, these recidivists are also mentioned in the wide series of conservative treatment of palpable tumours without being invalidated because of being infrequent.

Finally, all the opinions coincide in that the results of the evolution of these patients T₀N₁ is at least equal to, and in general better than, the rest of the patients with TN₁ included in study II of the classification of the U.I.C.C (even though the reason is not very clear). This is based on the importance of the size of the tumour as a prognosis factor, even in cases with an important early regional affectation.

In this same sense, most of the times there is an aid in the fact that the appearance of the tumour in the subsequent evolution of the patients will make us act in one way or another on them, but it does not impair the prognosis comparing them to those where the tumour never appeared.

Having heard all these comments, our surgical protocol regarding the breast of the patient will follow. If a suspicious area or lesion were to be found during the explorations there would be a segmentectomy or radiosurgical tumourectomy, following, logically, a stereotaxis. As in all radiosurgical biopsies, if the suspicion were radiological it would confirm, with the radiograph of the removed operation part, that there would be a lesion. Also as in all radiosurgical biopsies we believe that the study of the anatomopathological part must be done at a later stage with a diagnosis of the lesion and the margins as well as the extension of the intraductal component, which has been extensively described (9); and in relation with the microscopic size, the study of microinfiltration with electron

microscopes (13), and the determination of hormonal receptors and markers already studied in the adenopathy of the biopsy. In that same intervention a complete axillary cleaning would be performed.

If there were nothing suspicious in the study of the breast only the ganglionic cleaning would be carried out. Both if there is a tumour in the operated breasts or not, and certainly if they go directly to observation and control, they will receive radiotherapy treatment on the breasts as in any conservative treatment during the post-operative period. This will be before, after or at the same time as the complementary chemotherapy treatment which the prognosis factors of each patient recommend.

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