Surgical Therapy after Preoperative Chemotherapy

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Surgical Decisions

- Breast Conservation Therapy
- Mastectomy
- Sentinel Lymph Node Biopsy
- Breast Reconstruction
Goals

- Increase the rate of breast conservation therapy (BCT)
  - 80-90% of patients will undergo a response to preoperative chemotherapy
    - Large percentage can then be offered BCT
- Obtain prognostic information
A surgeon should evaluate the patient at least prior to chemotherapy and before surgery

- Thorough, documented physical exam
  - Clinical tumor size
  - Location of tumor
  - Lymph node involvement
  - Skin erosion
  - Fixation to the chest wall
  - Skin inflammation
Pre-Therapy Assessment

• All patients need to undergo thorough radiographic evaluation prior to chemotherapy and before surgery
  – Mammogram
  – Supplemental ultrasound and MRI
  – All suspicious areas should be biopsied prior to the initiation of chemotherapy
    • Multiple biopsies may be necessary
    • Especially important for patients contemplating BCT
Pre-Therapy Assessment

- Location of the tumor needs to be “marked” in some manner prior to initiation of chemotherapy
  - Even in patients who want mastectomy
    - “Patients change their minds”
  - Radiologic clip(s) or coil(s)
  - Outline the extent of tumor on the breast and then photograph the patient
    - Outline extent of tumor on clear sheet of plastic with appropriate breast markings
  - Extent of tumor tattooed on skin
    - Usually 4 points tattooed
  - Calcifications will not disappear after preoperative chemotherapy
    - Can be used as target
Pre-Therapy Assessment

- If tumor is not marked before chemotherapy, subsequent localization for BCT may prove difficult
  - May compromise overall local control
  - Adequate localization may be impaired in up to 30% of cases
  - If patient desires BCT and the tumor was not marked, attempts to localize the tumor based on post-treatment imaging has to be performed
    - Recent study observed that more breast volume excised
      - Quadrantectomy

Dash N, Am J Roentgenol, 1999;173:911
Chattopadyay R, SSO, Abstract #P191
On multivariate analysis, the omission of tumor bed clips was associated with a hazard ratio of 3.69 for increased local recurrence compared to patients who did have radiopaque clips placed (p=.083, 95% CI 0.84-16.16).

Oh, JL, MD Anderson, personal communication
Timing of Surgery

• Surgery should be performed after predetermined chemotherapy is completed
  – Includes patients with dramatic responses to chemotherapy
  – Patients prefer to complete chemotherapy if possible before surgery
  – Prior to surgery hematologic ramifications need to be assessed
  – All repeat imaging needs to be performed
Tumor Response to Chemotherapy

Pre-Chemotherapy Tumor → “Honeycomb or Swiss Cheese” Shrinkage → Post-Chemotherapy Tumor

Pre-Chemotherapy Tumor → Concentric Shrinkage → Post-Chemotherapy Tumor
BCT Selection

• Same selection criteria used for patients undergoing preoperative chemotherapy or primary surgery
  – Absence of multicentric cancer
    • Selected cases of multifocal cancer appropriate
  – Wide-spread malignant appearing calcifications
  – Ability to excise the residual tumor with negative margins and acceptable cosmetic result
  – Patient able and willing to undergo radiation therapy

• Decision for BCT is made after completion of chemotherapy
BCT

- Technique for BCT is the same as for patients who do not undergo preoperative chemotherapy
  - Key: need to excise all residual palpable and radiologic abnormalities
    - Multiple guidewires or radioactive seeds maybe needed
    - Oncoplastic techniques may facilitate BCT
  - Meticulous assessment of the margins is critical
    - Specimen margins should be inked
    - Adequate margins: controversial
      - Most agree 1-10 mm
        » My preference is 2 mm
Outcomes of BCT after Preoperative Chemotherapy
BCT Outcomes

• **GEPARDUO Trial**
  – Phase III randomized trial with operable breast ca (≥2 cm) to preoperative dose dense doxorubicin + docetaxel vs. doxorubicin + cyclophosphamide followed by docetaxel
    • 607 Patients
    • 493 (81%) BCT attempted
    • 450 (74%) BCT successful
    • Tumor size
      – T1 5 (0.8%)
      – T2 438 (72.2%)
      – T3 157 (25.9%)

## BCT Outcomes
### GERPARDUO Trial

### Pre-Operative Predictors of BCT

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. Patients N (%)</th>
<th>Univariate</th>
<th>Multivariate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical tumor size before chemotherapy (palpation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥40 mm (n = 415)</td>
<td>329 (79.3)</td>
<td>&lt; .0001</td>
<td>&lt; .0001</td>
</tr>
<tr>
<td>&gt; 40 mm (n = 185)</td>
<td>118 (63.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical N classification before chemotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N0 (n = 364)</td>
<td>280 (76.9)</td>
<td>.10</td>
<td></td>
</tr>
<tr>
<td>≥N1 (n = 243)</td>
<td>170 (70.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ductal (n = 444)</td>
<td>349 (78.6)</td>
<td>&lt; .0001</td>
<td>.003</td>
</tr>
<tr>
<td>Lobular (n = 105)</td>
<td>64 (61.0)</td>
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<td></td>
</tr>
<tr>
<td>Grade</td>
<td></td>
<td>&lt; .0001</td>
<td>.46</td>
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<tr>
<td>1 (n = 34)</td>
<td>25 (73.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 (n = 297)</td>
<td>216 (72.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 (n = 195)</td>
<td>164 (84.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estrogen receptor</td>
<td></td>
<td>.029</td>
<td>.47</td>
</tr>
<tr>
<td>Positive (n = 382)</td>
<td>281 (73.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative (n = 160)</td>
<td>128 (80.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of neoadjuvant chemotherapy</td>
<td></td>
<td>.028</td>
<td>.047</td>
</tr>
<tr>
<td>ADOC (n = 306)</td>
<td>215 (70.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AC-DOC (n = 301)</td>
<td>235 (78.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical response (palpation)</td>
<td></td>
<td>&lt; .0001</td>
<td>&lt; .0001</td>
</tr>
<tr>
<td>CR (n = 260)</td>
<td>215 (82.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PR (n = 210)</td>
<td>153 (72.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD (n = 98)</td>
<td>62 (63.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PD (n = 13)</td>
<td>5 (38.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical tumor size after chemotherapy (palpation)</td>
<td></td>
<td>&lt; .0001</td>
<td>&lt; .0001</td>
</tr>
<tr>
<td>≤20 (n = 443)</td>
<td>355 (80.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 20 (n = 146)</td>
<td>60 (56.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Center size *</td>
<td></td>
<td>&lt; .0001</td>
<td>.001</td>
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<tr>
<td>≥10 patients/center (n = 469)</td>
<td>365 (77.8)</td>
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</tr>
<tr>
<td>&lt; 10 patients/center (n = 138)</td>
<td>86 (62.3)</td>
<td></td>
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</table>
## Post-Operative Factors Predicting Successful BCT

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. Patients (%)</th>
<th>$P$ value Univariate</th>
<th>$P$ value Multivariate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathologic response rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pCR (n = 71)</td>
<td>62 (87.3)</td>
<td>.002</td>
<td>.004</td>
</tr>
<tr>
<td>No pCR (n = 536)</td>
<td>388 (72.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathologic nodal status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative (n = 356)</td>
<td>288 (80.9)</td>
<td>&lt;.0001</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Positive (n = 250)</td>
<td>161 (64.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphovascular space invasion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not present (n = 357)</td>
<td>272 (76.1)</td>
<td>.026</td>
<td>.047</td>
</tr>
<tr>
<td>Present (n = 40)</td>
<td>24 (60.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multifocality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unifocal disease (n = 339)</td>
<td>269 (79.4)</td>
<td>.001</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Multifocal-multicentric disease (n = 57)</td>
<td>27 (47.4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
BCT Outcomes
GERPARDUO Trial

• Trial Conclusions
  – Majority of patients can undergo BCT after preoperative chemotherapy for operable breast cancer
  – Factors associated with BCT rate were
    • Initial and residual tumor size
    • Response to chemotherapy
    • Histology
      – Invasive lobular carcinoma
        » Lower BCT rate 56%
        » Lower clinical response rate (only 5% CR rate)
    • Lymphovascular invasion
    • Pathologic nodal status
    • Multifocality
    • Center size
Risk of Local Recurrence after BCT

- Analysis of 340 Patients
- 1987-2000
- Single institution – MD Anderson Cancer Center
- Overall local recurrence was 9%
- Increased risk of local recurrence with:
  - Clinical N2 or N3 disease
  - Pathologic residual tumor > 2 cm
  - Multifocal residual tumor pattern
  - Lymphovascular invasion

Chen AM, J Clin Oncol, 2004;22:2303
Risk of Local Recurrence after BCT

Clinical N0-N1 vs N2-N3

Residual Tumor Size

Lymphovascular Invasion

Residual Tumor Pattern
Risk of Local Recurrence after BCT

• This led to the development of a prognostic index score
  – 1 point for each factor present
  – Prognostic score of 0 or 1 had a very low risk of local recurrence
  – Prognostic score of 3 or 4 had a high risk of local recurrence
    • Mastectomy should be considered for these patients

• The prognostic index score still needs to be validated on other data sets

Chen AM, Cancer, 2005;103:689
Huang EH, Int J Rad Onc Biol Phys, 2006;66:352
### Risk of Local Recurrence after BCT

#### IBTR-Free Survival

<table>
<thead>
<tr>
<th>MDAPI Score</th>
<th>No. of Patients</th>
<th>No. of Patients with IBTR (%)</th>
<th>No. Expected</th>
<th>RR</th>
<th>5-yr IBTR-free Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>157</td>
<td>2 (1)</td>
<td>7.0</td>
<td>0.3</td>
<td>99</td>
</tr>
<tr>
<td>1</td>
<td>119</td>
<td>6 (5)</td>
<td>5.5</td>
<td>1.0</td>
<td>94</td>
</tr>
<tr>
<td>2</td>
<td>43</td>
<td>4 (9)</td>
<td>2.0</td>
<td>2.0</td>
<td>88</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>3 (25)</td>
<td>0.7</td>
<td>7.0</td>
<td>82</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0 (0)</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
</tr>
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</table>

#### LRR-Free Survival

<table>
<thead>
<tr>
<th>MDAPI Score</th>
<th>No. of Patients</th>
<th>No. of Patients with LRR (%)</th>
<th>No. of Expected</th>
<th>RR</th>
<th>5-Yr LRR-free Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>157</td>
<td>4 (3)</td>
<td>12.8</td>
<td>0.3</td>
<td>97</td>
</tr>
<tr>
<td>1</td>
<td>119</td>
<td>9 (8)</td>
<td>9.9</td>
<td>0.9</td>
<td>91</td>
</tr>
<tr>
<td>2</td>
<td>43</td>
<td>8 (19)</td>
<td>3.6</td>
<td>2.2</td>
<td>83</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>6 (50)</td>
<td>0.7</td>
<td>8.2</td>
<td>58</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0 (0)</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
Local Recurrence Mastectomy vs. BCT Based on Prognostic Index Score

Prognostic Index = 0: 96% Mastectomy, 95% BCT

Prognostic Index = 1: 93% Mastectomy, 91% BCT

Prognostic Index = 2: 66% Mastectomy, 72% BCT

Prognostic Index = 3, 4: 81% Mastectomy, 39% BCT

Patients with a prognostic index core of 0-1 are equally well served by BCT or mastectomy.
Local Recurrence after BCT

- Retrospective review 257 patients treated with BCT (1985-1994)
  - A variety of chemotherapy regimens
  - A variety of radiotherapy regimens
  - T stage
    - T1 15 (6%)
    - T2 216 (84%)
    - T3 26 (10%)
  - 159 (62%) were clinical N0
  - 92% infiltrating ductal

Rouzier R, J Clin Oncol, 2001;19:3828
Local Recurrence after BCT

- Local failure at 5 and 10 years is 16% and 21.5%.
- Factors associated with local recurrence were age, margin status, S-phase, and tumor size at surgery.
- Pre-chemotherapy factors did not play a role.
- Local recurrence negatively impacted overall survival.

<table>
<thead>
<tr>
<th>Covariate</th>
<th>RR</th>
<th>95% Confidence Interval</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 40 years</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 40 years</td>
<td>3.55</td>
<td>1.89-6.67</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Margin status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 2 mm</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 2 mm</td>
<td>2.48</td>
<td>1.26-4.86</td>
<td>.04</td>
</tr>
<tr>
<td>Positive</td>
<td>0.94</td>
<td>0.35-2.54</td>
<td>.04</td>
</tr>
<tr>
<td>S-phase fraction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 4%</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 4%</td>
<td>2.64</td>
<td>1.19-5.85</td>
<td>.03</td>
</tr>
<tr>
<td>Size at surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 2 cm</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 2 cm</td>
<td>2.09</td>
<td>1.08-4.03</td>
<td>.04</td>
</tr>
</tbody>
</table>

Margin status:
- Positive: 11%
- Close (≤ 2 mm): 18%
- Negative: 67%
- Unknown: 4%

Rouzier R, J Clin Oncol, 2001;19:3828
Nomograms

- 3 published preoperative nomograms
  - Prediction of CR
  - Prediction of residual tumor < 3 cm
    - Surrogate for the ability to perform BCT
  - Prediction of BCT after preoperative chemotherapy

Prediction of BCT after anthracycline or anthracycline + taxane chemotherapy was based on tumor characteristics
- ER status, tumor diameter, histologic grade, multicentricity, histologic type

Concordance index was 0.67

Conversion of Mastectomy to BCT

- Data regarding local recurrence is conflicting
- Some studies demonstrate increase rate of local recurrence other do not
• Overall, no difference in local recurrence in BCT patients
  – pre-operative (10.7%) vs. post-operative (7.6%) chemotherapy
• Difference in preoperative chemotherapy group determined to be secondary to:
  – Age
  – Tumor size at presentation

Wolmark N, JNCI, 2001;30:96
EORTC 10902

- Randomized patients to preoperative and postoperative chemotherapy
- 698 Patients
- 199 underwent BCT
- Overall Local Recurrence 10% in both groups (BCT + Mastectomy)
- Only patient who underwent BCT after chemotherapy analyzed
  - Patients who converted from mastectomy to BCT had worse overall survival than those who were initially BCT eligible

Van der Hage JA, J Clin Oncol, 2001;19:4224
Impact of Margin Status

- Retrospective review 390 patients
  - 1994-2002
  - Single institution – European Institute of Oncology, Milan, Italy
  - All T2 or T3 tumors
    - 76% T2
  - All patients mastectomy only candidates
  - 195 (63%) underwent BCT
    - 72% T2
    - 34% T3
  - Median F/U 41 months

Gentilini O, J Surg Oncol, 2006;94:375
Impact of Margin Status

- BCT patients
  - 19% pCR
  - 44% tumors <2 cm
  - 24 (12%) +margins on final pathology (not re-excised)
  - 13 (7%) local recurrence
    - 5% with –margins
    - 13% with +margins
  - Local recurrence did not influence overall survival
    - Short F/U

- Conclusion: margin status important in overall local control

Gentilini O, J Surg Oncol, 2006;94:375
Local Recurrence after BCT

• Many single center studies report much lower local recurrence rates than multi-institutional trials
  – Not all have addressed initial surgical options
  – Lower incidence of local recurrence attributed to:
    • Multi-disciplinary approach
    • Strict BCT guidelines
    • Large volume centers
Special Considerations
Multifocal or Multicentric (MFMC) Breast Cancer

- Retrospective analysis of 706 patients treated with preoperative chemotherapy
- 97 (14%) had MFMC disease
  - Diagnosed before starting chemotherapy
- Patients where all tumor could be removed through one lumpectomy were offered BCT

Table 1. Patient and Tumor Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Unicentric (n = 609)</th>
<th>MFMC (n = 97)</th>
<th>( \chi^2 ) test P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>&lt; 35</td>
<td>96</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>( \geq 35 )</td>
<td>513</td>
<td>84</td>
<td>79</td>
</tr>
<tr>
<td>1-2</td>
<td>298</td>
<td>64</td>
<td>69</td>
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<tr>
<td>Unknown</td>
<td>88</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>1</td>
<td>51</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>2</td>
<td>272</td>
<td>45</td>
<td>47</td>
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<tr>
<td>0</td>
<td>184</td>
<td>30</td>
<td>37</td>
</tr>
<tr>
<td>1</td>
<td>279</td>
<td>46</td>
<td>39</td>
</tr>
<tr>
<td>I-II</td>
<td>313</td>
<td>51</td>
<td>59</td>
</tr>
<tr>
<td>III</td>
<td>296</td>
<td>49</td>
<td>38</td>
</tr>
<tr>
<td>Negative</td>
<td>247</td>
<td>41</td>
<td>38</td>
</tr>
</tbody>
</table>
| Positive       | 271 | 44 | 48  | 50 | \n| Unknown        | 91  | 15 | 11  | 11 | \n
Abbreviation: MFMC, multifocal and multicentric.

Oh JL, J Clin Oncol, 2006;24:4971
Multifocal and Multicentric (MFMC) Breast Cancer

- Mean F/U was 66 months
- Overall locoregional failure was 7% in patients with MFMC disease and 10% in patients with unifocal disease
  - Equal success with BCT or mastectomy
- Only 20 patient with multifocal disease underwent BCT
## Infiltrating Lobular Carcinoma

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Pathologic CR</th>
<th>BCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cristofanilli, 2005</td>
<td>ILC 122 (12%) IDC 912 (88%)</td>
<td>3% 15%</td>
<td>16% 29%</td>
</tr>
<tr>
<td>Cocquyt, 2003</td>
<td>ILC 26 (19%) IDC 101 (75%)</td>
<td>0% 15%</td>
<td>38% 50%</td>
</tr>
<tr>
<td>Tubiana-Hulin, 2006</td>
<td>ILC 118 14% IDC 742 88%</td>
<td>1% 9%</td>
<td>30% 48%</td>
</tr>
</tbody>
</table>

Tubiana-Hulin M, Ann Oncol, 2006;17:1228
Cristofanilli S, J Clin Oncol, 2005;23:41
## NSABP B27
### IDC vs. ILC

### Ipsilateral Breast Tumor Recurrence

<table>
<thead>
<tr>
<th>Histologic Type</th>
<th># Pts</th>
<th># IBTR</th>
<th>Annual IBTR Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ductal</td>
<td>989</td>
<td>41</td>
<td>3.72</td>
</tr>
<tr>
<td>Lobular</td>
<td>151</td>
<td>2</td>
<td>2.09</td>
</tr>
</tbody>
</table>

P-value in Cox proportional hazards = 0.09

### Clinical Prediction of pCR

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coeff</th>
<th>SE</th>
<th>P-value</th>
<th>Odds Ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment (Pre-OP AC†, Pre-OP AC+T)</td>
<td>0.774</td>
<td>0.166</td>
<td>&lt; 0.0001</td>
<td>2.167</td>
<td>1.566 – 2.999</td>
</tr>
<tr>
<td>Clinical Nodal Status (Negative†, Positive)</td>
<td>0.366</td>
<td>0.173</td>
<td>0.034</td>
<td>1.443</td>
<td>1.028 – 2.024</td>
</tr>
<tr>
<td>Histologic Type (Ductal†, Lobular)</td>
<td>0.543</td>
<td>0.289</td>
<td>0.060</td>
<td>1.721</td>
<td>0.977 – 3.030</td>
</tr>
</tbody>
</table>

† Baseline for comparison

Model based on 1108 patients for whom all covariates were known

Conclusions

• Surgeons are integral in the multi-disciplinary approach to breast cancer patients
  – Need to evaluate patients before preoperative chemotherapy and after

• Breast conservation therapy safe and effective after pre-operative chemotherapy
  – Increases the options for women with breast cancer
Conclusions

- Appropriate selection criteria for BCT must be employed
  - Thorough pre-operative assessment is critical
  - Factors consistently associated with successful BCT (not absolute criteria)
    - Residual tumor
    - Invasion
    - Residual disease
- Histology – IDC
  - Negative margins
  - Excision specimen
Thank You

Questions?