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abstracts

XXV National Congress of the "Società Polispecialistica Italiana dei Giovani Chirurghi"
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INTRAOPERATIVE RADIOTHERAPY ASSOCIATED WITH ONCOPLASTIC SURGERY IN EARLY BREAST CANCER: PRELIMINARY REPORT OF A NOVEL APPROACH IN CONSERVATIVE BREAST SURGERY

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Objective: Oncoplastic surgery has been popularized as a method to hide the cosmetic effects of central or large-volume resections associated with breast conservation surgery for breast cancer. In our opinion this technique allows a large exposure of breast gland that facilitates the preparation of glandular flaps that will be treated with IORT. In addition, the combined use of this two techniques overcomes the problem of postoperative localization of tumoral bed, because radiotherapy is given during surgery. Contralateral adjustment can be carried out immediately or delayed: we prefer to postpone it when the results of the first intervention have been consolidated. Long term follow up will be necessary to validate oncological and aestetic results.
Methods: We selected 10 patients that were affected by low risk early breast cancer (> 45 y.o., invasive ductal carcinoma with intraductal component < 25%, T1 , N0, single lump) and moderate – severe breast ptosis (II – III degree according to Regnault Classification). Patients were subjected to lumpectomy with oncoplastic technique, sentinel node biopsy, IORT and reduction mammaplasty. Controlateral mastopexy was performed immediately in 2 cases, delayed in 3.
We observed no short term morbility (infections, liponecrosis, haematoma, skin flap or nipple-areolar complex (NAC) necrosis).
Results: We observed no short term morbility (infections, liponecrosis, haematoma, skin flap or nipple-areolar complex (NAC) necrosis).
Conclusions: Preliminary results encourage us to believe that the association between these two techniques is not only feasible but also safe and acceptable by patients for good aesthetic results. Further studies are necessary to evaluate the long-term efficacy of IORT in local control of breast cancer.

LIPOSTRUCTURE IN BREAST PLASTIC SURGERY, REVIEW OF THE LITERATURE AND NEW TECHNIQUES

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Objective: The fat grafting has been one of the most popular procedures over the last years. Sydney Coleman was the first plastic surgeon who described and popularized this procedure (LIPOSTRUCTURE) in 1997. Many surgeons have described modifications of this technique since then. With this study we try to compare different methods of fat grafting for breast surgery.
Methods: We retrospectively studied 230 patients: 17 of them treated with Coleman's technique, 25 with Del Vecchio's technique, 81 with the Khouri approach and 107 treated with Clinica Planas' approach. We include cases of breast reconstruction and aesthetic breast augmentation. We analyze the pre-operative photos, the method of aspiration (high or low pressure), the method of centrifugation, the amount of fat infiltration and the 6 months post-operative photos.
Results: With an equal amount of infiltration, the fat graft survival rate of the Clinica Planas' technique is higher than Coleman's one. If we need higher augmentative volume it is better to use Khouri or Del Vecchio's technique with the help of Brava System.
Conclusions: These new techniques improve the limits of fat grafting that have been published before by Sydney Coleman. Therefore it's possible to use this procedure in many different ways depending on each patient.

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PRIMARY NEUROENDOCRINE CARCINOMA OF THE BREAST: CONSIDERATIONS FROM A SMALL SERIES AND REVIEW OF THE LITERATURE

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Primary neuroendocrine carcinoma of the breast (bNEC) is a rare and slow-growth tumor derived from neuroendocrine cells. Its incidence is estimated between 0.1 and 0.3 percent of all the breast malignancies, and less than 1 percent of all the neuroendocrine tumors throughout the body. Since 2003, the World Health Organization (WHO) considers bNEC as an independent neoplastic form, characterized by the expression of at least 50% of neuroendocrine markers in the total cell population, as well as a typical pattern of receptors. Accordind to WHO Classification of tumors, bNEC includes four fundamental histotypes: solid neuroendocrine carcinoma, small cells/ oat cells carcinoma, atypical carcinoid and large cells neuroendocrine carcinoma. However, the most important prognostic factor seems to be the grading. Unfortunately, bNEC shows no pathognomonic clinical or diagnostic characteristics. In fact, radiological and sonographic characteristics of these lesions do not have special features that allow a precise diagnosis. Preoperative citology by fine needle biopsy allows for a correct diagnosis of malignancy, but it doesn't discriminate a neuroendocrine form. Frequently the diagnosis of bNEC comes after surgery, by specific immunoreaction and cellular patterns. No specific guidelines on the treatment of bNEC exist at the moment. We herein report three different cases of bNEC successfully treated, and discuss about the diagnostic pathway and surgical treatment.

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