Lannin and Haffty provide an interesting and informative review on the management and clinical course of an ipsilateral breast tumor recurrence (IBTR) following lumpectomy and breast irradiation for primary breast cancer. They present an engaging discussion concerning the distinction of a true recurrence from a new primary tumor within the ipsilateral breast. Although both events are included in the term IBTR, the authors point out that the more favorable outcome follows treatment of a new primary as opposed to a true recurrence. Presumably, the true recurrence would indicate tumor that has not been eradicated by surgery and radiotherapy (with or without systemic therapy), which would be a more aggressive malignancy. The better prognosis for a new primary notwithstanding, there is still a lack of data to indicate whether treatment should be different for these two entities.

**Risk Factors**

The authors reiterate the known risk factors for IBTR after lumpectomy and breast irradiation, including young age, positive or close microscopic margins, multifocality, extensive intraductal component, and no history of tamoxifen use. However, it is important to realize that whereas these various patient, tumor, and treatment factors increase the risk of an IBTR, the majority of patients with some or all of these factors will still be free of an in-breast tumor recurrence 10 years later. Using the recursive partitioning model described by Freedman et al, who identified subgroups of patients with different risks for IBTR, the highest-risk group (with a 34% 10-year risk of IBTR) comprised only 10 of 912 patients. Patients with an IBTR are at greater risk for distant metastases, and Lannin and Haffty discuss the controversy concerning whether or not the IBTR is a marker or an instigator of distant metastases. Regardless, it has been difficult to show a significant difference in overall or disease-free survival for patients treated by breast-conservation therapy vs mastectomy. Therefore, a woman with one or more risk factors for an IBTR should not necessarily be denied breast-conservation therapy.

**Optimal Treatment**

As the authors point out, mastectomy is considered to be the standard therapy for IBTR. However, there have been a few reports with small numbers of patients in which reexcision alone, reexcision with high-dose external-beam radiotherapy, or reexcision and brachytherapy have been used. The local recurrence rate following mastectomy is likely to be lower than that following a repeat lumpectomy, but there is little evidence to suggest that mastectomy for IBTR vs repeat excision with or without radiotherapy provides a statistically significant improvement in overall survival. That said, there have been no randomized clinical trials addressing this issue. Following mastectomy for an IBTR, radiotherapy should be considered for cases in which tumor is found at the margin of resection, there is underlying pectoral muscle involvement, or there is skin involvement. I have occasionally administered radiotherapy to the chest wall following mastectomy for IBTR that developed after previous lumpectomy and breast irradiation, and have not observed any serious sequelae. Similarly, radiotherapy should also be considered for subsequent recurrence on the chest wall following mastectomy for an IBTR.

**Cosmetic Results**

The cosmetic result following a salvage lumpectomy for IBTR is likely to be less favorable than after the initial lumpectomy for the original tumor. Factors influencing the cosmetic result after a second lumpectomy include the appearance of the breast before the IBTR, the quadrant in which the IBTR is...
located, size of the recurrent tumor, and amount of breast tissue excised. In my experience, the salvage lumpectomy (as opposed to repeat irradiation) was the main determinant of the cosmetic result.[2] Of 36 evaluable patients treated with salvage lumpectomy and a repeat course of radiotherapy (5,000 cGy/25 fractions), the cosmetic result was excellent or very good in 12 patients. In this same series, 15 patients had a good cosmetic result but with a noticeable asymmetry between the two breasts and/or noticeable pigmentation. Nine patients had a fair or poor cosmetic result with marked deformity or marked difference in size between the two breasts, usually with obvious pigmentation changes. Final Recommendations

In the above series of repeat high-dose external-beam irradiation for IBTR after previous lumpectomy and whole breast irradiation, the initial nodal status appeared to be a strong predictor for post-IBTR distant metastases.[2] Thus, I strongly advocate systemic therapy for all such patients with an IBTR, whether they are treated by mastectomy or repeat lumpectomy. In addition, given that a sizeable proportion of in-breast tumor recurrences may actually be "new primaries," one should consider systemic therapy in most, if not all, cases of IBTR, perhaps with the same criteria that are used for patients presenting with a first cancer in the breast. It is important to emphasize that salvage therapy of an IBTR "results in a reasonably good chance for cur......." This suggests that the presence of one or two risk factors for an IBTR following breast-conservation therapy should not necessarily be considered a reason for performing a mastectomy. As the authors note, the increased use of adjuvant systemic therapy has resulted in lower rates of IBTR than seen in the initial trials where just radiotherapy was administered postlumpectomy. I agree with the authors that there must be close and thorough follow-up of all patients following lumpectomy and breast irradiation, so that an IBTR, if it occurs, can be detected and treated promptly to maximize the chance of subsequent long-term disease-free survival.

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