

SPECIAL REPORT**TREATMENT OF PRIMARY BREAST CANCER**

A CONSENSUS-development conference on "The Treatment of Primary Breast Cancer: Management of local disease" was held at the National Institutes of Health on June 5, 1979. The purpose of the conference was to address the question of whether there are clinical alternatives to radical mastectomy that minimize patient morbidity and do not decrease the likelihood of survival.

The NIH Consensus Development Program brings together practicing physicians, biomedical researchers, consumers and others in an effort to reach general agreement on the safety and efficacy of a medical technology, whether it be a drug, a device or a medical or surgical procedure. At the meeting on primary breast cancer, three broad categories of surgical techniques were discussed: radical mastectomy; total mastectomy, in which the axillary lymph nodes are removed but the pectoralis muscles are preserved; and lesser surgical procedures, such as segmental mastectomy with or without radiotherapy. Radiotherapy was also discussed as a primary treatment for localized breast cancer.

The Halsted radical mastectomy was initially introduced as a treatment for locally advanced breast cancer and has been the traditional treatment for the past 80 years. Until recently, selection was generally based on this tradition, rather than the stage of the disease or the patient's histologic type. Now that breast cancer is more often diagnosed in its earlier stages (Stages I and II), a major question in the medical community is whether this "standard," developed at a time when most cases were not diagnosed until women had extensive local disease, needs to be changed.

The panel discussed a variety of surgical approaches other than the Halsted radical mastectomy. Data from several series indicate that a total mastectomy with axillary dissection can be regarded as a satisfactory alternative to the Halsted radical mastec-

tomy in women with Stage I or Stage II disease. The axillary dissection in this procedure is performed for the purpose of staging as well as for therapeutic benefit.

The panel agreed that a procedure that preserves the pectoral muscles, i.e., a total mastectomy with axillary dissection, provides equivalent benefit to women with Stage I or selected Stage II breast cancer. Therefore, total mastectomy with axillary dissection should be recognized as the current standard treatment. The panel also agreed that a two-step procedure should be used in most cases, i.e., a diagnostic biopsy specimen should be studied with permanent histologic sections before definitive therapeutic alternatives are discussed with the patient.

It was the consensus of this panel that a decision on the value of postoperative radiotherapy must await further results of adjuvant therapy in clinical trials. Lesser surgical procedures, such as segmental mastectomy with or without radiotherapy, were discussed. Segmental mastectomy poses a problem in that residual breast tissue remains. The early data presented by Dr. Umberto Veronesi, from the National Cancer Institute of Milan, Italy, indicate that the breast tissue that remains after segmental resection and postoperative radiation does not appear to harbor clinically important breast-cancer cells. The length of patient follow-up observation in this trial is approximately four years.

Primary radiation therapy can be used in addition to a minimal surgical procedure or as a single mode of treatment. The trials involving primary radiation therapy and those dealing with segmental mastectomy are not advanced enough to allow determination of survival benefits, but control of local recurrence appears to be similar to that achieved with current surgical procedures. The trials involving lesser surgical procedures or treatments other than surgery warrant further follow-up observation and enthusiastic support. These studies should also help to explain the clinical importance of multifocal disease.

The panel supported further clinical investigation into the roles of segmental mastectomy and primary radiotherapy. They endorsed the effort of the National Surgical Adjuvant Breast Project to ascertain the effectiveness of lesser surgical procedures in women with Stage I or Stage II breast cancer. If these ongoing clinical trials, with their exciting preliminary results, are supported by patients and physicians, the continuing search for the optimal patient treatment may lead to maximal patient survival and minimal patient morbidity.

Members of the Consensus Development Panel were: John Moxley, III, M.D., University of California, La Jolla, California, Chairman; John R. Durant, M.D., University of Alabama, Birmingham; Bernard Fisher, M.D., University of Pittsburgh, Pittsburgh; Samuel Hellman, M.D., Harvard Medical School, Boston; Mrs. Rose Kushner, Breast Cancer Advisory Center, Kensington, Maryland; Bernard Pierquin, M.D., Universitaire Henri Mondor, France; Jerome Urban, MD., Memorial Sloan-Kettering Cancer Center, New York; Umberto Veronesi, M.D., Istituto Nazionale per lo Studio e la Cura dei Tumori, Italy; and Joseph C. Allegra, M.D., Jane Henney, M.D., and Franco Muggia, M.D., National Cancer Institute.