

Ablative Options Advance Breast Cancer Treatment

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FORT LAUDERDALE, FLA. — Ablation is playing an increasingly important role in the treatment of breast cancers, according to experts at the annual meeting of the American College of Surgeons.

Ablation-assisted lumpectomy techniques, including radiofrequency ablation-assisted lumpectomy and cryoassisted lumpectomy, which were designed to reduce the need for reexcision after breast tumor removal, are showing promise for improving outcomes in breast cancer patients.

Percutaneous laser ablation, which targets the tumors themselves, is also showing promise.

As tumors are detected earlier and at smaller sizes, surgical precision becomes more of a challenge, said Lorraine Tafra, M.D., who is the director of the breast center at Anne Arundel Medical Center, Annapolis, Md.

She added that conventional techniques may remove more tissue than necessary, leaving patients with excessive scarring, pain, and loss of tissue volume. Ablative techniques are being explored to provide more precision and reduce the need for additional surgical procedures to clear margins.

Lumpectomy assisted with radiofrequency ablation (RFA) involves the use of heat to sear a 1-cm margin around a tumor that has been excised. The goal is to reduce the risk of tumor recurrence and, thus, the need for repeat lumpectomy and/or radiation therapy, said Suzanne Klimberg, M.D., director of the division of breast surgical oncology at the University of Arkansas, Little Rock.

In an ongoing pilot study, 26 patients have undergone the procedure, which is followed by intraoperative immunofluorescence to ensure no residual live cells remain in the ablation zone. Of seven patients with positive margins who were successfully ablated, six most likely would have required reexcision had they undergone standard needle localization and lumpectomy, Dr. Klimberg noted.

The patients, who had been followed for up to 6 months at the time of her presentation, are doing well, she said.

Cryoassisted lumpectomy, which involves ultrasound-guided prelumpectomy insertion of a cryoprobe through the center of the tumor via a 3-mm incision, appears to facilitate more accurate tissue resection and to decrease positive margin rates, said Dr. Tafra.

The cryoprobe technique, which creates an ice ball that envelopes the tumor and the adjacent 5-10 mm of normal surrounding tissue, creating a template for excision, has been used successfully for fibroadenomas. It also appears to be of benefit for early breast cancers, said Dr. Tafra, who has served as a paid consultant for Sanarus.

In a pilot study, 24 patients with ultrasonographically visible stage T1 breast cancers that otherwise would have required wire localization underwent the

cryoablative procedure. All lesions were successfully localized without complications. The mean tumor size was 1.2 cm (Ann. Surg. Oncol. 2003;10:1018-24).

The cryoassisted technique appears to eliminate many of the challenges associated with prelumpectomy wire localization, including patient discomfort associated with the relatively invasive procedure.

Studies are also underway to evaluate the use of percutaneous laser ablation on

small breast cancers. This minimally invasive technique uses a needle the size of that used for stereotactic breast biopsy to deliver laser energy directly into a tumor until the tumor is heated to 140° F for 12-15 minutes, according to Kambiz Dowlatshahi, M.D., of Rush Medical College, Chicago.

The technique is useful for early invasive or in situ breast cancers that are less than 5 cm, he said.

Dr. Dowlatshahi said the benefits of

percutaneous laser ablation include a low complication rate (there have been no complications in his experience), a short procedure duration (about 30 minutes), and the ability to perform the procedure in an office setting under local anesthesia. Most patients are sent home on acetaminophen, he said.

In early studies, lumpectomy following this procedure revealed that the laser energy completely destroyed the tumor and surrounding tissue. ■

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