Association of Breast Surgery Consensus Statement

Management of the Malignant Axilla in Early Breast Cancer

The following summary statement has been agreed by the Trustees of the Association of Breast Surgery (ABS) following the ABS Multidisciplinary Consensus Meeting on the further management of the malignant axillary node, held in London on 26th January 2015. This should be read in conjunction with the 'Summary of Proceedings' of the meeting and the speaker presentations, both of which will be available on the ABS website. A review and full update of the ABS guidelines on the management of the axilla is under consideration and will be published shortly.

Further local treatment for the malignant sentinel lymph node in patients with early invasive breast cancer

Isolated tumour cells and micrometastases:

If the sentinel node(s) shows isolated tumour cells and/or micrometastases no further axillary treatment is required in addition to breast conserving surgery or mastectomy.

1-2 sentinel nodes with macrometastases:

Further axillary treatment is no longer mandatory in patients who are receiving breast conservation with whole breast radiotherapy, that are post menopausal and have T1, grade 1 or 2, ER positive and HER2 negative tumours.

These patients could also be entered into the POSNOC or equivalent clinical trial.

Further axillary treatment should usually be recommended for patients undergoing mastectomy, or with tumours with one or more of the following features: T3, grade 3, oestrogen receptor negative or HER2 positive.

These patients could also be entered into the POSNOC or equivalent clinical trial.

No consensus was reached on the management of patients with one or more of the following features: premenopausal status, T2 tumours, lymphovascular invasion or extranodal spread.

3 or more sentinel nodes with macrometastases:

Patients should usually be recommended to have further axillary treatment.

Axillary Treatment

Radiotherapy to the axilla is a valid alternative treatment to axillary lymph node dissection in patients with a low burden of axillary disease.

Pre-operative Axillary Staging

All patients with invasive early breast cancer should have a preoperative ultrasound examination of the axilla and subsequent ultrasound guided nodal biopsy when indicated.

Adjuvant Treatment Planning

The total number of involved axillary nodes is no longer considered to be essential information to decide on the most appropriate systemic treatment. The choice of systemic treatment should be based on the prediction of response rather than the perceived prognosis.

Consensus was not reached on the importance of the total number of involved axillary nodes as essential information for post mastectomy radiotherapy decision making.

Please refer to the summary of proceedings of the meeting.

Management of the malignant axillary node diagnosed pre-operatively by ultrasound guided FNA or core biopsy

There was considerable discussion regarding the management of the pre-operatively diagnosed positive axillary node where patients are planned to undergo breast conservation surgery with whole breast radiotherapy, and where pre-operative information indicates a likely good prognosis and low axillary nodal burden (T1 tumour, grade 1-2, ER positive and postmenopausal status).

However consensus was not reached as to whether sentinel node biopsy should be considered as the next step in such patients. Although there was support for this option, it was apparent that appropriate processes and protocols will be required before further guidelines are agreed.

The ABS Trustees aim to develop appropriate guidelines on this issue as soon as possible.

Association of Breast Surgery Trustees 16th March 2015