

Oncology Clinical Service Line
System-wide Consensus Guidelines: **Ductal Carcinoma In Situ (DCIS): Management of Surgical Margins and Recommendations for Margin Re-excisions in Patients Having Breast Conserving Therapy**

These guidelines apply to clinical interventions that have well-documented outcomes, but whose outcomes are not clearly desirable for all patients

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System-wide Information Resource: Director of Clinical Programs

SCOPE:

Sites, Facilities, Business Units	Departments, Divisions, Operational Areas	People applicable to (Physicians, NP, Administration, Contractors etc.)
Allina – all facilities	Breast Surgeons, Pathology, Radiation Oncology, Medical Oncology	MDs, NPs, PAs

CLINICAL PRACTICE GUIDELINES:

- Wire or seed localization procedures will be utilized intra-operatively in non-palpable lesions, with confirmatory specimen radiographs obtained** to assess adequacy of removal of designated lesion.
- The surgeon will orientate the lumpectomy margins** using the standard inking scheme (see below). **The surgeon will orientate the mastectomy specimen** with a stitch at 12 o'clock.
- Specimens will be sent immediately to pathology for evaluation** of margins (for known cancers) and for handling of specimens according ASCO/CAP guidelines.

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4. **Pathologist will grossly assess margin status of known cancers.** Frozen sections may be obtained at pathologist's discretion. Pathologists will report to surgeons any close margins requiring immediate re-excision.
 - a. Pathologist will record time specimen placed in formalin on requisition slip.
5. **All margins involved with DCIS and all DCIS margins within 0.2 cm should be considered for re-excision.** Exceptions may occur, such as DCIS near or at a posterior fascial margin may not require re-excision. The grade of the DCIS, age of the patient, and the volume of DCIS at or near the margin may also influence the decision for re-excision.
6. **Exceptions should be discussed by the surgeon, radiation oncologist and pathologist and perhaps presented at a multi-disciplinary conference** (if there are still questions regarding the need for re-excision).

SUPPORTING EVIDENCE:

Margin status is an important issue in the management of patients undergoing breast conserving therapy (BCT) for treatment of invasive carcinoma and ductal carcinoma in situ (DCIS). The incidence of ipsilateral breast tumor recurrence (IBTR) in patients with breast cancer who undergo lumpectomy or partial mastectomy has been shown to be directly affected by margin status.

Re-excision of margins for both invasive breast cancer and DCIS in clinical practice is determined by the closeness of the surgical resection margin. Controversy surrounds the recommendations for re-excision for both invasive carcinoma and DCIS since multiple factors including pathologic handling of specimens, tumor characteristics and biology can have an effect on local recurrence.

Intra-operative and pathologic examination of breast specimens has been standardized for Allina Hospitals & Clinics that are served by Hospital Pathology Associates (HPA). These include orientation of lumpectomy specimens intra-operatively by using a standardized multi-colored inking scheme (blue=superior, red=inferior, green=medial, yellow=lateral, orange=anterior, black=deep). All mastectomy specimens should be oriented with a stitch at 12 o'clock.

A standardized protocol developed by HPA for sectioning the lumpectomy and mastectomy specimens for gross assessment of margins is utilized on all specimens. Specimens are cut at approximately 0.5 cm sections along the long axis of the specimen. Shaved tangential margins are not used since this overestimates the "positive margin rate" and increases the likelihood of unnecessary re-excisions. Intra-operative touch preps are also not advocated for margin assessment because of inconsistent results. The pathologist evaluates the closeness of the margins on gross examination (and when necessary by frozen section). The decision for immediate re-excision is made by joint decision of the pathologist and surgeon. Final margin status for both invasive and non-invasive breast cancer is reported in pathology report for all 6 margins less than 1 cm from tumor.

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Following gross evaluation, the specimens are placed in 10% neutral buffered formalin within 60 minutes from removal from the patient, and are fixed in formalin for a minimum of 6 hours, not to exceed 72 hours, according to American Society of Clinical Oncology (ASCO) and College of American Pathology (CAP) guidelines.

Scientific information regarding margin status and recurrence for DCIS include:

1. In a review of 4,660 patients treated with BCT and radiation therapy (RT) for DCIS, a negative margin significantly reduced the incidence of IBTR. (1, 4, 11, 24, 27-33)

When margin thresholds were examined, a 2 mm margin was superior to a <2mm margin. However margins >2 mm did not show a decrease IBTR. (1, 4, 11, 24, 27-33)

2. The volume of tumor near the margin is also important in regards to IBTR. One duct involved within a 2 mm margin is less likely to recur than multiple ducts near or at a margin. And, forty percent of patients with DCIS will have skip lesions, making it common to have residual DCIS in the breast following “clear margins”. (5)

3. Other biological factors may also affect the risk of IBTR irrespective of the tumor margins. Size and grade of DCIS, presence of necrosis, as well as patient age, have all been shown to increase risk of local recurrence irrespective of the margin status. (1, 11, 24)

4. Many studies have shown that BCT without radiation therapy is associated with a marked increase in IBTR. Thus, radiation therapy has been proven to be necessary to control residual DCIS in the breast of patients undergoing BCT. (22)

5. Adjuvant hormonal therapy reduces the risk of local recurrence even further in patients with estrogen receptor positive DCIS. (1, 21-23)

6. Silverstein’s studies with the Van Nuys nomogram have shown that for small low grade DCIS, excision with a 1 cm margin may not require RT with no increase in local recurrence. (24) However, subsequent studies have been unable to duplicate his results. All randomized studies have shown an increase in IBTR for all grades of DCIS in which RT is eliminated. (25)

7. Invasive cancer with extensive DCIS also referred to as extensive intraductal component (EIC) has a higher rate of local recurrence than invasive cancer without EIC and the recurrences may manifest as DCIS or invasive cancer. Thus, the margin status of DCIS in patients with invasive carcinoma associated with EIC is extremely important in predicting IBTR. (11, 26, 34)

SPECIAL ENTITIES:

Lobular carcinoma in situ

Lobular carcinoma in situ (LCIS) is a pathological finding associated with an increased risk of developing breast cancer in either breast. However, classic LCIS at or near a margin does not increase the risk of local recurrence, and thus classic LCIS does not require re-excision for margin

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involvement or proximity. The exceptions to this are special types of LCIS, such as pleomorphic LCIS, and LCIS with necrosis. These “high grade” types of LCIS are thought to behave similarly to DCIS. Thus, re-excision of margins is recommended for pleomorphic type LCIS or LCIS with necrosis located near or at surgical margins (following the guidelines above for DCIS). (35, 36)

Atypical ductal hyperplasia

Atypical ductal hyperplasia (ADH) has been found to be associated with an increased risk of cancer in the breast. And, in some cases, the classification of ADH may be based on a quantitative assessment of atypical ducts. There may be quantitatively insufficient atypical ducts in a particular specimen to qualify for a diagnosis of DCIS. Thus, if ADH is present at an excised margin in an excisional biopsy specimen, or at an excised margin in a BCT specimen, re-excision will be recommended to exclude the possibility of DCIS at that margin. (37)

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Alternate Search Terms:

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