Lipofilling nowadays is a part of the clinical practice for breast reshaping in patients who underwent surgery for breast cancer [1]. However, a strong debate in the literature is open about a higher risk of cancer relapse caused by growth factors produced by adipocyte stem cells after their engraftment in the recipient tissue. Even if it is now clear enough that there is no risk in case of infiltrative tumors, we cannot say the same thing in case of in situ ones. Petit et al. [2, 3] hypothesize in two different papers, a higher risk of tumor relapse after lipofilling following surgery for intraductal cancer, showing in one of them four cases of relapse against a control group with no events. In all of these cases, the author clears that the resection edges were clear of neoplastic cells.

We think that this statement could be a matter of discussion. It is known that breast cancer, above all its intraductal version, can produce small nodules surrounding the principal one, and that these are often so little that they are under the resolution
limit of the common imaging exams, mammography and ultrasonography, which are generally carried out. Moreover, intraductal cancer has also a intraductal growth, and so we cannot talk about a nodule, but we must consider a zone involved in the disease. This is the reason why patients affected by ductal carcinoma in situ (DCIS) need more than anything else to be studied to achieve an accurate knowledge of the area involved and of the resection edges. In our breast group, we have decided to perform an magnetic resonance imaging in every case of breast cancer. We think this is the only exam able to pick out also the smallest nodules [4]. This exam is made on all the patients and not just in ambiguous cases, as also clear cases hiding small undiscovered lesions do exist. Then we also ask the pathologist to study the resection edges in a shaving way using hematoxylin–eosin staining and immunohistochemistry to get the hormonal asset, so we have a clear image of a possible microscopic disease infiltration of the surgical limits.

Thanks to these solutions, the cancer relapse rate, considered as a radiological or clinical appearance of a new nodule within the first 2 years after breast cancer surgery, is nonessential in our survey, being ~0.5%, both in invasive ductal carcinoma and DCIS. Patients coming from our survey and undergone lipofilling do not show any cancer relapse. Our data, which are still unpublished as we are waiting to reach a higher number of cases, include 22 patients who underwent lipofilling using the traditional Coleman technique and 40 controls. Each patient has a median follow-up time of 3 years before lipofilling and 3 years after. This evidence has brought us to consider that lipofilling is not a risk factor after surgery for DCIS, and that data shown by Petit should be linked to the high rate of multifocality or multicentricity typical of this tumor and to the concrete possibility that cancer could be spread into the breast more than mammography and ultrasonography show. We think that a thorough preoperative study of breast cancer could help to minimize the risk of relapse in the short and medium period, and that lipofilling is a safe procedure, which could be used in any case no matter the tumor histology.

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disclosure

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references


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