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German, Austrian and Swiss consensus conference on the diagnosis and local treatment of the axilla in breast cancer

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Abstract The German, Austrian and Swiss (D.A.CH) Societies of Senology gathered together in 2012 to address dwelling questions regarding axillary clearance in breast cancer patients. The Consensus Panel consisted of 14 members of these societies and included surgical oncologists, gynaecologists, pathologists and radiotherapists. With regard to omitting axillary lymph node dissection in sentinel lymph node macrometastases, the Panel consensually accepted this option for low-risk patients only. A simple majority voted against extending radiotherapy to the axilla after omitting axillary dissection in N1 disease. Consensus was yielded for the use of axillary ultrasound and prospective registers for such patients in the course of follow-up. The questions regarding neoadjuvant therapy and the timing of sentinel lymph node biopsy failed to yield consensus, yet both options (before or after) are possible in clinically node-negative disease.

1. Introduction

Both the omissions of axillary surgery in node-positive breast cancer patients and sentinel lymph node biopsy (SNB) before or after neoadjuvant therapy (nT) have gained in evidence over the past years. Several important questions have been investigated in prospective trials and retrospective studies. Further evidence obtained by additional prospective trials may be unlikely due to logistical and ethical reasons. Thus, the available evidence is to be translated into clinical

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practice. In this respect, one method to bring scientific data into clinical practice may be to constitute a panel consisting of internationally renowned clinical and scientific specialists with the objective of discussing the most pertinent questions and establishing practical answers. While the St. Gallen consensus conference[1] accepted the option of omitting axillary lymph node dissection (ALND) in the presence of SNB macrometastasis, the National Comprehensive Cancer Network (NCCN) guidelines (www.nccn.com) as well as other consensus panels[2,3] only accepted this option in patients with a low recurrence risk.

The German, Austrian and Swiss (D.A.CH) Societies of Senology, together with the Working Group for Gynecological Oncology, decided to form the D.A.CH Panel in order to create a consensus statement regarding axillary diagnosis and treatment in breast cancer. The goal of this consensus statement was to guide physicians in their clinical practice worldwide regarding axillary staging in breast cancer. The difference between this statement and existing guidelines is that the former intends to integrate an extended discussion process and apply the mini-Delphi process.

2. Methods

The D.A.CH Societies of Senology and the German Working Group for Gynecological Oncology (AGO) include a total of 3420 members, all of whom are dedicated to the diagnosis and treatment of breast cancer in Central Europe. Each of the four societies' Executive Boards nominated four delegates (two surgical specialists, one pathologist and one radiation oncologist) as representatives. One delegate (surgical specialist) called off participation on short notice and another delegate (radiation oncologist) was nominated by two societies, thus 14 delegates remained.

The modified or mini-Delphi method was applied in this process. On 20th March 2012, the delegates convened in Vienna at the Medical University Hospital. In total, 11 questions (Table 1) were addressed. After minor adaptations, eight questions were answered face-to-face in the course of that meeting and three were answered at an E-mail conference the week thereafter. The answers were immediately discussed during the meeting.

The questions, answers and discussion points were brought into context and presented to all Panel members via E-mail. Each question had been circulating twice to four times (not each question and not to all Panel members). Following an interdisciplinary agreement on the manuscript, the results were finally forwarded to the Executive Boards. The manuscript was submitted subsequent to further minor adaptations and agreement within the Boards.

3. Questions and results (Table 1)

The following sections include the questions and answers as well as discussion points. All questions are formulated in the context of "**as standard of care**". The Panelists were able to vote with yes, no or abstention. According to the criteria of the German S3 Guidelines, the extent of agreement was defined as follows[4]:

Agreement among 50–75% of the Panelists: simple majority;

Agreement among >75% of the Panelists: consensus

Table 1
Comparison of statements between St. Gallen consensus and the German, Austrian and Swiss (D.A.CH) consensus regarding axillary surgery.

Should we	Clinical standard before 2011	Consensus St. Gallen	ConsensusD.A.CH	Extend of agreement	D.A.CH
Questions asked in St. Gallen 2011 and D.A.CH panel 2012					
1. Look for isolated cells	NO	NO	No consensus	Simple majority	NO
2. Do immunohistochemistry	NO	NO	No consensus	Simple majority	NO
3. Perform axillary dissection in pN0(i+)/1 mic	NO	NO	ConsensusNO		
4. Omit axillary dissection in pN1 all patients the American College of Surgeons Oncology Group (ACOSOG) criteria	NO	YES	No consensus	Simple majority	YES
5. Omit axillary dissection in pN1 all patients low risk	NO	YES	ConsensusYES		
Questions asked only at D.A.CH panel 2012					
6. Extend radiotherapy in pN1 patients without axillary dissection	X		No consensus	Simple majority	NO
7. Use nomograms for decision of axillary dissection in pN1	NO		No consensus	Simple majority	NO
8. Use ultrasound for follow-up after pN1 without axillary dissection	X		ConsensusYES		
9. Use registers for pN1 patients without axillary dissection	X		ConsensusYES		
10. Perform sentinel lymph node biopsy (SNB) before nCT	NO		No consensus	Simple majority	YES
11. Perform SNB after nT	NO		No consensus	Simple majority	YES