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Pathological behaviors of breast cancer which could alternate surgical decisions

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Surgical pathologists have a definitive role in cancer patient prognosis. The task of surgical pathologist is to provide accurate, specific, and sufficiently comprehensive information about the tumour behavior so the clinician can develop an optimal plan of treatment and estimate prognosis. The simple designation "benign" or "malignant" is not enough today. Breast cancer is not a single disease. There are distinct varieties of tumors, each with a characteristic biology. Details of breast cancer pathological behavior as the type, its differentiation, level of invasion, the number of lymph nodes with and without metastatic tumor, the presence or absence of hormone receptors, the activity of specific enzymes, ploidy, frequency of mitosis, and percentage of cells in the S-phase may all be relevant in the pathologic assessment of neoplasia. Intraoperative examination by frozen tissue sections could not usually give enough information; pathologists rely on better preservation of structure afforded by permanent tissue sections stained with hematoxylin and eosin (H & E) and occasionally other dyes. These raise the importance of preoperative diagnosis using core tissue biopsy rather than FNAC. In this presentation, the evaluation, prognostic factors, and treatment options for different pathologically different breast cancers will be discussed. Methods of surgical & oncological treatments of locally advanced cancer breast will be also discussed according to biology and clinical behavior.

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Chest closure without drainage after open patent ductus arteriosus ligation in Ugandan children: A non-blinded randomized controlled trial

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Background: There is clinical equipoise regarding post-operative management of patients with patent ductus arteriosus (PDA) without insertion of a chest drain.

Objective: This study evaluated post-operative outcomes of chest closure with or without a drain following patent ductus arteriosus ligation among children at Uganda Heart Institute.

Method: This was an open label randomized controlled trial of 62 children of 12 years of age and diagnosed with patent ductus arteriosus at Mulago National Teaching and Referral Hospital, Uganda. Participants were randomized in the ratio of 1:1 with surgical ligation of patent ductus arteriosus to either thoracotomy closure with a chest tube or without a chest tube. All participants received standard care and were monitored hourly for 24 hours then until hospital discharge. The combined primary endpoint consisted of significant pleural space accumulation of fluid or air, higher oxygen need or infection of the surgical site. Analysis was conducted by multivariable logistic regression analysis at 5% significance level.

Results: We enrolled 62 participants, 46 (74%) of whom were females. Their median age was 12 months (IQR: 8-36). Participants in the no-drain arm significantly had less post-operative complications compared to the drain arm (Unadjusted odds ratio [uOR]: 0.21, 95% CI: 0.06-0.73, p=0.015). This "protective effect" remained without statistical significance in the multivariable regression model (Adjusted odds ratio [aOR]: 0.07, 95% CI: 0.00-2.50, p=0.144).

Conclusion: Children aged below six years with patent ductus arteriosus can safely and effectively have thoracotomy closure without using a drain in uncomplicated surgical ligation of the PDA. Chest drain was associated with post-operative complications.

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