

ABCP Radiation Therapy Guidelines  
Reviewed January 2011

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|-------------|---|---|
| <i>DCIS</i> | Surgery: <b>breast conserving</b>   | Whole breast radiotherapy 4250 cGy/16# or 5000 cGy/25# are standard, but other fractionation can also be used.<br>Partial breast radiotherapy investigational as part of clinical trial |
|             | For margins <2 mm, re-excision recommended (close margin at fascia is an exception) | For margins <2 mm not treated with re-excision, role of RT boost not well defined   |
| <i>DCIS</i> | Surgery: <b>mastectomy</b>  | No adjuvant radiotherapy recommended, even if margins close. Adjuvant RT can be considered when margin positive but benefit not defined.  |

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|---|---|---|
| <i>Invasive breast cancer<br/>Node<br/>negative</i>               | Surgery: <b>breast conserving</b>   | Whole breast radiotherapy 4250 cGy/16# or 5000 cGy/25# are standard, but other fractionation can also be used.<br>Partial breast radiotherapy investigational as part of clinical trial                 |
|   | For margins <2 mm, re-excision recommended (close margin at fascia is an exception) | Radiotherapy boost recommended:<br>In all women <40 yrs regardless of margin<br>In women >40 yrs boost individualized based on risk assessment (grade 3 disease, <2 mm margin)<br>4#-8# are most common |
| <i>Invasive breast cancer<br/>T1/T2 and<br/>Node<br/>negative</i> | Surgery: <b>mastectomy</b>  | No adjuvant radiotherapy recommended even if resection margin close. Adjuvant RT can be considered when margin positive but benefit not defined.  |
| <i>Invasive breast cancer<br/>T1/T2 and<br/>Node<br/>positive</i> | Surgery: <b>breast conserving</b><br>1-3 nodes positive                             | For both pre and postmenopausal women, whole breast radiotherapy recommended. Regional nodal radiation is not recommended. Results from MA-20 study pending.  |
|   | 4 or more positive nodes  | For both pre and postmenopausal women, breast plus regional nodal radiotherapy recommended; inclusion of  |

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|  |  | IM nodes at oncologist discretion<br>16#, 20# or 25# are common, but other fractionation can also be used.<br>If >10 nodes resected, may limit field to supraclavicular +/- IM nodes |
| <i>Invasive breast cancer T1/T2 Node positive</i>                          | Surgery: <b>Mastectomy</b><br>1-3 nodes positive | Pre and postmenopausal women: chest wall with regional nodal RT is individualized.   |
|  | 4 or more positive nodes                         | Same recommendation as for BCS with 4 or more positive nodes. Use of bolus on chest wall at oncologist discretion.   |
| <i>Invasive breast cancer T3/T4 disease Node negative or node positive</i> | Surgery: <b>Mastectomy</b>                       | Radiotherapy same as for mastectomy with 4 or more positive nodes.<br>Use of bolus on chest wall recommended for T3/T4 disease.  |