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Cancer is an incredibly difficult diagnosis to face. And along with the diagnosis comes a whole new vocabulary and barrage of terms to learn when dealing with the disease.What all patients hope to hear is that treatment was successful. Terms that are typically used include remission, cancer-free, or no evidence of disease, but these terms arent always understood.What is remission and what does it mean when a patient is in remission?When I tell a patent they are in remission, I typically mean that following a treatment (surgery, definitive radiation, chemoradiation, or chemotherapy) there is:No evidence of visible disease on medical imaging.I have a reasonable expectation that it wont come back.But they have risk for recurrence within a specified period, typically five years.Most cancers, if they recur or relapse, meaning there is now visible disease, typically do so within five years after the last treatment. After that point, the risk of recurrence decreases so substantially that the benefits of ongoing surveillance monitoring with tumor markers or imaging do not outweigh the risks.After five years of surveillance, I typically tell patients that I believe they are cured because ongoing surveillance is so unlikely to demonstrate recurrence. With cancer, unfortunately, this is never 100 percent certain. There are some cancers that can come back more than five years after treatment, but these are typically the outliers and not the norm.What does cancer-free mean?The term cancer-free is a little more ambiguous and its definition varies depending on who you talk to. In fact, it is so ambiguous that it is not a term I typically use.After a potentially curative treatment, I usually define disease status as remission rather than cure. I think some may use the term to mean there is no visible cancer at the time of encounter but I prefer to define this state as remission. I dont think I would use cancer-free until I was ready to say that someone is cured.What does No Evidence of Disease mean?No evidence of disease or, NED, is a term I use frequently, meaning there is no evidence of visible or detectable disease at the moment. The best example is when a patient who had cancer has repeated imaging and/or bloodwork drawn for tumor markers and neither demonstrates any findings of recurrent malignancy.When the patient comes for a surveillance visit, I would say that the surveillance workup at this time demonstrates no evidence of disease and the patient was reassured that he/she remains in remission at this time. Are the terms interchangeable and used consistently by individual doctors?Unfortunately, given the variable nature of cancer, nothing is absolute, and these terms are not well defined. The terms in and of themselves might mean different things to different providers. That is why I usually define the terms from my perspective when I meet patients and I am consistent with that message moving forward. NED and remission are often used interchangeably.Are there certain timeframes that determine whether someone is cancer-free?For most cancers, it is reasonable to state that if it doesnt come back in five years, it is unlikely to return. Sadly, some cancers do come back after five years, but this is not common.Does cancer-free or in remission mean the cancer is cured?The Websters definition of cure is a complete or permanent solution or remedy. For that reason, I dont tell a patient that a cancer is cured until I have followed them for five years after completion of treatment and they havent had recurrence. Up until that time, they might still have had hidden disease that has not grown enough to be seen in imaging studies. If you have questions about what these terms mean, just ask your doctor, so you are both on the same page.Can cancer return after a patient is declared cancer-free?I suppose it depends on how you define cancer-free, but the short answer is yes, unfortunately. Some cancers, particularly slow growing cancers, can recur after an appropriate surveillance period.Living life in remissionMy best advice for patients in remission is to enjoy and live your life. Unfortunately, there are a number of things, cancer recurrence included, that can cut life short unexpectedly. Each day we have on this earth is a gift.We must plan for the worst but hope for the best. Continue to pursue your regular health care screenings and come to your surveillance visits. Dont let your cancer diagnosis rule your life. The whole reason we are here is to treat people, and ideally cure them, so they can continue to live so live your life!For more information on cancer treatment, visit the Lifespan Cancer Institute website here. Breast Tumors Molecular Subtype Key in Treatment Choice Positive margins (ink on invasive carcinoma or ductal carcinoma in situ) are linked to two-fold increased risk of ipsilateral breast tumor recurrence. (HealthDay News) Positive margins (ink on invasive carcinoma or ductal carcinoma in situ) are associated with increased risk of ipsilateral breast tumor recurrence (IBTR), according to consensus guidelines published online Feb. 10 in the Journal of Clinical Oncology.Meena S. Moran, MD, from the Yale University School of Medicine in New Haven, CT, and colleagues conducted a systematic review of 33 studies involving 28,162 patients. The researchers sought to reach a consensus regarding optimal margin width in breast-conserving surgery for invasive breast cancer and the risk of IBTR.RELATED:Breast Cancer Resource Center The researchers found that, compared with negative margins, positive margins (ink on invasive carcinoma or ductal carcinoma in situ) correlated with a two-fold increase in IBTR risk. Neither favorable biology, nor endocrine therapy, nor radiation boost mitigated the increased risk. Compared with no ink on tumor, more widely clear margins did not significantly decrease the rate of IBTR. No evidence was observed in support of more widely clear margins for reducing IBTR in young patients or for patients with unfavorable biology, lobular cancers, or cancers with an extensive intraductal component.The use of no ink on tumor as the standard for an adequate margin in invasive cancer in the era of multidisciplinary therapy is associated with low rates of IBTR and has the potential to decrease re-excision rates, improve cosmetic outcomes, and decrease health care costs, the researchers wrote.Several researchers disclosed financial ties to the medical device industry.References To a cancer patient, one of the most magical words in the English language may be remission. For those fortunate enough to hear it, it imparts not only a much-hoped-for dose of good news, but also a profound sense of relief.But what does the term remission actually mean? And how does it differ if at all from no evidence of disease, or even cancer-free?We asked medical oncologistPhat Le, M.D., for insight.Whats the difference between remission, cancer-free, and no evidence of disease?A lot of people use those terms synonymously, but remission and no evidence of disease (also known as NEOD or NED) are probably the closest by definition. Officially, both mean that no cancer is currently detectable in the body. That may be based on scans, bloodwork or some other kind of test, such as a breast biopsy or a bone marrow biopsy.Cancer-free is a little more complicated, because its not based on something we can measure. Instead, it implies that not only is there nothing detectable in your body as cancer, but we also believe no residual cancer is left anywhere, so theres no chance of the cancer ever coming back. And thats a lot trickier to say, because theres always at least a very slight risk of recurrence, if youve ever had cancer before.So, how do doctors determine which term to use with a particular patient?Thats really based on the doctor and what they feel comfortable with. Personally, I tend to use remission and no evidence of disease the most.Does the type of cancer influence which term you use?No. But it will determine which type of surveillance testing your doctor chooses.With solid tumors like lung cancer, for instance, doctors might order a CT scan. But with prostate cancer and ovarian cancer, doctors might use blood tests to look for tumor markers or certain proteins. Doctors also look for evidence of diseased cells in blood or bone marrow samples with leukemia, lymphoma and other blood cancers.Does the length of time a cancer survivor has gone without a relapse affect which term doctors use?No. Not really. There are no special terms used for going 5, 10 or any other number of years without a recurrence.But sometimes, doctors will declare a patient cancer-free after a certain amount of time has passed without a relapse. It usually coincides with the transition from active surveillance into survivorship, when patients begin needing fewer or less frequent check-ups.Whats the one thing people should know about this topic?Though all of these terms are sometimes used interchangeably, its important to ask your oncologist specifically what they mean. Because I may use it one way, and another physician might use it another.Its also important for all cancer survivors to be on some type of surveillance program. Some cancers are considered very low-risk, so if youve already gone 5 or 10 years without a recurrence, its highly unlikely that youll ever have one. But its still not impossible. So, you need to keep an eye on it, just to make sure that if the cancer ever does come back, you catch it as soon as possible.Request an appointment at MD Anderson online or by calling 1-877-632-6789.Positron emission tomography (PET) scans can detect cancer earlier than other imaging tests. But some types of cancer are harder to detect on a PET scan. In particular, they may miss cancers that dont use a lot of glucose.Positron emission tomography (PET) is a nuclear medicine imaging test. Using a special dye that contains radioactive tracers, PET scans help doctors diagnose a variety of diseases, including cancer, particularly in the early stages.PET imaging can also help determine how well cancer treatment is working.Its an effective way to find cancer, but a negative PET scan doesnt always mean theres no cancer.There are some conditions that can lead to a false-negative or a false-positive result. Thats why its often performed in combination with computed tomography (CT) scans, magnetic resonance imaging (MRIs), and other diagnostic tests.Lets take a closer look at PET scans for cancer and what a negative result may mean.PET scans are effective imaging tests. They can detect abnormal activity in the body and often find cancerous tumors earlier than other imaging tests can.But the degree of accuracy varies with the type of cancer and how its combined with other tests.The most commonly used radioactive substance in PET imaging is F-FDG, a type of glucose. Once this solution is injected into a vein, it makes parts of your body that use a lot of glucose light up on the scan. Many types of cancer cells use a lot of glucose, so they show up as hot spots on the scan. But F-FDG isnt cancer-specific. So, PET scans may reveal hot spots that arent necessarily related to cancer.False positives can happen due to conditions such as:Blood sugar and insulin levels can also affect results. So, you can get a false-positive result if you have diabetes or if you ate something within a few hours of the test.For these reasons, PET scans are often performed along with other tests, such as CT scans or MRIs. It takes a specially trained radiologist or nuclear medicine specialist to evaluate and interpret the results.Other tracers may be used to look for specific types of cancer. For example, prostate-specific membrane antigen (PSMA) can help detect prostate cancer.A negative PET scan means that the test did not detect cancer. But certain types of cancer dont use a lot of glucose.A negative PET scan may miss certain cancerous tumors, such as:Low-activity tumors are a major cause of false negatives.Some cancers can. A PET scan may not detect tumors with low activity or those that are very small and slow growing.If a PET scan is negative, your doctor may recommend other tests to help diagnose or rule out cancer. Depending on the type of cancer they suspect, this may include:other imaging tests, such as CT, MRI, or bone scansblood testsurine testsMost of the time, youll need a biopsy to confirm a cancer diagnosis.Your doctor will provide instructions on how to prepare, which includes not eating for several hours before you have a PET scan.You may get more detailed instructions if you:are pregnanthave diabetesare breastfeedinghave claustrophobiaA nurse or technician will insert an intravenous (IV) catheter into your arm or hand to inject the radiotracer solution. It takes about 30 to 60 minutes for your body to absorb the tracer. During this time, youll need to move as little as possible. Youll lie flat on a narrow bed that will slide into a cylindrical scanner. Its important to stay perfectly still and not talk during the scan.It can take 30 minutes to an hour, depending on the area being scanned. You can go home soon after the scan is complete, and the results will go to your doctor.A PET scan is painless, with the possible exception of inserting the IV. You might feel a cold sensation in your arm when you get the radiotracer injection. Some people may have temporary discomfort, swelling, or redness at the injection site.You may experience nervousness or anxiety if you have:trouble staying still for a long timea fear of needlesa fear of tight or closed-in spacesPET scans, especially when combined with CT scans or MRIs, can help diagnose, stage, and monitor treatment for cancer.Potential benefits include:more detailed pictures of body structures and how theyre functioning than other imaging tests can providefinding cancer earlier than other diagnostic tests wouldpossibly being able to determine whether cancer is spreading and if treatment is workingpinpointing the precise location and size of tumorsoffering a possible alternative to exploratory surgeryOf course, medical tests come with some potential risks as well. PET scan risks include:false-positive or false-negative resultsan allergic reaction to the radiotracersexposure to radiationRadiation exposure from PET scans is low, as the radiation usually passes out of your body in a matter of hours. Speak with your doctor if you have any concerns about radiation exposure from a PET scan.A PET scan is a type of nuclear imaging test that can help detect cancer. Its an effective tool in diagnosing, staging, and monitoring cancer treatment.But you can still have cancer if a PET scan is negative. Thats because a few types of tumors are harder for PET scans to detect.For this reason, many doctors will also request PET scans in combination with CT scans, MRIs, and other diagnostic tests. This helps radiologists or nuclear medicine specialists evaluate the results more accurately. Your doctor can give you more information about the need for a PET scan and provide details on what you need to do before you have this procedure. True. Confusion can arise because the words tumor and cancer are often regarded as the same thing. A tumor is not necessarily cancer, however. A tumor is defined as the swelling of a part of the body, generally without inflammation, caused by an abnormal growth of tissue, whether benign or malignant. It is also defined as a swelling of any kind, or a mass. So by definition, a collection of pus can be a tumor.Not all tumors are cancerous, but a cancer is a particularly threatening type of tumor.The following terms are often used by doctors, nurses and other healthcare professionals.Neoplasm:An abnormal formation of tissue that grows at the expense of the healthy organism and competes with normal cells for nutrients. It refers to either benign or malignant growths. It is a synonym for tumor.Tumor:A swelling or enlargement. This is the more commonly used term for neoplasm. This general term can refer to either benign or malignant growths.Benign tumor:A non-malignant/non-cancerous tumor. It is usually localized, rarely spreads to other parts of the body, and can be usually treated by surgery only. If left untreated, however, benign tumors in certain localization can cause serious problems.Malignant tumour:Cancer. A malignant tumor may spread to other parts of the body and often recurs after removal if not treated with chemotherapy or radiotherapyCancer:A malignant tumor (a malignant neoplasm). Used to describe approximately 200 types of malignant neoplasms.When you hear doctors talk about cancer and its treatment, it can sound like they are speaking a foreign language. It helps to learn some of the most common terms they use and what those words mean. Understanding the lingo can help you work with your doc as you fight your disease together.Ablation (.a-BLAY-shun) is a minimally-invasive cancer treatment that uses heat, cold, or alcohol to directly destroy tumors.Acute (a-CUTE) describes symptoms that get worse very quickly but dont last very long. Sometimes, symptoms that start as acute can stick around and last for a while. Then they become chronic (see below).Atypical (ay-TIP-ih-cul) is a medical word for abnormal. Doctors may use this word to describe cells or body tissues that look unusual under a microscope. They might also say your case is atypical if you dont have the usual symptoms of your type of cancer.Benign (buh-NINE) means that a tumor is not cancer. It doesn't spread to other parts of your body. Biopsy (BYE-opp-see) is when a doctor removes a small piece of tissue from your body and sends it to a lab for testing. Its the main way to diagnose cancer. Your doctor may use a needle, scalpel, or other tool to do the biopsy.Carcinoma (CAR-sin-OH-muh) is cancer that starts in the lining of your organs or the outer layer of your skin.Chemotherapy (KEE-moh-THER-uh-pee) is a treatment that uses powerful drugs to kill cancer cells or to stop them from growing.Chronic (CRAH-nik) describes a condition that lasts a long time.Immunosuppressive (ih-MYOON-oh-suh-PRESS-iv) refers to treatments that turn down your bodys immune system so it cant fight infections as well. People who are about to get a bone marrow or organ transplant get these therapies to keep their bodies from rejecting the new tissue.Immunotherapy (ih-MYOON-oh-THER-uh-pee) is treatment that stimulates the immune system to help the body fight diseases like cancer.In situ (in SIGH-too) describes when abnormal cells look like cancer cells that have not spread to other tissue nearby. Malignant (muh-LIG-nant) refers to cancer cells that can invade and kill nearby tissue and spread to other parts of your body.Mass is a medical word for a solid group of abnormal cells.Metastasis (meh-TASS-tuh-sis) is the spread of cancer from the place where it started. If it has spread far, doctors will call it distant metastasis. The word for more than one metastasis is metastases (meh-TASS-tuh-sees). If the cancer has spread, your doctor may say it has metastasized.Oncology (on-COLL-uh-gee) is the type of medicine that focuses on cancer. Doctors who specialize in oncology are called oncologists. Other health professionals like nurses and pharmacists can specialize in oncology, too.Primary cancer is the original cancer in your body. If the disease spreads or comes back, this is called metastasis.Prognosis (prog-NO-sis) is a medical word for outlook. It includes your chances of recovering from the cancer, the chances the disease will come back, and your doctors predictions for the course of the disease. Even if you have the same type of cancer as someone else, your prognosis will be unique to you. Radiotherapy (RAY-dee-oh-THER-uh-pee) is treatment that uses radiation to kill cancer cells and shrink tumors. It is also called radiation therapy. You might get it from outside the body through special machines, or inside the body, such as with your doctor might put a tiny radioactive implants placed inside the part of your body where the cancer is (brachytherapy).Recurrence (ree-CUR-ents) means the cancer has come back after treatment. It can happen at the place where the cancer started (local), near where it started (regional), or farther away in your body (distant).Refractory (ree-FRACK-tor-ee) describes a condition that does not get better with treatment. Your doctor may also say your cancer is resistant.Remission (reh-MIH-shun) means your signs and symptoms of cancer have gone away. If you have no more signs or symptoms at all, its a complete remission. If you still have some but not as many as before, its a partial remission. Remission doesnt necessarily mean your cancer has been cured. It means the disease is under control. Secondary cancer is a new primary cancer that appears after youve already been treated for cancer. This cancer is different from the one you already had.Stage is a term doctors use to describe how far along your cancer is. The stages are 0 through IV, and the higher the number, the more advanced the disease is. The stage is based on how big the tumor is, how far it has grown into neighboring tissues, whether your lymph nodes have cancer, and whether the disease has spread to other parts of your body.Targeted therapy is treatment that specifically identifies and targets cancer cells.Tumor (TOO-mer) is an abnormal lump of body tissue. You can get a tumor if cells grow and copy themselves too fast or dont die when they should. A tumor can be malignant (cancerous) or benign (not cancerous).Your doctor may use other words that are specific to your kind of cancer, too. But remember: If you hear something you dont understand, dont be afraid to speak up and ask the doctor to explain it in simple terms. Approximately 25% of patients with invasive carcinoma and onethird of those with DCIS undergo reexcision,With approximately half of the reexcisions performed in patients with negative margins, defined as no ink on tumor.This is done in the belief that a larger negative margin improves patient outcomes.The appropriate negative margin width for women undergoing breastconserving surgery for both ductal carcinoma in situ (DCIS) and invasive carcinoma is controversial.Consensus guidelines support a negative margin, defined as no ink on tumor, for invasive carcinoma treated with breastconserving therapy.Because of differences in the growth pattern and utilization of systemic therapy, a margin of 2 mm has been found to minimize the local recurrence risk for women with DCIS undergoing lumpectomy and radiation therapy (RT).Wider negative margins do not improve local control for DCIS or invasive carcinoma when they are treated with lumpectomy and RT.Thr routine practice of performing additional surgery to obtain a wider negative margin is not supported by the literature.The only defined microscopic margin width in the prospective randomized trials that established the safety of BCT in invasive carcinoma was no ink on tumor, the margin definition in the National Surgical Adjuvant Breast and Bowel Project (NSABP) B06 study.Margin measurement is an inexact science.Approximately half of reexcisions are performed in patients with negative margins, defined as no ink on tumor, in the belief that a larger negative margin improves patient outcomes.Margin width is dependent on multiple factors, including: the number of sections examined, and the technique of margin assessment as perpendicular, shaved, or cavity margins, the defined margin when ink tracks through the irregular fatty surface overlying the tumor, and the use of specimencompression devices for radiography.When comparing measurements of the anteriorposterior diameter of breast specimens in the operating room and the pathology laboratory, 46% of the specimen height was lost by the time of measurement in the pathology laboratory, indicating the potential for error in determining margins.The use of specimencompression devices increases these discrepancies in diameters.It is theoretically estimated that 3000 sections would be required to completely examine the margin surfaces of a spherical lumpectomy specimen.A negative margin does not guarantee the absence of residual tumor in the breast, and suggests a negative margin indicates that the residual tumor burden in the breast is low enough that it is likely to be controlled with radiotherapy.Ink markings are used to define the margin surface can be seen at various distances from the tumor edge because of the irregular nature of the specimen surface and ink tracking through the breast fat: making reproducible measurements of the margin width difficult.The rate of local recurrence (LR) varies with the hormone receptor (HR) and human epidermal growth factor receptor 2 (HER2) status.Local recurrence is lowest among patients with HR+, HER2 tumors and highest among those with triplenegative tumors, regardless of whether the treatment includes BCT or mastectomy.Among those with HR+, HER2 tumors, the risk of LR also varies significantly with the ((21gene Recurrence Score)).LR can be observed even among the smallest cancers (microinvasive, T1a,b),16 and this indicates that this is a fundamental tumor characteristic and not one that is acquired over time.Five years of adjuvant tamoxifen reduces the risk of LR by approximately 50%.Newer endocrine therapies, such as the use of aromatase inhibitors and more prolonged treatment durations, provide further risk reductions.Conventional cytotoxic chemotherapy in women younger than 50 years reduces the relative risk of LR to 0.63 in comparison with no treatment.The use of trastuzumab provides a further relative risk reduction of 0.47.Studies of LR outcomes for HER2+ patients in those undergoing BCT, the 3year rate of LR was 7% before the use of adjuvant trastuzumab, and it decreased to 1% in the period immediately after the adoption of trastuzumab.A positive margin in HER2 + breast cancer defined as ink on tumor, is associated with a significant increase in LR risk and warrants consideration for additional surgery.In a metaanalysis that included 33 eligible studies and more than 28,000 women with earlystage breast cancer. A positive margin was associated with increasing LR, odds ratio for positive margins versus negative margins, 2.44.There isn no evidence of a decreased LR risk with negative margin widths increasing from 1 to 2 to 5 mm.A negative margin reduces the risk of LR; however, increasing the size of a negative margin is not significantly associated with an improvement in local control.A negative margin of no ink on tumor optimizes local control and that the routine practice of obtaining a more widely negative margin than no ink on tumor is not indicated.Young age and triplenegative cancers are both independent risk factors for local recurrence, but the available evidence indicates that it is the tumor biology, not the extent of surgical excision, that is associated with a worse outcome because LR rates are similar among women in these highrisk groups treated with BCT or mastectomy.In a series examining margin width and local recurrence (LR) among women with triplenegative breast cancer found no difference in 5year LR rates between margins 2 mm and margins > 2 mm (4.7% and 3.7%, respectively.extensive intraductal componentkk (EIC) was associated with an increased risk of LR30; however, more recent reports of patients withAn extensive intraductal component positive margin tumors subsequently excised to negative margins have local recurrence rates similar to rates of those without an extensive intraductal component.No ink on tumor is an adequate negative margin to avoid reexcision.DCIS has a 10year causespecific mortality rate under 1% after breast conserving surgery.Optimizing local control in DCIS is important because half of all LR events are invasive cancers with an associated increased risk of breast cancerspecific mortality.Surveys of surgeons and radiation oncologists report significant heterogeneity regarding what constitutes an acceptable margin width for DCIS treated with BCT, which ranges from no ink on tumor to > 1 cm.Multicentric DCIS is uncommon.DCIS within one quadrant may be extensive, with 46% of the lesions measuring > 3 cm in one study.90% of poorly differentiated lesions of DCIS grow continuously, 70% of welldifferentiated lesions had a multifocal, skip pattern, with 82% of skip lesions measuring between 0 and 5 mm, and only 8% having skip lesions > 10 mm.A small negative margin may lie within a skip lesion and may be associated with a substantial residual tumor burden.Approximately 55% to 70% of women with DCIS treated with lumpectomy receive adjuvant RT.20% to 50% of DCIS patients receive adjuvant endocrine therapy.For women with DCIS treated with lumpectomy and RT, the optimal margin is that which leaves a subclinical volume of residual microscopic disease within the breast that can likely be controlled by RT.The proportion of women with DCIS treated by excision alone ranges from 17% to 44%.It is suggested that a margin of 1 cm or greater negated the benefit of RT; but findings have not been replicated in subsequent studies.In a study of 1374 women undergoing excision alone, margin width was significantly associated with LR, with 10year LR rates ranging from 41% with a positive margin to 16% with a > 1 cm margin.In a multivariate analysis incremental increases in margin width were associated with decreasing LR risk.In contrast, after 12 years of followup in the Eastern Cooperative Oncology GroupAmerican College of Radiology Imaging Network E5194 trial, which included women with low to intermediategrade DCIS 2.5 cm in size or highgrade DCIS 1 cm in size treated with excision alone and with a negative margin of at least 3 mm, no significant relation between the margin widths of < 5 mm, 5 to 9 mm, and 1 cm was observed.52.There are cohorts of DCIS lowrisk patients undergoing excision alone who have low local failure rates with a range of negative margin widths.Reexcision or RT for DCIS is multifactorial, with the margin width being one factor that may affect the decision for further riskreducing therapy.Other factors: age, the size of the DCIS, the tumor grade, the margin width, and the patients comfort with recurrence risk are all taken into consideration when the decision is made to omit RT or return to the operating room.No uniform negative margin width is routinely associated with a low recurrence risk among women with DCIS treated with excision alone.The odds of LR are reduced by more than 50% with a negative margin versus a positive margin.With respect to a positive margin, significant reductions were seen for all negative margin widths.When a 2 mm margin was compared with a smaller negative margin, a nonsignificant trend toward a decrease in LR is observed.No additional benefit is seen for margins greater than 2 mm.DCIS treated with BCT, and both found that close margins (< 2 mm) were not inferior to wider negative margins among women treated with RT.The invasive cancer margin guideline endorses no ink on tumor, whereas the DCIS guideline states that 2 mm is an optimal margin.The behavior of microinvasive carcinoma is more similar to the behavior of DCIS than invasive cancer and that the use of systemic therapy is more similar to that seen in DCIS.Invasive cancer with associated DCIS, whether an extensive intraductal component or lesser amounts, should be managed according to the invasive guideline, as the biology of the invasive cancer is the primary determinant of outcome, and the majority of patients will receive systemic therapy.For invasive and in situ breast carcinomas, the margin status is one of a number of factors affecting LR risk, and the tumor biology rather than an arbitrary anatomic margin cutoff is the major determinant of LR.For invasive breast cancer, the data support obtaining a negative margin, defined as no ink on tumor, and do not identify an additional benefit for more widely clear margins.In patients with DCIS receiving RT, a margin of 2 mm minimizes LR, but larger margins do not provide added benefit.

No tumor. Does no malignancy mean no cancer. What does no residual tumor mean. What does no ink on tumor mean. What does no tumor markers mean. What is a non cancerous tumor called. What does no tumor necrosis mean. Not a tumour. What is a non cancerous tumor. What does it mean if a tumor has no blood flow. Which tumor is not cancerous.