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Oral Presentations

OP1 "FIRST DO NO HARM": SIGNIFICANCE OF DELAYS TO SURGERY IN PATIENTS WITH NON-METASTATIC BREAST CANCER

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Background

The majority of patients in Australia with non-metastatic breast cancer will undergo primary surgery with curative intent. This involves many complex decisions that inevitably increase time from diagnosis to surgery. Current guidelines suggest surgery should occur within 30 days of a decision to treat[1]. However, there may be appropriate reasons to justify a delay to surgery. This study aims to analyse factors that contribute to an increased time to surgery (TTS) and establish whether the associated wait time is justifiable in the context of improved individualised breast cancer management.

Methods

This is a retrospective analysis of all patients at Austin Health surgically managed for non-metastatic invasive breast carcinoma between 20013 and 2019. TTS was defined as time between informed diagnosis and cancer surgery. Patients were categorised into TTS groups of ≤30 and >30 days. Kaplan-Meier survival analysis was used to evaluate the impact of TTS on survival outcomes.

Results

A total of 842 patients were included. Median number of days to surgery was 34 days. 43.9% of the total cohort received surgery within the recommended 30 days. Factors identified to be associated with an increased TTS were screening, transfer of care, ER positive tumour, mastectomy, immediate reconstruction and use of pre-operative imaging including MRI and staging scans. Median follow up for the cohort was 30 months. Between wait groups of ≤30 and >30 days, there were no significant association found between TTS and survival outcomes for DFS (HR 1.20 95% CI 0.56 to 2.60) and OS (HR 1.58 95% CI 0.82 to 3.03).

Conclusions

Breast cancer management involves many complex factors that significantly increases time from diagnosis to surgery. Surgery within 30 days of diagnosis is not associated with improved DFS and OS. Time delays associated with integral element of care should be used to guide a revision of current TTS recommendations.

References

1. Royal Australasian College of Surgeons. Elective Surgery Urgency Categories. 2019.

OP2 ROLE OF BREAST ULTRASOUND IN BREAST CANCER SURVEILLANCE; INCREMENTAL CANCERS FOUND AT WHAT COST?

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Background and Purpose

Breast Ultrasound (US) in surveillance for breast cancer after curative treatment is governed by Australian Clinical Guidelines. Criteria for US are; age < 35, breast density > 50%, or mammographically occult primary breast cancer. Breast US is often included in surveillance regardless of these criteria at Austin Health. Evidence is limited in use of US for breast cancer surveillance. Breast US may increase costs due to a propensity to detect benign lesions.

Methods

We retrospectively analysed 851 patients who underwent breast cancer surgery at Austin Health from July 2009 to December 2015. Clinicopathological and radiological data was obtained. 145 patients were excluded. Diagnostic parameters of US were determined and financial costs of US was determined using the Medicare Benefits Schedule. Survival outcomes were determined using the Logrank test.

Results

622 women underwent radiological surveillance, generating 2638 total rounds of surveillance and a median of 4.24 rounds per patient. 579 (93.1%) patients underwent mammography and breast US surveillance. 221 (38.2%) fit criteria for use of additional breast US. 177 abnormal imaging episodes occurred, leading to 17 screen detected cases of locoregional recurrence. In negative mammography, US generated 107 abnormal images and found 9 cancers. US had a sensitivity of 90.0%, specificity of 95.8% and positive predictive value of 8.4%. US alone lead to 33 biopsy per 1000 US, and only 3.8 cancers per 1000 US. The average cost of detecting an additional cancer by US was $31,464 and $468 per patient included. Survival outcomes based on method of detection of recurrence were insignificant (p value = 0.942)

Conclusion

Breast US detected few recurrences that were mammographically occult. Breast US has a significantly low PPV in surveillance, leading to high biopsy rates and costs. A Review of current guidelines and stricter adherence to them may be suggested.

OP3 ARE VICTORIAN WOMEN INTERESTED IN RISK STRATIFIED BREAST SCREENING?

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Background and purpose

Population breast screening commenced in Australia in the 1990's. Since then more information has been uncovered about the harms of screening as well as the skewed distribution of breast cancer risk in the population. A

model of screening which is stratified according to an individuals' risk would appear logical and this idea has been considered internationally and in Australia for the last few years. How Australian women view this approach is largely unknown however this most acceptable in overseas studies.

This study aimed to explore breast screening participants' views of the current program in Victoria, Australia, examine their openness to change and attitudes toward an individualised screening model. This work was designed to inform the development of a decision aid to facilitate women's decisions about participating in individualised screening.

Methods

A qualitative approach was taken using focus groups that were facilitated in community settings in Melbourne, Victoria. Women were recruited from a population-based breast screening cohort, who are without a personal breast cancer history, and were currently engaged in the public breast screening program offered in Victoria, Australia. Focus group discussion was facilitated following three main themes: 1) experience of breast screening; 2) breast cancer risk perception, and 3) views on individualised screening.

Results

A total of 52 women participated in one of 4 focus groups and were experienced with screening with 90% of participants having had more than 3 mammograms. They had strong, positive, emotional ties to breast screening in its current structure but were supportive, with some reservations, of the idea of individualised screening. There was good understanding about the factors contributing to personalised risk and a wide range of opinions about the inclusion of genetic testing with genetic testing being considered a foreign and evolving domain.

Conclusions

Individualised breast screening that takes account of risk factors such as mammographic density, lifestyle and genetic factors would be acceptable to a population of women who are invested in the current system. The communication and implementation of a new program would be critical to its acceptance and potential success. Reservations may be had regarding uptake of genetic testing, motivations behind the change and management of the women allocated to a lower risk category.

OP4 INCIDENCE OF INVASIVE RECURRENCE IN DCIS >5CM TREATED WITH SKIN SPARING OR NIPPLE SPARING MASTECTOMY: THE AUSTRALIAN EXPERIENCE

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Background

Skin sparing (SSM) and nipple sparing mastectomy (NSM) techniques have been critiqued for higher local recurrence rate (LRR) in patients with extensive DCIS, with rates of 5-11% reported. Reported predictors include younger age, high-grade, comedo necrosis present, and involved margins[1]. This study aimed to identify frequency and predictors of loco-regional recurrence for patients undergoing SSM or NSM for DCIS in our practice.

Methods

Data retrieved using BreastSurgANZ BQA from 2001 to 2018 for patients undergoing NSM or SSM for DCIS >5cm. Cases with microinvasion or previous invasive disease or synchronous contralateral cancer were excluded.

Results

603 cases of DCIS treated including 78 tumour with size >5cm undergoing SSM/NSM. Mean follow-up was 74months, mean age 58, mean tumour size 77mm, high-grade in 55, micropapillary architecture in 11, necrosis present 64, and involved margins in 6. Sentinel node biopsy was performed on all patients and was negative. There were 3 recurrences including 2 at 96months and 1 at 48months. All were diagnosed age > 50yrs, were high grade, micropapillary subtype and had extensively involved margins in the superficial plane and focally circumferentially. Tumour sizes were 75, 100, 145mm with comedo necrosis in 2/3.

Conclusion

Although the incidence of invasive LRR after SMM or NSM for DCIS >5cm is <4% in our practice, this audit has highlighted that involved margins and extensive high grade micropapillary DCIS predict recurrence. Therefor we have now changed our practice and recommend re-excision of margins that are involved and long-term follow up of patients with these risk factors. SSM and NSM are oncologically safe for the majority of patients undergoing mastectomy for DCIS>5cm.

References

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OP5 STAGE IV BREAST CANCER: FACTORS AFFECTING SURVIVAL RATES IN A TERTIARY INSTITUTION, A 7-YEAR EXPERIENCE

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Introduction

Surgery has a conflicting role in the management of metastatic breast cancer. Recent literature suggests that surgery may confer a survival benefit to patients with stage IV disease. We compared the outcomes of surgery to other treatment modalities in the management of these patients in our institution between 2012 and 2018 and its effect on overall survival.

Methods

A retrospective study of metastatic breast cancer patients was conducted using logbook data and the SHARE Multidisciplinary Meeting data management system at Sir Charles Gairdner Hospital (SCGH) between 2012 and 2018. We included female patients aged 18 or over who were diagnosed with metastatic Stage IV breast cancer. We correlated data on treatment modalities, metastatic burden and associated life expectancy within this cohort.

Results

81 out of 3003 patients with breast cancer managed at our institution had stage IV disease averaging 11.6 cases per year. The median survival was 72 months in the operative group in comparison to 20 months in the non-operative group. 22 out of 56 patients with oligo-metastatic disease died within our study period with a median survival of 24 months whilst 13 out of 25 patients with poly-metastatic disease died with a median survival of 21 months. 5 patients declined all form of treatment with a median survival of 7.5 months.

Conclusion

In our institution, surgery conferred a survival benefit compared to the non-operative group. Patients who declined all forms of treatment expectedly demonstrated the shortest median survival. The burden of metastatic disease at time of diagnosis did not influence overall survival.

OP6 FIGHT BACK WITH FITNESS: A FOCUS ON IMPROVEMENT IN GENERAL WELLBEING AND REDUCTION OF RECURRENCE OF BREAST CANCER WITH EXERCISE

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Background and Purpose

The correlation between reduction in breast cancer recurrence associated with exercise is still the subject of research. It has been proposed that there is a 'sweet spot' in level of exercise needed to achieve positive outcomes in reduction of recurrence in breast cancer patients.[2] There is also ongoing research into the additional effects that exercise has on the general wellbeing for these patients.[1]

Methods

Through multidisciplinary team input including exercise physiologists, with programs based on Edith Cowan protocols, dieticians, nursing and medical specialists the outcomes of breast cancer patients in the Greater Darling Downs region participating in a 10 week individualised and supervised program have been measured over varying parameters.

Parameters such as quality of life data assessed by the DAS 42, aerobic fitness and strength, body measurements (waist and hip circumference) and DEXA scans assessing body weight, fat mass and lean mass have all been collected for each patient.

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