172 Poster

Defining a "dedicated" breast cancer team

N. Maliko[1], N. Bijker[2], M. Wouters[1], M.J. Vrancken-Peeters[1]. [1]*Antoni van Leeuwenhoek, Surgical Oncology, Amsterdam, Netherlands;* [2]*Amsterdam Universitair Medische Centra, Radiotherapy, Amsterdam, Netherlands*

Background: The quality of breast cancer (BC) care in the Netherlands is high. All patients are discussed in pre- and post-operative multidisciplinary meetings and treated by certified medical specialists. Some characteristics of the medical team and the organization involved in BC care are monitored in the national multidisciplinary NABON breast Cancer Audit (NBCA) by quality indicators measuring the structure of the teams. The scientific committee of the NBCA is responsible for the multidisciplinary set of quality indicators. For some quality indicators variation is seen. The aim of this study was to explore if the presence of a defined "dedicated" BC team influences this variation.

Material and Methods: We chose the following characteristics at hospital level to define a "dedicated" BC team: minimum of 50 new BC patients per year, two certified surgical oncologists who treat BC patients, two certified internist oncologists who treat BC patients, one plastic surgeon who treats BC patients, plastic surgeon participating standard in multidisciplinary meeting, radiotherapist participating standard in multidisciplinary meeting, PALGA protocol (synoptic pathology reporting) being used, the median time between diagnosis and surgery (excluding direct reconstruction) being ≤30 days. The composite measure "dedicated" BC team was used to assess if a "dedicated" BC team influences the outcomes of quality indicators.

Table 1

	6 criteria	7 criteria	8 criteria
Preserving breast contour	56.5%	71.5%	72.7%
Consultation radiotherapist in 28 days	13.3%	57.5%	72.9%
MRI by patients receiving neo adjuvant chemotherapy	76%	86%	91%

Results: In 2017 83 hospitals registered their BC patients in the NBCA. 75.9% (n = 63) from all the hospitals meet all criteria of a "dedicated" BC team. 19 (22.9%) hospitals meet seven and one hospital meets six (1.2%) criteria.

The results show that hospitals that meet all the criteria of a "dedicated" breast cancer team scored on average higher on the quality indicators preserving breast contour, breast MRI performed in patients treated with neo-adjuvant chemotherapy (NAC), and consultation with the radiotherapist within 28 days after start NAC, compared with hospitals that meet seven or six criteria (Table 1).

Conclusion: The results suggest that defining a "dedicated" BC team and motiving hospitals to develop these treatment teams can lead to better outcomes of BC care.

No conflict of interest.

173 Poster

Predictive factors involved in determining response to neoadjuvant chemotherapy in breast cancer and impact of response on 5 years disease free survival and overall survival

B. Rehman[1], M.A. Parvaiz[1]. [1]*Shuakat Khanum Memorial Cancer Hospital and Research Center Lahore, Breast and Oncoplastic, Lahore, Pakistan*

Background: The advantages of Neo-Adjuvant chemotherapy (NAC) are more breast conservation surgeries and ability to monitor treatment response in vivo. Not all patients respond well to NAC in term of tumor size reduction and lymph nodal response. The goal of the study is to identify all the known factors that may play a role in predicting response to chemotherapy, thus identifying a group of patients which would be resistant to NAT and thus potential harmful effects are avoided in that subset of patients.

Material and Methods: We retrospectively reviewed data from Jan 2012 to Dec 2012 in a single center in Shaukat Khanum hospital Lahore, Pakistan. All those who received NAC (as they were not candidates for upfront surgery) and having no distant metastasis were included. 156 patients were studied. Tumor grade, receptor status, menopausal status, family h/o ca breast, parity, initial T and N stage were studied as predictive factors for response to chemotherapy. HER-2 Neu positivity was not considered as only 2 patients received Transtuzumab. The response was measured in term of percentage reduction from 1st radiological size on presentation to final size on histopathology (on resected specimen). Four groups were identified, complete responder group with 100% reduction, Non responder group, Partial responder PR (<50% reduction), Responders R (>50% reduction). 5 year disease free survival, overall survival and recurrence were noted for each group.

Results: Mean Age was 47 years. 96% of patients were invasive ductal carcinoma, rest were lobular. 57% of patients were grade III, 90% of patients were T2 and 66% were LN positive (both at presentation). 67% of patients underwent BCS (Breast conserving surgery) rest underwent Mastectomy. Mortality for whole group was 19%, and recurrence was shown in 30% (Majority was distant 26%, while contralateral were 3%). Out of 156 patients, 25% of patients were complete responders, 13% were non responders, 23% were partial responder (<50% reduction) and 37% were responders (>50% response). ER and PR negative Tumors and Grade III tumors showed more complete responses. Rest of factors, including triple negative, Initial T and N stage and other factors showed no impact on chemo-response. Survival was significantly poor in non responder group (45% OS, 40% DFS), while rest of 3 groups had comparable survival outcome, with complete responder group having best survival outcome (86% OS, 80% DFS).

Conclusion: Only ER and PR negative tumors and grade 3 tumors showed more complete response. Survival outcomes were significantly poor in Non-responders while it was better in complete responders.

No conflict of interest.

174 Poster

Male breast cancer: A high volume centre experience

F. Combi[1], S. Papi[2], E. Palma[2], A. Gambini[2], A. Andreotti[2], G. Esposito[3], G. Tazzioli[2]. [1]*University of Modena and Reggio Emilia, PHD Clinical and Experimental Medicine, Modena, Italy;* [2]*Azienda Ospedaliero Universitaria Policlinico di Modena, Breast Unit, Modena, Italy;* [3]*University of Modena and Reggio Emilia, Scuola di Specializzazione in Chirurgia Generale, Modena, Italy*

Background: Male breast cancer (MBC) accounts for less than 1% of all cancers in men. Several genetic disorders, such as Lynch, Cowden, Klinefelter and Li-Fraumeni syndrome contribute to increase the lifetime risk to develop breast cancer in males.

In general population, the lifetime risk for MBC is 0.1%, but it rises to 7–8% with a BRCA2 mutation and 1% with a BRCA1 mutation.

Material and Methods: We describe the surgical experience of a single high volume center (Breast Surgical Oncology Unit of Modena University Hospital) from 2006 to 2019.

Results: We treated 29 patient with MBC.

Median age at diagnosis was 64 years (minimum 45 to maximum 84).

A minority of patients presented with bilateral disease at the onset (10.3%). Most patients (75.1%) had retroareolar tumor.

41.4% had significant familiar history for breast cancer. Genetic testing was performed in all patients, but only 26.1% was positive for BRCA2 mutation. No BRCA1 mutation was found.

All the patients underwent simple mastectomy. The 3.4% had distant metastasis, but surgery was performed for local control of the disease.

We performed immediate axillary dissection in 21.8% of patient for nodal positivity at the time of diagnosis; the remaining were treated with sentinel node biopsy and only three of them underwent following axillary dissection for sentinel node positivity.

No significant post-operative complications were observed and medial hospital stay was two days.

At the final histology ductal carcinoma was found in all breasts, in only one specimen lobular carcinoma coexisted with the ductal one.

Almost all cases showed intermediate or high grade disease (G2-G3).

None of patients had triple negative cancer; c-erbB2 positivity was found in only 8%, the rest of tumors were luminal-like.

In addition to surgery 10.9% of patients received neoadjuvant chemotherapy, 24.1% adjuvant chemotherapy and 82.8% endocrine therapy, mostly tamoxifen.

Radiotherapy was applied in locally advanced disease, in one case for the treatment of nodal recurrence and in another case on bone metastasis.

Conclusions: Our experience does not differ from other case series described in literature in terms of epidemiological, histopathological and genetic findings.

From a surgical point of view we confirmed radical mastectomies as the preferred choice of resection. Sentinel node biopsy is safe and feasible in men as in women. Post-operative course in men is similar to women's one and also oncological adjuvant strategy is chosen following the same guidelines.

To achieve optimal management of male breast cancer, patients must be centralized to a hospital with a breast unit, to give the possibility of genetic counseling and to share with the multidisciplinary team every step of both diagnostic and therapeutic phases.

No conflict of interest.