Conclusion: Conservative surgery in locally advanced BC patients with neoadjuvant treatment and tumor bed margins appears to be safe, increases the rate of conservative surgery and is followed by low local recurrence rates. The insertion of tumor markers before NACT should be part of standard multidisciplinary approach for locally advanced BC patients.

No conflict of interest.

Usefulness of locoregional nerve blocks in breast surgery. A comparative study

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Background: Ultrasound-guided locoregional nerve blocks have been recently used in patients undergoing surgery for breast cancer. In particular, Paravertebral block (PVB) and newer Pectoralis nerve (PECS) blocks can be used with the main aims of improving postoperative pain control and reducing use of opioids during general anesthesia. In this comparative study we investigated the effects of PVB and PECS in intraoperative opioid consumption, postoperative opioid consumption, postoperative nausea and vomiting (PONV), operative time, and post-operative hospital stay.

Material and Methods: Between January and August 2019, 198 patients underwent surgery for breast cancer. Among them, 91 patients received ultrasound-guided locoregional blocks (Block group) and 107 patients did not (Control group). Demographic characteristics, type of surgery and outcomes of interest were compared between the two groups by using the Student t-test, the Chi-square test or the Fisher exact test when indicated.

Results: Mean age was similar in the Block group and the Control group (62.5 vs 61.8 years, p = 0.48). Type of performed operation (breast conserving surgery, mastectomy, mastectomy plus immediate reconstruction) did not differ between the two groups (p = 0.35). In the Block group, 65 (71.4%) patients received PECS block, 3 (3.3%) PVB block, and 23(25.3%) PECS + PVB block. Intraoperative opioid consumption (Fentanyl) was significantly lower in the Block group (mean 182.75 vs 245.65 µg, p < 0.001), as well as the use of perioperative antinfectives (15 patients vs 42 patients, p < 0.01). Operative time was slightly longer in the blocks group (102.6 vs 89.7 minutes, p = 0.16). We did not observe difference in postoperative opioid consumption (5.6% vs 14.05% patients in the Block and Control group, respectively, p = 0.38), postoperative PONV (8.5% vs 12.1% patients in the Block and Control group, respectively, p = 0.14), and postoperative hospital stay (2.5 vs 3.0 days in the Block and Control group, respectively, p = 0.21).

Interestingly, in the Block group, 16 (17.6%) patients received surgery with sedation without general anesthesia. None of them complained of PONV or required opioids after surgery.

Conclusions: Locoregional blocks in breast surgery can reduce the use of intra-operative opioids and anesthetics. Further studies are needed to ameliorate patient selection, in order to identify those suitable of locoregional blocks and sedation, avoiding the use of general anesthesia.

No conflict of interest.

Multidisciplinary breast cancer guideline in the Netherlands: Modular revisions aiming for improved personalized breast cancer care

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Background: In 2000 the first national evidence based guideline on screening and diagnostics for breast cancer was released. Two years later, in 2002, the first national multidisciplinary guideline for treatment followed. In 2008 these two guidelines were merged and revised in 2012, resulting in one national guideline for breast cancer which is widely accessible in the online guideline database Oncoline (www.oncoline.nl).

Materials and Methods: Due to new developments and insights, we executed a modular revision process in four parts. The revision was carried out by a working group consisting of mandated representatives from several scientific and professional associations, the Dutch Breast Cancer Organization (NABON) and the Breast Cancer Patient Association.

Results: In contrary to previous revisions performed each five years, the new modular revisions are characterized by a solid interaction with clinical practitioners supplemented with insight in new developments and up to date evidence leading to a more up to date guideline. The following topics were revised in the breast cancer guideline using the modular revision process: Individualized diagnostics, treatment, follow up and aftercare. Screening advices for new mutations of breast tumors (such as CHEK2 and PALB2). Imaging for screening, diagnostics, staging and response monitoring, also for pregnant women. Treatment options for DCIS and low risk invasive carcinoma, including no treatment or less treatment. Locoregional treatment in multiple phases of the treatment. Gene expression testing. Indication for systemic treatment (specific for N0-tumours). Available drugs for systemic treatment (neo adjuvant and adjuvant treatment, metastatic settings). Inclusion of prediction models in the guideline. Preventive removal of ovaries as a part of endocrine treatment. Systemic treatment after recurrence. Sexual problems and fatigue. Impact of cancer on family life. Breast cancer in men, pregnancy and fertility.

Further, throughout the whole guideline more focus on shared decision making was realized.

Conclusion: The new developments in breast cancer treatment are going fast. Therefore, the working group will continue making modular revisions of the multidisciplinary guideline for breast cancer patients as an ongoing process involving mandated representatives from several scientific and professional associations, NABON and patient representatives. Parallel and based on guidelines, we developed digital decision trees (www.oncolined.nl), leading to recommendations for diagnosis and treatment based on individual patient and disease characteristics. We hope that the guideline improves the care for over 17000 newly diagnosed breast cancer patients.

No conflict of interest.

Versatility, clinical outcomes and mammographic follow-up of Chest Wall Perforator Flaps (CWPF): A single-centre experience

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Background: Partial breast reconstruction (PBR) using chest wall perforator flaps (CWPF) is offered as a means of volume replacement, to facilitate better cosmetic outcomes in breast conservation surgery. We hereby present a 4-year prospective database of all CWPF performed in University Hospitals of Leicester, to evaluate the clinical outcomes and any impact on mammographic follow-up.

Material and Methods: We undertook a retrospective analysis of a prospectively maintained database of 40 patients who underwent a CWPF between September 2015 and August 2019. Analysis of clinical outcomes included demographics, indications, complications, re-operation rates, recurrence rates, and the proportion of patients who were seen in a symptomatic clinic post-operatively. All mammograms at one-year after surgery and annually thereafter were double reported and reviewed to evaluate whether the flap could be seen, the proportion with new calcifications and flap necrosis, and the recall and subsequent biopsy rates.

Results: 33 Lateral (LICAP) and 7 Anterior (AICAP) Intercostal Artery Perforator flaps were analysed. The median age was 54.6 (range 32–75) and median follow-up was 17.6 months (range 3–46 months). 5% were performed for the correction of deformity after previous Wide Local Excision and radiotherapy, and 12.5% had mastectomy and immediate reconstruction with autologous flap. The remaining 82.5% were indicated to prevent deformity in BCS. 95% were immediate and 97.5% were single stage

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