No conflict of interest.

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164. Open access follow up for breast cancer patients at East Surrey hospital: The way forward for breast cancer care

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Background: In the UK there has been a nationwide movement towards patient led follow up care after breast cancer treatment. This open access follow up has been found to be more effective, enabling cancer survivors to take control of their condition and get on with their lives. This study aimed to assess the impact of an open access follow up system for breast cancer patients at East Surrey hospital. Instead of a routine appointment, follow up patients with a benign mammogram would be given open access telephone contact with breast care nurses and offered a hospital appointment only when necessary.

Materials and methods: Mammogram results were reviewed for follow up breast cancer patients attending clinic for their annual review. Results were divided into those reported as benign and those as indeterminate or suspicious. Patient selection for entrance to open access was determined by questionnaire consent. Following the introduction of open access, breast care nurses monitored phone calls received over a one month period. Questionnaires were used to grade the appropriateness of the queries and any actions required to resolve them.

Results: Of 100 clinic encounters analysed, 69 had mammograms that were reported as benign and 31 as indeterminate or suspicious. On average, 2080 breast cancer patients are seen in follow up clinics at East Surrey hospital per annum. Of these approximately 69%, or 1435 patients, will have a benign mammogram. Following introduction of open access, an increase in call volume was reported by breast care nurses. However, further analysis showed that 98% of telephone encounters were entirely managed by breast care nurses and none required a hospital appointment. The cost of a single follow up clinic appointment is £150, so £215,250 per year is spent at East Surrey hospital on patients who may not have needed to attend.

Conclusions: This study demonstrated that open access follow up provided adequate and timely support for patients after breast cancer treatment, while simultaneously preventing unnecessary hospital attendances. Furthermore, there are clear financial benefits to the introduction of open access follow up for this patient group. As a result, open access is being proposed by the East Surrey Breast Unit for follow up patients with a benign mammogram. Further analysis is needed to evaluate the long term impact. Nevertheless, the initial results are promising.

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165. Can we safely avoid axillary clearance when sentinel node is minimally involved in early breast cancer?

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Background: Sentinel Lymph Node Biopsy (SLNB) represents a minimally invasive technique for axillary staging in early breast cancer. SLNB is useful in surgical complications risk reducing compared to complete axillary lymph node dissection (CALND). Micrometastases (MM) prognostic value has been recently challenged. The 2011 St Gallen Consensus Conference recommended that micrometastases in a single sentinel node should not be an indication for axillary dissection irrespective of the type of breast surgery given. Results from IBCSG 23-01 trial have shown that the rate of disease recurrence is reassuringly low in the undissected axilla (<1%) with minimally sentinel node involvement and that overall survival did not differ in patients spared from CALND compared to those whom had been treated with. Endpoints of this study were micrometastases incidence in SLNB evaluation; Non Sentinel Nodes (NSNs) involvement rate when sentinel node positive for MM and predictive variables of metastasis in NSNs finding out when MM were detected at sentinel node biopsy.

Materials and methods: Histopathological features of 901 patients with breast cancer cT1 − T2 ≤3 cm cN0 treated with SLNB have been evaluated from single institution database. 566 of them underwent axillary clearance. Patients presenting MM or ITC underwent CALND as well as patients with macrometastases in SLNB. Tumour size, histotype, grading, lymphatic vessel infiltration, age at diagnosis have been analyzed and correlated to Non Sentinel Nodes (NSNs) risk of metastasis.

Results: 270 patients were found to have SN positive (29.9%). Metastasis distribution in the sentinel node was 74% for macrometastases; 24% for micrometastases; 2% for ITC. After complete axillary dissection the rate of Non Sentinel Nodes positive when sentinel node was minimally involved with micrometastases was 3.5%. Non sentinel node positive were found in only in two cases (one multicentric and one T2, high grade, lobular cancer). Overall survival and disease free survival were 100% in median 5 years (49.5 months) follow−up for patients presenting micrometastases at SLNB.

Conclusions: Outcomes from our research group can confirm that complete axillary node dissection can be safely omitted when micrometastasis occur in sentinel node biopsy in early breast cancer. Micrometastasis at sentinel node in multicentric disease and lobular histotype has to be further investigated.

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166. Patterns of care in the administration of neoadjuvant chemotherapy for breast cancer: A population based study

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Background: Neoadjuvant chemotherapy (NAC) is used to facilitate radical surgery for initially irresectable or locally advanced breast cancer. The indication for NAC has been extended to clinically node negative (cN0) patients in whom adjuvant systemic therapy is foreseen. No definitive evidence exists regarding the timing of the sentinel node biopsy (SNB) in relation to NAC. NAC could theoretically sterilize the axilla and thus reduce the need for axillary lymph node dissection (ALND). On the other hand, patients could be subjected to a potentially worse oncological outcome if SNB is performed after NAC due to the higher false negative rate. A population based study was conducted to evaluate the use of NAC and the timing of SNB.

Methods: All female patients with breast cancer, treated in 10 general hospitals in the Eindhoven Cancer Registry area in the Netherlands between 2003 and June 2012 were included (N=18,427).

Results: A total of 1,402 patients (7.6%) were treated with NAC during this period, increasing from 2.5% in 2003 to 13.0% in 2011. This increase was significant (P<0.001) for all tumour sizes. Use of NAC increased from 0.5% up to 2.3% for clinically T1 tumours, from 2.8% to 27.0% for T2, from 30.6% to 70.9% for T3 and from 40.5% to 58.1% for T4 tumours. In clinically N0 patients use of NAC increased from 1.0% to 4.4% and in clinically N+ from 12.0% to 57.5% (P<0.001). Patients receiving NAC were younger (P<0.001) and showed a higher clinical T and N status (P<0.001) compared to those undergoing surgery first.