

P023. IS AXILLARY CLEARANCE NEEDED FOR ALL NODE-POSITIVE PATIENTS WHO ARE HAVING NEOADJUVANT CHEMOTHERAPY?

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Introduction: Controversy exists regarding ideal axillary staging procedure for node-positive patients who have neoadjuvant chemotherapy (NAC). For one abnormal lymph node (LN) and positive core biopsy, we offer sentinel node biopsy (SLNB) as an option if ultrasound scan (USS) showed good radiological response of LN and main tumour following NAC. Patients with multiple positive LN on core biopsy are offered axillary node clearance (ANC).

Aim: To investigate what proportion of patients developed nodal pathological complete response (PathCR) after SLNB and ANC and identify factors that could predict nodal PathCR.

Methods: Ninety-four consecutive NAC patients from October 2014 to January 2018 were studied.

Results: 66% (62/94) had positive nodes on core biopsy pre-NAC. 15 (24%) patients had SLNB, of which 73% (11/15) developed nodal PathCR. 47 (76%) patients had ANC, 40% (19/47) had nodal PathCR and 60% (28/47) remained node-positive. Looking at Her2 positivity and Path CR in these 47 ANC patients, 19 were Her2 positive and 68% (13/19) showed nodal PathCR. 28 patients were Her2 negative and only 21% (6/28) had nodal PathCR. This was statistically significant (p value < 0.002, Fisher's exact test, Two-tailed). 8/13 (61%) Her2 positive and nodal PathCR patients showed good nodal radiological response in their post-NAC US scan.

Conclusion: Patients with one abnormal node and good radiological response after NAC and those with more than one abnormal node but are Her2 positive and with good radiological response on US scan will have nodal PathCR in 73% and 68% respectively. SLNB can be considered in these patients.

P024. AXILLARY MANAGEMENT AFTER NEOADJUVANT CHEMOTHERAPY IN NODE POSITIVE BREAST CANCER

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Introduction: The surgical management of the axilla in patients who are undergoing neoadjuvant chemotherapy (NAC) remains unclear. There is little consensus on how best to proceed in patients with low volume axillary disease who have radiological evidence of response to treatment. **Aims:** Our aim was to identify patients who can safely avoid axillary clearance in low volume nodal disease after NAC.

Methods: A retrospective single Centre analysis of 95 consecutive breast cancer patients (Jan. 2012 to Dec. 2016) who were assessed as being node positive at diagnosis and who received NAC was performed. Patient demographics, radiological assessment of response to therapy, and final histopathological data were analysed.

Results:

Response to NAC by clinical & radiological assessment = 95	No. Pts	Final nodal Status		
		Node Negative ITC/Micromet	1-3 LNS +ve (N1)	>3 LNs +ve
No tumour response + No LN response	7	1 (14.3%)	1 (14.3%)	5 (71.4%)
Partial tumour response + No /partial LN response	48	24 (50%)	16 (33.3%)	8 (16.7%)
Partial tumour response + complete LN response	9	8 (88.9%)	1 (11.1%)	0
Complete tumour response + incomplete LN response	9	5 (55.6%)	2 (22.2%)	2 (22.2%)
Complete tumour response + complete LN response	12	12 (100%)	0	0
Inflammatory carcinoma	6	3	0	3

Conclusion: In patients who had evidence of partial radiological axillary/tumour response, 49% of these had persistent nodal disease, therefore

necessitating complete axillary dissection. However, those patients with evidence of complete radiological response after NAC were all node negative, suggesting that these patients can safely avoid axillary clearance.

P025. SHOULD WE DO SENTINEL LYMPH NODE BIOPSY AFTER NEOADJUVANT CHEMOTHERAPY?

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Aim: There is a controversy with regard to timing of sentinel lymph node biopsy (SLNB) in patients undergoing neo-adjuvant chemotherapy (NAC). In our hospital, patients having NAC undergo SLNB prior to neoadjuvant chemotherapy. Aim of our study was to assess the incidence of further axillary disease at ALND after NAC and compare with those not receiving NAC.

Methods: Retrospective review of patients undergoing ALND with positive sentinel nodes between January 2016 to December 2017 at Peterborough City Hospital. Data were collected from the cancer and pathology registries. Patients who had ALND were divided into 2 groups; group 1 underwent ALND after NAC and group 2 who did not have NAC. Statistical difference between the 2 groups were calculated using Fisher's exact test.

Result: SLNB were performed in 455 patients. Only 5 patients (18%) in group 1 had further metastasis on ALND as compared to 39% in group 2 as shown in table 1. However, the difference between the 2 groups was not statistically significant (P > 0.09). Five other patients in group 1 showed only fibrosis.

Table 1

	No of patients	Mean age Years	Mean tumour size mm	Grade 3 %	Triple -ve %	Further nodal metastasis on ALND Patients (%)
Group 1	28	47	48	54	14	5 (18%)
Group 2	38	60	29	45	8	15 (39%)

Conclusion: SLNB after NAC could avoid unnecessary ALND because of downstaging of the disease. A larger randomised controlled trial should be done to establish the long-term outcome of SLNB after NAC.

P026. IS THE RESPONSE TO NEOADJUVANT CHEMOTHERAPY IN LOCALLY ADVANCED BREAST CANCER HOMOGENOUS AND PREDICTABLE?

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Introduction: 20-25% of breast cancer in developing countries present with skin involvement. The challenge in them is to achieve adequate down-sizing and R0 resection. Apart from 10% of patients which shows scattered cytorreduction, a large group show differential response pattern at the surface (skin) and in the parenchyma.

Aims: To study the post-NACT disease pattern in surface and core of the lesion histopathologically and correlate the results with cancer stem cell distribution.