highest pCR rates. Our data suggest that neoadjuvant chemotherapy is best utilised in 'triple-negative' or HER2+ patients and upfront surgery followed by genomic testing may be more appropriate in ER+ patients.

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Endocrine Therapy in Breast Cancer: a Snapshot of Current Practice

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Purpose: Recent data have demonstrated improved disease-free survival with ovarian function suppression (OFS) + aromatase inhibitors in high-risk premenopausal women under 35 years with hormone receptor-positive early breast cancer [1]. We aimed to establish whether there is any consensus on selecting patients for this treatment among UK breast oncologists.

Method: An electronic survey of six questions was distributed to breast oncology consultants in the UK.

Results: Seventy-three consultants responded to the survey. Thirty-nine (55%) reported using OFS in all high-risk patients. Forty-five (60%) are routinely offering OFS to patients aged under 35 years. A further eight (11%) used a cut-off of 40 years. Eleven (15%) respondents would offer OFS to any woman remaining premenopausal irrespective of age. Forty-five (60%) used the administration of chemotherapy to define high-risk disease. Twenty-one (28%) used a percentage chance of relapse and 5% used the patient's age or lymph node status. When initiating OFS, the majority (34%) choose to start OFS concurrently with aromatase inhibitors. The remaining respondents were equally split between starting concurrently with tamoxifen, starting tamoxifen first or switching to aromatase inhibitors if well tolerated. Deciding between tamoxifen or aromatase inhibitors was predominantly influenced by expected tolerance (38% of respondents), side-effects (14%), risk factors (14%), patient preference (11%), age (9%) and available data (9%). Adjuvant bisphosphonates were standardly offered by 62% of respondents to those patients being treated with OFS.

Conclusion: There is a lack of consensus regarding the initiation and use of endocrine therapy and OFS. Although patient factors will continue to influence practice, we suggest that it would be helpful to develop a UK-wide guideline incorporating the latest data. Further work to identify factors that promote tolerance to challenging treatment regimens alongside studies looking at the long-term adherence to ovarian suppression would be useful in guiding initial treatment options.

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Identifying and Monitoring Steroid-induced Hyperglycaemia in Breast Cancer Patients Receiving Steroids as Part of their Systemic Anticancer Therapy

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Purpose: Steroid-induced hyperglycaemia is a common adverse effect in patients with either known diabetes or without a previous history of diabetes. Many chemotherapeutic regimens include corticosteroids to prevent chemotherapy-induced nausea and vomiting or to prevent allergic reactions. The purpose of this audit was to determine whether steroid-induced hyperglycaemia in breast cancer patients is being identified correctly and monitored appropriately.

Methods: Breast cancer patients attending the chemotherapy unit over a period of 1 month were included. The local outpatient pathway for identifying and monitoring steroids and hyperglycaemia was used as a reference tool. HbA1c at the start of treatment and random blood glucose measurements throughout treatment were audited. Following the initial audit, the local pathway was refined and a training session was provided by a diabetic specialist nurse. The audit was repeated 6 months after the initial audit.

Results: Data were collected for 95 patients during the audit and re-audit period. During the initial audit, a baseline HbA1c was performed on 11/41 (26.8%) patients and random glucose monitoring was performed on 41/41 (100%) patients. A raised HbA1c was identified in three patients, two of whom were not previously known to have diabetes. At the time of re-audit, 5/16 (31.3%) patients on steroids had a baseline HbA1c performed and 52/54 (96.3%) patients had random glucose monitoring.

Conclusion: Random glucose monitoring was consistently performed but baseline HbA1c was not performed adequately. Our audit highlighted that HbA1c monitoring during steroid treatment is important, as patients were identified with newly impaired glucose control and diabetes. The low rate of HbA1c monitoring could be due to insufficient knowledge of the local steroid-induced hyperglycaemia guideline in the oncology outpatient setting. We plan to improve education in this area and then repeat the audit in 6 months.

Impact of Routine Use of CDK4/6 Inhibitor Therapy on Breast Cancer Outpatient Clinic Workload and Patient Experience

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Purpose: The cyclin-dependent kinase 4 and 6 (CDK4/6) inhibitors are important new agents in the care of patients with hormone receptor-positive (HR+) and HER2-negative (HER2−) advanced breast cancer. CDK4/6 inhibitors are generally well tolerated, although neutropenia is a significant class-wide adverse effect. Frequent monitoring of the full blood count (FBC) is required during treatment so that neutropenia is managed with appropriate dose interruption and/or dose reduction. We sought to assess the impact of repeated visits to the oncology outpatient clinic as well as waiting time for FBC results.

Methods: This was a retrospective observational study of data from an electronic medical record database. Female patients receiving palbociclib or ribociclib from 14 June 2017 to 31 August 2018 were included.

Results: In total, 45 patients were treated with the combination of endocrine therapy plus a CDK4/6 inhibitor during the study period. Overall there was a total of 565 outpatient visits for these patients (median 11 per patient, range 2–28). Patients required FBC monitoring at all OPAs (outpatient appointments) and we calculated median waiting times for FBC results as 81 min (range 11–415 min). In total, 18/45 (40%) patients required at least one dose reduction. A permanent discontinuation of treatment occurred in 7/45 (15.6%) patients and the longest duration of treatment was 16 cycles (ongoing response).

Conclusion: CDK4/6 inhibitors have demonstrated meaningful improvement in progression-free survival in clinical trials [1–3]. However, integration of these agents into routine clinical care comes with challenges. These results demonstrate a significant increase in the outpatient workload and significant waiting times for blood results, which adversely impact quality of life for patients. Strategies to reduce the waiting times for FBC results and repeated oncology outpatient appointments include using point-of-care FBC testing, homecare services for monitoring and pharmacy or nurse-led clinics. We welcome discussion of how these demands are being met nationally via the UKBCG.

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