had pCR in the axillary lymph node and primary breast tumour and 2/7 had pCR in the axillary lymph node with a partial response in the primary breast tumour. Five patients had residual disease in the axillary lymph node and a pCR in the primary breast tumour. All axillary clips were successfully retrieved at surgery.

Conclusion: 35.7% of patients who had primary chemotherapy achieved pCR in the axilla (30% in the published data) [1,2]. 23.3% with a marker clip had SLNB at the time of surgery. Our results suggest that not all patients with lymph node-positive disease need ANC if they respond well to chemotherapy. More work is needed to establish if we can accurately recognise which patients can be managed with SLNB.

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A Closed-loop Audit of 5 versus 10 Days of Primary GCSF Prophylaxis to Reduce the Incidence of Febrile Neutropenia in Early Breast Cancer Treatment

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Purpose: Current guidelines recommend that patients with early breast cancer receiving chemotherapy that confers >20% risk of febrile neutropenia should have primary prophylactic granulocyte colony-stimulating factor (GCSF) on days 2–6 of chemotherapy [1,2]. An initial audit [3] demonstrated non-inferiority of 5 days versus 10 days of primary prophylactic GCSF in respect of febrile neutropenia rates seen in early breast cancer chemotherapy. Since 1 August 2016, our centre has switched from 10 days of prophylactic GCSF to 5 days. We re-audited febrile neutropenia rates following our change in practice.

Methods: The initially audited patient cohort received chemotherapy between August 2016 and February 2017. We closed the audit loop by analysing data for all patients at our centre receiving chemotherapy for early breast cancer between April 2017 and March 2018. Patient and treatment details were taken from ChemoCare© and blood results from Medway©.

Results: We identified 49 patients. The rates of febrile neutropenia were 24% in the 5-day GCSF cohort compared with 7.4% in the 10-day cohort. Eighty-five per cent of the admissions with febrile neutropenia occurred after the 5-day course of prophylactic GCSF was completed. The median length of stay was 2.5 days. Four patients (33%) had their prophylactic GCSF extended following febrile neutropenia. Eight patients (66%) had their chemotherapy dose reduced and one patient had their chemotherapy stopped following admission. The cost–benefit analysis, per patient, for 10 days GCSF is £540.29 and for 5 days GCSF is £383.95[1].

Conclusion: The previously demonstrated non-inferiority of 5 days versus 10 days of prophylactic GCSF in relation to febrile neutropenia rates was not corroborated in our re-audit. This may be partly attributable to a variation in patient characteristics between the two cohorts. Additionally, although a cost–benefit analysis favours the 5-day regimen, this does not account for morbidity related to GCSF or neutropenia. Patients of increased body weight should receive a higher dose of GCSF.

[1]Cost–benefit analysis: GCSF cost + (chance of febrile neutropenia × cost per bed day × median length of stay). For 10 days GCSF: (250.75 × 2) + (0.07 × 222 × 2.5) = £540.29. For 5 days GCSF: (250.75 × 1) + (0.24 × 222 × 2.5) = £383.95.

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Partial Breast Radiotherapy: a Single Centre Experience

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Purpose: This audit was undertaken to assess if the recurrence rates following partial breast radiotherapy at the Christie were in keeping with the IMPORT LOW trial [1], which showed non-inferiority when compared with whole breast radiotherapy for local recurrence. We also evaluated our selection criteria for partial breast radiotherapy with inclusion criteria used in the IMPORT LOW trial [1].

Methods: A retrospective analysis between April 2010 and April 2013 was undertaken using clinical records and local PACs systems. All patients reached 5 years post-treatment. Local protocol for follow-up is annual mammographic surveillance.

Results: In total, 63 patients were treated with partial breast radiotherapy, with one having bilateral treatment. The median age was 62 years. Twenty patients were aged 50–59, 43 aged >60 years and one <50 years (46 years). Fifty-six patients had invasive ductal carcinoma; the majority had grade 1 (42%) or grade 2 disease (44%). Sixty patients (95%) had hormone-positive disease. Fifty-four had standard hypofractionated radiotherapy (40 Gy in 15 fractions). Seven had a lower total dose (37.5 Gy and 38.5 Gy). One patient received 37.5 Gy in 14 fractions. All patients completed the intended treatment course.

Sixty of 63 were alive at the time of the retrospective review. Three died from metastatic disease from an unrelated second primary. Of those 59 patients who completed 5 years of mammographic follow-up there was no evidence of local recurrence (100%). Of the four patients who did not have 5 years of mammography, two were lost to follow-up, one died of a second primary and one had 4 years of mammography follow-up but no final mammogram. Adherence to the patient inclusion criterion set in the IMPORT LOW trial was good (98–100%).

Conclusion: The rate of local recurrence following partial breast radiotherapy is low when appropriately used in the low-risk patient and should be considered in this cohort routinely.

Reference

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Clinical Outcomes in HER2-positive Lobular Breast Cancer: a Single-institution Experience

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Purpose: Invasive lobular carcinomas (ILC), characterised by loss of the cell adhesion molecule E-cadherin, are typically oestrogen receptor (ER)-positive/HER2-negative luminal tumours with a similar prognosis to that expected for luminal invasive ductal carcinomas (IDC). Less than 5% of classical ILC but up to 35% of pleomorphic ILC are HER2-positive. Previous studies have suggested similar benefit from trastuzumab for HER2-positive ILC and IDC, but data are limited [1].

Methods: Retrospective collection of clinical data from all patients with HER2-positive ILC diagnosed between 2004 and 2014 at the Royal Marsden Hospital. The primary end point was median overall survival in patients with metastatic HER2-positive ILC, secondary end points included timing and pattern of relapse after treatment for early HER2-positive ILC and rate of pathological complete response (pCR) to neoadjuvant chemotherapy (NAC).