Results: Fifteen patients were identified. Nine patients had ductal carcinoma, the remaining were mixed. Six had grade 3 tumours, the remaining were grade 2. Nine were ER-positive. The median tumour size was 26 mm at diagnosis. Twelve had pertuzumab and trastuzumab with FEC-T (FEC-T PH) and three with docetaxel and carboplatin (TC-PH). Six were currently receiving chemotherapy or awaiting surgery and one patient died due to coexisting morbidity. There was no cardiac toxicity. Three patients relapsed (20%). The median time between first administration of treatment and relapse was 7.5 months. Radiologically, eight patients had a partial response and five had a complete response (pCR). Eight had undergone histological review of their surgical specimens. ER-positive patients had a pCR of 75% (3), whereas ER-negative patients had a 25% (1) rate. TC-PH was more successful than FEC-T (FEC-T PH) (100 and 33.33%, respectively).
Conclusion: Pertuzumab and trastuzumab has been successfully delivered to patients and is associated with radiological and pathological responses. TC-PH seems to be more effective than FEC-T PH. Further evaluation will take place on a larger cohort.

A National Retrospective Multicentre Audit of Long-term Trastuzumab Use in Metastatic Breast Cancer: Breast Cancer Trainees Research Collaborative Group (BCTRCG)

P. Closier [*], N. Chopra [†], F. Mark [‡], A. Jenner [*], T. McCartney [§], E. Copson [||]
[*] *Royal United Hospital, Bath, UK*
[†] *University College London Hospital, London, UK*
[‡] *Royal Devon & Exeter Hospital, Exeter, UK*
[§] *Northern Ireland Cancer Centre, Belfast, UK*
[||] *University of Southampton, Southampton, UK*

Purpose: Approximately 25–30% of breast cancers overexpress HER2, previously associated with higher risk of relapse and worse prognosis [1,2]. The addition of anti-HER2 targeted agents has improved the prognosis for metastatic HER2-positive patients [3]. Current NICE guidance is to continue trastuzumab until evidence of extracranial disease progression [4]; in some this may be many years. Long-term trastuzumab is not without impact on quality of life, risk of cardiotoxicity and cost. There is a clear indication for a need to gain more information on long-term trastuzumab use to inform future practice.
Methods: This project proposal was presented at the inaugural meeting of the BCTRCG in May 2018 and subsequently adopted as a BCTRCG research project. A project steering group, run by trainees with oversight by clinical clinicians, has been set up and key tasks have been allocated. A literature search has been performed and feasibility data have been collected from local trusts to estimate patient numbers.
Results: The project protocol has been written; this includes both a current practice questionnaire and a national retrospective audit, for patients who have undergone a minimum of 2 years of trastuzumab for metastatic breast cancer without disease progression. The current practice questionnaire will obtain an overview of trastuzumab prescribing practice throughout the UK and highlight variations. The audit will focus on overall and progression-free survival, evidence of cardiotoxicity, previous and current systemic anticancer treatments and indications for discontinuing trastuzumab.
Conclusion: This national retrospective audit and current practice questionnaire will provide a large quantity of data on treatment and outcomes of HER2-positive metastatic breast cancer in the UK. This will allow an in-depth analysis and a platform for future research. The audit and questionnaire will be piloted locally, with data capture on an electronic database. We aim to start national recruitment in the first half of 2019.
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Variation in the Delivery of Breast Boosts in Adjuvant Radiotherapy Across the UK

P. Closier, M. Beresford, S. Whittle
Royal United Hospital, Bath, UK

Purpose: Breast tumour bed boosts are used as an adjunct to standard adjuvant radiotherapy for a proportion of patients (a recent RCR consensus document states this includes all patients with invasive breast cancer who are less than 50 years old, and to be considered if over 50 years with higher risk pathological features [1]). The benefits of tumour bed boosts were demonstrated in EORTC Boost, with a reduced rate of local recurrence [2]. There is no universally accepted dose and fractionation for breast boosts, and with the move towards intensity-modulated radiotherapy in some centres, simultaneous integrated boost (SIB) use may well increase pending the results of IMPORT HIGH. We set out to gain information about different practice for breast boosts across the UK.
Methods: A survey was sent to the heads of radiotherapy physics in all centres in the UK, to assess fractionation schedules of boosts and frequency of SIB versus sequential tumour bed boost. An option for free text commentary was included.
Results: In total, 23 centres replied to the survey, all of which give tumour bed boosts to high-risk patients. Two centres are using SIB, with the remainder using sequential boosts. Fractionation schedules were varied, with six different sequential fractionations used, ranging from 9 Gy/3 fractions to 16 Gy/8 fractions. Eight centres volunteered that they were in discussion or planning on implementing SIB. Both centres using SIB were giving 48 Gy to the tumour bed.
Conclusion: This survey demonstrates that practice is variable throughout the UK. The RCR consensus statement had no 100% consensus on any one fractionation [1]. A move towards SIB is occurring or being considered in a number of centres, and standardisation of fractionation may occur as a result. We recommend more work is carried out to establish clear recommendations, including indication, suggested dose and fractionation to standardise treatment, and we await IMPORT HIGH results to help guide this.
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Prevention of Everolimus-related Stomatitis: a Retrospective and Prospective Study

M. Coakley, I. Leslie, F. Swann, B. Asare, A. Okines
The Royal Marsden NHS Foundation Trust, London, UK

Purpose: In 2017, the SWISH trial reported that prophylactic dexamethasone mouthwash was effective in preventing everolimus-associated stomatitis [1,2]. In December 2017, the Royal Marsden Hospital (RMH) breast unit changed from aspirin mucilage (AM) prophylaxis alone to AM + steroid-based mouthwash (AM+S) using betamethasone soluble tablets, due to the high cost of dexamethasone mouthwash.
Methods: Data were collected for patients receiving everolimus between August 2016 and August 2017 for the AM group and from December 2017 to May 2018 for the AM+S group. Chi-squared test was used to determine whether the rate of toxicities differed between the two groups.
Results: In total, 54 patients received AM and 23 patients received AM+S during the study period. The median starting dose of everolimus in both