

2nd Australasian International Breast Congress (AIBC)



Australasian Society
for Breast Disease



World Congress on
Controversies in Breast
Cancer (CoBrCa)



**BREAST
SURGEONS**
of Australia & New Zealand

Brisbane, Australia

October 8-10, 2026

Congress Program



Timetable

Pre-Congress Workshop Plenary Session Parallel Session Free Papers Session Industry Symposium

Thursday, October 8, 2026

	HALL A (Great Hall 1)	HALL B (Great Hall 2)	HALL C (Room M1)	HALL D (Room F1)
09:30-11:00	Pre-Congress Workshop 1: Breast imaging workshop: Strengths, limitations and personalisation in breast imaging	Pre-Congress Workshop 2: The expanding role of genetic testing in breast cancer: Therapeutic, surgical and surveillance implications	Pre-Congress Workshop 3: Treating the extremes: Optimising management of the youngest and oldest breast cancer patients	Pre-Congress Workshop 4: The art of communication: Hope, honesty and hard conversations
11:00-11:20	Coffee break			
11:20-12:30	Pre-Congress Workshop 1 ctd:	Pre-Congress Workshop 2 ctd:	Pre-Congress Workshop 3 ctd:	Pre-Congress Workshop 4 ctd:
12:30-13:30	Lunch break (for workshop participants)			
15:00-15:15	Congress Opening			
15:15-17:00	Plenary Session 1: Neoadjuvant therapy			
17:00-18:00	Networking Reception in Exhibition Area			

Friday, October 9, 2026

	HALL A (Great Hall 1)	HALL B (Great Hall 2)	HALL C (Room M1)
07:30-08:30		Morning Industry Symposium:* New data in breast cancer genomic testing to advance personalized treatment decisions <i>Supported by Veracyte</i>	
08:30-09:30	Parallel Session 2: Screening	Parallel Session 3: Fear of cancer recurrence	Industry Symposium : In conversation with Prof. Javier Cortes: Navigating the complexities of HR+ HER2- early breast cancer <i>Supported by Lilly</i>
09:30-11:00	Plenary Session 4: Genetics		
11:00-11:30	Coffee break, poster viewing and exhibition visit		
11:30-12:30	Parallel Session 5: Lymphoedema	Industry Symposium : Evolving treatment paradigm in HER2+ early breast cancer <i>Supported by Daiichi-Sankyo AstraZeneca</i>	Parallel Session 6: Free Papers: Locoregional therapy
12:30-13:30	Lunch break, poster viewing and exhibition visit		
13:30-14:30	Parallel Session 7: DCIS	Parallel Session 8: Triple negative breast cancer	Parallel Session 9: Free Papers: Supportive care
14:30-15:50	Plenary Session 10: Adjuvant endocrine therapy		
15:50-16:10	Coffee break, poster viewing and exhibition visit		
16:10-17:15	Parallel Session 11: Imaging	Parallel Session 12: Metastatic breast cancer	Parallel Session 13: Supportive Care: Management of endocrine therapy side effects

Saturday, October 10, 2026

	HALL A (Great Hall 1)	HALL B (Great Hall 2)	HALL C (Room M1)
07:30-08:30		Morning Industry Symposium:* Recurrence risk and adjuvant treatment decision-making in HR+/HER2- early breast cancer <i>Supported by Novartis</i>	Morning Industry Symposium:* Optimizing local therapy in early breast cancer: The role of genomic biomarkers DCISionRT® and AidaBreast® <i>Supported by PreludeDx</i>
08:30-09:30	Parallel Session 14: Controversies in reconstruction	Parallel Session 15: Survivorship	Parallel Session 16: Free Papers: Systemic therapy
09:30-11:00	Plenary Session 17: Locoregional therapy		
11:00-11:30	Coffee break, poster viewing and exhibition visit		
11:30-13:00	Parallel Session 18: Local therapy	Parallel Session 19: HER2 positive disease	
13:00-14:00	Lunch break, poster viewing and exhibition visit		
14:00-15:00	Plenary Session 20: Palliative care	13:10-13:55 Lunch Industry Symposium: ** Redefining the surgical pathway: Contemporary innovations in breast cancer management <i>Supported by Hologic</i>	
15:00-16:15	Plenary Session 21: Breast cancer 2036		
16:15-16:30	Congress closing and Award presentation		

*Breakfast will be served from 07:00-07:30 to session participants

** Lunch from the congress may be taken into the hall.

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Welcome Letter

Dear Friends and Colleagues,

We are delighted to welcome you to the **2nd Australasian International Breast Congress (AIBC)**, which continues the successful collaboration between the Australasian Society for Breast Disease (ASBD), the World Congress on Controversies in Breast Cancer (CoBrCa), and Breast Surgeons of Australia and New Zealand (BreastSurgANZ).

This year's scientific program explores the key challenges and advances shaping breast cancer, with sessions spanning medical oncology, surgery, radiation oncology, breast imaging, pathology, reconstruction, allied health, and survivorship. Bringing together an outstanding national and international faculty, the Congress provides a valuable forum for sharing knowledge, discussing emerging evidence, and exchanging diverse perspectives that will enhance patient care.

We extend our sincere gratitude to our distinguished faculty, abstract presenters and supporters, whose commitment and contributions have made this Congress possible. We also warmly thank each of you for travelling from across Australia and around the world to join us.

We encourage you to take full advantage of the scientific sessions, engage with colleagues, and participate in the many opportunities to learn, network, and collaborate throughout the Congress. We hope you find the experience both professionally rewarding and personally enjoyable.

We wish you a successful Congress and hope you enjoy your time in the beautiful city of Brisbane.

Sincerely,

Congress Chairpersons



Peter Chin, New Zealand
Australasian Society for
Breast Diseases (ASBD)



Bruce Mann, Australia
World Congress on Controversies
in Breast Cancer (CoBrCa)



Caroline Baker, Australia
Breast Surgeons of Australia and
New Zealand (BreastSurgANZ)

Scientific Advisory Board

Angela Allen
Samantha Moules

Richard de Boer
Kirsten Pilatti

Sanjeev Kumar
Melanie Walker

General Information

REGISTRATION DESK

The registration desk will be open at the BCEC during the following hours:

Thursday, October 8, 2026 08:00-18:30

Friday, October 9, 2026 06:45-17:30

Saturday, October 10, 2026 06:45-16:30

CERTIFICATE OF ATTENDANCE (NON CME/CPD)

Certificates of attendance will be sent electronically to all registered participants after the congress.

SPEAKERS' PREVIEW ROOM

Invited speakers and oral presenters are invited to visit the Speaker's Preview Room to upload their presentations at least one hour before their session. The Centre is situated in Room M5 on the Mezzanine Level.

POSTER DISPLAY

Posters can be viewed in the Exhibition Hall. Please check the Scientific Program for the board number on which you should display your poster(s).

INFANTS IN ARMS

The BCEC offers a parent's room which is located behind the Merivale's Café on the main floor. Infants in arms are welcome in all sessions. To ensure your comfort and minimise disruption to speakers and attendees, we kindly ask that, where possible, you choose an aisle seat near an exit, for easy access.

PHOTOGRAPHY

It is forbidden to take photographs, film or make recordings during the scientific program (sessions and posters).

SAFETY AND SECURITY

Please do not leave any bags or suitcases unattended at any time, whether inside or outside session halls.

LIABILITY

The Congress Secretariat and Organizers cannot accept liability for personal accidents or loss or damage to private property of participants either during or directly arising from the 2nd Australasian International Breast Congress (AIBC). Participants should make their own arrangements with respect to health and travel insurance.

CONGRESS ORGANIZER



www.congressmed.com

CPD ACCREDITATION

The Royal Australian College of Physicians (RACP)

Fellows of the Royal Australian College of Physicians (RACP) may claim CPD hours via quick log.

The Royal Australasian College of Surgeons (RACS)

Fellows of the Royal Australian College of Surgeons (RACS) may claim CPD hours via quick log.

General Practitioners may self-record any eligible CPD activities with their own CPD Home.

The Royal Australian and New Zealand College of Radiologists (RANZCR)

21 RANZCR CPD hours may be claimed. In addition, the following Program Level Requirements may be claimed: Professionalism, Addressing Health Inequities, Cultural Safety, and Ethical Practice.

Australian College of Nursing (ACN)

The AIBC program is endorsed by the Australian College of Nursing (ACN). The course has been assessed as being equivalent to an average of 15 CPD hours according to the Nursing and Midwifery Board of Australia – Continuing Professional Development Standard.

Scientific Program



SCIENTIFIC PROGRAM

Pre-Congress
Workshop

Plenary Session

Parallel Session

Free Papers Session

Industry Symposium

Thursday, October 8, 2026

09:30-12:30	Pre-Congress Workshop 1: Breast imaging workshop: Strengths, limitations and personalisation in breast imaging	Hall A (Great Hall 1)
Chairperson	Allison Rose, Melbourne, Australia	
09:30-11:00	Interactive multidisciplinary case discussion: A practical, imaging-based multidisciplinary session exploring real-world cases, controversies, and clinical decision-making Bruce Mann, Melbourne, Australia Elizabeth Morris, Davis, CA, USA Alastair Thompson, Indianapolis, IN, USA Merran McKessar, Sydney, Australia	
11:00-11:20	Coffee break	
11:20-12:30	Learning objectives: - Understand the strengths and limitations of mammography, DBT, ultrasound, MRI, and CEM - Apply breast density and individual risk factors to screening and surveillance decisions - Identify when supplemental imaging is appropriate - Review a practical framework for personalised screening pathways Q&A	
09:30-12:30	Pre-Congress Workshop 2: The expanding role of genetic testing in breast cancer: Therapeutic, surgical and surveillance implications	Hall B (Great Hall 2)
Chairperson	Maree Colosimo, Brisbane, Australia	
09:30-11:00	Mainstream genetic testing and therapeutic implications Annabel Goodwin, Sydney, Australia Surgical considerations in the context of expanded genetic testing Caroline Baker, Melbourne, Australia Imaging considerations following genetic testing Thomas Lloyd, Brisbane, Australia	
11:00-11:20	Coffee break	
11:20-12:30	Reflections from a consumer advocate Robyn Smith, Canberra, Australia Case-based discussion Po-Ling Inglis, Brisbane, Australia	
09:30-12:30	Pre-Congress Workshop 3: Treating the extremes: Optimising management of the youngest and oldest breast cancer patients	Hall C (Room M1)
Chairpersons	Sanjeev Kumar, Sydney, Australia Susan Carroll, Sydney, Australia	
09:30-11:00	Contemporary management of young women with breast cancer Belinda Yeo, Melbourne, Australia Nuances of treating older women Michael Krasovitsky, Sydney, Australia Radiation oncology perspective Susan Carroll, Sydney, Australia	
11:00-11:20	Coffee break	
11:20-12:30	Surgical perspective Susannah Graham, Sydney, Australia Case-based discussion Lachlan Fitzpatrick, Sydney, Australia	

09:30-12:30	Pre-Congress Workshop 4: The art of communication: Hope, honesty and hard conversations	Hall D (Room F1)
Chairperson	Jenny Gilchrist, Sydney, Australia	
Panel	Angela Allen, Brisbane, Australia Belinda Kiely, Sydney, Australia Brienne Abussi, Brisbane, Australia	
09:30-11:00	Program description: This interactive workshop, based on the HEARSAY communication skills program developed by SHORE-C, will explore how clinicians approach some of the most challenging conversations in cancer care. Using patient quotes, facilitated discussion and practical exercises, participants will reflect on how they discuss prognosis, treatment planning, palliative care, advance care planning and clinical uncertainty. The session will focus on clear, compassionate communication, avoiding assumptions, using language patients can understand, and balancing honesty with hope.	
11:00-11:20	Coffee break	
11:20-12:30	continued.	
12:30-13:30	Lunch break (for Workshop participants only)	
15:00-15:15	Congress Opening	Hall A (Great Hall 1)
Chairpersons	Bruce Mann, Melbourne, Australia Caroline Baker, Melbourne, Australia Peter Chin, Tauranga, New Zealand	
	Welcome to Country	
	Welcome from Congress chairpersons	
15:15-17:00	Plenary Session 1: Neoadjuvant therapy	Hall A (Great Hall 1)
Chairpersons	Alastair Thompson, Indianapolis, IN, USA Angela Allen, Brisbane, Australia	
15:15-15:55	Debate: That cT1cN0 TNBC should have Neoadj CT and IO	
15:15	Yes: Kevin Kalinsky, Atlanta, GA, USA	
15:30	No: Alistair Ring, London, UK	
15:45	Discussion	
15:55-16:15	How best to monitor a patient during neoadjuvant therapy	
	Elizabeth Morris, Davis, CA, USA	
16:15-17:00	Debate: That patients with pN+ luminal cancer who are ypN0 after NAST should receive regional nodal radiotherapy	
16:15	Yes: Yvonne Zissiadis, Perth, Australia	
16:30	No: Naamit Gerber, New York, NY, USA	
16:45	Discussion	
16:55	Consumer perspective: Naveena Nekkalapudi, Melbourne, Australia	
17:00-18:00	Networking Reception in Exhibition Area	

Friday, October 9, 2026

07:30-08:30	Morning Industry Symposium: New data in breast cancer genomic testing to advance personalized treatment decisions <i>Supported by Veracyte</i> <i>Light refreshments will be served, from 07:00-07:30, to session participants only.</i> <i>For full session details, please refer to page 64</i>	Hall B (Great Hall 2)
08:30-09:30	Parallel Session 2: Screening	Hall A (Great Hall 1)
Chairpersons	Allison Rose, Melbourne, Australia Alastair Thompson, Indianapolis, IN, USA	
08:30-08:55	Risk adjusted screening - what might it look like? Carolyn Nickson, Sydney, Australia	
08:55-09:10	The future of post-breast cancer surveillance Julia Matheson, Melbourne, Australia	
09:10-09:30	Artificial intelligence in breast cancer screening Elizabeth Morris, Davis, CA, USA	
08:30-09:30	Parallel Session 3: Fear of cancer recurrence	Hall B (Great Hall 2)
Chairpersons	Ben Smith, Sydney, Australia Lesley Stafford, Melbourne, Australia	
08:30-08:40	Addressing fear of cancer recurrence in practice: From evidence to everyday care Ben Smith, Sydney, Australia	
08:40-08:55	Adapting a clinician-led fear of cancer recurrence intervention for breast cancer patients (CIFeR) for people living with advanced cancer Howard Yu, Sydney, Australia	
08:55-09:10	Recommendations from Aboriginal and Torres Strait Islander women diagnosed with breast cancer for improved fear of cancer recurrence care Mackenzie Rhodes, Newcastle, Australia	
09:10-09:30	Panel discussion, including consumer representative from BCNA Cherise Donovan, Melbourne, Australia	
08:30-09:30	Industry Symposium: In conversation with Prof. Javier Cortes: Navigating the complexities of HR+ HER2- early breast cancer <i>Supported by Lilly</i> <i>For full session details, please refer to page 64</i>	Hall C (Room M1)
09:30-11:00	Plenary Session 4: Genetics	Hall A (Great Hall 1)
Chairpersons	Michael Kerin, Galway, Ireland Sanjeev Kumar, Sydney, Australia	
09:30-09:50	Panel testing in early breast cancer: Who, when and why? Annabel Goodwin, Sydney, Australia	
09:50-10:30	Debate: That Breast-Conserving Surgery is an inappropriate recommendation for most patients with high-penetrance germline mutations 09:50 Yes: Michael Boland, Dublin, Ireland 10:05 No: Shelley Potter, Bristol, UK 10:20 Discussion	
10:30-10:50	Management of ovaries/fallopian tubes in gene carriers – what to do and when to do it Amy Tang, Brisbane, Australia	
10:50-11:00	Discussion	
11:00-11:30	Coffee break, poster viewing and exhibition visit	

11:30-12:30	Parallel Session 5: Lymphoedema	Hall A (Great Hall 1)
Chairpersons	Samantha Moules, Sydney, Australia Vicki Durston, Melbourne, Australia	
11:30-11:50	Surgery for lymphoedema: Prevention and treatment Satomi Koide, Melbourne, Australia	
11:50-12:10	Empowering the at-risk patient: Evidence-based strategies for long-term prevention Jen McKenzie, Sunshine Coast, Australia	
12:10-12:30	Established lymphoedema treatment: Evidence, myths, and the role of ICG lymphography Megan Trevethan, Brisbane, Australia	
11:30-12:30	Industry Symposium: Evolving treatment paradigm in HER2+ early breast cancer <i>Supported by Daiichi-Sankyo AstraZeneca</i> <i>For full session details, please refer to page 64</i>	Hall B (Great Hall 2)
11:30-12:30	Parallel Session 6: Free Papers: Locoregional therapy	Hall C (Room M1)
Chairpersons	Peter Chin, Tauranga, New Zealand Stuart McIntosh, Belfast, Ireland	
11:30-11:40	The two-year Australian and New Zealand targeted axillary dissection registry: Final results Adam Ofri, Sydney, Australia	
11:40-11:50	Clipping the cavity: Are surgeons and radiation oncologists on the same page? Matthew Ng, Melbourne, Australia	
11:50-12:00	Dosimetric comparison of incidental sentinel lymph node irradiation with whole breast versus partial breast radiotherapy Luke Kissane, Sydney, Australia	
12:00-12:10	What drives supplemental screening? A discrete choice experiment on women's preferences and uptake following breast density notification Jennifer Isautier, Sydney, Australia	
12:10-12:20	How has implant-based breast reconstruction changed? Twelve years of national registry data Melanie Walker, Melbourne, Australia	
12:20-12:30	Patterns and variation in breast reconstruction type following mastectomy in Australia and Aotearoa New Zealand using the BreastSurgANZ quality audit Melissa Bochner, Adelaide, Australia	
12:30-13:30	Lunch break, poster viewing and exhibition visit	
13:30-14:30	Parallel Session 7: DCIS	Hall A (Great Hall 1)
Chairpersons	Steven David, Melbourne, Australia Caroline Baker, Melbourne, Australia	
13:30-14:00	Debate: That genomic assays should be used to help make decisions regarding adjuvant RT for DCIS 13:30 Yes: Naamit Gerber, New York, NY, USA 13:40 No: Stuart McIntosh, Belfast, Ireland 13:50 Discussion	
14:00-14:30	Debate: That active surveillance for low risk DCIS is a reasonable option 14:00 Yes: Alastair Thompson, Indianapolis, IN, USA 14:10 No: Judy Boughey, Rochester, MN, USA 14:20 Discussion	
13:30-14:30	Parallel Session 8: Triple negative breast cancer	Hall B (Great Hall 2)
Chairpersons	Kevin Kalinsky, Atlanta, GA, USA Belinda Kiely, Sydney, Australia	
13:30-13:45	TNBC subtypes: Do they have clinical significance? Nirmala Pathmanathan, Sydney, Australia	
13:45-14:30	Debate: That all stage 2/3 TNBC patients should be treated according to Keynote522 regimen 13:45 Yes: Javier Cortes, Madrid, Spain 14:00 No: Alistair Ring, London, UK 14:15 Discussion	

13:30-14:30	Parallel Session 9: Free Papers: Supportive care	Hall C (Room M1)
Chairpersons	Jenny Gilchrist, Sydney, Australia Kirsten Pilatti, Melbourne, Australia	
13:30-13:40	Lymphoedema prevalence after axillary lymph node dissection for breast cancer in the de-escalation era Mansha Jiwane, Sydney, Australia	
13:40-13:50	The MASCC international healthcare professional survey of current practices of managing breast cancer-related lymphoedema and lymphoedema-related cellulitis: An ongoing international study Kaori Tane, Kobe, Japan	
13:50-14:00	An evidence-informed framework for co-designing a national breast cancer policy and advocacy strategy Helena Rodi, Melbourne, Australia	
14:00-14:10	Living flat after mastectomy: Australian healthcare professionals perspectives on women's surgical choices Robyn Smith, Canberra, Australia	
14:10-14:20	Evaluating breast cancer quality indicators in young women (<45 years) within a rural Australian health service: A retrospective clinical audit Azra Tabassum, Coffs Harbour, Australia	
14:20-14:30	Variation in breast cancer care and outcomes among culturally and linguistically diverse women in Victoria (2019–2023) Beverley Woon, Melbourne, Australia	
14:30-15:50	Plenary Session 10: Adjuvant endocrine therapy	Hall A (Great Hall 1)
Chairpersons	Alistair Ring, London, UK Nicole McCarthy, Brisbane, Australia	
14:30-15:10	Debate: That CDK4/6i's should be recommended for T2N0 ER+ HER2- early breast cancer	
14:30	Yes: Javier Cortes, Madrid, Spain	
14:45	No: Richard de Boer, Melbourne, Australia	
15:00	Discussion	
15:10-15:35	Oral SERDS in early breast cancer: Where to now? Kevin Kalinsky, Atlanta, GA, USA	
15:35-15:50	Modern management of hot flushes in breast cancer patients Belinda Yeo, Melbourne, Australia	
15:50-16:10	Coffee break, poster viewing and exhibition visit	
16:10-17:15	Parallel Session 11: Imaging	Hall A (Great Hall 1)
Chairpersons	Elizabeth Morris, Davis, CA, USA Shelley Potter, Bristol, UK	
16:10-16:55	The role of highly sensitive imaging in the management of early stage breast cancer Bruce Mann, Melbourne, Australia	
16:55-17:15	How to select which contrast imaging to use Allison Rose, Melbourne, Australia	
16:10-17:15	Parallel Session 12: Metastatic breast cancer	Hall B (Great Hall 2)
Chairpersons	Javier Cortes, Madrid, Spain Annabel Goodwin, Sydney, Australia	
16:10-16:55	Debate: That SABR should be considered in most patients with oligometastatic breast cancer	
16:10	Yes: Steven David, Melbourne, Australia	
16:25	No: Angela Allen, Brisbane, Australia	
16:40	Discussion	
16:55-17:15	The role of molecular testing to adapt breast cancer treatment in clinical practice Alistair Ring, London, UK	

16:10-17:15	Parallel Session 13: Supportive care: Management of endocrine therapy side effects	Hall C (Room M1)
Chairpersons	Belinda Yeo, Melbourne, Australia Kerry Patford, Sydney, Australia	
16:10-16:30	Brain fog/cognition on breast cancer survivors Tahnee Downs, Toowoomba, Australia	
16:30-16:50	“Intimate” toxicities of endocrine therapy Janine Porter-Steele, Gold Coast, Australia	
16:50-17:10	Moving through the pain: Optimising bone and muscle health in breast cancer survivorship Jen McKenzie, Sunshine Coast, Australia	
17:10-17:15	Discussion	

Saturday, October 10, 2026

07:30-08:30	Morning Industry Symposium: Recurrence risk and adjuvant treatment decision-making in HR+/HER2- early breast cancer <i>Supported by Novartis</i> <i>Light refreshments will be served, from 07:00-07:30, to session participants only.</i> <i>For full session details, please refer to page 64</i>	Hall B (Great Hall 2)
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07:30-08:30	Morning Industry Symposium: Optimizing local therapy in early breast cancer: The role of genomic biomarkers DCISionRT® and AidaBreast® <i>Supported by PreludeDx</i> <i>Light refreshments will be served, from 07:00-07:30, to session participants only.</i> <i>For full session details, please refer to page 64</i>	Hall C (Room M1)
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08:30-09:30	Parallel Session 14: Controversies in reconstruction	Hall A (Great Hall 1)
Chairpersons	Peter Barry, London, UK Melanie Walker, Melbourne, Australia	
08:30-08:45	Scaffolds in reconstruction – past, present and future Owen Ung, Brisbane, Australia	
08:45-09:15	Debate: That implant reconstruction should not be performed on patients who require PMRT	
08:45	Yes: Gillian Lamoury, Sydney, Australia	
08:55	No: Shelley Potter, Bristol, UK	
09:05	Discussion	
09:15-09:30	Consumer voice informing the future of breast reconstruction in Australia Vicki Durston, Melbourne, Australia	

08:30-09:30	Parallel Session 15: Survivorship	Hall B (Great Hall 2)
Chairpersons	Jen McKenzie, Sunshine Coast, Australia Jenny Gilchrist, Sydney, Australia	
08:30-08:35	Introduction: What matters most to consumers? Jodi Steel, Sydney, Australia	
08:35-08:50	Survivorship MoC based around nurse led clinics Leilani Way, Brisbane, Australia	
08:50-09:05	The McGrath model of care and the living well framework Kerry Patford, Sydney, Australia	
09:05-09:20	Living well with metastatic disease/fear of cancer progression Marina Reeves, Brisbane, Australia	
09:20-09:30	Discussion	

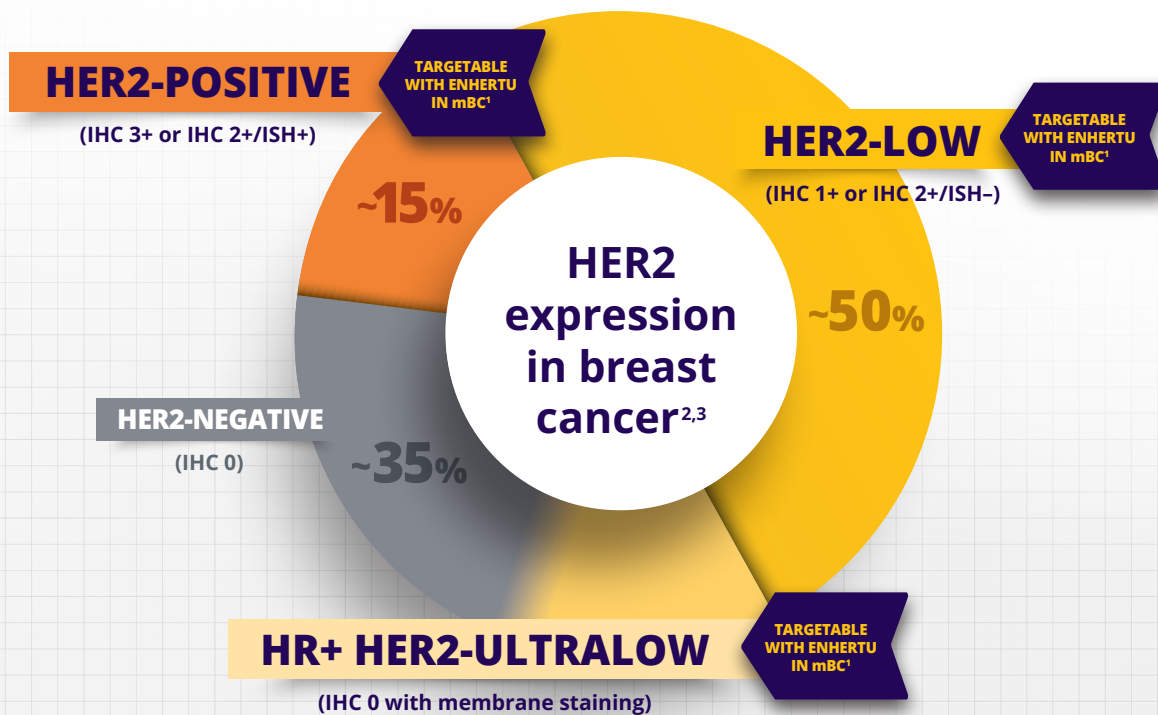
08:30-09:30	Parallel Session 16: Free Papers: Systemic therapy	Hall C (Room M1)
Chairpersons	Catherine Shannon, Brisbane, Australia Maree Colosimo, Brisbane, Australia	
08:30-08:40	Sterotactic Ablative Body Radiotherapy (SABR) defers systemic therapy change across breast cancer subtypes: Real-world outcomes and the role of repeat SABR Karen Olden, Melbourne, Australia	
08:40-08:50	The changing landscape of breast cancer recurrence risk: Contemporary subtype-specific patterns from a population-based Queensland cohort Meghan Stephensen, Brisbane, Australia	
08:50-09:00	The relationship between prior menopausal hormonal therapy and breast cancer subtypes, endocrine symptoms and endocrine therapy outcomes: A retrospective cohort study Caroline Baker, Melbourne, Australia	
09:00-09:10	The role of acupuncture for aromatase inhibitor related joint symptoms: Clinicians' perspectives Evie Yeap, Clayton, Australia	
09:10-09:20	Changes in HER2 status following neoadjuvant systemic therapy: Stability of HER2-low disease and implications for antibody-drug conjugate eligibility Aswin Shanmugalingam, Sydney, Australia	
09:20-09:30	MonarchE: Primary Overall Survival (OS) results of adjuvant abemaciclib (abema) + endocrine therapy (ET) for HR+, HER2-, high-risk Early Breast Cancer Catherine Shannon, Brisbane, Australia	
09:30-11:00	Plenary Session 17: Locoregional therapy	Hall A (Great Hall 1)
Chairpersons	Michael Boland, Dublin, Ireland Owen Ung, Brisbane, Australia	
09:30-10:10	Debate: That omission of SNB should be considered for all women >50 with clinically negative axillae 09:30 Yes: Alastair Thompson, Indianapolis, IN, USA 09:45 No: Stuart McIntosh, Belfast, Ireland 10:00 Discussion	
10:10-10:30	Axillary surgery post-neoadjuvant therapy Judy Boughey, Rochester, MN, USA	
10:30-11:00	Debate: That most patients with Stage 2+ early breast cancer should have staging PET/CT 10:30 Yes: Nicole McCarthy, Brisbane, Australia 10:40 No: Melanie Walker, Melbourne, Australia 10:50 Discussion	
11:00-11:30	Coffee break, poster viewing and exhibition visit	
11:30-13:00	Parallel Session 18: Local therapy	Hall A (Great Hall 1)
Chairpersons	Caroline Baker, Melbourne, Australia Angela Allen, Brisbane, Australia	
11:30-12:00	Debate: New intraoperative margin assessment technology will become standard of care 11:30 Yes: Caroline MacCallum, Melbourne, Australia 11:40 No: Susan Bell, Brisbane, Australia 11:50 Discussion	
12:00-12:40	Breast Conservation: Radiotherapy for surgeons and oncoplastics for radiation oncologists – everything you wanted to know but were afraid to ask!	
12:00	Radiotherapy 101 for surgeons: Fundamentals meet emerging boost solutions Gillian Lamoury, Sydney, Australia	
12:15	Advances in oncoplastic surgery 101 for radiation oncologists: What are you boosting? Peter Barry, London, UK	
12:30	Discussion/Q&A	
12:40-13:00	The future of breast surgery: European perspective Michael Kerin, Galway, Ireland	

11:30-13:00	Parallel Session 19: HER2 positive disease	Hall B (Great Hall 2)
Chairpersons	Richard de Boer, Melbourne, Australia Alistair Ring, London, UK	
11:30-11:50	Role of endocrine therapy in advanced TPBC Rebecca Moor, Brisbane, Australia	
11:50-12:40	Debate: That T-DXd should be included in the neo-adjuvant treatment for higher risk HER2+ve patients	
11:50	Yes: Catherine Shannon, Brisbane, Australia	
12:05	No: Sanjeev Kumar, Sydney, Australia	
12:20	Discussion	
12:40-13:00	Is chemotherapy still necessary in early-stage HER2+ve breast cancer? Javier Cortes, Madrid, Spain	
13:00-14:00	Lunch break, poster viewing and exhibition visit	
13:10-13:55	Lunch Industry Symposium: Redefining the surgical pathway: Contemporary innovations in breast cancer management <i>Supported by Hologic</i> <i>Session delegates may take lunch plates into the hall.</i> <i>For full session details, please refer to page 65</i>	Hall B (Great Hall 2)
14:00-15:00	Plenary Session 20: Palliative care	Hall A (Great Hall 1)
Chairpersons	Judy Boughey, Rochester, MN, USA Helena Rodi, Melbourne, Australia	
14:00-14:40	Debate: Is palliative care involvement necessary from initial diagnosis of metastatic disease	
14:00	Yes: Belinda Kiely, Sydney, Australia	
14:15	No: Jenny Gilchrist, Sydney, Australia	
14:30	Discussion	
14:40-15:00	Medicinal cannabis in advanced cancer: Pot or panacea? Phillip Good, Brisbane, Australia	
15:00-16:15	Plenary Session 21: Breast cancer 2036	Hall A (Great Hall 1)
Chairpersons	Javier Cortes, Madrid, Spain Richard de Boer, Melbourne, Australia	
15:00-15:15	Early detection in 2036 Elizabeth Morris, Davis, CA, USA	
15:15-15:30	A pathologist's view of breast cancer in 2036 Sunil R. Lakhani, Brisbane, Australia	
15:30-15:45	Locoregional therapy in 2036 Judy Boughey, Rochester, MN, USA	
15:45-16:00	Systemic therapy in 2036 Kevin Kalinsky, Atlanta, GA, USA	
16:00-16:15	A consumer's perspective of breast cancer in 2036 Kirsten Pilatti, Melbourne, Australia	
16:15-16:30	Congress closing and Award presentation	Hall A (Great Hall 1)
Chairpersons	Caroline Baker, Melbourne, Australia Sanjeev Kumar, Sydney, Australia Alastair Thompson, Indianapolis, IN, USA	

PUSH THE PARADIGM

IN mBC WITH ENHERTU. NOW AVAILABLE FOR MORE PATIENTS THAN EVER BEFORE^{1*}

*Indicated for HER2-positive, HER2-low and HER2-ultralow mBC. Refer to Product Information for details.



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PBS Information: ENHERTU is listed on the PBS for HER2-positive and HER2-low metastatic breast cancer. Authority required. ENHERTU is not listed on the PBS for HER2-ultralow metastatic breast cancer. Refer to PBS Schedule for full information.

▼ This medicinal product is subject to additional monitoring in Australia due to approval of an extension of indication. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse events at www.tga.gov.au/reportingproblems.

HER2: human epidermal growth factor receptor; IHC: immunohistochemistry; ISH: in situ hybridisation; mBC: metastatic breast cancer. **References:** 1. ENHERTU (trastuzumab deruxtecan) Product Information. 2. Tarantino P et al. *J Clin Oncol*. 2020;38(17):1951–1962. 3. Schettini F et al. *NPJ Breast Cancer*. 2021;7(1):1.

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In node-positive, high-risk*, HR+, HER2- EBC

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†VERZENIO + ET outperformed ET alone at 7-year analysis of IDFS (primary endpoint, HR=0.734; 95% CI: 0.657-0.820; nominal $p < 0.0001$) and DRFS (secondary endpoint, HR=0.746; 95% CI: 0.662-0.840; nominal $p < 0.0001$).²

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- AEs of any grade in the VERZENIO + ET arm ($\geq 10\%$ and $\geq 2\%$ higher than ET alone) included diarrhoea (84%), infections (51%), fatigue (41%), nausea (30%), headache (20%), vomiting (18%), stomatitis (14%), decreased appetite (12%), dizziness (11%), rash (11%), and alopecia (11%).¹
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PBS Information: Authority required: For the adjuvant treatment of hormone receptor positive (HR+), human epidermal growth factor receptor 2 negative (HER2-), lymph node positive, resected early breast cancer (EBC) at high risk of recurrence and for locally advanced or metastatic hormone receptor positive (HR+), human epidermal growth factor receptor 2 negative (HER2-) Breast Cancer. Refer to PBS schedule for full Authority information.



Please refer to the full Product Information before prescribing. Product Information can be accessed by scanning the QR code or on request by calling 1800 454 559.

▼ This medicinal product is subject to additional monitoring in Australia. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse events at www.tga.gov.au/reporting-problems.

REFERENCES: 1. VERZENIO Approved Product Information. 2. Johnston S et al. *Ann Oncol.* 2026;37(2):155-165. 3. Johnston SRD et al. *J Clin Oncol.* 2020;38(34):3987-98. 4. Fasching P et al. *Breast Cancer Res Treat.* 2019;175(3):617-25. 5. Ruqo HS et al. *Ann Oncol.* 2022;33(6):616-27. 6. Rastogi P et al. *J Clin Oncol.* 2024;42(9):987-93.

AE: adverse event. **CDK4/6i:** cyclin-dependent kinase 4 and 6 inhibitor. **CI:** confidence interval. **DRFS:** distant relapse-free survival. **EBC:** early breast cancer. **ET:** endocrine therapy. **HER2-:** human epidermal growth factor receptor 2-negative. **HR:** hazard ratio. **HR+:** hormone receptor-positive. **IDFS:** invasive disease-free survival. **OS:** overall survival. VERZENIO™ is a trademark of Eli Lilly and Company. © 2026 Eli Lilly Australia Pty Ltd. Level 9, 60 Margaret Street, Sydney NSW 2000, Australia. ABN 39 000 233 992. Medical Information: 1800 454 559. CMAT-53429. Date of preparation: September 2026. 2010675.

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Abstracts



INVITED SPEAKER ABSTRACTS

WILL NEW INTRAOPERATIVE MARGIN ASSESSMENT TECHNOLOGY BECOME STANDARD OF CARE? — NO

Susan Bell

Mater Hospital Springfield, Brisbane, Australia

Breast-conserving surgery aims to achieve adequate oncological clearance while minimising unnecessary removal of normal breast tissue. Although positive margins remain an important cause of re-excision, the clinical significance of margin width and the management of residual disease have evolved considerably with advances in systemic therapy, radiotherapy and surgical technique. Contemporary guidelines have established that wider margins do not necessarily improve local control, while increasing use of neoadjuvant systemic therapy, oncoplastic surgery and improved localisation and imaging techniques are changing the landscape of breast-conserving surgery. At the same time, re-excision rates appear to be declining. Consensus guidelines regarding margin width, advances in preoperative imaging and localisation, and increasing adoption of oncoplastic techniques have all contributed to more precise surgery. Furthermore, a substantial proportion of re-excision specimens contain no residual disease, raising questions about the clinical significance of some positive or close margins and the extent to which further surgery is always necessary. Against this background, numerous technologies have been developed to provide intraoperative margin assessment, including radiofrequency spectroscopy, fluorescence imaging, mass spectrometry, bioimpedance spectroscopy, optical coherence tomography and artificial intelligence-assisted imaging. These technologies are promising and may allow identification of patients who would benefit from additional excision during the initial operation. However, significant limitations remain, including false-positive and false-negative results, variable performance across tumour subtypes and treatment settings, additional tissue removal, workflow implications, cost and the requirement for validation across different institutions and surgeons. Importantly, many current technologies assess the excised specimen after resection, rather than determining the true extent of disease within the breast before excision. The question, therefore, is not simply whether these technologies can detect tumour at a margin, but whether they provide sufficient clinical benefit to justify becoming **standard of care**. A technology would need to demonstrate a substantial and clinically meaningful reduction in re-excision without compromising cosmetic outcomes, be applicable across relevant patient groups, integrate seamlessly into surgical workflow, be reproducible and demonstrate cost-effectiveness. This debate will argue that, although intraoperative margin assessment represents an exciting area of technological development, it is unlikely to become universal standard of care. Rather, the future may lie in **preventing positive margins**, through increasingly sophisticated imaging, localisation, operative planning, precision medicine and personalised assessment of recurrence risk. The goal should not simply be better detection of an inadequate excision, but increasingly accurate surgery that makes intraoperative correction unnecessary.

MEDICINAL CANNABIS IN ADVANCED CANCER: POT OR PANACEA?

Phillip Good, MBBS, FRACP, FACHPM, PhD

Director of Cancer Services, Mater Health Brisbane; St Vincent's Private Hospital Brisbane; Mater Research Institute, University of Queensland, Australia

Medicinal cannabis has moved from the margins to the mainstream of conversations in advanced cancer care. Up to one-quarter of people with advanced cancer already use a cannabis product, most commonly for pain, nausea, anxiety, appetite and sleep, and often without prescriber oversight. Clinicians caring for people with metastatic disease are increasingly asked, "Should I try it?". The best available randomised evidence tempers therapeutic enthusiasm. In MedCan1-CBD, a phase IIb, dose-escalated,

placebo-controlled trial of cannabidiol oil (up to 600 mg/day) added to specialist palliative care, CBD produced no improvement in total symptom distress, individual symptoms, quality of life, depression, anxiety or opioid use compared with placebo. In the follow-up MedCan2 trial of a 1:1 THC:CBD oil, total symptom distress again did not differ from placebo; a modest, statistically significant reduction in cancer-related pain was observed, but at the cost of more confusion, feeling "high" and exaggerated wellbeing. MedCan3, now recruiting (including through a Queensland-wide teletrial cluster), is testing a 1:20 THC:CBD preparation with an embedded sleep sub-study, extending trial access to regional, rural and remote patients. Qualitative work with trial participants highlights realities clinicians must address: strong hopes of benefit, fear of financial toxicity, driving restrictions, family pressure, and belief that cannabis may be anti-cancer.

Take-home messages for the advanced-cancer clinician:

1. Cannabidiol alone does not add measurable symptom benefit beyond good specialist palliative care.
2. THC-containing products may offer a small analgesic signal but carry psychoactive costs and driving restrictions.
3. Ask openly about cannabis use, discuss cost and driving, and support patients into properly designed trials rather than unsupervised prescribing.

Medicinal cannabis is neither pot nor panacea — it is a modest, still-emerging tool best used within a rigorous evidence framework.

SYSTEMIC THERAPY IN 2036

Kevin Kalinsky, MD, MS, FASCO

Emory University at Winship Cancer Institute, Atlanta, GA, USA

Systemic therapy in breast cancer over the next decade will be defined not only by new drug classes but also smarter and more individualized selection of who needs what, for how long, and with new tools. Artificial intelligence, including pathomics, will play a growing role in risk prediction for HR-positive, HER2-negative disease. Models trained on routine H&E slides are already extracting prognostic information that rivals genomic assays, and because they run on pathology infrastructure that already exists throughout much of the world, they carry the potential to extend risk-stratified care globally, including to parts of the world that will never have access to a genomic assay costing thousands of dollars. There will also be a continued push towards appropriate de-escalation. For instance, STOP-HER2 (NCT05721248) is asking whether a full year of HER2-directed therapy is necessary for all patients, and OptimICE-pCR (NCT05812807) is asking the same question for pembrolizumab in patients with triple negative breast cancer (TNBC) who achieve a pathologic complete response. Oral SERDs, meanwhile, are moving beyond the metastatic setting into early-stage adjuvant therapy, and newer mutant-specific PI3K inhibitors are offering more targeted, better-tolerated alternatives to first-generation pan-PI3K agents. In addition, CDK-specific inhibitors, such as atimociclib being evaluated in the FourLight-3 trial (NCT06760637), and KAT6 inhibitors, such as prifetrastat being evaluated in the KATSIS-1 trial (NCT07062965), will play an important role in metastatic HR-positive, HER2-negative disease. ADCs will continue reshaping TNBC with trials such as TROPION-Breast03 (NCT05629585) supporting approval of TROP2-directed ADCs. Bispecific antibodies represent the next immunotherapy modality to watch in TNBC, extending beyond checkpoint inhibition alone. Radioligand therapy, already reshaping metastatic prostate cancer, is beginning to be evaluated in metastatic breast cancer and could offer a genuinely new treatment approach. GLP-1 receptor agonists are likely to find a growing role in prevention and treatment, given the link between obesity, metabolic dysfunction, and breast cancer outcomes. ctDNA platforms will keep improving in sensitivity, but the real advance will hopefully be moving from prognostic to predictive. Finally, personalized neoantigen vaccines, following encouraging melanoma data, have the potential to open an entirely new modality for high-risk early disease, including in TNBC. Taken together, these advances point toward a field that treats precisely with new approvals as well as matching the correct agent to the right resistance mechanism once it emerges.

THAT cT1cN0 TNBC SHOULD HAVE NEOADJ CT AND IO

Kevin Kalinsky, MD, MS, FASCO

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Under current guidelines, neoadjuvant pembrolizumab and immunotherapy is approved in patients with T1cN1-2 or T2-4N0-2 triple negative breast cancer (TNBC), excluding node-negative T1c tumors, based on KEYNOTE-522. Consider a 39-year-old woman with a 1.9 cm, node-negative triple-negative breast cancer. Her exclusion reflects trial eligibility criteria, not evidence that immunotherapy would not help her. That gap matters given the overall survival (OS) data from KEYNOTE-522. At 7 years, OS was 85.1% with pembrolizumab versus 77.2% with placebo (HR 0.64), consistent with the 5-year analysis (86.6% vs 81.7%; HR 0.66). A post-hoc analysis restricted to T2N0 disease, the smallest node-negative subgroup in the trial, demonstrated the same pattern, with a 5-year OS of 93.3% versus 89.2%. If OS benefit is demonstrated in the patients with the smallest amount of disease, there is no biological reason it would not extend to a patient with a high-risk T1c lesion. Other checkpoint inhibitor trials have directly enrolled T1cN0 disease, and their subgroup data reinforce this. Neo-N, a nivolumab-based, non-anthracycline-containing neoadjuvant TNBC trial that included cT1cN0, reported 48.6% pathologic complete response (pCR) in that subgroup versus 54.9% in stage II. NeoPACT (pembrolizumab) reported 69% pCR in its stage I subgroup (n=14) versus 58%-60% in the overall study also with a non-anthracycline-containing regimen. neoMono (atezolizumab), which enrolled TNBC >10 mm, reported pCR of 100%/90% (PD-L1-positive) and 66%/76% (PD-L1-negative) in its prespecified cT1cN0 subgroup. GeparNuevo (durvalumab) included patients with cT1b-cT4 disease, 52% node-negative, and showed an overall trial-wide pCR of 53.4% with durvalumab versus 44.2% with placebo. The ongoing SCARLET (SWOG S2212) excludes node-negative T1c disease, even as earlier-phase data argue this population should be included. Overtreatment is a legitimate concern here, given the toxicity and cost of checkpoint inhibition, but there remains an opportunity with future trials, such as biomarker-based selection (sTILs) that includes this population, not blanket exclusion, particularly when the alternative is withholding a therapeutic approach with a demonstrated mortality benefit.

ORAL SERDS IN EARLY BREAST CANCER: WHERE TO NOW?

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Despite standard adjuvant endocrine therapy, patients with HR+/HER2- early breast cancer can still recur. CDK4/6 inhibitors (abemaciclib, ribociclib) can further reduce residual risk. Oral selective estrogen receptor down regulators (SERDs) remain under clinical investigation, and the ongoing trials differ in design such that they are answering different clinical questions.

Upfront trials. lidERA (NCT04961996) is the first trial with an oral SERD to read out. In the trial, clinical benefit was demonstrated with an oral SERD. In lidERA, 4,170 participants were randomly assigned upfront after surgery to giredestrant 30 mg daily versus physician's-choice endocrine monotherapy. CDK4/6i was not part of the regimen. Giredestrant reduced invasive recurrence or death by 30%, with a 3-year invasive disease free survival rate of 92.4% vs. 89.6% at a 32.3-month median follow-up. CAMBRIA-2 (NCT05952557) also randomizes upfront (~5,500 patients) to camizestrant versus standard of care endocrine therapy but permits abemaciclib in both arms at investigator discretion in a subgroup of patients.

Switch trials. CAMBRIA-1 (NCT05774951), EMBER-4 (NCT05514054), and ELEGANT (NCT06492616) each use a late-switch design in patients who have already completed a defined period of adjuvant endocrine therapy (2-5 years, $\pm$ CDK4/6i) and are recurrence-free. Participants are randomly assigned to switch to a SERD (camizestrant, imlunestrant, or elacestrant, respectively) or continue standard of care.

Biomarker-triggered trial. TREAT ctDNA (EORTC 2129-BCG, NCT05512364) takes a different approach. Participants undergo serial ctDNA surveillance on standard endocrine therapy, and only those who have ctDNA-positivity with no radiographic metastasis are randomly assigned to elacestrant versus continued SOC endocrine therapy. Approximately 1,960 patients will undergo ongoing ctDNA with bespoke testing every 6 months, with 220 participants randomly assigned. The primary endpoint is distant metastasis-free survival.

In this talk, the oral SERD landscape will be contextualized alongside CDK4/6 inhibitors in current adjuvant practice, including how their differing designs could shape where each agent might ultimately fit.

THE MCGRATH MODEL OF CARE AND THE LIVING WELL FRAMEWORK

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Introduction: The cancer nursing workforce is the largest involved in the delivery of cancer care in Australia, and there has been significant investment in specialist cancer nursing roles in recent years through the Australian Cancer Nursing and Navigation Program. To ensure equitable access to coordinated and high-quality supportive nursing care, the McGrath Foundation developed the McGrath Model of Care that can be universally applied to all cancer types regardless of the persons stage of cancer treatment or the nurse's location. **Methods:** A co-design process was undertaken to develop the McGrath Model of Care which involved listening to and learning from people with a lived experience of cancer, their carers, and clinicians who provide direct care to people with cancer. During this co-design process, themes around survivorship were thoroughly examined, with findings underpinning the implementation of supportive cancer nursing care actions that promote people to live well at whatever stage of care they are in. **Results:** A framework for *Living Well* was created which embraces holistic and person-centred care from diagnosis onwards. The Framework outlines people affected by cancers' desire to have care that encompasses management of disease and treatment symptoms and side effects, quality of life through independence and peer connection, timely information provision, and connection and trust with their care team. People with a diagnosis of advanced cancer particularly expressed feeling excluded from traditional survivorship models of care and emphasized the desire to having concepts of *Living Well* included within their treatment and care plans. **Conclusion:** The McGrath Model of Care is developing a theoretical base in this field of literature to support the living well framework. The *Living Well* Framework is a holistic approach to cancer care that prioritizes a patient's physical, emotional, and social needs as well as quality of life alongside clinical care.

RECOMMENDATIONS FROM ABORIGINAL AND TORRES STRAIT ISLANDER WOMEN DIAGNOSED WITH BREAST CANCER FOR IMPROVED FEAR OF CANCER RECURRENCE CARE

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Little is known about optimal management of fear of cancer recurrence (FCR) among Aboriginal and Torres Strait Islander people. This qualitative study aimed to identify recommendations and strategies for improving FCR care from discussions with Aboriginal and Torres Strait Islander women with breast cancer. Aboriginal and Torres Strait Islander women with breast cancer were recruited via Breast Cancer Network Australia (BCNA) and support networks. Semi-structured interviews focused on recommendations related to FCR screening, information and support, and cancer care team support were conducted via telephone with Aboriginal and Torres Strait Islander women with breast cancer. Thematic analysis was conducted on the resulting interview transcripts. Eight women took part in the interviews. Six themes were developed, four documenting specific recommendations for improving FCR care. The themes identified were the following; 1) Fear of cancer recurrence, a pervasive concern; 2) Routine FCR screening; 3) Information to overcome the unknown; 4) Coping strategies and support for addressing FCR; 5) Improved relationships and communication with the cancer care team; and 6) Address system barriers that hinder access to support and care. This research highlights key issues that cancer services need to address to ensure Aboriginal and Torres Strait Islander women with breast cancer have access to FCR support that is culturally safe and responsive. Larger co-designed studies are needed to develop and implement strategies for routine FCR screening, support for Indigenous staff, culturally relevant communication training for health professionals, and improved care co-ordination in clinical practice.

DEBATE: THAT cT1cN0 TNBC SHOULD HAVE NEOADJ CT AND IO: NO

Alistair Ring

Royal Marsden Hospital NHS Foundation Trust, London, UK

Neoadjuvant systemic therapy is a routine standard of care, supported by a number of national and international guidelines for patients with triple negative breast cancer where tumours are more than 2cm or with axillary lymph node involvement (stage II and III). However, this debate proposes that neoadjuvant systemic therapy, may also extend to patients with smaller ($>10\text{mm}$ T1c $\leq 20\text{mm}$) node negative tumours. The stated rationales to give NACT are to facilitate breast conserving/axillary conserving surgery, enable early systemic therapy delivery, tailor (post-operative) treatment according to response and to enable time for genetic testing results to become available. It will be argued that in the setting of small node negative breast cancers, pre-operative downsizing of tumours will rarely influence surgical approach, except in those rare cases with a high tumour to breast ratio/suboptimal tumour location. Perhaps most importantly a significant proportion of patients with T1c N0 breast cancer may not need systemic therapy at all or may be treated with abbreviated taxane-only regimens. In contrast the existing evidence base for neoadjuvant immunotherapy (approved for patients with cT2 N0 or node positive early breast cancer) involves prolonged anthracycline-taxane-carboplatin-pembrolizumab combination therapy. This regimen has quite significant short and long-term toxicities and will be non-evidence-based, significant over treatment for most patients with cT1cN0 early breast cancer. In patients who require genetic testing offering pre-operative systemic therapy does enable time for genetic testing results to be available prior to definitive surgery. However, the majority of patients with TNBC do not have an underlying germline mutation, and even if they do, patients may well not choose to have immediate risk reducing surgery (including reconstructive surgery) post neoadjuvant systemic therapy. The most compelling argument for neoadjuvant therapy is as a measure of in vivo chemosensitivity. Patients who achieve a pathological complete response may be reassured that their risk of recurrence is low. (Although if one has chosen the neoadjuvant route these patients still receive ongoing systemic therapy (including pembrolizumab)). Patients who do not achieve a pathological complete response may be offered additional/escalated adjuvant therapy: ongoing pembrolizumab, capecitabine or Olaparib. However, the majority of patients with cT1N0 breast cancer treated with neoadjuvant systemic therapy would achieve a pathological complete response. Exposure of all cT1cN0 patients to toxic neoadjuvant systemic therapy in order to identify the few who may merit escalated post-operative systemic therapy (from which they may or may not benefit) would be to risk widespread over-treatment.

DEBATE: THAT ALL STAGE 2/3 TNBC PATIENTS SHOULD BE TREATED ACCORDING TO KEYNOTE 522 REGIMEN: NO

Alistair Ring

Royal Marsden Hospital NHS Foundation Trust, London, UK

Immunotherapy including anti-PD1 and anti-PDL-1 therapies have had a significant impact on the management of a number of malignancies, including melanoma, lung and urological malignancies. Pembrolizumab and Atezolizumab also have approval in some parts of the world for the first line treatment of PDL-1 positive triple negative metastatic breast cancer. Following the publication of the KEYNOTE 522 trial, the addition of Pembrolizumab onto a backbone chemotherapy of paclitaxel, carboplatin and anthracycline has become a guideline-supported established standard of care internationally. According to the regimen all patients receive pembrolizumab for 1 year irrespective of pathological response. It will be argued that in this setting up to 50% of patients may achieve a pathological complete response with conventional cytotoxic treatment, usually comprising an anthracycline and taxane with or without a platinum. It will be debated whether the incremental benefit seen with Pembrolizumab is sufficient to justify routine use, given the attendant short and long-term toxicities, and high financial cost. We will review which patients, based on the clinical trial data, will benefit, and which may not. This will clearly need to take into account that a significant proportion of patients may have a good outcome with chemotherapy alone: and may not benefit from Pembrolizumab at all, or (in those achieving a pathological complete response) may

not benefit from continuing pembrolizumab post-operatively. It will also be argued that in those patients who do not achieve a pathological response, continuing pembrolizumab (as per Keynote 522) may not be the best strategy. Switching to capecitabine, olaparib and clinical trials may all be preferable approaches. Overall, the debater will argue that whilst the results of the trials to date are impressive, following the Keynote 522 regimen should not be regarded as a standard of care for all patients and alternative strategies are available.

THE ROLE OF MOLECULAR TESTING TO ADAPT BREAST CANCER TREATMENT

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Molecular testing has become an essential component of the management of metastatic breast cancer (MBC), enabling precision oncology approaches that improve patient selection for targeted therapies and monitoring of response with the potential to improve clinical outcomes. Advances in genomic technologies, including next-generation sequencing (NGS) of tumour tissue and circulating tumour DNA (ctDNA), have expanded the identification of actionable molecular alterations across breast cancer subtypes. Current international guidelines recommend biomarker assessment in metastatic disease not only for established predictive markers such as oestrogen receptor (ER), progesterone receptor (PR), and HER2, but also for a growing range of genomic aberrations with therapeutic relevance. This talk with focus predominantly on the role of molecular testing for somatic mutations in the setting in hormone receptor-positive (HR+)/HER2-negative MBC and will be divided into two sections: identification of therapeutic targets and monitoring of treatment response. *Identification of therapeutic targets:* molecular testing to identify therapeutic targets is well established, but practical questions remain as to what samples should be tested (tissue vs blood), which patients to test and when to test. There are an (increasing) number of relevant targetable mutations including PIK3CA/PTEN/AKT mutations as well as the less common targetable mutations such as HER2 mutations and somatic BRCA mutations. *Monitoring of treatment response:* there is a significant potential role for ctDNA as a minimally invasive method for serial monitoring of tumour response, evolution and detection of resistance mechanisms. There are now a number of studies which show that the reduction in ctDNA after starting systemic therapy correlates with improved outcomes. These observations may have implications for clinical practice and for future trial design. Emerging data also show that that serial ctDNA monitoring can detect molecular progression before conventional imaging. This observation led to the SERENA-6 trial, which investigated whether changes in systemic therapy in the context of molecular progression (but in the absence of radiological progression) could impact breast cancer outcomes. Despite these obvious advances, there remain challenges associated with molecular testing regarding test accessibility, cost-effectiveness, interpretation of genomic findings and integration into routine clinical practice. In conclusion, molecular testing has transformed the therapeutic landscape of metastatic breast cancer by facilitating personalised treatment strategies. As the repertoire of actionable biomarkers continues to expand, comprehensive and timely molecular profiling is increasingly central to improving outcomes in advanced breast cancer.

ADDRESSING FEAR OF CANCER RECURRENCE IN PRACTICE: FROM EVIDENCE TO EVERYDAY CARE

Ben Smith

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Fear of cancer recurrence (FCR), defined as the fear that cancer may return or progress, is the most commonly reported unmet supportive care need among people affected by cancer. Moderate to severe FCR affects up to 60% of people affected by cancer and is associated with poorer psychological wellbeing, reduced quality of life and increased healthcare utilisation. With an estimated 1.6 million Australians currently living with and beyond cancer, projected to increase to 2.6 million by 2050, FCR represents a growing challenge for the cancer workforce. Over the past decade, substantial progress has been made in the development of validated screening tools and evidence-based interventions for FCR. However, translating this evidence into routine clinical practice remains challenging. Many health professionals report uncertainty about how to initiate conversations about recurrence fears, recognise clinically significant FCR, and provide appropriate support or referral within the constraints of busy clinical settings. To address this gap, Canadian clinical practice guidelines for FCR were recently complemented by the development of an Australian clinical pathway for FCR screening, assessment, and stepped care support. The pathway was developed through a national Delphi study involving almost 100 Australian clinicians and researchers and identified key barriers, enablers and implementation strategies to support uptake in routine care. Building workforce confidence and capability to address FCR was identified as a critical implementation priority. In response, a multidisciplinary team of researchers, clinicians and consumers developed a freely available online training module, supported by The Daffodil Centre, McGrath Foundation, Peter MacCallum Cancer Centre, and Cancer Institute NSW, which is now hosted on eviQ Education

<https://education.eviq.org.au/courses/addressing-fear-of-cancer-recurrence-in-clinical-p>. The training provides practical guidance on identifying, assessing and managing FCR, including culturally responsive approaches for First Nations peoples and culturally and linguistically diverse communities, illustrated through real-world case studies. An evaluation involving Australian oncology health professionals found the training was highly acceptable and led to significant improvements in participants' knowledge, confidence and perceived ability to deliver pathway-aligned care. This presentation will translate the latest evidence into practical actions that can be implemented immediately in clinical practice. Attendees will learn how to recognise signs of FCR, use brief evidence-based approaches to assess severity, initiate supportive conversations, and determine when referral for specialised care is required. Participants will leave with greater confidence and practical strategies to better support people living with fear of cancer recurrence across the cancer continuum.

SURVIVORSHIP MODEL OF CARE BASED AROUND NURSE LED CLINICS

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Problem statement: Advances in cancer treatment have significantly improved breast cancer survival, with the global median five-year survival rate reaching 77.8%¹ and the Australian five-year survival rate 92.7%.² However, unmet needs among cancer survivors, particularly breast cancer survivors (BCSs), remain a significant concern.³ Despite extensive evidence documenting the unmet needs of BCSs, survivorship services remain limited and multidisciplinary care underutilised, creating a growing gap between survivor needs and health system capacity.⁴

Aim: To describe the implementation of a nurse-led survivorship model of care that provides tailored support according to individual needs, risk profiles, and available health system resources. **Model of Care:** The survivorship model has been implemented within the Mater Statewide Cancer Survivorship Service in Queensland, Australia, to support the delivery of stratified, person-centred survivorship care. The model directs survivors to the most appropriate level of care based on risk, self-management capability, and unmet needs identified through patient-reported outcome measures (PROMs). The model comprises four complementary pathways. A nurse transition service supports patients identified as low risk who primarily require education,

information, and preparation for self-management following completion of active treatment. Nurse-led care provides specialist assessment, intervention, education, and self-management support. Nurse-enabled care facilitates timely access to multidisciplinary expertise when needs extend beyond the nursing scope of practice. Nurse navigation coordinates care and prioritises access to services when specialist resources are constrained, helping patients connect with the most appropriate physical and community-based supports. Structured survivorship PROMs underpin the model by systematically identifying unmet needs and informing allocation to the most appropriate care pathway. Implementation data from the service illustrate patient stratification, pathway utilisation, and the distribution of supportive care needs identified through PROM assessment. **Impact:** The model shifts survivorship care beyond traditional disease surveillance towards proactive management of the physical, psychological, and practical consequences of cancer and its treatment. By matching service intensity to patient need, the model supports self-management among low-risk survivors while facilitating timely access to nursing and multidisciplinary care for those with more complex needs. It also supports more efficient utilisation of limited survivorship and specialist healthcare resources. **Conclusion:** A stratified nurse-led survivorship model incorporating transition, nurse-led, nurse-enabled, and navigation pathways offers a flexible and scalable approach to delivering person-centred care. Guided by PROM-based needs assessment, the model aligns support with individual needs and risk profiles, facilitating the transition from active treatment to survivorship while promoting efficient use of health system resources. The model provides a practical and scalable framework that is adaptable to diverse cancer survivorship services and healthcare systems internationally.

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FREE PAPER PRESENTATION ABSTRACTS

THE RELATIONSHIP BETWEEN PRIOR MENOPAUSAL HORMONAL THERAPY AND BREAST CANCER SUBTYPES, ENDOCRINE SYMPTOMS AND ENDOCRINE THERAPY OUTCOMES: A RETROSPECTIVE COHORT STUDY

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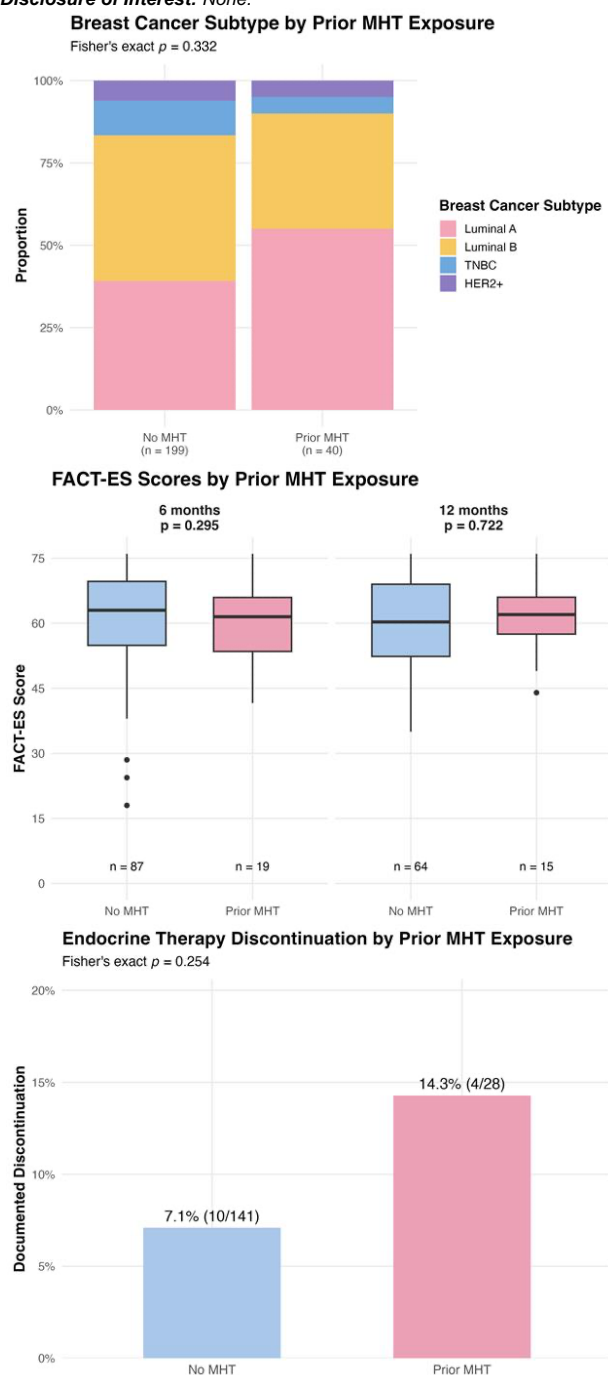
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Problem statement: Menopausal hormonal therapy (MHT) is widely used for menopausal symptoms and has been associated with increased breast cancer risk. Less is known about whether prior MHT exposure is associated with breast cancer subtype, post-treatment endocrine symptoms, or subsequent endocrine therapy uptake and continuation. **Methods:** This retrospective cohort study included women aged ≥18 years diagnosed with breast cancer at a tertiary hospital in Melbourne, Australia between February 2023 and February 2025. Patients with unknown MHT status or non-invasive disease were excluded. Associations between MHT exposure and breast cancer subtype were assessed using Fisher's exact test and multinomial logistic regression adjusted for age and smoking status. Endocrine symptoms and wellbeing were assessed using the Functional Assessment of Cancer Therapy - Endocrine Symptoms (FACT-ES) questionnaire at 6 and 12 months. Group differences were analysed using Wilcoxon rank-sum tests and longitudinal trajectories using a linear mixed-effects model. Exploratory analyses assessed endocrine therapy uptake and documented continuation at last available follow-up. **Results:** The primary analysis included 239 patients (40 with prior MHT

exposure and 199 without). MHT exposure was not associated with breast cancer subtype ($p = 0.332$), including after adjustment for age and smoking status. FACT-ES scores were similar between MHT and non-MHT groups at 6 months (median [interquartile range], 61.5 [53.5–66.0] vs 63.0 [54.9–69.6]; $p = 0.295$) and 12 months (62.0 [57.5–66.0] vs 60.3 [52.4–69.0]; $p = 0.722$), with no evidence of differing trajectories over time. Endocrine therapy uptake was similar (72.5% vs 73.0%; odds ratio [OR] 0.98, 95% confidence interval [CI] 0.44–2.33; $p = 1.00$). Among 169 patients with known continuation status, discontinuation was more frequent with prior MHT exposure (14.3% vs 7.1%), although this was not statistically significant (OR 2.17, 95% CI 0.46–8.34; $p = 0.254$).

Conclusion: Prior MHT exposure was not associated with breast cancer subtype, post-treatment endocrine symptom burden, endocrine therapy uptake or documented endocrine therapy continuation. These findings provide a foundation for future research to better understand the relationship between prior MHT exposure, breast cancer characteristics, post-treatment wellbeing and long-term endocrine therapy outcomes.

Disclosure of Interest: None.



PATTERNS AND VARIATION IN BREAST RECONSTRUCTION TYPE FOLLOWING MASTECTOMY IN AUSTRALIA AND AOTEAROA NEW ZEALAND USING THE BREASTSURGANZ QUALITY AUDIT

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Problem statement: Breast reconstruction following mastectomy is increasingly utilised, yet variation in reconstructive practice and access persists across health systems. In 2023, the Breast Surgeons of Australia and New Zealand (BreastSurgANZ) Quality Audit (BQA) introduced dedicated breast reconstruction data fields capturing reconstruction type and technique, enabling detailed evaluation of reconstructive practice across Australia and Aotearoa New Zealand (AoNZ). This study evaluated national patterns of breast reconstruction and factors associated with variation in reconstruction type according to sociodemographic, clinical, and health-system characteristics. **Methods:** A retrospective cohort study was conducted using BQA data and included women diagnosed with breast cancer between 2023 and 2024 who underwent immediate or delayed post-mastectomy breast reconstruction. Breast reconstruction characteristics, including reconstruction type, implant location, reconstructive method, autologous flap type, and contralateral procedures, were evaluated according to jurisdiction, patient age, socioeconomic status, remoteness, insurance status, and surgeon caseload. **Results:** A total of 2555 patients undergoing breast reconstruction were included (Australia, $n = 1951$; AoNZ, $n = 604$). Prosthetic reconstruction was the predominant reconstructive modality in both countries (Australia, 58.4%; AoNZ, 56.1%), followed by autologous reconstruction, which was more frequent in AoNZ (34.3% vs. 27.8%). Implant-based reconstruction method also differed between countries, with direct-to-implant reconstruction predominating in Australia (61.9%), whereas tissue expander reconstruction was more common in AoNZ (51.5%). Among autologous reconstructions, the Deep Inferior Epigastric Perforator (DIEP) flap was the predominant autologous flap in both countries, accounting for 80.2% of procedures in Australia and 62.8% in AoNZ, although latissimus dorsi flaps accounted for a greater proportion of autologous procedures in AoNZ (15.1% vs. 5.3%). Breast reconstruction type demonstrated substantial variation according to jurisdiction, treating hospital remoteness, socioeconomic status and surgeon caseload, with autologous reconstruction performed more frequently in metropolitan hospitals, among patients from higher socioeconomic groups, and by surgeons with higher annual breast surgery caseloads. **Conclusion:** Substantial variation in breast reconstruction practice was observed across Australia and Aotearoa New Zealand according to patient and health-system factors. These findings identify opportunities to improve equitable access to breast reconstruction across Australia and Aotearoa New Zealand.

Disclosure of Interest: None to declare.

WHAT DRIVES SUPPLEMENTAL SCREENING? A DISCRETE CHOICE EXPERIMENT ON WOMEN'S PREFERENCES AND UPTAKE FOLLOWING BREAST DENSITY NOTIFICATION

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Problem statement: High breast density is an independent risk factor for breast cancer and reduces mammogram sensitivity, prompting a global shift toward routinely notifying women of their breast density. While breast density notification aims to support informed decisions regarding supplemental screening (e.g., ultrasound, magnetic resonance imaging, or contrast-enhanced mammogram), patient uptake depends on personal preferences which are not yet fully understood. This study aims to quantitatively examine women's values and preferences for supplemental

screening following breast density notification. **Method:** An online discrete choice experiment with women eligible for breast cancer screening aged 40 to 74 years. Participants completed a series of choice tasks, asking them to choose between three scenarios: two hypothetical supplemental screening options, or an 'opt-out' (no screening) alternative. Each screening option described the imaging modality, additional cancer detected, chance of false-positive, supplemental screening interval and the environmental impact of screening. Preferences were quantified using conditional logit, latent class analysis and willingness-to-pay. **Results:** On average, the 974 women showed a strong willingness to participate in supplemental screening ($p < 0.001$) and valued increased cancer detection most highly (willingness-to-pay: AU\$361). However, there was significant heterogeneity in preferences, revealing six distinct patient preference classes for supplemental screening. Under private-billing conditions, women prioritized affordability over cancer detection yield; ultrasound had the highest predicted uptake (34.5%), followed by CEM (26.6%) and MRI (20.8%), while 18.1% opted-out of supplemental screening. However, under a fully subsidized model (\$0 out-of-pocket costs), preference shifted toward cancer detection yield and MRI became the preferred choice (40.3%), while ultrasound and opt-out rate decreased to 23.4% and 7.9%, respectively. **Conclusions:** While women generally value the increased cancer detection afforded by supplemental screening, their preferences are heterogeneous. A successful clinical pathway will need to adopt a preference-sensitive approach; however, the benefits of shared decision-making may be limited if supplemental screening remains financially out of reach. To ensure equitable access to supplemental screening, appropriate funding is required to prevent disparities in supplemental screening uptake among women with dense breasts.

LYMPHOEDEMA PREVALENCE AFTER AXILLARY LYMPH NODE DISSECTION FOR BREAST CANCER IN THE DE-ESCALATION ERA

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Problem statement: Breast cancer remains a commonly diagnosed malignancy and whilst survival outcomes have significantly improved, breast cancer-related lymphoedema following axillary node dissection (ALND) continues to pose a substantial burden on survivorship. Despite broader shifts in practice toward axillary de-escalation in breast cancer surgery, ALND remains indicated for select patients, especially those with extensive nodal disease or residual disease post-neoadjuvant systemic therapy. Historical lymphoedema rates may not reflect current practice due to these changes in patient selection. This study aimed to benchmark contemporary prevalence and severity of lymphoedema following ALND and identify associated risk factors. **Methods:** Retrospective cohort study of patients with locally advanced node-positive breast cancer who underwent ALND alongside breast-conserving surgery (BCS) or mastectomy between 2021 and 2025 at a single tertiary institution. Lymphoedema was diagnosed using a composite definition incorporating both clinical diagnosis (arm circumference, bioimpedance spectroscopy) and/or patient self-report (validated Norman Questionnaire). The primary outcome was the presence of upper limb lymphoedema at any time during at least 12 months of follow-up. Univariate and multivariable analyses were performed to identify risk factors. **Results:** One hundred patients were included, of whom 28 (28%) developed lymphoedema based on the composite outcome. Norman-defined lymphoedema was identified in 25 patients with a substantial proportion classified as moderate-severe (52%). On univariate analysis, BMI, tumour grade, radiotherapy and chemotherapy were associated with lymphoedema ($p < 0.20$). On multivariable analysis, no factors reached statistical significance; however, adjuvant chemotherapy,

BMI ≥ 30 and regional radiotherapy demonstrated non-significant trends toward increased risk. **Conclusion:** Lymphoedema remains a clinically significant complication in patients requiring ALND, with a substantial proportion of affected patients experiencing moderate-severe symptoms. Although no independent predictors were identified, treatment-related factors showed the strongest association with lymphoedema risk. As these largely reflect underlying disease burden and are not readily modifiable, targeted preventative strategies, including immediate lymphaticovenous anastomosis, warrant consideration.

Disclosure of interest: Authors declare no conflicts of interest.

DOSIMETRIC COMPARISON OF INCIDENTAL SENTINEL LYMPH NODE IRRADIATION WITH WHOLE BREAST VERSUS PARTIAL BREAST RADIOTHERAPY

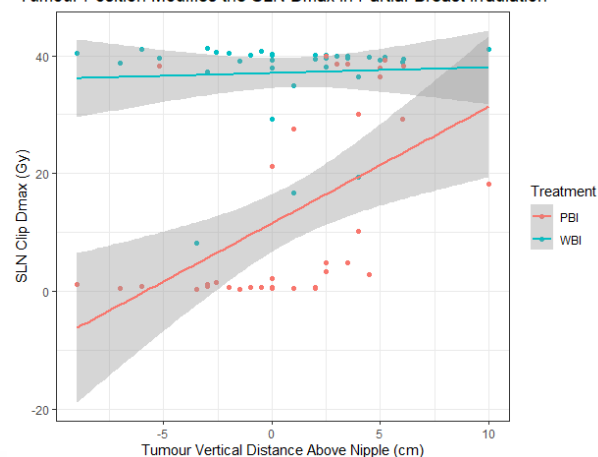
Luke Kissane¹, Kirsty Stuart¹, Verity Ahern¹, Najmun Nahar¹, Liam O'Brien¹, Teresa Chim¹, Sabrina Naz², Tim Wang¹

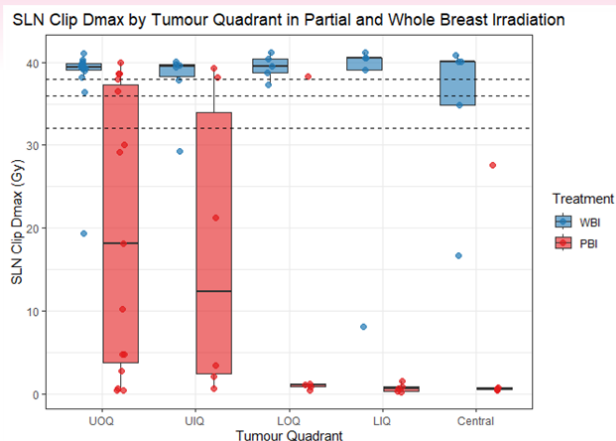
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Problem statement: Treatment de-escalation strategies for early breast cancer include omission of the sentinel lymph node (SLN) biopsy and partial breast irradiation (PBI). Incidental irradiation of the axilla during whole breast radiation (WBI) may contribute to axillary nodal control when SLN biopsy is omitted. Similarly, PBI may reduce incidental SLN irradiation and potentially compromise this effect. **Methods:** Thirty-five patients with T1N0 breast cancer and a surgical clip marking the excised SLN bed, who were treated with adjuvant WBI (40 Gy in 15 fractions), were identified from the radiotherapy treatment planning system. Primary tumour location was converted from ultrasound-recorded clock-face position and distance from the nipple to Cartesian coordinates centred on the nipple. Each patient was replanned using tangential IMRT-based PBI. Dose-volume histogram (DVH) metrics for the SLN clip and axillary nodal levels were compared between WBI and PBI using paired Wilcoxon signed-rank tests. The influence of tumour location on dosimetric differences was assessed using mixed-effects modelling. **Results:** PBI resulted in significantly lower incidental doses to the SLN clip and axillary nodal levels compared with WBI across all examined DVH metrics (all FDR-adjusted $p < 0.001$). Mixed-effects modelling estimated a mean WBI-PBI difference of 25.5 Gy for the SLN clip maximum radiation dose (Dmax) ($p < 0.001$). Tumour position significantly modified this treatment effect. For each centimetre increase superior to the nipple there was an associated reduction in the WBI-PBI difference for SLN clip Dmax (-1.88 Gy/cm, FDR-adjusted $p = 0.024$) and SLN clip Dmean (-1.72 Gy/cm, FDR-adjusted $p = 0.033$). Similar location-dependent effects were observed for axillary level 1 mean dose and axillary level 2 Dmax (both FDR-adjusted $p = 0.022$). No significant treatment-by-quadrant interactions remained after correction for multiple comparisons. **Conclusion:** PBI significantly reduces incidental irradiation of the SLN and axilla compared with WBI. Continuous spatial measures of tumour location better predicted nodal dose differences than quadrant-based classification. These findings raise concern regarding potential under-treatment of regional lymph nodes when PBI is combined with omission of SLN biopsy and highlight the need for further investigation of the oncological safety of this dual de-escalation strategy.

Tumour Position Modifies the SLN Dmax in Partial-Breast Irradiation





CLIPPING THE CAVITY – ARE SURGEONS AND RADIATION ONCOLOGISTS ON THE SAME PAGE?

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Problem statement: Accurate tumour bed delineation is essential for radiotherapy tumour bed boost and partial breast irradiation techniques after breast conservation surgery. Oncoplastic techniques may displace and distort the tumour bed, whereas surgically placed fiducial cavity markers can improve tumour bed delineation. Anecdotally, radiation oncologists have been quite keen for cavity marking to become routine, however there is large variation in surgical practice across Australia and New Zealand. This study explores radiation oncologist preferences, surgical practice, and their rationales. **Methods:** A cross-sectional online survey of breast surgeons and radiation oncologists in Australia and New Zealand presented clinicians with multiple clinical scenarios of varying oncoplastic complexity to determine cavity marking practices of surgeons and preferences of radiation oncologists. Responses were aggregated and interdisciplinary concordance was measured with pairwise acceptance criteria. **Results:** 50 surgeons and 31 radiation oncologists responded to the survey. Metallic haemostatic clips were the only fiducial cavity marker used or encountered by respondents, and various techniques are suggested to differentiate these from clips for haemostasis. Routine cavity marking was supported by 70% of surgeons and 90% of radiation oncologists. Surgeons' marking strategies varied widely between surgeons and between cases. 53% of radiation oncologists preferred combination radial and deep marking of the breast parenchyma and chest wall. Overall concordance between surgeon and radiation oncologist strategies was 28% and declined with increasing surgical complexity (26-33%). While there are differences between practitioner groups from different location, settings, seniority, and practice throughput, correlating these demographic variables did not improve concordance. **Conclusion:** Substantial variation exists in tumour bed marking practices across Australia and New Zealand, with limited alignment between surgeons and radiation oncologists, particularly following oncoplastic surgery. Greater interdisciplinary standardisation of cavity marking and documentation may improve radiotherapy planning and patient outcomes.

Disclosures: There are no conflicts of interest to disclose.

THE TWO-YEAR AUSTRALIAN AND NEW ZEALAND TARGETED AXILLARY DISSECTION REGISTRY: FINAL RESULTS

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Problem statement: Targeted axillary dissection (TAD) has emerged as a preferred method of axillary staging following neoadjuvant systemic therapy (NAST) for patients with biopsy-proven node-positive breast cancer. While prospective studies have demonstrated excellent diagnostic accuracy, contemporary implementation and the impact of TAD on surgical decision-making across Australia and New Zealand has yet to be described. The Australian and New Zealand (ANZ) TAD Registry was established to evaluate real-world adoption, pathological response and evolving axillary management following NAST. **Methods:** The ANZ TAD Registry was a prospective multicentre registry of patients undergoing TAD after NAST across Australia and New Zealand. Consecutive patients enrolled during the first two years of the registry were analysed. Demographic, tumour, operative and pathological variables were collected, including localisation technique, clipped-node retrieval, treatment response and subsequent axillary management. **Results:** A total of 207 patients underwent TAD during the study period, with annual recruitment increasing by 15.6% (96 to 111 patients) and registry expansion to include centres in New Zealand. Node marking exceeded 95% and clipped-node retrieval remained consistently high (100% in Year 1 and 96.3% in Year 2 among marked nodes), demonstrating reliable implementation in routine clinical practice. Biological response differed according to tumour subtype, with axillary pCR rates highest in HR-/HER2+ (81%) and TNBC (63%), while Luminal subtypes (HR+/HER2-) demonstrated substantially lower response (13%). Within Luminal cancers, Ki67 greater than 50% was associated with a markedly higher axillary pCR rate than Ki67 ≤50% (60% versus 10.1%). Following complete axillary response, omission of further axillary treatment increased from 47.1% to 60.7% over the 2 years. In contrast, management of residual nodal disease remained heterogeneous, with varying use of axillary lymph node dissection, axillary radiotherapy and combined treatment strategies across participating centres. **Conclusion:** The Registry demonstrated successful implementation of TAD with increasing axillary de-escalation. However, marked differences in axillary pathological complete response between biological subtypes suggest tumour biology should inform patient selection for TAD rather than a generic approach. Persistent variation in the management of residual nodal disease highlights an important evidence gap requiring prospective longitudinal follow-up.

Disclosure of Interest: The authors declare no conflicts of interest.

STEREOTACTIC ABLATIVE BODY RADIOTHERAPY(SABR) DEFERS SYSTEMIC THERAPY CHANGE ACROSS BREAST CANCER SUBTYPES: REAL-WORLD OUTCOMES AND THE ROLE OF REPEAT SABR

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Problem statement: Oligoprogressive breast cancer may represent focal resistant clones in patients otherwise responding to systemic therapy (ST). SABR to progressing sites may allow ST continuation, delaying change to next-line treatment. The AVATAR trial demonstrated this benefit in ER+/HER2- breast cancer(1). Real-world data across broader populations and the role of repeat SABR remains limited. **Methods:** We performed a single-centre retrospective study of patients with metastatic breast cancer treated with SABR at Peter MacCallum Cancer Centre. Eligible patients received SABR to 1-5 extracranial metastatic lesions for oligoprogression. The primary endpoint was freedom from ST initiation/change at 6 months. Secondary endpoints included time to ST initiation/change, progression-free survival(PFS), overall survival(OS), time to treatment failure(TTF), toxicity, and repeat SABR before ST change. Outcomes were estimated using Kaplan-Meier methods. **Results:** Between February 2010 and December 2024, 105 patients underwent SABR to 142 lesions, most commonly bone/spine(n=95, 67%), liver(n=19, 13%) and lung(n=17, 12%). Most patients had ER+/HER2- disease(n=82, 78%). Median follow-up was 38 months. Freedom from ST change was 69%(95% CI:59-77) at 6 months and 44%(95% CI:35-53) at 12 months. Median time to ST change, PFS and OS were 10.3, 6.7 and 55.6 months, respectively. Distant progression was the dominant first failure pattern, with a cumulative incidence of 68% at 12 months and 82% at 24 months. Subsequent SABR for further

oligoprogression before ST change occurred in 16% by 12 months and 21% by 24 months. 23(22%) patients remained free from ST change beyond 18 months. This prolonged benefit subgroup included patients with ER+/HER2-(n=16), HER2+(n=5) and triple-negative disease(n=2). On multivariable analysis, bone only disease was independently associated with inferior PFS(HR 1.7 [95% CI:1.1-2.9],p=0.025). No clinicopathological factors were significantly associated with time to ST change. Grade 1/2 adverse events occurred in 28%. No grade 3/4 adverse events were recorded. **Conclusion:** In this real-world cohort, SABR deferred systemic therapy change by a median of 10.3 months, and durable benefit beyond 18 months in one in five patients. Benefit was seen across subtypes, extending the AVATAR signal beyond ER+/HER2- disease. SABR is a low-toxicity, repeatable strategy for preserving effective systemic therapy in oligoprogressive breast cancer, and warrants prospective evaluation in broader, biomarker-selected populations.

AN EVIDENCE-INFORMED FRAMEWORK FOR CO-DESIGNING A NATIONAL BREAST CANCER POLICY AND ADVOCACY STRATEGY

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Problem statement: Patient advocacy organisations play a critical role in influencing policy, improving healthcare, and representing consumer priorities. However, a key challenge in breast cancer policy is ensuring advocacy priorities reflect the diverse and sometimes competing perspectives of people affected by breast cancer, and key stakeholders. There is limited evidence describing systematic, evidence-informed approaches to developing organisational advocacy strategies that are co-produced with lived experience and integrated clinical, research and policy perspectives. As patient organisations increasingly influence health policy internationally, there is a need for transparent and transferable approaches to advocacy priority-setting that ensure consumers remain central to decision-making. **Methods:** Breast Cancer Network Australia (BCNA), Australia's leading breast cancer consumer organisation, developed a co-designed framework to inform its 2026–2030 Policy & Advocacy Strategy. The framework combines consumer partnership, evidence synthesis and national stakeholder engagement to ensure advocacy priorities are transparent, representative and responsive to emerging needs. A project working group, including Consumer Representatives, guided the design of a mixed-methods consultation process. An anonymous national online survey was co-designed with consumers following a rapid review. The survey explored priorities across the breast cancer continuum and health system reform. Quantitative findings were analysed descriptively and qualitative responses using thematic analysis. Findings were triangulated with targeted stakeholder consultations to establish strategic priorities. **Results:** The framework provides a structured approach to integrating lived experience with multidisciplinary stakeholder perspectives in organisational strategy development. It demonstrates how consumer partnership can extend beyond consultation to shape advocacy priorities, identify emerging policy issues and strengthen transparency and accountability in decision-making. The framework is adaptable across health systems, policy contexts, and diseases. Final survey and consultation findings will be presented at the conference. **Conclusion:** As breast cancer care continues to evolve, transparent approaches are needed to navigate competing priorities and ensure policy reflects the issues that matter most to people affected by breast cancer. This framework offers a practical model for organisations seeking to develop advocacy strategies through meaningful consumer partnership and broad stakeholder engagement. Embedding consumers throughout strategy development supports advocacy that is evidence-informed, transparent and responsive to community priorities.

Disclosure of Interest: None

CHANGES IN HER2 STATUS FOLLOWING NEOADJUVANT SYSTEMIC THERAPY: STABILITY OF HER2-LOW DISEASE AND IMPLICATIONS FOR ANTIBODY-DRUG CONJUGATE ELIGIBILITY

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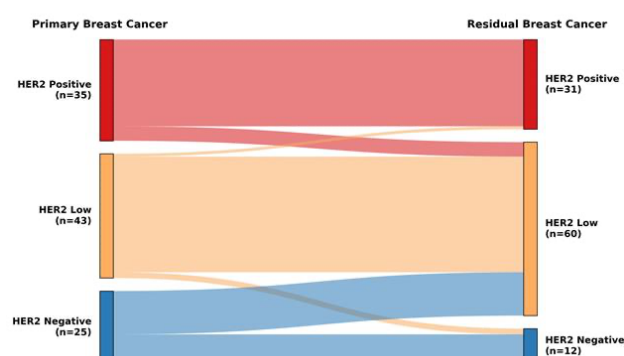
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Position statement: HER2 is an increasingly important therapeutic biomarker with the introduction of antibody-drug conjugates (ADCs) for HER2-low metastatic breast cancer. Although HER2 status is highly concordant between diagnostic core needle biopsy (CNB) and surgical specimens after upfront surgery, its stability following neoadjuvant systemic therapy (NAST) is less well defined. Biomarker conversion after NAST may affect eligibility for HER2-directed treatment. This study assessed HER2 concordance before and after NAST, with particular attention to HER2-low disease. **Methods:** We retrospectively analysed 242 patients with invasive breast cancer diagnosed through the BreastScreen NSW Sydney West program who received NAST between January 2018 and December 2023. Biomarker results from pre-treatment CNB were compared with those from post-treatment surgical specimens. Concordance for HER2, oestrogen receptor (ER), progesterone receptor (PR), Ki-67 and tumour grade was evaluated using percentage agreement and Cohen's kappa (κ). **Results:** HER2 status showed substantial concordance after NAST (77.7%, $\kappa=0.643$), with excellent agreement for ER (93.1%, $\kappa=0.808$) and substantial agreement for PR (86.1%, $\kappa=0.686$). HER2-low expression was highly stable: only three HER2-low tumours changed classification after NAST, with one converting to HER2-positive and two to HER2-negative. In contrast, 60% of HER2 negative tumours converted to HER2-low disease; while only 15% of HER2-positive tumours evolved into HER2-low disease after NAST. Tumour grade showed poor concordance (51.3%, $\kappa=0.163$) and Ki-67 demonstrated fair concordance (45%, $\kappa=0.212$), indicating greater instability of morphological than biological features. **Conclusion:** HER2 expression, including HER2-low status, demonstrated substantial stability following NAST. These findings support the reliability of pre-treatment HER2 assessment for therapeutic decision-making, while recognising that a small proportion of patients, particularly with HER2-negative disease, may undergo clinically relevant biomarker conversion.

Changes in HER2 Status Following Neoadjuvant Systemic Therapy



monarchE: PRIMARY OVERALL SURVIVAL (OS) RESULTS OF ADJUVANT ABEMACICLIB (ABEMA) + ENDOCRINE THERAPY (ET) FOR HR+, HER2-, HIGH-RISK EARLY BREAST CANCER (EBC)

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Problem statement: Two years (yrs) of adjuvant abema+ET demonstrated statistically significant and clinically meaningful improvement over ET alone in invasive disease-free survival (IDFS) and distant relapse-free survival (DRFS) in patients (pts) with HR+, HER2-, node-positive, high-risk EBC. Here, we report primary OS (secondary endpoint) and updated IDFS and DRFS.

Methods: monarchE is an open-label, randomized, phase 3 trial in pts with HR+, HER2-, high-risk EBC. Pts were randomized (1:1) to receive ET for at least 5yrs ± abema for the first 2yrs. High-risk EBC was defined as either ≥4 positive axillary lymph nodes (ALN), or 1-3 ALN + either Grade 3 disease and/or tumor ≥5cm (Cohort 1). Pts with 1-3+ ALN and central Ki67 ≥20% were enrolled to Cohort 2. The intent-to-treat (ITT) population consisted of Cohorts 1 (n=5120) and 2 (n=517). Hazard ratios (HRs) for efficacy endpoints were estimated using the cox proportional hazard model. The primary OS analysis was triggered by approx.~650 deaths in the ITT population to allow adequate follow-up time. **Results:** In the ITT population (median follow-up: 6.3yrs) 301 pts in the abema+ET and 360 pts in the ET arm had died. The addition of abema to ET reduced the risk of death by 15.8% vs ET (HR 0.84; 95%CI, 0.72–0.98; P = 0.027), meeting the prespecified boundary for significance. OS benefit was consistent across prespecified subgroups. IDFS and DRFS benefit persisted up to 7yrs (HR 0.73; 95%CI, 0.66–0.82 and 0.75, 0.66–0.84, respectively). At 7yrs, IDFS was 77.4% with abema+ET vs 70.9% with ET, and DRFS was 80.0% vs 74.9% (absolute benefit: 6.5% and 5.1% respectively). More pts in the ET arm (52%) received subsequent CDK4/6 inhibitors in any line metastatic setting than in the abema+ET arm (34%). In Cohort 1, IDFS, DRFS, and OS were consistent with the ITT population. Long-term safety data did not support concerns of delayed toxicities. **Conclusion:** The addition of 2yrs of adjuvant abema to ET resulted in statistically significant and clinically meaningful improvement in OS over ET in pts with HR+, HER2-, node-positive, high-risk EBC. At 7yrs, abema+ET demonstrated a sustained IDFS and DRFS benefit.

LIVING FLAT AFTER MASTECTOMY: AUSTRALIAN HEALTHCARE PROFESSIONALS PERSPECTIVES ON WOMEN'S SURGICAL CHOICES

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Problem statement: Flat closure after mastectomy, where women choose not to undergo breast reconstruction, is an increasingly

visible option within breast cancer care. Despite growing advocacy and awareness, women who choose to remain flat may encounter variable levels of support, information, and acceptance from health professionals. **Aim:** To explore healthcare professionals' perceptions of flat closure after mastectomy and their experiences supporting women who choose not to undergo breast reconstruction. **Methods:** A mixed-methods online survey was distributed to Australian healthcare professionals involved in surgical breast care. The survey examined attitudes toward flat closure, confidence in discussing surgical options, and perceived barriers to supporting women who choose to remain flat. Quantitative data were analysed using descriptive statistics, while free-text responses underwent content analysis. **Results:** A total of 100 responses were analysed from surgeons (48%) and nurses (52%) who had predominantly worked in surgical breast care for over five years (85% female). Most participants reported 'always' discussing flat closure as an option (79%) and were 'very or extremely confident' that patients received a timely and satisfactory flat closure finish (76%). Key barriers to supporting informed decision-making included lack of photos showing flat closure outcomes (23%), inadequate flat closure patient resources (18%), and concerns about the emotional impact of living without breasts (18%). Notably, 29% of participants were aware of instances where a patient's decision to remain flat was met with disapproval from the healthcare team. Qualitative findings highlighted broad acceptance of flat closure when based on informed patient choice, while emphasising the need for discussion of realistic outcomes based on body habitus. **Conclusions:** While health professionals recognised the importance of respecting women's autonomy, variability in knowledge, confidence, and access to resources may affect the support provided to women choosing to remain flat. The proportion of health professionals never providing patients with resources highlights the number of women who are being left out of discussion around options. Improving education, communication, and access to flat closure resources may help ensure women who choose to remain flat feel informed, respected, and supported throughout their breast cancer care.

THE CHANGING LANDSCAPE OF BREAST CANCER RECURRENCE RISK: CONTEMPORARY SUBTYPE-SPECIFIC PATTERNS FROM A POPULATION-BASED QUEENSLAND COHORT

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Problem statement: Current evidence on breast cancer recurrence is largely derived from cohorts diagnosed before widespread use of modern targeted systemic therapies. Recurrence patterns, predominantly informed by Early Breast Cancer Trialists' Collaborative Group (EBCTCG) meta-analyses and population-based studies, continue to shape perceptions of "high-risk" disease, yet may no longer align with real-world outcomes. We aimed to estimate how population-based recurrence risk has shifted by subtype in the modern treatment era. **Methods:** All Queensland women diagnosed with primary invasive breast cancer in 2017-2018 were ascertained through the Queensland Cancer Registry, which links with other data in the Queensland Oncology Repository (QOR), including pathology reports, hospital admissions, multidisciplinary team notes, treatment records, surgical procedure details, public radiology, and death certificates. Tumour characteristics, risk factors, treatment pathways, and outcomes were extracted from the QOR to form the BRAVE dataset. We then generated subtype-specific cumulative incidence curves using Kaplan-Meier estimates, adjusted for competing risks. **Results:** Overall, 7,141 women were diagnosed in the study period. Preliminary analysis of the first 1,821 women in BRAVE showed a five-year cumulative incidence of any first recurrence of 9.5%, including 5.4% distant recurrences. Non-luminal HER2-positive disease demonstrated a five-year cumulative incidence of any first recurrence of 10.7%, comparable to Luminal B (HER2-negative) disease (9.9%). Five-year cumulative incidence for triple-negative disease was 20.3% (with most in the first 2.5 years; Figure

1), whereas Luminal B (HER2-positive) and Luminal A disease showed similar recurrence patterns (8.0% and 6.2% at five years, respectively). **Conclusion:** These early findings suggest that contemporary recurrence patterns differ from historical estimates. EBCTCG meta-analyses, based on cohorts diagnosed before routine HER2 testing and standardised use of HER2-targeted therapy, shaped long-standing perceptions of “high-risk” disease through higher early recurrence rates in ER-negative tumours. In contrast, BRAVE estimates indicate that HER2-positive disease behaves more like luminal subtypes in contemporary practice, while triple-negative disease continues to dominate early recurrences. These estimates require confirmation in the full BRAVE cohort and other populations to inform updated, contemporary risk-stratification frameworks.

Disclosure of Interest: Associate Professor Nicole McCarthy: Novartis (Advisory Board, travel grant), Astra-Zeneca (Advisory Board), Menarini (Advisory Board), MSD (travel grant), Daiichi Sankyo (Advisory Board), and Eli Lilly (Advisory Board)

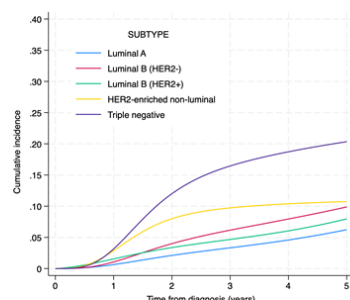


Figure 1: Cumulative incidence of all first breast cancer recurrences by subtype in Queensland women diagnosed with primary invasive non-metastatic breast cancer (N=1,790).
HER2, human epidermal growth factor receptor 2.

EVALUATING BREAST CANCER QUALITY INDICATORS IN YOUNG WOMEN (<45 YEARS) WITHIN A RURAL AUSTRALIAN HEALTH SERVICE - A RETROSPECTIVE CLINICAL AUDIT

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Background: Young breast cancer patients (<45 years) often present with aggressive tumour biology requiring complex, multimodal care. Delivering this in rural environment is challenging due to resource limitations and geographic isolation. This study reviews clinical performance at a regional Australian health service against National Breast Quality Audit (BQA) standards and international quality assurance benchmarks. **Methods:** A retrospective review was conducted of 56 consecutive patients under the age of 45 treated at rural regional hospital. We tracked performance across 13 Key Performance Indicators (KPIs) set by the BQA covering care coordination, systemic therapies, and surgical outcomes under a single-surgeon model. The diagnostic-to-surgery timeline was benchmarked at 45 days, matching validated Australian survival models. **Results:** Our health service, located within the Mid North Coast Local Health District NSW showed strong performance against national benchmarks across all core care domains. Compliance reached 100% for multidisciplinary team (MDT) discussions, Breast Care Nurse involvement, endocrine therapy, and post-lumpectomy radiotherapy. In high-risk cases, chemotherapy referrals achieved 97% compliance. Neoadjuvant chemotherapy (NAC) for triple-negative and HER2-positive disease was delivered to 79% of eligible patients (target ≥70%), outperforming real-world trends reported by Roberts et al.,¹ where only 23.9% of eligible women received upfront NAC due to lacking pre-treatment MDT reviews. Axillary staging compliance was 98% (target ≥90%). Immediate breast reconstruction after total mastectomy reached 100% for DCIS and 67% for invasive disease. While Pestana et al.² observed that young women heavily favour extensive surgeries despite equivalent survival with breast conservation, our cohort maintained a breast-conserving surgery rate of 62%. One main deviation emerged: the 45-day time-to-surgery target was met in only 64% of cases (target ≥90%), reflecting local diagnostic delays and long-distance patient travel. Interestingly, four contemporary metrics lack formal numerical targets under the BQA protocols, unlike European models³. This mirrors Osorio et al.⁴, who demonstrated

that missing specific quality targets in certified centres does not necessarily equate to worse oncological outcomes, but rather reflects local adaptation of multimodal care. **Conclusion:** This single-surgeon, specialist-trained rural model delivers high-quality breast cancer care that consistently meets national standards. Australian protocols should adopt formal numerical thresholds for modern quality indicators to minimise regional care gaps.

THE MASCC INTERNATIONAL HEALTHCARE PROFESSIONAL SURVEY OF CURRENT PRACTICES OF MANAGING BREAST CANCER-RELATED LYMPHOEDEMA AND LYMPHOEDEMA-RELATED CELLULITIS: AN ONGOING INTERNATIONAL STUDY

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Problem statement: Although recent evidence supports prospective surveillance, early diagnosis, and timely intervention, implementation of optimal BREAST CANCER-RELATED ARM LYMPHOEDEMA (BCRAL) care remains inconsistent worldwide. Variations in awareness, diagnostic criteria, healthcare resources, and insurance coverage create barriers to delivering standardized care. This international survey aims to characterize current practices in BCRAL diagnostic methods, interventions and prospective surveillance program, and to identify barriers, facilitators, and unmet needs across different healthcare settings. **Methods:** An international online survey is being conducted among regulated healthcare professionals involved in BCRAL care. The target sample size is 100–200 participants worldwide. The questionnaire collects information on participant demographics, BCRAL surveillance, diagnosis, treatment, and cellulitis management. The survey is available in five languages (English, Spanish, Traditional Chinese, Simplified Chinese, and Japanese). Data collection will continue until October 31, 2026. Ethical approval was obtained from the Hyogo Cancer Center Human Research Ethics Committee, Japan (Project No. R24-004). The survey link of the English version is as follows;

<https://forms.gle/uuUP8uaWZ6MRNRAJ9>. **Results:** As of July 15, 2026, 172 healthcare professionals from 30 countries had completed the survey. Participants were from Asia (108, 63%), Latin America (23, 13%), North America (17, 10%), Europe (13, 8%), Oceania (11, 6%), and Africa (0). Respondents included surgeons (63, 41%), massage/physical/occupational therapists (47, 31%), nurses (25, 16%), medical/clinical oncologists (6, 4%), radiation oncologists (6, 4%), physiatrists (5, 3%) and lymphedema specialist (1, 1%). Only 40 respondents (27%) reported having a prospective surveillance program for the early detection of BCRAL. Table 1 summarizes the diagnostic methods that participants reported were available for clinical lymphoedema (INTERNATIONAL SOCIETY OF LYMPHOLOGY (ISL) stage ≥I) and latent lymphoedema (ISL stage 0). Table 2 summarizes the intervention methods reported to be available for these conditions.

Conclusion: This ongoing international survey will provide valuable insights into current global practice patterns and barriers to optimal BCRAL management. The findings are expected to support the development of standardized, evidence-based care pathways for early detection, comprehensive management of

BCRAL, and prevention of lymphoedema-related cellulitis in breast cancer survivors. Healthcare professionals involved in BCRAL care are encouraged to participate before survey closure.

Table 1. Diagnosis methods participants can offer for clinical lymphoedema (ISL stage>= 1) or latent lymphoedema (ISL stage 0)

	Clinical lymphoedema (ISL stage>= 1) N(%)	Latent lymphoedema (ISL stage 0) N(%)	Not used/unavailable N(%)
Clinical Diagnosis	123 (90)	86 (63)	10 (7)
Tape measurement	118 (89)	74 (53)	9 (7)
Peritaps	0 (0)	0 (0)	95 (100)
Bioimpedance spectroscopy (BIS)	34 (32)	30 (28)	71 (66)
Lymphoscintigraphy	33 (31)	15 (14)	71 (66)
Magnetic resonance lymphangiography (MRL)	8 (9)	5 (5)	85 (90)
Indocyanine green (ICG) lymphangiography	33 (32)	20 (19)	70 (67)
Ultrasound	61 (55)	36 (33)	48 (44)
Computed Tomography (CT)	34 (37)	19 (21)	56 (61)
Perometry	10 (11)	9 (10)	81 (88)
Water displacement	5 (5)	3 (3)	88 (95)
Tonometry	4 (4)	4 (4)	88 (95)

Table 2. Intervention methods participants can offer for clinical lymphoedema (ISL stage>= 1) or latent lymphoedema (ISL stage 0)

	Clinical lymphoedema (ISL stage>= 1) N(%)	Latent lymphoedema (ISL stage 0) N(%)	Not used/unavailable N(%)
Education	132 (94)	121 (86)	4 (3)
Self-management education	130 (93)	116 (83)	6 (4)
Skin Care	134 (94)	119 (84)	3 (2)
Weight Management	116 (89)	100 (76)	12 (9)
Exercise	125 (93)	107 (80)	4 (3)
Bandaging	106 (86)	36 (29)	17 (14)
Compression Wrap	72 (71)	30 (29)	30 (29)
Compression Sleeve, Custom made	79 (74)	32 (30)	27 (25)
Compression Sleeve, Off the shelf	109 (86)	51 (40)	14 (11)
Manual Lymph Drainage (MLD)	111 (87)	54 (43)	15 (12)
Compression Pump	41 (42)	21 (22)	55 (57)
Lymphaticovenous Anastomosis (LVA)	49 (44)	15 (14)	60 (54)
Lymph Node Transfer	16 (17)	4 (4)	76 (83)
Debulking Surgery, Liposuction	19 (20)	5 (5)	79 (79)
Return to work support	37 (69)	43 (45)	36 (38)
Body image coping	41 (44)	28 (30)	51 (55)
Sexuality coping	36 (40)	25 (27)	54 (59)
Psychosocial coping	42 (47)	31 (34)	47 (52)
Refer to a Certified Lymphoedema professionals for CDT treatment	72 (72)	42 (42)	25 (25)

HOW HAS IMPLANT-BASED BREAST RECONSTRUCTION CHANGED? TWELVE YEARS OF NATIONAL REGISTRY DATA

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Problem statement: Implant-based breast reconstruction has changed substantially over the past decade in response to device safety concerns, regulatory action and adoption of newer techniques, including direct-to-implant and pre-pectoral reconstruction. National registry data can define the scale of these practice changes and whether contemporary approaches are associated with acceptable longer-term revision outcomes.

Methods: The Australian Breast Device Registry (ABDR) is a national clinical quality registry monitoring breast implants, tissue expanders and matrix/mesh. We analysed reconstructive breast device procedures recorded from 2012 to 31 December 2024. Reconstructive indications included post-cancer, risk-reducing and developmental deformity procedures. Outcomes included procedural trends, device characteristics, matrix/mesh use and time-to-revision, using Kaplan-Meier survival methods for primary breast implants. **Results:** By 31 December 2024, the ABDR had captured 22,477 reconstructive patients, 32,767 reconstructive procedures and 48,276 reconstructive devices. In 2024, 3,166 reconstructive procedures were recorded. Direct-to-implant reconstruction accounted for 68.6% of reconstructive implant insertions, continuing the shift away from two-stage tissue expander-based reconstruction. Smooth implants predominated in 2024 (66.7%), replacing the earlier predominance of textured devices. Pre-pectoral placement was the most common plane for direct-to-implant reconstruction (41.6%), while sub-pectoral placement remained most common for two-stage procedures (44.7%). Matrix/mesh was used in 65.1% of direct-to-implant and 30.7% of two-stage procedures. At nine years, all-cause revision incidence after post-cancer reconstruction was 20.4%, with approximately 13% due to complications. Revision incidence at nine years was similar for procedures performed with and without matrix/mesh. Revision incidence at 12 months after first reconstructive implant insertion decreased slightly from 3.9% in 2016 to 3.2% in 2024. **Conclusion:** Australian implant-based breast reconstruction has undergone substantial evolution, shifting towards direct-to-implant, pre-pectoral reconstruction using smooth implants. Despite this major practice transition, longer-term revision outcomes remain acceptable, while 12-month revision

incidence has decreased slightly over time. National registry surveillance provides a mechanism to evaluate surgical innovation, device safety and quality of reconstruction at scale.

Disclosure of Interest: The authors declare no relevant conflicts of interest.

VARIATION IN BREAST CANCER CARE AND OUTCOMES AMONG CULTURALLY AND LINGUISTICALLY DIVERSE WOMEN IN VICTORIA (2019–2023)

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Problem statement: Culturally and linguistically diverse (CALD) populations face persistent inequities across the breast cancer care continuum, including access to screening, diagnosis, treatment, and outcomes. In Victoria's universal healthcare system, disparities remain due to language barriers, cultural differences, variable health literacy, and systemic challenges. In February 2026, the Victorian Integrated Cancer Services (VICS) CALD Cancer Summit examined patterns of care across multiple tumour streams. This analysis focuses on breast cancer-specific findings to examine whether CALD women face higher risks of advanced disease at diagnosis and delays in accessing timely care.

Methods: A population-level retrospective cohort study was conducted using Victorian Cancer Registry data for women diagnosed with primary breast cancer (2019–2023). CALD status was defined by country of birth. Data were linked with hospital admissions, radiotherapy, emergency, and mortality datasets, while breast screening data were analysed separately. **Results:** Re-screening participation among women aged 50–74 years was highest in English-speaking participants; while participation among CALD groups improved by 36 months, notable disparities persisted, particularly for Arabic-speaking women. Women from Arabic-speaking countries, India, and South Eastern Europe were significantly more likely than English-speaking patients to be diagnosed at stage II–IV disease or have missing stage at diagnosis, with Southern European patients particularly at higher risk for stage IV disease. Time to first treatment for stage I–III breast cancer was significantly longer for Arabic-speaking, South Eastern European, and Vietnamese patients, whereas Chinese-speaking patients experienced shorter intervals. Emergency admissions in the last 30 days of life varied between 42% (Chinese-speaking) and 61% (Vietnamese), with Arabic-speaking patients at increased risk. **Conclusion:** CALD women with breast cancer in Victoria experience multiple inequities, including more advanced disease at diagnosis, delayed treatment initiation, lower treatment uptake, and higher emergency care utilisation. We performed a comprehensive review of these disparities and examined variation in inequity across CALD subgroups to identify priority targets for intervention. Targeted strategies addressing language, cultural, and health literacy barriers, alongside system-level improvements in care coordination, service accessibility, and culturally responsive practices are essential to improve equity and reduce unwarranted variations in breast cancer outcomes across CALD populations.

The authors declare no conflicts of interest.

THE ROLE OF ACUPUNCTURE FOR AROMATASE INHIBITOR RELATED JOINT SYMPTOMS: CLINICIANS' PERSPECTIVES

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Problem statement: Aromatase inhibitors (AI) are a key component of treatment for many patients with breast cancer. However, AI-related arthralgia can compromise adherence and may adversely affect oncological outcomes. Acupuncture has demonstrated safety and efficacy in managing AI-related joint symptoms but access remains limited in Australia. This study aimed to examine Australian clinicians' perspectives on acupuncture and identify perceived barriers to access. **Methods:**

An online survey was distributed to members of the Australasian Society for Breast Disease and Breast Surgeons of Australia and New Zealand, and to clinicians involved in breast cancer care through local interest groups. The survey collected demographic data and used Likert scales to evaluate clinicians' views on acupuncture for AI-related side effects, access barriers and strategies to improve availability. **Results:** Forty-two clinicians responded, most commonly breast surgeons (24), followed by surgical trainees and fellows (9), breast care nurses (4), medical oncologists (3) and radiation oncologists (2). Most respondents agreed joint symptoms are a common adverse effect of AI (90.4%) and affect adherence (85.7%). Only 16.7% agreed that acupuncture is effective, while 71.4% neither agreed nor disagreed; however, most agreed acupuncture is safe (69%). Acupuncture had previously been discussed by 19.1%, and 38.1% would recommend it in future. Most clinicians were open to learning more about acupuncture (45.2% agreed, 47.6% strongly agreed), and 78.6% already discuss non-medication therapies with patients. Only 11.9% of respondents felt acupuncture was currently accessible. The main barriers to access were availability, cost and patient perceptions, while ten respondents also cited limited clinician knowledge and evidence as barriers. Identified strategies to improve access included clear referral pathways, patient education and publicly funded services. **Conclusion:** Few clinicians perceive acupuncture as an effective or accessible treatment option. Although many may consider complementary therapies, acupuncture is infrequently discussed. Further research to support clinician and patient education, referral pathways and funding for acupuncture may improve access.

POSTER PRESENTATION ABSTRACTS

ADJUVANT ENDOCRINE THERAPY

monarchE: SUBGROUP ANALYSIS OF ADJUVANT ABEMACICLIB + ENDOCRINE THERAPY (ET) FOR HR+, HER2-, HIGH-RISK EARLY BREAST CANCER (EBC) BY NODAL STATUS

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Problem statement: Adding two years of adjuvant abemaciclib to ET improved overall survival (OS) in patients with HR+, HER2-, node-positive, high-risk EBC. At 7-years, abemaciclib+ET demonstrated sustained IDFS (HR=0.73[95%CI:0.66,0.82]) and DRFS benefits (HR=0.75[0.66,0.84]). Previous monarchE data highlight that patients with N1 disease (1-3 ALN) and additional risk factors (grade 3 [G3] and/or large tumor size) are at high recurrence risk. We show subgroup analyses by ALN (N1, N2, N3). **Methods:** In monarchE open-label, phase-3 trial, patients were randomized 1:1 to ET for ≥5-years +/- abemaciclib for 2-years (treatment period). High-risk EBC was defined as either 1-3 ALN (N1) with G3 disease and/or tumor ≥5cm or, ≥4 ALN (N2:4-9, N3:≥10) (Cohort 1 [C1]). Patients in C2 had N1 disease with G≤2,

tumor <5cm and Ki-67>20%. IDFS/DRFS/OS were assessed in C1. **Results:** Of 5120 randomized patients in C1, 1761(34.4%) had N1, 2223(43.4%) had N2, and 1123(21.9%) had N3 disease. Patients with N1 high-risk disease presented more G3 tumors (69%) and Ki-67 ≥20% (49%) vs N2 (27%/33%) and N3 (28%/36%). At a median follow-up of 76.8-months in C1, in the ET arm, a comparable number of patients with N1 and N2 disease had IDFS events at 6years (21.6% and 25.4%), with notably higher rate (38.1%) in the N3 group. A similar trend was observed in DRFS and OS. Adding abemaciclib to ET reduced the risk of developing an IDFS event across subgroups: N1 HR=0.75[0.61,0.94], N2 HR=0.69[0.57,0.82] and N3 HR=0.73[0.59,0.89] vs ET. The risk of developing DRFS events was reduced: N1 HR=0.75[0.59,0.95], N2 HR=0.69[0.57,0.84], and N3 HR=0.74[0.60,0.92]. Abemaciclib+ET consistently reduced the risk of death vs ET across ALN subgroups: N1 HR=0.88[0.65,1.18], N2 HR=0.85[0.66,1.09], and N3 HR=0.73[0.56,0.96]. **Conclusions:** In the ET arm, patients with N1 + ≥1 additional risk factor had recurrence and death risks comparable to patients with N2, while patients with N3 had poorer prognosis. Adjuvant abemaciclib+ET led to a clinically meaningful reduction in the risk of recurrence and death regardless of nodal burden, confirming the consistent and sustained benefit of 2years of treatment with abemaciclib and supporting its use in eligible patients with node-positive high-risk EBC.

LONG TERM EFFICACY OF ADJUVANT ABEMACICLIB + ENDOCRINE THERAPY (ET) IN KEY SUBGROUPS IN THE monarchE TRIAL

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Problem statement: In monarchE, addition of 2-yrs of adjuvant abemaciclib to ET demonstrated statistically significant improvement over ET alone in invasive disease-free survival (IDFS) and overall survival (OS) in patients with HR+, HER2-, node-positive, high-risk early breast cancer (EBC). An updated efficacy analysis (76.8 months median follow-up; data cutoff 15 July 2025) for key subgroups in Cohort 1 (C1) is presented. **Methods:** Patients were randomized (1:1) to ET for ≥5-yrs ± abemaciclib for the first 2-yrs. High-risk EBC was defined as 1-3 axillary lymph nodes (ALN) with grade 3 disease and/or tumor ≥5 cm, or ≥4 positive ALN. For subgroups: age (≤40/>40 yrs), menopausal status (pre/post), prior chemotherapy (neo-adjuvant (NAC)/adjuvant (Adj)), region (North America/Europe, Asia, other), treatment effect was estimated using unstratified Cox PH model within each subgroup. **Results:** Abemaciclib+ET consistently improved IDFS vs ET across subgroups: age ≤40 HR=0.661 (95%CI:0.496-0.880, 6-year Δ8.3%); >40 HR=0.743 (95%CI:0.656-0.842, 6-year Δ5.7%); premenopausal status HR=0.681 (95%CI:0.566-0.819, 6-year Δ7.2%), postmenopausal HR=0.764 (95%CI:0.660-0.885, 6-year Δ5.2%); NAC HR=0.690 (95%CI:0.584-0.815, 6-year Δ9.9%), adj HR=0.751 (95%CI:0.636, 0.886 6-year Δ3.9%); NA/Europe HR=0.731 (95%CI:0.622-0.860, 6-year Δ5.5%), Asia HR=0.762 (95%CI:0.583-0.995, 6-year Δ5.7%), other HR=0.707 (95%CI:0.575-0.869, 6-year Δ7.4%). Recurrence risk was higher in ET only arm, for patients ≤40-yrs vs >40-yrs (6-year IDFS rates: 69% vs 74%) and in neoadjuvant chemotherapy vs adjuvant (63% vs 80%). DRFS and OS benefit were consistent across all subgroups. **Conclusion:** In patients with high-risk EBC, abemaciclib+ET showed consistent and clinically meaningful, long-term treatment benefit across key subgroups. Patients in ≤40 or NAC subgroups previously shown to have high risk features, had poorer prognosis among subgroups. These data support adjuvant abemaciclib use in eligible patients to reduce recurrence and mortality risk.

REAL-WORLD EVALUATION OF MAINSTREAM GERMLINE GENETIC TESTING IN PATIENTS WITH EARLY BREAST CANCER

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Problem statement: Mainstream genetic testing (MGT) enables germline testing to be initiated within routine oncology care, improving access and reducing reliance on specialist genetics services. However, pathogenic or likely pathogenic (P/LP) variant detection rates in real-world mainstream pathways may differ from those reported in clinical trials and selected published cohorts. This evaluation examined the implementation and outcomes of MGT among patients with breast cancer treated in routine clinical practice. **Methods:** We conducted a real-world evaluation of consecutive patients with breast cancer referred to a single centre in Sydney and assessed for germline genetic testing between 1 July 2024 and 30 June 2026. Patients were classified as eligible or ineligible for MGT according to local testing criteria. Patients considered unsuitable for mainstream testing because of eligibility criteria, complex clinical family histories, or specific counselling needs were referred to a familial cancer service (FCS). Outcomes included the number and proportion of patients eligible for genetic testing, the detection rate and spectrum of P/LP variants, and referrals to FCS. The observed P/LP variant detection rate was compared descriptively with published estimates. **Results:** A total of 176 patients were referred to the breast oncology nurse practitioner. Of these, 109 patients were eligible for germline genetic testing, and all completed testing through either the mainstream pathway or referral to the FCS. P/LP variants were identified in 21 patients, representing 11.9% of all patients assessed and 19.3% of those who underwent testing, compared with a published population-based detection rate of approximately 5%. P/LP variants were identified in BRCA1, BRCA2, PALB2, CHEK2, ATM, BRIP1 and TP53. All patients with a P/LP variant were subsequently referred to the FCS for specialist counselling, risk management and cascade testing advice. **Conclusion:** MGT was feasible within routine breast oncology practice and enabled eligible patients to access germline testing through their treating team. The observed P/LP variant detection rate was higher than published population-based estimates, likely reflecting the use of clinical eligibility criteria to select patients for testing. Clear eligibility criteria, robust result-tracking processes and established referral pathways to FCS are essential to support safe, equitable and clinically appropriate genetic testing.

EARLY OUTCOMES OF A MAINSTREAM GERMLINE GENETIC TESTING PROGRAM FOR PATIENTS WITH BREAST CANCER: A RETROSPECTIVE COHORT STUDY FROM AN AUSTRALIAN TERTIARY HEALTH SERVICE

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Problem statement: Mainstream genetic testing integrates hereditary cancer assessment into routine breast oncology care and improves access to testing that may guide treatment, surveillance and risk-reducing strategies. This study evaluated diagnostic yield of panel testing and surgical outcomes of the Sydney Local Health District breast cancer mainstream testing pathway. **Methods:** Eligible patients were affected by breast cancer and met eviQ and/or Medicare criteria for panel testing. Surgical teams initiated testing for newly diagnosed patients, while medical oncologists requested testing for treatment-related indications, including PARP inhibitor eligibility. The Cancer Genetics Service supported eligibility assessment, result interpretation and post-test counselling. We retrospectively reviewed all patients undergoing mainstream germline testing

between July 2024 and June 2026. Patient, genetic, tumour, treatment and surgical data were extracted from the cancer genetics database and hospital records. Ethics approval was obtained from the Sydney Local Health District and Chris O'Brien Lifehouse Human Research Ethics Committees. **Results:** Testing was arranged for 449 patients aged 22–89 years, predominantly by breast surgeons. PV/LP variants were identified in 53 individuals (12%): 30 (57%) in high-risk breast cancer genes (BRCA1, BRCA2, PALB2 and ATM c.7271), 15 (28%) in moderate-risk breast cancer genes (ATM, CHEK2 and RAD51C), and eight (15%) in ovarian cancer risk genes not associated with breast cancer (PMS2 and BRIP1). Among carriers, eight (15%) were diagnosed before age 40, 22 (42%) at 40–49 years and 23 (43%) at ≥50 years. Among 45 carriers of breast cancer susceptibility gene variants, pathology included 10 triple-negative cancers, 28 grade II/III ER/PR-positive/HER2-negative cancers, three HER2-positive cancers and four high-grade DCIS. Bilateral mastectomy was more frequent among high-risk than moderate-risk gene carriers (61%, 17/28 versus 31%, 4/13). Of 28/53 women who had reached the eviQ-recommended age for RRSO and had no previous ovarian cancer, 14 (50%) completed RRSO, including five concurrently with bilateral mastectomy. **Conclusions:** The pathway achieved a 12% PV/LP detection rate and identified clinically relevant findings across breast and ovarian cancer risk genes. Timely testing supported coordinated breast and ovarian risk management, including combined risk-reducing procedures. Longer follow-up is required to determine its full effect on surgical decision-making.

INTEGRATING DOSE MODIFICATIONS FOR EFFECTIVE MANAGEMENT OF HR+, HER2- EARLY BREAST CANCER WITH ABEMACICLIB

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Problem statement: Patients with node-positive, high-risk HR+, HER2- early breast cancer (EBC) have substantial recurrence risk. In monarchE, 2 years of adjuvant abemaciclib+endocrine therapy (ET) is recommended for patients with node-positive, HR+, HER2- high-risk EBC based on improved IDFS, DRFS, and OS. Optimal use of abemaciclib-based therapy requires adequate tolerability management to support consistent treatment adherence. We provide evidence-based management strategies for adjuvant abemaciclib + ET in EBC. **Methods:** Data from eligible patients treated with abemaciclib from the phase 3 monarchE and phase 2 TRADE studies were summarized and supported by real-world data. **Results:** Abemaciclib demonstrated a manageable safety profile across trials. In monarchE, the most frequent any-grade adverse events (AEs) in abemaciclib + ET arm were diarrhea, neutropenia, and fatigue, with a higher incidence of grade ≥3 AEs vs ET alone (50% vs 17%). Overall, 84% of patients receiving abemaciclib reported diarrhea, typically low grade with early onset (median 8 days), and incidence decreased over time. At 27 months median follow-up, diarrhea was effectively managed, with antidiarrheal medications (79% of patients) and dose modifications (<25%). 5% of patients discontinued due to diarrhea. High estimated 4-year IDFS rates of 87%/86%/84% with abemaciclib dose intensities of ≤66%/66–93%/≥93%, respectively, indicated that efficacy was not negatively impacted by dose reductions. Seven-year monarchE data confirmed the known safety profile of abemaciclib. In TRADE, a dose-escalation approach was utilized: abemaciclib 50mg twice daily (BID) on days 1-14, 100mg BID on days 15-28 and 150mg BID thereafter. This strategy allowed more patients to reach and maintain abemaciclib 150mg BID at 12 weeks (71%) vs monarchE (~60%) and discontinuation was infrequent (7%). These results are supported by real-world data in EBC from the US, demonstrating improved abemaciclib persistence with dose reductions. **Conclusion:** Abemaciclib-associated AEs are manageable through dose modifications without compromising efficacy, allowing patients to continue treatment and maximize the benefit of abemaciclib treatment.

CLINICIAN-DEVELOPED ARTIFICIAL INTELLIGENCE-ASSISTED WEB APPLICATION FOR DETERMINING ELIGIBILITY FOR MAINSTREAM BREAST CANCER GERMLINE PANEL TESTING UNDER CURRENT EVIQ GUIDELINES

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Problem statement: Treatment-focused germline testing (TFGT) is increasingly required at breast cancer diagnosis to inform surgical, radiotherapy and systemic treatment decisions, including poly(ADP-ribose) polymerase inhibitor (PARPi) eligibility. In Australia, mainstream genetic testing (MGT) eligibility is determined using multiple criteria linked to distinct Medicare Benefits Schedule (MBS) items (73296 for diagnostic testing; 73295 for PARPi eligibility). To facilitate timely TFGT, non-genetic clinicians require rapid determination of MGT eligibility and guidance regarding consent, test ordering and result management. We explored the feasibility of developing an AI-assisted clinical decision support application by clinicians without formal software development expertise. **Methods:** One radiation oncologist and two genetic oncologists, developed a browser-based application using AI-assisted coding (Claude, Anthropic). The November 2025 eviQ breast cancer panel testing and adjuvant olaparib PBS eligibility criteria were translated into decision rules and refined through multidisciplinary review across New South Wales Familial Cancer Services. An adaptive questionnaire comprising 11 core questions (expanding to 13 where required) minimises clinician burden, with assessment terminating once eligibility is established. All decision logic executes locally within the browser; no patient information is entered, transmitted or stored. **Results:** The application determines MGT eligibility, identifies the applicable MBS item and criterion satisfied, and provides guidance regarding consent, pathology referral and follow-up. Patients with pathogenic, likely pathogenic or uncertain variants are directed to Familial Cancer Services (FCS) for post-test management. Patients with tumour variants demonstrating variant allele frequency >30% or clinical features suggestive of a syndromic hereditary cancer syndrome are redirected to FCS for pre-test genetic assessment rather than MGT. For patients ineligible for MGT, the application identifies FCS referral indications based on family history. The application is mobile-compatible, distributed via QR code and freely available to clinicians at <https://breastmainstreamgenetic.netlify.app>. **Conclusion:** AI-assisted software development enabled clinicians without formal programming expertise to develop a guideline-concordant clinical decision support application supporting TFGT in breast cancer. Such tools have the potential to empower non-genetic clinicians to accurately identify eligible patients and streamline TFGT within routine oncology practice. Future work will prospectively evaluate clinician uptake, usability, workflow integration, user acceptability, concordance with evolving clinical guidelines, and effectiveness in routine practice.

BREAST IMAGING AND SCREENING

BEYOND THE SCAR: PITFALLS AND PEARLS IN POST-SURGICAL BREAST IMAGING

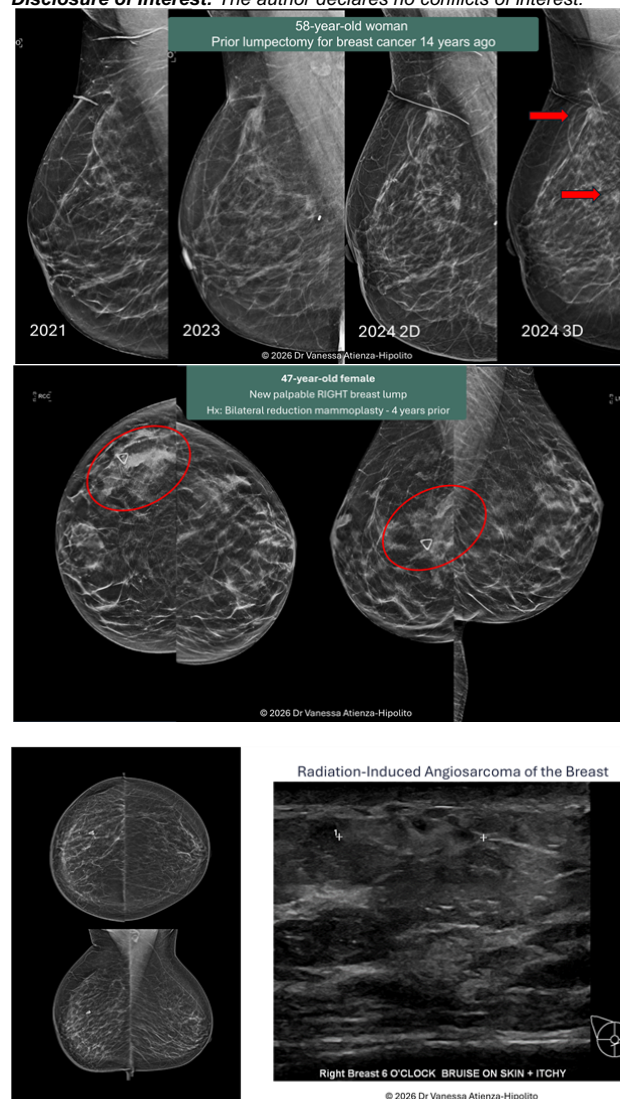
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Problem statement: Post-surgical breast imaging presents a frequent diagnostic challenge in contemporary breast practice. Benign post-operative findings may closely mimic malignancy, while new primary cancers, recurrent malignancies, and treatment-related complications may be obscured by expected surgical change. Distinguishing between these entities is essential to avoid both delayed diagnosis and unnecessary intervention. This educational review highlights common diagnostic pitfalls and demonstrates a structured approach to evaluating post-surgical breast findings. **Methods:** Representative cases from a specialist breast imaging practice were selected to illustrate common diagnostic dilemmas encountered in the assessment of post-surgical breasts. Cases included patients following breast-conserving surgery, reduction mammoplasty, radiotherapy, implant

surgery, Stability on serial imaging, and Triple Test correlation (POST™) was applied to each case. Clinical presentation, multimodality imaging findings, pathology outcomes, and management decisions were reviewed. **Results:** Cases demonstrated a broad spectrum of benign and malignant outcomes, including fat necrosis, organising fat necrosis, duct carcinoma in situ following reduction mammoplasty, ipsilateral breast cancer recurrence, radiation-induced angiosarcoma, implant-associated lesions, surveillance-detected malignancy, and imaging-occult invasive lobular carcinoma. Several cases highlighted the limitations of imaging alone and reinforced the importance of clinical-radiological-pathological concordance. Surgical history, serial imaging comparison, and completion of the triple test were critical in differentiating expected post-operative change from clinically significant disease. **Conclusion:** Post-surgical breast findings are commonly encountered across breast imaging and surgical practice and remain a source of diagnostic uncertainty. A structured approach incorporating surgical context, interval assessment, serial imaging review, and triple test correlation can improve diagnostic confidence and support appropriate management. Understanding the pearls and pitfalls of post-surgical breast imaging may reduce unnecessary procedures while facilitating earlier detection of significant pathology.

Disclosure of Interest: The author declares no conflicts of interest.



CULTIVATING COLLABORATIVE CHANGE: CONSUMER ENGAGEMENT IN BREAST DENSITY POLICY, PRACTICE AND RESEARCH

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Problem statement: Breast density is an important factor affecting both breast cancer risk and mammographic sensitivity, yet notification practices and access to information remain inconsistent across Australia. Variability in communication about breast density can contribute to inequities in consumer knowledge, uncertainty regarding individual risk, and challenges in shared decision-making. Consumer organisations and advocates have played a key role in highlighting these gaps and calling for transparent, evidence-based information to support women, healthcare professionals and policymakers. **Methods:** Breast Cancer Network Australia (BCNA) trains individuals with lived experience of breast cancer to become Consumer Representatives (CRs) enabling meaningful participation in policy, practice and research. Responding to consumer concerns and emerging scientific evidence, BCNA established breast density advocacy as a priority. During 2025 following national recommendations, BCNA and CRs contributed consumer perspectives to the development of national breast density guidance for General Practitioners (GPs). This included participation in a multidisciplinary workshop, structured consultation and targeted advocacy to ensure consumer priorities were reflected alongside clinical and scientific expertise. **Results:** The first national risk-based breast screening guidance for GPs was co-produced, with consumer lived experience informing content alongside clinical expertise. This created a resource that responds to consumer need and evidence, while helping to address a supportive care gap. Consumer perspectives contributed to discussions informing national approaches to breast density communication and risk-based screening information, highlighting the need for clear, consistent and accessible information to support informed decision-making and reduce uncertainty. This represents an important step towards addressing a long-standing gap in breast cancer risk communication and supporting more informed conversations between individuals and healthcare professionals. **Conclusion:** BCNA's breast density advocacy demonstrates how consumer leadership can challenge existing approaches and drive meaningful system change. By bringing lived experience into complex areas of breast cancer risk and screening, consumers can help shape solutions that are both evidence-based and responsive to community needs. This approach highlights the importance of embedding consumer partnership in future supportive care and cancer policy reform.

Disclosure of Interest: None

FIRST-YEAR OUTCOMES OF A POPULATION-BASED BREAST CANCER SCREENING PROGRAMME AT A REGIONAL TERTIARY HOSPITAL IN SINGAPORE

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Problem statement: BreastScreen Singapore (BSS) is a nationwide mammographic screening programme for early breast cancer detection. However, there is limited published evidence on the early performance of newly participating centres, including biopsy recommendation rates, patient adherence, histopathologic outcomes, and lesion upgrade rates. Evaluating these metrics is important for assessing programme effectiveness. This study aimed to describe the clinicopathologic outcomes of patients screened at a single tertiary centre participating in BSS. **Methods:** A retrospective study was conducted from May 2025 to April 2026. All patients screened under BSS during the study period, and all patients who had abnormal imaging from breast screening in Woodlands Hospital from May 2025 to April 2026 were included. Data consists of the following: number of patients who underwent screening mammograms, those recalled for further imaging, and those advised to undergo biopsy. The final histopathological

diagnoses of those biopsied and the subsequent management outcomes were also reviewed. **Result:** A total of 598 patients underwent BSS screening and were recalled during the study period. Of these, 277 patients (46.3%) were advised to undergo biopsy. 256 patients (92.4%) proceeded with biopsy, while 21 patients (7.58%) declined. Histopathological results among biopsied patients showed 168 benign lesions (65.6%), 36 B3 lesions (lesions of uncertain malignant potential) (14.1%), and 52 malignant lesions (20.3%). Among the patients with B3 lesions, 5 were upgraded to ductal carcinoma in situ (DCIS) on final surgical pathology. Of the malignant lesions diagnosed on biopsy, 28 were invasive carcinomas, 23 were DCIS, and one was pleomorphic lobular carcinoma in situ. Among the 23 patients diagnosed with DCIS on biopsy, 5 were found to have invasive carcinoma (21.7%) on definitive surgery. **Conclusions:** This single-centre study shows a high biopsy compliance rate among patients recalled after BSS screening. Histopathologic evaluation identified both benign and malignant lesions, with clinically relevant upgrade rates among B3 lesions and DCIS on final pathology. These findings provide updated local data on the early performance of a newly participating BSS centre and may help in further planning of population-based health screening strategies.

BRAIX AI 3RD READS AT MONASH BREASTSCREEN PILOT: INITIAL EXPERIENCE

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Problem statement: There is an ongoing collaborative Australian project assessing BRAIx artificial intelligence (AI) model as a reader within BreastScreen Victoria, which was first introduced as a pilot at Monash BreastScreen in December 2025. This project aimed to review the BRAIx reads that led to a third read and to identify any patterns, similarities or differences, as well as the interaction between the radiologist and BRAIx reader. The current standard is two independent radiologist reads and cases going to a third radiologist read, if there is discordance. **Methods:** BRAIx reads that resulted in a third read were reviewed from 13/12/2025-09/04/2026. Data was collected from Gecko database, and images were reviewed on the Sectra picture archiving and communication system (PACS). **Results:** There were 121 clients with 69 BRAIx and 79 radiologist recall lesions, of which 49% (BRAIx) and 44% (radiologist) were assessed after the third read. Compared with the radiologist, BRAIx recalled more multiple lesions and more category 4 lesions, subsequently affecting clinic bookings as calcifications and category 4 lesions have specific allocations. The distribution across recall categories also differed: BRAIx generated more recalls for calcification, whereas the radiologists generated more recalls for indistinct and circumscribed masses. In total, 57 clients were assessed and 52 returned to routine recall. Among the single-reader recalls, there were 5 BRAIx and 4 radiologist recall biopsies; two BRAIx recall biopsies were ductal carcinoma in situ, and one radiologist recall was invasive carcinoma. **Conclusion:** Our initial experience at Monash BreastScreen has been a learning process. These first few months have demonstrated the benefits of BRAIx, with fewer recalls at the third read and two single-reader cancers detected. BRAIx produced more category 4 cases and multiple lesions, which initially affected assessment clinic bookings; discussions with the BRAIx team enabled recalibration of the risk category assignment. Overall, this highlights BRAIx as a strong individual reader with a low recall rate, noting some differences to radiologist readers and our dynamic ongoing interaction with the model. Our experience demonstrates the importance of ongoing collaboration between radiologists and AI developers during implementation to optimise model integration into clinical workflow.

CONTRAST ENHANCED MAMMOGRAM GUIDED BIOPSIES- AN ALTERNATIVE TO MRI GUIDED BREAST BIOPSIES- A YEAR IN REVIEW

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Contrast-enhanced mammography (CEM)-guided biopsy is a relatively new technique that has emerged following the

introduction of contrast-enhanced mammography into breast imaging practice. One of its most valuable applications is as an alternative to MRI-guided breast biopsy for lesions detected on breast MRI that are occult on second-look ultrasound. Compared with MRI-guided biopsy, CEM-guided biopsy offers several advantages, including shorter procedure times, improved patient comfort, and more efficient utilisation of imaging resources, particularly in settings with limited MRI availability. Furthermore, CEM-guided biopsy may represent a more cost-effective alternative and, once established within an institution, may facilitate earlier biopsy access, expediting diagnosis and management and potentially improving patient outcomes. This poster presents our institution's experience with CEM-guided breast biopsies over the past year at Maroondah Hospital Breast Care Centre, where fellowship-trained breast radiologists have been performing these procedures in the public setting. The current study cohort comprises 24 cases, with additional data to be collected until the end of July. We review imaging findings, histopathological outcomes, procedural complications, and other relevant outcomes from our experience to date. The aim of this poster is to educate the breast imaging community regarding the potential benefits of CEM-guided biopsy as an alternative to MRI-guided breast biopsy and to encourage wider adoption of this technique among breast imaging specialists.

LYMPHOID MALIGNANCY MIMICKING BREAST CANCER ON IMAGING – A PATHOLOGY PERSPECTIVE.

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Problem statement: Primary haematolymphoid malignancies of the breast are exceedingly uncommon, with lymphomas comprising 0.5% of breast cancers. Diagnosis is complicated by their mimicking of primary breast carcinoma both clinically and radiologically (1). We present three cases of haematolymphoid malignancies manifesting as breast lesions. **Methods:** Three women with palpable breast masses and without known history of haematolymphoid disorders were referred to a breast radiologist with suspected primary breast cancers. Following radiological assessment, biopsies were taken for histological and molecular assessment. **Results:** Radiological findings were variable, with mammography showing asymmetric density in one case and a well defined, ovoid lesion in another. Biopsies demonstrated haematolymphoid proliferations with diffuse lymphocytes in one case and an atypical spindle cell proliferation in another. In all cases, immunohistochemistry demonstrated positive staining for haematolymphoid markers, with the spindle cell proliferation consistent with a myeloid sarcoma. Ancillary tests such as flow cytometry and molecular testing were required for diagnosis in the lymphoma cases. The patients were referred to Haematology for further review. **Conclusion:** Primary breast haematolymphoid malignancies can mimic breast carcinoma both clinically and radiologically. If a haematolymphoid malignancy is suspected, tissue should be sent fresh for flow cytometry, and comprehensive clinicopathological correlation undertaken prior to treatment.

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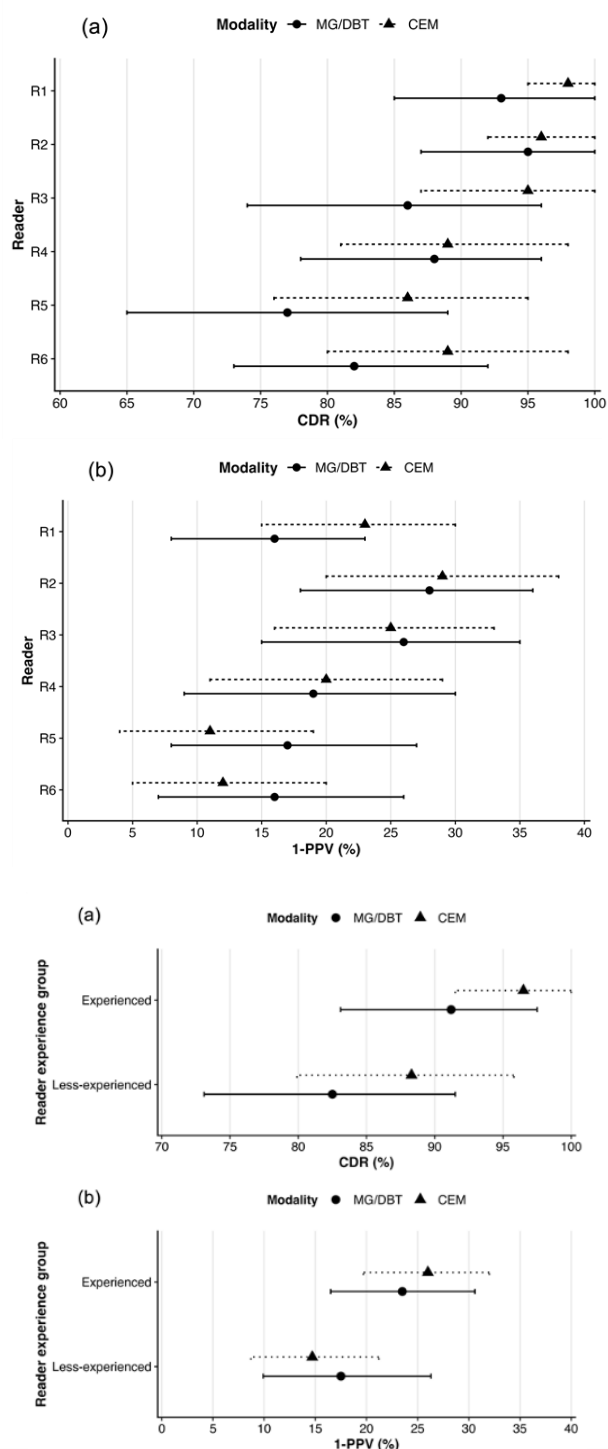
SEQUENTIAL CONTRAST-ENHANCED MAMMOGRAPHY FOLLOWING DIGITAL BREAST TOMOSYNTHESIS IMPROVES CANCER DETECTION AND BI-RADS CATEGORISATION IN PRE-OPERATIVE BREAST CANCER STAGING: A MULTI-READER STUDY

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Problem statement: Contrast-enhanced mammography (CEM) combines mammographic morphology with contrast-based functional information. This multi-reader study compared the diagnostic performance of sequential CEM interpretation following mammography/digital breast tomosynthesis (MG/DBT) and explored the influence of reader experience. **Methods:** Fifty women with biopsy-proven breast cancer underwent pre-operative staging imaging. Six radiologists (three experienced, three less-

followed by CEM. Fifty-seven surgically proven malignant lesions were used as the reference standard. Cancer detection rate (CDR) and false-positive burden (1-PPV) were calculated. Changes in BI-RADS category across the modalities were assessed. **Results:** Pooled CDR was higher with CEM than MG/DBT: 92.4% vs 86.8% absolute difference of 5.6 percentage points (95% CI 2.2-8.5). The difference was larger in dense breasts: 6.5 percentage points (95% CI 2.7-9.7). Pooled 1-PPV was similar between modalities: 21.0% for CEM and 20.8% for MG/DBT, difference 0.2 percentage point (95% CI -5.4 to 5.7). CEM prompted 22 upgrade and 13 downgrade events; 17/22 upgrades and 10/13 downgrades were appropriate respectively. CEM improved CDR in both experience groups although experienced readers continued to outperform less experienced readers. **Conclusion:** Sequential CEM interpretation following MG/DBT improved CDR compared with MG/DBT alone particularly in dense breasts, without a clear increase in false positive burden. Most BI-RADS reclassification events were appropriate. The persistence of reader-experience difference suggests that CEM interpretation still requires dedicated training.



CONTRALATERAL WHOLE-BREAST ULTRASOUND IN NEWLY DIAGNOSED BREAST CANCER

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Problem statement: Australian and European guidance recommends bilateral mammography and breast ultrasound during the assessment of newly diagnosed breast cancer. However, the incremental clinical value of routinely performing whole-breast ultrasound of the asymptomatic contralateral breast remains uncertain. In our breast cancer centre, ultrasound evaluation of the contralateral whole-breast is routinely undertaken to assess for bilateral breast cancer. This study evaluated its diagnostic yield, downstream investigations and impact on treatment planning to determine whether routine use provides meaningful clinical benefit.

Methods: A retrospective audit was conducted of patients diagnosed with unilateral breast cancer at Robina Hospital, Queensland, Australia, during all of 2025. Patients were excluded if they had previously undergone contralateral mastectomy or if contralateral whole-breast ultrasound was not performed. Radiological, pathological and clinical outcome data were collected. The primary outcome was the detection of synchronous contralateral breast malignancy attributable to contralateral ultrasound. Secondary outcomes included additional imaging, biopsy rates and benign findings generated by contralateral ultrasound. **Results:** A total of 296 patients were identified, of whom 262 met the inclusion criteria. Routine contralateral whole-breast ultrasound identified 38 pathological appearing lesions (14.50%), prompting 30 biopsies and 5 breast MRIs. Ultrasound detected 26 new pathological appearing lesions in the absence of associated mammographic abnormalities. The mammographic breast density (BI-RADS) of these patients included 4A, 8B, 7C, and 6D. Histopathology demonstrated 22 benign lesions and 8 synchronous contralateral breast cancers. Routine contralateral ultrasound altered definitive surgical management in 4 patients (1.52%), as the other detected synchronous contralateral breast cancers underwent a concurrent MRI given their breast density.

Conclusion: Routine contralateral whole-breast ultrasound in patients with newly diagnosed unilateral breast cancer demonstrated a low diagnostic yield and did not alter definitive surgical management in most patients. Its use resulted in additional biopsy investigations with associated healthcare resource utilisation and the potential for increased patient anxiety and delays to definitive treatment. In contemporary breast cancer practice, many patients with additional imaging indications undergo pre-operative breast MRI, further limiting the incremental value of routine contralateral whole-breast ultrasound. These findings support a more selective approach to contralateral ultrasound based on specific clinical or radiological indications.

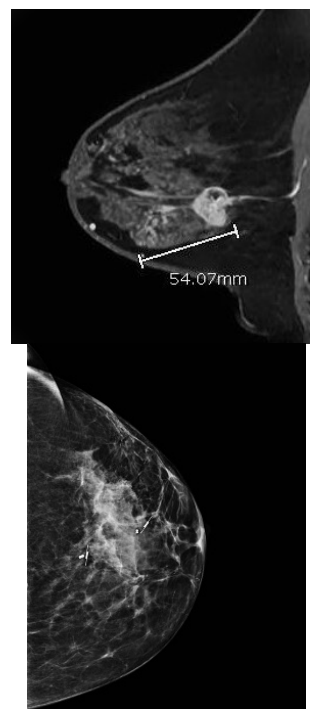
FEASIBILITY OF MULTI-MODALITY IMAGE-GUIDED SCOUT® RADAR LOCALISATION FOR SURGICAL “BRACKETING” FOR BREAST CONSERVATION SURGERY: INITIAL EXPERIENCE IN AN AUSTRALIAN TERTIARY CENTRE

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Problem statement: Large impalpable malignant abnormalities, such as large areas of non-mass enhancement or microcalcification, multifocal or multicentric disease, require “bracketing” localisation for accurate margin planning in breast conservation surgery (BCS). This is traditionally performed with bracketing hookwire localisation, which poses technical and logistical limitations. The SCOUT® radar localisation system provides a wire-free alternative to hookwire localisation, with overall limited literature on wire-free technologies for bracketing purposes. We assess feasibility of multi-modality image-guided SCOUT® placement for bracketing of large malignant abnormalities for BCS. **Methods:** SCOUT® was introduced at our institution in September 2023. Single-centre retrospective analysis of patients who had SCOUT® reflectors placed for bracketing of malignant disease for BCS, utilising ultrasound, mammographic or magnetic resonance imaging (MRI) guidance, between October 2023 and June 2026, was performed. Patient demographics, reflector placement accuracy (migration), distance between reflectors and surgical outcomes (margin status and re-excision rates) were evaluated using electronic medical records (EMR) and

the Picture Archiving Communications System (PACS). **Results:** 20 SCOUT® reflectors were placed for bracketing purposes in 10 patients: 8 under ultrasound guidance, 10 under mammographic guidance, and 2 under MRI guidance. Indications for bracketing in our cohort were: multifocal disease (n=5), non-mass enhancement (n=4), second malignant lesion only seen on MRI (n=1). All were placed accurately, with no migration. All SCOUT® markers were retrieved intraoperatively. Surgical margins were clear in all except the first case which required re-excision. The average distance between bracketing SCOUT® reflectors was 38 mm (range: 20 mm to 75 mm). **Conclusion:** SCOUT® is a viable, accurate “bracketing” technique for large impalpable malignant abnormalities for BCS in our early experience. It offers the versatility of ultrasound, mammographic or MRI-guided placement, and an attractive alternative to bracketing hookwire localisation. MRI-guided insertion capability is particularly beneficial for bracketing large lesions, such as non-mass enhancement, that are best or only seen on MRI, an essential adjunct given MRI's growing role in breast staging. SCOUT® decouples radiology and theatre schedules, streamlines workflows and obviates limitations of hookwires. Further prospective larger studies are needed, especially for long term oncologic outcomes.



INVASIVE DUCTAL CARCINOMA ARISING WITHIN A BREAST HAMARTOMA: A CASE SERIES AND REVIEW OF THE LITERATURE

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Problem statement: Mammary hamartomas account for less than 5% of benign breast tumours with an exceedingly rare incidence of containing malignant transformation. **Case report:** We report the case of a 38-year-old woman presenting with left mastalgia and a palpable breast lump. Breast MRI revealing a hormone receptor positive invasive ductal cancer contained within a hamartoma. This lesion was mammographically occult, and the patient subsequently

underwent surgical management. **Literature review:** A literature review was performed using PubMed revealing twenty-five reported cases worldwide, not including the case presented here, since the term was first described in 1971. There have only been two other cases reported in Australia emphasising the rare nature of this disease. **Conclusion:** Malignant transformation of mammary hamartoma is a diagnostic challenge as there is minimal evidence on diagnosis and management of this condition. The incidence may increase with the advent of breast screening, use of contrast enhanced mammography and Breast MRI.

HER2 POSITIVE BREAST CANCER

A RETROSPECTIVE ANALYSIS OF CLINICOPATHOLOGIC FEATURES ASSOCIATED WITH LONG-TERM RESPONSE TO FIRST-LINE HER2-TARGETED THERAPY IN ADVANCED OR METASTATIC HER2-POSITIVE BREAST CANCER

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Problem statement: Real-world data supports a 25% complete response rate to first-line systemic therapy for metastatic HER2-positive breast cancer, which has proven to be a predictive marker for long-term durability of response. We aimed to examine the clinicopathologic features associated with sustained long-term response to HER2-targeted therapy in patients with advanced or metastatic HER2-positive breast cancer to identify key prognostic indices that may be predictive of response. **Methods:** This was a retrospective institutional review of patients diagnosed with advanced or metastatic HER2-positive breast cancer and treated between 2010 and 2023 at Chris O'Brien Lifehouse in Sydney, Australia. Patients were included if they remained free from progression 36 months or more from time of commencement of first-line therapy. Key baseline characteristics, histopathological features and response to treatment were recorded. **Results:** A total of 31 patients were identified, with a median follow-up of 7.3 years. Most patients had de novo metastatic disease (68%) with luminal (ER+) HER2-positive biology (74%) and a high proportion of visceral metastatic disease at baseline (77%). In patients who underwent metastasis-directed treatment and were able to continue systemic therapy, the median time on treatment before progression was 10 months. 10 patients (32%) achieved a complete metabolic response and of these patients, 80% remain alive and free from progression with 50% continuing first-line therapy. 17 patients (55%) were identified as progression-free >60 months from treatment commencement and these patients predominately had ER-positive disease (76%). 10 of these 'ultra-long responders' (59%) currently remain progression-free on first line treatment. **Conclusion:** Despite this cohort being high-risk with most patients presenting with de novo and visceral metastatic disease, more than half of patients remained on first-line treatment for >60 months from commencement. Most patients deriving durable long-term benefit had luminal (ER+) biology and achieving a radiological complete response was predictive of long-term benefit. Considered use of metastasis-directed treatment was also shown to prolong progression-free survival in patients continuing first-line therapy.

Disclosure of Interest: Nil.

LOCOREGIONAL THERAPY

REAL-WORLD MANAGEMENT OF INFLAMMATORY BREAST CANCER IN AUSTRALIA AND NEW ZEALAND: TREATMENT PATTERNS, GUIDELINE ADHERENCE AND PATHOLOGICAL COMPLETE RESPONSE RATES FROM A BINATIONAL QUALITY REGISTRY

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Problem statement: Inflammatory breast cancer (IBC) is a rare and biologically aggressive form of breast cancer. Guidelines recommend trimodality therapy with neoadjuvant systemic therapy (NAST), mastectomy with axillary lymph node dissection (ALND), and post-mastectomy radiotherapy (PMRT). Surgical de-escalation is not standard-of-care, yet contemporary treatment patterns and pathological complete response (pCR) rates remain poorly characterised. We examined real-world IBC management using a binational clinical quality registry to assess guideline adherence and pCR rates. **Methods:** All females (≥18 years) with IBC diagnosed during 2023-2024 were identified from the BreastSurgANZ Quality Audit (BQA), a binational quality registry. Patient demographics, tumour and treatment patterns, guideline adherence, and pCR were analysed descriptively. pCR was defined as residual cancer burden (RCB) class 0 and stratified by tumour subtype. **Results:** 228 cases (189 Australia, 39 New Zealand) were identified. 138 (60.5%) patients were post-menopausal, 64 (28.1%) pre-menopausal and 15 (6.6%) perimenopausal. Tumours were hormone-receptor-positive/HER2-negative in 109 (47.8%), triple-negative in 51 (22.4%) and HER2-positive in 58 (25.4%). NAST was delivered in 161 (70.6%) patients including chemotherapy in 146 (64.0%), anti-HER2 therapy in 38 (16.7%) and immunotherapy in 33 (14.5%). 46 (20.2%) patients had upfront breast conservation surgery, with four requiring subsequent mastectomy resulting in 146 (64.0%) patients undergoing mastectomy. The axilla was managed with an upfront sentinel lymph node biopsy, targeted axillary dissection or axillary sampling in 84 (36.8%) patients including 11 who had subsequent ALND resulting in 118 (51.8%) patients undergoing ALND. 111 (76.0%) mastectomy patients received PMRT. Among patients receiving neoadjuvant chemotherapy, 42 (28.8%) patients achieved pCR. pCR by tumour subtype was 46.0% in HER2-positive, 37.8% in triple-negative and 3.9% in hormone-receptor-positive/HER2-negative disease. Trimodality therapy was documented in 86 (37.7%) patients. **Conclusion:** This binational analysis reveals considerable variation in real-world management of IBC, with full trimodality therapy delivered in only 37.7% of patients. Surgical de-escalation in both the breast and axilla occurred in approximately one in five patients despite limited supporting evidence. pCR followed established biological patterns. Although the rarity of IBC makes it challenging, prospective, adequately powered studies are required to determine whether de-escalation is safe in this aggressive variant of breast cancer.

COMPARISON OF 0.4ML VS 0.6ML DILUTED INDIA INK SOLUTION FOR TATTOOING OF AXILLARY LYMPH NODES IN THE PATIENT WITH BREAST CANCER: A RANDOMIZED CONTROLLED TRIAL.

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Problem statement: A significant proportion of breast cancer patients present with clinically node-positive disease (cN+) and achieve nodal downstaging (cN0) following primary systemic therapy (PST). Targeted axillary dissection (TAD) has emerged as a strategy to improve staging accuracy; however, no standardized localization technique exists. Carbon suspension (India ink) is an emerging, cost-effective method for lymph node marking prior to chemotherapy, but the optimal injection volume remains undefined. Reported volumes vary widely (0.2–4.2 mL), highlighting the need for evidence-based standardization. **Methods:** This single-centre randomized controlled trial included 46 patients with node-positive breast cancer (cN1; T1–T4a). Patients were randomized into two groups (n=23 each) for tattooing of the metastatic axillary lymph node prior to neoadjuvant chemotherapy using either 0.4 mL or 0.6 mL of diluted India ink under clinical guidance. Following neoadjuvant chemotherapy (NACT), all patients underwent modified radical mastectomy with sentinel lymph node biopsy and excision of the tattooed node. Outcomes assessed included detection rate of the tattooed node, false-negative rate (FNR), negative predictive value (NPV), technical feasibility, and procedure-related complications. **Results:** A total of 36 patients underwent modified radical mastectomy. Localization of the targeted node was successful in all cases. Detection rates of tattooed lymph nodes were comparable between the two groups (p=0.790), with no significant benefit observed with the higher

injection volume. The overall false-negative rate was 11.1%, and the negative predictive value was 90%, indicating moderate diagnostic accuracy. **Conclusion:** Low-volume carbon tattooing is a feasible and cost-effective method for axillary lymph node localization, with comparable detection rates across tested volumes. However, reliance on non-image-guided injection is associated with a relatively high false-negative rate. The findings suggest caution in adopting this approach for targeted axillary dissection.

OCCULT MALIGNANCY AND SENTINEL LYMPH NODE METASTASIS IN PROPHYLACTIC MASTECTOMY

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Problem statement: Guidelines recommend against routine sentinel lymph node biopsy (SLNB) at the time of prophylactic mastectomy, with a recent meta-analysis reflecting the low incidence of occult invasive malignancy and the avoidable morbidity of axillary surgery. Despite this, surveyed practice patterns show considerable variation, and contemporary Australian data are lacking. This study aimed to determine the incidence of occult malignancy and SLNB metastasis in patients undergoing prophylactic mastectomy at a tertiary Australian breast centre.

Methods: A retrospective cohort study was performed of consecutive female patients aged ≥ 18 years undergoing prophylactic mastectomy at Robina Hospital between July 2019 and December 2025. Patients were identified using operative records. Clinical, radiological and pathological data were collected from the integrated electronic medical record, including patient characteristics, surgical indication, preoperative imaging, histology, reconstructive procedures, occult malignancy and SLNB results.

Results: A total of 631 patients underwent prophylactic mastectomy, including 592 synchronous contralateral prophylactic mastectomies (CPM), 19 delayed CPM and 20 bilateral risk-reducing mastectomies. Median age was 54 years. All patients underwent preoperative breast imaging, including breast MRI in 411 (65%). Immediate breast reconstruction was performed in 316 patients (50%), and of those, 249 (79%) were implant-based. Fifty-two patients (8%) carried a pathogenic genetic variant. Final pathology demonstrated benign findings in 572 patients (91%), high-risk lesions in 40 (6%) and occult malignancy in 19 (3%), comprising 10 ductal carcinoma in situ and nine invasive carcinomas. Eighteen occult malignancies occurred following synchronous CPM and one following delayed CPM. SLNB was performed in 607 prophylactic mastectomies. Four positive sentinel lymph nodes (0.7%) were identified; all occurred during synchronous CPM and were attributable to metastases from the index breast cancer rather than occult malignancy within the prophylactic breast. Eight of nine patients with occult invasive carcinoma underwent SLNB, all of which were negative.

Conclusion: Occult malignancy after prophylactic mastectomy is uncommon, and node-positive occult invasive carcinoma within the prophylactic breast did not occur in this cohort. These findings support existing guideline recommendations against routine SLNB at prophylactic mastectomy and reinforce that a selective approach, guided by preoperative clinical, radiological, and pathological findings, remains the appropriate standard of care.

LYMPHOEDEMA

FROM THUMB TO AXILLA: NECROTISING LYMPHADENITIS WITH MULTI-ORGAN FAILURE AND RESULTING LYMPHOEDEMA

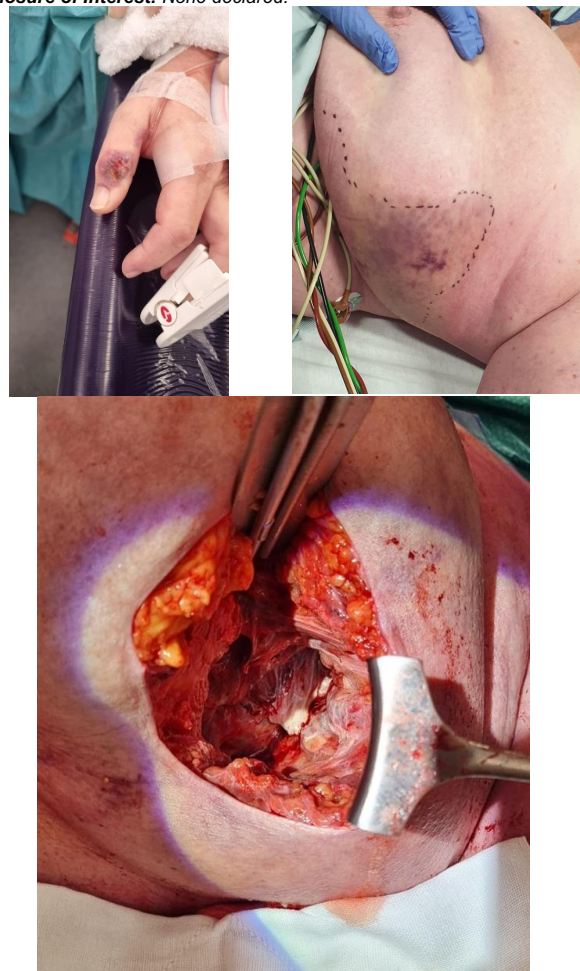
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Problem statement: Axillary pathology is frequently encountered in breast surgical practice, where the differential diagnosis spans malignancy, reactive lymphadenopathy, and infectious processes. Necrotising lymphadenitis (NL) of the axilla is exceptionally rare and, if not promptly recognised, can be rapidly fatal. Group A Streptococcus (GAS; *Streptococcus pyogenes*) is an under-reported cause of NL, with only four prior cases in the literature — three cervical and one axillary — none complicated by multiorgan failure or chronic lymphoedema. **Methods:** We report a single case of GAS axillary NL presenting to a tertiary surgical centre. Clinical, laboratory, microbiological, operative, and follow-up data

were reviewed. Relevant literature was identified through a PubMed search of GAS lymphadenitis case reports. **Results:** A 61-year-old immunocompetent woman presented in septic shock with left axillary pain and ecchymosis two days after a minor thumb laceration sustained while cutting fruit. Computed tomography demonstrated fat stranding of the left chest wall and axilla without subcutaneous gas. Surgical exploration revealed necrotic level I axillary lymph nodes with posterior axillary tracking of purulent fluid, with relative sparing of fascia and soft tissue — distinguishing this from necrotising fasciitis (NF). Blood cultures confirmed GAS bacteraemia consistent with streptococcal toxic shock syndrome (STSS). Management required resection of necrotic nodes, multiple operative debridements of axillary and breast tissue, haematoma evacuation, vacuum-assisted dressings, intravenous immunoglobulin (IVIg) and antibiotics, and continuous renal replacement therapy for acute renal failure. The patient spent 16 days in the intensive care unit (ICU) and 41 days in hospital. Long-term sequelae included persistent left upper limb lymphoedema and bilateral sudden sensorineural hearing loss (SSNHL), an under-recognised complication of severe sepsis. **Conclusion:** This is the first reported case of GAS axillary NL complicated by STSS and multiorgan failure, and represents the most severe phenotype described to date. For breast surgeons, GAS NL should be considered in patients with axillary pain, skin changes, or imaging abnormalities — even in the absence of an obvious portal of entry or subcutaneous gas. Early surgical exploration, aggressive debridement, and adjunctive IVIg are essential. Patients require close surveillance for lymphoedema and unexpected sequelae including SSNHL.

Disclosure of Interest: None declared.



CLINICAL BREAST CANCER RISK FACTORS AND MANAGEMENT OF BREAST LYMPHOEDEMA AFTER BREAST-CONSERVING TREATMENT: A SCOPING REVIEW

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Problem statement: Breast lymphoedema is poorly understood adverse effect of breast conserving treatment (BCT) and is often underdiagnosed. Symptoms of breast lymphoedema can significantly affect quality of life, however it is often underdiagnosed in clinical practice. Reported incidence varies from 0-94%, likely due to a lack of universally accepted diagnostic criteria. This scoping review aimed to characterize the literature regarding risk factors of breast lymphoedema and explore current evidence around management options. **Methods:** The study was conducted according to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Databases searched were PubMed, Medline, Embase, and Google Scholar, including papers published between 2010-2025. 39 manuscripts were included in the final analysis. **Results:** The main risk factors identified in this review were larger breast volume, high BMI, higher breast density, diabetes mellitus, larger tumor size, post-operative infection, increased breast separation, and use of conventional fractionation radiation therapy. Current evidence supports complex decongestive therapy (CDT), exercise alone or in combination with manual lymphatic drainage (MLD), and surgical techniques such as lymphaticovenous anastomosis (LVA) or vascularized lymph node transplant (VLNT) for the management of breast lymphoedema. **Conclusion:** Management of breast lymphoedema is understudied. A variety of risk factors have been associated with the development of breast lymphoedema, however many of them are supported by weak or conflicting evidence. Many of these risk factors require further investigation with more robust methodology.

METASTATIC BREAST CANCER

DEVELOPMENT AND CONTENT VALIDATION OF A TREATMENT SUMMARY AND WELLNESS PLAN FOR PEOPLE LIVING WITH METASTATIC BREAST CANCER

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Problem statement: People living with metastatic breast cancer (MBC) often require prolonged and complex care across oncology, palliative care, supportive care, primary care, and allied health services. Existing survivorship care plans may not adequately address ongoing treatment and evolving needs of this population. This study aims to develop and establish the content validity of a comprehensive treatment summary and wellness plan tailored to people living with MBC. **Methods:** A systematic, multiphase development and content-validation process was undertaken with a multidisciplinary stakeholder panel comprising clinicians from medical oncology, palliative care, supportive care, and allied health, together with people with lived experience of MBC recruited through Cancer Voices Australia and MBC Action Australia. Across two iterative review rounds, participants evaluated the plan's relevance, clarity, comprehensiveness, usability, and format. Feedback informed successive revisions, and Content Validity Index (CVI) scores were calculated to quantify stakeholder agreement. **Results:** A total of 32 stakeholders were invited to participate, (18 clinicians, 14 people with lived experience of MBC). Twenty six responses were received in Round 1, sixteen in Round 2. The treatment summary and wellness plan demonstrated excellent content validity, with the overall Scale-level Content Validity Index (S-CVI) increasing from 0.95 in Round 1 to 0.97 in Round 2. Round 1 resulted in 16 modifications with a further 5 refinements undertaken following Round 2. Revisions strengthened multidisciplinary team involvement, key contacts, and care-coordination arrangements. Symptom management information was revised, while psychosocial and practical domains including employment, family circumstances, and financial concerns were expanded. Individualised care planning and supportive care content were also enhanced. Clinical sections were refined to better reflect the evolving nature of MBC, including

clearer terminology and more comprehensive treatment history documentation. Layout modifications improved readability and usability for both patients and healthcare professionals. **Conclusions:** An iterative, multidisciplinary, and consumer-informed process produced a comprehensive treatment summary and wellness plan with excellent content validity for people living with MBC. The tool has the potential to support more coordinated, person-centred communication and care planning. Prospective clinical evaluation is required to assess its feasibility, acceptability, implementation, and impact on patient and health-service outcomes.

EXTRAMEDULLARY HAEMATOPOIESIS IN AXILLARY LYMPH NODES MIMICKING METASTATIC CARCINOMA OF BREAST: A POTENTIAL DIAGNOSTIC PITFALL

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Problem statement: Extramedullary haematopoiesis is rare and can affect the axillary lymph nodes. We present a case of extramedullary haematopoiesis mimicking metastatic breast carcinoma in the axillary clearance of a male patient with a history of myelofibrosis. **Results:** Extramedullary haematopoiesis (EMH) in adults is associated with haematological conditions, such as myelofibrosis, leukaemia, and haemolytic anaemias.¹ It usually occurs in the liver, spleen, paravertebral region, and lymph nodes. We highlight a case of a male patient with ER/PR positive and HER2 ultralow Grade 2 invasive duct carcinoma and multiple enlarged axillary nodes on imaging. An FNA highlighted a node with metastatic carcinoma. The histology of the axillary clearance reveals a single node with metastatic carcinoma and several enlarged nodes with extramedullary haematopoiesis. This patient was known to the haematolymphoid services for primary myelofibrosis diagnosed 4 years earlier. **Conclusion:** Extramedullary haematopoiesis can mimic malignancy, both clinically and radiologically. If a history of haematological conditions is known, vigilance when assessment of axillary nodes for clearance. A comprehensive clinicopathological correlation, special imaging like a FES PET for Hormone positive cancer would be advisable for surgical planning and appropriate treatment.

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METASTATIC LOBULAR CARCINOMA TO THE GASTROINTESTINAL TRACT MIMICKING PRIMARY GI MALIGNANCY

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Problem statement: Metastatic disease involving the gastrointestinal tract is rare with an incidence of 1% in clinical and autopsy series.^{1,2} The common primary tumours associated with gastrointestinal metastases include lung, ovary, breast, prostate, kidney, skin, stomach, and hepatobiliary system. The most common breast tumour to present as a gastrointestinal metastasis is lobular carcinoma which can present and mimic primary malignancy of the GI tract. **Methods:** To present two cases of secondary metastatic malignancies in biopsies taken from the gastric body and colonic splenic flexure. These are of breast lobular carcinoma, detailing the clinical presentations, endoscopic and histological findings, and patient outcomes. Our gastric metastasis presented within 6 months of primary breast cancer diagnosis. Our colonic metastasis presented after five years of primary breast cancer diagnosed in a different country. We will summarise similar cases over a 4-year period in our hospital. **Results:** The diagnosis of both cases required awareness of the past medical history, recognition on histology, and subsequent confirmation with immunohistochemistry. Metastatic lobular breast carcinoma to the gastrointestinal tract often presents with non-specific clinical manifestations, making diagnosis challenging as it can mimic inflammatory conditions or primary GI tract tumours.² **Conclusion:** Detecting and diagnosing metastatic lobular carcinoma to the GI tract can be challenging. This review highlights the importance of awareness of the possibility of this condition in the diagnostic assessment of GI lesions, particularly for cases with a history of primary breast cancer. The identification of the two reported cases as metastatic breast cancer in GI biopsies enabled these patients

to then follow the appropriate management pathway for metastatic lobular breast cancer and prevented unnecessary gastrointestinal tract resections and further management that would have been undertaken for a primary GI malignancy.

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REAL-WORLD PROGRESSION-FREE SURVIVAL (PFS) OF ABEMACICLIB + FULVESTRANT IN ER+, HER2- METASTATIC BREAST CANCER (MBC) IN US CLINICAL PRACTICE

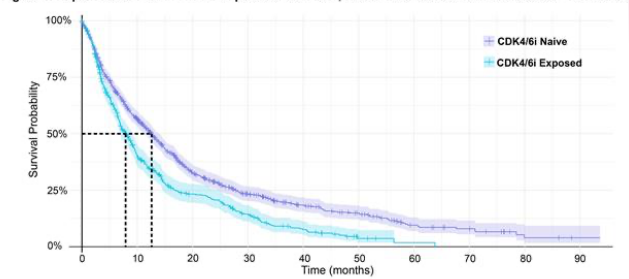
Aarohan Pruthi¹, Nada Boualam², Catherine Keane², Aashay Mehta², Madeline Richey², Brenda Grimes¹, Lindsay Williams¹, Jade Dreyer¹, Anna Emde¹, Adrienne M. Gilligan¹
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Problem statement: In the phase 3 MONARCH 2 and postMONARCH trials in HR+, HER2- MBC, abemaciclib+fulvestrant demonstrated a statistically significant PFS benefit vs placebo+fulvestrant in patients with endocrine resistant disease (MONARCH 2) and who had received a prior CDK4/6 inhibitor (CDK4/6i) (postMONARCH). However, effectiveness data from the real-world clinical setting is limited. This study describes real-world PFS (rwPFS) among patients with ER+, HER2- MBC receiving abemaciclib+fulvestrant in routine clinical practice in the US. **Methods:** This retrospective study used de-identified data from the Flatiron Health Research Database. Patients with ER+, HER2- BC and progression on a prior aromatase inhibitor [AI]; including the adjuvant setting) alone or with a CDK4/6i and who received abemaciclib+fulvestrant from September 2017 through May 2025 (index date) in the first line (1L) or second line (2L) were included. Patients with no evidence of treatment with SERD/chemotherapy/inhibitor of PI3K/mTOR treatment prior to the index date were excluded. Patient characteristics were reported descriptively. Median rwPFS (95% confidence interval [CI]), defined as time from index to progression or death, was estimated using the Kaplan-Meier method. **Results:** Of the 1,372 patients who received abemaciclib+fulvestrant in either the 1L (n=827; 60%) or 2L (n=545; 40%) (3 of 1,372 excluded for lack of follow-up), 64% (n=877) were CDK4/6i-naïve and 36% (n=492) were CDK4/6i-exposed. Median age was 66 years (IQR; 59-74) and 79% were treated in a community practice setting (Table 1). Median follow-up for rwPFS was 18 months (IQR; 8-32). Median duration of abemaciclib+fulvestrant was 7.1 months (IQR; 2.8-15.8). Progression occurred in 1,049 (77%) patients (Figure 1). Median rwPFS was 10.3 months (95% CI 9.5-11.4) overall, 12.6 months (95% CI 11.3-13.9) in CDK4/6i-naïve patients, and 7.9 months (95% CI 6.9-9.1) in CDK4/6i-exposed patients (Table 2). **Conclusions:** These real-world data in patients with ER+, HER2- MBC demonstrate the benefit of abemaciclib+fulvestrant established in MONARCH 2 and postMONARCH in patients with HR+, HER2- MBC translates into routine clinical practice in patients with or without prior CDK4/6 inhibitor exposure. Future studies will be needed to assess the evolving MBC treatment landscape as oral SERDs and PI3K inhibitors are incorporated into earlier lines of treatment.

Disclosures of interest:

A. Gilligan, A. Emde, L. Williams are employees of Eli Lilly and Company. A. Pruthi is an employee and holds stocks in Eli Lilly and Company. J. Dreyer and B. Grimes are employees and minor shareholders of Eli Lilly and Company.
C. Keane is an employee of Flatiron Health Inc., has stock ownership in Roche Pharmaceuticals.
M. Richey and A. Mehta are employees of Flatiron Health Inc., and report stock ownership in Roche Pharmaceuticals.
N. Boualam is an employee of Flatiron Health Inc.

Figure 1. Kaplan Meier Plot of rwPFS in patients with ER+, HER2- MBC treated with abemaciclib+fulvestrant



CDK4/6i Naïve	At Risk 877	443	212	120	74	49	20	13	3	1
Cumulative events 7	367	537	593	615	628	643	646	650	650	
CDK4/6i Exposed	At Risk 492	166	81	46	20	4	1	0	0	0
Cumulative events 1	275	339	369	389	397	398	399	399	399	

Footnote: rwPFS is defined as the time from the index date to the earliest date of progression or death, whichever comes first. Data were available through August 2025 to allow for at least 3 months follow-up. Patients are censored on the last clinic note date.

Table 1. Demographic and clinical characteristics of patients with ER+, HER2- MBC			
Abemaciclib+Fulvestrant			
	Overall N=1,372	CDK4/6i-naïve n=880	CDK4/6i-exposed n=492
Age (years) at index date			
Median (IQR)	66 (59, 74)	67 (61, 74)	64 (57, 73)
Age (years) at index date, n (%)			
18-64	593 (43%)	344 (39%)	249 (51%)
65-74	453 (33%)	320 (36.4%)	133 (27%)
≥75	326 (24%)	216 (25%)	110 (22%)
Birth Sex, n (%)			
Male	6 (<1%)	3 (<1%)	3 (<1%)
Female	1,366 (>99%)	877 (>99%)	489 (>99%)
ECOG PS at metastatic diagnosis date, n (%)			
0/1	759 (55%)	544 (62%)	215 (44%)
2+	29 (2%)	13 (2%)	16 (3%)
Missing	584 (43%)	323 (37%)	261 (53%)
Prior treatment with CDK4/6i, n (%)			
Abemaciclib	184 (13%)	0 (0%)	184 (37%)
Palbociclib	272 (20%)	0 (0%)	272 (55%)
Ribociclib	48 (4%)	0 (0%)	48 (10%)
Index Line Number, n(%)			
1L	827 (60%)	778 (88%)	49 (10%)
2L	545 (40%)	102 (12%)	443 (90%)
Adjuvant Regimen of CDK4/6i, n (%)			
Yes	40 (3%)	0 (0%)	40 (8%)
No	1,332 (97%)	880 (100%)	452 (92%)
Practice Type, n (%)			
Academic	193 (14%)	117 (13%)	76 (15%)
Community	1,077 (79%)	703 (80%)	374 (76%)
Both	102 (7%)	60 (7%)	42 (9%)

*Percentages may not total 100 because of rounding.

Table 2. rwPFS of patients with ER+, HER2- MBC treated with abemaciclib+fulvestrant			
rwPFS N (%)			
	Overall N=1,369	CDK4/6i-naïve n=877	CDK4/6i-exposed n=492
Progression	1,049 (77)	650 (74)	399 (81)
Censored	320 (23)	227 (26)	93 (19)
Median rwPFS, months (95% CI)	10.3 (9.5-11.4)	12.6 (11.3-13.9)	7.9 (6.9-9.1)

Footnote: rwPFS is defined as the time from the index date to the earliest date of progression or death, whichever comes first. Patients are censored on the last clinic note date.

COUNTED AT LAST: LEADING CONSUMER-DRIVEN DATA REFORM TO MAKE METASTATIC BREAST CANCER VISIBLE

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Problem statement: The lack of comprehensive data on metastatic breast cancer (MBC) has been a significant barrier to recognising the needs of people living with metastatic disease and delivering optimal, equitable care. While cancer data systems routinely capture incidence and mortality, many registries do not systematically record stage and recurrence, leaving people living with MBC underrepresented in national data. This invisibility creates a fundamental controversy: how can health systems effectively plan services, allocate resources and address inequities when the true burden of metastatic disease is unknown? Breast Cancer Network Australia (BCNA) identified this gap through consumer advocacy and called for improved national measurement of MBC prevalence. **Methods:** Guided by lived experience and consumer leadership, BCNA prioritised national MBC visibility

through policy advocacy and stakeholder collaboration. Following BCNA's 2023 National Roundtable and roadmap report, state-based linked-data methodologies were developed and refined. Building on this foundation, the Australian Institute of Health and Welfare (AIHW), supported by Cancer Australia and government partners, used linked national datasets, including cancer diagnoses, mortality, medicines and healthcare utilisation data, to estimate national MBC prevalence. **Results:** Australia's first national MBC prevalence estimate identified approximately 20,950 people living with MBC at the end of 2024, including approximately 20,800 women and 150 men. This estimate is more than double BCNA's previous 2020 estimate of 10,553 people, revealing the extent to which MBC has historically been undercounted. These findings challenge assumptions about the scale of metastatic disease in Australia and highlight the consequences of data gaps for people living with advanced disease. The project demonstrates the value of linked-data approaches to quantify disease burden and inform future cancer planning. **Conclusion:** This national first demonstrates how consumer advocacy can challenge established systems, drive data reform and ensure previously overlooked populations are recognised. Improved visibility of MBC provides a stronger evidence base for supportive care planning, policy advocacy and equitable cancer care. This approach provides a model for collecting stage and recurrence for other cancers and demonstrates the critical role of consumers in shaping future cancer data systems.

Disclosure of Interest: None

FROM BENIGN APPEARING BREAST LESION TO RAPID METASTATIC DISEASE. A CASE REPORT OF A MALIGNANT PHYLLODES TUMOUR

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Problem statement: Malignant phyllodes tumours are rare fibroepithelial breast neoplasms, accounting for less than 1% of breast malignancies. Although most remain localised, malignant phyllodes tumours have the potential for haematogenous metastasis, most commonly to the lungs and less frequently to bone. There are currently no established guidelines for systemic staging or treatment of metastatic disease, and prognosis following distant metastasis remains very poor. **Case report:** We present the case of a 56-year-old woman who presented with a palpable breast lump. Initial core biopsy demonstrated low grade spindle neoplasm and she underwent excisional biopsy of this lesion. Her post-operative histopathology demonstrated a malignant phyllodes tumor measuring 55mm. Due to involved margins, she underwent further breast conserving surgery with subsequent clear margins. Post-operative CT staging demonstrated small indeterminate pulmonary nodules and surveillance was planned as per MDT recommendation. Three months later, she developed new-onset back and shoulder pain, with imaging demonstrating multifocal osseous lesions involving the sacrum, thoracic spine, and proximal humerus, alongside progression of pulmonary nodules. FDG PET/CT and image-guided bone biopsy confirmed metastatic malignant phyllodes disease. **Conclusion:** Metastatic malignant phyllodes tumours are rare, aggressive neoplasms with limited evidence to guide staging or management. This case highlights the potential for rapid progression despite adequate local control with a very poor prognosis. Further research is required to establish evidence-based strategies for the management of metastatic malignant phyllodes tumours.

NEOADJUVANT THERAPY

THE EFFECT OF BODY COMPOSITION ON NEO-ADJUVANT CHEMOTHERAPY RESPONSE, TOXICITY, AND PROGNOSIS IN BREAST CANCER: A SCOPING REVIEW

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Problem statement: Breast cancer is the leading cause of cancer-related death in women worldwide. There is increasing interest in the use of detailed body composition parameters, such as skeletal muscle mass and adiposity, to better predict treatment response, toxicity, and survival in breast cancer patients receiving neoadjuvant chemotherapy (NAC). The study aims to synthesize

current literature on the effect of body composition on pathological response, chemotherapy toxicity, and prognosis in breast cancer patients undergoing NAC, and to identify gaps for future research. **Methods:** A scoping review was conducted per PRISMA-ScR and Arksey & O'Malley frameworks. Embase, MEDLINE, PubMed, and Google Scholar were searched for studies published from 2010–2025. Eligible studies included female breast cancer patients receiving NAC with body composition assessments performed and at least one of the relevant outcomes of response, toxicity, or prognosis investigated. Data was extracted and summarized based on each outcome. **Results:** Twenty studies met inclusion criteria (16 pathological response, 6 toxicity, 10 prognosis); 19 were retrospective. Computed tomography at the L3 vertebral level was the most common assessment method. Sarcopenia was linked to reduced pathological response in 3 studies, while findings for adiposity and response were inconsistent. Half the studies investigating toxicity reported greater toxicity related events in patients with sarcopenia and/or adiposity. Prognostic impact was more frequently associated with visceral adiposity, while sarcopenia predicted worse survival in only one study. Heterogeneity in body composition parameters and outcome definitions, measurement techniques used, and patient populations included limits comparability of these studies. **Conclusion:** Adiposity may adversely affect NAC toxicity and prognosis in breast cancer patients, while the impact of sarcopenia remains inconsistent. Prospective, standardized research is needed to further establish the prognostic value of body composition in breast cancer patients, and its potential use in treatment planning.

OUTCOMES FOR EARLY-STAGE TRIPLE-NEGATIVE BREAST CANCERS RECEIVING NEOADJUVANT SYSTEMIC TREATMENT IN TBCCpo

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Problem statement: Triple negative breast cancer (TNBC) is an aggressive subtype lacking hormone receptors, limiting targeted therapies. Neoadjuvant systemic therapy is standard for early-stage TNBC, aiming to achieve a pathological complete response (PCR), which correlates with improved survival. However, local outcome data from Brunei remain limited. **Methods:** A retrospective cohort study was conducted using medical records of patients diagnosed with early-stage (Stage I-III) TNBC who received neoadjuvant systemic therapy at The Brunei Cancer Centre (TBCC) between October 2021 and June 2025. Within the final cohort of 31 patients, 87.0% (n = 27) received carboplatin/paclitaxel or nab/paclitaxel + pembrolizumab, followed by doxorubicin and cyclophosphamide (AC) + pembrolizumab regimen, 9.8% (n = 3) received an AC + carboplatin/paclitaxel or nab/paclitaxel regimen, and 3.2% (n = 1) received another non-immuno-oncology (IO)-based regimen. **Results:** Among 31 patients (mean age 49.9 years), 55.2% (16/29) achieved PCR. At a median follow-up of 29 months, the overall survival (OS) for the cohort was 86%. Relapse-free survival (RFS) at 30 months was approximately 94% for patients achieving pCR compared to 84% for those who did not; however, this difference was not statistically significant (P=0.61). Treatment-related toxicities were predominantly CTCAE Grade 1-2. Nonetheless, severe (Grade 3-4) events occurred across dermatologic, endocrine, and neurologic categories, alongside one fatal (Grade 5) infectious event. **Conclusion:** Our institutional data from TBCC suggest that patients with TNBC receiving neoadjuvant chemotherapy and immunotherapy achieved outcomes comparable to those reported in international cohorts.

Disclosure of Interest: The authors declare no conflicts of interest. No funding was received for this study.

Figure 1. Patient Flow Chart

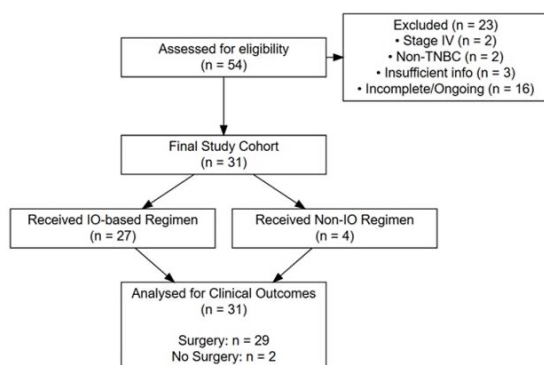


Table 1. Baseline Clinical and Pathological Characteristics of the Study Cohort (n = 31)

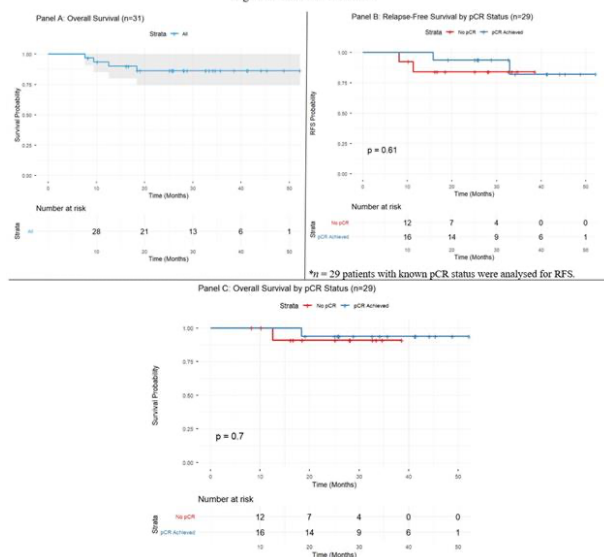
Variable	Mean (SD)	n (%) ¹	n (%) ^{2*}	n (%) ^{3*}
Age at Diagnosis (Year)				
¹ Overall	49.9 (13.1)	-	-	-
² Achieved	46.7 (10.5)	-	-	-
³ Not Achieved	55.2 (14.2)	-	-	-
Ethnicity				
Malay	-	25 (80.6)	13 (81.0)	10 (77.0)
Chinese	-	4 (12.9)	1 (6.3)	3 (23.0)
Others	-	2 (6.5)	2 (13.0)	0 (0.0)
Clinical Stage				
Stage I	-	2 (6.5)	1 (6.3)	1 (7.7)
Stage II	-	18 (58.1)	9 (56.0)	9 (69.2)
Stage III	-	11 (35.5)	6 (38.0)	3 (23.1)
Histological Type				
Ductal	-	29 (93.5)	15 (94.0)	12 (92.3)
Metaplastic	-	1 (3.2)	1 (6.3)	0 (0.0)
Ductal & Lobular	-	1 (3.2)	0 (0.0)	1 (7.7)
Ki67 Expression				
Low (<30%)	-	3 (9.7)	1 (6.3)	2 (15.4)
High (>30%)	-	28 (90.3)	15 (93.7)	11 (84.6)
Germline BRCA Status				
Positive	-	4 (12.9)	3 (18.8)	1 (7.7)
Negative	-	19 (61.3)	11 (68.8)	7 (53.8)
Not Tested	-	8 (25.8)	2 (12.5)	5 (38.5)

¹ Overall (n = 31)² Achieved (n = 16)³ Not Achieved (n = 13)

*Two patients did not undergo surgery due to disease progression/death and were therefore excluded from the pCR denominator

SD = Standard Deviation; BRCA = BRCA2/BRCA1 gene

Figure 2. Survival Outcomes



ONCOPLASTIC/RECONSTRUCTIVE SURGERY

FAVOURABLE OBJECTIVE AESTHETIC OUTCOMES FOLLOWING CHEST WALL PERFORATOR FLAP RECONSTRUCTION

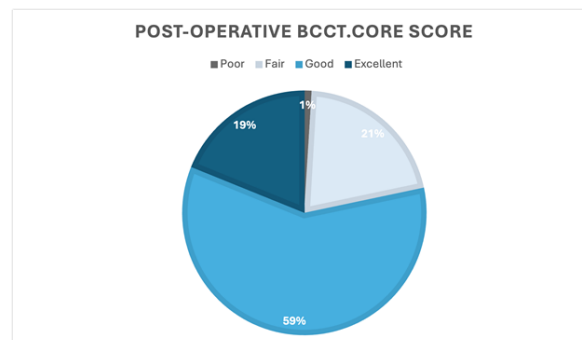
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Problem statement: Chest wall perforator flaps (CWPF) are an established oncoplastic option for volume replacement in breast conserving surgery (BCS) for patients requiring larger resections. However, objective data evaluating aesthetic outcomes remains limited. This study assesses aesthetic outcomes using BCCT.core software in a contemporary CWPF cohort. Secondary outcomes

included revision rate and complications. **Methods:** This retrospective single-institution cohort study included consecutive patients who underwent BCS with CWPF reconstruction at Westmead Breast Cancer Institute between January 2020 and April 2025. Demographic, oncological, operative, and follow-up data were collected from medical records. Clinical photography databases were used for BCCT.core assessment. **Results:** 283 patients underwent CWPF reconstruction (222 LICAP, 31 AICAP, 27 MICAP, 3 LTAP flaps). Mean age was 57.8±11.6 years. Objective post-operative aesthetic assessment using BCCT.core software was available for 106 patients, demonstrating 0.9% poor, 20.7% fair, 59.4% good, and 18.9% excellent results. Median time to photographic assessment was 8.0 months (IQR 0.6–13.3 months). Among 81 patients with paired pre- and post-operative photography, 65.4% had maintained, whilst 17.3% improved and 17.3% worsened their aesthetic score. Worse aesthetic outcomes were not significantly associated with post-operative complications, adjuvant radiotherapy or specimen resection weight. Delayed revisional surgery was required in 5.4% of patients, including wound revision (3.1%), lipofilling (2.7%), and procedures for fat necrosis (0.8%). Patients requiring revisional surgery were more likely to have experienced immediate post-operative complications (OR 4.52, 95%CI 1.48–13.82, p=0.004), and had heavier specimen resection (median 87g vs 46g; Mann-Whitney U=795.5, p=0.04). Margin re-excision was required in 17.8% (n=50) of patients, with 4.4% (n=12) required conversion to mastectomy. Fat necrosis occurred in 9.6% (n=25) of patients. Post-operative complications occurred in 15.7% (n=41) patients, most commonly wound infection/dehiscence (8.8%), haematoma (3.1%), and recurrent/complex seromas (3.8%). **Conclusion:** This represents the largest reported cohort of CWPF cases with objective aesthetic assessment using BCCT.core. Overall, 78.3% of patients achieved good or excellent BCCT.core scores, with most maintaining aesthetic appearance compared to their native breast. Delayed revisional procedures were infrequent. These outcomes support CWPF as a durable oncoplastic volume replacement option that facilitates breast conservation in patients requiring larger resections where mastectomy may otherwise have been considered.

Characteristic	Overall cohort (n=283)
Age, mean ± SD	57.8 ± 11.6
BMI, median (IQR)	27.4 (7.4)
Tumour size on imaging (mm), median (IQR)	23 (19)
Specimen weight (grams), median (IQR)	46.0 (48.7)
Adjuvant radiotherapy	96.2%
Adjuvant radiotherapy & boost	69.6%
Neoadjuvant chemotherapy	25.1%
Margin re-excision	17.8%
Conversion to mastectomy	4.4%
Fat necrosis	9.6%
Post-operative complication	15.7%
Delayed revisional Surgery	5.4%



IMMEDIATE PARTIAL BREAST RECONSTRUCTION WITH MODIFIED CHEST WALL PERFORATOR FLAPS FOR BREAST CANCER: LONGITUDINAL ONCOLOGICAL, IMAGING AND PATIENT-REPORTED OUTCOMES FROM A 50-PATIENT SERIES

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Problem statement: Chest wall perforator flaps offer an elegant solution for single-stage autologous volume replacement following

breast cancer wide local excision. We first presented our early experience with the modified lateral intercostal artery perforator (LICAP) flap in 2018. Unanswered questions remain regarding the effects of this reconstructive technique on surveillance imaging and patients' subjective experiences. We aimed to address these questions in our cohort of patients. **Methods:** This retrospective cohort study included all patients undergoing immediate chest wall perforator flap reconstruction following breast cancer excision by a single surgeon (SE). Ethical approval was gained from our institution. Demographics, comorbidities, and tumour characteristics were collected. Surgical outcomes including re-excision rate, conversion to mastectomy and postoperative complications were documented; as were oncologic outcomes of local/distant recurrence. Surveillance ultrasound reports were reviewed for the presence of flap-related changes and whether these led to further investigations; and correlated with outpatient clinical examination. Patient were invited to complete the BREAST-Q questionnaire. **Results:** Fifty women underwent chest wall perforator flap reconstruction. Of these, 34 (68%) were modified LICAP flaps, ten were extended AICAP flaps, and six were MICAP or combined perforator flaps. No patients developed flap necrosis. One patient experienced a Clavien-Dindo ≥ 3 complication (seroma aspirated under ultrasound guidance). Four patients (8%) required re-excision of margins, and five (10%) underwent mastectomy. Over a median follow-up of 48 months, one patient developed both local breast recurrence and distant metastasis, while another developed distant metastasis alone. Twenty-eight patients had reached their two-year surveillance imaging at the time of analysis. Twelve (43%; 95% CI 26.5%–60.9%) demonstrated flap-related sonographic changes, including fat necrosis, oil cysts, or chronic seroma. Only one patient in the cohort (4%) had sonographic changes which caused sufficient concern to warrant a biopsy (which showed benign calcifications).

Twenty-seven patients completed the postoperative BREAST-Q questionnaire with a median satisfaction-with-breasts score of 93%. **Conclusion:** Partial breast reconstruction using modified chest wall perforator flaps demonstrates favourable oncological and patient-reported outcomes. Although flap-related changes are common on surveillance imaging, they rarely necessitate biopsy, suggesting an acceptable impact on postoperative breast cancer surveillance.

Figure 1: Modified LICAP flap

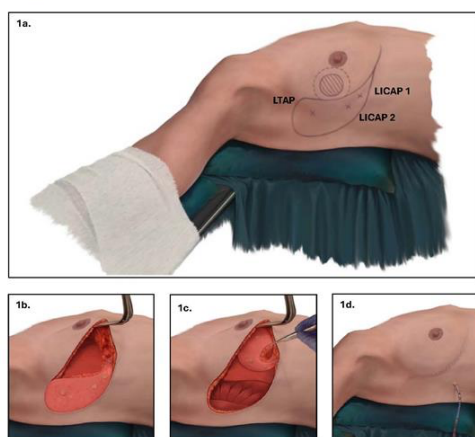


Figure 1: Schema of modified LICAP flap. 1a: Positioning and marking, with lateral thoracic and lateral intercostal artery perforators marked (labelled LTAP, and LICAP 1 and 2). 1b: Appearance post-resection, with vascular pedicles preserved. 1c: Positioning of flap. 1d: Post-operative appearance. Artist: Dr Lucy O'Brien

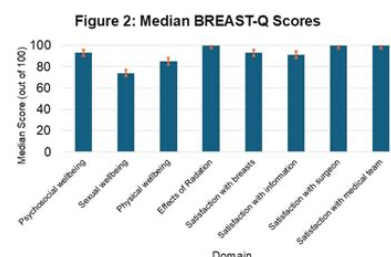


Figure 2: Median BREAST-Q questionnaire version 2.0 scores across the 27 patients who completed the survey.

LOOKING BEYOND RAW IMMEDIATE BREAST RECONSTRUCTION RATES: ACCESS, PATIENT HEALTH AND CHOICE IN A PUBLIC HOSPITAL

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Problem statement: Immediate breast reconstruction (IBR) is an established part of breast cancer care, and hospital IBR rates are increasingly used to judge quality and access. In 2020–2021, 22% of mastectomies for primary invasive breast cancer in NSW public hospitals included IBR. (1) However, a single institutional rate may be misleading because reconstruction decisions are also shaped by age, general health, cancer complexity, operative risk and patient preference. We examined the factors influencing IBR uptake in a public hospital. **Methods:** We retrospectively reviewed all women undergoing mastectomy at Nepean Hospital from January 2023 to December 2025. Demographic, oncological, medical and operative data were collected. As part of routine consent, patients were counselled about simple, skin-sparing and nipple-sparing mastectomy, with or without reconstruction. Established unit pathways provided access to reconstructive expertise and aimed to minimise barriers related to patient cost and theatre availability. **Results:** Of 145 patients, 54 (37%) underwent IBR; 80% were implant-based. Patients receiving IBR were younger than those who did not (median age 52 vs 71 years) and were more commonly lower-risk ASA I–II patients (85%). Among patients aged ≤ 60 years with ASA I–II status, 73% underwent IBR. In the remainder, non-reconstruction reflected locally advanced disease or an informed preference not to undergo immediate reconstruction. Increasing age independently predicted lower IBR uptake. **Conclusion:** High IBR uptake can be achieved in a public hospital when reconstructive options are routinely discussed, and access barriers are minimised. However, the overall hospital rate alone cannot distinguish limited access from appropriate clinical selection or patient choice. A fairer quality measure should combine universal discussion of options, documented shared decision-making and case-mix-adjusted uptake. The 73% IBR rate in younger, lower-risk patients may offer a clear sentinel measure of public-hospital access but requires multicentre validation and should not become a target that overrides oncological considerations or individual preference.

1. Cancer Institute NSW Reporting for Better Cancer Outcomes 2022 report

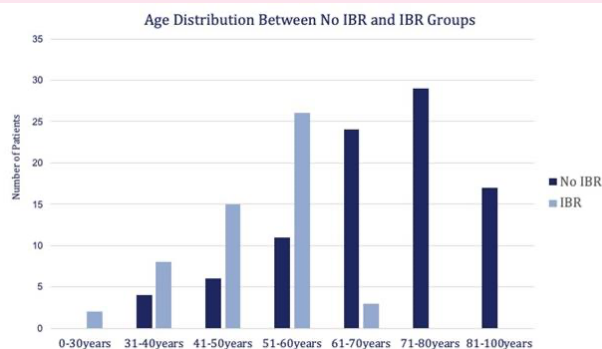


Table of IBR Uptake by ASA Categories in Women ≤ 60 years

	No IBR (N)	IBR (N)	Total(N)	IBR Rate (%)
ASA1+2	16	44	60	73.3
ASA3+4	5	7	12	58.3
Total	21	51	72	70.8

Multivariable logistic regression analysis of factors associated with immediate breast reconstruction (IBR)

Predictor	Adjusted OR (95% CI)	p-value
Age (years)	0.88 (0.84–0.92)	<0.001
BMI (kg/m ²)	1.09 (1.00–1.18)	0.059
ASA2 vs ASA1	0.30 (0.04–2.03)	0.216
ASA3 vs ASA1	0.07 (0.01–0.72)	0.025
Ex-smoker vs non-smoker	2.87 (0.91–9.16)	0.076
Active smoker vs non-smoker	1.46 (0.25–8.52)	0.675
CALD vs non-CALD	0.36 (0.12–1.10)	0.073
PMRT	1.13 (0.43–2.98)	0.809
Neoadjuvant chemotherapy	0.74 (0.23–2.38)	0.612

Model adjusted for age, BMI, ASA, smoking status, CALD status, PMRT, and neoadjuvant chemotherapy. Outcome: IBR status (Yes=1). AUC=0.90.

CLINICAL PATHWAYS AND OUTCOMES FOLLOWING IMMEDIATE IMPLANT-BASED BREAST RECONSTRUCTION AND POST-MASTECTOMY RADIOTHERAPY: A 9-YEAR ANALYSIS

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Problem statement: Post-mastectomy radiotherapy (PMRT) is increasingly encountered in patients undergoing implant-based breast reconstruction, highlighting the importance of understanding the impact of PMRT on reconstructive outcomes and identifying approaches to reduce associated morbidity. PMRT is associated with higher rates of implant-related complications, including capsular contracture, reconstructive failure, and revision surgery. The optimal reconstructive strategy and timing of radiotherapy remain uncertain however, and there is limited high-quality comparative data regarding pre-pectoral versus sub-pectoral implant placement, direct-to-implant versus staged reconstruction and irradiation of tissue expanders versus permanent implants.

Methods: A retrospective single-centre review was performed of consecutive patients who underwent post-mastectomy radiotherapy following nipple- or skin-sparing mastectomy with immediate implant-based breast reconstruction (direct-to-implant or two-stage) between January 2015 and December 2023. The primary outcome was reconstructive failure, defined as the permanent removal of the breast prosthesis without subsequent implant or autologous reconstruction. Secondary outcomes included re-operation, infection, delay to adjuvant therapy, capsular contracture and unplanned conversion to autologous reconstruction. Outcomes were classified as short term (≤30 days) or long term (>30 days) from the date of surgery. **Results** A total of 123 patients were included. Single-stage direct to implant reconstruction occurred in 76 cases and approximately half of all patients had pre-pectoral implant placement. After accounting for

implant plane (pre-pectoral or sub-pectoral), reconstruction type (direct-to-implant or two-stage), and the timing of PMRT (to tissue expander or permanent implant), six clinical pathways were identified. Outcomes according to reconstructive pathway will be presented, including short-term outcomes (infection and implant salvage), long-term reconstructive outcomes (capsular contracture and revision surgery including lipofilling, unplanned conversion to autologous reconstruction) and disease recurrence. Changes in reconstructive practice over the study period demonstrated increased utilisation of nipple-sparing mastectomy, pre-pectoral implant placement, and direct-to-implant reconstruction.

Conclusion: This study provides contemporary Australian data on short and long term outcomes following immediate implant-based breast reconstruction in patients receiving PMRT. By evaluating a cohort including pre-pectoral and subpectoral implant placement, direct-to-implant and two-stage reconstruction, and irradiation of tissue expanders and permanent implants, this study aims to characterize outcomes across different reconstructive pathways and inform multidisciplinary decision-making and patient counselling.

CAN ABSORBABLE MESH REPLACE /MINIMISE THE NEED OF PEDICLED FLAPS TO RECONSTRUCT MODERATE TO LARGE SIZE DEFECT FOLLOWING BREAST CONSERVATION SURGERY; A NOVEL TECHNIQUE. PROSPECTIVE PILOT STUDY

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Problem statement: Moderate to large size defects resulting after breast cancer surgery are usually reconstructed by pedicled flaps, among which Latissimus Dorsi and Thoracoabdominal flaps are the most common flaps. These flaps can be used to reconstruct more than one quadrants, but these options have inherent donor site morbidity. Objective was to reconstruct moderate to large size defects of two or more quadrants using absorbable mesh after resection of breast cancer lump following breast cancer surgery.

Methods: A pilot study including 32 patients of breast cancer was conducted from May 2025 to June 2026. The size of the tumor was 5 cm to 8 cm (mean - 6.8 cm). Location of tumor was UIQ, UOQ, LOQ, LIQ, CENTRAL QUADRANT and combination as in MULTIFOCAL/ MULTICENTRIC breast cancers. Post resection defect size of residual breast cavity was 12 cm x 8 cm x 6 cm (L x W x D). Absorbable single mesh of sizes measuring 7cm x 10cm and 11cm x 11 cm was used. A 3 D scaffolding was created in situ. Mesh was fixed to the underlying pectoralis major muscle using PDS 3-0 suture. Wound closed in layers. Patients were followed for a period of 12 months after surgery including 3 months post radiation therapy. Mesh resorption and tissue remodelling was monitored with serial breast ultrasound at the interval of 3 months after surgery till 3 months after adjuvant radiation therapy. The BREAST-Q Reconstruction questionnaire were conducted and patient reported outcomes measures (PROMs) were assessed.

Results: Majority of the patients revealed no residual mesh segment after 5 months from surgery where > 90% of the patients showed complete breast tissue modelling within 3 to 4 months. There was no wound infection, fistula or scarring after radiation therapy. There was no delay in adjuvant treatment. Post-operative q score analysis of 32 patients reported to be ranging from 86 to 96 (mean value of different parameters in score). **Conclusion:** Absorbable mesh can be utilised to reconstruct the post breast conservation surgery defects with satisfactory functional and cosmetic outcome. This technique does not compromise oncological safety outcome.

Disclosure: There was no conflicts of interest.



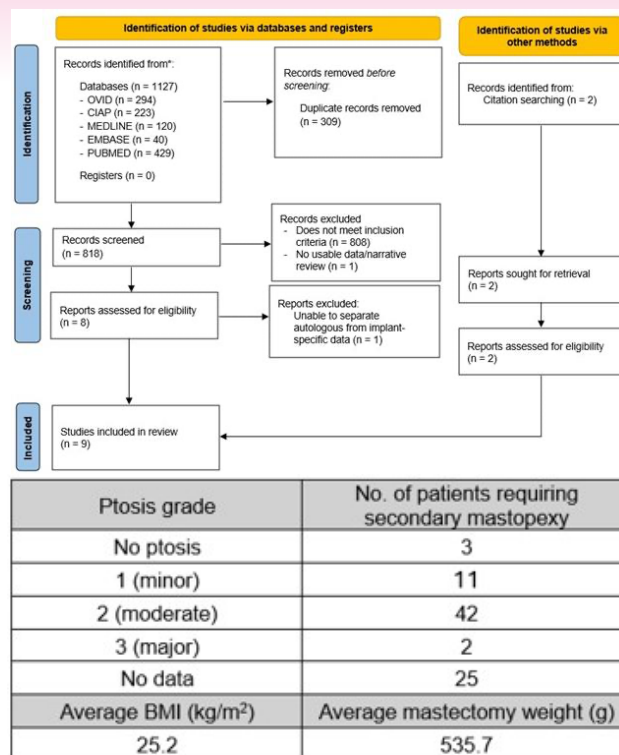


SECONDARY MASTOPEXY FOLLOWING IMPLANT-BASED BREAST RECONSTRUCTION: A SYSTEMATIC REVIEW

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Problem statement: Implant-based reconstruction following nipple-sparing mastectomy (NSM) is widely used for breast cancer treatment and risk reduction. Subsequent skin-envelope ptosis, nipple-areola complex (NAC) malposition and combined implant-pocket deformity may compromise reconstructive outcomes and require secondary correction. Mastopexy in this setting differs from cosmetic mastopexy because mastectomy-flap thickness, vascularity and mobility may be altered, while the implant, capsule and reconstructed pocket influence operative planning. This review evaluated the techniques, safety and durability of secondary mastopexy following implant-based NSM reconstruction. **Methods:** The review was conducted in accordance with PRISMA guidelines and prospectively registered with PROSPERO (CRD420261449028). MEDLINE and Embase via Ovid and PubMed were searched using terms relating to secondary or delayed mastopexy, revision mammoplasty, nipple malposition, NSM and implant-based reconstruction. Studies reporting delayed mastopexy, skin-envelope reshaping or repositioning of the preserved native NAC were included. Cosmetic mastopexy, autologous-only reconstruction, procedures performed before or during the index mastectomy, and studies without an eligible delayed corrective procedure were excluded. Risk of bias was assessed using Joanna Briggs Institute critical appraisal tools, and certainty of evidence was evaluated using GRADE. Owing to clinical and methodological heterogeneity, findings were synthesised descriptively. **Results:** Nine studies, comprising six retrospective case series and three case reports, included 83 patients and 129 treated breasts. Techniques included periareolar, vertical and inverted-T mastopexy, mastectomy-flap re-elevation and dermo-capsular flap procedures. Adjunctive procedures included implant exchange, capsulorrhaphy, pocket revision and autologous fat grafting. Reported complications included partial wound dehiscence, transient NAC epidermolysis and recurrent malposition or asymmetry. No total NAC necrosis, implant exposure or implant loss was reported. Methodological concerns included small selected cohorts, retrospective design, inconsistent outcome definitions, variable follow-up and limited use of objective measurements or validated patient-reported outcomes. Certainty was very low because of risk of bias, serious imprecision, clinical heterogeneity and possible selective publication. **Conclusion:** Secondary mastopexy and native NAC repositioning appear technically feasible in selected patients following implant-based NSM reconstruction. However, very-low-certainty evidence precludes firm conclusions regarding procedural safety, comparative effectiveness or long-term durability. Prospective multicentre studies using standardised anatomical measurements, complication definitions and BREAST-Q outcomes are required.



Paper	Sample size		Mastopexy technique					Adjuncts
	Patients	Breasts	Directional skin excision	Crescent	Inverted-T	Donut	Vertical	
Ahmed et al.	33	60	0	32	0	0	1	Free flap as 2nd stage reconstruction
Campbell et al.	1	10	0	0	10	0	0	Anterior capsulotomy, lateral capsulorrhaphy, mesh placement
Cantrell et al.	1	2	0	2	0	0	0	None described
Cogliandro et al.	20	28	0	5	7	0	0	Dermo-capsular inferior pedicle flap
Salibian et al.	10	14	0	0	14	0	0	Bipedicle inferior and superior dermal fat flaps, capsulotomies, lateral capsulorrhaphy
Salgarello et al.	1	1	0	0	0	1	0	Lateral partial capsulotomy and capsulorrhaphy, contralateral subglanular implant
Small et al.	10	10	0	8	2	0	0	Exchange to smaller implant
Taneda et al.	1	1	0	0	1	0	0	Rotation flap and an advancement flap
Takayanagi	2	3	0	0	0	3	0	Use of tissue expanders, subcutaneous tissue grafting, lipofilling

PREVENTION

OPIOID OVERPRESCRIBING AFTER BREAST CANCER SURGERY: A PROSPECTIVE OBSERVATIONAL STUDY FROM AN AUSTRALIAN QUATERNARY CANCER CENTRE

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Problem statement: Postoperative opioids are routinely prescribed after breast cancer surgery, yet procedure specific data on actual consumption and overprescribing in Australian practice are limited. Patients with early stage breast cancer are typically opioid naïve and long term survivors, making avoidance of unnecessary opioid exposure a priority. **Methods:** We conducted a prospective observational study of opioid naïve adults undergoing breast cancer surgery between June 2021 and January 2023. Demographic, surgical, and perioperative analgesic data were collected, and discharge opioid prescriptions were converted to oral morphine equivalent dose and endone. Overprescribing was defined as $\geq 50\%$ of unused opioids at postoperative day 7. Patients were followed up on day 7 and 28. **Results:** Thirty three patients were included: 16 underwent wide local excision and 17 underwent mastectomy. At day 7, 38% of WLE patients reported no outpatient opioid use at all. Half of patients in the WLE groups had more than 50% of unused opioids at day 7, whereas 69% of mastectomy patients had used more than 50% of their prescription, rising to 86% by day 28. Discharge prescriptions ranged from 37.5...

300 mg oMEDDD, with no clear relationship to procedure type or inpatient use. **Conclusion:** Postoperative opioids were frequently prescribed in excess of patient requirements, particularly after WLE, resulting in substantial unused medication. The reasons for this are multifactorial including patient education, junior medical staff overprescribing and the lack of guidelines for dispensing opioids in this population. These findings support procedure specific, data informed prescribing to reduce unnecessary opioid exposure without compromising analgesia.

FEASIBILITY, ACCEPTABILITY, AND PRELIMINARY EFFICACY OUTCOMES FROM A PILOT RANDOMISED TRIAL OF A DIGITAL HEALTH INTERVENTION TO SUPPORT RECOVERY AFTER BREAST CANCER SURGERY

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Problem statement: Optimising recovery following breast cancer surgery is critical for restoring function, minimising complications, and enabling timely initiation of adjuvant therapies. Enhanced Recovery After Surgery (ERAS) protocols recommend patient-led behaviours such as early mobilisation and return to oral food and fluid consumption, postoperative exercises, and multimodal pain management. Adherence to these behaviours is often suboptimal, limiting recovery. Digital Health Interventions (DHIs) may provide scalable strategies to support adherence, but evidence in breast cancer surgery is limited. **Methods:** In a single-site, two-arm pilot randomised controlled trial, participants undergoing mastectomy with or without implant-based reconstruction were allocated to usual care (control) or usual care plus the RecoverEsupport DHI. The DHI included educational videos, behavioural checklists, quizzes, and daily reminders, incorporating evidence-based behaviour change techniques. Primary outcomes assessed feasibility (recruitment, retention, data completeness, safety) and acceptability (usability, engagement, willingness to recommend). Secondary outcomes included preliminary efficacy (adherence to patient-led ERAS behaviours). Bayesian analyses provided preliminary probabilistic estimates of intervention effects. **Results:** Twenty-three participants were recruited (control n=12, intervention n=11), which was below the planned recruitment target, although retention and data completeness were 100%. No serious adverse events occurred. Intervention acceptability was high: all intervention participants engaged with the DHI, and most indicated they would recommend it to others. Preliminary analyses of secondary outcomes suggest mobilisation increased by ~4 hours, compared with usual care. These findings indicate feasibility, acceptability and potential efficacy. **Conclusion:** The RecoverEsupport DHI is feasible, safe, and acceptable, with high participant engagement. Early evidence suggests it may support patient-led recovery behaviours and improve key recovery outcomes. These promising results warrant progression to a fully powered randomised trial with amendments made to recruitment processes.

RADIOTHERAPY

SETUP ERRORS WITH FREE BREATHING AND DEEP INSPIRATORY BREATH HOLD TECHNIQUES IN BREAST CANCER RADIOTHERAPY (FAITH): PRELIMINARY RESULTS OF RETROSPECTIVE STUDY

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Introduction: This study aimed to evaluate setup errors and identify factors influencing them in breast cancer patients receiving adjuvant radiotherapy. **Methods:** We retrospectively analysed 144

breast cancer patients who received adjuvant VMAT radiotherapy (40–48 Gy in 15 fractions) at two Indian institutions between 2021 and 2022. Categorical variables were summarised as frequencies and percentages and association between categorical variables were assessed using chi-square test or Fisher's test. Setup shifts in lateral (X), superior–inferior (Y), and anterior–posterior (Z) directions were collected from all available treatment fractions using offline image review. Population systematic (Σ) and random (σ) setup errors were calculated for each axis. Setup errors were compared between free-breathing (FB) and deep inspiration breath-hold (DIBH) techniques and across patient and treatment subgroups using Mann–Whitney U test with Bonferroni correction. PTV margins were calculated using Van Herk and Stroom formulas. **Results:** A total of 144 female patients were included, with median age of 47 years and median BMI of 25.96 kg/m². Left-sided cancer was common (63.9%), with T4 (41.7%) and N3 (45.8%) stages being most common. Most patients received IMRT (72.9%) and treated using CBCT image guidance (77.8%). Mastectomy followed by chest wall irradiation was performed in 54.9% of patients and breast-conserving surgery followed by whole breast radiotherapy with simultaneous boost in 45.1%. All patients were immobilized using vacuum bag. Overall, 73% (n=1590) offline images were available for analysis and total of 4,770 setup shifts were assessed. The largest calculated PTV margins were in superior–inferior direction (9.46 mm by Van Herk and 7.70 mm by Stroom), whereas smallest were in anterior–posterior direction (7.11 mm and 5.78 mm, respectively). Significant association was found between left-sided disease and IMRT–DIBH ($p < 0.001$), and between IMRT–DIBH and CBCT image guidance ($p < 0.001$). Systematic and random setup errors in superior–inferior direction were significantly higher in left-sided cancers, IMRT–DIBH, CBCT-guided treatments. In right–left direction, significantly higher errors were observed with breast irradiation and higher BMI; anterior–posterior errors were significantly greater in IMRT–DIBH and CBCT-guided treatments. **Conclusion:** Preliminary results suggest setup errors are associated with multiple patient and radiotherapy related factors, warranting confirmation of subgroup-specific associations in larger cohort.

Table 1: Demographic details:

Variables	N (%)
Number of patients	144
Age in years (median, range)	47 (24–74)
Sex	
Female	144 (100)
ECOG	
0	104 (72.2)
1	39 (27.1)
2	01 (00.7)
Menopausal status	
Premenopausal	84 (58.3)
Postmenopausal	60 (41.7)
Literacy	
Yes	113 (78.5)
No	31 (21.5)
BMI (median, range)	25.9 (19.29–40.58)
BMI < 25	58 (40.3)
BMI ≥ 25	82 (57.0)
NA	04 (02.7)
Laterality	
Left	113 (78.5)
Right	31 (21.5)
T stage	
T1	05 (03.5)
T2	50 (34.7)
T3	29 (20.1)
T4	60 (41.7)
N stage	
N0	15 (10.4)
N1	49 (34.0)
N2	14 (09.8)
N3	66 (45.8)
Type of surgery	
Mastectomy	79 (54.9)
BCS	65 (45.1)
Reconstruction procedure	
Yes	25 (17.4)
No	119 (82.6)
RT Technique	
IMRT	105 (72.9)
IMRT DIBH	39 (27.1)
SIB	
Yes	65 (45.1)
No	79 (54.9)
Target volumes	
RT to breast	65 (43.1)
RT to CW	79 (54.9)
Radiation dose	
48Gy/15#	65 (45.1)
40Gy/15#	79 (54.9)
Type of immobilisation device	
Vacuum bag	144 (100)
Type of online imaging	
CBCT	112 (77.8)
EPID	32 (22.2)

Table 2: Errors and calculated PTV margins for entire population

	Right to left(X)	Superior to inferior (Y)	Anterior to posterior
Error			
Systemic	3.05 ± 1.98	3.53 ± 1.51	2.65 ± 1.02
Random	0.78 ± 0.51	0.91 ± 0.39	0.69 ± 0.26
PTV margins			
Van Herk formula	8.17 mm	9.46 mm	07.11 mm
Stroom formula	6.65 mm	7.70 mm	05.78 mm

Table 3a: Subgroup analysis for systematic errors

Age	Gender	Number of patients	Systematic error X	Systematic error Y	Systematic error Z	P value
Age < 60	65	2,207	0.54	0.60	0.10	0.001
Age ≥ 60	108	2,047	0.60	0.67	0.19	0.001
Postmenopausal	84	2,032	0.43	0.57	0.10	0.001
Premenopausal	88	2,061	0.65	0.67	0.19	0.001
Rural	52	2,429	0.56	0.61	0.10	0.001
Urban	121	2,051	0.58	0.68	0.19	0.001
Urban pop	118	2,058	0.60	0.69	0.20	0.001
Urban non	31	2,019	0.53	0.63	0.16	0.001
DMET	107	2,36	0.52	0.51	0.00	0.001
DMET DMET	39	2,676	0.56	0.61	0.10	0.001
DMET	52	2,30	0.54	0.61	0.10	0.001
DMET	117	2,01	0.58	0.68	0.19	0.001
DMET to Breast	15	0.002	0.000	0.000	0.000	0.001
DMET to Breast	79	2,238	0.57	0.61	0.10	0.001
DMET to Breast	58	2,108	0.60	0.69	0.20	0.001
DMET to Breast	62	2,190	0.60	0.69	0.20	0.001

Table 3b: Subgroup analysis for random errors

Age	Gender	Number of patients	Random error X	Random error Y	Random error Z	P value
Age < 60	65	2,207	0.41	0.41	0.10	0.001
Age ≥ 60	108	2,047	0.41	0.41	0.10	0.001
Postmenopausal	84	2,032	0.41	0.41	0.10	0.001
Premenopausal	88	2,061	0.41	0.41	0.10	0.001
Rural	52	2,429	0.41	0.41	0.10	0.001
Urban	121	2,051	0.41	0.41	0.10	0.001
Urban pop	118	2,058	0.41	0.41	0.10	0.001
Urban non	31	2,019	0.41	0.41	0.10	0.001
DMET	107	2,36	0.41	0.41	0.10	0.001
DMET DMET	39	2,676	0.41	0.41	0.10	0.001
DMET	52	2,30	0.41	0.41	0.10	0.001
DMET	117	2,01	0.41	0.41	0.10	0.001
DMET to Breast	15	0.002	0.000	0.000	0.000	0.001
DMET to Breast	79	2,238	0.41	0.41	0.10	0.001
DMET to Breast	58	2,108	0.41	0.41	0.10	0.001
DMET to Breast	62	2,190	0.41	0.41	0.10	0.001

SUPPORTIVE CARE

FEATURES TO LOOK FOR IN A BRA IF YOUR PATIENT HAS LYMPHOEDEMA

Heidi Flaherty¹

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Problem statement: After cancer surgery & treatment, patients may develop secondary lymphoedema. Early management of lymphoedema is key in slowing progression of symptoms. An incorrectly fitted bra may cause disruption to the lymphatic system. Given 80% of women are wearing the wrong size bra, the patient may not feel equipped to choose a bra that is supportive of their lymphatic system. **Objective:** Ensure health care professionals (HCPs) know what bra features will support their lymphoedema patients so they can confidently recommend these features to their patients. **Method:** Create a checklist of bra features that support the lymphatic system. Increase awareness of these features in HCPs & patients. Utilise multiple channels & networking opportunities, including training courses & conferences to increase awareness.

Bra Feature Checklist

Ensure the bra is correctly fitted, with no pinch points that disrupt lymph drainage.

- Wide, fitted under bust band. This needs to support 80% of the breast weight. A wider band distributes the weight over a broader area.
- Wide straps. Bra straps support 20% of the breast weight. They should sit smoothly on the shoulder, without digging into the skin.
- Higher coverage, especially under the arms. If lymph nodes have been removed or there is reduced sensation around the axilla, the bra should not dig into or irritate the area.
- Seamless or minimal seams that sit flat. Avoid bulky seams.
- Massaging textures. Some bras utilise a textured fabric that can provide a light massage sensation when worn (helpful to have but not essential)
- Front opening. Helpful for those with limited shoulder mobility (helpful to have but not essential)

Conclusion: By increasing awareness around bra features that support the lymphatic system, we can ensure patients do not further aggravate their lymphoedema symptoms and find a well fitted bra that offers support.

Disclosure of interest: I am the Marketing and Education Manager for Amoena Australia

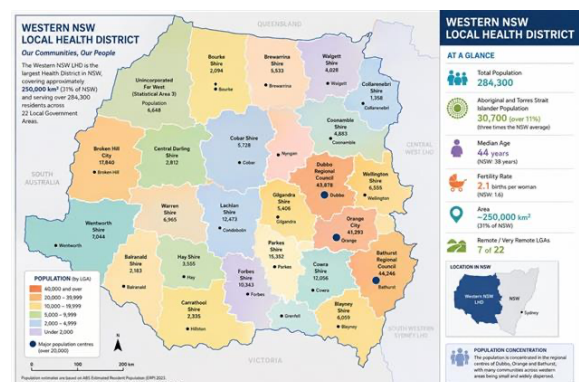
THE CLOCK STARTS AT DIAGNOSIS: ARE BREAST CANCER PATIENTS IN WESTERN NSW MEETING OPTIMAL TREATMENT TIMEFRAMES?

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Problem statement: Timely initiation of breast cancer treatment is a modifiable determinant of survival. The Queensland Breast Cancer Outcomes Study (Kou et al, MJA 2023; n=3,044) found 45% of women experienced at least one treatment interval exceeding Cancer Australia's guideline timeframes, conferring a 43% higher risk of breast cancer-specific death (aHR 1.43, 95% CI 1.04–1.96), greatest when diagnosis-to-surgery (aHR 1.76), surgery-to-chemotherapy (aHR 1.63), or chemotherapy-to-radiotherapy (aHR 1.83) intervals were exceeded, with rural and publicly-treated women disproportionately affected. The accompanying editorial (Wilcken, MJA 2023) affirmed that despite modest absolute differences, “extensive delays cannot be good”, and guideline-concordant timeframes remain the benchmark of care- particularly for regional services. This project audits whether Western NSW Health meets these benchmarks, and whether a pre-triage model can close any gap. **Methods:** This retrospective audit included patients discussed at the fortnightly Western NSW Health Breast MDT during 2025: new diagnoses and recurrences requiring further treatment. Patients without histologically confirmed disease, or not treated for personal reasons, were excluded. The audit spanned Orange, Bathurst and surrounds (Figure 1), assessing six guideline intervals – diagnosis-to-neoadjuvant therapy, neoadjuvant therapy-to-surgery, diagnosis-to-surgery, surgery-to-chemotherapy, surgery-to-radiotherapy, and chemotherapy-to-radiotherapy – against the proposed EXPRESS Oncology pre-MDT triage model. **Results:** Preliminary six-month 2025 data (n=94) indicate that, after adjusting for confounders, Western NSW Health operates within optimal timeframes across five of six intervals, with completion of adjuvant chemotherapy to radiotherapy (Table 1, Figure 2) exceeding recommendations. Among 38patients with diagnosis dates recorded on both Aria (radiation oncology) and Mosaik (medical oncology) systems, only 16% showed concordant dates, exposing a documentation-driven timeliness risk independent of clinical delay. **Conclusion:** Western NSW Health meets most guideline timeframes, though intervals cluster near the upper-limit and the chemotherapy-to-radiotherapy transition remains vulnerable – echoing the equity gap Wilcken highlighted for rural and public patients. These findings support prospective evaluation of EXPRESS Oncology, a pre-MDT expert triage and navigator-coordinated pathway piloted across Western NSW and Northern Sydney Local Health Districts, targeting rapid specialist input and guideline compliance toward 100%. Prospective data will determine whether earlier review can compress diagnosis-to-treatment intervals and translate timeliness gains into measurable survival benefit for regional Australian women.

Measure	Diagnosis to Neoadjuvant	Neoadjuvant to Surgery	Diagnosis to Surgery	Surgery to Chemotherapy	Surgery to Radiotherapy	Chemotherapy to Radiotherapy
Sample Size (n)	21	21	59	14	57	5
Mean Time	26 days	27 days	30 days	37 days	55 days	29 days
Guideline Target	14–28 days	28–42 days	30 days	28–42 days	56 days	21–28 days



Interval	Guideline recommendation	Level of evidence*
1. Diagnosis to neoadjuvant therapy	Neoadjuvant systemic therapy should start as soon as diagnosis and staging are completed (ideally within 2–4 weeks)	Level V, grade A (ESMO 2019 guidelines) ¹
2. Neoadjuvant therapy to surgery	Perform surgery within 4–6 weeks of neoadjuvant systemic therapy, allowing for recovery from myelosuppression	Expert consensus (no evidence-based recommendation identified)
3. Diagnosis to surgery	Perform surgery within one month of decision to treat with surgery women who do not receive neoadjuvant therapy	Expert consensus (no evidence-based recommendation identified)
4. Surgery to chemotherapy	Adjuvant chemotherapy should commence within 4–6 weeks of surgery	1. Level I, grade A (ESMO 2019 guidelines) ¹ 2. Level II, grade C (RACP 2017 guidelines) ²
5. Surgery to radiotherapy	Women who have completed definitive surgery for breast cancer should commence radiotherapy as soon as possible after wound healing, and within eight weeks of surgery if no adjuvant chemotherapy received	Expert consensus (no evidence-based recommendation identified)
6. Chemotherapy to radiotherapy	Women who have completed definitive surgery for breast cancer should commence radiotherapy within 3–4 weeks of completing adjuvant chemotherapy	Expert consensus (no evidence-based recommendation identified)

ESMO = European Society for Medical Oncology; RACP = Royal Australian College of Physicians; *ESMO Infectious Diseases Society of America-United States Public Health Service system; RACP= National Health and Medical Research Council system [Supporting information, box 1].

DETERMINANTS OF ACUTE SKIN TOXICITY IN ADJUVANT BREAST AND CHEST WALL RADIOTHERAPY: A REAL WORLD COHORT STUDY OF OVER 1000 PATIENTS

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Authors: Paidá K, Estoesta P, Briffa A, Leung C, O'Connor C, Tse R, Morajir K, Heller G, Harris G

Problem statement: Acute radiation induced dermatitis (RID) is common following adjuvant radiation therapy (RT) for breast cancer. We evaluated the impact of target volumes, fractionation schedule, RT technique and prophylactic skin care on RID severity in a contemporary real-world cohort. **Methods:** Patients receiving curative-intent adjuvant whole breast or chest wall RT at a single tertiary centre between January 2021 and December 2024 were included. Treatment variables came from retrospective chart review. Acute skin toxicity was prospectively graded weekly during treatment and at 6 weeks post-completion using RTOG criteria. Clinical and treatment factors associated with RID Grade ≥ 2 were assessed using bivariate and multivariable logistic regression.

Results: Of 1158 evaluable patients, 914 patients (79%) received whole breast RT and 244 (21%) chest wall RT. Median age was 59 years (IQR 50-70). The most common schedule was 40.5Gy in 15 fractions (n=555, 48%), followed by 50Gy in 25 fractions (n=262, 23%) and 45Gy in 20 fractions (n=205, 18%). Techniques were Hybrid IMRT (n=701, 61%), VMAT (n=302, 26%) and IMRT (155, 13%). A tumour bed boost was delivered in 844 (73%) and bolus in 254 (22%). Prophylactic skin care was Strata XRT (n=571, 49%) or non-silicone emollients (n=587, 51%). Overall, 429 (36.7%) experienced RID Grade ≥ 2 . On multivariable analysis, conventional fractionation (OR 2.95, 95% CI 2.06-4.22, $p<0.001$) and bolus use (OR 2.72, 95% CI 1.11-6.88, $p=0.030$) were associated with higher rates of RID Grade ≥ 2 ; VMAT (OR 0.43, 95% CI 0.29-0.62, $p<0.001$) and older age (OR 0.98, 95% CI 0.97-0.99, $p=0.004$) were associated with lower rates. StrataXRT showed no difference versus standard emollients (OR 1.11, 95% CI 0.82-1.51, $p=0.50$). Target volume, nodal irradiation and boost were not independently associated with RID Grade ≥ 2 . **Conclusion:** In this large contemporary cohort, severe acute skin toxicity was uncommon. Conventional fractionation, bolus use and younger age were independently associated with higher RID Grade ≥ 2 rates, and VMAT with lower rates. StrataXRT was no different to standard emollients.

Disclosure of interest: nil

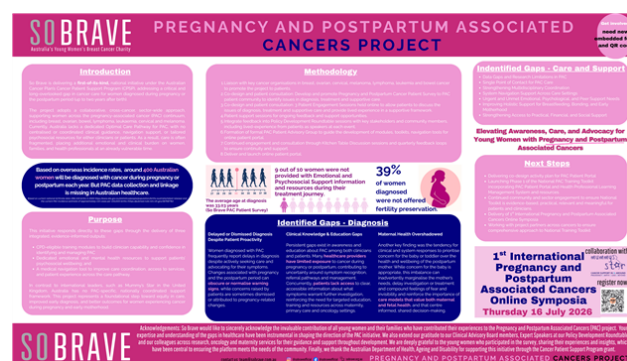
PREGNANCY AND POSTPARTUM ASSOCIATED CANCERS: TRANSLATING LIVED EXPERIENCE INTO NATIONAL PRIORITIES FOR EARLIER DIAGNOSIS AND BETTER CARE

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Background: Pregnancy and postpartum associated cancers (PAC) are becoming more common as women delay childbearing, yet they remain poorly recognised within cancer and maternity care. Women frequently experience delays in diagnosis, fragmented care and limited access to tailored information and support. Despite the complexity of these diagnoses, there are few national resources or coordinated approaches to improve awareness, care pathways and patient outcomes. **Aim:** To present findings and lessons from Australia's national Pregnancy and Postpartum Associated Cancers Project, highlighting opportunities to improve awareness, multidisciplinary care and health system responses through meaningful patient partnership. **Methods:** The project combined evidence review, national stakeholder engagement and co-design with women diagnosed during pregnancy or within 2 years postpartum, alongside clinicians, researchers and advocacy organisations. The presentation will describe how lived experience informed the identification of priority gaps and the development of practical recommendations and resources. **Results:** The project identified consistent challenges relating to delayed diagnosis, communication across maternity and oncology services, psychosocial support, navigation of complex treatment decisions and inequitable access to information. Co-design demonstrated the value of partnering with patients to develop resources and recommendations that are clinically relevant, practical and responsive to the needs of women and families. **Conclusion:** Pregnancy and postpartum associated cancers require greater recognition across oncology. Embedding patient partnership within research, education and service design can improve awareness, support earlier diagnosis and strengthen

coordinated multidisciplinary care. This presentation will outline practical recommendations that can be translated into clinical practice, research and policy to improve outcomes for women diagnosed during pregnancy and the postpartum period.



A FEASIBILITY STUDY: CAN WE USE A SMARTPHONE APPLICATION TO MONITOR ANXIETY IN BREAST CANCER PATIENTS?

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Problem statement: Breast cancer services are responsible for an ever-growing cohort of patients, who require mental health support throughout their patient journey. Unfortunately, many centres cannot always meet the increasing demand for psychology services. This has a documented impact on patients' treatment pathway and survivorship. Innovative solutions via existing technology can be used to help address this important clinical need. **Methods:** Upon ethics approval, we conducted a prospective feasibility pilot study on a cohort of patients within first 5 years of their breast cancer journey. We used an existing validated Western Australian application (app) called "i-yarn". It was used to check in with patients, at a time of their choosing, using the Hospital Anxiety and Depression Score (HADS). Patients scanned a QR code to answer 10 questions on their mental health and 10 questions on usability of the app. **Results:** We aimed to receive 30 completed questionnaires. This was achieved after approaching 33 patients in the outpatient clinic. The completed questionnaires were sent via the app to the Principal Investigator. The Primary aim was to determine feasibility of using "i-yarn" for anxiety screening. This was measured by questionnaire completion rate. 30 out of 33 patients (91%) completed the questionnaire. The Secondary Outcomes were the patients' HADS anxiety scores, previous access to psychology support services and patient-reported app usability. 80% of all patients scored borderline or abnormal HADS anxiety scores. 80% had not seen a psychologist despite high anxiety scores. 60% wanted more psychological support. 100% of all responders found the app easy to use and were happy to share their mental health state with their treating team via the app. 93% were keen to use such an app throughout their journey. 92% wished it was made available to them previously.

Conclusion: This app has the ability to revolutionise patient centred holistic care in breast cancer. Our results show it is easy to use and acceptable to patients. Our clinics are busy, with limited psychologist access. By assessing and stratifying patients' clinical need in an efficient and cost-effective way, resources can be better allocated and utilised.

EVALUATION OF A BIODEGRADABLE SILK FIBROIN MESH DRESSING IN BREAST AND SURGICAL ONCOLOGY PATIENTS: A RETROSPECTIVE PILOT AUDIT

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Background: Wound dressing selection is important in postoperative breast and surgical oncology care, where uncomplicated healing avoids delays to adjuvant therapy. Cyanoacrylate-based mesh dressings, including Dermabond and Prineo, are widely used for convenience and waterproofing properties but are increasingly associated with wound complications ranging from 4.9 to 52%,¹⁻³ including hypersensitivity reactions such as contact dermatitis, pruritus, blistering and delayed-onset reactions. These complication may contribute to

wound breakdown, infection, postponement adjuvant treatment. Biodegradable silk fibroin mesh dressings have shown reduced hypersensitivity in other surgical settings and offer a cost-effective alternative for anatomically complex, mobile sites such as the breast and axilla. This study evaluated allergic reactions and wound complications associated with silk fibroin mesh dressing in breast and surgical oncology patients. **Methods:** A retrospective pilot audit was conducted of 47 consecutive patients undergoing breast surgery or other surgical oncology/skin cancer procedures at a rural Australian health service between January and June 2026, in whom silk fibroin mesh dressing was applied postoperatively. Demographic, comorbidity, surgical and dressing data were recorded. Clinical review was performed at two weeks, wound assessed for infection, breakdown, allergic reaction, delayed healing, emergency presentation, antibiotic use, return to theatre and adjuvant therapy delay. Further, telephone follow-up occurred at 15 days. **Results:** Forty-seven patients were included (43 female and 4 male), mean age 66.0 ± 14.8 years, mean BMI 28.1 ± 4.1 kg/m². Most were ASA grade 2 (30/47, 63.8%) and breast cancer was the indication in 59.6%. Overall complication rate was 4.3% (2/47): two wound infections, one requiring bedside washout and one resolving with oral antibiotics. No allergic reactions, theatre returns or therapy delays occurred. Both complications occurred in patients with BMI ≥ 30 (mean 32.3 versus 27.9). No wound problems were identified at follow-up, and all patients reported satisfaction. **Conclusion:** Silk fibroin mesh dressing demonstrated excellent tolerability and safety, achieving 95.7% uncomplicated wound healing with no allergic reactions, theatre returns or therapy delays. Elevated BMI may represent a risk factor for wound complications. These findings support routine postoperative use of silk fibroin dressing in breast and oncological surgery, and justify larger prospective studies to confirm safety, efficacy and cost-effectiveness.

PROVIDER PERSPECTIVES ON A BUNDLED CARE PILOT FOR EARLY-STAGE BREAST CANCER IN THE AUSTRALIAN PRIVATE HEALTH SYSTEM: ADDRESSING FRAGMENTATION AND INTEGRATING SUPPORTIVE CARE

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Problem statement: Women with early-stage breast cancer treated in the Australian private health system frequently encounter fragmented care, unexpected out-of-pocket costs, and limited access to supportive care services. Australia's fee-for-service (FFS) payment model funds individual consultations and procedures rather than coordinated episodes of care, creating structural barriers to integrated care, including allied health and psychological support. This evaluation examined whether a novel bundled care model could address these shortcomings, as experienced by the providers who delivered it. **Methods:** A mixed-methods evaluation of the Early Stage Breast Cancer Care Bundle Pilot was undertaken across two cohorts (Cohort 1.1: n=29; Cohort 1.2 n=43). The Bundle incorporated all treatments in the first year of treatment at a capped price (Cohort 1.1), and a partially capped price (Cohort 1.2). Both cohorts had access to a patient navigator. This paper reports on the semi-structured interviews with clinicians and managers (n=38) at pilot commencement and conclusion. Data were analysed using deductive thematic analysis. **Results:** Providers identified fragmentation of the private system as the core problem the Bundle addressed. Although the pre-existing multidisciplinary team (MDT) structure enabled care integration, supportive care in private practice was routinely underutilised. The Bundle normalised supportive care as a standard component of treatment rather than an optional add-on, with providers reporting increased patient uptake across all allied health disciplines. Administrative impacts of the Bundle were less burdensome than anticipated, and the patient navigator was consistently identified as the most effective element: reducing coordination burden, improving MDT communication, and facilitating proactive supportive care referrals. While bundled care arrangements proved difficult to sustain within the current FFS environment, providers reported the pilot met or exceeded expectations. **Conclusion:** Fragmentation of the Australian private health system creates structural barriers to integrated cancer care, particularly limiting

access to supportive services. This pilot demonstrated that a coordinated model, built on existing MDT networks and anchored by a non-clinical navigator, can successfully embed supportive care within standard oncology practice. Future models should prioritise navigation and proactive supportive care access; policy reform should address the FFS barriers that prevent their routine inclusion.

SURGERY

RETROSPECTIVE REVIEW OF THE MANAGEMENT OF BREAST ABSCESSSES WITH PREDICTORS OF SURGICAL INTERVENTION

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Problem statement: Breast abscesses are a common condition but have a high recurrence rate. Often management involves antibiotic with aspirations but operative management with incision and drainage is sometimes required. This study aims to review the management of breast abscesses and determine if there are predictors for those patients who will require surgical intervention. **Method:** Retrospective study of women who were treated at the Redcliffe Hospital for a clinical or radiologically confirmed breast abscess between 1st January 2024 and 30th June 2026. Patients' records reviewed to obtain age, length of stay and risk factors including smoking, diabetes, lactational status, history of breast cancer or previous abscess along with the treatment or intervention reviewed was included. Imaging was reviewed to determine largest dimensional measurement and estimated abscess volume. Microbiology on any cultured organisms were reviewed along with sensitivities. **Results:** 73 patients with a mean age of 40.3 years (range 11-76) were included across the 30-month period. 47 patients (64.4%) were treated with aspirations, of these 8 (17.0%) progressed to surgery. 28 patients (38.4%) required surgical management. Patients that required surgery were more likely to be older (mean age 41.7 Vs 39.4 years), smokers (46.4% Vs 42.2%), diabetic (17.9% Vs 13.3%) and have had previous abscesses (39.3% Vs 33.3%) than those managed without. Skin compromise was the most common indication for surgical management (53.6%). Size of abscess was not a predictor for surgical intervention with those undergoing surgery having an average lower volume (15.3 Vs 18.6mls). There was no difference in the inpatient length of stay, nor the organisms cultured for those treated surgically or conservatively. **Conclusion:** These results suggest that smokers, diabetics and those who have previously been treated for breast abscesses are more likely to require surgical intervention. Overlying skin integrity remains the biggest indicator for definitive surgical management. Volume of the abscess and causative organism were not predictors for surgical intervention in this study. The choice of management did not impact on the inpatient length of stay.

WIRE-FREE LOCALISATION REDUCES TIME-TO-SURGERY FOR PATIENTS UNDERGOING BREAST-CONSERVING SURGERY: A COHORT STUDY FOLLOWING IMPLEMENTATION OF SCOUT®

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Problem statement: Hookwire localisation (HWL) of impalpable breast lesions requires same-day coordination between radiology and surgery, potentially limiting access to operating theatre lists. Timely surgery is an important quality indicator in breast cancer care, yet scheduling constraints associated with same-day localisation may contribute to treatment delays. Wire-free localisation technologies such as SCOUT® permit localisation to occur independently of surgery and may improve workflow efficiency. This study evaluated whether implementation of SCOUT localisation reduced time-to-surgery compared with HWL. **Methods:** A single-centre observational cohort study was

conducted between January 2022 and September 2025. Patients undergoing localisation of impalpable breast lesions before breast-conserving surgery were included. The primary outcome was time-to-surgery, defined as the interval between surgical booking and operation. Secondary outcomes included localisation accuracy, specimen weight, margin excision, re-excision rates, and radiologist-reported experience. **Results:** A total of 237 patients were included (HWL n = 109; SCOUT n = 128). Baseline demographic and operative characteristics were comparable between cohorts. Among urgent cases, SCOUT localisation was associated with a significantly shorter time-to-surgery than HWL (20.6 versus 25.7 days; p = 0.003). Within the SCOUT cohort, patients requiring lymphoscintigraphy experienced longer waiting times than those who did not (22.3 versus 17.6 days; p = 0.017), suggesting that lymphoscintigraphy became the principal scheduling constraint once localisation was decoupled from surgery. Exploratory analysis suggested greater flexibility in rescheduling patients following short-notice theatre cancellations when SCOUT localisation had already been performed. Re-excision rates were lower in the SCOUT cohort and reached statistical significance when all breast-conserving surgical techniques were included (22% versus 39%; p = 0.029). All participating radiologists preferred SCOUT localisation. **Conclusion:** Implementation of SCOUT localisation was associated with a clinically meaningful reduction in time-to-surgery for patients undergoing breast-conserving surgery for impalpable breast lesions. These findings suggest that wire-free localisation may improve access to timely surgery by reducing dependence on same-day radiological scheduling, while providing greater flexibility in operating theatre management.

MINIMALLY INVASIVE ROBOTIC MASTECTOMY IN THE SETTING OF PRIOR RADIOTHERAPY: A NOVEL APPLICATION

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Background: Robotic mastectomy with prior breast-conserving surgery (BCS) and radiotherapy presents significant surgical challenges due to fibrosis, altered anatomy, and higher complication risk. Minimally invasive robotic approaches may offer improved precision and cosmetic outcomes in this complex setting. We report a novel application of robotic nipple and skin sparing mastectomy (RNSM) with immediate implant-based reconstruction in a previously irradiated breast. **Methods:** A 42-year-old BRCA1-positive female with triple-negative carcinoma of the right breast underwent neoadjuvant chemotherapy followed by breast-conserving surgery, based on appropriate counselling and a patient-centred decision. She subsequently received adjuvant chemoradiotherapy as per standard treatment protocols. As a risk-reducing strategy, she underwent contralateral prophylactic robotic skin- and nipple-sparing mastectomy (RNSM) along with bilateral minimally invasive risk-reducing salpingo-oophorectomy. One year after completion of adjuvant chemoradiotherapy, and following detailed discussion with the patient and her family, robotic nipple- and skin-sparing mastectomy was performed on the previously irradiated right breast. This was followed by immediate implant-based reconstruction using a prepectoral technique. The procedure was completed without intraoperative complications or the need for conversion. **Results:** The procedure was completed without intraoperative complications or the need for conversion. Adequate flap viability was achieved despite prior treatment-related changes. Postoperative recovery was uneventful, with no evidence of skin necrosis, infection, or implant-related complications. The patient achieved excellent cosmetic symmetry and high satisfaction. **Conclusion:** RNSM with implant-based reconstruction is feasible and safe even in complex settings with prior BCS and radiotherapy. This approach expands the role of robotic breast surgery in high-risk patients and offers superior aesthetic outcomes with minimal morbidity. Traditionally, post-radiation mastectomies were done by open technique. However this is the first case wherein robotic approach had yield non inferior outcomes to standard approach. Long term results awaited.

ENDOSCOPIC NIPPLE- AND SKIN-SPARING MASTECTOMY: A PRACTICAL ALTERNATIVE IN RESOURCE-LIMITED SETTINGS

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Introduction: Endoscopic mastectomy is an alternative technique to robotic surgery in cost-sensitive and low- and low-middle-income countries, with an efficient cosmetic outcome and lower complications. **Methods:** A 26-year-old unmarried female with left locally advanced infiltrating ductal carcinoma with triple-negative histology and BRCA1-positive status. She underwent NACT (Neoadjuvant chemotherapy) with excellent radiological response post-therapy. A patient-centred decision was made and planned for unilateral endoscopic nipple and skin-sparing mastectomy. A Gel point port was placed, and instruments were passed. CO₂ insufflation was used to create and maintain the working space. A high-definition endoscopic camera provided magnified visualisation. Careful subcutaneous flap dissection was performed in the avascular plane, ensuring preservation of skin flap vascularity. The nipple-areola complex was preserved with meticulous retroareolar dissection. The entire breast gland was dissected endoscopically and removed en bloc through the same incision. Haemostasis was secured, and a drain was placed. **Results:** Post surgery, she had a good cosmetic outcome with faster recovery & discharged on postoperative day 2. Histopathological examination showed no residual tumour. **Conclusion:** Endoscopic nipple sparing mastectomy happens through smaller incisions and lower cost compared with robotic nipple sparing mastectomy. Endoscopic nipple sparing mastectomy is efficient with a cosmetic outcome and comparable oncologic safety in cost-sensitive settings.

POTENTIAL FOR OMISSION OF SENTINEL LYMPH NODE BIOPSY IN BREAST CANCER: A RETROSPECTIVE ELIGIBILITY AUDIT USING SOUND AND INSEMA TRIAL CRITERIA AT A NEW ZEALAND CENTRE

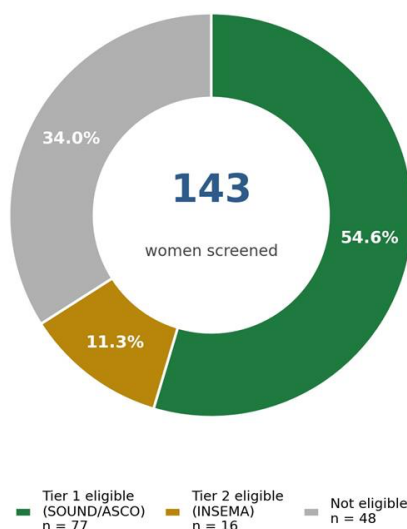
Morgan Chambers¹, Peter Chin

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Problem statement: Sentinel lymph node biopsy (SLNB) has historically been standard for axillary staging in early breast cancer but is associated with morbidity including lymphoedema and shoulder dysfunction. The SOUND and INSEMA randomised trials demonstrated that SLNB can be safely omitted in selected low-risk patients, and the American Society of Clinical Oncology (ASCO) 2025 guideline update has operationalised these findings into a recommended candidate profile. Uptake of SLNB omission outside trial settings remains poorly characterised. We aimed to determine the proportion of women treated for early breast cancer at a New Zealand regional hospital who would meet contemporary criteria for SLNB omission. **Methods:** We conducted a retrospective screening audit of women undergoing breast-conserving surgery for invasive breast cancer at Tauranga Hospital, Bay of Plenty, between 1 January 2024 and 31 December 2025. Patients were classified against two tiers of guideline-informed eligibility criteria: Tier 1 (SOUND/ASCO-recommended: age ≥50 years, tumour size ≤2cm, grade 1-2, hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative, clinically/sonographically node-negative) and Tier 2 (INSEMA-eligible, exploratory: as above but tumour size >2-5cm). Menopausal status was recorded descriptively only, given its unreliable retrospective documentation. Eligible patients were logged in a structured screening register. **Results:** 143 women were screened. Seventy-seven (53.8%) met Tier 1 criteria and 16 (11.2%) met Tier 2 criteria, giving 93 women (65.0%) potentially eligible for SLNB omission across both tiers. Forty-eight women (33.6%) were ineligible, most commonly due to grade 3 disease (21, 43.8% of exclusions), multifocal/multicentric disease (10, 20.8%), HER2-positive disease (9, 18.8%), tumour size >5cm (5, 10.4%), and triple-negative disease (2, 4.2%). Analysis of sentinel lymph node positivity, nodal disease burden, and the impact of nodal status on adjuvant treatment decisions among eligible patients is ongoing. **Conclusion:** Almost two-thirds of women undergoing breast-conserving surgery for early breast cancer at our centre would meet contemporary criteria for SLNB omission, suggesting substantial scope for surgical de-escalation.

Completion of the ongoing pathological and treatment-impact analysis will clarify the safety of extending this practice locally.

Eligibility for Sentinel Lymph Node Biopsy Omission (Bay of Plenty Screening Audit, Jan 2024-Dec 2025)



SINGLE-PORT ENDOSCOPIC NIPPLE-SPARING MASTECTOMY: AN EARLY AUSTRALIAN EXPERIENCE AND DESCRIPTION OF OUR OPERATIVE APPROACH

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Problem statement: Endoscopic nipple-sparing mastectomy (E-NSM) has been developed predominantly in high-volume Asian centres, with limited reported Australian experience. We describe the introduction of single-port E-NSM at an Australian tertiary breast centre, including patient selection, operative technique and initial outcomes. **Methods:** A prospective database captured consecutive E-NSM procedures. Patients were selected for nipple-sparing mastectomy with small-to-moderate, non-ptotic breasts. Initial open posterior dissection was performed through a 4-cm lateral axillary incision before insertion of a single-port device. Carbon dioxide insufflation was maintained at 8 mmHg and dissection completed using a standard two-dimensional laparoscopic system. The specimen was extracted through the same incision. Sentinel lymph node biopsy or targeted axillary dissection was performed through a separate incision. Indocyanine green (ICG) angiography guided skin-flap assessment and reconstructive timing. Immediate reconstruction used acellular dermal matrix (ADM) in the pre-pectoral plane. All procedures were performed by the same surgeon and first assistant. Mastectomy-only, reconstruction and total operating times were recorded separately; reconstruction time included ICG assessment. **Results:** Between May and July 2026, six therapeutic E-NSMs were performed in five patients, including one who underwent a bilateral procedure. Mean patient age was 51 years (range 45–64), and all had A–B cup breasts without ptosis. Mean specimen weight was 139 g (range 107–186). All mastectomies were completed endoscopically without conversion or an incision on the breast envelope. Mean mastectomy-only time, excluding axillary surgery and reconstruction, was 107 minutes (range 90–143). The nipple-areolar complex was preserved in all six breasts. Immediate ADM-assisted pre-pectoral implant-based reconstruction was performed in five breasts: two direct-to-implant and three tissue-expander reconstructions. Mean reconstruction time, including ICG perfusion assessment, was 55 minutes (range 25–99). In the remaining breast, reconstruction was deliberately delayed after ICG assessment raised concern regarding skin-flap perfusion. **Conclusion:** Single-port E-NSM was successfully introduced using standard two-dimensional laparoscopic infrastructure. This early Australian experience describes a reproducible approach,

ICG-guided flap assessment and ADM-assisted prepectoral reconstruction. Continued prospective analysis will evaluate complications, patient-reported outcomes, the learning curve and oncological follow-up.

NODE-NEGATIVE AXILLARY CLEARANCE IN BREAST CANCER SURGERY: KEY PERFORMANCE INDICATOR INSIGHTS FROM THE BREASTSURGANZ QUALITY AUDIT

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Problem statement: Contemporary evidence supports minimising axillary surgery where oncologically safe, as unnecessary axillary clearance can result in substantial morbidity and reduced quality of life, without impacting adjuvant treatment or survival. **Previous Breast Surgeons of Australia and New Zealand (BreastSurgANZ) Quality Audit (BQA) key performance indicators (KPIs) addressing axillary surgery focused on axillary staging in invasive disease and avoidance of axillary clearance for in situ disease. A reverse KPI was introduced in 2023 to monitor evidence-based de-escalation of axillary surgery. This study evaluated KPI performance and factors associated with non-compliance. Methods:** A retrospective review of BQA data was undertaken for all axillary clearance episodes recorded between 2018 and 2024 in Australia and Aotearoa New Zealand. KPI 'compliant' was defined as axillary clearance in invasive tumours with zero positive nodes (excluding neoadjuvant therapy) or in patients with in situ disease. As a reverse KPI, lower rates indicate better performance (target <5%). Temporal trends, regional variation, number of axillary procedures, and nodal yield were assessed. Potential data entry errors were identified using predefined criteria, and KPI performance was re-evaluated following their exclusion. **Results:** Overall KPI performance was 14.4%, improving from 14.7% in 2018 to 8.1% in 2024, but not meeting the <5% target. Jurisdictional variation was observed, with multiple regions meeting the target in 2023 and 2024. Of 1763 episodes not meeting the KPI, 920 (52.2%) were identified as potential data entry errors. Most (817/920; 88.8%) involved zero positive nodes across multiple axillary procedures, suggesting incomplete nodal pathology recording. After excluding potential data entry errors, overall KPI performance improved from 14.4% to 6.5%, with annual performance meeting the <5% target from 2021 to 2023. Episodes with zero positive nodes despite >10 nodes examined suggested potential overtreatment, whereas procedures yielding <5 nodes suggested sentinel node biopsy or sampling had been recorded as axillary clearance. **Conclusion:** Performance on this KPI improved over time, reflecting progress towards evidence-based de-escalation of axillary surgery. However, opportunities remain to improve clinical practice and data quality through appropriate de-escalation, accurate pathology recording, and correct procedure classification. Addressing these issues will improve BQA performance reporting and support continuous quality improvement.

IMPACT OF SENTINEL LYMPH NODE BIOPSY ON SHOULDER FUNCTION FOLLOWING WIDE LOCAL EXCISION FOR BREAST CANCER: A RETROSPECTIVE COHORT STUDY

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Problem statement: Sentinel lymph node biopsy (SLNB) is the standard method of axillary staging in clinically node-negative breast cancer but is associated with treatment-related morbidity, including pain, paraesthesia, lymphoedema and shoulder dysfunction. Recent trials, including SOUND and INSEMA, have demonstrated that omission of SLNB is oncologically safe in selected patients while reducing postoperative morbidity. Despite this, the impact of SLNB on shoulder function in routine clinical practice remains incompletely characterised. This study aims to evaluate the effect of SLNB on patient-reported shoulder function following breast cancer surgery at a tertiary Australian breast unit. **Methods:** A retrospective cohort study will be undertaken using the prospectively maintained BRENDA database at St Vincent's Hospital Melbourne. Patients undergoing surgery for invasive breast cancer or ductal carcinoma in situ between January 2024

and January 2026 will be eligible if they completed both preoperative and postoperative patient-reported outcome measures (PROMs). Patients undergoing wide local excision or mastectomy, with and without SLNB, will be included. The primary outcome is change in patient-reported shoulder function from baseline to postoperative follow-up. Secondary outcomes include lymphoedema, pain, paraesthesia, upper limb function, compression therapy requirements and health-related quality of life. Longitudinal changes will be analysed using linear mixed-effects models, adjusting for patient, tumour and treatment-related factors. **Results:** Approximately 300–400 patients undergoing SLNB are expected to be included, together with a comparator cohort managed without SLNB. The study will quantify the association between SLNB and postoperative shoulder dysfunction and compare patient-reported functional outcomes between surgical groups. Data analysis is currently underway. **Conclusion:** This study will provide contemporary Australian data regarding the functional impact of SLNB in routine breast cancer practice. The findings will inform patient counselling regarding expected postoperative recovery and contribute to the growing evidence supporting selective de-escalation of axillary surgery in appropriately selected patients.

Nii disclosures to declare

DEFINING MODERN BREAST PRESERVATION AFTER IPSILATERAL BREAST TUMOUR RECURRENCE: AN UPDATED SYSTEMATIC REVIEW AND META-ANALYSIS OF REPEAT BREAST-CONSERVING SURGERY USING CONTEMPORARY PARTIAL BREAST RE-IRRADIATION

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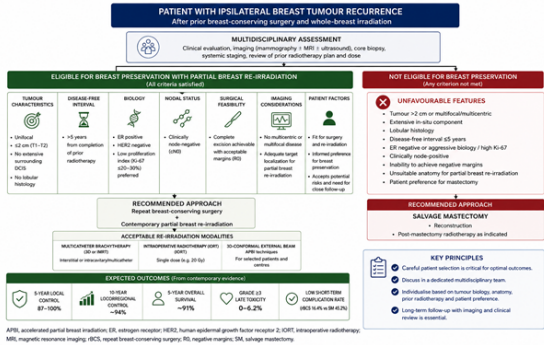
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Problem statement: Management of ipsilateral breast tumor recurrence (IBTR) is evolving as advances in partial breast re-irradiation (reRT) expand opportunities for repeat breast-conserving surgery (rBCS). However, evidence guiding multidisciplinary decision-making remains fragmented, with comparative oncologic outcomes, reRT efficacy, toxicity and selection criteria reported separately. We performed an updated systematic review and meta-analysis to define the contemporary role of breast preservation after IBTR. **Methods:** PubMed, MEDLINE and Embase were systematically searched (2005–June 2026). Comparative studies evaluating rBCS versus salvage mastectomy (SM) were pooled using random-effects meta-analysis for 5-year disease-free survival (DFS) and overall survival (OS). Modern partial breast reRT studies using multicatheter brachytherapy, intraoperative radiotherapy and prospective clinical cohorts were synthesized to evaluate local control, toxicity, cosmesis and selection criteria. Where applicable, the review followed PRISMA 2020 principles, and findings informed a proposed contemporary multidisciplinary treatment algorithm. **Results:** Thirteen comparative cohorts and modern reRT studies with follow-up to 10 years were included. Meta-analysis demonstrated comparable 5-year DFS (OR 1.24, 95% CI 0.63–2.45) and OS (OR 1.16, 95% CI 0.62–2.17) between rBCS and SM. Across reRT studies, 5-year local control ranged from 87–100%, 10-year locoregional control reached 94%, grade ≥3 late toxicity remained 0–6.2%, and excellent/good cosmesis exceeded 90%. Prospective RE-IORT data demonstrated 90.6% freedom from Grade ≥2 fibrosis at 12 months and 92.3% mastectomy-free survival at 60 months. Favorable candidates consistently demonstrated unifocal tumors ≤2 cm, recurrence >5 years after initial radiotherapy, favorable tumor biology, clinically node-negative disease and negative margins. Short-term postoperative complications were lower after rBCS than SM (16.4% vs 45.2%). **Conclusion:** This updated systematic review and meta-analysis demonstrates that repeat breast-conserving surgery combined with partial breast re-irradiation achieves oncologic outcomes comparable to salvage mastectomy while preserving excellent local control, favorable cosmesis and low severe toxicity in appropriately selected patients. The proposed multidisciplinary treatment algorithm translates current evidence into a practical

framework to support individualized treatment planning, multidisciplinary decision-making, future guideline development and informed patient selection across contemporary breast cancer practice.

Disclosure of Interest: The authors declare no conflicts of interest.

Figure 1. Evidence-based contemporary multidisciplinary treatment algorithm for repeat breast-conserving surgery with partial breast re-irradiation after ipsilateral breast tumour recurrence.



HOW DO DECISION AID TOOLS INFLUENCE DECISION REGRET IN BREAST CANCER SURGERY? A SYSTEMATIC REVIEW

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Background: Decision regret is an increasingly recognised patient-reported outcome following breast cancer surgery. Women must make complex, personalised surgical decisions regarding breast-conserving surgery, mastectomy, contralateral prophylactic mastectomy, and breast reconstruction, often under conditions of emotional distress and uncertainty. This study aims to understand if the type of surgery chosen influences decision regret. **Methods:** As part of a larger systematic review screening 53 total studies on decision regret in breast cancer surgery, this specific analysis focused on the types of surgery that women may come to regret. A search of the literature was undertaken using MEDLINE, Pubmed and Embase databases. Data was extracted on surgical decision type, patient characteristics, decision support, and decision regret. Procedures were grouped into breast-conserving surgery (BCS), unilateral mastectomy, bilateral mastectomy, re-excision after BCS, and breast reconstruction. Narrative synthesis was performed due to substantial heterogeneity in study design and regret measurement. **Results:** Fifty-three studies involving over 15,000 women were included. Overall decision regret was generally low. 738 women undergoing unilateral mastectomy consistently reported higher regret than those undergoing bilateral mastectomy or breast-conserving surgery. 705 women requiring additional surgery after an initial BCS, including re-excision or conversion to mastectomy, experienced the highest levels of regret, largely attributable to unmet expectations, increased treatment burden, and worsening emotional wellbeing. By contrast, bilateral mastectomy was associated with the lowest regret in comparative studies. Among women undergoing breast reconstruction, reconstructive modality (implant versus autologous) did not consistently influence regret. Postoperative complications, reconstructive failure, unplanned revision and dissatisfaction with the treatment journey emerged as the strongest drivers of regret. Several studies demonstrated that high-quality preoperative counselling, shared decision-making and realistic expectation setting were associated with lower regret. **Conclusions:** Decision regret following breast cancer surgery appears to be driven less by the choice of surgery itself than by whether the treatment experience aligns with patient expectations. Additional operations, unilateral mastectomy, reconstructive complications, or failed reconstruction are associated with the greatest regret. Procedures accompanied by effective shared decision-making and realistic preoperative counselling demonstrate consistently low regret. Future interventions should focus on improving decision quality and managing expectations rather than promoting one surgical option over another.

DECISION REGRET IN BREAST CANCER SURGERY: WHICH SURGICAL DECISIONS DO PATIENTS COME TO REGRET? A SYSTEMATIC REVIEW

Nargus Ebrahimi, Nicholas Shannon, **Ruth Hodson**¹, Tan Si Ying, Christopher Harris

¹Wollongong Hospital, Wollongong, Australia

Background: Decision regret is an increasingly recognised patient-reported outcome following breast cancer surgery. Women must make complex, personalised surgical decisions regarding breast-conserving surgery, mastectomy, contralateral prophylactic mastectomy, and breast reconstruction, often under conditions of emotional distress and uncertainty. This study aims to understand if the type of surgery chosen influences decision regret. **Methods:** As part of a larger systematic review screening 53 total studies on decision regret in breast cancer surgery, this specific analysis focused on the types of surgery that women may come to regret. A search of the literature was undertaken using MEDLINE, Pubmed and Embase databases. Data was extracted on surgical decision type, patient characteristics, decision support, and decision regret. Procedures were grouped into breast-conserving surgery (BCS), unilateral mastectomy, bilateral mastectomy, re-excision after BCS, and breast reconstruction. Narrative synthesis was performed due to substantial heterogeneity in study design and regret measurement. **Results:** Fifty-three studies involving over 15,000 women were included. Overall decision regret was generally low. 738 women undergoing unilateral mastectomy consistently reported higher regret than those undergoing bilateral mastectomy or breast-conserving surgery. 705 women requiring additional surgery after an initial BCS, including re-excision or conversion to mastectomy, experienced the highest levels of regret, largely attributable to unmet expectations, increased treatment burden, and worsening emotional wellbeing. By contrast, bilateral mastectomy was associated with the lowest regret in comparative studies. Among women undergoing breast reconstruction, reconstructive modality (implant versus autologous) did not consistently influence regret. Postoperative complications, reconstructive failure, unplanned revision and dissatisfaction with the treatment journey emerged as the strongest drivers of regret. Several studies demonstrated that high-quality preoperative counselling, shared decision-making and realistic expectation setting were associated with lower regret. **Conclusions:** Decision regret following breast cancer surgery appears to be driven less by the choice of surgery itself than by whether the treatment experience aligns with patient expectations. Additional operations, unilateral mastectomy, reconstructive complications, or failed reconstruction are associated with the greatest regret. Procedures accompanied by effective shared decision-making and realistic preoperative counselling demonstrate consistently low regret. Future interventions should focus on improving decision quality and managing expectations rather than promoting one surgical option over another.

THE MANAGEMENT AND OUTCOMES OF BREAST CANCER AMONG CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) POPULATIONS

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Problem statement: With the rise in the migrant populations in Australia, our society has become more culturally and linguistically diverse (CALD). Cancer care inequities exist for patients with CALD backgrounds. Decisions on the type of surgical and medical management in breast cancer are influenced by cultural, ethnic, and sociodemographic factors. This study aimed to address the needs of CALD Australians with breast cancer and to reduce inequities in care. **Methods:** This retrospective cohort study included breast cancer patients who underwent surgery at Campbelltown hospital between 2015 and 2019. The data from electronic medical records included demographics, disease characteristics, treatments, and clinical outcomes. The primary objective was to compare surgical management between CALD and non-CALD groups. The secondary objective was to compare 5-year recurrence and mortality rates. **Results:** 289 patients were included in the study and 86 patients had CALD backgrounds (29.8%). In the CALD group, 59 patients (68.6%) underwent wide local excision (WLE) as the first surgical treatment for breast cancer and 27 patients (31%) had mastectomy. In the non-CALD group, 150 patients (73.9%) had WLE, and 53 patients (26%) underwent

mastectomy. The percentage of breast reconstruction was 11.63% in the CALD group and 8.37% in the non-CALD group. The 5-year recurrence and mortality rates were 9.3% and 2.33%, respectively, in the CALD group, and 13.3% and 7.88%, respectively, in the non-CALD group. **Conclusion:** This study demonstrated the cultural diversity among breast cancer patients at Campbelltown hospital; however, no significant inequity was observed between the two groups. Further multicentre research is required to ensure equity in breast cancer care and to improve outcomes for CALD Australians.

ASSESSING FEASIBILITY OF AXILLARY SURGEY DE-ESCALATION IN CLINICALLY NODE NEGATIVE PATIENTS WHO ACHIEVE A PATHOLOGICAL COMPLETE RESPONSE IN THE BREAST FOLLOWING NEOADJUVANT SYSTEMIC THERAPY FOR BREAST CANCER

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Problem statement: Axillary management in breast cancer has shifted from routine axillary lymph node dissection (ALND) toward less invasive strategies, including sentinel lymph node biopsy (SLNB). Landmark trials have shown that when the sentinel node is negative, SLNB provides comparable survival and regional control to ALND, with reduced morbidity. Further de-escalation trials demonstrated similar axillary control with axillary radiotherapy (e.g., AMAROS) and low loco-regional recurrence rates with limited surgery in selected patients (e.g., ACOSOG Z0011). More recently, trials have evaluated omission of SLNB in low-risk groups (e.g., SOUND and INSEMA), reporting comparable disease outcomes alongside reduced lymphoedema and improved arm function. Despite this evidence, practice remains variable—particularly in patients treated with neoadjuvant systemic therapy (NAST) where the clinical nodal status at baseline may be node-negative (cN0) and the optimal need for SLNB at the end of treatment is unclear. In cN0 patients achieving pathological complete response (pCR), reported SLNB positivity after NAST for HER2-positive and triple-negative disease can be very low, suggesting that routine SLNB may not be necessary for all patients. **Methods:** A retrospective feasibility study is underway using data from patients treated at St Vincent's Hospital Melbourne (SVHM). Ethics approval was obtained from Clinical Trials and Research, Victoria. The analysis will evaluate local feasibility of SLNB omission in node-negative patients undergoing NAST, focusing on the proportion of patients with residual SLN involvement and potential implications for axillary staging and management. **Results:** Data collection is currently in progress. Preliminary outcomes will report SLN positivity rates after NAST in the eligible cN0 cohort, and will quantify the proportion who could potentially avoid SLNB without compromising axillary control. **Conclusion:** This project will assess whether omission of SLNB is locally feasible for selected node-negative breast cancer patients treated with NAST. Findings will inform whether evolving evidence from national/international trials can be safely translated into local practice, with the goal of reducing axillary surgery morbidity while maintaining oncologic safety.

ASSESSMENT OF THE USE OF THE HISTOLOG @ SCANNER DURING WIDE LOCAL EXCISION OF BREAST CANCER TO REDUCE RE-EXCISION RATES

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Problem statement: Current internationally accepted breast cancer guidelines state that an acceptable oncological margin for invasive cancer is no ink on tumour. Further margin excision is recommended if there is a positive margin to reduce the risk of locoregional recurrence, with variable re-excision rates quoted in the literature from 10-23% or higher. The Histolog Scanner is a digital confocal microscopy scanner used for rapid, in-theatre specimen scanning for cancer margin assessment. It has been shown in a European setting to reduce re-excision rates for patients undergoing breast conserving surgery (BCS). Our observational cohort study aims to assess the utility of the Histolog Scanner in the Australasian breast cancer setting for the first time. We aim to assess the Histolog Scanner in our patient cohort to investigate concordance between the intraoperative histological assessment and the final histology report. The ability to perform accurate intraoperative identification of positive margins will allow immediate margin excision at time of index operation, reducing the need for women to return for margin re-excision at a future date. **Methods:** We aim to recruit 30 consecutive patients with biopsy proven breast

cancer aged 18 and older undergoing BCS. The ex-vivo breast specimen will be oriented as per standard orientation and undergo usual specimen radiography. Following this, the specimen will be processed in the Histolog scanner according to manufacturer instruction. After scanning, the tissue is sent to the pathology laboratory, for standard histopathology reporting. Histolog images will be de-identified, reviewed and reported prior to routine pathology assessment. Final histopathological findings will then be compared to the findings from Histolog Scanner specimen reporting. **Results:** Collated for presentation at time of AIBC. **Conclusion:** This is the first study in Australasia assessing the use of the Histolog scanner in breast cancer patients. We aim to demonstrate a high concordance between Histolog image identification of positive margins with the final histopathology report. Potential benefits of intraoperative positive margin assessment include reduced surgical morbidity/risk in women undergoing re-excision, reductions in patient wait times, cost-effectivity, reduced delays to adjuvant treatment, and an overall improved patient experience. *The authors have no financial disclosures.*

RETROSPECTIVE REVIEW COMPARING OUTCOMES FOR THE USE OF ARTISS FIBRIN SEALANT VS DRAIN MANAGEMENT POST BREAST SURGERY FOR CHRISTCHURCH HOSPITAL

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Problem statement: Seroma formation remains a common complication following breast cancer surgery, contributing to patient morbidity, prolonged hospitalisation, and increased healthcare utilisation.^{1,2} Although fibrin sealants have been proposed as an alternative to routine closed suction drainage within enhanced recovery pathways, evidence regarding their effectiveness in reducing postoperative complications and facilitating same-day discharge remains inconclusive.^{1,2} This study aims to evaluate whether the use of ARTISS fibrin sealant at Christchurch Public Hospital is associated with better outcomes compared to drain use. **Methods:** A retrospective cohort study was performed of all patients undergoing simple mastectomy and/or axillary clearance between September 2025 and March 2026, with each surgical site analysed as a single unit. Primary outcomes were clinically significant seroma requiring aspiration and length of hospital stay, measured from discharge from postoperative recovery to ward discharge. Secondary outcomes included complications such as infected seroma and cost analysis. **Results:** A total of 92 cases were reviewed, with 77 having a drain and 15 using ARTISS as the seroma prevention technique. Though ARTISS was associated with more seroma this was not statistically significant $p=0.09$. The table below summarises the main findings. **Conclusion:** Overall, at our institution, the use of ARTISS helps support enhanced recovery pathways which is consistent with international evidence.² A potential limitation is the use of ARTISS is only performed by a single surgeon at our institute and therefore a smaller cohort. The fibrin sealant supports these pathways through fewer complications and facilitating earlier discharge while maintaining an acceptable morbidity profile.

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	Drain (77)	ARTISS (15)
Seroma (%), $p = 0.09$	39	67
Length of stay (mean hours), $p < 0.001$	40	18
Infected Seroma (%)	8	0
Wound infection (%)	13	7
Unplanned return to theatre (%)	8	0
Unplanned hospital readmission within 30 days (%)	19	7

BREAST CANCER CARE IN AUSTRALIA AND NEW ZEALAND: AN UPDATED REVIEW OF BREASTSURGANZ QUALITY AUDIT COMPLIANCE

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Background: The BreastSurgANZ Quality Audit (BQA) monitors breast cancer care across Australia and New Zealand through predefined quality indicators and thresholds. This study evaluated compliance with BQA indicators following the introduction of High-Quality Performance Indicators (HQPIs) and compared contemporary performance with international standards. **Methods:** The BQA database was interrogated for cases diagnosed between 2018 and 2023. Thirteen BQA indicators were analysed by annual trends and stratified by state, country (Australia/New Zealand), insurance status, geographic location (metropolitan/regional/rural), and surgeon volume. Performance was compared with BQA quality targets and relevant international benchmarks, including European Society of Breast Cancer Specialists (EUSOMA) standards. **Results:** A total of 97,702 cases of in situ and invasive breast cancer managed by 415 surgeons were analysed. Compliance exceeded BQA quality targets for most indicators, including referral for radiotherapy, endocrine therapy, chemotherapy, multidisciplinary discussion, breast care nurse involvement, and neoadjuvant systemic therapy. Immediate breast reconstruction rates remained below international benchmarks, with lower uptake among public patients and those in regional and rural areas. Breast-conserving surgery rates for small invasive tumours improved but remained below EUSOMA standards. Compliance with axillary de-escalation indicators remained suboptimal, and timeliness of surgery declined over the study period, particularly among public patients and those in New Zealand. **Conclusion:** Breast cancer care delivered by BreastSurgANZ members demonstrated high adherence to evidence-based standards and compared favourably with international benchmarks. Future quality improvement should prioritise equitable access to reconstruction, optimisation of treatment pathways, and evidence-based de-escalation of axillary management.

PATIENT PREFERENCES FOR INTRAOPERATIVE TECHNOLOGIES TO REDUCE RE-EXCISION AFTER BREAST-CONSERVING SURGERY

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Background: Re-excision affects approximately 20% of women undergoing breast-conserving surgery (BCS) and is a significant issue for breast cancer patients. Emerging intraoperative residual tumour detection technologies aim to reduce re-excision, yet little is known about patient preferences regarding the trade-offs these technologies entail. Understanding preferences is essential for patient-centred surgical innovation and increasingly for regulatory evaluation. **Methods:** An anonymous cross-sectional survey was administered to fifty two adults who had previously undergone BCS at a single institution. The survey assessed concerns about residual cancer, willingness to accept trade-offs (extra tissue removal or longer operative time), attitudes toward intraoperative margin technologies, emotional reassurance, influence on provider choice, and preferences relating to mastectomy risk thresholds. Descriptive statistics summarised responses. **Results:** Fifty-two participants completed the survey; 14 (26.9%) had undergone re-excision—consistent with international rates. Concern about residual cancer before surgery was common (75%). Complete tumour removal in the initial operation was rated “extremely important” by 80.8% and “very important” by 19.2%. Most participants accepted removing extra healthy tissue (86.6%) and using a technology that added 10 minutes to operative time (98.1%) to reduce re-excision. Support for intraoperative cancer detection devices was high: 88.5% wanted such a device used, and 94.2% were likely or very likely to want it used if it reduced re-excision risk from 20% to 2%. Emotional reassurance was substantial, with 98.1% reporting this type of technology would be very or extremely reassuring. Technology availability would influence surgeon choice for 65.4% and hospital choice for 63.5%. Equitable access to such technology was deemed very or extremely important by 98.1%. **Conclusion:** Patients strongly prioritise complete cancer removal and are overwhelmingly willing to accept meaningful clinical trade-offs for technologies that may reduce re-excision. Emotional reassurance emerged as a major patient-valued outcome. These

findings fill a critical evidence gap and offer foundational patient preference information to support clinical development and implementation, as well as regulatory evaluation, of intraoperative residual tumour detection technologies.

MAGSEED VERSUS WIRE-GUIDED LOCALISATION FOR IMPALPABLE BREAST LESIONS IN A MULTI-SURGEON REGIONAL AUSTRALIAN CENTRE

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Problem statement: Accurate peri-operative localisation of non-palpable breast lesions is essential in breast-conserving surgery to optimise oncological, surgical and aesthetic outcomes. Wire-guided localisation can entail drawbacks including disruptive logistical challenges and patient discomfort, as well as impacting the surgical approach, and excessive removal of healthy tissue. Magseed localisation offers a wire-free alternative, without radioactivity, however, comparative evidence from Australian regional centres remains limited. This study compares the outcomes of Magseed and wire-guided localisation for non-palpable breast lesions in a major regional Australian centre.

Methods: A retrospective comparative cohort study was performed of patients undergoing breast surgery at a regional breast unit between February 2022 and May 2025. The primary outcomes were successful lesion excision and the absence of re-excision requirement. Secondary outcomes included technical success of localisation, margin status, operative timing, and any complications related to Magseed placement or retrieval. **Results:** 154 participants were included, comprising 132 Magseed-guided and 22 wire-guided participants. Magseed localisation was successfully performed in 99.2% (n=131) of cases. The re-excision rate for Magseed was lower than wire-guided, 7.6% (n=10) of participants requiring re-excision in comparison to 9.5% (n=2) respectively. The missed lesion rate for Magseed was 0.8% cases, with no missed lesions in the wire-guided group. The majority of re-excisions were performed for involved or close margins rather than failure of localisation. No significant complications directly attributable to Magseed placement were identified. **Conclusion:** This study proves the effectiveness and value of Magseed localisation in Regional Australia. Magseed technology is a safe, effective, and practical technique for guiding excision of non-palpable breast lesions in our single-centre cohort. Magseed use was associated with high rates of successful lesion retrieval, a low missed lesion rate, and a low re-excision rate. These findings support the feasibility and benefit of Magseed implementation outside metropolitan centres and suggest that wire-free localisation improves surgical workflow while maintaining oncological safety, and ultimately improving patient outcomes pre, intra, and post-operatively.

No disclosure of interests.

INTRODUCTION OF MAGTRACE IN A PERIPHERAL CENTRE AND EVALUATION OF LOCALISATION RATES OF MAGTRACE COMPARED TO LYMPHOSCINTIGRAPHY AND PATENT BLUE

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Problem statement: The aim of this study was to evaluate if there is a difference between localisation rates of Magtrace, compared to dual localisation with lymphoscintigraphy and patent blue or patent blue alone. **Methods:** All breast cancer excision cases that underwent sentinel lymph node biopsy at Redcliffe Hospital from January 2026 to June 2026 were evaluated. These were separated into groups based on localisation techniques: patent blue alone, lymphoscintigraphy with patent blue and Magtrace with patent blue. Two-way contingency tables were used to compare localisation rates between Magtrace and patent blue compared to patent blue alone. It was also used to compare localisation rates between Magtrace and lymphoscintigraphy and patent blue. **Results:** There were 36 eligible patients in total, with 19 patients undergoing localisation with patent blue alone, 5 patients with lymphoscintigraphy and patent blue and 12 patients with Magtrace and patent blue. The success rate of lymph node localisation was 74% in the patent blue only group, 100% in the lymphoscintigraphy group and 92% in the Magtrace group. There was no statistical

difference between the rates of localisation in the patent blue only group compared to the Magtrace group (p=0.22). Furthermore there was no statistically significant difference between rates of localisation between the Magtrace group and lymphoscintigraphy group (p = 0.5) **Discussion:** This study has shown no statistical difference between Magtrace with patent blue and lymphoscintigraphy with patent blue localisation techniques. Overall, there is decreased localisation with patent blue alone compared to Magtrace with patent blue. However, this is not statistically significant. A major limitation of this study is the sample size as this will affect statistical significance. This is an important field to evaluate as there is limited access to lymphoscintigraphy in peripheral hospitals due to limited access to nuclear medicine. Thus, using Magtrace in these centres will enable surgical flexibility and decrease time from diagnosis to definitive surgery for breast cancer patients.

TRANSITIONING TO STANDALONE INDOCYANINE GREEN FOR SENTINEL LYMPH NODE BIOPSY IN BREAST CANCER: A SINGLE-SURGEON LEARNING CURVE SERIES

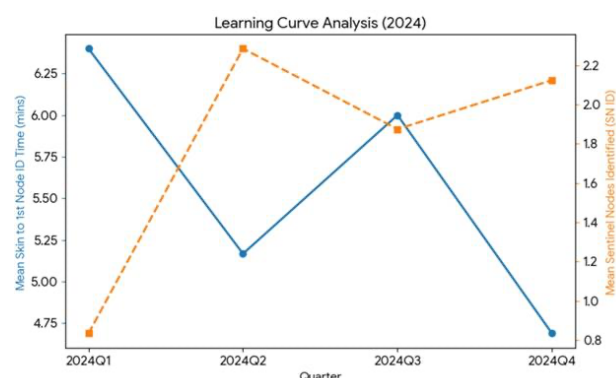
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Problem statement: Dual-tracer breast cancer sentinel lymph node (SLN) staging using radiocolloid and blue dye is a historical benchmark with issues related to nuclear medicine logistics, radiation exposure, and skin tattooing. While our previous pilot series demonstrated 100% concordance using indocyanine green (ICG) with patent blue with non-inferiority compared to traditional dual-tracer technique, ICG dual-tracer mapping retains blue dye drawbacks. This study evaluates a single-surgeon learning curve of transitioning to standalone ICG as well as its efficacy and safety.

Methods: Following a 14-month dual-tracer validation trial (n=35), 40 consecutive breast cancer patients underwent SLN biopsy (SLNB) by the same single senior breast surgeon at one institution using single-agent ICG (2.5 mL subareolar/peritumoral injection) over the subsequent 12-month period. Performance and technical time intervals were stratified chronologically by quarters. **Results:** Two patients (5.0%) with iodine allergies were excluded. In the remaining cohort (n=38; mean age 63.9 years), the SLN detection rate was 89.5%, which was highly comparable to our baseline dual-tracer pilot cohort (p=0.68). Mean time from incision to first node identification was 5.39 minutes; mean time from ICG injection to node identification was 7.93 minutes. No axillary recurrences occurred over follow-up period of 18-29 months (0%). Chronological stratification demonstrated a distinct learning curve across consecutive quarters: Procedural Speed: Mean incision-to-first node identification time improved by 26.7%, falling from 6.40 minutes in Q1 to 4.69 minutes in Q4 (p=0.18). Nodal Yield: Mean optical SLN yield per case rose significantly from 0.83 in Q1 to 2.13 in Q4 (p= 0.04), aligning with total mean surgical yield (2.19) and matching our dual-tracer pilot baseline (2.3 nodes). Failures (n=4) were restricted to established non-identification risk factors: high body mass index (n=2), and prior axillary surgery (n=2).

Conclusions: Standalone ICG demonstrated clinically acceptable SLN identification in a real-world transition cohort while eliminating nuclear medicine reliance, radiation exposure, and blue dye-related staining or allergy. Early adoption was associated with a measurable learning curve, with improvements in procedural speed and optical nodal yield after modest case accumulation. These findings support structured transition, case monitoring, and local audit when implementing standalone ICG for breast cancer SLNB.



EVALUATION OF A RADIOISOTOPE-FREE DUAL-TRACER TECHNIQUE USING INDOCYANINE GREEN AND BLUE DYE FOR SENTINEL LYMPH NODE BIOPSY IN BREAST CANCER

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Problem statement: Sentinel lymph node biopsy (SLNB) is the standard of care for axillary staging in early breast cancer. Although the combined radioisotope and blue dye technique has traditionally achieved the highest identification rates, radioisotope requires licensing and radiation-safety governance and is unavailable in many centres, including ours. Single-agent blue dye is widely used and has been shown to be sufficient for SLNB in many centres,¹ although it carries a recognised failure rate. With increasing use of neoadjuvant chemotherapy and targeted axillary dissection, accurate sentinel node identification has become increasingly important. Our centre therefore adopted indocyanine green (ICG) fluorescence, a non-radioactive tracer, alongside blue dye.

Methods: We retrospectively analysed 25 breast cancer patients who underwent dual-tracer SLNB between June 2025 and June 2026, with each patient serving as their own control. For each excised sentinel node, the identifying tracer was recorded. Patient- and node-level identification rates, concordance, and mean nodes detected per patient were compared between tracers. **Results:** Eighty-one sentinel nodes were retrieved (mean 3.24 per patient). At least one sentinel node was identified in every patient (100%): ICG in all 25 patients (100%, 95% CI 86.3–100.0%) and blue dye in 23/25 (92.0%, 95% CI 74.0–99.0%). ICG identified sentinel nodes in both patients in whom blue dye failed, with no reciprocal failures. Overall, ICG detected 84.0% of sentinel nodes compared with 65.4% for blue dye. Nodes detected by ICG alone accounted for 28.4%, compared with 9.9% detected by blue dye alone. Mean nodes detected per patient were higher with ICG (2.83 vs 2.21, $p=0.040$). Concordance was 92.0% per patient and 59.2% per node. **Conclusion:** ICG achieved a 100% patient identification rate, rescued all blue dye failures, and detected significantly more sentinel nodes than blue dye alone. These findings support the use of ICG with blue dye as a practical radioisotope-free dual-tracer technique for SLNB in centres without radioisotope access.

Reference:

1. Ang CH, Tan MY, Teo C, Seah DW, Chen JC, Chan MY, et al. Blue dye is sufficient for sentinel lymph node biopsy in breast cancer. *Br J Surg*. 2014;101(4):383–389

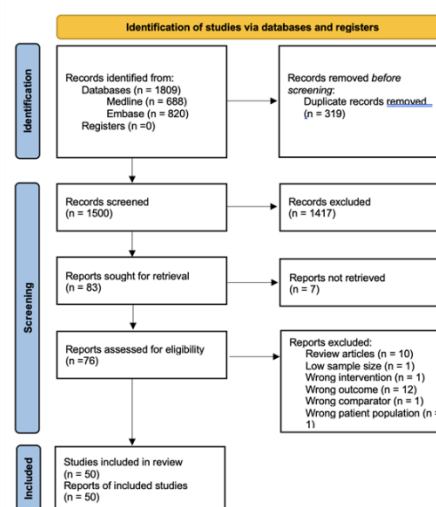
BREAST ASYMMETRY FOLLOWING BREAST CANCER TREATMENT: A SYSTEMATIC REVIEW OF ASSESSMENT, PATIENT-REPORTED OUTCOMES AND MANAGEMENT

Kor Woi Tiang¹, Li Xian Lim¹, Bing Wang¹, Deborah Cheung¹

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Background: Breast asymmetry is a common and clinically significant outcome of breast cancer local treatment. It may involve differences in breast volume, shape, nipple position, projection, ptosis, footprint and tissue quality, contributing to body image dissatisfaction, physical discomfort, psychosocial distress and reduced satisfaction with treatment. This systematic review aimed to identify patient-, tumour-, treatment- and surgery-related contributors to breast asymmetry; evaluate objective and patient-reported methods of assessment; examine its psychosocial impact; and review preventative and corrective management strategies across the breast cancer treatment pathway. **Method:** This systematic review was prospectively registered with PROSPERO (CRD420261448672) and conducted in accordance with PRISMA 2020. PubMed/MEDLINE and Embase were searched for English-language full-text studies published from January 2010 to July 2026. Search terms included “breast cancer,” “breast asymmetry,” “breast symmetry,” “BREAST-Q,” “BCCT.core,” “breast-conserving surgery,” “oncoplastic surgery,” “mastectomy,” “mammoplasty,” “breast reconstruction,” “cosmesis,” “satisfaction” and “patient-reported outcomes.” Reference lists of eligible studies were manually screened. Studies were included if they addressed the development, assessment, patient-reported impact, prevention or management of breast asymmetry following breast cancer treatment. Risk of bias was assessed using design-specific tools, and certainty of evidence for key outcome domains was assessed using GRADE where applicable. **Results:** A total of 50 studies were included. Key evidence domains included baseline patient and breast morphology, tumour-to-breast volume ratio, resection

volume and location, radiotherapy-related tissue change, reconstructive technique, postoperative complications, objective symmetry assessment, patient-reported outcomes and corrective surgical strategies. Clinically significant asymmetry was influenced by baseline breast morphology, tumour location, radiotherapy, reconstructive technique, complications, ageing and contralateral breast change. Assessment methods included clinical evaluation, standardised photography, anthropometric measurements, BCCT.core, three-dimensional imaging and BREAST-Q. Management strategies included oncoplastic volume displacement or replacement, contralateral symmetrisation, fat grafting, implant revision, autologous reconstruction and staged revisional surgery. Overall certainty was limited by heterogeneity in study design, definitions of asymmetry, assessment methods and follow-up duration. **Conclusion:** Breast asymmetry after breast cancer treatment is complex, dynamic and highly patient-relevant. This review provides a practical framework to support counselling, risk anticipation and individualised management, aiming to improve breast symmetry, physical comfort, psychosocial well-being and survivorship quality of life.



EARLY OUTCOMES OF SCOUT RADAR LOCALISATION FOR BREAST-CONSERVING SURGERY IN AN AUSTRALIAN REGIONAL HOSPITAL

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Problem statement: Wire-free localisation may improve perioperative workflow and avoid limitations associated with day-of hookwire localisation, particularly in a regional setting. We evaluated oncological, operative, and logistical outcomes following recent implementation of SCOUT radar localisation at a regional Australian hospital. **Methods:** A retrospective cohort study evaluated adults undergoing breast-conserving surgery for non-palpable biopsy-proven invasive carcinoma or ductal carcinoma in-situ between May 2024 to May 2026. Consecutive SCOUT localisation (SL) cases were compared with a historical hookwire localisation (HWL) cohort. Outcomes were margin status, re-excision, theatre duration, postoperative complications within 6 weeks, position on operative lists, and timing of localisation. Categorical outcomes were compared using Fisher’s exact test due to limited sample size. Continuous variables were assessed using independent-samples t-test. Ethics approval was granted by the Central Queensland Human Research Ethics Committee (HREC/2026/QCQ/126859). **Results:** A total of 43 cases were included for analysis, comprising 32 HWL and 11 SL. Positive, close (DCIS <2mm), and negative margins occurred in 6%, 19%, and 75% of HWL, compared with 27%, 18%, and 55% of SL cases, respectively. Overall margin distribution did not differ significantly between groups ($p=0.216$). Re-excision was required in 25% of HWL and 36% of SL cases ($p=0.467$). Mean theatre duration was 131.3 minutes for HWL and 145.5 minutes for SL, with no statistically significant difference between groups (mean difference 14.1 minutes; 95% CI -6.7 to 34.9; $p=0.177$). Early postoperative complications occurred in 22% HWL cases and 9% SL cases ($p=0.656$). SL cases were significantly more likely to be placed first

on the operative list than HWL cases (46% vs 3%; $p=0.003$). All HWL cases required same-day localisation, whereas SL cases underwent localisation on average 60.7 days pre-operatively (mean difference 60.7 days; 95% CI 34.2 to 87.3; $p<0.001$). **Conclusion:** In this preliminary Australian regional experience, SL demonstrated comparable oncological and operative outcomes to HWL, with significant logistical advantages to operative list position and timing of localisation. Interpretation is limited by the small early SL cohort and possible case-selection and learning-curve effects. Ongoing case accrual and adjusted analysis are required before definitive conclusions can be drawn.

SURVIVORSHIP

PROGESTINS IN BREAST CANCER SURVIVORS: A SYSTEMATIC REVIEW

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⁴Bond University HSM, Australia

Purpose: As breast cancer survival rates improve, the quality of survivorship becomes more important. Historically there has been less overlap between age groups with the highest incidence of breast cancer and younger populations using progestins for contraception and period management. However, with trends towards younger age at diagnosis and improvements in treatments contributing to preserved fertility and ovulation in survivors, the safety of progestins must be re-examined. **Methodology:** A two-armed systematic review was undertaken for (1) depot progestin injection and (2) progestin-releasing IUD in breast cancer survivorship. This resulted in 11 papers for (1) and 20 papers for (2). **Results:** The volume of research in this area is very small. The published literature predominantly arises from North American and large Scandinavian database research. Although data is often collected prospectively, it is not collected with a primary focus on progestins and the analyses are always retrospective. However, despite limited data and the quality limitations described, depot progestins are not associated with an increase in breast cancer incidence or recurrence except in specific subgroups such as women under 35 years, and women with recent use of progestin within 5 years. For progestin-releasing IUDs, there is a small increase in breast cancer incidence de novo, but insufficient evidence to make conclusions regarding safety in breast cancer survivors. **Conclusion:** The safety of progestins in breast cancer survivors is an area that is under-studied despite being likely to assume greater importance with changes in epidemiology and treatment. Available evidence suggests that depot progestins may be safe except in specified subgroups while progestin-releasing IUDs are associated with an increased risk in de-novo incidence. This is at odds with their mechanisms of action (depot acting systemically and IUD acting locally) and deserves much more research.

SUSTAINED IMPROVEMENTS IN PHYSICAL ACTIVITY AND FATIGUE FOLLOWING AN INDIVIDUALISED EXERCISE PROGRAM INTEGRATED INTO ROUTINE BREAST CANCER CARE: A MIXED-METHODS COHORT STUDY

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Problem statement: Exercise is recognised as an important component of breast cancer care, improving physical and psychosocial outcomes. Although exercise programs improve short-term exercise participation and outcomes, the sustainability of these benefits remains unclear. This study evaluated the long-term impact of the Maple Tree Alliance Exercise Program on exercise participation and patient-reported outcomes and explored factors influencing sustained engagement. **Methods:** Women with early-stage breast cancer receiving care through the Westmead Breast Cancer Institute in Western Sydney were invited to participate in a 12-week individualised exercise program involving weekly land-based and/or hydrotherapy sessions. Participants who commenced the program ≥ 18 months prior were invited to complete a follow-up survey assessing program perceptions, pain,

fatigue and physical activity. Baseline and follow-up outcomes were compared using descriptive statistics and paired t-tests. Semi-structured interviews were analysed thematically to contextualise quantitative findings and identify themes related to ongoing exercise participation. **Results:** Of the 100 women invited, 65 responded (65.0% response rate; mean age 55.6 ± 11.4 years), representing a socioeconomically and culturally diverse cohort. Baseline physical activity was low, with 70% classified as 'insufficiently active.' At follow-up, mean physical activity significantly increased from 8.48 ± 10.21 to 19.75 ± 14.87 ($p < 0.001$), corresponding to a shift from insufficiently to moderately active. Fatigue scores improved significantly, decreasing from 4.77 ± 2.45 to 3.51 ± 2.49 ($p < 0.001$), while pain scores showed a non-significant reduction ($p = 0.234$). Participants reported improved wellbeing (95.0%), confidence (85.0%) and long-term exercise motivation (88.4%). All participants reported feeling supported by the program and would recommend it to others. Interviews ($n = 6$) contextualised these findings, identifying recovery, empowerment and social connection as key influences on sustained engagement, while highlighting accessibility barriers. **Conclusion:** Participation in the Maple Tree Alliance Exercise Program was associated with sustained improvements in exercise participation and fatigue at ≥ 18 -month follow-up. Qualitative findings suggest that exercise programs may support lasting behaviour change through improved confidence, self-management and social support, while acknowledging ongoing individual and environmental barriers influencing participation. These findings support the integration of individualised exercise programs into routine breast cancer care. The authors declare no competing interests.

REAL-WORLD IMPLEMENTATION AND EFFECTIVENESS OF COMBINED NUTRITION AND EXERCISE INTERVENTIONS FOR BREAST CANCER SURVIVORS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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²Cancer and Palliative Care Outcomes Centre, Centre for Healthcare Transformation, School of Nursing, Queensland University of Technology, Kelvin Grove, Australia

³ULTRA (The University of Queensland's Randomised trials Capability), Faculty of Health, Medicine and Behavioural Sciences, The University of Queensland, Herston, Australia

⁴School of Health, University of the Sunshine Coast, Sippy Downs, Australia

Problem statement: Combined nutrition and exercise interventions have demonstrated efficacy for breast cancer survivors under controlled trial conditions; however, their implementation and effectiveness in routine care remain unclear. This systematic review evaluated real-world implementation and effectiveness using the RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) Framework. **Methods:** Five databases were searched (2000-2025) for real-world studies evaluating combined nutrition and exercise interventions in predominantly breast cancer survivors. Quality of life (QoL) outcomes were synthesised using random-effects meta-analysis across four domains: global, breast cancer-specific, mental, and physical QoL. Leave-one-out sensitivity analyses assessed robustness of pooled estimates. Findings across RE-AIM dimensions were synthesised using descriptive statistics. **Results:** Thirty-six studies (across 45 reports) were included. Most programs were multidisciplinary (92%), hospital outpatient-based (64%), group-delivered (64%), and face-to-face (83%); median duration 12 weeks. Reported participation rates were moderate (median: 65% [range: 35-93%]), though definitions varied and broader reach indicators were limited. Demographics were poorly reported (race/ethnicity: 33%, socioeconomic status: 50%), but available data indicated participants were predominantly White, well-educated, and had early-stage disease. Eligibility criteria (e.g. language, literacy and clinical exclusions) created structural barriers to participation, while organisational adoption and sustainment were rarely explicitly reported. Interventions were associated with improvements across all QoL domains. Global QoL ($k=12$; Figure 1) showed a moderate pooled effect ($SMD=0.33$, 95% CI 0.16–0.49, $I^2=83\%$); not altered by sensitivity analysis. Moderate improvements were also observed for breast cancer-specific QoL ($k=3$; $SMD=0.41$, 95% CI 0.28–0.54; $I^2=0\%$) and physical QoL ($k=4$; $SMD=0.39$, 95% CI 0.11–0.66; $I^2=68\%$),

although the latter was sensitive to exclusion of one large implementation study. Mental QoL showed a small but significant improvement ($k=4$; $SMD=0.25$, 95% CI 0.17–0.33; $I^2=0\%$). Only five studies reported QoL follow-up, with most suggesting maintenance of gains. **Conclusion:** Combined nutrition and exercise interventions were associated with improved QoL among breast cancer survivors when implemented in real-world settings. However, limited reporting of reach, adoption, and program maintenance restricts understanding of who benefits and how programs can be implemented equitably at scale. Addressing structural barriers and strengthening implementation reporting will be critical to support scalable, equitable supportive care for breast cancer survivors.

Disclosure of Interest: None declared.

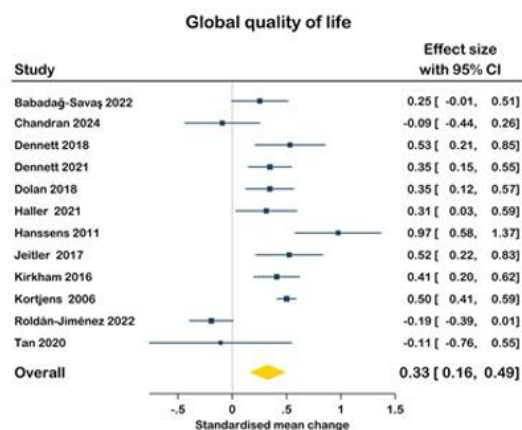


Figure 1. Forest plot of pooled standardised mean change in global quality of life following combined nutrition and exercise interventions.

TRIPLE NEGATIVE BREAST CANCER

METAL-PHENOLIC NANOMEDICINE SYNERGIZES CHEMODYNAMIC THERAPY, FERROPTOSIS, AND IMMUNOTHERAPY FOR BREAST CANCER TREATMENT

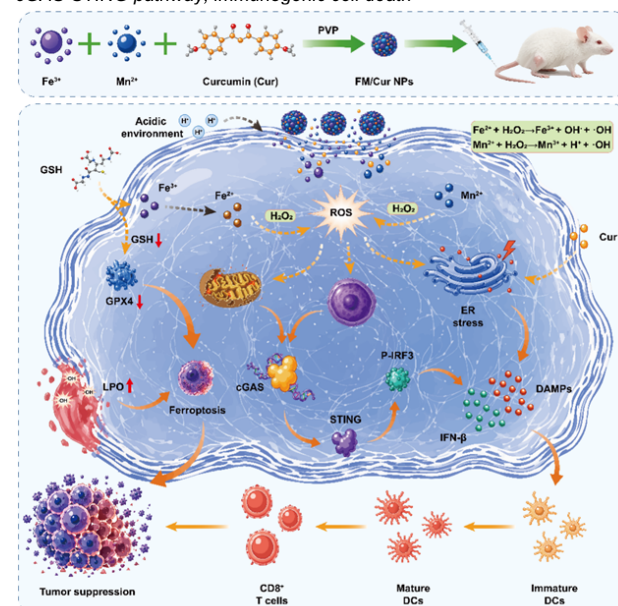
Yuxin Cheng¹, Haiting Wang¹, Jiayi Xie¹, Miaojie Xu¹, Fan Wang¹, Ouyang Xue¹, Lierui Chen¹, Kangni Chen¹, Yongxuan Yuan¹, Hongyan Jiang¹, Yexi Chen¹, Zhiyang Li¹

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Background: Chemodynamic therapy (CDT) has emerged as a promising antitumor strategy that exploits the relatively elevated levels of hydrogen peroxide (H₂O₂) in the tumor microenvironment (TME) to trigger oxidative stress-mediated tumor cell damage. However, the therapeutic efficacy of conventional metal-based catalysts is often limited by insufficient catalytic activity under weakly acidic conditions. Metal-phenolic networks (MPNs), characterized by favorable biocompatibility and TME-responsive properties, provide a versatile platform for constructing efficient CDT nanomedicines. Meanwhile, metal ion-mediated immune activation and curcumin (Cur)-induced immunogenic cell death (ICD) offer potential avenues for synergizing CDT with antitumor immunity. **Methods:** A bimetallic metal-phenolic nanomedicine (FM/Cur NPs) was synthesized via coordination-driven self-assembly using Cur as the organic ligand and Fe³⁺ and Mn²⁺ as functional metal ions. Following physicochemical characterization, FM/Cur NPs were evaluated in vitro using 4T1 triple-negative breast cancer (TNBC) cells for cytotoxicity, ferroptosis induction, DNA damage, and cGAS–STING pathway activation. In vivo antitumor efficacy, immune response, and biosafety were investigated in 4T1 tumor-bearing mice. **Results:** FM/Cur NPs exhibited a uniform octahedral morphology (~84.1 nm) and underwent acid-triggered disassembly with efficient hydroxyl radical (·OH) generation. In vitro, the NPs showed robust cellular internalization and cytotoxicity. Mechanistically, FM/Cur NPs triggered ferroptosis by depleting glutathione (GSH), downregulating glutathione peroxidase 4 (GPX4), and accelerating reactive oxygen species (ROS) and lipid peroxidation (LPO) accumulation. This oxidative stress induced mitochondrial dysfunction and DNA damage, activating the cGAS–STING pathway and increasing interferon-β (IFN-β) secretion. Concurrently, the NPs triggered ICD, as indicated by calreticulin (CRT) exposure and HMGB1 release. In vivo, FM/Cur NPs preferentially accumulated at tumor sites via the EPR effect, significantly suppressed tumor growth, and stimulated systemic

immunity by promoting dendritic cell maturation and CD8⁺ T cell infiltration, without causing systemic toxicity. **Conclusion:** This study demonstrates a bimetallic metal-phenolic nanomedicine that integrates Fenton reaction-driven ferroptosis with cGAS–STING activation and ICD-associated immunity. This framework effectively couples redox disruption with immunotherapy, offering a synergistic strategy for TNBC treatment with translational potential.

Keywords: Chemodynamic therapy, metal-phenolic networks, ferroptosis, cGAS-STING pathway, immunogenic cell death



Industry



Industry Symposia

Friday, October 9, 2026

07:30-08:30	Morning Industry Symposium: New data in breast cancer genomic testing to advance personalized treatment decisions <i>Supported by Veracyte</i> <i>Light refreshments will be served, from 07:00-07:30, to session participants only.</i>	Hall B (Great Hall 2)
Chairperson	Kelly Marcom, Durham, NC, USA	
07:30-07:45	OPTIMA: Results Stuart McIntosh, Belfast, Ireland	
07:45-08:00	The Australian perspective, and the importance of OPTIMA Young Belinda Kiely, Sydney, Australia	
08:00-08:15	Case studies and practical implementation Nick Zdenkowski, Newcastle, Australia	
08:15-08:30	Q&A	
08:30-09:30	Industry Symposium: In conversation with Prof. Javier Cortes: Navigating the complexities of HR+ HER2- early breast cancer <i>Supported by Lilly</i>	Hall C (Room M1)
Chairperson	Belinda Yeo, Melbourne, Australia	
	Join us for an in-depth discussion with Prof. Javier Cortes, Madrid, Spain	
11:30-12:30	Industry Symposium: Evolving treatment paradigm in HER2+ early breast cancer <i>Supported by Daiichi-Sankyo AstraZeneca</i>	Hall B (Great Hall 2)
Chairperson	Bruce Mann, Melbourne, Australia	
Faculty	Steven David, Melbourne, Australia	
	Julia Dixon-Douglas, Melbourne, Australia	

Saturday, October 10, 2026

07:30-08:30	Morning Industry Symposium: Recurrence risk and adjuvant treatment decision-making in HR+/HER2- early breast cancer <i>Supported by Novartis</i> <i>Light refreshments will be served, from 07:00-07:30, to session participants only.</i>	Hall B (Great Hall 2)
Chairperson	Richard de Boer, Melbourne, Australia	
07:30-07:50	Opening presentation Richard de Boer, Melbourne, Australia	
07:50-08:20	Case-based Panel Discussion Sanjeev Kumar, Sydney, Australia Nicole McCarthy, Brisbane, Australia	
08:20-08:30	Audience Q&A and wrap-up	
07:30-08:30	Morning Industry Symposium: Optimizing local therapy in early breast cancer: The role of genomic biomarkers DCISionRT® and AidaBreast® <i>Supported by PreludeDx</i> <i>Light refreshments will be served, from 07:00-07:30, to session participants only.</i>	Hall C (Room M1)
Chairperson	Alastair Thompson, Indianapolis, IN, USA	
07:30-07:50	AidaBreast®: Personalizing treatment decisions for early-stage invasive breast cancer Naamit Gerber, New York, NY, USA	
07:50-08:10	Interim analysis of the PREDICT study: A 7-gene biosignature predicts radiation benefit in DCIS Yvonne Zissiadis, Perth, Australia	
08:10-08:30	Discussion board: Clinical utility of biomarker tests for DCIS Bruce Mann, Melbourne, Australia Ben Green, Brisbane, Australia Naamit Gerber, New York, NY, USA Yvonne Zissiadis, Perth, Australia Alastair Thompson, Indianapolis, IN, USA	

13:10-13:55	Lunch Industry Symposium: Redefining the surgical pathway: Contemporary innovations in breast cancer management <i>Supported by Hologic</i> <i>Session delegates may take lunch plates into the hall.</i>	Hall B (Great Hall 2)
Symposium Overview	Breast cancer surgery continues to evolve, with emerging approaches challenging traditional treatment pathways and creating new opportunities to improve patient experience, surgical efficiency, and clinical outcomes. Join internationally recognised breast surgeons Mr. Peter Barry and Professor Alastair M. Thompson as they share their experience and insights on innovations that are reshaping breast cancer treatment pathways. Drawing on their extensive clinical and research expertise, they will explore emerging approaches to tumour localisation, lymphatic mapping and surgical decision-making, and discuss how these advances can streamline surgical management and support personalised patient care. This session offers a valuable opportunity to hear from two global leaders in breast surgery and gain practical perspectives on the future of breast cancer management.	
Symposium Speakers	Professor Alastair M. Thompson is a world-renowned breast surgeon, clinician-scientist, and breast cancer researcher. He is Professor and Director, Vera Bradley Foundation Breast Research Center, Indiana University Simon Comprehensive Cancer Center, Indianapolis, Indiana, USA. Over more than three decades, he has led major international clinical trials and translational research programs focused on breast cancer prevention, diagnosis, and treatment. His work has helped shape modern breast cancer care, particularly in breast-conserving surgery, ductal carcinoma in situ (DCIS), and multidisciplinary cancer research. Mr. Peter Barry is a Consultant Oncoplastic Breast Surgeon at The Royal Marsden Hospital in London. Originally trained at the University of Sydney, he completed a Fellowship in Surgical Oncology and has built an international reputation in breast cancer surgery, oncoplastic reconstruction, and preventative surgery for women at high risk of breast cancer. His clinical and research interests include breast conservation techniques, targeted axillary surgery, tumour biology, and the development of innovative surgical approaches that improve patient outcomes and quality of life.	
13:10-13:25	Alastair Thompson, Indianapolis, IN, USA	
13:25-13:40	Peter Barry, London, UK	
13:40-13:55	Discussion / Q&A	

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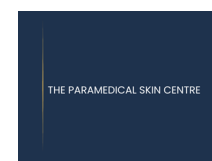
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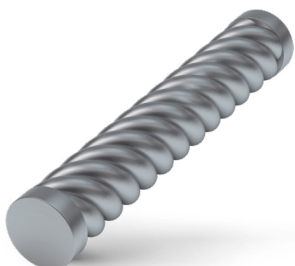
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VISION: Better breast health outcomes in Australia and New Zealand

PURPOSE: We support health professionals to achieve better health outcomes



Baylor St. Luke's Medical Center, a member of CommonSpirit and headquartered in the Texas Medical Center in Houston, is a leading academic medical center within the St. Luke's Health system, which includes hospitals, physician groups, specialty institutes and one of three comprehensive cancer centers in Texas. Our affiliation with Baylor College of Medicine positions us as a leader and drives our commitment to advancing health care standards through groundbreaking research and the development of advanced treatments found nowhere else.



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BCAL is an Australian health care company engaged in early cancer detection. BCAL launched its first test BREASTESTplus™ as a 'rule-out' test designed to be used in the clinical evaluation of breast disease for women with dense breasts. BREASTESTplus™ is a simple, non-invasive blood test used in conjunction with mammography to improve screening and diagnostic outcomes for breast health in women. BCAL holds exclusive license with ClearNote Health Inc., a US-based precision diagnostics company, for the sale and distribution of Avantect Pancreatic, Avantect Ovarian and Avantect multi-cancer blood tests in Australia and New Zealand. BCAL is headquartered in Sydney, Australia and listed on the Australian Securities Exchange (ASX:BDX).



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Breast Cancer Network Australia (BCNA) is Australia's leading breast cancer consumer organisation that has supported a network of over 250,000 people through breast cancer. As consumer led organisation, BCNA ensures the voices of lived experience is represented in breast cancer policy, research and service development. BCNA works with governments, health service providers, researchers, and the broader community to ensure that decisions and practices adopt patient-centred care.



www.bd.com

BD is one of the largest global medical technology companies in the world and is advancing the world of health by improving medical discovery, diagnostics and the delivery of care. The company develops innovative technology, services and solutions that help advance both clinical therapy for patients and clinical process for health care providers. BD has 65,000 employees and a presence in virtually every country around the world to address some of the most challenging global health issues. BD helps customers enhance outcomes, lower costs, increase efficiencies, improve safety and expand access to health care.



www.breastsurganz.org

Breast Surgeons of Australia and New Zealand (BreastSurgANZ) is the peak professional membership society representing specialist breast surgeons who manage benign and malignant breast disease across Australia and Aotearoa New Zealand. The Society sets and upholds post-Fellowship training standards and promotes excellence in patient care through education, quality audit, research, and the advancement of evidence-based surgical practice.



Brisbane Radiology

www.brisbaneradiology.com

Brisbane Radiology we offer pioneering technology and subspecialty radiology reporting. We're passionate about moving medicine beyond existing standards, with a view to informed and confident decision making. Our purpose is to illuminate wellbeing for all through pioneering technology and medicine. At the core of our innovation is Australia's first, non-compression breast imaging technology — an advanced modality available exclusively at Brisbane Radiology. This next-generation approach delivers exceptional image clarity with a more comfortable experience, particularly for women with dense breast tissue, and is transforming global expectations around breast screening and diagnostic accuracy.



**World Congress on
Controversies in Breast
Cancer (CoBrCa)**

www.cobrca.org

The **World Congress on Controversies in Breast Cancer (CoBrCa)** was initiated by CongressMed in 2015, chaired by Professors Bruce Mann (Australia), Richard De Boer (Australia), Javier Cortes (Spain) and Alastair Thompson (USA). The congress aim is to ensure innovative medical education. CoBrCa is based on the worldwide successful concept of controversies in medicine in a wide range of medical specialties. CoBrCa addresses the most controversial topics in breast cancer management with key issues explored and audience participation encouraged. Through debates and ample time for expert-audience discussions, the congress focuses on issues faced by clinicians in daily practice and strives to provide practical take-home messages. The CoBrCa Scientific Program is aimed for medical oncologists, breast surgeons, radiologists, nurses and allied health professionals to meet and debate novel treatments. Since its launch, CoBrCa has been held in Melbourne, Barcelona, Tokyo, San Francisco, Edinburgh, Dubai, Lima and Brisbane. The next edition of CoBrCa will be held in 2028.



CIRDAN
Improving Wellbeing Through Innovation

www.cirdan.com

Cirdan is a leading provider of healthcare informatics and imaging solutions designed to support and accelerate patient diagnosis. With operations in the United Kingdom, Australia and Canada, we are proud to support breast clinicians both across Australia and internationally. We are committed to helping surgeons reduce re-operation rates through rapid, high-quality imaging at the point of care. Our X-ray specimen cabinets support both core biopsy and surgical specimen assessment, enabling faster clinical decision-making in theatres. Solas OR delivers high-resolution imaging with seamless workflow integration, helping clinical teams manage cases accurately and efficiently.



www.astrazeneca.com.au

AstraZeneca is leading a revolution in oncology with the ambition to provide cures for cancer in every form, following the science to understand cancer and all its complexities to discover, develop and deliver life-changing medicines to patients. The Company's focus is on some of the most challenging cancers. It is through persistent innovation that AstraZeneca has built one of the most diverse portfolios and pipelines in the industry, with the potential to catalyse changes in the practice of medicine and transform the patient experience. AstraZeneca has the vision to redefine cancer care and, one day, eliminate cancer as a cause of death.

www.daiichisankyo.com.au

Daiichi Sankyo is a global pharmaceutical company with corporate origins in Japan with over 120 years of innovation and is expanding its Australian presence. Our mission is to create innovative pharmaceuticals addressing diverse medical needs and we aim to become a global top five oncology company by 2035. Our pipeline, which includes medicines utilising our proprietary DXd (deruxtecan) ADC (antibody drug conjugate) technology as well as other novel entities, targets a wide range of difficult-to-treat cancers, including breast, lung, gastric, ovarian, and endometrial. In Australia, we are a dedicated partner in the fight against cancer. Our team is conducting a growing number of clinical trials across Australia to support patient access to the latest innovations in cancer care. We are proud to partner with researchers, clinicians, patient advocates, and government to advance research and improve outcomes for patients.



www.device.com.au

Since 1992, **Device Technologies** has been dedicated to improving patients' lives through leading edge technology and services. Successfully supplying hospitals and healthcare professionals with the finest medical solutions for their patients, we continue to grow, with over 200 trusted brands over 1000 highly skilled staff throughout Australia, New Zealand, and Asia. Behind every brand distributed by Device Technologies is the concept that we are delivering leading technology into the most capable hands. We nurture the relationship between distributor and healthcare professionals, guiding the process from concept to delivery and ongoing support with training and technical service specialty teams.



www.dilon.com

Dilon Technologies offers a strong medical device portfolio focused on advancing surgical precision and patient care. The Navigator 2.0™ Surgical Guidance System, a trusted and world-renowned gamma probe platform, supports radio-guided lymphatic mapping and tumor localization. Its reusable probe technology is designed for reliable performance through validated sterilization processes, supporting efficient operating room workflows. MarginProbe® is a groundbreaking technology providing real-time margin assessment during breast-conserving surgery, helping surgeons identify positive margins while the patient is still in the operating room. Together, Navigator and MarginProbe provide innovative, clinically proven solutions designed to enhance surgical confidence, efficiency, and patient outcomes.



Endotherapeutics
IMPROVING HEALTHCARE

www.endotx.com.au

Since 1999, **Endotherapeutics** has been committed to improving healthcare by delivering innovative medical technologies that enhance patient outcomes. Over the past 25 years, the company has grown into a leading healthcare technology provider across Australia and New Zealand. As a proudly 100% Australian-owned business, Endotherapeutics is dedicated to innovation, collaboration, and making a meaningful impact within the healthcare community. Through strong customer relationships, strategic partnerships with leading global healthcare companies, and a highly skilled team supported by ongoing professional development, Endotherapeutics continues to advance access to life-improving healthcare solutions.

eurobio gendx

www.eurobio-scientific.com/oncology

Eurobio GenDx is a French founded specialty diagnostics group, established in 1962 and now present in over 12 countries. We work across transplantation, oncology, and infectious diseases, with a shared purpose of improving patient outcomes through better diagnostic information. Our GenDx business, based in Utrecht in the Netherlands, is recognised internationally for its expertise in transplantation diagnostics and HLA typing. EndoPredict, our genomic test for early-stage breast cancer, now sits within the GenDx portfolio. In Australia and New Zealand, our oncology focus centres on EndoPredict, available through Australian Clinical Laboratories (ACL) and listed on the Medicare Benefits Schedule. We're pleased to be attending the AIBC for the first time and look forward to connecting with clinicians and researchers working in breast cancer care.



www.gathermycrew.org.au

Gather My Crew is an Australian charity helping people with cancer and their families coordinate practical and emotional support from their own networks. Our free app turns offers like "let me know if I can do anything" into organised help with meals, transport, childcare, household tasks, appointments and check-ins. By making it easier to ask for, offer and coordinate support, Gather My Crew reduces carer strain, strengthens connection and helps people feel less alone. Designed to complement clinical care, the app supports people between appointments and empowers family, friends and communities to step in with meaningful, coordinated informal care when it matters most.



GenesisCare
Experts in cancer care

www.genescare.com/au

GenesisCare is a proudly Australian-run cancer care provider, specialising in radiation therapy with a growing footprint in medical oncology, theranostics and personalised medicine. Our relentless pursuit for better care is reflected in our modern treatment techniques, technology and contemporary service experience. Our dedicated doctors and research team partner globally to be first movers in bringing clinical innovations to patients close to home. Around 30,000 people a year entrust us with their care across 50 locations nationally.



www.genomicdiagnostics.com.au

Genomic Diagnostics is the nationally coordinated genetic testing service for Healius Pathology. As a leader in diagnostic genomics, we are committed to supporting breast cancer specialists—including oncologists, breast care nurses and surgeons—with vital hereditary breast and ovarian cancer genetic testing. Our advanced technology provides critical insights into BRCA1, BRCA2, and other cancer-related genes, helping identify patients at higher risk and enabling personalised care. With an expert team dedicated to delivering timely, high-quality results, we empower and support healthcare professionals and their patients to make informed decisions.



www.gilead.com/en-au

Gilead Sciences, Inc. is a biopharmaceutical company that has pursued and achieved breakthroughs in medicine for more than three decades, with the goal of creating a healthier world for all people. The company is committed to advancing innovative medicines to prevent and treat life-threatening diseases, including HIV, viral hepatitis and cancer. Gilead operates in more than 35 countries worldwide, with headquarters in Foster City, California. Based in Melbourne, Gilead Sciences Australia and New Zealand employs over 100 people.



www.hologic.com.au

Hologic is your trusted breast health partner, delivering innovative solutions across the entire breast care continuum, from screening and diagnosis to surgical guidance and treatment planning.

For more than 40 years, we have helped advance the standard of care through breakthrough technologies, including the world's first 3D mammography system. Today, our comprehensive breast health portfolio combines industry-leading imaging, intervention, AI-powered workflow solutions and, now, the Endomag portfolio of magnetic localisation and lymphatic mapping. As the direct provider of Endomag products, Hologic offers healthcare professionals a more connected approach to breast cancer care, supporting greater confidence and efficiency at every stage of the patient journey. Through continuous innovation, we remain committed to working with you to improve patient outcomes and advance the future of women's health.



www.iconcancercentre.com.au

Icon Cancer Centre is a leading cancer care organisation with centres across Australia and globally in New Zealand, Singapore, Indonesia, Malaysia, Germany, and the UK. We provide integrated medical oncology, haematology, radiation oncology, molecular imaging, theranostics and clinical research services, with the aim of delivering the best care possible close to home. In Australia, our network of 50 centres brings together more than 250 specialists, offering multidisciplinary expertise and comprehensive breast cancer care. Our treatment capabilities include chemotherapy, hormone therapy and targeted therapies, supported by advanced radiation techniques such as stereotactic treatments, surface-guided radiotherapy surface-guided radiotherapy (SGRT) for tattoo-less positioning, and deep inspiration breath hold (DIBH) to help protect the heart and lungs during treatment. Through a collaborative and patient-centred approach, we are committed to achieving the best possible outcomes for patients.



www.inheritedcancers.org.au

Inherited Cancers Australia is a national charity supporting, educating and advocating for Australians with inherited cancer risk. Supported by our Medical Advisory Committee, we empower people with evidence-based information so they can understand their options to manage their high cancer risk. We provide peer connection, education events, online genetic counsellor support, community catch ups and online support groups, all aimed at empowering people to manage their cancer risk.



www.lilly.com/au

Lilly is a medicine company turning science into healing to make life better for people around the world. We've been pioneering life-changing discoveries for nearly 150 years, and today our medicines help tens of millions of people across the globe. Harnessing the power of biotechnology, chemistry and genetic medicine, our scientists are urgently advancing new discoveries to solve some of the world's most significant health challenges: redefining diabetes care; treating obesity and curtailing its most devastating long-term effects; advancing the fight against Alzheimer's disease; providing solutions to some of the most debilitating immune system disorders; and broadening treatment options for cancer patients. With each step toward a healthier world, we're motivated by one thing: making life better for millions more people. That includes delivering innovative clinical trials that reflect the diversity of our world and working to ensure our medicines are accessible and affordable.



www.menarini.com.au

Menarini is a family-owned Italian pharmaceutical company, with a strong heritage and a history extending over 135 years in 140+ countries. The company offers a fully integrated portfolio of high-quality proprietary and licensed healthcare brands across a wide range of therapeutic areas (Cardio-metabolic, Dermatology, Allergy/Respiratory, Gastroenterology, Anti-infectives, Oncology/Specialty Care and Men's Health, Consumer Health). Menarini Stemline is the wholly-owned subsidiary of the Menarini Group focused on bringing transformational oncology treatments to cancer patients, expanding access to targeted therapies across Australia for treatment of high-need cancers such as ESR1-mutated breast cancer and blastic plasmacytoid dendritic cell neoplasm (BPDCN).



www.merit.com

Founded in 1987, **Merit Medical** manufactures medical devices used in interventional, diagnostic, and therapeutic procedures across radiology, cardiology, breast, vascular, and dialysis specialties. Locally, Merit Medical Australia opened for business in 2016 with an office in Melbourne, followed by an office in Auckland in 2017. Merit Medical ANZ is dedicated to supplying and supporting our customers with best-in-class innovative products, dedicated education offerings, and our commitment to social and environmental responsibility.



www.msa.com.au

Medical Specialties Australasia (MSA) is a privately and wholly owned Australian medical device distribution company and is a leader in providing innovative, minimally invasive medical devices for vascular access, surgery, peripheral vascular disease. MSA was founded in 1982 on the introduction of next-generation medical technology and has pioneered the establishment of many new medical and surgical technologies in the Australasia region over the last 41 years, including the first Vascular Access Port, Implantable Pump, PICC Line, AAA Stent Graft and Insulin Pump. Our diverse product lines for use in hospitals and private practices include surgical implants, venous ablation systems, vascular access products, colorectal surgery and diagnostic equipment, angiographic products and accessories, drainage products, thrombolytic products, and ENT consumables. MSA's core business strategy is to analyse long-term trends in health economics and international medical device markets, conduct extensive and precise market research, find the best technology internationally in our specialised fields which hold strong clinical and economical benefits, strategically align ourselves with like-minded medical device manufacturers and then introduce new technologies to the Australasian market with regulatory and launching strategy expertise. As a distributor, we have the power to choose the products we represent, and we only select the best. Many products in our range require high levels of clinical and technical support as the technology we introduce often requires a significant change in practice or procedure changing technique. Our customers receive comprehensive support through our highly trained field representatives, clinical educators, technical services specialists and customer service team and are committed to the continuous improvement of the services we provide.



www.msd.com

At **MSD**, known as Merck & Co., Inc., Rahway, NJ, USA in the United States and Canada, we are unified around our purpose: We use the power of leading-edge science to save and improve lives around the world. For more than a century, we've been at the forefront of research, bringing forward medicines, vaccines and innovative health solutions for the world's most challenging diseases.



www.nokori.co

Nokori provides natural, science-backed scar care solutions that simplify and support post-surgical recovery. Our integrated approach blends clinical expertise with personalised guidance to help patients achieve the best recovery outcomes, both physically and emotionally. Developed in collaboration with leading healthcare professionals, our products are formulated with carefully selected ingredients that work with the skin's natural healing process. As a trusted Australian brand built at the intersection of clinical expertise, innovation, and human warmth, we are a place of rest, comfort, and care — empowering patients to feel confident, supported, and in control of their healing journey.

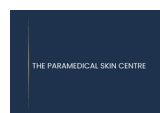
www.novartis.com/au-en

Novartis is improving the lives of more than 2.5 million patients across Australia and New Zealand through our medicines. By partnering with the healthcare system we are working for patients to address their needs, and we are committed to accelerating patient access to life saving treatments and associated healthcare. We are reimagining medicine by using innovative science and technology to address challenging healthcare issues and our rich research pipeline has 50+ ongoing Phase III programs. We are transforming how clinical trials are run to increase patients' access to our industry-leading clinical trials footprint in Australia.



www.obexmedtech.com

Obex MedTech Australia (formerly GRC Surgical) is a medical technology company specialising in solutions that support Anaesthesia & Critical Care, Breast Cancer, Gynaecology, and General Surgery. Founded in 2012, the company has developed deep expertise in delivering devices that enhance clinical practice in the operating theatre and improve patient care before, during, and after surgery. In 2023, the company was acquired by Bunnz plc, joining its healthcare portfolio and benefiting from strengthened logistics, regulatory, and operational support structures. In March 2026, GRC Surgical was renamed Obex MedTech Australia, marking the next phase in the organisation's evolution and further aligning with Bunnz's broader MedTech strategy.



www.paramedicalskin.com.au

Australia's leader in Scar Camouflage and Paramedical Tattoo. With over a decade of experience, **Paramedical Skin** has restored thousands of scars, areolas, and pigment loss across Australia. At Paramedical Skin, we have pioneered a scientifically informed Scar Camouflage Method, developed through years of rigorous testing. Unlike conventional scar tattooing, our approach is evidence-based, methodical, and customised, achieving results previously considered unattainable in scar concealment. Trusted by Surgeons and Nurses nationwide and recommended by health professionals for complex scar and pigment restoration.



www.pinkinkaustralia.org.au

Pink Ink Australia is a national charity dedicated to helping cancer survivors reclaim confidence, identity and a sense of normality after treatment. We address a critical gap in cancer aftercare, supporting survivors who live with the physical and emotional scars of cancer. We provide funding for paramedical and scar camouflage tattooing so that financial circumstances are not a barrier to accessing the care they need. We believe surviving cancer should be the beginning of recovery, not the end of care for their body and mental health. We help survivors reclaim their bodies to become a powerful new version of themselves.



www.preludedx.com

PreludeDX is a leader in personalized breast cancer diagnostics, offering precision tools that empower patients and physicians worldwide to make more informed, shared treatment decisions. The company offers DCISionRT® for Ductal Carcinoma In Situ (DCIS) and AidaBreast® for early-stage invasive breast cancer, which provide genomic insights into a patient's unique tumor biology. These personalized, clinically actionable test results help guide surgical and radiation treatment decisions, reducing the risks of over- or undertreatment. The company utilizes multi-omic technology to provide comprehensive prognostic and predictive information at critical treatment decision points to enhance patient care.



www.riancorp.com

RianCorp Australia's only organisation dedicated specifically to supporting young women with breast cancer. We deliver education, advocacy, connection, and support for women diagnosed under 40, recognising that the experience of breast cancer is different for young women. Through awareness campaigns, peer support, community programs, and research funding, So Brave works to empower young women to be #breastaware, advocate for their health, and navigate diagnosis and treatment with strength and support.



www.sobrave.org.au

So Brave is Australia's only organisation dedicated specifically to supporting young women with breast cancer. We deliver education, advocacy, connection, and support for women diagnosed under 40, recognising that the experience of breast cancer is different for young women. Through awareness campaigns, peer support, community programs, and research funding, So Brave works to empower young women to be #breastaware, advocate for their health, and navigate diagnosis and treatment with strength and support.



www.solventum.com/en-au/home

At **Solventum**, we enable better, smarter, safer healthcare to improve lives. As a new company with a long legacy of creating breakthrough solutions for our customers' toughest challenges, we pioneer game-changing innovations at the intersection of health, material and data science that change patients' lives for the better while enabling healthcare professionals to perform at their best. Because people, and their wellbeing, are at the heart of every scientific advancement we pursue. We partner closely with the brightest minds in healthcare to ensure that every solution we create melds the latest technology with compassion and empathy. Because at Solventum, we never stop solving for you.



www.sonicpathology.com.au

Sonic Healthcare Australia Pathology is Australia's largest integrated pathology network, delivering excellence in diagnostic, molecular and genetic pathology through its Medical Leadership model. With more than 400 specialist pathologists across a national network of laboratories, Sonic provides expert diagnostic services that support clinicians and patients across the cancer care continuum. Through Sonic Genetics, its specialist genetic pathology service, Sonic Healthcare Australia Pathology offers advanced hereditary cancer testing and oncology services, providing genomic insights that support personalised cancer care and informed treatment decision-making. Together with Sullivan Nicolaides Pathology, we are proud supporters of the AIBC Congress, helping clinicians navigate emerging evidence and controversial issues in breast disease management.

SORSIX

www.sorsix.com

Sorsix is a specialist digital health company delivering configurable, interoperable healthcare platforms that streamline clinical, administrative, and patient-facing workflows. Our flagship SaaS product, Pinga®, is a no code, modular health platform designed to digitise end to end patient pathways, automate referrals and scheduling, and enhance patient engagement. Built to integrate with national health infrastructure and third party systems, Pinga supports FHIR aligned interoperability and scalable deployments across local, state wide, and national health systems. Sorsix solutions are trusted by public healthcare organisations to reduce wait times, improve access to care, and deliver measurable operational and clinical outcomes.



www.stratpharma.com

Swiss company **Stratpharma** has developed breakthrough treatments for faster wound healing and abnormal scar prevention and many of these treatments are suitable for patients going through cancer treatments. **StrataXRT** is a wound dressing clinically proven to prevent and treat radiation dermatitis. **StrataCTX** uses the same formulation as **StrataXRT** and is designed as a steroid sparing gel to treat cutaneous rashes caused by chemotherapy and is also ideal for healing the skin post 5FU treatment. **Stratamed** is a self-drying wound dressing that can be applied to open wounds and compromised skin. **Strataderm** is Australia's most trusted scar gel and when applied once daily, prevents and treats abnormal scars.



www.surgeonschoice.com.au

Surgeons Choice (Australia) Pty Ltd is a trusted and innovative provider of high-quality surgical and medical solutions, dedicated to supporting healthcare professionals across Australia. Established with a commitment to excellence and patient safety, we specialise in sourcing and distributing premium surgical instruments, medical devices, and consumables from leading international manufacturers. Our mission is to empower surgeons and healthcare providers with reliable, cutting-edge tools that enhance precision, efficiency, and outcomes in clinical environments. Surgeons Choice takes pride in its strong partnerships with hospitals, surgical centres, and clinics, delivering tailored solutions backed by responsive service and deep industry expertise. At Surgeons Choice, quality, integrity, and innovation drive everything we do. We remain committed to advancing Australian healthcare through superior products and a client-first approach.



www.united.com

At **United Airlines**, Good Leads The Way. With U.S. hubs in Chicago, Denver, Houston, Los Angeles, New York/Newark, San Francisco and Washington, D.C., United operates the most comprehensive global route network among North American carriers and is now the largest airline in the world as measured by available seat miles. United has more flights between Australia and the U.S.A. than any other U.S. airline, offering nonstop service from Sydney, Melbourne, Brisbane and seasonally from Adelaide. Plus, United's partnership with Virgin Australia expands the footprint of departure cities throughout Australia and adds more benefits for both MileagePlus and Velocity Frequent Flyer members. Eligible members can earn and redeem miles/points, receive priority check-in and boarding, and access lounge locations.



www.veracyte.com

Veracyte is a global diagnostics company whose vision is to transform cancer care for patients all over the world. We empower clinicians with the high-value insights they need to guide and assure patients at pivotal moments in the race to diagnose and treat cancer. Our Veracyte Diagnostics Platform delivers high-performing cancer tests that are fueled by broad genomic and clinical data, deep bioinformatic and AI capabilities, and a powerful evidence-generation engine, which ultimately drives durable reimbursement and guideline inclusion for our tests, along with new insights to support continued innovation and pipeline development.



How does it work

01	Scan & Enter Scan the QR code below (and posted around the congress) 
02	Go to the Matching Zone The Meeter platform guides you to your specified matching zone. 
03	Flip Your Phone Hold your phone up the way you would at an airport to easily find your match. 
04	8-Minute Chat Found each other? Great! Start your 8-minute conversation. Use the suggested ice-breakers to keep the conversation flowing and fun. 
05	Stay Connected Choose which details to share and continue the connection beyond the event. Connection is taking action. 


The HBM

This year, AIBC is putting networking and meaningful professional connections at the heart of the congress experience.

Participants are invited to join a series of focused eight-minute, one-on-one conversations through the simple and user-friendly networking platform Meeter. Use the opportunity during coffee and lunch breaks to meet someone new.

**Step outside your usual circle.
See where the conversation takes you.**



Scan. Meet. Repeat

Floor Plan

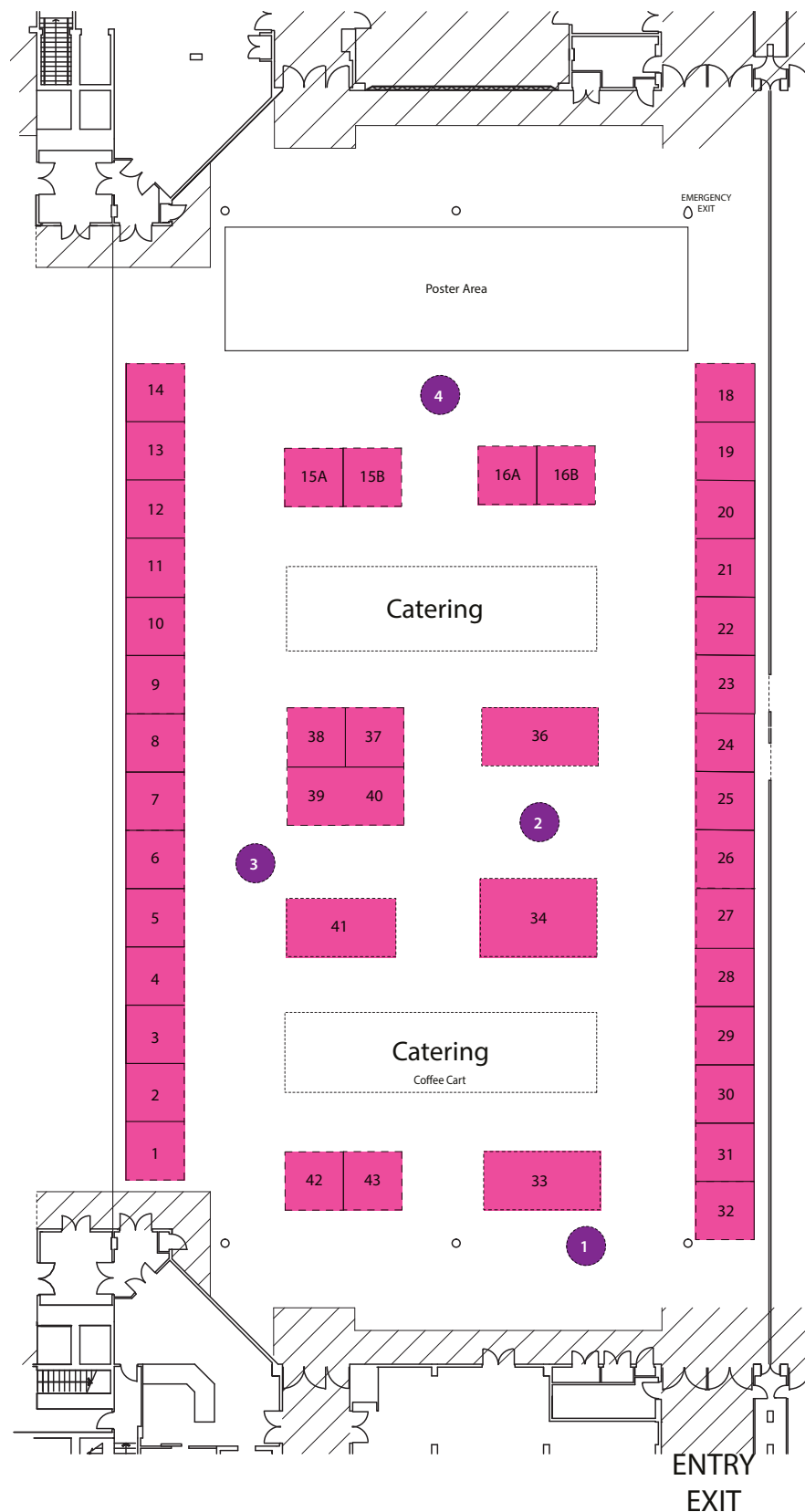


Exhibitors



**Networking
Matching Zone**

- 1 - Stratpharma
- 2 - BCAL Diagnostics
- 3 - MSA
- 4 - Veracyte
- 5 - Sonic Healthcare Australia Pathology
- 6 - SoBrave
- 7 - GenesisCare
- 8 - ASBD
- 9 - BreastSurgANZ
- 10 - Inherited Cancers Australia
- 11 - Applied Medical
- 12 - Solventum
- 13 - Cirdan
- 14 - Endotherapeutics Pty Ltd
- 15A - Device Technologies
- 15B - Gilead
- 16A - Sorsix
- 16B - Paramedical Skin
- 18 - Gather My Crew
- 19 - MSD
- 20 - OBEX MedTech
- 21 - BD
- 22 - RianCorp Pty Ltd
- 23 - PreludeDx
- 24 - BCNA
- 25 - Anita
- 26 - Menarini Stemline
- 27 - Novartis
- 28 - Nokori
- 29 - Dillon Technologies
- 30 - Arthrex Australia
- 31 - Pink Ink Australia
- 32 - Amoena
- 33 - Hologic
- 34 - Lilly
- 36 - Daiichi-Sankyo | AstraZeneca
- 37 - Merit Medical
- 38 - ICON
- 39 & 40 - Genomic Diagnostics
- 41 - Brisbane Radiology
- 42 - Eurobio Scientific
- 43 - Surgeons Choice





CoBrCa

Edinburgh, Scotland, UK

Stay Tuned
September 2028

11th World Congress on Controversies in Breast Cancer



Australasian Society for Breast Disease 15th Scientific Meeting

7-9 October 2027

Tākina, Wellington, Aotearoa New Zealand

From Research to Reality in Breast Oncology

asbd2027.com.au



**BREAST
SURGEONS**
of Australia & New Zealand

Advancing breast surgery. Improving patient care.

As the peak professional body representing breast surgeons across Australia and Aotearoa New Zealand, BreastSurgANZ is committed to the education and training of current and future breast surgeons. We advance standards in breast surgery and support high-quality patient care through quality audit, research, advocacy and evidence-based practice.



EDUCATION



TRAINING



ADVOCACY



AUDIT



RESEARCH



For membership, BreastSurgANZ Quality Audit information or event partnership opportunities, visit **breastsurganz.org** or email **admin@breastsurganz.org**