



**5th International
Breast Cancer
CONFERENCE**

*“Breast preserving
treatment”*

**Hotel Ibis Styles Klaipeda Aurora
Nemuno str. 51, Klaipeda, Lithuania**

2019

PROGRAM

10:00–13:00 I SESSION

Welcome speech 5 min.

I session. New trends in breast cancer diagnostic and treatment

Chairmen:

Alvydas Česas, Klaipeda University Hospital, Klaipeda, Lithuania.

Guy Jerusalem, The University Hospital of Liege, Belgium.

- 10:05–10:20 New old strategy in the treatment breast cancer. What Can You Do to Change the World? Agne Čizauskaitė, Klaipeda University Hospital, Klaipeda, Lithuania.
- 10:20–10:40 Robotic surgery, the future of breast surgery? Benjamin Sarfati, Gustave Roussy Institute of Oncology, Paris, France.
- 10:40–11:00 Breast cancer molecular testing: Genomic risk stratification of early relapses. Roman Rouzier, Institute Courie, Paris, France.
- 11:00–11:20 New targets in the treatment breast cancer. Guy H. Jerusalem, Liege, Belgium.
- 11:20–11:50 Contemporary treatment of HER2 positive early breast cancer. Marc Thill, Frankfurt am Main, Germany.
- 11:50–12:00 *Q&A (10 min.)*
- 12:00–13:00 Satellite presentation (Roche): New possibilities in mTNBC disease management. Marc Thill, Frankfurt am Main, Germany.
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13:00–14:00 Lunch break

14:00–18:00 PARALLEL SESSIONS

Ila session. Systemic treatment breast cancer

Chairmen:

Rasa Jančiauskienė, Lithuanian University of Health Sciences Kaunas Clinics, Kaunas, Lithuania.

Skaistė Tulytė, Vilnius University Santaros Clinics, Vilnius, Lithuania

Lina Daukantienė, Nacional Cancer Institute, Vilnius, Lithuania.

- 14:00–14:30 Evidence base for treatment with CDK4/6 inhibitors. Guy H. Jerusalem, Liege, Belgium.
- 14:30–14:50 Systemic treatment HER 2 positive breast cancer. Alvydas Česas, Klaipeda university hospital, Klaipeda, Lithuania.
- 14:50–15:10 BRCA mutation positive breast cancer. How we need to change our practice? Skaistė Tulytė, VU Santaros Clinics, Vilnius, Lithuania.
- 15:10–15:30 Risk factors for chemotherapy cardiotoxicity in breast cancer patients. Is molecular testing better than patient's history? Domas Vaitiekus, Hospital of Lithuanian University of Health Sciences Kauno Klinikos, Kaunas, Lithuania.
- 15:30–15:45 Male breast cancer. Laura Steponavičienė, National Cancer Institute, Vilnius, Lithuania.
- 15:45–16:00 Retrospective analysis of the impact of anthracycline dose modification on the outcomes of early breast cancer molecular subtypes. Sigita Liutkauskienė, Oncology Hospital of Lithuanian University of Health Sciences, Kaunas, Lithuania.
- 16:00–16:10 *Q&A (10 min)*
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16:10–16:30 Coffee break

16:30-16:50	QoL breast cancer patients. Hair loss study. R. Pikturniene, Klaipeda university hospital, Klaipeda, Lithuania.
16:50-17:10	Supportive care prevention of nausea and vomiting, febrile neutropenia. Guidelines. Aušra Bankauskaitė, Klaipeda university hospital, Klaipėda, Lithuania.
17:10-17:50	Case presentations session: board discussion. Expert board: Rasa Jančiauskienė, Skaistė Tulytė, Lina Daukantienė. (4 cases until 10 min each). Case No. 1. mBC. Sigita Hasnere, Pauls Stradiņš Clinical University Hospital, Riga, Latvia. Case No. 2 Metastatic triple negative breast cancer - is cure possible? Lina Simaškaitė, Hospital of Lithuanian University of Health Sciences Kauno Klinikos, Kaunas, Lithuania. Case No. 3. Giedrė Anglickienė, National Cancer Institute, Vilnius, Lithuania Case No. 4. Anastasija Ranceva, Vilnius University Santaros clinics, Lithuania
17:50-18:00	Q&A (10 min)
IIb session. Surgical session	
Chairmen: Algirdas Bogusevicius, Kaunas Clinics, Lithuania Valerijus Ostapenko, National Cancer Institute, Lithuania Donatas Petrauskas, Klaipeda University Hospital, Lithuania	
14:00-14:20	Implementing Reconstructive Surgery in a Breast Unit - Our Experience. Ansis Gilis, Pauls Stradins Clinical University Hospital, Riga, Latvia.
14:20-14:40	Surgical Treatment of Breast Cancer in Belarus. Anton Khorau, N.N. Alexandrov National Cancer Centre of Belarus, Minsk, Belarus.
14:40-15:00	Radiotherapy and Breast Surgery: Risks and Indications. Daiva Gudaviciene, National Cancer Institute, Vilnius, Lithuania.
15:00-15:40	DEBATE Pathologic Complete Response and Radiotherapy PROS – radiation oncologist Aista Plieskiene, KUH, Lithuania (10 min). CONS – breast surgeon oncologist Valerijus Ostapenko, NCI, Lithuania (10 min). Discussion (20 min)
15:40-16:00	How does She Feel when Her Surgeon Thinks: ‘Could Look Better...?’ Direct-to-Implant Breast Reconstruction. Agne Cizauskaite, Klaipeda University Hospital, Klaipeda, Lithuania.
16:00-16:20	Lipofilling for Breast Asymmetry Correction. Simonas Kaupas, Vilnius University Santaros Clinics, Vilnius, Lithuania.
16:20-16:40	Coffee break
16:40-17:00	How I Took on a Challenge. Case presentations.
17:00-17:45	COMPETITION Homo Chirurgicus against Artificial Intelligence Moderator: Agne Cizauskaite, Klaipeda University Hospital, Klaipeda, Lithuania.
17:45-18:00	Q&A (15 min)
18:00	Closing remarks

Breast cancer hypofractionated radiotherapy: ASTRO 2018 studies review

Vita Žeromskienė, Radiation Oncology department, Klaipėda university hospital, Klaipėda, Lithuania

Introduction. Hypofractionated radiotherapy is the use of $>2\text{Gy}/\text{fraction}$. Hypofractionated whole breast radiotherapy (HF-WBRT) is being increasingly used in the treatment of breast cancer worldwide. The most widely used hypofractionated regimens are delivered over three weeks instead of five weeks during the standard fractionation regimen. Despite of evidence based studies, implementation of this method in Lithuania is still quite slow. Even more questions comes in to the discussion regarding the hypofractionated whole breast (HF-WBI) radiotherapy use for young women or for regional lymphnodes treatment.

Method and purpose. Studies with long follow up, dedicated for breast cancer hypofractionated radiotherapy, were represented in ASTRO 2018, which was held in October 21-24 in San Antonio, Texas, USA. My aim of this presentation is briefly review this studies and to encourage the use of this method as a standard of care for WBRT in Lithuania.

The topic covers studies review, where hypofractionated radiotherapy was compared with standard fractionation ($1.8\text{-}2\text{Gy}/\text{fr.}$) for adjuvant radiotherapy to breast/chest wall + regional nodes radiotherapy, hypofractionated whole-breast irradiation (HF-WBI) for women younger than 50, HF-WBI with boost, hypofractionated postmastectomy radiotherapy (HF-PMRT)+ lymphnodes, HF-PMRT after the reconstruction with implants. The studies demonstrates no differences for locoregional recurrence free survival and distant recurrence free survival between 2 fractionation groups and comparable cosmetic results.

Conclusion. ASTRO 2018 consensus guidelines define that hypofractionated radiotherapy preferred for most women with early stage breast cancer. Decision to offer HFRT should be independent of grade, receptor status, laterality, receipt of systemic therapy, age or breast size.

Hypofractionation is safe and should be considered a viable alternative to conventional fractionation for patients with breast cancer in whom the RT volume will include the regional lymph nodes.

Postoperative radiotherapy after nipple sparing or skin sparing mastectomy

Daiva Gudiničienė, National Cancer Institute, Vilnius, Lithuania

After introducing preoperative breast magnetic resonance imaging (MRI) and gene testing, need for mastectomy raised and remains high. Approximately 25% of the breast cancer patients' are still candidate to mastectomy because of the extent of tumour, extent of ductal carcinoma in situ, multi-centricity of the cancer, or the local recurrence after a previous conservative treatment. For these patients the nipple-sparing mastectomy and skin-sparing mastectomy have been introduced and demonstrated to be effective and safe.

Nipple-sparing mastectomy (NSM) and skin –sparing mastectomy (SSM) have found their place by reducing heavy psychological effects of radical mastectomy. The preservation of the nipple-areola complex (NAC) or overlying breast skin enable easier and more natural reconstruction result, but raise some concerns about increased risk for local recurrence (LR).

NSM is criticized because of possibly increased risk of recurrence behind the areola because of the remaining glandular tissue and terminal ducts, kept to preserve NAC blood supply.

It is known that postmastectomy radiotherapy (PMRT) reduces the risk of loco-regional failure (LRF), and increases disease specific survival and overall survival, particularly in patients with positive lymph nodes. In high or intermediate risk patients, the use of radiation therapy (RT) is recommended. There is a general consensus that PMRT should be considered for patients with four or more positive axillary lymph nodes, primary tumour larger than 5 cm, T4 tumour with skin involvement and for positive margin. PMRT could be omitted in elderly patients with poor clinical conditions or serious co-morbidities and short life expectancy.

In the literature, there are few reports about indication and technique of radiation after NSM and SSM. Still there is no consensus for decision-making in delivering postoperative radiotherapy after NSM or SSM.

According to literature review, adjuvant RT after NSM and SSM should be given in high-risk patients. In patients with intermediate risk or lower stage, the indication should be discussed individually.

Current recommendations for PMRT after SSM and NSM are: patients with triple negative breast cancers, tumours larger than 5 cm, positive node(s), positive surgical margins, patients with skin flaps >5 mm thickness, or skin flaps <5 mm with high risk factors such as age <50 years, nodal metastases, lympho-vascular invasion or multi-centric tumours. Flap thickness strongly recommended to measure using MRI.

Increase of complications rate after PMRT after NSM and SSM is documented, but immediate breast reconstruction using tissue expanders and implants is an acceptable option.

So far, there is no controlled prospective clinical study that assessed benefit from PMRT after NSM or SSM. Data that we have are based on retrospective analyses. This definitely warrants need of randomized trials in this clinical field.

Keywords: Nipple-sparing mastectomy (NSM), skin-sparing mastectomy (SSM), breast cancer, post-mastectomy radiation therapy (PMRT).

Clinical case presentation

Ph.d. Saulius Bružas- National Cancer Institute, Breast Surgery Department

Ph.d. Daiva Gudavičienė- National Cancer Institute, Breast Surgery Department National Cancer Institute, Breast Surgery Department

Med. Dr. Marius Gutauskas – Vilnius University Santaros Clinics

Patient O.S. was born in 1936. In 1989, aged 53, she was diagnosed with left breast cancer and Halsted mastectomy was performed. After the operation she received 3 courses of chemotherapy.

19 years later, in December 2008, she returned to National Cancer Institute due to palpable tumor in the left infraclavicular area. Physical examination resulted in about 5cm infiltration that palpated below the left clavicle. The examination of other systems showed no dissemination of disease. CT of thorax showed the tumor of about 5cm size, located below the left clavicle. It was also contacted with muscles and v. subclavia, and the length of accretion was about 4cm. The fine needle aspiration of tumor was performed and the histological answer was “adenocarcinoma”.

In the same month the operation was performed. The incision was done below the left clavicle and left infraclavicular zone was opened. The revision showed that the tumor overgrew v. subclavia. 5cm of vena was resected and the fragment of vena from the hip was used to fill up the defect of v. subclavia. Tumor was removed radically. The histological examination showed invasive ductal cancer, with intravascular, perineural spreading and diffusion to v. subclavia. ER and PR positive, HER2 – negative.

The patient received further treatment of radiotherapy (50 Gr) to supra, infraclavicular and axillary areas, and hormonotherapy.

The follow up was done regularly. In February 2019 (patient’s age at this date is 83) the right breast cancer was diagnosed. No relapses in the left infra-supraclavicular areas.

Operation performed was right simple mastectomy and biopsy of right axilla sentinel lymphnode.

Histological examination showed 12mm invasive ductal cancer, ER and PR positive, G2, HER2 – negative, Ki67 – 3%, sentinel lymphnode – without metastases.

The adjuvant treatment – hormonotherapy.

CONCLUSIONS:

The purpose of the presentation is not only to show the long-term survival rate for breast cancer (in this case, 30 years), but also to provide good results in the spread of the disease to rarely operated areas.

Usually, the supra-infraclavicular areas are not operated. However, this case shows that the choice was right and that different options were always worth considering.

Clinical practice guidelines on the evidence-based use of integrative therapies during and after breast cancer treatment: An Overview

AUTHOR: D.Mačiulienė¹, prof. K. Šmigelskas²

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INTRODUCTION

Patients with cancer face many psychological and physical challenges as they move through a cancer diagnosis, treatment, and survivorship. 75% of individuals with a history of cancer using one or more complementary and integrative therapies by the United States of America National Health Interview Survey.

Integrative oncology, the diagnosis-specific field of integrative medicine, addresses symptom control with nonpharmacologic therapies. Complementary therapies are an evidence-based adjunct to mainstream care that effectively controls physical and emotional symptoms, enhances physical and emotional strength, and provide patients with skills enabling them to help themselves throughout and following mainstream cancer treatment. Combining complementary therapies with mainstream oncology care to address patients' physical, psychologic and spiritual needs constitutes the practice of integrative oncology.

The goal of this review is to provide clinicians with practical information about clinical recommendations of integrative therapies during and after breast cancer treatment made by the Society for Integrative Oncology.

GUIDELINE DEVELOPMENT PROCESS

Founded in 2003, the Society for Integrative Oncology (SIO) is the premier multi-disciplinary professional organization for integrative oncology. In 2014, the Society for Integrative Oncology the first time published clinical practice guidelines to inform both clinicians and patients on the use for integrative therapies during breast cancer treatment and to treat breast cancer treatment-related symptoms. In 2017 clinical practice guidelines were updated, which were based on a systematic review of the literature. According to the clinical guideline development process, drafts prepared by the SIO Guideline Working Group were distributed to an interdisciplinary group of SIO internal and external reviewers.

The guideline recommendations provide a summary of the evidence-based use of the integrative therapies on the use for specific conditions. These guidelines are the only comprehensive evidence-based guidelines for incorporating complementary and integrative therapies into conventional oncology clinical practice.

In clinical practice guidelines very important are definitions for each integrative therapy that had a sufficiently large body of evidence to formulate a specific recommendation. Information is also provided on how to implement the recommendations into the clinical setting.

DEFINITION OF COMPLEMENTARY AND INTEGRATIVE THERAPIES

Integrative oncology is the coordinated use of evidence-based complementary and integrative practices in collaboration with conventional oncology care. Complementary therapies are generally defined as any medical system, practice, or product that is not part of conventional medical care, these therapies used as a complement alongside conventional medicine.

In oncology, individuals use integrative therapies to manage symptoms and side effects, enhancing wellness, improving quality of life during and after breast cancer treatment.

PRACTICE GUIDELINES' MAIN IDEA

In clinical practice guidelines on the evidence-based use of integrative therapies are described randomized control trials that provide support for the highest graded therapy recommendations for the use of integrative therapies during the patient experience of breast cancer and for side effects related to breast cancer treatment. In the recommendation grading system used in the SIO guidelines, grade A – signifies a high certainty of substantial net benefit, grade D – recommend against a therapy due to no benefit, harm or insufficient data. High levels of evidence support the routine use of mind-body practices, oncology massage, natural products, music therapy, stress reduction programs.

Given the high level of evidence of benefit coupled with the relatively low level of risk, these therapies can be incorporated as an option into patient care. The impact of integrative approaches on symptom management is highly individualized.

CONCLUSION

Cancer patients are increasingly using complementary and integrative medicine (CAM) as supportive care during cancer treatment, for management of treatment-related side effects and for improving quality of life during and after cancer treatment.

These SIO guidelines support the provision of clinical services to include both evidence-based conventional and integrative therapy options.

An important feature of integrative medicine is that it actively involves patients in their own treatment, encouraging them to take responsibility for maintaining their own health. Instead of expecting to cure their disease, patients learn to deal with it, using CAM to strengthen their immune system, relieve pain and manage the side effects from disease or its treatment.

One of the things that come out of these Society for Integrative Oncology guidelines is education for oncologists enabling them to be better prepared to answer questions patients may have about integrative therapies.

Reference:

H. Greenlee, M.J. DuPont-Reyes, L.G. Balneaves et al. Clinical Practice Guidelines on the Evidence-Based Use of Integrative Therapies During and After Breast Cancer Treatment. *A Cancer Journal for Clinicians*, 2017;67:194-232.

Predictors of postoperative hypocalcemia occurring after a total thyroidectomy: Results of prospective multicenter study

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ABSTRACT

Background: Thyroid surgeries are among the most common operations performed in the world. Hypocalcemia following total thyroidectomy is a common complication that is sometimes difficult to correct. The aim of this study is to determine the risk factors for hypocalcemia following total thyroidectomy and their clinical value.

Subjects and Methods. From January 2015 through to April 2017, 400 patients were included in this prospective multicenter study. All patients underwent total thyroidectomy due to various thyroid diseases. The following risk factors were analyzed: pre-operative and post-operative biochemical blood parameters, clinical effects and factors related to surgery, the patient, and the disease.

Results. Post-operative hypocalcemia developed in 257 patients (64.2%). Of them, 197 patients (76.7%) were diagnosed with asymptomatic hypocalcemia. Clinical symptoms were present in 60 of the 257 patients with hypocalcemia (23.3%). The statistically significant predictors of hypocalcemia were calcium and ionized calcium pre- and post-operatively ($p < 0.001$), parathyroid hormone on day one following surgery ($p < 0.001$), thyrotoxicosis <10 years before surgery (odds ratio 1.65, 95% CI 1.01–2.70, $p = 0.046$), the number of parathyroid glands found during surgery (odds ratio 0.52, 95% CI 0.38–0.70, $p < 0.001$), ligation of the trunk of the left inferior thyroid artery (odds ratio 2.04, 95% CI 1.27–3.29, $p = 0.003$), ligation of the trunk of the right inferior thyroid artery (odds ratio 2.37, 95% CI 1.47–3.81, $p < 0.001$), and the number of transplanted parathyroid glands (odds ratio 1.87, 95% CI 1.12–2.97, $p = 0.015$). In the multivariate analysis, age (odds ratio 1.05, 95% CI 1.01–1.09, $p = 0.029$) and gender (odds ratio 5.94, 95% CI 1.13–31.26, $p = 0.035$) were statistically significant predictors.

Conclusions. This study demonstrates that there is a number of different patient (gender, age, and duration of thyrotoxicosis <10 years before surgery) and surgical (number of parathyroid glands found during surgery, calcium and ionized calcium before and after surgery, parathyroid hormone

on day one following surgery, and ligation of the trunk of the left and right inferior thyroid artery) risk factors predictive of hypocalcemia following total thyroidectomy. Optimization of the surgical technique could possibly prevent the occurrence of hypocalcemia after total thyroidectomy in some cases; in other cases, identification of known risk factors post-operatively could permit early detection and effective treatment of these patients.

Keywords: Total thyroidectomy; Hypocalcemia; Thyroid surgery; Predictors.

1. Karamanakos SN, Markuo KB, Panagopoulos K, et al. (2010) Complications and risk factors related to the extent of surgery in thyroidectomy-results from 2,043 procedures. *Hormones*. 9: 318-325.
2. Ho TW, Shaheen AA, Dixon E, Harvey A. (2011) Utilization of thyroidectomy for benign disease in the United States: a 15-year population-based study. *Am J Surg.*, 201: 570-574.
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