2\textsuperscript{nd} NAVIGATING CLINICAL CONUNDRUMS IN BREAST CANCER 2019

26\textsuperscript{th} - 28\textsuperscript{th} April 2019 | Mumbai, Hotel Taj, Santacruz

Organising Chairs
Dr. B. K. Smruti
Dr. Anita Borges
Dr. Hemant Malhotra
Dear Colleagues & Friends,

On behalf of the Mumbai Oncologist Association and the Indian Society of Medical and Pediatric Oncology it gives us great pleasure in inviting you to participate for the 2nd edition “Navigating Clinical Conundrums in Breast cancer” from 26th-28th April, 2019 at Hotel Taj, Santacruz, Mumbai

This conference is endorsed by European School of Oncology.

This multi-disciplinary conference will focus on the learning’s from early and advanced breast cancer consensus from St.Gallens 2019 and ABC4, Immuno-Oncology, specific clinical dilemmas in breast cancer. This conference will have didactic lectures, debates and case based discussions. The important highlights would be to address challenging and complex issues presented by the occurrence of breast cancer through multidisciplinary panel discussions.

We have 5 international speakers and we expect a participation of 300 oncologists from across India.

We welcome you all for this conference that intends to showcasing the best practices in breast cancer.

Dr. B.K. Smruti
Program Director
General Secretary, Mumbai Oncology Association
Sr. Consultant Medical Oncologist and Hemato-Oncologist, Lilavati Hospital and Research Center,
Bombay Hospital and Medical Research Center

Dr. Anita Borges
Sr. Consultant Surgical Pathologist
President of Centre of Excellence in Histopathology & IHC,
SRL Diagnostics Pvt Ltd.
President, Mumbai Oncology Association

Dr. Hemant Malhotra
President, Indian Society of Medical & Pediatric Oncology (ISMPO)
President Elect, Immuno-Oncology Society of India
Professor & Head
Dept. of Medical Oncology, Shri Ram Cancer Centre,
Mahatma Gandhi Medical College & Hospital, Jaipur
CONFERENCE HIGHLIGHTS

- Learning’s from St.Gallen Early Breast Cancer Consensus Conference
- Learning’s from ABC Consensus Conference
- Address Clinical Conundrum in Young Women with Breast Cancer
- Key Note Talks from International Speakers
- Talks on Future of Breast Oncology
- Multidisciplinary Tumor Board
- Immunotherapy in Breast Cancer
- Breast Cancer Preceptorship Program
## Multidisciplinary Management of Breast Cancer 2019: Practice Essentials

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<td>09:30 - 09:50</td>
<td>Imaging: Diagnosis and Screening</td>
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<td>09:50 - 10:05</td>
<td>New AJCC Staging: More Relevant?</td>
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<td>Conventional Pathology and Molecular Subtypes</td>
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<td>Q&amp;A</td>
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<td>10:45 - 11:00</td>
<td><strong>Tea/Coffee Break</strong></td>
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<td>11:00 - 11:45</td>
<td>Surgery: Strategies Inoperable, “Less is More”</td>
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<td>• BCS vs Mastectomy</td>
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<td>• Skin Sparing Mastectomy</td>
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<td>• SNB vs ALND</td>
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<td>11:45 - 12:00</td>
<td>The Role of Surgery: Post Neoadjuvant Therapy &amp; Oligometastatic Disease</td>
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<td>Q&amp;A</td>
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<td>12:10 - 12:40</td>
<td>Optimizing Radiotherapy in Breast Cancer - Part 1 (Post Mastectomy,</td>
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<td>Post Breast Conserving Surgery)</td>
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<td>12:40 - 12:55</td>
<td>Optimizing Radiotherapy in Breast Cancer - Part 2 (Post Neoadjuvant</td>
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<td>Therapy, Metastatic Breast Cancer &amp; Oligometastatic Breast Cancer)</td>
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<tr>
<td>12:55 - 13:05</td>
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<td>13:05 - 13:50</td>
<td><strong>Lunch</strong></td>
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## Multidisciplinary Management of Breast Cancer 2019: Practice Essentials

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<td><strong>Systemic Therapy Current Standards and The Way Forward</strong></td>
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<td>13:50-14:10</td>
<td>Impact of Genomic Tools in Early Breast Cancer Management</td>
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<td><strong>Triple Negative Breast Cancer</strong></td>
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<td>Current Treatment of TNBC 2019: Adjuvant and Neoadjuvant</td>
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<td>14:50-15:00</td>
<td>TNBC: MBC “The Standard and Emerging Options Beyond Chemotherapy”</td>
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<td>Q&amp;A</td>
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<td><strong>HER2 Positive Breast Cancer: The Success Story</strong></td>
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<td>Adjuvant &amp; Neoadjuvant: Singles, Double, How Short or Extended</td>
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<td>MBC: The Current Algorithm</td>
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<td><strong>Luminal Breast Cancer</strong></td>
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<td>Who Needs Chemotherapy?</td>
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<td>Adjuvant &amp; Neoadjuvant Endocrine Therapy: “Selecting the Option and</td>
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<td>Endocrine Therapy: MBC: “Navigating the Maze”</td>
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<td><strong>Hereditary Breast Cancer: Recognition and Pearls of Management</strong></td>
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<td>Genetic Testing: Whom Which When?</td>
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<td>Management of BRCA Carrier with Breast Cancer: Is it Different?</td>
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<td>Risk Reducing Strategies</td>
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<td><strong>Breast Cancer Case Presentation Contest</strong></td>
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<td>Case 1: HER2</td>
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<td>Case 3: MBC</td>
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<td>08:45 - 09:15</td>
<td><strong>Session 1: Case Discussion</strong></td>
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<td><strong>Session 2: Lessons from St.Gallen 2019: From Consensus to Clinic</strong></td>
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<td>Consensus to Clinic: Surgery</td>
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<td>Consensus Panel on Individualising Radiotherapy-Post Breast Conserving Surgery, Mastectomy, Primary Systemic Therapy and Reconstruction</td>
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<td>Consensus to Clinic: Radiation</td>
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<td>Proton Therapy in Breast Cancer</td>
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<td>Consensus Panel on HR+ve Breast Cancer: Risk Stratification and Making Right Choice</td>
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<td>Pfizer Symposium: CDK 4/6 Inhibitor: Whats New and What’s Left to Learn?</td>
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<td>Consensus Panel on Optimising Chemotherapy</td>
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<td>Consensus Panel on Neoadjuvant Therapies: Breast Cancer Subtypes and Specific Strategies</td>
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<td>Consensus to Clinic: Neoadjuvant Therapy</td>
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<td><strong>Debate</strong>: Are Clinico-Pathologic Online Tools: A Valid Alternative to Genomic Profile</td>
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<td>Does Hormone Receptor Status Impact Biology &amp; Therapy In HER2 Postive Breast Cancer</td>
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<td>Consensus on HER2 Breast Cancer : To Ease or To Intensify</td>
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<td><strong>Session 3: SHE: Shaping HER2 Evolution</strong></td>
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<td>Welcome Address &amp; Introduction</td>
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<td>HER2+ve Breast Cancer – Evolving Story</td>
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<td>• ASCO CAP HER2 Guidelines</td>
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<td>• Neoadjuvant Therapies – Integrated Newer Strategies for Better Outcome</td>
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<td>• Short HER – Touch base in Last 2 Slides</td>
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<td>19:40 - 20:10</td>
<td>Adjuvant Therapy – Escalating &amp; De-escalating – What is the Future?</td>
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<td>HER2+ve Metastatic Breast Cancer : A Chronic Disease?</td>
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<td>HER2+ve Breast Cancer &amp; Pregnancy</td>
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<td>Brain Mets in Patients With HER2 Positive Breast Cancer</td>
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**Day 3 - Sunday, 28th April**

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<td><strong>Session 5: Metastastic Breast Cancer: Building on Success of Current Strategies</strong></td>
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<td>Targeting DNA Repair: Parp Inhibitor and Emerging Novel Targets</td>
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<td>Immune Check Point Blockade: Expanding the Role Beyond TNBC &amp; MBC</td>
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<td>Oligometastatic Breast Cancer: &quot;The Transitional Zone of Oligometastasis&quot;</td>
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<td><strong>Session 6: Young Women with Breast Cancer: Meeting the Challenges</strong></td>
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<td>Clinical Experience of CDK 4/6 Inhibitor in Premenopausal Patients with Breast Cancer</td>
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<td>Biology of Young Women with Breast Cancer: Is it Unique?</td>
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<td>Issues in Fertility Preservation</td>
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<td><strong>Panel Discussion</strong></td>
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<td><strong>Session 7: Multidisciplinary Case Discussion</strong></td>
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<td>Team Cytecare, Bangalore</td>
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<td>Team MAX Hospital, Delhi</td>
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<td>13:55 - 14:00</td>
<td>Vote of Thanks &amp; Lunch</td>
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Day 2 - Saturday, 27th April

QUESTIONS TO BE DISCUSSED DURING THE SESSION ON LESSONS FROM ST. GALLEN 2019: FROM CONSENSUS TO CLINIC

Surgical Consensus

Question 1: Estimated clinical benefit of margins
Residual invasive breast cancer after Primary Systemic Therapy (PST)
In 2017 the panel suggested that the “no tumour on ink” was applicable to unifocal residual. Which margin in multifocal residual disease, provides adequate clinical benefit (low LRR and lower 2nd surgeries) in patients that in addition receive radiotherapy?

Question 2: Estimated clinical benefit of margins
Invasive breast cancer (including intraductal components)
The St. Gallen Consensus of 2017 has accepted “no ink on tumour” margins (in patients receiving standards radiotherapy) to provide adequate clinical benefit with low LRR and lower 2nd surgeries. This consensus included aggressive biology. Should the margin required be greater if lobular carcinoma?

Question 3: Estimated clinical benefit of margins
Invasive breast cancer (including intraductal components)
The St. Gallen Consensus of 2017 has accepted “no ink on tumour” margins (in patients receiving standards radiotherapy) to provide adequate clinical benefit with low LRR and lower 2nd surgeries. This consensus included aggressive biology. Does focally positive margin (foci of invasive tumour<4mm on ink) require 2nd surgery?

Question 4: Estimated clinical benefit of preserving the skin envelope (SSM/NSM procedures)
The risk of LLR outweighs gains in cosmesis and therefore these procedures should not be performed in: Inflammatory breast cancer even with clinical complete response to PST?
Question 5: Estimated clinical benefit of preserving the skin envelope (SSM/NSM procedures)

The risk of LLR outweighs gains in cosmesis and therefore these procedures should not be performed in: Absence of any distance between tumour and skin on preoperative imaging, but without clinical signs of skin infiltration?

Question 6: Estimated clinical benefit of preserving the skin envelope (SSM/NSM procedures)

The risk of LLR outweighs gains in cosmesis and therefore these procedures should not be performed in: Cases where imaging surgeries centrally located tumors near nipple?

Question 7: Surgery of the axilla:

In patients undergoing surgery before systemic treatment

• Omitting SLND in low-risk invasive breast cancer
• Omitting ALND in patients with macrometastatic sentinel lymph nodes

In patients undergoing neoadjuvant treatment

• Indications for SLND (sufficient to predict ypN0?)
• Indications for special approaches to SLN (e.g. >2 nodes, TAD)
• Indications for ALND

Question 8: Estimating the benefit of axillary surgery

In patients undergoing surgery before systemic treatment

• Omitting SLND in low-risk invasive breast cancer
• Omitting ALND in patients with macrometastastatic sentinel lymph nodes

• Can lead to lower rates of typical side effects such as lymphedema, dysesthesia, arm/shoulder morbidity
• These benefits need to be weighed against loco-regional recurrence risk
Day 2 - Saturday, 27th April

Surgical Consensus

Question 9: When can SLN biopsy be omitted?

Should we use axillary ultrasound to investigate lymph nodes before deciding to forgo SLNB?

Question 10: When can SLN biopsy be omitted?

For patients with a clinically negative axilla, should we forgo SLNB in: T1 luminal A-like patients of age >70 years independent of co-morbidities?

Question 11: When can SLN biopsy be omitted?

For patients with a clinically negative axilla, should we forgo SLNB in: T1 luminal A-like patients of age >70 years only if co-morbidity present?

Question 12: When can SLN biopsy be omitted?

For patients with a clinically negative axilla, should we forgo SLNB in: T2 luminal A-like pts?

Question 13: Radiotherapy approach in patients with macrometastatic SLN that did not undergo ALND

In a patients with a tumour below 5cm and 1-2 positive SLNs that has undergone a breast conserving procedure and is scheduled for whole breast irradiation («Z11 criteria»):

- This patient can be treated with whole breast irradiation without 3rd or additional axillary field / high tangents
- Additional axillary radiation should be added in all cases
- Additional axillary radiation should be added in all cases of aggressive histologies / subtypes such as TNBC
- Abstain
Question 14: Surgery of the Axilla: postmastectomy

Based on e.g. the AMAROS trial and other data sets, the preferred approach for women with T1 cancers undergoing mastectomy and SLN mapping with macro-metastases in 1-2 sentinel nodes should be (assuming standard systemic adjuvant therapy):

- No additional therapy to the axilla
- Completion axillary dissection
- Axillary/RNI per AMAROS
- Depends on tumor biology
- Abstain

Question 15: ALND in patients with macrometastatic SLN

ALND can be omitted in: Mastectomy with 1-2 positive SNs, TNBC, and RNI planned?

Question 16: ALND in patients with macrometastatic SLN

ALND can be omitted in: Mastectomy with 1-2 positive SNs and CW* but not RNI* RNI planned?

Question 17: ALND in patients with macrometastatic SLN

ALND can be omitted in: Mastectomy with 1-2 positive SNs, ER+ or HER2+, and RIN planned?

Question 18: ALND can be omitted in: With tumor >5 cm undergoing BCT with 1-2 positive SNs and undergoing WBI?

Question 19: Approach to axillary surgery in patients undergoing primary systemic therapy

Response can lead to lower axillary tumor burden. The benefits of less axillary local therapy need to be weighed against loco-regional recurrence risk and the risk of “understaging” and overtreatment.

- Indication for SLND
- Indication for “SLND plus” (e.g. >2 nodes, tailored axillary dissection)
- Indication for ALND (e.g. in cN2 or resistance)
Question 20: Use of SLND in cN1 undergoing PST

In a patient who is clinically node positive (cN1) at presentation and downstages to cN0 after neoadjuvant, SLN can substitute for ALND if: 1-2 neg SLNs obtained?

Question 21: Use of SLND in cN1 undergoing PST

In a patient who is clinically node positive (cN1) at presentation and downstages to cN0 after neoadjuvant, SLN can substitute for ALND if: 3 or more neg SLNs obtained?

Question 22: Use of SLND in cN1 undergoing PST

In a patient who is clinically node positive (cN1) at presentation and downstages to cN0 after neoadjuvant, SLN can substitute for ALND if: a clipped (marked) node, with or without additional SLNs is removed and is negative?

Question 23: ALND after PST when there is residual axillary disease

In a patient who is cN1 at presentation and has a good clinical response; SLN mapping identifies 3 SLN: ALND may be avoided if there is limited involvement with micrometastasis in one positive node only (no radiotherapy planned)?
Radiation Therapy Consensus

Question 1: Regional Lymph node irradiation following PST
In initially cN+ patients who have a negative SLN procedure after PST, lymph node irradiation is?
- The standard
- Not the standard
- Indicated in the presence of risk factors (tumor size, grade, vascular invasion, initial number of suspicious LN)
- Indicated if no pCR of the breast tumor was obtained
- Abstain

Question 2: (Accelerated) Partial breast irradiation
Based on the data of the published/recently presented trials, (A)PBI can be considered in what patient populations?
- Is not standard because of worst cosmetic outcomes and/or higher recurrence risk
- In patient with low risk features (suitable) according to the ASTRO and GEC-ESTRO definitions
- In patients with low risk and intermediate risk/cautionary risk features according to the ASTRO and GEC-ESTRO definitions
- In all patients with an indication for regional LN irradiation
- Asbtain

Question 3: Hypofractionated breast irradiation
Hypofractionated irradiation is a standard of care in (breast/chest wall irradiation only)?
- For all patients except rare circumstances like re-irradiation
- Following BCS only, age > 50 years only
- Following BCS only, all ages
- Following BCS and mastectomy, age > 50 years only
- Abstain
Question 4: Hypofractionated breast irradiation
Hypofractionated irradiation is a standard of care in (breast/chest wall irradiation And RNI)?
• For all patients except rare circumstances like re-irradiation
• Following BCS only, age > 50 years only
• Following BCS only, all ages
• Following BCS and mastectomy, age > 50 years only
• Abstain

Question 5: Regional node irradiation
Following breast conserving surgery, radiation should include regional nodes:
If 1-3 nodes are positive?
• No
• Only if poor feature (e.g. TNBC, residual diseases after PST)
• At any cases
• Abstain

Question 6: Regional node irradiation
Following breast conserving surgery, radiation should include regional nodes:
If 4 nodes are positive?
• No
• Only if poor feature (e.g. TNBC, residual diseases after PST)
• At any cases
• Abstain

Question 7: Radiation therapy: After mastectomy
Should post mastectomy RT (chest wall & regional nodes) be standard for patients for with: pT3 pN0?

Question 8: Radiation therapy: after mastectomy
Should post mastectomy RT (chest wall & regional nodes) be standard for patients for with: pT2 pN0 with bad features only?
Radiation Therapy Consensus

Question 9: Radiation therapy: After mastectomy
Should post mastectomy RT (chest wall & regional nodes) be standard for patients for with: N+ 1 to 3, ER+ and/or HER2+  ?

Question 10: Radiation therapy: After mastectomy
Should post mastectomy RT (chest wall & regional nodes) be standard for patients for with: N+ 1 to 3, with adverse features (TN)?

Question 11: Regional node irradiation
Should post mastectomy RT (chest wall & regional nodes) be standard for patients (not having received PST with: 1 or 2 positive SLNs but no axillary dissection?

Question 12: Radiation therapy: After mastectomy and breast reconstruction
In women who have undergone immediate reconstruction (IBR)?

• PMRT indications are the as those after mastectomy without IBR
• PMRT should be limited to patients with very high-risk features only because of the increased complication risk after IBR
• PMRT in patients with implants should be limited to very high risk
• Abstain

Question 13: Radiation therapy after PST
Consider a healthy who presents with a T3N0 TNBC. Good response to PST. pCR at mastectomy with 6 cm of Fibrosis; negative SLN ?

• Patient should receive PMRT because of baseline stage
• Patient need not receive PMRT because of excellent clinical response
• Abstain

Question 14: Elderly patients (> 70 y): Radiation
The preferred treatment after BCS for stage 1 ER+ disease (screening detected) in a healthy 70 year old woman is?

• No further treatment
• Endocrine therapy alone
• Radiation therapy alone
• Radiation and endocrine therapy
• Abstain
QUESTION 1: Luminal A (ER positive, HER2 negative, G1, +/- low risk on multigene signature)
In cancers with features above, what is your threshold for giving adjuvant chemotherapy?:
• 1 positive LN
• 2-3 positive LN
• 4-9 positive LN
• More than 10 positive LN
• Abstain

QUESTION 2: Chemotherapy Lobular Breast Cancer
In management of “classic” lobular breast cancer, with a low risk genomic signature, what is your threshold for giving adjuvant chemotherapy?
• 1 positive LN
• 2-3 positive LN
• 4-9 positive LN
• Never
• Abstain

QUESTION 3: TAILORx and beyond
The 21-gene recurrence score, if available, is widely used to assist adjuvant chemotherapy decisions, and that based on TAILORx, women with node-negative cancers and recurrence scores ≤ 25 do not need chemotherapy. Women of age < 50 years with node-negative cancer and RS 21-25 should receive?
• Chemo + ET
• OFS + ET
• Chemo + OFS + ET
• Tamoxifen only
• Abstain
Day 2 - Saturday, 27th April

Chemotherapy Consensus

Question 4: **Postmenopausal women with node-negative cancers and RS ≥ 26**

Postmenopausal women with node-negative cancers and RS ≥ 26 should be offered chemotherapy?

- Routinely
- In selected settings depending on other histopathologic characteristics and patient references
- Never
- If score is greater than 30 only
- Abstain

Question 5: **Recurrence score in LN+ (PlanB trial)**

RS < 11 or equivalent in women of age > 50 years and 1-2 positive LN may be used to recommend against chemotherapy?

Question 6: **Mammaprint in LN+ (based on MINDACT)**

Mammaprint low in women of age > 50 years and 1-2 positive LN may be used to recommend against the indication for adjuvant chemotherapy?

Question 7: **Mammaprint in LN+ (based on MINDACT)**

Mammaprint low in women of age < 50 years and 1-2 positive LN may be used to recommend against the indication for adjuvant chemotherapy?

- PMRT indications are the as those after mastectomy without IBR
- PMRT should be limited to patients with very high-risk features only because of the increased complication risk after IBR
- PMRT in patients with implants should be limited to very high risk
- Abstain

Question 8: **Preferred chemotherapy regimens in ER+ breast cancer in Node Negative**

The preferred chemo-regimen should be?

- Anthracyclines, alklators and taxanes
- Alklators and taxanes
- Alkylators only
- Abstain
Question 9: Chemotherapy in TNBC
In women with stage 1 TNBC, the preferred chemo-regimen should be?

- Anthracyclines, alkylators and taxanes
- Alkylators and taxanes
- Alkylators only
- Abstain

Question 10: Chemotherapy in TNBC: Anthracyclines
Women with stage 2 or 3 TNBC should receive which chemotherapy regimen?

- Anthracyclines, alkylators and taxanes
- Alkylators and taxanes
- Alkylators only
- Abstain

Question 11: TNBC chemotherapy: Neoadjuvant platinum
Should a platinum based regimen be recommended: In addition to T/C/A based regimens?

Question 12: TNBC chemotherapy: Neoadjuvant platinum
Should a platinum based regimen be recommended: In patients with known BRCA mutation?

- PMRT indications are the as those after mastectomy without IBR
- PMRT should be limited to patients with very high-risk features only because of the increased complication risk after IBR
- PMRT in patients with implants should be limited to very high risk
- Abstain
Chemotherapy Consensus

Question 13: TNBC chemotherapy: Neoadjuvant platinum
Should a platinum based regimen be recommended: In addition to T/C/A based regimens?

Question 14: TChemotherapy in TNBC: Tumor less than 6 mm N0
Should women with unifocal pT1a pN0 receive chemo?

Question 15: Optimal chemotherapy schedule
When giving adjuvant / neoadjuvant chemotherapy with anthracycline and taxanes, the preferred schedule is:

• Standard
• Dose- dense
• Abstrain
Day 2 - Saturday, 27th April

QUESTIONS TO BE DISCUSSED DURING THE SESSION ON LESSONS FROM ST. GALLEN 2019: FROM CONSENSUS TO CLINIC

HER2+ Breast Cancer Consensus

Question 1: HER2+ breast cancer
It is understood that standard management for HER2+ breast cancer includes chemotherapy and trastuzumab, including patients with stage 1 tumors. Do the large majority of patients with HER2 positive node-negative disease require anti-HER2 therapy? With T1a disease?

Question 2: It is understood that standard management for HER2+ breast cancer includes chemotherapy and trastuzumab. The preferred regimen for stage 1 adjuvant, HER2+ is?
- TH
- THP
- TCHP
- AC/TH(P)
- Abstain

Question 3: HER2+ Tumors: stage 2 (N+) or 3
The preferred adjuvant or neoadjuvant approach for stage 2 (N+) or stage 3 HER2 positive breast cancer is?
- Docetaxel, Carboplatin, Trastuzumab, Pertuzumab
- AC/EC -> Taxane, Trastuzumab, Pertuzumab
- Docetaxel, Carboplatin, Trastuzumab
- AC/EC -> Taxane, Trastuzumab
- Abstain

Question 4: HER2+/ER+ tumors: Stage 1
Pertuzumab is a standard when using trastuzumab with indication for neoadjuvant therapy?
Question 5: HER2+ preferred approaches stage 1
Pertuzumab should be added in?

- All cases
- ER + only
- ER - only
- None
- Abstain

Question 6: HER2+ preferred approaches stage 2 (N+) or 3

- All cases
- ER + only
- ER - only
- None
- Abstain

Question 7: Pertuzumab should be added in?

- All cases
- ER + only
- ER - only
- None
- Abstain

Question 8: Duration of trastuzumab therapy
For optimal results for given patients, the preferred duration of trastuzumab therapy is?

- 9 week
- 6 months
- 12 months
- Depends on stages: stage 1 only 6 months
- Abstain
Day 2 - Saturday, 27th April

**HER2+ Breast Cancer Consensus**

**Question 9:** Duration of trastuzumab therapy  
Are there any patients for whom 6 months is an acceptable option?  
- Stage 1?  
- Any node negative  
- Triple Positive  
- None  
- Abstain

**Question 10:** HER2 positive tumors: neratinib  
Adjuvant neratinib is recommended after neo/adjuvant trastuzumab for?  
- Never  
- All cases of stage 2 or 3, HER2+ breast cancer  
- All cases of ER+, N+, HER2+ breast cancer  
- ER+, N+ (4 or more), HER2+ breast cancer  
- Abstain

**Question 11:** HER2 positive tumors: neratinib  
Adjuvant neratinib is recommended following neo/adjuvant trastuzumab + pertuzumab in?  
- Never  
- All cases of stage 2 or 3, HER2+ breast cancer  
- All cases of ER+, N+, HER2+ breast cancer  
- ER+, N+ (4 or more), HER2+ breast cancer  
- Abstain
Neoadjuvant Chemotherapy Consensus

Question 1: Neoadjuvant systemic therapy
Neoadjuvant systemic therapy is the preferred initial treatment for women with stage II and III TNBC and HER2+ breast cancer regardless of suitability for lumpectomy at presentation?

Question 2: Management of residual disease after neoadjuvant therapy: TNBC
If there is residual cancer in axillary LN or breast (≥1 cm residual cancer and/or LN+) following neoadjuvant sequential AC -> T chemotherapy for TNBC, your preferred systemic therapy is?

- No further therapy
- Capecitabine
- Platinum based
- Classical CMF
- Abstain

Question 3: Management of residual disease after neoadjuvant therapy: TNBC
If there is residual cancer in axillary LN or breast (<1.0 cm residual cancer and/or LN+) following neoadjuvant sequential AC -> T chemotherapy for TNBC, your preferred systemic therapy is?

- No further therapy
- Capecitabine
- Platinum based
- Classical CMF
- Abstain

Question 4: Management of residual disease after neoadjuvant therapy: HER+
If there is residual cancer in breast and/or axillary LN (no pCR/near pCR) following neoadjuvant TCH or AC/EC -> TH (without P), in HER2+ breast cancer, your preferred systemic therapy is?
Day 2 - Saturday, 27th April

Neoadjuvant Chemotherapy Consensus

- No further therapy
- H
- HP
- TDM1
- Abstain

Question 5: Management of residual disease after neoadjuvant therapy: HER+
If there is residual cancer in breast and/or axillary LN (≥1 cm residual cancer) following neoadjuvant TCHP or AC/EC -> THP in HER2+ breast cancer, the preferred systemic therapy is?

- No further therapy
- H
- HP
- TDM1
- Abstain

Question 6: Management of pCR after neoadjuvant therapy: HER2+

- None
- H
- HP
- HP in ER negative
- Abstain

Question 7: Management of pCR after neoadjuvant therapy: HER2+
In a patient with nodes Negative at diagnosis having pCR or near pCR with polychemotherapy + HP, the preferred adjuvant regimen is?

- None
- H
- HP
- HP in ER negative
- Abstain

Question 8: Neoadjuvant endocrine therapy
When considering neoadjuvant therapy in postmenopausal women, a luminal-A subtype based on IHC (or equivalent based on genomic testing) suggests neoadjuvant endocrine therapy should be preferred instead of neoadjuvant chemotherapy?
Neoadjuvant Chemotherapy Consensus

Question 9: Neoadjuvant endocrine therapy
The appropriate duration of neoadjuvant endocrine therapy is?

- 3-4M
- 6M
- 12M
- Until optimal reduction in tumor size however long it takes
- Abstain
Day 2 - Saturday, 27th April

QUESTIONS TO BE DISCUSSED DURING THE SESSION ON LESSONS FROM ST.GALLEN 2019 : FROM CONSENSUS TO CLINIC

Endocrine Therapy Consensus

Question 1: Endocrine therapy
Ideal cut off prescribe endocrine therapy?
  • ER>1%
  • ER>5%
  • ER>10 %
  • The answer is not clear
  • Abstain

Question 2: Endocrine therapy premenopausal: Selection factors
Clinico-pathological indications for ovarian function suppression (OFS) are:
Those given chemotherapy?

Question 3: Endocrine therapy premenopausal: Selection factors
Clinico-pathological indications by itself for ovarian function suppression (OFS) include:
Age ≤ 35 years?

Question 4: Endocrine therapy premenopausal: Selection factors
Clinico-pathological indications by itself for ovarian function suppression (OFS) include:
Moderate risk, not getting chemo?

Question 5: Endocrine therapy premenopausal: Selection factors
Clinico-pathological indications by itself for ovarian function suppression (OFS) include:
Involvement of 4 or more nodes?

Question 6: Endocrine therapy premenopausal: Selection factors
Clinico-pathological indications by itself for ovarian function suppression (OFS) include:
Adverse result of multi-gene test?

Question 7: Endocrine therapy premenopausal: Selection factors
Clinico-pathological indications by itself for ovarian function suppression (OFS) include:
HER2+ status?
Day 2 - Saturday, 27th April

Endocrine Therapy Consensus

Question 8: Endocrine therapy premenopausal: 'Typical cases'
Age 33, T1, node positive, ER+, PR+, grade 3, decision made to proceed with adjuvant chemotherapy?
  • Plan tam alone after CT
  • Plan OFS plus either tamoxifen or AI depending on tolerance
  • Plan OFS plus AI
  • Abstain

Question 9: Endocrine therapy premenopausal: Selection factors
The appropriate duration planned of OFS is?
  • 2-3 years
  • 5 years
  • 10 years
  • Indefinitely
  • Abstain

Question 10: Endocrine therapy postmenopausal
It is preferred that most patients consider AI therapy at some point in the course of treatment?

Question 11: Endocrine therapy postmenopausal
Parameters for inclusion of an AI at some point are: Grade 3 or high Ki-67?

Question 12: Endocrine therapy postmenopausal
Parameters for inclusion of an AI at some point are: HER2 positivity?

Question 13: Endocrine therapy postmenopausal
If an AI is used, should it be started upfront: In all patients?

Question 14: Endocrine therapy postmenopausal
If an AI is used, should it be started upfront: In patients at higher risk by stage?

Question 15: Preferred therapy for women who remain premenopausal after 5 years of tamoxifen
Stage 1?
  • Stop therapy
  • Continue to 10 years tamoxifen
  • Switch to OFS / AI
  • Abstain
Day 2 - Saturday, 27th April

Endocrine Therapy Consensus

Question 16: Preferred therapy for women who remain premenopausal after 5 years of tamoxifen
Stage 2/ N+ premenopausal patients at high risk (e.g. stage 2/positive nodes and/or stage 3) at presentation?

- Stop therapy
- Continue to 10 years tamoxifen
- Switch to OFS / AI
- Abstain

Question 17: Endocrine therapy
Duration (postmenopausal) beyond 5 years

It is understood that 5 years of endocrine therapy is a historic standard, and that only patients who have tolerated such treatment reasonably well would discuss longer durations of therapy. Would you recommend extended therapy for: Stage 1, after 5 years of an AI?

Question 18: Endocrine therapy
Duration (postmenopausal) beyond 5 years

It is understood that 5 years of endocrine therapy is a historic standard, and that only patients who have tolerated such treatment reasonably well would discuss longer durations of therapy. Would you recommend extended therapy for: Stage 2, node-negative, after 5 years of tamoxifen?

Question 19: Endocrine therapy
Duration (postmenopausal) beyond 5 years

It is understood that 5 years of endocrine therapy is a historic standard, and that only patients who have tolerated such treatment reasonably well would discuss longer durations of therapy. Would you recommend extended therapy for: Stage 2, node-positive, after 5 years of tamoxifen?

Question 20: Endocrine therapy
Duration (postmenopausal) beyond 5 years

It is understood that 5 years of endocrine therapy is a historic standard, and that only patients who have tolerated such treatment reasonably well would discuss longer durations of therapy. Would you recommend extended therapy for: Stage 2, node-Positive, after 5 years of a tamoxifen?
Endocrine Therapy Consensus

Question 21: Endocrine therapy
Duration (postmenopausal) beyond 5 years

It is understood that 5 years of endocrine therapy is a historic standard, and that only patients who have tolerated such treatment reasonably well would discuss longer durations of therapy. Would you recommend extended therapy for: Stage 2, node-positive, after 5 years of an AI?

Question 22: Endocrine therapy
Duration (postmenopausal) beyond 5 years

Patients receiving extended endocrine therapy should aim for total treatment duration of?

• 10 years
• 7 -8 years
• Abstain

Question 23: Endocrine therapy
Duration (postmenopausal) beyond 5 years

Patients at very high risk (e.g. 10 or more positive nodes) should receive endocrine therapy beyond 10 years?
Day 2 - Saturday, 27th April

QUESTIONS TO BE DISCUSSED DURING THE SESSION ON LESSONS FROM ST. GALLEN 2019: FROM CONSENSUS TO CLINIC

Special Subjects

Question 1: Bisphosphonates
Bisphosphonates is bisphosphonate treatment, such as zoledronic acid q 6 months or oral clodronate, during adjuvant endocrine therapy indicated to improve DFS irrespective of BMD?

In postmenopausal patients?

Question 2: Bisphosphonates
Bisphosphonates is bisphosphonate treatment, such as zoledronic acid q 6 months or oral clodronate, during adjuvant endocrine therapy indicated to improve DFS irrespective of BMD?

In premenopausal patients receiving LHRH plus TAM or AI?

Question 3: Denosumab
Should adjuvant denosumab (60 mg twice a year) substitute for bisphosphonate?

Question 4: Fertility preservation
Ovarian function suppression during chemotherapy for HR-negative disease should be offered for women who want future pregnancy?

Question 5: Fertility preservation
Ovarian function suppression during chemotherapy for HR-positive disease should be offered for women who want future pregnancy?

Question 6: High risk germline mutations
Genetic testing for high risk mutations after counselling should be considered in: All women with breast cancer?

Question 7: High risk germline mutations
Genetic testing for high risk mutations after counselling should be considered in: Patient with a strong family history?
Day 2 - Saturday, 27th April

Special Subjects

Question 8: **High risk germline mutations**
Genetic testing for high risk mutations after counselling should be considered in: Patient under 35 years at diagnosis?

Question 9: **High risk germline mutations**
Genetic testing for high risk mutations after counselling should be considered in: Patient under 50 at diagnosis?

Question 10: **High risk germline mutations**
Genetic testing for high risk mutations after counselling should be considered in: Patient under 60 with TNBC?

Question 11: **High risk germline mutations**
Genetic testing for high risk mutations after counselling should be considered in: Patient with TNBC at any age?

Question 12: **Pregnancy after breast cancer**
For patients planning pregnancy in the 5 years following surgery, after balanced discussion of risks, it is a reasonable option to interrupt endocrine therapy to allow attempted pregnancy: At any time during endocrine therapy?

Question 13: **Pregnancy after breast cancer**
For patients planning pregnancy in the 5 years following surgery, after balanced discussion of risks, it is a reasonable option to interrupt endocrine therapy to allow attempted pregnancy: After 18 months endocrine therapy?

Question 14: **Pregnancy after breast cancer**
For patients planning pregnancy in the 5 years following surgery, after balanced discussion of risks, it is a reasonable option to interrupt endocrine therapy to allow attempted pregnancy: Patient should undergo restaging prior to attempted conception?

Question 15: **Pregnancy after breast cancer**
For patients planning pregnancy in the 5 years following surgery, after balanced discussion of risks, it is a reasonable option to interrupt endocrine therapy to allow attempted pregnancy: In case of patients preference pregnancy after breast cancer should not be discouraged in?
Special Subjects

• ER+ disease
• ER- disease
• In both cases
• In all non-high risk situations
• Abstain

Question 16: Diet and exercise
Should an exercise regimen be recommended to be part of standard care?

Question 17: Diet and exercise
Should avoidance of weight gain be recommended in all patients?

Question 18: Other histological and clinical features: DCIS
Small DCIS have a better prognosis and may require less intensive treatment if screening detected in patients of age > 50+ years and associated with favorable biological features (i.e. G1-2, other slow risk»...)

Question 19: Other histological and clinical features: DCIS
With favorable prognostic features and clear margin (≥ 5mm) it is a reasonable option to omit radiotherapy?

Question 20: Other histological and clinical features: DCIS
It is reasonable to omit endocrine therapy in?

Question 21: Other histological and clinical features: DCIS
With favorable prognostic features and clear margin (≥ 5mm) it is a reasonable option to omit both radio- and endocrine therapy?

Question 22: Magnitude of absolute benefit
We acknowledge that most patients will not benefit from adjuvant therapies in terms of OS (the ultimate goal of adjuvant therapies) and many adjuvant treatments offered have a small to marginal impact.

Do you agree that patients should be informed about magnitude of benefit of interventions with small to marginal benefit and be offered no treatment as a reasonable alternative?
Dr. Tiffany Traina is Assistant Attending Physician on the Breast Cancer Medicine Service at Memorial Sloan-Kettering Cancer Center (MSKCC) and Assistant Professor of Medicine at Weill Medical College of Cornell University. She has received grant support for her work from the Breast Cancer Alliance and the Translational Breast Cancer Research Consortium, where she also serves on the Triple Negative Breast Cancer working group. She received the Hally Yaccino Steiner Award from the Susan G. Komen Breast Cancer Foundation in recognition of her work.

Dr. Tiffany’s research has centered on the use of novel, targeted therapies for the treatment of triple negative breast cancer (TNBC). Currently, she is the lead investigator for a multicenter trial studying the use of androgen receptor inhibition for patients with advanced TNBC.

Dr. Tiffany has lectured internationally and presented her research findings at forums including the annual San Antonio Breast Cancer Symposium and the annual meeting of the American Society of Clinical Oncology (ASCO). She is a member of the New York Metropolitan Breast Cancer Group and serve on the editorial board of the European Journal of Clinical & Medical Oncology. Additionally, Dr Tiffany is also ad hoc reviewer for several clinical journals and have published in scientific journals including the Journal of Clinical Oncology and Clinical Cancer Research.
Prof. Andrew Tutt qualified in medicine in 1990. After postgraduate training in General Medicine, he trained in clinical oncology at the The Royal Marsden NHS Foundation Trust before gaining a Doctoral Research Training Fellowship from the Medical Research Council to work in Professor Alan Ashworth’s laboratory at The Institute of Cancer Research.

He worked on the then-unknown DNA repair functions of the BRCA2 breast cancer predisposition gene and was awarded his PhD in 2002. In his postdoctoral work as a Clinician Scientist he identified the synthetic lethality between PARP inhibitors and BRCA1/2 mutations with Dr. Chris Lord and Professor Alan Ashworth.

He went on to design the Single Agent Proof of Concept Phase I trials and associated DNA repair biomarker studies with the ICR and The Royal Marsden Drug Development Unit, and has since led international Phase II and III trials for BRCA1/BRCa2-associated malignancy.

He cares for women with breast cancer as a Consultant Oncologist in the multidisciplinary Breast Unit at Guy’s and St Thomas’ NHS Foundation Trust. He is Professor of Breast Oncology and Director of the Breast Cancer Now Research Unit at King’s College London and has recently been appointed Director of the Breast Cancer Now Toby Robins Breast Cancer Research Centre, Head of the Division of Breast Cancer Research and Professor of Breast Oncology at the ICR.

Prof. Tutt has developed a translational laboratory for triple negative breast cancer. He leads a clinical trial programme focusing on triple negative forms of breast cancer and cancers associated with functional deficiencies in BRCA1 and BRCA2.

He has published papers from these programmes in the journals Nature, The New England Journal of Medicine, The Lancet, Journal of Clinical Oncology, Cancer Research, Science Translational Medicine and Cancer Discovery. He is Chief Investigator for the recently reported multicentre UKCRN “Triple Negative Trial” and is Global Study Chair of the ‘OlympiA’ study – an adjuvant PARP inhibitor trial in patients with germline BRCA 1/2 mutations and breast cancer.

He has been a Visiting Professor at British Columbia Cancer Agency, Jean Lubrano Visiting Scholar at Harvard Medical School, and is a member of the St Gallen Early Breast Cancer International Consensus Panel and recently received the Addarii Award for his work in the field of breast and ovarian cancer research.
Dr. Matteo Lambertini is a medical oncologist specialized at the National Cancer Institute in Genova (Italy), currently working at the Institut Jules Bordet, a multidisciplinary center totally dedicated to cancer in Brussels (Belgium) under the supervision of Prof. Martine Piccart. He is mainly focused in the care of breast cancer patients and is deeply involved in breast cancer research. Above all, he has a particular expertise in the management of breast cancer in young women, with a specific attention to both the fertility and pregnancy issues that they have to face after diagnosis.

During his medical oncology training, he had the opportunity to work and collaborate with several national and international leading experts in the field; these experiences have played a crucial role to deepen his skills in the management of breast cancer in young women. He is part of the scientific board of the Italian Association of Medical Oncology (AIOM) clinical recommendations on fertility preservation in cancer patients.

He has authored several publications in peer-reviewed journals and book chapters in the field of fertility preservation in breast cancer patients. His most important research conducted so far under the supervision of Dr. Lucia Del Mastro, addressed the role of administering luteinizing hormone-releasing hormone (LHRH) analogs during chemotherapy as a strategy to preserve ovarian function and fertility in early breast cancer patients who are candidates for cytotoxic therapy. Thanks to the support of the European Society for Medical Oncology (ESMO), he is currently working on a challenging PhD project at the Free University of Brussels (ULB) aiming to improve the understanding of many controversial aspects related to fertility and pregnancy issues in breast cancer patients, with the ultimate goal to further improve the care and quality of life of young survivors.
Pierfranco Conte is Professor of Oncology at the University of Padova, Italy, Director of the Division of Medical Oncology 2 at the Istituto Oncologico Veneto in Padova and Chairman of Rete Oncologica Veneta. He specializes in Clinical Oncology, Clinical Immunology and Haematology.

Throughout his career, Prof. Conte has been involved in the development of new regimens for the treatment of solid tumours, with special emphasis on breast and ovarian cancer. He was Principal Investigator of numerous research projects supported by the National Research Council (CNR), the Italian Association for Cancer Research (AIRC), the Ministry of Health and the Ministry of Education and Research.

He has published more than 300 papers in peer-reviewed journals. The majority of these discuss the biological characterization of breast and ovarian cancer and clinical trials in these disorders.

Prof. Conte is the recipient of the 2007 “Claude Jacquillat” Award for Achievement in Clinical Oncology and the 2015 “Stelle della Fenice in the world” Award.
Prof. Helena Earl was appointed to the University of Cambridge, as clinical lecturer and Consultant in Medical Oncology in 1996. She was promoted to Reader in Clinical Cancer Medicine at the University in 2007 for her work in clinical and translational research in breast cancer. This includes leadership roles (Chief Investigator-CI) on the following multi-centre NCRN clinical trials:

NEAT adjuvant (Co-CI), Neo-TANGO neoadjuvant (CI), PERSEPHONE adjuvant (CI), and ARTemis neoadjuvant (Co-CI). Translational Cambridge studies in collaboration include NEAT-Science, TANGO-Science, Trans-PERSEPHONE, and Neo-TANGO-Science. Local clinical/translational studies within the Cambridge Breast Research Unit include: DIAMOND – imaging neoadjuvant study; MONET – neoadjuvant endocrine therapy (CI); and ARTiST – neoadjuvant endocrine therapy +/- sunitinib (CI).

She is also an active trial management group member for the following adjuvant breast cancer trials: ABC, aTTom, TACT and tAnGo.

Prof. Earl has collaborative research links with the Universities of Birmingham, Warwick, and Edinburgh in the UK, and Internationally with the Institut National du Cancer (INCa) in France, and with the University of Modena (Italy).

She has published 114 peer-reviewed original papers and 167 abstracts from National and International meetings. She has also contributed 22 book chapters, book reviews and articles for patients.
Participants Details:

Full Name: ____________________________________________

Mobile No: ___________________ Email Id: ____________________

Hospital: ________________________________________________

Department: ___________________ Specialization: ________________

Postal Address: ____________________________________________

City: ___________________________ State: ________________________

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*only for student & practicing oncologist with less than 5 year in clinical practice.

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