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negative hormone receptors and dual anti-HER2 treatment. Although overall survival rates were not significantly different between arms, patients who reached pCR with L + T therapy were nearly doubled compared to the patients in the single agent arms. Additional exploratory analyses will be presented.

Conflict of interest:
Ownership: AM declares that she is a Novartis employee.
Advisory Board: CS has served as consultant, participated in advisory boards or received travel grants from AstraZeneca, Celgene, Daiichi Sankyo, Eisai, F. Hoffmann - La Roche Ltd, Genentech, Merck, Pfizer, Shire/Hyperion, and Zealand Pharma.
Corporate-sponsored Research: PN declares that his institution received funding from GSK and later Novartis for the conduct of the NeoALTO trial. JT declares that his institution received support from Novartis to undertake work on NeoALTO, and support from other sponsors (AZ, Roche, Janssen) to support work on other studies. CS declares that her institution received support from AstraZeneca, Celgene, Daiichi Sankyo, Eli Lilly and Company, Genentech, Immunomedics, Macrogenics, Merck, Sharp and Dohme Espana S.A., Novartis, Pfizer, Piqur Therapeutics, Puma, Roche, Synthorx and Zenith Pharma. EdA declares that his institution received research grants to his institution from Roche/GNE, AstraZeneca, GSK/Novartis and Servier. FH declares that her institution received funding from Astra Zeneca, Equity Health Systems, Merck, Pfizer, AbbVie, Hexal, Daiichi.
Board of Directors: MPG is a Board Member (Scientific Board) of Oncolytics.
Corporate-sponsored Research: PN declares that his institution received funding from GSK and later Novartis for the conduct of the NeoALTO trial.

Materials and methods:
The Microsimulation Screening ANalyses breast cancer model (MISCAN-Breast) was used to simulate restart strategies for breast cancer screening. The model estimated required screening capacity, breast cancer incidence, and breast cancer mortality after a screening disruption of six months. Four restart strategies were simulated varying in the population affected, duration of effects, and stopping age. Similar modelling was performed for cervical and colorectal cancer screening.

Results: The impact of the disruption heavily depended on the restart strategy. Immediately catching-up on missed screens after the disruption was estimated to lead to 0.13 additional breast cancer deaths per 100 000 women between 2020 and 2030 compared to undisrupted screening (table 1). This strategy minimised the impact of the disruption, but also required a surge in screening capacity. Delaying screening, resulting in one less screen for a quarter of the women, required the least capacity, but also had the largest impact on incidence and mortality (2.35 additional deaths per 100 000 individuals between 2020 and 2030 compared to undisrupted screening). A scenario with delays in screening, but still offering all screening rounds gave the best balance between required capacity, incidence, and mortality. The effects for cervical and colorectal cancer screening followed similar patterns, but the effect sizes were smaller.

Table 1 Cumulative breast cancer mortality per 100 000 individuals compared to undisrupted screening for four restart strategies

| Restart strategies | Delaying all screens, resulting in one less screen for 1/4th of the women | Delaying all screens, except for first screening rounds | Delaying all screens and increasing the stopping age | Immediately catching-up on missed screens after the disruption |
|--------------------|---------------------------------------------------------------|---------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------|
| 2020               | 0.02                                                          | 0.02                                              | 0.02                                          | 0.01                                                         |
| 2021               | 0.10                                                          | 0.10                                              | 0.10                                          | 0.10                                                         |
| 2022               | 0.44                                                          | 0.42                                              | 0.42                                          | 0.10                                                         |
| 2023               | 0.66                                                          | 0.61                                              | 0.61                                          | 0.12                                                         |
| 2024               | 0.93                                                          | 0.85                                              | 0.84                                          | 0.14                                                         |
| 2025               | 1.18                                                          | 1.06                                              | 1.04                                          | 0.14                                                         |
| 2026               | 1.42                                                          | 1.26                                              | 1.21                                          | 0.14                                                         |
| 2027               | 1.72                                                          | 1.51                                              | 1.43                                          | 0.14                                                         |
| 2028               | 2.00                                                          | 1.71                                              | 1.61                                          | 0.15                                                         |
| 2029               | 2.35                                                          | 1.98                                              | 1.85                                          | 0.13                                                         |
| 2030               | 5.35                                                          | 3.93                                              | 2.98                                          | 0.10                                                         |
| 2031               | 7.99                                                          | 4.74                                              | 3.16                                          | 0.06                                                         |
| 2032               | 10.27                                                         | 4.71                                              | 2.84                                          | 0.02                                                         |

Conclusions: The strategies with the smallest loss in health effects were also the most burdensome for the screening organisations. Which strategy is preferred depends on the organisation and capacity of the breast screening programme in a country.

No conflict of interest.

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The COVID-19 outbreak may have been associated to a reduced level of care for breast cancer. A comparative study with the pre-COVID era in an Italian Breast Unit

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Background: The recent COVID-19 pandemic has caused profound changes on the health-care systems as well as deleterious repercussions on the care of patients with cancer. In this comparative study, we sought to evaluate the effects the COVID-19 pandemic on the surgical management of breast cancer in a Breast Unit belonging to an Italian region with a low incidence of COVID-19 infection.

Methods: Eighty-three patients were included, of whom 41 received surgery during the heights of the pandemic (Group A-operated on in March and April 2020), and 42 during the same period (March-April) of the year 2019 (Group B). Clinicopathological characteristics and surgical outcomes were compared between the two groups.

Results: There were no significant differences in the baseline characteristics of the two groups in regard to age (p = 0.62), tumour size (p = 0.25), grade (p = 0.27), histology (p = 0.45), positive lymph nodes (p = 0.35). ER positive status (0.35). Waiting time for surgery was slightly longer in Group A (49.11 vs 46.39, p = 0.38). Patients receiving immediate breast reconstruction was significantly less in patients of Group A (p < 0.001). Use of sentinel node biopsy was similar in the two groups (p = 0.84). Hospital stay was longer in patients of Group B (p = 0.008). Use of regional nerve blocks was lower in the Group A (p < 0.001).

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PROFFERED PAPER SESSION

Measuring Impact of COVID-19 on Breast Cancer Care

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Effects of cancer screening restart strategies after COVID-19 disruption

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