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P049. HOW COMMON IS UPGRADE FROM DUCTAL CARCINOMA IN SITU (DCIS) TO INVASIVE CARCINOMA FOLLOWING MASTECTOMY FOR DCIS ONLY?

Hamed Hajiesmaeili, Zaid Al-Ishaq, Chris Neophytou, Pilar Matey, Senthurun Myliravanam, Brian Igar, Raghavan Vidya, Tapan Sirca. The Royal Wolverhampton NHS Trust, Wolverhampton, United Kingdom

Background: According to NICE guidelines patients who are having mastectomy for DCIS should be offered sentinel lymph node biopsy (SLNB). The aim of our study was to investigate the incidence of upgrade from DCIS to Invasive carcinoma (IC) in the final post mastectomy histology and the proportion of patients who have a positive SLNB.

Methods: We conducted a retrospective review analysing patient with DCIS who underwent total mastectomy over the last 10 years. Information was obtained from Somerset cancer database and the hospital clinical web portal.

Results: In all 145 patients were identified with pre-mastectomy diagnosis of only DCIS either on core biopsy or excision biopsy. The mean age was 57.5 years (range 26-85). Five patients underwent mastectomy due to incomplete excision margin, 3 patients had recurrent DCIS and the rest underwent mastectomy due to the extent of disease or patient’s choice. SLNB was performed in 128 patients (88.2%), 17 patients did not have SLNB. Post-mastectomy histology showed invasive carcinoma in 37 patients (25.5%). 5 out of 37 (13.5%) invasive cancer patients had positive SLNB. Overall, 3.9% of patients (5/128) who had mastectomy for initial diagnosis of DCIS had positive SLNB.

Conclusions: In our cohort nearly 90% of patients having mastectomy for preoperative diagnosis of DCIS had SLNB. The incidence of upgrade to invasive carcinoma occurred in 1 in 4 cases (25.5%). SLNB was positive in 1 in 25 patients. This information is vital in preoperative counselling and consenting process.

P050. BREAST CANCER MANAGEMENT DURING A PANDEMIC: A DGH EXPERIENCE

Anu Sandhya, Helen Dent, Tania De Silva. East Surrey Hospital, Redhill, United Kingdom

Introduction: COVID-19 has put a strain on regular healthcare worldwide. The delivery of breast cancer care has changed significantly to reduce the risk of transmission of COVID-19 and immunosuppression secondary to cancer treatment. This study shares a DGH experience of the effect of covid-19 on decision making in breast cancer treatment during the pandemic and a description of novel ways of service delivery to reduce the delay in treatment.

Methods: This is a single centre retrospective cohort study. Patients referred under TWR from 16th March to 15th July 2020 were included. We triaged our patients using telephone consultation and utilised the local temporarily closed screening centre for symptomatic patient triple assessment. Cancer surgery was delivered in a regional cold site where patients and staff were Covid tested. We referred to national ABS guidelines in our treatment decisions. The primary outcome was changes in treatment pathway for cancer patients. Secondary outcomes were number of patients referred, cancers diagnosed, and breaches in 62 day pathway. Results: 1231 symptomatic patient were referred under TWR of which 91 patients were diagnosed with breast cancer. 10 patients had bridging endocrine and a further 10 were denied immediate reconstruction. 14 patients had short course radiotherapy rather than the conventional protocol. There were 22 breaches in the 62-day pathway.

Conclusion: COVID-19 changed our practice but we were able to continue to offer cancer services throughout the pandemic, without significant delays. The long term effects of these changes in the treatment pathway have yet to be determined.
Data collected: Demographics, co-morbidities, type of operation, pre and post op COVID status, post-operative complications. Patients were followed up 2 weeks post-operatively via telephone conversation or clinic appointment. Screening protocols included CXR &/or swabs.

Results: 117 patients (pts) of which 41pts (35%) were operated on at the acute hospital and 76pts (65%) at the private hospital. One male patient and the median age was 59 years (36 - 89). 35pts (30%) were ASA 1, 78pts (67%) ASA 2. 4pts (3%) ASA 3. None of the patients had COVID-19 related symptoms or re-admissions in the 2 weeks post-surgery. One post-neoadjuvant chemotherapy patient had SARS-CoV-2 positive swab test post-operatively, another patient had typical radiological changes of COVID on staging CT but consecutive negative swabs. Both patients were postponed for 4 weeks then achieved negative swab results and resolution of CT changes. Trainees were involved in the majority of operations on both sites minimising the impact on training.

Conclusion: In our experience breast cancer surgery during the COVID-19 pandemic has been demonstrated to be safe and not training averse. It eliminated any backlog and limited potential consequences.

**P053. PROSPECTIVE SINGLE-CENTRE QUALITATIVE SERVICE EVALUATION ON MAGSEED FOR WIDE LOCAL EXCISION**

Martha Kedrzycki1, Jhia Teh1, Wenyi Cai1, Ahmed Ezzat2, Paul Thiruchelvam1, Daniel Elson1, Daniel Leff1, 1 Imperial College London, London, United Kingdom; 2 Imperial College Healthcare NHS Trust, London, United Kingdom

Magseed is an effective non-inferior alternative to wire guidance (WGL) that enables intraoperative localisation of tumours during breast conserving surgery (BCS). The COVID-19 pandemic has necessitated a Magseed pathway in our hospital to enable patients to self-isolate pre-operatively. Previous studies have not evaluated patient experience; thus, here we report the qualitative data on patients’ perspectives regarding Magseed. A prospective service evaluation of BCS patients was conducted between 1st July 2020 and 1st December 2020 (Audit Committee Approval Registration No 410). Data was collected on patient demographics, tumour specification, and procedural outcomes. Qualitative results were obtained using binary outcomes and 10-point Likert scales. 41 women were included, with median age 62 years (IQR 53-69) and median BMI 27.3 kg/m² (IQR 22.6-30.8). 29 patients had IDC, 5 had other invasive carcinomas, 4 had preinvasive disease, and 3 had benign lesions. 25 patients were ER+, 21 PR+, 3 HER2+, and 1 was triple negative. Median waiting time between insertion and operation for Magseed was 13 days (IQR 4-119). 11 patients had close margins, 6 of whom required re-operative intervention. 1 (2.4%) seed was misplaced, 4 (10%) found the procedure uncomfortable, and 2 (5%) had complications (1 difficult insertion, 1 developed pain). All excisions had successful retrieval. After an explanation of Magseed and WGL techniques, 43/49 (88%) patients said they preferred the Magseed approach. Magseed localisation methods are acceptable to staff and patients based on our prospective service evaluation. Magseed enables preoperative self-isolation in the era of COVID-19 in view of safer surgical outcomes.

**P054. RETROSPECTIVE AUDIT OF IMPLANT SALVAGE USING PERI-PROSTHETIC IRRIGATION SYSTEM AND CONVENTIONAL WASH OUT IN IMMEDIATE BREAST RECONSTRUCTION**

Manoj Couda S, Kirti Kabeer, Sadaif Jafferbhoy, Krishna Banavathi, Soni Soumian, Sanilatran Narayanjan, Sekhar Marla. University Hospitals of North Midlands, Stoke-on-Trent, United Kingdom

Introduction: Implant related complications leading to implant loss are a major morbidity in immediate breast reconstruction (IBR). Various techniques have been advocated to improve implant salvage. The objective of our study was to assess if the peri-prosthetic irrigation system is an effective adjunct to conventional technique of wash out in improving implant salvage.

Methods: The study included patients undergoing implant reconstruction from January 2015 to November 2020. Conventional technique of implant wash out and exchange with systemic use of antibiotics was used until May 2019. Following that, peri-prosthetic irrigation with Vancomycin (1g/L normal saline over 24 hours) for 2 days was added as an adjunct. Treatment details and clinical outcomes were compared between the groups. The study was submitted to the audit department and approval was obtained.

Results: During the study period 335 patients underwent IBR. Sixty-five patients (19.4%) returned to theatre due to post-operative complications of which 45 (13.4%) were due to infection. Conventional technique was used in 38 (84.4%) patients and peri-prosthetic irrigation was used as an adjunct in 7 patients (15.6%). Sixteen (42.1%) in conventional group and all 7 (100%) in the irrigation group had successful implant salvage. No patients had complications due to antibiotic irrigation.

Conclusion: Peri-prosthetic irrigation system is a simple, safe and an effective adjunct to conventional techniques in improving implant salvage in IBR.

**P055. THE EFFECTS OF THE COVID-19 PANDEMIC ON BREAST CANCER SERVICES AT A TERTIARY UNIVERSITY HOSPITAL**

Aonghus Ansari, Mini Sardar, Tim Rattay, Ahmed Gaber, Monika Kaurhik. Glenfield Hospital, Leicester, United Kingdom

Introduction: The COVID-19 pandemic significantly impacted the treatment of breast cancer. Management deviated from standard practice. The Association of Breast Surgery (ABS) advised - aim for day case surgery with priority given to: estrogen receptor (ER)-ve, HER2+ve, and pre-menopausal ER+ve patients. Neoadjuvant chemotherapy was advised for inoperable disease only. Oncoplastic procedures and breast reconstruction was not advised. ER+ves were to be considered for bridging endocrine treatment. We audited this change in practice.

Methods: Prospective audit of patients with breast cancer seen at University Hospitals of Leicester under the implemented ABS recommendations from March to July 2020.

Results: 110 patients were seen. Median age was 63yrs. 79 were postmenopausal. 27 patients had Grade 1 (low if DCIS), 60 had Grade 2 (low if DCIS) and 22 patients had Grade 3 (high if DCIS) tumours. 91 patients were ER+ve, 9 HER2+ve. 38 patients received standard management, 72 patients received altered management. 58 had bridging endocrine therapy (Median length of days 68). 60 patients had delayed surgery (> 31 days from diagnosis). 6 patients eligible for immediate reconstruction underwent mastectomy without reconstruction. 5 patients had altered adjuvant radiotherapy (hypofractionation: 5 Fractions) and 1 patient suitable for adjuvant chemotherapy was not offered it.

Conclusion: 70.9% of our patients received altered management. The impact in delays of breast cancer surgery on survival remains unknown. It will be worthwhile to follow these patients long term to see the effects of these changes.

**P056. AUDIT ON RECORDING POST-OPERATIVE COMPLICATIONS IN BREAST SURGERY**

Khadija Tariq, Kaushiki Singh, Avi Agrawal, Lucy Mansfield, Masooma Zaidi, Queen Alexandra Hospital, Portsmouth, United Kingdom

Introduction: Post-operative complications rate is used as a marker of quality assurance in surgery. Association of Breast Surgery (ABS) oncoplastic surgery guidelines recommend accurate recording of post-operative complications. We noted that our local practice relied on documenting readmissions and reoperations for clinical governance meetings, which may have under-reported complications managed purely as outpatients. Hence, we introduced a complications’ register and audited the outcome.

Materials and methods: We introduced a register in the outpatients’ clinic in a single breast unit and informed all clinical staff to record postoperative complications. The audit was registered with the audit department of our trust. Data was recorded prospectively from 1st June 2019 to 30th June 2019. The results were compared with the true incidence by retrospective review of clinic letters and theatre records. Compliance to the register was evaluated. Rates of postoperative complications were also noted.