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P157. INTRODUCTION AND EVALUATION OF CONCENTRIC DIGITAL CONSENT APPLICATION TO A BREAST SURGICAL UNIT

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Introduction: Consent for treatment is a key element of care. Paper consent processes have been associated with significant errors and variation in practice. The aim was to evaluate Concentric, a digital consent application, within the breast unit.

Method: Between April-December 2020, Concentric was used optionally for consent for breast surgical procedures as a registered service evaluation (SE472). Data was obtained from Concentric analytics. User and patient feedback was obtained via optional satisfaction surveys. Scores 1-5 (1=awful, 2=bad, 3=ok, 4=good, 5=amazing). A time trial was performed with a standardised patient scenario.

Results: 11 clinicians completed 150 Concentric consent episodes for 51 unique procedures. Patients were aged 19 - 88 years. 30 (20%) were consented remotely, 69 (46%) consented on day of surgery. 141 (94%) shared unique procedures. Patients were aged 19 - 88 years. 30 (20%) were consented remotely, 69 (46%) consented on day of surgery. 141 (94%) shared unique procedures.

Conclusion: Concentric has been successfully introduced into a busy breast unit. Patients and clinicians report high satisfaction scores. The introduction of digital consent solutions may be considered for all breast units.

P158. OUTCOMES OF TRIPLE-NEGATIVE BREAST CANCER IN OLDER VERSUS YOUNGER WOMEN

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Background: Triple-negative breast cancer (TNBC) is an aggressive disease characterized by lack of targeted therapy; main-stay of treatment being limited to surgery and chemotherapy. Older patients with TNBC are often underrepresented in the clinical trials, due to competing mortality risks. This study aims to assess the treatment and outcomes of triple-negative breast cancer (TNBC) in older women relative to younger women.

Methods: This was a retrospective cohort study of patients who presented with primary TNBC, age 34-94 years; stage I-III from Jan 1, 2013 to Dec 31, 2015. Patients' demographics, clinical characteristics, treatment and outcomes were retrieved from the CANISC Register and individual patient (N=88). Breast cancer-specific survival (BCSS) was estimated by using Kaplan–Meier method, and adjusted for age, tumor size, tumor grade, nodal status and chemotherapy, using SPSS-19.

Results: Fifty-one patients were less than 70 years old (57.9%) and 37 were 70 years and older (42.1%). There was no difference in the stage at presentation (stage I: 43% vs. 35%; stage II: 49% vs. 45%; stage III: 8% vs. 11%; P=0.29). Older patients were less often treated with adjuvant chemotherapy (75% vs. 24%; P<0.001). Mean follow-up was 48 months. Five-year BCSS was significantly poorer for older patients (54% vs. 75%, P=0.032). 5-year overall survival was also significantly worse for patients who did not receive adjuvant chemotherapy (50% vs. 88%, P=0.002).

Conclusions: Overall survival in triple negative breast cancer is much worse in older women as compared to younger women and there is a significant benefit with adjuvant chemotherapy.

P159. SNAPSHOT OF RANDOMISED CONTROLLED TRIALS IN BREAST SURGERY

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Introduction: High-quality randomised controlled trials (RCTs) are lacking in surgery compared to medicine due to perceived difficulties. This study assesses the state of play of RCTs in Breast Surgery by assessing all registered breast RCTs and published RCTs.

Methods: To assess registered RCTs we searched clinical.gov for randomised interventional trials in the last 5 years (01/12/19-20) under Breast Cancer, then manually categorised into subgroups. To investigate influential RCTs over 5 years we searched PubMed, filtering for journals by impact factor (IF) >29 then categorising into subgroups.

Results: 4.9% (60/1208) of breast-trials on clinicaltrials.gov, are in surgery. In the UK, 20.6% (6/29) (Table 1, breakdown in Table 2). Prior to presentation further in-depth review of all registered and published RCTs will be conducted to elicit funding and additional details.

Table 1

| Category                               | Global | UK |
|----------------------------------------|--------|----|
| Anaesthetic                            | 65     | 1  |
| Behavioural                            | 95     | 2  |
| Diagnostic                             | 28     | 3  |
| Genetic                                | 5      | -  |
| Nutritional                            | 26     | 1  |
| Oncology                               | 488    | 10 |
| Other                                  | 61     | 4  |
| Other Treatment                        | 155    | 2  |
| Radiology                              | 55     | 2  |
| Supportive (Physical/Psychological)    | 219    | 4  |
| Surgical                               | 60     | 6  |
| Total                                  | 1202   | 29 |

Table 2

| Combination Treatment                  | Global | UK |
|----------------------------------------|--------|----|
| Dietary Supplement - Peri-operative    | 2      | -  |
| Radiation - Surgical                   | 2      | -  |
| Surgical - Oncology                    | 21     | -  |
| Surgical - Other                       | 14     | -  |
| Surgical - Reconstruction              | 20     | 4  |
| TOTAL                                  | 60     | 6  |

In the last 5 years in journals with IF >29,5.4% (10/184) of published RCTs were surgical research - ranging across operative techniques, decisions, localisation and reconstruction.

Discussion: The potential impact and breadth of breast-surgical research is large, and it is important to continue and increase RCT funding in breast surgery.

P160. COVID-19: MORAL DISTRESS IN HEALTHCARE PROFESSIONALS - A QUALITATIVE AND QUANTITATIVE SURVEY

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Introduction: COVID-19 has placed undue pressure on health services affecting not only patients but also healthcare workers. The aim of this study was to evaluate the impact of COVID-19 on the psychological well-being of healthcare professionals.

Methods: Between 1–28 August 2020 healthcare professionals were asked to complete an online survey, of 24 binary, multiple choice and Likert-scale questions. The data was anonymised. Simple descriptive statistics were used.

Results: Fifty responses were analysed. The modal age was 26 – 30 years old (range 18-25) with 24 (48%) males and 26 (52%) females, 12 (24%) consultants, 16 (32%) registrars, 5 (10%) core trainees, 12 (24%) foundation trainees, 5 (10%) others. 17 (34%) felt there was sufficient PPE, 14 (28%) felt inadequately trained in its use and 20 (40%) felt that employers did not ensure their safety. 33 (66%) reported challenging moral decisions, 27 (54%) had rationed care, and 24 (48%) found this difficult. 34 (68%) expressed concerns for their safety, with 14 (28%) considering leaving their job. There was a median of 6 (0-14) symptoms of moral distress experienced; only 3 (6%) reached out for professional support.

| Symptoms of moral distress experienced | Responses |
|----------------------------------------|-----------|
| Avoidance of family                    | 25 (50%)  |
| Avoidance of friends                   | 32 (64%)  |
| Inability or hesitancy to make decisions | 11 (22%) |
| Sleeplessness / altered sleep patterns | 32 (64%)  |
| Anxiety                                | 33 (66%)  |
| Toearfulness                           | 13 (26%)  |
| Anger                                  | 16 (32%)  |
| Frustration                            | 34 (68%)  |
| Lack of appetite                       | 8 (16%)   |
| Overeating                             | 22 (44%)  |
| Feelings of lack of self-worth         | 8 (16%)   |
| Feelings of guilt                      | 7 (14%)   |
| Feelings of shame                      | 5 (10%)   |
| Low mood / negative affect             | 32 (64%)  |
| None of the above                      | 2 (4%)    |

Conclusion: There are no guidelines regarding the timing of conception on the breast cancer journey. This is an increasing priority for patients concerned about an impact on fertility from cancer and treatment. There may be an increasing role for education and referral to fertility services for this emerging demographic.

P162. ASSESSMENT OF PATHOLOGICALLY ADJUSTED MANCHESTER SCORE IN BRCA 1/2 WOMEN WITH BREAST CANCER

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Introduction: The new pathologically adjusted Manchester score (PAM) adjusts for tumour characteristics in breast cancer patients with family history. We looked at the known BRCA1/2 cancer patients in our specialist carrier service to see if this risked underscoring patients who do not have triple negative disease.

Methods: From 247 women on our prospective database 58 were diagnosed with breast cancer before being diagnosed with BRCA1/2 mutation. Full information about the referral to genetics was available for 48. Referrals were made according to ICR protocol - specific criteria, Manchester Scoring System (MSS) or predictive if there is a gene mutation in the family.

Results: 29 had BRCA2 and 19 had BRCA1. Of the 19 BRCA1 mutation carriers, 16 were referred based on ICR criteria and 3 were referred based on predictive criteria. None were referred based on MSS. Of the 29 BRCA2 carriers, 20 were referred based on ICR criteria, 6 based on predictive criteria and 3 based on MSS. When we retrospectively applied the PAM score instead of the MSS score, there was slight difference in the score for 3 patients but none of them would have missed getting tested.

Conclusion: Application of the PAM score did not affect referral for genetic testing in our cohort of breast cancer patients diagnosed with BRCA mutations. It should also be applied to those who were referred based on MSS but were not found to harbour any mutations in order to assess its sensitivity and specificity further.

P163. ASSESSMENT OF SERVICE PROVISION IN PATIENTS INVESTIGATED FOR BREAST-IMPLANT ASSOCIATED SEROMAS AT LEEDS TEACHING HOSPITALS - SHOULD MORE BE DONE FOR SEROMAS WHICH ARE NOT SUSPICIOUS FOR BIA-ALCL?

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Introduction: Increased awareness of BIA-ALCL led to a rise in investigation of implant-associated breast swelling. The recently published UK guidelines on BIA-ALCL is the standard against which this study is compared.

Method: The electronic patient records were interrogated for all patients who had fluid drained from around their implant under radiological guidance or at surgery between January 2016 to September 2020.

Results: 27 cases were identified. Median age was 48 (range 26-68). 22 had cosmetic implants and 5 were post-cancer surgery. 24 (80%) patients presented with breast swelling. Seven had a history of at least one seroma aspiration within the previous 12 months. Investigation with imaging and cytology was conducted in all cases. Four had atypical cytology and 3 (11.1%) were confirmed as BIA-ALCL by HMDS (CD30+ve/ALK-ve). In 23 patients with normal cytology, 21 were CD30 negative and 2 were not tested. All BIA-ALCL cases had total en-bloc capsulectomy and remain disease free. 18 patients with benign seromas had exploration capsulectomy with benign histology. From this operated group, 5 patients had recurrent seromas: 4 required further aspirations and 1 managed conservatively. Only 1 patient from the non-operated group, who refused en-bloc capsulectomy, required 2 further aspirations and triamcinolone injection for resolution of symptoms.

Conclusion: Management of delayed peri-implant seromas must follow the UK BIA-ALCL diagnostic and treatment guidelines. Benign seromas often require capsulectomy for definitive treatment. In the absence of...