

# High Risk Patients MDT

---

Mr Dhafir Alazawi (Breast surgeon)

Dr Lisa Prior (Medical Oncologist)

Prof Frances Duane (Radiation Oncologist)

**13<sup>th</sup> September 2025**





# Case Presentation 1

---

52 y.o.

2 children

Hypothyroidism, Spinal surgery

Maternal aunt breast cancer 50 years

Maternal first cousin breast cancer 40 years

Asymptomatic

Known lumpy breasts

Increased awareness due to family history

Visited GP

MMG - bilateral abnormal calcifications



# Triple Assessment – Breast Examination

---

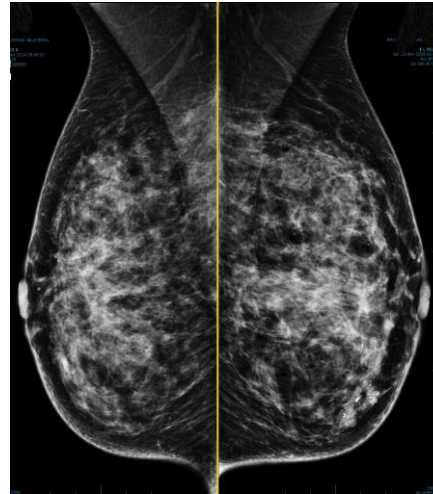
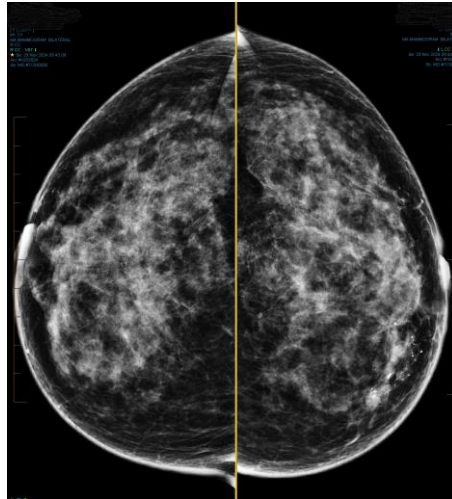
Right and left breast – normal examination with some nodularity but nothing suspicious

# Triple Assessment - Radiology

## Mammogram

Extensive microcalcifications in the left breast. The findings are highly concerning for malignancy. Architectural distortion and microcalcifications in the central and 12 o'clock right breast.

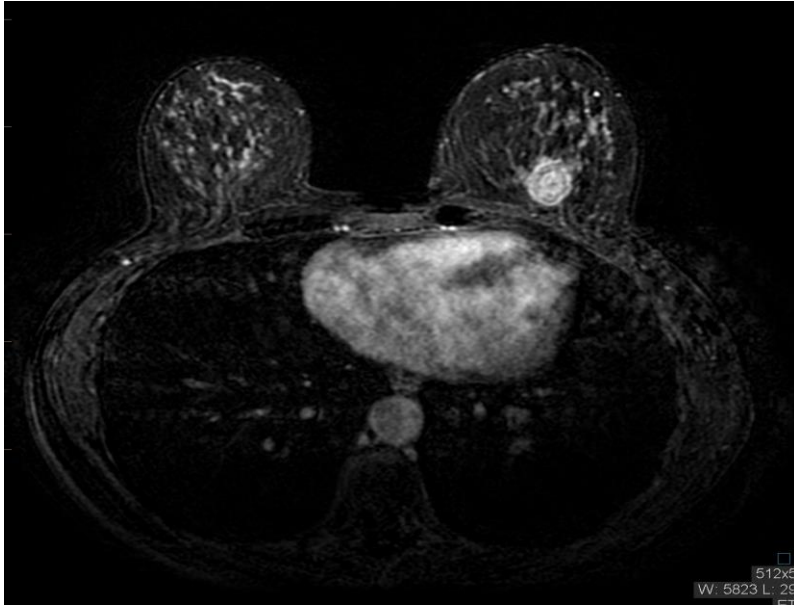
Category R-5



**USS Axilla** – Single abnormal node low left axilla

# Triple Assessment - Radiology

## MRI



cT2mN1

# Triple Assessment - Biopsy

---

Left Breast : IDC, G3, ER-, PR-, HER2+ and high grade DCIS

Right breast: High grade DCIS only

Lt Axillary LN: positive for metastatic ca



# Breast Cancer MDT

---

Staging CT brain/TAP and bone scan - clear

Small indeterminant lung nodule (for surveillance)

MRI confirms 6cm abnormality – non-conservable disease left breast

Biopsy results discussed

Plan for NACT

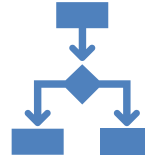


# Neoadjuvant therapy



## Rationale behind neoadjuvant therapy:

- Downstaging
- Measure tx effectiveness
- Allows escalation of adj tx if residual disease
- Tx micro-metastases



## Choice of regimen

TCHP  
(Docetaxel, Carboplatin,  
Herceptin, Pertuzumab)  
x 6 cycles



## Regular clinical examination and intensive supportive care

- Breast examination
- GCSF
- Anti-emetics
- Mouth care
- Echo
- Etc.

Complete radiological response



## **Options**

Left Mastectomy and right Savi guided excision

Bilateral mastectomy and reconstruction

Types of reconstruction?

Management of the axilla (Rt and Lt)

The need for RT...

## What are the indications for ALND now?

Clinically node negative patients who end up with more than 2 positive sentinel lymph nodes

Clinically node positive patients for upfront surgery

Residual nodal disease after NACT

Locally advanced breast cancer considered ineligible for downstaging – cT4, cN2-3



# Surgical counselling

---

Left upfront sentinel LN biopsy

Later...

Bilateral skin sparing mastectomy and reconstruction with breast implant and mesh for right breast and left breast reconstruction with tissue expander and mesh and right SLNB

## Post surgery MDT and histology

---

Left mastectomy- no residual invasive or in situ disease present, 20mm tumour bed present. ypT0

Right mastectomy- no in situ or invasive disease present

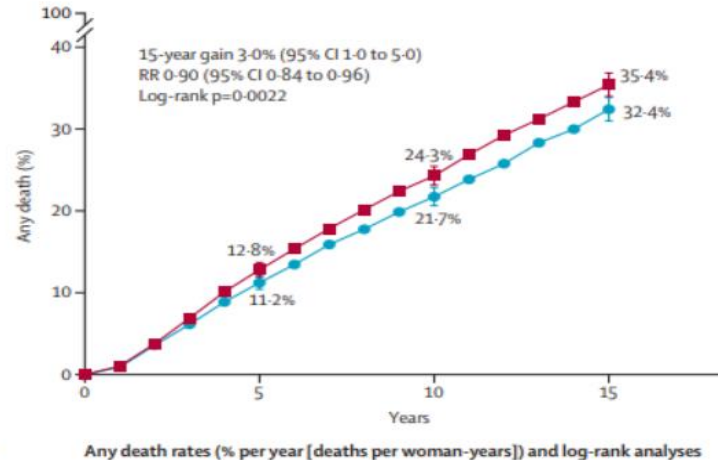
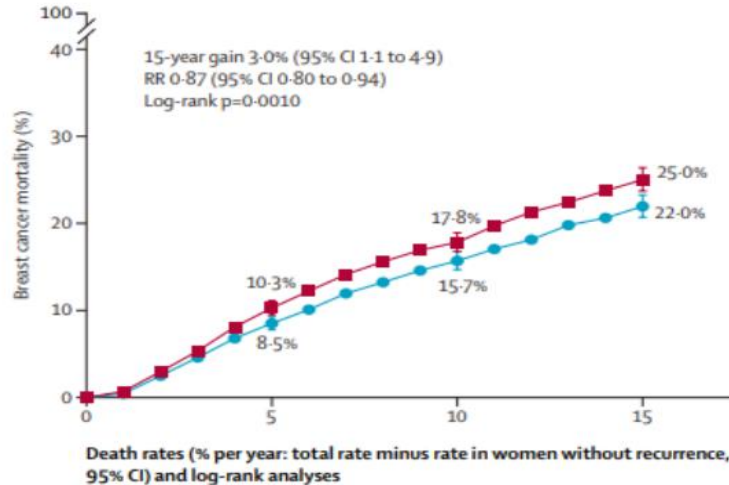
Extensive benign breast disease + fibrosis B/L

Left and right SLNBx – negative for disease

Plan: Radiation oncology

# The need for Radiotherapy

## Regional Nodal radiotherapy EBCTCG 2024, Lancet



‘For such a common disease, widely practicable treatments that produce only moderate effects on long-term survival, such as increasing the number of women surviving for more than ten years after diagnosis by 3-5% could result in the avoidance of many thousands of deaths each year’ Sir Richard Peto



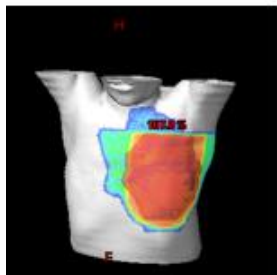
# The need for Radiotherapy

## Regional Nodal Irradiation

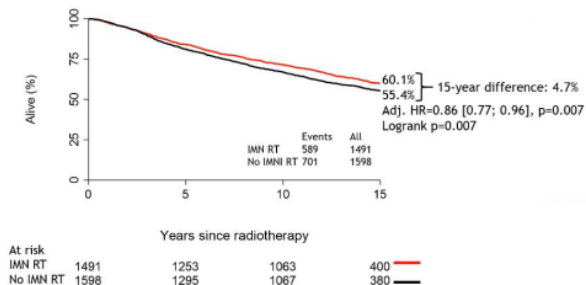
**Journal of Clinical Oncology®**  
An American Society of Clinical Oncology Journal

### DBCG-IMN: Long-term survival gain with internal mammary node irradiation to breast cancer patients

Lise B J Thorsen, M Berg, S Vallentin, I Jensen,  
J Overgaard, M Overgaard, A N Pedersen, Nielsen MH, B V Offersen



#### Overall Survival



2003  
Right side  
+ IMN RT



Left side  
No IMN-RT



All  
Patients  
Node +

With everyday node positive breast cancer the incidence of metastatic disease decreased with internal mammary node irradiation as did breast cancer death. This led to a long lasting beneficial effect from IMN RT on overall survival.

The NEW ENGLAND JOURNAL of MEDICINE

June 9<sup>th</sup> 2025

ORIGINAL ARTICLE

## Omitting Regional Nodal Irradiation after Response to Neoadjuvant Chemotherapy

E.P. Mamounas,<sup>1</sup> H. Bandos,<sup>2,3</sup> J.R. White,<sup>4</sup> T.B. Julian,<sup>5</sup> A.J. Khan,<sup>6</sup> S.F. Shaitelman,<sup>7</sup> M.A. Torres,<sup>8</sup> F.A. Vicini,<sup>9</sup> P.A. Ganz,<sup>10,11</sup> S.A. McCloskey,<sup>12</sup> P.C. Lucas,<sup>13-16</sup> N. Gupta,<sup>17</sup> X.A. Li,<sup>18</sup> B. McCormick,<sup>6</sup> B. Smith,<sup>7</sup> R.D. Tendulkar,<sup>19,20</sup> V.S. Kavadi,<sup>21</sup> K. Matsumoto,<sup>22</sup> S.A. Seaward,<sup>23</sup> W.J. Irvin, Jr.,<sup>24</sup> J.Y. Lin,<sup>8</sup> R.W. Mutter,<sup>25</sup> T.M. Muanza,<sup>26</sup> J. Stromberg,<sup>27</sup> R. Jagsi,<sup>8</sup> A.C. Weiss,<sup>28</sup> W.J. Curran, Jr.,<sup>29</sup> and N. Wolmark<sup>14,15,30</sup>

Typical patient

Her2 positive

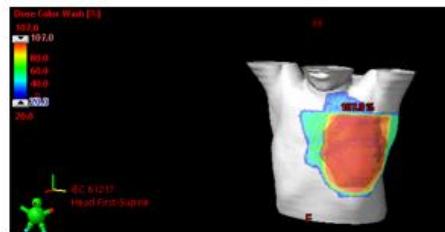
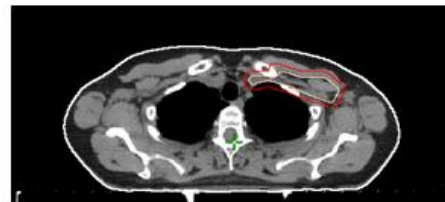
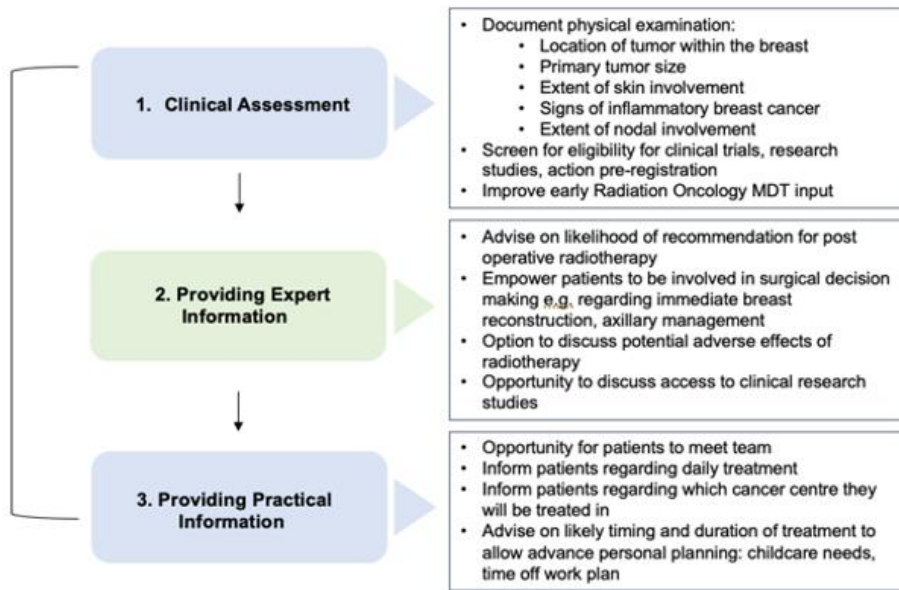
T1-2

N1

Complete response in breast and nodes

# The need for Radiotherapy

## Domains of Radiation Oncology Consultation Structure Prior to Neoadjuvant Chemotherapy



Haley et al, ESTRO 2025

# The need for Radiotherapy

---

Left

Stage IIb T2mN1M0

Largest dominant mass 2.2cm

Background DCIS

Single axillary lymph node on diagnostic imaging

Clinically not T3

Right

DCIS only



**Mr Alazawi: Can you commit to omitting the RT – looks likes a CR on imaging?**

# The need for Radiotherapy

**\*\* CR on path confirmed both in breast and nodes\*\***

**Do you believe the benefits outweigh the risks?  
Consider for each individual patient**

Considering de-escalation to minimise the risk of toxicity is important.

The potential late adverse effects although uncommon may significantly impair quality of life and could lead to a second malignancy

**Irreversible lymphoedema**

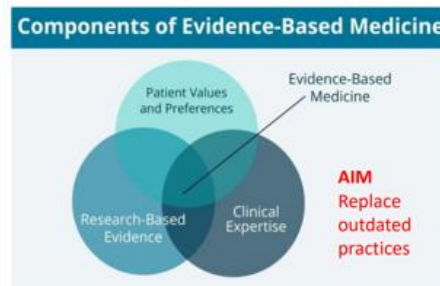
**Fibrosis, chest wall syndrome, shoulder stiffness**

**Cosmetic detriment if upfront reconstruction**

**Radiation related heart disease**

**Doubling the risk of lung cancer in ongoing smokers**

**Risk second malignancy e.g. angiosarcoma**



Avoids burden of attendance for treatment

# Adjuvant systemic treatment

- Herceptin (Trastuzumab) alone every 3 weeks to complete a year in total as no residual disease
- Options if residual disease?



# Future Surgical management

---

Replacement of the left breast implants with permanent breast implant.

## Case Presentation 2

---

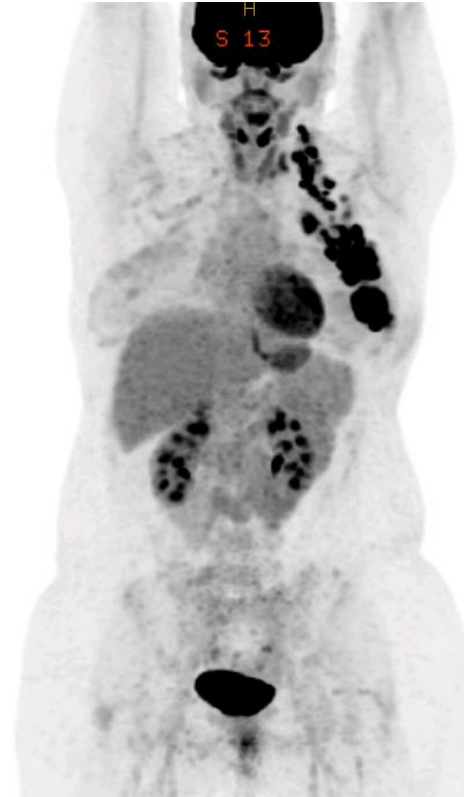
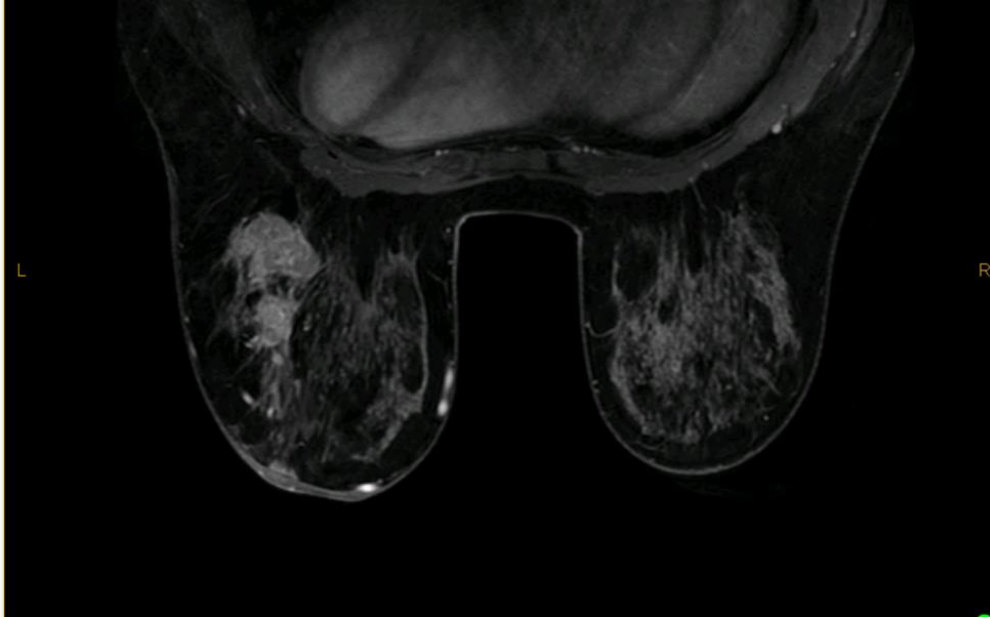
### Clinical history:

- 28yo. Presented with 3 week hx of L breast pain & mass
- PMHx: Asthma, hayfever
- FHx: Mother - TNBC age 49, Mat grandmother TNBC age 69, Pat uncle - prostate ca age 67
- Gynae hx: Para 0. Mirena coil x 2 years, regular periods before this.

### Examination:

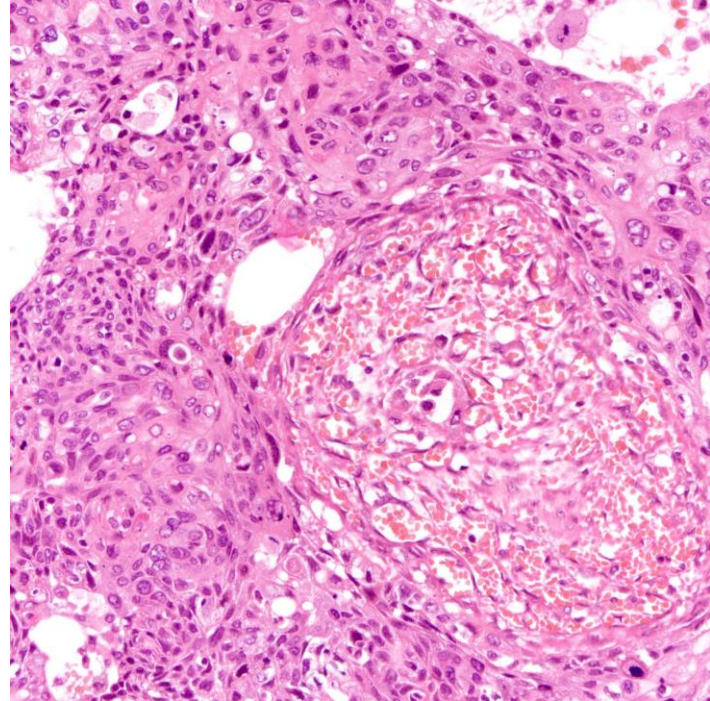
- Palpable 6cm deep mass in UOQ of left breast
- No obvious palpable axillary nodes
- Palpable 1.5cm node in left supraclavicular fossa





# Pathology

- Left breast biopsy - IDC, G3, ER-, PR-, HER2-
- Left axillary lymph node & SCLN biopsy – metastatic carcinoma
- Final dx: Stage IIIC TNBC



# Holistic care considerations...

---

- Young age
- Genetics
- Fertility
- Psycho-oncology
- Menopause and sexual health
- Exercise as part of the medicine prescription!
- Neoadjuvant therapy (spotlight on immunotherapy!)
- Newer surgical techniques to improve cosmetic outcome
- Survivorship

# Thank you