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Poster

**Breast referral management and outcome during COVID 19 Pandemic – A UK experience**

L. Noor<sup>1</sup>, S. Horn<sup>1</sup>, H. Shin<sup>1</sup>, E.J. Turner<sup>1</sup>. <sup>1</sup>Croydon University Hospital, Surgery, London, United Kingdom

**Background:** The new respiratory illness commonly referred to as “corona virus” and officially called COVID-19 has changed life and delivery of health care worldwide. In UK it has resulted in major changes as not only halted the breast screening but also forced the breast unit to undergo reconfiguration for safety of patients and staff. The risk of becoming seriously ill from COVID-19 is low for most people. However, it's very important to know that people being treated for breast cancer may have a higher risk of severe illness if they get COVID-19. We conducted this observational study to assess the impact of COVID 19 on breast referral and breast cancer management.

**Material and methods:** We collected the data both retrospectively and prospectively from 16 March 2020 to 15 June 2020, while England was facing lock down restrictions. Total number of breast clinics scheduled, were 116 with 818 slots in Croydon University Hospital. We included 479 patients, 469 new referrals to breast clinic and 10 breast cancer patients referred back following neo adjuvant treatment. All new referrals were offered telephonic consultation (TC) prior to their face to face consultation (F2F) on the scheduled appointment day, within 2 weeks, 4–6 weeks and >12 weeks. All health care staff involved in direct care of these patients were provided with personal protective equipment (PPE) and guidelines.

Number of new referrals	469
TC	All
TC + discharge	92
F2 F	112
F 2 F in 2/52	151
F2F in 4–6/52	60
F2 F >3/12	54
B 3	11
New breast cancer	35
Post NACT	9
Post neo RT	1
Recurrent cancer/sarcoma	9
Primary Surgery	14
Bridging-ET	17
Primary ET	1
NACT	2
Neo RT	1

NACT – Neoadjuvant chemotherapy  
Neo RT- Neo radiotherapy

**Results:** Out of 479 patients, 92 were discharged after TC due to low risk referral, 112 patients had F2F consultation on scheduled day, 151 within 2 weeks and 60 within 4–6 weeks after TC. 54 patients had their F2F appointments rescheduled after 3 months due to co-morbidities. During this 3 months period, we diagnosed 35 new breast cancers, 5 recurrent cancer and 4 patients with sarcoma/malignant phyllodes. Primary surgery was performed in 14/35 patients with new cancer diagnosis, while 17 had bridging endocrine therapy prior to surgery. 10 patients had surgery following neoadjuvant treatment (chemotherapy in 9 and radiotherapy in 1). Total of 41 patients underwent surgery and COVID test was performed in all except 2 patients with one positive test result in whom surgery was deferred until converted negative. All patients had day case surgery with no adverse outcome noted.

**Conclusions:** After required reconfiguration in both clinics and theatre settings and following precautions and guidelines we found it safe to manage patients referred with breast symptoms or diagnosed with breast cancer during COVID-19 restrictions.

**No conflict of interest.**

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Poster

**Traumatic fat necrosis of the breast: a review of the spectrum of appearances of the ‘great mimicker’ of breast carcinoma**

L. Sweeney<sup>1</sup>, A. O'Brien<sup>1</sup>. <sup>1</sup>Mater Misericordiae University Hospital, Breast Imaging, Dublin 7, Ireland

**Background:** It can be extremely difficult to confidently diagnose fat necrosis of the breast given its variety of appearances and often striking resemblance to breast carcinoma. We rely on a correlation with a definite clinical history of

trauma (accidental, biopsy-related or surgical) to that exact site, however even in this context it can be difficult to definitively outrule a co-incidental breast carcinoma/recurrence. This often leads to histological sampling of the region in question, despite a clear history of a traumatic insult to this site. We aim to review classic imaging characteristics of fat necrosis of the breast to aid radiological diagnosis.

**Materials/methods:** Using mammography, ultrasound and MRI, we demonstrate several examples of fat necrosis of the breast from both accidental and iatrogenic/surgical aetiologies.

**Results:** We exhibit both the typical and atypical features of breast fat necrosis which would cause concern and necessitate the need for histological sampling. We demonstrate its range of appearances on mammogram: from reassuring radiolucent oil cyst with curvilinear calcification to more indeterminate asymmetric mass-like density. We show its sonographic range, including focal regions of hyperechogenicity, cystic areas with peripheral hyperechogenicity and more indeterminate focal heterogeneity. On MRI, we demonstrate how the presence of fat signal or fat suppression within a lesion and enhancement of granulation tissue surrounding a non-enhancing central mass can also suggest fat necrosis versus malignancy.

**Conclusion:** Traumatic Breast Fat necrosis has a myriad of appearances on mammogram, ultrasound and MRI, presenting a dilemma for definitive radiological diagnosis. We present this spectrum of imaging characteristics and discuss the more atypical features which would necessitate histological confirmation.

**No conflict of interest.**

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Poster

**Advancing the age limit for core biopsy for U2 ultrasound lesions – are we ready?**

C. Ruwan Kasturi<sup>1</sup>, R. Shah<sup>1</sup>, N. Kankanamage<sup>1</sup>, F. Mihaimeed<sup>1</sup>, J. Saunders<sup>1</sup>. <sup>1</sup>Barts Health NHS Trust, Breast Surgery Department, London, United Kingdom

**Introduction:** In November 2019 the Royal College of Radiologists (RCR) suggested that a higher age cut-off of 30 years, as opposed to 25, may be appropriate in assessment of a lump when a fibroadenoma, lipoma or hamartoma is suspected, and a needle biopsy may not be required. We assessed whether this change in practice could be safely implemented, supported by local data and if we could adopt this in a multi-ethnic inner-city population.

**Method:** A retrospective audit of patients aged between 25- and 30-years undergoing core biopsy for well-defined U2 lesions from December 2018 to December 2019. Review of electronic health records for clinical grading and assessment, ultrasound and histology reports.

**Results:** There was a total of 46 female patients with a mean age of 27 years. All patients had benign clinical findings, P2. All ultrasound reports were U2, a fibroadenoma was mentioned in 25, and a well-defined lesion in 21. Histology confirmed B2 pathology in 40 cases (87%) [fibroadenoma in 28, benign changes 4, stromal fibrosis 3, inflammation 2, hamartoma 2 and sclerosing adenosis 1.] Four cases were B1 (9%) [minor benign changes] and 2 (4%) were B3, phyllodes cannot be ruled out. The latter 2 were excised with a final pathology of a cellular fibroadenoma in one case and a benign phyllodes.

**Conclusion:** Our retrospective data suggests that to raise the biopsy threshold to 30 years would potentially miss a clinically significant diagnosis in only 2% of cases. However, further prospective audit is required before adoption of the new recommendation.

**No conflict of interest.**