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21st SIS WORLD CONGRESS ON BREAST CANCER AND BREAST HEALTHCARE

MAY 3-6, 2023 | RHODES ISLAND - GREECE

INTERNATIONAL CONFERENCE CENTER - RODOS PALACE HOTEL

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Lydia Ioannidou - Mouzaka *(GR)*

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Μήνυμα για το σπίτι από το
21st SIS World Congress on Breast Cancer and Breast Healthcare

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Το Υπουργείο Υγείας και ο Εθνικός Οργανισμός Φαρμάκων συνιστούν:
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Φαρμακευτικό προϊόν που ενδείκνυται για την βραχυπρόθεσμη συμπτωματική θεραπεία του ήπιου έως μέτριου πόνου.
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GPN/PPM/JAD/10_2022/04

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ΧΑΙΡΕΤΙΣΜΟΙ

ΧΑΙΡΕΤΙΣΜΟΣ

Αγαπητοί συνάδελφοι,

Με μεγάλη μας χαρά, σας προσκαλούμε στο **21ο Παγκόσμιο Συνέδριο της Διεθνούς Εταιρείας Μαστολογίας για τον Καρκίνο του Μαστού και την Υγεία του Μαστού**, το οποίο θα πραγματοποιηθεί στη **Ρόδο – Ελλάδα, στις 3–6 Μαΐου 2023**, στο Διεθνές Συνεδριακό Κέντρο Rodos Palace. Το Συνέδριο θα πραγματοποιηθεί αποκλειστικά με ζωντανή παρουσία των Συνέδρων.

Το Συνέδριο τελεί υπό την Αιγίδα της Α.Ε. της Προέδρου της Ελληνικής Δημοκρατίας κας Κατερίνας Σακελλαροπούλου και της Α. Θ. Παναγιότητος του Οικουμενικού Πατριάρχη κ. κ. Βαρθολομαίου 1ου.

Το βασικό πλαίσιο του Συνεδρίου θα είναι το Επιστημονικό Πρόγραμμα, το οποίο έχει αναπτυχθεί από ειδική Επιστημονική Επιτροπή.

Το 21ο Παγκόσμιο Συνέδριο της Διεθνούς Εταιρείας Μαστολογίας στη Ρόδο θα βοηθήσει όλους τους παρευρισκόμενους Συνέδρους αυξήσουν τις γνώσεις τους και να περιηγηθούν στον περίπλοκο κόσμο των πιο αποτελεσματικών πρωτοβουλιών και βέλτιστων πρακτικών του σήμερα σε όλο το φάσμα του Καρκίνου του Μαστού και της Υγείας του Μαστού. Η υγειονομική περίθαλψη δεν πρέπει να θεωρείται ως έξοδο, αλλά ως επένδυση.

Το Συνέδριο θα ασχοληθεί με τα πιο πρόσφατα επιστημονικά επιτεύγματα τόσο στη διάγνωση όσο και στη θεραπεία των παθήσεων του μαστού και ιδιαίτερα του Καρκίνου του Μαστού. Είναι η πρώτη φορά που ένα Συνέδριο της Διεθνούς Εταιρείας Μαστολογίας ασχολείται με την Υγεία του Μαστού.

Μετά από τρία χρόνια συνεχών αναβολών του Συνεδριου λόγω της πανδημίας COVID-19 τελικά πραγματοποιείται επιτέλους ζωντανά με αναγνωρισμένους Ομιλητές από όλο τον κόσμο. Είναι μια εξαιρετική ευκαιρία για ανταλλαγή απόψεων μεταξύ εξειδικευμένων ιατρών και για τους νεότερους συμμετέχοντες να μάθουν από τους πιο εμπείρους.

Θα θέλαμε να ευχαριστήσουμε όλους τους συμμετέχοντες στο Επιστημονικό Πρόγραμμα και τον καθένα ξεχωριστά για την προσφορά και την άψογη συνεργασία.

Με τις καλύτερες ευχές μας,

Δρ Λυδία Ιωαννίδου-Μουζάκα MD, PhD
Πρόεδρος του Συνεδρίου

Pr Schlomo Schneebaum MD, PhD
Πρόεδρος της Επιστημονικής Επιτροπής

ΧΑΙΡΕΤΙΣΜΟΣ ΕΝΑΡΚΤΗΡΙΑΣ ΤΕΛΕΤΗΣ

- Σεβασμιότατε Μητροπολίτη της Ρόδου κ. Κύριλλε Β', εκπρόσωπος της Α.Θ. Παναγιότητος του Οικουμενικού Πατριάρχη Κ.κ. Βαρθολομαίου Α',
- Εκπρόσωπε του Υπουργείου Υγείας κ. Φωτεινή Κουλούρη
- Αντιπεριφερειάρχη Υγείας Ν. Αιγαίου, εκπρόσωπος του Περιφερειάρχη Ν. Αιγαίου κ. Γιώργο Χατζημάρκο,
- Αντιδήμαρχε Ρόδου κ. Κωνσταντίνε Ταρασλιά, εκπρόσωπος του Δημάρχου Ρόδου κ. Αντώνη Καμπουράκη,
- Αξιότιμη Πρόξενος Γαλλίας κ. Μοσχή Αλίκη,
- Δρ Μάριε Γεωργανά, Ταμία του Ιατρικού Συλλόγου Ρόδου, εκπρόσωπος του Προέδρου του Ιατρικού Συλλόγου Ρόδου κ. Ηλία Τσέρκη,
- Πρόεδρε της Διεθνούς Εταιρείας Μαστολογίας Καθ. Schlomo Schneebaum και μέλη του Διοικητικού Συμβουλίου,
- Πρόεδρε του Παραδοσιακού Χορευτικού Συλλόγου Τηλίων Ρόδου, Αγ. Παντελεήμων, κ. Πόπη Κατσουράκη και Χοροδιδάσκαλε κ. Ματίνα Μορφωπού

Κυρίες και Κύριοι,
Αγαπητοί Συνάδελφοι,

Είμαι ιδιαίτερα συγκινημένη που βρίσκομαι ανάμεσα σε εκλεκτούς Συναδέλφους τόσο από τον Διεθνή όσο και από τον Ελληνικό χώρο αλλά και βαθύτερα συγκινημένη που έχω την τιμή και τη χαρά το **"21ο Παγκόσμιο Συνέδριο της Διεθνούς Εταιρείας Μαστολογίας για τον Καρκίνο του Μαστού και την Υγεία του Μαστού"** να λαμβάνει χώρα υπό την Προεδρεία μου στον ίδιο Συνεδριακό χώρο αλλά και στις ίδιες ακριβώς ημερομηνίες με το 7ο Διεθνές Συνέδριο Μαστολογίας της Διεθνούς Εταιρείας Μαστολογίας το 1992.

Η πρώτη μου επαφή με το Διεθνές Συνεδριακό Κέντρο του Ξενοδοχείου Rodos Palace ήταν το 1992 όταν διοργάνωσα το 7ο Παγκόσμιο Συνέδριο Μαστολογίας, σε μια εποχή που το Ξενοδοχείο Rodos Palace υπό την Διεύθυνση του αείμνηστου Βασίλειου Καμπουράκη ξεκίνησε τα πρώτα του βήματα και «εγκαινιάστηκε» ο Συνεδριακός του χώρος με την διεξαγωγή του 7ου Παγκοσμίου Συνεδρίου Μαστολογίας, ενός Συνεδρίου που εκτός της επιστημονικής του οντότητας και της πλούσιας θεματολογίας του, «άφησε εποχή» αφού η συμμετοχή των Συνέδρων έφτασε το απίστευτο νούμερο των 2.003 συμμετεχόντων και των Συνοδών Μελών ξεπέρασε κάθε προσδοκία, φτάνοντας τα 1.500 άτομα.

Στη συνέχεια θα μου επιτρέψετε να αναφερθώ στην προσπάθεια και την υπομονή που έκανα για να διατηρηθεί το "21st SIS World Congress on Breast Cancer and Breast Healthcare» στην Ελλάδα επί μία 3ετία, για να μπορέσω να έχω την ικανοποίηση να φροντίσω για ακόμη μια φορά τα μέλη του Δ.Σ. της Διεθνούς Εταιρείας Μαστολογίας καθώς και τα μέλη των Εθνικών Εταιρειών Μαστολογίας.

Η εμπιστοσύνη κι εκτίμηση του Προέδρου και των Μελών του Δ.Σ. της Διεθνούς Εταιρείας Μαστολογίας στο άτομο μου, επέτρεψε αυτήν την επιλογή, δηλ. το Συνέδριο να μην ακυρωθεί

αλλά ούτε και να λάβει χώρα διαδικτυακά και να πραγματοποιηθεί δια ζώσης.

Το παρόν Συνέδριο δεν μοιάζει καθόλου με όλα τα προηγούμενα που έχω διοργανώσει, 14 Πανελλήνια και 4 Διεθνή.

Με την ευκαιρία αυτή, επιτρέψτε μου να στείλω ένα τεράστιο ευχαριστώ στα μέλη των Εθνικών Εταιρειών Μαστολογίας και στα μέλη του Δ.Σ. της Διεθνούς Εταιρείας Μαστολογίας.

Για την ιστορία θα ήθελα να σας αναφέρω ότι προσφέρω τις υπηρεσίες μου στη SIS από το 1977, τότε που Διευθυντής του τμήματος Μαστολογίας, όπου εγώ ειδικευόμουν στη Μαστολογία, ήταν ο Charles Marie Gros, Ιδρυτής της SIS.

Επίσημα εισήχθη στο Δ.Σ. της SIS μετά την εκλογή μου στη Γενική Συνέλευση του Συνεδρίου στο Παρίσι το 1986, ως Ειδικός Γραμματέας, για 2 χρόνια, 1986-1988 και στη συνέχεια εξελέγη:

- 1986-1988, Ειδικός Γραμματέας,
- 1988-1992, Γενικός Γραμματέας,
- 1992-1994, Πρόεδρος της Διεθνούς Εταιρείας Μαστολογίας (S.I.S.)
- 1994-1996, Αντιπρόεδρος για την Ευρώπη,
- 1996-1998, Ειδικός Γραμματέας ξανά, μετά την επιμονή του Gabriel Hortobaghy και
- 2016 έως σήμερα, Μέλος του Διοικητικού Συμβουλίου

Ιδιαίτερες όμως ευχαριστίες θα ήθελα να εκφράσω δημόσια στους προηγούμενους Προέδρους με τους οποίους είχα πολύ στενή συνεργασία, όπως οι Miguel Prats Esteve, Jean Gest, Leonardo MacLean, Douglas Marchand, Antonio Figueira, Gabriel Hortobaghy και Alex Mundinger.

Επιπλέον θα ήθελα να ευχαριστήσω τον προηγούμενο Πρόεδρο της SIS, τον εκλεκτό Συνάδελφο από την Βραζιλία, Καθ. κ. Mauricio Malgahaes Costa και τον νυν Πρόεδρο και εκλεκτό Συνάδελφο από το Ισραήλ κ. Schlomo Schneebaum για την εξαιρετική συνεργασία μας.

Ξεχωριστά θα ήθελα να εκφράσω την ευγνωμοσύνη μου στον αείμνηστο Καθ. Charles Marie Gros και στον Καθ. Hans Joachim Frischbier από το Αμβούργο, που με αγκάλιασε στα πρώτα μου βήματα στην Μαστολογία. Φυσικά, με τον Καθ. Frischbier η αμοιβαία μας εκτίμηση συνεχίζεται μέχρι σήμερα και ως απόδειξη αυτού, (slide) σας προβάλλω το e-mail που έλαβα πριν από δύο ημέρες για λογαριασμό του, καθώς δεν μπορεί να έρθει.

Θα ήθελα επίσης δοθούμενης της ευκαιρίας αυτής, να ευχαριστήσω από τα βάθη της καρδιάς μου την Γαλλική Κυβέρνηση, από την οποία πήρα διετή Υποτροφία το 1977 ώστε να ειδικευθώ στη Μαστολογία στο Στρασβούργο, Μέκκα της Μαστολογίας εκείνα τα χρόνια, δίπλα στον αείμνηστο Καθ. Charles Marie Gros.

Το 21ο Παγκόσμιο Συνέδριο Μαστολογίας τελεί υπό την Αιγίδα της Α.Ε. Προέδρου της Δημοκρατίας Κατερίνας Σακελλαροπούλου και της Α.Θ. Παναγιότητος του Οικουμενικού Πατριάρχου Κ.κ. Βαρθολομαίου Α'.

Ευχαριστώ θερμά όλους τους προσκεκλημένους Ομιλητές που ανταποκρίθηκαν στο κάλεσμά μας και συμμετέχουν ενεργά στο Επιστημονικό Πρόγραμμα του Συνεδρίου.

Θερμές ευχαριστίες θα ήθελα να απευθύνω:

- στον Υπουργό Υγείας κ. Θάνο Πλεύρη και
- στον Υπουργό Τουρισμού κ. Βασίλη Κικίλια, για τη συνεργασία τους

Είναι αδύνατον να τους έχουμε μαζί μας εδώ σήμερα καθώς διανύουμε προεκλογική περίοδο και προετοιμάζουν την προεκλογική τους εκστρατεία.

Θα ήθελα επίσης να ευχαριστήσω:

- τον Περιφερειάρχη Νοτίου Αιγαίου κ. Γιώργο Χατζημάρκο και τον Περιφερειάρχη Αττικής Δρ Γεώργιο Πατούλη για την υποστήριξή τους.
- τον Δήμαρχο Ρόδου και διαχρονικό φίλο κ. Αντώνη Καμπουράκη,
- τον Πρόεδρο του Ιατρικού Συλλόγου Ρόδου κ. Ηλία Τσέρκη, και τον Πρόεδρο του ιατρικού Συλλόγου αθηνών κ. Γεώργιο Πατούλη
- όλους τους Φορείς και Υποστηρικτές του Συνεδρίου,
- τις συνεργαζόμενες Επιστημονικές Εταιρείες που συμμετέχουν στο Επιστημονικό Πρόγραμμα του Συνεδρίου,
- τους διακεκριμένους Συναδέλφους-Ομιλητές από την Ελλάδα και το Εξωτερικό,
- τους εκλεκτούς Χορηγούς μας που στηρίζουν το Συνέδριο,
- την ιδιοκτήτρια του Rodos Palace Hotel κ. Μαίρη Καμπουράκη και την Διευθύντρια κ. Κατερίνα Μανουσάκη,
- την Πρόεδρο του Παραδοσιακού χορευτικού Συλλόγου Τηλίων Ρόδου, Άγιος Παντελεήμων, κ. Πόπη Κατσουράκη και την Χοροδιδάσκαλο κ. Ματίνα Μορφωπού,
- το Γραφείο World Congress που ανέλαβε την γραμματειακή υποστήριξη του Συνεδρίου και ιδιαίτερα τον Διευθυντή του Γραφείου κ. Κώστα Παπαπαναγιώτου που δεν σταμάτησε τη συνεργασία μας, όταν διαπίστωσε τις οικονομικές δυσκολίες που προέκυψαν λόγω της γενικής οικονομικής κατάστασης παγκοσμίως.

Λόγω ηλικίας, δεν ταξιδεύει με αεροπλάνο και έτσι δεν είναι σήμερα μαζί μας. Θα ήθελα να του προσφέρω ένα αναμνηστικό δώρο για να εκφράσω δημοσίως τις ευχαριστίες μου σε εκείνον. Θα ζητήσω από την κόρη του κ. Μαρία Παπαπαναγιώτου να έρθει και να το παραλάβει.

Τέλος θα ήθελα να ευχαριστήσω όλους εσάς που είστε εδώ παρόντες και μας τιμάτε με την παρουσία σας.

Καλωσορίζω όλους τους Συμμετέχοντες του Συνεδρίου και πιστεύω ακράδαντα ότι τα συμπεράσματα αυτού του Συνεδρίου θα είναι προς όφελος όχι μόνον των Επιστημόνων αλλά και των Γυναικών.

Εύχομαι από καρδιάς καλή επιτυχία στο Συνέδριο και καλή διαμονή στο νησί της Ρόδου.

Δρ Λυδία Ιωαννίδου-Μουζάκα MD, PhD
Πρόεδρος του Συνεδρίου

ΧΑΙΡΕΤΙΣΜΟΣ ΕΝΑΡΚΤΗΡΙΑΣ ΤΕΛΕΤΗΣ

Πρόεδρε του Συνεδρίου: Καθ. Λυδία Ιωαννίδου Μουζάκα
Διακεκριμένοι Σύνεδροι
Μέλη της Εταιρείας

Είναι μεγάλη τιμή και χαρά να συμμετέχω στην τελετή έναρξης του 21ου Παγκόσμιου Συνεδρίου της Διεθνούς Εταιρείας Μαστολογίας (SIS) για τον Καρκίνο του Μαστού και την Υγεία του Μαστού.

Αυτό το συνέδριο είναι ξεχωριστό: είναι το πρώτο Παγκόσμιο Συνέδριο της SIS με κατ' ιδίαν συνάντηση μετά την επιδημία του Κορώνα-ιού, ένα συνέδριο με εθνικούς και διεθνείς ομιλητές.

Η πολυεπιστημονική φύση της Εταιρείας μας αντικατοπτρίζεται επίσης στο Πολυθεματικό Συνεδριακό Πρόγραμμα που περιλαμβάνει χειρουργική, παθολογική και ακτινολογική ογκολογία, απεικόνιση, παθολογία και ψυχολογία.

Μια διεπιστημονική ομάδα είναι μια ομάδα μελών με ποικίλη αλλά συμπληρωματική εμπειρία, προσόντα και δεξιότητες που συμβάλλουν στον ίδιο στόχο.

Μια διεπιστημονική προσέγγιση έχει σημαντικό αντίκτυπο στη διαχείριση των ασθενών αυξάνοντας το επίπεδο περίθαλψης, τον προγραμματισμό θεραπείας, την επιβίωση, την αναγνώριση των συναισθηματικών αναγκών, την ποιότητα ζωής, την ομαδική επικοινωνία και τις εκπαιδευτικές ευκαιρίες και παράλληλα μειώνοντας τη θνησιμότητα, τις διπλές υπηρεσίες, το κόστος υγειονομικής περίθαλψης και την επιθετική χειρουργική επέμβαση.

Οι σκοποί της SIS είναι:

Να συγκεντρώσει όλες τις επιστημονικές εταιρείες, συλλόγους και ομάδες οπουδήποτε στον κόσμο, με στόχο την προώθηση της γνώσης στη βιολογία, την ιατρική και τις ανθρωπιστικές επιστήμες, που σχετίζονται με τον μαστό, με σκοπό τη δημιουργία μιας διεθνούς ομοσπονδίας, με σκοπό την προώθηση της πρόληψης, διάγνωση και θεραπεία παθήσεων του μαστού, για τη διάδοση της γνώσης της Μαστολογίας και την προώθηση της αλληλεπίδρασης με την κοινότητα.

Να υποστηρίζει και να αναπτύσσει την έρευνα, καθώς και να ενθαρρύνει επιστημονικές δημοσιεύσεις που σχετίζονται με το σκοπό της S.I.S. δηλαδή να οργανώνει συναντήσεις· για την προώθηση της δημόσιας συνείδησης, χρησιμοποιώντας κάθε διαθέσιμο μέσο εκπαίδευσης, ενημέρωσης και δημοσιότητας.

Να συνεργάζεται με αρμόδιες κυβερνητικές αρχές και υπηρεσίες καθώς και με Διεθνείς Οργανισμούς Υγείας.

Να συντονίζει τις επιστημονικές δραστηριότητες διαφορετικών ενώσεων και εταιρειών.

Για την επίτευξη των στόχων του, η SIS είναι ελεύθερη να συνεργάζεται με άλλα φυσικά ή νομικά πρόσωπα.

Ένα τέτοιο παράδειγμα είναι το BCN.
Το Breast Centers Network είναι το πρώτο διεθνές δίκτυο κλινικών κέντρων αποκλειστικά αφιερωμένο στη διάγνωση και θεραπεία του καρκίνου του μαστού. Είναι ένα έργο που δημιουργήθηκε από την ESO (Ευρωπαϊκή Σχολή Ογκολογίας) με στόχο την προώθηση και βελτίωση της φροντίδας για τον καρκίνο του μαστού στην Ευρώπη και σε όλο τον κόσμο. Από το έτος 2020, η Senologic International Society έγινε ο εκτελεστικός διαχειριστής του προγράμματος.

Ήταν μια πρόκληση να οργανώσουμε μια συνάντηση σε αυτούς τους καιρούς αβεβαιότητας: Covid, Πόλεμος.
Χρειάστηκε να το αναβάλουμε αρκετές φορές.
Αυτό το διάστημα,
Δημιουργήσαμε έναν νέο ιστό,
Κάναμε ένα επιτυχημένο Webinar,
Και δημοσιεύουμε πολλά άρθρα συνδεδεμένα με την SIS στο περιοδικό μας.

<u>Διεθνές πρόγραμμα διαπίστευσης και πιστοποίησης</u>
Η SIS έχει δημιουργήσει ένα διεθνές πρόγραμμα διαπίστευσης και πιστοποίησης για μονάδες μαστού που πληρούν ήδη μια σειρά ποιοτικών κριτηρίων και έχουν ήδη εθνική πιστοποίηση (είτε από εθνική επιστημονική εταιρεία είτε από την ανώτατη αρχή της Εθνικής Υγείας της χώρας). Αυτή η διεθνής πιστοποίηση μπορεί να δοθεί μόνο στις μονάδες μαστού όπου μέρος της ιατρικής ομάδας είναι μέλος μιας επιστημονικής εταιρείας που συνδέεται με το Διεθνές πρόγραμμα διαπίστευσης και πιστοποίησης SIS.

Στόχοι Διαπίστευσης:
Καθολικότητα: οι διαδικασίες ποιότητας στη διάγνωση και τη θεραπεία του καρκίνου του μαστού θα πρέπει να είναι προσβάσιμες σε όλες τις γυναίκες ανεξάρτητα από τη γεωγραφική θέση του σπιτιού τους.
Ομοιομορφία: οι απαιτούμενοι δείκτες ποιότητας πρέπει να είναι ίσοι για όλα τα κέντρα μαστού.
Ξεκινήσαμε επίσης μια υποτροφία SIS στη Χειρουργική Μαστού.
Το Επιστημονικό Πρόγραμμα αυτού του συνεδρίου είναι διεθνές και πολυεπιστημονικό και περιλαμβάνει όλες τις πτυχές της θεραπείας του καρκίνου του μαστού.
- 31 Διαλέξεις
- 11 Στρογγυλές Τράπεζες
- 4 Εργαστήρια
- 2 Συνεδρίες Αντιπαράθεσης
- 36 Προφορικές Παρουσιάσεις

Θα ήθελα να ευχαριστήσω:
Τ μέλη της Επιστημονικής Επιτροπής,
Την Δρ Αντιγόνη Σούρλα, Γραμματέα της Επιτροπής,
Τους Προηγούμενους Προέδρους της Επιτροπής και Αντιπροέδρους,
Όλα τα μέλη της Οργανωτικής Επιτροπής,
Την Οργανωτική Εταιρεία: Congress World,
Τις κ. Μαρία Δεσύλλα και Γαρυφαλιά Μπουσιοπούλου,
Όλους τους ομιλητές και προέδρους,
Όλα τα μέλη του Εταιρείας και τους Συνέδρους.
Τέλος, ευχαριστώ την καθηγήτρια Λυδία Ιωαννίδου-Μουζάκα

Σας ευχαριστώ όλους που ήρθατε. Εύχομαι σε όλους μας μια επιτυχημένη συνάντηση.

Pr Schlomo Schneebaum MD, PhD
Πρόεδρος της Επιστημονικής Επιτροπής

ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Carole Mathelin, carole.mathelin.x@gmail.com
Προς: lydiamouzaka@yahoo.gr
Monday, May 8, 2023

Αγαπητή Λυδία,

Μετά από αυτή τη μακρά περίοδο κατά την οποία περιοριστήκαμε σε εικονικές συναντήσεις, όλοι χρειαζόμασταν να έχουμε ξανά μια φιλική ευκαιρία να μιλήσουμε και να μοιραστούμε, όπως μπορέσαμε να κάνουμε στη Ρόδο την περασμένη εβδομάδα.

Βλέπουμε στις φωτογραφίες τη χαρά που είχαμε να συζητήσουμε στο τόσο ευγενικό εορταστικό δείπνο. Συγχαρητήρια και σ' ευχαριστώ πολύ. Περιμένοντας τη χαρά να σε συναντήσουμε ξανά.

Πολύ φιλικά,

Carole Mathelin

MD PhD, Head of Surgery department at ICANS (Institute of Cancerology Strasbourg Europe, France), Professor at the Faculty of Medicine, University of Strasbourg, France; Researcher in the Breast Cancer Molecular and Cellular Biology team, Institute of Genetics and Molecular and Cellular Biology (IGBMC), CNRS UMR 7104, INSERM U964, University of Strasbourg, France; Past president of SIS, in charge of international cooperation of SIS; Associate Member of the Academy of Surgery, France

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Maurício Magalhães Costa, mamcosta@yahoo.com
Προς: lydiamouzaka@yahoo.gr
Τετάρτη 10 Μαΐου στις 8:22 π.μ.

Αγαπητή Λυδία,

Θα ήθελα να σ' ευχαριστήσω για την ευγενική υποδοχή στη Ρόδο και για όλες τις προσπάθειες να γίνει το συνέδριο ΔΥΝΑΤΟ, όταν φαινόταν αδύνατο. Συγχαρητήρια.

Το ταξίδι στη Σύμη ήταν φανταστικό και ο εορτασμός των γενεθλίων μου μοναδικός. Ευχαριστώ.

Εύχομαι τα Καλύτερα,

Maurício Magalhães Costa

Mebro Titular da Academia Nacional de Medicina, Past-President da Sociedade Internacional de Senologia, Coordenador do Núcleo de Mama do Ameicas Centro de Oncologia Integrada, Centro Médico Sorocaba, Brazil

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ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Verhoeven Didier, didier.verhoeven@klina.be
Προς: lydiamouzaka@yahoo.gr
Τετάρτη 10 Μαΐου στις 4:39 μ.μ.

Αγαπητή Λυδία,

Ήταν υπέροχο να σε δω "εν δράση"!!

Ευχαριστώ για το Συνέδριο και τους παριστάμενους φίλους.

Ελπίζω να σας δω στην Αμβέρσα,

Didier

MD, PhD, Medical oncologist, Guest Professor University of Antwerp; Chair Breast Clinic Voorkempen Brasschaat, Belgium

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Luzia Travado, luziatravado@gmail.com
Προς: lydiamouzaka@yahoo.gr
Τετάρτη10 Μαΐου στις 5:39 μ.μ.

Αγαπητή Λυδία,

Σ' ευχαριστώ πολύ για όλα Λυδία, ήταν χαρά μου να συμμετάσχω στο Συνέδριο, και συγχαρητήρια για την υπέροχη διοργάνωση!! Σας στέλνω μερικές φωτογραφίες. Ευχαριστώ!

Ό, τι καλύτερο,

Luzia

PhD, MSc, ClinPsych, Clinician and Researcher of Psycho-Oncology, Champalimaud Clinical & Research Centre, Avenida Brasília, Lisboa, Portugal; IPOS President-Emeritus, 2022 Jimmie Holland Memorial Award; International Psycho-Oncology Society, Portugal

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Dr L H Gebrim, lgebrim@uol.com.br
Προς: lydiamouzaka@yahoo.gr
Πέμπτη 11 Μαΐου στις 3:07 μ.μ.

Αγαπητή Καθηγήτρια Λυδία,

Σε ευχαριστώ για το e-mail σου και τα συγχαρητήρια μου για την επιτυχία του Συνεδρίου. Ευχαριστώ!

Με εκτίμηση,

Luiz Henrique Gebrim

Professor of Medicine of Department of Mastology of Federal University of São Paulo, Brazil; Director of Perola Byington Hospital of São Paulo-Brazil; Member of Brazilian Academy of Ginecology and Mastology, Brazil

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ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Soran Atilla, soraax@upmc.edu
Προς: lydiamouzaka@yahoo.gr
Πέμπτη 11 Μαΐου στις 6:11 μ.μ.

Γεια σου Λυδία,

Ήταν ένα υπέροχο Συνέδριο και σ' ευχαριστώ για τη φιλοξενία.

Έχε υπόψιν σου ότι η BHWGI έχει τρέχουσες συνεχιζόμενες μελέτες και οι συνάδελφοί σου μπορούν να συμμετάσχουν σε αυτές.

Να προσέχεις τον εαυτό σου,

Αγάπες,

Soran Atilla

MD, MPH, FNCBC, FACS, Professor of Clinical Surgery, Division of Surgical Oncology, Director-Breast Disease Clinical Research Program, Director-International Breast Fellowship Program, Director-Comprehensive Lymphedema Center, Chair-SIS Research and Clinical Trials Committee, Chair-Breast Health Working Group International, Chair-NCBC Abstract Committee, Editor-European Journal of Breast Health, Maggee-Womens Hospital, University of Pittsburgh Medical Center, United States of America

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Alexander Mundinger, mundinger.alexander@gmail.com
Προς: lydiamouzaka@yahoo.gr
Πέμπτη 11 Μαΐου στις 6:36 μ.μ.

Αγαπητή Λυδία,

Το Συνέδριό σου ήταν υπέροχο και ήσουν το λαμπρό αστέρι του. Απόλαυσα κάθε λεπτό και σ' ευχαριστώ για άλλη μια φορά για αυτή τη μεγάλη εμπειρία. Ελπίζω ότι θα βρείς αρκετό χρόνο για τον εαυτό σου για να επαναφορτίσεις τις μπαταρίες.

Εύχομαι τα καλύτερα,

Alex

MD, Breast Imaging and Minimal Invasive Procedures, Breast Centre Osnabrueck, Academic Hospital NSK, Franziskus Hospital, Georgsmarienhuette, Germany

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ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Mamounas Terry, terry.mamounas@orlandohealth.com
Προς: lydiamouzaka@yahoo.gr
Σάββατο 13 Μαΐου στις 8:41 μ.μ.

Αγαπητή Λυδία,

Σ' ευχαριστούμε πολύ για όλη τη σκληρή δουλειά σου στη διοργάνωση ενός τόσο επιτυχημένου Συνεδρίου στη Ρόδο και για την υπέροχη φιλοξενία σου! Απόλαυσα απόλυτα τη συμμετοχή μου στο Συνέδριο. Η Λίζα και εγώ απολαύσαμε επίσης όλες τις κοινωνικές εκδηλώσεις, τη Ρόδο και το υπέροχο ταξίδι στη Σύμη! Ήταν υπέροχο να γνωρίσουμε τον σύζυγό σου!
Ελπίζω να σε δω σύντομα στην Ελλάδα ή σε κάποιο άλλο Συνέδριο.

Εύχομαι τα καλύτερα,
Λευτέρης
MD, MPH, Medical Director, Comprehensive Breast Program, Orlando Health Cancer Institute, United States of America

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Schlomo Schneebaum, schlomos999@gmail.com
Προς: lydiamouzaka@yahoo.gr
Σάββατο 13 Μαΐου στις 8:41 μ.μ.

Αγαπητή Λυδία,

Θέλω να σ' ευχαριστήσω και να σε συγχαρώ για το επιτυχημένο Συνέδριο.
Εύχομαι να ξανασυναντηθούμε σύντομα.

Με τις καλύτερες ευχές,
Schlomo
President Senologic International Society, President Israel Senologic Society, Professor of Surgery, Tel Aviv University, Former Head Breast Health Center and Radio Guided Surgery Unit, Tel Aviv Sourasky Medical Center, Israel

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ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Mutlu Doğan, mutludogan1@yahoo.com
Προς: lydiamouzaka@yahoo.gr
Δευτέρα 15 Μαΐου στις 11:07 μ.μ.

Αγαπητή Καθηγήτρια Μουζάκα,

Ήταν χαρά μου να παρευρεθώ σε αυτό το Συνέδριο. Ήταν εξαιρετικό.
Ελπίζω να σας συναντήσω ξανά τα επόμενα χρόνια.

Με εκτίμηση,
Mutlu Doğan
MD, Professor of Medical Oncology, University of Health Sciences; Dr Abdurrahman Yurtaslan Ankara Oncology Training and Research Hospital; Medical Oncology Department, Ankara, Turkey

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Gustavo Zucca-Matthes, anguz75@gmail.com
Προς: lydiamouzaka@yahoo.gr
Τρίτη16 Μαΐου στις 2:21 μ.μ.

Αγαπητή Λυδία,

Ήταν ένα μακρύ ταξίδι, αλλά μια φανταστική εμπειρία και μια υπέροχη ευκαιρία να επικοινωνήσω με υπέροχους και σεβαστούς φίλους.
Εκτιμώ πραγματικά που το απολαύσατε.
Ανυπομονώ να ακούσω νέα από εσάς σύντομα!

Με εκτίμηση,
Gustavo
MD, PhD, Breast Surgery/ Oncoplastic Breast Surgery, Clinica Mamare, Ribeirão Preto, Brazil

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Amir Sonnenblick, amirson@tlvmc.gov.il
Προς: lydiamouzaka@yahoo.gr
Τρίτη 16 Μαΐου στις 2:48 μ.μ.

Αγαπητή Λυδία,

Ευχαριστώ πολύ για το εξαιρετικό Συνέδριο.

Εύχομαι τα καλύτερα,
Amir Sonnenblick
Head, Breast Cancer Unit, The Oncology Division, Tel Aviv Sourasky Medical Center, Israel

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ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Alexander Mundinger, mundinger.alexander@gmail.com
Προς: lydiamouzaka@yahoo.gr
Τρίτη 16 Μαΐου στις 8:30 μ.μ.

Αγαπητή Λυδία,

Σε ευχαριστώ πολύ. Η ανταλλαγή εντυπώσεων και σκέψεων μετά από αυτό το φοβερό Συνέδριο θα αυξήσει ακόμη περισσότερο την επιτυχία του. Πολύ ωραίες εικόνες.

Εύχομαι τα καλύτερα,

Άλεξ

MD, Breast Imaging and Minimal Invasive Procedures, Breast Centre Osnabrueck, Academic Hospital NSK, Franziskus Hospital, Georgsmarienhuette, Germany

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Mehmet Ali Gülçelik, mgulcelik@yahoo.com
Προς: lydiamouzaka@yahoo.gr
Τετάρτη 17 Μαΐου στις 7:17 π.μ.

Αγαπητή Λυδία Ιωαννίδου-Μουζάκα,

Όπως ανέφερα στο μήνυμα που σας έστειλα μετά το Συνέδριο, ο χρόνος, η προσπάθεια και η αφοσίωση που επενδύσατε σε αυτό το γεγονός ήταν πραγματικά αξιοσημείωτο και φάνηκε στην άψογη εκτέλεση κάθε πτυχής του Συνεδρίου.

Ως ομιλητής και συμμετέχων, εντυπωσιάστηκα πλήρως με την ποιότητα του προγράμματος και το εύρος των θεμάτων που καλύπτονται.

Οι παρουσιάσεις ήταν ενδιαφέρουσες και ενημερωτικές και οι ευκαιρίες δικτύωσης ήταν ανεκτίμητες. Επιπλέον, εκτιμώ την προσοχή στη λεπτομέρεια που δόθηκε σε κάθε πτυχή του Συνεδρίου. Είναι προφανές ότι η ομάδα σας πήγε ένα βήμα παραπάνω για να διασφαλίσειότικάθεσυμμετέχωνείχεμιαθετικήεμπειρία.Στέλνωτομήνυματakehomesesυνημμένο

Mehmet Ali Gülçelik

MD, Professor of Radiation Oncology, Hacettepe University Medical School, Department of Radiation Oncology, Turkey

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ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Cleopatra Rapti, cleopatrapti@gmail.com
Προς: lydiamouzaka@yahoo.gr
Τετάρτη 17 Μαΐου 2023 στις 13:06

Αγαπητή Πρόεδρε της ΕΕΜ,

Ελπίζω να είστε καλά.

Θα ήθελα να εκφράσω την ευγνωμοσύνη μου για την πρόσκληση ως ομιλητή του Συνεδρίου και μου έδωσε την ευκαιρία να είμαι ανάμεσα στους ειδικούς του χώρου.

Τις καλύτερες ευχές,

Cleopatra

MD, MSc, Consultant Medical Oncologist 251 HAF ex-fellow UCLH, Breast Unit, Greece

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Effrosyni Tzintziropoulou, ftzin@almazois.gr
Προς: lydiamouzaka@yahoo.gr
Πέμπτη 18 Μαΐου στις 11:28 π.μ.

Αγαπητή Καθηγήτρια κ. Μουζάκα,

Θα ήθελα να σας ευχαριστήσω για την πρόσκληση στο Συνέδριο.

Ήταν τιμή μου να συμμετάσχω.

Τις καλύτερες ευχές,

Ευφροσύνη

Health Psychologist, MSc - Cognitive Behavioral Psychotherapist, Hellenic Association of Women with Breast Cancer "Alma Zois", Greece

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Nazim Serdal Turhal, turhal@superonline.com
Προς: lydiamouzaka@yahoo.gr
Παρασκευή 19 Μαΐου στις 6:07 μ.μ.

Αγαπητή Λυδία,

Ευχαριστώ και πάλι τόσο εκ μέρους μου, όσο και εκ μέρους της Esra για την πρόσκληση και για το ότι ήσουν υπέροχη οικοδέσποινα.

Θα θέλαμε να σε συναντήσουμε ξανά αν μας ενημερώσεις την επόμενη φορά που θα είσαι στην Κωνσταντινούπολη.

Εύχομαι ό, τι καλύτερο,

Serdal

MD FACP, Professor, Anadolu Medical Center President, Turkish Oncology Group; National Representative of Turkey in European Society of Medical Oncology; Past President of European Society of Medical Specialists, Medical Oncology Section; Past President of Turkish Society of Medical Oncology, Turkey

ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Aliki Moschis, alikimoschis@gmail.com
Προς: lydiamouzaka@yahoo.gr
Saturday, May 20 at 7:14 p.m.

Αγαπητή κυρία Μουζάκα,

Σας ευχαριστώ πολύ για την ευγενική σας επιστολή.

Ήταν και δική μου χαρά και τιμή να παραστώ στην Εναρκτήρια Τελετή του 21ου Παγκόσμιου Συνεδρίου της Διεθνούς Εταιρείας Μαστολογίας για τον Καρκίνο του Μαστού και την Υγεία του Μαστού.

Θα ήθελα να σας συγχαρώ για μία ακόμα φορά, εσάς προσωπικά και τα μέλη της Οργανωτικής Επιτροπής, για το εξαιρετικά ενδιαφέρον και σημαντικό αυτό Συνέδριο που διοργανώσατε, καθώς και για την επιλογή της Ρόδου για τη φιλοξενία του.

Το γεγονός αυτό μας τιμά και μας χαροποιεί ιδιαιτέρως.

Ελπίζω να σας έχουμε σύντομα κοντά μας και για διακοπές !

Με ιδιαίτερη εκτίμηση,

Αλίκη Μοσχή

Honorary Consul of France in Rhodes

Evrım Tezcanli, tezcanlievrim@gmail.com
Προς: lydiamouzaka@yahoo.gr
Δευτέρα 22 Μαΐου στις 7:38 μ.μ.

Αγαπητή Λυδία,

Ήταν πολύ ευχάριστο να είμαι μέρος αυτού του Συνεδρίου και να σας γνωρίσω.

Ήταν μια εξαιρετική συνάντηση, τόσο επιστημονικά όσο και κοινωνικά.

Αν έρθετε στην Κωνσταντινούπολη, θα ήθελα πολύ να σας ξαναδώ. Εάν υπάρχουν μέρη που θέλετε να πάτε, θα χαρώ να σας συνοδεύσω.

Καλή ευκολία

Χαιρετισμούς και αγάπη,

Evrim

Associate Professor of Radiation Oncology, Acibadem Altunizade Hospital, Turkey

ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Fritz.Schaefer@uksh.de, fritz.schaefer@uksh.de
Προς: lydiamouzaka@yahoo.gr
Δευτέρα 22 Μαΐου στις 4:36 μ.μ.

Αγαπητή Λυδία,

Τις καλύτερες ευχές και τις ευχαριστίες για το υπέροχα οργανωμένο Συνέδριο στη Ρόδο!! Σου βγάζω το καπέλο !!

Με εκτίμηση,
Fritz
Breast Imaging and Interventions, University Hospital Schleswig Holstein Campus Kiel, Germany

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Ei Ueno, ueno@tsukuba-breast.jp
Προς: lydiamouzaka@yahoo.gr
Δευτέρα 22 Μαΐου στις 5:38 μ.μ.

Αγαπητή Λυδία,

Θα ήθελα να σας ευχαριστήσω για την καλή σας φροντίδα σας στη Ρόδο.

Με εκτίμηση,
Ei
Director of Tsukuba International Breast Clinic. University of Tsukuba, Japan, Honorary president of the Japan Association of Breast and Thyroid Sonology, Japan

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Sechopoulos Ioannis, ueno@tsukuba-breast.jp
Προς: lydiamouzaka@yahoo.gr
Τρίτη 23 Μαΐου στις 11:58 μ.μ.

Αγαπητή Δρ Ιωαννίδου-Μουζάκα,

Σας ευχαριστώ πολύ για την πρόσκληση να συμμετάσχω και να συνεισφέρω στο Συνέδριό σας, και συγχαρητήρια για την επιτυχία του!

Με εκτίμηση,
Sechopoulos Ioannis
PhD, DABR, FAAPM, Head, Advanced X-ray Tomographic Imaging (AXTI) lab, Department of Medical Imaging Radboud University Medical Centerñ Chair of Advanced X-ray Imaging Systems, Multi-Modality Medical Imaging (M3I) Group, Technical Medical Center, University of Twenteñ Scientific Advisor, Dutch Expert Centre for Screening (LRCB), Greece

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ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Erkin Aribal, earibal@gmail.com
Προς: lydiamouzaka@yahoo.gr
Τρίτη 23 Μαΐου στις 2:24 μ.μ.

Αγαπητή Λυδία,

Ευχαριστώ πολύ για την πρόσκληση της IBUS στο Συνέδριο της SIS. Περάσαμε ευχάριστα και το Σεμινάριο της IBUS ήταν πολύ καλό. Όλοι οι συνάδελφοί μου έμειναν πολύ ευχαριστημένοι.

Καλές ευχές,
Erkin
MD, Professor of Radiology, President International Breast Imaging School (IBUS)/Zurich; Acibadem MAA University, Acibadem Altunizade Hospital, Istanbul Turkey, Turkey

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Berk Göktepe, berkgoktepe@gmail.com
Προς: lydiamouzaka@yahoo.gr
Τρίτη 23 Μαΐου στις 10:44 π.μ.

Αγαπητή Καθηγήτρια Λυδία Ιωαννίδου-Μουζάκα,

Θέλω να εκφράσω την ευγνωμοσύνη μου που μου επιτρέψατε να παρουσιάσω στο 21ο Παγκόσμιο Συνέδριο της SIS για τον καρκίνο του μαστού και την Υγεία του Μαστού. Ήταν μια απίστευτη εμπειρία για μένα.

Καλές ευχές,
Berk Göktepe
Consultant MD, Ege University Faculty of Medicine, General Surgery Department, Breast Unit, Turkey

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Lütfi Doğan, lutfidogan1@yahoo.com
Προς: lydiamouzaka@yahoo.gr
Τρίτη 23 Μαΐου στις 7:26 π.μ.

Αγαπητή Λυδία,

Σας ευχαριστώ για τη φιλοξενία σας στο 21ο Παγκόσμιο Συνέδριο της SIS για τον Καρκίνο του Μαστού και την Υγεία του Μαστού. Ελπίζω να σας ξαναδώ.

Ευχαριστώ και πάλι για όλα,
Δρ Lütfi Doğan
MD, Professor of Surgical Oncology, Head of Surgical Oncology Department, University of Health Sciences, Etlik City Hospital, Ankara, Turkey

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ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Prof. Enzo Durante - IBUS, enzodurante.ibus@gmail.com
Προς: lydiamouzaka@yahoo.gr
Τετάρτη 24 Μαΐου στις 1:50 μ.μ.

Αγαπητή Λυδία,

Ήταν χαρά μου που είχα την ευκαιρία να παρευρεθώ για άλλη μια φορά σε Συνέδριο της SIS στη Ρόδο, και σε ευχαριστώ πολύ για την πρόσκληση.

Ελπίζω ότι θα έχουμε την ευκαιρία να συναντηθούμε ξανά σύντομα.

Με θερμούς χαιρετισμούς και τις καλύτερες ευχές,

Enzo

Formen Head Institute of General Surgery, University of Ferrara, Italy

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Mimi Marcellou, mimimarcellou@gmail.com
Προς: lydiamouzaka@yahoo.gr
Τετάρτη 24 Μαΐου στις 10:41 π.μ.

Αγαπητή Δρ Μουζάκα,

Καταρχάς, επιτρέψτε μου να εκφράσω τη βαθιά ευγνωμοσύνη μου για την πρόσκληση στο Συνέδριο. Συγχαρητήρια για την προσπάθειά σας και το συνεχιζόμενο έργο σας και τη συμβολή σας στην καταπολέμηση του καρκίνου του μαστού και για την προαγωγή της υγείας στον καρκίνο του μαστού.

Με εκτίμηση,

Μιμή Μαρσέλλου

PT, MSc., PhD (c), Specialist Musculoskeletal Disorders & Pelvic Floor Physiotherapist; Vice President Europa Donna Hellas; Research Fellow of LANECASM, UNIWA, Athens, Greece

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ΚΑΛΑ ΛΟΓΙΑ - ΣΥΓΧΑΡΗΤΗΡΙΑ

Avisar Eli, eavisar@med.miami.edu
Προς: lydiamouzaka@yahoo.gr
Πέμπτη 25 Μαΐου στις 4:21 μ.μ.

Γεια σας Λυδία,

Ήταν τόσο ωραίο να σας συναντήσω προσωπικά και να επισκεφθώ το όμορφο νησί της Ρόδου.

Με εκτίμηση,

Eli

M.D., F.A.C.S., Professor of Surgery, Division of Surgical Oncology, Department of Surgery University of Miami Miller School of Medicine, Director Breast Surgical Oncology Fellowship University of Miami and Jackson Memorial Hospital; Medical Director, Taylor Chaplin Breast Health Center, Jackson Memorial Hospital, United States of America

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Nicholl Ciarán, ciaran.nicholl@ec.europa.eu
Προς: lydiamouzaka@yahoo.gr
Πέμπτη 25 Μαΐου στις 4:59 μ.μ.

Γεια σου αγαπητή Λυδία,

Και το πιο σημαντικό, ελπίζω ο σύζυγός σου να έχει εν τω μεταξύ αναρρώσει πλήρως.

Ευχαριστώ και πάλι για αυτή τη μεγάλη ευκαιρία και τους χαιρετισμούς μου,

Ciarán

Phd, MSc, BSc, NDSc, NCSc, NDQC, Head of Unit, European Commission-Joint Research Centre, Italy; European Commission, Directorate General Joint Research Centre, Directorate F – Health and Food Unit F1 - Disease Prevention - Head of Unit, Italy

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Sardeli Cristina, sardeli@ekirikas.com
Προς: lydiamouzaka@yahoo.gr
Πέμπτη 25 Μαΐου στις 5:33 μ.μ.

Καλησπέρα κα Μουζάκα & κα Ξανθή,

Σας μεταφέρω τα θερμά συγχαρητήρια της Διοίκησης του Εθνικού Κήρυκα, μας κάνατε ιδιαίτερα υπερήφανους ως Έλληνες.

Παρακαλώ δείτε στην Home page το Δελτίο Τύπου, αναρτήθηκαν από τη διεξαγωγή του "21st SIS World Congress on Breast Cancer and Breast Healthcare" που έλαβε χώρα 3-6 Μαΐου 2023 στη Ρόδο.

Καλές ευχές,

Cristina Sardeli

Journalist of the Newspaper «Ethnikos Kirikas»

Hagigat Valiyeva, doctorhagigat1@gmail.com
Προς: lydiamouzaka@yahoo.gr
Πέμπτη 25 Μαΐου στις 6:09 μ.μ.

Αγαπητή Καθηγήτρια Λυδία Μουζάκα,

Σας ευχαριστώ για την πρόσκλησή σας και το σπουδαίο Συνέδριο.

Με εκτίμηση,

Hagigat

MD, PhD, Associate professor of Oncology Department of Azerbaijan Medical University; Faculty Member on Azerbaijan Medical University; Founder of Azerbaijan Breast Diseases Specialists Association, Azerbaijan

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Răzvan Andrei, andreiioanrazvan@gmail.com
Προς: lydiamouzaka@yahoo.gr
Κυριακή, 10 Ιουνίου στις 10:59 μ.μ.

Αγαπητή Καθηγήτρια κ. Μουζάκα,

Σας ευχαριστώ πολύ για την ευκαιρία να γνωρίσω εμπνευσμένες προσωπικότητες από όλο τον κόσμο, να μιλήσω και να προεδρεύσω Συνεδρίας. Μου άρεσε πραγματικά αυτή η εμπειρία.

Η Ρόδος και ειδικά η Ελλάδα θα μείνει για πάντα στην καρδιά μου, γιατί ήταν το πρώτο μου Διεθνές Συνέδριο.

Ανυπομονώ για το επόμενο!

Răzvan Andrei

MD, PhD, Candidate -"Carol Davila" University of Medicine and Pharmacy Bucharest; Scientific Officer - Romanian Society of Breast Surgery and Oncology; Fellowship in General Surgery – "Prof. Dr. Al. Trestioreanu" Institute of Oncology Bucharest, Romania

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Hans-Joachim Frischbier, hjfrischbier@gmail.com
Προς: lydiamouzaka@yahoo.gr
Κυριακή, 11 Ιουνίου στις 11:47 μ.μ.

Αγαπητή μου Λυδία,

Εγκάρδια συγχαρητήρια για το υψηλής επιτυχίας Συνέδριο το οποίο διοργάνωσες κάτω από προβληματικές συνθήκες.

Με τα καλύτερά μου αισθήματα

Joachim

Professor of Gynecological RadioTherapy University of Hamburg, f. Vice President of the Cenologic International Society for Europe

ΜΗΝΥΜΑ ΓΙΑ ΤΟ ΣΠΙΤΙ

003 PREGNANCY-ASSOCIATED BREAST CANCER; TIMING OF SURGERY

Didem Can Trabulus

MD, Bahcesehir University School of Medicine Göztepe Medicalpark Hospital General Surgery Department, Turkey

- PABC is defined as breast cancer diagnosed during pregnancy and in the first postpartum year
- It is the most common cancer in pregnant women
- Diagnosis and staging work-up are difficult due to the physiologic changes in the breast and radiation exposure to the fetus
- Pathology is mostly infiltrating ductal adenocarcinomas (IDC) Nonluminal type with or without Her2 positivity
- Mammography is not contraindicated with an abdominal shielding but its' sensitivity is low.
- Ultrasonography is safe
- Breast MRI without gadolinium is more sensitive than mammography
- Core biopsy under local anesthesia is safe during pregnancy
- Systemic staging is necessary only for LABC disease.
- Chest radiograph is used with fetal shielding, computed tomography (CT) scans are avoided, MRI is preferred without gadolinium.
- Treatment is the same as nonpregnant patients, with some modifications to protect the fetus. Treatment should be curative and should not be unnecessarily delayed. Termination of pregnancy has no effect to improve outcomes.
- Surgery is safe in any trimester. SLNB can be safe with 99mTc sulfur colloid but blue dye is contraindicated.
- Radiation therapy should be postponed after delivery. Breast conservation in the first trimester can cause radiotherapy delays.
- Anthracycline-based chemotherapy can be started at the13th week after organogenesis and should be completed at the 35th week, in order to avoid transient neonatal myelosuppression and postpartum bleeding. Smart drugs are contraindicated during pregnancy and postponed after delivery.
- For the Luminal tumors HT is delayed to be used after delivery.

005 INTERMEDIATE AND MALIGNANT PHYLLODES TUMORS; WHAT IS THE CURRENT GUIDELINES FOR LOCAL THERAPY?

Hagigat Valiyeva

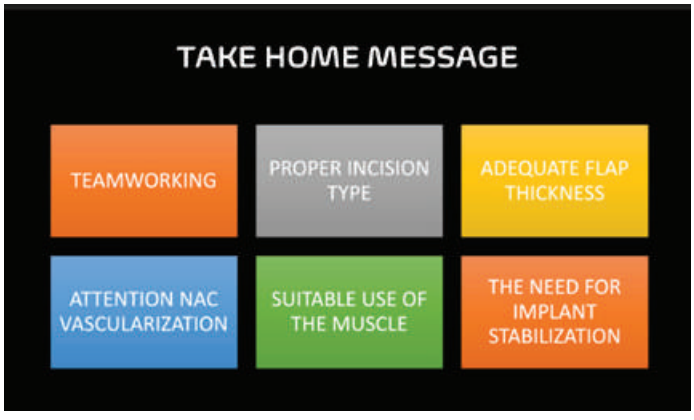
MD, PhD, Associate professor of Oncology Department of Azerbaijan Medical University; Faculty Member on Azerbaijan Medical University; Founder of Azerbaijan Breast Diseases Specialists Association, Azerbaijan

- Ultrasound, magnetic resonance imaging, and core needle biopsy are valuable preoperative diagnostics tools.
- Pathology reporting should include stromal overgrowth, stromal cellularity, nuclear atypia, mitotic rate, borders, and presence of heterologous elements. Ki67 may have a role in grading and prognosticating.
- Breast conversation is safe in all grades of phyllodes but may be associated with increased local recurrence in malignant phyllodes.
- Surgical margins should depend on grade.
- Axillary node positivity rate is very low, even with clinically enlarged lymph nodes.
- Adjuvant radiation is a useful tool to decrease local recurrence in malignant PTs, tumors >5cm, age <45years, close margins, and breast conservation.
- There is no evidence supporting adjuvant chemotherapy.
- Recurrence can be managed with repeat wide excision; however, mastectomy is associated with lower re-recurrence.
- Surveillance protocols are variable in the literature.

006 NSM INDICATIONS AND CONTRAINDICATIONS

Mustafa Şehsuvar Gökgöz

MD, Professor, Nipple-Sparing Subcutan Mastectomy (NSSM), Endication And Contra-Endication Bursa Uludağ University Faculty Of Medicine, Oncological Breast Surgery, Turkey



009 ROLE OF RADIOTHERAPY TO METASTATIC SITES IN DE NOVO STAGE IV BREAST CANCER

Melis Gultekin

MD, Professor of Radiation Oncology, Hacettepe University Medical School, Department of Radiation Oncology, Turkey

Approximately 6-10% of the patients with breast cancer present with oligometastatic disease (OMD) at the time of diagnosis, which is called "de novo OMD".1 It is usually defined as 1 to 5 metastases confined to ≤2 organs.2 Although the primary treatment modality in OMD is still systemic treatment, local ablative treatment may be curative in selected patients. Stereotactic body radiotherapy (SBRT) or stereotactic ablative radiotherapy (SABR) is the application of high-dose radiation in a single or few fractions to the extracranial sites. There are a limited number of studies regarding the role of SABR in oligometastatic breast cancer (OMBC). The 2-year local control (LC) rates were reported as more than 87% and the 2-year overall survival (OS) rates were reported between 57% and 100% with low toxicity profile.3 Patients with primary controlled and young age, with solitary metastasis and small tumor volume, at least partial response to systemic treatment and have long disease-free interval after the first diagnosis and favorable molecular subtypes benefited most from SABR. In addition, patients with bone only metastases show favorable prognosis. The SABR-COMET trial is the first phase II randomized trial comparing the efficacy and toxicity of SABR with standard of care (SOC) in patients with OMD.4 There was an absolute 25% of OS benefit with SABR. In addition, SABR offers improved durable long-term control compared to SOC treatment, but three patients died due to the toxicity. Although this study is the first randomized phase II study demonstrating the benefit of ablative treatment in OMD, only 20% of the patients had breast cancer. The NRG-BR002 trial is the only randomized phase II trial confined to the OMBC.5 In this trial patients with primary controlled disease, 1-4 extracranial metastases and no clinical progression for up to 12 months on systemic treatment were randomized to receive systemic treatment alone or systemic treatment plus local ablative treatment to all metastatic sites. Most of the patients had only one metastasis and 80% of them were with hormone receptor positive and HER2 negative. In addition, 80% of the patients had metachronous OMD. Although majority of the patients have favorable prognosis in this trial, no beneficial effect of local ablative treatment was shown on the contrary to retrospective series. Though there was no difference in new metastases outside the treated lesion, there was a lower rate of progression within the treated sites. Based on the phase II analysis, the subsequent planned phase 3 trial enrollment was cancelled. There are many ongoing trials evaluating the role of local ablative treatment in OMBC patients. Until these studies are completed, it is difficult to make clear recommendations on the role of local ablative treatment in OMBC. As a conclusion, OMBC patients have a long-life expectancy, and they deserve multidisciplinary approach. Although systemic treatment is the SOC, local ablative therapies may produce LC and survival benefit in a selected group of patients. More phase III breast-specific trials are required especially for HER2 positive and synchronous OMBC patients.

010 DE-ESCALATION OF RADIOTHERAPY IN PATIENT WITH PATHOLOGIC COMPLETE RESPONSE

Evrim Tezcanli
Associate Professor of Radiation Oncology, Acibadem Altunizade Hospital, Turkey

The landscape of breast cancer treatment has undergone significant changes, with numerous studies assessing the potential benefits of de-escalating various treatment modalities. Neoadjuvant therapy, in particular, holds promise for altering the radiotherapy paradigm, particularly in cases of complete responders. However, despite these encouraging prospects, the implementation of de-escalation strategies in clinical practice awaits the outcome of randomized controlled trials.

012 DCIS; SURGERY VS NO SURGERY

Göktürk Maralcan
MD, Professor of General Surgery, Department of Sanko University Medical Faculty; Breast Surgeon, Endocrin Surgeon, Turkey

DCIS: Heterogen pre-invasive breast lesion.

Why do we treatment DCIS?
«To prevent to breast cancer»

DCIS is not agresive disease.
Can we plan to do «active surveillance?»
No Overdiagnosis
No Overtreatment

Pathologists Can Do De – escalation? Pathologist is very important person for DCIS management. ADH vs DCIS patological diagnosis: Pathologists have a potential to play a critical role. The introduction of molecular testing has increased the recognition of lower risk subtypes, and less aggressive treatments are more commonly recommended for these subtypes.

SOME CASES of DCIS CAN NOT OPERATE: Low risk DCIS cases can management without surgery.
Clinical Trials of Active Surveillance for DCIS
There are some studies about low risk group patients with DCIS (Loris, Lord, Comet, Loretta)
Low Risk DCIS
>40 years old
Core/vacum biopsy: Low or intermediate grade
There is no invasive cancer story
ER/PR: positive, HER 2: negative
No mass (physical exam, radiological) Small one: 1cm, <2.5cm

Take Home Message

The group of patients that without locoregional treatment can be follow actively:

>40 years old
low grade DCIS
unifocal
ER, PR +
Risk stratification with genomic molecular assay

Finally, randomize studies results can help our decision for DCIS treatment in the future.

Summary

Some DCIS cases do not progress invasive cancer without surgery.
Low risk DCIS can treat without surgery.
Active surveillance can perform to low risk DCIS cases.
Patients should be discussed within a multidisciplinary team.
Results are eagerly awaited as 4 phase III trials.

013 "LCIS TYPES AND SURGERY INDICATIONS"

Levent Yeniay

Professor in Surgery, Fellow of European Breast Surgery (FEBS), Ege University Medical Faculty Dept of General Surgery, Izmir, Turkey

"According to the WHO, 3 types of Lobular Carcinoma In-situ have been defined as Classical, Florid and Pleomorphic. The incidence of this entity, which does not have a typical examination and imaging finding, in benign breast biopsies is between 0.5-4%. It is mostly multicentric. The risk of breast cancer increases 8-10 times on both sides, higher on the ipsilateral side. If LCIS is seen in Tru-cut biopsy, it can be followed without surgical excision if there is no doubt in the radiological-pathological correlation. Otherwise, surgical excision is recommended. Chemoprevention has been shown to be effective in reducing the risk of breast cancer in classical type LCIS. The biological behavior of pleomorphic LCIS is very similar to DCIS. Therefore, unlike other forms, surgical margin negativity should be ensured in P-LCIS and adjuvant RT should be evaluated. Risk-reducing mastectomy should only be considered in the presence of additional risk factors."

014 LEVEL I ONCOPLASTIC BREAST SURGERY; BASICS

Berk Göktepe
Consultant MD, Ege University Faculty of Medicine, General Surgery Department, Breast Unit, Turkey

Today, oncoplastic surgery techniques have become growingly used with the increase of patient requests and cosmetic concerns. Many different techniques have been described at different levels. Some of these techniques require advanced skills and experience. However, there are a few points that should be considered in order to obtain a satisfactory result for both the patient and the surgeon. The first is to choose the proper technique for the patient. It varies according to the size, shape, and structure of the breast, the age of the patient and additional diseases, the size and location of the tumor. If the patient does not desire or require a lift +/- reduction, and if the tumor can be removed with excision of <20% of breast tissue, then usually level I oncoplasty is the proper technic. Level I techniques are the simplest to apply. The most crucial point to be considered in this technique is to free the glandular flaps sufficiently and not to leave any cavities in the breast tissue. Remember that sometimes simple is best. Choosing the simplest technique with the most minor complications among the suitable techniques for the patient will be appropriate.

016 CHEMOTHERAPY INDICATIONS IN LUMINAL B-LIKE TUMORS

Mutlu Doğan
MD, Professor of Medical Oncology, University of Health Sciences; Dr Abdurrahman Yurtaslan Ankara Oncology Training and Research Hospital; Medical Oncology Department, Ankara, Turkey

Luminal like breast cancer is defined as hormone receptor [ER (estrogen receptor) and/or PR (progesterone receptor)] positive breast cancer. Luminal A-like tumors are HER2 negative tumors have favorable prognosis with mainly endocrine treatment. However, HER2 positivity has key role in luminal B-like tumors. HER2 positive luminal B-like breast cancer treatment is mainly based on anti-HER2 treatments. HER2 negative luminal B-like breast cancer differs from luminal A-like tumors for PR positivity and/or ki67 levels. HER2 negative luminal B-like tumors are ER(+), PR(- / low positive) and/or ki67 (high) tumors. Cut-off level as 20% for PR and ki67 is generally acceptable as optimal level in recent years. Major component of these patients' treatment is also endocrine treatment. However, some of them also need chemotherapy, almost in early stage.

HER2 negative luminal-like breast cancer patients with nodal involvement (LN >4) are generally given neoadjuvant treament. If they are directly operated with postoperative pathology reveals pN2-pN3 disease, they are given adjuvant treatment including chemotherapy and endocrine treatment. The patients with lymph nodes (LN: 0-3) should be evaluated by molecular genomic tests. Molecular genomic tools, such as «*Oncotype-Dx, MammaPrint, PAM-50, EndoPredict and BCI tests*» are available for adjuvant treatment decision in luminal-like breast cancer. All of these tests are prognostic. Lower risk patient are treated with adjuvant endocrine treatment while higher risk groups get benefit from adjuvant chemotherapy. However, intermediate risk group in Oncotype Dx should be evaluated more carefully. In TailorX trial,

OncotypeDx intermediate risk (RS: 11-25) node negative patients were detailed. Younger (<50 years) premenopausal women in intermediate risk group with higher clinical risk had more benefit from adjuvant chemotherapy. In longer follow-up of ITT population, younger women with RS (16-25) had marginal adjuvant chemotherapy benefit, however those with RS (21-25) had evident greatest benefit in intermediate risk group (1). In RxPONDER trial, node positive (LN: 1-3) premenopausal patients with OncotypeDx RS (< 25) had survival benefit from adjuvant chemotherapy (2). MINDACT trial showed adjuvant chemotherapy benefit in younger (<50 years) 'clinical/genomic discordant' patients according to MammaPrint, as well (3).

In conclusion, HER2 negative luminal like tumors (T1b-3N0-1) should be evaluated by molecular genomic tests for adjuvant treatment decision, if it is possible. Pathological and clinical characteristics should be taken into account for better outcomes.

017 STATE OF THE ART AND ADVANCEMENTS IN MULTIMODALITY BREAST IMAGING

Fritz Schaefer

Breast Imaging and Interventions, University Hospital Schleswig Holstein Campus Kiel, Germany

- High accuracy for dig. Mx
- 3D Tomo for now and the future
- Add US for dense breasts
- Double reading and expert reading with better performance than CAD
- AI and ABUS: wait and see
- Elastography with good potential
- MRI for special indications

018 ELASTOGRAPHY IN MASS AND NON-MASS LESIONS

Ei Ueno

Director of Tsukuba International Breast Clinic. University of Tsukuba, Japan, Honorary president of the Japan Association of Breast and Thyroid Sonology, Japan

Generally, breast cancer is harder to the touch, in comparison with normal fatty tissue. This property serves as the basis for some examinations used in the clinical assessment of breast abnormalities, such as palpation. Dynamic tests using real-time ultrasound to assess the consistency of breast masses were described by Ueno and others in 1986 and before. Elastography is a development from this type of technique and can be roughly divided into strain elastography and shear wave elastography. The description below relates to strain elastography, and more specifically in the form implemented by Hitachi Medical Systems.

Classification of Non-mass lesions

The multi-step genesis type of abnormality does not form a mass for a long time, and it is not rare that cancer is detected in this period by breast screening with mammography or ultrasound. Cancer cells initially mainly multiply in the duct and ductule of the terminal duct-lobular unit (TDLU). Ductules are extended while unfolding with the growth of cancer, and, as a result,

lobules are expanded. Then, cancers spread along the mammary ducts, so that lobules are observed to continue through mammary ducts on ultrasound images. Furthermore, cancers proliferate in mammary ducts and fuse with each other. Finally, mutation happens in a part of the DCIS and develops into invasive carcinoma. On the other hand, the De novo type suddenly develops into an invasive cancer without passing through multi-steps . Non-mass abnormalities are detected in the middle of the multi-step sequence, and most are DCIS. On breast ultrasound, they are subdivided into four types:

(1) Abnormalities of the ducts, (2) Hypoechoic areas in the mammary glands, (3) Multiple small cysts, (4) Architectural distortion.

Elasticity Score classification of non-mass lesions

The Tsukuba elasticity score is judged on the basis of strain colour in the low echo area. The hardness is displayed along a colour spectrum: the soft tissues are displayed in red, and the hard tissues in blue. The lesions that have a low echo level and are shown in the red - green are classified with a Score of 1, and the lesions in which blue is mixed with green are classified with a Score of 2. The cases with much blue are classified with a Score of 3, the cases which show as blue in the whole low echo area are classified with a Score of 4, and the cases which appear blue over the entire low echo area are classified with a Score of 5. It is extremely rare for the lesion to be malignant if the elasticity Score is 1. When micro-calcifications are confirmed in the solid part, it is more likely to be malignant. Therefore, if tissues are displayed in green by strain elastography in the presence of micro-calcifications, the microcalcification findings are given priority over the elasticity score. The benign/malignant cut-off was between 3 and 4 for mass cases, whereas the cut-off score for non-mass lesions was between 2 and 3.

019 PRE-TREATMENT LOCAL AND REGIONAL STAGING BY ULTRASOUND

Enzo Durante

Full Professor of General Surgery University of Ferrara - Italy former Head Inst. of General Surgery Former Head Multidisciplinary Breast Team

- US is an effective, readily available, and inexpensive tool for evaluating the breast cancer size enabling a 3D imaging
- Accurate assessment of tumor extension becomes increasingly important for guiding adequate surgical treatment
- US should be performed in all the patients before every surgical procedure
- Preoperative axillary staging plays an important role in surgical planning.
- US-guided biopsy of index lesions and abnormal nodes may identify completely the disease increasing the disease stage and providing important prognostic implications for the patient.

Breast US valuable in low-income countries. A study conducted in Africa found that breast ultrasound can be used successfully by trained nurses and clinicians to detect lesions in areas where radiologists are scarce. Breast ultrasound performed by non-radiologists with adequate training and ongoing mentorship could play an important role in efficient evalua-

tion of palpable masses.

Pace LE, Vianney Dusengimana JM, Hategekimana V, et al.: Clinical Diagnoses and Outcomes After Diagnostic Breast Ultrasound by Nurses and General Practitioner Physicians in Rural Rwanda. JACR 2022, 19, 8:983-989.

If the US are good for women in low income countries why can't they be used for all women in all rich and less rich countries at the highest level by real experts combining expertise with the gold standard?

There has been much talk in recent days about the announcement that highly effective mRNA vaccines against cancer, cardiovascular disease, and other diseases will be available soon. The news has been accompanied by premature enthusiasm, especially in light of the TRACERx study.

Lead author Professor Charles Swanton, in an interview with BBC, took stock of the situation.

"In his view, the situation is not so rosy despite mRNA vaccines. According to what TRACERx has brought to light, cancer has an almost infinite capacity to evolve. As a result of this, finding a universal cure at present appears rather utopian.

To get the most out of it, we must continue to focus on prevention, early detection and early diagnosis of relapsed cases".

In conclusion, although US has long been considered an imaging technique only as an adjunct, at least in our field, clinical US used for diagnostic and staging purposes appears to be an important aid to the physician by helping him or her to perform visual medicine. All this takes place in a context where the physician remains a physician and the patient a patient. Even in the age of AI, this force will remain an invaluable aid. I foresee a bright future for US, this «sleeping giant» as many say, as a real stethoscope according to our knowledge or as the surgeon's third hand according to my experience.

020 NEOADJUVANT – TREATMENT IMAGING TO ASSIST THE ONCOPLASTIC SURGEON

Erkin Aribal

MD, Professor of Radiology, President International Breast Imaging School (IBUS)/Zurich; Acibadem MAA University, Acibadem Altunizade Hospital, Istanbul Turkey, Turkey

For Neoadjuvant Patient Evaluation:

- Multimodality – multiparametric documentation tumor is essential to make clear:
- Mutifocality- multicentricity
- Simultaneous Contralateral breast tumor
- Extent of the disease – DCIS component
- For fatty breasts MMG and US is sufficient
- For Dense breast tissue MRI should be added
- Axillary Status – US is the best choice of imaging and Biopsy must be performed if necessary
- Monitoring for Response with MRI

Surgery Planning: Should be done before treatment with Surgeon and Radiologist

021 UPGRADE AND ADVANCEMENT IN INTERVENTIONAL BREAST ULTRASOUND

Alexander Mundinger

MD, Breast Imaging and Minimal Invasive Procedures, Breast Centre Osnabrueck, Academic Hospital NSK, Franziskus Hospital, Georgsmarienhuette, Germany

1. Puncture always parallel to the transducer plane
2. US-guided Core biopsy is method of choice, vacuum assisted biopsy for special cases
3. New marking tools can expand the time span to surgery

022 FUTURE HORIZONS OF ULTRASOUND AND OPTICAL IMAGING

Jeff Bamber

PhD, Joint Department of Physics, Institute of Cancer Research and Royal Marsden Hospital Deputy Dean, ICR; Team Leader, Ultrasound and Optical Imaging; Professor of Physics Applied to Medicine, United Kingdom

I provided a brief review of some selected research and developments in the technology for breast ultrasound, including: novel forms of elastography that should provide new biomechanical information on viscosity and interstitial permeability currently not used in the clinic, quantitative imaging of breast density and tumour composition using ultrasound computed tomography, photoacoustic imaging of oxygen saturation for patient stratification prior to radiotherapy or chemotherapy, and new interventional uses of clusters of microbubbles and oil microdroplets for biomechanically assisting chemotherapy by increasing the proportion of circulating drug that is delivered to the tumour. These are just a few of the exciting current developments that indicate the strong potential for substantial improvements in the technology and hence the role for breast ultrasound.

023 BREAST CANCER RECCURENCE OR NOT?

Salete Rego

MD, Radiological Department, Federal University Antonio Pedro, Fluminense/UFF, Rio De Janeiro, Brazil

NODULAR FASCIITIS

- Nodular fasciitis was the unexpectated diagnosis of a fast growing tumor developing 8 years after mastectomy
- Nodular fasciitis showed infiltrative and pseudosarcomatous features.
- Combined clinical and pathological features made the final diagnosis.

024 QUALITY ASSURANCE IN SCREENING MAMMOGRAPHY

Solveig Hofvind

Professor at the Artic University of Norway, University of Tromsø; Head of Cancer Registry Breast Screen, Norway

- Breast cancer screening with mammography is recommended for women aged 50-60 by European and international health institution
- European guidelines for quality assurance are available
- One common way of measuring and reporting results of QA indicators will make us able to use data from different programs for quality improvements
- Guidelines require continuous updating to be of value
- Quality assurance should be stratified by "age" of the screening program – different indicators are important for new-established programs versus those ran for a long time

025 BREAST CANCER SCREENING IN 2023. TOMOSCREENING TO ALL WOMEN

Filiz Elbüken

MD, Associate Professor of Radiology, Turkey

Breast cancer is the leading cause of cancer aged 20–59 years women.

Mammography is the standard of care for the early detection and reduces mortality from breast cancer .

Digital breast tomosynthesis (DBT) is a nice development of the traditional mammography technique which is very well known.

DBT can eliminate superimposition and is especially superior for younger women with dense breasts.

There have been many proscpective and retrospective trials performed in Europe and United States that investigated DBT vs DM. All these studies showed increase in cancer detection (36%) although performed with different protocols and different age groups.

Reduction in false positive recalls 20% by using DBT.

DBT is replacing DM.

Artificial AI can also be used as an adjunct tool to DBT to reduce time.

026 BREAST CANCER. SCREENING FOR SPECIFIC GROUPS

Gebrim Henrique Luiz

Professor of Medicine of Department of Mastology of Federal University of São Paulo, Brazil; Director of Perola Byington Hospital of São Paulo-Brazil; Member of Brazilian Academy of Ginecology and Mastology, Brazil

- Importance of CBE (Fast growing tumors and < 50y)
- Difficulties in individualize risk
- Cost and effectiveness

- Acceptability in low risk population
- Uncertain mortality reduction and overdiagnosis
- New risk score feasible
- Risk reduction strategies

027 BREAST CANCER. SCREENING FOR SPECIFIC GROUPS. COST-EFFECTIVENESS OF SCREENING

Alexander Mundinger

MD, Breast Imaging and Minimal Invasive Procedures, Breast Centre Osnabrueck, Academic Hospital NSK, Franziskus Hospital, Georgsmarienhuette, Germany

- Importance of CBE (Fast growing tumors and < 50y)
- Difficulties in individualized risk
- Cost and effectiveness
- Acceptability in low risk population
- Uncertain mortality reduction and overdiagnosis
- New risk score feasible
- Risk reduction strategies

030 ROUND TABLE 2: SENOLOGY AS SPECIALTY "JAPANESE VIEW"

Shigeru Imoto

M.D., Ph.D., Professor, Department of Breast Surgery, Kyorin University School of Medicine, Japan

The 21th SIS World Congress on Breast Cancer and Breast Healthcare.

I presented 3 topics at this session: current status of breast cancer (BC) in Japan, projects on the Japanese Breast Cancer Society (JBCS) and an international retrospective cohort study of the Federation of Asian Clinical Oncology (FACO).

The incidence of BC for Japanese women is increasing in number since 1993. The Lifetime probability of BC was estimated at 10.6% from the report of the National Cancer Research. From the trend of clinical stage distributionin annual report of JBCS, the proportion of early BC gradually increases, but advanced or metastatic BC still has a constant proportion. As mentioned about some characteristics, the three-fourth hasso-called "luminal-like" subtype. Absolute numbers of initial diagnosis at age distribution have 2 peaks of age 45-49 and 60-64. This clinicopathological finding is similar among the neighboring countries of Japan. By the way, premenopausal women often have dense breast,which is difficult to detect early BCby mammography. Therefore, the Japan Strategic Anti-Cancer Randomized Trial (J-START) conducts a randomized phase III study on sensitivity and specificity of mammography and adjunctive ultrasonography to screen for BC at age 40s. From the first report published in the "Lancet" in 2016, the sensitivity was significantly higher in the intervention group screened by clinical breast examination, mammography and ultrasound than in the control group done by clinical breast examination and mammography (91.1% versus 77,0%). On the other

hand, the specificity was significantly lower (87.7% versus 91.4%). The outcome among the 2 groups is being investigated.

JBCS started as the "Japanese Breast Cancer Seminar" in 1964 and was founded in 1992. We cerebrated the 30th anniversary of the foundation last year. As of April 2022, 8,749 medical staff belonged to our society. Among them, 68% of members was classified as surgical oncologist.JBCS encourages clinical study, research, education and training regarding BC for members.Finally, JBCS contributes to public health for Japanese women. About ourmission, general meeting and 7-local society meetings are held annually. The official journal "Breast Cancer (IF: 3.307)", several guidelines for physicians and BC patients, bulletins and educational bookfor members are published. JBCS also cooperates with national and international academic societies. JBCS became an active member of SIS in 2020.JBCS and the "Global Breast Cancer Conference"concluded the MOU in 2020 and mutual joint session is held at each annual meeting. JBCS has been training breast specialist since 1997. As of January 2023, 1,944 active members were qualified. Furthermore, JBCS promotes BC registry by using the "National Clinical Database" andclinical cohort studies on Japanese BC are reported to high quality journals every year.

To improve the standard of care of cancer treatment through cooperative studies on more effectivetherapeutic strategies, FACO was established in 2012 by theChinese Society of Clinical Oncology, the Korean Society of Medical Oncology and theJapan Society of Clinical Oncology. FACO performed an international retrospective cohort studyto clarify the survival benefit of locoregional and systemic therapy (ST) in oligometastatic BC (OLIGO-BC1,UMIN No.000030047). Patients with oligometastatic BC diagnosed from 2007 to 2012 were enrolled from center hospitals in China,Korea and Japan. The primaryendpoint was overall survival (OS) from the initial diagnosis of oligometastases. Among 1,295 cases registered from February 2018 to May 2019, 932 remained for analysis after theexclusion of unavailable cases and locoregional recurrence. At the median follow-up of 4.5 years, 5-year OS was 54.7% and 39.7%for 321 cases in the combination therapy group and 611 cases in the ST group, respectively. An adjusted hazard ratio was 0.66 (95% confidence interval: 0.55, 0.79). Some type of ST without chemotherapy alone, youngerage, ECOG performance status 0, early-stage BC, non-triple negative subtype, fewer metastatic sites andlonger duration of surgery to relapse were significantly favorable prognostic factors. Our findings suggests that combination therapy should be considered for longer survival under some conditions in oligometastatic BC.

In conclusions, BC in Japan is increasing in number and characteristic of the proportion ofluminal subtype and premenopausal women. JBCS actively contributes to overcoming BC. A retrospective cohort study suggests clinical benefits of locoregional and ST in oligometastatic BC.

031 SENOLOGY AS SPECIALTY- CHINESE VIEW. BREAST CANCER SCREENING AND MANAGEMENT IN CHINA

Dr. Xishan Hao
MD, PhD, Director, Tianjin Cancer Institute; Honorary President, China Anti-Cancer Association, China

Breast cancer is a significant public health issue in China, with incidence rates steadily increasing over the past decade. The estimated incidence and mortality rate of breast cancer among Chinese women in 2020 were 416,371 (19.9%) and 117,174 (9.9%), respectively ranking first and fourth. The implementation of comprehensive breast cancer regular screening and timely management programs has been identifiedas an essential strategy to reduce the burden of this disease in China.

Several large-scale population-based pilot projects have recently been conductedfor breast cancer screening, utilizing physical examination, mammography, breast ultrasonography (BUS), and breast MRI as common screening methods. For example, from 2008 to 2011, we implemented a breast screening project that covered 829,000rural and 432,000 urban women, among whom were diagnosed with 431 and 307 cases of breast cancer respectively. Our findings suggest that the combination of mammography and ultrasonography is a more sensitive approach for detecting small and early-stage breast cancer, especially among Chinese women who have smaller and denser breasts.

Based on these findings, the first large population-based «Breast Cancer Screening Guidelines for Chinese Women» was released in 2019. These guidelines recommend regular breast cancer screening for women over the age of 40, includingan annual clinical breast exam and mammography every 2 years. For women withdense breasts and negative mammograms, additional ultrasound screening is recommended. For women with a high risk of breast cancer due to family history or other factors, it is recommended that they start regular screening earlier using MRI as the primary screening method.

Overall, significant progress has been made in breast cancer screening and earlydiagnosis in China through the utilization of imaging and biomarkers, as well as education and awareness campaigns. Continued efforts are necessary to further reducethe morbidity and mortality of breast cancer in China. This includes regular screenings for early detection, access to high-quality healthcare services, increasedpublic awareness of breast cancer, and optimized treatment and supportive cancer care for patients with this disease.

032 SENOLOGY AS SPECIALTY. QUALITY IN BREAST PRACTICE

Ayfer Kamali Polat
MD, FACS, Ondokuz Mayıs University, General Surgery Department, Breast Surgery, Turkey

Breast Cancer is heterogenous disease, and its different molecular characteristics require specific management approach and multidisciplinary decision making. On the other hand, quality of life, lymphedema, fertility and risk management are specific problems and important concerns for breast cancer survivors and are main topics for quality in breast practice.There are many organizations in the world working on standardization of breast centers. One of them

is "the National Quality Measures for Breast Centers" (NQMBC) focused on breast centers, and the quality of breast surgeons called "the NQMBC-Surgeon

Program" developed by the National Consortium of Breast Centers™ in United States since 2005.The NQMBC® is a web based voluntary quality program that identifies 42 performance measures designed to evaluate quality breast care, provides immediate access to quality information and allows breast centers to compare their performance with other centers across the United States and beyond. New Project of NQMBC is international adaptation of quality measures. Prof.Dr. AyferKamalıPolat, responsible for international Collaboration of NQMBC, has announced the invitation of message of Prof. Dr. Cary S. Kaufman, the chairman of NQMBC program, for breast specialist colleagues to participate the NQMBC international programs.

Breast surgeons must have the most up-to-date knowledge about all areas of senology, including oncology, radiology, pathology, reconstructive surgery, genetics and survivor issues.

Currently, improving experience for senology as specialty is based on obtaining by voluntary post-residency surgery educations and enhancing the skills, such as

hands-on courses such as oncoplastic surgery, ultrasound, stereotactic biopsy, cryosurgery, genetics etc. Breast surgery fellowships programs are the most structured examples for senology specialty in the world,organizing by some oncology and surgery societies, that are focusing in all areas of breast diseases, however these societies are professional associations not governmental bodies. It is known that none of the fellowship programs are recognized by governments.

Due to complexity of breast care, senology should be a specialty in medicine. There must be specific structured "specialization training educational program of senology" and worldwide recognized diploma for senologyas specialty.

033 SENOLOGY AS SPECIALTY: HIGHLIGHTINGS ON THE NEED FOR SENOLOGY TO BECOME A SPECIALTY

Lydia Ioannidou-Mouzaka

MD, PhD, Ass. Professor, University of Athens Medical School; Gynecologist-Surgeon-Senologist; National Representative of Greece in the European Committee Initiative on Breast Cancer in Breast Cancer and Breast Centers; Representative of the Hellenic Medical Association in UEMS for the needs in Breast Cancer Surgery President, Hellenic Senologic Society, Director, Hellenic School of Senology

The specialized Breast Surgeon-Senologist should know how to read a mammography or how to perform a breast ultrasound. And I am not referring to a palpable and isolated tumor, I am referring to all other situations such as a non palpable radiological abnormality that was not diagnosed by the Radiologist, as could happen with a group of microcalcifications that has not been detected, or an abnormality of the architecture in one site of breast parenchyma, or a small size of some millimeters nodule etc., findings which constitute generally an early stage breast cancer, which can escape sometimes even the attention of an experienced Radiologist.

Also a good Breast Surgeon-Senologist should not rely on the mammography report of the Radiologist who performed the mammography and wrote the report, but he should be able to read it himself too. The Radiologist may be trained,

may be competent, but we should not forget that he is a human being and maybe make a mistake or may be his is inadequate too.

At this point, allow me to say that after 8 years of experience in the Greek Courts, as an expert for law suits that are referred to incidents in problems in breast diagnosis or in breast surgical treatment, I have to mention something very important. Doctors who are dealing with breast diseases, either General Surgeons or Gynecologists, but not specialized in Senology, when a Radiologist lose the correct diagnosis and them do not know how to read the mammography and save the situation, and they are based only on the mammographic report that is included, when the Radiologist is referred to Court, they are also accused together with the Radiologist.

034 SESSION: SENOLOGY AS SPECIALTY. BRAZILIAN EXPERIENCE WITH SENOLOGY RESIDENCY PROGRAM

Alfredo Barros[1] and Maurício Magalhães Costa[2]

[1]Gynecologist, Mastologist, Professor, University of São Paulo, Beneficência, Portuguesa Hospital, Brazil, [2]Mebro Titular da Academia Nacional de Medicina, Past-President da Sociedade Internacional de Senologia, Coordenador do Núcleo de Mama do Ameicas Centro de Oncologia Integrada, Centro Médico Sorocaba, Brazil

In 2003 has been created the Brazilian program of Residency in Mastology, was recognised by the Education Ministry.

Lenght: 2 years

Prerequisite: previous Residency in General Surgery or Gynecology and Obstetrics

Institutions: specialized centers with multidisciplinary teams approved after expert inspection (at last 100 new cases of breast cancer per year)

Objectives:

- Fulfill the matrix of competencies
- Trainning in Comprehensive centers and in primary care
- Humanistic formation
- Scientific initiation
- Cognitive
- Anatomy, physiology, diagnosis, treatment and rehabilitation in benign and malignant diseases (both sexes and all ages)
- Skills
- Percutaneous and open biopsies, surgical procedures, oncoplastic reconstruction
- Emotional
- Empathy development, cancer coping, sexuality recovery, family support, communication challenges

The Brazilian experience with a Mastology Residency Program is considered a success. It standardized the formation process, optimized the training period, and may be an example for other countries.

037 INDICATIONS FOR SURGERY : BENIGN BREAST DISEASE

Prof Carol Benn
MB, BCh (Wits) FCS (SA), Specialist Surgeon

Benign breast disease can be classified according to presentation. Most commonly mass or lump; pain ;nipple discharge; Inflammation or infection

Whilst the most common reason for patients to present to a doctor; they are often overlooked in the quest to exclude a cancer diagnosis. Every patient should undergo triple assessment and only when the lump is proven non-malignant, can the patient be reassured. Treatment is often necessary for benign conditions, although surgery should be discouraged in the presence of proven benign disease.

The principles however require robust clinical radiology review; Radiology includes age dependent mammography ; ultrasound ; use of elastography; and MRI . Access to sufficient tissue via core biopsy and an insurance that there is no discordance is critical prior to considering surgery.

The high risk lesion can range from lobular carcinoma in situ to atypical ductal hyperplasia and other confounding lesions such as papillary lesions (simple ; central ; peripheral ; encysted ; and complex) ; mucinous lesions; radial scars and complex sclerosing lesions can provide a complexity of options for the treating physician as to whether to operate or not

Whilst surgery for benign breast masses is usually for rapidly growing 'giant' fibroadenomas simple fibroadenomas are non-proliferative and do not increase the risk of cancer (and don't require surgery) . If the lesion is enlarging at a rapid rate, painful, surgical excision should be considered through cosmetic incisions.

Triple assessment may aid in differentiating a Phyllodes tumour from fibroadenoma, with Phyllodes presenting as larger and with a branching leaf-like pattern on histology (Phullon=leaf [Gk]). They can be divided into benign, borderline and malignant based on the microscopic and clinical pattern. Malignant lesions should be considered as sarcomas (soft tissue tumours),. If a Phyllodes tumour has been shelled out, as a presumed fibroadenoma, watch-and-wait policies result in an unacceptably high rate of recurrence. Phyllodes tumours should be excised initially with a minimum margin, through carefully placed excisions. The pathologist should be allowed to assess the aggressive nature of the tumour fully. Discussion in the multidisciplinary and onco-reconstructive meetings should then precede a second surgical procedure which should involve adequate clearance of margins followed by some form of reconstruction.In the presence of adequately excised margins, immediate reconstruction does not increase the risk of recurrence.

Unusual rare indications for surgery may be conditions such as gigantomastia. Avoid surgery for breast abscesses; and inflammatory conditions and beware of missing diagnosis such as TB breast.

In patients with atypical ductal hyperplasia (ADH) (or DIN3) and a family history of breast cancer or who are premenopausal (most commonly picked up on screening mammography as areas of microcalcifications), can have excision under localisation guidance to allow for full diagnosis and investigation of intercurrent DCIS.

Other risk lesions of the breast include **atypical lobular hyperplasia, lobular carcinoma in**

situ (often grouped together as lobular neoplasia), papillomatosis and sclerosing adenosis (the latter two being of lower risk than lobular neoplasia). Lobular carcinoma-in-situ is not an obligate precursor to breast cancer as its name would suggest, but rather a risk marker for invasive disease. That means that a lobular carcinoma in situ will not necessary become a lobular cancer, but is marker for the development of either a ductal or lobular cancer. The risk of development of breast cancer following LCIS appears to be bilateral and occurs within 15-20 years following diagnosis.

Careful risk assessment and breast evaluation should follow a finding of any of these with discussion around surgery (of the lesions) and /or chemoprevention (endocrine medications to decrease risk ; a better term would be endo-prophylaxix).

Papillary lesions should be carefully assessed by the clinical triad team (radiology; pathology and surgeon). Today central papillomas diagnosed via spontaneous nipple discharge and core (if benign; non blood stained discharge can probably be followed up. Spontaneous blood stained discharge (excise); peripheral papillomas and encysted lesions excise . The use of magtrace can assist should a later sentinel lymph node biopsy is required if pathology finds a malignancy.

All in all benign breast surgery is about not over operating. Reviewing all patients in a combined breast radiology pathology meeting and understanding risk lesions are about careful decisions as to when to avoid surgery and counseling of the patient. As Aristotle so wisely said. "virtue for the prudent man lies moderation between excess and deficiency.

038 BENIGNBREASTDISEASES; FOLLOW-UP ANDRELATION TO MALIGNANCY

Mehmet Ali Gülçelik
MD, PhD, Medical Sciences University, Gulhane Medical School, Department of Surgical Oncology, Turkey

Relationtomalignancy

Theselesionsareconsidered as risk markers, ratherthan as premalignantlesions. Becausethosecancersthatsubsequentlydevelopare not necessarily in thearea of thebiopsy. Andmayoccur in thecontralateralbreast

Risk factors associated with benign breast diseases (BBD) and Breast cancer:

- Histologicfeatures
- Theage at biopsy
- Breast density
- Family History of Breast Cancer
- Reproductive history
- Status of menopause

Benign Breast DiseasesFollow-up:

- Results support routine follow-up after benign breast biopsies
- A safe and more cost-effective strategy may beresumption of routine mammography at 12 months post-biopsy. Short-term imaging follow-up did not contribute to improved breast cancer detection

- Annual diagnostic screening after benign breast biopsy may be sufficient.
- Closer follow-up is needed in growing and palpable ones

039 AN OVERVIEW OF CANCER INITIATIVES IN THE EUROPEAN COMMISSION

Nicholl Ciaran

Phd, MSc, BSc, NDSc, NCSc, NDQC, Head of Unit, European Commission-Joint Research Centre, Italy; European Commission, Directorate General Joint Research Centre, Directorate F – Health and Food Unit F1 - Disease Prevention - Head of Unit, Italy

"By planning, coordinating and uniting our efforts to reduce the burden of cancer, we will leverage unimaginable impact"

040 BREAST SURGERY STATE OF THE ART: HISTORICAL PERSPECTIVE, RECENT DEVELOPMENTS AND FUTURE TRENDS

Mamounas Terry

MD, MPH, Medical Director, Comprehensive Breast Program, Orlando Health Cancer Institute, United States of America

The surgical treatment of breast cancer has undergone considerable evolution over the past 40 years. As a result of changes in the biologic understanding of breast cancer spread and dissemination, two testable clinical hypotheses regarding early breast cancer management were formulated: (1) De-escalation of surgical therapy would not affect long-term outcomes and (2) Development and escalation of adjuvant systemic therapy would improve long-term outcomes.

Based on several randomized clinical trials, breast conserving therapy has become the preferable treatment for women with stage I and II breast cancer because it provides survival equivalent to total mastectomy while preserving the breast. Similar findings have also been observed for women with ductal carcinoma in situ.

Margins Consensus Guidelines have established "no tumor on ink" as adequate margin for invasive breast cancer and a 2 mm margin as optimal margin for ductal carcinoma in situ.

The role of radiotherapy after breast conserving surgery is well-established as it significantly reduces rates of in-breast recurrence. Novelgenomic classifiers that predict risk of local recurrence are currently being evaluated in prospective trials as a means by which breast radiation could be omitted in select groups.

For patients who need or choose mastectomy there has been an increasing use of post-mastectomy breast reconstruction along with more cosmetic mastectomies such as skin-sparing and nipple-sparing mastectomy, improving the quality of life of patients after surgery. A recently observed trend is the increasing use of contralateral prophylactic mastectomy.

Increasing use of neoadjuvant chemotherapy, has allowed further de-escalation of the extent of surgical treatment in the breast as well as in the axilla.

With the advent and widespread application of sentinel lymph node biopsy, a roadmap for

decreasing the role of axillary lymph node dissection over sentinel lymph node biopsy without affecting disease-free survival has been implemented.

Use of axillary lymph node dissection has been essentially eliminated in patients with clinically negative axilla and negative sentinel lymph node(s) and has diminished considerably in patients with clinically negative axilla and positive sentinel lymph nodes. Also, there has been a diminished use of axillary lymph node dissection in patients with clinically involved axilla (with or without histologic confirmation) with the use of neoadjuvant chemotherapy.

During the next decade we expect to see incorporation of new technologies for margin assessment (optical image-guided surgery, fluorescent agents), observation for low grade DCIS, consideration of omission of surgery in exceptional responders after neoadjuvant chemotherapy and development of predictive biomarkers of radiation benefit after breast conserving surgery. Regarding the axilla, we expect to see expansion in the use of sentinel lymph node biopsy alone in patients with positive sentinel lymph nodes after neoadjuvant chemotherapy, incorporation of new techniques for lymphatic mapping and omission of sentinel lymph node biopsy in low-risk, postmenopausal ER+/HER2 negative patients (several RCTs underway/completed).

046 ARTIFICIAL INTELLIGENCE IN BREAST CANCER

Sechopoulos Ioannis

PhD, DABR, FAAPM, Head, Advanced X-ray Tomographic Imaging (AXTI) lab, Department of Medical Imaging Radboud University Medical Centerñ Chair of Advanced X-ray Imaging Systems, Multi-Modality Medical Imaging (M3I) Group, Technical Medical Center, University of Twenteñ Scientific Advisor, Dutch Expert Centre for Screening (LRCB), Greece

AI for interpretation of mammographic images, both stand-alone and as an aid for radiologists, is currently on-par with the abilities of an average breast screening radiologists. As such, it is an important potential tool to improve screening performance and/or cost-effectiveness.

047 REAL WORLD IMPACT OF AI ON INDIVIDUALS READERS AND PROGRAM PERFORMANCE IN MAMMOGRAPHY SCREENING

Gräwingholt Axel

MD, Radiology Consultant, Germany

«AI algorithms used as a supportive tool in breast cancer screening can help increase the breast cancer detection rate without appreciably increase the abnormal interpretation/consensus rate“

048 USE OF HORMONE REPLACEMENT TREATMENT IN WOMEN OF REPRODUCTIVE AGE & POTENTIAL RISK OF BREAST CANCER

Mutlu Doğan
MD, Professor of Medical Oncology, University of Health Sciences; Dr Abdurrahman Yurtaslan Ankara Oncology Training and Research Hospital; Medical Oncology Department, Ankara, Turkey

Hormone replacement treatment (HRT) is substitution of ovarian hormones at physiological doses when they are not produced physiologically. It has been widely used in postmenopausal women for years in daily practice until its risks including breast cancer risk has been shown. Despite its risks, it has to be used almost at reproductive age with premature hypoestrogenism (i.e. hypogonadism, bilateral ooferectomy, primary ovarian insufficiency) until average age of menopause (approximately 51 years).

In the literature, data is mainly based on outcomes of the HRT trials in postmenopausal women. Outcomes of these trials are mainly extrapolated to younger females with primary ovarian failure, since there is no more data in this younger subpopulation at reproductive age. In Women's Health Initiative (WHI) trial, women with intact uterus were given combination HRT [CEE (estrogen) and MPA (progestrone)], women who had histerectomy were given CEE (estrogen) HRT, and third arm was placebo arm (1). Invasive breast cancer risk was higher in combination arm (HR: 1.26) whilst second arm with estrogen monotherapy HRT had lower risk. Updated outcomes of this trial supported early results (2). However, it seems to be not rationale to use estrogen monotherapy HRT in younger women since most of them have intact uterus. It is well-known that unopposed estrogen increases endometrial hyperplsia and endometrial cancer risks. Therefore, combination estrogen and progesterone as HRT is the option for younger ones despite breast cancer risk. However, HRT formulations also have been evolved in years. In recent years, transdermal combination HRT formulations wih CEE and natural micronized progesterone are feasible. Combination oral contraceptives are also alternatives (3). So, younger population at reproductive age with absolute HRT indications should be followed-up closely for breast cancer risks. These females should be discussed in multidiciplinary boards, including gynecologists, endocrinologists, medical oncologists and psichiatrists.

052 HOW TO USE GENOMIC TESTS IN ER+ BREAST CANCER

Amir Sonnenblick
Head, Breast Cancer Unit, The Oncology Division, Tel Aviv Sourasky Medical Center, Israel

- Clinical risk assessment is still very important!
- know what you're looking for... (escalation vs. de-escalation)
- There are different levels of evidence (prospective vs. retrospective) for different tests

053 THE GLOBAL STATUS AND FUTURE OF ONCOPLASTIC SURGERY. LIPOFILLING FOLLOWING BREAST RECONSTRUCTION

Anastasios Tsekouras

MD PhD, Aesthetic, Plastic & Reconstructive Surgeon, Surgeon in Chief in Plastic Surgery Leto Maternity & Gynecology Private Hospital, Greece

Lipofilling is an effective and versatile technique following breast reconstruction that offers numerous benefits. By utilizing the patient's own fat cells, it allows for natural-looking results with minimal scarring. Lipofilling can be used as a standalone procedure or in combination with other breast reconstruction techniques to enhance the shape, symmetry, and volume of the breasts.

Adult human adipose tissue contains a population of mesenchymal stem cells, termed 'adipose-derived stem cells' (ASC), which seem to fulfill most, if not all, of general mesenchymal stem cells criteria. This increased number of ASCs in the adipose tissue has been postulated to improve graft survival. Studies have also shown that stem cells have angiogenic properties with recent evidence of their potential involvement in the healing and regeneration of irradiated tissues, probably through secretion of vascular endothelial growth factors.

The adipose tissue is obtained by liposuction with a standardized technique and may be used after processing:

- either directly as a Stromal Vascular Fraction (SVF) or
- after cell culture as a pure mesenchymal population of adipose-derived stem cells (ADSCs or ASCs)The postoperative monitoring protocol does not change clinically or radiologically. In cases of suspected clinical or radiological findings in the breast, the investigation should be performed in the same way as if they had not performed fat transfer. There may be an increased likelihood though of fat necrosis and presence of micro calcifications in the mammogram which is usually easily recognized, but can lead to an increased frequency of needle biopsy.

Indications for lipofilling include:

- Correction of defects and asymmetry following wide local excision with or without radiotherapy (Delay, Coleman)
- Improvement of soft tissue coverage following implant based breast reconstruction (Delay, Spear, Kanchwala)
- Augmentation of volume and refinement of autologous whole breast reconstruction (Delay, Spear, Sinna)
- Stimulation of neo-vascularisation of chronically ischemic irradiated tissue (Missana)
- Replacement of implants in unsatisfactory breast reconstruction outcomes where a flap is combined with implant
- To disguise capsular contracture

Concluded lipofilling has its position in breast reconstruction and after conservation treatment and following mastectomy. For best results though and minimization of complications, lipofill-

ing is often better to be performed in stages. Surgeon's technique and experience may affect the outcome and efficacy of fat graft survival. Finally, it seems that ADRC-enriched fat grafting for breast enhancement following reconstruction is promising even after a single treatment.

055 THE FUTURE OF THE ONCOPLASTIC SURGERY

Gustavo Zucca Matthes

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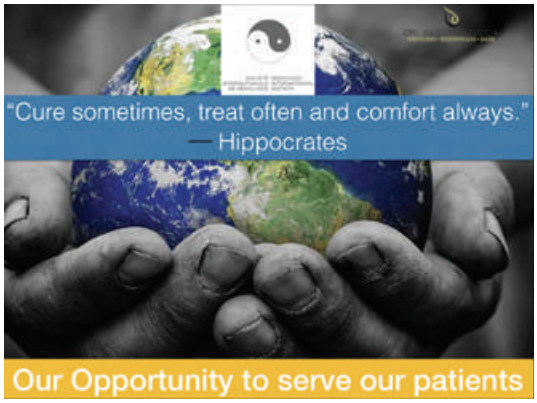

056 BREST RECONSTRUCTION. VERTICAL SCAR MAMMOPLASTY. "THE CINDERELLA" OF MAMMOPLASTY VERTICAL SCAR TECHNIQUE

Ioan Răzvan Andrei

MD, PhD, Candidate -"Carol Davila" University of Medicine and Pharmacy Bucharest; Scientific Officer - Romanian Society of Breast Surgery and Oncology; Fellowship in General Surgery – "Prof. Dr. Al. Trestioreanu" Institute of Oncology Bucharest, Romania

The concept of vertical reduction mammoplasty dates back nearly a century, with mentions by Dartigues and Arie in the past. However, it was Claude Lassus who revolutionized this technique. His method involved a central and inferior resection of the breast, an upper pedicle for the areola, no undermining, and a vertical scar to finish. Over time, Lassus modified his technique to eliminate the long vertical scar that extended below the inframammary fold. Madeleine Lejour further contributed to the development of this technique by lifting the breast using only a vertical scar. Initially, the scar may appear unpleasant, but it gradually stretches and flattens over several months, resulting in a beautiful breast with a narrow base, a short vertical scar, and a stable projection.

Contrary to popular belief, the shaping of the breast in vertical mammoplasty primarily relies on suturing the gland rather than the skin. The key to a successful breast reduction lies in controlling the lower pole, ensuring a balance between shape, scar appearance, and the stability

of the final result. While vertical scar mammoplasty offers remarkable benefits, it demands a higher level of expertise from the surgeon, given its longer and steeper learning curve. The challenging nature of shaping the lower pole contributes to the popularity of the "wise pattern" technique. Additionally, patients must understand that they need to be patient as the final results of the procedure take time. Despite its advantages, vertical scar mammoplasty does have some drawbacks, including immediate less aesthetic outcomes, excess skin above the inframammary fold, reliance on skin elasticity for final results, potential need for additional revisions, and challenges in correcting highly repositioned NAC.

In conclusion, vertical scar mammoplasty is a demanding yet rewarding surgical technique. It offers the advantage of fewer scars, improved breast projection, narrowed breast shape, and more stable outcomes. While the "wise pattern" mammoplasty technique provides certain advantages, vertical scar mammoplasty surpasses it in terms of aesthetics and overall beauty. By embracing this procedure, surgeons can achieve exceptional results and provide patients with enhanced satisfaction.

058 PARTICULARITIES OF BREAST CANCER IN YOUNG WOMEN

Zavos Apostolos

MD, PhD, Obstetrician Gynaecologist, Breast Surgeon, Lecturer at University of Thessalia, Larissa. Greece

CONCLUSIONS

Young women DO GET BREAST CANCER

They are less in number BUT TO MANY

They have

- Worce prognosis – mortality rates
- Agresive tumor – Late Diagnosis
- No Screening
- Gene mutations

Conservative Surgery have the same results as Mastectomy, Immediate Breast Reconstruction should be offered when mastectomy is necessary

Radiation is of great importance in this population

Neoadjuvant chemotherapy is of great importance and should be given when needed.

Great attention is needed FOR supportive care and survivorship - fertility preservation issues.

Pregnancy is possible after breast cancer and also Pregnancy termination has no benefit,

TAKE HOME MESSAGE

Young women with breast cancer are…

- Less but too many
- Same but different with the rest population

We should be able to ….

- Identify their particularities

- Treat them correctly having the same principals but differently than the general population.
- Protect their life with special interest in survivorship issues.

059 GENETIC TESTS. SHOULD EVERY BREAST CANCER PATIENT BE SCREENED FOR GENETIC PREDISPOSITION TO CANCER?: YES

Friedman Eitan

Professor, Assuta Medical Center, Tel'Aviv; Meirav High Risk Clinic, Sheba Medical Center, Tel-Hashomer, Israel

Based on the rate of detection of germline pathogenic sequence variants (PSVs) in consecutive breast cancer (BC) cases in ethnically diverse populations ~ 10-15%, the clinical impact of PSV detection on clinical decision making, surgical options (including risk reducing surgeries), possible therapeutic impact in advanced BC cases (PARP inhibitor therapy) and the ability to accurately and based on genotype assess cancer risk for family members, it seems logical to recommend germline PSV genotyping to all consecutive BC cases. This recommendation is in line with the one adopted by the American Society of Breast Surgeons in 2019.

060 EVERY PATIENT NEEDS GENETIC TESTS: NO

Lina Florentin

B.Sc., Ph.D., ErCLG, Clinical Laboratory Geneticist, Director of Genetics, A-Lab Genetics and Genomics Center, Greece

Every breast cancer patient appears to benefit from genetic testing. Once a pathogenic variant of a cancer gene is found, diagnosis is reached, and the patient's clinical management is tailored made. Prior to testing, these possibilities along with targeted therapy options, presymptomatic testing in relatives or the patient itself and reproductive options are key points that should be discussed with the patient. Extensive counseling before and after the test is extremely important so that an informed decision can be made and anxiety can be minimized.

063 MANAGEMENT OF THE AXILLA IN EARLY BREAST CANCER: CURRENT PRACTICE. SURGICAL APPROACH

Armando E. Giuliano, MD

Director, Surgical Oncology, Associate Director, Cedars-Sinai Cancer Cedars-Sinai Medical Center; Clinical Professor of Surgery, UCLA, United States of America

The management of the axilla and breast cancer has changed dramatically over the past three or four decades. Initially, all patients with breast cancer were subject to axillary dissection, even those with DCIS or even LCIS. It soon became apparent that these patients with carcinoma *in situ* derived no benefit from axillary lymph node dissection (ALND).

In the early 1990's, we began to experiment with the elimination of axillary dissection and began to perform sentinel node biopsy for patients with early invasive breast cancer. It became clear that identification of one or two lymph nodes could accurately stage the axilla. Now almost all patients with early stage breast cancer can be spared the morbidity of ALND. Patients who

are clinically node-negative, even if they have biopsy-proven nonpalpable axillary metastasis, can be treated according to the findings of the American College of Surgeons Oncology Group Z0011 (A Randomized Trial of Axillary Node Dissection in Women With Clinical T1-2 N0-1 M0 Breast Cancer Who Have a Positive Sentinel Node) or AMAROS (After Mapping Of The Axilla: Radiotherapy Or Surgery) studies showing that ALND is not necessary. Z0011 showed that patients with T1 or T2 clinically node-negative breast cancer treated with lumpectomy and who have only one or two involved sentinel nodes can be treated with whole breast irradiation and adjuvant systemic therapy. The AMAROS trial treated similar patients but added nodal irradiation. It is not clear that nodal irradiation is necessary for all patients since AMAROS treated very similar patients to the Z0011 trial and recurrences are similar in both trials, but Z0011 did not use nodal irradiation. AMAROS included some mastectomy patients and, for this reason, patients treated with mastectomy who have only one or two involved nodes can be treated with post-mastectomy irradiation or ALND. It is important in these patients to avoid the use of both ALND and regional nodal irradiation, whenever possible, because of the high rate of lymphedema when ALND and irradiation are combined.

Management of the axilla has become far more complicated and is clearly multidisciplinary, involving consultation and consideration by medical oncologists, radiation oncologists, and surgeons in order to provide optimal care for the patient with breast cancer.

064 MANAGEMENT OF THE AXILLA IN EARLY BREAST CANCER: CURRENT PRACTICE ROLE OF RADIOTHERAPY AXILLARY RADIOTHERAPY

Yvonne Zissiadis

FRANZCR, Radiation Oncologist, Medical Director Genesiscare, Hollywood Private Hospital, Australia

Current role:

- After axillary dissection:
- Suspected residual microscopic or macroscopic disease.
- For undissected axilla (sentinel lymph node biopsy [SLNB] only):
- Recommended in patients who have undergone SLNB alone but do not meet the Z11 criteria e.g. T3 tumour, >2 positive nodes (if axillary dissection will not be performed).
- Consider in patients similar to those enrolled on AMAROS/Z11 (cT1-2N0 with 1-2 positive sentinel lymph nodes) with other high risk features
- Consideration should be given to also include the SCF ± IMC irradiation in these patients.

Case Selection: axillary clearance VS axillary RT

- If considering axillary management: ART is preferred over ALND for patients with SN-positive, cT1-2
- Case selection important
- For those with limited nodal disease, do we really need any further axillary treatment ie ITC, micrometastatic disease?
- Axillary RT has lower morbidity than ALND
- Axillary RT can be delivered safely today

- RT for low volume nodal disease pN0(i), pN1(mi) – case selection
- Increasing need to tailor regional nodal radiotherapy recommendations eg cT1/2, SNB positive with other risk factors to have nodal RT rather than ALND (case selection)
- Mulitdisciplinary engagement important in decision-making

Post Neoadjuvant systemic therapy(NAST): cN1, ypN0 pts. What are we doing now?

- Awaiting results of the ALLIANCE (B51) trial
- Targeted axillary dissection (TAD) provides useful data for the Radiation Oncologist
- If fibrosis is present within lymphnode (post NAST) indicating previous involvement of node, consider RT (if minimal involvement) OR ALND (if more extensive previous involvement or other poor prognostic features)
- Case selection: RISK vs BENEFIT

061 BREAST CANCER SURGERY: PAST, PRESENT, AND FUTURE

Prof. Schlomo Schneebaum

President Israel Senologic Society, President International Senologic Society (SIS), Breast Health Center Department of Surgery, Tel Aviv Sourasky Medical Center

From mastectomy to lumpectomy

Survival rates are largely the same among women with early breast cancer who received either treatment. This suggests that a lumpectomy with radiation is at least as good as a mastectomy. However, a few studies suggest that lumpectomies with radiation have a slightly higher survival rate.

From axillary lymph node dissection (ALND) to sentinel lymph node (SLN) biopsy

Sentinel Lymph node Biopsy is the Standard of care for better staging with less morbidity.

No Completion Axillary lymph node dissection for negative SLN

And no completion ALND for positive SLN

Dealing with Neoadjuvant Chemotherapy (NAC)

Sentinel feasible and accurate post-Neoadjuvant.

SLN post-chemotherapy should be done with a marking of the biopsied node

Positive L.N. is followed by ALND

Completion of Axillary lymph node dissection is limited to positive lymph nodes post-neoadjuvant.

Surgery post PCR?

The omission of surgery for clinical and radiological complete response is investigational only.

Future Trends in Breast Surgery

Omission of Axillary Surgery **Selective** for ER-positive HER 2 Negative Small tumors **(<2 cm)**

Old age >>70? >75?

No Additional Axillary Dissection –less than 4 positive lymph nodes (eligible for Abemaciclib)

No Contralateral Mastectomy for nongenetic mutation carriers

Future??

065 MANAGEMENT OF THE AXILLA IN EARLY BREAST CANCER: CURRENT PRACTICE. ROLE OF CHEMOTHERAPY

Banu Arun

M.D. , FASCO, Professor Medical Oncology, Co-Director Clinical Cancer Genetics, Executive Director Cancer Genetics MD Anderson Cancer Network, The University of Texas MD Anderson Cancer Center, United States of America

" With knowledge gained in the classifications of breast cancer, such as triple negative, Her-2/Neu positive and hormonal positive breast cancer; data now indicates that it is rather the biology and breast cancer molecular subgtype that determines the need for chemotherapy in lymph node positive disease rather than solely the lymph node status."

067 NEOADJUVANT TREATMENT IN SPECIFIC GROUPS WITH BREAST CANCER. NEO-ADJUVANT SYSTEMIC THERAPY FOR BREAST CANCER

Başaran Gül

Prof Dr, Acıbadem University, Internal Medicine Department, Medical Oncology Altunizade Hospital Breast Health Center, Turkey

- We are using neoadj systemic therapy more (all pts with LABC and stage 2-3 TN and Her-2 pos BC)
- pCR is a good surrogate, but not perfect
- TNBC: Incorporation of platinum and ICI improved pCR and survival
- Her-2 + BC: Dual blocakade is better (pCR/ survival)
- Non-pCR: T-DM1 for Her-2 pos; Pembrolizumab, capecitabine and olaparib improved survival; but still more is needed
- ER+ Her-2 neg BC: Patient selection improves pCR and clinical outcome with neoadjuvant therapy
- Predictive marker search: ongoing, advancing…

071 ADVANCED BREAST CANCER TREATMENT: STATE OF THE ART TREATMENT IN HER-2 NEGATIVE DISEASE

Arun Banu

M.D. , FASCO, Professor Medical Oncology, Co-Director Clinical Cancer Genetics, Executive Director Cancer Genetics MD Anderson Cancer Network, The University of Texas MD Anderson Cancer Center, United States of America

"Several important advances have been made for the treatment of Her-2/neu positive advanced breast cancer. New agents such as antibody drug conjugates have made improvements, not only in disease free survival, but also overall survival. Newer agents are being studied in clinical trials that are believed to further improve out come of these patients."

072 SURGERY FOR METASTATIC BREAST CANCER

Lütfi Doğan
MD, Professor of Surgical Oncology, Head of Surgical Oncology Department, University of Health Sciences, Etlik City Hospital, Ankara, Turkey

Breast cancer has a wide spectrum with many intermediate stages between local and systemic disease and oligometastatic disease is a very special subgroup in the metastatic disease.4-7% of newly diagnosed breast cancers are stage 4 patients and 10-20% of these are olgometastatic disease. A more aggressive treatment is appropriate, as the oligometastatic disease is thought to be caused by cells of lower malignant potential. The target in treatment should be clinical and pathological complete response. Loco-regional surgery for intact primary tumor is one of the treatment modalities that is the subject of research for denovo oligometastic disease.The first data on this subject is based on single-center retrospective series. A survival advantage in favor of surgery was evident in most of these series.The results of these studies have generated a debate and numerous objections.Considering that the survival advantage in retrospective series is due to biased patient selection, randomized controlled studies were planned.Three randomized controlled studies have been published and there are two more ongoing randomized trials from Japan and the United States.Majority of randomized studies did not show a survival benefit in loco-regional treatment groups but there are subgroups of patients which deserve indepth analysis.We cannot claim that every patient benefits from primary loco-regional treatment but we have to accept that a group of patients may benefit from primary loco-regional treatment. Extend of metastatic disease, tumor phenotypes and responsiveness to metastatic therapy are the parameters to be used to select the good candidate forloco-regional treatment.

We have enough data for patients witholigometastasis, soliter metastasis, bone only metastasis, HR (+) patients and metastases are under control with systemic treatment. But we have no enough data for patients expected withshort survival, metastasis are not under control and TN patients.

073 FAIRER BREAST CANCER CARE IN A GLOBALIZED WORLD

Didier Verhoeven
MD, PhD, Medical oncologist, Guest Professor University of Antwerp; Chair Breast Clinic Voorkempen Brasschaat, Belgium

More than fifteen years we dedicated to our initiative for fairer breast cancer care.

An exiting time of collaborations, bringing together more than 130 experts coming from 30 countries from the five continents.

2020 the book: «Breast cancer: Global quality care» was published by Oxford University Press.It provides a comprehensive guide to deliver high quality breast cancer care around the globe developing the highest possible care within local resource limitations.We are now working hard for a second, open acces edition to make the message freely available for all.

Another exiting initiative is the start of live interactive webinars together with eCANCER

promoting peer to peer discussions of high value breast cancer care, open for all healthcare professionals.

Feel free to contact for further information about these initiatives : didier.verhoeven@KLINA.be

Key messages of the presentations during the SIS conference

- For early diagnosis, awareness and clinical breast examination are critical in LMIC.
- Screening is more important in HIC.
- In a world of disparities health care systems play an important role.
- Breast units and multidisciplinary care are most efficient.
- Introduce value-based breast cancer care

076 ELDERLY PATIENTS WITH BREAST CANCER. AGGRESSIVE AND CONSERVATIVE APPROACH

Nazim Serdar Türhal

MD FACP, Professor, Anadolu Medical Center President, Turkish Oncology Group; National Representative of Turkey in European Society of Medical Oncology; Past President of European Society of Medical Specialists, Medical Oncology Section; Past President of Turkish Society of Medical Oncology, Turkey

«The treatment of elderly breast cancer patients is an increasingly prominent issue for the cancer specialists. The management decision should not be based alone on age of the patient. The Geriatric assessment tools should be used for general comprehensive evaluation. Although the validation in elderly population is not complete yet, the benefit calculation tools should be factored in oncological treatment decisions. A geriatrician should be consulted if available. Overall, individualization is essential in this patient population.»

078 PSYCHOSOCIAL SUPPORT FOR WOMEN WITH METASTATIC BREAST CANCER

Luzia Travado, PhD, MSc, ClinPsych

PhD, MSc, ClinPsych, Clinician and Researcher of Psycho-Oncology, Champalimaud Clinical & Research Centre, Avenida Brasília, Lisboa, Portugal; IPOS President-Emeritus, 2022 Jimmie Holland Memorial Award; International Psycho-Oncology Society, Portugal

Women who live with Metastatic Breast cancer face many challenges:

- an Incurable/chronic disease with shorter survival time
- frequent medical procedures, chronic side effects (e.g., occupational disability, pain, fatigue, cognitive impairment, sexual dysfunction), and practical concerns (e.g., work and family role disruption, financial strain)
- the Impact of the initial diagnosis of cancer 'revisited'at multi-dimensional levels: physical, psychological/emotional, family, social, existential, occupational, financial, etc.
- uncertainty about future and threat of dying
- they are more discouraged, and less hopeful

These women are at risk for emotional severe distress, including symptoms of depression and anxiety, as well as existential distress and loneliness (distress can range from 32% in Early BC to 60% in Advanced BC); these psychosocial needs need to be screened and addressed during their treatment and care by the health care professionals (HCPs) team to ensure best quality cancer treatment and care.

Good communication is the best and first level of emotional of support we ALL (as HCPs -doctors and nurses first, as the frontline of diagnosis and treatment) can give to our patients. Good communication skills helps to understand each patient and their partner/ caregiver's doubts, concerns, preferences, to identify patients who are highly distressed and in need for psychological support, to then refer them to the psychologist or psycho-oncologist.

There are good protocols such as the SPIKES and the PREPARED to help doctors on how to communicate clinical bad news in a sensible way, that is supportive to patients. Further communication skills training can assist doctors (e.g., surgeons, oncologists, radiation-oncologists) on how to deal with patients' emotions by using techniques such as empathic responses, validation, exploratory questions. These trainings help doctors to be better prepared to handle difficult communications, with their patients, such as the progression of the disease, and help patients manage their life and resources as challenges arise, and at the same time still feeling confident and trustful on their doctor. For more information on this visit:

https://www.vitaltalk.org/resources/

There are many psychological interventions that have proven its efficiency and efficacy in reducing the emotional distress particularly depression but also anxiety in this population: either in individual format or group format. One of these recent interventions is CALM therapy, Cancer and Living Meaningfully (CALM), a manualized intervention developed in Canada. CALM is delivered in 3-6 individual sessions, that cover 4 modules:

1. symptom management and communication with healthcare providers;
2. changes in self and relations with close others;
3. spiritual well-being, or sense of meaning and purpose; and
4. preparing for the future, sustaining hope and facing mortality.

CALM intervention model was successfully tested through a randomized controlled trial and has proven its efficacy in reducing depression and death anxiety in advanced cancer patients. Our team at the Champalimaud Clinical and Research Center, tested and validated it for our population, having obtained good results with Portuguese patients.

In another research project called **DistressBrain**, conducted by myself with a multidisciplinary team, at Champalimaud, **we have studied emotional distress, brain functioning, social well-being and biobehavioral processes in metastatic breast cancer (mBC) patients. The outcomes of the DistressBrain Project were quite interesting**. We observed that:

- Negative affect was significantly negatively correlated with the metabolism of the insula, thalamus, hypothalamus, ventromedial prefrontal cortex, and lateral prefrontal cortex. That is higher levels of negative affect were significantly associated with lower metabolism on these key brain regions

- **Higher levels of emotional distress, lower levels of perceived stress management skills efficacy and lower levels of social/family well-being are associated with low metabolism in key brain regions, HPA dysregulation and higher levels of pro-inflammatory proteins**.

This work was an initial step in identifying key brain regions that may underlie successful adaptation to the personal challenges of cancer and its treatment.

Screening for high distress levels and/or low stress management skills in mBC patients, and offering psychological support aimed at training these skills could help reduce distress, improve psychological adaptation and possibly health outcomes.

Psychological support for this population is highly relevant and an essential part of quality cancer treatment and care, as mentioned in the ABC clinical guidelines.

086 MEDIA AND DIGITAL INFORMATION FOR BREAST CANCER PATIENTS. HOW SHOULD BE THE MESSAGE TO THE NON-MEDICAL AUDIENCE- GENERAL PUBLIC

Lydia Ioannidou-Mouzaka MD, PhD

MD, PhD, Ass. Professor, University of Athens Medical School; Gynecologist-Surgeon-Senologist; National Representative of Greece in the European Committee Initiative on Breast Cancer in Breast Cancer and Breast Centers; Representative of the Hellenic Medical Association in UEMS for the needs in Breast Cancer Surgery President, Hellenic Senologic Society, Director, Hellenic School of Senology; President of 21st SIS World Congress on Breast Cancer and Breast Health Care, Greece

How should medical knowledge be communicated to the public?

I will start my speech with the phrase of the English Philosopher Francis Bacon «Knowledge is power» and I will refer to the huge development and the steps that have been taken in our country for prevention and early diagnosis in the fight against diseases and illnesses as well as in informing public by specialized doctors who transmit the information to the public in an understandable way.

The news from the health field is becoming more and more impressive. The Mass Media, aided by technology, are mediators of specialized scientific knowledge to the wider public, which is informed through articles, broadcasts, reports, social media. The role of journalists is important and helpful in the direction of transmitting scientific developments. The cooperation between a Doctor and a Journalist is a catalyst for the correct information of the public.

It is a fact that for most people the scientific truth is what they read on websites, in newspapers or watch on the news as it has been repeatedly pointed out.

However, the doctor in a more commonway, with simple words, can properly use his «art» and give the public to understand clearly and without fear the necessity of access to the health structures and in particular to the specialized doctors, depending on the problem they face.

I will close my speech with the saying «A man makes his living with what he gets, but he makes his life with what he gives».

That is, «Man lives by what he takes, but completes his life by what he gives.»

The same should apply to Doctors too.

Thank you!

087 MALE BREAST CANCER

Bolivar Arboleda-Osorio

MD FACS FICS, Medical Director HIMA San Pablo Caguas Hospital, Puerto Rico; Assistant Professor of Surgery, Universidad Central del Caribe, Puerto Rico; Presidente, Sociedad Puertorriqueña de Senología; Miembro Directivo, Federación Latinoamericana de Senología FLAM; Vice President for North America, Société Internationale de Sénologie SIS, Puerto Rico

1. breast conserving surgery is an option in male breast cancer.
2. special populations such as transgender individuals have different screening methods depending on their schedule of transitioning.

088 IMMUNOTHERAPY IN BREAST CANCER: MORE QUESTIONS THAN ANSWERS!

Didier Verhoeven

MD, PhD, Medical oncologist, Guest Professor University of Antwerp; Chair Breast Clinic Voorkempen Brasschaat, Belgium

Most triple negative breast cancer receive chemotherapy. In the Netherlands around 75% of all node-negative, triple negative breast cancer patients receive adjuvant systemic treatment.

Keynote 522 showed a difference of pCR of 7% in the final evaluation and a difference of 7% in EFS (84% versus 77 %). OS data are waiting !

Nevertheless a lot of questions remain, before accepting immunotherapy as a real breakthrough for triple negative breast cancer.

- Are they all created equal: NO
- What are the ideal endpoints?
- What is the optimal dose?
- Which patients need adjuvant immunotherapy after pCR?
- What about the biomarker PDL-1?
- How to make it affordable for all?
- What about long-term toxicity?
- What about the metastatic patients?

090 BREAST CANCER WITH SPECIAL PATHOLOGY - PATHOLOGY DIAGNOSIS

Antigoni Sourla

MD, PhD, Scientific Collaborator-Consultan Pathologist Pathology Department; Medical School University of Athens; Consultant Pathologist, Pathology Department Biomedicine Laboratories and REA Hospital Athens, Greece

Breast cancer represents an heterogenous disease encompassing various entities showing significant differences in both morphologic and molecular characteristics.

These differences are reflected on Tumor Biology, Clinical Behavior and Prognosis determining management plans.

The basis for histological classification of BC lies on specific cell differentiation from multipotent progenitor or stem cells originating from TDLU and ducts.

Genetic changes and reprogramming of a multipotent progenitor or stem cell result in a broad spectrum of morphology and extensive variation in Histological Type (type of differentiation) and Grade (degree of differentiation).

Molecular Classification of BC further classifies different types of breast cancer according to their genetic signature which significantly relates with morphology and determine prognosis.

According to WHO classification (5th edition), Infiltrating Ductal Carcinomas IDC-NST represents 75-80 % of breast cancer cases followed by Infiltrating Lobular Carcinomas ILC with a prevalence of 10%–15%.

Special- rare subtypes of breast cancer with an individual prevalence of 0,1-6% are recognized as distinct morphologies which often correlate with distinct clinical outcomes.

Despite their rarity, they are important because they have distinct molecular, morphological and clinical features such as

- Mucinous, Tubular, Cribriform and Medullary, Apocrine or Secretory carcinoma with good or intermediate prognosis
- Pleomorphic Lobular, Inflammatory , Micropapillary, Neuroendocrine and Metaplastic carcinoma with poor prognosis
- Tall cell carcinoma with reversed polarity – new entity (WHO 5th edition)
- Salivary Gland –Type tumors with site - specific clinical behavior and different mutation profiles, prognosis and management from their salivary gland counterparts.

A way to tackle with the biggest obstacle faced in clinical practice including intertumoral and intratumoral heterogeneity and mechanisms of multiple drug resistance in the systemic treatment of the disease is to **focus on Accurate Diagnosis.The histological classification of breast cancer** through **a) designation of special tumour types** with diagnostic concordance and level of evidence and **b) recognition of molecular alterations including specific molecular alterations** of some rare BCs **responsible for their clinical behaviour and distinct phenotypes can improve our understanding of tumour biology providing the basis for Targeted Personalized Therapy**.

091 RARE BREAST CANCER WITH SPECIAL PATHOLOGY THE SURGEON'S VIEW

Christos Kanistras

MD, Scientific Consultant of B Propedeutic Surgery Clinic of Hippokrateio Hospital, Aristotle University of Thessaloniki; Private Practitioner, Greece

Since definite diagnosis of a rare subtype of breast cancer is usually received post surgery with the detailed pathologic evaluation that follows, the most important part concerning the therapeutic treatment of such patients is the close and efficient communication between all the involved specialisations such as the oncologist, surgeon and pathologist. Especially in the neoadjuvant chemotherapeutic setting this close communication is even more important because many of those rare cancer subtypes involve triple negative carcinomas, but

with low proliferation rates, which means that in some cases, maybe an interruption on the chemotherapeutic plan is needed in order to proceed with surgery mid-way, to remove the bulk of the non-recessive cancer and later on proceed with the remaining chemotherapy in order to control the disease.

092 RARE BREAST CANCER WITH SPECIAL PATHOLOGY SYSTEMIC TREATMENT

Vasileios Barmpounis
MD, PhD, Medical Oncologist, IASO Hospital, Greece

- Breast cancers are divided into different types. We call rarer breast cancers special type, and the more common breast cancers no special type.
- Most breast cancers are invasive carcinoma - no special type. Around 70% of breast cancers are this type. They are written as NST or NOS (not otherwise specified).
- However, breast cancer is a heterogenous disease, exhibiting a wide range of morphological phenotypes shaping its prognosis and clinical course.
- Rare histologic types of primary breast cancers are not represented in practice guidelines due to the lack of large studies and randomized trials.
- They present a challenge to the doctors who must make recommendations for surgical treatment, axillary staging, and adjuvant therapy,
- Counseling patients as to their expected disease course and prognosis is another problem.
- Case reports and published series of rare types of primary breast cancer provide a basis for treatment for patients with these rare primary breast malignancies.

093 THE IMPORTANCE OF ACUPUNCTURE IN BREAST CANCER

Zafeiria ZourmpakI
Physiotherapist UNIWA, Biomedical Acupuncture Specialist UNIWA, Certified Schroth Method Therapist-(BSPTS), Greece

Acupuncture appears to help CA patients with:

- Nausea and vomiting related to chemotherapy.
- Xerostomia related to radiation therapy.
- Hot flashes related to hormone treatment.
- Physical pain
- Peripheral neuropathy, a common side effect of chemotherapy that causes pain, numbness and muscle weakness in the hands or feet.

& Could also relieve a wide range of symptoms, regarding the patient's psychosomatic health.

- The loss of appetite,
- fatigue, insomnia and other sleep disorders,
- dyspnea (breathing difficulties), anxiety, depression

As for now the clinical evidence has assured us that acupuncture is an effective therapy for patients to manage in a safe way the related symptoms.
Acupuncture STANDS against BREAST CANCER
and becoming a PROTECTIVE SHIELD TO ALL THOSE PATIENTS WHO TRY and dare
to win this unequal battle.

Acupuncture services, may be proved to be supportive in the patient's progress, in the evidence informed field of oncology.
Speaking in the name of physiotherapists our job is to improve the quality of life of our patients and as long as acupuncture is a method of therapy in our hands to relieve people afflicted by CA, it would be God's work, to establish as far as we can acupuncture to Cancer care, so we could notify our patients about the options they have to strengthen themselves,come out victorious & defeat CA.

094 RARE CHALLENGING CASES PRESENTATION

Morrow Monica
MD, Professor of Surgery, Chief, Breast Service, Department of Surgery, Anne Burnett Windfohr Chari of Clinical Oncology, Weill Medical College of Cornell University, United States of America

1. Fibromatosis or desmoid tumor can be reliably diagnosed with core biopsy and can be observed. Excision to negative margins has a high risk of local recurrence.
2. Angiosarcoma after radiation to the breast is a poor prognosis tumor which is usually treated with mastectomy with wide skin resection. Due to poor outcomes, neoadjuvant therapy should be considered.

096 SYSTEMIC TREATMENT FOR ADVANCED DISEASE: WILL PRECISE ONCOLOGY REPLACE STANDARD CHEMOTHERAPY?

Cleopatra Rapti
MD, MSc, Consultant Medical Oncologist 251 HAF ex-fellow UCLH, Breast Unit, Greece

- ABC hallmark biomarkers: ER, PgR, HER2 (amplified or low)
- PIK3CA, gBRCAm, PDL1 are crucial biomarkers
- MSI, TMB, NTRK, ESR1 are important
- gPALB2, AKT, somaticBRCA, HER2 mutations will have a role in the future
- The precision medicine in Advanced Breast Cancer has demonstrated a positive impact on clinical outcome
- Chemotherapy has been replaced to some point, but still relevant in 2023

097 YOUNG PATIENTS WITH BREAST CANCER: CHARACTERISTICS AND HOLISTIC APPROACH

Morrow Monica

MD, Professor of Surgery, Chief, Breast Service, Department of Surgery, Anne Burnett Windfohr Chari of Clinical Oncology, Weill Medical College of Cornell University, United States of America

Young women present with cancers that are larger due to lack of screening and biologically more aggressive. In spite of this, there is no advantage for mastectomy over BCT, and CPM is not routinely indicated.

Fertility and other psychosocial concerns should be addressed as a routine part of treatment.

099 TECHNIQUES FOR BETTER COMMUNICATION BETWEEN PHYSICIANS AND BREAST CANCER PATIENTS

Froso Tzintziropoulou

Health Psychologist, MSc - Cognitive Behavioral Psychotherapist, Hellenic Association of Women with Breast Cancer "Alma Zois", Greece

"Effective physician-patient communication is a milestone for the psychosocial adjustment of the patient and the better adherence to the treatment. It promotes collaboration and partnership, creates common ground with patient in the decision making process, results in fewer return visits, validates patient's emotion and needs and enhances satisfaction both for the patient and the physician.

In order to achieve effective communication it is necessary to have training programs that include defined skills to be learned, observation of other physicians best practicing those skills, practice and descriptive feedback of performance and rehearsal of those skills again and again."

101 PATIENTS FAMILY ISSUES. SEXUALITY AFTER BREAST CANCER TREATMENT

Mimi Marcellou

PT, MSc., PhD (c), Specialist Musculoskeletal Disorders & Pelvic Floor Physiotherapist; Vice President Europa Donna Hellas; Research Fellow of LANECASM, UNIWA, Athens, Greece

During the conference, in her 30 minute speech, she covered the subject of genitourinary syndrome of menopause in women survivors, its symptoms related to sexual function and treatment options with a small emphasis on pelvic floor physical therapy in order to introduce it to the audience.

Her focus, among others, is on supportive physiotherapy intervention for the treatment of genitourinary syndrome of menopause in women diagnosed with breast cancer. Mimi Marcellou explained how survival should be accompanied by joy and pleasure after breast cancer and how pelvic floor physical therapy acts supportively and therapeutically to help women who have survived the disease to return to a sexual life supported by science and proper care of the female body.

102 NUTRITIONAL GUIDELINES DURING CHEMOTHERAPY

Lida Papakonstantinou
BSc, MSc, PhD, RD, Nutrition & Dietetics Greece

Healthy eating is important during and after cancer treatment. A diet based on protein rich plant-based meals alongside with regular exercise will help cancer patients keep a healthy BMI, maintain strength, and decrease side effects both during and after chemotherapy.

103 NUTRITIONAL GUIDELINES AFTER CHEMOTHERAPY

Fotini Konstantinou
BSc, ND, FABNO, Naturopathic Doctor (Canada), Clinical Biologist, Fellow to the American Board of Naturopathic Oncologists, Clinical Biologist, Consultant -Oncology Clinic Mitera Hospital, Athens, Greece

After a breast cancer diagnosis, it is not unusual for a patient to start searching for strategies that they themselves can implement so that they can improve their outcomes and quality of life. Nutrition plays a critical role in the management of the breast cancer patient.

In this presentation, we discussed which foods have evidence for increased consumption and lifestyle interventions and what the patient can easily do to implement, thus improving the quality of life and reducing their chance of recurrence. The evidence shows that eating foods primarily of plant based origin have the most benefit in decreasing the odds of a breast cancer recurrence. Phytochemicals found in plants work on the epigenetic level in our cells and alter how our genome is read thus influencing health. It is postulated that many small hits confuse a complex system, thus eating a wide range of fruit and vegetables (7-9 daily servings) seems to offer a protective effect against recurrence. This is seen in particular when it comes to triple negative breast cancers and fruit and vegetables of the red , orange and yellow variety.

The most researched diet is the Mediterranean diet and certain foods found within it may benefit the breast cancer patient. In particular, the mustard-cruciferous family: broccoli, kale, cabbage etc. have demonstrated anti cancer effects via sulforaphane. The importance of avoiding/ minimizing highly processed foods, maintaining proper BMI and the role exercise plays in improved outcomes was also highlighted in this presentation.

ΧΑΙΡΕΤΙΣΜΟΣ ΤΕΛΕΤΗΣ ΛΗΞΗΣ

Πρόεδρε της Διεθνούς Εταιρείας Μαστολογίας, Καθ. Schlomo Schneebaum,
Μέλη του Δ.Σ. της Διεθνούς Εταιρείας Μαστολογίας

Αγαπητοί Συνάδελφοι,

Θα ήθελα από καρδιάς να ευχαριστήσω την Διεθνή Εταιρεία Μαστολογίας και ιδιαίτερα τους Προέδρους των δυο τελευταίων Διοικητικών Συμβουλίων. Τον εκλεκτό Συνάδελφο από την Βραζιλία, πρώην Πρόεδρο Καθ. κ. Mauricio Malgahaes Costa και τον νυν Πρόεδρο και εκλεκτό Συνάδελφο από το Ισραήλ κ. Schlomo Schneebaum και τα μέλη του Διοικητικού Συμβουλίου για την τιμή που έκαναν στο πρόσωπό μου με την ανάθεση της διοργάνωσης του 21St SIS World Congress on Breast Cancer and Breast Healthcare στην Ελλάδα, στη Ρόδο.

Επιπλέον θα ήθελα να εκφράσω τις ιδιαίτερες ευχαριστίες μου στον πρώην Πρόεδρο Της SIS Καθ. Alexander Mundinger για την συνεχόμενη ψυχολογική υποστήριξη.

Από καρδιάς ένα μεγάλο ευχαριστώ θα ήθελα επίσης να απευθύνω σε όλους τους εκλεκτούς Συναδέλφους που αποδέχθηκαν την πρόσκλησή μας να συμμετάσχουν ως ομιλητές και προεδρεία στο **21st SIS World Congress on Breast Cancer and Breast Healthcare** τόσο από την Ελλάδα όσο και από τον Διεθνή χώρο αλλά και στους Συμμετέχοντες που τίμησαν με την παρουσία τους το εν λόγω Συνέδριο.

Εκφράζω, λοιπόν τις πιο βαθιές και ειλικρινείς ευχαριστίες μου σε όλους εσάς, και στον καθένα σας ξεχωριστά, και οφείλω να τονίσω ότι πρέπει να νιώθουμε πραγματικά περήφανοι για τα επιστημονικά συμπεράσματα του Συνεδρίου, σε μια περίοδο που η κρίση της πανδημίας επηρέασε και τον Τομέα της Υγείας, αλλά οι άοκνες και συλλογικές προσπάθειες των επιστημόνων για γνώση και πληροφόρηση, δεν σταματούν ποτέ, και παρά τα εμπόδια που αντιμετωπίσαμε για την πραγματοποίηση του ανωτέρω Συνεδρίου, έγινε πραγματικότητα και στέφθηκε με απόλυτη επιτυχία.

Πιστεύω ότι το ανωτέρω Συνέδριο επιτέλεσε το σκοπό του και το έργο του και θα οδηγήσει στους ασχολούμενους με τον Μαστό Ιατρούς στην ανάδειξη και εφαρμογή των τελευταίων επιστημονικών εξελίξεων και στον «συγκερασμό» των βασικών γνώσεων με τα νεότερα επιστημονικά δεδομένα, που ακούστηκαν από αξιόλογους και διακεκριμένους Επιστήμονες από όλο τον κόσμο.

Λαμβάνοντας την ευκαιρία αυτή, θα ήθελα να ευχαριστήσω την Εξοχότατη Πρόεδρο της Ελληνικής Δημοκρατίας κ. Κατερίνα Σακελλαροπούλου και την Α.Θ. Παναγιότητα τον Οικουμενικό Πατριάρχη κ. Βαρθολομαίο Α' για τις Αιγίδες τους.

Επίσης θα ήθελα να ευχαριστήσω ιδιαιτέρως τον διαχρονικό μου φίλο και ιδιοκτήτη του Διεθνούς Συνεδριακού Κέντρου του Ξενοδοχείου Rodos Palace, κ. Αντώνη Καμπουράκη, και την ιδιοκτήτη και Διευθυντή του Ξενοδοχείου κ. Μαίρη Καμπουράκη, για τη θερμή ελληνική φιλοξενία που μας παρείχαν στο όμορφο νησί της Ρόδου.

Πολλές ευχαριστίες επίσης στον Περιφερειάρχη Ν. Αιγαίου, κι επίσης προσωπικό μου φίλο, κ. Γιώργο Χατζημάρκο,

στον Πρόεδρο του Ιατρικού Συλλόγου Ρόδου, Δρ Ηλία Τσέρκη, Συνάδελφο και φίλο,

σε όλους τους Φορείς και Υποστηρικτές του Συνεδρίου και

Στις Συνεργαζόμενες Επιστημονικές Εταιρείες.

Τελευταίο αλλά εξίσου σημαντικό και πιστέψτε με, χρειάζεται περισσότερο από όλα τα άλλα, επιτρέψτε μου να απευθύνω τις θερμότερες ευχαριστίες μου στον Διευθυντή του Γραφείου Διοργάνωσης του Συνεδρίου, κ. Κώστα Παπαπαναγιώτου, ο οποίος είχε το θάρρος να συνεχίσει την πραγματοποίηση αυτού του Συνεδρίου, παρά την οικονομικές δυσκολίες που αντιμετωπίσαμε. Τον ευχαριστώ θερμά καθώς και την κόρη του κυρία Μαρία Παπαπαναγιώτου.

Ευχαριστώ επίσης το προσωπικό του Γραφείου Διοργάνωσης και ιδιαίτερες ευχαριστίες στην κ. Βίκυ Πολίτη, τον κ. Τάσο Μαλλά και την κ. Γαρυφαλιά Μπουσιοπούλου καθώς και τη Γραμματέα της Ελληνικής Εταιρείας Μαστολογίας κ. Ξανθή Παπαηλία που χωρίς τη βοήθειά τους τα πράγματα θα ήταν πολύ πιο δύσκολα.

Πριν από το τέλος της ομιλίας μου, θα ήθελα να σας δείξω τι έλαβα χθες το βράδυ από τον προηγούμενο Πρόεδρο της SIS Καθ. Mauricio Magalhaes Costa, λέγοντάς μου ότι έκανα το αδύνατο δυνατό.

Και θα ήθελα να ευχηθώ μεγάλη επιτυχία στο 22ο Παγκόσμιο Συνέδριο της SIS στο Πουέρτο Ρίκο υπό την Προεδρία του φίλου μου Pr Bolivar Arboleda Osorio.

Ως Πρόεδρος του Συνεδρίου, εύχομαι σε όλους και στον καθένα σας ξεχωριστά καλή επιστροφή και σας ευχαριστώ από καρδιάς για την συμμετοχή σας!

Αντίο.

Δρ Λυδία Ιωαννίδου-Μουζάκα
President of the Congress
ε. Καθηγήτρια Ιατρικής Σχολής Παν/μίου Αθηνών
Χειρουργός-Γυναικολόγος, Μαστολόγος-Ογκολόγος
Πρόεδρος της Ελληνικής Εταιρείας Μαστολογίας
Εθνικός Εκπρόσωπος στην Ε.Ε. για τον καρκίνο του μαστού και τα Κέντρα μαστού
Εκπρόσωπος του Π.Ι.Σ. στην UEMS για τις ανάγκες στη χειρουργική εκπαίδευση στον καρκίνο του μαστού
Δ/ντής Ελληνικής Σχολής Μαστολογίας
Πρόεδρος 21st SIS World Congress on Breast Cancer and Breast Health Care

ΧΑΙΡΕΤΙΣΜΟΣ ΤΕΛΕΤΗΣ ΛΗΞΗΣ

Πρόεδρε του Συνεδρίου: Καθηγήτρια κα Λυδία Ιωαννίδου - Μουζάκα
Διακεκριμένοι επίσημοι ομιλητές
Μέλη της Εταιρείας

Είναι μεγάλη μου τιμή και χαρά εκ μέρους του Διοικητικού Συμβουλίου της Διεθνούς Εταιρείας Μαστολογίας και εμένα ως Πρόεδρου της να σας ευχαριστήσω όλους για τη συμμετοχή σας στο 21ο Παγκόσμιο Συνέδριο για τον Καρκίνο του Μαστού και την Υγεία του Μαστού.

Η συμμετοχή σας συνέβαλε σημαντικά στην επιτυχία αυτού του Συνεδρίου.

Είχαμε συμμετέχοντες από 5 ηπείρους και 25 χώρες.

Θα ήθελα να ευχαριστήσω την Επιστημονική Επιτροπή, για το επίκαιρο και ενδιαφέρον πρόγραμμα, και την οργανωτική επιτροπή για ένα πολύ καλά οργανωμένο Συνέδριο.

Ευχαριστίες στο Γραφείο Οργάνωσης Συνεδρίων Congress World που είναι μια επαγγελματική και αποτελεσματική εταιρεία οργάνωσης που έλυσε, πριν και κατά τη διάρκεια του Συνεδρίου, κάθε πρόβλημα γρήγορα και με χαμόγελο και καλή θέληση.

Ευχαριστούμε τον κ. Κώστα Παπαπαναγιώτου για την εμπιστοσύνη του και τις αποφάσεις που έκαναν πραγματικότητα το Συνέδριο.

Για την οπτικοακουστική ομάδα που έκανε το Συνέδριο μια άψογη εκδήλωση.

Την εταιρεία Dilon Medical Technologies για την υποστήριξη του εορταστικού μας δείπνου.

Ελπίζω ότι όλοι θα συνεχίσετε τη σύνδεσή σας με τη Διεθνή Εταιρεία Μαστολογίας μέσω των διαφορετικών δραστηριοτήτων της.

Pr Schlomo Schneebaum MD, PhD
Πρόεδρος της Επιστημονικής Επιτροπής

ΧΑΙΡΕΤΙΣΜΟΣ ΤΕΛΕΤΗΣ ΛΗΞΗΣ

Χαιρετισμούς από το Πουέρτο Ρίκο, το Νησί της Μαγείας,

Η Πορτορικιανή εταιρεία Μαστολογίας είναι το αντιπροσωπευτικό σώμα του κλάδου της μαστολογίας στο Πουέρτο Ρίκο. Είμαστε μια νέα Εταιρεία, που ιδρύθηκε το 2013, αλλά που είναι πολύ δυναμική. Τα τελευταία εννέα χρόνια πραγματοποιήσαμε το εθνικό μας συμπόσιο, το Caribbean Breast Symposium, με μεγάλη επιτυχία μεταξύ των συναδέλφων μας. Σε συμμόρφωση με τις διατάξεις της Senologic International Society, έχουμε επιλεγεί επίσημα ως ο χώρος διεξαγωγής του 22ου Παγκόσμιου Συνεδρίου SIS για τον Καρκίνο του Μαστού και την Υγεία του Μαστού. Σχεδιάζουμε ένα ολοκληρωμένο πρόγραμμα με ομιλητές παγκόσμιας κλάσης στον τομέα της υγειονομικής περίθαλψης του μαστού, προσυνεδριακά εργαστήρια και συζητήσεις στρογγυλής τραπέζης που αφορούν την πραγματικότητα της υγειονομικής περίθαλψης σε κάθε χώρα μας.

Έχουμε προτείνει ως δοκιμαστική ημερομηνία την άνοιξη του 2025, μεταξύ των μηνών Απριλίου και Μαΐου. Διαθέτουμε ένα συνεδριακό κέντρο πρώτης τάξης με δυνατότητα διεξαγωγής πολλαπλών ταυτόχρονων συνεδριών και έναν εκτεταμένο χώρο για συνεδριάσεις ολομέλειας. Το νησί μας λειτουργεί ως τουριστικός κόμβος για την Κεντρική και τη Λατινική Αμερική μέσω πολλών αεροπορικών εταιρειών και έχει απευθείας πτήσεις σε πολλές ευρωπαϊκές πόλεις, εκτός από πολλαπλές διεθνείς πτήσεις μέσω πόλεων στις ΗΠΑ. Η φιλοξενία μας είναι θρυλική και θα θέλαμε πολύ να παρουσιάσουμε τις πολιτιστικές, εκπαιδευτικές και τουριστικές ευκαιρίες που μπορεί να προσφέρει το νησί μας.

Ελπίζω να σας δούμε όλους στο Σαν Χουάν ντε Πουέρτο Ρίκο το 2025!

Prof. Bolívar Arboleda-Osorio MD FACS
President, Sociedad Puertorriqueña de Senología
Vice President for N.A., Senologic International Society Board Member, Federación Latinoamericana de Mastología


Join us for 22nd WORLD CONGRESS ON BREAST CANCER AND BREAST HEALTHCARE!
San Juan, Puerto Rico- Spring 2025
"mi casa es su casa"
Sociedad Puertorriqueña de Senología
SIS ISS


¡Acompáñanos al 22do Congreso Mundial de Cuidado Mamario y Cáncer de Mama!
San Juan, Puerto Rico- primavera 2025
"mi casa es su casa"
Sociedad Puertorriqueña de Senología
SIS ISS


Rejoignez-nous au 22e Congrès Mondial sur la santé du sein et le cancer du sein !
San Juan, Puerto Rico- Primtemps 2025
"mi casa es su casa"
Sociedad Puertorriqueña de Senología
SIS ISS


Join us for 22nd WORLD CONGRESS ON BREAST CANCER AND BREAST HEALTHCARE!
San Juan, Puerto Rico- Spring 2025
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