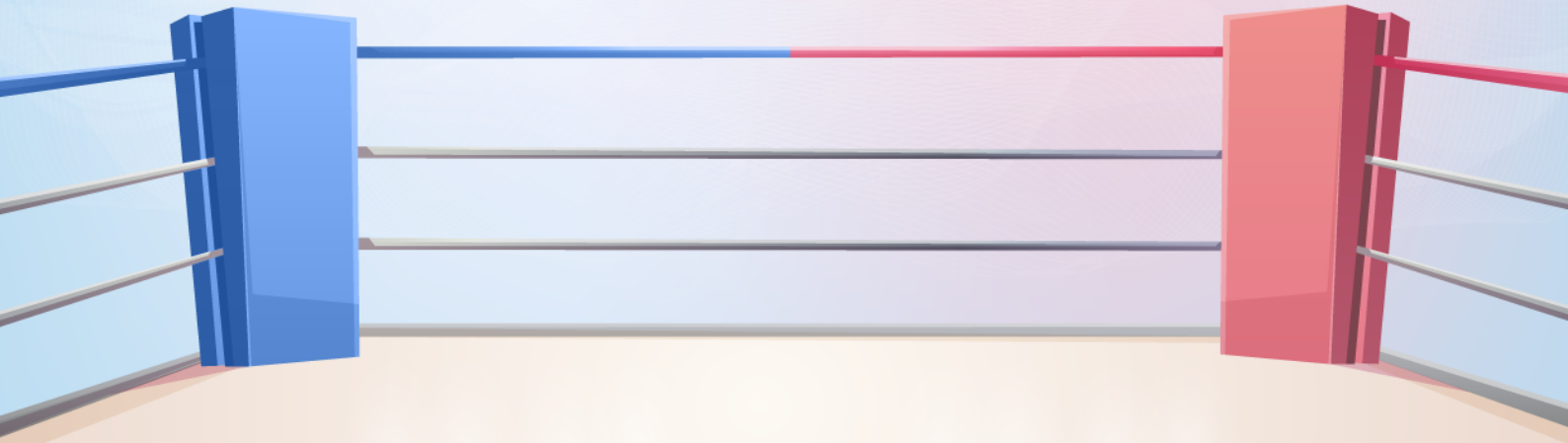
TIBCS 2025
Taipei International Breast Cancer Symposium

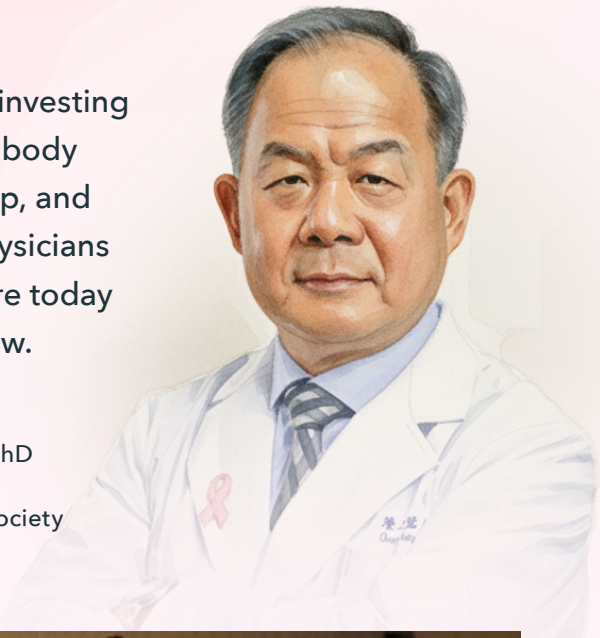
YOUNG DOCTORS

FORUM & DEBATE

TIME Sat., October 25, 2025

ROOM 701D, Taipei Nangang Exhibition Center, Hall 2





Guided by our belief that investing in young doctors is investing in the future, the Young Doctors Forum and Debate embody TBCS's long-term commitment to education, mentorship, and opportunity. By empowering the next generation of physicians and researchers, we strive to advance breast cancer care today while building a more sustainable and hopeful tomorrow.

Fang-Ming Chen, MD. PhD
President
Taiwan Breast Cancer Society

An-Chieh Feng | YDF/YDD Chairman. Tri-Service General Hospital.

The 3rd Young Doctors Forum (YDF) and Young Doctors Debate (YDD) in 2025 Taipei International Breast Cancer Symposium (2025 TIBCS) are exclusive events designed to empower young medical professionals in the breast cancer field around Asia.

Chi-Cheng Huang | TBCS Secretary. Taipei Veterans General Hospital.

Before the competitive discussions commence, two exceptional keynote addresses will establish the groundwork for our program. Through expert mentorship and meaningful dialogue on 2025 TIBCS, we aim to foster the advancement of emerging breast cancer specialists. 💪

An-Chieh Feng. YDF/YDD Chairman. Tri-Service General Hospital.

Participants from nine different countries, including **Taiwan, Korea, Japan, Indonesia, Singapore, Vietnam, Philippines, Mongolia, and America** –were invited to join this program. As a key feature of the Taipei International Breast Cancer Symposium, the YDF/YDD serves as a dynamic platform for young physicians, researchers, and clinicians to exchange perspectives, discuss emerging science, and explore multidisciplinary challenges in breast cancer care

The forum encourages participants to showcase their research, engage in dialogue around cutting-edge developments, and learn directly from senior faculty and thought leaders. Through active knowledge exchange and capacity building, the YDF aims to **cultivate the next generation of breast cancer experts.** In addition to strengthening clinical insight, the forum also supports professional networking, enabling early-career specialists to build meaningful global connections.

Within the debate component, young doctors and researchers have the unique opportunity to present evidence-based arguments, engage with diverse viewpoints, and sharpen analytical thinking under expert guidance. Beyond enhancing clinical knowledge, the debate **fosters critical reasoning, scientific communication, and collaborative learning.** Through participation in the YDD, young clinicians actively contribute to advancing the future landscape of breast cancer care while **expanding professional networks across the international community.**

Agenda

Young Doctors Forum (YDF)			
14:00-14:05	Opening	Chi-Cheng Huang	
14:05-14:30	Beyond the White Coat: Challenges Facing Young Female Breast Oncologists and How to Address Them	Kelly Hunt	
14:30-14:55	Global Perspectives: Navigating Career Pathways in Breast Cancer Treatment for Young Doctors	Tristen Park	
14:55-15:00	Q&A	ALL	
Young Doctors Debate (YDD)			
15:05-15:45	Should ALND Be Dmitted in ypN1micro Luminal Breast Cancer Patient with initial cN1 After Neoadjuvant Chemotherapy?	Team 1 vs. Team 2	Chiao Lo
15:45-16:25	Should adjuvant chemotherapy be avoided in this patient given her low recurrence score, despite the presence of nodal micrometastasis?	Team 3 vs. Team 4	Chun-Yu Liu
16:25-16:30	QA & Closing	Jeong Eon Lee	

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TIBCS 2025
Taipei International Breast Cancer Symposium

Young Doctors Forum

(YDF)

Beyond the White Coat: Challenges Facing Young Female Breast Oncologists and How to Address Them

Kelly K. Hunt, MD, FACS, FSSO

Professor and Chair, Department of Breast Surgical Oncology; The University of Texas MD Anderson Cancer Center

How bad is physician burnout really? 🤔

Early-career oncologist burnout rates jumped from 45% in 2013 to 59% in 2023 - driven by staffing shortages, electronic health records, and insurance processes. We need systemic change now.

Three Core Insights

- **Institutions Don't Love You Back.** Recognize the business nature of institutions and actively advocate for yourself. Build personal support networks and set work boundaries
- **Push vs Pull Career Choices.** Avoid leaving due to dissatisfaction (Push); choose to move toward opportunities (Pull). Clarify your career needs and values
- **Build Your Support Network.** Mentors (career guidance), Coaches (emotional support), Sponsors (advocate for you), Allies (daily support)

Practical Strategies

- Work-Life Integration: Time-blocking to protect important work, **learn to say "no" to unnecessary commitments.** Delegate personal tasks just as you would professional ones
- Redefining Success: Shift from **individual competition to team collaboration, from hours worked to actual impact.** Maintain life outside work when facing difficulties
- Finding Your Purpose: Use the **WHY-HOW-WHAT framework to think about career direction.** Align your goals with personal values

The Importance of Mentorship

Don't limit yourself to assigned mentors; actively **seek those who are a good fit**

Build diverse, long-term relationships; **mentorship doesn't end with fellowship**

Young specialists need **continuous support systems and growth opportunities**

Organizational Reform & Personal Action

- Organizations Need: Flexible work arrangements, mental health support, fair evaluation systems
- You Can: Advocate for yourself, build professional support networks, maintain work-life balance

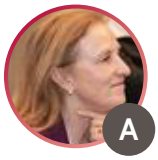
Final Reminders

- Medicine is both a noble calling and a job - you don't need to sacrifice everything for work

  Healthy physicians provide the best patient care
- Global demand for oncologists continues to grow - your work matters, and so does your well-being

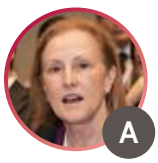
You are needed. The global demand for oncologists is rapidly increasing. Find the place where you can thrive – and grow into your fullest potential.

Q You mentioned that "institutions won't love you back." Have you ever experienced very frustrating or difficult moments in your career? How did you overcome them?



A Yes. I've had many tough moments in my career. I learned that I must find joy not only at work, but also outside of work. When I have a hard day, I reconnect with the patient I'm helping, and I decompress through time with family, watching Netflix, meeting friends, or traveling. Ultimately, we can't expect institutions to love us back, so we need to take care of ourselves and find balance beyond work.

Q After fellowship, does the mentor–mentee relationship still continue? And how should young specialists seek help when they struggle?



A We do assign mentors to junior faculty, but the most meaningful mentorship often comes organically – by approaching someone you truly admire. Just reach out, ask to talk, have coffee, and mentors are usually very willing to support you when you take the initiative.

FACS, Fellow of the American College of Surgeons; FSSO, Fellow of the Society of Surgical Oncology.

Global Perspectives: Navigating Career Pathways for Early Career Doctors

Tristen S Park, MD FACS
Mount Sinai Hospital; Icahn School of Medicine, Associate Professor of Surgery

Why should early career doctors pursue international opportunities 🤔

Three transformative benefits - experiencing the same disease in different settings, gaining deep appreciation for diverse healthcare approaches, and building lifelong international friendships and networks.

From Personal Exchange to Formal Program

Dr. Park's Korean Journey

- Dr. Park's transformative experience at Seoul National University and Asan Medical Center sparked a bilateral exchange that would reshape international medical collaboration. Following her visit, Korean physicians began coming to Mount Sinai Hospital.
- After the visit of Korean physicians, Mount Sinai Hospital initiated its international exchange program. From 2022–2023, the program was developed in collaboration with Yale Medical School, and from **2024–2025, it entered full-scale implementation and tracking at Mount Sinai.**

Mount Sinai International Breast Surgery Program

- The program is designed as a **2–4 week experience.** Participants spend most of the time in clinical rotations, primarily in **Breast Surgery (about 50%) and Breast Reconstruction (about 20%)**, with additional **one-day exposures to Radiation Oncology, Imaging, Medical Oncology**, and **Pathology**. Educational activities include participation in tumor boards, research presentations, grand rounds, and one-on-one mentoring, complemented by welcome dinners and cultural experiences in New York City.

Graduate Success Stories

- Many graduates shared that the program **broadened their worldview** and **influenced their careers**. Dr. YJ Lee (Asan Medical Center) later became Assistant Professor and received the SSO ICDE scholarship at Moffitt; Dr. JJ Jung (Seoul National University) became Assistant Clinical Professor and earned the SSO-ICDE scholarship at Mayo Clinic; Dr. HK Kim noted that

the program changed his life and subsequently was promoted to Assistant Professor and joined the Korean Breast Cancer Society International Division Committee.

- Overall, more than **90% of graduates achieved career advancement** with new international collaborations established.

Other International Exchange Opportunities

Society of Surgical Oncology (SSO) - ICDE Program

- The SSO-ICDE Program offers a $3,000 travel stipend, one year of free SSO membership, a 5-day observership at a U.S. institution, and ongoing mentorship from SSO members. Participants have come from Japan, Korea, Taiwan, Mexico, Peru, and West Africa, with over **90% achieving career advancement.**

The Global Breast Cancer Conference (GBCC)

- GBCC in Seoul brings together over 5,000 participants from 64 countries. Dr. Park serves on the International Scientific Committee, mentors the Junior Doctor Forum, and moderates the Junior Doctor Debate (2022–2024). The debate features teams from the United States, United Kingdom, Spain, Korea, Japan, Taiwan, China, Singapore, and the Philippines, discussing early breast cancer treatment controversies such as DCIS management, radiation therapy, and BRCA carriers, using a structured debate format with team presentations and audience interaction.

The world is smaller than we think, but opportunities for growth through international collaboration are limitless. Early career doctors who embrace global perspectives become bridge-builders in the international medical community.

Q After fellowship, does the mentor–mentee relationship still continue? And how should young specialists seek help when they struggle?

A There is the concept of "mosaic mentorship." You can have a primary mentor, but also add other mentors over time who support different parts of your growth. They don't need to be from your specialty – choose people you connect with and who can guide you in different areas. One mentor doesn't have to do everything.

DCIS, ductal carcinoma In-Situ; ICDE, The International Career Development Exchange.

TIBCS 2025
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Young Doctors Debate

(YDD)

Scan the QR code to watch
highlights of the Young Doctors Debate

送審用

Topic 1: Team 1 vs. Team 2

Should ALND Be Omitted in ypN1micro Luminal Breast Cancer Patient With Initial cN1 After Neoadjuvant Chemotherapy

送審用

Topic 2: Team 3 vs. Team 4

Should Adjuvant Chemotherapy Be Avoided in This Patient Given Her Low Recurrence Score, Despite the Presence of Nodal Micrometastasis?

Young Doctors Debate: Topic 1

Team 1 vs. Team 2

SHOULD AXILLARY LYMPH NODE DISSECTION BE OMITTED IN ypN1MICRO LUMINAL BREAST CANCER PATIENT WITH INITIAL cN1 AFTER NEOADJUVANT?

Moderator

Chiao Lo | National Taiwan University Hospital, Taipei, Taiwan.

Case 1 scenario

Age / Status	47-year-old premenopausal woman
Diagnosis	Clinical T2N1 triple-negative breast cancer (TNBC)
Neoadjuvant Therapy (NAC)	Pembrolizumab + Paclitaxel+Carboplatin
	Pembrolizumab + Doxorubicin + Cyclophosphamide
Treatment Response	Excellent clinical and radiological response
Preoperative Imaging	No residual axillary disease on ultrasound
Surgical Management	Targeted axillary dissection (TAD)
Lymph Node Findings	Clip-marked node negative -1 of 3 sentinel lymph nodes positive with isolated tumor cells (ITCs)
Final Pathology	pTONO(I+)

Should axillary lymph node dissection be performed on this patient?

Cons - Team 1: Omit Axillary Lymph Node Dissection

Go Team 1!


Leader
Chih-Hao Huang
Taiwan
China Medical University Hospital

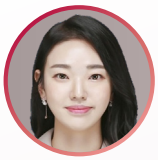

Deputy
Zhu-Jun Loh
Taiwan
National Cheng Kung University Hospital


Hsiang-Wei Huang
Taiwan
National Taiwan Univ. Cancer Center


Ting-Yi Liao
Taiwan
China Medical University Hospital


Wen-Pei Wu
Taiwan
Taichung Municipal Geriatric and Rehabilitation Hospital


Batsukh Pushkin
Mongolia
National Cancer Center of Mongolia


Doyoun Woen
Korea
Sungkyunkwan Univ. School of Medicine


Asdi Wihandono
Indonesia
Dr. Soetomo General Hospital


Mai Kitazawa
Japan
Asahi University Hospital


Jennifer Tseng
USA
City of Hope Orange County

Pros - Team 2: Perform Lymph Node Dissection

Team 2, Fighting!


Leader
Chieh-Ni Kao
Taiwan
Kaohsiung Medical Univ. Chung-Ho Memorial Hospital


Deputy
Han-Fang Cheng
Taiwan
Taipei Veterans General Hospital


Ruoh-Yun Gau
Taiwan
Chang Gung Memorial Hospital


Hsueh-Han Tsai
Taiwan
Tri-Service General Hospital


Wen-Chi Yang
Taiwan
National Taiwan University Hospital


Hitomi Mori
Japan
Japanese Red Cross Fukuoka Hospital


Jeffrey Hing
Singapore
Singapore Changi General Hospital


Young-Won Lee
Korea
Korea University Anam Hospital

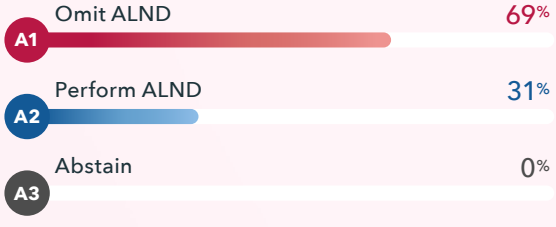

Yi Ping Lim
Malaysia
University of Malaya


Tuguldur Dashzeveg
Mongolia
National Cancer Center of Mongolia

Pre-voting

In this scenario, should ALND be omitted based on current evidence, or is completion ALND still necessary to ensure adequate staging and local control?

(Results presented as number of participants voted. N = 59)



ALND, axillary lymph node dissection.

Team 1 presentation (5 min)

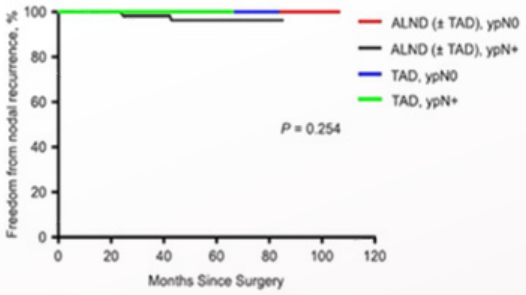
Omit Axillary Lymph Node Dissection

Asdi Wihandono

- Although ALND has been the traditional standard, it carries significant morbidity (e.g., lymphedema, shoulder dysfunction), and contemporary axillary management is shifting toward de-escalation (SLNB/TAD).
- In patients with ypN1 ITC after neoadjuvant systemic therapy, ALND has not demonstrated survival benefit nor does it change systemic treatment, while TAD provides adequate diagnostic accuracy and ypN0 with ITC shows similar prognosis as ypN0.

Ting-Yi Liao

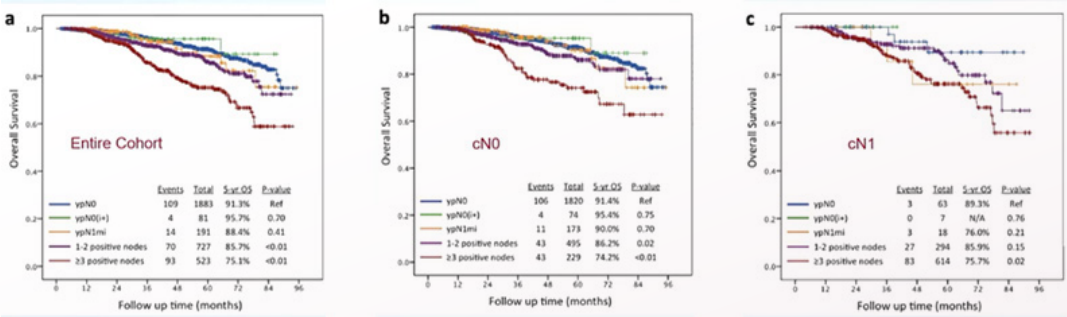
- Large retrospective cohorts show that omitting ALND does not negatively impact DFS, OS, nor increase local or distant recurrence[1].
- TAD after NAC demonstrates a false-negative rate similar to ALND (4–7%), and studies consistently show no significant difference in 3-year RFS between TAD and ALND[2].



- For TAD-negative or low-burden nodal patients, omission of ALND is safe, and ALND provides minimal additional diagnostic or therapeutic value in this setting[3].

Doyoun Woen

- Five-year OS was similar among ypN0, ypN0 ITC, and ypN1 micro groups, and 3-year axillary / invasive recurrence rates showed no difference regardless of whether ALND was performed[4].



- Other studies consistently support that omission of ALND in ypN1 or ypN1 micro patients does not adversely impact DFS or OS[5,6].

Conclusion

- TAD is reliable and sensitive, and ypN0 ITC patients have similar prognosis as pure ypN0.
- After neoadjuvant systemic therapy, ypN0 ITC patients have low nodal burden and very low recurrence risk, even when ALND is omitted.
- Therefore, considering safety, evidence-based practice, and patient-centered care, ALND should be omitted in this population.

1. Chen F, et al World J Surg. 2023;47(10):2446-2456. 2. Kuemmel S, et al. Ann Surg. 2022;276(5):e553-e562. 3. Wu SY, et al. Int J Surg. 2023;109(7):1863-1870. 4. Kantor O, et al. NPJ Breast Cancer. 2020;6:35. 5. Montagna G, et al. J Clin Oncol. 2025;43(7):810-820. 6. Jessica N, et al. Annals of Surgical Oncology. 2024;31:8813-8820.

ALND, axillary lymph node dissection; DFS, disease-free survival; ITC, isolated tumor cells; OS, overall survival; RFS, recurrence-free survival; SLNB, sentinel lymph node biopsy; TAD, targeted axillary dissection.

Team 2 presentation (5 min)

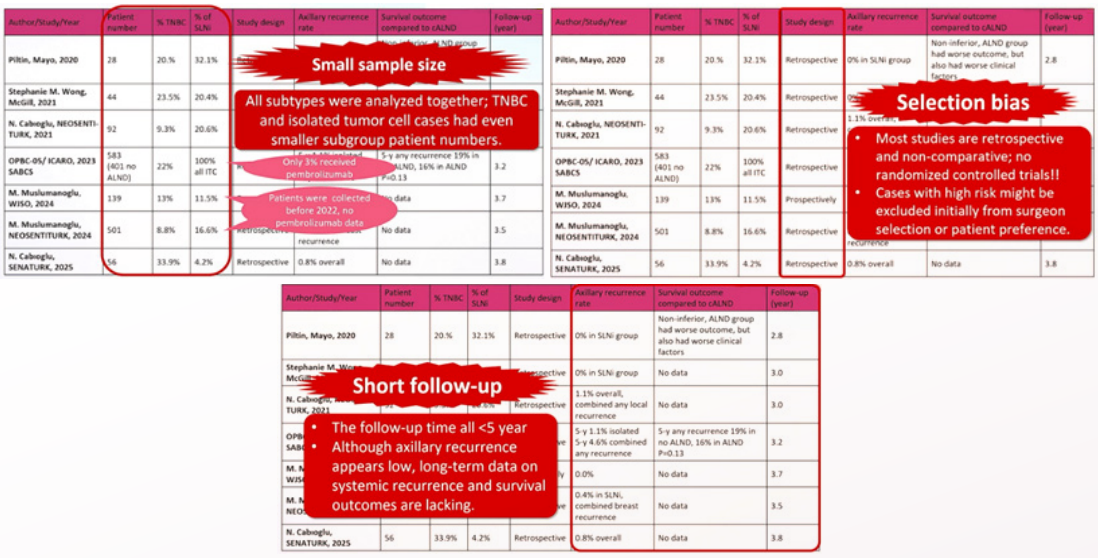
Perform Lymph Node Dissection

Hsueh-Han Tsai

- Current major guidelines remain uncertain regarding omission of ALND. According to 2025 NCCN and 2024 ESCO guidelines, any residual nodal disease after neoadjuvant therapy (regardless of size) still favors ALND[1,2].
- The AGO 2025 recommendation against ALND for ypN0(i+) is mainly based on OPBC05[3], which is retrospective with insufficient TNBC proportion, thus limited evidence strength[4].
- Particularly in HER2+ and TNBC, ALND may still reveal additional positive nodes that could alter treatment decisions; therefore, ALND should remain the standard strategy at present[4].

Ruoh-Yun Gau

- Studies supporting omission of ALND in ITC-only disease suffer from small sample sizes, high heterogeneity, low pembrolizumab usage, and short follow-up (<5 years), lacking long-term survival validation[4-10].



- In the ICARO study, even among ITC-only patients, ALND still identified ~30% additional positive nodes, suggesting substantial residual axillary disease may remain[4].
- Therefore, using ITC alone as a "low-risk" basis to omit ALND may be too risky in clinical practice.

I couldn't get a chance to say it.

Conclusion

- Current evidence and major guidelines still show uncertainty toward omitting ALND, and in certain subgroups (e.g., HER2+ / TNBC / ITC-only cases), additional nodal disease may still be uncovered by ALND, potentially altering treatment recommendations.
- Many studies supporting omission of ALND have methodological limitations (small samples, selection bias, short follow-up, low pembro exposure), and real-world data (e.g., ICARO) show that even ITC-only cases can still harbor significant residual nodal burden.
- Therefore, based on current evidence quality and heterogeneous risk across subtypes, ALND omission should remain cautious and not broadly generalized to all ITC / micro disease after neoadjuvant systemic therapy.

1. NCCN Guidelines Version 4.2025. Invasive Breast Cancer. 2. Gennari A et al. 2021;32(12): 1475-1495 3. AGO guidelines breast cancer version 2025. 1E. 4. Montagna G, et al. J Clin Oncol. 2025;43(7):810-820. 5. Piltin MA, et al. Ann Surg Oncol. 2020;27(5):1524–1532. 6. Wong SM, et al. Ann Surg Oncol. 2021;28(8):4482–4493. 7. Cabıoğlu N, et al. Eur J Surg Oncol. 2021;47(10):2506-2514. 8. Muslumanoglu, M, et al. World J Surg Onc. 2024;22.A286. 9. Muslumanoglu M, et al. Cancer. 2025 ;131(1):e35610. 10. Cabıoğlu N, et al. Eur J Surg Oncol. 2025;51(6):109642.

AGO, Arbeitsgemeinschaft Gynäkologische Onkologie; ALND, axillary lymph node dissection; ESMO, European Society for Medical Oncology; HR, hormone receptor; ITC, isolated tumor cells; NCCN, National Comprehensive Cancer Network; SLNB, sentinel lymph node biopsy; TAD, targeted axillary dissection; TNBC, triple negative breast cancer.

Debate: pre-informed question

Phase 1 Team 2 presents Question for Team 1

Given that the ICARO study evaluated patients with isolated tumor cells (ITCs) after surgery or neoadjuvant therapy and showed that 30% of those who underwent ALND still had additional positive nodes–including 5% macrometastases–yet did not stratify by molecular subtype nor report systemic treatment details, how can omission of ALND be considered oncologically safe in TNBC patients with residual ITCs, where aggressive tumor biology suggests even minimal residual disease may be clinically meaningful?

Phase 2 Team 1 defends (3 min)

Zhu-Jun Loh

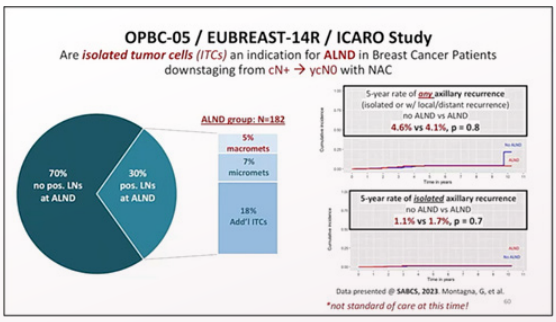
- Although ICARO did not stratify by subtype or systemic therapy[1], multiple SLN trials (e.g., SOUND, INSEMA) also had low TNBC representation[2,3], yet consistently showed that when residual disease is limited to ITC, performing ALND does not impact DFS or OS.
- The key determinant is tumor burden, not molecular subtype; omission of ALND remains oncologically safe when the burden is low (ITC).

Batsukh Pushkin

- Even though minimal residual TNBC disease could theoretically be clinically meaningful, data from KEYNOTE-522[4], real-world evidence of KEYNOTE-522[5], and ICARO1 all indicate that TNBC/HER2+ patients who achieve breast pCR still harbor extremely low axillary residual burden (predominantly ITCs).
- In the immunotherapy era, the biological impact of ITCs still warrants study, but available evidence shows the burden remains extremely low.

Hsiang-Wei Huang

- Even when small amounts of residual tumor cells exist in the axilla, overall survival and axillary recurrence rates are not significantly different[6].
- Therefore, routine ALND is not necessary and can maintain both oncologic safety and better patient quality of life.



Left more, right choice!
Left more, live better!

1. Montagna G, et al. J Clin Oncol. 2025;43(7):810-820. 2. Gentilini OD, et al. JAMA Oncol. 2023;9(11):1557-1564. 3. Reimer T, et al Trial. N Engl J Med. 2025;392(11):1051-1064. 4. Schmid P, et al. N Engl J Med. 2020;382(9):810-821. 5. Connors C, et al Cancer. Ann Surg Oncol. 2025;32(2):912-921. 6. Montagna G, et al. SABCS 2023.

ALND, axillary lymph node dissection; DFS, disease-free survival; ITC, isolated tumor cells; OS, overall survival; SLN, sentinel lymph node; TNBC, triple negative breast cancer.

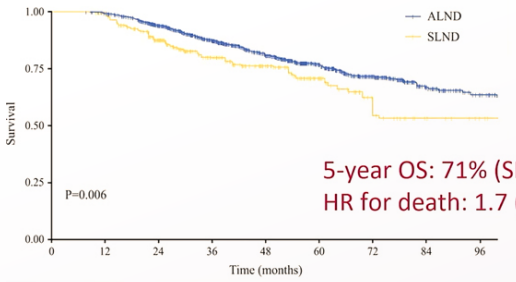
Phase 3 Team 1 presents Question for Team 2

Recent studies show no survival disadvantage when ALND is omitted in ypN0(i+) patients. Given that ALND increases morbidity (e.g., lymphedema, shoulder dysfunction) and does not alter systemic therapy, how is routine ALND still justified from an evidence-based and patient-centered perspective?

Phase 4 Team 2 defends (3 min)

Jeffrey Hing

- Although some argue ALND has no survival benefit, a large 2021 retrospective study showed a 5-year OS advantage with ALND; the SLNB group actually had higher mortality risk[1].



- The concept of "ITC behaves like N0" only applies to Luminal tumors; in TNBC, ITC behaves more like N1 disease. Therefore, we cannot assume TNBC ITC is still low-risk – omitting ALND may be overly optimistic.

Wen-Chi Yang

- Evidence supporting omission of ALND mainly comes from upfront surgery populations[2,3] and does not apply to the neoadjuvant setting.
- In upfront surgery, ITC represents low burden – but post-neoadjuvant ITC represents treatment-resistant clones, which is biologically different. Not performing ALND may also under-stage ~1/3 of patients, directly impacting adjuvant therapy and radiation decisions[4].

Yi Ping Lim

- ALND precisely defines residual axillary tumor burden and is foundational for individualized risk-stratified treatment decisions.
- Modern lymphatic reconstruction and early rehabilitation reduce risks of lymphedema and shoulder dysfunction5. When comparing "possible undetected residual disease" vs "ALND morbidity," maintaining ALND may actually be the lower-risk and safer option.

Known risk may be manageable; unknown risk may be irreversible – which would you choose?

1. Almahariq MF, et al. Ann Surg Oncol. 2021;28(2):930-940. 2. de Boniface J, et al. BMC Cancer. 2017;17(1):379. 3. Donker M, et al. Lancet Oncol. 2014;15(12):1303-10. 4. Montagna G, et al. J Clin Oncol. 2025;43(7):810-820. 5. Desai A, et al. Surgery. 2024;176(5):1485-1491.

ALND, axillary lymph node dissection; HR, hormone receptor; ITC, isolated tumor cells; OS, overall survival; SLNB, sentinel lymph node biopsy.

Re-battle

Question to Team 2:

You said you support ALND because guidelines recommend it – but in patient-centered care, we treat patients, not guidelines. How do you justify that? And if the evidence for SLNB-only is limited, why does that automatically favor doing more aggressive surgery?

Team 2 defends (5 min)

Chieh-Ni Kao

- In ICARO, most additional positive nodes were still ITC, with only ~5% micrometastasis.
- Residual TNBC disease ultimately requires effective systemic therapy rather than assuming ALND can cure it.
- Modern techniques (reverse mapping, lymphatic reconstruction) can lower lymphedema risk, making ALND morbidity more controllable.

Ruoh-Yun Gau

- In ICARO, beyond ITCs there were still 7% micrometastasis and 5% macrometastasis.
- These represent clinically meaningful residual disease and still require radiotherapy – so ITC cannot simply be considered low risk.

Wen-Chi Yang

- Omitting ALND shifts all treatment intensity to systemic therapy/radiation – both of which have long-term toxicities.
- With surgical refinements and lymphatic reconstruction, ALND toxicity can be reduced, so systemic therapy era does not mean we should de-emphasize local control.

Young-Won Lee

- TNBC biology is highly aggressive and systemic adjuvant options are limited.
- Therefore, TNBC particularly requires stronger local control rather than further surgical de-escalation.

If evidence is limited, why is your default always **"do more harm" instead of "do less harm"**?

If you omit ALND, you're just **shifting all the toxicity to systemic therapy and RT**. Since **surgery toxicity can be reduced** while systemic toxicity lasts way longer. Is that omitted ALND really good for patients?

TNBC is extremely **aggressive and systemic adjuvant options are limited**. For TNBC, **stronger local control is the safer choice**, not further de-escalation.

ALND, axillary lymph node dissection; ITC, isolated tumor cells; RCT, randomized controlled trial; TNBC, triple negative breast cancer.

Re-battle

Question 1 to Team 1:

In KEYNOTE-522, ypN0 patients with ITCs were still considered non-pCR, and even with maximized systemic therapy (immunotherapy + capecitabine), outcomes were still poor. If systemic treatment can't be further intensified, how can you feel confident de-escalating surgery and omitting ALND?

What other effective treatment can actually be added at this point?

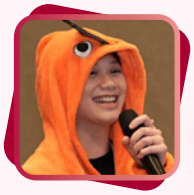
Team 1 defends (5 min)

Jennifer Tseng

- Even when non-pCR patients receive intensified systemic therapy, historical data still show that axillary surgery does not improve survival – prognosis depends on tumor biology + systemic therapy, not surgical intervention.
- Today systemic options are broader than capecitabine + IO – ADCs and olaparib are also available.
- If ALND does not increase survival but harms quality of life, then from a patient-centered perspective, we should not perform an invasive procedure with no benefit.

Chih-Hao Huang

- The debate here is specifically about whether ALND itself is needed – not about whether capecitabine, immunotherapy or radiation are needed.
- In this scenario, ALND does not provide incremental therapeutic benefit – therefore it should not be performed.



The reason we were able to begin de escalating surgery is largely due to advances in systemic therapy and radiotherapy. Treatment modalities should be viewed as an integrated strategy; they work together, and surgery should not be discussed in isolation.

Question 2 to Team 1:

ALND has not shown an additional survival benefit, but this evidence comes solely from the pre-immunotherapy era. Today, patients may still have residual disease after neoadjuvant chemotherapy plus immunotherapy and experience poor outcomes despite adjuvant capecitabine with IO. In this context, how can we be confident that complete axillary surgical clearance is not clinically meaningful?

- How can we be so certain that ALND has no therapeutic effect as a cytoreduction modality?

Team 1 defends (5 min)

Jennifer Tseng

- KEYNOTE-522 shows that immunotherapy before and after neoadjuvant systemic therapy is standard, and performing ALND does not alter the systemic treatment that follows.
- Minimal residual disease (ITC/micro) is better controlled by radiation, which is more effective for small and scattered residual burden than surgery.
- Therefore, within this modern treatment framework, additional axillary surgery does not provide extra survival benefit. If ALND does not increase survival but harms quality of life, then from a patient-centered perspective, we should not perform an invasive procedure with no benefit.

Without immunotherapy era evidence, who is prepared to claim that ALND omission is truly “safe” for a high-risk subtype with ongoing unmet medical needs?

Even in non-pCR patients who escalate systemic therapy, surgery has never shifted survival curves. **Why do an invasive operation that doesn’t change survival but only harms quality of life?**

ADC, antibody-drug conjugate; ALND, axillary lymph node dissection; IO, immunotherapy; ITC, isolated tumor cells; NAC, neoadjuvant systemic therapy; PARP, poly ADP- ribose polymerase; pCR, pathological complete response.

Topic 1 conclusion

Should ALND Be Omitted in ypN1micro Luminal Breast Cancer Patient With Initial cN1 After Neoadjuvant Chemotherapy?

Team 1

Cut less and cure better!

Wen-Pei Wu

- Evidence shows no oncologic or survival disadvantage, and targeted axillary dissection is reliable.
- Therefore, omitting ALND remains safe, evidence-based, and patient-centered.

Team 2

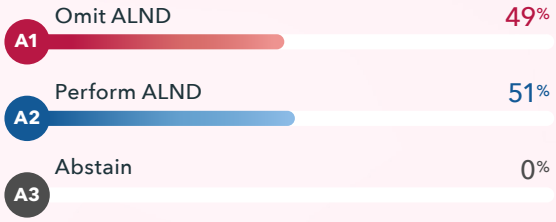
Known risk is safer than unknown! metastasis

Hitomi Mori

- Guidelines still support ALND, and evidence for omission remains weak, especially in TNBC with ypN0(i+) which may still reflect residual disease.
- Therefore, performing ALND manages a known and controllable risk, rather than taking the unknown risk of leaving behind undetected metastasis.

Post-voting

(Results presented as number of participants voted. N = 83)



Moderator comments

- Both teams presented strong arguments and supported them with data, and the shift in votes reflects how convincing both sides were.
- In real-world practice, ypN0 with ITC is still considered non-pCR, therefore the pros and cons of omitting or performing ALND must be thoroughly discussed with each patient.
- Ultimately, every modality – surgery, systemic therapy, and their potential adverse effects – carries trade-offs, and shared decision-making with patients remains essential in clinical practice.

ALND, axillary lymph node dissection; ITC, isolated tumor cells; pCR, pathological complete response; TNBC, triple negative breast cancer.

Young Doctors Debate: Topic 2

Team 3 vs. Team 4

SHOULD ADJUVANT CHEMOTHERAPY BE AVOIDED IN THIS PATIENT GIVEN HER LOW RECURRENCE SCORE, DESPITE THE PRESENCE OF NODAL MICROMETASTASIS?

Moderator

Chun-Yu Liu | Taipei Veterans General Hospital, Taipei, Taiwan

Case 2 scenario

Age / Status	47-year-old premenopausal woman
Diagnosis	Invasive ductal carcinoma, grade 2
Tumor Size	2.3 cm
Nodal Status	1 of 3 sentinel lymph nodes positive (micrometastasis)
Hormone Receptors	ER positive (95%), PR positive (80%)
HER2 Status	Negative
Ki-67	20%
Genomic Profile	Oncotype DX recurrence score: 9

Would you offer adjuvant chemotherapy?

ER, estrogen receptor; PR, progesterone receptor.

Cons - Team 3: o Adjuvant Chemotherapy

Get ready, Team 3!


Leader
Ming-Han Yang
Taiwan
National Taiwan University Hospital


Deputy
Chia-Chen Li
Taiwan
National Taiwan Univ. Cancer Center

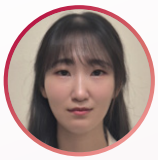

Chan-Keng Yang
Taiwan
Chang Gung Memorial Hospital


Fu-Ming Cheng
Taiwan
China Medical University Hospital


Desak Gede Agung Pramesti Devi
Indonesia
Dr. Soetomo General Hospital


Kaori Tane
Japan
Hyogo cancer Center


Yoshie Kobayashi
Japan
Oikawa Breast Care Hospital


Su Min Lee
Korea
Samsung Medical Center


Kibum Kim
Korea
Samsung Medical Center


Thu Hang Hoang
Vietnam
National Cancer Hospital Vietnam

Pros - Team 4: Adjuvant Chemotherapy

Team 4 accepts the challenge!


Leader
Shih-Yu Huang
Taiwan
Kaohsiung Chang Gung Memorial Hospital


Deputy
I-Chen Tsai
Taiwan
Taichung Veterans General Hospital


Wei-Nung Liu
Taiwan
Tri-Service General Hospital


Chia-Yen Hung
Taiwan
MacKay Memorial Hospital


Saranzaya Damdin
Mongolia
National Cancer Center of Mongolia


Dahn Byun
Korea
Samsung Medical Center


Kyunghwan Kim
Korea
Soonchunhyang University


Donghyeon Oh
Korea
Yeungnam Univ. Medical Center

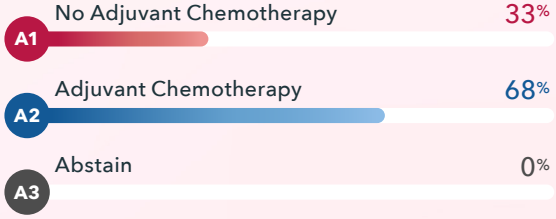

Seung Ah Lee
Korea
Samsung Medical Center


Adrianne Carmel Cabrera
Philippines
The Medical City Ortigas

Pre-voting

Should adjuvant chemotherapy be avoided in this patient given her low recurrence score, despite the presence of nodal micrometastasis?

(Results presented as number of participants voted. N = 80)



Team 3 presentation (5 min)

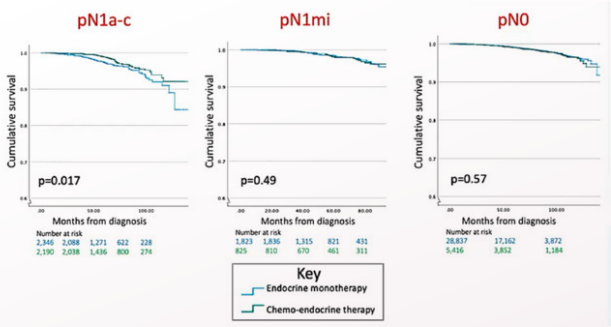
No Adjuvant Chemotherapy

Desak Gede Agung Pramesti Devi

- Oncotype DX individualizes treatment based on tumor biology rather than stage alone. TAILORx and RxPONDER show that with low RS (<15), even node positive (1–3) postmenopausal patients do not benefit from chemotherapy[1,2]; premenopausal benefit mainly comes from ovarian suppression effects.
- Guidelines consistently recommend endocrine therapy alone for low RS. For this patient (RS = 9, N1 micro)[3,4], the behavior is essentially N0 – no chemotherapy needed.

Kaori Tane

- N1 micrometastasis does not significantly worsen prognosis and should not drive chemotherapy decisions[5].
- National database studies show RS <26 with pN1 micro does not gain survival benefit from chemotherapy – micrometastasis alone should not force chemo use[6].



Su Min Lee

- Chemotherapy decisions should weigh benefit vs toxicity – chemo has significant short/long-term side effects and impacts quality of life[7].
- For RS 0–10, benefit is minimal and N1 micro behaves similarly to N0. In younger patients, much of the perceived benefit is due to ovarian suppression, not chemotherapy cytotoxicity – therefore overtreatment should be avoided.

Conclusion

- Low RS is the true driver of treatment decisions; N1 micrometastasis behaves clinically similar to N0.
- In RS <15 (especially 0–10), chemotherapy benefit is minimal; in premenopausal patients, most of the observed benefit mainly comes from ovarian suppression rather than true cytotoxic effect.
- Avoid overtreatment – endocrine therapy alone is appropriate; chemotherapy toxicities outweigh the small/no benefit in this profile.

1. Sparano JA, et al. N Engl J Med. 2018;379(2):111-121. 2. Kalinsky K, et al. N Engl J Med. 2021;385(25):2336-2347. 3. NCCN Guidelines Version 4.2025. Invasive Breast Cancer. 4. Gennari A et al. 2021;32(12): 1475-1495. 5. Houvenaeghel G, et al. ESMO Open. 2021;6(3):100151. 6. Bilani N,et al. Oncologist.2023;28(12):1049-1054. 7. Franzoi MA,et al. JAMA Netw Open. 2024;7(2):e240688.

RS, recurrence score.

Team 4 presentation (5 min)

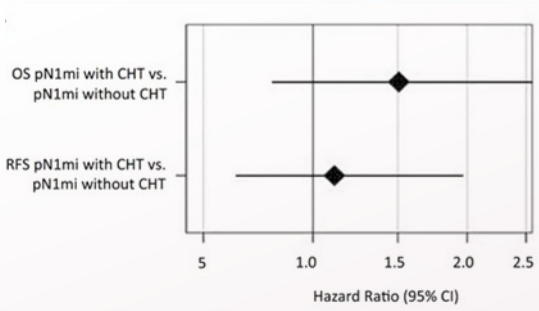
Adjuvant Chemotherapy

Dahn Byun

- Although RS=9 appears low risk, patients' clinical risk is not low: tumor >2 cm1, Ki67 ~20% borderline high proliferation1, premenopausal2, age 47[3].
- These combined factors indicate her true recurrence risk is higher than what her RS alone suggests – RS cannot be the sole determinant of "low risk.".

Adrianne Carmel Cabrera

- Premenopausal women derive the greatest benefit from chemotherapy – not only from cytotoxic killing but also from ovarian suppression[4].
  - Micrometastasis is not equivalent to N0; when combined with other high-risk features, chemo benefit becomes more pronounced5. In RxPONDER, premenopausal micro-positive patients still gained ~7% DFS improvement[6].



- Ki67 high proliferation tumors are also more chemo sensitive – treatment should not rely on RS alone but integrate clinical biologic factors[7].

Time's up. What a pity I didn't get to speak.

Conclusion

- RS alone cannot define "low risk"; clinical and biologic factors (tumor >2 cm, borderline high Ki-67, premenopause, age <50) still substantially elevate true recurrence risk.
- pN1 micrometastasis is not equivalent to N0; when combined with other high-risk features, chemotherapy provides additional benefit – in RxPONDER, premenopausal micro-positive patients still gained ~7% DFS improvement.
- In premenopausal patients, chemotherapy benefit is driven not only by cytotoxic effect but also by ovarian suppression – therefore treatment decisions must integrate tumor biology + clinical context, not rely on RS alone.

1. Pan H, et al. N Engl J Med. 2017;377(19):1836-1846. 2. Aninye IO, et al. Menopause. 2021;28(10):1186-1191. 3. Dumas E, et al. J Clin Oncol. 2025;43(16):1863-1874. 4. Paluch-Shimon S. et.al ESMO Breast Cancer 2022. 5. Hetterich M, et al. Breast Cancer Res Treat. 2021;187(3):715-727. 6. Kalinsky K, et al. N Engl J Med. 2021;385:2336–2347. 7. Pagani O, et al. N Engl J Med. 2014;371(2):107-18.

DFS, disease-free survival; RS, recurrence score.

Debate: pre-informed question

Phase 1 Team 4 presents Question for Team 3

Donghyeon Oh

It is generally known that the benefit of chemotherapy is relatively small in patients with a low recurrence score on Oncotype DX. However, given that this patient is relatively young and premenopausal, the possibility of late recurrence cannot be completely excluded. So can we justify omitting adjuvant chemotherapy solely based on recurrence score?

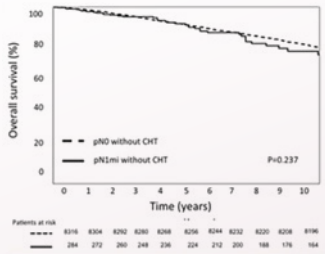
Phase 2 Team 1 defends (3 min)

Fu-Ming Cheng

- In RxPONDER, endocrine therapy intensity in premenopausal women was inadequate (mostly Tamoxifen alone; very few received OFS + AI)[1], so the "chemo benefit" seen there could actually be replaced by OFS + AI[2].
- pN1 micro cases were later excluded[1], making the conclusion unstable. For low RS patients who can receive OFS + AI, chemotherapy is not necessary.; premenopausal benefit mainly comes from ovarian suppression effects.

Yoshie Kobayashi

- Large datasets show pN1 micrometastasis has a prognosis similar to N0 disease[3].
- Studies also show chemotherapy does not improve outcomes in this group – micrometastasis alone is not a valid reason to give chemotherapy[4].



Kibum Kim

- OFS + AI already provides DFS benefit superior to chemotherapy.
- pN1 micro has excellent prognosis with small sample size and weak supporting evidence – chemotherapy has no meaningful quantifiable advantage in this subgroup.

If you can already win without chemo – why pay chemo's price?

1. Kalinsky K, et al. N Engl J Med. 2021;385:2336-2347. 2. Francis PA, et al. N Eng J Med.2018;379(2):122-137. 3. Roberts MC, et al. Breast Cancer Res Treat. 2017;163:303-310. 4. Hetterich M, et al. Breast Cancer Res Treat. 2021;187:715-27.

AI, aromatase inhibitor; DFS, disease-free survival; OFS, ovarian function suppression.

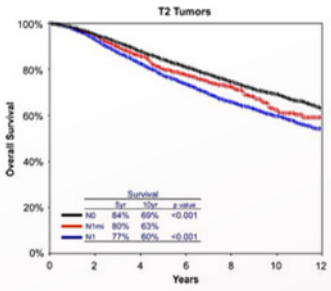
Phase 3 Team 3 presents Q1 for Team 4

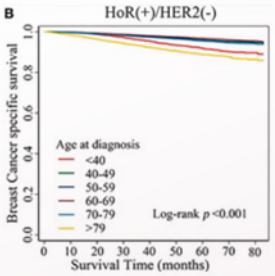
Since the responder acts, excluding micrometastasis in the final protocol, and N1 micro, as we just mentioned, behaves more like node-negative patients, why can you extrapolate chemotherapy data from patients with a larger node-positive disease to this low-risk cases?

Phase 4 Team 4 defends (3 min)

I-Chen Tsai

- This patient should not be viewed as truly low risk. Large datasets indicate N1 micro behaves closer to N1 rather than N0; plus young age + premenopausal status are adverse factors.





- Predict modeling still supports chemotherapy benefit. Chemotherapy-induced menopause itself improves prognosis – therefore chemo should not be excluded solely because RS is low.

Wei-Nung Liu

- Even though RxPONDER excluded pN1 micro[1], real-world still sees these cases. NCDB data show pN1 micro is intermediate risk, not low risk[2] – and AJCC still classifies it as N1.
- IBCSG 23-01 may support omitting surgery[3], but cannot be extrapolated to support omitting chemotherapy.

Kyunghwan Kim

- Age <50, premenopausal status, T2 tumor, Ki67 ~20% and N1 micro together represent higher clinical risk.
- Chemotherapy provides both cytotoxic effect and ovarian suppression benefit – therefore there is clear justification for chemotherapy in this patient.

Chemotherapy isn't escalation – it's necessary protection!

1. Kalinsky K, et al. N Engl J Med. 2021;385:2336-2347. 2. Bilani N, et al. Oncologist. 2023;28(12):1049-1054. 3. Galimberti V, et al. Lancet Oncol. 2013;14(4):297-305.

Re-battle

Question 1 to Team 4:

If this patient will already receive ovarian function suppression, what additional absolute benefit from the cytotoxic effect of chemotherapy do you expect, given her very low recurrence score?

Team 4 defends (5 min)

Shih-Yu Huang

- Chemotherapy should not be decided by Recurrence Score alone – this patient still has multiple high-risk clinical factors (T2 tumor size, Ki67 ~20%, premenopausal status).
- Even with ovarian suppression, she remains a higher-risk profile; RS does not fully capture this risk.
- With newer data since 2023 (e.g., MONARCH, NATALEE), this category of patients is considered clinically high-risk, therefore chemo consideration is still justified.

Question 2 to Team 4:

If this is a low-proliferation, high ER-signaling tumor (as reflected by the low RS), and chemotherapy historically shows limited benefit in low-proliferation disease, then what biological mechanisms can still plausibly explain chemotherapy benefit in this patient?

Team 4 defends (5 min)

I-Chen Tsai

- Although her Oncotype DX RS is 9, we must also recognize she has a 2.3 cm tumor and Ki-67 of 20%.
- A Ki-67 around 20% still indicates a relatively higher proliferation rate and higher recurrence risk.
- Therefore, she cannot be classified as purely “low risk” based on RS alone.

Question 3 to Team 4:

Given the discrepancy between Ki-67 and the low RS – and knowing Ki-67 has high inter-observer variability – which would you trust more for decision making: your local Ki-67 IHC or the Oncotype Recurrence Score?

Team 4 defends (5 min)

Chia-Yen Hung

- Every test, including Oncotype DX, has limitations – we cannot rely on one result alone.
- This patient is premenopausal and likely a long-term survivor; therefore, we should avoid taking unnecessary risk by omitting chemotherapy in someone with traditional high-risk factors.
- As long as there remains meaningful recurrence risk, recommending chemotherapy is still the safer choice.

If patient already receives ovarian suppression, **what EXTRA meaningful cytotoxic benefit do you actually expect from chemotherapy** – with RS only 9?

Because **high clinical risk still matters** – T2 tumor, Ki-67 ~20% and premenopause don't become "low risk" just because RS says so.

ADC, antibody-drug conjugate; ALND, axillary lymph node dissection; ER, estrogen receptor; IO, immunotherapy; ITC, isolated tumor cells; NAC, neoadjuvant systemic; RS, recurrence score.

Question 1 to Team 3:

Since chemotherapy will not benefit everyone and may harm some, and based on your rationale that chemo is not the right answer for this population, what do you believe is the most beneficial treatment strategy for this group overall?

Team 3 defends (5 min)

Ming-Han Yang

- If chemotherapy is not given, ovarian suppression plus endocrine therapy would be essential – for at least 5 years, possibly up to 7 years.
- Additional targeted agents could also be considered if specific genomic alterations are identified.

Question 2 to Team 3:

If ovarian function suppression is not reimbursed in your country, what alternative treatment strategy would you consider?

Team 3 defends (5 min)

Ming-Han Yang

- In most Asian countries, ovarian function suppression is widely accessible and less toxic than chemotherapy.
- Therefore, ovarian function suppression may serve as an appropriate alternative strategy for this type of patient.

Question 3 to Team 3:

How did your team approach the decision of whether to add ribociclib or abemaciclib in this type of clinical scenario?

Team 3 defends (5 min)

Ming-Han Yang

- This case does not meet MONARCH criteria, but could potentially fit NATALEE in the future – however, ribociclib is not yet approved in Japan/Taiwan, so it would not be offered currently.
- Even though this patient is not truly low-risk, adding chemotherapy does not reduce long-term recurrence risk based on current evidence.
- If future approvals become available, additional targeted agents may be considered for long-term benefit – but chemotherapy is unlikely to meaningfully change outcomes here.

Chia-Chen Li

- In the NATALEE trial, although patients were considered intermediate-to-high risk, 10–15% of them still did not receive adjuvant chemotherapy.
- This reflects that even within this risk category, physicians still individualized decisions – chemotherapy was not automatically mandated.
- Therefore, eligibility for NATALEE does not necessarily mean chemotherapy is always required for every patient.

Question 4 to Team 3:

Would you consider adjuvant TS-1 for this patient if she does not receive chemotherapy?

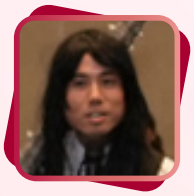
Team 3 defends (5 min)

Ming-Han Yang

- Based on the POTENT trials, adding TS-1 could be considered as an additional option for reducing recurrence risk.
- This could be discussed as part of individualized escalation strategy for this patient.

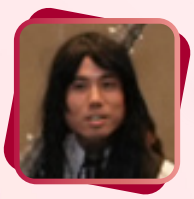
If chemo isn't the answer – what IS the best systemic strategy for this group?

Ovarian suppression + endocrine therapy remains the backbone – long enough (5–7 yrs) and possibly with targeted agent add-on if genomics support it.



If you truly believe chemo is unnecessary, would you at least consider **TS-1 as escalation?**

Hey, you're my man! …but yes – based on POTENT, **TS-1 could still be considered as a lower-toxicity escalation option.**



TS-1 is chemo – just the **easier chemo**~

Topic 2 conclusion

Should Adjuvant Chemotherapy Be Avoided in This Patient Given Her Low Recurrence Score, Despite the Presence of Nodal Micrometastasis?

Team 3

Less is more!

Thu Hang Hoang

- Despite low RS, this patient has favorable tumor biology and micrometastasis; chemotherapy toxicity outweighs meaningful benefit.
- Optimal strategy is endocrine therapy + ovarian function suppression (± CDK4/6 inhibitor if eligible), rather than chemo-endocrine escalation.
- Goal is to avoid avoidable harm – endocrine-based systemic control is sufficient.

Team 4

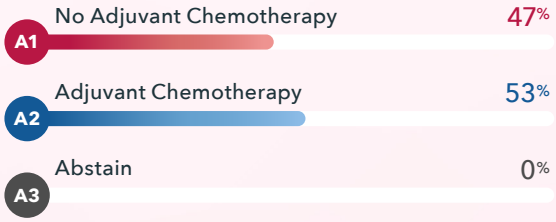
High risk, high treatment

Saranzaya Damdin

- Chemotherapy provides dual benefit in premenopausal women – cytotoxic effect + ovarian suppression – especially important in higher clinical risk (T2, Ki-67 >20%, young age, pN1 micro).
- Oncotype DX is informative, but N1mi subgroup was largely excluded from major genomic trials – RS cannot replace clinical risk assessment.
- High-risk HR+/HER2-negative premenopausal patients may gain >5% recurrence risk reduction with chemo + endocrine intensification (supported by MONARCH-E / NATALEE).

Post-voting

(Results presented as number of participants voted. N = 76)



Moderator comments

- N1 micrometastasis patients were largely excluded from major genomic trials, creating uncertainty when a very low RS result appears in this subgroup – leading to debate on whether low RS truly predicts chemosensitivity here.
- Another key controversy is whether premenopausal status alone should trigger chemotherapy, especially when combined with traditional pathological risk factors (T2, Ki-67, N1 micro) and how N1 micro should be classified (N0 vs N1).
- Both teams demonstrated strong preparation and thoughtful argumentation, reflecting the complexity and real-world challenge of decision making in this scenario.

RS, recurrence score.

QA & Closing

Jeong Eon Lee, M.D., Ph.D.

Breast Division, Department of Surgery. Sungkyunkwan University School of Medicine
Samsung Medical Center

Everything is not clear at this moment!

Considerations in Topic 1

- How much can we truly rely on large-scale, global, multicenter, but retrospective studies, such as the OPBC-05/ICARO or OPBC-07/microNAC studies?
- Should we strictly adhere to the existing guidelines, or is it sometimes acceptable to deviate from them under the guise of multidisciplinary decision-making?
- In case of ypbCR/ypN0(i+), how big will be the difference from ypbCR/ypN0 (The latter is pCR, but both are RCB-0), considering that the prognosis of ybT0 and ypTis is not so different from each other.
- How could we practically design and conduct a prospective study for TNBC in the post-neoadjuvant setting?

Considerations in Topic 2

Ex 1. RxPONDER trial did not clearly separate the true cytotoxic effect of chemotherapy from the ovarian-suppression effect in pre(peri)menopausal women, making its conclusions for young or N1mi patients uncertain.

Ex 2. Early immune checkpoint inhibitor (ICI) trials were confusing as the ER(+) cutoff changed from 1% to 10%. Should therapy depend on ER percentage alone, or on identifying patients likely to achieve pCR with NAC and enhancing it with ICIs?

- Before conducting a clinical trial, careful design with the concept of multidisciplinary approach is essential. Anything is better than nothing! Maybe consider single arm observation study?

You May be the Change

“盡信書，則不如無書” - 孟子

"Wisdom begins in wonder." - Socrates

"Progress is impossible without change, and those who cannot change their minds cannot change anything." - George Bernard Shaw

ER, estrogen receptor; ICI, immune checkpoint inhibitor; NAC, neoadjuvant systemic therapy; pCR, pathological complete response; TNBC, triple negative breast cancer.