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Table: 634P

Median [IQR]	Bodyfat %	Muscle Mass %	Phase Angle	VO2 Max	Grip Strength
Baseline	29.9	38.3	5.6	30.0	30.0
Cond 1 p value	0.934	0.855	0.097	0.802	0.07
Mon 1	29.4	38.9	5.5	29.0	30.0
Hyp 1 p value	0.729	0.638	**0.038**	0.096	**0.004**
Mon 2	29.5	38.7	5.6	31.0	29.0
Washout p value	0.359	0.252	0.665	**0.030**	0.359
Mon 3	28.0	39.24	5.6	29.0	26.0
Cond 2 p value	0.421	0.561	**0.013**	0.599	0.073
Mon 4	26.9	39.63	5.9	30.0	28.0
Hyp 2 p value	0.599	0.846	0.121	0.339	**0.037**
Mon 5	26.6	39.7	5.7	31.0	29.5

Conclusions: Both hypertrophy- and conditioning-focused advanced resistance training regimens are safe and effective for breast cancer survivors. Notably, hypertrophy-focused resistant training regimens to uniquely optimize muscle mass, combat sarcopenia, improve balance and coordination, and enhance bone density, do not appear less efficacious than conditioning-focused regimens with respect to RMR or VO_2 max.

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635P Yield of annual surveillance mammography in patients ≥ 65 years treated for low-risk early breast cancer

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Background: Surveillance after treatment of early breast cancer aims to find potentially curable locoregional recurrence or contralateral breast cancer, and breast imaging is important for early detection. Annual mammography surveillance is established in clinical practice, but knowledge about the yield of this strategy is limited. The aim of this study was to assess the yield of annual surveillance mammography in women $\geq$ 65 years treated for low-risk early breast cancer.

Methods: This was a retrospective study based on the population from a prospective Swedish cohort study evaluating risk of local recurrence after omission of postoperative radiotherapy in women $\geq$ 65 years with low-risk, estrogen receptor (ER)-positive, pT1N0 breast cancer treated with breast-conserving surgery and endocrine therapy and followed-up with annual mammography for 10 years. We collected data from radiology information systems or medical records on surveillance mammograms including indication, findings and additional testing as well as diagnoses of locoregional recurrence and contralateral breast cancer events. We calculated detection rates for locoregional recurrence and contralateral breast cancer, false-positive rate, and interval cancer rate with 95% confidence intervals (CI).

Results: The final study cohort included 526 patients (87.5% of the original cohort) with a median age of 70 years (range 65 — 90 years) and a median tumor size of 11 mm (range 3 — 20 mm). All tumors were pT1N0, ER-positive ($\geq$ 10%), grade 1 or 2 and non-lobular. A total of 4292 mammograms were performed, of which 4205 were surveillance mammograms. Detection rates for locoregional recurrence and contralateral breast cancer were 5.9 (95% CI 3.6 — 8.3) and 3.8 (95% CI 2.4 — 4.6) per 1000 surveillance mammograms, respectively. The false-positive rate was 8.4 (95% CI 6.0 — 11.7) per 1000 mammograms. The rate of interval cancer was 1.4 (95% CI 0.6 — 3.1) per 1000 mammograms (all indications).

Conclusions: In older women with favorable breast cancer characteristics, the yield of annual surveillance mammography was modest, with false-positive findings as frequent as true cancer detections and a low rate of interval cancers, suggesting that follow-up strategies could be individualized in this population.

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637P Breast cancer survivorship: Implementing a movement-based supportive care program

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Background: Since March 2023, a structured supportive care program incorporating a movement-based intervention (TANGO-MOVE) has been implemented at our center to assist breast cancer patients during the transition from active treatment to survivorship. Since March 2023 this program is offered to patients who completed at least 6 months of standard oncological therapy in a certified breast cancer center.

Methods: Enrolled participants complete standardized self-assessments of global health (European Organization for Research and Treatment of Cancer QLQ-C30), cancer-related fatigue (Cancer Fatigue Scale Germany), and treatment adherence (Medical Adherence Report Scale Germany), followed by participation in an 8-week, once-weekly movement-based intervention and scheduled multi-professional assessments after program completion and at 6-month follow-up. Fatigue outcomes were contextualized against fatigue data from a randomized controlled trial conducted at the same centers.

Results: Participants had a mean age of 57.9 years; 92.6% had an Eastern Cooperative Oncology Group) performance status of 0. After completion of the program, clinically relevant improvements were observed in health-related quality of life, particularly in role functioning (+14 points; $p = 0.04$) and social functioning (+20 points; $p = 0.01$), with sustained or further improvements at 6 months. Cancer-related fatigue decreased markedly from baseline to post-intervention (mean change −8.3; $p < 0.001$) and at follow-up (−11.2; $p < 0.001$). When compared with reference data from a randomized controlled Tango-Movement trial conducted at the same center, patients participating in the structured TANGO-MOVE program showed a more pronounced reduction in cancer-related fatigue. Standard oncological treatment adherence was high at baseline and remained stable over time.

Conclusions: The TANGO-MOVE program was feasible in follow-up care and associated with sustained, clinically meaningful improvements in cancer-related fatigue and selected health-related quality-of-life domains, with treatment adherence that persisted even after 6 months. These findings support the integration of structured movement-based program as a supportive component of breast cancer survivorship care.

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