STATMENT OF THE BULGARIAN JOINT CANCER NETWORK
February 2026

NEW CONCEPTS AND RECOMMENDATIONS IN BREAST CANCER from Best of SABCS® 2025 Bulgaria

Introduction

This document is an official expert statement of the Bulgarian Joint Cancer Network (BJCN). It contains essential results and messages from the San Antonio Breast Cancer Symposium (SABCS® 2025) and the licensed presentation of the best of it in Bulgaria in February 2026. The aim of the statement is to transform the presented scientific research and results into findings and recommendations that will upgrade the clinical thinking and behavior of Bulgarian oncologists working with breast cancer.

1. Tumor biology

- In residual disease from triple-negative breast cancer after neoadjuvant systemic treatment, assessment of Ki-67 and tumor-infiltrating lymphocytes (TILs) is recommended due to prognostic value, the possibility of more precise risk stratification, and the selection of adjuvant strategies [J. Holdtschmidt et al. / Neoadjuvant GBG/AGO-B Trials, SABCS 2025].
- In residual disease from triple-negative breast cancer after neoadjuvant systemic treatment, assessment of TILs and molecular subtype with predictive value is recommended to identify high-risk subgroups (low TILs level + basaloid phenotype) [SS. Badve et al. / ECOG-ACRIN EA1131, SABCS 2025].
- In stage II/III luminal HER2-positive (HER2+) breast cancer treated neoadjuvant with taxane + trastuzumab/pertuzumab (THP), analysis of TIL levels may be considered due to its predictive value for response to systemic therapy and correlation with a higher rate of pathological complete response (pCR), allowing for risk stratification and consideration for personalization of post-neoadjuvant treatment [SS. Badve et al. / EA1181/Compass HER2 pCR trial, SABCS 2025].
- In HER2+ breast cancer in stages I-III and neoadjuvant systemic treatment with dual anti-HER2 blockade with trastuzumab/pertuzumab, a digital and AI-based approach can be added to the assessment of TILs by traditional manual methodology due to better prognostic and predictive value [R. Salgado et al. / Aphinity trial, SABCS 2025].

- In early HER2+ breast cancer in stages I-IIIA treated with neoadjuvant systemic therapy, baseline and dynamic monitoring of circulating tumor DNA (ctDNA) during systemic therapy could be considered due to its predictive value for pCR and correlation with invasive disease-free survival (iDFS) [AL. Llombart-Cussac et al. / PHERGain trial, SABCS 2025].
- In de novo metastatic HER2+ breast cancer, tumor-wide genomic profiling could be considered for prognostic purposes: presence of a pathogenic PIK3CA mutation correlates with poorer survival, and a shift in mutational signatures from HRD to APOBEC suggests a risk of resistance [S. Fernando et al., SABCS 2025].
- In early high-risk triple-negative breast cancer, a tissue-free approach for ctDNA detection and serial surveillance after initial systemic treatment may be considered to provide more frequent and earlier identification of molecular residual disease (MRD) and higher predictive rates for recurrence compared with ddPCR-based tumor-informative approaches [N. Cunningham et al. / TRAK TN trial, SABCS 2025].
- In postmenopausal women with non-metastatic luminal (ER+) breast cancer who have completed 5 years of adjuvant endocrine therapy, the use of a SET ER/PR signature (> 1.50) with predictive value for extended endocrine therapy could be considered, especially in patients with involved lymph nodes, aromatase inhibitor treatment, or preserved bone density (BMD T-score > −2.0) [EP. Mamounas et al. / NRG oncology / NSABP-42 trial, SABCS 2025].
- In early triple-negative breast cancer treated with neoadjuvant chemotherapy ± atezolizumab, MRD monitoring by personalized (tumor-informed) ctDNA testing based on whole-exome sequencing (WES) could be considered, with prognostic value and for risk stratification for distant recurrence and 3-year disease-free survival [M. Balic et al. / NSABP B-59 / GBG-96-GeparDouze trial, SABCS 2025].
- In non-metastatic luminal ER+/HER2-negative breast cancer, clinicians may consider personalized (tumor-informed) ctDNA testing to assess MRD at key time points (C1D1, C6D1, EOT) with prognostic value for distant recurrence-free survival (DRFI) [HA. Parsons et al. / PALLAS trial, SABCS 2025].
- In metastatic HER2-negative breast cancer with a proven pathogenic variant in BRCA1/2 or PALB2, clinicians may consider using RAD51 (RAD51-low phenotype) as a predictive biomarker for sensitivity to PARP inhibitors [I. Pimentel et al. / Radiola trial, SABCS 2025].
- When discussing neoadjuvant immunochemotherapy for early triple-negative breast cancer, clinicians may consider using gene expression subtyping in combination with quantitative assessment of TILs to refine prognosis and aid therapeutic decision-making: identification of BLIA subtype and/or TILs ≥ 30% correlates with a higher probability of pCR and better event-free survival (EFS) with the addition of atezolizumab [C. Denkert et al. / NSABP B-59 / GBG-96-GeparDouze trial, SABCS 2025].
- In immunologically “cold” luminal B-like HER2-negative breast cancer and a decision for neoadjuvant systemic treatment, the addition of an immune checkpoint inhibitor and/or adenosine blocker may be considered with

aim to increase the rate of pCR as a result of reprogramming the tumor microenvironment [M. Carauso et al. / Neo-CheckRay trial, SABCS 2025].

2. Prevention and supportive care

- For the control of menopausal symptoms (natural menopause or from risk-reducing pelvic surgery) in healthy women carrying a pathogenic gmBRCA 1/2, oral hormone replacement therapy with monoestrogen or estrogen-progesterone containing combined preparations may be considered due to the lack of worsening of the cumulative incidence of invasive breast cancer [J. Kotsopoulos et al., SABCS 2025].
- In women from the general population, a higher intake (> 5/6 servings per week) of cruciferous vegetables and dietary glucosinolates is recommended to reduce the risk of breast cancer [A. Romano-Nanclares et al. / SABCS 2025].
- In healthy women without a personal history of breast cancer, genetic testing is recommended as part of risk-based, individualized screening strategies due to the potential for more accurate risk stratification and optimization of preventive and screening approaches [K. Fergus et al. / WISDOM, SABCS 2025].
- In individuals with established pathogenic gmPALB2, intensified surveillance, selective screening and prophylaxis are recommended compared to the general population due to a significantly increased risk of developing malignant neoplasms, primarily breast carcinoma and pancreatic ductal adenocarcinoma [Y. Tan et al., SABCS 2025].
- In premenopausal women aged 18-45 years with stage I-III breast cancer and planned systemic (neo)adjuvant treatment, referral to an oncofertility specialist is recommended due to significant receptivity to fertility and ovarian function preservation procedures: addition of targeted fertility and ovarian function preservation strategies (GnRH analogues ± cryopreservation) is recommended due to improved ovarian function recovery and reproductive outcomes, without compromising oncological safety – no impact on progression-free survival and overall survival [Lambertini et al. / PREFER trial, SABCS 2025].
- In young women aged 15-39 years with breast cancer stage 0 (DCIS)-III, less than 3 years after the end of active treatment and with no evidence of recurrence, symptom monitoring (PRO) using validated tools specifically designed for this target group is recommended to reduce disease burden, improve quality of life and reduce the need for follow-up visits, despite the lack of significant improvement in levels of depression, anxiety and fatigue [A. Partridge et al. / YES trial, SABCS 2025].
- In patients with stage 0 luminal breast carcinoma (DCIS)-III and requiring adjuvant endocrine therapy for ≥ 1 year, frequent visits for toxicity assessment and use of “smart” tablet storage/taking devices are recommended due to doubling of adherence rates after 12 months, regardless of drug type [S. Manobianco et al., SABCS 2025].
- In patients who have survived treatment for non-metastatic breast cancer and have cognitive impairment and sleep disturbances, it is recommended to conduct

of acupuncture due to significant objective improvement in cognitive impairment [J. Mao et al. / Enhance trial, SABCS 2025].

- For treatment and end-of-life care decisions in patients with advanced cancer, questionnaires completed by the patients and their caregivers are recommended to overcome discrepancies between preferences and end-of-life decisions [A. Ozaki et al., SABCS 2025].
- In women eligible for breast cancer screening, risk-based individualized screening is preferred over a standard approach without individual risk stratification due to proven safety, better identification of those at highest risk, higher levels of preference and satisfaction, and the potential for more efficient and personalized use of screening resources [LJ. Esserman et al. / WISDOM 1.2, SABCS 2025].
- In early luminal breast carcinoma, the use of multimodal artificial intelligence (AI) models integrating imaging, clinical and molecular data may be considered due to higher prognostic potential for detection of early and late recurrences, personalized follow-up and therapeutic planning [J. Sparano et al. / Tailor X, SABCS 2025; EP. Mamounas et al. / Tailor X, SABCS 2025; CE Geyer, SABCS 2025].

3. Imaging diagnostics

- In the case of residual involvement of internal mammary chain (IMC) lymph nodes after neoadjuvant systemic therapy, confirmed by preoperative breast magnetic resonance imaging (MRI), postoperative radiotherapy with high-dose radiation to the area is recommended due to a significant improvement in distant recurrence-free survival [Y. Peng et al, SABCS 2025].
- In breast cancer with neoadjuvant systemic treatment and initial (at diagnosis) presence of metastatic (cN3) lymph nodes from the IMB, preoperative evaluation with breast MRI is recommended to de-escalate postoperative radiotherapy and avoid overdosing in the area of complete response (ycN0) due to lack of benefit for local and distant recurrence-free survival [Y. Peng et al, SABCS 2025].
- In early triple-negative or non-luminal HER2-positive (HER2+) breast cancer without pathogenic gmBRCA 1/2, in stages I-II (cT1-cT3 cN0 or cT0-2 cN1) and with planned conservative surgery, routine addition of breast MRI to conventional preoperative locoregional staging by contrast-enhanced ultrasound and mammography is not recommended due to the lack of a significant reduction in the risk of locoregional recurrence [I. Bedrosian et al./ Alliance A011104/ACRIN 6694, SABCS 2025].
- In metastatic bone disease from luminal breast carcinoma, serial FDG PET/CT scans may be considered to assess response to a specific line of systemic therapy due to correlation with progression-free survival: categorizing response as complete or partial, stable disease, and progression according to mPERCIST criteria is recommended, despite significant variability in assessment [J. Specht et al. / FEATURE - ECOG-ACRIN EA1183, SABCS 2025].

4. Surgery

- In the case of macrometastases in 1-3 sentinel lymph nodes after conservative surgery in the axilla, routine addition of axillary dissection (after sentinel lymph node dissection) is not recommended due to lack of

significant difference in 5-year invasive disease-free survival (iDFS), overall survival (OS), and locoregional recurrence rate; in high proliferative index (Ki-67 > 20%), the addition of axillary lymph node dissection is recommended due to a significant difference in 5-year iDFS [T. Reimer / INSEMA Rando2, SABCS 2025].

- In patients > 50 years of age with luminal HER2-negative breast cancer at stage cT1 cN0 and G1-2 and with planned breast-conserving surgery and postoperative radiotherapy, sentinel lymph node dissection could be omitted due to the lack of significant deterioration in 5-year local recurrence-free survival [M. Shmidt et al. / BOOG 2013-08, SABCS 2025].
- In case of baseline nodal axillary involvement (cN1-3a), regardless of baseline T-status and biological subtype, and with conversion to negative axillary status (ycN0) after neoadjuvant systemic therapy, de-escalation in axillary surgery (SLNB/TAD/TLNB) is recommended as an alternative to axillary dissection due to similar 3-year axillary recurrence-free survival. Sentinel or target dissection can be considered as similar alternatives. Decision on the volume of axillary surgery according to baseline cT/cN-stage is not recommended due to lack of correlation with axillary recurrence rate [T. Kuehn et al. / AXSANA/ EUBREAST 3(R), SABCS 2025].
- In case of baseline nodal involvement (cN+) with initial (or after neoadjuvant systemic treatment) targeted axillary dissection, assessment of the number of positive axillary lymph nodes is recommended to predict residual disease in the axilla and the need for subsequent axillary dissection [W. Weber et al. / TAXIS study, SABCS 2025].
- In planned radical surgery for breast cancer, a minimally invasive procedure is preferred over conventional mastectomy in order to reduce the incidence of early and late postoperative complications (Clavien-Dindo ≥ 3) [HS. Park et al. / MARRES trial, SABCS 2025].
- In postmenopausal women with non-metastatic luminal HER2-negative breast cancer at stage cT2-4 cN0-3, consideration of neoadjuvant endocrine therapy (NEOT) with the aim of de-escalation from mastectomy to conservative surgery is recommended. Pathological complete response rate in the breast or axilla is not recommended for assessment of response. In preoperative cN0- or ycN0-stage patients with planned conservative breast and axilla surgery, including planned postoperative radiation and systemic therapy, if stage pN1(sn) is established, omitting axillary dissection and management according to ACOSOG Z-011 criteria could be considered [A. Leitch et al. / ALTERNATE Trial, SABCS 2025].

5. Radiation therapy

- In non-low-risk DCIS treated with organ-conserving surgery, the addition of an over-dose to the tumor bed may be considered to reduce the risk of local recurrence, regardless of the whole-breast fractionation regimen used, despite an increased risk of breast pain and/or fibrosis ≥ grade 2 [BH. Chua et al. / BIG 3-07 / TROG 07.01 trial, SABCS 2025].
- In selected low-risk patients with organ-sparing surgery for early breast cancer at stage cT1/2 (≤ 5 cm) cN0, omitting postoperative radiotherapy may be considered due to the lack of a statistically significant difference in invasive disease-free survival (IDFS),

despite an increased risk of local recurrence [G. Hildebrandt et al. / Insema trial, SABCS 2025].

- In luminal B-like HER2-negative breast cancer at stage cT1c-4 cN1-3 cM0 and with at least one high-risk feature (G3, Ki-67 ≥ 20%, high genomic risk, G1-2 and cN2-N3), the addition of preoperative radiotherapy (24 Gy) to systemic chemotherapy combined with pembrolizumab could be hypothesized for a clinical trial due to reliable immune activation (increased T-cell infiltration and formation of tertiary lymphoid structures), despite the lack of a significant improvement in the rate of pathological complete response (pCR) and proven clinical significance [G. Gupta et al. / P-RAD trial, SABCS 2025].
- Protons may be considered as an option for adjuvant radiotherapy in breast cancer, rather than photons, due to lower average radiation doses to the heart [JL. Right et al. / RadComp trial, SABCS 2025].

6. Medical oncology

6.1. ER+ DCIS

- In low-risk G1-2 ER+ ductal carcinoma in situ (DCIS) without comedonecrosis and < 2.0 cm in size (by imaging), 5 years of tamoxifen 20 mg is not recommended as an alternative to surgery due to a lower 5-year cumulative incidence of invasive disease, despite similar surgery-free survival for ipsi- or contralateral invasive disease and overall survival [H. Iwata et al. / LORETTA trial: JCOG1505, SABCS 2025].

6.2. Non-metastatic carcinoma

- In high-risk breast cancer and neoadjuvant systemic therapy, early assessment (after 3 weeks of treatment) of symptoms of toxicity is recommended due to its correlation with the rate of pathological complete response (pCR). Early breast magnetic resonance imaging (MRI) (after 3 weeks) may be considered to predict pCR. It is not recommended to change the therapeutic behavior based on the type and time of onset of symptoms of toxicity [A. Basu et al. / I-SPY Trial, SABCS 2025].

6.2.1. Triple negative non-metastatic carcinoma

- In stage I-III triple-negative breast cancer and initial surgery, the addition of carboplatin to adjuvant treatment with epirubicin/cyclophosphamide followed by a taxane is recommended due to improved disease-free survival, distant recurrence rate, and overall survival [X. Chen et al. / RJBC 1501, SABCS 2025].
- In early high-risk triple-negative breast cancer with radical surgery, intensification of adjuvant chemotherapy with the addition of carboplatin to standard anthracycline/taxane-based systemic therapy is recommended due to higher 3-year disease-free survival (PFS), local and distant recurrence-free survival, and overall survival (OS) [JJ. Li et al. / Citrine trial, SABCS 2025].
- In early triple-negative breast cancer and a decision for neo-adjuvant systemic treatment, regardless of carrier status of pathogenic gmBRCA 1/2, the addition of carboplatin is recommended due to a significant improvement in event-free survival, despite the lack of improvement in pathological complete response (pCR) rate and OS [BM. Felsheim et al. / BrighTNess, CALGB 40603 (Alliance), and GeparSixto, SABCS 2025].

- In ER(0), HER2-negative breast cancer harboring pathogenic somatic (sm) or gmBRCA 1/2 in stages I and II (cT1b-c cN0), neoadjuvant systemic treatment with olaparib may be considered as an alternative to systemic chemotherapy due to the achievement of a significant pCR rate (68%). Neoadjuvant systemic treatment with olaparib + durvalumab may be considered as an alternative to systemic chemotherapy due to the achievement of a significant pCR rate (80%) [N. Tung et al. / OlympiaN, SABCS 2025].
- In triple-negative breast cancer with a carrier of pathogenic gm BRCA 1/2 in stages I and III and a primary tumor ≥ 1 cm, an 18-week neoadjuvant systemic treatment with niraparib + dostarlimab can be considered to achieve a significant pCR rate (50%), especially with high baseline levels of TILs (> 15%) [EL. Meyer et al. / TBCRC-056, SABCS 2025].

6.2.2. Luminal HER2-negative non-metastatic carcinoma

- In stage II and III luminal HER2-negative breast cancer, the addition of 2 years of adjuvant palbociclib to adjuvant endocrine therapy is not recommended due to the lack of benefit in invasive disease-free survival, distant recurrence, and OS [A. De Michele et al. / Pallas trial, SABCS 2025].
- In early luminal HER2-negative breast cancer, adjuvant administration of giredestrant may be considered over standard endocrine therapy (aromatase inhibitor or tamoxifen) due to a significant improvement in 3-year survival without invasive recurrence and without distant dissemination [AL. Bardia et al. / lidERA trial, SABCS 2025].

6.2.3. HER2-positive (HER2+) non-metastatic carcinoma

- In neoadjuvant systemic treatment for HER2+ breast cancer, administration of the anti-HER2 antibody-drug conjugate ARX788, compared with conventional sequential neoadjuvant administration of THP and AC regimens, significantly improves pCR and residual cancer burden (RCB) rates 0/I [PR. Pohlman et al. / I-SPY 2.2 – ARX788, SABCS 2025].
- In high-risk early HER2+ breast cancer, neoadjuvant systemic treatment with T-DXd, alone or followed by neoadjuvant paclitaxel + trastuzumab + pertuzumab (THP), may be considered as an alternative to ddAC-THP regimens due to a comparable safety profile and comparable pCR rates [G. Currigliano et al. / DESTINY-Breast 11, SABCS 2025].
- In high-risk early HER2+ breast cancer with residual invasive disease after neoadjuvant systemic therapy, adjuvant treatment with trastuzumab deruxtecan (T-DXd) is preferred over trastuzumab emtansine (T-DM1) due to improved invasive disease-free survival (iDFS) and distant recurrence-free survival (DRFS) [S. Modi et al. / DESTINY-Breast05, SABCS 2025].
- In early luminal HER2+ breast cancer with adjuvant chemotherapy plus anti-HER2 treatment, regardless of menopausal status, an aromatase inhibitor is preferred over tamoxifen for adjuvant endocrine therapy due to improved disease-free survival (PFS) and lower incidence of local and distant recurrence, without a significant difference in OS [M. Lambertini et al. / ALTTO, SABCS 2025].

6.3. Metastatic carcinoma

6.3.1. Luminal HER2-negative metastatic carcinoma

- In advanced luminal HER2-negative breast cancer, including high-volume, symptomatic, or clinically aggressive disease, first-line abemaciclib and endocrine therapy ± LHRH agonist is preferred over mono- or polychemotherapy due to a credible benefit in progression-free survival [V. Dieraz et al. / AMBRE, SABCS 2025].
- In advanced luminal HER2-negative breast cancer treated first-line with an aromatase inhibitor (AI) + CDK4/6 inhibitor, monitoring ctDNA every 2-3 months to detect ESR1m and switching from AI to camizestrant instead of continuing standard therapy until progression could be considered due to a reliable benefit in progression-free survival (PFS), numerical prolongation of PFS2 and benefit in time to subsequent chemotherapy/antibody-drug conjugate (ADC) [FC. Bidard et al. / SERENA-6, SABCS 2025].
- In advanced/metastatic HER2-negative luminal breast cancer treated with endocrine therapy (ET) ± CDK4/6 inhibitor and lacking PIK3CA/AKT/PTEN/ESR1 mutations, oral SERD monotherapy is not recommended instead of fulvestrant due to lack of PFS benefit. The combination of gedatolisib + fulvestrant (± palbociclib) could be considered instead of fulvestrant monotherapy due to a credible PFS benefit [B. Pistili et al. / Viktoria-1, SABCS 2025; H. Rugo et al. / evERA, SABCS 2025; KL Jhaveri et al. / EMBER-3, SABCS 2025].
- In advanced luminal HER2-negative breast cancer, treated with ≤ 2 lines of ET ± CDK4/6 inhibitor and with the presence of ESR1 mutation, monotherapy with oral SERD or combination of oral SERD + mTOR inhibitor/abemaciclib is preferred over standard ET due to a reliable benefit for PFS [KL. Jhaveri et al./ EMBER-3, SABCS 2025; H. Rugo et al. / evERA, SABCS 2025; H. Rugo et al. / ELEVATE, SABCS 2025].
- In advanced/metastatic luminal HER2-negative breast cancer treated with ET ± CDK4/6 inhibitor and confirmed carrier of PIK3CA/AKT/PTEN alteration, fulvestrant + alpelisib (for PIK3CAmut) or capivasertib is preferred over fulvestrant monotherapy due to a reliable benefit for PFS and OS [M. De Laurentis et al. / EPIK-B5, SABCS 2025].
- In advanced/metastatic luminal HER2-negative breast cancer treated with ET ± CDK4/6 inhibitor and confirmed PIK3CA/AKT/PTEN- and ESR1-mutation carrier, the use of imlunes-trant + abemaciclib or giredestrant + everolimus could be considered instead of imlunes-trant monotherapy or standard of care + everolimus due to a credible benefit in PFS [KL. Jhaveri et al./ EMBER-3, SABCS 2025; H. Rugo et al. / evERA, SABCS 2025].
- In advanced/metastatic luminal HER2-negative breast cancer not eligible for subsequent endocrine therapy, sacituzumab govitecan is not recommended over (nab)paclitaxel/capecitabine chemotherapy due to lack of PFS benefit and higher incidence of adverse events [K. Jhaveri et al. / ASCENT-07, SABCS 2025].

6.3.2. Triple negative metastatic carcinoma

- In metastatic triple-negative breast cancer with indications for first-line systemic treatment, who is not a candidate for PD-(L)1-inhibitors, sacituzumab govitecan may be considered as an alternative to chemotherapy due to a credible benefit in patient-reported outcomes, quality of care, and safety.

life and functionality, despite more frequent gastrointestinal symptoms [K. Punie et al. / Ascent 03, SABCS 2025].

6.3.3. HER2-positive (HER2+) metastatic carcinoma

- In metastatic HER2+ breast cancer, regardless of hormonal status, after first-line induction chemotherapy in combination with a taxane, the addition of tucatinib to maintenance therapy with trastuzumab and pertuzumab ± ET is recommended due to a reliable benefit for PFS [E. Hamilton et al. / HER2 CLIMB trial, SABCS 2025].
- In selected patients with metastatic luminal HER2+ breast cancer, first-line chemotherapy-free regimens including a combination of dual anti-HER2 blockade and ET + ribociclib may be considered as an alternative to chemotherapy + trastuzumab/pertuzumab due to a credible benefit in PFS and OS [W. Janni et al. / Detect V trial, SABCS 2025].
- In metastatic HER2+ breast cancer that has progressed on at least one line of anti-HER2 therapy, the use of trastuzumab envedotin (DP303c) (as a second or subsequent line) instead of T-DM1 could be considered due to a credible benefit in PFS and objective response rate [H. Li et al., SABCS 2025].
- In metastatic HER2+ breast cancer, first-line treatment with trastuzumab deruxtecan (T-DXd) + pertuzumab could be considered as an alternative to taxane and dual anti-HER2 blockade with trastuzumab + pertuzumab (THP) due to similar quality of life, slower and longer time to significant clinical worsening of symptoms [MF. Rimawi et al. / Destiny-Breast 09, SABCS 2025].
- In metastatic luminal HER2+ breast cancer treated first-line with a taxane and trastuzumab/pertuzumab, the addition of palbociclib to maintenance dual anti-HER2 blockade and ET could be considered due to a lower cumulative incidence of central nervous system progression or death, including a trend towards delaying the onset or progression of cranial secondary dissemination by up to 3 years [O. Metzger et al. /, SABCS 2025].
