

ifen was 88%. By NPI group 5-year survival in the moderate I group was 90%, in the moderate II group it was 86% and in the poor prognostic group it was 77%. Tumour grade ( $p = 0.03$ ) and node stage ( $p = 0.01$ ) were significant independent predictors of survival. Tumour size, H-score, and Age were non-significant.

The 2 most heavily weighted factors in the NPI (grade and nodal stage) remain the most significant predictors of outcome after 5-years of Tamoxifen. Patients in the poor prognostic NPI group may be considered for extended hormone therapy.

### O-30. Survival of elderly patients with breast cancer treated with primary Tamoxifen therapy

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Between 1990 and 2005, 181 elderly women over the age of 70 years (mean 82 years), who were either unfit for anaesthesia or reluctant to consider surgery were treated with Primary Tamoxifen therapy (PT). (49 patients under 70 years were also treated with PT, because of extensive disease or severe co-morbidity).

Patients underwent frequent and indefinite clinical follow up, to monitor tumour size and identify any possible need for change in management.

Patient survival and causes of any deaths have been studied using cancer registry data.

The overall 5 year survival of these patients is 34% and 10 year survival is 7%. 123 patients died at a mean of 31 months (7 days–103 months). 55 (45%) died from causes other than breast cancer. 47 patients (26%) required further treatment in view of disease progression. 32 women (18%) underwent limited surgery, 7 had radiotherapy (4%) and 8 had a change of hormonal treatment (4%).

The overall survival of these elderly patients is not unduly poor. Many women were considered to have died with the disease rather than as a result of the breast cancer. Patients receiving PT require careful follow up as one in four may require a change of management.

### O-31. Trial of mastectomy versus Tamoxifen for treating elderly patients with operable breast cancer – results after a 20 year follow up

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**Background and Aims:** This randomised trial of operable breast cancer treated by either wedge mastectomy or tamoxifen earlier showed a reduced incidence of local, regional and metastatic recurrence in the mastectomy group at 24 months follow up. 135 consecutive patients with breast cancer aged over 70 yrs and fit for surgery, with operable primary breast cancers were randomised.

68 were allocated to tamoxifen (Tam) and 67 to the mastectomy [(wedge mastectomy and excision of symptomatic axillary lymph nodes), (Mx)] Tam received continuous treatment with tamoxifen 20mg twice daily and wedge mastectomy

on local progression. Mx received further excision or radiotherapy for locoregional recurrence and/or when local treatments were exhausted or metastatic disease diagnosed, tamoxifen.

**Results:** At 20 yrs follow-up only 2 patients of 131 are alive and this is therefore the final data on this trial.

	Tamoxifen group <i>n</i> = 66	Mastectomy group <i>n</i> = 65
Local recurrence	45 (68.1%)	16 (24.6%)
Regional recurrence	20 (30.3)	24 (36.9)
Distant metastases	23 (34.8)	27 (41.5)
Median time to death (mths)	73 ± 10	74 ± 18

**Conclusions:** There is no significant difference in regional recurrence, distant metastases or overall survival between the mastectomy and tamoxifen group in elderly patients with breast cancer at 20 yrs follow-up. In keeping with earlier reports, there has remained a significantly lower incidence of local recurrence in the Mx group.

### O-32. A computer programme to calculate for the individual: the expected improvement in survival chance from adjuvant therapies

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The EBCTCG overviews of adjuvant therapies provide figures of relative risk reduction (RRR). Applied to the survival chance of the individual, shown by the Nottingham Prognostic Index (NPI) the absolute improvement expected from therapies for that individual, may be calculated.

The baseline figure (“observed 1980–86”) is the survival in NPI groups in patients treated without any adjuvant systemic or local (RT) therapies. (1) The “Expected” figures are the effects on these from the relative risk reductions (RRR) demonstrated in the EBCTCG overviews for each therapy.

Example: Women 50+, % 10 year survival

NPI Group	Observed 1980-86 No Adjuvant (local, regional nor systemic)	Expected	
		Tam 5 yr (ER+) RRR 27%	CMF (all) RRR 11%
EPG	84	89	86
GPG	63	73	67
MPG I	59	70	64
MPG II	43	59	49
PPG	15	39	24

Patient age and pathological tumour characteristic (grade, LN stage, size, ER, VLI) must be entered. The expected improvements will be given for individual NPI values rather than for groups (Blamey, 2005).

Survivals have improved in the 1990's in all prognostic groups to a greater degree than predicted by the EBCTCG estimate of risk reduction for adjuvant systemic therapies.

A further calculation is given for the extra gain expected from improved local management (free margins, case selection for breast conservation, selective local and regional RT or clearance).

The combined figure gives the present day expected survival from modern therapeutic management.