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Mode of presentation is a prognostic factor in breast cancer

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Background: Controversy exists concerning the survival benefit of screening for breast cancer. Our study set out to see if the mode of presentation had any bearing on the outcome of patients with breast cancer.
Methods: All women aged 50–65 treated for breast cancer between October 1995 and September 1997 in two regional centres were studied. These patients were followed up for five years, and had data collected prospectively including mode of presentation, treatment, and relapse. Patients with in-situ disease were excluded from our study.
Results: A total of 369 women were diagnosed and treated for invasive breast cancer over the 24 month period, of which 270 were screen-detected and 99 were symptomatic. We found, as expected, commonly-accepted prognostic factors correlate with outcome – nodal status, size and grade. Multi-variate analysis (Kaplan-Meier survival curves, 95%CI, logrank test for statistical significance) also revealed that in our cohort, mode of presentation is a prognostic factor. Symptomatic breast cancer was associated with greater chance of death ($P = 0.004$) and recurrence ($P = 0.02$).
Conclusions: Our results support the theory that symptomatic patients have a worse prognosis than screen-detected patients, and screening does have a survival benefit. Mode of presentation should also be borne in mind in deciding appropriate adjuvant therapy.

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Postoperative radiotherapy in male breast cancer

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Background: To evaluate the outcomes of radiation therapy treatment of male patients with breast cancer in our single institutional cohort and discover possible adverse prognostic factors.
Methods: We retrospectively evaluated 42 male patients (median age 55; range 33–77 years) with breast cancer treated between July 1994 and August 2001 at Hacettepe University Radiation Oncology Department. All patients were irradiated postoperatively in 2 Gy/fraction/day to chest wall $\pm$ lymphatics to a total median dose of 50 Gy (range, 46–60 Gy). Prescription of chemotherapy varied as neoadjuvant or adjuvant due to initial tumor burden and referral centers. Possible prognostic factors used in this retrospective analysis were as follows: tumor size ($\leqslant$5 cm vs. >5cm), number of metastatic nodal involvement (0 vs. 1–3 vs.> 4 LN), percent positive nodal involvement (metastatic nodes $\times$ 100/total nodes; 0% vs. $\leqslant$25% vs. 26–50% vs. >50%), AJCC 2002 staging, type of surgery (biopsy, excision, mastectomy), surgical margin status (negative vs. positive), neoadjuvant chemotherapy (present vs. absent), adjuvant chemotherapy (present vs. absent), and grade (grade I vs. grade II vs. grade III/IV). Calculations were based on the date of initiation of radiotherapy. Actuarial survival analyses were performed using the Kaplan-Meier method. A chi-square test was used to assess differences in patient distribution between groups. Outcome for overall survival (OS), disease-free survival (DFS), loco-regional relapse free survival (LRRFS), and distant metastasis-free survival (DMFS) in this cohort was compared with our institutional results of 1033 female breast cancer patients.
Results: Median follow-up was 39 months (range, 4.5–118 months). Initial surgery was as follows: excisional biopsy, 2; simple mastectomy, 1; modified radical mastectomy, 29; radical mastectomy, 10 patients. TNM staging was recorded as stage I, 1 (2.4%); stage IIA, 10 (23.8%); stage IIB, 7 (16.7%); stage IIIA, 6 (14.3%); stage IIIB, 7 (16.7%); stage IIIC, 11 (26.1%) patients. Eleven patients had neoadjuvant and 36 patients had adjuvant Adriamycin based chemotherapy. Eighteen (43%) patients were disease free, while 9 (21%) had local, 2 (5%) had distant and 1 (2.5%) had both local and distant disease at the time of analysis. Only one patient died without disease, but 2 (5%) with local, 6 (14%) with distant and 3 (5%) with local + distant disease. The actuarial 5-year OS was 77%, whereas the actuarial 5-year DFS, LRRFS, and DMFS rates were 45%, 69%, and 66%, respectively. Univariate analysis of variables including patient characteristics, treatment modalities and factors, and tumor characteristics failed to show an association with OS, DFS, LRRFS, and DMFS. Only LRRFS was found to be significantly worse in this cohort in comparison to female patients (Hazard Ratio for female patients: 0.34).
Conclusion: The outcome of male patients with breast cancer in this cohort is in accordance with the previous literature while our analysis for prognostic factors was limited due to the relatively small number of patients. However, it seems that male patients have a worse outcome in regard to LRRFS in comparison with our female patients.

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Outcome of node-negative mucinous, medullary and tubular breast carcinoma

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Backgroud: Among breast cancer, invasive carcinoma(NOS) is the most common histologic subtype of invasive breast cancer. The less common subtype-mucinous, medullary, and tubular cancer has known good histologic subtype, especially node negative tumor. The purpose is to evalulate tumor characteristics and outcome of the mucinous, medullary, and tubular carcinoma.
Materials and methods: Twenty-six node negative medullary carcinoma, 14 with tubular carcinoma, 65 with mucinous carcinoma and 3129 with invasive carcinoma(NOS) were identified. The database was used to evaluate patient's tumor characteristics, and outcome. Survival curves and predictors of survival were analyzed.
Results: Disease free survival and overall survival of mucinous, tubular and medullary carcinoma is statistically significant between four histologic subtypes within the first 10year after treatment. Disease free survival-invasive (DFS) – mucinous, medullary, tubular – is 81%, 94%, 100%, 100% respectively($p = 0.02$). Overall survival (OS) is 87%, 96%, 100%, 100% respectively($p = 0.06$). Between size group, there are no significant difference of outcome. DFS and OS of invasive carcinoma with 1.0 cm or less is 92% and 89%.
Conclusions: Difference in prognosis by histologic type-invasive ductal, mucinous medullary, tubular carcinoma were identified. Node negative minor type carcinoma has better prognosis than those of invasive carcinoma(NOS). Especially, IDC with 1 cm or less in size (DFS: 92% OS: 89%) is comparable with other type without association with size. SO, we recommend that is needed that adjuvant therapy – chemotherapy – is reconcerned about good prognostic histologic type.

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A comparison between adjuvant and numeracy; two freely available, web-based prognostic models for early breast cancer

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Introduction: Adjuvant! and Numeracy, are two freely available, web-based programs that determine for patients with early breast cancer the 10-year risk of recurrence and/or death without adjuvant therapy, and with different popular adjuvant therapies.
Methods: We have compared the prognostic and predictive estimates made by Adjuvant! and Numeracy in a population-based cohort of 434 breast cancer patients. In this cohort, we have also compared estimated outcomes with observed outcome.
Results: Baseline 10-year recurrence rates estimated with Adjuvant! and Numeracy correlated well. But, independent of prognosis, baseline Numeracy recurrence rate estimates were slightly lower than baseline Adjuvant! recurrence rate estimates. Estimates of the benefit of adjuvant systemic therapy were also lower with Numeracy than with Adjuvant!. Average Adjuvant! disease free interval estimates, but not average Numeracy disease free interval estimates corresponded well with observed disease free interval percentages.
Conclusion: In our opinion Adjuvant! is the preferable prognostic mode l.

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Dose finding study of sequential administration of biweekly docetaxel followed by epirubicin and cyclophosphamide in high-risk breast cancer patients

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Background: Biweekly schedule of docetaxel (Doc) shows a high efficacy and decreases the hematologic toxicities in comparison with normal schedule. Therefore, biweekly Doc facilitates outpatient administration and maintains QOL. We planned the clinical study of sequential administration of biweekly Doc followed by EC (epirubicin / cyclophosphamide) combination chemotherapy. The purpose of this study was to establish a maximum-tolerated dose (MTD) of biweekly Doc and recommend a phase II Doc dose.
Patients and methods: Doc was administrated over 1 hour once every 14 days in postoperative breast cancer patients with axillary lymph node