parameters for 30 patients (p) with metastatic breast cancer (MBC) for which they got docetaxel-based chemotherapy in our clinic (september 2004-may 2005).
Docetaxel 25 mg/m, day 1, 8, 15 was associated to Epirubicin 60 mg/m^2 day 1 (23 p), to 5 Fluorouracil 450 mg/m, day 1, 8 (2 p) or to Carboplatin AUC6 day 1 (5 p) and the cycles were repeated every 21 days.
All patients were evaluated after 4 cycles of therapy. Response rate was 86.6% (26 p) (4p had disease progresion). Common secondary effects were: neutropenia (grade 3; only 1p, after cycle 4, grade 2; 8p, after cycle 3, grade 1; 12p, during chemotherapy), mucositis (grade 2; 3p after cycle 2, 4p after cycle 3, 3p after cycle 4, grade 1; 20p during chemotherapy), nausea (grade 2; 8p after cycle 1, 9p after cycle 2, 7p after cycle 3 and 7p after cycle 4) and fatigue (grade 3; 1p after cycle 1, 1p after cycle 2, 2p after cycle 3, 2p after cycle 4, grade 2; 15p after cycle 1, 14p after cycle 2, 20p after cycle 3, 21p after cycle 4). All toxicities were corrected by supportive means, none was life threatening.
Comparing our results to the published data on Docetaxel 3 weekly chemotherapy we consider the weekly Docetaxel schedule highly effective and better tolerated with one exception: fatigue, that is obviously worse for Docetaxel weekly schedules than for 3 weekly schedules, but manageable with regular supportive means.

477 PUBLICATION

Preliminary results of a Phase II study of neoadjuvant treatment with docetaxel (T), doxorubicin (A) and capecitabine (X) in locally advanced or inflammatory breast cancer

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Background: Previous studies suggest that combined treatment of chemotherapy+surgery+radiotherapy has a high survival rate in patients with locally advanced or inflammatory breast cancer. Primary objective was evaluate response rate. Secondary objectives were time to progression and toxicity profile of neoadjuvant chemotherapy T, A and X in patients with locally advanced or inflammatory breast cancer.
Patients and methods: Eligibility criteria: Patients with histological confirmation of locally advanced or inflammatory breast cancer, ECOG PS $\leqslant$ 2, age $\leqslant$ 75 years and LVEF >50%, adequate bone marrow, renal and hepatic function. Prior systemic therapy, surgery or radiotherapy for breast cancer was not allowed. Patients with invasive bilateral breast cancer were not included. Treatment: T (30 mg/m^2) iv day 1, 8 and 15, A (50 mg/m^2) iv day 1 and X (1500 mg/m^2 o.d.) days 1–14, in a 4 weeks course. This scheme was repeated up to 4 cycles followed by surgery. According to investigator criteria patients receive a maximum of six cycles. Radiotherapy and hormonal treatment are allowed depending on molecular markers. Expression of markers was performed by inmunohistochemistry before chemotherapy.
Results: thirty-four patients were included in this interim analysis, with a median age of 48 years (25–68). The ECOG PS was 0 in 31.3% and 1 in 68.8% of patients. Hormonal receptor status was ER+ 30%, PR+ 42% and C-erb2+ 50%. Primary tumour sites were breast: left (n = 18) and right (n = 16). A total of 118 cycles (median 3.5, range 1–4) were administered. Median relative dose intensity was 87% for T, 91% for A and 92% for X. Thirteen patients are still undergoing treatment; of 29 evaluable patients for efficacy, 9 achieved CR, 19 PR and 1 PD resulting in an ORR of 96.6% (95%CI: 90–100). Surgery was performed in 25 patients: three (12.0%) of them achieved pathological CR. All patients were evaluable for toxicity. Grade III/IV toxicity per patient was neutropenia (70.6%), leucopenia (50.0%), febrile neutropenia (8.8%); diarrhea (11.8%), mucositis (11.8%), nausea/vomiting (5.9%), dysgeusia (5.9%) and asthenia (2.9%). Median follow up time was 5.7 months.
Conclusions: T, A and X every 28 days administered during 4 cycles as neoadjuvant chemotherapy in locally advanced or inflammatory breast cancer is an active and well tolerated regimen.

478 PUBLICATION

Preliminary analysis of cisplatin (C) and gemcitabine (G) as second-third line treatment in metastasic breast cancer (MBC)

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Background: Combination C and G has demonstrated to be an active treatment in patients (p) with MBC. The less number of previous treatments for MBC more effectiveness this combination has shown. We conducted a study of C and G to evaluate the activity and toxicity profile of this combination.
Patients and methods: P with histological confirmation of MBC, ECOG performance status < 2, age > 18 years and adequate bone marrow, hepatic and renal functions, were included. Prior therapy with anthracyclines, taxanes and herceptin (erb-2 positive p) is mandatory. Treatment: C 25 mg/m^2 iv day 1, 8 and G 1000 mg/m^2 iv day 1, 8, every 3 weeks. At least 6 cycles was administered and the schedule was continued until progressive disease, unacceptable toxicity, consent withdrawal or investigator criteria. Response was evaluated every 3 cycles according to RECIST criteria.
Results: 31 p were enrolled, with a median age of 57 years (31–76), ECOG PS was 0–1 in 92.9% of p, hormonal receptor status was positive in 51.6% and ductal carcinoma in 93.1% of p. Median number of metastatic sites was 2 (83.9% with $\geqslant$ 2 sites), bone (58.1%), lung (41.9%), liver (38.7%) and nodes (38.7%), mainly. Neoadjuvant and adjuvant chemotherapy was administered to 23% and 77% of p respectively, 26% of p had received a second line treatment of chemotherapy for advanced disease and none received a third line. P received anthracyclines in a 97%, taxanes in a 90% and herceptin in a 29% (of erb-2 positive p). Up to date, a total of 130 cycles (median 3, range 1–10) were administered. Median relative dose intensity was 95% for C and 97% for G. Intent-to-treat efficacy analysis: over 21 evaluable p, 1 achieved CR, 6 PR, 5 SD and 9 PD, resulting in an ORR of 33.3% (95%CI: 13.1–53.5). Ten p were not evaluated: 1 protocol deviation, 1 lost of follow-up, 2 withdrawal consent and 6 ongoing with no evaluation yet. All p were evaluable for toxicity. During C-G treatment, grade III/IV hematologic toxicity shown per p was neutropenia (22.6%) and anaemia (9.7%). Grade III/IV non-hematologic toxicity shown per p was nausea (6.5%), vomiting (6.5%), asthenia (6.5%), anorexia (3.2%) and fever (3.2%). Median follow up time was 3.8 months, median time to progression was 7.5 months (95%CI: 0.8–14.2) and median overall survival 9.4 months (95%CI: 4.6–14.3).
Conclusion: In the interim analysis, G and C combination appears to be an active and well-tolerated regimen as second-third line in p with MBC.

479 PUBLICATION

Capecitabine second-line monotherapy for metastatic breast cancer

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Objective: objective measures of response and survival have been the targeted endpoints in clinical trial design and in physician selection of therapy for metastatic breast cancer (MBC). The evidence suggests that therapy for MBC should be continued until disease progression or development of unacceptable toxicities. Capecitabine is a useful and active oral chemotherapy in MBC, both in combination with paclitaxel in anthracycline-pretreated patients, and as moinotherapy in heavily pretreated patients. The proven activity of Capecitabine has provided the rationale to explore its use earlier in the course of the metastatic disease. Also there is a rationale for Capecitabine as maintenance therapy after response until progression.
Material and methods: The characteristics of the 62 evaluable patients(median age = 53 years) were well balanced. Around one half (46%) patients has more than one metastatic site involved. More than two-thirds (68%) of the patients has visceral metastases. All patients received first-line chemotherapy regimen. Approximately half of the patients had progressed while on prior anthracycline therapy; the others had progressed within 12 months of anthracycline therapy. Almost two-thirds(62%) of the patients had been exposed to 5-fluorouracyl (5-FU) and anthracyclines(67%).
Combination therapy consisted of Capecitabine 1250 mg/m^2 twice daily for 2 weeks of every 3-week cycle until grade 3/4 toxicities or progression.
Results: 62 patients are enrolled from our institution. Baseline characteristics were: median age 53 (34–75) years, KPS 80% (60–100%), 46% had 2 or more involved sites.
Median number of cycles was 9 (3–18). There were 17 complete and 32 partial responses so far (overall response rate in evaluable patients 69.5% [95%CI: 49.5–74.3%]) A further 19 patients had disease stabilisation.
The median time to disease progression was impressive. The primary objective of the study, to achieve a response rate in the range of 25–30% with Capecitabine, was met.
Furthermore, the time to disease progression and survival data (median survival in the subpopulation of patients who responded had not been reached at the time of the data analysis) were also encouraging. There were only five (5) relapses in this study so far. Hand–foot syndrome and gastrointestinal adverse events were the predominant toxicities. Most adverse events were mild: the incidence of grade 4 toxicities was very low, and the incidence of grade 3 hand–foot syndroma was <10%.

Conclusion: There is a rationale for use of Capecitabine in the earlier course of metastatic disease, especially after progression of first-line chemotherapy for MBC.

481 PUBLICATION

Multicenter study of weekly trastuzumab, paclitaxel and carboplatin followed by a week of rest every 28 days in patients with her-2+ metastatic breast cancer (MBC)

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Background: Combination of Trastuzumab with Carboplatin and Paclitaxel have shown a significant activity in HER2 positive metastatic breast cancer (MBC). We have conducted a Phase II study to investigate the efficacy and safety of the combination given weekly × 3 followed by a week of rest. We present here preliminary results. Primary endpoint was objective response rate and secondary endpoints were time to progression, overall survival and toxicity of the combination.
Methods: Between October 2003 and April 2005, 16 patients (pats) with Her-2+ MBC (IHC 3+ or FISH+) have been included in the study. Pats received Trastuzumab (loading dose of 4 mg/kg/wk and 2 mg/kg/d following weeks), Paclitaxel (80 mg/m^2) and Carboplatin (AUC 2) all given weekly × 3 followed by 1 week of rest. Treatment was given until disease progression or unacceptable toxicity.
Results: Sixteen patients have been enrolled. Median age was 50 years (range 30–60). All pats received prior adjuvant/neoadjuvant treatment and 4 pats received one prior line for metastatic disease. All pats had PS = 0–1. Disease sites were liver 9 (56%), bone 7 (44%), lymph nodes 5(31%) and lung 3 (19%). Ten pats (63%) had ⩾ 2 lesions. 16 patients are evaluable for toxicity and have received 89 cycles with a median of 5 cycles (range 2–13). Grade 3/4 toxicities were: 4 (5%) leukopenia, 12 (13%) neutropenia, 2 (2%) thrombopenia, 3 (4%) alopecia and 1 (1%) nausea and vomiting. 14 patients have been evaluable for response; 6 CR (43%), 3 PR (21%), 3 SD lasting more than 3 mo (21%) and 2 PD (14%) resulting in an ORR of 64% (95%CI: 39.2–89.4%) and tumor growth control rate (RR+SD) in 86% of patients (95%CI: 67.4–100%). Two pats were not evaluable in this analysis for efficacy (1 too early and 1 lost to follow-up). Median duration of response is 8.4 mo. Median TTP 7.7 mo (95%CI: 2.9–12.5 mo).
Conclusions: This interim analisis shows a good safety profile and a promising activity. Further results would be available for presentation.

482 PUBLICATION

Results of Intercancer Cohort: epidemiologic Brazilian data of women with HER-2 positive metastatic breast cancer treated with trastuzumab as first-line therapy

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The efficacy and safety of trastuzumab in HER-2 positive metastatic breast cancer have been documented in clinical trials. In particular, these trials have demonstrated that treatment with trastuzumab improves overall survival and disease-free survival in first-line therapy as monotherapy and in combination with chemotherapy. Three years after the Brazilian approval of trastuzumab it was of great interest to determine the profile of patients that are being treated with trastuzumab in first-line in clinical practice and the treatment regimens that are being used. Intercancer is a large epidemiological Brazilian data base. Eligible patients (> 18 years) were all HER-2 positive metastatic breast cancer women who started trastuzumab between October 2003 and April 2005. Patients were followed-up for at least 8 months. A total of 106 oncologists agreed to participate and to enroll all their patients data treated with trastuzumab as first-line therapy in the period.

Table 1: Patients characteristics

Pre-menopausal	40.6%	Post-menopausal	40.6%
ER+	34.9%	ER−	49.1%
PR+	41.5%	PR−	33%
HER-2 IHQ 3+	77.4%	HER-2 FISH+	13.2%
Family History	38%	No family history	62%
Smoker	15%	Non smoker	85%
Oral contraceptives	45%	No oral contraceptives	55%

Results are presented on 123 patients. Trastuzumab was used as monotherapy in 52% of the patients. The prefered dose scheduling was the 3 weekly regimen. Table 1 resumes the main patients characteristics.

Central Nervous System

Oral presentations (Mon, 31 Oct, 9.15–11.15)
Central nervous system

483 ORAL

Impact of extent of resection on overall survival in newly-diagnosed glioblastoma after chemo-irradiation with temozolomide: further analysis of EORTC study 26981

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Background: The impact of the extent of surgery on survival in patients with newly-diagnosed glioblastoma multiforme (GBM) remains controversial. A recent, large, multicenter, randomized controlled trial of radiotherapy (RT) versus RT with concomitant and adjuvant temozolomide chemotherapy (RT/TMZ) showed an improved median survival after combined RT/TMZ (14.6 months, 95% confidence interval (CI): 13.2–16.8); as compared to 12.1 months (95%CI: 11.2–13.0) after standard RT alone). This trial also provided an opportunity to retrospectively examine the impact of extent of resection on the outcome, and relate this to the type of adjuvant treatment.
Methods: 573 newly-diagnosed GBM patients were randomized to either RT or RT/TMZ. Extent of surgery was estimated by the surgeon at the time of surgery (either biopsy, partial resection, complete resection). Overall median survival (MS) and 2-year survival (2-yr S; both intent-to-treat analysis) was examined for patients receiving biopsy only (16%), partial resections (44%), or complete resections (39%) per treatment arm.
Results: The two treatment groups were well balanced with regard to extent of resection. Treatment with RT/TMZ was superior (in terms of overall survival) to RT alone across all groups with varying degrees of resection. This benefit was most striking in patients with complete resections, where 2-yr S was 37.1% months (95%CI: 28.0–46.3) for patients receiving RT/TMZ, compared with 14.5% (95%CI: 7.8–21.2) in those receiving RT alone. For patients with a biopsy only, 2-yr S after RT/TMZ was 10.0% (95%CI: 1.3–18.7), in contrast to 4.6% (95%CI: 0.00–10.8) for RT patients. 2-yr S in partially resected patients was 23.2% (95%CI: 15.5–30.9) after RT/TMZ, and 8.94% (95%CI: 3.9–14.0) after RT. MS in biopsied patients treated with RT/TMZ was 9.4 months (mo, 95%CI: 7.5–13.2), and 7.9 mo (95%CI: 5.4–10.6) in RT patients. For partially resected patients MS was 13.5 mo (95%CI: 11.9–16.3) after RT/TMZ and 11.7 mo (95%CI: 9.7–13.1) after RT. However, after complete resection MS was 18.3 mo (95%CI: 15.7–22.5) in RT/TMZ patients, but 14.2 mo (95%CI: 12.7–16.2) in RT patients.
Conclusion: The benefit of combined RT/TMZ in GBM is more pronounced in patients that have undergone more extensive resections as compared to biopsied patients. This provides a further rationale to aim for extensive resections in GBM patients.

484 ORAL

Functional outcome and local control after radiotherapy for metastatic spinal cord compression in breast cancer and prostate cancer patients

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Background: Breast cancer and prostate cancer patients presenting with metastatic spinal cord compression (MSCC) have a better survival