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Localization of non palpable tumours in breast surgery: "the easy way"

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Background: Radio guided surgery is common practice in breast cancer surgery. In our institute the possibility of radio guided resection of non palpable lesions in the breast was explored using an iodine-125 labelled titanium seed.

Material and methods: After an extensive ex vivo study a feasibility study including 25 patients was performed. A radioactive titanium seed containing to 10 Mbq of Iodine-125 was implanted by the radiologist in the non palpable lesion one week before surgery. During surgery the lesion was excised using a gamma probe. Before and after surgery an X-ray was made respectively of the breast and the lump to check the position of the seed. Following this trial standard localization of non palpable lesions with a hook wire was abandoned in favor of the I-125 seed method.

Results: Extensive ex vivo research showed that the additional radio active dose of the I-125 seed to the patient and surgeon is negligible. The X-rays made in the feasibility study showed no dislocation of the seed after implantation. Performing a SN biopsy procedure in the same operation using Tc99 is not a problem. Using this technique didn't lengthen operation time. So far 151 patients underwent a lumpectomy using this method. Of these 45 patients had DCIS, 10 had positive margins further treated. 5 patients had a lobular carcinoma. One was multifocal and was removed with positive margins. 101 patients had a ductal carcinoma of which 12 had positive margins, 6 of the 12 were part of the feasibility study. The average T size is 1.8 cm the median lump is 6, 2 cm in diameter. These results are at least comparable to the historical group in our institute in which the hook wire was used.

Conclusions: The presented technique is unique in The Netherlands. After a successful trial of 25 procedures it is now the standard procedure for non-palpable breast lesions in our institute. We present our experience with the technique and the prospectively gathered data from 151 patients treated with this technique. Being able to localize the tumour days before the planned operation is a great benefit. Because of the accurate localization that is possible with this technique we use it during IORT procedures in breast cancer as well as in tumours eligible for neo-adjuvant systemic therapy that are located with the seed prior to this treatment.

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Maturity of data from the ATAC ('Arimidex', Tamoxifen, Alone or in Combination) trial

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Third-generation aromatase inhibitors (AIs) have demonstrated efficacy benefits over tamoxifen for adjuvant hormonal therapy in breast cancer and current treatment guidelines now recognise these agents as optimal adjuvant treatment. The ASCO technology assessment favoured using the AI that has been most studied in the setting most closely approximating to any individual patient's clinical circumstance, as data from all settings are not available for all agents, and it is unknown if the AIs are interchangeable in clinical practice.

Results from the Completed Treatment Analysis of the ATAC trial reinforce results of the first and updated analyses and demonstrate that anastrozole remained consistently superior to tamoxifen for both disease-free survival (DFS) and time to recurrence (TTR). The divergence in curves, which begins at 1 year, continues and increases out to 6 years, after completion of treatment. Furthermore, early improvements in DFS and TTR have translated into a benefit in time to distant recurrence. Treatment with anastrozole was associated with a lower incidence of serious adverse events and significantly fewer withdrawals from treatment compared with tamoxifen. No new safety concerns emerged with the treatment safety data virtually complete at 60 months' median treatment duration.

Data from several other ongoing trials support the use of anastrozole in the adjuvant setting: ITA, ABCSG 8/ARNO, ABCSG 6a, median follow-up 58, 28 and 60 months, respectively. Trials involving the AIs letrozole and exemestane further support the benefit of AIs over tamoxifen for the adjuvant treatment of postmenopausal women. The median follow-up in these trials was 26 months and 30 months for letrozole in the BIG 1-98 and MA-17 trials, respectively, and 37 months for exemestane in IES. All trials collectively suggest that tamoxifen should no longer be viewed as the optimal treatment. However, when considering the choice of AI, it is important not only to consider the availability of data in the setting but also

the maturity of the data. The full benefit: risk profile of anastrozole is known, and anastrozole remains the only AI with established efficacy and safety data with over 5 years' long-term follow-up in the adjuvant setting.

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Oral CMF regimen does not lead to adequate Relative Dose-Intensity (RDI) as early breast cancer (EBC) patients (pts) treatment; results from the NORA study

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NORA study aimed at investigating modalities of treatment and patterns of relapse in 3500 EBC pts, radically treated with surgery. CMF is one of the chemotherapy regimens used as adjuvant treatment in EBC pts, mainly in N- ones. We analyzed pathological characteristics of the pts who received this regimen, as well typology and dose-intensity of CMF schedules. The most frequent typology was iv 1, 8-28 CMF (77.3%), followed by 1-21 regimen (18.6%), while classical (oral CTX) regimen was chosen only in 3.9% of the pts.

1-21 CMF was administered in a population slightly older than the others (median age 62.3 vs 56.3 and 55.8 years for classical and iv 1-8, 28 CMF, respectively) and more frequently postmenopausal (82.8% vs 72.2% and 67.9%). On the contrary, classical CMF was preferred in comparison to the other two schedules in the case of positive axillary nodes (72.2% vs 53.8% and 62.5% for 1-21 and 1, 8-28 CMF). Principal reason for selecting CMF was tumor stage for classical and 1-21 regimens (66.7% and 33.9%, respectively), while standard guidelines have been considered for choosing 1, 8-28 CMF.

The planned treatment was completed in 85.9% of 1-21 CMF pts, held in 15.4% of classical CMF pts and completed with timing or dose modifications in 16.9% of 1.8-28 CMF pts. The highest Relative Dose-Intensity (RDI = actually administered/planned) was observed in 1-21 regimen (C = 81.4%, M = 83.8%, F = 81%), while classical CMF presented a median dose reduction of 25% of all drugs (C = 76.3%, M = 74.6%, F = 74.6%). Median RDI of 1, 8-28 regimen was 78% for all drugs.

Despite international clinical studies indicated the oral CMF as the only one with proven efficacy in EBC adjuvant treatment, only a minority of pts are treated with this regimen and RDI data suggest that its efficacy could be compromised due the median reduction of all drugs by 25%. Even if not recommended and inefficient, 1-21 CMF is largely used in older pts and it is the only one with adequate RDI.

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Invasive ductal carcinoma and invasive lobular carcinoma of the breast differ in response following neoadjuvant therapy with epidoxorubicin and docetaxel+G-CSF

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Background: Preoperative chemotherapy in patients with primary breast cancer treated with anthracyclines and taxanes results in high response rates, allowing breast conserving surgery in patients primarily not suitable for this procedure. Pathological responses are important prognostic parameters for progressive free and overall survival. We questioned the impact of histologic type invasive lobular carcinoma (ILC) versus invasive ductal carcinoma (IDC) on response to primary chemotherapy.

Patients and methods: 143 patients with breast cancer received preoperative chemotherapy consisted of epirubicin 75 mg/m² and docetaxel 75 mg/m² administered as a short i.v. infusion and a 1-hour infusion on day 1 of each 3-week treatment cycle. Therapy was administered in combination with granulocyte-colony stimulating factor (G-CSF) on days 3-10. Pathological complete response (pCR), biological markers, and type of surgery were compared between ILC and IDC.

Results: Out of 143 patients, 116 patients presented with IDC and 27 with ILC. Overall survival for IDC was 88% with a pCR of 22% compared to 81.5% with a pCR of 3.7% for ILC, respectively. Breast conserving surgery was performed in 79.3% of patients with IDC and in 55.6% of the patients with ILC. Patients with ILC were more frequently ER-positive (85.2% vs. 54.3%) and HER2 negativ (92.6% vs. 74.1%) than patients with IDC.

Conclusion: Our results demonstrates that breast cancer patients with ILC achieved a lower response rate, especially lower pCR rate, than patients