

81 Poster The UK Breast Cancer Clinical Outcome Measures (BCCOM) Project

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Introduction: The BCCOM Project aims to set up routine methods to support the efficient, effective and confidential collection of data relating to symptomatic breast cancer patients diagnosed and treated in the UK.

Description: At the heart of the BCCOM project was the observation that cancer services already contribute breast cancer data to national datasets and that most of the data needed for an audit of symptomatic breast cancers could therefore be collected from tapping into existing sources such as the data currently collected by cancer registries and individual clinicians. In collaboration with the UK cancer registries, agreed data items for cancers diagnosed in 2002 were sent for validation to breast surgeons who were registered with the UK Association of Breast Surgery at the British Association of Surgical Oncology who had agreed to participate in the audit. Surgeons were encouraged to check their own data but could submit data unchecked into the audit.

Summary of results: Data were received from 11 cancer registries incorporating 191 consultant surgeons who contributed a total of 16,407 cases. 92.6% were invasive and 95% had a histological diagnosis. 37% underwent a mastectomy, 42% had breast conserving surgery, 12% had no surgery and for 9% the type of operation was unknown. Individual surgeons' mastectomy rates varied from 17.5% (caseload of 57 cases) to 77.1% (caseload of 70 cases). Overall, 54% of cases had hormone therapy, 59% chemotherapy and 63% radiotherapy. The proportion of cases undergoing chemotherapy and radiotherapy decreased with age while the proportion having hormone therapy increased.

Conclusion: The first year of the BCCOM audit was successful, with good quality data being collected for over 16,000 symptomatic breast cancers. The detailed audit of case ascertainment and data completeness undertaken in the first year of the BCCOM audit has been of benefit to cancer registries in helping them to identify missing data. The collaboration between cancer registries and surgeons encouraged by the BCCOM audit has helped to identify ways of improving the data collection process.

82 Poster Breast cancer in African women: the magnitude of the problem

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Introduction: Breast cancer is the second leading cause of death in women today (after lung ca) and it is the most common cancer among women worldwide. It represents 23% of all new cancer cases.

African women have lower lifetime risk of developing breast cancer compared to western countries, but unfortunately they have higher incidence in mortality rates from breast cancer.

Materials and Methods: This is an overview of breast cancer incidence and mortality in the African continent, based on review of literature and global cancer statistics regarding Africa.

Results: First, we should mention that there is a lack of epidemiological studies and proper cancer registries, throughout Africa. Only few data were available to be published:

There is a wide variation in breast cancer incidence all over the African continent, having the highest incidence in southern and northern parts of Africa.

But all African countries have higher mortality rates compared to developed countries.

African breast cancer patients are also more likely to be premenopausal. Incidence peaks between 35 and 45y, almost 10–15y earlier than peak incidence for western countries.

In addition, 60% of breast cancer patients present with locally advanced disease, most tumors have higher mitotic indices, and the majority of cancers are invasive duct carcinoma (85%).

In Egypt, second largest country in Africa after Nigeria, (population 72 Million) breast cancer is the first malignancy encountered in females. Average age at presentation is 47y (60% of the patients are premenopausal), 52% of cases have T2 and T3 tumors. Incidence of lymph node metastasis may reach 70%, with high grade tumors and high mitotic activity.

Conclusion: Most of the African countries lack cancer registries. They all have limited resources causing absence of national screening programs, absence of cancer awareness, leading to delay in cancer diagnosis. African countries suffer also from many other health problems either communicable or non-communicable disease. A global action is warranted to establish

national screening programs, national cancer registries and definitive treatment protocols.

83 Poster Weight and body mass index (BMI) affect HER-2 expression in postmenopausal breast cancer

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Background: In our population, HER-2 is expressed in 10.9% of primary breast cancers (J Clin Path 2005;58:611–6). Postmenopausal obesity is a risk factor for hormone sensitive tumours. These tumours are more likely HER-2 negative (Breast Cancer Res Treat 2005;91:81–7). We therefore hypothesised that postmenopausal obesity is associated with fewer HER-2 positive tumours.

Patients and Methods: Between January 1st 2002 and December 31st 2004, 549 postmenopausal women with a unilateral, not previously treated, operable breast cancer were evaluated the evening prior to operation for body weight, height, abdominal and hip circumference. Waist-to-hip ratio (WHR) and BMI [Weight/(Length in meters)²] were calculated. HER-2 staining was done by immunohistochemistry (MoAbCB11) and scored between 0 and 3+. HER-2 negativity was defined as 0, 1+ or 2+; HER-2 positivity as 3+. We compared HER-2 negative patients with HER-2 positive patients for all parameters of body composition and assessed the frequency of HER-2 positivity in each quartile from the lowest (Q1) to the highest (Q4) for these same parameters.

Results: Length and WHR were not significantly different between patients with HER-2 negative and HER-2 positive tumours. Abdominal and hip circumference were lower in HER-2 positive patients. This trend however, was not statistically significant. In Table 1 mean values for weight and BMI are compared between HER-2 negative and HER-2 positive patients. Table 2 shows the proportion of HER-2 positive tumours per quartile for weight and BMI in all patients.

Table 1. Comparison of mean values for weight and BMI between HER-2 negative and HER-2 positive patients

	HER-2 negative		HER-2 positive		P-value
	N	Mean±SD	N	Mean±SD	
Weight (kg)	474	69.19±13.18	58	65.09±11.29	0.0215
BMI (kg/m ²)	472	26.98±9.21	56	24.93±4.27	0.0065

SD: standard deviation.

Table 2. Proportion of HER-2 positive tumours per quartile for weight and BMI in all patients (N = 549)

	HER-2 positivity (%)				P-value (Q1–Q4)
	Q1	Q2	Q3	Q4	
Weight	16.30	10.32	9.93	6.92	0.0214
BMI	14.50	12.21	10.69	5.19	0.0127

Conclusion: Low weight and low BMI are risk factors for HER-2 positivity in postmenopausal women with breast cancer. The linear decrease in HER-2 positivity per increasing quartile for both parameters suggests our hypothesis may be correct. Larger numbers of HER-2 positive cases may be required to confirm our findings for other parameters of body composition.

84 Poster Breast cancer – developing clinical guidelines for England and Wales

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Introduction: The National Collaborating Centre for Cancer (NCC-C) has been commissioned by the National Institute for Health and Clinical Excellence (NICE) to develop two evidence-based clinical guidelines for the NHS in England and Wales on the diagnosis and management of early and advanced breast cancer. These will make recommendations on