lower with 3Diso (p = 0.00), heart V30 was comparable. However, a significant increase in lung mean dose (p = 0.00) and lung V20 (p = 0.00) is found with 3Diso. Planning and treatment time were significantly reduced with 3Diso.
Conclusions: The optimised technique produced significantly more homogeneous coverage of the target volumes at the cost of higher, but acceptable, lung doses. Given these results and in view of the more efficient, easy and reproducible treatment delivery of isocentric techniques, 3Diso is implemented as standard practice.

2042 POSTER

Trasuzumab in multimodality treatment of inflammatory breast carcinoma

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Background: inflammatory breast carcinoma (IBC) is a rare but agressive form of cancer. HER2/neu is overexpressed in 50%-60% of IBC.
Material and Methods: 98 patients (pts) with confirmed HER2-positive IBC were enrolled between February 2002 and January 2007. The treatment plan consisted of chemotherapy (CT) with or without trastuzumab (H) according randomization. 47 pts received CT (doxorubicin 60 mg/m^2 and paclitaxel 175 mg/m^2 concomitant H (8 mg/kg loading dose, then 6 mg/kg) administered 3 weekly for 6 cycles. 51 pts received the same CT without H. Radiotherapy must follow surgery and H was recommended as adjuvant treatment for both groups for 1 year. Primary end point was objective response (ORR), ppathological complete response (pCR) and safety.
Results: 39 pts (82.9%) from CT+H group became resectable and underwent mastectomy; 1 patient refused from treatment. 27 pts (52.9%) from CT group also became resectable. 42 pts (91%) in CT+H group and 27 pts (52.9%) in CT group achieved an objective clinical remission (ORR; p = 0.058). 24 pts (52.1%) in CT+H group and 11 pts (21.5%) in CT group achieved pCR (p = 0.05). There were no significant differences in disease-free survival (DFS) between CT+H and CT groups (median follow up was 2 years). The pathologic response to treatment was shown to be a strong predictor for prognosis. DFS was 83% in pts with pCR vs 65% for other pts (log-rank test x^2=2.14, p = 0.03). The most serious adverse event of CT was febrile neutropenia (5% vs 8% with H).

	ORR	pCR
CT+H, n = 46	42 (91%)	24 (52.1%)
CT, n = 51	27 (52.9%)	11 (21.5%)
p	0.058	0.050

Conclusion: H improved ORR and significantly increased pCR compared with CT alone.

2043 POSTER

The feasibility of fine needle aspiration cytology (FNAC) and core needle biopsy (CNB) in the diagnosis of breast lesions

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Background: Our aim was to compare the feasibility of FNAC and CNB in the diagnosis of breast lesions. The special aim was to evaluate the extra costs and delay in surgical treatment due to unsuccessful preoperative biopsies.
Methods: The diagnostic work-up in 632 consecutive patients with 642 dubious, suspicious or malig-nant breast lesions was evaluated. FNAC was the first biopsy method for in 339 lesions (333 patients), CNB or vacuum biopsy (the CNB group) for 303 lesions (298 patients). In addition, one patient with bilateral lesions had FNAC in the one and CNB in the other breast. The postoperative diagnosis was ductal carcinoma in situ (DCIS) or invasive cancer for 550 lesions in 542 patients. Eight patients had bilateral cancer.
The basic costs were 160 € for FNAC, 176 € for ultrasonographically guided CNB, 228 € for stereotactically guided CNB and 760 € for the vacuum biopsy. The cost for the surgical biopsy was 780 € when the biopsy was performed in local anaesthesia and 1220 € when performed in general anaesthesia. The costs included the imaging and the cyto- or histopathological assessment of the specimens.
Results: The sensitivity was 67% (194/289) for FNAC and 94% (245/261) for the CNB group, p < 0.0001. Invasion was revealed in the surgical specimen in 5 lesions with DCIS in CNB. Two lesions with FNAC 5 were benign and one lesion was DCIS. There were no false positives in the in the CNB group.
In order to achieve the definite diagnosis, in patients with FNAC as the initial biopsy method, a subsequent FNAC was obtained in 4 lesions and a subsequent CNB was obtained in 89 lesions. In addition, a surgical biopsy was performed in altogether 68 lesions showing invasive cancer in 16 lesions and DCIS in 5 lesions. In the CNB group, a subsequent CNB was obtained in 2 lesions. A surgical biopsy was performed in 57 lesions showing invasive cancer in 7 lesions and DCIS in 8 lesions.
The total costs of the diagnostic work-up were 279.8 € per patient when the initial biopsy method was US-guided FNAC, 199.5 € when it was US-guided CNB and 234.5 € for the entire CNB group.
The extra needle biopsies delayed the first surgical treatment in 69 of the 283 patients with FNAC and in 1 of the 252 patients in the CNB group. The mean delay in surgery was 9 days in these patients. Six patients with neoadjuvant treatment or co-morbidity postponing surgery were excluded from this analysis. Also the patient with FNAC in the one and CNB in the other breast was excluded.
Conclusion: Although sole FNAC is less expensive than CNB, the frequent need of additional biopsies and extra imaging raised the total expenses of FNAC over those of CNB. In addition to generating extra expenses, multiple biopsies also delayed the surgical cancer treatment in almost every fourth patient with FNAC as the initial biopsy method.

2044 POSTER

Phase II trial with letrozole (2.5 mg) to maximal response as neoadjuvant endocrine therapy in postmenopausal patients with ER/PgR[+] operable breast cancer

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Background: Randomized trials in postmenopausal patients with ER/PgR[+] operable breast cancer had shown that neoadjuvant therapy with an aromatase inhibitor (AI) is more effective than tamoxifen and equivalent to chemotherapy in terms of objective response rate (ORR) and preserving breast surgery. However, trials were conducted with a predetermined length of 3 to 4 months of therapy, and no study has analyzed as yet the optimal duration of AI as induction therapy. In this study we assessed the safety and efficacy for letrozole (Femara®), in postmenopausal women with ER and/or PgR[+] until maximal response is reached.
Material and Methods: An open, multicentric, phase II clinical trial to evaluate the efficacy and safety of letrozole over a preoperative period of 3 months to 1 year was conducted. Inclusion criteria: Postmenopausal status, histological diagnosis (tru-cut) of infiltrating breast carcinoma, ER and/or PgR[+] (by IHC), tumor stage II to IIIb (T2 > 2 cm, T3, T4b, N0−2, M0) non suitable for conservative surgery. Inflammatory or T4a tumors were excluded. The primary endpoint was to determine the median duration of treatment to optimal response defined as the interval of time required to achieve the maximal response by clinical exam. The ratio of clinical responses and the frequency of conservative surgery were secondary objectives. Data on adverse and severe adverse events was also presented.
Results: Seventy patients have been recruited in four centers from June 2003 to September 2005. Median age: 79.0 years (66−91), Stage T2 N0 (50.0%), ER[+] (92.9%). The median times to objective and to maximal response were 3.9 months (3.3−4.5) and 4.2 months (4.0−4.5) respectively. At the time of maximal response, the ORR was 76.8%; 67.4% obtaining a partial response and 32.6% a complete response. Only, one serious adverse event related with the drug that fulfilled NCI criteria was reported.
Conclusions: Letrozole shows a high activity and tolerability as neoadjuvant endocrine therapy in elderly patients with endocrine dependent criteria breast cancer. Mature results with the optimal duration of this approach will be helpful to increase local disease control.