HER2 unknown; 12 pts (21%) HER2−/ER−/PR− (as Triple Negative) and 34 pts (59%) not-Triple Negative.

Results: After a median follow up of 99 months (8–135), Kaplan–Meier estimated DFS and OS at 10y were 40% and 50% for overall group, respectively. Pts with either HR− or Triple Negative disease had significantly worse DFS and OS compared to patients with either HR+ or not-Triple Negative.

Conclusions: Our data confirm that failure to achieve pCR following primary chemotherapy does not equate with poor outcome in all pts. Indeed, pts with HR− and Triple negative tumors have poorer survival, probably because they do not benefit from standard endocrine and or anti-HER2 therapies; therefore, they should be considered for innovative therapies following primary treatment.

	ER− PgR− (18)	ER+ PgR+ (22)	p value	Triple Neg (12)	not Triple Neg (34)	p value
10 y DFS %	27.8	50.0	0.012	33.3	50.0	0.127
10 y OS %	30.3	72.7	0.001	41.7	70.6	0.027

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Adjuvant trastuzumab in routine clinical practice – the Sheffield experience and impact of cardiac monitoring guidelines on treatment delivery

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Background: Adjuvant trastuzumab was introduced into routine practice in the UK in 2006. National treatment guidance and cardiac monitoring recommendations were defined by the NCRI Breast Group and based on the HERA trial protocol[1,2]. Early experience of the use of adjuvant trastuzumab in routine practice within a UK cancer network has been evaluated.

Material and Methods: 68 consecutive patients (pts) under the care of Weston Park Hospital, Sheffield, who had either completed (n = 61) or should have completed (n = 7) a one year course of adjuvant trastuzumab (3 weekly cycles; loading dose and 17 maintenance doses) were identified from pharmacy records. Baseline characteristics, delivery of adjuvant trastuzumab and results of three monthly assessments of cardiac function were reviewed. Left ventricular ejection fraction (LVEF) was to be assessed by MUGA scan at baseline, 3, 6, 9 months on treatment and on completion of trastuzumab; treatment was to be interrupted or discontinued as defined in the HERA study[2].

Results: 57 (84%) pts completed treatment on schedule and 4 (6%) completed all 18 cycles despite at least one delay in treatment because of temporary falls in LVEF. The remaining 7 pts stopped treatment early: 5 (7%) discontinued treatment early because of insufficient recovery in LVEF following delays in treatment and 2 (3%) discontinued treatment early for other reasons (1 relapse, 1 patient choice). One patient (1.5%) developed symptomatic, partially reversible cardiac failure (New York Class II) during treatment. There were no marked differences in baseline characteristics between pts who completed treatment without delays, and those with LVEF changes that triggered treatment delays or prevented completion of treatment. LVEF remained constant throughout treatment with median values at baseline, 3, 6, 9 months and end of treatment of 59%, 58%, 59%, 58% and 57.5% respectively.

Conclusions: Adjuvant trastuzumab was well tolerated by the majority of patients, with 90% completing 18 cycles. Median values of LVEF were well maintained and it is unclear whether all the delays and interruptions for LVEF falls were clinically necessary. Less stringent guidelines for cardiac monitoring are being developed by the NCRI and the impact that this guidance would have had on treatment decisions will be presented.

References

[1] NCRI Nov 2005; www.dh.gov.uk / prod_consum_dh / groups / dh_digitalassets/@dh/@en/documents/digitalasset//dh_4126384.pdf
[2] Piccart-Gebhart et al. *N Engl J Med* 2005;353:1659−72.

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Baseline assessment of fracture risk in women with breast cancer using current and emerging guidance

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Background: The importance of monitoring bone health in women diagnosed with breast cancer (BC) has become increasingly apparent, especially considering the known negative effects of some cancer therapies on bone. Recent studies noted a 31% increased fracture risk in BC survivors. Current WHO and ASCO clinical guidelines recommend therapy based on bone mineral density (BMD), but emerging guidelines now recognize the contribution of both clinical risk factors and BMD to a patient's overall fracture risk. This retrospective, case-controlled study was conducted to determine the percentage of women with newly diagnosed breast cancer who may be at increased risk for fracture and require preventive therapy using current and emerging guidelines.

Material and Methods: This study compared 88 pre- and 402 postmenopausal women (PMW) with BC with an equal number of healthy, age and body mass index-matched women. BMD was assessed using dual-energy x-ray absorptiometry (DEXA) at the lumbar spine (LS) and total hip. Quantitative ultrasonometry (QUS) was performed at the os calcaneus and at the phalanges. Measurements of BMD were performed at a mean duration of 15 and 242 days after diagnosis of cancer in pre- and PMW, respectively.

Results: Baseline characteristics were well balanced between the BC and healthy control groups. When stratified by estrogen receptor-positive (ER+) status, 18.8% of premenopausal women and 36.9% of PMW were osteopenic, and 8.9% of PMW were osteoporotic at the LS. In ER+ PMW with BC, osteoporosis was detected in 15.9% of patients >65 years of age, in 8.3% of patients 55 to 65 years old, and in only 1.4% of patients <55 years old. Applying the current WHO and ASCO treatment guidelines, approximately 9% of ER+ PMW with BC would receive bone protective therapy. After applying the emerging guidance, clinical risk factors alone identified 6.5% of patients who should receive therapy. When both clinical risk factors and BMD were included in the fracture risk assessment, 28.6% of women were eligible for bone protective therapy.

Conclusions: Fracture risk assessment using clinical risk factors alone does not increase the proportion of PMW with BC eligible for bone-protective therapy. Including both BMD and clinical risk factors increased the number of eligible women and may more effectively identify patients at risk for fracture, although further studies are needed.

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Is three-day steroid medication compulsory to prevent fluid retension in TAC adjuvant chemotherapy for node-positive breast cancer?

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Background: TAC (docetaxel, doxorubicin and cyclophosphamide; 75−50–500 mg/m^2) chemotherapy has been used as one of the adjuvant treatments for the node-positive breast cancer these days. Also, it has been proving itself as effective as FAC chemotherapy protocol for the similar subset of breast cancer patients. Fluid retension is well known as one of the major complications that may result from the use of TAC chemotherapy. So, it is suggested that steroid should be given to the patients having TAC chemotherapy for three days starting from day 0 (previous day) to day 2 (the very next day of chemotherapy). Steroid itself may provoke many adverse effects to the patients. We tried to determine if abbreviated use of steroid is good enough to prevent fluid retension from TAC chemotherapy.

Patients and methods: From Jan. 2006 to Nov. 2007, we randomly assigned patients (node-positive breast cancer) into two subgroups after getting informed consent which had been approved by our institutional review board. Group one was comprised 30 patients who were given steroid medication as suggested (three-day prescription; 16 mg oral dexamethasone daily), and group two (n = 30) were given steroid as follows: 12 hours before chemotherapy (15 mg oral dexamethasone), 30 minutes before starting chemotherapy (15 mg) and in the evening of day 1 (chemotherapy day). All patient were followed up while measuring circumferences of extremieties, body weight, and patients' interview daily for 10 days. All other reported adverse reactions were evaluated during the study period.

Results: All patients were chemo-naive women with no other co morbid disease affecting renal or any other systemic function. Mean age was 42.3 years (group 1) and 45.5 years (group 2). Each group evaluated 180 cycles of TAC chemotherapy. The incidence of neuropenia (grade III or more), febrile neutropenia, infection, fluid retension and other known adverse

reaction was not significant between two groups. No other previously unknown problem was occured.

Conclusions: Short-course but dose-dense steroid premedication for TAC chemotherapy may be adopted for the patients without giving more harms or additional hazard. Patients – especially Asians like ours – tend to think that they are really in the middle of chemotherapy, while they are taking any kind of medications even after the chemotherapeutic injection. Therefore, they are very nervous and anxious by the time all medications are stopped. We think that this premidication regimen may give more emotional comfort to the patients having TAC chemotherapy.

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Early breast cancer in France and Italy – different treatments for the same biological reality

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Background: Adjuvant medical treatment is defined by several guidelines, but various other factors may influence the treatment choice.

Patients and Methods: Two national surveys conducted in France and in Italy included 1159 and 3515 BC patients (pts) to collect clinical and pathological data as well as locoregional and systemic treatment. We present main data of the two surveys to analyse differences between the two Countries.

Results: Median age was similar (57 vs 58 ys). Pts over 70 years were 20.4% in France and 18.5% in Italy. Histology was similar for the main type: ductal 82.4% and 78%, lobular 11.8% in both Countries, other 5.8% and 10.2%, in France and in Italy. Undifferentiated tumours (G3) accounted for 27.5% and 34.4%, respectively. T0−T1 tumours were 58% in France and 59.7% in Italy. pN+ rate was identical (44.5%) for the whole population and similar for pN1−3 pts: 29.5% and 26.4%. HR+ rates were similar (83.9% vs 82.5%). Conservative surgery was performed in 77.5% and 63.7% of the cases In France and in Italy. Axillary dissection was performed in 94.9% and 89.9% of the cases in the two countries. 58.7% and 66.8% of the pts received chemotherapy (CHT) alone or followed by endocrine therapy (HT) (71.5% and 49.5%) in France and in Italy, respectively. Delivery of CHT in pN0 pts was 39% in France and 51.4% in Italy. 54% of the French HR+ pts received CHT vs 62.6% of the Italian ones. An anthracycline-based protocol was used in 522/605 (86.3%) French pts and only 52.2% in Italy, where pts were largely treated with CMF (27.3%). In both Countries, 3-drugs regimens were mostly used. Hormonal treatment was performed in 77.7% of the pts in both Countries, but aromatase inhibitors (AIs) $\pm$ LHRH analogs were used in 8% in France and 13.1% in Italy.

Conclusion: The main differences between the two Countries, despite an almost identical pN+ and HR+ rates, concern the choice of CHT followed by HT, the use of anthracycline-based CHT and the specific AIs choice. The French scientific background in the use of epirubicin and some educational campaigns for the use of AIs in Italy could be the reasons for these results. A detailed comparison in terms of radiotherapy use is under evaluation.

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Neoadjuvant docetaxel plus adriamycin combination chemotherapy in patients with inflammatory breast cancer – a single institution experience

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Background: Inflammatory breast cancer (IBC) is a rare, but highly aggressive form of breast cancer. The objective of this study was to evaluate clinical outcome of patients with IBC treated with neoadjuvant docetaxel plus adriamycin (DA) regimen.

Materials and Methods: From May 2002 through July 2007, we treated 63 patients (median age, 46 years) with non-metastatic IBC with docetaxel 75 mg/m^2 plus adriamycin 50 mg/m^2 administered every 3 weeks before surgery. The pathologic and clinical records were reviewed retrospectively.

Results: All 63 patients presented with typical skin change including peau d'orange or breast erythema. Median number of the neoadjuvant chemotherapy was 4 cycles (range, 2−6). After neoadjuvant chemotherapy, responses by clinical examination were seen in 95% of patients (60/63), with 13% experiencing a clinical complete response (CR), whereas the other 3 had stable disease (2) or locally progressive disease (1). After the completion of neoadjuvant chemotherapy, 61 patients underwent modified radical mastectomy and breast conserving surgery was performed in two patients. A pathologic CR (eradication of invasive carcinoma in tumor and axillary LN) was found in 4 (6.3%) patients, and axillary lymph node was not involved in 18 (29%) patients. Thirty-two (51%) of all patients showed negative for hormone receptor, and 24 (38%) showed c-erb-B2 overexpression. Pathologic CR was common in triple-negative breast cancer (18%). With a median follow-up period of 23 months, tumor recurrence was observed in 25 of 63 (40%) patients. Two of 4 patients achieving pathologic CR showed distant metastasis within 1 year of surgery. Median progression-free survival time was 29 months (range, 4−88+ month), and 3-year overall survival rate was 68%. There was no treatment-related death during neoadjuvant chemotherapy.

Conclusions: Neoadjuvant DA chemotherapy produced very high clinical response rate in unfavorable series of IBC and enabled these patients to receive curative surgery. However, pathologic CR to this regimen was rarely achieved, and it was not connected with long-term survival in IBC patients. Therefore, additional investigation is needed to develop more effective and safe chemotherapeutic regimens for IBC patients.

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Quality of life in Thai women with early stage breast cancer during adjuvant therapy

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Background: The level of breast cancer incidence among Thai women which has been increasing in the current decade. The purpose of this study was to describe the quality of life in Thai women who coping with breast cancer during adjuvant therapy.

Material and Methods: Following ethical approvals, data collecting was carried out in three hospitals. One is the National cancer institute of Thailand, and two are the university hospitals. A longitudinal study was performed on data collected from women who were newly diagnosed with early breast cancer during the period from November 2006 to October 2007. The EORTC QLQ-C30/-BR23 and the FACT-B questionnaires were administered to a consecutive sample 3 phases; phase 1 was immediately after surgery, but before commencing adjuvant treatment. Phase 2 was during adjuvant therapies at 6−8 weeks intra treatment. Phase 3 was a week to a month after treatments were finished.

Results: Total sample at 3 phases consisted of 112, 110 and 95 subjects respectively. The participants varied in age between 29 and 79 years, with the mean age was 49.1. Most participants underwent mastectomy (81.3%) and had adjuvant chemotherapy (92.0%). For EORTC, global health status mean scores at 3 phases were 66.7, 56.4 and 77.9 respectively. For FACT, the total mean scores of FACT-B at 3 phases were 104.3, 98.4 and 117.3 respectively. The results from repeated measures show that quality of life was significant changes over time. The mean scores indicated that during adjuvant therapy those women had decreased levels of functioning and increased level of symptoms. Conversely, after adjuvant therapy those women had increased levels of functioning and decreased level of symptoms. There were demographic factors influenced the quality of life of these women; such as, age, marital status, and caregiver. The differences between chemotherapy and non-chemotherapy groups during adjuvant therapy were statistically significant on nausea and vomiting, financial difficulties, upset by hair loss, and breast subscales. Chemotherapy group had the lower quality of life than non-chemotherapy.

Conclusion: For the times studied, adjuvant therapy had the effects on quality of life during treatment. After chemotherapy and radiotherapy, breast cancer women reported the highest quality of life compared with before and during adjuvant therapies. It can be suggested that nurses should sort the problems relating to the vulnerable factors to improve their quality of life.

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Non-endocrine responsive breast cancer in post-menopausal patients – a different approach dependent on age

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Background: Breast cancer (BC) is common in the elderly. Selecting therapy in elderly patients (pts) with BC remains difficult. In patients with negative hormone-receptors (NHR) the only systemic treatment available is chemotherapy. Our goal was to access therapeutic options in elderly pts