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

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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