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

with NHR BC and evaluate overall outcome compared to younger post-menopausal pts also with NHR.

Methods: Retrospective study of postmenopausal pts admitted in our institution during Jan.2003–Jan.2005 with BC and NHR. Information collected from clinical records: demographic features, tumour characteristics, treatment choices, complications and results. SPSS 11.0 ® used for statistical analysis. Differences were considered statistically significant if $p < 0.05$.

Results: 98 pts with BC and NHR, about 15% of 647 pts admitted. 35 patients (35.7%) were ⩾65 years. Diagnosis more frequently based on symptoms for both group ages, but for pts ⩽65 yrs the percentage of asymptomatic mammography was higher ($p = 0.007$). All pts ⩽65 years had ECOG 0−1, for older pts 9.4% ECOG 2 ($p = 0.003$). More frequent comorbility in older pts ($p = 0.03$). Trend for more advanced TNM stage for older pts ($p = 0.03$). No difference between groups related to histologic type, grade or St. Gallen risk classification. Mastectomy most frequent in both groups, but conservative surgery in more younger pts. 4 pts (4.1%) not submitted to chemotherapy. In younger pts antracycline-based chemotherapy was preferred, for older pts chemotherapy not including an antracycline was more often chosen (($p < 0.0001$). Interruption of treatment more frequent after 65 yrs ($p = 0.03$). Significant toxicities did not vary between groups. After 50 months follow up 71.5% of all pts were alive, with significant difference between age groups [79.9% pts ⩽65 yrs and 45.8% ⩾65 yrs ($p = 0.04$)].

Conclusions: NHR BC is heterogeneous related to presentation and treatment according to age. Advanced age, worse performance status and comorbidity explain the less aggressive treatment. Advanced stage of diagnosis and less aggressive treatment relate to a higher mortality among older pts. Treatment of NHR BC in older pts is challenging, and target-therapies may have an important role.

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Clinico-pathological features and pathological Complete Responses (pCR) to primary chemotherapy (PC)

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Background: Primary chemotherapy (PC) is considered the standard of care for locally advanced or inflammatory breast cancer, but can be applied to all women who may require postoperative chemotherapy for early-stage breast cancer. Clinical and pathological responses (PR), in particular when complete, are good predictors of outcome.

Purpose: To correlate clinico-pathological features and pCR rates after PC, in a consecutive series of breast cancer (BC) pts.

Patients and Methods: Ninety four pts (median age 49 years) with stage 46 IIA (49%), 15 IIB (16%), 8 IIIA (8%), 25 IIIB (27%) BC were treated in our institution, from 2000 to 2007, with preoperative Doxorubicin 60 mg/m^2 and Taxol 175 mg/m^2 for 4 cycles, followed by 1.8 iv CMF for 4 cycles. Moreover, 11 pts with over-expressed or amplificated HER2 received concomitant trastuzumab for 8 cycles. A chi-2 test was used to evaluate the relationship between pCR rate and clinico-pathological presentation (age, menopausal status, histology, grade, ER, PgR, MIB-1, HER-2, p53).

Results: After PC, 45 Objective Remissions (7 CR and 38 PR) were observed (48%), while 1 pt had SD and 4 progressed. At the completion of the PC, 92 pts (98%) underwent breast conservation (64%) or mastectomy (34%); 2 pts (2%) died for causes no BC related. At definitive surgery, 16 pCR (17%) and 4 (4%) ~pCR (residual microinvasion ⩽0.1 cm) were reported, mostly in pts with rapid clinical response (after 1−2 cycles). A statistically significant correlation ($p < 0.01$) was shown between pCR+~pRC and ductal type, MIB-1 >20%, negative or low ER expression or HER2 overexpression, but not age, menopausal, stage, grading, p53 or PgR status. The pCR and ~pCR vs no pCR were significantly more frequent in ER/PR negative HER2 positive (56%) or ER/PR negative HER2 negative (33%) or ER/PR positive HER2 positive (35%) subsets, rather than in ER/PR positive HER2 negative (8%) pts. The 36 months DFS and OS are 94% and 84% respectively, with all pCR pts alive and relapse free and only 1 ~pCR pt relapsed and died.

Conclusions: In our study, as in the literature, pts with ductal histology and low or absent ER and/or positive HER-2 expression, appear to benefit more from PC. For pts with lobular histology and positive ER and negative HER2 expression, alternative strategies, such as a neoadjuvant hormone-therapy, should be considered.

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Anastrozole shows greater carryover effects compared with tamoxifen and resolution of fracture risk post-treatment – data from ATAC at 100 months' median follow-up

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Background: ATAC showed that anastrozole (A) is significantly more effective than tamoxifen (T) in preventing recurrences and is better tolerated but associated with a higher risk of fractures on treatment. Little data exist on whether effects persist after aromatase inhibitor (AI) treatment is completed. Data from ATAC at 100 months' median follow-up are presented.

Material and Methods: The primary endpoint, disease-free survival (DFS), and secondary endpoints, time to recurrence (TTR), incidence of new contralateral breast cancer (CLBC), time to distant recurrence (TTDR), overall survival (OS) and death after recurrence, were assessed in the total (ITT) and hormone receptor-positive (HR+ve) populations (84% of ITT). After treatment completion, fractures and serious adverse events (SAEs) continued to be collected in a double-blinded fashion.

Results: Significant improvements were seen for A over T for DFS, TTR, TTDR and CLBC. In the HR+ve group: DFS (HR 0.85; 95% CI 0.76, 0.94; $p = 0.003$), TTR (HR 0.76; 95% CI 0.67, 0.87; $p = 0.0001$) TTDR (HR 0.84; 95% CI 0.72, 0.97; $p = 0.022$), and CLBC (HR 0.6; 95% CI 0.42, 0.85; $p = 0.004$). Absolute benefit of A over T continued to increase over time (TTR 2.8% at 5 yrs; 4.8% at 9 yrs) and recurrence rates remained significantly lower on anastrozole compared with tamoxifen after treatment completion (HR 0.75; 95% CI 0.61, 0.94; $p = 0.01$). Deaths following recurrence were non-significantly fewer with A than T (245 vs 269) but there was no difference in OS (472 vs 477; HR 0.97; 95% CI 0.86, 1.11; $p = 0.7$). After treatment completion, fracture rates fell for the A-treated patients and post-treatment rates were similar in both groups (annual fracture rate A 146 [1.56%] vs T 143 [1.51%]). Treatment-related SAEs were lower on A during treatment and similar between A and T after treatment completion.

Conclusions: Analysis of ATAC at 100 months is the longest median follow-up for initial AI 5 years' treatment to date. The data shows that following completion of treatment, the efficacy benefit of A over T continues and there is statistically significant evidence of a greater carryover effect for A compared with T. These data represent the first demonstration of a carryover effect for an AI. Fracture rates for A and T are similar after cessation of therapy. No statistically significant difference in OS is observed in this study, in which there are competing causes of mortality.

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Comparison of the cost-effectiveness of upfront letrozole or anastrozole versus tamoxifen for early breast cancer in hormone receptor positive (HR+) postmenopausal women – the Cypriot perspective

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Background: The BIG 1-98 and ATAC randomized controlled trials demonstrated that, in postmenopausal women with hormone receptor positive (HR+) early breast cancer, initial adjuvant therapy for 5 years with the aromatase inhibitors (AIs) letrozole (LET) or anastrozole (ANA) is superior to tamoxifen (TAM). Previous economic analyses modelled constant hazard rates for recurrent events, which did not reflect the observed variation over the five year treatment period. This study reflects the observed time dependency in hazard rates by recurrence type to evaluate the incremental cost per quality-adjusted life year (QALY) gained with five years of initial adjuvant therapy with LET or ANA versus TAM in postmenopausal women with HR+ early stage breast cancer, from a Cypriot perspective.

Methods: The analysis used the same Markov model structure used in the independent assessment conducted for the National Institute for Clinical Excellence (NICE) in the. A pooled set of variable annual hazard rates for TAM were estimated, to which were applied variable annual hazard ratios for time to recurrence for the 5 year treatment period estimated from the BIG 1-98 and ATAC trials for LET and ANA, respectively. Probabilities of breast cancer event type (contralateral; locoregional; soft tissue, bone, and visceral metastases) and Adverse Events (endometrial cancer, hip fractures, stroke, thromboembolic events, and vaginal bleeding) were based on published results of the BIG 1-98 and ATAC trials and population-based studies as appropriate. Treatment costs for AEs, and health-state utilities (QALY weights) were obtained from primary studies. Resource use for treating recurrent breast cancer was informed by a survey of clinicians,