tumour microarrays. Primary endpoint was disease-free survival (DFS) (time to loco-regional or distant relapse, contralateral invasive BC or death without relapse). Secondary endpoints included overall survival (OS), CT tolerability and quality of life.

Results: With a median follow-up of 52 months, 97.3% alive pts have complete follow-up. 957 DFS events have been observed (484 control, 473 FEC-T) giving a Hazard Ratio (HR) = 0.97 (95% CI 0.86−1.10) p = 0.62, with 73.9% control and 74.7% FEC-T pts alive and disease free at 5 years. 639 pts have died (323 control, 316 FEC-T) (7 related to treatment) giving a HR = 0.98 (95% CI 0.84−1.14) p = 0.76 with 81.8% control and 82.0% FEC-T alive at 5 years. Possible differences in treatment effect are suggested by HER2 and ER status, however with low statistical power for formally testing treatment interactions these are not convincing. Analyses according to ER and HER2 will be discussed in the context of findings from similar trials.

Conclusions: With almost 5 years of follow-up, no evidence was observed of an overall benefit of FEC-T. Adding TACT to results of other trials allows consideration of whether any sub-groups can be identified which consistently appear to benefit (or not) from taxane based therapy.

4LB Late Breaking

Long-term mortality results from the UK Breast Screening Frequency Trial

S. Duffy[1], R.W. Blamey[2], for the UKCCCR Breast Cancer Frequency Trial Group. MRC London, Nottingham City Hospital and National Health Service Breast Screening Programme. *[1]Cancer Research UK, London, United Kingdom; [2]Nottingham City Hospital, Breast Institute, Nottingham, United Kingdom*

In the UK Breast Screening Frequency Trial, 49173 women aged 50−62 were randomised to three annual incidence screens after their prevalence screen date (study group) and 50162 to one incidence screen three years after the prevalence screen (control group).

Primary interest was in those who attended the prevalence screen. Results of predicted case survival based on the Nottingham Prognostic Index of the tumours diagnosed were published early in the study and indicated an insignificant 5−11% reduction in breast cancer mortality.

Here we present actual mortality results to the end of 2006 (median follow-up 162 months). There were 373 breast cancer deaths in the study group as a whole and 374 in the control group (RR = 1.02, 95% CI 0.88−1.17, p = 0.8). In the prevalence screen attenders, there were 209 breast cancer deaths in the study group and 231 in the control group (RR = 0.89, 95% CI 0.73−1.07, p = 0.2).

When we consider mortality only from cancers diagnosed during the three-year screening period of the trial, there was no significant difference between the study and control group (RR = 0.96, 95% CI 0.67−1.37, p = 0.8). This remained the case when restricted to those who had attended the prevalence screen (RR = 0.93, 95% CI 0.63−1.37, p = 0.7).

These results indicate that the predicted mortality figures were accurate. There is no evidence in favour of shortening the current three-year screening interval.

5LB Late Breaking

Is mammography screening effective up to 75 years?

J. Fracheboud[1], R. de Gelder[1], G. Draisma[1], S.J. Otto[1], A.L.M. Verbeek[2], H.J. de Koning[1]. *[1]Erasmus M.C., Public Health, Rotterdam, The Netherlands; [2]Radboud University Medical Center, Epidemiology and Biostatistics, Nijmegen, The Netherlands*

Background: Although there was little evidence of efficacy of mammography screening in women older than 70 years, the Dutch breast cancer screening programme extended the upper age limit from 69 to 75 years in 1998. This decision was based on microsimulation modelling that resulted in a favourable balance of benefits and harms of mammography screening up to at least 75 years. Beyond this age, however, screening might lead to overdiagnosis of breast cancer due to a probable slower tumour growth rate. Based on first results 1998–2000, 75 years appeared to be an appropriate upper age limit for mammography screening. We updated this previous study with screening results up to 2007, and also assessed age-specific breast cancer mortality.

Material and Methods: We used aggregated national data on screening 1998–2006 and age-specific population and breast cancer mortality data 1986–2006 from Statistics Netherlands. Main outcome parameters (as detection rate and breast cancer mortality rates) were compared with model-simulated results for the age categories 50−69 and 70−75.

Results: In 1998–2006, 7.37 million screening examinations were performed, of which 862,655 in women aged 70−75 years. The participation rate was 81.2% for ages 50−69 and 71.9% for ages 70−75. In the latter age category, participation increased from 62.5% in 1998 to 77.6% in 2006. Per 1000 women screened, 12.8 women aged 50−69 were referred for diagnostic assessment, and 16.4 aged 70−75. The breast cancer detection rate was 4.5 and 7.8 per 1000 women screened, respectively, resulting in a positive predictive value of mammography of 36% and 47%, respectively. One-year age-specific detection rates from 70 through 75 years showed a continuous increase, suggesting a gradually slower tumor growth with age. As of 2003, the breast cancer mortality rate among women aged 75−79 (when assuming a lag time of 5 years to take effect) started to decline statistically significantly, and was 29.5% lower in 2006 than the mean rate during 1986–1997. This breast cancer mortality reduction showed a similar pattern as previously found in women aged 50−69.

Conclusions: The results of our study suggest that screening in women aged 70−75 years has a strong impact on breast cancer mortality, and that mammography screening of high quality is effective and appropriate up to 75 years. Since the detection rates gradually increase with age, however, screening beyond 75 years will become less favourable.