27 Poster

Breast cancer update – analysis of knowledge of Brazilian breast surgeons

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Background: Nowadays the medical knowledge is developing fast. Because of that, there are always need for education events like congresses and meetings. However, the degree of knowledge of the participants of these events is not usually known. In this enquiry, the authors provide a panorama evaluation of the participants of one of the largest brazilian's breast congresses. The questions were compared to international guidelines.

Material and Methods: During the 3rd São Paulo Breast Congress about 600 questionnaires were distributed between the participants. The questions were about general concepts of breast cancer, including conservative surgery, diagnosis and sentinel node biopsy. 234 people have answered them. Of these 60.6% were breast specialists (BS) and 39.4% were gynecologists (G) who also perform breast surgery.

Results: The percentages of right answers are shown in the table.

Question	Correct answers		
	Total	Breast Specialist	Gynecologist
Conservative breast surgery	80.8%	81.7%	76.3%
Diagnosis	83.9%	84.2%	83.4%
Sentinel node biopsy	79.5%	80.6%	77.9%

It was also possible to notice that 46.8% of the interviewed physicians consider that there is a size limit to perform conservative breast people (39.7% of BS and 39.1% of G). Most of them use blue dye to perform sentinel node biopsy (43.8%), don't perform oncoplastic surgery (62.7%), 17.2% don't perform sentinel node biopsy and 95.9% order MRI before conservative surgery in special cases.

Conclusion: Most of the physicians who were in the congress answered the questions according to the international guidelines. There wasn't a clear difference between the groups of specialists and gynecologists. After analyzing these data we conclude that it is important to have more educational events in breast surgery, mainly in the area with higher percentage of mistakes.

28 Poster

Proposal for using an international unified draft for chemotherapeutic regimen time schedule table: Chemo Box

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Most cancers require surgery and adjuvant therapy for an effective treatment. Early detection of cancer, development of standardized supplementary therapy, and the standard of treatment for cancers have all improved recently. In fact, continuous development of new anti-cancer chemotherapeutic agents is constantly improving the survival rate of cancer patients. The characteristics of cancer cells are in such a way, the composite use of anti-cancer medicines increases the effect of a treatment.

However, chemotherapy used in the current anti-cancer treatment consists of many medications and various recipe methods. Many authors and pharmaceutical companies are describing a variety of meanings in their articles and books. On the other hand, many cancer societies are announcing leaning toward the standardization of treatments and are providing guidance on the appropriate regimen for various types of cancer in an attempt to increase the effectiveness of treatments, and to increase the quality of medical managements. However, authors and cancer societies use their own notations and are yet to standardize any formats to mark the various anti-cancer chemotherapies. In future, combination of methods for administration of treatment can increase further with the development of more anti-cancer medicines.

Therefore, means to mark different kinds of anti-cancer medicines and an individual cycle will be necessary. The author proposes an anti-cancer chemotherapy notation scheme (called Chemo Box) as a simple table containing standardized notation as shown below for example of TAC regimen. This notation scheme may give direct assistance to patients receiving anti-cancer chemotherapy in addition to hospital staff and medical workers who are involved in the actual treatment process. It may also assist people learning to use the anti-cancer therapy. Many examples are presented to illustrate the usefulness of the proposed notation system.

TAC	mg/m^2	1 1	2 8	3 15	4 1	5 8	6 15	7 1	8 8	9 9	10 1	11 8	12 15	13 1	14 8	15 15	16 1	17 8	18 15
T Docetaxel	75	*			*			*			*			*			*		
A Doxorubicin	50	#			#			#			#			#			#		
C Cyclophosphamide	500	@			@			@			@			@			@		

Day 3: Start prophylactic G-CSF & antibiotics.

Wednesday, 16 April 2008 12:30–14:30

POSTER SESSION

Biological response and outcome

29 Poster Discussion

The effect of body mass index (BMI) on disease-free and overall survival in node-positive breast cancer treated with docetaxel and doxorubicin-containing adjuvant chemotherapy: the experience of the BIG 02-98 trial

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Background: Approximately 20% of cancer deaths in women are associated with obesity, which is also an indicator of poor prognosis for patients with primary breast cancer (BC) even after systemic therapy.

Material and Methods: This is a retrospective analysis of 2,887 node-positive BC patients enrolled in the BIG 02-98 adjuvant trial, a randomised phase III trial whose primary objective was to evaluate disease-free survival (DFS) by adding docetaxel to doxorubicin-based chemotherapy (CT) (J Natl Cancer Inst 2008; 100: 121–133). Our study evaluated the effect of BMI on DFS and overall survival (OS). BMI was obtained before the first cycle of CT. Obesity was defined as a BMI $\geqslant 30\ kg/m^2$. Cox model and Log-rank tests were used to compare DFS and OS between obese and non-obese patients.

Obese vs non-obese

Subgroup	DFS (HR)	Interaction P value	OS (HR)	Interaction P value
ER and/or PgR positive	1.29	0.79	1.46	0.91
ER and PgR negative	1.22		1.42	
1−3 positive nodes	1.22	0.94	1.44	0.91
$\geqslant$4 positive nodes	1.24		1.40	
Premenopausal	1.30	0.99	1.68	0.69
Postmenopausal	1.24		1.26	
Age <50	1.37	0.52	1.96	0.022
Age $\geqslant$50	1.22		1.15	

Results: In total, 547 (19%) patients were obese at baseline while 2,340 (81%) patients were non-obese. Estimated 5-years DFS was 75.9% for non-obese and 70.0% for obese patients (HR 1.29; 95% CI 1.08−1.52; P = 0.005). Estimated 5-year OS was 87.5% for non-obese and 82.9% for obese patients (HR 1.48; 95% CI 1.18−1.85; P = 0.0007). These differences were also evident when the population was divided according to the 5 subgroups WHO criteria (trend log-rank test P = 0.004 for DFS and P = 0.00002 for OS). The detrimental effect of obesity on OS was greater for younger patients than for older women (see table). The effect of the docetaxel versus no docetaxel appeared to differ between obese and non-obese patients for OS (HR 1.28 and 0.83, respectively, interaction test = 0.087) but not for DFS (HR 0.96 and 0.84, respectively, interaction test = 0.49).