Patients and Methods: Fifty primary breast cancer patients (T1: 2; T2: 35; T3: 5; T4: 8 cases, median size 32 mm) who underwent standard neoadjuvant chemotherapy following surgery were evaluated with US, EG and MRI before and after chemotherapy. The diagnosis was made by board certified radiologists/doctors. EG (Hitachi EUB-8500, Hitachi Medical Systems, Japan) images were assigned an elasticity score (1 to 5) according to the Tsukuba Elastography Score [1]. Clinical response was categorized as a clinically complete response (cCR, no enhanced lesion by MRI, no mass by US or score 1 or 2 by EG), or residual tumor (score 3 to 5 by EG). The pathological complete response (pCR) was defined as no invasive cancer with or without remaining DCIS.

Results: Breast conserving operation was performed in 37 patients (74%) and mastectomy was performed in 13 patients (26%). Pathological CR was confirmed in 15 patients (30%). The sensitivity and positive predictive value to predict pathological CR was 53.3% and 57.1% by MRI and 73.3% and 68.7% by EG ($p < 0.05$), respectively. The specificity, negative predictive value was 82.8% and 80.5% by MRI and 85.7% and 88.2%, respectively.

Conclusion: The Elastography is a reliable modality and predicted pCR slightly better than MRI. Together with conventional ultrasonography, mammography and MRI, Elastography will improve the surgical management of breast cancer after Neoadjuvant chemotherapy.

References

[1] Matsumura T, Tamano S, Shinomura R et al. Proceedings of the Third International Conference on the Ultrasonic Measurement and Imaging of Tissue Elasticity. 2004.

Wednesday, 16 April 2008 12:30–14:30

POSTER SESSION

Epidemiology, prevention, follow-up, management and care

58 Poster

Nab-paclitaxel or docetaxel; as alternatives to conventional paclitaxel for the treatment of metastatic breast cancer (MBC): cost utility analysis from the perspective of the United Kingdom (UK)

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Background: Paclitaxel and docetaxel are commonly used for the treatment of MBC. However, one important drawback in their use, particularly with docetaxel, is their potential for dose-limiting toxicity. To improve the side effect profile and efficacy of paclitaxel, an albumin-bound formulation (nab) was developed (Abraxane®). Clinical trials have demonstrated that n*ab*-paclitaxel is safer and more clinically active than both docetaxel and paclitaxel. To provide health economic data from the perspective of the UK, a cost utility analysis comparing n*ab*-paclitaxel to docetaxel, both as alternatives to paclitaxel was conducted.

Methods: The clinical data were obtained from a meta analysis of randomized trials comparing either n*ab*-paclitaxel (260 mg/m^2 q3wk) or docetaxel (100 mg/m^2 q3wk), to conventional solvent-based paclitaxel (175 mg/m^2 q3wk). Health care resource use for the delivery of chemotherapy and the management of grade III/IV toxicity was collected from a survey of medical oncologists and from the cancer literature. Using the Time Trade-off technique, treatment preferences and utility estimates were obtained from interviewing 35 female oncology nurses from 25 centres across the .

Results: N*ab*-paclitaxel had the most favourable safety profile characterized with the lowest incidence of grade III/IV neutropenia, febrile neutropenia, anemia, emesis and stomatitis. This translated to lower overall costs for managing the grade III/IV side effects of n*ab*-paclitaxel relative to both docetaxel and paclitaxel (£137 vs. £819 vs. £344). Using the median number of cycles administered as reported in the randomized trials and the cost impact of grade III/IV toxicity, the overall cost for n*ab*-paclitaxel would be £7,770 compared to £8,151 for docetaxel and £3,494 for paclitaxel respectively. In the preference assessment, 26 of 35 (74.3%) respondents selected n*ab*-paclitaxel as their preferred agent. As an alternative to paclitaxel, the incremental cost per QALY gained was determined to be more favourable with n*ab*-paclitaxel than docetaxel (£15,700 vs. £22,400).

Conclusions: N*ab*-paclitaxel is safer and less costly than docetaxel in MBC patients. As an alternative to paclitaxel, the National Health Service of the UK must decide if the £15,700 cost per QALY gained represents good economic value. Compared to other new cancer agents (e.g. cetuximab for metastatic colorectal cancer), this seems to be a reasonable proposition.

59 Poster

Breast care nurse led follow-up is associated with high levels of patient satisfaction

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Background: Following a diagnosis of breast cancer, women commonly enter a physician led follow-up care programme. Published patient perceptions of such follow-up models have included patients feeling hurried, clinic appointments lacking reassurance or continuity and patients feeling uncomfortable about expressing emotional concerns to a doctor. The role of the breast care nurse (BCN) in patient follow-up is starting to be evaluated, and where examined the majority of patients reported a preference to receive their follow-up from a BCN. There is, however, a paucity of published data on patient satisfaction with this method of follow-up.

Materials and methods: Local ethical committee approval was granted for this study. A peer-reviewed, validated questionnaire was given to women receiving BCN led follow-up after diagnosis and treatment for breast cancer. This comprised 47 statements relating to the BCN led follow-up programme, with response alternatives arranged as a five-point scale ranging from “strongly disagree” to “strongly agree”. Questionnaires were distributed to patients attending follow-up clinics in plain, sealed envelopes which also contained a pre-paid and addressed envelope for return. Patients were asked to complete their questionnaires at home following the appointment. Responses from the first 10 questionnaires returned were examined as a pilot study to ensure that the questionnaires had been presented in an intelligible format.

Results: A questionnaire return rate of 92% was achieved (55/60), with most questionnaires fully completed. Respondents had a mean age range of 55−64 (35%). 100% (53/53) of respondents agreed or strongly agreed that they knew who to contact if they had a problem between appointments, and 98% (52/53) felt able to contact the BCN in this situation. 96% (53/53) strongly agreed or agreed that they were given a chance to say what was on their mind and that their views were being fully considered, and 100% (53/53) of respondents agreed or strongly agreed that they felt able to express themselves and ask the BCN questions. Overall, 100% (52/52) agreed or strongly agreed that they were satisfied with their care and 92% (47/51) agreed or strongly agreed that they had had thorough follow-up care (data collection ongoing).

Conclusions: High levels of patient satisfaction with BCN led follow-up are expressed in this study, and these results may identify an important future role for BCN’s within the multidisciplinary breast care team.

60 Poster

Prognosis and survival of patients with T1a breast carcinoma: a single center retrospective study

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Background: Management of patients with breast cancer $\leqslant$5 mm remains controversial. No clear-cut treatment guidelines are currently available for this increasing population. The aim of this study was to better characterize these tumors and to find prognostic factors.

Methods: We retrospectively studied 247 patients treated at the Bergonié Institute (France) between 1980 and 2006. All patients with breast tumors measuring >0.1 cm and $\leqslant$5 mm (pathological size, pt1a) were included in this study. Patients having bilateral or anterior controlateral invasive breast cancer were excluded. Axillary lymph node dissection was done in 139 patients. Survival curves were evaluated by Kaplan–Meier method and univariate analysis by the logrank test.

Results: Median follow-up was 90.9 months. Overall survival was 96% at 5 years and 94% at 10 years. Distant disease free survival was 98% at 5 years and 94% at 10 years. Distant disease free survival was 98% at 5 years and 97% at 10 years for pT1aN0 versus 68% at 5 years and 57% at 10 years for pT1aN+. In univariate analysis, axillary nodal status, mitotic index, lymphovascular invasion and estrogen receptor status (positive or negative) were significant pronostic factors. ($p = 7.3 \times 10^{-9}$; $p = 0.01$; $p = 0.05$ and $p = 0.05$).

Conclusions: pT1a breast tumors have an excellent prognosis. Axillary nodal status seems to be the strongest prognostic factor. Randomized