362

NEO-ADJUVANT CHEMOTHERAPY: A COMBINATION CONTAINING MITOXANTRONE FOR THE TREATMENT OF LOCALLY ADVANCED BREAST CANCER. RANDOMIZED TRIAL COMPARING AN INITIAL CHEMOTHERAPY VERSUS A CHEMOTHERAPY/RADIOTHERAPY COMBINATION

H. Gervásio; J. Albano, J. Gordilho, C.F. Oliveira, L. Pedro, M. Pereira, E. Abraul, G. dos Santos, N. Amaral, C. Marques, D. Raimundo, C. Azevedo, F. Bianchi, A. Ribeiro e J.T. Brandão
Breast Cancer Cooperative Group - IPO Coimbra - Portugal

With the purpose to assess the role of neo-adjuvant chemotherapy (CT) for the treatment of locally advanced breast cancer, was started a randomized study in April 1990 comparing a combinated CT arm (GR I) with the same regimen plus radiotherapy (RT) (GR II). The patients were previously stratificated according to the institutions, hormonal status (pre or post-menopause) and high or low risk (defined by staging, hormonal receptors or differentiation grade). The regimen of GR I was the combination FNM: 5-Fu 750 mg/m^2 I.V., d_1-d_{21}; Mitoxantrone 10 mg/m^2, d_1-d_{21}; Methotrexate 35 mg/m^2 I.V., d_1-d_{21}. In both Gr's patients (pts) were previously submitted to 3 cycles, and after, in GR I the pts responding to CT did two more cycles. In GR II post 3 initially cycles were submitted to RT 60 Gy in mamarian area during 3 weeks, and 50 Gy during 5 weeks at ganglionary areas. After initial treatment both GR were evaluated and pts responding (CR + PR) were submitted to radical modified mastectomy followed by 6 adjuvant CT cycles with same regimen. In this first evaluation we analised the results of the 82 pts, being 77 evaluable (40 in GR I and 37 GR II). Both GR are similar concerning age, hormonal status and tumor characteristics. CT toxicity was similar in both GR, exception for hematologic toxicity, slightly high in GR II. The response rate was 82.6% for GR I and 86.3% for GR II, and progression rate was 8.7% for GR I and 13.7% for GR II. In GR I 65.2% were submitted to mastectomy and in GR II 68.2%. Though the survival rate was not yet evaluated the response up to now show significant efficacy of neo-adjuvant CT, and the combination of RT doesn't seem to show any impact in the results.

363

HOW WILL THE ROLE OF RADIOTHERAPY IN EARLY BREAST CANCER CHANGE OVER THE NEXT TEN YEARS?

J. Kurtz

Division of Radiation Oncology, University Hospital Geneva, Switzerland

Current demographic and therapeutic developments in breast cancer might be expected to have a future impact on radiotherapy (RT). Twelve radiation oncologists engaged in breast cancer research in 10 countries completed a questionnaire regarding the potential influence of screening, population aging, and changing treatment strategies on future practice. 92% of the "experts" believe that screening will influence the practice of RT moderately or greatly, with a modest/marked increase in the number of patients requiring RT. A modest overall increase in the percentage of conservatively-operated patients not receiving RT is predicted by 58%, but in elderly patients 50% forsee an increased use of RT in conjunction with conservative surgery. Although only 25% expect neo-adjuvant chemotherapy to gain widespread use, 75% see a future role in selected patients, resulting in increased breast conservation; only 42% favor RT alone without surgery in case of complete response. Concerning boost RT, 75% expect that randomized trials will have defined its precise role. The use of boost RT alone, without whole-breast RT was not generally favored. RT to lymph nodal areas was expected by 67% to gain new credibility and to be used more often. Regarding in situ ductal cancers, most experts forsee RT to be used only for a minority of selected lesions. Although only 50% feel that the percentage of patients receiving RT will increase, all agree that the use of total mastectomy will decrease moderately/markedly, and 50% expect a reduction in axillary surgery as well. This study reflects a certain diversity of opinion regarding the current and future use of RT in breast cancer among "authorities" in the field.

364

QUADRANTECTOMY FOLLOWED BY RADIOTHERAPY (RT) IN T1 - T2 BREAST CANCER.

M Roncadin,E Candiani*,M Arcicasa,R Bortolus, L Del Pup, C Gobitti, C Rossi*, A Carbone**, MG Trovò.
Radiotherapy,*Surgery,**Pathology Depts. C.R.O. Aviano (I).

In order to evaluate the usefulness of the boost on local control and cosmetic results, 2 consecutive studies were carried out in 232 evaluable pts with T1-T2 breast cancer. From '81 to '87, 116 pts were treated by quadrantectomy followed by breast RT, with a dose of 50 Gy/25 fr/5 wks using a 6 MV Lin.Acc. plus a boost of 10 Gy/5 fr on the tumor bed with e$^-$ of 8-12 MeV (Group I). From '87 to '89, another 116 pts received the same treatment without boost (Group II). Pts with positive lymph nodes received adjuvant chemotherapy and/or hormonotherapy. At present, 5 local recurrences (4.3%) have been observed in both groups. Cosmetic results (acc. to Beadle criteria, Cancer 1984) were excellent to good in 64 pts (55%) of Group I and in 100 pts (86%) of Group II. In our experience, quadrantectomy followed by RT, without boost, allows to achieve higher rates of excellent to good cosmetic results without compromising local control.

Breast Cancer – Adjuvant Therapy

365

HIGH-DOSE CHEMOTHERAPY (HDC) WITH AUTOLOGOUS PROGENITOR CELL SUPPORT (APCS) FOR BREAST CANCER PATIENTS WITH HIGH RISK STAGE II-III, AND STAGE IV WITH NO EVIDENCE OF DISEASE (NED) .

Stemmer S.M, Jones R.B., Shpall E.J., Bearman S.I., Myers S.E., Taffs S., McDermitt J.. University of Colorado Health Sciences Center, Denver, CO.

To investigate the role of low tumor burden in breast cancer patients, 29 patients were treated with HDC (cyclophosphamide 5625mg/M2, cisplatin 165mg/M2 and carmustine 600mg/M2), followed by APCS. All patients received induction chemotherapy with 1-4 cycles of Adriamycin, 5FU, and methotrexate or cyclophosphamide prior to HDC. Of the 29, 19 patients had high risk (>10 involved axillary lymph nodes) stage II-III, and 10 had stage IV NED breast cancer. Of the 19 patients with stage II-III disease, the two year overall and progression-free survival is 83% and 92% respectively. 2 patients died of toxic death (D +4, +183) and 1 relapsed (D+ 83). Overall survival at 15 months for the 10 patients with stage IV NED is 90%. No patient relapsed in this group. These results suggest that minimal tumor burden is the best time for HDC in patients with breast cancer, as in hematological malignancies. Moreover, tumor burden more then stage of disease, may influence the outcome of HDC treatment.

366

CMF VERSUS OOPHORECTOMY IN PREMENOPAUSAL (PREMP) STAGE II BREAST CANCER (BC)

Everington D, Stewart H J, Leonard RCF ,
For The Scottish Cancer Trials and Guy's Hospital Breast Groups The Medical School, University of Edinburgh, EH8 9AG.

332 preMP women with pathological node +ve BC were randomised, after mastectomy or conservation therapy, to either ovarian ablation (OA) or CMF (6 cycles), each with or without prednisolone 7.5mg daily for 5 years. There are no significant differences in relapse rates, event-free or total survival for OA compared to CMF or for prednisolone vs no prednisolone (max FU 12 yrs). Comparing CMF with OA, the hazard ratio and 95% confidence interval for total survival is 1.12 (0.76-1.63) and, overall, 60% of those entered have survived for 8 yrs or more.

The randomisation included, without reference to ER level, 270 (81%) who had oestrogen receptor (ER) assays. There was a significant interaction between ER level and treatment for event-free survival, favouring OA for levels ≥20 fmol/mg protein and CMF for levels < 20. But treatment comparisons within these 2 ER subgroups do not reach significance. No such trend was found in the assessment of prednisolone. These results highlight the need for trials to assess OA and chemotherapy, alone and in combination, with selection by ER level.