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BREAST CANCER: INFLUENCE OF AGE ON TREATMENT CHOICE OF SURGEON AND RADIATION ONCOLOGIST

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Conservative surgery with radiotherapy or radical surgery offer equal chances for local control and survival of breast cancer but may have a different impact on quality of life. The few available data indicate that breast conservative surgery is less often proposed to elderly patients, an attitude often based on the premises that breast conservation is of less concern to older women. The aim of this retrospective study was to investigate the influence of age on treatment choice between conservative and radical surgery. The population consisted of 492 patients referred to our department for primary treatment of T1-T3, N0-N1, M0 breast carcinoma from january 1983 to december 1988.Mean age was 54.1 years (range 24-81), with 100 patients aged 0-44, 294 patients aged 45-64 and 98 patients older than 65, the latter considered as elderly. There was a significant trend toward more advanced T-stage with increasing age (p=0.03). Multivariate analysis revealed that, after correction for stage, younger patients were more often offered conservative surgery than older patients (p<0.001). Moreover, node dissection was less frequent in older patients (p<0.001). Breast conservative treated elderly patients were significantly less boosted than younger patients (p<0.001). Finally, elderly patients were less likely to receive axillary irradiation (p=0.047). There was thus a trend, in our breast cancer population, to treat older patients with more radical surgery. Perhaps more important is the finding that axillary clearance was less frequent in the older age group, indicating that tumor staging was not optimal in elderly patients. Moreover, this was not compensated by an increase in axillary irradiation. This had no measurable impact on local control and survival, but the elderly group consisted of only 98 patient, i.e. probably too small to detect small differences.

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ADJUVANT CHEMOTHERAPY IN BREAST CANCER, CMF I.V./3 WEEKS, IMPACT OF DOSE INTENSITY ON TREATMENT OUTCOME.

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Ninety three pts. with operable breast carcinoma recieved adjuvant I.V. as follow: Cyclophosphamide 600 mg/m2, Methotrexate 40 mg./m2 and 5 Fluorouracyl 600 mg./m2, every 3 weeks, 6 cycles. Their median age was 49 years, (range 22-69). 55 pts.(59%) were premenopausal and 37 (41%) postmenopausal. 78 pts. (84%) had stage II disease and 62 (67%) had positive axillary lymph nodes. The median follow up was 30 months. (range 10-70).
The individual dose intensity (IDI) was calculated as a fraction of the planned treatment dose intensity for each pts. The mean relative dose intensity was 0.93 and the median 0.95. three year actuarial survival rate was 89% and disease free survival 68%. Pts. with relative IDI greater than 0.80 had better 3 year disease-free survival than those with lower IDI (77% VS. 56%, p<0.001),but the number of pts.in the low IDI group is too small to get statistical significance. No overall survival difference was observed between the two groups. This result suggest that dose intensity in adjuvant CMF therapy may influence disease free survival but has no effect on overall survival.

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MALIGNANT UTERINE TUMORS (M.U.T.) AFTER TAMOXIFEN TREATMENT FOR BREAST CANCER (B.C.). A 22 CASES REPORT

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From 1985, twelve reports and five case-control studies suggested that Tamoxifen (TAM) may cause M.U.T.. We analysed 22 cases of M.U.T. occurred from 1985 to 1992, among women treated by TAM for B.C. 1980 to 1990.
The median age at diagnosis of B.C. was 56 years. 6 underwent radiotherapic castration (R.C.). All received adjuvant TAM at 40 mg/day (10) or 20 mg/day (12), during two years or less in 14 cases, and from three to seven years in 8 cases.
The M.U.T. was discovered with a median delay of 53 months (range : 9 - 108). 20 were adenocarcinomas (one in situ, 12 grade I, 3 grade II, and 4 grade III) and 2 sarcomas (both grade III). Globally, we noted 15 stage I, 4 stage II, one stage III and two stage IVa. 21 women underwent surgery (10 with radiotherapy). One was treated only by radiotherapy. 13 women are alive and well. One died by colic carcinoma, one by B.C., and two had metastases from B.C. Three died by E.C. and two have now metastases. Thus, 23 % of our patients had dramatic evolution due to M.U.T. For informatic registration problems, we evaluated the real frequency of M.U.T. after TAM in 789 women treated for B.C. by conservative therapy from 1980 to 1989. We noted 5 cases (1 %), 2 among the 428 (0.5 %) women treated by TAM, and 3 among the 71 (4.2 %) treated by TAM + RC. Among the 290 women without adjuvant treatment by TAM, no M.U.T. was observed.
Our data confirm a possible role of TAM in the development of M.U.T., maybe increased by long term duration, dose more than 20 mg/day, and R.C.
A careful gynecologic follow-up is now required for women under TAM treatment, especially in these enrolled in chemoprevention trials and presenting other risk factors of M.U.T. (obesity, hypertension, diabetis, nulliparity). Ultrasonography and hysteroscopy seems to be currently the best investigation to explore the possible uterine abnormalities.

Key words : Breast Cancer - Tamoxifen - Uterine tumors

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FLUOROURACIL , EPIRUBICIN , CYCLOPHOSPHAMIDE (FEC) PRIMARY CHEMOTHERAPY TO AVOID MASTECTOMY IN OPERABLE BREAST CANCER

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From Jan.1991 to Dec.1992 , 33 patients with localized operable breast cancer , who were candidates for radical mastectomy because of large primay (T2 > 3cm or T3, N0-N2,M0) , received primary chemotherapy in the attempt to substitute conservative for multialting surgery.The regimen used was FEC (fluorouracil 500 mg/m^2 on days 1 - 8 , epirubicin 75 mg/m^2 and cyclophosphamide 500 mg/m^2 on day 1 by bolus injection) administered every 3 weeks for a total of 3 cycles. Surgery was planned , after full clinical and mammographic re-assessment of tumor diameter , within 3-4 weeks of the last dose of chemotherapy. Modified radical mastectomy was chosen in pts. with tumor measuring 3 cm or more in diameter at surgery, while quadrantectomy (as proposed by Veronesi et al., 1981) was performed when tumor diameter at surgery was less than 3 cm. The median time to delivery 3 FEC cycles was 49 days (42-56) and the median time to surgery was 70 days (63- 77). Herein we report results obtained in 33 fully evaluable pts. in terms of tumor shrinkage and type of surgery.

Intial T (cm)	N.°cases	T at surgery (cm)		Quadrantectomy	%
		<3	>3		
3.0 - 4.0	8	7	1	7 / 8	87.5%
4.1 - 5.0	8	6	2	6 / 8	75.0%
5.1 - 6.0	8	5	3	5 / 8	62.5%
>6	9	3	6	3 / 9	33.3%
Total	**33**	**21**	**12**	**21 / 33**	**63.6 %**

The main side effects of chemotherapy were : alopecia requring transient use of a wig (100%) , grade 3 leukopenia and thrombocitopenia 10% and 3% respectively. Our results are in agreement with those previously obtained in neoadjuvant setting (J.Natl.Cancer Inst.82: 1539,1990) , thus confirming the capacity of FEC regimen of substituting conservative for mutilating surgery in more than 60% of pts. with operable breast cancer.

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INFLAMMATORY BREAST CANCER:COMBINED TREATMENT WITH CHEMOTHERAPY PLUS LONIDAMINE,SURGERY AND RADIOTHERAPY.

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Patients with non metastatic inflammatory breast cancer (IBC) are treated at our Institute with Chemotherapy (FEC:5-FU 500 mg/sqm i.v.,Farmorubicin 100 mg/sqm i.v. d 1,CTX 500 mg/sqm i.v. d 1 every 3 weeks x 4 cycles) plus Lonidamine 450 mg/die/os. After 4 cycles of chemotherapy,responsive patients (CR+PR) are operated on radical mastectomy followed by a further 4 cycles of FEC + Lonidamine and Radiotherapy.Stable and progressive patients are treated with primary Radiotherapy and Salvage Chemotherapy (Mitomicyn 15 mg/sqm i.v. every 6 weeks + Mitoxantrone 10 mg/sqm i.v. every 3 weeks x 4 cycles).
From April 1,1991 trough December 1992, 27 patients entered in the study. We obtained CR + PR in 22 patients (81%),a Minimal response (MR) in 3 patients,NC in 2 patients. The patients MR were operated on radical mastectomy after Radiotherapy.
At present 23 patients are alive and are free of disease 4 patients relapsed:1 locally only and 3 at distance.
This approach allowed the majority of patients to obtain a good local control.

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PRIMARY TREATMENT WITH TAMOXIFEN IN ELDERLY PATIENTS WITH LOCALISED BREAST CANCER

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90 women with localised and operable breast cancer, aged 70 or more, entered the study and were given tamoxifen 20 mg/die as primary treatment and then followed for between 6 and 60 months. Currently, 74 patients are evaluable, including 44 (59.5%) responders (minimum response duration 6+ months; maximum 55 months: 8 complete (CR: 10.8%) and 36 partial responses (PR: 48.6%). The "no change" (NC) observed in 26 pts (35.1%) can also be considered good (minimum duration 6 months; maximum 52+ months). After an initial response, 13 of these pts (2 CR, 5 PR, 6 NC) relapsed after a median time to progression of 15 months (range 9-29). Disease progression was recorded in 4 pts (5.4%) from the beginning of treatment. After a median follow-up of 21 months (range 6-60), only 3 pts have died because of their tumour (4%). On the basis of this data, updated since the last report (Cobelli S. Abs.175, ECCO 6, Florence '91), tamoxifen would appear to be a valid alternative to the conventional surgical treatment of breast cancer in elderly pts, particularly given its low level of toxicity.