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CHANGES IN SERUM LIPIDS IN POSTMENOPAUSAL PATIENTS WITH NODE-POSITIVE BREAST CANCER TREATED WITH TAMOXIFEN

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Tamoxifen is now widely used as adjuvant therapy in breast cancer patients. In this trial 64 newly diagnosed postmenopausal women with node-positive breast cancer receiving adjuvant tamoxifen (20 mg per day) were studied. Total serum cholesterol (C), triglycerides, HDL-C, LDL-C, VLDL-C, apoA1, apoB and Lp(a) were determined before the surgery as well as 3 and 6 months after the treatment started. Tamoxifen significantly reduced total serum cholesterol (6.6 ± 0.8 mmol/l vs. 5.3 ± 1.1 mmol/l) ($p < 0.005$), Lp(a) ($p < 0.01$) from 0.91 ± 0.01 to 0.73 ± 0.02 g/L, LDL-C ($p < 0.005$) and VLDL-C ($p < 0.01$), but increased HDL-C ($p < 0.01$).

We conclude that tamoxifen may have a beneficial effect on serum lipoproteins and presumed decrease in cardiovascular risk may prove to be an additional benefit to those patients.

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SEPARATE ANALYSIS OF PREDICTORS FOR LOCAL, REGIONAL & DISTANT RECURRENCE IN NODE+ OPERABLE BREAST CANCER (OBC)

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Survival(S) by site of 1st recurrence(REC) was determined in 216 node+ OBC pts. Primary therapy: M.R.mastectomy & 5-FU+ melphalan. At median follow-up of 110m, the site of 1st REC was local(L) in 12%, regional(R) in 11% & distant(D) in 27% of pts. An advantage in S for pts with L as compared with D REC was evident (5yS: 67%vs43%; $p = 0.04$). DFI data for each of these 3 subsets (uni/multivariate analysis) indicate that: 1) L REC was related primarily with medial/central location of 1ary tumor (T), residual tumor found after biopsy in the mastectomy specimen & $T > 3$ cm; 2) R REC was best predicted by $> 3+$ nodes & tumor spread in axillary fat(SAF); and 3) for D REC the relevant factors were $T > 3$ cm, SAF & ProgR-. In conclusion, our data suggest that identification of specific predictors for L, R & D REC by using easily available parameters is feasible. This may lead to more accurate selection of pts for either chest wall or nodal irradiation & allow better focus on pts at high risk for distant spread. Moreover, the difference in S between pts with L & those with D REC indicates that separate analysis of L- and D-DFI in adjuvant therapy trials may prove valuable.

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TIL WITH SPECIFICITY FOR AUTOLOGOUS TUMOR CELLS IN BREAST CANCER

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TIL were isolated from primary tumors of breast carcinoma from ten patients who underwent surgical procedures. TIL proliferated by > 325 -fold (mean 1,692) after 28-76 days in cultures containing mixtures of TIL, autologous tumor cells and rIL-2. Freshly isolated TIL consisted of $77.5 \pm 10.7\%$ CD3+ T cells, with a CD4/CD8 ratio of 0.70. After expansion of lymphocytes with rIL-2 CD3+CD8+ T lymphocytes were present in greater numbers than CD3+CD4+ T lymphocytes. rIL-2-activated CD3+CD8+ cells exhibited preferential cytolytic activity against autologous tumor cell targets which was inhibited either by anti-TCR α / β and anti-CD3 monoclonal antibodies (Mab) or after pretreatment of tumor target cells with Mab against the class I major histocompatibility complex (MHC) antigens. CD3+CD8+ T-cell clones isolated from representative TIL exhibited preferential autologous tumor-specific cytotoxicity whereas the cytolytic activity of CD3+CD4+ T-cell clones was mostly (12 of 14 clones) nonrestricted to the autologous tumor. This is the first report to demonstrate that TIL from primary tumors of breast carcinomas can be propagated in large numbers and to lyse autologous tumor cells.

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THE VALUE OF PRIMARY CHEMOTHERAPY IN LOCALLY ADVANCED BREAST CANCER

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The effect of primary chemotherapy (CT) on locally advanced breast cancer was studied in 36 pts. All pts received 2-9 (median 5) courses of CT prior to definitive surgery (28 pts) or radiotherapy (8 pts). Seven pts with clinical stage IIB were treated with CMF; 15 pts with stage IIIA and 14 pts with stage IIIB received CAF (CTX 600mg/m², Adria 60mg/m² and 5-FU 600mg/m² q.3 weeks). Median follow-up was 15 months (7-38). None of the 36 pts had disease progression during chemotherapy. Three of the 22 pts with stage IIB and IIIA had clinically complete remission (CR), one confirmed by pathology. Of 14 pts with stage IIIB (all with inflammatory carcinoma), 6 had clinical CR and are disease-free 13-24m from diagnosis while 6 of the remaining 8 pts who achieved only partial or minimal response to chemotherapy had recurrent disease after 9-22 months. In conclusion, primary CT prevents disease progression during treatment and response to CT might be a prognostic indicator in inflammatory breast cancer.

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LONG TERM EFFECT OF TREATMENT BY TAMOXIFEN IN WOMEN TREATED FOR BREAST CANCER. A RETROSPECTIVE STUDY AND COMPARISON WITH CONTROL SUBJECTS.

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18 women treated by Tamoxifene (T) for breast cancer for a mean time of 35,7 months had a study of bone mineral density (BMD) of spine (mean value L2-L4) and hip (femoral neck, Ward's triangle, trochanteric region) versus a control group (C) of 19 women. There is no significant difference of age and post menopausal age between the 2 groups.

| | T | C | P |
|-----------|-------------|-------------|-------|
| Spine BMD | 1,05 (0,17) | 0,94 (0,16) | <0,05 |
| Neck BMD | 0,85 (0,13) | 0,79 (0,15) | NS |
| Ward BMD | 0,75 (0,18) | 0,67 (0,19) | NS |
| Troch.BMD | 0,74 (0,12) | 0,67 (0,14) | NS |

Conclusion : Long term effect of treatment by T in bone has a benefic effect by maintaining hip BMD and increasing spine BMD.
Key-words: Breast cancer. Bone mineral density.

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NATIONAL ADJUVANT CHEMOTHERAPY PROTOCOL IN STAGE II CARCINOMA OF THE BREAST. CMF VERSUS CNF

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149 patients with Stage II Adenocarcinoma of the breast were entered on a prospective controlled randomized multicenter study. The patients received CMF protocol (Cyclophosphan, Methotrexate and 5 FU) or CNF protocol (Cytophosphan, Novantrone and 5 FU). Median time of follow-up was 37 months and the relapse was statistically significant higher in the CMF group ($p = 0.0008$). DFS was found to be significantly better in the CNF premenopausal group compared to the CMF ($p = 0.001$). DFS was documented better in the CNF group regarding ER negative patients ($p = 0.007$) and PR negative patients ($p = 0.005$). In ER and PR positive patients the above statistically significance was not found. The better response was documented regarding lymph nodes involvement. Up to 10 metastatic lymph nodes were found to respond better to CNF than to CMF (0 - 3 positive nodes $p = 0.02$). 4 - 10 positive lymph nodes $p = 0.001$. Overall survival was significant better in the CNF combination arm ($p = 0.05$). The above correlation was found only in premenopausal patients.