

(136 pts) $8.6 \pm 3.7\%$, margins unknown (540 pts) $8.2 \pm 1.3\%$ NS. Boost dose (942 pts) $5.5 \pm 1.2\%$ no boost dose (632 pts) $8.6 \pm 1.4\%$ NS. Interval between surgery and radiotherapy ≤ 6 weeks (200 pts) $9.5 \pm 2.6\%$; 7–12 weeks (580 pts) $7.3 \pm 1.4\%$; 13–18 weeks (511 pts) $7.0 \pm 2\%$; > 18 weeks (283 pts) $5.2 \pm 1.9\%$ $p = 0.03$. No adjuvant ther. (1074 pts) $8.5 \pm 1.2\%$; Adjuvant chemother. (178 pts) $5.4 \pm 2\%$; NS Adjuvant hormonother. (322 pts) $2.8 \pm 1.5\%$ $p = 0.0008$.

SY-3-3 The Need for Boost Doses in Breast Conserving Therapy

H. Bartelink. *The Netherlands*

Abstract not available.

SY-3-4 Impact of Local Control on Survival

J. Kurtz. *Radiation Oncology, University Hospital, Geneva, Switzerland*

It is generally accepted that most breast cancer deaths result from metastatic deposits already present at time of diagnosis, and that secondary metastases resulting from locally persistent or recurrent tumor foci play a subsidiary role. Unlike systemic therapies, adjuvant local treatment (radiotherapy or more radical surgery) can favorably influence survival only by preventing secondary metastases in the subgroup of patients having residual locoregional cancer but no viable metastatic deposits following initial surgery. Moreover, most risk factors for local failure also in themselves reflect metastatic risk. As a consequence of the above considerations, one might expect that 1) local failure should be a *marker* for subsequent metastases. 2) if more aggressive local therapies have a positive influence on survival, this effect will be both *small* and *delayed* in onset with respect to the effect of systemic treatments, and it may be difficult to demonstrate because of competing causes of death (including those related to the possible toxicity of treatment). This lecture will discuss the above aspects in the light of results from the literature, with particular emphasis on randomized clinical trials.