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Activity of exemestane, an irreversible, oral, aromatase inhibitor in metastatic postmenopausal breast cancer patients (MBC) failing tamoxifen (TAM)

S. Kvinnsland[1], G. Anker[2], L.Y. Dirix[3], J. Bonneterre[4], A.M. Prové[5], N. Wiking[6], K. De Belder[7], O. Mariani[8], E. Di Salle[8], G. Massimini[8]. *And Participating Investigators; [1]Radium Hosp., Oslo; [2]Univ. of Bergen, Norway; [3]St. Augustinus Ziek, Antwerp; [5]U.Z. Antwerpen, Edgem; [7]P & U Bruxelles, Belgium; [4]Lille, France; [6]Karolinska Hosp., Stockholm, Sweden; [8]P & U Milan, Italy*

Purpose: To evaluate the activity of exemestane in postmenopausal MBC patients failing Tam.

Methods: A multicenter, multinational, phase II study was conducted. Exemestane 25 mg was administered orally once daily.

Results: 134 women were enrolled including 9% unresponsive to prior Tam therapy, 40% with PD after an initial response, 25% with metastatic disease ≤12 months since discontinuation of adjuvant Tam, and 25% with unassigned stratum. The predominant disease site was visceral in 46%, bone in 38%, and soft tissue in 16%. The objective response rate (CR + PR) was 22% in all patients (95% CI: 16%–30%), 25% in Tam-resistant patients, and 25% in patients with predominant visceral disease. An addition 26% had no change for ≥ 24 weeks, for an overall benefit rate of 48%. Median duration of objective response, overall benefit, and time to progression were 68, 56 and 27 weeks, respectively. Adverse events (AEs) were usually mild to moderate. The most common AEs were hot flushes (14%), dizziness (9%), nausea (8%), and increased sweating (5%). 3% of patients experienced greade 3 AEs, and 2% withdrew because of AEs. Estrogens (E_1S_1, E_1 E_2) were suppressed to ≤10% to 15% of baseline by 8 weeks of therapy.

Conclusion: Exemestane is efficacious and well tolerated in MBC. A large, double-blind multicenter, multinational, phase II study of exemestane versus Mergace is ongoing in this patient population.

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CMF and mitoxantrone in elderly patients with advanced breast cancer. A randomized phase II study

M.A. Nooij, E. Steenland, L.V.A.M. Beex, B. van de Bos, L. Ruiter, J.C.J.M. Haes. *LUMC, Clinical Oncology, P.O. Box 9600, 2300 RC Leiden, The Netherlands*

Although breast cancer incidence increases with age, clinical studies especially with cytostatics are scarce in patients older than 70 years. A phase II study in advanced breast cancer is being conducted to define effect, morbidity and quality of life in patients 70 years and older. Patients were randomized between Mitoxantrone 14 mg/m^2 and a modified CMF scheme (cyclo 75 mg/m^2 p.o., mtx 30 mg/m^2, 5 Fu 450 mg/m^2 d 1,8 q 4 w). A total of 61 patients were included. RSCL was used to assess quality of life in 52 patients. Measurements took place before, during and after treatment.

Results: patients characteristics: median age 73 yrs., performance WHO 0–2, dominant side of disease: visceral 50, bone 4, soft tissue 5, unknown 2. Median numbers of cycles: M 4.8, CMF 4.2, median TTF 5 m and m. survival 7.3 m. 73% of the expected Q of L forms have been received. During treatment patients became more physically distressed (p = .06) and experienced a significant drop in their level of activity (p < .0001). Their overall and psychological well-being were not influenced by treatment. Even with a TTF of median 5 m, the patients themselves considered chemotherapy worthwhile.

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Surgical treatment of vertebral breast cancer metastatsis

J. Gligorov[1], C. Garreau de Loubresse[2], P. Debourdeau[1], P. Pirriou[2], T. Andrei[1], J.P. Lotz[1], T. Judet[2]. *Departments of [1]Clinical Oncology; [2]Surgery, Hôpital TENON, Paris, France*

Purpose: Vertebral breast cancer metastasis (VBCM) is a common problem in patient suffering from metastatic breast cancer. However, different therapeutic approaches are used for VBCM without any available guidelines. In our institution, all patients suffering from VBCM are discussed by a staff of oncologists and spine surgeons.

Methods: Between 1986 and 1994, 26 operations were performed in our institution for VBCM. All this patients had a neurological decompression associated with a stabilization by osteosynthesis. The data records of each patient were reviewed retrospectively for the following information: age; performance status; number and sites of metastases; preoperative and postoperative clinical symptoms; preoperative and postoperative neurological evaluation using the Frankel scoring; Tokuashi scoring; and preoperative and postoperative treatments. The statistical analysis concerned survival from the date of surgery to the last follow-up.

Results: Twenty-five patients, median age 53 years [range, 28–74], were operated. The median interval time between initial cancer and the discovering of VBCM was 55 months [range, 0–180], and between discovering of VBCM and surgery 15 months [range, 0–59]. The mean number of VBCM was 5 [range, 1–10]. The mean site was dorsal. After surgery, we observed improvement in 14 patients (54%) and nether rise of neurological symptoms. The evaluation of post-operative stability showed 3 plates dismantling (11%). With a 31 months follow up median [range, 0–81], the overall median survival time was 29 months. Statically shorter median survival time was associated in the subgroups of patients with extraosseous metastasis (12 months, p = 0.0007) and epidural compression (15 months, p = 0.0309). The Frankel and Tokuashi scoring and post operative "adjuvant" treatment were not statistically correlated with overall median survival time. Four patients had a vertebrectomy for a solitary VBCM with a longer survival (69 months, p = 0.0207).

Conclusion: This results suggest that surgical treatment for VBCM (always associated with osteosynthesis) is an interesting approach with good results and longer life expectancy in selected subgroups of patients.

Friday, 2 October 1998 16:00-18:00

PARALLEL SESSION

Screening

411 INVITED

Breast cancer screening

D. Amadori. *Medical Oncology Department, L. Pierantoni Hospital, Forlì, Italy*

Breast cancer screening has been the subject of extensive research. The types of screening that have been shown to reduce mortality are two view mammography and physical examination combined, and single-view or two-view mammography alone. The schedules of screening that have been shown to be effective vary from approximately yearly (two-view mammography an physical examination together) to approximately every 33 months (single view mammography alone). The value of screening women aged 50–74 (about 25% reduction in mortality) is clear. The benefit for women 40–49 years of age is less certain. Studies that will provide adequate information on this issue are in progress. Almost no information is available on the value of screening under age 40. The maximum age at which the benefit would become too small to be useful is unknown. The effects of screening among older women as well as the implications of different screening protocols in relation to different time intervals (net gain in mortality reduction and extra costs) remain major areas of research.

The effect of screening in women aged 50–74 years justifies the implementation of population-based programmes. Nationally, regionally, and locally organized programmes are in progress in many European Countries. Others are expected to start in the next few years. The adoption of mammography screening as a public health policy requires stringent quality control measures and monitoring systems. The impact of adverse effects of the procedure (radiation exposure, psychological morbidity, discomfort, false reassurance, overdiagnosis, unnecessary investigations, unnecessary biopsies, under/overtreatment, and over-use of clinical services) needs to be carefully assessed. Adequate methods for the epidemiologic surveillance of screening (including early indicators of efficiency and efficacy) as well as the control of the technical quality of mammography have been developed.

Despite the demonstrated benefits of mammography screening, breast cancer will continue to be a major public health problem. A balance between the resources allocated to large-scale early detection programmes and those devoted to biological and clinical research is a prerequisite of a global strategy for breast cancer control.