dance with other previous series with a quoted American National average of 15%. The majority of Stage I and in situ carcinomas was presented as a suspicious lesion (opacity-mass or developing density – with ill-defined borders) with microcalcifications.

830 PUBLICATION

Uracil-ptegafur (UFT) + Prednimustine (P) as an oral adjuvant treatment for premenopausal women with node positive breast cancer

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In 1997 the Grupo Oncológico de Sevilla reported on a trial of oral adjuvant treatment for premenopausal women with node-positive breast cancer using (P), 60 mg/m^2 for 7 days every 4 weeks for 6 cycles, and (UFT) 400 mg/day in two divided doses continuosly for 24 weeks. They randomly compared this treatment vs Cyclophosphamide, 600 mg/m^2, Methotrexate, 40 mg/m^2 and 5-fluoruracil, 600 mg/m^2, (CMF) once every 4 weeks for 6 cycles, and after a median follow up of 5 years they didn't find any difference in disease free survival (DFS) or overall survival (OS) nor in the whole group nor in the groups defined by the number of axillar involved nodes. The toxicity had a low profile. (Oncology. 1997. 11 (9 suppl 10). 74–81). We report now, after a median follow up of 7 years, on the group of patients from our Hospital that were involved in this trial. They were 105 premenopausal women, 54 included in the arm CMF and 51 in the arm P + UFT. Their characteristics (age, stage, number of involved nodes) were similar although in the CMF arm the patients were younger, but this hadn't any effect in the survival curves. Again there were no differences in the outcome of both arms, as much in DFS as in OS, and the same in the whole group as in the groups with 3 or less or more than 3 involved nodes.

We conclude that UFT + P is as active as the CMF as used in this trial, and it could be useful in patients who are inelegible for intravenous therapy or simply prefer oral administration.

831 PUBLICATION

A single centre experience of adjuvant doxorubicin-CMF chemotherapy for multiple node positive breast cancer

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Sequential doxorubicin and CMF chemotherapy (Bonadonna et al JAMA 1995;542–547) has the best non-myeloablative medium and long term result in the treatment of multiple node (N) positive breast cancer. Over 4 years, 75 patients (pts) (median age 48, range 26–62) with operable multiple N positive breast cancer (median 10 N; 3N, 2 pts; 4–9 N, 35 pts; 10+ N, 38 pts) were treated with doxorubicin 75 mg/m^2 × 4 followed by i.v. CMF (cyclophosphamide 600 mg/m^2, 5-FU 600 mg/m^2 and methotrexate 40 mg/m^2) both q21 days. Tamoxifen 20 mg/day was given to 57 ER positive pts on completion of chemotherapy. Standard adjuvant locoregional radiotherapy was given to 61 pts.

The projected overall survival (OS) is 95% at 3 years for the 4–9 N group and 70% for the 10+ group (p = 0.027) similar to that reported by Bonadonna. Grade, ER and use of Tamoxifen are not significant for survival. Disease free survival at 3 years for the same groups are 62% and 60%. Site of relapse was local in 8 and distant (with or without local) in 18. Local control at 3 yrs is 80%. Toxicity was predictable and acceptable with no deaths and no observed clinical cardiac toxicity. There was no difference in OS for 18 pts who were receiving sequential doxorubicin and CMF as the control arm of the Anglo-Celtic Group trial compared with the 57 pts receiving sequential doxorubicin and CMF as standard therapy.

Endocrine tumours

832 POSTER

Current treatment for papillary carcinoma of the thyroid in the US and Germany: Report on 5612 cases

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Purpose: There is no complete agreement on treatment modalities for differentiated thyroid cancer, especially for patients at low risk.

This includes the extent of surgical procedures as well as the indication for adjuvant radio-iodine therapy.

Methods: In order to compare and evaluate the management of patients with thyroid cancer in the United States and Germany a Patient Care Evaluation Study (PCES) was carried out parallel in the year 1996. PCES are designed to monitor the quality of diagnosis, therapy, and follow-up of specific tumour diseases.

Results: 3927 patients in the US and 1685 in Germany, first diagnosed in 1996, have been included in this study. Our results indicate that patients with papillary thyroid cancer of all UICC stages, especially stage I and II, underwent more extensive tumour operations in Germany. Lobectomy was performed in only 2% of the German cases against 18% in the US for patients in stage I. Total thyroidectomy plus lateral lymph node dissection was done in 23% of the German and 7% of the American cases. 85% of the German patients with papillary thyroid cancer were receiving a combined treatment including radio-iodine, whereas in the US less than 50% of these patients were treated this way.

Conclusion: Our analysis show differences in the treatment of papillary thyroid cancer between the US and Germany, with in general an interdisciplinary and more radical approach in Germany. Long term observation within this PCES will demonstrate how variances in treatment will affect outcome.

833 POSTER

Primary treatment and survival in anaplastic thyroid carcinoma

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Purpose: Anaplastic thyroid carcinoma (ATC) is a fatal tumor despite combined treatment. The optimal sequence of treatment modalities is not known. The aim of our study was to find out if primary surgery (S) prolongs survival in comparison to combination of primary radiotherapy (RT) and/or chemotherapy (ChT).

Methods: In our retrospective study there were 79 patients (26 men, 53 women, age: 40–86 years, mean 65 years) with ATC treated at our Institute from 1972–98. Excluded were patients with distant metastases, without treatment or with survival shorter than one month. The patients were classified into (1) primary surgery group (n = 26) and (2) primary RT and/or ChT group (n = 53, among them RT and ChT enabled S in 12). Survival of both groups was compared by log rank test and group characteristics by ANOVA and χ^2 test using SPSS program.

Results: There was no difference in survival of both groups (p = 0.17). Longer survival than one year was observed in 25% of patients with primary S and in 21% of patients with primary RT and/or ChT. In comparison to primary RT and/or ChT group the patients from primary S group were younger with more frequent slow-growing, smaller and to thyroid confined tumors without regional metastases.

Conclusion: Primary S does not prolong survival in comparison to primary RT and/or ChT. This study suggests that treatment should start by RT and ChT (with S to follow if possible) because it was equally effective in locoregionally more advanced ATC than primary S in less advanced ATC.