influencing treatment uptake may be the attitude of individual patients to certain treatments. In some situations, if patients are offered less disruptive or toxic treatments, they may choose these options in order to reduce the risk of side-effects or loss of independence.
Healthcare professionals may over-estimate the impact of chronological age on the acceptibility and tolerance of treatment in older patients as few oncologists will have received any training in the principles of geriatric medicine. In order to address this problem, a number of approaches should be considered. Clinical trials should be designed to focus specifically on older patients including those with comorbidity and frailty. The knowledge and skills of geriatric medicine should be extended to the management of older patients with cancer. This includes the introduction of comprehensive geriatric assessment (CGA) and appropriate targeted interventions to address reversible comorbidity in cancer patients. This may require the introduction of multidisciplinary oncogeriatric clinics to optimise patient care.

Society Session (Sun, 25 Sep, 16:45−18:15)
European Society of Gynaecological Oncology (ESGO)

220 INVITED
ESGO and the Future of Gynaecologic Oncology in Europe

Abstract not received

221 INVITED
How to Evaluate Targeted Therapy in Ovarian Cancer

Abstract not received

222 INVITED
New Targets for Personalised Medicine in Endometrial Cancer

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With lifetime risk among women of 2−3%, endometrial cancer is the most common pelvic gynaecologic malignancy in industrialized countries. Approximately 75% of cases are diagnosed at an early stage with tumour confined to the uterine corpus. Although most patients are cured by surgery alone, about 15−20% with no signs of locally advanced or metastatic disease at primary treatment recurs, with limited responsiveness to systemic therapy. In light of these recurrences, patients with localized endometrial cancer have 2 major needs: 1) adjuvant therapies that will reduce the recurrence rate, and 2) the ability to target these therapies to the patients most likely to recur. In addition, women with metastatic disease require more effective systemic therapy.
The most common basis for determining risk of recurrent disease has been classification of endometrial cancers into two subtypes. Type I, associated with good prognosis, accounts for the majority of cases and is associated with low stage and grade and endometrioid histology. In contrast, type II, is characterized by high stage, high grade and non-endometrioid histology and poor prognosis. However, the prognostic value of this distinction is limited, as up to 20% of type I endometrial cancers recur, while half of type II cancers do not. It is a paradox that despite the fact that several clinically validated prognostic markers are available in endometrial cancer, they are not yet systematically applied for treatment stratification. Also, recent studies have identified new potential targets for novel therapeutics in endometrial carcinomas, such as FGFR2 mutations, mTOR-PTEN changes and alterations in the PI3Kinase- and MYC signalling pathways. The current literature on epidemiology, aetiology, pathology, molecular alterations, staging, treatment and prognostic factors in endometrial cancer will be reviewed. Novel molecular markers will be presented in relation to a clinical case to illustrate how personalized therapy may be implemented for this large patient group in the future.

Society Session (Sun, 25 Sep, 16:45−18:15)
European Society of Breast Cancer Specialists (EUSOMA) − Age and Breast Cancer

223 INVITED
The Impact of Age on Breast Cancer Survival

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An estimated 12.7 million new cancer cases and 7.6 million cancer deaths occur in 2008 across the world. Breast cancer is the second most common cancer overall (1.4 million cases, 10.9%) but ranks 5th as cause of death (458,000, 6.1%). [1] In most statistics the risk of breast occurrence shows a complex pattern by age: the risk increases from the young-ages, where breast cancer is a quite rare disease, up to mead-ages, then it remains constant for some postmenopausal years and finally it increases again over the advanced ages. Age may affect also survival but the real phenomenon is obscured by other important determinants for the last decades. According to recently published EUROCARE-4 figures, breast cancer survival was significantly heterogeneous across Europe: for cases diagnosed in 1997–1999, the age-adjusted 5-year survival ranged from 73% in Poland to 85% in Sweden. [2] The trend in breast cancer age-adjusted 5-year survival in five European regions showed that, in the contest of a general improvement, patients in Eastern Europe had the highest improvement during 1991–2002 − from 60% to 73.9% − although survival in Eastern Europe remained lower than in the other European areas [3]. Over time the influence of age in survival changed because improvement was more evident for mature than elderly women, with however some discrepancies across Europe. Some heterogeneity in survival in relation to age at diagnosis may actually exist, even if this is lower in comparison to that showed by other solid cancers. For cases diagnosed in 1997–1999 in Europe as whole, 5-year relative survival was 77.6% in elderly patients (70−84 yrs) and 85.7% in middle-aged patients (55−69 yrs) [4].

References

[1] Ferlay J., Shin H.R., Bray F., Forman D., Mathers C., Parkin D.M. Estimates of worldwide burden of cancer in 2008: GLOBOCAN 2008. IJC 2010
[2] Verdecchia A., Guzzinati S., Francisci S., De Angelisa R., Bray F., Allemani C., Tavilla A., Santaquilania M., Sant M., the EUROCARE Working Group. Survival trends in European cancer patients diagnosed from 1988 to 1999. EJC 2009
[3] Verdecchia A, Francisci S, Brenner H, et al. Recent cancer survival in Europe: a 2000−02 period analysis of EUROCARE-4 data. Lancet Oncol. 2007
[4] Quaglia A., Tavilla A., Shack L., Brenner H., Heijnen M.J., Allemani C., Colonna M., Grande E., Grosclaude P., Vercelli M.,the EUROCARE Working Group. The cancer survival gap between elderly and middle-aged patients in Europe in widening. EJC 2009

224 INVITED
Age, Screening and High Risk Groups Surveillance

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Breast cancer screening has been around now for more than 30 years and is available in most developed countries in various forms. Despite this wealth of experience there continues to be debate about who should be screened, what techniques are best and, indeed, whether screening is effective at all in reducing breast cancer mortality. There is also continuing debate about the side-effects of breast screening, including overdiagnosis, overtreatment, the anxiety caused by false positive results and the morbitity associated with needle and surgical biopsy for what proves to be benign disease.
There is consensus that breast screening does reduce breast cancer mortality, particularly when targeted at women age 50 to 70 years, but a wide range of opinion on overall benefit. In this age range there is reasonable consensus that for every eight women diagnosed with breast cancers through screening the outcome will not be affected in 6 (three would not have died of breast cancer anyway and three will die of breast cancer despite earlier diagnosis), one that would have died will not, and one represents overdiagnosis and overtreatment (the breast cancer would never have presented without screening). There is less evidence of mortality benefit in women over 70 but these data were from an era when life expectance was significantly less and there is emerging evidence that screening older women should be considered. Screening women younger that 50 does not reduce mortality to the same degree but there is evidence