

(95% CI 101–117) for the surgical group and 59 months (95% CI 45–72) for the non-surgical group ($P < 0.002$). In patients with locally advanced breast cancer, BCSS was 59 months in the surgery group (95% CI 48–70) and 51 months in the non-surgical group (95% CI 36–65) ($P < 0.180$).

Conclusions: Advanced age should not be considered a contraindication for surgery. This study shows that BCSS is significantly better in elderly patients with early breast cancer who undergo surgery.

53 **Medical Utilization and Cost of Elderly Breast Cancer Patients Under National Health Insurance in Taiwan: a Population-based Cross-sectional Study**

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Background: There is a trend of increasing elderly population worldwide. Few studies have examined the medical cost of elderly breast cancer patients. Taiwan implemented a comprehensive and universal National Health Insurance (NHI) program which covers over 99% inhabitants. This study aimed to assess the medical utilization and cost of elderly (≥ 70 years) breast cancer patients under NHI in Taiwan.

Materials and Methods: This retrospective cross-sectional study used a sampled NHI research database containing one million beneficiaries. A total of 3146 breast cancer patients who used medical services in 2009 were identified. Their claims in 2009 were obtained for analysis.

Results: There were 399 (12.7%) elderly breast cancer patients in this cohort. The medical cost of elderly breast cancer patients accounted for 13.0% of the total cost of all breast cancer patients. The elderly patients had a higher mean frequency of outpatient visits than non-elderly patients (42.8 vs. 31.9; $p < 0.0001$). There were no statistical significance between elderly and non-elderly patients in mean frequency of inpatient admission (1.0 vs. 0.9 time/year; $p = 0.2117$), mean annual outpatient cost (US\$2558.3 vs. US\$2485.5; $p = 0.7733$), mean annual inpatient cost (US\$1609.7 vs. US\$1388.2; $p = 0.2861$) and mean annual total cost (US\$4168.0 vs. US\$3873.7; $p = 0.4193$).

Conclusions: Elderly breast cancer patients visited outpatient services more frequently. There was no difference in the mean medical cost between elderly and non-elderly breast cancer patients.

Table 1. Medical utilization and cost of elderly and non-elderly breast cancer patients

Characteristics		Mean	Standard Deviation	95% Confidence Interval for Mean		P value*
				Lower Bound	Upper Bound	
Outpatient visit (time/year/patient)	Non-elderly	31.9	20.5	31.2	32.7	<0.001
	Elderly	42.8	24.5	40.4	45.2	
	Total	33.3	21.4	32.6	34.1	
Inpatient admission (time/year/patient)	Non-elderly	1.0	2.4	0.9	1.1	0.2117
	Elderly	0.9	1.7	0.7	1.0	
	Total	1.0	2.3	0.9	1.1	
Outpatient cost (US\$/year/patient)	Non-elderly	2485.5	4786.4	2306.4	2664.5	0.7733
	Elderly	2558.3	4230.6	2141.9	2974.7	
	Total	2494.7	4718.9	2329.7	2659.7	
Inpatient cost (US\$/year/patient)	Non-elderly	1388.2	3794.4	1246.2	1530.1	0.2861
	Elderly	1609.7	4396.1	1177.0	2042.4	
	Total	1416.3	3875.8	1280.8	1551.8	
Total cost (US\$/year/patient)	Non-elderly	3873.7	6861.3	3617.0	4130.3	0.4193
	Elderly	4168.0	6380.6	3540.0	4796.0	
	Total	3911.0	6802.0	3673.2	4148.8	

*By ANOVA.

54 **Breast Cancer in Young and Elderly Women. Experience in the Estereotaxic Clinic Center (CECLINES), Caracas-Venezuela**

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Background: More than 80% of breast cancer occurs in women older than 50yo and more than 35% will be in patients older than 70yo. In the other hand there are few cases of breast cancer in women less than 40yo even though there is a trend of increasing incidence in this group of women. There is evidence that breast cancer in younger and elderly patients behaves in a different way.

Methods: Retrospectively we study 926 patients in the data base of CECLINES from 1996–2010, in which we found that the younger group (YG, <40yo) represented 8% (68/926) and the elderly group (EG, ≥ 75 yo) was 6.37% (50/926). We studied variables such as: tumor size, histologic type (HT), stage (ST), immunohistochemistry (IHC), type of surgery, axillary status, adjuvant and neoadjuvant treatment, overall survival (OS) and

disease free survival (DFS). We excluded all patients with insufficient information or who were receiving neoadjuvant treatment by the time of the analysis.

Results: the median follow up was 33 months. The median age at presentation was 35.13yo (SD 3.5) for YG and 80.04yo (SD 3.8) for the EG. The most common HT for both the YG and EG was infiltrating ductal carcinoma with 66.2% and 56.0% ($p = 0.345$), respectively. Even though there was not statistical difference regarding the immunohistochemical staining the EG had a more favorable profile than the YG: ER+ 87% vs 70.7% ($p = 0.057$), PR+ 69.9% vs 70.2% ($p = 0.946$), C-erbB-2 3+ 32.6% vs 51.9% ($p = 0.053$), Ki67 high 26.5% vs 40.5% ($p = 0.374$), Triple Negative 2% vs 10.3% ($p = 0.077$). The median tumor size was for YG 30.6mm (SD 19.1) and for EG 23.9mm (SD 12.8) ($p = 0.032$). We performed breast conservative treatment in 44.1% of YG and 52.0% in EG ($p = 0.397$). The ST at presentation more common was for YG IIA 39.3% and for EG IA 51.1% ($p = 0.104$). As expected there are substantial differences between the administration of neoadjuvant chemotherapy with 44.1% for the YG and 0% for the EG ($p = 0.001$) and the neoadjuvant hormonotherapy with 18% for the EG and 0% for the YG ($p = 0.001$). The axilla was positive by sentinel lymph node in the YG in 39.4% and in the EG in 27.1% ($p = 0.171$). The overall recurrence for the YG was 20.6% and for the EG 12% ($p = 0.219$), being local recurrence for the YG 1.47% (1/68) and for the EG 4% (2/50), locoregional recurrence for the YG 1.47% (1/68) and for the EG 0% (0/50). The 5y DFS rate was for the YG 63.3% and for the EG 58.4% ($p = 0.009$). Of the EG 30% died from another cause. The 5y OS for YG was 73.0% and for EG 68.3% ($p = 0.001$).

Conclusions: The prognosis for the YG is better than the EG. An explanation for our results could be that because traditionally tumors of elderly patients behaves in a more indolent way, maybe we are 'under treating' some of this patients as well as treating more aggressively the young patients creating a shift in the outcome we are use to see in other publications. Nevertheless even though the immunohistochemistry reactions tends to show a more favorable profile for the EG than the YG, is important to outline that the outcome for these groups seems to be influenced more by the biology of the tumor, stage at presentation and its according treatment than by the age group itself.

55 **Clinicopathological Pattern and Mammaglobin Immunohistochemistry as a Prognostic Marker in Breast Carcinomas Presenting in Young Pakistani Women**

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Introduction: Breast cancer among young women is scarcely reported in the literature even when it has long been observed that these patients are more likely to suffer from recurrence and death after diagnosis. In most studies published so far within our country, this patients group is not being analyzed separately. Apart from the conventional markers, mammaglobin (MGB A) protein is coming out as a specific and important marker impacting the disease prognosis along the age of the patient.

Objectives: To compare the expression of prognostically meaningful immunohistochemical markers such as estrogen receptor (ER), progesterone receptor (PR), HER-2 and p53 in tumor cells of the female patients with breast cancer aged less than 36 years with or without the positive MGB A immunohistochemistry. Breast cancers expressing MGB A were also analyzed clinicopathologically to determine whether these cancers constitute a characteristic subset in young women.

Methods: About one hundred seventy-five patients (mean age: 25 ± 2) presenting with breast cancer during January 2006–2008 were assessed both clinically as well as expression of ER, PR, HER-2, p53 and MGB A was determined by indirect immunohistochemical method. The patients were followed up clinically from the hospital record for 3 years till January 2011.

Results: Positive immunostaining for MGB A was seen in 87.6% of breast carcinomas, 12.06% of cases with lymph node micro-metastases not diagnosed on conventional microscopy, 72.2% cases of premalignant, 78.6% of benign and 98.4% of normal breast tissues present adjacent to the tumour area. A significant correlation was found between the positive expression of MGB A in the malignant breast tissue and ER positivity but not with the histological and nuclear grades of the tumors, HER2 or p53 immunoreactivity. Yet it varied according to the histological type of the tumor with ductal carcinomas showing stronger and diffuse staining than other varieties. More aggressive clinical course of the disease with recurrence in 2% and advanced stage in 7.01% was seen in patients expressing weaker to none staining with MGB A as compared to those with a stronger and diffuse pattern of immunostaining. Kaplan–Meier analysis revealed prolonged disease-free survival in patients with MGBA-positive