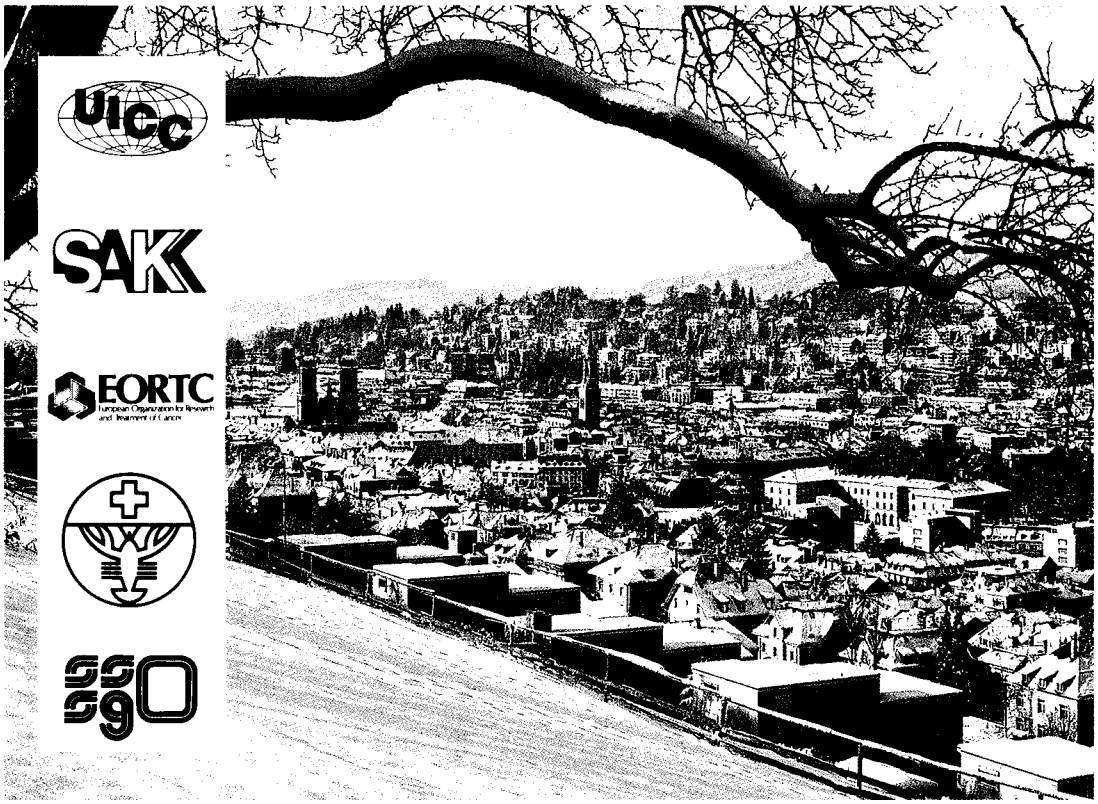
Volume 10
Supplement 1
February 2001
ISSN 0960-9776

THE
BREAST

Adjuvant Therapy of Primary Breast Cancer



7th International Conference
February 21-24, 2001
St. Gallen/ Switzerland

ABSTRACT BOOK

CHURCHILL LIVINGSTONE
A Harcourt Health Sciences Company

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ADJUVANT THERAPY OF PRIMARY BREAST CANCER

7th International Conference

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Institute. The case records of these patients were studied in detail with regard to the clinical presentation, treatment and follow-up data obtained. The median age at diagnosis was 56 years (range 33–74 yrs). The right breast was affected in 15 and the left in 21. The TNM status was T1 in 1, T2 in 15, T3 in 3 and T4 in 15, N1 in 18 and M1 in 3 patients. Thirty-four patients had infiltrating duct carcinoma, and 1 patient each had mucinous and medullary. Lymph node was positive pathologically in 15 cases. Thirty-five patients underwent surgery (simple mastectomy (SM): 7, SM+axillary clearance: 13, radical mastectomy: 12 and lumpectomy: 3). Postoperatively, 23 patients received radiotherapy, 4 chemotherapy and 18 received tamoxifen. Orchidectomy was done in 1 patient. Survival data was available in 29 patients only. The median survival of the series is 48 months. Ten patients survived more than 5 years.

P6 Breast cancer in men. A review of 79 patients who presented to the Transcarpathian Regional Oncological Clinical Dispensary during 53 years: 1946–1999

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Men's breast cancer is a relatively rare disease. It occurs 100 times less often than women's breast cancer. The scantiness of early stages symptoms, men's low level of awareness concerning breast cancer, and lack of oncological alertness among doctors in the general care network lead to this disease being neglected and define its urgentness.

In the report, cases of 79 male patients with breast cancer who were cured in the Transcarpathian Regional Oncological Clinical Dispensary from 1946 till 1999 are analysed. The patients' average age was 59.8 ± 7.9. Thirty-two patients (49.3%) were treated in stages I–II of the disease, 28 patients (35.4%) in stage III and 19 (15.3%) patients were treated in stage IV. The patients are also divided into groups according to the kind of treatment they underwent (only radiation therapy, only surgical, different kinds of combined and comprehensive treatment).

Five-year survival depending on disease stages, stages and kind of treatment, are presented. 42% of patients survived the 5-year boundary. Moreover this indicator fluctuates from 5.3% among patients in stage IV of the disease to 85.7% among patients in stage I.

Owing to timely diagnosis and adequate treatment of men's breast cancer we can gain high indicators of 5-year survival (86%). With increasing of the process stage this indicator decreases greatly to 5%. Thus, early disease detection and adequate comprehensive treatment are guarantees of successful treatment in men's breast cancer.

P7 Telephone call interventions can improve rescreen compliance in a regional mammography screening programme

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For mammography screening to be effective in reducing mortality from breast cancer, high compliance for continued rescreening at defined intervals is important. Hunter Breast Screen (BreastScreen NSW Hunter Region and Wyong Shire) (HBS), is a regional screening programme. HBS screens 40,000 women per year, and 100,000 women have had at least one screen since 1989. In Australia, all women ages 40 or over are eligible for free screening under the BreastScreen Australia guidelines, but only women ages 50–69 are actively recruited by an electoral roll based invitation. HBS serves a catchment area of 62,000 square kilometres, and has an eligible population of 142,988. In the target age group of 50–69 there are 67,509 women. Two mobile units provide screening services to rural women and to women who live on the outskirts of the urban areas. Screening is also offered at five fixed sites in the Newcastle area. The rescreen interval is 2 years, and all women are sent a reminder letter when their rescreen is due.

Poor compliance progressively reduces the number attending for screening at later rounds. For example, a constant rescreen rate of 80% for each subsequent screening round, would leave only 33% of the original prevalent screen population after five screening rounds, assuming there is little or no resumption of screening after the period of non-compliance. Hence, it is particularly important to achieve a high round two rescreen rate, as this sets an upper limit of compliance for subsequent screening. To increase rescreen compliance, the existing strategy of two rescreen reminder letters to women due for rescreen, was augmented by up to two attempted telephone contacts for women targeted for mobile unit sites. From January 1, 1997 to December 31, 1998, of 3,372 women due for rescreening who had not responded to the two reminder letters, telephone contact was made with 1,913 (56.7%) and of these women, 1,113 (58.2%) made an appointment at the time of the telephone call and kept that appointment. An additional 391 women who were successfully contacted by telephone but who did not make an immediate appointment at the time of the telephone call, subsequently did so. Hence, a total of 1,504 (78.6%) of women who were contacted by telephone attended for their rescreen. In contrast, of 1,459 women who we were not able to contact by telephone, only 595 (40.8%) eventually made a self-initiated appointment and attended for rescreen. Currently, the average rescreen compliance at HBS is 92.6% compared to 88% prior to the telephone contact strategy. The strategy was labour intensive but cost effective.

Conclusion: Rescreen reminder telephone calls as part of a sequence of prompts are an efficient strategy for increasing rescreen compliance in HBS.

P8 Reappraisal of St Gallen classification of node-negative breast cancer patients in Taiwan

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Goals: International consensus panel on the treatment of primary breast cancer held in St Gallen in 1998 classified node-negative breast cancer patients into low-, intermediate-, and high-risk groups. Accordingly, we have attempted to examine whether the prognosis of T1-2N0 breast cancer of Taiwan female population is consistent with this new classification.

Patients and Methods: Between 1990 and 1998, 758 patients underwent modified radical mastectomy or breast-conserving surgery in our institution. Three hundred and sixty-nine patients had T1-2N0 disease. Among these node-negative patients, 260 patients were in the high-risk group (having one of the factors: tumour size >2 cm, ER negative, nuclear grade 3, or age <35), 93 in the intermediate-risk group and 16 in the low-risk group (having all of the following factors: tumour size ≤ 1 cm, ER positive, nuclear grade 1, or age ≥ 35).

Results: The disease-free survival rates at 5 years for low-, intermediate- and high-risk patients were 100%, 93%, and 86% respectively. Among high-risk patients, age of onset of disease is the only prognostic factor. Using age as the factor for analysis, the disease-free survival rate at 5 years for patients under the age of 35 was 69%, over the age of 35 was 88% ($p = 0.01$). Disease-free survival rate at 5 years for patients with age <40 was 69%, and age >40 was 95% ($p = 0.0001$). Patients with age <40 received more adjuvant chemotherapy compared to patients with age >40 (69% versus 48%). Among intermediate-risk patients, all patients were 35 or older. Their disease-free survival rate at 5 years for patients with age 35–40 was 60%, and age >40 was 99% ($p = 0.0036$). Patients in the younger age group also had received more adjuvant chemotherapy compared to the older age group (61% versus 29%).

Conclusion: Our data demonstrated that patients who develop breast cancer at a young age are considered to be at high risk of relapse; the exact age cutoff for this increased risk appears to center around the age of 40 rather than 35 years old in Taiwanese women.

P9 Implementing guidelines into practice: strategy procedures and adherence

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Objectives: Improving health care quality requires the adoption of guidelines and recommendations into practice. Their availability does not automatically lead to their adoption. The aim of this study is to optimize regional quality of care by a multifaceted approach to implement current valid guidelines and recommendations for women with primary breast cancer.

Methods:

1. Small area analysis (Wennberg, N Engl J Med, 1986): population-based, prospective, longitudinal study in a defined rural area in the middle of Germany with 250,000 inhabitants. Patients with surgery for primary breast cancer recruited 04/01/1996–03/31/1998, follow-up 5 years.
2. Strategies of implementation: continuous quality management to empower patients, physicians and health care services.
3. Trialability: evaluating the adherence to the guidelines and recommendations of the 5th International Consensus Panel on treatment of primary breast cancer, St Gallen 1995, by selected quality indicators (first endpoint of efficacy).

Results: The incidence of breast cancer in the country studied is 107.9 (raw incidence). 367 invasive carcinomas were diagnosed out of 389 women with breast cancer. Quality of care indicators: a) axillary lymph node dissection with a least 10 nodes rated 87%; b) radiation after breast-conserving surgery