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SURVIVAL FOLLOWING LOCOREGIONAL RECURRENT BREAST CANCER - RESULTS FROM A PROSPECTIVE STUDY WITH MORE THAN 10 YEARS OF FOLLOW-UP.

C. Kamby, L. Sengeløv

Finsen Centre, Rigshospitalet and Department of Oncology
Copenhagen University Hospital in Herlev, Denmark.

We evaluated prognostic factors for survival after locoregional recurrence (SAR) in 140 patients (pts) with breast cancer. The patients were entered in a staging protocol for pts with first recurrence of breast cancer in the period 1983-85. If possible, the pts received local treatment (surgery or radiotherapy). The aim was to identify pts with long survival by relating the duration of SAR to therapeutic, demographic, biological and pathological variables. Local treatment was given to 99 pts. As of Feb. 1995, 78 pts had developed distant metastases and 93 pts had died. The median SAR was 67 months and 30% were alive after 10 years (38% for local and 18% for systemic therapy, $p=0.004$). Nine potential prognostic factors for SAR ($p<0.25$) were included in Cox analyses. S-lactate dehydrogenase (LDH) and the number of positive regional nodes (Npos) were significant independent prognostic factors. A prognostic index with 3 groups showed the following survival rates at 10 years: 49% (normal LDH and Npos=0); 29% (normal LDH and Npos>0 or elevated LDH and Npos=0); 12% (elevated LDH and Npos>0). The study showed that one third of the pts was alive and without distant metastases ten years after locoregional recurrence. SAR can be estimated by level of LDH and regional node status. These variables may be used to stratify pts in future studies evaluating locoregional treatments.

RADIOTHERAPY AFTER OPERATION OF BREAST CANCER : THE QUESTION OF "SAFE OMISSION"

J. Fodor, M. Pálfi

National Institute of Oncology Dept. of Radiotherapy, Budapest, Hungary

Background: Till now there has been no consensus on the use of post-mastectomy adjuvant irradiation. Even the usefulness of radiotherapy (RT) after breast conserving surgery has been discussed recently, and omission is suggested in early cases. **Purpose:** The aim of this study is to define which patients need or do not need adjuvant RT. **Patients and Methods:** In this study between 1983 and 1988, 1040 women were surgically treated by mastectomy (826) or by sector resection (214) and in both of these cases axillary dissection was performed. For statistical analysis, patients with the same pTpN status were assigned to subgroups according to whether they received adjuvant RT or didn't. The impact of intraductal components on the local relapses was also analysed. **Results:** 1./ Mastectomy group: Patients with pT1pN0 status after RT had 2% chest wall-scar relapses and the rate of recurrence was 5% in the untreated cases. Irradiated women with pT2pN0 status had significantly better results than unirradiated ones. The relapse rate was 5% and 10% respectively. 2./ Breast conserving group: with pT1-2N0 status the percentage of tumor-bed relapse was 10% in the irradiated and 31% in the untreated group. However the rate of relapse was the highest with pT1/b status in both groups, 13% and 46% respectively. One possible explanation for this is that the extended intraductal component was most frequently found in this status and therefore had an impact on tumor-bed relapses. The recurrence rate was 43% with extensive intraductal component and 7% without. **Conclusion:** After mastectomy the cut off tumor diameter of local relapses was > 2 cm. Under this tumor size the recurrence rate was ≤ 5% in both groups. After breast conserving surgery there is not a cut off tumor diameter in the invasive breast cancer. Irradiation can not be safely omitted even with minimal ≤ 1 cm. breast cancer.

Prophylactic mastectomy is not a self-evident choice for women carrying a germ line BRCA1 or BRCA2 mutation: description and first results of a decision support procedure.

Lia C.G. Verhoef*, Ivana J. Unic*, Peep F.M. Stalmeier**, Willem A.J. van Daal* and the Nijmegen Breast Cancer Working Party.

*Institute of Radiotherapy and the **Nijmegen Institute for Cognition and Information, University of Nijmegen, The Netherlands.

Background. The cloning of the breast/ovarian cancer susceptibility genes BRCA1 and BRCA2 has led to the identification of a group of healthy women carrying an extremely high breast cancer risk (85%). Bilateral prophylactic mastectomy (PM) is often suggested as a preventive measure in these women.

Purpose. To develop and evaluate a decision support procedure to assist women in the choice between PM and screening.

Methods. With a decision model, using Markov processes of medical prognosis, PM and screening are compared with respect to their effect on life-expectancy (LE) and quality-adjusted life-expectancy (QALE). The risks to develop breast cancer and to die from it after both options are modeled. The gene carriers were provided with extensive oral, written and audiovisual information. Each individual woman's subjective valuations of life after PM and with screening (utilities) are assessed at at least two occasions by means of the time tradeoff test and the certainty equivalent method. The resulting utilities are implemented into the model, so that for each individual woman the effect of both choices on (quality-adjusted) LE can be estimated. The option with the highest QALE is the best choice.

Results. Seven women with a proven BRCA1 or BRCA2 mutation completed the decision support procedure. For all women, the estimated LE was higher after PM than with screening (median gain 9.7 yrs, range 3.4-11.4 yrs.). However, in only 4 women the estimated QALE was better after PM (median gain 2.1 QALY'S, range -8.2 - +13 QALY's). Therefore, the best choice according to the decision support procedure was screening in 3 cases and PM in 4 cases. Five women made a final choice: 3 times screening, 2 times PM. All were conform the decision analytic advice, even though the advice of the Breast Cancer Working Party is PM in all gene carriers. All 5 felt supported in their decision by the decision support procedure. The 2 remaining women have not yet decided.

Conclusions. Our preliminary results indicate, that it is far from obvious that PM is the best choice for these women if quality of life is taken into account. Formal decision analytic support may help to ascertain that the patients' own values play an appropriate role in the final decision.

CONSERVATIVE TREATMENT OF BREAST CANCER: MORBIDITY OF RADIOTHERAPY

MORENO E, MARTINEZ A, RODRIGUEZ D, GOMEZ J, POLO A, RUBIO E, VILLA S, GUTIERREZ C, PETRIZ L, PERA J.
Radiation Oncology. Institut Català D'Oncologia. C.S.U. de Bellvitge. L'Hospitalet de LL. (Barcelona). Spain

Purpose: To assess the morbidity of radiotherapy in women with breast conservative treatment.

Methods and Materials: Medical records of 1007 women with stage I and II breast cancer who were treated in our Institution from 11/1982 to 12/1995 have been analyzed. All women received limited breast surgery (LS), axillary dissection and radiation therapy (RT). The mean age was 52 years (r23-86). Ductal infiltrant carcinoma was present in 94% of the patients; other types were found in 6%. After LS, the mean doses received were 50Gy in the whole breast and 18Gy in the tumoral bed as a boost irradiation. Adjuvant chemo-hormonotherapy was administered to 47% of the patients.

Results: arm edema was present in 5.6% of the cases, brachial plexopathy in 1%, pneumonitis in 0.9% and unresolved skin changes in 25%; infectious mastitis was observed in 1.8% of the patients who received brachithrapy.

Conclusions: our incidence of pneumonitis was low; arm edema and brachial plexopathy were independent of axillary and supraclavicular irradiation; interstitial boost increases cutaneous pigmentation and, perhaps it has a role in infectious mastitis.