ifen resistant cells after zinc treatment. These results suggest a mechanism whereby cells can continue to grow in the presence of tamoxifen and may provide a useful new therapeutic target for anti-hormone resistant breast cancer.

O-80. The introduction of better therapies lengthened survival in advanced breast cancer

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Over the last 20 years new endocrine, cytotoxic and biologically targeted agents have been introduced into breast cancer therapy, Claims for their greater efficacy over the agents used in the 1980's have been based on the result of clinical trials in the adjuvant setting and in advanced disease.

Comparison is made between the time from implementation of therapy to death, for symptomatic distant metastases, in breast cancer diagnosed in 1980-86 ($n = 428$) and in those diagnosed as previous in 1990-99 ($n = 280$),

Although the assumptions here are made that the secondary therapy will have been applied earlier in the 80-86 dataset, this is open to bias.

Therefore another analysis has to be carried out of only those women in these datasets who had distant metastases diagnosed within 5 years of the primary tumour.

Table 1. All Distant Recurrence

Dataset	Median time from DR to death
1980-86	12
1990-96	12

Table 2. Distant recurrences

Dataset	Median time from DR to death
1980-86	10
1990-96	11

Although more systemic therapies appear advantageous in the adjuvant setting there is little evidence of this greater efficacy in the treatment of distant metastases.

O-81. Fulvestrant in pretreated patients with advanced breast cancer: experience from the Institut Bergoni

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Background: Fulvestrant ('Faslodex') is a new oestrogen receptor antagonist with no agonist effects that is licensed for use in patients with advanced breast cancer (ABC) following progression on an antioestrogen.

Methods: The fulvestrant Compassionate Use Programme (CUP) permits use of the drug in patients who have progressed on prior endocrine and chemotherapies for ABC. As part of the CUP, 41 women and one man were treated with fulvestrant between August 2001 and September 2004 according to the guidelines of the French Drug Agency (AFSSAPS).

Results: Patients had a median age of 65 years (range 41–86 years) and all had ABC, including 19 patients with visceral metastases (liver and lung) and 25 patients with bone metastases. Sixteen patients received adjuvant endocrine treatment (tamoxifen) and three patients received adjuvant chemotherapy. Fulvestrant was given after a median of 3 (range: 1–5) prior endocrine treatments and a median of 1 prior (range: 0–5) chemotherapy for ABC. Twelve patients had a partial response (PR) with fulvestrant and 10 had stable disease $\geq$6 months (SD), giving an overall clinical benefit (CB) rate of 52%. Five of the six (83%) patients who received fulvestrant as 2nd-line endocrine therapy for ABC gained CB (2 PR, 3 SD). The remaining 36 patients received fulvestrant as 3rd to 9th-line endocrine ABC treatment (CB rate: 47%; 10 PR, 7 SD). In patients with visceral metastases the CB rate was 58% (6 PR, 5 SD). All patients have now ceased fulvestrant treatment; the median duration of treatment was 5 months (range: 1–38 months). Following fulvestrant, two patients received further endocrine therapy (progestins) and 21 received palliative chemotherapy. Fulvestrant was well tolerated; six patients (14%) experienced adverse events during treatment.

Conclusions: In our experience, fulvestrant is effective and well tolerated in the treatment of patients with ABC following progression on prior therapies. The CB rate appeared highest when fulvestrant was given early in the therapy sequence; however, efficacy was also retained in more heavily pre-treated patients.

O-82. Goserelin plus Anastrozole as first-line endocrine therapy for premenopausal oestrogen receptor positive (ER+) advanced breast cancer (ABC)

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We have previously reported the use of goserelin plus anastrozole as second-line endocrine therapy for premenopausal ER+ ABC. With randomised data showing superiority of third-generation aromatase inhibitors over tamoxifen as first-line therapy, we now report our clinical experience of using anastrozole alongside ovarian suppression (with goserelin) in the same setting in premenopausal women.

Twenty premenopausal patients (mean age = 42 (30–57) years) (advanced primary = 3, soft tissue = 2, bone = 8, pleura/lung = 3, stomach = 1, liver = 2, bone + liver = 1) with ER+ ABC seen over a 3-year period were treated with goserelin 3.6 mg 4-weekly plus anastrozole 1 mg daily as first-line therapy. Endocrine therapy was considered therapy of choice except in two patients with liver metastases who did not have chemotherapy due to pulmonary embolism or patient choice. All had disease assessable by UICC criteria and received therapy for $\geq$6 months (except for those who progressed prior).

Twelve patients (60%) derived clinical benefit (CB) (complete ($N = 1$) or partial ($N = 5$) response, or stable disease ($N = 6$) for $\geq$6 months) while eight progressed before 6 months. For the 12 CBs, the median duration of response is 20+ months (6–36 months). At the time of analysis, therapy is continuing in nine patients. When the two patients with liver metastases for whom chemotherapy was therapy of choice were excluded, the CB rate rose to 66%. Therapy has been well tolerated and no patients came off it because of side effects.