213 Invited

Facts and hopes for improvement in elderly breast cancer patient care

M. Aapro. *Imo – Clinique de Genolier, and EORTC Task Force Elderly, Genolier, Switzerland*

As age advances, comorbidities and the aging process decrease the body's reserves. Thus cancer treatment could become an issue for some elderly patients. Progress in anesthesia and surgical assessment allow for safe surgery, and patients requiring special care can be identified prospectively. Surgery remains a key factor for therapeutic success even in the elderly, as studies have shown increased mortality if only a hormonal treatment is used. Radiation therapy might play a more limited role in selected cases, as suggested by studies in patients with small endocrine-responsive tumours. Adjuvant therapy needs to be defined and ongoing studies in USA, France, Germany, UK, and within IBCSG will be described. Drug usage guidelines from SIOG will be presented.

214 Proffered Paper Oral

Breast conserving therapy (BCT) for stage I-II breast cancer in elderly. Analysis of 927 cases

B. Cutuli[1], B. De Lafontan[2], C. Aristei[3], E. Vitali[4], C. Marchal[5], P. Quetin[6], R. Fay[7]. [1]*Polyclinique de Courlancy, Radiation Oncology, Reims, France;* [2]*Institut Regaud, Toulouse, France;* [3]*Policlinico Monteluce, Perugia, Italie;* [4]*Istituto Del Radio, Brescia, Italie;* [5]*Cav, Nancy, France;* [6]*Cps, Strasbourg, France;* [7]*Cic, Toul, France*

Introduction: Approximately 25% of all breast cancers (BC) occur in women older than 70 years. However, data on BCT use are very limited in this population. Our study assesses in details the results of a large cooperative Franco-Italian population.

Material: From 1983 to 2000, 910 women (927 treated breasts) older than 70 years were treated in five centres by BCT (+/− adjuvant therapy) for stage I-II BC. 637 women were 70–75 years old, 212 were 76–80 and 61 were older than 80. We accounted for 670 pT1 (72.3%), 245 pT2 (26.4%) and 12 pTx (1.3%). 763 tumors (82.3%) were ductal carcinomas, 92 (9.9%) lobular and 72 (7.8%) others. All women underwent breast conserving surgery, with axillary dissection in 869 cases (93.7%). Axillary nodal involvement was found in 30.7% of the cases (with 22.3% pN1–3 and 8.4% pN>3). ER and PgR were positive in 85% and 71% of the cases. All patients underwent whole breast irradiation. 777 received classical irradiation and 133 frailer patients received a once-a-week (6.5 Gy) hypofractionated RT (total dose: 32.5 Gy). 508 (55.8%) patients received Tamoxifen and 44 (4.8%) chemotherapy.

Results: with a 65-month median follow-up, 28 (3%) local recurrences (LR) occurred. LR rates were similar in women treated by classical or hypofractionated RT (2.7% vs 3.7%). No clinical (age) or histopathological (pT, pN, HR, subtype) LR risk factor was found. 83 (9.1%) women developed metastasis. Three significant factors of metastatic risk were found: pT2 vs pT1 (13.6% vs 7.2%, $p = 0.002$), HR- vs HR+ (15.5% vs 8.2%, $p = 0.01$) and pN+ vs pN- (16.4% vs 6%, $p < 0.0001$). A contralateral BC and second cancer occurred in 26 (2.9%) and 51 (5.6%) women. The 5 and 8-year overall survival (OS) rates were 86% and 74%. The 5 and 8-year specific survival (SS) rates were 94% and 90%. The 8-year OS and SS are similar according to irradiation modalities. 8-year OS and SS rates were 79% and 91% vs 60% and 86% among patients of 70–75 years and older (NS). The 8-year OS and SS rates were 75% and 91% vs 65% and 81% in patients with HR+ and HR− ($p < 0.0001$).

The 8-year OS and SS rates were 77% and 92% vs 65% and 84% in pT1 vs pT2 patients ($p = 0.01$). With the same FU OS and SS rates were 77%, 70% and 63% vs 92%, 91% and 72% in pN0, pN1–3 and pN>3 groups respectively ($p < 0.001$).

Finally, 676 patients were in complete remission (74.3%); 22 were evolutive (2.4%). 206 patients died (22.6%): 67 of BC (7.4%), 107 of intercurrent disease (11.8%) and 32 of unknown cause (3.5%).

Conclusion: our study shows the excellent local control in elderly patients treated by BCT with classical or hypofractionated RT. Furthermore, our data identify some subgroups at high risk of distant relapse requiring more aggressive treatment and suggest some adaptations in elderly women follow-up.

Thursday, 23 March 2006 13:00–14:00

SPECIAL SESSION

Barriers to effective tissue banking in Europe

215 Invited

Barriers to effective tissue banking in Europe

E. Jaffe[1], R. Carpenter[2], C. Ratcliffe[3], B. Clark[4], S. Harrison[5]. [1]*Europa Donna UK Forum, London, United Kingdom;* [2]*St Bartholomew's Hospital, London, United Kingdom;* [3]*National Translational Cancer Research Network, Oxford, United Kingdom;* [4]*onCore UK, London, United Kingdom;* [5]*Human Tissue Authority, London, United Kingdom*

A public awareness campaign on tissue banking for research is an initiative of the EUROPA DONNA UK Forum to address patient concerns and the effect of new legislation, through information and education. This campaign aims to raise understanding of the necessity for the involvement of breast cancer patients as donors and advocates. Launch is planned for 2006.

The effect on tissue storage of new UK legislation: the Human Tissue Act 2004 regulates the removal, storage and use of human tissue. The Act establishes a Human Tissue Authority (HTA) that is currently developing good practice guidance and establishing licensing and inspection procedures. Consent is a fundamental principle of the Act. However, further consent is not needed for the use of 'residual' tissue in research provided the research project has ethical approval, and the researcher cannot identify the tissue donor. This allows for linking with medical records, but patient-identifying information cannot be accessed. The new legislation will impact on the collection, storage and use of human tissue for cancer research – onCore UK is currently being established as a national cancer tissue resource that will meet the requirements of the new legislation.

Educating the public on the need for tissue storage is fundamental if patients and the public are to become active partners in tissue banking for research. Patient and public involvement helps ensure openness and transparency of operation, high ethical standards and can help increase public awareness and confidence.

Tissue banks for breast cancer research – the patients' perspective: encompasses personal experience including a current role as a member of the Human Tissue Authority, implications for future diagnosis and treatment: anonymisation and confidentiality versus possible benefits of tissue matching, genetic testing and implications for families.

Thursday, 23 March 2006 14:15–16:00

SCIENTIFIC SESSION

What is new in predictive factors

216 Invited

What is new in predictive factors?

J. Bergh. *Karolinska University Hospital Solna, Department of Oncology, Stockholm, Sweden*

Breast cancer is a wide spectrum of diseases ideally requiring a tailored management based on relapse risk and benefit/risk calculations for available therapies with partly different aims in the adjuvant- and metastatic setting. In the adjuvant setting we have focused on risk level identification using histopathological grading, stage and receptor status aiming at separating patients who have presumed endocrine responsive- and endocrine unresponsive cancers, respectively. Prognostication and therapy prediction are today based on group statistical analyses giving the likelihood for breast cancer recurrence and death and the statistical likelihood that a selected therapy or combination of therapies will work, although so far with major shortcomings regarding prognostication and therapy prediction for individual patients.

Receptor status for endocrine therapies and amplification of the HER-2/neu oncogene/verified HER2/neu protein overexpression for trastuzumab therapy are the only globally accepted therapy predictive factors. Recent data reveal discordance in the expression of receptors in the primary tumours compared with the corresponding metastatic lesions, the same findings seem also to be present for HER-2/neu, but the data