partial response > 50%). Pathological complete response was obtained in 3 patients (4%). Postoperative complications occurred in 19 patients (24%). These complications included 7 infections with delayed wound healing, and 9 persistent lymphorrea. None required a second surgery.

Local relapses after breast conserving surgery and mastectomy were 4 and 4, respectively. Nine-year local and metastatic disease-free survival rates were 87% (95%CI [74–94]) and 60% (95%CI [46–73]), respectively.

Cosmetic results were satisfactory in 80% of patients after conservative surgery.

Conclusion: For many years, preoperative hormonal therapy is an interesting alternative to neoadjuvant chemotherapy for RE/RP positive tumors. In our experience, combined pre-operative hormone-radiotherapy is well tolerated with very few postoperative complications and may render more locally advanced tumors to conserving surgery. In this setting, we are conducting a pilot study with concurrent radiotherapy and a non-steroidal aromatase inhibitor, letrozole.

360 Poster

A computer programme to calculate for the individual the expected improvement in survival chance from adjuvant therapies

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The EBCTCG overviews of adjuvant therapies provide figures of relative risk reduction (RRR). Applied to the survival chance of the individual, shown by the Nottingham Prognostic Index (NPI) the absolute improvement expected from therapies for that individual, may be calculated.

The baseline figure ('observed 1980–86') is the survival in NPI groups in patients treated without any adjuvant systemic nor local (RT) therapies. (1) The 'Expected' figures are the effects on these from the relative risk reductions (RRR) demonstrated in the EBCTCG overviews for each therapy.

Example: Women 50+, % 10 year survival

NPI group	Observed 1980–6 (No Adj: local/systemic)	Tam 5 Yr (ER+) RRR 27%	CMF RRR 11%
EPG	88	91	89
GPG	72	80	75
MPGI	61	72	65
MPGII	42	58	48
PPG	14	37	23

Patient age and pathological tumour characteristic (grade, LN stage, size, ER, VLI) must be entered. The expected improvements will be given for individual NPI values rather than for groups (Blamey, 2005).

Survivals have improved in the 1990's in all prognostic groups to a greater degree than predicted by the EBCTCG estimate of risk reduction for adjuvant systemic therapies.

A further calculation is given for the gain in survival expected from the selected systemic therapy plus the survival gain from a recommended programme of local and regional management (based on free margins, case selection for breast conservation, selective local and regional RT or clearance).

The combined figure gives the present day expected Breast Cancer Specific (BCS) survival from modern therapeutic management, which is specified for each case.

Example: Age 60 years. Inv. Ca, 2 cm, LN +ve (1/4), Grade II → NPI 4.4. ER +ve
Expected 10 yr BCS survival without adjuvant treatments = 61%
with 5 years Tam = 72%
with clear margins and intact breast RT
with Ax clearance or RT
Expected 10 yr BCS survival with above therapeutic program = 81%
Expected 10 yr BCS survival after age correction = 73%

The programme will be accessible at http://www.absolutegain.com

361 Poster

Dose intensity and outcomes of epirubicin-based adjuvant breast cancer therapy: FEC100 vs CEF/PO

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Adjuvant therapy with Epirubicin-based chemotherapy is standard in many jurisdictions. While there has been no direct, head-to-head comparisons made of CEF/PO and FEC100, the two regimens have been assumed to be equivalent. FEC100 has been shown to be easier to deliver and better tolerated than CEF. We have undertaken a retrospective analysis indirectly comparing CEF and FEC100.

In this analysis, 391 pts were prescribed FEC100 or CEF and received a full 6 cycles of adjuvant therapy. 220 pts were treated with FEC100, and 171 pts were treated with CEF. Patients treated with CEF had a longer median follow-up (50.6 months) than FEC100 (34 months) due to an earlier adoption of CEF. More pts that received CEF developed recurrences (46/171, 26.9%) compared to FEC100 (31/220, 14.1%). Kaplan-Meier analysis did not demonstrate statistical superiority (Log Rank p = 0.2436) but differences in length of followup may account for this.

Patients were balanced for nodal status, hormone receptor status as well as disease stage in this analysis. Patients that received a high relative dose intensity (RDI) of FEC100 (>95%) demonstrated a trend towards superiority in recurrence free survival (p = 0.07371, see Figure 1).

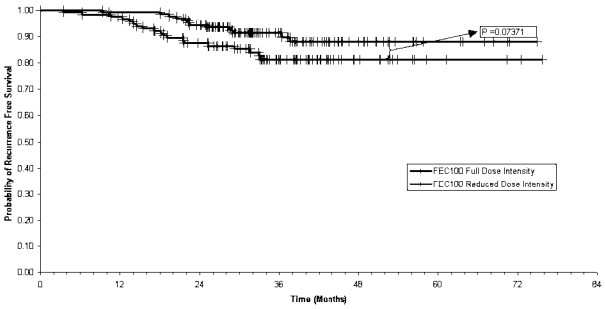

Figure 1. FEC100 adjuvant therapy – dose intensity.

Patients treated with CEF that received a high RDI (>85%) did not show a statistical recurrence free survival advantage (p = 0.7548) despite a higher proportion of patients that developed a recurrence in the low dose intensity group (34/107 vs 12/64, p = 0.01746). Overall, all patients with a high RDI of therapy with either FEC or CEF demonstrated a trend towards superiority in recurrence free survival when compared to a lower RDI (p = 0.1708). However, when patients that had a high RDI delivered for FEC100 were compared to patients that received a low RDI for FEC and any dose intensity of CEF, they demonstrated a statistically significant improvement in recurrence free survival (p = 0.04359, see Figure 2).

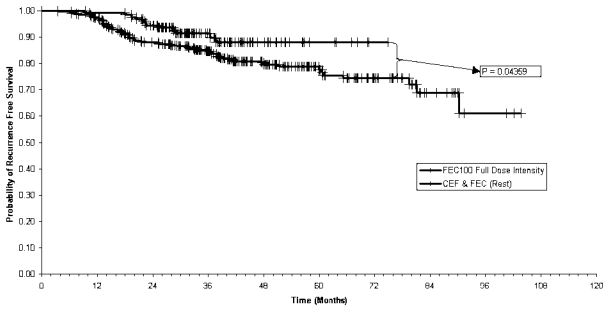

Figure 2. Epirubicin adjuvant therapy – dose intensity.

In conclusion, Epirubicin-based adjuvant therapy is an effective chemotherapy treatment. In this retrospective study, a higher RDI appears to improve recurrence-free survival. As well, CEF does not appear to be any more effective than FEC100. In the absence of prospective trials comparing the two regimens, a meta-analysis of Epirubicin-based therapies may potentially confirm or corroborate these observations