and HER-2/neu status, duration of disease-free interval, location of metastases and previous therapy.

The CECOG expert panel included specialists in clinical oncology and translational research from Europe, USA and Australia. Systematic review of the literature on management of MBC was performed and articles or conference abstracts reporting randomized controlled trials with appropriate control groups or meta-analyses were selected for inclusion. Data from phase II clinical trials or retrospective analyses were considered only if there was no evidence from phase III trials. Overall survival was the primary endpoint of interest. Disease-free survival, response rate and treatment toxicity were also considered as secondary outcomes. Evidence-based recommendations for state-of-the-art treatment of MBC were defined depending on clinical and biologic variables. The first consensus on medical treatment of MBC was reached and published in 2003. An updated version of this document, developed in 2005, will be presented at the conference.

References

[1] Beslija S, et al: Consensus on medical treatment of metastatic breast cancer (statement for Central European Cooperative Oncology Group). Breast Cancer Res Treat 2003, 81(Suppl. 1), S1-S7.

439   Invited
Therapeutic management of metastatic breast cancer. Are guidelines (GL) possible?: the French approach

M. Namer. Nice-Mougins, France

Metastatic breast cancer management is a difficult and a complex task.
Oncologists have to take the following things into account:
- The component of the adjuvant treatment received and the Disease Free Interval.
- The biological profile of the tumor,
- The location and the number of the metastases
- Symptoms and the threaten on life due to the disease
- The age and the co morbidity of the patients
- The knowledge that these treatments are palliative and not curative.
Some points are known:
- The review done by the Cochrane group has shown that polychemotherapy (PCT) is more efficient than monochemotherapy (MCT) in terms of objective remissions, time to progression and overall survival. These results have been found in both situations: drug A versus the same drug plus others and drug A versus a chemotherapy combination excluding the drug A.
- For PCT regimens, concomitant addition of the drugs is not more efficient than the same combination in a sequential way
However, there are several points which have not been tackled:
- *The influence of the proliferation rate on the therapeutic choice.* It is widely accepted that a high proliferation rate is associated with a good chemosensitivity of the tumor. We would have liked the Cochrane meta analysis comparison in high and slow proliferative tumor separately. We are tempted to think that for high proliferative tumors concomitant PCT could be more efficient than either MCT or PCT sequentially prescribed.
- *The definition of the chemoresistance.* It is obvious that a recurrence occurring early after the adjuvant chemotherapy could be resistant for the products used during this treatment. However, there are still questions:
- What is the time interval linked with this resistance: 6, 12 or 24 months?
- Does the resistance vary according to the anthracyclin used?
- Does the resistance vary according to the number of cycles done before:
Are guidelines possible in this setting? There are two ways of setting up a GL:
- The dogmatic one: several meetings of an expert group has been done last year, ending, with the help of medical literature, to an "evidence based medicine" report. Unfortunately several problems have not been solved yet. Furthermore, there are several parameters, like the patient's preference which are difficult to analyze objectively.
- The pragmatic one: we performed this form of guideline. After designing an algorithm, we have highlighted 8 different situations according to disease free interval, hormone receptor setting and HER2 expression. We have gathered 25 experts and we have set up a vote in order to know their decision for each situation
Conclusion: the management of metastatic breast cancer patients is difficult. There are many parameters to consider: some of them are known and others not; some of them are objective and others are subjective. New targeted treatments and new predictive parameters could soon modify our old principles.
We hope that GLs will help us in a near future.

440   Invited
Should there be guidelines for the treatment of metastatic breast cancer: the U.S. perspective

E.P. Winer. Dana-Farber Cancer Institute and Harvard Medical School, Boston, Massachusetts, USA

Metastatic breast cancer is a highly heterogeneous clinical entity. A variety of pathologic and clinical factors can explain the variability in patient outcomes. Some of the most important factors include ER, PgR, and HER2 status, disease free interval, site(s) of disease, response to prior therapy, performance status, and presence of co-morbidity. The median overall survival of patients with metastatic breast cancer is in the range of 2–3 years, but it is highly variable and ranges from a matter of weeks to 10 or more years.

As a consequence of the variability in presentation and natural history, it is impossible to identify a single preferred treatment program for all patients with metastatic disease. For that matter, it would be difficult even if one were to consider separately the three major subtypes of breast cancer (HER2 positive, triple negative, and hormone receptor positive). Many treatment decisions for women with metastatic disease will depend on the specific site of disease, the prior treatment and response to prior treatment, and the tempo of the disease.

In general, guidelines for patients with metastatic breast cancer should be based on general principles. For example, guidelines should strongly encourage the use of endocrine therapy in patients with hormone receptor positive disease and the use of trastuzmab in those with HER2 positive disease. Furthermore, guidelines can encourage biopsies to confirm the receptor status of the metastases and suggest imaging studies to evaluate the outcome of treatment. An effective guideline generally should not prescribe specific treatment regimens, since individualization is often necessary both for medical reasons and to optimize quality of life. As the number of biologic therapies increase and the cost of these therapies place a growing strain on the health care system, guidelines surrounding the use of specific agents, such as bevacizumab, may be extremely helpful.

Friday, 24 March 2006   9:00–10:30

EUROPA DONNA WORKSHOP

Should advocates be involved in the design of clinical trials?

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441   Proffered Paper Oral
A breast cancer terminology for lay people

R. Messai[1], M. Simonet[1], M. Mousseau[2]. [1]Albert Bonniot. University of Joseph Fourier, TIMC – IMAG laboratory. Faculty of Medicine, La Tronche, France; [2]Faculty of medicine, CHU of Grenoble, Oncology service, La tronche, France

Many studies show that patients want to get more information about their illness, and to participate in the decision relative to their treatment. Some studies indicate that from 79% to 96% cancer patients prefer to know as much as possible about their illness. Another study showed that only 19% of 232 patients were satisfied with the information they received from their physicians.

The Internet is becoming an important resource for patients seeking health information. Despite the increasing availability of medical information, lay people often encounter barriers in health information seeking. Studies have identified some of these obstacles. The main obstacle being the differences in language use between patients and health professionals.

In order to improve information retrieval for breast cancer patients the TIMC laboratory and CHU of Grenoble collaborated with the French League against Cancer to build a patient oriented terminology. The latter relates every day expressions about breast cancer to technical terms or jargon used by health professionals. It will be used like an interpretative layer to help lay people understand the information retrieved and write accurate queries with the proper concepts and terms.

We used a corpus of texts to extract terms and expressions used by lay people to speak about breast cancer. This corpus was collected from online health information web sites targeted to patients and web-based discussion forums on breast cancer. N-Grams have then been automatically extracted from the corpus (a n-gram is a sequence of n consecutive words). We then analyzed the terms extracted to decide which should be kept in the terminology. Since the terminological properties of patient discourse on medical topics are not well characterized, this work

has been done manually using a concordancer. A concordancer is a tool which makes it possible to view the occurrences of the terms in the texts and therefore specify their meanings. Expressions having the same meaning were grouped into one concept, and concepts were structured using different relationships.

We identified over 1300 concepts expressed by over 3000 terms. Patients use a language different from the one used by health professionals. Building such terminologies will help to bridge the gap between the two languages.

Friday, 24 March 2006   13:00–14:00

SPECIAL SESSION

Breast cancer and its management in the emerging world

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442   Invited
Overview of breast cancer in Latin America

Abstract not received.

443   Invited
Overview of breast cancer in India

I. Mittra. *Bhopal Memorial Hospital and Research Centre, Bhopal, India*

India is vast country with a female population of approximately 500 million. 82,951 women develop breast cancer and 44,795 women die of the disease in the country every year. Breast cancer incidence in India is low as compared with the west with an age adjusted incidence of 19.1 per 100,000 women and a crude incidence of 16.5 per 100,000 women. These are average figures obtained from the several cancer registries located in the major cities and large towns; however, in metro cities like Mumbai and Delhi the figure is nearer 30 per 100,000. The only population based rural registry at Barshi in the State of Maharashtra has recorded a lower age adjusted rate of 8.1 per 100,000 women. This is presumably related to earlier age at first child birth, larger number of children delivered, longer duration of lactation and possibly a protective diet that are prevalent in rural India. There are no organized screening programmes in the country but some opportunistic screening with mammography is practiced in major cities. Similarly, mammography machines are largely aggregated around the metros, but no accreditation programmes are in place and there are few radiologists who are specifically trained in mammography. As a country as a whole, 60% women present with locally advanced (LABC) or metastasis (MBC) breast cancer. At Tata Memorial Hospital (TMH) in Mumbai, the premium Cancer Centre in the country, 30% patients present with LABC and 14% with MBC (most having had prior primary surgery elsewhere). Modified radical mastectomy is the standard treatment of operable causes, although at TMH 50–60% of patients undergo breast conserving treatment (BCT) and 30% of LABCs undergo BCT after anterior chemotherapy. Hormone receptor assays are available in many major cities and towns or are outsourced to commercial concerns in metro cities. There are 203 radiotherapy centers with 259 ^{60}Co teletherapy units, 68 linear accelerators and 135 brachytherapy facilities. Most hormonal and chemotherapy drugs are commercially available but Tamoxifen and CAF/CMF are the most commonly used systemic agents. Several national and international collaborative trials are being conducted in the country, while the Indian Breast Group is the only national collaborative research organization.

444   Invited
Overview of breast cancer in the Arabic world

N.S. El Saghir. *American University of Beirut Medical Center, Department of Medicine/Hematology-Oncology, Beirut, Lebanon*

Breast Cancer represents 22% of all female cancer cases worldwide. Data on breast cancer in Developing countries and Arabic countries is variable. Some countries have national or regional tumor registries, others have population studies, and many have hospital-based registries and studies. Breast cancer is the most common cancer among Arabic women. According to reported data, breast cancer constitutes between 13% to 35% of all female cancer cases in Arab countries. Lower rates are reported from Morocco, Tunisia and Algeria. There is also an increased proportion of younger-aged women with breast cancer at presentation. Almost half of patients reported are below the age of 50 and median age is 49–52 years, while in the USA and Europe a median age of around 63 years is observed and only about 25% of patients are under the age of 50 at presentation. A

suspected high prevalence rate was recently concluded from Egypt when a detection rate of 8 per 1000 breast cancer cases was found upon first screening of a target group of 4116 invited women aged 35–64 living in a geographically defined area in Cairo. Some countries have reported increased incidence rates. For example, studies from Lebanon show that breast cancer represents 23% to 35% of cancer in women and that age-standardized incidence rates (ASR) have recently increased from 20 to 40.6 per 100.000 women per year. Incidence of breast cancer increased by 93.7% from 1970 until 1995 in Palestinian women.

While in-situ has become most commonly seen in more industrialized nations due to the widespread application of screening mammography, advanced disease remains very common in Arabic countries. Personal observations and studies from Egypt, Tunisia, Saudi Arabia, palestinians and others show that patients tend to present with larger tumors and more locally advanced and metastatic disease.

Although significant variations exist between countries, mastectomy is still the most commonly performed surgery for most women with breast cancer in Arab countries. Mastectomy rates still represent more 80% of breast cancer surgeries in many countries. The reason for this practice is mostly due to the lack of close radiation therapy centers which tend be available only in capital or major cities, and to the different training backgrounds of general surgeons. However, it is important to point out that many centers have recently increased their rates of breast-conserving surgery and axillary-conserving sentinel lymph node biopsy.

Population screening is rarely practiced. Awareness campaigns are done in some countries. Although countries with more affluent resources should implement population screening, countries with truly limited resources should reduce the incidence of large tumors and locally advanced disease.

Surgeons education should emphasize breast-conserving surgery. Radiation therapy centers should become more available and better distributed. Other suggestions are also dicussed to improve the current state of suboptimal breast cancer care. Individual and academic work, as well as some governmental planning are being done but more investment in data collection and cancer registries, regular updates and publications, quality medical care and scientific research are suggested and will be discussed.

Friday, 24 March 2006   14:15–16:00

PLENARY KEYNOTE

Breast cancer research and management: striving for the best

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445   Invited
European women's expectations

S. Kyriakides. *Europa Donna, Nicosia, Cyprus*

The expectations of society imposed on womens roles, particularly as reflected in areas such as marriage, beauty and employment have changed radically over the last century and still continue to change.

Expectations held by a society defines the roles of its members. Many factors influence the parts that individuals play in their cultures and communities, but education has in fact always been the crucial element in the establishment of social roles. It is education that has acted as a catalyst and over the centuries played a major part in changing the role of women in different societies.

In the latter decades, women's roles have shifted for, in the past they were severely limited by society's concepts of what could be called male supremacy, women's priorities were to run a household, they were discriminated against in employment, in political life and even in education.

But, as women began to receive higher levels of education, their role on society began to change dramatically, women became activists and eventually were in many cases successful in pursuing their demands.

It is this changing role in society that needs to be addressed when discussing the European women's expectations in any one area, not least in that pertaining to health, and, more specifically, to breast care management.

For, there is a diversity in how one could define as the profile of the EUROPEAN WOMAN, as this would depend on her country of origin, culture, religion and even which part of a country she lives in.

Similarly, there is a diversity in what expectations a woman perceives that she is allowed to have in areas of health, depending on the role of women in that specific society. Furthermore, where breast health is concerned, there are possibly many more variables that will determine what her expectations could be.