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

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Metastatic breast cancer management is a dificult 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?

441 Proffered Paper Oral

A breast cancer terminology for lay people

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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