for Oncology and Radiology of Serbia. We defined synchronous bilateral breast cancer (SBBC) as cancer diagnosed in both breasts at the same time or within a 3 months period of diagnosis of the first tumor. In metachronous BBC (MBBC) second cancer is diagnosed more than 3 months after the first one. We had both breast specimens available for 20 SBBC and 23 MBBC pts, for 21 pts there was only one breast specimen.

Results: Out of a total of 64 pts, 48% (31 pts) suffered from synchronous and 52% (33 pts) from MBBC. Median age at diagnosis was 59.3 in SBBC group. In MBBC group median age at first diagnosis was 51.4 and 58.7 for contralateral BC diagnosis, with the median period from first to second BC of 79 months. 84% of SBBC pts were postmenopausal, compared to 55% in the MBBC group. In a group of SBBC, 52% of tumors were found to be lobular and 32% were ductal carcinoma. In a group of MBBC frequency of ductal and lobular carcinoma was similar, 42% of ductal and 40% of lobular. One MBBC patient had both-side tubular carcinoma. Same HP results in both breasts were found in 85% of SBBC and only 48% of MBBC. 70% of SBBC were hormone receptor positive, comparing to only 43% in MBBC group. 16% of SBBC were manifested as inflammatory breast cancer (IBC). In MBBC group, 15% of first and 39% of second malignancy were diagnosed as cancer mastitis. Initial metastases (stage IV) were more frequent in SBBC group, 32%, compared to 12% in MBBC. In SBBC group 8 pts out of 21 (38%) without initial metastasis had a disease progression during follow-up, with a median DFI of 28 months. In MBBC progression was detected in 28% (8/29) pts with a median DFI 34 months after the second BC.

Conclusions: Our study showed that SBBC is more frequent in postmenopausal women, presented more often as hormone receptor positive lobular carcinoma with same HP findings in both breasts. MBBC are usually presented as IBC without distant metastasis. BBC is definitely an unusual clinical entity and because of its atypical and complex presentation patients with bilateral breast cancer require compound and individualized treatment.

466 Poster

Re-irradiation for recurrent breast cancer − a second curative approach

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Background: Repeat radiation is a rarely used and with caution performed treatment strategy. We investigated the efficacy of a second adjuvant radiotherapy series in case of recurrent and surgically removed breast cancer.

Patients and Methods: Forty-four patients were treated from 1993 to 2003 with modified radical mastectomy or local excision and postoperative re-irradiation for recurrent breast cancer. The median age was 58 years (range 33−76 years). The median exposure due to pre-radiation was 50.4 Gy. Postoperative re-irradiation was conventionally fractionated with single doses of 1.8−2.0 Gy to a median total dose of 60 Gy including regional lymphatics in 17 patients (39%) to a total dose of 50 Gy. In case of close or positive margins, local radiofrequency hyperthermia was offered as additional modality leading to a concurrent application in thirty patients (68%). Further adjuvant treatment consisted of chemotherapy (n = 20, 46%) and/or hormonal therapy (n = 14, 32%).

Results: After a median follow-up of 44 months (range 3−92 months) higher graded late toxicity (⩾G3) according to CTC 2.0 and LENT-SOMA was not observed. The estimated 5-year local control rate reached 62%. Additional hyperthermia for patients at higher risk for local failure resulted in 67% local control. Furthermore, a total dose of ⩾60 Gy given with photons was associated with complete local control (n = 14). The estimated 5-year overall survival and disease-free survival rates were 52% and 48%, respectively. The overall survival improved to 65% when supraclavicular +/− parasternal nodes were also covered by radiation portals.

Conclusions: Up to now, the available data are limited or heterogeneous. Thus, we present a single institution series including only patients with at most microscopic positive margins (R0−1) and sufficient follow-up. Our study reveals that postoperative re-irradiation with a median total dose of 60 Gy can be performed with acceptable toxicity. The local control rate is encouraging and translates into improved long-term survival for almost every other patient. It might be speculated whether additional hyperthermia compensates for positive margin. However, long-term local control depends on manifold and overlapping parameters which can not be isolated evaluated due to sample size. Therefore, the relevance of hyperthermia as well as the impact of irradiation of regional lymph nodes on long-term control need further investigation.

Friday, 26 March 2010 18:15–19:15

POSTER SESSION

Metastatic disease

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Platinum-based chemotherapy in triple-negative metastatic breast cancer: results of the Institut Curie experience with cisplatinum and ifosfamide

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Background: Although recent experimental data strongly suggest that platinum-based chemotherapy (PBCT) could improve triple-negative breast cancer (TNBC) outcome, clinical data are missing in this specific subgroup of patients. In the present study, we reviewed clinical outcome in patients with metastatic TNBC treated with PBCT.

Patients and Methods: We conducted a retrospective analysis of the patients treated between 2000 and 2008 at Institut Curie, Paris, France. 146 female patients, with metastatic breast cancer who received PBCT, were eligible for this study. 93 (63.7%) of them had TNBC. 115 patients (78.8%) received PBCT after more than one line of CT (median 2, from 0 to 6). Mean age was 49 year (range from 29 to 76), median number of delivered CT-cycles was 4.2 (1−9). 123 of 146 patients received cisplatinum (CDDP), the other received carboplatin. The main combination used was CDDP-Ifosfamide N = 118 (80.8%). We analysed overall response rate (OR), OS, PFS, prognosis factors for OS, and safety, for TNBC versus non-TNBC.

Results: Median follow-up was 44 months. For the whole population, median OS and median PFS were 11 months and 5 months respectively. OR was 33.3% in the TNBC group, versus 20.8% for the others, $p = 0.1$. Median response duration was 8 versus 7 months (NS). Median OS and median PFS were statistically improved in the patients responding to CT: 25 months (PR) versus 7 months (PD), $p < 0.001$, and 12 months (PR) versus 3.5 months (PD), $p < 0.001$ respectively. No difference was observed for OS, PFS and response duration between TNBC and others. Other prognostic factor for worse OS was visceral metastasis sites ($p < 0.001$). One patient died from sepsis during aplasia, one other developed CDDP-related grade 3 renal failure. 15 patients had to switch to carboplatin because of unacceptable CDDP-related side effects.

Conclusions: In this series, PBCT tend to increase response rate in metastatic patients with TNBC compared to non-TNBC patients, but did not translate into a significant improvement for PFS and OS. Tolerance was acceptable. Longer observations and further analysis are warranted. Prognosis of metastatic TNBC remains poor and new targeted therapies are needed.

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Individually dose-adjusted treatment with epirubicin and paclitaxel with or without capecitabine as 1st line treatment in metastatic breast cancer. A randomized multicenter trial

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Background: Epirubicin, paclitaxel and capecitabine are effective drugs in the treatment of breast cancer. In the present trial, patients previously untreated with chemotherapy for metastatic disease were randomized to a combination of epirubicin and paclitaxel (ET, epirubicin 75 mg/m^2; paclitaxel 175 mg/m^2, q3w) alone, or with the addition of capecitabine (TEX, epirubicin 75 mg/m^2; paclitaxel 155 mg/m^2; capecitabine 1650 mg/m^{2}x14, q3w). Primary endpoint was time to progression (TTP) with a prolongation from 6 to 8.5 months being a significant clinical improvement.

Material and Methods: 287 patients were randomized to either ET (n = 143) or TEX (n = 144). Doses for each of the drugs were adjusted (escalated/de-escalated) according to predefined levels individually in relation to toxicity. If treatment was discontinued due to side effects