doses and its impact on the disease free survival in obese female breast cancer patients.

Method: We compared disease free survival between two groups of female breast cancer patients receiving adjuvant chemotherapy, both groups received FEC 100 regimen (Epirubicin 100 mg/m^2, 5-FU 500 mg/m^2, Cyclophosphamide 500 mg/m^2) for 6 cycles in the period between 2000–2008. Group A: (149 patients) received their regimen based on their actual body weight calculation of body surface area (BSA [m^2] = vHt. [cm]·Wt. [kg]/3600). Group B: (100 patients) received their regimen based on their adjusted body weight. (Adjusted Body Weight = Ideal Body weight + 0.4(Actual Body Weight − Ideal Body Weight.) Ideal Body Weight for females = 45 + 2.3kg for each inch >60 inches [60 inches = 152 cm]). Correlation with age, T & N status, hormonal status and HER2 status was done in the two groups.

Results: At median follow up period of 17 months there was statistical significance of disease free survival in favor of group B (70.3 months Vs. 52.4 months, p = 0.004). Both groups showed non-significant difference as regards correlation with other parameters: ER, PR, HER2 status, Age, T & N.

Conclusion: Using adjusted body weight is considered a proper alternative method for the calculation of anti-cancer drugs doses. An effort is currently using the substantial information to retrospectively examine outcome with respect to toxicities.

40 Poster

Adjuvant taxane chemotherapy is associated with a significant risk of febrile neutropenia

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Background: Taxane based adjuvant chemotherapy has shown benefit in terms of overall survival when compared to non-taxane containing regimens and is increasingly used in high risk patients. The risk of febrile neutropenia (FN) is known to be higher with taxane based chemotherapy. In South West Wales, taxane based chemotherapy is recommended for node positive and selected high risk node negative patients. Commonly used regimens include TAC (docetaxel, doxorubicin, cyclophosphamide x6q3w), FEC 100-D (fluorouracil, epirubicin, cyclophosphamide ×3q3w − docetaxel ×3q3w), AC-T (doxorubicin, cyclophosphamide ×4q3w − docetaxel ×4q3w) or dose dense AC-P (doxorubicin, cyclophosphamide ×4q2w − paclitaxel ×4q2w). Where anthracyclines are contraindicated, TC (docetaxel, cyclophosphamide ×4) or TCH (docetaxel, carboplatin, herceptin ×6) are used. Only patients receiving TAC or AC-P receive primary prophylaxis as routine. This study was peformed to determine the incidence of febrile neutropenia in patients receiving adjuvant taxane based chemotherapy.

Materials and Methods: A retrospective analysis of all patients who received adjuvant taxane based chemotherapy at Singleton Hospital and Prince Philip Hospital between January 2007 and Sept 2008 were included. FN was defined as fever >38ºC (single reading) and neutrophil count $<1\times10^9$. Admissions for FN and use of secondary GCSF were recorded.

Results: 135 patients were identified, including 2 male patients. 29 patients were admitted with FN (21%). 23 were receiving a taxane at the time of the episode with 6 patients receiving either FEC100 or AC. The median duration of hospital stay was 6 days. 2 patients had grade 4 toxicity requiring intensive support and >60 day hospital stay. There were no deaths.

96% of patients who did not receive primary prophylaxis, received pegylated GCSF with subsequent cycles and only 1 patient (4%) had a further episode of FN.

FN rates according to regimen are summarised in the table.

Chemotherapy regimen	No. of patients	Rate of FN (%)	Published FN rate (%)
AC-T	44	5(11)	16 (ECOG 1199)
AC-P	3	1(33)	3 (CALGB 9741)
FEC100-D	32	7(21.8)	11.2 (PACS-01)
TAC	29	6(20.7)	24.7 (BCIRG 001)
TC	18	6(33)	8 (US Oncology)
CH	7	3(42)	9.8 (BCIRG 006)
TH	1	1(100)	

Conclusion: The FN rate following taxane based adjuvant chemotherapy in our population is higher than expected according to published trial data. Most admissions were short in duration. The use of secondary GCSF is effective at reducing subsequent episodes.

ASCO guidelines recommend the use of primary prophylaxis if the FN rate is higher than 20%. This study suggests that primary GCSF should be routine for patients receiving TC and FEC-D. The number of patients receiving AC-P and TCH is too small for recommendations to be made and further data will be collected as these regimens become more common. For patients receiving TAC primary prophlaxis should include the combination of ciprofloxacin and pegylated GCSF.

41 Poster

Prognostic factors and survival outcome in triple negative breast cancer patients in routine clinical practice in Slovenia

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Background: Triple negative breast cancer (TNBC) is characterized by negative hormonal receptors (ER and PR) and negative HER-2 status. It is a subgroup of breast cancer (BC) with poor survival despite aggressive systemic treatment when compared to other subgroups of BC.

The aim of our study was to analyze clinical and pathological characteristics and to evaluate prognostic significance of some well established prognostic factors in a large group of consecutive TNBC patients (pts) treated in a routine clinical practice.

Methods: Our retrospective study included 269 TNBC pts treated at Institute of Oncology Ljubljana between March 2000 and December 2006. Median age was 55.3 yrs (23–88.5). Most of pts were postmenopausal (58.7%), 41 (15%) were older than 65 yrs. Tumors were mostly IDC (90.7%), larger than 2 cm (59%), grade 3 (80.7%), without lymphovascular invasion (LVI) (73.3%), with high uPA (76.2%) and PAI-1 (60.5%) levels. The lymph node metastases were found in 46.1% of pts. Majority of pts were treated with adjuvant chemotherapy (CT) (80%), only 12% received neoadjuvant CT. Predominant CT regimen was anthracycline based CT (60%), 24.5% of pts received CMF regimen and 14.5% sequential anthracyclines and taxanes and 1% other regimens.

The survival outcomes were computed using the Kaplan-Meier method. Cox proportional hazard model was used in the multivariate analysis.

Results: After a median follow up of 5.9 yrs 6 (2%) pts experienced local, 79 (29%) pts distal recurrence and 66 (24%) pts died. Five-yrs PFS was 68.2% and 5-yrs OS 74.5%. Most of the relapses (72%) and deaths (63.6%) were in the first three yrs after treatment.

The results of Cox analysis are presented in Table 1.

Table 1

Characteristic	PFS			OS		
	univariate	multivariate		univariate	multivariate	
	p	p	HR (95% CI)	p	p	HR (95% CI)
Menopausal status (pre/peri vs. post)	0.172			0.278		
Age ⩾65 yrs vs. <65	0.009	0.012	1.79 (1.14−2.82)	0.035	ns	
Nodal status positive vs. negative	<0.001	<0.001	2.71 (1.64−4.46)	0.001	0.002	2.96 (1.51−5.82)
Size >2 vs. ⩽2 cm	0.004	ns		0.002	ns	
Grade III vs. I+II	0.315			0.917		
LVI yes vs. no	<0.001	ns		0.006	ns	
uPA >3 vs. ⩽3 ng/mg prot.	0.827			0.732		
PAI-1 >14 vs. ⩽14 ng/mg prot.	0.487			0.632		

ns = not significant.

Conclusions: In our series of TNBC pts nodal status and age >65 yrs were found to be an independent prognostic factor for PFS, whereas for the OS nodal status only. We found a pattern of high recurrence rate in the first 3 yrs following diagnosis and a decline in recurrence rate over the next 3 years.

42 Poster

Magnetic resonance imaging (MRI) evaluation of pathologically residual tumors in breast cancer after neoadjuvant chemotherapy: experience of 2 centres in Spain

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Background: The objective of this study was to evaluate the accuracy of MRI in assessing tumor response following neoadjuvant chemotherapy in patients with locally advanced breast cancer (LABC).