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Indications of adjuvant chemotherapy for breast cancer according to local guidelines, recursive partition and Adjuvant! Online: how to improve patient management?

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Background: Adjuvant treatments are decided according to guidelines. However, many individual factors, such as performance status, patient refusal, complex interactions between factors (discrepancies between grade and Ki67 for example) and complex cases (borderline age, . . .) could introduce discrepancies between guidelines and final decision.

The aim of this study was to quantify discrepancies and to assess if machine learning could take into account this fact, efficiently redefine guidelines and eventually improve patient management.

Material and Methods: Between 2003 and 2005, 581 consecutive patients underwent surgery for breast cancer in our institution. Patients, tumours characteristics, adjuvant treatment and outcome were recorded. We compared three models for the decision of adjuvant chemotherapy: our local guidelines, recursive partition model build with effective received treatment and the risk of recurrence on Adjuvant On line.

Results: The rate of decisions that were compliant with the reference guideline was 13.3%. The recursive partitioning model was mainly based on nodal status and Ki67. It did not improve significantly the virtual compliance: 11.5%, demonstrating that non-compliance was individual-based and did not involve particular subgroups. Survival curves found significant difference between patients who rightly received or not chemotherapy according to the models and patients wrongly managed. Best overall and disease free survival occurred for patients who rightly received no treatment. Interestingly patients who "inadequately" received chemotherapy had a decreased survival, suggesting that the decision to give chemotherapy was correlated with a poorer prognostic. Adjuvant On Line discriminated correctly patient prognosis and could have been used to allocate adjuvant treatment in a risk-based intent to treat.

Conclusion: More than 10% of patients did not received adjuvant chemotherapy according to guidelines. This decision was individual based and cannot be corrected by recursive partitioning. Adjuvant On Line discriminated correctly patient prognosis and could have been used to allocate adjuvant treatment in a risk-based intent to treat.

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POSTER SESSION

Educating the patient and breast cancer specialist

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Pre-counselling information seeking and health behaviours among unaffected high-risk women

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Background: High-risk women are often referred by their GP to risk assessment clinics for estimation of their risk and to discuss risk management. The High-Risk Breast Assessment clinic of The Ottawa Hospital Women's Breast Health Centre provides risk counselling for women with: 1) demonstrated or suspected BRCA1/2 genetic mutation in the family or the patient, 2) high-risk benign pathology such as lobular carcinoma in situ or atypical hyperplasia, 3) prior thoracic radiation therapy or 4) Gail score >1.7. Depending on actual risk level, recommended preventive measures include clinical examination (CBE) every 6−12 months, yearly screening, prophylactic surgery (PS), pharmaco-prevention and adoption of a healthy lifestyle. We undertook a study to examine the level of interest for these options and the lifestyle and surveillance behaviours among high-risk women prior to attendance at the clinic.

Material and Methods: Data from 60 high-risk women (mean Gail score=2.14) aged 28−68 (mean age=47) who completed an intake questionnaire before their first visit at the High-Risk Breast Assess clinic were analyzed.

Results: A majority of women indicated that they were interested in discussing screening schedule (97%) and lifestyle choices (90%). Interest in screening was related to age ($p < 0.05$), whereas interest in lifestyle was affected by perceived risk ($p < 0.1$) and by the number of first degree relatives (FDR) with breast cancer ($p < 0.1$). Most women had no interest in pharmaco-prevention (no=70%) or in PS (no=75%). Women interested in tamoxifen had lower perceived risk than uninterested women (48 vs 67%, $p < 0.05$). Although 76% reported having yearly CBE, only 47% had yearly mammogram and only 34% self-examined their breast every month (BSE). Women who did not have yearly mammography had higher BMI ($p < 0.1$), and those who did not perform BSE were younger (44y vs 51y). Though 85% were non-smokers, 44% did not exercise regularly and 80% drank alcohol regularly. Older women were more likely to exercise ($p < 0.1$).

Conclusions: Before attendance at a high-risk clinic, high-risk women seek information on early detection and lifestyle as options to manage their risk. However, <50% are appropriately screened and the majority have lifestyle behaviour that increases their risk for breast cancer. These results reinforce the need to provide education on breast cancer risk management to high risk women and their primary care providers.

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Care continuity after discharge from the breast surgery division

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Background: Returning to their homes is a particularly critical moment for patients, both psychologically and clinically: they need not only a number of follow-up wound dressings, but also a lot of information on how to solve possible problems caused by their disease. We have a dedicated outpatients service to discuss pathological aspects and to assess wound evolution. From interviews and telephone calls, it emerged that post-discharge care was lacking and inadequate to patients' requests. There is a need to improve the Service by offering patients care continuity and reassurance

Materials and Methods: We applied the following solutions:

1. A phone line dedicated to patients discharged was activated and 3 dedicated nurses were chosen from the Breast Surgery Division who underwent a period of training. During the morning dedicated nurse follows patients'discharges while in the afternoon the same nurse follows outpatients service.
2. An informative booklet containing all Frequently Asked Questions was published and evaluated by a questionnaire.
3. An existing database dedicated to multidisciplinary decision-making for breast cancer patients was modified and improved. A user manual was created.
4. Several informative booklets were created and are currently in use.
5. Questionnaire was created to evaluate the post-discharge outpatient service.

Results: The above-listed interventions yielded the following results:

1. *MULTIDISCIPLINARY-DECISION-MAKING DATABASE:* all medical personnel can easily access decisions on post-operative treatments both chemotherapy and radiotherapy
2. *Referrals*: patients coming from other parts of Italy can be treated in their home town by physicians chosen by IEO
3. *Questionnaire on booklet*: the booklet was highly appreciated (over 50% of patients evaluated it 10/10)
4. *Questionnaire on outpatient care quality*: First visit and surgery resulted as critical moments. On a 1−5 scale, the Service organization scored 4.73; personnel's competence scored 4.84 and the informative booklet scored 4.88.

Conclusions: The dedicated nurse has become a reference point for both patients and clinicians. The number of telephone calls to both the ward and the dedicated line has decreased, proving that during post-discharge outpatient interview patients are given exhaustive and clear information which aims at improving wellbeing at home, where the patient has to face the physical and psychological effects of their operation.

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Breast cancer patients' treatment related knowledge after clinical pathway in the field of empowerment

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Background: The aim of patient education is to increase patient's knowledge and competence about her health problems and cure. With knowledge and competence, the breast cancer patient can be empowered with her health problems and be enabled to participate in decision about her care. The essential part of empower process is knowledge. In the