O-18. EVALUATION OF LONG TERM RECURRENCE RATE FOLLOWING BREAST CONSERVING SURGERY AFTER NEOADJUVANT ENDOCRINE THERAPY

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There is no published information on the recurrence rates following breast conserving surgery after neoadjuvant endocrine therapy. In Edinburgh neoadjuvant endocrine therapy has been used for many years and we report a series of 108 patients with a median four year follow up who were treated by breast conserving surgery after neoadjuvant endocrine therapy.

Of the 108 patients who underwent breast conserving surgery following neoadjuvant therapy, 43 were treated by tamoxifen, 33 by letrozole, 22 by anastrozole and 10 by exemestane. Details are provided in the table.

Drug	N	No XRT	Local recur.	XRT	Local recur.	F/U (months)
Tam	43	13	2	30	0	78
Letr	33	12	2	21	0	61
Anastro	22	1	0	21	1	37
Exem	10	3	0	7	0	24
Total	108	29	4	79	1	48

Median follow-up is now 48 months, five patients in total have developed local recurrence.

These data illustrate the safety and efficacy of performing breast conserving surgery after neoadjuvant endocrine therapy particularly if radiotherapy is given after breast conserving surgery.

O-19. BREAST CANCER IN THE ELDERLY: SURGERY IMPROVES SURVIVAL. THE RESULTS OF A CANCER RESEARCH CAMPAIGN TRIAL

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In 1984 a trial was initiated to test the hypothesis that tamoxifen alone would provide adequate control of breast cancer in elderly woman, thereby sparing them surgery. Change of management (COM) due to disease progression, or changing treatment because of toxicity or for other reasons, was the primary endpoint. 455 patients aged over 70, with operable disease were randomised to tamoxifen alone, 40 mg daily, or surgery plus the same dose of tamoxifen. The current analysis is based on a median follow-up of 12.3 years. The COM-free interval (HR = 2.80 (95%CI = 2.09–3.74)) and progression-free interval (HR = 4.42 (95%CI = 3.33–5.87)) were significantly shorter in the tamoxifen-alone group. For surgery-plus-tamoxifen patients the most frequent intervention was hormonal therapy (51%) whereas for tamoxifen-alone patients it was surgery (64%). The greater hazard ratio for progression-free interval compared to COM-free interval is due to a delay in changing management once patients in the tamoxifen-alone group had evidence of progression. Overall mortality and mortality from breast cancer were significantly increased in the tamoxifen-alone group compared to the surgery-plus-tamoxifen group, HR = 1.3 (95%CI = 1.05–1.61) and HR = 1.75 (95% CI = 1.18–2.59), respectively. Stratification of overall mortality by age and tumour size suggested that patients aged 70–72 or with T3 tumours had an increased mortality when treated with tamoxifen-alone compared to surgery-plus-tamoxifen, HR = 2.00 (95%CI = 1.18–3.39) and HR = 2.51 (95%CI = 1.21–5.20) respectively. The results of this trial show that omission of primary surgery for operable breast cancer in elderly patients, who were fit for the procedure, resulted in earlier therapeutic interventions overall and an increased mortality.

O-20. TAMOXIFEN BEYOND FIVE YEARS – PATIENT'S EQUIPOISE

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Aim: To assess among a population of women who had taken adjuvant tamoxifen for five years, how many were prepared to enter a randomised trial of tamoxifen duration and what was the preference of those who declined trial entry.

Methods: There is uncertainty as to the optimum duration of adjuvant tamoxifen and this is the subject of the aTTom trial in which patients are randomised to continue or stop tamoxifen after 5 years. Patients have been recruited to the aTTom trial in Dundee since 1996 and a record kept of all patients with whom the trial was discussed. Patients who declined trial entry were allowed to choose whether to electively stop or continue tamoxifen.

Results: 306 patients were eligible for trial entry of whom 171 (56%) consented to randomisation (82 to continue and 89 to stop). Amongst the 135 (44%) who declined randomisation, 28 (21%) elected to stop tamoxifen, 90 (67%) elected to continue and in 16 (12%) their decision was unclear. There was no significant difference with regard to the oestrogen receptor status, lymph node status and menopausal status between those entering and those declining trial entry.

Conclusions: These results illustrate that patients eligible for the aTTom trial share our clinical equipoise. A majority (56%) of patients were agreeable to randomisation, but among those who declined, some (67%) preferred to continue, some (21%) to stop tamoxifen. This trial is unusual in that the patients have already experienced the treatment options, so the patients' preferences reflect a truly informed choice.