SURVIVAL FOLLOWING LOCOREGIONAL RECURRENT BREAST CANCER - RESULTS FROM A PROSPECTIVE STUDY WITH MORE THAN 10 YEARS OF FOLLOW-UP.

C. Kamby, L. Sengeløv  
Finsen Centre, Rigshospitalet and Department of Oncology  
Copenhagen University Hospital in Herlev, Denmark.

We evaluated prognostic factors for survival after locoregional recurrence (SAR) in 140 patients (pts) with breast cancer. The patients were entered in a staging protocol for pts with first recurrence (SAR) in 140 patients (pts) with breast cancer. The We evaluated prognostic factors for survival after locoregional recurrence, SAR can be estimated by level of S-lactate dehydrogenase (LDH) and the number of positive regional nodes (Npos). These variables may be used to stratify pts in future studies evaluating locoregional treatments.

Methods

In this study between 1983 and 1988, 1040 women were surgically treated by mastectomy (826) or by sector resection (214) and in both of these cases axillary dissection was performed. For statistical analysis, patients with the same pTlnN status were assigned to subgroups according to whether they received adjuvant RT or didn’t. The impact of intraductal components on the local relapses was also analysed. Results: 1/ Mastectomy group: Patients with pT1n0 status after RT had 2% chest wall-scar relapses and the rate of recurrence was 5% in the untreated cases. Irradiated women with pT2pN0 status had significantly better results than unirradiated ones. The relapse rate was 5% and 10% respectively. 2/ Breast conserving group: with pT1-2N0 status the percentage of tumor-bed relapses was 10% in the irradiated and 31% in the untreated group. However the rate of relapse was the highest with pT1a and regional node status. These variables may be used to stratify pts in future studies evaluating locoregional treatments.

Purpose: To assess the morbidity of radiotherapy in women with breast conservative treatment.

Methods and Materials: Medical records of 1047 women with stage I and II breast cancer who completed the decision support procedure. For all women, the estimated QALE was better after PM and screening (median gain 9.7 yrs, range 8.4-11.4 yrs.). However, in only 4 women the estimated QALE was better after PM (median gain 2.1 QALYs, range 3.4-41 QALY’s). Therefore, the best choice according to the decision support procedure was screening in 3 cases and PM in 4 cases. Five women made a final choice: 3 times screening, 2 times PM. All were conform the decision analytic advice, even though the advice of the Breast Cancer Working Party is PM in all gene carriers. All 5 felt supported in their decision by the decision support procedure. The 2 remaining women have not yet decided.

Conclusions: Our preliminary results indicate, that it is far from obvious that PM is the best choice for these women if quality of life is taken into account. Formal decision analytic support may help to ascertain that the patients’ own values play an appropriate role in the final decision.

RADIOThERAPY AFTER OPERATION OF BREAST CANCER : THE QUESTION OF "SAFE OMISSION"

J. Fodor, M. Pálfy  
National Institute of Oncology Dept. of Radiotherapy, Budapest, Hungary

Background: Till now there has been no consensus on the use of post-mastectomy adjuvant irradiation. Even the usefulness of radiotherapy (RT) after breast conserving surgery has been discussed recently, and omission is suggested in early cases. Purpose: The aim of this study is to define which patients need or do not need adjuvant RT. Patients and Methods: In this study between 1983 and 1988, 1040 women were surgically treated by mastectomy (826) or by sector resection (214) and in both of these cases axillary dissection was performed. For statistical analysis, patients with the same pTlnN status were assigned to subgroups according to whether they received adjuvant RT or didn’t. The impact of intraductal components on the local relapses was also analysed. Results: 1/ Mastectomy group: Patients with pT1pN0 status after RT had 2% chest wall-scar relapses and the rate of recurrence was 5% in the untreated cases. Irradiated women with pT2pN0 status had significantly better results than unirradiated ones. The relapse rate was 5% and 10% respectively. 2/ Breast conserving group: with pT1-2N0 status the percentage of tumor-bed relapses was 10% in the irradiated and 31% in the untreated group. However the rate of relapse was the highest with pT1a and regional node status. These variables may be used to stratify pts in future studies evaluating locoregional treatments.

CONSERVATIVE TREATMENT OF BREAST CANCER: MORBIDITY OF RADIOThERAPY

ERNEST J. MARTINEZ A, RODRIGUEZ D, GOMEZ J, POLO A, RUBIO E, VILLA B, GUMILALDI E, PETRIZ L, PERA J.  
Radiation Oncology, Instituto Catalá d'Oncologia, C.S.U. de Bellvitge. L'hospital de ll. (Barcelona). Spain

Purpose: To assess the morbidity of radiotherapy in women with breast conservative treatment.

Methods and Materials: Medical records of 1047 women with stage I and II breast cancer who were treated in our Institution from 11/1982 to 12/1995 have been analyzed. All women received limited field (LF), surgery (LE), axillary dissection and radiation therapy (RT). The mean age was 52 years (r23-86). Ductal infiltrant carcinoma was present in 94% of the patients; other types were found in 6%. After LF, the mean doses received were 50Gy in the whole breast and 18Gy in the tumoral bed as a boost irradiation. Adjuvant chemo-hormonotherapy was administered to 47% of the patients. Results: arm edema was present in 5.6% of the cases, brachial plexopathy in 1%, pneumonitis in 0.9% and unresolves skin changes in 25%; infectious mastitis was observed in 1.8% of the patients after radiotherapy. Conclusions: Our incidence of pneumonitis was low; arm edema and brachial plexopathy were independent of axillary and supraclavicular irradiation; interstitial boost increases cutaneous pigmentation and, perhaps it has a role in infectious mastitis.