16.

ANALYSIS OF SOME PROGNOSTIC FACTORS IN ADVANCED BREAST CANCER TREATED WITH SIMULTANEOUS OR SEQUENTIAL HORMONOTHERAPY (HT) AND CHEMOTHERAPY (CT). M. Beer, F. Jungi, G. Martz, B. Mermillod, K.W. Brunner and F. Cavalli for the Swiss Group for Clinical Cancer Research (SAKK), 1205 Geneva, Switzerland.

464 patients (pts) with metastatic breast cancer were treated in a randomized prospective study of the SAKK comparing combined HT and CT versus HT followed by CT on non-response or progression. 3 different CT regimens were used. HT was ovarectomy for premenopausal and Tamoxifen for postmenopausal pts. CT regimens and treatment results are reported elsewhere (UICC Conference on Clinical Oncology, 28-31 Oct. 1981). Of 406 evaluable pts, 109 were premenopausal and 297 postmenopausal. Analysed prognostic factors were age, menopausal status, disease-free interval from mastectomy to metastasis (DFI), localisation and number of metastatic sites, response to treatment, and, for the sequential HT-CT group, response to HT. Age and menopausal status did not significantly influence response, response duration or survival. Survival had a statistically significant correlation with DFI, site and grade of the response to either HT or CT or to HT & CT. Response to treatment correlated well with the localisation and number of sites. Time to progression in responding pts was significantly influenced by the grade of response. In the sequential treatment group, time to progression from the beginning of CT correlated with the grade of previous response to HT. The less favourable disease site was liver (median survival 15 months) and the most favourable locoregional or bone (median survival 39 and 29 months). Low or high risk criteria based on DFI and disease sites and used for prospective stratification proved to be statistically significant.

18.

INFLAMMATORY BREAST CARCINOMA: PROGNOSTIC SIGNIFICANCE AND SURVIVAL AFTER MULTIDISCIPLINARY TREATMENT. G. Rosset, P. Alberto et F. Krauer, Hôpital Cantonal Universitaire, 1211 Geneva 4, Switzerland.

The bad prognosis of inflammatory type of breast carcinoma (what is described as PEV II and III) may be linked to the high frequency of undecteted micrometastases at the time of diagnosis, leading to frequent and rapid dissemination of the disease. Therefore, it seems of interest to combine early general chemotherapy with local treatment. We have treated 18 patients (8 premenopausal and 10 postmenopausal) with the following chemotherapy schedule: adriamycine 6 mg/m^2 i.v. days 1 and 8, chlorambucil 5 mg/m^2 p.o. days 1 to 14, methotrexate 10 mg/m^2 i.v. days 1 and 8 and fluorouracil 500 mg/m^2 i.v. days 1 and 8. The same treatment was repeated for 2 to 6 cycles according to clinical results. Modified radical mastectomy was then performed as well as postoperative radiotherapy. Clinical response to pre-operative chemotherapy was obtained in 75 % of 16 evaluable cases with complete remission in 25 %, but histological examination showed persistance of numerous malignant cells in the mastectomy specimen in all cases except one. Two patients are now under treatment. Two out of 18 patients have died of diffuse metastatic disease within 11 to 24 months. Four out of 18 patients have developed metastases 6 to 36 months after mastectomy. All are alive with various chemotherapy regimens. Twelve patients are alive and free of disease 4 to 50 months after mastectomy.

17.

RADIOTHERAPIE POST-OPERATOIRE DES CARCINOMES MAMMAIRES. L'ENVAHISSEMENT MICROSCOPIQUE GANGLIONNAIRE, FACTEUR PRONOSTIQUE PRIMORDIAL. V. Dragon, S. Bernasconi, P. Lazarevski. Service de Radiothérapie, CHUV, 1011 Lausanne, Suisse.

557 carcinomes de la glande mammaire stade I, II et III, irradiés après intervention chirurgicale radicale, de 1966 à 1976 inclus. La grande majorité de ces cas (85,8%) était des T1 ou T2, avec ou sans envahissement microscopique des ganglions axillaires.
Les tumeurs T1 et T2 situées dans les quadrants internes et la région centrale du sein sans métastases ganglionnaires axillaires (105 cas) ont reçu par la télécobaltothérapie un traitement limité sur les chaînes ganglionnaires mammaires internes et sus-claviculaires homolatérales.
Pour les tumeurs T1, T2 et T3 avec envahissement des ganglions axillaires - ou avec un évidement axillaire considéré comme insuffisant -, l'irradiation post-opératoire complète a été effectuée sur toutes les régions lymphatiques homolatérales, ainsi que sur la cicatrice opératoire (452 cas).
L'ensemble des 557 cas suivis au moins 5 ans après l'irradiation post-opératoire présente 62,3% de survie sans signes cliniques de cancer (SSC) : 83,0% pour le stade I, 59,8% pour le stade II et 44,3% pour le stade III.
L'envahissement microscopique des ganglions axillaires est le critère pronostique principal : 79,0% (188/238) SSC si les ganglions sont négatifs et 49,9% (159/319) si les ganglions sont positifs. Le facteur pronostique essentiel réside cependant dans le nombre de ganglions envahis : 66,5% (117/176) SSC si 1 à 3 ganglions sont envahis et seulement 29,4% (42/143) s'il y a plus de 4 ganglions positifs (22,0% - 13/59 - pour les tumeurs internes et centrales avec 4 ou plus de ganglions axillaires envahis).

19.

SECOND MALIGNANCIES IN OPERABLE BREAST CANCER PATIENTS. E.E.Holdener, J.Osterwalder, H.J.Senn and F.Enderlin, Div of Oncol, Dept of Med, & Tumor Registry of Regional Cancer League St.Gall-Appenzell, Kantonsspital, CH-9007 St.Gallen, Switzerland.

Second malignancies (SM) represent one of the potential hazards of modern cancer treatment, especially radio- and chemotherapy, after surgery for breast cancer. For this reason, regional tumor registry data (1960-1975) on 1985 breast cancer patients were analyzed for SM in the retrospective part of our study. SM were observed in 77 cases (=4%), of which 17% were found before, 18% simultaneously and 65% after the diagnosis of breast cancer. Most frequent SM were of GI-(35%), GYN-(22%), breast-(13%) and CNS-(10%) origin. No difference in the rate of SM was found between the major treatment groups: surgery only(n=578), surgery+radiotherapy (n=861) and surg.+radiother.+chemotherapy(n=116). The median time from mastectomy to diagnosis of SM was 3 years. 66% of SM were observed within 5 and 89% within 10 years. Median survival of pts.with SM diagnosed post-mastectomy was 4.8 yrs from primary breast surgery while it was only 4 months in pts with a SM observed before and 12 months in pts with a SM diagnosed simultaneously with breast cancer. These data were confronted with the prospective part of the study, where 5/123(=4.1%) of pts in the surgical control group and only 1/118(=0.8%) with adj.LMF+BCG developped SM within 6 yrs median observation time after mastectomy. These data are compared with other current adjuvant breast cancer trials and do not indicate an increased risk of SM by present adjuvant therapy.