

African-American Breast Cancer Patients Have Proportionately Higher Recurrence Scores after TAILORx Reclassification vs Caucasian Patients: An Examination of the National Cancer Database

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INTRODUCTION: The recurrence score (RS) is used in early stage, hormone positive breast cancers, to predict the benefit of adjuvant chemotherapy. The TAILORx study built upon previous RS data and stratified “intermediate risk” patients into either “low or high risk” categories. This study aimed to determine if there was a difference in risk reclassification between African-American (AA) and Caucasian patients after incorporation of TAILORx scoring.

METHODS: AA and Caucasian patients with early stage, node negative, hormone positive/HER2-neu negative breast cancers who underwent RS testing in the National Cancer Database 2004 to 2014 were included. RS was defined in 2 ways: “pre-TAILORx” scores, classified into low (0-17), intermediate (18-30), and high risk (> 30) groups; and “post-TAILORx” scores, classified into low (0-25) and high risk (> 25) groups.

RESULTS: A total of 80,532 women were included; 87.7% were Caucasian and 7.3% were AA; 61.3% (n = 43,263) Caucasians and 55.6% (n = 3,249) AA had a low RS using pre-TAILORx scores, while 87.5% (n = 61,815) Caucasians and 82.6% (n = 4,824) were reclassified with low RS using post-TAILORx scores; and 6.5% (n = 4,602) Caucasians and 9.9% (n = 579) AA had a high RS using pre-TAILORx scores, while 12.5% (n = 8,820) Caucasian patients and 17.4% (n = 1,015) AA patients were reclassified with a high RS using post-TAILORx scores.

CONCLUSION: TAILORx results have allowed more patients with early stage, hormone positive breast cancers to omit chemotherapy overall. However, a proportionately lower number of AA patients can safely omit chemotherapy when compared to Caucasian patients with similar tumor characteristics and clinical risk after reclassification of the RS using new TAILORx scoring.

Does Locoregional Treatment in de Novo Stage IV Bone-Only Metastatic Breast Cancer Prolong Survival? An Ongoing Multicenter Registry Study

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INTRODUCTION: Surgical treatment of primary tumor is a controversial treatment of stage IV de novo metastatic breast cancer

(BC). This study aims to present early results of the ongoing registry in a cohort of patients.

METHODS: Two hundred and fourteen patients treated for de novo stage IV bone-only metastatic BC were analyzed in this study. The inclusion criteria were: primary BC that was suitable for complete surgical resection and patients who could be treated by systemic treatment (ST). The exclusion criteria were: patients with inflammatory BC or bilateral BC, patients who had a contraindication for ST, or patients who were not suitable for follow-up.

RESULTS: Mean patient age was 54 ± 13 and median follow-up was 22 months. Fifty-three (25%) patients died; 10 (13%) in Group 1 (locoregional treatment [LRT]) and 43 (32%) in Group 2 (ST) ($p = 0.002$). Age, follow-up time, tumor type, and receptor status were similar between the groups, but more patients with solitary bone metastasis underwent primary tumor surgery. Hazard of death was 59% lower in Group 1 than in Group 2 (hazard ratio [HR] 0.41, 95% CI 0.20-0.82; $p = 0.01$). LRT significantly decreased systemic (Group 1 = 30% vs Group 2 = 51%; $p = 0.002$) and locoregional progression (Group 1 = 6% vs Group 2 = 18%; $p = 0.02$).

CONCLUSION: More women were alive in the LRT group with median 2 years follow-up. Systemic and locoregional progression was higher in ST-only patients compared to patients who underwent LRT. An ongoing multicenter registry study with longer follow-up is expecting to show survival benefit of primary tumor surgery in de novo stage IV bone-only BC patients.

Efficient and Economical Alternative to Breast Image-Guided Localization

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INTRODUCTION: The disadvantages of current wire-localization are well known (unpredictable start times, inaccurate placement, patient discomfort, and wire dislodgement). New tumor-site markers are placed secondarily using expensive localizing tools to locate these new markers. Randomized studies have not identified a single device that is better than all the rest. All methods appear equally reliable including wire localization. Intraoperative ultrasound guided lumpectomy by surgeons, facilitated by using ultrasound visible clips at initial biopsy, is an efficient, economical, and patient friendly method that solves traditional problems of wire-guided surgery while being more patient friendly and less costly.

METHODS: We studied 168 consecutive intraoperative ultrasound localized lumpectomies for breast cancer after an ultrasound visible clip was placed at the initial biopsy. No second localizing procedure was needed. Intraoperatively the surgeon used ultrasound to identify the target, obtain diagnostic images in 2 planes and place a hook wire and/or dye at the site of the tumor or clip. These non-palpable or barely palpable lesions has common tumor characteristics (age 64.6 y, mean size 18 mm [range 3-40 mm], 92%