Gruppo di Studio per la Patologia Mammaria

FATTORI DECISIONALI PER L'IRRADIAZIONE LINFONODALE (1-3 N+)

Alfio Di Grazia

(Pergolizzi ha la febbre)

ZOOM JOURNAL CLUB 2012
Roma 25 Gennaio 2013

LE DUE IPOTESI

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- **Fisher**

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CLINICAL INVESTIGATION

RISK FACTORS FOR REGIONAL NODAL RELAPSE IN BREAST CANCER PATIENTS WITH ONE TO THREE POSITIVE AXILLARY NODES

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No. LNs	Grade	1	2	3
1	5 y	1.4	4.9	6.5
	10 y	1.4	8.9	8.9
2	5 y	0	7.6	12.1
	10 y	0	11.8	19.4
3	5 y	0	10.9	21.1
	10 y	0	14.8	29.6

	G1	G2	G3
1 N	Low	Int	Int
2 N	Low	Int	High
3 N	Low	High	High

Table 4b. 5- and 10-year SCFR rate and hazard ratios according to the three risk* groups

Risk Group	Number (%)	5-y SCFR (%)	10-y SCFR (%)	HR (95% CI)	*p* Value
Low	131 (14)	0.8	0.8	1.0	<0.001
Intermediate	580 (60)	6.0	9.6	13.5 (1.9–97.9)	
High	252 (26)	14.6	21.0	30.3 (4.2–220.3)	

Yates et al , IJROBP: 2012; 82 (5): 2093-2103

Criticità:

- Studio retrospettivo
- Periodo di arruolamento troppo lungo
- Chemioterapia adiuvante (CMF 37%)
- OT solo 6% prima del 1985 vs 79% dopo il 1985
- Tasso di recidiva tende a diminuire nel tempo

Yates et al , IJROBP: 2012; 82 (5): 2093-2103

Original article

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Postoperative periclavicular radiotherapy in breast cancer patients with 1–3 positive axillary lymph nodes

Outcome and morbidity

Tab. 2 Sites of failure for patients with (*PCLNI*) or without periclavicular lymph node irradiation (*noPCLNI*)

Site of relapse	noPCLNI (n = 168) (n, %)	PCLNI (n = 67) (n, %)	p value
Local	15 (8.9)	7 (10.4)	0.718
Contralateral	8 (4.8)	1 (1.5)	0.238
Axillary	6 (3.6)	3 (4.5)	0.744
Periclavicular	2 (1.2)	2 (3.0)	0.337
Distant	29 (17.3)	12 (17.9)	0.906

Biancosino et al , Strahlenther Oncol: 2012; 188: 417-423

Criticità:

- Studio retrospettivo
- 1+ criterio di esclusione a RTSC
- ECE

Elementi di interesse:

- Tossicità trascurabile

Biancosino et al , Strahlenther Oncol: 2012; 188: 417-423

Curr Oncol, Vol. 19, pp. e319-328; doi: http://dx.doi.org/10.3747/co.19.1038

ORIGINAL ARTICLE

Evaluating the efficacy of current clinical practice of adjuvant chemotherapy in postmenopausal women with early-stage, estrogen or progesterone receptor–positive, one to three positive axillary

Breast surg					72
Breast-c					86
Mastect					
Unknow					
Radiothera					99
Endocrine					43
Tamoxi	07 (85.6)	81 (56.6)	64 (43.5)	<0.0001	<0.0001
AIS + tamoxifen	9 (7.2)	51 (35.7)	25 (17)		
AIS	9 (7.2)	11 (7.7)	58 (39.5)		
Adjuvant chemotherapy[b] [*n* (%)]	44 (28.2)	103 (64)	111 (64.9)	<0.0001	0.85
Non-anthracycline-based	32 (72.7)	30 (29.1)	24 (21.6)	<.0001	<.0001
Anthracycline-based	8 (18.2)	66 (64.1)	51 (46)		
Combination taxane–anthracycline	2 (4.5)	4 (3.9)	32 (28.8)		
Unknown	2 (4.5)	3 (2.9)	4 (3.6)		

Fattori di rischio per recidiva locoregionale

Post mastectomy radiotherapy in one to three lymph node positive breast cancer

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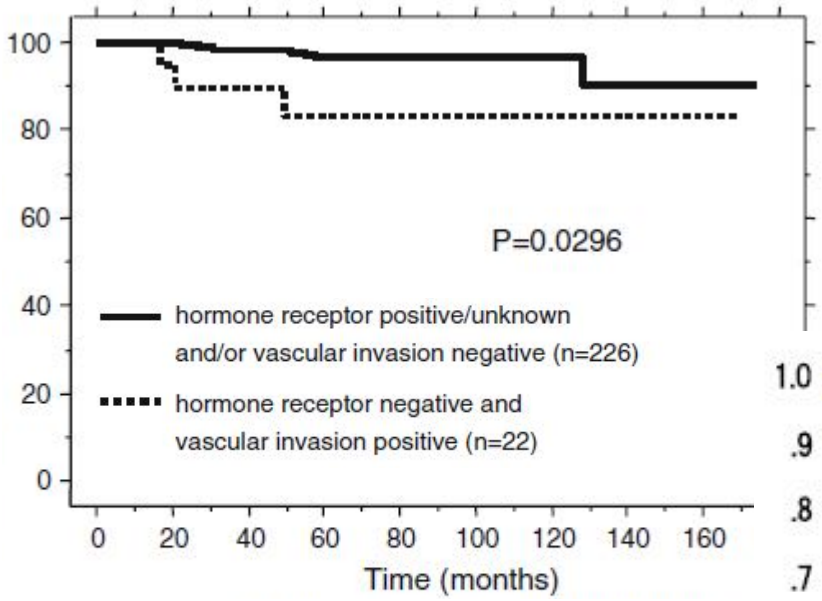
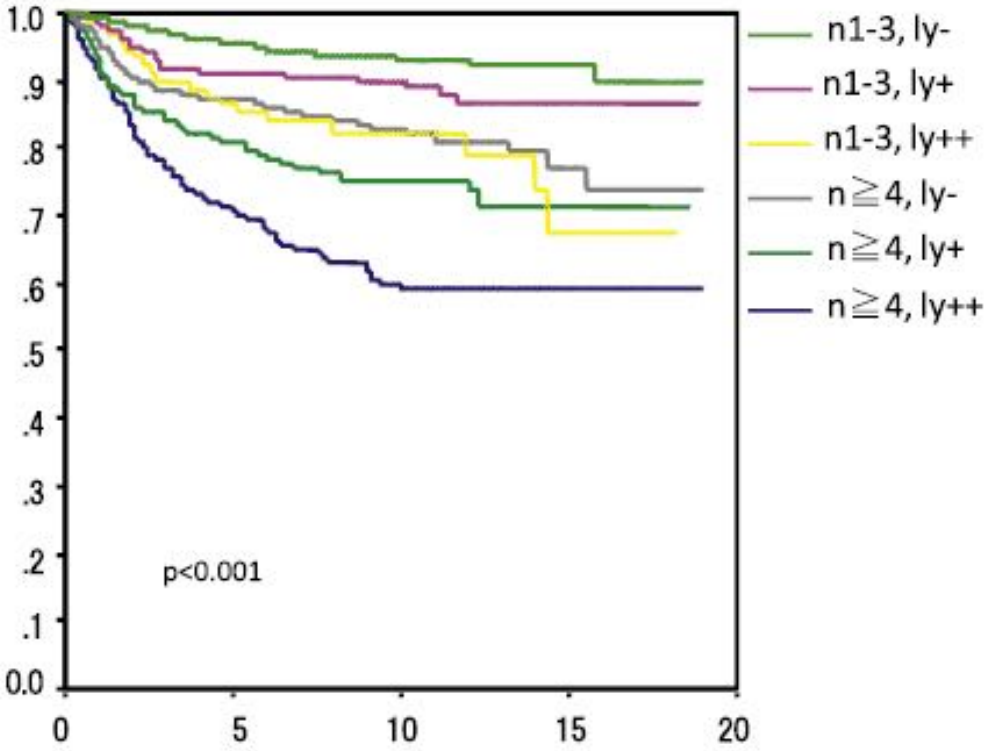
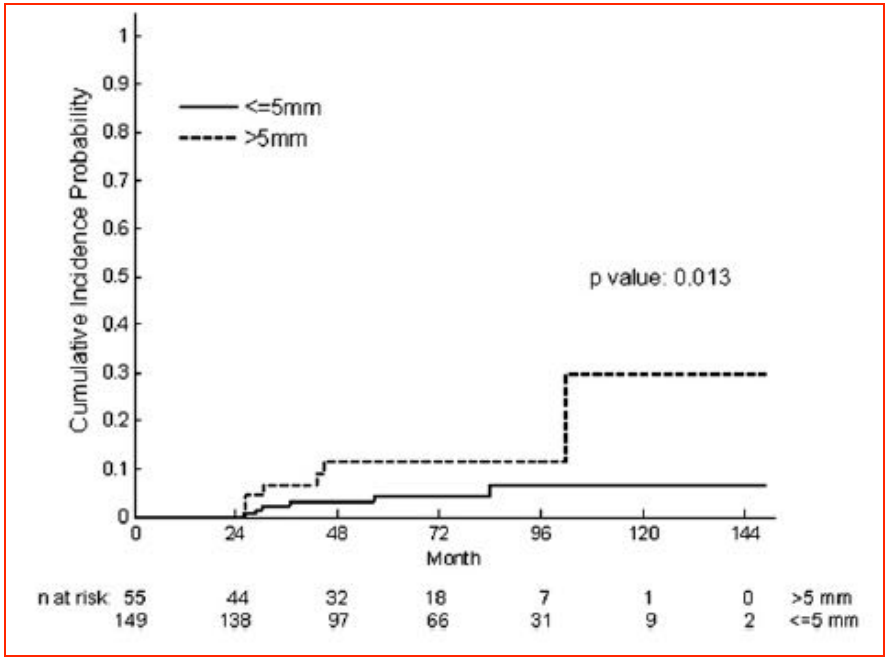
Do any risk factors predict benefit from local radiotherapy in patients with one to three nodes?

Autori	Fattori di rischio
Ragaz, JNCI 2005.	Age, >25 % N+, ER-.
Shang, IJROBP 2010.	G, ER-, LVI, No RT.
Truong, IJROBP 2007.	NR>0.2,
Kyndi, RO 2009.	N+, T, G, ER-

Recettori-
+
Invasione linfovascolare







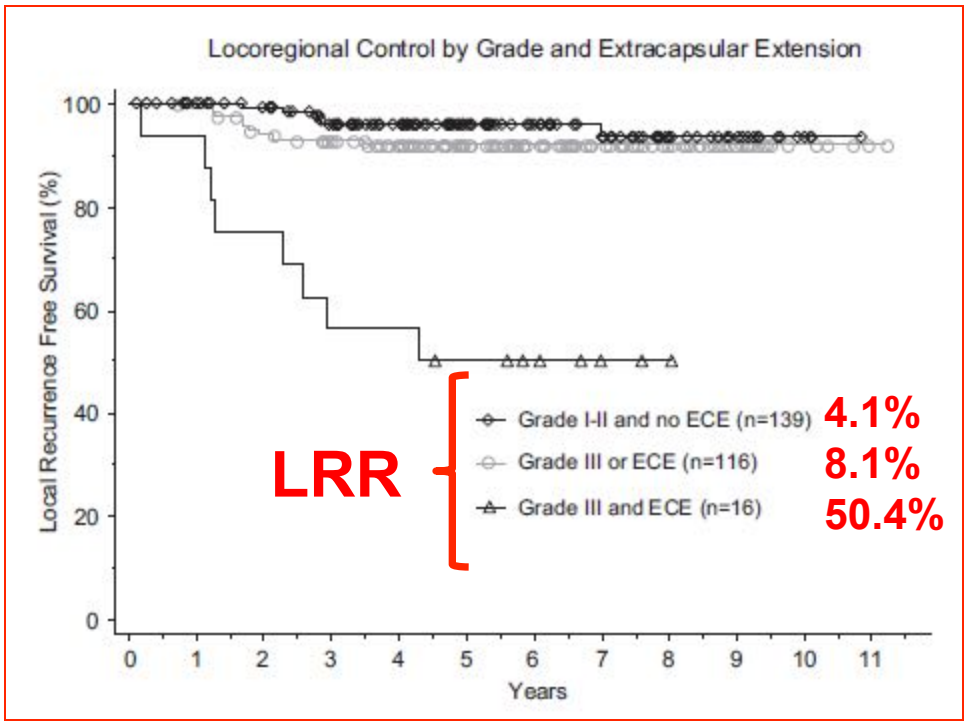
>10 mm **16%**

Potenziamento delle anatomie patologiche

Criticità:

- Studio retrospettivo
- Follow-up 5 anni e piccolo numero di pazienti

IJROBP: 2012; (in press)



Potenziamento delle anatomie patologiche

IJROBP: 2012; 83(5):e577-e581

Table 2 Univariate Cox proportional hazard regression analysis for locoregional recurrences in patients who did not receive radiation therapy ($n = 271$)

Variable	Hazard ratio (95% CI)	*P* value
Age (y)		
<50	0.80 (0.33-1.94)	.62
≥50		
ER/PR status		
Both negative	2.60 (1.10-6.12)	**.03**
Either positive		
Lymphovascular invasion		
Present	2.36 (1.033-5.37)	**.04**
Absent		
Number of positive lymph nodes		
2-3	2.59 (1.12-5.99)	**.03**
1		
Extracapsular extension		
Present	3.72 (1.63-8.48)	**.002**
Absent		
Microscopic vs absent	4.21 (1.60-11.09)	**.004**
Gross vs absent	3.16 (1.03-9.70)	**.04**
Tumor size (cm)		
>2	1.92 (0.83-4.44)	.13
≤2		
Bloom-Richardson grade		
3	3.14 (1.33-7.41)	**.009**
1-2		
Surgical margin		
Negative	1.08 (0.25-4.62)	.92
Positive/close		
Menopause		
Pre/peri	1.05 (0.45-2.46)	.91
Post		
Percent of positive lymph nodes		
>25%	2.73 (1.16-6.46)	**.02**
≤25%		

Abbreviations: CI = confidence interval; ER = estrogen receptor; PR = progesterone receptor.
Values in bold are statistically significant.

0-1 risk factor → LRR 3.4%
≥ 2 risk factors → LRR 14.6%

IJROBP: 2012; 83(5):e577-e581

Breast Cancer
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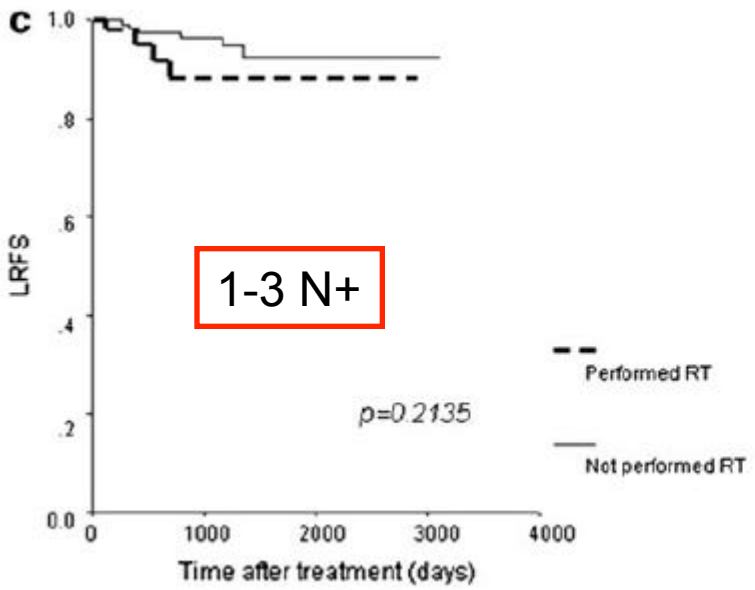
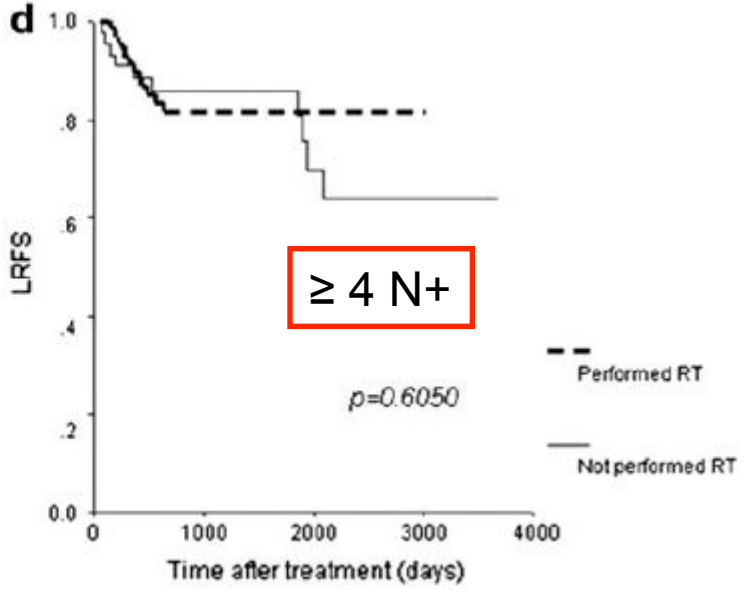
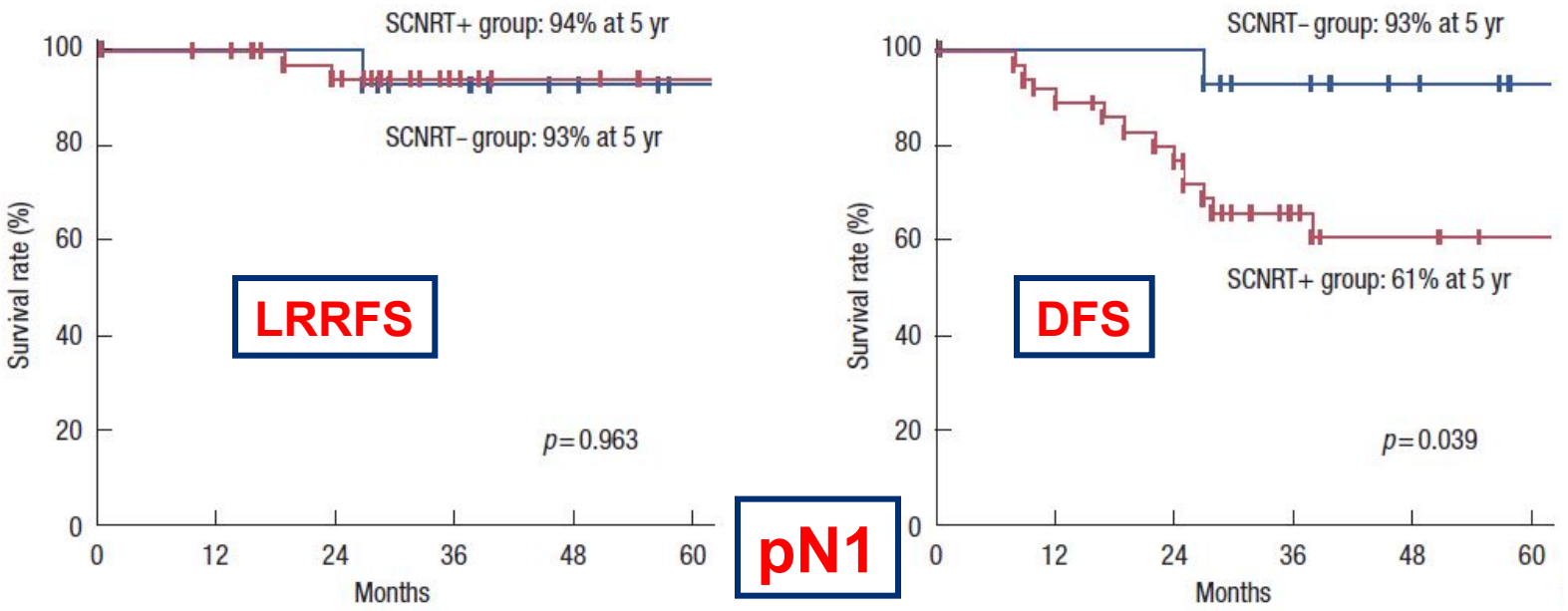
Locoregional recurrence risk factors and the impact of postmastectomy radiotherapy on patients with tumors 5 cm or larger

Tomoya Nagao · Takayuki Kinoshita · Nobuko Tamura · Takashi Hojo · Madoka Morota · Yoshikazu Kagami







Criticità:

◎ peggiore DFS dopo NAC perché T3-T4

Il dato 1-3 vs >3 E' ARBITRARIO!!!! Proviene dal vecchio studio di Fisher con chemioterapia non adeguata!!

I "chemioterapisti" si pongono il problema del numero di linfonodi positivi? NO, non gliene frega nulla!!!!

Molti dati provengono da studi retrospettivi su RT postmastectomia e sulle conoscenza dei dati di recidiva loco regionale dopo terapia conservativa e dissezione ascellare

L'MA20 ci potrà dire qualcosa sulla chirurgia conservativa (lo studio è chiuso ma i risultati ancora non sono riportati)

CAN-NCIC-MA20 – ClinicalTrials Group
Phase III RandomisedStudy

	WBI	WBI + RNI	HR	p
Loco-regional relapse	48	29		
At 5 years isolated LR DFS	94.5%	96.8%	0.59	0.02
Distant metastases	116	77		
At 5 years distant DFS	87%	92.4%	0.64	0.002
Total relapse	144	102		
At 5 years DFS	84%	89.7%	0.68	0.003
Deaths	96	74		
At 5 years overall survival	90.7%	92.3%	0.76	0.07

Per i risultati riguardanti il controllo loco regionale e l'impatto sulla sopravvivenza della RT infra-sopraclaveare con 1-3 N+ BISOGNA AVERE PAZIENZA poiché si possono valutare solo a 10-15 anni di follow-up.

E’ prudente prendere in considerazione RT su apice ascella sovraclaveare in caso di più fattori prognostici negativi: T grosso, Triple negative, N con ECE, Nodal ratio, G3, età?, invasione linfovascolare, etc. vista anche la ormai forte evidenza di scarsa-nulla tossicità significativa dopo RT.


BOLOGNA