BREAST CANCER IN BABYLON: PROGNOSTIC INDEX AND EVALUATION OF TREATMENT RESULTS

Sharif Fadhil A. Al-Alawchi & Ali Hassan Al-Timimi

Abstract

Breast cancer is the most common malignancy in females all over the world. It represents about 34% of total malignancies among Iraqi females with high mortality rate representing 1-2% of female mortality and 16% of cancer deaths in females in Iraq. Many prognostic factors which can affect the treatment outcome have been studied to identify patients at high risk of disease relapse who might benefit from post-operative adjuvant therapy. The aim of this study was evaluation of different prognostic factors to drive a reliable (Prognostic Index) that best fits our breast cancer patients, hoping to give the adjuvant treatment accordingly. This is a study analysis of 566 female patient treated for primary breast cancer between 1992 and 2001 at Oncology Unit, Marjan teaching Hospital. Modified prognostic index (PI) was used to identify different prognostic groups. We could divide patients into 4 groups: Group 1 with PI<2.5, group 2 with PI>2.5-3, group 3 with PI>3-3.5 and group 4 with PI>3.5. The 5 year overall survival (OS) and relapse free survival (RFS) were calculated for the whole group and for the different 4 prognostic groups as well as for influence of systemic adjuvant treatment. The 5 year OS and RFS were 75% and 55% respectively for patient with PI<2.5 and decreased with the increase of the value of PI to reach 50% and 10% respectively in patients with PI>3.5. The difference in both 5 year OS, RFS for different prognostic groups was found statistically significant only between patients with PI<3. (Groups 1 & 2) and those with PI>3. (Groups 3 & 4) with P<0.001. It was shown those patients with PI<3 could benefit from the addition of adjuvant systemic treatment with better 5 year RFS of 60% in comparison to 40% for patients who did not receive adjuvant systemic treatment (P=0.01). Minimal benefit was obtained in patients with PI>3. It was concluded that more intensive adjuvant treatment may be warranted for group 3 and 4 of patients.

Introduction

Breast cancer is the most common malignancy in females all over the world. It represents about 34% of total malignancies among Iraqi females with high mortality rate representing 1-2% of female mortality and 16% of cancer deaths in females in Iraq. Many prognostic factors that can affect the treatment outcome have been studied to identify patients at high risk of disease...
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relapse who might benefit from post-operative adjuvant therapy. The most important factors are tumour size, lymph node status, pathological grade, age of menstrual status and estrogen receptor status.

A modified prognostic index has been calculated by Todd et al. for group of patients with longer follow – up period (minimum 6 year). Also it has been applied prospectively to a further group of 320 patients of 320 patients and shown to be similarly effective in predicting the survival pattern in a group of patients treated by mastectomy.

This prognostic index helped in the selection of patients with excellent prognosis in whom adjuvant therapy was inappropriate and patients with high index score who may benefit from local or systemic adjuvant therapies.

Three prognostic factors were identified by Brown et al. after the study of 1186 patients from 8 centers in Yorkshire Breast Cancer Group, (YBCG). An index had been derived which is a modified of Nottingham PI.

YBCGI = 0.1 x Clinical tumor size (cm.) + 0.5 x grade + 0.6 x nodal involvement.

The coding for the various prognostic factors in NPI and YBCGI was as follows:

<table>
<thead>
<tr>
<th>YBCGI</th>
<th>N.PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumour size</td>
<td>Clinical (cm.)</td>
</tr>
<tr>
<td>Lymph node involvement</td>
<td>1 = no</td>
</tr>
<tr>
<td></td>
<td>2= tumour present, low axillary</td>
</tr>
<tr>
<td></td>
<td>3= yes</td>
</tr>
<tr>
<td>Tumour grade</td>
<td>1=I</td>
</tr>
<tr>
<td></td>
<td>2=II+III</td>
</tr>
<tr>
<td></td>
<td>3=III</td>
</tr>
</tbody>
</table>

Patients in YBCG were divided into 3 groups according to their index score, good (1<1.21), Moderate (1.21 < PI < 1.82) and poor (PI > 1.82). The 10 year O.S. was 65% for the good prognostic patients against 29% for the poor prognostic patients.

The aim of the present study was to evaluate different prognostic factors and to derive a reliable PI that best fits our breast cancer patients, hoping to give the adjuvant treatment accordingly. We also aimed to compare our P.I. with the NPI that was modified by Brown et al.

Patients and Methods

This is a clinical pathological analysis of 566 female patients with breast cancer treated at the Oncology Unit Merjan Teaching Hospital Babylon, in the period between 1992-2001. The patient’s files were reviewed for detailed information’s about age, menopausal status, stage, histopathological type and grade, lymph node status, clinical and pathological size of the tumours and treatment results.

All patients were treated by radical or modified radical mastectomy followed by comprehensive post-operative radiotherapy. The dose given was 45 Gy/20 fractions over 4 weeks (225 cGy/fraction) to chest wall and peripheral lymphatics using telecobalt-60 machine, similar to the technique used by Fletcher. Systemic adjuvant chemotherapy was given to 250 patients; 203 patients received CMF combination (Cyclophosphamide, 600 mg/m² day 1, Methotrexate 50 mg/m² day 1 and 5 Fluourouracil 600 mg/m² day) and 47 patients received FAC combination (5 Fluourouracil 600 mg/m² day 1, Adriamycin 40 mg/m² day 1 and Cyclophosphamide 600 mg/m² day 1). The course was repeated every 21 days for 6 courses.

All patients were followed-up regularly, 3 monthly for 2 years, 4 monthly for 5 more years and annually thereafter. The minimum follow-up period was 2 years and the maximum was 8 years.

Relapse free survival (RFS) and overall
Survival (OS) were calculated from the date of mastectomy to the date of relapse or last follow – up.

A trial of application of the prognostic index used by Brown et al. 1993 in the YBCG study was done with some modifications to suit our group of patients.

\[ P1 = 0.1 \times \text{pathological tumours size (cm.)} + 0.5 \times \text{grade} + 0.6 \times \text{L.N. status.} \]

As the majority of our patients had positive axillary lymph nodes and high grade tumours, the coding for the various prognostic factors were modified as follow:

<table>
<thead>
<tr>
<th>Tumours size</th>
<th>Pathological (cm.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No L.N.</td>
</tr>
<tr>
<td>2</td>
<td>1-3 + ve L.N.</td>
</tr>
<tr>
<td>3</td>
<td>4-7 + ve L.N.</td>
</tr>
<tr>
<td>4</td>
<td>&gt; 8+ ve L.N.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lymph nodes</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I + II</td>
</tr>
<tr>
<td>2</td>
<td>I + II</td>
</tr>
<tr>
<td>3</td>
<td>I + II</td>
</tr>
</tbody>
</table>

The patients in our study were then divided into groups according to the P1: good (P1 < 1.25) moderate (1.25 ≤ P1 < 1.75) and poor (P1 ≥ 1.75).

We noticed that the majority of our patients were allocated in the poor prognosis group with P1> 1.75. There was only 4 patients with P1, 1.25 and only 6 patients (17%) had P1 <1.75, the lowest index detected was 1.20 while the highest was 5.25. These results lead to the search for new cut off values before starting statistical analysis. These new cut off values were 2.5, 3 and 3.5 dividing the sample into 4 groups, each group included approximately one quarter of our sample:

<table>
<thead>
<tr>
<th>Group</th>
<th>Prognostic index value</th>
<th>Prognosis</th>
<th>No. of patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>≤2.5</td>
<td>Low</td>
<td>130</td>
<td>23%</td>
</tr>
<tr>
<td>2</td>
<td>≥2.5-3</td>
<td>Intermediate low</td>
<td>113</td>
<td>20%</td>
</tr>
<tr>
<td>3</td>
<td>&gt;3-3.5</td>
<td>Intermediate high</td>
<td>158</td>
<td>28%</td>
</tr>
<tr>
<td>4</td>
<td>&gt;3.5</td>
<td>High</td>
<td>165</td>
<td>29%</td>
</tr>
</tbody>
</table>

**Statistical methods**

All data were tabulated and statistically studied by descriptive analysis as well as survival analysis using the life test procedure (product limit survival estimates)\(^{21}\).

Comparisons between groups were performed using the long rank test. AP value 0.05 was considered significant.

The analysis was performed for the whole studied groups as well as different prognostic groups after application of PI. The OS and RFS were performed in correlation to different tumours size, L.N. status, grade as well as the use of adjuvant systemic treatment.

**Results**

The characteristics of the 566 patients included in the study are shown in Table I. Their ages ranges between 26 and 75 years with a median age of 43 years, 374 patients (66%) were premenopausal while 192 patients (34%) were postmenopausal.

Patients were staged according to TNM classification (UICC/AJCC). Ten patients (1.7%) had stage I disease, 204 patients (36%) had stage II, and the majority, and I, 351 patients (62%) has stage III disease.

Twenty eight patients (5%) had pathological T1 tumours, 255 patients (45%) had T2 tumours, while T3 was present in 187 patients (33%) and T4 in 96 patients (17%).

As regards axillary lymph nodes, 79 patients (14%) had negative lymph nodes while 487 patients (86%) had positive lymph node. Within the positive lymph node group, 153 patients (27%) had 1-3 positive node, 198 patients (35%) had from 4 to 7 positive nodes and 136 patients (24%) had more than 7 positive nodes.
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Median age 43 years
   Range 26-75

Menopausal status:
Premenopausal 374 66%
Postmenopausal 192 34%

Stage:
I 10 1.7%
II 204 36%
III 351 62%

Tumour size:
T1 <2cm. 28 5%
T2 >2-5cm. 255 45%
T3 >5 cm. 187 33%
T4 96 17%

Lymph node status:
Negative 79 14%
Positive 487 86%
1-3+ve 153 27%
4-7+ve 198 35%
>7+ve 136 24%

The majority of patients (90%) had invasive duct carcinoma, 14 patients (2.4%) had grade I tumours, 434 (76.6%) had grade II tumours and 119 patients (21%) had grade III tumours.

The 5 years OS and RFS for all patients were 75% and 55% respectively. Locoregional relapse occurred in 20 patients (3.5%), distant relapse in 303 patients (53.5%) while 243 patients (43%) had both locoregional and distant relapses.

The majority of relapses were observed in the first 2 years postoperatively with gradual decrease in the incidence thereafter. Bone metastasis was the commonest site of distal relapse and was observed in 311 patients (55%) followed by lung metastasis in 142 patients (25%). Other sites of distant metastases included liver, brain, pleura, contralateral breast and axilla.

The effect of adjuvant systemic treatment was studied in relation to PI. There has been better 5 year RFS for those patients who received adjuvant treatment only in the group of patients with PIs ≤ 3.2 (36% and 46% respectively with p=0.017). The 5 year RFS for patients who received adjuvant treatment with PI > 3.2 was 16% which is nearly similar to 15% for those who did not receive treatment.

Discussion

In the present study of 566 patients with breast cancer, the median age was 43 years, which is younger than Western series where the median age was reported to be 54 years. The frequency of T1 tumours in the present study was 4% only. This finding differs from that reported in western series as T1 constitute about 30% of cases. The majority of our patients presented with T2 tumours (44%) which is similar to western series. T3 and T4 tumours constitute about 35% and 17% of our patients respectively. The frequency is higher than 20% and 5% reported in western series.

The majority of patients in the present study had positive axillary lymph nodes (90%). About 64% of patients had 4 or more positive nodes. These figures are different from western series where the incidence of positive lymph nodes was reported to be about 45% with low incidence of 4 or more positive lymph nodes about 17%. These findings show that our patients presented in more advanced stage than western series. The most frequent pathological type in this study was invasive duct carcinoma (88%), which is similar to most western series. Grade I tumour was recorded in 2.5% of our patients. This frequency is considered very low compared to about 30% reported in western series. The majority of our patients had grade 2 tumour (74%). Grade III was recorded in 23.5% of our patients, which is similar to most reported series.

Locoregional relapse occurred in 18% of patients, the majority within the 1st 3
years after treatment. Chest wall relapse constituted 85% of locoregional relapse while axillary recurrence was found in 10.4% of patients. The incidence of locoregional recurrence in our study is similar to that reported in Person reported series. Mitchell et al reported 5 years locoregional relapse in 10% of patients.

Distant relapse occurred in 69% of the study group. This high percentage of distant relapses in comparison to western series can be explained by the fact that 90% of our patients had positive axillary lymph node and 52% had T3 and T4 tumours. Kaufann et al showed that only 20-25% of patients with negative lymph node had distant relapse 10 years after treatment while 75% of those patients with positive axillary lymph node had distant relapse.

The 5-year OS for whole group was 75% while 5 year RFS was 55%. The 5 year OS reported to be 80%, in western series. The low value of OS in our study may be explained by the prevalence of more advanced stage that in western series.

Prediction of the patients with breast cancer had been tried by Haybittle et al, they introduced the prognostic index concept (NPI) which is a reflection of tumour size, lymph node status and grade. Brown et al modified the NPI to suit best their materials. They divided patients depending on PI (YB-CG) into three groups good prognosis (I<1.21), intermediate prognosis (I>1.21 -1.82) and poor group (I≥1.82) with 5-year OS of 84% and 47% respectively.

Reviewing our available materials led us to introduce some modification to suit best our patients. In our modified PI, we used pathological rather than clinical tumour size because we think it is more accurate. Grade was recorded as 1 and 2 versus 3 as the incidence of grade 1 in our patients was very low. As the majority of our patients had positive lymph nodes, nodal status was coded as 1 for negative lymph nodes, 2 for 1-3 positive lymph nodes, 3 for 4-7 positive nodes and 4 for more than 8 positive nodes. Thus new cuts off values (2.5-3-3.5) were tested statistically to separate groups of patients with different survival.

Statistical analysis of patients with PI≤ 3 compared to those >3 showed difference in 5 years OS and RFS which was statistically highly significant (p≤0.001). Thus, our PI succeeded in dividing the patients into two main groups with different prognosis.

There had been better RFT for patients who received than for those who did not receive adjuvant systemic treatment. This difference was more significant for the patients PI≤ 3 (p=0.017). These results suggest that patient with PI≥ 3 probably need more intensive adjuvant therapy than those with PI≤3. This is in agreement of most reported series who use intensive chemotherapy for those high risk patients. Further validation of the PI in a randomised prospective study should be considered for proper evaluation of its value and addition of other prognostic factors.

Conclusion

We may conclude from the present study that our patients with breast cancer present with advanced stage so the results of treatment were inferior to that reported in western series. Using PI we succeeded in dividing patients into two main groups. The prognosis of patients PI> 3 in poorer than those patients with PI≤3. More intensive adjuvant systemic treatment should be considered for patients with PI>3.
References

