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PROSPECTIVE RANDOMIZED STUDY OF BROMOERGOCRYPTIN (B) IN PATIENTS WITH METASTATIC BREAST CANCER: RESULTS FROM THE X/82 MULTICENTER TRIAL. D. Fritze, W. QueiBer, G. Hoffmann, H. Schmid, M. Kaufmann, J. Rüger, M. Westerhausen, K. Brunnert, R. Schmidt U. Abel, L. Edler

Until Jan. 85, 92 patients with metastatic breast cancer were entered in this trial. 86 patients are eligible for final analysis. All patients were stratified according to prolactin plasma level. Hyperprolactinemic patients (prolactin > 50 ng/ml 1/2 hour after i.v. injection of 200 µg TRH) were randomized to receive VAC/FMC chemotherapy with or without B (10 mg daily orally). Normoprolactinemic patients (prolactin < 50 ng/ml) were stratified according to hormone receptor status of the tumor and disease free interval (DFI). "low risk" patients (ER+, DFI > 30 mon.) were treated with high dose Medroxyprogesteronacetate (MAP) or VAC/FMC chemotherapy. "high risk" patients (ER+, DFI < 30 mon.) were randomized to receive VAC/FMC chemotherapy with or without high dose MAP. **Results:** 31 patients were hyperprolactinemic, 57 normoprolactinemic. Of the latter, 44 patients were classified as "high risks" and 13 patients as "low risks". Complete and partial remission, duration of response and survival are almost identical in hyperprolactinemic patients with and without B (median survival 11.7 vs 13.2 mon.). However, patients with normal plasma prolactin and "low risk" metastatic disease enjoyed significant longer survival than all other patients (and subgroups) regardless of type of treatment (median 22 mon.). **Conclusions:** The results suggest that treatment with Bromoergocryptin normalizes elevated plasma prolactin but does not improve prognosis. Tumorzentrum Heidelberg/Wannheim/Darmstadt, Med. Klinik V, Grafenstr. 9, 6100 Darmstadt

**Bre 52**

TUMORECTOMY IN THE TREATMENT OF BREAST CANCER: A LONG TERM FOLLOW-UP STUDY (1963 - 1982)  
T. Genz

Between 1963 and 1982, 1,139 patients underwent surgery for unilateral mammary malignoma at the Charlottenburg Gynaecological Clinic of the Free University Berlin. Primary therapy consisted of simple mastectomy in 948 cases and extended tumorectomy with subsequent radiotherapy (40 Gy) in 191 cases. We performed a retrospective analysis of 'matched samples' of tumorectomy and mastectomy. The observation period of both groups spans a minimum of 2 years to a maximum of 20 years after primary operation.

In pT 1-tumors the overall survival after tumorectomy at 5, 10 and 15 years was no worse than after total breast removal: A total of 88 per cent of women treated with tumorectomy survived at five years, as compared with 86 per cent treated with mastectomy (84 % and 76 % at ten years, 61 % and 63 % at fifteen years). There is a tendency of better survival prognosis in patients with pT 2-tumors after tumorectomy. The results of our long term follow-up study lead us to conclude that tumorectomy and breast irradiation are suitable for the primary treatment of mammary cancer.

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**Bre 53**

CHANGES IN THE PRIMARY TREATMENT OF BREAST CANCER FROM 1976-1984  
H.v. Matthiessen, O. Fishedick, H. Willems

During the last decade, primary treatment of breast cancer was influenced by the results of many studies. The question we wanted to address was, with which delay new therapeutic modalities are accepted in our hospitals. Are there differences in the acceptance between greater or smaller hospitals and how important is the size of the city, in which the therapy is done. Therefore the data of the stage at diagnosis and primary treatment were collected from 2420 pats. and evaluated according to three different time periods as well as different sizes of hospitals and cities. Tumorectomie increased from 1976 to 1984 in T1, N0, M0 patients from 1 to 8% and was practised more often in greater cities, while postoperative irradiation in these women decreased from 83% to 28%. Systemic adjuvant therapy was influenced by the size of the city and of the hospital: In towns with more than 380000 inhabitants 50% of T1-3, N+, M0 pats. younger than 66 years got a systemic adjuvant treatment, compared to 16% in cities with less than 70000 inhabitants. According to the size of the hospital (<380, 380-530, >530 beds) the rates of adjuvant systemic treatment were 24, 52 and 38%. **Conclusion:** Surgical and adjuvant treatment of primary breast cancer has changed significantly during the last decade. Regarding the primary treatment of breast cancer in 1984, the type of therapy is strongly influenced by the size of the town and the hospital.

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PROGNOSTIC SIGNIFICANCE OF LOCOREGIONAL RECURRENCE IN BREAST CANCER

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89 patients were examined who first developed locoregional recurrences without distant metastases after excision of the primary tumor by modified radical mastectomy combined with axillary dissection and adjuvant CMF-therapy in node positive disease. The mean observation time was 46 months. The sides of locoregional recurrences were: ipsilateral chest wall in 50 (56%) cases, supraclavicular or parasternal region in 15 (17%) cases, and simultaneous affections of both sides in 11 (12%) cases. The analysis of 5-years survival probabilities gave the following results: 42% in the total group. 73% in cases who developed locoregional metastases only during the observation period. 72% in patients with multiple locoregional metastases emerging subsequently without distant metastases during the analysis. 59% in patients whose locoregional metastases could be eradicated completely. 35% when removal of metastases was feasible only partially. 23% when distant metastases appeared after treatment of the initial locoregional failure. The mean disease free survival (DFS) turned out to be influenced by the following 2 determinants: Hormonal receptor status of the primary tumor: DFS being 20 months in receptor positive tumors and 10 months in negative tumors. Side of recurrence: DFS being 30 months in cases with axillary metastases, 23 months in chest wall recurrences, and 11 months if both sides were affected simultaneously.

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