

**Table 4** Predictive variables for QpCR by univariate analysis

Variables	QpCR	Non-QpCR	<i>p</i> value
<b>Study</b>			
JBCRG-01	47 (25.3 %*)	139	0.43
JBCRG-02	13 (35.1 %)	24	
JBCRG-03	38 (29.2 %)	92	
<b>Median age (range)</b>			
Tumor size	47.5 (29–60)	46 (24–62)	0.57
≤3 cm	43 (26.6 %)	103	0.55
>3 cm	55 (29.5 %)	152	
<b>Nuclear grade</b>			
Grade 3	25 (32.9 %)	51	0.18
Grade 2, 1	42 (24.6 %)	129	
<b>Subtype</b>			
Luminal	32 (15.5 %)	174	<0.001
Luminal/Her2-positive	14 (41.2 %)	20	
Her2-positive	21 (52.5 %)	19	
Triple-negative	42 (42.5 %)	42	
<b>Clinical response (response rate)</b>			
After the first half of NAC			
SD, PD	29 (20.9 %)	145	0.018
CR, PD	69 (32.2 %)	110	
Before surgery			
SD, PD	15 (16.9 %)	74	0.023
CR, PD	82 (31.4 %)	179	

CR complete response, NAC neoadjuvant chemotherapy, PD progressive disease, PR partial response, pCR pathologic complete response, SD stable disease

\* QpCR rate

**Table 5** Predictive variables for QpCR by logistic regression analysis

Variables	OR	95 % CI	<i>p</i> value
<b>Study</b>			
JBCRG-02	2.11	0.87–5.05	0.10
JBCRG-03	1.22	0.69–2.17	0.50
Age	1.01	0.97–1.04	0.65
<b>Tumor size</b>			
>3 cm	0.68	0.39–1.20	0.19
<b>Nuclear grade</b>			
Grade 3	0.70	0.33–1.42	0.32
<b>Subtype</b>			
Luminal/Her2-positive	4.15	1.75–9.86	0.002
Her2-positive	6.24	2.76–14.48	<0.001
Triple-negative	4.24	2.14–8.54	<0.001
<b>Clinical response (CR, PR)</b>			
After the first half of NAC	1.35	0.74–2.50	0.32
Before surgery	2.41	1.15–5.27	0.019

CI confidence interval, CR complete response, NAC neoadjuvant chemotherapy, OR odds ratio, PR partial response

sequential FEC and DOC regimens as NAC. The QpCR rate was high in patients with luminal/Her2-positive, Her2-positive, and TN tumors as compared to luminal tumors; however, the survival of patients with TN tumors was inferior. This study underscores the significance of a subtype-based, individualized approach for NAC.

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## Randomized trial of preoperative docetaxel with or without capecitabine after 4 cycles of 5-fluorouracil–epirubicin–cyclophosphamide (FEC) in early-stage breast cancer: exploratory analyses identify Ki67 as a predictive biomarker for response to neoadjuvant chemotherapy

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**Abstract** This randomized, multicenter study compared the efficacy of docetaxel with or without capecitabine following fluorouracil/epirubicin/cyclophosphamide (FEC) therapy in operable breast cancer and investigated the role of Ki67 as a predictive biomarker. Patients were randomized to 4 cycles of docetaxel/capecitabine (docetaxel: 75 mg/m<sup>2</sup> on day 1; capecitabine: 1,650 mg/m<sup>2</sup> on days 1–14 every 3 weeks) or docetaxel alone (75 mg/m<sup>2</sup> on day 1 every 3 weeks) after completion of 4 cycles of FEC (5-fluorouracil 500 mg/m<sup>2</sup>, epirubicin 100 mg/m<sup>2</sup> and cyclophosphamide 500 mg/m<sup>2</sup> on day 1 every 3 weeks). The primary endpoint was the pathological complete response

(pCR) rate. Predictive factor analysis was conducted using clinicopathological markers, including hormone receptors and Ki67 labeling index (Ki67LI). A total of 477 patients were randomized; the overall response in the docetaxel/capecitabine and docetaxel groups was 88.3 and 87.4 %, respectively. There were no significant differences in the pCR rate (docetaxel/capecitabine: 23 %; docetaxel: 24 %;  $p = 0.748$ ), disease-free survival, or overall survival. However, patients with mid-range Ki67LI (10–20 %) showed a trend towards improved pCR rate with docetaxel/capecitabine compared to docetaxel alone. Furthermore, multivariate logistic regression analysis showed pre-treatment Ki67LI (odds ratio 1.031; 95 % CI 1.014–1.048;  $p = 0.0004$ ) to be a significant predictor of pCR in this neoadjuvant treatment setting. Docetaxel/capecitabine

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(after 4 cycles of FEC) did not generate significant improvement in pCR compared to docetaxel alone. However, exploratory analyses suggested that assessment of pre-treatment Ki67LI may be a useful tool in the identification of responders to preoperative docetaxel/capecitabine in early-stage breast cancer.

**Keywords** Breast cancer · Neoadjuvant chemotherapy · Ki67 · Capecitabine · Pathological complete response · Docetaxel

## Introduction

Neoadjuvant chemotherapy has become increasingly significant in the treatment of operable early-stage breast cancer, with the advantage of the potential to downgrade tumors and increase the rate of breast conserving surgery (BCS) in patients that may have otherwise required a mastectomy [1]. Results from the National Surgical Adjuvant Breast and Bowel Project (NSABP) protocol B-18 trial demonstrated an increased likelihood in BCS in breast cancer patients treated with a neoadjuvant anthracycline-based regimen [1]. Although the B-18 trial did not demonstrate a survival advantage in patients treated with preoperative chemotherapy, it established pathological complete response (pCR) as a prognostic marker for disease-free survival (DFS). Indeed, pCR after neoadjuvant chemotherapy is considered a marker for favorable prognosis in breast cancer patients [2].

As such, clinical and molecular biomarkers capable of predicting pCR have been assessed following neoadjuvant treatment in breast cancer patients [3, 4]. In particular, the

proliferation marker Ki67 has been reported to have predictive and prognostic value in patients with invasive breast cancer who received a range of neoadjuvant chemotherapy regimens, including anthracycline-based regimens without taxanes and anthracycline and taxane-based protocols [5].

While neoadjuvant treatment with anthracycline-based regimens is highly effective in the treatment of breast cancer, the sequential addition of a taxane to an anthracycline-based neoadjuvant regimen has been demonstrated to induce additive efficacy. In the NSABP B-27 trial, the sequential addition of docetaxel after doxorubicin and cyclophosphamide (AC) therapy doubled the rate of pCR, increased clinical response and increased the proportion of negative axillary nodes in early breast cancer patients [6]. In addition, 5-fluorouracil–epirubicin and cyclophosphamide (FEC) followed by docetaxel as neoadjuvant chemotherapy in the Japan Breast Cancer Research Group (JBCRG) 01 trial resulted in a pCR rate of 16 % with BCS possible for 85 % of the patients assessed [7].

In addition to inducing increased efficacy with anthracyclines, docetaxel has demonstrated significant synergy with the oral prodrug capecitabine [8]. Capecitabine is converted to 5-fluorouracil in a three-step process catalyzed by thymidine phosphorylase (TP) [9] and exhibits tumor specificity by exploiting the significantly higher activity of TP in tumor tissue in comparison to healthy tissue [8, 9]. Docetaxel has been demonstrated to upregulate TP expression in tumor tissues, possibly accounting for the synergistic effect observed with capecitabine [8]. Clinical studies have shown that single-agent capecitabine was an active and tolerable treatment for metastatic breast cancer (MBC) with disease progression during and after anthracycline and

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taxane therapy, achieving response rates of 20–29 % and a median survival in excess of 1 year [10, 11].

On the basis of these findings, the docetaxel/capecitabine regimen has been demonstrated to be well tolerated and effective for neoadjuvant treatment of stage II/III or locally advanced breast cancer [12–14]. Another study by O'Shaughnessy and colleagues also demonstrated a superior clinical response and survival outcome when the docetaxel/capecitabine regimen was compared with docetaxel alone in women with anthracycline-pretreated MBC [15]. However, these studies [12–15] did not undertake analyses to identify the tumor characteristics that define patients likely to respond to neoadjuvant docetaxel/capecitabine treatment.

Our randomized trial compared the efficacy of preoperative FEC followed by docetaxel with or without capecitabine in patients with early-stage breast cancer and assessed biomarkers that may be used to identify responders, in order to establish individualized treatment regimens.

## Patients and methods

### Study design

This multicenter, randomized, open study compared the efficacy of 4 cycles of FEC followed by 4 cycles of docetaxel and capecitabine or 4 cycles of docetaxel alone as neoadjuvant chemotherapy in patients with operable breast cancer. The study was approved by the Institutional Review Board of the Organisation of Oncology and Translational Research and conducted according to the Declaration of Helsinki. The primary endpoint was the pCR rate; secondary endpoints included toxicity, clinical response, frequency of breast and axillary lymph node conservation surgery, DFS, and overall survival (OS).

### Patient eligibility

Women (20–70 years) with histologically confirmed operable invasive breast adenocarcinoma (T1C-3, N0, M0 (>1 cm)/T1-3, N1, M0) were eligible. In women without clinically suspicious axillary adenopathy, the primary breast tumor had to be >1 cm in diameter; patients with clinically suspicious axillary adenopathy could present with a primary tumor of any size (in accordance with cancer staging as per the American Joint Committee on Cancer).

Inclusion criteria were as follows: no prior treatment for breast cancer, Eastern Cooperative Oncology Group performance status of 0–1, white blood cell count >4,000–12,000 mm<sup>3</sup> or neutrophil count >2,000 mm<sup>3</sup>, platelets >100,000 mm<sup>3</sup>, hemoglobin >9.5 g/dL, bilirubin <1.25 × institutional upper limit of normal (ULN), creatinine <1.5 × institutional ULN, creatinine clearance >30 mL/

min, aspartate aminotransferase and alanine aminotransferase <1.5 × institutional ULN, a normal electrocardiogram for cardiac function, and left ventricular ejection fraction of >60 %.

Exclusion criteria included uncontrolled medical conditions, significant interstitial pneumonia or pulmonary fibrosis, suspected of infection with fever, symptomatic varicella, required treatment for pleural or pericardial effusions, severe edema, severe peripheral neuropathy, required steroid pre-treatment, severe psychiatric disorders, inflammatory breast cancer, bilateral cancer (if both tumors were within the inclusion criteria, bilateral cancer was not excluded), and a history of other malignancies within the last 5 years (except for adequately treated non-melanoma skin cancer or carcinoma in situ of the cervix).

### Study treatment

Patients were scheduled to receive 4 cycles of intravenous FEC (5-fluorouracil 500 mg/m<sup>2</sup>, epirubicin 100 mg/m<sup>2</sup>, cyclophosphamide 500 mg/m<sup>2</sup>) on day 1 every 3 weeks. Patients who completed 4 FEC cycles were randomly assigned to receive either 4 cycles of docetaxel (75 mg/m<sup>2</sup>, on day 1) plus capecitabine (825 mg/m<sup>2</sup> twice daily on days 1–14) or 4 cycles of docetaxel alone (75 mg/m<sup>2</sup>, on day 1) every 3 weeks. For patients with a creatinine clearance of 30–50 mL/min, the initial dose of capecitabine was reduced to 75 % of the planned dose. Patients with disease progression while on FEC were excluded from randomization. A maximum 25 % dose reduction and 3-week dose delay were permitted for adverse events. Whereas a 75 % dose level was used as the initial dose for patients with low creatinine clearance, a further 25 % dose reduction was permitted for adverse events. Treatment prior to docetaxel comprised dexamethasone (8 mg oral; administered the morning and night before docetaxel). In addition, dexamethasone (10 mg intravenous) was administered 30 min before docetaxel. If a patient missed the 8 mg oral dexamethasone, the 10 mg intravenous dose was still administered and docetaxel administration occurred as planned. Primary surgery was undertaken within 3–6 weeks of neoadjuvant chemotherapy completion. Supportive care and postoperative endocrine or radiation therapy were administered at the investigator's discretion. No patients received trastuzumab before surgery, as it was not approved in Japan at the time of the study.

### Study assessments

Pre-enrolment assessments included medical history, physical examination, blood chemistry, bilateral mammogram, bone and computed tomography scans. Initial diagnosis of invasive adenocarcinoma was made by core needle biopsy.

Estrogen receptor (ER) and progesterone receptor (PgR) status were confirmed by immunohistochemistry (IHC) before randomization. Human epidermal growth factor receptor 2 (HER2) status was confirmed by IHC or fluorescent in situ hybridization. For biomarker analysis, IHC was undertaken using a mouse anti-human TP monoclonal antibody (Chugai Pharmaceutical Co., Japan). TP immunoreactivity was detected in the cytoplasm of carcinoma cells and semi-quantitative evaluation was undertaken using >1,000 carcinoma cells in each case. Ki67 immunostaining was performed using MIB1 monoclonal antibody (Dako Co.Ltd.) as previously described [16]. Briefly, Ki67 was stained after overnight preparation using a 1:100 dilution of the antibody. Evaluation of Ki67 was performed by counting  $\geq 1,000$  carcinoma cells from each patient in the hot spots and the percentage of immunoreactivity was subsequently determined by a labelling index [17].

Clinicopathological assessments were undertaken at the central laboratory (Department of Anatomic Pathology, Tohoku University, Graduate School of Medicine, Japan). The clinical response was evaluated in accordance with the Response Evaluation Criteria In Solid Tumors guidelines. Tumor response evaluation was performed after cycles 4 and 8, and after each cycle where possible pCR was defined as no histological evidence of invasive carcinoma, or the appearance of only non-invasive or in situ carcinoma on pathologic examination of the surgical specimen. When histological diagnosis of pCR was difficult based on hematoxylin-eosin-stained tissue sections, irrespective of whether carcinoma cells were present as ductal carcinoma in situ components, immunohistochemistry of myoepithelial markers such as cytokeratin 5/6 and p63 was used to determine the presence of invasive carcinoma [18–20]. Toxicity was graded and reported according to the NCI Common Terminology Criteria for Adverse Events version 3.

#### Statistical analysis

Following a reported 16 % pCR rate when FEC was followed by docetaxel alone in the JBCRG 01 trial [7], it was determined that 434 assessable patients were required for randomization to achieve 80 % power for the detection of an increase in the proportion of pCR rate of the docetaxel/capecitabine versus docetaxel group. Differences in pCR rates were calculated using a one-sided Chi square test with Schouten correction at the alpha level of 5 %; 95 % confidence interval (CI) was also calculated. In predictive factor analysis, the interaction of pCR with Ki67 as a continuous variable was explored using the subpopulation treatment effect pattern plots (STEPP) method. For each risk factor, the odds ratio (OR) for pCR and 95 % CI was calculated using simple and multivariate logistic regression

models. DFS and OS were calculated using the Kaplan–Meier method. For each prognostic factor, hazard ratio (HR) for DFS and 95 % CI was calculated using the simple Cox model. Factors associated with DFS in univariate analysis were included in the multivariate Cox model.

## Results

### Patient population

A total of 504 patients were enrolled into the study (15 centers in Japan, 1 in China, and 1 in Hong Kong), 27 of whom withdrew during FEC therapy. Following FEC therapy, 239 patients were randomly assigned to the docetaxel/capecitabine group and 238 patients to the docetaxel alone group; all 477 patients were included in the intent-to-treat (ITT) population. Patients randomized to both groups were well balanced with respect to age, menopausal status, and baseline tumor characteristics (Table 1).

### Treatment administration and study completion

No significant differences were observed in the delivery of FEC therapy between the treatment groups. However, the relative dose intensities for docetaxel were significantly lower in the docetaxel/capecitabine group than in the docetaxel alone group ( $p = 0.0006$ ). A 25 % dose reduction was required for 33 % (79/239) of patients in the docetaxel/capecitabine group and 5.9 % (14/238) of patients in the docetaxel alone group. The rate of completion after the initial dose was significantly lower in the docetaxel/capecitabine group compared with the docetaxel alone group (44.8 and 88.7 %, respectively;  $p < 0.0001$ ). Study discontinuation was significantly higher in the docetaxel/capecitabine (53/239; 22 %) group compared to docetaxel alone (13/238, 5.5 %;  $p < 0.0001$ ). The majority of study withdrawals were attributed to drug toxicity (docetaxel/capecitabine: 31/53 patient; docetaxel alone: 9/13 patients; Fig. 1).

### Clinical and pathological response

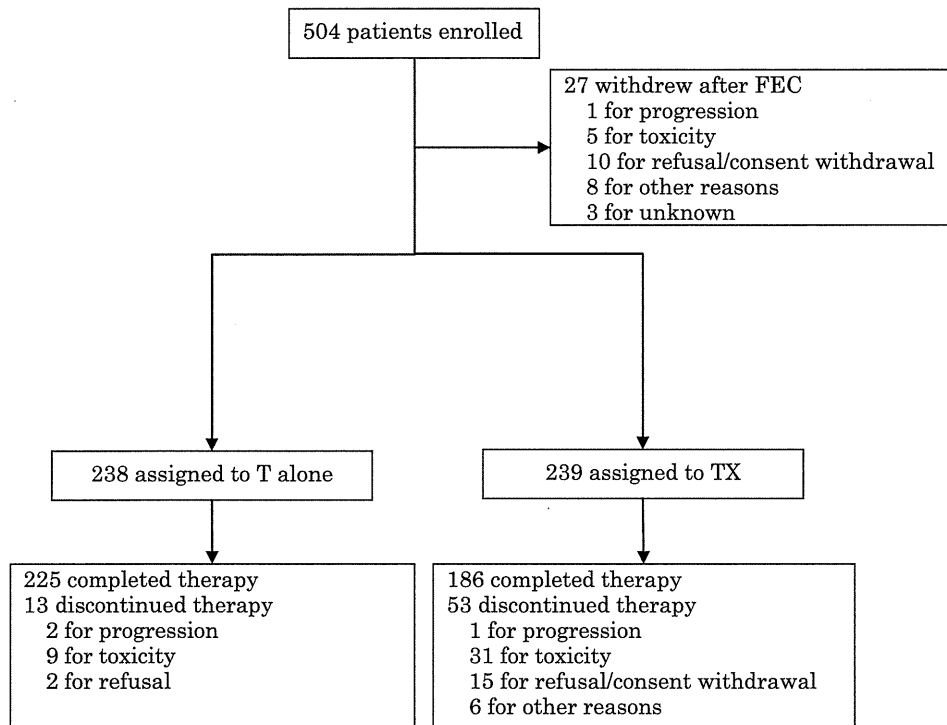
The overall response rate (cCR and cPR) was 88.3 % (211/239) in the docetaxel/capecitabine group and 87.4 % (208/238) in the docetaxel group; no significant differences in clinical response were noted. The proportion of BCS was 70.7 % (169/239) in the docetaxel/capecitabine group and 71.4 % (170/238) in the docetaxel group; the proportion of axillary lymph node conservation surgery was 28.9 % (69/239) and 27.7 % (66/238), respectively (data not shown).

The pCR rate was 23 % in the docetaxel/capecitabine group and 24 % in the docetaxel group ( $p = 0.748$ ;

**Table 1** Baseline patient demographics and clinical characteristics

Number	Total 504	FEC only 27	FEC + T 238	FEC + TX 239	<i>p</i> value
<b>Age</b>					
Median	49.0	47.0	49.0	49.0	W:0.8769
Range	25.0–70.0	28.0–65.0	25.0–68.0	25.0–70.0	
<b>Menopausal status</b>					
Premenopausal	282 (56.0 %)	16 (59.3 %)	133 (55.9 %)	133 (55.6 %)	C:0.9590
Postmenopausal	222 (44.0 %)	11 (40.7 %)	105 (44.1 %)	106 (44.4 %)	
<b>Initial tumor size</b>					
Median	3.5	3.5	3.5	3.5	W:0.7508
Range	0.8–10.5	2.0–10.5	0.8– 8.0	1.0– 9.0	
<b>Axillary lymph nodes*</b>					
Positive	280 (55.6 %)	12 (44.4 %)	134 (56.3 %)	134 (56.1 %)	C:0.9586
Negative	224 (44.4 %)	15 (55.6 %)	104 (43.7 %)	105 (43.9 %)	
<b>Clinical stage</b>					
I	5 (1.0 %)	0 (0.0 %)	2 (0.8 %)	3 (1.3 %)	C:0.9170
IIA	218 (43.3 %)	12 (44.4 %)	100 (42.0 %)	106 (44.4 %)	
IIB	226 (44.8 %)	11 (40.7 %)	110 (46.2 %)	105 (43.9 %)	
IIIA	55 (10.9 %)	4 (14.8 %)	26 (10.9 %)	25 (10.5 %)	
<b>Histologic type</b>					
Infiltrating ductal carcinoma	491 (97.4 %)	25 (92.6 %)	233 (97.9 %)	233 (97.5 %)	C:0.1087
Infiltrating lobular carcinoma	8 (1.6 %)	1 (3.7 %)	1 (0.4 %)	6 (2.5 %)	
Mucinous carcinoma	1 (0.2 %)	0 (0.0 %)	1 (0.4 %)	0 (0.0 %)	
Invasive micropapillary carcinoma	1 (0.2 %)	0 (0.0 %)	1 (0.4 %)	0 (0.0 %)	
Infiltrated apocrine carcinoma	2 (0.4 %)	0 (0.0 %)	2 (0.8 %)	0 (0.0 %)	
Invasive small cell carcinoma	1 (0.2 %)	1 (3.7 %)	0 (0.0 %)	0 (0.0 %)	
<b>Histologic type</b>					
Infiltrating ductal carcinoma	491 (97.4 %)	25 (92.6 %)	233 (97.9 %)	233 (97.5 %)	C:0.7657
Otherwise	13 (2.6 %)	2 (7.4 %)	5 (2.1 %)	6 (2.5 %)	
<b>Nuclear grade</b>					
G1	86 (17.1 %)	8 (29.6 %)	42 (17.6 %)	36 (15.1 %)	C:0.6716
G2	243 (48.2 %)	14 (51.9 %)	110 (46.2 %)	119 (49.8 %)	
G3	167 (33.1 %)	5 (18.5 %)	81 (34.0 %)	81 (33.9 %)	
NA/ND	8 (1.6 %)	0 (0.0 %)	5 (2.1 %)	3 (1.3 %)	
<b>ER</b>					
Positive	327 (64.9 %)	15 (55.6 %)	157 (66.0 %)	155 (64.9 %)	C:0.7423
Negative	163 (32.3 %)	9 (33.3 %)	75 (31.5 %)	79 (33.1 %)	
NA/ND	14 (2.8 %)	3 (11.1 %)	6 (2.5 %)	5 (2.1 %)	
<b>PgR</b>					
Positive	242 (48.0 %)	10 (37.0 %)	113 (47.5 %)	119 (49.8 %)	C:0.5775
Negative	246 (48.8 %)	14 (51.9 %)	119 (50.0 %)	113 (47.3 %)	
NA/ND	10 (2.0 %)	3 (11.1 %)	6 (2.5 %)	1 (0.4 %)	
<b>ER/PgR*</b>					
Positive	331 (65.7 %)	15 (55.6 %)	158 (66.4 %)	158 (66.1 %)	C:0.8930
Negative	159 (31.5 %)	9 (33.3 %)	74 (31.1 %)	76 (31.8 %)	
NA/ND	14 (2.8 %)	3 (11.1 %)	6 (2.5 %)	5 (2.1 %)	
<b>HER2*</b>					
Positive	99 (19.6 %)	7 (25.9 %)	44 (18.5 %)	48 (20.1 %)	C:0.6576
Negative	380 (75.4 %)	17 (63.0 %)	183 (76.9 %)	180 (75.3 %)	
NA/ND	25 (5.0 %)	3 (11.1 %)	11 (4.6 %)	11 (4.6 %)	

ER estrogen receptor, FEC fluorouracil/epirubicin/cyclophosphamide, HER2 Human epidermal growth factor receptor 2, NA not available, ND no data, PgR progesterone receptor, T docetaxel alone, TX docetaxel plus capecitabine



**Fig. 1** Study completion. FEC: fluorouracil/epirubicin/cyclophosphamide; T: docetaxel alone; TX: docetaxel plus capecitabine

**Table 2** Pathological response by (a) central assessment, (b) central assessment in patients who discontinued or received a reduced dose

	FEC ( <i>n</i> = 27) % (95% CI)	TX ( <i>n</i> = 239) % (95% CI)	T ( <i>n</i> = 238) % (95% CI)	Difference (TX-T) (95 %CI)	<i>p</i> value
(a)					
pCR	7.4	23 (17.8–28.9)	24.4 (19.1–30.3)	−1.4 (−9.0 to 6.3)	0.7476
pINV	48.1 (28.7–68.1)	72.4 (66.3–78.0)	71.4 (65.2–77.1)	1	
Missing*	44.4 (25.5–64.7)	4.6 (2.3–8.1)	4.2 (2.0–6.7)	0.4	
(b)					
pCR	7.4	23 (17.8–28.9)	24.4 (19.1–30.3)	−1.4 (−9.0 to 6.3)	0.7476
With discontinuation		( <i>n</i> = 12/53)	( <i>n</i> = 1/13)		
pCR	–	22.6 (12.3–36.2)	7.7 (0.2–36.0)	14.9 (−3.4 to 33.3)	
With dose reduction		( <i>n</i> = 19/79)	( <i>n</i> = 2/14)		
pCR	–	24.1 (15.1–35.0)	14.3 (1.8–42.8)	9.8 (−10.8 to 30.4)	

*pCR* pathological complete response, *pINV* pathological presence of invasive tumor, \* patients missing post-baseline mainly due to discontinuation as a result of toxicity, *CI* confidence interval, *FEC* 5-fluorouracil–epirubicin–cyclophosphamide, *TX* docetaxel plus capecitabine, *T* docetaxel alone

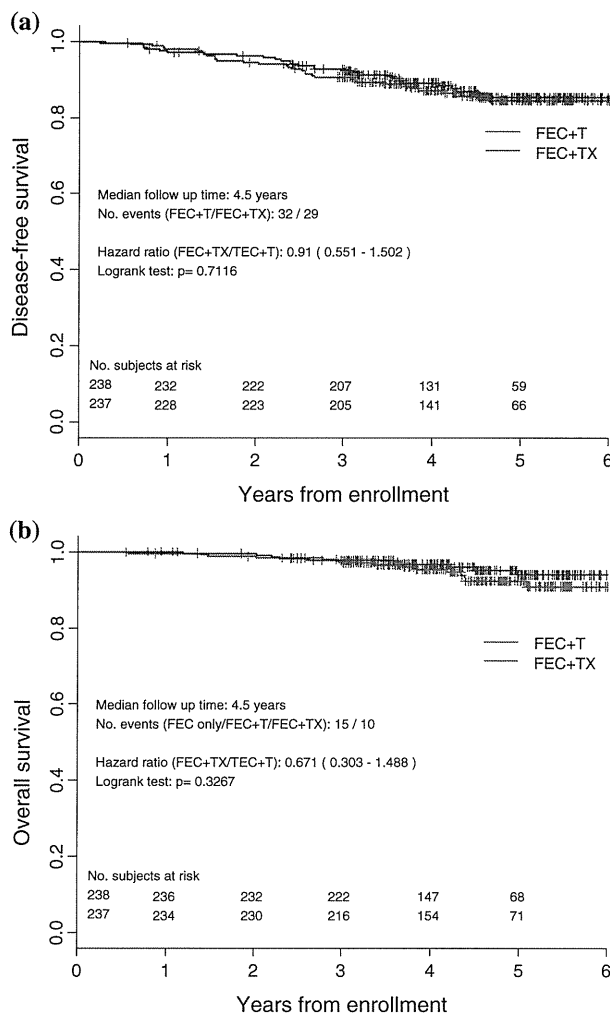
Table 2a). However, we observed an interesting trend in the subset of patients who had discontinued treatment or received a 25 % dose reduction. Despite treatment withdrawal, 12/53 in the docetaxel/capecitabine group and 1/13 in the docetaxel group achieved a pCR with rates of 22.6 and 7.7 %, respectively. A similar trend was observed in the 33.1 % (79/239) and 5.9 % (14/238) who received a 25 % dose reduction and achieved pCR rates of 24.1 % (19/79) and 14.3 % (2/14), respectively (Table 2b).

Although not statistically significant, pCR rates were higher in the docetaxel/capecitabine group in comparison to the docetaxel group in this subpopulation.

#### Disease-free and overall survival

After a median 4.5-year follow-up, the 3-year DFS was estimated at 92.7 % in the docetaxel/capecitabine group and 90.7 % in the docetaxel group. Four patients were



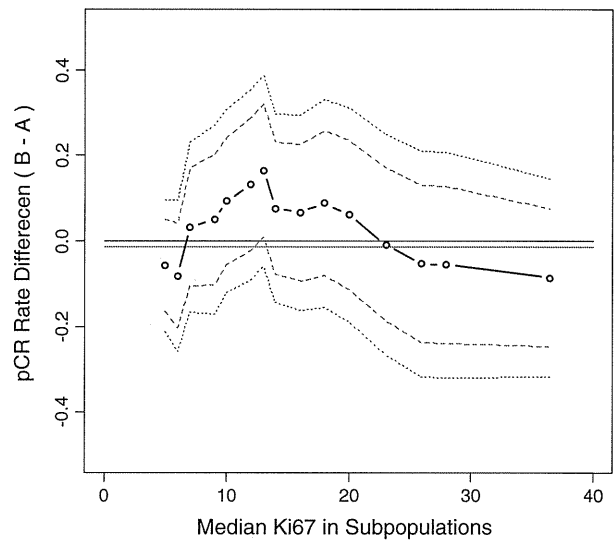


**Fig. 2** a Disease-free survival. b Overall survival. FEC: fluorouracil/epirubicin/cyclophosphamide; T: docetaxel alone; TX: docetaxel plus capecitabine

excluded from the ITT population due to missing data. A total of 29 events occurred in the docetaxel/capecitabine group and 32 in the docetaxel group, with a HR of 0.910 (95 % CI 0.551–1.502; Fig. 2a). During follow-up, 10 deaths occurred in the docetaxel/capecitabine group and 15 in the docetaxel group, with a point of estimate HR of 0.671 (95 % CI 0.303–1.488; Fig. 2b).

Predictive factor analyses for pathological response and survival status

Subpopulation analysis for pathological response showed no significant difference between treatment groups (data not shown). To identify predictive factors for pathological response using age and Ki67 as continuous variables, an overlapping subpopulation of 84 patients was constructed and analyzed using the STEPP method. Although no



**Fig. 3** STEPP analysis of the treatment effect of docetaxel/capecitabine compared with single-agent docetaxel as measured by pCR. Values  $>0$  suggested that the combination regimen was better;  $<0$  indicated that single-agent docetaxel was better. Difference in pCR is shown (dashed black lines) with corresponding 95 % CI (dashed red lines) and corresponding 95 % confidence band (dashed blue lines). Overall difference in pCR (solid horizontal red line) is shown

statistical significance was achieved, STEPP analysis indicated a trend in favor of improved pCR rate in patients with mid-range of Ki67LI (10–20 %) following docetaxel/capecitabine compared with docetaxel alone (Fig. 3). To further investigate the predictive value of Ki67 relative to pCR, univariate and multiple logistic regression models were fitted to calculate the odds ratio (OR) and 95 % CI for each risk factor.

Univariate analysis showed that nuclear grading, ER and/or PgR status, HER2 status, baseline Ki67 and TP-SI were all strongly associated with pCR (Table 3a). Multivariate analysis was performed using the predictive variables identified in the univariate analysis. To evaluate the effect of Ki67, a multivariate logistic regression analysis was undertaken in 410 patients with available baseline data for nuclear grading, ER and/or PgR, HER2, and Ki67. In the first model, all of these factors continued to be 15 % significant predictors for pCR. In the final model, pre-treatment levels of Ki67 proved to be a predictive factor for pCR, with an OR of 1.031 (95 % CI 1.014–1.048;  $p = 0.0004$ ). Using this model, the random cross-validated sensitivity and specificity were 83.3 and 63.4 %, respectively (Table 3b).

Predictive factors for DFS were analyzed using a multiple Cox model in a landmark analysis (Online Resource). When pCR and postKi67 were included in the final model, tumor stage (I, IIa/III: HR 0.144, 95 % CI 0.051–0.404; IIb/III: HR 0.264, 95 % CI 0.107–0.651;  $p = 0.0006$ ), cancer cell TP status (continuous variables: HR 0.966,

**Table 3** Prediction of pCR using (a) simple logistic regression model, (b) multiple logistic regression model with Ki67

Factor	# pat	# res	OR	95 %CI	<i>p</i> value	
<b>(a)</b>						
Age						
≤49	248	56	0.880	0.577–1.343	0.5534	
≥50	229	57	1			
Initial tumor size						
≤2.0	29	7	1.047	0.409–2.682	0.9919	
2.1–4.0	315	75	1.028	0.637–1.659		
≥4.1	133	31	1			
Axillary lymph node						
Positive	268	62	0.932	0.610–1.426	0.7467	
Negative	209	51	1			
Menopausal status						
Pre	266	60	0.868	0.568–1.326	0.5135	
Post	211	53				
Stage						
I/IIa	54	211	1.849	0.818–4.179	0.3355	
IIb	51	215	1.671	0.738–3.786		
III	8	51	1			
Nuclear grading						
G1	78	9	0.240	0.112–0.517	<.0001	
G2	229	46	0.463	0.293–0.731		
G3	162	57	1			
ER and/or PgR						
Positive	327	58	0.265	0.167–0.422	<.0001	
Negative	116	52	1			
HER2						
Positive	62	33	4.552	2.604–7.958	<.0001	
Negative	380	76	1			
Baseline of Ki67 (%)						
≥10	299	95	4.572	2.348–8.903	<.0001	
<10	119	11	1			
Continuous	418		1.043	1.027–1.059	<.0001	
TP-CI						
1 + , 2 + , 3+	282	73	1.715	0.851–3.456	0.1316	
0	65	11	1			
2 + , 3+	119	33	1.332	0.801–2.213	0.2690	
0, 1+	228	51	1			
TP-SI						
1 + , 2 + , 3+	324	84	4.025	0.929–17.438	0.0627	
0	25	2	1			
2 + , 3+	197	59	1.979	1.182–3.315	0.0095	
0, 1+	152	27	1			
	OR	95 %CI	<i>p</i> value	Sensitivity specificity	ROC (95 % CI)	Contrast with final model
<b>(b)</b>						
Grading						
1	0.312	0.129–0.756	0.0027	Random cv	Apparent	
2	0.461	0.274–0.773		Sen: 0.8113	0.7510	

**Table 3** continued

	OR	95 %CI	<i>p</i> value	Sensitivity specificity	ROC (95 % CI)	Contrast with final model
3	1			(0.6034, 0.8958)	(0.6999, 0.8021)	
ER and/or PgR						
Positive	0.384	0.230–0.642	0.0003			
Negative	1			Spe: 0.6097	Random cv	
HER2						
Positive	3.816	2.056–7.081	<.0001	(0.5517, 0.7391)	0.7353	
Negative	1				(0.6664, 0.7901)	
Grading						
1	0.402	0.163–0.991	0.00281	Random cv	Apparent	Apparent
2	0.536	0.316–0.909		Sen: 0.8000	0.7657	0.0147
3	1			(0.6599, 0.8889)	(0.7172, 0.8143)	(–0.0055, 0.0350)
ER and/or PgR						
Positive	00.413	0.247–0.692	0.0008			
Negative	1			Spe: 0.6458		
HER2						
Positive	3.522	1.890–6.563	<.0001	(0.5792, 0.7452)	Random cv	Random cv
Negative	1				0.7489	0.0168
Ki67 (%)						
≥10	2.718	1.331–5.549	0.0061		(0.6827, 0.7986)	(–0.0303, 0.041)
<10	1					
Grading						
1	0.418	0.169–1.035	0.0298	Random cv	Apparent	Apparent
2	0.530	0.312–0.900		Sen: 0.8333	0.7774	0.0264
3	1			(0.6735, 0.9400)	(0.7289, 0.8259)	(0.0015, 0.0513)
ER and/or PgR						
Positive	0.447	0.265–0.754	0.0026			
Negative	1			Spe: 0.6344	Random cv	Random cv
HER2						
Positive	3.794	2.038–7.065	<0.0001	(0.5063, 0.7713)	0.7607	0.0274
Negative	1				(0.6993, 0.8099)	(–0.0175, 0.0596)
Ki67 (continuous)	1.031	1.014–1.048	0.0004			

#*pat* number of patients, #*res* number of responders, *CI* confidence interval, *ER* estrogen receptor, *HER2* human epidermal growth factor receptor 2, *OR* odds ratio, *PgR* progesterone receptor, *TP-CI* thymidine phosphorylase, interstitial, *TP-SI* thymidine phosphorylase, stromal

*ER* estrogen receptor, *HER2* human epidermal growth factor receptor 2, *PgR* progesterone receptor, *OR* odds ratio

95 % CI 0.941–0.993;  $p = 0.0125$ ), pCR, and post-treatment Ki67LI (pCR/Ki67 <10/≥10: HR 0.269, 95 % CI 0.110–0.655;  $p = 0.0038$ ) were all significantly associated with DFS (Table 4).

#### Safety profile

The frequency of major adverse events (≥grade 3) of docetaxel/capecitabine and docetaxel group were as follows: leukopenia (36 and 34 %, respectively), neutropenia (38 and 34 %, respectively), febrile neutropenia (8 and 5 %, respectively), and hand-foot syndrome (15 and 2 %, respectively). Docetaxel/capecitabine was associated with more capecitabine-related toxicity, including hand-foot

syndrome, nausea, mucositis, and increased alanine aminotransferase. Six serious adverse events were reported for 3 patients in the docetaxel/capecitabine group (pneumonitic cough, muscle pain, neutropenia fever) and 3 patients in the docetaxel group (suicide, loss of eyesight of left eye, hematological toxicity). The event of suicide in the docetaxel alone group occurred after completion of treatment and was considered as unrelated to study treatment.

#### Discussion

We have presented results from a randomized study comparing preoperative capecitabine/docetaxel with docetaxel

**Table 4** Hazard ratio for disease-free survival using a multiple cox model in landmark analysis

Factors	HR	(95 % CI)	<i>p</i> value
The final model			
Stage			
I/IIa	0.160	0.059–0.436	0.0016
IIb	0.390	0.170–0.893	
III	1		
ER and/or PgR			
Positive	0.468	0.235–0.932	0.0308
Negative	0.974	0.953–0.996	0.0193
TP-CP			
Continuous	1		
Extended model 1			
Stage			
I/IIa	0.170	0.065–0.444	0.0011
IIb	0.360	0.165–0.787	
III	1		
ER and/or PgR			
Positive	0.327	0.160–0.670	0.0023
Negative	1		
TP-CP			
Continuous	0.975	0.954–0.997	0.0253
pCR			
Responder	0.191	0.052–0.696	0.0121
Nonresponder			
Extended model 2			
Stage			
I/IIa	0.133	0.051–0.349	0.0002
IIb	0.308	0.134–0.706	
III	1		
ER and/or PgR			
Positive	0.441	0.221–0.878	0.0198
Negative	1		
TP-CP			
Continuous	0.974	0.953–0.996	0.0199
Treatment			
Completion	0.633	0.209–1.917	0.3560
Reduction	1.125	0.339–3.729	
Discontinuation	1		
Extended model 3			
Stage			
I/IIa	0.134	0.051–0.350	0.0002
IIb	0.309	0.135–0.706	
III	1		
ER and/or PgR			
Positive	0.439	0.220–0.878	0.0200
Negative	1		
TP-CP			
Continuous	0.974	0.953–0.996	0.0183

**Table 4** continued

Factors	HR	(95 % CI)	<i>p</i> value
Treatment			
Completion	0.584	0.278–1.226	0.1554
Otherwise	1		
Extended model 4			
Stage			
I/IIa	0.153	0.056–0.419	0.0006
IIb	0.279	0.116–0.673	
III	1		
ER and/or PgR			
Positive	0.577	0.229–1.454	0.2433
Negative	1		
TP-CP			
Continuous	0.967	0.941–0.993	0.0144
p CR & PostKi67			
Responder	0.137	0.034–0.549	0.0140
PostKi67 < 10	0.388	0.143–1.052	
PostKi67 ≥ 10	1		
Extended model 5			
Stage			
I/IIa	0.144	0.051–0.404	0.0006
IIb	0.264	0.107–0.651	
III	1		
ER and/or PgR			
Positive	0.756	0.334–1.712	0.5030
Negative	1		
TP-CP			
Continuous	0.966	0.941–0.993	0.0125
pCR & PostKi67			
Responder	0.269	0.110–0.655	0.0038
PostKi67 < 10			
PostKi67 ≥ 10	1		
Extended model 5			
Stage			
I/IIa	0.200	0.072–0.561	0.0031
IIb	0.264	0.103–0.676	
III	1		
ER and/or PgR			
Positive	0.385	0.152–0.977	0.0445
Negative	1		
TP-CP			
Continuous	0.970	0.943–0.997	0.0301

*ER* estrogen receptor, *HER2* human epidermal growth factor receptor 2, *PgR* progesterone receptor, *OR* odds ratio, *TP-CP* thymidine phosphorylase, plasma

alone after FEC in early-stage breast cancer, and have identified Ki67 as a predictive biomarker that may be used to identify patients likely to respond to this neoadjuvant regimen.

In contrast to previous reports, we observed no difference in the pCR rate between the docetaxel/capecitabine and the docetaxel group. Our observation was similar to that from the GeparQuattro study, in which docetaxel/capecitabine did not improve pCR rate in comparison to docetaxel after epirubicin/cyclophosphamide treatment in the neoadjuvant setting [21]. Although a 16 % pCR rate was expected in the docetaxel group based on previous observations [5], the pCR rate in our study was higher (24 %). The variation in clinical outcome may be attributed to the currently limited means with which to select patient subpopulations most likely to respond to a given treatment regimen.

The docetaxel/capecitabine regimen was less well tolerated than docetaxel alone, with withdrawal rates of 22.2 and 5.5 % and dose reduction rates of 33.1 and 5.9 %, respectively. Despite treatment withdrawals and dose reductions, achievement of higher pCR rates in the docetaxel/capecitabine group in comparison to the docetaxel group in this subpopulation suggests that dose reduction does not negatively impact capecitabine efficacy. Our data confirms a similar observation in a MBC study, which reported no significant effect on efficacy when dose reduction occurred in 65 and 36 % of patients receiving the docetaxel/capecitabine regimen and docetaxel alone, respectively. However, an increased risk of disease progression was seen in patients with a dose reduction to 50 % of the starting dose in the docetaxel group (HR 1.91) [15]. As reported by other groups [22], our data demonstrate that the capecitabine dose can be reduced to minimize adverse effects without compromising efficacy. It was, however, interesting to observe that patients who discontinued or received a dose reduction in the docetaxel/capecitabine group achieved a higher pCR compared with the docetaxel alone group, while there was no difference in pCR between both groups in patients that completed the study at the original dose. Although the reason for this observation is unclear, the observation that the relative dose intensity for docetaxel was significantly lower in the combination arm compared with the single agent docetaxel arm may at least in part, account for the lack of difference in pCR. In addition, levels of toxicity may have had an impact on drug delivery and thus, pCR.

In addition to comparing the efficacy of neoadjuvant docetaxel/capecitabine with docetaxel alone, our study also sought to identify biomarkers that can identify patients likely to respond to treatment with docetaxel/capecitabine in early-stage breast cancer. Previously identified biomarkers, such as nuclear grading, ER and/or PgR status, HER2 status and Ki67, correlated with pCR in our study, as in other published studies [23]. Of particular interest was pre-treatment Ki67LI, which had a strong correlation with pCR and added to the predictive value of the multivariate

logistic regression model. Indeed, data from several other studies suggest that high Ki67 levels in breast cancer are a predictive factor for pCR rate [5, 24–27]. This effect was present in our study, as patients with  $\geq 10$  % pre-treatment Ki67LI achieved a higher pCR rate in both the docetaxel/capecitabine (32.6 %) and docetaxel alone (31 %) groups, in comparison to patients with  $< 10$  % pre-treatment Ki67LI (pCR rates 6.5, 12.3 %, respectively). These findings support the suggestion that detection of pre-treatment Ki67LI could identify patients most likely to benefit from neoadjuvant chemotherapy. The prognostic value of Ki67 was also confirmed in our study, as post-treatment Ki67LI and pCR were significantly associated with DFS using a multiple Cox model in a landmark analysis. Thus, prognostic and predictive value was detected for Ki67, showing it to be a feasible marker for development of individualized treatment options for early-stage breast cancer patients.

To our knowledge, this is the first multicenter randomized study showing that assessment of pre- and post-treatment Ki67 may be a useful tool in predicting pCR and DFS with neoadjuvant docetaxel treatment with or without capecitabine in patients with early-stage breast cancer. Although further studies are required, our data suggests that the routine detection of the Ki67 proliferation marker in early-stage breast cancer could be a useful prognostic tool for the identification of patients most likely respond to preoperative docetaxel with or without capecitabine. As such, in addition to the current leading parameters (ER, PgR, and HER2 status), we propose that Ki67 should be included in the list of required routine biological markers that are used to define treatment recommendations in patients with early-stage breast cancer. Indeed, detection of predictive biomarkers prior to chemotherapy is likely to prove to be of the greatest advantage for neoadjuvant chemotherapy.

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**Conflict of interest** The authors have declared no conflicts of interest.

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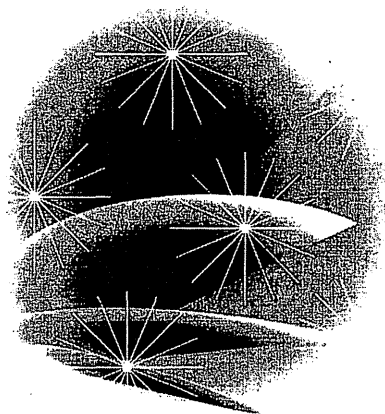
# 乳がん患者の サバイバーシップ

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がんと診断された瞬間から、人はがんサバイバー (cancer survivor) となり、一生サバイバーでありつづけます。がんサバイバーシップ (cancer survivorship) とは、人ががんと診断されたときに生活していくうえで直面する課題を、家族や友人、医療関係者、ほかの経験者とともにのりこえていくこと、またそのためのサポートです。本稿では、乳がん患者のサバイバーシップを、がんサバイバーとがんサバイバーシップの定義、世界および日本におけるサバイバーシップの現状 (身体的問題、心理的問題、疫学的問題、就労問題、ピアサポート、セクシュアリティ、家族の問題)、今後の展望という項目に分けて概説します。

## がんサバイバーと

## がんサバイバーシップの定義

.....

がんサバイバーとがんサバイバーシップについては、1984年に全米がんサバイバーシップ連合 (National Coalition for Cancer Survivorship) が、「がんと診断された瞬間から人はがんサバイバーとなり、一生サバイバーでありつづける。その家族、友人、ケアにあたる人びともその影響を受けるので、サバイバーシップに含まれるべきである」と定義しています。すなわち、「がんサバイバー」

は人を表す言葉ですが、「がんサバイバーシップ」という言葉は、がんと診断された瞬間からはじまり、時間とともに変化していく過程を表す言葉です。そして、がんを経験した人が、生活していくうえで直面する課題を、家族や友人、医療関係者、ほかの経験者とともにのりこえていくこと、また、そのためのサポートを表しています。

## 世界および日本の現状

.....

現在、米国では、がんサバイバーは1200万人を超えています。早期発見と治療の向上のため、その数は増えつづけています。サバイバーのうち最大の集団は女性乳がんサバイバーで、米国では推定230万人の乳がんサバイバーがいます。

米国では古くからサバイバーに対するさまざまな取り組みが行われてきており、1996年に米国国立がん研究所 (National Cancer Institute) にサバイバーシップ室 (Office of Cancer Survivorship) が設置され、がんサバイバーに関する研究が行われています。わが国では、2006年にがん対策基本法が制定されて以降、がんサバイバーシップに対する取り組みが行われてきていますが、まだまだ遅れているというのが現状です。

図1 サイコオンコロジー分野の論文数 (英文)

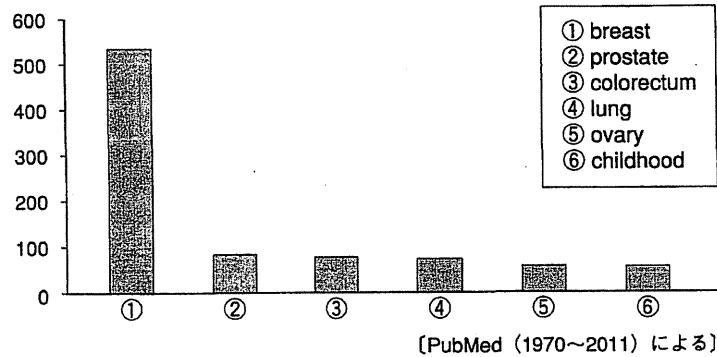
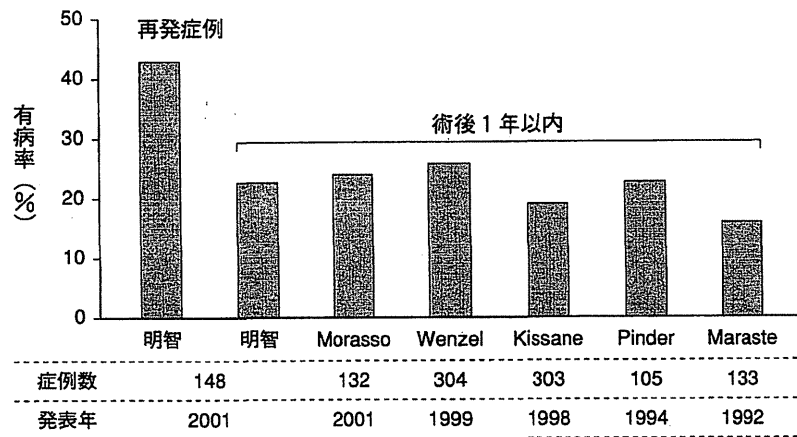


図2 乳がん患者の精神症状 (適応障害・抑うつ)



### 1) 身体的問題

乳がんのサバイバーの身体的問題には、がん自体によるもの、治療（手術、放射線、化学療法）によるものがあります。がん自体によるものには、痛み、倦怠感、皮膚の自壊、リンパ浮腫、神経障害、胸腹水、脳浮腫などがあります。治療によるものなかで、手術によるものは、ボディイメージの変化（とくに乳房切除時）、腋窩リンパ節郭清時のリンパ浮腫、神経障害などがあり、放射線治療によるものは皮膚障害、肺障害などがあります。化学療法によるものは多く、アンスラサイクリン系抗がん剤やトラスツズマブによる心機能障害や、まれではありますが、多くの抗がん剤で起こりうる薬剤性間質性肺炎、ほかには末梢神経障害、皮膚障害、脱毛、ケモブレ

イン（認知機能低下）、性的障害が知られています。また、二次性白血病などの二次がんの問題もあります。

### 2) 心理的問題

心理的問題は乳がんサバイバーの問題のなかでも非常に重要な問題です。サイコオンコロジー分野の論文数も乳がん関連が最多です（図1）。「がんがここに及ぼす影響」や「ところががんに及ぼす影響」を研究する医学の領域をサイコオンコロジーと呼びます。

乳がん患者は告知の後、通常不安と抑うつが生じます。その後、手術や放射線治療、薬物療法を行うことで治療中は気分が向上します。しかし、再発した際にはふたたび適応障害や抑うつが生じます（図2）。



表1 サバイバーシップ・ケアプラン

<p>米国医学研究会：サバイバーシップケアの必要不可欠な構成要素</p> <ul style="list-style-type: none"> <li>・再発と新たながん，およびその他の遅発性副作用の防止</li> <li>・がんの転移・再発や二次がんの監視</li> <li>・医学的・心理社会的な遅発性副作用の評価</li> <li>・がんとその治療の結果に対する治療介入</li> <li>・すべてのサバイバーの健康上のニーズを確実に満たすことを目的とした，専門医と家庭医の協働</li> </ul> <p>サバイバーシップ・ケアプランに組み込む要素</p> <ul style="list-style-type: none"> <li>・がんの種類，受けた治療法とそれによっておこりうる結果</li> <li>・推奨される経過観察の時期と内容についての詳細情報</li> <li>・予防診療および健康と満足できる生活状態の維持方法に関する推奨事項</li> <li>・雇用および医療保険の受給に関する法的保護についての情報</li> <li>・地域社会における心理社会的サービスの利用可能性</li> </ul>
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再発していない場合でも，がん患者・がんサバイバーには，治療中，治療が終わった後のフォローアップ期間中につねに再発の恐怖がともなっていて，がん患者からがんサバイバーへ移行することのむずかしさから気分障害が生じることもあります。たとえば，乳房温存手術と放射線治療を受けてからホルモン療法を5年間行い，初期治療が終了した場合，再発所見がなければ，がん専門医以外の医師が経過観察のためのがん検診を実施したり，長期的なケアを管理します。がんサバイバーには，がん専門医以外の医師が経過観察を担当することに対する不安が生じます。そこで，治療を終えた患者はみな，治療後の人生計画となるサバイバーシップ・ケアプラン (survivorship care plan) を受けるべきだと考えます (表1)。

### 3) 疫学的問題

身体活動が，乳がん予防および予後の向上と関連していることを示す研究が非常に多くなってきています。現在もっとも簡単で，エビデンスの裏づけがある身体活動としては，中強度のレクリエーションの身体活動，たとえば早歩きといったものを30分間，週に5回行うことが推奨されています。

また，がんサバイバーシップにおける食事の役割も注目されています。がんの一次予防における食事の効果は広く研究されていますが，がんサバイバーへの効果についての研究はまだ限定的です。現在のところ，一般的ながん予防のための米国がん協会ガイドラインががんサバイバーにも推奨されています。すなわち，①健康体重を維持し，②身体活動の多いライフスタイルを取り入れ，③高脂肪食，とくに動物性脂肪の摂取を制限し，④植物性食品の摂取を強調し，⑤アルコール摂取量を制限することです。

### 4) 就労問題

乳がん患者は，好発年齢が40～50歳代であり，仕事面ではちょうど重要な仕事を任されたり，重要な役割をこなしている人が多く，簡単には仕事の空きをつくれないことが多いです。乳がんと診断されてからは，検査，手術，放射線療法，化学療法など仕事を休んで検査・治療をしなければなりません。勤務先が病気に関して理解がある場合，休職の後に復職できる場合もありますが，そのまま解雇となってしまう場合もあります。櫻井なおみ氏が主宰するCSR Projectは，がん就労に関するさまざまな問題の調和と解決を旨

表2 化学療法を受けた患者の痛み

順位	1983年	1993年	2002年
1	嘔吐	脱毛	家族への影響
2	悪心	悪心	脱毛
3	脱毛	全身倦怠感	全身倦怠感
4	治療への不安	治療への不安	家事・仕事への影響
5	治療時間の長さ	うつ状態	社会活動への影響
6	注射の不快感	家族への影響	性感減退
7	呼吸促進	不安	立ちくらみ
8	全身倦怠感	家事・仕事への影響	下痢
9	睡眠障害	嘔吐	体重減少
10	家族への影響	多尿	息切れ

[Eur J Cancer Clin Oncol (1983), Ann Oncol (1996), Cancer (2002)より]

したプロジェクトです。詳細はホームページ (<http://workingsurvivors.org/>) をご参照ください。

#### 5) ピアサポート

ピアサポート (peer support ; “対等な支援”) とは、一般に、「同じような立場の人によるサポート」といった意味で用いられる言葉です。乳がん領域では、乳がん体験者の仲間による支え合いのことを示しています。すなわち、乳がん患者とその家族の不安を和らげるなどの支援を行うため、がんを経験した患者さんや家族らが相談を受けてサポートしています。現在、がんサバイバーがみずから作り出したがんサポートコミュニティー (Cancer Support Community <http://www.csc-japan.org/>) などのいくつかのピアサポート団体が設立されていますが、その活動の場が限られているのが現状です。サポートしてくれる乳がん体験者のスキルアップも重要ですが、サポートする場を提供することが急がれます。

#### 6) セクシュアリティ (性生活)

性は暮らしの大切な一部分ですが、長いあいだがん患者も医療従事者も、セクシュアリティに関して話し合う機会を避けてきたよう

に思います。手術後のボディイメージの変化や、化学療法、ホルモン療法時の膣の乾燥や腔粘膜の萎縮などにもなる性交痛、全身倦怠感などから、セクシュアリティに関して、がん患者には不安がともないます。手術後の患者や、化学療法、ホルモン療法、放射線療法を受けている患者を含めて、サポートが必要です。詳細はパンフレット『乳がん患者さんとパートナーの幸せな性へのアドバイス』をご参照ください。

#### 7) 家族 (夫・子ども) の問題

化学療法を受けた乳がん患者の痛みとして、最近では家族への影響をあげる人が多くなっています (表2)。乳がんの治療において家族のサポートは重要です。夫は乳がんになった妻と、子どもは乳がんになった母親とどのように接してよいかわからないことがよくあります。乳がん患者だけでなく、その家族も含めたサバイバーへの対応が大切です。子どもに対しての対処法は、パンフレットのお子さんといっしょに読む絵本『お母さん どうしたの?—乳腺の病気で治療されているお母様へ』を参考にしてください。子育てや妊娠などの問題をもたれる患者さんを対象とした「若年乳がん患者のサバイバーシップ支援プログラム」 (<http://www.jakunen.com/>) を

ご参照ください。

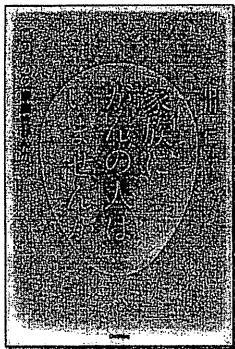
## 今後の展望

乳がん患者が増加するにともない、がんサバイバーの数も増加しています。現在、日本ではまだまだサバイバーシップに関する取り

組みが発展途上段階にありますが、がん患者が自分らしく生きることができるよう、さまざまなサポートが必要です。がんサポートコミュニティなどのがん患者支援非営利団体も多くつくられており、今後が期待されます。

[よしやま・ともゆき／乳腺科]

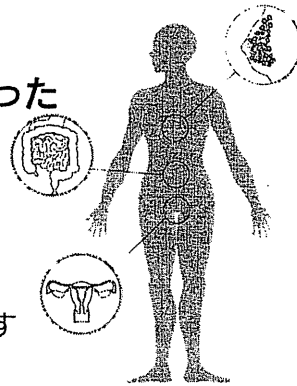
[おおの・しんじ／臨床腫瘍学]



▶親族にこんな人はいませんか？

- ①何人もが同じ臓器のがんになった
- ②若くしてがんになった
- ③何度もがんになった

この条件にあてはまるなら、  
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# 家族にがんの人は いませんか

女性のための「家族性がん」の本

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特集/エビデンスに基づく乳癌診療の最前線

エビデンスに基づく補助療法

# 内 分 泌 療 法

中村 吉昭 石田 真弓 大野 真司

## はじめに

70%近くの乳癌症例がホルモン受容体陽性でホルモン感受性乳癌である。EBCTCGのメタアナリシス<sup>1)</sup>の結果では、ホルモン受容体陽性乳癌に対する補助内分泌療法が再発リスクおよび死亡率を低下させることが示されている。しかしながら個々の症例により、生物学的性状およびステージが異なり、治療の有用性、再発リスクが異なるので、最適な個別化治療を施行する必要がある。本稿では臨床試験などのエビデンスに基づきながら補助療法を実践する手順について論ずる。

### 最適な個別化治療<sup>2)</sup>の施行のために

エビデンスに基づく補助療法を選択するには、個々の症例においてⅠ. 治療感受性、再発リスクを検討し、Ⅱ. クリニカルクエスチョン (CQ) をたて、Ⅲ. Evidence-based-medicine (EBM) の実践を行う必要がある。

Ⅰ. 治療感受性や再発リスクを検討すると、これまでの報告において、CALGB9344 試験やBIG1-98のレビューなど、エストロゲン受容体 (ER)、プロゲステロン受容体 (PgR)、ヒト上皮細胞増殖因子受容体2 (HER2)、細胞増殖マーカー Ki-67 の発現では、ER、PgR 強陽性、HER2 陰性、Ki-67 低値の方がホルモン感受性はあり、再発リスクが低いことがわかる。このうち、Ki-67 抗原の発現は、これを認識する抗体 (MIB-1 抗体など) で組織標本の免疫組織化学法を行うと、休止期 (G0 期) 以外の活動性の細胞で核内に陽性染色

が得られることから、その陽性細胞割合 (index) を評価して、腫瘍の増殖性・悪性度の判断をするが、その cut-off 値は施設によりばらつきがあることに注意する必要がある。また、T 因子、N 因子、histological grade らの高いもの、脈管侵襲の有るものは再発リスクが高く、予後不良因子を有することになる。

Ⅱ. これに対して、CQとして最適な内分泌療法、化学療法の適応、卵巣機能抑制の適応を考慮する。表1に参考となる臨床試験の一覧を示す。

#### 1. 最適な内分泌療法

1) 閉経前ホルモン受容体陽性浸潤性乳癌に対して (日本乳癌学会の診療ガイドライン薬物療法 CQ4)

タモキシフェン (TAM) 5年間は現在のところは標準治療である。最近の San Antonio Breast Cancer Symposium (SABCS2012) での ATLAS 試験の報告では、TAM10年間投与により10年以降の再発抑制効果があるとされた。LH-RH アゴニストの追加投与の効用<sup>3)</sup>は、NSABP B-30, ZIPP, INT0101 試験などで、2~3年、5年の投与により再発率が減少することが示されているが、至適投与期間は不明である。

2) 閉経後ホルモン受容体陽性浸潤性乳癌に対して (日本乳癌学会の診療ガイドライン薬物療法 CQ8)

以前は TAM 5年間は標準治療であったが、2005年頃より施行された TAM と第3世代アロマターゼ阻害薬 (AI) との複数のランダム化第Ⅲ相比較試験の結果より、現在は AI 5年が推奨される。

初期治療として ATAC 試験は、アナストロゾール (ANA) vs TAM。TEAM 試験はエグ