We have read with interest the recently published paper by Goldhirsch et al. [1] on 'Thresholds for therapies: highlights of the St Gallen International Expert Consensus on the primary therapy of early breast cancer 2009'[1] and we certainly agree with the ‘feeling’ of the members of the panel that a new era is coming and that we now face with a new concept in the decision of adjuvant therapies that corresponds to better define the ‘biology’ of the tumour before thinking to the risk of relapse as defined, for instance, by tumour–node–metastasis (TNM) system. All of us feel, for sure, more anxious in taking the decision of how to better treat a young woman with a triple-negative breast cancer, even if defined as T1 N0 (stage I), than an older woman with a large indolent estrogen receptor- and progesterone receptor-positive breast cancer T3 N2 (stage III). The utility of the TNM system in the classification of risk categories is now
challenged by the newer genomic classifications but this is another open question. On the other hand, age <35 years that was present in previous consensus meetings now apparently disappeared without any explanation. This is not, in our mind, a trivial issue as was pointed out some years ago by retrospective studies [2, 3]. On the other hand, as recently discussed in a paper [4], many factors are to be considered in young women when we propose an adjuvant treatment.

Furthermore, these young patients typically are more concerned and alert on the risk due to their young or very young age. The fact that, in the new version of the St Gallen 'Expert Consensus', age <35 years is not any more mentioned should be better explained by the members of the panel and should not be included, in our mind, in the so-called patient preferences because young women particularly need to be guided in their preferences by the so-called evidence-based data.

In a recent case, reported in the New England Journal of Medicine [5], a woman >35 years affected by early breast cancer, after deep evaluation of pro and contra data, was treated with hormone therapy alone without chemotherapy (luteinizing hormone releasing hormone analogue plus tamoxifen and radiotherapy on the breast) but the same authors pointed out the issue of younger age problem.

In conclusion, we think that younger age remains, at least until we will have new data, a factor that should be taken in consideration and in favour of the use of adjuvant chemotherapy.

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