

SWITCHING OF POSTMENOPAUSAL WOMEN WITH ENDOCRINE-RESPONSIVE EARLY BREAST CANCER TO ANASTROZOLE AFTER 2 YEARS' ADJUVANT TAMOXIFEN: COMBINED RESULTS OF ABCSG TRIAL 8 AND ARNO 95 TRIAL

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Summary

Background Tamoxifen has been the standard adjuvant treatment for postmenopausal women with hormone-responsive early breast cancer for more than 20 years. However, the third-generation aromatase inhibitor anastrozole has proven efficacy and tolerability benefits compared with tamoxifen when used as initial adjuvant therapy. We investigate whether women who have already received a period of adjuvant tamoxifen would benefit from being switched to anastrozole.

Methods We present a combined analysis of data from two prospective, multicentre, randomised, open-label trials with nearly identical inclusion criteria. Postmenopausal women with hormone-sensitive early breast cancer who had completed 2 years' adjuvant oral tamoxifen (20 or 30mg daily) were randomised to receive 1mg oral anastrozole (n=1618) or 20 or 30mg tamoxifen (n=1606) daily for the remainder of their adjuvant therapy. The primary endpoint was event-free survival, with an event defined as local or distant metastasis, or contralateral breast cancer. Analysis was by intention-to-treat.

Findings 3224 patients were included in analyses. At a median follow-up of 28 months, we noted a 40% decrease in the risk for an event in the anastrozole group as compared with the tamoxifen group (67 events with anastrozole vs 110 with tamoxifen, hazard ratio 0.60, 95% CI 0.44–0.81, p=0.0009). Both study treatments were well tolerated. There were significantly more fractures (p=0.015) and significantly fewer thromboses (p=0.034) in patients treated with anastrozole than those on tamoxifen.

Interpretation These data lend support to a switch from tamoxifen to anastrozole in patients who have completed 2 years' adjuvant tamoxifen.

Introduction

Breast cancer is the most common female cancer. It is diagnosed in more than a million women worldwide each year and accounts for more than 400,000 deaths yearly. More than 110 cases per 100,000 of the population are diagnosed in Germany and Austria every year.¹ The incidence of breast cancer increases with age, and about three-quarters of the women affected are postmenopausal. In these individuals, about 80% of tumours are hormone receptor-positive.²

For more than 20 years, the antioestrogen tamoxifen has been the established endocrine adjuvant therapy after surgery for postmenopausal women with early breast cancer. 5 years of tamoxifen is generally considered to be the optimum duration for treatment,³ as tamoxifen therapy beyond 5 years seems to confer no extra benefit in terms of disease-free survival.^{4,5} However, several side effects are inherent with long-term tamoxifen treatment. The partial oestrogenic activity of tamoxifen in some tissues leads to an increased risk of endometrial cancer and thromboembolic events over the course of treatment.⁶⁻⁸ Tamoxifen resistance can also develop.⁹ The 5-year standard for adjuvant tamoxifen therapy, therefore, seems to be imposed by the limitations of the drug rather than by the optimum duration of therapy. In particular, the relapse pattern for low-risk and intermediate-risk tumours indicates that adjuvant treatment should continue after 5 years, with overview results suggesting that there is a 1.5–2 % yearly risk of recurrence of breast cancer in years 5-15 after initial diagnosis.^{10,11}

The 15-year outcome of some oestrogen receptor-positive tumours might be worse than that of oestrogen receptor-negative lesions.¹² The administration of tamoxifen beyond the optimum time of efficacy might, therefore, result in side effects without a concomitant therapeutic benefit.

The limitations of tamoxifen have led to a search for alternative endocrine therapies with increased efficacy and fewer long-term complications. The third-generation aromatase inhibitors anastrozole, letrozole and exemestane are highly selective for aromatase and inhibit 97–99% of oestrogen synthesis from this source.^{13,14} Results of trials such as the ATAC study have shown the improved efficacy and tolerability of anastrozole compared with tamoxifen,¹⁵ and data now support the use of 5 years' anastrozole as adjuvant therapy for postmenopausal women with early breast cancer. However, tamoxifen is still a useful and ubiquitous treatment option, and by employing a strategy of switching therapy from tamoxifen to an aromatase inhibitor, the unnecessary longer-term side effects of tamoxifen might be obviated and the complications of long-term tamoxifen therapy avoided. Data have shown a positive effect on recurrence-free survival when switching from tamoxifen to an aromatase inhibitor.^{16,17}

The most recent technical assessment from the American Society of Clinical Oncology (ASCO) recommends that optimal adjuvant therapy for postmenopausal women should now include the use of an aromatase inhibitor, either as initial treatment or after 2–5 years' treatment with tamoxifen, to reduce the risk of tumour recurrence.¹⁸ The aim of the Austrian Breast & Colorectal Cancer Study Group (ABCSCG) trial 8/Arimidex-Nolvadex (ARNO) 95 combined analysis was to assess whether switching to anastrozole after 2 years' tamoxifen treatment is more effective than the standard 5 years' adjuvant tamoxifen therapy.

Methods

This study is a prospectively-planned, event-driven combined analysis of two trials - ABCSCG trial 8 and the ARNO 95 trial by the German Adjuvant Breast Cancer Group (GABG) - both of which were prospective, multicentre, randomised, open-label studies and had broadly similar inclusion criteria and outcome measures.

Eligible patients were postmenopausal women 80 years or younger (ABCSCG trial 8) or 75 years or younger (ARNO 95) with histologically verified, locally radically treated invasive or minimally invasive breast cancer without previous chemotherapy, hormone therapy or radiotherapy.

Postmenopausal status was assumed for patients whose last menstruation took place at least 12 months before study entry, for those who had undergone bilateral ovariectomy, or for whom follicle-stimulating hormone and luteinising hormone concentrations indicated postmenopausal status. All patients had endocrine-responsive tumours, with concentrations of oestrogen or progesterone receptors of more than 10 fmol/mg cytosol protein, or were oestrogen or progesterone receptor-positive as assessed histochemically. ABCSG trial 8 included patients with G1 and G2 ductal carcinoma and Gx lobular tumours, whereas patients with ductal carcinoma of any grade were recruited to ARNO 95. Tumours were graded according to the Bloom and Richardson scale in both studies.¹⁹

Inclusion criteria common to both trials were absence of preoperative chemotherapy, hormone therapy or radiotherapy, tumour infiltration of up to 10 (ABCSG Trial 8) or 9 (ARNO 95) lymph nodes, and absence of organ metastases. Exclusion criteria across both trials were indeterminate menopausal status (or menopausal status maintained by medication), presence of secondary malignant disease, tumour infiltration of skin or breast muscle (T4 tumours), and presence of other concomitant serious medical conditions, those involving bone marrow function, the central nervous system, uncompensated cardiac insufficiency, or uncontrolled local or systemic infection. While hormone replacement therapy was not excluded in the protocol, it was considered as explicitly contraindicated in both countries for patients receiving adjuvant breast cancer treatment.

Eligible patients underwent modified radical mastectomy or breast-conserving surgery with axillary lymph node dissection or sentinel lymph node biopsy (with or without subsequent radiotherapy), followed by adjuvant tamoxifen therapy started within 6 weeks (ABCSG trial 8) or 4 weeks (ARNO 95) of surgery or radiotherapy, where applicable.

For both studies, patients had to complete 2 years' adjuvant tamoxifen therapy in accordance with local guidelines (20 mg daily for ABCSG trial 8 and 20 or 30 mg daily for ARNO 95; patients administered 30 mg continued on that dose unless otherwise indicated). Women were randomised before beginning treatment with tamoxifen in ABCSG trial 8 and within two years of tamoxifen treatment in ARNO 95. The accrual period for this combined analysis was January 1996 to August 2003. Since the randomisation processes in Austria and Germany differed, the timepoint of 2 years post-surgery was used as a starting point for this analysis.

All patients provided written informed consent and both studies were done in accordance with the Declaration of Helsinki. ABCSG trial 8 and ARNO 95 were approved by the relevant ethics committees in Austria and Germany, respectively.

Procedures and assessments

Randomisation for ABCSG trial 8 was done centrally at the ABCSG Randomisation Centre, Vienna, Austria. Randomisation for ARNO 95 was performed at the Department of Medical Biometry and Statistics, Freiburg, Germany. The computer-assisted randomisation schedules for ABCSG trial 8 were based on minimisation as a dynamic algorithm designed to counteract imbalance between treatments, taking stratification factors into account. For ARNO 95, these schedules were based on block randomisation. Patients were randomised to either continue tamoxifen or switch to anastrozole (1 mg per day per os) for a further 3 years after completion of two years' adjuvant therapy. In Austria, this randomisation was performed within 6 weeks after surgery, whereas in Germany, it was conducted at any time between surgery and 6 weeks after completion of the first 2 years' adjuvant therapy.

Patients received a physical examination and were monitored for safety and tolerability. Case report forms were provided for documentation and adhered to as per protocol. In Austria, the monitoring took place at 3-monthly intervals throughout the first year of randomised therapy, at 6-monthly intervals in the second and third year, and yearly thereafter. In Germany, assessment of

patients was done at 6-monthly intervals. There were no observation-free intervals. Gynaecological examinations, thoracic X-rays, skeletal scintigraphy and abdominal sonography, liver ultrasound and standard mammography were done as appropriate (at least yearly), in order to identify the presence of disease recurrence (locoregional, contralateral, or distant metastatic tumour [lymph node or organ]). The assessments done at each visit were common to, and the number of patients with data was similar in, both treatment groups. Events were confirmed histologically, cytologically, or, where not clinically obvious, by the various radiological screening methods employed at the regular assessments.

The primary endpoint was event-free survival, defined as time to relapse at any site or incidence of contralateral breast cancer. Distant recurrence-free survival and tolerability issues were also compared.

Statistical analysis

In Austria, patients were allocated to the treatment groups according to the method of Pocock and Simon,²⁰ stratifying for the following prognostic factors: age, tumour grade, tumour stage, nodal status and participating centres grouped into federal states. In Germany, only the participating centre was considered during randomisation. For the common analysis, we calculated that 278 events would be required for the final analysis to detect a hazard ratio (HR) of 0.7 for event-free survival between the treatment groups with a power of 80% and a two-sided significance level of 0.05. Interim analyses were planned on reaching 139 and 209 events, using a significance level of 0.001 (stopping boundary) to maintain a significance level of 0.05 for the final analysis. The number of events needed to trigger the first interim analysis was reached in April 2004 (143 observed events). The Steering Committee decided to re-assess all data for accuracy. As the stopping boundary for event-free survival was reached at this analysis, the Independent Data Monitoring Committee decided, in November 2004, to recommend close of recruitment and to publish the combined analysis data.

Analyses were by intention-to-treat. Data are presented in Kaplan-Meier curves,²¹ and tested by log-rank tests.^{22,23} HRs and their corresponding 95% CIs were estimated by the proportional-hazards regression model of Cox.²⁴ Main analyses were based on the first corresponding event per patient. In additional sensitivity analyses, first events only were considered. Thus, for analysis of distant recurrence-free survival, the first observed distant metastasis was included in the main analysis. In the sensitivity analysis, however, patients who did not have a distant metastasis as first cancer-related event - e.g. secondary cancer, locoregional event, or contralateral event - were censored at the first observed event.

All analyses were done with SAS (version 8.02). Adverse events were only counted once per patient and are described with absolute frequencies and proportions. Differences in the adverse event rates were estimated with exact odds ratios (OR) and corresponding 95% CIs. Exact ORs stratified by country were calculated for the five types of serious adverse events available for Austrian and German patients (myocardial infarct, embolism, thromboses, fractures and endometrial cancer). The exact calculations were done with StatXact (version 6). All p-values are two-sided and a p less than 0.05 was judged significant.

Role of the funding source

The study designs were developed by the ABCSG and the GABG. The management of the trial has been undertaken by the ABCSG and GABG with funding and organisational support from the trial sponsors: AstraZeneca in Austria and the GABG in Germany. The ABCSG statistician analysed all data. AstraZeneca funded editorial assistance in the form of technical preparation of references, figures, tables, technical editing for English language, formatting of the report to *Lancet* style and administrative support. AstraZeneca had no role in data interpretation. The

corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Results

Figure 1 shows the trial profile. 3224 patients (2262 in ABCSG trial 8 and 962 in ARNO 95) were randomised to either continue tamoxifen (n=1606) or switch to anastrozole (n=1618). Median follow-up was 28 months (95% CI 26-30) after initial treatment with tamoxifen. The treatment groups were well balanced in terms of age, nodal status, tumour stage, tumour grade, oestrogen-receptor and progesterone-receptor status and previous surgery (table 1). At the time of disclosure of trial data, 882 (55%) of patients assigned anastrozole and 884 (55%) assigned tamoxifen had completed 5 years of treatment.

Figure 1: Study design flow diagram showing numbers of patients randomised to each arm and withdrawals (CONSORT diagram)

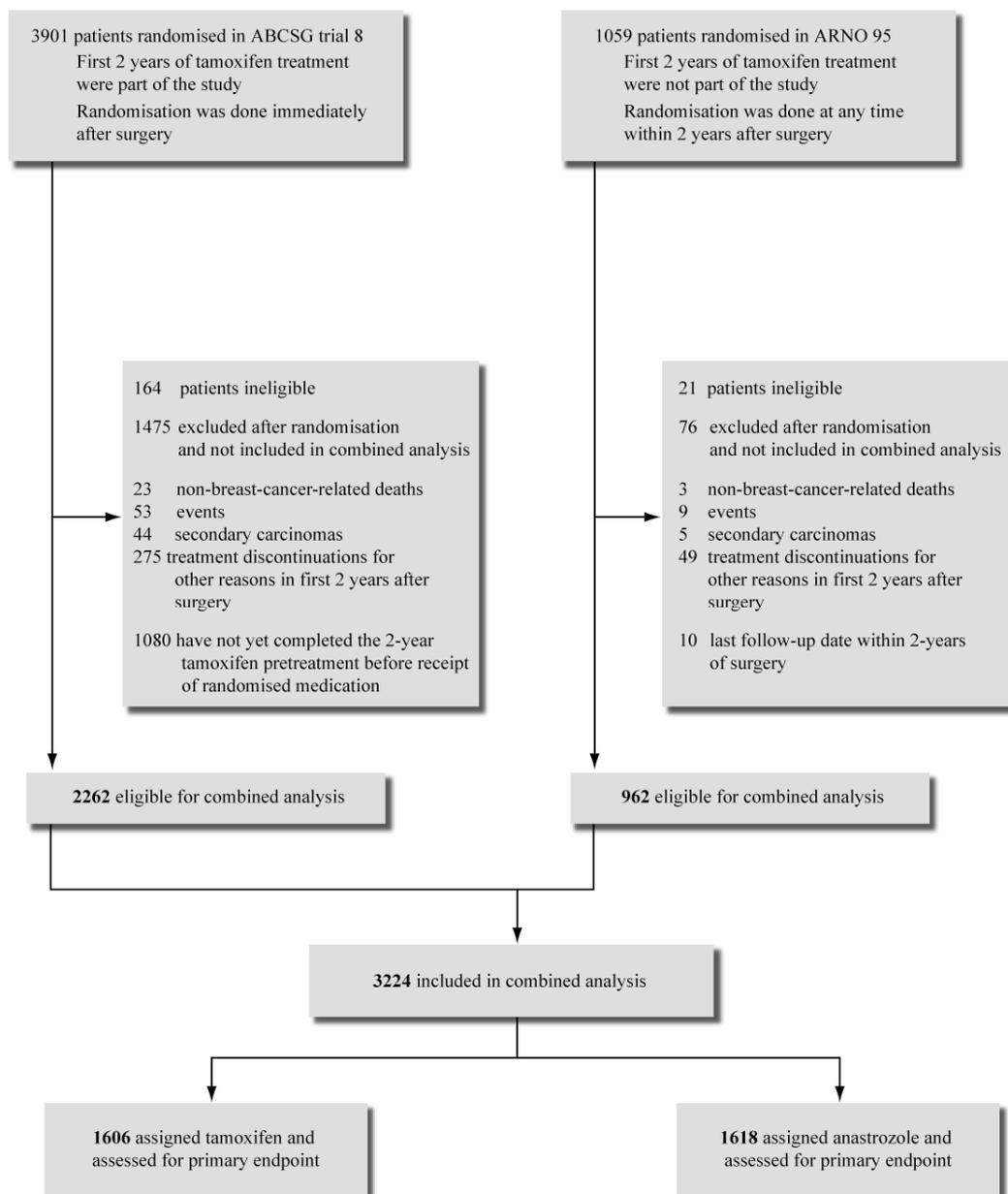


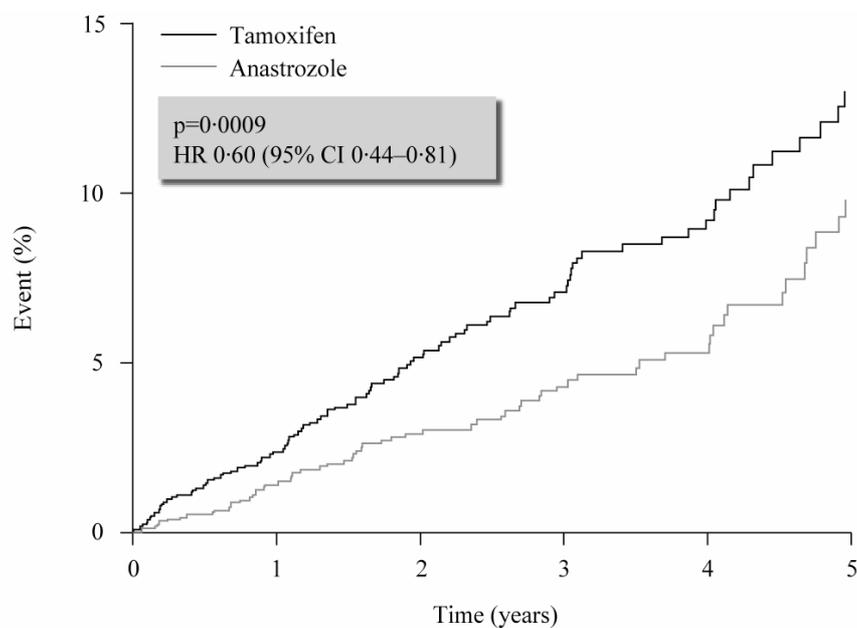
Table 1: Baseline characteristics

	Tamoxifen (n=1606)	Anastrozole (n=1618)
Age at surgery (years; median, range)	62.0 (41.4, 80.0)	62.3 (46.0, 80.3)
Affected nodes		
None	1188 (74%)	1201 (74%)
1-3	358 (22%)	346 (21%)
4-9	59 (4%)	70 (4%)
Unknown	1 (<1%)	1 (<1%)
Tumour size		
T1	1119 (70%)	1136 (70%)
T2	464 (29%)	463 (29%)
T3	21 (1%)	18 (1%)
Unknown	2 (<1%)	1 (<1%)
Tumour grade		
G1, G2, Gx	1504 (94%)	1540 (95%)
G3	91 (6%)	76 (5%)
Unknown	11 (<1%)	2 (<1%)
Surgery		
Breast-conserving surgery	1242 (77%)	1236 (76%)
Radical modified mastectomy	362 (23%)	382 (24%)
Unknown	2 (<1%)	0
Hormone receptor status		
ER-positive/PgR-positive	1247 (78%)	1272 (79%)
ER-positive/PgR-negative	281 (18%)	283 (18%)
ER-negative/PgR-positive	39 (2%)	28 (2%)
Unknown	39 (2%)	35 (2%)

Data are number (%) unless otherwise indicated. ER=oestrogen receptor; PgR=progesterone receptor

Event-free survival was higher in patients who took anastrozole than in those who continued treatment with tamoxifen (figure 2). 67 events were noted in the anastrozole group and 110 events in the tamoxifen group. In the combined analysis, there was a HR of 0.60 (0.44–0.81, $p=0.0009$) in favour of anastrozole at 3 years post-switch for the occurrence of an event. With respect to first events only, the HR was 0.59 (0.44–0.81, $p=0.0008$). Event-free survival 3 years after switching was 92.7% (SD 0.81) for the tamoxifen group and 95.8% (SD 0.65) for the group switched to anastrozole, corresponding to an absolute benefit at 3 years of 3.1% (figure 2).

Figure 2: Kaplan-Meier curves showing event-free survival for combined data set

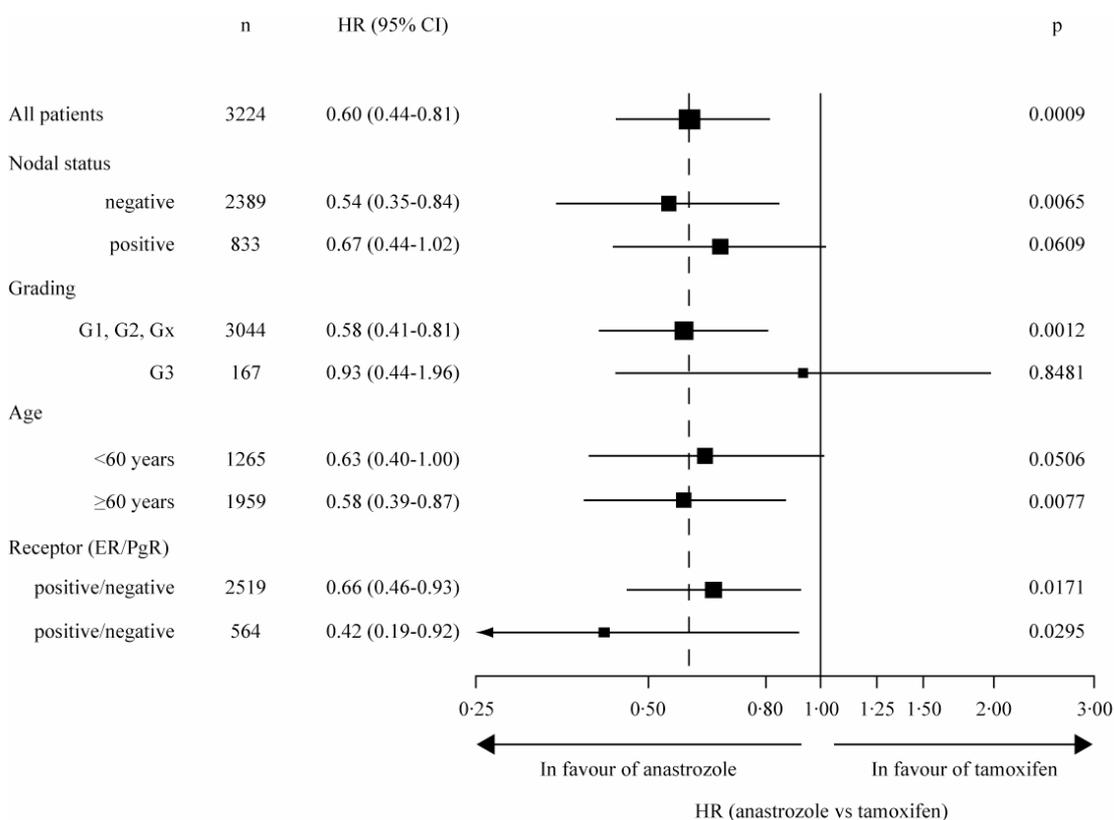


Numbers at risk (estimated proportion of events):

Tamoxifen	1217 (2.5%)	858 (5.4%)	593 (7.3%)	343 (9.4%)	176 (13.2%)
Anastrozole	1243 (1.4%)	874 (2.9%)	623 (4.3%)	375 (5.2%)	178 (9.7%)

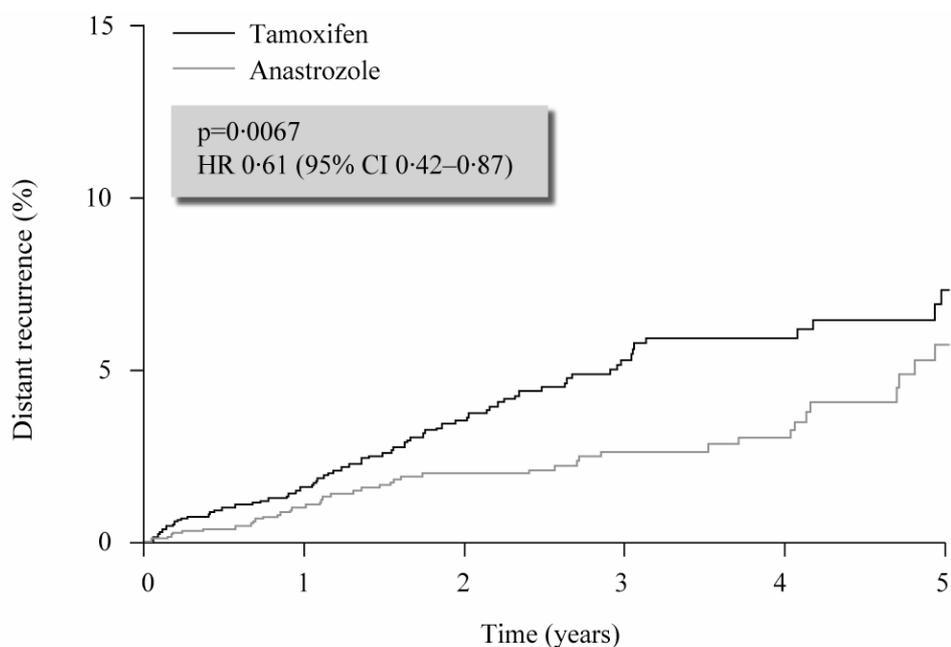
Figure 3 shows the risk of recurrence of cancer stratified by nodal status, tumour grading, age, and receptor status. Although the 95% CIs of the subgroups overlap, and so the differences are not significant, the data suggest that women with G1, G2 and Gx lobular tumours responded better to anastrozole than to tamoxifen than did those with G3 tumours. For all patients, irrespective of tumour grading, the advantage of switching to anastrozole over continuing with tamoxifen was not affected by nodal status, age at surgery, or receptor positivity, although there is a (non-significant) suggestion that the benefit of anastrozole in oestrogen-receptor-positive, progesterone-receptor-negative patients may be greater (figure 3).

Figure 3: Hazard ratio (HR) plot for nodal status, tumour grade, age and hormone receptor status stratifications



In women in whom disease progressed, distant metastases accounted for 63% (n=110) of recurrences (figure 4). Metastases arose in 3% of anastrozole-treated patients and in 5% of patients treated only with tamoxifen HR 0.61 (0.42–0.87, p=0.0067), indicating a 39% decrease in risk of metastases for women switching to anastrozole. When looking at distant metastases as first events only, the univariate model gives an HR of 0.54 (0.37–0.80, p=0.0016). Contralateral or ipsilateral recurrence accounted for only 16% (n=28) and 23% (n=41) of recurrences, respectively. More recurrences were observed in the tamoxifen group than in the anastrozole group (table 2). 59 individuals in the tamoxifen group and 45 in the anastrozole group died.

Figure 4: Kaplan-Meier curves showing distant recurrence-free survival for combined data set



Numbers at risk (estimated proportion of distant recurrences):

Tamoxifen	1224 (1.8%)	869 (4.1%)	600 (6.1%)	351 (6.7%)	181 (8.3%)
Anastrozole	1247 (1.1%)	879 (2.2%)	631 (2.9%)	382 (3.3%)	181 (6.3%)

Table 2: Recurrences and deaths by treatment group

All documented events	Tamoxifen	Anastrozole	Total
Total events	110 (2)	67 (2)	177 (4)
Locoregional events	24 (0)	20 (3)	44 (3)
Distant metastasis events	75 (4)	46 (7)	121 (11)
Contralateral events	16 (0)	12 (0)	28 (0)
Deaths			
Breast cancer related	31	24	55
Non breast cancer related	28	21	49

Number of patients who had had a previous event of a different type is given in parentheses.

Overall survival at 3 years post-switch was slightly higher in patients who switched to anastrozole (97%) compared with those patients continuing on tamoxifen (96%), although this difference was not significant ($p=0.16$; table 2).

Table 3 shows the incidence of serious adverse events by treatment group. There were significantly more fractures ($p=0.015$) and significantly fewer thromboses ($p=0.034$) in patients treated with anastrozole than in those treated with tamoxifen. There was also a trend towards fewer emboli ($p=0.064$) and endometrial cancers ($p=0.069$) in patients treated with anastrozole. The incidence of predefined adverse events in ABCSG Trial 8 is shown in table 4. No adverse events were prespecified in the study protocol of ARNO 95. There were significantly more reports of nausea ($p=0.0162$) and a trend towards more reports of bone pain ($p=0.0546$) in the anastrozole group than in the tamoxifen group.

Table 3: Incidence of serious adverse events by treatment group (ABCSG Trial 8 / ARNO 95 Trial)

Adverse event	Tamoxifen (n=1597)	Anastrozole (n=1602)	OR (95% CI), p
Myocardial infarct	2 (<1%)	3 (<1%)	1.50 (0.17–17.9), 1.0
Embolism	9 (<1%)	2 (<1%)	0.22 (0.02–1.07), 0.064
Thromboses	12 (<1%)	3 (<1%)	0.25 (0.04–0.92), 0.034
Fractures	16 (1%)	34 (2%)	2.14 (1.14–4.17), 0.015
Endometrial cancer	7 (<1%)	1 (<1%)	1.14 (0.003– 1.11), 0.069

Table 4: Predefined adverse events by treatment group in ABCSG trial 8

Adverse event	Tamoxifen (n=1117)	Anastrozole (n=1120)	OR (95% CI), p
Hot flushes	560 (50%)	537 (48%)	0.92 (0.77–1.09), 0.3209
Asthenia, somnolence	29 (3%)	37 (3%)	1.28 (0.76–2.18), 0.3880
Allergy, cutaneous toxicity, skin rash	16 (1%)	26 (2%)	1.63 (0.84–3.28), 0.1628
Hair loss	24 (2%)	35 (3%)	1.47 (0.84–2.60), 0.1901
Diarrhoea	9 (<1%)	15 (1%)	1.67 (0.68–4.35), 0.3080
Nausea	10 (<1%)	25 (2%)	2.53 (1.17–5.92), 0.0162
Vaginal bleeding/discharge	195 (17%)	198 (18%)	1.02 (0.81–1.27), 0.9348
Bone pain	177 (16%)	213 (19%)	1.25 (1.00–1.56), 0.0546

Data are number (%) unless otherwise indicated

Discussion

Our data show that in postmenopausal women with early breast cancer, switching to anastrozole after 2 years' tamoxifen treatment results in reduced rates of disease recurrence, particularly with respect to distant metastases. There are two possible explanations for this finding: tamoxifen resistance might be overcome by a change in treatment; or aromatase inhibitors might simply be a better treatment option, since they reduce peripheral oestrogen concentrations to extremely low levels, whereas tamoxifen is a partial agonist.

The number of women in the combined analysis who had G3 tumours was small, yet nearly a third of recurrences arose in this group. Overall, patients with G1, G2, or Gx lobular tumours responded better to adjuvant therapy than did those with G3 tumours, as expected. Undifferentiated tumours generally have a less pronounced response to endocrine therapy and could, therefore, be expected to progress more readily; the 5-year survival rate of patients with undifferentiated tumours at diagnosis is about 20% lower than that of patients with highly-differentiated or moderately-differentiated tumours.²⁵ In recognition of this difference in response, patients with undifferentiated tumours would be less likely to receive adjuvant endocrine treatment alone.

Since ABCSG trial 8 and ARNO 95 enrolled a good prognosis population (about three-quarters of patients were node-negative and a similar proportion received breast conservation surgery), we did not expect to see a survival difference at this stage. Furthermore, longer follow-up is needed to show a significant difference in overall survival in a trial between two active treatments than in a trial of an active treatment versus placebo.

The contrasting safety profiles of anastrozole and tamoxifen are well known. We noted significantly more fractures and significantly fewer thromboses in patients treated with anastrozole than in those who received only tamoxifen. However, we also noted a non-significant tendency towards fewer emboli and endometrial cancers in women on anastrozole. The ATAC trial¹⁵ has already provided evidence of the long-term safety and tolerability of anastrozole treatment, and no new safety concerns arose during this analysis.

As expected, the fracture rate in the group switched to anastrozole was higher than in the group who received continuous tamoxifen. However, the fracture rate in the anastrozole group was lower than that seen at a similar point in the anastrozole group of the ATAC trial.²⁶ This finding could suggest a continued protective effect of tamoxifen on bone in ABCSG trial 8/ARNO 95 patients; anastrozole-treated patients in the ATAC trial had received no previous treatment with tamoxifen. However, data from another aromatase inhibitor, exemestane, does not support this hypothesis,¹⁷ since patients switched to exemestane after 2–3 years' tamoxifen were more likely than patients who continued on tamoxifen to suffer arthralgia and osteoporosis. Results from a bone substudy of that trial showed that after 1 year, exemestane was associated with significantly greater reductions in the lumbar spine and total hip bone-mineral density (BMD) than tamoxifen. The decrease in BMD was rapid - within 6 months of switching to exemestane - and by the end of the first year, the BMD loss was similar to that seen with other aromatase inhibitors.²⁷

In a recent placebo-controlled trial²⁸ of the effect of exemestane on BMD in postmenopausal women with early breast cancer, the aromatase inhibitor modestly increased bone loss from the femoral neck. Management of the increased risk of fractures caused by BMD loss includes regular BMD screening. For patients with concomitant risk factors for developing osteoporosis - eg, advanced age, smoking status, family history and high body-mass index - the administration of bisphosphonates could be considered as a prophylactic measure.

Overall, the published work indicates that there are potential benefits to switching from tamoxifen to an aromatase inhibitor after 2 years, and that patients could benefit from the antitumour effects of tamoxifen in the short term while avoiding the complications of long-term tamoxifen therapy.

However, to date, the studies have been structured such that the analyses relate only to the period of switched treatment. Patients in whom cancer recurs at an early stage or who do not survive to the end of the initial tamoxifen phase are, therefore, excluded, and the randomised population is selected from patients with tumours that show a good response to endocrine therapy. As such, the results of this investigation and other switching trials apply only to those women who have successfully completed 2–3 years' adjuvant therapy for early breast cancer. They are not applicable to newly diagnosed patients, and should not be used to support a treatment strategy of starting with tamoxifen with the intention of changing to an aromatase inhibitor after 2 or more years. Overall, however, these studies demonstrate the efficacy advantages attached to aromatase inhibitor treatment, despite the qualitative differences cross-trial comparisons reveal as to the magnitude of such advantages, definitions of predefined adverse events, or patient demography.

The benefits of reduced recurrence of cancer when switching adjuvant therapy to an aromatase inhibitor before progression on tamoxifen might be related to cellular changes within the tumour in response to tamoxifen treatment. The effect of switching from one endocrine treatment to another after less than 2 years needs further investigation, as does switching from primary therapy with an aromatase inhibitor to other treatment modalities. Although even less thoroughly understood than tamoxifen resistance, resistance to aromatase inhibitors over 5 years of exposure also leads to the recurrence of the original disease.²⁹

Switching treatment to an aromatase inhibitor also offers the opportunity to continue adjuvant therapy for longer than 5 years, since the problems of tolerability that arise from the partial agonist effects of tamoxifen are circumvented. In one study,³⁰ extended adjuvant therapy with letrozole, another non-steroidal aromatase inhibitor, conferred a significant benefit in terms of disease-free survival after 5 years' tamoxifen therapy. The extended adjuvant approach is also being investigated with 3 years' anastrozole therapy (compared with no treatment) after the standard 5 years' treatment with tamoxifen in ABCSG trial 6A.³¹

Research indicates that 5 years of treatment with tamoxifen is no longer the optimum therapy for postmenopausal women with endocrine-responsive early breast cancer. The results of the ATAC trial¹⁵ show that 5 years of anastrozole as initial endocrine therapy is better than tamoxifen for adjuvant monotherapy, and several trials support changing adjuvant therapy to an aromatase inhibitor after initial treatment with tamoxifen. Both of these findings are taken into account in the ASCO technology assessment.¹⁸ Although further investigation of the use of aromatase inhibitors is necessary to ascertain the ideal sequence and duration of adjuvant endocrine therapy, this combined analysis confirms that postmenopausal women who receive tamoxifen as adjuvant therapy should be switched to anastrozole after 2 years of treatment.

Contributors

R Jakesz is the current principal investigator and chairs the writing and steering committees. W Jonat, M Gnant and M Kaufmann participated in the coordination of the trial and the preparation of trial results for analysis. M Mittlboeck was responsible for the statistical analysis and participated in trial design. All authors contributed to the design of the study, participated in the overall operational management of the trial, contributed to data interpretation and participated in the writing of this report.

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