DCISに対する他の良い治療選択肢 (Abstract LBA500)

閉経後DCIS患者においてアナストロゾールを使用した方がタモキシフェンよりも無再発率が高い

Anastrazole offers higher breast cancer-free survival rates than tamoxifen in postmenopausal women with DCIS

第51回American Society of Clinical Oncology年次集会で発表された第III相試験の結果、閉経後DCIS（非浸潤性乳管がん）には乳がん予防の他の選択肢がある可能性が示された。スタディでは、DCIS生存者3,000人あまりにおいて標準的な5年間のタモキシフェン治療と5年間のアロマターゼ阻害剤アナストロゾール治療とを比較した。スタディでは、閉経後ホルモン受容体陽性DCIS患者3,104人がタモキシフェンまたはアナストロゾールを毎日5年間内服する群にランダムに割り付けられた。ホルモン療法開始前に全員が腫瘍摘出術および放射線療法を受けた。平均追跡期間8.6年後に乳がんが検出されたのは、タモキシフェン群で114人であったのに対しアナストロゾール群では84人であった。これには、同側または対側の新たな乳がん発症（DCISまたは浸潤性がん）に加え、DCIS再発が含まれた。10年乳がん無再発率はアナストロゾール群においてタモキシフェン群よりも高く（93.5%対89.2%）、この差は統計学的に有意であった。乳がんによる死亡はタモキシフェン群で8人であり、アナストロゾール群で5人であった。サブグループ解析では、60歳を超える女性においてはアナストロゾールはタモキシフェンより優れてはいない可能性が示された。

Full Text

A federally funded phase III trial presented at the American Society of Clinical Oncology's 51st Annual Meeting suggests that postmenopausal women with ductal carcinoma in situ (DCIS) may have an additional option for breast cancer prevention. The study compared the standard five-year treatment of tamoxifen to five years of the aromatase inhibitor anastrazole in more than 3,000 DCIS survivors. The 10-year breast cancer-free survival rates were higher in the anastrazole group than in the tamoxifen group (93.5% vs. 89.2%).

"The good news is tamoxifen and anastrazole are both very effective, but it seems that women have better chances of staying well with anastrazole," said lead study author Richard G. Margolese, MD, a professor of surgical oncology at The Jewish General Hospital, McGill University in Montreal, Canada. "Women should also consider differences in side effects when discussing treatment options with their doctors."

Women with DCIS are at increased risk of developing invasive breast cancer, although breast cancer-related death is uncommon following DCIS treated with radiation and lumpectomy.

While both tamoxifen and aromatase inhibitors have been used to prevent recurrences of more advanced forms of breast cancer, this is the first study to compare the two treatments in women with DCIS. In the study, 3,104 postmenopausal patients with hormone receptor-positive DCIS were randomly assigned to daily tamoxifen or anastrazole, each given for five years. Prior to starting hormone therapy, all had undergone lumpectomy and radiation therapy.

After an average follow-up period of 8.6 years, 114 breast cancers were detected in the tamoxifen group compared to 84 in the anastrazole group. This included recurrences of DCIS as well as development of a new breast cancer (DCIS or invasive) in the same or other breast. The 10-year breast cancer-free rates were higher in the anastrazole group than in the tamoxifen group (93.5% vs. 89.2%), and this difference was statistically significant.

There were eight deaths due to breast cancer in the tamoxifen group and five in the anastrazole group. While the 10-year overall survival rates were comparable in the two groups (92.5% for anastrazole and 92.1% for tamoxifen), a subgroup analysis revealed that anastrazole may not be superior to tamoxifen in women older than 60 years.

Hormone receptor-positive breast cancer is dependent on estrogen for growth. Tamoxifen and anastrazole block the estrogen growth signal in different ways. While tamoxifen blocks the estrogen receptor, anastrazole suppresses the manufacturing of estrogen.

Generally, there were no significant differences in the toxicity profiles of these agents. The main side effect of anastrazole is hastening of osteoporosis, which increases the risk of bone fracture. Indeed, anastrazole resulted in a higher rate of bone fractures compared to tamoxifen, though the difference was not statistically significant. In addition, treatment with tamoxifen was associated with higher rates of uterine cancer, though the difference also did not reach statistical significance.

ASCO expert Don S. Dizon, MD commented on the study. "Women with DCIS already have several great treatment options, and now they have one more. Aromatase inhibitors offer important advantages, but patients and their doctors should still consider the full range of options, including tamoxifen or even foregoing adjuvant treatment, as every approach carries its own risks and benefits."

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