

RADIOTHERAPY IN BREAST DUCTAL CARCINOMA *IN SITU*

Radioterapia em carcinoma ductal *in situ* de mama

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ABSTRACT

Breast ductal carcinoma *in situ* (DCIS) comprises a heterogeneous group of lesions with different forms of clinical and pathological presentation. Postoperative radiotherapy is usually performed in DCIS patients who underwent conservative breast surgery. The objective of the present study was to describe indications and clinical evidences of radiotherapy for breast DCIS patients.

KEYWORDS: Breast; ductal carcinoma in situ; radiotherapy.

RESUMO

O carcinoma ductal *in situ* (CDIS) de mama compreende um grupo heterogêneo de lesões com diferentes formas de apresentação clínica e patológica. A radioterapia pós-operatória é normalmente realizada nas pacientes com CDIS submetidas à cirurgia conservadora de mama. O presente estudo teve o objetivo de apresentar as indicações e as evidências para a utilização da radioterapia na abordagem do CDIS de mama.

PALAVRAS-CHAVE: Mama; carcinoma ductal in situ; radioterapia.

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INTRODUCTION

Ductal carcinoma in situ (DCIS) of the breast comprises a heterogeneous group of lesions with different forms of clinical and pathological presentation. Traditionally, DCIS is classified according to its architectural pattern, which is usually encompassed in five main subdivisions: comedo, cribriform, micropapillary, papillary or solid¹. It's a distinctive set of proliferative lesions with heterogeneous invasion potential. Therefore, identifying lesions with more aggressive potential is necessary to establish the most appropriate therapeutic proposal¹.

DCIS diagnosis has increased very markedly over the last years due to population-based mammography screening programmes¹. When radical mastectomy was the method of choice to approach DCIS, cure rate was close to 98%, with low recurrence rate after surgical procedure².

With the advent of conservative treatment (quadrantectomy/lumpectomy followed by whole breast radiotherapy) for invasive breast carcinomas, this type of therapy started being used for DCIS (specially for small and unicentric tumors), though it's important to mention that there are only retrospective studies backing this kind of approach for DCIS. Therefore, there are no prospective or randomized clinical trials comparing conservative therapy and radical mastectomy for these patients^{3,4}.

Whole breast radiotherapy after conservative surgery reduces the risk of local recurrences (both *in situ* and invasive). Local control benefits are the most significant gains of this approach and the results are more significant when combined with radiotherapy, even though there are no direct gains regarding overall survival rates.

THE ROLE OF ADJUVANT WHOLE BREAST RADIOTHERAPY FOR DUCTAL CARCINOMA *IN SITU*: CLINICAL EVIDENCE

Randomized clinical trials

Four randomized clinical trials with over 4,000 patients showed local control benefit when adjuvant radiotherapy was added to the treatment of DCIS patients who underwent conservative surgery.

The National Surgical Adjuvant Breast and Bowel Project (NSABP) Protocol B-17 involved 818 patients randomly divided into two groups: whole breast isolated or radiotherapy-associated surgery. The main result was local recurrence (invasive or intraductal). In a 12-year follow-up, radiotherapy reduced the cumulative local recurrence rate (16.0 *versus* 32.0%). Considering invasive and non-invasive recurrences, in both subgroups the gains were maintained though the invasive recurrence decrease was higher than non-invasive recurrence (16.8 *versus* 7.7% and 14.6 *versus* 8.0%, respectively). There was no impact over overall or cancer-specific survival rates⁵. An update of this study (with conjoint analysis of NSABP B-24 data) corroborates the benefits of adjuvant radiotherapy⁶.

The European Organization for Research and Treatment of Cancer (EORTC 10853) assessed 1,010 DCIS patients (with ≤ 5 -cm tumors) treated with conservative surgery. The patients randomly received whole breast radiotherapy or a clinical approach. After 4.3 years of trial, the group treated with radiotherapy showed lower invasive (4.8 *versus* 8.0%) and non-invasive (5.8 *versus* 8.8%) recurrence rates when compared to the non-adjuvant group⁷. In 15 years, there was a 48% decrease in the risk of local recurrence, with a longer recurrence-free interval, over the same period for the radiotherapy group (82 *versus* 69%). No difference was observed between cancer-specific and overall survival⁸.

A cooperative study conducted by researchers from England, Australia and New Zealand randomly submitted 1,701 patients to DCIS surgery with free margins to the following groups: isolated surgery, surgery with whole breast radiotherapy, surgery with tamoxifen treatment and surgery with both whole breast radiotherapy and tamoxifen treatment. After 53 months of follow-up, on average, radiotherapy was able to decrease the recurrence rate of *in situ* and ipsilateral invasive carcinoma. Hormone therapy did not reduce the occurrence of ipsilateral invasive tumors, although DCIS overall recurrence was shown to be lower⁹. After 12.7 years of study, it was once again confirmed that radiotherapy decreased the incidence of ipsilateral invasive tumors recurrence (*hazard ratio* 0.32; 95% confidence interval — 95%CI 0.19–0.56; $p < 0.0001$) and *in situ* recurrence (*hazard ratio* 0.38; 95%CI 0.22–0.63; $p < 0.0001$)¹⁰.

An investigation by the Swedish Breast Cancer Group analyzed the role of whole breast radiotherapy after conservative surgery in 1,046 DCIS patients. After 5.2 years of study, the group that underwent radiotherapy showed less recurrences (44 *versus* 117 cases). No difference was observed between groups regarding contralateral breast cancer, distant metastasis and death rates¹¹. A recent 20-year follow-up update of this study placed radiotherapy as related to a 37.5% reduction of ipsilateral recurrence risk. Once again, no impact on overall survival rates was observed¹².

The study 9.804 by the Radiation Therapy Oncology Group (RTOG) randomly submitted 636 DCIS patients (with unicentric tumor smaller than 2.5 cm and low or intermediate nuclear grade) to whole breast radiotherapy or to observation. The use of tamoxifen was optional (62% of the patients received it). With average follow-up of 7.17 years, local ipsilateral recurrence in the radiotherapy group was rare (2 *versus* 19 occurrences). In a seven-year period, local recurrence rate was 0.9% in the radiotherapy group and 6.7% in the observation group (*hazard ratio* 0.11; 95%CI 0.03–0.47; $p < 0.001$)¹³.

It is worth noting that studies NSABP B-17⁶ and EORTC⁸ pointed out the benefits of radiotherapy even for the subgroup of patients considered at low risk (free surgical margins, > 2 -cm tumors and low-grade lesion). Also importantly, even though there were no direct overall survival benefits, breast cancer mortality rate was higher among patients with ipsilateral breast invasive carcinoma recurrence.

Some of the aforementioned studies, however, have limitations mainly regarding pathological evaluation (measurement of the tumor size and definition of free margins), surgical specimen radiography, and postoperative mammography.

Table 1 sums up the characteristics and results of randomized clinical trials selected.

Meta-analysis

The Early Breast Cancer Trialists' Collaborative Group (EBCTCG) published in 2010 a meta-analysis compiling data from clinical trials and showed an absolute risk reduction of 15.2% over ten years when whole breast radiotherapy was combined with conservative surgery. The benefits of radiotherapy were the same regardless of age, surgery type (quadrantectomy or lumpectomy), use of tamoxifen, diagnosis method (clinical or radiologic), surgical margin (free, narrow or unknown), nuclear grade, presence of comedonecrosis, architectural subtype or tumor size. Furthermore, the impact of radiotherapy on the outcome was similar in terms of *in situ* and invasive local recurrences: 6.5 versus 14.9% and 6.9 versus 15.4%, respectively. The analysis of the subgroup of patients rated as low-risk (≤ 2 -cm tumor, grade 1 and free margins) showed that radiotherapy was able to reduce the absolute risk of local recurrence by 18% (12 versus 30%; $p=0.002$)¹⁴.

Another meta-analysis carried out by the Cochrane Group confirmed the statistically significant benefits of radiotherapy in cases of ipsilateral local recurrence (*hazard ratio* 0.49; 95%CI 0.41–0.58; $p<0.00001$), ipsilateral invasive recurrence (*hazard ratio* 0.50; 95%CI 0.32–0.76; $p=0.001$), and ipsilateral *in situ* recurrence (*hazard ratio* 0.61; 95%CI 0.39–0.95; $p=0.03$). Analysis of all subgroups showed benefits of adopting radiotherapy, with no long-term toxicity associated to this treatment¹⁵.

RADIATION BOOST AFTER WHOLE BREAST RADIOTHERAPY FOR DUCTAL CARCINOMA *IN SITU*

The role of booster doses in the treatment of breast invasive tumors has been established through randomized clinical trials¹⁶.

Regarding DCIS, a retrospective multicenter study showed, in a 72-month follow-up, that women younger than 45 years had local recurrence rates after conservative breast treatment of 54, 28 and 16%, considering patients treated exclusively with surgery, with surgery combined with whole breast radiotherapy, and with surgery combined with whole breast radiation boost on surgical bed, respectively¹⁷. Corroborating those results, other

Table 1. Randomized clinical trials.

Study	Recruitment period	Duration (years)	Number of patients	Pathology central revision (%)	Negative margins (%)	RT doses	Booster doses
NSABP B-17	1985–1990	17.25	818	76	78	50Gy/25 fractions	10 Gy/5 fractions (9% of the patients)
EORTC 10853	1986–1996	15.8	1.010	85	83	50Gy/25 fractions	10 Gy/5 fractions (5% of the patients)
UK/ANZ DCIS	1990–1998	12.7	1.030	0	100	50Gy/25 fractions	-
SweDCIS	1987–1999	20	1.067	26	80	50 - 54Gy/25 -27 fractions	-
RTOG 9804	1998–2006	7.17	636	100	100	50 - 54Gy/25 -27 fractions or 42,5Gy/16 fractions	-

Study	Local recurrence (%)						Overall survival (%)	
	Total		Invasive		In situ		Without RT	With RT
	Without RT	With RT	Without RT	With RT	Without RT	With RT		
NSABP B-17	35,0	19,8	19,6	10,7	15,5	9,0	86,0	87,0
EORTC 10853	30,0	17,0	15,0	9,5	15,0	7,5	90,0	88,0
UK/ANZ DCIS	19,4	7,0	9,1	3,3	9,7	3,8	97,9	96,2
SweDCIS	20,0	32,0	-	-	-	-	77,7	73,0
RTOG 9804	6,7	0,9	-	-	-	-	95,1	91,7

RT: radiotherapy; NSABP: National Surgical Adjuvant Breast and Bowel Project; EORT: European Organization for Research and Treatment of Cancer; RTOG: Radiation Therapy Oncology Group.

retrospective studies reported low local recurrence rates when booster radiation doses were systematically used^{18,19}.

However, some studies reported no benefit related to the use of radiation boost in the treatment of DCIS patients²¹.

This matter remains open, and currently two randomized clinical trials are ongoing with the goal of evaluating booster doses for DCIS patients.

WHOLE BREAST HYPOFRACTIONATED RADIOTHERAPY FOR DUCTAL CARCINOMA *IN SITU*

The hypofractionated radiotherapy, which has a fraction number smaller than the standard 25 to 30, is becoming popular after the publishing of two studies that evaluated the long-term evolution of patients submitted to this procedure^{22,23}. Treatment schemes with 15 and 16 radiotherapy fractions have been assessed. No differences between local control, survival rate and toxicity were observed, and schemes were deemed equivalent to standard, if not better in terms of late toxicity. Most patients included in both studies were aged over 50 years and had low-risk invasive tumors in early stages. Regarding DCIS, however, the hypofractionated schemes were not randomly tested.

Despite that, the appeal for a shorter-term, more efficient treatment led several health centers to evaluate the effects of hypofractionated radiation on DCIS, and the outcomes were all gathered in a meta-analysis of observational studies published in 2015. Among the 13 studies analyzed, four (2,534 patients) compared the hypofractionated radiation to standard fractioning, but found no differences in local recurrence rate between the groups (*hazard ratio*: 0.78, 95%CI 0.58–1.03). The authors concluded that hypofractionated radiotherapy seems to be safe and efficient for DCIS patients and can be used as long as professionals keep in mind that the studies included in the meta-analysis carry a low level of evidence²⁴.

WHOLE BREAST ADJUVANT RADIOTHERAPY IN ELDERLY PATIENTS WITH DUCTAL CARCINOMA *IN SITU*

The benefits of radiotherapy for low-risk DCIS patients is a controversial question, especially in advanced ages. Also, women over 70 years old either are generally not included in clinical trials or represent a small portion of the studied population. According to a data collection in France, only 13.4% of the studied DCIS patients were aged 70 years or older²⁵.

The best available data about conservative breast cancer treatment with or without radiotherapy in elderly patients (above 70 years old) come basically from two randomized studies conducted with early-stage invasive tumor patients. The patients

submitted to radiation had good results as to local control, but overall survival rates were not impacted^{26,27}.

Regarding DCIS, the EBCTCG¹⁵ meta-analysis also showed good outcomes of adjuvant radiotherapy after conservative surgery. Results were proportionally better in patients aged 50 years or older, with absolute risk of ipsilateral recurrence after 10 years of 18,5 *versus* 29,1% for patients below the age of 50, and of 10,8 *versus* 27,8% for the other age groups. It is worth noting that the cut-off age was 50 years old, and still the risks with or without adjuvant radiotherapy in this group were lower compared to patients under this age. There are no specific data addressing patients over 70 years old, however, the proportional reduction of occurrences in the group receiving radiation therapy increased with aging, for every decade added: 60 to 69 and 70 and above ($p=0.02$).

Even elderly DCIS patients benefit in terms of local control from radiotherapy after conservative surgery and, to the present moment, there is not a subgroup of patients that can be safely kept from radiation therapy. Age alone can not be a contraindication for the treatment. In the long run, the potential impact of local recurrence on elderly patients' quality of life and psychological state should not be underestimated.

However, at least for patients with lower life expectancy, whether by presence of comorbidities or advanced age, the extent of risk reduction should be evaluated, keeping in mind that at least nine patients must be submitted to radiation therapy as a means of preventing ipsilateral recurrence¹⁵; among the elderly, this number can range from 20 or 21 (70 to 80 years old) to 160 (80 years and older) patients²⁸.

The International Society of Geriatric Oncology (SIOG) and the European Society of Breast Cancer Specialists (EUSOMA)²⁹ recommend that, once survival rates do not change, the level of local control must be assessed considering individual risk, physiological age, life perspective, treatment tolerance, patient's preference and other potential matters such as daily visits to the radiotherapy service for adjuvant therapy.

ACCELERATED PARTIAL BREAST RADIATION FOR DUCTAL CARCINOMA *IN SITU*

Accelerated partial breast radiation (APBR) has been evaluated in several randomized clinical trials. When compared to whole breast radiotherapy, results are controversial when it comes to local control rates. Some studies report similar local recurrence rates, while others point out lower rates in the group of patients submitted to APBR. It's important to emphasize that the number of DCIS patients included in such studies is small, hence it's difficult to outline the true effect of APBR in this subgroup of patients³⁰.

The American Society for Radiation Oncology (ASTRO)³¹ and the American Brachytherapy Society (ABS)³² consider DCIS patients good candidates to APBR. On the other hand, the European

Society for Radiotherapy and Oncology (ESTRO) states that new studies are necessary to prove the efficiency of APBI for DCIS patients and they do not recommend this therapy as a routine procedure³³.

CONCLUSIONS

- Whole breast adjuvant radiotherapy is related to reduction of *in situ* and invasive recurrences in breast DCIS patients. Therefore, it should be adopted as a routine procedure;
- The action of booster radiation doses in the treatment of DCIS patients is not clear;
- Hypofractionated radiotherapy can strongly be regarded as a procedure for DCIS patients, following the same selection criteria used for invasive tumors;
- For elderly DCIS patients, the indication of radiotherapy must be based on the balance between treatment benefits and patients' life perspective;
- APBI for DCIS patients is a controversial matter despite some international guidelines supporting its use in clinical practice.

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