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LETTER TO THE EDITOR

What is the best clinical pathological score to identify high-risk patients with lobular carcinoma of the breast who are likely to benefit from adjuvant chemotherapy?

Roberta Maltoni[1] · **Sara Bravaccini**[1]

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To the Editor,

Invasive lobular carcinomas (ILCs) represent around 10% of all breast cancers, and the role of adjuvant chemotherapy (CT) has yet to be clarified. In a retrospective multicenter study, de Nonneville et al. [1] investigated whether chemotherapy impacted disease-free (DFS) and overall survival (OS) in a subgroup of patients with hormone receptor-positive and Her2-negative ILC treated with endocrine therapy alone or chemotherapy plus endocrine therapy. 2318 patients were retrospectively identified from a cohort of 23,319 patients who underwent primary surgery in 15 French centers between 1990 and 2014.

We congratulate the authors on their very interesting paper but would like to underline some points. It is neither clear how patients undergoing chemotherapy were treated (type of drugs and schedules), nor is the time to initiation of chemotherapy (TTC) specified. In fact, TTC after surgery is important in terms of patient outcome [2]. Moreover, it is not mentioned whether patients underwent full dose or toxicity-related dose reduction.

In addition, the authors did not analyze the role of Ki-67 or other proliferative markers in the clinical pathological score. Despite difficulties in Ki-67 standardization and reproducibility, this protein could represent a useful prognostic marker in the clinical decision-making of adjuvant breast cancer patients [3].

Calibration of a common scoring method would help to obtain high inter-laboratory reproducibility in Ki-67 scoring. Furthermore, despite the encouraging literature data on the role of Ki-67 in other BC histotypes, standardization of Ki-67 scoring is needed among pathology laboratories [3].

We previously published a paper in which we analyzed the TTC in patients with rapidly proliferating early breast cancer defined by thymidine labeling index (TLI) > 3%, histological grade (G) 3, and S-phase > 10% or Ki-67/MIB 20% [4]. Although only a limited number of ILCs were analyzed, our results strongly suggested that a shorter TTC can reduce the risk of relapse and possibly also improve clinical outcomes in patients with highly proliferating early BC.

The best clinical pathological score should probably include Ki-67 or another proliferative index to better identify high-risk ILC patients. As reported by the authors, the use of Oncotype Dx has shown that ILCs rarely (about 2%) have high recurrence rates compared to those of invasive ductal carcinoma (about 20%), but obviously this 2% in respect of the former needs to be identified. We previously observed an elderly patient with highly expressing Ki-67 ILC who developed soft tissue relapse (Fig. 1). She was treated with hormone therapy rather than chemotherapy because of her age and the presence of comorbidities. More information on molecular features inherent to lobular carcinoma is needed for next-generation tailored therapies.

✉ Sara Bravaccini
sara.bravaccini@irst.emr.it

[1] Istituto Scientifico Romagnolo per lo Studio e la Cura dei Tumori (IRST) IRCCS, Meldola, FC, Italy

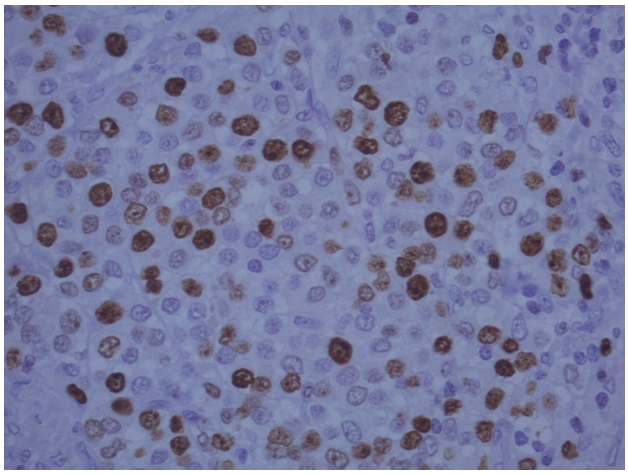

Fig. 1 Undifferentiated invasive lobular carcinoma highly expressing Ki67 by immunohistochemistry (×40 magnification)

Compliance with ethical standards

Conflict of interest We have no conflicts of interest to declare.

Ethical approval The manuscript complies with the ethical rules applicable for this journal.

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