Closing Remarks to the Conference, *Aromatase: New Perspectives for Breast Cancer*

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From 1930 to 1960, surgery was the dominant modality used to palliate the disease of patients with advanced breast cancer. It was during this period that ovariectomy, adrenalectomy, and hypophysectomy came to be widely used. Patients were not cured of their disease, but certainly objective responses and symptomatic relief were obtained.

The next period in the treatment of breast cancer was the development of the concept of combination chemotherapy in the early 1960's. Marked improvement in response rates was noted during this period. Indeed, up to 60 to 70% of patients so treated had an objective tumor response. Unfortunately, 50 to 60% of these responses were partial in nature. A further breakthrough occurred in the 1970's when chemotherapy was used in the adjuvant or high-risk setting. We are still in the process of trying to learn which patients will most benefit from the use of adjuvant chemotherapy. Also, the best way to use chemotherapy in the adjuvant setting must still be defined. Unfortunately, despite the use of adjuvant chemotherapy, many patients with breast cancer still relapse and require further treatment.

We believe that the information presented in the manuscripts that comprise this supplement heralds a new era in the understanding and the treatment of breast cancer. New forms of endocrine therapy have been introduced which will replace the older palliative surgical procedures. Examples of such agents are the antiestrogen tamoxifen and the aromatase inhibitor aminoglutethimide. It would appear as if the biochemist and endocrine oncologist have replaced the surgeon in the forefront of treatment of breast cancer once the disease is metastatic.

The future would appear to hold new hope for patients with metastatic disease. Newer agents that can inhibit the conversion of androgenic precursors to estrogenic compounds are on the horizon. The goal is that these will be even less toxic and more efficacious than are the agents currently available. The reversibility of treatment with antiestrogens or aromatase inhibitors represents another major area of advance to patients who are treated in palliative fashion. This would mean that when patients no longer respond they will not be committed to a lifetime of replacement hormonal therapy. Certainly, the toxicities of tamoxifen and aminoglutethimide are not nearly as severe or life threatening as are the major complications sometimes encountered in patients undergoing surgical adrenalectomy or hypophysectomy.

Finally, the concepts elaborated in these proceedings hold the promise of newer approaches to therapy that will lead us into the decade of the 1990's. One such concept is that of combination hormonal therapies. The second exciting area of investigation is the more rational integration of these newer hormonal modalities with combination chemotherapy. A final avenue of investigation is the use of hormonal therapy to convert breast cancer cells from a dormant (G0) to a more active phase of the cell cycle. These dividing cells would then be more susceptible to combination chemotherapy.

The organizers of this workshop sincerely thank all participants. The thought-provoking presentations and discussions both formal and informal made the entire venture worthwhile. We confidently expect to see the fruits of this scientific collaboration expressed in the near future as new insights and improved therapies for our patients with breast cancer.
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