Hong Kong Breast Cancer Registry
A HK Breast Cancer Foundation Initiative

Breast Cancer Facts in Hong Kong 2008 Report

香港乳癌實況2008報告

About the Hong Kong Breast Cancer Registry

The Hong Kong Breast Cancer Registry (HKBCR), a project operated by Hong Kong Breast Cancer Foundation, aims to collect information about every case of breast cancer reported in Hong Kong. Upon consent received from patients, the Registry's staff collects the medical data from private clinics and hospitals as well as health information, life style and risk factors from participants. The data are analyzed in aggregate and serve as a basis for further researches. The Registry has strict safeguards to protect the privacy of participants. The data allows us to analyse data on patient demographics and risk factors for breast cancer, disease distribution and pattern, treatment trends, clinical outcome and survival information. A very important component of the Registry is annual lifetime follow-up, which not only gauges the disease status, recurrence and survival rates but also serves a reminder to former patients on routine medical checkups.

The vision of the Hong Kong Breast Cancer Registry is:

- To enhance effectiveness of diagnosis and treatment of breast cancer.
- To help bring about changes in public policies for improved breast healthcare in Hong Kong.

Objectives

HKBCR collects and analyzes territory wide breast cancer data, as a means to offer insight of, and to support further research for more effective breast cancer prevention, treatment and breast healthcare solutions. These formal data will back analyses and recommendations.

- To analyze the causes and risk factors of local breast cancer cases
- To study the general situation of the disease and treatment trends in the local context
- To investigate the impact of breast screening in early detection
- To advocate and support people-oriented public healthcare policies
- To enhance public education

The importance of collecting information about breast cancer in Hong Kong

Collecting information about who gets breast cancer, and the results of their treatment is important for several reasons. Information can help scientists to:

- understand how the disease develops and how to better treat it.
- identify whether strategy such as widespread use of mammograms to detect breast cancer, is saving lives and help women makes decisions about their own health.

A comprehensive picture of breast cancer in Hong Kong

The report we present here summarizes the important information about local breast cancer cases collected in the report period. It covers personal and life style information of participants, prevalence of risk factors, clinical presentation, clinical and pathological characteristics of breast cancer, trends of treatment and results of treatment across the territory of Hong Kong and physical and psychosocial impact of breast cancer on the participants. The Registry makes this information available to health care professionals, health policy makers and the public, who may use information for their own reference or platform for further in-depth researches.

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If there is any inconsistency between the English version and the Chinese version, the English version shall prevail.

關於香港乳癌資料庫

香港乳癌資料庫是一項由香港乳癌基金會策動的項目，目的是搜集本地每宗乳癌數據。在獲得乳癌病人的同意後，資料庫人員將從參加者的主診醫生中搜集相關的醫療資料，以及透過問卷調查搜集健康資料、生活習慣及風險因素等。

資料數據經綜合分析，能促使進一步本港乳癌的研究。資料庫確保所有參加者的資料，均絕對保密。數據將有助我們分析乳癌病人人口特徵、高危因素、疾病分佈及模式、治療趨勢與效果，及存活等資料。

資料庫其中一個重要的元素，就是爲所有參加者作每年度病況的跟進，不但讓我們了解病人的健康狀況、復發風險及存活率之餘，藉此參加者亦可視爲每年一度安排接受覆診或身體檢查的提示。

香港乳癌資料庫的抱負包括：
- 提高乳癌的確診及治療效率
- 希望改善公共醫療政策，令乳房醫療服務得到更大重視

目標

香港乳癌資料庫搜集及分析全港乳癌數據，予以提供深入理解，及支持研究更有效預防乳癌方法、乳癌治療及醫療護理方案的深入研究。這些數據會支持分析，協助提供有用的建議。
- 分析本地乳癌成因及高危因素
- 研究本地乳癌病況及治療趨勢
- 檢視乳房普查的效用，驗證及早發現乳癌的好處
- 倡議及支持以民爲本的公共醫療教育
- 提升公衆對乳癌的認知

收集本地乳癌個案資料的重要性

搜集誰較易患乳癌及治療效果的資料是重要的。這些資料有助研究人員及醫護人員：
- 掌握乳癌怎樣形成及如何更有效治療乳癌
- 驗明某項特定的預防策略(例如實施乳房X光造影普查)是否有效及早確診乳癌，從而令婦女可就自己的健康作出選擇

了解全港乳癌狀況

此報告綜合了時段內成功搜集的本港乳癌資料，包括個人資料、生活習慣、高危因素、臨床徵狀、乳癌臨床及病理特徵、治療趨勢、治療效果及乳癌帶來的身心影響。資料庫將公開予醫護人員、制定醫療政策的官員及有興趣的公衆人士，讓他們作參考或用作深入研究之用。

如對本報告有任何查詢，請聯絡：

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節錄建議：香港乳癌基金會之香港乳癌實況2008報告

如中、英文兩個版本有不相符之處，應以英文版本爲準。

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From the Chairman of Hong Kong Breast Cancer Foundation

When our Foundation was inaugurated in 2005, it was already our belief that a population-wide breast cancer registry would be of great benefit to the community as it collects and captures comprehensive local data regarding breast cancer. The analysis and interpretation can help doctors make more informed decisions on the risk factors, disease characteristics and tailor-made treatment for patients. Policy makers will have solid local data to formulate policy on prevention and early detection of the disease. Moreover, it can provide information on any disparity on breast cancer and health awareness, breast cancer distribution among different geographical areas of Hong Kong and facilitate the Government in formulating appropriate, comprehensive health care policies to manage the burden of breast cancer to the society.

With the kind support from donors and supporters in January 2008, we hosted a charity concert and were able to raise an initial fund to kick-start the first-of-its-kind Hong Kong Breast Cancer Registry. We first engaged doctors from private clinics to participate. Through them, we obtained consent from patients and survivors allowing us to capture their medical data. Since 2009, we have also started data collection in several public and private hospitals. As in July 2009, there are over 2000 participants in the Registry.

We believe early detection saves lives. Through the work of the Hong Kong Breast Cancer Registry, we hope to shed light on the way to remove the threat of breast cancer to human lives and minimize the physical and psychosocial hardship of breast cancer on patients and their family members. For the Registry to be successful, we need the continuous support of healthcare professionals to facilitate the participation of as many breast cancer patients as possible. Their help in making the program known to patients and urging them to participate will be invaluable.

If you cannot measure it, you cannot control it. Likewise, without funding, research work is not possible. To sustain the immense work ahead of us in the Registry, we call on all to give unreservedly. Your generous donation will support us in our endeavours for the good of Hong Kong.

Mrs. Joanna Choi, BBS
Chairman, Hong Kong Breast Cancer Foundation
September 2009

香港乳癌基金會主席的話

自香港乳癌基金會於2005年成立起，我們便一直相信，策動一個全民特定的乳癌資料庫，將能令社會各界受惠。資料庫搜集本地乳癌個案的數據作研究分析，有關資料可協助醫生考慮乳癌的各種風險因素、乳癌特性，以及治療與護理方案等；至於制訂公共政策的政府官員，亦能憑藉充分的本地個案資料，考慮訂立有關乳癌普查的政策。

此外，資料庫亦能提供乳癌與及早檢查乳房的意識之差異，及乳癌個案在本港不同區域分佈的資料等，以讓政府制訂更全面和適當的醫療政策，減輕乳癌對社會造成的負擔。

香港乳癌基金會爲籌募資料庫的運作經費，在2008年1月曾舉辦一場籌款音樂會，在各方善長及贊助商的慷慨支持下，順利爲資料庫籌得開展的營運經費。2008年起，我們首先邀請來自私人診所的醫生參加；透過他們的幫助，我們開始從病人及康復者處取得同意書，以向他們索取病歷資料。自2009年起，計劃亦擴展至部份公立及私立醫院進行。截至2009年7月，共有逾2000名病患者已參加資料庫。

我們深信，及早發現，絕對是乳癌的治療關鍵。我們希望香港乳癌資料庫能提供佐證讓有關人士參與研究，有助帶領我們克服乳癌的威脅，並讓此症帶給病人與家屬的身心影響減至最低。如各方醫護人員欲支持此項別具意義的資料庫研究項目，請將有關資料介紹予所認識的乳癌病人及康復者，並鼓勵她們踴躍參與。

有足夠的研究及統計，才能令抗癌工作更有成效。但若缺乏經費，則研究工作難以持續進行。我們在此呼籲各位的慷慨支持，讓香港乳癌資料庫這個全港首個乳癌數據搜集系統，可更順利地推行與運作。

蔡梁婉薇, BBS
香港乳癌基金會主席
2009年9月

From the Hong Kong Breast Cancer Registry Steering Committee Chair

Steering Committee

Dr. Polly Cheung, Chairman, Surgeon (private) Founder of Hong Kong Breast Cancer Foundation

Members

Mrs. Veronica Bourke, Vice Chairman of Hong Kong Breast Cancer Foundation
Dr. Emily Ying Yang Chan, Assistant Professor, School of Public Health, Chinese University of Hong Kong
Dr. Keeng Wai Chan, Pathologist (private)
Dr. Sharon Wing Wai Chan, Surgeon (HA)
Dr. Peter Choi, Clinical Oncologist (private)
Mrs. Joanna Choi BBS, Chairman of Hong Kong Breast Cancer Foundation
Ms. Yvonne Chua, Partner, Wilkinson & Grist
Ms. Doris Kwan , Past chairman of Hong Kong Breast Cancer Foundation
Dr. Wing Hong Kwan, Clinical Oncologist (private)
Dr. Stephen CK Law, Clinical Oncologist (HA)
Dr. Lawrence Li, Clinical Oncologist (private)
Mrs. Sandra Mak, Council Member of Hong Kong Breast Cancer Foundation
Dr. Ting Ting Wong, Surgeon (private)
Dr. Chun Chung Yau, Clinical Oncologist (HA)

IT Subcommittee

Dr. Peter Choi, Clinical Oncologist (private)
Mr. Peter Kwan, veteran IT professional
Dr. Chun Chung Yau, Clinical Oncologist (HA)
Dr. Gary Yeoh, Pathologist (private)

More than one year ago, the Hong Kong Breast Cancer Registry Steering Committee, comprised of dedicated surgeons, pathologists, clinical oncologists and public health professionals from both private and public sectors as well as academic institution, management professionals, legal experts and representative of breast cancer patients, accepted the charge to develop the first population-wide cancer specific registry in Hong Kong. In carrying out this charge, the Committee provides guidance on the setting up and development of the Registry and monitors progress of the project, specifically to

- advise on types of data and how the data should be collected
- provide advice and guidance and oversee the implementation of the Registry
- formulate strategies for promoting the Registry to the public and healthcare professionals
- provide directions on recruiting participation of patients and healthcare professionals
- direct data compilation and analytical output and advise on continuous improvement of the Registry

The data collection and management are kept strictly confidential according to the personal data (Privacy Ordinance Chapter 486)

An IT subcommittee is also established to direct the system requirement and development. The expert views/advices from both committees provide, we believe, a blueprint for building a database platform for the Registry.

On behalf of the Hong Kong Breast Cancer Registry Steering Committee, we are pleased to present this first comprehensive report about breast cancer facts in Hong Kong.

This very first report "Breast Cancer Facts in Hong Kong 2008" summarizes information of approximately 1000 breast cancer cases collected mostly from private sector in 2008. It consists of analysis of demographics, life style information, clinical pattern and characteristics of breast cancer, pathological data and treatment trends. Analysis is performed in aggregate without individual identification.

We acknowledge the weakness of this first attempt that this 2008 Report largely consisting of private patients data, is not representative from statistical point of view. Starting from 2009 the Registry also collects patient data in several public and private hospitals, namely Princess Margaret Hospital, Prince of Wales Hospital, United Christian Hospital and Hong Kong Sanatorium & Hospital. Building up a population-based breast cancer registry is a long journey. But we deeply believe with the commitment of healthcare professionals, patients and others, a population-based registry consisting of breast cancer data, from both private and public sectors, is achievable.

We are excited about this meaningful journey ahead to facilitate enhancing breast health and cancer care in Hong Kong.

Dr. Polly Cheung
Founder, Hong Kong Breast Cancer Foundation
September 2009

香港乳癌資料庫 – 督導委員會主席的話

督導委員會

張淑儀醫生：主席及香港乳癌基金會創會人

成員

白美娜女士
陳英凝教授
陳健慧醫生
陳穎懷醫生
蔡浩強醫生
蔡梁婉薇女士 BBS
蔡映媚律師
關智鸞女士
關永康醫生
羅振基醫生
李沛基醫生
麥黃小珍女士
黃亭亭醫生
邱振中醫生

資訊科技小組委員會

蔡浩強醫生
關伯明先生
邱振中醫生
楊佩成醫生

逾一年多前，由來自公立醫院或私營醫療機構的醫生、管理專業人士、法律專家及乳癌病人代表所組成的香港乳癌資料庫「督導委員會」，同意策動全港首個全民特定的乳癌資料庫。督導委員會對資料庫的成立、發展及監督程序提供指導性的建議，尤其是：

- 所需搜集的數據種類，以及搜集有關數據的方法
- 指導及監督資料庫的運作
- 建議相關策略促進公衆及醫療人員對資料庫的認識
- 對推動乳癌病人及醫療人員的參與提供指導性建議
- 指導乳癌數據分析，以及持續改善資料庫

我們根據《個人資料(私隱)條例》(香港特別行政區法例第486章) 所載的保障資料原則嚴謹行事，確保所搜集的資料絕對保密。

與此同時，亦成立「資訊科技小組委員會」，指導數據系統發展及運作。兩個委員會對協助資料庫建立一個完整及資料性，可謂不可或缺。

我們在此，謹代表香港乳癌資料庫督導委員會，向各位簡介首份綜合的香港乳癌實況報告。

「香港乳癌實況2008」報告，綜合了於2008年期間所搜集約1000多宗主要來自私營醫療機構的本港乳癌個案，當中綜合分析了乳癌病患者特徵資料、生活模式、臨床乳癌病徵的形態、病理學數據，以至治療趨勢等。

我們承認這份2008年報告的不足之處，其個案來源主要來自在私家診所或醫院求診的病人，未必可完全代表全港乳癌病人的實際情況。因此，由2009年起，香港乳癌資料庫已於幾間公立及私立醫院開始搜集資料工作，當中包括瑪嘉烈醫院、威爾斯親王醫院、基督教聯合醫院及養和醫院等。建立一個全民性而又具代表性的乳癌資料庫，箇中所需時間極長，但我們深信，在各方醫護人員、病友及其他熱心人士幫助下，這個目標終可達成。

香港乳癌資料庫的成立與運作，是一個饒富意義的旅程，我們期待參與其中，爲推動本港的乳房健康及乳癌護理，獻上一點力量。

張淑儀醫生
香港乳癌基金會創會人
2009年9月

Highlights of Breast Cancer Facts in Hong Kong 2008 Report

- Breast cancer becomes a leading cancer in women since 1994 and is the fastest growing cancer in incidence among women in Hong Kong. Hong Kong tops Asia countries/cities in terms of crude and age-standardized rates of breast cancer.

- Median age at diagnosis of our subjects was 47.6 years in Hong Kong compared with 61 years in USA, 62 years in Australia and 50 years in Singapore. According to Hong Kong Cancer Registry 2006 statistics, incident breast cancers were peak at age 40-59, accounting for about 60% of breast cancer cases in 2006 (< age 40:11%; age 40-49: 33%; age 50-59:26%; age 60-69: 13%; age 70-79: 10%; ≥ age 80: 7%).

- Percentage distribution of risk factors among 1006 subject cohort in Hong Kong were summarized as follows:

Risk factors	Percentage of occurrence (%)
Lack of exercise	74%
No breast feeding	64%
High stress level	40%
Use of oral contraceptives	38%
Overweight/ obese	34%
Nulliparious/ first childbirth >35 years of age	28%
Early menarche (<12 years of age)	17%
Meat/dairy product rich	15%
Use of hormonal replacement therapy	14%
Alcohol drinker	9%
Late menopause (>55 years of age)	8%
Smoker	4%

- Majority of our subjects (80%) were incidental self-discovered, whereas 20% were detected through breast screening modalities such as screening mammogram, screening ultrasound, regular clinical breast examination and regular breast self-examination. Our figures were comparable to Asian (87% in Singapore) and western counterparts (80% in USA and 75% in Australia).

- Median tumour sizes were 1.7 cm in screen-detected and 2.2 cm in symptomatic cases in Hong Kong, whereas median tumour sizes were 1.8 cm and 2.3 cm among screen-detected cases and symptomatic cases in Singapore.

- According to American Joint Committee on Cancer (AJCC) 2002 Cancer Staging Classification, the distribution of overall cancer stage of our breast cancer cases was:

Cancer stage	Percentage distribution
Stage 0	15%
Stage I	34%
Stage II	38%
Stage III	12%
Stage IV	1%

Distribution of cancer stage among breast cancer cases in Hong Kong were compared with the whites reported in Surveillance Epidemiology and End Results (SEER) Program in the US.

	Breast Cancer Facts in Hong Kong 2008 Report	SEER (Whites)
Localized cancer	60%	62%
Regional cancer	24%	31%
Metastasized cancer	1%	4%
Unstaged	--	3%

香港乳癌實況2008報告重點

◆乳癌自1994年起便成香港婦女最常見的癌症，並且是增長速度最快的婦女癌症。其粗發病率及年齡標準化發病率是亞洲國家或城市之冠。

◆我們的參加者的確診年齡中位數爲47.6歲，而美國乳癌病人的確診年齡中位數爲61歲、澳洲乳癌病人的確診年齡中位數爲62歲、新加坡乳癌病人的確診年齡中位數爲50歲。根據2006年的香港癌症統計中心的數字，年齡介乎40-59歲乳癌病人爲最多，佔整體2006年乳癌新症約六成（40歲以下：11%；40-49歲：33%；　50-59歲：26%；60-69歲：13%；70-79歲：10%；80歲或以上：7%）。

◆1006名本地乳癌病人的高危因素資料的百份比分佈綜合如下：

	百份比（%）
缺乏運動	74%
從未餵哺母乳	64%
感到高度壓力	40%
口服避孕藥	38%
超重 / 肥胖	34%
從未懷孕 / 首次生育 >35歲	28%
月經過早（<12歲）	17%
多吃肉類或乳類製品	15%
荷爾蒙補充治療	14%
有飲酒習慣	9%
延遲收經（>55歲）	8%
有吸煙習慣	4%

◆大部份乳癌病人(80%) 在偶然情況下自行發現乳癌徵狀，餘下20%則是透過乳癌診普查確診，包括定期臨床醫生檢查、乳房X光造影、乳房超聲波檢查或定期乳房自我檢查方法等。香港乳癌實況2008報告的數據與亞洲（新加坡：87%）及西方社會（美國：80%，澳洲：75%）的數據相約。

◆在香港，透過乳癌普查確診的乳癌病人的乳癌腫瘤大小中位數是1.7厘米；在偶然情況下自行發現乳癌徵狀的乳癌病人的腫瘤大小中位數是2.2厘米。在新加坡，透過乳癌普查確診的乳癌病人的乳癌腫瘤大小中位數是1.8厘米及在偶然情況下自行發現乳癌徵狀的乳癌病人的腫瘤大小中位數是2.3厘米

◆根據2002年美國癌症協會所訂定的分級系統，本港整體乳癌情況爲：

癌症期數	百份比（%）
第0期	15%
第1期	34%
第2期	38%
第3期	12%
第4期	1%

本港乳癌期數的分佈與美國「監測、流行病學及最終結果計劃」(SEER) 白人的乳癌期數分佈作出比對。

	香港乳癌實況2008報告數據	「監測、流行病學及最終結果計劃」(白人)
癌症範圍局部在乳房內	60%	62%
癌症擴散至乳房周邊淋巴組織	24%	31%
癌症擴散至其他器官	1%	4%
不明	—	3%

- Histological and molecular characteristics of invasive breast cancers were tabulated and compared with western figures:

	Breast Cancer Facts in Hong Kong 2008 Report	Western
Histological types		
Ductal	82.7%	91% (Canada)[1]
Lobular	5.3%	8% (Canada)[1]
Others	12%	<2% (Canada)[1]
Molecular characteristics		
ER+	77%	69% (Canada)[1]
PR+	62%	46% (Canada)[1]
HER2+	19%	13% (Canada)[1]
Ki67 index >12-16%	50%	--
ER- PR- HER2-	13%	16% (Canada)[2]
Lymphovascular invasion	39%	43% (Canada)[1]

ER+: estrogen receptor positive; ER-: estrogen receptor negative; PR+: progesterone receptor positive; PR-: progesterone receptor negative; HER2+: human epidermal growth factor receptor 2 positive; HER2-: human epidermal growth factor receptor 2 negative

- Treatment methods:
  - 99.8% underwent surgical operation to remove tumours.
  - 71% were treated with radiation therapy.
  - 58% were treated with endocrine therapy.
  - Among invasive breast cancers, 71% were treated with chemotherapy and 11% were treated with targeted therapy.

	Breast Cancer Facts in Hong Kong 2008 Report	Western
Surgery	99.8%	98% (Canada)[1] / 98% (UK)[3]
Breast conserving surgery	61%	44% (Canada)[1] / 72% (UK)[3]
Mastectomy	39%	55% (Canada)[1] / 26% (UK)[3]
Reconstruction among patients with mastectomy	26%	16.8% (USA)[4]
Radiotherapy	71%	81% (UK)[5]
Radiotherapy among patients with breast conserving surgery	22%	41% (Canada)[1]
Radiotherapy to chest wall & regional nodal involvement among patients with mastectomy	11%	16% (Canada)[1]
Endocrine therapy	58%	83% (Australia)[6]
Chemotherapy	71%	78% (Australia)[6]
Targeted therapy	11%	--
Alternative medicine	8%	28.1% (USA)[7]

◆入侵性乳癌組織學及分子學特性表列如下，並與西方數據作比對：

	香港乳癌實況2008報告	西方
組織學分類		
乳腺管癌	82.7%	91% (加拿大)[1]
乳小葉癌	5.3%	8% (加拿大)[1]
其他	12%	<2% (加拿大)[1]
分子學特性		
雌激素受體呈陽性	77%	69% (加拿大)[1]
黃體素受體呈陽性	62%	46% (加拿大)[1]
上皮生長素受體呈陽性	19%	13% (加拿大)[1]
Ki67 指數 >12-16%	50%	—
雌激素受體呈陰性、黃體素受體呈陰性及上皮生長素受體呈陰性	13%	16% (加拿大)[2]
淋巴血管侵蝕	39%	43% (加拿大)[1]

◆治療方法：

- 99.8%乳癌病人均接受了乳房切除手術
- 71%乳癌病人接受電療
- 58%乳癌病人接受內分泌治療
- 入侵性乳癌病人當中，71%病人接受化療治理及11%病人採用針對性治療

	香港乳癌實況2008報告	西方
乳癌手術	99.8%	98% (加拿大)[1] / 98% (英國)[3]
乳房保留手術	61%	44% (加拿大)[1]/ 72% (英國)[3]
全乳切除手術	39%	55% (加拿大)[1]/ 26% (英國)[3]
全乳切除手術後之乳房重建手術	26%	16.8% (美國)[4]
電療	71%	81% (英國)[5]
乳房保留手術後接受局部電療	22%	41% (加拿大)[1]
全乳切除手術後於胸壁、或區域性淋巴系列處接受電療	11%	16% (加拿大)[1]
內分泌治療	58%	83% (澳洲)[6]
化療	71%	78% (澳洲)[6]
針對性治療	11%	—
另類療法	8%	28.1% (美國)[7]

- Recurrence was observed in 8 cases (1.3%) of 625 patient cohort with mean follow up of 12.6 months.

	Breast Cancer Facts in Hong Kong 2008 Report	Western figures
Recurrence	1.3%	--
Local recurrence	0.8%	5-year local recurrence rates: 7% (France)[8]
Distant metastasis	0.5%	5-year distant metastasis rate: 8.5% (France)[8]
Death from breast cancer	0%	--
Death from unrelated cause	0%	--

[1] Cheang MCU et al. JNCI 2009; 101(10): 736-750
[2] Carey LA et al. JAMA 2006; 295(21): 2492-2502
[3] CancerStats- Breast Cancer-UK 2009 May
[4] Alderman AK et al. JAMA 2006; 295(4): 387-388
[5] Sotiriou C et al. PNAS 2003;100(18):10393-10398
[6] Cuncins-Hearn AV et al. ANZ J Surg 2006;76: 745-750
[7] Burstein HJ et al. NEJM 1999;340(22):1733-1739
[8] Touboul E et al. Int J Radiat Oncol Bio Phy 1999;43(1):25-38

◆追蹤625名參加者的健康狀況及追蹤時間平均數爲12.6個月，共有8宗個案 (1.3%)乳癌復發

	香港乳癌實況2008報告	西方
乳癌復發	1.3%	—
局部復發	0.8%	5年期局部復發率：7% (法國)[8]
遠端復發	0.5%	5年期遠端復發率：8.5% (法國)[8]
死於乳癌	0%	—
死於其他病因	0%	—

Introduction
引言

Introduction

Burden of female breast cancer worldwide

Breast cancer is the most common cancer among women worldwide. In 2002, it was estimated more than one million incident breast cancer emerged worldwide where 636,000 incident cases occurred in developed countries and 514,000 in developing countries.[1] Breast cancer is also a leading cause of cancer deaths among women; 373,000 women died of (14% of all cancer deaths among women) breast cancer in 2002.[2]

Globally, incidence rates of breast cancer are higher in North America and Western Europe, followed by South America and Eastern Europe, and lowest in Asia (Figure 1).[3-4] In recent years, the incidence of breast cancer increase in many Asian countries at a more rapid rate than in Western countries[5-8] and becomes the commonest female malignancy in many Asian countries.[9] Among Asian countries, Hong Kong has the highest incidence[10] with crude incidence rate of 59.4 per 100 000 standard population as compared to 59.0 in Singapore, 49.6 in Japan and 20.1 in China.[11-12]

Female breast cancer in Hong Kong

In Hong Kong, breast cancer becomes a leading cancer in women since 1994. According to Hong Kong Cancer Statistics 2006 figures, crude incidence rate and age-standardized rate of breast cancer were 72 and 52.1 per 100 000 standard population respectively (Figure 2), there were 2,584 women diagnosed of breast cancer in 2006, accounting for 23.5% of all cancers in women, and its incidence doubled in the 1990s, overtaking lung cancer as the number one cancer affecting Hong Kong women (Figure 3a).[11]

On average, more than 7 women were diagnosed with breast cancer every day whereas 4 women were diagnosed with lung cancer daily in 2006. Sixty percent of breast cancer patients were in age 40-59, 10.5% of patients below age 40 with the youngest patient below 20 years old. Cumulative lifetime risk of developing breast cancer was 5% indicating 1 in every 20 women stood a chance of developing breast cancer in lifetime up to age 74. About 10% of female cancer deaths were due to breast cancer during 2006, which ranked as third major cause of cancer deaths in women (Figure 3b).

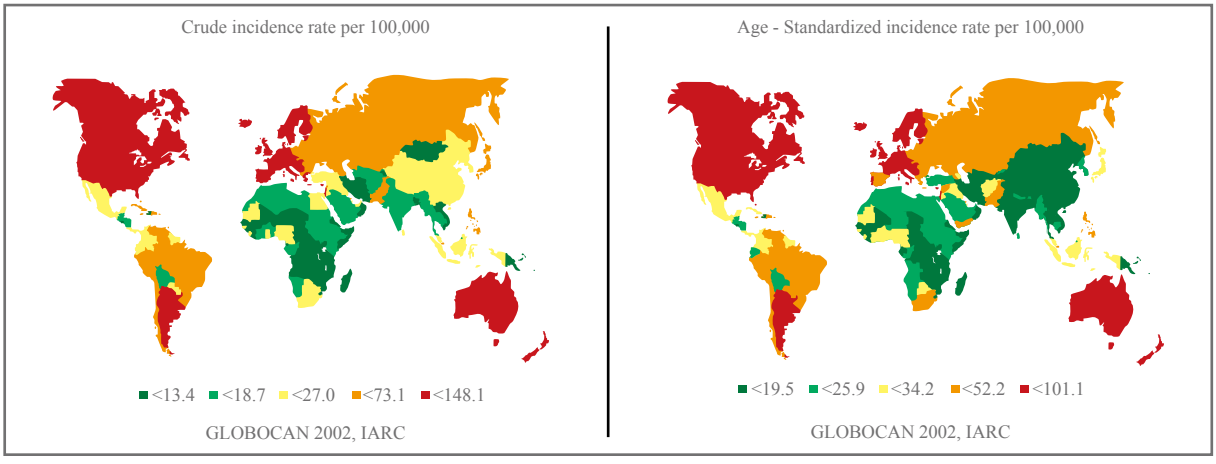

Figure 1. Crude and Age-standardized incidence rate of breast cancer (per 100,000)
Source: GLOBOCAN 2002

引言

乳癌：全球女性的健康負擔

乳癌是全球最普遍的婦女癌症。2002年，全球估計共有逾百萬宗乳癌病例，其中636,000宗出現在已發展國家，而餘下的514,000則在發展中國家。[1] 乳癌亦是導致婦女因癌症死亡的主因之一，2002年，共373,000名婦女死於乳癌（佔婦女因癌症死亡個案的14%）。[2]

以全球不同區域比較，乳癌發病率在北美洲及西歐最高，緊接是南美洲及東歐，而亞洲則較低(圖1)。[3-4] 但近年不少亞洲國家的乳癌個案，上升幅度均較西方國家爲高[5-8]，乳癌更成爲不少亞洲國家的最常見婦女癌症。[9] 在亞洲各國中，香港又擁有最高的乳癌發病率[10]：粗發病率（每十萬人中患上該病症的新個案人數）爲59.4，較新加坡的59.0、日本的49.6及中國的20.1均爲高。[11-12]

本港的婦女乳癌

在本港，乳癌自1994年起已成爲婦女最常見的癌症。根據2006年的香港癌症統計數字，乳癌的粗發病率及年齡標準化發病率分別爲72 及 52.1 (圖2)。共有2,584名女性於2006年確診患上乳癌，佔該年女性患癌數字的23.5%，此發病率較上世紀90年代上升一倍，令乳癌取代肺癌，成爲本港婦女最常見的癌症（圖3a）。[11]

2006年，本港平均每天有7名婦女不幸確診患上乳癌，較平均每天4名婦女患上肺癌爲多。約六成的乳癌病人年齡介乎40至59歲，約10.5%的乳癌病人年齡在40歲以下，而最年輕的患者不足20歲。本港婦女患癌的一生累積風險爲5%，表示每20名婦女中，就有1人在74歲前有機會患上乳癌。2006年，因乳癌導致婦女死亡個案佔所有癌症死亡個案約10%，令乳癌成爲本港婦女癌症的第三號殺手(圖3b)。

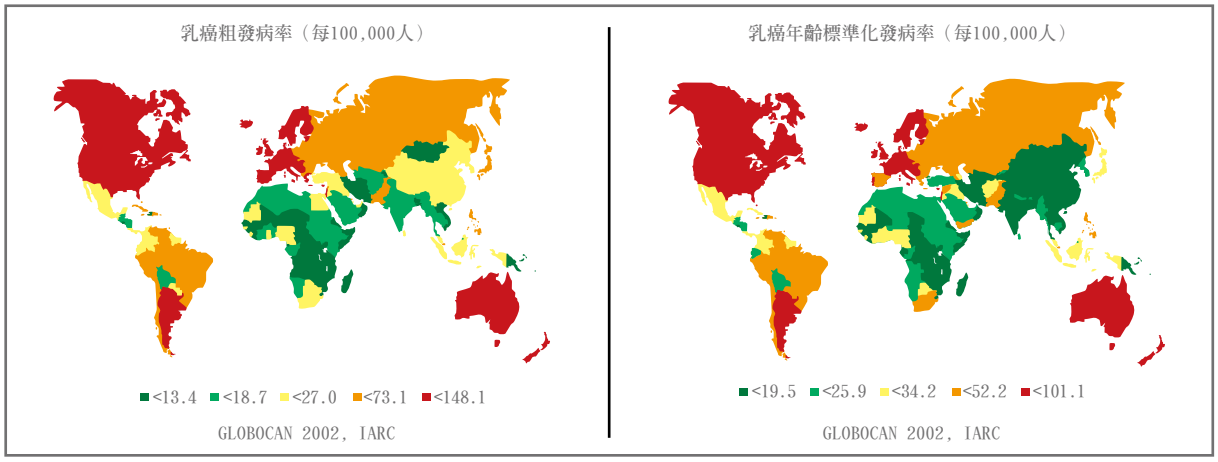

圖1. 全球區域乳癌的粗發病率及年齡標準化發病率（每100,000人）
資料來源：GLOBOCAN 2002

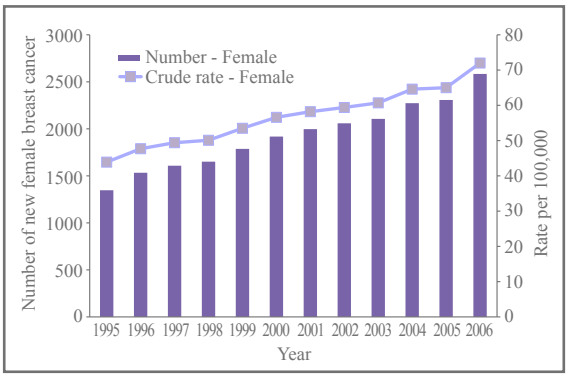

Figure 2. Incidence trend of female breast cancer in Hong Kong, 1995-2006
Source: Hong Kong Cancer Registry

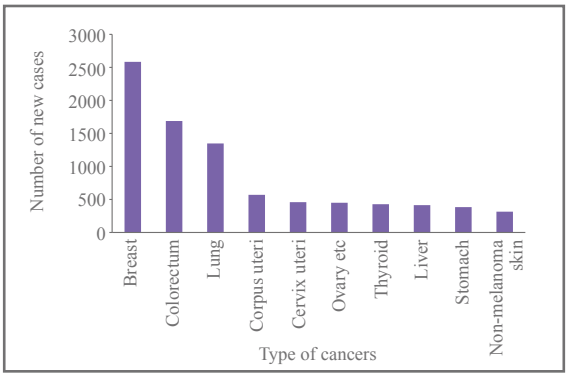

Figure 3a. Top 10 cancers in Hong Kong women, 2006
Source: Hong Kong Cancer Registry

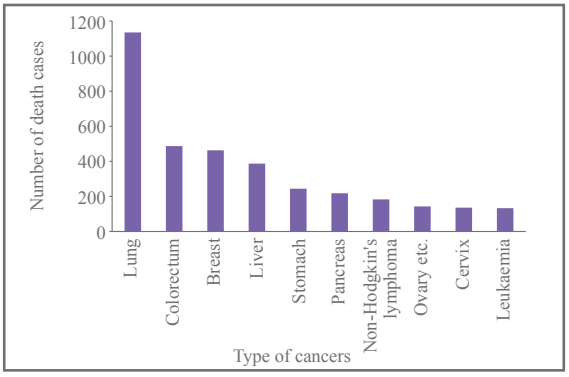

Figure 3b. Top 10 cancers deaths in Hong Kong women, 2006
Source: Hong Kong Cancer Registry

As mentioned, breast cancer is the most common and fastest growing cancer in numbers among women in Hong Kong. Hong Kong tops Asian countries/cities in this regard with one in 4 cancer cases in women being a breast cancer case.

Paradoxically, very little is known about local breast cancer picture. Breast cancer health care management in Hong Kong is currently designed on western data and information. No local, population-wide, breast cancer specific information is available anywhere in the territory. Without such information, which is stored in Cancer Registries elsewhere in the world as the basis for effective cancer control research & development, Hong Kong cannot even start to identify risk factors, disease/treatment trends etc so as to undertake further research to come up with evidence-based local breast cancer prevention and treatment options.

The Hong Kong Government operates a Hong Kong Cancer Registry (HKCR) under the Hospital Authority which focuses on incidence and mortality rates rather than risk factors and disease or detection/treatment trends. In this connection, a population-wide Hong Kong Breast Cancer Registry (BCR) is of great benefit to the community as it collects and captures local data regarding breast cancer. The BCR captures comprehensive information of local breast cancer cases and look into various aspects of this fastest growing cancer in women in Hong Kong in terms of prevalence of risk factors, detection method, disease pattern and treatment trends. Analyses and interpretation could help doctors make more evidence-based decisions on treatment management. Policy makers will have solid local data to formulate policy on early detection and effective control measures of the cancer. Moreover, it could enhance public awareness of breast cancer and facilitate the Government in formulating appropriate, comprehensive healthcare policies to manage the burden of breast cancer to the society in the long term.

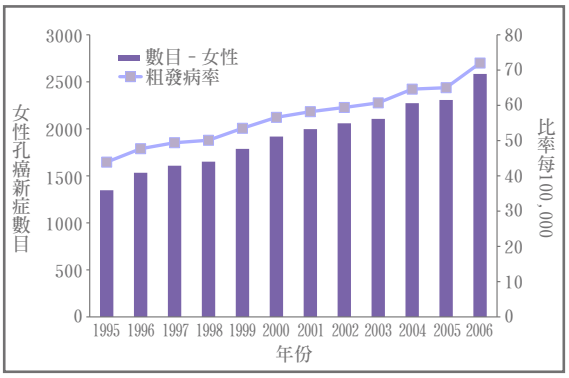

圖2. 香港女性乳癌發病率，1995-2006
資料來源：香港癌症資料統計中心

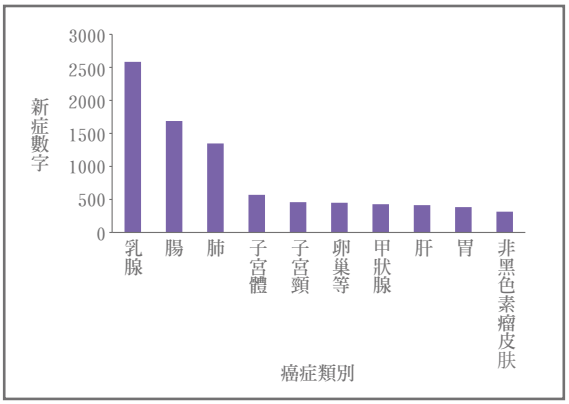

圖3a. 十大香港女性常見癌症，2006
資料來源：香港癌症資料統計中心

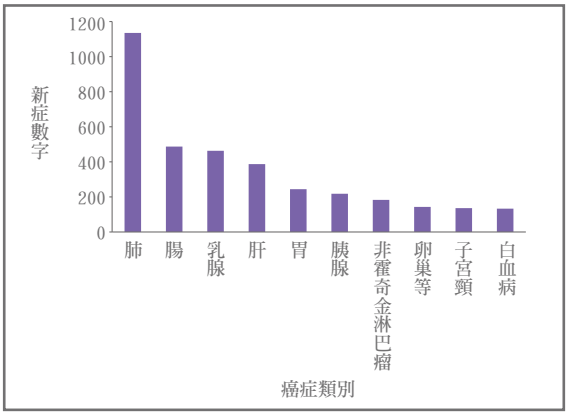

圖3b. 十大引致死亡的香港女性癌症，2006
資料來源：香港癌症資料統計中心

正如前文提及，乳癌已成爲本港婦女最常見及發病率增長速度最快的癌症，每4個婦女患癌個案中，便有1個屬乳癌，比例均高於亞洲其他各國家或城市。

然而，我們對於本地乳癌個案，仍未有確切了解。由於本港一直未有一個以本地個案爲標準、全民性及以乳癌爲研究中心的資料庫，故有關乳癌護理及治療等的資訊，均建基於西方的數據及資料。相對於香港，世界多國均有搜集本土的乳癌個案資料，並紀錄在當地的癌症資料庫中，以作爲研究及制訂有效控制及治療乳癌方案的基礎參考資料。相反，由於本港一直未有這樣的乳癌資料庫，令本港未能對高危因素，以及乳癌或乳癌治療趨勢作深入研究，令有關的防治乳癌研究工作一直未有相關的醫學基礎。

香港醫院管理局轄下的香港癌症資料統計中心，主要統計癌症的發病及死亡率，而非其風險因素、確診及治療方法等。正因如此，一個全民性及全面性的香港乳癌資料庫，將可搜集本地乳癌的詳細數據，從而讓我們對這個增長速度驚人的癌症有更深了解，包括其風險因素、確診方法、疾病模式及治療趨勢等。數據的研究及詮釋，可讓醫生爲病人作出治療建議時，有更多實質的本地數據作參考，並顯示出本地乳癌具體發展趨勢，讓制訂公共政策的官員考慮更全面和適當的醫療政策，長遠而言減輕乳癌爲社會及病人帶來的負擔。

Overview of Hong Kong Breast Cancer Registry Activities

香港乳癌資料庫活動概要

Overview of Hong Kong Breast Cancer Registry Activities

The success of HKBCR relies on participation of breast cancer patients and support of healthcare professionals. Since the inception in 2008, we first started collecting data at private clinics and at the same time explored the workflow collecting data at public hospitals.

Collaborating centers/doctors

The success of HKBCR also relies on the support of healthcare professionals to facilitate the participation of as many breast cancer patients as possible. They help in making the Registry known to their patients and urging them to participate by giving consent for the Registry to capture their medical data. There are more than 100 specialists and experts in breast cancer field indicating support to the Registry. Starting from 2009, HKBCR also collects patient data in several public and private hospitals, namely Princess Margaret Hospital, Prince of Wales Hospital, United Christian Hospital and Hong Kong Sanatorium & Hospital.

Participation of breast cancer patients

Currently, there are over 2000 breast cancer patients participating in the Registry (Figure 4). Majority of the participants are enrolled through private clinics.

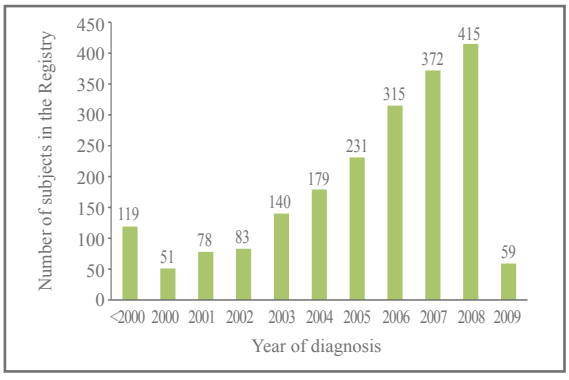

Figure 4. Total number of subjects participated in the Hong Kong Breast Cancer Registry by year of diagnosis

Data introduction

Over 200 data items are collected for each breast cancer case including but not limited to risk factors, diagnostic method, pathological and clinical data, types of treatment, physical and psychological effects. A very important component of the Registry is annual lifetime follow-up on patient status. It allows us to not only analyse clinical outcomes but also capture recurrence and survival information.

Part 1:

Personal information:
- Detailed contact information, demographics (age, race/ethnicity, household income etc)

Lifestyle factors:
- Smoking, alcohol use, exercise level, stress level

Past health:
- Weight, height, past breast health, history of tumor

Family history of breast cancer
- First / second degree relative etc

Reproductive history:
- Age at menarche, first delivery, menopause, use of hormonal replacement therapy etc

Part 2:

Clinical characteristics
- Tumor location (right, left, bilateral)
- Node involvement

Diagnostic characteristics
- Diagnostic methods
- Staging methods

Histological & molecular characteristics
- Histological type
- Molecular characteristics (ER, PR, c-erbB2, etc)

Treatment related information
- Surgery
- Radiation therapy
- Chemotherapy
- Endocrine therapy
- Targeted therapy

香港乳癌資料庫活動概要

香港乳癌資料庫的順利運作，有賴乳癌病人及各醫療人員的支持。由2008年起，我們於私家診所開展搜集病人資料工作，同時，並與各公共醫院聯絡，希望將搜集乳癌資料工作拓展至各醫院。

與醫生/醫療診所中心的合作

資料庫若要順利運作，便不可缺少各方醫護人員的支持，鼓勵及協助更多乳癌病人參加此項研究計劃。現時資料庫已獲得逾100位專科醫生或與乳癌相關的醫護人員的支持。自2009年起，資料庫已於公私兩方醫療機構開展資料搜集工作，參與機構包括瑪嘉烈醫院、威爾斯親王醫院、基督教聯合醫院及養和醫院等。

乳癌病人的參與

現時共有逾2000名乳癌病人已參加香港乳癌資料庫（圖4），參加者主要來自私家診所。

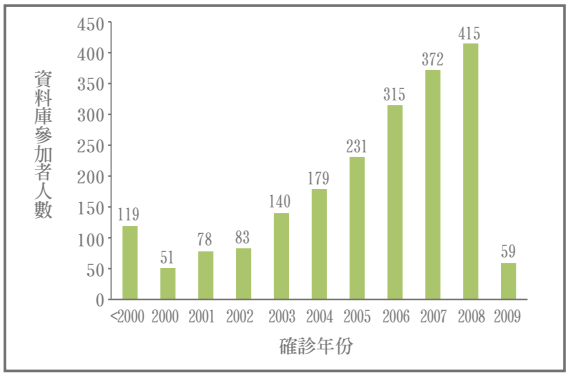

圖4. 按確診年份劃分的參與香港乳癌資料庫的人數

搜集數據簡介

資料庫搜集逾200項乳癌相關的資料，包括其風險因素、診斷方法、病理學及臨床數據、治療種類、生理及心理影響等。資料庫其中一個重要的元素，就是爲所有參加者作每年度病況的跟進，能讓我們分析病人治療後的健康狀況，以及復發風險及存活率相關的資料。

第1部份
個人資料
-詳細聯絡方法、個人資料（年齡、種族、家庭入息等）
生活習慣
-吸煙、飲酒、運動習慣及壓力狀況等
過往健康狀況
-體重、身高、病前乳房健康及過往腫瘤病歷等
乳癌家族病史
-直系親屬、次系親屬等
生育紀錄
-月經、生育資料、更年期、賀爾蒙補充治療等

第2部份
臨床資料
-腫瘤位置(右乳/左乳/雙邊乳房)
-淋巴擴散
診斷資料
-確診方式
-斷定期數方法
組織學及分子學特性
-組織學分類
-分子學特性（ER、PR及 c-erbB2等）
治療方法
-外科手術
-電療
-化療
-賀爾蒙治療
-針對性治療

Part 2:

Follow up on patient status
- Recurrence (local/ distant)
- Metastasis
- Patient status (no evidence of disease, alive with disease, death)
- Date of death
- Death from breast cancer/ death from unrelated cause

The Registry is used to collect, manage and analyse data on breast cancer cases. To ensure data quality, the Registry staff, now consists a team of 3, are trained to coordinate and collect medical data at sites. The system is protected with security measure. The data are validated, verified and analysed in aggregate. Patient confidentiality is assured.

About this Report

A population-based breast cancer registry requires patient participation from private clinics and public hospitals. The dataset consisting of 1006 cases in this Report was collected during the period from February 2008 - January 2009 upon the project commencement. Over 95% of the breast cancer cases in this dataset were collected from private clinics. In this connection, the facts reported should be interpreted with special attention. The data collection is a long drawn process. With support and participation from various parties, the Breast Cancer Registry shall be able to review an overall picture of the breast cancer facts in Hong Kong in the long run.

第2部份
病人狀況跟進
-復發(局部/遠端)
-轉移擴散
-病人狀況(沒有乳癌徵狀、與癌症共存、去世)
-去世時期
-去世原因：乳癌/其他病症

資料庫將會搜集、管理及分析乳癌病人提供的資料。爲確保數據的質素，資料庫的3位職員均接受過專業訓練，並定期到訪醫院或診所進行資料搜集工作，而資料庫系統亦由嚴密保安系統保護，而所取得的資料數據將作綜合分析，參加者的個人資料絕對保密。

關於此報告

一個全民性的乳癌資料庫，需同時得到來自公私立醫院與私家診所的病人支持參與。自2008年2月至2009年1月期間，資料庫已完成處理1006宗個案資料分析，其中超過95%的參加病人來自私家診所，因此，本報告闡述的數據及乳癌趨勢等，亦應作出相應的解讀調整。

搜集資料往往是一個漫長的過程，然而，隨著各醫院、醫護人員及相關的熱心人士踴躍支持，不久將來，香港乳癌資料庫將可確切反映本港整體的乳癌概況。

Patient Demographics
病人統計資料

Patient Demographics

Out of 1006 accessioned breast cancer patients, 1004 (99.8%) of the subjects were female, whereas 0.2% were male. The major ethnic groups were Chinese (97%), followed by Caucasian (2%) and other Asians (1%) in this report.

With reference to other national cancer registries, the median ages at diagnosis of breast cancer were 61 years in USA, 62 years in Australia and 50 years in Singapore[13-15]. In United Kingdom, 81% of cases occurred in women aged 50 years and over, 50% of the cases were diagnosed in the age group of 50-69.[16]

The mean and median age at diagnosis of our subjects were 48.9 and 47.6 years respectively (age range: 25.4 -101.4 years). About 69% of breast cancer patients were aged 40-59, about 18% below aged 40 and only 13% aged 60 and over (Figure 5).

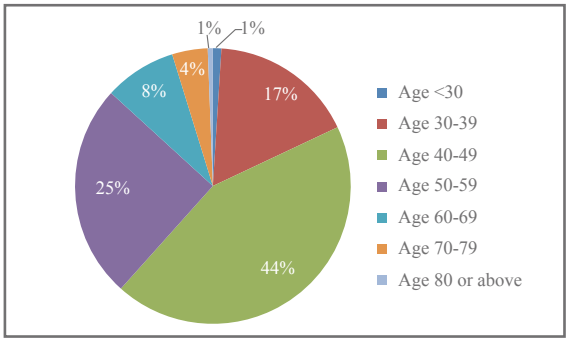

Figure 5. Percent distribution of age groups

Majority (73%) of the subjects were married, 17% did not get married and 10% were widowed, divorced or cohabitating (Figure 6).

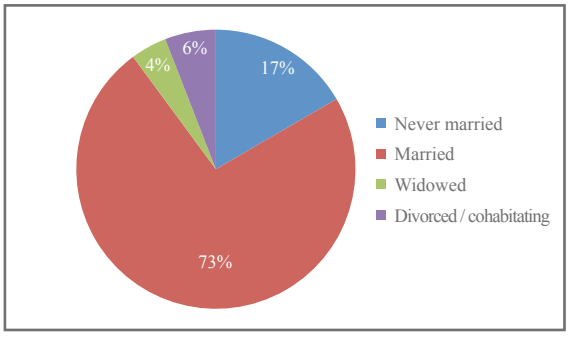

Figure 6. Marital status

Regarding socio-demographic characteristics, 50% of the subjects' occupation were professionals or clerks, 30% were housewife, 5% were self-employed, only 4% were workers and 11% were retired or unemployed. In general, the subject cohort attained relatively higher education level, with 88% attained secondary education or above, only 12% of the subjects had educational level below secondary school. Majority of the subjects were in higher socioeconomic strata. Over 50% of the subjects had monthly household income more than $30,000 a month, and about 30% had their family income between $10,000- $29,999 a month and less than 10% had their family income below $10,000 a month (Table 1).

Table 1. Occupation, educational level and monthly household income

	Relative percentage (%)
Occupation	
Professional	17%
Clerical	33%
Housewife	30%
Self-employed	5%
Non-clerical/ Labor	4%
Retired/ Unemployed	11%
Educational level	
No schooling/ Kindergarten	1%
Primary school	11%
Secondary school	60%
Matriculation or above	28%
Monthly household income	
<$10,000	9%
$10,000-29,999	33%
>$30,000	58%

病人統計資料

報告中的1006名乳癌病人中，1004 (99.8%) 人爲女性，餘下的0.2%屬男性。主要的種族爲華裔(97%)，其次爲白種人 (2%) 及其他亞裔 (1%)。

參照其他國家的癌症資料庫，美國、澳洲及新加坡的乳癌確診年齡中位數分別是61歲、62歲及50歲。[13-15]在英國，81%的乳癌個案發生在50歲或以上的婦女身上，接近五成確診個案年齡介乎50-69歲。[16]

我們的參加者的確診年齡平均數及中位數分別爲48.9歲及47.6歲 (年齡範圍：25.4 -101.4歲)。約69%乳癌病人年齡介乎40至59歲，約18%爲40歲以下，只有約13%在60歲或以上 (圖5)。

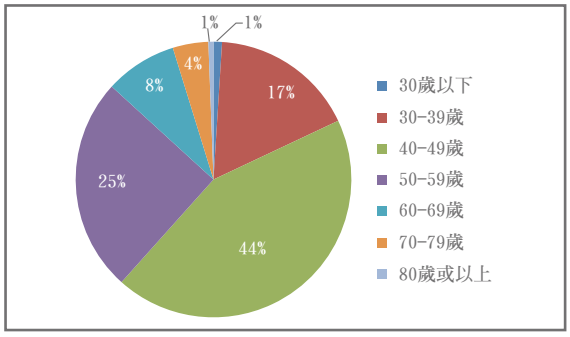

圖5. 年齡層分佈

大部份 (73%) 的參加者已婚，17%未婚及有10%爲喪偶、離婚或同居 (圖6)。

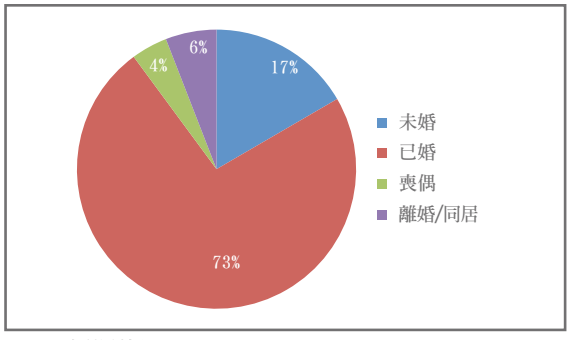

圖6. 婚姻狀況

職業方面，50% 的參加者爲專業人士或文職人員、30%爲家庭主婦、5%爲自僱人士、4%爲非文職，並有11%爲退休及待業人士。整體而言，參加者有較高的教育水平，其中有88%爲中學畢業或以上，只有12%的教育水平是在小學或以下。大部份參加者的經濟條件亦較佳，逾50%參加者的每月家庭入息爲 $30,000以上，約30%的家庭月入在$10,000至 $29,999之間，餘下少於10%的家庭月入少於 $10,000 (表1)。

表1. 參加者的職業、教育水平及每月家庭入息統計

	所佔百份比(%)
職業	
專業人士	17%
文職	33%
家庭主婦	30%
自僱人士	5%
非文職/ 勞工	4%
退休/ 待業	11%
教育水平	
未受教育/ 幼稚園	1%
小學	11%
中學	60%
大專或以上	28%
家庭月入	
<$10,000	9%
$10,000-29,999	33%
>$30,000	58%

As tabulated in Table 2, the subjects resided in different districts throughout the territory: Hong Kong Island (38%), Kowloon (27%) and New Territories (35%).

Table 2. Residence districts of the subjects

	Relative percentage (%)
Hong Kong Island	
Southern	6%
Central and Western	9%
Wan Chai	5%
Eastern	16%
Islands	2%
Kowloon	
Kwun Tong	5%
Wong Tai Sin	4%
Yau Tsim Mong	5%
Sham Shui Po	4%
Kowloon City	9%
New Territories	
Kwai Tsing	3%
Tsuen Wan	5%
Sai Kung	6%
Tai Po	3%
Sha Tin	9%
Yuen Long	4%
Tuen Mun	3%
North	2%

如表2所示，參加者住所平均分佈於香港島(38%)、九龍(27%)及新界(35%)。

表2. 參加者的住所區域分佈

	所佔百份比（%）
港島	
南區	6%
中西區	9%
灣仔區	5%
東區	16%
離島區	2%
九龍	
觀塘區	5%
黃大仙區	4%
油尖旺區	5%
深水　區	4%
九龍城區	9%
新界	
葵青區	3%
荃灣區	5%
西貢區	6%
大埔區	3%
沙田區	9%
元朗區	4%
屯門區	3%
北區	2%

Lifestyle
生活習慣

Lifestyle

Smoking and alcoholic drinking habits

There are lack of evidences[17-19] to suggest smoking increases risk of breast cancer, however, not smoking cigarette and avoiding exposure to secondhand smoke have multiple health benefits. Most report revealed alcohol consumption to be consistently associated with increased breast cancer risk.[19-21] In a meta-analysis study, the relative risk of breast cancer was increased by 7% for each additional 10g per day of alcohol consumed on a daily basis.[19]

Majority of the subjects were non-smokers, only 4% of the subjects had smoking habit. For those subjects who ever smoked consumed about 5 cigarette packs per week and on average smoked for 18.2 months. Also, the prevalence of alcohol consumption was relatively lower in our patient cohort as compared to the western countries.[22-24] About 9% of the subjects were alcohol drinkers. On average, the subjects consumed about 6 glasses of alcohol per week and drank for 15.2 months (Figure 7).

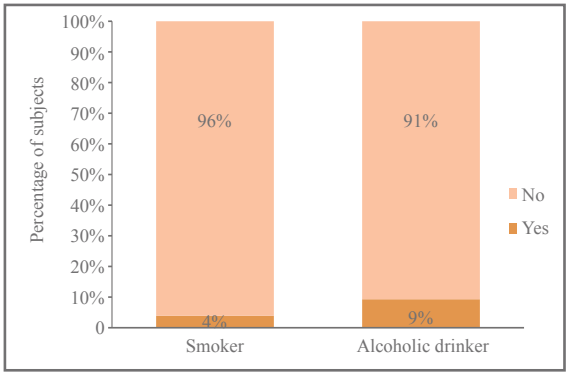

Figure 7. Smoking and alcoholic drinking habits

Previous dietary habit

A number of studies have reported mixed findings on dietary habit and its relation to increased risk of breast cancer.[25-27] In recent years, an epidemiologic study indicated western diet (i.e. meat-sweet pattern diet) increases breast cancer risk in postmenopausal Chinese women.[28]

More than 70% of the subjects claimed to have balanced diets at the time of diagnosis of breast cancer. 15% of the subjects were vegetarian or had vegetable rich diet, whereas 12% of the subjects had meat rich diet habit, while 3% of the subjects had dairy product rich diet (Figure 8).

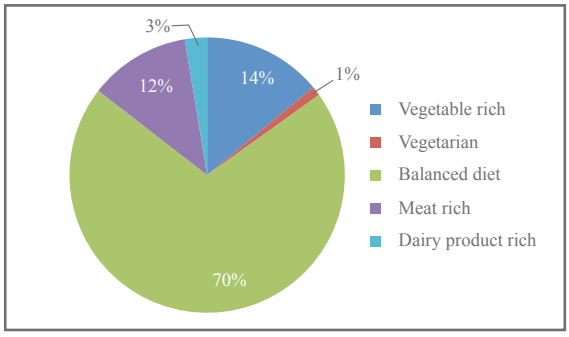

Figure 8. Previous dietary habit

Previous physical activity

Some studies showed greater level of physical activity in women had protective effect of development of breast cancer in women.[29-30]

In the subject cohort, 15% of the subjects did not practise any exercise at all. Almost 60% of the subjects undertook exercise less than 3 hours per week and only 26% had exercise 3 hours or more per week (Figure 9).

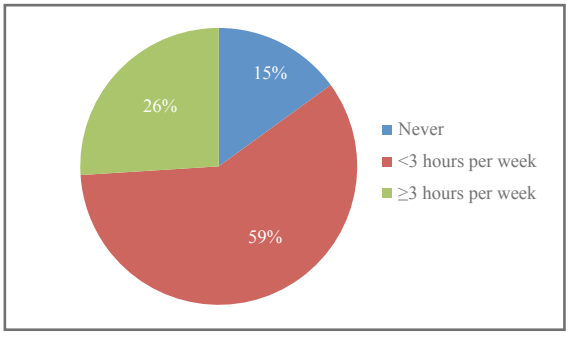

Figure 9. Previous physical activity

生活習慣

吸煙及飲酒習慣

現時並未有大量證據證明吸煙會增加患乳癌的風險[17-19]，然而，不吸煙或避免吸入二手煙，則對健康有各種好處。衆多報告指出，飲酒與乳癌風險有連帶關係。[19-21] 根據一項綜合分析報告，每天多飲用10克的酒類，患乳癌風險便上升7%。[19]

大部份的參加者都不吸煙，僅4%有吸煙習慣。曾吸煙的參加者，平均每星期抽5包香煙，煙齡平均爲18.2月。 而且，本港乳癌病人的飲酒習慣的普遍程度較西方國家爲低[22-24]，只有9%參加者有飲酒習慣，平均計算，每周喝酒類飲品6杯，並已持續15.2月（圖7）。

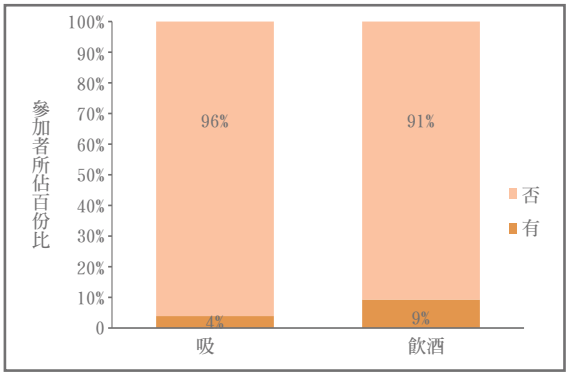

圖7. 吸煙及飲酒習慣

病前飲食習慣

雖然不少研究調查飲食習慣會否增加患上乳癌風險，報告卻沒有一致的定論。[25-27] 近年，有流行病學研究指出，西方飲食 （多肉及多糖的飲食模式）增加了收經後華裔婦女的患乳癌風險。[28]

逾70%的參加者表示，在確診乳癌時，她們已持續均衡飲食，15%的參加者爲素食人士或飲食含豐富蔬果，而12% 參加者常吃肉類，餘下的3%則常吃乳類製品（表8）。

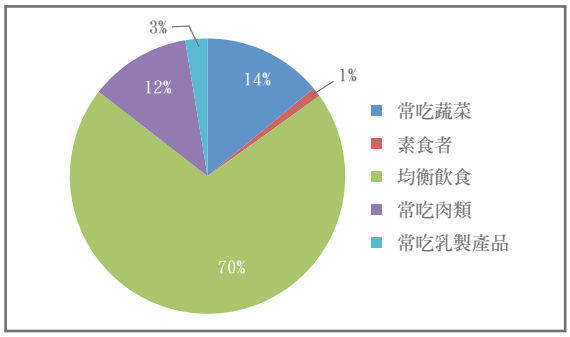

圖8. 病前飲食習慣

病前運動習慣

部份研究指出，定期進行適當運動，可令婦女減低患乳癌的風險。[29-30]

參加者中，15%並無任何運動習慣。約60%參加者每周運動時間少於3小時，只有26%每周運動時間達3小時以上（圖9）。

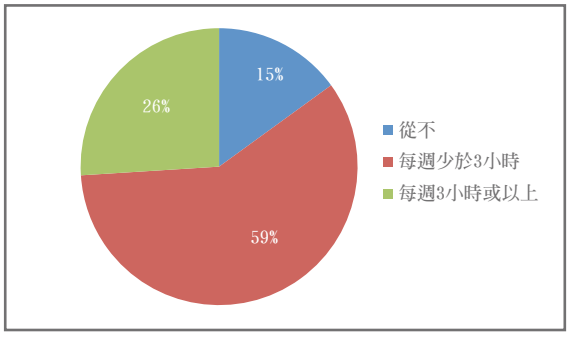

圖9. 病前運動習慣

Previous stress level

Before breast cancer was diagnosed, 40% of the subjects perceived high level of stress, whilst 38% and 22% of the subjects perceived moderate and low stress levels respectively (Figure 10).

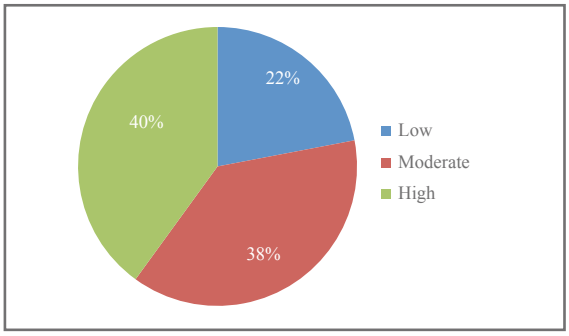

Figure 10. Previous stress level perceived

病前壓力狀況

在患乳癌前，有40%參加者在生活中承受高度壓力，38%感到中度壓力及22%感到輕微壓力 (圖10)。

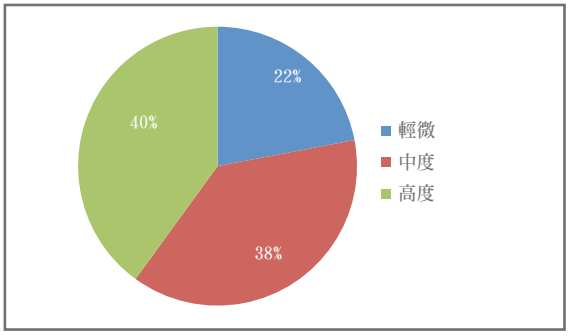

圖10. 病前壓力狀況

Health Background
過往健康狀況

Health Background

Body Mass Index / Obesity

About one-third of the subjects were overweight (BMI=23.0-24.9) or obese (BMI≥25). More than 50% of the subjects had ideal body weight (BMI=18.5-22.9) and 11% of the subjects were underweight (BMI<18.5) (Figure 11).

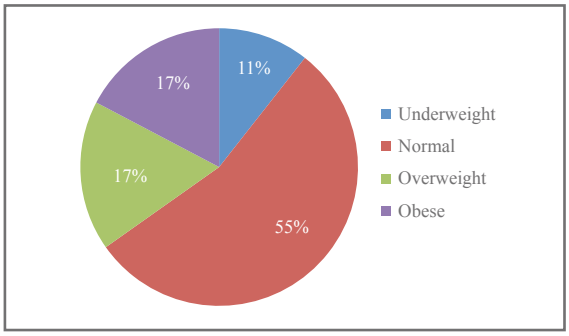

Figure 11. Body mass index (BMI) of the subjects

Obesity or overweight after menopause

Obesity or overweight was observed in 44% of postmenopausal women compared to 27% in premenopausal women (Figure 12).

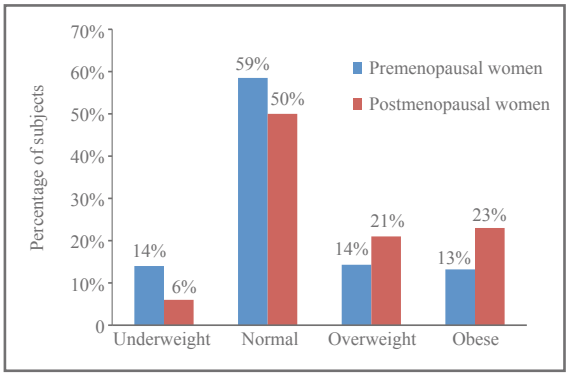

Figure 12. Obese or overweight by menopausal status

Bra size and cup size

Twenty-eight percent of the subjects had bra size of 32 inches or smaller (Figure 13). Among them, majority of the subjects (94%) had either cup A or B. For those with bra size of 34 inches and over, 75% of them had either cup A or B (Figure 14).

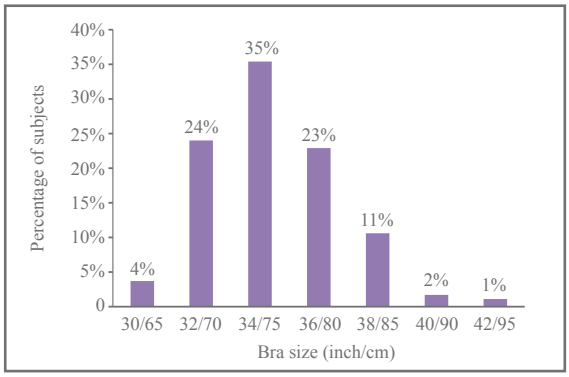

Figure 13. Bra size of the subjects

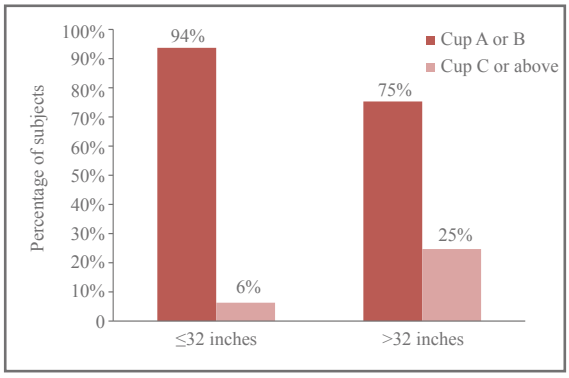

Figure 14. Bra size and cup size of the subjects

Significant past health and history of previous breast disease or tumours

Sixty-three percent enjoyed good past health. Twenty five percent of the subjects had history of tumours, among which 37% were malignant tumours. The majority of malignant tumours were breast cancer (20%), followed by thyroid cancer(5%), tongue cancer(1%), stomach cancer(1%), nasopharyneal carcinoma(1%), ovary cancer(1%), colon cancer(1%), lymphoma(1%), medullary cancer(1%) and

過往健康狀況

體重指數(BMI) / 肥胖

接近三份一參加者的體重指數爲超重 (BMI水平=23.0-24.9) 或肥胖 (BMI≥25)，逾50%參加者體重在理想水平內 (BMI=18.5-22.9)，亦有約11%參加者體重過輕 (BMI<18.5) (圖11)。

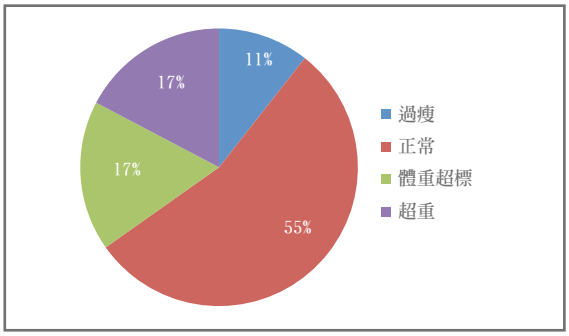

圖11. 參加者的體重指數(BMI)

更年期後體重肥胖或超重

44%步入更年期的參加者屬體重屬肥胖或超重，相比之下更年期前組別的婦女中，只有27%屬體重肥胖或超重 (圖12)。

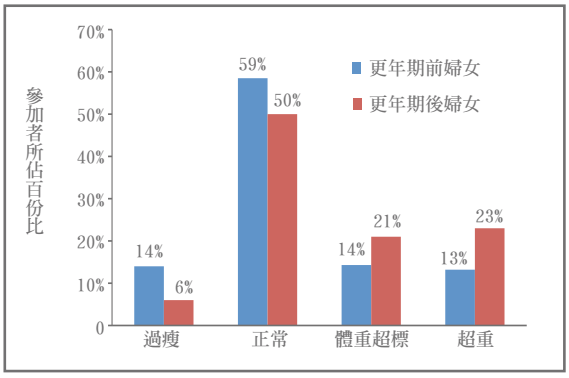

圖12. 更年期前後婦女組別的體重指標

胸圍尺吋與罩杯尺碼

28%的參加者，胸圍尺寸在32吋或以下 (圖13)。在這個組別中，大多數人 (94%) 的罩杯尺碼是A或B。至於胸圍尺碼在34吋或以上的參加者，只有75%罩杯尺碼是A或B (圖14) 。

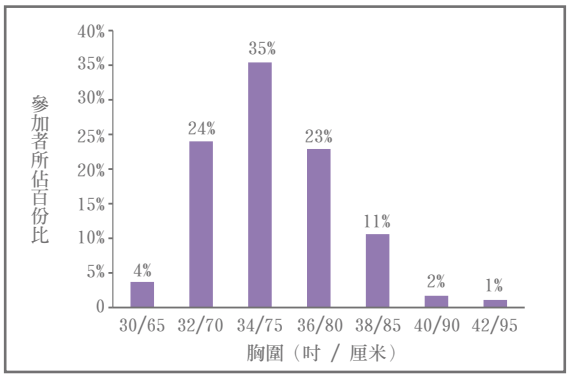

圖13. 參加者的胸圍尺吋分佈

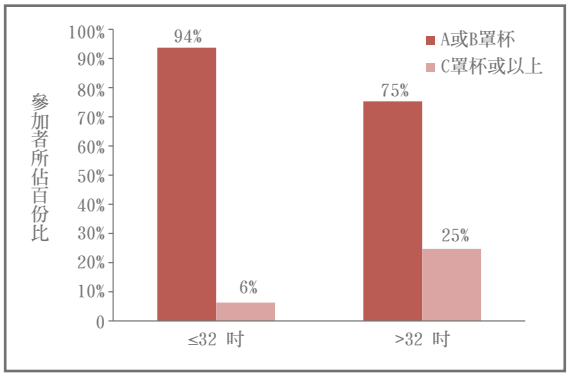

圖14. 參加者的胸圍尺吋與罩杯尺碼

過往健康狀況、乳房或腫瘤病史

63%參加者過往健康狀況理想，25%曾有腫瘤病史，其中37%爲惡性腫瘤。主要的惡性腫瘤爲乳癌 (20%)、甲狀腺癌 (5%)、舌癌 (1%)、胃癌 (1%) 、鼻咽癌 (1%)、卵巢癌 (1%)、腸癌 (1%)，淋巴癌 (1%)及髓質癌 (1%) 及沒有詳細資料 (68%)。約17%參加者曾患其他乳房疾病，種類包括纖維乳腺瘤 (33%)、囊變性纖維瘤 (5%)、乳頭狀瘤 (3%)、

unreported(68%). Other previous breast diseases were reported in 17% of the subjects; the types of other previous breast diseases were fibroadenoma (33%), fibrocystic disease(5%), papilloma(3%), papillomatosis(1%), atypia(2%), other benign tumours(10%) and unreported(48%) (Table 3).

Family history of breast cancer

Study showed a woman with one affected first-degree relative (mother or sister) has two-fold the risk of breast cancer of a woman with no family history of the disease. The risk will further elevate if two or more relatives are affected.[31-32]

Almost one-fifth of the subjects reported having family members affected by breast cancer. Among these, 74% were first degree relatives including mother or sister but no father or brother (Table 3).

Table 3. Past health information of the subjects

	Relative Percentage (%)
Significant past health	
Good past health	63%
Minor problem	34%
Major problem	3%
History of tumours	
Yes	25%
No	75%
Type of previous malignant tumours	
Breast cancer	20%
Thyroid cancer	5%
Tongue cancer	1%
Stomach cancer	1%
Nasopharyneal carcinoma	1%
Ovary cancer	1%
Colon cancer	1%
Lymphoma	1%
Medullary cancer	1%
Unreported	68%
Previous breast disease	
Yes	17%
No	83%
Type of other previous breast disease*	
Fiboadenoma	33%
Fibocystic disease	5%
Papilloma	3%
Papillomatosis	1%
Atypia	2%
Other benign tumour	10%
Unreported	48%
Family history of breast cancer	
No	81%
Yes*	19%
Mother	30%
Sister	44%
Father	0%
Brother	0%
Maternal side (non FDR)	21%
Paternal side (non FDR)	12%

*Note: * = percentages add to more than 100% because respondents could be checked more than one response*
non FDR: non First degree relative

Age at menarche

Early menarche is a known risk factor for breast cancer.[33-34] With reference to the established cut-off for age at menarche[35], early menarche was defined as <12 years of age, whereas average or late menarche was defined as 12 years or older. In our subject cohort, the median age at menarche was 13 years and the earliest age was 8 years. Using 12 years of age as cut-off age for increased risk of breast cancer, 17% of the subjects had early menarche, whereas 83% had menarche started at 12 years and older (Figure 15).

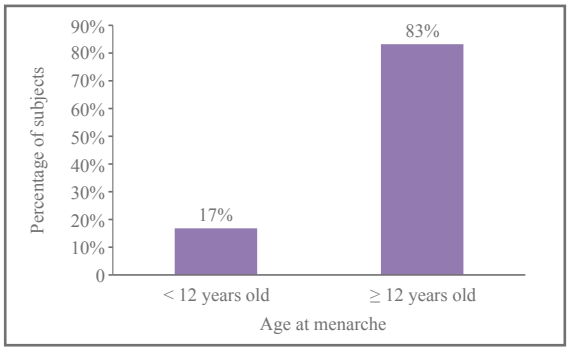

Figure 15. Percentage of the subjects with early menarche

乳頭狀瘤病 (1%)、異常增生 (2%)、其他良性腫瘤 (10%) 及沒有詳細資料 (48%) (圖3)。

乳癌家族病史

研究發現，女士如有一名直系親屬(母親或姊妹)有乳癌病史，則其本身患乳癌的風險會較沒乳癌家族病史的女士高出一倍。如有一個或以上家族成員曾患乳癌，則其本身患乳癌的風險亦會再增加。[31-32]

接近五分之一的參加者的家族中曾有成員患乳癌。在此組別中，74%乳癌直系親屬病史均是母親或姊妹，其父親或兄弟有乳癌病史所佔百份比均爲0 (表3)。

表3. 參加者的過往健康狀況

	所佔百份比 (%)
過往健康狀況	
良好	63%
小問題	34%
大問題	3%
過往腫瘤病歷	
有	25%
否	75%
過往惡性腫瘤類別	
乳癌	20%
甲狀腺癌	5%
舌癌	1%
胃癌	1%
鼻咽癌	1%
卵巢癌	1%
腸癌	1%
淋巴癌	1%
髓質癌	1%
沒有詳細資料	68%
乳房病史	
有	17%
否	83%
曾患其他乳房疾病類別*	
纖維乳腺瘤	33%
囊變性纖維瘤	5%
乳頭狀瘤	3%
乳頭狀瘤病	1%
異常增生	2%
其他良性腫瘤	10%
沒有詳細資料	48%
乳癌家族病史	
否	81%
有*	19%
母親	30%
姊妹	44%
父親	0%
兄弟	0%
母方親戚 (非直系親屬)	21%
父方親戚 (非直系親屬)	12%

備注 = 因參加者可作多於一個選擇，故百份比高於100%*

月經開始年齡

月經開始年齡愈早，患乳癌的風險亦相對提高。[33-34] 以年齡劃分月經時間屬是否正常，過早或延遲[35]，初經提早的定義爲12歲之前，而平均初經或初經年齡延遲的定義，則爲12歲或以後。資料庫的參加者中，首次月經年齡中位數是13歲，最早者則爲8歲。以12歲初經作爲乳癌患病風險增加的分界線，17%參加者屬初經提早，餘下的83%則於12歲或之後首次來經 (圖15)。

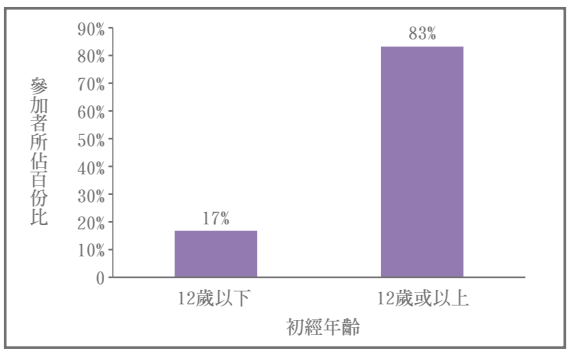

圖15. 參加者月經開始年齡

Age at menopause

Late menopause increases the risk of breast cancer.[36] Women of the same age and childbearing have a lower risk of breast cancer when they are menopaused compared to those who are still menstruating.[37]

The median age at menopause was 50 years in this cohort, with age range from 34 to 60 years. Using 55 years of age as cut-off for increased risk of breast cancer, 8% of the subject had late menopause (Figure 16). Forty-four percent of the subjects aged 55 or below had menopause induced by surgery or drugs whereas 23% of the subjects above aged 55 had menopause induced by surgery or drugs (Figure 17).

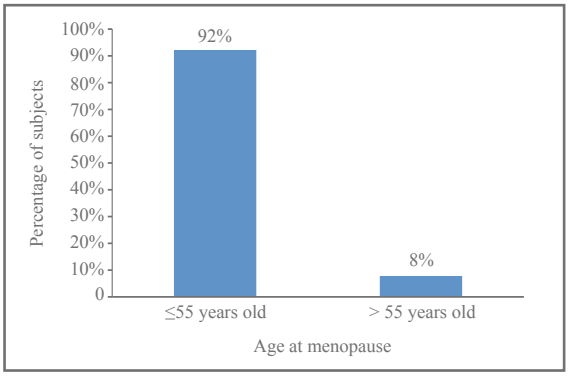

Figure 16. Percentage distribution of the subjects with late menopause

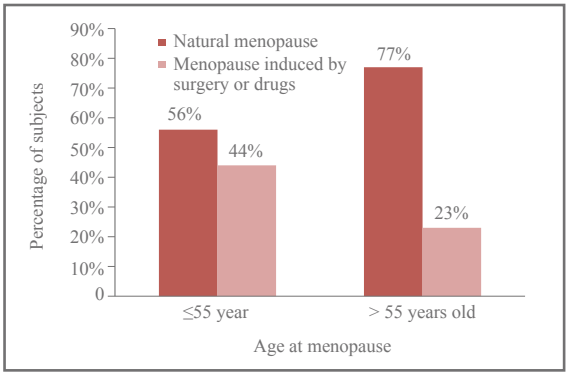

Figure 17. Percentage distribution of the types of menopause among menopausal women

Reproductive history

Age at first live birth and number of live births

Late age at first full-term birth is also a well-known elevated risk for breast cancer.[36,38] It is well known that pregnancy induces the differentiation of breast tissue, which results in a long-term reduction in breast cancer risk, particularly among women who have completed their full-term pregnancy.[39] Increasing number of livebirths has been found to be associated with reduction of risk for breast cancer.[40]

Twenty-one percent of the women were nulliparous. Seventy-two percent of the subjects gave first live birth at younger age (<35 years old), whereas 7% gave first live birth at older age (≥35 years old) (Figure 18).

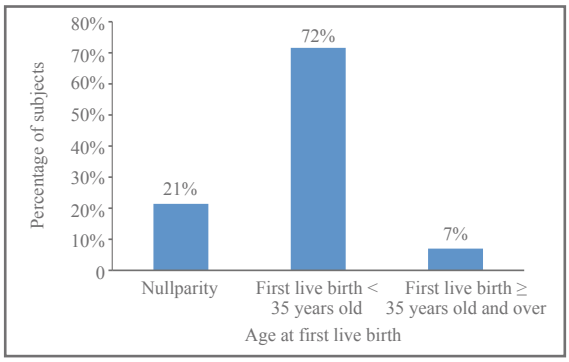

Figure 18. Nullparity and reproductive age of the subjects

The median number of childbirths was 2 for those women with first live birth before age of 35 compared to median of 1 childbirth for those who gave first live birth at age 35 and older (Figure 19).

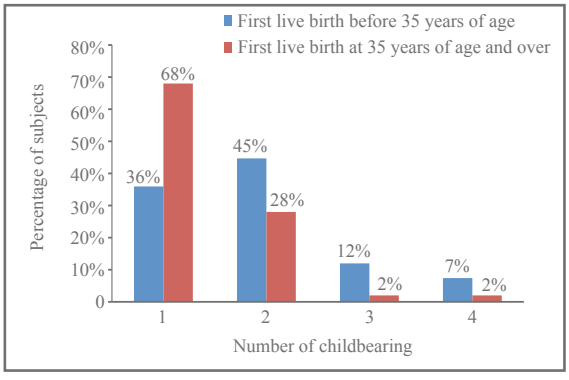

Figure 19. First live birth age by number of child bearing

更年期年齡

更年期年齡愈遲，患乳癌的風險亦相對提高。[36] 更年期婦女較相同年齡及相同生育紀錄、但仍未開始更年期的婦女，有較低的乳癌風險。[37]

參加者中，更年期的年齡中位數是50歲，範圍介乎34至60歲。以55歲作爲更年期年齡分界線（遲收經者乳癌風險增加），8%參加者屬延遲收經（圖16）。44%在55歲或以下的參加者因手術或藥物等因素導致停經，與之相比，在55歲以後才出現更年期的參加者中，有23%是因此停經（圖17）。

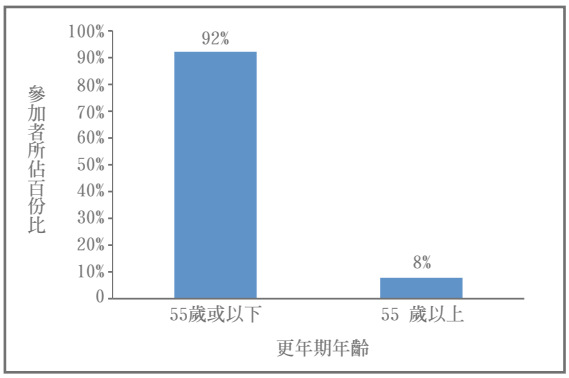

圖16. 參加者更年期年齡分佈

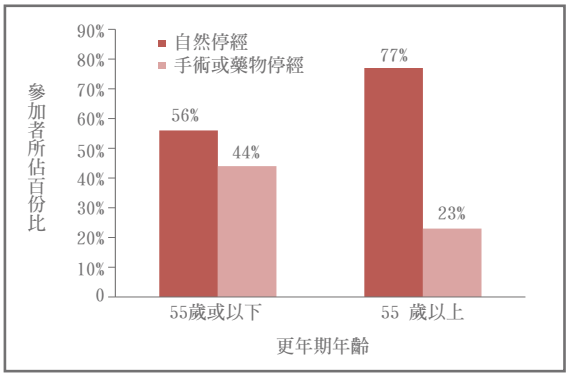

圖17. 更年期婦女收經模式比率

生育紀錄

首次生育年齡及生育數目

生育年齡推遲，是其中一個衆所周知的乳癌高危因素。[36,38] 懷孕期間，乳房組織產生變化，這些變化可保護乳房減少受癌症威脅，尤其當婦女完成整個懷孕及生育過程。[39] 因此，研究亦發現女性生育次數增加，可令患乳癌的風險下降。[40]

參加者中，21%從未懷孕及生育。72%的參加者在較年輕時首次生育（<35歲），而7%首次生育的年齡較遲（≥35歲）（圖18）。

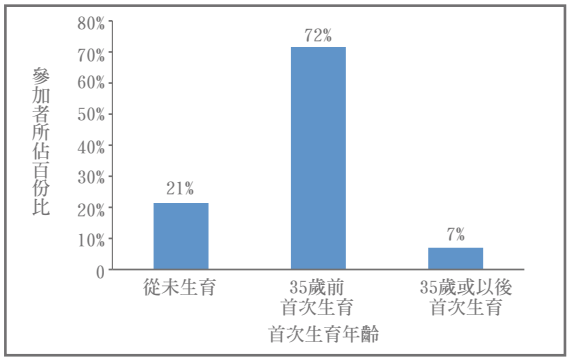

圖18. 參加者首次生育年齡分佈

35歲前首次生育的參加者，子女數目中位數爲2個；與之相比，35歲後首次生育的參加者，子女數目中位數爲1個（圖19）。

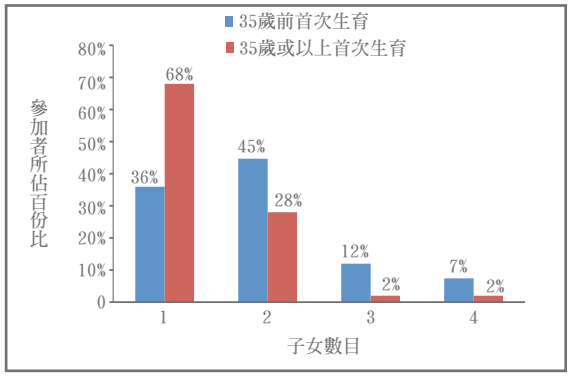

圖19. 首次生育年齡(以參加者子女數目劃分)

Breast Feeding

Thirty-six percent of the subjects had breast feeding with mean duration of 5.3 months (Figure 20) .

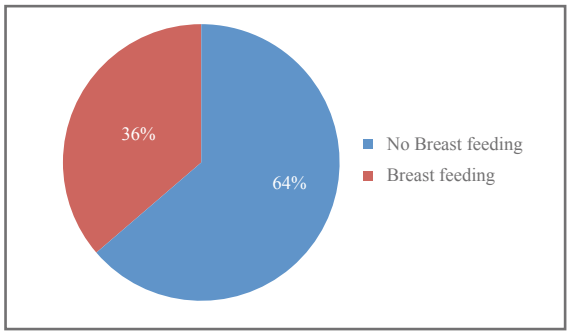

Figure 20. Breast feeding

Use of oral contraceptives

The use of oral contraceptives (OC) as exogenous hormones is shown to be related to increased risk of breast cancer in current and recent users, but the excess risk is insignificant after stopping use for 10 years or more.[37]

The use of OC was reported in 38% of the subjects with a mean duration of 8.7 years (16% OC use for < 5 years; 12% OC use for 5-10 years and 10% OC use for > 10 years), whereas 62% was non-users (Figure 21).

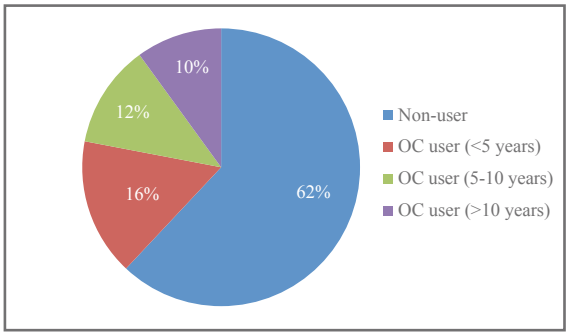

Figure 21. Use of oral contraceptives (OC)

Use of hormone replacement therapy (HRT)

Both Women's Health Initiatives (WHI) in the United States and the Million Women Study in United Kingdom conducted in 2001 showed increased risk of breast cancer with HRT users compared to non-users by 1- to 2-fold. Subsequent to the WHI study, HRT user in US dropped from 61 million to 21 million, and in the following year, breast cancer incidence dropped for the first time in the last 3 decades by 6.7%.[41-43]

An international collaborative study has shown that prolonged use of HRT is associated with increase in breast cancer risk. The relative risk was increased by 35% for women who had used HRT for 5 years or longer compared to the non-user group.[37] However, the prevalence of the use of HRT may vary from country to country. In Singapore only about 6% of women were on HRT compared with 21% of women in Sweden[44-45].

Use of HRT after menopause was reported in 14% of the subjects (Figure 22) with mean duration of HRT use of 3.5 years.

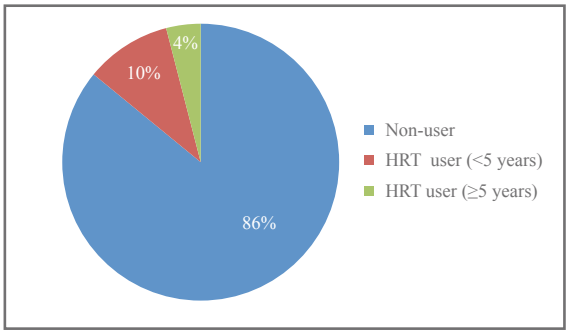

Figure 22. Use of hormone replacement therapy (HRT)

餵哺母乳

36%參加者曾餵哺母乳，餵哺期數中位數爲5.3月(圖20)。

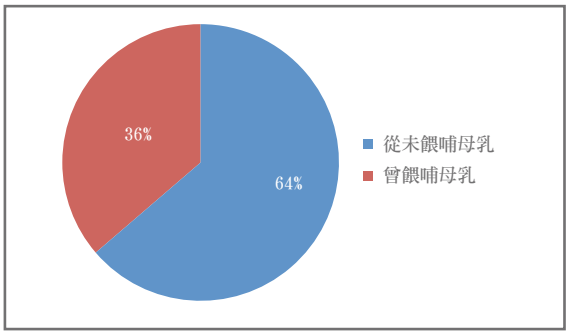

圖20. 餵哺母乳

口服避孕藥

口服避孕藥 (OC) 作爲外在性荷爾蒙，會對正在服用或最近曾服用的女性，增加乳癌的風險，但有關風險在婦女停服避孕丸10年或以上後，便變得不明顯。[37]

38%參加者曾使用口服避孕丸，使用時間的中位數爲8.7年 (16%使用時間< 5年；12% 的使用時間持續5至10年；10% 則持續使用10年以上)，餘下的62%從未使用口服避孕丸 (圖21) 。

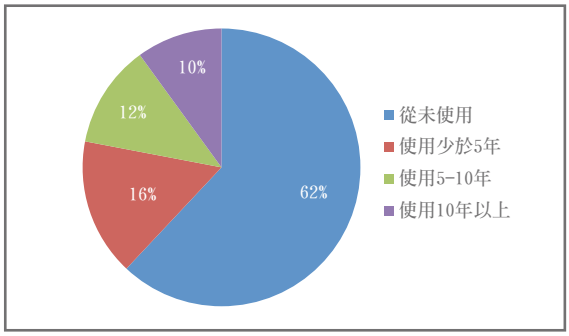

圖21. 口服避孕丸的使用概況

荷爾蒙補充治療

兩項大型研究調查於2001年進行研究調查(美國婦女健康行動 (WHI) 及英國一百萬婦女)，研究指出荷爾蒙補充治療的使用者較非使用者患乳癌的風險高1至2倍。美國婦女健康行動 (WHI) 報告發表後，美國荷爾蒙補充治療的使用者由六千一百萬人大幅減少至二千一百萬人，及其後一年的乳癌發病率於30年內首次下跌6.7%。[41-43]

另一份國際研究指出，荷爾蒙補充治療可增加乳癌的風險，使用有關治療的時間愈長，風險亦相對提高。連續使用荷爾蒙補充治療5年或以上，乳癌風險較從未接受此療法的婦女增加35%。[37] 不同國家對荷爾蒙補充治療的普及程度有所分別，在新加坡使用率僅6%，而在瑞典，使用率則達21%。[44-45]

參加者中，14%在更年期後開始使用荷爾蒙補充治療 (圖22)，平均的使用時間爲3.5年。

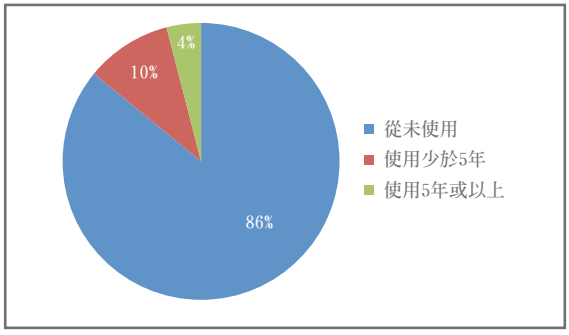

圖22. 使用荷爾蒙補充治療概況

Clinical Characteristics
臨床徵狀

Clinical Characteristics

With reference to the figures from some international cancer registries, symptomatic patients were reported in 80% of women in USA , 75% in Australia and 87% in Singapore.[46-48]

Eighty percent of our subjects were incidental self-discovery of breast cancer whilst 20% detected breast cancer through screening examinations, either by mammography screening, breast ultrasound regular clinical breast examination; breast self examination or other breast screening modalities (Figure 23).

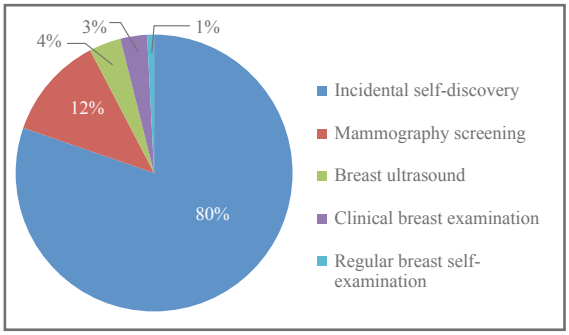

Figure 23. Mode of first breast cancer detection

Among those subjects who were incidental self-discovery of breast cancer, 91% had breast lump, 5% nipple discharge, 3% pain, 2% nipple retraction, 1% asymmetry and 1% other symptoms such as breast discomfort and chest pain at their first clinical consultation (Figure 24).

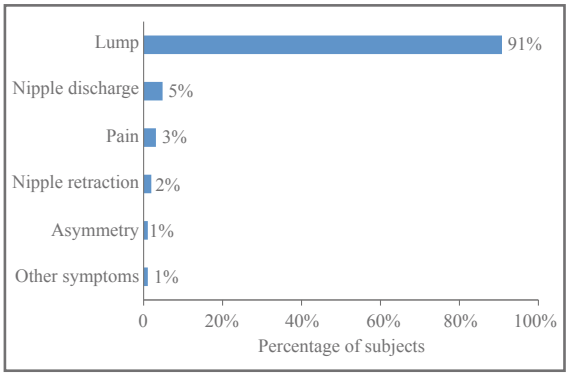

Figure 24. . Major presenting symptoms among those subjects who were incidental self-discovery of breast cancer
*Note: * = precentages added to more than 100% becasue more than one response could be checked*

Median tumour sizes were 1.7cm in screen-detected and 2.2cm in symptomatic cases in Hong Kong, whereas median tumour sizes were 1.8cm and 2.3cm among screen-detected cases and symptomatic cases in Singapore.

Prolonged patient delay (defined as the interval between first detection of symptom and first medical consultation greater than 12 weeks)[49] is associated with advanced staging and poorer outcome.[50]

On average, the subjects sought medical consultation 4 months after the appearance of presenting symptoms. More than 80% sought medical consultation within 3 months of onset of symptoms, 10% sought medical consultation 4 to12 months after onset of symptoms and 6% sought medical consultation after 1 year of onset of symptoms (Figure 25).

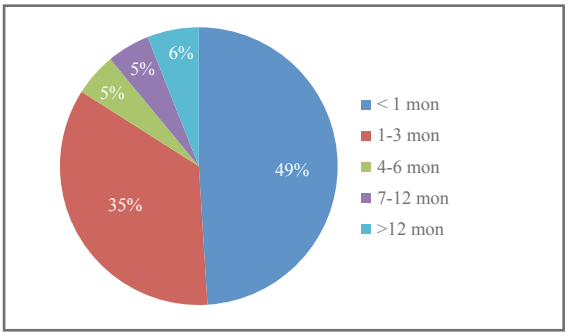

Figure 25. Number of months to seek for medical consultation since onset of symptoms

臨床徵狀

根據一些國際性的癌症資料庫資料顯示，因出現病徵才確診乳癌的婦女，在美國佔80%，在澳洲佔75%，及在新加坡佔87%。[46-48]

香港乳癌資料庫中，80%參加者是在偶然情況下自行發現乳癌徵狀，餘下20%則是透過乳癌普查確診，包括醫生臨床檢查、乳房X光造影、超聲波檢查、定期自我檢查乳房或其他方法等（圖23）。

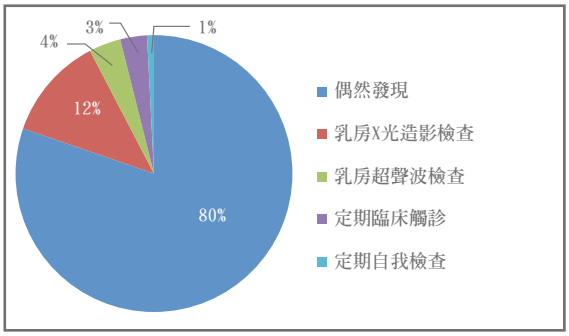

圖23. 首次發現乳癌的方式

在偶然情況下自行發現乳癌徵狀的參加者中，在首次求診時91%有乳房腫塊、5%有乳頭分泌 、3%疼痛、2%有乳頭凹陷、1%有兩邊乳房不對稱及1%有其他徵狀，例如乳房不適及胸痛等（圖24）。

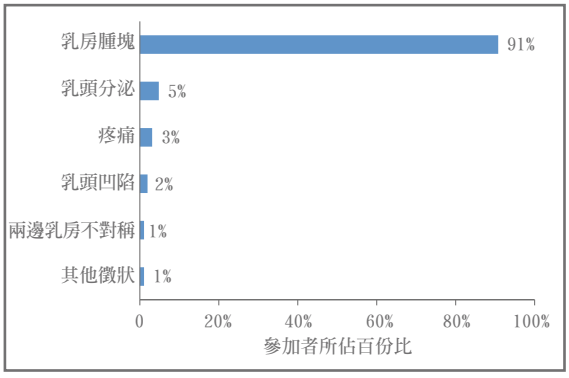

圖24. 參加者在偶然情況下自行發現乳癌徵狀
備注： =因參加者可作多於一個選擇，故百份比高於100%*

在香港，透過乳癌普查確診的乳癌病人的腫瘤大小中位數是1.7厘米；在偶然情況下自行發現乳癌徵狀的乳癌病人的腫瘤大小中位數是2.2厘米。在新加坡，透過乳癌普查確診的乳癌病人的腫瘤大小中位數是1.8厘米；在偶然情況下自行發現乳癌徵狀的乳癌病人的腫瘤大小中位數是2.3厘米。

病人拖延求診 （定義：出現乳癌徵狀與首次求診相距時間多於12星期）[49] 與乳癌期數較爲晚期及較差的結果有關。[50]

平均而言，參加者在出現乳癌徵狀4個月後才求診：超過80%參加者在發現徵狀3個月內求診，10%則在4至12 個月內，亦有6%參加者在徵狀出現一年後，才前往求醫（圖26）。

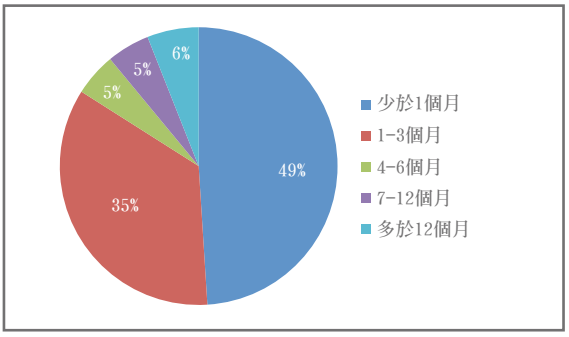

圖25. 參加者出現乳癌徵狀與首次求診相距時間

Overall Cancer Characteristics
整體癌症特徵

Overall Cancer Characteristics

Regarding laterality of breast cancer, cancer occurred in right breast only (49%) patients, in left breast only (48%) and bilateral breasts (3%) (Figure 26). Out of 27 bilateral cases, 85% were synchronous tumours (diagnosed simultaneously or <6 months apart) and 15% were metachronous tumours.

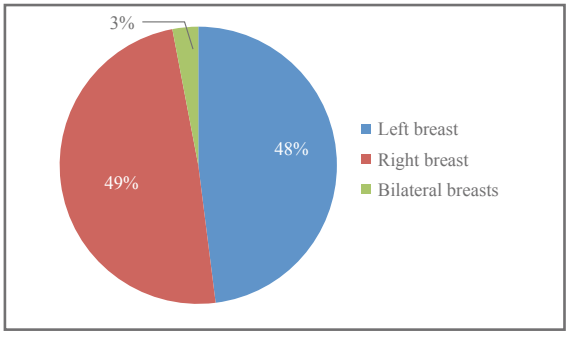

Figure 26. Laterality of breast cancers

Breast cancer occurred in the locations of upper outer quadrant (48%), upper inner quadrant (20%), lower outer quadrant (15%), central (11%) and lower inner quadrant (9%) (Figure 27).

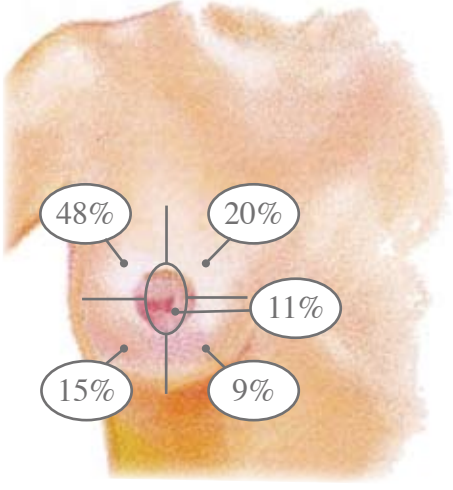

Figure 27. Location of breast cancers
*Note: * = percentages add to more than 100% because more than one response could be checked*

A number of imaging and cytohistological examinations were used to confirm the diagnosis of breast cancer. These included diagnostic mammography, breast ultrasound, magnetic resonance imaging (MRI), fine needle aspiration (FNA), core needle biopsy (CNB) or excisional biopsy (Tables 4-5).

Table 4. Diagnostic results of mammography, breast ultrasound and magnetic resonance imaging (MRI)

Diagnostic method	Mammogram	Ultrasound	MRI
Total no.	979	963	96
Normal (BI-RADS 1)	113 (12%)	33 (3%)	1 (1%)
Benign (BI-RADS 2)	112 (11%)	45 (5%)	2 (2%)
Probably benign (BI-RADS 3)	136 (14%)	143 (15%)	2 (2%)
Indeterminate (BI-RADS 4a)	367 (38%)	405 (42%)	28 (29%)
Suspicious (BI-RADS 4b)	13 (1%)	12 (1%)	3 (3%)
Diagnostic / malignant (BI-RADS 5)	238 (24%)	325 (34%)	60 (63%)

BI-RADS: Breast Imaging Reporting And Data System

Table 5. Diagnostic results of fine needle aspiration (FNA), core needle biopsy (CNB) and excisional biopsy

Diagnostic method	FNA	CNB	Excisional biopsy
Total no.	601	396	112
Scanty benign (Class I)	6 (1%)	0 (0%)	-
Benign (Class II)	31 (5%)	3 (1%)	-
Atypical (Class III)	50 (8%)	6 (2%)	-
Suspicious (Class IV)	156 (26%)	20 (5%)	1 (1%)
Diagnostic / malignant Class V	358 (60%)	367 (92.7%)	111 (99%)

FNA: Fine needle aspiration; CNB: Core needle biopsy

整體癌症特徵

以乳癌出現位置作統計，49%參加者在右邊乳房發現有乳癌腫瘤、48%在左邊乳房發現有乳癌腫瘤，並有3%病人兩邊乳房均有乳癌腫瘤（圖26）。在27個雙邊乳癌個案中，85%爲「同時性腫瘤」（同時確診或兩邊確診時間相距少於6個月），另15%爲「非同時性腫瘤」。

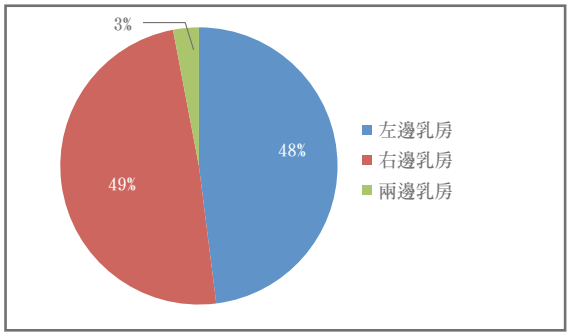

圖26. 乳癌發病位置

乳癌腫瘤位於乳房上外側部（48%），於乳房上內側部（20%）、乳房下外側部（15%）、中央（11%）及乳房下內側部（9%）（圖27）。

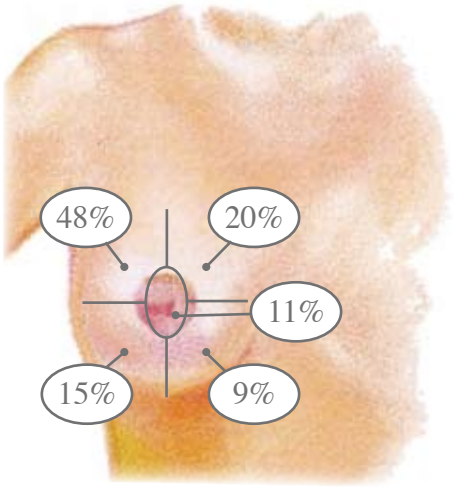

圖27. 乳癌腫瘤位置
備注： =因參加者可作多於一個選擇，故百份比高於100%*

一系列造影及細胞組織性測試，均用於確診乳癌，包括診斷性乳房X光造影、乳房超聲波、磁力共振測試、幼針活組織抽檢、粗針活組織抽檢及切除式活組織檢查（表4至5）。

表4. 乳房X光造影、乳房超聲波及磁力共振之斷診結果

檢查方式	乳房X光造影	乳房超聲波	磁力共振
總數字	979	963	96
正常（BI-RADS 1）	113（12%）	33（3%）	1（1%）
良性（BI-RADS 2）	112（11%）	45（5%）	2（2%）
很可能良性(BI-RADS 3)	136（14%）	143（15%）	2（2%）
不確定(BI-RADS 4a)	367（38%）	405（42%）	28（29%）
懷疑（BI-RADS 4b）	13（1%）	12（1%）	3（3%）
確診/惡性(BI-RADS 5)	238（24%）	325（34%）	60（63%）

BI-RADS：乳房造影報告及數據系統

表5. 幼針活組織抽檢、粗針活組織抽檢及切除式活組織檢查之診斷結果

檢查方式	幼針活組織抽檢	粗針活組織抽檢	切除式活組織檢查
總數字	601	396	112
極少良性(等級1)	6（1%）	0（0%）	—
良性(等級2)	31（5%）	3（1%）	—
異常(等級3)	50（8%）	6（2%）	—
懷疑(等級4)	156（26%）	20（5%）	1（1%）
確診/惡性(等級5)	358（60%）	367（93%）	111（99%）

Diagnostic mammography was used in 98% of cases. Thirteen percent of the subjects had normal findings. Abnormalities detected included microcalcifications (48%), followed by opacity (27%), architectural distortion (11%), asymmetric density (8%) and other findings (7%) such as skin thickening and lymph node metastasis (Figure 28).

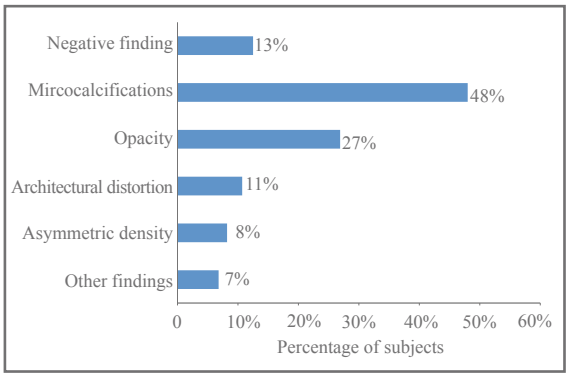

Figure 28. Mammographic findings
*Note: * = percentages add to more than 100% because more than one response could be checked*

Heterogeneous or extreme dense breast were found in 75% of the subjects (Figure 29).

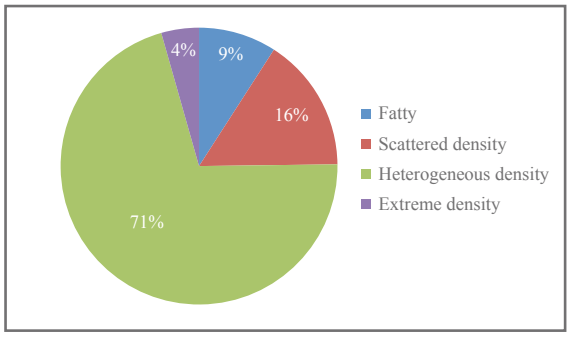

Figure 29. Breast density

Figure 30 showed the common staging methods which were used to determine the extent of cancer spread. Most of the subjects (73%) had chest x-ray and ultrasound abdomen, 23% PET scan, 3.5% either chest x-ray or ultrasound abdomen, 0.5% MRI whole bodyand 0.1% CT thorax, CT abdomen and bone scan as their staging methods.

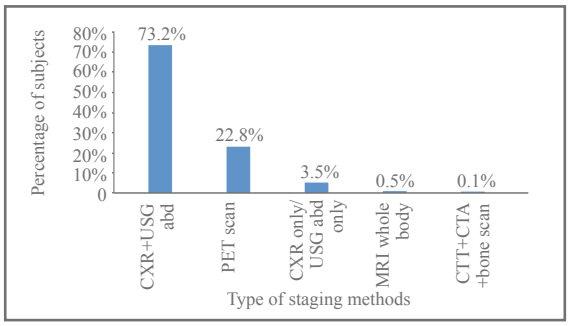

Figure 30. Type of staging methods
Note: CXR + USG abd: Chest X-ray + Ultrasound abdomen
CXR only / USG abd only: Chest X-ray only / Ultrasound abdomen only
MRI whole body: Magnetic resonance imaging whole body
CTT + CTA + bone scan: CT Thorax + CT Abdomen + bone scan

Overall cancer stage

From Surveillance Epidemiology and End Results (SEER) program, stage distribution among the Whites for localized, regional and metastasized cancers were 62%, 31% and 4% respectively while 3% were unstaged.[51] The figure from Sweden Cancer Registry reported more local cancers than that from Singaporean Cancer Registry (82% versus 53%) during 1990-1999.[15]

The distribution of cancer stage in the subject cohort was: stage 0 (15%), stage I (34%), stage IIA (26%), stage IIB (12%), stage III (12%) and stage IV (1%) (Figure 31). Among the cancers with advanced stage, 6% of cancers metastasized to other organs such as bone, liver and lung (1 patient), bone and liver (1 patient), bone only (2 patients), lung only (1 patient), liver only (1 patient) and thyroid only (1 patient).

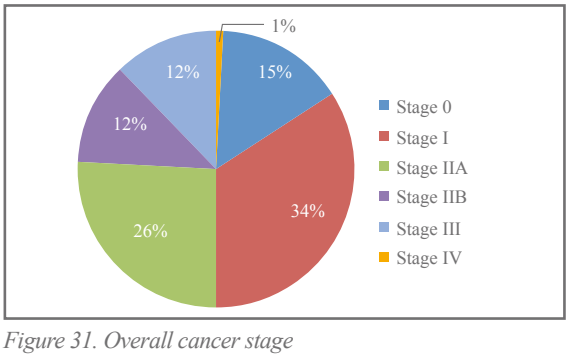

Figure 31. Overall cancer stage

98%個案使用診斷性乳房X光造影。13%的乳房X光造影檢查屬正常結果。不尋常的結果包括微鈣化點(48%)、不透明影像 (27%)、結構扭曲 (11%)、非對稱性陰影 (8%) 及其餘發現 (7%)，包括皮膚增厚及淋巴轉移等 (圖28)。

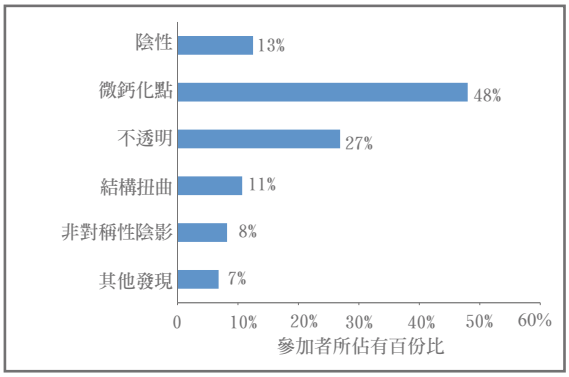

圖28. 乳房X光造影的檢查結果
備注： =因參加者可作多於一個選擇，故百份比高於100%*

根據圖29顯示，75%病人的乳房密度爲異質性或極高密度。

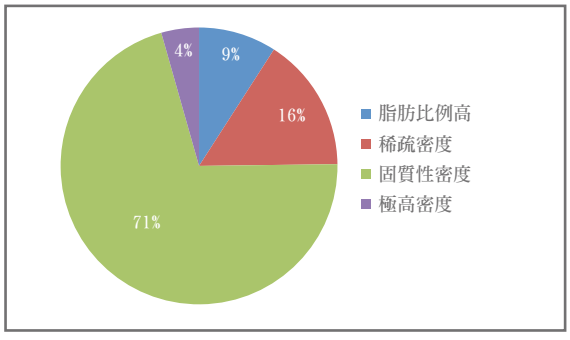

圖29. 乳房密度

圖30列出主要的診斷乳癌期數方式，用來斷定癌症腫瘤的擴散情況。大部份 (73%) 是透過胸部X光及腹部超聲波作診斷乳癌期數，23%的參加者使用正電子電腦掃描，3.5%使用胸部X光或腹部超聲波，0.5%使用全身磁力共振，以及0.1%使用胸部電子掃描、腹部電子掃描及骨骼掃描來診斷乳癌期數。

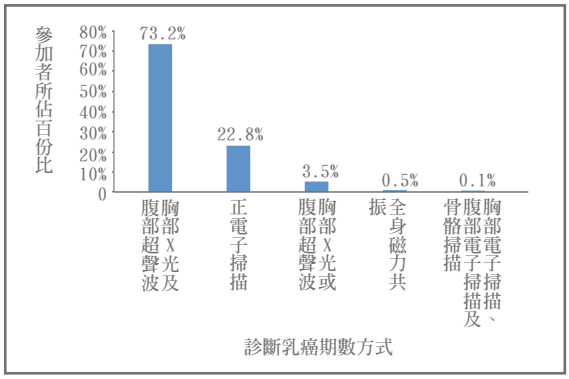

圖30. 診斷乳癌期數的方式

整體乳癌期數

根據「監測、流行病學及最終結果計劃」(SEER)，白人的乳癌期數分佈爲62%癌症範圍局部在乳房內，31%癌症擴展至乳房周邊淋巴組織，4%癌症擴散至其他器官，並有3%爲不明個案。[51] 除此以外，瑞典癌症資料庫提供的數據指，1990至1999年當地的局部癌症個案，較新加坡癌症資料庫所記錄的爲多 (82%比53%)。[15]

參加者的癌症期數分佈爲：第0期 (15%)、第I期 (34%)、第IIA期 (26%)、第IIB期 (12%)、第III期 (12%)，及第IV期 (1%)。在晚期個案中，6%癌細胞擴散至其他器官如骨、肝及肺部 (1名病人)、骨與肝臟 (1名病人)、骨骼 (2名病人)、肺部 (1名病人)、肝臟 (1名病人)及甲狀腺 (1名病人)。

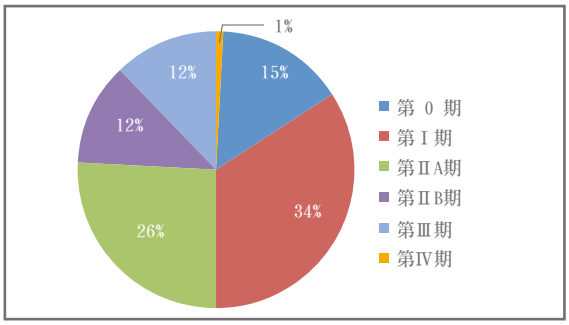

圖31. 病人的癌症期數

Cancer characteristics of invasive breast cancer

In 2002 Singapore has introduced a nation-wide mammographic screening program- BreastScreen Singapore, the clinical details showed the median size of lesions were smaller in screen-detected cancers compared to symptomatic cancers (18mm vs. 23mm).[48]

In our patient cohort, invasive breast cancer accounted for 85% of all breast cancer cases. More than 80% of invasive breast cancers were early stage, only 15% were advanced stage. The median and mean sizes of invasive breast cancer were 1.8 cm and 2.2cm respectively (range: 0.01-20.1 cm). More than 50% had invasive tumours of 2 cm or below, 40% with tumour size between 2.01-5 cm and 4% with tumour size of 5 cm and over (Figure 32).

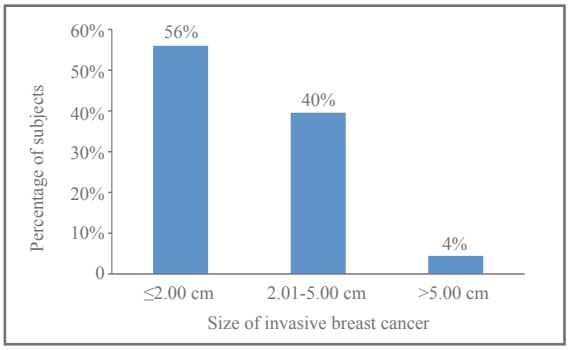

Figure 32. Size of invasive breast cancers

Ninety-two percent of invasive breast cancer cases underwent sentinel lymph node biopsy or axillary dissection to detect lymph node involvement. Nodal status was negative in 60% of the patients, 28% had 1-3 positive lymph nodes, 8% had 4-9 positive lymph nodes and 4% had more than10 positive lymph nodes (Figure 33).

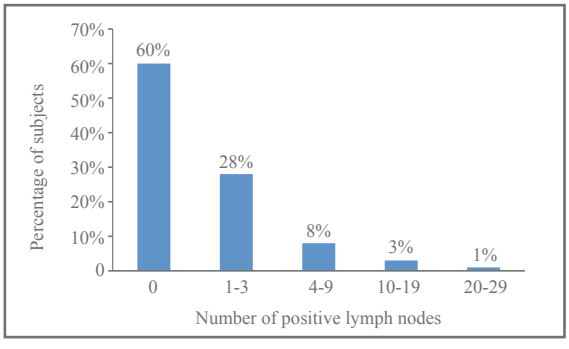

Figure 33. Number of nodes positive in invasive breast cancer patients

Cancer characteristics of in situ breast cancer only

Among all breast cancers, 15% had carcinoma in situ only. Amongst them, 4% only had lymph node involvement. The median and mean sizes of in situ breast cancer were 2.0 cm and 2.5 cm respectively (range: 0.2-9.0 cm). Fifty-four percent of patients had in situ tumours below 2.0 cm, 39% between 2.01-5 cm and 7% 5 cm and over (Figure 34).

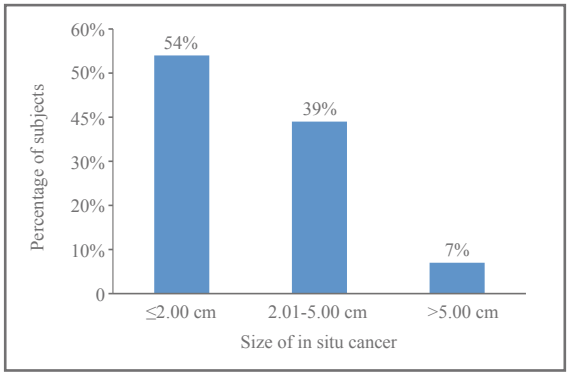

Figure 34. Size of in situ breast cancers only

入侵性乳癌資料

在2002年，新加坡政府策動一個全民性的乳房X光造影檢查——「新加坡乳房普查計劃」(BreastScreen Singapore)。經臨床診斷發現，透過乳癌診斷檢查確診的病人，其腫瘤面積的中位數，較出現病徵才確診的病人小（18毫米比23毫米）。[48]

在我們的參加者中，入侵性乳癌佔所有乳癌個案的85%。逾80%的入侵性乳癌個案屬早期，只有15%屬晚期。入侵性乳癌腫瘤大小中位數及平均數分別爲1.8厘米及2.2厘米（範圍：0.01-20.1厘米）。超過50%的入侵性腫瘤大小在2厘米或以下，40%的腫瘤大小介乎2.01至5厘米，4%的腫瘤大小在5厘米或以上（圖32）。

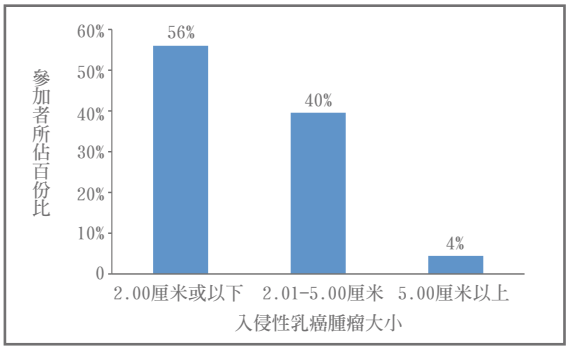

圖32. 入侵性乳癌腫瘤大小

92%的入侵性乳癌個案透過前哨淋巴組織檢查或腋下淋巴摘除，診斷癌細胞擴散至腋下淋巴的程度。60%病人的淋巴結感染測試呈陰性反應。28%有1至3個陽性淋巴結、8%有4至9個陽性淋巴結、4%有10個或以上陽性淋巴結（圖33）。

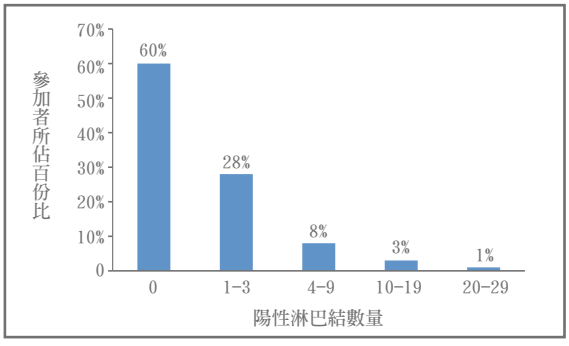

圖33. 入侵性乳癌病人的陽性淋巴結數量

原位癌資料

在所有乳癌病人中，15%屬原位癌。當中只有4%病人的癌細胞擴散至淋巴結。原位癌個案的大小中位數及平均數分別爲2.0厘米及2.5厘米（範圍：0.2至9.0厘米）。54%的原位癌腫瘤在2厘米以下，39%介乎2.01至5厘米、7%在5厘米或以上（圖34）。

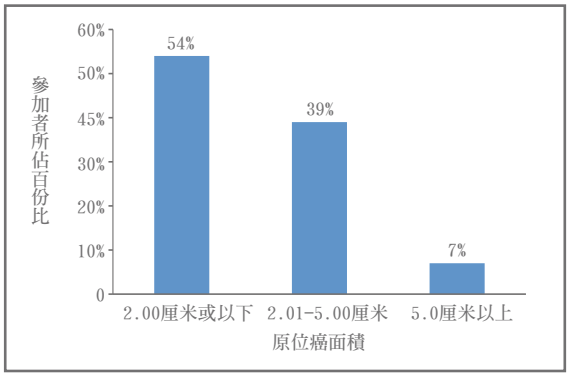

圖34. 原位癌腫瘤大小

Histological & Molecular Characteristics
乳癌組織學及分子學特性

Histological and Molecular Characteristics

Invasive breast cancer

Table 6 depicted the histological types of invasive breast cancer. The 5 most common histological types of invasive breast cancer were ductal (82.7%), lobular (5.3%), mucinous (3.4%), microinvasive (1.8%), mixed ductal & lobular (1.5%) and tubular (1.3%).

Grade 3 invasive breast cancer was found in 47% of the cases . Lymphovascular invasion was found in 39% of invasive breast cancer. Nineteen percent of the subjects had more than one invasive breast tumours and 5% of the subjects had tumours involving more than one quadrant of the breast.

Table 6. Histological type, grading, multifocality and multicentricity of invasive breast cancer

	Relative percentage (%)
Histological type	
Ductal	82.7%
Lobular	5.3%
Mucinous (colloid)	3.4%
Microinvasive	1.8%
Mixed ductal & lobular	1.5%
Tubular	1.3%
Borderline/ malignant phyllodes	0.9%
Medullary	0.9%
Papillary	0.6%
Micropapillary	0.6%
Paget's disease of nipple	0.1%
Cribiform carcinoma	0.3%
Neuroendocrine carcinoma	0.2%
Adenoid cystic carcinoma	0.2%
Inflammatory	0.1%
Metaplastic carcinoma	0.1%
Grading	
1	16%
2	37%
3	47%
Lymphovascular invasion	
Yes	39%
No	61%
Multifocality	
Yes	19%
No	81%
Number of foci	
2	51%
3-4	33%
≥5	16%
Multicentricity	
Yes	5%
No	95%
Number of quadrants	
2	81%
3	17%
4	2%

Molecular characteristics of breast cancer may provide crucial information for clinicians to decide appropriate treatment for breast cancer patients.

Positive results of estrogen receptor (ER+) or progesterone receptor (PR+) biomarker tests indicate cancer may respond well to hormone treatment. Overexpression of c-erbB2 (HER2+) indicates cancer may respond well to targeted therapy against HER 1&2. High level of Ki-67 index indicates a highly proliferative cancer.

Table 7 and Table 8 summarized molecular characteristics of breast cancer including estrogen receptor (ER), progesterone receptor (PR), c-erbB2 and Ki-67 index for invasive breast cancer cases.

乳癌組織學及分子學特性

入侵性乳癌

表6列出各入侵性乳癌的組織學分類特性。首五種最常見的入侵性乳癌組織學類別爲乳腺管(82.7%)、乳小葉 (5.3%)、黏液性 (3.4%)、微侵襲癌 (1.8%)、乳腺管及乳小葉混合型癌 (1.5%)及管狀癌 (1.3%)。

47%個案屬入侵性乳癌的第3級。39%入侵性乳癌患者出現淋巴血管侵蝕現象。19%病人有超過一個入侵性乳癌腫瘤，5%病人的癌腫瘤涉及超過一個乳房部位。

表6. 入侵性乳癌病人的組織學類別、分級、腫瘤多灶性及腫瘤多中心性

	所佔百份比（%）
組織學分類	
乳腺管癌	82.7%
乳小葉癌	5.3%
黏液性癌	3.4%
微侵襲癌	1.8%
乳腺管及乳小葉混合型癌	1.5%
管狀癌	1.3%
臨界性/惡性葉狀莖瘤	0.9%
髓狀癌	0.9%
乳突狀癌	0.6%
微小乳突狀癌	0.6%
乳頭柏哲氏病	0.1%
篩狀癌	0.3%
神經內分泌癌	0.2%
腺樣囊狀癌	0.2%
炎性癌	0.1%
化生癌	0.1%
分級	
1	16%
2	37%
3	47%
淋巴血管侵蝕	
有	39%
否	61%
腫瘤多灶性	
Yes	19%
No	81%
腫瘤病灶數目	
2	51%
3-4	33%
≥5	16%
腫瘤多中心性	
有	5%
否	95%
涉及乳房部位數目	
2	81%
3	17%
4	2%

分辨乳癌的分子學特性，可讓醫生爲病人制訂更有效率的治療方案。

如在雌激素及黃體素生物標籤測試中，雌激素受體 (ER+) 或黃體素受體 (PR+) 呈陽性反應，代表荷爾蒙抑制治療對癌細胞的效果理想。上皮生長素受體呈陽性 (HER2+) 的過度表現，則代表上皮生長素治療對HER 1及2的治療反應理想。至於Ki-67指數愈高，代表體內癌症屬高繁殖性。

表7及表8綜合了各種入侵性乳癌的分子學類別，包括雌激素受體(ER)、黃體素受體(PR)、上皮生長素受體及Ki-67 指數。

Table 7. Molecular characteristics of invasive breast cancer

	Positive	Negative	
Estrogen Receptor (ER)	77%	23%	
Progesterone Receptor (PR)	62%	38%	
c-erbB2	19%	81%	
	<12%	12-50%	>50%
Ki67 index	50%	38%	12%

Table 8. Characteristics of molecular subtypes of estrogen receptor, progesterone receptor and HER2 receptor in the patients of invasive breast cancer

	Relative percentage(%)
ER+PR+HER2+	6%
ER+PR+HER2-	55%
ER+PR-HER2+	4%
ER+PR-HER2-	12%
ER-PR+HER2+	1%
ER-PR+HER2-	1%
ER-PR-HER2+	8%
ER-PR-HER2-	13%

ER+: estrogen receptor positive; ER-: estrogen receptor negative; PR+: progesterone receptor positive; PR-: progesterone receptor negative HER2+: human epidermal growth factor receptor 2 positive; HER2-: human epidermal growth factor receptor 2 negative

In situ breast cancer only

Table 9 depicted the histological type of in situ breast cancer only. The most common histological type of in situ breast cancer was ductal (95.5%), followed by papillary (2.6%), lobular (1.3%) and Paget's disease of nipple (0.6%). In situ breast cancer of high nuclear grade was found in 45% of the cases. Ten percent of the subjects had more than one focus of cancer and 3% of the subjects had tumours involved more than one quadrant of the breast. Microcalcification was present in 59% of in situ cancers only (Figure 35).

Table 9. Histological type, grade, multifocality and multicentricity of in situ breast cancer only

	Relative percentage (%)
Histological type	
Ductal	95.5%
Papillary	2.6%
Lobular	1.3%
Paget's disease of nipple	0.6%
Necrosis	
Yes	70%
No	30%
Nuclear Grade	
Low	18%
Intermediate	37%
High	45%
Multifocality	
Yes	10%
No	90%
Number of foci	
2	75%
3	17%
4	8%
Multicentricity	
Yes	3%
No	97%
Number of quadrants	
2	75%
3	25%

表7. 入侵性乳癌的分子學類別

	陽性	陰性	
雌激素受體 (ER)	77%	23%	
黃體素受體 (PR)	62%	38%	
上皮生長素受體 (c-erbB2)	19%	81%	
	<12%	12-50%	>50%
Ki67指數	50%	38%	12%

表8. 入侵性乳癌中雌激素受體、黃體素受體及上皮生長素受體的分子學副品種

	所佔百份比(%)
ER+PR+HER2+	6%
ER+PR+HER2-	55%
ER+PR-HER2+	4%
ER+PR-HER2-	12%
ER-PR+HER2+	1%
ER-PR+HER2-	1%
ER-PR-HER2+	8%
ER-PR-HER2-	13%

ER+: 雌激素受體呈陽性; ER-:雌激素受體呈陰性,
PR+: 黃體素受體呈陽性; PR-:黃體素受體呈陰性,
HER2+:上皮生長素受體呈陽性; HER2-:上皮生長素受體呈陰性

原位癌

表9列出原位癌乳癌病人的組織學類別。最常見的原位癌乳癌組織學類別爲乳腺管癌(95.5%)，接著是乳突狀癌(2.6%)、乳小葉癌(1.3%)及乳頭柏哲氏病(0.6%)。原位癌的核分級爲最高級數佔45%。10%病人有超過一個原位乳癌病灶，3%病人的乳癌腫瘤涉及多於一個乳房部位。59%原位癌病人出現乳房微鈣化徵狀。(圖35)

表9. 原位癌病人組織學分類、分級、腫瘤多灶性及腫瘤多中心性

	所佔百份比 %
組織學分類	
乳腺管癌	95.5%
乳突狀癌	2.6%
乳小葉癌	1.3%
乳頭柏哲氏病	0.6%
壞疽	
有	70%
否	30%
核分級	
低	18%
中度	37%
高	45%
腫瘤多灶性	
有	10%
否	90%
腫瘤病灶數目	
2	75%
3	17%
4	8%
腫瘤多中心性	
有	3%
否	97%
涉及乳房部位數目	
2	75%
3	25%

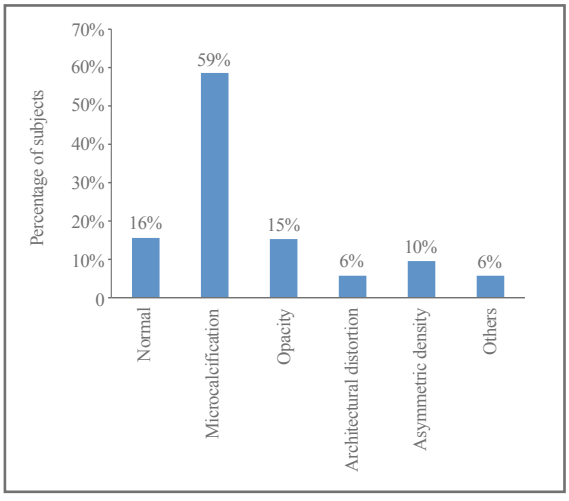

Figure 35. Mammographic findings of in situ breast cancer only
*Note: * = percentages add to more than 100% because more than one response could be checked*

Table 10 summarized the molecular characteristics including estrogen receptor, progesterone receptor, c-erbB2 and Ki67 index for in situ breast cancers only.

Table 10. Molecular characteristics of in situ breast cancer only

	Positive	**Negative**	
Estrogen Receptor (ER)	77%	23%	
Progesterone Receptor (PR)	67%	33%	
c-erbB2	33%	67%	
	<12%	12-50%	>50%
Ki67 index	63%	34%	3%

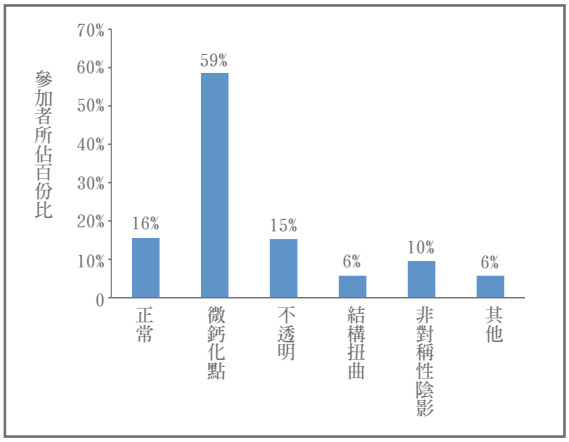

圖35. 原位癌個案進行乳房X光造影的發現
備注： =因參加者可作多於一個選擇，故百份比高於100%*

表10列出乳癌原位癌病人的病人分子學特性，包括雌激素受體、黃體素受體、上皮生長素受體及Ki67指數。

表10. 乳癌原位癌病人分子學特性

	陽性	陰性	
雌激素受體(ER)	77%	23%	
黃體素受體 (PR)	67%	33%	
上皮生長素受體(c-erbB2)	33%	67%	
	<12%	12-50%	>50%
Ki67指數	63%	34%	3%

Treatment Methods
治療方法

Treatment Methods

Breast cancer surgery

Almost all breast cancer patients (99.6%) underwent surgical operation to remove tumours (Figure 36). Sixty-one percent of the patients had breast conserving treatment whilst 39% had total mastectomy. Among the mastectomy group, 26% of the subjects had immediate breast reconstruction (Table 11).

Irrespective of the type of breast surgery (lumpectomy or mastectomy), removal of lymph nodes from axilla of the affected side helped to determine whether the disease has spread beyond the breast. However, removal of lymph nodes may result in lymphoedema. In recent years, sentinel node biopsy was developed to determine axillary involvement in early breast cancer with clinically negative axilla. If sentinel nodes were positive, the standard treatment was to perform level I & II axillary dissection. If sentinel nodes were negative, patient can be spared further axillary surgery, thereby reducing the risk of lymphoedema. For patients with involved axillary node on clinical examination, conventional axillary dissection was performed.

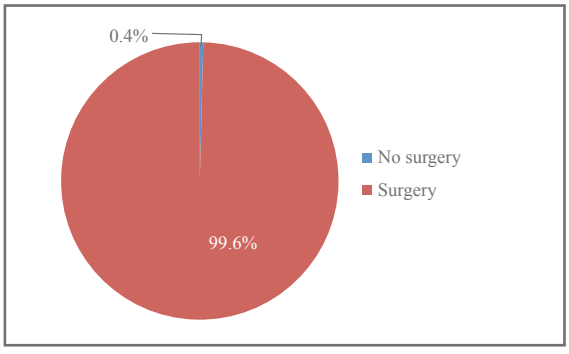

Table 36. Percentage of the subjects undergone surgical operations

Table 11. Types of surgical operation in breast cancer patients

	Relative percentage (%)
Breast conserving surgery	
Yes	61%
No	39%
Mastectomy	
Yes	39%
No	61%
Reconstruction among mastectomy group	
Yes	26%
No	74%
Nodal surgery	
Yes	86%
No	14%
Type of nodal surgery	
Sentinel node biopsy	60%
Sentinel node biopsy & axillary dissection	18%
Axillary dissection	22%

治療方法

乳癌手術

幾乎所有乳癌病人（99.6%）均接受了乳房切除手術，以將癌腫瘤切去（圖36）。61%的病人接受了乳房保留手術，另39%接受了全乳切除手術。26%在接受全乳切除手術的同時，亦接受乳房重建手術（表 11）。

不論使用何種乳房手術（硬塊切除手術或全乳切除手術），將受感染一邊的腋下淋巴切除，有助測出癌細胞是否已擴散至乳房之外。然而，將腋下淋巴切除可導致淋巴水腫。近年，前哨淋巴抽檢術可用於診斷臨床上早期乳癌的淋巴受感染程度。如前哨淋巴屬陽性，病人便需接受I 及II期淋巴切除。如前哨淋巴屬陰性，則可免除額外的腋下手術，減低淋巴水腫風險。如腋下淋巴受感染，需作傳統腋下淋巴切除手術。

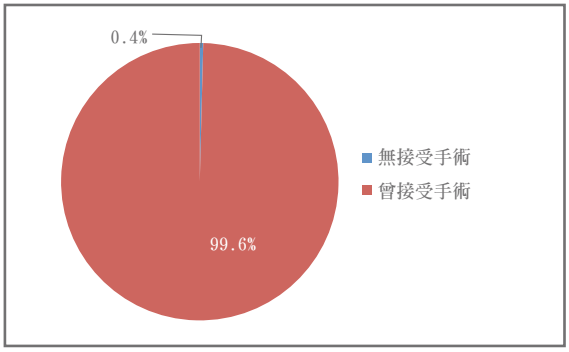

表36. 乳癌病人接受手術的比率

表11. 乳癌病人的手術種類

	所佔百份比（%）
乳房保留手術	
有	61%
否	39%
全乳切除手術	
有	39%
否	61%
全乳切除手術後的乳房重建	
有	26%
否	74%
淋巴結手術	
有	86%
否	14%
淋巴結手術種類	
前哨淋巴抽檢術	60%
前哨淋巴抽檢術與腋下淋巴切除	18%
腋下淋巴切除	22%

Radiation therapy

Radiation therapy was performed in 71% of the cases (Figure 37). Figure 38 depicted the percentage distribution of radiated regions. These included 22% of the subjects with breast conserving surgery to the affected breast and 11% of the subjects with mastectomy either to chest wall, supraclavicular fossa (SCF), internal mammary chain (IMC) or axilla.

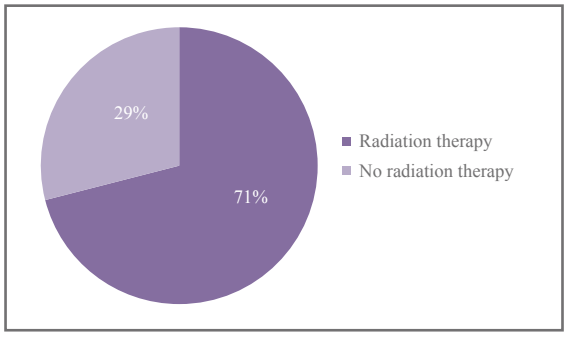

Figure 37. Percentage of the subjects receiving radiation therapy

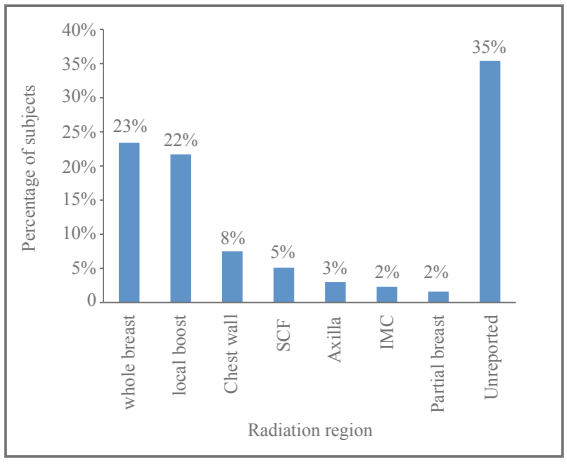

Figure 38. Radiated regions
*Note: * = percentages add to more than 100% because more than one response could be checked*
SCF: supraclavicular fossa
IMC: internal mammary chain

Chemotherapy

Chemotherapy was a form of systemic therapy to reduce risk of recurrence in subjects with breast cancer for curative intent, or as therapeutic measure in de novo metastatic cancer. More than 70% of invasive breast cancer cases underwent chemotherapy. (Figure 39). The used chemotherapy regimen included: AC+T (33%), FAC/ FEC (19%), AC (19%), TC/DC (15%), FEC+T (3%), CMF (1%) and TAC (1%) and others (9%) (Figure 40).

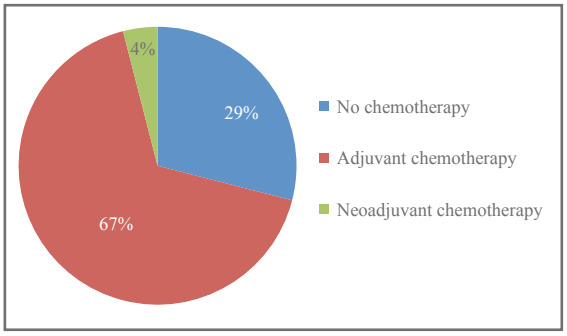

Figure 39. Percentage of invasive breast cancer patients on chemotherapy

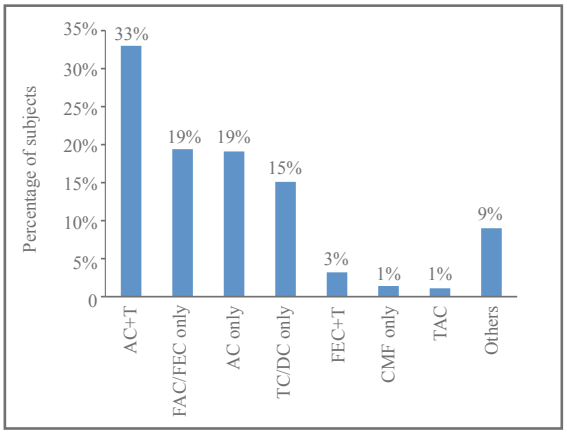

Figure 40. Regimen of chemotherapy

電療

71%乳癌病人均曾接受電療 (圖37)。圖38則列出接受電療的位置比率，包括22%接受乳房保留手術的病人接受局部電療，另有11%接受全乳切除的病人，術後於胸壁、或區域性淋巴系列處接受電療(圖38)。

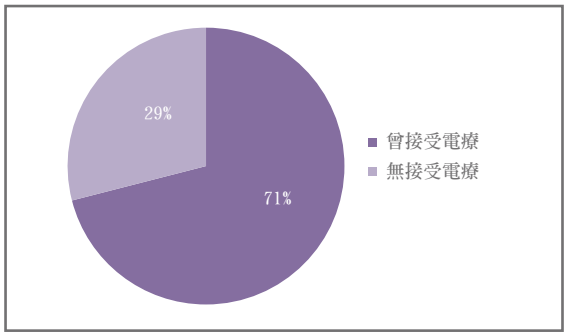

圖37. 乳癌病人接受電療的比率

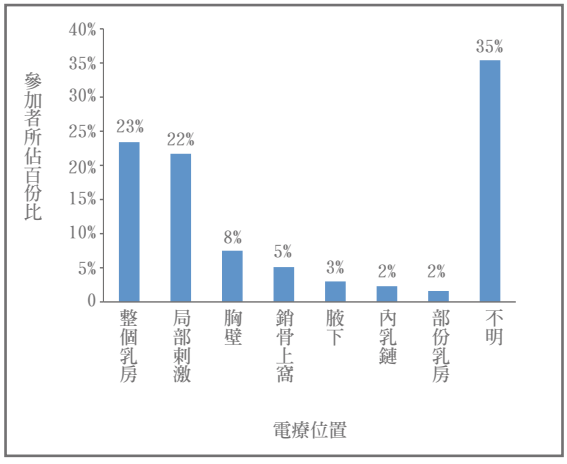

圖38. 接受電療位置
備注： =因參加者可作多於一個選擇，故百份比高於100%*

化療

化療屬全身治療的其中一種，目的是減低乳癌患者的復發機率，同時亦可作爲治療惡性轉移腫瘤的方法之一。超過70%入侵性乳癌病人接受化療(圖39)。所使用的化療藥物療程包括: AC+T (33%), FAC/ FEC (19%), AC (19%), TC/DC (15%), FEC+T (3%), CMF (1%), TAC (1%) 及其他 (9%) (圖40)。

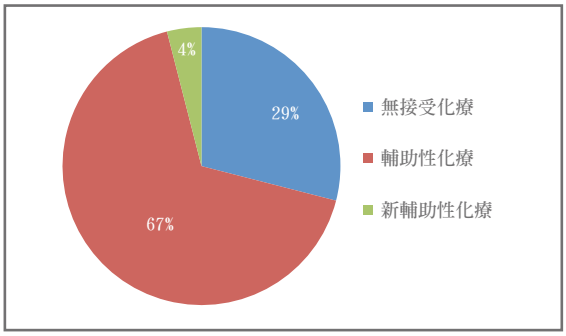

圖39. 入侵性乳癌病人接受化療的比率

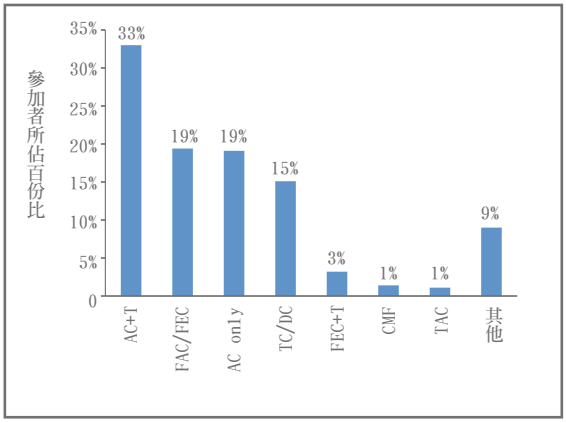

圖40. 化療藥物療程使用的比率

Endocrine therapy

Endocrine therapy was a form of systemic therapy targeted at hormone responsive tumours. Figure 41 showed 58% of the subjects underwent endocrine therapy. Endocrine therapy was used in 65% of invasive cancer as treatment modalities and in 18% of in situ cancer only as chemopreventive measure.

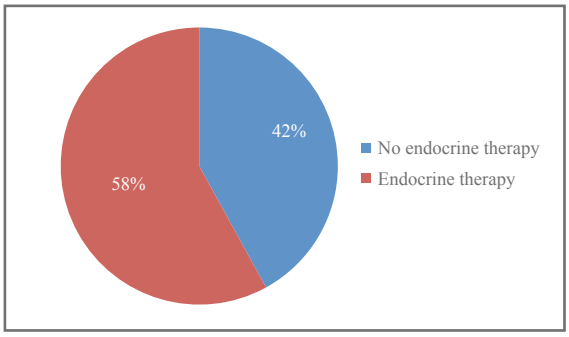

Figure 41. Percentage of the subjects on endocrine therapy

The most common drug used for endocrine therapy was Tamoxifen (77%), followed by aromatase inhibitor (17%), medical ovarian suppression (1%) and unreported (6%). Other forms of endocrine therapy including ovarian irradiation (0%) and oophorectomy (0%) was not reported (Figure 42).

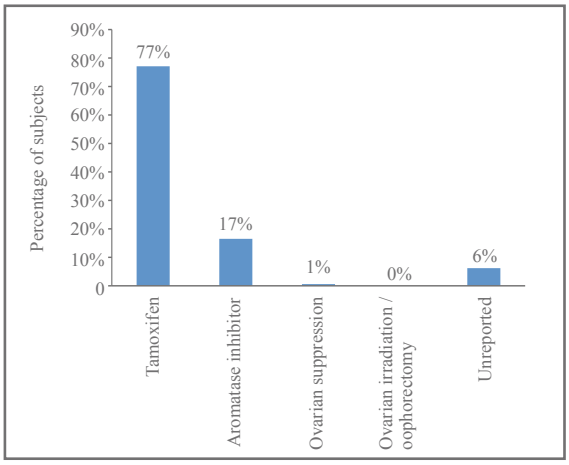

Figure 42. Forms of endocrine therapy
*Note: * = percentages add to more than 100% because more than one response could be checked*

Targeted therapy

Targeted cancer therapy was a form of treatments that targeted specific processes of cancer cell growth, division and lifecycle or, in some cases, the blood vessels nourishing a tumour.

About 11% of invasive cancer was treated with targeted therapy (Figure 43).

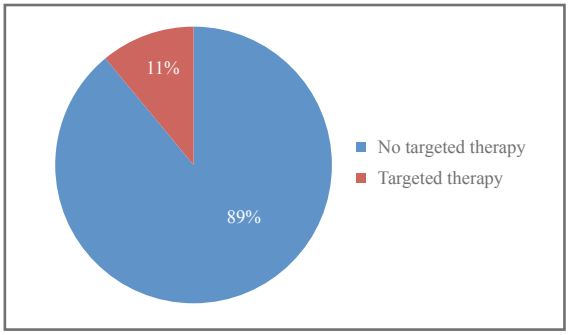

Figure 43. Percentage of invasive breast cancers treated with targeted therapy

Among those receiving targeted therapy, all (100%) used trastuzamab as their first line drug in targeted therapy (Figure 44).

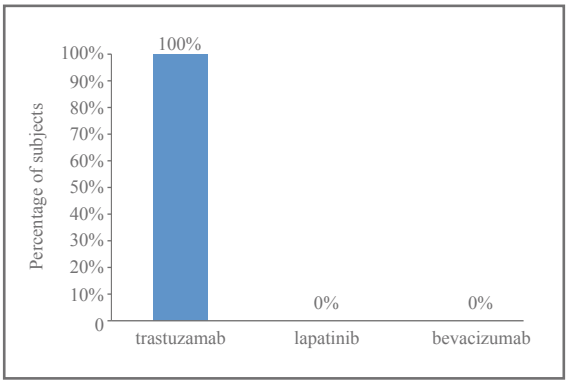

Figure 44. Types of targeted therapy drug used for patients with invasive cancer

內分泌治療

內分泌治療亦爲全身治療的其中一種，內分泌治療是一種針對女性荷爾蒙受體呈陽性的腫瘤的全身療法。圖41指，共有58%乳癌病人曾接受內分泌治療。入侵性乳癌病人當中，65%曾接受內分泌治療作治療乳癌之用，而原位癌乳癌病人當中，18%亦曾接受內分泌治療作預防之用。

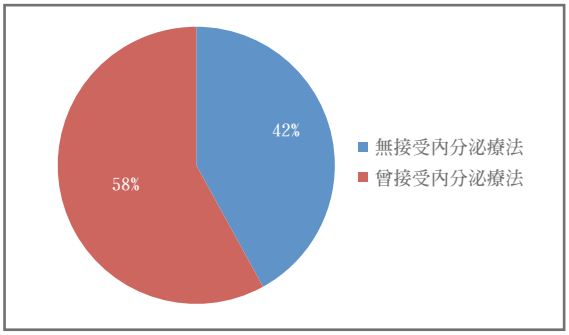

圖41. 乳癌病人接受內分泌療法的比率

最常使用的內分泌治療藥物爲三苯氧胺 (77%)，接著爲「芳香 抑制劑」(17%)、「卵巢抑制劑」(1%)，有6%沒有詳細資料，其他內分泌療法包括卵巢放射治療(0%)及卵巢切除術(0%) 則較少採用(圖 42) 。

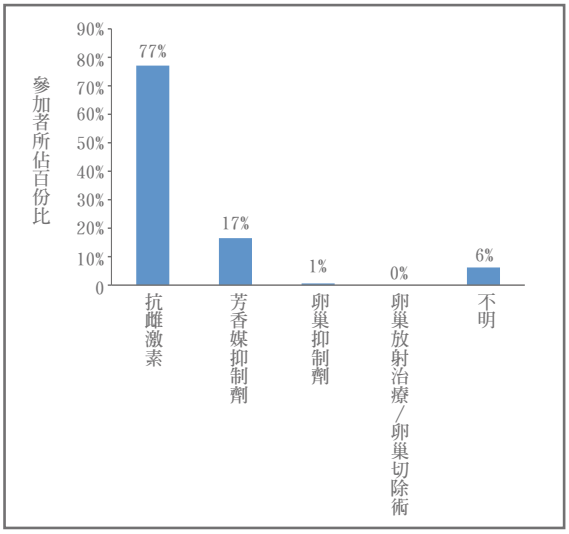

圖42. 病人接受的內分泌治療形式比率
備注： =因參加者可作多於一個選擇，故百份比高於100%*

針對性治療

針對性治療是用藥物針對癌細胞的生長特性、分裂及生命循環，或爲腫瘤供應養份的血管作出阻擊。

約11%入侵性乳癌病人採用針對性治療 (圖43)。

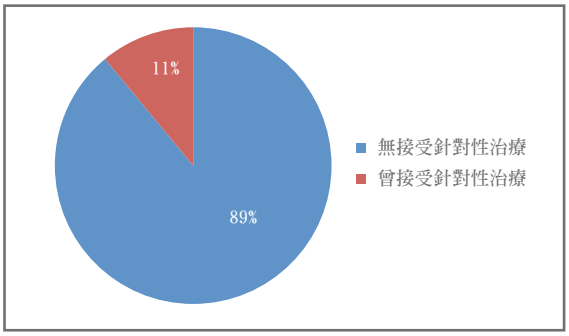

圖43. 入侵性乳癌病人接受針對性治療的比率

在接受針對性治療的個案中，所有人 (100%) 均以trastuzamab作爲針對性治療的第一線藥物 (圖44)。

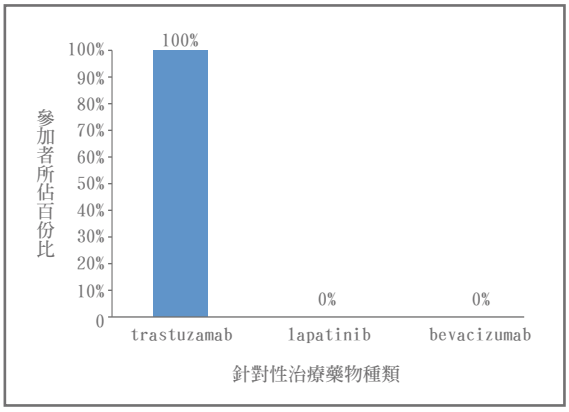

圖44. 入侵性乳癌病人使用的針對性治療藥物種類

Alternative medicine management

Apart from conventional western medical management for breast cancer, some patients may include complementary medicine, for example, herbal medicine or taking health pills in their fight against breast cancer.

Less than 10% of the subjects took alternative medicine (Figure 45). Among them, 89% took Chinese medicine whilst 16% took health pills as complementary medicine to uplift their health status (Figure 46).

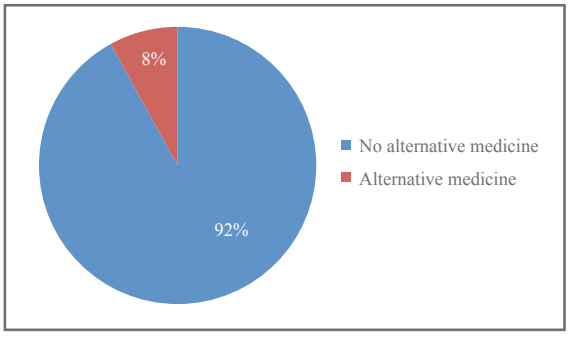

Figure 45. Percentage of the subjects on alternative medicine

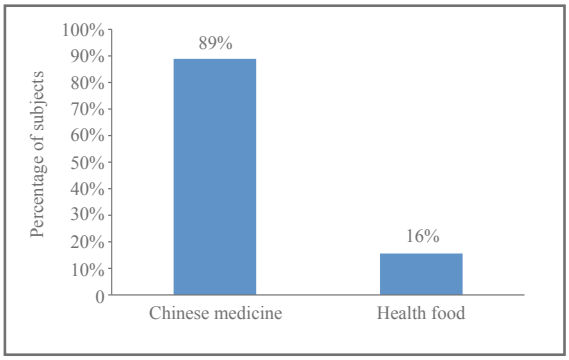

Figure 46. Types of alternative medicine
Note: = percentages add to more than 100% because more than one response could be checked*

另類療法

除了各種傳統西方的乳癌治療方法外，部份病人會在抗癌期間使用一些補充性的醫藥，例如中草藥及健康藥丸等。

少於10%病人曾使用另類療法（圖45）。當中，89%病人是使用中藥，16%服用健康藥丸等補充性藥物，以提升他們的健康狀況（圖46）。

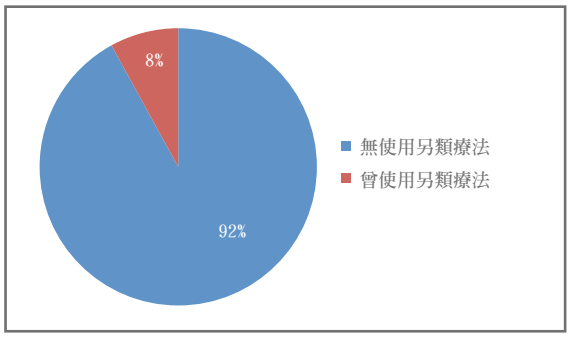

圖45. 使用另類療法的病人比率

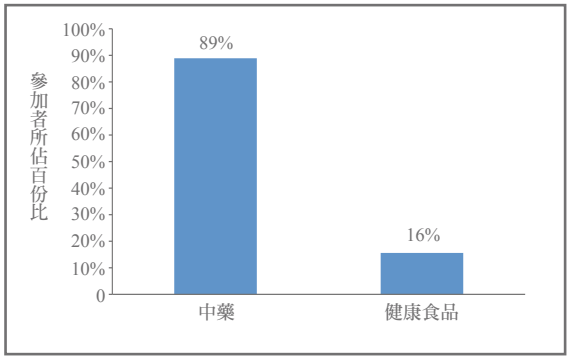

圖46. 病人使用的另類療法
備注： =因參加者可作多於一個選擇，故百份比高於100%*

Patient Status
病人狀況

Patient Status

A total of 625 breast cancer patients were followed up with a mean follow up of 12.6 months (range: 0.1-89.0). No mortality occurred among the patient cohort, however 8 cases (1.3%) were recorded to have recurrence (Table 12).

Table 12. Follow up of 625 subjects

	Relative percentage (%)
Total number of follow up cases	625
Mean follow-up period	12.6 months
Median follow-up period	12.0 months
Range (months)	0.1-89 months
Recurrence	8 (1.3%)
Local recurrence	5 (0.8%)
Distant metastasis	3 (0.5%)
Death from breast cancer	0 (0%)
Death from unrelated cause	0 (0%)

病人狀況

香港乳癌資料庫共追蹤了625名參加者的健康狀況，追蹤時間平均數爲12.6個月 (範圍：0.1-89個月)。獲跟進的參加者中，並無出現死亡個案，但有8宗個案 (1.3%) 有乳癌復發 (表12)。

表12. 625名參加者的跟進狀況

	所佔百份比%
跟進個案總數	625人
跟進時間平均數	12.6月
跟進時間中位數	12.0月
範圍 (月)	0.1- 89月
乳癌復發人數 (%)	8 (1.3%)
局部復發人數 (%)	5 (0.8%)
遠端復發人數 (%)	3 (0.5%)
死於乳癌的人數 (%)	0 (0%)
死於其他病因的人數 (%)	0 (0%)

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Appendices
附錄

SUBSCRIPTION FORM FOR
Breast Cancer Facts in Hong Kong 2008 Report (Report)
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我願意捐款支持「香港乳癌基金會」
I would like to make a donation to support Hong Kong Breast Cancer Foundation

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多謝 Thank You!

港幣$100或以上捐款可申請免稅
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If you would like to learn more about us, please visit our website www.hkbcf.org or contact us at 2525 6033.

Patient Participation

To Support and Participate in the Hong Kong Breast Cancer Registry

No information. No Control. At present, breast cancer treatment options are founded on researches, data and analyses from the West. Through the compilation of information on local breast cancer cases, the Breast Cancer Registry will be able to provide our medical practitioners, public policy makers and the general public and our Foundation with insights of basic breast cancer data and analyses, therefore enabling doctors to consider a range of risk factors, offering recommendations for prevention and early detection, as well as treatment and care solutions.

Moreover, the Registry helps focus further the public concern for breast cancer and can assist the HKSAR Government to draw up more comprehensive and appropriate healthcare policies for improved breast healthcare, which will lessen the burdens on patients and the society.

We need you to join hands with us in our fight against breast cancer. Here are four simple steps of how you can participate in this first-of-its-kind population-wide cancer-specific database in Hong Kong.

Step 1:

Please download the consent form from http://www.hkbcf.org/breastcancerregistry/ and read the form thoroughly. If there you have questions please do not hesitate to call us at the Foundation. It is important to us that you understand why we need your information and how it will be used.

Step 2:

Sign and return the Consent Form to us by mail or via your doctors-in-charge. Please do not return the completed form via facsimile. Your consent will give us permission to access and collect your medical and treatment records from your doctors, and to use them in future statistical analysis.

Step 3:

Fill in the Personal Profile questionnaire that we will send you on receipt of your consent. We urge you to complete this questionnaire as best as you can as data collected here is of vital importance to provide for the most accurate data for future research and analyses to be conducted.

Step 4:

Once a year, we will contact you and/or your physicians updating your status and collect latest medical information on your health status. Data collection will be either by phone or by mail, whichever is convenient to you at that time.

Important note:

Please be assured that the information we collect from you and your medical and treatment records we obtain from your doctors and clinic will be handled in the strictest confidence, and will solely be used for statistical analysis in aggregate only. At no time will your identity be revealed and/or made known to a third party or be put to use for any other purposes.

If you wish to know more, you are welcome to come to our office in person or contact us via phone (2525 6033), fax (2525 6233) or email (hkbcr@hkbcf.org).

病人參與

請支持和參與香港乳癌資料庫

沒有資料作參考，所有防癌工作都變得事倍功半。 現時，本地預防乳癌的策略，均建基於西方的研究、數據及分析。透過從本地乳癌個案中取得的資料，香港乳癌資料庫可就有關數據作全面的分析判斷，不但令醫護人員、制訂公共政策的官員、社會大眾以至本會對本地乳癌狀況有進一步掌握，也讓醫生在考慮乳癌風險因素、提出防癌建議，制訂及早檢查政策及治療選擇時，有更充足的資料作參考。

除此以外，資料庫將提升公眾對乳癌的關注，並有助香港政府規劃更全面及適當的乳癌保健政策，以減輕病人及社會的負擔。

爲減少乳癌帶來的威脅，我們需要閣下的支持。如您願意伸出援手，請依照下列四項簡單步驟，參加香港乳癌資料庫：

第1步：

請於http://www.hkbcf.org/breastcancerregistry/下載同意書，並細閱內容。如有任何疑問，請聯絡本會職員，以確保所有參加者均了解參加資料庫的目的，以及收集所得的資料將如何使用。

第2步：

請將簽妥的同意書以郵寄方式交回本會，或透過您的主診醫生轉交，但請勿以傳眞方式遞交。您的同意書將授權資料庫職員透過您的主診醫生，取得您的醫療紀錄，並用作日後的數據分析之用。

第3步：

當我們收到您交回的同意書後，會寄回一份個人資料問卷。請儘量填妥問卷內的項目，讓我們可取得更多關於乳癌的重要資料及數據，以讓日後的研究及分析更爲準確。

第4步：

每年，我們均會聯絡您或您的醫生，以更新及搜集最新的健康及治療資料。搜集資料可透過電話或郵件進行，以最方便您的方式爲主。

重要資訊：

請放心，我們將確保所有參與香港乳癌資料庫人士的資料，包括從參加者本人及其醫生處取得的健康狀況及醫療紀錄等，均經絕對保密處理，並只供用於資料庫的分析及研究用途。在任何情況下，有關資料均不會披露予第三者或被用作其他用途。

如欲查詢更多關於資料庫的詳情，歡迎親臨本會辦公室或以電話(2525 6033)、傳眞 (2525 6233)及電郵 (hkbcr@hkbcf.org)與本會職員聯絡。

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鳴謝

Acknowledgements 鳴謝

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此外，我們亦衷心鳴謝以下機構慷慨贊助本報告的製作費用：

AstraZeneca 阿斯利康 · gsk GlaxoSmithKline Oncology · NOVARTIS ONCOLOGY · Roche · sanofi aventis Because health matters

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通過研發優質的創新藥物
為病人帶來意義深遠的轉變

Making The Most Meaningful Difference
To Patient Health Through Great Medicines

HK-4010.0709.003

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Tykerb™
lapatinib ditosylate

Tykerb™ is the First & Only Approved therapy in heavily pre-treated ErbB2 +ve MBC patients[1*]

* Patients who have received prior therapy including an anthracycline, a taxane and trastuzumab

TYKERB™

INDICATIONS TYKERB is indicated in combination with capecitabine for the treatment of patients with advanced or metastatic breast cancer whose tumours overexpress HER2 and who have received prior therapy including an anthracycline, a taxane and trastuzumab. **DOSAGE AND ADMINISTRATION** Recommended dose: 1250mg (5 tablets) orally once daily on Days 1-21 continuously in combination with capecitabine 2000mg/m^2/day (orally in 2 doses approx. 12 hrs apart) on Days 1-14 in a repeating 21 day cycle. TYKERB should be taken at least 1 hr before or 1 hr after a meal and the dose should be once daily; dividing the daily dose is not recommended. Capecitabine should be taken with food or within 30 min. after food. If a day's dose is missed, the patient should not double the dose the next day. Treatment should be continued until disease progression or unacceptable toxicity occurs. Prior to the initiation of treatment and during treatment with TYKERB, left ventricular ejection fraction (LVEF) must be evaluated and monitored to ensure that LVEF is within the institutional limits of normal. Modify dose of TYKERB for cardiac and other toxicities, hepatic impairment, concomitant use of strong CYP3A4 inhibitors/inducers, and interstitial lung disease (ILD)/pneumonitis. **CONTRAINDICATIONS** None. **WARNINGS AND PRECAUTIONS** TYKERB has been reported to decrease LVEF. Caution if TYKERB is to be administered to patients with conditions that could impair left ventricular function. LVEF should be evaluated in all patients prior to and during treatment. TYKERB has been associated with reports of ILD & pneumonitis. Monitor patients for pulmonary symptoms indicative of ILD/pneumonitis. Hepatotoxicity has occurred with TYKERB use and rarely may be severe. Monitor liver function before initiation of treatment and monthly thereafter. Discontinue TYKERB if changes in liver function are severe and patients should not be retreated. Caution if prescribed to patients with moderate/severe hepatic impairment. Diarrhoea has been reported. Proactive management of diarrhoea with anti-diarrhoeal agents is important. Severe cases of diarrhoea may require administration of oral/IV electrolytes & fluids, and interruption/discontinuation of TYKERB. **INTERACTIONS** TYKERB is predominantly metabolised by CYP3A. Inhibitors/inducers of these enzymes may alter the pharmacokinetics of TYKERB. Coadministration of TYKERB with known inhibitors/inducers of CYP3A4 should proceed with caution and clinical response and adverse events should be carefully monitored. TYKERB inhibits CYP3A4 & CYP2C8 in vitro at clinically relevant concentrations. Exercise caution when dosing TYKERB concurrently with medications with narrow therapeutic windows that are substrates of CYP3A4/CYP2C8. TYKERB is a substrate for the transport proteins Pgp & BCRP. Inhibitors & inducers of these proteins may alter the exposure and/or distribution of TYKERB. It cannot be excluded that TYKERB will affect the pharmacokinetics of substrates of Pgp, BCRP & OATP1B1. Concomitant administration of TYKERB with capecitabine/trastuzumab did not meaningfully alter the pharmacokinetics of these agents (or the metabolites of capecitabine) or TYKERB. The bioavailability of TYKERB is affected by food. **PREGNANCY AND LACTATION** TYKERB can cause fetal harm when administered to a pregnant woman. Women should be advised not to become pregnant when taking TYKERB. It is not known whether TYKERB is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for adverse reactions in breast-feeding infants from TYKERB, a decision should be made whether to discontinue nursing or to discontinue the drug. **ADVERSE REACTIONS** Decreased LVEF. Diarrhoea. Anorexia. ILD/pneumonitis. Nausea. Vomiting. Hyperbilirubinaemia. Rash. Fatigue. Dyspepsia. Dry skin. Stomatitis, constipation, abdominal pain. Palmar-plantar erythrodysaesthesia. Mucosal inflammation. Pain in extremity, back pain. Headache. Insomnia. Hepatotoxicity. **OVERDOSE** There is no known antidote for overdoses of TYKERB. The maximum oral dose of TYKERB administered in clinical trials is 1800mg once daily. More frequent ingestion of TYKERB could result in serum concentrations exceeding those observed in clinical trials, therefore missed doses should not be replaced, and dosing should resume with the next scheduled daily dose. Haemodialysis would not be expected to be an effective method to enhance the elimination of TYKERB.

Abridged PI (GDS 03)

Reference: 1. Geyer CE, Forster J, Lindquist D, et al. Lapatinib plus capecitabine for Her2-Positive Advanced Breast Cancer. NEJM 2006;355:2733-43.

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N08TK264/16092008

Improving Survival in Cancer Patients with BONE METASTASIS

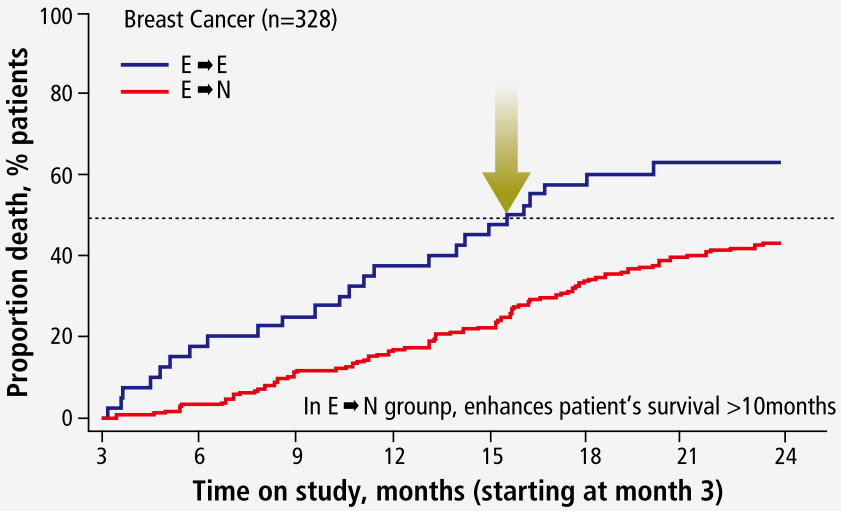
BREAST CANCER

ZOMETA® reduces risk of death and first SRE in breast cancer patients with bone metastasis when NTX levels normalized at 3 months[1]

REDUCE Death 55%[1]

REDUCE First SRE 50%[1]

Kaplan - Meier estimates of survival[1] (Breast Cancer)



- **Median survival time of patients in E ➡ N group was 790 days[1]**
- **In contrast, the median survival time of patients in E ➡ E group was 446 days[1]**

SRE = Skeletal related events
E ➡ E = N-Telopeptide of type 1 collagen (NTX) remains elevated after 3 months
E ➡ N = N-Telopeptide of type 1 collagen (NTX) normalized after 3 months

ZOMETA®
zoledronic acid

References: 1. A. Lipton, R.J. Cook, P. Major, et al. Zoledronic acid and survival in breast cancer patients with bone metastases and elevated markers of osteoclast activity. The Oncologist 2007;12:1035-1043

ZOMETA® 4 MG POWDER AND SOLVENT FOR SOLUTION FOR INFUSION. PRESENTATION: Zoledronic acid.Vials containing 4 mg of zoledronic acid supplied as a powder together with ampoules containing 5 mL of water for injections for reconstitution. **INDICATIONS:** Prevention of skeletal-related events (pathological fractures, spinal compression, radiation or surgery to bone, or tumour-induced hypercalcaemia) in patients with advanced malignancies involving bone.Treatment of hypercalcaemia of malignancy (HCM). **DOSAGE:** For "prevention of skeletal-related events in patients with advanced malignancies involving bone," the recommended dose is 4 mg (reconstituted and diluted with 100 mL 0.9% w/v sodium chloride or 5% w/v glucose solution) given as an intravenous infusion of no less than 15 minutes every 3 to 4 weeks. Dose reduction is recommended in patients with preexisting mild to moderate renal impairment. For "treatment of HCM," the recommended dose is 4 mg given as a single intravenous infusion for no less than 15 minutes. No dose adjustment in patients with mild to moderate renal impairment. Patients without hypercalcaemia should also be administered an oral calcium supplement of 500 mg and 400 IU vitamin D daily. **CONTRAINDICATIONS:** Pregnancy, breast-feeding women, patients with clinically significant hypersensitivity to zoledronic acid or other bisphosphonates, or any of the excipients in the formulation of ZOMETA. **PRECAUTIONS/WARNINGS:** Patients must be assessed prior to administration of ZOMETA to assure that they are adequately hydrated. Monitoring of standard hypercalcaemia-related metabolic parameters such as serum levels of calcium, phosphate and magnesium, and, particularly, serum creatinine. Severe and occasionally incapacitating bone, joint, and/or muscle pain has been reported infrequently in patients taking bisphosphonates. In view of the potential impact of bisphosphonates on renal function and the lack of extensive clinical safety data in patients with severe renal impairment with ZOMETA, its use in this population is not recommended. Dose reduction in patients with preexisting mild to moderate renal impairment. In patients requiring repeated administration of ZOMETA, serum creatinine should be evaluated prior to each dose. If renal function has deteriorated, the dose should be withheld. Limited clinical data in patients with severe hepatic insufficiency; no specific recommendations can be given for this patient population. Overhydration should be avoided in patients at risk of cardiac failure. No experience in children. Patient should inform the dentist while under dental treatment or if dental surgery is foreseen. **INTERACTIONS:** Zoledronic acid shows no appreciable binding to plasma proteins and does not inhibit human P450 enzymes *in vitro*, but no formal clinical interaction studies have been performed. Caution is advised when bisphosphonates are administered with aminoglycosides since both agents may have an additive effect, resulting in a lower serum calcium level for longer periods than required. Caution is asked when used with other potentially nephrotoxic drugs. Attention should also be paid to the possibility of hypomagnesaemia developing during treatment. In multiple myeloma patients, the risk of renal dysfunction may be increased when IV bisphosphonates are used in combination with thalidomide. **ADVERSE REACTIONS:** Usually mild and transient and similar to those reported for other bisphosphonates: most commonly reduction in renal calcium excretion is accompanied by a fall in serum phosphate levels (hypophosphataemia); commonly flu-like syndrome consisting of fever, fatigue, chills, and bone, joint, and/or muscle pain; headache; elevation of serum creatinine and blood urea; renal impairment; anaemia; conjunctivitis; gastrointestinal reactions such as nausea and vomiting, anorexia, serum calcium may fall to asymptomatic hypocalcaemic levels; uncommonly thrombocytopenia, leucopenia; hypersensitivity reactions; hypertension, hypotension, resulting very rarely in syncope or circulatory collapse; shortness of breath, cough; dizziness, paraesthesia, taste disturbance, hypoaesthesia, hyperaesthesia, tremor, anxiety, sleeping disturbances; blurred vision; diarrhoea, constipation, abdominal pain, dyspepsia, stomatitis, dry mouth; local reactions at the infusion site such as redness or swelling; asthenia, peripheral oedema, weight increase, chest pain; rash and pruritus, increased sweating; muscle cramps, osteonecrosis (primarily of the jaw); acute renal failure, haematuria proteinuria, hypomagnesaemia, hypokalaemia; rarely pancytopenia, confusion, bradycardia, angioneurotic oedema, hyperkalaemia, hypernatraemia; very rarely uveitis and episcleritis. **PACKS AND PRICES:** Countryspecific. **NOTE:** Before prescribing, please read full Prescribing Information.

NOVARTIS ONCOLOGY

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HKC-ZOM-A305-1008

抗癌戰士
用意志燃點希望

抗癌戰熱線：2733 4676

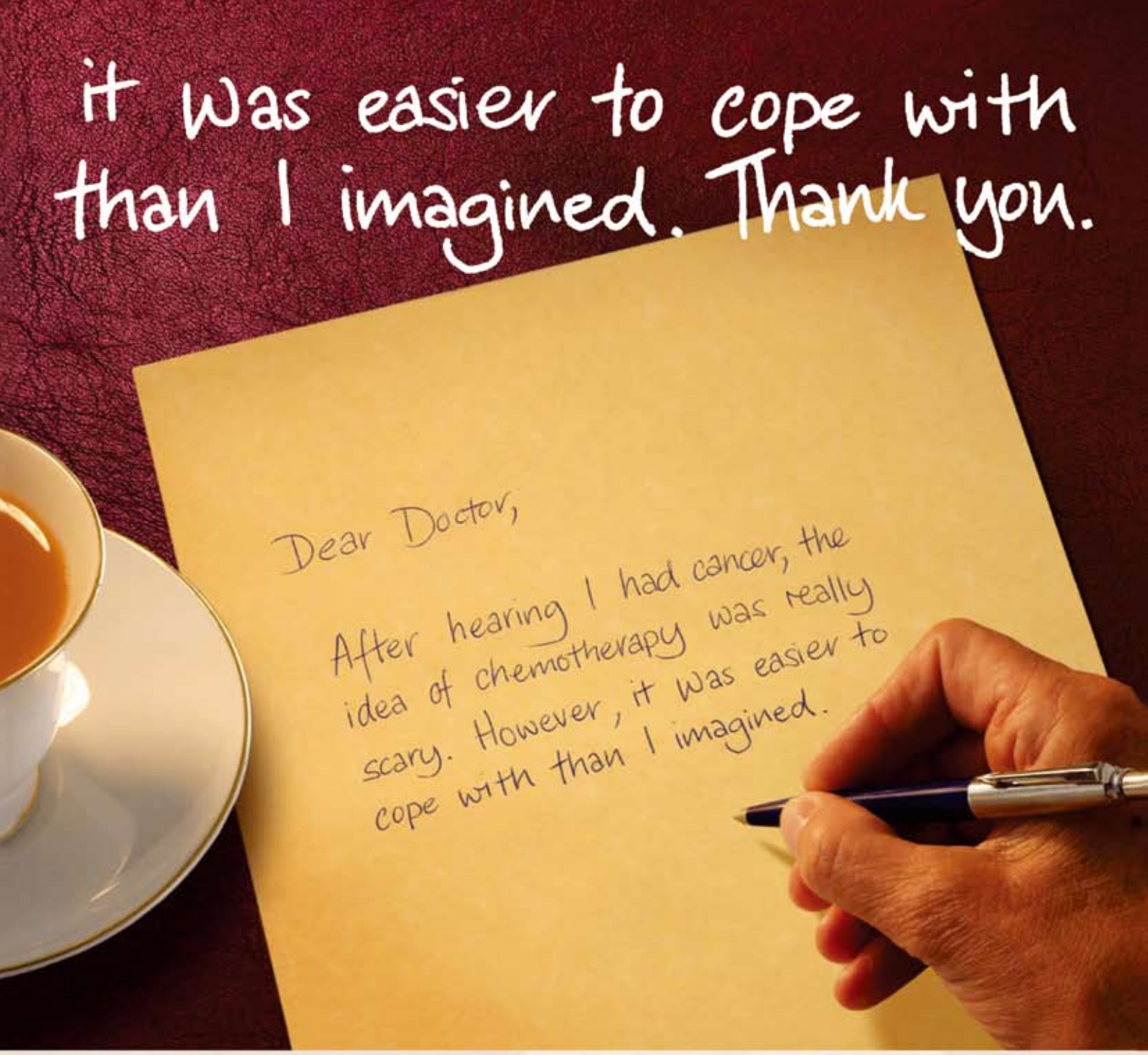
抗癌戰士為您燃點希望

由羅氏大藥廠成立的《**抗癌戰士**》病人教育小組，致力推動及參與各項抗癌活動，尤其關注教育及治療資訊。一直以來，《**抗癌戰士**》都希望透過不同渠道，為普羅大眾提供最新的抗癌資訊。

而 2eCancer 網頁是一個全天候及多元化的抗癌資訊網站，例如認識癌症版面從癌症分類、如何預防和面對癌症到患者的飲食需知等都有詳盡解釋。此外，您還可以重溫專科醫生講解癌症及其治療的電視短片，內容深入淺出，絕對是入門者的好幫手。

請立即登入網址：

www.2eCancer.com，
瀏覽真正切合您需要的醫療專科網站！



TAXOTERE®
(docetaxel)

Time Life Confidence

sanofi aventis
Because health matters

About Hong Kong Breast Cancer Foundation

Hong Kong Breast Cancer Foundation is a charitable organization inaugurated in March 2005. As a non-government funded organization, we are the first charity dedicated to breast cancer in Hong Kong. With the combined efforts of breast cancer survivors, their supporters and health care professionals, we serve the community by our dedication to breast cancer education, support and advocacy. We are a focused group with first-hand experience and knowledge from patients and doctors, who know their treatment path and ordeal best.

Education

- Provide essential information on breast cancer and breast health through our regular educational talks, website and a comprehensive collection of free publications
- Raise public awareness of breast health and emphasize the importance of early detection for breast cancer through outreach public seminars delivered to schools, community organizations and corporations; as well as exhibitions and media
- Promote the importance of organized breast screening to the public and offer free mammogram service to underprivileged women in the community

Support

- Operate a Resource Centre with facilities dedicated for provision of breast cancer information and resource support to patients
- Provide financial support to patients who are financially challenged by their medication costs
- Provide counseling services to breast cancer patients and their family members and psychosocial support throughout their treatment path
- Conduct interest classes and activities for patients to gain rapport, share experiences, build friendship and enrich their quality of life
- Maintain and enrich a resource library with essential and up-to-date information and knowledge on breast cancer and breast health

Advocacy

- Improve the welfare of breast cancer patients in Hong Kong
- Lobby for better policy in breast healthcare via breast cancer researches and the establishment of the first-of-its-kind Breast Cancer Registry in Hong Kong.

香港乳癌基金會簡介

香港乳癌基金會成立於2005年3月，爲一個非政府的註冊慈善機構。我們亦是首個專注本地乳癌概況的機構。有賴衆多乳癌康復者及專業醫護人員的支持，我們致力向公衆提供乳癌教育、支援及倡議服務。

憑著病人及醫生提供關於乳癌的第一手資料及治療經驗，我們掌握乳癌的最新資訊，爲乳癌病人提供最緊密的支援。

教育

- 透過每月定期教育講座、網站及一系列免費印刷品，介紹乳房健康及乳癌資訊
- 與全港各區的學校、社會團體及商業機構舉辦講座，並透過媒體，提醒大衆關注乳房健康，以及乳癌「及早發現、治療關鍵」的重要性
- 教育公衆有關定期乳房檢查的重要性，並爲低收入婦女提供免費乳房X光造影檢查服務

支援

- 爲乳癌病人提供全面的乳癌資訊與情緒支援服務
- 爲病人提供實質的乳癌藥物經濟資助
- 爲乳癌病人及家屬提供諮詢輔導服務，並爲治療前後或正接受治療的病人，提供心理社交支援
- 舉辦興趣班及各項會員活動，讓病人參與其中，與同路人分享樂趣及建立友誼，活出豐盛人生
- 設立圖書館，提供乳癌及乳房健康的相關書籍及最新資訊

倡議

- 爭取提升香港乳癌病人的福利
- 通過各項乳癌研究及成立香港乳癌資料庫，倡議有效的乳房保健政策

香港乳癌基金會
HK Breast Cancer Foundation

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