Introduction

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Despite significant advances in treatment, breast cancer is second only to lung cancer in causing cancer deaths in women. An estimated 40,000 patients in the United States will die from breast cancer in 2002.[1] Metastatic or locally advanced disease is essentially incurable; the goals of treatment in this setting, therefore, are to delay disease progression, prolong survival, and improve or maintain patient quality of life (QOL).[2,3]

Several treatment modalities, including surgical, radiation, and systemic therapies, play a role in the treatment of metastatic breast cancer (MBC). In advanced disease with multiple sites of recurrence and/or visceral involvement, systemic therapy is the first-line treatment option.[3,4] Systemic treatments include either hormonal therapies or cytotoxic chemotherapy. Patients whose tumors are positive for estrogen receptor (ER) and/or progesterone receptors are likely to achieve a response with hormonal therapy.[5] Therefore, due to its improved tolerability compared with that of cytotoxic chemotherapy, hormonal therapy is the preferred first-line treatment option in receptor-positive, non–life-threatening MBC.[2,4] Furthermore, patients who have had a response to one type of hormonal therapy and whose disease has become refractory may have a response to another type of hormonal therapy. In fact, some patients may benefit from sequential second-, third-, or fourth-line hormonal therapies and have good QOL, with minimal symptoms and side effects, for several years.[2]

The need for effective hormonal agents with improved tolerability for use in sequential therapy has resulted in the introduction of several hormonal agents in the past decade, including the aromatase inhibitors anastrozole, exemestane, and letrozole. A more recent addition is fulvestrant, an ER antagonist that has no agonist activity. With a larger armamentarium of hormonal agents now available, it has become increasingly important to determine the optimal sequencing of hormonal therapies to provide patients with the maximal benefit in terms of tumor response and QOL.

The first article in this supplement reviews the evolution of evidence that has defined the current role of the newer hormonal therapies in breast cancer treatment. As additional trial results become available, the role of these hormonal therapies will continue to change. In the second article, the impact of hormonal therapy on patient QOL is discussed. The final article reviews the use of the currently available hormonal agents in sequential therapy and the evidence supporting their use as initial or subsequent therapy of

Accepted for publication April 2, 2002.

0149-2918/02/$19.00

MBC. We sincerely hope that you find the information contained in these papers useful in managing patients with breast cancer in your clinical practice.

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