spotlight on health

Study Finds Breast Cancer Relapse Risk Significantly Reduced With Targeted Therapy

(NAPSA)—For many, the battle with breast cancer does not end with initial treatment. The public announcement by Elizabeth Edwards that her breast cancer has returned and is now in her bones has raised awareness among breast cancer patients. The spread of breast cancer to other parts of the body can increase the likelihood that a woman may die from the disease.

With more than 2 million Americans living with breast cancer, newly published data in the *Annals of Oncology* offer some hope in the battle against early breast cancer recurrence.

According to the published data, women with hormone-sensitive breast cancer are more likely to benefit from an anti-estrogen treatment, such as Femara (letrozole tablets), in the first two years of treatment than with the standard therapy, tamoxifen. In the study, patients treated with Femara, an aromatase inhibitor, were 30 percent less likely to develop distant metastases in that time.

"While this data doesn't suggest an overall survival advantage, this study helps confirm that postmenopausal women with hormone-sensitive breast cancer may be able to greatly reduce their risk of a breast cancer recurrence through treatment with an aromatase inhibitor," said Gary Frenette, M.D., PhD, Medical Oncologist, Carolinas Medical Center.

Knowing one's own personal risk of recurrence and specific health factors can help further ward off potentially dangerous metastases in the future. Women with breast cancer should discuss appropriate treatment options to help reduce the risk of recurrence with their health care professional.

The most commonly reported adverse events for Femara include hot flashes and joint and muscle pain. Women should be postmenopausal and not be pregnant to be considered for Femara.

For more information about these medications, please talk to your doctor and visit www.Femara.com or www.NovartisOncology.com.

Note To Editors: Femara is a once-daily oral prescription medication approved for the adjuvant (following surgery) treatment of postmenopausal women with hormone receptor-positive early breast cancer. The benefits of Femara in clinical trials are based on 24 months of treatment. Further follow-up will be needed to determine long-term results, including safety and efficacy.

Femara is also approved for the extended adjuvant treatment of early-stage breast cancer in postmenopausal women who are within three months of completion of five years of adjuvant tamoxifen therapy. The benefits of Femara in the extended adjuvant setting are based on 24 months of treatment. Further follow-up will be needed to determine long-term results, including side effects. Femara is also approved for the first-line treatment of postmenopausal women with hormone receptor-positive or hormone receptor-unknown locally advanced or metastatic breast cancer. Femara is also indicated for the treatment of advanced breast cancer in postmenopausal women with disease progression following anti-estrogen therapy.

Important safety information: Patients must be postmenopausal to take Femara. Patients should talk to their doctor if they are allergic to Femara or any of its ingredients. If patients have the potential to become pregnant, the doctor should discuss the necessity of adequate contraception with them. Some women reported fatigue and dizziness with Femara. Until patients know if Femara affects them, they should use caution before driving or operating machinery. Some patients taking Femara had an increase in cholesterol. Additional follow-up is needed to determine the risk of bone fracture associated with long-term use of Femara.

In the adjuvant setting, commonly reported side effects are generally mild to moderate. Side effects that are comparable between Femara and tamoxifen include night sweats, weight gain, nausea and tiredness. Side effects seen more often with tamoxifen vs. Femara were hot flashes and vaginal bleeding. Joint pain was experienced more often with Femara vs. tamoxifen. The incidence of stroke was 1.1% for women on Femara and 1.0% for women on tamoxifen, and the incidence of other cardiovascular events was 6.6% for Femara vs. 6.2% for tamoxifen. The percentage of women reporting osteoporosis was 2% for Femara vs. 1.1% for tamoxifen.

In the extended adjuvant setting, commonly reported side effects are generally mild to moderate. Those seen more often with Femara vs. placebo were hot flashes (50% vs. 43%), joint pain (22% vs. 18%) and muscle pain (7% vs. 5%). Other side effects, which were comparable to placebo, include fatigue (34% vs. 32%), swelling due to fluid retention (18% vs. 16%), headache (20% vs. 20%), increase in sweating (24% vs. 22%) and increase in cholesterol (16% vs. 16%). The percentage of patients on Femara vs. placebo reporting a fracture was 5.9% vs. 5.5%. The percentage of patients reporting osteoporosis was 6.9% vs. 5.5%. Bisphosphonates, drugs to increase bone strength, were given to 21.1% of Femara patients and 18.7% of placebo patients.

In the metastatic setting, commonly reported side effects are generally mild to moderate and may include bone pain, hot flashes, back pain, nausea, joint pain, shortness of breath, fatigue, coughing, constipation, limb pain, chest pain and headache.