**Name of Journal:** *World Journal of Clinical Oncology*

**Manuscript NO:** 53841

**Manuscript Type:** ORIGINAL ARTICLE

***Retrospective Cohort Study***

**Human epidermal growth factor receptor 2 positive rates in invasive lobular breast carcinoma: The Singapore experience**

Kee GJ *et al*. *HER2* positive rates in invasive ILC

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**Received:** December 31, 2019

**Revised:** April 16, 2020

**Accepted:** May 16, 2020

**Published online:** May 24, 2020

**Abstract**

BACKGROUND

Invasive lobular carcinomas (ILC) form 5%-10% of breast cancer and rarely show overexpression of human epidermal growth factor receptor 2 (*HER2*).

AIM

To describe the prevalence and prognostic factors of *HER2* positive (*HER2+*) ILC in an Asian population.

METHODS

A retrospective review of patients with ILC seen between January 1985 and March 2018 at various SingHealth medical institutions was conducted. Demographic and clinical data were collected from medical records. We examined clinicopathological characteristics and survival in relation to *HER2* status.

RESULTS

A total of 864 patients were included. Prevalence of *HER2* positivity was 10.1% (87 patients). Compared with *HER2* negative (*HER2-*) ILC, *HER2+* ILC was associated with a higher proportion of estrogen receptor negative (24.4% *vs* 5.9%, *P* < 0.001), progesterone receptor negative (*PR-*) (40.2% *vs* 24%, *P* = 0.002) and grade 3 tumours (Grade 3, 29.0% *vs* 10.2%, *P* < 0.001). Overall survival rate was poorer in patients with *HER2+* compared to *HER2-* ILC (56.7% *vs* 72.9% alive at 10 years; hazard ratio 1.87, 95% confidence interval: 1.21-2.90, *P* = 0.004). Based on multivariate analysis, negative prognostic factors for overall survival included *HER2* positivity, *PR* negativity, older age, Indian ethnicity and higher tumour stage.

CONCLUSION

Prevalence of *HER2+* ILC was 10.1%*.**HER2+* ILC was more likely to have poorer prognostic features such as estrogen receptor negative, *PR-* and higher tumour grade, and have a poorer survival.

**Key words:** Lobular breast cancer; Invasive breast cancer; Human epidermal growth factor receptor 2 positive; Singapore; Clinicopathological characteristics; Prognostic value

**Citation:** Kee GJ, Tan RYC, Rehena S, Lee JJX, Zaw MWW, Lian WX, Yeong J, Tan SM, Lim SH, Tan BKT, Yap YS, Dent RA, Wong FY, Lee GE. Human epidermal growth factor receptor 2 positive rates in invasive lobular breast carcinoma: The Singapore experience. *World J Clin Oncol* 2020; 11(5): 283-293

**URL:** https://www.wjgnet.com/2218-4333/full/v11/i5/283.htm

**DOI:** https://dx.doi.org/10.5306/wjco.v11.i5.283

**Core tip**: We conducted a retrospective review of 864 patients with invasive lobular breast carcinoma (ILC) and examined the clinicopathological characteristics and survival in relation to human epidermal growth factor receptor 2 (*HER2*) status. Interestingly, our cohort reports a higher prevalence of *HER2* positive ILC (10.1%) as compared to some previous studies. *HER2* positiveILC was more likely to have poorer prognostic features such as estrogen receptor negative, progesterone receptor negative and higher tumour grade, and these patients have a poorer survival compared to those with *HER2* negative ILC.

**INTRODUCTION**

Invasive lobular carcinomas (ILC) represent about 5%-10% of breast cancer[1-3].Prevalence of overexpression of human epidermal growth factor receptor 2 (*HER2*) in breast cancer has been reported at 4.8%-5.1%[4,5]. The clinicopathological characteristics of *HER2* positive (*HER2+*) invasive ductal carcinomas (IDC) are known to differ from that of *HER2* negative (*HER2-*) IDC. *HER2+* IDC is associated with estrogen receptor negativity (*ER-*), progesterone receptor negativity (*PR-*) and higher histologic grade[4,6]. A number of reports suggest that these associations are also present inILC and that *HER2* positivity may be a prognostic factor[7-13]. However, there remains a paucity of research examining the characteristics of *HER2+* as opposed to *HER2-* ILC, particularly in Asian populations. This study aims to investigate the prevalence and prognostic clinicopathological factors of *HER2+* ILC.

**MATERIALS AND METHODS**

***Study design***

A retrospective review of patients with ILC seen between January 1985 and July 2018 at National Cancer Centre Singapore, Singapore General Hospital, Changi General Hospital and KK Women’s and Children’s Hospital was conducted. We obtained the clinical and pathological data of ILC patients from the Joint Breast Cancer Registry, our prospective database. Clinical variables included patient demographic factors such as age at diagnosis, gender, ethnicity, disease factors such as tumour side, size, grade, stage, nodal status, *ER*, *PR* and *HER2* status, as well as treatment given such as chemotherapy, radiotherapy, surgery and anti-*HER2* therapy. The study was reviewed and approved by the SingHealth Institutional Review Board CIRB Ref: 2019/2419.

***Inclusion and exclusion criteria***

From 1985 to 2018, 1095 patients were diagnosed with ILC. Of these, 242 patients with unknown *HER2* status were excluded from the study. Twelve patients with pathological stage 0 breast cancer were also excluded from the study. The remaining 864 patients were analysed (Figure 1).

***Pathology assessment***

Histopathological diagnoses of ILC were made by pathologists at various SingHealth medical institutions, namely Singapore General Hospital, Singapore; Changi General Hospital and KK Women’s and Children’s Hospital. Pathologic variables collected included *ER*, *PR* and *HER2* status. ASCO-CAP guidelines were used to define positivity cut-offs for the tumours as follows: A positive *ER/PR* result was defined as the presence of at least 1% of tumour cell nuclei displaying unequivocal staining of any intensity, and for *HER2*, tumour positivity was defined as > 10% of tumour cells exhibiting 3+ membrane staining. Ambiguous *HER2* cases were tested and confirmed by fluorescence *in situ* hybridization testing based on the ASCO-CAP guidelines[6-9]. In the Joint Breast Cancer Registry database, tumours were also classified into a molecular subtype as follows: Basal (*ER-*, *PR-* and *HER2-*); *HER2+* (*ER-*, *PR-* and *HER2*+); Luminal A (*ER-* or *PR-* and *HER2*-); Luminal B (*ER+* or *PR+* and *HER2+*).

***Statistical analysis***

All demographic and clinicopathological characteristics were summarized in terms of *HER2* status, as *HER2+* and *HER2-* ILC. Categorical and continuous variables were summarized as frequency with percentage and median [interquartile range (IQR)] respectively. Differences between *HER2+* and *HER2-* ILC were tested using chi-squared test for categorical variables and Mann-Whitney *U* test for continuous variables.

The primary outcome overall survival (OS) was treated as time-to-event data and survival time was defined as time from date of diagnosis to date of death or date last seen. Secondary outcomes included disease-free survival (DFS) and breast cancer-specific overall survival (BCSS). DFS was treated as time-to-event data and duration of DFS was defined as duration from date of last treatment to date of relapse or date last seen or date of mortality. BCSS was treated as time-to-event data and duration of BCSS was defined as duration from date of last treatment to date last seen or date of mortality if cause of death was attributed to breast cancer. OS, DFS and BCSS were analysed for *HER2+* and *HER2-* status using Kaplan-Meier survival analysis and were tested using log-rank test.

Univariate and multivariate Cox proportional hazard (CPH) regression analysis were used to find associations between OS and other prognostic factors in these patients with ILC. The following clinicopathological characteristics were investigated in the model: age, ethnicity, *ER* status, *PR* status, *HER2* status, tumour size, stage, grade and treatment modalities such as chemotherapy, radiotherapy and surgery. Variables with *P* < 0.03 in the univariate CPH model were selected for multivariable model. Final multivariate CPH model was selected using stepwise, forward and backward variable selection method. Quantitative association from CPH regression model was expressed in terms hazard ratio with corresponding 95% confidence interval. Three separate CPH models were used for OS, DFS and BCSS. All statistical tests were two-sided and *P* < 0.05 was considered statistically significant. Analyses were performed using SAS Institute Inc 2013. SAS/ACCESS® 9.4 Interface to ADABAS (SAS Institute Inc., Cary, NC, United States).

**RESULTS**

***Clinical characteristics***

A total of 864 patients with ILC were included in the analysis. Study population characteristics are shown in Table 1. Of note, a total of 87 (10.1%) were diagnosed with *HER2+* ILC. Compared with *HER2-* ILC, *HER2+* ILC was associated with a higher proportion of *ER-* (24.4% *vs* 5.9%, *P* < 0.001), *PR*- negative (40.2% *vs* 24%, *P* = 0.002) and grade 3 tumours (Grade 3, 29.0% *vs* 10.2%, *P* < 0.001) (Table 1).

***Treatment characteristics***

Among the 87 patients with *HER*2+ ILC, 47 (54.0%) received *HER*2-directed therapy, 12 (13.8%) did not receive *HER*2-directed therapy and treatment data was not available for the remaining 28 (32.2%) patients. Of the patients who did not receive *HER*2-directed therapy, reasons cited upon review of clinical charts included cardiac comorbidities, poor performance status, very early stage cancer, refusal of therapy or lack of access to therapy in the years prior to the availability of *HER2*-directed therapy.

***Survival outcomes***

The median survival time was 2.95 (IQR: 1.89-8.87) years and 4.16 (IQR: 1.84-8.32) years respectively for *HER2+* and *HER2–* ILC patients (*P* = 0.315). The 5-year and 10-year OS rates were 68.3% (59/87 patients) and 56.7% (49/87 patients) respectively in *HER2+* patients and 83.4% (648/777 patients) and 72.9% (566/777 patients) respectively in *HER2-* patients (log-rank *P* = 0.004). The 5-year and 10-year BCSS and DFS rates in *HER2+* and *HER2-* ILC patients are also shown in Figure 2.

We performed a univariate and multivariate CPH regression analysis of OS in all 864 ILC patients. Based on the multivariate analysis, significant negative prognostic factors were *HER2+*, age, ethnicity and stage. *HER2+* and luminal B molecular subtypes also had also notably poorer OS compared to Luminal A subtype (Table 2, Figure 3). Additional univariate and multivariate CPH regression analyses of BCSS and DFS demonstrated that *HER2* positivity remained a significant negative prognostic factor for BCSS and DFS on both the univariate and multivariate analysis (Tables 3 and 4).

**DISCUSSION**

Interestingly, although most ILC patients have *HER2-* tumours, our cohort reports a higher prevalence of *HER2+* ILC (10.1%) as compared to some previous studies[1-5]. The largest known study to date of 85,048 ILC patients in the United States SEERS database found a *HER2+* prevalence of only 4.8%[5]. Given that our study is one of the first few to describe prevalence of *HER2+* ILC in Asian populations, this may suggest differences across ethnic and geographical populations, although further studies are required to validate this finding.

In our cohort, *HER2+* ILC was significantly associated with *ER* negativity, *PR* negativity and higher tumour grade. This affirms findings in a previous study which concluded that *HER2* positivity had an inverse relationship with *ER* and *PR* expression in ILC[10]. In the same study, *PR* negativity was notably more common than *ER* negativity in *HER2+* ILC. This was also seen in our study with the frequency of *PR-* being nearly twice that of *ER-* in the *HER2+* population. Our study reports a higher tumour grade in *HER2+* ILC patients. This is not consistent with findings from previous studies which did not find significant associations with *HER2* positivity and tumour grade or size[11-14]. We hypothesize that this may be due the smaller sample sizes in those studies and the heterogeneity of *HER2+* ILC[15,16].

Our study also demonstrates poorer survival rates in *HER2+* ILC as compared to *HER2-* ILC for OS, BCSS and DFS. On exploratory analyses of molecular subtypes, both *HER2+* and luminal B molecular subtypes reflected this poorer OS, corroborating with a separate study which showed similar survival outcomes for the different molecular subtypes of ILC[17]. One possible biological explanation for poorer survival rates in *HER2+* ILC is a synergistic effect of *HER2* and cadherin 1 mutations which promotes tumourigenesis and early relapses in *HER2+* ILC[18]. The finding of Indian ethnicity being a poorer prognostic factor for ILC on multivariate analysis also deserves further validation in a larger sample size as they formed < 5% of patients in this cohort, making it challenging to draw definitive conclusions.

Due to the retrospective nature of this study, missing data limited our ability to perform analyses on treatments received with regards to survival outcomes. Prospective studies with larger long-term follow-up sample sizes are needed to validate our observations in this study.

In conclusion, our study demonstrates the prevalence of *HER2+* ILC to be 10.1%*.**HER2+* ILC patients were more likely to have poorer prognostic features such as *ER-*, *PR-* and higher tumour grade. Lastly, patients with *HER2+* ILC had poorer OS, BCSS and DFS compared to those with *HER2-* ILC. These findings warrant further prospective studies to validate observation and investigate the benefit of various treatment modalities to improve outcomes in *HER2+* ILC.

**ARTICLE HIGHLIGHTS**

***Research background***

Invasive lobular carcinomas (ILC) represent about 5%-10% of breast cancer.Prevalence of overexpression of human epidermal growth factor receptor 2 (*HER2*) in breast cancer has been reported at 4.8%-5.1%. The clinicopathological characteristics of *HER2* positive (*HER2+*) invasive ductal carcinomas are known to differ from that of *HER2* negative (*HER2-*) invasive ductal carcinomas. However, there remains a paucity of research examining the characteristics of *HER2+* as opposed to *HER2-* ILC, particularly in Asian populations.

***Research motivation***

This study compares the clinicopathological characteristics of *HER2+* and *HER2-* ILC to assess the differences in survival probability between the two groups.

***Research objectives***

This study aims to investigate the prevalence and prognostic clinicopathological factors of *HER2+* ILC in an Asian population.

***Research methods***

A retrospective review of patients with ILC seen between January 1985 and March 2018 at various SingHealth medical institutions was conducted. Demographic and clinical data were collected from medical records. We examined clinicopathological characteristics and survival in relation to *HER2* status. Differences between *HER2+* and *HER2-* ILC were tested using chi-squared test for categorical variables and Mann-Whitney *U* test for continuous variables. Overall survival (OS), disease-free survival (DFS) and breast cancer-specific overall survival (BCSS) were analyzed for *HER2+* and *HER2-* status using Kaplan-Meier survival analysis and were tested using log-rank test. All statistical tests were two-sided and *P* < 0.05 was considered statistically significant.

***Research results***

Interestingly, although most ILC patients have *HER2-* tumours, our cohort reports a higher prevalence of *HER2+* ILC (10.1%) as compared to some previous studies. The median survival time was 2.95 (interquartile range: 1.89-8.87) years and 4.16 (interquartile range: 1.84-8.32) years respectively for *HER2+* and *HER2-* ILC patients (*P* = 0.315). Based on the multivariate analysis, significant negative prognostic factors were *HER2+*, age, ethnicity and Stage. *HER2+* and Luminal B molecular subtypes also had also notably poorer OS compared to Luminal A subtype. Additional univariate and multivariate Cox proportional hazard regression analyses of BCSS and DFS demonstrated that *HER2* positivity remained a significant negative prognostic factor for BCSS and DFS on both the univariate and multivariate analysis.

***Research conclusions***

In conclusion, our study demonstrates the prevalence of *HER2+* ILC to be 10.1%*.**HER2+* ILC patients were more likely to have poorer prognostic features such as estrogen receptor negativity, progesterone receptor negativity and higher tumour grade. Lastly, patients with *HER2+* ILC had poorer OS, BCSS and DFS compared to those with *HER2-* ILC.

***Research perspectives***

The findings from our study warrant further prospective studies to validate observation and investigate the benefit of various treatment modalities to improve outcomes in *HER2+* ILC.

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**Footnotes**

**Institutional review board statement:** The study was reviewed and approved for publication by our Institutional Reviewer (IRB 2019/2419).

**Informed consent statement:** Informed consent was not required by the International Review Board (IRB 2019/2419) as our study did not require collection of personal/identifiable data from subjects or investigators.

**Conflict-of-interest statement:** All the Authors have no conflict of interest related to the manuscript.

**Data sharing statement:** The original anonymous dataset is available on request from the corresponding author at ryan.shea.tan.y.c@singhealth.com.sg.

**STROBE statement:** The authors have read the STROBE Statement—checklist of items, and the manuscript was prepared and revised according to the STROBE Statement—checklist of items.

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**Manuscript source:** Invited manuscript

**Peer-review started:** December 31, 2019

**First decision:** March 15, 2020

**Article in press:** May 16, 2020

**Specialty type:** Oncology

**Country/Territory of origin:** Singapore

**Peer-review report’s scientific quality classification**

Grade A (Excellent): 0

Grade B (Very good): B

Grade C (Good): C

Grade D (Fair): D, D

Grade E (Poor): 0

**P-Reviewer:** Ding MX, Ieni A, Lim SC, Wada R **S-Editor:** Yan JP **L-Editor:** A **E-Editor:** Liu JH

**Figure Legends**

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**Figure 1** **Consort flow diagram showing inclusion and exclusion of patients in study population**. Human epidermal growth factor receptor 2 positive(*HER2+*)invasive lobular carcinomas was defined as an immunohistochemistry score of 3+ or an immunohistochemistry score of 2+ with a *HER2* to chromosome 17 ratio ≥ 2.0 for samples after 1 January 2014 and *HER2* to chromosome 17 ratio ≥ 2.2 for samples before 1 January 2014 on fluorescence *in situ* hybridization testing[4]. ILC: Invasive lobular carcinomas; *HER2*: Human epidermal growth factor receptor 2; IHC: Immunohistochemistry; FISH: Fluorescence *in situ* hybridization; *HER2+*: Human epidermal growth factor receptor 2 positive; *HER2-*: Human epidermal growth factor receptor 2 negative.

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**Figure 2 Kaplan–Meier estimates of difference in 5-yr and 10-yr overall survival, breast cancer-specific survival and disease-free survival in all 864 human epidermal growth factor receptor 2 positiveandhuman epidermal growth factor receptor 2 negativeinvasive lobular carcinomas patients by human epidermal growth factor receptor 2 status.** A: Overall survival; B: Breast cancer-specific survival; C: Disease-free survival for human epidermal growth factor receptor 2 positiveand human epidermal growth factor receptor 2 negativeinvasive lobular carcinomaspatients. *HER2*: Human epidermal growth factor receptor 2; *HER2+*: Human epidermal growth factor receptor 2 positive; *HER2-*: Human epidermal growth factor receptor 2 negative.

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**Figure 3 Overall survival of all Invasive lobular carcinomas patients by molecular subtype.** Basal: Estrogen receptor(*ER*), progesterone receptor(*PR*) and human epidermal growth factor receptor 2 (*HER2*) negative; *HER2+*: *ER*, *PR* negative and *HER2* positive; Luminal A: *ER* or *PR* positive and *HER2* negative; Luminal B: *ER* or *PR* positive and *HER2* positive. *HER2+*: Human epidermal growth factor receptor 2 positive.

**Table 1 Clinical and histopathological characteristics of human epidermal growth factor receptor 2 positiveand human epidermal growth factor receptor 2 negative****invasive lobular carcinomaspatients, *n* (%)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Characteristics** | ***HER2+* (*n* = 87)** | | ***HER2-* (*n* = 777)** | | **Total (*n* = 864)** | | ***P* value** |
| Age (yr) |  |  |  |  |  |  | 1.000 |
| ≤ 50 | 30 (34.5) |  | 272 (35.0) |  | 302 (35.0) |  |
| > 50 | 57 (65.5) |  | 505 (65.0) |  | 562 (65.0) |  |
| Ethnicity |  |  |  |  |  |  | 0.594 |
| Chinese | 68 (78.2) |  | 558 (72.1) |  | 626 (72.7) |  |  |
| Indian | 4 (4.6) |  | 60 (7.8) |  | 64 (7.4) |  |  |
| Malay | 8 (9.2) |  | 68 (8.8) |  | 76 (8.8) |  |  |
| Others | 7 (8.0) |  | 88 (11.4) |  | 95 (11.0) |  |  |
| ER |  |  |  |  |  |  | < 0.001 |
| Negative | 21 (24.4) |  | 46 (5.9) |  | 67 (7.8) |  |  |
| Positive | 65 (75.6) |  | 730 (94.1) |  | 795 (7.8) |  |
| PR |  |  |  |  |  |  | 0.002 |
| Negative | 35 (40.2) |  | 185 (24.0) |  | 220 (25.6) |  |  |
| Positive | 52 (59.8) |  | 587 (76.0) |  | 639 (74.4) |  |  |
| Tumour size |  |  |  |  |  |  | 0.765 |
| 0.1-2 cm | 21 (41.2) |  | 230 (38.7) |  | 251 (38.9) |  |  |
| > 2 cm | 30 (58.8) |  | 365 (61.3) |  | 395 (61.1) |  |  |
| Tumour grade |  |  |  |  |  |  | <0.001 |
| Grade 1 | 7 (10.1) |  | 148 (22.5) |  | 155 (21.3) |  |  |
| Grade 2 | 42 (60.9) |  | 443 (67.3) |  | 485 (66.7) |  |
| Grade 3 | 20 (29.0) |  | 67 (10.2) |  | 87 (12.0) |  |
| Tumour stage |  |  |  |  |  |  | 0.066 |
| Stage 1 | 20 (24.1) |  | 216 (30.3) |  | 236 (29.7) |  |  |
| Stage 2 | 25 (30.1) |  | 267 (37.5) |  | 292 (36.7) |  |
| Stage 3 | 27 (32.5) |  | 179 (25.1) |  | 206 (25.9) |  |
| Stage 4 | 11 (13.3) |  | 50 (7.0) |  | 61 (7.7) |  |
| Treatment |  |  |  |  |  |  |  |
| Chemotherapy1 | 50 (66.7) |  | 390 (54.2) |  | 440 (55.3) |  | 0.038 |
| With *HER*2 therapy | 47 (54.0) |  | - | - | 47 (54.0) |  |  |
| No *HER*2 therapy | 12 (13.8) |  | - | - | 12 (13.8) |  |  |
| Unknown if any *HER*2 therapy | 28 (32.2) |  | - | - | 28 (32.2) |  |  |
| Radiotherapy2 | 47 (62.7) |  | 404 (56.1) |  | 451 (56.7) |  | 0.276 |
| Surgery3 | 73 (92.4) |  | 690 (92.1) |  | 763 (92.1) |  | 0.929 |

1There were 69 patients with unknown chemotherapy histories which were excluded from analysis; 2There were 69 patients with unknown radiotherapy histories which were excluded from analysis; 3There were 36 patients with unknown surgery histories which were excluded from analysis. *HER2*: Human epidermal growth factor receptor 2; *HER2+*: Human epidermal growth factor receptor 2 positive; *HER2-*: Human epidermal growth factor receptor 2 negative; *ER*: Estrogen receptor; *PR*: Progesterone receptor.

**Table 2 Univariate and multivariate** **Cox proportional hazard regression analysis for overall survival among all 864 invasive lobular carcinomas patients**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Characteristics** | **Univariate analysis** | | | **Multivariate analysis** | | |
| **HR** | **95%CI** | ***P* value** | **HR** | **95%CI** | ***P* value** |
| Age (reference: ≤ 50 yr) |  |  |  |  |  |  |
| > 50 yr | 2.32 | 1.68-3.20 | < 0.001 | 2.17 | 1.37-3.44 | < 0.001 |
| Ethnicity (reference: Chinese) |  |  | < 0.0011 |  |  | 0.0011 |
| Indian | 2.53 | 1.62-3.94 | < 0.001 | 3.41 | 1.78-6.54 | < 0.001 |
| Malay | 0.95 | 0.50-1.82 | 0.889 | 0.98 | 0.42-2.29 | 0.961 |
| Others | 0.40 | 0.15-1.08 | 0.070 | 0.64 | 0.19-2.12 | 0.462 |
| *ER* (reference: Negative) |  |  |  |  |  |  |
| Positive | 0.74 | 0.44-1.24 | 0.255 |  |  |  |
| *PR* (reference: Negative) |  |  |  |  |  |  |
| Positive | 0.62 | 0.44-0.87 | 0.005 | 0.57 | 0.35-0.91 | 0.018 |
| *HER2* (reference: Negative) |  |  |  |  |  |  |
| Positive | 1.87 | 1.21-2.90 | 0.005 | 2.14 | 1.16-3.95 | 0.016 |
| Tumour size (reference: ≤ 2 cm) |  |  |  |  |  |  |
| > 2 cm | 2.43 | 1.45-4.06 | < 0.001 |  |  |  |
| Tumour stage (reference: Stage 1) |  |  | < 0.0011 |  |  | < 0.0011 |
| Stage 2 | 2.33 | 1.09-4.99 | 0.030 | 1.75 | 0.76-4.03 | 0.191 |
| Stage 3 | 6.98 | 3.42-14.25 | < 0.001 | 4.52 | 2.06-9.89 | < 0.001 |
| Stage 4 | 61.82 | 29.73-128.57 | < 0.001 | 41.74 | 17.95-97.04 | < 0.001 |
| Tumor grade (reference: Grade 1) |  |  | < 0.0011 |  |  | 0.0751 |
| Grade 2 | 1.45 | 0.83-1.89 | 0.190 | 1.05 | 0.57-1.93 | 0.877 |
| Grade 3 | 4.72 | 2.55-8.74 | < 0.001 | 1.89 | 0.93-3.84 | 0.079 |
| Chemotherapy (reference: No) |  |  |  |  |  |  |
| Yes | 0.97 | 0.69-1.37 | 0.866 |  |  |  |
| Surgery (reference: No) |  |  |  |  |  |  |
| Yes | 0.06 | 0.04-0.09 | < 0.001 |  |  |  |
| Radiotherapy (reference: No) |  |  |  |  |  |  |
| Yes | 0.89 | 0.63-1.27 | 0.518 |  |  |  |
| Molecular subtype  (reference: Luminal A) |  |  | 0.0251 |  |  | 0.0021 |
| Basal | 1.52 | 0.79-2.90 | 0.206 | 1.13 | 0.38-3.29 | 0.830 |
| *HER2* positive | 2.08 | 0.85-5.10 | 0.108 | 4.21 | 1.43-12.44 | 0.009 |
| Luminal B | 1.89 | 1.16-3.07 | 0.011 | 2.52 | 1.41-4.49 | 0.002 |

1Refers to type 3 *P* value. HR: Hazard ratio; CI: Confidence interval; *HER2*: Human epidermal growth factor receptor 2; *ER*: Estrogen receptor; *PR*: Progesterone receptor.

**Table 3 Univariate and multivariate Cox proportional hazard regression analysis for breast cancer-specific survival among all 864 invasive lobular carcinomas patients**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Characteristics** | **Univariate analysis** | | | **Multivariate analysis** | | | | |
| **HR** | **95%CI** | ***P* value** | **HR** | **95%CI** | | ***P* value** | |
| Age (reference: ≤ 50 yr) |  |  |  |  |  | |  | |
| > 50 yr | 2.16 | 1.53-3.05 | < 0.001 |  |  | |  | |
| Ethnicity (reference: Chinese) |  |  | < 0.0011 |  |  | | 0.0041 | |
| Indian | 2.60 | 1.63-4.14 | < 0.001 | 2.55 | 1.28-5.05 | | 0.008 | |
| Malay | 0.89 | 0.43-1.82 | 0.744 | 1.07 | 0.43-2.67 | | 0.885 | |
| Others | 0.32 | 0.10-1.02 | 0.054 | 0.19 | 0.04-0.84 | | 0.028 | |
| *ER* (reference: Negative) |  |  |  |  |  | |  | |
| Positive | 0.72 | 0.42-1.26 | 0.255 |  |  | |  | |
| *PR* (reference: Negative) |  |  |  |  |  | |  | |
| Positive | 0.61 | 0.42-0.88 | 0.008 | 0.40 | 0.23-0.70 | | 0.001 | |
| *HER2* (reference: Negative) |  |  |  |  |  | |  | |
| Positive | 2.08 | 1.32-3.26 | 0.002 |  |  | |  | |
| Molecular subtype (reference: Luminal A) |  |  | 0.0111 |  |  | | 0.0041 | |
| Basal | 1.49 | 0.72-3.07 | 0.281 | 1.16 | 0.36-3.77 | | 0.801 | |
| *HER2+* | 2.34 | 0.95-5.74 | 0.064 | 3.74 | 1.26-11.09 | | 0.018 | |
| Luminal B | 2.08 | 1.26-3.44 | 0.004 | 2.79 | 1.44-5.37 | | 0.002 | |
| Tumour size  (reference: ≤ 2 cm) |  |  |  |  |  | |  | |
| > 2 cm | 2.76 | 1.53-4.97 | < 0.001 |  |  | |  | |
| Tumour stage (reference: Stage 1) |  |  | < 0.0011 |  |  | | < 0.001 | |
| Stage 2 | 3.11 | 1.09-8.92 | 0.034 | 2.19 | 0.74-6.49 | | 0.159 | |
| Stage 3 | 13.02 | 4.89-34.68 | < 0.001 | 6.49 | 2.35-17.89 | | < 0.001 | |
| Stage 4 | 117.79 | 43.5-317.87 | < 0.001 | 56.27 | 18.44-171.68 | | < 0.001 | |
| Tumor grade  (reference: Grade 1) |  |  | < 0.0011 |  |  | | 0.0011 | |
| Grade 2 | 1.89 | 0.96-3.75 | 0.066 | 1.63 | 0.78-3.44 | | 0.196 | |
| Grade 3 | 7.10 | 3.44-14.64 | < 0.001 | 4.16 | 1.80-9.62 | | 0.001 | |
| Chemotherapy (reference: No) |  |  |  |  |  | |  | |
| Yes | 1.23 | 0.84-1.80 | 0.290 |  |  | |  | |
| Surgery (reference: No) |  |  |  |  |  | |  | |
| Yes | 0.06 | 0.04-0.08 | < 0.001 | 0.23 | 0.11-0.51 | | < 0.001 | |
| Radiotherapy (reference: No) |  |  |  |  |  | |  | |
| Yes | 0.94 | 0.65-1.37 | 0.758 |  | |  | |  |

1Refers to type 3 *P* value. HR: Hazard ratio; CI: Confidence interval; *HER2*: Human epidermal growth factor receptor 2; *ER*: Estrogen receptor; *PR*: Progesterone receptor; *HER2+*: Human epidermal growth factor receptor 2 positive.

**Table 4 Univariate and multivariate Cox proportional hazard regression analysis for disease-free survival among all 864 invasive lobular carcinomas patients**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Characteristics** | **Univariate analysis** | | | **Multivariate analysis** | | |
| **HR** | **95%CI** | ***P* value** | **HR** | **95%CI** | ***P* value** |
| Age (reference: ≤ 50 yr) |  |  |  |  |  |  |
| > 50 yr | 1.60 | 1.11-2.30 | 0.012 | 1.63 | 1.04-2.55 | 0.033 |
| Ethnicity (reference: Chinese) |  |  | 0.001 |  |  |  |
| Indian | 2.61 | 1.52-4.48 | < 0.001 |  |  |  |
| Malay | 0.99 | 0.48-2.05 | 0.984 |  |  |  |
| Others | 1.99 | 1.10-3.58 | 0.022 |  |  |  |
| *ER* (reference: Negative) |  |  |  |  |  |  |
| Positive | 1.04 | 0.57-1.90 | 0.886 |  |  |  |
| *PR* (reference: Negative) |  |  |  |  |  |  |
| Positive | 0.97 | 0.65-1.43 | 0.876 |  |  |  |
| HER2 (reference: Negative) |  |  |  |  |  |  |
| Positive | 1.68 | 1.04-2.71 | 0.03 |  |  |  |
| Molecular subtype (reference: Luminal A) |  |  | 0.2171 |  |  |  |
| Basal | 0.98 | 0.45-2.12 | 0.965 |  |  |  |
| *HER2+* | 1.69 | 0.62-4.61 | 0.304 |  |  |  |
| Luminal B | 1.67 | 0.98-2.83 | 0.058 |  |  |  |
| Tumour size  (reference: ≤ 2 cm) |  |  |  |  |  |  |
| > 2 cm | 2.02 | 1.26-3.25 | 0.004 |  |  |  |
| Tumour stage  (reference: Stage 1) |  |  | < 0.0011 |  |  | < 0.0011 |
| Stage 2 | 1.92 | 1.05-3.53 | 0.035 | 1.66 | 0.83-3.28 | 0.149 |
| Stage 3 | 5.66 | 3.21-9.98 | < 0.001 | 5.26 | 2.76-10.03 | < 0.001 |
| Stage 4 | 0.62 | 0.04-10.84 | 0.745 | 0.71 | 0.04-12.61 | 0.813 |
| Tumor grade  (reference: Grade 1) |  |  | < 0.0011 |  |  | 0.0131 |
| Grade 2 | 1.79 | 1.02-3.16 | 0.044 | 1.32 | 0.73-2.40 | 0.357 |
| Grade 3 | 3.72 | 1.89-7.34 | < 0.001 | 2.69 | 1.32-5.50 | 0.007 |
| Chemotherapy (reference: No) |  |  |  |  |  |  |
| Yes | 1.64 | 1.12-2.42 | 0.011 |  |  |  |
| Surgery (reference: No) |  |  |  |  |  |  |
| Yes | 0.14 | 0.08-0.23 | < 0.001 |  |  |  |
| Radiotherapy (reference: No) |  |  |  |  |  |  |
| Yes | 1.57 | 1.05-2.34 | 0.028 |  |  |  |

1Refers to type 3 *P* value. HR: Hazard ratio; CI: Confidence interval; *HER2*: Human epidermal growth factor receptor 2; *ER*: Estrogen receptor; *PR*: Progesterone receptor; *HER2+*: Human epidermal growth factor receptor 2 positive.