

A high absolute lymphocyte count predicts a poor prognosis in HER-2- positive breast cancer patients treated with trastuzumab

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Background: Immune responses play an important role in the development of breast cancer. Trastuzumab can activate antibody-dependent cellular cytotoxicity (ADCC) in human epidermal growth factor receptor-2 (HER-2)-positive breast cancer. Many studies have demonstrated that inflammatory markers, such as the neutrophil-to-lymphocyte ratio (NLR) and absolute lymphocyte count (ALC), are associated with prognosis in breast cancer. The aim of this study was to explore whether preoperative NLR, ALC or the absolute neutrophil count (ANC) is associated with prognosis in HER-2-positive breast cancer patients who received adjuvant trastuzumab.

Patients and methods: Three hundred sixty-seven female patients with HER-2-positive invasive breast cancer who were treated with one-year adjuvant trastuzumab were analysed in this retrospective study. Preoperative haematological parameters, clinicopathological data and survival data were obtained. The cut-off points for ALC, ANC and NLR were based on the median values. Disease-free survival (DFS) and Overall survival (OS) were analysed by the Kaplan-Meier method. Multivariable Cox regression was used to determine the independent prognostic significance of ALC, ANC and NLR.

Results: Survival analysis revealed that the 3-year DFS in patients with high ALC was 89.0%, which was significantly worse than 95.0% in patients with low ALC ($p=0.014$). Kaplan-Meier analysis also showed that patients with low NLR had a poorer 3-year DFS than patients with high NLR (89.7% vs 94.0%, respectively; $p=0.047$). Multivariate analysis showed that ALC was an independent prognostic factor for DFS (HR=2.723; 95% CI=1.211–6.122; $p=0.015$). Neither ANC, ALC nor NLR could predict OS independently.

Conclusion: In HER-2-positive breast cancer patients who were treated with adjuvant trastuzumab, a high ALC is significantly associated with a poor DFS.

Keywords: breast cancer, HER-2 positive, trastuzumab, absolute lymphocyte count, neutrophil-to-lymphocyte ratio

Introduction

Breast cancer is a heterogeneous disease, and there are four subtypes that call for different treatment approaches: two types of estrogen receptor (ER)-positive breast cancer (luminal A like and luminal B like), human epidermal growth factor receptor-2 (HER-2)-positive tumors regardless of ER status and triple-negative tumors.¹ Patients with HER-2 overexpression account for 20–25% of invasive breast cancer, for whom treatment with trastuzumab can decrease the risk of relapse greatly in the adjuvant setting.² Trastuzumab has not only cytostatic but also

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cytotoxic properties and can induce antibody-dependent cellular cytotoxicity (ADCC).³

Inflammatory responses play distinct roles at different stages of tumor development, and have effect on immune surveillance and responses to therapy.⁴ An increasing number of studies have shown that peripheral haematologic parameters, such as the neutrophil to lymphocyte ratio (NLR) and platelet-to-lymphocyte ratio (PLR), can predict the prognosis for breast cancer patients.^{5,6} Our previous retrospective study indicated that elevated preoperative NLR predicted a poor disease-free survival (DFS) in Chinese breast cancer patients, especially in those with triple-negative breast cancer, although no significant difference for DFS was observed in the HER-2-enriched subgroup.⁷ Meanwhile, few studies have demonstrated the prognostic and predictive values of ALC and the absolute neutrophil count (ANC) in breast cancer. However, in HER-2-positive advanced breast cancer, a recent study showed that ALC was superior to NLR and PLR for predicting progression-free survival (PFS).⁸ In breast cancer patients treated with neoadjuvant chemotherapy, a high lymphocyte count is predictive for a pathological complete response.⁹ Therefore, we sought to explore whether preoperative ANC, ALC or NLR has a prognostic role in HER-2-positive early breast cancer patients who received adjuvant trastuzumab in this study.

Patients and methods

Eligibility

Three hundred sixty-seven consecutive female patients with primary HER-2-positive invasive breast cancer were identified retrospectively in our study from January 2012 to February 2016. The last follow up on those patients was December 2017. All the patients were treated with one-year adjuvant trastuzumab at Shanghai Ruijin Hospital affiliated to Shanghai Jiao Tong University School of Medicine. The patients in the study should have complete preoperative haematological parameters and have received all phases of adjuvant treatment suggested, including chemotherapy, radiotherapy or endocrine therapy. Patients with the following characteristics were excluded: HER-2 negative breast cancer, no one-year trastuzumab treatment, stage IV breast cancer, breast cancer in situ, patients who received neoadjuvant treatment, clinical evidence of acute infection, presence of haematological disorders, chronic inflammatory or autoimmune diseases, severe renal disease or any other malignancies.

The study was conducted in accordance with the Declaration of Helsinki. The protocol was reviewed and

approved by the independent ethical committee/institutional review board of Shanghai Ruijin Hospital affiliated with Shanghai Jiao Tong University School of Medicine. Written informed consent was obtained from all patients involved.

Clinical and laboratory data

Before any surgical intervention, routine blood tests were performed in all patients, and parameters such as the neutrophil count and lymphocyte count were obtained and analysed using the XN-series blood analyser (Sysmex, Japan). Other clinical characteristics of the patients, including the menopausal status, age, surgery type, comorbidities and adjuvant treatment details, were obtained from the electronic patient's history system.

The histopathological features were reviewed and identified by two different pathologists independently, including the breast cancer histological type, tumor size, grade, number of lymph node involved, ER expression, progesterone receptor (PR) expression, CerbB-2 and Ki-67 index. More than 1% positive tumor cells with nuclear staining was deemed as ER positive or PR positive. Tumors with a HER-2 3+ status in the immunohistochemistry (IHC) assay and/or HER-2 gene overexpression confirmed by fluorescence in situ hybridization (FISH) were defined as HER-2 positive.

Statistical analysis

NLR was calculated as the absolute neutrophil count divided by the absolute lymphocyte count. The cut-off points for ANC, ALC and NLR were based on the median values. Patients were categorized into two cohorts according to the median ALC (low ALC cohort: $ALC < 1.80 \times 10^9/L$ and high ALC cohort: $ALC \geq 1.80 \times 10^9/L$). The categorical variables of the two cohorts were compared using chi-square tests or Fisher's exact test. DFS was defined as freedom from any event as follows in the follow-up: newly diagnosed contralateral breast cancer (invasive or non-invasive); local or regional recurrence; distant organ metastasis; second primary malignancy or death from any cause. OS was defined as the proportion of patients free from any death. The Kaplan-Meier method and the log-rank test were used to analyse DFS and OS. The independent prognostic values of ALC, ANC and NLR were determined by the multivariate Cox proportional hazards model. Clinicopathological variables with p -value < 0.05 in the univariate analysis and several important clinicopathological characteristics were included in the Cox proportional hazards model. The backward: LR method was chosen in the analysis. Statistical

analyses were performed using SPSS (version 22.0) software (IBM Corporation, Armonk, NY, USA). A p -value <0.05 was considered to indicate statistical significance.

Results

Patients' characteristics

Six hundred forty HER-2-positive invasive breast cancer patients were collected from our clinical database, and 367 patients who met the inclusion criteria were enrolled finally in our study. The median ALC was $1.80 \times 10^9/L$ (range, 0.70 – $4.20 \times 10^9/L$), the median ANC was $3.20 \times 10^9/L$ (range, 1.30 – $7.05 \times 10^9/L$) and the median NLR was 1.77 (range, 0.45–5.99). Patients were categorized into the high ALC cohort ($ALC \geq 3.20 \times 10^9/L$) and low ALC cohort ($ALC < 3.20 \times 10^9/L$), high ANC cohort ($ANC \geq 1.80 \times 10^9/L$) and low ANC cohort ($ANC < 1.80 \times 10^9/L$), high NLR cohort ($NLR \geq 1.77$) and low NLR cohort ($NLR < 1.77$). The median follow-up was 39.0 months.

Table 1 shows the patients' clinicopathological characteristics presented by ALC categories. The median age of these patients was 53 years old, ranging from 23 to 81 years. One hundred fifty-six (42.5%) patients were premenopausal, and 57.5% of those patients were postmenopausal. Of the 367 patients, 83 received breast-conserving surgery, and 91.8% of those cases were invasive ductal carcinoma (IDC). Additionally, 207 cases were node negative, and 160 cases had one or more lymph node involved. 47.1% of those cases were ER positive and 30.5% of them were PR positive. The patients' clinicopathological characteristics were well balanced, and there were no significant differences between the low ALC cohort and high ALC cohort.

The adjuvant treatment details for patients are summarized in Table 2. Of those patients, 300 (81.7%) cases received epirubicin and cyclophosphamide followed by the docetaxel regimen, 41 (11.3%) cases received the docetaxel

Table 1 Patients' characteristics of the two ALC cohorts

| Characteristics | | Overall, n(%) | ALC | | p-Value |
|-------------------|----------------|---------------|------|------------|---------|
| | | | <1.8 | ≥ 1.8 | |
| Age | ≤ 50 | 146(39.8) | 75 | 71 | 0.217 |
| | > 50 | 221(60.2) | 99 | 122 | |
| Menopausal status | Premenopausal | 156(42.5) | 79 | 77 | 0.287 |
| | Postmenopausal | 211(57.5) | 95 | 116 | |
| Surgery | Mastectomy | 284(77.4) | 136 | 148 | 0.736 |
| | BCS | 83(22.6) | 38 | 45 | |
| Pathology | IDC | 337(91.8) | 161 | 176 | 0.641 |
| | Others | 30(8.2) | 13 | 17 | |
| Tumors | ≤ 2 cm | 165(45.0) | 82 | 83 | 0.428 |
| | > 2 cm | 202(55.0) | 92 | 110 | |
| Nodes involved | 0 | 207(56.4) | 94 | 113 | 0.383 |
| | ≥ 1 | 160(43.6) | 80 | 80 | |
| Stage | I | 123(33.5) | 62 | 61 | 0.548 |
| | II | 167(45.5) | 74 | 93 | |
| | III | 77(21.0) | 38 | 39 | |
| Grade | I | 3(0.8) | 1 | 2 | 0.163 |
| | II | 113(30.8) | 45 | 68 | |
| | III | 229(62.4) | 119 | 110 | |
| | NA | 22(6.0) | 9 | 13 | |
| ER | Positive | 173(47.1) | 84 | 89 | 0.679 |
| | Negative | 194(52.9) | 90 | 104 | |
| PR | Positive | 112(30.5) | 57 | 55 | 0.376 |
| | Negative | 255(69.5) | 117 | 138 | |
| Ki67 | $\leq 30\%$ | 179(48.8) | 80 | 99 | 0.309 |
| | $> 30\%$ | 188(51.2) | 94 | 94 | |

Abbreviations: IDC, invasive ductal carcinoma; NA, not available; BCS, breast conserving surgery; ER, estrogen receptor; PR, progesterone receptor; ALC, absolute lymphocyte count.

Table 2 Treatment for patients in the two ALC cohorts

| Characteristics | | Overall, n(%) | ALC | | p-value |
|-------------------|--------|---------------|------|------|---------|
| | | | <1.8 | ≥1.8 | |
| Chemotherapy | EC-T | 300(81.7) | 144 | 156 | 0.581 |
| | TCb | 41(11.2) | 18 | 23 | |
| | P | 21(5.7) | 11 | 10 | |
| | Others | 5(1.4) | 1 | 4 | |
| Radiation | Yes | 207(56.4) | 100 | 107 | 0.695 |
| | No | 160(43.6) | 74 | 86 | |
| Endocrine therapy | Yes | 160(43.6) | 77 | 83 | 0.810 |
| | No | 207(56.4) | 97 | 110 | |

Abbreviations: EC-T, epirubicin and cyclophosphamide followed by docetaxel; TCb, docetaxel and carboplatin; P, paclitaxel; ALC, absolute lymphocyte count.

and carboplatin regimen, and 21 cases received weekly paclitaxel. Additionally, 207 patients received radiation and 160 patients received endocrine therapy.

Disease-free survival

Thirty-one events occurred in 367 patients during the follow-up. Distant metastasis of breast cancer occurred in 10 patients, local recurrence occurred in 6 patients, contralateral newly diagnosed breast cancer occurred in 2 patients, and secondary malignancies occurred in 2 patients. Nine patients died of breast cancer, 1 patient died of pancreatic cancer and 1 patient died of viral myocarditis.

The numbers of events in each cohort are summarized in Table 3. The 3-year DFS was 93.8% in the low ANC cohort and 89.9% in the high ANC cohort ($p=0.645$) (Figure 1A). Eight events occurred in the low ALC cohort and 23 events occurred in the high ALC cohort. Kaplan-Meier analysis showed that patients in the low ALC cohort had significantly better 3-year DFS than patients in the high ALC cohort

(95.0% vs 89.0%, $p=0.014$) (Figure 1B). In the high NLR cohort, there were 10 events and the 3-year DFS was 94.0%; however, in the low NLR cohort, there were 21 events and the 3-year DFS was 89.7% ($p=0.047$) (Figure 1C).

A multivariate Cox proportional hazards model, including age, lymph node involved, tumor size, ER status, PR status, Ki-67 index, ALC and NLR, was set up. The results showed that ALC was an independent prognostic factor for DFS in HER-2-positive breast cancer patients who received adjuvant trastuzumab treatment (HR=2.723; 95%CI=1.211–6.122; $p=0.015$) (Table 4).

Regarding the subgroups and the P -value for interaction, Figure 2 shows a forest plot of hazard ratio for DFS. Across all subgroups, there was a trend that patients with low ALC had a better DFS, especially in breast cancer subgroups with an ER-positive status or $Ki67 \leq 30\%$. In ER-positive and HER-2-positive patients, the 3-year DFS was 98.5% in the low ALC cohort and 86.6% in the high ALC cohort. Additionally, in the subgroup of patients with $Ki67 \leq 30\%$, the 3-year DFS was 94.7% in the low ALC cohort and 84.3% in the high ALC cohort.

Overall survival

Overall, there were 11 deaths during the follow-up in the study. The 3-year OS was 97.8% in the low ANC cohort and 97.5% in the high ANC cohort ($p=0.813$) (Figure 1D). In the low ALC cohort, the 3-year OS was 99.4%; in the high ALC cohort, the 3-year OS was 96.0% ($p=0.054$) (Figure 1E). Kaplan-Meier analysis showed that patients in the high NLR cohort had significantly better 3-year OS than patients in the low NLR cohort (99.4% vs 95.8%, respectively; $p=0.037$) (Figure 1F). However, multivariate analysis showed that no factor in the analysis could predict OS independently in HER-

Table 3 Disease free survival and overall survival for each cohort

| Cohort | | No. of patients | DFS | | | OS | | |
|--------|------|-----------------|---------------|------------|---------|---------------|-----------|---------|
| | | | No. of events | 3-year DFS | p-Value | No. of deaths | 3-year OS | p-Value |
| ANC | Low | 182 | 14 | 93.8% | 0.645 | 5 | 97.8% | 0.813 |
| | High | 185 | 17 | 89.9% | | 6 | 97.5% | |
| ALC | Low | 174 | 8 | 95.0% | 0.014 | 2 | 99.4% | 0.054 |
| | High | 193 | 23 | 89.0% | | 9 | 96.0% | |
| NLR | Low | 186 | 21 | 89.7% | 0.047 | 9 | 95.8% | 0.037 |
| | High | 181 | 10 | 94.0% | | 2 | 99.4% | |

Abbreviations: ANC, absolute neutrophil count; ALC, absolute lymphocyte count; NLR, neutrophil to lymphocyte ratio; DFS, disease free survival; OS, overall survival.

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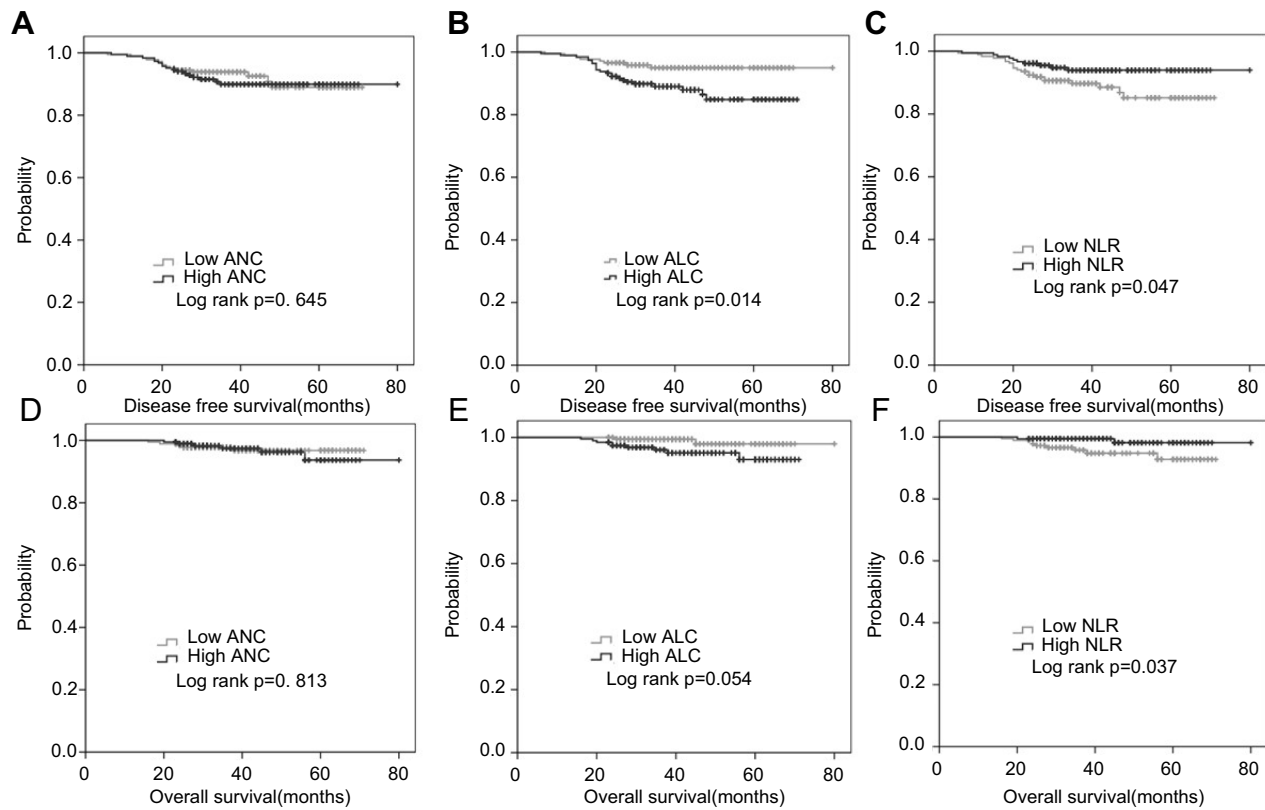


Figure 1 Cumulative DFS and OS curves of patients. **(A)** Cumulative DFS curve for the two ANC cohorts. **(B)** Cumulative DFS curve for the two ALC cohorts. **(C)** Cumulative DFS curve for the two NLR cohorts. **(D)** Cumulative OS curve for the two ANC cohorts. **(E)** Cumulative OS curve for the two ALC cohorts. **(F)** Cumulative OS curve for the two NLR cohorts. A p -value <0.05 was considered to indicate statistical significance.

Abbreviations: ALC, absolute lymphocyte count; NLR, neutrophil to lymphocyte ratio; DFS, disease free survival; OS, overall survival.

Table 4 Univariate and multivariate analysis for DFS

| Characteristics | Univariate | Multivariate | | |
|---------------------------------------|------------|--------------|-------------|------------|
| | p -Value | HR | 95%CI | p -Value |
| Age (>50 vs ≤50) | 0.069 | 0.485 | 0.237–0.989 | 0.047 |
| Menopausal status (pre vs post) | 0.765 | | | |
| Surgery (mastectomy vs BCS) | 0.334 | | | |
| Pathology (IDC vs others) | 0.799 | | | |
| Tumors (≤2 cm vs > 2 cm) | 0.252 | 1.365 | 0.643–2.897 | 0.417 |
| Nodes involved (negative vs positive) | 0.013 | 2.866 | 1.371–5.992 | 0.005 |
| Grade (I-II vs III) | 0.848 | | | |
| ER (positive vs negative) | 0.557 | 0.725 | 0.351–1.495 | 0.383 |
| PR (positive vs negative) | 0.591 | 0.837 | 0.276–2.543 | 0.754 |
| Ki67 (≤30% vs > 30%) | 0.013 | 0.404 | 0.185–0.885 | 0.023 |
| Chemotherapy (EC-T vs others) | 0.721 | | | |
| Radiation (yes vs no) | 0.323 | | | |
| Endocrine therapy (yes vs no) | 0.910 | | | |
| ALC (≥1.8 vs < 1.8) | 0.014 | 2.723 | 1.211–6.122 | 0.015 |
| NLR (≥1.77 vs < 1.77) | 0.047 | 0.619 | 0.275–1.394 | 0.247 |
| ANC (≥3.2 vs < 3.2) | 0.645 | | | |

Abbreviations: IDC, invasive ductal carcinoma; BCS, breast conserving surgery; ER, estrogen receptor; PR, progesterone receptor; ANC, absolute neutrophil count; ALC, absolute lymphocyte count; NLR, neutrophil to lymphocyte ratio.

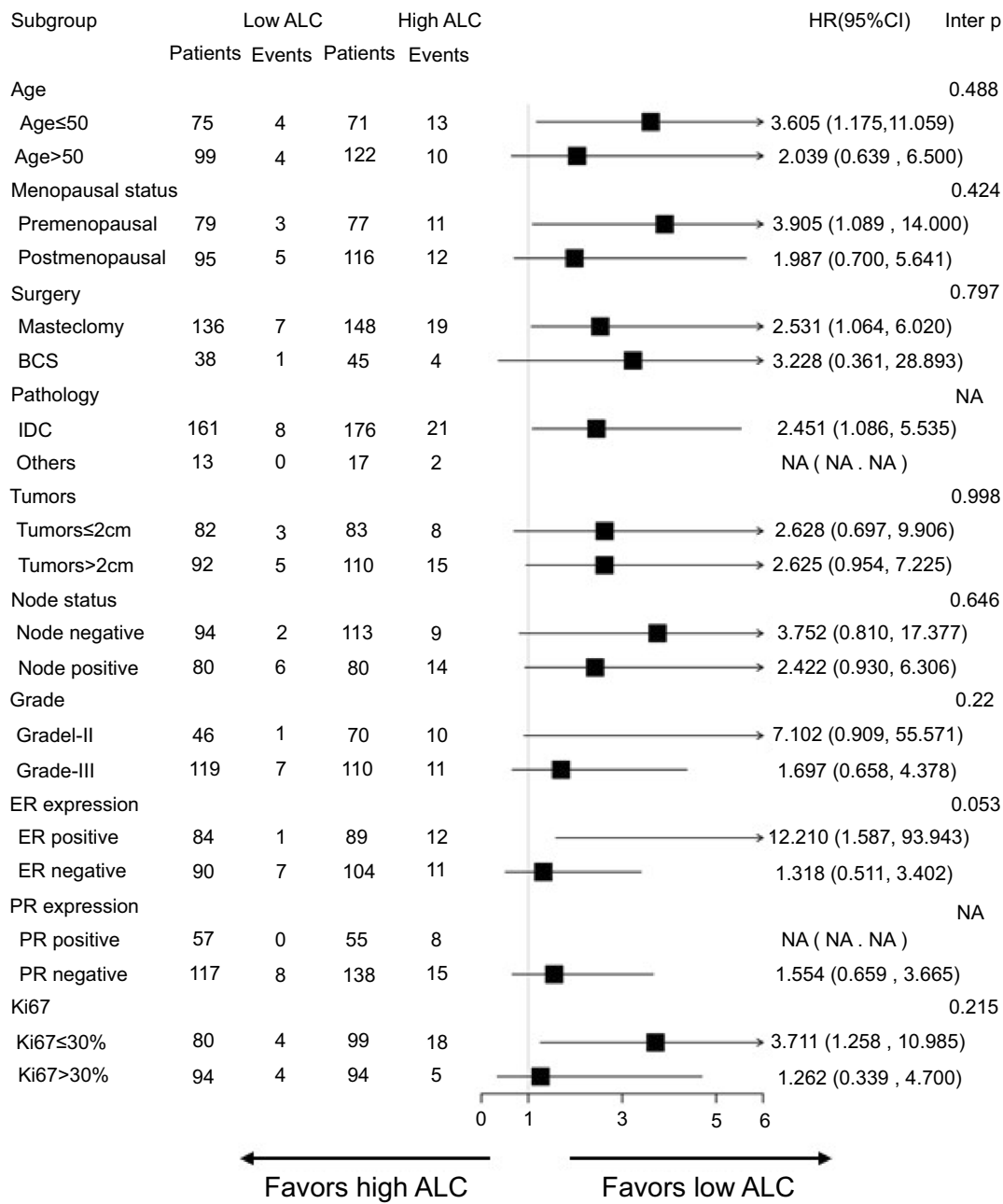


Figure 2 Forest plots of subgroup analysis for disease-free survival.

Abbreviations: ALC, absolute lymphocyte count; BCS, breast-conserving surgery; IDC, invasive ductal carcinoma; ER, estrogen receptor; PR, progesterone receptor; NA, not available.

2-positive breast cancer patients who received adjuvant trastuzumab (Table 5).

Discussion

Numerous previous studies have evaluated the prognostic value of NLR in breast cancer and showed that pretreatment high NLR was associated with adverse DFS or OS.⁵ Nevertheless, our retrospective study revealed that, in HER-2-positive breast cancer patients who received

adjuvant one-year trastuzumab, preoperative ALC instead of NLR was an independent prognostic factor for DFS and a high ALC was significantly associated with a poor DFS.

Inflammation is a hallmark of cancer and represents a link between intrinsic and extrinsic factors contributing to tumor development.¹⁰ The trafficking of T cells into tumors is a crucial process, and higher tumor-infiltrating lymphocytes (TILs) are significantly associated with improved survival.^{11,12} Several inflammatory markers,

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Table 5 Univariate and multivariate analysis for OS

| Characteristics | Univariate | Multivariate | | |
|---------------------------------------|------------|--------------|--------------|---------|
| | p-Value | HR | 95%CI | p-Value |
| Age (>50 vs ≤50) | 0.089 | 0.323 | 0.094–1.108 | 0.072 |
| Menopausal status (pre vs post) | 0.811 | | | |
| Surgery (mastectomy vs BCS) | 0.711 | | | |
| Pathology (IDC vs others) | 0.832 | | | |
| Tumors (≤2 cm vs > 2 cm) | 0.218 | 2.087 | 0.542–8.039 | 0.285 |
| Nodes involved (negative vs positive) | 0.199 | 2.674 | 0.774–9.238 | 0.120 |
| Grade (I–II vs III) | 0.990 | | | |
| ER (positive vs negative) | 0.930 | 0.786 | 0.236–2.617 | 0.695 |
| PR (positive vs negative) | 0.674 | 1.887 | 0.285–12.480 | 0.510 |
| Ki67 (≤30% vs > 30%) | 0.791 | 0.895 | 0.263–3.041 | 0.859 |
| Chemotherapy (EC-T vs others) | 0.575 | | | |
| Radiation (yes vs no) | 0.923 | | | |
| Endocrine therapy (yes vs no) | 0.839 | | | |
| ALC (≥1.8 vs <1.8) | 0.054 | 4.433 | 0.955–20.583 | 0.057 |
| NLR (≥1.77 vs <1.77) | 0.037 | 0.338 | 0.068–1.694 | 0.187 |
| ANC (≥3.2 vs <3.2) | 0.813 | | | |

Abbreviations: IDC, invasive ductal carcinoma; BCS, breast conserving surgery; ER, estrogen receptor; PR, progesterone receptor; ANC, absolute neutrophil count; ALC, absolute lymphocyte count; NLR, neutrophil to lymphocyte ratio.

such as NLR, PLR and the lymphocyte to monocyte ratio (LMR), have explored their predictive values in cancers.^{13,14} Our previous study indicated that an elevated preoperative NLR predicted a poor DFS, particularly in triple-negative breast cancer, but there was no significant difference observed in the HER-2-enriched subgroup.⁷ Additionally, a study with 187 cases also revealed that in HER-2-positive breast cancer patients receiving trastuzumab, NLR was not a predictor for DFS or OS.¹⁵

Few studies have validated the prognostic value of ALC and ANC in breast cancer. In HER-2-positive advanced breast cancer patients treated with trastuzumab and pertuzumab plus eribulin or nab-paclitaxel, a study with 51 cases demonstrated that a high baseline ALC was significantly associated with improved PFS.⁸ For early-stage patients, higher ALC, but not ANC, predicted a lower overall mortality and breast cancer-specific mortality in triple-negative breast cancer.¹⁶ Our study also validated that ALC was superior to NLR and ANC to predict DFS in HER-2-positive patients treated with trastuzumab, although both ALC and NLR were significantly associated with DFS in the univariate analysis. However, the results of our study were completely different from previous studies in which a low ALC was significantly associated with better DFS.

Preclinical studies have shown that trastuzumab can kill HER2-expressing tumor cells by interfering with

HER2 signalling and through immune mechanisms such as ADCC and complement-dependent cytotoxicity.¹⁷ Thus, trastuzumab can induce a substantial increase in natural killer cells and CD8-positive T cells, implying that trastuzumab can activate different mechanisms to recruit lymphocytes to the tumor site.¹⁷ Higher TILs were significantly associated with a higher pathological complete response in patients receiving the neoadjuvant regimen and better overall survival in HER-2-positive advanced breast cancer.^{12,18} However, CD8+TILs and ALC were negatively correlated in breast cancer.¹⁹ HER-2 overexpression in ductal carcinoma was significantly associated with higher FOXP3+ TILs, and increased FOXP3+ TILs were associated with more aggressive tumor features.²⁰ Additionally, in the tumor microenvironment, there also co-exist many other infiltrating immune cells, such as tumor-associated macrophages (TAMs) and cancer-related neutrophils (CRNs), which can enhance tumor cell invasion and metastasis.^{21,22} Beyond that, chemotherapy, like the taxane regimen, can also enhance trastuzumab-mediated ADCC in tumor cells.²³ Therefore, the tumor immune microenvironment is very complex and influenced by numerous factors, such as treatment with trastuzumab and effect of chemotherapy.

In the subgroup analysis, we observed the tendency that, in patients with an ER-positive status or Ki67≤30%, a high ALC predicted a poor disease free survival. No sufficient

evidence can explain these results. A recent study showed that ALC was correlated with DFS only in hormone receptor-positive breast cancer but not in HER-2-positive or triple-negative breast cancer.¹⁹ Regarding another prognostic marker, a meta-analysis demonstrated that ER and HER-2 positivity had a negative effect on the association between NLR and DFS.⁵ Many other studies also had verified the predictive and prognostic value of NLR in triple-negative breast cancer.^{24,25} Only a few studies have supported the prognostic value of NLR in ER-positive breast cancer. In a study concerning ER positive/HER2-negative breast cancer patients who received neoadjuvant chemotherapy, a high NLR was correlated with poor recurrence-free survival and OS.²⁶ However, data are lacking regarding the prognostic value of ALC in ER-positive/HER-2-positive breast cancer.

This study possesses several limitations. First, this was a retrospective analysis, and the patients' prognosis were influenced by many factors, although the patients' characteristics and treatment were balanced. Second, the median follow-up for those patients was relatively short. Most events occurred after 18 months during the follow-up and only 6 events occurred in 18 months; thus Kaplan-Meier analysis showed that survival differences appeared after 18 months. Third, we observed that ALC was correlated with DFS, but we could not clearly identify the subtypes of lymphocytes.

Conclusion

Our retrospective study suggested that preoperative ALC is an independent prognostic factor for DFS in HER-2-positive breast cancer patients treated with adjuvant trastuzumab. In those patients, a high ALC was significantly associated with a poor DFS. Further studies should be carried out to illuminate the underlying mechanism and validate the result.

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Disclosure

The authors report no conflict of interest in this work.

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