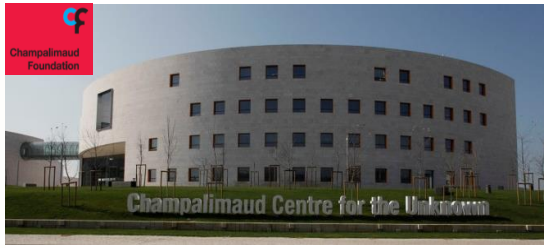
ESMO Clinical Practice Guidelines

Breast Cancer
Clinical Case Presentation

F. Cardoso, MD
Director, Breast Unit, Champalimaud Clinical Center, Lisbon, Portugal
ESMO Board of Directors & NR Committee Chair
ESO Breast Cancer Program Coordinator
EORTC Board of Directors & Breast Group Chair

EORTC
European Organisation for Research and Treatment of Cancer

ESO
European School of Oncology
learning to care



Disclosures

Consultant:

Astellas/Medivation, AstraZeneca, Celgene, Daiichi-Sankyo,

Eisai, GE Oncology, Genentech, GlaxoSmithKline (GSK)

Merck-Sharp, Merus BV, Novartis, Pfizer, Pierre-Fabre

Roche, Sanofi, Teva

- CS, a 39-year-old lady came to our Breast Unit on June 2012, with a recent diagnosis of breast cancer relapse.
- In Nov 2009, she had been diagnosed with T2N1M0 left ductal invasive breast cancer, grade 3, ER and PR negative, HER-2+.
- She was treated with breast conserving surgery and axillary dissection. Pathology: ductal invasive carcinoma, 23 mm, 4+LN, ER/PR neg and HER-2+.
- She was treated with 6 cycles of TAC, trastuzumab for 1 year (end: May 2011) and adjuvant RT. BRCA 1 & 2 negative.
- In May 2012, she noticed a left supraclavicular lump. Work-up was performed with US and a biopsy that confirmed a lymph node metastasis of a ER/PR neg and HER-2+ BC.
- She had no other symptoms and tumour markers were normal. A PET-CT was performed and confirmed as only site of metastases supraclavicular LNs.

SINGAPORE 2015 ESMO ASIA 18-21 DECEMBER SINGAPORE

Q1: Do you regularly biopsy metastatic disease?

1. Yes
2. No
3. Only when receptors are negative in the primary tumour
4. Abstain

BIOPSY OF METASTATIC LESION

A biopsy (preferably providing histology) of a metastatic lesion should be performed, if easily accessible, to confirm diagnosis particularly when metastasis is diagnosed for the first time. (LoE: 1 B) (98%)

Biological markers (especially HR and HER-2) should be reassessed at least once in the metastatic setting, if clinically feasible.
(LoE: 1 B) (98%)

Depending on the metastatic site (e.g. bone tissue), technical considerations need to be discussed with the pathologist.

Q2: Do you regularly use PET-CT in the initial work-up of metastatic breast cancer?

1. Always
2. No
3. Only to confirm oligo-metastatic disease
4. In selected cases
5. Abstain

IMAGING, TUMOR MARKERS & EVALUATION OF RESPONSE

Minimal staging workup for MBC includes a history and physical examination, hematology and biochemistry tests, and imaging of chest, abdomen and bone (LoE: 2 C). (67%)

Notes:

- ✓ **Biochemistry tests including liver function tests, renal function, electrolytes, calcium, total proteins and albumin**
- ✓ **In many cases a chest X-ray, an abdominal ultrasound and a bone scan are sufficient (lot of discussion about the optimal imaging modality- LoE 2C)**
- ✓ **Consensus that a PET-scan should NOT be part of the minimal staging workup but should be reserved for specific situations**

Q3: Which of the following would be your preferred option for 1st line therapy outside a clinical trial? (please note that Pertuzumab was not yet available at that time)

1. Trastuzumab + Vinorelbine
2. Trastuzumab + Capecitabine
3. Trastuzumab + Taxane
4. Lapatinib + Capecitabine
5. T-DM1
6. CT alone

Q4: What if pertuzumab was available? Would you choose for this particular patient Docetaxel + Trastuzumab + Pertuzumab?

1. Yes
2. No
3. Abstain

- The patient was started on Trastuzumab + Vinorelbine in July 2012.
- PET-CT performed after 3 cycles showed a good PR and continued response after 6 cycles (only 1 small LN remained). Some hematological toxicity.
- Vinorelbine was stopped (Nov 2012) and trastuzumab monotherapy continued.
- In Feb 2013, PD with cutaneous lesions in the left breast. PET-CT showed 1 mediastinal LN. No other lesions. Tumour markers always normal.
- A cutaneous biopsy confirmed infiltration by ductal invasive carcinoma ER/PR negative and HER-2 positive.

Q5: Which of the following would be your preferred option for 2nd line therapy outside a clinical trial?

1. Trastuzumab + Capecitabine
2. Trastuzumab + Taxane
3. Lapatinib + Capecitabine
4. Docetaxel + Trastuzumab + Pertuzumab
5. T-DM1
6. Trastuzumab + Lapatinib
7. CT alone

- The patient was started on Trastuzumab + Capecitabine in Feb 2013.
- Evaluated clinically and with photographs, showing a good response.
- PET-CT performed after 7 cycles: still 1 small mediastinal LN and FGD captation in left breast; no other lesions.
- Trastuzumab + Capecitabine was maintained.
- Re-irradiation was performed to left breast + left supraclavicular (capecitabine stopped during RT and then continued).
- Good response (almost CR).
- After 15 cycles, reappearance of cutaneous lesions. Biopsy confirmed malignancy with the same biology.

  PET-CT did not show any lesion.

Q6: Which of the following would be your preferred treatment option outside a clinical trial?

1. Trastuzumab + Taxane
2. Trastuzumab + liposomal anthracycline
3. Docetaxel + Trastuzumab + Pertuzumab
4. T-DM1
5. Trastuzumab + Lapatinib
6. CT alone

- The patient was started on Trastuzumab + Lapatinib in Jan 2014.
- Evaluated clinically and with photographs, showing good response.
- In August 2014, cutaneous PD and in left breast, confirmed by mammography/US.
- Proposed to the patient T-DM1 or Trastuzumab + metronomic CM. She decided for the latter.
- In the meantime, a MRI of the left braquial plexum was requested since the patient had developed important neurological pain in the left arm, after RT.
- It showed post-RT fibrosis but also 1 brain metastasis in the cerebellum, with 30 mm. The patient was asymptomatic and a neurologic exam was normal. The brain metastasis was confirmed to be a solitary one with a brain MRI.
- The patient had just started the metronomic CT, and trastuzumab continued.

SINGAPORE 2015 ESMO ASIA 18-21 DECEMBER SINGAPORE

Q7: Which of the following would be your preferred local treatment option for solitary brain metastasis?

1. Surgery alone
2. Radiosurgery alone
3. Surgery followed by radiosurgery
4. Whole brain radiotherapy
5. Surgery followed by whole brain radiotherapy
6. Other

Q8: And regarding systemic therapy, which of the following would be your preferred choice?

1. Keep the same ongoing systemic therapy
2. Change to i.v. chemotherapy + trastuzumab
3. T-DM1
4. Taxane + trastuzumab + pertuzumab
5. Stop chemotherapy and continue trastuzumab alone

- Brain surgery followed by radiosurgery to the lesion bed, without complications in September 2014.
- Pathology of brain metastasis: ductal invasive carcinoma, ER/PR negative HER-2 positive.
- Systemic therapy was maintained without change (metronomic CM + trastuzumab).
- 2 months later, progression of lesion in the breast and cutaneous lesions. No surgical indication. No new metastatic sites.
- Decided to start T-DM1. She received 6 cycles with the best response as SD, followed by PD of cutaneous lesions.
- She was started on wPaclitaxel + Trastuzumab + Pertuzumab in April 2015. After 4 cycles, paclitaxel was stopped and the 2 antibodies continued, with good PR. She is still on treatment.

Bridging the Gap

ABC4

European School of Oncology

learning to care

Advanced Breast Cancer

November 2017 • Lisbon, Portugal

Fourth International Consensus Conference

SAVE THE DATE

RECEIVE UPDATES AT: WWW.ABC-LISBON.ORG • #ABClisbon