

ESMO PRECEPTORSHIP
ON BREAST CANCER

16-17 SEPTEMBER 2016
LISBON, PORTUGAL

Lisbon, Portugal - 16 Sep - 17 Sep 2016

Why are Breast Units and Multidisciplinary care indispensable for BC management?

F. Cardoso, MD

Director, Breast Unit, Champalimaud Clinical Center, Lisbon, Portugal

ESMO Board of Directors & NR Committee Chair

ESO Breast Cancer Program Coordinator

EORTC Breast Group Chair



European Society for Medical Oncology

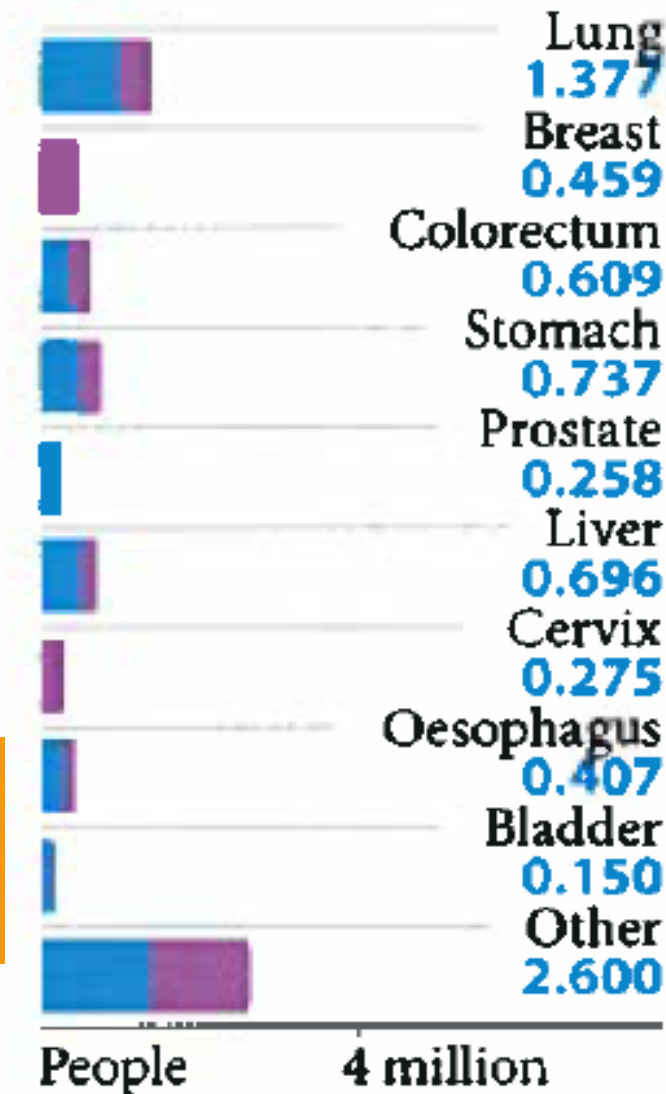


THE BURDEN OF CANCER IN THE 21st CENTURY

Mortality

Cancer is a leading cause of death worldwide, with 7.6 million deaths (around 13% of all deaths) in 2008. Half of all cancer deaths each year are due to lung, stomach, liver, colorectal and female breast cancers¹.

**13% of all deaths in
2008: 7.6 million people!**

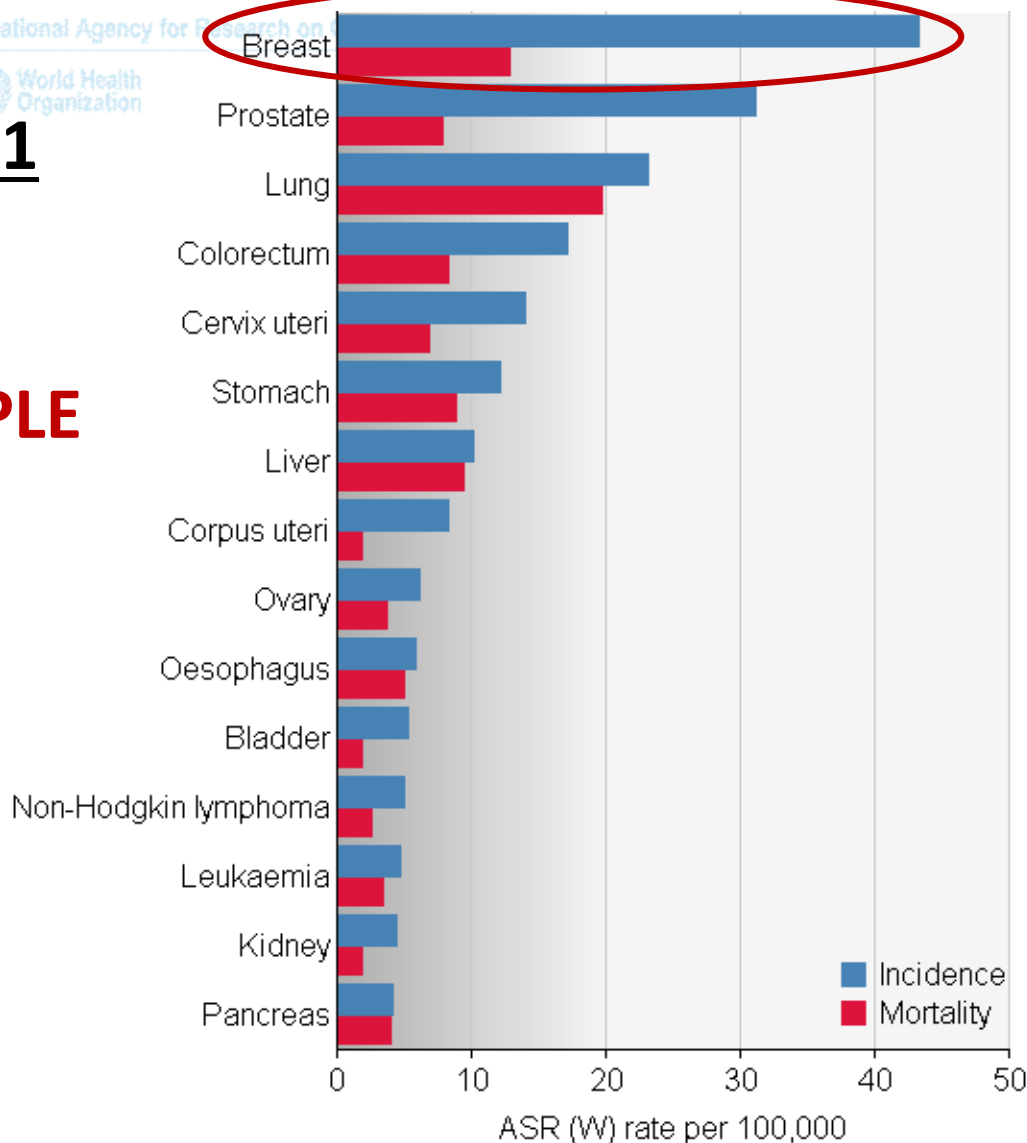


THE BURDEN OF CANCER IN THE 21st CENTURY

**2030: an estimated 13.1
million deaths/year**

**Soon, 1 OUT OF 2 PEOPLE
WILL GET CANCER IN
THEIR LIFETIME**

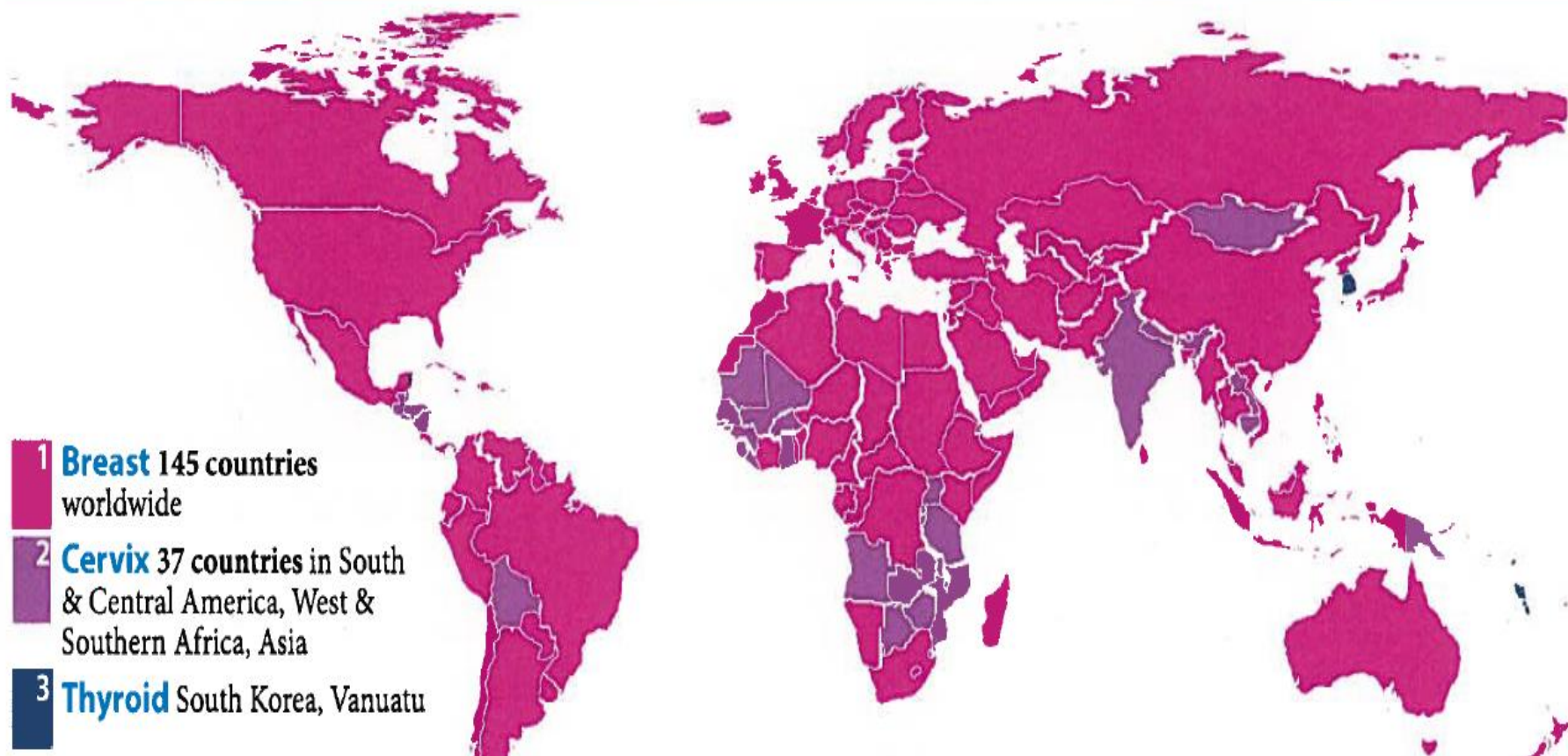
International Agency for Research on Cancer



Globocan 2012

THE BURDEN OF CANCER IN THE 21st CENTURY

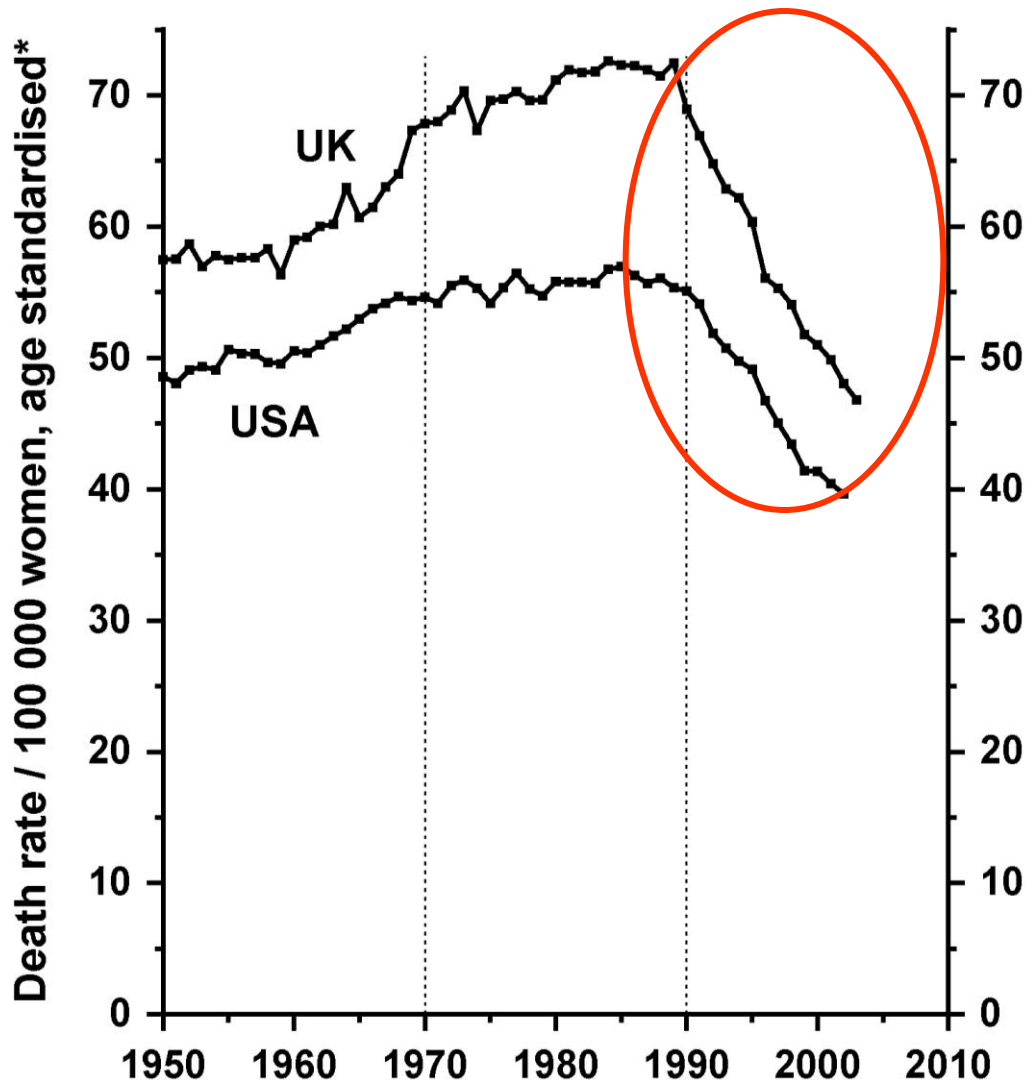
Most prevalent cancer by country – females



561,334 deaths worldwide in 2015 and an estimated **805,116 by 2030**, representing a 43% increase in absolute number of deaths from BC

UK and USA 1950–2003/2: Females
Breast cancer mortality at ages 35–69

EBC OUTCOME EVOLUTION



*Mean of annual rates in the seven component 5-year age groups

Source: WHO mortality & UN population estimates

Breast Cancer

Despite ↑ incidence - ↓ mortality

* Screening & early diagnosis

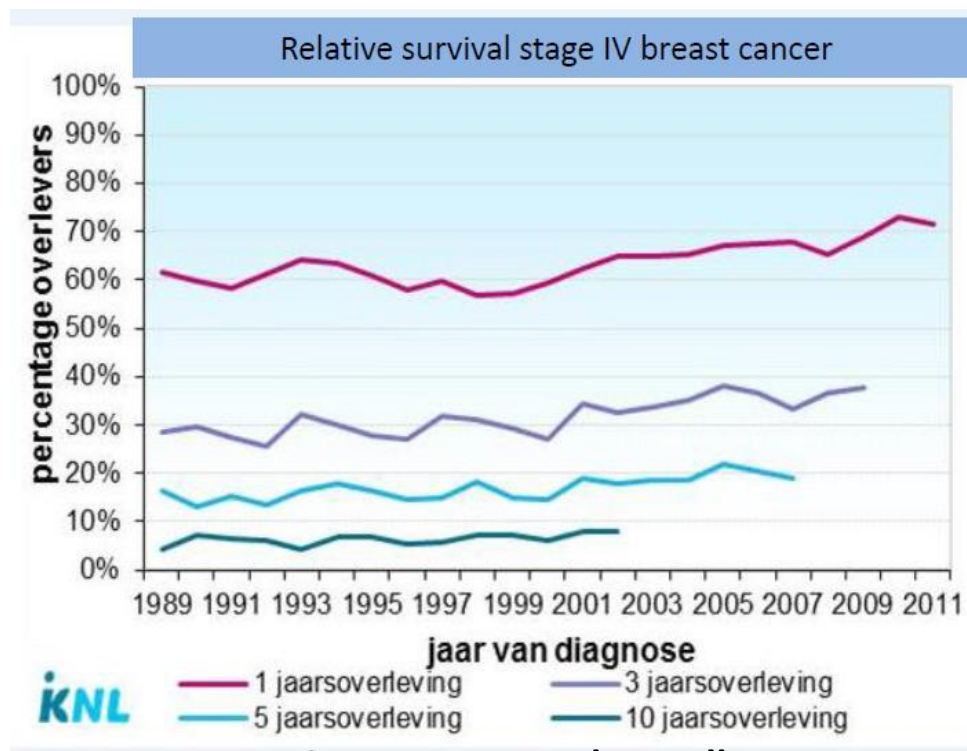
* Education & advocacy

but also

* Better treatment options

* Better treatment strategies

ABC OUTCOME EVOLUTION



Courtesy E. van der Wall

Only 1 out 4 ABC pts are alive at 5 years!

Median OS: 2 to 3 years!

In Europe :

1 diagnosis every 2,5 minutes

1 death every 6,5 minutes



MULTIDISCIPLINARY TEAM

Indispensable for

EBC

LABC

MBC

In CLINICAL PRACTICE & RESEARCH



MULTIDISCIPLINARY TEAM MEETING (MDT)

DEFINITION FROM THE UK DEPARTMENT OF HEALTH

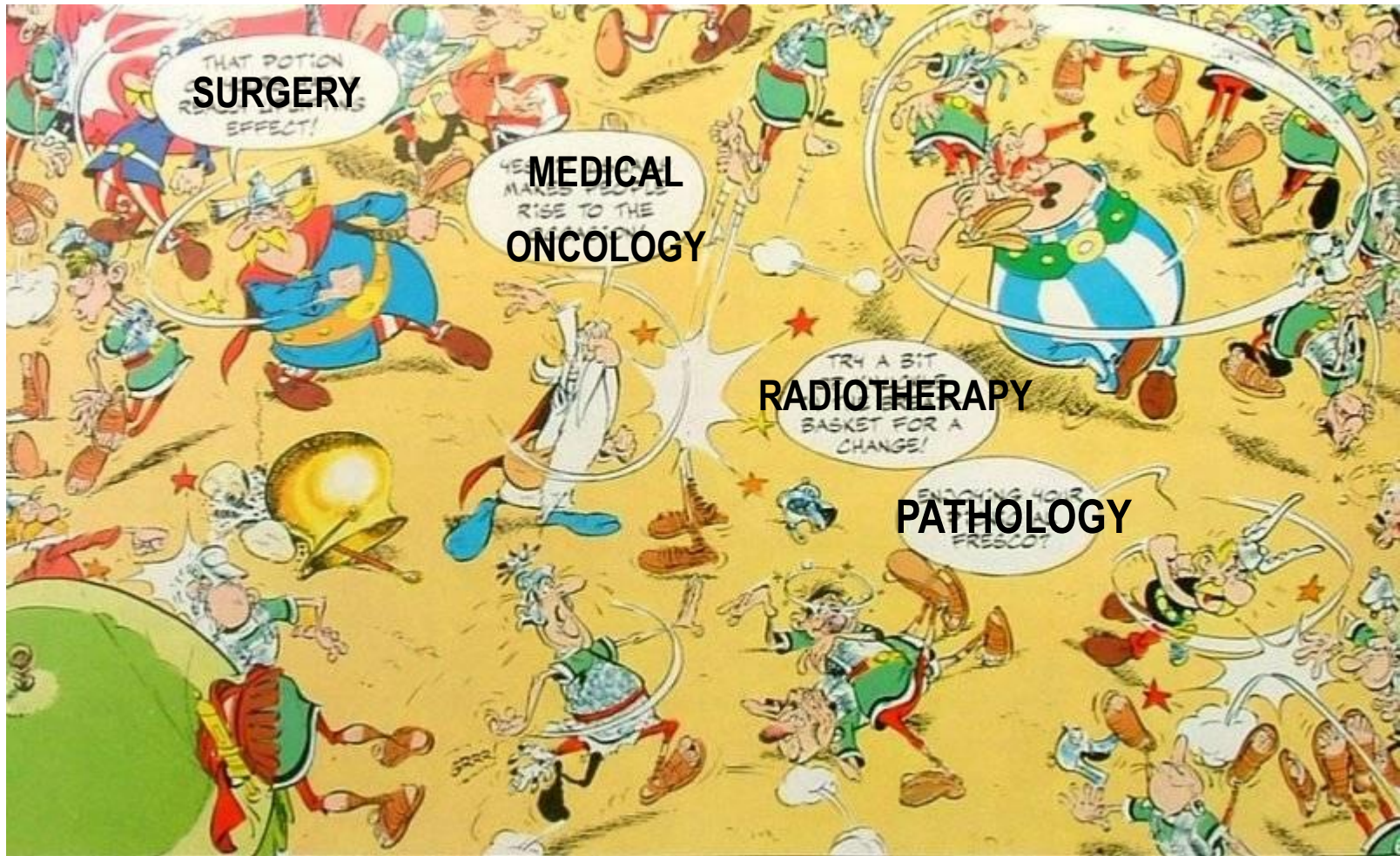
(in the UK, MDTs are MANDATORY by law)

“A group of people of different health care disciplines which meets together at a given time (whether physically in one place or by video or teleconferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient.”

DECISION MAKING TEAM



What a multidisciplinary meeting should NOT be:



THE EUSOMA BREAST UNITS REQUIREMENTS & CERTIFICATION SYSTEM

EUROPEAN JOURNAL OF CANCER 43 (2007) 660–675



available at www.sciencedirect.com



journal homepage: www.ejconline.com



Position Paper

Guidelines on the standards for the training of specialised health professionals dealing with breast cancer

L. Cataliotti^{a,*}, C. De Wolf^b, R. Holland^c, L. Marotti^d, N. Perry^e, K. Redmond^f,
M. Rosselli Del Turco^g, H. Rijken^c, N. Kearney^h, I.O. Ellisⁱ, A. Di Leo^j, R. Orecchia^k,
A. Noel^l, M. Andersson^m, W. Audretschⁿ, N. Bjurstam^o, R.W. Blamey^p, M. Blichert-Toft^m,
H. Bosmans^q, A. Burch^r, G. Bussolati^s, M.R. Christiaens^q, M. Colleoni^t, G. Cserni^u, T. Cufer^v,
S. Cush^w, J. Damilakis^x, M. Drijckoningen^q, P. Ellis^y, J. Foubert^z, M. Gambaccini^{aa},
E. Gentile^g, F. Guedea^{ab}, J. Hendriks^{ac,ap}, R. Jakesz^{ad}, J. Jassem^{ae}, B.A. Jereczek-Fossa^k,
O. Laird^{af}, E. Lartigau^{ag}, W. Mattheiem^{ah}, N. O'Higgins^{ai}, E. Pennery^{aj}, D. Rainsbury^{ak},
E. Rutgers^{al}, M. Smola^{am}, E. Van Limbergen^q, K. von Smitten^{an}, C. Wells^{ao}, R. Wilson^p,
on behalf of EUSOMA^{aq}

European Journal of Cancer (2013) xxx, xxx–xxx



Available at www.sciencedirect.com

ScienceDirect

journal homepage: www.ejcancer.com



The requirements of a specialist Breast Centre

A.R.M. Wilson^{a,*}, L. Marotti^b, S. Bianchi^c, L. Biganzoli^d, S. Claassen^e, T. Decker^f,
A. Frigerio^g, A. Goldhirsch^h, E.G. Gustafssonⁱ, R.E. Mansel^j, R. Orecchia^k, A. Ponti^g,
P. Poortmans^l, P. Regitnig^m, M. Rosselli Del Turcoⁿ, E.J.Th. Rutgers^o,
C. van Asperen^p, C.A. Wells^q, Y. Wengströmⁱ, L. Cataliotti^r

MULTIDISCIPLINARY TEAM MEETING (MDT)

European Journal of Cancer (2013) 49, 3579–3587



Available at www.sciencedirect.com

ScienceDirect

journal homepage: www.ejcancer.com



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C. van Asperen^p, C.A. Wells^q, Y. Wengströmⁱ, L. Cataliotti^r

Breast core team member: Radiologist, radiographer, surgeon, reconstructive surgeon, pathologist, medical oncologist, radiation oncologist, breast care nurse and data manager consistently spending at least part of their working time in breast cancer

MULTIDISCIPLINARY TEAM MEETING (MDT)

European Journal of Cancer (2013) 49, 3379–3387



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A.R.M. Wilson^{a,*}, L. Marotti^b, S. Bianchi^c, L. Biganzoli^d, S. Claassen^e, T. Decker^f,
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C. van Asperen^p, C.A. Wells^q, Y. Wengström^r, L. Cataliotti^r

The Breast Centre **must hold at least weekly a multidisciplinary case management meeting** (MDM) to discuss diagnostic preoperative and postoperative cases, as well as any other issue related to breast cancer patients, which requires multidisciplinary discussion. The Breast Centre **must discuss at least 90% of all breast cancer cases at MDM.**

... the following team members must be present: **radiologist, pathologist, medical oncologist, surgeon/oncoplastic surgeon, breast care nurse and radiation oncologist.** ... The other team members should be encouraged to attend and, in any case, should be reachable for consultation.

MULTIDISCIPLINARY TEAM MEETING (MDT)

- Many studies have shown the benefits of receiving treatment from a **specialist center**, and evidence continues to accrue from comparative studies of **clinical benefits of an MDT approach, including improved survival.**
- Yet we **lack randomized controlled trials** (very difficult to perform since MDTs are already implemented)

Effects of multidisciplinary team working on breast cancer survival: retrospective, comparative, interventional cohort study of 13 722 women



OPEN ACCESS

Eileen M Kesson *project manager*^{1,4}, Gwen M Allardice *statistician*^{1,4}, W David George *school of medicine honorary professor*², Harry J G Burns *chief medical officer for Scotland*³, David S Morrison *director*⁴

BMJ 2012;344:e2718 doi: 10.1136/bmj.e2718 (Published 26 April 2012)

Contemporaneous comparative design (thereby overcoming temporal bias); provided by the introduction of MDT-work in one but not other health boards in a region of Scotland.

Adjusting for case mix (including year of incidence, age at diagnosis, and deprivation), breast cancer mortality was 11% higher in the intervention area compared with other areas in the region, but **after MDTs were introduced, mortality was 18% lower than the other areas.**

CRUCIAL IMPORTANCE OF EXPERIENCE

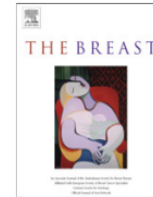
The Breast 21 (2012) 261–266



Contents lists available at SciVerse ScienceDirect

The Breast

journal homepage: www.elsevier.com/brst



Original article

Effect of hospital volume on processes of care and 5-year survival after breast cancer: A population-based study on 25 000 women

France Vrijens^{a,*}, Sabine Stordeur^{a,c}, Koen Beirens^{b,d}, Stephan Devriese^{a,c}, Elizabeth Van Eycken^{b,d}, Joan Vlayen^{a,c}

^a Belgian Health Care Knowledge Centre (KCE), Boulevard du Jardin Botanique, 55, B-1000 Brussels, Belgium

^b Belgian Cancer Register, Koningsstraat 215, B-1210 Brussels, Belgium

< 50 bcp vs > 150 bcp
75% vs 84% survival at 5
years

Conclusion: Survival benefits reported in high-volume hospitals suggest a better application of recommended processes of care, justifying the centralization of breast cancer care in such hospitals.

Compliance With Consensus Recommendations for Systemic Therapy Is Associated With Improved Survival of Women With Node-Negative Breast Cancer

Nicole Hébert-Croteau, Jacques Brisson, Jean Latreille, Michele Rivard, Nadia Abuleluz, and Ginette Martin

A B S T R A C T

From the Direction des systèmes de
santé et services, Institut national de
santé publique du Québec; Programme
d'oncologie, Hôpital Charles Lebel; Centre
intégral de lutte contre le cancer de
la Montérégie, Greenfield Park;
Unité de recherche en santé des popula-
tions, Hôpital du Saint-Sauveur;
Département de médecine sociale et
préventive, Université Laval, Québec;
Département de médecine sociale et
préventive, Université de Montréal; and
Département de chirurgie, Centre
hospitalier de l'Université de Montréal,
Montréal, Québec, Canada.

Submitted July 7, 2003; accepted April 7, 2004.

Supported by the Canadian Breast Cancer Research Alliance.

Part of the work was presented at the 2nd International Conference on Female

Purpose

Purpose The impact of consensus recommendations for systemic therapy on outcome of disease is unclear. We evaluated if compliance with guidelines for systemic adjuvant treatment is associated with improved survival of women with node-negative breast cancer.

Patients and Methods

Patients and Methods The study population included women diagnosed with invasive node-negative breast cancer in Québec, Canada, in 1988 to 1989, 1991 to 1992, and 1993 to 1994. Information was collected by chart review, linkage with administrative databases, and queries to attending physicians. Guidelines from the 1992 St Gallen conference were used as standard of care. Survival was estimated by Kaplan-Meier and Cox proportional hazards analyses.

Results

Results

Among 1,541 women, 358 died before December 1999. Median follow-up was 6.8 years. Annual event-free rates were 70%, 60% and 50% among low-, moderate- and high-risk groups, respectively. Survival was 86%, 84%, and 74% in women treated according to the consensus [98.4% of 370]. In women at minimal risk, adjusted hazard ratios of death were 1.0 [95% CI, 0.6 to 1.7] and 2.3 [95% CI, 1.3 to 4.0] among women at moderate risk treated according to the consensus or high risk, respectively. Both risk categories

Conclusion

Treatment
women v
treatment

One of the most important recommendations:

DISCUSS ALL EBC CASES IN A MDT!

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Oncology
0732-183X/04/2218-3685/\$20.00
DOI: 10.1200/JCO.2004.07.018

Practice guidelines are used to improve quality of care, reduce inappropriate interventions and control costs.^{1,2} Although several studies have shown reasonable compliance with consensus recommendations for treatment of breast cancer,³⁻⁸ their impact on survival remains unclear. A recent hospital-based investigation in Rhode Island showed higher

consistent with an extensive review of the available evidence that suggests a positive impact of clinical guidelines on both the process and outcome of care for several health conditions,¹⁰ although opposite views have been expressed.¹¹ Overall, however, population-based evaluations of the

MULTIDISCIPLINARY TEAM MEETING (MDT)

- **BARRIERS** to effective teamwork and poor decision-making: **excessive caseload, low attendance at meetings, lack of leadership, poor communication, role ambiguity, and failure to consider patients' holistic needs.**
- Existent **PROBLEMS:**
 - a) MDT are **not universally present**;
 - b) **most lack national or regional guidelines** regarding composition or practice to ensure consistency of provision;
 - c) often are **solely “medically” focused** (forgetting nurses, social workers, nutritionists, or palliative care specialists)

Taylor et al, Breast Cancer: Targets and Therapy 2013:5 79–85

MOST FREQUENTLY ONLY EBC CASES ARE DISCUSSED!

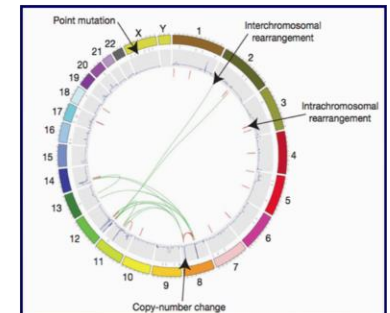
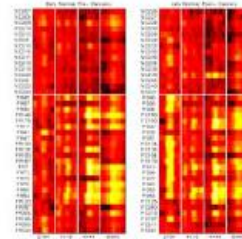
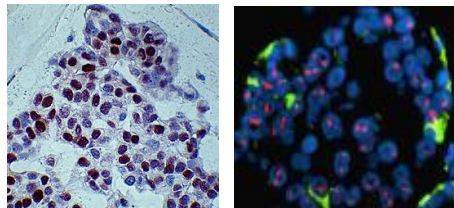
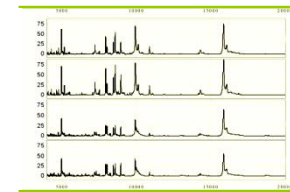
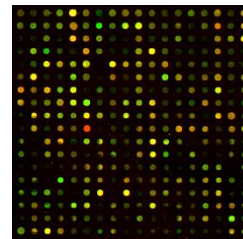
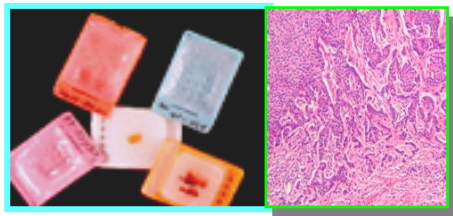
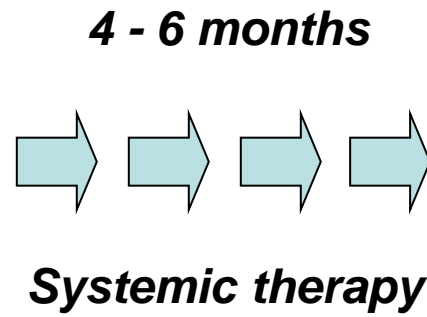
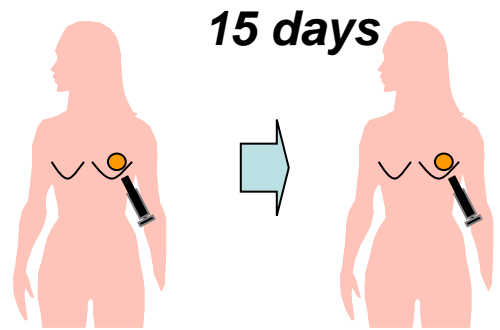


MULTIDISCIPLINARY TEAM

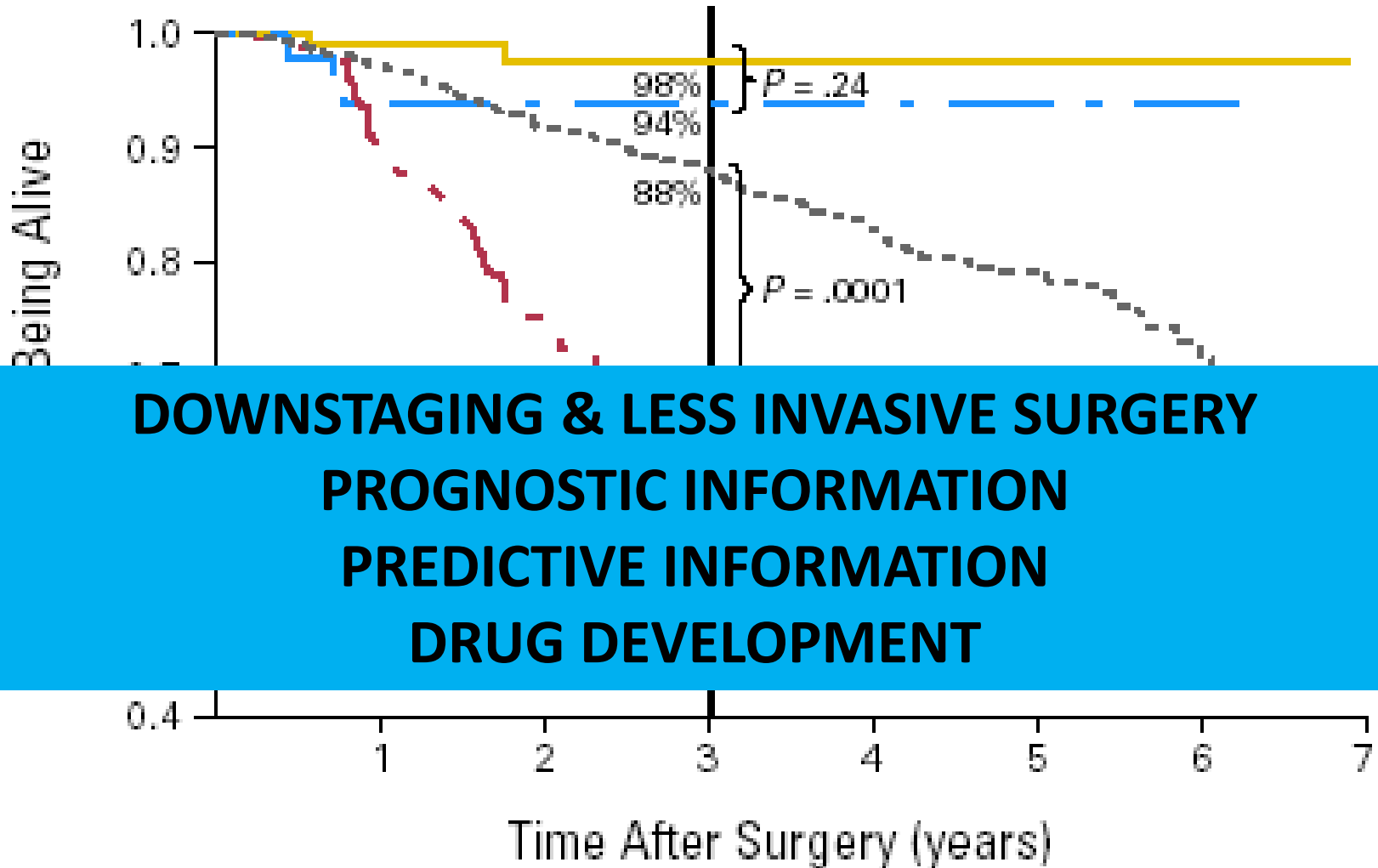
Indispensable for **EBC**



NEOADJUVANT SETTING



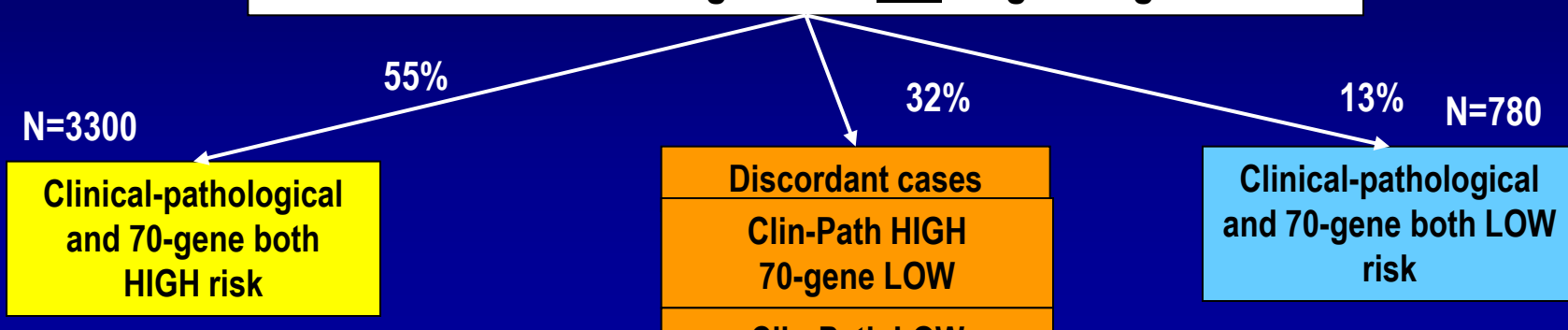
Overall survival as a function of response to neoadjuvant PCT



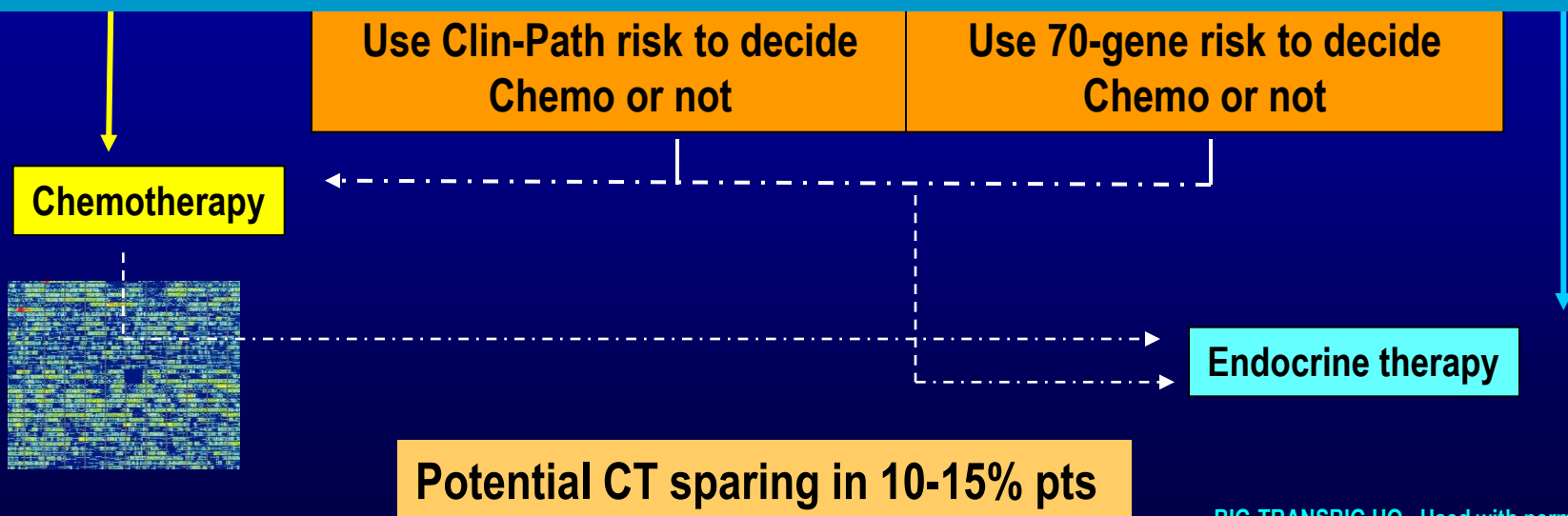
EORTC 10041 BIG 3-04 trial MINDACT TRIAL DESIGN

6,000 Node - & 1-3 N+ women

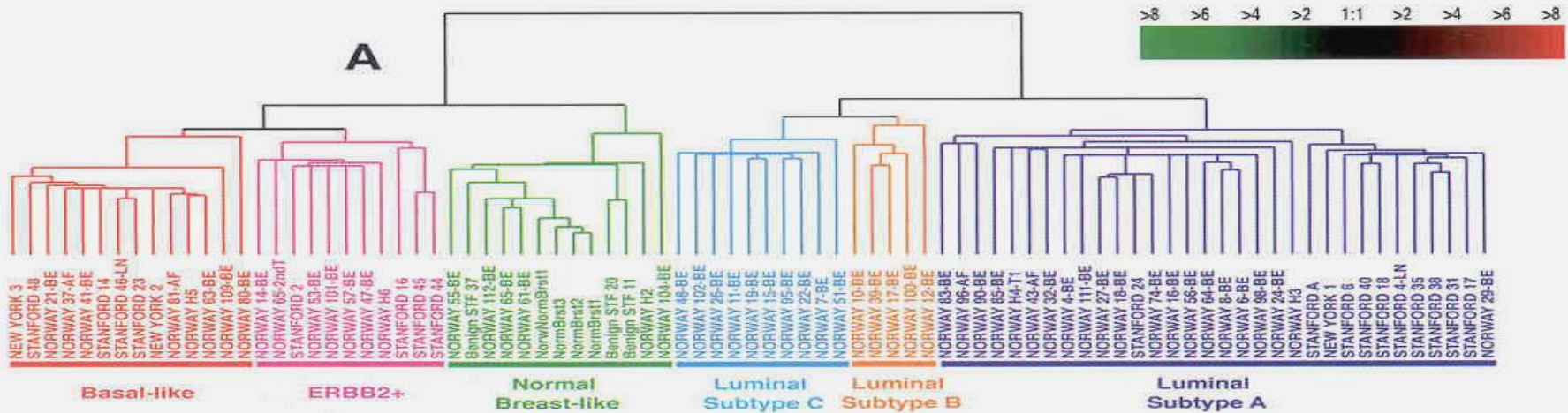
Evaluate Clinical-Pathological risk and 70-gene signature risk



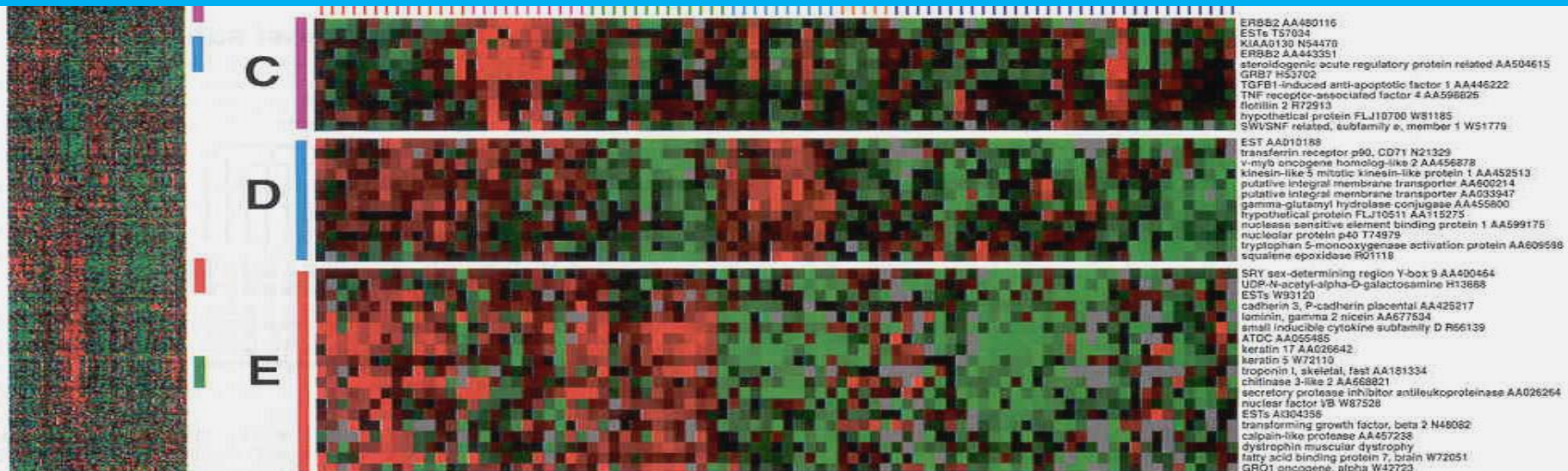
**RESULTS PRESENTED AT AACR 2016
& PUBLISHED IN NEJM 2016**



MOLECULAR CLASSIFICATION OF BREAST CANCER



THE ROLE OF THE MOLECULAR BIOLOGIST IN THE MULTIDISCIPLINARY TEAM





MULTIDISCIPLINARY TEAM
Indispensable for **LABC**





INOPERABLE LABC

Systemic therapy (not surgery or RT) should be the initial treatment.

If LABC remains inoperable after systemic therapy and eventual radiation, “palliative” mastectomy should not be done, unless the surgery is likely to result in an overall improvement in quality of life.

(LoE: Expert opinion) (100%)

A **combined treatment modality** based on a **multidisciplinary approach** (systemic therapy, surgery and radiotherapy) is strongly indicated in the vast majority of cases. (LoE: I A) (100%)

For inflammatory LABC, overall treatment recommendations are similar to those for non-inflammatory LABC, with **systemic therapy** as first treatment. (LoE: I B) (93%)

Mastectomy with axillary dissection is recommended in almost all cases, even when there is good response to primary systemic therapy. (LoE: I B) (95%)

Immediate reconstruction is generally not recommended in patients with inflammatory LABC (LoE: Expert opinion) (95%)

Loco-regional radiotherapy (chest wall and lymph nodes) is required, even when a pCR is achieved with systemic therapy. (LoE: I B) (98%)



MULTIDISCIPLINARY TEAM
Indispensable for **MBC**





GENERAL RECOMMENDATIONS

The management of ABC is complex and, therefore, involvement of all appropriate specialties in a **multidisciplinary team** (including but not restricted to medical, radiation, surgical oncologists, imaging experts, pathologists, gynecologists, psycho-oncologists, social workers, nurses and palliative care specialists), is **crucial (LoE: Expert opinion). (100%)**



TREATMENT - GENERAL

Treatment choice should take into account at least these factors:

HR & HER-2 status,
previous therapies and their toxicities, disease-free interval,
tumor burden (defined as number and site of metastases),
biological age, performance status, co-morbidities (including organ dysfunctions),
menopausal status (for ET),
need for rapid disease/symptom control

INDISPENSABLE PRESENCE OF OTHER HEALTH CARE PROFESSIONALS (besides physicians) IN THE MULTIDISCIPLINARY TEAM

TAILOR FOR THE PATIENT

TAILOR FOR THE DISEASE
both biologically and clinically

Target

INDIVIDUALIZED
TREATMENT





SURGERY OF THE PRIMARY

To date, the **removal of the primary tumor in patients with de novo stage IV breast cancer** has not been associated with prolongation of survival, with the possible exception of the subset of patients with bone only disease. **(LoE: 1B)**

However, it can be considered in selected patients, particularly to improve quality of life, always taking into account the patient's preferences.

Of note, some studies suggest that surgery is only valuable if performed with the same attention to detail (e.g. complete removal of the disease) as in patients with early stage disease. **(LoE: 2 B) (71%)**

Additional prospective clinical trials evaluating the value of this approach, the best candidates and best timing are currently ongoing.



A small but very important subset of patients with ABC, for example those with **oligo-metastatic disease or low volume metastatic disease** that is highly sensitive to systemic therapy, can achieve complete remission and a long survival.

A **multimodal approach**, including local-regional treatments with **curative intent**, should be considered for these selected patients.

(LoE: Expert opinion) (91%)

A prospective clinical trial addressing this specific situation is needed.



BRAIN METASTASES

MAIN MESSAGES:

- ✓ A **multi-disciplinary discussion** including neurosurgeons, radiation oncologists and medical oncologists is indispensable in determining the optimal treatment for each patient.
- ✓ The treatment plan can also be a **combination of these three available therapeutic approaches** (surgery, RT, radiosurgery).

THE SAME FOR BONE, LIVER, CHEST WALL METASTASES,

....

Optimal COLLABORATION is crucial

TEAM WORK



**THE BEST EXPERTISE IN EACH FIELD
DECIDING TOGETHER, FOR THE
BENEFIT OF THE PATIENT!**

European breast units manifesto

Theme:

Access to specialist, multidisciplinary breast cancer units (or centres or services)

Manifesto – ***CALL TO ACTION***

- The 2016 deadline for all patients in European Union countries to access specialist, multidisciplinary breast cancer units, or centres, will be missed by most countries, despite numerous resolutions and declarations issued since the year 2000 that have called for universal specialist services
- This means that many women, and some men, do not receive optimal breast cancer care in Europe
- We call on policymakers and politicians to ensure, as soon as possible, that ***all women and men with breast cancer in Europe are treated in a specialist breast unit***
- There is still time for a major step forward in 2016

In 2013 started the collaboration with ITALCERT in order to develop a scheme called «Breast Centres Certification» according to EUSOMA requirements

Breast Centres Certification



www.breastcentrescertification.com



European Cancer Care Certification

**Certification
procedures in
compliance with the
European Regulation
UNI CEI EN 45011-1999
UNI EN ISO 19011-2003**

EUROPEAN COMMISSION GUIDELINES AND ACCREDITATION PROJECT



A European Commission initiative
supporting **quality** in

breast cancer care:

*breast cancer guidelines
& quality assurance scheme
for breast cancer services*

The European Commission (EC), in response to the Council of the European Union's conclusions on reducing the burden of cancer, initiated a ground-breaking project to develop a European quality assurance (QA) scheme for breast cancer services underpinned by accreditation and referring to high quality, evidence-based guidelines.

- Will still be volunteer-basis

- Will cover all spectrum of cancer services

**There is nothing more fulfilling in your job than
working with the best team in the world!**



To do this, **we ask that** policymakers and politicians, together with healthcare professionals and patient advocates:

- **Promote**, in public and professional settings, the evidence that breast units staffed with specialist multidisciplinary teams **deliver superior care and quality of life** to women and men with breast cancer
- **Acknowledge** the evidence that treatment in multidisciplinary units leads to **overall cost savings** as well as **higher quality of care**
- **Audit** the current national provision of breast cancer care using **accredited auditors**
- **Implement mandatory reimbursement and care models** that mean treatment can only be carried out in specialist breast units
- **Introduce** a breast unit **quality scheme** that is **certified** by accredited bodies
- Join European-wide scientific societies and groups that **promote the availability and quality of breast units**, and together commit to providing access to such units for all patients

CERTIFICATION PROCEDURE QUALITY INDICATORS

EUROPEAN JOURNAL OF CANCER 46 (2010) 2344–2356



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available at www.sciencedirect.com



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Position Paper

Quality indicators in breast cancer care

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T. Decker ^g, M. Dietel ^c, O. Gentilini ^h, T. Kuehn ^k, M.P. Mano ^j, P. Mantellini ⁱ, L. Marotti ^a,
P. Poortmans ^l, F. Rank ^m, H. Roe ⁿ, E. Scaffidi ^h, J.A. van der Hage ^o, G. Viale ^p, C. Wells ^q,
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