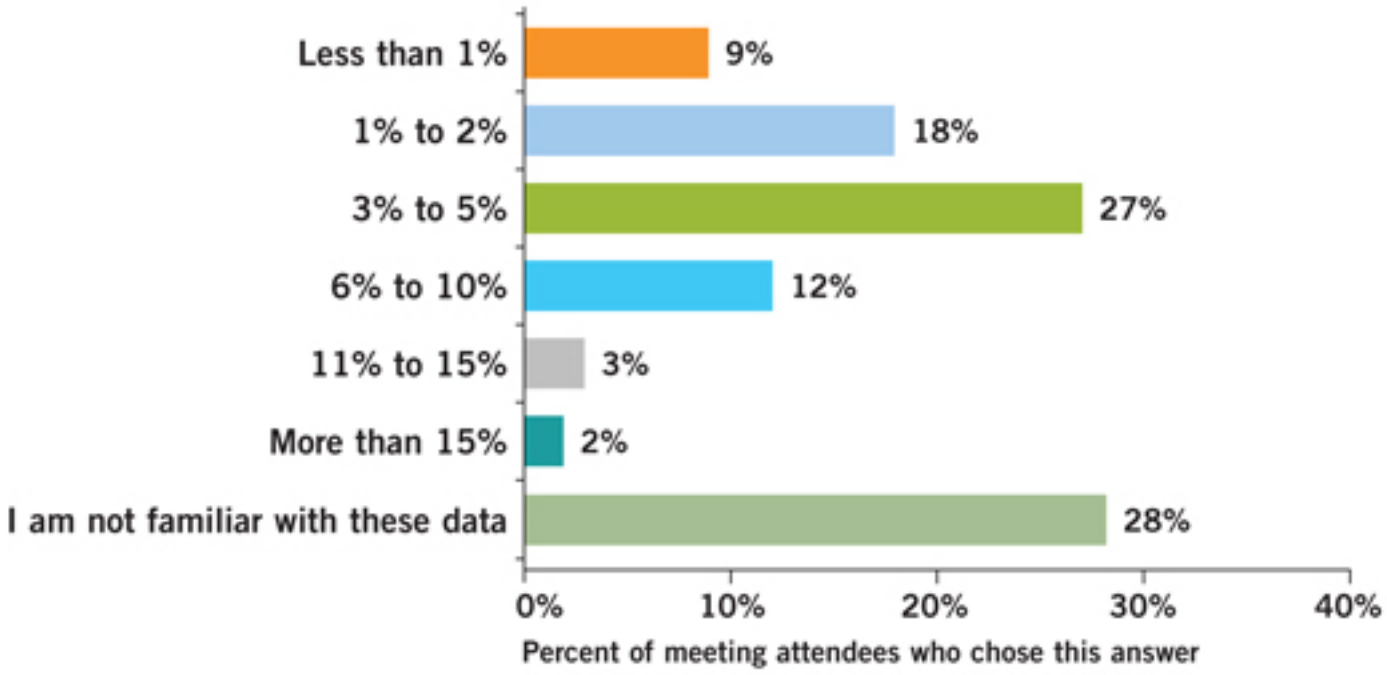
Year in Review

Proceedings from a Multitumor CME Symposium Focused on the Application of Emerging Research Information to the Care of Patients with Common Cancers

Genomic Assays, Novel Agents and Treatment Strategies for ER-Positive Breast Cancer — Howard A Burris III, MD

Based on the just-reported results of the TAILORx trial, what is the risk of breast cancer recurrence in patients with node-negative tumors and 21-gene Recurrence Scores of 0 to 10?



DR LOVE: This question, we were just kind of curious whether people had seen — this was presented in Vienna, I think it was 2 weeks ago. And as is the case nowadays, incredible simultaneous publication in the *New England Journal* of the TAILORx study. I guess the answer here, Skip, I think, is 1.3%.

DR BURRIS: Correct. The data is interesting.

DR LOVE: Could you just clarify what that was?

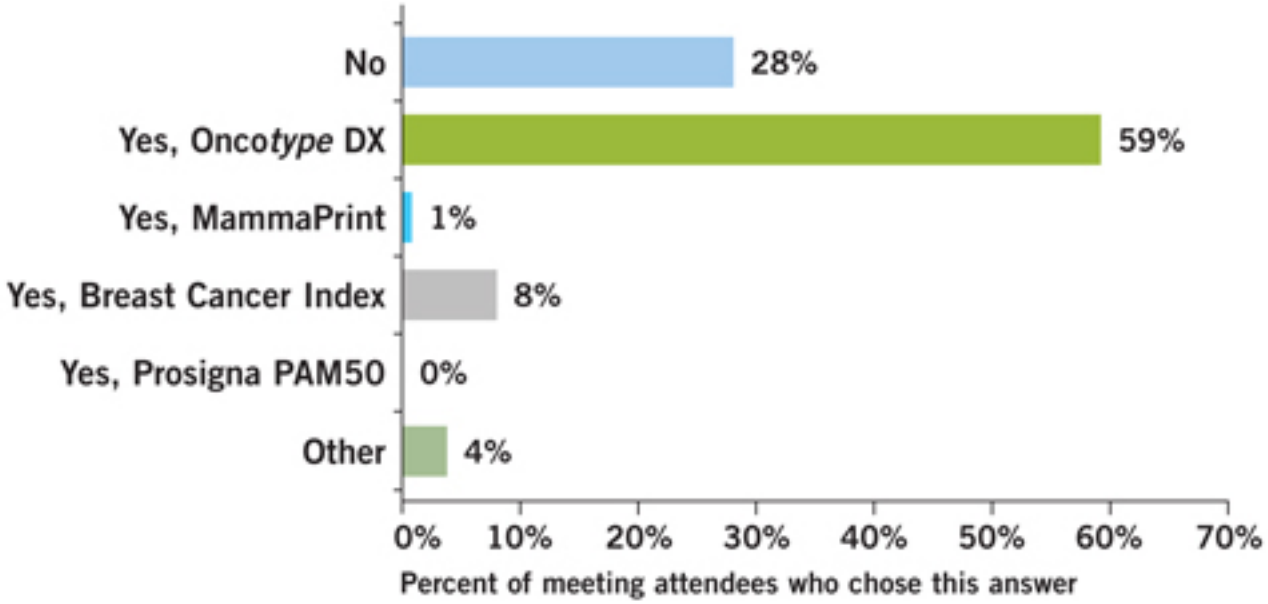
DR BURRIS: In the TAILORx trial, remember, we had patients classified by the 21-gene Recurrence Score into low, intermediate or high groups. The high groups got chemotherapy, the low groups were treated with hormonal therapy and, in the middle, the randomization, 6,000-plus women who received either hormonal therapy or chemotherapy. In this trial, this low-risk group, 1.3% of patients actually had a recurrence. Less than 1% had a distant recurrence. It was more common that you got a second cancer and died from a second cancer than dying from breast cancer in the low group. So the impact for the hormonal therapy in low-risk is impressive and certainly advocated that no additional therapy was needed.

DR LOVE: Ruth, one of the docs came up to me ahead of time, just 15 minutes ago, and said, "Why did they make it look at 0 to 10? We're used to thinking about 0 to 13." How do you, yourself, Ruth, think about what you consider low? Is it a continuum to some extent?

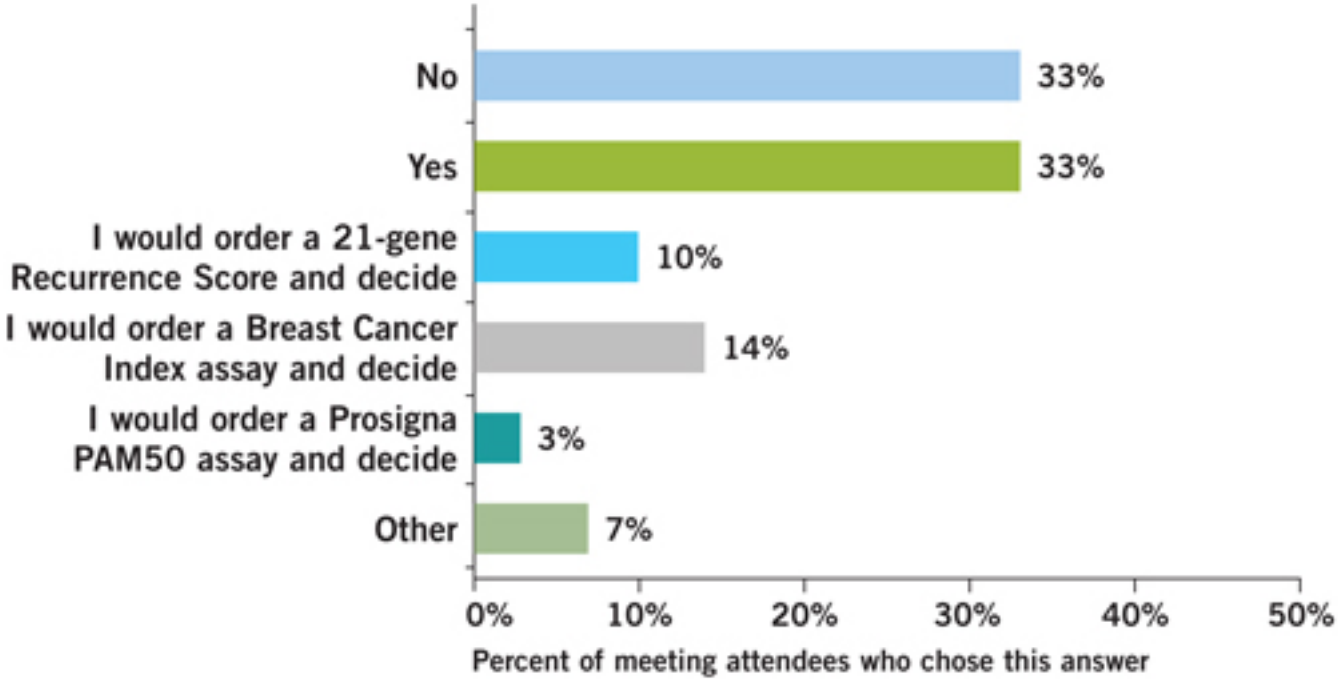
DR O'REGAN: I think it is a continuum. I still kind of buy into: Up to 18, you don't get really much benefit from chemo. I think these results are impressive because they're confirmatory for what we would have thought. I think we would have been very worried if we hadn't seen something like this. The other caution with this data is: It's relatively short follow-up for these kind of luminal A, low Recurrence Score cancers. So obviously it's something that we need to follow going forward. But I think it's nice to have this data because I think, at least now, we know that we should be very comfortable in these very low scores not giving them chemo. Obviously, this probably will translate into the node-positive setting as well.

DR LOVE: It's interesting when you look at that paper, Kim, more than 90% of the people in the study had tumors more than a centimeter. There was a time — the last time I remember was 2000 NIH Consensus Conference — 1-cm tumor or over, you're getting chemo. So pretty much 90% of these people would have gotten chemo, an amazing statement on how things are going in practice.

A 60-year-old woman is s/p breast-conserving treatment for a 0.9-cm, ER-positive/HER2-negative, node-negative IDC. In general, would you likely order a genomic tumor assay?



A 60-year-old woman is s/p breast-conserving treatment for a 3.2-cm, ER-positive/HER2-negative, node-negative IDC. The patient receives AC → T adjuvant chemotherapy followed by anastrozole with good tolerance for 5 years. Would you continue the aromatase inhibitor?



DR LOVE: Another situation where genomic assays have been discussed, Ruth, is at 5 years. As we've been looking at various assays, when you look, there's, in some patients, a significant risk of recurrence between 5 and 10. Some of the assays that are out there, you can pick up people who have maybe 15% to 18% chance of recurrence in years 5 to 10.

So we presented a situation. It's the same patient. She doesn't get an Onco*type*. She gets chemo, the way you would think for 3.2 centimeters if you didn't have genomic information, gets anastrozole, gets out to 5 years and is doing fine. Would you continue? The audience is split between yes and no, and they would get some kind of genomic assay to decide. It looks like a few more people would use the Breast Cancer Index. What do you do, Ruth?

DR O'REGAN: I think the problem with the aromatase inhibitors — there's really no data right now on continuing beyond 5 years. That said, I do use Breast Cancer Index in this scenario, and I have found it somewhat useful. I'm not sure I'm willing, based on the numbers from the MA.17 analysis, to say if there's a low likelihood of benefit that I'm not going to give them extended therapy. But certainly if there's a high likelihood, at least it's confirmatory for patients, because a lot of times they don't want to stay on the medication. But we are still waiting for the results of the aromatase inhibitor through 5 years data, which we don't have yet. So even though I would say, "No, because there's no data," I might consider sending Breast Cancer Index and continuing treatment if it came back with a high likelihood of benefit.

DR LOVE: We have the 2015 method of doing a consensus, which is: We ask people what they do. If everybody does the same thing, it's a consensus. And if they don't, it's not a consensus. So let's see. Ruth says she'd get a Breast Cancer Index. Skip, you've got this 3.2-cm tumor. She's out to 5 years. Stop, continue or genomic assay?

DR BURRIS: Genomic assay.

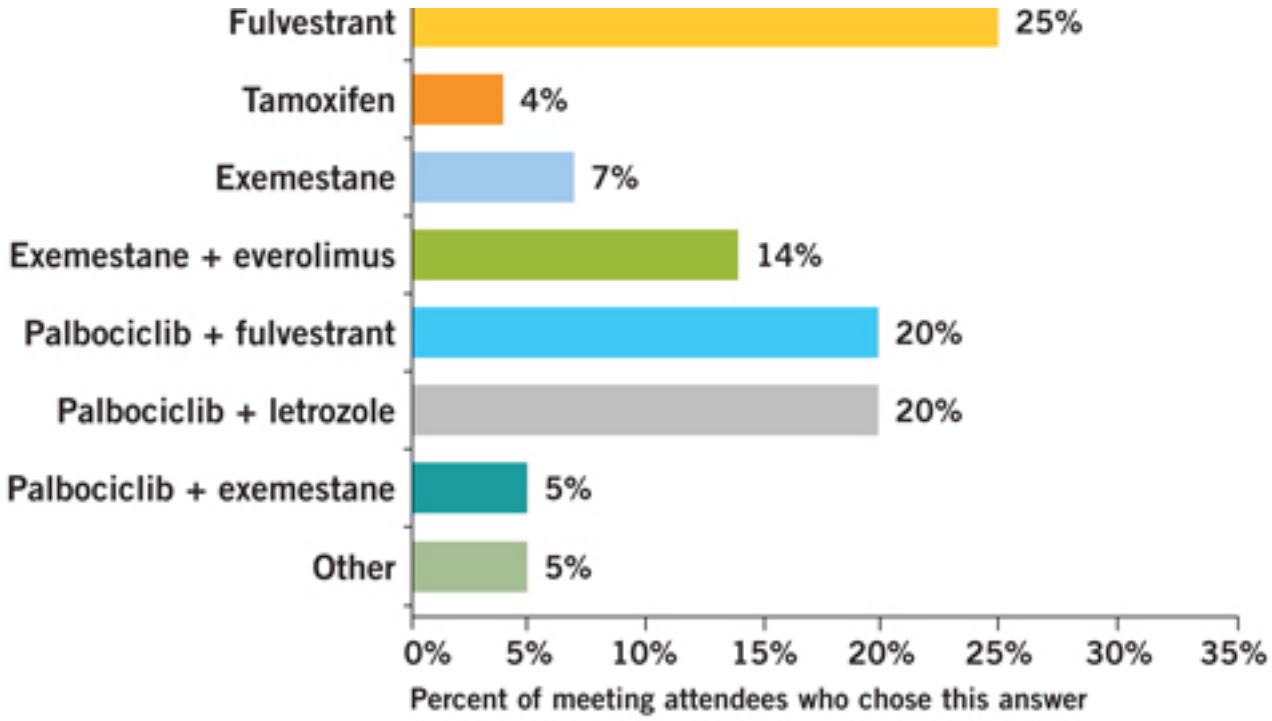
DR LOVE: Which one?

DR BURRIS: The BCI, the Breast Cancer Index. And one thing, just to plug how important these educational programs are — until you sent me this data to present, I'd ordered one Breast Cancer Index. Women that are on hormonal therapy, doing well, many times it's a point about whether they'd want to continue or not. Women that are not doing well, they want to get off of them. But after reading the data, reading the papers, I'll be ordering more BCIs than I did prior to coming to this meeting.

DR LOVE: Kim, let's see if we have a consensus. Three point two centimeters. Yes, no or genomic assay?

DR BLACKWELL: My answer would be yes, and obviously there's permutations of the patient whose life has been made miserable with an aromatase inhibitor. But in general if I've made her life miserable in the first 2 years with an AI, then she's already on tamoxifen. We have good data continuing that past the 5-year point. So I think in general you get a good sense of tolerability and impact on quality of life with the AIs long before you hit the 5-year point. For those patients who are doing just great on the AI, who want to stay on it, I don't think it's unreasonable to continue it. For the patients who just really can't decide, I would use a Breast Cancer Index. But I think I've ordered two.

In general, which endocrine treatment would you recommend for a postmenopausal woman with ER-positive/HER2-negative breast cancer who develops minimally symptomatic bone and lung metastases 2 years after starting anastrozole (in addition to bone-targeted therapy)?



In general, which endocrine treatment would you recommend for a postmenopausal woman with ER-positive/HER2-negative breast cancer who relapses after 2 years of adjuvant anastrozole and then receives fulvestrant/palbociclib with response for 11 months followed by disease progression?