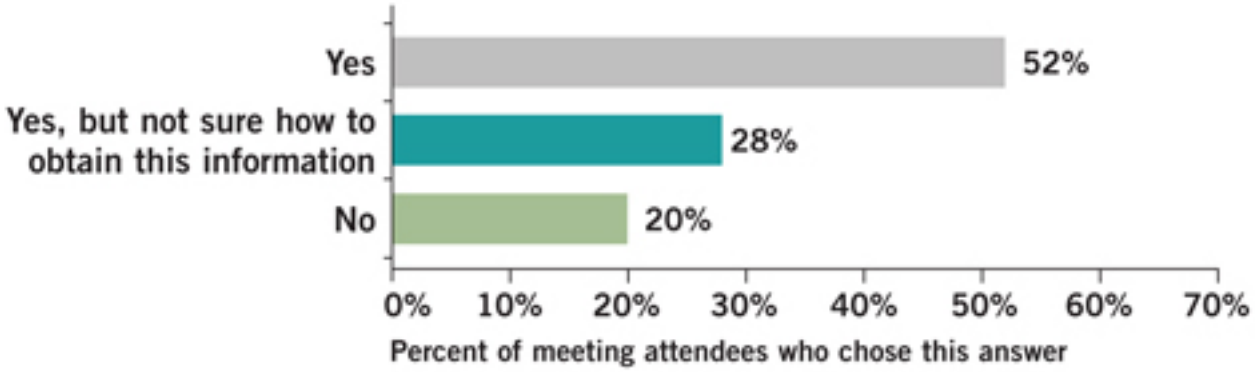
Year in Review

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

Triple-Negative Breast Cancer — Ruth O'Regan, MD

For a patient with refractory metastatic triple-negative breast cancer (TNBC) who wished to receive further treatment would you order a multiplex genomic assay such as next-generation sequencing?



DR LOVE: We're always asking this first question, which relates to next-generation sequencing. It's not uncommon in oncology today to have people who've gone through approved therapies, nonapproved therapies, and still are in pretty good condition, wanting to receive treatment.

So, Kim, we asked the audience: Would you consider for a patient with triple-negative disease, who's run out of options, sending it off for a multiplex assay such as next-gen sequencing? FoundationOne is a common one. The vast majority of this audience, Kim, says yes, which is really a change in practice. This isn't lung cancer we're talking about now, Kim. It's triple-negative breast cancer. Do you agree with the audience?

DR BLACKWELL: I would answer yes, but compared to where I was a year and a half ago, I'm a little underwhelmed as to how to use this information. A year and a half ago I would have said something like, "I'll order it. I'll find out what drives the tumor, mutational changes, and then I will seek out a clinical trial for my patient to participate in." And even today, we have the NCI MATCH trial, which, for other diseases, there are some very good options.

I think for breast cancer, the initial wave of drugs available through that trial are not all that exciting. Several of the drug companies have genomic detection and then matching it with a drug. In particular, Novartis has one.

So I'd order it because I'm data driven. I would bill it to — not bill financially but tout it to the patient as: This is probably not going to help, but I think the information will be valuable. I made a mistake a year and a half ago in using these assays, or even 2 years ago, where I'd say, "Let's do this, and we're going to figure out what's going to drive your tumor forward." And I've been overwhelmingly depressed at how very few hits I've gotten by ordering the assay. So I would order it, but I would certainly tout it to the patient as perhaps not going to be the end-all/be-all for our treatment decisions at the current time.

Consider the last patient in your practice with TNBC who died. Which of the following agents did that patient receive for metastatic disease?