INTERVIEW

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Tracks 1-21

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Track 1

DR LOVE: What are your thoughts about the AZURE trial results evaluating adjuvant zoledronic acid?

DR SWAIN: I have spoken to many younger patients about whether or not they should receive adjuvant bisphosphonates because of the prior Austrian study results (Gnant 2009). So the AZURE trial data were important because it was clearly a negative study (Coleman 2010). I don't buy into the subset analysis that showed a benefit in postmenopausal women.

The NSABP trial with adjuvant clodronate has not yet been reported, and that study could be a tiebreaker. However, I believe it is now clear that the routine use of adjuvant bisphosphonates is not a standard treatment.

Track 17

DR LOVE: What are your thoughts on the role of Onco*type* DX for younger patients?

DR SWAIN: Breast cancer in younger women is usually correlated with an increased risk of recurrence and decreased survival compared to older patients.

In view of this, many clinicians are concerned about making treatment decisions on the basis of the Onco*type* DX assay and not administering adjuvant chemotherapy to patients with breast cancer who are younger than age 40 if the Recurrence Score® (RS) is low.

We recently presented our findings at San Antonio from more than 5,000 women younger than age 40 in whom we found results similar to the rest of the breast cancer population. The only difference we found was that younger patients tended to have a higher proportion of tumors with high RS (Shak 2010; [1.1]).

I find these data interesting, and I hope they will convince clinicians that Onco*type* DX is a useful test in this group also.

1.1

Recurrence Score (RS) in a Large Cohort of Patients in Three Separate Age Groups

		RS group		
Patient age (in years) (n)	Median RS	RS < 18	RS 18-30	RS ≥ 31
≤40 (5,794)	18.8	45.7%	39.4%	14.9%
41-69 (117,744)	17.0	55.4%	35.0%	9.6%
≥70 (21,702)	16.7	56.1%	33.5%	10.4%
All patients (145,240)	17.0	55.1%	35.0%	9.9%

"A wide range of RS was observed across all age groups. Many younger patients have low-RS disease, and many older patients have high-RS disease. These data also indicate that, for ER-positive breast cancer, age does not predict individual tumor biology."

Shak S et al. San Antonio Breast Cancer Symposium 2010;**Abstract P3-10-01**.

Track 18

DR LOVE: What are your thoughts on the Recurrence Score-Pathology-Clinical (RSPC), reported by your group, the NSABP, and developed as an integration of RS and clinicopathologic factors, including age, tumor size or tumor grade, in node-negative, ER-positive breast cancer?

DR SWAIN: Physicians use clinicopathologic features all the time in everyday practice. The goal of the RSPC is to objectively refine that information, especially for a patient with an intermediate RS.

What has been shown is that RSPC downgrades approximately 10 percent of cases from intermediate risk to low risk, but the final conclusions are that RS used alone remains the best predictor of chemotherapy benefit in ER-positive, node-negative breast cancer and the interaction of RSPC with treatment is not significant, although the trend was in the same direction as RS (Tang 2010).

Track 19

DR LOVE: Where are we in terms of evaluating RS in patients with node-positive breast cancer?

DR SWAIN: SWOG is planning a prospective study, SWOG-S1007, which will evaluate Onco*type* DX in patients with ER-positive, node-positive breast cancer. The study will randomly assign patients with an RS less than 25 to either receive chemotherapy or not. I believe it is the correct study to conduct, but it might make some physicians nervous when randomly assigning patients with positive nodes to receive or not receive adjuvant chemotherapy because there is an overall risk of recurrence of approximately 40 percent, even in patients with a low RS. ■

SELECT PUBLICATIONS

Coleman RE et al. **Adjuvant treatment with zoledronic acid in Stage II/III breast cancer. The AZURE trial (BIG 01/04).** San Antonio Breast Cancer Symposium 2010;**Abstract S4-5**.

Eng-Wong J et al. **Prediction of benefit from adjuvant treatment in patients with breast cancer.** *Clin Breast Cancer* 2010;10(Suppl 1):E32-7.

Gnant M et al. **Endocrine therapy plus zoledronic acid in premenopausal breast cancer.** *N Engl J Med* 2009;360(7):679-91.

Kelly CM et al. **Utility of Onco*type* DX risk estimates in clinically intermediate risk hormone receptor-positive, HER2-normal, grade II, lymph node-negative breast cancers.** *Cancer* 2010;116(22):5161-7.

Shak S et al. **Quantitative gene expression analysis in a large cohort of estrogen-receptor positive breast cancers: Characterization of the tumor profiles in younger patients (≤40 yrs) and in older patients (≥70 yrs).** San Antonio Breast Cancer Symposium 2010;**Abstract P3-10-01**.

Tang G et al. **Comparing the prediction of chemotherapy benefit in patients with node-negative, ER-positive breast cancer using the recurrence score and a new measure that integrates clinical and pathologic factors with the recurrence score.** San Antonio Breast Cancer Symposium 2010;**Abstract S4-9**.