



INTERVIEW

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Tracks 1-21

- Track 1** AZURE trial: Adjuvant zoledronic acid in early breast cancer (BC)
- Track 2** Neoadjuvant trials of chemotherapy/anti-HER2 therapy for patients with HER2-positive early BC
- Track 3** Lapatinib-associated diarrhea
- Track 4** Selection of anti-HER2 therapy for patients with HER2-positive metastatic BC
- Track 5** Mechanism of action of pertuzumab
- Track 6** Neoadjuvant studies in operable HER2-positive BC
- Track 7** Choice of adjuvant chemotherapy for HER2-positive, node-positive BC
- Track 8** Neoadjuvant and adjuvant studies of pertuzumab for HER2-positive BC
- Track 9** Rationale for and activity of bevacizumab combined with trastuzumab in HER2-positive BC
- Track 10** Upcoming NSABP trials for HER2-positive early BC
- Track 11** Activity of T-DM1 in heavily pretreated, HER2-positive metastatic BC
- Track 12** Perspective on the use of bevacizumab in metastatic BC
- Track 13** PARP inhibitors and BRCA testing in triple-negative BC (TNBC)
- Track 14** Microtubule stabilizing agents in BC
- Track 15** NCCTG-N9831 and BCIRG 005/006 studies: Round-robin review of HER2 testing in the context of adjuvant therapy for BC
- Track 16** Results of clinical trials incorporating capecitabine into the adjuvant treatment of early BC
- Track 17** Role of *Oncotype DX*[®] for younger patients with ER-positive BC
- Track 18** RSPC — Recurrence Score-Pathology-Clinical as an additional prognostic factor
- Track 19** Use of *Oncotype DX* in patients with node-positive tumors
- Track 20** 500-mg monthly fulvestrant dosing in ER-positive metastatic BC
- Track 21** Neoadjuvant aromatase inhibitors in ER-positive BC

Select Excerpts from the Interview

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 *Oncotype 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 *Oncotype 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 *Oncotype 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**

Patient age (in years) (n)	Median RS	RS group		
		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 *Oncotype 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 *Oncotype 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.**