



INTERVIEW

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- Track 2** Impact of *Oncotype* DX Recurrence Score on selection of adjuvant therapy for ER-positive, node-negative BC
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- Track 15 Case discussion:** A 30-year-old BRCA1-positive woman with a family history of BC presents with a 6-cm, node-negative TNBC with 8-mm residual disease after neoadjuvant dose-dense AC → dose-dense paclitaxel in combination with bevacizumab followed by mastectomy
- Track 16** Activity of bevacizumab for patients with TNBC in the neoadjuvant setting
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- Track 23 Case discussion:** A 45-year-old woman with a 2.5-cm, Grade II, ER/PR-positive, infiltrating ductal carcinoma with 1 positive node is found to have an *Oncotype* DX Recurrence Score of 43 after receiving 3 out of 4 planned cycles of docetaxel/cyclophosphamide

Select Excerpts from the Interview

Tracks 1-5

Case discussion

A 52-year-old premenopausal woman with a 7.5-cm, ER/PR-positive, HER2-negative, node-negative interval BC with ductal and lobular features

► **DR OVERMOYER:** This woman had a mammogram 1 year earlier, with good follow-up, but she subsequently presented to her primary care physician with a palpable mass in her breast. Imaging revealed numerous microcalcifications and a biopsy confirmed invasive ER-positive, HER2-negative invasive carcinoma. She decided to undergo a simple mastectomy. She was also experiencing dysfunctional vaginal bleeding and anticipated undergoing total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH-BSO).

I was leaning toward primary hormonal therapy, but I informed her nothing was wrong with receiving chemotherapy in this setting and that with a tumor this large, many physicians would recommend it. I proposed the *Oncotype DX* assay to her, and she was very much in favor of it. I understand the assay is not perfect, but it does provide a lot of information that reflects the biology of this disease.

I always discuss with patients beforehand what our objectives will be if they receive an intermediate Recurrence Score — proceed with adjuvant chemotherapy or not. This decision must be made up front. Fortunately, her Recurrence Score was 6, which is low. She subsequently underwent a TAH-BSO and has been receiving an aromatase inhibitor for the past 2 years without any evidence of disease.

► **DR LOVE:** If this patient's tumor were not as large and you were considering neoadjuvant therapy, would you consider ordering an *Oncotype DX* assay to help guide the preoperative decision-making process?

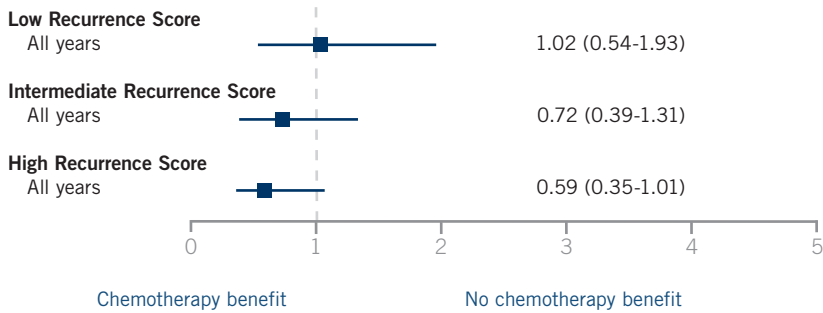
► **DR OVERMOYER:** I do order an *Oncotype DX* assay in this setting, and if the Recurrence Score is low, I feel comfortable administering primary endocrine therapy, and I inform the patient that it's going to take a longer time to get the adequate response that we want.

► **DR LOVE:** What is your approach for a patient with node-positive disease, in terms of the role of assays like *Oncotype DX*?

► **DR OVERMOYER:** Analysis of data from the SWOG-8814 trial supports a correlation between *Oncotype DX* Recurrence Score and outcome in terms of prognosis for postmenopausal patients with node-positive disease (Albain 2010; [3.1]). Unless my patient is highly motivated to go forward with chemotherapy, I discuss the role of the *Oncotype DX* assay for patients who have 1 to 3 positive nodes.

I also feel comfortable in pursuing *Oncotype DX* analysis to ascertain whether I should administer chemotherapy for patients who are receiving radiation therapy after breast conservation surgery in which a sentinel lymph node dissection has revealed 1 out of 3 involved sentinel lymph nodes without a completion axillary lymph node dissection, following the data from ACOSOG-Z0011.

Disease-Free Survival Hazard Ratios (95% CI) for Tamoxifen Alone versus CAF → Tamoxifen in Patients with ER-Positive, Node-Positive Breast Cancer According to OncoType DX Recurrence Score Risk Group



CI = confidence interval

Albain KS et al. *Lancet Oncol* 2010;11(1):55-65.

Tracks 7-10

Case discussion

A 37-year-old woman with a 4.6-cm, Grade III, ER/PR-negative, HER2-positive, LVI-positive breast cancer with 11 of 14 positive nodes receives adjuvant TAC without trastuzumab in another country in 2007, and her disease recurs with pulmonary metastases 1 year later

► **DR OVERMOYER:** In February 2008 this patient presented with asymptomatic pulmonary metastases and received capecitabine/trastuzumab until disease progression. She was switched to vinorelbine/trastuzumab and tolerated it well for 1 year. I discussed stopping the vinorelbine, which brings up the issue of how long one should continue chemotherapy in patients with metastatic disease. Older data suggest that continuous chemotherapy isn't more effective, but that may not be true with newer agents. I don't know the correct answer, but I was concerned about causing so much bone marrow suppression that I wouldn't be able to administer adequate doses when her disease progressed.

So she continued trastuzumab monotherapy until October 2009 before she experienced minimal disease progression in her lungs. I always like to avoid chemotherapy if possible, and she received lapatinib/trastuzumab until March 2010 before her disease progressed again. At that time, she enrolled on a Phase I study with T-DM1, pertuzumab and paclitaxel and experienced a rapid complete response after 2 cycles. T-DM1 has significantly affected patients who have received a lot of prior HER2-directed therapy, and I look forward to this drug receiving FDA approval. ■

SELECT PUBLICATIONS

Albain KS et al. **Prognostic and predictive value of the 21-gene recurrence score assay in postmenopausal women with node-positive, oestrogen-receptor-positive breast cancer on chemotherapy: A retrospective analysis of a randomised trial.** *Lancet Oncol* 2010;11(1):55-65.

Solin LJ et al. **A quantitative multigene RT-PCR assay for predicting recurrence risk after surgical excision alone without irradiation for ductal carcinoma in situ (DCIS): A prospective validation study of the DCIS score from ECOG E5194.** San Antonio Breast Cancer Symposium 2011; **Abstract S4-6.**