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PRIMARY TREATMENT OF EARLY BREAST CANCER ST. GALLEN 2017

ESCALATING AND DE-ESCALATING TREATMENT IN EARLY BREAST CANCER ACROSS SUBTYPES AND TREATMENT MODALITIES

Consensus and Controversy

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International Consensus Panel 2017

Chairpersons: G. Curigliano (Italy), E. P. Winer (USA)

Consensus Writing Committee: G. Curigliano (Italy), H. Burstein (USA), M. Colleoni (Italy), P. Dubsky (Austria/Switzerland), M. Gnant (Austria), S. Loibl (Germany), M. Piccart (Belgium), M. Regan (USA), H.-J. Senn (Switzerland), B. Thuerlimann (Switzerland), E. P. Winer (USA)

Fabrice André (France)
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Fatima Cardoso (Portugal)
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Eva Ciruelos (Spain)
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Viviana Galimberti (Italy)
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Pamela J. Goodwin (Canada)
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Daniel F. Hayes (USA)
Chiun-Sheng Huang (Taiwan)
Jens Huober (Germany)
Hussein Khaled (Egypt)
Jacek Jassem (Poland)
Zefei Jiang (PR China)
Per Karlsson (Sweden)
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Roberto Orecchia (Italy)
C. Kent Osborne (USA)
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Ann Partridge (USA)
Kathleen I. Pritchard (Canada)
Jungsil Ro (Korea)
Emiel J.T. Rutgers (The Netherlands)
Felix Sedlmayer (Austria)
Vladimir Semiglazov (Russian Fed.)
Zhiming Shao (PR China)
Ian Smith (UK)
Masakazu Toi (Japan)
Andrew Tutt (UK)
Toru Watanabe (Japan)
Timothy Whelan (Canada)
Binghe Xu (PR China)

Expert Opinion on Areas of Controversy

- Escalation and de-escalation of treatment are major issues for management of early breast cancer
- Evidence from randomized clinical trials does not cover all controversies that arise in treating individuals
- The opinion of the panel members is used to implement guidance for controversial issues
- When data are lacking, expert opinion can be used
- This is the unique feature of the St. Gallen International Consensus

Panelists' Answers

- Questions have been prospectively reviewed by the panelists and revised to be as clear as possible.
- Panelists are asked to answer either

1 Yes or *2 No*

for most questions
or in certain cases

select from mutually exclusive choices, *1, 2, 3, 4,* etc.

- Option for *Abstain* if Panelist has insufficient data, lack of specific expertise on the issue, or conflict of interest. Do not hesitate to abstain, if appropriate.

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Practice Question

T1. The venue of the 2017 St.Gallen International Breast Cancer Conference is in Vienna/Austria?

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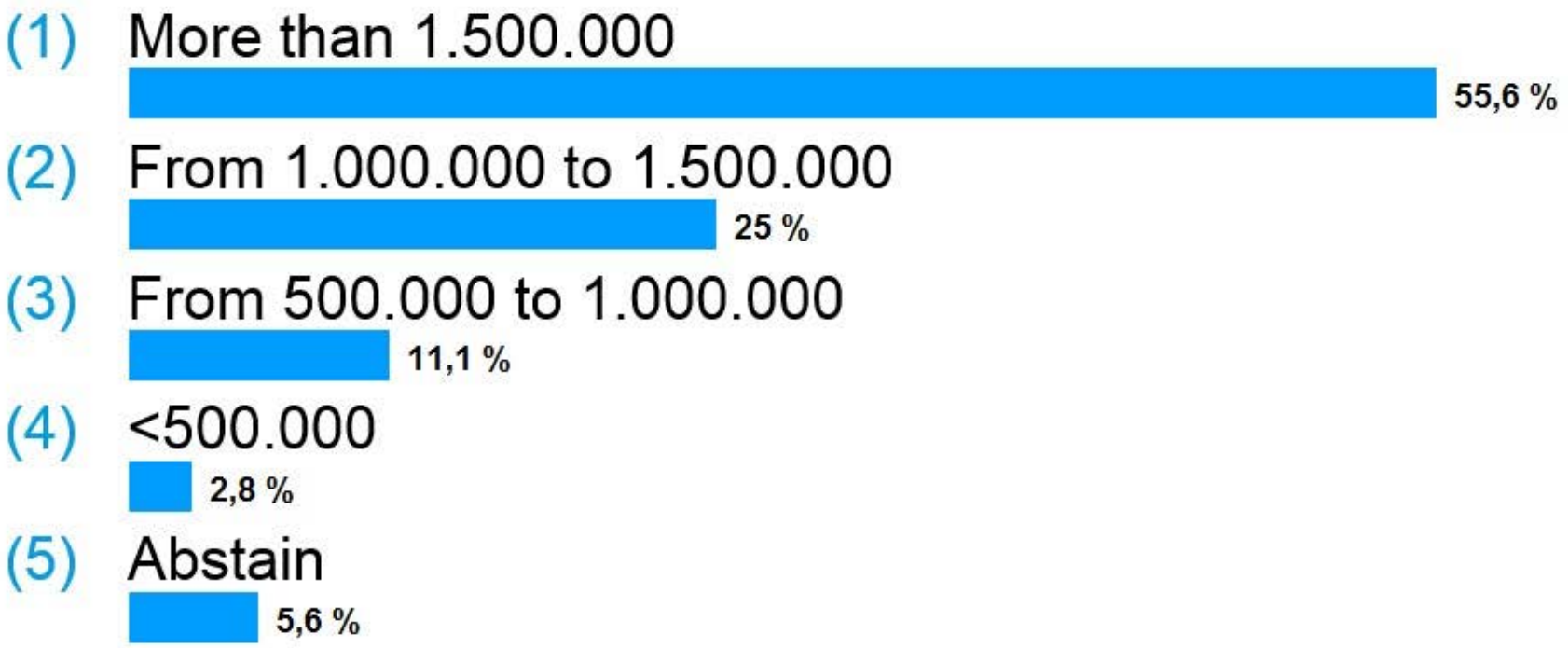
Practice Question

T2. The population of Vienna is (select one):



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LET'S START

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Escalating and De-escalating

APPROPRIATE MARGINS IN PRIMARY SURGERY AND IN SURGERY FOLLOWING NEO-ADJUVANT SYSTEMIC THERAPY

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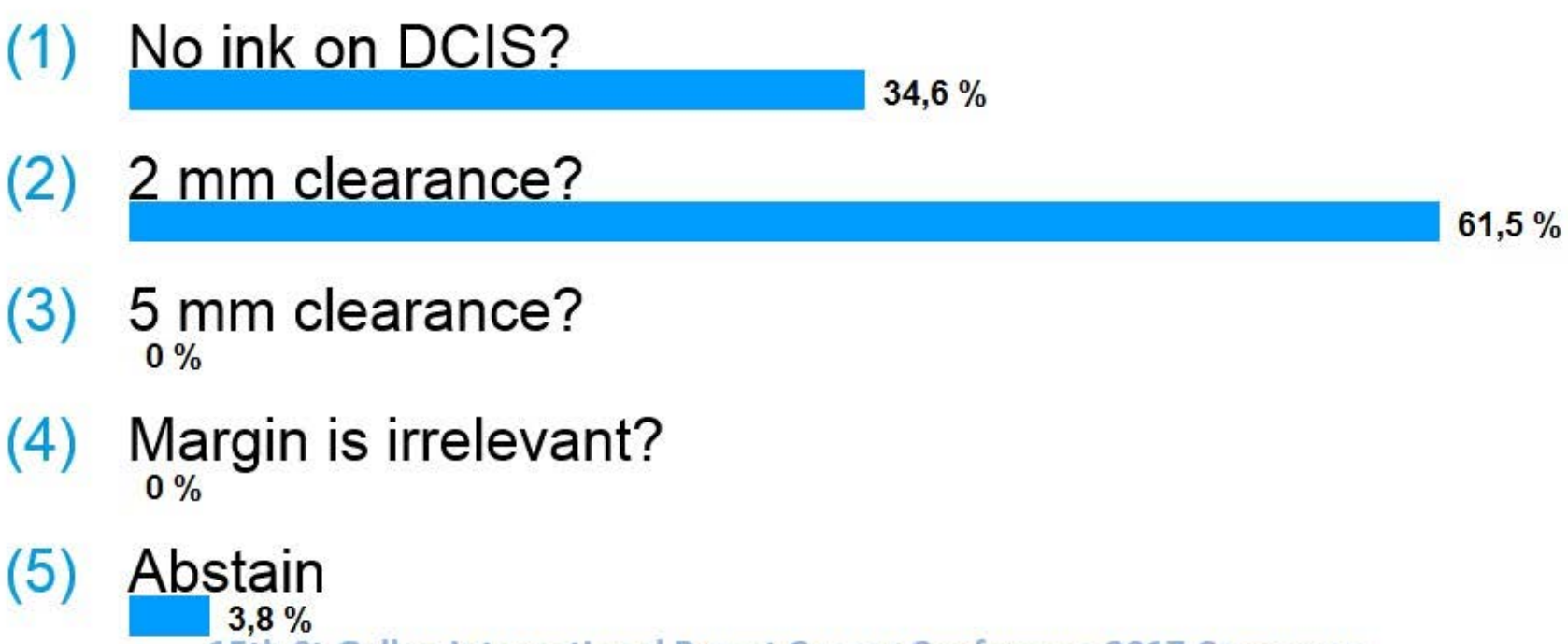
Breast Conserving Surgery of the Primary (DCIS)

1. **In women undergoing breast conserving surgery for DCIS and planned whole breast radiation treatment which minimum margin width is sufficient to avoid re-excision?**



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Primary Surgery of Multi-focal/ Multicentric Disease

2. >2 tumor foci contained in one 'quadrant' of the breast (**multifocal**) can be treated with breast conservation, provided margins are clear and adequate RT is planned.

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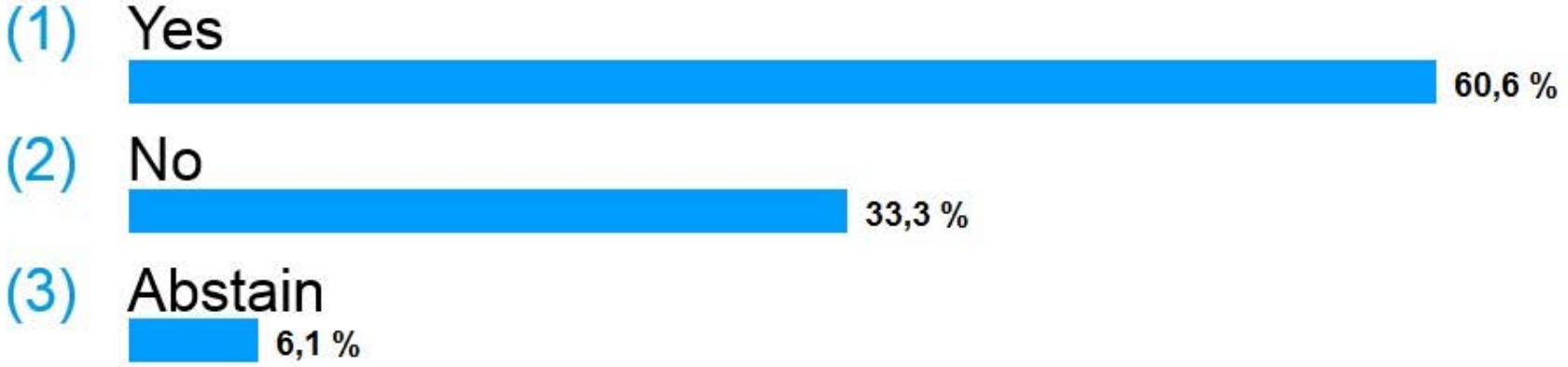
Primary Surgery of Multi-focal/ Multicentric Disease

3. Tumor foci in more than one 'quadrant' of the breast (**multicentric**) can be treated with breast conservation, provided margins are clear and adequate RT is planned.



Surgery of the Primary Tumor

4. Should the margin required be dependent on tumor biology?

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Surgery of the Primary (IBC) after Neo-Adjuvant Systemic Therapy

9. **In women undergoing breast conserving surgery after neo-adjuvant chemotherapy and proceeding to standard radiation with or without additional adjuvant systemic therapy.**

Should the entire area of the original primary be resected after downstaging?

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Surgery of the Primary (IBC) after Neo-Adjuvant Systemic Therapy

10. **In women undergoing breast conserving surgery after neo-adjuvant chemotherapy and proceeding to standard radiation with or without additional adjuvant systemic therapy.**

Which is the ***minimum*** acceptable surgical margin to avoid re-excision (with multifocal residual disease in the pathological specimen)?

(1) No ink on invasive tumor or DCIS? **55,2 %**

(2) 2 mm clearance? **27,6 %**

(3) > 2 – 5 mm clearance? **6,9 %**

(4) > 5mm clearance? **3,4 %**

(5) Margin is irrelevant? **0 %**

(6) Abstain **6,9 %**

Surgery of the Primary (IBC) after Neo-Adjuvant Systemic Therapy

11. **In women undergoing breast conserving surgery after neo-adjuvant chemotherapy and proceeding to standard radiation with or without additional adjuvant systemic therapy.**

Which is the *minimum* acceptable surgical margin to avoid re-excision (without multifocal residual disease in their pathological specimen)?

(1) No ink on invasive tumor or DCIS? 95,8 %

(2) 2 mm clearance? 4,2 %

(3) > 2 – 5 mm clearance? 0 %

(4) > 5mm clearance? 0 %

(5) Margin is irrelevant? 0 %

(6) Abstain 0 %

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Surgery of the Primary (IBC) after Neo-Adjuvant Systemic Therapy

12. **In women undergoing breast conserving surgery after neo-adjuvant chemotherapy and proceeding to standard radiation with or without additional adjuvant systemic therapy.**

Is nipple-sparing mastectomy safe after neo-adjuvant treatment?

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Escalating and De-escalating

WHEN CAN AXILLARY SURGERY BE REDUCED?

Surgery of the Axilla

13. **In patients with macro-metastases in 1-2 sentinel nodes, completion of axillary dissection can safely be *omitted* following:**

Mastectomy (no radiotherapy to lymph nodes planned)

Surgery of the Axilla

14. **In patients with macro-metastases in 1-2 sentinel nodes, completion of axillary dissection can safely be *omitted* following:**

Mastectomy (radiotherapy to lymph nodes planned)

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Surgery of the Axilla

15. **In patients with macro-metastases in 1-2 sentinel nodes, completion of axillary dissection can safely be *omitted* following:**

Conservative resection with radiotherapy using standard tangents

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Surgery of the Axilla

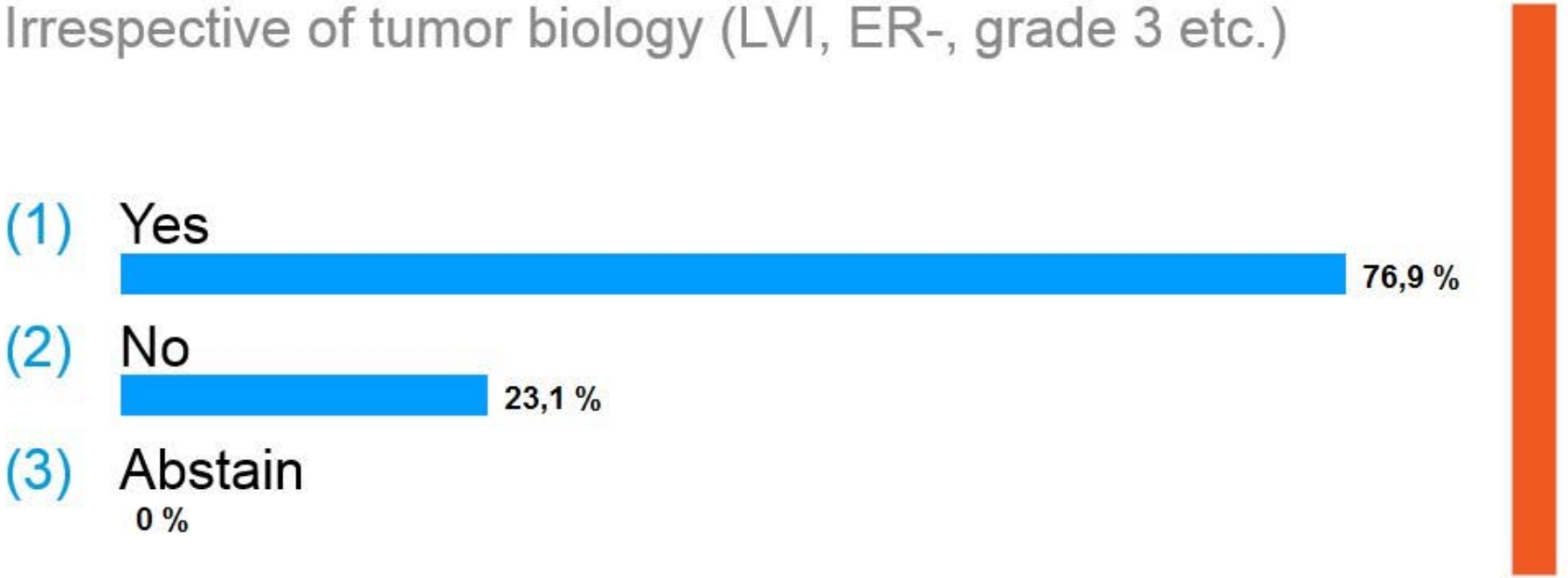
16. **In patients with macro-metastases in 1-2 sentinel nodes, completion of axillary dissection can safely be *omitted* following:**

Conservative resection with radiotherapy using high tangents

Surgery of the Axilla

17. **In patients with macro-metastases in 1-2 sentinel nodes, completion of axillary dissection can safely be *omitted* following:**

Irrespective of tumor biology (LVI, ER-, grade 3 etc.)



Surgery of the Axilla following Neo-Adjuvant Chemotherapy

18. **In a patient who is clinically (at palpation and US) node-negative at diagnosis:**

Is SN biopsy appropriate?

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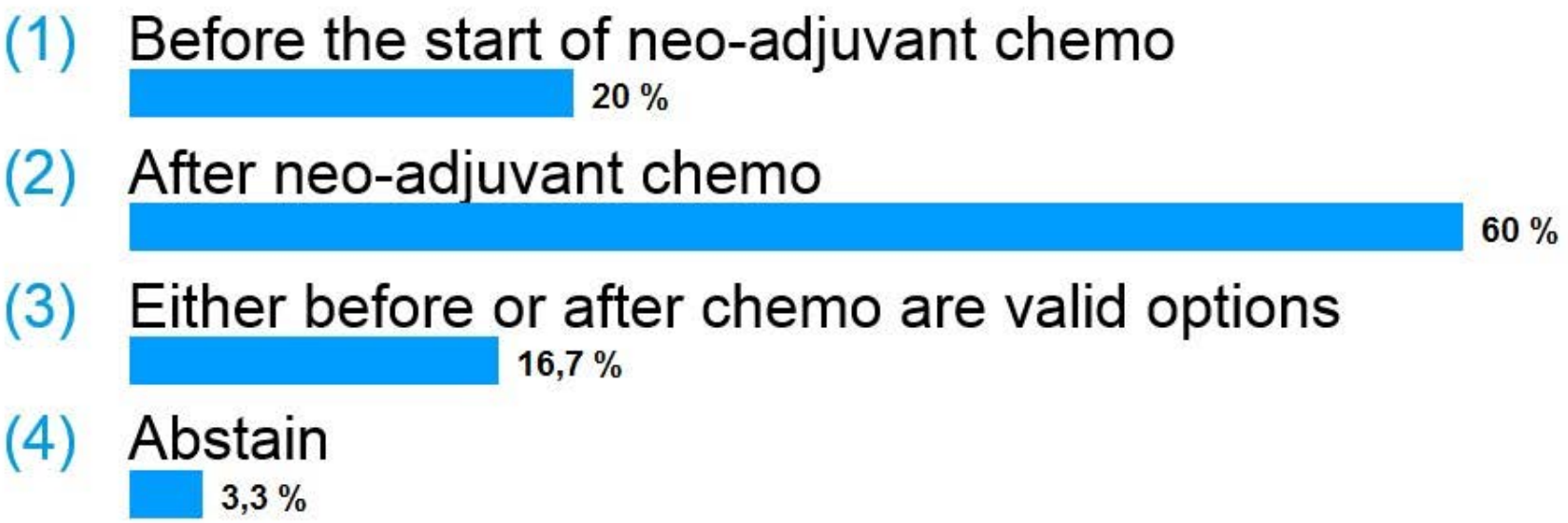
Surgery of the Axilla in the context of Neo-Adjuvant Chemotherapy

19. **In a patient who is clinically (at palpation and US) node-negative at diagnosis:**

When is the best time point for SN biopsy?



Surgery of the Axilla following Neo-Adjuvant Chemotherapy

20. **In a patient who is clinically node-positive at diagnosis and who downstages after chemotherapy:**

Is SN biopsy appropriate with 1-2 LN detected?

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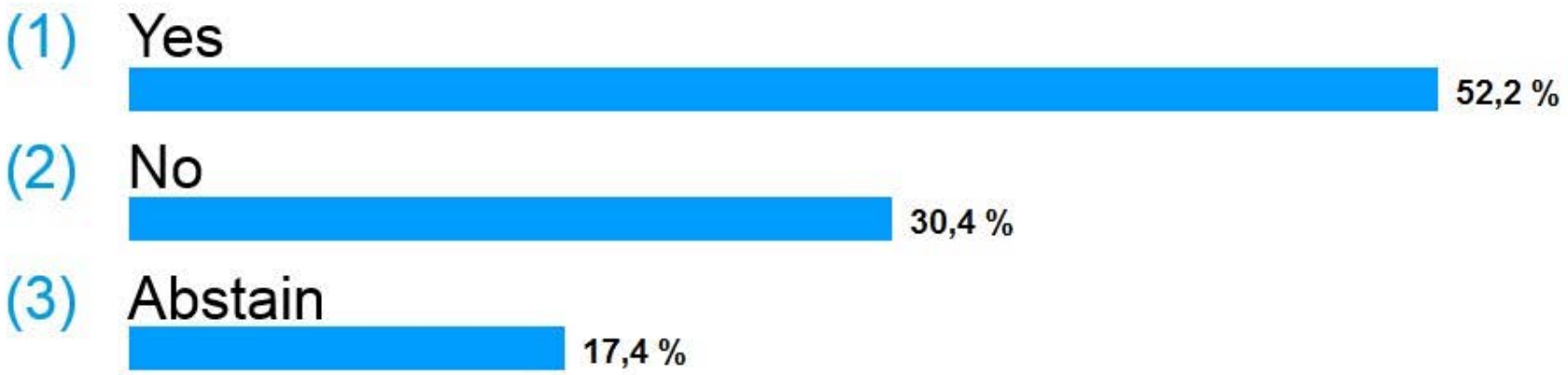
Surgery of the Axilla following Neo-Adjuvant Chemotherapy

21. **In a patient who is clinically node-positive at diagnosis and who downstages after chemotherapy:**

Is SN biopsy appropriate only in selected cases such as:

More than 2 SN detected?



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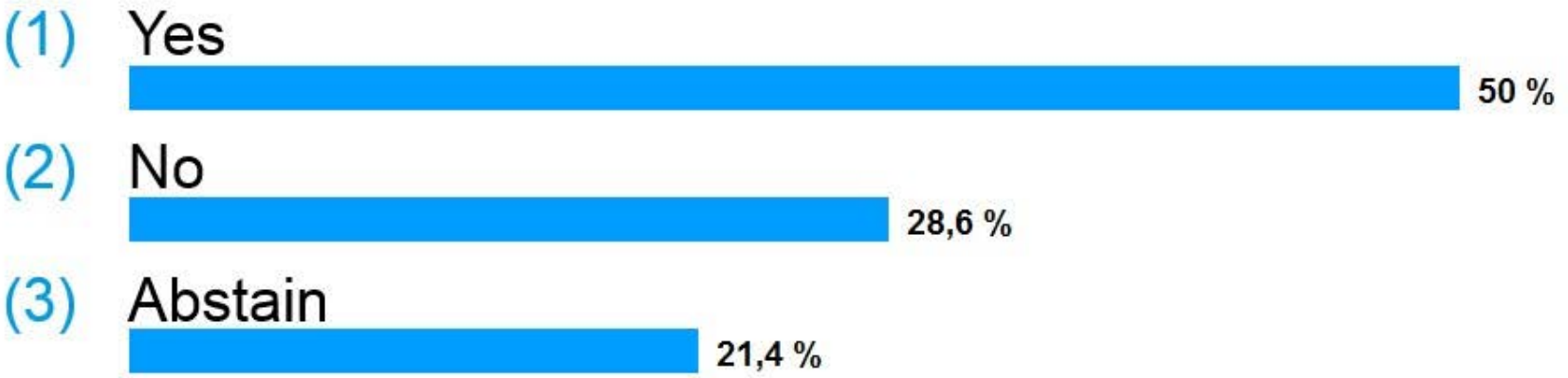
Surgery of the Axilla following Neo-Adjuvant Chemotherapy

23. **In a patient who is clinically node-positive at diagnosis and who downstages after chemotherapy:**

Is SN biopsy appropriate only in selected cases such as:

Clipping/seeding of involved nodes at diagnosis and targeted removal?



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Surgery of the Axilla following Neo-Adjuvant Chemotherapy

25. **In a patient who is clinically node-positive at diagnosis and who downstages after chemotherapy:**

Can ALND be avoided if micrometastasis is present in the SN?

Surgery of the Axilla following Neo-Adjuvant Chemotherapy

26. **In a patient who is clinically node-positive at diagnosis and who downstages after chemotherapy:**

Can ALND be avoided if a single SN is positive (macrometastasis)?

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Escalating and De-escalating

IN WHICH CLINICAL SCENARIO MAY RADIOTHERAPY COURSES BE SHORTENED?

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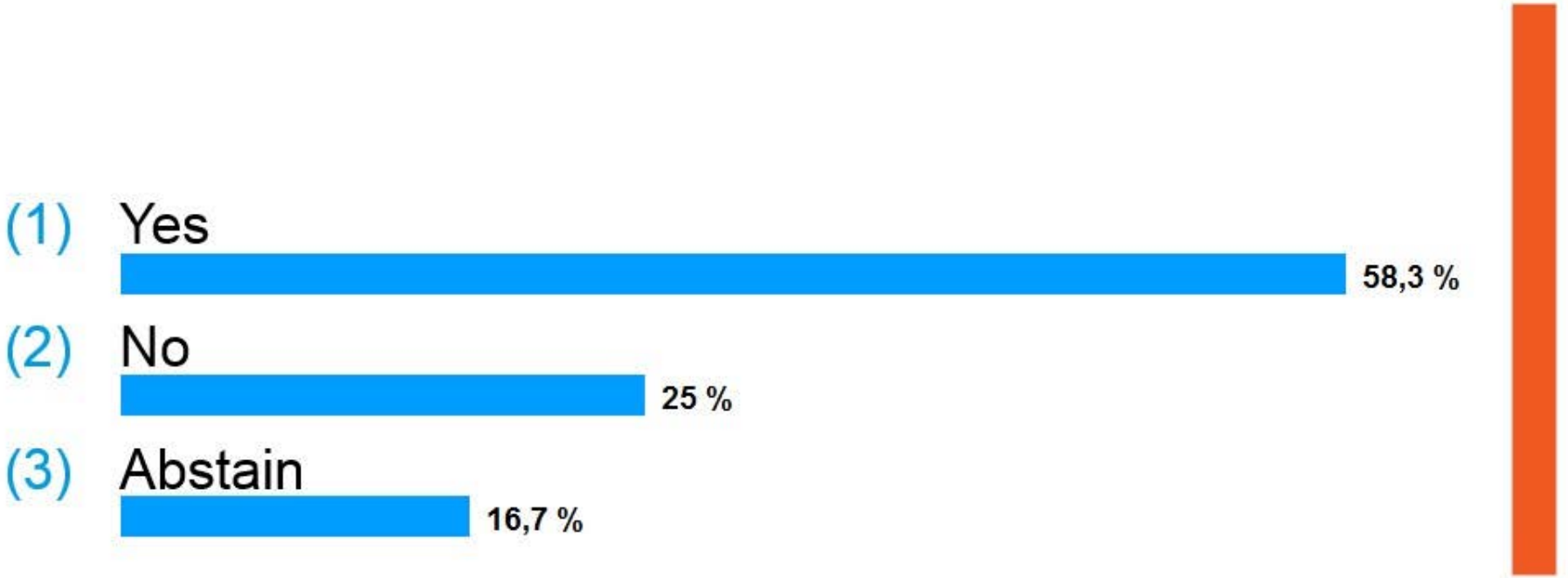
Hypofractionated Breast Irradiation

27. **Following breast conserving surgery, hypofractionated whole breast irradiation is a standard of care in:**

All patients



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Hypofractionated Breast Irradiation

28. **Following breast conserving surgery, hypofractionated whole breast irradiation is a standard of care in:**

Patients over 50 years

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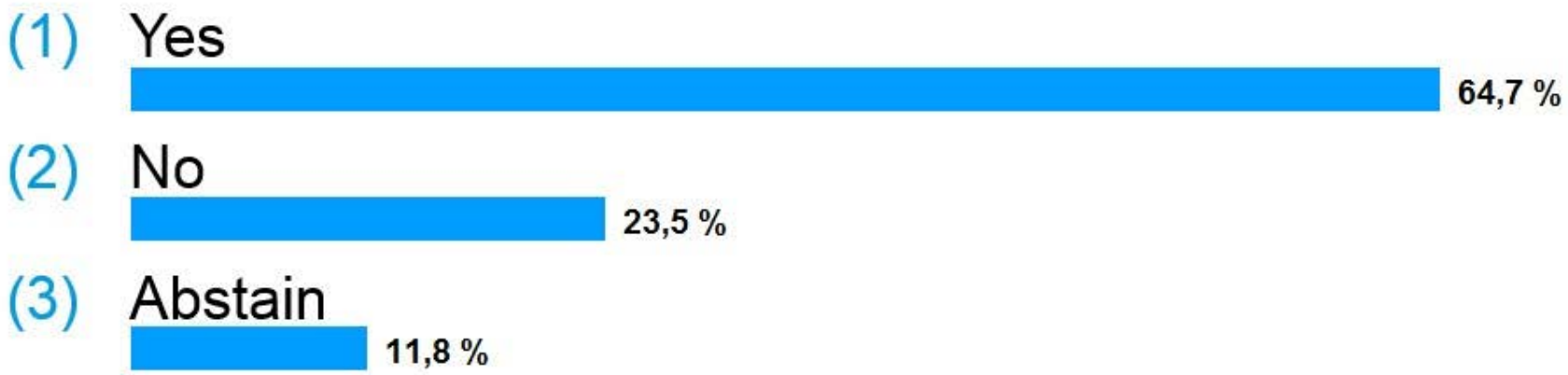
Partial Breast Irradiation

32. **Following breast conserving surgery, partial breast irradiation may be used:**

As the definitive irradiation, without whole breast irradiation in ASTRO/ESTRO "suitable" patients?



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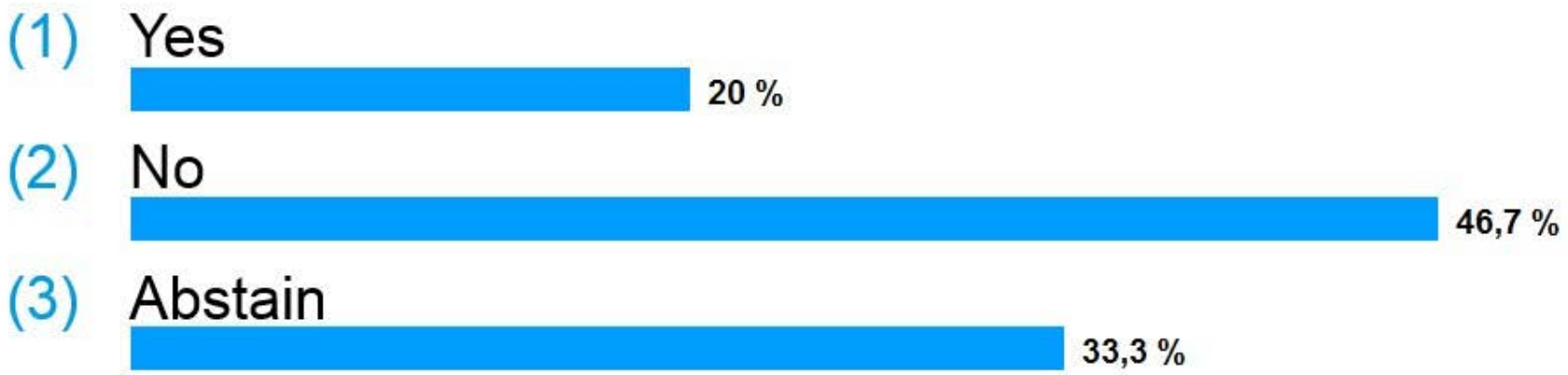
Partial Breast Irradiation

33. **Following breast conserving surgery, partial breast irradiation may be used:**

As the definitive irradiation, without whole breast irradiation in ASTRO "cautionary" / ESTRO "intermediate" patients?



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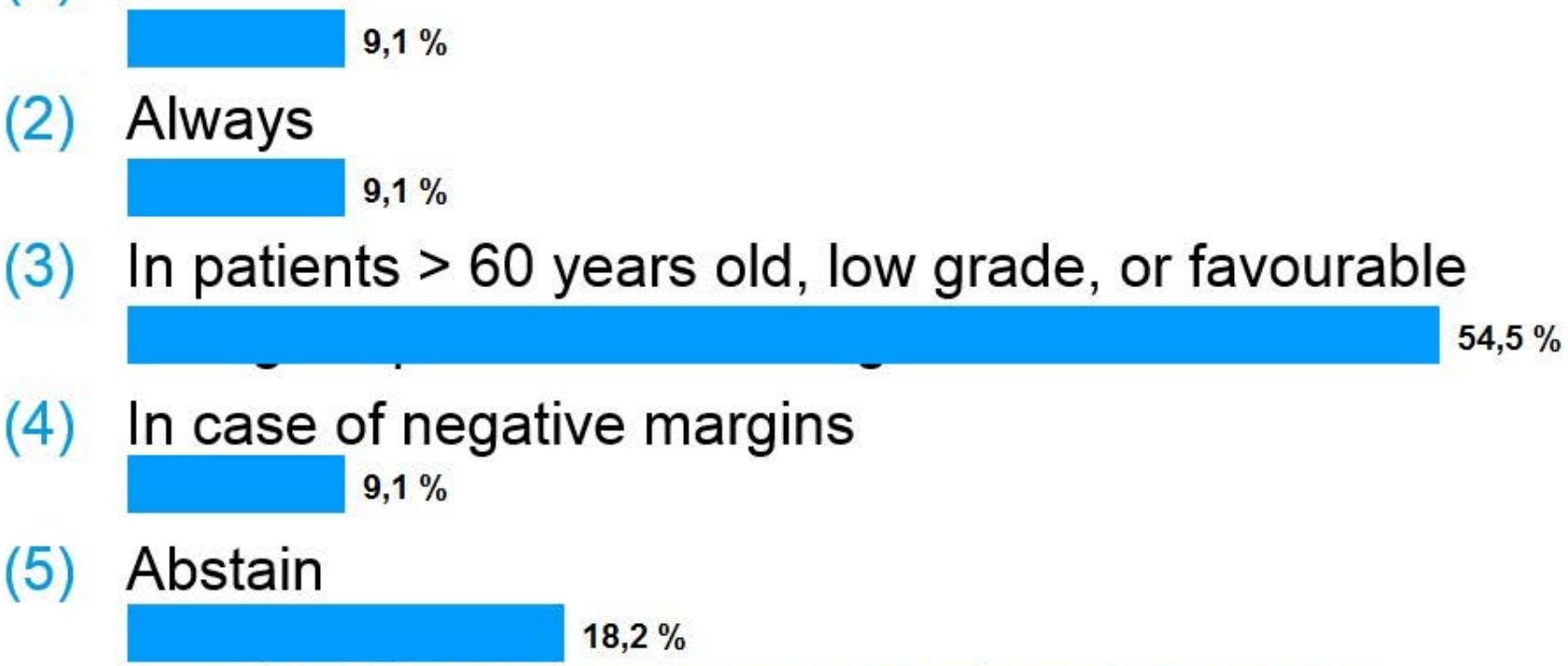
"Boost" Radiotherapy to Primary Tumor Bed

40. "Boost" Radiotherapy to Primary Tumor Bed after Breast Conservative Surgery can be omitted



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Escalating and De-escalating

WHEN SHOULD RADIOTHERAPY VOLUMES BE EXPANDED?

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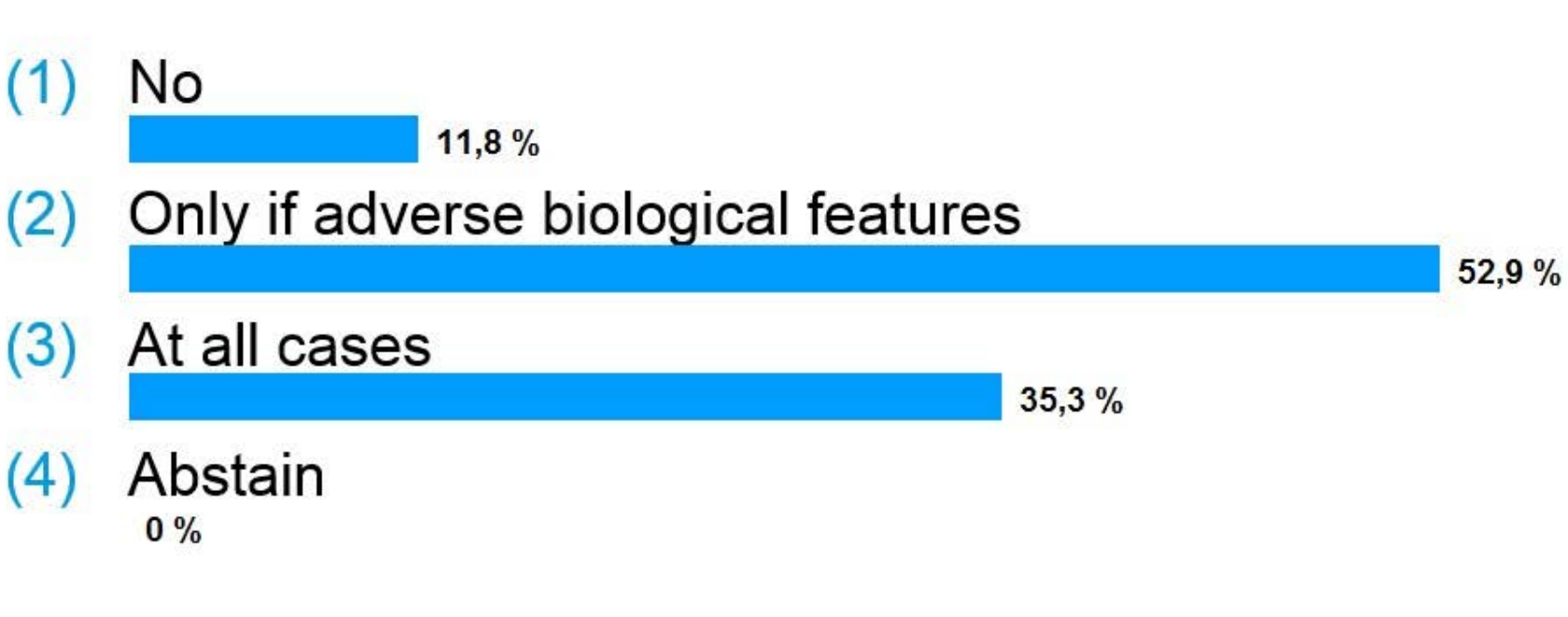
Regional Node Irradiation

41. **Following breast conserving surgery, radiation should include regional nodes:**

If number of positive nodes is 1-3



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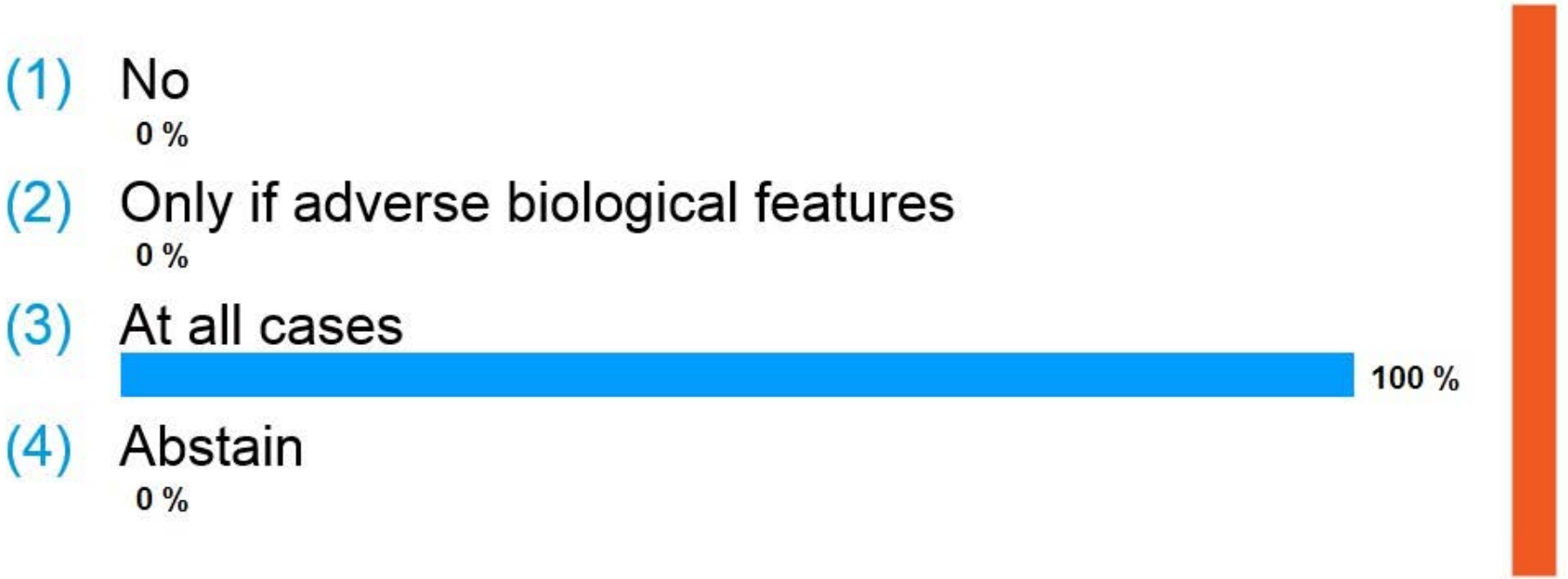
Regional Node Irradiation

42. **Following breast conserving surgery, radiation should include regional nodes:**

If number of positive nodes is 4 or more



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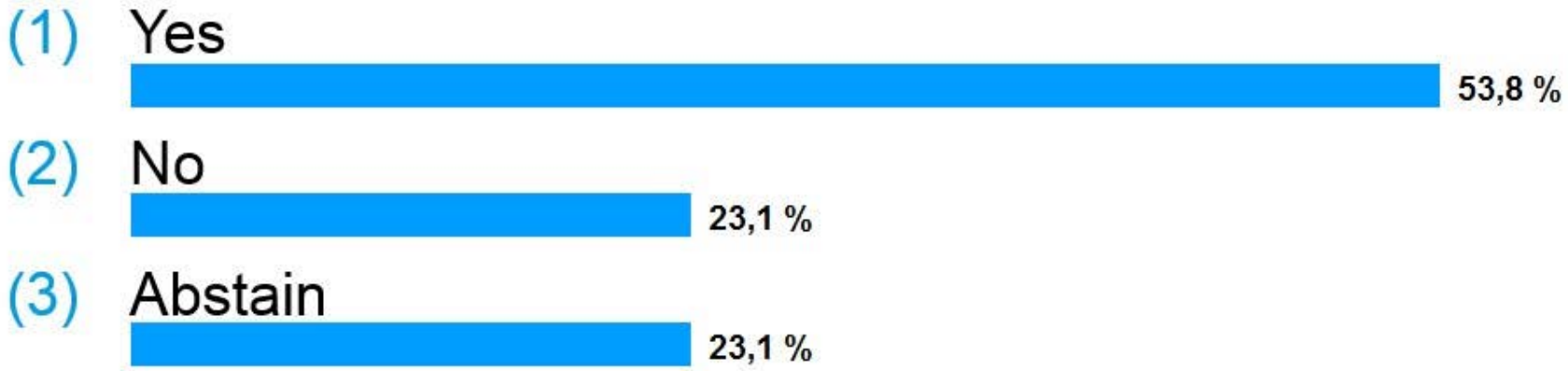
Radiation Therapy: After Mastectomy

44. **Should post mastectomy RT (chest wall and regional nodes) be standard for patients with:**

T size >= 5 cm and N0?



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Radiation Therapy: After Mastectomy

45. **Should post mastectomy RT (chest wall and regional nodes) be standard for patients with:**

N+ 1 to 3 all patients?

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Radiation Therapy: After Mastectomy

46. **Should post mastectomy RT (chest wall and regional nodes) be standard for patients with:**

N+ 1 to 3 with adverse pathology?

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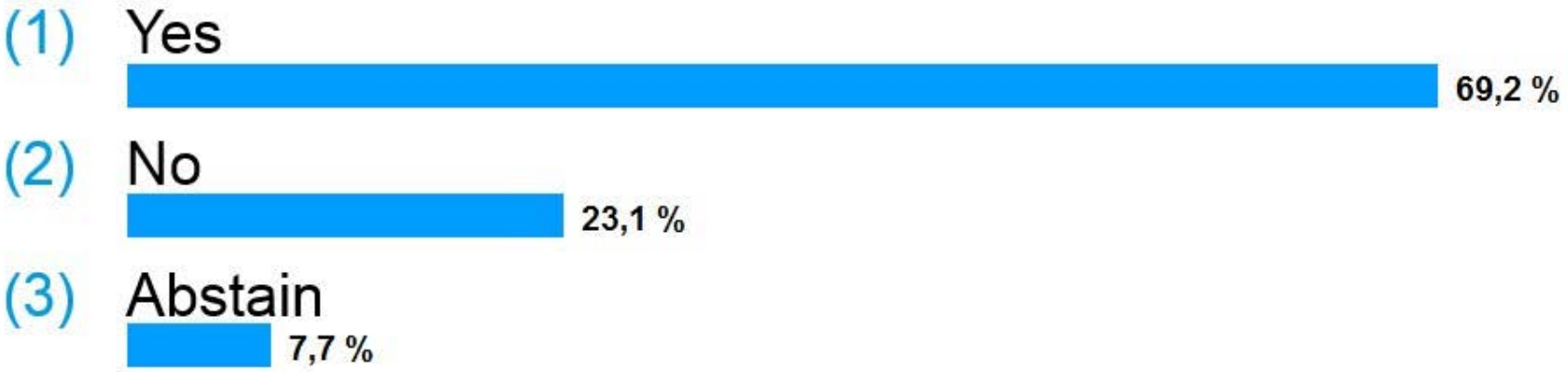
Radiation Therapy: After Mastectomy

47. **Should post mastectomy RT (chest wall and regional nodes) be standard for patients with:**

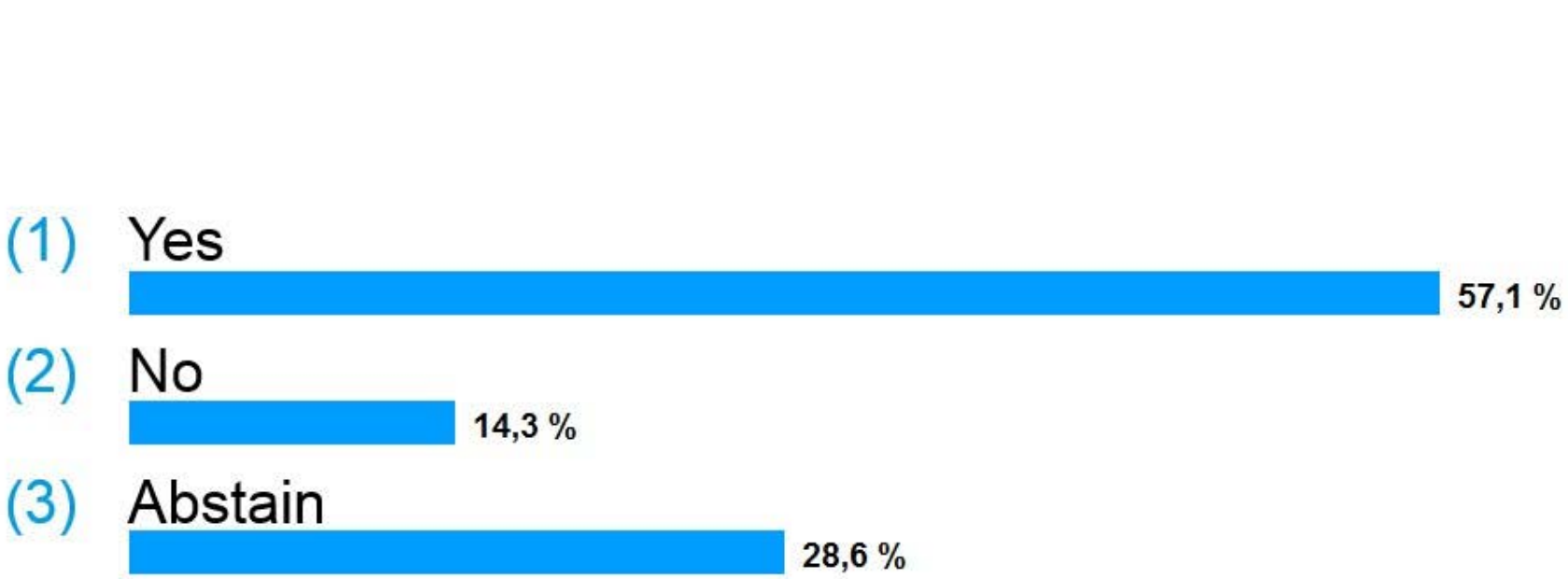
N+ 1 to 3 at young age (< 40 years)?



Radiation Therapy: After Mastectomy

48. **Should post mastectomy RT (chest wall and regional nodes) be standard for patients with:**

Positive sentinel node biopsy but no axillary dissection?



Radiation to Breast Following Neo-Adjuvant Systemic Therapy

50. Should follow the stage

(1) *Before* neo-adjuvant therapy?

11,1 %

(2) *After* neo-adjuvant therapy?

0 %

(3) Should take into account the stage *before and after*

77,8 %

(4) Can be omitted in women with pCR after NAC?

11,1 %

(5) Abstain

0 %

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Escalating and De-escalating

WHEN IS TRADITIONAL PATHOLOGY (STAGE, GRADE, LVI, ER/PR/HER2) NOT INFORMATIVE ENOUGH?

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Pathology: Subtypes

51. **If derived using IHC, distinction between 'Luminal A-like' and 'Luminal B-like' (HER2 neg.):**

Describes important categories in the biology of luminal breast cancer

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Pathology: Subtypes

52. **If derived using IHC, distinction between 'Luminal A-like' and 'Luminal B-like' (HER2 neg.):**

Should be used for therapy decisions

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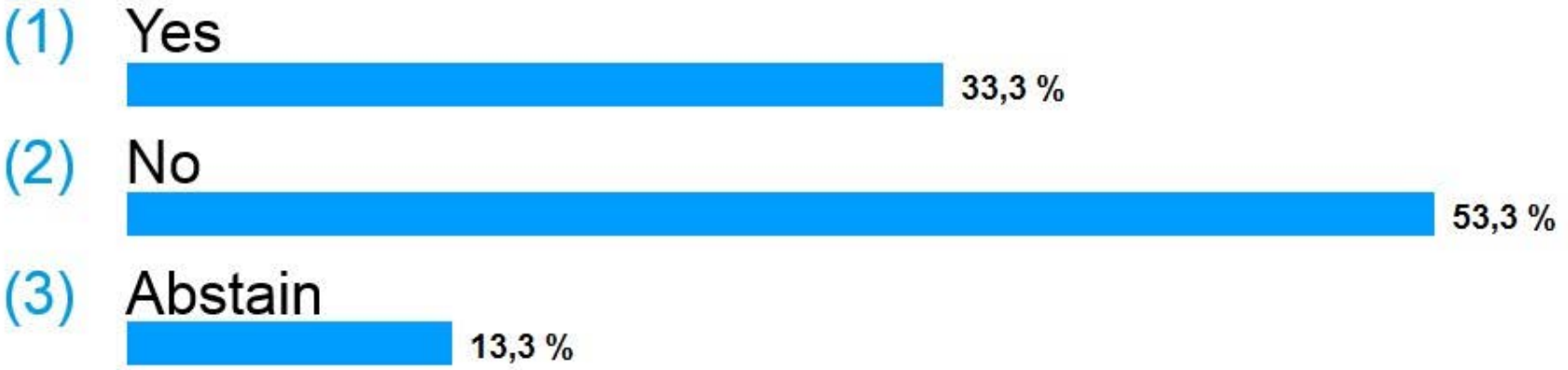
Pathology: Subtypes

53. **If derived using IHC, distinction between 'Luminal A-like' and 'Luminal B-like' (HER2 neg.):**

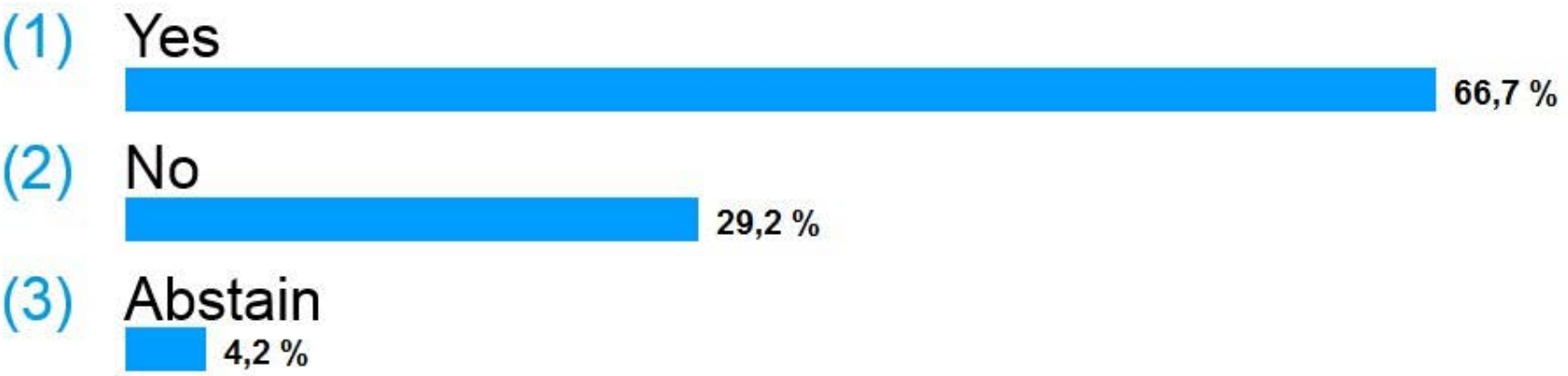
Generates working categories but should not be used for clinical decisions due to low analytical validity



Pathology: Subtypes

54. **Distinction between 'Luminal A-like' and 'Luminal B-like' (HER2 neg.) can be derived:**

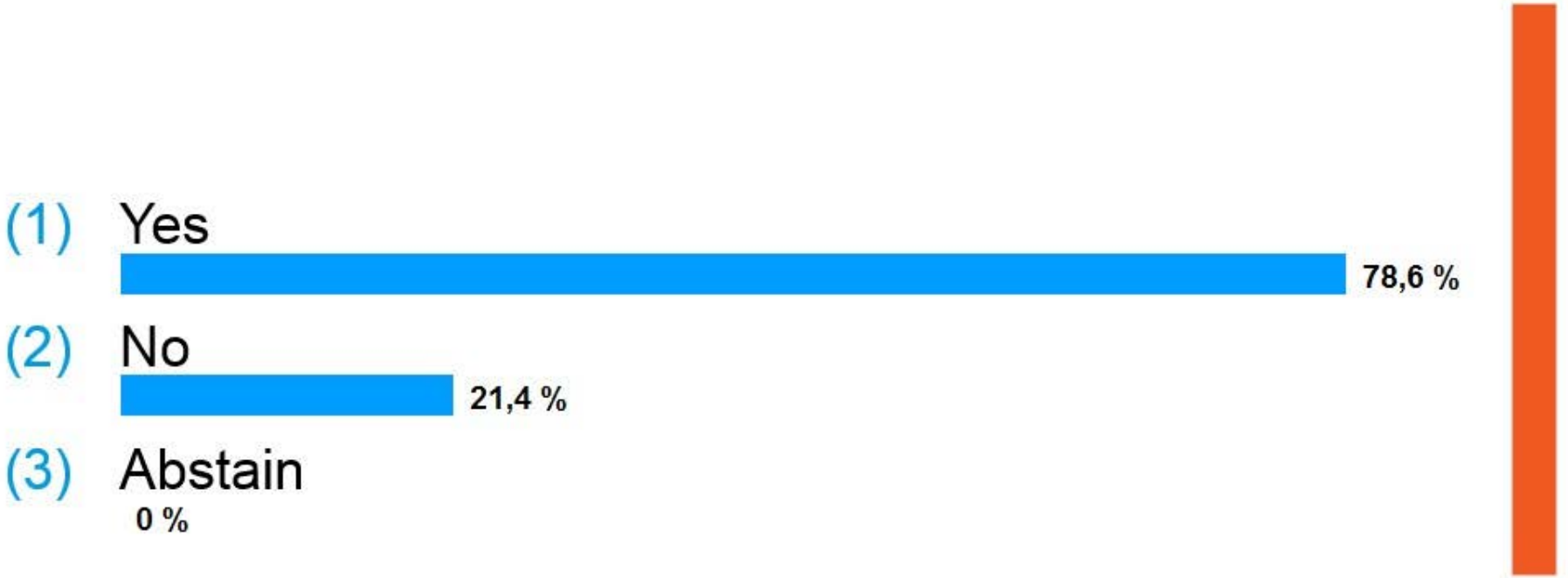
Using IHC (ER, PR and grading) to approximate multigene testing



Pathology: Subtypes

55. **Distinction between 'Luminal A-like' and 'Luminal B-like' (HER2 neg.) can be derived:**

Using ER, PR and 'high' Ki67



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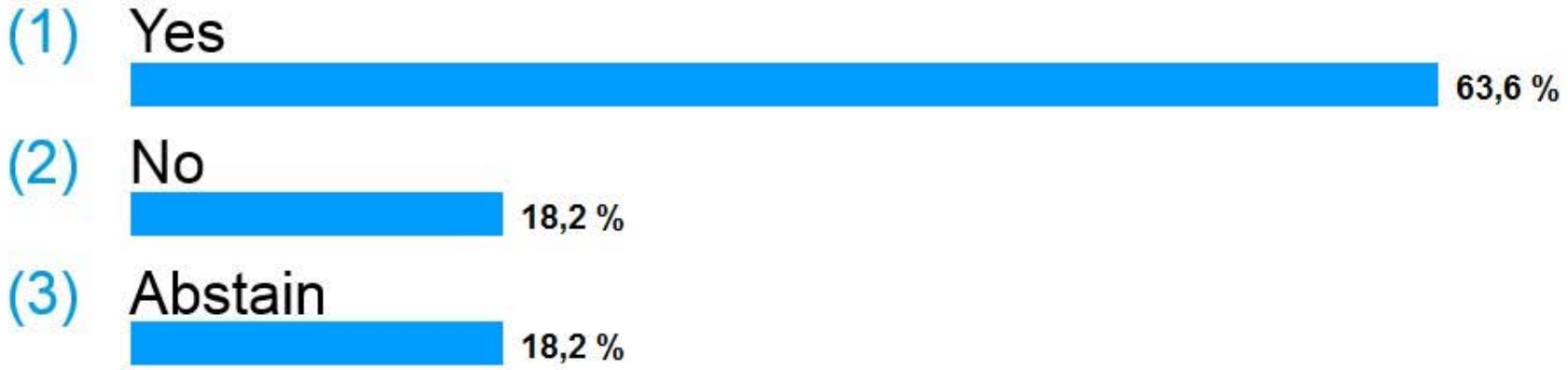
Pathology: Subtypes

57. **Distinction between 'Luminal A-like' and 'Luminal B-like' (HER2 neg.) can be derived:**

Subtype can be more appropriately determined by multi-gene tests (when available)?



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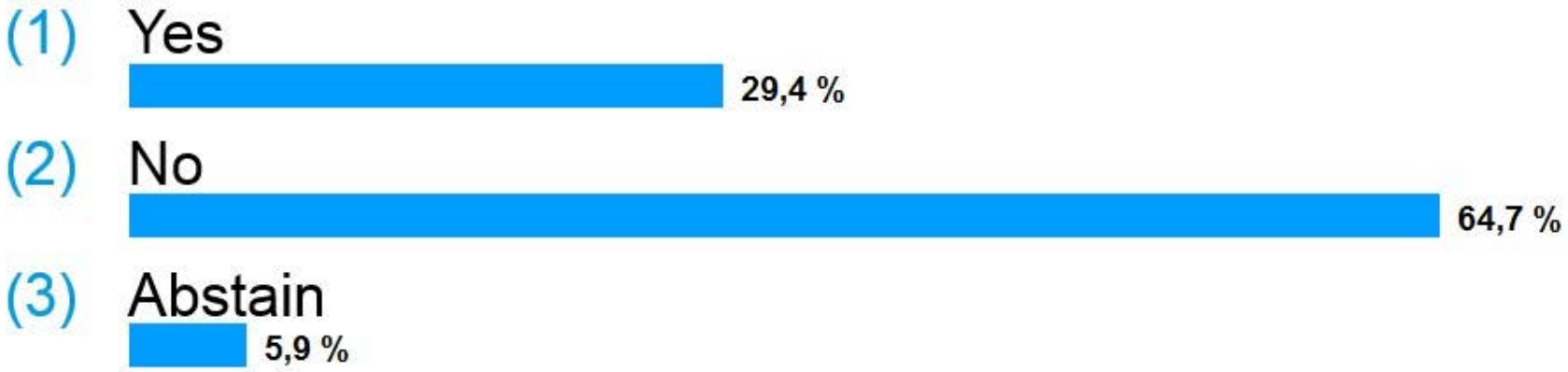
Pathology: TILs

58. **Should the evaluation of tumor-infiltrating lymphocytes (TILs) be reported in the pathology report of Triple-Negative and HER2 positive EBC?**



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Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

59. **Is there a role for multi-gene testing in node-negative, pT1a, pT1b, ER positive, PgR positive, HER2 negative, low grade, low Ki67 breast cancer?**

Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

60. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

Oncotype DX® RS

Prognosis: Years 1-5?

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Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

62. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

MammaPrint 70®

Prognosis: Years 1-5?

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Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

64. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

PAM-50 ROR Score

Prognosis: Years 1-5?

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Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

66. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

EndoPredict® (EpClin)

Prognosis: Years 1-5?

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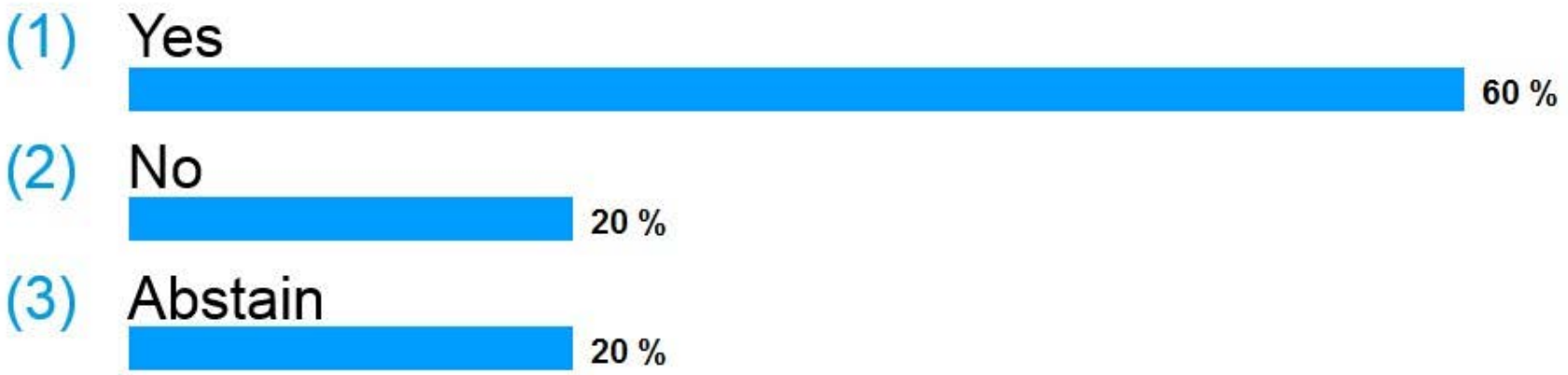
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

68. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

Breast Cancer Index

Prognosis: Years 1-5?



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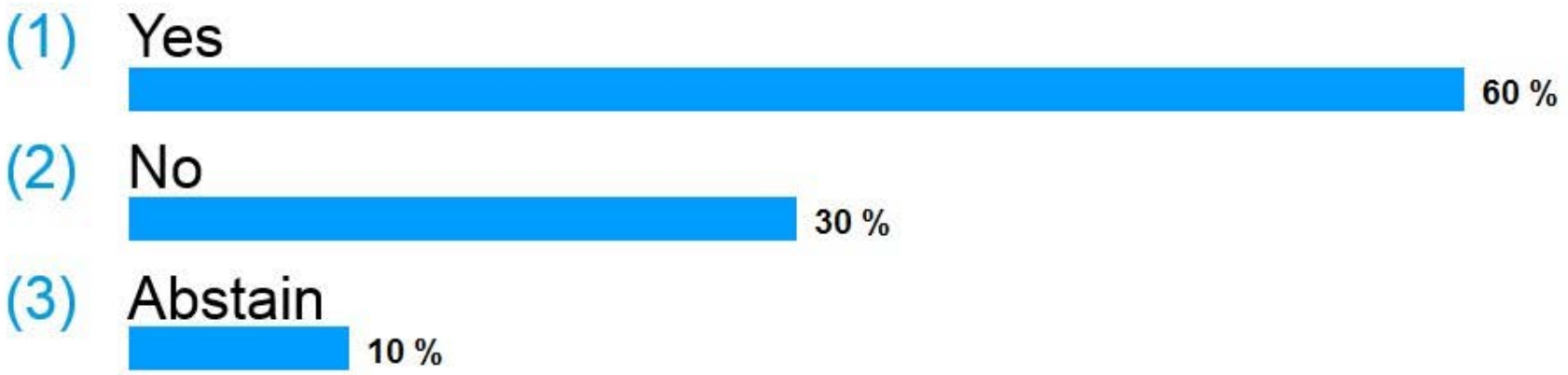
Multi-Gene Signatures and Chemotherapy: Node-Positive Patients

70. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

Oncotype DX® RS

Prognosis: Years 1-5?



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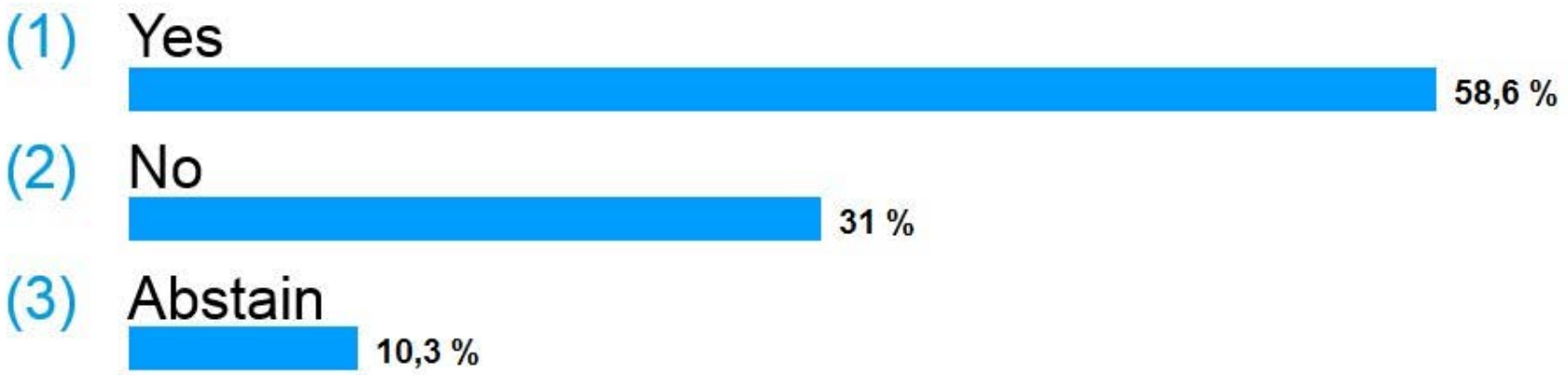
Multi-Gene Signatures and Chemotherapy: Node-Positive Patients

71. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

Oncotype DX® RS

Chemotherapy?



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Multi-Gene Signatures and Chemotherapy: Node-Positive Patients

72. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

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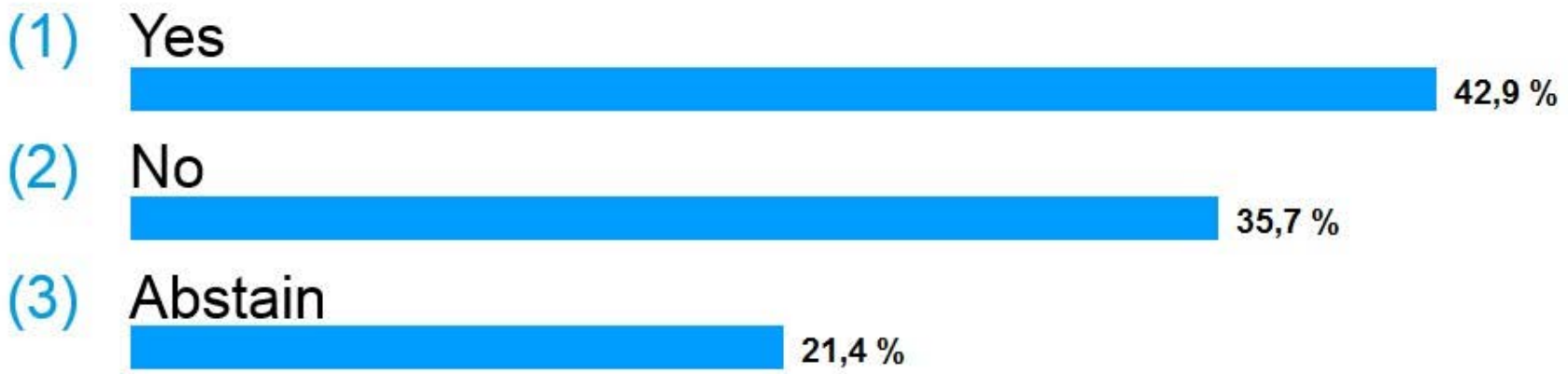
Prognosis: Years 1-5?



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Multi-Gene Signatures and Chemotherapy: Node-Positive Patients

73. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

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Chemotherapy?

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Multi-Gene Signatures and Chemotherapy: Node-Positive Patients

74. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

PAM-50 ROR Score

Prognosis: Years 1-5?

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Multi-Gene Signatures and Chemotherapy: Node-Positive Patients

75. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

PAM-50 ROR Score

Chemotherapy?

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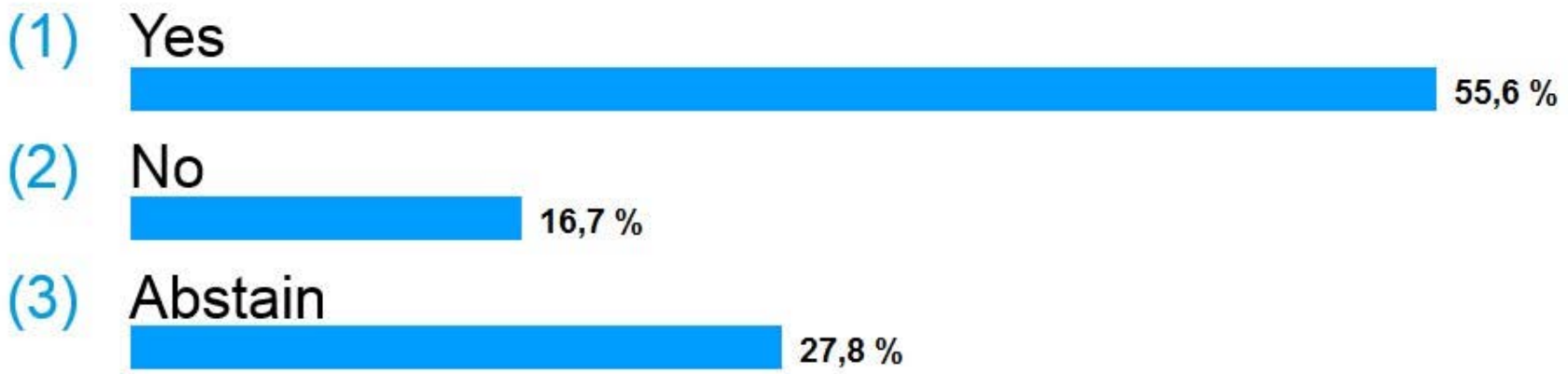
Multi-Gene Signatures and Chemotherapy: Node-Positive Patients

76. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

EndoPredict® (EpClin)

Prognosis: Years 1-5?



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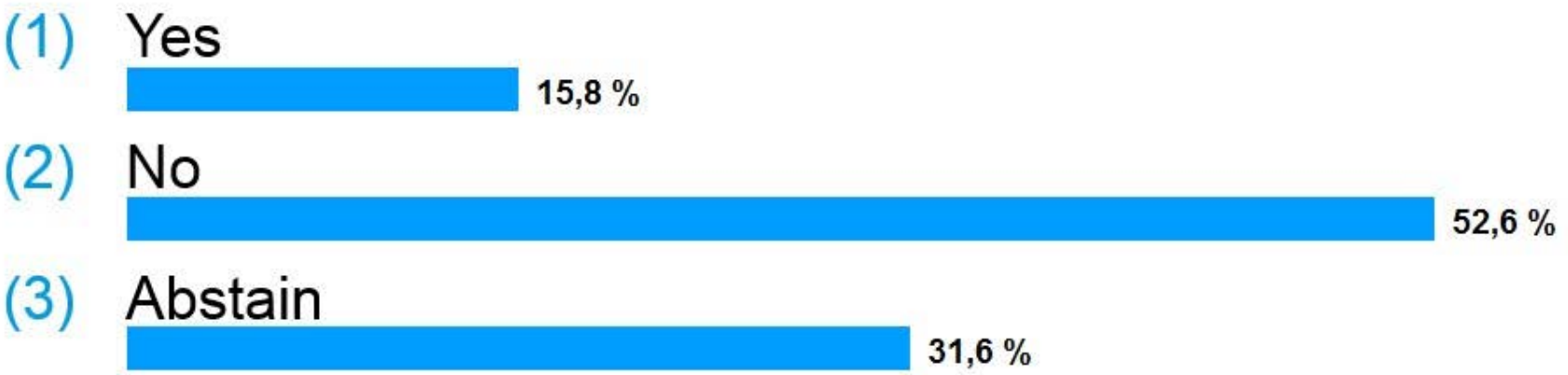
Multi-Gene Signatures and Chemotherapy: Node-Positive Patients

77. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

EndoPredict® (EpClin)

Chemotherapy?



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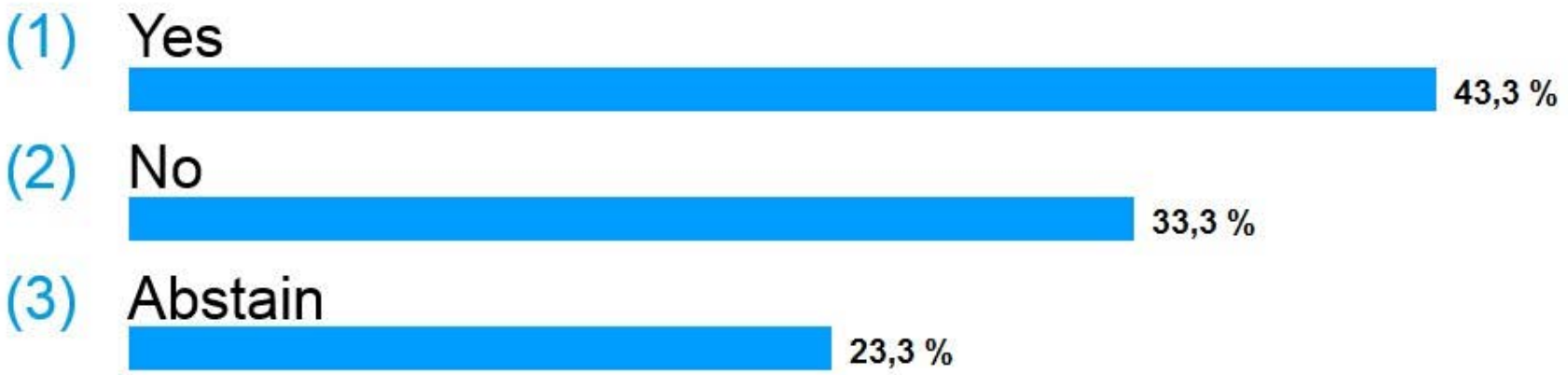
Multi-Gene Signatures and Chemotherapy: Node-Positive Patients

78. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

Breast Cancer Index

Prognosis: years 1-5?



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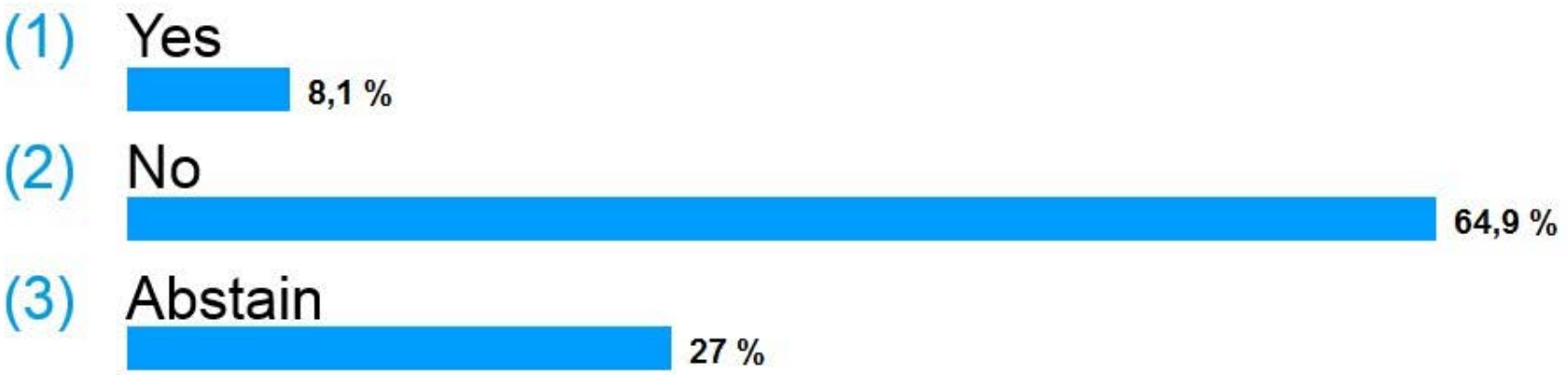
Multi-Gene Signatures and Chemotherapy: Node-Positive Patients

79. **In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:**

Breast Cancer Index

Chemotherapy?



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Multi-Gene Signatures and Extended Endocrine Therapy:

80. **In a patient with ER + /HER2 negative, clinically valuable information on prognosis and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by one or more multigene signatures**

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Escalating and De-escalating

WHICH WOMEN SHOULD RECEIVE OVARIAN SUPPRESSION AS PART OF ADJUVANT ENDOCRINE THERAPY?

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Endocrine Therapy

Premenopausal: Selection Factors

81. **Does each of the following clinico-pathological features by itself argue for inclusion of ovarian function suppression (OFS)?**

Age < 35 years

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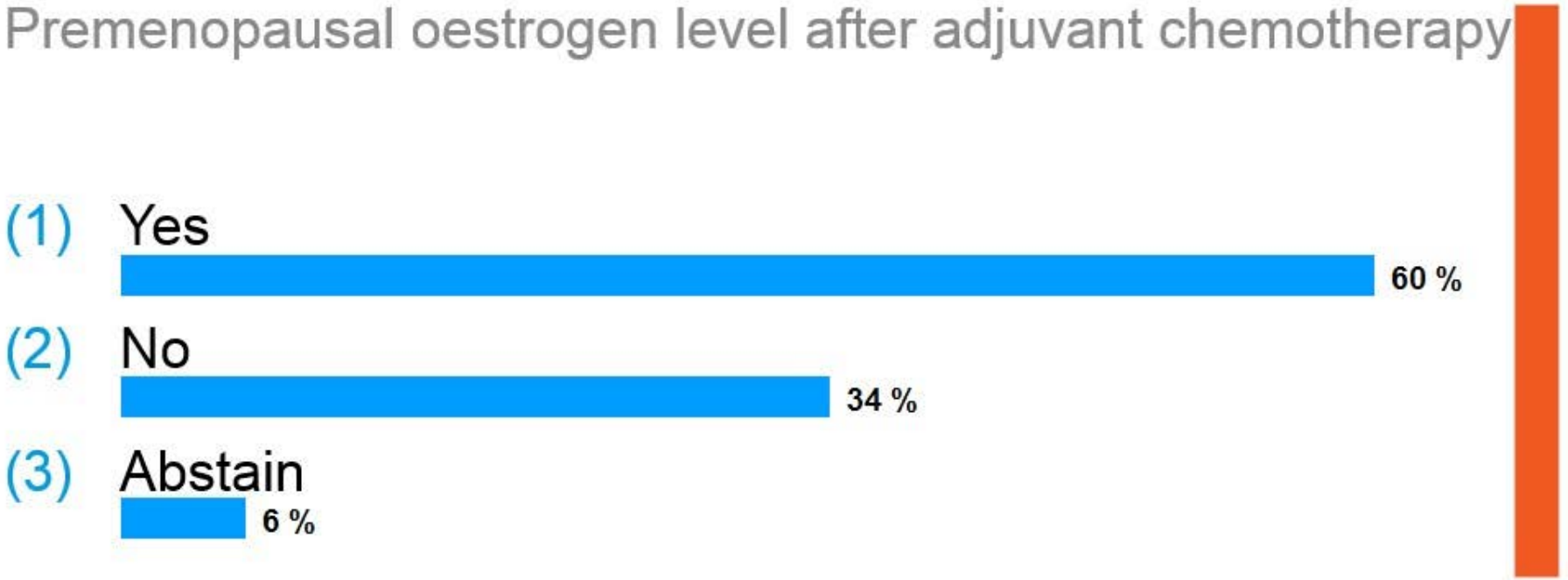
Endocrine Therapy

Premenopausal: Selection Factors

82. **Does each of the following clinico-pathological features by itself argue for inclusion of ovarian function suppression (OFS)?**

Premenopausal oestrogen level after adjuvant chemotherapy



Endocrine Therapy

Premenopausal: Selection Factors

85. **Does each of the following clinico-pathological features by itself argue for inclusion of ovarian function suppression (OFS)?**

Involvement of 4 or more nodes

Endocrine Therapy Premenopausal Patients: (assessed by Estradiol, FSH and LH): Selection Factors

87. Should some patients receive OFS + AI?

Endocrine Therapy

Postmenopausal Patients

93. **Is Tamoxifen alone still appropriate for some patients?**

Endocrine Therapy

Postmenopausal Patients

94. **Parameters for inclusion of an AI at some point are:**

All postmenopausal patients

Endocrine Therapy

Postmenopausal Patients

95. **Parameters for inclusion of an AI at some point are:**

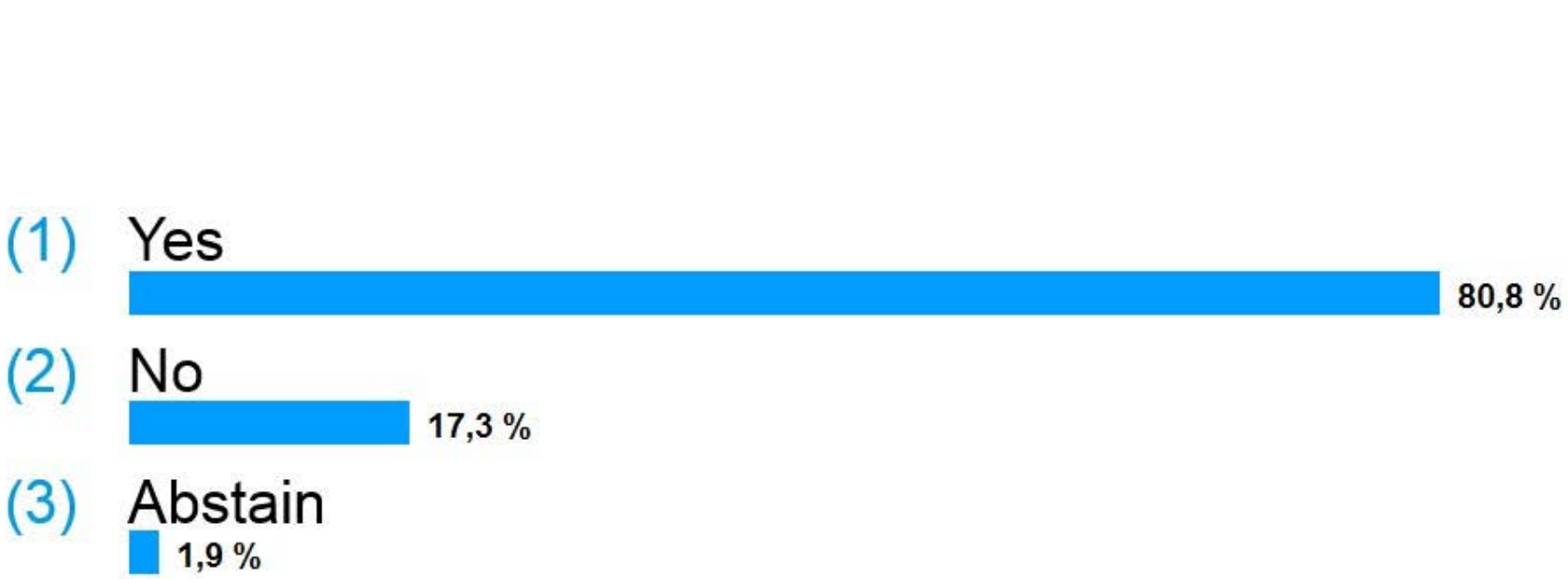
Node-positive

Endocrine Therapy

Postmenopausal Patients

96. **Parameters for inclusion of an AI at some point are:**

Grade 3 or high Ki67

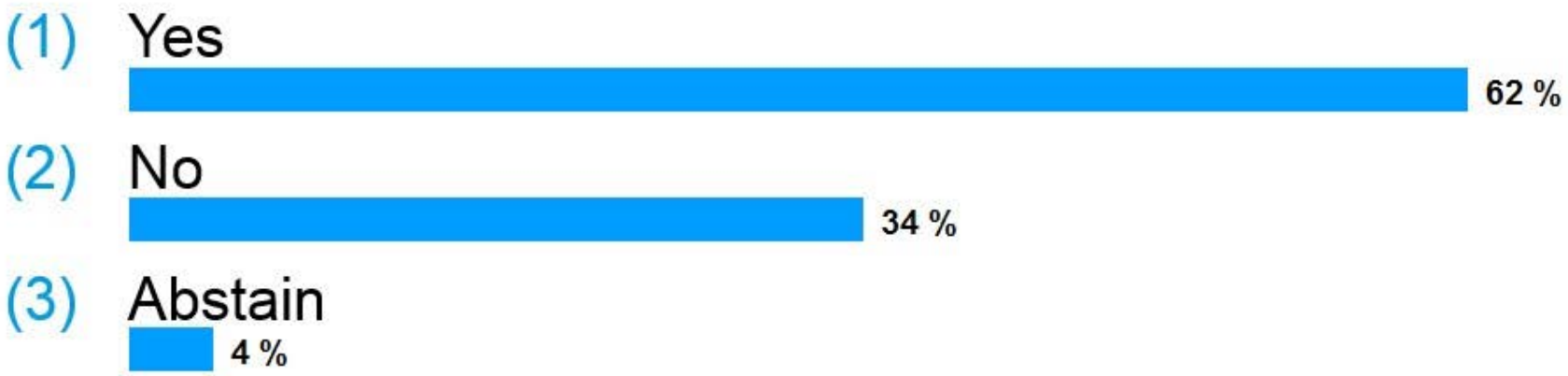


Endocrine Therapy

Postmenopausal Patients

97. **Parameters for inclusion of an AI at some point are:**

HER2 positivity



Endocrine Therapy

Postmenopausal Patients

98. **If an AI is used, should it be started upfront:**

In any patients?

Endocrine Therapy

Postmenopausal Patients

99. **If an AI is used, should it be started upfront:**

In patients at higher risk?

Endocrine Therapy

Postmenopausal Patients

100. **If an AI is used, should it be started upfront:**

In lobular cancer (letrozole or other AI)?

Endocrine Therapy

Postmenopausal Patients

101. **Can upfront AI be switched to TAM after 2 years in all?**

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Escalating and De-escalating

WHICH WOMEN SHOULD RECEIVE LONGER DURATION OF ADJUVANT ENDOCRINE THERAPY?

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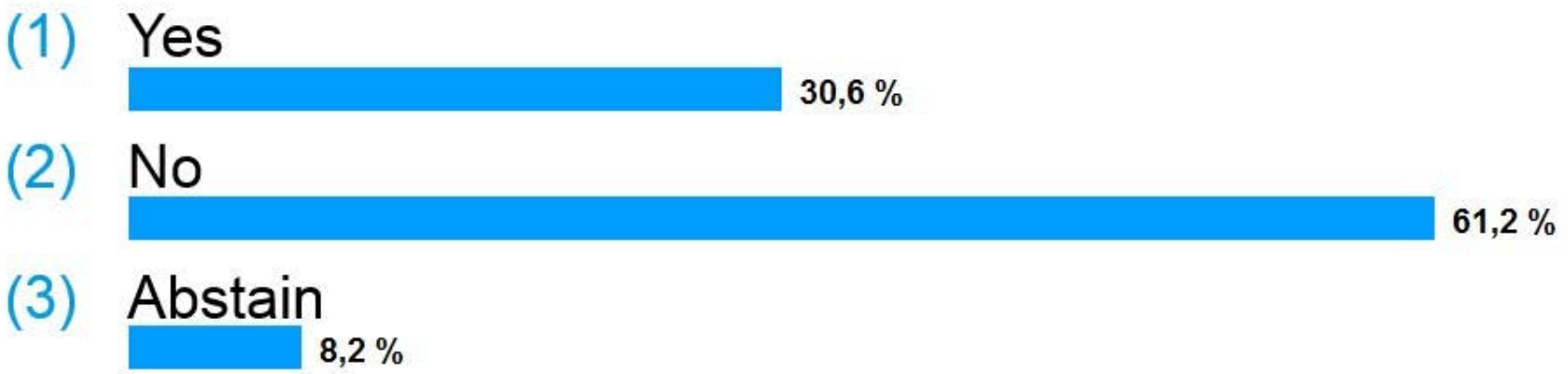
Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

103. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of adjuvant therapy involving *switch from TAM to an AI* (therefore assuming postmenopausal status at the 5 year time point and reasonable tolerance to endocrine therapy), patients at moderate or high risk of recurrence should be recommended to receive:

A further 5 years of Tamoxifen



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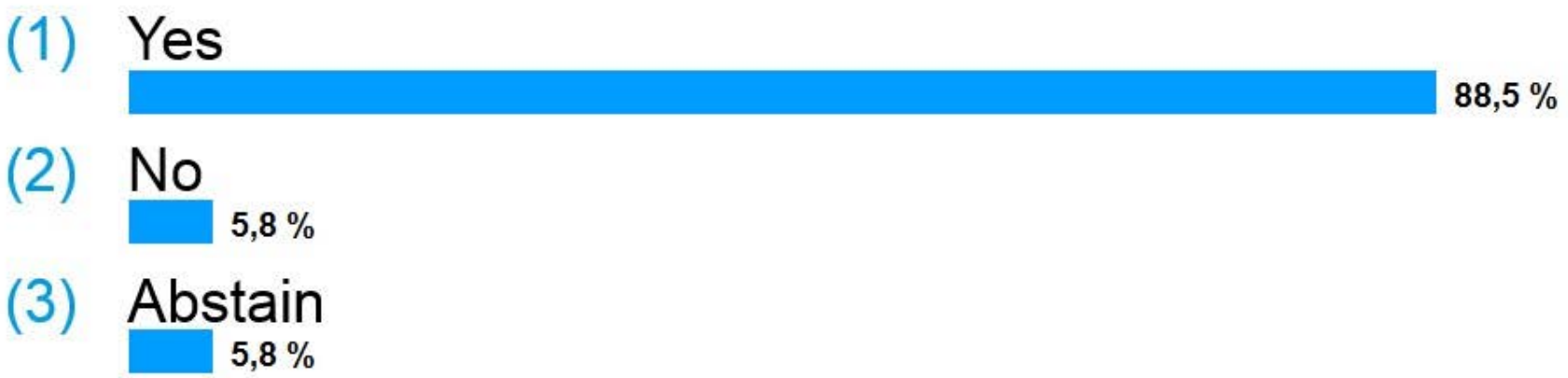
Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

104. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of adjuvant therapy involving *switch from TAM to an AI* (therefore assuming postmenopausal status at the 5 year time point and reasonable tolerance to endocrine therapy), patients at moderate or high risk of recurrence should be recommended to receive:

Continue AI to a cumulative total of 5 years AI



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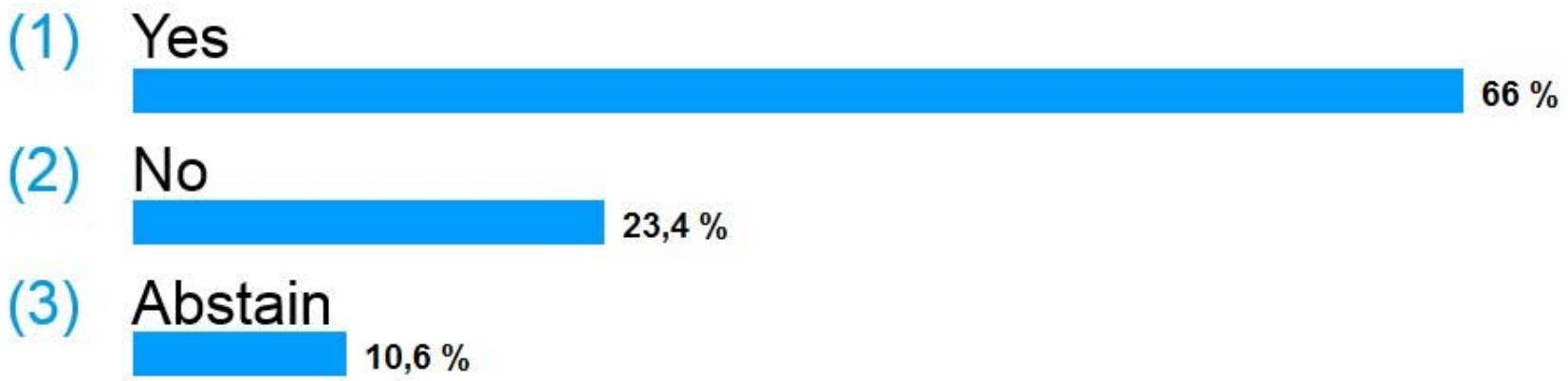
Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

105. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of adjuvant therapy involving *switch from TAM to an AI* (therefore assuming postmenopausal status at the 5 year time point and reasonable tolerance to endocrine therapy), patients at moderate or high risk of recurrence should be recommended to receive:

A further 5 years AI



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Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

106. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of adjuvant therapy involving *switch from TAM to an AI* (therefore assuming postmenopausal status at the 5 year time point and reasonable tolerance to endocrine therapy), patients at moderate or high risk of recurrence should be recommended to receive:

No further endocrine therapy

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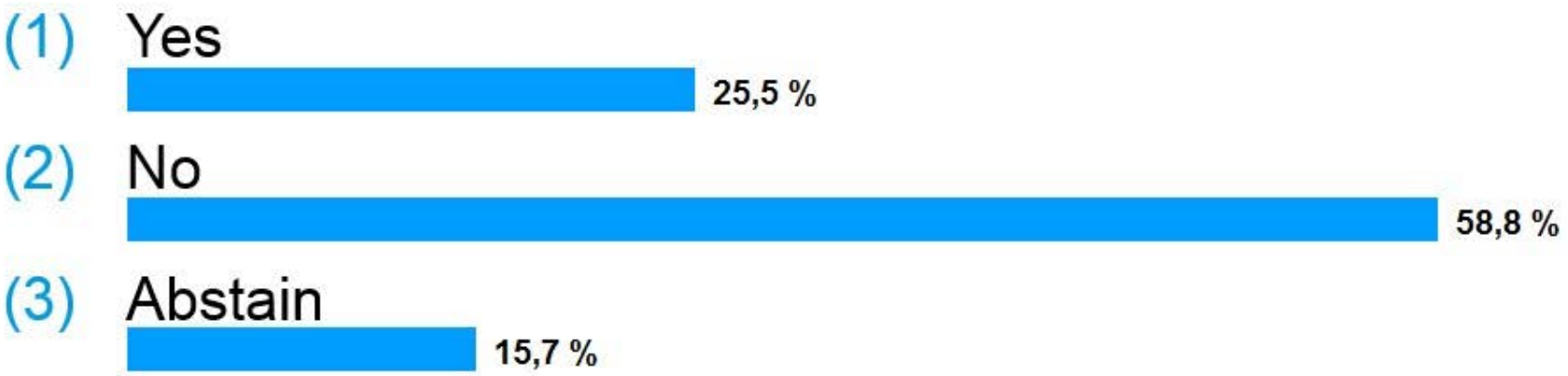
Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

107. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of *straight AI* adjuvant therapy, patients should be recommended to receive:

A further 3 to 5 years of Tamoxifen



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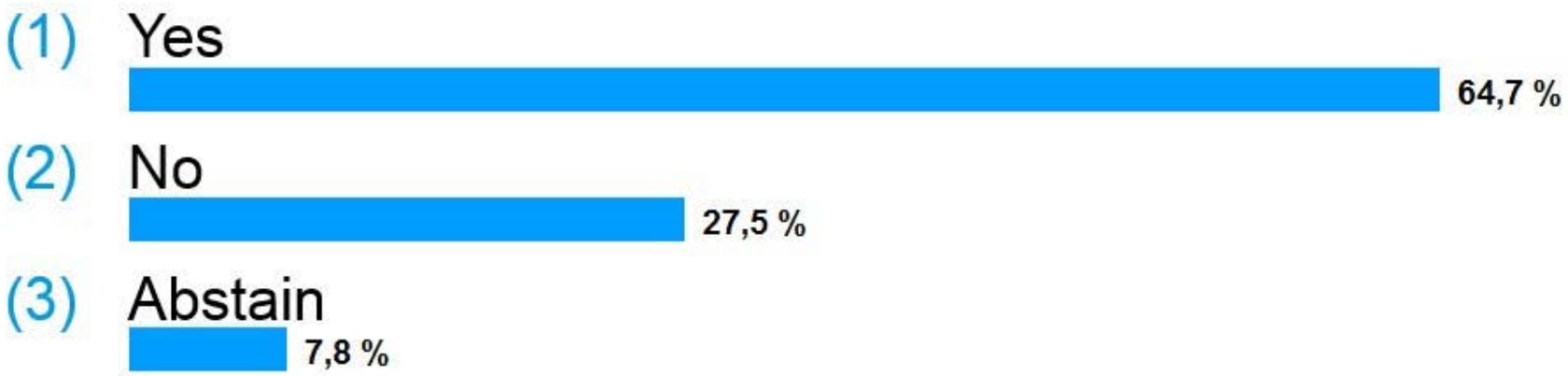
Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

108. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of *straight AI* adjuvant therapy, patients should be recommended to receive:

A further 3 to 5 years of AI



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Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

109. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of *straight AI* adjuvant therapy, patients should be recommended to receive:

Duration of AI depend upon tolerance and absolute risk

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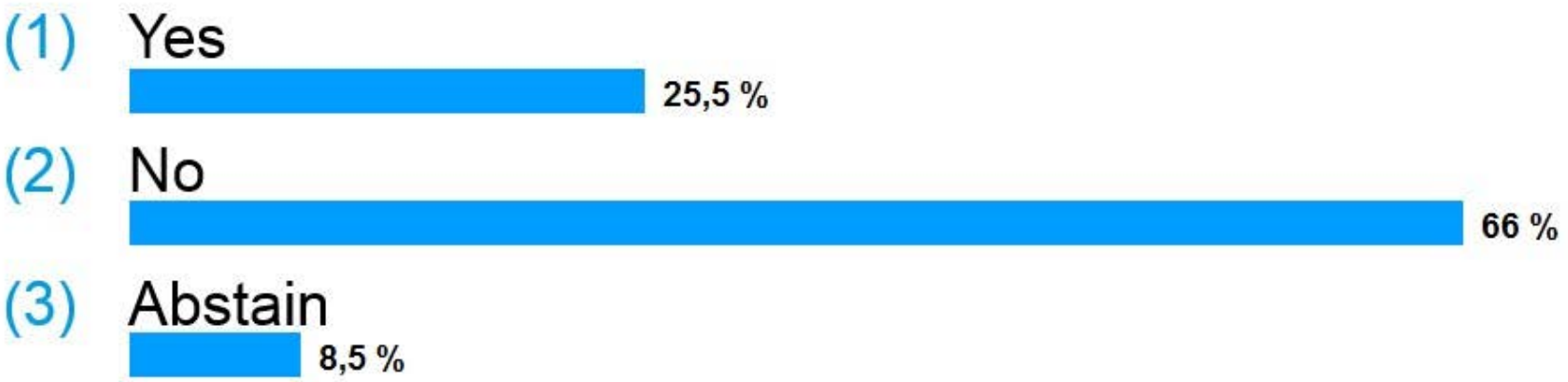
Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

110. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of *straight AI* adjuvant therapy, patients should be recommended to receive:

No further endocrine therapy



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Adjuvant Endocrine Therapy Duration (Premenopausal Patients)

111. **For premenopausal women (who remain premenopausal) TAM to 10 years should be recommended to:**

Premenopausal patients at high risk at presentation?

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Adjuvant Endocrine Therapy Duration (Premenopausal Patients)

112. **For premenopausal women (who remain premenopausal) TAM to 10 years should be recommended to:**

Premenopausal patients with any risk at presentation?

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Escalating and De-escalating

WHICH WOMEN SHOULD RECEIVE ADJUVANT CHEMOTHERAPY?

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Adjuvant Chemotherapy

115. **Treatment decision about both prognosis and the potential benefits of chemotherapy in N0 disease can be aided by which of the following:**

Biology defined by IHC features

Adjuvant Chemotherapy

116. **Treatment decision about both prognosis and the potential benefits of chemotherapy in N0 disease can be aided by which of the following:**

Multigene risk predictor

Adjuvant Chemotherapy

117. **If IHC is used, factors which are *relative* indications for the inclusion of adjuvant cytotoxic chemotherapy include:**

Histological grade 3 tumor

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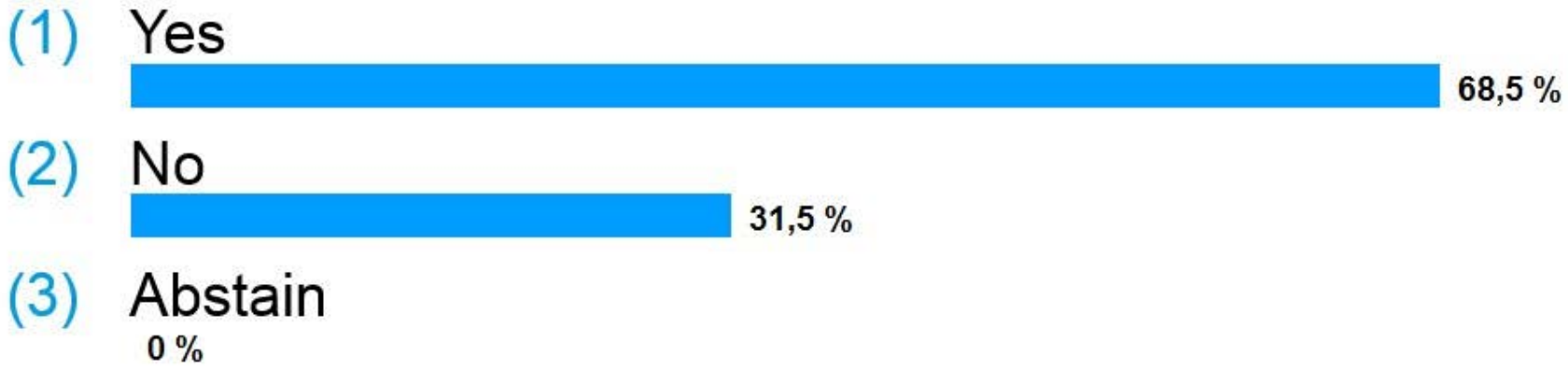
Adjuvant Chemotherapy

118. **If IHC is used, factors which are *relative* indications for the inclusion of adjuvant cytotoxic chemotherapy include:**

Any positive node



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Adjuvant Chemotherapy

120. **If IHC is used, factors which are *relative* indications for the inclusion of adjuvant cytotoxic chemotherapy include:**

Ki67 high

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Adjuvant Chemotherapy

121. **If IHC is used, factors which are *relative* indications for the inclusion of adjuvant cytotoxic chemotherapy include:**

Age < 35

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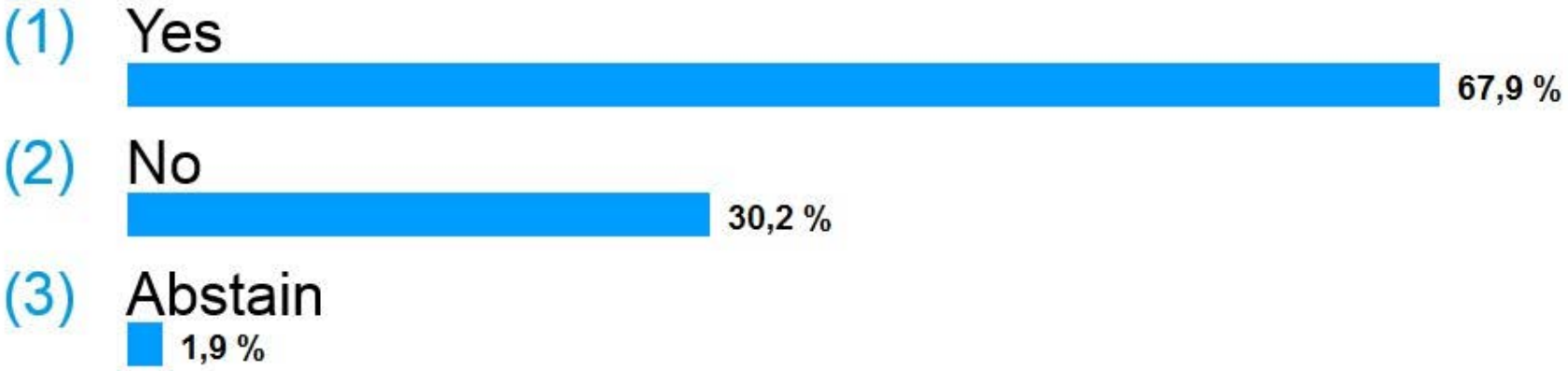
Adjuvant Chemotherapy

122. **If IHC is used, factors which are *relative* indications for the inclusion of adjuvant cytotoxic chemotherapy include:**

Extensive lympho-vascular invasion



Adjuvant Chemotherapy

123. **If IHC is used, factors which are *relative* indications for the inclusion of adjuvant cytotoxic chemotherapy include:**

Low hormone receptor staining

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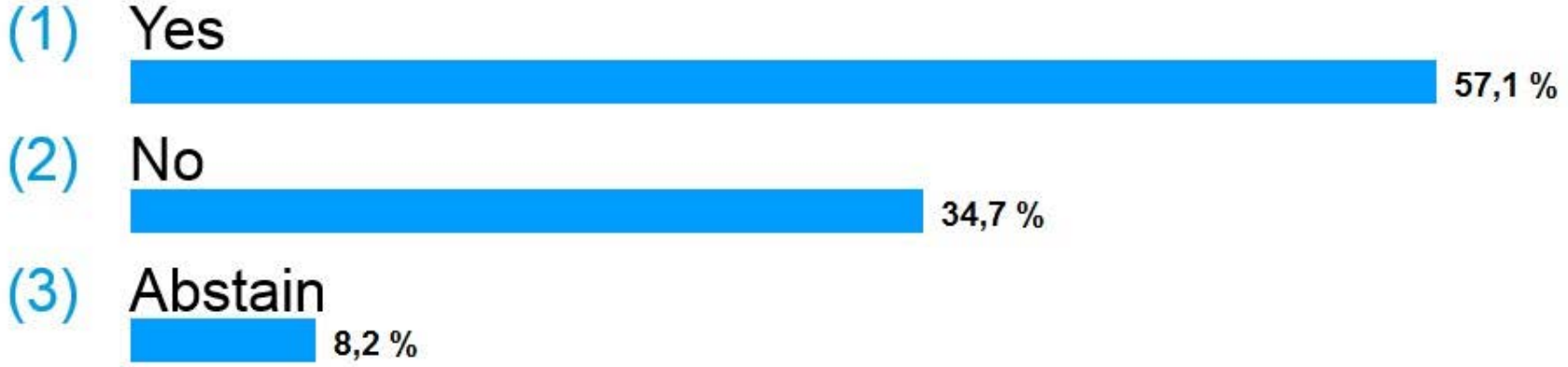
Adjuvant Chemotherapy

Luminal B-like Patients

127. **In patients with poor prognosis biology by *IHC* chemotherapy should be recommended in:**

All patients N0 and N+



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Adjuvant Chemotherapy

Luminal B-like Patients

128. **Chemotherapy may be safely *omitted* for N+ patients with:**

Low risk Oncotype Dx® score

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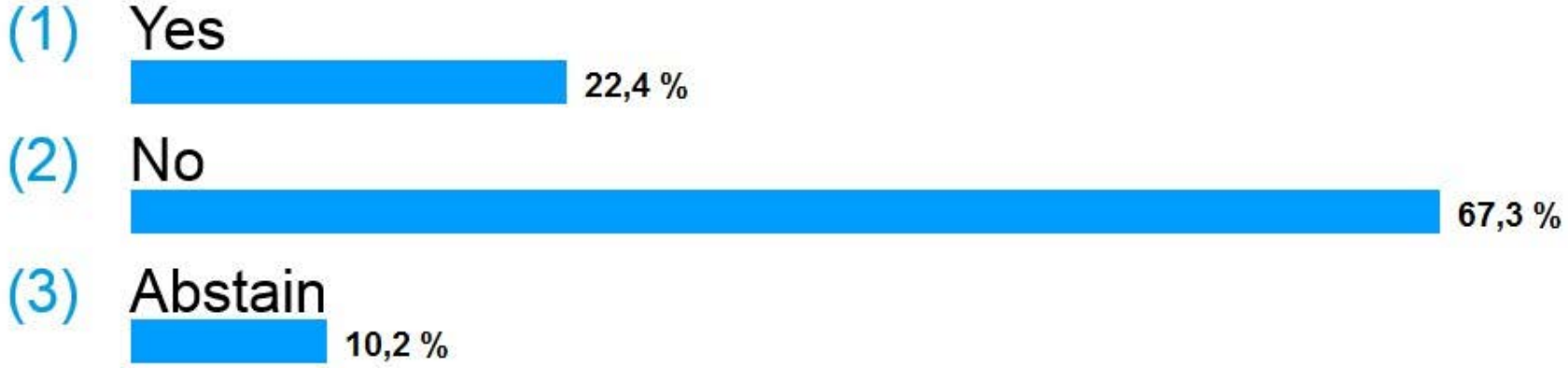
Adjuvant Chemotherapy

Luminal B-like Patients

129. **Chemotherapy may be safely *omitted* for N+ patients with:**

Intermediate Oncotype Dx® score



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Adjuvant Chemotherapy

Luminal B-like Patients

130. **Chemotherapy may be safely *omitted* for N+ patients with:**

MammaPrint® Low Risk

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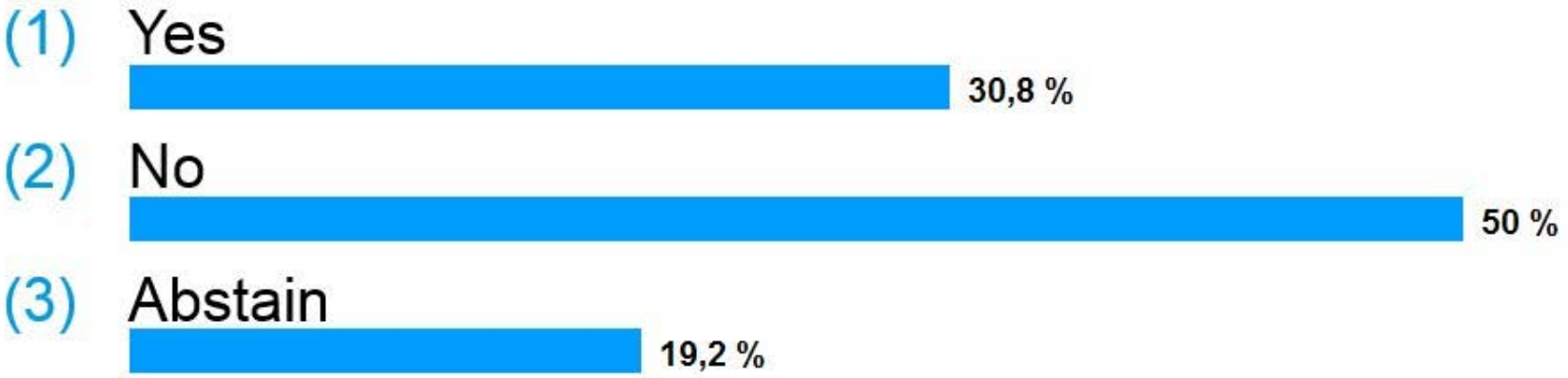
Adjuvant Chemotherapy

Luminal B-like Patients

131. **Chemotherapy may be safely *omitted* for N+ patients with:**

Low PAM50 ROR score



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Adjuvant Chemotherapy

Luminal B-like Patients

132. **Chemotherapy may be safely *omitted* for N+ patients with:**

EndoPredict® Low Risk

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Adjuvant Chemotherapy

Patients with Luminal B-like tumors (HER2 negative)

135. **If given, should the regimen contain anthracyclines and taxanes?**

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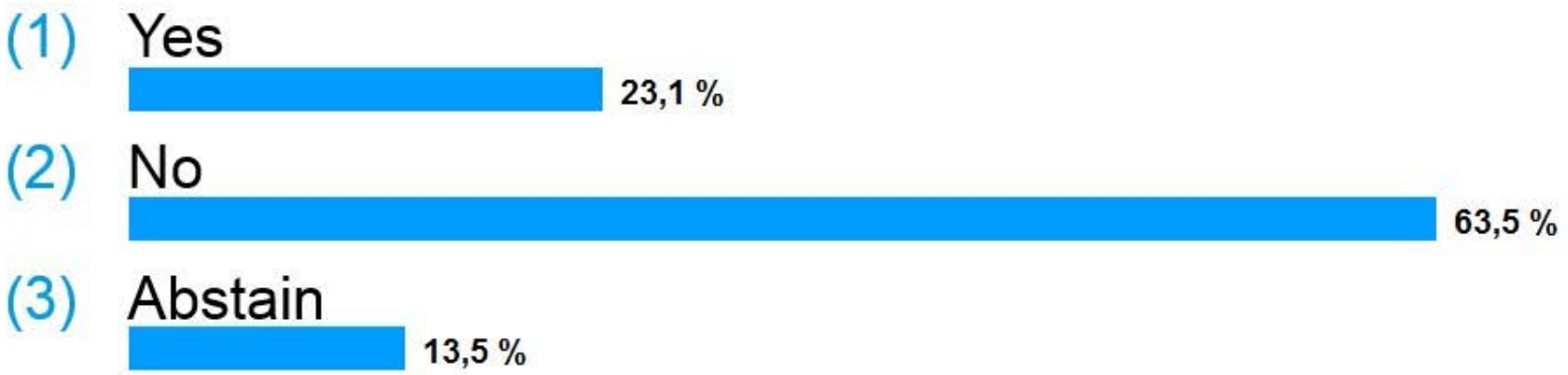
Adjuvant Chemotherapy

Patients with Luminal B-like tumors (HER2 negative)

136. **Should chemotherapy ever comprise 6 cycles of the same therapy (e.g. 6 courses of EC or AC or TC)?**



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Adjuvant Chemotherapy in patients with Ductal Triple-Negative BC

138. In stage I should the regimen for all TNBC phenotype contain anthracyclines and taxanes?

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Adjuvant Chemotherapy in patients with Ductal Triple-Negative BC

139. In stage II-III should the regimen for all TNBC phenotype contain anthracyclines and taxanes?

Adjuvant Chemotherapy in patients with Ductal Triple-Negative BC

140. **Should a platinum based regimen be considered?**

In all patients with TNBC?

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Adjuvant Chemotherapy in patients with Ductal Triple-Negative BC

141. **Should a platinum based regimen be considered?**
Only with known germline mutation?

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Adjuvant Chemotherapy in patients with Ductal Triple-Negative BC

142. Can we avoid chemotherapy in pT1a pN0 stage?

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Adjuvant Chemotherapy in patients with Ductal Triple-Negative BC

143. Should dose-dense chemotherapy be a preferred regimen?

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Adjuvant Chemotherapy

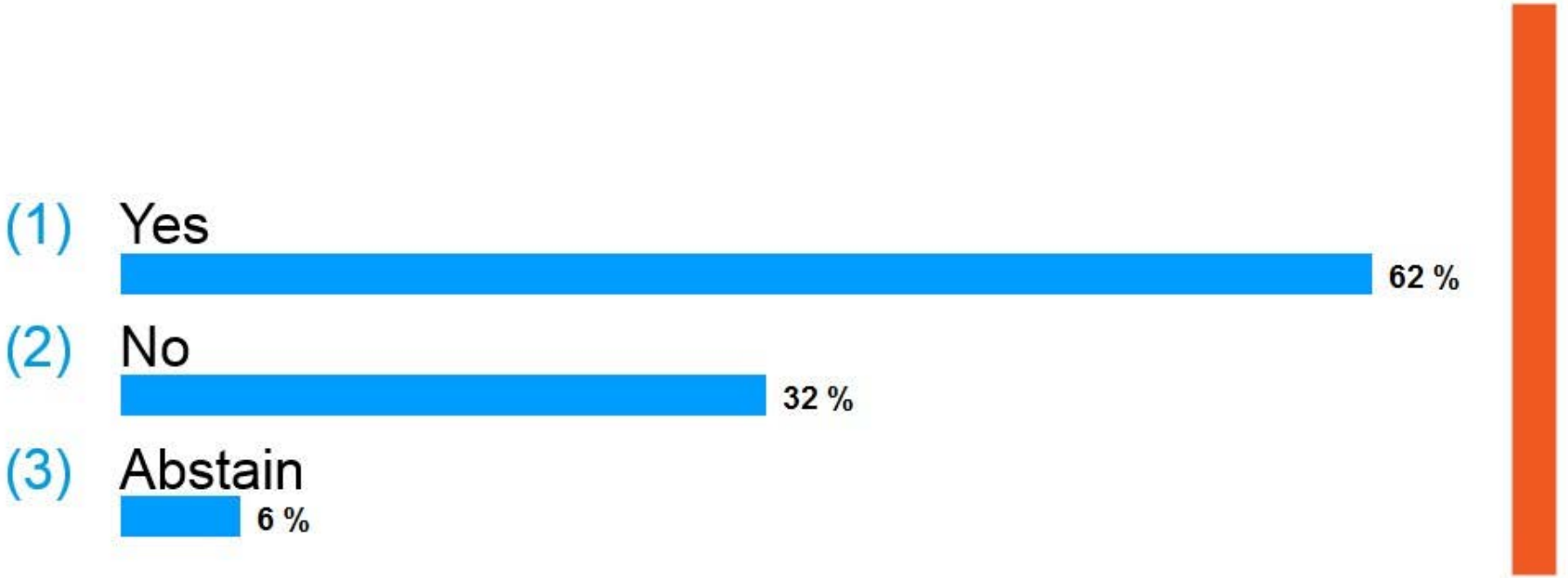
HER2-positive (node-positive disease) patients

144. **Should chemotherapy always be given to patients with N+ disease who require anti-HER2 therapy?**

Adjuvant Chemotherapy

HER2-positive (node-positive disease) patients

145. **Should the chemotherapy regimen for these patients include anthracyclines?**



Adjuvant Chemotherapy

HER2-positive (node-positive disease) patients

146. **Should the chemotherapy regimen for these patients include taxanes?**

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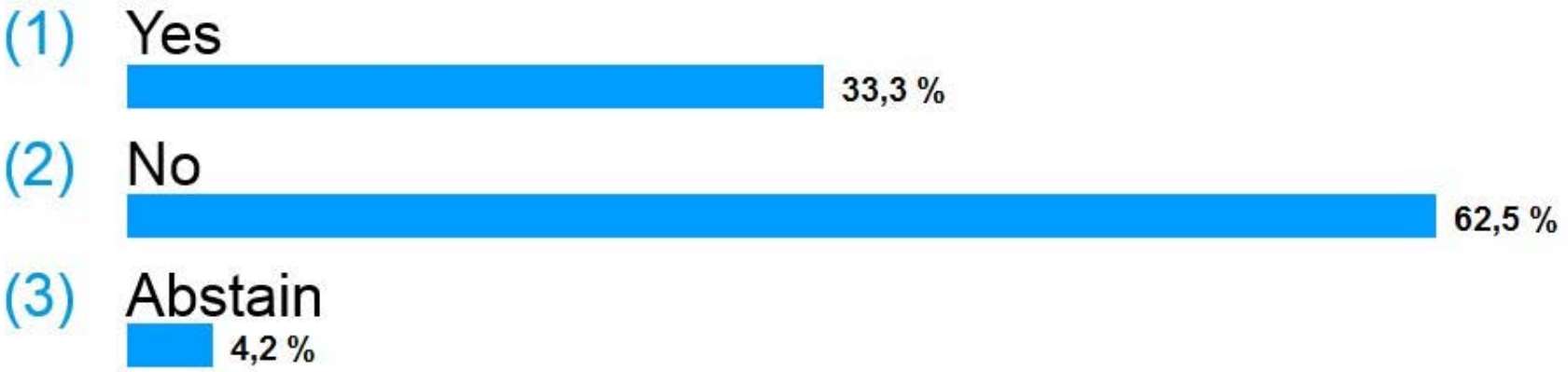
Adjuvant Chemotherapy

HER2-positive (node-negative disease) Patients

148. **With HER2 positivity determined according to ASCO/CAP guidelines:**

Do the large majority of patients with HER2 positive node-negative disease require anti-HER2 therapy:

With pT1a disease?



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Adjuvant Chemotherapy

HER2-positive (node-negative disease) Patients

149. **With HER2 positivity determined according to ASCO/CAP guidelines:**

Do the large majority of patients with HER2 positive node-negative disease require anti-HER2 therapy:

With pT1a disease?

Adjuvant Chemotherapy

HER2-positive (node-negative disease) Patients

150. **With HER2 positivity determined according to ASCO/CAP guidelines:**

Do the large majority of patients with HER2 positive node-negative disease require anti-HER2 therapy:

With pT1c disease?

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Adjuvant Chemotherapy

HER2-positive (node-negative disease) Patients

151. **With HER2 positivity determined according to ASCO/CAP guidelines:**

If given, is the combination of Paclitaxel and Trastuzumab a reasonable option?

Adjuvant Chemotherapy

HER2-positive (node-negative disease) Patients

152. **With HER2 positivity determined according to ASCO/CAP guidelines:**

If given, is the combination of Paclitaxel and Trastuzumab a reasonable option?

With primary less than 1 cm?

Adjuvant Chemotherapy

HER2-positive (node-negative disease) Patients

153. **With HER2 positivity determined according to ASCO/CAP guidelines:**

If given, is the combination of Paclitaxel and Trastuzumab a reasonable option?

With primary of 1-2 cm?

Adjuvant Chemotherapy

HER2-positive (node-negative disease) Patients

154. **With HER2 positivity determined according to ASCO/CAP guidelines:**

If given, is the combination of Paclitaxel and Trastuzumab a reasonable option?

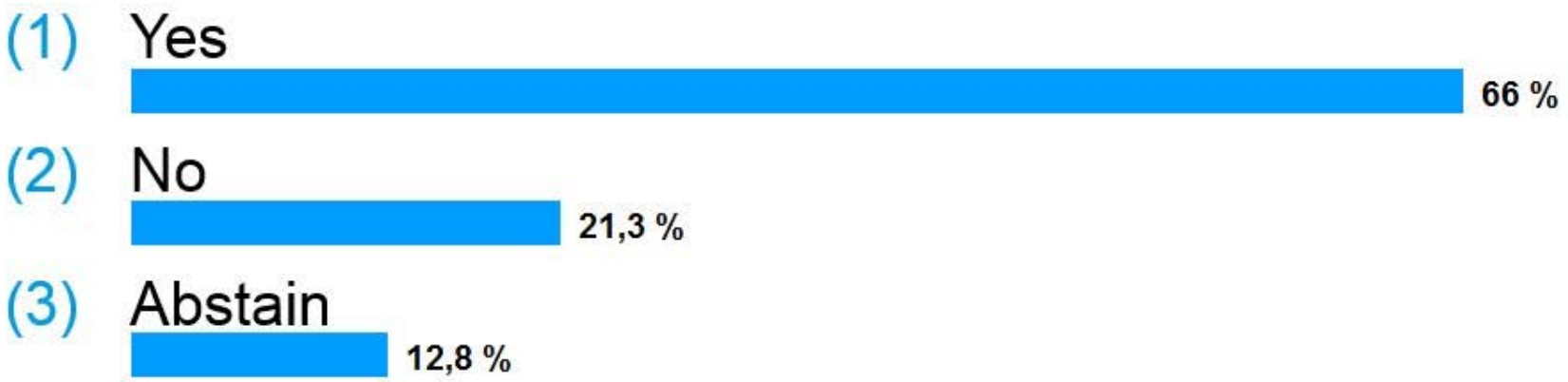
With primary of 2-3 cm?

Adjuvant Chemotherapy

HER2-positive (node-negative disease) Patients

155. **With HER2 positivity determined according to ASCO/CAP guidelines:**

If given, is the combination of Docetaxel and cyclophosphamide x 4 and Trastuzumab a reasonable option?



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Adjuvant Anti-HER2 Therapy

159. **In a patient who received neo-adjuvant chemotherapy with Trastuzumab and Pertuzumab, adjuvant therapy should include:**

Trastuzumab alone at completion of one year

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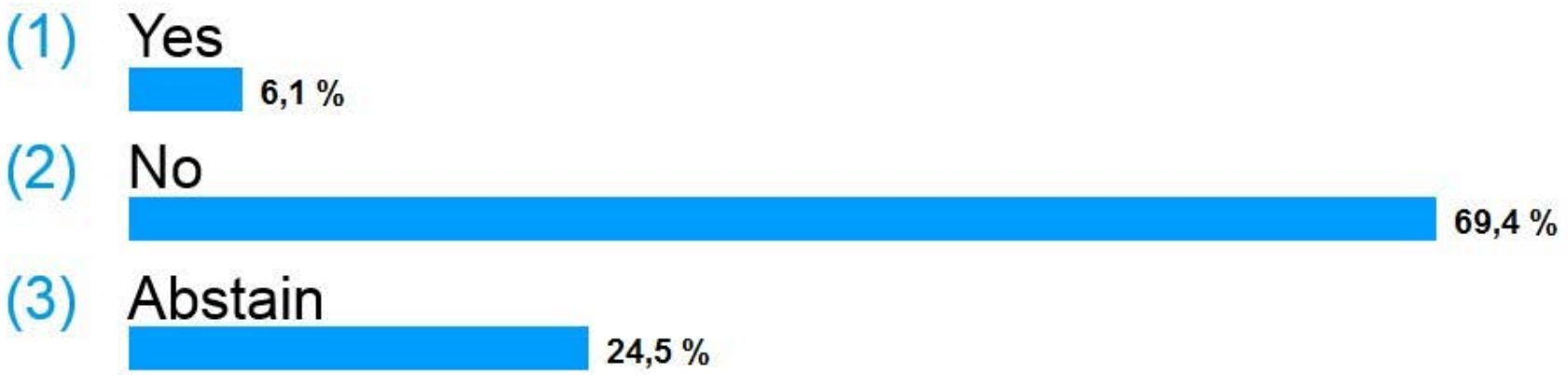
Adjuvant Anti-HER2 Therapy

160. **In a patient who received neo-adjuvant chemotherapy with Trastuzumab and Pertuzumab, adjuvant therapy should include:**

Trastuzumab + Pertuzumab at completion of one year



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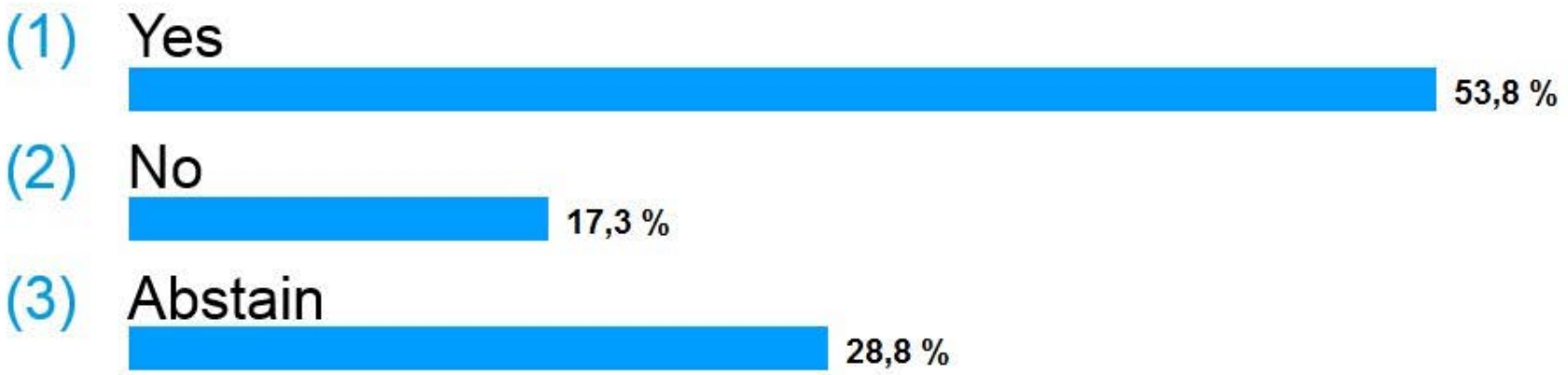
Biosimilars in HER2-Positive Disease

161. **If approved, are biosimilars of Trastuzumab acceptable in the neo-adjuvant and/or adjuvant treatment of HER2+ disease, based on current evidence?**



Neo-Adjuvant Systemic Therapy

(possibly followed by additional adjuvant chemo)

162. **In a woman eligible to breast conservative surgery should neo-adjuvant chemotherapy and anti-HER2 therapy be the preferred option for HER2-positive EBC patients in stage II-III?**

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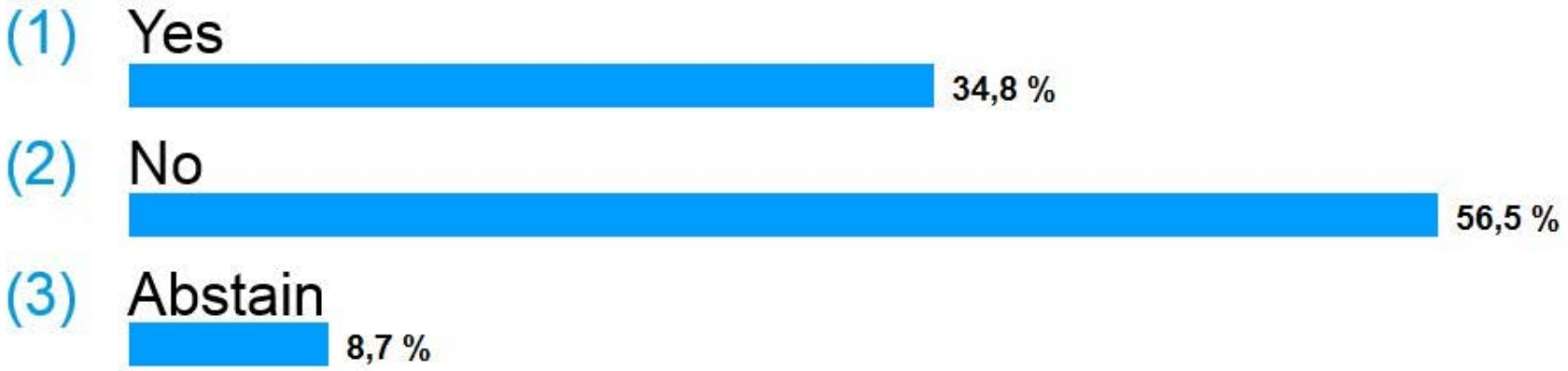
Neo-Adjuvant Systemic Therapy

(possibly followed by additional adjuvant chemo)

Stage II-III HER2-positive Disease

163. **If given, in patients with HER2-positive tumors, acceptable regimen include:**

Taxane + Trastuzumab only



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Neo-Adjuvant Systemic Therapy

(possibly followed by additional adjuvant chemo)

Stage II-III HER2-positive Disease

164. **If given, in patients with HER2-positive tumors, acceptable regimen include:**

Taxane, Trastuzumab and Pertuzumab

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Neo-Adjuvant Systemic Therapy

Stage II-III Triple-Negative Disease

168. **In a woman eligible to breast conservative surgery should neo-adjuvant chemotherapy be a preferred option for TN EBC patients?**

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Neo-Adjuvant Systemic Therapy

Stage II Triple-Negative Disease

169. **If given, in patients with ductal triple-negative tumors (irrespective of BRCA status), the preferred regimen should include:**

Platinum or alkylating agents containing regimen

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Neo-Adjuvant Systemic Therapy

Stage II Triple-Negative Disease

170. **If given, in patients with ductal triple-negative tumors (irrespective of BRCA status), the preferred regimen should include:**

Anthracycline –> taxane non-dose dense

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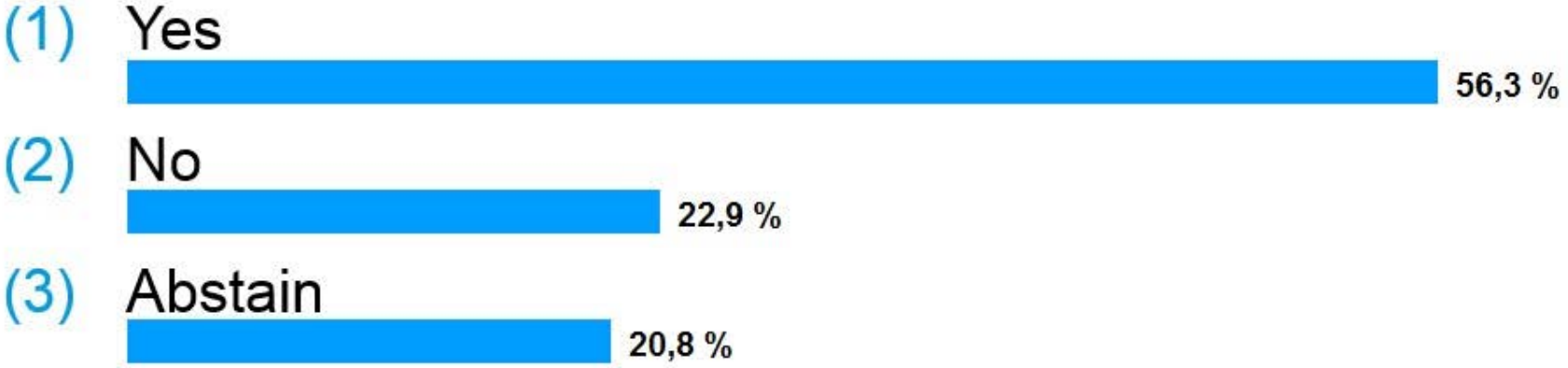
Neo-Adjuvant Systemic Therapy

Stage II Triple-Negative Disease

172. **If given, in patients with ductal triple-negative tumors (irrespective of BRCA status), the preferred regimen should include:**

Nab-Paclitaxel -> EC



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Escalating and De-escalating

WHICH WOMEN SHOULD RECEIVE ADDITIONAL THERAPY AFTER NEO-ADJUVANT TREATMENT?

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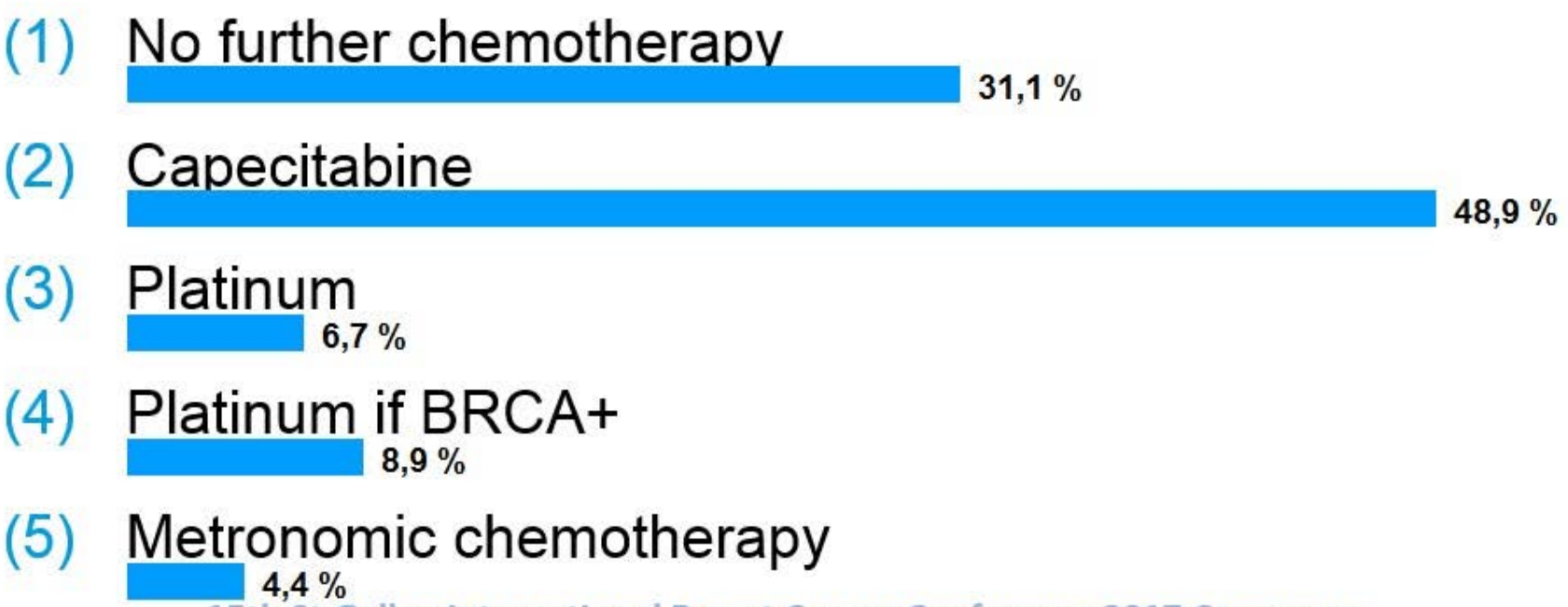
Additional Adjuvant Chemotherapy in the Post-Neo-Adjuvant Setting

174. **In case of clinical response and residual disease of greater than 1 cm and/or a positive node at surgery following neo-adjuvant (anthracycline-, taxane- and alkylator-based) chemotherapy for TNBC, we should propose:**



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Additional Adjuvant Chemotherapy in the Post-Neo-Adjuvant Setting

175. **In case of clinical response and residual disease of greater than 1 cm and/or a positive node at surgery following neo-adjuvant (anthracycline-, taxane- and alkylator-based) chemotherapy for TNBC, we should propose:**

A clinical trial when available

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Scalp-Cooling

176. **Is a scalp cooling device an option to prevent hair loss during (neo-)adjuvant chemotherapy?**

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Escalating and De-escalating

SHOULD WE ROUTINELY ADD BONE-MODIFYING THERAPY AS ADJUVANT TREATMENT?

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Adjuvant Bisphosphonates

177. **Is bisphosphonate treatment, such as zoledronic acid q 6 months or oral clodronate, during adjuvant endocrine therapy, indicated to improve DFS irrespective of BMD?**

In premenopausal patients receiving LHRH plus TAM or plus AI?

Adjuvant Bisphosphonates

178. **Is bisphosphonate treatment, such as zoledronic acid q 6 months or oral clodronate, during adjuvant endocrine therapy, indicated to improve DFS irrespective of BMD?**

In premenopausal patients not receiving LHRH?

Adjuvant Bisphosphonates

179. **Is bisphosphonate treatment, such as zoledronic acid q 6 months or oral clodronate, during adjuvant endocrine therapy, indicated to improve DFS irrespective of BMD?**

In postmenopausal patients?

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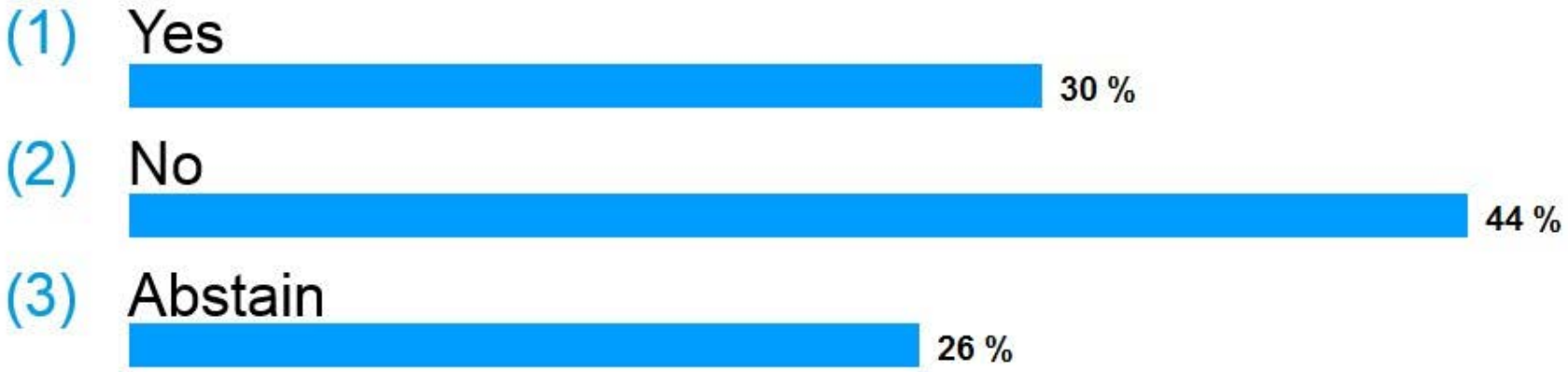
Adjuvant Bisphosphonates

180. **Should adjuvant denosumab (60 mg twice a year) substitute for bisphosphonate?**



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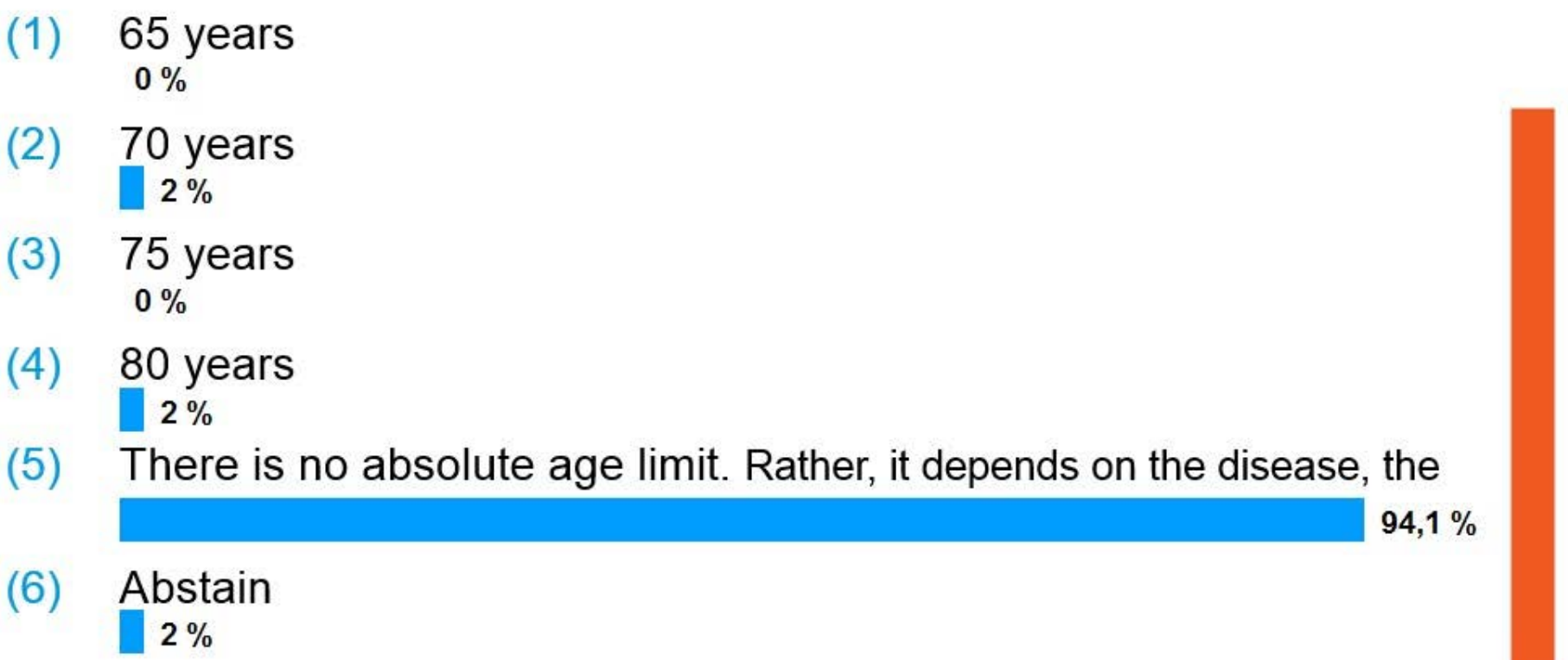
Escalating and De-escalating

SPECIAL POPULATIONS

Age and Adjuvant Chemotherapy

181. **In the absence of significant co-morbidity, the maximum age at which a standard adjuvant chemotherapy regimen should be advised is:**



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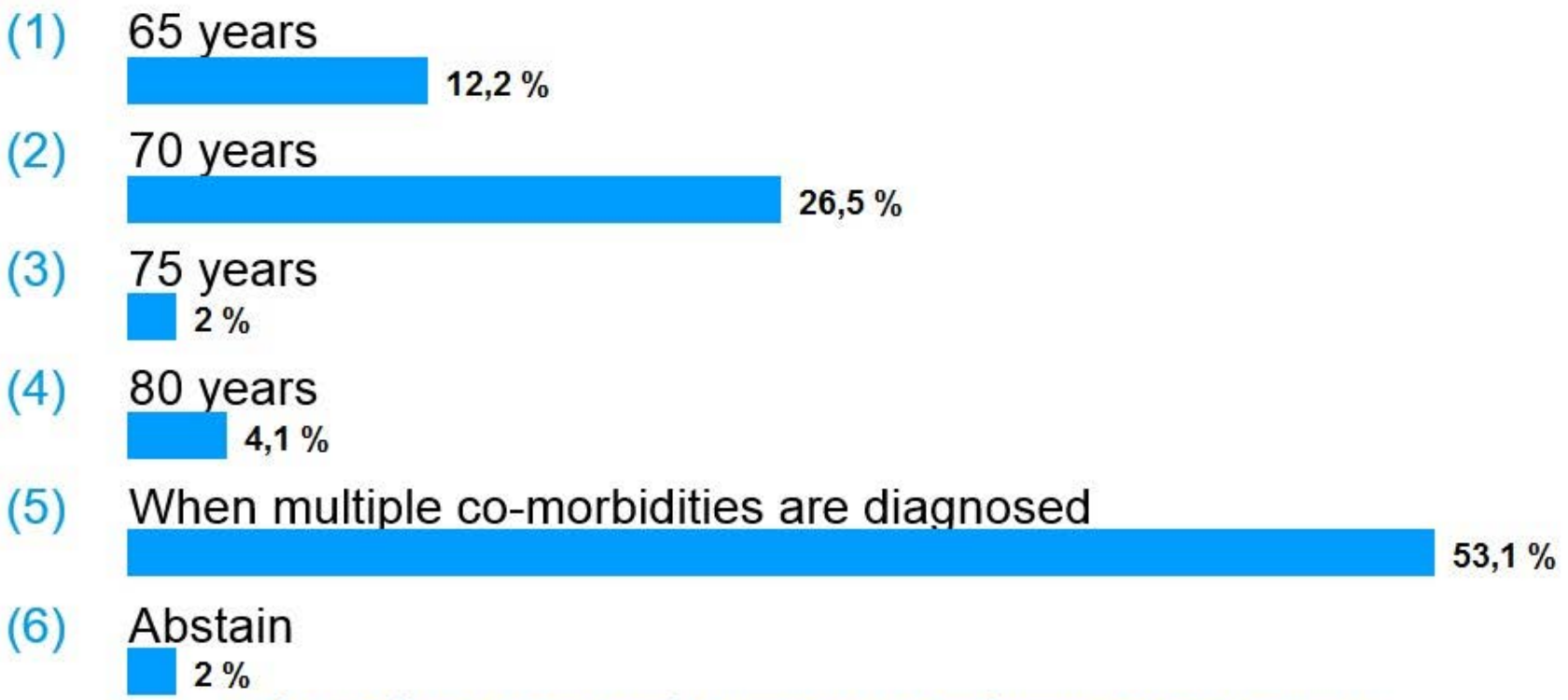
Elderly Patients: Adjuvant Radiation

182. **In postmenopausal patients with ER-positive tumors, who have a low-risk genomic score, node-negative, receiving endocrine therapy, radiation after breast conserving surgery may be omitted in patients:**



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Pregnancy After Breast Cancer

183. **For patients planning pregnancy in the 5 years following surgery, is it reasonable to discuss to interrupt endocrine therapy to allow attempted pregnancy:**

At any time during endocrine therapy?

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Male Breast Cancer

187. **In male patients with ER positive breast cancer, post-operative adjuvant Tamoxifen is currently advised.**

Adjuvant therapy options beyond Tamoxifen (if TAM is contraindicated in the adjuvant setting) include:

Aromatase inhibitors alone

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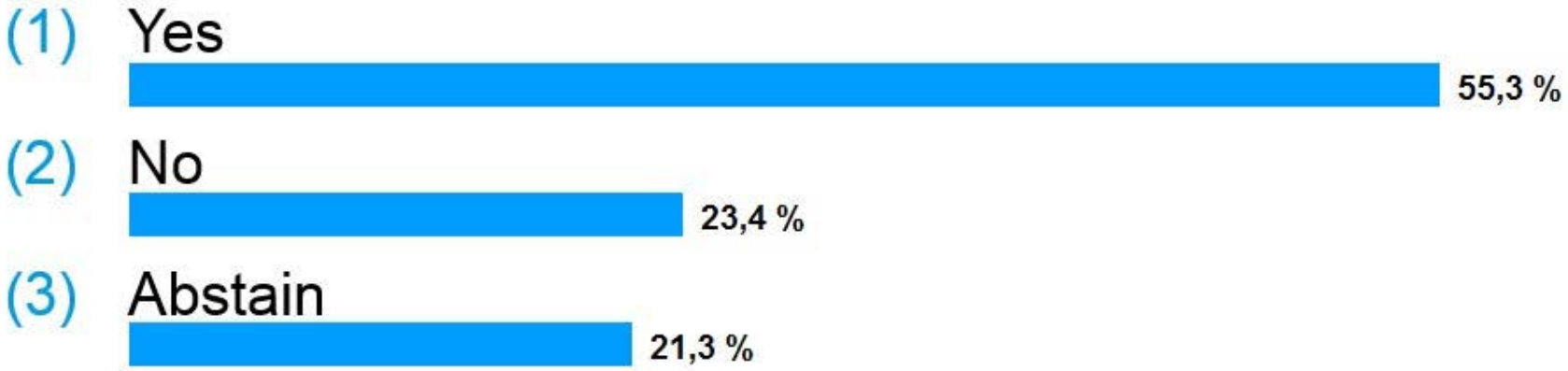
Male Breast Cancer

188. **In male patients with ER positive breast cancer, post-operative adjuvant Tamoxifen is currently advised.**

Adjuvant therapy options beyond Tamoxifen (if TAM is contraindicated in the adjuvant setting) include:

Aromatase inhibitors + LHRH a



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Escalating and De-escalating

SHOULD WE EXPAND THE USE OF GENETIC TESTING IN BREAST CANCER PATIENTS?

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High Risk Mutations

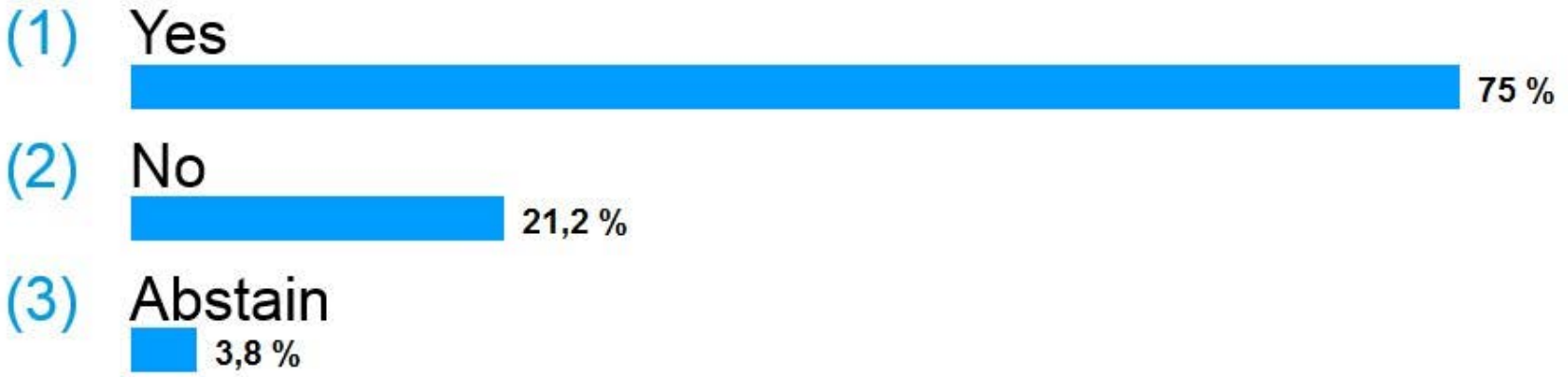
192. **Genetic testing for high risk mutations should be considered, after counselling, in:**

Patients with a strong family history

High Risk Mutations

193. **Genetic testing for high risk mutations should be considered, after counselling, in:**

Patients under 40 at breast cancer diagnosis



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High Risk Mutations

194. **Genetic testing for high risk mutations should be considered, after counselling, in:**

Patients under 50 at breast cancer diagnosis

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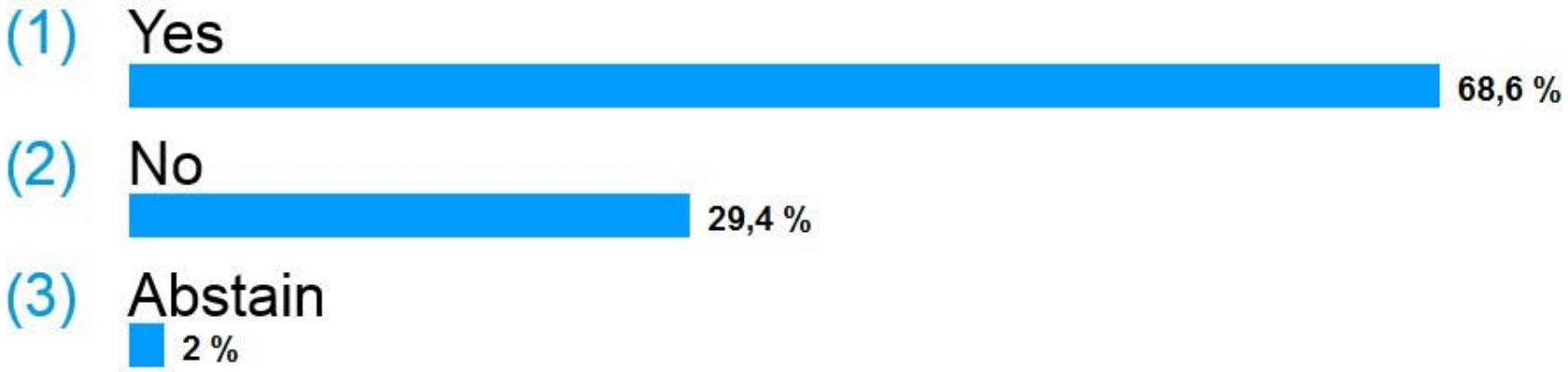
High Risk Mutations

195. **Genetic testing for high risk mutations should be considered, after counselling, in:**

Patients under 60 with TNBC only



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High Risk Mutations

196. **BRCA 1 or 2 mutations may impact treatment decisions on**

Breast surgery

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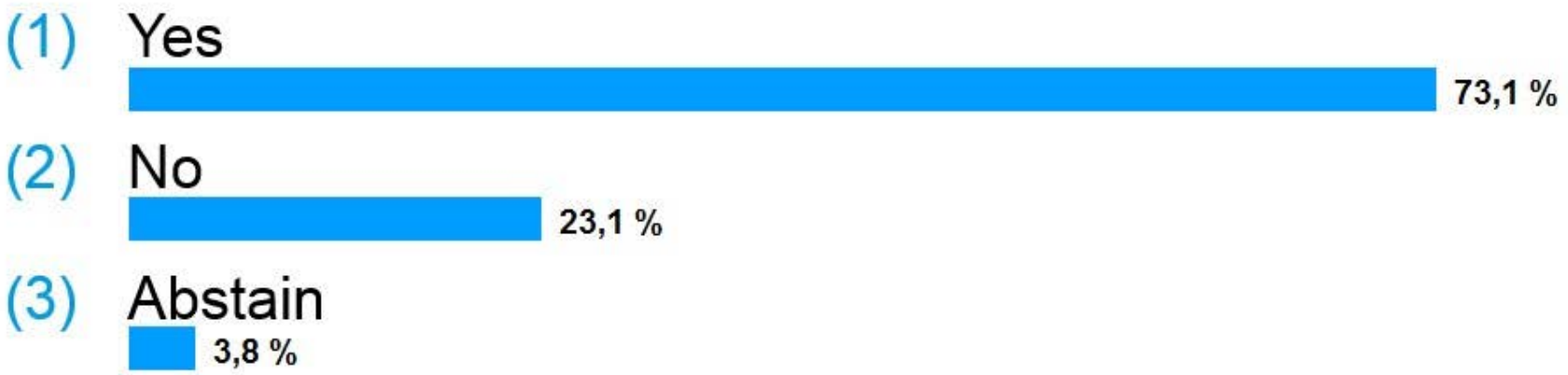
High Risk Mutations

197. **BRCA 1 or 2 mutations may impact treatment decisions on**

Systemic therapies



High Risk Mutations

198. **BRCA 1 or 2 mutations may impact treatment decisions on**

Other prophylactic interventions

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Escalating and De-escalating

SHOULD BREAST CANCER PATIENTS RECEIVE SPECIFIC DIET AND LIFESTYLE INTERVENTIONS BEYOND 'ORDINARY' ADVICE ON MAINTAINING HEALTHY LIFESTYLES?

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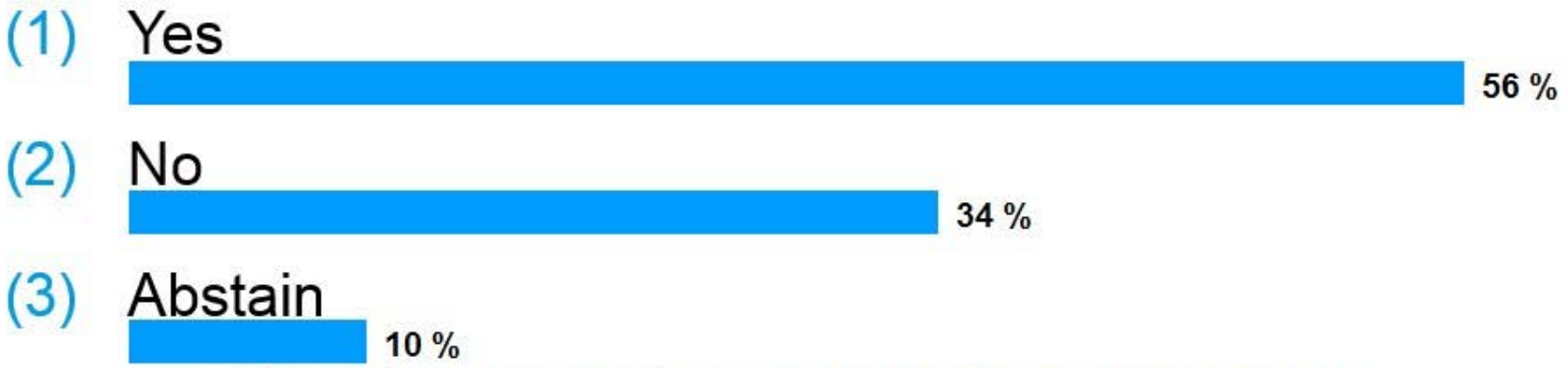
Adjuvant Diet and Exercise

199. **Independent of any lifestyle recommendations that may be offered for rehabilitation, symptom control and/or general health, would you ALSO recommend the following with the goal of reducing risk of recurrence and/or death from breast cancer?**

That patients should receive dietary advice in keeping with national guidelines?



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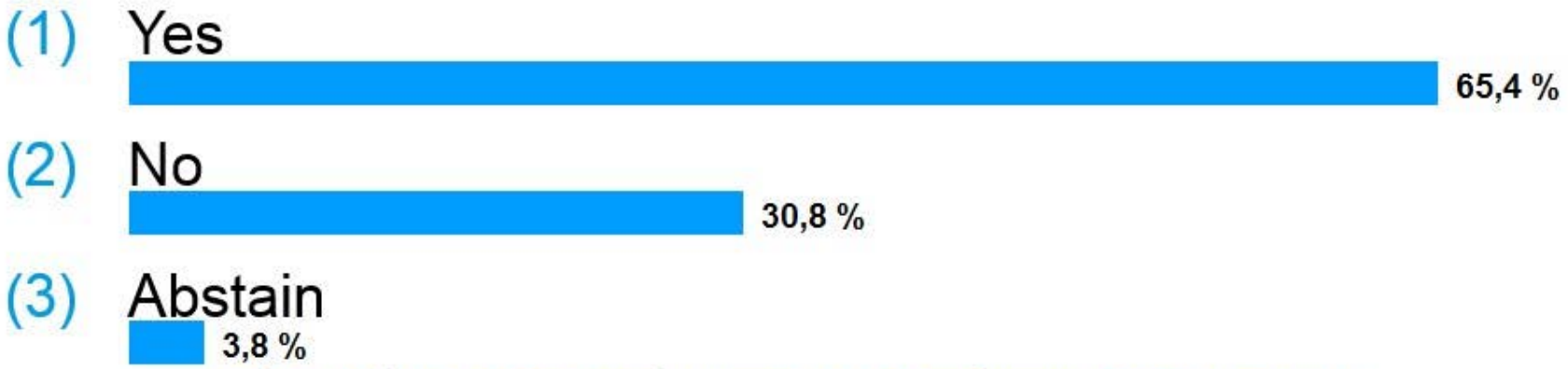
Adjuvant Diet and Exercise

200. **Independent of any lifestyle recommendations that may be offered for rehabilitation, symptom control and/or general health, would you ALSO recommend the following with the goal of reducing risk of recurrence and/or death from breast cancer?**

That physical activity (at least 150 minutes per week) be recommended as part of standard care?



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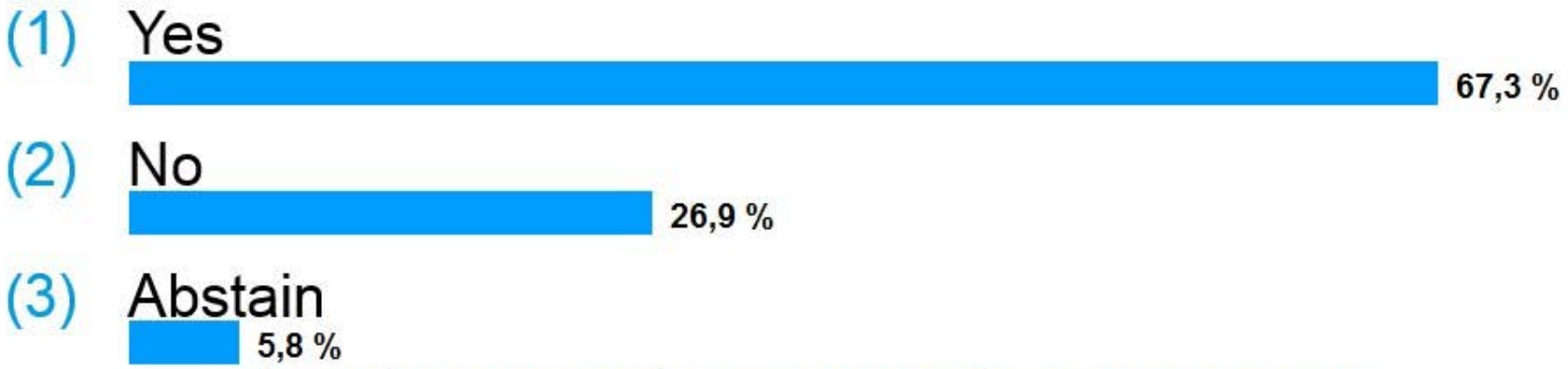
Adjuvant Diet and Exercise

201. **Independent of any lifestyle recommendations that may be offered for rehabilitation, symptom control and/or general health, would you ALSO recommend the following with the goal of reducing risk of recurrence and/or death from breast cancer?**

That weight loss to a normal BMI (20-25) and avoidance of weight gain (providing BMI at least 20) be recommended?



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THANK YOU

Would you please remain in your seats for some minutes to allow the closing message of the conference

174 B

1) Yes

2) No

3) Abstain