Highlights from the 2018 San Antonio Breast Cancer Symposium
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It’s been 40 years since doctors in San Antonio first organized a conference about breast cancer to educate local physicians. A few nationally known experts flew in, and at an airport hotel, some 140 people talked over slide presentations.

The event has grown — and evolved — since 1978. This year, some 7,500 people gathered in early December at the San Antonio Breast Cancer Symposium (SABCS), the world’s largest annual conference devoted to breast cancer. The SABCS is also unique with the inclusion of patient advocates alongside scientists and clinicians. In San Antonio, advocates stand up and ask questions after plenary talks, sit on panels, contribute papers and weigh in on research priorities.

This was my 8th San Antonio Breast Cancer Symposium attending as a patient advocate. In those 8 years with the growth of routine tumor genomic testing and targeted therapies, I have seen the science of breast cancer and its treatment moving faster than ever before. I always listen to the presentations with an ear towards what new research will change the direction of clinical diagnosis, treatment and survivorship. The following are what I thought were some of the most important take-home messages important to patients.

The chemo decision just got easier for some patients
For many early-stage breast cancer patients, one of the most difficult treatment decisions is whether or not to have chemotherapy. Many doctors use the Oncotype DX test to help figure out a woman’s risk of early-stage, estrogen-receptor-positive (ER+), HER2-negative breast cancer coming back (recurrence), as well as how likely she is to benefit from chemotherapy after breast cancer surgery. The Oncotype DX test is a genomic test that analyzes the activity of a group of 21 genes from a breast cancer tissue sample that can affect how a cancer is likely to behave and respond to treatment. The Oncotype DX test assigns a Recurrence Score — a number between 0 and 100. A recurrence score lower than 18 indicates that the cancer has a low risk of recurrence and the benefit of chemotherapy is likely to be small and will not outweigh the risks of side effects. A recurrence score of 18 up to and including 30 indicates the cancer has an intermediate risk of recurrence. It’s unclear whether the benefits of chemotherapy outweigh the risks of side effects in this group. A recurrence score greater than or equal to 31 indicates the cancer has a high risk of recurrence, and the benefits of chemotherapy are likely to be greater than the risks of side effects. Women and their doctors wondered about women with an intermediate Recurrence Score of 11 to 25 -- could they also skip chemotherapy? The TAILORx study was a large randomized trial involving 10,200 patients. It found that for patients in the middle range (scores between 11 and 25) there is a similar rate of cancer-free survival for those who had chemo combined with hormone therapy, and those who had hormone therapy alone, after nine years. Overall this is good news for those with this intermediate risk score who can forego chemotherapy. Women younger than 50 still saw some benefit from chemotherapy, especially with scores between 21-25. As always, discuss with your doctor if these results apply to you and what other factors need to be considered when developing your treatment plan.


Time to make sure you see an oncologist before a surgeon
There were numerous studies reporting on the benefits of neoadjuvant chemotherapy and/or hormonal therapy before surgery. I believe this should change clinical workflow for patients. No longer should
patient be diagnosed by the radiologist then go directly to a surgeon. There should be a conversation with an oncologist to see if the patient is a candidate for neoadjuvant (chemo, hormonal or radiation before surgery) therapy. Data presented from a new meta-analysis indicated that for patients with localized breast cancer achieving a pathological complete response (pCR), adjuvant therapy (chemo after surgery) did not improve 5-year event-free survival. This study suggests that the impact of chemotherapy occurs early in the course of treatment, and if used early, the impact will persist. At a minimum, it is not worse to give neoadjuvant chemotherapy and there may be some benefits associated with it. Such as measuring a response to treatment (tumor shrinkage) and the possibility of breast conserving surgery. The relationship between pathological complete response and survival was strongest for triple negative breast cancer and a lesser extent for ER-positive and HER2-negative breast cancer.

1. pCR: One-way doctors judge the effectiveness of neoadjuvant chemotherapy is to look at the tissue removed during surgery to see if any actively growing cancer cells are present. If no active cancer cells are present, doctors call it a “pathologic complete response” or pCR.

2. Event-free-survival: the length of time after primary treatment for a cancer ends that the patient remains free of certain complications or events that the treatment was intended to prevent or delay.


**Tamoxifen for high-risk prevention**

Treatment with a low dose of tamoxifen (5 mg per day) halved the risk of disease recurrence and new disease for women who had been treated with surgery following a diagnosis of breast intraepithelial neoplasia compared with placebo, and did not cause more serious adverse events, according to data from the randomized, phase III clinical. Breast intraepithelial neoplasia is a term for a group of noninvasive conditions in which abnormal cells are found in the breast, including ductal carcinoma in situ (DCIS), lobular carcinoma in situ (LCIS), and atypical ductal hyperplasia (ADH). “Unfortunately, tamoxifen is associated with an increased risk of endometrial cancer, venous thromboembolism and can cause menopausal symptoms that lead to treatment discontinuation,” said Andrea DeCensi M.D., PI of the study. “Our data show that in a randomized trial, low-dose tamoxifen was effective at reducing the risk of breast cancer development and recurrence for women with DCIS, LCIS, and ADH, and it did not cause significant serious adverse events or any increase in menopausal symptoms. Therefore, we strongly believe that these data are practice-changing.”


**Accelerated partial vs whole breast radiation**

Women diagnosed with early-stage breast cancer who have lumpectomy to remove the cancer usually have radiation therapy after surgery. Radiation therapy after lumpectomy lowers the risk of the cancer coming back (recurrence) and makes lumpectomy as effective as mastectomy. Radiation can be delivered to the entire breast — called whole-breast radiation (WBI)— or to just the area of the breast where the cancer was — called accelerated partial-breast radiation (PBI). The NSABP B-39/RTOG 0413 study looked at 4,216 patients with ductal carcinoma in situ (DCIS) or invasive stage 1 node negative disease. 95.9% of women who underwent WBI were free of an in-breast recurrence at 10 years, compared with 95.2% of women who had undergone PBI. This difference in the risk of recurrence was very small — less than 1% — and was not statistically significant. This means that it was likely due to chance and not because of the difference in treatment. Still, the results did not meet the statistical standards needed to say the two types of radiation therapy were equal. So, what do these results mean for patients? Partial-breast radiation is an important option for certain women where the daily trips to a
treatment center would be a burden because of distance, jobs or other commitments. –

Immuono- oncology for Triple Negative Breast Cancer
An important study called the IMpassion 130 trial showed that adding an anti-PD-L1 drug to first-line therapy benefited those with PD-L1-positive locally advanced or metastatic triple negative breast cancer. Some cancer cells have large amounts of the protein PD-L1 which helps them hide from immune attack. Anti-PD-L1 drugs, also known as checkpoint inhibitors, help the immune system to recognize and attack cancer cells. This study looked at the combining the anti-PD-L1 drug atezolizumab with nab-paclitaxel vs placebo with nab-paclitaxel. The results showed that adding the anti-PD-L1 offered better progression-free survival and overall survival compared to nab-paclitaxel alone. This is the first compelling evidence for therapeutic benefit of a checkpoint inhibitor in breast cancer. –

HER2-positive breast cancer
The KATHERINE study seemed to the most talked about trial at the symposium. This trial could have an immediate impact for patients with aggressive HER2-positive early stage disease. It showed that adding T-DM1 would be a more effective treatment after surgery for patients than the current standard of care drug, trastuzumab (Herceptin). The drug T-DM1 is the antibody trastuzumab, that targets HER2, attached to a second drug, emtansine (DM1). Trastuzumab recognizes tumor cells with HER2 and blocks it, but with T-DM1, the drug also delivers a chemotherapy drug that helps to kill the tumor cells directly. This antibody-drug conjugate ideally limits damage to healthy cells by delivering the chemotherapy directly to the cancer cells with HER2. This combination was shown to improve outcomes in early stage, HER2+ patients who still had invasive cancer after pre-treatment (neo-adjuvant treatment) when they went in for surgery. T-DM1 now joins the list of HER2-targeted therapies that could improve outcome in the setting of micrometastatic disease.

Metastatic ER-positive Breast Cancer
According to results of the randomized phase III SOLAR-1 trial the combination of alpelisib and fulvestrant prolongs progression-free survival in patients with PIK3CA-mutant, estrogen receptor-positive (ER+) advanced breast cancer whose cancer progressed on or after prior aromatase inhibitor-based therapy. Approximately 40% of estrogen receptor-positive breast cancers harbor mutations in the PIK3CA gene, resulting in tumor growth and treatment resistance. The study reported progression-free survival with the addition of alpelisib to fulvestrant from 5.7 months to 11 months. Overall survival is still not known, but for advanced ER+ patients with a PIK3CA mutation is a new possible treatment.

Symptom management
Unfortunately, hot flashes, a common symptom of menopause, can be more severe in breast cancer survivors. Chemotherapy may induce early menopause; antiestrogen medications, which are a major component of breast cancer treatment, may exacerbate hot flashes; and hormone replacement therapy, which is sometimes prescribed to treat hot flashes, is generally not recommended for breast cancer survivors. Hot flashes not only impact quality of life; they can also be associated with premature discontinuation of breast cancer treatment, which may increase the risk of breast cancer recurrence and mortality. In a study presented at the meeting, researchers looked at placebo compared with two different doses of oxybutynin. Oxybutynin (Ditropan XL) is most commonly used to treat overactive
bladder. Oxybutynin significantly improved hot flash frequency and severity and was associated with a positive impact in several quality of life measures. Although long-term toxicities of the drug have not been studied, based on this study, some clinicians felt comfortable prescribing oxybutynin to their patients.

Exercise
There were quite a few presentations on the benefits of exercise. The Norwegian EBBA-II trial was the first exercise trial to look specifically at cardiovascular function in women who had surgery for Stage I or II breast cancer. Most women were receiving adjuvant chemotherapy, radiation and/or hormonal therapy. Women in the study who underwent a supervised program of cardiovascular exercise during adjuvant breast cancer treatment experienced better cardiovascular function than those who were not part of the exercise program, according to trial results.

In the Phase III SUCCESS C study women were randomly assigned to receive either telephone-based, individualized guidance aimed at helping them achieve moderate weight loss for 2 years, or general recommendations for a healthy lifestyle alone. The women were given advice on how to improve their diets, lower fat intake, increase physical activity, and other tips that were geared to their specific needs. Evidence has shown that obesity and low physical activity are associated with higher risks of developing breast cancer, as well as an increased risk of recurrence and reduced survival. The study reaffirmed that control weight is one possible way to improve prognosis and outcomes for breast cancer patients. Again, this study adds to other research suggesting that along with healthy diet and lifestyle choices, regular exercise is one of the best things women can do to reduce fatigue, improve quality of life and keep the risk of breast cancer recurrence as low as it can be.

There were so many presentations over the 5 days of the meeting that I could not possibly report on all of them. Please contact me if you’d like to know if there were presentations on a subject you are interested in. If you would like to see the presentations from the 2018 SABCS, they will be available to the public on February 3, 2019. Log onto: https://www.sabcs.org/, then go down the page to “SABCS 2018 Resources Log In.” If you like further information on any study or copies of presentation slides before February 3, 2019, please contact me at joni@thescondopinion.org.