Fourth Annual

Orlando Breast Cancer Conference

Chairman:
Hyman B. Muss, MD
Professor of Medicine
University of Vermont
School of Medicine

Co-Chairs:
Olufunmilayo I. Olopade, MD
Professor of Medicine
University of Chicago
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Program Director:
John Pippen, Jr., MD, FACP
Attending Physician
Chair, Breast Tumor Site Committee
Baylor-Sammons Cancer Center

March 31 - April 1, 2007

Rosen Shingle Creek,
Orlando, Florida

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Panel Discussion Cases

The Fourth Annual Orlando Breast Cancer Conference

March 31-April 2, 2007

John E. Pippen Jr. MD, FACP
Baylor-Sammons Cancer Center
Dallas, Texas

Case #1

- A healthy 56 year old postmenopausal woman comes to your office to discuss prevention
- Screening mammogram and clinical exam are negative
- Mother had breast cancer at age 70
- One of her 2 sisters had ER+ breast Ca at age 54
- No other relatives with breast or ovarian cancer
- Ancestry is Scotch/Irish
- Prior hysterectomy, ovaries still in

Case 1 continued

- Would you order BRCA testing on this patient?
- A. Yes
- B. No

Case 1 continued

- After discussion with the patient, it is decided to try a preventive strategy. If a clinical trial is not available, your choice would be:
- A. Tamoxifen
- B. Raloxifene
- C. Anastrozole
- D. Other

Case #2

- A 32 year old AA patient comes in to discuss prevention
- The patient has no siblings. Her maternal GM had breast cancer at age 60, and her mother died of breast cancer at age 42
- Physical exam is normal
- She is G0 P0 with regular menses
- BRCA testing is ordered/pending
- Mammogram reveals dense breast tissue

Case 2 continued

- MRI reveals a suspicious 1.4 cm area in the UOQ of the left breast
- The center at which the study was done does not have MRI guided biopsy capability. You would:
- A. Refer to a center with MRI guided biopsy capability
- B. Await BRCA result prior to doing anything else

Case 2 continued

- The patient is BRCA 1 positive. MRI guided biopsy reveals DCIS, which is grade III, ER/PR-. The patient strongly desires breast conservation. You would suggest:
- A. Bilateral prophylactic surgery
- B. Right mastectomy and reconstruction
- C. Right lumpectomy and breast RT

Case 2 continued

- A right lumpectomy is done. There is a 1.4 cm area of high grade DCIS, which contains a 3 mm area of microinvasion. Margins are clear, and a sentinel node is negative.
- ER/PR-, MIB-1 60%, HER2-. You suggest:
- A. Whole breast irradiation
- B. Partial Breast irradiation
- C. Chemotherapy followed by irradiation

Case #3

- A 55 year old patient presents after left mastectomy with a:
- 1.5 cm grade II infiltrating ductal cancer with LVI
- The cancer is ER positive and HER/2 negative
- SLN has a 1mm deposit of carcinoma (H and E)
- Completion axillary dissection is suggested, to be followed by chemotherapy

Case #3, continued

- What chemotherapy would you give this patient, assuming no additional findings at axillary nodal dissection?
- A. AC x 4
- B. TC x 4
- C. TAC x 4-6
- D. Dose dense AC, followed by T
- E. None…endocrine therapy only

Case 3, continued

- While discussing adjuvant options, the patient says she will not allow additional axillary surgery. Would you ask radiation oncology to consider post-mastectomy radiation after chemotherapy?
- A. Yes
- B. No

Case 3 continued…

- The patient's menses ceased 7 years ago. For adjuvant endocrine therapy you suggest
- A. Tamoxifen followed by an AI
- B. Anastrozole x 5 years
- C. Letrozole x 5 years
- D. Exemestane x 5 years

Case # 4

- A 46 year old patient is now 1 year out from AC followed by paclitaxel for a 1.8 cm cancer with 1 positive axillary node.
- Strong ER +, PR -, and HER/2 –
- Menses ceased during chemotherapy, and have not returned
- Tamoxifen was started after chemotherapy. The patient now has “a few” hot flashes. Her estradiol, FSH, and LH are “equivocal” according to her gynecologist

Case # 4 continued

- You decide to continue tamoxifen
- She is told to avoid drugs known to interfere with cytochrome p450 2D6. At this point you should:
- A. Continue tamoxifen as noted above
- B. Continue Tamoxifen but order 2D6 genotype
- C. Consider ovarian ablation/suppression and an AI

Case #4 continued…

- When starting a patient on tamoxifen, you should ***routinely*** order the 2D6 genotype
- A. Yes
- B. No

Case # 5

- A 54 year old postmenopausal patient with no family history of breast or ovarian cancer sees you after excision of a 1.9 cm of DCIS with comedonecrosis
- ER/PR +, HER/2 +, and high grade
- No invasive tumor is found
- Final surgical margins are clear
- Although not considered standard of care, her surgeon removed 2 sentinel nodes, both of which show clusters of cytokeratin positive cells
- Should additional nodes be removed from this patient?

Case # 5 continued…

- In addition to radiation, you suggest…
- A. No rx
- B. Tamoxifen
- C. Anastrozole
- D. Chemotherapy, followed by endocrine therapy

Case #6

- A healthy 55 year old postmenopausal patient presents with:
- 1.8 cm grade II infiltrating ductal cancer
- Node -, HER/2 -, and strongly ER +, No LVI
- An OncotypeDx profile shows intermediate risk (12% risk of recurrence at 10 years if tamoxifen taken). You would suggest:
- A. Chemo, then adjuvant endocrine therapy
- B. Tamoxifen, followed by an AI
- C. An AI

Case 6 continued

- If after discussion chemo is decided on, what would you use?
- A. AC x 4
- B. TC x 4
- C. FEC x 4-6
- D. TAC x 4-6
- E. AC x 4, followed by docetaxel x 4
- F. AC, followed by paclitaxel x 4, dose dense
- G. Something else

Case #7

- A 40 year old patient comes to see you with a 0.7 cm grade II infiltrating ductal cancer
- ER/PR negative, no LVI
- Two sentinel nodes are negative
- FISH is positive for HER/2 overexpression
  You would:
- A. Offer no further treatment
- B. AC
- C. AC, followed by a taxane
- D. AC, followed by a taxane and trastuzumab
- E. A non-anthracycline regimen with trastuzumab (TCH)

Case #8

- A 71 year old patient with a history of coronary artery disease and well controlled hypertension on metoprolol and ASA comes to see you after a right mastectomy
- 2.7 cm infiltrating ductal cancer, grade II, with mixed lobular features
- ER is strongly positive, and PR is negative
- Node negative and HER/2 negative
- There is a question of one area of LVI
- Perineural invasion is present
- She wants to “do everything” to make sure that this cancer does not return

Case 8 continued

- What is the oldest patient that you have prescribed adjuvant chemotherapy for?
- A. 70-75
- B. 76-80
- C. 81-85
- D. Older than 85

Case 8 continued

- What is the “best” adjuvant chemotherapy to use in a healthy 72 year old?
- A. AC followed by T, dose dense
- B. TC x 4
- C. FEC x 4-6
- D. CMF
- E. AC alone

Case #9

- A 60 year old patient is currently on anastrozole, two years after a right mastectomy for a 1.9 cm infiltrating ductal cancer
- The cancer was node negative, HER/2 negative, and ER+
- The patient insists on lab work, which reveals a CA 27-29 of 81. CBC and CMP are normal
- Mammogram on the opposite breast is negative
- She had no chemotherapy in the adjuvant setting

Case 9 continued

- Imaging studies are ordered because of the elevated tumor marker. A bone scan is negative. CT scans reveal a 1.8 cm mass in the liver, which is suspicious for metastatic disease.
- Needle biopsy reveals breast cancer, with the same characteristics as the original

Case 9 continued

- At this point you would…
- A. Resect the lesion, followed by endocrine therapy
- B. Refer her for gamma knife, followed by endocrine therapy
- C. Proceed to other endocrine therapy
- D. Proceed to chemotherapy

Case 9 continued

- What is the ideal endocrine therapy for this patient?

- A. Exemestane
- B. Letrozole
- C. Fulvestrant 250 mg IM monthly
- D. Fulvestrant 500 mg D1, 250 mg D14, then 250 mg monthly
- E. Tamoxifen

Case 9 continued

- A year later while taking fulvestrant, she develops multiple liver nodules, and a CA 27-29 of 220. She has lost 10 pounds, and has a several fold increase in transaminases, with a bilirubin of 1.2.
- If she has never had chemotherapy, your choice of palliative treatment would be:
- A. AC
- B. A taxane
- C. Paclitaxel plus bevacizumab
- D. Docetaxel plus capecitabine
- E. Paclitaxel plus gemcitabine
- F. Capecitabine
- G. Other

Case #10

- A 42 year old patient with metastatic disease comes to you for a 2nd opinion regarding further palliative treatment
- Her original cancer is ER/PR-, and HER/2 was 2+ by IHC
- FISH was done at the original institution, and states “4 copies, gene amplified”
- Prior chemo included AC followed by T in the adjuvant setting

Case 10, continued

- In the metastatic setting she had trastuzumab/ capecitabine, which was stopped after two cycles
- She then had weekly docetaxel, carboplatin/ gemcitabine, and most recently liposomal doxorubicin
- Her current disease includes liver lesions to 12 cm, small lung nodules, and supraclavicular nodes which are easily palpable
- ECOG performance status is 1, and bilirubin is normal

Case #10, continued

- At this point, you would…
- A. Re-biopsy the easily palpable node for current characteristics of the tumor
- B. Send a blood specimen for levels of circulating levels of HER/2
- Proceed with treatment planning without any further determination of HER/2 status

Case #10, continued

- Circulating levels are HER/2 are high
- At this point you suggest…
- A. trastuzumab plus chemotherapy
- B. single agent trastuzumab
- C. lapatinib plus chemotherapy
- D. single agent lapatinib
- E. other

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