The Patterns of Care Study indicates that key factors determining choice of systemic treatment in the metastatic setting are patient age, performance status, site of disease, and ERP and HER2 assay results. Endocrine therapy alone is generally utilized in patients with good performance status and ER-positive tumors. Trastuzumab, usually in combination with chemotherapy, is widely utilized as first-line therapy for women with HER2-positive disease. A key issue in selection of chemotherapy is the choice between sequential single agents and combinations. Oncologists often use single agents for patients with good performance status, and the decisions regarding sequencing vary. Side-effect profiles alter choices in individual situations. Anthracycline-based regimens are commonly utilized in patients who have not previously received adjuvant chemotherapy. The combination of docetaxel and capecitabine is frequently utilized in women who have previously received chemotherapy.

**CHEMOTHERAPY FOR ASYMPTOMATIC PATIENTS WITH METASTASES: PRIOR AC + DOCETAXEL**

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<th>Age (years)</th>
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**CHEMOTHERAPY FOR SYMPTOMATIC PATIENTS WITH METASTASES: PRIOR AC + DOCETAXEL**

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**SELECT PUBLICATIONS**


**TREATMENT OF PATIENTS WITH RECEPTOR-NEGATIVE DISEASE FOLLOWING ADJUVANT AC + PACLITAXEL**

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**TREATMENT OF CHEMOTHERAPY-NAIVE PATIENTS WITH RECEPTOR-NEGATIVE DISEASE**

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**SELECTED POSTERS**


**RESEARCH TO PRACTICE: CHEMOTHERAPY IN METASTATIC DISEASE**

We are currently investigating capecitabine, 1,025 mg/m² daily dose, for 14 days with paclitaxel 80 mg/m² days 1 and 8, alternating in a two-week cycle in patients with metastatic breast cancer. The regimen has been very well tolerated, although the side effects we have seen have been those we expected from paclitaxel—some alopecia, fluid retention, Grade 1–2 myopathy, ataxia and nail changes—but capecitabine doesn’t seem to add much to the toxicity and the clinical benefit is extraordinary. We have had some patients on this trial for one to two years.

In the taxane-naive subset, we found this regimen to be exceedingly effective and well tolerated. It has been more difficult to accrue patients who have taken a taxane, so we can’t draw final data yet. However, this is an ideal trial for patients who have received docetaxel in the past and progressed.

We have been unable to show responses with capecitabine/docetaxel, and it is more tolerable than cisplatin/docetaxel. Capecitabine has also been combined with trastuzumab, which is also a very well-tolerated regimen.

— Joanne L. Blum, MD, PhD

**SELECTION OF CHEMOTHERAPY IN THE METASTATIC SETTING**

I think it is consistent with the responses to the survey in that I am remarkably inconsistent and do not follow a single regimen. Little evidence exists to suggest that any one chemotherapy regimen provides a meaningful advantage in terms of response rates, duration of response, survival, or side effects, relative to other combinations or single agents. I tend to discuss what she expects from her treatment, how much my intervention is wanted and when she would be willing to do so, however, in an asymptomatic patient, only tumor control and not clinical benefit, why should I make a woman sick when she feels well?

In an asymptomatic patient with chemotherapy-naive disease who has metastatic disease, and who starts on an agent such as capecitabine regardless of her age, I can’t be critical of the choices that have been made. My second-line therapy tends to be a taxane.

— Robert W. Cortes, MD

There are several combinations for which good data exist, such as docetaxel and paclitaxel/gemcitabine. The docetaxel/docetaxel combination improved response rate but did not improve overall survival. Since George Slodicka’s EOCOG 11202, docetaxel vs. single-agent therapy was as good as combination treatment in terms of overall survival, I tend to use sequential single agents for the vast majority of patients.

In a patient who is chemo-naive and needs a rapid response, I would consider an anthracycline-based combination regimen. It would probably be doxorubicin/docetaxel, but could also be doxorubicin/paclitaxel. If a patient had docetaxel/docetaxel as first-line, I’d definitely be interested in incorporating a gemcitabine-based combination or a capecitabine-based combination. I prefer a combination of capecitabine. I think it is great, it is generally well-tolerated when given at non-package-insert doses.

For the patient who had adjuvant AC 1x, frequently use capecitabine or vinorelbine as first-line therapy. For someone who’s chemotherapy-naive, one choice would probably be weekly paclitaxel followed by either vinorelbine or capecitabine.

I seldom use sequential chemotherapy upfront in my asymptomatic patients, because I think it causes a lot of fatigue and alopecia. Weekly paclitaxel also results in alopecia, but I prefer to use weekly paclitaxel more than docetaxel in the metastatic setting.

— Elmo E. Dicker, MD

**CAPECITABINE/DOCETAXEL: TRIAL IN METASTATIC DISEASE**

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