3:15 PM

66-year-old woman with history of severe COPD and 0.8 cm mass in right breast, core biopsy –IDC, ER+PR+. Patient would prefer BCT if possible. Your suggested local therapy:

1. Lumpectomy alone 20%
2. Lumpectomy plus radiation ... 79%
3. Modified mastectomy 1%
4. Radiation therapy 0%
5. Other 0%

3:30 PM

43-year-old woman: 0.8-cm cribriform DCIS. Margins: 1 cm. Rx: Radiation therapy, tamoxifen. One year later: nodule in suture line excised (recurrent DCIS). Your recommended local therapy:

1. Re-excision 49%
2. Mastectomy 50%
3. Other 1%

3:45 PM

43-year-old woman: 0.8-cm cribriform DCIS. Margins: 1 cm. Rx: Radiation therapy, tamoxifen. One year later: nodule in suture line excised (invasive breast cancer). Your recommended local therapy:

1. Re-excision 20%
2. Mastectomy 78%
3. Other 2%

4:00 PM

78-year-old woman: 0.8-cm cribriform DCIS. Margins: 1 cm. Rx: Radiation therapy, tamoxifen. One year later: nodule in suture line excised (recurrent DCIS). Your recommended local therapy:

1. Re-excision 62%
2. Mastectomy 37%
3. Other 1%

4:15 PM

43-year-old woman: 0-8 cm cribiform DCIS. Margins: 1 cm. Rx: Radiation therapy, tamoxifen. Three years later: nodule in suture line excised (recurrent DCIS). Your recommended local therapy:

1. Re-excision 45%
2. Mastectomy 54%
3. Other 1%

4:30 PM

78-year-old woman: 0-8-cm noncomedo DCIS. Margins: 1 cm. Rx: Radiation therapy, tamoxifen. Three years later: nodule in suture line excised (recurrent DCIS). Your recommended local therapy:

1. Re-excision 74%
2. Mastectomy 25%
3. Other 1%

4:45 PM

What percentage of your breast cancer patients who are presented with the option of breast conservation choose to have a mastectomy?

1. ≤ 10% 40%
2. 11%-30% 37%
3. 31%-50% 17%
4. 51%-70% 4%
5. 71%-90% 1%
6. >90% 1%

5:00 PM

43-year-old woman with a 2-cm breast mass, which on core biospy proves to be poorly differentiated infiltrating ductal carcinoma, ER-negative. Patient wishes to have mastectomy and reconstruction. What type of reconstruction would you generally recommend?

1. Implants 30%
2. Latissimus dorsi flap 8%
3. TRAM flap 60%
4. Other 2%

5:15 PM

(Surgeons) Do you ever do skin-sparing mastectomy?

1. Yes 78%
2. No 22%

Session B
Meet the Professors

Breast Cancer UPDATE

LOCATION: COWRIE ROOM - 3RD FLOOR MODERATOR: NEIL LOVE, MD

These sessions will provide a small group atmosphere for attendees to meet with faculty, who will discuss clinical trials and recently published papers and abstracts and respond to audience questions and cases.

Friday, February 28, 2003

8:00 - 9:00 AM PANELISTS: AMAN BUZDAR, MD
EDITH PEREZ, MD

9:00 - 10:00 AM PANELISTS: NANCY DAVIDSON, MD
CHARLES LOPRINZI, MD

20TH ANNUAL MIAMI BREAST CANCER CONFERENCE

QUICK RESULTS Newsletter

Friday, February 28

This newsletter is an outgrowth of numerous requests over the years to provide meeting attendees with documentation of the audiences responses to the many interactive questions presented during the meeting. These results will be incorporated into a special post-meeting report that will be mailed to attendees.

RESULTS OF THURSDAY'S INTERACTIVE QUESTIONS

Mechanism of Carcinogenic Progression

8:00 AM

What is the setting of your practice/ work?

1. Private practice 66%
2. Academic center 13%
3. Cancer center 6%
4. Breast center 9%
5. HMO, etc. 2%
6. Other 6%

8:15 AM

What percentage of your total practice/work consists of patients with breast cancer or breast concerns?

1. ≤ 10% 5%
2. 11%-20% 18%
3. 21%-40% 23%
4. 41%-60% 13%
5. 61%-80% 13%
6. >80% 29%

8:30 AM

To what extent do you believe that trastuzumab will be used as adjuvant therapy for HER2-positive patients 5 years from now?

1. Frequently 63%
2. Occasionally 33%
3. Not at all 4%

8:45 AM

Should HER2 status be considered in deciding whether or not to use adjuvant endocrine therapy?

1. Yes 66%
2. No 34%

Targeting the Tumor

9:00 AM

How do you generally identify a breast cancer as ER-positive?

1. Any staining 22%
2. Staining above specific cut-off defined by doing lab test 65%
3. Staining above specific cut-off as you define it 10%
4. Other 2%

9:15 AM

65-year-old woman with 4-cm, ER+ IDC and modest breast size. Patient wishes to have breast conservation but currently is a suboptimal candidate based on tumor size. Your recommendation:

1. Mastectomy 13%
2. Lumpectomy 3%
3. Pre-op chemotherapy 41%
4. Pre-op tamoxifen 6%
5. Pre-op aromatase inhibitor 20%
6. Pre-op endocrine therapy and chemotherapy 16%
7. Other 1%

9:30 AM

Very ill 65-year-old woman with lymphangitic lung mets, 2 years ago AC➜T adjuvant therapy. Tumor is ER-negative, HER2-negative. Your recommendation:

1. Taxane 8%
2. Capecitabine 25%
3. Vinorelbine 3%
4. Other single agent chemo 2%
5. Capecitabine/docetaxel 43%
6. Anthracycline/taxane 8%
7. Other chemo combination 3%
8. Other 8%

9:45 AM

How would you compare oral versus intravenous administration of chemotherapy?

1. Oral administration is a major advantage 68%
2. Oral administration is somewhat of an advantage ... 22%
3. Equivalent options 4%
4. Oral administration is somewhat of a disadvantage ... 5%
5. Oral administration is a major disadvantage 1%

Invasion of the Basement Membrane

10:30 AM

About how many high-risk breast cancer patients have you started on tamoxifen the past year?

1. None 17%
2. 1-5 .... 27%
3. 6-20 .... 27%
4. 21-50 .... 12%
5. > 50 .... 5%
6. Not applicable 12%

10:45 AM

What percentage of your patients with DCIS receive tamoxifen?

1. ≤ 10 .... 11%
2. 11%-20% 9%
3. 21%-40% 15%
4. 41%-60% 15%
5. 61%-80% 21%
6. >80% 29%

This newsletter is supported by education grants from AstraZeneca Pharmaceuticals LP and Roche Laboratories, Inc.

11:00 AM

63-year-old woman with 2-cm IDC, 5 nodes positive, ER-positive. What adjuvant endocrine therapy would you recommend (+/- chemo)?

1 None 0%
2 Tamoxifen 56%
3 Anastrozole 36%
4 Letrozole 6%
5 Exemestane 0%
6 Other 1%

11:15 AM

In 2003, how do you expect anastrozole to be used as adjuvant therapy in postmenopausal patients with invasive breast cancer?

1 It will almost completely replace tamoxifen 16%
2 Will be utilized a great deal . . . 71%
3 Will be utilized too sparingly . . 12%
4 Generally not utilized 0%

11:30 AM

Overall, how would you compare the side effects/toxicity of anastrozole to tamoxifen?

1 Anastrozole much better than tamoxifen 45%
2 Anastrozole somewhat better than tamoxifen 49%
3 Equivalent 5%
4 Anastrozole somewhat worse than tamoxifen 1%
5 Anastrozole much worse than tamoxifen 0%

Tumor Panel #1:

11:30 AM **CASE #1**

Case Summary: This 63-year-old woman had a breast biopsy 12 years ago demonstrating fibrocystic changes. Her mother developed breast cancer at age 54, and her sister developed breast cancer at age 58. A recent breast biopsy demonstrated atypical hyperplasia. The patient's Gail model risk is 15.2% at 5 years and 49.3% lifetime.

1.1 Outside a clinical trial, what intervention, if any, should be suggested?

1 None 8%
2 Bilateral prophylactic mastectomies 6%
3 Tamoxifen 76%
4 Other chemoprevention 6%
5 Other 3%

1.2 If this woman were eligible for the STAR trial, comparing tamoxifen to raloxifene, what advice should she be given regarding participation?

1 Strongly encourage participation 59%
2 Provide the option of participation but not encourage very strongly 35%
3 Discourage participation 6%
4 Other 1%

1.3 If this woman were eligible for the IBIS-II trial, comparing anastrozole to placebo, what advice should she be given regarding participation?

1 Strongly encourage participation 19%
2 Provide the option of participation but not encourage very strongly 38%
3 Discourage participation 7%
4 Discourage participation – don't like placebo arm 35%
5 Other 5%

CASE #2

Case Summary: This 58-year-old woman has been on HRT for 6 years for severe vasomotor symptoms, which were not responsive to other interventions. A breast biopsy of a palpable lesion demonstrates infiltrating ductal carcinoma.

2.1 What should be suggested regarding HRT use?

1 Continue 1%
2 Stop immediately 72%
3 Gradually taper down and stop over several weeks 24%
4 Gradually taper down and stop over several months 4%
5 Gradually taper down and stop over a year 0%
6 Other 0%

The patient is treated with lumpectomy and negative sentinel node biopsy and is found to have a 1.2-cm infiltrating ductal carcinoma, which is strongly ER/PR positive, and HER2-positive (3+ on IHC, FISH+).

2.2 If this woman were eligible for the NSABP B-32 sentinel node trial, comparing axillary dissection to no further surgery, what advice should she be given regarding participation?

1 Strongly encourage participation 33%
2 Provide the option of participation but not encourage very strongly 39%
3 Discourage participation 28%
4 Other 0%

2.3 What chemotherapy, if any, should be suggested?

1 None 28%
2 AC x 4 . . . . . 37%
3 CMF 11%
4 Anthracycline regimen x 6 . . . . . 6%
5 Taxane/anthracycline regimen . . . 9%
6 Dose-dense chemotherapy approach including ATC 5%
7 Other 3%

2.4 What endocrine therapy, if any, should be suggested?

1 None 1%
2 Tamoxifen 37%
3 Anastrozole 59%
4 Other aromatase inhibitor 2%
5 Other 0%

CASE #3

Case Summary: This 58-year-old postmenopausal woman presented four years ago with a 4-cm breast mass and moderate rib pain. Breast biopsy revealed an ER/PR-positive, HER2-negative infiltrating ductal carcinoma. Bone scan revealed multiple lesions in the ribs, skull and spine, with negative x-rays. Chest x-ray and CAT scan demonstrated multiple bilateral pulmonary nodules. The patient was treated with pamidronate and doxorubicin/cyclophosphamide/ 5-FU (FAC). After 6 cycles of chemotherapy, the breast mass had decreased in size to 1 cm and the pulmonary lesions had decreased in size. The bone pain resolved. Chemotherapy was stopped and the patient was switched to tamoxifen.

3.1 What should be the suggested management of the breast lesion at this time?

1 No specific therapy at this time 25%
2 Excision 23%
3 Excision and local radiation . . . 24%
4 Excision and axillary dissection 1%
5 Excision, axillary dissection and local radiation 10%
6 Mastectomy 6%
7 Mastectomy and axillary dissection 5%
8 Mastectomy, axillary dissection and local radiation 5%
9 Other 1%

CASE #3 (Continued)

The patient had no local therapy and continued on tamoxifen for 2 years, at which point the breast mass increased to 4 cm and the pulmonary lesions increased in size. There was no change on the bone scan and the patient remained asymptomatic.

3.2 What systemic treatment strategy should be suggested?

1 Aromatase inhibitor 53%
2 Fulvestrant 9%
3 Other endocrine therapy 3%
4 Single-agent chemotherapy 3%
5 Combination chemotherapy . . . 12%
6 Chemotherapy plus endocrine therapy 18%
7 Other 2%

The patient was treated with fulvestrant, 250 mg IM monthly. The breast mass and pulmonary lesions again decreased in size and the patient tolerated the therapy well. After one year, the patient progressed and was treated with anastrozole and again had a partial response, this time lasting 6 months. The patient then presented with severe bone pain and multiple lesions on bone scan in the ribs, skull, L-S spine and femur. The lung lesions had increased significantly in size. Exemestane was started and radiation to the left ribs was delivered. One month later, the rib pain has improved but other sites of pain are worse and the lung lesions have increased in size.

3.3 What systemic treatment strategy should be suggested?

1 Endocrine therapy 5%
2 Anthracycline 6%
3 Taxane 20%
4 Capecitabine 16%
5 Vinorelbine 1%
6 Gemcitabine 3%
7 Capecitabine/docetaxel 30%
8 Anthracycline/taxane 12%
9 Other 6%

CASE #4

Case Summary: This 37-year-old premenopausal woman presents with a 2.1-cm ER/PR-positive, HER2-positive (IHC 3+) infiltrating ductal carcinoma. Modified radical mastectomy with immediate implant reconstruction is performed and axillary dissection demonstrates 3 positive nodes.

4.1 Should regional radiation therapy generally be recommended?

1 Yes 36%
2 No 64%

4.2 If the patient were to receive regional radiation therapy, should the tissue expander be removed prior to radiation treatment?

1 Yes 23%
2 No 77%

4.3 If this patient were eligible for Intergroup trial (SWOG-S9927, RTOG-9915), comparing radiation therapy to no radiation therapy, what advice should she be given regarding participation?

1 Strongly encourage participation 35%
2 Provide the option of participation but not encourage very strongly 48%
3 Discourage participation 17%
4 Other 0%

4.4 What chemotherapy, if any, should be suggested?

1 None 0%
2 AC x 4 . . . . . 34%
3 CMF 6%
4 Anthracycline regimen x 6 . . . . . 9%
5 Taxane/anthracycline regimen . . 32%
6 Dose-dense chemotherapy approach including ATC 18%
7 Other 1%

4.5 At the completion of chemotherapy, the patient is still menstruating. What endocrine therapy, if any, should be suggested?

1 None 3%
2 Tamoxifen 43%
3 LH/RH agonist or other ovarian ablation 12%
4 Tamoxifen plus LH/RH agonist/ other ovarian ablation 23%
5 Aromatase inhibitor 9%
6 Aromatase inhibitor plus LH/RH agonist/ other ovarian ablation 9%
7 Other 1%

SESSION A – Management of the Primary Lesion

2:15 PM

What percentage of your patients with atypical hyperplasia receive tamoxifen?

1 ≤ 10% 31%
2 11%-20% 18%
3 21%-40% 15%
4 41-60% 11%
5 61%-80% 12%
6 >80% 13%

2:30 PM

What percentage of your patients with lobular carcinoma *in situ* (LCIS) receive tamoxifen?

1 ≤ 10% 29%
2 11%-20% 16%
3 21%-40% 14%
4 41-60% 11%
5 61%-80% 11%
6 >80% 19%

2:45 PM

What biopsy technique do you generally use for a nonpalpable mass on a mammogram that is identified to be a solid lesion on ultrasound?

1 Stereotactic percutaneous core needle biopsy 26%
2 Stereotactic percutaneous fine needle aspiration 1%
3 Ultrasound-guided percutaneous core needle biopsy 58%
4 Ultrasound-guided percutaneous fine needle aspiration 4%
5 Wire localization and biopsy . . . 11%
6 Other 1%

3:00 PM

66-year-old woman with history of severe COPD and 3-cm mass in right breast, core biopsy – IDC, ER+PR+. Patient would prefer BCT if possible. Your suggested local therapy:

1 Lumpectomy alone 7%
2 Lumpectomy plus radiation . . . 76%
3 Modified mastectomy 12%
4 Radiation therapy 1%
5 Other 5%