

Progress and promise: highlights of the international expert consensus on the primary therapy of early breast cancer 2007

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Abstract

The 10th St Gallen (Switzerland) expert consensus meeting in March 2007 refined and extended a target-oriented approach to adjuvant systemic therapy of early breast cancer. Target definition is inextricably intertwined with the availability of target-specific therapeutic agents. Since 2005, the presence of HER2 on the cell surface has been used as an effective target for trastuzumab much as steroid hormone receptors are targets for endocrine therapies. An expert Panel reaffirmed the primary importance of determining endocrine responsiveness of the cancer as a first approach to selecting systemic therapy. Three categories were acknowledged: **highly endocrine responsive, incompletely endocrine responsive and endocrine non-responsive**. The Panel accepted **HER2-positivity** to assign trastuzumab, and noted that adjuvant trastuzumab has only been assessed together with chemotherapy. They largely endorsed previous definitions of risk categories. While recognizing the existence of several molecularly-based tools for risk stratification, the Panel preferred to recommend the use of high-quality standard histopathological assessment for both risk allocation and target identification. Chemotherapy, although largely lacking specific target information, is the only option in cases which are both endocrine receptor-negative and HER2-negative. Chemotherapy is conventionally given with or preceding trastuzumab for patients with HER2-positive disease, and may be used for patients with endocrine responsive disease in cases where the sufficiency of endocrine therapy alone is uncertain. Recommendations are provided not as specific therapy guidelines but rather as a general guidance emphasizing main principles for tailoring therapeutic choice.

Introduction

Incremental rather than fundamental change in the approach to the management of early breast cancer was the hallmark of the 10th St Gallen conference held in March 2007, attended

by more than 4700 participants from 95 countries. Successive St Gallen conferences since 1978 have brought into focus contemporary insights and produced general principles based upon available evidence and expert opinion to provide guidance for the therapy of early breast cancer outside clinical trials [1]. The publication in 2005 of trials of trastuzumab for HER2-positive disease [2–4] represented such an important advance as to necessitate an interim update in 2006 [5].

Some new information presented at the conference is summarized in Table 1. In light of this information, a Panel of 39 experts from around the world (see Appendix) considered specific questions to arrive at recommended principles for the selection of therapies in early breast cancer. Intrinsically different subtypes of breast cancer were clearly recognized based on genetic profile and immunohistochemical (IHC) demonstration of selected targets [18, 73]. Overall treatment strategy stressed the paramount importance of targeted therapies wherever possible, though acknowledging that supplementation with less target-specific chemotherapy may be required. An obvious corollary is the absolute importance of timely, accurate and reliable histopathological assessment including target identification and quantification; an ideal regrettably not yet universally attained. Enhanced partnership between clinicians and pathologists therefore offers the opportunity for substantially improved outcomes.

Table 1. Recent research findings presented at the 10th International Conference on Primary Therapy of Early Breast Cancer and their implications for patient care

Field or Treatment	Status of research/Implications for patient care
Genetic susceptibility and therapeutic implications	<p>Overall, inherited genetic susceptibility accounts for only ~5-10% of breast cancer [6]. Discovered genes include BRCA1 (20-40% of hereditary breast cancers), BRCA2 (10-30%), TP53 (<1%), PTEN (<1%), ATM, CHK2, STK11 (~1%) and Fanconi's Anemia genes (~1%) [7]. BRCA1 tumors are typically poorly differentiated, ER, PgR and HER2/<i>neu</i> negative, often with basal-like phenotype, EGFR positive, cyclin E positive, express basal keratins and have little DCIS. BRCA1-deficient cells were found to be hypersensitive to platinum compounds and PARP.1 [poly(ADP-ribose) polymerase-1] inhibitors, which have shown efficacy in basal-like tumors [8]. Carriers of mutations of BRCA1 and BRCA2 were investigated for the effects of bilateral prophylactic salpingo-oophorectomy (BPSO) [9] or for bilateral or contralateral mastectomy [10] for reduction of the risk of breast and ovarian cancer.</p> <p>MRI is sensitive and cost effective for follow up of BRCA1 carriers (less so for BRCA2 carriers) [11]. The cost-effectiveness of adding MRI to mammography varies greatly by age.</p>

Pathology of breast cancer

Pathological heterogeneity of breast cancer was substantially enhanced by the recognition of cellular markers through immunohistological and molecular classifications. These include lobular and ductal invasive cancers, but also basal-like cancers bearing various molecular markers of myoepithelial cells. Luminal types A, B, C, normal breast, HER2-positive, and basal-like phenotypes have been reproducibly separated [12-14].

Reliability of the pathological diagnosis [15], quality determination of the degree of endocrine responsiveness, through hormone receptors [16] and HER2/*neu* status for response to trastuzumab [17] are essential for a proper treatment allocation.

Endocrine therapies, estrogen and progesterone receptors and epithelial growth factors

Estrogen receptor positive breast cancer, although endocrine responsive, might develop resistance to endocrine therapies through altered transcription of progesterone receptors [18], through the presence of amplified epithelial growth factors [19], and through acquired resistance to aromatase inhibitors (AIs) by altered apoptosis, which might be reversed by the use of low-dose estrogens [20]. Overcoming resistance to AIs through the therapeutic association between endocrine therapies and epithelial growth factors or IGF inhibitors, MTor inhibitors, and antiangiogenesis has been described [21]. It is now recognized that the efficacy of tamoxifen might be compromised due to altered metabolism of this drug through altered transformation into its active metabolite due to constitutional or induced alteration of CYP2D6 [22]. Some selective serotonin reuptake inhibitor antidepressants can affect tamoxifen metabolism.

Comparisons between AIs are being studied in randomized clinical trials. Indirect comparisons do not seem to demonstrate reasons to prefer one or other of the available agents [23]. Difference in the intensity of recording and grading undesirable effects may account for apparent differences in side effects [24]. More than 10 000 patients will be included in trials which directly compare different AIs (MA-27 and FACE) [23].

Chemotherapy regimens and their interaction with endocrine responsiveness

New information on the degree of responsiveness to chemotherapy of cohorts of patients selected according to the type of disease emerged as an important feature [25]. The effectiveness of chemotherapy advances may depend on estrogen receptor status [26].

Taxane combinations are effective in the adjuvant setting but especially in cohorts of patients with endocrine non-responsive or incompletely responsive tumors. Exploratory analyses to identify those for whom the addition of a taxane-

containing regimen might be superfluous has not been attempted [27-29]. The question on how best to schedule taxanes seemed to favor the weekly administration of paclitaxel, or the three-weekly docetaxel, but must be best studied within the context of optimal ER, PgR and HER2 determination [27, 28, 30].

Microtubule binding protein Tau was identified as a new marker of response to paclitaxel. Its low expression was associated with increased sensitivity to paclitaxel in human breast cancers, while its down regulation increased their sensitivity to paclitaxel but not to anthracyclines [31].

Retrospective studies suggest that topoisomerase II alpha (topo II) gene amplification and protein overexpression predict anthracycline efficacy. Protein levels are however regulated by proliferation signals, independently of topo II gene status. It was suggested that studies on topo II gene amplification might be more useful if conducted in biologically more homogeneous populations (i.e. with similar proliferation, HER2 overexpression, and endocrine responsiveness patterns) [32].

Basal-like tumors, many of which are associated with BRCA1 mutation, were found to be particularly sensitive to DNA damaging chemotherapy such as platinum compounds or classical alkylating agents. This information is from small retrospective studies and thus controversial [33].

Immunity and vaccinations

Attempts at tumor immunotherapy have an unsuccessful history extending for more than a century. Current vaccines include HER2/*neu* protein, which has been shown to be immunogenic but has yet to demonstrate therapeutic efficacy [34].

Targeted biological therapies

Molecular testing may identify new features to aid therapeutic targeting [35]. Lapatinib has shown significant efficacy (together with capecitabine) in advanced breast cancer after failure of trastuzumab [36]. Its testing in the adjuvant setting is imminent [37].

Bevacizumab has shown efficacy when combined with capecitabine and taxanes in advanced breast cancer [38], and the drug will be tested in the adjuvant setting - E5103 Trial [39].

Combined bevacizumab with trastuzumab has shown efficacy in metastatic disease [39]. Other promising treatments include combination therapy with bevacizumab and a tyrosine kinase inhibitor and combining anti-VEGF therapy with metronomic chemotherapy [40].

Ductal carcinoma *in situ*

DCIS is more commonly diagnosed in the screening era.

(DCIS; DIN)

DCIS is treated with surgical excision, although mastectomy followed by proper reconstruction might be required in case of extensive disease [41]. Radiation therapy and/or tamoxifen are generally used following breast-conserving surgery except for some small, low grade lesions or in elderly patients [42–47].

Women with DCIS frequently overestimate their risk of recurrence and mortality and should be reassured accordingly [48].

There remains a need for predictors of which cases of DCIS are more likely to recur.

Surgical treatments: focus on sentinel node evaluations and surgery of the breast during course of metastatic disease

Sentinel node biopsy was accepted as reliable and safe even in elderly patients [49]. Avoidance of axillary dissection reduces morbidity of local regional therapy. Avoiding axillary dissection despite micrometastatic sentinel lymph node involvement is a subject of ongoing randomized clinical trial research [50].

Special problems arise with surgery in the setting of metastatic disease. There is a lack of evidence but in selected cases primary tumor resection or removal of accessible metastases may be considered [51, 52]. Prospective trials are required in patients with limited metastatic burden to formally assess the value of surgical excision plus or minus radiation therapy aimed at removal of all detectable disease [53].

Preoperative systemic therapy

The primary objective of this therapy is to improve resectability and cosmesis [54]. Assessment of responsiveness to preoperative therapy may in the future be useful in selection of postoperative adjuvant therapy.

Radiation therapy in early breast cancer

Treatments which achieved a reduction in local recurrence were also associated with a reduction in mortality after long-term follow up [55].

In practical terms this was felt to justify post-mastectomy radiation therapy for all patients with 4 or more involved lymph nodes, while the indication for such therapy with 1-3 nodes was less clear and patients with node-negative disease do not require post-mastectomy irradiation if not otherwise indicated (e.g. T4). Modern radiation therapy techniques allow reduction of normal tissue damage to heart and lungs [56].

Radiation therapy limited to the part of the breast closest to the site of the excised tumor (accelerated partial breast irradiation, APBI) was discussed but definitive results of ongoing trials are awaited [57].

Adjuvant therapies for older women with breast cancer

Review of patients with ER-poor disease in the EBCTCG overview revealed a benefit of chemotherapy which was substantial and similar in all age groups [58]. Similarly, a review of population based data from the SEER and Medicare databases suggested that the beneficial impact of chemotherapy on survival was best seen in patients with ER-negative disease [59]. Ongoing randomized trials in this population are investigating chemotherapy regimens selected for relatively low morbidity.

Staging and follow-up of patients after successful treatment of operable breast cancer

The benefits of extensive staging procedures in patients with early breast cancer have not been established. Similarly, during follow up the ASCO guidelines recommend history and physical examination, breast self examination, annual mammography and pelvic examination, and appropriate assessment of bone health. Other procedures such as blood tests, chest x-ray, bone scan, CT, MRI, PET and tumor markers are not recommended [60, 61].

Specific quality of life issues: cardiovascular side effects, cognitive function, fertility and menopausal symptoms

Trastuzumab induced cardiac dysfunction is largely reversible based on short observations. Prolonged oxidative stress associated with anthracyclines may lead to myocyte necrosis and irreversible cardiac dysfunction [62].

Association between malignancy and thrombosis is long established. Mechanisms include invasion of vessel walls and more recently specific anticancer agents and vascular access catheters. Risk of thrombosis may be reduced by selection of anticancer agents (e.g. aromatase inhibitors in place of tamoxifen and avoiding concurrent tamoxifen and cytotoxic therapy). Screening for increased thrombotic predisposition is not routinely recommended and antithrombotic prophylaxis should be limited to unusual cases with a history of idiopathic thrombosis who require relevant cancer therapies [63].

Cognitive dysfunction after chemotherapy («chemo-brain») is frequently perceived by patients [64], though objective psychological testing correlates poorly with subjective experience [65]. Functional imaging documents variable areas of brain activation but their significance remains uncertain [66].

Maintaining fertility: women who wish to maintain fertility may prefer to avoid systemic adjuvant therapy in situations in which it is only marginally indicated. Ongoing research is investigating a possible protective role for LHRH agonists during chemotherapy especially for patients with endocrine non-responsive tumors in whom no benefit could be anticipated from therapy induced ovarian suppression [67]. Cryopreservation of ovarian tissue, oocytes or embryos may

be considered [68].

Avoiding premature menopause: even in patients who do not become immediately amenorrheic, menopause occurs earlier following chemotherapy, particularly in patients aged 40 years or older who received prolonged cytotoxic regimens [68].

Breast cancer diagnosed during pregnancy: breast cancer diagnosed during pregnancy poses therapeutic problems particularly requiring delay in radiation therapy until after delivery and delay of chemotherapy at least until completion of organogenesis [69, 70]. Several cytotoxics and endocrine agents are contraindicated throughout pregnancy.

Safety of pregnancy after the diagnosis of breast cancer: most observational studies of pregnancy following treatment for breast cancer are reassuring and do not suggest that this carries a danger of breast cancer recurrence [71, 72].

A subtle but important clarification of terminology was introduced relative to endocrine responsiveness. The three categories described in 2005 remain essentially unchanged but can more clearly be described as: (i) **highly endocrine responsive** [high expression of both estrogen receptor (ER) and progesterone receptor (PgR) in a majority of tumor cells]; (ii) **incompletely endocrine responsive** (lower expression of ER and or PgR); and (iii) **endocrine non-responsive** (complete absence of both ER and PgR). The degree of endocrine responsiveness varies quantitatively, and will contribute, together with an assessment of the level of risk of relapse, to a decision about whether endocrine therapy alone may be sufficient. While no absolute threshold can be defined, highly endocrine responsive tumors in patients with low risk ([Table 2](#)) may be suitable for endocrine therapy alone, while supplementary chemotherapy may be required for patients with highly endocrine responsive tumors in the presence of intermediate- or high-risk factors, and for patients with incompletely endocrine responsive tumors.

Table 2. Definition of risk categories for patients with operated breast cancer

Risk category	
Low risk ^a	Node negative AND all of the following features: pT* ≤2 cm, AND Grade 1**, AND Absence of extensive peritumoral vascular invasion ^b , AND ER and/or PgR*** expressed ^c , AND HER2/ <i>neu</i> gene neither overexpressed nor amplified ^d , AND

	Age \geq 35 years
Intermediate risk ^c	Node negative AND at least one of the following features: pT* >2 cm, OR Grade 2-3**, OR Presence of extensive peritumoral vascular invasion ^b , OR ER and PgR absent ^c , OR HER2/ <i>neu</i> gene overexpressed or amplified ^d , OR Age <35 years Node positive (1-3 involved nodes) AND ER and/or PgR expressed, AND HER2/ <i>neu</i> gene neither overexpressed nor amplified ^d
High risk	Node positive (1-3 involved nodes) AND ER and PgR absent, OR HER2/ <i>neu</i> gene overexpressed or amplified ^d Node positive (4 or more involved nodes)

^a Some Panel members view pT1a and pT1b (i.e. pT <1 cm) tumors with node-negative disease as representing low risk even if higher grade and/or younger age.

^b Extensive peritumoral vascular invasion (i.e. neoplastic emboli seen in two or more blocks of the tumor) was recognized as a discriminatory feature of increased risk; its presence defined intermediate risk for node-negative disease, but did not influence risk category for node-positive disease [74].

^c Some cases such as medullary carcinoma and apocrine carcinoma may be regarded as low risk despite the absence of steroid hormone receptor expression.

^d HER2/*neu* gene overexpression or amplification must be determined by quality-controlled assays using immunohistochemistry or FISH analysis.

^e Note that the intermediate risk category includes both node-negative and node-positive 1–3 disease.

* pT, pathological tumor size (i.e. size of the invasive component); **histologic and/or nuclear grade; ***ER, estrogen receptor; PgR, progesterone receptor.

The risk categories as defined in 2005 [1] remained essentially unchanged (Table 2), except that (i) peritumoral vascular invasion should be extensive (i.e. neoplastic emboli seen in two or more blocks of the tumor) to justify incremental risk; (ii) some small tumors and histological types might be at low risk despite the absence of steroid hormone receptors (e.g. medullary carcinoma, apocrine carcinoma, etc.); and (iii) the level of steroid hormone receptor expression and overexpression or amplification of HER2 constitute risk factors as well as therapeutic targets.

The resulting algorithms ([Table 3](#)) should serve to assist selection of optimal therapy in the immediate future.

Table 3. Choice of treatment modalities 2007 (see text)

	Highly endocrine responsive ^a	Incompletely endocrine responsive ^a	Endocrine non-responsive ^a
HER2-negative	ET ^b (consider adding CT according to risk) ^c	ET ^b (consider adding CT according to risk) ^c	CT
HER2-positive	ET + Trastuzumab ^{de} + CT ^e	ET + Trastuzumab ^{de} + CT ^e	Trastuzumab ^{de} + CT

ET, endocrine therapy; CT, chemotherapy.

^a Responsiveness to endocrine therapies is defined in the text.

^b Endocrine therapy is effective for prevention and DCIS and therefore might be considered even for very low risk invasive breast cancer.

^c Within the highly and incompletely endocrine responsive categories, addition of chemotherapy may be based on degree of steroid hormone receptor expression and level of risk (see text).

^d Trastuzumab should not be viewed as a standard treatment in women with a primary tumor <1 cm of size and with no axillary node involvement. This is particularly true in patients with highly and perhaps also incompletely endocrine responsive disease.

^e Trastuzumab should be given concurrently and after chemotherapy or following completion of all chemotherapy according to clinical trial evidence available at present, though a majority of the Panel agreed that trastuzumab without prior or concurrent chemotherapy may become appropriate for some patients in the future.

St Gallen 2007: news and progress

St Gallen conferences typically concentrate on breast cancer therapeutics, but various other aspects deserve to be mentioned for completeness, including epidemiology of breast cancer in various geographical areas and across socio economic strata. Reduced breast cancer incidence has been attributed to reduced prescribing of hormone replacement therapies [75]. Adherence

to therapeutic guidelines is affected by affordability of systemic therapies in various geographic settings. [Table 1](#) displays selected news in several of these areas.

categories of endocrine responsiveness

Three endocrine responsiveness categories were defined. (i) **Highly endocrine responsive** (previously referred to as endocrine responsive): tumors express high levels of both steroid hormone receptors in a majority of cells (identified with proper immunohistological methods). (ii) **Incompletely endocrine responsive** (previously referred to as endocrine response uncertain): some expression of steroid hormone receptors but at lower levels or lacking either ER or PgR. (iii) **Endocrine non-responsive**: tumors having no detectable expression of steroid hormone receptors. While this group is clearly defined in terms of lack of responsiveness to endocrine therapies, it includes tumors of diverse phenotype [76].

HER2-positivity

Two technologies are recognized for the determination of HER2-positivity. Either strong IHC staining (3+) of >30% of the tumor cells, or, alternatively, determination of gene amplification by FISH (fluorescence *in situ* hybridization: ratio of HER2 gene copies to chromosome 17 centromeres > 2.2) or CISH (chromogenic *in situ* hybridization: more than six HER2 signals per cell) [77] is sufficient. The presence of strong IHC staining (3+) is associated with response to trastuzumab in several clinical trials. Theoretically, weaker staining (1+ or 2+) even in the presence of amplification could be associated with a lesser degree of efficacy of trastuzumab. The preliminary data from the N9831 trial are consistent with this hypothesis [78], indicating the urgent need for more research on correlation between specific biological markers and response to anti HER2 agents. It is recognized that these are arbitrary thresholds in a biological continuum, but a pragmatic decision needs to be made particularly because of the high cost of trastuzumab therapy, and the definitions used in the clinical trials upon which such therapy is based.

risk categories

The Panel in 2007 recognized few changes for the risk classification ([Table 2](#)). Peritumoral vascular invasion was considered to elevate risk category only if it was extensive [74]. Total absence of steroid hormone receptors and amplification or overexpression of HER2 were each considered sufficient to exclude low risk assignment except for rare tumors such as medullary or apocrine carcinoma (which usually lack any of these receptors). Again, the Panel did not accept the molecularly based tools such as Oncotype Dx™ or gene expression profiling by MammaPrint™ as sufficiently established to define risk categories. Both methods are being currently tested within prospective clinical trials [79, 80].

specific considerations for treatment choice

local and regional treatments

Surgical considerations presented during the conference included reaffirmation of breast

conservation, sentinel node technology to avoid unnecessary axillary surgery, and the challenging role of surgical treatment in the presence of metastatic disease (see [Table 1](#)). These aspects were not subsequently considered by the Panel.

Several aspects of radiation therapy were discussed. In general, recommendations of the American Society for Clinical Oncology (ASCO) or European Society of Mastology (EUSOMA) might be used to guide radiation treatment choice [81, 82]. Current standards for proper irradiation include CT scan simulation for all left-sided cancers, and use of techniques to minimize cardiac irradiation [83]. There was strong agreement to avoid postmastectomy radiation therapy for patients with node-negative disease and T1–T2 tumors, while a slender majority would restrict such treatment to those with 4 or more involved axillary lymph nodes. Publication of the findings from the EBCTCG presented in San Antonio in December 2006 showing an advantage for postmastectomy radiation in women with 1–3 positive nodes is awaited with interest. Postmastectomy irradiation volume should include chest wall and supraclavicular fossa for those with axillary nodes involved. It was agreed that in general axillary radiation should be avoided if proper axillary clearance had been performed. Even following breast conservation, a majority of the Panel would avoid radiation therapy in elderly patients who would receive endocrine therapy. It was the opinion of some of the Panel members, however, that elderly patients should not be denied standard radiation therapy if indicated. No other radiation therapy question commanded majority support among the Panel. These included questions regarding concurrent chemo–radio therapy, delay of endocrine therapy until completion of radiation therapy, partial breast irradiation and shortened courses with hypofractionation.

the systemic adjuvant therapy program

As in 2005, the first consideration is the use of appropriately targeted therapy. For highly and incompletely endocrine responsive disease the selection of endocrine therapy will depend upon menopausal status of the patient. This may be difficult to determine in patients who have recently received cytotoxic chemotherapy, a matter of particular importance if an aromatase inhibitor is being considered: the Panel insisted on ensuring a postmenopausal status *before* and *during* the use of an aromatase inhibitor. Other host-related factors governing selection of therapy may include a history of thromboembolic disease contraindicating tamoxifen. Likewise, host factors such as the existence of concomitant cardiac disease might influence the choice of particular chemotherapy agents or the suitability of treatment with trastuzumab. Patient age or co-morbid conditions may further restrict the feasibility of more intensive cytotoxic regimens. Different patterns of expected adverse events may influence patient preference for one or other treatment strategy.

endocrine therapy in postmenopausal patients

Clearly the availability of third generation aromatase inhibitors (AIs) [24, 84–88] has added substantially to the available treatment choice after a quarter century of successful use of tamoxifen. Nevertheless, a clear majority of the Panel felt that 5 years of tamoxifen alone was still a viable option for certain patient categories. Among strategies for the use of AIs, the Panel expressed a clear preference for a switch from tamoxifen to an AI after 2–3 years of tamoxifen, with a substantial minority also supporting an initial use of an AI and very few in favor of a prospective policy of 5 years of tamoxifen followed by an AI. For patients who have completed 5 years of tamoxifen, the majority of the Panel would support the addition of an AI for a further period of time only for patients with node-positive disease. Initial AI was more acceptable in patients at higher risk or with HER2-positive disease. A slim majority also favored initial AIs in patients receiving SSRI anti-depressants.

The Panel clearly preferred sequential rather than concurrent administration of cytotoxic and endocrine therapies. The total duration of optimal adjuvant endocrine treatment was seen as between 5 and 10 years.

Most Panelists considered it wise to check for ovarian function suppression in younger postmenopausal women receiving an AI, though the timing of such an assessment was uncertain.

The Panel supported evaluation of bone mineral density prior to commencement of an AI and the use of calcium, vitamin D and especially physical exercise to reduce the risk of bone loss and treatment-related symptoms.

endocrine therapy for premenopausal patients

The Panel accepted either tamoxifen plus ovarian function suppression or tamoxifen alone as standard endocrine therapies in this group. Ovarian function suppression alone was considered a possibility if subsequent pregnancy is planned, although avoiding tamoxifen for this reason may not be completely justified.

The Panel strongly endorsed a GnRH analogue as a means of ovarian function suppression and a substantial majority also regarded surgical oophorectomy as an appropriate option with the choice of method depending upon disease type and circumstances. Ovarian radiation was overwhelmingly rejected. It is important to recognize that in some patients GnRH analogue alone may not suppress ovarian function completely [89].

While admitting that evidence was lacking about the optimal duration of ovarian function suppression by GnRH analogue for women with hormone receptor positive breast cancer, a clear majority favored a period of 5 years, especially in patients at higher risk of relapse and/or with HER2-positive disease [90]. It was recognized that individual patients would exercise choice regarding the type and duration of ovarian function suppression.

Again without specific evidence, most Panelists preferred to defer GnRH analogue until completion of chemotherapy.

The use of AIs as the sole endocrine therapy for premenopausal patients is not appropriate. The use of AIs together with ovarian function suppression is currently being tested in clinical trials but might be considered outside trials when tamoxifen is contraindicated. Patients who were premenopausal at diagnosis and became postmenopausal after chemotherapy or during adjuvant endocrine therapy may receive AIs [85], but loss of ovarian endocrine function should be verified *prior* to and *during* exposure of these drugs, which typically stimulate endocrine ovarian function [91].

trastuzumab

The Panel was prepared to accept strong IHC staining as justifying trastuzumab therapy with only a small minority demanding FISH testing in all cases. The opinion of several Panelists was that, considering the absence of relevant data from randomized trials trastuzumab cannot be viewed as a standard treatment in women with a primary tumor <1 cm of size and with no axillary node involvement. This is particularly true in the setting of endocrine responsive disease. The role of trastuzumab in patients with small, endocrine responsive tumors and no axillary node involvement has not been adequately evaluated.

The standard duration of trastuzumab therapy was accepted as 1 year. A shorter duration (9 weeks) as used in the FinHER study [92] was not generally accepted.

A majority of the Panel found both the sequential HERA model (trastuzumab commencing after completion of all chemotherapy) [2] and the concurrent model (trastuzumab commencing concurrently with a taxane following anthracycline) [3, 4] as equally acceptable. A slim majority found the use of carboplatin and docetaxel administered concurrently with trastuzumab without anthracycline [4] to be an acceptable alternative.

Interestingly, a majority of the Panel was prepared, for selected women, to contemplate trastuzumab with endocrine therapy but without chemotherapy despite the absence of clinical trial evidence to support this approach. The Panel thought it important to avoid trastuzumab in patients with low LVEF (<50%).

chemotherapy

Perhaps the most difficult decision in current adjuvant therapy is selection of patients with highly or incompletely endocrine responsive disease for whom additional chemotherapy should be given. Features that raise doubt about the adequacy of endocrine therapy alone include relatively lower expression of steroid hormone receptor, involvement (and particularly extensive involvement) of axillary lymph nodes, higher grade or proliferative markers, larger tumor size and extensive peri-tumoral vascular invasion. Molecular-based technologies have been proposed to assist in this discrimination (OncotypeDX™, MammaPrint™) but were not regarded by the Panel as yet sufficiently reliable to make a definitive contribution to the therapeutic decision.

A wide variety of chemotherapy regimens was considered acceptable with little agreement on any particular favorite. Most Panelists supported the use of anthracyclines for all patients and an even greater majority supported anthracycline use for patients with HER2-positive disease. For treatment of patients with triple negative tumors, the Panel was careful to include DNA damaging compounds [33]. Combinations of cyclophosphamide, 5-fluorouracil and an anthracycline (variously abbreviated as CAF, CEF, FEC, FAC [93–96]), commanded relatively wide support, as did the sequence of anthracycline and cyclophosphamide followed by paclitaxel or docetaxel. There was only minority support for dose-dense therapy, while high-dose therapy requiring peripheral blood stem cell support was rejected overwhelmingly.

In general, the Panel was prepared to accept less intensive chemotherapy such as four courses of doxorubicin and cyclophosphamide or six courses of classical CMF in patients with highly (but at high risk of relapse) or incompletely endocrine responsive HER2-negative disease. Other regimens considered suitable for this group included CAF and the combination of docetaxel and cyclophosphamide. Preference for various chemotherapy regimens was geographically heterogeneous, a fact which explains the large range of therapies considered by the Panelists.

The majority of the Panel considered that a shorter duration of chemotherapy (12–16 weeks) might be suitable for elderly patients and that an early initiation of such therapy was important for patients with steroid hormone receptor negative disease. Panel members noted the importance of offering standard chemotherapy to fit elderly patients with sufficient life expectancy. While a clear majority of the Panel supported a role for hematopoietic growth factors in patients with a clinical indication, only a minority supported their routine use. An excess of MDS and acute leukemia has been reported in older recipients of hematopoietic

growth factors during adjuvant chemotherapy [97], but this finding is derived from non-randomized series, and no similar excess is evident in prospective randomized trials.

choice of systemic adjuvant treatment modalities 2007

Bringing together these various concepts, [Table 3](#) presents a summary in terms rather simpler than on previous occasions. In 2007 we have two therapeutic targets. Risk plays a minor role and is not a first order consideration in treatment selection, though it may guide selection of patients with endocrine responsive tumors for addition of chemotherapy. All patients receiving trastuzumab should also receive prior or concurrent chemotherapy according to available clinical trial evidence. Patients with triple negative disease are limited to chemotherapy. Thus, the only ambiguity arises in the two boxes describing treatment for patients with HER2-negative disease and at least some degree of endocrine responsiveness. Those with highly endocrine responsive tumors, particularly in the absence of other adverse factors (**those at low or intermediate risk of relapse and no indication for trastuzumab**), might well receive only endocrine adjuvant therapy, while others may also require at least some chemotherapy. The judgment required in advising such patients on the addition of chemotherapy will involve many factors of risk assessment, degree of endocrine responsiveness, and patient preference. No absolute rules can be defined for this decision which remains a matter for discussion between each patient and her treating clinician. [Appendix Table 4](#) is provided to illustrate treatment decision algorithms incorporating information on therapeutic target and risk category. Current trials on the role of gene profiling in defining efficacy of adjuvant chemotherapy for patients with endocrine responsive disease might provide clinically relevant information [79, 80].

preoperative systemic therapy

Apart from the routine use of such treatment for large tumors, a majority of the Panel supported preoperative systemic therapy to improve resectability and thus cosmesis, while a minority also considered that the assessment of responsiveness constituted a reason to employ this treatment approach. A clear majority supported the inclusion of trastuzumab in the preoperative treatment program for patients with HER2-positive disease.

special considerations

Presentations covered at the conference addressed the specific needs of very young patients with particular reference to the preservation of fertility, the avoidance of premature menopause, the safety of pregnancy after the diagnosis of breast cancer and the special therapeutic problems when breast cancer is diagnosed during pregnancy ([Table 1](#)). Although not discussed by the Panel, other presentations canvassed the question of cognitive impairment after breast cancer therapy, and the prevention of cancer associated thromboembolic disease ([Table 1](#)).

Particular problems recognized in elderly patients included the presence of co-morbidities which might limit the feasibility of particular therapeutic options.

commentary

Clearly there has been continued progress in definition of effective systemic adjuvant therapies for early breast cancer. Future studies should define the molecular basis for treatment selection and in particular the definition of patients who might not require chemotherapy [98].

The best way to achieve optimal treatment of today's patients is to ensure the availability of reliable and timely pathological assessment in routine practice including treatment target identification.

appendix and acknowledgements

Members of the Panel are listed below. All had a significant input to the discussion and manuscript. Drs A. Costa and L. Norton were unable to attend the Panel session, but provided input for the planning of the meeting and reviewed and approved the manuscript. Profs H. Mouridsen and A. Wallgren were also unable to attend, but maintained significant input throughout the process and were represented by B. Ejlertsen and P. Karlsson, respectively, senior members of their research teams. For the first time, a patient representative, I. Kössler, joined the Panel.

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Appendix Table 4. Treatment allocation by therapeutic target and risk categories. Treatment options in each cell are listed in the order of preference (see text and footnotes)

HER2/ <i>neu</i> gene overexpression and/or amplified		HER2 negative					HER2 positive					
		highly responsive		incompletely responsive		non-responsive	highly responsive		incompletely responsive		non-responsive	
Endocrine responsiveness ^a		pre	post	pre	post	pre and post	pre	post	pre	post	pre and post	
Menopausal status												
Risk category	Low	Node negative and all of the following features: pT ≤2 cm, Grade 1, no vascular invasion, HER2(-), ER and/or PgR expressed, Age ≥35 years										
	Intermediate	Node negative and at least one of the following features: pT >2 cm, Grade 2-3, vascular invasion, HER2(+), ER and PgR absent, Age <35 years										
	High	1-3 nodes positive AND ER and/or PgR expressed and HER2(-)										
	High	1-3 nodes positive AND ER and PgR absent OR HER2(+)										
		>4 nodes positive										

^aResponsiveness to endocrine therapies is defined in the text.

^bEndocrine therapy is effective for prevention and DCIS and therefore might be considered even for very low risk invasive breast cancer.

C, chemotherapy; E, endocrine therapy (selected according to menopausal status); Tr, trastuzumab (note 1: trastuzumab should not be viewed as a standard treatment in women with a primary tumor <1 cm of size and with no axillary node involvement. This is particularly true in patients with highly and perhaps also incompletely endocrine responsive disease; note 2: trastuzumab should be given concurrently and after chemotherapy or following completion of all chemotherapy according to clinical trial evidence available at present, though a majority of the Panel agreed that trastuzumab without prior or concurrent chemotherapy may become appropriate for some patients in the future).

Footnotes

See Appendix for members of the Panel.

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