UCCH Pathway

UCCH Guideline
Metastatic Breast Cancer

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Ein Kompetenznetzwerk des UKE

Guideline Metastatic Breast Cancer

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Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

= Clinical trial

= Supportive measure

= Referral

= Tumorboard (including post tumorboard interaction with patient that follows the principles of shared decision-making)

Pathway: Metastatic Breast Cancer

Work up

Baseline:

- Medical history
- Physical examination
- Blood count
- Serum profile (transaminases, creatinine, AP, Ca^{2+}, bilirubin, LDH, albumin)
- Tumor markers CA 15.3 and CEA as baseline and for monitoring
- CT scan thorax /abdomen
- Bone scintigraphy
- Additional imaging (sono/MRI) if required
- **If possible biopsy at first recurrence and also at further progression**
- If possible receptor and HER-2/neu expression of metastatic lesion

Supportive:

- Offer contact to self help group
- Offer psychooncological support

TB

HER2 positive

HER2 negative

HR negative or HR-pos. and no indication for endocrine-based therapy[a,b]

HR* positive

Consider psychooncological support and palliative care/ intervention* at each stage of the disease

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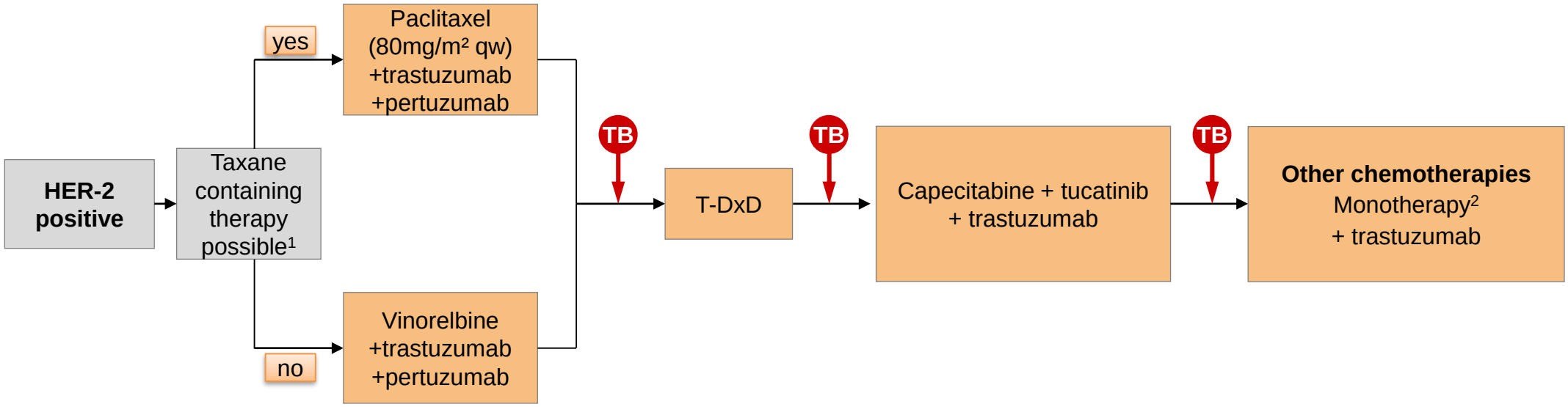
*HR hormone receptor

[a] Endocrine-based therapy is preferred as first line treatment of HER2 neg./HR pos. tumors. Reasons for use of first line chemotherapy could be e.g. progression during adjuvant DCK 4/6 inhibitor treatment or severe organ failure.

[b] Additional therapy with denusomab (preferred) or bisphosphonates in patients with metastatic spread to the bones, continuation of treatment also in progressive disease

* See palliative care screening tool on page 5. Therapy recommendation should also consider patient preference.

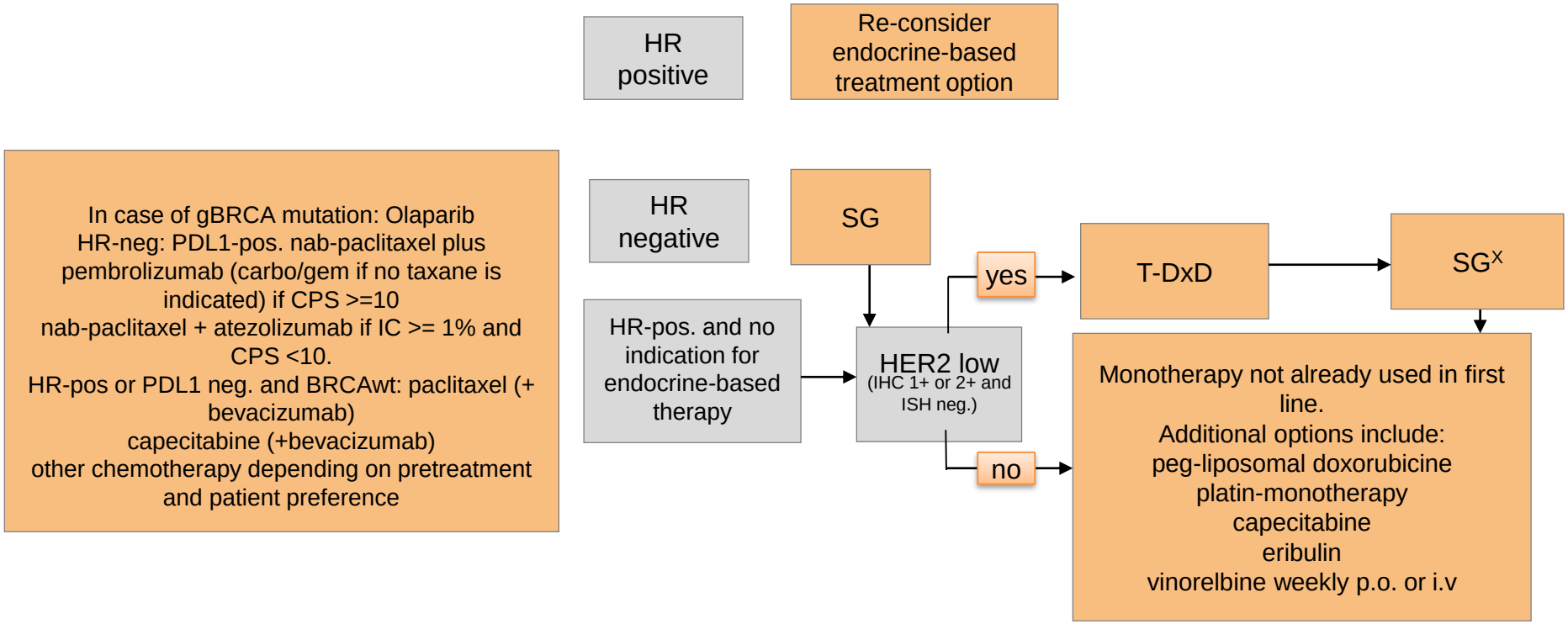
Pathway page 2: HER2 positive



[1] **Treatment principles:**
Chemotherapy depending on previous treatment regimens in hormone receptor pos. patients maintenance with endocrine therapy. In cases with longer lasting taxane free treatment periods a reinduction with taxanes should be considered.

[2] **Treatment principles:**
Chemotherapy in combination with trastuzumab and pertuzumab in first line, no combination of anthracyclines + trastuzumab. If possible combination first line with paclitaxel. If Paclitaxel is not indicated (e.g. short taxane free interval, relevant toxicity of previous taxane treatment, patients refusal) combination of vinorelbine with trastuzumab and pertuzumab is also possible in analogy to the equal effectivity observed of both chemotherapies in combination with trastuzumab alone.
In case of tumor remission stop of chemotherapy and continuation of antibody treatment. Selection of treatment schedule depending on previous therapies and duration of treatment-free periods. When stable remission is obtained, 18 weeks (equal to six cycles q3w) of therapy are regularly administered, afterwards maintenance therapy with trastuzumab + pertuzumab. Continuation of trastuzumab therapy in progressive disease after initial response to trastuzumab in combination with chemotherapy seems to be of benefit for patients. Endocrine maintenance therapy after the stop of chemotherapy if there is an option should be offered to the patients although prospective trials are lacking. The combination of endocrine treatment in combination with Trastuzumab could be offered to patients with bone only disease not eligible for chemotherapy although the combination with chemotherapy is preferred.

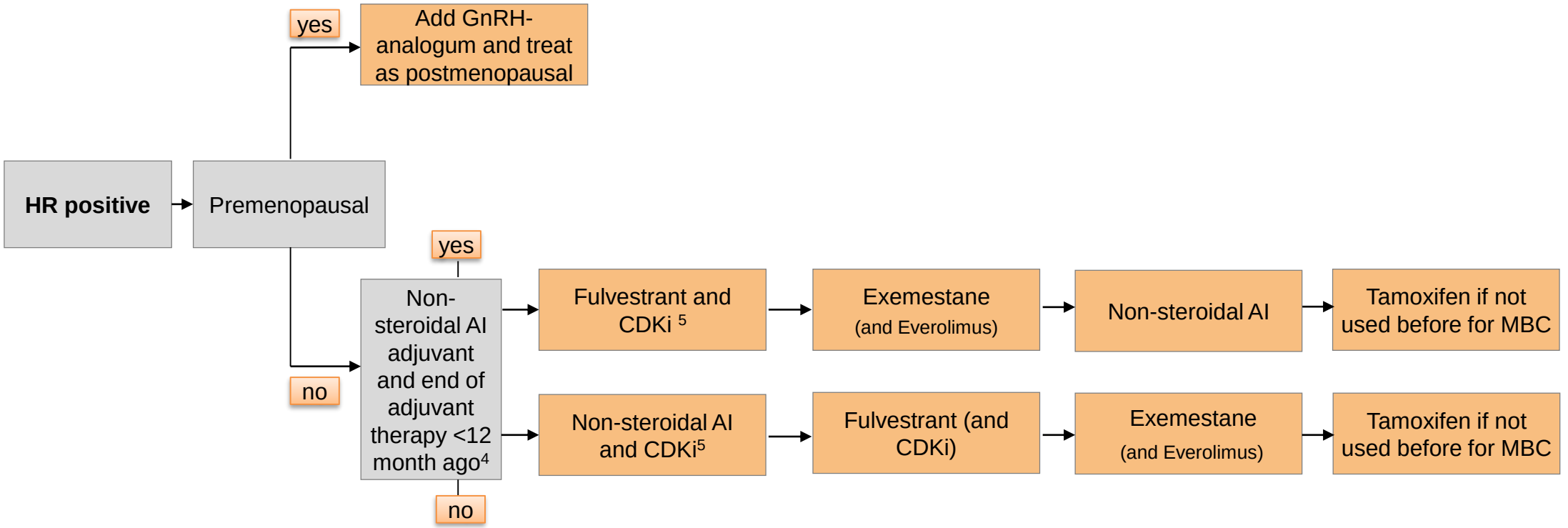
Pathway page 3: No indication for endocrine-based therapy, HER2 negative (including HER2 low)



[6] **Treatment principles:**
Sequential monotherapies (secondary to the possible endocrine principles treatment strategies in hormone receptor positive patients) adapted to previous therapies, patients status and preference. In case of remission:
checkpoint inhibitor or bevacizumab maintenance therapy and endocrine maintenance therapy if HR positive and endocrine treatment option

[X] SG (Sacituzumab Govitecan) in HR pos. pats after two or more lines of systemic therapy for MBC

Pathway page 4: HR positive, Her-2/neu negative



4 The optimal treatment schedule for recurrent disease secondary to adjuvant therapy with an aromatase inhibitor has not been finally clarified. After longer lasting treatment free periods (12 month in most trials) therapy with an aromatase inhibitor can be re-induced. Patients with gBRCA mutations should be offered PARP-inhibitor after first-line endocrine treatment.

5 If no contraindications against CDKi exist. gBRCA testing should be initiated during first line therapy and patients with a gBRCA mutation should be offered a PARP inhibitor as second line treatment.

Pathway page 5: Palliative care screening tool

Screening items			Points
1.	• Presence of metastatic or locally advanced cancer		**2**
2.	• ECOG score (functional status score, performance status)		**0-4**
3.	• Presence of one or more serious complications of advanced cancer usually associated with a prognosis of < 12 months (e.g. brain metastases, hypercalcemia, delirium, spinal cord compression, cachexia)		**1**
4.	• Presence of one or more serious comorbid diseases also associated with poor prognosis (e.g. moderate-severe COPD or CHF, dementia, AIDS, end stage renal failure end stage liver cirrhosis)		**1**
5.	• Presence of palliative care problems		**1**
	a.	• Symptoms uncontrolled by standard approaches	**1**
	b.	• Moderate to severe distress in patient or family, related to cancer diagnosis or therapy (personal targets and expectations, educational and informational requirements, cultural factors)	**1**
	c.	• Patient/family requests palliative care consult	**1**
	d.	• Team needs assistance with complex decision making or determing goals of care (benefit/side effects of treatment)	**1**
	e.	• Instable or deficient network especially for emergency situation or 24-h care	**1**

A total of > 5 points signalizes need for supportive palliative care

According to Glare et al. (2011); NCCN Clinical Practice guidelines in Oncology 2015