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Modern Approaches to Long-Term Metastatic Breast Cancer Care

**Announcer:**
You're listening to *On the Frontlines of Metastatic Breast Cancer* on ReachMD. Here's your host, Dr. Charles Turck.

**Dr. Turck:**
This is *On the Frontlines of Metastatic Breast Cancer* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss strategies for optimizing long-term management for patients with metastatic breast cancer is Dr. Adam Brufsky. He's a Professor of Medicine at the University of Pittsburgh School of Medicine and member of the UPMC Hillman Cancer Center. Dr. Brusky, welcome to the program.

**Dr. Brufsky:**
Thank you very much, Dr. Turck, for having me.

**Dr. Turck:**
Well, let's start with the big picture, Dr. Brufsky. How have advances in systemic therapies changed the outlook for patients living with metastatic breast cancer in recent years?

**Dr. Brufsky:**
Well, we really have had dramatic changes—definitely in estrogen receptor-positive metastatic breast cancer as well as HER2-positive metastatic breast cancer, and even now with triple-negative breast cancer. Especially for ER-positive and HER2-positive metastatic breast cancer, women now live at least five to almost 10 years in a lot of cases—I have patients who are now in excess of 10 years and who are living great lives—with very minimal kind of side effects from their systemic therapy. It really has completely changed the nature of the disease.

30 years ago, someone would maybe have a year and a half or less to live. Now, people are living in excess of five to 10 years and living really good lives—not lives that are constantly coming to clinic and getting chemotherapy. And we have now oral therapies, and people live dramatically longer.

**Dr. Turck:**
Now, with that in mind, how do care teams approach survivorship differently when the disease is incurable but treatable long-term?

**Dr. Brufsky:**
I think the big thing that we do is orient people. People are used to—especially for other cancers, like lung cancer, and pancreatic cancer—saying, "Oh my goodness, I have stage four disease, and I'm going to die in a year or two." And I think it's really orienting people to the fact that this is going to be a chronic disease. It's something they're going to live with a long time, which is a good thing.

And we really are focused on maintaining someone's quality of life—not really giving them, say, intensive therapy for a few months or a year or so with the understanding that they go to something more moderate, or even to begin with, in ER-positive disease, for example, CDK4/6 inhibitors and telling them, "Look, it'll be a month or two or three where we're adjusting your therapy, and then you could be on something for a long time and live with it and go on with your life." And I think that adjusting people to that is a big thing.

For example, with chronic pain management, the hope is that maybe we'll have intensive management for the first couple of months and then hopefully back off on a lot of their pain medication if we can. And I think just getting people oriented to that is really one of the primary tasks for us as medical oncologists and care providers for people with metastatic disease in the first couple of months—saying, "Look, there is a light at the end of the tunnel. You will be able to live well." It's not everybody, unfortunately, but I think for the majority of people right now, especially with ER-positive and HER2-positive metastatic breast cancer, we're orienting them to, "Look, there'll be a

couple months where it's going to be a little intense. We'll adjust things. You may not feel well, but the hope is, within a couple months, getting you to some sort of stability where you can live your life."

**Dr. Turck:**
And now that patients often stay in therapy longer, what are some of the most common comorbidities or chronic side effects clinicians need to be on the lookout for? You mentioned chronic pain management. I was wondering if there were any others.

**Dr. Brufsky:**
For CDK4/6 inhibitors in metastatic breast cancer, one of the things that we often run into with long-term use is you have a little bit more frequency of infection—so urinary tract infection, skin infection, sinusitis—because the neutrophil count is going to be on the low end. It's not going to be zero, but it's not going to be 500. It'll be, like, a thousand. And I think that makes you sometimes a little more prone to the typical infections that people get. Viral infections, no, because this doesn't affect lymphocytes. It affects more of the neutrophils, so it's more against skin infections, bacterial infections, and that sort of thing, and those patients will be a little bit more prone to that.

Other things people are more prone to tend to be hair thinning and hair loss, but not complete hair loss—just more hair thinning. Some people can have fatigue. We have to really focus on fatigue a lot. The nonpharmacologic management of fatigue, I think, is something that we do a lot more of now because people tend to live longer.

Other things we may run into—bone health. A lot of women are on bone-strengthening agents because they have bone metastases with breast cancer, and the risk of fracture and things like that goes up. So we try to prevent that with the use of bisphosphonates and other drugs.

**Dr. Turck:**
For those just tuning in, you're listening to *On the Frontlines of Metastatic Breast Cancer* on ReachMD. I'm Dr. Charles Turck, and I'm speaking to Dr. Adam Brufsky about navigating long-term management and survivorship in metastatic breast cancer.

So, Dr. Brufsky, let's talk about multidisciplinary care for a moment. What role does that play in supporting patients with metastatic breast cancer who are navigating long-term management?

**Dr. Brufsky:**
Well, I'll first start with multidisciplinary care with palliative care. I think getting palliative care specialists involved fairly early if possible—obviously I'm in an area of the country and a tertiary care center where we have this available—but getting palliative care involved earlier on and helping manage the symptoms is important. Especially when we're going to be using chronic pain management for a long period of time, it's good to have somebody with that sort of experience and also somebody who can discuss the goals of care. Obviously, as oncologists, we should be doing that, and primary care doctors should be doing that, but having a specialist is also very helpful.

I think that having radiation therapists involved is also very helpful. Sometimes what will happen is someone will have systemic stability of say a lot of bone metastases, and say one grows—having a radiation therapist involved fairly early who understands the patient is a good idea.

And third of the three is having surgeons involved, because what will happen a lot of times is someone's systemic disease will be completely controlled, and then maybe they'll have a growth in their breast or regrowth of their primary breast tumor that's been left in place, and how we manage that is really important. Do we take it out? Do we not? I think that's a huge debate that we're having right now in the breast cancer world—how aggressive to be locally in someone who has systemic disease elsewhere in their body. I think having everybody involved fairly early is a good idea because then they get to know the patient and what they're like now. And when something happens maybe three, four, five, or six years from now, they have a baseline to go back to.

So I think the treatment of advanced metastatic breast cancer is really evolving to not just be systemic therapy. It's really evolving to have everybody involved very early and being able to know kind of the patient's natural history as it evolves, or as she evolves with her natural history of her breast cancer.

**Dr. Turck:**
Now, as a follow-up to that, what psychosocial challenges do patients face when living with metastatic breast cancer as a chronic illness? And what strategies can care teams use to support their patients?

**Dr. Brufsky:**
Well, it's a really good question. They're always wondering, "When is the hammer going to drop? You've kept me alive, and my disease is actually not progressing, but it could progress at any time." And, again, involving palliative care as well as psychosocial resources, be it a counselor or psychiatrist, is very important here to let people know and help them understand that they're doing better than they

thought, and it may never progress.

30 years ago, I had people come in—"So, why were you late for clinic?" "Well, I'm preparing my funeral arrangements. I'm going to die in the next six months." And that isn't what happens anymore. People really do live for a long period of time. And they have a serious illness—you can't minimize that. But on the other hand, it's a serious illness, but it's something that is far more controllable than it was 10 or 20 years ago. And really, having people understand that and being able to live their lives without having to worry about that black cloud hanging over them the whole time is really one of the goals that we have. I think psychosocial support is really important to try to help that happen.

**Dr. Turck:**
As we come to the end of our program, Dr. Brufsky, do you have any final thoughts you'd like to share with our audience?

**Dr. Brufsky:**
I do. I think the real success that I've seen over the last 30 years is just dramatic. The example I always give is that we did a clinical trial a couple of years ago in metastatic breast cancer where the median time that people had had metastatic breast cancer was four years, and we were doing a randomized clinical trial to fifth-line chemotherapy or fifth-line therapy. It was actually the antibody-drug conjugate. And that would have been unheard of when I first started 30 years ago. I mean, 30 years ago, we were just trying to keep people alive for a couple of years, and now we're doing randomized clinical trials for fourth-line and fifth-line therapy, and people have been alive four years and beyond. And 10 years from now, 15 years on, it's going to be even greater. It's a message of optimism to everybody.

Sure, we can't cure everybody, but on the other hand, we're just in a totally different era now. The challenges and the issues are completely different than they used to be. This is more of a chronic disease now, and I think that we can keep people alive for a long period of time with a good quality of life.

**Dr. Turck:**
Well, with those thoughts in mind, I want to thank my guest, Dr. Adam Brufsky, for joining me to discuss how long-term management is evolving for patients with metastatic breast cancer. Dr. Brufsky, it was great having you on the program.

**Dr. Brufsky:**
Thank you very much, and thanks for having me.

**Announcer:**
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