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Putting Patients First: Personalized Care in Metastatic Breast Cancer

Ms. Baker:
This is *On the Frontlines of Metastatic Breast Cancer* on ReachMD. I'm Ashley Baker, and joining me to discuss a patient-centric approach to metastatic breast cancer care is Dr. Giancarlo Moscol, who is an Associate Professor in the Department of Breast Medical Oncology at the University of Texas MD Anderson Cancer Center in Houston.

Dr. Moscol, thanks for being here today.

Dr. Moscol:
I'm very excited to participate in the discussion, Ashley.

Ms. Baker:
So, Dr. Moscol, let's dive right in. When selecting a treatment approach, what clinical and patient-specific factors typically guide your decision-making process?

Dr. Moscol:
To me it's a three-tier decision. The very first tier is where I look at what is considered clinical efficacy. So basically, what is going to be the overall response rate, the complete response, the progression-free survival, duration of response, and overall survival? How clinically effective the medication is.

In the second tier, I mostly consider the most common adverse events. What are the Grade 3 toxicities? What is the rate of treatment interruptions? And also the rate of discontinuation to try to understand the toxicity versus benefit ratio.

Finally, on tier three, I mostly consider the logistics around administration. Is this going to be an IV treatment that has a prolonged infusion time that requires monitoring pre and post infusion, or are we talking about a subcutaneous formulation with a very hands-off approach? Or is this going to be an oral medication that may have a higher copay?

I think that at the end of the day, you have to reconcile these three tiers of evidence and then have an informed discussion with the patient on what you believe is going to be the best match for her disease.

Ms. Baker:
Now, when you're discussing treatment options with patients, what concerns or questions come up most often, and how do you address them?

Dr. Moscol:
Well, the number one issue for sure is toxicity. So how severe are going to be the side effects? Are they going to interrupt daily work? Are any of these toxicities going to be short term versus long term or irreversible? And what are the strategies that we have available to palliate them?

I would say a second common issue is also around the administration. If you have a treatment that is going to need multiple toxicity check visits that happen every so often, like every week or every other week, that could be a little more prohibitive, especially for younger patients who are still trying to work full time in order to keep insurance access. And they also very frequently ask if, as a consequence of the infusion, the expectation is that they need to come with a friend or a family member to be around them because sometimes the medications can produce some neurological toxicities. So if eventually, they need to have somebody driving for them to the lab appointments or the infusions, that also imposes extra toll on the family members and the social network. They also want to know

if they're still allowed to drive and how close can they remain to the family members while they're on treatment, mostly because of the risk of infection.

Ms. Baker:
And when deciding between distinct mechanisms of action, how do you help patients understand those differences and why they matter?

Dr. Moscol:
Well, I usually start by explaining the subtype of breast cancer the patient has. So I think that the conversations are very different if we're dealing with an ER-positive, HER2-negative breast cancer patient where we're looking at a longer overall survival and we're basically looking at endocrine manipulation for the first two or three years versus a triple-negative breast cancer where the options are significantly more limited and they tend to have more toxicity.

I also tell them that it's very important that we get hands on and try to do a broad testing of the cancer so we can look for the presence of some alterations or mutations that can be of greater utility later as the cancer progresses on different lines of therapy. I also explain that sometimes these results may take two or three weeks to come back, but that is okay because for the majority of cases, we do not necessarily need to get the results back in order for us to proceed and determine what is going to be the best next treatment. So I think that this is a fluid communication strategy. You are empowering the patient because you are helping them understand their disease. We give them printouts with education and then I'm also creating the expectation of getting back together when we have your results so we can discuss what we have found.

Finally, I think it's also important to remind that even when you find a mutation, that doesn't necessarily mean that you're going to be able to target it. So you need to be able to meet the patient eye to eye and tell them, "Well, the fact that you have this mutation—like p53 for example—is not something that we can administer a drug or intervene for at this moment." And still I would support doing best supportive care, for example.

Ms. Baker:
For those just tuning in, you're listening to *On the Frontlines of Metastatic Breast Cancer* on ReachMD. I'm Ms. Ashley Baker, and I'm speaking with Dr. Giancarlo Moscol about personalizing treatment decisions in metastatic breast cancer.

So, Dr. Moscol, as we weigh the efficacy of treatments with the potential side effects, how do you approach that conversation with patients, especially when the most effective option may not be the easiest to tolerate?

Dr. Moscol:
I think it's patient dependent. These are tough conversations. I always use this analogy—I tell the patients that in life, we're usually trying to always maximize the quantity while keeping quality of life. But eventually, we end up needing to choose one versus the other. For younger, motivated patients, for example, I tell them that maybe it's preferable to endure a little more initial toxicity in order to obtain a deeper initial response and get better symptomatic relief and a possible longer survival. If I'm going to be dealing with a very elderly and frail patient, for example, then I would endorse a more hands-off approach where I would say, "Let's mostly focus on palliative treatment and try to control pain and enrich quality of life."

Ms. Baker:
Now, if we look ahead for a moment, are there any emerging innovations in diagnostics, biomarkers, or treatment personalization that you're particularly excited about?

Dr. Moscol:
So in the recent ASCO meeting, we all learned about the SERENA-6. So this is a very interesting trial because it's the very first time that we're seeing the use of sequential liquid biopsies on patients who have metastatic ER-positive breast cancer. And what they're doing is trying to test for the presence of a molecular relapse. They're trying to follow these patients with metastatic disease. They were doing the repetitive liquid biopsy testing, and whenever they were able to find that the patient has developed this activating mutation called the ESR1 mutation, then these patients were switched to treatment to a different agent called camizestrant.

So this is, of course, a quite innovative approach and quite intriguing. The data that they have presented so far to me is still immature, but it looks very promising. It is pretty much telling you that having this hands-on approach and doing an early switch to a newer drug can potentially not only give patients a longer duration of response in first line but may also have a carryover effect and have even further benefits down the line in second and third lines and eventually may even hit overall survival. But of course, in order to get that judgment call, we'll have to wait another three to four years to see more mature data.

The other very hot topic is the use of MRD. I think we know that we have a myriad of tests that can look for the presence of molecular

residual disease or minimal amount of ctDNA in the circulation, and potentially, we can start using this type of strategy to diagnose patients that are at risk of relapse or to determine deescalation. So this is also in very early stages. The initial limited sets of data that we have seen do appear to show that MRD positivity has a very strong prognostic value, so it can identify patients that have the highest risk of relapse, but it still lacks a predictive role, meaning we don't know if we can intervene—if we can intercept this positive result and then change the natural outcome. I'm very hopeful that the upcoming prospective trials, like LEADER and DARE, which are recruiting patients who test positive for MRD and then are offered intervention, may end up validating that these MRD technologies not only have a prognostic value but will eventually also gather a predictive value.

Ms. Baker:
Finally, Dr. Moscol, do you have any key takeaways you'd like to share with clinicians who are navigating treatment decisions alongside their patients?

Dr. Moscol:
I think it's extremely important to keep an open communication channel with the patient and with the family members. I always remind my team, at the end of the day, we're just humans who are helping other humans. So it's always good advice that you recognize your limitations. Don't be afraid to acknowledge when you don't have the answers, call somebody that may have it. And most importantly, if there is a mistake, be responsible and notice that as soon as possible.

Ms. Baker:
Those are great comments for us to think on as we come to the end of today's program, and I want to thank my guest, Dr. Giancarlo Moscol, for joining me to discuss patient-centric decision-making in metastatic breast cancer.

Dr. Moscol, it was great having you on the program.

Dr. Moscol:
Thank you, Ashley.

Ms. Baker:
You've been listening to *On the Frontlines of Metastatic Breast Cancer* on ReachMD. To access this and other episodes in our series, visit *On the Frontlines of Metastatic Breast Cancer* on ReachMD.com, where you can Be Part of the knowledge. Thanks for listening.