Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/frontlines-metastatic-breast-cancer/balancing-efficacy-and-tolerability-in-metastatic-breast-cancer-treatment/35459/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Balancing Efficacy and Tolerability in Metastatic Breast Cancer Treatment

Announcer:
Welcome to *On the Frontlines of Metastatic Breast Cancer* on ReachMD. On this episode, we'll hear from Dr. Paolo Tarantino, who's a medical oncologist and Clinical Research Fellow in the Breast Oncology Program at Dana-Farber Cancer Institute and Harvard Medical School. He will discuss treatment selection strategies for patients with metastatic breast cancer. Here's Dr. Tarantino now.

Dr. Tarantino:
When we look at the clinical and patient-related factors that influence the choice of treatment in metastatic breast cancer, the most important ones are the receptor profile of the disease—so, in particular, the estrogen receptor and HER2 receptor expression of disease—which allows us to divide breast tumors into three different subgroups: ER+, HER2-, or luminal; HER2+; and triple-negative. And each one of these has a very distinct treatment algorithm. Then, within these treatment algorithms, we further refine treatment depending on the location of disease. And so, for instance, a patient that has brain metastases may be treated differently from patients that have less high-risk locations, such as bone or lymph node metastasis. And then patient preferences. And it's important to always take into account not only preference but also age and expectations.

The time where we usually think of switching the type of treatment or mechanism of action of the treatment is upon development of progression of disease, meaning when monitoring CT scans that usually we perform every two to four to six months depending on the clinical profile, we see an increase in the disease. One paradigm that has been emerging as a research concept is to switch treatment before progression on the scans, when you detect some marker of resistance in the blood. And this is something that has been studied in ER+ breast cancer with switching from aromatase inhibitors to SERDs upon development of ESR1 mutations in the blood. But they're still experimental, and so for the moment, the standard is to switch the type of treatment whenever you see on the scans—usually CT scans—that there is a growth in the disease despite the treatment that you're giving.

The tradeoff between the efficacy and the tolerability profile of each treatment we give for breast cancer is critical. Every time we have to select the treatment, it's super important not just to look at the clinical benefit it can provide, but also if the toxicity profile aligns with the clinical aspect of the patient—for instance, the comorbidities, preferences, and expectations of the patient. And so, for instance, there are some patients who easily tolerate alopecia or peripheral neuropathy, whereas other patients may really not tolerate that and would rather prefer to receive a different treatment that does not cause alopecia or for which you can prevent it with cooling. Or, for instance, they may not afford to have peripheral neuropathy because of the job they conduct. So it's always extremely important to put on the table both sides of every treatment—the positive effect it can have on progression-free survival, overall survival, and control of disease—together with the potential toxicity profile. And gladly, this is becoming easier with the availability of more treatment options because you can offer different options and select the one that better aligns in terms of balance between activity and toxicity with the profile of the patient. But in truth, at the same time, we are seeing an emergence of combination treatments that are extremely effective in certain cases, but they usually come with increased side effects.

And so, in order to make our patients benefit from these combination strategies that can be very beneficial, it's important for physicians to become very aware of management strategies for side effects and preventive strategies because there are some cases where if you utilize the right prophylaxis, you can really avoid any troublesome nausea for the patient or diarrhea. For instance, there is neratinib. When we started to use that drug, it was causing a lot of diarrhea, but once you dose-escalate it, use loperamide in the right way, you can really avoid severe diarrhea. And that's just one of many examples where you can really benefit from the efficacy of a drug while minimizing toxicity with adequate prophylaxis and management.

And so, in truth, I do feel it's always an important and careful balance that needs to be made, but the balance can be optimized if you have adequate management in prophylaxis, and it should always be put in the context of the patient profile and preferences.

Announcer:
That was Dr. Paolo Tarantino talking about how we can optimize treatment selection in metastatic breast cancer. 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!