PRIMARY TREATMENT OF EARLY BREAST CANCER
ST. GALLEN 2017

ESCALATING AND DE-ESCALATING TREATMENT IN EARLY BREAST CANCER ACROSS SUBTYPES AND TREATMENT MODALITIES

Consensus & Controversy
International Consensus Panel 2017

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Expert Opinion on Areas of Controversy

- Escalation and de-escalation of treatment are major issues for management of early breast cancer.
- Evidence from randomized clinical trials does not cover all controversies that arise in treating individuals.
- The opinion of the panel members is used to implement guidance for controversial issues.
- When data are lacking, expert opinion can be used.
- This is the unique feature of the St. Gallen International Consensus.
Panelists’ Answers

- Questions have been prospectively reviewed by the panelists and revised to be as clear as possible.

- Panelists are asked to answer either

  1 Yes or 2 No

  for most questions

  or in certain cases

  select from mutually exclusive choices, 1, 2, 3, 4, etc.

- Option for Abstain if Panelist has insufficient data, lack of specific expertise on the issue, or conflict of interest.

  Do not hesitate to abstain, if appropriate.
Practice Question

T1. The venue of the 2017 St. Gallen International Breast Cancer Conference is in Vienna/Austria?

(1) Yes
(2) No
(3) Abstain
Practice Question

T2. The population of Vienna is (select one):

(1) More than 1,500,000
(2) From 1,000,000 to 1,500,000
(3) From 500,000 to 1,000,000
(4) <500,000
(5) Abstain
LET’S START
Escalating and De-escalating

APPROPRIATE MARGINS IN PRIMARY SURGERY AND IN SURGERY FOLLOWING NEOADJUVANT SYSTEMIC THERAPY
Breast Conserving Surgery of the Primary (DCIS)

1. In women undergoing breast conserving surgery for DCIS and planned whole breast radiation treatment which minimum margin width is sufficient to avoid re-excision?

(1) No ink on DCIS?
(2) 2 mm clearance?
(3) 5 mm clearance?
(4) Margin is irrelevant?
(5) Abstain
Primary Surgery of Multi-focal/ Multicentric Disease

2. >2 tumor foci contained in one ‘quadrant’ of the breast (multifocal) can be treated with breast conservation, provided margins are clear and adequate RT is planned.

(1) Yes

(2) No

(3) Abstain
Primary Surgery of Multi-focal/ Multicentric Disease

3. Tumor foci in more than one ‘quadrant’ of the breast (multicentric) can be treated with breast conservation, provided margins are clear and adequate RT is planned.

(1) Yes

(2) No

(3) Abstain
4. Should the margin required be dependent on tumor biology?

(1) Yes
(2) No
(3) Abstain
Surgery of the Primary Tumor

5. Should the margin required be dependent on tumor histology (greater if lobular)?

(1) Yes
(2) No
(3) Abstain
Surgery of the Primary Tumor

6. Should the margin required be dependent on age (greater if age < 40)?

(1) Yes
(2) No
(3) Abstain
Surgery of the Primary Tumor

7. Should the margin required be greater in presence of extensive intraductal component?

(1) Yes
(2) No
(3) Abstain
Surgery of the Primary Tumor

8. Is nipple-sparing mastectomy safe in germline BRCA mutated patients?

(1) Yes
(2) No
(3) Abstain
Surgery of the Primary (IBC) after Neoadjuvant Systemic Therapy

9. In women undergoing breast conserving surgery after neoadjuvant chemotherapy and proceeding to standard radiation with or without additional adjuvant systemic therapy. Should the entire area of the original primary be resected after downstaging?

(1) Yes

(2) No

(3) Abstain
Surgery of the Primary (IBC) after Neoadjuvant Systemic Therapy

10. In women undergoing breast conserving surgery after neoadjuvant chemotherapy and proceeding to standard radiation with or without additional adjuvant systemic therapy. Which is the minimum acceptable surgical margin to avoid re-excision (with multifocal residual disease in the pathological specimen)?

(1) No ink on invasive tumor or DCIS?
(2) 2 mm clearance?
(3) > 2 – 5 mm clearance?
(4) > 5mm clearance?
(5) Margin is irrelevant?
(6) Abstain
Surgery of the Primary (IBC) after Neoadjuvant Systemic Therapy

11. In women undergoing breast conserving surgery after neoadjuvant chemotherapy and proceeding to standard radiation with or without additional adjuvant systemic therapy. Which is the minimum acceptable surgical margin to avoid re-excision (without multifocal residual disease in their pathological specimen)?

(1) No ink on invasive tumor or DCIS?

(2) 2 mm clearance?

(3) > 2 – 5 mm clearance?

(4) > 5mm clearance?

(5) Margin is irrelevant?

(6) Abstain
Surgery of the Primary (IBC) after Neoadjuvant Systemic Therapy

12. In women undergoing breast conserving surgery after neoadjuvant chemotherapy and proceeding to standard radiation with or without additional adjuvant systemic therapy. Is nipple-sparing mastectomy safe after neoadjuvant treatment?

(1) Yes
(2) No
(3) Abstain
Escalating and De-escalating

WHEN CAN AXILLARY SURGERY BE REDUCED?
13. In patients with macro-metastases in 1-2 sentinel nodes, completion of axillary dissection can safely be omitted following:
Mastectomy (no radiotherapy to lymph nodes planned)

(1) Yes
(2) No
(3) Abstain
Surgery of the Axilla

14. In patients with macro-metastases in 1-2 sentinel nodes, completion of axillary dissection can safely be omitted following:
Mastectomy (radiotherapy to lymph nodes planned)

(1) Yes
(2) No
(3) Abstain
Surgery of the Axilla

15. In patients with macro-metastases in 1-2 sentinel nodes, completion of axillary dissection can safely be omitted following:
Conservative resection with radiotherapy using standard tangents

(1) Yes
(2) No
(3) Abstain
16. **In patients with macro-metastases in 1-2 sentinel nodes, completion of axillary dissection can safely be omitted** following:
Conservative resection with radiotherapy using high tangents

(1) Yes
(2) No
(3) Abstain
Surgery of the Axilla

17. In patients with macro-metastases in 1-2 sentinel nodes, completion of axillary dissection can safely be omitted following:
Irrespective of tumor biology (LVI, ER-, grade 3 etc.)

(1) Yes
(2) No
(3) Abstain
Surgery of the Axilla following Neo-Adjuvant Chemotherapy

18. In a patient who is clinically (at palpation and US) node negative at diagnosis:
Is SN biopsy appropriate?

(1) Yes
(2) No
(3) Abstain
Surgery of the Axilla following Neo-Adjuvant Chemotherapy

19. **In a patient who is clinically (at palpation and US) node negative at diagnosis:**
   When is the best time point for SN Biopsy?

(1) Before the start of neoadjuvant chemo

(2) After neoadjuvant chemo

(3) either before or after chemo are valid options

(4) Abstain
Surgery of the Axilla following Neo-Adjuvant Chemotherapy

20. In a patient who is clinically node positive at diagnosis and who downstages after chemotherapy:
   Is SN biopsy appropriate with 1-2 LN detected?

(1) Yes
(2) No
(3) Abstain
Surgery of the Axilla following Neo-Adjuvant Chemotherapy

21. **In a patient who is clinically node positive at diagnosis and who downstages after chemotherapy:** Is SN biopsy appropriate only in selected cases such as:
   more than 2 SN detected

(1) Yes

(2) No

(3) Abstain
Surgery of the Axilla following Neo-Adjuvant Chemotherapy

22. In a patient who is clinically node positive at diagnosis and who downstages after chemotherapy: Is SN biopsy appropriate only in selected cases such as: dual tracer technique

(1) Yes
(2) No
(3) Abstain
Surgery of the Axilla following Neo-Adjuvant Chemotherapy

23. **In a patient who is clinically node positive at diagnosis and who downstages after chemotherapy:** Is SN biopsy appropriate only in selected cases such as:
   - Clipping/seeding of involved nodes at diagnosis and targeted removal

(1) Yes

(2) No

(3) Abstain
Surgery of the Axilla following Neo-Adjuvant Chemotherapy

24. In a patient who is clinically node positive at diagnosis and who downstages after chemotherapy: Is SN biopsy appropriate only in selected cases such as:
   Sonography after chemo and more than one SN

(1) Yes
(2) No
(3) Abstain
Surgery of the Axilla following Neo-Adjuvant Chemotherapy

25. In a patient who is clinically node positive at diagnosis and who downstages after chemotherapy: Can ALND be avoided if micrometastasis is present in the SN?

(1) Yes

(2) No

(3) Abstain
Surgery of the Axilla following Neo-Adjuvant Chemotherapy

26. In a patient who is clinically node positive at diagnosis and who downstages after chemotherapy: Can ALND be avoided if a single SN is positive (macrometastasis)?

(1) Yes
(2) No
(3) Abstain
Escalating and De-escalating

IN WHICH CLINICAL SCENARIO RADIOTHERAPY COURSES MAY BE SHORTENED?
Hypofractionated Breast Irradiation

27. Following breast conserving surgery, hypofractionated whole breast irradiation is a standard of care in:
   All patients

(1) Yes
(2) No
(3) Abstain
Hypofractionated Breast Irradiation

28. Following breast conserving surgery, hypofractionated whole breast irradiation is a standard of care in:

- Patients over 50 years

(1) Yes
(2) No
(3) Abstain
29. Following breast conserving surgery, hypofractionated whole breast irradiation is a standard of care in:

Patients with prior chemotherapy

(1) Yes
(2) No
(3) Abstain
Hypofractionated Breast Irradiation

30. Following breast conserving surgery, hypofractionated whole breast irradiation is a standard of care in:
   Following mastectomy or with N+

   (1) Yes
   (2) No
   (3) Abstain
Hypofractionated Breast Irradiation

31. **Following breast conserving surgery, hypofractionated whole breast irradiation is a standard of care in:**
   - Never

(1) Yes
(2) No
(3) Abstain
Partial Breast Irradiation

32. **Following breast conserving surgery, partial breast irradiation may be used:**
As the definitive irradiation, without whole breast irradiation in ASTRO/ESTRO “suitable” patients?

(1) Yes
(2) No
(3) Abstain
Partial Breast Irradiation

33. **Following breast conserving surgery, partial breast irradiation may be used:**
As the definitive irradiation, without whole breast irradiation in ASTRO “cautionary” / ESTRO “intermediate” patients?

(1) Yes

(2) No

(3) Abstain
Partial Breast Irradiation

34. Following breast conserving surgery, partial breast irradiation may be used: Only in the absence of adverse tumor pathology or poor prognosis multigene testing?

(1) Yes

(2) No

(3) Abstain
Partial Breast Irradiation

35. Following breast conserving surgery, partial breast irradiation may be used:

Never

(1) Yes
(2) No
(3) Abstain
Accelerated Partial Breast Irradiation (ABPI)

36. Which patients may be considered for APBI outside of a clinical trial?

Patients with age greater than or equal to 50 years with negative margins and pT1 stage

(1) Yes

(2) No

(3) Abstain
Accelerated Partial Breast Irradiation (ABPI)

37. **Which patients may be considered for APBI outside of a clinical trial?**

Patients with age 40-49 years with negative margins and pT1 stage

(1) Yes

(2) No

(3) Abstain
Accelerated Partial Breast Irradiation (ABPI)

38. Which patients may be considered for APBI outside of a clinical trial?
Patients with age <40 years with negative margins and pT1 stage

(1) Yes
(2) No
(3) Abstain
Accelerated Partial Breast Irradiation (ABPI)

39. Which patients may be considered for APBI outside of a clinical trial?

Never

(1) Yes

(2) No

(3) Abstain
40. “Boost” Radiotherapy to Primary Tumor Bed after Breast Conservative Surgery can be omitted

(1) Never
(2) Always
(3) In patients > 60 years old, low grade, or favourable biological profile or low risk genomics score
(4) In case of positive margins
(5) Abstain
Escalating and De-escalating

WHEN SHOULD RADIOTHERAPY VOLUMES BE EXPANDED?
Regional Node Irradiation

41. Following breast conserving surgery, radiation should include regional nodes:

*If number of positive nodes is 1-3*

(1) No

(2) Only if adverse biological features

(3) At all cases

(4) Abstain
Regional Node Irradiation

42. Following breast conserving surgery, radiation should include regional nodes:

*If number of positive nodes is 4 or more*

(1) No

(2) Only if adverse biological features

(3) At all cases

(4) Abstain
Regional Node Irradiation

43. Following breast conserving surgery, radiation should include regional nodes: *If clinically negative and no axillary staging is available*

(1) No

(2) Only if adverse biological features

(3) At all cases

(4) Abstain
Radiation Therapy: After Mastectomy

44. Should post mastectomy RT (chest wall & regional nodes) be standard for patients with:
T size $\geq$ 5 cm and N0?

(1) Yes
(2) No
(3) Abstain
Radiation Therapy: After Mastectomy

45. Should post mastectomy RT (chest wall & regional nodes) be standard for patients with: N+ 1 to 3 all patients?

(1) Yes
(2) No
(3) Abstain
Radiation Therapy: After Mastectomy

46. Should post mastectomy RT (chest wall & regional nodes) be standard for patients with:
N+ 1 to 3 with adverse pathology?

(1) Yes
(2) No
(3) Abstain
Radiation Therapy: After Mastectomy

47. Should post mastectomy RT (chest wall & regional nodes) be standard for patients with: N+ 1 to 3 at young age (< 40 years)?

(1) Yes
(2) No
(3) Abstain
Radiation Therapy: After Mastectomy

48. Should post mastectomy RT (chest wall & regional nodes) be standard for patients with: Positive sentinel node biopsy but no axillary dissection?

(1) Yes
(2) No
(3) Abstain
Radiation Therapy: After Mastectomy and Breast Reconstruction

49. If RT is given (node positive or pT3) following immediate breast reconstruction, it should include:
   Regional lymph nodes only

(1) Yes
(2) No
(3) Abstain
Radiation Therapy: After Mastectomy and Breast Reconstruction

50. If RT is given (node positive or pT3) following immediate breast reconstruction, it should include: Nodes and the residual part of the chest wall in most cases

(1) Yes

(2) No

(3) Abstain
Radiation Therapy: After Mastectomy and Breast Reconstruction

51. If RT is given (node positive or pT3) following immediate breast reconstruction, it should include:
Nodes and the residual part of the chest wall:
Only in pts with adverse pathological features

(1) Yes
(2) No
(3) Abstain
Radiation to Breast Following Neo-Adjuvant Systemic Therapy

52. Should follow the stage

(1) *Before* neo-adjuvant therapy?

(2) *After* neo-adjuvant therapy?

(3) Should take into account the stage *before and after* neo-adjuvant therapy at surgery?

(4) Can be omitted in women with pCR after NAC?

(5) Abstain
Escalating and De-escalating

WHEN IS TRADITIONAL PATHOLOGY (STAGE, GRADE, LVI, ER/PR/HER2) NOT INFORMATIVE ENOUGH?
Pathology: Subtypes

53. If derived using IHC, distinction between ‘Luminal A-like’ and ‘Luminal B-like’ (HER2 neg.):
Describes important categories in the biology of luminal breast cancer

(1) Yes
(2) No
(3) Abstain
Pathology: Subtypes

54. If derived using IHC, distinction between ‘Luminal A-like’ and ‘Luminal B-like’ (HER2 neg.):
Should be used for therapy decisions

(1) Yes
(2) No
(3) Abstain
Pathology: Subtypes

55. If derived using IHC, distinction between ‘Luminal A-like’ and ‘Luminal B-like’ (HER2 neg.):
Generates working categories but should not be used for clinical decisions due to low analytical validity

(1) Yes
(2) No
(3) Abstain
Pathology: Subtypes

56. Distinction between ‘Luminal A-like’ and ‘Luminal B-like’ (HER2 neg.) can be derived:
Using IHC (ER, PR and grading) to approximate multigene testing

(1) Yes
(2) No
(3) Abstain
Pathology: Subtypes

57. Distinction between ‘Luminal A-like’ and ‘Luminal B-like’ (HER2 neg.) can be derived:
Using ER, PR and ‘high’ Ki67

(1) Yes
(2) No
(3) Abstain
Pathology: Subtypes

58. Distinction between ‘Luminal A-like’ and ‘Luminal B-like’ (HER2 neg.):
If Ki67 is used in which range is the cut-off for ‘high’?

(1) 14 – 19 %

(2) 20 – 29 %

(3) 30 % or more

(4) Abstain
Pathology: Subtypes

59. Distinction between ‘Luminal A-like’ and ‘Luminal B-like’ (HER2 neg.) can be derived:

*Subtype can be more appropriately determined by multi-gene tests (when available)?*

(1) Yes

(2) No

(3) Abstain
Pathology: Subtypes

60. If the absence of genomic information distinction between ‘Luminal A-like’ and ‘Luminal B-like’ (HER2 neg.) can be derived from IHC?

(1) Yes
(2) No
(3) Abstain
Pathology: TILs

61. Should the evaluation of tumor-infiltrating lymphocytes (TILs) be reported in the pathology report of triple negative and HER2 positive BC?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

62. Is there a role for multi-gene testing in node negative, pT1a, pT1b, ER positive, PgR positive, HER2 negative, low grade, low Ki67 breast cancer?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

63. In a patient with ER+/HER2 negative clinically valuable information on **prognosis** and risk helping us to decide to omit chemotherapy may be provided by:

**Oncotype DX® RS**

Prognosis: years 1-5?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

64. In a patient with ER+ /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by: Oncotype DX® RS.

Chemotherapy?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

65. In a patient with ER + /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide to omit chemotherapy may be provided by: **MammaPrint 70®**

Prognosis: years 1-5?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

66. In a patient with ER+ /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by: MammaPrint 70®

Chemotherapy?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

67. In a patient with ER + /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide to omit chemotherapy may be provided by:

**PAM-50 ROR Score**

Prognosis: years 1-5?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

68. In a patient with ER+ /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide to omit chemotherapy may be provided by:

**PAM-50 ROR Score**

Chemotherapy?

1. Yes
2. No
3. Abstain
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

69. In a patient with ER + /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide to omit chemotherapy may be provided by: **EndoPredict® (EpClin)**

Prognosis: years 1-5?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

70. In a patient with ER+ /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide to omit chemotherapy may be provided by: 

EndoPredict® (EpClin)

Chemotherapy?

- (1) Yes
- (2) No
- (3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

71. In a patient with ER+ /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide to omit chemotherapy may be provided by:

**Breast Cancer Index**

Prognosis: years 1-5?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-Negative Patients

72. In a patient with ER+ /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by: Breast Cancer Index

Chemotherapy?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-positive Patients

73. In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:

**Oncotype DX® RS**

Prognosis: years 1-5?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-positive Patients

74. In a patient with ER+/HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:

Oncotype DX® RS    Chemotherapy?

(1) Yes

(2) No

(3) Abstain
75. In a patient with ER + /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide to omit chemotherapy may be provided by: **MammaPrint 70®**

- (1) Yes
- (2) No
- (3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-positive Patients

76. In a patient with ER+ /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:

MammaPrint 70®

Chemotherapy?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-positive Patients

77. In a patient with ER+ /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide to omit chemotherapy may be provided by:

PAM-50 ROR Score  Prognosis: years 1-5?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-positive Patients

78. In a patient with ER+ /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide to omit chemotherapy may be provided by:

**PAM-50 ROR Score**  
Chemotherapy?

**1**  Yes

**2**  No

**3**  Abstain
79. In a patient with ER+ /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide to omit chemotherapy may be provided by:

EndoPredict® (EpClin)  Prognosis: years 1-5?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-positive Patients

80. In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by: EndoPredict® (EpClin) chemotherapy?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-positive Patients

81. In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:

Breast Cancer Index

Prognosis: years 1-5?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Chemotherapy: Node-positive Patients

82. In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide to omit chemotherapy may be provided by:

- Breast Cancer Index
- Chemotherapy?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Negative Patients

83. In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

**Oncotype DX® RS** Prognosis: years 5-10?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Negative Patients

84. In a patient with ER+/HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

**Oncotype DX® RS**  Extended endocrine therapy?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Negative Patients

85. In a patient with ER+ /HER2 negative clinically valuable information on *prognosis* and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

MammaPrint 70® Prognosis: years 5-10?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Negative Patients

86. In a patient with ER+ /HER2 negative clinically valuable information on prognosis and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

MammaPrint 70® Extended endocrine therapy?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Negative Patients

87. In a patient with ER + /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

PAM-50 ROR Score

Prognosis: years 5-10?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Negative Patients

88. In a patient with ER + /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

PAM-50 ROR Score | Extended endocrine therapy?

(1) Yes
(2) No
(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Negative Patients

89. In a patient with ER + /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

**EndoPredict® (EpClin)**

Prognosis: years 5-10?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Negative Patients

90. In a patient with ER + /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

- **EndoPredict® (EpClin)**

Extended endocrine therapy?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Negative Patients

91. In a patient with ER+/HER2 negative clinically valuable information on *prognosis* and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

**Breast Cancer Index**  Prognosis: years 5-10?

(1) Yes

(2) No

(3) Abstain
92. In a patient with ER+ /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

**Breast Cancer Index**  
Extended endocrine therapy?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Positive Patients

93. In a patient with ER+ /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

**Oncotype DX® RS** Prognosis: years 5-10?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Positive Patients

94. In a patient with ER+/HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

**Oncotype DX® RS** Extended endocrine therapy?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Positive Patients

95. In a patient with ER + /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

MammaPrint 70® Prognosis: years 5-10?

1. Yes
2. No
3. Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Positive Patients

96. In a patient with ER+ /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

MammaPrint 70® Extended endocrine therapy?

(1) Yes

(2) No

(3) Abstain
In a patient with ER+ /HER2 negative clinically valuable information on prognosis and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

PAM-50 ROR score

Prognosis: years 5-10?

(1) Yes
(2) No
(3) Abstain
In a patient with ER+ /HER2 negative clinically valuable information on prognosis and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

**PAM-50 ROR score**

- Extended endocrine therapy?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Positive Patients

99. In a patient with ER+ /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

**EndoPredict® (EpClin)** Prognosis: years 5-10?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Positive Patients

100. In a patient with ER + /HER2 negative clinically valuable information on prognosis and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

EndoPredict® (EpClin)  
Extended endocrine therapy?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Positive Patients

101. In a patient with ER+/HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

**Breast Cancer Index**  Prognosis: years 5-10?

(1) Yes

(2) No

(3) Abstain
Multi-Gene Signatures and Extended Endocrine Therapy: Node-Positive Patients

102. In a patient with ER + /HER2 negative clinically valuable information on **prognosis** and risk helping us to decide for an extended endocrine therapy (beyond five years) may be provided by:

**Breast Cancer Index**

Extended endocrine therapy?

(1) Yes

(2) No

(3) Abstain
Escalating and De-escalating

WHICH WOMEN SHOULD RECEIVE OVARIAN SUPPRESSION AS PART OF ADJUVANT ENDOCRINE THERAPY?
Endocrine Therapy
Premenopausal: Selection Factors

103. **Does each of the following clinico-pathological features by itself argue for inclusion of ovarian function suppression (OFS)?**

**Age < 35 years**

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Premenopausal: Selection Factors

104. Does each of the following clinico-pathological features by itself argue for inclusion of ovarian function suppression (OFS)?
Premenopausal oestrogen level after adjuvant chemotherapy

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Premenopausal: Selection Factors

105. Does each of the following clinico-pathological features by itself argue for inclusion of ovarian function suppression (OFS)?

‘Higher risk’ Composite Risk Index (CRI)

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Premenopausal: Selection Factors

106. Does each of the following clinico-pathological features by itself argue for inclusion of ovarian function suppression (OFS)?

Grade 3

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Premenopausal: Selection Factors

107. Does each of the following clinico-pathological features by itself argue for inclusion of ovarian function suppression (OFS)?

Involvement of 4 or more nodes

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Premenopausal: Selection Factors

108. Does each of the following clinico-pathological features by itself argue for inclusion of ovarian function suppression (OFS)?

Poor prognosis at multi-gene testing

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy  Premenopausal Patients: (assessed by Estradiol, FSH and LH): Selection Factors

109. Should some patients receive OFS + AI?

(1) Yes

(2) No

(3) Abstain
Endocrine Therapy Premenopausal Patients: (assessed by Estradiol, FSH and LH): Selection Factors

110. Which of the following clinico-pathological parameters argue for the use of OFS + AI rather than OFS + Tamoxifen:
Age < 35 years

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy  Premenopausal Patients: 
(assessed by Estradiol, FSH and LH): Selection Factors

111. Which of the following clinico-pathological parameters argue for the use of OFS + AI rather than OFS + Tamoxifen:
Grade 3

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy Pre-menopausal Patients: (assessed by Estradiol, FSH and LH): Selection Factors

112. Which of the following clinico-pathological parameters argue for the use of OFS + AI rather than OFS + Tamoxifen:
Involvement of 4 or more nodes

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy  Premenopausal Patients: (assessed by Estradiol, FSH and LH): Selection Factors

113. Which of the following clinico-pathological parameters argue for the use of OFS + AI rather than OFS + Tamoxifen:
‘High risk’ Composite Risk Index

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy  Premenopausal Patients: (assessed by Estradiol, FSH and LH): Selection Factors

114. Which of the following clinico-pathological parameters argue for the use of OFS + AI rather than OFS + Tamoxifen:

Poor prognosis multi-gene testing

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Postmenopausal Patients

115. Is Tamoxifen alone still appropriate for some patients?

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Postmenopausal Patients

116. Parameters for inclusion of an AI at some point are:
All post-menopausal patients

(1) Yes

(2) No

(3) Abstain
Endocrine Therapy
Postmenopausal Patients

117. Parameters for inclusion of an AI at some point are:
Node positive

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Postmenopausal Patients

118. Parameters for inclusion of an AI at some point are:
Grade 3 or high Ki67

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Postmenopausal Patients

119. **Parameters for inclusion of an AI at some point are:**
HER2 positivity

(1) Yes

(2) No

(3) Abstain
Endocrine Therapy
Postmenopausal Patients

120. If an AI is used, should it be started upfront: In any patients?

(1) Yes

(2) No

(3) Abstain
Endocrine Therapy
Postmenopausal Patients

121. If an AI is used, should it be started upfront:
In patients at higher risk?

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Postmenopausal Patients

122. If an AI is used, should it be started upfront:
In lobular cancer (letrozole or other AI)?

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Postmenopausal Patients

123. Can upfront AI be switched to TAM after 2 years in all?

(1) Yes
(2) No
(3) Abstain
Endocrine Therapy
Postmenopausal Patients

124. All approved AI have similar efficacy?

(1) Yes
(2) No
(3) Abstain
Escalating and De-escalating

WHICH WOMEN SHOULD RECEIVE LONGER DURATION OF ADJUVANT ENDOCRINE THERAPY?
Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

125. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of adjuvant therapy involving **switch from Tam to an AI** (therefore assuming postmenopausal status at the 5 year time point and reasonable tolerance to endocrine therapy), patients at moderate or high risk of recurrence should be recommended to receive:

A further 5 years of Tamoxifen

(1) Yes

(2) No

(3) Abstain
Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

126. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of adjuvant therapy involving **switch from Tam to an AI** (therefore assuming postmenopausal status at the 5 year time point and reasonable tolerance to endocrine therapy), patients at moderate or high risk of recurrence should be recommended to receive:

Continue AI to a cumulative total of 5 years AI

1. Yes
2. No
3. Abstain
127. Provided an indication exists for therapy beyond the first 5 years:

After 5 years of adjuvant therapy involving **switch from Tam to an AI** (therefore assuming postmenopausal status at the 5 year time point and reasonable tolerance to endocrine therapy), patients at moderate or high risk of recurrence should be recommended to receive:

- A further 5 years AI

(1) Yes
(2) No
(3) Abstain
Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

128. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of adjuvant therapy involving *switch from Tam to an AI* (therefore assuming postmenopausal status at the 5 year time point and reasonable tolerance to endocrine therapy), patients at moderate or high risk of recurrence should be recommended to receive:

- No further endocrine therapy

(1) Yes
(2) No
(3) Abstain
Adjuvant Endocrine Therapy
Duration (Postmenopausal Patients)

129. Provided an indication exists for therapy beyond the first 5 years:
After 5 years of *straight AI* adjuvant therapy, patients should be recommended to receive:

A further 3 to 5 years of Tamoxifen

(1) Yes
(2) No
(3) Abstain
Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

130. Provided an indication exists for therapy beyond the first 5 years:

After 5 years of *straight AI* adjuvant therapy, patients should be recommended to receive:

A further 3 to 5 years of AI

(1) Yes

(2) No

(3) Abstain
Adjuvant Endocrine Therapy 
Duration (Postmenopausal Patients)

131. Provided an indication exists for therapy beyond the first 5 years:
After 5 years of **straight AI** adjuvant therapy, patients should be recommended to receive:

Duration of AI depend upon tolerance and absolute risk

(1) Yes

(2) No

(3) Abstain
Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

132. **Provided an indication exists for therapy beyond the first 5 years:**

After 5 years of *straight AI* adjuvant therapy, patients should be recommended to receive:

- No further endocrine therapy

(1) Yes

(2) No

(3) Abstain
Adjuvant Endocrine Therapy Duration (Premenopausal Patients)

133. For premenopausal women (who remain premenopausal) Tam to 10 years should be recommended to:
Premenopausal patients at high risk at presentation?

(1) Yes
(2) No
(3) Abstain
Adjuvant Endocrine Therapy Duration (Premenopausal Patients)

134. For premenopausal women (who remain premenopausal) Tam to 10 years should be recommended to:

Premenopausal patients with any risk at presentation?

(1) Yes
(2) No
(3) Abstain
Adjuvant Endocrine Therapy
Duration (Premenopausal Patients)

135. For premenopausal women (who remain premenopausal) Tam to 10 years should be recommended to:
Only in case of Tam (with or without OFS) given for first 5 years?

(1) Yes
(2) No
(3) Abstain
Adjuvant Endocrine Therapy Duration (Premenopausal Patients)

136. For premenopausal women (who remain premenopausal) Tam to 10 years should be recommended to:

After any therapy (T +/-OFS or AI) during first 5 years?

(1) Yes
(2) No
(3) Abstain
Escalating and De-escalating

WHICH WOMEN SHOULD RECEIVE ADJUVANT CHEMOTHERAPY?
Adjuvant Chemotherapy

137. Treatment decision about both prognosis and the potential benefits of chemotherapy in N0 disease can be aided by which of the following:

Biology defined by IHC features

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy

138. Treatment decision about both prognosis and the potential benefits of chemotherapy in N0 disease can be aided by which of the following:

Multigene risk predictor

(1) Yes  
(2) No  
(3) Abstain
Adjuvant Chemotherapy

139. If IHC is used, factors which are **relative** indications for the inclusion of adjuvant cytotoxic chemotherapy include:
Histological grade 3 tumor

(1) Yes

(2) No

(3) Abstain
Adjuvant Chemotherapy

140. If IHC is used, factors which are relative indications for the inclusion of adjuvant cytotoxic chemotherapy include:

Any positive node

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy

141. If IHC is used, factors which are *relative* indications for the inclusion of adjuvant cytotoxic chemotherapy include:
4 or more positive node

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy

142. If IHC is used, factors which are **relative** indications for the inclusion of adjuvant cytotoxic chemotherapy include:

Ki67 high

(1) Yes  
(2) No  
(3) Abstain
Adjuvant Chemotherapy

143. If IHC is used, factors which are *relative* indications for the inclusion of adjuvant cytotoxic chemotherapy include:
Age < 35

(1) Yes  
(2) No  
(3) Abstain
Adjuvant Chemotherapy

144. If IHC is used, factors which are relative indications for the inclusion of adjuvant cytotoxic chemotherapy include:
Extensive lympho-vascular invasion

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy

145. If IHC is used, factors which are *relative* indications for the inclusion of adjuvant cytotoxic chemotherapy include:
Low hormone receptor staining

(1) Yes
(2) No
(3) Abstain
146. Should chemotherapy be added for high risk patients (based on extensive LVI)?

(1) Yes

(2) No

(3) Abstain
Adjuvant Chemotherapy
Luminal A-like (by IHC) Patients

147. Should chemotherapy be added for patients with 1 – 3 nodes involved or T > 5 cm?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Luminal A-like (by IHC) Patients

148. Should chemotherapy be added for high risk (based on 4 or more nodes involved)?

(1) Yes

(2) No

(3) Abstain
Adjuvant Chemotherapy
Luminal B-like Patients

149. In patients with poor prognosis biology by IHC chemotherapy should be recommended in:
All patients N0 and N+

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Luminal B-like Patients

150. Chemotherapy may be safely **omitted** for N+ patients with:
Low risk Oncotype Dx® score

(1) Yes  
(2) No  
(3) Abstain
Adjuvant Chemotherapy
Luminal B-like Patients

151. Chemotherapy may be safely omitted for N+ patients with:
Intermediate Oncotype Dx® score

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Luminal B-like Patients

152. Chemotherapy may be safely omitted for N+ patients with:
MammaPrint® Low Risk

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Luminal B-like Patients

153. Chemotherapy may be safely **omitted** for N+ patients with:
Low PAM50 ROR score

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Luminal B-like Patients

154. Chemotherapy may be safely *omitted* for N+ patients with:
EndoPredict® Low Risk

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Patients with Luminal B-like tumors (HER2 negative)

155. If given, should the regimen contain anthracyclines only (e.g., AC x 4)?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Patients with Luminal B-like tumors (HER2 negative)

156. If given, should the regimen contain taxanes (TC) without anthracyclines?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Patients with Luminal B-like tumors (HER2 negative)

157. If given, should the regimen contain anthracyclines and taxanes?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Patients with Luminal B-like tumors (HER2 negative)

158. Should chemotherapy ever comprise 6 cycles of the same therapy (e.g. 6 courses of EC or AC or TC)?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Patients with Luminal B-like tumors (HER2 negative)

159. Is there an high risk group for which dose-dense therapy should/may be preferred?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy in patients with Ductal Triple Negative BC

160. In stage I should the regimen for all TNBC phenotype contain anthracyclines and taxanes?

(1) Yes

(2) No

(3) Abstain
Adjuvant Chemotherapy in patients with Ductal Triple Negative BC

161. In stage II-III should the regimen for all TNBC phenotype contain anthracyclines and taxanes?

(1) Yes

(2) No

(3) Abstain
Adjuvant Chemotherapy in patients with Ductal Triple Negative BC

162. Should a platinum based regimen be considered? In all patients with TNBC?

(1) Yes

(2) No

(3) Abstain
Adjuvant Chemotherapy in patients with Ductal Triple Negative BC

163. Should a platinum based regimen be considered? Only with known BRCA mutation?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy in patients with Ductal Triple Negative BC

164. Can we avoid chemotherapy in pT1a pN0 stage?

(1) Yes

(2) No

(3) Abstain
Adjuvant Chemotherapy in patients with Ductal Triple Negative BC

165. Should dose-dense chemotherapy be a preferred regimen?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node positive disease) Patients

166. Should chemotherapy always be given to patients with N+ disease who require anti-HER2 therapy?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node positive disease) Patients

167. Should the chemotherapy regimen for these patients include anthracyclines?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node positive disease) Patients

168. Should the chemotherapy regimen for these patients include taxanes?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node positive disease) Patients

169. Should anti-HER2 therapy start concurrently with taxanes?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node negative disease) Patients

170. With HER2 positivity determined according to ASCO/CAP guidelines:
Do the large majority of patients with HER2 positive node-negative disease require anti-HER2 therapy:
With T1a disease?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node negative disease) Patients

171. With HER2 positivity determined according to ASCO/CAP guidelines:
Do the large majority of patients with HER2 positive node-negative disease require anti-HER2 therapy: With T1b disease?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node negative disease) Patients

172. With HER2 positivity determined according to ASCO/CAP guidelines: Do the large majority of patients with HER2 positive node-negative disease require anti-HER2 therapy: With T1c disease?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node negative disease) Patients

173. With HER2 positivity determined according to ASCO/CAP guidelines:
If given, is the combination of paclitaxel and trastuzumab a reasonable option?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node negative disease) Patients

174. With HER2 positivity determined according to ASCO/CAP guidelines:
If given, is the combination of paclitaxel and trastuzumab a reasonable option?
with primary less than 1 cm?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node negative disease) Patients

175. With HER2 positivity determined according to ASCO/CAP guidelines:
If given, is the combination of paclitaxel and trastuzumab a reasonable option?
with primary of 1-2 cm?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node negative disease) Patients

176. With HER2 positivity determined according to ASCO/CAP guidelines:
If given, is the combination of paclitaxel and trastuzumab a reasonable option?
with primary of 2-3 cm?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node negative disease) Patients

177. With HER2 positivity determined according to ASCO/CAP guidelines:
If given, is the combination of docetaxel and cyclophosphamide x 4 and trastuzumab a reasonable option?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node negative disease) Patients

178. With HER2 positivity determined according to ASCO/CAP guidelines:
If given, is the combination of docetaxel and cyclophosphamide x 4 and trastuzumab a reasonable option? with primary less than 1 cm?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node negative disease) Patients

179. With HER2 positivity determined according to ASCO/CAP guidelines:
If given, is the combination of docetaxel and cyclophosphamide x 4 and trastuzumab a reasonable option? with primary of 1-2 cm?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
HER2-positive (Node negative disease) Patients

180. With HER2 positivity determined according to ASCO/CAP guidelines:
If given, is the combination of docetaxel and cyclophosphamide x 4 and trastuzumab a reasonable option? with primary of 2-3 cm?

(1) Yes

(2) No

(3) Abstain
Adjuvant Anti-HER2 Therapy

181. In a patient who received neoadjuvant chemotherapy with trastuzumab and pertuzumab, adjuvant therapy should include:
Trastuzumab alone at completion of one year

(1) Yes

(2) No

(3) Abstain
Adjuvant Anti-HER2 Therapy

182. In a patient who received neoadjuvant chemotherapy with trastuzumab and pertuzumab, adjuvant therapy should include:
Trastuzumab + pertuzumab at completion of one year

(1) Yes
(2) No
(3) Abstain
Biosimilars in HER2-Positive Disease

183. If approved, are biosimilars of trastuzumab acceptable in the neoadjuvant and/or adjuvant treatment of HER2+ disease, based on current evidence?

(1) Yes

(2) No

(3) Abstain
184. In a woman eligible to breast conservative surgery should neoadjuvant chemotherapy and anti HER2 therapy be the preferred option for HER2 positive EBC patients in stage II-III?

(1) Yes

(2) No

(3) Abstain
Neo-Adjuvant Systemic Therapy
*(possibly followed by additional adjuvant chemo)*
Stage II-III HER2-positive Disease

185. If given, in patients with **HER2-positive** tumors, acceptable regimen include:

- Taxane + trastuzumab only

(1) Yes
(2) No
(3) Abstain
Neo-Adjuvant Systemic Therapy
(possibly followed by additional adjuvant chemo)
Stage II-III HER2-positive Disease

186. If given, in patients with **HER2-positive** tumors, acceptable regimen include:
   Taxane, trastuzumab and pertuzumab

(1) Yes
(2) No
(3) Abstain
Neo-Adjuvant Systemic Therapy
(possibly followed by additional adjuvant chemo)
Stage II-III HER2-positive Disease

187. If given, in patients with HER2-positive tumors, acceptable regimen include:

   Platinum salts, taxane, trastuzumab ± pertuzumab

(1) Yes
(2) No
(3) Abstain
Neo-Adjuvant Systemic Therapy
*(possibly followed by additional adjuvant chemo)*
Stage II-III HER2-positive Disease

188. If given, in patients with HER2-positive tumors, acceptable regimen include:

- Non-taxane regimen containing platinum salts, trastuzumab ± pertuzumab

(1) Yes
(2) No
(3) Abstain
Neo-Adjuvant Systemic Therapy
(possibly followed by additional adjuvant chemo)
Stage II-III HER2-positive Disease

189. If given, in patients with HER2-positive tumors, acceptable regimen include:
   Anthracycline -> taxane and anti-HER2

(1) Yes
(2) No
(3) Abstain
Neo-Adjuvant Systemic Therapy
Stage II-III Triple-Negative Disease

190. In a woman eligible to breast conservative surgery should neoadjuvant chemotherapy be a preferred option for TN EBC patients?

(1) Yes

(2) No

(3) Abstain
Neo-Adjuvant Systemic Therapy
Stage II Triple-Negative Disease

191. If given, in patients with ductal *triple-negative* tumors (irrespective of BRCA status), the preferred regimen should include:

Platinum or alkylating agents containing regimen

(1) Yes

(2) No

(3) Abstain
Neo-Adjuvant Systemic Therapy
Stage II Triple-Negative Disease

192. If given, in patients with ductal \textit{triple-negative} tumors (irrespective of BRCA status), the preferred regimen should include:

Anthracycline $\rightarrow$ taxane non-dose dense

(1) Yes

(2) No

(3) Abstain
Neo-Adjuvant Systemic Therapy
Stage II Triple-Negative Disease

193. If given, in patients with ductal *triple-negative* tumors (irrespective of BRCA status), the preferred regimen should include:

Anthracycline → taxane dose dense

(1) Yes
(2) No
(3) Abstain
Neo-Adjuvant Systemic Therapy
Stage II Triple-Negative Disease

194. If given, in patients with ductal triple-negative tumors (irrespective of BRCA status), the preferred regimen should include:

   Nab-paclitaxel -> EC

(1) Yes
(2) No
(3) Abstain
Neo-Adjuvant Systemic Therapy
Stage II Triple-Negative Disease

195. If given, in patients with ductal \textit{triple-negative}\n tumors (irrespective of BRCA status), the preferred regimen should include:

\begin{itemize}
  \item Anthracycline -> regimen with alkylating agents
  \item (e.g. classical CMF)
\end{itemize}

(1) Yes

(2) No

(3) Abstain
Escalating and De-escalating

WHICH WOMEN SHOULD RECEIVE ADDITIONAL THERAPY AFTER NEOADJUVANT TREATMENT?
Additional Adjuvant Chemotherapy in the Post-Neoadjuvant Setting

196. In case of clinical response and residual disease of greater than 1 cm and/or a positive node at surgery following neoadjuvant (anthracycline-, taxane- and alkylator-based) chemotherapy for TNBC, we should propose:

(1) No further chemotherapy

(2) Capecitabine

(3) Platinum

(4) Platinum if BRCA+

(5) Metronomic chemotherapy
Additional Adjuvant Chemotherapy in the Post-Neoadjuvant Setting

197. In case of clinical response and residual disease of greater than 1 cm and/or a positive node at surgery following neoadjuvant (anthracycline-, taxane- and alkylator-based) chemotherapy for TNBC, we should propose:

A clinical trial when available

(1) Yes

(2) No

(3) Abstain
Scalp-Cooling

198. Is a scalp cooling device an option to prevent hair loss during (neo-)adjuvant chemotherapy?

(1) Yes
(2) No
(3) Abstain
Escalating and De-escalating

SHOULD WE ROUTINELY ADD BONE-MODIFYING THERAPY AS ADJUVANT TREATMENT?
Adjuvant Bisphosphonates

199. Is bisphosphonate treatment, such as zoledronic acid q 6 months or oral clodronate, during adjuvant endocrine therapy, indicated to improve DFS irrespective of BMD?

   In premenopausal patients receiving LHRH plus TAM or plus AI?

(1) Yes

(2) No

(3) Abstain
Adjuvant Bisphosphonates

200. Is bisphosphonate treatment, such as zoledronic acid q 6 months or oral clodronate, during adjuvant endocrine therapy, indicated to improve DFS irrespective of BMD?

In premenopausal patients not receiving LHRH?

(1) Yes

(2) No

(3) Abstain
Adjuvant Bisphosphonates

201. Is bisphosphonate treatment, such as zoledronic acid q 6 months or oral clodronate, during adjuvant endocrine therapy, indicated to improve DFS irrespective of BMD?

In postmenopausal patients?

(1) Yes

(2) No

(3) Abstain
Adjuvant Bisphosphonates

202. Should adjuvant denosumab (60 mg twice a year) substitute for bisphosphonate?

(1) Yes
(2) No
(3) Abstain
Escalating and De-escalating

SPECIAL POPULATIONS
Age and Adjuvant Chemotherapy

203. In the absence of significant co-morbidity, the maximum age at which a standard adjuvant chemotherapy regimen should be advised is:

(1) 65 years  (5) There is no absolute age limit. Rather, it depends on the disease, the presence of co-morbidity, the life expectancy, and the patient’s preferences
(2) 70 years  (3) 75 years
(4) 80 years  (6) Abstain
Elderly Patients: Adjuvant Radiation

204. In postmenopausal patients with ER-positive tumors, who have a low-risk genomic score, node negative, receiving endocrine therapy, radiation after breast conserving surgery may be omitted in patients:

(1) 65 years
(2) 70 years
(3) 75 years
(4) 80 years
(5) When multiple co-morbidities are diagnosed
(6) Abstain
Pregnancy After Breast Cancer

205. For patients planning pregnancy in the 5 years following surgery, is it reasonable to discuss to interrupt endocrine therapy to allow attempted pregnancy: At any time during endocrine therapy?

(1) Yes
(2) No
(3) Abstain
Pregnancy After Breast Cancer

206. For patients planning pregnancy in the 5 years following surgery, is it reasonable to discuss to interrupt endocrine therapy to allow attempted pregnancy: After 18 – 30 months endocrine therapy?

(1) Yes
(2) No
(3) Abstain
Pregnancy After Breast Cancer

207. For patients planning pregnancy in the 5 years following surgery, is it reasonable to discuss to interrupt endocrine therapy to allow attempted pregnancy:
Only in absence of high risk factors?

(1) Yes

(2) No

(3) Abstain
Pregnancy After Breast Cancer

208. For patients planning pregnancy in the 5 years following surgery, is it reasonable to discuss to interrupt endocrine therapy to allow attempted pregnancy: In case of patient’s preference for pregnancy after breast cancer it should not be discouraged in case of:

(1) ER+ disease

(2) ER- disease

(3) In both cases

(4) Abstain
209. In male patients with ER positive breast cancer, post-operative adjuvant tamoxifen is currently advised. Adjuvant therapy options beyond tamoxifen (if TAM is contraindicated in the adjuvant setting) include:

Aromatase inhibitors alone

(1) Yes
(2) No
(3) Abstain
Male Breast Cancer

210. In male patients with ER positive breast cancer, post-operative adjuvant Tamoxifen is currently advised. Adjuvant therapy options beyond tamoxifen (if TAM is contraindicated in the adjuvant setting) include:

   Aromatase inhibitors + LHRH a

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Lobular cancer

211. Should chemotherapy be added for treatment of patients with lobular cancer?

(1) Yes
(2) No
(3) Abstain
Adjuvant Chemotherapy
Lobular cancer

212. Would you prescribe chemotherapy in case of 4 or more nodes involved?

(1) Yes
(2) No
(3) Abstain
213. Would you prescribe chemotherapy in case of pleomorphic lobular cancer histotype?

(1) Yes

(2) No

(3) Abstain
Escalating and De-escalating

SHOULD WE BE EXPANDING THE USE OF GENETIC TESTING IN BREAST CANCER PATIENTS?
High Risk Mutations

214. Genetic testing for high risk mutations should be considered, after counselling, in:
Patients with a strong family history

(1) Yes
(2) No
(3) Abstain
High Risk Mutations

215. Genetic testing for high risk mutations should be considered, after counselling, in:
Patients under 40 at breast cancer diagnosis

(1) Yes
(2) No
(3) Abstain
High Risk Mutations

216. Genetic testing for high risk mutations should be considered, after counselling, in:
Patients under 50 at breast cancer diagnosis

(1) Yes
(2) No
(3) Abstain
High Risk Mutations

217. Genetic testing for high risk mutations should be considered, after counselling, in:
Patients under 60 with TNBC only

(1) Yes
(2) No
(3) Abstain
High Risk Mutations

218. **BRCA 1 or 2 mutations may impact treatment decisions on Breast surgery**

(1) Yes

(2) No

(3) Abstain
High Risk Mutations

219. BRCA 1 or 2 mutations may impact treatment decisions on Systemic therapies

(1) Yes
(2) No
(3) Abstain
High Risk Mutations

220. **BRCA 1 or 2 mutations may impact treatment decisions on**

Other prophylactic interventions

(1) Yes  
(2) No  
(3) Abstain
SHOULD BREAST CANCER PATIENTS RECEIVE SPECIFIC DIET & LIFESTYLE INTERVENTIONS BEYOND ‘ORDINARY’ ADVICE ON MAINTAINING HEALTHY LIFESTYLES?
221. Independent of any lifestyle recommendations that may be offered for rehabilitation, symptom control and/or general health, would you ALSO recommend the following with the goal of reducing risk of recurrence and/or death from breast cancer?

That patients should receive dietary advice in keeping with national guidelines?

(1) Yes

(2) No

(3) Abstain
Adjuvant Diet and Exercise

222. Independent of any lifestyle recommendations that may be offered for rehabilitation, symptom control and/or general health, would you ALSO recommend the following with the goal of reducing risk of recurrence and/or death from breast cancer? That physical activity (at least 150 minutes per week) be recommended as part of standard care?

(1) Yes
(2) No
(3) Abstain
Adjuvant Diet and Exercise

223. Independent of any lifestyle recommendations that may be offered for rehabilitation, symptom control and/or general health, would you ALSO recommend the following with the goal of reducing risk of recurrence and/or death from breast cancer? That weight loss to a normal BMI (20-25) and avoidance of weight gain (providing BMI at least 20) be recommended?

(1) Yes

(2) No

(3) Abstain
Adjuvant Diet and Exercise

224. Independent of any lifestyle recommendations that may be offered for rehabilitation, symptom control and/or general health, would you ALSO recommend the following with the goal of reducing risk of recurrence and/or death from breast cancer? If vitamin D is deficient, that supplementation be recommended?

(1) Yes
(2) No
(3) Abstain
THANK YOU

Would you please remain in your seats for some minutes to allow the closing message of the conference.