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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

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International Consensus Panel 2017

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Ian Smith (UK)
Masakazu Toi (Japan)
Andrew Tutt (UK)
Toru Watanabe (Japan)
Timothy Whelan (Canada)
Binghe Xu (PR China)

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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

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LET'S START

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Escalating and De-escalating

APPROPRIATE MARGINS IN PRIMARY SURGERY AND IN SURGERY FOLLOWING NEOADJUVANT SYSTEMIC THERAPY

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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

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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

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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

Surgery of the Primary Tumor

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

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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

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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

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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

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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

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Escalating and De-escalating

WHEN CAN AXILLARY SURGERY BE REDUCED?

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Surgery of the Axilla

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

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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

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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

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Surgery of the Axilla

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

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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

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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

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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

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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

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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

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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

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Escalating and De-escalating

IN WHICH CLINICAL SCENARIO RADIOTHERAPY COURSES MAY BE SHORTENED?

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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

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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

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Hypofractionated Breast Irradiation

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

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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

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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 >= 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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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Multi-Gene Signatures and Chemotherapy: Node-positive Patients

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® Prognosis: years 1-5?

(1) Yes

(2) No

(3) Abstain

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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

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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

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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

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Multi-Gene Signatures and Chemotherapy: Node-positive Patients

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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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Multi-Gene Signatures and Extended Endocrine Therapy: Node-Negative Patients

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

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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

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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

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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

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Multi-Gene Signatures and Extended Endocrine Therapy: Node-Positive Patients

97. **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

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Multi-Gene Signatures and Extended Endocrine Therapy: Node-Positive Patients

98. **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

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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

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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

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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

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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

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BCC 2017

Escalating and De-escalating

WHICH WOMEN SHOULD RECEIVE OVARIAN SUPPRESSION AS PART OF ADJUVANT ENDOCRINE THERAPY?

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BCC 2017

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

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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 Premenopausal 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

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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

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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

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Endocrine Therapy

Postmenopausal Patients

120. **If an AI is used, should it be started upfront:**

In any patients?

(1) Yes

(2) No

(3) Abstain

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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

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Escalating and De-escalating

WHICH WOMEN SHOULD RECEIVE LONGER DURATION OF ADJUVANT ENDOCRINE THERAPY?

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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

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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

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Adjuvant Endocrine Therapy Duration (Postmenopausal Patients)

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

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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

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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

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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

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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

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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 of 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

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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

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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

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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

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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

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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

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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

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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

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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

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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

Adjuvant Chemotherapy

Luminal A-like (by IHC) Patients

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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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Neo-Adjuvant Systemic Therapy

(possibly followed by additional adjuvant chemo)

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

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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

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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

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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

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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

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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

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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

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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 *triple-negative* tumors (irrespective of BRCA status), the preferred regimen should include:**

Anthracycline –> taxane non-dose dense

(1) Yes

(2) No

(3) Abstain

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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

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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

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Neo-Adjuvant Systemic Therapy

Stage II Triple-Negative Disease

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

Anthracycline -> regimen with alkylating agents (e.g. classical CMF)

(1) Yes

(2) No

(3) Abstain

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Escalating and De-escalating

WHICH WOMEN SHOULD RECEIVE ADDITIONAL THERAPY AFTER NEOADJUVANT TREATMENT?

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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

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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

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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

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Escalating and De-escalating

SPECIAL POPULATIONS

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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

(2) 70 years

(3) 75 years

(4) 80 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

(6) Abstain

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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

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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

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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

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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

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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

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Male Breast Cancer

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

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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

Adjuvant Chemotherapy

Lobular cancer

213. Would you prescribe chemotherapy in case of pleomorphic lobular cancer histotype?

(1) Yes

(2) No

(3) Abstain

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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

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Escalating and De-escalating

SHOULD BREAST CANCER PATIENTS RECEIVE SPECIFIC DIET & LIFESTYLE INTERVENTIONS BEYOND 'ORDINARY' ADVICE ON MAINTAINING HEALTHY LIFESTYLES?

Adjuvant Diet and Exercise

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

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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

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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

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THANK YOU

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