

Reference

[1] Erickson K, Patterson RE, Flatt SW, Natarajan L, Parker BA, Heath DD et al. Clinically defined type 2 diabetes mellitus and prognosis in early stage breast cancer. *J Clin Oncol* 2012;29:54–60.

First-line Chemotherapy (FLC) Regimens in Older Adults (>65 years old) with Metastatic HER2-negative Breast Cancer (MBC): a Single-centre Experience of Tolerability and Efficacy

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Purpose: In MBC there is no consensus regarding the optimal regimen sequence and older adults are at increased risk from chemotherapy toxicity. Treatment decisions are often driven by the ability to tolerate treatment and maintain quality of life.

Methods: Retrospective data were collected about treatments used for 87 older adults with MBC in a single centre between 2009 and 2016 to assess tolerability and efficacy of FLC. Student's *t*-tests and Kaplan–Meier statistical methods were applied.

Results: Seventy per cent of patients were commenced on a standard dose (SD) of chemotherapy; 84% (21/25) of the anthracycline group (AG), 65% (20/31) of the capecitabine group (CG), 48% (10/21) of the taxane group (TG) and 100% (10/10) of other agents. Thirty-two per cent of patients had dose reductions; 16% in AG, 19% in TG, 58% in CG. Overall, 30% of patients received six cycles of SD chemotherapy; 36% in AG, 29% in CG, 14% in TG. Twenty-three per cent of patients suffered \geq grade 3 toxicity; 28% in AG, 29% in CG, 10% in TG. There were four treatment-related deaths, two in AG and one in both CG and TG. Sixty-one per cent of the CG received 6+ cycles with a mean on treatment time of 445 days (1–2150). There was no statistical significance in progression-free survival (PFS) between groups. The median PFS for all patients was 244 days (87–381).

Conclusion: Chemotherapy was well tolerated in older adults. Anthracycline-based regimens were used in patients who had not received adjuvant chemotherapy. Capecitabine required the most dose reductions. Taxanes were generally started at reduced doses, resulting in fewer grade 3+ toxicities. Physicians should consider lower starting doses in older adults and recognise that dose reductions may be required to improve tolerability. The PFS of all regimens were similar in this study. This study highlights the need for further research to define the optimal FLC and starting dose in older adults with MBC.

Cardiac Monitoring during Trastuzumab Therapy in Patients with Breast Cancer: Results of a Local Audit and National Survey

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Purpose: The 2018 NICE guidelines [1] advocate 3 monthly cardiac monitoring during adjuvant trastuzumab and 6 monthly for 2 years following completion of therapy. Cardiac monitoring in the metastatic setting is at the clinician's discretion. Our aims:

- (1) To audit local and national trastuzumab cardiac monitoring in the adjuvant setting compared with the 2018 NICE guidelines.
- (2) To review variation in practice nationally when monitoring metastatic patients.

Methods: (1) Local audit: clinical notes and electronic prescribing records were retrospectively reviewed for all patients who received trastuzumab between 2013 and 2016. (2) National survey: a questionnaire was emailed to consultant oncologists at 32 NHS Trusts across the UK.

Results: (1) Local audit: 75 patients received adjuvant trastuzumab; echocardiograms were performed at baseline and every 4 months and until completion of therapy only. Twenty-six patients received trastuzumab in the metastatic setting; echocardiograms were performed 3 monthly. The median number per patient was 10.5 (range 2–23). Six patients developed cardiac toxicity (five adjuvant, one metastatic), all within 12 months of treatment initiation. (2) National survey: responses were received from 32/32 Trusts. (a) Adjuvant monitoring: all sites performed baseline and serial cardiac monitoring with ECHO or MUGA. Monitoring frequency: 34.3% 3 monthly ($n = 10$), 6.3% 3–4 monthly, 56.3% 4 monthly, 3.1% 5 monthly. One site (3%) performed monitoring for 2 years after cessation of trastuzumab. (b) Metastatic monitoring: all sites did baseline monitoring. Serial monitoring frequency: 9.4% not performed, 31.3% 3 monthly, 9.4% 3–4 monthly, 28% 4 monthly, 21.9% 6 monthly. 37.5% continued to monitor at the same frequency indefinitely, 43.8% reduced the frequency of monitoring over time, 9.4% stopped monitoring at a defined end point.

Conclusion: Only one site was compliant with 2018 NICE guidelines for adjuvant monitoring. Implementing these guidelines would incur ≥ 4 extra ECHO/MUGAs per patient. Wider variation in practice was seen in the metastatic setting.

Reference

[1] NICE Guideline NG101. Early and locally advanced breast cancer: diagnosis and management. July 2018. Available at: <https://www.nice.org.uk/guidance/ng101/chapter/Recommendations#adjuvant-chemotherapy-for-invasive-breast-cancer>.