Response Rates to Newly Implemented Neoadjuvant TCHP Chemotherapy in the Dorset Cancer Network

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Purpose: The neoadjuvant chemotherapy regimen: docetaxel, carboplatin, trastuzumab and pertuzumab (TCHP) was first introduced to the Dorset Cancer Network (Royal Bournemouth County Hospital, Dorset County Hospital and Poole Hospital Foundation Trust) formulary in January 2017. The purpose of this audit was to assess the response to treatment and adherence to local guidelines.
Methods: All patients treated with neoadjuvant TCHP chemotherapy within the Dorset Cancer Network and who had undergone subsequent surgery with available histology results were included in this audit. Electronic notes including histology, radiology and breast multidisciplinary team reports were reviewed, together with the prescribing system, to ascertain information. Patients were excluded if they had not had surgery or had available histology at the time of the audit or were thought to have features on imaging that subsequently turned out to be metastatic disease.
Results: In total, 27 patients underwent TCHP chemotherapy with start dates from January 2017 until November 2017. 46.2% had a complete pathological response. Ductal carcinoma *in situ* was not included as residual invasive disease in keeping with other similar studies. All the patients were female with an average age of 53.4 years (30–74 years). All cancers were classified as invasive ductal carcinoma with 50% being ER-positive and 61.5% being node-positive. Tumour size varied from 10 to 90 mm. Fifty per cent of women managed six cycles at the full dose, with each cycle at the correct 3 weekly time intervals. Fifty-eight per cent of patients did not receive granulocyte colony-stimulating factor (GCSF) and of those who did, GCSF was usually started after a delay or infection.
Conclusion: The response rate seen within the Dorset Cancer Network is comparable with those from other centres and studies. A high percentage of patients required a dose reduction or delay in treatment. It is felt that GCSF should be introduced as a standard supportive medicine with the aim of maintaining dose intensity.

Adjuvant Bisphosphonates in Postmenopausal Women with Breast Cancer in Lanarkshire

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Purpose: According to EBCTCG meta-analysis, adjuvant bisphosphonates reduce the incidence of breast cancer mortality, bone recurrence and fractures [1]. The aim of our study was to review the prescribing practices of adjuvant bisphosphonate treatment in postmenopausal women with high-risk breast cancer.
Methods: Patients attending Lanarkshire oncology clinics between July and December 2017 were included in this retrospective analysis. We defined high risk as those who merited neoadjuvant or adjuvant chemotherapy from discussion at Lanarkshire Breast MDT. Data were collected on patient age, acceptance or refusal of treatment, timing in relation to radical surgery and reasons for delay in starting treatment.
Results: Among 80 patients (median age 66 years; range 46–97 years), 70 patients were offered treatment. Of these, 39 (56%) went on to receive it. Twenty-seven received oral ibandronic acid and 12 received intravenous zoledronic acid. All except one (38/39) patient received the drug in the adjuvant setting. The median duration of the interval from surgery to treatment initiation was 13 weeks (2–43 weeks). Treatment was delayed >8 weeks in 25/39 (64%). Reasons for delay were awaiting pretreatment dental assessment (13/25), awaiting completion of chemotherapy (10/25) and patient's indecision (2/25).
Thirty-one patients were offered but did not receive treatment. Among these, 27 declined and four were undecided and/or awaiting dental assessment prior to commencement.
Conclusion: Most women eligible for adjuvant bisphosphonates were offered the treatment. However, only 56% went on to receive it. Among those who received it, one-third of patients started treatment within an 8 week interval from surgery.

Reference

[1] Adjuvant bisphosphonate treatment in early breast cancer: meta-analyses of individual patient data from randomised trials Early Breast Cancer Trialists' Collaborative Group. Lancet 2015;386(10001):1353–61.

Oncotype Dx in Node-negative Breast Cancer: Our Experience

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Purpose: This audit was conducted to review our practice for testing the gene signature, Oncotype Dx score, as per NICE guidelines, to risk stratify our breast cancer patients to choose the right advice regarding adjuvant chemotherapy. We also calculated the NHS Predict score for all of these patients. This is an online tool used conventionally to identify suitable candidates for chemotherapy. In our practice, all patients who have more than 3% improvement in survival with adjuvant chemotherapy on the NHS Predict tool are offered/recommended adjuvant chemotherapy.
Methods: Current NICE guidelines recommend Oncotype Dx testing for all chemotherapy eligible patients who undergo curative breast surgery and are node negative, hormone receptor positive and Her2neu negative. We reviewed all patients who were recommended to undergo Oncotype Dx testing between April 2016 and August 2017 for their recurrence score and subsequent adjuvant treatment. Demographic and clinicopathological features were also documented.
Results: Forty patients were identified in this cohort. All but one patient was node positive and another was found to be node mic positive. The average turnaround time for the Oncotype Dx result was 10 days, which was better than the overall UK result, as well as for central England and the London region, which was 12 days. A great majority of our patients were younger than 65 years (33 patients), whereas the rest (seven patients) were older than 65 years. Seventeen (42%) of these patients had grade 3 pathology and 22 were found to have grade 2 pathology, with only one having grade 1 pathology. Furthermore, 33 patients had a tumour dimension (T stage) <3 cm and seven had T stage measured as >3 cm. The online tool (NHS Predict) estimated that only three patients would have more than a 3% survival advantage with adjuvant chemotherapy. The Oncotype Dx recurrence score results showed that 22 patients had a recurrence score < 18 (low score), none of these patients received adjuvant chemotherapy. Ten patients had a recurrence score in the intermediate risk group (Oncotype DX recurrence score 18–30); records showed that two patients in this group received adjuvant chemotherapy. There were eight patients in the high-risk recurrence score group (>30); all of these eight patients received adjuvant chemotherapy.
Conclusion: In our experience, more patients (25% of total) were identified as suitable for adjuvant chemotherapy, as against based on the online NHS Predict estimation (7.5% showing survival advantage >3% with chemotherapy).

Real-world Factors Predicting Complete Pathological Response to Neoadjuvant Chemotherapy in Breast Cancer

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Purpose: Despite its widespread use, there is a lack of consensus as well as national guidelines as to who should be offered neoadjuvant chemotherapy (NACT) for locally advanced breast cancer. However, several factors associated with pathological complete response (pCR) have been identified in the published literature [1]. This study aims to evaluate whether these factors are predictive of pCR in the real world.
Methods: Patients undergoing NACT for breast cancer over a 2 year period from 1 January 2014 to 31 December 2015 were identified from the chemotherapy unit booking system. Data on clinical and pathological factors, including age, type and grade of tumour, oestrogen receptor and HER2 positivity, Ki67 proliferation index and final pathological response, were collected using electronic patient records, including histopathological and radiological reports.