



Recurrence Risk in HR+ / HER2- Early Breast Cancer



Dr. Nathalie Levasseur
Medical Oncologist, Vancouver
REAL Canadian Breast Cancer Alliance



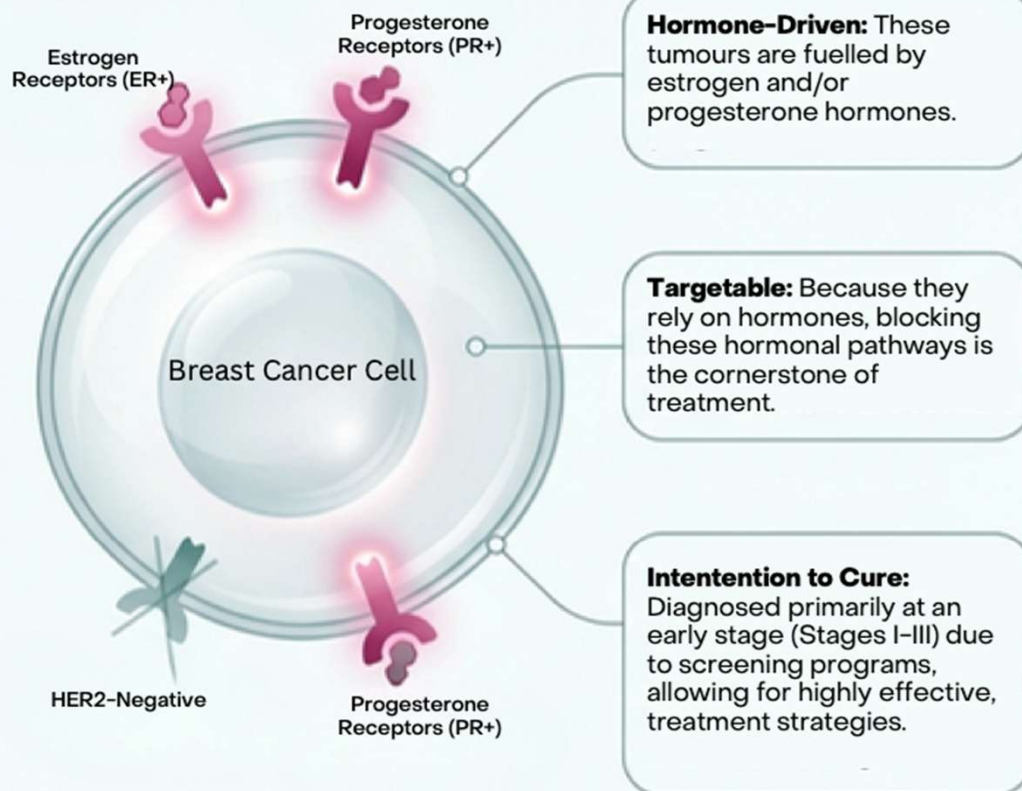
What does HR+/HER2-Mean?

What is considered 'early stage'?

The Dominant Subtype: HR+/HER2-

~66%

Two-thirds of all early breast cancer diagnoses are Hormone Receptor-Positive and HER2-Negative.

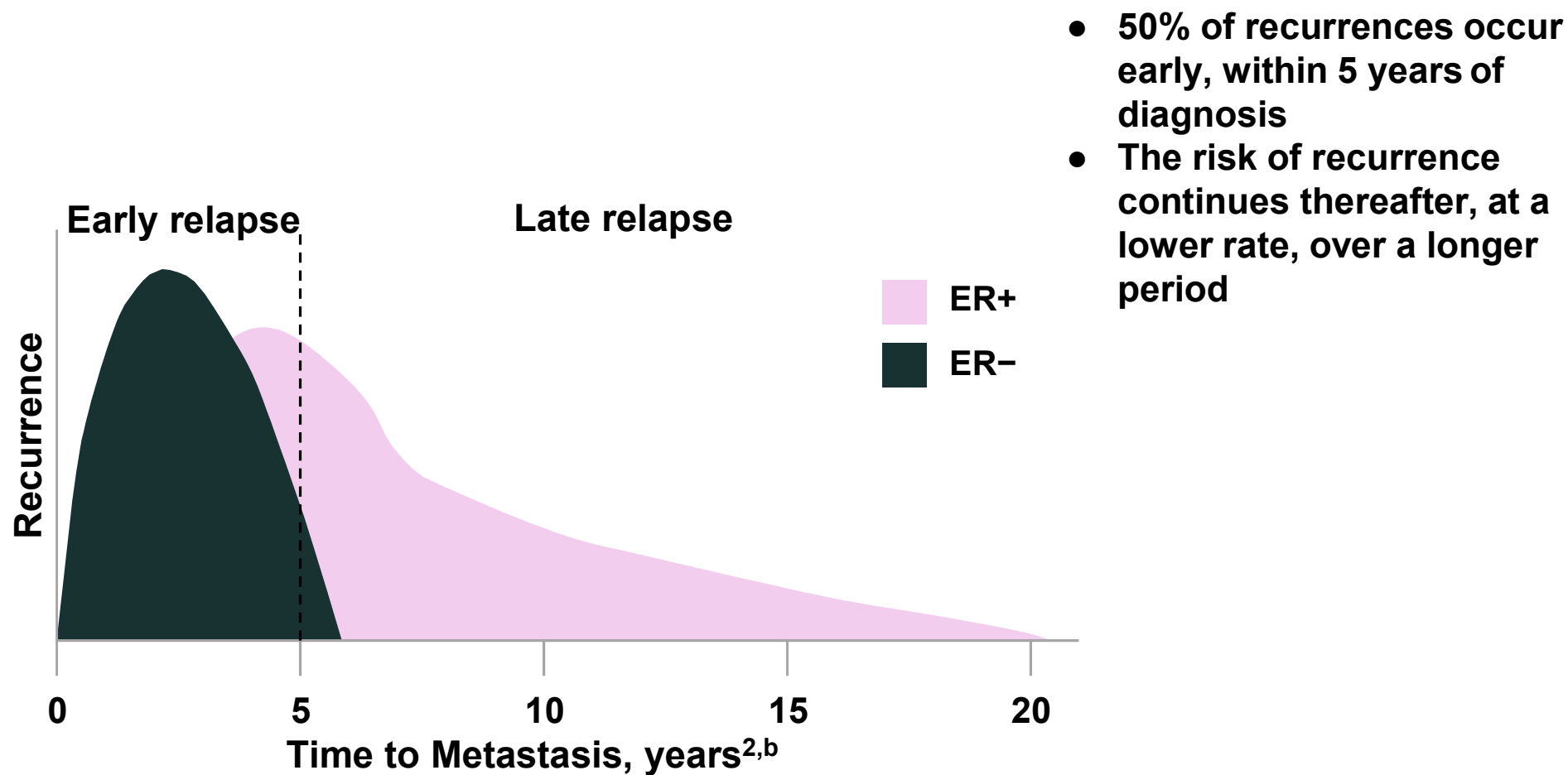




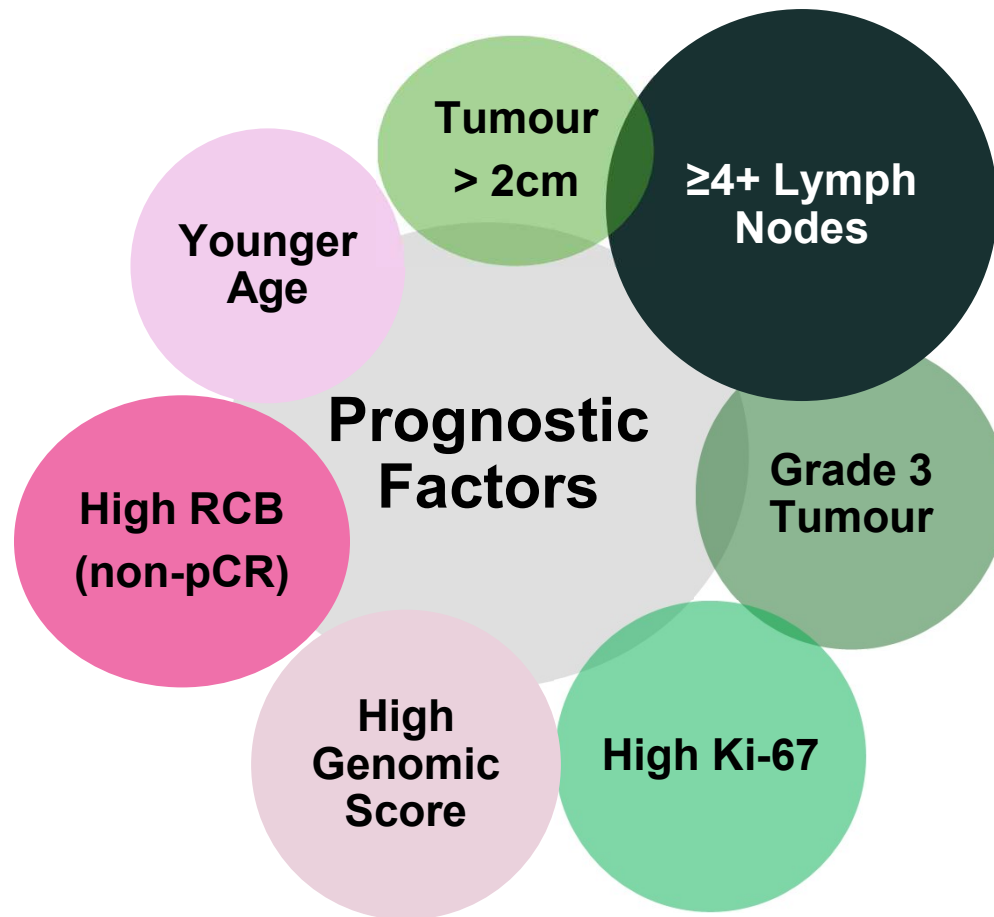
Risk of Recurrence

What is the chance that my breast cancer returns?

Patients with HR+/HER2- EBC are at risk of both early and late recurrence



How is Risk of Recurrence Defined?



**Prognosis =
What is the
Chance of the Cancer
Coming Back ?**

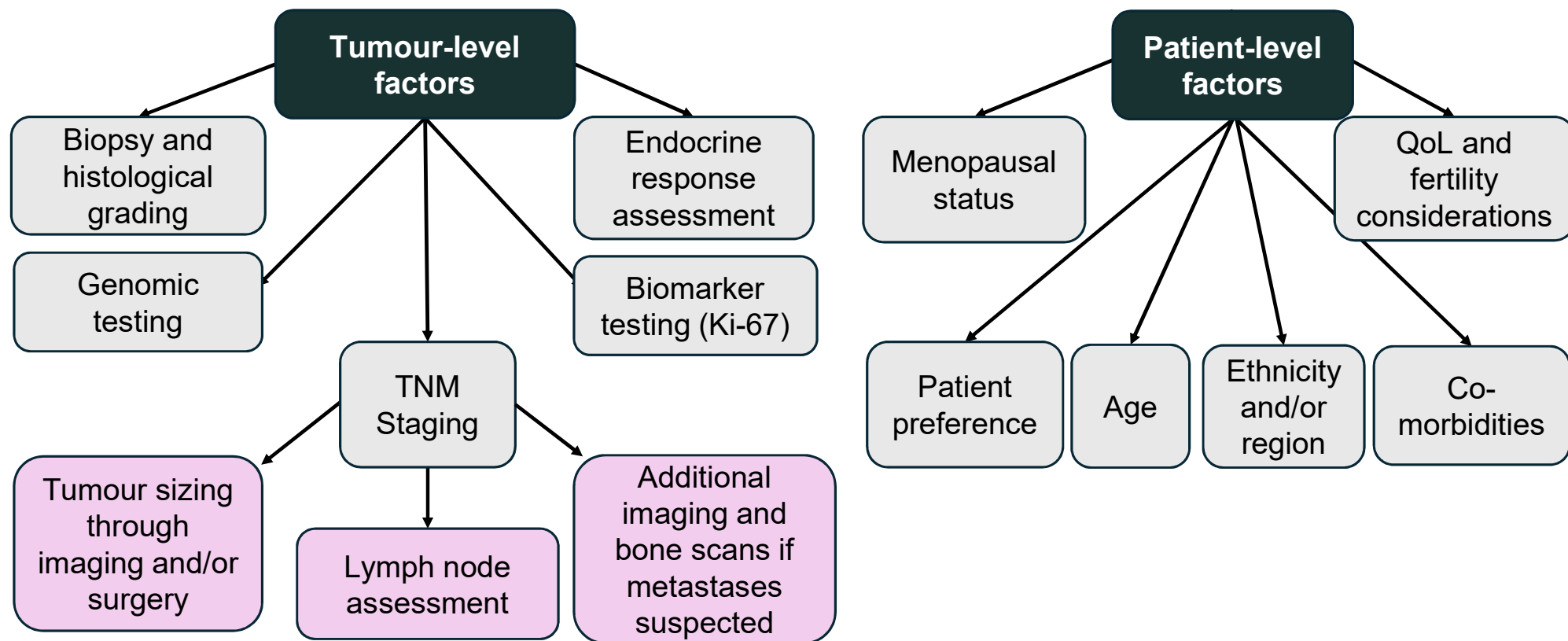
The size of each bubble is an approximation for its relative contribution to the prognosis



Risk of Recurrence

Is there anything we can do as a team to reduce risk of recurrence?

Factors impacting decision-making in HR+/HER2- EBC



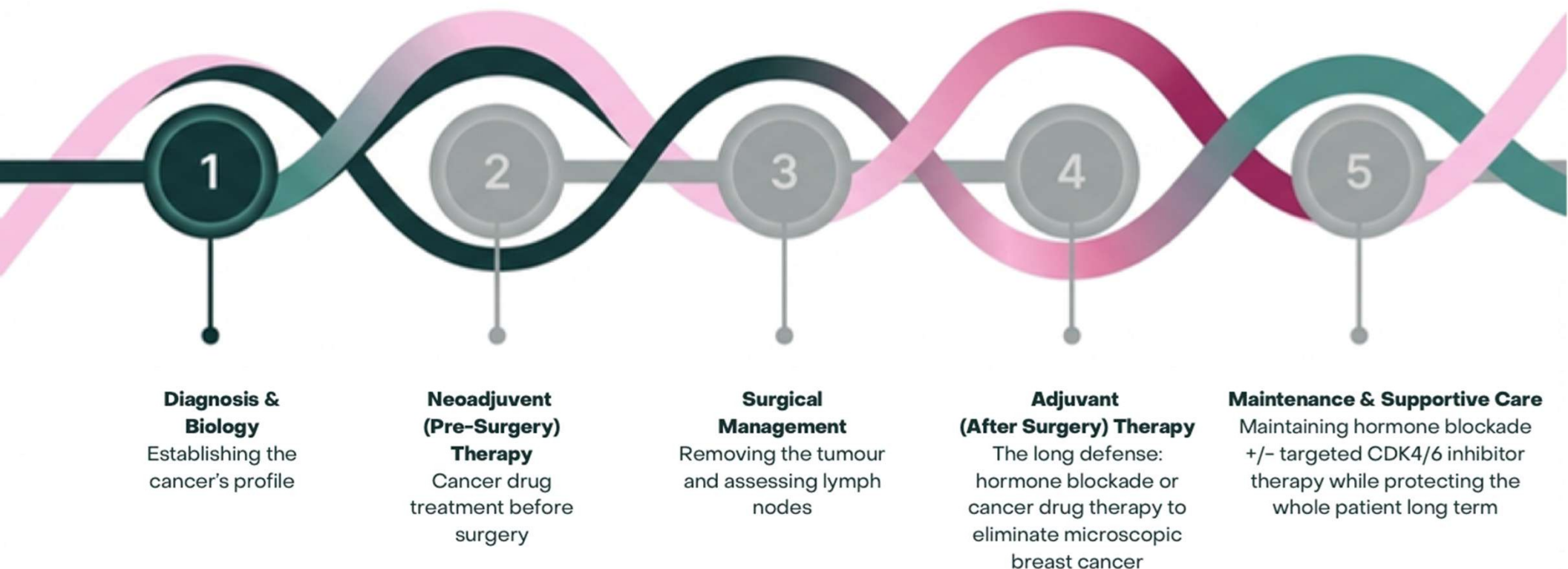


Treatment

What are the treatments for this type of breast cancer?

Will I need chemotherapy?

The Patient Journey Timeline



Surgery

Upfront Surgery: The Standard in Low Risk of Recurrence

Key Principle: For patients with 1 of 3 low-risk profiles, treatment before surgery (neoadjuvant therapy) offers no survival advantage. Upfront surgery followed by cancer drug therapy, based on final pathology, is the gold standard.



Profile 1: Stage 1 or 2 with low-risk of returning based on breast cancer features (e.g. no cancer spread to underarm lymph nodes, low grade / slow growing).

Profile 2: Postmenopausal women with small to medium-sized breast tumour (called T1 or T2) that has spread to a few lymph nodes (proven after a biopsy), Luminal A characteristics.

Profile 3: Older patients able to have surgery (≥ 70 years) with breast tumour size that can be removed by surgery.



Diagnosis & Biology

The Tipping Point: Genomic Risk Testing

Clinical Features
(i.e., Tumour size, Nodes)



Genomic Recurrence Score
(i.e., Oncotype DX)

Who needs testing?

- Patients with mid-level risk of cancer recurrence based on features
- Postmenopausal patients with 1–3 positive lymph nodes, test results will guide chemotherapy omission.

The Challenge: Is there a high-risk of breast cancer returning after surgery?

The Solution: Multigene expression assays (like Oncotype DX or MammaPrint) analyze the breast tissue biopsy to provide a range of risk for the cancer returning to determine if chemotherapy is needed.

Who avoids testing?

- Very small or clearly low level risk of cancer recurrence (Grade 1, Luminal A). This type of breast cancer does well on hormone-blockade (Endocrine) therapy alone.

There is a medical need to help identify which patients are likely to benefit from chemotherapy

Chemotherapy benefit cannot be reliably discerned from clinicopathological prognostic factors such as age, tumour size and grade, lymph node status, and ER and HER2 status



Prognostic

Likely course of disease

- Clinical and pathological features such as tumour grade, tumour size and patient age



Predictive

Likely effect of treatment

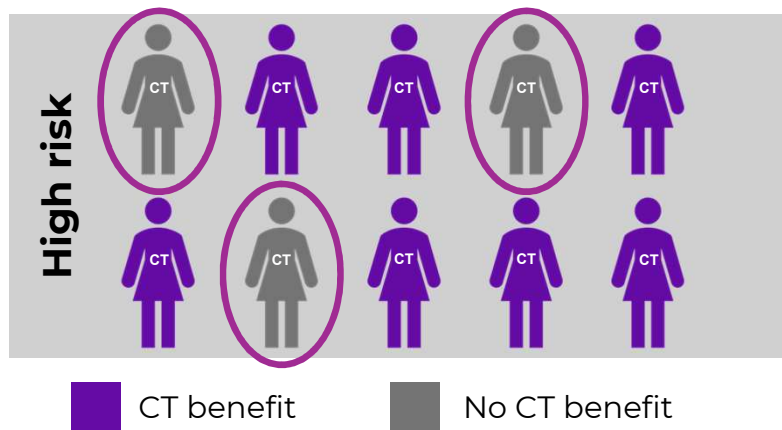
- Based on data testing the treatment in the applicable population

To demonstrate that a biomarker can safely guide treatment de-escalation, evidence should come from randomized controlled non-inferiority trials with predefined margins, which represent the gold standard for establishing level IA evidence

There is a medical need to help identify which patients are likely to benefit from chemotherapy

Though powerful prognostic tools, clinicopathological factors do not offer predictive value. A more quantitative and personalized approach is required for tailoring treatment

Owing to a lack of predictive factors, patients with high-clinical-risk breast cancer may be **overtreated** and exposed to unnecessary adverse events^{1,3}



Patients with low-clinical-risk breast cancer are not routinely given chemotherapy, and so some patients may be at risk of **undertreatment**^{3,4}





Treatment

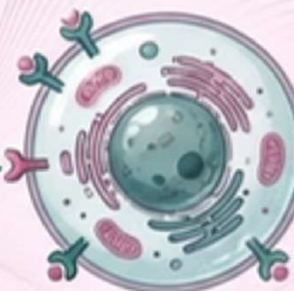
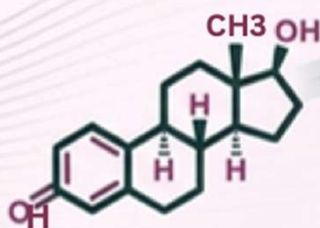
Are there other treatments for this type of cancer?



The Cornerstone: Adjuvant Endocrine Therapy (ET)

Surgery

5-10 Years



Core Philosophy

Because HR+ tumours are fueled by hormones, long-term estrogen blockade reduces recurrence and mortality across all stages.

Duration

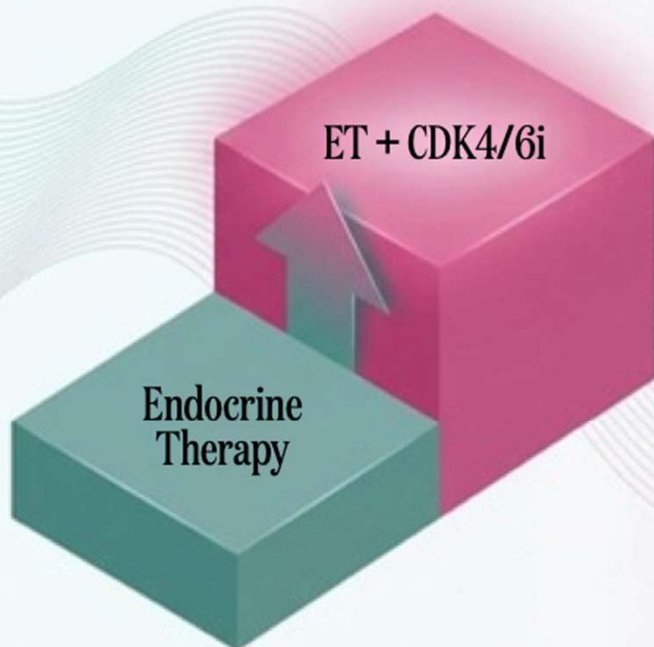
Standard duration is 5 years, but can be extended to 7 or 10 years based on individualized recurrence risk.

The Endurance Challenge

The challenge full blockade on cancer growth, WITH endurance. ET has side effects that require active partnership with your care team to remain on treatment as best possible while providing a personalized balance of quality living while on therapy.



Treatment Intensification: Enter CDK4/6 Inhibitors



The Reality: For patients with high-risk clinical features, there is a persistent risk of late recurrence despite Endocrine Therapy.

The Standard of Care: For high-risk early breast cancer (pre- or post-menopausal), adding a targeted CDK4/6 inhibitor (Abemaciclib or Ribociclib) to ET is standard practice.

Who is High Risk?

- >4 positive lymph nodes in the underarm with breast cancer
- 1-3 positive nodes plus tumour size > 5cm, Grade 3 speed of growth, or Ki-67 biomarker count > 20%
- No cancer in lymph nodes but mid-size tumour with high recurrence risk features (take Ribociclib specifically)

Adjuvant ET for HR+/HER2- EBC

**ET
building
blocks**

Postmenopausal patients

AI

TAM

Premenopausal patients

AI + OFS

TAM + OFS

TAM

**Other
modalities in
combination**

**Who are the patients that need
CDK4/6 inhibitors + ET?**



Treatment

What can I do to ensure the treatment is as effective as possible?

Your Voice is Your Most Powerful Tool

Quality of Life

A primary goal is keeping you active and comfortable. Alert your oncologist early about any side effects so they can be managed promptly.

You

Shared Decisions

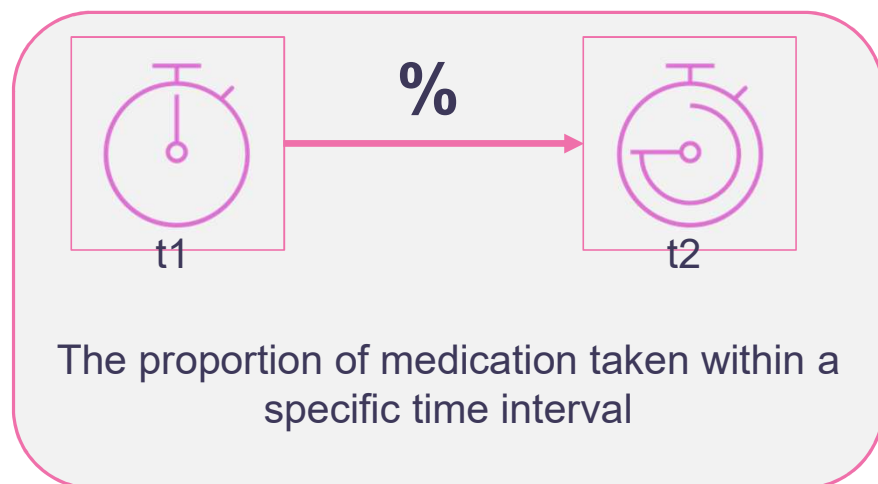
Your thoughts, values, and life goals must be included at every step. You and your health care team decide your path together.

Clinical Trials

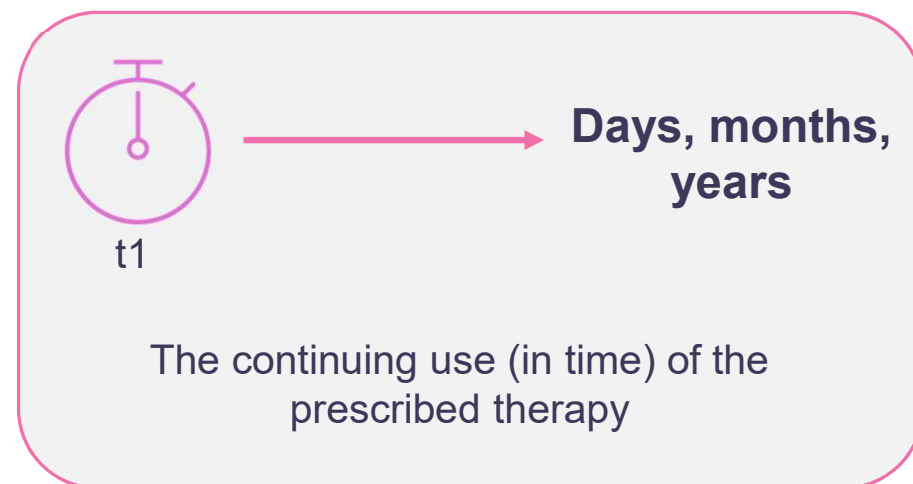
If you qualify, clinical trials are highly encouraged. They ensure you receive the current standard of care plus access to promising new treatments to help doctors find better ways to treat cancer.

Getting the most out of treatment

Taking medication daily



Over the full amount of time (5 years)



- Self-report vs prescription database
 - Self-reported medication adherence is associated with an overestimation of objective adherence, particularly in older patients

	INITIATION	ADMINISTRATION	MONITORING	MANAGEMENT	
ADJUVANT ABEMACICLIB	- Within 16 months of definitive breast cancer surgery - Within 12 weeks of ET after the last non-ET (e.g., chemotherapy)	Start: 150mg twice daily <i>dose reduction 1</i> → 100mg twice daily <i>dose reduction 2</i> → 50mg twice daily	CBC + LFT: - Prior to start of therapy - Q2W for months 1 and 2 - QM for months 3 and 4 - As clinically indicated Lytes: - Renal and biochemical parameters, especially if experiencing diarrhea Other: - Signs of VTE and ILD/pneumonitis	- Manage with dose interruptions and/or reductions, per prescribing information - Any abnormality should be corrected before resuming treatment - Manage diarrhea with loperamide; advise patient to drink more fluids - Be aware that abemaciclib may increase serum creatinine due to inhibition of renal tubular secretion transporters, without affecting glomerular function	TREAT FOR 2 YEARS or until recurrence or unacceptable toxicity
ADJUVANT RIBOCICLIB	- Within 18 months of initial breast cancer diagnosis (cytologic or histologic) - Within 12 months of starting standard (neo) adjuvant ET	Start: 400mg once daily (3wks on, 1 wk off) <i>dose reduction</i> → 200mg once daily	CBC + LFT: - Prior to start of therapy - Q2W for cycles 1 and 2 - QM for cycles 3-6 - As clinically indicated Lytes: - Prior to start of therapy and at regular intervals in later cycles - As clinically indicated ECG: - Prior to the start of therapy - Day 14 of cycle 1 - As clinically indicated Other: - Signs of ILD/pneumonitis	- Manage with dose interruptions and/or reductions, per prescribing information - Any abnormality should be corrected before resuming treatment - Monitor ECG more frequently if clinically indicated (e.g., if QTc prolongation occurs, risk factors for Torsade de Pointes, or concomitant medications)	TREAT FOR 3 YEARS or until recurrence or unacceptable toxicity



After 5 Years

Now that I won't be seeing you as often, what does my future check-up and screening schedule look like?



After Treatment

Now that my treatment is finished, I feel a sense of uncertainty about what's next.



There is beauty in the numbers.

PROgress Tracker brings together the experiences of people affected by breast cancer. The information is organized according to the type of cancer, age, ethnicity, and geographic location of those affected and will show the complexity of the treatment and long-term effects. Researchers will use the data to assess quality of life while identifying gaps and disparities. Our goal is to inform cancer policy and clinical care standards from coast-to-coast.

**Consider sharing your lived experience with HR+ /
HER2- breast cancer.**

progresstracker.ca



Breast
Cancer
Canada



PROGRESS
CONNECT

Knowledge is a powerful tool.

Research has shown us that there are more than 50 types of breast cancer. Progress CONNECT is an online tool that provides people with breast cancer with information specific to their diagnosis. After completing a series of questions, a personalized report is generated. Designed by Breast Cancer Canada and validated by cutting edge research, Progress CONNECT aims to educate people with breast cancer and enable them to have informed discussions with their oncology team.

Learn more about your HR+/ HER2- treatment.

progressconnect.ca

