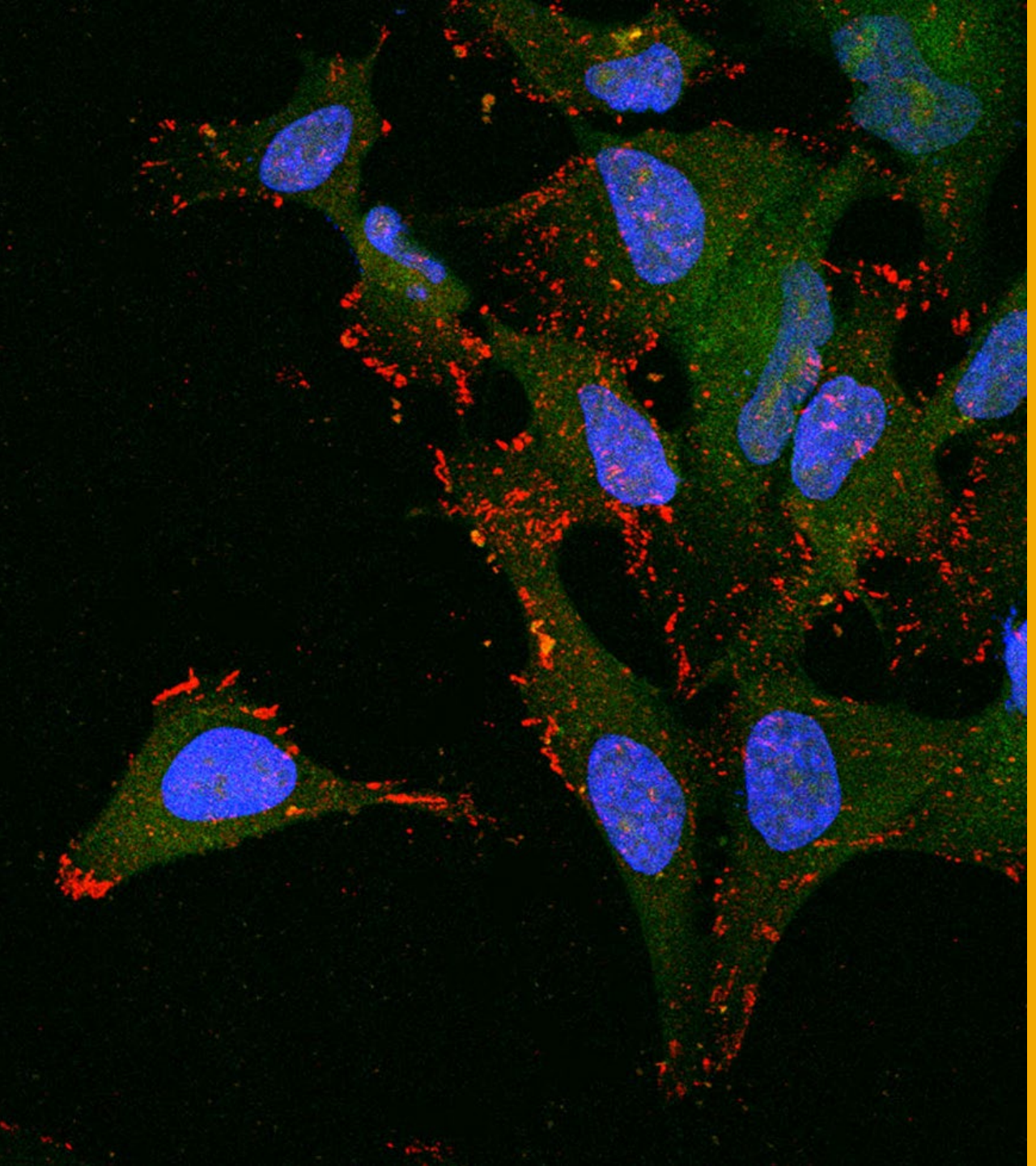

PATIENT-BASED PANEL DISCUSSION

BREAST CANCER

Speakers: Drs. Arciero, Torres, Lin, Kalinsky, Meisel, Gogineni, Bhave, and Pakkala.

Presented by Emory University Heme/Onc Fellow: Andrew McDonald, MD

EMORY WINSHIP CANCER INSTITUTE
National Cancer Institute Designated Comprehensive Cancer Center

NCI Designated Comprehensive Cancer Center

CASE PRESENTATION

- 58 yo F presenting to oncology clinic to establish care for breast cancer.
- 7 months prior patient self palpated a left breast mass.
- 4 months prior OSH b/l MMG and US showed a 6.6cm irregular hypoechoic solid mass in left breast with no left axillary LNs seen.
- 1 week later stereotactic bx of left breast: invasive lobular carcinoma, grade II, ER 98%, PR 75%, HER2/neu 1+, Ki-67 49.1% in the background of LCIS.
- No systemic imaging acquired after diagnosis.
- Labs prior to diagnosis notable for alk phos 142 and eGFR 38 (Cr 1.56)

CASE PRESENTATION

Next steps in diagnosis and treatment?

PATIENT MEDICAL HISTORY

PMHx: HTN, CKD3, anxiety, depression, tobacco use disorder, Basal cell carcinoma s/p Moh's in 2003

FHx: H/o HTN & DM2 in family, father with lung cancer

Social Hx: Former smoking (quit 6 years ago, 74 PY), no alcohol or recreational drug use.

GYN Hx: Menopause unclear, hysterectomy preformed 10-15 years ago, still has ovaries. H/o breastfeeding, no h/o hormone use.

Allergies: Hydrocodone, codeine

ECOG: 0

CASE PRESENTATION

- Started on tamoxifen about 1-2 months after diagnosis with surgery occurring about 2 weeks later.
- Left modified radical mastectomy with right breast reduction pathology:
  - Multifocal invasive lobular carcinoma (largest 6.5cm), grade 2, with involvement of the skeletal muscle and posterior anterior margin.
  - 3/3 sentinel LN positive (largest 10mm, no extranodal extension) and 1 intramammary LN positive
  - Full axillary LN dissection positive for 6/8 LN with metastatic involvement
  - ER 98%, PR 75%, HER2/neu 1+ on IHC, Ki-67 49%
  - No reconstruction surgery to date.

CASE PRESENTATION

- CT C/A/P 3 weeks later with diffuse blastic metastases involving axial/appendicular skeleton.
  - No subsequent biopsies were obtained after surgery.
- Seen by OSH medical oncology 2 weeks later with plan to initiate abemaciclib, anastrozole, and bisphosphonate vs. denosumab.
- 1 week later established care with Emory.
  - Recommended to continue abemaciclib and tamoxifen.
  - Ordered FSH/LH/estradiol to confirm menopause with plans to switch to anastrozole if menopausal.
  - Ordered baseline PET/CT.
  - Started denosumab rather than zoledronic acid d/t CKD.

CASE PRESENTATION

- Could you comment on factors present in this case that would have raised your suspicion for more advanced disease prior to surgery?
- When would you consider a palliative mastectomy in the metastatic setting?
- What role could XRT have in this patient's care if she had oligometastatic disease rather than diffuse osseous mets?
- How accurate are hormone studies at predicting menopause? Do we care more about FSH or LH?
- What CDK4/6 inhibitor would be your first choice in this patient?

QUESTIONS OR COMMENTS?

Thank you to the patient and family involved in this case.

Thank you to Dr. Keerthi Gogineni for providing this case.

Thank you to the panelists for their insight.

AND THANK YOU!!!