Atlanta Breast Cancer CONFERENCE

Multidisciplinary Case Discussion

September 27, 2025

Partners for Advancing Clinical Education

Bio Ascend™

Atlanta Breast Cancer CONFERENCE

Multidisciplinary Case Discussion

Case Presenter: Agreen Hadadi, MD

Emory Hematology/Oncology Fellow

Partners for Advancing Clinical Education

Bio Ascend™

Case 1

- 45 y/o black F with BRCA1 mutation (germline) self palpated lump in right breast
- Diagnostic mammogram: irregular hypoechoic mass at 1:00, 8cm from the nipple, extending anteriorly, worrisome for disease extension
- Right breast biopsy: invasive papillary carcinoma, grade 3, negative nodes.
  - ER 5% 1+; PR negative; HER2 negative. Ki67 85%. cT2N0
- CT CAP without evidence of metastatic disease
- Received 4 cycles neoadjuvant carboplatin/paclitaxel/pembrolizumab per KEYNOTE-522, tolerated very well
- Received 1 cycle of doxorubicin /cyclophosphamide (AC)/ pembro
- Hospitalized prior to cycle 2 due to urosepsis. Declined further cycles of AC

Panel Discussion

- How would you proceed in this case?
  - Would you rescan at this juncture and, if demonstrates significant response, go to surgery?
  - Would you proceed with AC, but dose reduced/fewer cycles?
  - Would you give more cycles of carbo/paclitaxel instead?

Case 1 (continued)

- Proceeded with 2 more cycles of carbo/paclitaxel/pembro per NEOPACT
- Had bilateral mastectomy, with a pCR to NACT . Did not receive adjuvant RT
- Completed additional 4 cycles of pembrolizumab after surgery
- 3 years out from surgery, she remains disease free on surveillance

Panel Discussion

- If she had positive nodes at time of biopsy, would you consider PMRT or no?
- How often in practice do you offer NeoPACT regimen to your patients? For which patients do you favor offering this regimen?
- Is this patient someone you would have considered for OptimICE-PCR trial?

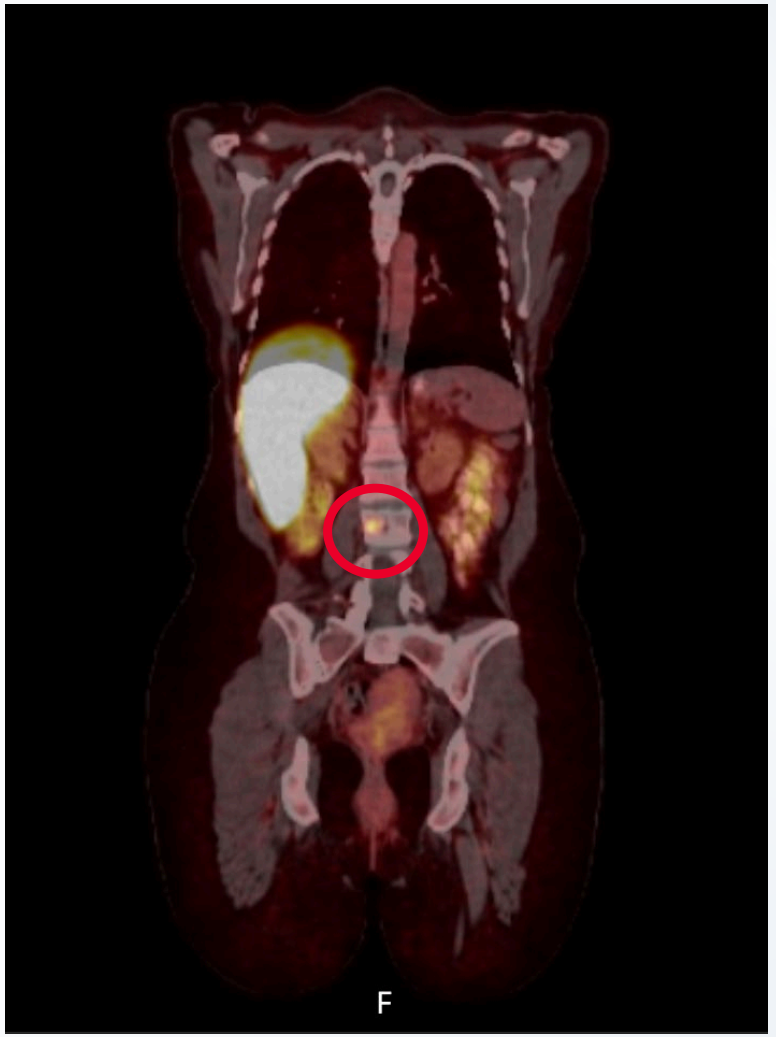
Case 2

Case 2

- 46 y/o F has screening MMG: shows calcifications and a focal asymmetry in the right breast, axillary lymphadenopathy
- Diagnostic MMG and breast US showed a 2.2 x 1.4 x 1.3cm mass in right breast, a 6x6x5mm mass in right axillary tail, as well as mildly prominent nodes including a 1.3cm right axillary node. All were suspicious.
- Biopsy of all 3 samples revealed IDC, grade 2; ER 99% PR 99% Her2 IHC 0
- CT C/A/P revealed a lytic lesion in L3 concerning for metastatic focus

Case 2 (continued)

- FES PET: Intensely FES positive uptake in lytic lesion involving L3 vertebra. No other disease noted outside of right breast.



Panel Discussion

- What would be your approach to treatment for this patient?
  - Treat as metastatic HR+?
  - Manage as early stage disease with local therapy to oligometastatic site?

- How do you incorporate the use of FES-PET scans in your practice?

Case 2 (continued)

- Completed radiation to L3 (1200 cGy)
- She received 4 cycles of dd-AC followed by 4 cycles of paclitaxel
- Underwent bilateral mastectomies: pathology revealed 1.8cm IDC with 80% cellularity in the breast, and 3/7 nodes with involvement. Clear margins.
- Started OS + AI with leuprolide and letrozole
- She then completed radiation therapy
- Started abemaciclib 1 month later
- FES-PET showed no progression
- Switched from abemaciclib to ribociclib due to GI side effects. Continued letrozole.

Case 2 (continued)

- She underwent ppx BSO, thus leuprolide no longer required
- Remains on letrozole + ribociclib with plans to continue ribociclib until 2 year mark at which time, can consider whether to stop, continue, or go down to 200mg dose as a kind of maintenance therapy
- She remains disease free on surveillance with FES-PET scans every 6 months