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ABC2 Consensus Conference on Advanced Breast Cancer: Brief Summary of the Consensus Panel on Saturday November 9, 2013

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Introduction

The Advanced Breast Cancer Second International Consensus Conference (ABC2) took place in Lisbon, Portugal, from 7–9 November 2013. More than 1,000 participants from 71 countries attended the 2 days of state-of-the art lectures on locally advanced and metastatic breast cancer and the consensus panel discussion. This article briefly summarizes the topics discussed at the public consensus meeting in Lisbon on Saturday morning – a more detailed discussion of the consensus and its conclusions in the light of the German guidelines will follow in the first issue of Breast Care in 2014. Under the chairmanship of Fatima Cardoso (Portugal), Alberto Costa (Italy), Larry Norton (USA) and Eric Winer (USA), 41 international and multidisciplinary panel members (table 1) discussed the ABC2 statements. These statements included new statements for ABC2, statements of the ABC1 consensus (2011) that, based on new evidence, needed some modifications, and last but not least ABC1 statements that were still considered valid and thus were not discussed again. Given the limited time available on the Saturday morning, the international panel primarily discussed the new statements for ABC2. This report only briefly summarizes the results of the consensus discussion and voting in Lisbon. The final ABC2 consensus with the final written version of the consensus statements and all modified ABC1 statements will be published in the official consensus publication by Dr. Cardoso and her colleagues in early 2014.

Locally Advanced Breast Cancer (LABC)

This topic was one of the main themes of ABC2 and refers to inoperable LABC without distant metastases. The panel agreed on the need for a pre-therapeutic biopsy to determine histology and tumor biology (estrogen receptor (ER), progesterone (PR), HER2, and proliferation). Given the high risk for distant metastasis, the panel unanimously opted for a subtle staging work-up, including clinical history, physical examination, and extensive imaging before the start of therapy. The panelists agreed on systemic therapy and not surgery or radiotherapy as the first therapeutic choice in this setting. If the tumor remains inoperable after systemic treatment and radiotherapy, 'palliative' mastectomy should only be used in cases for which an overall improvement of quality of life can be expected. A multidisciplinary treatment approach was seen as indicated for the majority of LABC cases. After systemic therapy (with or without radiotherapy), surgery would still be possible in the majority of cases. This would usally consist of mastectomy plus axillary dissection, although in a small proportion of patients breast conserving therapy may be an option.

The different tumor-biological subtypes were then discussed separately. For triple-negative LABC, anthracycline- and taxane-based chemotherapy was considered optimal. In HER2-positive LABC, concurrent taxane and anti-HER2 therapy is recommended and anthracyclines should be incorporated sequentially. In ER-positive LABC, anthracycline- and taxane-based chemotherapy as well as endocrine therapy were accepted as therapeutic options. In the discussion it was emphasized that the choice of chemotherapy vs. endocrine therapy as the primary treatment depends on the patient (e.g. menopausal status, performance status, comorbidities, and preference) as well as tumor (e.g. grade and biomarkers) characteristics.

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Table 1. ABC 2 consensus panellists

Matti S. Aapro, CH	Clifford A. Hudis, US
Fabrice André, FR	Bella Kaufman, IL
Carlos H. Barrios, BR	Ian E. Krop, US
Jonas Bergh, SE	Nancy U. Lin, US
Elizabeth Bergsten Nordström, IT	Musa Mayer, US
Laura Biganzoli, IT	Sofia D. Merjaver, US
Kimberley L. Blackwell, US	Larry Norton, US
Fatima Cardoso, PT	Olivia Pagani, CH
Maria João Cardoso, PT	Ann H. Partridge, US
Alberto Costa, CH/IT	Frédérique Penault-Llorca, FR
Tanja Cufer, SL	Martine J. Piccart, BE
Nagi S. El Saghir, LB	Hope S. Rugo, US
Lesley Fallowfield, UK	Elzbieta Senkus-Konefka, PL
Doris Fenech, MT	George W. Sledge, US
Prudence A. Francis, AU	Christoph Thomssen, DE
Karen Gelmon, CA	Laura van't Veer, US
Sharon H. Giordano, US	Conny Vrieling, CH
Joseph Gligorov, FR	Nicola West, UK
Nadia Harbeck, DE	Eric P. Winer, US
Nehmat Houssami, AU	Binghe Xu, CN

Special Situations

For inflammatory breast cancer, the same treatment recommendations as for non-inflammatory LABC hold true. In general, modified radical mastectomy is recommended, even in cases with good response to primary systemic therapy. Immediate reconstruction is not recommended. Locoregional radiotherapy (chest wall and lymph nodes) is required.

In BRCA-associated triple-negative or endocrine-resistant metastatic breast cancer (MBC) with anthracycline and taxane pretreatment, platinum-based chemotherapy may be considered.

In patients with liver metastases, it was pointed out in the discussion that local treatment was only being looked at in a highly selected series of patients. So far, no survival advantage was proven. Nevertheless, local therapy was considered an option for patients with liver metastases if no extra-hepatic metastases were present and the disease was well controlled by systemic therapy.

In case of malignant pleural effusions, after cytological confirmation of diagnosis, the need for systemic therapy was emphasized. Drainage is indicated in symptomatic cases and intrapleural administration of talc or drugs such as bleomycin or biological-response modifiers may be helpful.

Chest Wall and Regional (Nodal) Recurrences

Chest wall and locoregional (nodal) recurrences were considered as potentially curable diseases, but with the burden of a risk of metastasis. Therefore, before any therapeutic decision is made, distant metastases should be excluded by clinical examination and extensive imaging. If local treatment is not feasible, palliative therapy should be performed, according to the principles that are valid in metastatic breast cancer. If locoregional treatment seems to be successful, after radical surgery and radiotherapy, 'secondary' adjuvant systemic therapy including chemotherapy should also be administered. Chemotherapy seems to be most effective in ER-negative disease.

Concluding the section of new statements, there was some discussion on definitions with regard to the term 'visceral crisis' and 'endocrine resistance', both often used in the literature aimed at stratification for treatment approaches. For 'endocrine resistance', an arbitrary threshold of 2 years was defined to distinguish between primary and secondary resistance, although most agreed that endocrine resistance develops in a continuous manner rather than sporadically after a distinct time interval. However, it was agreed that a pragmatic definition should be sought.

A special issue at the ABC2 Meeting was the integration of a patient's advocacy committee with specifically dedicated workshops. The results were then reported during the consensus discussion. Proposals of the patient's advocacy committee were included as new statements that referred to the need for a comprehensive and understandable communication between care givers and patients with advanced breast cancer, the need for including a breast care nurse in the multidisciplinary team, and the need for protocolling the therapy side effects in a clear and standardized manner.

Modifications of Statements of the ABC1 2011

Initially, it was agreed that age should not be used as a sole criterion for treatment decisions (to withhold or to administer more aggressive therapies). With regard to ER-positive/HER-2-negative MBC, the statements on treatment with everolimus were updated, acknowledging the substantially positive effect on the progression-free survival when balanced with potential toxicities occurring in some patients. Statements regarding HER2-positive MBC were also revised in the light of the recent data on the efficacy of the third generation of anti-HER2 drugs (pertuzumab, T-DM1) and the value of different combinations (e.g. capecitabine-lapatinib, trastuzumab-chemotherapy combinations, and trastuzumab-lapatinib).

Finally, the type and sequence of second-line endocrine therapies and chemotherapies were discussed. Considering the multiple types, effects and duration of pretreatment, a single general recommendation no longer seems reasonable. Special attention was given to the treatment of male MBC regarding the question of whether sole aromatase inhibition is sufficient. The majority felt that the available data do not support the omission of gonadotropin suppression using GnRH agonists if aromatase inhibitors were used.

The slides of the ABC1 consensus 2011 that were not modified and not discussed in the current meeting will be placed into the supplementary material of the final publication of the ABC2 consensus statements, expected in spring 2014 in 'The Breast'. We can congratulate the organizers, particularly Fatima Cardoso (Lisbon), Eric Winer (Boston), Alberto Costa (Milan), and Larry Norton (New York), for this important initiative and the organization of these fruitful meetings on advanced breast cancer, and we are awaiting the next meeting, ABC3, planned in 2015.