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GUIDELINES

Metastatic breast cancer

Recommendations proposal from the European School of Oncology (ESO)–MBC Task Force

Treatment of metastatic breast cancer is considered to be an art. Contrary to the early breast cancer setting, where level 1 evidence exists for the majority of treatment options, for metastatic breast cancer there are few approved standards of care, particularly after first-line treatment. Consequently, while several international guidelines exist and are used worldwide for adjuvant therapy, international guidelines on metastatic breast cancer treatment are rare and not usually adhered to by the majority of treating oncologists.

Advances in breast cancer care and new drug development over the last few decades have been impressive and currently, fortunately, a wide array of options exists for the management of metastatic breast cancer. Notwithstanding these improvements, many questions remain unanswered or are controversial, particularly since it is still an incurable disease where the main goal is to improve the quality and, whenever possible, increase the quantity of life. Therefore, the treatment of this disease is remarkably different among countries, centres and even among individual oncologists. With the ever-increasing costs of new treatments, biological markers, and supportive and palliative care measures, a wise and balanced use of resources is paramount.

Based on these facts, the European School of Oncology, in collaboration with the European Breast Cancer Conference (EBCC) organisers, has created a task force with the aim of developing international guidelines for the management of metastatic breast cancer. Acknowledging the difficulty of the task, it was decided to launch the process in two steps. The first, which took place at EBCC-5 in Nice in March 2006, was to prepare a list of 12 statements highlighting the main issues and providing general recommendations regarding MBC management. This list of statements was discussed by a panel of experts with active interaction with the audience in a plenary session during EBCC-5, and received with great interest. This short publication presents these statements. The second step will be the development and publication, in a peer-reviewed form, of more detailed guidelines and formal recommendations with adequate supporting references and documentation.

12 Recommendations statements

(1) The management of metastatic breast cancer (MBC) is complex; therefore, involvement of all appropriate specialties in a multi/interdisciplinary team (medical, radiation, surgical and imaging oncologists, palliative care, psycho-social, among others) is crucial.
(2) From the first diagnosis of MBC, patients should be offered personalised appropriate psychosocial, supportive, and symptom-related interventions as a routine part of their care.
(3) Following thorough assessment and confirmation of MBC, the realistic treatment goals must be specified and discussed. Patients and family members should be invited to participate in all decision-making.
(4) A small but very important subset of MBC patients, for example, those with a solitary metastatic lesion, can achieve complete remission and a long survival. For these selected patients, a more aggressive and multidisciplinary approach should be considered.

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A clinical trial addressing this specific situation is needed.

(5) Minimal staging work-up for MBC includes a history and physical examination, complete haematology and biochemistry, and imaging of the chest, abdomen and bone. The clinical value of tumour markers is not well established for diagnosis or follow-up; however, their use as an aid to evaluate response to treatment, particularly in patients with non-measurable disease, is acceptable.

(6) Treatment choice should take into account: endocrine responsiveness, HER-2 status, menopausal status, disease-free interval, previous therapies and response obtained, tumour burden (defined as number and site of metastases), biological age and co-morbidities (including organ dysfunctions), performance status, need for rapid disease/symptom control, socio-economic and psychological factors, patient's preference and available therapies in the patient's country (this list is not exhaustive).

(7) Endocrine therapy is the preferred option for hormonal receptor-positive disease, unless there is concern or proof of endocrine resistance. The optimal first-line hormonal treatment for postmenopausal patients is an aromatase inhibitor; however, tamoxifen remains a viable option. For pre-menopausal women, tamoxifen combined with ovarian suppression/ablation is the first choice except for tamoxifen-resistant tumours. Optimal post-aromatase inhibitor treatment is uncertain. Maintenance of hormonal treatment after chemotherapy is not established, but is reasonable. Concomitant chemo+endocrine therapy should be discouraged.

(8) Trastuzumab should be offered early to all HER-2-positive MBC patients, after failure of endocrine therapy if this is appropriate. Trastuzumab in combination with endocrine therapy is under evaluation in clinical trials and cannot yet be considered as standard. Currently, the optimal management of patients progressing on trastuzumab is uncertain and active research is ongoing in this area.

(9) The choice between sequential use of single cytotoxic drugs and combination chemotherapy should be taken after consideration of the factors mentioned in paragraph 6, with greatest emphasis on the need for a rapid and significant response and on quality of life. For the majority of patients, overall survival outcome from sequential use of single cytotoxic drugs seems to be equivalent to that after combination chemotherapy. Duration of each regimen and number of regimens should be tailored to each individual patient.

(10) There are few proven standards of care in MBC management. Therefore, inclusion of patients in well-designed, independent, prospective randomised trials must be a priority whenever available. Every proposed option must have a sound scientific rationale, preferably evidence-based.

(11) The medical community is aware of the problems raised by the cost of MBC treatment. Balanced decisions should be made in all instances, but the patient's well-being, length and quality of life must always be the main decision factors.

(12) Formal (not just informal) quality of life assessments provide useful information and should be encouraged. If collected, such information should be integrated with that from clinic assessments to allow management decisions on initiating, changing, or stopping drug therapy.

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