第8回　中部乳癌会議

症例2

3012/3/4　D班

症例2

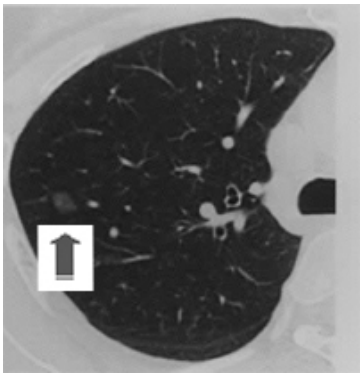
- 38歳、左乳癌でBp+SLNB施行
- T=2.3cm, n=0/2, ER:8, PgR:3, HER2:3+,で
  術後FEC×4→wPTX×12→TAM+RT
- 術後6年(TAM終了後半年)の定期チェックで無症状の肺孤立性腫瘤が発見された(1cm)
- 腫瘍マーカーは正常

A) 肺の生検→治療法決定　**B) 乳癌の肺転移として治療開始**

肺転移として治療開始する立場から

生検する意味

1　原発性肺癌
2　乳癌の再発（subtypeを含めて） の鑑別



肺転移として治療開始する立場から

	Risk	Benefit
針生検	侵襲的 サンプルエラー 気胸等の合併症	組織診断
VATS生検	さらに侵襲的 医療費　160万以上 **評価可能病変がなくなる**	組織診断

- 針生検･･･1cmの孤立性腫瘤は気胸等のriskが高い。
  ⇒実臨床ではかなり難しい。
- VATS生検･･･評価可能病変がなくなる。

（K514－2 胸腔鏡下肺悪性腫瘍手術
1 リンパ節郭清を伴わないもの61,500点）

肺転移として治療開始する立場から

● 肺，骨，肝転移巣に対する外科的切除は勧められるか

改訂日：2011/09/01　CQID：202801　外科療法

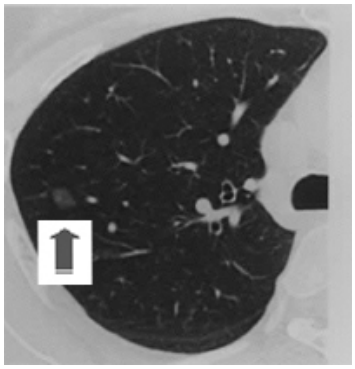
推奨グレード	C2	多発転移および多臓器への転移が多く，生存の延長に寄与するエビデンスはないため，限られたケースを除き，外科的切除は勧められない。

生検を示すデータですべてretorospective
ハーセプチンがない時代のデータ

肺転移として治療開始する立場から

治療の反応性を見てから生検してもいいのでは？

1cmの腫瘤なので急ぐ必要ないと思われる
3カ月程度、治療効果を見てから決めてみては？



肺転移として治療開始する立場から

具体的な治療
～乳癌再発として～

Prospective Study Evaluating the Impact of Tissue Confirmation of Metastatic Disease in Patients With Breast Cancer

Eitan Amir, Naomi Miller, William Geddie, Orit Freedman, Farrah Kassam, Christine Simmons, Maria Oldfield, George Dranitsaris, George Tomlinson, Andreas Laupacis, Ian F. Tannock, and Mark Clemons

See accompanying editorial on page 575 and article on page 593; listen to the podcast by Dr Davidson at www.jco.org/podcasts

A B S T R A C T

Purpose
Decisions about treatment for women with metastatic breast cancer are usually based on the estrogen (ER), progesterone (PgR), and human epidermal growth factor receptor 2 (HER2) status of the primary tumor. Retrospective data suggest that discordance between primary and metastatic lesions leads to detrimental outcome. This prospective study investigated receptor status of primary tumors and metastases in the same patient and assessed the impact of discordance on patient management and survival.

Patients and Methods
Biopsies of suspected metastases were analyzed for ER, PgR, and *HER2*. Primary tumors and metastases were analyzed using similar methodology. The treating oncologist indicated a treatment plan before and after biopsy to determine whether the result influenced management. Patients were followed up for progression or death.

Results
Of 121 women undergoing biopsy, 80% could be analyzed for receptor status. Discordance in ER, PgR, and *HER2* between the primary and the metastasis was 16%, 40%, and 10%, respectively. Biopsy led to a reported change of management in 14% of women (95% CI, 8.4% to 21.5%). Fine-needle aspiration and biopsy of bone led to reduced ability to analyze receptors. After a median follow-up of 12 months, there were no trends for an association between receptor discordance and either time to treatment failure or overall survival.

Conclusion
Biopsy of metastases is technically feasible. Clinicians alter immediate management in one of seven patients on the basis of results of the biopsy, and discordance is not then associated with detrimental effects on outcome. Tissue confirmation should be considered in women with breast cancer and suspected metastatic recurrence.

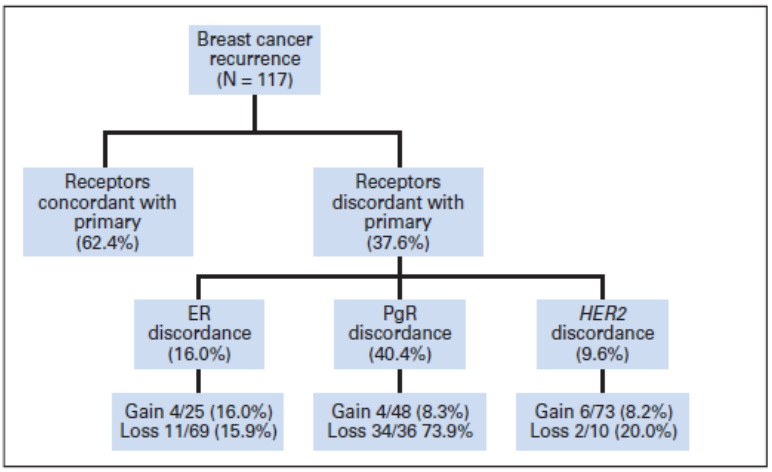
肺転移として治療開始する立場から

Table 1. Patient Demographics and Clinical Characteristics

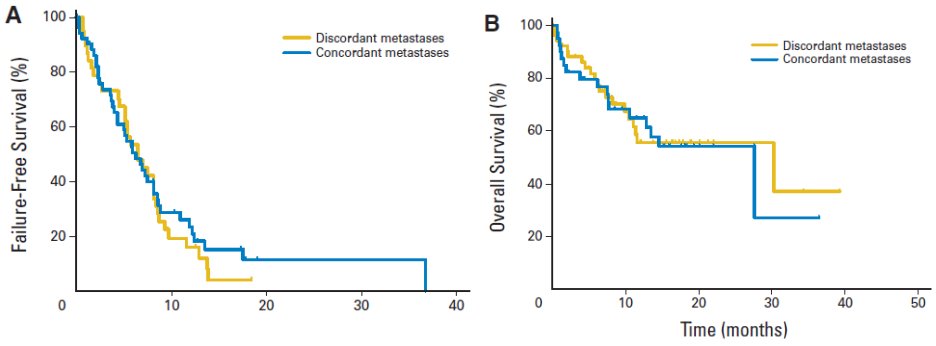
Characteristic	All Biopsied Patients (n = 121) No.	%	Concordant Group* (n = 53) No.	%	Discordant Group* (n = 41) No.	%	P
Age, years							
Median	59		58.5		59		.20
Range	29-83		35-83		36-72		
Adjuvant treatment							
Chemotherapy	63	52.1	20	36.4	21	51.2	.19
Endocrine therapy	90	75	28	50.9	17	41.5	.50
Trastuzumab	5	4.1	2	3.6	2	4.9	.85
Advanced disease status							
Newly diagnosed metastatic	56	46.3	11	20.0	7	17.1	
1 prior line of treatment in metastatic setting	21	17.4	15	27.3	10	24.4	.65
≥2 lines of treatment in metastatic setting	44	36.4	29	52.7	24	58.5	
Duration of metastatic disease, months							
Median	35		18		24		.35
Range	0-274		0.5-79		0.5-108		
Palliative treatment							
Median lines of endocrine therapy	2		1		1		.10
Median lines of chemotherapy	1		1		0		.26

*Includes only those patients with availability of matched primary and metastatic tissue.

肺転移として治療開始する立場から



肺転移として治療開始する立場から



肺転移として治療開始する立場から

原発巣と転移巣でhormone status,
HER2 statusに不一致があっても治療内容
に関わらずOSは同等。

⇩

<u>原発巣のsubtypeで治療内容を考慮</u>

肺転移として治療開始する立場から

乳癌の再発と考えた場合

TAM終了後半年での再発

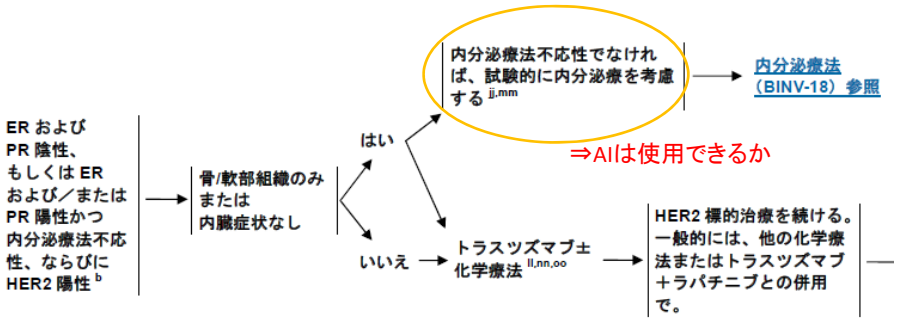
⇩

TAM不応性の可能性

肺転移として治療開始する立場から

再発/病期 IV 疾患の全身治療

ER および PR 陰性、もしくは ER および/または PR 陽性かつ内分泌療法不応性；HER2 陽性



NCCN　ガイドライン　2011より

Trastuzumab Plus Anastrozole Versus Anastrozole Alone for the Treatment of Postmenopausal Women With Human Epidermal Growth Factor Receptor 2–Positive, Hormone Receptor–Positive Metastatic Breast Cancer: Results From the Randomized Phase III TAnDEM Study

Bella Kaufman, John R. Mackey, Michael R. Clemens, Poonamalle P. Bapsy, Ashok Vaid, Andrew Wardley, Sergei Tjulandin, Michaela Jahn, Michaela Lehle, Andrea Feyereislova, Cédric Révil, and Alison Jones

A B S T R A C T

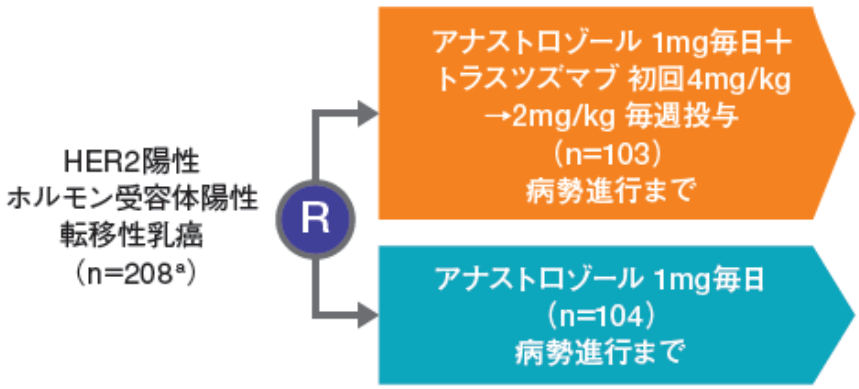
Purpose
TAnDEM is the first randomized phase III study to combine a hormonal agent and trastuzumab without chemotherapy as treatment for human epidermal growth factor receptor 2 (HER2)/hormone receptor–copositive metastatic breast cancer (MBC).

Patients and Methods
Postmenopausal women with HER2/hormone receptor–copositive MBC were randomly assigned to anastrozole (1 mg/d orally) with or without trastuzumab (4 mg/kg intravenous infusion on day 1, then 2 mg/kg every week) until progression. The primary end point was progression-free survival (PFS) in the intent-to-treat population.

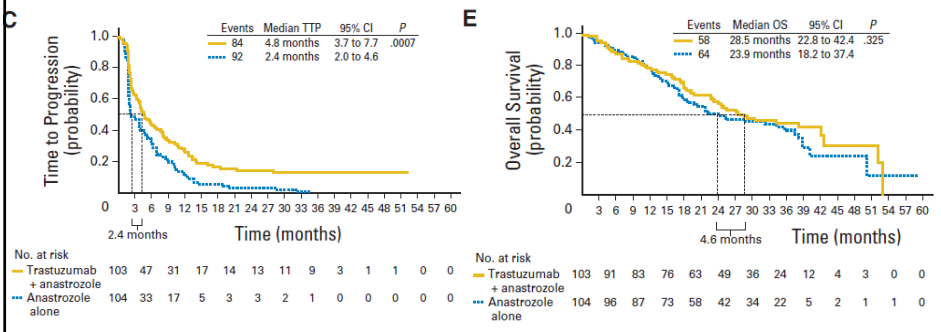
Results
Overall, 103 patients received trastuzumab plus anastrozole; 104 received anastrozole alone. Patients in the trastuzumab plus anastrozole arm experienced significant improvements in PFS compared with patients receiving anastrozole alone (hazard ratio = 0.63; 95% CI, 0.47 to 0.84; median PFS, 4.8 *v* 2.4 months; log-rank *P* = .0016). In patients with centrally confirmed hormone receptor positivity (n = 150), median PFS was 5.6 and 3.8 months in the trastuzumab plus anastrozole and anastrozole alone arms, respectively (log-rank *P* = .006). Overall survival in the overall and centrally confirmed hormone receptor–positive populations showed no statistically significant treatment difference; however, 70% of patients in the anastrozole alone arm crossed over to receive trastuzumab after progression on anastrozole alone. Incidence of grade 3 and 4 adverse events was 23% and 5%, respectively, in the trastuzumab plus anastrozole arm, and 15% and 1%, respectively, in the anastrozole alone arm; one patient in the combination arm experienced New York Heart Association class II congestive heart failure.

Conclusion
Trastuzumab plus anastrozole improves outcomes for patients with HER2/hormone receptor–copositive MBC compared with anastrozole alone, although adverse events and serious adverse events were more frequent with the combination.

肺転移として治療開始する立場から



肺転移として治療開始する立場から



肺転移として治療開始する立場から

Table 2. Summary of Response Data From the 147 Patients Evaluated for Response in the Reconciled Population

	Best Overall Response			
	Trastuzumab + Anastrozole (n = 74)		Anastrozole Alone (n = 73)	
Response	No. of Patients	%	No. of Patients	%
Complete response*	0	0	0	0
Partial response	15	20.3†	5	6.8
Stable disease	28	37.8	28	38.4
Progressive disease	30	40.5	36	49.3
Not evaluable	1	1.4	4	5.5

NOTE. The analysis population for response required patients to have at least one bidimensionally measurable and evaluable lesion, and this excluded bone lesions, pleural effusions, and lesions assessed by ultrasound.
*Three complete responses (anastrozole alone arm, n = 2; trastuzumab plus anastrozole arm, n = 1) were determined by investigators but not confirmed in the reconciliation process.
†P = .018 *v* anastrozole alone.

ANA+TraがANA単独よりTTP、PRとも優れている

まとめ

✓ 肺生検はリスクが高く、評価可能病変がなくなってしまう。

✓ まずは乳癌の治療効果を見てから生検の必要性を再度考える。

✓ 具体的な治療に関しては、原発巣のsubtypeに準じた治療でANA+Tra。