ABC 1: 1st International Consensus Guidelines Conference for Advanced Breast Cancer

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Unlike early-stage breast cancer, there are few recognized therapeutic standards for advanced breast cancer (ABC), particularly following first-line treatment Fatima Cardoso, MD, Champalimaud Cancer Center, Lisbon, Portugal, provided an overview of the 1st International Consensus Guidelines for Advanced Breast Cancer (ABC 1) [Cardoso F et al. *Breast* 2012].

The main principles of the ABC 1 recommendations include applying the foremost standards of modern oncology, remembering the specificities of the ABC setting, and taking into account the patient's preferences. The main standards of modern oncology involve multidisciplinary treatment, specialized breast cancer units/departments, evidence-based medicine, and therapy tailored to individuals.

The ABC 1 guidelines indicate that management of ABC by a multidisciplinary team is crucial, including but not limited to medical, radiation, and surgical oncologists; pathologists; imaging experts; gynecologists; psycho-oncologists; nurses; social workers; and palliative care specialists.

As part of routine care, patients with ABC should be offered appropriate psychosocial care, supportive care, and symptom-related interventions. Personalization of this approach to meet the needs of the individual patient is necessary. In addition, potential treatment goals should be discussed with the patient after a thorough assessment and confirmation of metastatic breast cancer (MBC) has been made. Physicians should explain to the patient that MBC is incurable but treatable and it is possible to live with MBC for extended periods of time. Accessible language should be used during this conversation, while respecting patient privacy and cultural differences, and written information should be provided whenever possible. Patients should always be invited to participate in the decision-making process, and should be encouraged to bring people who can support them and share in treatment decisions when possible.

At the minimum, a staging workup for MBC should include a history and physical exam; hematology and biochemistry laboratory tests; and imaging of the chest, abdomen, and bone. Liver function, renal function, electrolytes, calcium, total protein, and albumin tests should be included in the biochemistry testing. A positron emission tomography scan should not be part of the workup but should be reserved for necessary cases.

Brain imaging should not be routinely performed as part of the workup for asymptomatic patients with MBC. While patients with human epidermal growth factor receptor 2 (HER2)-positive and triple-negative MBC are at higher risk for brain metastases relative to patients with ER+ disease, it is still not standard to do brain imaging to screen for metastatic disease. Careful evaluation of signs and symptoms of possible brain metastases is necessary since clinical manifestations may be subtle. Imaging may be considered if suggestive signs or symptoms are present.

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The minimum factors that should be included in treatment choice include hormone receptor (HR) and HER2 status, previous therapies and their toxicities, disease-free interval, tumor burden, biological age, performance status, comorbidities, need for rapid disease/symptom control, menopausal status if endocrine therapy is being considered, patient preference, socioeconomic and psychological factors, and available therapies in the patient's country. The patient's age alone should not be a justification for withholding effective therapy or prescribing more aggressive treatment. Inclusion of patients in well-designed, prospective, randomized trials should be a consideration if the patient is willing to participate and a trial is available.

In patients with stage IV breast cancer, the true value of removing the primary tumor is currently unknown, but it can be considered in selected patients. If easily accessible, biopsy of a metastatic lesion should be performed to confirm diagnosis. This is particularly important when metastasis is diagnosed for the first time. Receptors for ER, PR, and HER2 should be reassessed at least once in the metastatic setting. If the biological markers provide different results in the metastatic lesion than the primary tumor, the panel recommends considering the use of targeted therapy if the receptors are positive in one of the biopsies, irrespective of timing.

Although both combination and sequential single-agent chemotherapy are reasonable treatment options for patients with MBC, the panel recommends sequential monotherapy as the preferred choice based on the available data. Combination chemotherapy should be reserved for patients with rapid clinical progression, life-threatening visceral metastases, or the need for rapid symptom and/or disease control.

For patients with HR-positive disease, including those with limited visceral metastases, endocrine therapy is the preferred option unless there is concern for visceral crisis or concern of endocrine resistance. All patients with HER2-positive MBC should be offered anti-HER2 therapy early in the treatment process.

The panel unanimously recommended that "every agent and regimen used does not necessarily need regulatory approval but must be evidence-based, with proven efficacy and acceptable toxicity." Acceptable toxicity should be determined from both the patient and physician perspectives.

In general, response to therapy should be evaluated every 2 to 4 months depending on the disease dynamics, the location and extent of metastatic involvement, and the type of treatment. A physical examination and thorough history should be performed during every follow-up. In many patients, imaging of a target lesion may be sufficient to evaluate response to treatment. Less frequent monitoring is acceptable in certain patients such as those with indolent disease. If progressive disease is suspected, additional testing should be performed in a timely manner regardless of the planned intervals.

Treatment decisions should not be based solely on a change in tumor markers, but tumor markers may aid in the evaluation of response to treatment, particularly in patients with nonmeasurable metastatic disease. Systematic collection of validated patient-reported outcome measures, such as symptom severity and burden, and impact on quality of life, should be integrated with other clinical assessments. These data should be included when making treatment and care decisions.