

Diagnosis and Treatment of Patients with Primary and Metastatic Breast Cancer



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Prognostic and Predictive Factors

Prognostic and Predictive Factors

- **Versions 2002–2016:**
**Costa / Fersis / Friedrichs / Gerber /
Göhring / Harbeck / Janni / Liedtke / Loibl /
Mundhenke / Nitz / Rody / Schaller /
Schmidt / Schmutzler / Schneeweiss /
Simon / Solomayer / Thomssen / Witzel**
- **Version 2017:**
Harbeck / Rody

Definition

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A Prognostic Factor* is any parameter available at the time of interest e.g. primary diagnosis that correlates with disease-free or overall survival, in the absence of any therapy and, as a result, is able to correlate with the natural history of the disease.

A Predictive Factor is any parameter associated with response to a given therapy.

***As mentioned in this context represent markers of BC recurrence**

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Information

References

“Low absolute risk implies low absolute benefit”

Quality Criteria

- **Biological hypothesis**
- **Simple and reliable determination method, quality assurance (QA) of the test**
- **Prospectively planned statistical evaluation (primary goal)**
- **Validation of clinical significance according to**
 - **„Oxford Level of Evidence (LoE_{Ox2001})“ criteria and „Grades of Recommendation (GR)“**
 - **„Grades of Recommendation (GR)“ as well as modified LoE criteria for the use in archived specimen (LoE₂₀₀₉) and category of tumor marker study (CTS)**
 - **Clinical relevance for treatment decisions**

¹Simon et al, J Natl Cancer Inst 101: 1446-1452, 2009

²Febbo et al, J Natl Compr Canc Netw 9 Suppl 5: S1-32, 2011

³McShane, Hayes, J Clin Oncol 30: 4223 – 4232, 2012

Elements of Tumor Marker Studies that Constitute Levels of Evidence Determination

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Category Element	A Prospective	B Prospective using archived samples	C Prospective/observational	D Retrospective/observational
Clinical trial	Prospective controlled trial (PCT) designed to address tumor marker	Prospective trial not designed to address tumor marker, but design accommodates tumor marker utility Accommodation of predictive marker requires Prospective randomized controlled trial (PRCT)	Prospective observational registry, treatment and follow-up not dictated	No prospective aspect to study
Patients and patient data	Prospectively enrolled, treated, and followed in PCT	Prospectively enrolled, treated, and followed in clinical trial and, especially if a predictive utility is considered, a PRCT addressing the treatment of interest	Prospectively enrolled in registry, but treatment and follow-up standard of care	No prospective stipulation of treatment or follow-up; patient data collected by retrospective chart review
Specimen collection, processing, and archival	Specimens collected, processed, and assayed for specific marker in real time	Specimens collected, processed, and archived prospectively using generic SOPs. Assayed after trial completion	Specimens collected, processed, and archived prospectively using generic SOPs. Assayed after trial completion	Specimens collected, processed and archived with no prospective SOPs
Statistical design and analysis	Study powered to address tumor marker question	Study powered to address therapeutic question and underpowered to address tumor marker question Focused analysis plan for marker question developed before doing assays	Study not prospectively powered at all. Retrospective study design confounded by selection of specimens for study Focused analysis plan for marker question developed before doing assays	Study not prospectively powered at all. Retrospective study design confounded by selection of specimens for study No focused analysis plan for marker question developed before doing assays
Validation	Result unlikely to be play of chance Although preferred, validation not required	Result more likely to be play of chance than A but less likely than C Requires one or more validation studies	Result very likely to be play of chance Requires subsequent validation studies	Result very likely to be play of chance Requires subsequent validation

Revised Determination of Levels of Evidence using Elements of Tumor Marker Studies

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Level of Evidence	Category	Validation studies available
I	A	None required
I	B	One or more with consistent results
II	B	None or inconsistent results
II	C	2 or more with consistent results
III	C	None or 1 with consistent results or inconsistent results
IV–V	D	Not applicable because LOE IV and V studies will never be satisfactory for determination of medical utility

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Requirements for a Marker-Based Test to Reach Level IB Evidence

- **1. Adequate amounts of archived specimen must be available from enough patients from a prospective trial ... for analyses to have adequate statistical power and for the patients included in the evaluation to be clearly representative of the patients in the trial.**
- **2. The marker-based test should be analytically and preanalytically validated for use with archived specimens.**
- **3. The plan for marker evaluation should be completely specified in writing before the performance of marker assays on archived specimens and should be focused on evaluation of a single completely defined marker-based test.**
- **4. The results from archived specimens should be validated using specimens from one or more similar, but separate, studies.**

Prognostic Factors I in Early Breast Cancer



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Factor	LoE _{Ox2001}	GR	AGO
➤ Tumor size	1a	A	++
➤ Nodal status	1a	A	++
➤ Distant metastases	1a	B	++
➤ Histological tumor type (colloid, mucinous, tubular etc.)	2b	B	++
➤ Grade (Elston & Ellis)	2a	B	++
➤ Age	2a	B	++
➤ Peritumoral lymphatic vessel and vascular invasion (L1 V1)	2b	B	+
➤ pCR after NACT* in (HR+/G3, HER2+, TN)	1a	A	++
➤ Obesity (BMI >30 kg/m ²)	1b	B	+

* NACT = Neoadjuvant Chemotherapy

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Reproducibility

- **ER/PR: concordance central vs local is high (97%; Plan B, SABCS 2014)**
- **Grading: concordance central vs local is 68 % (PlanB, JCO 2016)**
- **HER2: frequency of false-positive test results 6 % (ASCO /CAP JCO 2013)**
- **Impact of routine pathologic review in N0 BC: 20% changes : grading 40%, LVI 26%, N 15%, margin 12% (JCO 2012)**
- **pN0 from MIRROR study: pN0 was upstaged in 22%, in central pathology review (Ann Oncol 2012)**
- **Inter- and intraobserver variability in measurement of ki-67 is high (J Nat. Cancer Institute 2011)**

Critical Issues Regarding LoEs for Biomarkers



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It needs to be emphasized that the levels of evidence obtained by Oxford-criteria and CTS-criteria cannot be directly compared.

The prospectively-planned retrospective validation of a biomarker (CTS level 1) may be biased by an insufficient number of clinical trial samples used for the biomarker analysis.

This sample collection may not represent the reported outcome of the clinical trial. An optimal percentage of sample needed from clinical trials needed for optimal biomarker validation has not yet been established *

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Information

References

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* Simon, Paik, Hayes, J Natl Cancer Inst 101: 1446-1452, 2009

Prognostic Factors II in Early Breast Cancer



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Factor	LoE _{Ox2001}	GR	AGO
➤ ER / PgR	2a	B	+
➤ HER2 (IHC, FISH)	2b	B	+
➤ ER / PgR / HER2/ Ki-67 as surrogate markers for molecular subtypes	2b	B	+
➤ uPA / PAI (Femtelle [®] ELISA) [§] in N0	1a	A	+
➤ Proliferation markers			
➤ Ki-67 before, during or after treatment	2b	B	+

[§] Validated clinical data only available for this assay

Commercially Available Molecular Tests

	70 gene signature (MammaPrint®) \$	21 gene Recurrence score (Oncotype DX®) \$	8 gene signature (Endopredict®) \$	PAM 50 (Prosigna®) \$
Provider	Agendia	Genomic Health	Sividon	NanoString
Type of assay	70-gene assay	21-gene recurrence score	11-gene assay	50-gene assay
Type of tissue	fresh frozen (technical validation for FFPE available)	FFPE	FFPE	FFPE
Technique	Microarrays for RNA	qRT-PCR	q-RT-PCR	Direct hybridization
Central lab	yes	yes	no	no
Indication and population studied	prognostic N-/+, < 70 years	prognostic N-/+, ER+ endocrine treated	prognostic (pre-) postmenopausal N-/+, ER+ HER2- endocrine treated	prognostic postmenopausal N-/+, ER+ HER2- endocrine treated
Clinical Validation	yes	yes	yes	yes
Registration	FDA clearance as "In Vitro Diagnostic Multivariate Index Assay (IVDMIA)« CE-Mark (fresh tissue and FFPE)	Clinical Laboratory Improvement Amendments (CLIA) + College of American Pathologists (CAP)-accredited ref lab	CE-Mark	CE-Mark FDA 510(k) Clearance

\$ Validated clinical data only available for this assay

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	70 gene signature (MammaPrint®) \$	21 gene Recurrence score (Oncotype DX®) \$	8 gene signature (Endopredict®) \$	PAM 50 (Prosigna®) \$
Prognosis after 5 yrs (late recurrences)	not separately shown	no	yes	yes
Predictive impact (chemotherapy benefit)	poorly validated	yes *	not shown	not shown
Prospective- retrospective evidence (% of recruited patients)	Multicenter validation	NSABP B-14 (14%) NSABP B-20 (28%) ECOG 9127 SWOG 8814 (40%) ATAC (30%)	ABCSG 6 (19%) ABCSG 8 (36%) GEICAM-9906 (45%) ATAC (10%)	MA.12 (59%) MA.5 (66%) ABCSG 8 (44%) ATAC (16%)
Prospective evidence (5-year DFS, OS)	MINDACT (N0, N1)	TAILOR _X (N0, low-risk, RS<11) PlanB (N0, high- risk/N+)	-	-

\$ Validated clinical data only available for this assay

* Trial performed before HER2 testing, HER2 positive patients may have been included

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Prospective Randomised Trials

(Oncotype DX [TailorX, PlanB], MammaPrint [MINDACT])

Prognosis in the low-risk group is for both tests favourable
(94% 5-Jahres DFS with adjuvant endocrine therapy only)

	TailorX	PlanB	MINDACT
Follow-up period	Median 69 mo	5-yr-DFS	Median 60 mo
Proportion of low risk patients (study population suitable for chemotherapy)	16 %	15.3 %	23.2 % (high clinical and low genomic risk)
Test failure rate	n.r.	2.9 %	26 % (fresh frozen tissue)
Proportion of intermediate risk patients (applies only to OncotypeDX)	67.3 %	60.4 %	n.a.
10-yr-follow up	----	----	----

Prognostic Factors III in Early Breast Cancer

Faktor	LoE ₂₀₀₉	CTS	AGO
➤ Disseminated tumor cells (DTC, in bone marrow)	I	B	+/-
➤ Circulating tumor cells (CTC, in blood, Cell Search®) \$	I	A	+/-
➤ CTC before NACT (regarding OS, DDFS, LRFI)	I ^a	B	+/-
➤ Therapy decisions based on CTC phenotypes	III	C	-
➤ Multigene assays			
➤ EndoPredoct®, Prosigna® (N0-1, HR+, Her2 -)	I	B	+*
➤ 70 gene signature (MammaPrint®) (N0-1)	I	A	+*
➤ Oncotype DX® (N0-1, HR+ HER2-, 5 Jahre)	I	A	+*
➤ IHC4 (central pathology published algorithm) #	I	B	+/-

* Should only be used in selected patients if all other criteria are inconclusive for therapeutic decision making

\$ Validated clinical data only available for this assay

Cuzick et al., J Clin Oncol 29: 4273-4278, 2011

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Neoadjuvant Systemic Chemotherapy Response Prediction I

Factor	CTS	LoE _{Ox2001}	GR	AGO
➤ Young age	B	1a	A	+
➤ cT1 / cT2 tumors o. N0 o. G3	B	1a	A	++
➤ Negative ER and PgR status	B	1a	A	++
➤ Triple negative breast cancer (TNBC)	B	1a	A	++
➤ Positive HER2 status	B	1a	A	++
➤ Non-lobular tumor type	B	1a	A	+
➤ Early clinical response	B	1b	A	+

Neoadjuvant Systemic Chemotherapy Response Prediction II

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Factor	LoE ₂₀₀₉	CTS	GR	AGO
➤ Multigene signature	III	C	B	+/-
➤ (Mammaprint, Endopredict Oncotyp Dx, PAM50 Prosigna^{\$})				
➤ Ki-67	I	B	A	+
➤ Tumor infiltrating lymphocytes*	I	B	B	+
➤ PIK3CA mutation	I	B	B	+/-
➤ gBRCA in TNBC	II	B	B	+

^{\$} validated clinical data only available for this assay

*defined as dense lymphocytic infiltration of inner peritumoral stroma outside of the invasion front (lymphocytes make up >50% of stroma area)

Predictive Factors – Endocrine Therapy

Factor	LoE _{Ox2001}	GR	AGO
➤ Endocrine therapy			
➤ ER/PgR status	1a	A	++
➤ IHC staining intensity (ER/PgR)	1a	A	+
➤ Tamoxifen			
➤ CYP2D6 polymorphism	2b	D	-
➤ Ovarian ablation			
➤ Menopausal status	1c	A	++
➤ Aromatase inhibitors vs. Tamoxifen			
➤ Menopausal status	1c	A	++
➤ ER/PgR/HER2 as single markers	1c	A	-
➤ Lobular subtype	2b	B	+
➤ Ki-67 high (published cutoffs > 11% and >14%)	2b	B	+/-
➤ Obesity (BMI >30 kg/m²)	2b	B	+/-

Predictive Factors – HER2 Targeted Therapy / Adjuvant Chemotherapy

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Factor	LoE _{Ox2001} (\$ LoE _{Ox2009})	GR (\$ CTS)	AGO
➤ Anti-HER2-Therapy			
➤ HER2	1a	A	++
➤ Adjuvant Chemotherapy			
➤ uPA/PAI1 (Femtelle®) ELISA \$	1a	A	+
➤ 21 gene recurrence score (Oncotype DX®) \$	I \$	B \$	+/-

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Prognostic Factors – Metastatic Breast Cancer

Factor	LoE ₂₀₀₉	CTS	AGO
<ul style="list-style-type: none"> ➤ Circulating tumor cells (CTC in blood, Cell Search[®]) <ul style="list-style-type: none"> ➤ Prognosis at baseline ➤ Early response assessment (3w) ➤ Therapy decision solely based on dynamics of CTC numbers over time or CTC phenotype 	I	A	+
	I	B	+
	I	A	-*

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* Study participation recommended

Prognostic and Predictive Factors (2/21)

Further information:

Data bases screened: Pubmed 2008 - 2016, ASCO 2003 – 2016, SABCS 2003 – 2016, Cochrane data base (n.d.)

Guidelines screened:

St. Gallen 2015: Coates AS, Winer EP, Goldhirsch A, Gelber RD, Gnant M, Piccart-Gebhart M, Thürlimann B, Senn HJ; Panel Members. Tailoring therapies--improving the management of early breast cancer: St Gallen International Expert Consensus on the Primary Therapy of Early Breast Cancer 2015. *Ann Oncol.* 2015 Aug;26(8):1533-46.

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Definition (3/21)

No further information

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Low Absolute Risk Implies Low Absolute Benefit (4/21)

No further information

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Quality Criteria (5/21)

No further information

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Elements of Tumor Marker Studies that Constitute Levels of Evidence Determination (6/21 and 7/21)

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Requirements of a Marker-Based test to Reach Level IB Evidence (8/21)

No further information

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Prognostic Factors I in Early Breast Cancer (9/21)

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Reproducibility (10/21)

No further information

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Prognostic Factors II in Early Breast Cancer (11/21 and 12/21)

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Prospective randomized trials (15/21)

No further information

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Neoadjuvant Systemic Chemotherapy – Response Prediction I (17/21)

No further information

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See general references

Neoadjuvant Systemic Chemotherapy – Response Prediction II (18/21)

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