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Brain Metastases Management: From Detection to Multidisciplinary Care

Announcer:

Welcome to CE on ReachMD. This activity is provided by Global Learning Collaborative and is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. O'Brien:

This is CE on ReachMD. I'm Dr. Barbara O'Brien, a neuro-oncologist from MD Anderson Cancer Center in Houston, Texas. Today I'll discuss management strategies for brain metastasis, focusing on breast cancer and non-small cell lung cancer.

Brain metastases are increasingly common in both breast cancer and non-small cell lung cancer, and management is evolving quickly. I'll focus today on practical day-to-day decision-making, particularly how we integrate systemic therapy with local approaches.

Brain metastases are the most common of intracranial tumors in adults, affecting up to 40% of patients with cancer.

Screening for brain metastasis is nuanced. In breast cancer, the guidelines don't recommend routinely screening for asymptomatic patients, but this is a hot topic and may change at some point down the road. We do maintain always a low threshold for screening, especially in HER2-positive breast cancer and triple-negative breast cancer because of the increased risk for these patients.

In non-small cell lung cancer, MRI is recommended in advanced disease, and in practice, any new neurologic symptoms should trigger brain imaging, regardless of the timing.

The guidelines still largely favor local therapy, but the big shift is in the growing role of CNS-active systemic therapy. When I'm assessing a patient, I first consider whether there's a systemic option and, if so, if this is the appropriate time to use that option. One of the insights from the current guidelines is that if systemic disease is stable, you don't necessarily switch systemic therapy. We may opt to treat the brain locally. But if disease is progressing, prioritizing a CNS-active regimen, if available is a consideration.

Now in terms of systemic therapy, this really is where things have changed dramatically in some subsets of patients. In HER2-positive disease, the TKI tucatinib, in combination with trastuzumab and capecitabine, and trastuzumab deruxtecan—which I'll refer to as T-DXd, the antibody-drug conjugate—showed meaningful intracranial responses in both brain metastases and LMD.

There is also emerging data for T-DXd in patients with HER2-low disease, which opens up systemic therapy options for brain metastasis to a much larger cohort of patients with breast cancer. And in non-small cell lung cancer, again, osimertinib and the ALK inhibitors have excellent CNS penetration and are the first line to consider in selected patients.

There are a number of factors that we consider when considering the treatment modality and sequencing these treatment modalities. These include, number one, the tumor biology, particularly the molecular subtype of the patient's cancer and whether we have one that is targetable. We also consider the number, the size, and the location of brain mets, whether they're located in what we call an eloquent area of the brain or an area of the brain that might tolerate some growth of a brain metastasis without creating symptoms.

We consider neurologic symptoms and deficits, the systemic disease status, whether the patient has active cancer systemically or whether things are stable; their treatment history, whether they've previously been treated with any form of CNS radiation or whether they've previously been exposed to TKI, ADCs, or any brain-penetrant treatment.

In terms of sequencing systemic and local therapy, this is evolving in terms of our thinking. But CNS-active systemic therapy, when available and rational, can, in some cases, defer or replace local therapy. And this is a time when multidisciplinary discussion, multidisciplinary alignment is really essential.

In terms of the timing with systemic therapy and radiation, we do tend to avoid concurrent therapy because, in theory, this may increase the risk of symptomatic radiation necrosis. So again, something that warrants multidisciplinary discussion.

So finally, brain metastasis care is evolving. There are an increasing number of targeted systemic options which have really been a huge breakthrough in managing patients with brain mets. Screening is nuanced. Systemic therapies, again, changing the paradigm. Sequencing options are evolving, and multidisciplinary care is critical.

I hope this brief lecture helps you stay ahead in your day-to-day practice. Thanks for listening.

Announcer:

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