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Gaining Ground on HER2-Low Breast Cancer Priorities: Shared Decision-Making in Practice

Announcer:
You're listening to *Project Oncology* on ReachMD. This episode is sponsored by Daiichi-Sankyo. Here's your host, Dr. Jacob Sands.

Dr. Sands:
This is *Project Oncology* on ReachMD. I'm Dr. Jacob Sands and joining me to share their insights on collaborative care for patients with HER2-low breast cancer are Dr. Sara Hurvitz and Dr. Paolo Tarantino. Dr. Hurvitz is a professor at the David Geffen School of Medicine at UCLA. She's also the Medical Director of the Jonsson Comprehensive Cancer Center Clinical Research Unit, and co-director of the Santa Monica UCLA outpatient oncology practice. Dr. Hurvitz, welcome to the program.

Dr. Hurvitz:
Thanks so much for having me.

Dr. Sands:
We're also joined by Dr. Paolo Tarantino, a researcher at the European Institute of Oncology and a clinical research fellow at the Dana Farber Cancer Institute in Boston. Dr. Tarantino, thank you for joining us.

Dr. Tarantino:
Thanks so much for the invitation. Very happy to join you.

Dr. Sands:
Dr. Hurvitz, let's start with you. From your vantage point, what are some initial considerations that factor into your treatment approach for patients with HER2-low breast cancer?

Dr. Hurvitz:
The HER2-low subtype is a relatively new classification or subclassification of breast cancer. Approximately two-thirds of patients with hormone receptor positive HER2 non-amplified breast cancer have low expression levels of HER2 by immunohistochemistry 1+ or 2+ and somewhere around a third of patients with triple negative breast cancer do.

We don't necessarily think that this is a biologically distinct subtype with a differing prognosis, for example, but we are seeing emerging data that perhaps you can target that low level of HER2 expression on the tumor cells with a HER2 targeted antibody drug conjugate, for example, and achieve responses. We're seeing some early phase data that somewhere around 30 to 40 percent of patients with HER2-low breast cancer may have tumor responses with the drug called T-DXd, or trastuzumab deruxtecan. At this point, targeting HER2-low breast cancer with the therapy that targets HER2 is considered experimental. It would only be appropriate in the context of a clinical trial.

Dr. Sands:
And Dr. Tarantino, let me turn to you with the same question. How do you approach treating patients with HER2-low breast cancer?

Dr. Tarantino:
So as perfectly explained by Dr. Hurvitz, we're talking here of an experimental subgroup and all of the treatments that are being developed are still experimental. And right now, most of the drugs that have shown compelling activity in this subgroup are in the metastatic setting, and they're mostly antibody drug conjugates. So although we do have some data for HER2-low early breast cancer, mostly with cancer vaccines, most of the interest right now is in the advanced metastatic setting.

And here the current definition is that HER2-low tumors are stained with 1+ or 2+ score with negative FISH assay for HER2. And these are called HER2. But the definition is also evolving, because we have recently seen that T-DXd, an anti-HER2 antibody drug conjugate was active also in tumors, at zero staining, zero scored tumors for HER2. I believe that with novel assays, the definition might evolve.

Dr. Sands:
And sticking with you for another moment, Dr. Tarantino, patients come in, of course, with different priorities such as wanting the drugs to work well is a common one, wanting to tolerate the drugs well is another common one. But what are some of the priorities you're seeing from patients? And how do you balance those?

Dr. Tarantino:
So it's very important to discuss each patient's priorities. And as I said, since the focus is mostly in the advanced metastatic setting, two very important priorities both for patients and physicians is to prolong survival and maintain the most of the quality of life during treatment. And of course, quality of life is sometimes a subjective feature, so it must be discussed with the patient. With most of these novel antibody drug conjugates, you can have toxicities. Sometimes they are chemotherapy related. You do have some patients with alopecia, you do have some patients with gastrointestinal adverse events, and neutropenia. You can have also some new side effects, not really chemotherapy related, we're still understanding them such as interstitial lung disease.

Dr. Sands:
And building on that, Dr. Hurvitz, how do you utilize shared decision-making in your practice when discussing with your patients?

Dr. Hurvitz:
Shared decision-making is so critical for we clinicians to embrace as we embark on making any treatment decision with the patient. As a clinician, we bring to the table our experience, our knowledge of clinical trial results, in terms of efficacy, as well as safety. But patients also bring something very important to the table; they bring their own set of priorities, their life wishes, what they would like to achieve in their time.

We have to keep in mind in the metastatic or advanced disease setting, patients are contending with a chronic incurable condition. And so, one patient may desire nothing more than to live long and prolong quantity of life. Whereas another patient may place a much higher priority on being out of the clinic and utilizing oral drugs or avoiding hair loss or avoiding GI toxicity which would get in the way with being at home doing what she wants to do or being at work.

So I think when we come together as clinician and patient, we need to bring this information to the table as a partnership. Sometimes that partnership also includes family of the patient, not just the patient. But as that partnership unfolds, good decisions can be made that keep in mind all of these important factors.

Dr. Sands:
For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Jacob Sands, and I'm speaking with Dr. Sara Hurvitz and Dr. Paolo Tarantino, about how we can incorporate shared decision-making into our treatment approach to HER2-low breast cancer.

Now, Dr. Hurvitz, obviously collaborative care goes beyond patient involvement. But what are some challenges you and your colleagues face when taking a multidisciplinary approach to care?

Dr. Hurvitz:
Yes, right now it is becoming increasingly challenging to incorporate multidisciplinary care. I mean, I think during the pandemic, we've faced a number of challenges. We're no longer meeting in person at tumor boards, for example, and that has limited our ability to collaborate with other specialists. But I think we've done a pretty good job of overcoming it, utilizing the electronic medical record to correspond with our subspecialty colleagues in radiation oncology and surgery. And very importantly, pathology.

Pathology is going to be a real key, a critical component of care of the patient. If we see the clinical validation of HER2 targeted therapies for HER2-low breast cancer, defining someone's tumor as HER2-low by immunohistochemistry can be challenging. There is a lot of interlaboratory variability with respect to IHC results. And so I think, a lot of open communication with our pathologists regarding results, and making sure they understand the importance of accuracy, if we're making clinical decisions based on pathology, is going to become more and more important.

Dr. Sands:
And just to bring all this together, before we close, I'd like to get some final thoughts from both of you on how to utilize shared decision-making in a more comprehensive way and also to coordinate care for patients with HER2-low breast cancer. Dr. Tarantino, let's start with you.

Dr. Tarantino:
Alright. It's really important to remember that all of the treatments for HER2-low breast cancer are experimental. And this means that they need to be administered within clinical trials. And clinical trials come with requirements in terms of access to the hospital, in terms sometimes of biopsies, and other activities related to clinical trials. And these might need to be explained to the patient. And it is an option that often adds one potential treatment to the course of disease. But also not all of the patients might be willing to adhere to the strict requirements and might prefer instead the flexibility of a standard treatment. And especially patients, for instance, living far from the clinical trial center, they might prefer instead of traveling for long distances, to receive treatments that have more flexibility. So this is very important to be discussed ahead of starting any treatment.

And then there's a part related to side effects because patient needs to be instructed, and also needs to know all of the main side effects of the treatment, potential experimental and standard treatment.

And for instance, in the case of novel antibody drug conjugates, for HER2-low disease, one that is emerging is interstitial lung disease. And this needs to be known both by the patient that needs to know that if he develops any symptom, like cough, like shortness of breath, it could be related to drug but also to the rest of the healthcare team that is caring for the patient, including primary care physicians and including all the rest of the staff.

Also, for instance, it's important for radiation oncologists to know that the patient is receiving a treatment that might cause interstitial lung disease, which might overlap with pneumonitis induced by radiotherapy, for instance. And also pulmonologists, for instance, are a great help in the diagnosis of ILD. And is not just related to ILD. With all of the side effects of these treatments, there is a multidisciplinary need to address them and to optimally manage them in order for the patient to be on the drug if he is experiencing a benefit as long as possible.

Dr. Sands:
And same question for you, Dr. Hurvitz. What are some strategies we can adopt to improve care coordination and optimize outcomes?

Dr. Hurvitz:
Yeah, I couldn't agree with Dr. Tarantino more. I think he covered it quite beautifully in his response. What I would add is that it is just incredible to me to sit back and observe the pace of clinical trial results coming out. And I think there's never been a time where paying attention to data as it emerges has been as important as it is now. I cannot believe how much information general medical oncologists who treat multiple tumor types must keep up with.

And so, I think it's CME activities and conferences are really critical, because the only way to inform patients about the safety and efficacy of a new therapy or emerging data coming out that might support clinical trial participation is if clinicians are keeping on top of the data as it emerges. So another key component to this multidisciplinary shared decision-making is the oncologist who's guiding the patient, being apprised of the data as it emerges. So I don't think that there's a more important time than there ever has been relating to the need for medical education activities.

Dr. Sands:
Thank you both for those closing remarks, as that brings us to the end of today's program. I want to thank my guests, Dr. Sara Hurvitz and Dr. Paolo Tarantino, for sharing their insights on incorporating shared decision-making into our treatment approach to HER2-low breast cancer. Dr. Hurvitz. Dr. Tarantino, wonderful having you both on the program.

Dr. Hurvitz:
Thank you so much.

Dr. Tarantino:
Thanks so much.

Announcer:
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