Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/project-oncology/sabcs-2023-a-look-into-new-research-for-inflammatory-breast-cancer/16287/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

SABCS 2023: A Look into New Research for Inflammatory Breast Cancer

Announcer:
You're listening to *Project Oncology* on ReachMD. On this episode, we'll hear from Dr. Filipa Lynce, who's the Director of the Inflammatory Breast Cancer Program at the Dana Farber Cancer Institute and an Assistant Professor of Medicine at Harvard Medical School. Today, she'll be discussing inflammatory breast cancer, which was the topic of her session at the 2023 San Antonio Breast Cancer Symposium.

Let's hear from Dr. Lynce now.

Dr. Lynce:
Inflammatory breast cancer is defined by the American Joint Committee on Cancer, 8th Edition, as a combination of very specific clinical criteria, so you need to have pathology reports confirming that a patient has invasive breast cancer. That's together with some typical findings that often include rapid onset of breast erythema, so the redness, edema sometimes, peau d'orange looking that it's similar to the looking of the skin of an orange. Often the breast is warm, larger than the other one. Very commonly there is no underlying palpable mass, and that's where people might have some challenges in making the diagnosis because you think about breast cancer and you think about the lump or a palpable mass, and that often does not happen in inflammatory breast cancer. It's also characterized by rapid evolution, so this is not the patient that says that she has some skin findings for the last two or three years. Very often the interval period between the first symptom to diagnosis of inflammatory breast cancer is less than six months, and very often we are talking about a month or so.

I think that this was a very exciting meeting for inflammatory breast cancer. We had not only experts dedicated to talk about the genomics of inflammatory breast cancer challenges associated with the radiation therapy and surgical approaches in inflammatory breast cancer, but also we had three IBC patient advocates who have very important roles in the community about bringing awareness about IBC being involved in research efforts. Some of the takeaways is that we still have a long road ahead of us in terms of determining what makes this disease, or if there's something that makes this disease genomically distinct, because we all agree that it's clinically distinct. We learned that all the data that we saw presented in terms of the escalation of local regional therapy at the moment does not apply to inflammatory breast cancer, and trimodality therapy remains the standard of care for patients with inflammatory breast cancer.

We learned with Dr. Lucci from MD Anderson about some of the unique challenges associated with surgery in inflammatory breast cancer and the risks of deescalating and why we are not there yet, and he spoke about the role of sentinel lymph nodes, immediate reconstruction, which both we should not do at the moment. How do we address patients that only have contralateral axillary lymph node disease and the data around the role of local regional therapy in metastatic inflammatory breast cancer?

We saw important data in terms of the role of immunotherapy in triple-negative inflammatory breast cancer. So we know that our patients with triple-negative inflammatory breast cancer were underrepresented in the studies that led to approval to immunotherapy in combination with chemotherapy in early-stage triple-negative breast cancer. So both as in collaboration with MD Anderson and an international consortium decided to look at this question, and we reported that the outcomes, in particular PCR for those undergoing surgery, is lower than what has been reported with KEYNOTE 522. So still better overall than what was historically reported but lower than what was reported in KEYNOTE 522, so approximately half the PCR rates that you saw with breast cancer patients in general, so more work needs to be done in this field.

We also saw some interesting data of the role of anthracyclines in HER2-positive inflammatory breast cancer. The question that we get all the time, whether these patients should receive the TCHP regimens or THPAC in the absence of a clinical trial for patients with inflammatory breast cancer, and this was as well a retrospective combined analysis between patients coming from MD Anderson, Dana-Farber, and Medical College of Wisconsin, and what the authors presented was that the non-anthracycline-containing regimen, so TCHP, resulted in no difference in PCR rates, which is good because we are moving along of using less anthracyclines, but it was associated with a shorter local regional recurrence-free survival, so something to have in mind, and it's the first data to compare both regimens that might be helpful when we are counseling our patients in the clinic.

We also saw an abstracted presented by Dr. Wendy Woodward and myself and many other co-authors looking at or reporting the first result of the validation process of the IBC scoring system, and people are very interested and see how this current system can discriminate between IBC and non-IBC.

Finally, we need more education for providers about how to identify IBC and what is the standard care. And we need to continue the work already initiated by our IBC patient advocates and so many other organizations about how do we increase awareness? How can patients advocate for themselves? So if they go to see a physician who says, "Oh, this is not inflammatory breast cancer," but how can the patient be informed that he or she can bring that to the discussion?

Announcer:
That was Dr. Filipa Lynce discussing inflammatory breast cancer. To access this episode and others in our series, visit *Project Oncology* on ReachMD dot com, where you can Be Part of the Knowledge. Thanks for listening!