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Quality assurance in breast cancer care and breast implant surgery

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CHAPTER 3

Current decisions on neoadjuvant chemotherapy for early breast cancer: Experts' experiences in the Netherlands

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ABSTRACT

Purpose: To evaluate the opinion of surgical and medical oncologists on neoadjuvant chemotherapy (NAC) for early breast cancer.

Methods: Surgical and medical oncologists (N=292) participating in breast cancer care in the Netherlands were invited for a 20-question survey on the influence of patient, disease, and management related factors on their decisions towards NAC.

Results: A total of 138 surgical and medical oncologists from 64 out of 89 different Dutch hospitals completed the survey. NAC was recommended for locally advanced breast cancer (94%) and for downstaging to enable breast conserving surgery (BCS) (75%). Despite willingness to downstage, 64% of clinicians routinely recommended NAC when systemic therapy was indicated preoperatively. Reported reasons to refrain from NAC are comorbidities (68%), age >70 years (52%), and WHO-performance status ≥ 2 (93%). Opinions on NAC and surgical management were inconclusive; while 75% recommends NAC to enable BCS, some stated that BCS after NAC increases the risk of a non-radical resection (21%), surgical complications (9%) and recurrence of disease (5%).

Conclusion: This article emphasizes the need for more consensus among specialists on the indications for NAC in early BC patients. Unambiguous and evidence-based treatment information could improve doctor-patient communication, supporting the patient in chemotherapy timing decision-making.

INTRODUCTION

Neoadjuvant chemotherapy (NAC) is an important initial strategy for the management of operable breast cancer (BC). In accordance with international guidelines, the Dutch national breast cancer guideline recommends NAC as an option for all patients aged <70 with an indication for systemic treatment, as similar overall and disease-free survival rates were demonstrated between preoperative and postoperative application of chemotherapy¹⁻⁴. These guidelines disclose that NAC may be used for large tumours (T3; >5cm) to increase resectability and the rate of breast conserving surgery and axillary preserving surgery⁵. Besides, chemotherapy prior to breast surgery remains a valuable therapeutic approach for the assessment of biological anti-tumour activity and clinical efficacy of new treatments⁶. Furthermore, administration of NAC creates a time frame for testing on hereditary breast cancer and planning the final type of surgery, for example reconstruction surgery.

Despite these arguments in favour of NAC, large national and international variation in the application of NAC is observed between hospitals^{7,8}. Previous research based on data from the NABON Breast Cancer Audit (NBCA) revealed that most variation between hospitals consists in the treatment of BC stage IIB with a national average of 40% NAC use. For BC stage III, the national average is 80%. After adjustment for patient and tumour factors associated with the use of NAC, including hospital study participation, a considerable unaccountable variation still remained between all 89 Dutch hospitals^{9,10}.

Additional factors, such as clinician preferences and the level of shared decision-making, may play a role in the application of NAC¹¹. Since it has been demonstrated that clinicians' treatment recommendations exert one of the most powerful influences over patients' preferences, the clinicians' opinion on NAC is therefore of great importance¹². Some specialists adhere firmly to their personal treatment preferences which may lie outside evidence of best practice or safety¹³. Consequently, differences in surgeons and medical oncologists' opinions may lead to unwanted variation in treatment patterns. As options of chemotherapy timing are in equilibrium for overall and disease-free survival, but NAC also yields several advantages, it is important to gain insight in the

observed variation of NAC application, as each patient indicated for NAC deserves a choice in chemotherapy timing.

The aim of this study is to evaluate the current opinion of surgical and medical oncologists in the Netherlands on the use of NAC and their decisions towards NAC in early breast cancer.

METHODS

Participants

On November 11, 2015, an invitation for an online survey was sent by mail to 575 surgical and medical oncologists, invited by the network of the NABON Breast Cancer Audit (NBCA), covering all Dutch hospitals that are involved in breast cancer care. A reminder was sent to non-respondents 3 weeks later and the survey was closed on January 8th, 2016.

Demographics of participating hospitals were derived from the NBCA dataset. The surgical volume of a hospital was defined as the mean annual number of breast cancer surgeries during the period 2011–2015; divided into low-volume (<150), mid-range (150–300) and high-volume (>300) categories. Type of hospital was described as academic, teaching, and general hospitals. Academic hospitals are part of a university, and both academic and teaching hospitals provide medical training to surgical residents.

Survey

The survey was developed by a multidisciplinary taskforce, including a medical oncologist, a breast cancer surgeon, a clinical epidemiologist and medical researchers. Hereafter, the survey was pre-tested and modified based on the obtained feedback. The survey consisted of 20 questions about (contra) indications and considerations for NAC and general information about the survey participants. Part one of the survey consisted of eight questions about commonly accepted indications and contraindications of NAC on the following categories: tumour characteristics (tumour size, stage and biology), patient characteristics (age, performance status and comorbidities) and clinical disease management (genetic testing and timing of final surgery) (**supplement 1**). The 5-point Likert scale was used to allow the respondent to express how much they agree or disagree. Part two of the survey consisted of four questions about other possible considerations that could influence the use of NAC (evidence in overall and disease-free survival benefit of NAC, axillary conservation surgery, risk of complications, risk of non-radical resections), using a yes/no scale. Throughout the survey there was the ability to write and add comments in the responses. To get an idea of the level of experience per specialist, demographic data, numbers of years in specialty, numbers of patients treated, and questions on study participation were included in the survey.

Statistical analysis

Frequencies and percentages were used to display responses to individual questions. Differences between surgical and medical oncologists' responses were analysed using Pearson chi-square. Statistical significance is defined as a two-sided p value <0.05. All analyses are performed in PASW Statistics version 24 (SPSS inc Chicago, IL, USA).

RESULTS

A total of 292 clinicians opened the online program, of whom 138 clinicians from 64 out of 89 Dutch hospitals completed the survey, leading to a response rate of 473%. Of 138 respondent clinicians, 70 surgical oncologists (43% female, 57% male) and 68 medical oncologists (59% female, 41% male) participated in the survey. The respondents had been in clinical practice for a median of 12 years (range 1-35). The number of annually treated breast cancer patients varied from 50 patients for medical oncologists (range 15-110) to 70 patients for surgical oncologists (range 30-110). The majority of clinicians included more than 10 patients in neoadjuvant chemotherapy trials per year. This survey represented two-third of Dutch hospitals; 22 hospitals had only one representative and 42 hospitals were represented by 2-7 representatives. Medical oncologists and surgical oncologists were evenly represented according to type and volume of hospitals (**Table 1**).

Survey

Respondents rated locally advanced breast cancer (LABC) as the most distinguished indication for NAC (94%). The second commonly accepted indication is down staging of the tumour to enable breast conserving surgery (75%). Of all respondents, 64% "always to frequently" recommended NAC if systemic therapy is indicated preoperatively, based on known clinical tumour characteristics (**Fig. 1A**). Reported reasons to refrain from NAC were WHO-performance status ≥ 2 (93%), comorbidities (68%), and age >70 years (52%) (**Fig. 1C and D**).

A WHO-performance score of ≥ 2 , which implies an inability to carry out any work activities, was reported as the most common contraindication. Age by itself was no contraindication according to 48% of respondents. But if so, patients aged <70

Table 1. Respondents' and affiliated hospital demographics.

	Surgeons (N=70)	Oncologists (N=68)	Hospitals (N=64)	P-value
Sex				
Male	40	28		0,106
Female	30	40		
n of yrs in practice				
<10	27	27		0,774
10 - 19	32	27		
20+	11	14		
n of patients per specialist/year				
<50	8	24		0,001
50 - 99	23	25		
100+	32	15		
n of patients per specialist included in NAC studies/year				
<10	21	12		0,001
>10	39	52		
Volume of hospital*				
<150	27	29	31	0,578
150-300	23	25	22	
>300	20	14	11	
Type of hospital*				
General-	19	22	24	0,281
Teaching hospital-	43	33	34	
Academic-	8	13	6	

*Derived from the NBCA-registry.

seemed to be the main reason for restrained application of NAC. Clinical management factors, such as the time necessary for testing on hereditary breast cancer or to plan the final type of reconstructive surgery, were less frequently denominated as indications for NAC (**Fig. 1B**).

In the second part of the survey, clinicians were asked about other considerations that could influence the use of NAC (**Table 2**). More than half of the respondents (60%), especially medical oncologist (83%), stated that the evidence in overall and disease-free survival benefits of NAC compared to adjuvant chemotherapy is not established yet (p-value: 0,015). While in the first part of the survey 75 percent of the respondents

mentioned increased breast conservation rate as an indication for NAC, a concern about non-radical resections is raised by 21% of the respondents (surgeons 29%, medical oncologists 15%, p-value: 0,078). A minor consideration in performing surgery after NAC was the increased chance of surgical complications (9%). Finally, in a relative high percentage of clinicians (63%), NAC is also being used to enable axillary conserving surgery.

In added comments, a frequently described benefit of neo-adjuvant therapy was the extra time for patient work-up for surgery, for example in case of controlling diabetes or smoking cessation. Reported barriers for recommending NAC were lack of patient cooperation, logistic challenges (for example a far travel distance to the hospital), a term pregnancy, oocyte preservation, or a patient's desire to undergo surgery first.

Table 2. Agreement with statements on NAC by responding surgeons and medical oncologists.

	YES	Surgeons (N=70)	Oncologists (N=68)	P-value
"NAC improves the chance of achieving axillary conservation surgery"	63%	70,8% (46)	62,9% (39)	0,346
"NAC increases the risk of surgical complications"	9%	13,3% (8)	6,9% (4)	0,247
"Breast conservation surgery after NAC increases the risk of a non-radical resection"	21%	29,2% (19)	15,8% (9)	0,078
"Breast conservation surgery after NAC increases the risk of recurrence"	5%	6,5% (4)	4,8% (3)	0,697
"There is no evidence for an overall and disease-free survival benefit of NAC compared to AC"	60%	62,3% (33)	82,8% (48)	0,015

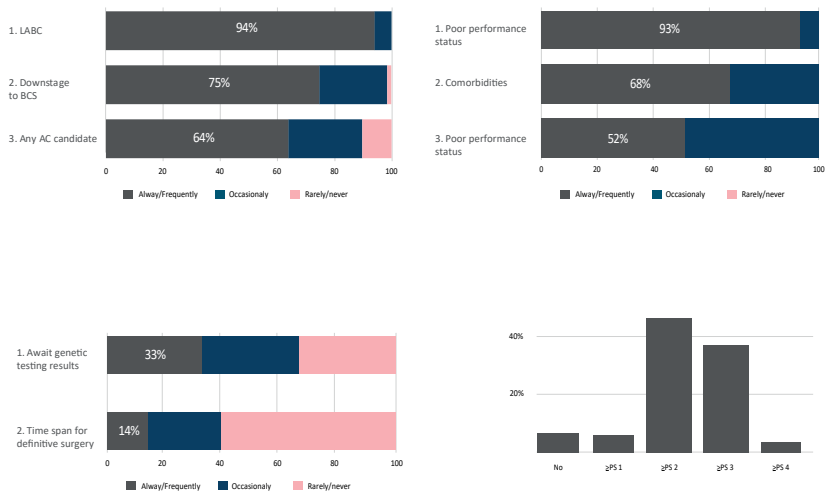


Figure 1A. Reported indications (tumour characteristics) for recommending NAC.

Figure 1B. Reported indications (clinical management factors) for recommending NAC.

Figure 1C. Reported contraindications (patient characteristics) for recommending NAC.

Figure 1D. Most common reported contraindication: performance status ≥ 2

DISCUSSION

This survey depicts the opinion of 138 Dutch surgical and medical oncologists from 64 out of 92 hospitals in the Netherlands on NAC in BC. Despite an international trend of increasing implementation for NAC in patients with early BC and the relatively high standard of care in the Netherlands, considerable variation in the use of NAC still exists between hospitals.

Respondents rated LABC as the most distinguished indication for NAC, in accordance with Dutch and international breast cancer guidelines¹². In addition, the St. Gallen Breast Cancer Conference, that focuses exclusively on the primary therapy of early breast cancer, recommends to consider NAC based on tumour biology^{14,15}. Our survey demonstrates that only 64% of clinicians recommends NAC instead of adjuvant chemotherapy when systemic therapy is indicated based on tumour biology. The actual NAC use is even lower based on NBCA-data (40% in BC stage II). With the increased evidence that subgroups of patients that achieve pCR after NAC do have a better prognosis in terms of disease-free and overall survival, NAC should nowadays be considered as a preferred option in the treatment of high risk triple negative BC and HER2 BC^{3,4,16}.

Another commonly accepted indication for NAC - confirmed by our survey - is to increase the chance of breast conservation surgery (BCS) without compromising the local recurrence rate. The ESMO guidelines on primary breast cancer advice primary systemic therapy in locally advanced and large operable cancers to allow for achieving operability or decreasing the extent of surgery¹⁷. In our survey, 75% of respondents recommend NAC to enable BCS. Contradictory, a relatively high percentage of 21% of respondents argued that BCS after NAC increases the risk of non-radical (i.e. resection with positive margins) resections. The restraint to use NAC to enable BCS may arise from the challenge for surgeons to determine the extent and original location of the residual lesion after NAC. More recently than our survey, a nationwide Dutch pathology study showed tumor-involved margins in 24.3% patients after BCS after NAC, compared to 103% after primary BSC¹⁸. According to Dutch National guidelines, a tumor-free margin is defined as the absence of tumor cells at the inked margins. Although surgical experiences have been improved by the introduction of iodine-125

seeds and ultrasound guided surgery, monitoring and localization techniques are still under research¹⁹. It is likely that clinicians' decisions towards NAC are mainly driven by surgical management goals, rather than tumour biology and survival.

Other incentives to consider NAC, such as time necessary for testing on hereditary breast cancer, are less frequently denominated as indication of importance. Only 33% of the clinicians recommends NAC to await genetic testing results, while the discovery of a BRCA1/2 mutation may influence treatment strategies. Also, extra time for patient work-up to plan the final type of reconstructive surgery is less frequently considered important. However, NAC has the potential for improving cosmetic outcomes in oncoplastic surgery²⁰. Another important consideration described by clinicians in favour of chemotherapy prior to breast surgery is the possibility to assess anti-tumour activity and clinical efficacy of new treatments in neoadjuvant chemotherapy trials²¹.

The survey also revealed concerns that prevented clinicians from recommending NAC. A patients' WHO-performance status of ≥ 2 was stated most frequently as reason to refrain from NAC, rather than advanced age. This is consistent with the idea that older patients, when selected correctly, can be treated safely with chemotherapy and that age only is no reason to refrain²². Although it can be questioned if these 138 experts represent the major opinion of NAC for breast cancer in the Netherlands, the main strength of this survey is that the respondents reflect practice preferences of 64 out of 89 Dutch hospitals: which means a 72% nationwide coverage, which stands for the treatment of almost 15.000 patients annually¹⁰. If this survey would be repeated, we expect same differences in opinions between experts' to be demonstrated. However, surveys rely heavily on the respondents' memory and opinion, thus bias should always be kept in mind when interpreting survey results.

CONCLUSION

Considerable variation exists in expert opinions on NAC for early breast cancer. This article highlights the complexity of decision making for early breast cancer patients and it emphasizes the need for more consensus among specialists on the indications for NAC in early BC patients.

Practice implications

The results of this survey highlight the importance of dynamic updates of reliable clinical practice guidelines, to standardize and ensure medical quality and safety. In other words: not only clinicians' awareness on multiple arguments in favour of the use of NAC could be improved, but also the sharing of considerations and experiences - as this brief report detailing clinical practices of Dutch surgical and medical oncologists - will speed up and clarify the implementation of NAC in early breast cancer. Ultimately, it is important that patients receive unambiguous and evidence-based treatment information in order to take part in a useful process of shared decision-making. The authors do not necessarily advocate that every patient should receive NAC; however, every patient eligible to NAC should receive a choice in chemotherapy timing. Another work by our group describes how patients perceived the choice in chemotherapy timing²³.

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SUPPLEMENT 1

20-question survey on the influence of patient, disease, and management related factors on decisions towards NAC.

General Information

1. What institute do you work for?
2. Are you working in an affiliated or other institute as well?
3. Sex m/v
4. Age
5. Specialism: surgeon / medical oncologist / other
6. Number of years in practice in current specialism (training excluded)
7. Number of new patients diagnosed with breast cancer treated per year

Diagnostics

8. Are the following diagnostic modalities typically applied prior to the commence of neoadjuvant chemotherapy (NAC)?

MRI Never – Rarely – Sometimes – Often – Always

PET-CT Never – Rarely – Sometimes – Often – Always

Add comments

PART I. Indications and contraindications of NAC

9. Which items do you consider to be indications for the use of neoadjuvant chemotherapy (NAC)?

"Locally advanced disease (stage III)"

Never – Rarely – Sometimes – Often – Always

"Downstage to breast conserving surgery"

Never – Rarely – Sometimes – Often – Always

"Any adjuvant chemotherapy candidate / systemic therapy is indicated preoperatively"

Never – Rarely – Sometimes – Often – Always

"Await genetic testing results"

Never – Rarely – Sometimes – Often – Always

"Time span for definitive surgery"

Never – Rarely – Sometimes – Often – Always

Other/ add comments

10. Other / missing indications?

11. Ranking from 1 – 6 (most – less important) indication for neoadjuvant chemotherapy (NAC):

- Locally advanced disease (stage III)
- Downstage to breast conserving surgery
- Any adjuvant chemotherapy candidate /
- systemic therapy is indicated preoperatively
- Awaiting genetic testing results
- Time span for definitive surgery

12. Do you consider age to be a contraindication for the use of neoadjuvant chemotherapy (NAC)?

- No, age alone is no contraindication
- Yes, for patients aged <55
- Yes, for patients aged <60
- Yes, for patients aged <65
- Yes, for patients aged <70
- Yes, for patients aged <75

13. Do you consider the presence of comorbidities to be a contraindication for the use of neoadjuvant chemotherapy (NAC)?

According to the Charlson Index Scale:

- No, comorbidities are no contraindication
- Yes, for cardiac disease
- Yes, for vascular disease
- Yes, for pulmonary disease
- Yes, for neurological disease
- Yes, for gastrointestinal disease
- Yes, for urogenital disease
- Yes, for thrombotic disease
- Yes, for muscle and joint disease
- Yes, for endocrine system disease

Other/ add comments

14. Do you consider a poor performance status (PS) to be a contraindication for the use of neoadjuvant chemotherapy (NAC)?

According to the ECOG/WHO Performance Scale:

- No, a poor performance status is no contraindication
- Yes, if PS=0 – Asymptomatic (Fully active, able to carry on all predisease activities without restriction)
- Yes, if PS=1 – Symptomatic but completely ambulatory (Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature. For example, light housework, office work)
- Yes, if PS=2 – Symptomatic, <50% in bed during the day (Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours)
- Yes, if PS=3 – Symptomatic, >50% in bed, but not bedbound (Capable of only limited self-care, confined to bed or chair 50% or more of waking hours)
- Yes, if PS=4 – Bedbound (Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair)

15. Ranking from 1 – 3 (most – less important) contraindication:

- High age
- Comorbidities
- Poor performance status

15. Other / missing contraindications?

Part II. Other considerations that could influence the use of NAC

16. To what extent do you agree or disagree with the following statements?

“NAC improves the chance of achieving axillary conservation surgery”

Agree/Disagree

“NAC increases the risk of surgical complications”

Agree/Disagree

“Breast conservation surgery after NAC increases the risk of a non-radical resection”

Agree/Disagree

“Breast conservation surgery after NAC increases the risk of recurrence”

Agree/Disagree

“There is no evidence for an overall and disease-free survival benefit of NAC compared to AC”

Agree/Disagree

Add comments

Final section about study participation and interests

18. Number of new patients included in trials a year (national and international level)

>10 or <10

Other/ add comments

19. Do you visit one of the following conferences on a regular base?

- SABCS
- Bossche mammadagen (Dutch conference - annual conference for breast surgeons and medical oncologists)
- EBCC
- St. Gallen
- Chirurgendagen (Dutch conference – annual conference for surgeons in general)
- No, I never visit one of these conferences

Other/ add comments

20. Possibility to add any questions or comments

