



**Universiteit
Leiden**
The Netherlands

Variation in use of neoadjuvant chemotherapy in patients with stage III breast cancer: results of the Dutch national breast cancer audit

Spronk, P.E.R.; Bommel, A.C.M. van; Siesling, S.; Wouters, M.W.J.M.; Peeters, M.T.F.D.V.; Smorenburg, C.H.

Citation

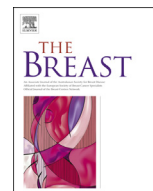
Spronk, P. E. R., Bommel, A. C. M. van, Siesling, S., Wouters, M. W. J. M., Peeters, M. T. F. D. V., & Smorenburg, C. H. (2017). Variation in use of neoadjuvant chemotherapy in patients with stage III breast cancer: results of the Dutch national breast cancer audit. *Breast Journal*, 36, 34-38. doi:10.1016/j.breast.2017.08.011

Version: Publisher's Version

License: [Creative Commons CC BY 4.0 license](https://creativecommons.org/licenses/by/4.0/)

Downloaded from: <https://hdl.handle.net/1887/4255613>

Note: To cite this publication please use the final published version (if applicable).



Original article

Variation in use of neoadjuvant chemotherapy in patients with stage III breast cancer: Results of the Dutch national breast cancer audit



P.E.R. Spronk ^{a,*}, A.C.M. van Bommel ^a, S. Siesling ^{b,c}, M.W.J.M. Wouters ^d,
M.T.F.D. Vrancken Peeters ^d, C.H. Smorenburg ^e

^a Department of Surgery, Leiden University Medical Centre, Leiden, The Netherlands

^b Department of Research, Comprehensive Cancer Centre the Netherlands (IKNL), Utrecht, The Netherlands

^c Department of Health Technology and Services Research, MIRA Institute for Biomedical Science and Technical Medicine, University of Twente, Enschede, The Netherlands

^d Department of Surgery, Antoni van Leeuwenhoek, Amsterdam, The Netherlands

^e Department of Medical Oncology, Antoni van Leeuwenhoek, Amsterdam, The Netherlands

ARTICLE INFO

Article history:

Received 24 February 2017

Received in revised form

23 August 2017

Accepted 28 August 2017

Keywords:

Breast cancer

Surgery

Neoadjuvant chemotherapy

Neoadjuvant therapy

Guideline compliance

Cancer registry

Quality of care

Study participation

Clinical auditing

ABSTRACT

Objectives: Neoadjuvant chemotherapy (NAC) is important in the optimal treatment of patients with locally advanced (stage III) breast cancer (BC). The objective of this study was to examine the clinical practice of NAC for stage III BC patients in all Dutch hospitals participating in BC care.

Materials and methods: All patients aged 18–70 years who received surgery for stage III BC from January 2011 to September 2015 were selected from the national multidisciplinary NABON Breast Cancer Audit. Multivariable logistic regression was used to assess independent predictors of NAC use, focussing on hospital factors.

Results: A total of 1230 out of 1556 patients with stage III BC (79%) received NAC prior to surgery. The use of NAC did not change over time. We observed a large variation of NAC use between hospitals (0–100%). Age <50 years, breast MRI, large tumour size, advanced nodal disease, negative hormone receptor status and hospital participation in neoadjuvant clinical studies were significant independent predictors of NAC use (all $P < 0.001$). NAC use in stage III BC was not influenced by hospital type and hospital surgical volume. After adjustment for all independent predictors, variation in NAC use between hospitals remained (0% to 97%).

Conclusion: NAC was used in 79% of patients with stage III BC, which represent a high quality of care in the NL. Patient, tumour, clinical management and hospital factors could not explain considerable variation in its use between hospitals. Hospital participation in neoadjuvant studies did show to improve the use of NAC in daily practice.

© 2017 Elsevier Ltd. All rights reserved.

1. Introduction

Locally advanced or stage III breast cancer (BC) is defined as a bulky tumour of the breast and/or extensive nodal disease. The prognosis of stage III BC is worse than early stage disease showing a ten-year overall survival in only 56% of patients [1]. As multi-modality treatment improves the outcome of Stage III BC, neoadjuvant chemotherapy (NAC) has become an important initial

treatment strategy. NAC aims to downsize the tumour to improve the possibility of a radical resection or even to enable breast conservation surgery [2–4]. Other potential advantages of NAC include the opportunity to investigate tumour biology, to monitor response and adapt to suboptimal response. Several studies have demonstrated that NAC, when compared to adjuvant chemotherapy, leads to similar overall and disease-free survival [5–8] and may even improve survival in triple-negative and HER2 positive BC subtypes when pCR is achieved [9]. In accordance with international guidelines [10,11], the Dutch national breast cancer guideline recommends NAC for patients with stage III BC aged <70 years [12].

The NABON Breast Cancer Audit (NBCA) is a multidisciplinary nationwide registry of all diagnostic and treatment modalities of

* Corresponding author. Department of Surgery, Leiden University Medical Centre, DICA, Poortgebouw Zuid 1e etage, Rijnsburgerweg 10, 2333 AA, Leiden, The Netherlands.

E-mail address: p.spronk@dica.nl (P.E.R. Spronk).

patients who are surgically treated for BC in the Netherlands since 2011. This audit provides the opportunity to gain insight into patterns of practice in different hospitals by creating a national benchmark. Knowledge of variation in the use of NAC for stage III BC and the reasons for this variation may help in bringing down barriers to use upfront chemotherapy and to improve outcome in these patients. The objective of the present study was therefore to examine the use of NAC in patients with stage III BC in the Netherlands and to assess which patient, tumour and hospital related factors influence clinical practice.

1.1. Patients and methods

The NBCA is a nationwide registry that captures 100% of all newly diagnosed and surgically treated breast cancer patients in the Netherlands. We selected data from the NBCA database on all patients aged 18–70 years diagnosed with stage III BC (clinical cT1–4N2, cT3N1–3, cT4N0, M0) from January 2011 to September 2015. In the given time frame, 63,315 patients with invasive breast cancer are registered in the NBCA, which means a proportion of 2,46% stage III patients aged 18–70 years. Tumour stage was defined according to the 7th edition of the International Union Against Cancer tumour node metastasis (TNM) classification [13]. We excluded patients with a prior cancer diagnosis or unknown sequence of chemotherapy and surgery. Patients aged 70 years and older were also excluded, because the use of NAC is not considered standard treatment in the elderly [12]. Patients who received both neo-adjuvant- and adjuvant chemotherapy were not excluded from this study.

1.2. Construction of variables

The primary outcome of the study was the use of NAC, defined as chemotherapy given within four weeks prior to surgery, for stage III BC in the different hospitals in the Netherlands. The hospital of treatment was defined as the hospital where the first therapeutic surgical intervention was conducted. Available data from the NBCA dataset regarding the use of NAC includes factors of the patient (year of incidence, age), the tumour (histologic subtype, clinical tumour stage, clinical nodal stage and hormone receptor status), clinical management and various hospital related factors. 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. Between 2011 and 2015, there were three clinical trials regarding neoadjuvant therapy in which participation was possible: NEO-ZOTAC, TRAIN-2 and TEAM IIa [14]. Information on tumour grade was excluded, because of missing data.

1.2.1. Statistical analysis

The Pearson's Chi-square test was applied to test associations of the use of NAC and the covariates in the entire study population. A multivariable logistic regression model was used to determine whether patient, tumour, clinical management and hospital factors were independent predictors associated with the odds of receiving NAC in comparison with patients who were treated only surgically with our without adjuvant therapy. The multivariable logistic regression model was used to quantify the percentage of NAC in daily practice and to reveal the variation among the 89 Dutch hospitals adjusted for the predictors [15]. Statistical significance was defined as a two-sided p value < 0.05. All analyses were

performed in PASW Statistics version 20 (SPSS inc Chicago, IL, USA).

2. Results

We identified 1556 surgically treated patients with stage III BC aged 18–70 between 2011 and 2015 in the Netherlands. A total of 1230 patients (79%) with stage III BC received NAC. The rate of NAC did not significantly change over time.

Table 1a shows the patient, tumour and clinical management factors according to the use of NAC. The median age of patients with stage III disease was 51 years (range 19–70 years). The median age of treated patients in general hospitals was 53.0 years compared to 51.4 years in teaching hospitals and 49.1 years in academic hospitals ($p < 0.001$). In case a breast MRI was performed or when the patient had been discussed in a preoperative MDT, a significantly higher rate of NAC use was observed (84% versus 57%, $p < 0.001$; 79% versus 68%, $p = 0.038$). Of notice, a total of 227 patients (87%) in which a breast conservation surgery was performed, received NAC compared to 1003 patients (77%) in which a mastectomy was performed ($p < 0.001$).

Hospital factors regarding NAC use are depicted in Table 1b. The median number of surgically treated patients with stage III BC per hospital was 15 (range 2–99). Significant more patients in academic hospitals received NAC (88%) as compared to patients in teaching hospitals (79%) or in general hospitals (75%) ($p < 0.001$). The use of NAC in hospitals participating in neoadjuvant clinical studies was significantly higher (83%) than in hospital not doing so (73%) ($p < 0.001$).

To determine the independent predictors of NAC use, a multivariable logistic regression analysis was conducted (Table 2). Age <50 years, breast MRI, large tumour size, advanced nodal disease,

Table 1A

Factors of patient, tumour and clinical management regarding the use of neo-adjuvant chemotherapy (NAC) in patients with stage III breast cancer ($n = 1556$).

		Stage III (n)	NAC		P-value
			(n)	%	
Year of incidence	2011	204	158	77%	0,283
	2012	306	244	80%	
	2013	357	271	76%	
	2014	377	299	79%	
	2015	312	258	83%	
Age	<40	162	137	85%	0,000
	40–50	547	462	84%	
	50–60	470	362	77%	
	60–70	377	269	71%	
Histologic subtype	ductal	1293	1044	81%	0,000
	lobular	263	186	71%	
Clinical tumor stage	cT1	20	7	35%	0,000
	cT2	48	31	65%	
	cT3	995	768	77%	
	cT4	493	424	86%	
Clinical nodal status	cNx/N0	116	85	73%	0,000
	cN1	1250	992	79%	
	cN2	95	64	67%	
	cN3	95	89	94%	
Hormone receptorstatus	triple -	235	200	85%	0,000
	HR – HER2+	171	152	89%	
	HR + HER2+	214	165	77%	
	HR + HER2-	936	713	76%	
Preoperative MDT	No	60	41	68%	0,038
	Yes	1496	1189	79%	
Breast MRI	No	284	162	57%	0,000
	Yes	1272	1068	84%	
Type of surgery	BCS	260	227	87%	0,000
	Mastectomy	1296	1003	77%	

MDT = multidisciplinary team.

BCS = breast conservation surgery.

Table 1B

Factors on hospital level regarding the use of neoadjuvant chemotherapy (NAC) in patients with stage III breast cancer (n = 1556).

		Hospitals (n)	Stage III (n)	NAC		P-value
				(n)	%	
Type of hospital	General	37	390	291	75%	0,001
	Teaching	43	957	755	79%	
	Academic	9	209	184	88%	
Hospital surgical volume	<150	44	455	348	76%	0,148
	150–300	34	692	547	79%	
	>300	11	409	335	82%	
PET-CT available	No	56	700	538	77%	0,055
	Yes	33	856	692	81%	
Hospital study participation	No	48	604	440	73%	0,000
	Yes	41	952	790	83%	

Table 2

Multivariable logistic regression of the use of neoadjuvant chemotherapy (NAC) in patients with stage III breast cancer (n = 1556).

		OR	95% C.I.		Sig.
			Lower	Upper	
Age	<40	ref.			0,000
	40–50	1,12	0,679	1849	
	50–60	0,677	0,41	1118	
	60–70	0,458	0,275	0,762	
Histologic subtype	ductal	ref.			0,021
	lobular	0,674	0,482	0,942	
Clinical tumor stage	cT1	0,091	0,025	0,337	0,000
	cT2	0,228	0,078	0,664	
	cT3	ref.			
	cT4	2,46	1,653	3,662	
Clinical nodal status	cN0	0,398	0,227	0,698	0,000
	cN1	ref.	1,195	4,19	
	cN2	1,671	0,671	4,158	
	cN3	5,13	1,734	15,178	
Hormone receptorstatus	triple -	ref.			0,004
	HR -, HER2+	1,502	0,8	2,821	
	HR+, HER2-	0,675	0,445	1,025	
	HR+, HER2+	0,567	0,342	0,94	
Preoperative MDT	No	ref.			0,495
	Yes	1,927	1,043	3,559	
Type of hospital	General-	ref.			0,058
	Teaching-	1,04	0,708	1,527	
	Academic-	1,824	1,042	3,194	
Hospital surgical volume	<150	ref.			0,999
	150–300	1,01	0,674	1,515	
	>300	1,013	0,596	1,721	
PET-CT available	No	ref.			0,517
	Yes	0,881	0,6	1,293	
Study participation	No	ref.			0,000
	Yes	1,832	1,366	2,457	

MDT = multidisciplinary team.

negative HR status and hospital participation in neoadjuvant clinical studies remained significant (all $p < 0.001$). Hospital type and hospital surgical volume were not independently associated with the use of NAC.

The variation between hospitals in the Netherlands in the percentage of patients with stage III BC receiving NAC during 2011–2015 is depicted in Fig. 1. The median is 48,3% and a large variation in its use was observed (0–100%). After adjusting for independent predictors according to our multivariable model, the rate of NAC per hospital over the period 2011–2015 were modified from minus 8,9% to plus 22%. One hospital with only two patients with stage III BC, neither of whom received NAC, accounted for the number of 0%. According to the 95% confidence interval (CI), three hospitals were negative outliers (significant lower rates than average).

3. Discussion

In this nationwide population-based study from 2011 to 2015 in the Netherlands, we observed that 1230 out of 1556 of women aged 18–70 years with stage III BC (79%) were treated with NAC prior to surgery. Various recent studies reveal an international trend on the increasing implementation for NAC in patients with BC. The high rate of NAC in The Netherlands did not significantly change over time. Our data compare favourably with those reported from cancer registries in other countries. For stage III BC, Mougalian et al. used data from the National Cancer Data Base of America and reported a mean use of NAC in 41.6% of 71,433 patients during 2003–2011, while they observed an increase to 59.3% in 2011 [16]. Recent studies from the United States on patients with all stages of BC showed a major increase in the use of NAC during the last decade, with a proportion of 10–20% of BC patients treated with NAC [2,17]. A similar increase was seen in a population study of 10 Dutch hospitals in which the use of NAC for BC increased from 2.5% in 2003 to 13% in 2012 [18]. During this time span, the use of NAC for cT3 BC increased from 30.6% to 70.9%. A French survey reported the use of NAC in 16.3% of patients with BC in 2010, but data on stage of disease were incomplete [19].

In line with other studies [16,17,20]; we found the following predictive patient and tumour factors for the use of NAC in patients with BC: young age, large tumour size, advanced nodal disease and a negative hormone receptor status. Going beyond the scope of prior studies, we also assessed factors at hospital level and observed that the surgical volume and type of hospital was not independently associated with the use of NAC in the Netherlands. This has been previously observed by a study in the Netherlands on variation in adjuvant chemotherapy [19] and is presumably due to the consultancy of experts in oncology meetings between academic, teaching and general hospitals. Of notice, we observed a significantly higher use of NAC in hospitals participating in neoadjuvant clinical studies (83% versus 73%). Study participation is an instrument of cultural change. It creates more awareness among physicians and it narrows the gap between the best available evidence and current practice. Moreover, it also requires an adjustment of the current pattern of care and may facilitate the implementation of new therapeutic concepts.

Variation in the use of NAC between hospitals is in line with international literature [16,20], except that these studies did not adjust for hospital related factors and did not exclude patients >70 years of age with possible contraindications [2,16,20]. After adjustment according to our multivariable model, we observed a constant proportion of 77% and considerable variation between 89 hospitals remained.

The preferences of both patient and clinician and the level of shared decision-making may be important factors in the decision to

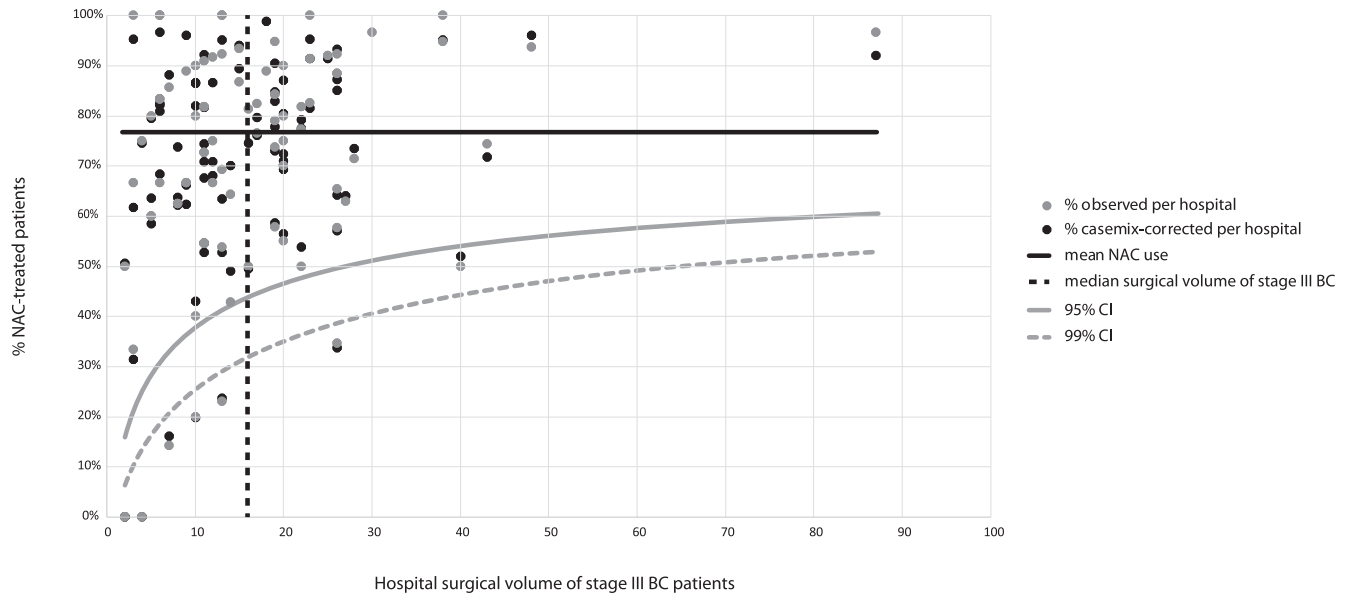


Fig. 1. Variation between hospitals in the use of neoadjuvant chemotherapy (NAC) in patients with stage III breast cancer ($n = 1556$) in the Netherlands in 2011–2015.

use or to refrain from NAC. It may be possible that many women prefer to undergo surgery first because of an incorrect idea of delayed surgery or because of a preference for mastectomy (in combination with a reconstruction). Patients may not realise that neoadjuvant treatment is a viable choice. It has been demonstrated that clinicians' treatment recommendations and preferences exert one of the most powerful influences over patients' decisions [21,22].

Valid options to refrain from NAC may be a contraindication for chemotherapy such as poor performance status or severe comorbidity, or the choice for neoadjuvant hormonal therapy in low-grade highly endocrine-sensitive BC. Other factors such as under capacity or financial incentives could negatively affect the implementation of NAC. In-hospital factors such as the level of training of physicians, the composition of MDT meetings and an integrated oncological care pathway for BC may also account for discrepancies between hospitals [23,24]. Confirmed by our univariate analyses, preoperative MDT is significantly associated with NAC use.

The main strength of the present study is the multivariable adjustment for hospital case mix, including factors regarding patient, tumour, clinical management and hospital level. Additionally, because our data covers all surgically treated BC patients in the Netherlands we can more reliably understand clinical practice. Unfortunately, we had no data available regarding the reason why NAC was omitted, such as patient performance status, comorbidities, genetic risk factors and other treatment decision-making factors.

In conclusion, our study shows that NAC is being used in 79% of patients with stage III BC, which stands for high quality of care compared to the international percentages of NAC use reported. Still, 21% of patients did not receive NAC prior to surgery. After adjustment for all independent predictors of NAC, a considerable variation remained between hospitals. Hospital participation in neoadjuvant clinical studies may be a major factor contributing to a more rapid implementation of NAC in daily practice.

We have deployed further research to examine the role of patient- and specialist preferences in shared-decision making on NAC in patients with BC.

Funding

This work was supported by a grant from the Dutch Cancer Society [grant number 2014–7106].

Ethical consent and the standards of animal care

Ethical approval was not required.

Disclosure

The authors have declared no conflicts of interest.

Acknowledgements

We would like to thank the Dutch Cancer Society (KWF) for their financial support and we would like to thank all data managers of the IKNL, surgeons, physician assistants and administrative nurses who registered all the patients in the NABON Breast Cancer Audit (NBCA).

References

- [1] Netherlands Cancer Registry. Available at: <http://www.cijfersoverkanker.nl> [TNM 6th ed. 2003–2009].
- [2] Killelea BK, Yang VQ, Mougalian S, Horowitz NR, Pusztai L, Chagpar AB, et al. Neoadjuvant docetaxel in breast cancer increases the rate of breast conservation: results from the national cancer database. *J Am Coll Surg* 2015;220:1063–9.
- [3] Heys SD, Hutcheon AW, Sarkar TK, Ogston KN, Miller LD, Payne S, et al. Neoadjuvant docetaxel in breast cancer: 3-year survival results from the Aberdeen trial. *Clin Breast Cancer* 2002;3:69–74.
- [4] Makris A, Powles TJ, Ashley SE, Chang J, Hickish T, Tidy VA, et al. A reduction in the requirements for mastectomy in a randomized trial of neoadjuvant chemohormonal therapy in primary breast cancer. *Ann Oncol* 1998;9:1179–84.
- [5] Mieog JSD, van der Hage JA, van de Velde CJH. Neoadjuvant chemotherapy for operable breast cancer. *Br J Surg* 2007;94:1189–200.
- [6] Wolmark N, Wang J, Mamounas E, Bryant J, Fisher B. Preoperative chemotherapy in patients with operable breast cancer: nine-year results from National Surgical Adjuvant Breast and Bowel Project B-18. *J Natl Cancer Inst Monogr* 2001;15212:96–102.
- [7] Rastogi P, Anderson SJ, Bear HD, Geyer CE, Kahlenberg MS, Robidoux A, et al. Preoperative chemotherapy: updates of national surgical adjuvant breast and

- bowel project protocols B-18 and B-27. *J Clin Oncol* 2008;26:778–85.
- [8] Peintinger F, Symmans WF, Gonzalez-Angulo AM, Boughey JC, Buzdar AU, Yu TK, et al. The safety of breast-conserving surgery in patients who achieve a complete pathologic response after neoadjuvant chemotherapy. *Cancer* 2006;107:1248–54.
 - [9] Cortazar P, Zhang L, Untch M, Mehta K, Costantino JP, Wolmark N, et al. Pathological complete response and long-term clinical benefit in breast cancer: the CTNeoBC pooled analysis. *Lancet* 2014;384:164–72.
 - [10] Holmes D, Colfry A, Czerniecki B, Dickson-Witmer D, Francisco Espinel C, Feldman E, et al. Guideline for the use of neoadjuvant systemic therapy in the management of breast cancer. *Ann Surg Oncol* 2015;10:3184–90.
 - [11] Cardoso F, Costa A, Norton L, Senkus E, Aapro M, Andre F, et al. ESO-ESMO 2nd international consensus for advanced breast cancer (ABC2). *Breast* 2014;23:489–502.
 - [12] Dutch national breast cancer guideline. Available at: <http://www.oncoline.nl/mammacarcinoom> [Version 2.0, 2012].
 - [13] Sobin LHCW. TNM classification of malignant tumours. seventh ed. Hoboken, NJ: John Wiley & Sons; 2009.
 - [14] Boog study center. Available at: <https://www.boogstudycenter.nl>.
 - [15] Dimick JB, Ghaferi AA, Osborne NH, Ko CY, Hall BL. Reliability adjustment for reporting hospital outcomes with surgery. *Ann Surg* 2012;255:703–7.
 - [16] Mougalian SS, Soulos PR, Killelea BK, Lannin DR, Abu-Khalaf MM, DiGiovanna MP, et al. Use of neoadjuvant chemotherapy for patients with stage I to III breast cancer in the United States. *Cancer* 2015;121:2544–52.
 - [17] Graham PJ, Brar MS, Foster T, McCall M, Bouchard-Fortier A, Temple W, et al. Neoadjuvant chemotherapy for breast cancer, is practice Changing? A population-based review of current surgical trends. 2015. p. 3376–82.
 - [18] Vughts G, Maaskant-Braat AJ, Nieuwenhuijzen GA, Roumen RM, Luiten EJ, Voogd AC. Patterns of care in the administration of neo-adjuvant chemotherapy for breast cancer. A population-based study. *Breast J* 2016;22:316–21.
 - [19] Clough KB, Acosta-Marin V, Nos C, Alran S, Rouanet P, Garbay J, et al. Rates of neoadjuvant chemotherapy and oncoplastic surgery for breast cancer Surgery: a French national survey. *Ann Surg Oncol* 2015;22:3504–11.
 - [20] Onitilo A a, Onesti JK, Single RM, Engel JM, James TA, Aiello EJ, et al. Utilization of neoadjuvant chemotherapy varies in the treatment of women with invasive breast cancer. *PLoS One* 2013;8:7–9.
 - [21] Caldon LJM, Walters SJ, Ratcliffe J, Reed MWR. What influences clinicians' operative preferences for women with breast cancer? An application of the discrete choice experiment. *Eur J Cancer* 2007;43:1662–9.
 - [22] Kunneman M, Engelhardt EG, Hove FLL, Marijnen CAM, Portielje JEA, Smets EMA, et al. Deciding about (neo-) adjuvant rectal and breast cancer treatment: missed opportunities for shared decision making. *Acta Oncol* 2016;55:134–9.
 - [23] Munro A, Brown M, Niblock P, Steele R, Carey F. Do Multidisciplinary Team (MDT) processes influence survival in patients with colorectal cancer? A population-based experience. *BMC Cancer* 2015;15:1–9.
 - [24] Van Hoeve J, de Munck L, Otter R, de Vries J, Siesling S. Quality improvement by implementing an integrated oncological care pathway for breast cancer patients. *Breast* 2014;23:364–70.