

Transcript Details

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What the Evidence Supports: Insights on Axillary Management from SABCS 2021

Announcer:

You're listening to *Project Oncology* on ReachMD. On this episode, sponsored by Lilly, we're going to hear from Dr. Terry Mamounas, who's the Medical Director of the Comprehensive Breast Program at the UF Health Cancer Center at Orlando Health. Dr. Mamounas is here to share highlights from his presentation at the 2021 San Antonio Breast Cancer Symposium titled, "Refining Axillary Management After Neoadjuvant Chemotherapy - What Does the Evidence Support?" Let's hear from Dr. Mamounas now.

Dr. Mamounas:

At the San Antonio meeting this year, I give a presentation of axillary management after neoadjuvant chemotherapy, titled, "What Does the Evidence Support?" And this was part of an educational session on the management of the axilla. And, you know, historically, that axilla lymph node dissection was a standard of care for patients with early-stage breast cancer, and the reason for that was that it gave us prognostic information, and also had very good luck at controlling the axilla. However, axillary dissection is also associated with significant comorbidities, particularly increased risk of lymphedema, and also other comorbidities in the axilla. So there has been considered therefore in the last two decades, I would say, to actually reduce the use of axillary lymph node dissection for patients early-stage breast cancer. And when we developed the procedure of sentinel lymph node biopsy, which is to remove only two to three lymph nodes, that gives us the same information and typically controls the disease in the axilla, also very well. It has been a shift towards management of the axilla with sentinel lymph node biopsy, particularly when the lymph nodes appear to be negative in clinically N0 patients. So, we have done that in the upfront setting, where patients present with early-stage breast cancer. The axilla is clinically negative. Typically, the approach is sentinel lymph node biopsy.

Another approach that we have taken to reduce the use of axillary lymph node dissection is to give patients neoadjuvant chemotherapy to downstage the disease of potentially, maybe involving the axilla at presentation, and then reduce the surgery performing sentinel lymph node biopsy. And over the years, we have seen that neoadjuvant chemotherapy has gotten much more effective with pathologic complete response rates and sterilization of the axilla, from only about 10 to 15 percent when we started giving chemotherapy to breast cancer patients, to now, in particular subtypes, maybe even up to 70 to 80 percent.

And then, of course, we've taken this a step further, for patients with clinically positive nodes, before neoadjuvant chemotherapy. Those are documented positive nodes. They're given neoadjuvant chemotherapy, to become clinically non-negative, then studies prospectively did the sentinel lymph node biopsy, then followed by an axillary dissection to see how accurate the procedure was. And the answer to that was it wasn't as accurate as we were hoping. It was about 13 percent false negative rate, which a little higher than you would expect with up-front sentinel lymph node biopsy. But these studies also show that as you remove more sentinel lymph nodes, the false negative rate goes down to the single digits if you remove at least three or more sentinel lymph nodes. So that was encouraging that you can find ways by doing dual tracer. Sometimes, by using immunohistochemistry, by removing more than two preferably more than three sentinel lymph nodes, you can bring the false negative rates to the same level. But what really has made a bigger difference, in this setting was the fact that when we realized that by targeting the lymph nodes, and removing the clipped nodes, that was clipped before neoadjuvant chemotherapy, and then also do a sentinel lymph node biopsy, then the accuracy of the procedure increases even further, with false negative rates to the range of about 3 to 4 percent.

So, this was an actually major advance, because now we know that if you remove that lymph node, it's very important, and if in addition to the sentinel lymph node biopsy a procedure that we now call targeted axillary lymph node dissection, then you can drive the false negative rate to almost better than it is with upfront, sentinel lymph node biopsy. So this now has allowed us to actually minimize further the use of axillary dissection for patients that present with axillary lymph node involvement.

So this approach is making a significant difference in further reducing the extent of axillary surgery in patients that present with bigger tumors and more advanced disease, so to speak, having also positive nodes before neoadjuvant chemotherapy. And I think in the long run, this approach will have a significant impact in further reducing the risk of lymphedema.

Well, this approach clearly has made a difference as we've seen in the upfront surgery setting, and now we see after neoadjuvant chemotherapy, is that by increasing the effectiveness of chemotherapy, we're able to downstage the disease in the breast as well as now in the lymph nodes, and by doing so, it appears at this point to be safe to not remove lymph nodes that were involved before, except the ones that we have biopsied, with the assumption that even if additional lymph nodes had disease. So I think this is the way we can personalize therapy, you know, because you presented with positive lymph nodes, doesn't mean necessarily nowadays, that you should have an axillary dissection, as long as you respond to neoadjuvant chemotherapy. And again, it's not for everybody. Different subtypes of breast cancer may respond differently to neoadjuvant chemotherapy, but particularly for those with triple negative disease, and HER2-positive disease, which is substantial, response in the breast and the axilla, that has allowed us to actually, significantly reduce the extent of surgery.

Announcer:

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