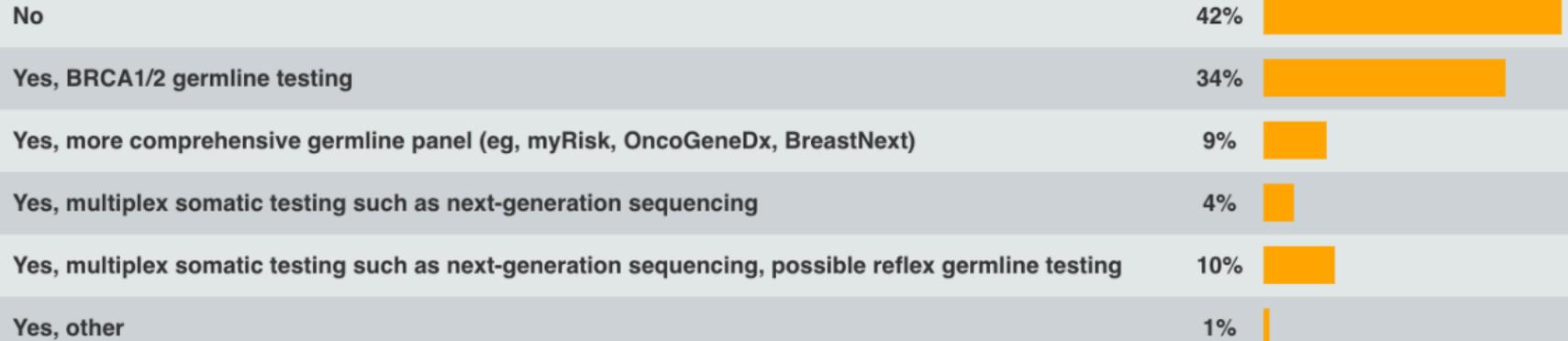
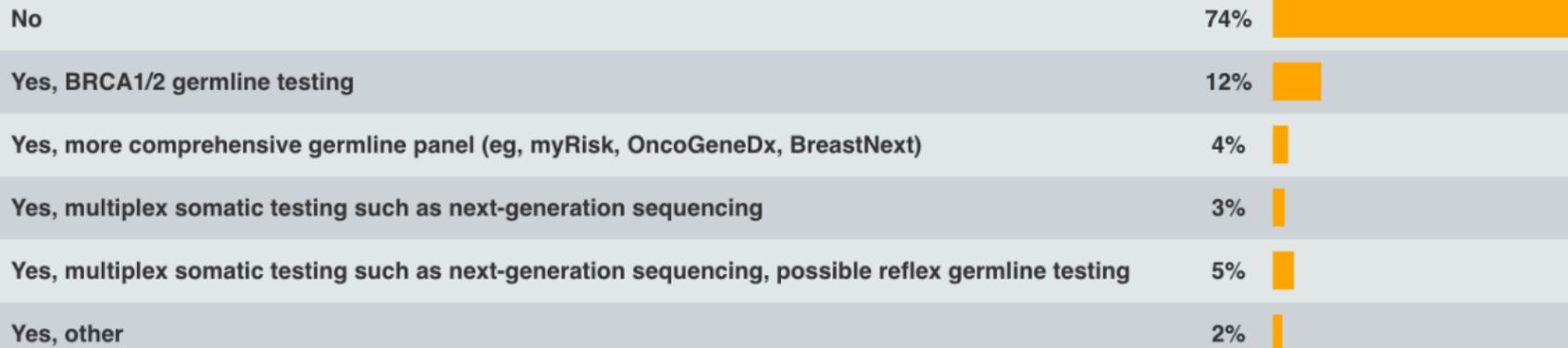


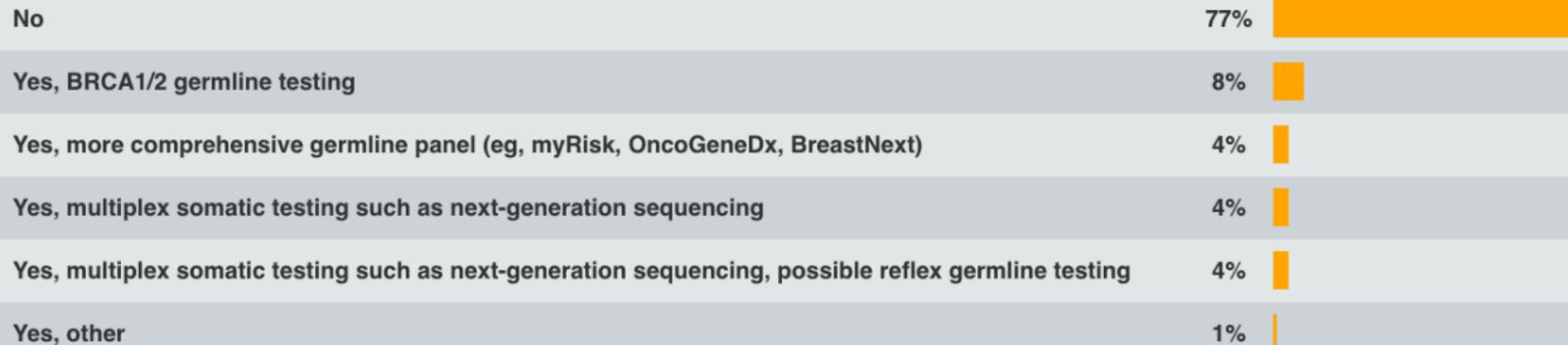
**In general, for an older patient (over age 60) with triple-negative metastatic breast cancer and no relevant family history, would you at some point order BRCA germline or somatic testing?**



**In general, for an older patient (over age 60) with ER-positive, HER2-negative metastatic breast cancer and no relevant family history, would you at some point order BRCA germline or somatic testing?**



**In general, for an older patient (over age 60) with HER2-positive metastatic breast cancer and no relevant family history, would you at some point order BRCA germline or somatic testing?**



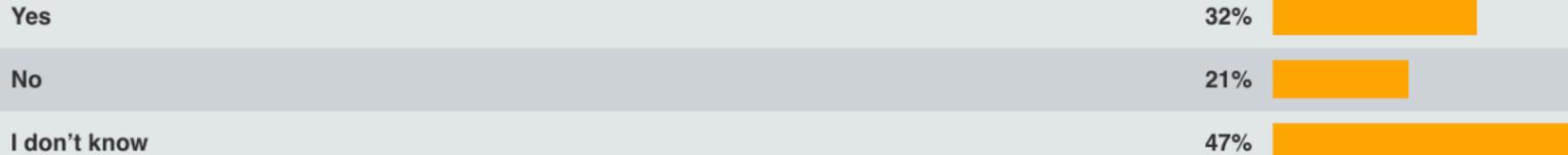
## Have you administered a PARP inhibitor to a patient with metastatic breast cancer?



## Reimbursement and regulatory issues aside, would you use a PARP inhibitor for a patient who has a somatic BRCA mutation?

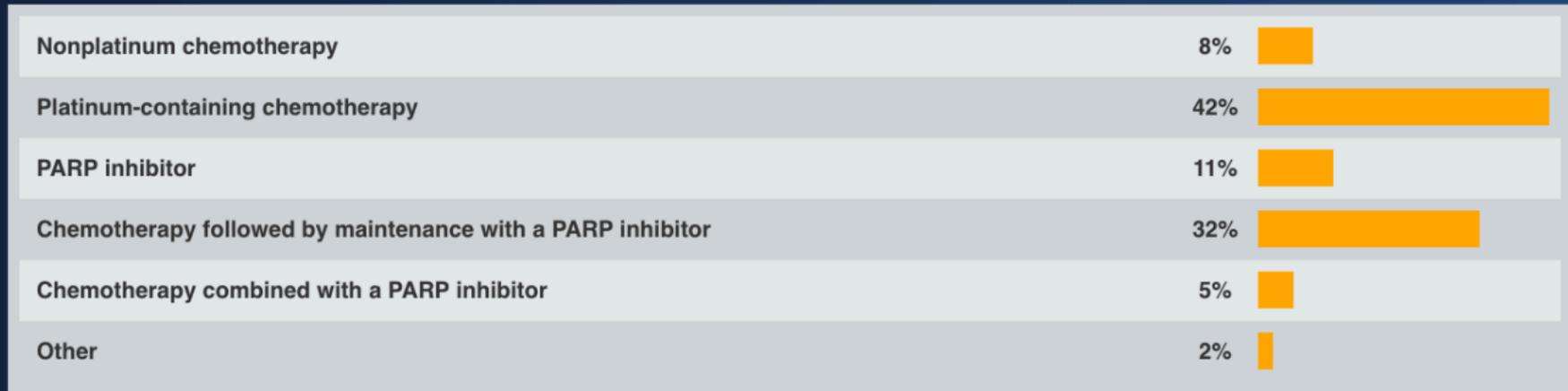


## Reimbursement and regulatory issues aside, would you use a PARP inhibitor for a patient with a PALB2 germline mutation?

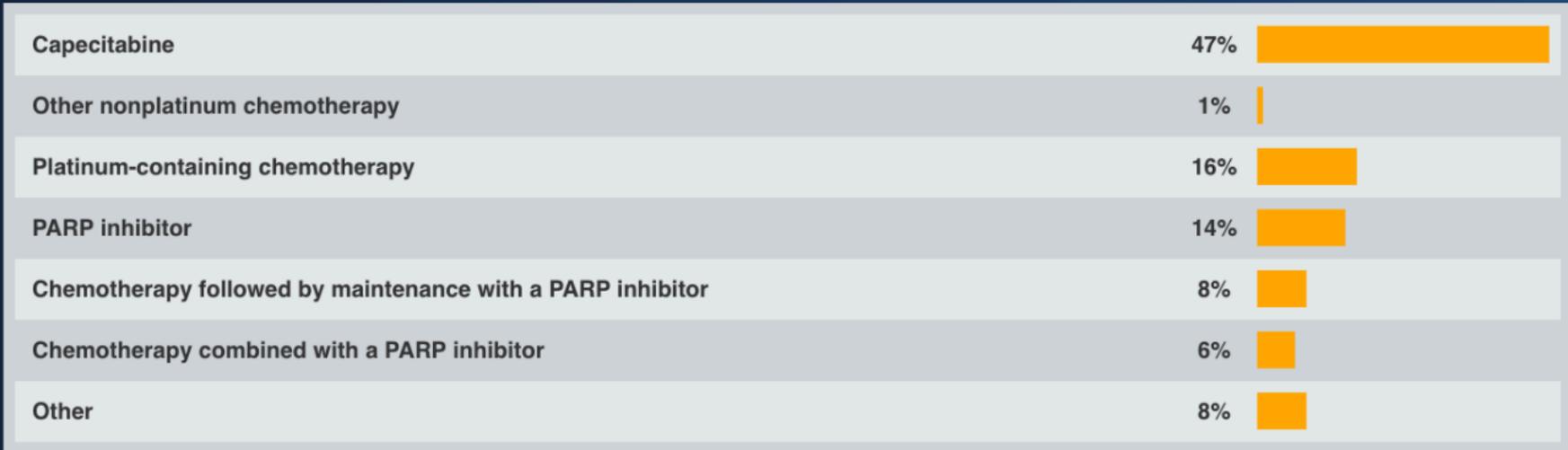


# Reimbursement and regulatory issues aside, what would be your preferred treatment approach for the following patients?

## A patient with de novo metastatic triple-negative breast cancer (TNBC) and a BRCA germline mutation



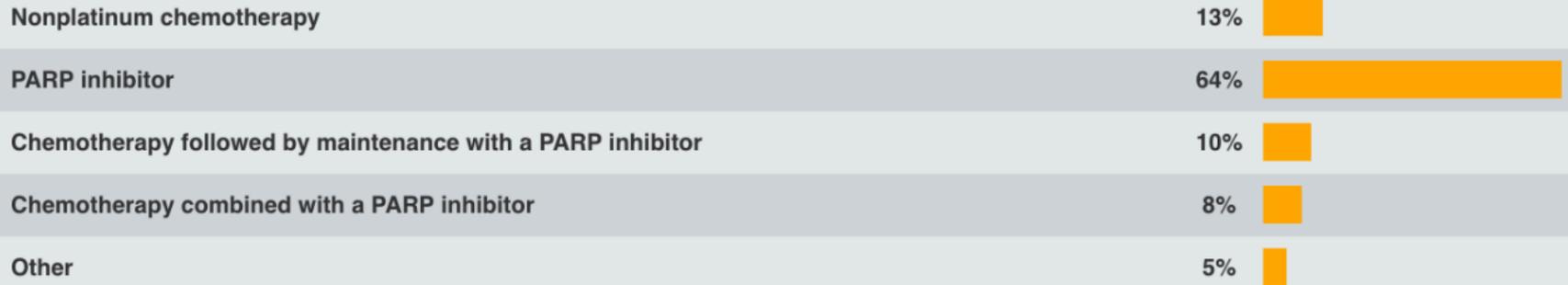
# A patient with locally advanced TNBC and a BRCA germline mutation who receives an anthracycline/taxane as neoadjuvant chemotherapy and has significant residual disease at surgery (assume radiation therapy is administered if indicated)



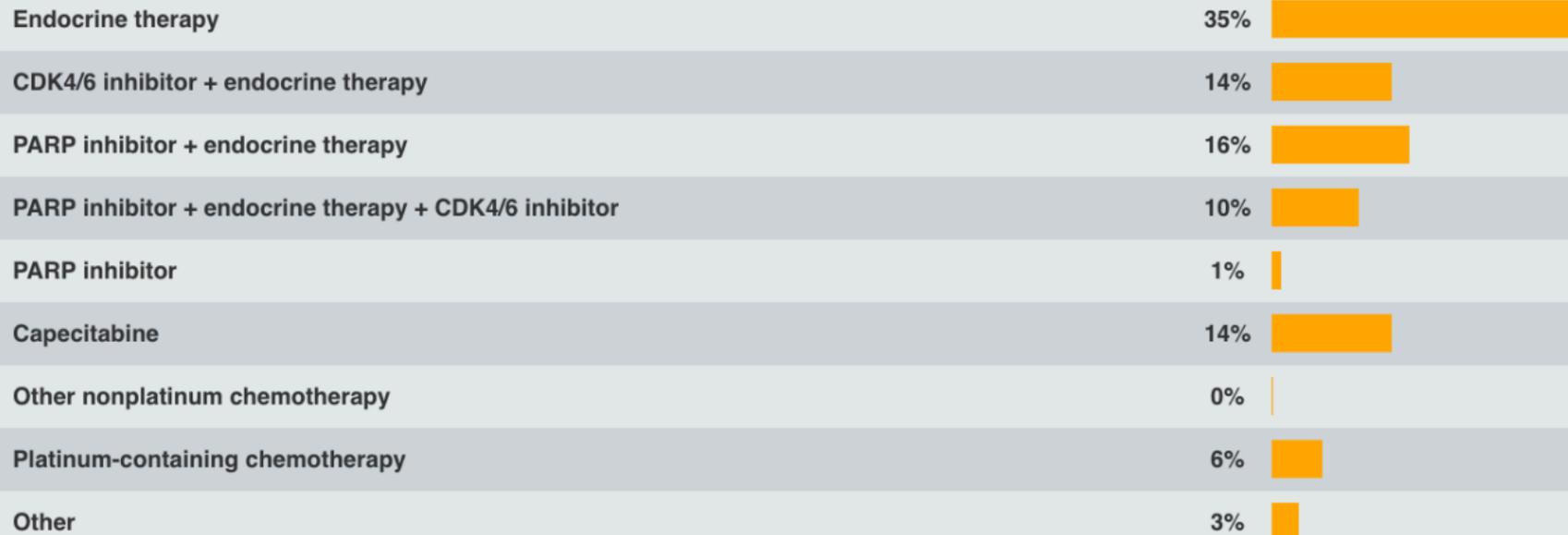
# A patient with TNBC and a BRCA germline mutation with metastatic minimally symptomatic disease recurrence 8 months after receiving adjuvant anthracycline/taxane



**A patient with TNBC and a BRCA germline mutation with metastatic minimally symptomatic disease recurrence 8 months after receiving adjuvant anthracycline/taxane who then receives cisplatin with response followed by progression**



**A patient with locally advanced ER-positive, HER2-negative breast cancer and a BRCA germline mutation who receives neoadjuvant anthracycline/taxane and has significant residual disease at surgery (assume radiation therapy is administered if indicated)**



# An asymptomatic woman presenting de novo with metastatic ER-positive, HER2-negative breast cancer and a BRCA germline mutation



# A woman with ER-positive, HER2-negative breast cancer who experiences disease recurrence 2 years after starting adjuvant anastrozole, receives palbociclib/fulvestrant with disease progression after 1 year and is found to have a BRCA germline mutation

Continue palbociclib and switch endocrine therapy

7%



Stop palbociclib and switch endocrine therapy

5%



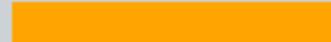
Exemestane + everolimus

18%



PARP inhibitor + endocrine therapy

31%



PARP inhibitor

29%



Capecitabine

5%



Other nonplatinum chemotherapy

0%



Platinum-containing chemotherapy

3%



Other

2%



**Would you use a PARP inhibitor for an asymptomatic patient with a BRCA germline mutation and ER-negative, HER2-positive metastatic breast cancer presenting with progressive disease who has received all standard anti-HER2 treatments?**

Yes, as a single agent

26%



Yes, combined with anti-HER2 therapy

44%

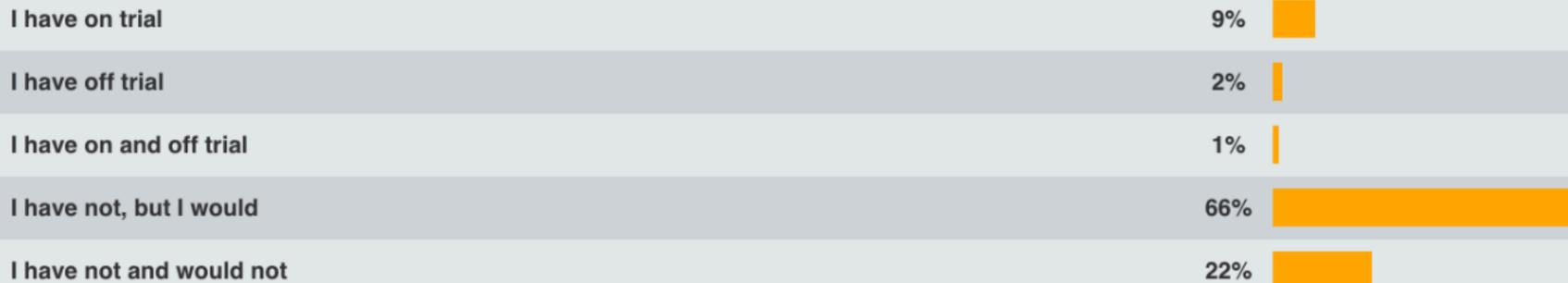


No

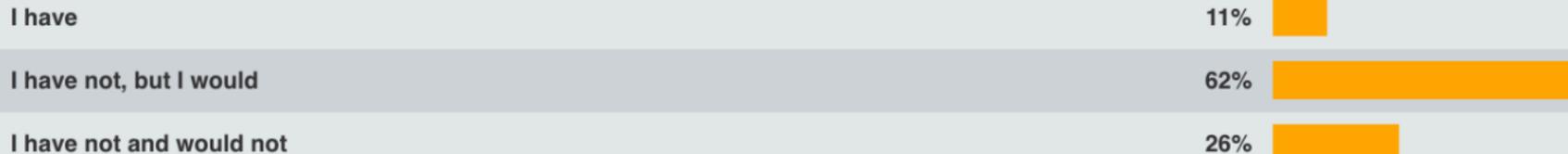
30%



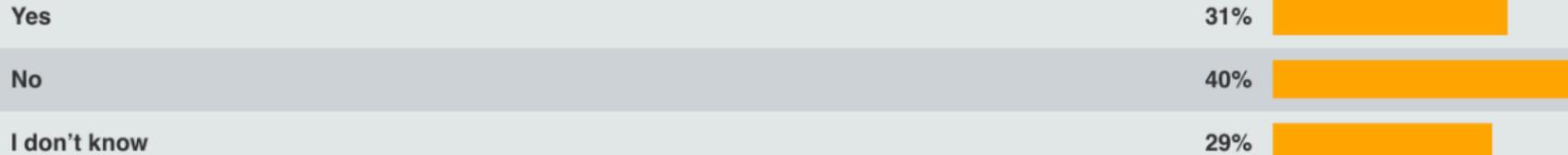
# Have you or would you administer a PARP inhibitor to a patient with HER2-positive breast cancer?



## Have you or would you use a PARP inhibitor as maintenance therapy in a patient with metastatic breast cancer after platinum-based chemotherapy as is done in ovarian cancer?



## When administering olaparib to a patient with metastatic breast cancer, would you use preemptive antiemetics?



**A 65-year-old woman with a BRCA1 germline mutation is started on olaparib, and after 6 weeks her hemoglobin has dropped from 11.0 to 8.8 g/dL with no evidence of hemolysis or bleeding. CA125 has decreased from 350 to 150. In addition to supportive measures such as erythropoiesis stimulating agents and transfusion, what would be your most likely management approach?**

