



POST-SABCS Issue 2, 2013

# **Pertuzumab with Trastuzumab and Docetaxel in Elderly Patients in the CLEOPATRA Study**

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## CME INFORMATION

### OVERVIEW OF ACTIVITY

The annual San Antonio Breast Cancer Symposium (SABCS) is unmatched in its significance with regard to the advancement of breast cancer treatment. This unique conference provides many clinicians and scientists from around the world a forum for discussing critical issues in the prevention and management of breast cancer. Therefore, SABCS is targeted by many members of the clinical research community as the optimal time to unveil new clinical data. This creates an environment in which yearly published results from a plethora of ongoing clinical trials lead to the emergence of new therapeutic agents and changes in the indications for existing treatments across all breast cancer subtypes.

Although SABCS currently offers online access to the vast majority of the poster and plenary presentations from the annual meeting, the absence of expert assessment concerning practical applications may yield confusion among community oncologists who are challenged almost daily to appropriately apply a multitude of scientific findings across diverse tumors. Thus, identification of those data sets with immediate or impending relevance to the delivery of quality breast cancer care, in conjunction with professional commentary to address resultant practice ambiguity, may prove vastly beneficial to those physicians who are unable to make the annual pilgrimage to San Antonio. To bridge the gap between research and patient care, this CME activity will deliver a serial review of the most important emerging data sets from the latest SABCS, including expert perspectives on how these new evidence-based concepts can and should be incorporated into on- and off-protocol patient care. This activity will assist medical oncologists, radiation oncologists, breast/general surgeons, nurses and other healthcare professionals in the formulation of optimal clinical management strategies and the timely application of new research findings to best-practice patient care.

### LEARNING OBJECTIVES

- Appraise recent clinical research findings from the second interim survival analysis of the CLEOPATRA study and the subset analysis of patients based on age, and apply this information to the treatment of patients with metastatic HER2-positive breast cancer.
- Recall the benefits and risks of combining HER2-targeted antibodies with chemotherapeutic agents for the treatment of HER2-positive advanced breast cancer.
- Understand the association between PI3 kinase mutational status and prognosis in patients with HER2-positive metastatic breast cancer.
- Evaluate the efficacy and safety of adding eribulin mesylate to trastuzumab for patients with HER2-positive advanced breast cancer.
- Compare the toxicity profile of T-DM1 across multiple studies in metastatic HER2-positive breast cancer, and consider this information in the selection of optimal HER2-targeted later-line therapy.

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Consulting Agreements: Genentech BioOncology, Novartis Pharmaceuticals Corporation.

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Consulting Agreements: Novartis Pharmaceuticals Corporation, Sandoz; Contracted Research: Celgene Corporation, Genentech BioOncology, Roche Laboratories Inc; Speakers Bureau: Genomic Health Inc.

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Hardware/Software Requirements:

A high-speed Internet connection

A monitor set to 1280 x 1024 pixels or more

Internet Explorer 7 or later, Firefox 3.0 or later, Chrome, Safari 3.0 or later

Adobe Flash Player 10.2 plug-in or later

Adobe Acrobat Reader

(Optional) Sound card and speakers for audio

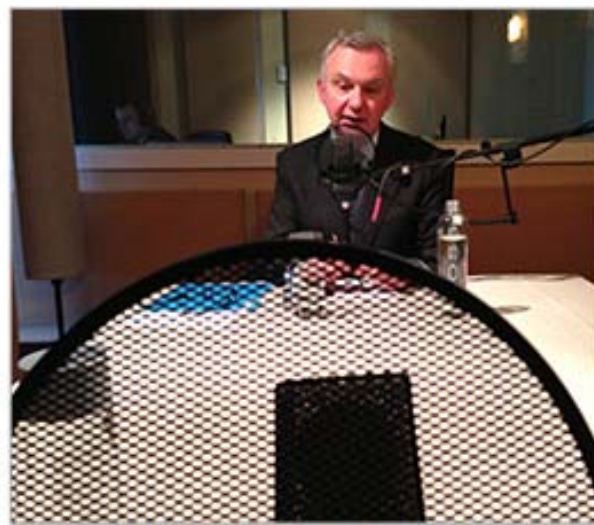
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## The new world of HER2-positive breast cancer

To go directly to slides and commentary for this issue, [click here](#).

Last week I met with the new Physician-in-Chief at Memorial Sloan-Kettering Cancer Center, Dr José Baselga, and after talking a bit about his vision for the future of that preeminent institution we focused on a corner of oncology he has influenced mightily throughout his career, breast cancer research. Not surprisingly, we spent much of our time reviewing anti-HER2 treatment — which has witnessed the FDA approval of 2 new agents in the past 9 months. Dr Baselga got things started by commenting on the Phase III trial he chaired, CLEOPATRA, which clearly demonstrated a substantial boost in efficacy when the HER2 dimerization inhibitor pertuzumab (P) was added to docetaxel and trastuzumab (T) as first-line therapy for metastatic HER2-positive disease. In the trial progression-free survival (PFS) increased from 12.4 to 18.5 months with a similar safety profile, and although the magnitude of this landmark finding surprised many observers, Dr Baselga stated that he fully expected the results based on the substantial antitumor activity seen when P was added to T in patients with disease progression on T in a prior Phase II trial.



**José Baselga, MD, PhD**  
RTP Studios (3-9-2013)

We then chatted about the antibody-drug conjugate trastuzumab emtansine (T-DM1) and the EMILIA trial that exploded onto the scene during the ASCO 2012 plenary session, revealing T-DM1's clear-cut superiority in both efficacy (PFS and overall survival) and tolerability over an established and frequently used regimen (capecitabine/lapatinib) among patients who had previously been treated with T + a taxane. As the agent was just approved 2 weeks before the interview, our conversation took on a different tone, as for the first time I was able to ask an investigator the practical (rather than hypothetical) question of current sequencing of therapy for metastatic HER2-positive disease. Dr Baselga, in commenting on this complex issue that has likely been discussed at every tumor board on the planet, slowly removed his eyeglasses, carefully put them on the desk, thought for a moment and then voiced his perspective, which is similar to

those I have heard recently from Dr Eric Winer and others: "Some people are so excited about T-DM1 that they want to use it first line, but I think this is a time for intellectual calm. Right now, trastuzumab, pertuzumab and a taxane is our standard first-line treatment, with T-DM1 as second line."

For the record, he and his Memorial colleagues usually choose paclitaxel as a partner for T + P, partially based on the reassuring Phase II data the group reported at San Antonio with this regimen. As I have been known to do, I tried to push Dr Baselga a bit regarding his strong feeling not to use T-DM1 first line and asked him how he would approach an 85-year-old patient with ER-negative, HER2-positive metastatic breast cancer for whom traditional chemotherapy might be out of place. He, however, stuck to his guns, commenting that a short taxane course (with T + P) in many fit, older patients is a well-tolerated life investment that results in a median progression-free interval of 18 months.

Whatever the algorithm is for now, it may very well change in a year or so when the MARIANNE study reports. This crucial Phase III first-line trial compares T + a taxane to T-DM1 alone or with P. Dr Baselga very clearly stated his opposition to the nonprotocol use of T-DM1 combined with P until more trial data become available, and other investigators, including Dr Winer, have done the same.

Of course, many other complex questions remain about the treatment of metastatic HER2-positive breast cancer, and below we review some of the more interesting efforts unveiled in San Antonio that attempt to provide needed answers:

### **1. More from the CLEOPATRA trial: Overall survival benefit; biomarker analysis; effects in older patients**

With 154 deaths in the control group and 113 in the T + P + docetaxel arm, [the study](#) has now allowed crossover to P. In terms of biomarkers, according to Dr Baselga, who presented [these data](#) in San Antonio, perhaps the key factor moving forward will be the identification of PI3-kinase mutations in approximately 25% of HER2-positive tumors and the potential use of PI3-kinase alpha inhibitors, which are currently being evaluated. Finally, although only 126 patients in [CLEOPATRA](#) were older than age 65, the benefit they derived from treatment was similar to what was seen with younger patients.

### **2. Choice of chemotherapy to combine with T + P**

Referred to earlier, a [San Antonio report](#) from Memorial demonstrated a 76% 6-month PFS rate in 33 evaluable patients receiving T + P + weekly paclitaxel. No unexpected toxicities were encountered, and this work provides additional strength to the conclusion everyone, including the NCCN, had already reached, namely that paclitaxel is a reasonable agent to combine with T and P. To obtain more real-world perspectives on this issue, an international single-arm study ([PERUSE](#)) is now evaluating T + P with 3 different taxanes (paclitaxel, *nab* paclitaxel and docetaxel).

### 3. Pooled safety analysis of single-agent T-DM1

**These data** from 882 patients on 6 clinical trials (including EMILIA) revealed few clinically apparent toxicities but did document transient laboratory abnormalities, such as thrombocytopenia and abnormal liver function tests, in a quarter or more of patients. Overall, treatment discontinuation due to toxicity was observed in only 55 patients (6.2%).

### 4. Eribulin combined with T

Indefinite anti-HER2 treatment is now a standard part of care for patients with HER2-positive metastatic disease, and as new chemotherapy agents are developed, studies are needed to document whether these are safe and efficacious partners for T. **This report** of 40 patients demonstrated what most observers expected — efficacy similar to other chemotherapy/T combinations (55% CR + PR) and acceptable tolerability comparable to what has been reported with eribulin alone.

For the next issue of this series we review the many San Antonio papers on genomic markers, including yet another analysis with the 21-gene recurrence score in tumor specimens from a prior randomized adjuvant trial, in this case NSABP-B-28, which evaluated the addition of paclitaxel to AC.

Neil Love, MD

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# **Pertuzumab with Trastuzumab and Docetaxel in Elderly Patients in the CLEOPATRA Study**

**Presentation discussed in this issue**

Miles D et al. **Pertuzumab (P) in combination with trastuzumab (T) and docetaxel (D) in elderly patients with HER2-positive metastatic breast cancer in the CLEOPATRA study.** San Antonio Breast Cancer Symposium 2012;[Abstract P5-18-01](#).

**Slides from a presentation at SABCS 2012 and transcribed comments from recent interviews with Edith A Perez, MD (1/17/13) and Kimberly L Blackwell, MD (1/8/13)**

## **Pertuzumab in Combination with Trastuzumab and Docetaxel in Elderly Patients with HER2-Positive Metastatic Breast Cancer in the CLEOPATRA Study**

**Miles D et al.**

*Proc SABCS 2012;Abstract P5-18-01.*

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# Background

- Patients aged  $\geq 65$  years are underrepresented in trials of cancer treatments, thus limiting the availability of efficacy and safety data for new therapies in this population.
- The results from the Phase III CLEOPATRA trial evaluating the addition of pertuzumab versus placebo to trastuzumab/docetaxel for patients with HER2-positive metastatic breast cancer (mBC) (*NEJM* 2012;366:109):
  - Demonstrated a significant improvement in PFS with pertuzumab by independent review.
  - Led to the FDA approval of pertuzumab/trastuzumab/docetaxel as first-line therapy for HER2-positive mBC.
- **Study objective:** To compare the efficacy and safety of pertuzumab/trastuzumab/docetaxel according to age group for patients in the CLEOPATRA trial ( $< 65$  versus  $\geq 65$  years).

Miles D et al. *Proc SABCS* 2012;Abstract P5-18-01.

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# CLEOPATRA Study Design

Centrally confirmed HER2-positive locally recurrent, unresectable or metastatic BC (mBC)

$\leq 1$  hormonal regimen for mBC

Prior (neo)adjuvant systemic Rx including trastuzumab allowed if followed by DFS  $\geq 12$  mo

Baseline LVEF  $\geq 50\%$ ; no CHF or LVEF  $< 50\%$  during or after prior trastuzumab

R

N = 406

Docetaxel ( $\geq 6$  cycles recommended)

Trastuzumab

Placebo

1:1

Docetaxel ( $\geq 6$  cycles recommended)

Trastuzumab

N = 402

Pertuzumab

**Primary endpoint:** Independently assessed progression-free survival (PFS)

Miles D et al. *Proc SABCS* 2012;Abstract P5-18-01.

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## Independently Assessed PFS (ITT Population)

	<65 years		≥65 years	
	PL/T/D (n = 339)	Pert/T/D (n = 342)	PL/T/D (n = 67)	Pert/T/D (n = 60)
Median PFS	12.5 mo	17.2 mo	10.4 mo	21.6 mo
Hazard ratio	0.65		0.52	
95% CI	0.53-0.80		0.31-0.86	
p-value	<0.0001		0.0098	

PL = placebo; Pert = pertuzumab; T = trastuzumab; D = docetaxel

Miles D et al. *Proc SABCS 2012*;Abstract P5-18-01.

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## Exposure to Docetaxel Treatment

	<65 years		≥65 years	
	PL/T/D (n = 332)	Pert/T/D (n = 346)	PL/T/D (n = 65)	Pert/T/D (n = 61)
Median no. of cycles administered (range)	8.0 (1-41)	8.0 (1-35)	6.5 (1-26)	6.0 (1-16)
Median dose intensity, mg/m <sup>2</sup> /week	24.8	24.5	24.8	24.8
Dose escalation, n (%) <sup>*</sup>	53 (16.0)	41 (11.8)	8 (12.3)	7 (11.5)
Dose reduction, n (%) <sup>†</sup>	72 (21.7)	85 (24.6)	17 (26.2)	19 (31.1)

\* Dose escalation to 100 mg/m<sup>2</sup>; † Dose reduction to <75 mg/m<sup>2</sup>

Miles D et al. *Proc SABCS 2012*;Abstract P5-18-01.

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## Most Common Adverse Events: Overall (O) and After (A) Docetaxel Discontinuation

All grades (O/A, %)	<65 years		≥65 years	
	PL/T/D	Pert/T/D	PL/T/D	Pert/T/D
Diarrhea	44.9/8.4	66.2/16.5	53.8/12.5	70.5/32.7
Neutropenia	51.2/3.7	54.3/2.0	41.5/2.5	44.3/0
Fatigue	36.1/7.9	36.1/10.0	40.0/12.5	45.9/16.3
Rash	22.9/6.0	34.7/10.8	30.8/7.5	27.9/16.3
Asthenia	29.2/7.9	25.7/10.8	35.4/7.5	27.9/4.1
Dysgeusia	14.8/0.9	16.8/0.8	20.0/0	27.9/4.1
Febrile neutropenia	7.8/0	14.7/0	6.2/0	8.2/0

Overall, the proportion of patients ≥65 y receiving G-CSF was lower than that of patients <65 y.

Miles D et al. *Proc SABCS 2012*;Abstract P5-18-01.

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## Most Common Adverse Events (≥Grade 3)

	<65 years		≥65 years	
	PL/T/D (n = 332)	Pert/T/D (n = 346)	PL/T/D (n = 65)	Pert/T/D (n = 61)
Neutropenia	47.0%	50.3%	40.0%	41.0%
Leukopenia	15.4%	12.7%	10.8%	9.8%
Febrile neutropenia	7.8%	14.7%	6.2%	8.2%
Diarrhea	4.8%	6.6%	6.2%	14.8%
Fatigue	2.7%	2.0%	6.2%	3.3%
Peripheral neuropathy	1.8%	1.7%	1.5%	8.2%
LVSD	2.4%	1.2%	4.6%	1.6%
Asthenia	1.2%	2.9%	3.1%	0%

Miles D et al. *Proc SABCS 2012*;Abstract P5-18-01.

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## Author Conclusions

- Treatment with Pert/T/D demonstrated a superior PFS by independent review in patients aged <65 years and ≥65 years compared with PL/T/D.
- In patients aged ≥65 years versus <65 years:
  - There were more dose reductions of docetaxel.
  - There was a lower median number of docetaxel cycles, which likely explains the lower incidence of neutropenia and febrile neutropenia and the less frequent use of G-CSF.
- The safety and efficacy data reported in the CLEOPATRA trial suggest that in patients with good ECOG PS, the combined use of Pert/T/D should not be limited by patient age.
- The PERUSE study will investigate the tolerability and efficacy of first-line Pert/T with one of a choice of taxanes in patients with HER2-positive mBC (NCT01572038).

Miles D et al. *Proc SABCS 2012*;Abstract P5-18-01.

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### **Investigator Commentary: Pertuzumab/Trastuzumab/ Docetaxel for Elderly Patients with HER2-Positive mBC**

The results of the subset analysis of the CLEOPATRA trial based on age demonstrated that patients benefit from combination therapy with pertuzumab, trastuzumab and docetaxel irrespective of age. These results are consistent with what was found with anti-HER2 therapy in the adjuvant setting. It is a reminder that breast cancer should be managed based on the biology of the disease and the patient's overall condition rather than age.

#### ***Interview with Edith A Perez, MD, January 17, 2013***

Anytime I see a survival advantage in any population of patients facing incurable metastatic breast cancer, I feel as if we're making some progress in this area. To see the survival data from CLEOPATRA was exciting, and it was nice to see that the elderly population from CLEOPATRA not only derived a benefit but seemed to tolerate treatment well. No large outstanding safety signal was apparent. They required more dose reductions, but in general there were no more treatment-related deaths, and the responses appeared to be similar across the age groups.

#### ***Interview with Kimberly L Blackwell, MD, January 8, 2013***