BREAST CANCER CHEMOTHERAPY TREATMENT ALGORITHM

ADJUVANT THERAPY FOR EARLY BREAST CANCER

Is the patient fit enough for anthracyclines?

NO

Are they node positive and fit enough for taxane?

CMF

YES

TC (Doce+Carbo)

NO

Is the patient node positive? And fit enough for FEC-T

YES

FEC

NO

FEC-T

BIOLOGICAL THERAPY FOR EARLY BREAST CANCER

Is the patient HER 2 positive

NO

No biological treatment

YES

Has the patient had adjuvant chemotherapy

NO

YES

Trastuzumab*

* Can be started whilst still on taxane component of chemotherapy regimen (anthracycline must have finished)

Notes

The algorithm assumes chemotherapy has been selected as the most appropriate form of adjuvant therapy for the patient. This would normally be restricted to patients for whom chemotherapy provides a greater than 3% benefit in chances of 10 year survival.

It is proposed that patients presenting with a 2nd primary tumour or local recurrence who have already received adjuvant anthracyclines should be offered Docetaxel 75mg/m² +Cyclophosphamide 600mg/m² 3 weekly as adjuvant therapy (rare situation). This regimen has also been proposed as an

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alternative to TC (Docetaxel+Carboplatin) in patients with borderline cardiac function who are not HER2+ve (the evidence for TC is mainly in the HER2+ve population). It may also be considered as an alternative to CMF in the node negative population if costs are not significantly different. AC regimen is no longer required as an option.

Neo-adjuvant treatment needs defining (no options listed on current standard regimen list). It is generally accepted that any adjuvant regimen may be used in the neo-adjuvant setting if it does not increase the overall costs of the early breast cancer chemotherapy pathway (e.g. if 6 cycles of trastuzumab are given neo-adjuvantly, then only another 11 may be given adjuvantly to total the normal 17 cycles). Although it is advisable to delay adjuvant trastuzumab until the completion of adjuvant anthracyclines, in the neo-adjuvant setting there may be a strong clinical case for concomitant use. Cardiac safety data to support this approach can be found in the initial reports of the TRYPHAENA study.

Neo-adjuvant therapy is primarily used to downstage the primary tumour to allow for breast conserving surgery. No overall survival advantage for this approach has been established. It should be reserved for tumours >2cm, or within clinical trials.