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Short Communication
Published: 26 Jan, 2018

Journal of Oncology Research Forecast

What is the Best Approach for Treatment of Hormone Positive/HER Positive Advanced Breast Cancer?

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Short Communication

The prognosis of patients with metastatic HER positive disease was improved by the anti-HER targeted therapies. Approximatively, 10% of all breast cancers are both HER2 positive and hormone receptor positive [1].

The optimal management of hormone positive/HER positive metastatic breast cancer (MBC) remains unclear.

The NCCN guidelines recommend first line endocrine therapy regardless of HER status excepted for visceral crisis [2]. Whereas, the ASCO recommendations offer more possibilities [3]:

- The use of anti-HER therapies is the main recommendation.
- Endocrine therapy is possible for selected patients.
- Endocrine maintenance therapy after combination of taxanes/anti-HER is allowed.

The review of the available data showed the following data:

In the Cleopatra trial, first line treatment with double HER blockage (pertuzumab/trastuzumab) plus docetaxel significantly improved overall survival for patients with HER2 positive metastatic breast cancer compared with trastuzumab/docetaxel. The experimental arm provided a 15.7 months increase in median overall survival. This benefit was obtained regardless of the hormone receptor status. But, in the inclusion criteria, a prior first line endocrine therapy in metastatic setting was allowed. In the original publication, the rate of patients previously exposed to first line endocrine therapy was not mentioned [4].

At the beginning of last decade, the trial with trastuzumab plus taxanes versus taxanes showed similar findings. In the trial by Marty et al, trastuzumab plus docetaxel was superior to the same dose of single-agent docetaxel in progression free survival and overall survival (31.2 *v* 22.7 months; P = .0062) [5]. In the trial by slamon and all there was also a statistically significant survival benefit when patients treated with chemotherapy plus trastuzumab were compared with those treated with chemotherapy alone (25.1 *v* 20.3 months; P = .046) [6].

The trials combining an endocrine therapy and anti-HER 2 therapy (without chemotherapy) despite their positivity showed a short median PFS [7-9]. In the main trial TAnDEM, trastuzumab plus anastrozole was superior to anastrozole alone but the PFS was only 4.8 (*versus* 2.4 months, p=0.0016) [7].

In our opinion, the standard in this population both HR and HER2 positive should be pertuzumab/trastuzumab/taxanes. The first line endocrine therapy should be discussed for very selected population (contraindication to HER2 therapies, very slow progressing disease).

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Received Date: *30 Nov 2017*
Accepted Date: *15 Jan 2018*
Published Date: *26 Jan 2018*

Citation: *Boutayeb S, Elghissassi I, Mrabti H, Errihani H. What is the Best Approach for Treatment of Hormone Positive/HER Positive Advanced Breast Cancer?. J Oncol Res Forecast. 2018; 1(1): 1004.*

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