

ABC4 Consensus: First Latin American Meeting—Assessment, Comments, and Application of Its Recommendations

Henry L. Gomez, MD, PhD¹; Carlos Castañeda, MD¹; Fernando Valencia, MD¹; Rene Muñoz-Bermeo, MD²; María del Carmen Torrico, MD³; and Silvia Neciosup, PhD¹

Breast cancer accounts for a high burden among all the neoplasms in Latin America, with more-advanced stages at presentation, which could result in high mortality rates. The 4th International Consensus Conference for Advanced Breast Cancer (ABC4) is focused on standardizing therapy for advanced breast cancer (ABC) and has held 5 meetings so far. ABC4 took place in Lisbon, Portugal, from November 2 to 4, 2017; however, the first Latin American ABC conference was held in Lima, Peru, from 18 to 19 May, 2018, chaired by Fatima Cardoso, MD, PhD. During these 2 days, the ABC4 consensus recommendations for advanced and locally advanced breast cancer were presented. Local treatment and systemic therapy were discussed with local experts, mainly focusing on anti-human epidermal growth factor receptor 2 therapy and newly approved drugs for hormone receptor-positive breast cancer, such as CDK4/6, mammalian target of rapamycin, and poly (ADP-ribose) polymerase inhibitors for triple-negative breast cancer. The discussion focused additionally on access to drugs and ABC4 consensus recommendations as regards Latin American patients.

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INTRODUCTION

Breast cancer (BC) is a neoplasm with high incidence and mortality in Latin American countries. Despite the mortality decline in North America and Europe, there has been a slight rise in Latin America.¹ Mortality-to-incidence ratio in the Latin American and Caribbean countries is 0.26 (range, 0.19-0.62), which is almost 1.5 times the ratio in North America.² These differences stem from limited access to health services, the high prevalence of advanced disease at diagnosis, and possibly more aggressive tumor features or prevalence.³ In this context, we underscore the importance of holding a discussion on treatment and access to therapy for advanced BC (ABC) in our region.

The first Latin American ABC conference was held in Lima, Peru, in May 2018. It was co-organized by the European School of Oncology, the Group of Clinical Trials of Peru, and the Peruvian Society of Mastology and was attended by 218 participants from Peru, Ecuador, Bolivia, and Venezuela. The aim of this event was to discuss and assess the access to recommendations and the applicability of the 4th International Consensus Conference for Advanced Breast Cancer (ABC4) consensus⁴ in Latin American countries.⁵⁻⁸

The main topics of discussion were locally ABC (LABC) and ABC, both of which are frequent conditions

requiring multidisciplinary management. Other topics included availability of and access to innovative drugs and the impact of recent data on treatment algorithms. The need for multidisciplinary treatment of and discussion about every case of metastatic BC (MBC) and LABC in BC units in public and private institutions was reinforced during the meeting.

OVERVIEW OF ABC MANAGEMENT IN LATIN AMERICA

Health systems in Latin America are divided into public, social security, and private insurance systems, and there is a sector of the population that does not have any coverage (25%-57%). Coverage by public systems is heterogeneous and depends on local policies as well as national cancer control plans.⁹ In this respect, there are countries where the government covers 100% of the costs of basic cancer treatment and, in contrast, countries where the public system coverage does not include cancer treatment, leading to high out-of-pocket expenditures for patients (Table 1). In most Latin American countries, including Peru, Ecuador, and Bolivia, public care is shared between the social security system and the Ministry of Health, which cover 20% to 30% and 30% to 45% of the population, respectively.

The lists of drugs approved by regulatory bodies in most Latin American countries include older drugs, all from the 1990s, and newer drugs; however, the latter

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CONTEXT

Key Objective

To discuss and assess the access to recommendations and the applicability of the 4th International Consensus Conference for Advanced Breast Cancer (ABC4) consensus in Latin American countries.

Knowledge Generated

We endorse the ABC consensus as an important contribution toward standardizing and optimizing therapy for ABC at an international level. However, its recommendations need to be adapted to the reality of Latin America in terms of access.

Relevance

Efforts must be made by Latin American countries to improve access to high-cost drugs, such as the universalization of health care services. We expect that this report will contribute to the call to action of the ABC consensus and reinforce the need to narrow the gap on access to ABC therapy in Latin America to improve the quality of life and survival of our patients.

are not widely accessible in most countries (Table 1), and access depends mainly on a patient's type of coverage.

Once a drug is approved, private insurance programs are able to provide it to patients, but coverage rates differ by country, insurance company, and even type of insurance plan, and private programs only cover between 3% and 10% of the population. In several countries, including Peru, private systems can provide treatment after approval of international organizations like the US Food and Drug Administration (FDA), which takes into account improvement in progression-free survival (PFS) or its surrogates.

Although cost is often cited as a reason for the slow incorporation of anticancer drugs into the coverage of public health systems, the lack of systematic health technology assessments delays the adoption of new therapies. In this regard, some Latin American countries have established state agencies or public-private partnerships for advising on the profitability of new drugs or technology implementation (eg, the National Committee for the Incorporation of Health Technologies in Brazil, the National Center for Technological Excellence in Health in Mexico, the Institute of Clinical and Healthcare Effectiveness in Argentina, and the National Ministry of Health in Peru), each with different evaluation criteria; in some cases, they are more concerned with issues regarding improvements in disease-free survival (DFS), PFS, and overall survival (OS), and in other cases, they are more concerned with issues regarding benefits in OS. In any case, the inclusion of drugs recently approved by the FDA in the coverage of public health systems can take a long time, even up to a decade.¹⁰

In Latin America, geography itself is an important barrier to socioeconomic development and access to specialized cancer care. Additionally, its population is genetically heterogeneous, composed of a mixture of indigenous, European, Asian, and African ancestries, in different proportions. Epidemiologic data have shown that there is an increased incidence of BC and shorter survival for Latinas,¹¹ whether living in Latin American countries or in the United States.¹² Additionally, higher rates of triple-

negative BC (TNBC) have been reported (12.2%-21.3%).¹³⁻²⁰ Because of these characteristics, the discussion of the ABC4 recommendations by a panel of Latin American experts is particularly relevant.

TOPICS IN MANAGEMENT OF ABC

General Statements

Staging and disease assessment. Staging for ABC should include at least medical history and physical examination, hematologic tests, chest and abdomen imaging, and bone scans (level of evidence [LoE]: II/A). Variation in tumor markers could indicate disease status, especially when it is elevated at baseline and for nonmeasurable metastatic disease, but no decision can be made solely based on these variations (LoE: II/C). Evaluation of treatment response should be conducted every 2 to 3 months for endocrine therapy (ET) and every 2 to 3 cycles for chemotherapy, although less frequent monitoring is acceptable for more indolent disease or patients with particular conditions (LoE: expert opinion/B).⁸

Role of surgery. Metastatic lesions should be confirmed by biopsy when feasible, and hormone receptors (HR) and human epidermal growth factor receptor 2 (HER2) should be reassessed in this sample (LoE: I/B), especially if they were previously negative. Removal of the primary tumor could be considered in selected patients with de novo stage IV disease with bone-only metastases and in selected patients for whom quality of life (QOL) could be improved (LoE: I/C), always considering patient preferences.⁸

Systemic therapy. Sequential monotherapy is preferred for ABC (there is not a specific sequence, and it depends on patient preference); combination regimens should be reserved for patients with rapid clinical progression or life-threatening visceral metastases or for whom there is a need for rapid symptom and/or disease control⁸ (LoE: I/A).

Anthracycline- or taxane-based regimens would be considered as first-line chemotherapy for patients with ABC with HER2-negative tumors, in the absence of medical contraindications and taking into account previously

TABLE 1. Access to High-Cost Recommendations of ABC4, According to Country and Health System

BC Subtype	Peru				Ecuador				Bolivia				
	Access ⁵²				Access ⁵³				Access ⁵⁴				
	Public		Private		Public		Social Security/ Other		Public		Ministry of Health		National Health Funds
Drug Approval	MINSA (44.4%)	EsSalud (24.8%)	Private (5.1%)	None (25.7%)	Drug Approval	Ministry of Public Health (60.6%)	Private (9%)	None (1.31%)	Drug Approval	Ministry of Health (ND)	Private (ND)	None (57.3%)	
HR positive/HER2 negative	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	No	No	
OFS	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	No	
Fulvestrant	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	No	
CDK4/6 inhibitor + AI	Yes	No	Yes	No	No	No	No	No	Yes	No	Yes	No	
CDK4/6 inhibitor + fulvestrant	Yes	No	Yes	No	No	No	No	No	Yes	No	Yes	No	
Everolimus + AI	Yes	No	Yes	No	No	No	No	No	Yes	No	Yes	No	
HER2 positive	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	No	
Trastuzumab (neoadjuvant)	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	No	
Trastuzumab (metastatic disease)	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	No	
Trastuzumab + pertuzumab (neoadjuvant)	Yes	No	Yes	No	No	No	No	No	Yes	No	Yes	No	
Trastuzumab + pertuzumab (metastatic disease)	Yes	No	Yes	No	No	No	No	No	Yes	No	Yes	No	
TDM-1	Yes	No	Yes	No	Yes	No	No	No	Yes	No	No	No	
TNBC	Yes	No	No	No	Yes	No	No	No	Yes	No	Yes	No	
Genetic testing for BRCA 1/2	No	No	Yes	No	No	No	No	No	Yes	No	Yes	No	
Olaparib	Yes	No	Yes	No	No	No	No	No	Yes	No	Yes	No	
Talazoparib	No	No	No	No	No	No	No	No	No	No	No	No	

Abbreviations: ABC4, 4th International Consensus Conference for Advanced Breast Cancer; AI, aromatase inhibitor; BC, breast cancer; EsSalud, Social Security in Peru; HER2, human epidermal growth factor receptor 2; HR, hormone receptor; MINSA, Ministry of Health of Peru; ND, no data available; OFS, ovarian function suppression/ablation; TNBC, triple-negative breast cancer.

received adjuvant or neoadjuvant regimens. Other options could include capecitabine, vinorelbine, or eribulin. Additional choices taking into account different toxicity profiles and previously received treatments include gemcitabine, platinum agents, taxanes, and liposomal anthracyclines (LoE: I/A). A taxane and anthracyclines can be reused as first-line treatment for metastatic disease in cases where a 1-year DFS was obtained and a maximum cumulative dose of anthracyclines and toxicity issues are considered. Metronomic chemotherapy is reasonable for patients not requiring rapid tumor response (LoE: I/B). The use of targeted therapy should be recommended when receptors are positive in at least 1 biopsy (LoE: expert opinion/B).

Each regimen should be administered until disease progression (PD) or unacceptable toxicity (LoE: I/B). Acceptance is defined by the patient; this is not the same as manageable toxicity. There is no evidence to define how many chemotherapy lines are enough; this depends on response or clinical benefit.

Regarding some definitions, the Latin American panel endorsed definitions of “oligometastatic disease,” “visceral crisis,” and “chronic conditions,” as established by ABC4 consensus.

BRCA mutation status. Genetic testing for *BRCA1/2* mutations should be performed in women age < 50 years at BC diagnosis and in women with bilateral BC, history of ovarian cancer at any age in any first- or second-degree relative, first-degree relative diagnosed with BC at age 50 years, 2 first- or second-degree relatives diagnosed with BC at any age, any male relative diagnosed with BC, or 1 grandparent of Ashkenazi Jewish heritage. All patients with TNBC and very young patients (ie, age < 35 years) must have genetic testing. Genetic testing should be performed in specialized BC centers or by a geneticist.

Only germ line mutations in *BRCA1/2* genes have current therapeutic value. Analysis of other moderate- to high-risk genes could be conducted after consultation with a geneticist, but patients must be informed that the results are not relevant to their treatment (LoE: expert opinion). Somatic *BRCA1/2* mutation testing in tumors should not be used in routine clinical practice.⁸

Some studies evaluating *BRCA* mutations in the Hispanic population living in the United States have found that *BRCA* gene prevalence could be higher than in whites,²¹ and other studies performed in Latin American countries have indicated that some deleterious founder *BRCA* mutations are repetitive in some countries.¹²

HR-positive, HER2-negative MBC. ET is the preferred option, even in the presence of visceral disease, unless there is visceral crisis or concern for endocrine resistance; treatment with ET depends on the type and duration of adjuvant or prior ET. The Latin American panel endorsed the definitions of “no endocrine resistance,” “primary endocrine resistance,” and “secondary endocrine

resistance” (LoE/grade of recommendation [GoR]: expert opinion/does not apply [n/a]).⁸

Most clinical trials of treatment of HR-positive MBC include only postmenopausal women; in this regard, the consensus promotes the inclusion of premenopausal women. Ovarian function suppression/ablation (OFS) must be recommended to each premenopausal woman with MBC.⁸

The Latin American expert panel strongly agreed with these statements, and OFS is widely recommended for premenopausal women in Latin America.

No endocrine resistance (first line). There are no head-to-head comparisons of studies of the different endocrine-based therapy options or with monochemotherapy (LoE: I/A).

Most ABC4 panelists recommended, based on the significant median PFS benefit, first-line treatment with the CDK4/6 inhibitor palbociclib²² or ribociclib^{23,24} plus an aromatase inhibitor (AI) as the preferred treatment option, while the safety profile remained acceptable and QOL was at least comparable to that experienced with ET alone.

Fulvestrant is an option for first-line ET in postmenopausal patients who are unable to receive a CDK4/6 inhibitor⁸ (LoE: I/B), particularly patients without visceral metastases, based on a longer median PFS compared with anastrozole²⁵ (LoE: I/B).

The Latin American expert panel agreed with these statements; however, it depends on the access to treatment (health system and coverage). This panel commented that where there is no access to CDK4/6 inhibitors or fulvestrant, AIs are a good option, but with less efficacy, as is tamoxifen. Patients need to be informed about the fact that there are currently no clear selection criteria to determine which specific patients would benefit.

Endocrine resistance (second line). The optimal sequence after first-line ET is not clear; however, it should be chosen depending on previous treatment, extent of disease, patient preferences, and access. The combination of fulvestrant plus palbociclib (LoE: I/A) is superior to fulvestrant alone based on PFS²⁶ and OS²⁷ benefit, and the combination of everolimus (mammalian target of rapamycin inhibitor) plus an AI or tamoxifen²⁸ (LoE: II/B) or fulvestrant,²⁹ may also be considered, although there is a lack of an OS benefit. Regarding adverse effects of everolimus, meticulous oral hygiene is important, and the daily use of steroid mouthwash with 0.5 mg/5 mL dexamethasone³⁰ is recommended.

Both CDK4/6 inhibitors and everolimus are available in Latin American countries but are restricted according to health system and coverage; the Latin American expert panel agreed that after progression with tamoxifen, therapy with an AI could be a reasonable option, and after PD with an AI, another AI could be used. The use of metronomic chemotherapy and then a return to ET is also an interesting

concept discussed by the expert panel. Tamoxifen, fulvestrant alone, or megestrol acetate and estradiol could be used in later lines of therapy.

HER2-positive MBC. Anti-HER2 therapy should be offered as soon as possible to all patients with HER2-positive ABC, except in the presence of contraindications (LoE: I/A). In the first-line setting, combinations of chemotherapy (taxane or vinorelbine) with trastuzumab are superior to chemotherapy alone in terms of PFS and OS (LoE: I/A). Other chemotherapy agents along with trastuzumab for first and later lines include capecitabine, eribulin, liposomal anthracyclines, platinum, gemcitabine, and metronomic cyclophosphamide and methotrexate, but these have not been as well studied and are not preferred (LoE: II/A).⁸

Dual anti-HER2 therapy (trastuzumab and pertuzumab) combined with taxane-based chemotherapy (docetaxel [LoE: I/A] or paclitaxel [LoE: I/B]) is currently the standard approach for patients with HER2-positive MBC, because it leads to better OS compared with trastuzumab plus docetaxel in patients with a trastuzumab-free interval > 12 months³¹ (LoE: I/A). Dual blockade could also be combined with vinorelbine (LoE: II/A), nabpaclitaxel (LoE: II/B), or capecitabine (LoE: II/A).⁸

Patients experiencing PD with an anti-HER2 therapy combined with a cytotoxic or endocrine agent should be offered additional anti-HER2 therapy with subsequent treatment, unless there are contraindications (LoE: I/A).⁸ Anti-HER2 therapy for ABC must be maintained until PD, unacceptable toxicity, or patient request; however, stopping anti-HER2 therapy after several years of sustained complete remission may be considered, particularly if treatment rechallenge is available in case of PD (LoE: expert opinion).⁸

T-DM1 improves PFS and OS (not reached v 23.3 months; $P = .0005$) when compared with lapatinib plus capecitabine³² or physician choice (PFS: 6.2 v 3.3 months; $P < .0001$)³³ in patients resistant to trastuzumab, with a favorable toxicity profile (LoE: I/A). However, there are no data on its use after dual HER2 blockade.⁸ The combination of trastuzumab and lapatinib is a reasonable treatment option for patients heavily pretreated with trastuzumab, based on increased response rates and longer PFS (12.0 v 8.1 weeks; hazard ratio, 0.73; $P = .008$) compared with lapatinib.³⁴ The combination of chemotherapy and trastuzumab plus pertuzumab could be used in a trastuzumab-refractory scenario,³⁵ but there are no data on its use after PD with pertuzumab or T-DM1⁸ (LoE: I/B).

In highly selected patients with HR-positive, HER2-positive MBC, ET could be used along with anti-HER2 monotherapy (trastuzumab plus letrozole,³⁶ trastuzumab plus anastrozole,³⁷ or lapatinib plus letrozole³⁸) as first-line treatment, because it offers a PFS benefit compared with ET alone, and a delay in the beginning of chemotherapy.

Combining ET with a dual HER2 blockade (trastuzumab and pertuzumab or trastuzumab and lapatinib) also offers better PFS³⁹ (LoE: I/A). Maintenance ET plus continued HER2 blockade (trastuzumab and pertuzumab or Trastuzumab alone) is the best strategy for patients with HR-positive, HER2-positive MBC who were successfully treated with chemotherapy plus anti-HER2 therapy, even if there are no randomized study data available yet.⁸

The Latin American expert panel agreed with all the statements discussed. Anti-HER2 therapies, including trastuzumab, pertuzumab, T-DM1, and lapatinib, are available in different Latin American countries in the metastatic scenario. However, in most public health systems, trastuzumab is approved only in the adjuvant or neoadjuvant setting and as first-line treatment for metastatic disease. The decision should be individualized, and different toxicity profiles, previous exposure, patient preferences, and country availability should be considered.

Metastatic TNBC. Chemotherapy is the cornerstone of TNBC treatment. Carboplatin has similar efficacy with a more favorable toxicity profile than docetaxel in patients previously treated with anthracyclines in the adjuvant or neoadjuvant setting^{7,8} (LoE: IA). Olaparib and talazoparib, poly (ADP-ribose) polymerase (PARP) inhibitors, are an option for patients with germ line *BRCA* mutation who have previously been exposed to chemotherapy and do not have platinum-resistant disease or luminal-like BC treated with at least 1 line of ET⁸ (LoE: 1A); these PARP inhibitors offer longer PFS and better QOL compared with chemotherapy.^{40,41} Patients with androgen receptor-positive tumors who no longer respond to standard therapies could receive bicalutamide after PD with standard therapies.⁸

The Latin American expert panel agreed with the previous statements. Chemotherapy is widely available; however, PARP inhibitors are limited to private health systems. Additionally, more research is needed regarding TNBC, given its higher prevalence in Latin American women.

Specific sites of metastasis. Treatment of brain metastases.

Patients with a single or potentially resectable brain metastasis should be treated with surgery or radiosurgery.⁸ Whole-brain irradiation could be administered after surgery or radiosurgery or alone; however, its benefit needs to be balanced against the risk of neurocognitive effects. Patients with stable extracranial disease who develop brain metastases should not change their systemic therapy if local therapeutic measures can be administered⁸ (LoE: I/C), and anti-HER2-targeted therapy (trastuzumab) should be restarted if it was previously interrupted⁸ (LoE: I/C). Progression of brain metastases after local measures requires a change of systemic treatment (LoE: III/A).

Radionecrosis as a consequence of stereotactic irradiation of brain metastases is a rare complication that can occur even many years later, especially in reirradiated patients.⁸

High-dose steroids are the treatment of choice for symptomatic patients with radionecrosis. A median of 4 cycles of bevacizumab could be an option if patients do not respond to steroid treatment^{8,42} (LoE: IIIB).

Treatment of bone metastases. Radiologic assessment is required in patients with pain resulting from bone metastases to determine whether there are impending or actual pathologic fractures.⁸ Orthopedic management is required in long bone fracture, which is generally followed by radiotherapy (RT). RT should be administered in the absence of a clear fracture risk scenario.

Clinical information suggesting spinal cord compression should require radiologic assessment, with magnetic resonance imaging (MRI) being the method of choice. Neurosurgeon opinion for an emergency surgical decompression should be obtained, and emergency RT should be administered when it is not possible to perform decompression or stabilization. Bone-modifying agent (bisphosphonate or denosumab) should be administered along with other systemic therapy. Zoledronic acid once every 3 months does not seem to be inferior to the monthly schedule.⁴³ Supplementation with calcium and vitamin D3 is mandatory.⁸

TOPICS IN THE MANAGEMENT OF LABC

LABC is defined as inoperable non-MBC (T3-T4, N1-N3 [CS IIA- IIIC]); it includes inflammatory BC (IBC) and T2 NO disease that fulfills criteria for breast-conserving surgery, except for tumor size.⁸

Studies Before Beginning Neoadjuvant Treatment

A core biopsy providing histology and biomarker expression (estrogen receptor, progesterone receptor, HER2, and proliferation/grade) is indispensable before initiating systemic treatment⁸ (LoE: I/A). Complete clinical examination, laboratory tests, computed tomography (CT) of the chest, abdomen, and pelvis, and a bone scan are recommended (LoE: I/A). [¹⁸F]fluorodeoxyglucose positron emission tomography (PET) scans may be used as an alternative to CT and bone scans or in the case of inconclusive results from other imaging studies (LoE: II/B).

These recommendations are followed in most Latin American countries. Access to PET-CT is limited (mainly available in private health systems) and could be considered when a tumor marker is elevated with no evidence of disease or when it is necessary to define surgical treatment for a single lesion. One PET-CT scan is available per 8.5, 15, and 11.3 million inhabitants in Ecuador, Peru, and Bolivia, respectively.

Neoadjuvant Treatment

Chemotherapy based on anthracyclines and taxanes is still considered the cornerstone of neoadjuvant treatment for LABC. Anthracycline-free schedules such as docetaxel plus cyclophosphamide may be an option when there are anthracycline contraindications. Adding carboplatin to

neoadjuvant therapy could improve pathologic complete response (pCR) rates in TNBC. The optimal duration should be 6 to 8 cycles, and the whole course should be administered before surgery.

Neoadjuvant ET instead of chemotherapy could be used in selected patients with a duration of < 12 months; lower ki67 level, luminal/HER2-negative postmenopausal status, and lobular histology could help to identify these patients. AIs are the agents of choice.

Addition of trastuzumab to taxanes during neoadjuvant chemotherapy (NAC) improves pCR and event-free survival, and a pooled meta-analysis found a trend toward OS benefit. Trastuzumab should not be concurrently administered with anthracyclines because of the risk of cardiotoxicity. Double HER2 blockade with trastuzumab and pertuzumab added to taxanes with or without carboplatin increases pCR.

Patients with tumors that remain inoperable after systemic therapy should eventually receive RT, including external-beam irradiation. Palliative mastectomy is not recommended, unless it would result in QOL improvement.⁸

Approach After Neoadjuvant Treatment

Response to systemic therapy can be evaluated through clinical examination, mammography complemented with ultrasonography, breast MRI, or pathologic response. Surgery is required for every patient, even in complete clinical response. Mastectomy without immediate reconstruction should always be recommended for IBC.⁸

Management of the axilla includes dissection in individual cases. Patients with a low axillary tumor load or clinically negative axilla (cNO-cN1) at initial diagnosis who achieve complete remission after NAC could also undergo sentinel lymph node biopsy with blue dye and technetium (LoE: III/B) and resection of at least 3 sentinel lymph nodes.⁴⁴ It is not an option for those with IBC because of the high rate of false-negative findings related to lymphatic vascular tumor-related emboli in the parenchyma of the breast and skin, which probably prevent normal lymphatic drainage to the axilla.^{44,45}

Recommendations regarding technical issues in postoperative RT in patients with LABC do not differ from those in early BC.⁴⁶ However, indications for RT and treatment fields should be based on the maximum stage from the pretherapy clinical stage, pathologic stage, and tumor characteristics.

The Latin American panel endorsed these recommendations. There are 0.8, 0.7, and 0.5 RT machines per 1,000 patients with cancer⁴⁷ in Ecuador, Peru, and Bolivia, respectively, which limits RT delivery.

Patients treated with curative intent should receive adjuvant anti-HER2 therapy for a total of 1 year⁸ (LoE: I/A). Adjuvant dual HER2 blockade is also an option for patients with LABC and a high risk of recurrence.⁴⁸ After 1 year of

treatment with trastuzumab, subsequent therapy with neratinib could be considered for patients with HR-positive, HER2-positive BC.⁴⁹

ABC4 STATEMENTS BY THE PATIENT ADVOCACY COMMITTEE

The Latin American expert panel agreed with the ABC4 conference to deliberately and specifically promote the communication and exchange of information between patient advocates and physicians.⁸

Proposals of the Patient Advocacy Committee:

- Every patient with ABC should be treated by a specialized multidisciplinary team working at a specialized BC center or institution that works together with these certified centers. This also includes the specialized management of adverse effects and a nursing team that specializes in dealing with MBC.
- Every patient with ABC should be given information early on long-term survival and options for palliative medicine.
- Quality assurance procedures must be implemented in every specialized center to ensure that patients receive quality-assured treatment and care at every stage of disease, from screening to diagnosis, rehabilitation, follow-up and palliative care.

- ABC or MBC is still an incurable disease, and life after diagnosis involves learning how to live with an incurable disease, with ongoing treatment and uncertainty.
- Every patient with ABC should have access to the most recent therapeutic options and new targeted therapies in properly certified centers.

DISCUSSION AND OUTLOOK

The Latin American conference was the first ABC meeting held in our region to our knowledge and for the first time offered an informative platform for discussions on LABC and MBC based on high-level evidence. We endorse the ABC consensus as an important contribution toward standardizing and optimizing therapy for ABC at an international level. However, its recommendations need to be adapted to the reality of Latin America in terms of access. Importantly, some efforts are being made by Latin American countries to propose funds to improve access to high-cost drugs, such as the universalization of health care and coverage by the comprehensive health insurance in Peru.^{50,51} We expect that this report will contribute to the call to action of the ABC consensus and reinforce the need to narrow the gap on access to ABC therapy in Latin America to improve the QOL and survival of our patients.

AFFILIATIONS

¹Instituto Nacional de Enfermedades Neoplásicas, Lima, Peru

²Clínica Pasteur, Quito, Ecuador

³Hospital Clínico Viedma, Cochabamba, Bolivia

CORRESPONDING AUTHOR

Fernando Valencia, MD, Av. Angamos Este 2520, Surquillo, Lima 34, Peru; Twitter: @HenryLGomez1; e-mail: dr.fvalenciaj@gmail.com.

AUTHOR CONTRIBUTIONS

Conception and design: Henry L. Gomez, Carlos Castañeda, Fernando Valencia, Silvia Neciosup

Financial support: Henry L. Gomez, Silvia Neciosup

Administrative support: Henry L. Gomez, Fernando Valencia, Silvia Neciosup

Provision of study material or patients: Henry L. Gomez, Rene Muñoz-Bermeo, María del Carmen Torrico, Silvia Neciosup

Collection and assembly of data: All authors

Data analysis and interpretation: Henry L. Gomez, Carlos Castañeda, Fernando Valencia, María del Carmen Torrico, Silvia Neciosup

Manuscript writing: All authors

Final approval of manuscript: All authors

Accountable for all aspects of the work: All authors

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Henry L. Gomez

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Rene Muñoz-Bermeo

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