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NCCN Guidelines Panel: Breast Cancer

On behalf of the Society of Interventional Oncology, we respectfully request the NCCN Breast Cancer Guideline panel to review the enclosed data for inclusion of locoregional therapies for metastatic breast cancer.

We suggest including a section for locoregional therapies for stage IV metastatic breast cancer. There is evidence that in selected patients and specific clinical scenarios locoregional therapies may benefit patients with metastatic breast cancer:

**Clinical scenario 1: Painful bone metastases.**

Bone metastasis occurs in 65—75% of patients with metastatic breast cancer. Image-guided cryotherapy, heat-based thermal ablation, and cementoplasty have been demonstrated to be effective and fast-acting methods to improve bone pain due to metastasis from a wide range of tumors, including breast cancer.

The following articles are relevant to this proposed change:


**Clinical scenario 2: Oligometastatic disease.**

Local ablative therapies for five or fewer sites of metastasis have been shown to provide longer progression free survival and may prolong overall survival. Hepatic resection and/or thermal ablation of hepatic oligometastatic disease can confer disease free intervals lasting several years and perhaps, more importantly, allow long intervals of disease control without chemotherapy. This is particularly beneficial in patients not tolerating systemic therapy.
The following articles are relevant to this proposed change:


**Clinical scenario 3: Liver-dominant hepatic metastasis refractory to systemic therapy.**

Liver metastasis commonly occurs in breast cancer patients and is associated with poorer oncologic outcomes. Liver tumors may cause abdominal pain or result in compression of the portal vein or obstruction of bile ducts. In selected patients who are not eligible for resection or ablation, transarterial therapies such as chemoembolization and radioembolization have demonstrated radiologic responses that translate to prolonged patient survival. Combining liver-directed treatments in the management of metastatic breast cancer with liver-only or liver-dominant disease can provide longer disease control while delaying the need to change to another line of systemic therapy. Also, in patients with hormonally responsive breast cancer and new-onset liver metastases, transarterial locoregional therapy can delay the initiation of systemic chemotherapy and benefit the patient’s quality of life.

The following articles are relevant to this proposed change:


We would like to thank the NCCN panel members for their time and effort in reviewing this submission.

Sincerely,

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