

Speaker 1 ([00:01](#)):

Welcome to the Cancer Wise Podcast, where we'll discuss cancer prevention, treatments, the latest in research and important news around cancer, brought to you by the University of Michigan Health Rogel Cancer Center. Today, we're here to discuss metastatic or advanced breast cancer with Dr. Lynn Henry, the Disease Lead of the University of Michigan Health Rogel Cancer Center's breast cancer program. When we talk about breast cancer, there's not a lot of general talk around metastatic breast cancer. Can you explain what it is exactly?

Dr. Lynn Henry ([00:34](#)):

Sure. And thank you so much for having me talk today. This is a really important question, and I think it does confuse a lot of people. So metastatic breast cancer, anytime we're thinking about that, what we're talking about is cancer that has spread to sites beyond the breast and beyond the lymph nodes that are right next to the breast. So the lymph nodes that are under the arm, things like that. So if you have breast cancer that has spread to a bone, or to the liver, or to the lung, that's considered metastatic breast cancer. Some people will think that if it's in the bone, it must be bone cancer. But actually, if you biopsy it, and look at it under a microscope, it looks just like breast cancer that was in the breast, just in the wrong place. So we consider that to be metastatic breast cancer, and we treat it with drugs that we use to treat breast cancer, as opposed to using drugs that we would use, for example, to treat bone cancer.

Dr. Lynn Henry ([01:29](#)):

Also, with metastatic breast cancer, it can be diagnosed at the same time that someone is diagnosed with breast cancer for the very first time. And that's when it's considered stage IV, or it can be discovered and diagnosed months, years, even decades after someone first is diagnosed with breast cancer.

Speaker 1 ([01:49](#)):

You talked about moving, and it could potentially have moved to bones. What are other areas that breast cancer can metastasize to?

Dr. Lynn Henry ([01:59](#)):

Yeah, so typical metastatic breast cancer, we usually think of as going to the bone, to the liver, to the lung, and sometimes to the brain. It can also sometimes just go to lymph nodes in other parts of the body, like in the middle of the chest or in the abdomen. There are some strange breast cancers though. And so especially ones that are called lobular breast cancers, and these can really go anywhere. I mean, we've seen them go to the skin, to the ovary, to the pancreas, to the stomach. So we can't say that breast cancer only ever goes to specific places, but by far the most common places are bone, liver, lung and brain.

Speaker 1 ([02:39](#)):

You briefly touched on that you treat the breast cancer if it's metastasized somewhere else, like you would treat breast cancer. What are some of those treatment options? Sounds like they are similar to early stage breast cancer, but are there other ones that maybe you wouldn't think about necessarily when you have an early-stage breast cancer?



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Dr. Lynn Henry ([02:58](#)):

Yeah, so certainly, there are a lot of different types of treatment that we have for metastatic breast cancer. And whenever we're making treatment decisions, we use a lot of different information. One of the first things that we need to look at is what type of breast cancer does a patient have? Breast cancers can be what's called estrogen receptor-positive or negative, depending on whether they use estrogen like food to help them grow. They can be HER2-positive or negative, which is something completely different from hormones, but also can drive a cancer to grow. And then finally, there are completely different things that we also look at, some changes in the cancer, mutations or other alterations, that can sometimes lead some cancers to respond better to one drug versus another.

Dr. Lynn Henry ([03:45](#)):

So we take all of that information, and then we also take information about the patient. Some patients have other health conditions. That means we can't use a drug that might affect the nerves or might affect the heart. Some people have different preferences, some people really don't want to lose their hair if they can at all avoid it. And so we have different ways that we can tailor our therapy treatment recommendations to try to take some of that into account. So we have some drugs that are the same that we use in early-stage breast cancer, some of the chemotherapies, immunotherapies, anti-HER2 drugs, anti-hormone therapies and targeted therapies. Some of these are medicines that we use in the early-stage setting as well. And we may use them the exact same way, or we may use them in different combinations.

Dr. Lynn Henry ([04:34](#)):

In addition to that though, we have a lot of other medicines that we use in the metastatic setting that we don't use in the early-stage breast cancer setting. And part of that is because whenever we're first developing drugs and testing drugs, we tend to test them in patients who have metastatic disease first. And then if we find that they look like they're effective and we find that they're well tolerated, then we will move them into what we call the earlier-stage setting, if we're trying to treat women with early-stage breast cancer. So we actually have quite a lot of medicines that we use to treat metastatic breast cancer that have not yet been tested to see if they work in early-stage breast cancer. Although I'm sure that, if they look promising, they will definitely be tested at some point in the future.

Speaker 1 ([05:19](#)):

How common is it for someone to get diagnosed with metastatic breast cancer as their first breast cancer diagnosis?

Dr. Lynn Henry ([05:27](#)):

Yeah, so being found to have metastatic disease, at the time someone's originally diagnosed with breast cancer, is not very common. It's about 6 out of every 100 women, are found to have stage IV or metastatic disease when they're first diagnosed. That does vary a little bit. And so, for example, for patients who have HER2-positive breast cancer, which is only about 15% of all breast cancers, they actually have a higher likelihood of being found to have metastatic disease at the time their cancer's first diagnosed, compared to people with other types of breast cancer. Also, breast cancer that is found, either because someone has a lump in her breast, or someone who hasn't had a mammogram for a really long time, and has had some changes in her breast and hasn't gone to the doctor, in patients in either of those settings, we're more likely to find metastatic disease, when we do scans like CT scans and



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PET scans, compared to people who are found to have breast cancer because they had a screening mammogram done.

Dr. Lynn Henry ([06:33](#)):

But certainly, there's a lot of people out there who have cancer diagnosed in between mammograms, or because of a lump in their breast, who do not have metastatic disease. But is something that we look for and think about whenever cancer arises in between mammograms, for example.

Speaker 1 ([06:53](#)):

When it comes to breast cancer, as well as other cancers, there's a lot of discussion about genetics, and going through that process if there's a family history. Is someone have a higher hereditary predisposition to getting metastatic disease, if there is that family history?

Dr. Lynn Henry ([07:14](#)):

Yeah, that's a really good question. So there's a lot of different predispositions that people can have for getting breast cancer. There's the ones that we always think about BRCA1, BRCA2, also called BRCA1 and 2, because they're the ones that were identified first, and they're the most common. But there's a lot of other ones that we now know about, gene changes, mutations that people can inherit from their parents, that can increase their risk of getting breast cancer during their lifetime. As far as we know today, there doesn't seem to be an increased risk for women, or men, within a predisposition to getting breast cancer in the first place to actually getting metastatic breast cancer, which is good. However, we now have treatments that seem to work specifically in patients who have BRCA1, BRCA2, or something called PALB2 mutations. These medicines called PARP inhibitors work quite well actually, in patients who have metastatic breast cancer, and have one of those mutations. They don't work as well if people haven't inherited the mutation from a family member. And so we use those drugs almost exclusively in patients who have those mutations.

Speaker 1 ([08:31](#)):

With metastatic disease, whether it's breast cancer or other cancers, a lot of people feel that, "I've been diagnosed with this, and that's it for me." Can you talk about survivorship with people with metastatic breast cancer, and if that's improved over time, and what that looks like?

Dr. Lynn Henry ([08:54](#)):

Sure. So in general, when someone is diagnosed with metastatic breast cancer, so breast cancer that's outside of the breast or the lymph nodes that are right around the breast, we generally know that most of those patients will ultimately die from their breast cancer. There have been a lot of studies ongoing to try to change that. And actually, more recently, for some specific types of breast cancer, such as HER2-positive breast cancer, there have been tremendous strides made, in that survival is longer than it ever has been, we're getting more and more new drugs where we actually can start to hope that some of the patients who are diagnosed with the disease will actually have long survival and may still be on treatment, so it may be more like a chronic disease. Some people end up stopping treatment, and go for a very long period of time without having their cancer returned.

Dr. Lynn Henry ([09:57](#)):



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So we are starting to feel more hopeful that some of these new drugs may actually cure the disease, although we usually don't admittedly use that word. It's a little different for estrogen-receptor-positive, or what's called triple-negative breast cancer. We haven't had the same success finding new drugs for treating those particular cancers, although new drugs are being tested all the time. There's a lot of clinical trials ongoing, trying to find new anti-hormone therapies, new targeted treatments, to try to exploit some part of the cancer that might really help kill it, some new immunotherapies, so using the body's immune system to try to fight the cancer, and different combinations of all of those types of treatment. These are all new things that are being tested. And we've had new drugs approved throughout the past years and decade, really against all types of breast cancer. So we are getting more hopeful, but it still remains a challenge.

Speaker 1 ([10:59](#)):

You talked about some of these new drugs and these new treatments that have been coming around, what other research is being done around metastatic breast cancer?

Dr. Lynn Henry ([11:10](#)):

Yeah, so there are a lot of different clinical trials, Phase I, Phase II, Phase III clinical trials, which are trying to find new drugs, make sure they're safe, see how well they work, and then test them against the current standard drugs that we use. So that's a lot of the research that we've had going on recently. There's a lot of other studies going on too though. There are studies looking at different ways of monitoring cancer. So blood tests that we can now do to try to look for changes in the cancer, that are floating around in the blood, that we can potentially use to say, "Hey, this new drug may work well for this particular patient because she has a PIK3CA we can find in her blood, for example, or a HER2 mutation." There are new imaging tests that are being developed as well, that can try to identify whose cancers have estrogen receptors and have HER2 receptors, and see how well the drugs that we use are working with these fancy new imaging tests.

Dr. Lynn Henry ([12:12](#)):

So a lot of these new tests that are being developed will hopefully not just tell us, "Is the cancer there? Is it getting worse? Is it not getting worse?" but actually may give us better guidance about how best to treat an individual patient, and be able to monitor how well that treatment is working. The other category of studies that are being done in metastatic disease is ways to try to improve symptoms, either from the cancer or from the treatments themselves, to try to reduce symptoms, to try to improve quality of life. Because we do now have a number of women, and men, who are living much longer than they ever have before with metastatic breast cancer. And we want to help people continue to actually live their lives as well as they possibly can, not just focusing entirely on the length of life, but also on the quality of life. And so we find that to be very important. So there's quite a number of studies going on in that setting as well.

Speaker 1 ([13:14](#)):

If there isn't a current study, open around a quality of life for someone with metastatic breast cancer, what are some guidance or suggestions to patients that might have metastatic breast cancer, to get in that mindset of really getting that quality of life that they deserve?

Dr. Lynn Henry ([13:34](#)):



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Quality of life's incredibly important. And so some of it is just basic lifestyle recommendations that we have, exercise and be active, have a healthy diet, as much as possible, knowing that food may not taste the same as it did before, knowing that there may be some reason why someone can't be as active as they were before. But most people can still be at least somewhat active, get outside, enjoy the fresh air, that kind of thing. In addition to that though, we have a lot better drugs now than we ever had before, that can help treat nausea, that can help treat constipation, symptoms that can be due to the cancer or to the treatment. Here at the Rogel Cancer Center, we have both a palliative care clinic, as well as a cancer rehabilitation clinic. They can assist us with pain management, they can do procedures sometimes, so that people may not have to take medications all the time.

Dr. Lynn Henry ([14:35](#)):

We can refer patients to radiation oncology sometimes to help if someone has a particularly painful bone metastasis, that can help reduce the pain from that site, which may mean they don't need to take pain medicine anymore. There's also different ways we can try to improve fatigue. Fatigue is a big issue for a lot of patients who have metastatic cancer, and who are on some of these medications. And so by giving some medications, we're able to actually allow people to be more active and awake during the day, but still sleep at night. And so sometimes, our cancer rehabilitation colleagues can try to help with that. So there are a number of different ways that we can try to promote health and promote enjoying your life, enjoying your family, being able to get out and do the things and travel, everything that everybody has on their list of things they want to do, we want to try to help people accomplish their goals. And really, if they hope to be able to do something, we want to see them actually be able to accomplish that.

Speaker 1 ([15:38](#)):

You mentioned palliative care, that they can receive that. When people hear palliative care, they sometimes also think of end-of-life care. And is palliative care the same as end-of-life or hospice care? Or is it a little bit different?

Dr. Lynn Henry ([15:51](#)):

Yeah, so that is an incredibly important distinction. So it is true that in the past, whenever we said the word palliative care, a lot of times, we meant hospice. That is actually not the case anymore. There's been a big push throughout the United States to try to have patients who have cancer be referred to palliative care clinics early, to try to help with coping, to try to help with individual symptoms, while they are still getting their active cancer treatment. So palliative care and hospice are no longer synonymous. There's actually been some studies from lung cancer that have shown that referring patients to palliative care as soon as they are diagnosed with lung cancer, that they actually end up doing better and living longer than patients who didn't get referred to palliative care until they were ready for hospice.

Dr. Lynn Henry ([16:45](#)):

So we actually strongly encourage patients who are having symptoms from their cancer, or from their cancer treatment, to consider a referral to palliative care. Because I think that those are physicians and other healthcare providers who are experts in managing symptoms, and helping with psychological symptoms, physical symptoms, and they may be trained a little bit better in that, a lot of times, than the patient's oncologist. And so working together as a team, with the patient, the oncologist and the palliative care provider, can really do a lot to help a patient feel better, compared to just relying on the oncology team themselves.



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Speaker 1 ([17:32](#)):

Well, Dr. Henry, I really appreciate the time, we've covered a lot here. Is there anything that we didn't get to or cover that you want to make sure that the listeners know about?

Dr. Lynn Henry ([17:41](#)):

Yeah. I think one of the main things to consider for patients who have metastatic breast cancer is really communication is key. And so staying in touch with your oncology team, whether it's the oncologist, him or herself, or the nurse practitioner, or the other nurses in the clinic. If a patient is having trouble with tolerating a medicine or with symptoms from their cancer, we really want to hear about it, and we want to hear about it sooner rather than later, so that we can try to help. Our goal is to really allow people to live as full lives as possible for as long as possible. And we can only do that if we are aware of what's going on. I think some people are afraid to tell us if they're having a problem, because they might think that we'll take them off of a treatment that they think is working. And we certainly will do everything we can to allow people to stay on an effective treatment for as long as possible.

Dr. Lynn Henry ([18:40](#)):

But really that open line of communication is critical. And so always keep that in the back of your mind, and always feel free to ask questions. We always enjoy answering questions and the questions help everybody understand more about what's going on. And so no question is stupid, no question shouldn't be asked. Always feel free to ask your team anything.

Speaker 1 ([19:04](#)):

Great. Thank you very much.

Dr. Lynn Henry ([19:04](#)):

Thank you.

Speaker 1 ([19:05](#)):

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