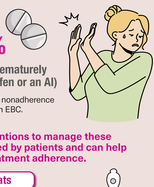
Anticipating and Managing Adverse Events From Adjuvant Therapy for HR+/HER2- EBC

Anticipating and Managing AEs From ET

Did You Know?

23%–28%
of patients with EBC prematurely discontinue ET (tamoxifen or an AI)

AEs are an important cause of nonadherence to adjuvant ET in patients with EBC.



Nurse-led interventions to manage these are positively received by patients and can help improve treatment adherence.

Hot Flashes/Night Sweats

- Cool layers, light blanket at night, or cooler air
- Acupuncture
- Avoid triggers through dietary modifications or stress reduction
- Take hormone therapy at a different time of day
- Use of SSRIs, oxybutynin, or gabapentin (off-label use)

Vaginal Dryness

- Refer to gynecology for examination and recommendations
- Lubrication during intercourse (water or oil based); avoid hormone-based lubricants or creams
- Daily lubrication at bedtime
- Low-dose local estrogen therapy (do not use in patients taking an AI)

Vaginal Bleeding

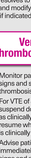
- Laboratory tests, including estradiol test, if patient has not had periods recently
- Pelvic ultrasound to rule out endometrial cancer and polyps/fibroids
- Refer to gynecology if postmenopausal or abnormal bleeding; consider endometrial biopsy

Cognitive Difficulties

- Referral for neuropsychiatric testing and evaluation may be appropriate if symptoms are intrusive

Hair Thinning

- Can occur with AIs (may also occur with CDK4/6 inhibitors)
- Refer to dermatology or onco-dermatology
- Provide support for psychological and emotional effects



Arthralgia

- Regular cardiovascular and weight resistance exercise
- NSAIDs: ibuprofen or naproxen as needed; monitor for gastritis; contraindicated in patients with thrombocytopenia; associated with neutropenia
- SNRI: must take every day; can cause lightheadedness, nausea and fatigue during the first week (off-label use)

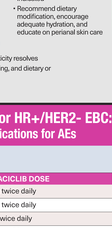
Osteoporosis

- Check bone density every 1-2 years while on AIs or ovarian suppression
- Weight-bearing exercise and calcium and vitamin D supplementation as recommended for women not affected by breast cancer
- Denosumab or bisphosphonates to prevent or reduce treatment-related bone loss

Anticipating and Managing AEs From Adjuvant Abemaciclib + ET

While patients generally believe that CDK4/6 inhibitor–associated AEs are not as bad as those experienced with chemotherapy, AEs can negatively affect quality of life and treatment adherence and persistence.

Nurses can have a proactive role in preparing patients for and addressing CDK4/6 inhibitor-related AEs.

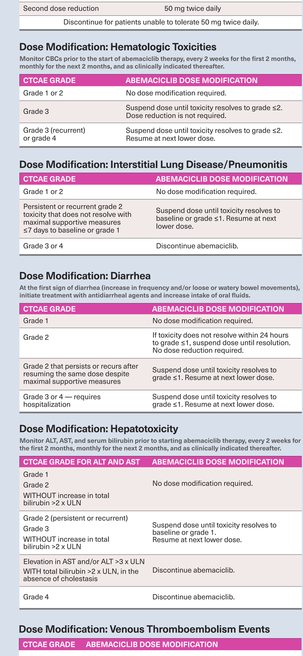


Neutropenia

- Monitor CBCs *prior* to the start of therapy, every 2 weeks for the first 2 months, monthly for the next 2 months, and as clinically indicated thereafter
- For CTCAE grade 3 or 4, suspend until toxicity resolves to grade ≤2 and modify dose if indicated

Hair Thinning

- Caused by AIs or CDK4/6 inhibitors
- Refer to dermatology or onco-dermatology
- Provide support for psychological and emotional impacts



Interstitial Lung Disease or Pneumonitis

- Counsel patients on the importance of promptly reporting dry cough with/without fever or shortness of breath
- Monitor for clinical symptoms or radiologic changes indicative of ILD/pneumonitis
- Interrupt or dose reduce therapy for persistent or recurrent grade 2 ILD/pneumonitis; permanently discontinue if grade ≥3

Venous Thromboembolism

- Monitor patients for signs and symptoms of thrombosis and PE
- For VTE of any grade, suspend dose and treat as clinically indicated; resume when patient is clinically stable
- Advise patients to immediately report signs and symptoms of VTE

Hepatotoxicity

- Perform LFTs before treatment initiation
- Inform patients of signs and symptoms of hepatotoxicity
- Monitor LFTs every 2 weeks for the first 2 months, monthly for the next 2 months, and as indicated thereafter

Diarrhea

- At the first sign of diarrhea, start antidiarrheal agents and increase intake of oral fluids
- For grade ≥2 toxicity, suspend dose until toxicity resolves to grade ≤1 and reduce dose as indicated
- Recommend dietary modification, encourage adequate hydration, and educate on perianal skin care

Fatigue

- Consider dose reduction then dose escalate again if toxicity resolves
- Recommend exercise, yoga, massage therapy, counseling, and dietary or nutritional counseling

Adjuvant Abemaciclib + ET for HR+/HER2- EBC: Recommended Dose Modifications for AEs

Dose Modification: AEs

DOSE LEVEL	ABEMACICLIB DOSE
Recommended starting dose	150 mg twice daily
First dose reduction	100 mg twice daily
Second dose reduction	50 mg twice daily
Discontinue for patients unable to tolerate 50 mg twice daily.	

Dose Modification: Hematologic Toxicities

Monitor CBCs prior to the start of abemaciclib therapy, every 2 weeks for the first 2 months, monthly for the next 2 months, and as clinically indicated thereafter.

CTCAE GRADE	ABEMACICLIB DOSE MODIFICATION
Grade 1 or 2	No dose modification required.
Grade 3	Suspend dose until toxicity resolves to grade ≤2. Dose reduction is not required.
Grade 3 (recurrent) or grade 4	Suspend dose until toxicity resolves to grade ≤2. Resume at next lower dose.

Dose Modification: Interstitial Lung Disease/Pneumonitis

CTCAE GRADE	ABEMACICLIB DOSE MODIFICATION
Grade 1 or 2	No dose modification required.
Persistent or recurrent grade 2 toxicity that does not resolve with maximal supportive measures ≤7 days to baseline or grade 1	Suspend dose until toxicity resolves to baseline or grade ≤1. Resume at next lower dose.
Grade 3 or 4	Discontinue abemaciclib.

Dose Modification: Diarrhea

At the first sign of diarrhea (increase in frequency and/or loose or watery bowel movements), initiate treatment with antidiarrheal agents and increase intake of oral fluids.

CTCAE GRADE	ABEMACICLIB DOSE MODIFICATION
Grade 1	No dose modification required.
Grade 2	If toxicity does not resolve within 24 hours to grade ≤1, suspend dose until resolution. No dose reduction required.
Grade 2 that persists or recurs after resuming the same dose despite maximal supportive measures	Suspend dose until toxicity resolves to grade ≤1. Resume at next lower dose.
Grade 3 or 4 — requires hospitalization	Suspend dose until toxicity resolves to grade ≤1. Resume at next lower dose.

Dose Modification: Hepatotoxicity

Monitor ALT, AST, and serum bilirubin prior to starting abemaciclib therapy, every 2 weeks for the first 2 months, monthly for the next 2 months, and as clinically indicated thereafter.

CTCAE GRADE FOR ALT AND AST	ABEMACICLIB DOSE MODIFICATION
Grade 1 Grade 2 WITHOUT increase in total bilirubin >2 x ULN	No dose modification required.
Grade 2 (persistent or recurrent) Grade 3 WITHOUT increase in total bilirubin >2 x ULN	Suspend dose until toxicity resolves to baseline or grade 1. Resume at next lower dose.
Elevation in AST and/or ALT >3 x ULN WITH total bilirubin >2 x ULN, in the absence of cholestasis	Discontinue abemaciclib.
Grade 4	Discontinue abemaciclib.

Dose Modification: Venous Thromboembolism Events

CTCAE GRADE	ABEMACICLIB DOSE MODIFICATION
Any grade	Suspend dose and treat as clinically indicated. Resume abemaciclib when the patient is clinically stable.

Dose Modification: Other Toxicities

CTCAE GRADE	ABEMACICLIB DOSE MODIFICATION
Grade 1 or 2	No dose modification required.
Persistent or recurrent grade 2 toxicity that does not resolve with maximal supportive measures ≤7 days to baseline or grade 1	Suspend dose until toxicity resolves to baseline or grade ≤1. Resume at next lower dose.
Grade 3 or 4	Suspend dose until toxicity resolves to baseline or grade ≤1. Resume at next lower dose.

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Abbreviations:

AE, adverse event; AI, aromatase inhibitor; ALT, alanine aminotransferase; AST, aspartate aminotransferase; CBC, complete blood count; CTCAE, Common Terminology Criteria for Adverse Events; EBC, early breast cancer; ET, endocrine therapy; HER2, human epidermal growth factor receptor 2; HR, hormone receptor; ILD, interstitial lung disease; LFT, liver function test; NSAID, nonsteroidal anti-inflammatory drug; PE, pulmonary embolism; SNRI, serotonin and norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor; ULN, upper limit of normal; VTE, venous thromboembolism.