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## Primary Locoregional Treatment in Metastatic Breast Cancer: A Reply

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### TO THE EDITORS

We read with interest the Letter to the Editor by Buyukhatipoglu et al. and appreciate the opportunity to respond to their comments (<http://www.surgonc.org/news-publications/annals-of-surgical-oncology/letters-to-the-editor>). While we agree that there is no convincing evidence that radiation therapy (RT) would provide a survival benefit in stage IV breast cancer, it certainly provides a local control benefit. For patients treated with breast-conserving surgery, the toxicity of RT is typically minimal, especially with hypofractionated whole-breast RT that can be completed in 3–4 weeks with little adverse effect on quality of life. For patients who are post-mastectomy, the toxicity of RT is greater; however, some of the morbidity these patients experience is as a result of surgery, and RT may be justifiable given that some of these patients had locally advanced disease, justifying RT for local control after completing induction chemotherapy and surgery. Locoregional therapy has proven benefit in preventing fungating or bulky disease recurrence, which is clearly detrimental to quality of life. However, determining which patients may progress to this point and benefit from preventive measures is unknown and further studies may be beneficial in this area. In practice, many patients with stage IV disease treated with surgery for an intact primary tumor would be rendered stage IV–no evidence of disease (NED) following surgery. RT may be helpful to improve local control and thus potentially prolong

survival for this patient population; hence, we evaluate the potential benefit of post-lumpectomy and post-mastectomy RT for each patient to individualize care in consideration of guideline-based practice for non-metastatic patients. At our institution, postoperative RT is presented as optional for our stage IV patients (outside the Eastern Cooperative Oncology Group [ECOG] trial) because of lack of available evidence; however, most such patients, once on the pathway of aggressive therapy, will also choose RT for the admittedly incremental local benefit.

Rapiti et al. demonstrated a particularly strong association with increased survival for patients with bone-only metastasis undergoing IPT resection.<sup>1</sup> We found that patients with liver metastases had superior survival compared with all other types of metastases, and that a survival benefit was achieved for patients who underwent surgical resection for both their breast primary and their metastasis. However, this subset analysis included far too few patients to merit inclusion in our paper, given that this finding is speculative at best. We respectfully contend that additional subset analyses based on dividing the surgical cohort according to corticosteroid hormone receptor status or human epidermal growth factor receptor 2 (HER2) status would be inappropriate given that the statistical power would thus be too small to be conclusive. Singletary et al. reported that selected patients with metastatic disease may experience longer survival when offered surgical resection for single or multiple metastases restricted to one organ.<sup>2</sup> Patients with oligometastatic disease are considered for potential resection of visceral metastasis, reflecting an inherent selection bias for those who we perceive will likely have the best outcome. Careful consideration is given to resection of liver metastasis from breast cancer based on our institutional experience, which reflects a potential institutional selection bias.

Retrospective studies such as our institutional series do reflect selection biases that cannot be controlled for completely. We look forward to the results of the Translational Breast Cancer Research Consortium multi-institutional prospective analysis, which, although not a randomized study, is closed to accrual and is pending follow-up analyses.

More definitive answers regarding the potential benefit of surgery and radiation for stage IV disease will likely come from the ECOG's prospective randomized trial.

## REFERENCES

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