A Feasibility Study of Bevacizumab plus Dose-Dense Doxorubicin–Cyclophosphamide (AC) Followed by Nanoparticle Albumin–Bound Paclitaxel in Early-Stage Breast Cancer

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Abstract

**Purpose:** Bevacizumab confers benefits in metastatic breast cancer but may be more effective as adjuvant therapy. We evaluated the cardiac safety of bevacizumab plus dose-dense doxorubicin–cyclophosphamide (ddAC) → nanoparticle albumin–bound (nab)-paclitaxel in human epidermal growth factor receptor 2 (HER2)–normal early-stage breast cancer.

**Experimental Design:** Eighty patients with normal left ventricular ejection fraction (LVEF) were enrolled. Bevacizumab was administered for 1 year, concurrently with ddAC → nab-paclitaxel then as a single agent. LVEF was evaluated at months 0, 2, 6, 9, and 18. This regimen was considered safe if fewer than three cardiac events or fewer than two deaths from left ventricular dysfunction occurred. Correlative studies of cardiac troponin (cTn) and plasma renin activity (PRA) were conducted.

**Results:** The median age was 48 years (range, 27–75 years), and baseline LVEF was 68% (53%–82%). After 39 months’ median follow-up (5–45 months): median LVEF was 68% (53%–80%) at 2 months (n = 78), 64% (51%–77%) at 6 months (n = 66), 63% (48%–77%) at 9 months (n = 61), and 66% (42%–76%) at 18 months (n = 54). One patient developed symptomatic LV dysfunction at month 15. Common toxicities necessitating treatment discontinuation were hypertension (HTN, 4%), wound-healing complications (4%), and asymptomatic LVEF declines (4%). Neither cTn nor PRA predicted congestive heart failure (CHF) or HTN, respectively.

**Conclusions:** Bevacizumab with ddAC → nab-paclitaxel had a low rate of cardiac events; cTn and PRA levels are not predictive of CHF or HTN, respectively. The efficacy of bevacizumab as adjuvant treatment will be established in several ongoing phase III trials. *Clin Cancer Res; 17(10); 3398–407. ©2011 AACR.*
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Hypothesize that a rise in PRA may predict for bevacizu-
mab-mediated HTN and that cTn elevations may predict
subsequent LVEF declines.

Dose-dense chemotherapy was developed with conven-
tional paclitaxel (8). Nanoparticle albumin-bound (nab)-
paclitaxel (Abraxane, Abraxis Oncology) may offer toxicity
advantages because it is a formulation free of polyoxeythyl-
lated castor oil (Cremophor EL; BASF) and is not associated
with the rare but severe hypersensitivity reactions reported
with the conventional solvent used with paclitaxel (28). In
addition, the administration of nab-paclitaxel every second
week may offer an efficacy advantage over administration
every third week (29). Previous studies have shown the
safety of substituting nab-paclitaxel for conventional pacli-
taxel in the dose-dense adjuvant regimen (30, 31). To
inform subsequent ongoing clinical trials, we built
on these observations by testing the cardiac safety and
tolerability of bevacizumab added to adjuvant dose-dense
doxorubicin–cyclophosphamide [ddAC] followed by nab-
paclitaxel and incorporated studies of potential predictors
of HTN and CHF.

Methods

Study and biostatistical design

The primary objective was to determine the cardiac safety
of adjuvant bevacizumab administered for 1 year (concur-
rently with ddAC — nab-paclitaxel and then as monother-
apy) as determined by the incidence of cardiac events
(Fig. 1). A cardiac event was defined as cardiac death from
left ventricular (LV) dysfunction or symptomatic CHF
(dyspnea with normal activity or at rest and an LVEF of
less than 50%). The secondary end points were noncardio-
toxicity, disease-free survival, and overall survival.

On the basis of prior studies of targeted therapies such as
tratuzumab and bevacizumab with anthracyclines (10, 19,
20), a 15% patient dropout rate due to significant asympt-
omatic declines in LVEF was anticipated during che-
motherapy with coadministered bevacizumab. To study
64 evaluable patients, with “evaluable patients” defined as
completing ddAC with bevacizumab and able to con-
tinue bevacizumab based on the month 2 multiple-gated
acquisition (MUGA) scan or echocardiogram (ECHO), we
planned to enroll 75 patients. The trial was to be termi-
nated if we observed 3 or more (≥4.7%) cardiac events
among the evaluable patients: 3 symptomatic CHF events
or one cardiac death from LV dysfunction and 2 sympto-
matic CHF events. If more than one cardiac death from LV
dysfunction was observed, the trial would be terminated.
The probability of declaring the regimen safe for a range of
ture cardiac event rates is shown in Supplemental Table 1
(32). For example, the probability of the trial being stopped
if the true cardiac event rate is 8% is 90%.

Because of rapid accrual of patients into the screening
phase toward the end of the trial, 80 patients were
enrolled. All patients provided informed consent. This

Translational Relevance

Bevacizumab, a humanized monoclonal antibody
that binds vascular endothelial growth factor, prolongs
progression-free survival in patients with metastatic
breast cancer but may be more effective when targeting
minimal residual disease in the adjuvant setting. There
is, however, some concern that administration of beva-
cizumab with adjuvant anthracycline-based therapy
will increase the risk of congestive heart failure
(CHF). This phase II study indicates that adjuvant
anthracycline-based chemotherapy plus bevacizumab
is safe and feasible and thus supports ongoing random-
ized studies. Although the primary end point of this
study was clinical cardiac safety, we also explored the
use of serum cardiac troponins as predictors of CHF and
baseline blood pressure and plasma renin activity as
predictors of hypertension. Our results can inform
clinical trial design.
study was reviewed and approved by the institutional review boards at both participating institutions [Memorial Sloan-Kettering Cancer Center (MSKCC) and University of California San Francisco (UCSF) Comprehensive Cancer Center].

Patients
Eligible patients were 18 years or more with pathologically confirmed HER2-normal early-stage invasive breast cancer; had completed all planned surgery 28 days or more prior to the start of therapy; had an Eastern Cooperative Oncology Group (ECOG) performance status less than or equal to 1; and had adequate hepatic, renal, and hematologic function. Baseline LVEF was within institutional normal limits as measured by MUGA scan or ECHO.

Patients were permitted to have received prior therapy for an ipsilateral or contralateral breast cancer but were excluded if they had received a taxane within the preceding year or previously received an anthracycline. Patients with baseline proteinuria [urine protein creatinine ratio (UPC) > 1], significant bleeding within 6 months of study entry, baseline BP of more than 150/100 mm Hg, unstable angina, CHF greater than New York Heart Association (NYHA) class II, myocardial infarction or stroke within 12 months, clinically significant peripheral vascular disease, prior antiangiogenesis therapy, or active full-dose anticoagulation were excluded.

Treatment
Treatment consisted of intravenous ddAC (60/600 mg/m²) every 2 weeks for 4 cycles followed by intravenous nab-paclitaxel (260 mg/m²) every 2 weeks for 4 cycles, with pegfilgrastim (6 mg subcutaneously) on day 2 (see Fig. 1). Bevacizumab was administered for a total of 52 weeks (20 doses): eight doses at 10 mg/kg intravenously every 2 weeks concurrent with chemotherapy and 12 doses administered at 15 mg/kg every 3 weeks thereafter. Standard premedica-

Parameters for holding or discontinuing therapy

Doxorubicin and cyclophosphamide (AC) with nab-paclitaxel. Patients experiencing 2 episodes of neutropenic fever and/or grade 3 or 4 nonhematologic toxicity had subsequent doses reduced by 20%. A maximum of 2 dose reductions was permitted. If the platelet count was less than 100,000/μL, and/or the absolute neutrophil count (ANC) less than 1,000/μL, and/or nonhematologic toxicities (excluding alopecia) had not recovered to grade 1 or lower on the day that chemotherapy was to be administered, treatment was delayed by 1 week. Complete blood count testing and toxicity grading were repeated weekly. If the platelet count, ANC, and nonhematologic toxicity did not recover, a further delay of up to 1 week was required. Patients were removed from study if treatment delays of more than 2 consecutive weeks were required. AC was discontinued with symptomatic, confirmed CHF, or myocardial infarction. If grade 3 or greater toxicity recurred after dose adjustments and/or delays, AC was discontinued, and the patient was permitted to proceed with nab-paclitaxel at the discretion of the treating physician.

Bevacizumab. Parameters were set for holding bevacizumab for patients with asymptomatic left LVEF declines (Table 1). Bevacizumab was to be permanently discontinued when 2 consecutive or 3 intermittent “holds” occurred. If LVEF was maintained at a “continue” category or improved from a “hold” to a “continue” category, additional MUGA scans (or ECHOs) could be ordered before the next scheduled MUGA scan at the investigator’s discretion. Bevacizumab administration was not impacted by dose reductions of AC and/or nab-paclitaxel. However, if
chemotherapy was delayed, bevacizumab was also delayed to maintain concurrent administration. Chemotherapy was continued alone if bevacizumab was held or discontinued before chemotherapy completion. If chemotherapy was permanently discontinued because of toxicity, patients were permitted to complete therapy with bevacizumab alone. There were no bevacizumab dose modifications for toxicity. The UPC ratio was calculated at baseline and prior to every other bevacizumab administration. Any patient developing a UPC ratio more than 3.5 had bevacizumab held until the UPC recovered to less than 3.5. Bevacizumab was discontinued in patients with grade 4 HTN, poorly controlled HTN despite oral medication, or proteinuria requiring a "hold" on bevacizumab administration for more than 8 weeks. Bevacizumab was administered only if the systolic BP was less than 150 mm Hg and the diastolic BP was less than 100 mm Hg. Bevacizumab was discontinued with symptomatic, confirmed CHF or myocardial infarction. A 4-week maintenance bevacizumab hold was recommended prior to and following delayed breast reconstruction with a maximum 9-week hold permitted.

Toxicity assessments. Toxicities were assessed using the National Cancer Institute Common Toxicity Criteria (NCI-CTC), version 3.0.

Exploratory correlative studies

Physical examination with BP measurement occurred every 2 weeks during treatment with concurrent bevacizumab with ddAC — nab-paclitaxel and every 6 weeks during treatment with bevacizumab alone. Peripheral blood for cTnI was collected at baseline, weeks 2, 4, 6, 8, 10, 12, and 14, and months 6, 9, and 18. cTnI values over time were examined as continuous variables by institution and as categorical variables, where cTnI values were categorized as "undetectable" (<0.06 ng/mL MSKCC or <0.05 ng/mL UCSF), "minimally detectable" (0.06–0.31 ng/mL MSKCC or 0.05–0.16 ng/mL UCSF), or "elevated" (>0.31 ng/mL MSKCC or >0.16 ng/mL UCSF). Baseline and maximum cTnI values were compared with the maximum change in LVEF values for all 80 enrolled patients over the study period using analysis of variance or regression. Baseline BP as a predictor of a maximum "minimally detectable" or "elevated" cTnI value was also explored.

Results

Between July 2006 and August 2007, 80 patients were enrolled. Baseline patient characteristics are outlined in Table 2. The median age was 48 years (range, 27–75 years). As of May 1, 2010, median follow-up was 39 months (range, 5–45 months). The median number of cycles administered was 20 (range, 1–21 with one patient receiving one additional cycle in error). Twenty-seven patients (34%) did not complete the planned course of therapy: 8 (10%) withdrew consent, 16 (20%) withdrew from study because of toxicity, 2 (3%) experienced disease progression on therapy, and 1 (1%) received only 17 of the planned 20 cycles in error. Twenty-seven patients (34%) did not complete the planned course of therapy: 8 (10%) withdrew consent, 16 (20%) withdrew from study because of toxicity, 2 (3%) experienced disease progression on therapy, and 1 (1%) received only 17 of the planned 20 cycles in error. As of May 1, 2010, 13 patients (16%) have experienced disease progression: 4 patients (5%) after completion of therapy (at 13, 23, 24, and 34 months), 2 (3%) on therapy, 1 (1%) after withdrawing consent, and 6 (7.5%) after study withdrawal secondary to toxicity (HTN, neuropathy, pain/ataxia, wound-healing complication, and migraines).

Cardiac outcomes

The median baseline LVEF was 68% (range, 53%–82%). Median LVEF was 68% (range, 53%–80%) for the 78 evaluable patients at 2 months, 64% (range, 51%–77%) for the 66 evaluable patients at 6 months, 63% (range,
Table 2. Patient characteristics (N = 80)

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<td>with axillary dissection and adjuvant XRT</td>
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<td>Post mastectomy XRT</td>
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<tr>
<td>Median baseline LVEF, % (range)</td>
<td>68</td>
<td>(53–82)</td>
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</table>

a According to the American Joint Committee on Cancer Staging Manual, 7th ed.

Abbreviations: XRT, radiation therapy; TRAM, transverse rectus abdominis musculocutaneous. LVEF, left ventricular ejection fraction.

48%–77%) for the 61 evaluable patients at 9 months, and 66% (range, 42%–76%) for the 54 evaluable patients at 18 months (Fig. 3A).

Seven patients [9%; 95% CI (4%–18%)] experienced either a symptomatic LVEF decline or an asymptomatic LVEF decline necessitating bevacizumab hold/discontinuation per protocol guidelines (Table 1; Fig. 3B). The median age for these 7 patients was 46 years (range, 42–60 years). One experienced symptomatic grade 3 LV dysfunction (nadir LVEF, 40%) 3 months after completing the planned course of therapy and underwent cardiac catheterization with stenting of a 99% left anterior descending artery occlusion; 2 experienced an asymptomatic grade 1 LVEF decline necessitating bevacizumab discontinuation at months 7 and 10 with subsequent LVEF recovery off therapy; 1 withdrew consent after a protocol-stipulated bevacizumab hold at month 2 despite subsequent LVEF recovery; one developed apical hypokinesis at month 6 (with an associated LVEF decline to 53%, from 62% at baseline and 59% at month 2) and was withdrawn from study at the treating physician’s discretion—a further decline in LVEF off therapy to 48% (grade 2) was noted at month 9, with LVEF recovery to 53% at month 12 and 52% at month 18; and 2 had bevacizumab held per protocol. Of these 2, 1 occurred at month 3 secondary to an absolute decrease of 11% from the baseline value of 62% (per protocol, chemotherapy alone was continued for 4 weeks and bevacizumab was subsequently successfully reinstated and completed after LVEF recovery to 58% at month 4). The second patient had bevacizumab held at month 9 secondary to a more than 15% LVEF decline from baseline (73% to 57%) with recovery (to 69%) at month 10 and successful reinstatement of bevacizumab. Thus, overall 3 (4%) patients withdrew from the study because of asymptomatic LVEF declines as specified per protocol, 1 (1%) withdrew consent after a bevacizumab hold despite LVEF recovery, and 2 (3%) had bevacizumab reinstalled.

There were no cardiac deaths in this study. Fifteen months after completing bevacizumab, 1 patient had placement of a defibrillator for arrhythmogenic right ventricular dysplasia, without a documented decline in LVEF. Fourteen months after completing bevacizumab, another patient underwent cardiac catheterization with placement of 2 stents for unstable angina, and her LVEF at that time was 60%.

Toxicity and serious adverse events

Commonly reported treatment-related toxicities included fatigue, sensory neuropathy, and nausea (Fig. 4). No grade 3 or 4 bone pain was reported. As of May 1, 2010, there were 35 hospitalizations in 26 (33%) of the 80 enrolled patients. Four patients (5%) were hospitalized after completion of the planned course of therapy: 1 with disease progression, one with biliary colic, 1 with chest pain requiring left anterior descending stenting as previously described, and 1 with seizure and a subsequent diagnosis of multiple sclerosis. One patient, off study secondary to HTN, was hospitalized with implant infection 7 months after tissue...
expander exchange. Among the 21 patients (26%) who were hospitalized during therapy, 1 patient was hospitalized on 4 occasions while on therapy (for grade 4 neutropenia, grade 4 febrile neutropenia, tissue expander infection, and tissue expander removal) and on one occasion off study (for persistent wound-healing complications after infected expander removal). Four patients had 2 hospitalizations during treatment: one was admitted with febrile neutropenia and later anorexia with dehydration, a second with grade 4 neutropenia and later chest pain with negative cardiac evaluation, a third with neuropathy and later pyelonephritis, and a fourth with severe hypothyroidism and then tissue expander exchange complicated by cellulitis 7 days later.

One patient was hospitalized once during treatment for HTN with headache and twice off study for wound-healing complications at 4 and 12 weeks after tissue expander exchange.

The reasons for hospitalization for the remaining 15 patients were infection requiring antibiotics (n = 4), febrile neutropenia (n = 2), chest pain of uncertain etiology (n = 2), nonspecific gastrointestinal complaints (n = 2), grade 2 headache (n = 1), grade 4 HTN with headache (n = 1), atrial fibrillation (n = 1), supraventricular tachycardia (n = 1), and rash secondary to probable hypersensitivity reaction (n = 1).

**Surgery-related complications**

Of the 56 (70%) study patients who underwent mastectomy, 39 (49%) underwent immediate (prestudy) tissue expander reconstruction, one (1%) underwent an uncomplicated delayed transverse rectus abdominis myocutaneous flap procedure after completion of the planned course of bevacizumab, and 16 (20%) did not undergo reconstruction. Five patients experienced cellulitis or wound-healing complications after mastectomy: one occurred 4 days after tissue expander exchange status after cycle 15 of bevacizumab; 1 occurred approximately 4 weeks after tissue expander exchange status after cycle 8 of bevacizumab; 1 occurred approximately 16 weeks after tissue expander exchange, approximately 7 weeks after completion of radiation, and after cycle 12 of bevacizumab; 1 occurred after the first cycle of bevacizumab (approximately 2 months after tissue expander placement); and 1 occurred after mastectomy without reconstruction, 4 days after completion of radiation therapy and after cycle 11 of bevacizumab. Of the 2 patients who underwent breast-conserving surgery and experienced wound-healing complications: 1 experienced grade 2 cellulitis after cycle 2 of bevacizumab (11 weeks after surgery) and 1 experienced grade 3 cellulitis that necessitated study discontinuation of bevacizumab after cycle 8 (5 months after surgery).
Baseline cTnI was “undetectable” in 79 patients (99%), and elevated in 0 (0%). There was no association between maximum categorical cTnl levels for women with significant LVEF declines compared with those without significant LVEF declines. Furthermore, neither systolic nor diastolic baseline BP predicted maximum categorical cTnl levels on study.

Discussion

Bevacizumab plus ddAC → nab-paclitaxel met our predefined feasibility criteria. Only 1 patient (1%) had symptomatic grade 3 CHF approximately 3 months after completing the planned 1-year course of bevacizumab, and we note that this patient had severe coronary artery disease that required a coronary artery stent. There were no cardiac deaths. Six patients (8%) had asymptomatic LVEF declines resulting in 4 (5%) withdrawals. Longer-term follow-up for cardiac events is ongoing.

Prior studies of bevacizumab with various chemotherapy agents have raised unresolved questions regarding cardiac safety. In a phase III study of capcitabine plus bevacizumab in women with anthracycline- and taxane-resistant metastatic breast cancer (MBC), the incidence of CHF or cardiomyopathy was significantly greater with the combination than with chemotherapy alone (3.1% vs. 0.9%, respectively; ref. 17). In a phase III study (E2100) of first-line weekly paclitaxel with or without bevacizumab in MBC, however, the incidence of grade 3 or 4 LV dysfunction was similar for both the combination and paclitaxel alone arms (0% grade 3 and 0.3% grade 4 events in the paclitaxel alone arm and 0.8% grade 3 and 0% grade 4 events in the combination arm; ref. 12).

The risk of cardiotoxicity is a clinical concern when adjuvant anthracycline-containing regimens are recommended and may be increased when biologic agents are coadministered (21). Specifically, the risk of a grade 3 or 4 cardiac event for adjuvant ddAC → paclitaxel is 1% (8, 34) and the 3-year risk of NYHA class III or IV CHF or death from cardiac causes in the North American multicenter studies of adjuvant AC → paclitaxel with or without trastuzumab was 4.1% versus 0.8%, respectively (10).

In studies in which anthracyclines and bevacizumab have been coadministered, cardiotoxicity rates have been highly variable. For example, in a phase II study of doxorubicin (75 mg/m² every 3 weeks) plus bevacizumab in 17 patients with metastatic soft tissue sarcoma, 2 patients (11.8%) developed grade 3 or greater cardiotoxicity (20). Preliminary data from a study of neoadjuvant doxorubicin (50 mg/m²) and docetaxel (75 mg/m²) plus bevacizumab every 3 weeks for 6 cycles in patients with locally advanced breast cancer indicated a 9.5% rate of asymptomatic LVEF decline (3 of 21 patients) with subsequent normalization on follow-up evaluation and no symptomatic CHF (19). However, in a recent report of first-line chemotherapy with or without bevacizumab in MBC (RIBBON 1 study), the

Exploratory correlative studies

Baseline median systolic BP predicted grade 3 or 4 HTN ($P = 0.045$; grade 0 or 1 vs. grade 3 or 4), when HTN was evaluated by first grade on study. Neither baseline diastolic BP ($P = 0.077$) nor PRA ($P = 0.862$) predicted grade 3 or 4 HTN. Patients with grade 2 and grade 3 or 4 HTN appeared to have an initial decline in PRA before the onset of HTN, but no statistically significant trends were identified (33).

Baseline cTnl was “undetectable” in 79 patients (99%), “minimally detectable” in 1 (1%), and elevated in 0 (0%). Maximum cTnl was “undetectable” in 17 patients (21%), “minimally detectable” in 57 (71%), and elevated in 6 (8%). There was no association between maximum LVEF% change [(max-min)/min] compared with maximum troponin when patients were evaluated by institution (MSKCC $P = 0.37$ and UCSF $P = 0.29$). There was no association between maximum categorical cTnl levels for women with significant LVEF declines compared with those without significant LVEF declines. Furthermore, neither systolic nor diastolic baseline BP predicted maximum categorical cTnl levels on study.
incidence of grade 3 or greater LV systolic dysfunction was 0% with anthracycline-based chemotherapy alone versus 3% with the addition of bevacizumab (14). The variability in reported cardiotoxicity rates may reflect differences in specific patient, tumor, and treatment characteristics, including comorbid conditions, prior chemotherapy regimens, and differences in anthracycline dosing.

In an indirect comparison, the regimen evaluated in this study had a lower rate of cardiotoxicity than was observed in another phase II adjuvant study, ECOG 2104, wherein breast cancer patients received ddAC→paclitaxel with 1 year of bevacizumab initiated with AC or paclitaxel (35). In ECOG 2104, 3 of the 223 (1%) patients experienced symptomatic CHF while on therapy. In addition, 13 of 93 patients (14%) who received concurrent ddAC plus bevacizumab and 7 of 113 patients (6%) who received ddAC alone followed by sequential administration of bevacizumab (initiated with paclitaxel) had asymptomatic LVEF declines of more than 10% after the first 4 cycles. Similar to our results, a study of preoperative bevacizumab in combination with doxorubicin (50 mg/m²) and docetaxel (75 mg/m²) every 3 weeks for 6 cycles has shown that none of the 21 patients experienced symptomatic CHF and only 2 patients had a grade 2 asymptomatic LVEF decline (19).

In our prospectively planned correliative studies, cTnI did not appear to predict LVEF changes with the evaluated regimen, although the analysis was limited as a result of the low cardiac event rate in this study. In addition, we now recognize that the timing of our cTnI measurements may have been suboptimal. Because cTnI peaks immediately after high-dose chemotherapy (27) and because we drew our samples prior to chemotherapy administration (i.e., potentially at nadir timepoints) per standard institutional guidelines, we could have missed the maximal impact on cTnI. Therefore, we believe that cTnI as a potential predictor of treatment-mediated cardiotoxicity should be explored further. Exploratory analyses of PRA as a predictor of bevacizumab-mediated HTN were similarly limited by the small number of patients. PRA at time of first HTN event (grade 2 or grade 3/4) appeared to decline before the onset of HTN, but no statistically significant trends were identified. Interestingly, the readily available clinical parameter of baseline systolic BP was the only predictor of grade 3/4 HTN, indicating that vigilance in BP monitoring on bevacizumab is warranted. Other clinically relevant toxicities reported in phase III trials of bevacizumab plus chemotherapy included HTN, proteinuria, and venous and arterial thromboembolic events (12, 17, 22, 36). The most commonly reported toxicities in our study were attributable to the chemotherapy component of the regimen; namely, fatigue, taxane-associated sensory neuropathy, and nausea. The 14% rate of grade 3 sensory neuropathy in the study is similar to rates reported with ddAC→nab-paclitaxel regimens without bevacizumab (30), suggesting that the addition of bevacizumab is unlikely to exacerbate neurotoxicity. Adverse events likely attributable to bevacizumab include HTN, proteinuria, epistaxis, and wound-healing complications. In this study, the rates of grade 3 and 4 HTN (19%), proteinuria (1%), and epistaxis (0%) were similar to those reported in a comparable study population (35). Among the 9 (11%) patients with cellulitis or wound-healing complications, 3 experienced the complication after delayed reconstruction (at 4 days, 4 weeks, and 16 weeks). The reported incidence of wound-healing complications after tissue expander or implant reconstruction is highly variable. In a prospective multicenter study, the infection rate after implant reconstruction was 35% in 79 evaluated patients (37). Although it is unknown whether the infection rate in our study was impacted by bevacizumab administration, the 11% incidence is consistent with other reports (38, 39). Furthermore, although a 4-week bevacizumab hold was recommended both before and after delayed reconstruction, the ideal perioperative hold interval is unknown.

Overall, 16 patients (20%) withdrew from this study because of toxicity. Because the consent-withdrawal rate was greater than anticipated at 8 patients (10%) and 2 patients (2.5%) experienced disease progression on
therapy, the 26 study withdrawals (33%) prior to completion of the planned therapy were more than expected. By comparison, it is worth noting that in the combined analysis of the North American adjuvant trastuzumab trials, 31% of patients who began treatment with trastuzumab did not complete the planned 1-year course of therapy (10). In terms of feasibility, the statistical plan for this study was originally developed to evaluate 64 patients who completed AC therapy and were able to continue bevacizumab based on their MUGA scan at month 2. This goal was met with 77 patients who had a MUGA scan at month 2 and continued therapy with bevacizumab. Hence, this pilot study has shown that bevacizumab with ddAC followed by nab-paclitaxel shows acceptable toxicity. Comparative efficacy information, along with additional cardiac safety data for bevacizumab in combination with adjuvant anthracycline-containing regimens is anticipated from ongoing phase III studies.

References

Disclosure of Potential Conflicts of Interest
M. Melisko: honoraria from speakers bureau, Genentech, M. Moasser, C. Dang, C.A. Hudis, M.N. Dickler: consultant/advisory board, Genentech. T. Traina: commercial research grant and consultant/advisory board, Genentech. J. Park: commercial research grant and consultant/advisory board, Genentech; honoraria from speakers bureau, Genentech and Abraxis. S. Sugarman: honoraria from speakers bureau, Genentech. The other authors disclosed no potential conflicts of interest.

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A Feasibility Study of Bevacizumab plus Dose-Dense Doxorubicin–Cyclophosphamide (AC) Followed by Nanoparticle Albumin–Bound Paclitaxel in Early-Stage Breast Cancer

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