Laurence Lousberg

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PROFESSOR

Neuroencodrine tumors
NTRK fusions

Head of Clinic, Department of Medical Oncology at University Hospital Center (CHU) in Liege, Belgium. Experience in trial research phases 1-3. Her therapeutic area is in solid tumors and breast cancer. Author and coauthor of oncology publications

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Country: Belgium
Current Position:

2011 - present	Medical Oncology, Internal Medicine specialization at University of Liege, Belgium.

Education:

2011	Medical Doctor at University of Liege, Belgium.

Experience:

2014 - present	Physician Assistant, Department of Medical Oncology University Hospital Center (CHU) in Liege, Belgium.
2014 - present	Trial research unit in Medical Oncology – local sub investigator of many phases 1, 2 and 3, University Hospital Center (CHU) in Liege, Belgium.

Scientific Publications:
Number of publications as author or co-author: 4
Recent scientific publications:

Everolimus combined with exemestane is an important treatment option for patients suffering from estrogen receptor-positive, human epidermal growth factor receptor 2-negative, advanced breast cancer (ABC) who have been previously treated with a nonsteroidal aromatase inhibitor (NSAI). After

presentation of phase III registration trial BOLERO-2, several phase IIIb trials have been started to evaluate this regimen in a more real-world setting. Here, we review the efficacy and safety data published or presented at selected international meetings. These studies confirmed the outcome observed in the BOLERO-2 trial. Patient acceptance rate is also discussed by focusing on the permanent everolimus discontinuation rate in these trials. Factors influencing the safety profile are also reported, including the impact of age. The optimal sequence of combined therapy approaches associating targeted and endocrine therapy (ET) has yet to be determined as new treatment options such as cyclin-dependent kinase inhibitors become available. However, everolimus–exemestane remains an important treatment option with a major impact on progression-free survival (PFS) and an acceptable safety profile, 2017.

Triple-negative breast cancers (TNBCs) are defined by the absence of estrogen and progesterone receptors and the absence of HER2 overexpression. These cancers represent a heterogeneous breast cancer subtype with a poor prognosis. Few systemic treatment options exist besides the use of chemotherapy (CT). The heterogeneity of the disease has limited the successful development of targeted therapy in unselected patient populations. Currently, there are no approved targeted therapies for TNBC. However, intense research is ongoing to identify specific targets and develop additional and better systemic treatment options. Standard adjuvant and neoadjuvant regimens include anthracyclines, cyclophosphamide, and taxanes. Platinum-based CT has been proposed as another CT option of interest in TNBC. We review the role of this therapy in general, and particularly in patients carrying BRCA germ-line mutations. Available data concerning the role of platinum-based CT in TNBC were acquired primarily in the neoadjuvant setting. The routine use of platinum-based CT is not yet recommended by available guidelines. Many studies have reported the molecular characterization of TNBCs. Several actionable targets have been identified. Novel therapeutic strategies are currently being tested in clinical trials based on promising results observed in preclinical studies. These targets include androgen receptor, EGFR, PARP, FGFR, and the angiogenic pathway. We review the recent data on experimental drugs in this field. We also discuss the recent data concerning immunologic checkpoint inhibitors, 2016.

Late relapses (> 10 years) of breast cancer are mainly observed in ER positive tumors. The yearly relapse rate is still 0.5 % after 10 years. These relapses occurred even if adjuvant chemotherapy was given. Consequently, a better knowledge of the metastatic process is warranted in order to define better treatment options. We will discuss here a case of hormone sensitive breast cancer relapsing 20 years after the initial treatment. We will discuss the most recent data concerning late relapses. New hypotheses concerning disseminated tumoral cells and circulating cells will be reported. We will also review data about stem cells, tumor initiating cells and dormancy state, 2011.