



COMMENTARY

# Shared Decision-Making on Using a CDK4/6 Inhibitor plus an Aromatase Inhibitor for HR+/HER2– Metastatic Breast Cancer: A Podcast

Brian Dong · Rita Lusen · Ella Chick · Lisa Kline

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**Abstract:** Shared decision-making involves patients engaging with their physicians to make informed decisions regarding treatment selection, a process that empowers patients and ensures that treatment decisions reflect their individual values and preferences. However, shared decision-making can be challenging to implement for various reasons, including time, staffing, or resource limitations at community practices and differences in patients' cultural backgrounds or health literacy. In this podcast, we discuss how to ensure that individual patients' needs and concerns are addressed, including an overview of different approaches for initial consultations, strategies for tailoring conversations based on a patient's background

or health literacy, and trustworthy resources that can help improve patients' understanding. As an illustrative example, we focus on how to implement shared decision-making to address the needs of a patient with hormone receptor-positive (HR+)/human epidermal growth factor receptor 2-negative (HER2–) metastatic breast cancer who is eligible for combination therapy with a cyclin-dependent kinase 4/6 inhibitor plus an aromatase inhibitor. Overall, this podcast illustrates how shared decision-making is an achievable goal, even in small or under-resourced practices, and provides an instructive guide on how to facilitate shared decision-making for patients with HR+/HER2– metastatic breast cancer.

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## Infographic:

### Shared Decision-Making on Using a CDK4/6 Inhibitor plus an Aromatase Inhibitor for HR+/HER2- Metastatic Breast Cancer: A Podcast

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 This podcast article discusses how to implement shared decision-making for **CDK4/6i + AI therapy in patients with HR+/HER2- mBC**

#### What is Shared Decision-Making?



Shared decision-making is a 2-way exchange of information between a patient and their physician to develop an agreed-upon treatment plan

**Patient can share:**

-  Values, preferences, and concerns
-  Treatment goals
-  Personal challenges







**Physician can explain:**

-  Disease information
-  Treatment options, including risks and benefits

Research shows that patients are more likely to follow a treatment plan when **involved in the decision-making**

#### Tips for Successful Shared Decision-Making Discussions





-  Enlist the help of other providers, such as APs/nurses, to gather information from the patient regarding goals and needs
-  Encourage patients to bring loved ones and lists of questions to visits
-  Gauge patients' health literacy and help fill in any knowledge gaps; utilize an interpreter when the patient and the physician speak different languages
-  Build a trusting relationship and provide patients with informational resources to access between visits


#### Shared Decision-Making for a Patient With Newly Diagnosed HR+/HER2- mBC

**CDK4/6i + AI therapy is a standard-of-care treatment** for this indication; the physician and patient should discuss the data available and key considerations for each of the 3 approved CDK4/6is




Select Factors That May Impact Shared Decision-Making for Patients Receiving CDK4/6i + AI Therapy for HR+/HER2- mBC

**Patient Factors**

-  Functional ability
-  Available physical and emotional support
-  Pre-existing conditions
-  Other medications




**Medication Factors**


-  Medication dose and schedule
-  Required laboratory monitoring
-  Potential side effects

#### KEY TAKEAWAYS

The process of shared decision-making ensures that treatment decisions reflect patients' values and preferences, which can enhance their overall well-being, outlook on treatment, and adherence to a treatment plan



AI, aromatase inhibitor; AP, advanced practitioner; CDK4/6i, cyclin-dependent kinase 4/6 inhibitor; HER2-, human epidermal growth factor receptor 2-negative; HR+, hormone receptor-positive; mBC, metastatic breast cancer.



PEER-REVIEWED  
 INFOGRAPHIC

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**Keywords:** Cyclin-dependent kinase 4/6 inhibitor; HR+/HER2– metastatic breast cancer; Shared decision-making

## DIGITAL FEATURES

This article is published with digital features, including podcast audio and an infographic, to facilitate understanding of the article. To view digital features for this article, go to <https://doi.org/10.6084/m9.figshare.23177987>.

## TRANSCRIPT

Rita Lusen (RL): Hello and welcome to this podcast on shared decision-making between physicians and patients. Today, we will be discussing shared decision-making, why it is important, and how it can be accomplished. We will also address some of the barriers to shared decision-making and possible solutions. As an example, we will consider shared decision-making for a patient with hormone receptor-positive/human epidermal growth factor receptor 2-negative, or HR+/HER2–, metastatic breast cancer who is eligible for combination therapy with a cyclin-dependent kinase 4/6, or CDK4/6, inhibitor plus an aromatase inhibitor, or AI.

My name is Rita Lusen. I am the Vice President of Partnerships for Breastcancer.org, a leading resource for patient information and support. I am also a 15-year breast cancer survivor myself and a melanoma survivor who has lived experience as an oncology patient. I will be representing the patient advocate perspective, and joining me is Dr. Brian Dong with the physician's perspective.

Brian Dong (BD): Thank you, Rita, for the opportunity. My name is Brian Dong. I am a medical oncologist at the University of Louisville Health Brown Cancer Center in Louisville, Kentucky. I specialize in breast cancer and see patients at all different stages, from patients at risk for breast cancer owing to genetic mutations all the way to patients with metastatic breast cancer on systemic therapy. I also wanted to add that any opinions expressed today by me are my own.

RL: Wonderful. Thank you, Dr. Dong. Can you briefly describe shared decision-making and why it is important for disease management?

Brian Dong (BD): Sure. Shared decision-making involves patients engaging with their physicians to make informed decisions regarding their own treatment selection [1]. It is a two-way exchange of information between the physician and patient about the potential benefits and risks of different treatments and the patients' values and preferences. Patients are given an open space to express their concerns and goals for treatment and are encouraged to be more involved with their treatment planning. Patients can then share information that may influence their treatment plan directly with their provider, such as any challenges they face, how much support they do or do not have, and other relevant information. With the patient's input, the physician can then determine the best options, and together they can come up with an agreed-upon treatment plan. Research has shown that patients are more likely to follow through with a treatment plan when they are involved in the decision-making [2].

RL: Thank you, Dr. Dong. Let us apply this to an example of a patient who comes to you with newly diagnosed HR+/HER2– metastatic breast cancer. There is a lot to discuss, and she likely has a million questions even before you cover treatment options. With the limited time available during an office visit, it may be hard for this person to really digest all the information and make quick treatment decisions. So, what can be done to help her partner with you in that decision-making process, with so little time to review the daunting amount of available information and answer all of her questions?

RL: Rita, you are absolutely right, as I am sure you have some personal experience with this as well. There is so much to cover in terms of diagnosis, prognosis, symptoms, and social and mental health impacts of a cancer diagnosis, and finally, on top of all those, treatment planning. It can easily be overwhelming for patients and their families. I emphasize at the beginning that there will be many opportunities for questions and discussion outside just the initial visit. I am also fortunate to have a large team of oncology nurse clinicians, pharmacists,

social workers, and nurse navigators who help me address all the different needs of a new cancer patient.

I start every new visit by reviewing diagnostic imaging and pathology reports. Oftentimes, the patient has seen these documents before the initial visit, but I find it helpful to review them together, so the patient knows what is most important to me in terms of extent of disease or pathologic features of a specific tumor. Additionally, this review is often helpful for a patient's family members, who may not have been present for every discussion during the initial workup and diagnosis.

The patient in the example you have given me has not received any prior treatment, so I would recommend the current standard of care—combination therapy with a CDK4/6 inhibitor plus an AI—and I would explain the data available on the use of the three approved CDK4/6 inhibitors for treating patients with HR+/HER2– metastatic breast cancer. There are many factors to consider, including the dosing and scheduling of these medications, laboratory monitoring, side effects, and preexisting medical conditions. After discussing the differences in these options, together we would make a decision about her treatment.

And, you know, my initial consultation with a new patient can sometimes take as long as 60 minutes. Now, I know that not all physicians can dedicate this amount of time to each patient, but physicians can utilize other staff members or methods to reach the same goals. For example, an advanced practitioner or nurse can meet with the patient ahead of the physician to gather important information about the patient's goals, challenges, and needs. This team member can also help answer any additional questions the patient may have at the end of the visit. Alternatively, the initial consultation could be split into two visits. The first visit would focus on the diagnosis and information-gathering, after which the patient is sent home with information about treatment options. Then, a second, in-person or virtual visit would focus on choosing a treatment plan. So even if you do not have a large team to work with, shared decision-making is still doable—it just requires doing things a bit differently, while

still being mindful of avoiding delays in starting treatment.

RL: That initial consultation is the critical first step in building trust between physician and patient. This is key to the shared decision-making process, and I certainly agree that the physician should get to know the patient and find out what is most important to them. It sounds like you really want to know all that you can about your patients, and you work hard to include them in the decision-making process. So, thinking about it from my perspective as a patient advocate, is there anything that you can recommend patients do to prepare for that initial appointment?

BD: Absolutely. It is hard to receive a cancer diagnosis and absorb all the information that the physician shares. Cancer is an overwhelming diagnosis no matter the stage, so building a support system is extremely important. Bringing a friend or a loved one to medical appointments as an extra set of ears is very helpful, so that patients are not on this journey alone. Patients can also bring a list of their questions to appointments, including those from family members and caregivers. And, I will tell you now, I love when patients bring lists.

RL: Yep, as you said, it is an overwhelming moment in a cancer patient's life, and there could be obstacles in the patient's own life that could impact the success of the treatment plan. What are some topics that are important for patients to bring up with their physician to make sure their choice is informed?

BD: As I have mentioned, it is so important for the patient to talk about their treatment and life goals with their physician. Different factors can influence the success of and adherence to their treatment plan. Before initiating any cancer treatment, it is important to consider a patient's functional status—and by that I mean, are they able to dress themselves? Can they make their own meals? Can they go to the restroom without assistance? Can I trust this patient to take a medication on a certain schedule reliably? CDK4/6 inhibitors require close monitoring, with regular blood work [3–5], and I need to make sure they can arrange frequent transportation to the cancer center.

Additionally, it is important to carefully consider each individual patient's preexisting medical conditions and current medication lists to identify the most suitable CDK4/6 inhibitor or other therapy on a case-by-case basis.

RL: I will add that it is also important to discuss topics such as affordability, emotional and physical support, and the burden associated with cancer diagnosis and treatment. And when these topics are discussed, the treatment journey can feel more like a partnership between the physician and the patient.

BD: I agree completely. It is really about balancing the scientific evidence we have available to us with what is feasible for each individual patient.

RL: And how about a patient's ethnic and cultural background? What about their health literacy? How do you bring these considerations into your conversation with patients? And can these factors influence shared decision-making or a patient's treatment outcome?

BD: They absolutely can. There are studies that show disparities in treatment outcomes and mortality between Black and White patients with breast cancer [6–9]. For example, in the USA from 2013 to 2017, the breast cancer mortality rate was 40% higher in Black women than in White women, despite a lower breast cancer incidence rate in Black women [9]. In addition, a patient's health literacy can directly affect their ability to participate in shared decision-making [10]. Higher health literacy has been associated with a preference for more active participation in treatment decision-making [11] and better medication adherence in breast cancer survivors [12]. Conversely, poorer health literacy has been associated with higher unmet information needs [13], worse upper extremity disability after breast cancer treatment [14], and increased number and length of hospital admissions [15].

A strategy I often use is to start a visit by asking a patient how much they understand about their cancer diagnosis and why they are seeing me today. From that answer, I can gather what their current level of understanding is and how much I need to fill in. For patients who do not understand English, I try everything

possible to arrange for an in-person interpreter so that the patient can feel as comfortable as possible communicating in their native language and not through a phone or a tablet. I also make a point to ask every family member present if they have questions about the treatment plan because family dynamics can vary, and there can also be cultural differences in how a treatment decision is made for a family member. I will also add that I often have a social worker present with me during my initial visit who can observe all the interactions, body language, and mood of everyone in the room to help identify stressors that I may not notice while focusing on medical care, such as social support, financial needs, and emotional stress.

RL: And thinking ahead to the rest of the patient's treatment journey, does shared decision-making end after that first treatment discussion?

BD: Certainly not. It is my philosophy that we work as a team during our entire time together. Clinical evaluations are a continuous process of assessing tolerability and response to treatment. Having those shared decision-making conversations early on is vital to treatment adherence and empowers the patient to come forward with any issues later. The longer I get to know a patient and the longer they get to know me and my team, the stronger our ability to make shared decisions together regarding their treatment. Everyone's cancer journey is unique, and my goal is for all my patients to have trust and confidence in the entire treatment team and to feel comfortable asking questions and having those difficult conversations.

RL: That is so important. So, how can patients stay informed throughout their cancer treatment and keep actively involved in the ongoing shared decision-making process?

BD: Yeah, it is important to provide the patient with trustworthy resources to help with questions in between appointments, including online resources such as Breastcancer.org and Cancer.gov. In my practice, we provide quick detail cards to patients that summarize key takeaways on treatments rather than giving them a 20-page booklet of information, which could be overwhelming. I also emphasize to my

patients that they will be seeing their oncology team frequently, and that they do not have to ask every possible question at the first visit. We are there every step of the way throughout their treatment, and they will have continuity with the treatment team. In addition, patients are always encouraged to bring family members to appointments and have as much support as possible.

RL: Dr. Dong, you have given some great information for successful shared decision-making. We discussed building that trusting relationship between the provider and the patient earlier. It is also important for patients to feel comfortable getting a second opinion on their treatment plan if they want. If the second physician agrees with the proposed treatment plan, the patient may return to the first physician with more confidence in the treatment decision, strengthening the trust in that relationship. Has that been your experience?

BD: You know, it is 2023, and I fully support any patient getting a second opinion as long as it does not significantly delay the treatment plan. Depending on the clinical situation, patients should take into account treatment delays, whether a possible delay in surgery or in starting chemotherapy or radiation. If a patient is looking for a possible clinical trial, I would recommend that they first discuss options with their local oncologist's office, who can often coordinate records and referrals with tertiary cancer centers.

RL: Agreed. Those are really important points for a patient to consider when seeking out a second opinion.

BD: So, Rita, as we wrap up our discussion for today, can you reflect on the overall importance of shared decision-making to patients, drawing on your own experiences as an oncology patient and a patient advocate?

RL: Of course. I have seen how the process of shared decision-making empowers patients and ensures that treatment decisions reflect their individual values and preferences. Personally, I take that approach myself and in every treatment decision that I have had to make through my experiences with cancer. This can make a world of difference in improving their overall well-being and outlook on treatment. And

when working with different patients, I often encourage them to open up to their providers and adopt a more proactive mindset regarding their treatment journey. At the end of the day, there is no more valuable perspective than that of the patient.

Well, I think that concludes our discussion for today. Thank you, Dr. Dong, for joining me in a robust discussion on the importance of shared decision-making and your example of a patient with HR+/HER2– metastatic breast cancer. As you have mentioned, shared decision-making is an achievable goal, even in small or underresourced practices. I hope our listeners have found this podcast to be a useful and instructive guide on how to facilitate shared decision-making with their patients.

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