Cameroon Townhall for Healthcare Professionals

Meeting Minutes, October 27, 2024

Host: Cameroon Townhall for Healthcare Professionals

Date: October 27, 2024

Chair: Dr. Munoh Kenne Foma

Guest Speaker: Dr. Munoh Kenne Foma, MD, MPH; medical oncologist and haematologist (thoracic oncology lead); former clinical pathologist in Cameroon, Presbyterian Healthcare Services, Albuquerque, New Mexico; Richmond University Medical Center (teaching)

Distinguished Guests: Dr. Joshua Tambe, radiologist and public health specialist, University of Buea, A surgical oncologist in the USA, A participant whose aunt received trastuzumab through a foundation

Title: Special Edition: Breast Cancer Educational Series for Health Professionals, Part 2: Systemic Treatment of Early and Metastatic Breast Cancer

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Agenda Items:

1. Welcome and recap of Part 1 by Dr. Munoh Kenne Foma
2. Clinical vignettes
3. Systemic treatment in the non metastatic setting: triple negative, HER2 positive, hormone receptor positive
4. Discussion break
5. Treatment of metastatic breast cancer
6. Bone health and conclusions
7. Open discussion and Q&A

Opening Remarks:

- Dr. Foma welcomed participants to Part 2, noting that Part 1 had drawn about 40 to 50 participants, and said this session would be more technical and aimed especially at nurses, physicians and medical students who treat breast cancer.
- He again presented the case of his 32 year old friend in Douala, treated without receptor testing or staging, whose ER 100% and PR 90% result arrived after her death, to show why every patient needs testing and team based care.

- He recapped Part 1: risk assessment, prevention with tamoxifen and aromatase inhibitors, the screening age debate, core biopsy, staging for stage 3 disease, and surgery adapted to limited radiotherapy.

Presentation Points:

Presentation by Dr. Munoh Kenne Foma: "Systemic Treatment of Breast Cancer and How to Adapt It in Cameroon"

1. Receptor status decides treatment:

Dr. Foma said hormone receptor positive, HER2 negative disease makes up 60 to 70% of breast cancers, HER2 positive about 15 to 20%, and triple negative about 20 to 30% in African populations. Because treatment differs completely between these groups, he called it 'criminal' to treat without ER, PR and HER2 results, which can be obtained for about 80,000 francs CFA through Mbingo or via Centre Pasteur. Invasive lobular carcinoma is almost always ER positive, so an ER negative result should be re-checked.

2. Hormone receptor positive disease: endocrine therapy first:

The main treatment is endocrine therapy, not chemotherapy: tamoxifen for premenopausal women (with ovarian suppression, such as leuprolide, for high risk), and anastrozole, letrozole or exemestane for postmenopausal women, for 5 to 10 years. He said many women in Cameroon receive chemotherapy they do not need; genomic tests such as Oncotype DX show most node negative and many postmenopausal node positive patients gain nothing from it, and where these tests are unavailable Ki-67 based risk tools can guide decisions. All these hormonal drugs are available and affordable in Cameroon.

3. CDK4/6 inhibitors are reachable:

Adding a CDK4/6 inhibitor (palbociclib, ribociclib or abemaciclib) to endocrine therapy improves outcomes in metastatic disease. He described a patient in Bamenda in complete remission after one year on tamoxifen plus palbociclib obtained through Noble Pharmacy, at under 60,000 francs CFA a month, without seeing an oncologist. He urged advocacy to make palbociclib generic and available.

4. HER2 positive disease: the cost barrier:

HER2 positive tumours from stage 1B onward should receive chemotherapy with trastuzumab before surgery, followed by trastuzumab to complete a year, with T-DM1 for residual disease. Trastuzumab is available but costs about 200,000 francs CFA per dose despite being generic, and pertuzumab adds cost for small benefit, so

he advised docetaxel with trastuzumab when pertuzumab is unaffordable. He called for trastuzumab to be added to Cameroon's essential medicines list. Trastuzumab deruxtecan has changed care for HER2 low disease but is not available in Cameroon.

5. Triple negative disease:

Standard care for stage 2 to 3 is anthracycline and taxane chemotherapy (with or without carboplatin) before surgery plus pembrolizumab (KEYNOTE-522), and capecitabine for residual disease. Mbingo can give dose dense regimens, but immunotherapy is not available in Cameroon, and he urged advocacy similar to that used for HIV drugs. BRCA testing matters because PARP inhibitors (olaparib, talazoparib) help BRCA positive patients, and he asked University of Buea researchers whether they could offer germline testing.

6. Metastatic disease and team care:

Metastatic breast cancer is incurable but patients live longer each decade. For hormone positive metastatic disease, surgery on the breast and radiation do not improve survival except for palliation; endocrine therapy with or without a CDK4/6 inhibitor is first line, and chemotherapy is reserved for visceral crisis (he noted that bone metastases are not visceral disease). Bone protecting agents (alendronic or zoledronic acid, denosumab) with dental review should be given. He stressed the need for radiation oncology, surgical oncology, pharmacists, nutritionists, palliative care and pain specialists, and referral to oncologists such as Dr. Francine Kouya at Mbingo rather than surgeons managing alone.

Discussions and Q&A Session:

- **A participant whose aunt received trastuzumab through a foundation asked whether fewer doses could be used in Cameroon to cut cost.** Dr. Foma said de-escalation trials, including Japanese data, suggest six months may be close to one year in some patients, but Cameroon needs its own trials. He said trastuzumab is generic and should not be so expensive, and that he would raise it with Dr. Yauba Saidu of the Clinton Health Access Initiative. He argued that helping one patient at a time is unsustainable and advocacy should target policy and essential medicines.
- **Dr. Joshua Tambe asked how response (complete, partial, stable, progressive) is assessed in practice, and noted that oncology imaging had been left out of the team slide.** Dr. Foma agreed this was an omission and said radiologists and pathologists are central to tumour boards. Response is judged by imaging using RECIST criteria, and in the USA he also uses circulating tumour DNA. Prof. Tambe said RECIST is rarely applied in Cameroon because baseline and previous scans are

often missing or done at different centres. Dr. Foma said radiologists should always compare with prior imaging and described PACS systems used in the USA.

- **A surgical oncologist in the USA asked whether Buea or Cameroon has capacity for molecular profiling, noting differences in tumour biology in African populations (for example high rates of MSI high colon cancer and triple negative breast cancer).** Dr. Foma said next generation sequencing and PCR machines installed for COVID-19 and tropical disease research exist in Buea and elsewhere, but capacity for cancer testing is unknown. He proposed first a needs and resource assessment and a directory of who can do what in Cameroon (for example who can safely perform bronchoscopy, EBUS or image guided biopsy), working with researchers such as Prof. Tambe.

Call to Action and Closing:

- Dr. Foma said the series would be repeated during breast cancer week each year, and that CME lectures on prostate cancer, cervical cancer and other common cancers were planned.
- He encouraged diaspora researchers with NIH and other grants to collaborate with universities in Buea and Yaoundé.
- He closed with 'difficult roads can lead to beautiful destinations' and wished participants a good Sunday.

Next Meeting

Regular town hall to resume on the usual fortnightly Saturday schedule; breast cancer series to be repeated in October 2025.

Recording: https://www.youtube.com/watch?v=wJHsLa3o8ul

Submitted by: Co-Moderators, Cameroon Townhall for Healthcare Professionals