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Intrinsic Subtype and Therapeutic Response Among HER2-Positive Breast Tumors from the NCCTG (Alliance) N9831 Trial

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Abstract

Background: Genomic data from human epidermal growth factor receptor 2-positive (HER2+) tumors were analyzed to assess the association between intrinsic subtype and clinical outcome in a large, well-annotated patient cohort.

Methods: Samples from the NCCTG (Alliance) N9831 trial were analyzed using the Prosigna algorithm on the NanoString platform to define intrinsic subtype, risk of recurrence scores, and risk categories for 1392 HER2+ tumors. Subtypes were evaluated for recurrence-free survival (RFS) using Kaplan-Meier and Cox model analysis following adjuvant chemotherapy (n = 484) or chemotherapy plus trastuzumab (n = 908). All statistical tests were two-sided.

Results: Patients with HER2+ tumors from N9831 were primarily scored as HER2-enriched (72.1%). These individuals received statistically significant benefit from trastuzumab (hazard ratio [HR] = 0.68, 95% confidence interval [CI] = 0.52 to 0.89, P = .005), as did the patients (291 of 1392) with luminal-type tumors (HR = 0.52, 95% CI = 0.32 to 0.85, P = .01). Patients with basal-like tumors (97 of 1392) did not have statistically significantly better RFS when treated with trastuzumab and chemotherapy compared with chemotherapy alone (HR = 1.06, 95% CI = 0.53 to 2.13, P = .87).

Conclusions: The majority of clinically defined HER2-positive tumors were classified as HER2-enriched or luminal using the Prosigna algorithm. Intrinsic subtype alone cannot replace conventional histopathological evaluation of HER2 status because many tumors that are classified as luminal A or luminal B will benefit from adjuvant trastuzumab if that subtype is accompanied by HER2 overexpression. However, among tumors that overexpress HER2, we speculate that assessment of intrinsic subtype may influence treatment, particularly with respect to evaluating alternative therapeutic approaches for that subset of HER2-positive tumors of the basal-like subtype.

With the advent of high-dimensional technologies for quantifying expression of large numbers of genes, it has become clear that breast tumors exhibit a considerable range of molecular/genomic heterogeneity, both between and among the clinically defined cohorts of hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-positive, and triple-negative tumors. The most thoroughly characterized classifier of molecular heterogeneity is the PAM50 signature (1,2), which uses the expression of 50 genes to stratify breast tumors into four major classes: basal-like, HER2-enriched, luminal A, and luminal B. There is a strong presupposition that these biological processes will prove to be informative of clinical/pathological features of breast tumors (2–6).

Our studies have focused upon defining molecular heterogeneity among HER2-positive (HER2+) breast tumors. We used the NanoString Prosigna algorithm and PAM50 genes to define intrinsic subtypes and assess their distribution and association with outcome within tumors from the North Central Cancer Treatment Group (NCCTG [Alliance]) N9831 trial of patients with early-stage HER2+ tumors (7,8) randomly assigned to receive adjuvant chemotherapy or chemotherapy plus trastuzumab. Our primary analytical focus was to test the hypothesis that benefit from adjuvant chemotherapy combined with trastuzumab, compared with benefit from adjuvant chemotherapy alone, varies as a function of intrinsic subtype.

Methods

Patients

The NCCTG (Alliance) N9831 trial enrolled 3505 patients who were randomly assigned to three study arms: arm A—chemotherapy (doxorubicin and cyclophosphamide followed by weekly paclitaxel); arm B—chemotherapy followed by 52 weeks of weekly trastuzumab; and arm C—chemotherapy with 12 weeks of trastuzumab concurrent with paclitaxel, followed by 40 more weeks of weekly trastuzumab alone, as previously described in detail (7). Patients in both trastuzumab-treated arms (B and C) received 52 weeks of trastuzumab and showed statistically significant improvement in relapse-free survival (7,8), compared with patients who received chemotherapy alone (arm A). We therefore combined patients from arms B and C into a single trastuzumab-treated group (arm B/C) for subsequent analysis. All patients included in this analysis were assessed for central HER2 immunohistochemistry (IHC) and/or fluorescence in situ hybridization (FISH) as part of the N9831 parent study, as previously described (7). Informed written consent to these studies was obtained from all patients. Studies were carried out under Mayo Clinic Institutional Review Board protocols 954-00 and 13-000290.

Statistical Analysis

The main objective of the analysis was to determine whether the effect of trastuzumab qualitatively differed for any of the intrinsic subtypes. If differing treatment effects were observed among the subtypes, a test for interaction was to be performed to determine whether this observation was statistically significant. The primary endpoint for outcome analysis was recurrence-free survival (RFS), defined as the time from random assignment to breast cancer recurrence (local, regional, or distant recurrence of breast cancer or breast cancer-related death). The time to event for patients who died without recurrence was considered censored at the

time of death. Cox proportional hazard models were used to generate point estimates of hazard ratios (HRs) and corresponding 95% confidence intervals (CIs) to assess the benefit of trastuzumab for RFS comparisons. The assumption of proportional hazards was verified with a Cox proportional hazard model containing the treatment indicator and the interaction of the indicator with the log of time. The test of proportionality involves a likelihood ratio test of the model containing the interaction term against the model that contains the treatment variable only. A nonsignificant *P* value of this test suggests there is not sufficient evidence to reject the assumption of proportional hazards. The *P* value of this test was .88, suggesting that there is not sufficient evidence to reject the assumption of proportional hazards. Wald Chi-squared *P* values were calculated for the Cox hazard ratios. Comparisons were made both within and between treatment arms. The interaction term of basal-like vs non-basal-like by treatment arm was determined using a Cox model that also included the main effects; this interaction was tested because the effect of trastuzumab appeared qualitatively different in this subtype. Kaplan-Meier plots were used to depict the proportion of patients free from breast cancer recurrence as a function of time. Chi-squared tests for nominal categories or Cochran-Mantel-Haenszel tests for ordered categories were performed to ascertain differences in eligible N9831 patients included in the analysis with those that were excluded. All statistical tests were two-sided, and a *P* value of less than .05 was considered statistically significant.

Assignment of Intrinsic Subtype

We constructed a NanoString custom CodeSet that includes the PAM50 genes plus appropriate housekeeping genes (B2M, GAPDH, POLR2A, UBC, YWHAZ) for normalization purposes. The Prosigna subtyping algorithm is trained for use with Prosigna CodeSet. To use this algorithm for subtyping N9831 data, adjustment factors that account for differences between the custom CodeSet used in the N9831 study and the Prosigna CodeSet were estimated and applied to the data. To this end, 30 samples, which were processed with the custom CodeSet, were reprocessed using the Prosigna CodeSet. For each probe, this provided 30 pairs of counts (corresponding to the two CodeSets), which were then used to estimate the adjustment factor between the two CodeSets. Specifically, for each of the PAM50 probes, first the ratio of the normalized counts from the custom CodeSet relative to their corresponding normalized counts from the Prosigna CodeSet were calculated, resulting in 30 ratios for each of the probes. Then, for each probe, the median of the 30 ratios was taken as the adjustment factor. Subsequently, the resultant 50 adjustment factors (one for each PAM50 gene) were applied to the PAM50 counts in the original data set and subtyping was performed on the adjusted counts per standard Prosigna algorithm. Quantitative real-time polymerase chain reaction data on mRNA abundance, proliferative scores, and mitotic indices were abstracted from a published study on the OncotypeDX analysis of N9831 samples (9).

Results

Assignment of Risk Scores and Intrinsic Subtype Using Prosigna

Samples from 1426 eligible patients had sufficient RNA for testing and were analyzed on the NanoString platform to measure

Table 1. Comparison of Prosigna intrinsic subtype, risk of recurrence, and risk category in arm A (chemotherapy alone) and arm B/C (chemotherapy plus trastuzumab) of N9831

Subtype	Arm A No. (%)	Arm B/C No. (%)	P*
Basal	38 (7.9)	59 (6.5)	.76
HER2	342 (70.7)	662 (72.9)	
Luminal A	47 (9.7)	85 (9.4)	
Luminal B	57 (11.7)	102 (11.2)	
ROR			
1. <70	140 (28.9)	207 (22.8)	.03
2. 70–81	116 (23.9)	220 (24.2)	
3. 82–91	108 (22.3)	240 (26.4)	
4. 92–100	120 (24.7)	241 (26.5)	
Risk category			
High	462 (95.4)	873 (96.1)	.54
Intermediate/low	22 (4.5)	35 (3.8)	

*P value from Chi-squared test for nominal categories or Cochran-Mantel-Haenszel test for ordered categories. All statistical tests were two-sided. HER2 = human epidermal growth factor receptor 2; ROR = risk of recurrence.

the abundance of mRNAs that define the intrinsic subtype patterns. Thirty-four samples were excluded for quality control issues, mostly low total gene counts; 1392 remaining samples (arm A: 484, arm B: 494, arm C: 414) were analyzed for intrinsic subtype in a blinded fashion. Patient demographics for samples that were included, as well as those from whom RNA was not available, are given in [Supplementary Table 1](#) (available online).

Distributions of intrinsic subtypes, risk of recurrence scores (ROR), and risk categories (high, intermediate, low) as a function of treatment arm are given in [Table 1](#), and clinical/pathological features of the tumors by treatment are in [Supplementary Table 2](#) (available online). There were small but statistically significant differences in nodal status between the two arms ($P = .04$). However, the observed increase in node 0 and node 1–3 patients in arm B/C did not translate into differences in risk category ([Table 1](#)).

The patients enrolled in N9831 were centrally confirmed as HER2+. The majority of the tumors (1004 of 1392, 72.1%) were classified by Prosigna as HER2-enriched. The remaining tumors were more or less equally distributed among the basal-like (97 of 1392, 7.0%), luminal A (132 of 1392, 9.5%), or luminal B (159 of 1392, 11.4%) subtypes.

Association Between Risk of Recurrence Score, Risk Category, and RFS

The Prosigna algorithm reports a risk of recurrence score that combines intrinsic subtype, tumor size, and proliferation score into a single metric. The majority of the N9831 samples (1045/1392) had ROR scores above 70, where low risk is considered 1–40, intermediate risk 40–60, and high risk above 60. We did not observe a statistically significant association between RFS and ROR, expressed as a discontinuous, quantile score, among patients who received chemotherapy alone (arm A, $P = .40$) ([Figure 1A](#)) or patients who received chemotherapy plus trastuzumab (arms B/C, $P = .37$) ([Figure 1B](#)).

Tumor size is incorporated into ROR to stratify tumors into high-, intermediate-, and low-risk categories. Almost all of the N9831 samples were classified as high risk (1335/1392) ([Table 1](#)). The Kaplan-Meier analysis suggested a quantitative tendency toward improved RFS in the few low-/intermediate-risk patients who received chemotherapy alone; however, this tendency did not achieve statistical significance (arm A, $P = .13$) ([Figure 1C](#)).

Low-/intermediate-risk patients who received trastuzumab appeared to receive statistically significant benefit (arm B/C, $P = .01$) ([Figure 1D](#)). Among the tumors with low/intermediate risk, those classified as estrogen receptor- and/or progesterone receptor-positive seldom recurred. Among 30 such patients, only one recurrence was reported, compared with the overall recurrence rate of about one in four (317/1392) for all patients in this study (Chi-squared $P = .01$).

A subset of the N9831 patients (445 from arm A and 397 from arm C) has previously been analyzed using the 21-gene OncotypeDX panel (9). As with the Prosigna analysis, almost all of the patients were classified as high risk (763/842). A number of molecular features associated with subtype were derived from the 21-gene signature, including ERBB2 mRNA, proliferative score, and Ki67 mRNA. Percent cells staining 3+ for HER2 was extracted from the clinical record, and mitotic index was assessed by histological examination, as shown in [Table 2](#). The proliferative markers associated with each subtype were ranked basal-like > HER2-enriched \approx luminal B > luminal A. HER2 expression generally followed the pattern HER2-enriched > luminal A > luminal B \approx basal-like. Among the four subtypes, the basal-like tumors exhibited the lowest HER2 expression and the highest proliferation, features that might be expected to influence outcome following HER2-targeted therapy.

Association Between Intrinsic Subtype and RFS

A statistically significant association between RFS and intrinsic subtype was observed when all patients (irrespective of therapy) were evaluated ([Figure 2A](#)). Patients with basal-like tumors exhibited statistically significantly worse RFS compared with patients with HER2-enriched, luminal A, or luminal B subtypes. When intrinsic subtype was evaluated within each treatment arm, there was no statistically significant association between subtype and RFS in the patients who received chemotherapy alone (HR_{basal} = reference, log-rank $P = .79$; HR_{HER2} = 0.75, 95% CI = 0.42 to 1.33, $P = .32$; HR_{lumA} = 0.76, 95% CI = 0.35 to 1.64, $P = .32$; HR_{lumB} = 0.83, 95% CI = 0.41 to 1.69, $P = .61$) ([Figure 2B](#)). However, a statistically significant association was observed between outcome and intrinsic subtype among patients who received trastuzumab (HR_{basal} = reference, log-rank $P = .007$; HR_{HER2} = 0.49, 95% CI = 0.30 to 0.78, $P = .003$; HR_{lumA} = 0.47, 95% CI = 0.25 to 0.90, $P = .02$; HR_{lumB} = 0.35, 95% CI = 0.18 to 0.68, $P = .002$) ([Figure 2C](#)).

RFS as a Function of Treatment and Subtype

The data in [Figure 2](#) suggest that there is a relationship between intrinsic subtype and outcome and that this relationship resides primarily in those patients who received adjuvant trastuzumab. We therefore evaluated the relationship between RFS and treatment within each subtype. Trastuzumab appeared to have little or no statistically significant association with RFS in HER2+ patients of the basal-like subtype (HR = 1.06, 95% CI = 0.53 to 2.13, $P = .87$) ([Figure 3A](#)). Patients with HER2-enriched genomic profiles received statistically significant benefit from trastuzumab, compared with chemotherapy alone (HR = 0.68, 95% CI = 0.52 to 0.89, $P = .005$) ([Figure 3B](#)). Patients with luminal A profiles exhibited a quantitative trend towards improved RFS, although this trend did not achieve statistical significance (HR = 0.62, 95% CI = 0.30 to 1.26, $P = .20$) (blue curve vs green curve in [Figure 3C](#)). HER2+ tumors with luminal B profiles benefitted statistically significantly (HR = 0.45, 95% CI = 0.22 to 0.88, $P = .02$) (red curve vs brown curve in [Figure 3C](#)). Because of the small number of

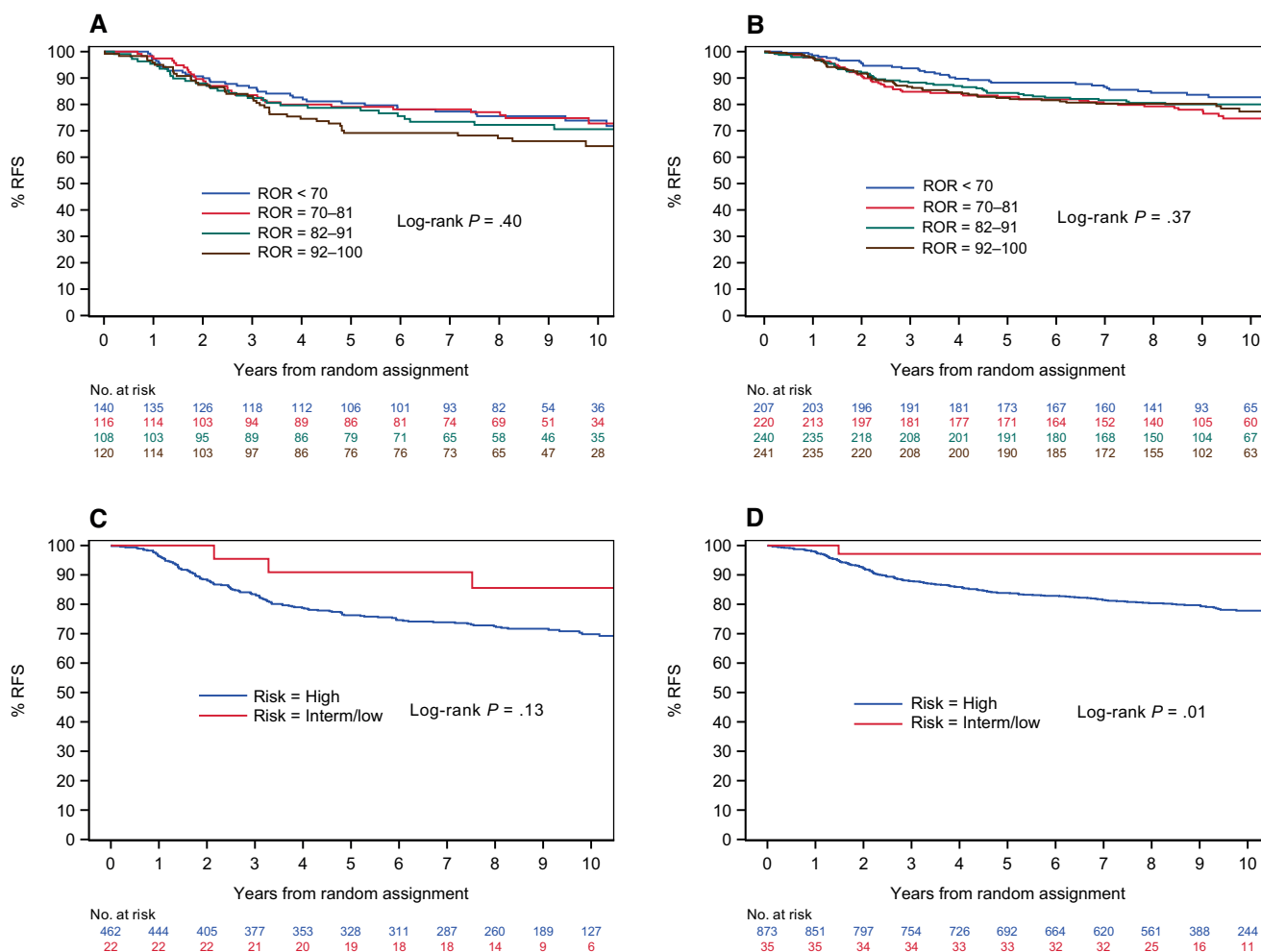


Figure 1. Risk of recurrence (ROR) scores and RISK categories among human epidermal growth factor receptor 2-positive (HER2+) tumors. The Prosigna algorithm reports two scores, ROR and RISK. The associations between ROR scores and relapse-free survival (RFS) after chemotherapy (A) or chemotherapy plus trastuzumab (B) are shown. The majority of the HER2+ tumors were assigned as high risk. The associations between RISK category and RFS after chemotherapy (C) or chemotherapy plus trastuzumab (D) are given. Kaplan-Meier log-rank survival analysis (two-sided) was used to calculate P values. RFS = relapse-free survival; ROR = risk of recurrence score, according to the Prosigna algorithm.;

Table 2. Basal-like HER2+ tumors exhibit lower ERBB2 expression and higher proliferation*

Subtype	ERBB2 mRNA		% IHC 3+ cells		Proliferative score (95% CI)		Ki67 mRNA (95% CI)		Mitotic score (95% CI)	
	(95% CI)	P†	(95% CI)	P†	(95% CI)	P†	(95% CI)	P†	(95% CI)	P†
Basal-like (n = 56)	10.8 (11.3 to 10.4)	Ref	49.2 (61.9 to 36.5)	Ref	6.91 (7.03 to 6.78)	Ref	7.93 (8.07 to 7.79)	Ref	2.55 (2.74 to 2.36)	Ref
HER2-enriched (n = 607)	13.0 (13.1 to 12.9)	<.001	91.2 (92.9 to 89.4)	<.001	6.52 (6.56 to 6.48)	<.001	7.50 (7.55 to 7.45)	<.001	2.01 (2.08 to 1.94)	<.001
Luminal A (n = 75)	11.7 (12.0 to 11.4)	.002	64.6 (74.6 to 54.6)	.03	5.78 (5.90 to 5.65)	<.001	6.79 (6.95 to 6.62)	<.001	1.37 (1.52 to 1.22)	<.001
Luminal B (n = 104)	11.1 (11.4 to 10.6)	.11	45.8 (55.2 to 36.4)	.67	6.56 (6.68 to 6.44)	<.001	7.49 (7.61 to 7.37)	<.001	1.56 (1.71 to 1.40)	<.001
Luminal all (n = 179)	11.4 (11.6 to 11.2)	.01	54.2 (61.2 to 47.3)	.42	6.23 (6.34 to 6.13)	<.001	7.20 (7.30 to 7.09)	<.001	1.48 (1.60 to 1.37)	<.001

*Data are summarized from 842 samples from arm A (445) and arm C (397) that were analyzed using the OncotypeDX 21-gene signature (9). Proliferative score is the average of five proliferative marker genes in this panel. Mitotic score was determined by histological examination by F. Baehner. All mRNA abundance data were normalized and scaled to log base 2. Immunohistochemistry staining for human epidermal growth factor receptor 2 abundance (%3+ cells) were extracted from the clinical record, as previously described. % IHC 3+ = percent of tumor cells with membrane scoring 3+ by clinical pathology; Ki67 = mRNA encoded by MKI67.

†Mann-Whitney U test, two-sided P value for comparison with basal-like tumors.

events in patients with luminal-type tumors, we combined the luminal A and B tumors into a single cohort of luminal-type tumors for subsequent analyses. Trastuzumab provided statistically significant benefit in patients whose tumors

exhibited luminal profiles (HR = 0.52, 95% CI = 0.32 to 0.85, $P = .01$) (Figure 3D).

A Cox model was used to evaluate RFS among basal and nonbasal tumors. The hazard ratios for RFS of basal-like tumors

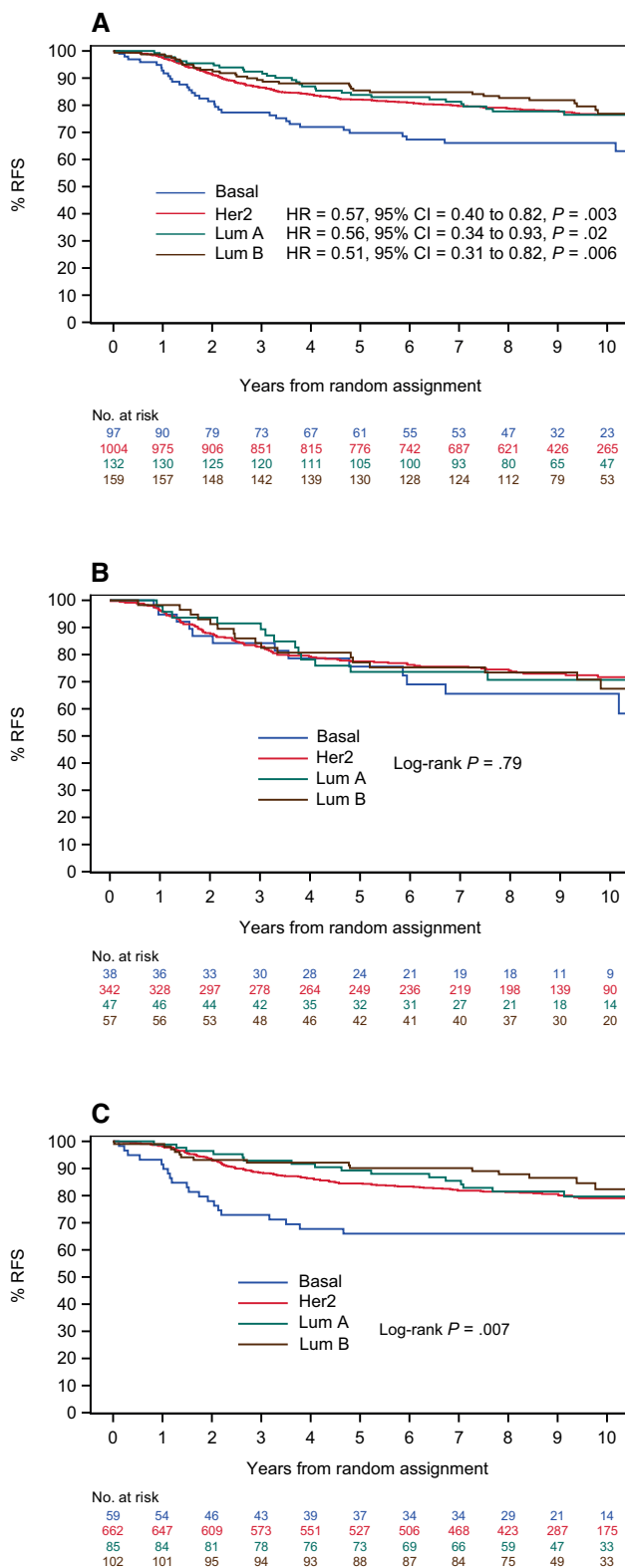


Figure 2 Intrinsic subtype and relapse-free survival (RFS) among patients in the N9831 trial. The relationship between RFS and time, evaluated as a function of Prosigna subtype in all arms of the N9831 trial, is shown in (A). The relationship between RFS and subtype in patients enrolled in arm A, chemotherapy alone, is shown in (B), whereas RFS as a function of subtype in patients enrolled in arm B/C, chemotherapy plus trastuzumab, is given in (C). Kaplan-Meier log-rank P values (two-sided) were calculated. The Cox model (two-sided) was used to estimate hazard ratios.

in arm A did not appear to be statistically significantly different from those of nonbasal tumors after chemotherapy (arm A basal-like vs arm A nonbasal: HR = 0.76, 95% CI = 0.43 to 1.34, $P = .34$) (Table 3). In addition, RFS was not statistically significantly different between basal-like tumors after chemotherapy vs after chemotherapy plus trastuzumab (arm A basal-like vs arm B/C basal-like: HR = 1.06, 95% CI = 0.53 to 2.13, $P = .87$) (Table 3). As expected, RFS among the nonbasal cohort was statistically significantly improved by trastuzumab (arm A nonbasal vs arm B/C nonbasal: HR = 0.65, 95% CI = 0.51 to 0.82, $P < .001$) (Table 3). Moreover, RFS after trastuzumab was statistically significantly better among non-basal-like tumors (arm B/C basal-like vs arm B/C non-basal-like: HR = 0.47, 95% CI = 0.29 to 0.74, $P = .001$) (Table 3). However, the test for interaction of treatment arm (A vs B/C) by tumor subtype (basal vs nonbasal) did not achieve statistical significance ($P = .20$), which may or may not be because of the small number of basal-like tumors in our sample cohort.

Hormone Receptor Status and Outcome Among Nonbasal Tumors

Because basal-like tumors are generally estrogen receptor (ER)- and/or progesterone receptor (PR)-negative, we evaluated the association between subtype, outcome, and ER/PR status. Patients with ER/PR-positive or ER/PR-negative non-basal-like tumors had similar RFS after chemotherapy (arm A ER/PR-neg vs arm A ER/PR-pos: HR = 0.90, 95% CI = 0.63 to 1.28, $P = .55$) (Table 3). Likewise, ER/PR status was not statistically significantly associated with outcome after trastuzumab treatment of nonbasal tumors (arm B/C ER/PR-neg vs arm B/C ER/PR-pos: HR = 0.84, 95% CI = 0.62 to 1.14, $P = .27$) (Table 3). Moreover, both patients with ER/PR-positive and -negative tumors with nonbasal features appeared to benefit from trastuzumab (arm A ER/PR-neg vs arm B/C ER/PR-neg: HR = 0.67, 95% CI = 0.47 to 0.85, $P = .02$; arm A ER/PR-pos vs arm B/C ER/PR-pos: HR = 0.62, 95% CI = 0.45 to 0.85, $P = .003$) (Table 3).

Discussion

Intrinsic subtype, defined by abundance of transcripts that correspond to the PAM50 cohort of genes, has gained wide acceptance as a tool for stratifying breast tumors based on the extent to which these tumors exhibit expression profiles that correspond to basal-like, HER2-enriched, luminal A, or luminal B samples. All of the samples included in this analysis were centrally evaluated for HER2 protein or gene copy number at the Mayo Clinic (7). Thus, our data reflect molecular heterogeneity within clinically well-defined HER2+ tumors, such that some HER2+ tumors exhibit basal-like or luminal gene expression profiles. These results are consistent with others published elsewhere (10,11). Evaluation of several molecular features associated with subtype suggests that there are statistically significant differences in HER2 expression and proliferation. Most notably, the basal-like tumors exhibited statistically significantly lower HER2 mRNA and percent of cells staining 3+ for HER2, coupled with high proliferative markers. Both of these features might plausibly be associated with outcome.

To our knowledge, this is the first report of the use of the Prosigna algorithm to define intrinsic subtype distribution and outcome following adjuvant trastuzumab therapy of HER2+ tumors. Our data are broadly consistent with analyses of intrinsic subtype among HER2+ tumors from The Cancer Genome Atlas (10), the NOAH neoadjuvant (11), and the NSABP B31 adjuvant

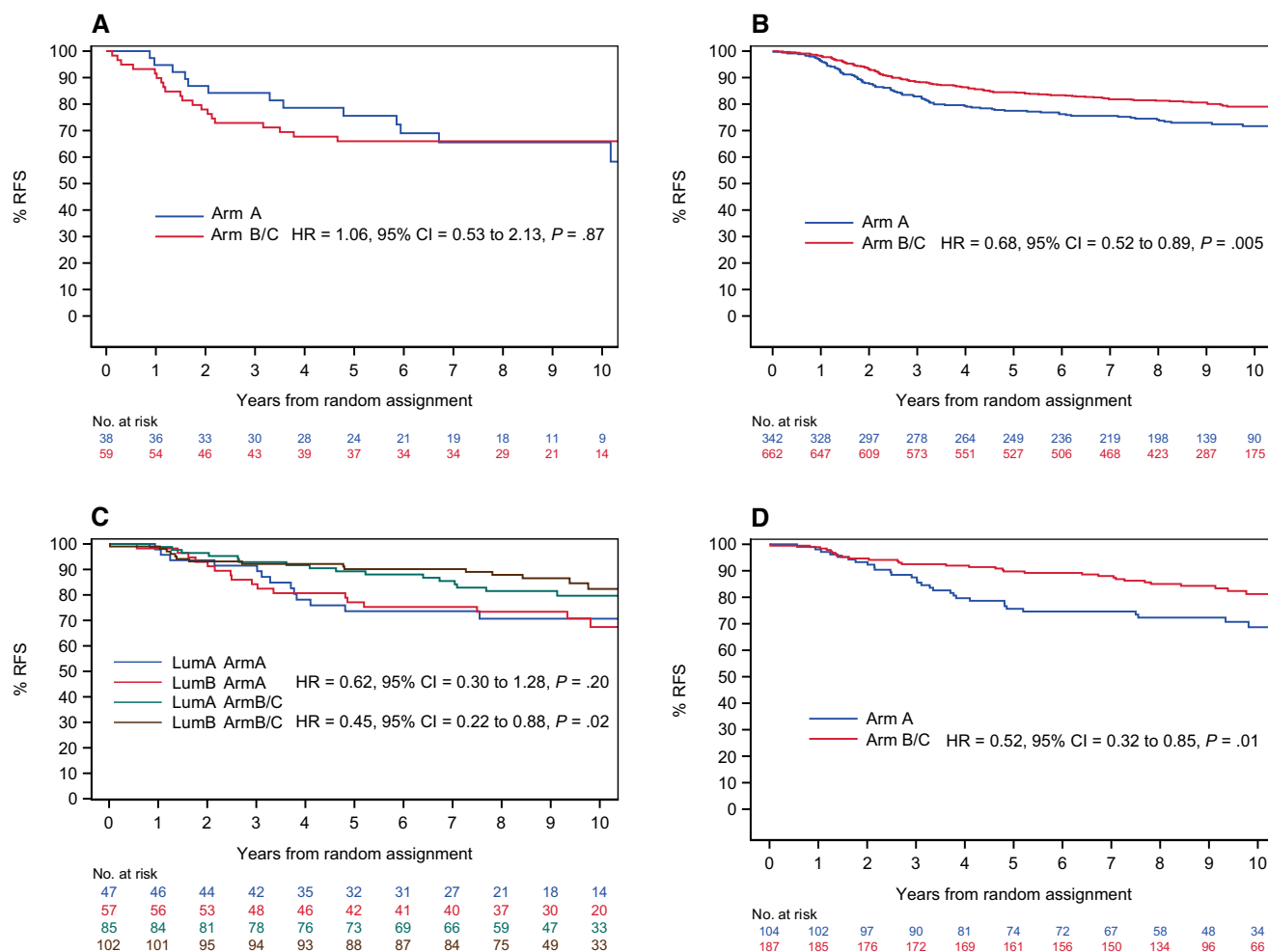


Figure 3. Human epidermal growth factor receptor 2-positive (HER2+) tumors with basal-like expression profiles compared with tumors with HER2-enriched or luminal-type expression profiles. Relapse-free survival, plotted as Kaplan-Meier curves was compared for arm A (chemotherapy alone) vs arm B/C (chemotherapy plus trastuzumab) for N9831 tumors with basal-like (A) or HER2-enriched (B) Prosigna subtype profiles. Log-rank statistics were used to calculate P values for relapse-free survival (RFS) as a continuous variable. Hazard ratios on the basis of % RFS 10 years following random assignment. Survival analysis was also carried out for luminal A and luminal B subtypes, individually (C) and combined into a luminal-type category (D). All statistical tests were two-sided.

trastuzumab trials (12), in which the research PAM50 algorithm was used to assess molecular heterogeneity among tumors that are clinically defined as HER2+. The key question is to what extent this molecular heterogeneity is associated with clinical outcome following trastuzumab. As reported in the NOAH and NSABP B31/PAM50 analysis, we observed that HER2+ tumors with HER2-enriched profiles are generally responsive to trastuzumab. Thus, the HER2-enriched profile is predictive of better outcome following adjuvant trastuzumab. The data with the HER2+ luminal subtypes are somewhat more difficult to evaluate. These patients tend to do very well, and few events were recorded. We observed a qualitative trend toward increased RFS in trastuzumab-treated patients with both luminal A and luminal B tumors, although statistical significance was not achieved with the luminal A subgroup. Nevertheless, the data suggest that HER2+ patients whose tumors express luminal signatures likely receive additional benefit from trastuzumab, above and beyond that received from chemotherapy alone.

The majority of the HER2+ tumors were classified as high risk by both Prosigna and OncotypeDX. It is unclear if the small subset of patients with low/intermediate risk, estrogen and/or progesterone receptor-positive early-stage HER2+ tumors

require adjuvant trastuzumab. The number of such patients enrolled in N9831 was small. Additional studies will be required to assess the relationship between risk category and RFS among patients with hormone receptor-positive tumors.

The data indicate that nonbasal HER2+ tumors (ie, those tumors with HER2-enriched, luminal A, or luminal B profiles) are responsive to trastuzumab, irrespective of hormone receptor status. A subset, about 7%, of HER2+ tumors in the N9831 study exhibited gene expression profiles that resemble those of basal-like tumors. Similar results were observed in analysis of 1225 samples from The Cancer Genome Atlas Network and METABRIC databases (14.1% basal-like) (13) and 1579 samples from the NSABP B31 trial (6.5% basal-like) (12). The data presented here suggest that HER2+ tumors with basal-like features may benefit less from adjuvant trastuzumab. This suggestion is consistent with the molecular features of these tumors, which express low levels of HER2 and appear to be highly proliferative. However, the conclusion that patients with such tumors will not benefit from trastuzumab is not warranted by the data. Although the hazard ratio for RFS following trastuzumab is not statistically significantly different from that observed with chemotherapy alone (HR = 1.06, P = .87), the 95% confidence

Table 3. HER2+ tumors with basal-like signatures have different outcomes than HER2+ tumors with nonbasal signatures*

Arm	Subtype or hormone receptor status	No.	Events (%)	HR (95% CI)	P
RFS as a function of subtype (basal vs nonbasal) by treatment arm					
A	Basal-like	38	13 (34.2)	1.0 (Ref)	
A	Non-basal-like	446	123 (27.5)	0.76 (0.43 to 1.34)	.34
B/C	Basal-like	59	20 (33.8)	1.0 (Ref)	
B/C	Non-basal-like	849	161 (19.0)	0.47 (0.29 to 0.74)	.001
RFS as a function of treatment (arm A vs arm B/C) by subtype					
A	Basal-like	38	13 (34.2)	1.0 (Ref)	
B/C	Basal-like	59	20 (33.8)	1.06 (0.53 to 2.13)	.87
A	Non-basal-like	446	123 (27.5)	1.0 (Ref)	
B/C	Non-basal-like	849	161 (19.0)	0.65 (0.51 to 0.82)	<.001
RFS by ER/PR status as a function of arm within nonbasal tumors					
A	ER/PR-negative	192	54 (28.1)	1.0 (Ref)	
A	ER/PR-positive	254	69 (27.2)	0.90 (0.63 to 1.28)	.55
B/C	ER/PR-negative	381	76 (19.9)	1.0 (Ref)	
B/C	ER/PR-positive	468	85 (18.2)	0.84 (0.62 to 1.14)	.27
RFS by treatment arm and ER/PR status with nonbasal tumors					
A	ER/PR-negative	192	54 (28.1)	1.0 (Ref)	
B/C	ER/PR-negative	381	76 (19.9)	0.67 (0.47 to 0.95)	.02
A	ER/PR-positive	254	69 (27.2)	1.0 (Ref)	
B/C	ER/PR-positive	468	85 (18.2)	0.62 (0.45 to 0.85)	.003

*Cox model analysis was carried out to compare relapse-free survival between basal-like and nonbasal tumors in arm A or in arm C. In addition, the Cox model was used to compare outcome as a function of treatment (arm A vs arm B/C) as a function of basal-like or nonbasal subtype. Test for interaction of arm and basal subtype status $P = .20$. A Cox model analysis was used to define hazard ratio (HR) for recurrence as a function of estrogen receptor/progesterone receptor (ER/PR) status and treatment. Wald Chi-squared P values were calculated from the Cox model data. The effect of treatment (arm A vs arm B/C) is shown as a function of ER/PR status. Test for interaction of arm and HR status $P = .79$. All statistical tests were two-sided. ER = estrogen receptor- α , the product of ESR1; HER2 = human epidermal growth factor receptor; PR = progesterone receptor, the product of PGR; Ref = referent; RFS = relapse-free survival, as defined in "Methods."

intervals are very large (95% CI = 0.53 to 2.13), and the test for interaction between treatment and subtype (basal vs nonbasal) was not statistically significant. Moreover, Pogue-Geile et al. reported that basal-like tumors in the NSABP B31 trial received statistically significant benefit from adjuvant trastuzumab (12). There are some differences in the algorithms used to call intrinsic subtype in our study and the study by Pogue-Geile et al. They reported disease-free survival, whereas we report breast cancer relapse-free survival. Perhaps more importantly, they used a modified version of the PAM50 algorithm, rather than the Prosigna algorithm used in our studies. These two algorithms use different normalization strategies, and they called 47% of the HER2+ tumors in B31 HER2-enriched, whereas we called 73% of the N9831 HER2+ samples HER2-enriched. Furthermore, both studies were limited in power by the relative small number of basal-like tumors that were identified. Given these considerations, we are inclined to the most conservative conclusion: that additional studies will be required to sort out the role of intrinsic subtype in predicting response to HER2-targeted therapy in the adjuvant setting.

There are a couple of limitations of this study. The first is that it is a retrospective analysis of samples from less than half of the patients enrolled on N9831. This because of the fact that the submission of patient samples was optional for this study and some samples were dropped due to poor quality. It is recognized that this could bias the results. A comparison of patients with samples used in this analysis to patients not included in the analysis only showed some clinical-pathological differences (eg, patients with larger tumors are included in this analysis), but there was no difference observed in the treatment effect between the patients included in this study and patients not included in this study. Another limitation is that some of the identified intrinsic subtype groups had a relatively small number of patients and events. This

limits the power of the analyses in these subgroups, which makes statistically nonsignificant results hard to interpret: They could be reflective of no real difference between the groups or could be because of lack of power to detect a difference of interest.

Finally, our data indicate that evaluation of HER2 status by IHC and/or FISH is an essential component of clinical management of breast cancer patients. Intrinsic subtype alone cannot replace conventional histopathological evaluation of HER2 status because many tumors that are classified as luminal A or luminal B will benefit from adjuvant trastuzumab if that subtype is accompanied by HER2 overexpression. However, among tumors that overexpress HER2, we speculate that assessment of intrinsic subtype may guide further treatment development, particularly with respect to evaluating alternative therapeutic approaches for that subset of HER2+ tumors of the basal-like subtype. Given the relative rarity of such tumors, additional studies will be required to evaluate this idea.

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Notes

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Drs. Edith A. Perez, E. Aubrey Thompson, and Karla V. Ballman had full access to all the data in the study, and these individuals take full responsibility, jointly and severally, for the integrity of the data and the accuracy of the data analysis.

Potential conflicts of interest include Nanostring employment for Drs. Mashadi-Hosseini and Ferree. Dr. Perou is a board of director's member, consultant, and stock holder in Bioclassifier LLC, as well as a patent applicant on PAM50 assay with royalties paid to Nanostring Technologies. Dr. Cheang has a patent, "Gene expression profiles to predict breast cancer outcomes (PAM50 classifier)," issued. Dr. Baehner is an employee of Genomic Health, Inc. All other authors declare no conflicts of interest.

Dr. Perez was involved in the conception and design of the manuscript, as well as provision of the study material or patients. Collection and assembly of data were provided by Drs. Ballman and Perez. Dr. Thompson had overall responsibility for data accumulation, analysis, and interpretation. All authors contributed to the analysis and interpretation of data, as well as drafting and final approval of the manuscript, and all authors agree to be accountable for all aspects of the work.

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