Year in Review: Management of Breast Cancer

A CME/MOC-Accredited Live Webinar

Tuesday, May 6, 2025
5:00 PM – 6:00 PM ET

Faculty

Ian E Krop, MD, PhD
Sara M Tolaney, MD, MPH

Moderator

Neil Love, MD

RTP Year in Review 2025

Faculty

Ian E Krop, MD, PhD
Professor of Internal Medicine
Associate Cancer Center Director for Clinical Research
Yale Cancer Center
New Haven, Connecticut

Sara M Tolaney, MD, MPH
Chief, Division of Breast Oncology
Dana-Farber Cancer Institute
Associate Professor of Medicine
Harvard Medical School
Boston, Massachusetts

MODERATOR
Neil Love, MD
Research To Practice
Miami, Florida

Commercial Support

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Dr Love — Disclosures

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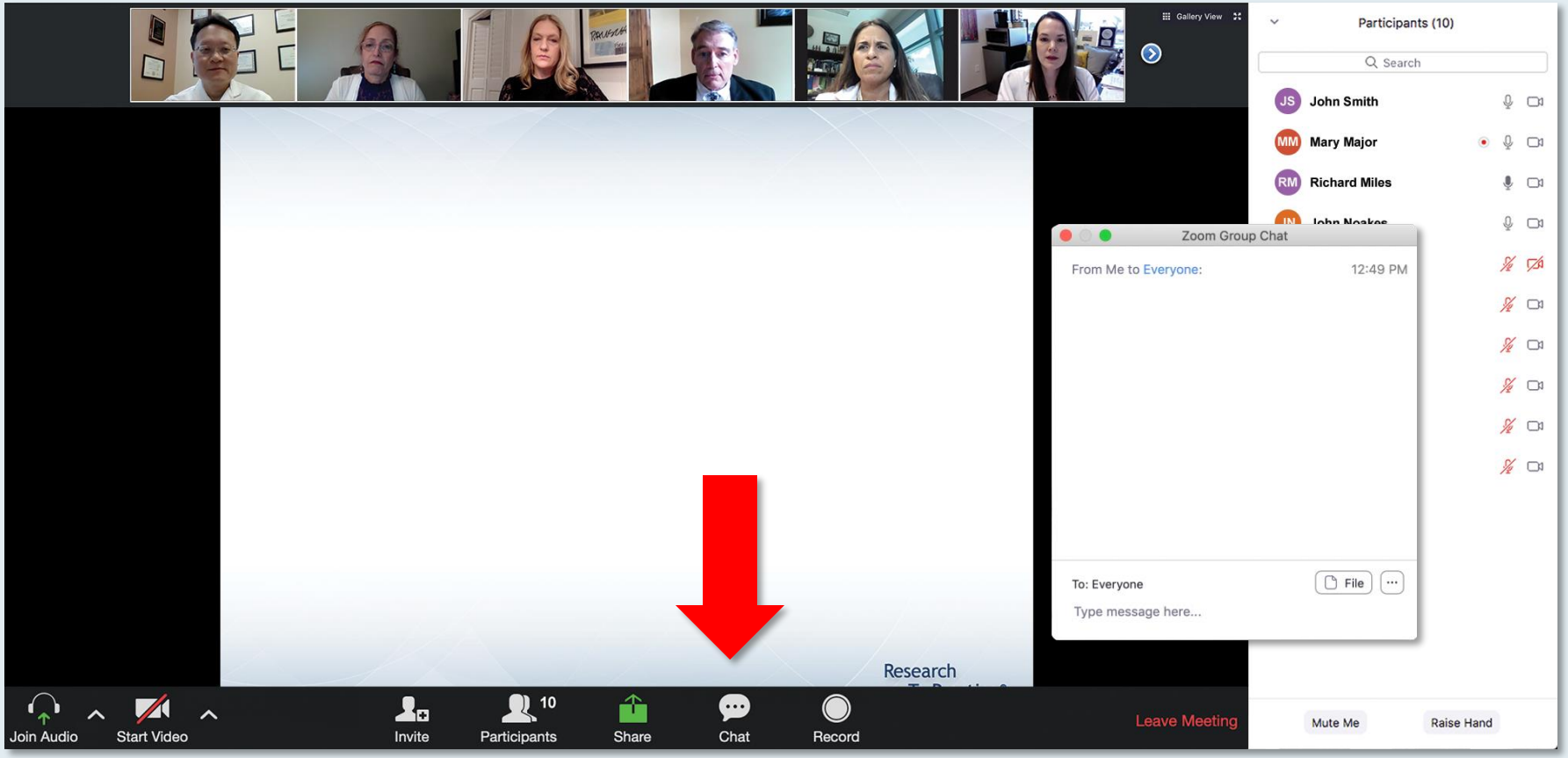

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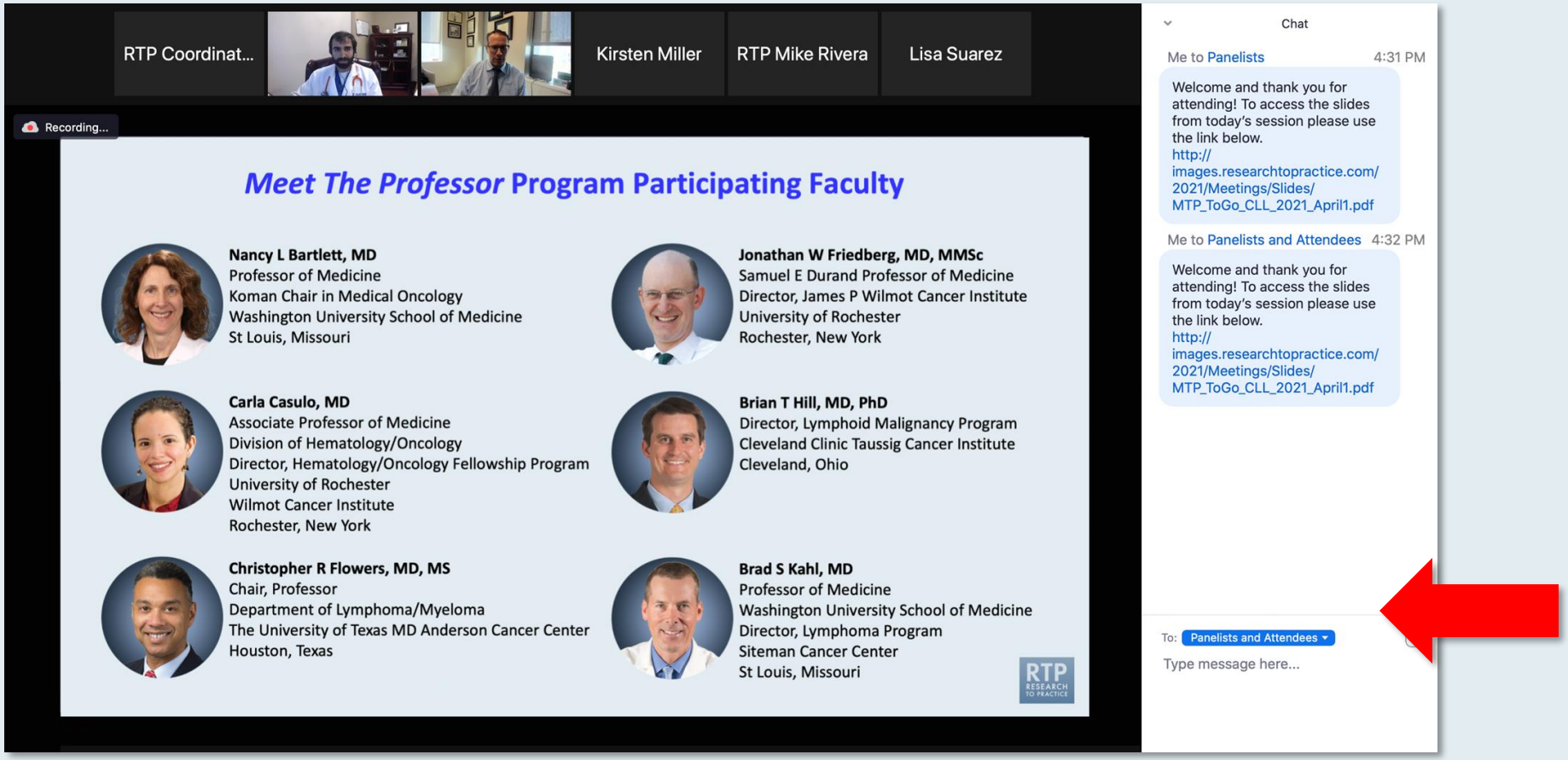

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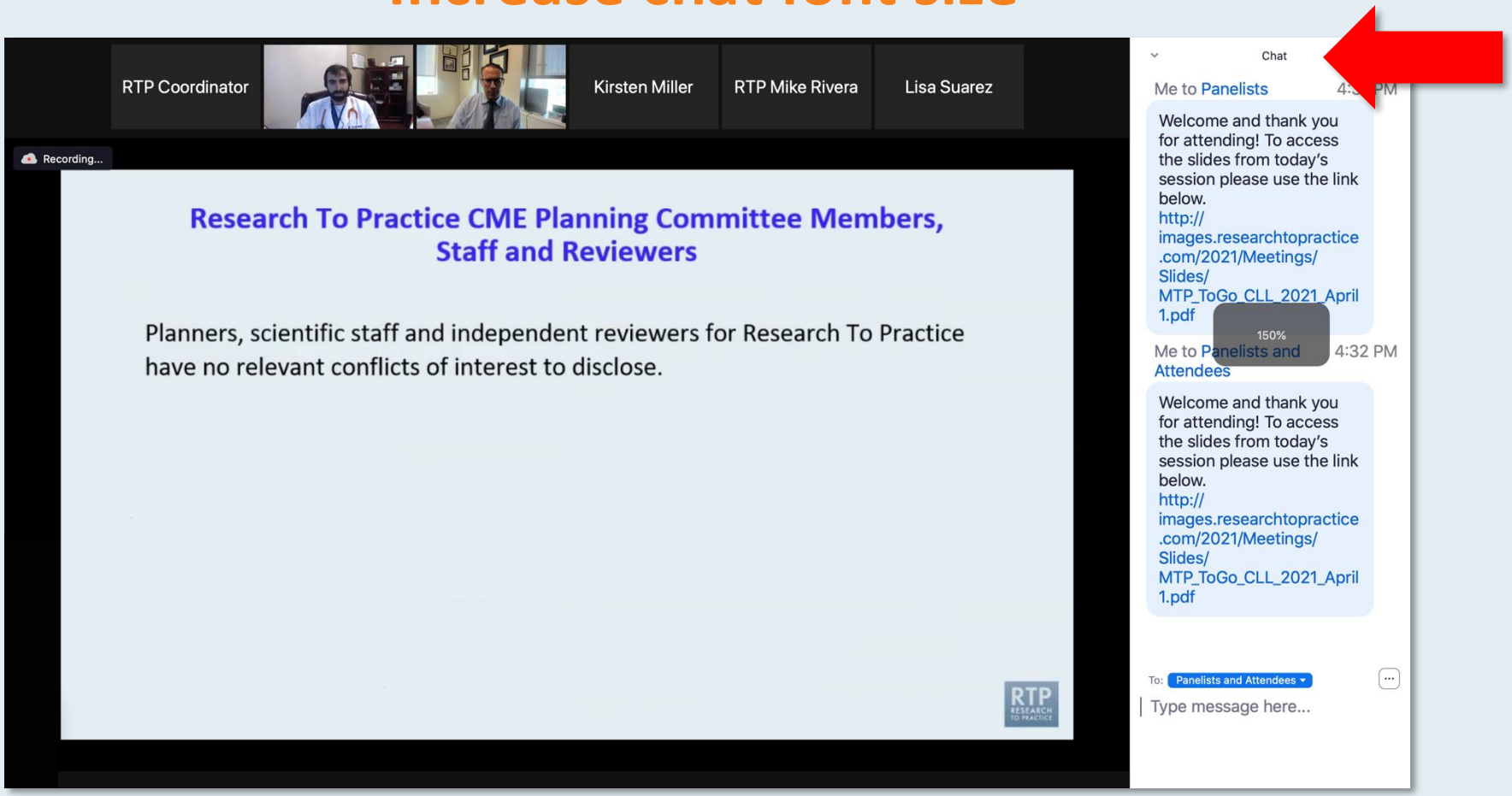

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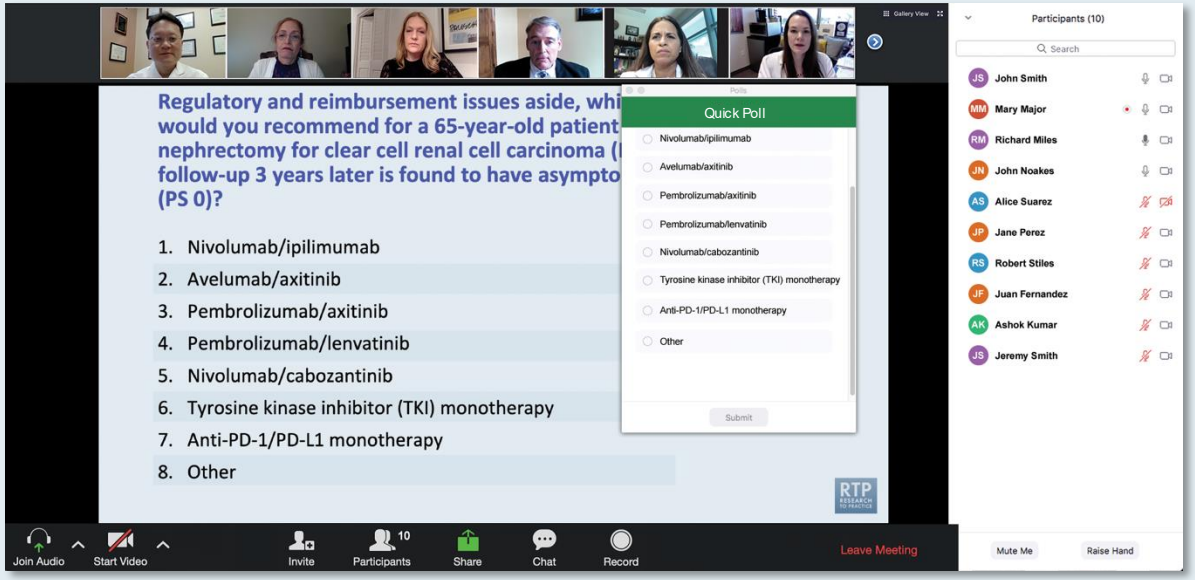

ONCOLOGY TODAY

WITH DR NEIL LOVE

Hormone Receptor-Positive Metastatic Breast Cancer — An Interview with Dr Adam M Brufsky on the Impact of Biomarkers and Existing Comorbidities on the Selection of First-Line Therapy

DR ADAM M BRUFSKY
UNIVERSITY OF PITTSBURGH

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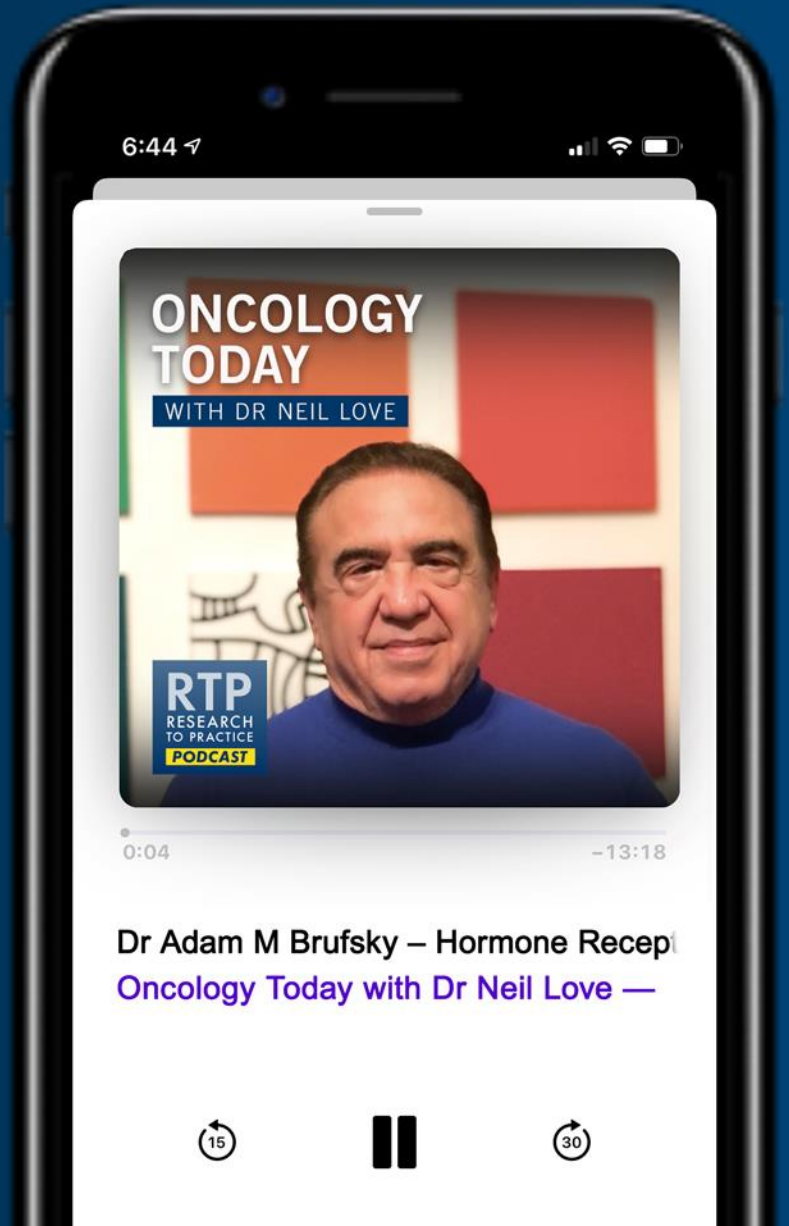

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Management of Multiple Myeloma

A CME/MOC-Accredited Live Webinar

Thursday, May 8, 2025
5:00 PM – 6:00 PM ET

Faculty

Meletios-Athanasios (Thanos) C Dimopoulos, MD
Robert Z Orlowski, MD, PhD

Moderator

Neil Love, MD

RTP Year in Review 2025

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Therapeutic Targets Beyond EGFR for Non-Small Cell Lung Cancer

A CME/MOC-Accredited Live Webinar

Thursday, May 15, 2025

5:00 PM – 6:00 PM ET

Faculty

Jessica J Lin, MD

Joel W Neal, MD, PhD

Moderator

Neil Love, MD

RTP Year in Review 2025

Practical Perspectives: Experts Review Actual Cases of Patients with Advanced Gastroesophageal Cancers

A CME/MOC-Accredited Live Webinar

Wednesday, May 21, 2025
5:00 PM – 6:00 PM ET

Faculty

Zev Wainberg, MD, MSc

Moderator

Neil Love, MD

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AGENDA

Year in Review: Management of Breast Cancer

INTRODUCTION: Adjuvant CDK4/6 Inhibition

MODULE 1: HER2-Positive Disease

MODULE 2: PARP Inhibition

MODULE 3: Antibody-Drug Conjugates

MODULE 4: Up-Front Treatment of HR-Positive Metastatic Disease

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1 to 3 business days with these instructions.

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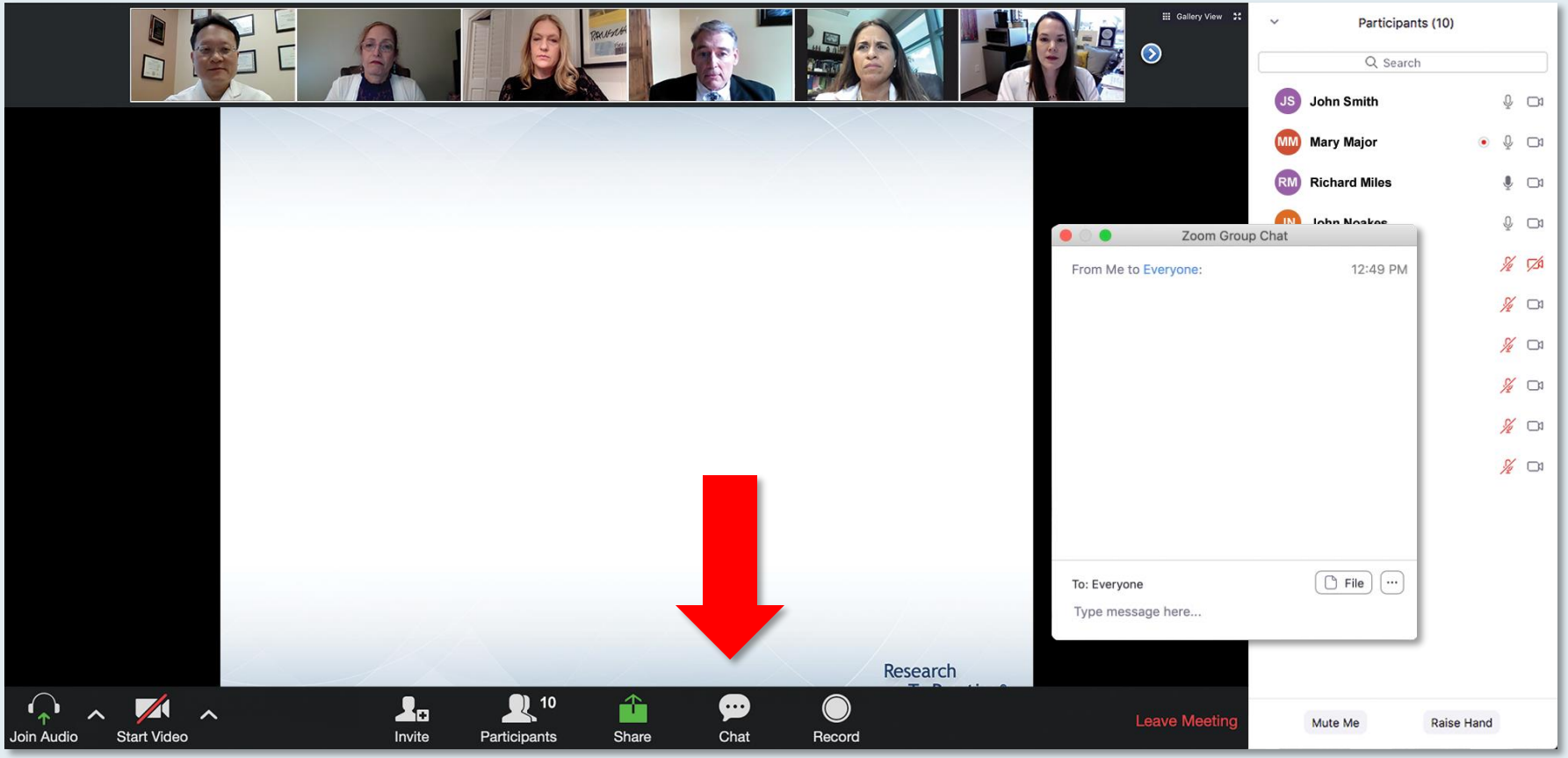

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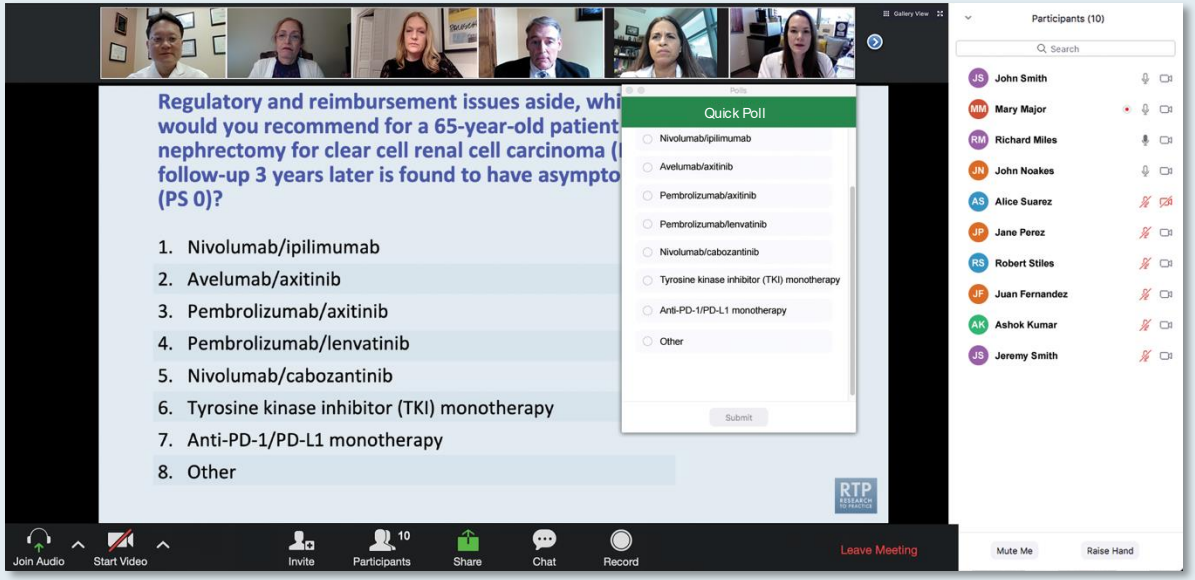

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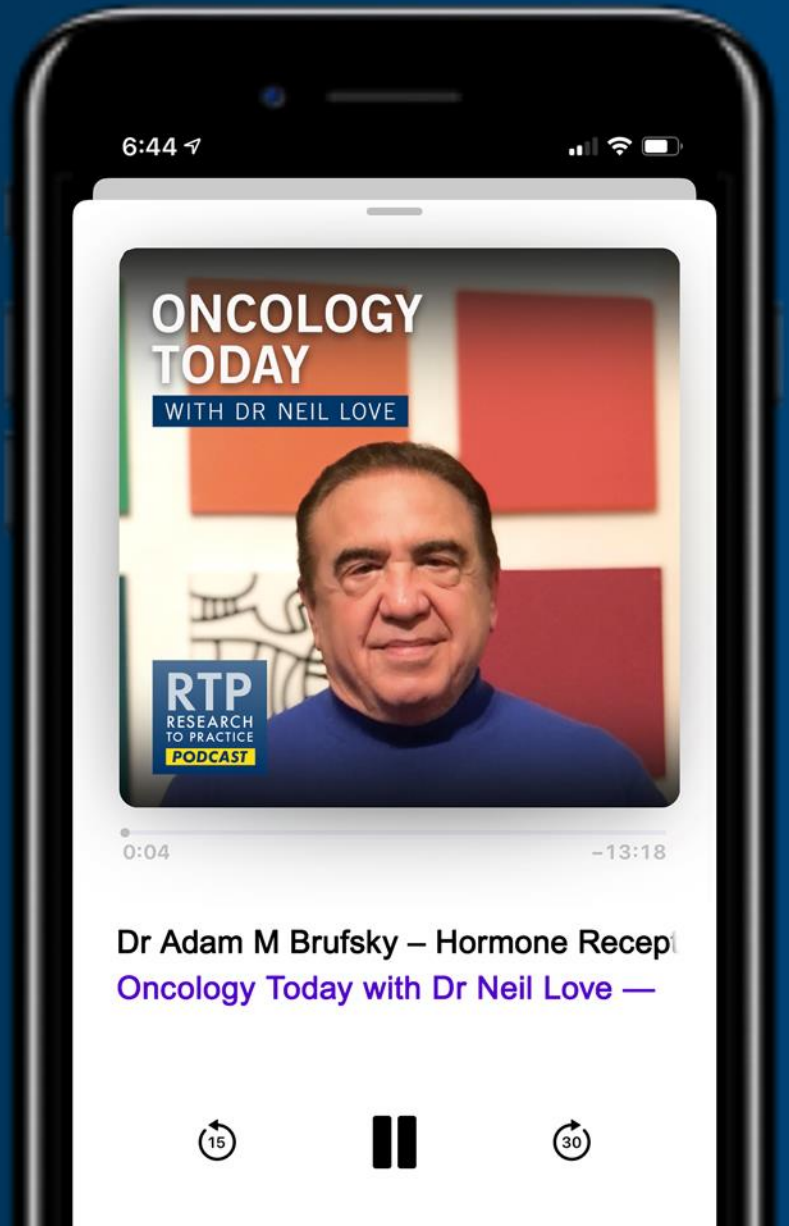

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Year in Review:
Management of Breast Cancer

A CME/MOC-Accredited Live Webinar

Wednesday, March 26, 2025
5:00 PM – 6:00 PM ET

Faculty

Rebecca A Dent, MD, MSc
Nancy U Lin, MD

Moderator

Neil Love, MD

RTP Year in Review 2025

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AGENDA

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Comments and Controversies

Why We Do Not Recommend That Women With Breast Cancer Receive Adjuvant Treatment With a CDK4/6 Inhibitor

Ian F. Tannock, MD, PhD, FRCPC, FASCO[1]; Qamar J. Khan, MD[2]; and Tito Fojo, MD, PhD[3,4]

DOI https://doi.org/10.1200/JCO-24-02683

J Clin Oncol 2025 April 14;[Online ahead of print].

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Meet The Professor

Optimizing the Selection and Sequencing of Therapy for Patients with HER2-Positive Breast Cancer

Sara M Tolaney, MD, MPH
Associate Director, Susan F Smith Center for Women's Cancers
Director of Clinical Trials, Breast Oncology
Director of Breast Immunotherapy Clinical Research
Senior Physician
Breast Oncology Program
Dana-Farber Cancer Institute
Associate Professor of Medicine
Harvard Medical School
Boston, Massachusetts

Trastuzumab Deruxtecan Significantly Improved Progression-Free Survival in Comparison to T-DM1 for HER2-Positive Metastatic Breast Cancer

Press Release – August 9, 2021

"Trastuzumab deruxtecan demonstrated superior progression-free survival (PFS) outcomes over trastuzumab emtansine (T-DM1) in patients with HER2-positive metastatic breast cancer, based on the phase 3 DESTINY-Breast03 trial (NCT03529110). The study's planned interim analysis identified a statistically significant and clinically meaningful improvement in the primary end point of PFS as assessed by an Independent Data Monitoring Committee (IDMC) for patients with HER2-positive, unresectable and/or metastatic breast cancer who received prior treatment with trastuzumab and a taxane.

Approximately 500 patients were enrolled in the DESTINY-Breast03 trial, who were randomized to either the experimental trastuzumab deruxtecan arm or the comparator T-DM1 arm. The primary end point was PFS assessed by IDMC, with secondary end points including overall survival (OS), objective response rate (ORR), duration of response, and PFS based on investigator assessment.

While patients treated with trastuzumab deruxtecan trended toward OS improvement, the data were immature. Furthermore, the safety profile was consistent with previously reported data regarding trastuzumab deruxtecan, with no new safety signals or grade 4/5 treatment-related interstitial lung disease events observed."

https://www.cancernetwork.com/view/trastuzumab-deruxtecan-significantly-improved-pfs-over-tdm-1-for-her2-metastatic-breast-cancer

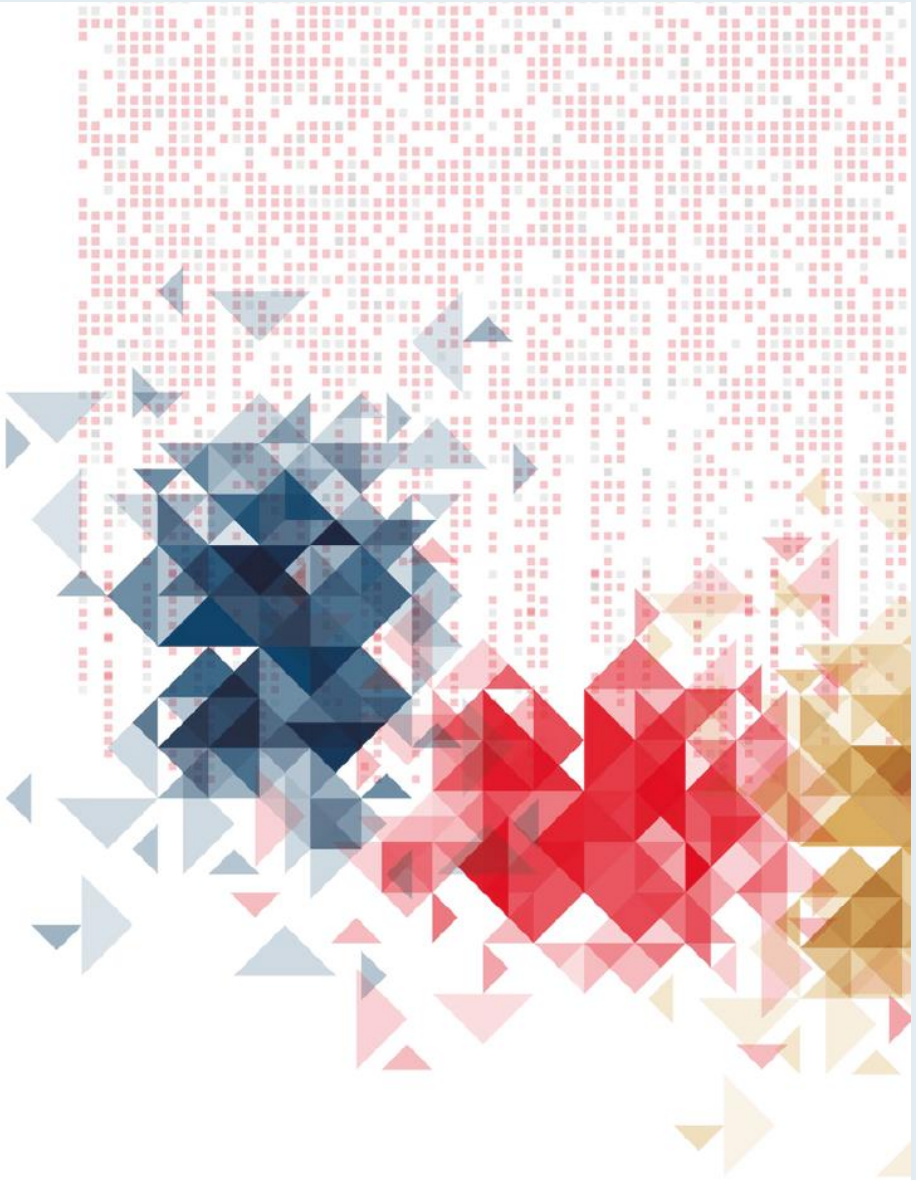
RTP RESEARCH TO PRACTICE

2021 ESMO congress

Trastuzumab Deruxtecan (T-DXd) vs Trastuzumab Emtansine (T-DM1) in Patients With HER2+ Metastatic Breast Cancer: Results of the Randomized, Phase 3 Study DESTINY-Breast03

Javier Cortés, MD[a], Sung-Bae Kim, Wei-Pang Chung, Seock-Ah Im, Yeon Hee Park, Roberto Hegg, Min-Hwan Kim, Ling-Ming Tseng, Vanessa Petry, Chi-Feng Chung, Hiroji Iwata, Erika Hamilton, Giuseppe Curigliano, Binghe Xu, Caleb Lee, Yali Liu, Jillian Cathcart, Emarjola Bako, Sunil Verma, Sara Hurvitz
On behalf of the DESTINY-Breast03 investigators

[a]Medical Oncology, International Breast Cancer Center (IBCC), Quironsalud Group, and Vall d'Hebron Institute of Oncology (VHIO), Barcelona, Spain; Universidad Europea de Madrid, Faculty of Biomedical and Health Sciences, Department of Medicine, Madrid, Spain.



Abstract LBA1

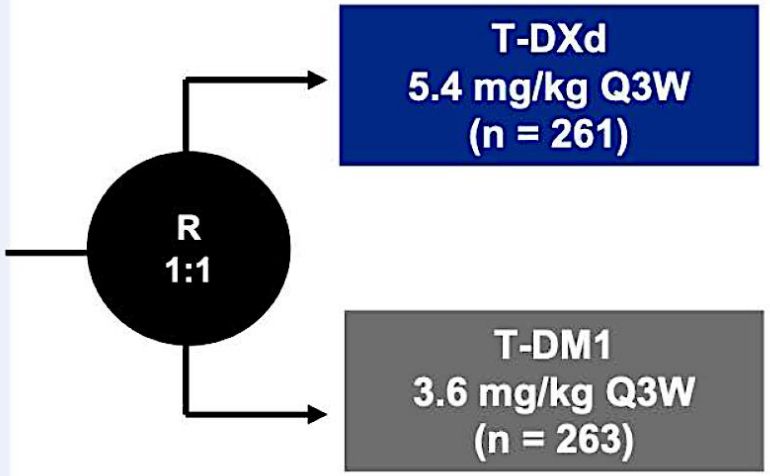
RTP RESEARCH TO PRACTICE

DESTINY-Breast03 Phase III Trial Schema

An open-label, multicenter study (NCT03529110)

Patients
- Unresectable or metastatic HER2-positive[a] breast cancer
- Previously treated with trastuzumab and taxane in advanced/metastatic setting[b]
- Could have clinically stable, treated brain metastases

Stratification factors
- Hormone receptor status
- Prior treatment with pertuzumab
- History of visceral disease



Primary endpoint
- PFS (BICR)

Key secondary endpoint
- OS

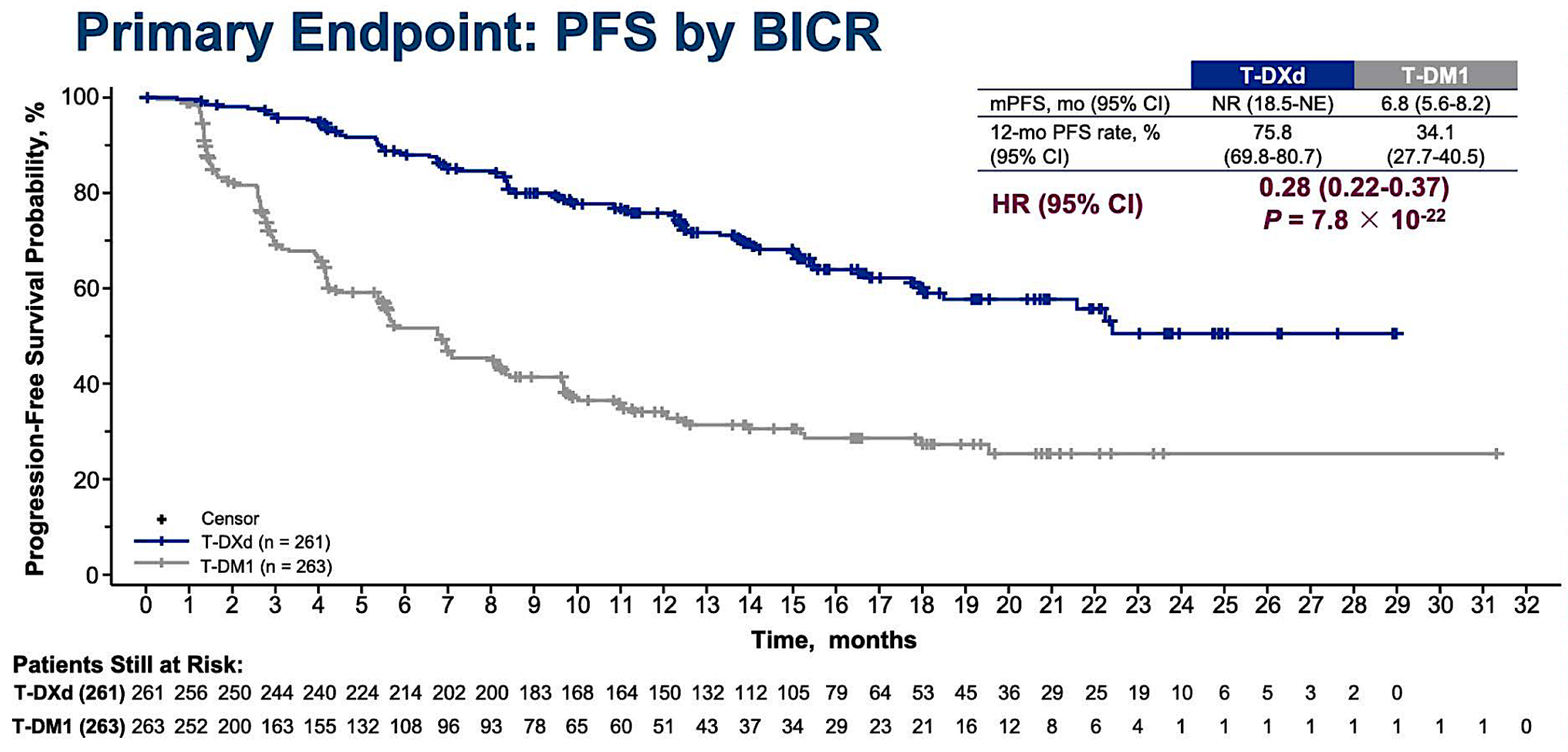
Secondary endpoints
- ORR (BICR and investigator)
- DOR (BICR)
- PFS (investigator)
- Safety

Interim analysis for PFS (data cutoff: May 21, 2021)
- Efficacy boundary for superiority: $P < 0.000204$ (based on 245 events)
- IDMC recommendation to unblind study (July 30, 2021)

Key secondary endpoint, OS: boundary for efficacy: $P < 0.000265$ (based on 86 events)

Cortés J et al. ESMO 2021;Abstract LBA1.

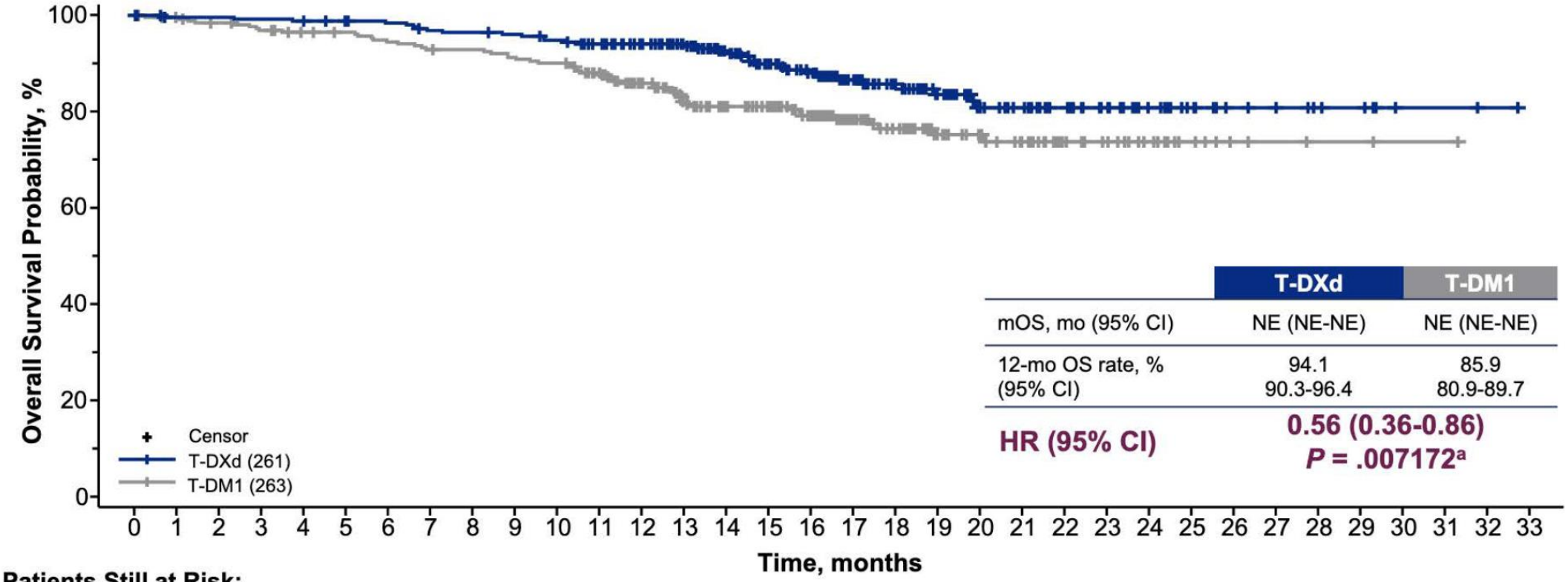
DESTINY-Breast03: PFS by Blinded Independent Central Review (BICR)



Cortés J et al. ESMO 2021;Abstract LBA1.

DESTINY-Breast03: Overall Survival (OS) by BICR

Key Secondary Endpoint: OS



	T-DXd	T-DM1
mOS, mo (95% CI)	NE (NE-NE)	NE (NE-NE)
12-mo OS rate, % (95% CI)	94.1 90.3-96.4	85.9 80.9-89.7
HR (95% CI)	**0.56 (0.36-0.86)**	
	***P* = .007172[a]**	

Patients Still at Risk:

T-DXd (261)	261	256	256	255	254	251	249	244	243	241	237	230	218	202	180	158	133	108	86	71	56	50	42	33	24	18	11	10	7	6	2	2	1	0
T-DM1 (263)	263	258	253	248	243	241	236	232	231	227	224	210	188	165	151	140	120	91	75	58	52	44	32	27	18	11	5	4	3	3	1	1	0	

2021 ESMO congress

Early OS data with relatively few events (33 in the T-DXd arm, 53 in the T-DM1 arm)

[a]*P* = .007172, but does not cross pre-specified boundary of *P* < .000265

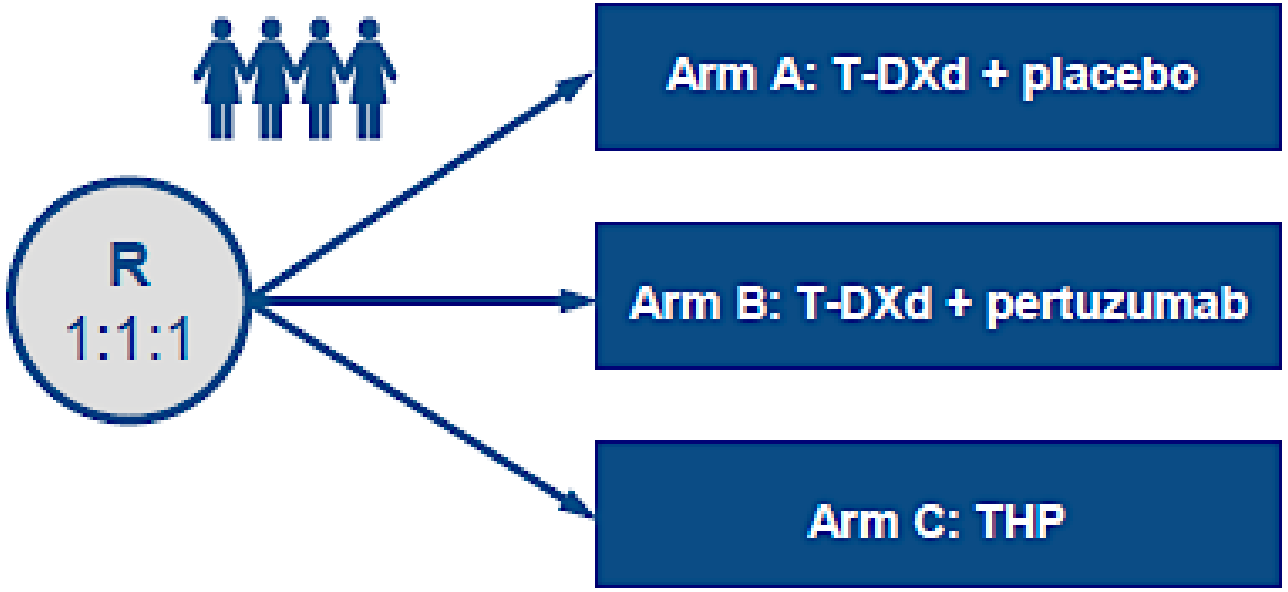
Cortés J et al. ESMO 2021;Abstract LBA1.

RTP RESEARCH TO PRACTICE

DESTINY-Breast09 Phase III Trial Design

Patient population (N≈1134)

- Advanced and/or metastatic breast cancer
- HER2 positive (IHC 3+ or ISH+) by central confirmation
- No previous chemotherapy or HER2-targeted therapy for advanced or metastatic breast cancer
- Patients will be stratified by prior treatment status (de novo vs recurrent), HR status (positive vs negative), and *PIK3CA* mutation status (detected vs not detected)



Tolaney SM et al. San Antonio Breast Cancer Symposium 2021;Abstract OT1-14-02.

Trastuzumab Deruxtecan with Pertuzumab Demonstrated Highly Statistically Significant and Clinically Meaningful Improvement in PFS in Comparison to THP as First-Line Therapy for Patients with HER2-Positive Metastatic Breast Cancer

Press Release: April 21, 2025

"Positive high-level results from a planned interim analysis of the DESTINY-Breast09 Phase III trial showed trastuzumab deruxtecan in combination with pertuzumab demonstrated a highly statistically significant and clinically meaningful improvement in progression-free survival (PFS) compared to a taxane, trastuzumab and pertuzumab (THP) as a 1st-line treatment for patients with HER2-positive metastatic breast cancer.

The PFS improvement was seen across all pre-specified patient subgroups with trastuzumab deruxtecan in combination with pertuzumab. The key secondary endpoint of overall survival (OS) was not mature at the time of this planned interim analysis; however, interim OS data showed an early trend favoring the trastuzumab deruxtecan combination compared with THP. The second arm assessing trastuzumab deruxtecan monotherapy versus THP remains blinded to patients and investigators and will continue to the final PFS analysis."

https://www.astrazeneca.com/media-centre/press-releases/2025/enhertu-combination-improved-pfs-in-1l-her-positive-mbc.html

RTP RESEARCH TO PRACTICE

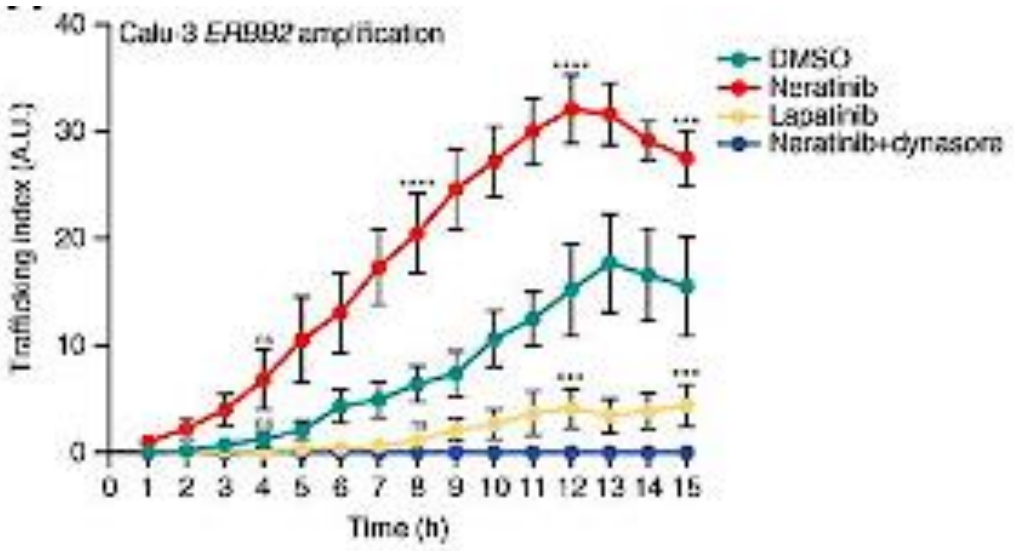
Trastuzumab Deruxtecan (T-DXd) + Pertuzumab (P) vs Taxane + Trastuzumab + Pertuzumab (THP) for First-Line (1L) Treatment of Patients (pts) with Human Epidermal Growth Factor Receptor 2-Positive (HER2+) Advanced/Metastatic Breast Cancer (a/mBC): Interim Results from DESTINY-Breast09

Tolaney S et al.

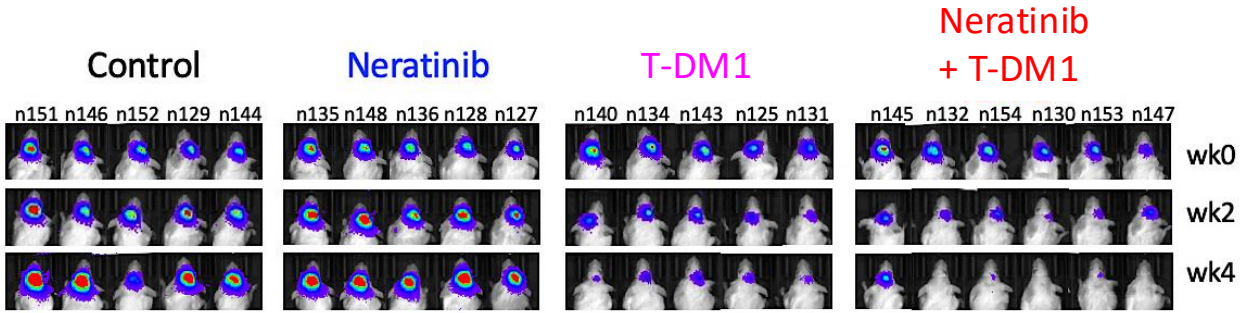
ASCO 2025;Abstract LBA1008.

MONDAY, JUNE 2| 7:30 AM CDT

TBCRC 022: T-DM1 + Neratinib for HER+ Brain Mets
Rationale for the Combination



Neratinib increases HER2 trafficking
and may overcome T-DM1 resistance



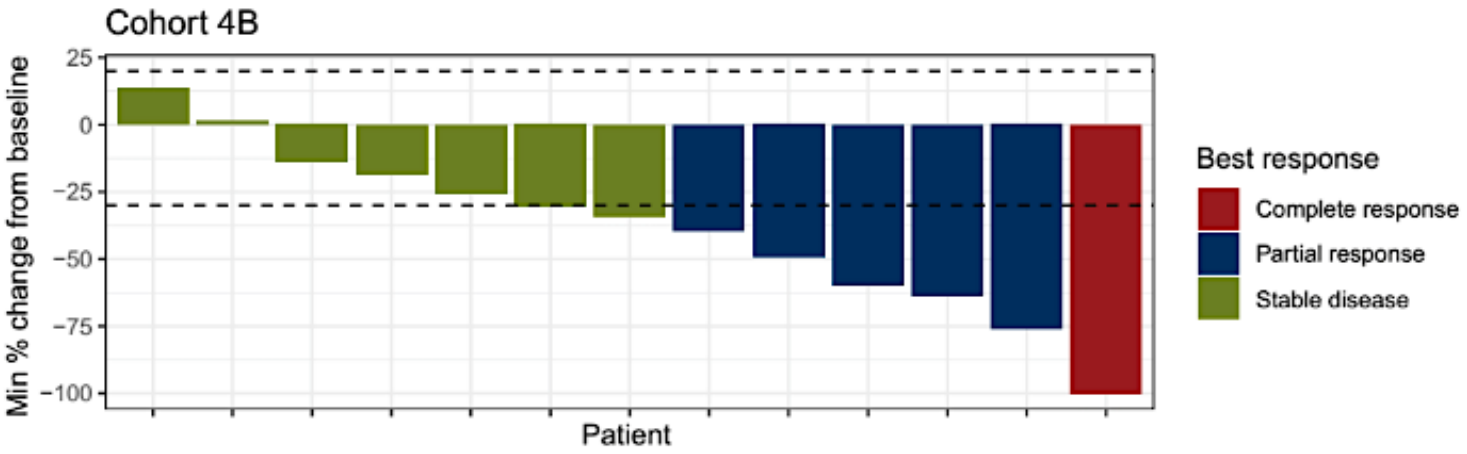
PDX model of HER2+ breast cancer brain mets
Deeper and more durable responses with the combination

Freedman RA et al. Ann Oncol 2024;35(11):993-1002.

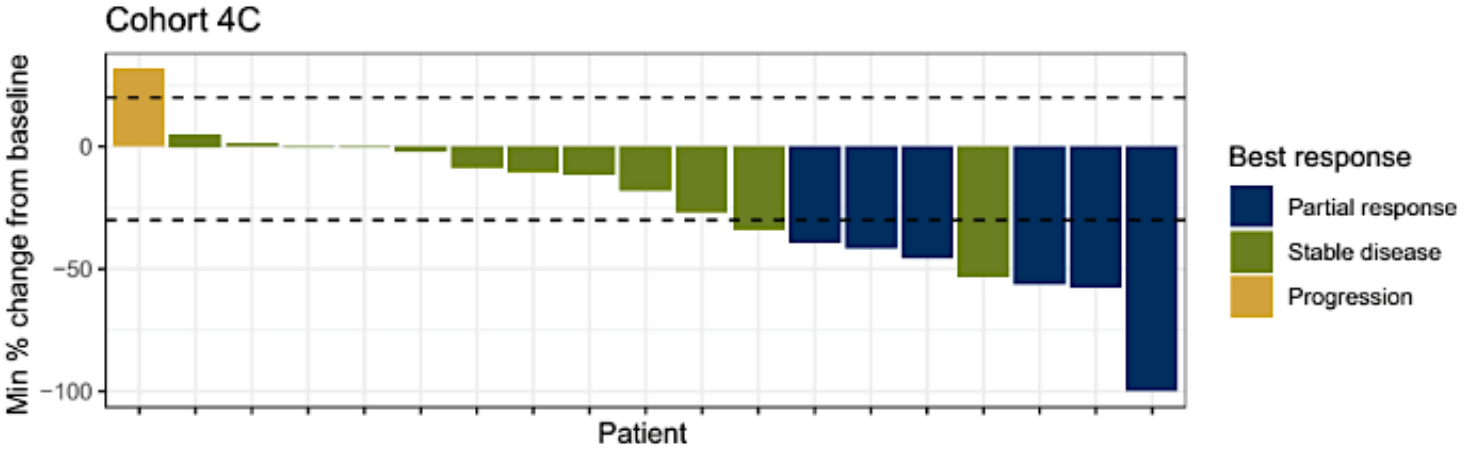
Li et al, Cancer Discov 2020

Courtesy of Nancy U Lin, MD

TBCRC 022: T-DM1 + neratinib for HER+ Brain Mets



Progressing after prior local tx
No prior T-DM1
CNS ORR 35.3%
Median PFS 4.1 mo
Median OS 23.3 mo
12 mo OS 87%



Progressing after prior local tx
Prior T-DM1 exposure
CNS ORR 28.6%
Median PFS 4.1 mo
Median OS 20.9 mo
12 mo OS 80%

Courtesy of Nancy U Lin, MD

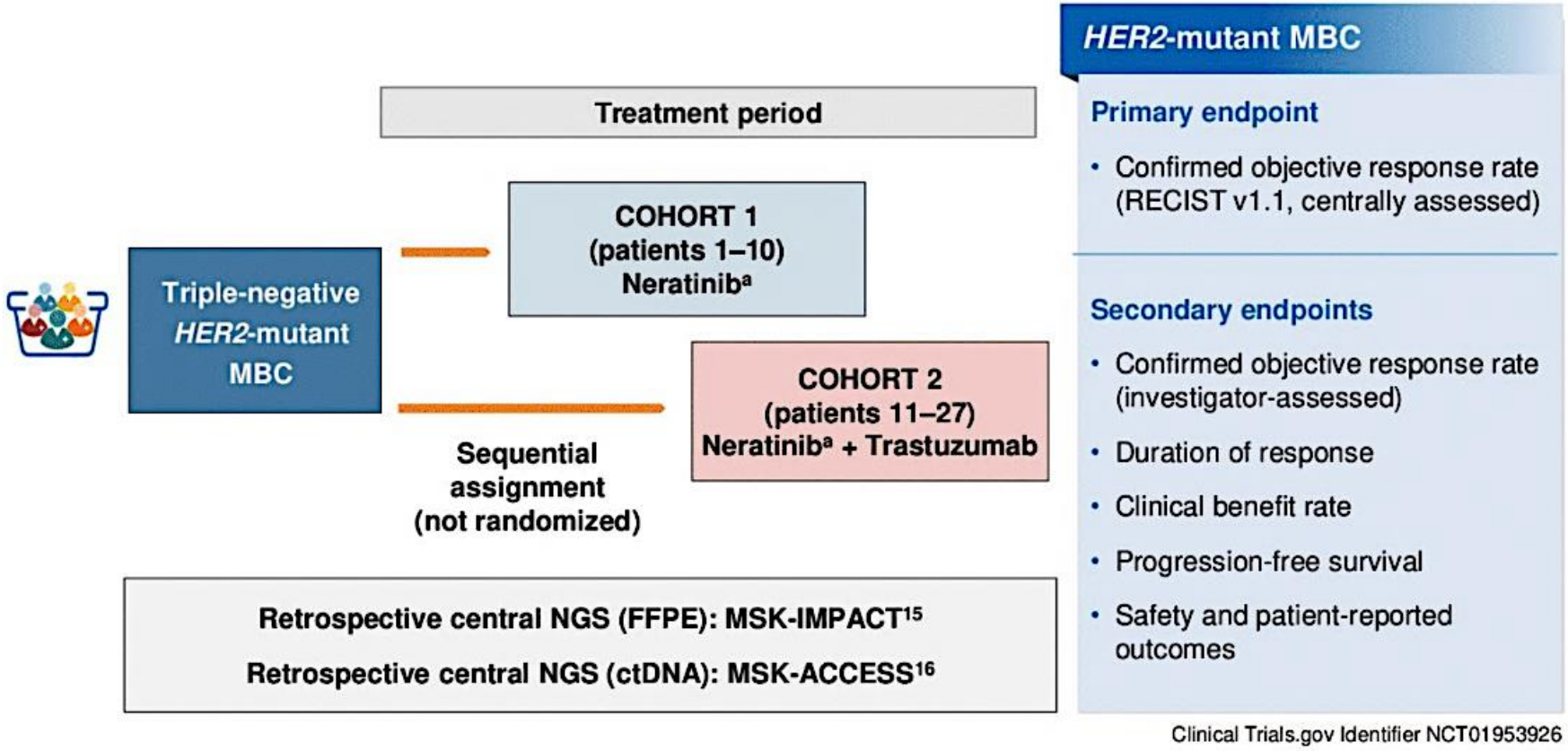
Freedman RA et al. Ann Oncol 2024;35(11):993-1002.

TBCRC 022: Conclusions and Thoughts

- Even with the advent of T-DXd and tucatinib, there is a substantial need for multiple lines of systemic therapy for patients with active brain metastases
- CNS ORR to T-DM1 + neratinib exceeds that of neratinib monotherapy (CNS ORR 8%)
- CNS responses are seen in about 1/3 of patients with prior T-DM1 exposure
- Limitations: no patients had received prior tucatinib, and only a few had prior T-DXd
- Await more granular CNS data from HER2CLIMB-02
- Provides another systemic option for patients with HER2+ BM

Courtesy of Nancy U Lin, MD

SUMMIT Trial: HER2-mutant TNBC treated with Neratinib or Neratinib + Trastuzumab



Cohort 1
Neratinib
N=10
Median 2.5 prior lines

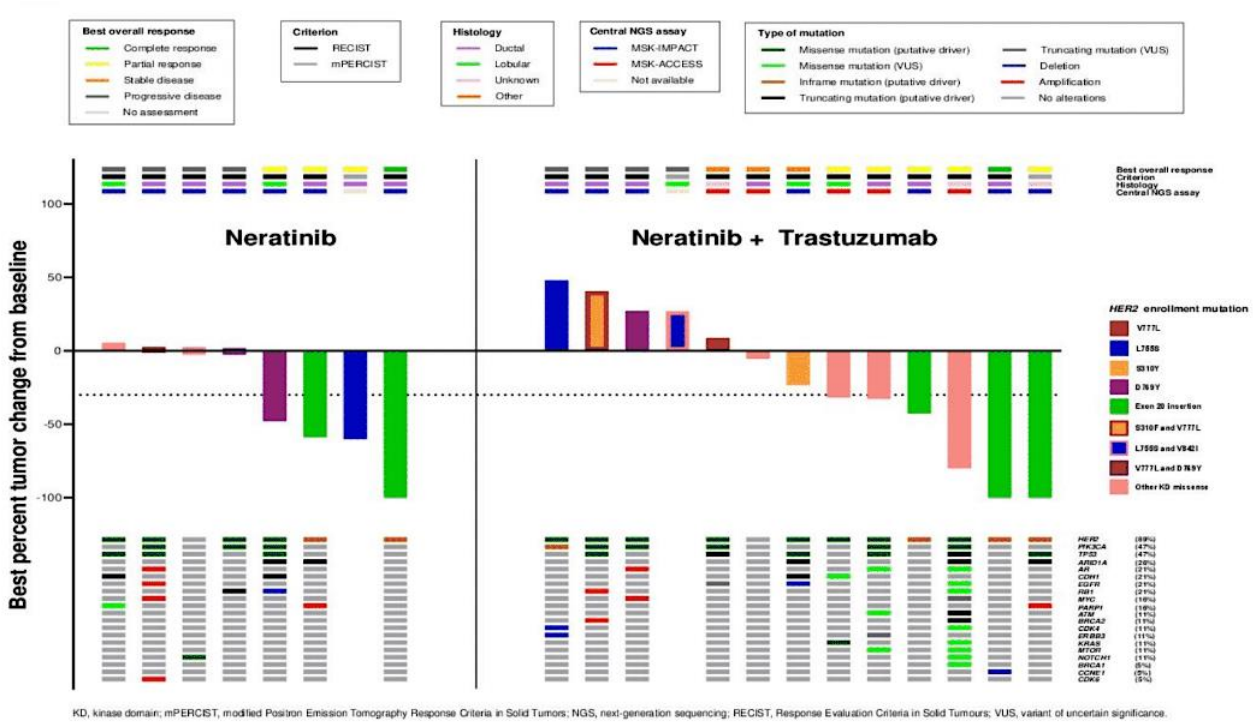
Cohort 2
Neratinib + trastuzumab
N=17
Median 2 prior lines

Courtesy of Nancy U Lin, MD

Jhaveri K et al. ASCO 2024;Abstract 1094.

SUMMIT Trial: HER2-mutant TNBC treated with Neratinib or Neratinib + Trastuzumab

Parameter	Neratinib (n=10)	Neratinib + Trastuzumab (n=17)
Objective response (confirmed PR or CR)[a], n (%)		
CR	1 (10.0)	2 (11.8)
PR	3 (30.0)	4 (23.5)
Objective response rate, % (95% CI)	40.0 (12.2–73.8)	35.3 (14.2–61.7)
Best overall response (confirmed or unconfirmed PR or CR), n (%)		
CR	1 (10.0)	2 (11.8)
PR	4 (40.0)	5 (29.4)
Best overall response rate (95% CI)	50.0 (18.7–81.3)	41.2 (18.4–67.1)
Median duration of response[b], months (95% CI)	3.78 (3.75–3.88)	6.14 (4.17–9.49)
Clinical benefit rate, %[c] (95% CI)	40.0 (12.2–73.8)	47.1 (23.0–72.2)
CR	1 (10.0)	2 (11.8)
PR	3 (30.0)	4 (23.5)
SD ≥24 weeks	0	2 (11.8)
Median PFS[b], months (95% CI)	2.89 (0.95–5.52)	6.24 (2.10–8.18)



Confirmed ORR 40% (N), 35.3% (N+T)
Median PFS 2.89 mo (N), 6.24 mo (N+T)

Deepest responses in those with Exon 20 insertions

Courtesy of Nancy U Lin, MD

Jhaveri K et al. ASCO 2024;Abstract 1094.

SUMMIT Trial TNBC basket: Conclusions and Thoughts

- Impressive response rates (40%) in pre-treated HER2-mut TNBC
- Longer DoR and PFS with the doublet of N+T
- Small numbers but compares favorably to “nth-line” chemo in TNBC

- Previously published data in HR+/HER2-mut MBC
  - ORR 38.6%, median PFS 8.3 months with neratinib + fulvestrant + trastuzumab

- New data for tucatinib + trastuzumab in HER2-mut MBC
  - Confirmed ORR 41.9%; median PFS 9.5 months
  - Pts with HR+ disease also received fulvestrant
  - Only 4 pts with TNBC included

Jhaveri K et al. ASCO 2024;Abstract 1094.

Jhaveri et al, Ann Oncol 2023

Okines et al, Nat Med 2025

Courtesy of Nancy U Lin, MD

2018 and 2024 Surveys of Clinical Investigator (CI) Use of Postoperative Systemic Therapy After Prior Neoadjuvant Treatment of HER2-Positive Breast Cancer (HER2+ BC)

Wallace T et al.

SABCS 2024;Abstract P3-11-20.

Survey Participants

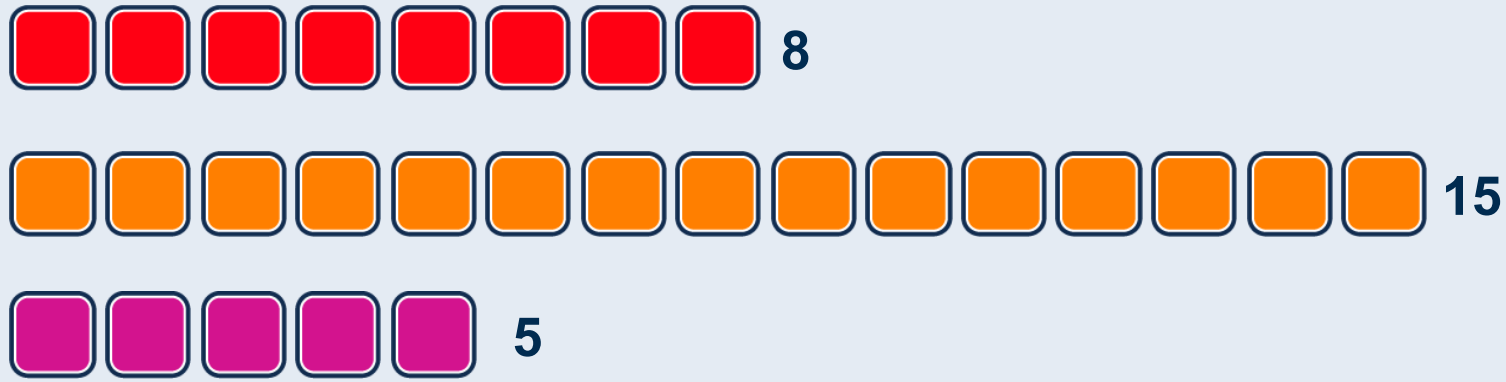
Virginia F Borges, MD, MMSc
Adam M Brufsky, MD, PhD
Harold J Burstein, MD, PhD
Karen A Gelmon, MD
Matthew P Goetz, MD
Virginia Kaklamani, MD, DSc
Kevin Kalinsky, MD, MS
Ian E Krop, MD, PhD
Erica Mayer, MD, MPH, FASCO
Jane Lowe Meisel, MD
Kathy D Miller, MD
Ruth O'Regan, MD
Joyce O'Shaughnessy, MD
Lajos Pusztai, MD, DPhil, FASCO
Mark E Robson, MD
Hope S Rugo, MD
Priyanka Sharma, MD
Laura Spring, MD
Sara M Tolaney, MD, MPH
Seth Wander, MD, PhD

RTP
RESEARCH TO PRACTICE

What adjuvant anti-HER2 treatment would you most likely recommend in the following scenario?

HER2-positive, ER-positive
Neoadjuvant TCHP
Minimal residual disease at surgery

2018



Survey of 28 US-based clinical investigators November 2018

2024

Survey of 20 US-based clinical investigators April-May 2024

Wallace T et al. SABCS 2024;Abstract P3-11-20.

RTP RESEARCH TO PRACTICE

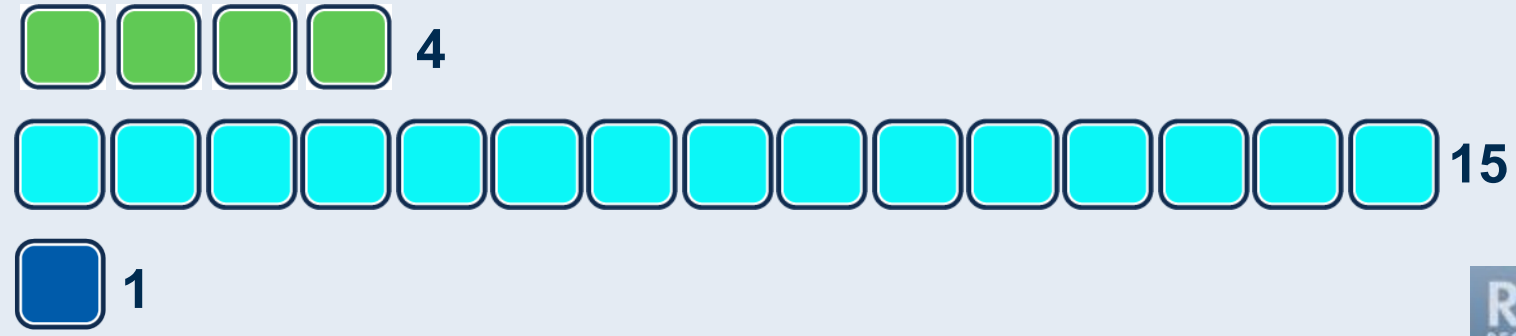
What adjuvant anti-HER2 treatment would you most likely recommend in the following scenario?

HER2-positive, ER-positive
Neoadjuvant TCHP
Macroscopic residual disease at surgery

2018

Survey of 28 US-based clinical investigators November 2018

2024



Survey of 20 US-based clinical investigators April-May 2024

Wallace T et al. SABCS 2024;Abstract P3-11-20.

RTP RESEARCH TO PRACTICE

ASCO 2025:
HER2-Positive Breast Cancer

Phase IB and II Study of Ribociclib with Trastuzumab plus Endocrine Therapy in HR+/HER2+ Advanced Breast Cancer Patients: Korean Cancer Study Group BR 18-2 MINI Trial

Sohn J et al.

ASCO 2025;Abstract 1016.

FRIDAY, MAY 30| 3:15 PM CDT

RTP RESEARCH TO PRACTICE

Treatment Rechallenge After Trastuzumab-Deruxtecan-Related Interstitial Lung Disease: A Multi-Institution Cohort Study

Rugo H et al.

ASCO 2025;Abstract 1015.

FRIDAY, MAY 30| 2:57 PM CDT

AGENDA

Year in Review: Management of Breast Cancer

INTRODUCTION: Adjuvant CDK4/6 Inhibition

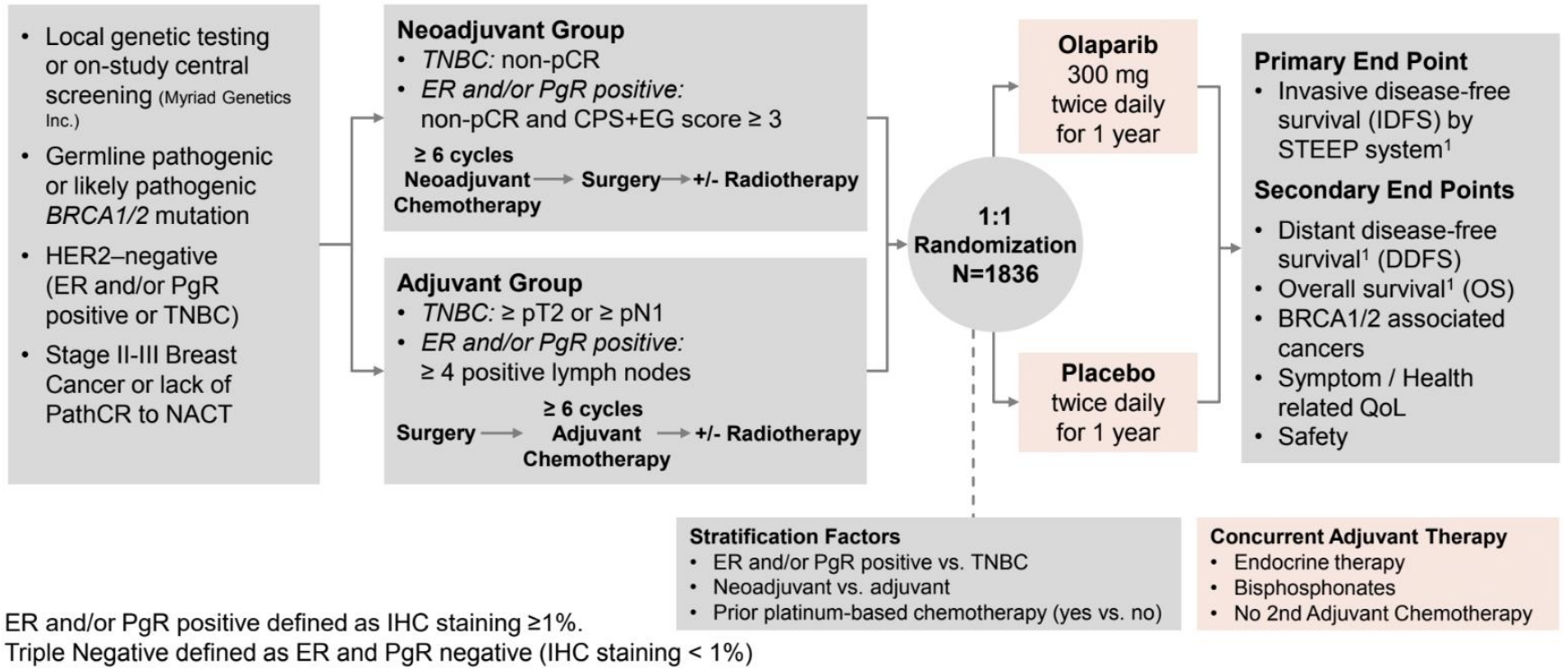
MODULE 1: HER2-Positive Disease

MODULE 2: PARP Inhibition

MODULE 3: Antibody-Drug Conjugates

MODULE 4: Up-Front Treatment of HR-Positive Metastatic Disease

OlympiA: Adjuvant Olaparib in gBRCA1/2 carriers



ER and/or PgR positive defined as IHC staining ≥1%.
Triple Negative defined as ER and PgR negative (IHC staining < 1%)

>70% enrolled pts were gBRCA1
>80% had TNBC

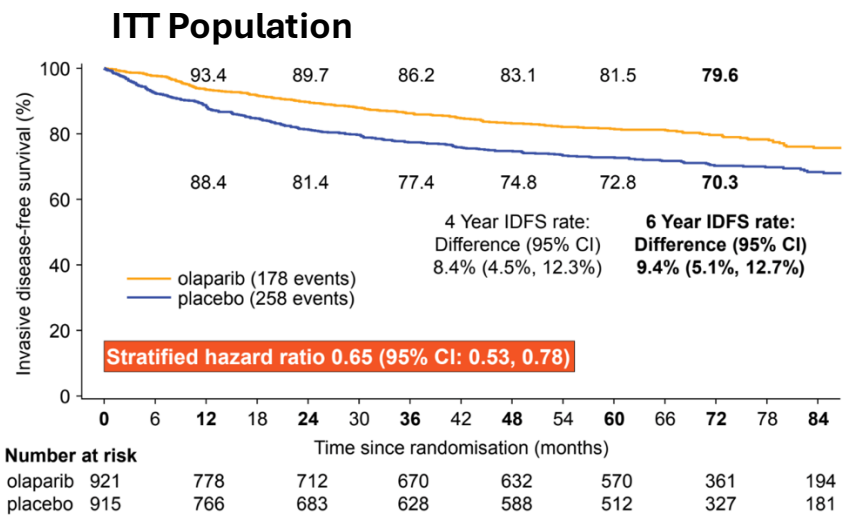
~50% adjuvant
~50% post neoadjuvant

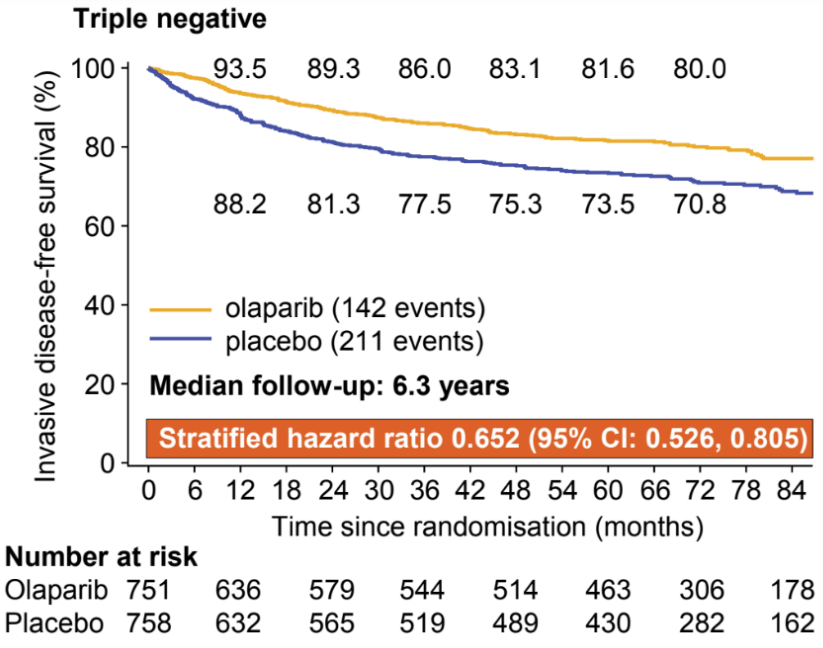
- Third pre-specified analysis at 10 years from first patient in
- Median follow up of 6.1 years (additional 2.6 y f/u since previous)

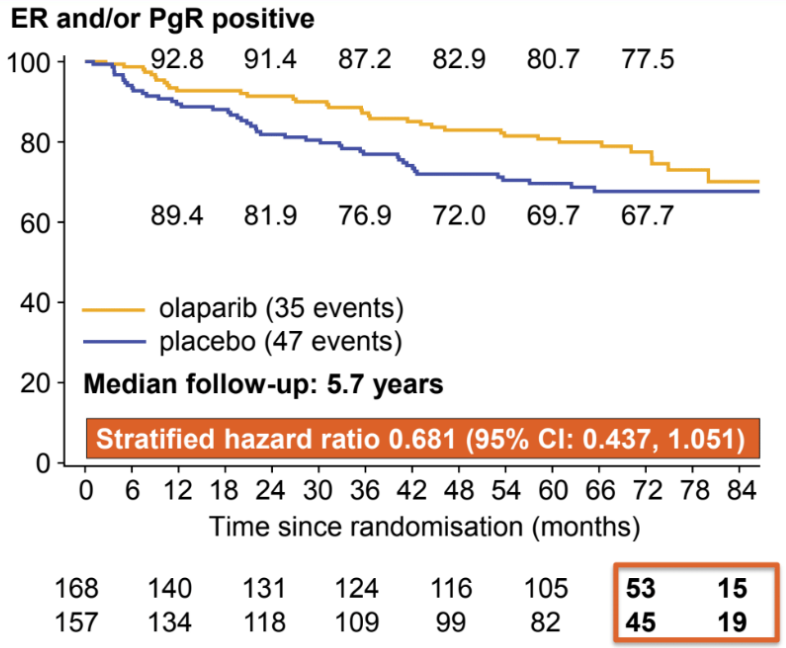
Courtesy of Nancy U Lin, MD

Garber J et al. SABCS 2024;Abstract GS1-09.

OlympiA: iDFS







Number at risk

Olaparib	751	636	579	544	514	463	306	178	168	140	131	124	116	105	**53**	**15**
Placebo	758	632	565	519	489	430	282	162	157	134	118	109	99	82	**45**	**19**

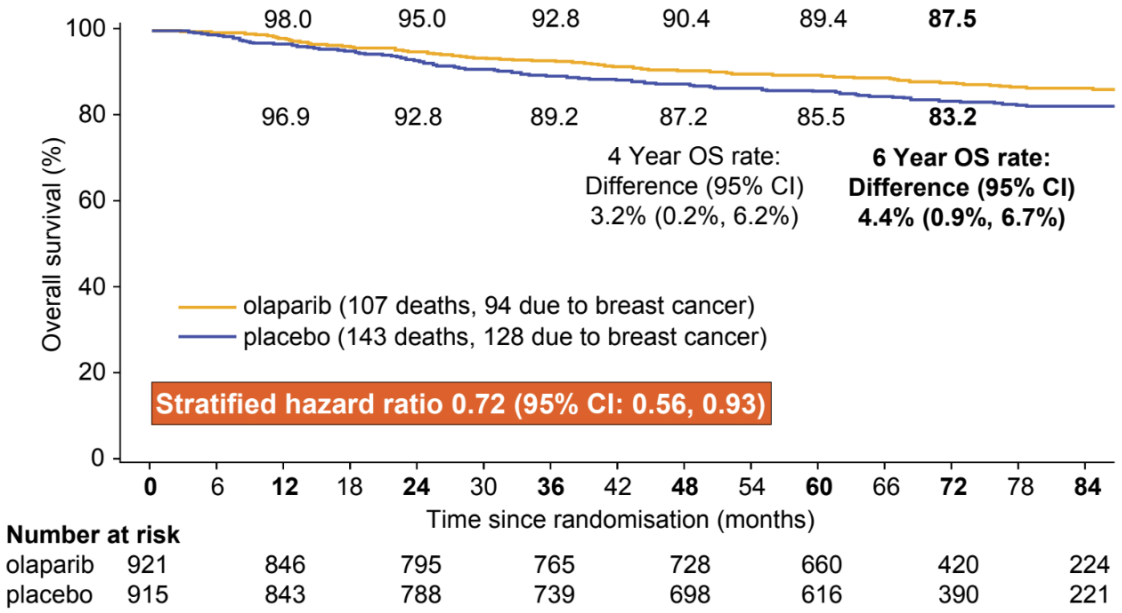
- Similar magnitude of benefit for DDFS
- Similar rates of MDS/AML (4 events (0.4%) for Olaparib; 6 events (0.7%) in placebo arm)
- Numerically fewer CNS events as 1st iDFS event (2.8% vs 4.4%)
- Fewer new primary cancers with olaparib (contralateral breast cancer, new primary ovarian/fallopian tube cancer)

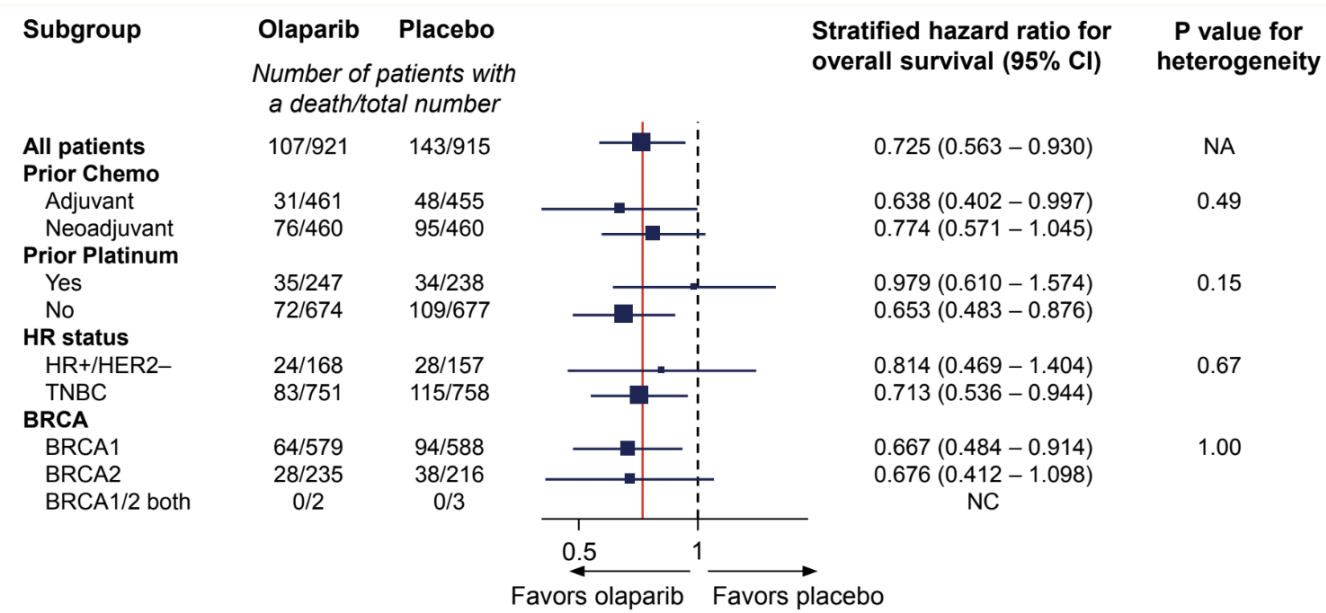
Courtesy of Nancy U Lin, MD

Garber J et al. SABCS 2024;Abstract GS1-09.

OlympiA: OS

ITT Population





Courtesy of Nancy U Lin, MD

Garber J et al. SABCS 2024;Abstract GS1-09.

OlympiA: Conclusions and Thoughts

- Significant benefit in iDFS (HR 0.65), DDFS, and OS (HR 0.72) with adjuvant Olaparib
- Effect seen in both HR+ and TN patients and in BRCA1 or BRCA2 carriers
- No signal of increase in MDS/AML at 6.1 y median f/u

- All patients who meet anatomic eligibility criteria for Olaparib (with drug access) ***should be offered germline genetic testing***

- TNBC: Cape vs Olaparib post NAC?
  - No direct comparison
  - CREATE-X OS HR 0.52, 8% absolute gain
  - GEICAM (adjuvant cape) suggested more benefit of capecitabine in non-basal subtypes
  - OlympiAD – Olaparib outperformed chemo of provider choice (~1/2 capecitabine) in MBC setting

- ER+: Abema or Ribo vs Olaparib?
  - No direct comparison
  - MONARCHE @ 54 mo median f/u, HR 0.68 for iDFS (7.6% absolute gain); no statistically significant OS benefit
  - NATALEE @ 34 mo median f/u, HR 0.75 for iDFS (3% gain at 3y); no difference yet in OS
  - For 4+ positive nodes, generally prefer Olaparib (or a sequence of ola -> CDK4/6i in very high-risk patients)
  - For 1-3 positive nodes (OlympiA did not include if adjuvant only), could consider CDK4/6i but lean towards olaparib: shorter duration of therapy and OS benefit already demonstrated
  - For node negative disease, olaparib has not been studied, and would consider ribo in carefully selected patients who would have met eligibility for NATALEE

Courtesy of Nancy U Lin, MD

“Beyond the Guidelines” Questions

What would be your most likely adjuvant treatment approach for a patient with an ER-positive, HER2-negative 1.8-cm IDC, 3 positive nodes and a germline BRCA mutation?

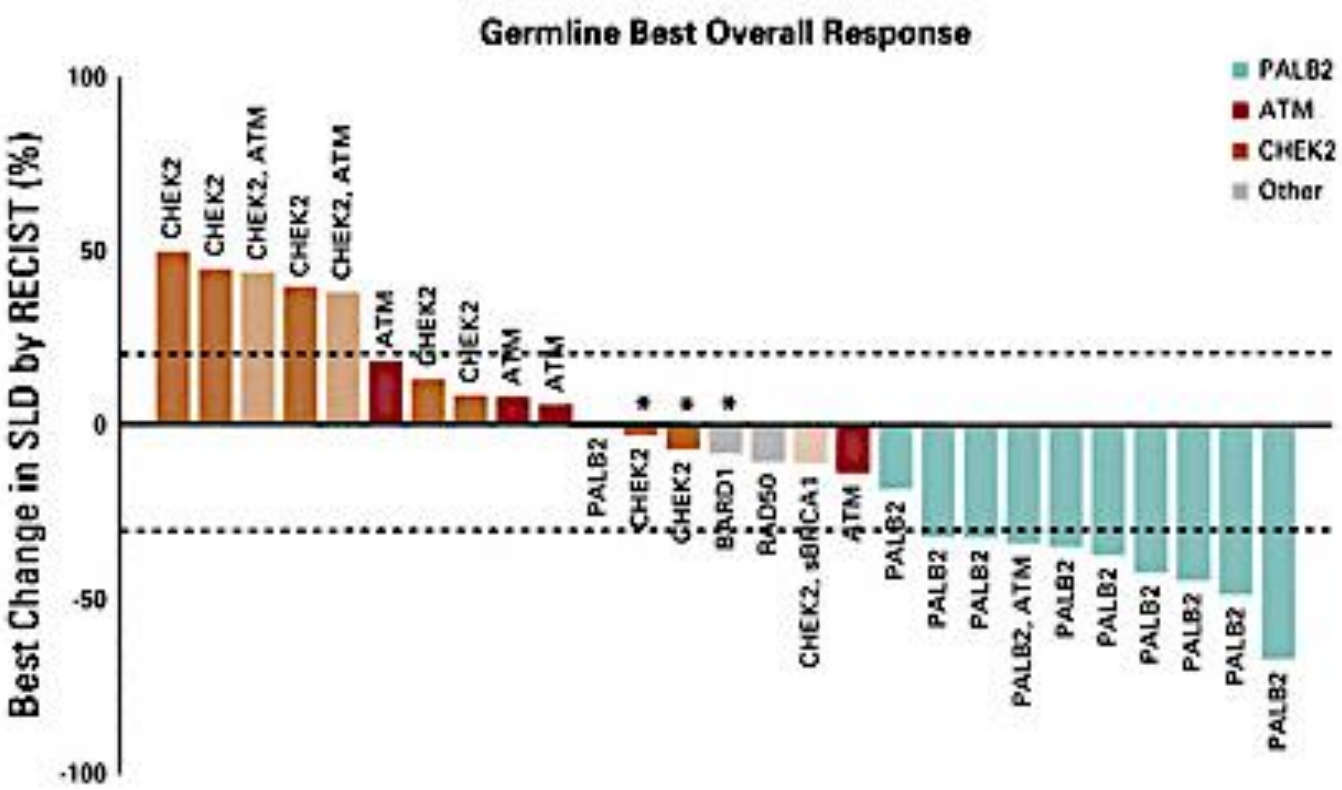
How, if at all, would you integrate a PARP inhibitor into current or future treatment?

“Beyond the Guidelines” Questions

What would be your most likely adjuvant treatment approach for a patient with a 1.8-cm ER/PR-negative, HER2-negative, node-negative IDC and a germline BRCA mutation?

How, if at all, would you integrate a PARP inhibitor into current or future treatment?

TBCRC 048: Olaparib Expanded Initial Cohort



Gene	ORR (90% CI)
gPALB2 (n=11)	82% (48-98%)
sBRCA (n=16)	50% (25-75%)
ATM, CHEK2 (n=18)	0%

Courtesy of Nancy U Lin, MD

Tung NM et al. J Clin Oncol 2020

TBCRC 048: Olaparib Expanded Expansion Cohorts

gPALB2 N=24	
Best Response	**Responses (rate, %)**
Complete Response (CR)	1 (4%)
Partial Response (PR)	17 (71%)
Stable Disease (SD)	5 (21%)
Progressive Disease (PD)	1 (4%)
ORR = 75% (18/24, 80%-CI: 60%-86%)	
CBR (18 wks) = 83% (20/24, 90%-CI: 66%-94%)	

Median PFS 9.6 months

sBRCA1/2 N=30	
Best Response	**Responses, (rate, %)**
Complete Response (CR)	1 (3%)
Partial Response (PR)^	10 (33%)
Stable Disease (SD)	13 (43%)
Progressive Disease (PD)	6 (20%)
ORR = 37% (11/30, 80%-CI: 25%-50%)	
CBR (18 wks) = 53% (16/30, 90%-CI: 37%-69%)	

Median PFS 7.2 months

Key Eligibility: 0-2 prior chemo for MBC
Key exclusion: prior PARP, progression on platinum

Courtesy of Nancy U Lin, MD

Tung NM et al. ASCO 2024;Abstract 1021.

TBCRC 048: Olaparib Expanded Expansion Cohorts

Exploratory objectives: predictors of olaparib response in s*BRCA*m (Cohorts 2* and 2a*)

Clinical/ Molecular factor	Total # response/ total
Tumor subtype (primary) TNBC ER+/HER2- HER2+	 7/10 (70%) 12/33 (36%) 0/3 (0%)
BRCA1 *BRCA2*	8/22 (36%) 10/24 (42%)
1L met RX > 1L metastatic Rx	12/17 (71%) 7/29 (24%)
Prior platinum No prior platinum	1/4 (25%) 18/42 (43%)
Method of dx s*BRCA*m cfDNA Tumor bx	 1/10 (10%) 18/36 (50%)
PV/LPV* Single *BRCA* copy loss Biallelic *BRCA* copy loss	16/39 (41%) 1/5 (20%) 2/2 (100%)

* (L)PV: (Likely) pathogenic variant

* Cohort 2: 16 pts ; Cohort 2a: 30 pts

- All subtypes respond
  - ↑RR in TNBC
- No Δ *BRCA1* vs *BRCA2*
- ↑ RR if olaparib given before chemo in MBC
- ↓ RR if s*BRCA*m identified by cfDNA only
- If s*BRCA* loss, ↑RR if confirmed biallelic loss

Courtesy of Nancy U Lin, MD

Tung NM et al. ASCO 2024;Abstract 1021.

TBCRC 048: Conclusions and Thoughts

- Confirms very high response rates and durability of benefit in g*PALB2* carriers
- Activity in s*BRCA* numerically less than in initial cohort but still respectable (37%, median PFS 7.2 mo)

- Estimates of frequency of *sBRCA* in primary tumors ~3-4%
- Frequency in MBC esp in later lines is not well-described

- Sufficient activity to consider on a routine basis and to justify:
  - Routine germline testing in MBC patients
  - NGS testing to identify somatic alterations

Courtesy of Nancy U Lin, MD

"Beyond the Guidelines" Questions

A 65-year-old woman presents with de novo HR-positive, HER2-negative (IHC 0) metastatic breast cancer (mBC) with a germline BRCA1 mutation. Biomarker evaluation is negative for ESR1 mutations and PIK3CA/AKT1/PTEN alterations. Regulatory and reimbursement issues aside, what would be your most likely treatment?

How, if at all, would you integrate a PARP inhibitor into current or future treatment?

RTP RESEARCH TO PRACTICE

"Beyond the Guidelines" Questions

A 65-year-old woman presents with de novo HR-positive, HER2-low (IHC 1+) mBC with a germline BRCA1 mutation. Biomarker evaluation is negative for ESR1 mutations and PIK3CA/AKT1/PTEN alterations. Regulatory and reimbursement issues aside, what would be your most likely treatment?

How, if at all, would you integrate a PARP inhibitor into current or future treatment?

RTP
RESEARCH TO PRACTICE

“Beyond the Guidelines” Questions

A 65-year-old woman presents with de novo HR-negative, HER2-negative (IHC 0) PD-L1-positive mBC with a germline BRCA1 mutation. Regulatory and reimbursement issues aside, what would be your most likely treatment?

How, if at all, would you integrate a PARP inhibitor into current or future treatment?

“Beyond the Guidelines” Questions

A 65-year-old woman presents with de novo HR-negative, HER2-negative (IHC 0) PD-L1-negative mBC with a germline BRCA1 mutation. Regulatory and reimbursement issues aside, what would be your most likely treatment?

How, if at all, would you integrate a PARP inhibitor into current or future treatment?

RTP
RESEARCH TO PRACTICE

ASCO 2025:
PARP Inhibitors; BRCA-Positive Disease

Prospective Randomized Phase II Trial to Assess the Efficacy and Safety of Neo-Adjuvant Olaparib/Carboplatin (OC) in Comparison to Docetaxel/Epirubicin/Cyclophosphamide (TAC) in Patients with Early Triple-Negative Breast Cancer (TNBC) with Homologous Recombination Deficiency (HRD): Primary Results from the ABCSG 45 Trial

Singer C et al.

ASCO 2025;Abstract 510.

SUNDAY, JUNE 1| 8:06 AM CDT

Menopausal Hormone Therapy After a Diagnosis of Breast Cancer in Women with a BRCA Pathogenic Variant and Risk of Death

Kotsopoulos J et al.

ASCO 2025;Abstract 10506.

SUNDAY, JUNE 1| 1:30 PM CDT

RTP RESEARCH TO PRACTICE

Video-Based Genetic Counseling to Reduce Physician Workload and Enhance Consulter Understanding: A Prospective Randomized Clinical Trial

Pfeiler G et al.

ASCO 2025;Abstract 1502.

MONDAY, JUNE 2| 3:24 PM CDT

RTP RESEARCH TO PRACTICE

AGENDA

Year in Review: Management of Breast Cancer

INTRODUCTION: **Adjuvant CDK4/6 Inhibition**

MODULE 1: **HER2-Positive Disease**

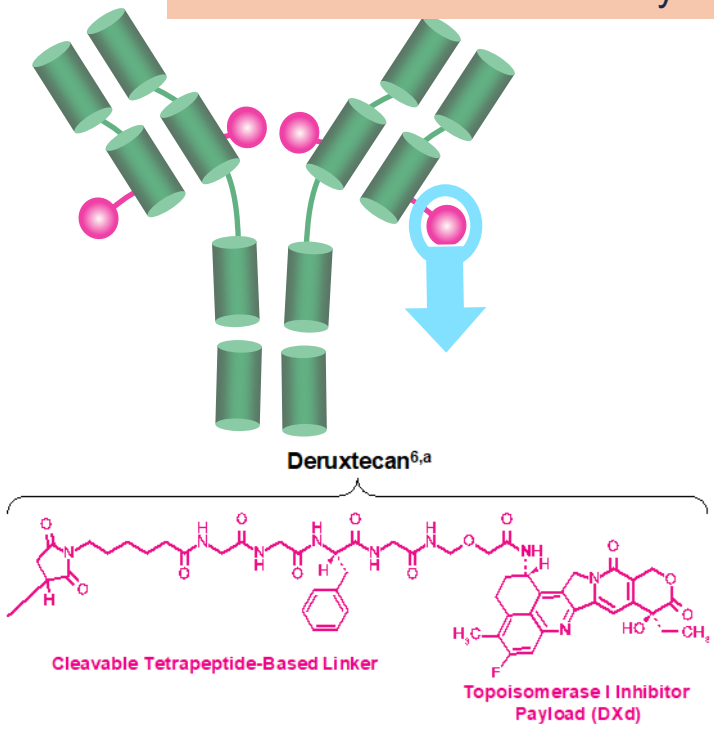
MODULE 2: **PARP Inhibition**

MODULE 3: Antibody-Drug Conjugates

MODULE 4: **Up-Front Treatment of HR-Positive Metastatic Disease**

TROPION-Breast01: Ph 3 trial of Dato-DXd in HR+/HER2- MBC

Dato-DXd: Humanised anti-TROP2 monoclonal antibody



- High-potency TOPO1 payload
- Payload with short systemic half-life
- Optimised DAR ~4
- Tumour-selective cleavable linker
- Bystander anti-tumour effect

TROPION-Breast01 Schema

Key inclusion criteria

- Patients with HR+/HER2– breast cancer* (HER2– defined as IHC 0/1+/2+; ISH negative)
- Previously treated with 1–2 lines of chemotherapy (inoperable/metastatic setting)
- Experienced progression on ET and for whom ET was unsuitable
- ECOG PS 0 or 1

1:1

Dato-DXd
6 mg/kg IV Day 1 Q3W
(n=365)

ICC
Q3W as per protocol directions† (eribulin mesylate, vinorelbine, capecitabine, or gemcitabine)
(n=367)

Endpoints:

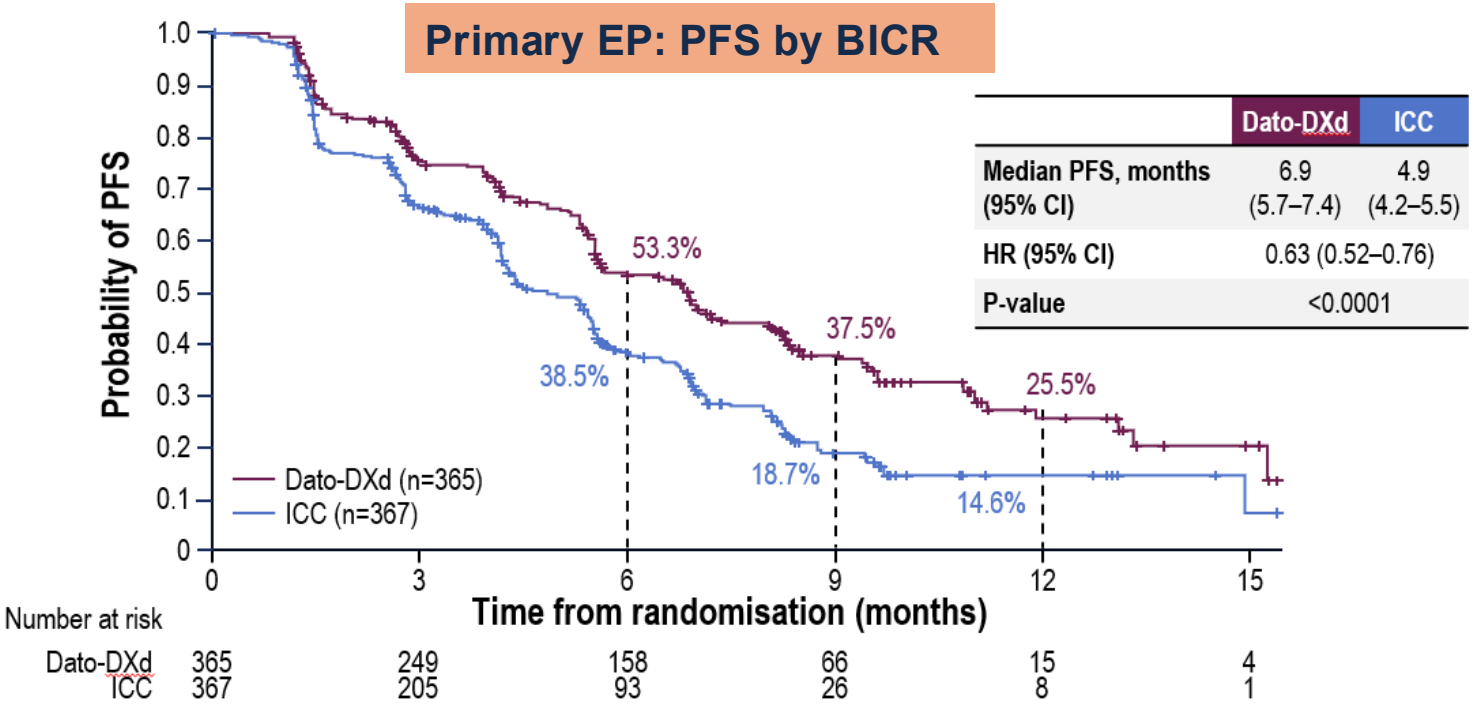
- **Dual primary:** PFS by BICR per RECIST v1.1, and OS
- **Key secondary:** ORR, PFS (investigator assessed) and safety

Courtesy of Rebecca A Dent, MD, MSc

Bardia A et al. ESMO 2023, LBA11

TROPION-Breast01: Efficacy outcomes

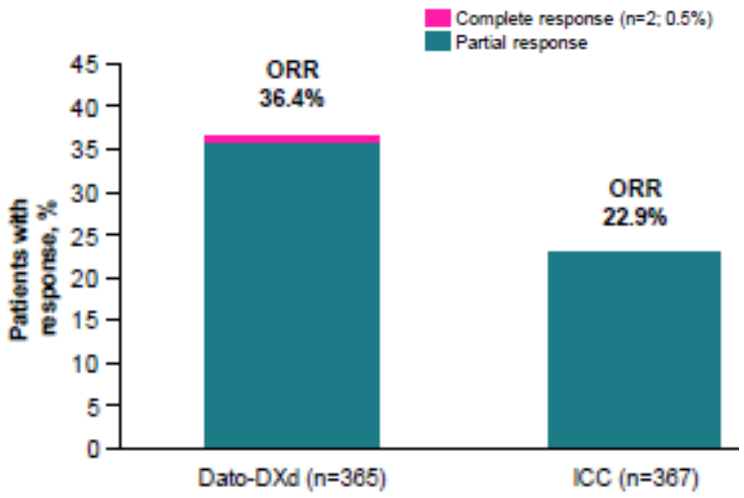
Primary EP: PFS by BICR



	Dato-DXd	ICC
Median PFS, months (95% CI)	6.9 (5.7–7.4)	4.9 (4.2–5.5)
HR (95% CI)	0.63 (0.52–0.76)	
P-value	<0.0001	

PFS by investigator assessment: Median 6.9 vs 4.5 months; HR 0.64 (95% CI 0.53–0.76)

Response rate by BICR



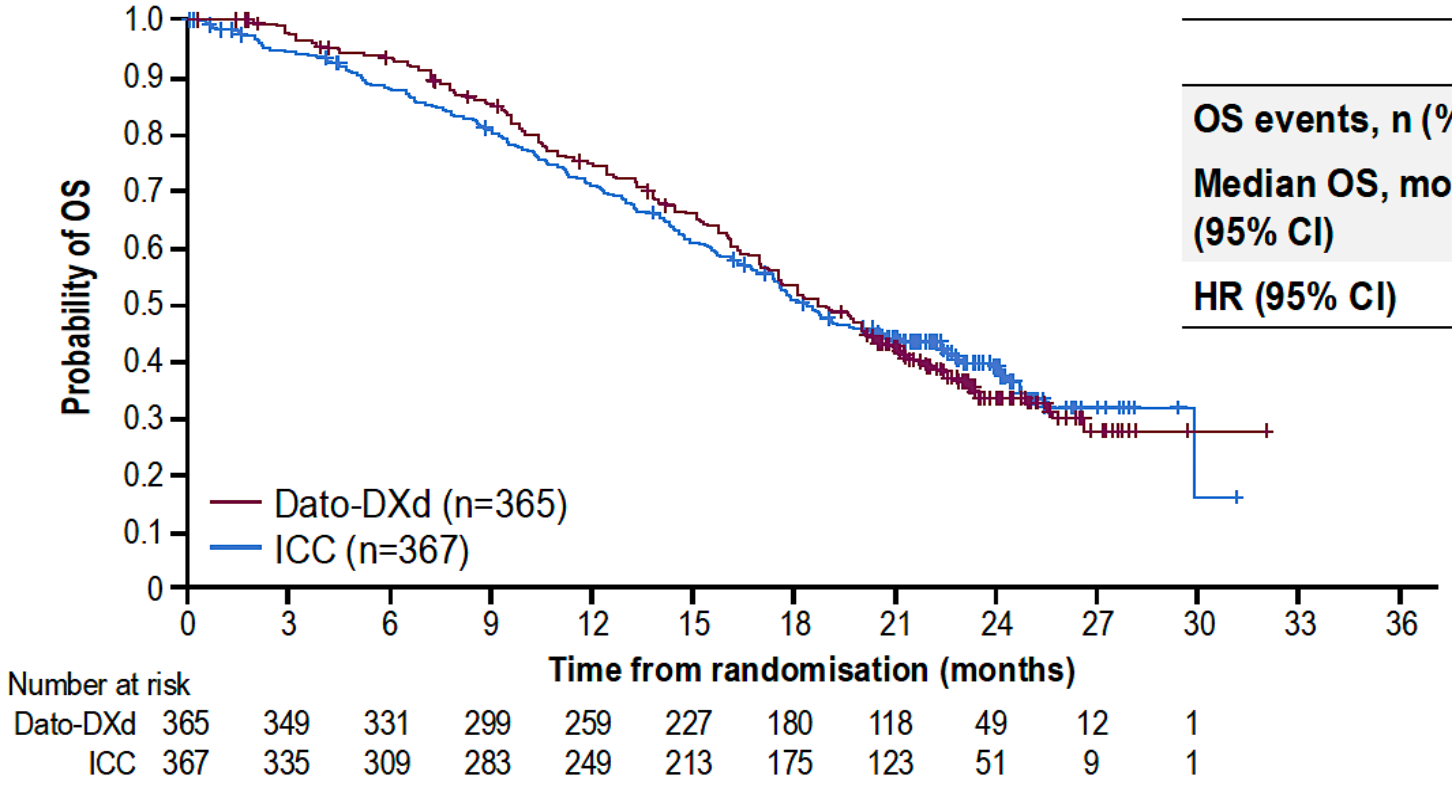
Overall survival (dual primary endpoint)

OS data were not mature (information fraction 39%): median follow-up 9.7 months.
A trend favoring Dato-DXd was observed: HR 0.84 (95% CI 0.62–1.14).

Courtesy of Rebecca A Dent, MD, MSc

Bardia A et al. ESMO 2023, LBA11; Rugo HS et al. MBCC 2024

TROPION-Breast01: Final Overall Survival Analysis with Datopotamab Deruxtecan (Dato-DXd) for Previously Treated HR-Positive mBC



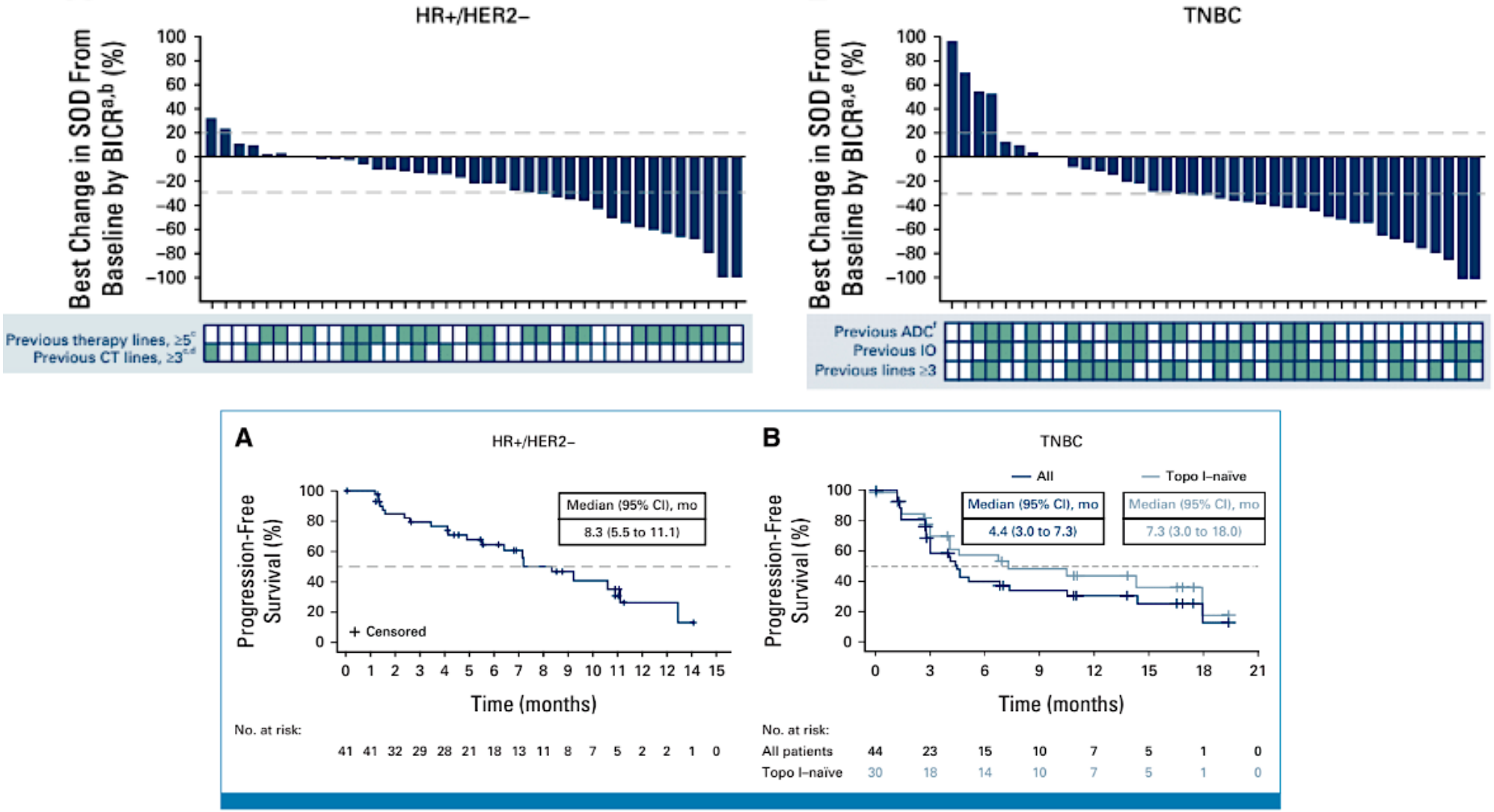
	Dato-DXd	ICC
OS events, n (%)	223 (61)	213 (58)
Median OS, months (95% CI)	18.6 (17.3–20.1)	18.3 (17.3–20.5)
HR (95% CI)	**1.01 (0.83–1.22)**	

- Maturity: 59.6%
- Median follow-up: 22.8 months
- Protocol prespecified OS sensitivity analysis based on the stratification factors according to the eCRF*: **HR 0.99 (95% CI: 0.82–1.20)**

Data cutoff: 24 July 2024. Pre-specified P-value boundary for OS analysis: α=0.0427.
*Mis-stratification between interactive response technology (where data entered could not be changed by the site) and eCRF (where data could be corrected by sites) was <5%.
eCRF, electronic case report form.

Pistilli B et al. ESMO 2024;Abstract VP1-2025.

TROPION-PanTumor01: Phase 1 Dato-DXd for HR+ or TN MBC



Courtesy of Nancy U Lin, MD

Bardia A et al. J Clin Oncol 2024;42(19):2281-94.

TROPION-PanTumor01: Phase 1 Dato-DXd for HR+ or TN MBC

		TNBC (N = 44)	
Treatment Response[a]	HR+/HER2− BC (N = 41)	All (N = 44)	Topo I–Naïve (n = 30)
Confirmed ORR	11 (26.8) [14.2 to 42.9]	14 (31.8) [18.6 to 47.6]	12 (40.0) [22.7 to 59.4]
Confirmed CR, No. (%)	0	1 (2.3)	1 (3.3)
Confirmed PR, No. (%)	11 (26.8)	13 (29.5)	11 (36.7)
Non-CR/non-PD, No. (%)	1 (2.4)[b]	3 (6.8)[b]	3 (10.0)[b]
SD, No. (%)	23 (56.1)	18 (40.9)	10 (33.3)
PD, No. (%)	5 (12.2)	8 (18.2)	4 (13.3)
NE for BOR, No. (%)	1 (2.4)	1 (2.3)	1 (3.3)
DCR	35 (85.4) [70.8 to 94.4]	35 (79.5) [64.7 to 90.2]	25 (83.3) [65.3 to 94.4]
CBR[c]	18 (43.9) [28.5 to 60.3]	17 (38.6) [24.4 to 54.5]	15 (50.0) [31.3 to 68.7]
DOR, months, median [95% CI]	NE [4.4 to NE]	16.8 [5.6 to NE]	16.8 [5.6 to NE]
TTR, months, median (range)	2.8 (1.2-5.6)	1.36 (1.2-2.8)	1.38 (1.2-2.8)
PFS, months, median [95% CI]	8.3 [5.5 to 11.1]	4.4 [3.0 to 7.3]	7.3 [3.0 to 18.0]
OS, months, median [95% CI]	NE [10.1 to NE]	13.5 [10.1 to 16.3]	14.3 [10.5 to NE]

Courtesy of Nancy U Lin, MD

Bardia A et al. J Clin Oncol 2024;42(19):2281-94.

TROPION-PanTumor01: Where does Dato-DXd fit in?

	HR+/HER2- MBC				
	DESTINY-Breast06	**DESTINY-Breast04**	**TROPION-PanTumor01**	**TROPION-Breast01**	**TROPiCS-02**
Treatment arms	T-DXd vs TPC	T-DXd vs TPC	Dato-DXd	Dato-DXd vs TPC	SG vs TPC
HER2 status	Low or ultralow	Low (1+, 2+/ISH-)	Any HER2-neg	Any HER2-neg	Any HER2-neg
Prior chemo for MBC	0	1-2	No upper limit*	1-2	2-4
Median PFS HR (95% CI)	13.2 vs 8.1 mo HR 0.63 (0.53-0.75)	9.6 vs 4.2 mo HR 0.37 (0.30-0.56)	8.3 mo	6.9 vs 4.9 mo HR 0.63 (0.52-0.76)	5.5 vs 4.9 mo HR 0.65 (0.53-0.81)
Median OS HR (95% CI)	N/A HR 0.81 (0.65-1.00)	23.9 vs 17.6 mo HR 0.69 (0.55-0.87)	NE	N/A HR 0.84 (0.62-1.14)	14.5 vs 11.2 mo HR 0.79 (0.65-0.95)
ORR	57.3% vs 31.2%	52.6% vs 16.3%	26.8%	36.4% vs 22.9%	21% vs 14%

*median of 5 prior lines for MBC

Courtesy of Nancy U Lin, MD

Slide adapted from Ana Garrido-Castro MD

TROPION-PanTumor01: Where does Dato-DXd fit in?

	Triple-Negative MBC				
	DESTINY-Breast04	**TROPION-PanTumor01**	**TROPION-Breast02**	**ASCENT**	**OptiTROP-Breast01**
Treatment arms	T-DXd vs TPC	Dato-DXd	Dato-DXd vs TPC	SG vs TPC	Sac-TMT vs TPC
HER2 status	Low (1+, 2+/ISH-)	Any HER2-neg	Any HER2-neg; Not a candidate for PD1/PDL1 inhibitor	Any HER2-neg	Any HER2-neg
Prior chemo for MBC	1-2	No upper limit*	0	≥1	≥2
Median PFS HR (95% CI)	6.3 vs 2.9 mo HR 0.29 (0.15-0.57)	4.4 mo (all) 7.3 mo (topo1-naïve)	??	5.6 vs 1.7 mo HR 0.41 (0.32-0.52)	6.7 vs 2.5 mo HR 0.32 (0.22-0.44)
Median OS HR (95% CI)	17.1 vs 8.3 mo HR 0.58 (0.31-1.08)	13.5 mo (all) 14.3 mo (topo1-naïve)	??	12.1 vs 6.7 mo HR 0.48 (0.38-0.59)	NR vs 9.4 mo HR 0.53 (0.36-0.78)
ORR	50.0% vs 16.7%	31.8% (all) 40.0% (topo1-naïve)	??	35% vs 5%	45.4% vs 12.0%

*median of 3 prior lines for MBC

Courtesy of Nancy U Lin, MD

“Beyond the Guidelines” Questions

A 65-year-old woman presents with de novo HR-positive, HER2-negative (IHC 0), BRCA wild-type (WT) mBC. She receives first-line ribociclib with anastrozole followed by second-line elacestrant on disease progression. Recent imaging shows evidence of asymptomatic bone and soft tissue metastases which are biopsy confirmed to be consistent with the primary. Biomarker evaluation is negative for PIK3CA/AKT1/PTEN alterations. Regulatory and reimbursement issues aside, what would be your most likely treatment?

RTP
RESEARCH TO PRACTICE

“Beyond the Guidelines” Questions

A 65-year-old woman presents with de novo HR-positive, HER2-low (IHC 1+, FISH negative), BRCA WT mBC. She receives first-line ribociclib with anastrozole followed by second-line elacestrant then trastuzumab deruxtecan on disease progression. Recent imaging shows evidence of asymptomatic bone and soft tissue metastases which are biopsy confirmed to be consistent with the primary. Biomarker evaluation is negative for PIK3CA/AKT1/PTEN alterations. Regulatory and reimbursement issues aside, what would be your most likely treatment?

RTP RESEARCH TO PRACTICE

“Beyond the Guidelines” Questions

In general, what is your approach to the prevention and management of mucositis associated with datopotamab deruxtecan?

ASCO 2025:
Antibody-Drug Conjugates

RTP
RESEARCH
TO PRACTICE

Sacituzumab Govitecan with Pembrolizumab Demonstrated a Statistically Significant and Clinically Meaningful Improvement in PFS for Patients with Previously Untreated PD-L1-Positive Metastatic Triple-Negative Breast Cancer

Press Release: April 21, 2025

"[The manufacturer] today announced positive topline results from the Phase 3 ASCENT-04/KEYNOTE D19 study, demonstrating that sacituzumab govitecan-hziy plus pembrolizumab significantly improved progression-free survival (PFS) compared to pembrolizumab and chemotherapy in patients with inoperable (unresectable) locally advanced or metastatic triple-negative breast cancer (mTNBC) whose tumors express PD-L1 (CPS ≥ 10). The study met its primary endpoint, showing a statistically significant and clinically meaningful improvement in PFS.

The safety profile of sacituzumab govitecan plus pembrolizumab in the ASCENT-04 study was consistent with the known safety profile of each agent. No new safety signals were identified with the combination."

https://www.gilead.com/news/news-details/2025/trodelvy-plus-keytruda-demonstrates-a-statistically-significant-and-clinically-meaningful-improvement-in-progression-free-survival-in-patients-with-previously-untreated-pd-l1-metastatic-trip

Sacituzumab Govitecan (SG) + Pembrolizumab (Pembro) vs Chemotherapy (Chemo) + Pembro in Previously Untreated PD-L1 Positive Advanced Triple-Negative Breast Cancer (TNBC): Primary Results from the Randomized Phase 3 ASCENT-04/KEYNOTE-D19 Study

Tolaney S et al.

ASCO 2025;Abstract LBA109.

SATURDAY, MAY 31| 3:35 PM CDT

RTP
RESEARCH TO PRACTICE

A Phase 2 Study of Response-Guided Neoadjuvant Sacituzumab Govitecan and Pembrolizumab (SG/P) in Patients with Early-Stage Triple-Negative Breast Cancer: Results from the NeoSTAR Trial

Abelman R et al.

ASCO 2025;Abstract 511.

SUNDAY, JUNE 1| 8:12 AM CDT

Exploratory Biomarker Analysis of Trastuzumab Deruxtecan (T-DXd) vs Physician's Choice of Chemotherapy (TPC) in HER2-Low/Ultralow, Hormone Receptor-Positive (HR+) Metastatic Breast Cancer (mBC) in DESTINY-Breast06 (DB-06)

Dent R et al.

ASCO 2025;Abstract 1013.

SATURDAY, MAY 31| 3:23 PM CDT

Use of Artificial Intelligence-Assistance Software for HER2-Low and HER2-Ultralow IHC Interpretation Training to Improve Diagnostic Accuracy of Pathologists and Expand Patients' Eligibility for HER2-Targeted Treatment

De Brot M et al.

ASCO 2025;Abstract 1014.

FRIDAY, MAY 30| 2:51 PM CDT

Patritumab Deruxtecan (HER3-DXd) in Active Brain Metastases (BM) from Metastatic Breast (mBC) and Non-Small Cell Lung Cancers (aNSCLC), and Leptomeningeal Disease (LMD) from Advanced Solid Tumors: Results from the TUXEDO-3 Phase II Trial

Preusser M et al.

ASCO 2025;Abstract 2005.

FRIDAY, MAY 30| 4:09 PM CDT

Sacituzumab Tirumotecan (Sac-TMT) as First-Line Treatment for Unresectable Locally Advanced/Metastatic Triple-Negative Breast Cancer (a/mTNBC): Initial Results from the Phase II OptiTROP-Breast05 Study

Yin Y et al.

ASCO 2025;Abstract 1019.

FRIDAY, MAY 30| 3:45 PM CDT

AGENDA

Year in Review: Management of Breast Cancer

INTRODUCTION: **Adjuvant CDK4/6 Inhibition**

MODULE 1: **HER2-Positive Disease**

MODULE 2: **PARP Inhibition**

MODULE 3: **Antibody-Drug Conjugates**

MODULE 4: Up-Front Treatment of HR-Positive Metastatic Disease

Optimizing Therapy for Patients with Hormone Receptor-Positive Metastatic Breast Cancer Harboring PI3K/AKT/PTEN Pathway Abnormalities

Beyond the Guidelines Survey

RTP Year in Review 2025

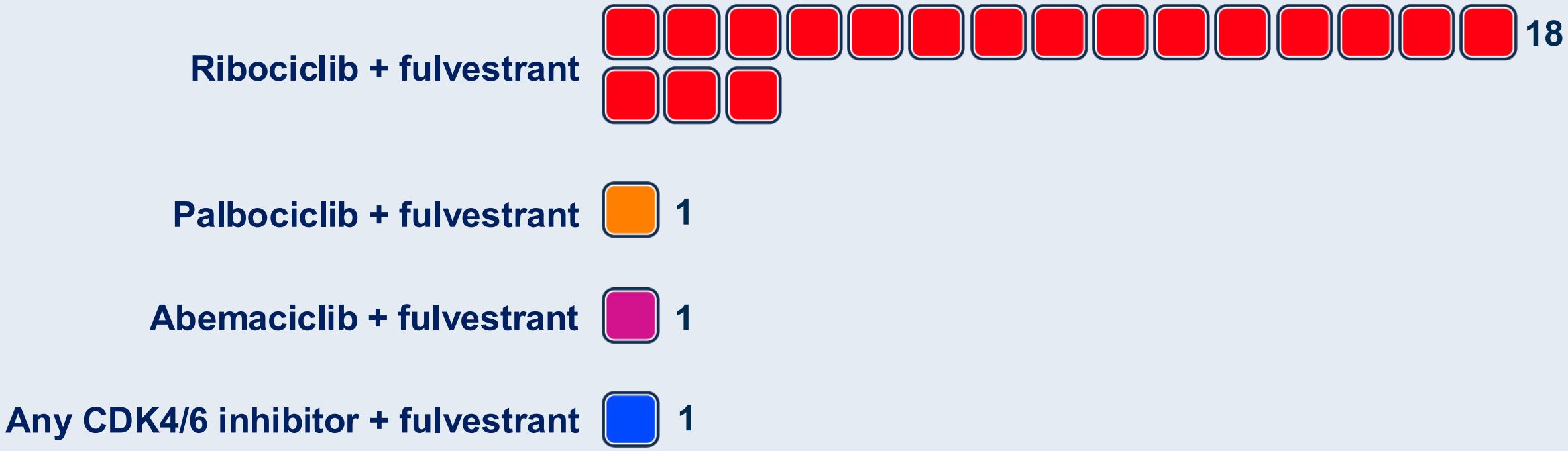
Breast Cancer Survey Respondents

Aditya Bardia, MD, MPH
Virginia F Borges, MD, MMSc
Adam M Brufsky, MD, PhD
Harold J Burstein, MD, PhD
Karen A Gelmon, MD
Stephanie L Graff, MD, FACP
Sara A Hurvitz, MD, FACP
Komal Jhaveri, MD, FACP
Virginia Kaklamani, MD, DSc
Kevin M Kalinsky, MD, MS
Ian E Krop, Md, PhD
Erica Mayer, MD, MPH, FASCO
Kathy D Miller, MD
Ruth O'Regan, MD
Joyce A O'Shaughnessy, MD
Lajos Pusztai, MD, DPhil, FASCO
Hope S Rugo, MD
Priyanka Sharma, MD
Paolo Tarantino, MD
Sara M Tolaney, MD, MPH
Seth Wander, MD, PhD

RTP RESEARCH TO PRACTICE

A 65-year-old woman with ER-positive, HER2-negative (HER2 IHC 0), node-negative breast cancer has developed multiple metastases 2 years after starting adjuvant anastrozole.

ESR1 mutation-negative	PIK3CA mutation-negative	AKT1 and PTEN mutation-negative

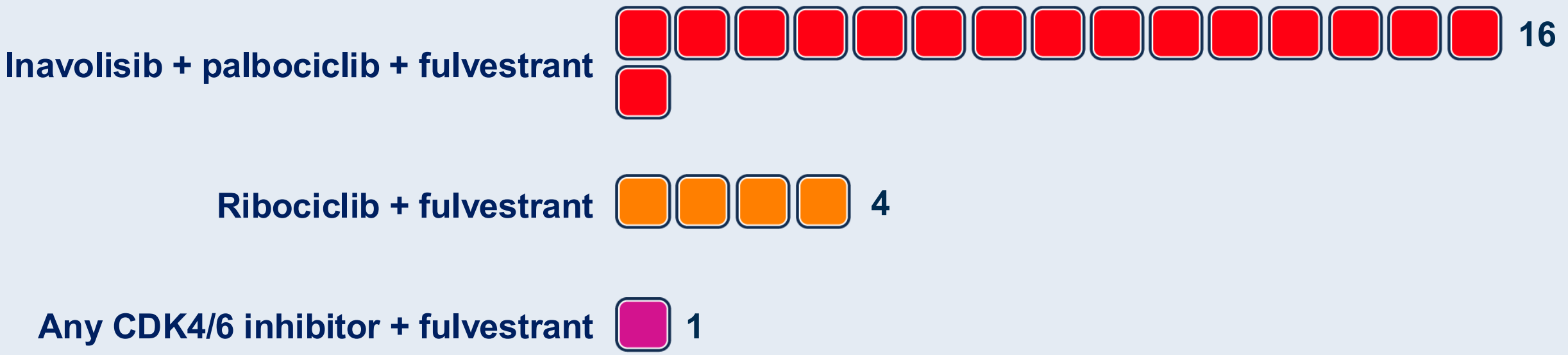


Survey of 21 US-based breast cancer clinical investigators, October 2024

RTP RESEARCH TO PRACTICE

A 65-year-old woman with ER-positive, HER2-negative (HER2 IHC 0), node-negative breast cancer has developed multiple metastases 2 years after starting adjuvant anastrozole.

ESR1 mutation-negative | **PIK3CA mutation-positive** | **AKT and PTEN mutation-negative**

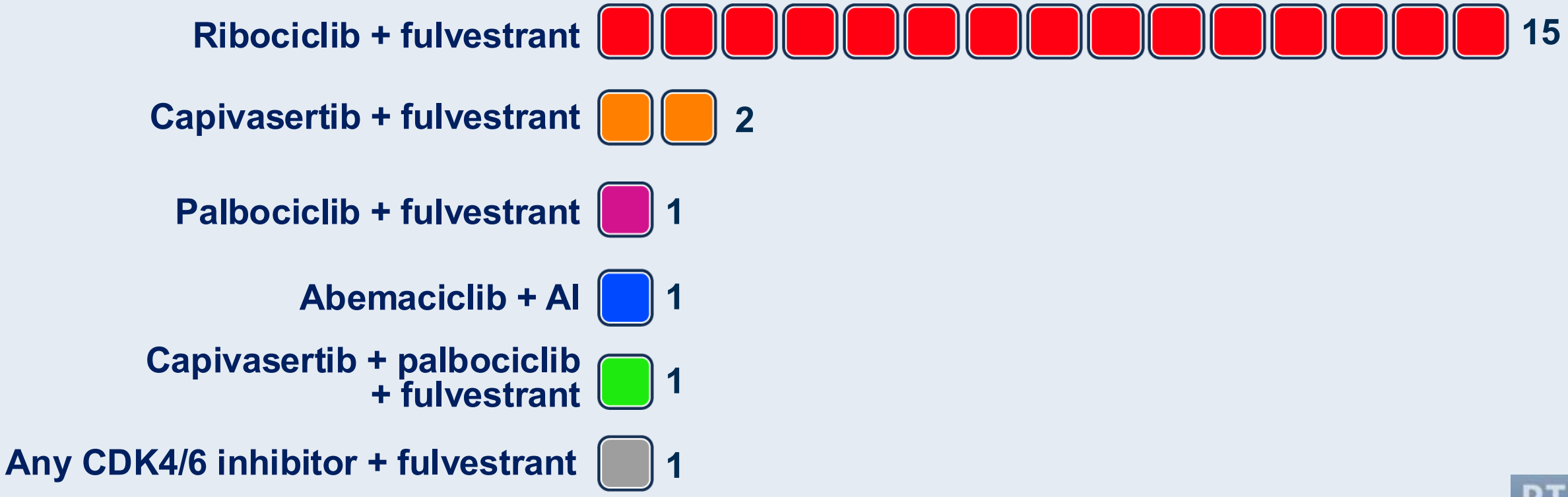


Survey of 21 US-based breast cancer clinical investigators, October 2024

RTP RESEARCH TO PRACTICE

A 65-year-old woman with ER-positive, HER2-negative (HER2 IHC 0), node-negative breast cancer has developed multiple metastases 2 years after starting adjuvant anastrozole.

ESR1 mutation-negative | **PIK3CA mutation-negative** | **AKT1 or PTEN mutation-positive**

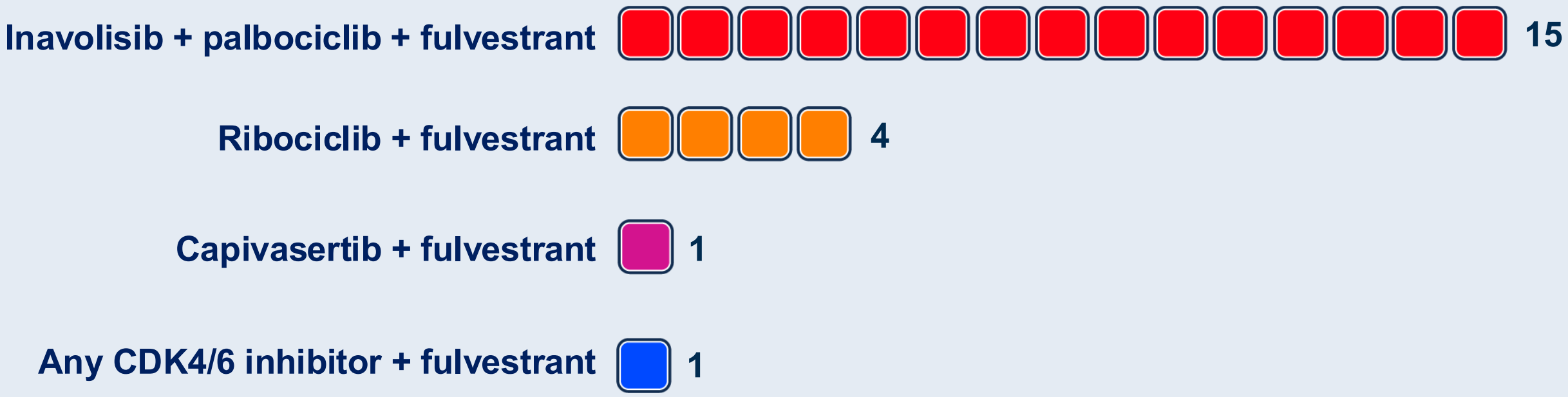


Survey of 21 US-based breast cancer clinical investigators, October 2024

RTP RESEARCH TO PRACTICE

A 65-year-old woman with ER-positive, HER2-negative (HER2 IHC 0), node-negative breast cancer has developed multiple metastases 2 years after starting adjuvant anastrozole.

ESR1 mutation-positive	PIK3CA mutation-positive	AKT1 and PTEN mutation-negative

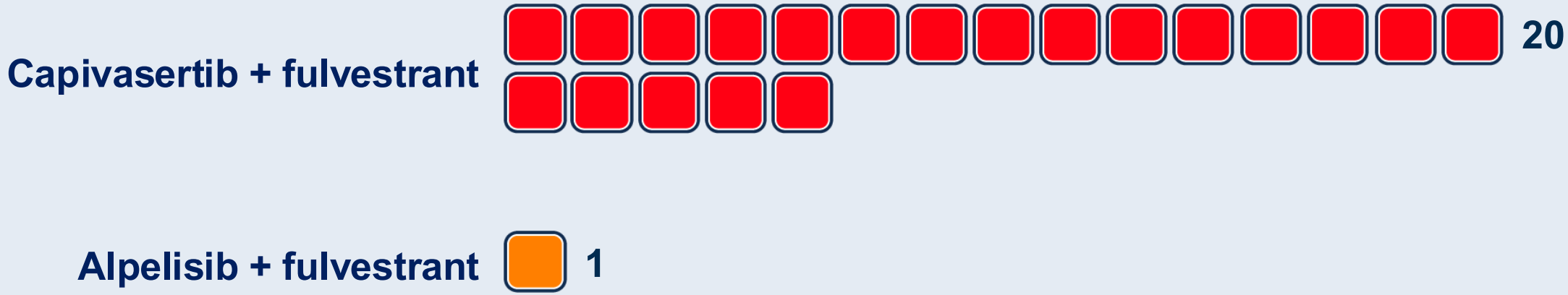


Survey of 21 US-based breast cancer clinical investigators, October 2024

RTP RESEARCH TO PRACTICE

A 65-year-old woman with ER-positive, HER2-negative (HER2 IHC 0), node-negative mBC receives a CDK4/6 inhibitor with an AI and initially responds but then experiences disease progression 18 months later.

ESR1 mutation-negative | **PIK3CA mutation-positive** | **AKT1 and PTEN mutation-negative**



AI = aromatase inhibitor

Survey of 21 US-based breast cancer clinical investigators, October 2024

RTP RESEARCH TO PRACTICE

A 65-year-old woman with ER-positive, HER2-negative (HER2 IHC 0), node-negative mBC receives a CDK4/6 inhibitor with an AI and initially responds but then experiences disease progression 18 months later.

ESR1 mutation-negative | **PIK3CA mutation-negative** | **AKT1 or PTEN mutation-positive**

Capivasertib + fulvestrant

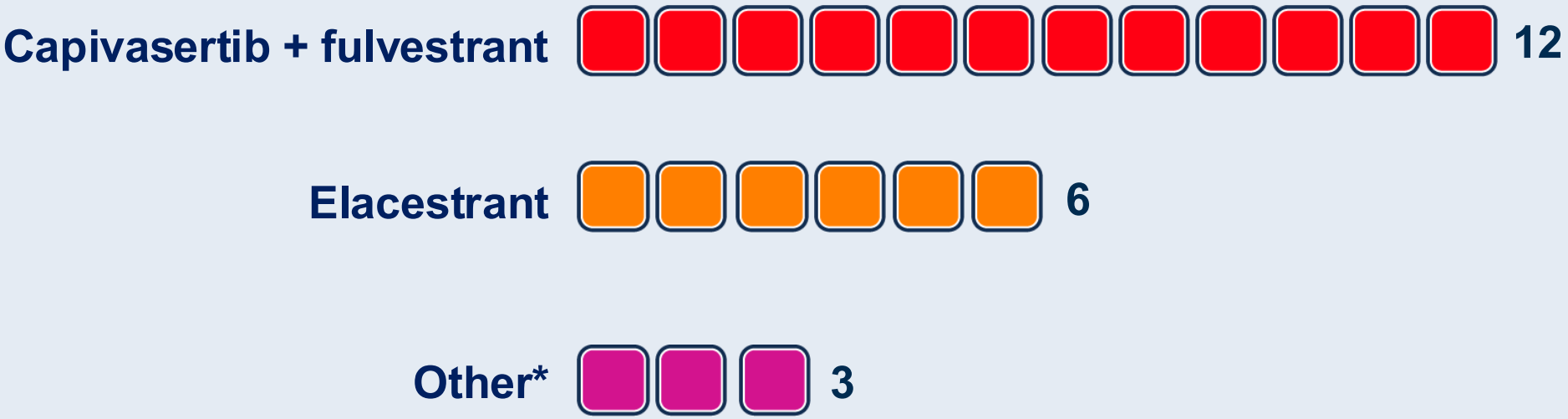
21

Survey of 21 US-based breast cancer clinical investigators, October 2024

RTP RESEARCH TO PRACTICE

A 65-year-old woman with ER-positive, HER2-negative (HER2 IHC 0), node-negative mBC receives a CDK4/6 inhibitor with an AI and initially responds but then experiences disease progression 18 months later.

ESR1 mutation-positive | **PIK3CA mutation-positive** | **AKT1 and PTEN mutation-negative**

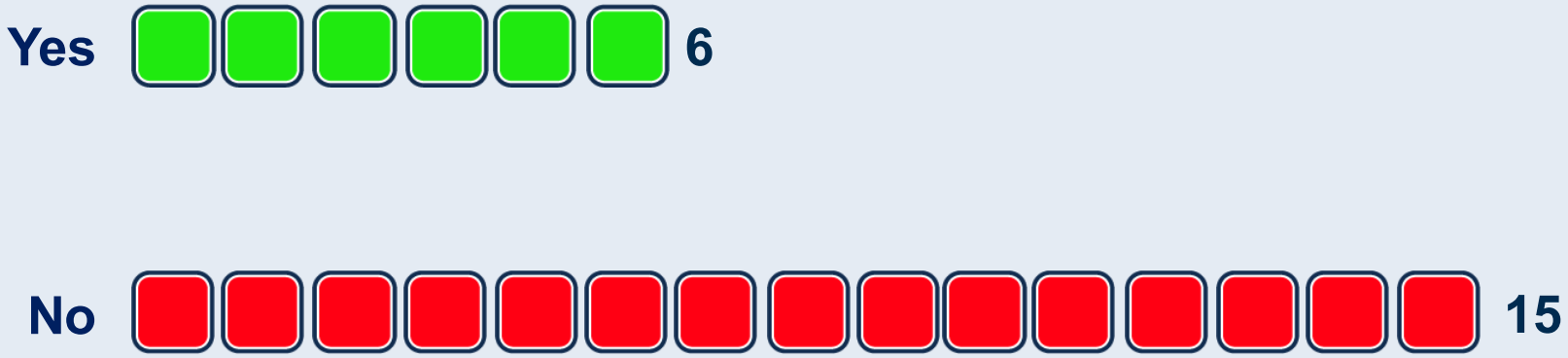


* Depends on extent of progression: Elacestrant if progression is less aggressive/asymptomatic, capivasertib + fulvestrant or combined with ET if progression is more aggressive/asymptomatic

Survey of 21 US-based breast cancer clinical investigators, October 2024

RTP RESEARCH TO PRACTICE

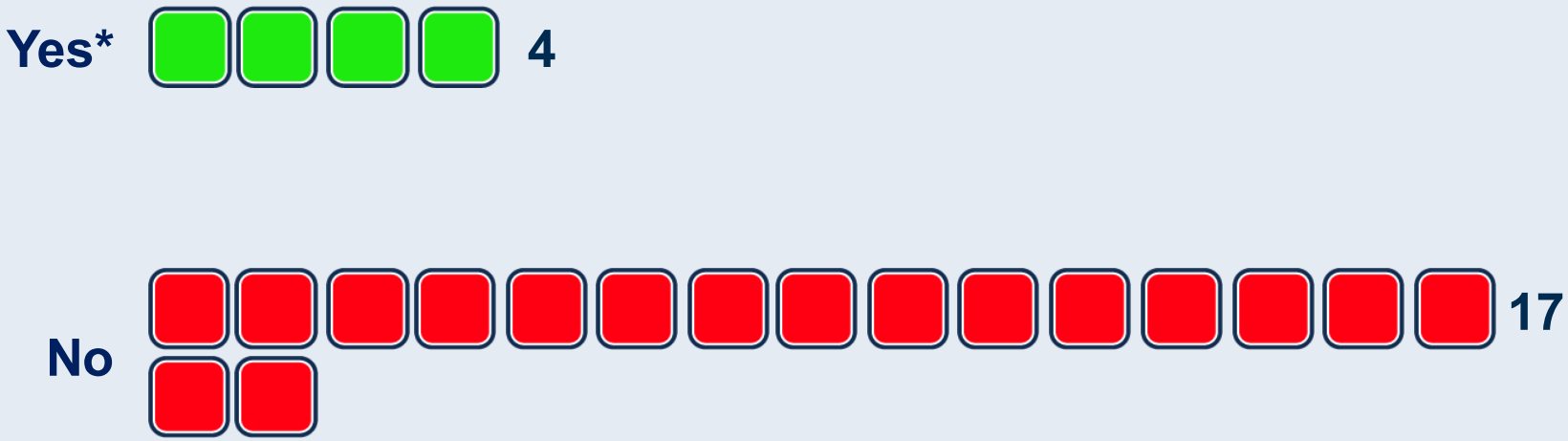
Would you administer alpelisib and capivasertib in sequence to the same patient?



Survey of 21 US-based breast cancer clinical investigators, October 2024

RTP RESEARCH TO PRACTICE

For patients about to receive capivasertib, do you take any prophylactic measures to prevent hyperglycemia?

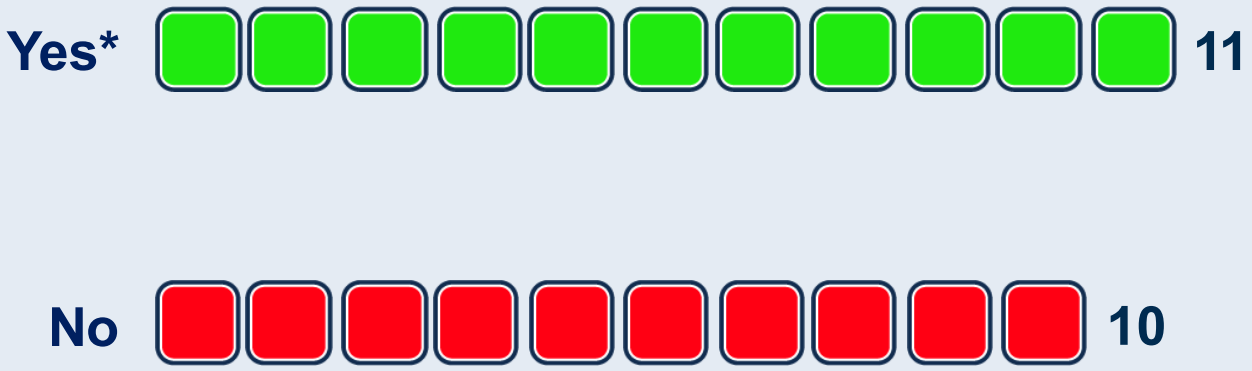


* Check HbA1C, finger stick blood glucose, dietary education, metformin

Survey of 21 US-based breast cancer clinical investigators, October 2024

RTP RESEARCH TO PRACTICE

For patients about to receive capivasertib, do you take any prophylactic measures to prevent cutaneous reactions?

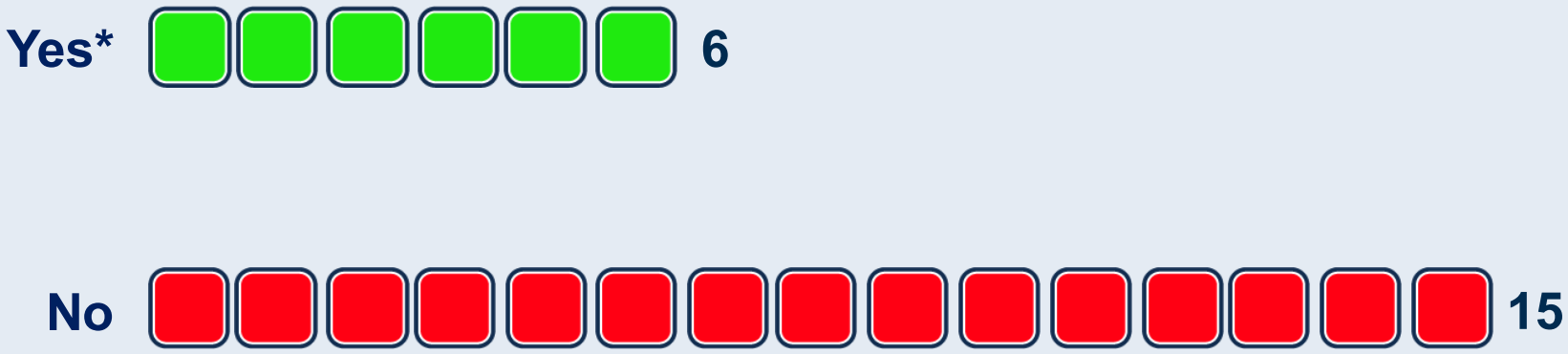


* Antihistamines

Survey of 21 US-based breast cancer clinical investigators, October 2024

RTP RESEARCH TO PRACTICE

For patients about to receive capivasertib, do you take any prophylactic measures to prevent gastrointestinal toxicity?



* Loperamide/antidiarrheal agents

Survey of 21 US-based breast cancer clinical investigators, October 2024

RTP RESEARCH TO PRACTICE

ASCO 2025:
HR-Positive Breast Cancer

First-Line Camizestrant Demonstrated Highly Statistically Significant and Clinically Meaningful Improvement in PFS for Advanced HR-Positive Breast Cancer with an Emergent ESR1 Tumor Mutation in the SERENA-6 Phase III Trial

Press Release: February 26, 2025

"Positive high-level results from a planned interim analysis of the SERENA-6 Phase III trial showed that camizestrant in combination with a cyclin-dependent kinase (CDK) 4/6 inhibitor (palbociclib, ribociclib or abemaciclib) demonstrated a highly statistically significant and clinically meaningful improvement in the primary endpoint of progression-free survival (PFS). The trial evaluated switching to the camizestrant combination versus continuing standard-of-care treatment with an aromatase inhibitor (AI) (anastrozole or letrozole) in combination with a CDK4/6 inhibitor in the 1st-line treatment of patients with hormone receptor (HR)-positive, HER2-negative advanced breast cancer whose tumors have an emergent ESR1 mutation.

The key secondary endpoints of time to second disease progression (PFS2) and overall survival (OS) were immature at the time of this interim analysis. However, the camizestrant combination demonstrated a trend toward improvement in PFS2. The trial will continue as planned to further assess key secondary endpoints."

https://www.astrazeneca.com/media-centre/press-releases/2025/camizestrant-improved-pfs-in-1l-hr-breast-cancer.html

Camizestrant + CDK4/6 Inhibitor (CDK4/6i) for the Treatment of Emergent ESR1 Mutations During First-Line (1L) Endocrine-Based Therapy (ET) and Ahead of Disease Progression in Patients (pts) with HR+/HER2- Advanced Breast Cancer (ABC): Phase 3, Double-Blind ctDNA-Guided SERENA-6 Trial

Turner N et al.

ASCO 2025;Abstract LBA4.

Plenary| SUNDAY, JUNE 1| 2:41 PM CDT

RTP RESEARCH TO PRACTICE

Patient-Reported Outcomes (PROs) in Patients with ER+, HER2- Advanced Breast Cancer (ABC) Treated with Imlunestrant, Investigator's Choice Standard Endocrine Therapy, or Imlunestrant + Abemaciclib: Results from the Phase III EMBER-3 Trial

Curigliano G et al.

ASCO 2025;Abstract 1001.

SATURDAY, MAY 31| 1:27 PM CDT

RTP RESEARCH TO PRACTICE

Vepdegestrant, A PROTAC Estrogen Receptor (ER) Degrader, vs Fulvestrant in ER-Positive/Human Epidermal Growth Factor Receptor 2 (HER2)-Negative Advanced Breast Cancer: Results of the Global, Randomized, Phase 3 VERITAC-2 Study

Hamilton E et al.

ASCO 2025;Abstract LBA1000.

SATURDAY, MAY 31| 1:15 PM CDT

INAVO120: Phase III Trial Final Overall Survival (OS) Analysis of First-Line Inavolisib (INAVO)/Placebo (PBO) + Palbociclib (PALBO) + Fulvestrant (FULV) in Patients (pts) with PIK3CA-Mutated, Hormone Receptor-Positive (HR+), HER2-Negative (HER2-), Endocrine-Resistant Advanced Breast Cancer (aBC)

Turner N et al.

ASCO 2025;Abstract 1003.

SATURDAY, MAY 31| 2:07 PM CDT

Phase I/Ib Study of Inavolisib (INAVO) Alone and in Combination with Endocrine Therapy ± Palbociclib (PALBO) in Patients (pts) with PIK3CA-Mutated, Hormone Receptor-Positive, HER2-Negative Locally Advanced/Metastatic Breast Cancer (HR+, HER2- LA/mBC): Analysis of Hyperglycemia (HG) in Prediabetic/Obese Patients

Oliveira M et al.

ASCO 2025;Abstract 1004.

SATURDAY, MAY 31| 2:19 PM CDT

A Double-Blind Placebo Controlled Randomized Phase III Trial of Fulvestrant and Ipatasertib as Treatment for Advanced HER-2 Negative and Estrogen Receptor Positive (ER+) Breast Cancer Following Progression on First Line CDK 4/6 Inhibitor and Aromatase Inhibitor: The CCTG/BCT MA.40/FINER Study (NCT04650581)

Chia S et al.

ASCO 2025;Abstract LBA1005.

SATURDAY, MAY 31| 2:31 PM CDT

15-Year Outcomes for Women with Premenopausal Hormone Receptor-Positive Early Breast Cancer (BC) in the SOFT and TEXT Trials Assessing Benefits from Adjuvant Exemestane (E) + Ovarian Function Suppression (OFS) or Tamoxifen (T)+OFS

Francis P et al.

ASCO 2025;Abstract 505.

MONDAY, JUNE 2| 4:48 PM CDT

RTP
RESEARCH TO PRACTICE

ASCO 2025:
Other Topics

A Randomized Controlled Trial of Cognitive Behavioral Therapy and Bright Light Therapy for Insomnia and Fatigue During Breast Cancer Treatment: SleepCaRe Trial

Wiley J et al.

ASCO 2025;Abstract 12009.

SUNDAY, JUNE 1| 9:45 AM CDT

Year in Review: Clinical Investigator Perspectives on the Most Relevant New Datasets and Advances in Oncology

Management of Multiple Myeloma

A CME/MOC-Accredited Live Webinar

Thursday, May 8, 2025
5:00 PM – 6:00 PM ET

Faculty

Meletios-Athanasios (Thanos) C Dimopoulos, MD
Robert Z Orlowski, MD, PhD

Moderator

Neil Love, MD

RTP Year in Review 2025

Thank you for joining us!

Please take a moment to complete the survey currently up on Zoom. Your feedback is very important to us. The survey will remain open for 5 minutes after the meeting ends.

Information on how to obtain CME, ABIM MOC and ABS credit is provided in the Zoom chat room. Attendees will also receive an email in 1 to 3 business days with these instructions.

RTP Year in Review 2025