Recent Advances in Cancer Care — New Paradigms, Novel Agents and What It Means for the Oncology Nurse

A Complimentary NCPD Symposium Series Held During the 51st Annual ONS Congress

Oral Selective Estrogen Receptor Degraders in Breast Cancer

Saturday, May 16, 2026

6:00 PM – 7:30 PM

Faculty

Blanca Ledezma, MSN, NP, AOCNP
Marissa Marti-Smith, DNP, APRN, AGNP-C, AOCNP
Ruth M O'Regan, MD

Moderator

Heather McArthur, MD, MPH, FASCO

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Faculty

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University of Rochester Medical Center
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Marissa Marti-Smith, DNP, APRN, AGNP-C, AOCNP
Nurse Practitioner
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Moderator

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UT Southwestern Medical Center
Dallas, Texas

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Ms Ledezma — Disclosures

Speakers Bureaus	AstraZeneca Pharmaceuticals LP, Daiichi Sankyo Inc, Lilly, Pfizer Inc
Steering Committees	AstraZeneca Pharmaceuticals LP

Ms Marti-Smith — Disclosures

Consulting Agreements	Amplity
Speakers Bureaus	AstraZeneca Pharmaceuticals LP, Biotheranostics Inc, A Hologic Company, Daiichi Sankyo Inc, Stemline Therapeutics Inc
Nonrelevant Financial Relationships	ASCO Quality Care Symposium, Clinical Care Options, Kaplan, OncLive, Oncology Nursing News

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Dr O'Regan — Disclosures

Advisory Committees	Biotheranostics Inc, A Hologic Company
Consulting Agreements	Biotheranostics Inc, A Hologic Company, Gilead Sciences Inc, Lilly, Puma Biotechnology Inc, Regor Therapeutics
Contracted Research	Novartis, Puma Biotechnology Inc
Data and Safety Monitoring Boards/Committees	Gilead Sciences Inc

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Dr McArthur — Disclosures

Advisory Committees	Arvinas, AstraZeneca Pharmaceuticals LP, Boston Scientific Corporation, Celcuity, Daiichi Sankyo Inc, Delcath Systems Inc, Genentech, a member of the Roche Group, Gilead Sciences Inc, Lilly, Merck, Novartis, Pfizer Inc
Consulting Agreements	ALX Oncology

Commercial Support

This activity is supported by educational grants from AstraZeneca Pharmaceuticals LP, Lilly, and Stemline Therapeutics Inc.

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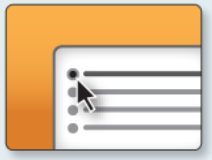
Planners, scientific staff and independent reviewers for Research To Practice have no relevant financial relationships to disclose.

This educational activity contains discussion of non-FDA-approved uses of agents and regimens. Please refer to official prescribing information for each product for approved indications.

Clinicians in the Meeting Room

Networked iPads are available.

Review Program Slides: Tap the Program Slides button to review speaker presentations and other program content.



Answer Survey Questions: Complete the pre- and postmeeting surveys. Survey questions will be discussed throughout the meeting.

Ask a Question: Tap Ask a Question to submit a challenging case or question for discussion. We will aim to address as many questions as possible during the program.

For assistance, please raise your hand. Devices will be collected at the conclusion of the activity.

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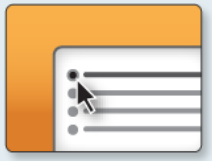
Clinicians Attending via Zoom

Review Program Slides: A link to the program slides will be posted in the chat room at the start of the program.



Answer Survey Questions: Complete the pre- and postmeeting surveys. Survey questions will be discussed throughout the meeting.

Ask a Question: Submit a challenging case or question for discussion using the Zoom chat room.

Get NCPD Credit: An NCPD credit link will be provided in the chat room at the conclusion of the program.

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About the Enduring Program

- The live meeting is being video and audio recorded.
- The proceedings from today will be edited and developed into an enduring web-based program. An email will be sent to all attendees when the activity is available.
- To learn more about our education programs, visit our website, **www.ResearchToPractice.com**

RTP RESEARCH TO PRACTICE ONCOLOGY NURSING UPDATE WITH NEIL LOVE, MD

NONMELANOMA SKIN CANCERS
Check out our recent program with Dr Nikhil I Khushalni from Moffitt Cancer Center in Tampa, Florida. Published May 7, 2026.

Overview of nonmelanoma skin cancers (12 min)

Systemic therapy for nonmelanoma skin cancers (8 min)

Immune checkpoint inhibitors for special patient populations (12 min)

Hedgehog inhibitors for basal cell carcinoma (6 min)

New developments in therapy for nonmelanoma skin cancers (5 min)

CASE: A man in his early 70s with cutaneous squamous cell carcinoma receives cemiplimab (8 min)

CASE: A man in his mid 70s with a history of basal cell carcinoma presents with disease of the ocular surface and receives immunotherapy (6 min)

CASE: A man in his early 70s with recurrent metastatic basal cell carcinoma receives vismodegib followed by cemiplimab on disease progression (6 min)

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Feedback (Please!)

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“Recent Advances in Cancer Care — New Paradigms, Novel Agents and What It Means for the Oncology Nurse”
Eighteenth Annual RTP-ONS NCPD Symposium Series

Wednesday May 13	Antibody-Drug Conjugates	11:15 AM – 12:45 PM CT
	Ovarian Cancer	6:00 PM – 7:30 PM CT
Thursday May 14	Immunotherapeutic Approaches for Endometrial Cancer	6:00 AM – 7:30 AM CT
	Prostate Cancer	12:15 PM – 1:45 PM CT
	Non-Muscle-Invasive and Muscle-Invasive Bladder Cancer	6:00 PM – 7:30 PM CT
Friday May 15	Pancreatic Cancer	6:00 AM – 7:30 AM CT
	Targeting the PI3K/AKT/mTOR Pathway in HR-Positive Metastatic BC	12:15 PM – 1:45 PM CT
	Non-Hodgkin Lymphoma and Chronic Lymphocytic Leukemia	6:00 PM – 8:00 PM CT
Saturday May 16	CDK4/6 Inhibitors for HR-Positive Breast Cancer	6:00 AM – 7:30 AM CT
	Relapsed/Refractory Multiple Myeloma	12:15 PM – 1:45 PM CT
	Oral SERDs for Breast Cancer	6:00 PM – 7:30 PM CT

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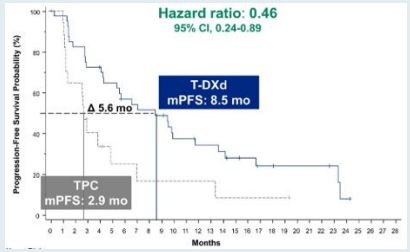
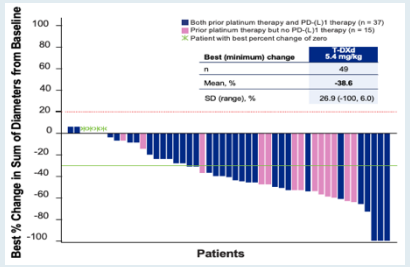
Recent Advances in Cancer Care — New Paradigms, Novel Agents and What It Means for the Oncology Nurse

New Agents, Therapies and Regimens

- When should it be used, for whom and why?
- How to prevent and manage side effects: dose holds and reductions
  - Kaplan Meier curves — HR and absolute benefit



  - Waterfall plots



Agenda

Module 1: Current Clinical Role of Oral Selective Estrogen Receptor Degraders (SERDs) in HR-Positive Metastatic Breast Cancer

Module 2: Practical Considerations with Oral SERDs

Module 3: Potential Role of Combination Approaches with Oral SERDs

Module 4: Gastrointestinal Adverse Events Documented with Oral SERDs

Module 5: Potential Role of Early Therapeutic Switching After Detection of an Emergent ESR1 Mutation

Module 6: Other Class-Effect Toxicities Associated with Oral SERDs

Module 7: Emerging Utility of Adjuvant Oral SERDs

Module 8: Unique Toxicities Associated with 1 or More Oral SERDs

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RTP RESEARCH TO PRACTICE

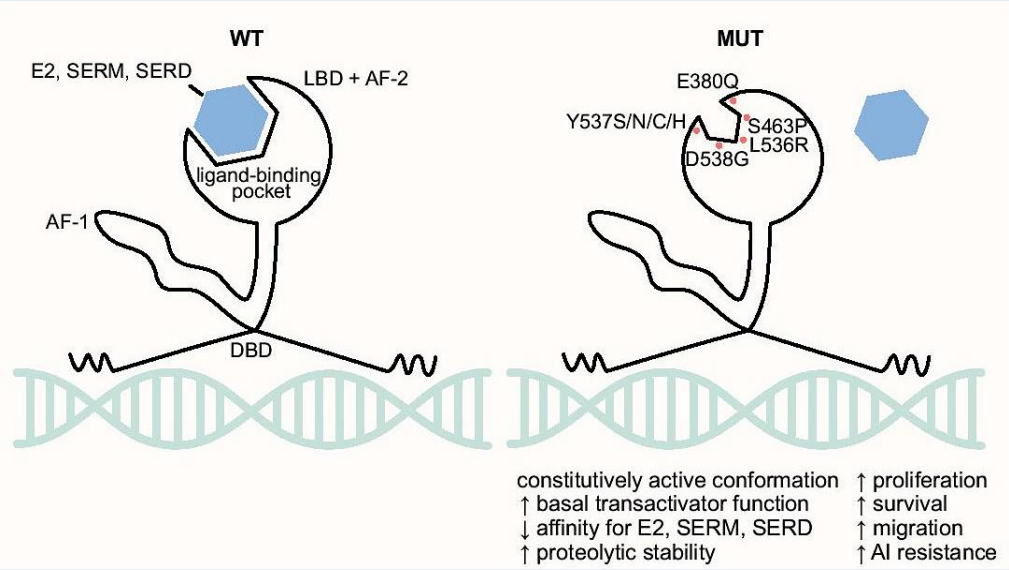
Current Clinical Role of Oral Selective Estrogen Receptor Degraders (SERDs) in HR-Positive mBC

Ruth M O'Regan, MD
Charles A Dewey Professor of Medicine and Oncology
Chair, Department of Medicine
University of Rochester Medical Center
Physician-in-Chief
Strong Memorial Hospital
Associate Director of Education and Mentoring
Wilmot Cancer Institute
Rochester, New York

ESR1 Mutations

- PIK3CA mutations are early events, present at baseline (~40%)
- ESR1 mutations are rare in primary/untreated HR+ breast cancer (<5%)
- Arise after exposure to aromatase inhibitors = **Acquired**
  - 25%-40% frequency in second-/third-line metastatic setting

ESR1 mutations are enriched in the ligand-binding domain
Constitutive signaling in the absence of ligand



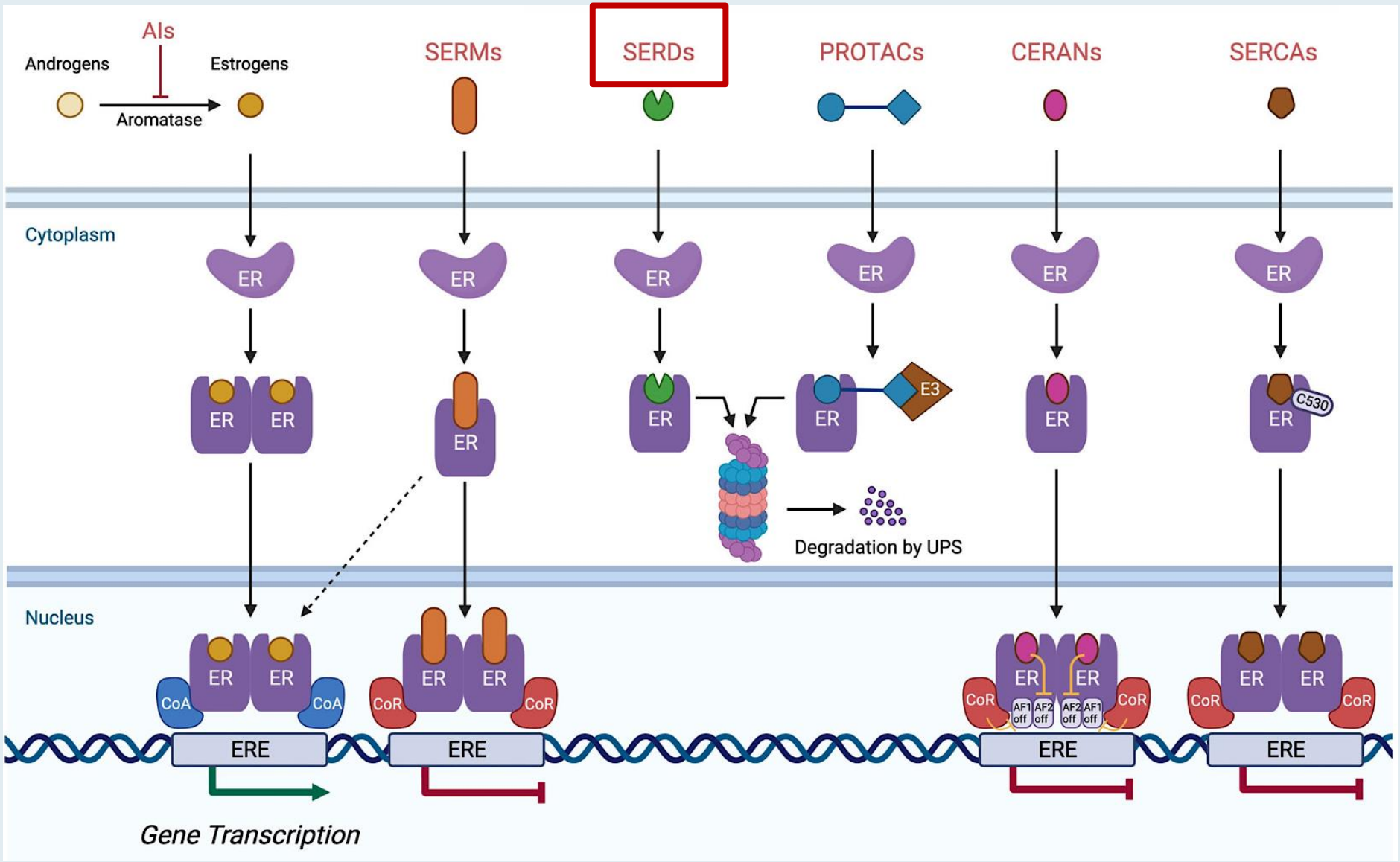
Jeselsohn R et al. *Nat Rev Clin Onc* 2015; Brett JO et al. *Breast Cancer Res* 2021.

ESR1 Mutation Testing — ASCO Recommendations

- Routine testing for emergence of ESR1 mutations at recurrence or progression on ET in patients with ER-positive, HER2-negative mBC
- Testing should be performed on blood or tissue obtained at the time of progression, with a CLIA-certified assay
- Blood-based ctDNA is preferred owing to greater sensitivity
- Patients whose tumor or ctDNA tests remain ESR1 wild-type may warrant retesting at subsequent progression(s) to determine if an ESR1 mutation has arisen

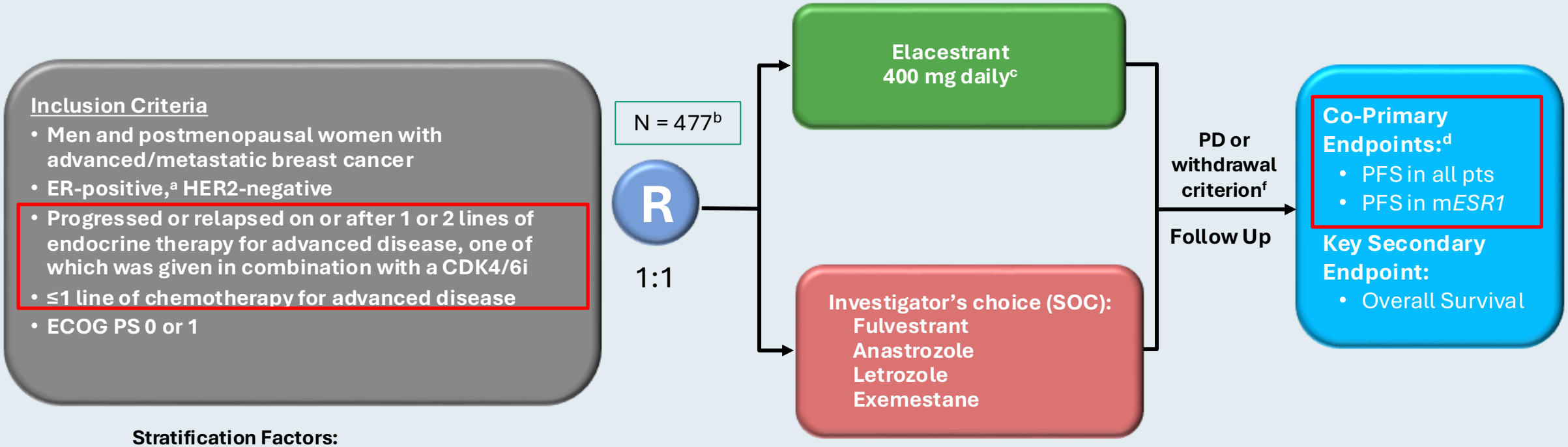
Burstein H et al. *J Clin Oncol* 2023;41(18):3423-25.

Mechanism of Action of Oral SERDs and Other Antiestrogen Therapies



Patel R et al. *npj Breast Cancer* 2023;9:20.

EMERALD Phase III Study



Stratification Factors:
- ESR1 mutation status[e]
- Prior treatment with fulvestrant
- Presence of visceral metastases

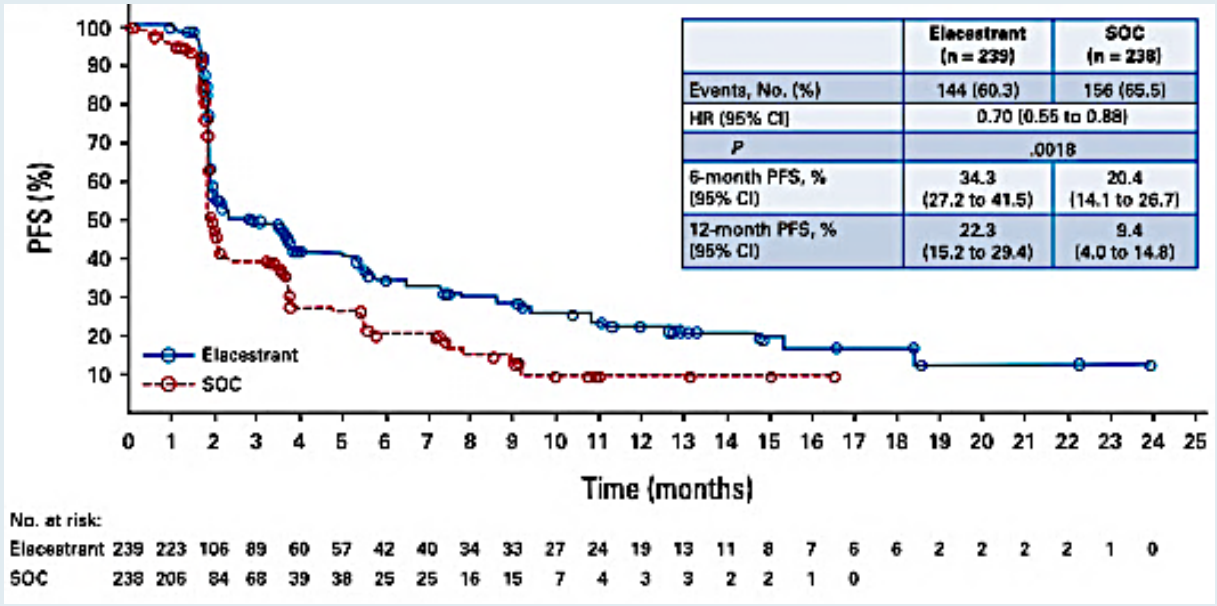
[a]Documentation of ER-positive tumor with ≥1% staining by immunohistochemistry; [b]Recruitment from February 2019 to October 2020; [c]Protocol-defined dose reductions permitted;
[d]Blinded Independent Central Review. [e]ESR1 mutation status was determined by ctDNA analysis using the Guardant360® assay (Guardant Health, Redwood City, CA). [f]Restaging CT scans every 8 weeks.

ECOG PS = Eastern Cooperative Oncology Group performance status; R = randomized; SOC = standard of care; PFS = progression-free survival; pts = patients

Bardia A. SABCS 2021; Bidard FC. *J Clin Oncol* 2022.

EMERALD Primary Endpoint: PFS in All and mESR1 Patients

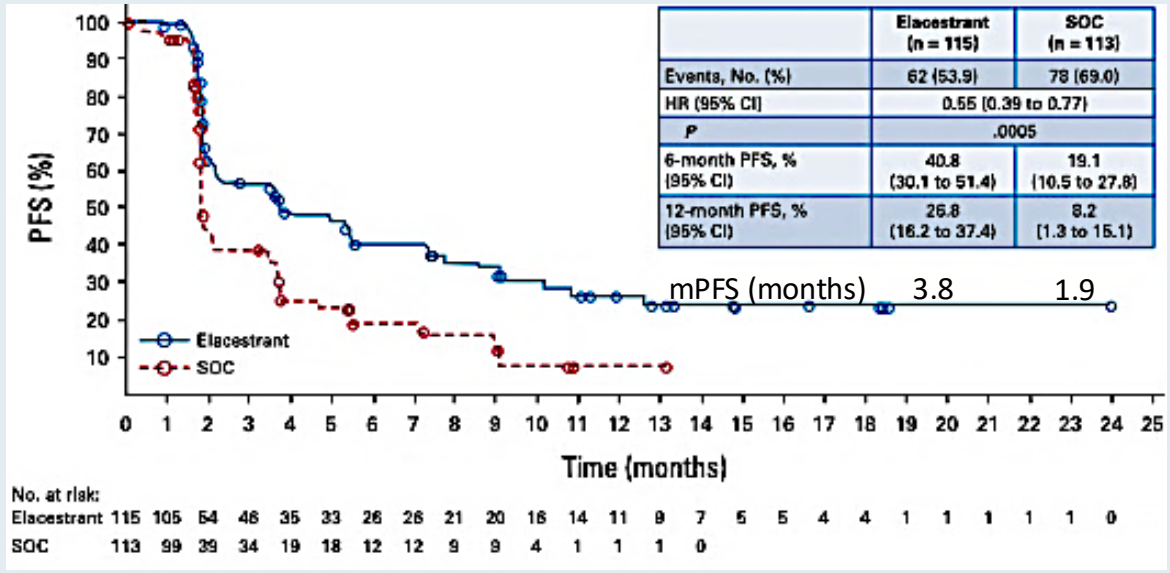
All patients (ITT)



	Elacestrant (n = 239)	SOC (n = 238)
Events, No. (%)	144 (60.3)	156 (65.5)
HR (95% CI)	0.70 (0.55 to 0.88)	
P	.0018	
6-month PFS, % (95% CI)	34.3 (27.2 to 41.5)	20.4 (14.1 to 26.7)
12-month PFS, % (95% CI)	22.3 (15.2 to 29.4)	9.4 (4.0 to 14.8)

mPFS (months): 2.8 versus 1.9

Patients with tumors harboring mESR1



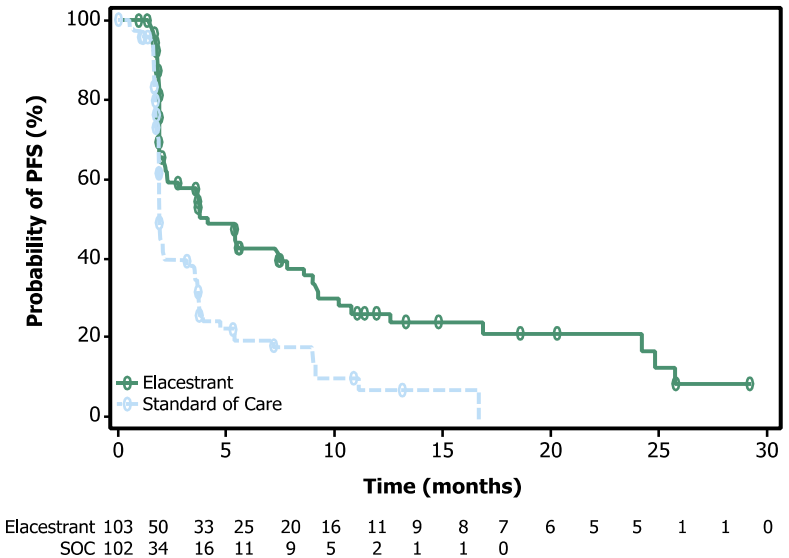
	Elacestrant (n = 115)	SOC (n = 113)
Events, No. (%)	62 (53.9)	78 (69.0)
HR (95% CI)	0.55 (0.39 to 0.77)	
P	.0005	
6-month PFS, % (95% CI)	40.8 (30.1 to 51.4)	19.1 (10.5 to 27.8)
12-month PFS, % (95% CI)	26.8 (16.2 to 37.4)	8.2 (1.3 to 15.1)

mPFS (months): 3.8 versus 1.9

Bardia A. SABCS 2021; Bidard FC. *J Clin Oncol* 2022.

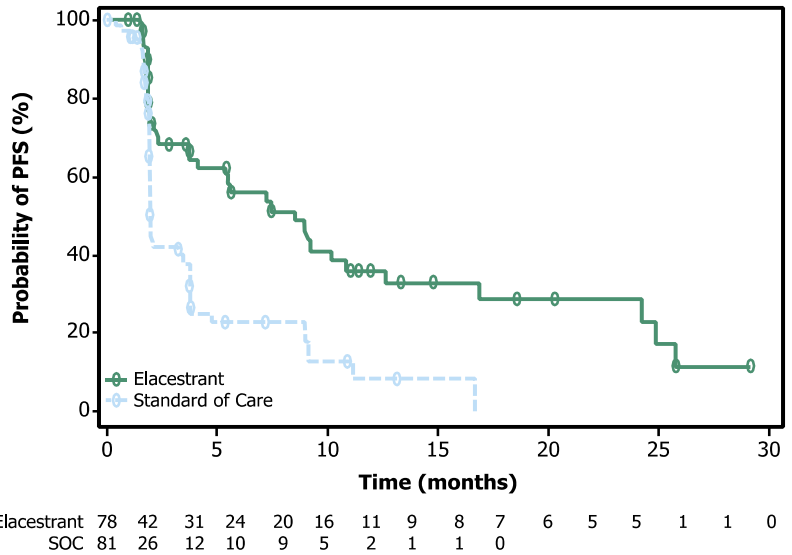
EMERALD: Efficacy Subgroups

At least 6 mo CDK4/6i



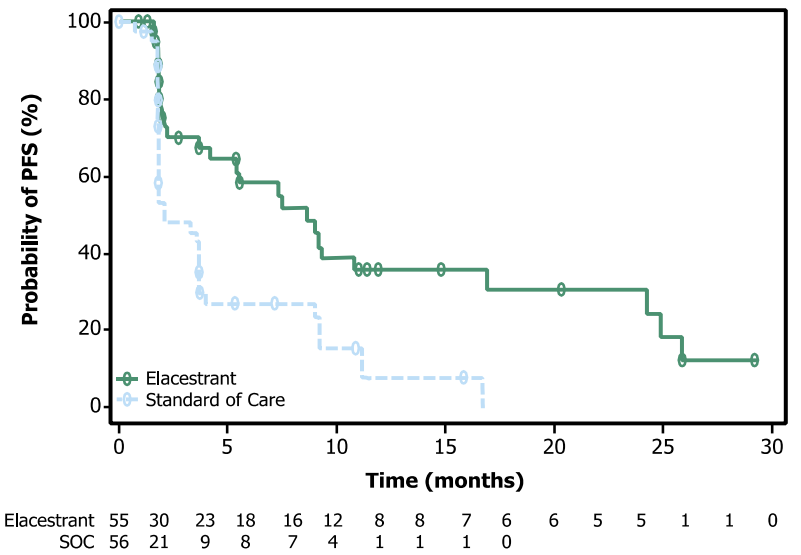
	Elacestrant	SOC Hormonal Therapy
Median PFS, months (95% CI)	**4.14** (2.20 - 7.79)	**1.87** (1.87 - 3.29)
PFS rate at 12 months, % (95% CI)	26.02 (15.12 - 36.92)	6.45 (0.00 - 13.65)
Hazard ratio (95% CI)	**0.517** (0.361 - 0.738)	

At least 12 mo CDK4/6i



	Elacestrant	SOC Hormonal Therapy
Median PFS, months (95% CI)	**8.61** (4.14 - 10.84)	**1.91** (1.87 - 3.68)
PFS rate at 12 months, % (95% CI)	35.81 (21.84 - 49.78)	8.39 (0.00 - 17.66)
Hazard ratio (95% CI)	**0.410** (0.262 - 0.634)	

At least 18 mo CDK4/6i



	Elacestrant	SOC Hormonal Therapy
Median PFS, months (95% CI)	**8.61** (5.45 - 16.89)	**2.10** (1.87 - 3.75)
PFS rate at 12 months, % (95% CI)	35.79 (19.54 - 52.05)	7.73 (0.00 - 20.20)
Hazard ratio (95% CI)	**0.466** (0.270 - 0.791)	

Bardia A et al. *CCR* 2024.

EMBER-3 Study Design

ER+, HER2- ABC

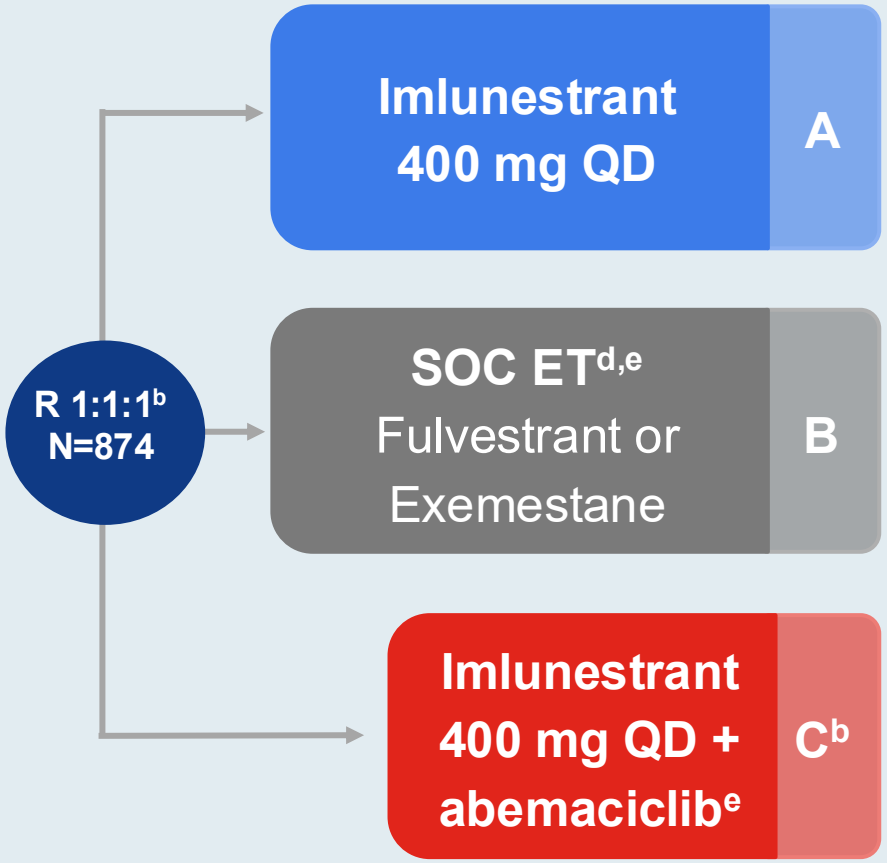
Men and Pre-[a]/Post-menopausal women

Prior therapy:

- **Adjuvant**: Recurrence on or within 12 months of completion of AI ± CDK4/6i
- **ABC:** Progression on first-line AI ± CDK4/6i
- No other therapy for ABC

Stratification Factors:

- Prior CDK4/6i therapy (Y/N)
- Visceral metastases (Y/N)
- Region[c]



Primary Endpoints

Investigator-assessed PFS for[f]:

- A vs B in patients with *ESR1*m[g]
- A vs B in all patients
- C vs A in all[h] patients

Key Secondary Endpoints

- OS, PFS by BICR, and ORR
- Safety

Exploratory Endpoints

- PFS and OS for C vs B in all[h] patients

ABC = advanced breast cancer; AI = aromatase inhibitor; SOC = standard of care; PFS = progression-free survival; OS = overall survival; BICR = blinded independent central review; ORR = objective response rate

Jhaveri KL et al. SABCS 2024; Jhaveri KL et al. *NEJM* 2025.

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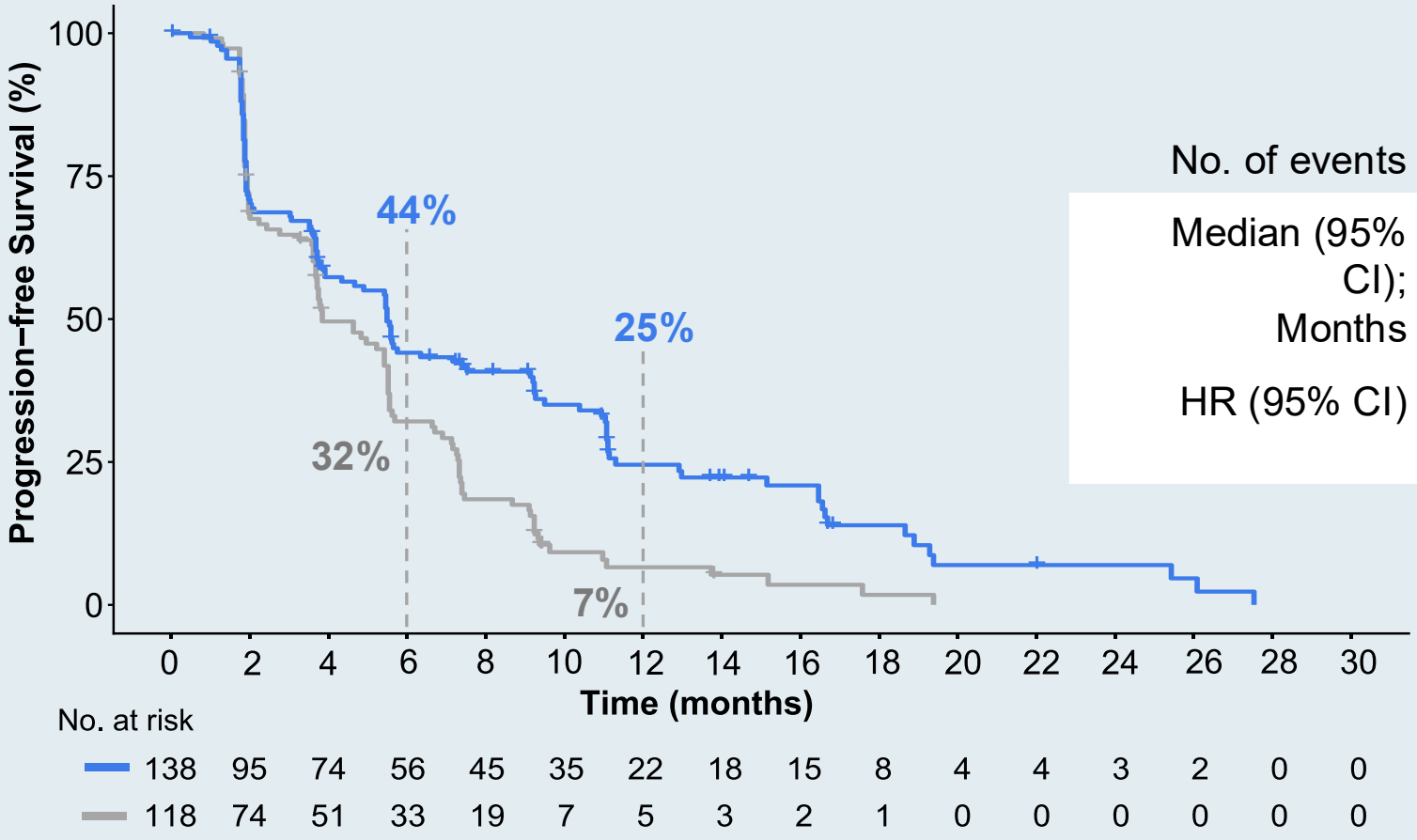
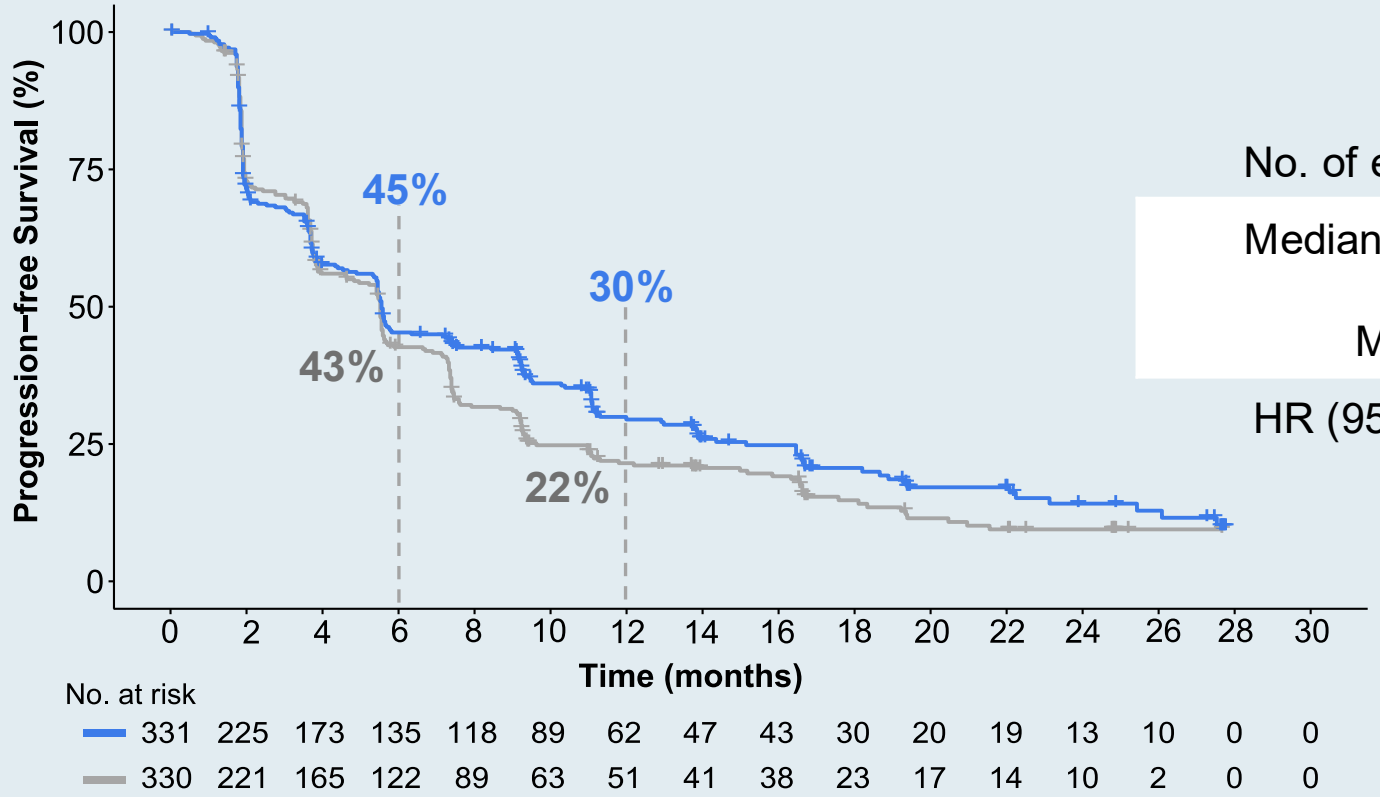
EMBER-3 Primary Endpoint: PFS in Patients with ESR1m



	Imlunestrant n=138	SOC ET n=118
No. of events	109	102
Median (95% CI); Months	**5.5** (3.9-7.4)	**3.8** (3.7-5.5)
HR (95% CI)	**0.62 (0.46-0.82)[a]** *p*-value<0.001	

Jhaveri KL et al. SABCS 2024; Jhaveri KL et al. *NEJM* 2025.

EMBER-3 Primary Endpoint: PFS in All Patients



	Imlunestrant n=331	SOC ET n=330
No. of events	237	253
Median (95% CI); Months	**5.6** (5.3-7.3)	**5.5** (4.6-5.6)
HR (95% CI)	**0.87 (0.72-1.04)** *p*-value 0.12	

Prespecified Critical HR < 0.84[a]

The majority subgroup of patients without ESR1m showed no difference in PFS (HR=1.00; 95% CI, 0.79-1.27)

Jhaveri KL et al. SABCS 2024; Jhaveri KL et al. *NEJM* 2025.

Discussion Questions

In which line of therapy are you using an oral SERD for patients with ESR1 mutations only? How do you sequence oral SERDs relative to other options for patients with ESR1 and PTEN/PI3K/AKT pathway alterations, and what factors influence your choice?

How do you choose between elacestrant and imlunestrant? Are any toxicities noted with one of these that have not been documented with other, and how does this influence your choice?

How do the tolerability profiles of camizestrant and giredestrant differ from those of elacestrant and imlunestrant?

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UCLA Health | David Geffen School of Medicine

Practical Considerations with the Use of Oral SERDs

Blanca Ledezma, MSN, NP, AOCNP

Elacestrant

UCLA Health

Dosing

- 345 mg (1tab) taken orally with food once daily
- Take at approximately the same time every day.
- Take with food to reduce symptoms of nausea and vomiting
- Swallow whole

Dosage forms:

345mg tablets and 86mg tablets

Dose Reduction	Dosage	Number and Strength of Tablets
First-dose reduction	258 mg once daily	Three 86 mg tablets
Second-dose reduction	172 mg once daily[1]	Two 86 mg tablets

Elacestrant, PI 2023

Imlunestrant

UCLA Health

Dosing

- 400 mg (2 tab) orally once daily
- Take on an empty stomach 2 hours before or 1 hour after food
- Take at approximately the same time every day.
- Swallow whole
- Pre/perimenopausal women and men should receive a gonadotropin-releasing hormone agonist (GnRH) according to current clinical practice standards

Dosage forms:

200mg tablets

Dose Reduction:

First dose reduction:200mg 1 tablet

Unable to tolerate 200 mg, permanently discontinue

Imlunestrant, PI 2025

Dose Modification: Elacestrant

Grade 1	Continue at current dose
Grade 2	consider hold until recovers to ≤1 or baseline, resume at same dose
Grade 3	hold until recovers to ≤1 or baseline, resume at next lower dose if grade 3 recurs hold until recovers to ≤1 or baseline, resume and reduce by another dose
Grade 4	hold until recovers to ≤1 or baseline, resume at next lower dose Intolerable grade 4 permanently discontinue

Elacestrant, PI 2023

Dose Modification: Imlunestrant

UCLA Health

General Modifications

Grade 2 persistent or recurrent that does not recover in 7 days with maximal supportive measures to baseline or grade 1

hold until recovers to ≤1 or baseline, resume at same dose

Grade 3 or 4 *(except non-hepatic asymptomatic lab changes)*

hold until recovers to ≤1 or baseline, resume at next lower dose

Hepatoxicity

Grade 2 hold until recovers to ≤1 or baseline, resume at same dose

Grade 3 OR **AST/ALT ≥ 3x** at baseline, **AST/ALT ≥ 1.5x** at baseline OR **AST/ALT ≥ 8x** ULN *(whichever is lower)*

hold until recovers to baseline or > 3x ULN, resume at next lower dose

or discontinue if at 200mg dose

Grade 4 OR **AST/ALT ≥ 3x + bili 2x ULN,** (AST/ALT < 1.5x ULN),in the absence of cholestasis at OR AST/ALT ≥ 2x at baseline + bili 2x ULN,(**AST/ALT ≥ 1.5x** at baseline), in the absence of cholestasis

Discontinue treatment

Imlunestrant, PI 2025

Unique considerations within specific patient populations

UCLA Health

Geriatric Population

Elacestrant

- 43% were 65 years of age or older of the 237 patients who received elacestrant in the EMERALD trial
- 17% were 75 years of age or older.
- No overall differences in safety or effectiveness were observed between patients 65 years or older of age compared to younger patients.
- There was insufficient number of patients 75 years of age or older to assess differences in safety or effectiveness

Imlunestrant

- 118 patients were ≥ 65 years of age and 37 patients were ≥ 75 years of age of 327 patients who received imlunestrant in the EMBER-3 study
- No overall differences in safety or effectiveness observed between patients 65 years of age and older and younger adult patients.

Bidard, F.C.,J Clin Oncol. 2022 May
Jhaveri, L.K., N Engl J Med 2025

Unique considerations within specific patient populations

UCLA Health

Hepatic Impairment

Elacestrant

- Patients with **mild** hepatic impairment (Child-Pugh A) no dosage adjustment
- Patients with **moderate** hepatic impairment (Child-Pugh B) reduce the dose (258 mg)
- Avoid use in patients with severe hepatic impairment (Child-Pugh C)

Imlunestrant

- Patients with **mild** hepatic impairment (Child-Pugh A) no dosage adjustment
- Patients with **moderate to severe** hepatic impairment (Child-Pugh B or Child-Pugh C) reduce the dose (200mg)

Imlunestrant, PI 2025
Elacestrant, PI 2023

Adherence with oral SERDs

UCLA Health

- **Understanding Key Barriers:**
  - Side effects
  - Financial
  - Mental health (anxiety)
  - Level of education
- **Ongoing follow-up and Engagement:**
  - Regular follow-up visits
  - Clinical pharmacist adherence monitoring
  - Written instructions at an accessible reading level and using teach-back methods
  - Expectations of possible side effects to avoid self-discontinuation
- **Simplifying medication logistics;**
  - 90 day prescription refill is associated with higher adherence
  - Medication reminders (apps, pill organizers, text messages) showed improvement in some studies, particularly technology-based interventions

Neuner JM., Breast Cancer Res Treat. 2023
Ganna S., J Cancer Surviv. 2025 Jun;19(3):930-939
Franzoi MA, Lancet Oncol. 2021 Jul;22(7)

Drug-drug interactions

UCLA Health

Elacestrant

Strong and Moderate CYP3A4 Inhibitors: *Avoid, increases elacestrant exposure*

Strong and Moderate CYP3A4 Inducers: *Avoid, decreases elacestrant exposure*

P-gp inhibition (digoxin): reduce the dosage of P-gp substrates

BCRP inhibition (rosuvastatin): reduce the dosage of BCRP substrates

Imlunestrant

Strong CYP3A4 inhibitor: *Avoid; if unavoidable, reduce dose*

Strong CYP3A4 inducer: Avoid; if unavoidable, increase dose

CYP3A substrate: decreases imlunestrant exposure

P-gp inhibition (digoxin): avoid, increases exposure

BCRP inhibition (rosuvastatin): avoid, increases exposure

Imlunestrant, PI 2025
Elacestrant, PI 2023

Clinical Summary of Oral SERDs

UCLA Health

- Elacestrant (345mg) must be taken **with food** daily; Imlunestrant (400mg) requires an **empty stomach**. Dosage must be swallowed whole.
- Imlunestrant utilizes specific LFT thresholds for hepatotoxicity management.
- Dose adjustments are required for Child-Pugh B/C hepatic impairment. Geriatric patients (≥65) show comparable safety profiles to younger cohorts.
- Avoid concomitant strong CYP3A4 inhibitors/inducers. Closely monitor P-gp substrates (e.g., digoxin) and BCRP substrates during co-administration.
- Leverage 90-day refills, simplified logistics, and teach-back methods to mitigate barriers like cost, education levels, and therapy anxiety.

UCLA Health | David Geffen School of Medicine

Case Presentation

Blanca Ledezma, MSN, NP, AOCNP

Case Presentation

UCLA Health

- 78-year-old retired female who lives with her husband and has 2 daughters

- **Diagnosis:** ER-positive, HER2-negative, ESR1-mutated (D538G) metastatic breast cancer with bone (thoracic spine, right iliac crest) and solitary liver metastasis

- **Treatment history:**
  - Adjuvant radiation
  - Adjuvant **letrozole** x 4 yrs → PD with imaging revealing new bone metastases in the thoracic spine and right iliac crest. liquid biopsy (ctDNA) confirmed an ESR1 D538G mutation
  - **Abemaciclib / letrozole** x 16 months + denosumab → PD current sites of disease and solitary liver lesion, liquid biopsy confirmed an ESR1 D538G mutation
  - **Elacestrant** started x 6 weeks + denosumab

- **Comorbidities:**
  - Mild CKD
  - Hyperlipidemia on rosuvastatin
  - HTN well controlled
  - Reflux
  - Mild forgetfulness

Case Presentation

UCLA Health

Approaches for Encouraging and Assessing Adherence:

- Pill organization: smart pill box with alarms
- Proactive side effect engagement: phone calls, video visits (when possible) and in person visits
- Diary of symptoms
- Medication review at every visit
- Written information on treatment and plan of action of possible adverse effects

- **Current status:**
  - Scans 3 months after treatment start
  - Mild nausea (grade 1) managed with dietary modifications and occasional ondansetron
  - Musculoskeletal discomfort (grade 1) managed with acetaminophen
  - She is tolerating the oral regimen well

Agenda

Module 1: Current Clinical Role of Oral Selective Estrogen Receptor Degraders (SERDs) in HR-Positive Metastatic Breast Cancer

Module 2: Practical Considerations with Oral SERDs

Module 3: Potential Role of Combination Approaches with Oral SERDs

Module 4: Gastrointestinal Adverse Events Documented with Oral SERDs

Module 5: Potential Role of Early Therapeutic Switching After Detection of an Emergent ESR1 Mutation

Module 6: Other Class-Effect Toxicities Associated with Oral SERDs

Module 7: Emerging Utility of Adjuvant Oral SERDs

Module 8: Unique Toxicities Associated with 1 or More Oral SERDs

Potential Role of Combination Approaches with Oral SERDs in HR-Positive, HER2-Negative MBC

Heather McArthur, MD, MPH, FASCO
Professor, Department of Internal Medicine
Clinical Director, Breast Cancer Program
Komen Distinguished Chair in Clinical Breast Cancer Research
UT Southwestern Medical Center
Dallas, Texas

EMBER-3 Study of Imlunestrant: Design

ER+, HER2- ABC

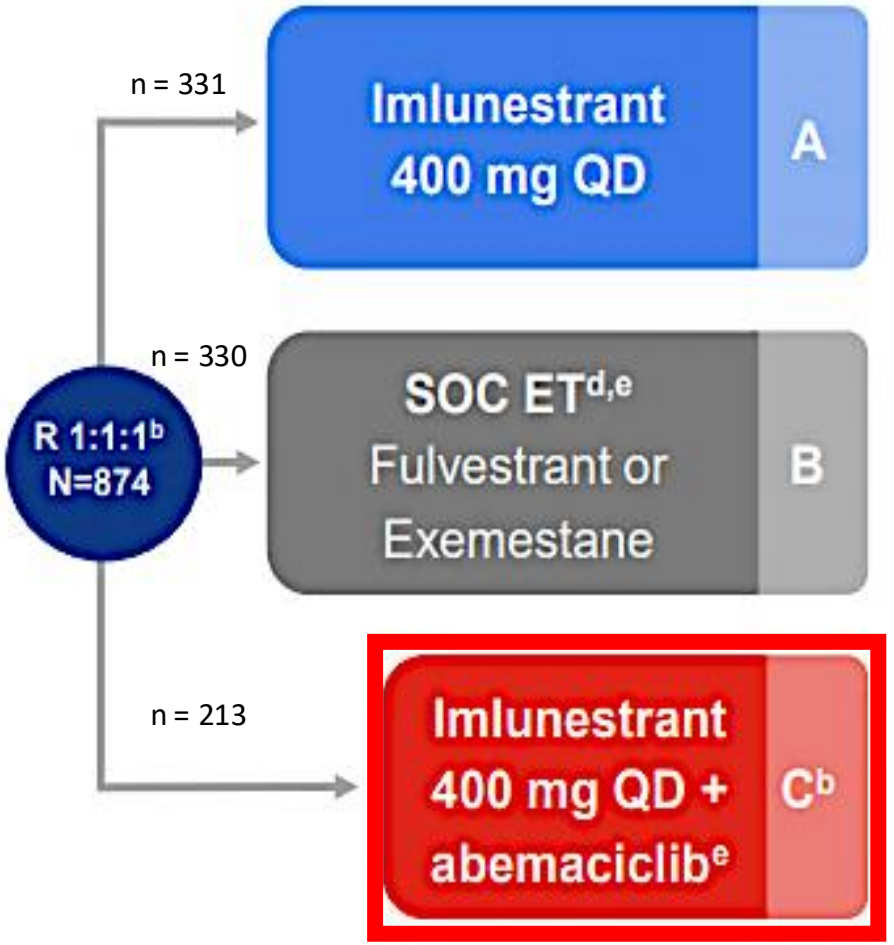
Men and Pre-[a]/Post-menopausal women

Prior therapy:

- **Adjuvant**: Recurrence on or within 12 months of completion of AI ± CDK4/6i
- **ABC:** Progression on first-line AI ± CDK4/6i
- No other therapy for ABC

Stratification Factors:

- Prior CDK4/6i therapy (Y/N)
- Visceral metastases (Y/N)
- Region[c]



Primary Endpoints

Investigator-assessed PFS for[f]:

- A vs B in patients with *ESR1*m[g]
- A vs B in all patients
- C vs A in all[h] patients

Key Secondary Endpoints

- OS, PFS by BICR, and ORR
- Safety

No prior CT (except for neoadjuvant/ adjuvant), FULV, or any investigational-ER-directed therapy (including SERDs and non-SERDs), any PI3K/mTOR/AKT inhibitor

Jhaveri K, et al. SABCS 2024. Abstract GS1-01.
Jhaveri K, et al. *N Engl J Med*. 2025;392:1189-1202.

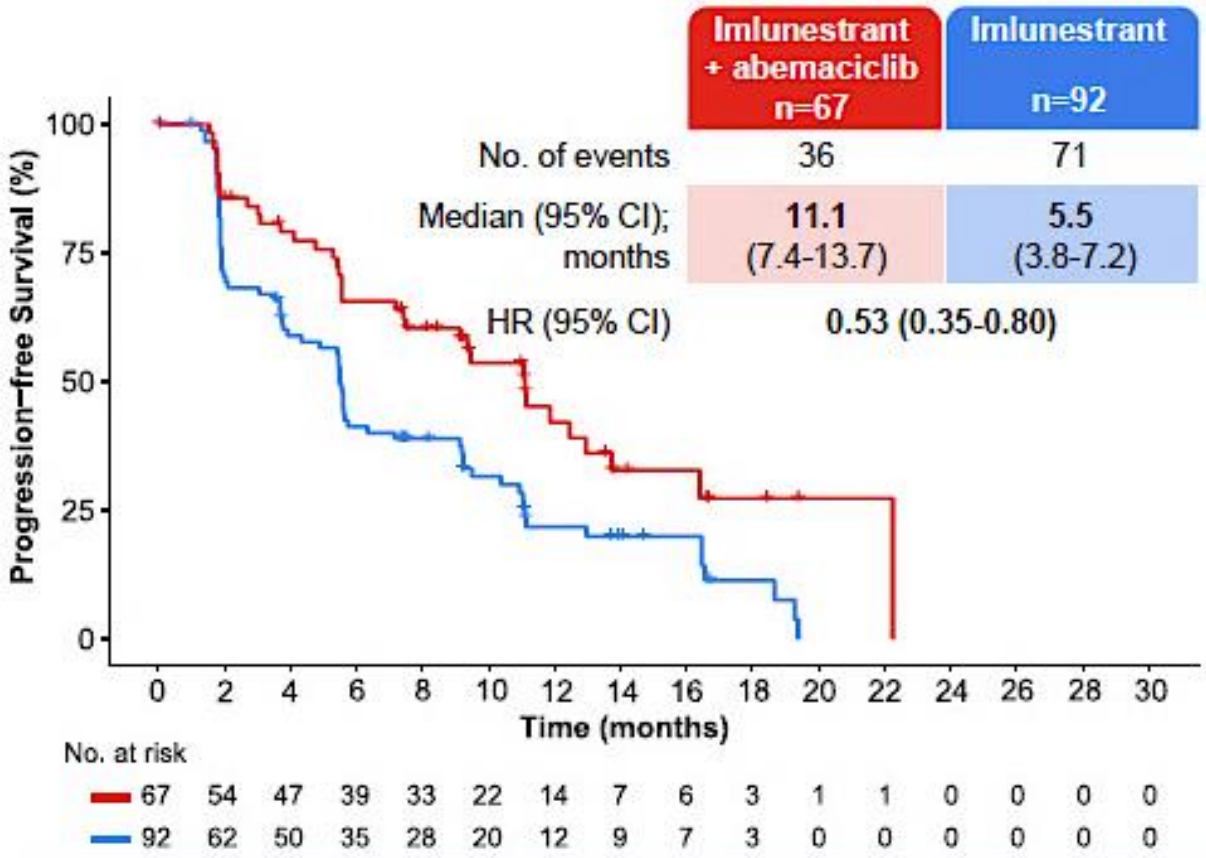
EMBER-3: Imlunestrant + Abemaciclib + Imlunestrant—Baseline Characteristics

Characteristic		All Patients		CDK4/6i pretreated patients	
		Imlunestrant + abemaciclib n=213	Imlunestrant n=213[a]	Imlunestrant + abemaciclib n=139	Imlunestrant n=140[a]
Region, %	East Asia	31	32	23	24
	North America/ Western Europe	45	43	55	55
	Other	24	25	22	21
ESR1 mutation[b], %		32	43	38	51
PI3K pathway mutations[c], %		41	39	44	45
ESR1 and PI3K-pathway co-mutations, %		15	19	17	26

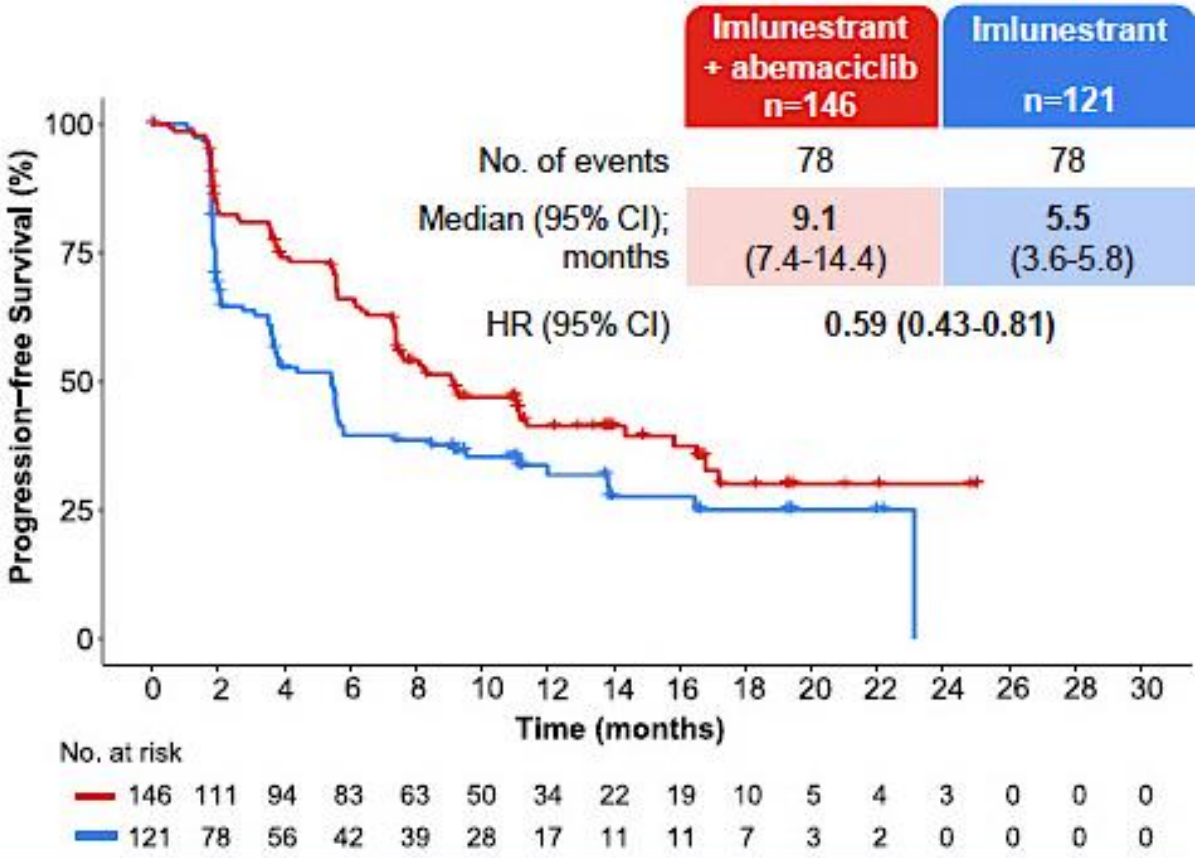
Saura C, et al. ESMO Br Cancer 2025.

EMBER-3: Imlunestrant + Abema vs Imlunestrant—PFS by *ESR1*m Status

Patients with *ESR1*m



Patients without *ESR1*m



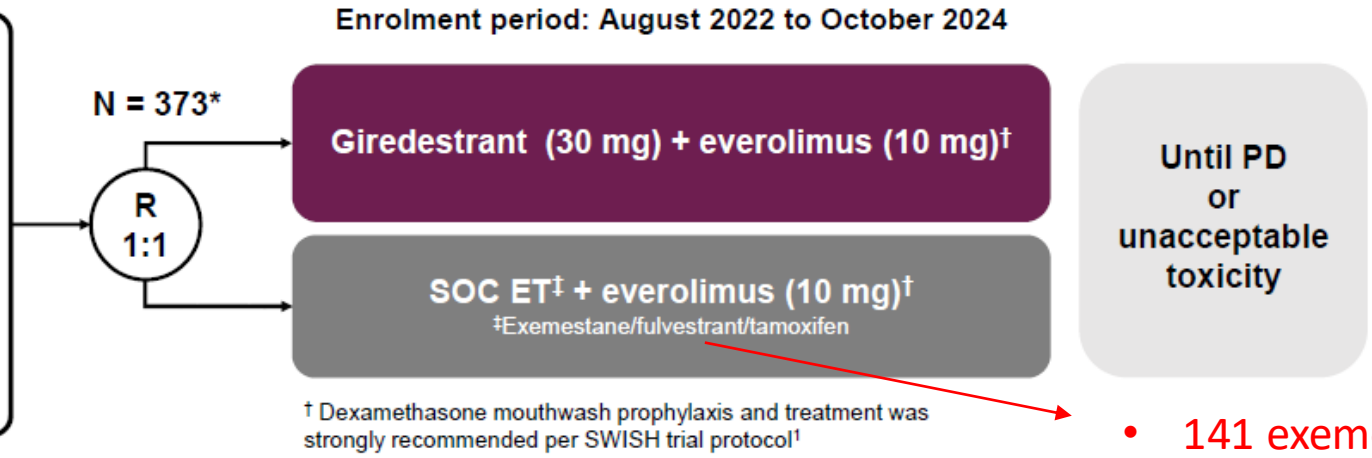
Consistent benefit of imlunestrant + abemaciclib regardless of *ESR1*m status

Saura C, et al. ESMO Br Cancer 2025.

Phase 3 evERA Study of Giredestrant + Everolimus

Key eligibility criteria*

- ER+, HER2– aBC (1–3L of therapy)
- ≤ 2 prior lines of ET in the aBC setting
- PD or relapse during/post-CDK4/6i + ET
- No prior chemotherapy in the aBC setting
- Measurable disease per RECIST v1.1 or evaluable bone metastases



- 141 exemestane
- 39 fulvestrant
- 6 tamoxifen

* Trial was enriched to 55% of patients with *ESR1*m at baseline (centrally tested via circulating tumour DNA)

Stratification factors

- Prior treatment with fulvestrant (yes vs no)
- *ESR1*m (yes vs no/indeterminate)
- Site of disease (visceral [lung and/or liver involvement] vs non-visceral)

Co-primary endpoints (RECIST v1.1)

- INV-PFS in patients whose tumours had *ESR1*m
- INV-PFS in the ITT population

Key secondary endpoints

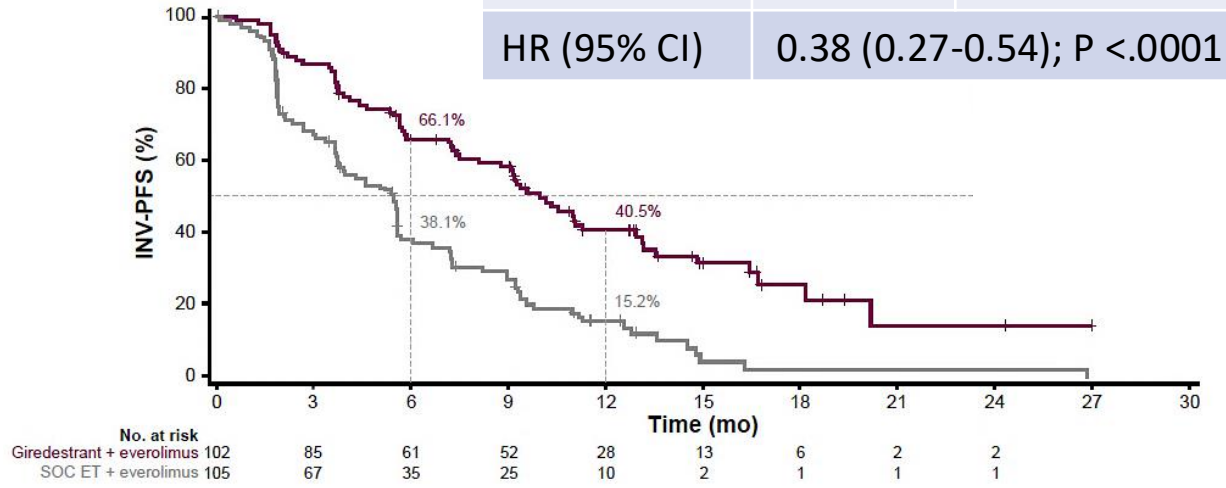
- OS
- INV-assessed ORR, DoR

Mayer E, et al. ESMO 2025. LBA16.

Phase 3 evERA Study

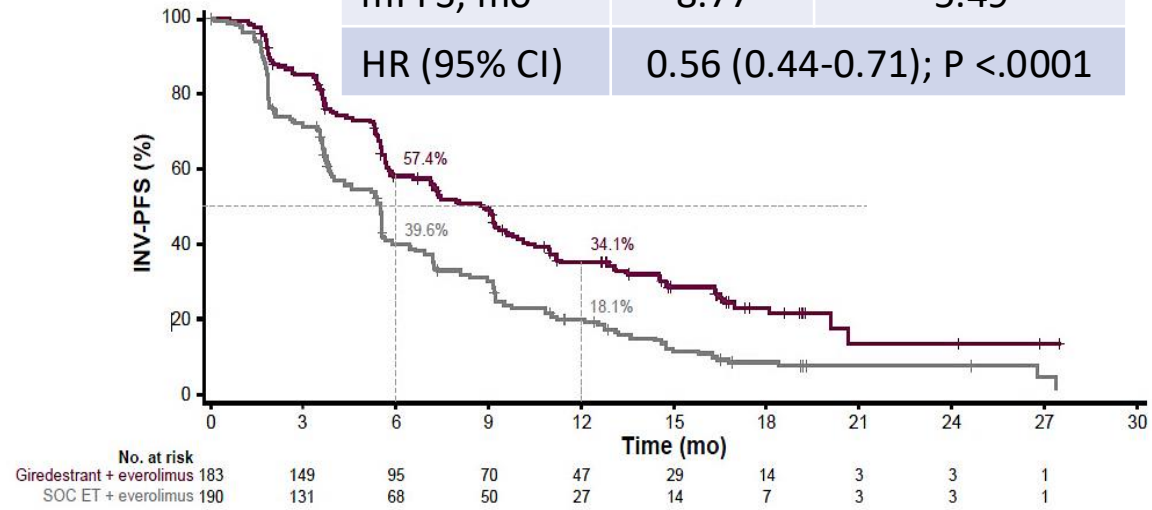
*ESR1*m Population

	G + EVE (n = 102)	SOC + EVE (n = 105)
Events, n (%)	63 (62)	89 (85)
mPFS, mo	9.99	5.45
HR (95% CI)	0.38 (0.27-0.54); P <.0001	



ITT Population

	G + EVE (n = 183)	SOC + EVE (n = 190)
Events, n (%)	126 (69)	163 (86)
mPFS, mo	8.77	5.49
HR (95% CI)	0.56 (0.44-0.71); P <.0001	

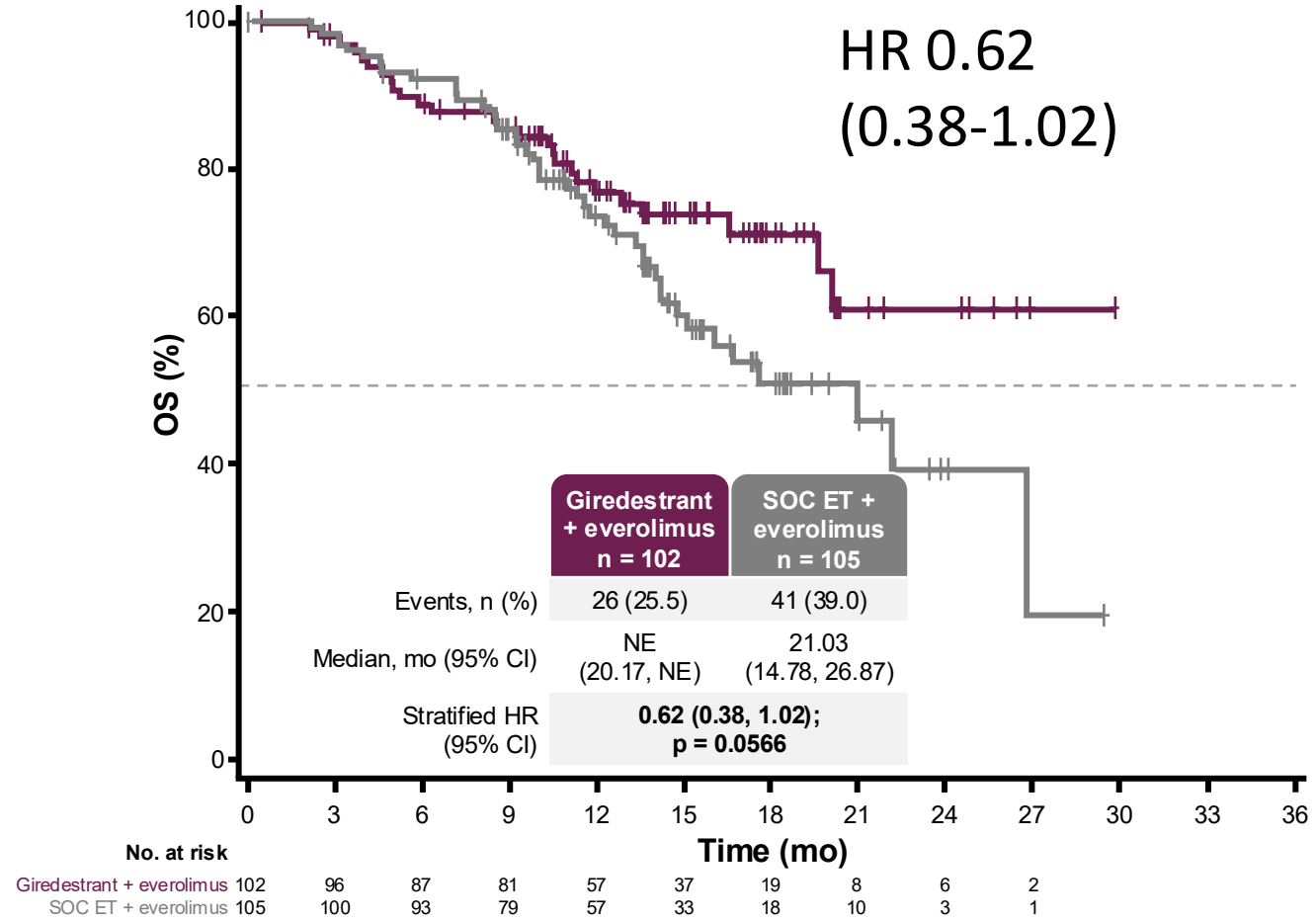


FDA decision expected by December 2026

Mayer E, et al. ESMO 2025. LBA16.

Interim analysis of OS in the *ESR1m* patients

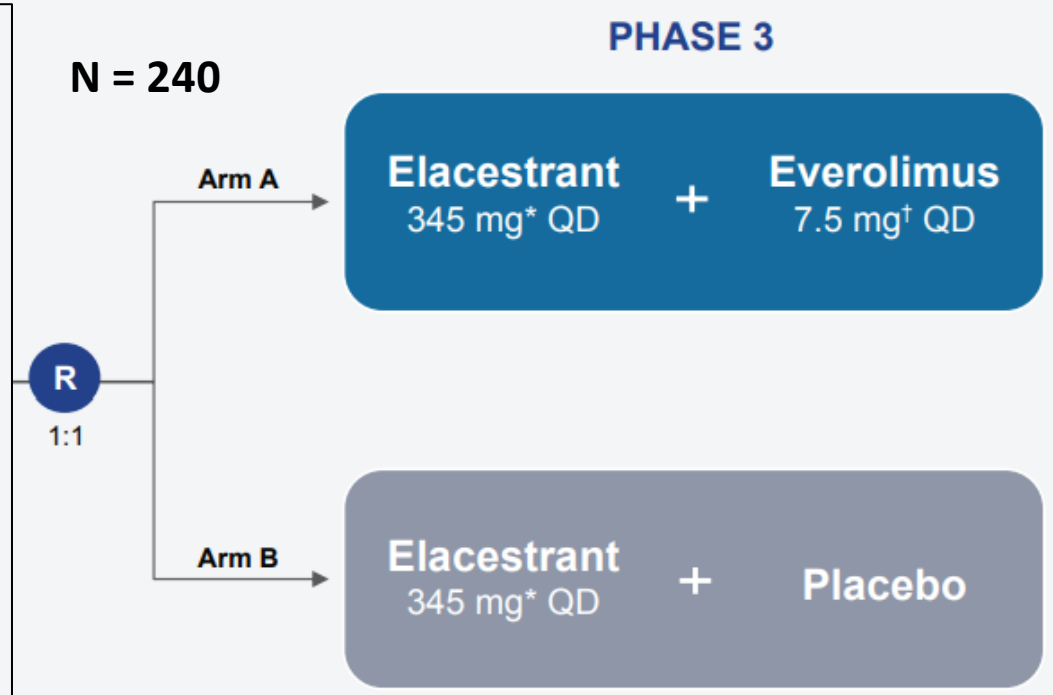
- ***ESR1* mutation (59% mature)**



Mayer E, et al. ESMO 2025. LBA16.

Phase 3 ADELA Study of Elacestrant ± Everolimus for ESR1mut, ER+/HER2– aBC After ET + CDK4/6i

- ER+/HER2– unresectable locally recurrent or metastatic disease
- Confirmed *ESR1*m
- PD on prior CDK4/6i + ET for aBC after ≥6 mo
  - Patients receiving CDK4/6i-based therapy in adj setting are eligible if PD is confirmed after ≥12 mo of treatment but < 12 mo following CDK4/6i treatment completion
- Previously received 1-2 lines of ET for aBC
  - PD during or within 12 mo of adj ET considered as a line of ET for aBC
- No prior CT for aBC
- No prior elacestrant, novel ET, and/or PI3K/AKT/mTOR inhibitors*
- ECOG PS 0 or 1
- Adequate BM and organ function



Stratification:
- Presence of visceral metastases (Y/N)
- Duration of prior CDK4/6i tx (≥12 vs <12 mo)

Endpoints

Primary: PFS by BICR

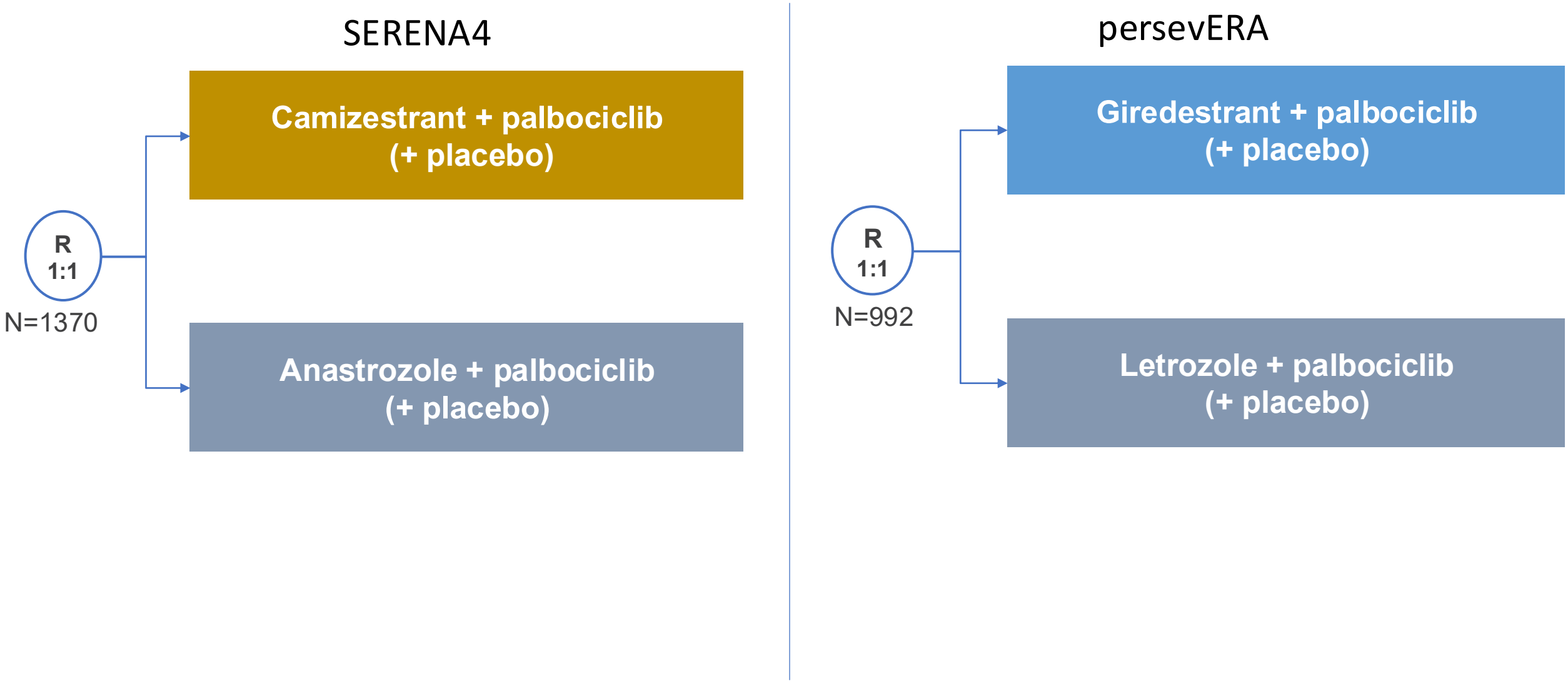
Secondary: PFS INV, OS, response, safety and HRQoL

☑ RECRUITING (NCT06382948)

*including everolimus.

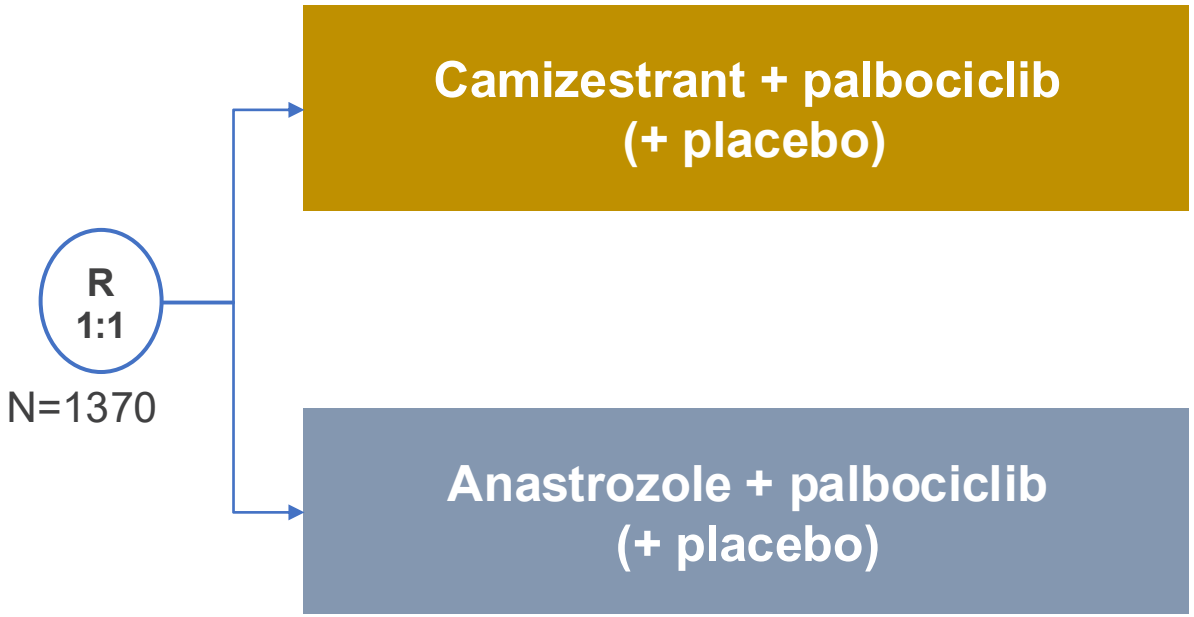
Llombart-Cussac A, et al. ASCO 2025. Abstract TPS1129.

First line oral SERD vs AI (+ CDK4/6i)

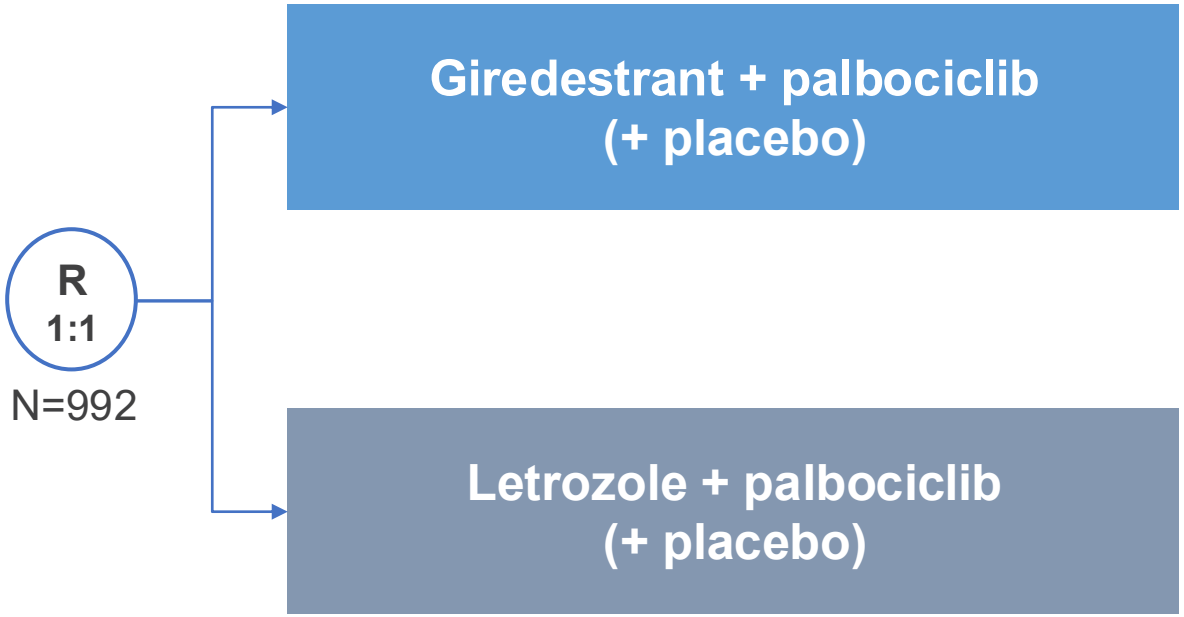


First line oral SERD vs AI (+ CDK4/6i)

SERENA4



persevERA



- March 8, 2026: persevERA did not meet the primary objective of a statistically significant improvement in PFS
- Despite this setback, giredestrant recently showed success in the Phase III lidERA trial in early-stage breast cancer, which may still support its adoption in other settings.

Case Presentation

Patient Case

54-year-old postmenopausal woman:

- Presents with persistent, worsening rib pain
- **PMH:** otherwise, healthy;
- **BMI** = 25.5 kg/m^2
- ECOG PS 0

Work-up:

- Bone scan shows lytic bone lesions in thoracic spine and ribs
- CT CAP also shows 4 lung lesions (largest 1.8 cm in diameter)
- Liver biopsy: Grade 3, ER+, PR+, HER2 IHC 1
- Labs: WNL
- Genetic testing shows no pathogenic variants
- Lung tissue NGS shows a *PIK3CA* mutation, no other actionable alterations

Treatment and response:

- She receives AI + ribociclib for 2 years (tolerates well)
- Slight growth in largest lung lesion noted on last 2 follow up CT scans; one new 1 cm lesion on latest scan
- ctDNA shows an *ESR1* mutation and a *PIK3CA* mutation, no other actionable alterations

Discussion Questions

Would you like to have access to imlunestrant/ abemaciclib for any of your patients with HR-positive, HER2-negative mBC? What about giredestrant/everolimus? If so, which ones?

In your experience, how problematic are the toxicities associated with oral SERD-containing combinations relative to oral SERD monotherapy?

Agenda

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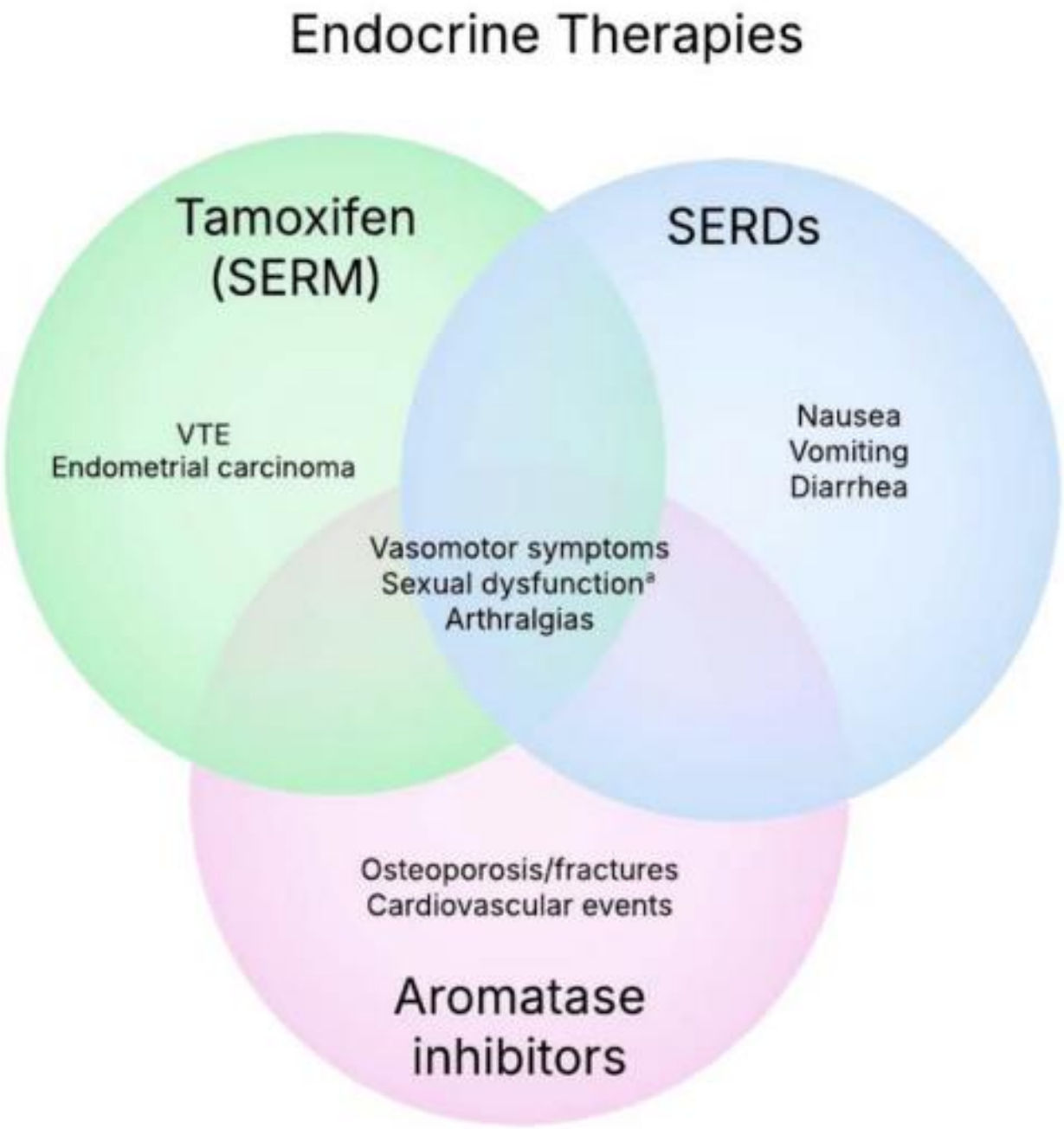
TEXAS ONCOLOGY

Gastrointestinal Adverse Events with oral SERDs

Marissa Marti-Smith
DNP, APRN, AGNP-C, AOCNP



TEXAS ONCOLOGY

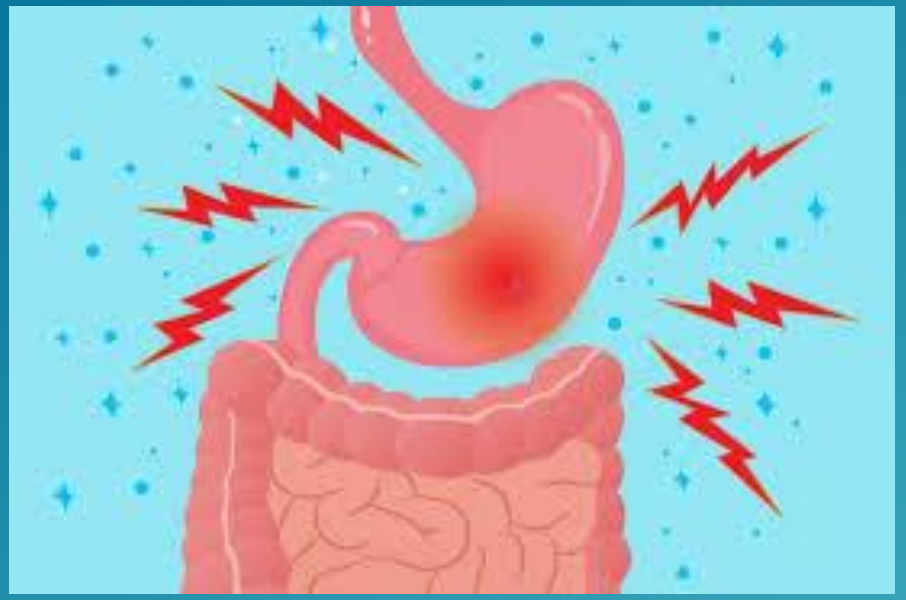
Oral SERDs overview

- ✓ Rates of GI side effects
- ✓ Mitigation strategies for GI AE's
- ✓ Nutritional counseling / diet modifications

Image from ASCO ebook (2025)

Rates of GI side effects

- **Elacestrant**
  - Well tolerated
  - Phase 3 trial -- any grade nausea (35%), vomiting (19%), diarrhea (14%)
- **Imlunestrant**
  - Very similar AE's, predominantly GI, but studied with Abemaciclib
- **Camizestrant**
  - Slightly higher rates hepatoxicity
  - Less GI toxicity observed in phase 2 & 3 trials



(LeVee et al., 2025 ASCO eBook)

Mitigation Strategies for GI related AE's

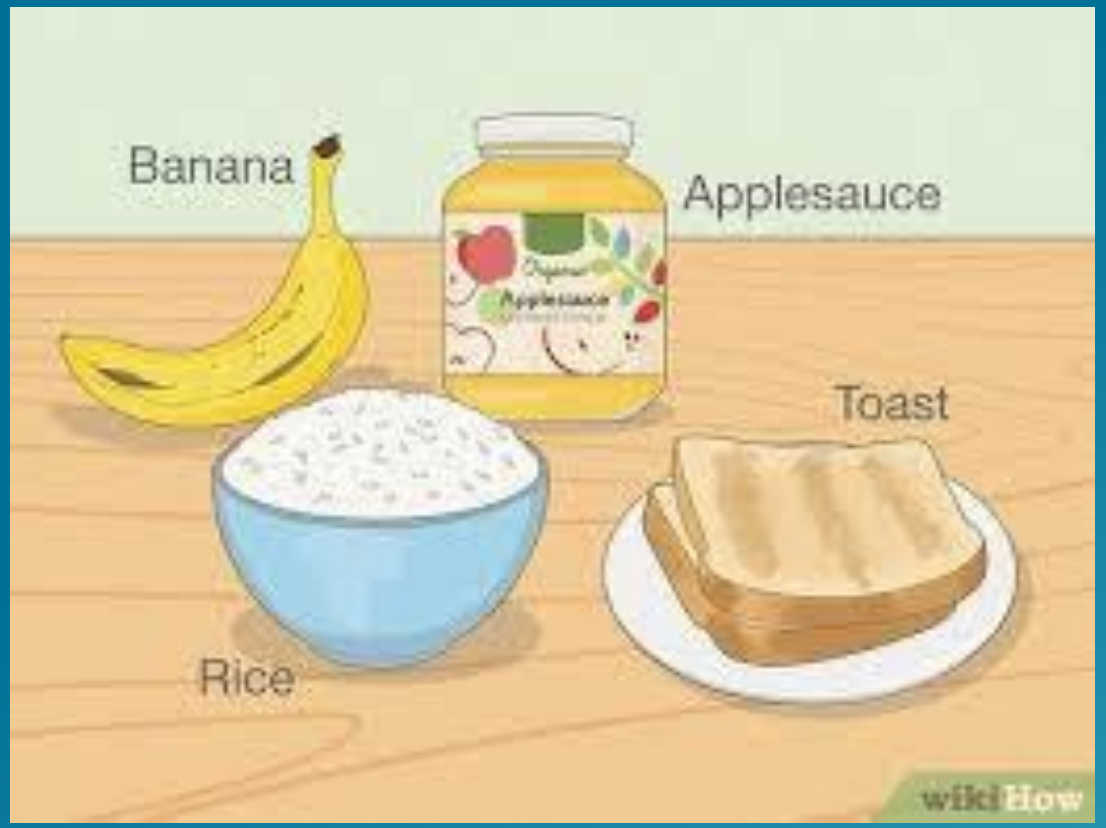
- **Elacestrant**
  - Take with food
- **Imlunestrant**
  - Empty stomach (2hrs before food) or (1hr after food)
- **Camizestrant**
  - With or without food

(Sykes et al., 2026)

Educate & Empower Patients

- Take med (if able to) with light meal to help with nausea prevention
- Pre-medicate with anti-nausea med
- Imodium PRN
- Stool softeners
- Laxative if necessary

Counseling / Diet Modifications

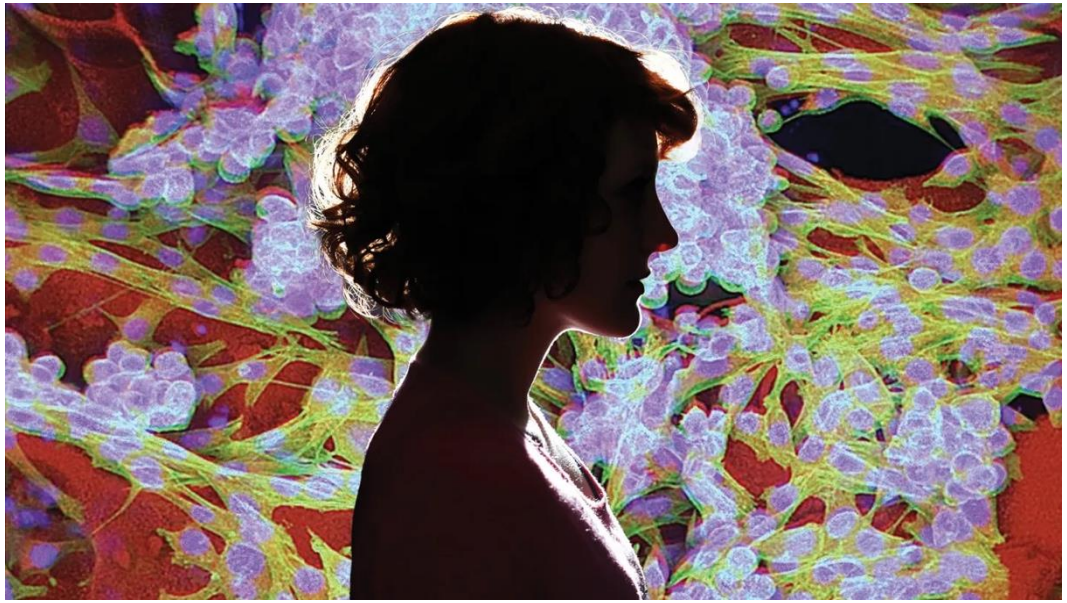


- BRAT diet
- Small meals
- Avoid triggers (greasy food, spicy, high fat)
- Room temperature foods
- Protein shakes
- Fluids w/ electrolytes
- Notify clinic with uncontrolled symptoms
  - Nausea
  - Vomiting
  - Diarrhea

Case Presentation

Case Study

- 39 yo female
- Recurrent metastatic breast CA to right lung
- 3rd line Elacestrant 345mg PO QD
- Diagnosed metastatic at age 26, chest wall recurrence w/2 pleural mets
- No children, BSO at age 26 + AI
- Changed jobs @ same time this therapy started
- Positive outlook



Management & Takeaway

- Nausea
- Pt initiated > PPI QD and probiotic
- MD initiated > Olanzapine 2.5mg @HS
- @ next f/u
  - pt declined need for Olanzapine
  - Ativan “a few days”
- Balance treatment & QOL

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Potential Role of Early Therapeutic Switching After Detection of an Emergent ESR1 Mutation

Ruth M O'Regan, MD
Charles A Dewey Professor of Medicine and Oncology
Chair, Department of Medicine
University of Rochester Medical Center
Physician-in-Chief
Strong Memorial Hospital
Associate Director of Education and Mentoring
Wilmot Cancer Institute
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PADA-1 Study: Monitoring ESR1 Mutations During First-Line Therapy

***ESR1* mutations**

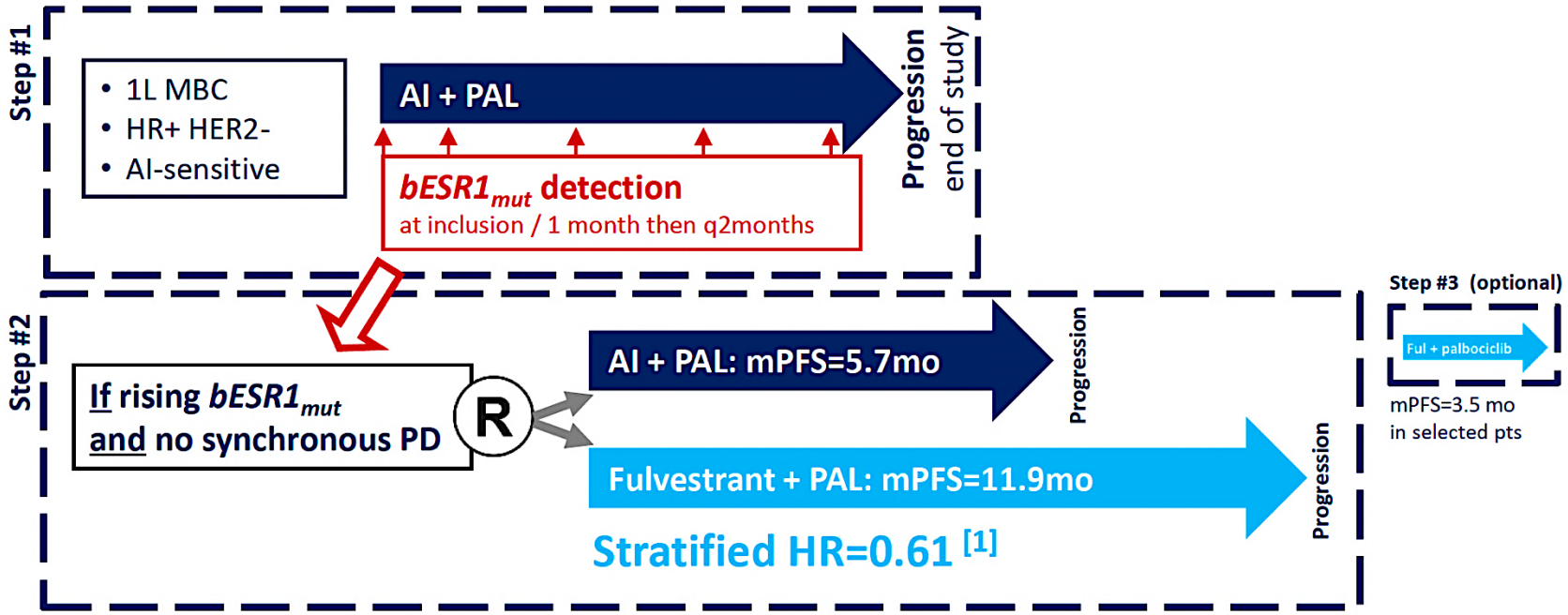
- are « *acquired* » during AI-based therapy in ~40% of ER+ HER2- mBC pts
- can be detected by ctDNA analysis
- drive resistance to AI -- not to CDK4/6i
- SERDs remain active on *ESR1mut* mBC -- but with limited efficacy after progression

PADA-1 (NCT03079011)

- 1st line academic proof-of-concept trial [1] ; largest first line CDK4/6i trial
- Aim: to detect [2] & target rising *ESR1mut* before tumor progression
  - ➔ delaying tumor progression
  - ➔ maximizing exposure to CDK4/6i

[1] Design: Berger *et al.*, BMJ Open 2022
[2] Multiplex drop-off ddPCR: Jeannot *et al.*, Oncogene 2020; QC: Callens *et al.*, Anal Chem 2022

PADA-1 Design



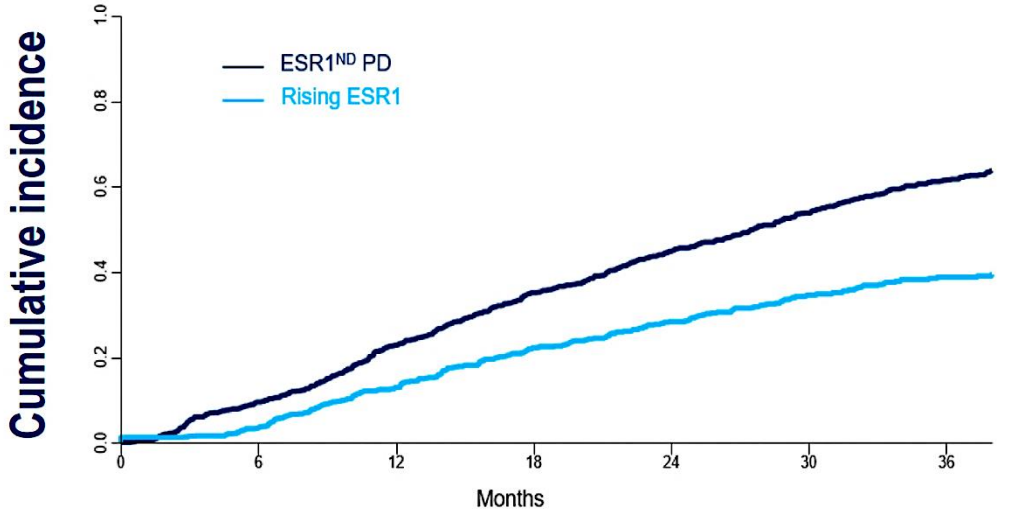
First evidence to support *ESR1mut* monitoring during the 1st line

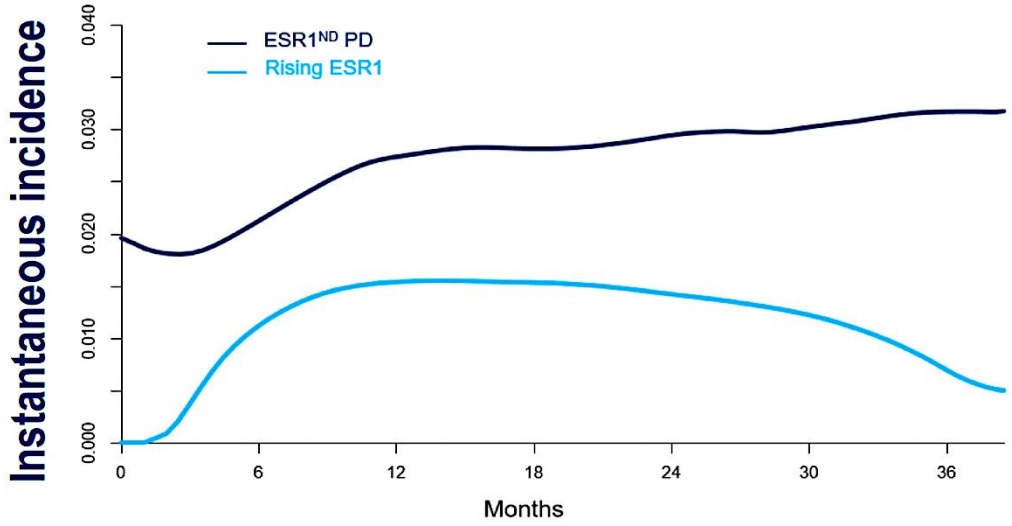
➔ **Understanding the kinetics of *ESR1mut* could help optimizing *ESR1mut* screening**

[1] Bidard *et al.*, Lancet Oncol 2022

Bidard FC et al. ESMO Breast 2025;Abstract 10.

PADA-1: Cumulative and Instantaneous Incidence of ESR1 Mutation





Bell-shaped curve

Fewer mutations detected (vs ESR1ND PD)

- before 6 months
- after 30 months

Result compatible with the selection of a minor pre-existing mutant subclone

Similar to emerging *KRASmut* kinetics in mCCR [1]

[1] Diaz *et al.*, Nature 2012

Bidard FC et al. ESMO Breast 2025;Abstract 10.

PADA-1: Conclusions

Emergence of *ESR1mut* during AI + CDK4/6i given in first line

- Overall incidence of ~40% before or at progression, but incidence is uneven over time (bell-shaped curve)
- Factors associated with more *ESR1mut* *(relative to ESR1ND PD)*: age, bone metastases, ER% and baseline LDH
- Interception of *ESR1mut* before PD is easier in mBC with bone mets and low proliferation
- → **These results may inform how to customize ESR1mut monitoring in first line**

(cross validation needed before implementation in routine practice)

Biologically, results suggest that *ESR1mut*

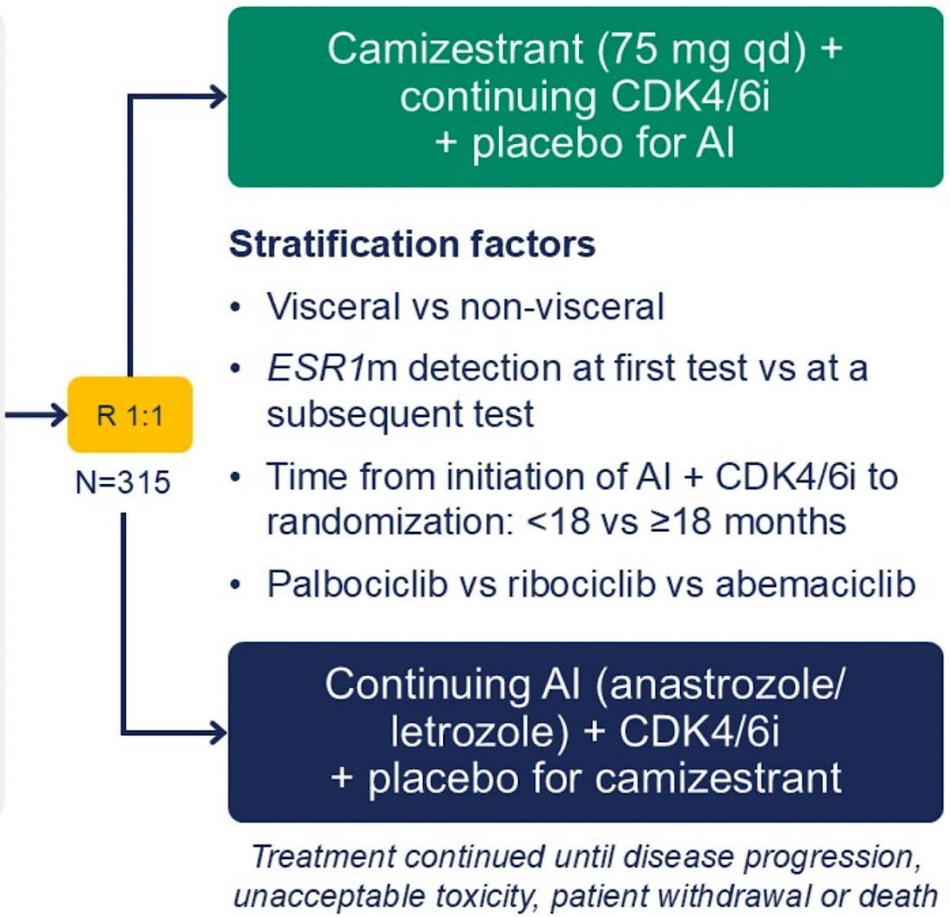
- Are selected rather than ~~acquired~~
- Reflect an oncogenic addiction to ER signalling

Bidard FC et al. ESMO Breast 2025;Abstract 10.

RTP RESEARCH TO PRACTICE

SERENA-6 Study Design

- Female/male patients with ER+/HER2– ABC*
- All patients that have received AI + CDK4/6i (palbociclib, ribociclib, or abemaciclib) as initial endocrine-based therapy for ABC for at least 6 months
- *ESR1*m detected in ctDNA with no evidence of disease progression



Primary endpoint

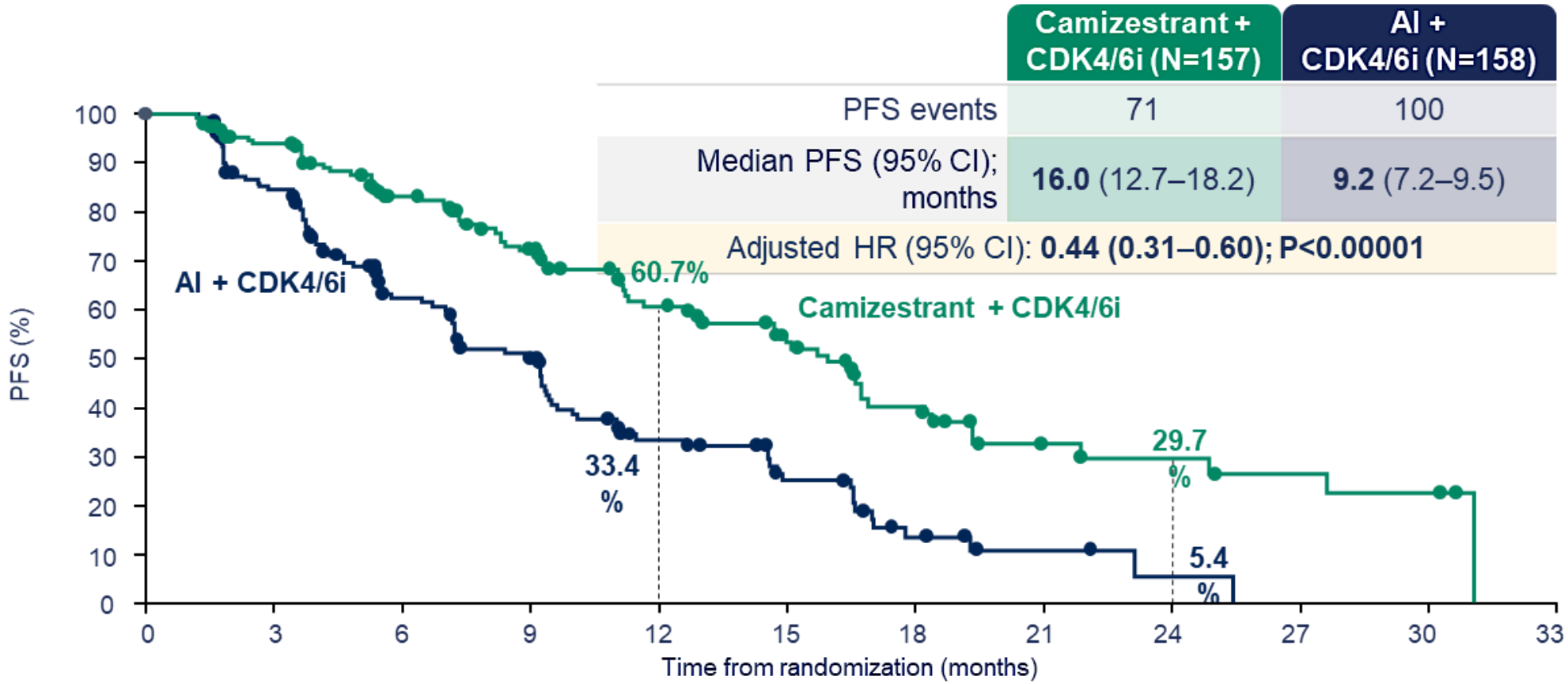
PFS by investigator assessment (RECIST v1.1)

Secondary endpoints

- PFS2**
- OS**
- Safety
- Patient-reported outcomes

Bidard F-C et al. *N Engl J Med* June 1, 2025;[Online ahead of print]. Turner N et al. ASCO 2025;Abstract LBA4.

SERENA-6 Primary Endpoint: Investigator-Assessed PFS



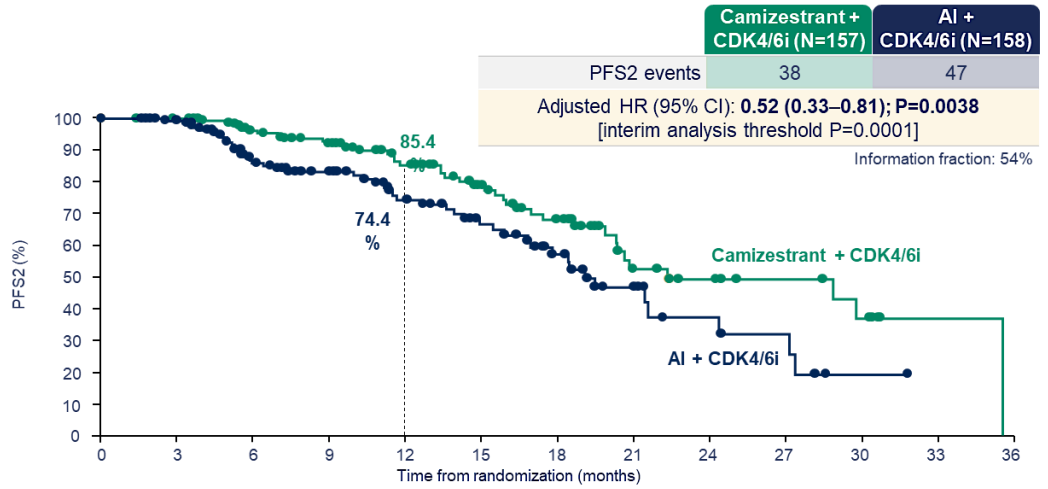
Number of patients at risk

Camizestrant + CDK4/6i	157	138	105	82	55	41	26	11	9	7	6	0
AI + CDK4/6i	158	124	73	55	29	17	7	3	1	0	0	0

Bidard F-C et al. *N Engl J Med* June 1, 2025;[Online ahead of print]. Turner N et al. ASCO 2025;Abstract LBA4.

SERENA-6 Secondary Endpoints

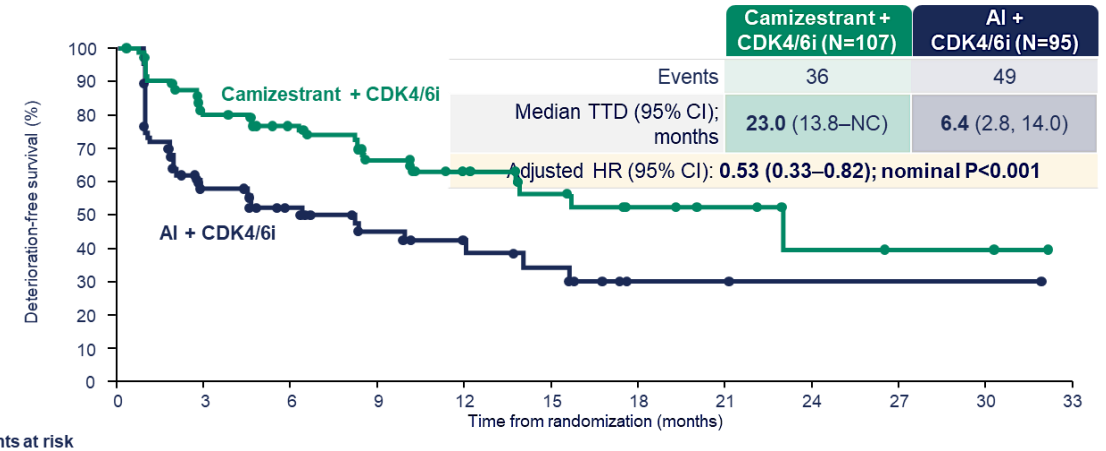
PFS-2



Number of patients at risk

Camizestrant + CDK4/6i	157	146	120	103	74	55	39	17	12	9	6	1	0
AI + CDK4/6i	158	144	98	78	55	38	25	12	7	5	1	0	0

Time to deterioration in global health status/quality of life



Number of patients at risk

Camizestrant + CDK4/6i	107	72	59	40	24	16	9	6	3	2	2	0	
AI + CDK4/6i	95	42	26	16	11	8	2	2	1	1	1	0	

Bidard F-C et al. *N Engl J Med* June 1, 2025;[Online ahead of print]. Turner N et al. ASCO 2025;Abstract LBA4.

Oncologic Drugs Advisory Committee (ODAC) Meeting: April 30, 2026

- "The morning session focused on the results of the **SERENA-6** trial, which was intended to support a new drug application (NDA) for camizestrant, an oral selective estrogen receptor degrader (SERD), for the treatment of patients with HR+/HER2- metastatic breast cancer. The committee evaluated whether a novel treatment-switching paradigm—where patients receiving an aromatase inhibitor (AI) and CDK4/6 inhibitor switched to camizestrant upon detection of an ESR1 mutation, rather than at radiographic progression—provided adequate evidence of clinically meaningful benefit on camizestrant."

- **"The committee voted 6-3 that the SERENA-6 trial did not demonstrate clinically meaningful benefit for camizestrant treatment.** Those in favor cited the magnitude of PFS improvement, the favorable early OS trend, and plausibility of the early treatment switching approach. Those opposed pointed to the trial's inability to determine whether earlier treatment switching improves patient outcomes, particularly in the absence of a statistically significant OS benefit or a crossover design to isolate treatment timing. Thus, the committee concluded that, although camizestrant appears active, the trial design could note establish whether the observed PFS gain represents a real, clinically meaningful benefit from the earlier treatment switching."

https://friendsofcancerresearch.org/blog/stakeholder-connect-insights-from-the-april-30-odac-meeting/

Discussion Questions

If the strategy evaluated in SERENA-6 were to be approved, would you use it in your own practice, and if, so for whom? How would you counsel an interested patient about the potential pros and cons of this approach?

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Agenda

Module 1: Current Clinical Role of Oral Selective Estrogen Receptor Degraders (SERDs) in HR-Positive Metastatic Breast Cancer

Module 2: Practical Considerations with Oral SERDs

Module 3: Potential Role of Combination Approaches with Oral SERDs

Module 4: Gastrointestinal Adverse Events Documented with Oral SERDs

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Module 6: Other Class-Effect Toxicities Associated with Oral SERDs

Module 7: Emerging Utility of Adjuvant Oral SERDs

Module 8: Unique Toxicities Associated with 1 or More Oral SERDs

UCLA Health | David Geffen School of Medicine

Class-Effect Toxicities Associated with Oral SERDs

Blanca Ledezma, MSN, NP, AOCNP

Class-Effect Toxicities Associated with Oral SERDs

UCLA Health

Common Adverse effects

- Nausea / Vomiting
- Diarrhea
- Musculoskeletal pain
- Fatigue
- Myelosuppression: anemia, neutropenia, thrombocytopenia
- Dyslipidemia

Other Side Effects

- headache, dizziness, hot flashes, elevated liver enzymes

Elacestrant, PI 2023
Imlunestrant,PI 2025

Elacestrant: Adverse Effects & Lab Abnormalities Monotherapy

UCLA Health

Frequency of Most Common Toxicities

	All Grades (%)	Grade 3/4 (%)
• Musculoskeletal Pain	41	7
• Nausea	35	2.5
• Cholesterol increased	30	1
• ALT increased	29	0
• Triglycerides increased	27	2
• Hemoglobin decreased	26	1
• Fatigue	26	2
• Vomiting	19	0.8
• ALT increased	17	0

Elacestrant, PI 2023

Imlunestrant: Adverse Effects & Lab Abnormalities Monotherapy

UCLA Health

Frequency of Most Common Toxicities

	All Grades (%)	Grade 3/4 (%)
• Musculoskeletal Pain	30	3.7
• Hemoglobin decrease	30	1.2
• Neutrophils decrease	26	4
• AST increased	25	1.9
• Triglycerides increased	21	0
• ALT increased	21	1.3
• Fatigue	23	0.3
• Diarrhea	22	0.6
• Nausea	17	0.3
• Platelet decreased	16	1.8
• Cholesterol increased	10	0

Imlunestrant, PI 2025

Management of Cytopenias

UCLA Health

- Obtain baseline CBC prior to oral SERD initiation
- Repeat CBC every 4–12 weeks during early therapy or per institutional guidelines
- Dose interruption or dose reduction for clinically significant cytopenias *(rare)*
- Resume therapy after hematologic recovery *(rare)*
- Growth factor support may be considered for severe neutropenia *(rare)*
- Transfusion support may be appropriate for symptomatic anemia or thrombocytopenia *(rare)*
- Evaluate for marrow infiltration, nutritional deficiencies, or concomitant medications

Elacestrant, PI 2023
Imlunestrant,PI 2025

Management of Musculoskeletal Pain

- Encourage physical activity, stretching, and low-impact exercise
  - Yoga
- Use acetaminophen or NSAIDs when clinically appropriate
- Consider physical therapy, massage, or acupuncture
- Evaluate for metastatic disease causes if symptoms worsen
- Dose hold and dose modification may be required for persistent Grade ≥2 symptoms

Franzoi MA.,Lancet Oncol. 2021
NCCN (2026) Survivorship Pain

Management of Fatigue

- Assess contributing causes: anemia, sleep disturbance, depression, endocrine dysfunction
- Nutritional deficits: electrolyte imbalance
- Promote sleep hygiene and energy conservation strategies
- Recommend structured exercise programs when feasible
- Optimize management of pain and concurrent medications
- Consider dose hold or dose reduction for severe fatigue

NCCN (2026) Cancer Related Fatigue

Dyslipidemia

- Elacestrant has a boxed-level warning for dyslipidemia in its label
- Elacestrant / Imlunestrant
  - Obtain baseline lipid levels
  - Periodically evaluate while on treatment or as clinically indicated

Baseline:	Fasting lipid panel before initiating the oral SERD
Early follow-up:	Repeat at 4–8 weeks
Ongoing:	Every 3–6 months while on therapy, or more frequently if abnormalities are detected

Elacestrant, PI 2023
Imlunestrant, PI 2025

Key Takeaways

- Oral SERDs are associated with manageable toxicities
- Toxicities are predominately grade 1/2
- Routine CBC monitoring supports early identification of cytopenias and other lab abnormalities
- Dose modifications and supportive interventions are central to toxicity management
- Comprehensive supportive care improves tolerability and treatment continuation
- Nurses / APP's are the frontline for early symptom detection and patient education to maintain treatment adherence and patient quality of life

Elacestrant, PI 2023

UCLA Health | David Geffen School of Medicine

Case Presentation

Blanca Ledezma, MSN, NP, AOCNP

Case Presentation

UCLA Health

- Age: 42 years old single female, no children, has a dog and sister is main support

•**Diagnosis**: stage IIA (T2N0M0) ER-positive, PR-positive, HER2-negative (IHC 1+), ESR1 D538G mutated, with bone and liver metastasis.

•**Treatment History:**

- •Adjuvant radiation
- •**Tamoxifen with goserelin** – *Patient started treatment and then stopped after 3 months as she she felt well and did not need to be on treatment*
- •Follow-up scans 9 months after tx d/c, demonstrate multiple osseous metastases (thoracic and lumbar spine, bilateral iliac bones) and two small hepatic lesions (1.2 cm and 0.8 cm)
- •Biopsy of liver confirmed metastatic disease
- •**Tamoxifen / abemaciclib** + goserelin & zoledronic acid→ PD after 14 months at current sites of disease with enlargement of existing bone metastases. Liquid biopsy confirmed **ESR1 D538G** mutation. No PIK3CA
- •**Imlunestrant** + goserelin & zoledronic acid

- **Comorbidities:**
  - No significant PMH

Case Presentation

UCLA Health

- **Supportive care strategies**
  - Diarrhea (grade 1) managed with loperamide
  - Musculoskeletal discomfort (grade 2) NSAIDs help control discomfort but does not like taking medications
    - Started yoga
    - At home stretching videos
  - She is tolerating the oral regimen well and has been compliant and not missed a dose
  - Using phone alarm for treatment reminder

- **Current status:**
  - 3 months after treatment start CT shows stable disease with slight reduction in hepatic lesions. Bone scan is stable

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RTP RESEARCH TO PRACTICE

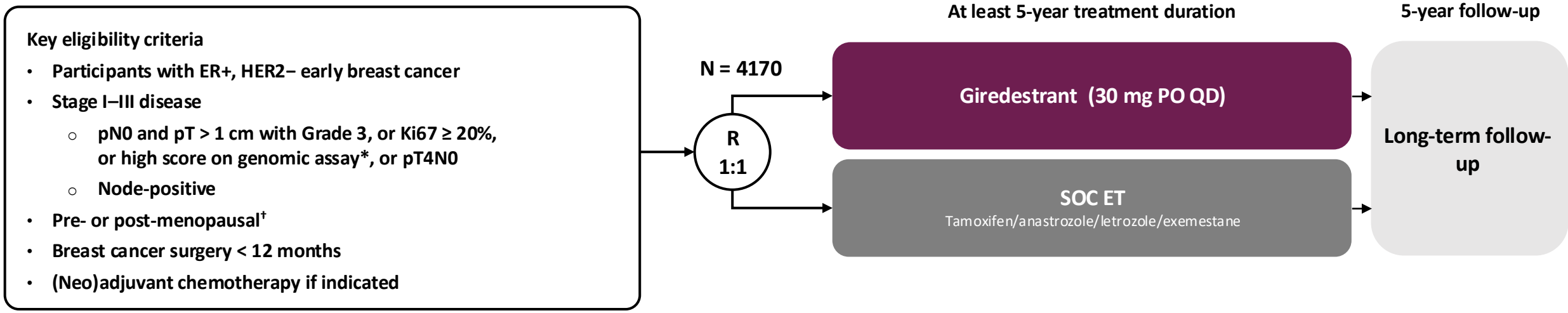
Emerging Utility of Adjuvant Oral SERDs

Heather McArthur, MD, MPH, FASCO
Professor, Department of Internal Medicine
Clinical Director, Breast Cancer Program
Komen Distinguished Chair in Clinical Breast Cancer Research
UT Southwestern Medical Center
Dallas, Texas

Oral SERD Adjuvant Trials

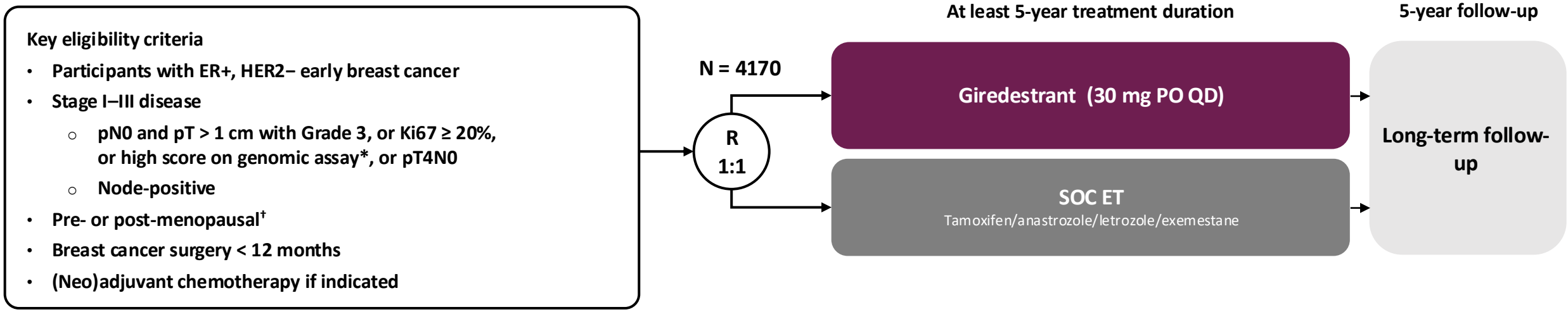
Trial Name	N	Arms	Patient Population	Adjuvant CDK4/6i allowed	Trial Identifier
CAMBRIA-2	5500	Camizestrant vs ET	High-risk ER+/HER2-, **first adjuvant therapy**	Yes	NCT05952557
lidERA	4200	Giredestrant vs ET	Medium to high-risk ER+/HER2-, **first adjuvant therapy**	No	NCT04961996
ELEGANT	4220	Elacestrant vs SoC	ER+/HER2-, Early Breast Cancer With High Risk of Recurrence; **2-5y of prior ET**	Prior to trial entry	NCT06492616
EMBER-4	6000	Imlunestrant vs ET	High-risk ER+/HER2-, **2-5 yr of adjuvant ET**	Prior to trial entry	NCT05514054
CAMBRIA-1	4300	Camizestrant vs ET	Intermediate to high-risk ER+/HER2-, **2-5 yr of adjuvant ET**	Prior to trial entry	NCT05774951
TREAT ctDNA	220	Elacestrant vs ET	↑ risk ER+/HER2-, ctDNA relapse, **2-7 yr adjuvant ET**	≥12 mo prior to trial entry	NCT05512364

lidERA Trial Design



Bardia A et al. SABCS 2025;Abstract GS1-10

lidERA Trial Design



- Stage I allowed (high risk)
- Premenopausal: giredestrant + OFS
  - SOC = AI (+ OFS) or tamoxifen (OFS not required)
- Prior ET including CDK4/6i x 12 weeks allowed
- No combination with CDK4/6i during trial

Bardia A et al. SABCS 2025;Abstract GS1-10

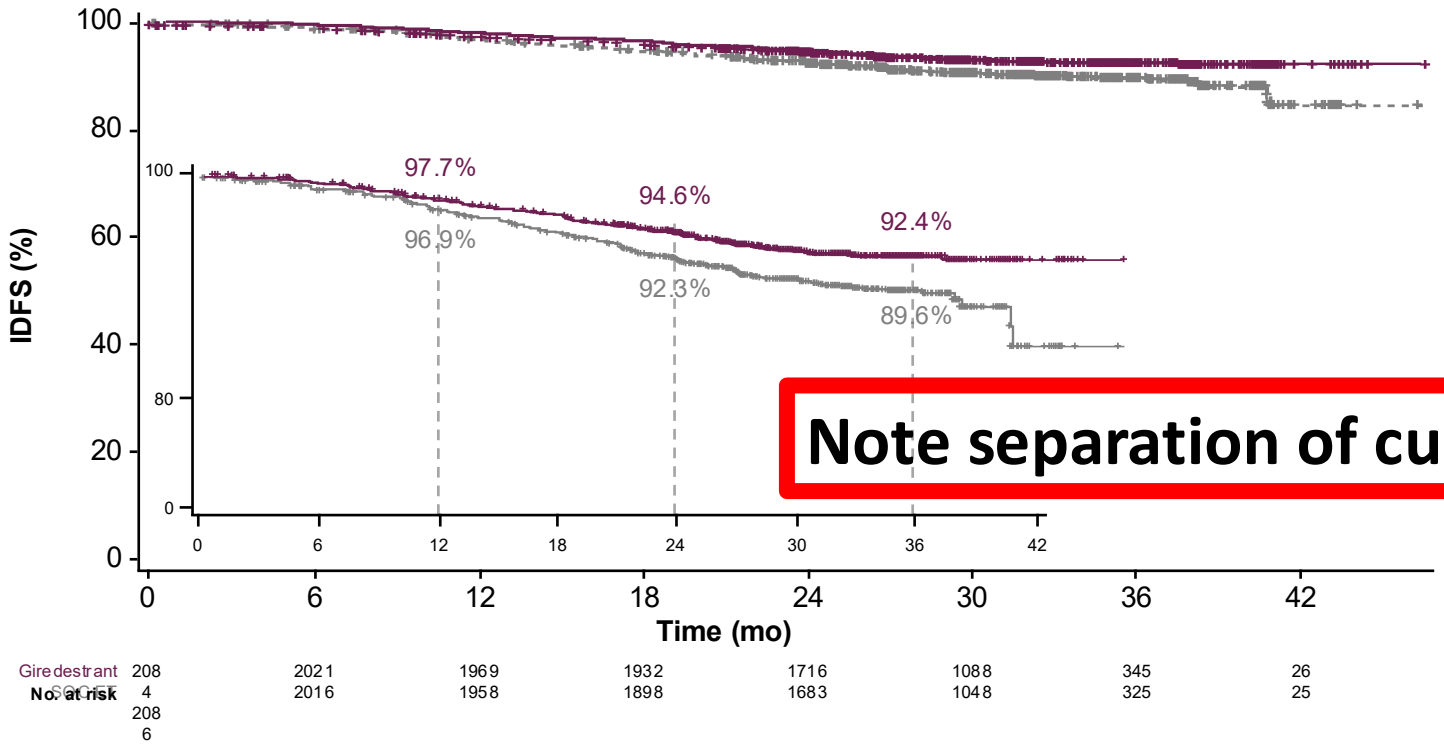
Participant Characteristics

	Giredestrant n = 2084	SOC ET n = 2086
Median age, years (range)	54.0 (22–91)	54.0 (25–89)
Female sex, n (%)	2073 (99.5)	2075 (99.5)
Race, n (%)		
American Indian or Alaska Native	77 (3.7)	62 (3.0)
Asian	461 (22.1)	467 (22.4)
Black or African American	50 (2.4)	50 (2.4)
Other*	263 (12.6)	232 (11.1)
White	1233 (59.2)	1275 (61.1)
Region, n (%)		
Asia–Pacific	544 (26.1)	544 (26.1)
USA/Canada/Western Europe	860 (41.3)	905 (43.4)
Latin America/Africa/Eastern Europe	680 (32.6)	637 (30.5)
Menopausal status, n (%)		
Pre-menopausal	849 (41.0)	838 (40.4)
Post-menopausal	1220 (59.0)	1236 (59.6)

	Giredestrant n = 2084	SOC ET n = 2086
ER status, n (%)	n = 2075	n = 2083
Low positive (1–10% of cells positive)	45 (2.2)	52 (2.5)
Positive (> 10% of cells positive)	2030 (97.8)	2031 (97.5)
AJCC stage at surgery, n (%)†	n = 2066	n = 2078
I	254 (12.3)	283 (13.6)
II	1013 (49.0)	950 (45.7)
III	799 (38.7)	844 (40.6)
Nodal status, n (%) on surgical specimen‡	n = 2079	n = 2085
pN0	449 (21.6)	441 (21.2)
pN1	968 (46.6)	953 (45.7)
pN2–3	662 (31.8)	691 (33.1)
Risk, n (%)		
High	1448 (69.5)	1447 (69.4)
Medium	636 (30.5)	639 (30.6)
Prior chemotherapy, n (%)		
No	396 (19.0)	450 (21.6)
Yes	1688 (81.0)	1636 (78.4)

Baseline demographics and characteristics were balanced

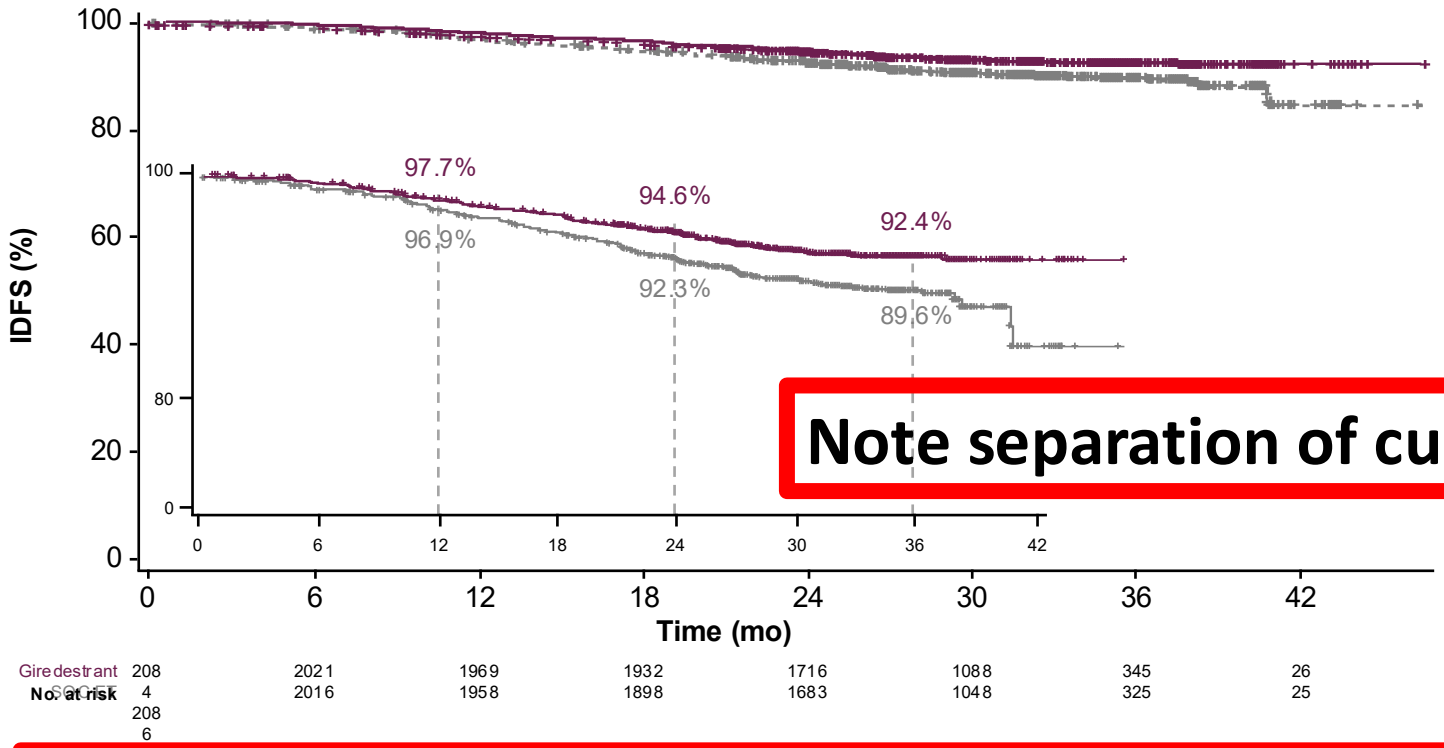
IDFS (randomized patients)



	Giredestrant n = 2084	SOC ET n = 2086
Events, n (%)	140 (6.7)	196 (9.4)
Median, mo (range)	**NE** (0.0,* 46.5*)	**NE** (0.0,* 46.3*)
Stratified HR (95% CI)	**0.70** (0.57, 0.87); p = 0.0014†	

Note separation of curves (although few data at 3y)

IDFS (randomized patients)



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Note separation of curves (although few data at 3y)

Absolute difference 2.8% @ 2.75y

Same direction for clinically important endpoints (e.g. DRFS 2.1% difference)

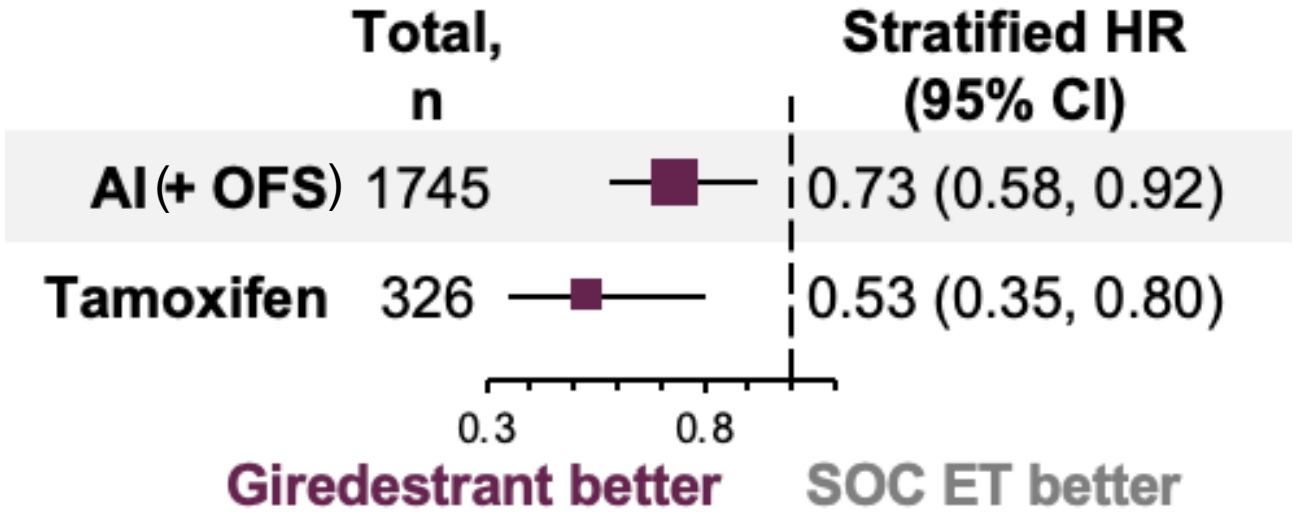
Medium risk group has few events (HR 0.74, 0.42-1.31)

Bardia A et al. SABCS 2025;Abstract GS1-10

lidERA Control ET Was Not Modern Therapy

Giredestrant IDFS vs SOC ET type* (16% Rx tamoxifen)

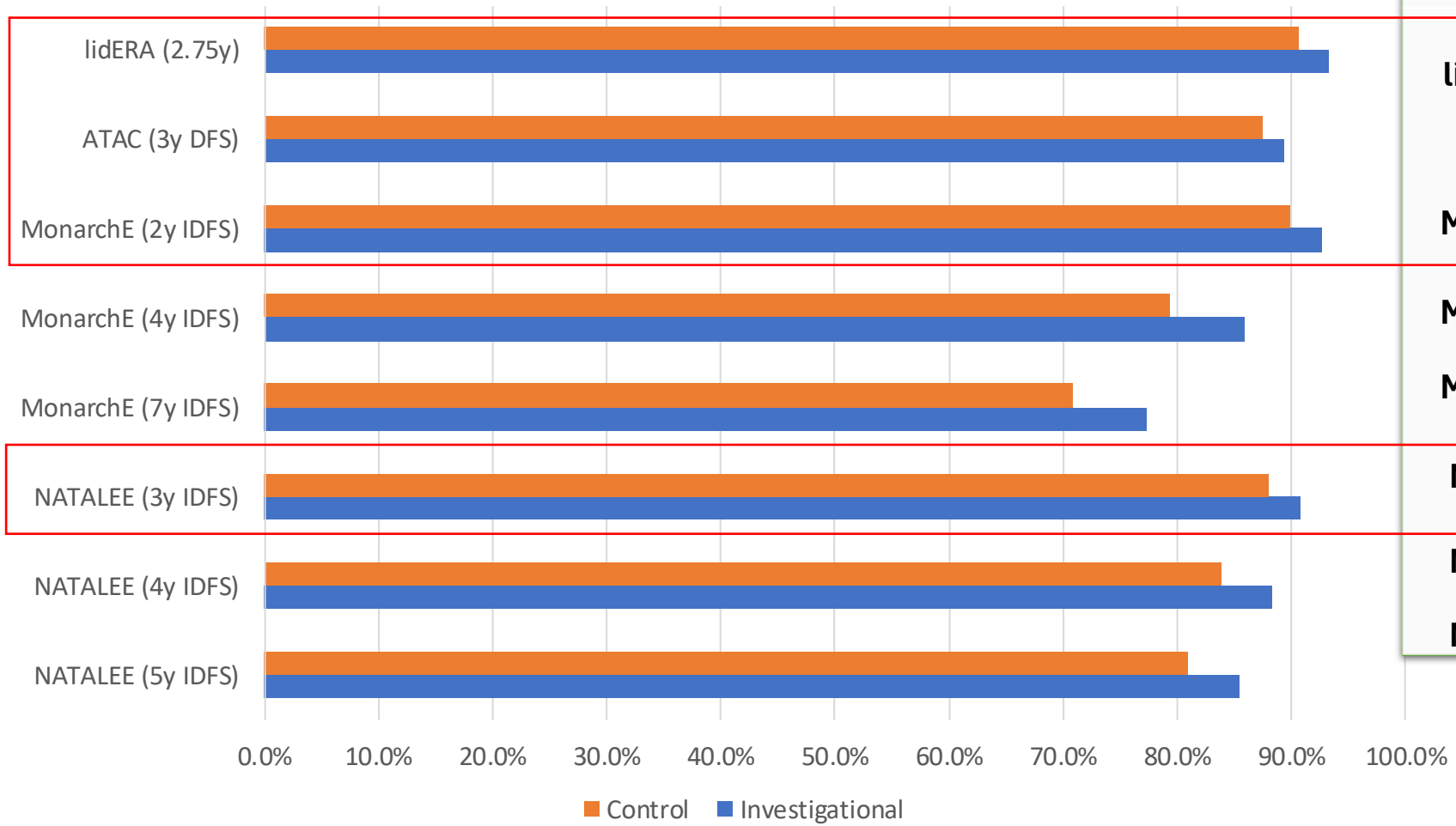
*exploratory analysis



Bardia A, SABCS 2025

Nearly 80% were node-positive, >30% N2-3
None received CDK4/6 inhibition

lidERA in Context of Other Adjuvant Advances



	absolute △	HR
lidERA (2.75y)	2.8%	0.70
ATAC (3y)	2.0%	0.83
MonarchE (2y)	2.8%	0.75
MonarchE (4y)	6.4%	0.66
MonarchE (7y)	6.5%	0.73
NATALEE (3y)	2.7%	0.75
NATALEE (4y)	4.4%	0.72
NATALEE (5y)	4.5%	0.72

Bardia A, SABCS2025; ATAC Trialists, Lancet 2005; Johnston S, JCO2020; Lancet Oncol 2023; ESMO2025; Hortobagyi G, Ann Oncol2025; Fasching PA, JAMA Oncol 2025; Crown J, ESMO2025

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Summary

- First improvement in adjuvant endocrine therapy in 20 years!
  - ~ 30% proportional improvement in IDFS and other endpoints
  - Absolute IDFS differences < 3% at 32m, likely to grow
- Combination data with CDK4/6i not yet available.
  - Given benefit in high-risk patients, continue AI + CDK4/6i during initial 2-3y
  - Need to determine if giredestrant benefit is additive to CDK4/6i benefit
- No predictive biomarkers to tailor therapy (besides ER) so lidERA has broad clinical implications
  - Biomarkers and models to guide decision-making will be crucial

Discussion Questions

If adjuvant giredestrant were available, for which patients would you prioritize its use? How would you select between giredestrant monotherapy and CDK4/6 inhibitor/endocrine therapy combinations for patients eligible to receive both?

How is adjuvant giredestrant tolerated compared to standard adjuvant endocrine therapy? Would your approach to counseling/education for patients receiving an oral SERD in the adjuvant setting differ from that for metastatic disease?

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RTP RESEARCH TO PRACTICE

TEXAS ONCOLOGY

Unique Toxicities Associated with One or More Oral SERDs

Marissa Marti-Smith
DNP, APRN, AGNP-C, AOCNP

TEXAS ONCOLOGY

SERD overview

- ✓ Hyperlipidemia
- ✓ Other lab abnormalities
- ✓ Cardiac AE’s
- ✓ Visual disturbances

Lipid monitoring

- **Elacestrant**, EMERALD 3 trial
- Hypercholesterolemia (30%), Grade 3/4 (0.9%)
- Hypertriglyceridemia (27%), Grade 3/4 (2.2%)
- Other SERDs (such as **Camizestrant**, **Giredestrant**, and **Imlunestrant)**
  - comparable or slightly elevated risks of dyslipidemia in early trial data, consistent with the broader class effect
- Baseline & “Periodic” monitoring
- Prevention, patient education on diet, exercise

(Shah et al., 2024), (Elacestrant PI, 2026).

Lab monitoring

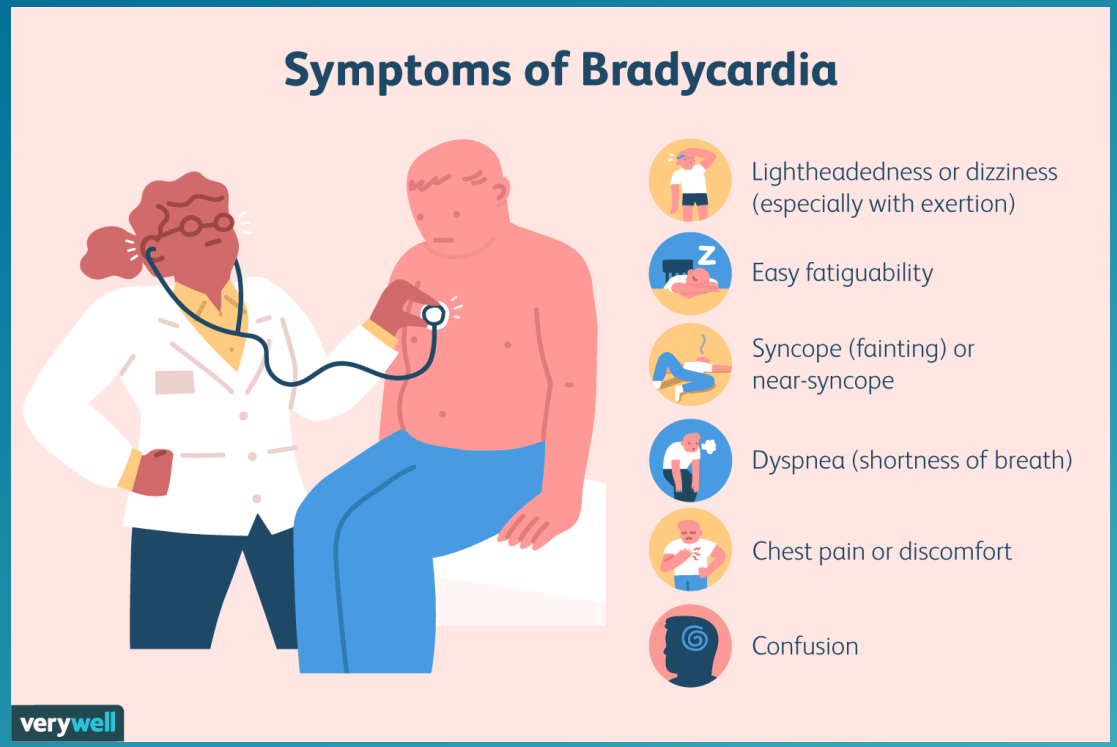
- **Elacestrant**
  - ↑ LFTs , AST (29%), ALT (17%)
  - CBC ~ decreased hgb (26%)
  - CMP (↑ creatinine, low Na+) (16%)
- **Imlunestrant**
  - ↑ LFTs, AST (25%), ALT (21%)
  - CBC ~ decreased hgb (30%), ANC (26%), Plts (16%)
  - CMP ~ low Ca+ (26%)

(Imlunestrant PI, 2025), (Elacestrant PI, 2026)

Cardiac AE's

Camizestrant (not yet approved)

- **Bradycardia:** SERENA-6, sinus bradycardia was ~7.7% *Severity:*
- The vast majority of these events are **Grade 1 or 2** (asymptomatic or mildly symptomatic).
- Median HR ↓ ~ 14 beats per minute.
- Concern combo therapy w/ QT prolonging drugs, synergistic risk
- **ECGs (frequent w/trials), CMP, Mg+**



(U.S. FDA, 2026).

AE's

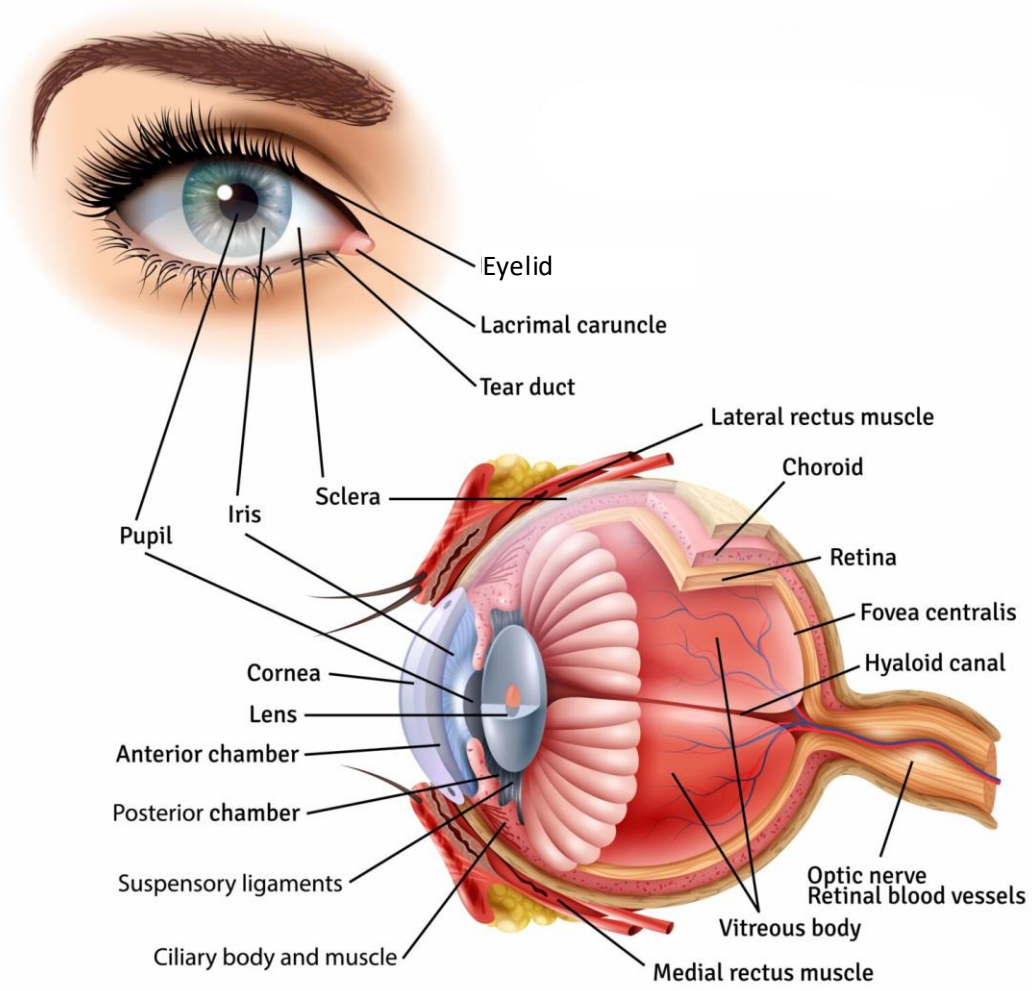
Giredestrant (not yet approved)

- **Bradycardia: evERA trial:**
- bradycardia Grade 1/2 (mild to moderate) was observed in **3.8%** of patients receiving the giredestrant combination, compared to 0.5% in the SOC arm.
- **No reports of Grade 3 or 4 (severe) bradycardia**.
- No photopsia (visual disturbances)

(Mayer et al., 2025)

Visual Disturbances

- **Incidence: 32%** of patients taking camizestrant in combination with a CDK4/6 inhibitor.
- Photopsia **12% to 20%** of patients, depending on the trial and dose
- SERENA-6 trial, 90% **Grade 1**, and 8% were Grade 2.
- **Onset and Duration:** median time to onset is roughly 8 days
- Symptoms: transient, reversible



(Brufsky et al., 2026).

Visual Disturbances

- **Education re: photopsia**
- Often transient and tend to occur when transitioning from dark to bright environments.
- When to seek medical attention
  - Severe, continuous vision changes or blurring.
  - If symptoms progress, unsafe completing daily tasks.

Case Presentation

Case Study

- 76 yo female
- MBC, extensive bone only disease
- 2nd line, Phase 1/2 Study, q2 week checks
- Elacestrant 345mg PO QD + EP0062 (Vosilasarm) 5mg PO BID
- Selective Androgen Receptor Modulator
- ~4 months into therapy
- Responding well, tolerating well
- LDL 271 (298 month prior), HDL 37
- Trigs normal, LFTs mildly elevated

Management & Takeaway

- Atorvastatin 10mg PO QD
- Dietary changes
- Exercise
- Communion wine, "sip" daily
- Avoiding hepatotoxic medications
- 2 mo later, LDL 90, HDL 36
- AST 54, ALT 72, Alk phos normal

Thanks for all you do as Oncology nurses!

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 up to 5 minutes after the meeting ends.

To Claim NCPD Credit

In-person attendees: Please refer to the program syllabus for the NCPD credit link or QR code.

Virtual attendees: The NCPD credit link is posted in the chat room.

NCPD/ONCC credit information will be emailed to each participant within 1 to 2 business days.

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