Clinical Investigators Discuss the Management of Metastatic Triple-Negative Breast Cancer

Pilot Project of an Innovative CME Tool

A CME/MOC-Accredited Live Webinar

Thursday, November 19, 2026
5:00 PM – 6:00 PM ET

Faculty

Rita Nanda, MD
Joyce O'Shaughnessy, MD

Moderator

Neil Love, MD

RTP RESEARCH TO PRACTICE

Faculty



Rita Nanda, MD
Director, Breast Oncology
Associate Professor of Medicine
Section of Hematology/Oncology
The University of Chicago
Chicago, Illinois

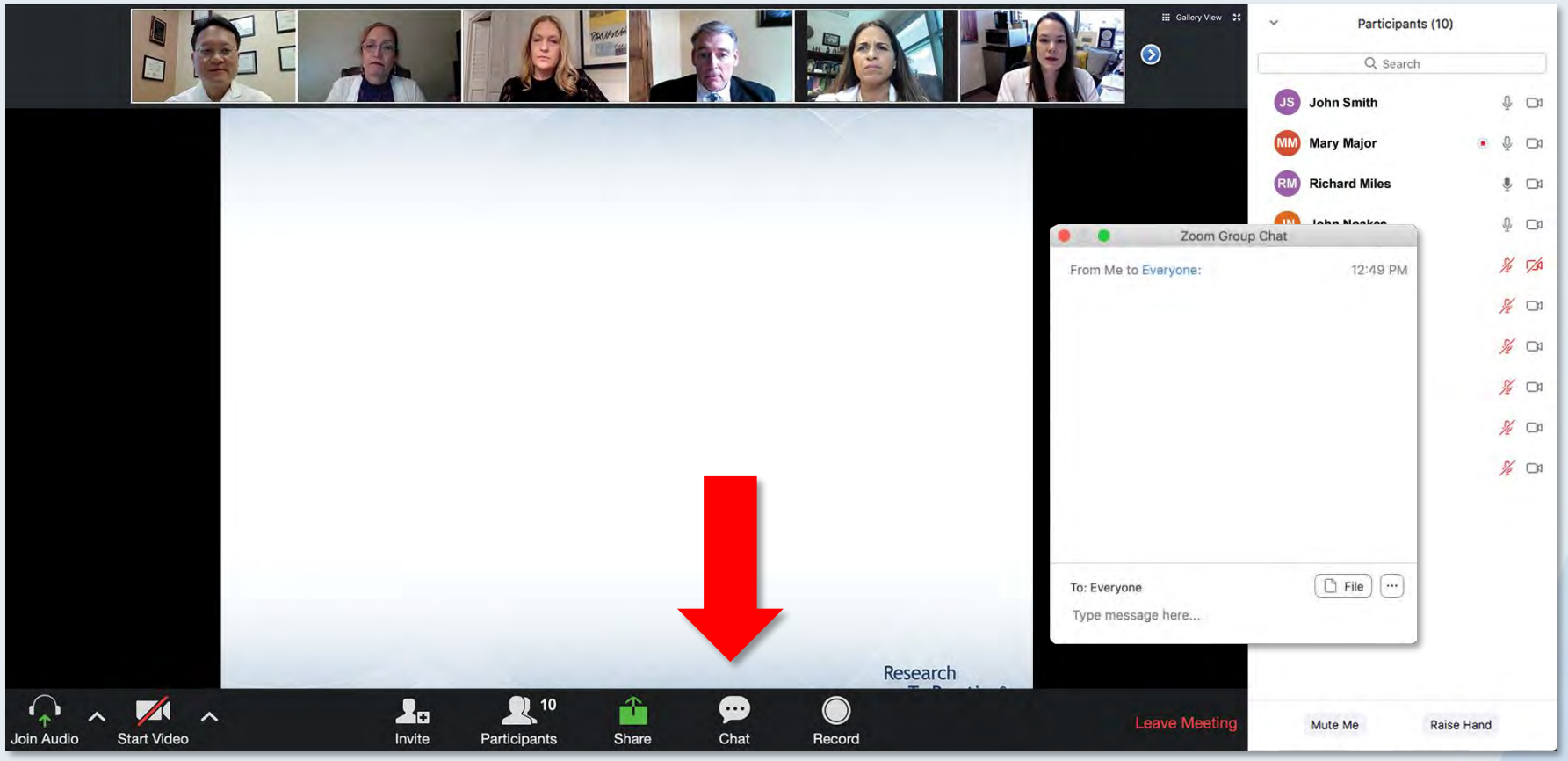


MODERATOR
Neil Love, MD
Research To Practice
Miami, Florida



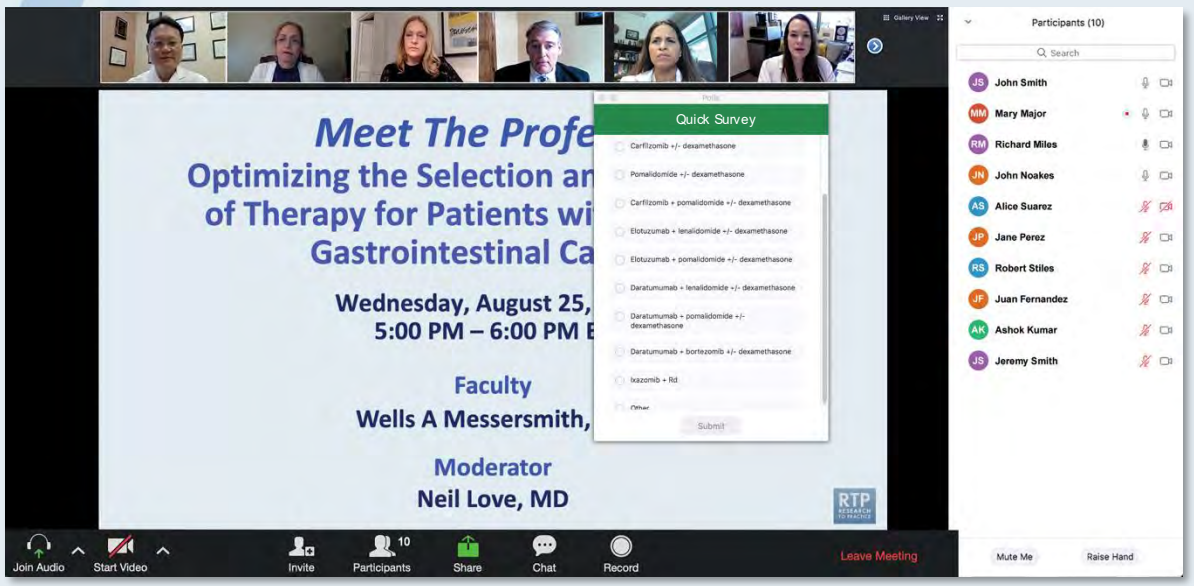
Joyce O'Shaughnessy, MD
Celebrating Women Chair in Breast Cancer Research
Baylor University Medical Center
Director, Breast Cancer Research Program
Texas Oncology
Sarah Cannon Research Institute
Dallas, Texas

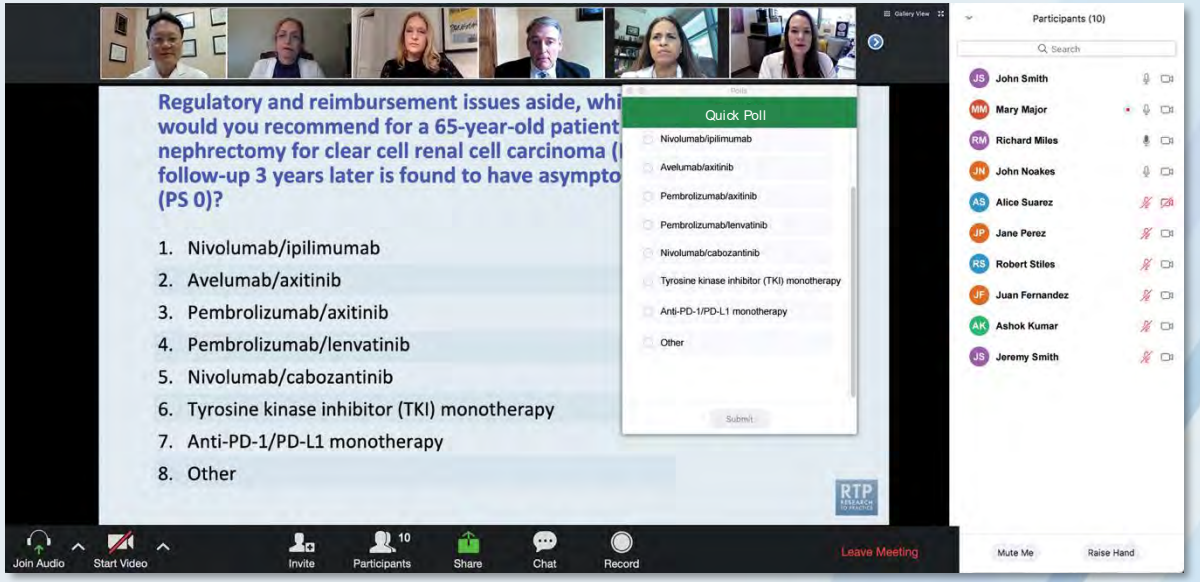
We Encourage Clinicians in Practice to Submit Questions



Feel free to submit questions now before the program begins and throughout the program.

Clinicians in the Audience, Please Complete the Pre- and Postmeeting Surveys





ONCOLOGY TODAY

WITH DR NEIL LOVE

Hormone Receptor-Positive Localized Breast Cancer — A Grand Rounds Activity

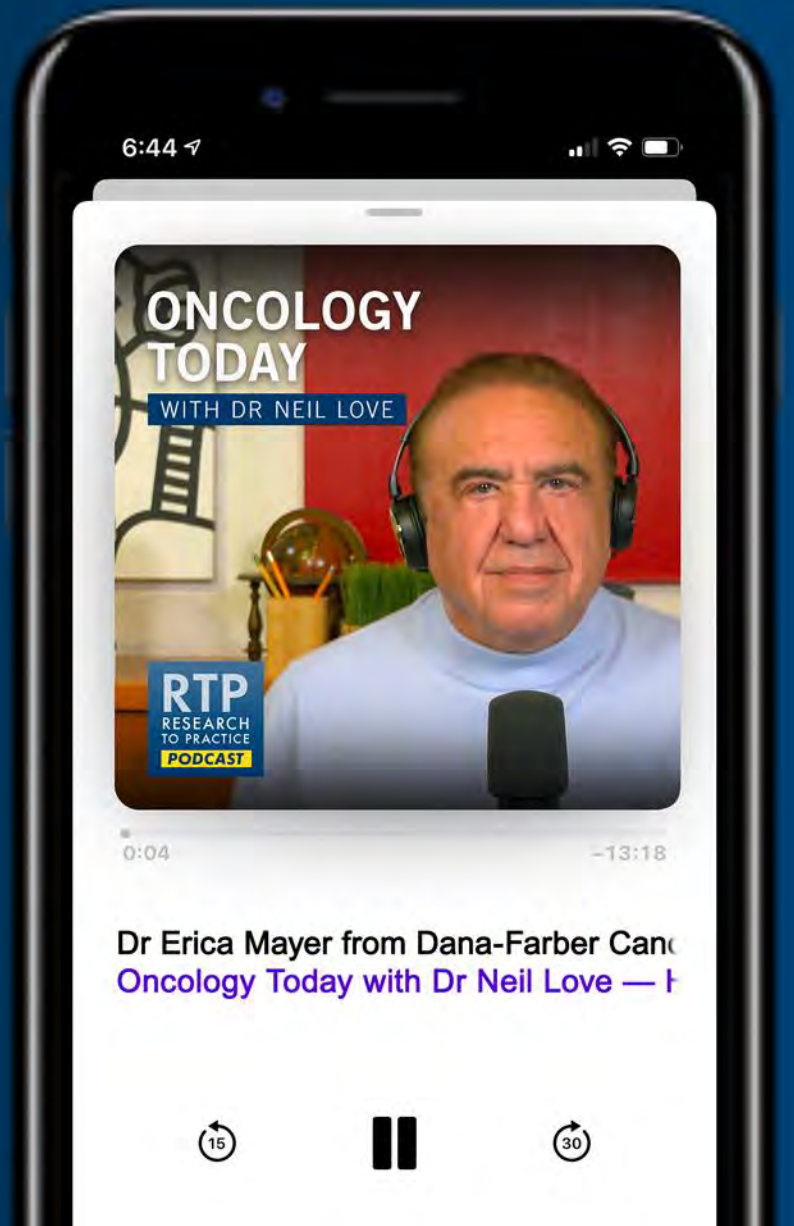


ERICA MAYER, MD, MPH, FASCO
DANA-FARBER CANCER INSTITUTE

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Second Opinion: A Case-Based Exploration of Clinical Investigator Best Practices Related to the Management of Breast Cancer

A CME Satellite Symposium Series in San Antonio

HER2-Positive Breast Cancer

Tuesday, December 8, 2026

7:00 PM – 9:00 PM CT

PI3K/AKT/mTOR Inhibitors for HR-Positive Breast Cancer

Tuesday, December 8, 2026

7:00 PM – 9:00 PM CT

Triple-Negative Breast Cancer

Wednesday, December 9, 2026

7:00 PM – 9:00 PM CT

Localized HR-Positive Breast Cancer

Thursday, December 10, 2026

7:00 PM – 9:00 PM CT

Oral SERDs for HR-Positive Breast Cancer

Thursday, December 10, 2026

7:00 PM – 9:00 PM CT

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A Friday Satellite Symposium Series Preceding the 68th ASH Annual Meeting in New Orleans

Friday, December 11, 2026

Acute Myeloid Leukemia
7:30 AM – 9:30 AM CT

Chronic Lymphocytic Leukemia
7:30 AM – 9:30 AM CT

Bispecific Antibodies for Non-Hodgkin Lymphoma
11:30 AM – 1:30 PM CT

Multiple Myeloma
11:30 AM – 1:30 PM CT

Myelofibrosis
3:15 PM – 5:15 PM CT

ADCs and Bispecific Antibodies for Multiple Myeloma
7:00 PM – 9:00 PM CT

Novel Therapies for Non-Hodgkin Lymphoma
7:00 PM – 9:00 PM CT

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Grand Rounds

CME/MOC-Accredited Interactive Series

Regional Activities

Seven Series

- Squamous Cell Carcinoma of the Head and Neck
- Gastroesophageal Cancers
- Hormone-Sensitive Prostate Cancer
- HER2-Positive Breast Cancer
- Pancreatic Cancer
- Relapsed/Refractory Multiple Myeloma
- HER2-Positive Gastrointestinal Cancers

Host a 1-hour session at your institution:
Email Meetings@ResearchToPractice.com
or call (800) 233-6153

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Save The Date

Sixth Annual
National General Medical Oncology Summit

A Multitumor CME/MOC-, NCPD- and ACPE-Accredited Educational Conference Developed in Partnership with Florida Cancer Specialists & Research Institute

Friday to Sunday, April 23 to 25, 2027

The Ritz-Carlton Orlando, Grande Lakes | Orlando, Florida

Moderated by Neil Love, MD

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RTP RESEARCH TO PRACTICE

Dr Nanda — Disclosures
Faculty

Advisory Committees	AstraZeneca Pharmaceuticals LP, Corcept Therapeutics Inc, Daiichi Sankyo Inc, Exact Sciences Corporation, Gilead Sciences Inc, Lilly, Mabwell Therapeutics Inc, Merck, Pfizer Inc, Summit Therapeutics
Contracted Research	Arvinas, AstraZeneca Pharmaceuticals LP, Corcept Therapeutics Inc, Genentech, a member of the Roche Group, Gilead Sciences Inc, Jazz Pharmaceuticals Inc, Mabwell Therapeutics Inc, Merck, Pfizer Inc, Relay Therapeutics

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Dr O'Shaughnessy — Disclosures
Faculty

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William J Gradishar, MD — Disclosures
Survey Participant

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Sara A Hurvitz, MD, FACP — Disclosures
Survey Participant

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Honoraria and Conference Travel	AstraZeneca Pharmaceuticals LP, Gilead Sciences Inc, Pfizer Inc
Nonrelevant Financial Relationships	Alliance for Clinical Trials in Oncology Foundation, InClin, Quantum Leap Healthcare Collaborative, ROMTech (stocks for orthopedic device for postop pts; not cancer related)

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Hope S Rugo, MD — Disclosures
Survey Participant

Consulting Agreements	BioNTech SE, Bristol Myers Squibb, Helsinn Therapeutics (US) Inc, Napo Pharmaceuticals
Contracted Research — Funding to City of Hope	ALX Oncology, Bicycle Therapeutics, Genentech, a member of the Roche Group, Mabwell Therapeutics Inc, Merck, NiKang Therapeutics, Pfizer Inc, Phoenix Molecular Designs, Relay Therapeutics, Stemline Therapeutics Inc
Contracted Research — Funding to UCSF	Ambrx, AstraZeneca Pharmaceuticals LP, Daiichi Sankyo Inc, Genentech, a member of the Roche Group, Gilead Sciences Inc, Lilly, Merck, Novartis, Pfizer Inc, Stemline Therapeutics Inc

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Prof Peter Schmid, MD, PhD — Disclosures
Survey Participant

Consulting Agreements	AstraZeneca Pharmaceuticals LP, Bayer HealthCare Pharmaceuticals, Boehringer Ingelheim Pharmaceuticals Inc, Celgene Corporation, Eisai Inc, Merck, Novartis, Pfizer Inc, Puma Biotechnology Inc, Roche Laboratories Inc

Dr Love — Disclosures

Dr Love is president and CEO of Research To Practice. Research To Practice receives funds in the form of educational grants to develop CME activities from the following companies: Aadi Bioscience, AbbVie Inc, ADC Therapeutics, Agendia Inc, Alexion Pharmaceuticals, Amgen Inc, Array BioPharma Inc, a subsidiary of Pfizer Inc, Arvinas, Astellas, AstraZeneca Pharmaceuticals LP, Aveo Pharmaceuticals, Bayer HealthCare Pharmaceuticals, BeOne, Biotheranostics Inc, A Hologic Company, Black Diamond Therapeutics Inc, Blueprint Medicines, Boehringer Ingelheim Pharmaceuticals Inc, Bristol Myers Squibb, Catalyst Pharmaceuticals Inc, Celcuity, Clovis Oncology, Coherus BioSciences, Corcept Therapeutics Inc, CTI BioPharma, a Sobi Company, Daiichi Sankyo Inc, Eisai Inc, Elevation Oncology Inc, Exact Sciences Corporation, Exelixis Inc, Genentech, a member of the Roche Group, Genmab US Inc, Geron Corporation, Gilead Sciences Inc, GSK, Helsinn Therapeutics (US) Inc, ImmunoGen Inc, Incyte Corporation, Ipsen Biopharmaceuticals Inc, Jazz Pharmaceuticals Inc, Johnson & Johnson, Karyopharm Therapeutics, Kite, A Gilead Company, Kura Oncology, Legend Biotech, Lilly, MEI Pharma Inc, Merck, Mersana Therapeutics Inc, Mirati Therapeutics Inc, Mural Oncology Inc, Natera Inc, Novartis, Novartis Pharmaceuticals Corporation on behalf of Advanced Accelerator Applications, Novocure Inc, Nuvalent, Nuvation Bio Inc, Pfizer Inc, Pharmacyclics LLC, an AbbVie Company, Puma Biotechnology Inc, Regeneron Pharmaceuticals Inc, Revolution Medicines Inc, Rigel Pharmaceuticals Inc, R-Pharm US, Sanofi, Seagen Inc, Servier Pharmaceuticals LLC, SpringWorks Therapeutics Inc, Stemline Therapeutics Inc, Sumitomo Pharma America, Summit Therapeutics, Syndax Pharmaceuticals, Taiho Oncology Inc, Takeda Pharmaceuticals USA Inc, TerSera Therapeutics LLC, Tesaro, A GSK Company, and Verastem Inc.

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Commercial Support

This activity is supported by an educational grant from Gilead Sciences Inc.

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Agenda

Introduction: “Phase I Trial” of an Innovative CME Tool

Module 1: Selection of First-Line Therapy for Metastatic Triple-Negative Breast Cancer

Module 2: Adverse Events Associated with TROP2-Directed Antibody-Drug Conjugates

Module 3: Other Clinical Scenarios

Agenda

Introduction: "Phase I Trial" of an Innovative CME Tool

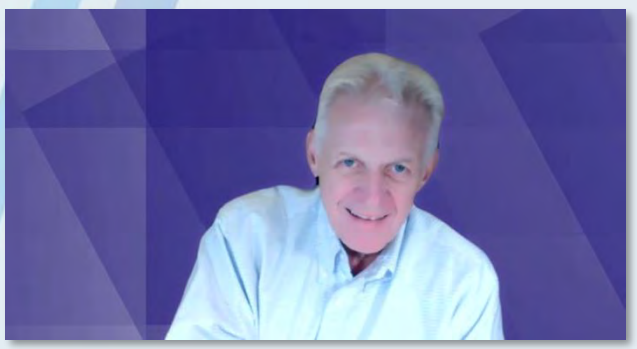
Module 1: Selection of First-Line Therapy for Metastatic Triple-Negative Breast Cancer

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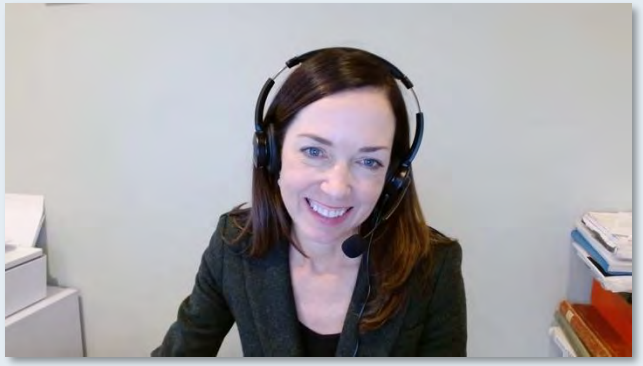
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Sara A Hurvitz, MD, FACP
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Prof Peter Schmid, FRCP, MD, PhD
Barts Cancer Institute
London, United Kingdom

100 ~2-minute video clips

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Clinical Investigator Survey: 25 Discussion Topics in Metastatic Triple-Negative Breast Cancer (mTNBC)

1. ER-low or TNBC?
2. HER2 testing and retesting and implications for the use of trastuzumab deruxtecan (T-DXd)
3. Tissue and liquid NGS: What findings actually change management?
4. BRCA/HRD status and PARP inhibitor use
5. First-line treatment before PD-L1 testing results are available
6. Selection of first-line therapy: PD-L1-positive
7. Selection of first-line therapy: PD-L1-positive but with prior immunotherapy treatment (eg KEYNOTE-522)
8. Determining immunotherapy eligibility beyond PD-L1 status
9. PD-L1-positive: Much older age and comorbidities
10. Brain metastases
11. Selection of first-line therapy: PD-L1-negative
12. PD-L1-negative: Much older age and comorbidities

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Clinical Investigator Survey: 25 Discussion Topics in mTNBC

13. Impact of disease burden and tempo on treatment decisions
14. Sequencing after a first-line antibody-drug conjugate
15. UGT1A1*28/*28 poor metabolizer status
16. Sacituzumab govitecan (SG): Primary G-CSF prophylaxis
17. SG: Prevention and management of diarrhea
18. SG: Antiemetic and supportive care
19. SG: Dose reductions and treatment modifications
20. T-DXd-associated alopecia and scalp cooling
21. T-DXd: Nausea prevention and baseline preparation
22. T-DXd: Prevention and management of interstitial lung disease (ILD)
23. Datopotamab deruxtecan (Dato-DXd): Ocular toxicity and risk mitigation
24. Dato-DXd: Risk of ILD
25. Dato-DXd: Prevention and management of mucositis

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Selected Discussion Topics for 1-on-1 General Medical Oncologist (GMO) Interviews

1. ER-low or TNBC?
2. Selection of first-line therapy: PD-L1 CPS >10
3. Selection of first-line therapy: PD-L1 CPS >10 but with prior immunotherapy treatment (eg, the KEYNOTE-522 trial)
4. Selection of first-line therapy: PD-L1 CPS <10
5. First-line treatment before PD-L1 testing results are available
6. BRCA/HRD status and PARP inhibitor use
7. Sacituzumab govitecan: G-CSF prophylaxis
8. Dato-DXd: Prevention and management of mucositis

20 GMOs interviewed 1-on-1 and surveyed on their treatment approaches

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mTNBC GMO Interviews: Summary Tables

Preliminary. GMO 1 to 18 of 20. 16 November 2026. Companion to the Early Findings document.

1. Each GMO against the investigators, before the clip

Topic	Investigators	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Agree	Would change
1. ER 5%: ER-low or TNBC	4/4 treat as TNBC	A	A	A	A	A	A	A	A	A	D	A	A	A	D	A	A	A	A	**16/18**	**0**
2. First line, PD-L1 positive (CPS 20)	4/4 SG + pembrolizumab	A	A	A	A	D	A	A	A	A	A	A	P	A	A	A	A	A	A	**16/18**	**0**
3. PD-L1 positive, relapse 7 months after KEYNOTE-522	3 SG + pembrolizumab; 1 SG or Dato-DXd alone	D	A	A	A	D	A	A	A	**D***	**D***	P	A	A	A	**D***	D	D	**D***	**9/18**	**4**
4. First line, PD-L1 negative (CPS 0)	4/4 SG or Dato-DXd	A	A	A	A	D	A	A	A	A	A	A	**D***	A	D	P	A	A	A	**14/18**	**1**
5. Treat before PD-L1 result	4/4 start SG, add pembrolizumab if positive	A	A	A	A	A	A	A	A	A	A	A	A	A	P	A	**P***	A	A	**16/18**	**1**
6a. gBRCA1, PD-L1 negative	4/4 PARP inhibitor	D	A	P	**D***	D	P	D	**D***	A	**D***	D	A	A	P	A	**D***	**D***	P	**5/18**	**5**
6b. gBRCA1, PD-L1 positive (CPS 20)	4/4 SG + pembrolizumab	–	A	A	A	–	**D***	A	**D***	A	–	A	A	A	A	D	A	A	A	**12/18**	**2**
7a. SG: primary G-CSF	3 select by risk; 1 all patients	A	P	P	P	D	A	P	A	A	P	A	P	P	A	A	A	A	P	**9/18**	**0**
7b. SG: grade 3 neutropenia despite G-CSF	4/4 reduce to 7.5 mg/kg	A	A	A	A	D	A	D	P	D	D	A	A	A	A	P	A	A	A	**12/18**	**–**
8. Dato-DXd mucositis prevention	3 steroid mouthwash + cryotherapy; 1 mouthwash alone	P	A	P	P	A	**D***	P	A	A	P	P	A	**P***	**–***	A	P	P	A	**7/18**	**3**

A Agrees with the investigator majority P Partly, or conditional D Differs – No clear answer * Said they would change practice after the clip

Columns are GMO numbers. SG = sacituzumab govitecan. "Agree" compares each GMO's first spoken answer with the investigator majority in the interview deck. GMO 3 treats only breast cancer. Counts describe these physicians only.

Comments from General Medical Oncologist Participants

"It's actually heartwarming to confirm that the majority of our practice as a general medical oncologist who sees everything from hematology to oncology lines up with these investigators. This is a quickly evolving field and we have only a certain amount of time to catch up with everything. So this was very helpful for me."

Comments from General Medical Oncologist Participants

"I think it's great that you can just kind of cut to the chase type of thing. Also sometimes there's no straight answer and one KOL's opinion may not reflect everybody else's opinion. But you want to hear everybody's view. I like the concept of different investigators.

I like the fact that you can just jump to certain topics that you want to hear about. I don't have time to listen to hours of material and I like the focus on the juicy stuff. I love the KOL comments and that it's interactive. It's going to make my learning process a little quicker and faster."

KOL = key opinion leader

Agenda

Introduction: “Phase I Trial” of an Innovative CME Tool

Module 1: Selection of First-Line Therapy for Metastatic Triple-Negative Breast Cancer

Module 2: Adverse Events Associated with TROP2-Directed Antibody-Drug Conjugates

Module 3: Other Clinical Scenarios

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Topic 1: ER-Low or TNBC?

For patients with metastatic disease, what ER level or status will lead you to treat it as "triple-negative" versus ER-positive?

Are there situations in which you would consider intrinsic subtyping such as using PAM50 or BluePrint® in your decision-making?

<u>Case scenario</u>
60-year-old woman
De novo metastatic breast cancer involving bone and lung
Mild cough but otherwise clinically stable with ECOG PS 0
Biopsy: ER 5%, PR 0%; the tumor is HER2 IHC 0 with no membrane staining (HER2 null)

For this patient, would your first-line therapy recommendation be for "ER+/HER2-neg" or TNBC?

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A 60-year-old woman presents with de novo metastatic breast cancer involving bone and lung. She has a mild cough but is otherwise clinically stable with ECOG PS 0. Biopsy shows ER 5%, PR 0%; the tumor is HER2 IHC 0 with no membrane staining (HER2 null) and PD-L1 combined positive score (CPS) 20. She is germline BRCA (gBRCA) wild type. Which first-line approach would you most likely recommend?



Dr Gradishar — Treat as TNBC



Dr Hurvitz — Treat as TNBC



Dr Rugo — Treat as TNBC



Prof Schmid — Treat as TNBC

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ER-Low or TNBC?



Professor Peter Schmid, FRCP, MD, PhD

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Comments from General Medical Oncologist Participants

"This was very useful and I like how he explained that the flip side is 5% positive and 95% negative. I had a patient with 10% ER and I treated her like TNBC and she had a path CR. And it was only until a year later that I thought about endocrine therapy. I felt very guilty and put her on endocrine therapy and she's been on it for a couple of years now. But I'm thinking it would probably fit the scenario where Dr. Schmidt is saying he would not have put that patient on endocrine therapy. I've had actually several patients like that."

Topic 2: Selection of First-Line Therapy — PD-L1 CPS >10

What is your likely first-line therapy recommendation for a patient with mTNBC and PD-L1 CPS >10 and HER2 IHC 0 (null)?

What is your likely first-line therapy recommendation for a patient with mTNBC and PD-L1 CPS >10 and HER2 IHC 2+ (FISH-negative)?

<u>Case scenario</u>
60-year-old woman
De novo mTNBC involving liver and bone
ECOG PS 0, gBRCA wild type
PD-L1 CPS 20, HER2 IHC 1+

Which first-line therapy would you most likely recommend?

A 60-year-old woman, gBRCA wild type, presents with de novo mTNBC involving liver and bone. She has an excellent performance status (ECOG PS 0), and liver biopsy confirms PD-L1 CPS 20, HER2 IHC 1+. Which first-line therapy would you most likely recommend?



Dr Gradishar — Sacituzumab govitecan + pembrolizumab



Dr Hurvitz — Sacituzumab govitecan + pembrolizumab



Dr Rugo — Sacituzumab govitecan + pembrolizumab



Prof Schmid — Sacituzumab govitecan + pembrolizumab

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Selection of First-Line Therapy: PD-L1 CPS >10



Sara A Hurvitz, MD, FACP

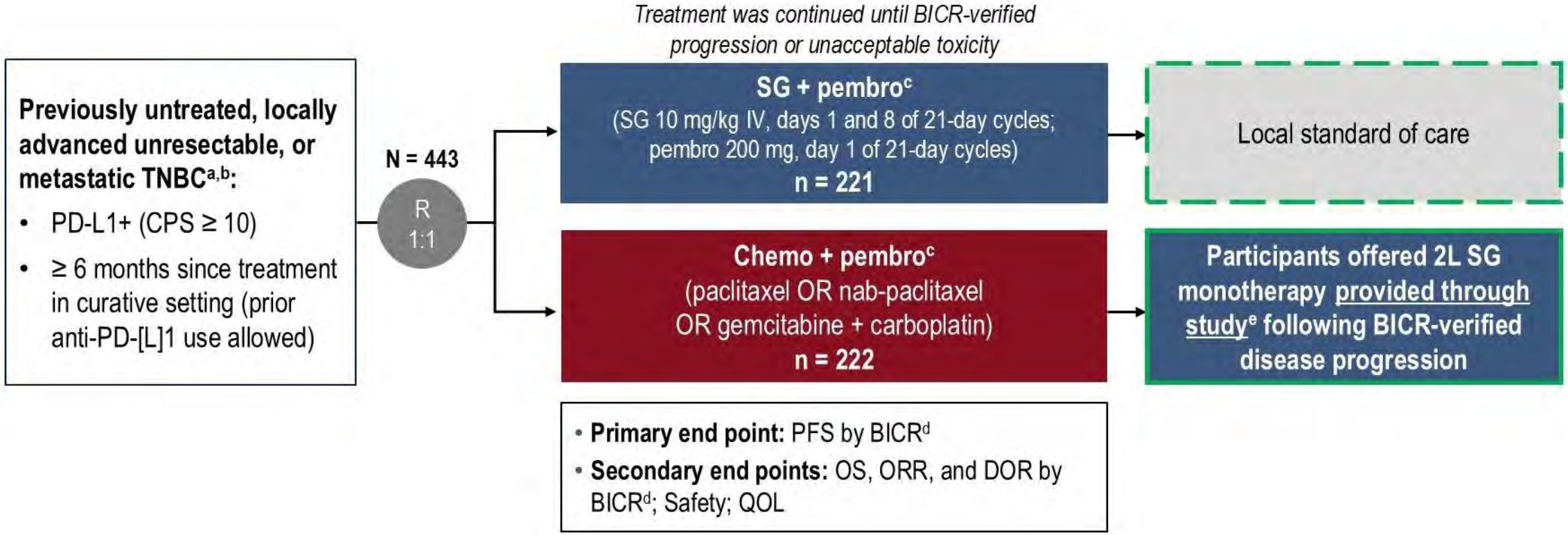
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Comments from General Medical Oncologist Participants

"So usually when somebody is HER2 low, I would be a little bit concerned that I might have to use T-DXd in the second-line setting. So, if I try to give sacituzumab govitecan first-line, it would be an ADC after an ADC. I get a little worried about possibility of interstitial lung disease. So, at that particular point, I might consider giving the patient gemcitabine/carboplatin with pembrolizumab for the CPS greater than 10. You know, the response rate is relatively similar. They're not more than 10% difference. And so usually, in my opinion, if a patient is probably going to end up having T-DXd, I try not to give sacituzumab and T-DXd back-to-back."

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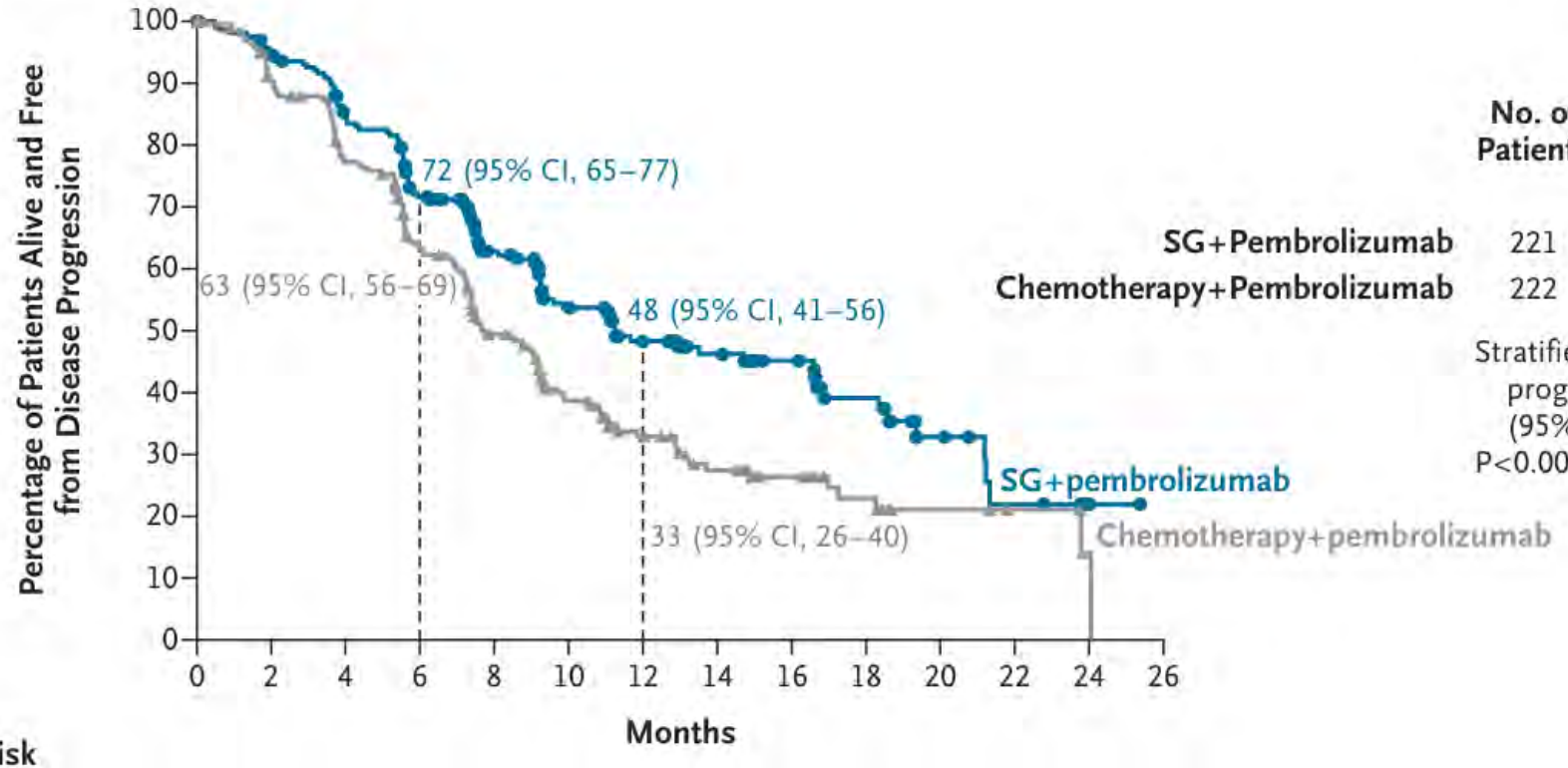
Phase III ASCENT-04 Study Design



CPS = combined positive score; SG = sacituzumab govitecan; pembro = pembrolizumab

Kalinsky K et al. ASCO 2026;Abstract LBA1000.

Phase III ASCENT-04/KEYNOTE-D19 Study: Progression-Free Survival



	No. of Patients	No. of Events	Median Progression-free Survival (95% CI)
			mo
SG+Pembrolizumab	221	109	11.2 (9.3–16.7)
Chemotherapy+Pembrolizumab	222	140	7.8 (7.3–9.3)

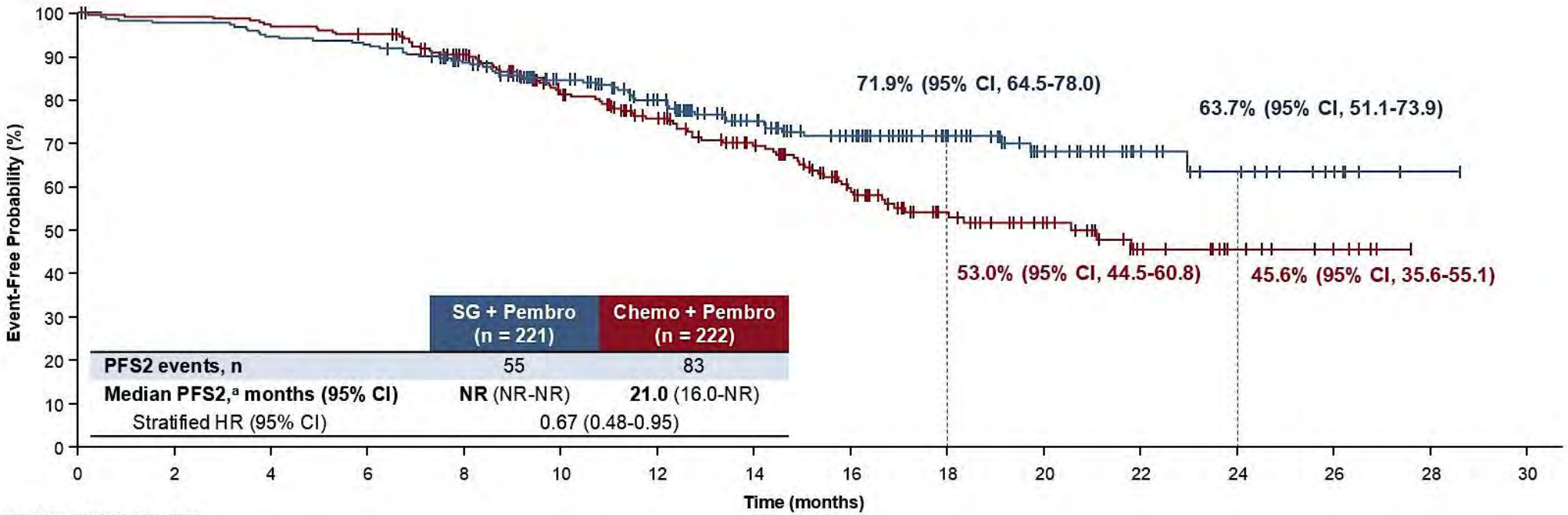
Stratified hazard ratio for disease progression or death, 0.65 (95% CI, 0.51 to 0.84)
P<0.001

No. at Risk (no. of events)

SG+pembrolizumab	221 (0)	202 (11)	174 (33)	142 (59)	105 (75)	78 (89)	58 (96)	42 (98)	34 (99)	22 (103)	11 (106)	6 (109)	2 (109)	0 (109)
Chemotherapy+ pembrolizumab	222 (0)	191 (21)	159 (48)	123 (76)	88 (102)	59 (120)	40 (128)	29 (134)	21 (135)	13 (137)	7 (138)	4 (138)	1 (139)	0 (140)

Tolaney SM et al. *N Engl J Med* 2026;394:354-66.

Phase III ASCENT-04: Progression-Free Survival After Next Line of Treatment (PFS2)



PFS2 was longer in the SG + pembro group compared with the chemo + pembro group despite the high rate of crossover in the chemo + pembro group, with a 33% reduction in risk of a PFS2 event with SG + pembro

Kalinsky K et al. ASCO 2026;Abstract LBA1000. Tolaney SM et al. *N Engl J Med* 2026;394:354-66.

Phase III ASCENT-04: PFS by Preselected Chemotherapy, Disease Status, and Brain and Visceral Metastases

Figure 1. Progression-Free Survival by BICR Across Subgroups

Subgroup	SG + Pembro		Chemo + Pembro		Unstratified HR (95% CI)
	n	Median PFS (95% CI), mo	n	Median PFS (95% CI), mo	
ITT population	221	11.2 (9.3-16.7)	222	7.8 (7.3-9.3)	0.66 (0.51-0.85)
Preselected chemo					
Taxane	116	11.1 (8.6-16.7)	114	9.2 (7.2-12.9)	0.82 (0.58-1.17)
Gem/carbo	105	11.3 (9.2-21.2)	108	7.4 (6.9-9.0)	0.52 (0.36-0.75)
Disease stratification					
De novo metastatic	75	8.1 (7.3-18.6)	75	7.7 (6.1-11.9)	0.89 (0.59-1.34)
Recurrent (6-12 mo)	40	9.9 (5.7-16.8)	40	7.2 (4.4-9.1)	0.62 (0.36-1.08)
Recurrent (> 12 mo)	106	16.6 (11.0-NR)	107	8.7 (7.3-10.8)	0.52 (0.35-0.76)
Brain metastases					
Yes	8	5.7 (0.5-NR)	6	3.7 (1.3-NR)	0.64 (0.19-2.14)
No	213	11.7 (9.3-16.8)	216	8.4 (7.4-9.3)	0.65 (0.50-0.84)
Visceral metastases					
Yes	147	9.3 (7.7-11.7)	140	7.0 (5.6-7.5)	0.64 (0.47-0.85)
No	74	16.8 (12.9-NR)	82	9.9 (9.0-12.9)	0.64 (0.39-1.05)



Data cutoff date: March 3, 2025. BICR, blinded independent central review; chemo, chemotherapy; gem/carbo, gemcitabine + carboplatin; HR, hazard ratio; ITT, intent-to-treat; mo, months; NR, not reached; pembro, pembrolizumab; PFS, progression-free survival; SG, sacituzumab govitecan.

de Azambuja E et al. ESMO 2026;Abstract 4648P.

FDA Approves Sacituzumab Govitecan-hziy as Monotherapy and in Combination with Pembrolizumab for the First-Line Treatment of Triple-Negative Breast Cancer

Press Release: June 24, 2026

"On June 24, 2026, the Food and Drug Administration approved sacituzumab govitecan-hziy for two indications in adults with triple-negative breast cancer (TNBC). The first indication, supported by ASCENT-03, is for sacituzumab govitecan-hziy as a single agent for the first-line treatment of adults with unresectable locally advanced or metastatic TNBC who are not candidates for PD-1 or PD-L1 inhibitor-based therapy. The second indication, supported by ASCENT-04/KEYNOTE D-19, is for sacituzumab govitecan-hziy in combination with pembrolizumab or pembrolizumab and berahyaluronidase alfa-pmph for the first-line treatment of adults with unresectable locally advanced or metastatic TNBC whose tumors express PD-L1 (CPS ≥ 10) as determined by an FDA-authorized test."

https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-sacituzumab-govitecan-hziy-monotherapy-and-combination-pembrolizumab-first-line

RTP RESEARCH TO PRACTICE

Topic 3: Selection of First-Line Therapy — PD-L1 CPS >10 but with Prior Immunotherapy Treatment

Do you include an immunotherapy (IO) for patients with mTNBC and PD-L1 CPS >10 and prior IO treatment, as in the KEYNOTE-522 trial, and does it matter how long ago the patient received the KEYNOTE-522 regimen?

<u>Case scenario</u>
60-year-old woman
mTNBC involving liver and bone
ECOG PS 0, gBRCA wild type
PD-L1 CPS 20, HER2 IHC 0
Prior KEYNOTE-522 regimen: completed adjuvant pembrolizumab 7 months ago

What is your likely first-line treatment recommendation?

A 60-year-old woman previously received the KEYNOTE-522 regimen for Stage II TNBC and completed adjuvant pembrolizumab 7 months ago. She now develops metastatic recurrence involving liver and lung and has an excellent performance status (ECOG PS 0). A liver biopsy confirms recurrent TNBC; the tumor is PD-L1 CPS 20 and HER2 IHC 0 with no membrane staining (HER2 null). She is gBRCA wild type. Which first-line therapy would you most likely recommend?



Dr Gradishar — Sacituzumab govitecan + pembrolizumab



Dr Hurvitz — Sacituzumab govitecan or datopotamab deruxtecan



Dr Rugo — Sacituzumab govitecan + pembrolizumab



Prof Schmid — Sacituzumab govitecan + pembrolizumab

RTP RESEARCH TO PRACTICE

Selection of First-Line Therapy: PD-L1 CPS >10 but with Prior Immunotherapy Treatment



Hope S Rugo, MD

Comments from General Medical Oncologist Participants

"One thing Dr Rugo mentioned is that these patients live a very short time. So, any chance you can give them for anything working, with immunotherapy, if it works, it works. And she had a patient who was in an exact similar situation and it worked for a very long time. The videos are great: the Q&A format sticks in your brain for a lot longer. It's like finding the cream of the cream."

"I had a patient who developed metastatic disease 12 months after Keynote-522. I still used pembro with sacituzumab, and she did really well for almost a year."

"We have the issue of IO continuation or rechallenge in other tumors and we'll be debating this for a long time but if you have a young woman who wants to be aggressive and the insurance approves it, I don't think it's wrong to give it."

RTP
RESEARCH
TO PRACTICE

Topic 4: Selection of First-Line Therapy — PD-L1 CPS <10

What is your usual first-line systemic treatment for patients with mTNBC and tumors that are PD-L1 CPS <10?

What is your usual first-line systemic treatment for patients with mTNBC and tumors that are PD-L1 CPS <10 and HER2 IHC 2+?

<u>Case scenario</u>
60-year-old woman
De novo mTNBC involving liver and bone
ECOG PS 0, gBRCA wild type
PD-L1 CPS 0 and HER2 IHC 1+

Which first-line therapy would you most likely recommend?

A 60-year-old woman, gBRCA wild type, presents with de novo mTNBC involving liver and bone. She has an excellent performance status (ECOG PS 0). A liver biopsy confirms mTNBC; the tumor is PD-L1 CPS 0 and HER2 IHC 1+. Which first-line therapy would you most likely recommend?



Dr Gradishar — Sacituzumab govitecan or datopotamab deruxtecan



Dr Hurvitz — Sacituzumab govitecan or datopotamab deruxtecan



Dr Rugo — Sacituzumab govitecan or datopotamab deruxtecan



Prof Schmid — Sacituzumab govitecan or datopotamab deruxtecan

RTP RESEARCH TO PRACTICE

Selection of First-Line Therapy: PD-L1 CPS <10



William J Gradishar, MD

Comments from General Medical Oncologist Participants

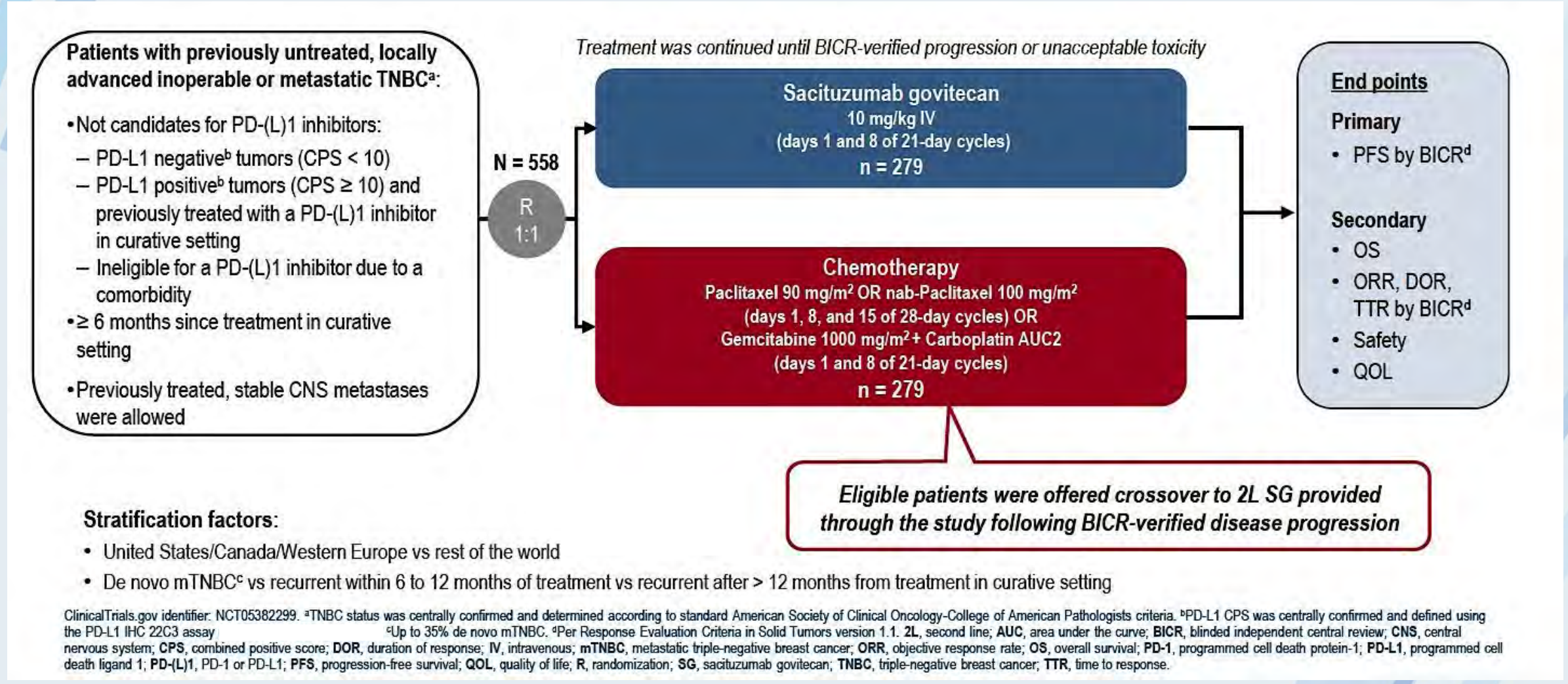
"I know that with PD-L1 negative you have a choice but my comfort level is with SG a lot because I've been using it for years. Datopotamab I've used in clinical trial setting for EGFR positive lung cancer and I recently used it in a patient with TNBC. I think the three-weekly dosing is pretty attractive."

"Some of these patients question why they need to see another doctor, like an ophthalmologist. So unless neutropenia or other issues come into play, saci is my preferred approach in this setting. I did have a patient who lives about half an hour or so from the clinic, and she finally decided after discussion of saci or dato to receive saci and she is doing quite well with a good response."

"We recently had a lady who was in her 50s who developed metastatic disease three years after initial chemotherapy. She did not receive immunotherapy because she had ulcerative colitis and it was very active. So I did put her on Dato-DXd because of possible GI issues with SG. This comes up a lot. As Dr Gradishar said it's all toxicity profile, the quality of life, and how often they want to come."

RTP
RESEARCH TO PRACTICE

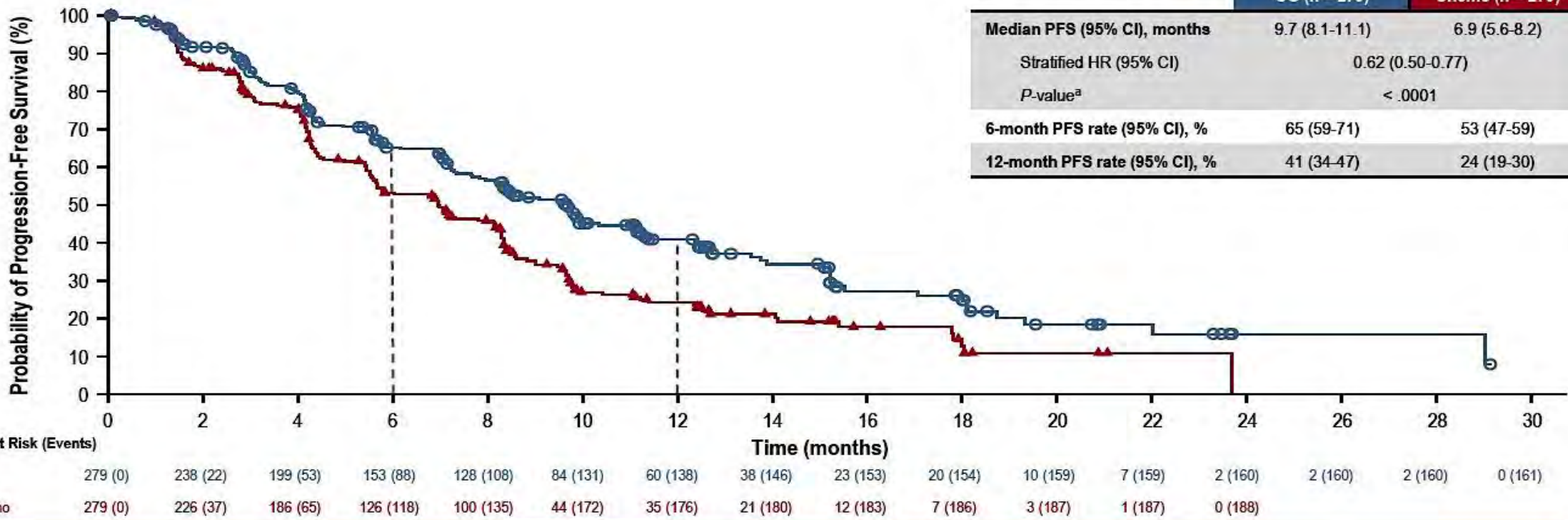
Phase III ASCENT-03 Study Design



ClinicalTrials.gov identifier: NCT05382299. [a]TNBC status was centrally confirmed and determined according to standard American Society of Clinical Oncology-College of American Pathologists criteria. [b]PD-L1 CPS was centrally confirmed and defined using the PD-L1 IHC 22C3 assay [c]Up to 35% de novo mTNBC. [d]Per Response Evaluation Criteria in Solid Tumors version 1.1. **2L**, second line; **AUC**, area under the curve; **BICR**, blinded independent central review; **CNS**, central nervous system; **CPS**, combined positive score; **DOR**, duration of response; **IV**, intravenous; **mTNBC**, metastatic triple-negative breast cancer; **ORR**, objective response rate; **OS**, overall survival; **PD-1**, programmed cell death protein-1; **PD-L1**, programmed cell death ligand 1; **PD-(L)1**, PD-1 or PD-L1; **PFS**, progression-free survival; **QOL**, quality of life; **R**, randomization; **SG**, sacituzumab govitecan; **TNBC**, triple-negative breast cancer; **TTR**, time to response.

Cortés J et al. ESMO 2025;Abstract LBA20. Cortés J et al. *N Engl J Med* 2025;393(19):1912-25.

Phase III ASCENT-03: PFS by BICR



	SG (n = 279)	Chemo (n = 279)
Median PFS (95% CI), months	9.7 (8.1-11.1)	6.9 (5.6-8.2)
Stratified HR (95% CI)	0.62 (0.50-0.77)	
P-value[a]	< .0001	
6-month PFS rate (95% CI), %	65 (59-71)	53 (47-59)
12-month PFS rate (95% CI), %	41 (34-47)	24 (19-30)

SG demonstrated statistically significant and clinically meaningful improvement in PFS vs chemo by BICR analysis, with a 38% reduction in risk of disease progression or death

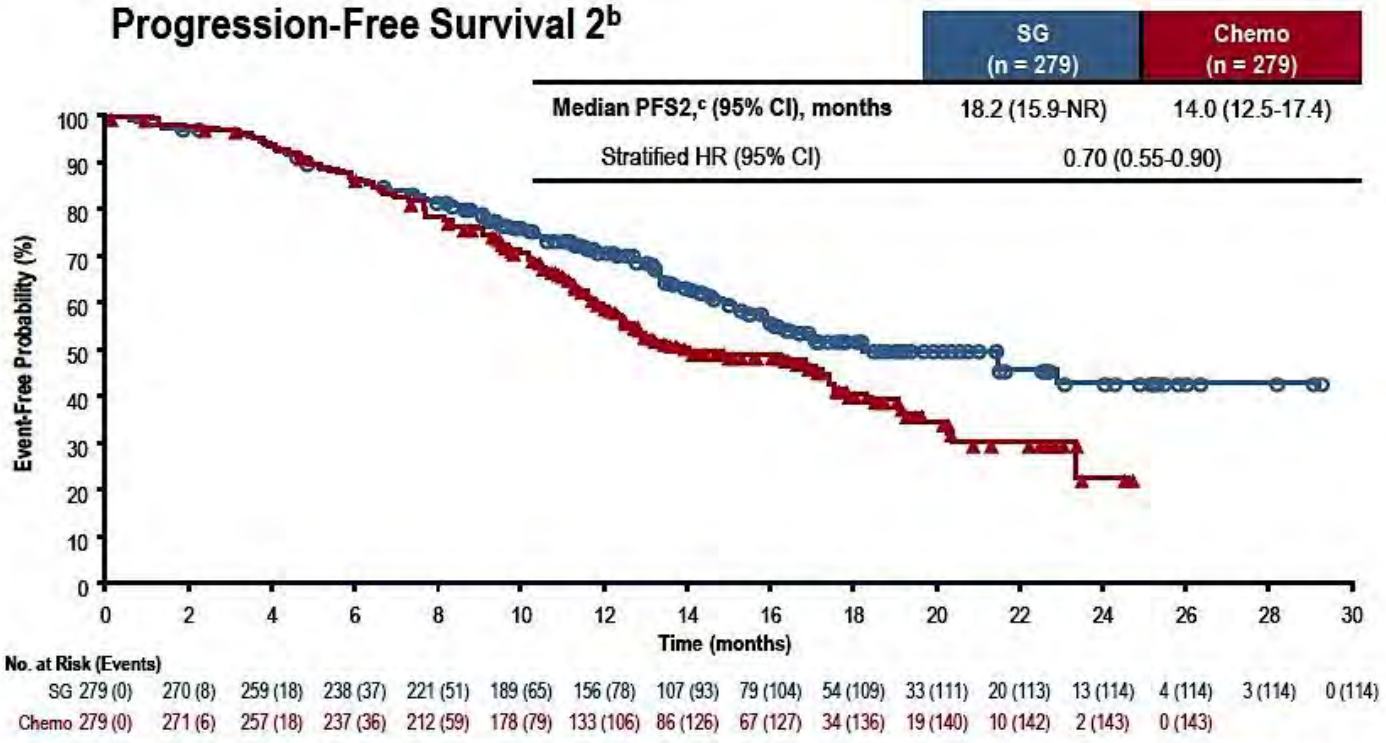
Data cutoff date: April 2, 2025. [a]Two-sided *P*-value from stratified log-rank test.
BICR, blinded independent central review; **chemo**, chemotherapy; **HR**, hazard ratio; **PFS**, progression-free survival; **SG**, sacituzumab govitecan.

Cortés J et al. ESMO 2025;Abstract LBA20. Cortés J et al. *N Engl J Med* 2025;393(19):1912-25.

Phase III ASCENT-03: Descriptive OS and PFS2

- **Overall survival not yet mature[a]**
- Study continues to first formal OS analysis
- Of 179 patients who initiated subsequent treatment after chemo, 147 (82%) received SG

Overall survival	SG (n = 279)	Chemo (n = 279)
Number of events, %	103 (37)	103 (37)
Median (95% CI) , months	21.5 (17.7-NR)	20.2 (18.2-NR)
Stratified HR (95% CI)	0.98 (0.75-1.30)	
OS rate (95% CI), %		
12-month	75 (70-80)	73 (67-78)
24-month	46 (36-56)	42 (29-54)



At the time of primary analysis, overall survival was immature and PFS2 was longer with SG vs chemo by investigator assessment

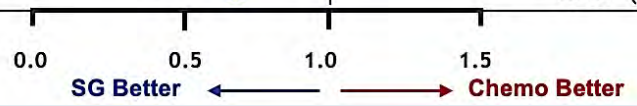
Data cutoff date: April 2, 2025. [a]At the time of this analysis, OS data maturity was 37%. [b]PFS2 is defined as the time from date of randomization to the first documented progression on next-line therapy based on investigator assessment of progressive disease or death due to any cause, whichever occurs first. [c]By investigator assessment.
2L, second line; **chemo**, chemotherapy; **HR**, hazard ratio; **NR**, not reached; **OS**, overall survival; **PFS2**, progression-free survival 2; **SG**, sacituzumab govitecan.

Cortés J et al. ESMO 2025;Abstract LBA20. Cortés J et al. *N Engl J Med* 2025;393(19):1912-25.

Phase III ASCENT-03: PFS by Preselected Chemotherapy, Disease Status, and Brain and Visceral Metastases

Figure 1. Progression-Free Survival by BICR Across Subgroups

Subgroup	SG		Chemotherapy		Unstratified HR (95% CI)
	n	Median PFS (95% CI), mo	n	Median PFS (95% CI), mo	
ITT Population	279	9.7 (8.1-11.1)	279	6.9 (5.6-8.2)	0.66 (0.53-0.82)
Preselected chemo					
Taxane	154	11.1 (8.1-12.7)	155	5.7 (4.3-8.1)	0.51 (0.38-0.68)
Gem/carbo	125	8.5 (6.9-9.9)	124	8.1 (5.7-8.3)	0.89 (0.64-1.22)
Disease stratification					
De novo metastatic	87	8.3 (5.6-12.4)	88	5.5 (4.2-7.3)	0.65 (0.45-0.94)
Recurrent (6-12 mo)	58	8.3 (5.6-9.9)	57	5.6 (4.2-6.7)	0.46 (0.29-0.72)
Recurrent (> 12 mo)	134	11.1 (8.4-13.5)	134	8.4 (7.2-9.8)	0.72 (0.52-1.00)
Brain metastases					
Yes	15	8.4 (4.0-9.7)	14	4.4 (1.5-8.1)	0.38 (0.15-1.01)
No	264	9.7 (8.0-11.4)	265	7.0 (5.6-8.3)	0.66 (0.53-0.82)
Visceral metastases					
Yes	215	8.5 (7.3-9.9)	210	5.7 (4.5-7.8)	0.66 (0.52-0.84)
No	64	13.7 (7.2-NR)	69	8.3 (6.8-9.8)	0.68 (0.42-1.12)



Punie K et al. ESMO 2026; Abstract 4649P.

Phase III TROPION-Breast02 Study Design

Randomised, phase 3, open-label, global study (NCT05374512)

Key inclusion criteria:

- Patients with histologically or cytologically documented locally recurrent inoperable or metastatic TNBC*
- No prior chemotherapy or targeted systemic therapy in the locally recurrent inoperable or metastatic setting
- Immunotherapy not an option†
- ECOG PS 0 or 1
- No minimum DFI‡

1:1

Dato-DXd
6 mg/kg IV Day 1 Q3W
(n=323)

Investigator's choice of chemotherapy (ICC)#
Paclitaxel, nab-paclitaxel, capecitabine, eribulin mesylate/eribulin, carboplatin
(n=321)

Endpoints

Dual primary:

- OS
- PFS by BICR per RECIST v1.1

Secondary included:

- PFS (investigator-assessed)
- ORR, DoR
- Safety

Randomisation stratified by:

- Geographic region (US/Canada/Europe vs other geographic regions)
- PD-L1 status (high [CPS ≥10] vs low [CPS <10])§
- DFI history (*de novo* vs prior DFI 0–12 months vs prior DFI >12 months)¶

- Treatment continued until investigator-assessed RECIST v1.1 progressive disease, unacceptable toxicity, or another discontinuation criterion was met
- Following progression or discontinuation of study treatment, patients could receive subsequent therapies, including approved ADCs or chemotherapy, at the investigator's discretion‖

*According to ASCO/CAP criteria. †Including patients with PD-L1-low tumours, or patients with PD-L1-high tumours with (a) disease relapse after prior PD-(L)1 inhibitor therapy for early-stage breast cancer, (b) comorbidities precluding PD-(L)1 inhibitor therapy, or (c) no regulatory access to PD-(L)1 inhibitor therapy. ‡DFI defined as time between date of completion of treatment with curative intent and date of first documented local or distant disease recurrence. §Recruitment of patients with PD-L1-high tumours who would otherwise be eligible for pembrolizumab if regulatory access was available was capped at ~10% of randomised patients. ¶Recruitment of patients with DFI 0–12 months was capped at ~20% of randomised patients. #If no prior taxane, or prior taxane in the (neo)adjuvant setting and DFI >12 months: paclitaxel 80 mg/m^2 IV, D1, 8, 15, Q3W, or nab-paclitaxel 100 mg/m^2 IV, D1, 8, 15, Q4W; if prior taxane and DFI 0–12 months: capecitabine 1000 or 1250 mg/m^2 orally twice daily, D1–14, Q3W (dose determined by standard institutional practice), or eribulin mesylate 1.4 mg/m^2 / eribulin 1.23 mg/m^2 IV, Day 1, 8, Q3W, or carboplatin AUC6 IV, D1, Q3W. ‖In the Dato-DXd vs ICC arm, 65% vs 72% of patients received any subsequent therapy in any treatment line; 14% vs 30% received a subsequent ADC (sacituzumab govitecan, sacituzumab tirumotecan, trastuzumab deruxtecan).

Rebecca A. Dent

ADC, antibody-drug conjugate; BICR, blinded independent central review; CPS, combined positive score; D, day; DFI, disease-free interval; DoR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; IV, intravenously; ORR, objective response rate; PD-(L)1, programmed cell death (ligand) 1; PFS, progression-free survival; QXW, every X weeks.

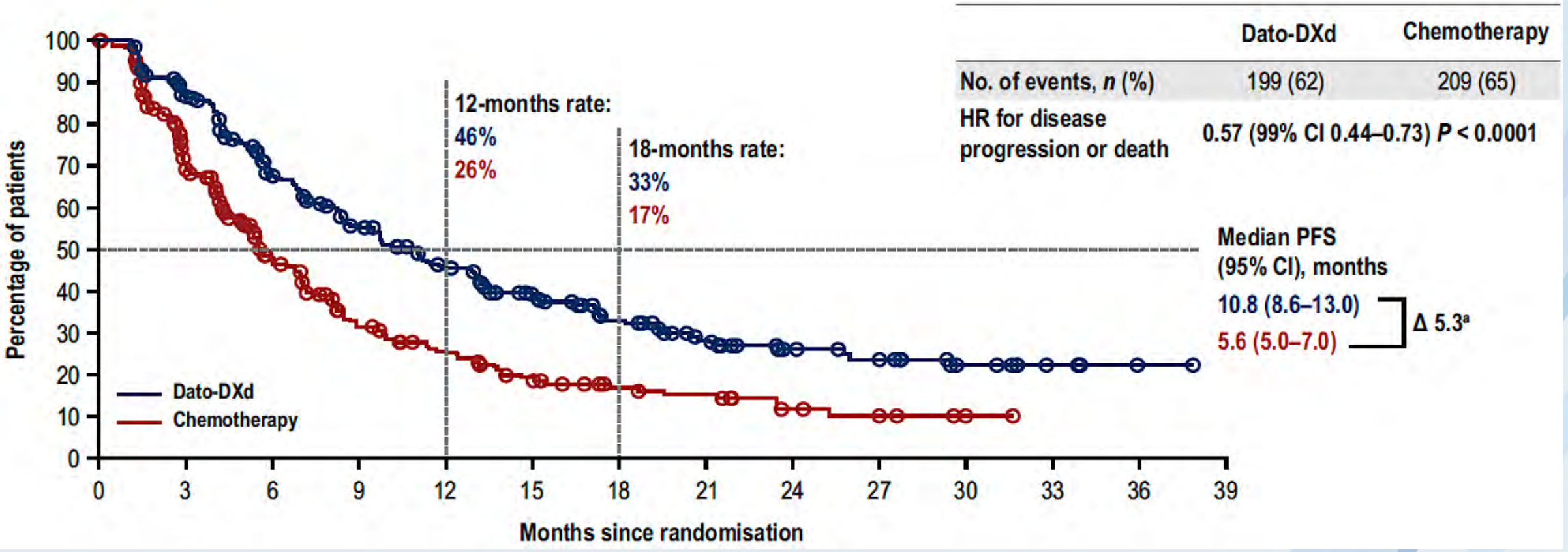
BERLIN 2025 ESMO congress

Dato-DXd = datopotamab deruxtecan

RTP RESEARCH TO PRACTICE

Dent R et al. ESMO 2025;Abstract LBA21. Dent R et al. *Ann Oncol* 2026;37(8):1066-80.

Phase III TROPION-Breast02: PFS by BICR



	Dato-DXd	Chemotherapy
No. of events, *n* (%)	199 (62)	209 (65)
HR for disease progression or death	0.57 (99% CI 0.44–0.73) *P* < 0.0001	

Median PFS (95% CI), months

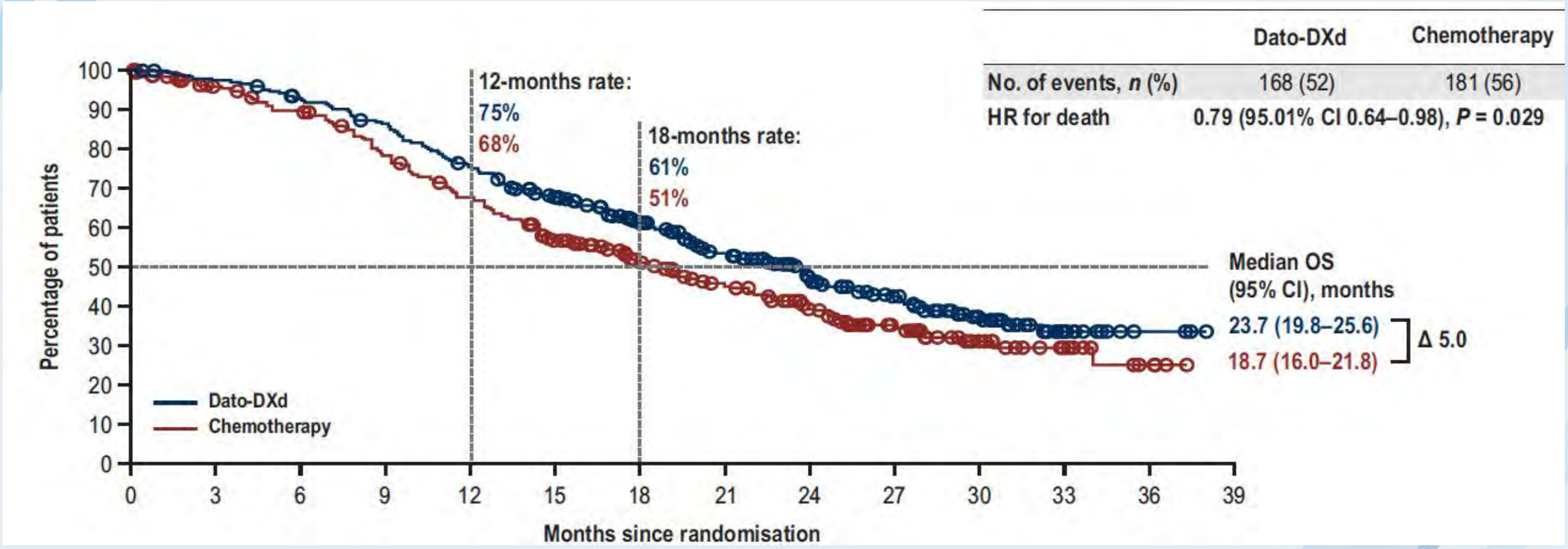
10.8 (8.6–13.0)

5.6 (5.0–7.0)

Δ 5.3[a]

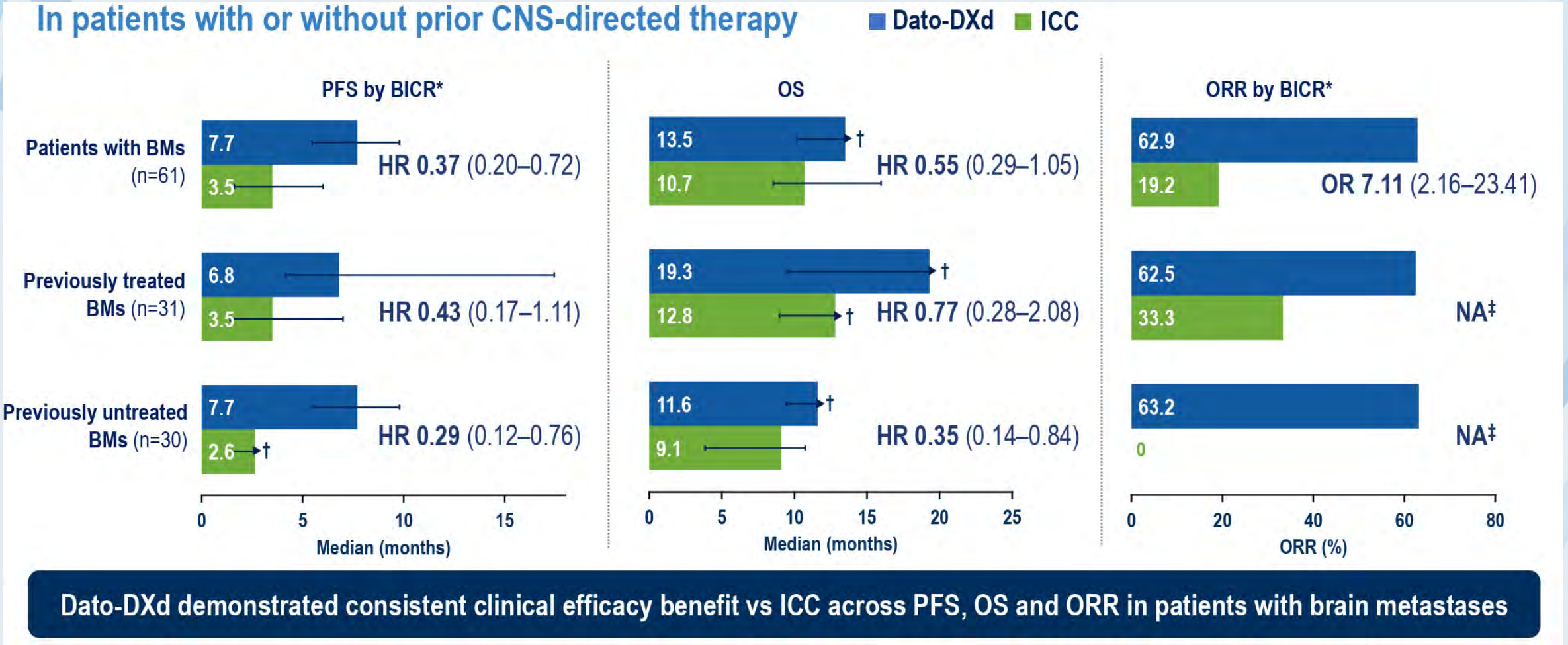
Dent R et al. ESMO 2025;Abstract LBA21. Dent R et al. *Ann Oncol* 2026;37(8):1066-80.

Phase III TROPION-Breast02: OS in the Intention-to-Treat Population



Dent R et al. ESMO 2025;Abstract LBA21. Dent R et al. *Ann Oncol* 2026;37(8):1066-80.

Phase III TROPION-Breast02: Systemic Efficacy in Patients with Brain Metastases (BM)

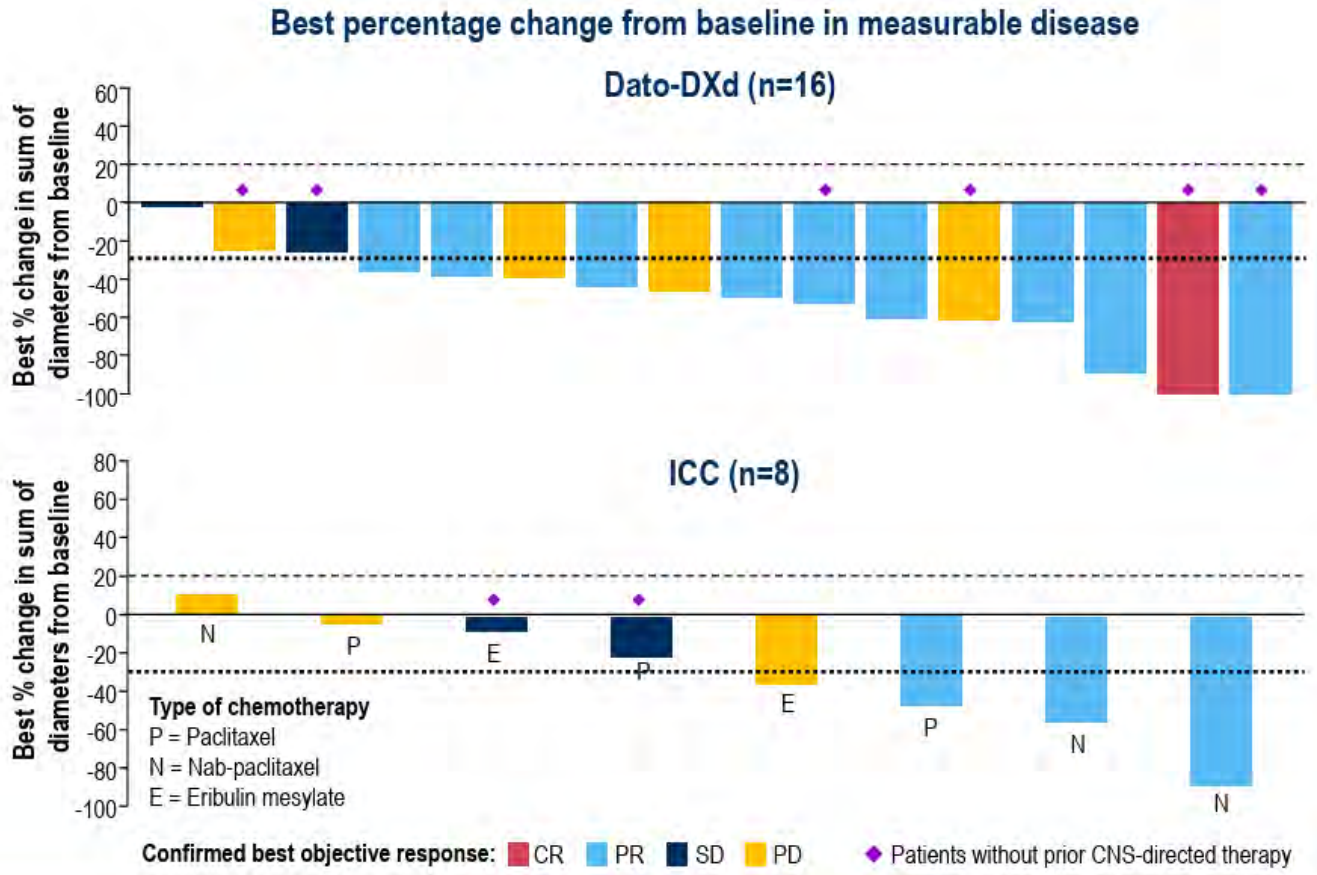


ICC = investigator's choice of chemotherapy; ORR = objective response rate

Dent R et al. ESMO 2026;Abstract LBA96.

Phase III TROPION-Breast02: Intracranial Efficacy

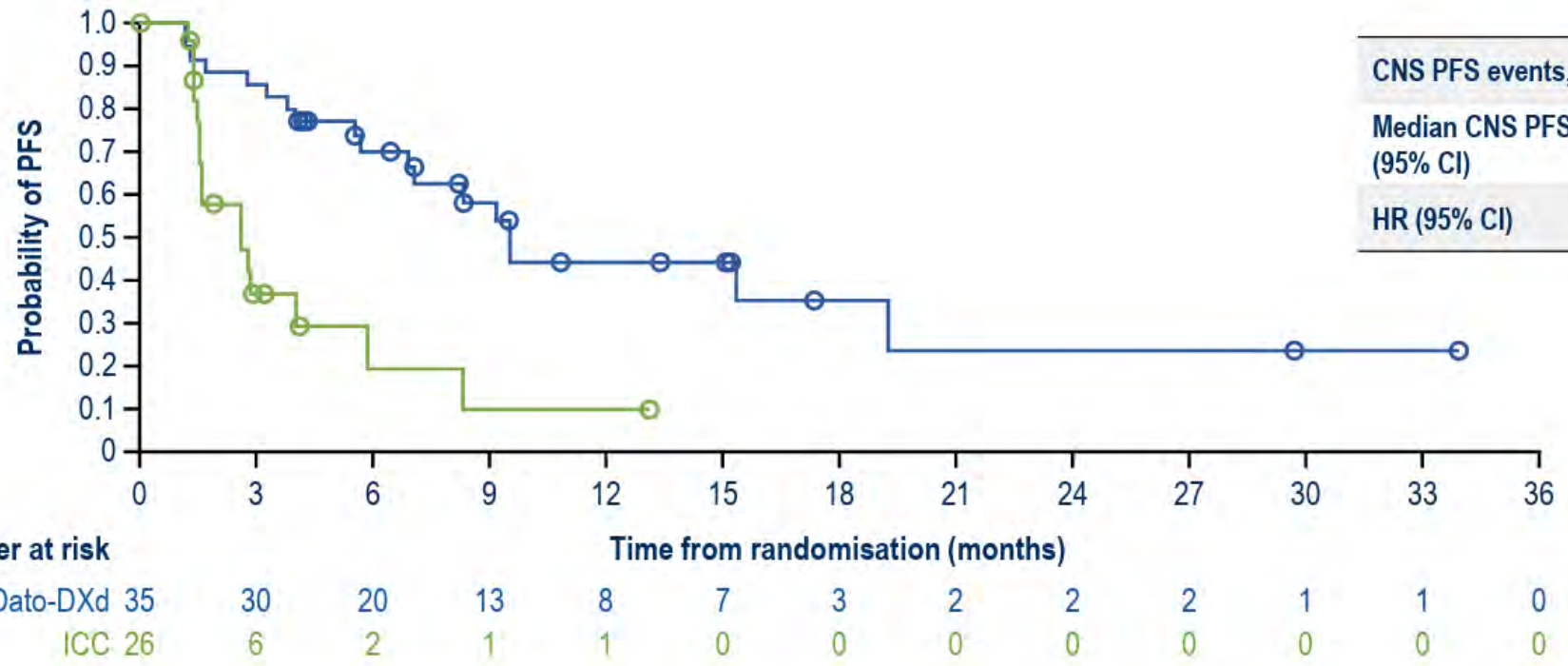
	Measurable disease*	
	Dato-DXd (n=16)	ICC (n=8)
Intracranial confirmed ORR,† %	62.5	37.5
Intracranial DCR at 12 weeks, %	75.0	50.0



In patients with measurable disease, Dato-DXd demonstrated a confirmed intracranial ORR of 62.5% vs 37.5% with ICC

Dent R et al. ESMO 2026;Abstract LBA96.

Phase III TROPION-Breast02: CNS PFS for Patients with BM



	Dato-DXd n=35*	ICC n=26*
CNS PFS events, n (%)†	18 (51.4)	16 (61.5)
Median CNS PFS, months (95% CI)	9.5 (6.9–19.3)	2.6 (1.5–5.8)
HR (95% CI)	0.27 (0.13–0.56)	

Dato-DXd demonstrated CNS PFS benefit compared with ICC, with an HR of 0.27

Dent R et al. ESMO 2026;Abstract LBA96.

FDA Approves Datopotamab Deruxtecan for First-Line Treatment of Unresectable or Metastatic Triple-Negative Breast Cancer
Press Release: May 22, 2026

"On May 22, 2026, the Food and Drug Administration approved datopotamab deruxtecan-dlnk for adult patients with unresectable or metastatic triple-negative breast cancer (TNBC) who are not candidates for PD-1/PD-L1 inhibitor therapy…

Efficacy was evaluated in TROPION-Breast02 (NCT05374512), a multicenter, open-label, randomized trial of 644 patients with unresectable or metastatic TNBC who had not received prior chemotherapy or other systemic anti-cancer therapy for unresectable or metastatic breast cancer and who were not candidates for PD-1/PD-L1 inhibitor therapy."

https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-datopotamab-deruxtecan-dlnk-unresectable-or-metastatic-triple-negative-breast-cancer

RTP RESEARCH TO PRACTICE

Phase III OptiTROP-Breast03 Trial of Sacituzumab Tirumotecan (sac-TMT) versus Chemotherapy as First-line Treatment for Advanced TNBC Met Primary Endpoint of PFS

Press Release: May 21, 2026

"…the Phase III clinical study (OptiTROP-Breast03) of the trophoblast cell-surface antigen 2 (TROP2)-directed antibody drug conjugate (ADC) sacituzumab tirumotecan (sac-TMT, also known as SKB264/MK-2870) versus investigator's choice of chemotherapy as first-line treatment for unresectable locally recurrent or metastatic triple-negative breast cancer (TNBC) has met its primary endpoint of progression-free survival (PFS) at a prespecified interim analysis, demonstrating a statistically significant and clinically meaningful improvement. Overall survival (OS) data are immature, a positive trend is currently observed.

The enrolled population includes patients with programmed death ligand 1 (PD-L1)-negative expression, as well as those with PD-L1-positive expression who have relapsed after prior anti-PD-(L)1 inhibitor in early-stage disease. Two independent primary endpoints of the study are PFS and OS.

Follow-up will continue per protocol and further evaluation will be conducted in subsequent prespecified analyses. The safety profile of sac-TMT was consistent with that observed in previously reported studies, and no new safety signals were observed."

https://www.prnewswire.com/news-releases/kelun-biotech-announces-phase-iii-trial-of-sacituzumab-tirumotecan-sac-tmt-versus-chemotherapy-as-firstline-treatment-for-advanced-tnbc-met-primary-endpoint-of-pfs-302779066.html

RTP RESEARCH TO PRACTICE

First-Line Sacituzumab Tirumotecan (Sac-TMT) vs Chemotherapy in Unresectable Recurrent or Metastatic Triple-Negative Breast Cancer (TNBC) with PD-L1 CPS <10 or Prior Early-Stage PD-(L)1 Exposure: Randomized Phase 3 OptiTROP-Breast03 Trial

Fan L.

SABCS 2026;Abstract GS1-8.

Wednesday, December 9, 2026
General Session 1
Hall 1
9:30 AM – 11:45 AM CST

Topic 5: First-Line Treatment Before PD-L1 Testing Results Are Available

In general, which first-line treatment would you likely recommend for a patient for whom you wish to begin treatment before PD-L1 results are available?

<u>Case scenario</u>
60-year-old woman
De novo mTNBC involving liver and lung. HER2 IHC 0; gBRCA wild type
She has symptomatic disease and you wish to start treatment before the PD-L1 results are available

Which treatment would you likely recommend?

A 60-year-old woman presents with de novo mTNBC involving liver and lung. She has symptomatic disease and you would like to begin treatment now. The tumor is HER2 IHC 0 with no membrane staining (HER2 null), her disease is gBRCA wild type, and PD-L1 testing has been sent but results are not yet available. What would you most likely do?



Dr Gradishar — Begin sacituzumab govitecan while awaiting PD-L1 results



Dr Hurvitz — Begin sacituzumab govitecan while awaiting PD-L1 results



Dr Rugo — Begin sacituzumab govitecan while awaiting PD-L1 results



Prof Schmid — Begin sacituzumab govitecan while awaiting PD-L1 results

RTP RESEARCH TO PRACTICE

First-Line Treatment Before PD-L1 Testing Results Are Available



Professor Peter Schmid, FRCP, MD, PhD

RTP
RESEARCH TO PRACTICE

Comments from General Medical Oncologist Participants

"Actually I had this situation just two weeks ago. A woman in her 60s — never sought any care and pretty much the breast was completely gone. Unfortunately, we see these patients again and again who delay seeking attention. This was very sad. Her sister is a nurse I know who brought her in. Lung and lymph node disease; biopsy showed it was triple negative. We immediately started her on SG, and about a week later her PD-L1 came back high so we added pembro."

Topic 6: BRCA/HRD Status and PARP Inhibitor (PARPi) Use

Which results on tissue NGS or genetic testing will lead you to consider the use of a PARPi in the first- or second-line metastatic setting?

For eligible patients, how do you incorporate a PARPi into treatment when PD-L1 CPS > 10?

For eligible patients, how do you incorporate a PARPi into treatment when PD-L1 CPS < 10?

<u>Case scenario</u>
60-year-old woman
De novo mTNBC involving liver and bone
HER2 IHC 0; gBRCA1 pathogenic variant
ECOG PS 0
PD-L1 CPS <10

Which first-line therapy would you most likely recommend?

A 60-year-old woman presents with de novo mTNBC involving liver and bone. She has a gBRCA1 pathogenic variant, ECOG PS 0, and the tumor is HER2 IHC 0 with no membrane staining (HER2 null) and PD-L1 CPS <10. Which first-line therapy would you most likely recommend?



Dr Gradishar — Olaparib or talazoparib



Dr Hurvitz — Olaparib or talazoparib



Dr Rugo — Olaparib or talazoparib



Prof Schmid — Olaparib or talazoparib

RTP RESEARCH TO PRACTICE

A 60-year-old woman presents with de novo mTNBC involving liver and bone. She has a germline BRCA1 pathogenic variant, ECOG PS 0, and the tumor is HER2 IHC 0 with no membrane staining (HER2 null) and PD-L1 CPS 20. Which first-line therapy would you most likely recommend?



Dr Gradishar — Sacituzumab govitecan + pembrolizumab



Dr Hurvitz — Sacituzumab govitecan + pembrolizumab



Dr Rugo — Sacituzumab govitecan + pembrolizumab



Prof Schmid — Sacituzumab govitecan + pembrolizumab

RTP RESEARCH TO PRACTICE

BRCA/HRD Status and PARPi Use

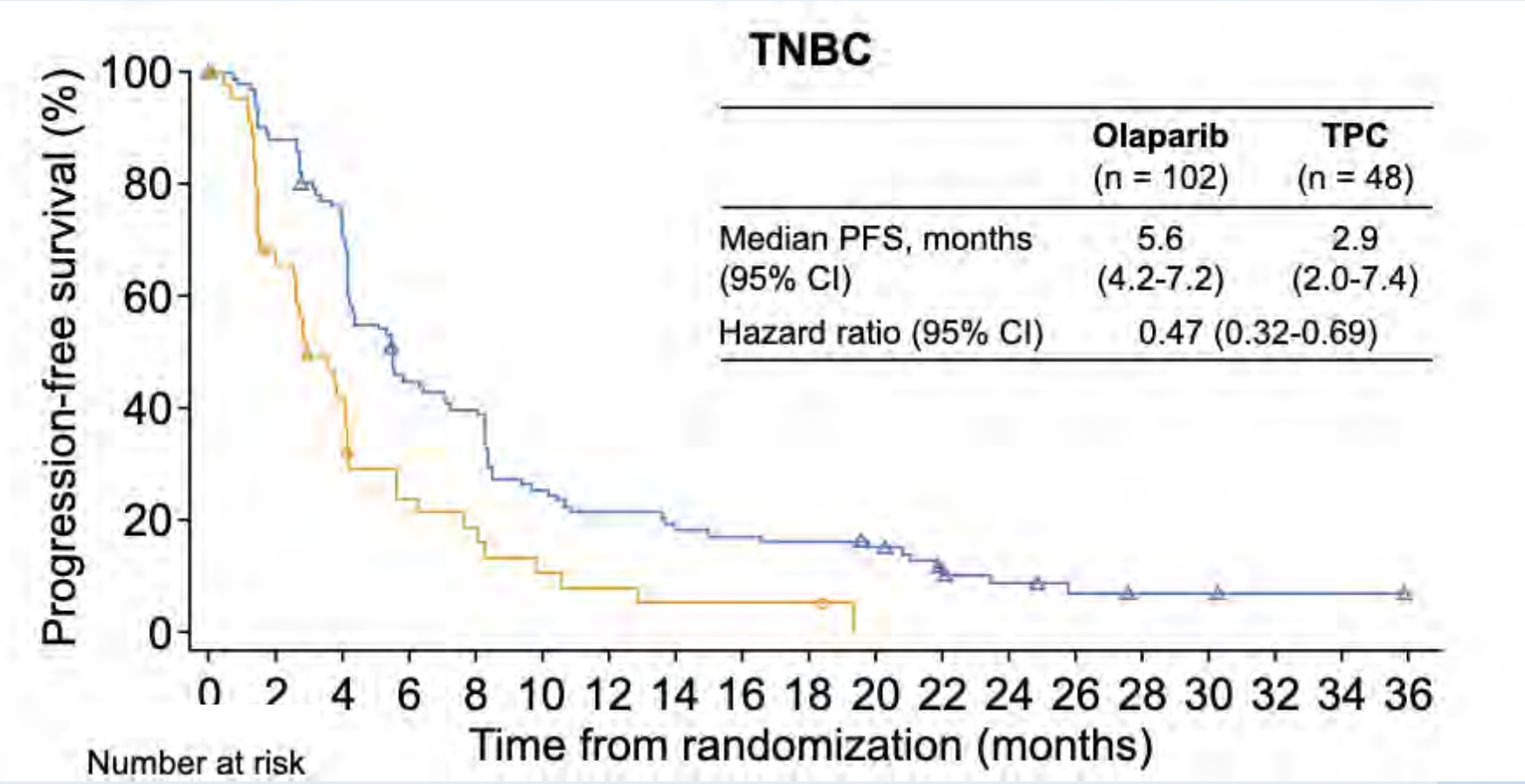


Sara A Hurvitz, MD, FACP

Comments from General Medical Oncologist Participants

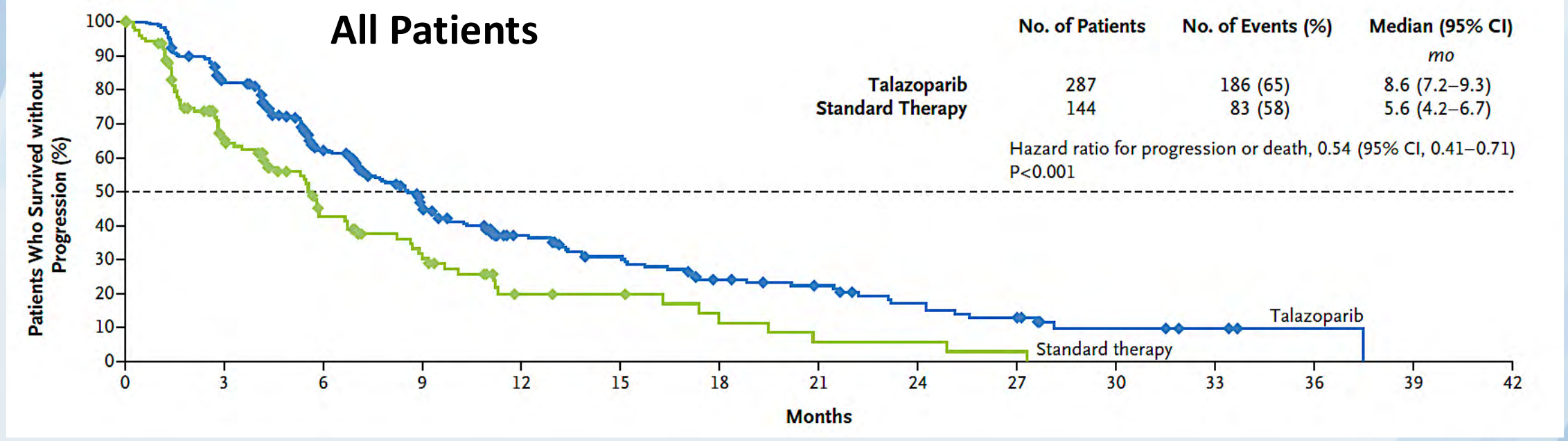
"Dr Hurvitz doesn't differentiate between olaparib and talazoparib. That's good to know because I've never used talazoparib. Overall, this is a setting where I would be very uncomfortable making a decision as to what to do and it's good to hear how the KOLs think this through."

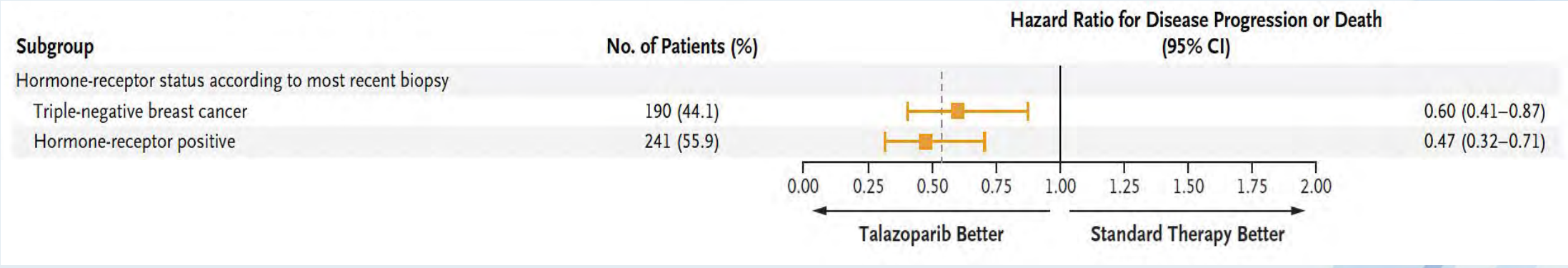
OlympiAD Trial Primary Endpoint: Progression-Free Survival with Olaparib for Advanced Breast Cancer with a Germline BRCA Mutation — TNBC Subgroup



Senkus E et al. *Int J Cancer* 2023;153(4);803-14.

EMBRACA Trial Primary Endpoint: Progression-Free Survival with Talazoparib for Advanced Breast Cancer with a Germline BRCA Mutation





Litton J et al. *N Engl J Med* 2018;379(8);753-63.

Agenda

Introduction: “Phase I Trial” of an Innovative CME Tool

Module 1: Selection of First-Line Therapy for Metastatic Triple-Negative Breast Cancer

Module 2: Adverse Events Associated with TROP2-Directed Antibody-Drug Conjugates

Module 3: Other Clinical Scenarios

RTP
RESEARCH TO PRACTICE

Topic 7: Sacitzumab Govitecan (SG) — G-CSF Prophylaxis

Do you use primary G-CSF prophylaxis for all patients who are beginning treatment with sacituzumab govitecan or only select patients at higher risk?

<u>Case scenario</u>
60-year-old woman
Excellent partial response to SG
Develops recurrent Grade 3 neutropenia after several cycles despite G-CSF support, resulting in treatment delays
Otherwise tolerates therapy well, ECOG PS 0

What would you most likely do in terms of dosing and schedule of SG?

Do you use primary G-CSF prophylaxis for all patients who are beginning treatment with sacituzumab govitecan or only select patients at higher risk?



Dr Gradishar — Select patients based on risk



Dr Hurvitz — Select patients based on risk



Dr Rugo — Select patients based on risk



Prof Schmid — All patients

RTP RESEARCH TO PRACTICE

A 60-year-old woman with mTNBC has had an excellent partial response to sacituzumab govitecan. After several cycles, she develops recurrent Grade 3 neutropenia despite G-CSF support, resulting in treatment delays. She otherwise tolerates therapy well and has ECOG PS 0. What would you most likely do?



Dr Gradishar

Reduce sacituzumab govitecan to 7.5 mg/kg and continue treatment



Dr Hurvitz

Reduce sacituzumab govitecan to 7.5 mg/kg and continue treatment



Dr Rugo

Reduce sacituzumab govitecan to 7.5 mg/kg and continue treatment



Prof Schmid

Reduce sacituzumab govitecan to 7.5 mg/kg and continue treatment

RTP RESEARCH TO PRACTICE

Sacituzumab Govitecan: G-CSF Prophylaxis



Hope S Rugo, MD

RTP RESEARCH TO PRACTICE

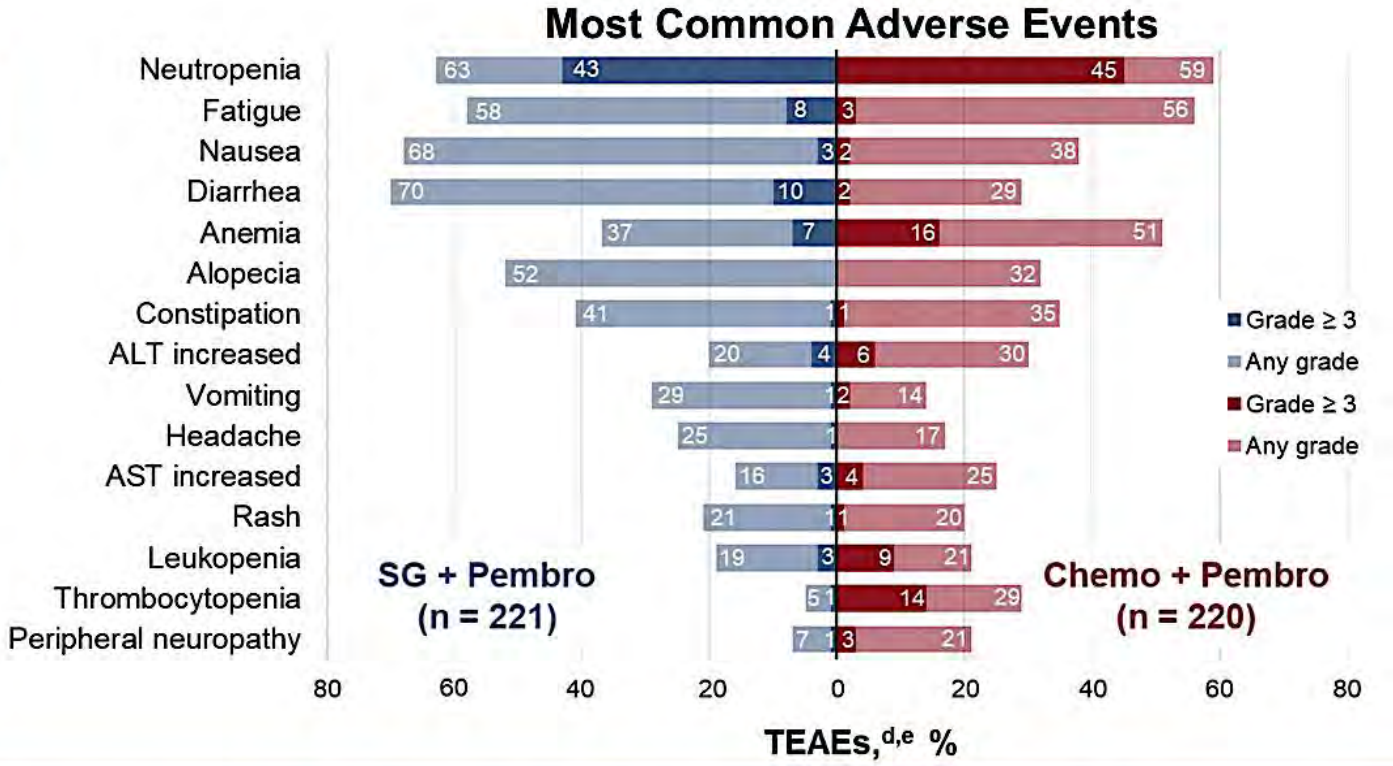
Comments from General Medical Oncologist Participants

"I had two recent patients who started saci. One was African-American with some baseline neutropenia as it is. She received GCSF but is still having neutropenia between day 1 and 8 — ANC between 0.5 and 1.0, but no febrile neutropenia. She did well."

"I've used saci for metastatic breast cancer far more than I have dato. I'm very comfortable managing neutropenia giving GCSF and loperamide for diarrhea. But, if someone has blurred vision on dato, I don't know what to do."

Phase III ASCENT-04: Common Adverse Events (AEs)

n (%)	SG + Pembro (n = 221)	Chemo + Pembro (n = 220)
Any TEAE	220 (> 99)	219 (> 99)
Grade ≥ 3	158 (71)	154 (70)
Treatment-emergent SAE	84 (38)	68 (31)
Treatment-related	61 (28)	42 (19)
TEAEs leading to treatment discontinuation[a]	26 (12)	68 (31)
TEAEs leading to dose interruption	171 (77)	162 (74)
TEAEs leading to dose reduction	78 (35)	96 (44)
TEAEs leading to death[c]	7 (3)	6 (3)
Treatment-related	3 (1)	1 (< 1)



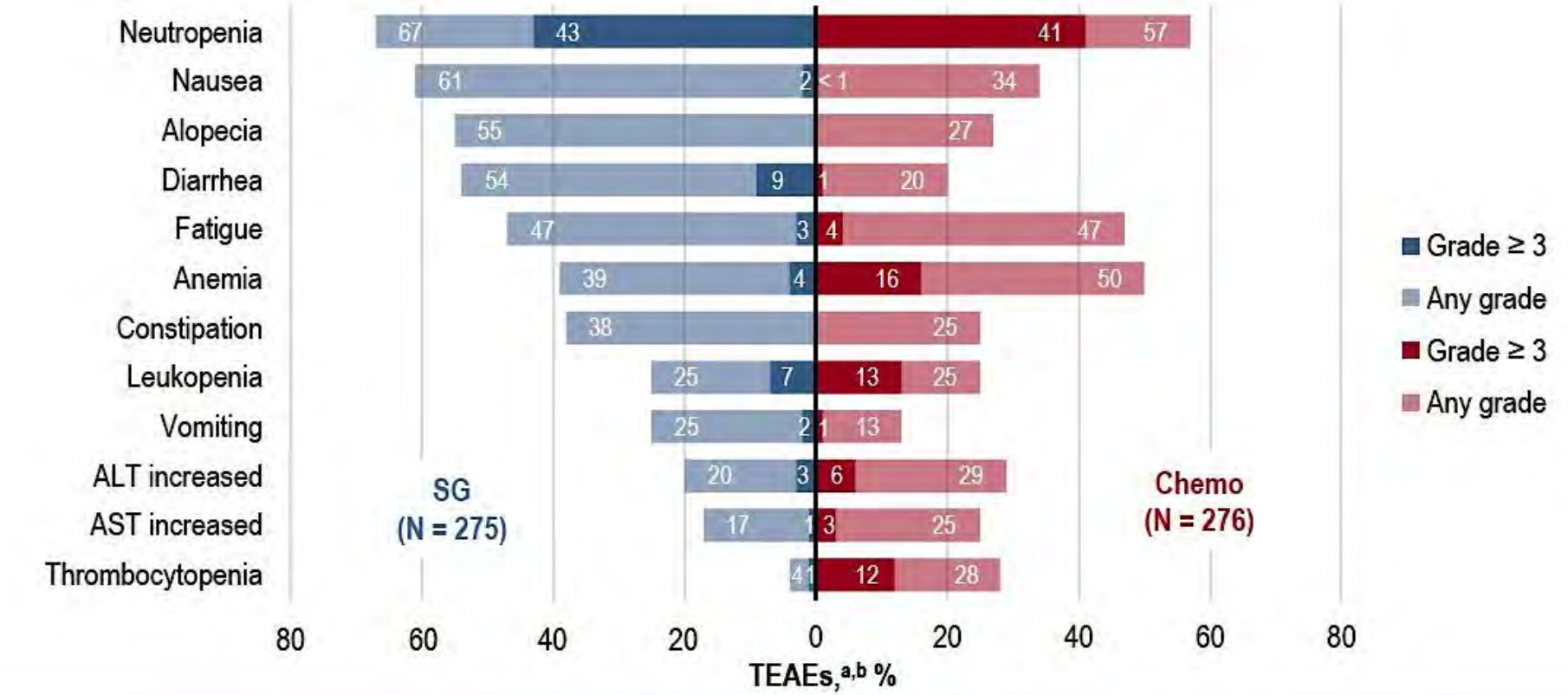
The AEs observed were consistent with the known profiles of both SG and pembro, with no new safety concerns

TEAE = treatment-emergent adverse event; SAE = serious adverse event

RTP RESEARCH TO PRACTICE

Kalinsky K et al. ASCO 2026;Abstract LBA1000. Tolaney SM et al. *NEJM* 2026;394:354-66.

Phase III ASCENT-03: Common AEs



The AEs observed are consistent with the known safety profile of SG

Data cutoff date: April 2, 2025. [a]TEAEs were included if they occurred in ≥ 20% of patients in either group. [b]Combined preferred terms of Neutropenia includes neutrophil count decreased, Fatigue includes asthenia, Anemia includes hemoglobin decreased and red blood cell count decreased, Leukopenia includes white blood cell count decreased, and Thrombocytopenia includes platelet count decreased.
AE, adverse event; **ALT**, alanine aminotransferase; **AST**, aspartate aminotransferase; **chemo**, chemotherapy; **SG**, sacituzumab govitecan; **TEAE**, treatment-emergent adverse event.

Cortés J et al. ESMO 2025;Abstract LBA20. Cortés J et al. *N Engl J Med* 2025;393(19):1912-25.

Topic 8: Dato-DXd — Prevention and Management of Mucositis

Which preemptive anti-mucositis approaches, if any, do you use for patients who receive Dato-DXd?

<u>Case scenario</u>
60-year-old woman
Recurrent mTNBC to bones and lungs, about to start Dato-DXd
No baseline oral lesions or history of significant mucositis

Which strategy would you routinely recommend to reduce the risk of stomatitis, if any, beginning with the first Dato-DXd dose?

A 60-year-old woman with recurrent mTNBC is about to start Dato-DXd. She has no baseline oral lesions or history of significant mucositis. Which strategy would you routinely recommend beginning with the first dose to reduce the risk of stomatitis?



Dr Gradishar

Steroid-containing mouthwash and oral cryotherapy during the infusion



Dr Hurvitz

Steroid-containing mouthwash and oral cryotherapy during the infusion



Dr Rugo

Steroid-containing mouthwash alone



Prof Schmid

Steroid-containing mouthwash and oral cryotherapy during the infusion

RTP RESEARCH TO PRACTICE

Dato-DXd: Prevention and Management of Mucositis



William J Gradishar, MD


COMPLETELY SOLID!
THE WORLD'S LARGEST LOLLIPOP!
1.75 LBS!

Comments from General Medical Oncologist Participants

"Ice chips I haven't done routinely, and the cryo device I have to look into. These videos are very, very helpful. Lollipop is interesting. I remember Neil asking about mucositis ages ago with everolimus."

Phase III TROPION-Breast02: Common AEs

Treatment-related AEs, n (%)	Dato-DXd (n=319)		ICC (n=309)	
	Any Grade	Grade ≥3	Any Grade	Grade ≥3
Dry eye*	76 (24)	4 (1)	9 (3)	0
Stomatitis	182 (57)	27 (8)	27 (9)	0
Nausea	142 (45)	2 (<1)	53 (17)	2 (<1)
Constipation	72 (23)	1 (<1)	31 (10)	0
Vomiting	65 (20)	4 (1)	23 (7)	1 (<1)
Decreased appetite	49 (15)	1 (<1)	20 (6)	1 (<1)
Neutropenia†	39 (12)	10 (3)	90 (29)	40 (13)
Anaemia‡	48 (15)	6 (2)	64 (21)	10 (3)
Leukopenia§	27 (8)	3 (<1)	55 (18)	13 (4)
Peripheral neuropathy¶	14 (4)	0	75 (24)	5 (2)
Alopecia	130 (41)	0	96 (31)	1 (<1)‖
Fatigue#	101 (32)	8 (3)	86 (28)	9 (3)

Dent R et al. ESMO 2025;Abstract LBA21. Dent R et al. *Ann Oncol* 2026;37(8):1066-80.

Agenda

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RTP RESEARCH TO PRACTICE

A 60-year-old woman with mTNBC had HER2 IHC 0 with no membrane staining (HER2 null) in the primary breast tumor. At metastatic recurrence, a lung biopsy shows HER2 IHC 1+ (HER2 low). She has now experienced disease progression after first-line therapy. Which HER2 result would most influence whether you consider T-DXd?



Dr Gradishar

Any prior specimen demonstrating HER2-low expression



Dr Hurvitz

Any prior specimen demonstrating HER2-low expression



Dr Rugo

Any prior specimen demonstrating HER2-low expression



Prof Schmid

Any prior specimen demonstrating HER2-low expression

RTP RESEARCH TO PRACTICE

A 60-year-old woman with mTNBC is about to start sacituzumab govitecan. Her baseline blood counts are normal. Prior liquid biopsy testing reported UGT1A1 *28/*28, consistent with poor metabolizer status. How would this result influence your initial management?



Dr Gradishar

Start sacituzumab govitecan at a reduced dose with primary G-CSF prophylaxis



Dr Hurvitz

Start sacituzumab govitecan at a reduced dose with primary G-CSF prophylaxis



Dr Rugo

Start sacituzumab govitecan at a reduced dose with primary G-CSF prophylaxis



Prof Schmid

Start sacituzumab govitecan at a reduced dose with primary G-CSF prophylaxis

G-CSF = granulocyte colony-stimulating factor

RTP RESEARCH TO PRACTICE

A 60-year-old woman receiving SG calls after cycle 1, day 8 reporting 6 watery stools over the preceding 12 hours. She is afebrile and has no abdominal pain but reports mild dizziness and reduced oral intake. What would you recommend initially?



Dr Gradishar

Begin loperamide and encourage aggressive oral hydration while monitoring closely



Dr Hurvitz

Begin loperamide and encourage aggressive oral hydration while monitoring closely



Dr Rugo

Begin loperamide and encourage aggressive oral hydration while monitoring closely



Prof Schmid

Begin loperamide and encourage aggressive oral hydration while monitoring closely

RTP RESEARCH TO PRACTICE

A 60-year-old woman with mTNBC is about to receive her first dose of SG. She has a history of significant nausea with prior chemotherapy but no other major comorbidities. Which antiemetic strategy would you most likely use with the first dose?



Dr Gradishar

5-HT3 antagonist + NK1 antagonist + dexamethasone + olanzapine



Dr Hurvitz

5-HT3 antagonist + NK1 antagonist + dexamethasone



Dr Rugo

5-HT3 antagonist + NK1 antagonist + dexamethasone



Prof Schmid

5-HT3 antagonist + NK1 antagonist + dexamethasone

RTP RESEARCH TO PRACTICE

A 60-year-old woman with mTNBC is about to start Dato-DXd. She wears contact lenses daily and has no history of significant ocular disease. Which approach would you most likely recommend?



Dr Gradishar

Evaluation by an eye care professional, eye drops, avoid contact lenses during treatment, visual acuity/slit lamp assessment every 3 cycles



Dr Hurvitz

Evaluation by an eye care professional, eye drops, avoid contact lenses during treatment, visual acuity/slit lamp assessment every 3 cycles



Dr Rugo

Evaluation by an eye care professional, eye drops, avoidance of contact lenses day before and a couple days after treatment, visual acuity/slit lamp assessment every 3 cycles



Prof Schmid

Evaluation by an eye care professional, eye drops, avoid contact lenses during treatment, visual acuity/slit lamp assessment every 3 cycles

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RESEARCH TO PRACTICE

A 60-year-old woman with mTNBC has a tumor that is PD-L1 CPS 0 and HER2 IHC 1+ (HER2 low). She received chemotherapy alone in the first-line setting and now has disease progression. Because of significant baseline gastrointestinal issues with chronic diarrhea, SG is felt to be a poor treatment option. She has an ECOG PS 1 and is a former smoker with mild COPD, but has no baseline dyspnea or oxygen requirement. Recent CT chest shows no evidence of interstitial lung disease. Would you proceed with T-DXd?



Dr Gradishar

Yes, at the standard dose with careful pulmonary monitoring



Dr Hurvitz

Yes, but only after pulmonary consultation



Dr Rugo

Yes, at the standard dose with careful pulmonary monitoring



Prof Schmid

Yes, at the standard dose with careful pulmonary monitoring

RTP RESEARCH TO PRACTICE

A 60-year-old woman with mTNBC and a tumor that is HER2 IHC 1+ is about to start T-DXd after progression on prior therapy. She has an ECOG PS 0 and a history of substantial nausea and vomiting with prior chemotherapy. Which antiemetic regimen would you most likely use beginning with the first dose of T-DXd?



Dr Gradishar

5-HT3 antagonist + NK1 antagonist + dexamethasone + olanzapine



Dr Hurvitz

5-HT3 antagonist + NK1 antagonist + dexamethasone + olanzapine



Dr Rugo

5-HT3 antagonist + NK1 antagonist + dexamethasone + olanzapine



Prof Schmid

5-HT3 antagonist + NK1 antagonist + dexamethasone

RTP RESEARCH TO PRACTICE

In general, how would you compare the risk of a patient developing interstitial lung disease with Dato-Dxd to the risk with T-DXd?



Dr Gradishar — Risk is lower with Dato-DXd



Dr Hurvitz — Risk is lower with Dato-DXd



Dr Rugo — Risk is lower with Dato-DXd



Prof Schmid — Risk is lower with Dato-DXd

RTP RESEARCH TO PRACTICE

A 60-year-old woman with mTNBC and a tumor that is HER2 IHC 1+ is about to start T-DXd. She is particularly concerned about hair loss and asks whether she should use scalp cooling. How would you counsel her?



Dr Gradishar

I would discuss that alopecia is common with T-DXd and that prospective data have not demonstrated a significant reduction in alopecia with scalp cooling



Dr Hurvitz

I would discuss that alopecia is common with T-DXd and that prospective data have not demonstrated a significant reduction in alopecia with scalp cooling



Dr Rugo

I would discuss that alopecia is common with T-DXd and that prospective data have not demonstrated a significant reduction in alopecia with scalp cooling



Prof Schmid

I would recommend scalp cooling; although its benefits are not proven, it has appeared to work for a small number of my patients

RTP
RESEARCH TO PRACTICE

Second Opinion: A Case-Based Exploration of Clinical Investigator Best Practices Related to the Management of Breast Cancer

A CME Satellite Symposium Series in San Antonio

HER2-Positive Breast Cancer

Tuesday, December 8, 2026

7:00 PM – 9:00 PM CT

PI3K/AKT/mTOR Inhibitors for HR-Positive Breast Cancer

Tuesday, December 8, 2026

7:00 PM – 9:00 PM CT

Triple-Negative Breast Cancer

Wednesday, December 9, 2026

7:00 PM – 9:00 PM CT

Localized HR-Positive Breast Cancer

Thursday, December 10, 2026

7:00 PM – 9:00 PM CT

Oral SERDs for HR-Positive Breast Cancer

Thursday, December 10, 2026

7:00 PM – 9:00 PM CT

RTP RESEARCH TO PRACTICE

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.

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RESEARCH TO PRACTICE