Patterns of Care: Exploring How Community Oncologists Manage Metastatic Triple-Negative Breast Cancer

A CME/MOC-Accredited Live Webinar

Tuesday, July 21, 2026

5:00 PM – 6:00 PM ET

Faculty

Professor Peter Schmid, FRCP, MD, PhD

Melinda Telli, MD, FASCO

Moderator

Neil Love, MD

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Faculty

Professor Peter Schmid, FRCP, MD, PhD
Lead, Centre of Experimental Cancer Medicine
Barts Cancer Institute
London, United Kingdom

MODERATOR
Neil Love, MD
Research To Practice
Miami, Florida

Melinda Telli, MD, FASCO
Professor of Medicine
Director, Breast Cancer Program
Associate Director for Clinical Research
Stanford University School of Medicine
Stanford Cancer Institute
Stanford, California

Commercial Support

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Dr Love — Disclosures

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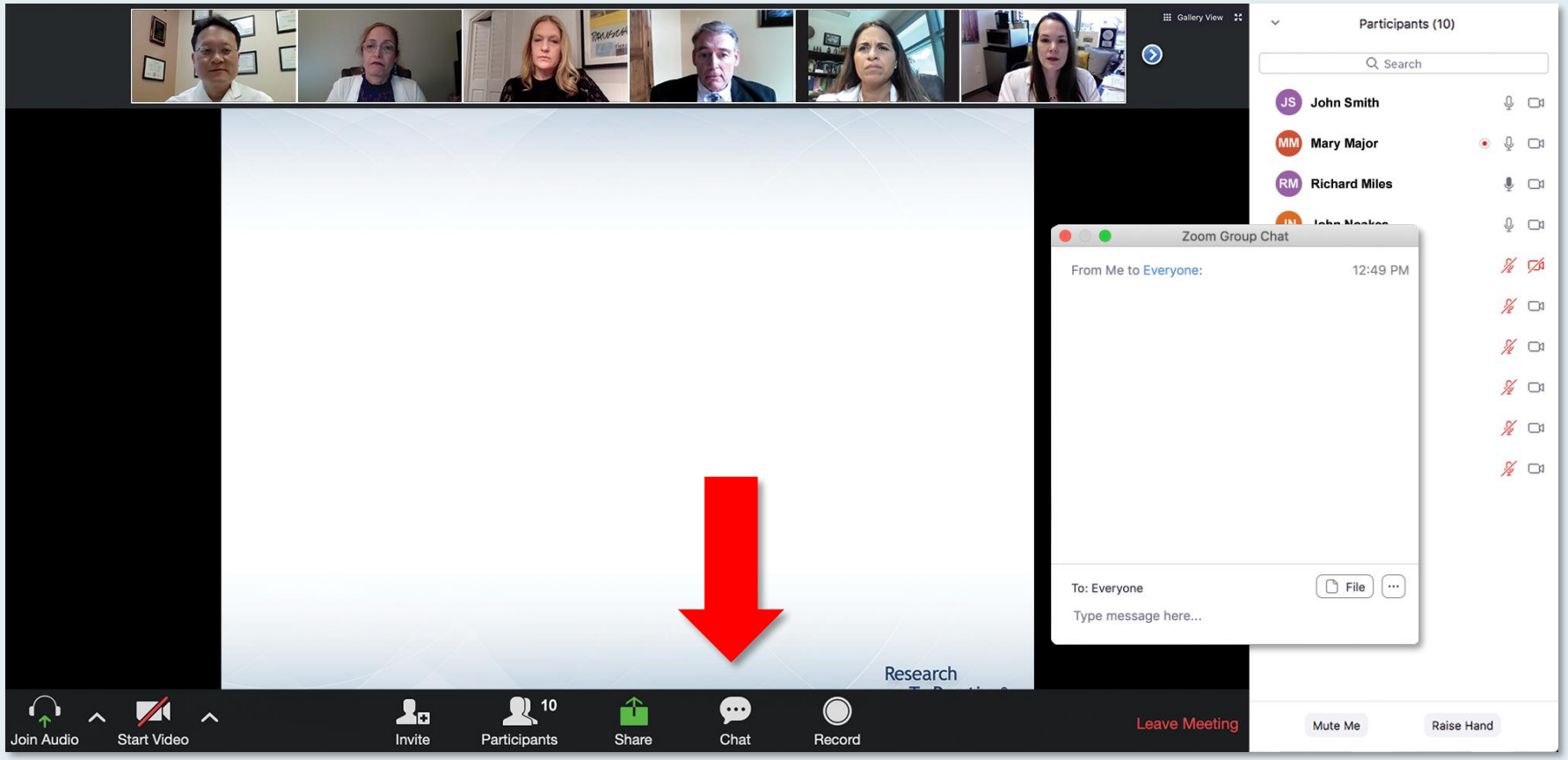

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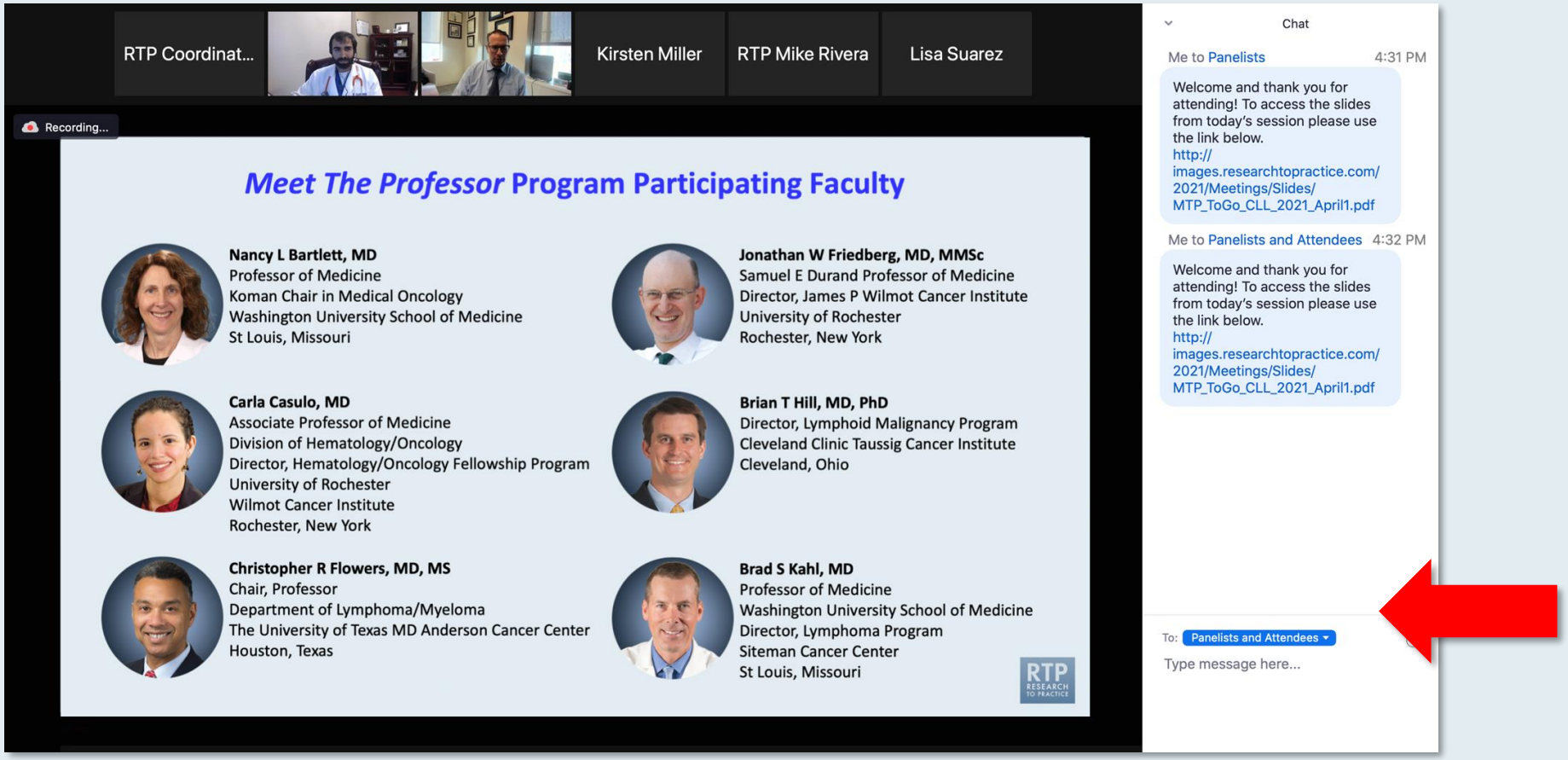

Drag the white line above the submission box up to create more space for your message.

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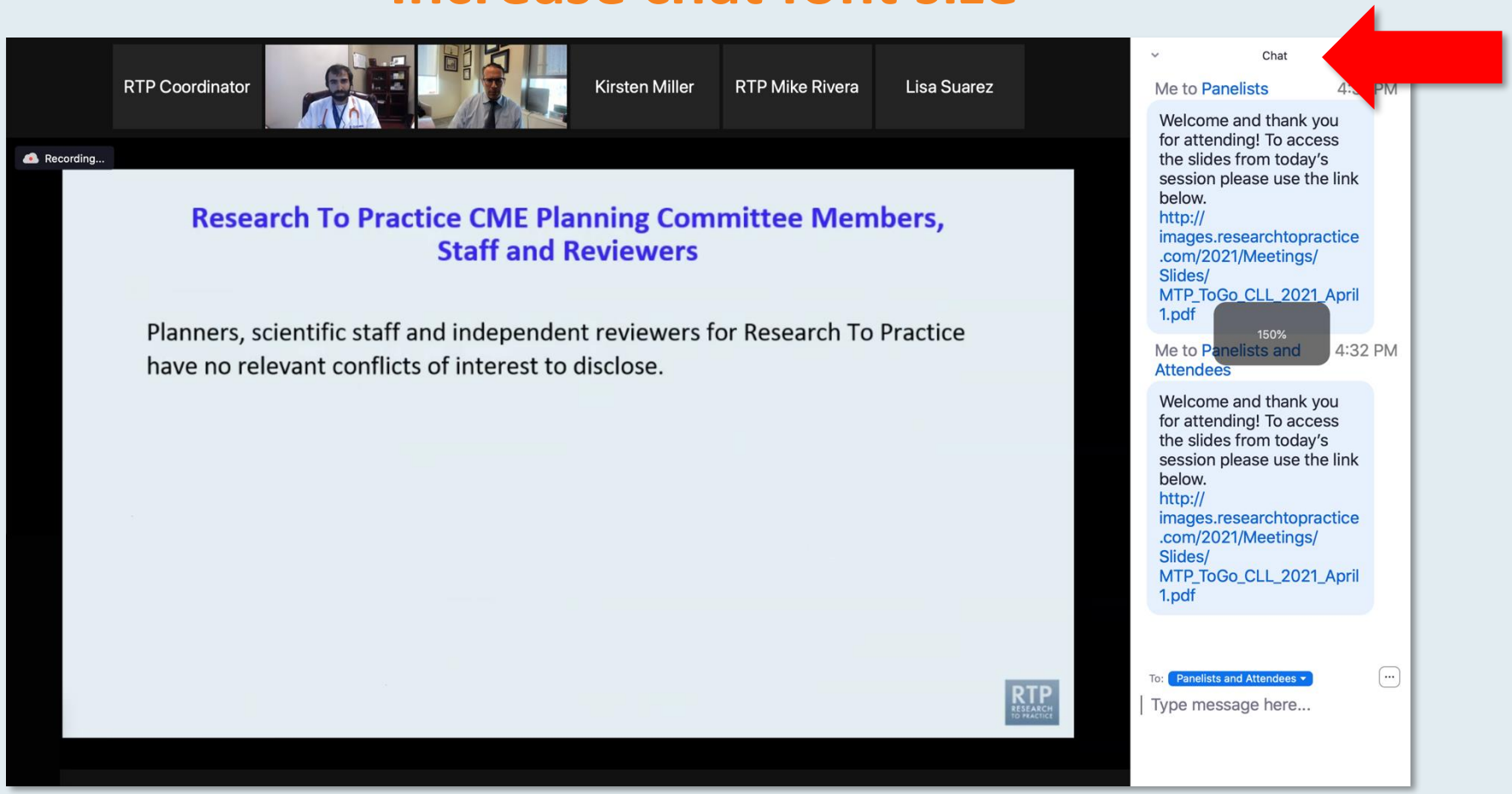

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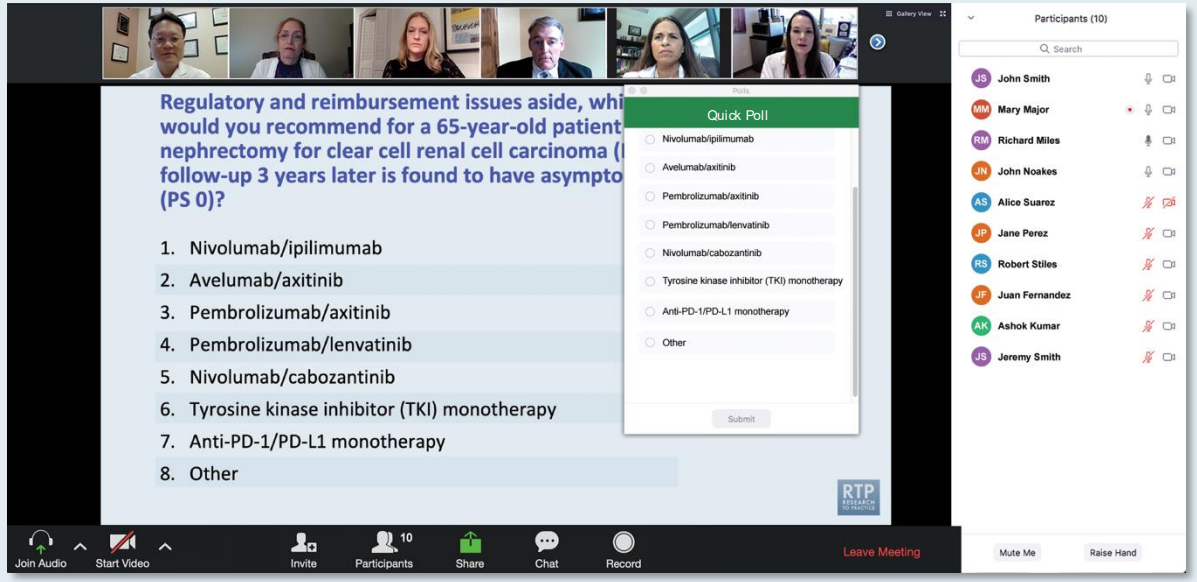

ONCOLOGY TODAY

WITH DR NEIL LOVE

Metastatic Triple-Negative Breast Cancer — What Clinicians Want to Know

KEVIN PUNIE, MD
ZAS HOSPITALS

TIFFANY A TRAINA, MD, FASCO
MEMORIAL SLOAN KETTERING CANCER CENTER

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Bringing the Investigator into the Equation — Optimal Use of Hormonal Therapy in the Care of Patients with Prostate Cancer

A CME/MOC-Accredited Live Webinar

Wednesday, July 29, 2026
5:00 PM – 6:00 PM ET

Faculty

William K Oh, MD
Mary-Ellen Taplin, MD

Moderator

Neil Love, MD

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The Implications of Recent Datasets for the Current and Future Management of Breast Cancer — An ASCO 2026 Review

A CME/MOC-Accredited Live Webinar

Thursday, July 30, 2026
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Aditya Bardia, MD, MPH
Kevin Kalinsky, MD, MS, FASCO
Joyce O'Shaughnessy, MD

Moderator

Neil Love, MD

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Join Us In Person or Virtually

Integrating New Advances into the Care of Patients with Cancer

A Multitumor Symposium Hosted in Conjunction with the American Oncology Network

Saturday, August 22, 2026

JW Marriott Nashville | Nashville, Tennessee

Chronic Lymphocytic Leukemia
9:00 AM – 9:50 AM CT

Gastroesophageal Cancers
9:50 AM – 10:40 AM CT

Gynecologic Cancers
10:55 AM – 11:45 AM CT

Diffuse Large B-Cell Lymphoma
12:35 PM – 1:25 PM CT

Lung Cancer
1:25 PM – 2:15 PM CT

Moderator
Stephen “Fred” Divers, MD

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Grand Rounds

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Optimizing the Use of Novel Therapies for Patients with Diffuse Large B-Cell Lymphoma

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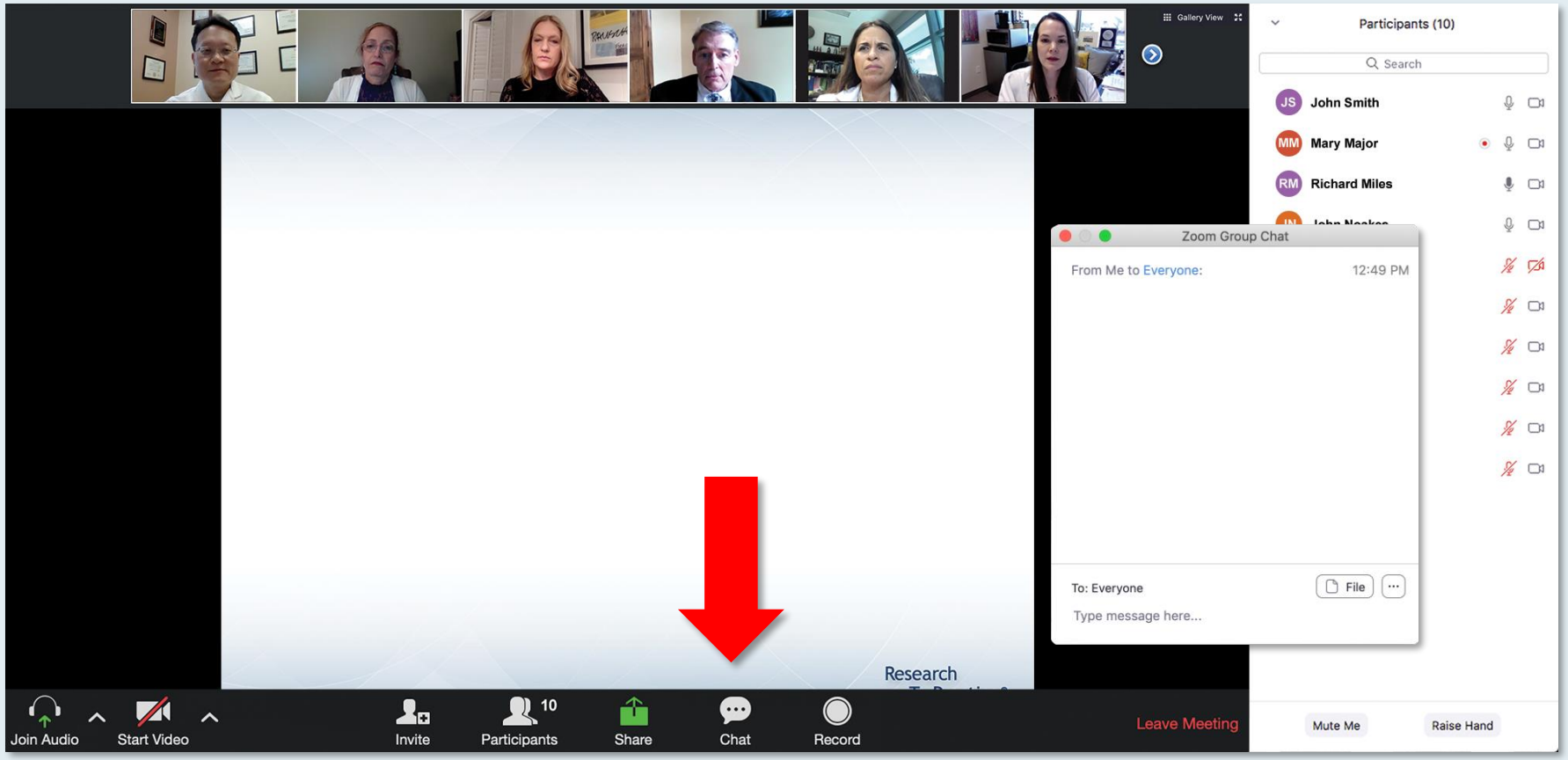

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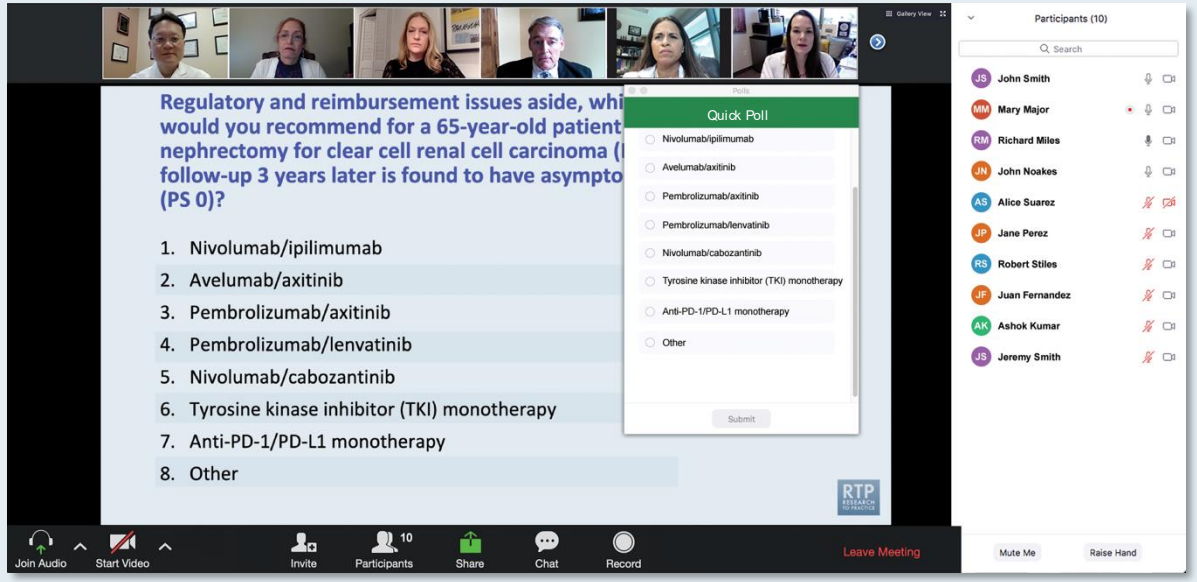

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Agenda:
Metastatic Triple-Negative Breast Cancer (mTNBC)

Introduction: TROP2-Targeting Antibody-Drug Conjugates (ADCs) for mTNBC

Module 1: First-Line Therapy (PD-L1 Negative)

Module 2: First-Line Therapy (PD-L1 Positive)

Module 3: Second-Line Therapy (Sequencing)

Module 4: Adverse Events with TROP2-Targeting ADCs

RTP Education Elements

- Research findings
- Clinical scenarios
- Real-world cases

Optimizing the Management of Metastatic Triple-Negative Breast Cancer

Survey of 50 Community-Based General Medical Oncologists
April 21 to 29, 2026

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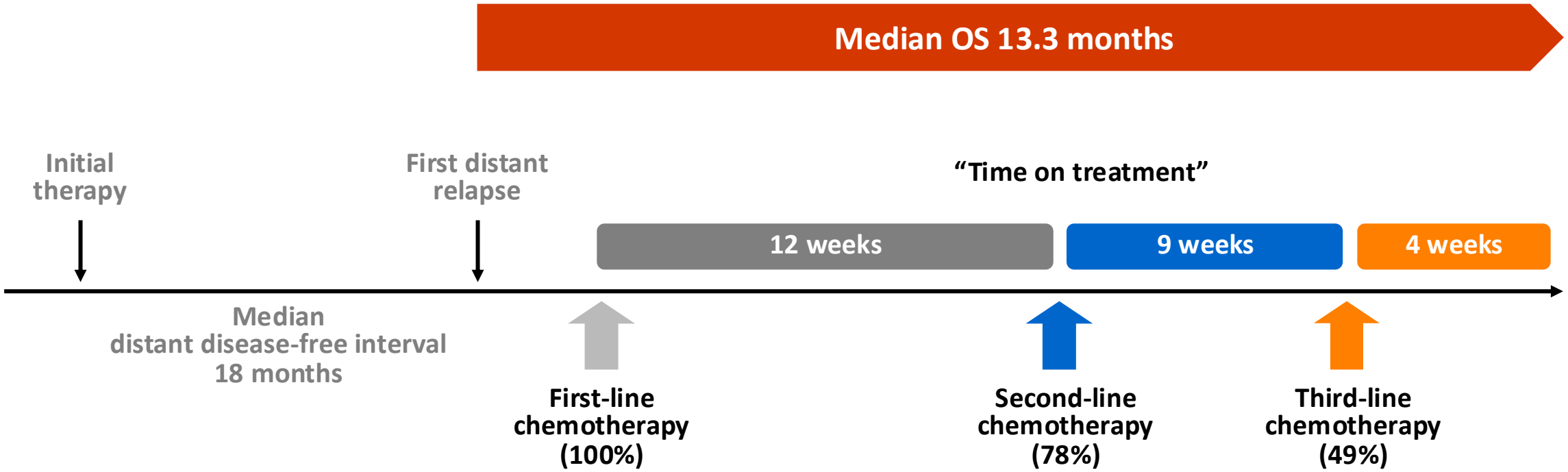
Evolving role TROP2-targeted ADCs in mTNBC

Professor Peter Schmid, MD PhD FRCP

Lead, Centre for Experimental Cancer Medicine

Barts Cancer Institute, St Bartholomew's Hospital
Queen Mary University of London

Poor outcome of metastatic TNBC

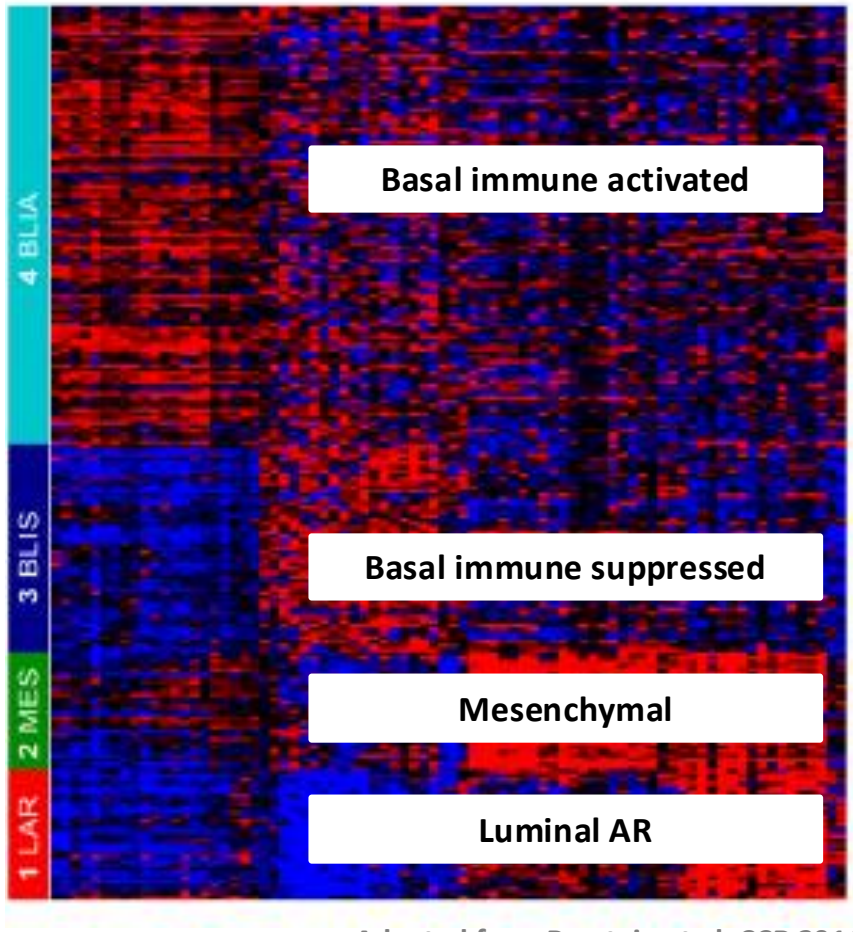


Kassam, et al. Clin Breast Cancer 2009

Understanding the Biology of TNBC

Heterogeneity of TNBC and Treatment Strategies

Gene Expression subtypes (Baylor)



Adapted from Burstein et al, CCR 2014

Target/Population

GE-Subtypes and Therapeutic Subgroups not aligned

- PD-L1+
- gBRCA-Mt+
- TROP2
- HER2
- HER3
- LIV1
- ?
- AR+/LAR

ADC targets don't need to be oncogenic drivers

Subgroups overlapping

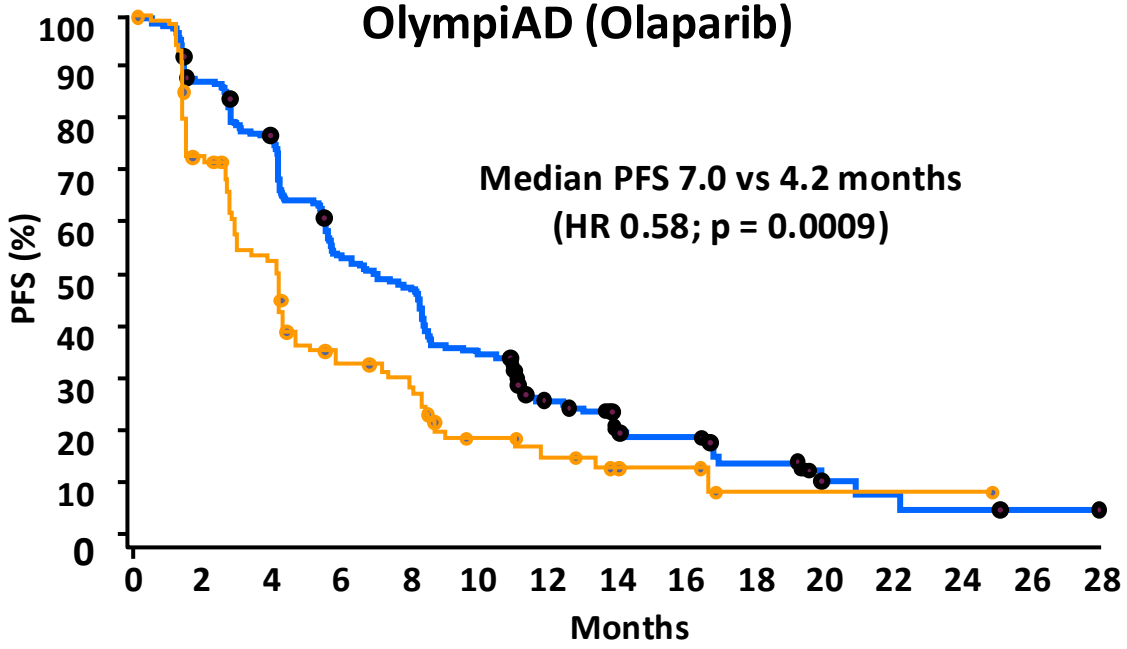
Therapeutic Strategies

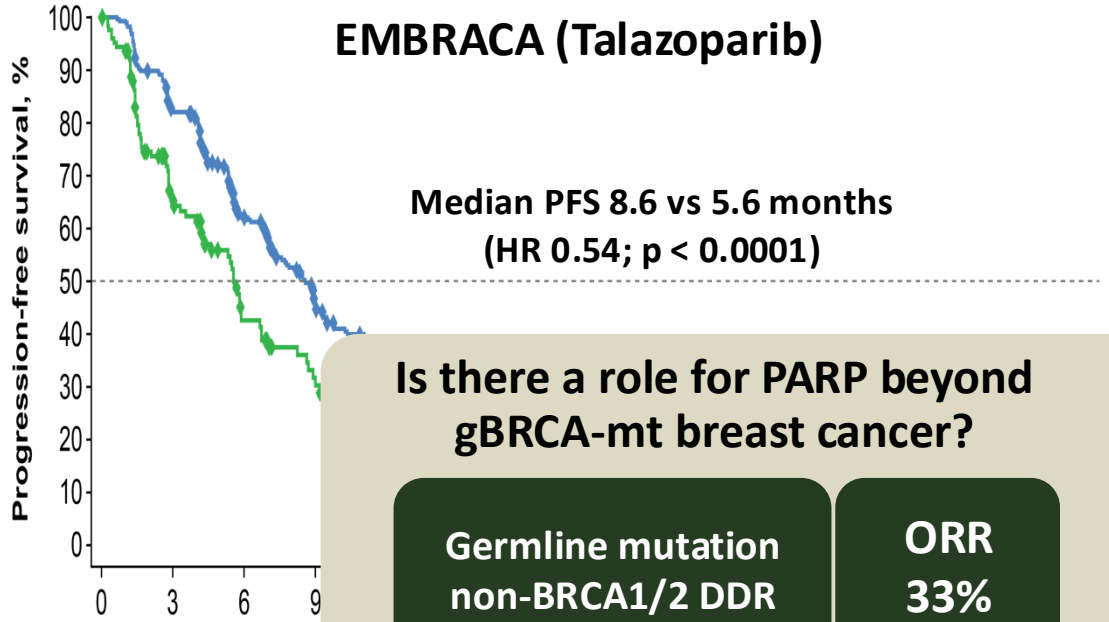
- Immunotherapy
- PARP inhibitors
- Antibody-Drug Conjugates
- AKT Inhibitors
- Anti-androgen

Schmid P, Personal Communication

Targeting PARP in breast cancer

Potential impact of platinum-based therapy on PARPi remains to be defined as trial excluded patients progressing on platinum-based therapy





RR	Olympia	EMBRACA
PARPi	60%	62.6%
Chemo	29%	27.2%

Carboplatin (TNT): ORR 68%

Is there a role for PARP beyond gBRCA-mt breast cancer?

Germline mutation non-BRCA1/2 DDR	ORR 33%
Somatic BRCA1/2-Mt or non-BRCA1/2 DDR	ORR 31%

Responses seen gPALB2 (82%) & sBRCA Mt (50%)

No responses seen in ATM or CHEK2 Mt

Tung, NM, et al. JCO 2020

Robson M, et al. NEJM 2017, Litton J, et al. NEJM 2018, Tutt A, et al Nature Med 2018

Immunotherapy provides OS benefit in PDL1+ mTNBC

IMpassion130 study design

- 1L mTNBC
- Treatment-free ≥ 12m
- PDL1+/- as per SP142

R 1:1

- Atezolizumab + *nab*-paclitaxel
- Placebo + *nab*-paclitaxel

Double blind; no crossover permitted

Stratification factors:
- Prior taxane use (yes vs no)
- Liver metastases (yes vs no)
- PD-L1 status (SP142 ≥1% vs < 1%)

KEYNOTE 355 study design

- 1L mTNBC
- Treatment-free ≥6m
- PDL1+/- as per CPD(22C3)

R 2:1

- Pembrolizumab + Chemotherapy*
- Pembrolizumab + Chemotherapy*

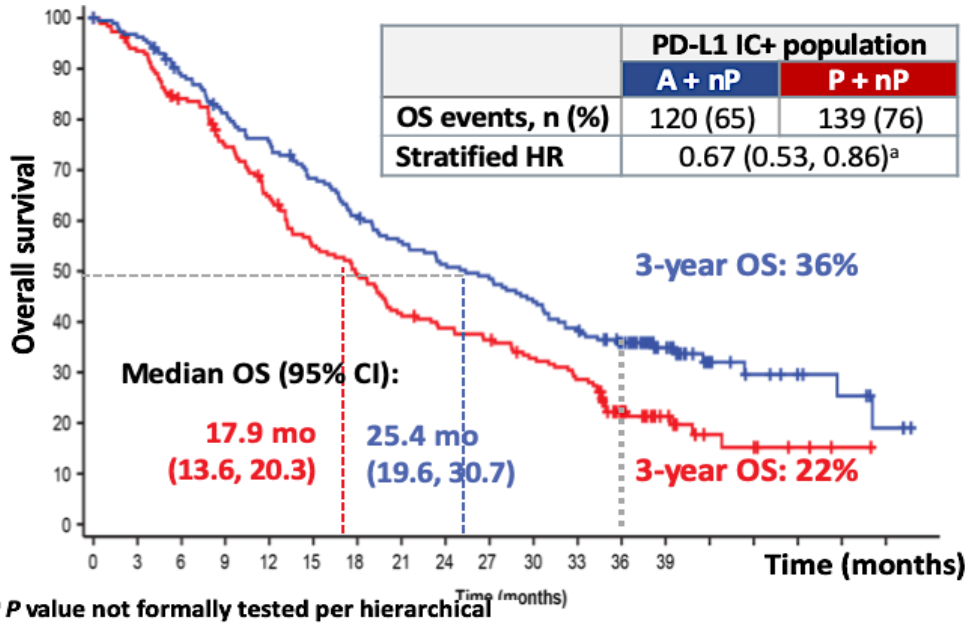
Double blind; no crossover permitted

Stratification factors:
- Prior therapy with same class chemo
- Chemo on study
- PD-L1 status (CPS ≥1 vs CPS <1)

*Nab-paclitaxel weekly or Paclitaxel weekly or Gemcitabine/Carboplatin

OS, SP142 ≥1%

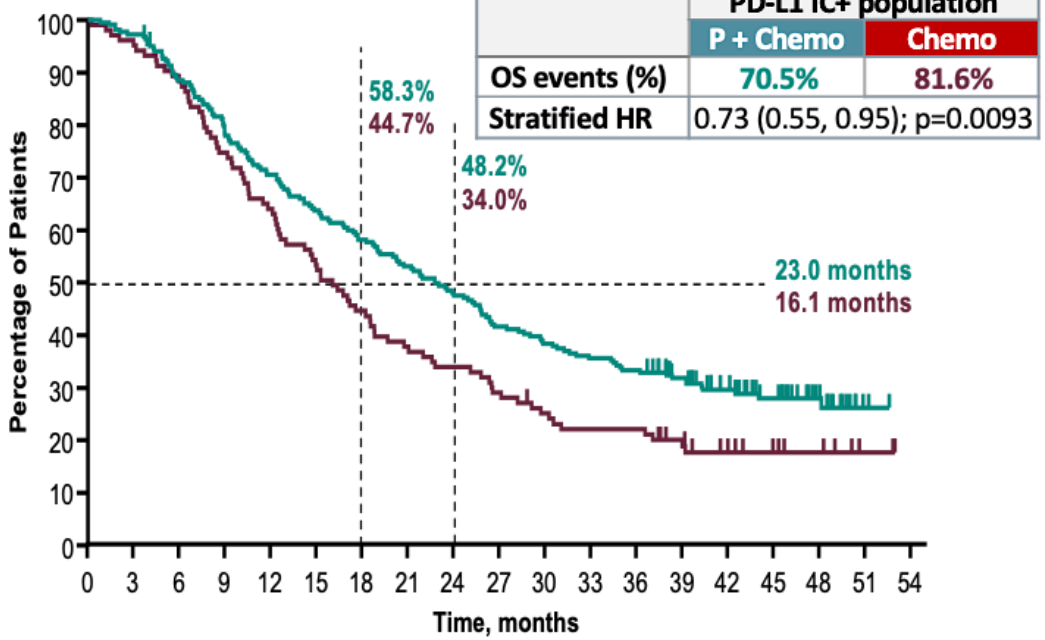
	PD-L1 IC+ population	
	A + nP	P + nP
OS events, n (%)	120 (65)	139 (76)
Stratified HR	0.67 (0.53, 0.86)[a]	



[a] *P* value not formally tested per hierarchical study design.

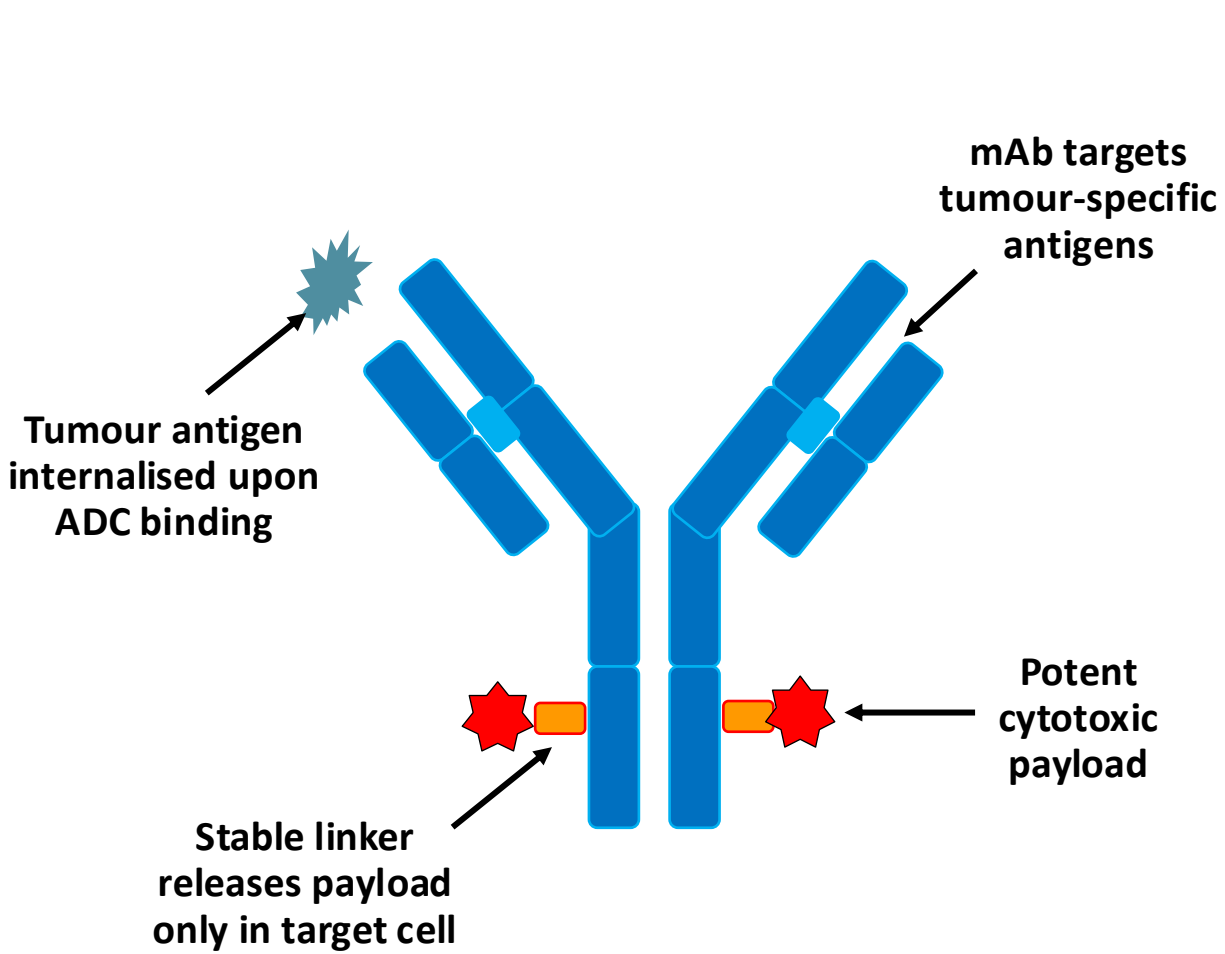
OS, CPS ≥10

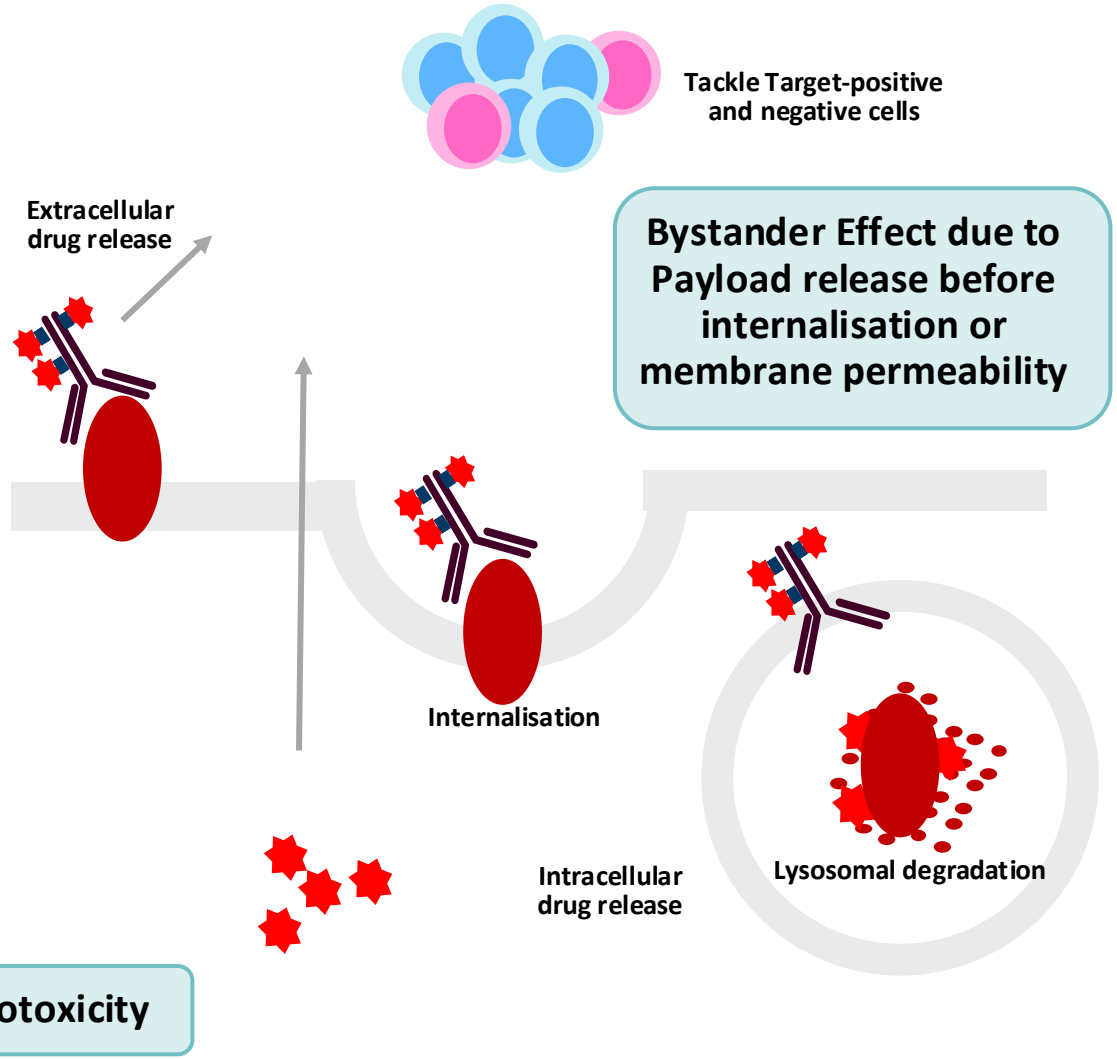
	PD-L1 IC+ population	
	P + Chemo	Chemo
OS events (%)	70.5%	81.6%
Stratified HR	0.73 (0.55, 0.95); p=0.0093	



Schmid, NEJM 2018; Emens LA, ESMO 2020; Cortes, SABCS 2021

New antibody–drug conjugates

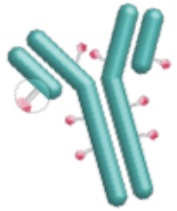




Schmid P, Personal Communication

ADC, antibody–drug conjugates; DCR, disease control rate
Modi S, et al. Presented at SABCS 2017. Abstract PD3-07.

TROP2-targeting ADCs in Breast Cancer



	Sacituzumab govitecan (SG)	Datopotamab deruxtecan (Dato-DXd)	Sacituzumab tirumotecan (Sac-TMT)
Antibody	hRS7 Humanized IgG1 mAb	MAAP-9001a Humanized IgG1 mAb	hRS7 Humanized IgG1 mAb
Payload	SN38 (DNA Topoisomerase I inhibitor)	DXd (DNA Topoisomerase I inhibitor)	KL610023 (DNA Topoisomerase I inhibitor)
Linker cleavage	Enzymatic and pH-dependent	Enzymatic	Enzymatic and pH-dependent
Bystander effect	Yes	Yes	Yes
DAR	7.6	4	7.4
Half-life	11-14h	~5 days	57h
Dosing	D1, D8 of Q3W schedule	Q3W	Q2W

Sands J et al. ASCO 2018; Okajima D et al. ASCO 2018; Bardia A et al. ESMO Breast Cancer 2021; Cheng Y et al. Front Oncol 2022.

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Cases from General Medical Oncologists

58 yo woman

- **mTNBC, PD-L1 CPS = 0, HER2-negative with metastases to liver, bone and LN. Prior DLBCL in remission. History of cardiomyopathy, heart failure, pacemaker.**
- **Neoadjuvant TC for TNBC without path CR, then adjuvant capecitabine. ctDNA negative at end of adjuvant treatment but both ctDNA and radiological progression in 3 months. On sacituzumab govitecan for 4 years.**

Do you retest PD-L1 status on progression? What are options for her as she has had R-CHOP, TCHP, TC, capecitabine and sacituzumab govitecan for different cancers, has cardiomyopathy but had durable response with saci? She is young and motivated with a very supportive spouse.

Cases from General Medical Oncologists

71 yo woman

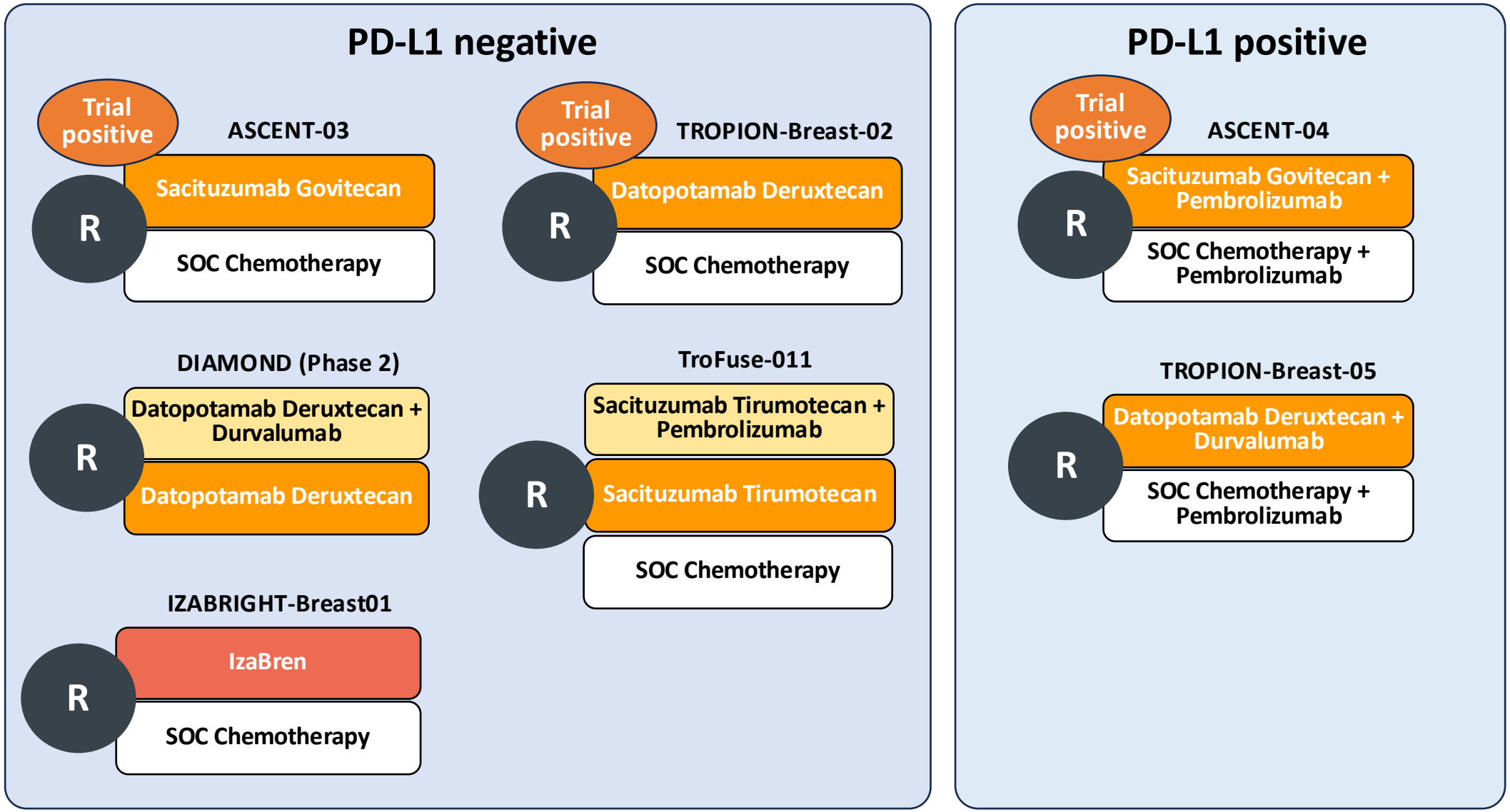
- **De novo metastatic TNBC, PD-L1 negative, HER2 IHC 0. No prior systemic therapy for breast cancer.**
- **Extensive liver metastases and peritoneal disease; anorexia, abdominal pain, rapidly declining performance status. Atrial fibrillation, diabetic neuropathy, frailty, ECOG 2 bordering on 3.**

For an older frail patient with PD-L1–negative visceral crisis-type mTNBC, what regimen would you favor up front to maximize likelihood of rapid response while preserving tolerability?

At what point do you move from combination chemotherapy to single-agent therapy or best supportive care in this setting?

TROP2 ADCs in 1st line metastatic TNBC

Ongoing 1st line trials with TOPO1-ADCs in mTNBC



Datopotamab-Deruxtecan (Dato-DXd) in 1L TNBC

TROPION-Breast02 Trial[1]

- Metastatic TNBC
- No prior chemotherapy
- Immunotherapy not an option
- Any DFI allowed
- Stable brain mets allowed

R 1:1

n = 323 → **Dato-DXd 6 mg/kg Q3W**

n = 321 → **TPC**: Paclitaxel, Nab-Paclitaxel (if DFI >12/12), Eribulin, Carboplatin, Capecitabine (if taxane and DFI <6/12)

Stratification factors:
- PDL1 (positive vs negative)
- Region: US/Canada/Europe vs Rest
- DFI: de novo vs 0-12m vs >12m

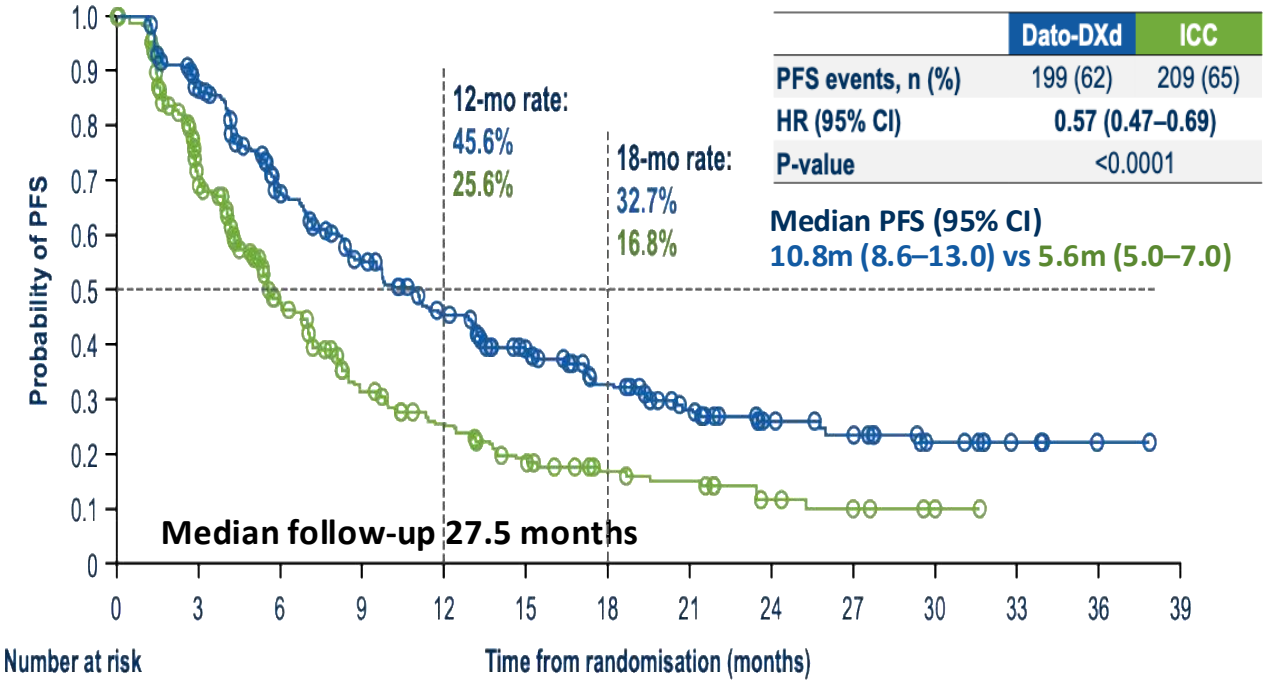
DFI:
- de novo mTNBC 34%,
- 0-6m 15%, 0-12m 21%,
- >12m 45%

No crossover offered. Use of 2L SG NOT provided through the study

42% of pts with subsequent Tx received SG

30% of all TPC pts with SG (72% had 2L+)

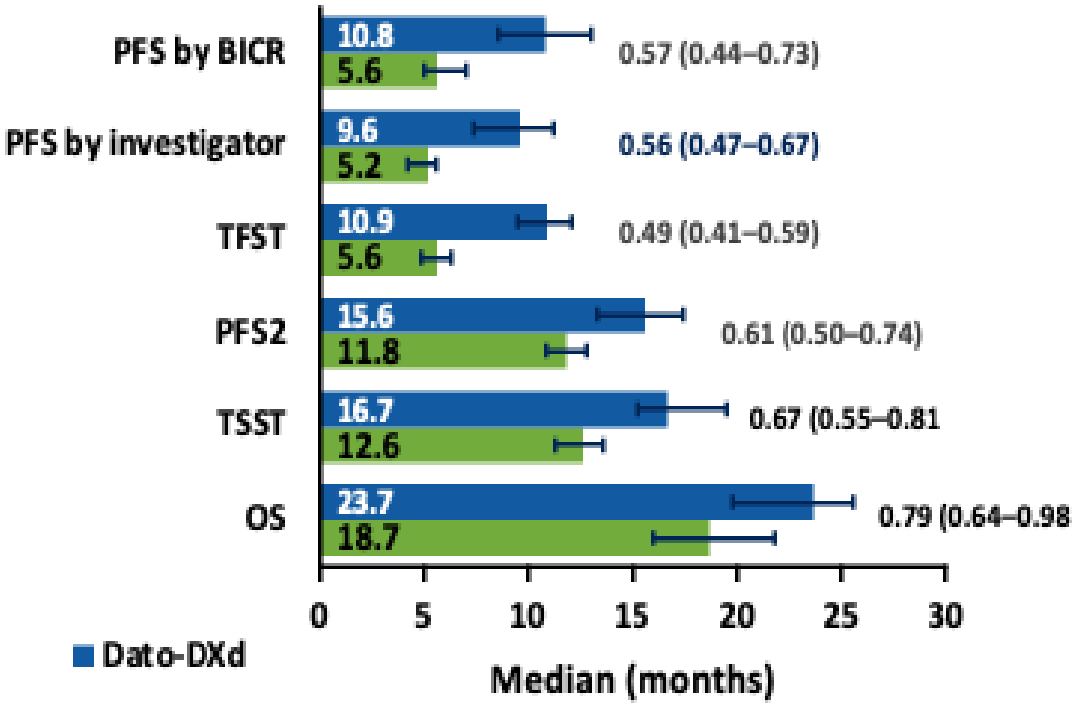
Progression-free Survival



	Dato-DXd	ICC
PFS events, n (%)	199 (62)	209 (65)
HR (95% CI)	0.57 (0.47–0.69)	
P-value	<0.0001	

Median PFS (95% CI)
10.8m (8.6–13.0) vs 5.6m (5.0–7.0)

PFS2 and time to 1st / 2nd Tx



Dent R, et al. ESMO 2025, Cescon, ASCO 2026

Datopotamab-Deruxtecan (Dato-DXd) in 1L TNBC

TROPION-Breast02 Trial[1]

- Metastatic TNBC
- No prior chemotherapy
- Immunotherapy not an option
- Any DFI allowed
- Stable brain mets allowed

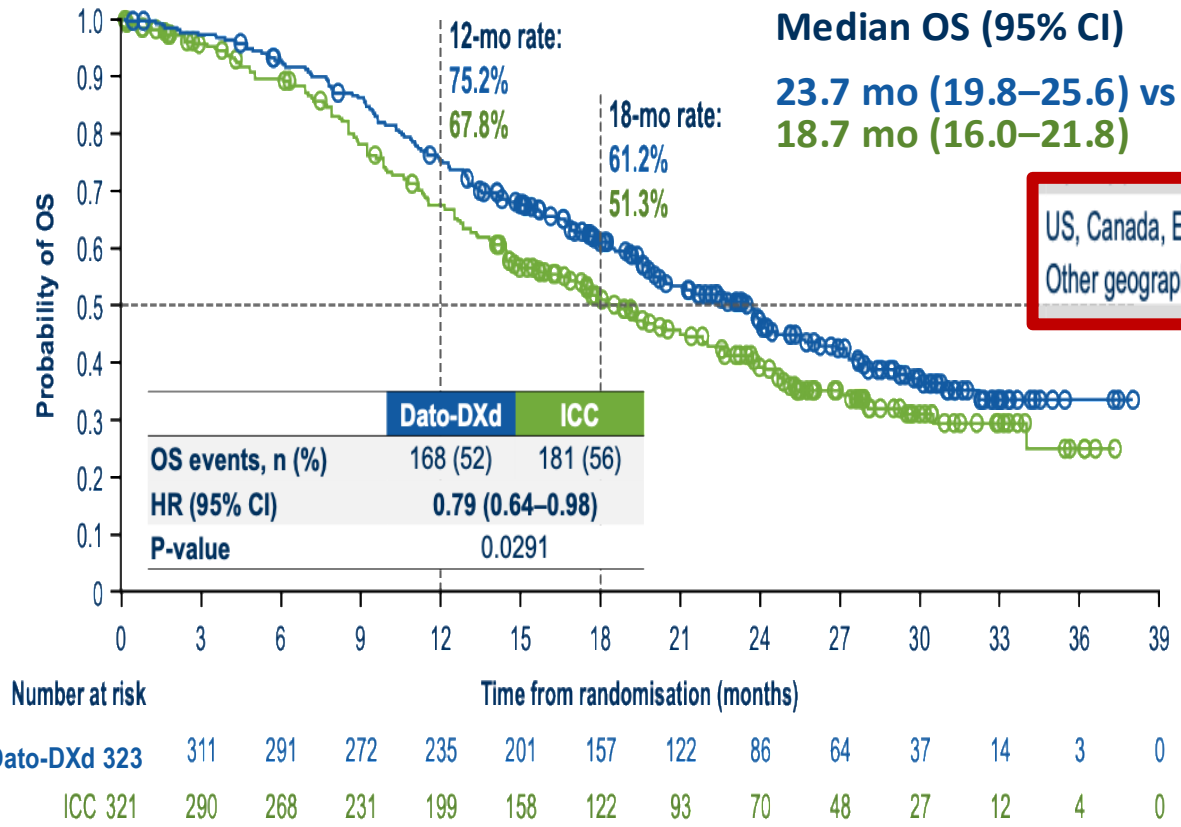
R 1:1

n = 323 → **Dato-DXd** 6 mg/kg Q3W

n = 321 → **TPC** Paclitaxel, Nab-Paclitaxel (if DFI >12/12), Eribulin, Carboplatin, Capecitabine (if taxane and DFI <6/12)

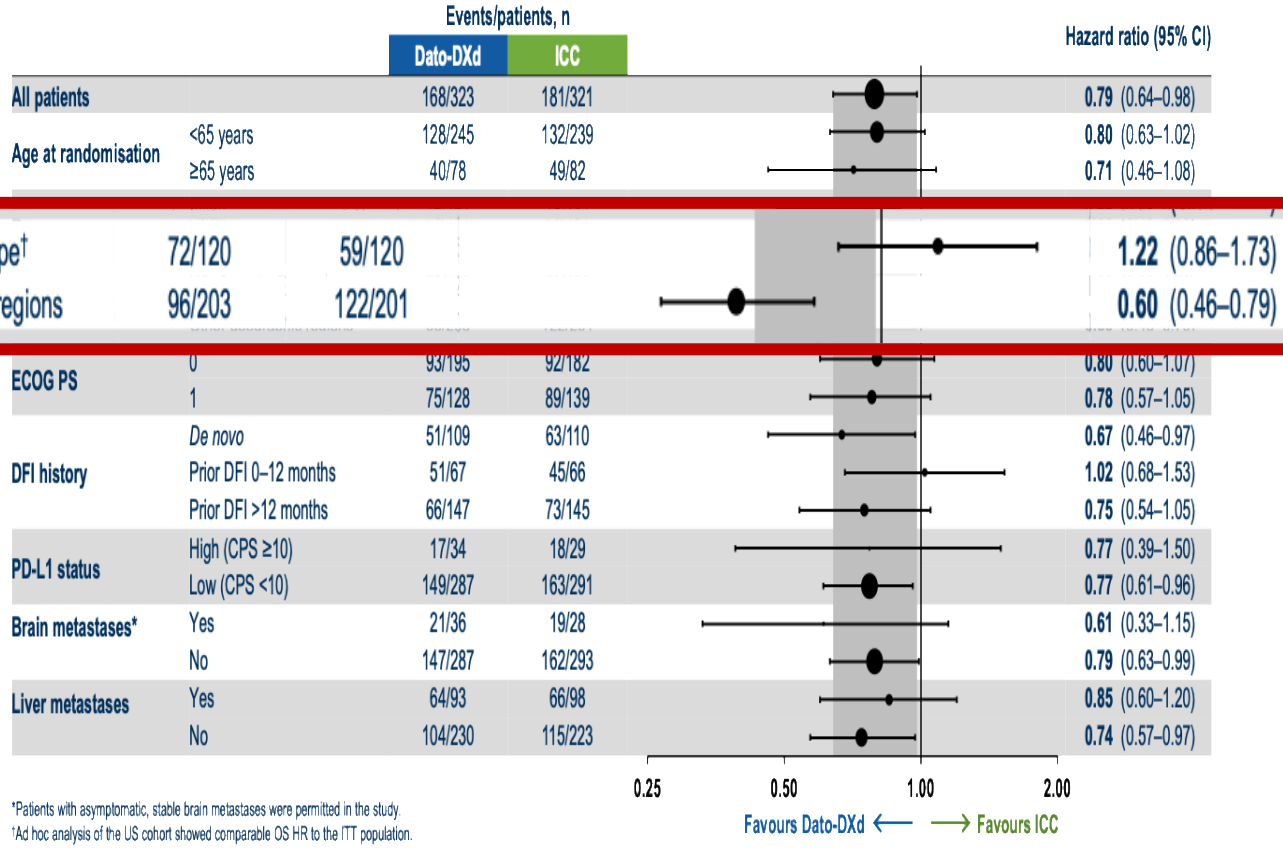
Stratification factors:
- PDL1 (positive vs negative)
- Region: US/Canada/Europe vs Rest
- DFI: de novo vs 0-12m vs >12m

Overall Survival



Median OS (95% CI)

23.7 mo (19.8–25.6) vs 18.7 mo (16.0–21.8)



*Patients with asymptomatic, stable brain metastases were permitted in the study.
†Ad hoc analysis of the US cohort showed comparable OS HR to the ITT population.

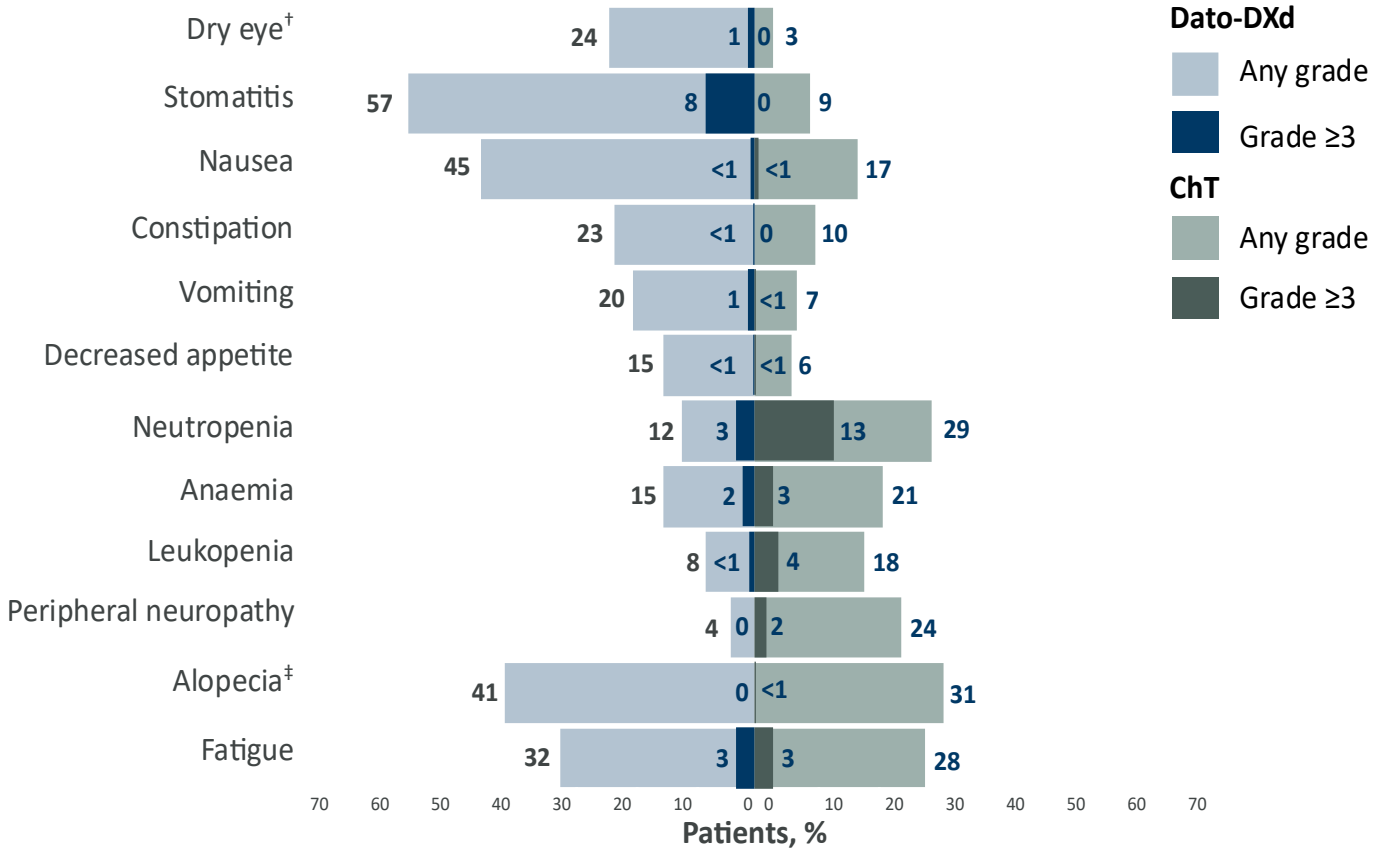
Dent R, et al. ESMO 2025

TROPION-Breast02: Summary of safety profile

Safety summary

Patients, n (%)	Dato-DXd (n=319)	ICC (n=309)
Any TRAE Grade ≥3	296 (93) 105 (33)	257 (83) 89 (29)
Serious TRAEs	29 (9)	26 (8)
TRAEs leading to discontinuation	14 (4)	23 (7)
TRAEs leading to dose interruption	76 (24)	60 (19)
TRAEs leading to dose reduction	85 (27)	56 (18)
TRAEs leading to death	0	0
Median total treatment duration, mo	8.5	4.1
Patients with total exposure >12 mo, %	35.1	9.4

Most common TRAEs* (≥15% of patients)

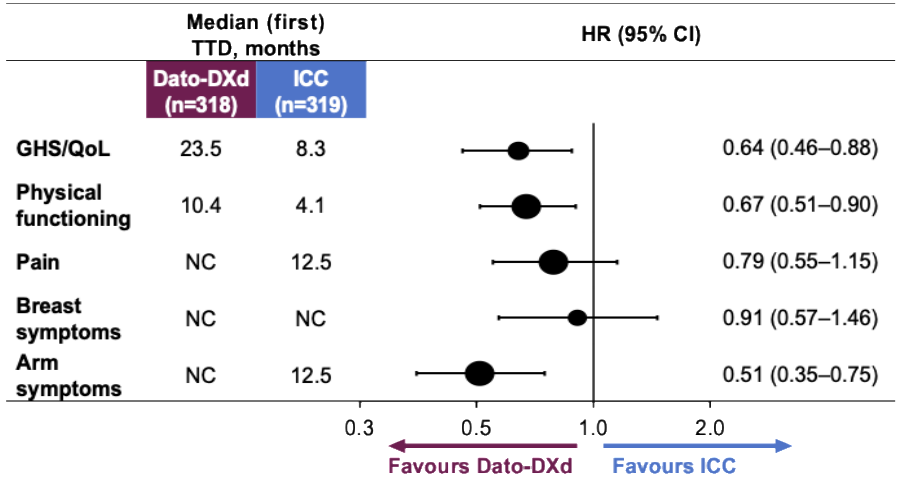


Primary PFS and final OS analysis: DCO 25 August 2025, median follow-up: 27.5 months. *Combined preferred terms of neutropenia includes neutropenia and neutrophil count decreased, anaemia includes haemoglobin decreased, red blood cell count decreased, anaemia and haematocrit decreased, leukopenia includes white blood cell count decreased and leukopenia, peripheral neuropathy includes neuropathy peripheral, polyneuropathy, paraesthesia and peripheral sensory neuropathy, and fatigue includes fatigue, asthenia and malaise; †In the Dato-DXd arm, ophthalmologic assessments were required every 3 cycles while on therapy (this was not required in the ICC arm), for all patients in both arms, ophthalmologic assessments were required at baseline, as clinically indicated and at end of therapy; ‡For CTCAE v5.0, the minimum grade for alopecia is Grade 2.
Please see the slide notes for abbreviations and references.

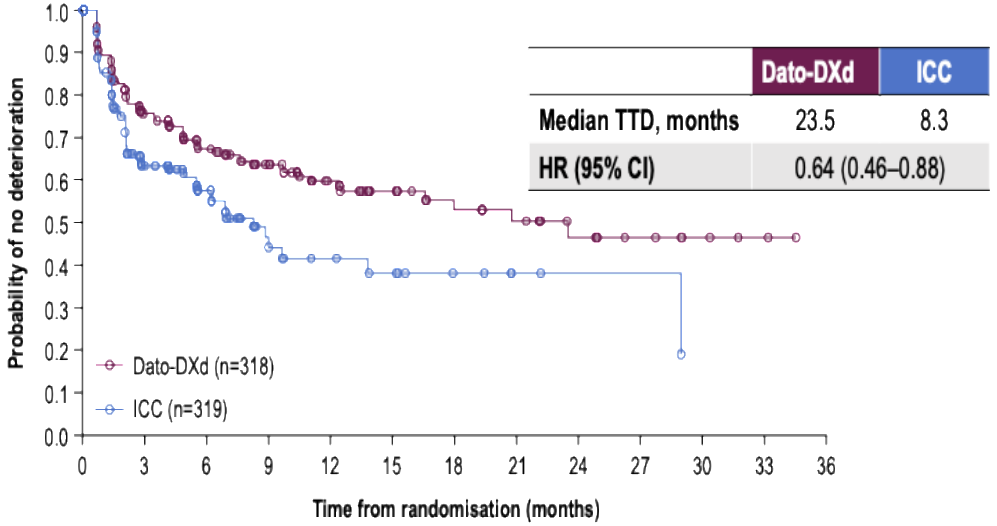
Dent RA, et al. ESMO 2025;Abstract LBA21

TROPION-Breast02: PROs and QoL

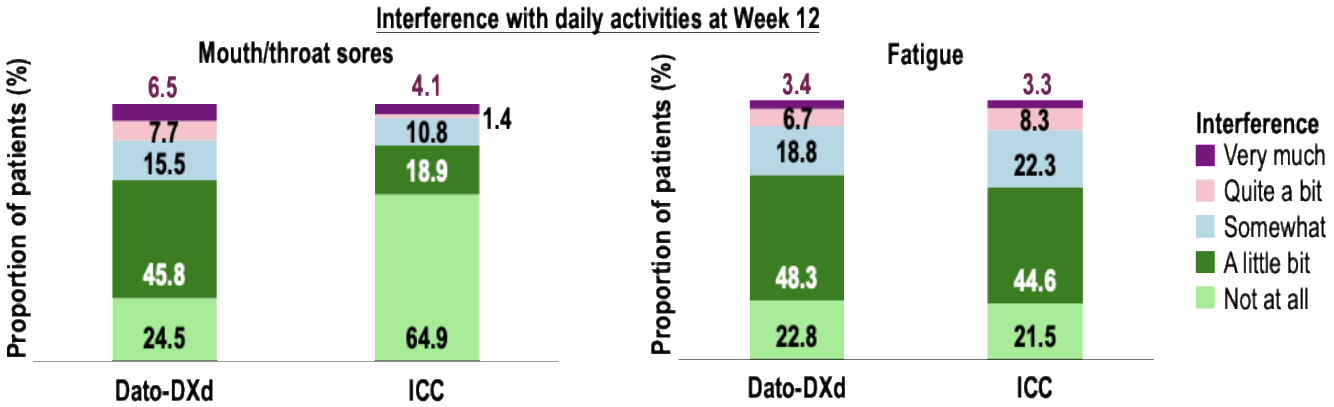
Time to deterioration in QoL



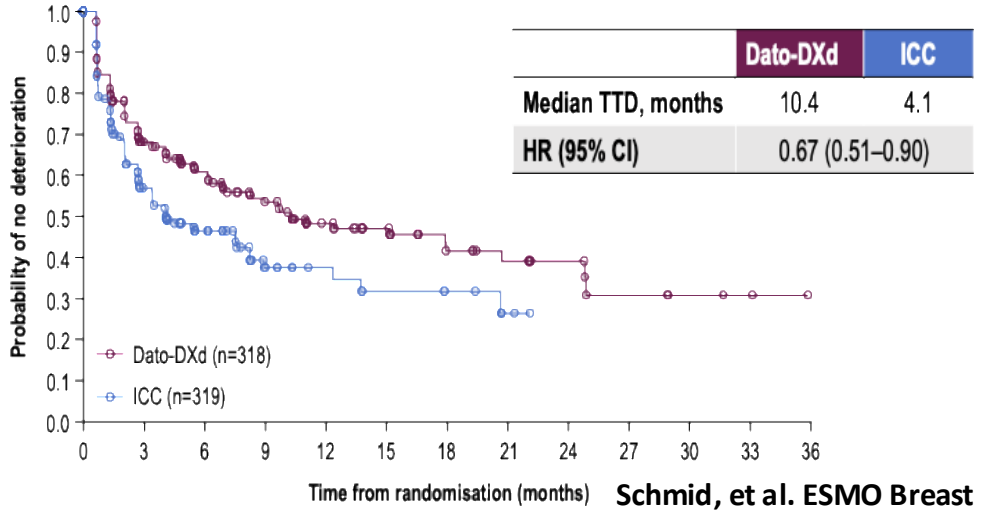
Time to deterioration in Global Health Status/QoL



Interference of Stomatitis and Fatigue with daily activities



Time to deterioration in physical functioning



Schmid, et al. ESMO Breast 2026

Sacituzumab Govitecan (SG) in 1L TNBC

ASCENT-03 Trial[1]

- Metastatic TNBC
- No prior chemotherapy
- Immunotherapy not an option
- DFI >6 months
- Treated & stable brain mets allowed

R 1:1

n = 279 → Sacituzumab-Govitecan 10 mg/kg d1&8 Q3W

n = 279 → TPC: Paclitaxel, Nab-Paclitaxel, Gemcitabine/Carboplatin

Stratification factors:
- Region: US/Canada/Europe vs Rest
- DFI: de novo vs 6-12m vs >12m

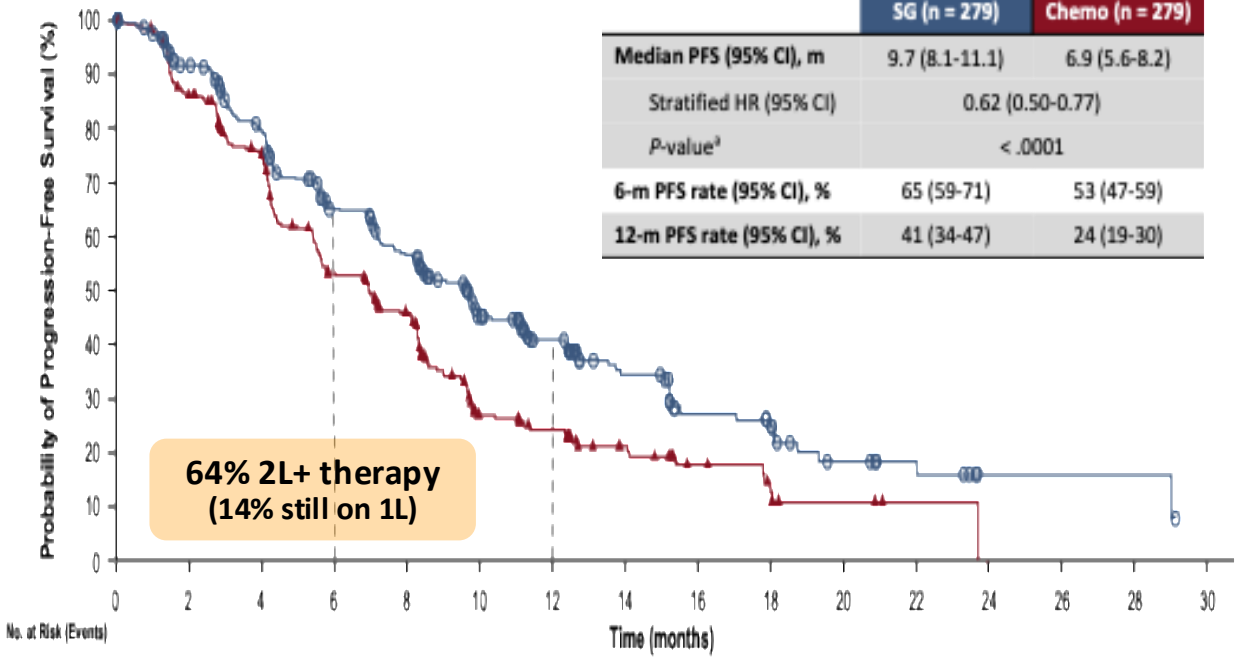
DFI:
- de novo mTNBC 32%,
- 0-6m 0%, 0-12m 20%,
- >12m 48%

Eligible patients offered crossover to 2L SG provided through the study

82% of pts with subsequent Tx received SG

53% of all TPC pts with SG (62% had 2L+)

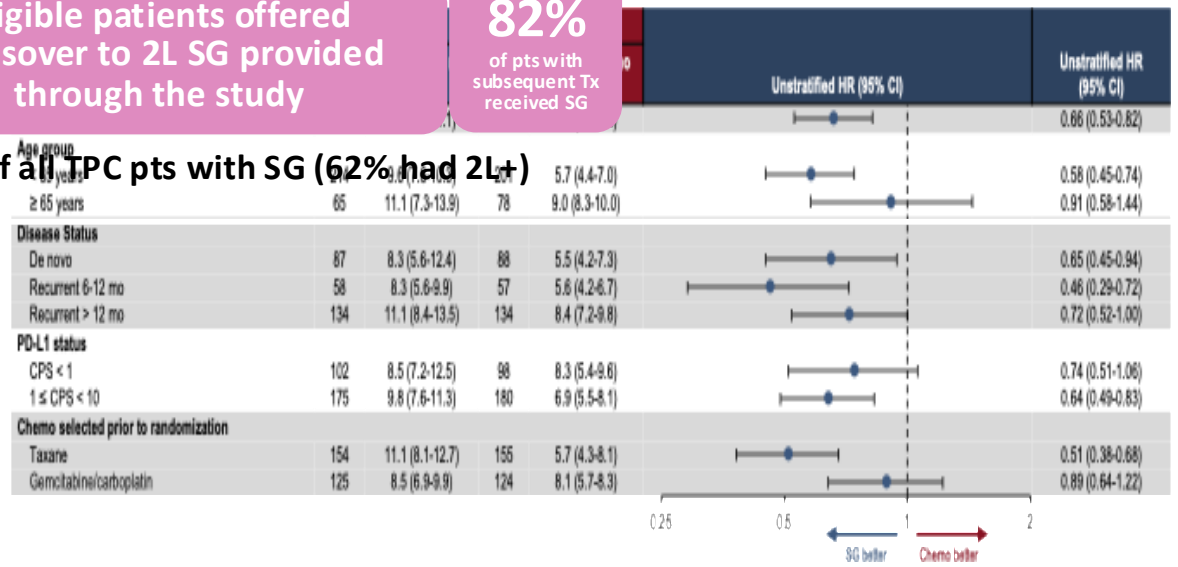
Progression-free Survival



64% 2L+ therapy (14% still on 1L)

	SG (n = 279)	Chemo (n = 279)
Median PFS (95% CI), m	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-m PFS rate (95% CI), %	65 (59-71)	53 (47-59)
12-m PFS rate (95% CI), %	41 (34-47)	24 (19-30)

PFS in Subgroups



PFS by TROP2-status

Subgroup	SG n	SG mPFS, mo	Chemo n	Chemo mPFS, mo	HR (95% CI)
ITT Population[1,b]	279	9.7 (8.1-11.1)	279	6.9 (5.6-8.2)	0.62 (0.50-0.77)
Trop-2 BAS[c]	252	9.7 (7.8-11.1)	247	6.8 (5.4-8.1)	0.64 (0.51-0.80)
Trop-2 H-score quartiles[c]					
Q1	68	8.5 (5.6-12.7)	55	5.5 (4.2-8.1)	0.54 (0.35-0.84)
Q2	60	8.3 (5.6-12.4)	62	6.8 (4.2-9.0)	0.62 (0.40-0.97)
Q3	50	9.7 (7.6-11.3)	74	7.0 (5.3-8.5)	0.84 (0.54-1.31)
Q4	74	9.9 (6.9-NE)	56	8.1 (4.4-8.5)	0.60 (0.38-0.95)

Cortes J, et al. ESMO 2025, Cortes NEJM 2025; Barrios ASCO 2026

Trop-2 H-score quartiles: Q1, 0-184; Q2, 185-239; Q3, 240-283; Q4, 284-300

Sacituzumab Govitecan (SG) in 1L TNBC

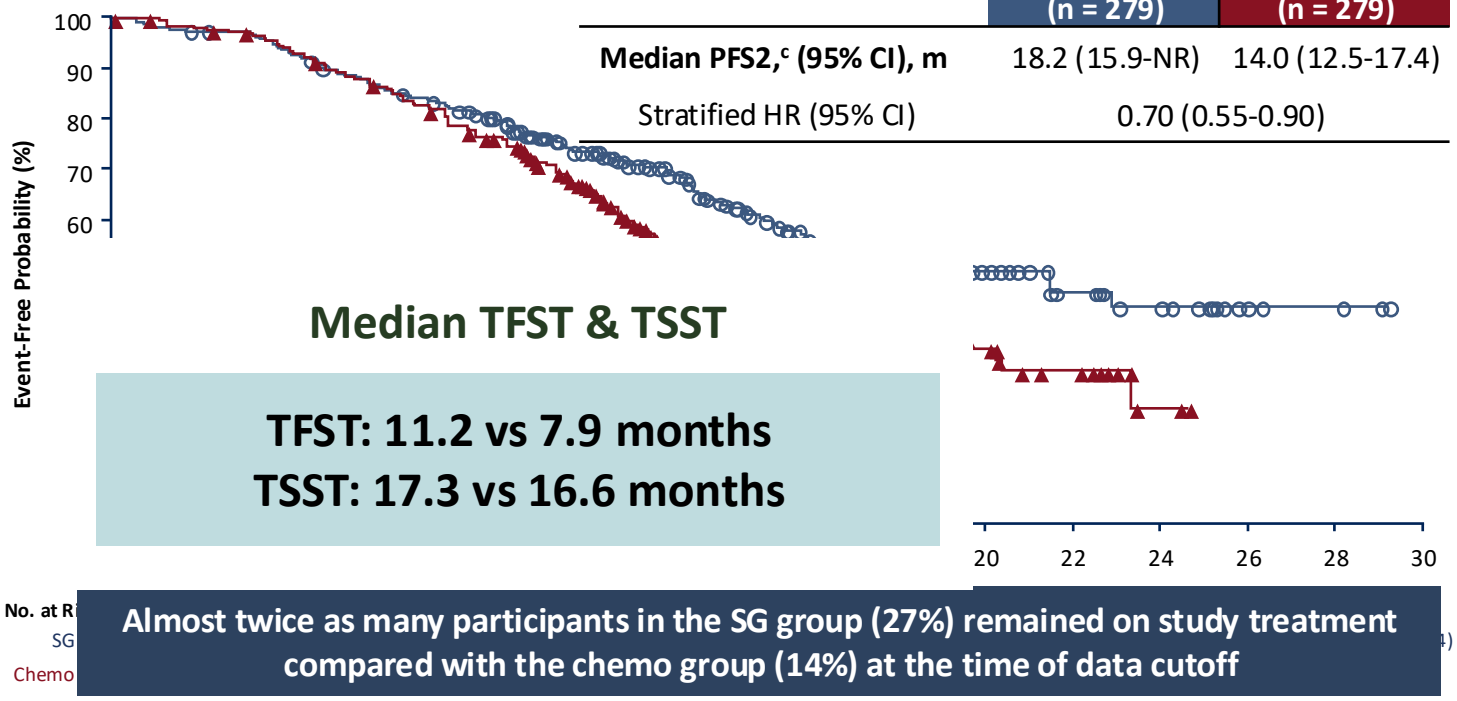
Descriptive Overall Survival

- **Overall survival not yet mature[a]**
- Study continues to first formal OS analysis
- Of 179 patients who initiated subsequent treatment, 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)

Progression-Free Survival 2

	SG (n = 279)	Chemo (n = 279)
Median PFS2,[c] (95% CI), m	18.2 (15.9-NR)	14.0 (12.5-17.4)
Stratified HR (95% CI)	0.70 (0.55-0.90)	



Median TFST & TSST

TFST: 11.2 vs 7.9 months
TSST: 17.3 vs 16.6 months

Almost twice as many participants in the SG group (27%) remained on study treatment compared with the chemo group (14%) at the time of data cutoff

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

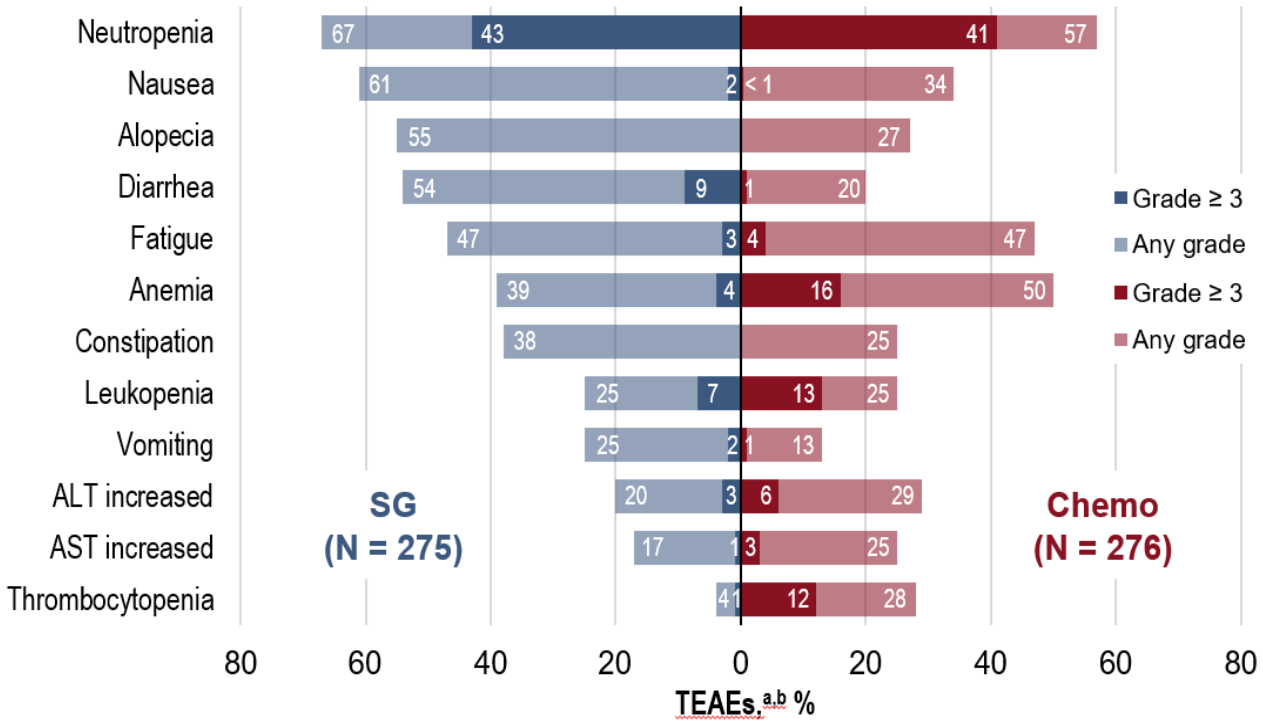
Data cutoff date: April 2, 2025. [a]At the time of this analysis, OS data maturity was 37%. [b]PFS2 is defined as the time from date of randomization to the first documented progression on next-line therapy based on investigator assessment of progressive disease or death due to any cause, whichever occurs 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.

Cortes J, et al. ESMO 2025, Hurvitz ASCO 2026

Sacituzumab Govitecan in 1L TNBC: Safety

TEAEs, n (%)	SG (n = 275)	Chemo (n = 276)
Any TEAE	273 (99)	269 (97)
Grade ≥ 3 TEAEs	181 (66)	171 (62)
Treatment-related	167 (61)	147 (53)
Treatment-emergent SAE	71 (26)	67 (24)
Treatment-related	46 (17)	37 (13)
TEAEs leading to treatment discontinuation	10 (4)	33 (12)
TEAEs leading to dose interruption	181 (66)	171 (62)
TEAEs leading to dose reduction	101 (37)	124 (45)
TEAEs leading to death	7 (3)	1 (< 1)
Treatment-related	6 (2)	1 (< 1)

Most Common Adverse Events



The AEs observed were consistent with the known safety profile of SG, with no new safety concerns[1]

Data cutoff date: April 2, 2025. TEAEs were defined as any AEs that began or worsened on or after the first dose date of study drug up to 30 days after the last dose date of study drug or the initiation of subsequent anticancer therapy (including crossover treatment), whichever occurred first. [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; **SAE**, serious adverse event; **SG**, sacituzumab govitecan; **TEAE**, treatment-emergent adverse event. 1. Cortés J, et al. *N Engl J Med*. 2025;393:1912-25.

A 65-year-old woman presents with de novo HR-negative, HER2 IHC 1+, PD-L1-negative (combined positive score [CPS] 0), BRCA wild-type metastatic breast cancer (mBC).

Regulatory and reimbursement issues aside, which first-line therapy would you most likely recommend in each of the following scenarios?

- **Asymptomatic, bone metastases**
- **Symptomatic visceral (including liver) metastases**
- **Multiple brain metastases requiring stereotactic radiosurgery (SRS)**

RTP RESEARCH TO PRACTICE

A 65-year-old woman presents with de novo HR-negative, HER2 IHC 1+, PD-L1-negative (CPS 0), BRCA-mutated mBC.

Regulatory and reimbursement issues aside, which first-line therapy would you most likely recommend in each of the following scenarios?

- **Asymptomatic, bone metastases**
- **Symptomatic visceral (including liver) metastases**
- **Multiple brain metastases requiring SRS**

RTP RESEARCH TO PRACTICE

Based on the published literature and your clinical experience, how would you indirectly compare the antitumor efficacy of datopotamab deruxtecan to that of sacituzumab govitecan for patients with previously untreated mTNBC?

RTP
RESEARCH
TO PRACTICE

Assuming equal access, which TROP2-targeted antibody-drug conjugate would you prefer for a patient with previously untreated PD-L1-negative mTNBC based on relevant comorbidities?

Agenda:
Metastatic Triple-Negative Breast Cancer (mTNBC)

Introduction: TROP2-Targeting Antibody-Drug Conjugates (ADCs) for mTNBC

Module 1: First-Line Therapy (PD-L1 Negative)

Module 2: First-Line Therapy (PD-L1 Positive)

Module 3: Second-Line Therapy (Sequencing)

Module 4: Adverse Events with TROP2-Targeting ADCs

Cases from General Medical Oncologists

40 yo woman

- **Metastatic TNBC, BRCA WT, HER2 1+, CPS = 10. Mets to lung, bone, lymph nodes.**
- **She received KN-522 for an initial cT2N0 right breast TNBC. She developed type 1 DM after 2 doses of pembrolizumab. She elected to stop pembrolizumab at that point. She completed NACT and had b/l mastectomy with 2 cm of residual disease in the breast. She palpated a lump in the same breast right before starting radiation.**
- **She then completed PMRT and had wide local excision with no residual disease found. She started capecitabine but had back pain after 1 cycle. Imaging showed metastatic recurrence to lungs, bones and abdominal lymph nodes. She was switched to sacituzumab for 11 months then experienced symptomatic and radiographic progression.**

What would the faculty consider at this point?

Cases from General Medical Oncologists

63 yo woman

- **De novo mTNBC, BRCA WT, PD-L1 CPS = 20 with symptomatic bone mets, several asymptomatic pulmonary mets. Hx of corneal abrasions (wears contact lenses).**
- **Hx of IBS, wants a chemotherapy-free regimen.**

Based on relevant clinical trials, would you select Datopotamab/Pembro or Sacituzumab/Pembro in terms of efficacy?

Would her hx of corneal abrasions/contact lenses and hx of controlled IBS influence your treatment decision?

Sacituzumab Govitecan + Pembro in PDL1+ 1L TNBC

Ascent04

- 1L mTNBC
- Treatment-free ≥ 6m
- PDL1+ (CPS10)

R 1:1

Sacituzumab Govitecan + Pembrolizumab

crossover to 2l SG offered

Chemo + *Pembrolizumab*

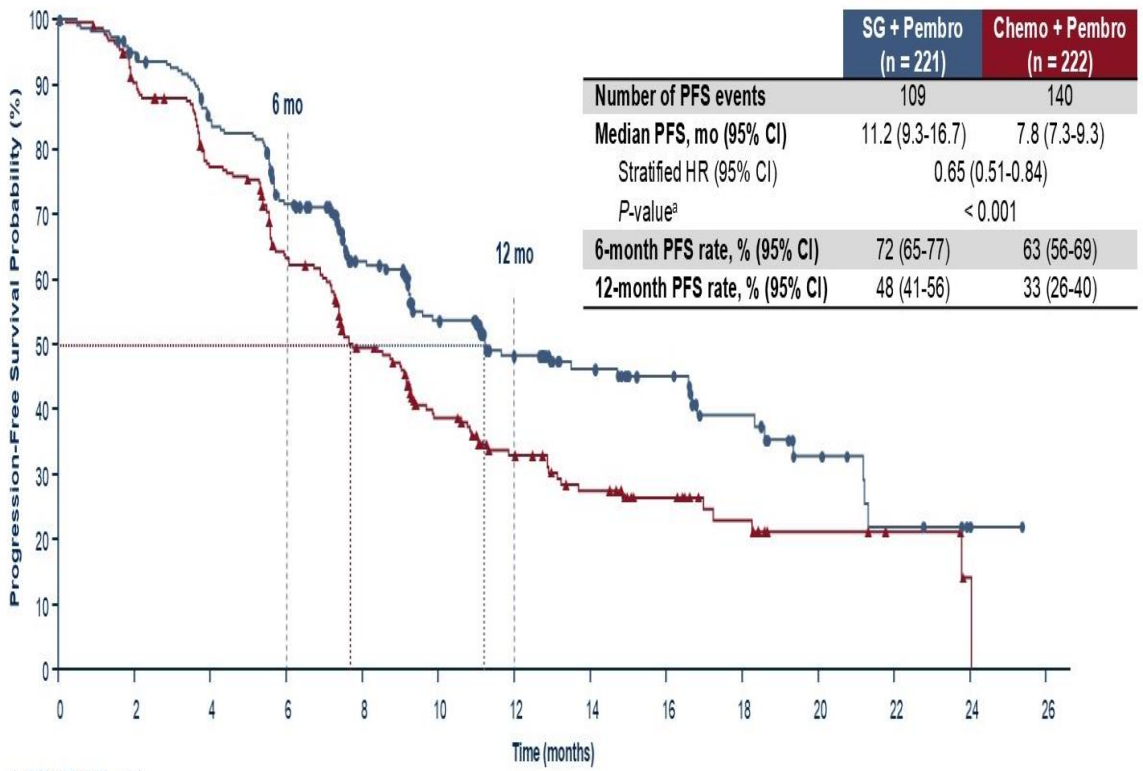
Stratification factors:
- Prior CIT (yes vs no)
- De novo vs 6-12 RFI vs >12m RFI
- Region

DFI:
- de novo mTNBC 34%,
- 0-6m 0%, 0-12m 18%,
- >12m 48%

Eligible patients offered crossover to 2L SG provided through the study

81% of pts with subsequent Tx received SG

Progression-free Survival

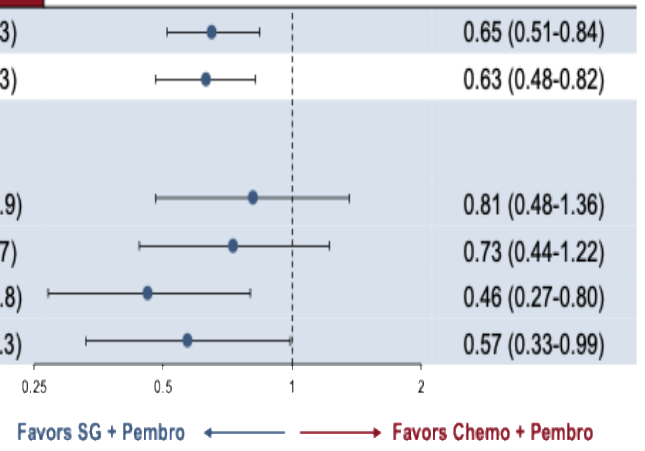


	SG + Pembro (n = 221)	Chemo + Pembro (n = 222)
Number of PFS events	109	140
Median PFS, mo (95% CI)	11.2 (9.3-16.7)	7.8 (7.3-9.3)
Stratified HR (95% CI)	0.65 (0.51-0.84)	
P-value[a]	< 0.001	
6-month PFS rate, % (95% CI)	72 (65-77)	63 (56-69)
12-month PFS rate, % (95% CI)	48 (41-56)	33 (26-40)

PFS by TROP2-status

Trop-2 H-score quartiles: Q1, 0-224; Q2, 225-279; Q3, 280-298; Q4, 299-300.

Subgroup	SG + Pembro n	SG + Pembro mPFS, mo	Chemo + Pembro n	Chemo + Pembro mPFS, mo	HR (95% CI)
ITT Population[1,b]	221	11.2 (9.3-16.7)	222	7.8 (7.3-9.3)	0.65 (0.51-0.84)
Trop-2 BAS[c]	204	11.7 (9.3-16.8)	196	7.8 (7.3-9.3)	0.63 (0.48-0.82)
Trop-2 H-score Quartiles[c]					
Q1	48	9.3 (7.4-19.4)	47	9.0 (6.0-10.9)	0.81 (0.48-1.36)
Q2	50	9.6 (7.3-16.7)	50	7.4 (6.9-9.7)	0.73 (0.44-1.22)
Q3	55	13.5 (9.3-NE)	50	8.4 (5.6-10.8)	0.46 (0.27-0.80)
Q4	51	16.6 (8.1-NE)	49	9.2 (5.5-11.3)	0.57 (0.33-0.99)



Tolaney et al, ASCO 2025, Tolaney ASCO 2026

Sacituzumab Govitecan + Pembro in PDL1+ 1L TNBC

Ascent04

- 1L mTNBC
- Treatment-free ≥ 6m
- PDL1+ (CPS10)

R 1:1

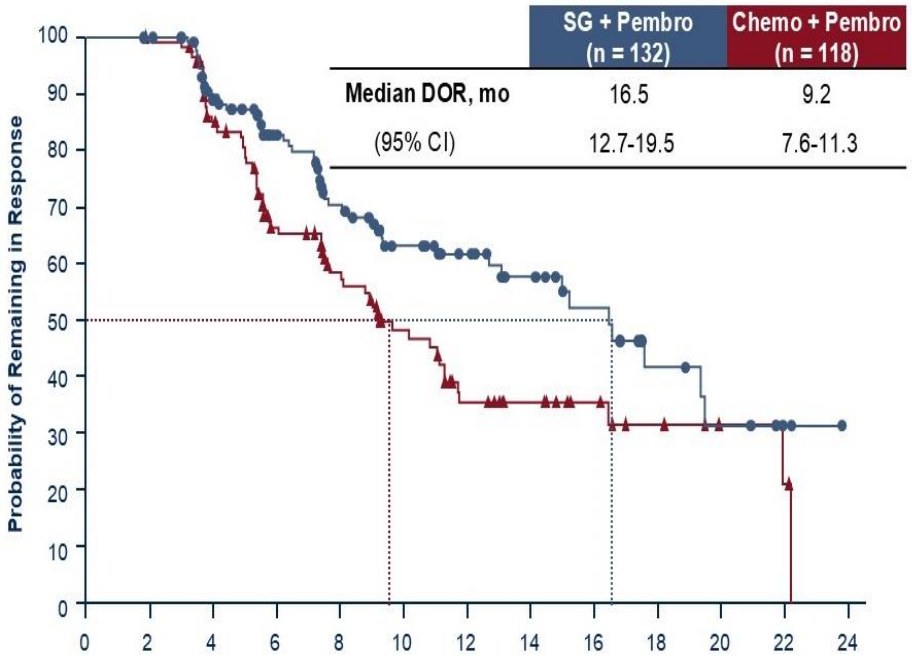
- Sacituzumab Govitecan + Pembrolizumab
- Chemo + *Pembrolizumab*

crossover to 2l SG offered

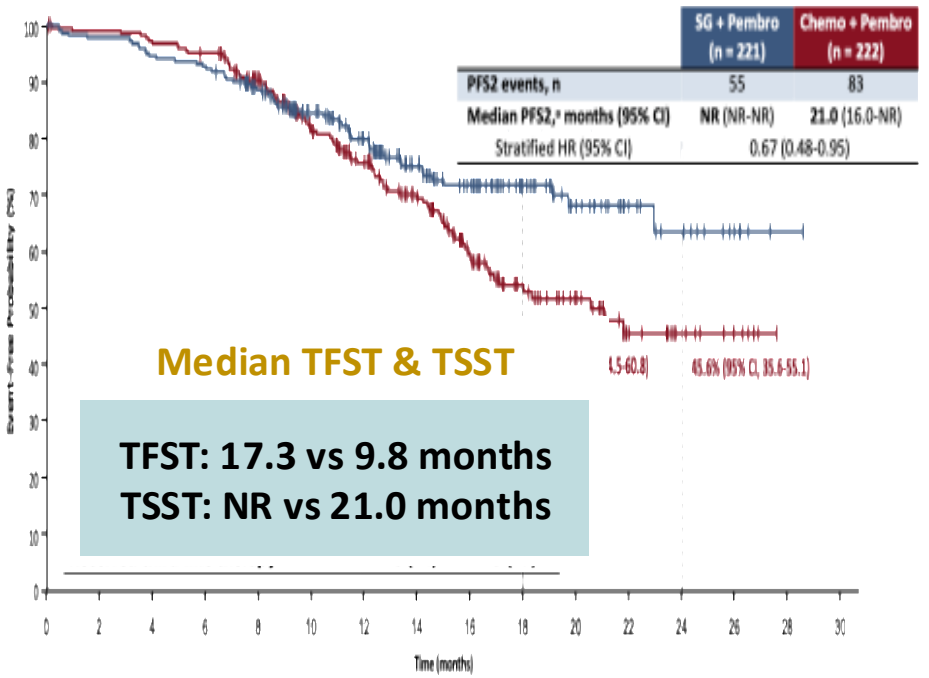
Stratification factors:

- Prior CIT (yes vs no)
- De novo vs 6-12 RFI vs >12m RFI
- Region

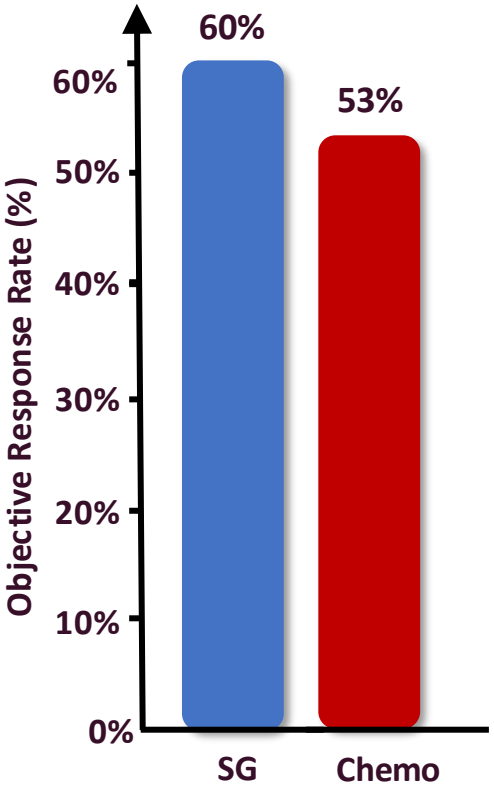
Duration of Response



Progression-Free Survival 2



Objective response



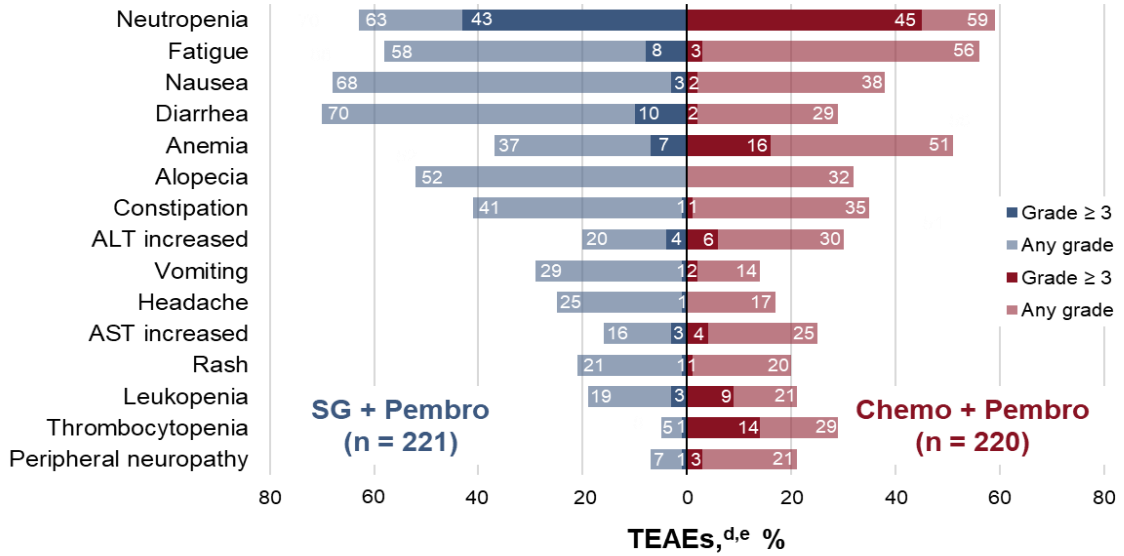
Almost twice as many participants in the SG + pembro group (43%) remained on study treatment compared with the chemo + pembro group (23%) at the time of data cutoff

Tolaney et al, ASCO 2025, Kalinsky, ASCO 2026

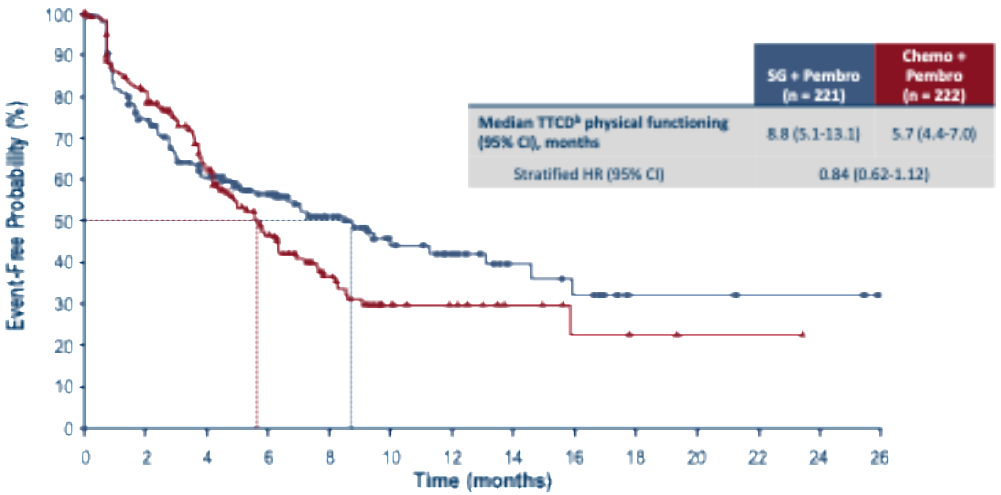
Sacituzumab Govitecan + Pembro: Safety and PROs

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)

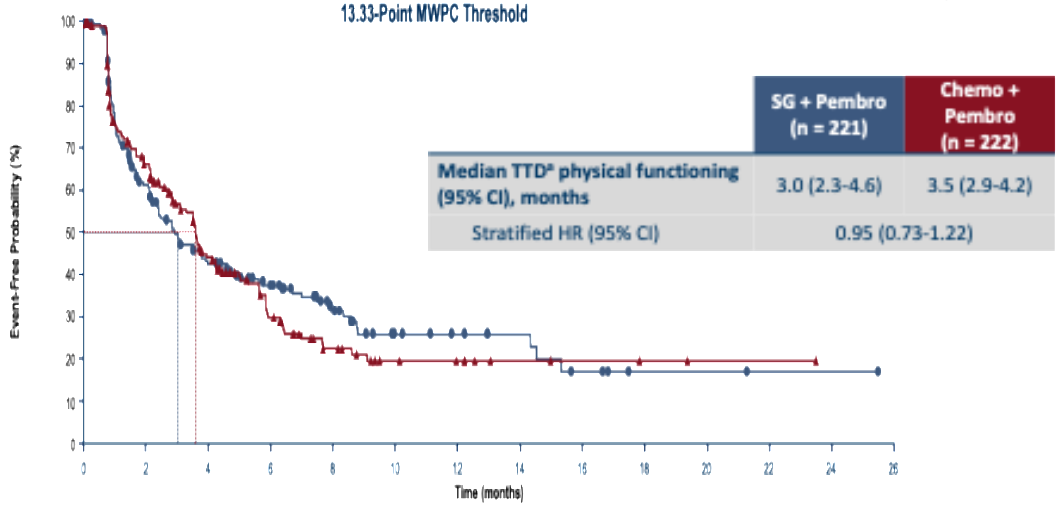
Most Common Adverse Events



Time to deterioration in physical functioning



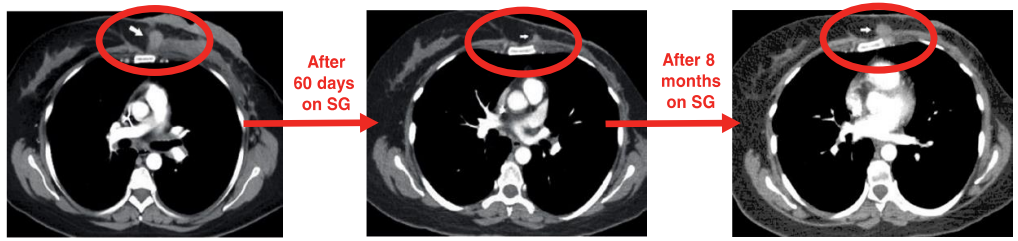
Time to deterioration in Global Health Status/QoL



Kalinsky, ASCO 2026, de Azambuja, ESMO 2025

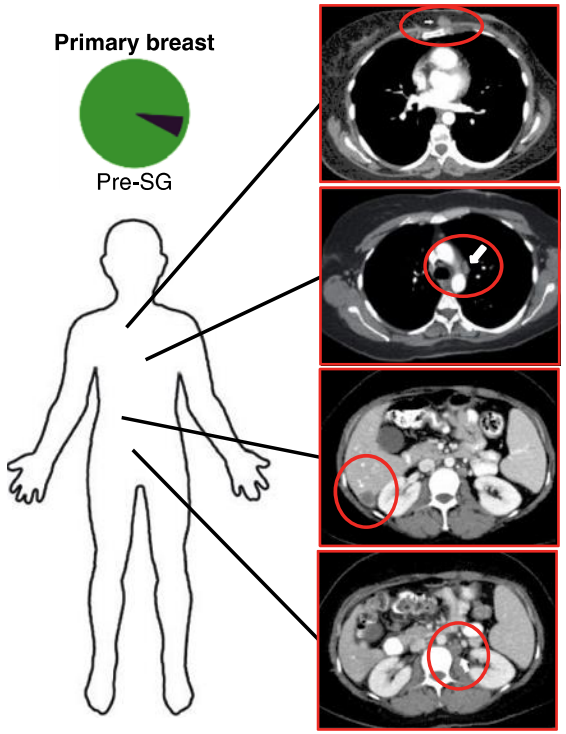
Resistance to ADCs

Serial biopsies of tumour lesions at progression on Sacituzumab



Resistance to Payload and/or Target:

- Resistance can be subclonal -> targeted Tx for Oligo-progression
- Rational sequences
- Combination of payloads and/or Targets
- Combination with immunotherapy



TROP2-expressing lesions at autopsy

Chest wall subcutaneous

65% *TACSTD2/TROP2* T256R
0% *TOP1* p.-122fs
0% *TOP1* E418K
Lesion E

Hilar LN

53% *TACSTD2/TROP2* T256R
0% *TOP1* p.-122fs
0% *TOP1* E418K
Lesion B

Inferior Liver

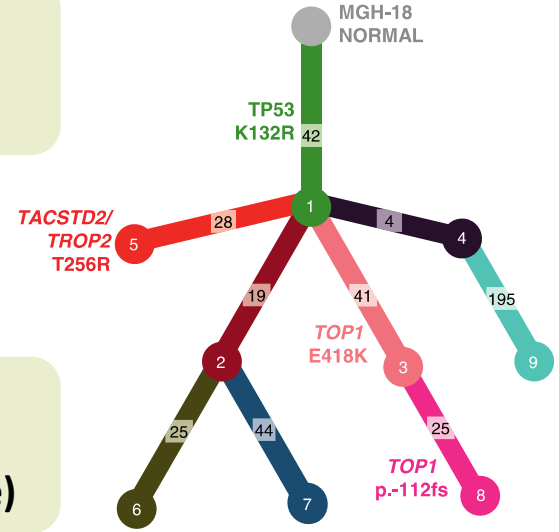
34% *TOP1* p.-122fs
99% *TOP1* E418K
0% *TACSTD2/TROP2* T256R
Lesion C

RP Periaortic LN

4% *TOP1* p.-122fs
97% *TOP1* E418K
0% *TACSTD2/TROP2* T256R
Lesion F

Altered TROP2 binding (Target resistance)

Failed SN38/TOP1 binding (Payload resistance)



Coates et al, Cancer Discovery 2021

A 65-year-old woman presents with de novo hormone receptor (HR)-negative, HER2 IHC 1+, PD-L1-positive (CPS 10), BRCA wild-type mBC.

Regulatory and reimbursement issues aside, which first-line therapy would you most likely recommend in each of the following scenarios?

- **Asymptomatic, bone metastases**
- **Symptomatic visceral (including liver) metastases**
- **Multiple brain metastases requiring SRS**

A 65-year-old woman with HR-negative, HER2 IHC 1+, BRCA wild-type breast cancer receives the KEYNOTE-522 regimen (neoadjuvant pembrolizumab/chemotherapy and adjuvant pembrolizumab) but experiences relapse after completing adjuvant pembrolizumab: PD-L1-positive (CPS 10).

Regulatory and reimbursement issues aside, which first-line therapy would you most likely recommend in each of the following scenarios?

- **Relapse 18 months after completing adjuvant pembrolizumab**
- **Relapse 5 months after completing adjuvant pembrolizumab**

RTP RESEARCH TO PRACTICE

A 65-year-old woman with a BRCA germline mutation presents with de novo HR-negative, HER2 IHC 1+, PD-L1-positive (CPS 10) mBC.

Regulatory and reimbursement issues aside, which first-line therapy would you most likely recommend in each of the following scenarios?

- **Asymptomatic, bone metastases**
- **Symptomatic, visceral (including liver) metastases**
- **Multiple brain metastases requiring SRS**

Agenda:
Metastatic Triple-Negative Breast Cancer (mTNBC)

Introduction: TROP2-Targeting Antibody-Drug Conjugates (ADCs) for mTNBC

Module 1: First-Line Therapy (PD-L1 Negative)

Module 2: First-Line Therapy (PD-L1 Positive)

Module 3: Second-Line Therapy (Sequencing)

Module 4: Adverse Events with TROP2-Targeting ADCs

RTP RESEARCH TO PRACTICE

Cases from General Medical Oncologists

45 yo woman

- **mTNBC, gBRCA-mutated, HER2 1+, PD-L1 CPS 20. Metastases to bone and lung. History of asthma.**
- **Locally advanced stage III, received KN-522 regimen, progressed after completing adjuvant pembro.**

What first line treatment is appropriate? Does the time from pembro relapse (6-month interval) play a factor?

Would you do PARPi or rechallenge with a pembrolizumab regimen (pembro/sacituzumab)? What about Dato-DXd?

Cases from General Medical Oncologists

48 yo woman

- **Presents with metastatic recurrence 14 months after completing capecitabine.**

She has a BRCA1 mutation, HER2 2+, low PD-L1 (CPS 2), and prior capecitabine exposure: How would you sequence therapy — would you favor a PARP inhibitor (olaparib or talazoparib) over sacituzumab govitecan in the first-line metastatic setting, and what data support this decision given the absence of head-to-head trials?

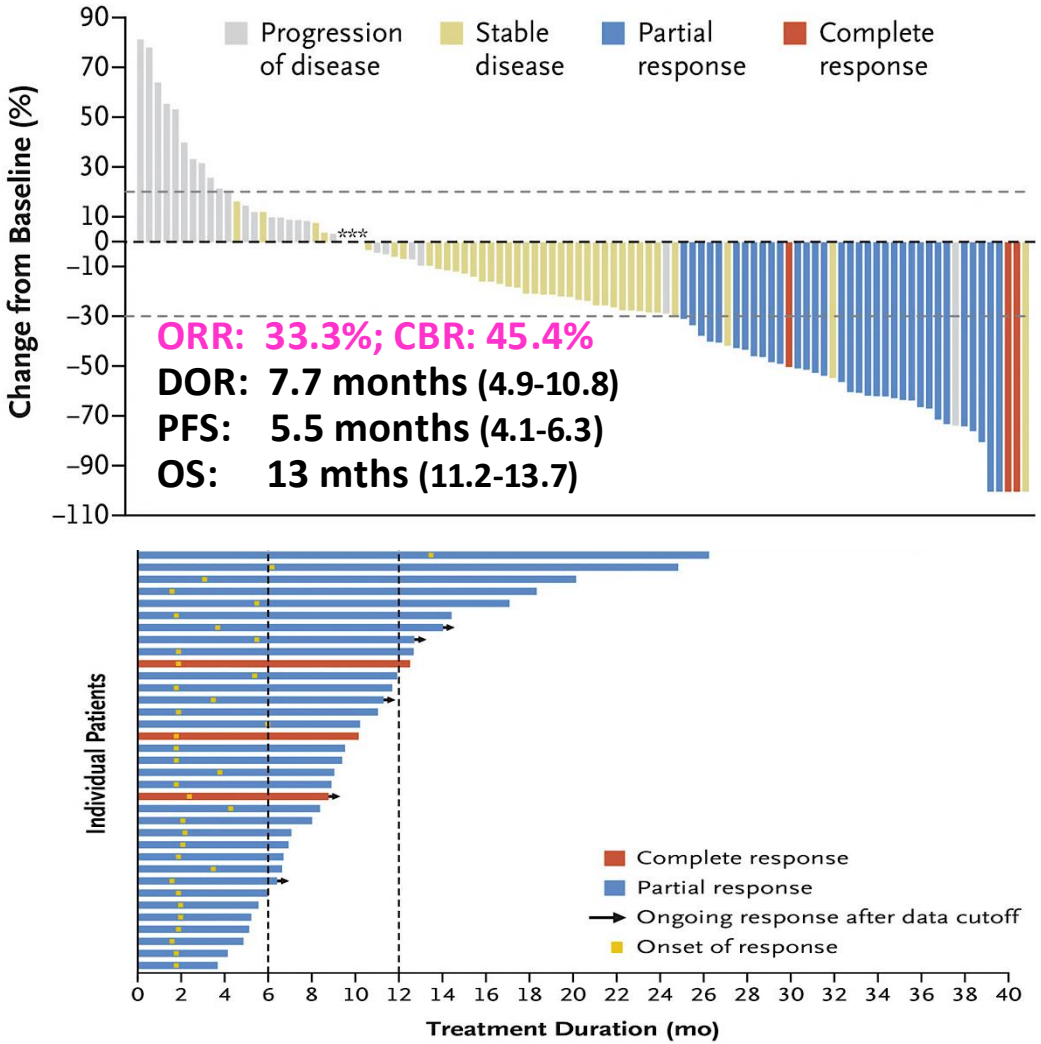
If she achieves a partial response on first-line PARP inhibitor therapy but progresses after 11 months with new pulmonary nodules, would you consider sacituzumab govitecan–pembrolizumab combination (per TROPION or ASCENT-04/SACI-IO data) despite her low PD-L1, or proceed with sacituzumab govitecan monotherapy — and how do you weigh the TROP2 expression status in this decision?

RTP RESEARCH TO PRACTICE

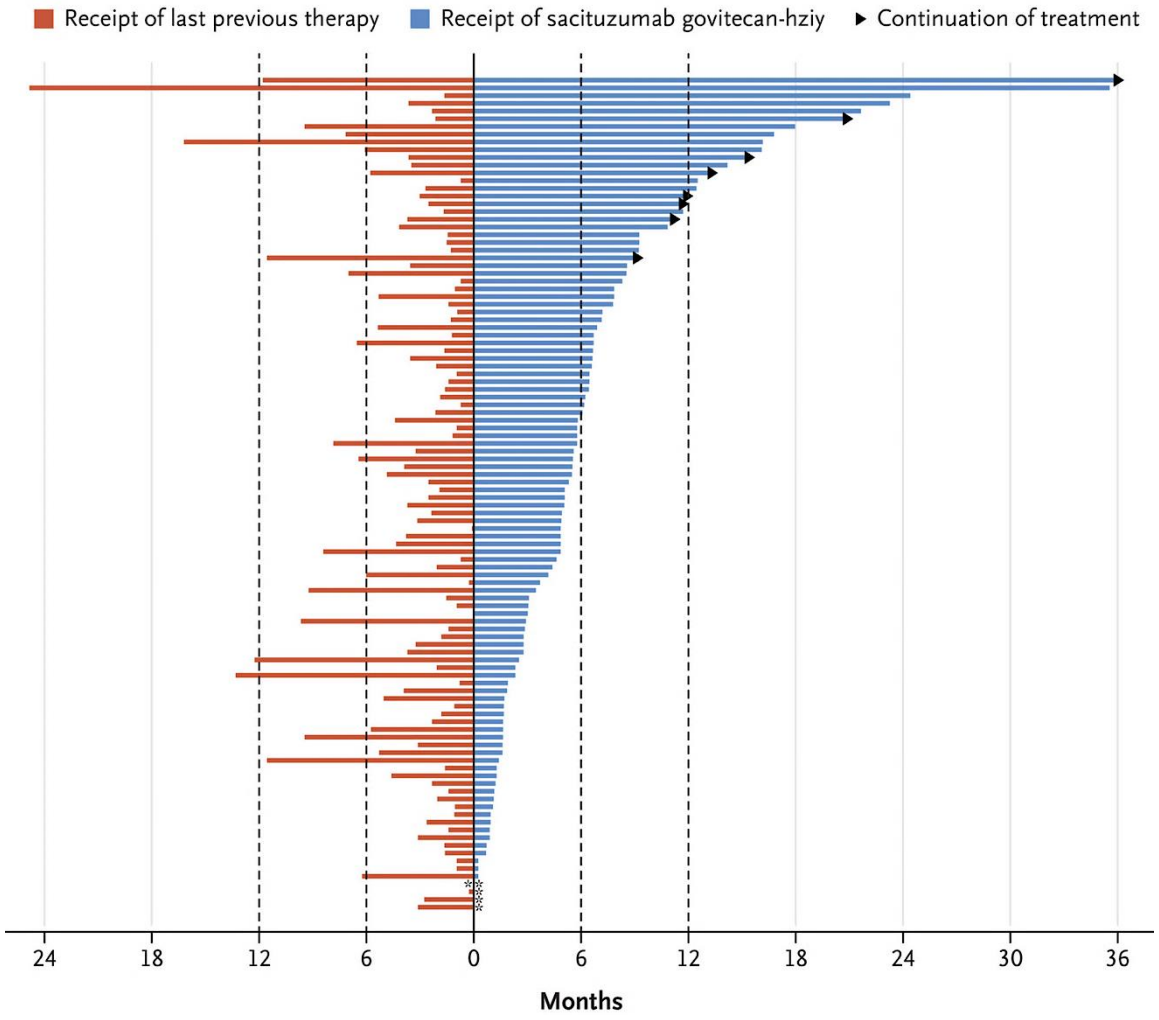
TROP2 ADCs in pretreated metastatic TNBC

TROP2 ADCs in TNBC: Sacituzumab Govitecan

Phase I Activity (≥3L)



Duration of Sacituzumab and prior therapy



Bardia A, et al. NEJM 2019

Sacituzumab Govitecan in pretreated mTNBC

Ascent trial

mTNBC
failed 2+ lines of therapy

- Median # of treatments: 4 (2-17)
- TNBC at initial diagnosis: 69%
- Prior CIT: 27%

R

n = 529

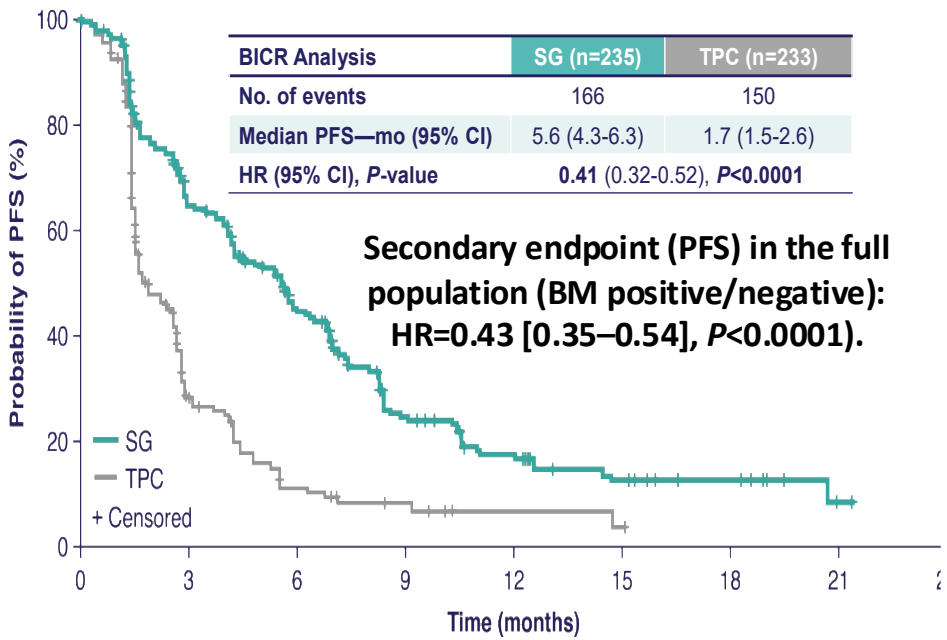
Sacituzumab

Tx of Physicians Choice
(Eribulin 53%, Capecitabine 13%, Vinorelbine 20%, Gemcitabine 15%)

Primary Endpoint:
- PFS (central review)

Secondary Endpoints:
- PFS (including brain mets)
- OS, ORR, DOR
- Safety

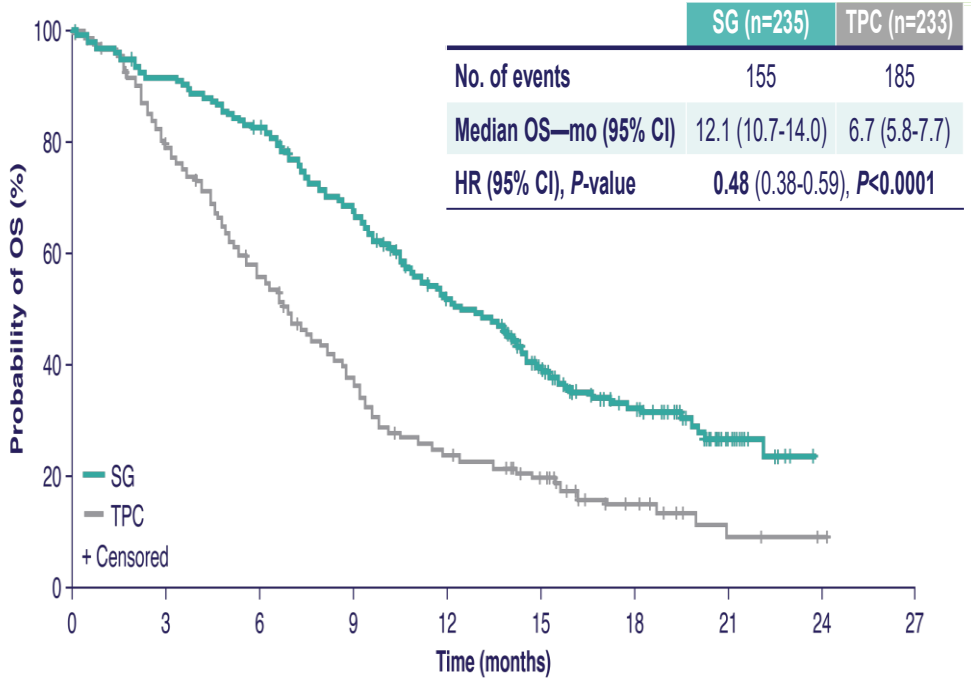
Progression-free Survival



BICR Analysis	SG (n=235)	TPC (n=233)
No. of events	166	150
Median PFS—mo (95% CI)	5.6 (4.3-6.3)	1.7 (1.5-2.6)
HR (95% CI), *P*-value	**0.41** (0.32-0.52), ***P*<0.0001**	

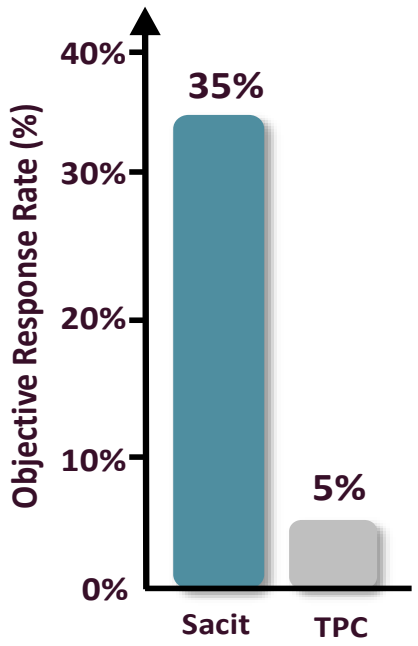
Secondary endpoint (PFS) in the full population (BM positive/negative): HR=0.43 [0.35–0.54], *P*<0.0001).

Overall Survival



	SG (n=235)	TPC (n=233)
No. of events	155	185
Median OS—mo (95% CI)	12.1 (10.7-14.0)	6.7 (5.8-7.7)
HR (95% CI), *P*-value	**0.48** (0.38-0.59), ***P*<0.0001**	

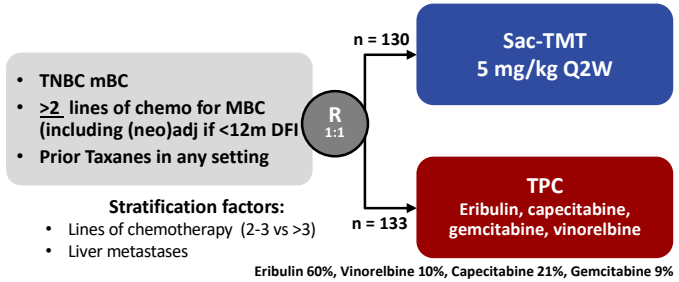
Objective Response



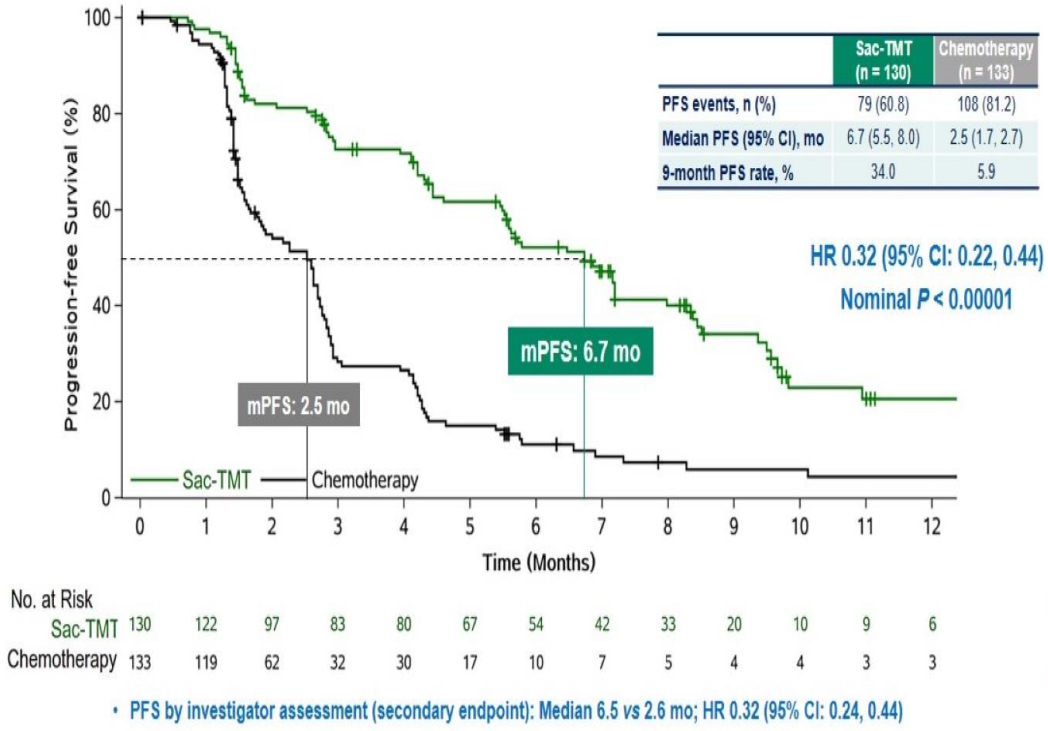
Bardia A, et al. NEJM 2021; Bardia A, et al Ann Oncol 2021.

Sacituzumab Tirumotecan (Sac-TMT) in mTNBC

OptiTROP-Breast01



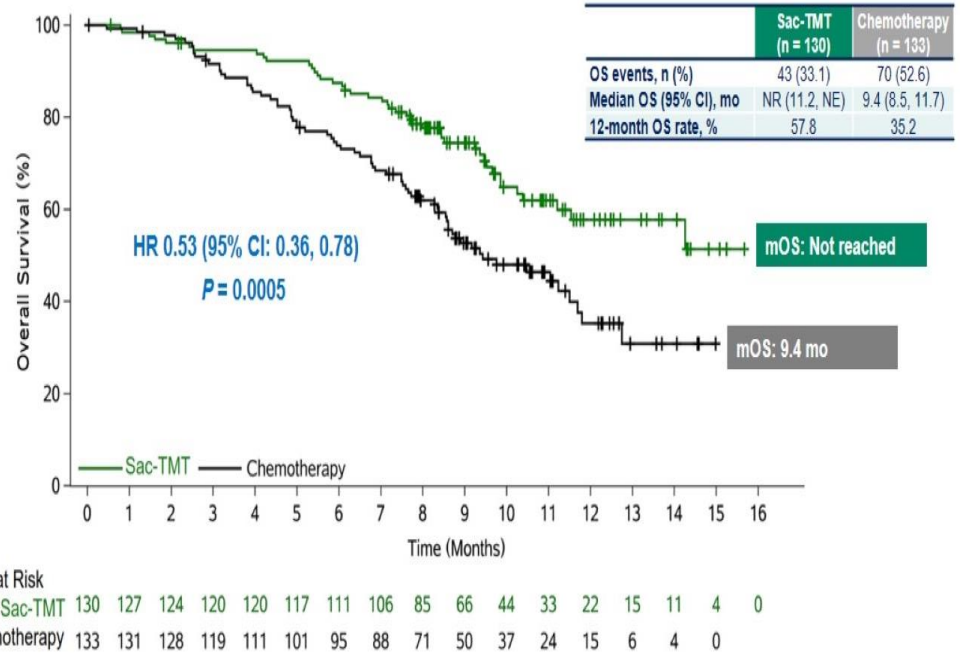
Progression-free Survival



	Sac-TMT (n = 130)	Chemotherapy (n = 133)
PFS events, n (%)	79 (60.8)	108 (81.2)
Median PFS (95% CI), mo	6.7 (5.5, 8.0)	2.5 (1.7, 2.7)
9-month PFS rate, %	34.0	5.9

• PFS by investigator assessment (secondary endpoint): Median 6.5 *vs* 2.6 mo; HR 0.32 (95% CI: 0.24, 0.44)

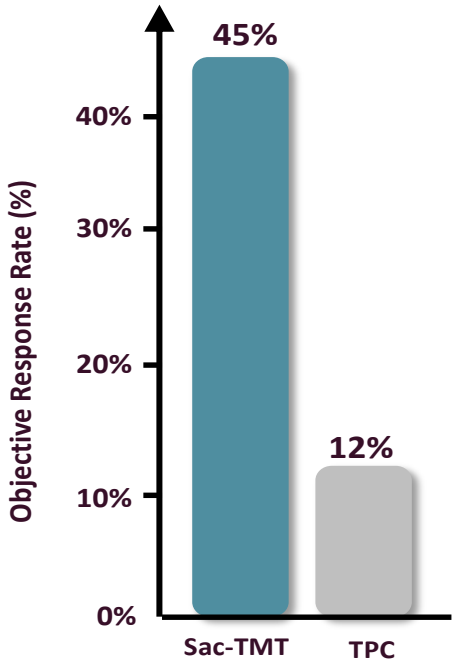
Overall Survival



	Sac-TMT (n = 130)	Chemotherapy (n = 133)
OS events, n (%)	43 (33.1)	70 (52.6)
Median OS (95% CI), mo	NR (11.2, NE)	9.4 (8.5, 11.7)
12-month OS rate, %	57.8	35.2

• Efficacy boundary (corresponding to actual OS events of 113): 0.0042. The study crossed OS efficacy boundary.

Objective Response

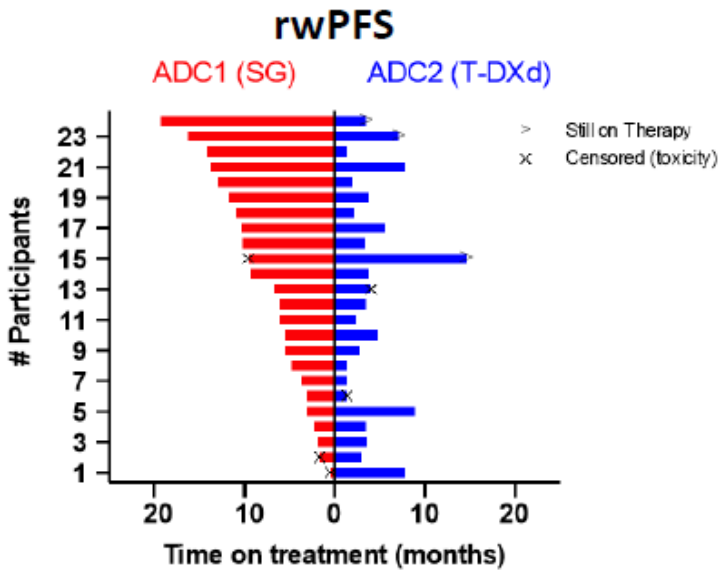


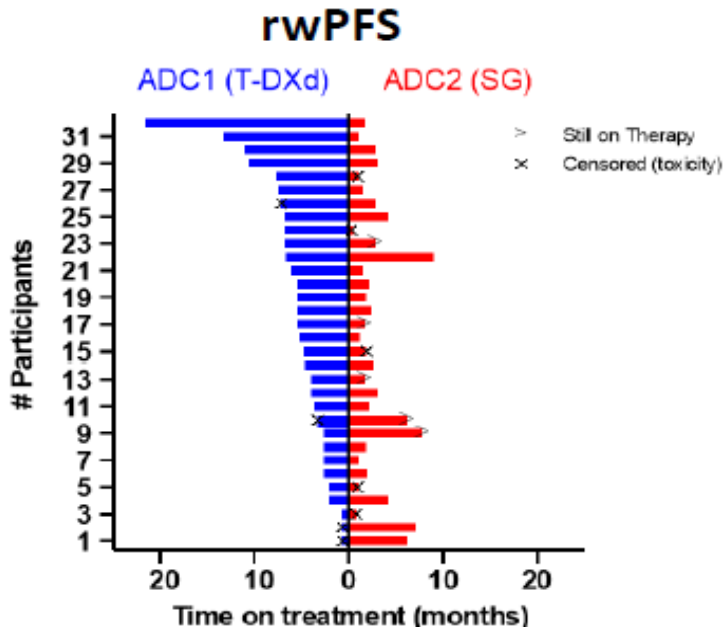
Xu B, et al. ASCO 2024

Sequencing of ADCs

Greatest magnitude of benefit generally derived from the 1st ADC used

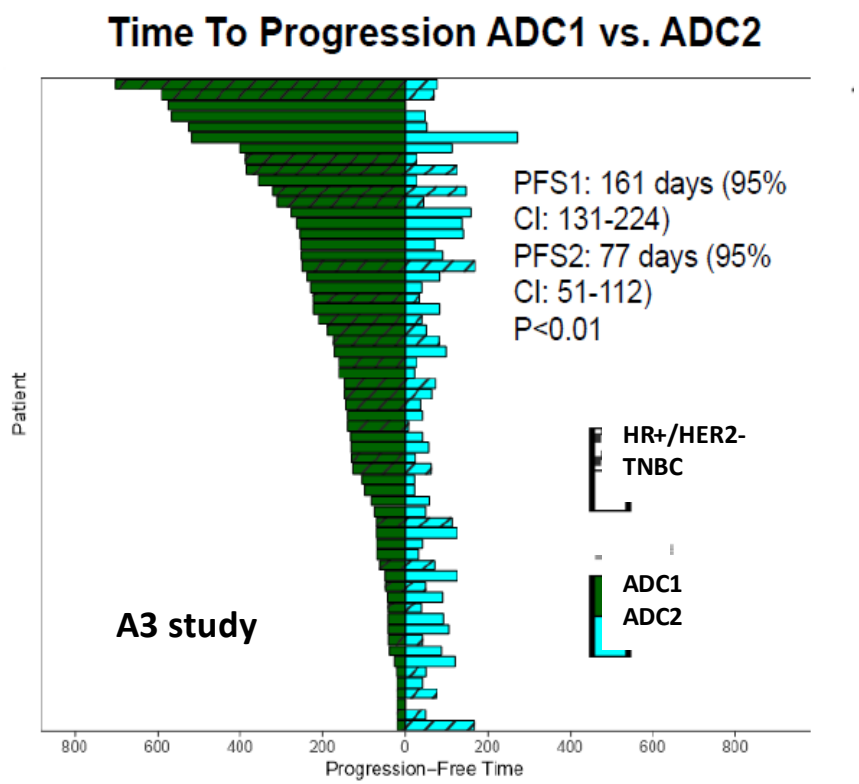
Sequencing T-DXd and SG in HER2-low MBC





Real world evidence study

Sequencing ADCs in HER2-neg MBC



Huppert L et al. SABCS 2023, Abelman R et al. ASCO 2023

A 65-year-old woman presenting with PD-L1-positive, BRCA wild-type, HER2-low (IHC 1+) mTNBC receives the following first-line therapy.

Regulatory and reimbursement issues aside, which systemic therapy would you most likely recommend next?

- **First line: Pembrolizumab/chemotherapy**
- **First line: Pembrolizumab/Sacituzumab govitecan**

RTP RESEARCH TO PRACTICE

A 65-year-old woman presenting with PD-L1-negative, BRCA wild-type, HER2-low (IHC 1+) mTNBC receives the following first-line therapy.

Regulatory and reimbursement issues aside, which systemic therapy would you most likely recommend next?

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- **First line: Sacituzumab govitecan**
- **First line: Datopotamab deruxtecan**

RTP RESEARCH TO PRACTICE

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Regulatory and reimbursement issues aside, which systemic therapy would you most likely recommend next?

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- **First line: Sacituzumab govitecan/pembrolizumab**

RTP RESEARCH TO PRACTICE

A 65-year-old woman presenting with PD-L1-negative, BRCA-mutated, HER2-low (IHC 1+) mTNBC receives the following first-line therapy.

Regulatory and reimbursement issues aside, which systemic therapy would you most likely recommend next?

- **First line: Chemotherapy**
- **First line: Sacituzumab govitecan**
- **First line: Datopotamab deruxtecan**

RTP RESEARCH TO PRACTICE

Cases from General Medical Oncologists

38 yo woman

- **mTNBC, HER2 IHC 1+ (low positive), PD-L1 CPS 2, MSI negative, TMB low, germline testing negative. Asymptomatic osseous involvement in the thoracic and lumbar spine, left scapula, sternum, left rib, bilateral iliac bones, and right femur. Indeterminate lesions in the liver and cervical lymph nodes.**
- **This patient was treated with first-line paclitaxel, per the prior standard of care, and progressed after two months with new lesions on PET. She also progressed on second-line therapy with trastuzumab deruxtecan after just two months with new lesions on PET.**
- **It is not typically favored to sequence ADCs; however, it felt like a de-escalation to try a single agent chemotherapy in the third line. She has been on sacituzumab govitecan 9 months now.**

Agenda:
Metastatic Triple-Negative Breast Cancer (mTNBC)

Introduction: TROP2-Targeting Antibody-Drug Conjugates (ADCs) for mTNBC

Module 1: First-Line Therapy (PD-L1 Negative)

Module 2: First-Line Therapy (PD-L1 Positive)

Module 3: Second-Line Therapy (Sequencing)

Module 4: Adverse Events with TROP2-Targeting ADCs

RTP RESEARCH TO PRACTICE

Mitigation and Management of Toxicities with TROP2-Targeted ADCs

Melinda Telli, MD, FASCO

Professor of Medicine
Stanford University School of Medicine
Director, Breast Cancer Program
Associate Director for Clinical Research
Stanford Cancer Institute

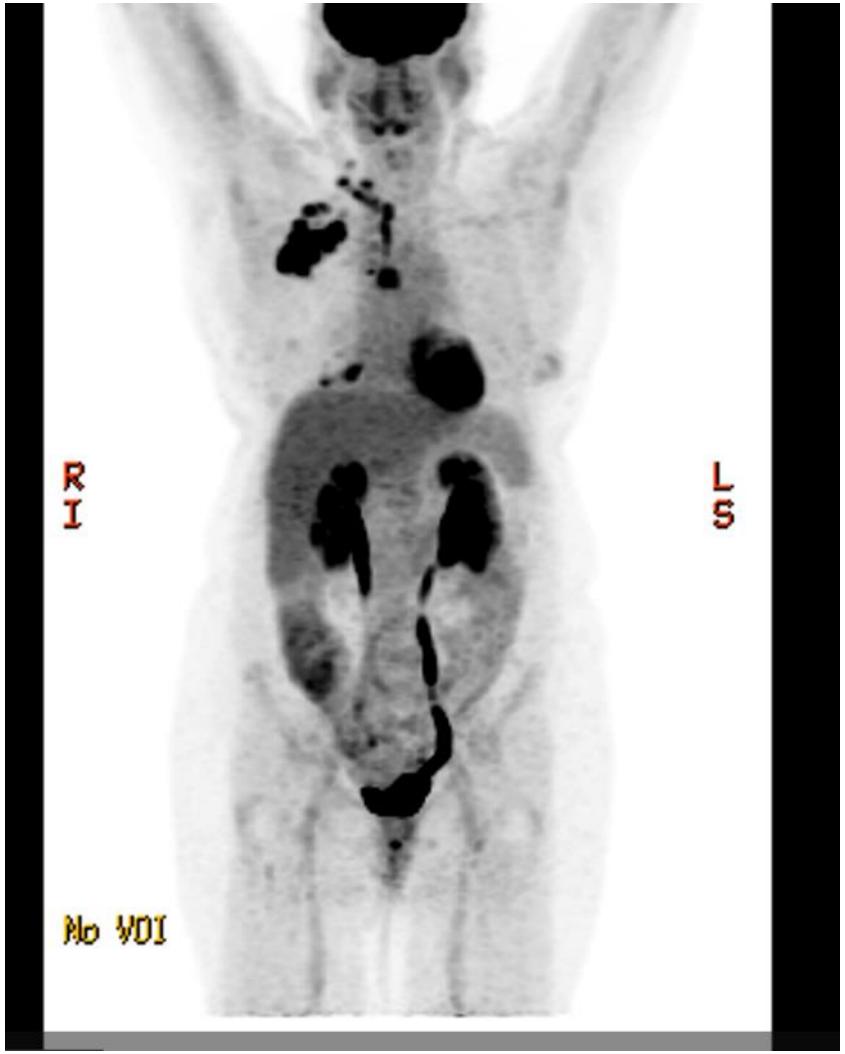
July 21, 2026

Patient Case:

- A 67-year-old postmenopausal woman is diagnosed with a T1miN0M0 IDC of the right breast associated with a 4 cm area of DCIS
  - ER 0%
  - PR 0%
  - HER2-negative (0 by IHC; FISH negative)
- She is treated with lumpectomy surgery and completes whole breast irradiation.
- No systemic chemotherapy is recommended.
- She tests negative for germline pathogenic variants in *BRCA1* & *BRCA2*

Patient Case:

- 2 years later, she is found to have suspicious right axillary adenopathy on routine breast imaging.
- Core biopsy of the right axillary node reveals recurrent IDC ER 0%, PR 0%, and HER2 0 (FISH negative)
- She undergoes PET/CT imaging for systemic staging which reveals:
  - Hypermetabolic right lower cervical, supraclavicular, internal mammary, cardiophrenic, axillary, subpectoral and mediastinal lymphadenopathy concerning for nodal metastatic disease.
- Biopsy of a mediastinal node reveals recurrent TNBC
  - PD-L1 CPS = 1
  - NGS reveals a somatic *BRCA2* pathogenic variant



Patient Case:

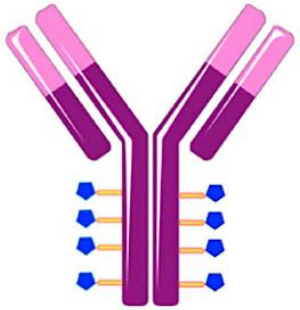
- She initiates 1st line sacituzumab govitecan 10 mg/kg IV days 1 & 8 of a 21-day schedule

- On C1D8 she is found to have grade 3 neutropenia with an ANC of 700
  - Treatment is held and G-CSF is initiated with improvement

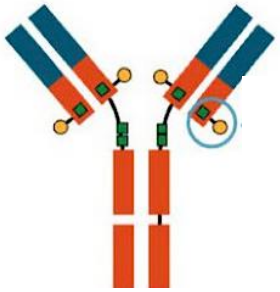
- She also endorses an increase of 5-6 loose bowel movements per day over baseline (grade 2 diarrhea)
  - She had not started the loperamide she was prescribed
  - She initiates loperamide BID with improvement to grade 1

TROP2 antibody-drug conjugates

Sacituzumab govitecan



Datopotamab deruxtecan
(Dato-DXd)



	Sacituzumab Govitecan (SG)	Datopotamab Deruxtecan (Dato-DXd)
Linker cleavage	pH and enzymatic	Yes
Membrane-permeable payload	Yes	Yes
Payload MOA	SN-38/Topo 1 inhibitor	Topo 1 inhibitor
Drug-antibody ratio	7.6:1	4:1
Key Toxicities	Neutropenia, diarrhea, nausea, fatigue	Nausea, ocular toxicity, stomatitis, ILD

ASCENT-03

Exposure and Safety Summary

Safety population	SG (n = 275)	Chemo (n = 276)	
Treatment component	**SG**	**Taxane**	**Gemcitabine/ Carboplatin**
All treated patients, n	275	154	122
Median duration of treatment, months (range)	8.3 (< 0.1-28.7)	6.3 (< 0.1-24.2)	5.8 (< 0.1-23.1)

TEAEs, n (%)	SG (n = 275)	Chemo (n = 276)
Any TEAE	273 (99)	269 (97)
Grade ≥ 3 TEAEs	181 (66)	171 (62)
Treatment-related	167 (61)	147 (53)
Treatment-emergent SAE	71 (26)	67 (24)
Treatment-related	46 (17)	37 (13)
TEAEs leading to treatment discontinuation	10 (4)	33 (12)
TEAEs leading to dose interruption	181 (66)	171 (62)
TEAEs leading to dose reduction	101 (37)	124 (45)
TEAEs leading to death	7 (3)	1 (< 1)
Treatment-related	6 (2)	1 (< 1)

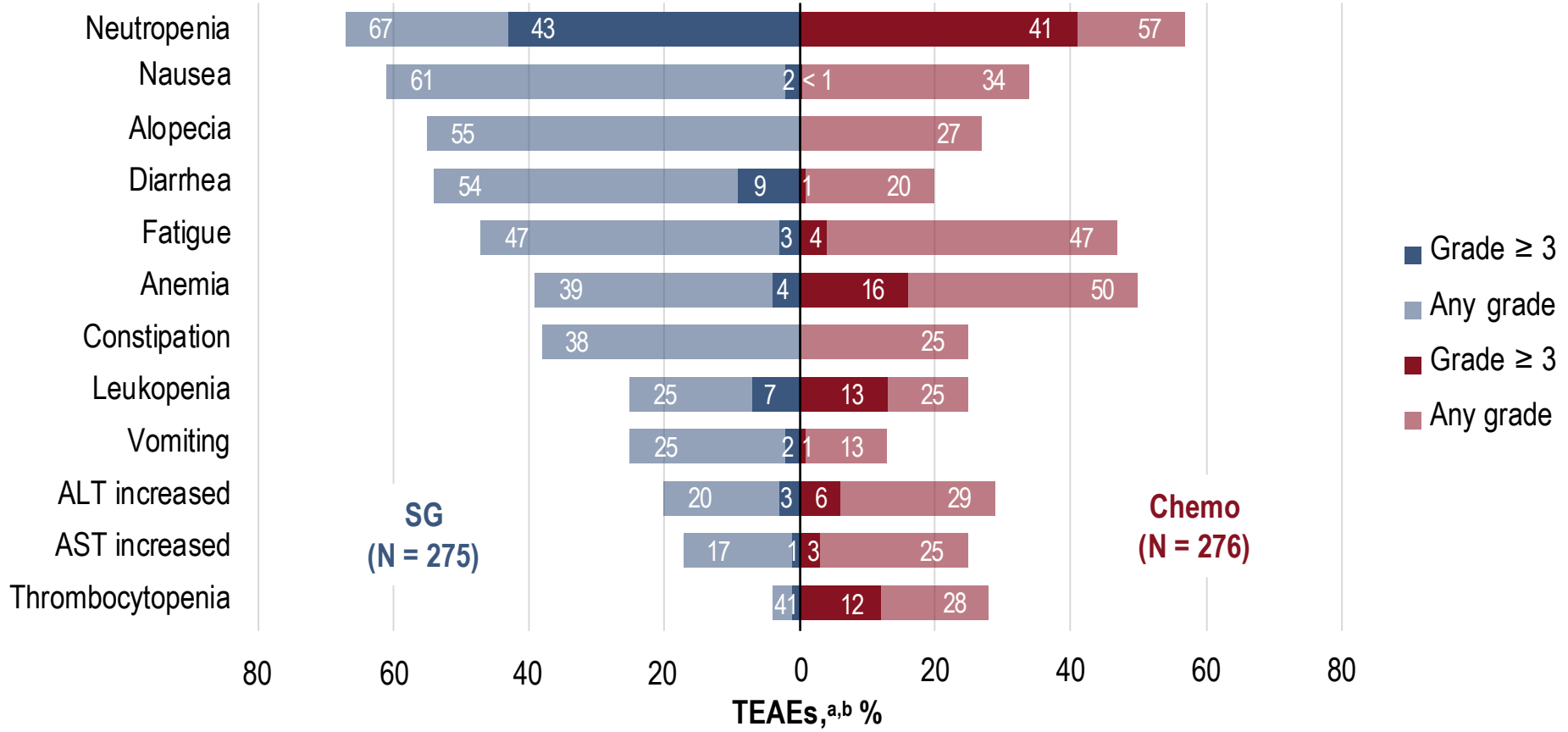
All treatment-related deaths with SG were due to infections; 5 infections were secondary to neutropenia. None of the 5 patients, who had risk factors for febrile neutropenia, received prophylaxis with G-CSF

Rates of grade ≥ 3 TEAEs and treatment-emergent SAEs were similar for both groups.
TEAEs leading to dose reduction or treatment discontinuation were lower with SG vs chemo

Data cutoff date: April 2, 2025. TEAEs were defined as any AEs that began or worsened on or after the first dose date of study drug up to 30 days after the last dose date of study drug or the initiation of subsequent anticancer therapy (including crossover treatment), whichever occurs first.
AE, adverse event; **chemo**, chemotherapy; **G-CSF**, granulocyte-colony stimulation factor; **SAE**, serious adverse event; **SG**, sacituzumab govitecan; **TEAE**, treatment-emergent adverse event.

Cortes J et al. ESMO 2025;Abstract LBA20

ASCENT-03: Most Common Adverse Events



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.

Javier Cortés, MD

Cortes J et al. ESMO 2025;Abstract LBA20

Sacituzumab govitecan toxicity management

- Nausea
  - High emetogenic risk
  - Premedicate: Dexamethasone + 5-HT3 receptor antagonist or NK1 receptor antagonist
- Neutropenia
  - Intermediate risk by NCCN Guidelines
  - Primary prophylaxis for patients with risk factors
    - Prior chemotherapy or neutropenia, older patients, organ dysfunction, poor PFS
- Diarrhea
  - Rule out infection
  - Initiate loperamide and supportive measures
- Other premedications
  - History of infusion reaction: antipyretic, H1/H2 blockers, corticosteroid
  - History of cholinergic reaction: Atropine

SG: PRIMED Strategy

Key Eligibility Criteria

- Patients ≥18 years old with <u>mTNBC or metastatic HR+/HER2- breast cancer</u>
- Received at least 1 and up to 2 prior SOC chemotherapy regimens for metastatic disease
- ECOG PS ≤1

Study Treatment

Sacituzumab govitecan
10 mg/kg IV D1 and D8

⊕

Loperamide
2 mg PO BID, or 4 mg QD on D2, D3, D4, and D9, D10, D11 (First two cycles*)

⊕

G-CSF
0.5 MU/kg/day SC QD on D3, D4, and D10, D11 (First two cycles*)

Study Endpoints

Primary endpoints

- Co-primary endpoints are incidence of grade ≥2 diarrhea and grade ≥3 neutropenia at cycle 2

Secondary endpoints

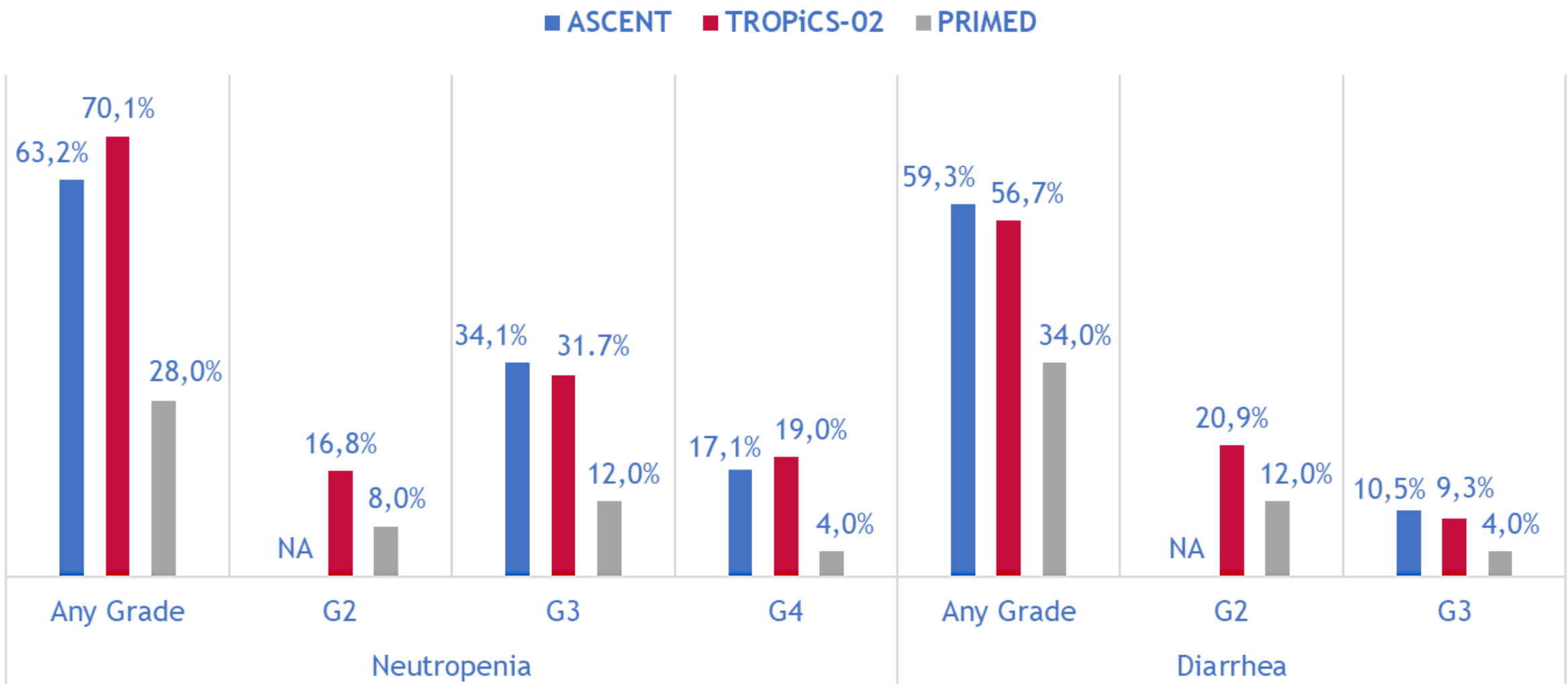
- Tolerability and safety per NCI-CTCAE v5 at cycle 2
- Discontinuation and dose reductions
- Efficacy in terms of PFS, ORR, clinical benefit rate, time to response, DOR, and best percentage of change in tumor burden

Incidence in first 2 cycles, n (%)	Any grade	Grade 2	Grade 3	Grade 4
Neutropenia	**14 (28.0)**	**4 (8.0)**	**6 (12.0)**	**2 (4.0)**
Diarrhea	**17 (34.0)**	**6 (12.0)**	**2 (4.0)**	**0**

Courtesy of Javier Cortés, MD, PhD

Perez-Garcia-J, et al EClinicalMedicine 2025

SG: PRIMED Strategy vs. ASCENT vs. TROPiCS-02



Courtesy of Javier Cortés, MD, PhD

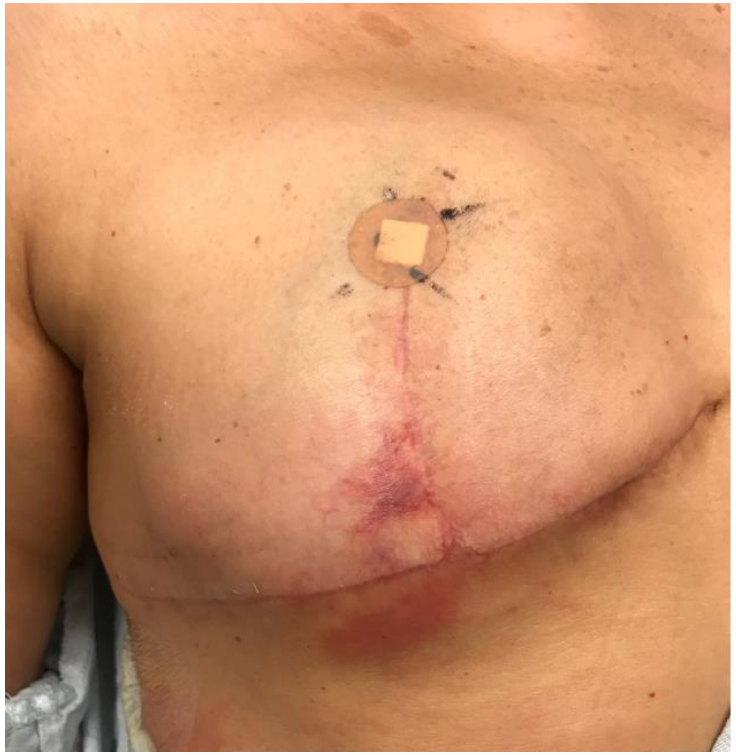
Bardia A, et al. NEJM 2021; Rugo H, et al. JCO 2022; Perez-Garcia-J, et al EClinicalMedicine 2025

Patient Case:

- A 54-year-old woman self-palpates a right breast mass
- Diagnostic mammogram shows 4.8 cm right breast mass and ultrasound demonstrates multiple atypical axillary nodes
- Core biopsy reveals grade 3 IDC:
  - ER 0%
  - PR 0%
  - HER2 IHC 1+
  - HER2 FISH negative
- Staging PET/CT demonstrates FDG avid disease in the right breast, axilla, and internal mammary region
- Clinical anatomic stage is T2N3M0 (stage 3C)

Patient Case:

- She initiates neoadjuvant chemotherapy and pembrolizumab per KN-522 with clinical response
- She undergoes right mastectomy and ALND:
  - No residual primary tumor
  - 12/21 lymph nodes involved, largest focus 1.8 cm, extensive lymphovascular invasion
  - Pathologic Stage = ypT0 ypN3
- While receiving post-mastectomy radiation, she develops biopsy-proven chest wall recurrence
- Restaging PET/CT shows new mediastinal nodes and pulmonary nodules



Patient Case:

- She initiates datopotamab deruxtecan 6 mg/kg IV every 3 weeks
- She completes 2 cycles with clinical response on her chest wall, but presents for cycle 3 reporting increased oral pain with mouth sores
  - She is able to eat, but is experiencing pain and can only tolerate liquids and soft foods
- She states that she has not been using her prescribed dexamethasone oral solution regularly

TROPION-Breast02 Overall Safety Summary

- **Median total treatment duration:**
  - **Dato-DXd: 8.5 months** (range 0.7–38.0)
  - **ICC: 4.1 months** (range 0.1–32.0)
- **Patients with total exposure >12 months:**
  - **Dato-DXd: 35.1%**
  - **ICC: 9.4%**

Treatment-related AEs, n (%)	Dato-DXd (n=319)	ICC (n=309)
Any grade	296 (93)	257 (83)
Grade ≥3	105 (33)	89 (29)
Serious TRAEs	29 (9)	26 (8)
Associated with dose interruption	76 (24)	60 (19)
Associated with dose reduction	85 (27)	56 (18)
Associated with discontinuation	14 (4)	23 (7)

Despite more than double the median duration of treatment in the Dato-DXd arm, rates of grade ≥3 and serious treatment-related AEs were similar, and discontinuations were lower, with Dato-DXd vs ICC

Dent R et al ESMO 2025;Abstract LBA21.

TRAEs, treatment-related adverse events.

TROPION-Breast02
Most Common Treatment-Related AEs (≥15% of Patients)

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)

*In the Dato-DXd arm only, ophthalmologic assessments were required every 3 cycles while on therapy; this was not required in the ICC arm. For all patients in both arms, ophthalmologic assessments were required at baseline, as clinically indicated, and at end of therapy.
†Grouped term comprising preferred terms of neutropenia and neutrophil count decreased. ‡Grouped term comprising preferred terms of haemoglobin decreased, red blood cell count decreased, anaemia, and haematocrit decreased. § Grouped term comprising preferred terms of white blood cell count decreased and leukopenia. ¶Grouped term comprising preferred terms of neuropathy peripheral, peripheral motor neuropathy, polyneuropathy, paraesthesia, and peripheral sensory neuropathy. #Grouped term comprising preferred terms of fatigue, asthenia, and malaise.
‖Per Common Terminology Criteria for Adverse Events version 5.0, the maximum grade for alopecia is grade 2.

Dent R et al ESMO 2025;Abstract LBA21.

TROPION-Breast02 Treatment-Related AESIs for Dato-DXd

AESI category, n (%) Preferred term*	Dato-DXd (n=319)			ICC (n=309)		
	Grade 1	Grade 2	Grade ≥3	Grade 1	Grade 2	Grade ≥3
Oral mucositis/stomatitis†	78 (24)	87 (27)	27 (8)	22 (7)	8 (3)	0
Stomatitis	72 (23)	83 (26)	27 (8)	19 (6)	8 (3)	0
Ocular surface events‡§	76 (24)	50 (16)	23 (7)	9 (3)	5 (2)	1 (<1)
Dry eye	51 (16)	21 (7)	4 (1)	6 (2)	3 (1)	0
Keratitis	21 (7)	14 (4)	7 (2)	1 (<1)	0	0
Conjunctivitis	7 (2)	13 (4)	1 (<1)	0	0	0
Adjudicated drug-related ILD/pneumonitis¶	1 (<1)	7 (2)	1 (<1)#	1 (<1)	1 (<1)	0

Treatment-related oral mucositis/stomatitis:

- In the Dato-DXd arm, events led to dose interruption, reduction, and discontinuation in 11 (3%), 36 (11%), and 0 patients, respectively
- Grade ≥2 events resolved to grade ≤1 in 103/114 patients (90%) at data cutoff

Treatment-related ocular surface events:

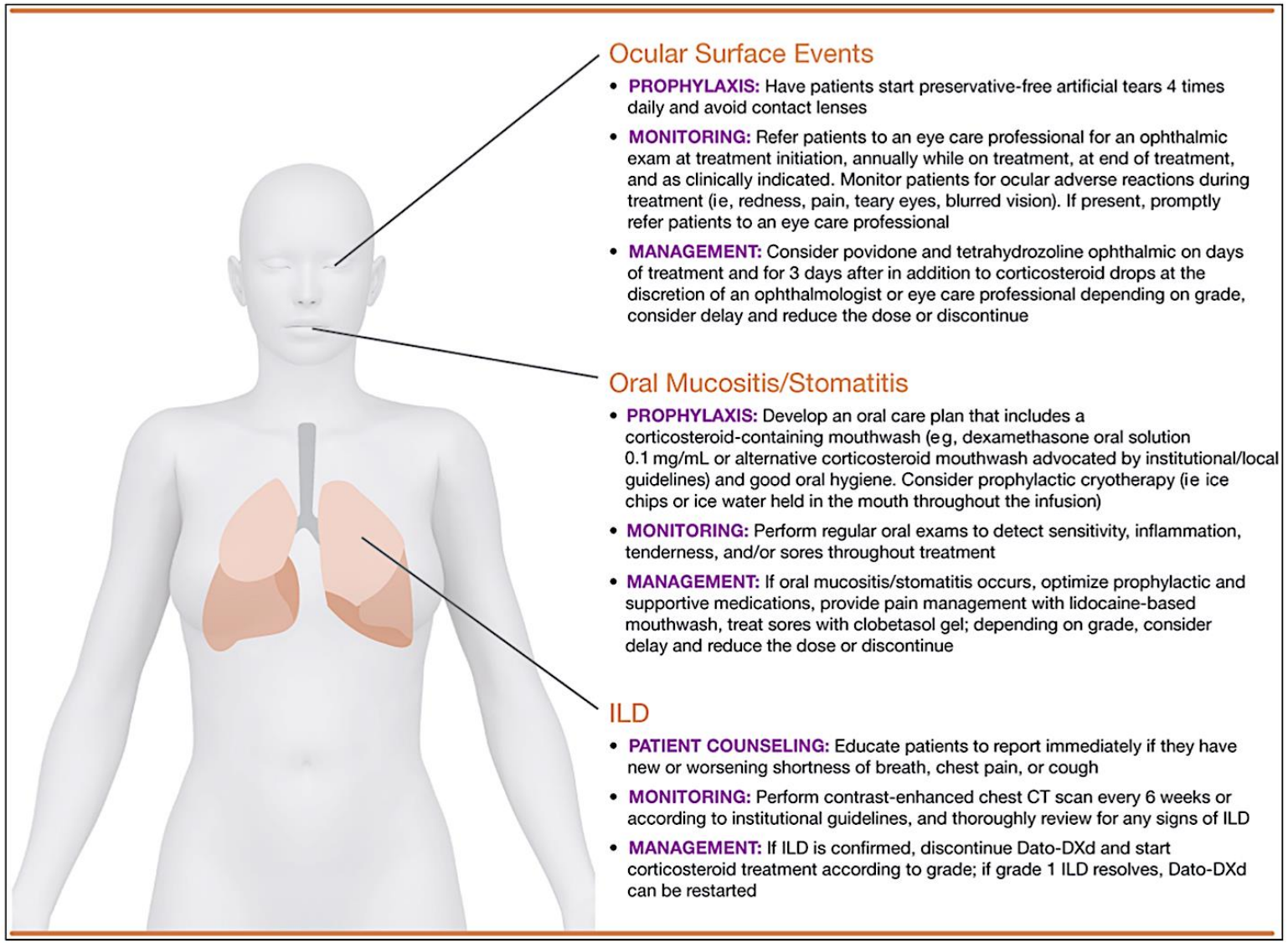
- In the Dato-DXd arm, events led to dose interruption, reduction, and discontinuation in 18 (6%), 14 (4%), and 3 (<1%) patients, respectively
- Grade ≥2 events resolved to grade ≤1 in 49/73 patients (67%) at data cutoff

*Details for preferred terms included if reported in ≥20 patients in either arm. †Comprising the preferred terms of aphthous ulcer, mouth ulceration, oral pain, oropharyngeal pain, pharyngeal inflammation, and stomatitis. ‡Comprising the preferred terms of acquired corneal dystrophy, blepharitis, conjunctivitis, corneal disorder, corneal epithelium defect, corneal erosion, corneal exfoliation, corneal lesion, corneal toxicity, dellen, dry eye, keratitis, keratopathy, lacrimation increased, limbal stem cell deficiency, meibomian gland dysfunction, photophobia, punctate keratitis, ulcerative keratitis, vision blurred, visual acuity reduced, visual impairment, and xerophthalmia. § In the Dato-DXd arm only, ophthalmologic assessments were required every 3 cycles while on therapy; this was not required in the ICC arm. For all patients in both arms, ophthalmologic assessments were required at baseline, as clinically indicated, and at end of therapy. ¶Comprising the preferred terms of interstitial lung disease and pneumonitis. #Grade 5 – this event was characterised by the investigator as grade 3 pneumonitis, with death assessed as related to breast cancer.

Dent R et al ESMO 2025;Abstract LBA21.

AESI, adverse event of special interest; ILD, interstitial lung disease.

Managing Dato-DXd Adverse Events



Nausea & Vomiting

High emetogenic risk

- Olanzapine
- NK1 receptor antagonist
- 5-HT3 receptor antagonist
- Dexamethasone

Lisberg A et al. *Oncologist* 2025 September 1;30(9):oyaf225; NCCN Antiemesis Guideline V2.2026 available at nccn.org

Management of ADC-associated Ocular Surface Toxicity

Required Eye Care

- Ophthalmic exam (visual acuity, slit lamp exam, intraocular pressure, and fundoscopy) at baseline/within the first cycle, annually on treatment, at end of treatment, and as clinically indicated
- Preservative-free lubricant eye drops at least QID (up to 8x/day)and as needed

Dry eye

- Eye redness
- Stinging
- Burning or scratchy sensation
- Sensation of having something in eye
- Sensitivity to light
- Blurred vision

Keratitis

- Eye pain
- Excess tears or discharge from eye
- Difficulty opening eyelid due to pain or irritation
- Decreased vision

Grade and Description	Protocol Management Recommendations*
1: asymptomatic	• Maintain dose • Ensure use of artificial tears • Consider ophthalmology assessment
2: symptomatic with moderate decrease in visual acuity	• Obtain ophthalmology assessment • Delay dose until resolved to grade ≤1
3: symptomatic with marked decrease in visual acuity limiting self-care ADL	• Obtain ophthalmology assessment • Delay dose until resolved to grade ≤1, then reduce by 1 dose level
4: perforation; best corrected visual acuity of 20/200 or worse in affected eye	• Obtain ophthalmology assessment • Discontinue drug

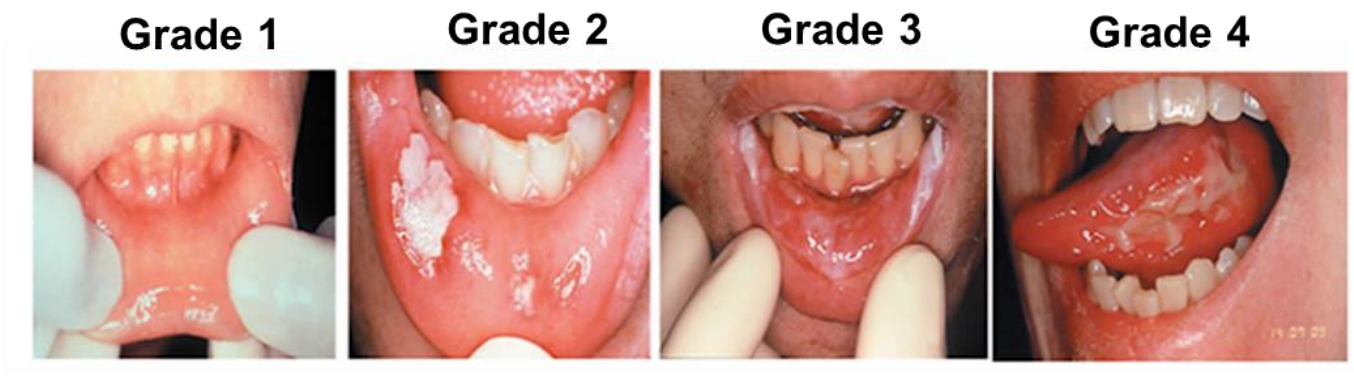
***Ensure that use of contact lenses is avoided**

Lu. J Adv Pract Oncol. 2023;14:300. D'Arienzo. 2023;62:102113. Heist. Cancer Treatment Reviews. 2024;125:102720.

Dato-DXd: Identification & Grading of Mucositis/Stomatitis

What to look for:

- Lips and mucosa appear redder than usual
- Visible sores on oral mucosa
- Mouth pain, which may affect chewing and swallowing
- Changes in ability to taste



Stomatitis	Characteristics
Grade 1	Asymptomatic or mild symptoms
Grade 2	Moderate pain/ulceration not interfering with oral intake
Grade 3	Severe pain/ulceration interfering with oral intake
Grade 4	Oral intake not possible; life-threatening consequences

Courtesy of Javier Cortés, MD, PhD

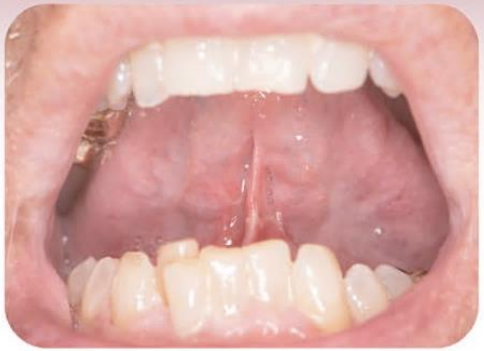
Management Recommendations for Stomatitis

STEP 1: Prophylaxis

Initiate daily oral care plan prior to administration of first Dato-DXd dose

- **Gently brushing** teeth after meals and at bedtime using a soft toothbrush and a **bland fluoride-containing toothpaste**
- **Daily flossing**, unless it causes pain or bleeding
- Daily use of a **steroid-containing mouthwash**[a,b]
- **Cryotherapy** should be considered
- **Education** on the importance of oral hygiene, hydration, and lubrication of the oral mucosa and **adherence to oral care plan**

STEP 2: Monitor



STEP 3: Manage

Supportive care

- Increase frequency of bland mouthwashes to up to every hour, if necessary
- As soon as oral pain, inflammation, and/or ulceration develops, strongly consider using a steroid-containing mouthwash[a]
- Provide pain management
- Consider referral to a dentist, oral surgeon, oral medicine expert, or dermatologist for severe or persistent events

Grading and dose modifications

Grade 1
- Maintain dose

Grade 2
- Consider a dose delay or reduction if clinically indicated

Grade 3
- If prophylactic/supportive medications have not yet been optimized, delay dose until event has been resolved to ≤ grade 1 or baseline, optimize medications, then maintain dose
- If prophylactic/supportive medications have already been optimized, delay dose until resolved to ≤ grade 1 or baseline, and then reduce dose by 1 level

Grade 4
- Discontinue Dato-DXd

Meric-Bernstam F et al. *Oncologist* 2025 March 10;30(3):oyaf031.

Cases from General Medical Oncologists

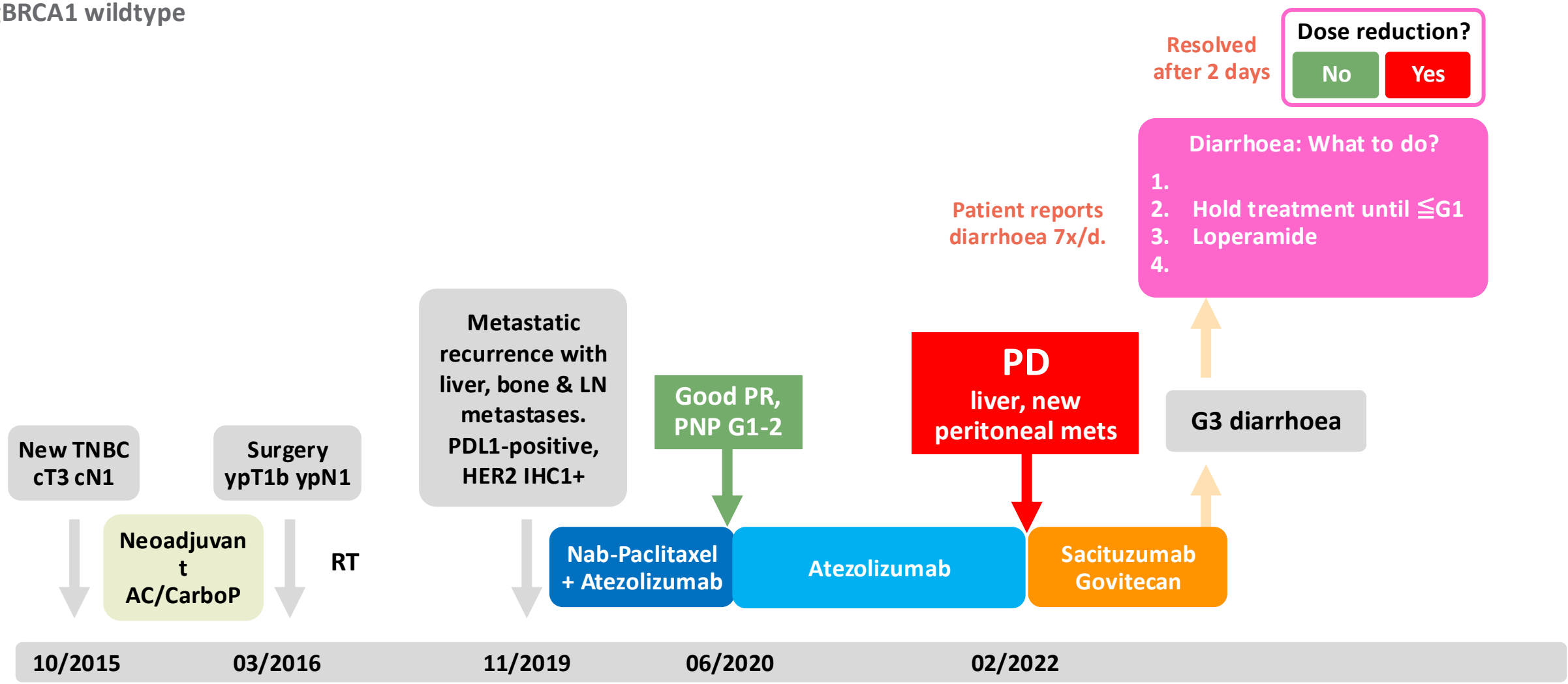
88 yo woman

- **De novo mTNBC, BRCA-negative, HER2 1+, PD-L1 5%. Bone metastases. History of HTN, dyslipidemia, CAD.**

How would you treat this patient? What do we know about TROP2 ADCs in the very elderly?

Case 1

42 y/o woman
gBRCA1 wildtype



How do you approach prevention and management of neutropenia and diarrhea in patients receiving sacituzumab govitecan?

How do you approach prevention and management of mucositis, pneumonitis and ocular keratitis in patients receiving datopotamab deruxtecan?

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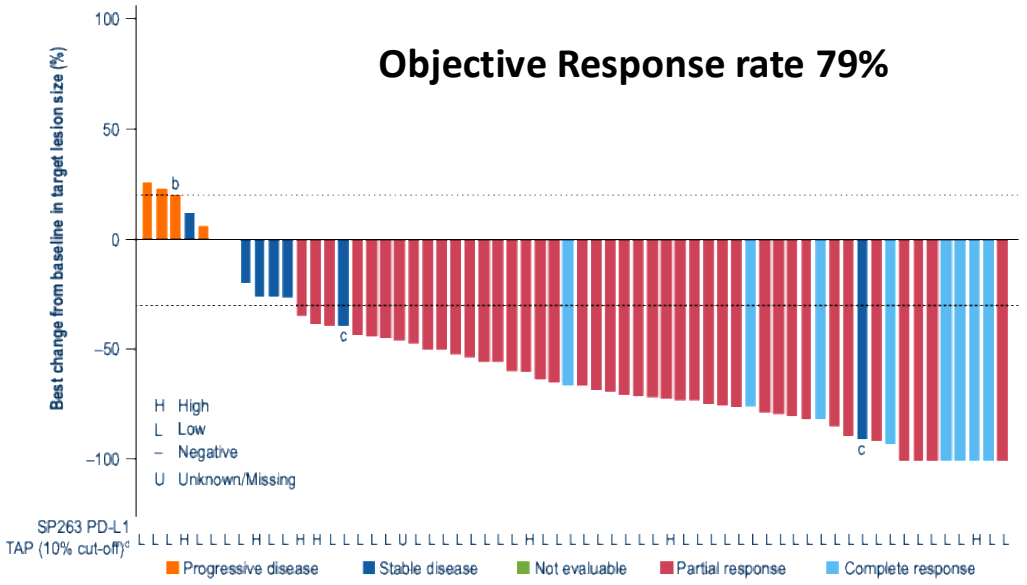
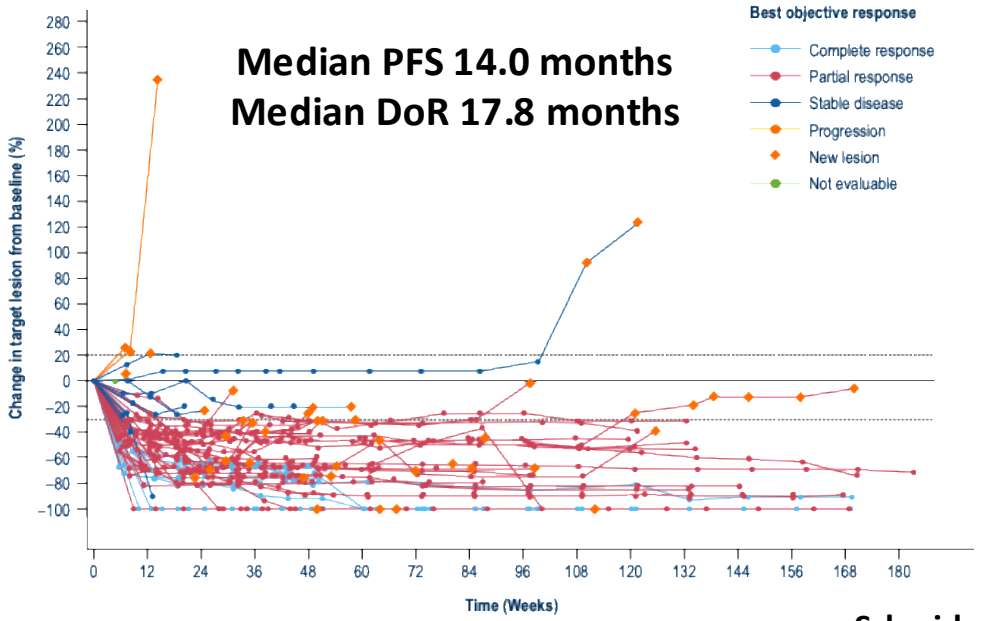
TO PRACTICE

Is there a role for ICI in PDL1- if combined with ADC?

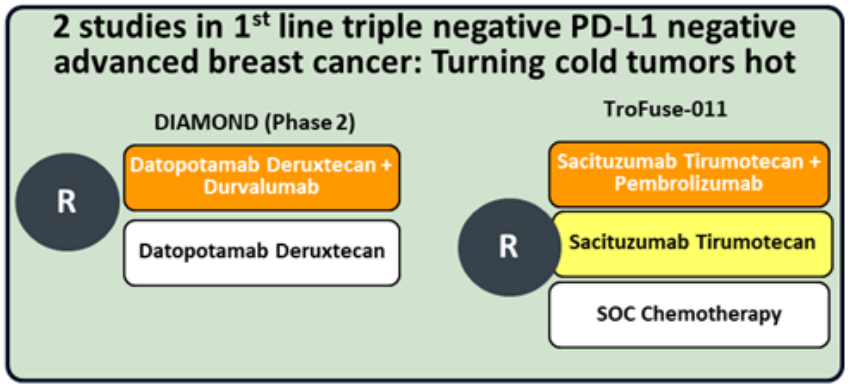
Dato-DXd plus Durvalumab in 1st line mTNBC (87% PDL1-negative)





Schmid, et al. ESMO 2025

Ongoing Trials



Case 2

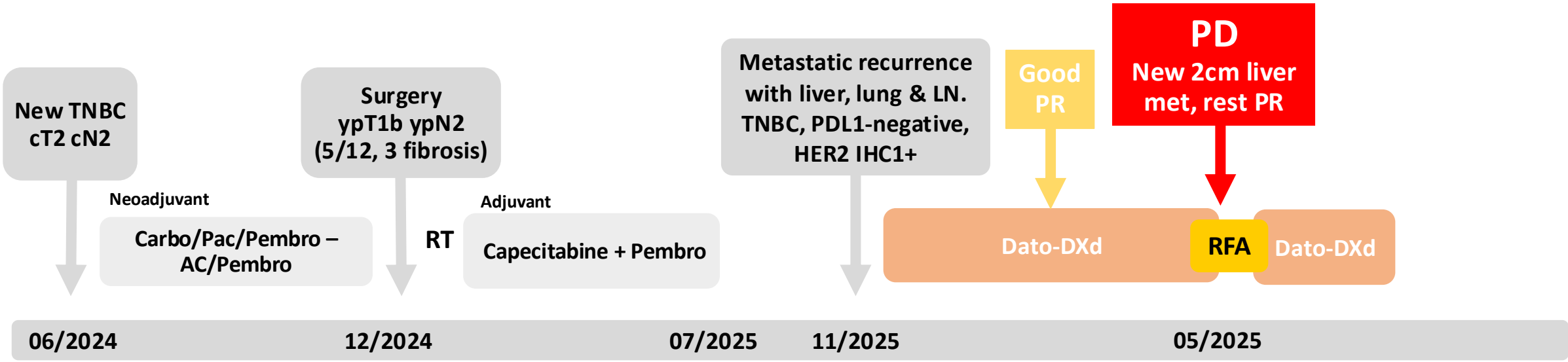
53 y/o woman
gBRCA1 wildtype

What would you do?

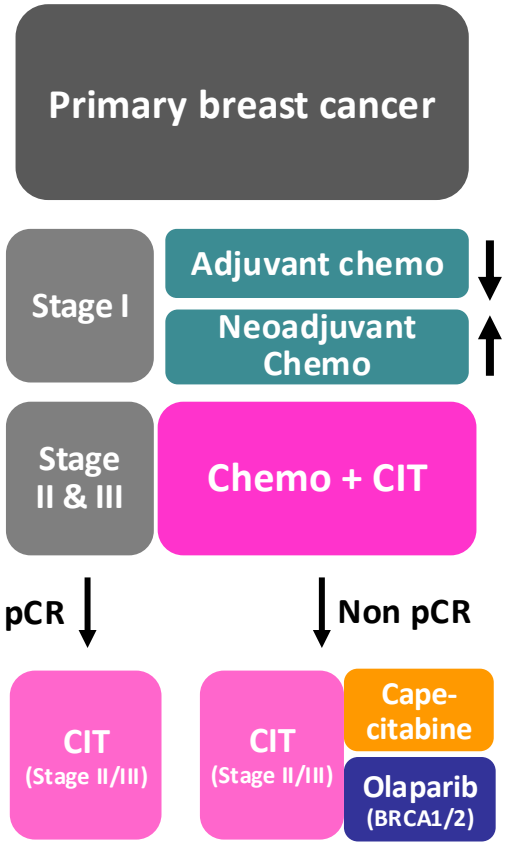
- Sacituzumab Govitecan
- Dato-DXd
- T-DXd
- Eribulin

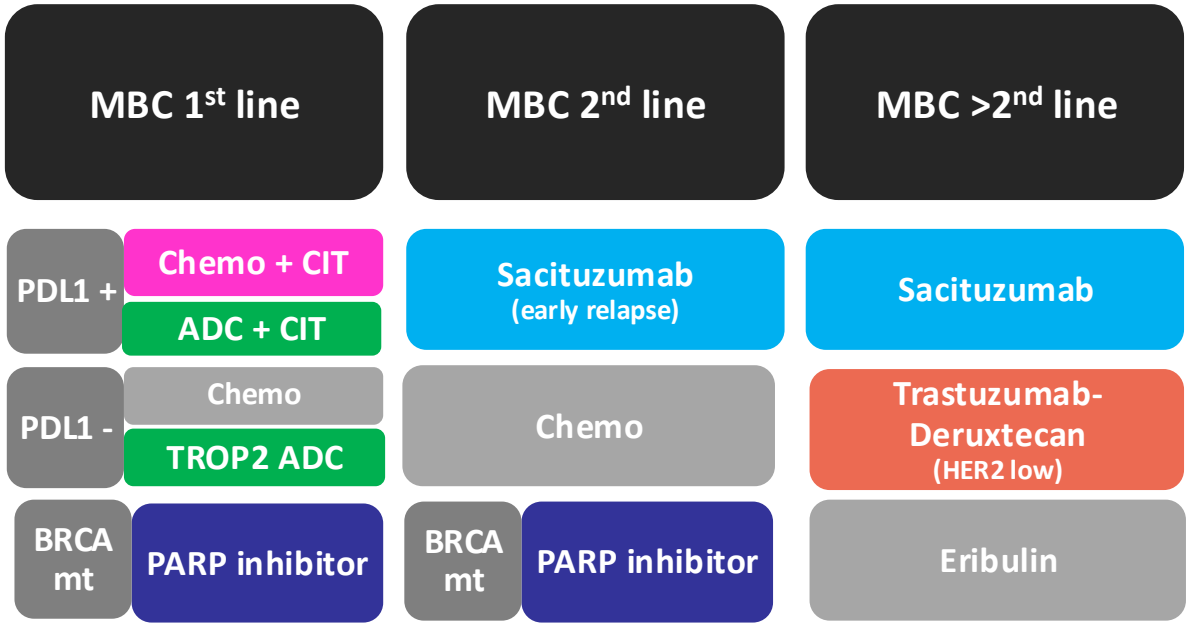
What would you do?

- Continue (no change)
- RFA or Cyberknife, continue Dato-DXd
- Eribulin
- T-DXd



TNBC Management in 2026





Bringing the Investigator into the Equation — Optimal Use of Hormonal Therapy in the Care of Patients with Prostate Cancer

A CME/MOC-Accredited Live Webinar

Wednesday, July 29, 2026
5:00 PM – 6:00 PM ET

Faculty

William K Oh, MD
Mary-Ellen Taplin, MD

Moderator

Neil Love, MD

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