What Clinicians Want to Know: Optimizing the Management of Metastatic Triple-Negative Breast Cancer

A CME/MOC-Accredited Live Webinar

Thursday, April 30, 2026

5:00 PM – 6:00 PM ET

Faculty

Kevin Punie, MD

Tiffany A Traina, MD, FASCO

Moderator

Neil Love, MD

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Faculty

Kevin Punie, MD
Medical Oncologist
ZAS Hospitals
Antwerp, Belgium

MODERATOR
Neil Love, MD
Research To Practice
Miami, Florida

Tiffany A Traina, MD, FASCO
Vice Chair, Department of Medicine
Section Head
Triple-Negative Breast Cancer Clinical Research Program
Associate Attending Physician
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Memorial Sloan Kettering Cancer Center
Associate Professor
Weill Cornell Medical College
New York, New York

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Dr Love — Disclosures

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Dr Traina — Disclosures

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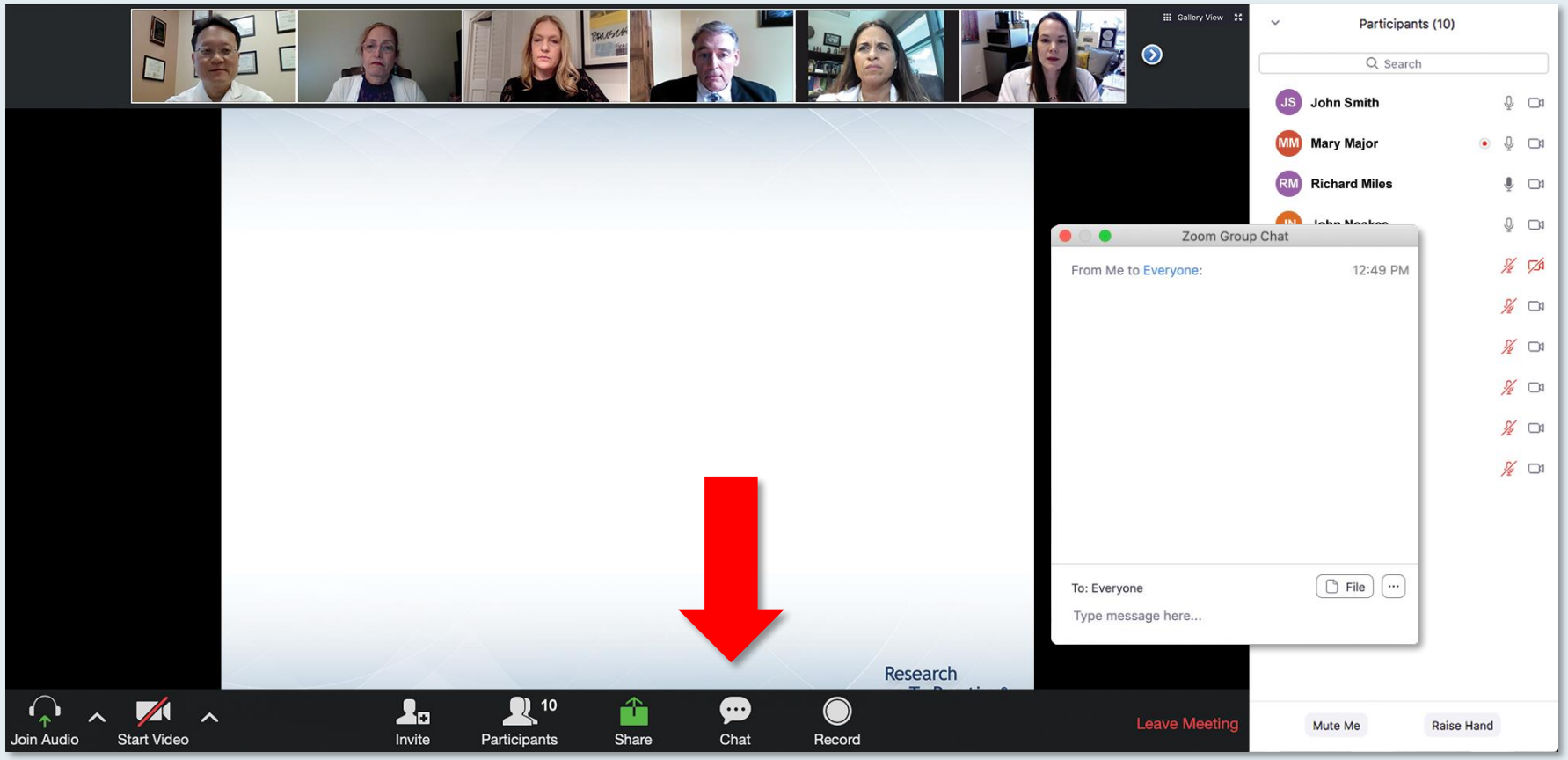

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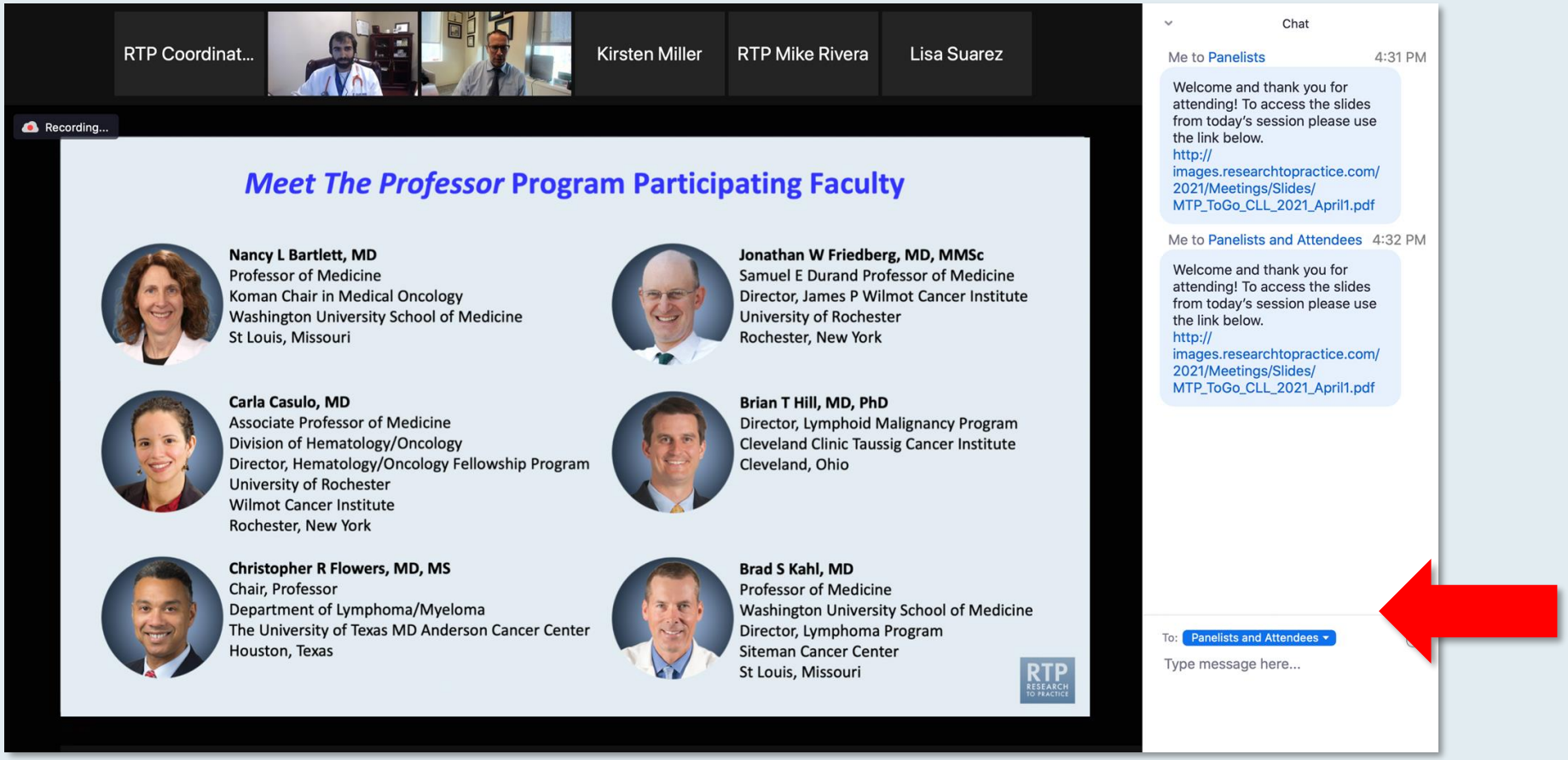

Drag the white line above the submission box up to create more space for your message.

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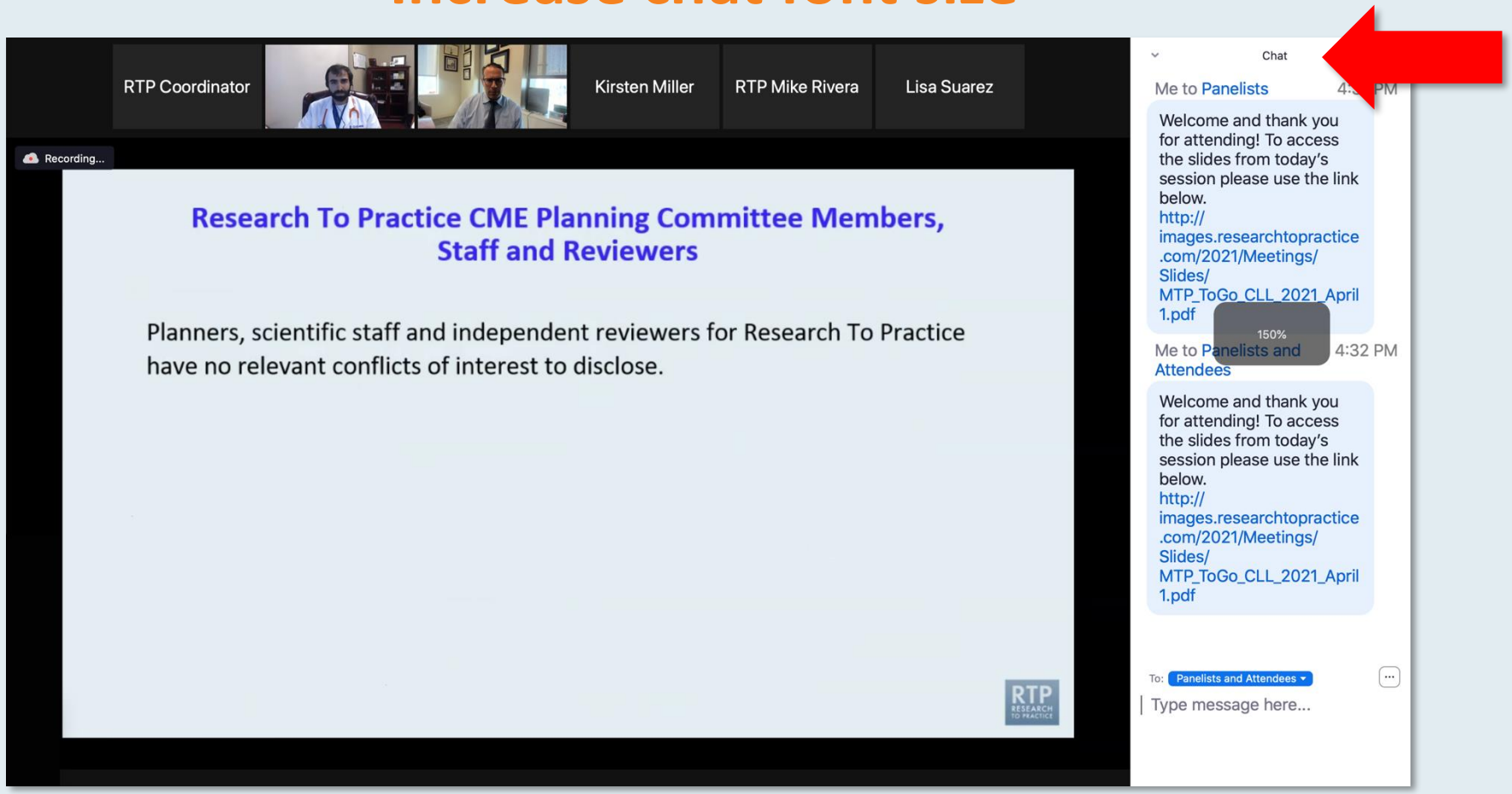

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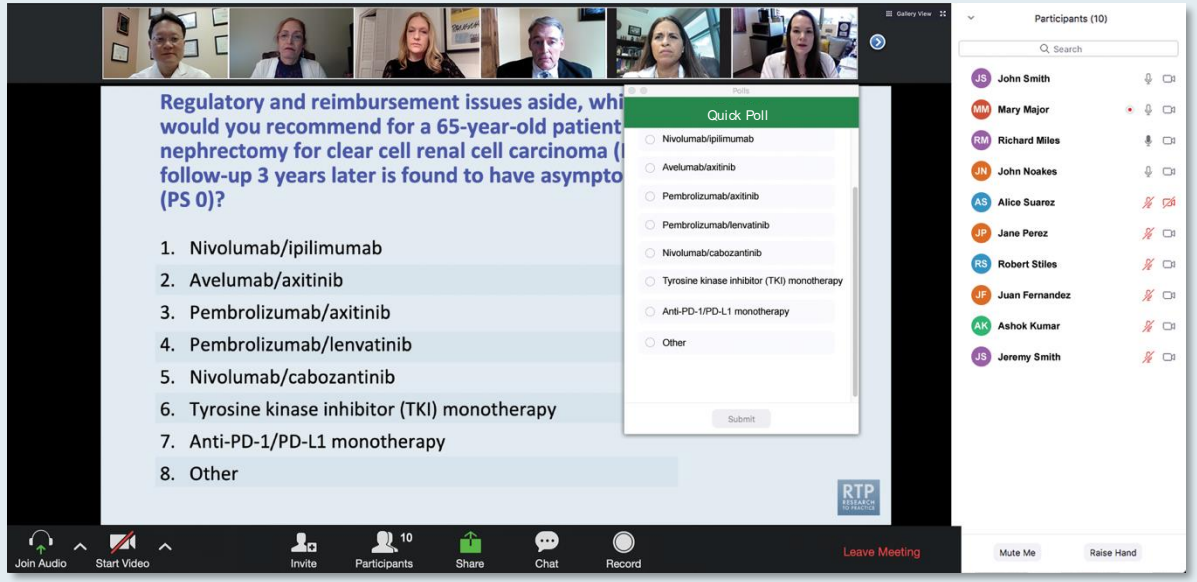

HR-Positive Metastatic Breast Cancer — An Interview with Dr Seth Wander on Optimizing Biomarker Assessment and Related Treatment Decision-Making

SETH WANDER, MD, PHD
MASSACHUSETTS GENERAL HOSPITAL

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

Non-Muscle-Invasive and Muscle-Invasive Bladder Cancer

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Ashish M Kamat, MD, MBBS

Thomas Powles, MBBS, MRCP, MD

Moderator

Neil Love, MD

RTP Year in Review 2026

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

A Complimentary NCPD Symposium Series Held During the 51st Annual ONS Congress May 13-16

San Antonio Marriott Rivercenter | San Antonio, Texas

Antibody-Drug Conjugates

Wednesday, May 13, 2026 | 11:15 AM – 12:45 PM CT

Prostate Cancer

Thursday, May 14, 2026 | 12:15 PM – 1:45 PM CT

Ovarian Cancer

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A 2-Part CME Satellite Symposium Series Held in Conjunction with the 2026 American Urological Association Annual Meeting (AUA2026)

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Prostate Cancer

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Grand Rounds

CME/MOC-Accredited Interactive Series

Regional Activities

Three Series

Optimizing Treatment for Patients with Relapsed/Refractory Chronic Lymphocytic Leukemia

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

Optimizing Therapy for Patients with Hormone Receptor-Positive Localized Breast Cancer

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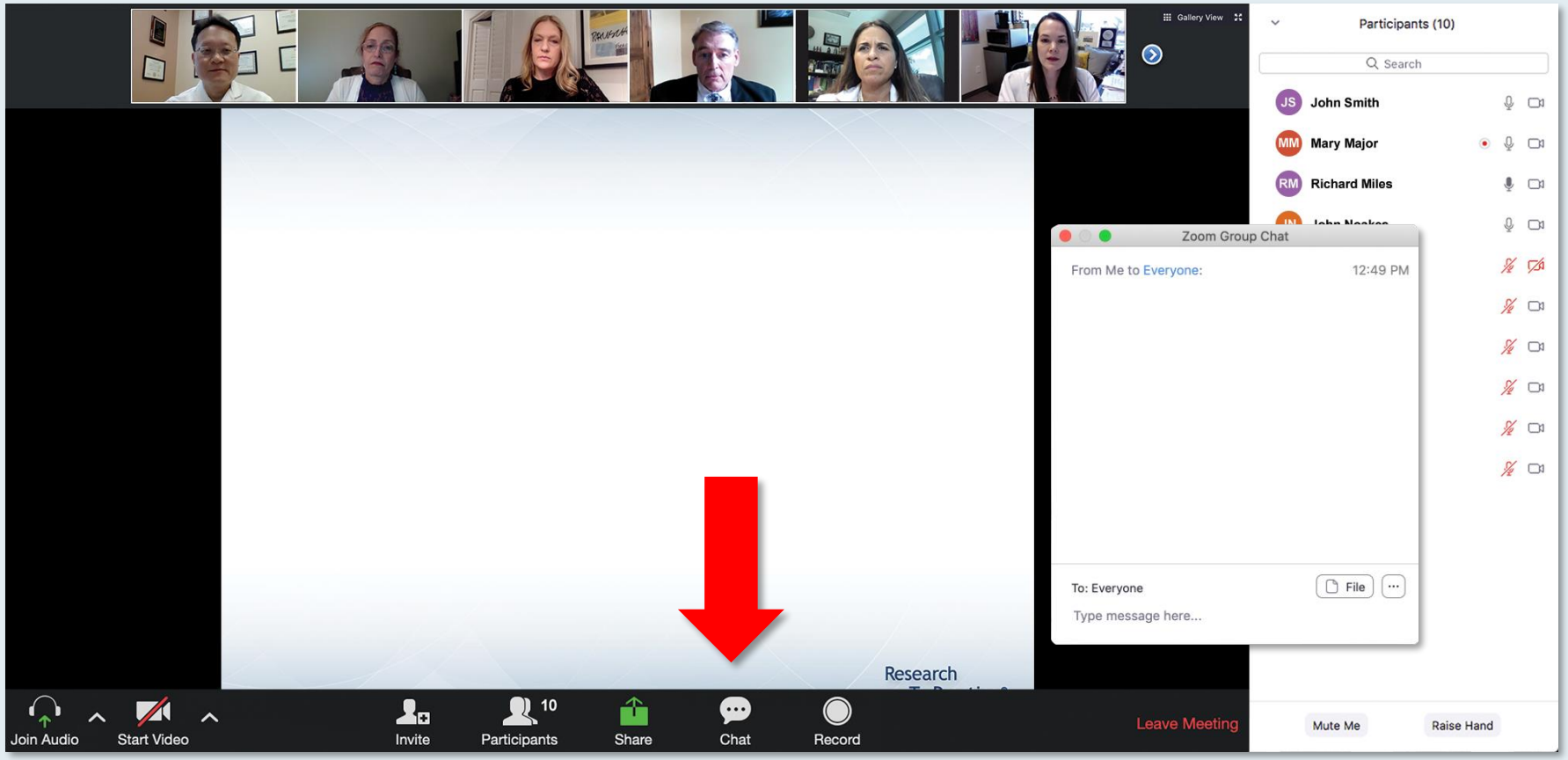

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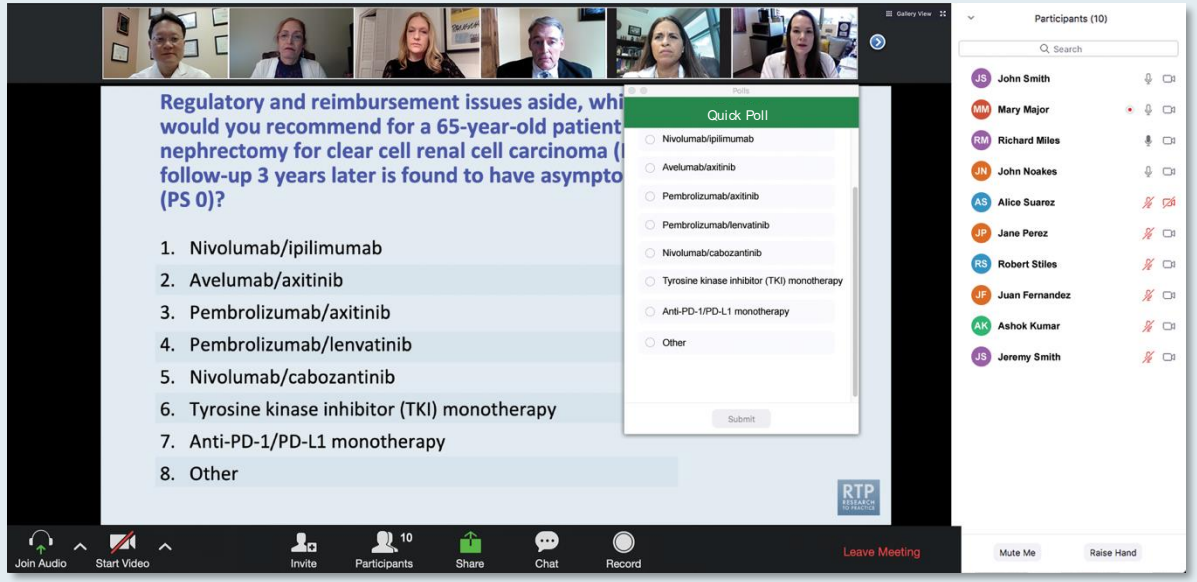

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Metastatic Triple-Negative Breast Cancer

Introduction: Where We Are; Where We're Heading

Module 1: First-Line Treatment of BRCA Wild-Type Disease

Module 2: First-Line Treatment of BRCA-Mutant Disease

Module 3: Novel Approaches

Module 4: ASCO 2026

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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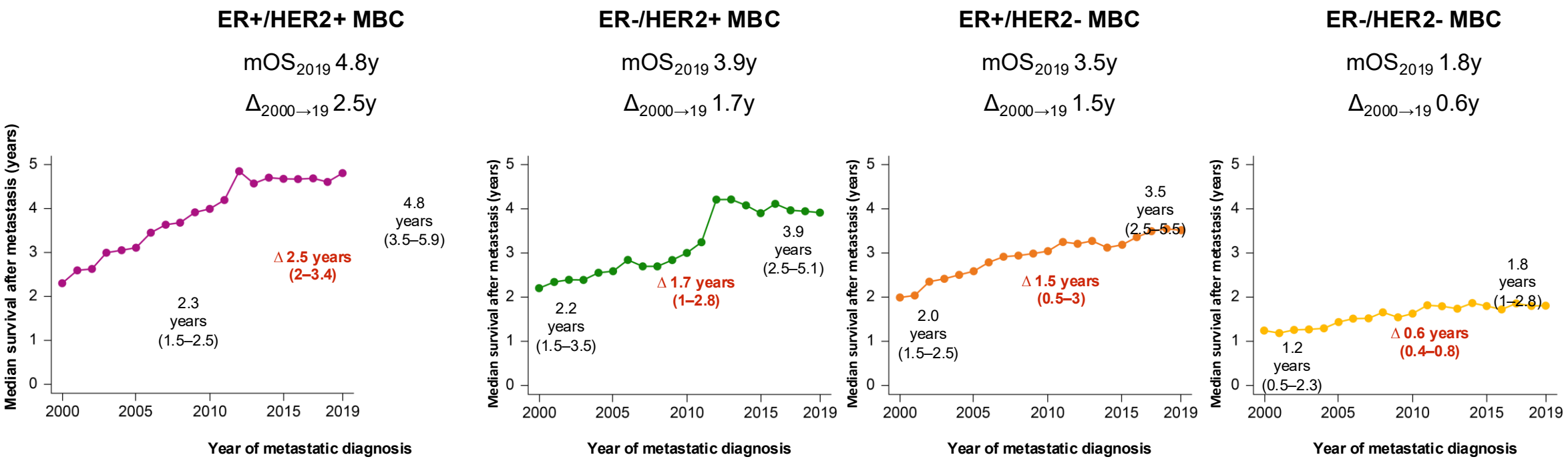
Improvement in Survival



Improvement of median OS in MBC

Mod. Caswell-Jin JL et al. 2022 ASCO Annual Meeting, Oral Abstract Session – Breast Cancer–Metastatic, Abstract No. 1008 AND JAMA 2024

Real-World Data in Metastatic TNBC

Punie K et al. Unmet need for previously untreated metastatic triple-negative breast cancer: A real-world study of patients diagnosed from 2011 to 2022 in the United States. *Oncologist* 2025;30(3):oyaf034.

Collin SM et al. Real-world treatment patterns and outcomes for patients with metastatic triple-negative breast cancer in the United States: An observational study. *JCO Oncol Pract* 2026;[Online ahead of print].

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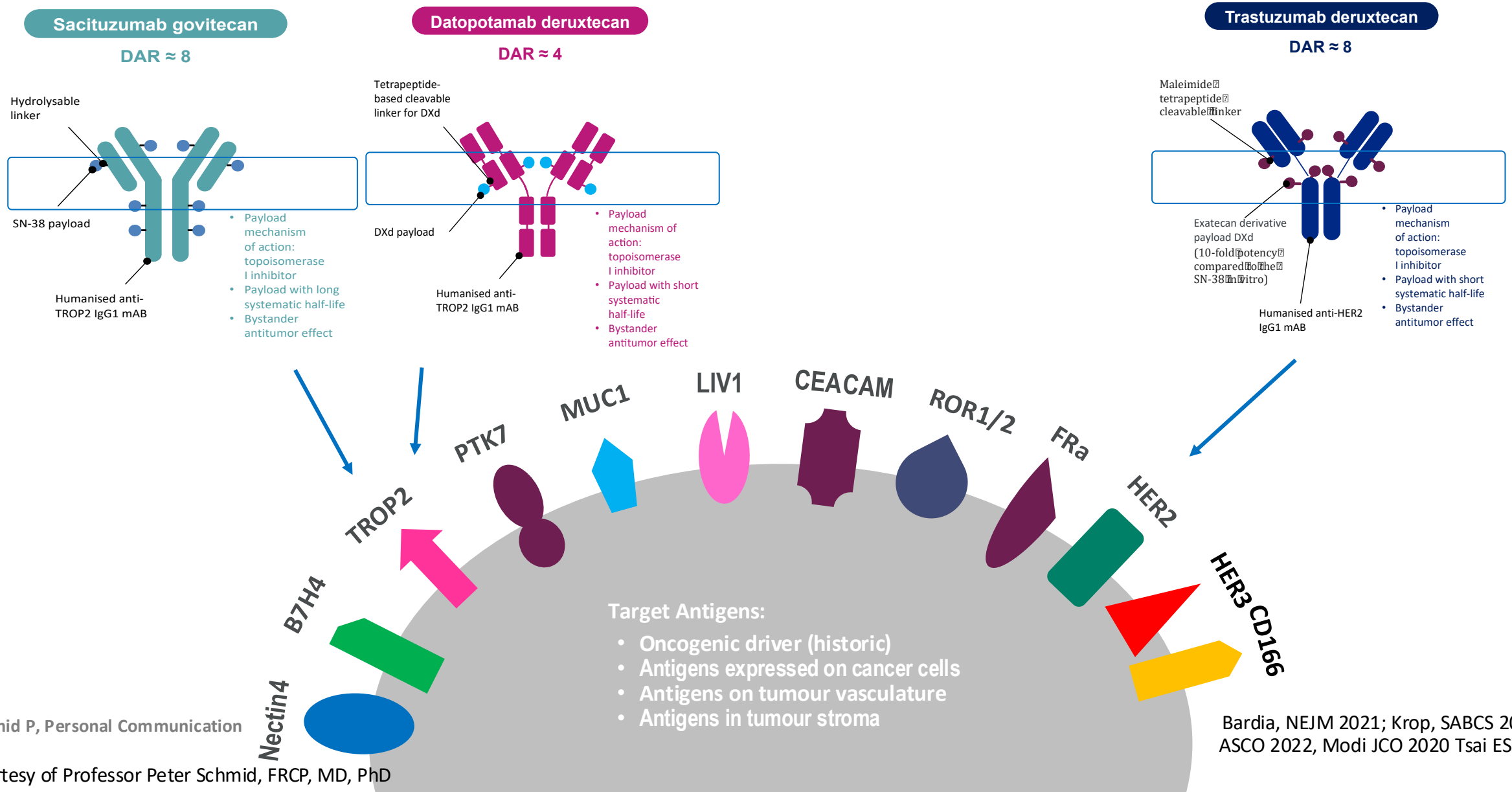
First-Line Treatment of Metastatic Disease

Borremans K et al. Expression of antibody-drug conjugate targets in post-mortem samples of breast cancer metastases and normal tissue. *Nat Commun* 2025;17(1):1080.

The LESLIE trial: Lifestyle intervention to enhance efficacy of neoadjuvant therapy in patients with triple negative breast cancer. NCT06831955. PI: Kevin Punie

Targets for Antibody-Drug Conjugates in Breast Cancer



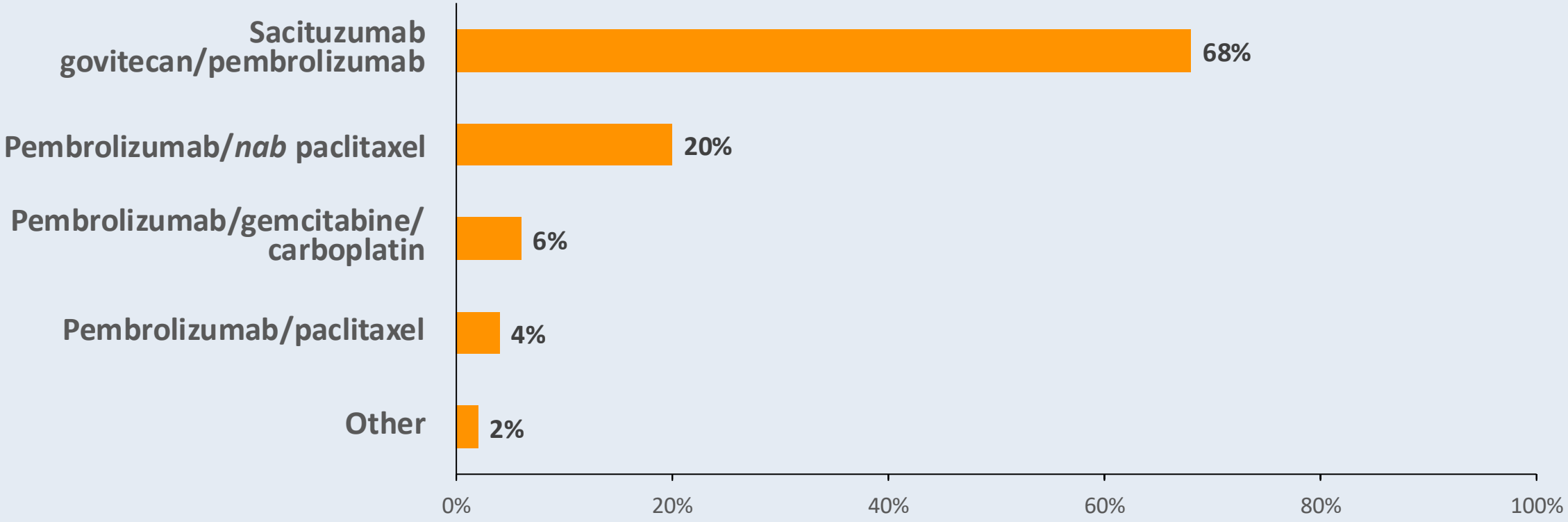
Schmid P, Personal Communication

Courtesy of Professor Peter Schmid, FRCP, MD, PhD

Bardia, NEJM 2021; Krop, SABCS 2021, Krop ASCO 2022, Modi JCO 2020 Tsai ESMO 2021

A woman presents with de novo hormone receptor (HR)-negative, HER2 IHC 1+, PD-L1-positive (combined positive score [CPS] 10), 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?

Age 65, PS 0, asymptomatic bone metastases



Survey of US-based general medical oncologists

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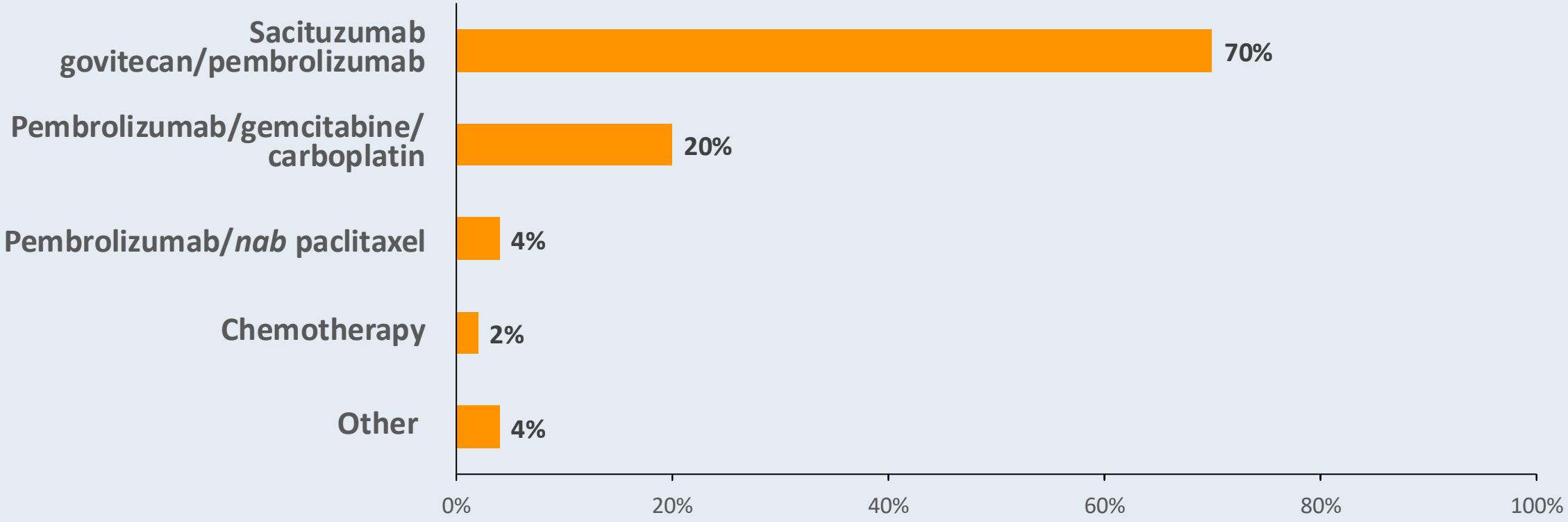

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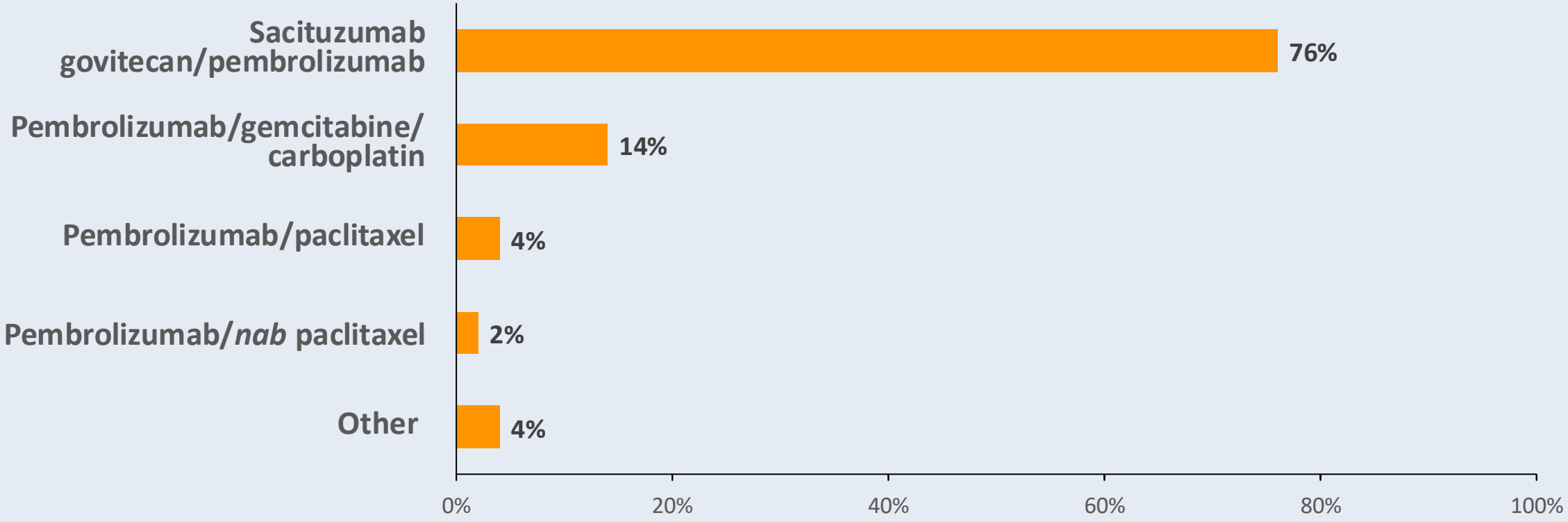
Age 65, PS 0, multiple brain metastases requiring stereotactic radiosurgery (SRS)



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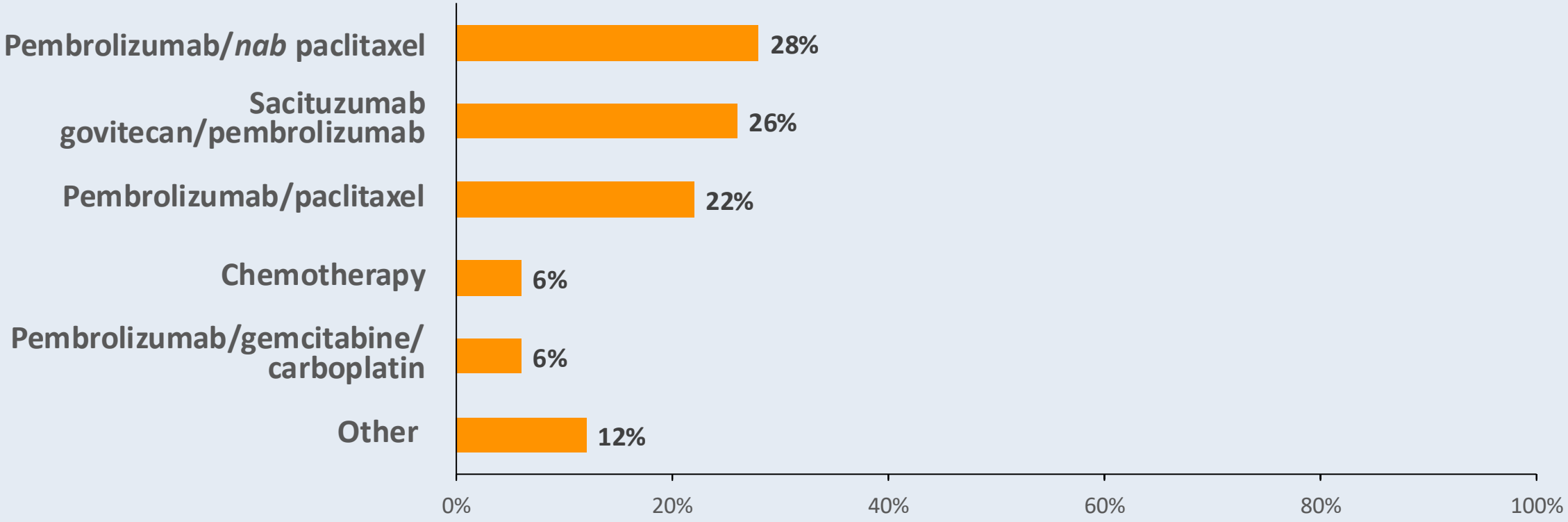
A woman presents with de novo HR-negative, HER2 IHC 1+, PD-L1-positive (CPS 10), BRCA wild-type mBC. Regulatory and reimbursement issues aside, which first-line therapy would you most likely recommend in each of the following scenarios?

Age 80, PS 2, asymptomatic bone metastases



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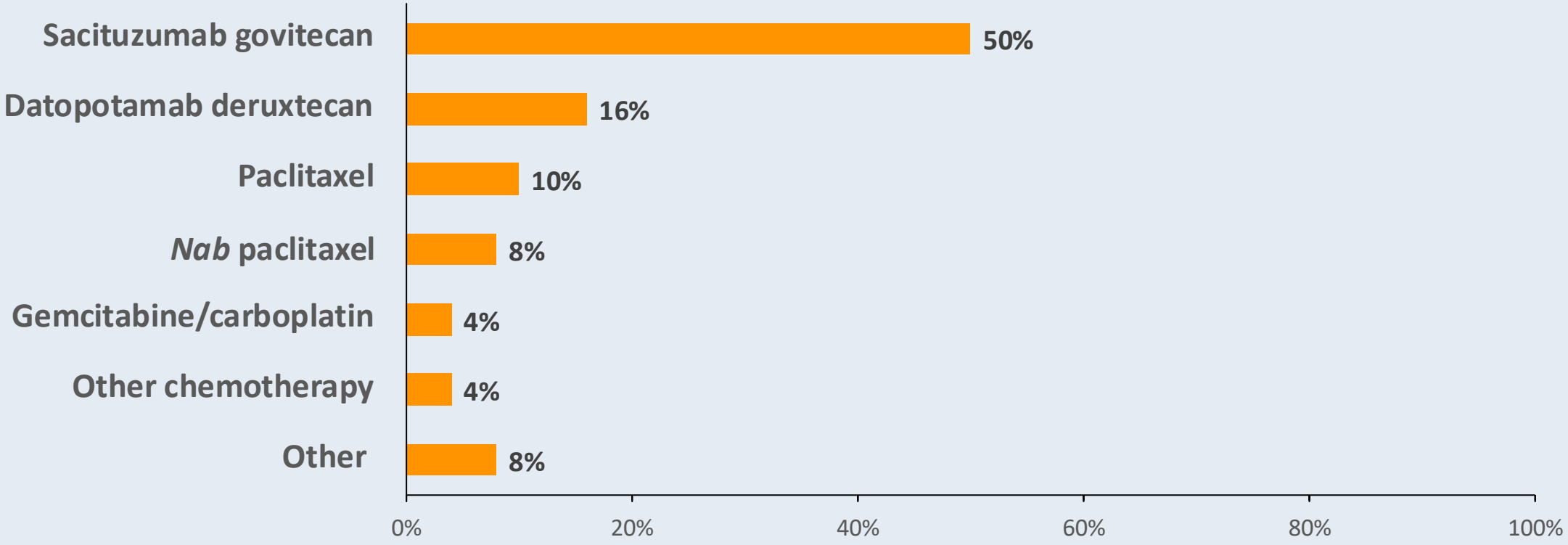

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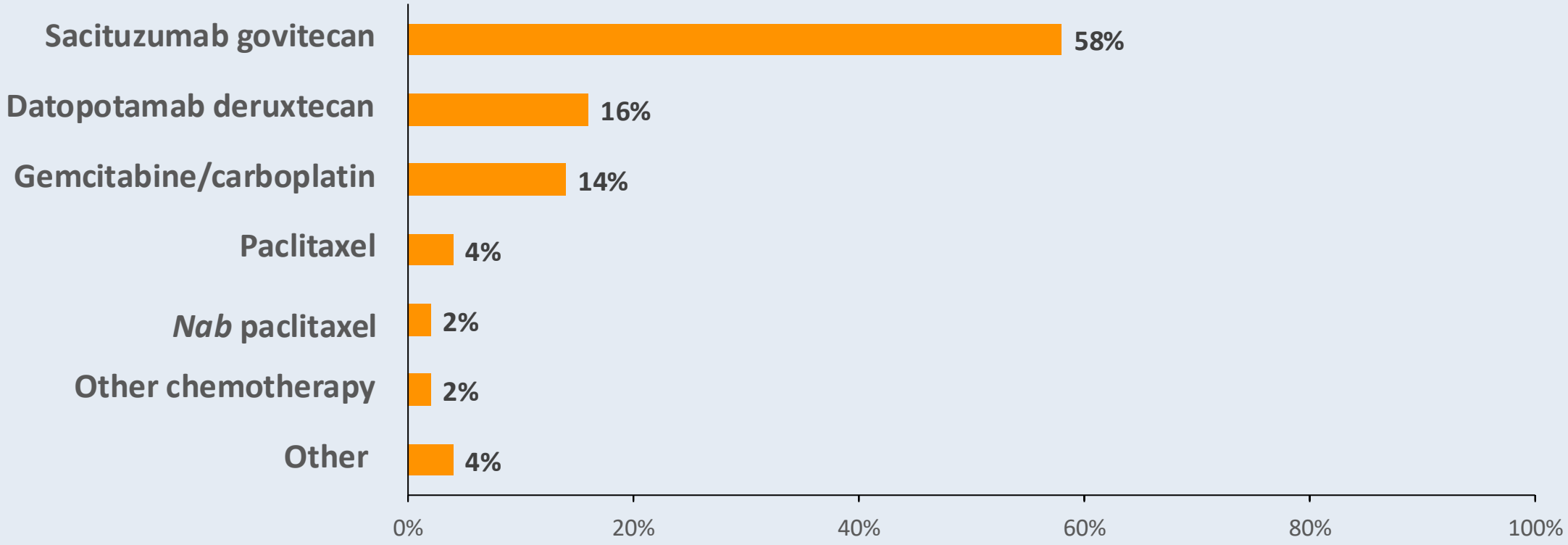

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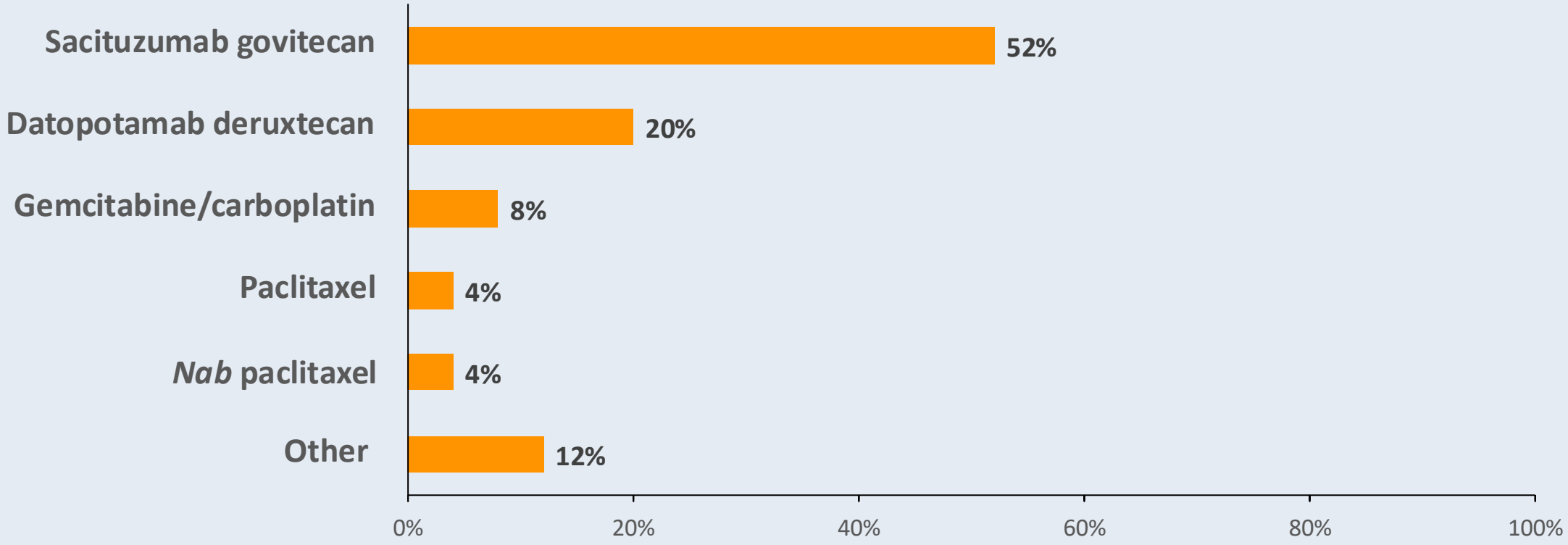
A woman presents with de novo HR-negative, HER2 IHC 1+, PD-L1-negative (CPS 0), BRCA wild-type mBC. Regulatory and reimbursement issues aside, which first-line therapy would you most likely recommend in each of the following scenarios?

Age 65, PS 0, multiple brain metastases requiring SRS

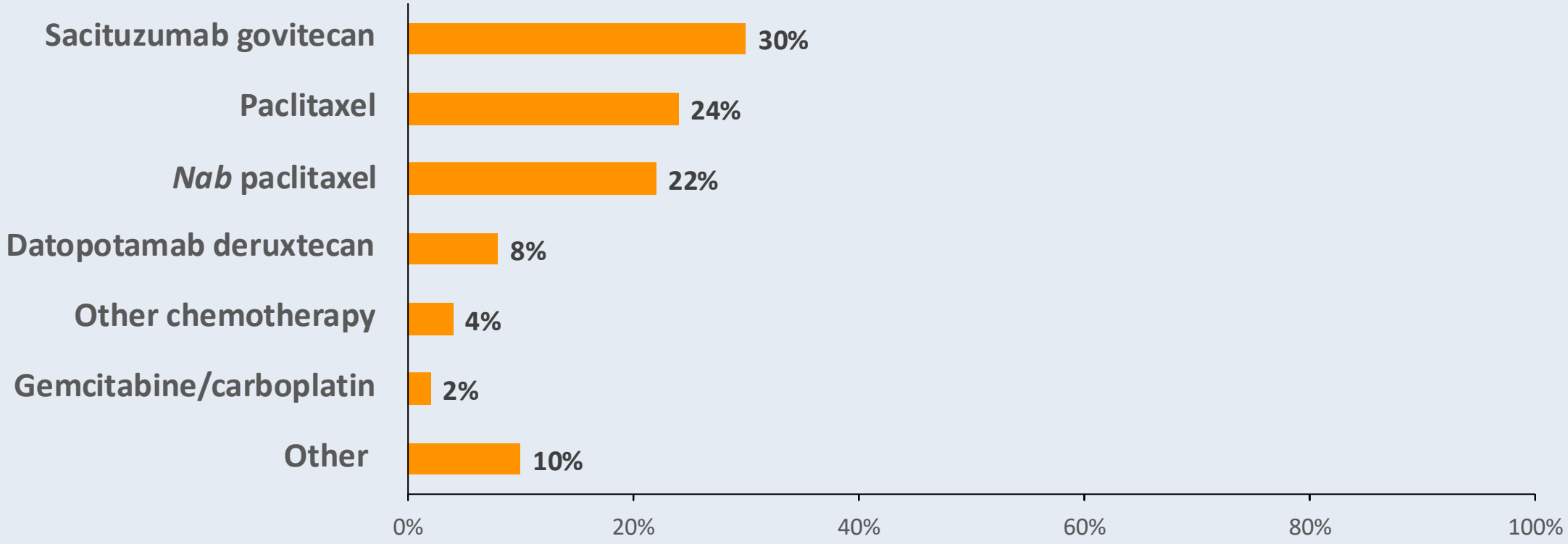


Survey of US-based general medical oncologists

RTP RESEARCH TO PRACTICE

A woman presents with de novo HR-negative, HER2 IHC 1+, PD-L1-negative (CPS 0), BRCA wild-type mBC. Regulatory and reimbursement issues aside, which first-line therapy would you most likely recommend in each of the following scenarios?

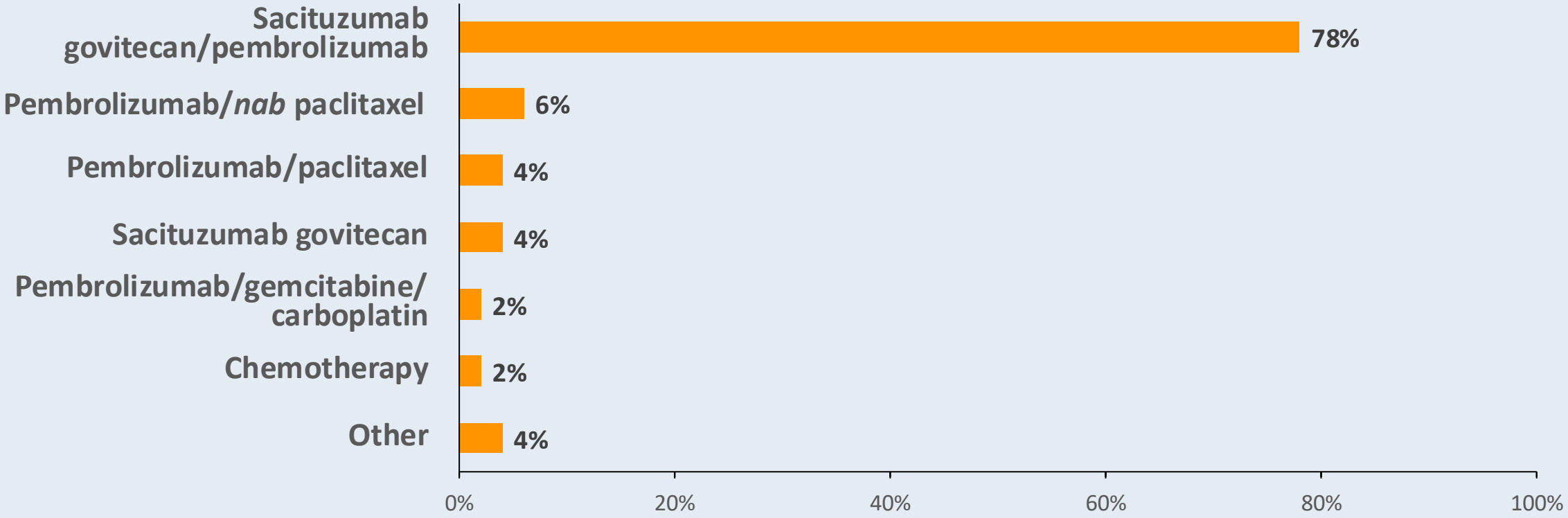
Age 80, PS 2, asymptomatic bone metastases



Survey of US-based general medical oncologists

A 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 18 months 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?

Age 65, PS 0, asymptomatic bone metastases

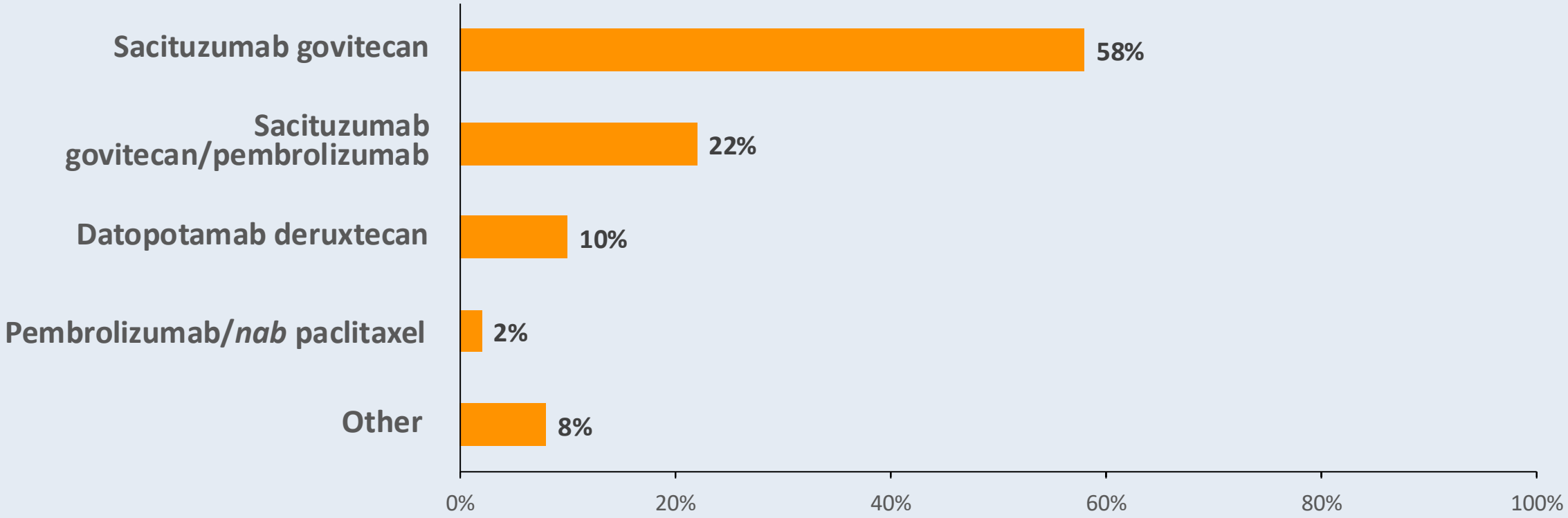


Survey of US-based general medical oncologists

RTP RESEARCH TO PRACTICE

A woman with HR-negative, HER2 IHC 1+, BRCA wild-type breast cancer receives the KEYNOTE-522 regimen but experiences relapse 5 months 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?

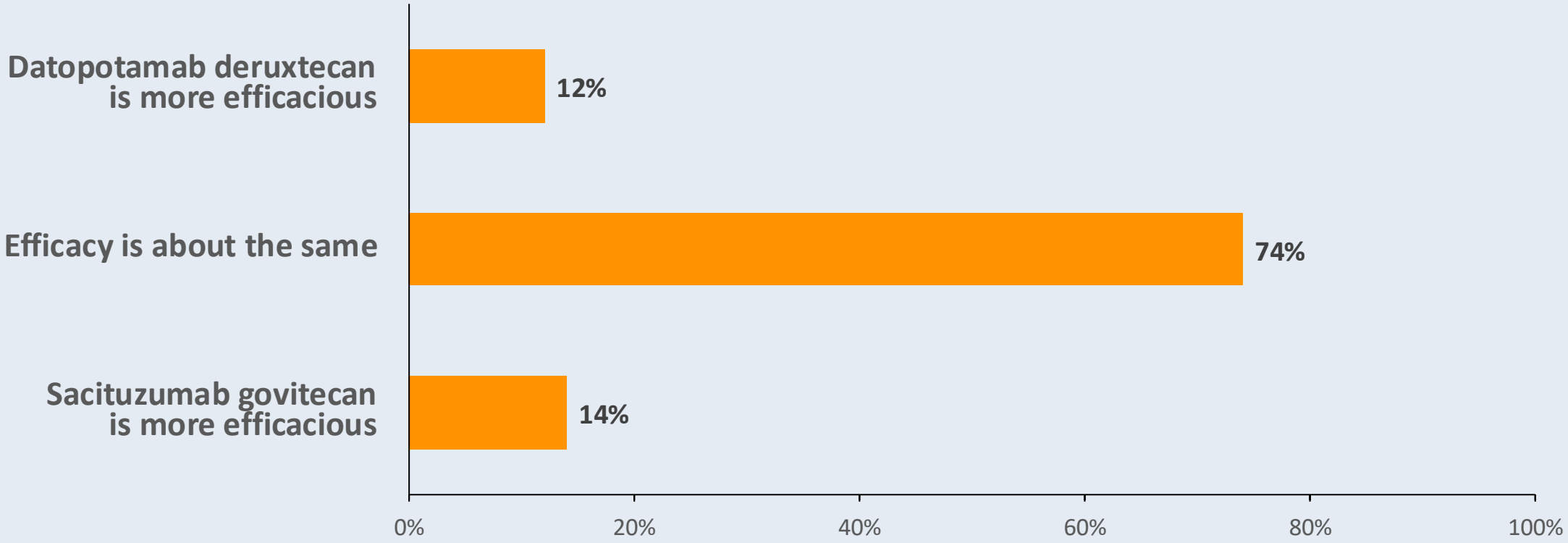
Age 65, PS 0, asymptomatic bone metastases



Survey of US-based general medical oncologists

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?

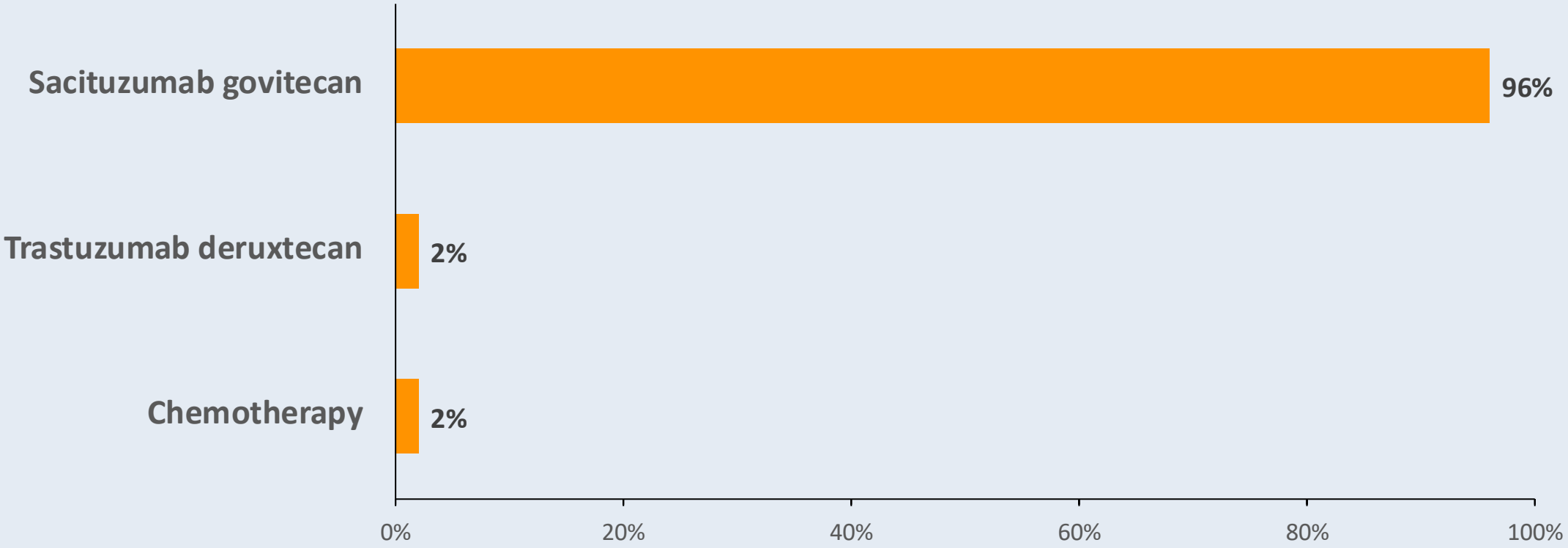


Survey of US-based general medical oncologists

RTP RESEARCH TO PRACTICE

A woman presenting with de novo PD-L1-positive, BRCA wild-type metastatic triple-negative breast cancer (mTNBC) receives first-line pembrolizumab/chemotherapy and initially responds but experiences disease progression 6 months later. Regulatory and reimbursement issues aside, which systemic therapy would you most likely recommend next in each of the following scenarios?

Age 65, PS 0, HER2-negative (IHC 0)



Survey of US-based general medical oncologists

RTP RESEARCH TO PRACTICE

Cases from General Medical Oncologists

42 yo woman

- **Metastatic TNBC to liver, lung. PD-L1 CPS = 15. No comorbidities.**
- **KEYNOTE-522 regimen (neoadjuvant pembrolizumab/chemotherapy and adjuvant pembrolizumab) completed 5 months ago.**

With promising data on Dato-DXd and likely approval in the near future how would you sequence Saci vs Dato? Would you add immunotherapy and which one?

After progression on your first choice of ADC, what is your next treatment?

Cases from General Medical Oncologists

58 yo woman

- **mTNBC, PD-L1 CPS = 0, HRD-negative with metastases to liver, bone and LN. Prior HER2-positive BC in remission, 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

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?

Cases from General Medical Oncologists

68 yo woman

- **mTNBC with isolated brain metastases. Received KEYNOTE-522 regimen.**
- **Patient has isolated brain mets s/p resection and SBRT, CT DNA negative, will give systemic therapy or monitor.**

Is ctDNA use in TNBC prime time yet?

RTP RESEARCH TO PRACTICE

Cases from General Medical Oncologists

88 yo woman

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

How do you manage sacituzumab in very elderly patients? Proactive dose reduction vs using G-CSF/antidiarrheals? In general, how is the tolerability in elderly patients?

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?

Cases from General Medical Oncologists

40 yo woman

- **Metastatic TNBC, BRCA WT, 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.**

Would the faculty consider chemo/pembrolizumab at this point?

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.**

Cases from General Medical Oncologists

38 yo woman (continued)

Is there anything that would compel you to try sequencing ADCs?

Ideally both the antibody and payload would differ when sequencing ADCs, but does that actually matter when predicting response to therapy, or is having either a different antibody or a different payload enough?

Is there anything clinically or pathologically that may predict response to therapy otherwise?

At progression, what regimen would you treat her with next?

Cases from General Medical Oncologists

48 yo woman

- **Metastatic TNBC, germline BRCA1 pathogenic variant, PD-L1 CPS 2 (negative by ≥10 threshold).**
- **Biopsy-confirmed liver metastases (3 lesions, largest 4.2 cm) and osseous metastases in thoracolumbar spine with moderate back pain. No CNS involvement on brain MRI.**
- **History of contralateral prophylactic mastectomy, bilateral salpingo-oophorectomy, mild chronic kidney disease (eGFR 52), well-controlled depression on sertraline.**
- **Diagnosed initially as stage IIA TNBC (pT2N0) 3 years ago. Received neoadjuvant dose-dense AC followed by paclitaxel with residual disease at surgery. Completed adjuvant capecitabine per CREATE-X for 6 cycles. No immunotherapy in the adjuvant setting.**

Cases from General Medical Oncologists

48 yo woman (continued)

- **Now presents with metastatic recurrence 14 months after completing capecitabine.**

Given her BRCA1 mutation, 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?

Summary of Key First-Line Clinical Trials

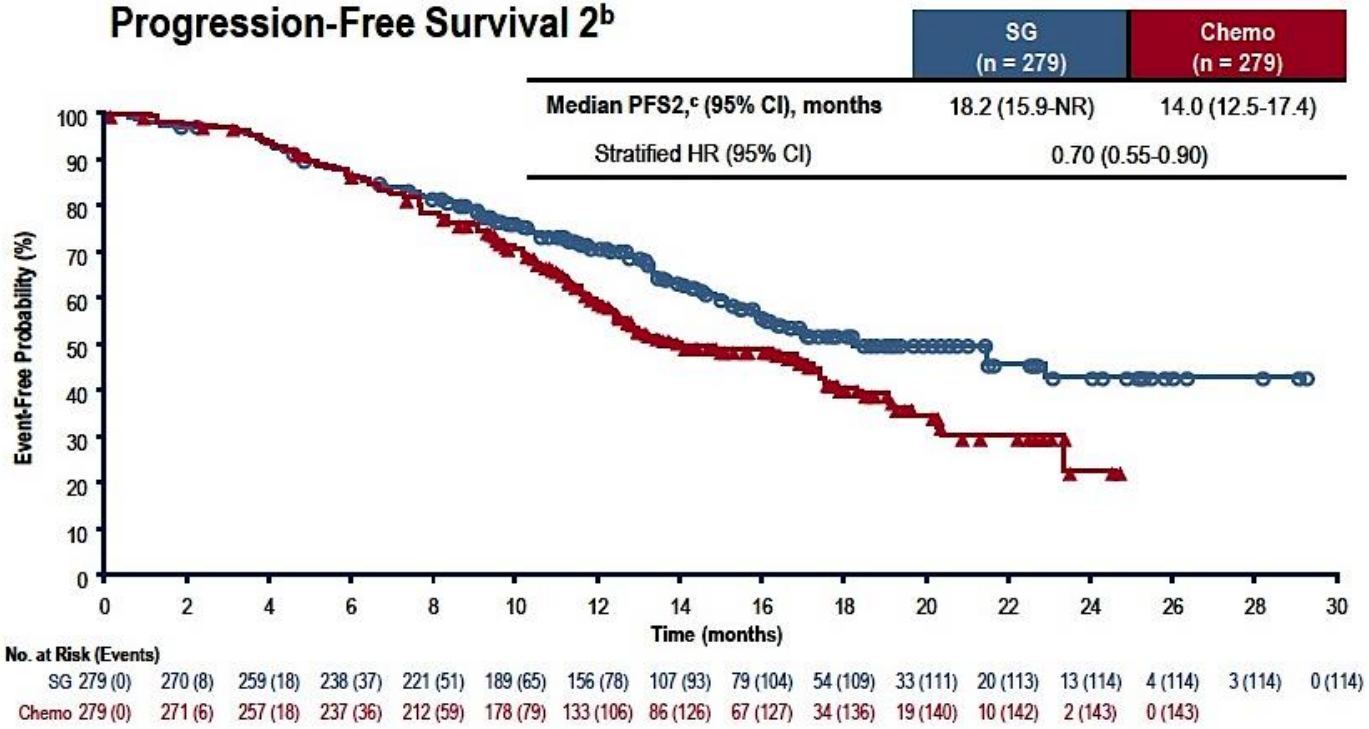
Trial name	Phase	Randomization	Regimen	Study population	ORR	mPFS	mOS
ASCENT-03	III	1:1	SG vs TPC	Ineligible for PD-(L)1 inhibitor	48% vs 46%	9.7 vs 6.9 (HR 0.62)	21.5 vs 20.2 (0.98)
ASCENT-04	III	1:1	SG + P vs TPC + P	PD-L1+	60% vs 53%	11.2 vs 7.8 (HR 0.65)	NR vs NR (HR 0.89)
TROPION-Breast02	III	1:1	Dato-DXd vs TPC	Ineligible for PD-(L)1 inhibitor	63% vs 29%	10.8 vs 5.6 (HR 0.57)	23.7 vs 18.7 (HR 0.79)
OptiTROP-Breast05	II	N/A	Sac-TMT	PD-L1+ or PD-L1-	70.7%	13.4	NR

ORR = objective response rate; mPFS = median progression-free survival; mOS = median overall survival; SG = sacituzumab govitecan; TPC = treatment of physician's choice; P = pembrolizumab; NR = not reached; Dato-DXd = datopotamab deruxtecan; Sac-TMT = sacituzumab tirumotecan

Phase III ASCENT-03: Descriptive Overall Survival 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)

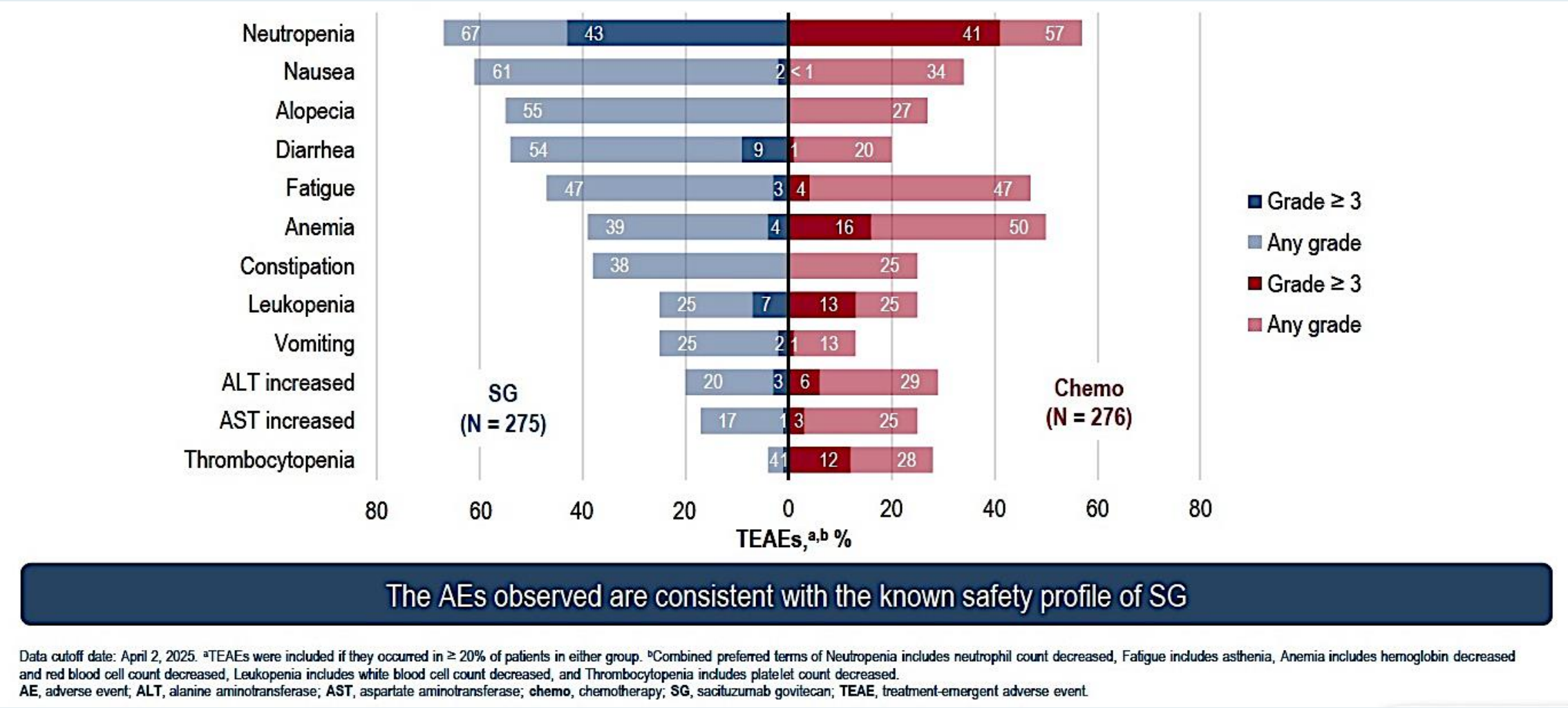


At the time of primary analysis, overall survival was immature and PFS2 was longer with SG vs chemo by investigator assessment

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.

Phase III ASCENT-03: Common Adverse Events (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.

Summary of Key First-Line Clinical Trials

Trial name	Phase	Randomization	Regimen	Study population	ORR	mPFS	mOS
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SG = sacituzumab govitecan; P = pembrolizumab

Rationale for Combining Sacituzumab Govitecan and Pembrolizumab

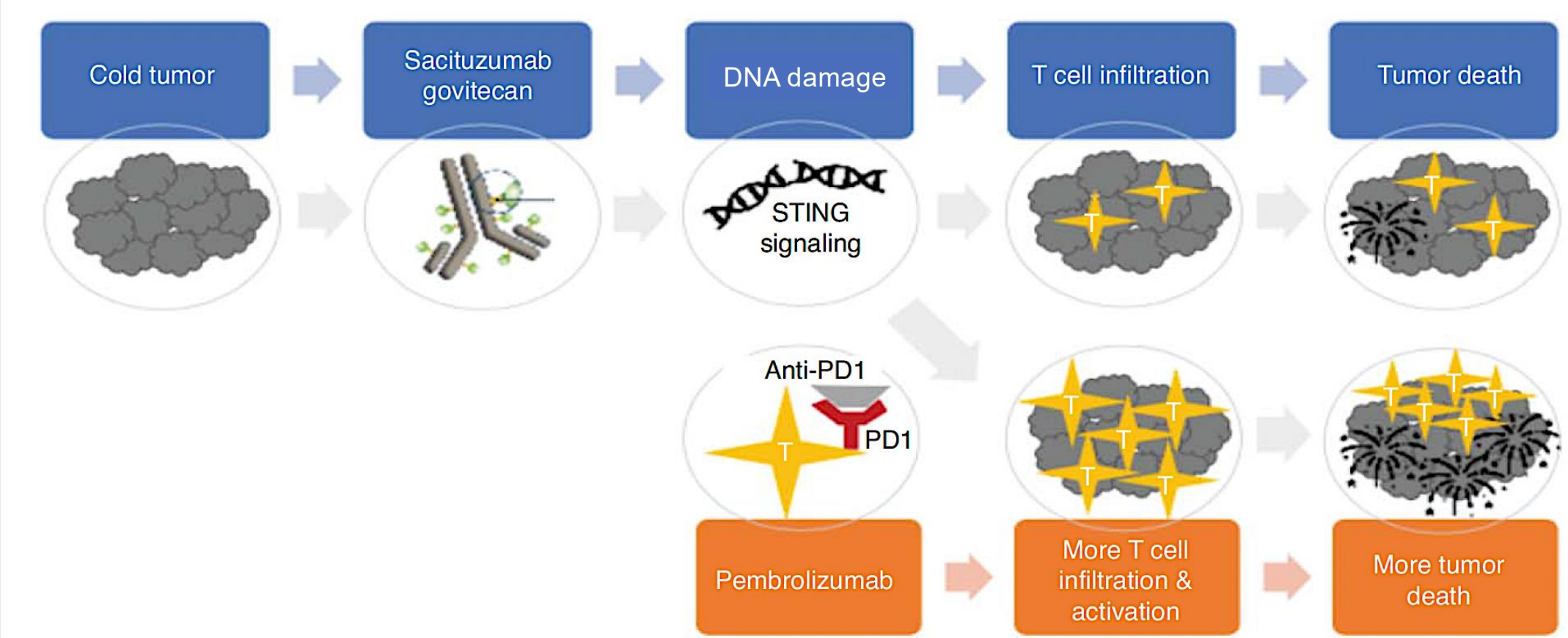
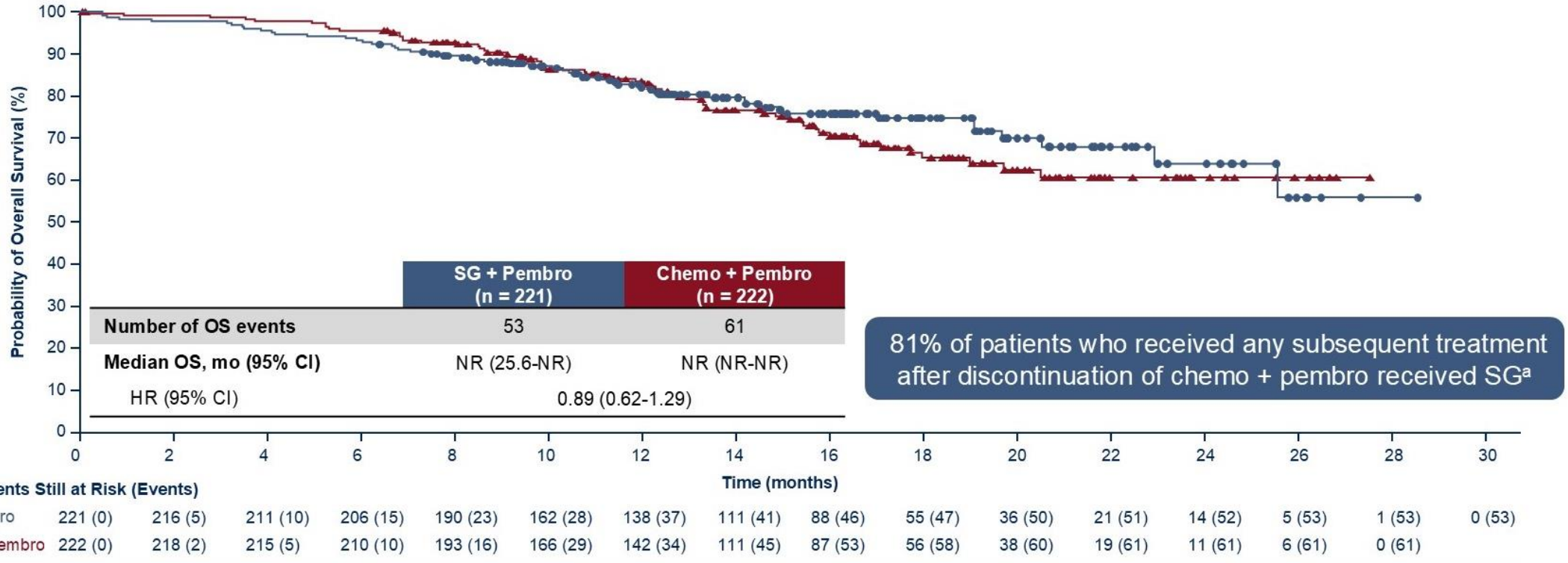


Figure 1. Primary hypothesis: Sacituzumab govitecan induces DNA damage, which results in STING activation and increased anti-tumor immunity. Efficacy will be synergistically enhanced through combination with pembrolizumab.

STING = stimulator of interferon genes

Tolaney SM et al. *Future Oncol* 2024;20(31):2343-55.

Phase III ASCENT-04/KEYNOTE-D19: Descriptive Overall Survival (OS) (Primary Analysis)



81% of patients who received any subsequent treatment after discontinuation of chemo + pembro received SG[a]

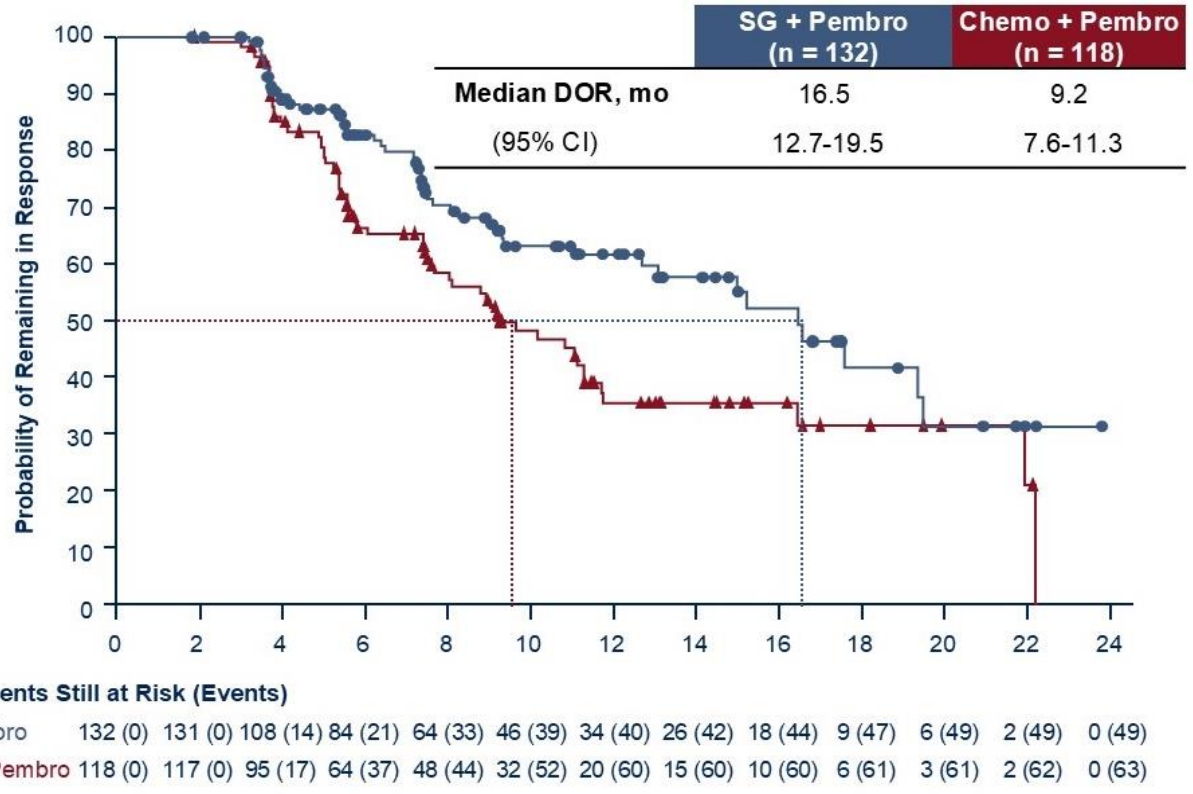
OS data were immature (maturity rate, 26%), however, a positive trend in improvement was observed for SG + pembro vs chemo + pembro

Data cutoff date: March 3, 2025. Median follow-up was 14.0 months (range, 0.1-28.6).
[a]Of the 96 patients who received SG monotherapy as subsequent anticancer therapy, 77 received it as part of the protocol-specified crossover after meeting all crossover eligibility criteria, including BICR-verification of disease progression; the remaining 19 patients received subsequent SG monotherapy as commercial supply.
2L, second line; chemo, chemotherapy; HR, hazard ratio; pembro, pembrolizumab; NR, not reached; OS, overall survival; SG, sacituzumab govitecan.

Tolaney SM et al. ASCO 2025;Abstract LBA109.

Phase III ASCENT-04/KEYNOTE-D19: Tumor Responses, Duration of Response

Variable	SG + Pembro (n = 221)	Chemo + Pembro (n = 222)
Objective response rate[a] (95% CI), %	60 (52.9-66.3)	53 (46.4-59.9)
Stratified odds ratio (95% CI)	1.3 (0.9-1.9)	
Best overall response, n (%)		
Complete response	28 (13)	18 (8)
Partial response	104 (47)	100 (45)
Stable disease	70 (32)	70 (32)
Stable disease ≥ 6 months	23 (10)	29 (13)
Progressive disease	9 (4)	26 (12)
Not evaluable	10 (5)	8 (4)
Time to response,[b] median (range), months	1.9 (1.0-9.3)	1.9 (1.1-11.4)



A substantially longer duration of response and a higher overall response rate (including an increased complete response rate) was observed for SG + pembro vs chemo + pembro

Data cutoff date: March 3, 2025.
[a]Objective response rate is defined as the proportion of patients who achieved a best overall response of complete response/partial response; [b]Time to response (months) = (date of first documented complete or partial response - date of randomization + 1)/30.4375.
BICR, blinded independent central review; DOR, duration of response; mo, months; pembro, pembrolizumab; SG, sacituzumab govitecan.

Tolaney SM et al. ASCO 2025;Abstract LBA109.

Phase III ASCENT-04/KEYNOTE-D19: AEs of Special Interest

	AESI,[a] n (%)	SG + Pembro (n = 221)		Chemo + Pembro (n = 220)	
		Any Grade	Grade ≥ 3	Any Grade	Grade ≥ 3
SG AESIs	Neutropenia[b]	143 (65)	104 (47)	132 (60)	100 (45)
	Hypersensitivity[b]	43 (19)	4 (2)	51 (23)	5 (2)
	Serious infections secondary to neutropenia[b]	6 (3)	5 (2)	3 (1)	3 (1)
	Diarrhea (Grade 3 or higher)	N/A	22 (10)	N/A	5 (2)
Pembro AESIs	Overall	30 (14)	9 (4)	56 (26)	16 (7)
	Infusion reactions (not immune-mediated)[a]	11 (5)	3 (1)	19 (9)	5 (2)
	Pneumonitis[b]	5 (2)	3 (1)	10 (5)	2 (1)
	Colitis[b]	4 (2)	1 (< 1)	1 (< 1)	1 (< 1)
	Hypothyroidism[b]	4 (2)	0	19 (9)	0
	Hypophysitis[b]	2 (1)	0	2 (1)	0
	Hyperthyroidism[b]	2 (1)	0	5 (2)	0
	Severe skin reactions,[b] including Stevens-Johnson syndrome and toxic epidermal necrolysis	2 (1)	2 (1)	2 (1)	2 (1)
	Hepatitis[b]	1 (< 1)	0	2 (1)	2 (1)
	Adrenal insufficiency[b]	1 (< 1)	0	2 (1)	1 (< 1)
	Pancreatitis[b]	0	0	2 (1)	2 (1)

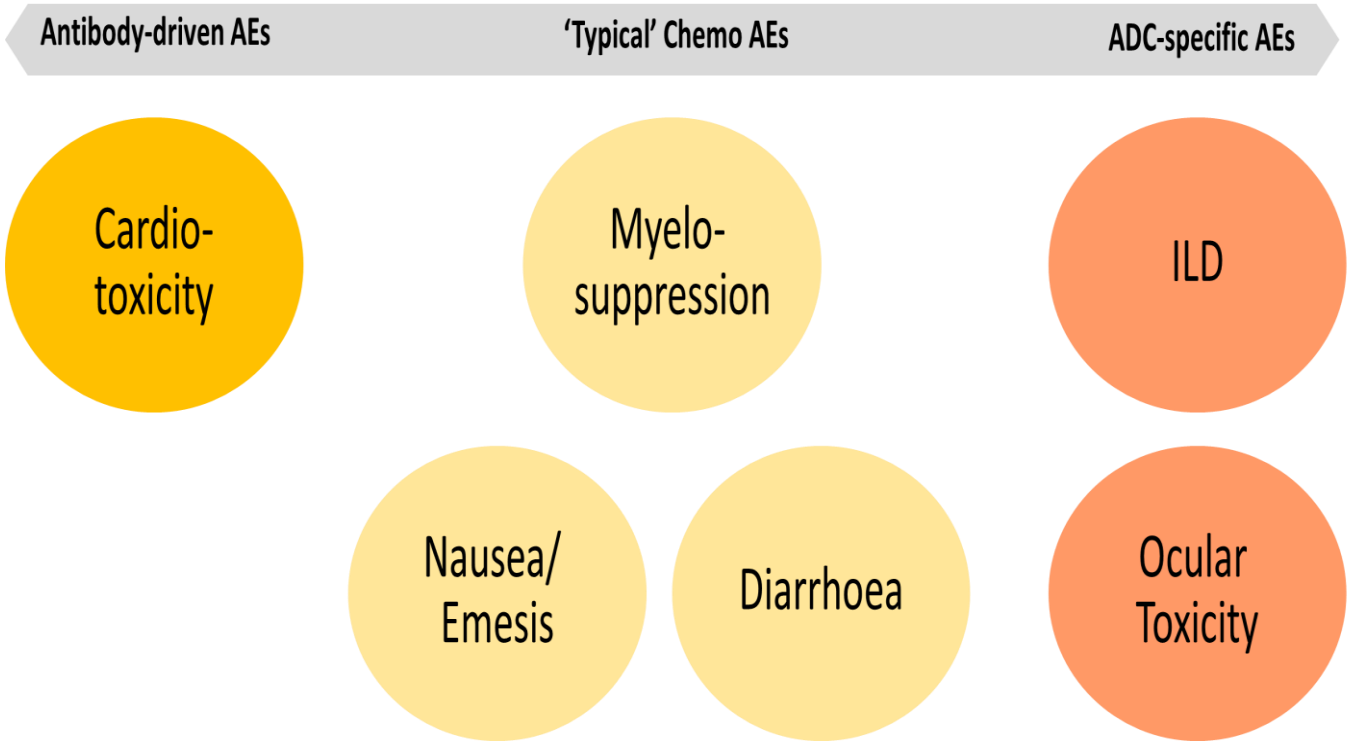
AESIs were consistent with the known safety profiles of each agent; no new safety concerns were observed and no increased rates of AESIs were observed when combining SG with pembro

AESIs were adverse events determined based on a prespecified list of Medical Dictionary for Regulatory Activities (MedDRA) terms, which was updated with each new version of MedDRA. Immune-mediated adverse events were determined based on a prespecified list of Medical Dictionary for Regulatory Activities (MedDRA) terms, which was updated with each new version of MedDRA and specified as immune-mediated by the investigator. Data cutoff date: March 3, 2025.
[a]AESIs observed in ≥1% of patients in either group are presented; [b]Grouped term.
AESI, adverse event of special interest; chemo, chemotherapy; pembro, pembrolizumab; SG, sacituzumab govitecan.

Tolaney SM et al. ASCO 2025;Abstract LBA109.

Is ADC-related toxicity truly better than that of chemotherapy?

Toxicities Are Not Inherent to the Antibody-Drug Conjugate Class



ADC	ADC Description	Characteristic Toxicity
Trastuzumab emtansine	HER2 targeted ADC with DM1 payload	Thromobocytopenia Elevated LFTs
Sacituzumab govitecan	TROP2 targeted ADC with SN-38 payload	Neutropenia
Trastuzumab deruxtecan	HER2 targeted ADC with DXd payload	Interstitial lung disease Nausea
Datopotamab deruxtecan	TROP targeted ADC with DXd payload	Ocular toxicity
Sacituzumab tirumotecan	TROP2 targeted ADC with belotecan-derivative payload	Hematologic toxicities Stomatitis
Trastuzumab botidotin	HER2 targeted ADC with duostatin-5 payload	Ocular toxicity

While antibody–drug conjugates (ADCs) exhibit specific toxicity profiles, they do not invariably confer a reduction in systemic toxicity relative to conventional cytotoxic chemotherapy

Courtesy of Javier Cortés, MD, PhD

Table, modified from Hamilton E. ASCO 2024

SG: Management of Neutropenia

- Withhold drug for ANC <1500/mm^3 on Day 1 of any cycle, ANC <1000/mm^3 on Day 8 of any cycle, or neutropenic fever
  - Initiate anti-infective treatment in patients with febrile neutropenia without delay
- Dose modifications may be required
  - Do not re-escalate dose after dose reduction for adverse events has been made
- Administer G-CSF as clinically indicated or as indicated in the table for severe neutropenia

Severe Neutropenia	Occurrence	Dose Modification
Grade 4 neutropenia ≥7 days *OR* grade 3/4 febrile neutropenia *OR* at time of scheduled treatment, grade 3/4 neutropenia that delays dosing by 2-3 wk for recovery to grade ≤1	First	25% dose reduction and administer G-CSF
	Second	50% dose reduction and administer G-CSF
	Third	Discontinue treatment and administer G-CSF
At time of scheduled treatment, grade 3/4 neutropenia that delays dosing by >3 wk for recovery to grade ≤1	First	Discontinue treatment and administer G-CSF

Courtesy of Javier Cortés, MD, PhD

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

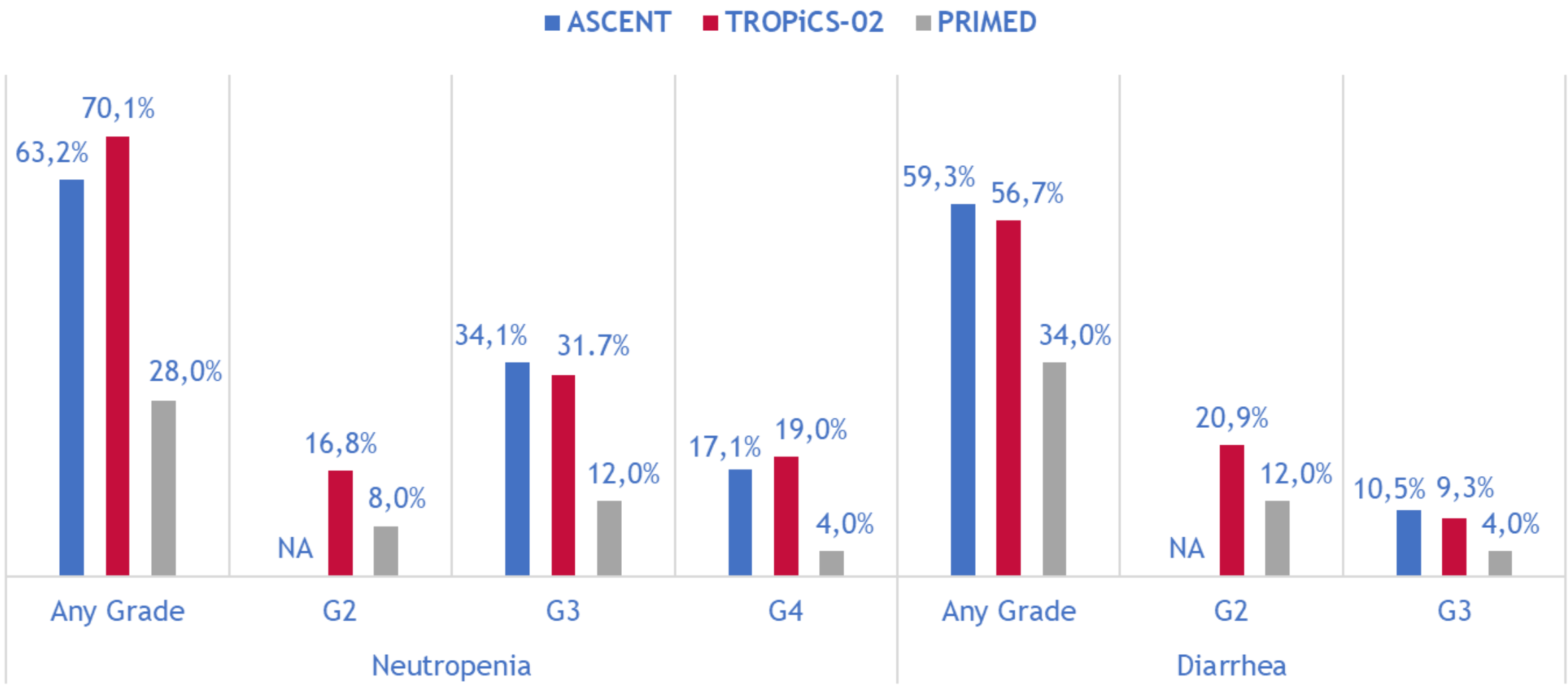
- Tolerability and safety per NCI-CTCAE v5 at cycle 2
- Discontinuation and dose reductions
- Efficacy in terms of PFS, ORR, clinical benefit rate, time to response, DOR, and best percentage of change in tumor burden

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

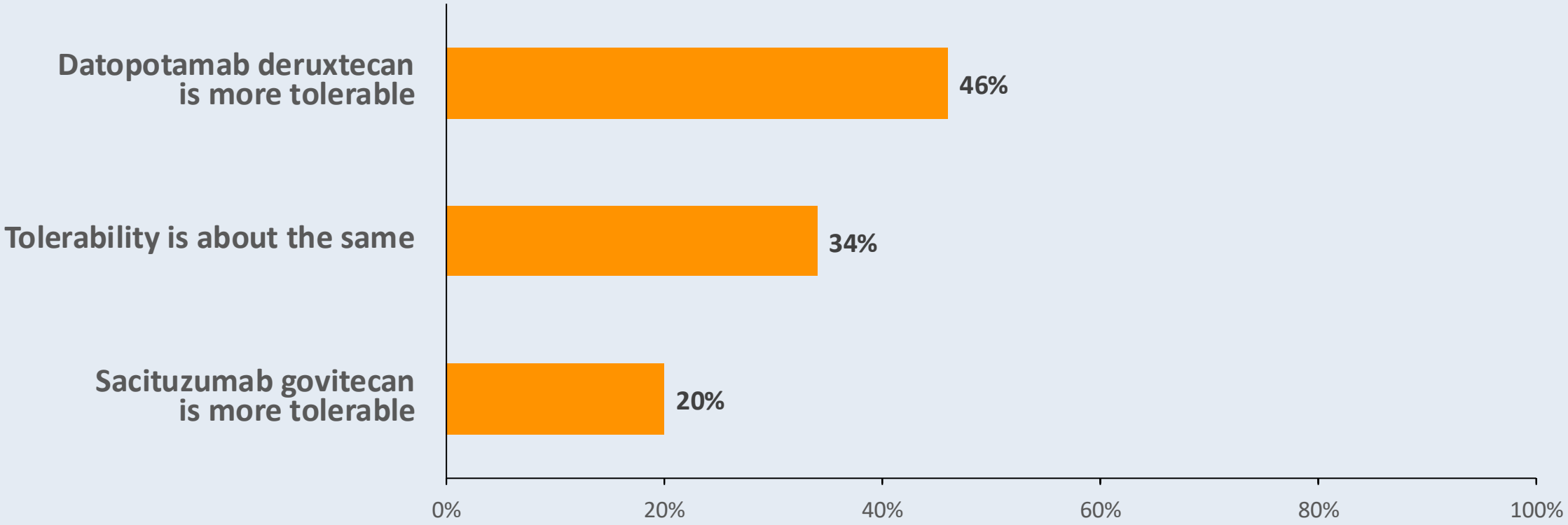
SG: PRIMED Strategy vs. ASCENT vs. TROPiCS-02



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

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

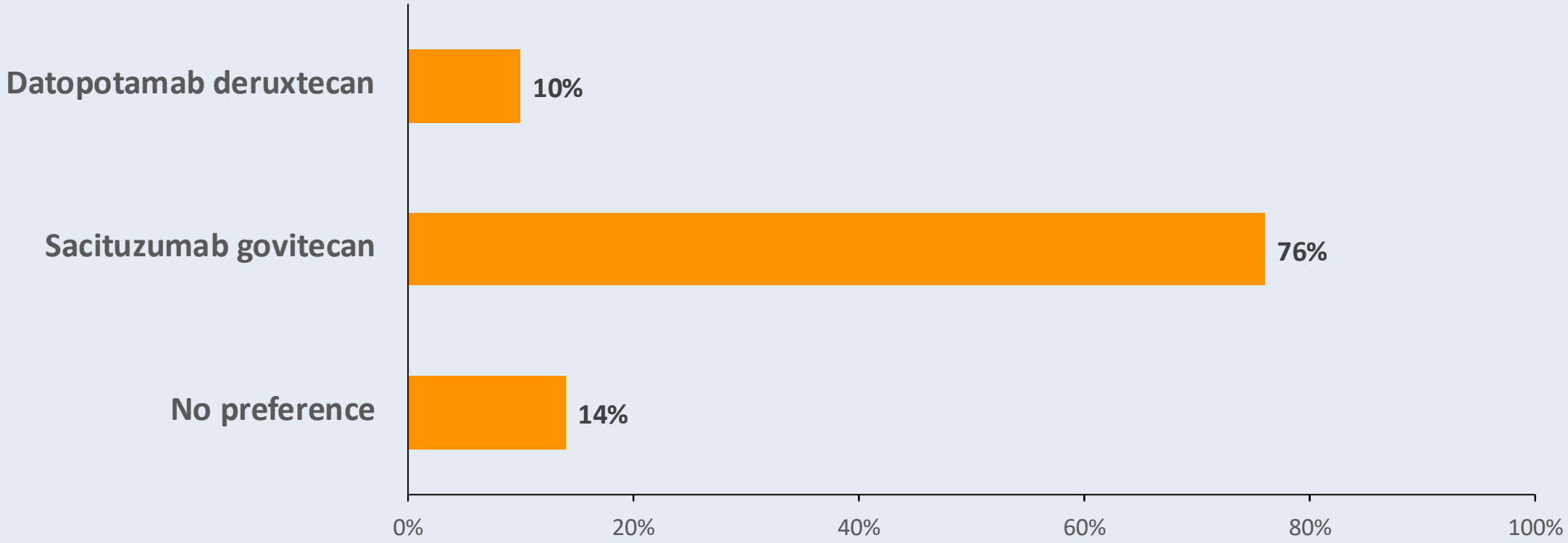


Survey of US-based general medical oncologists

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 and a history of …

COPD?

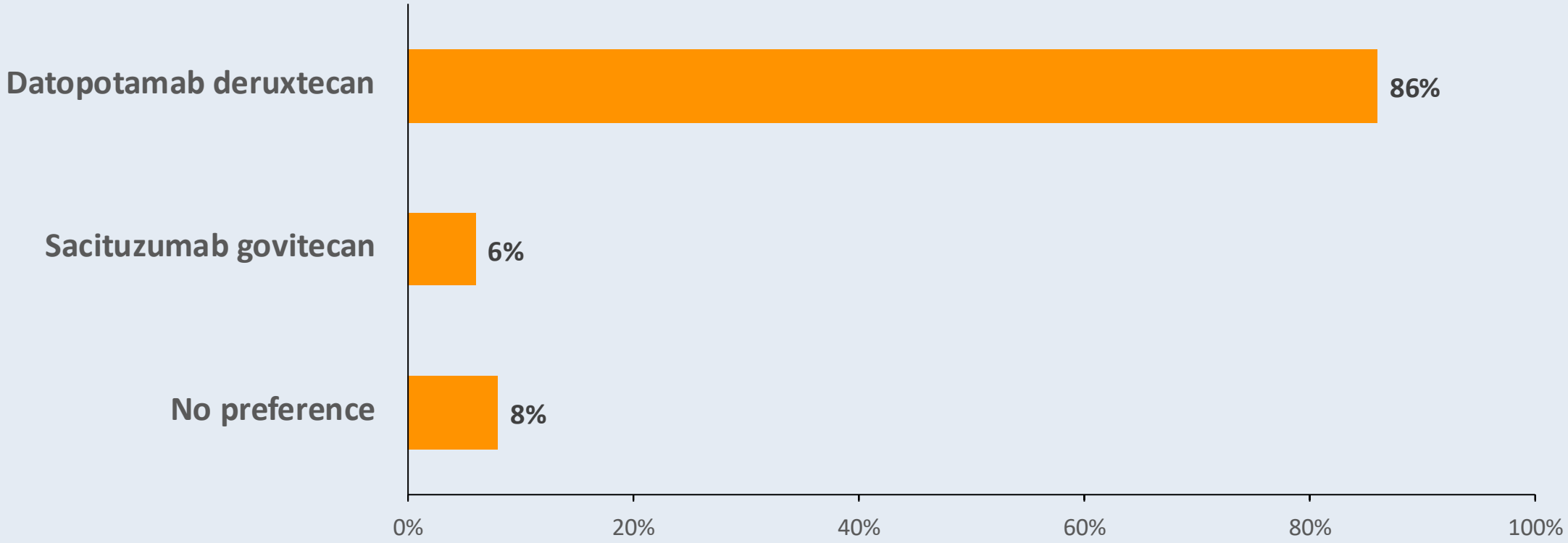


Survey of US-based general medical oncologists

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 and a history of …

Lingering cytopenias after (neo)adjuvant chemotherapy?



Survey of US-based general medical oncologists

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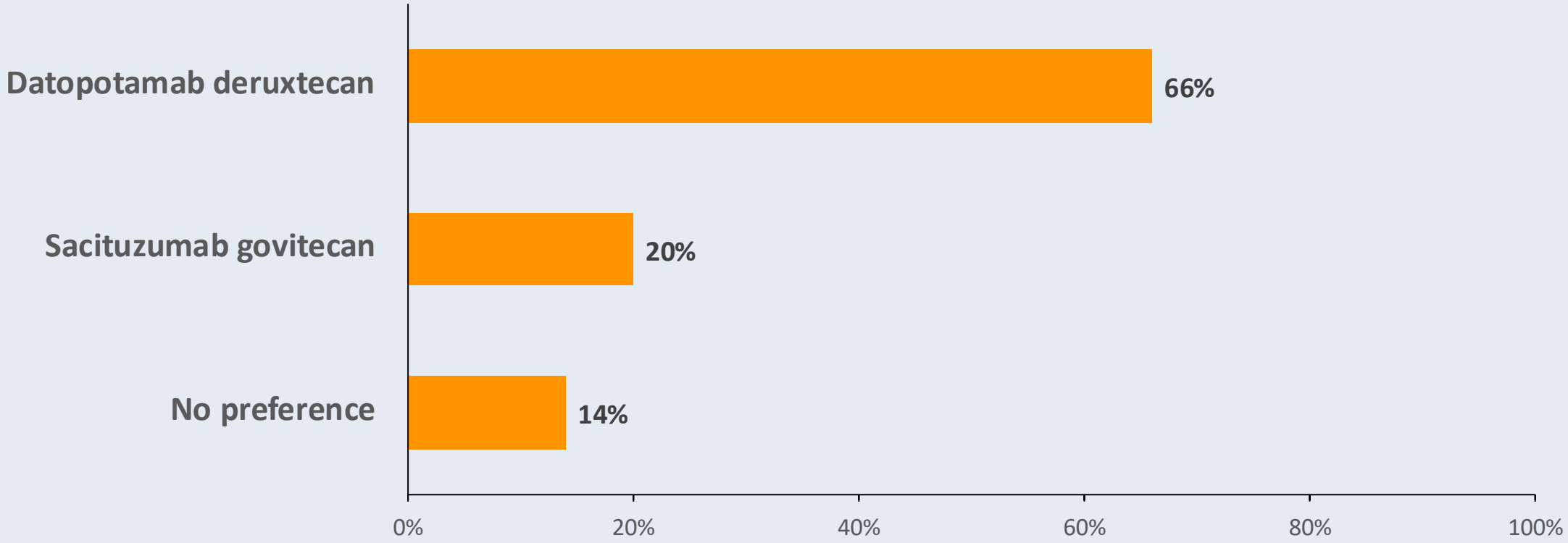
Inflammatory bowel disease?



Survey of US-based general medical oncologists

RTP RESEARCH TO PRACTICE

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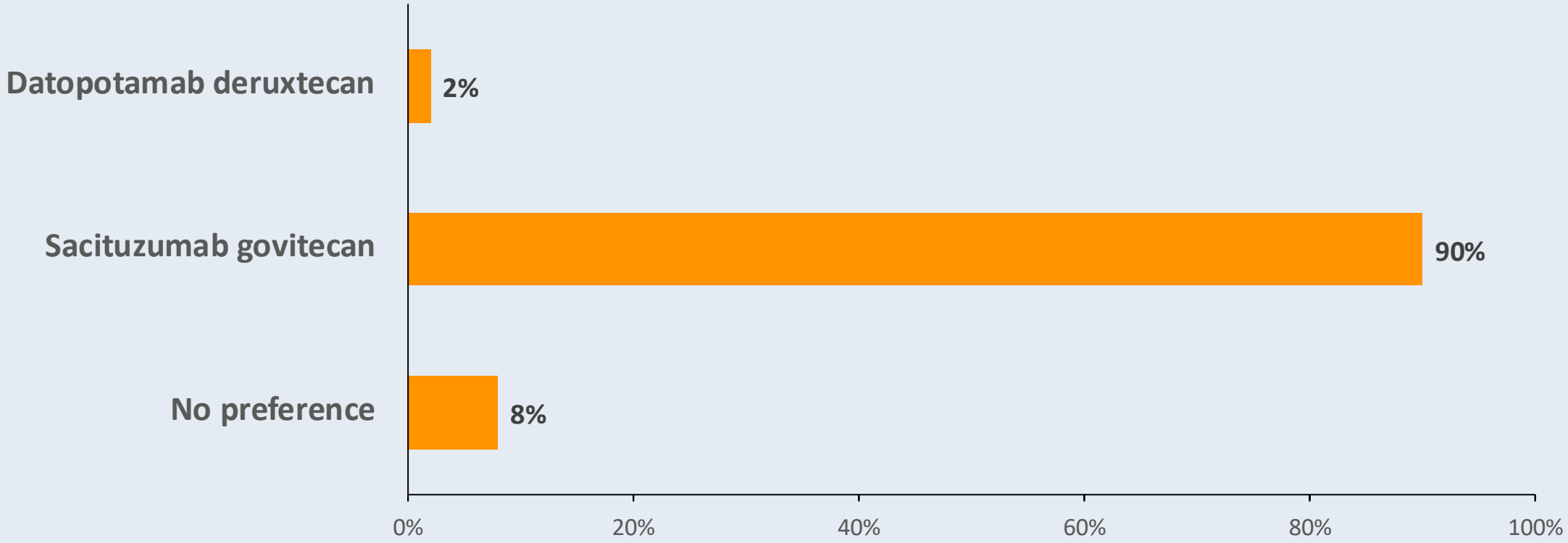
Contact lens use?

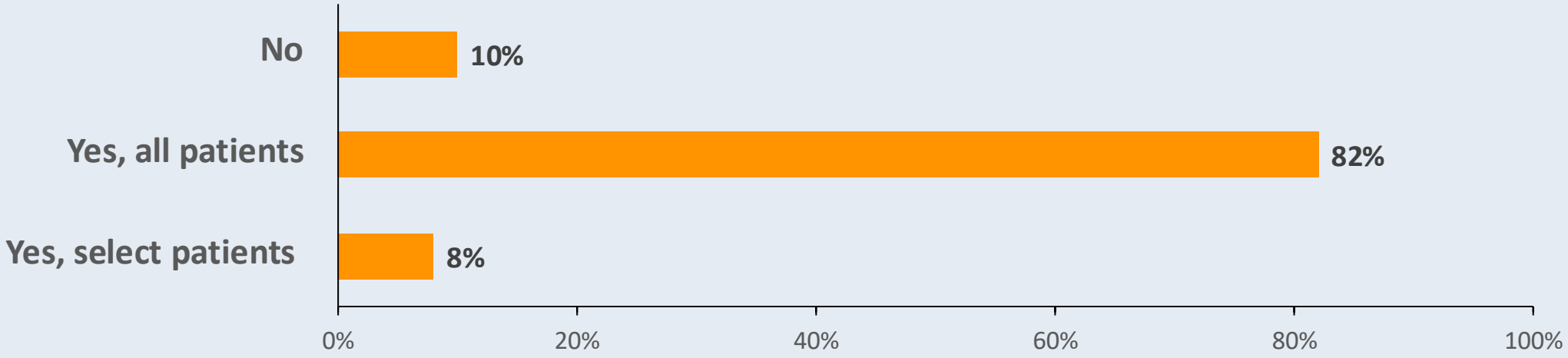


Survey of US-based general medical oncologists

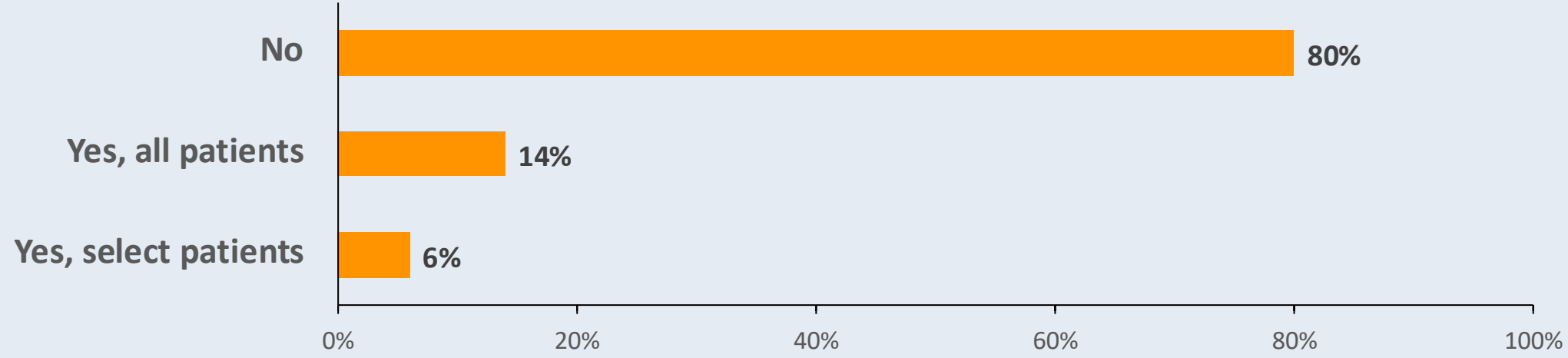
RTP RESEARCH TO PRACTICE

Do you routinely administer G-CSF prophylaxis for patients receiving …

Sacituzumab govitecan?



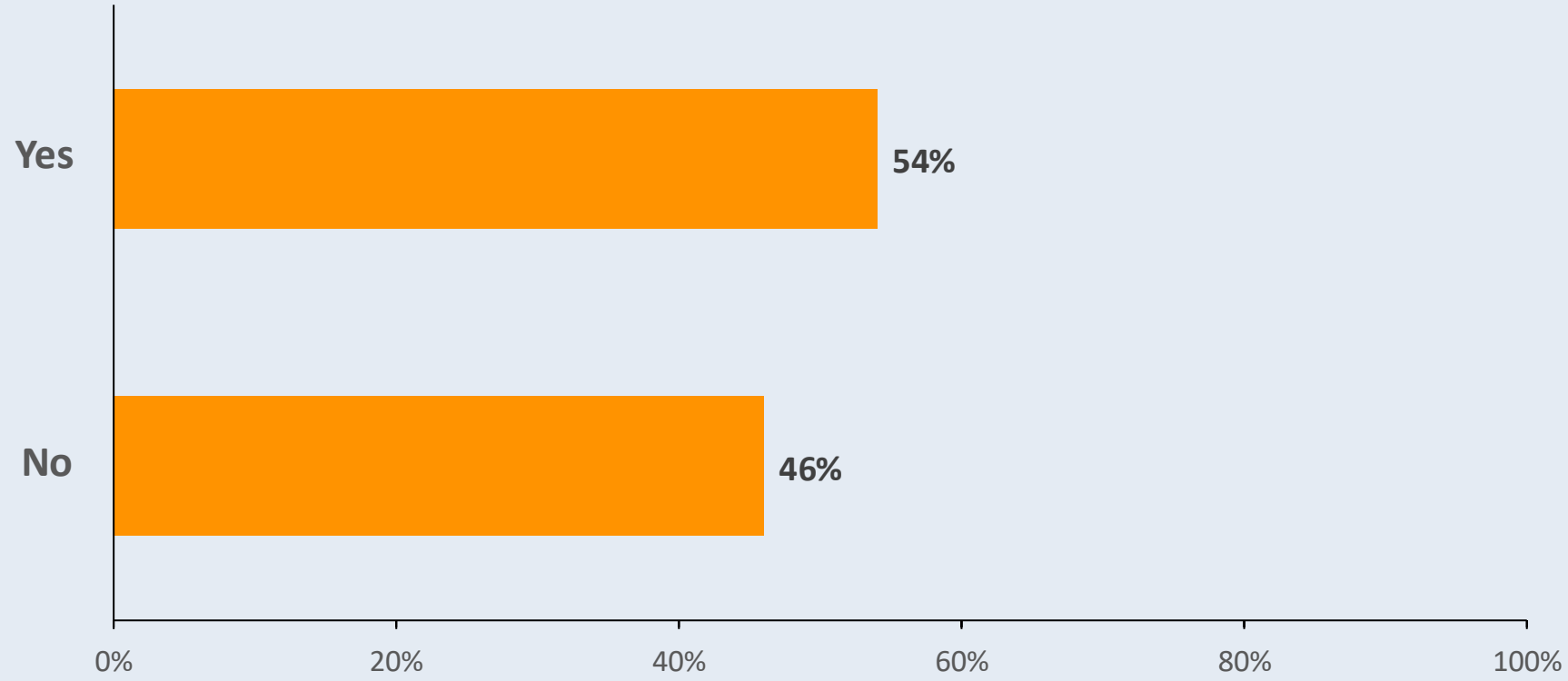
Datopotamab deruxtecan?



Survey of US-based general medical oncologists

RTP RESEARCH TO PRACTICE

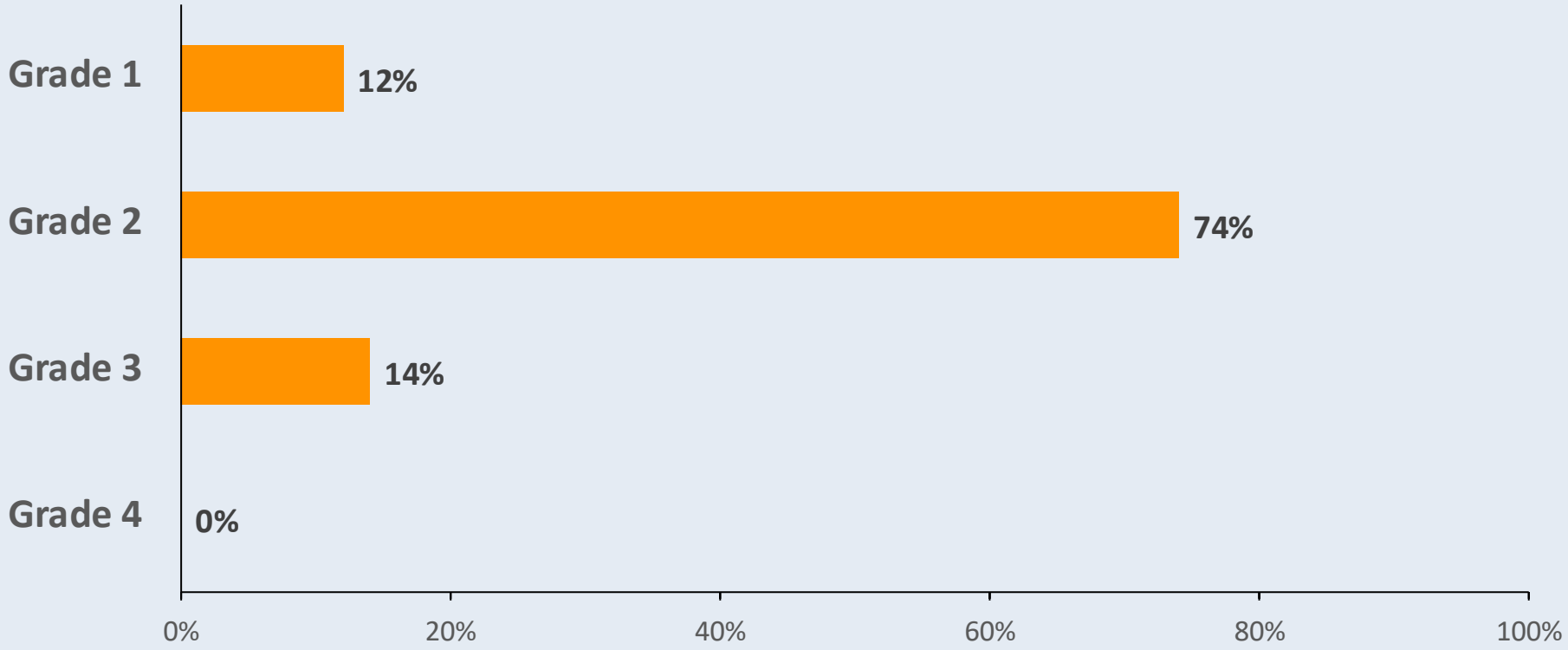
Do you use chest imaging to monitor for interstitial lung disease (ILD) in patients receiving datopotamab deruxtecan who otherwise do not require chest imaging?



Survey of US-based general medical oncologists

RTP RESEARCH TO PRACTICE

At what grade of ILD would you permanently discontinue datopotamab deruxtecan treatment for patients with documented ILD?



Survey of US-based general medical oncologists

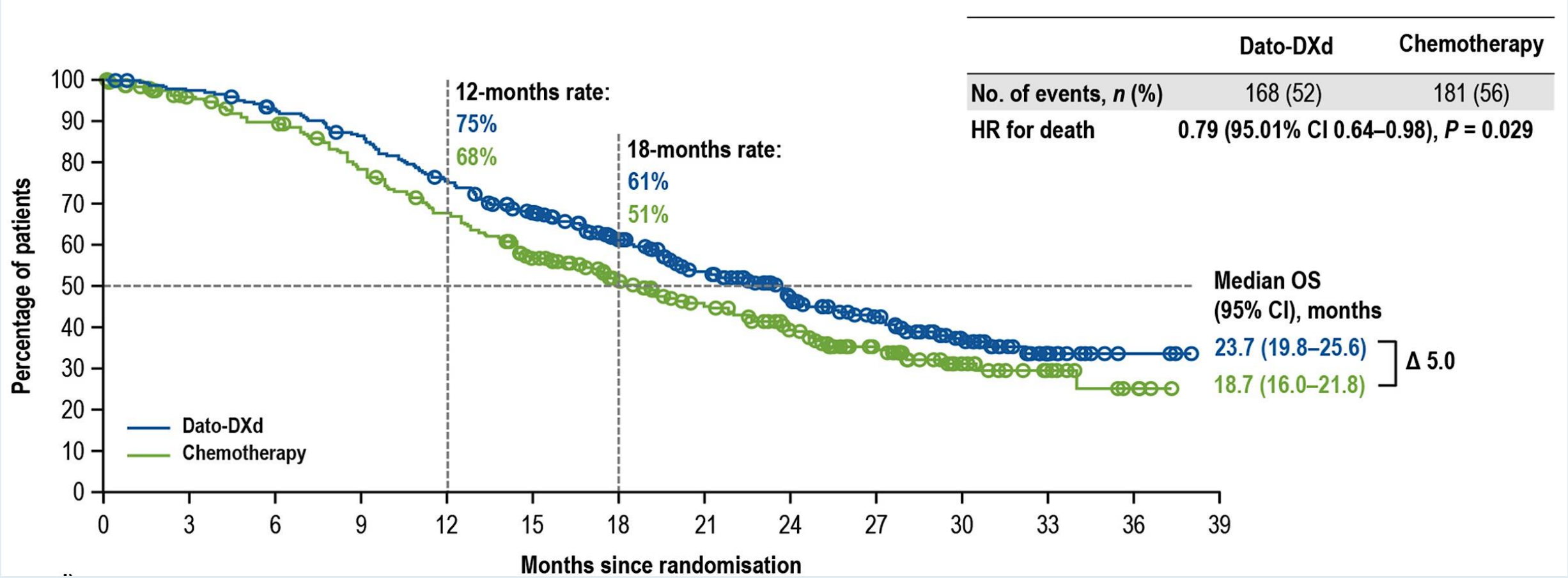
Summary of Key First-Line Clinical Trials

Trial name	Phase	Randomization	Regimen	Study population	ORR	mPFS	mOS
ASCENT-03	III	1:1	SG vs TPC	Ineligible for PD-(L)1 inhibitor	48% vs 46%	9.7 vs 6.9 (HR 0.62)	21.5 vs 20.2 (0.98)
ASCENT-04	III	1:1	SG + P vs TPC + P	PD-L1+	60% vs 53%	11.2 vs 7.8 (HR 0.65)	NR vs NR (HR 0.89)
TROPION-Breast02	III	1:1	Dato-DXd vs TPC	Ineligible for PD-(L)1 inhibitor	63% vs 29%	10.8 vs 5.6 (HR 0.57)	23.7 vs 18.7 (HR 0.79)
OptiTROP-Breast05	II	N/A	Sac-TMT	PD-L1+ or PD-L1-	70.7%	13.4	NR

Dato-DXd = datopotamab deruxtecan

RTP RESEARCH TO PRACTICE

Phase III TROPION-Breast02: Overall Survival



	Dato-DXd	Chemotherapy
No. of events, *n* (%)	168 (52)	181 (56)
HR for death	0.79 (95.01% CI 0.64–0.98), *P* = 0.029	

Dent RA et al. *Ann Oncol* 2026 April 3:S0923-7534(26)00130-4.

Phase III TROPION-Breast02: AEs of Special Interest with 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

*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.

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:

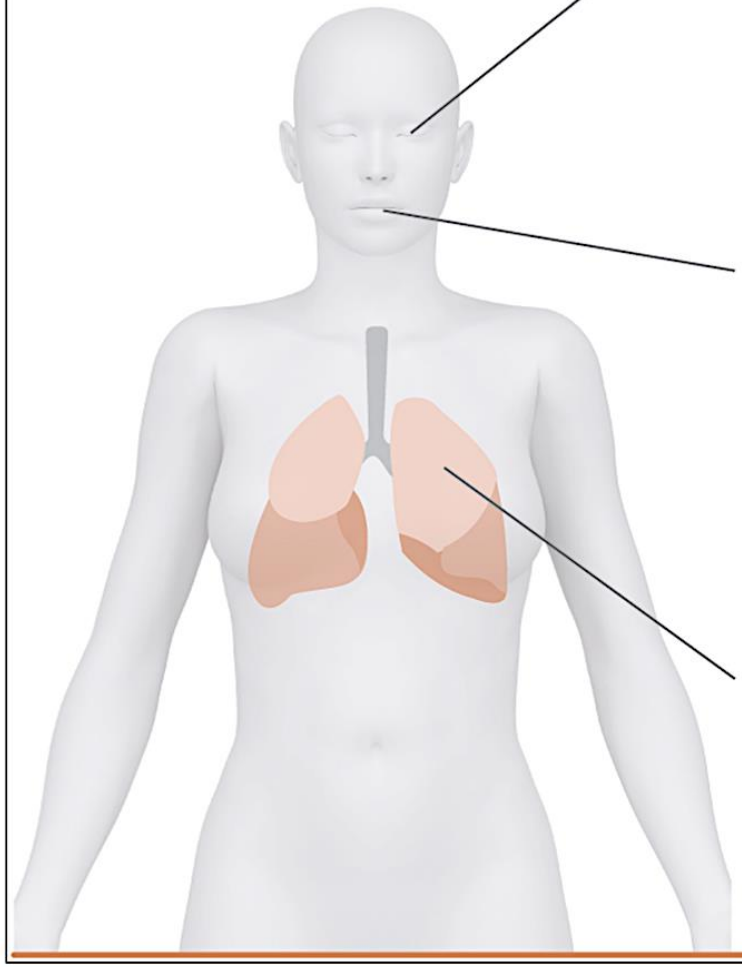
- In the Dato-DXd arm, events led to dose interruption, reduction, and discontinuation in 18 (6%), 14 (4%), and 3 (<1%) patients, respectively
- Grade ≥2 events resolved to grade ≤1 in 49/73 patients (67%) at data cutoff

ICC = investigator's choice of chemotherapy; ILD = interstitial lung disease

Dent R et al ESMO 2025;Abstract LBA21.

RTP RESEARCH TO PRACTICE

Managing Adverse Events Associated with Dato-DXd



Ocular Surface Events

- **PROPHYLAXIS:** Have patients start preservative-free artificial tears 4 times daily and avoid contact lenses
- **MONITORING:** Refer patients to an eye care professional for an ophthalmic exam at treatment initiation, annually while on treatment, at end of treatment, and as clinically indicated. Monitor patients for ocular adverse reactions during treatment (ie, redness, pain, teary eyes, blurred vision). If present, promptly refer patients to an eye care professional
- **MANAGEMENT:** Consider povidone and tetrahydrozoline ophthalmic on days of treatment and for 3 days after in addition to corticosteroid drops at the discretion of an ophthalmologist or eye care professional depending on grade, consider delay and reduce the dose or discontinue

Oral Mucositis/Stomatitis

- **PROPHYLAXIS:** Develop an oral care plan that includes a corticosteroid-containing mouthwash (eg, dexamethasone oral solution 0.1 mg/mL or alternative corticosteroid mouthwash advocated by institutional/local guidelines) and good oral hygiene. Consider prophylactic cryotherapy (ie ice chips or ice water held in the mouth throughout the infusion)
- **MONITORING:** Perform regular oral exams to detect sensitivity, inflammation, tenderness, and/or sores throughout treatment
- **MANAGEMENT:** If oral mucositis/stomatitis occurs, optimize prophylactic and supportive medications, provide pain management with lidocaine-based mouthwash, treat sores with clobetasol gel; depending on grade, consider delay and reduce the dose or discontinue

ILD

- **PATIENT COUNSELING:** Educate patients to report immediately if they have new or worsening shortness of breath, chest pain, or cough
- **MONITORING:** Perform contrast-enhanced chest CT scan every 6 weeks or according to institutional guidelines, and thoroughly review for any signs of ILD
- **MANAGEMENT:** If ILD is confirmed, discontinue Dato-DXd and start corticosteroid treatment according to grade; if grade 1 ILD resolves, Dato-DXd can be restarted

Lisberg A et al. *Oncologist* 2025 September 1;30(9):oyaf225.

ADC-associated Ocular Surface Toxicity

Prevention/Diagnostic

1. **Use lubricating eyedrops daily**
2. **Avoid the use of contact lenses**
3. **Ophthalmological Assessment**

Dry Eye

- **Stinging**
- **Burning or scratchy sensation**
- **Eye redness**
- **Foreign body feeling**
- **Sensitivity to light**
- **Blurred vision**
- **Difficulty with contact lenses**

Keratitis

- Symptoms of Dry Eye
- **Eye pain**
- **Excess tears**
- **Other discharge**
- **Difficulty opening eyelid due to pain or irritation**
- **Decreased vision**
- **Ulceration**

Management

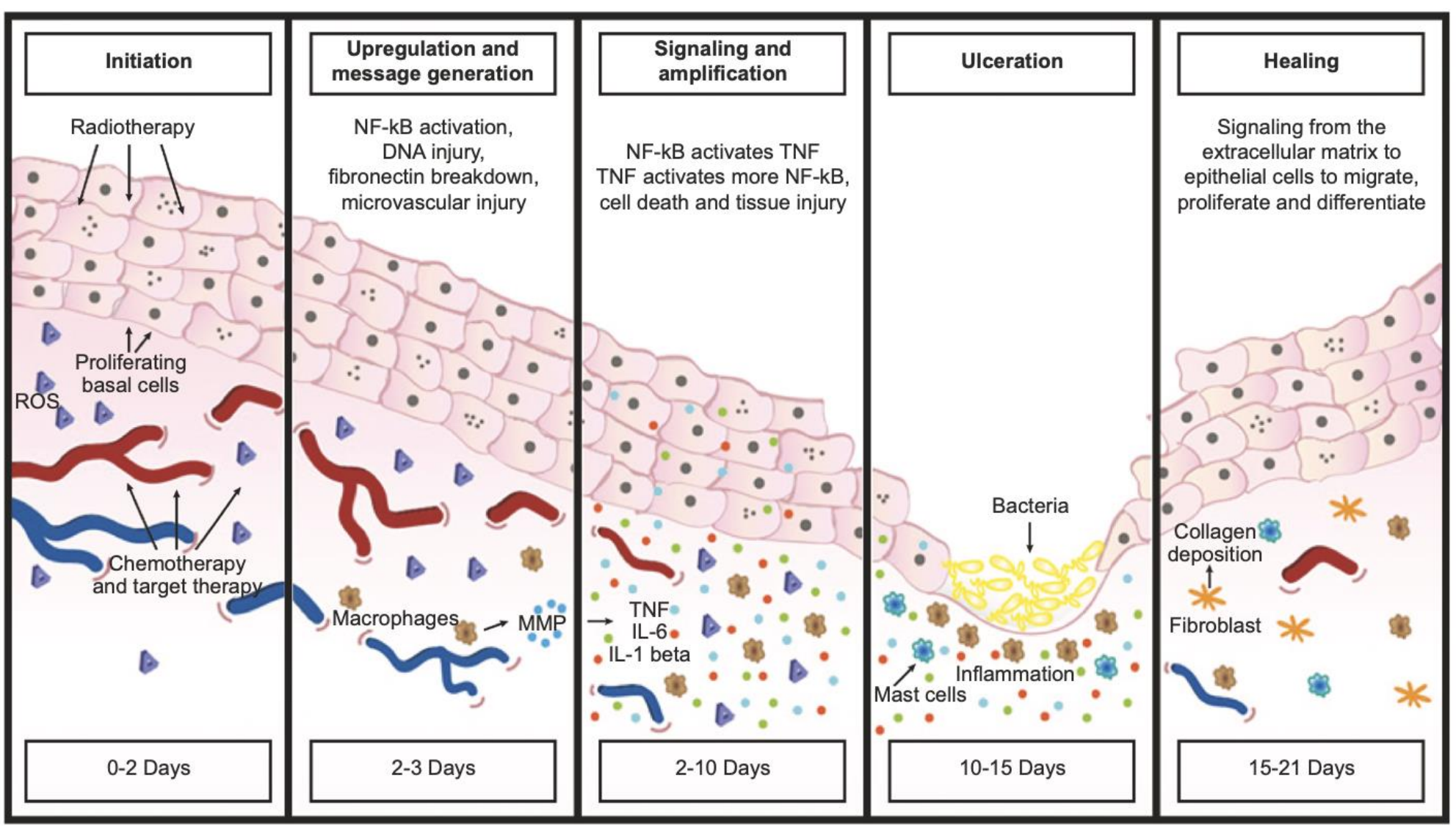
	G1	G2	G3	G4
ADC	Continue	Hold until <G2	Hold until <G2	Discontinue
Dose reduction	N/A	N/A	Reduce by 1 Level (if >7d)	Discontinue

1. **Lubricating eyedrops:** sodium hyaluronate **night gel 4/d, Hypromellose eyedrops 4-5/d,** carmellose sodium **4/d**
2. **Immune suppressive eyedrops: Ciclosporin eyedrops**

Courtesy of Javier Cortés, MD, PhD

Schmid P. ESMO Breast Cancer Annual Congress. 2024.

Pathogenesis of Oral Mucositis/Stomatitis

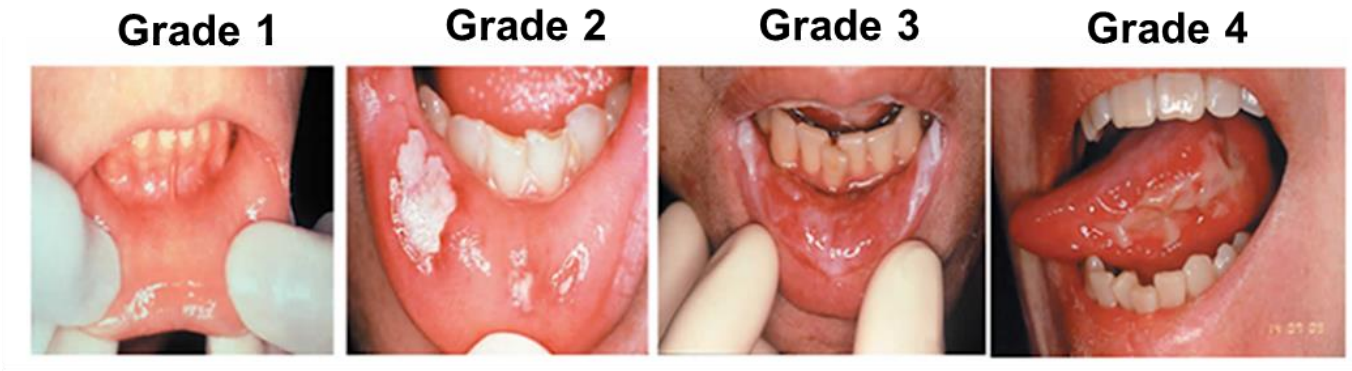


Meric-Bernstam F et al. *Oncologist* 2025 March 10;30(3):oyaf031.

Dato-DXd: Identification 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

CHEMO MOUTHPIECE®

Contact Our Team

Financial Assistance Available

How to Prescribe

Prescription Only

About the Chemo Mouthpiece®

The Chemo Mouthpiece® is an FDA-cleared oral cooling device used during chemo infusion and at home afterwards.

Developed by a cancer survivor **(see David's story)** who experienced firsthand the severe effects of oral mucositis, the device is easy to use and delivers consistent cooling to help reduce the risk of painful mouth sores.

Patients using the Chemo Mouthpiece experienced significantly **less pain** and used significantly **less analgesics and opioids**.

The Chemo Mouthpiece requires a prescription from a healthcare provider. The device is shipped directly to patients from a specialty pharmacy.

Questions about access or cost?
Submit the form and a member of our U.S.-based team will follow up promptly.

RTP RESEARCH TO PRACTICE

CHEMO MOUTHPIECE®

Contact Our Team

Financial Assistance Available

How to Prescribe

Prescription Only

Each Chemo Mouthpiece device contains prefilled internal chambers that are frozen before use.

When placed in the mouth, the device is designed to deliver **consistent cooling** in the oral cavity. Each kit includes:

- Six prefilled oral cooling devices
- Cooler, insulated sleeves & cold packs
- Cleaning tools
- Simple instructions for use

Patients typically use a frozen device immediately before, during, and after their chemotherapy infusion, based on guidance from their care team.

Questions about access or cost?

Contact Our Team

RTP RESEARCH TO PRACTICE

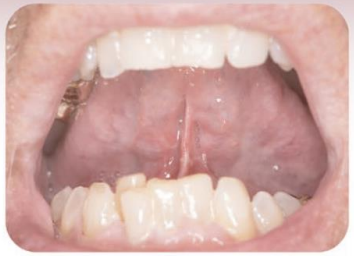
Management Recommendations for Stomatitis

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.

What is ILD?

ILD (Interstitial Lung Disease) is a broad term for a group of diffuse, parenchymal lung disorders including some types of pneumonitis

Symptoms

- Nonspecific cough[1,2]
- Fever[3]
- Shortness of breath (dyspnoea)[2]
- Pneumonitis and idiopathic pulmonary fibrosis[4]

Clinical signs

- Inflammation or scarring of the lung interstitium[2]
- Chest radiographic abnormalities[1]
- Changes in pulmonary function tests reflecting decreased lung volume[1]
- Microscopic patterns of inflammation and fibrosis[2]

Risk factors

- Patient history of ILD/pneumonitis or lung disease[4,5]
- Smoking status[4,5]
- Age >70 years[5]
- Male[5]
- Use of anticancer agents
- Dose
- Geographic Region

ILD, interstitial lung disease.

1. Wells AU et al. Thorax 2008; 2. Meyer KC. Transl Respir Med 2014; 3. Modi S et al. N Engl J Med 2020; 4. Kreuter M et al. Biomed Res Int 2015 5. Choi W et al. BMC Pulm Med. 2018

Courtesy of Javier Cortés, MD, PhD

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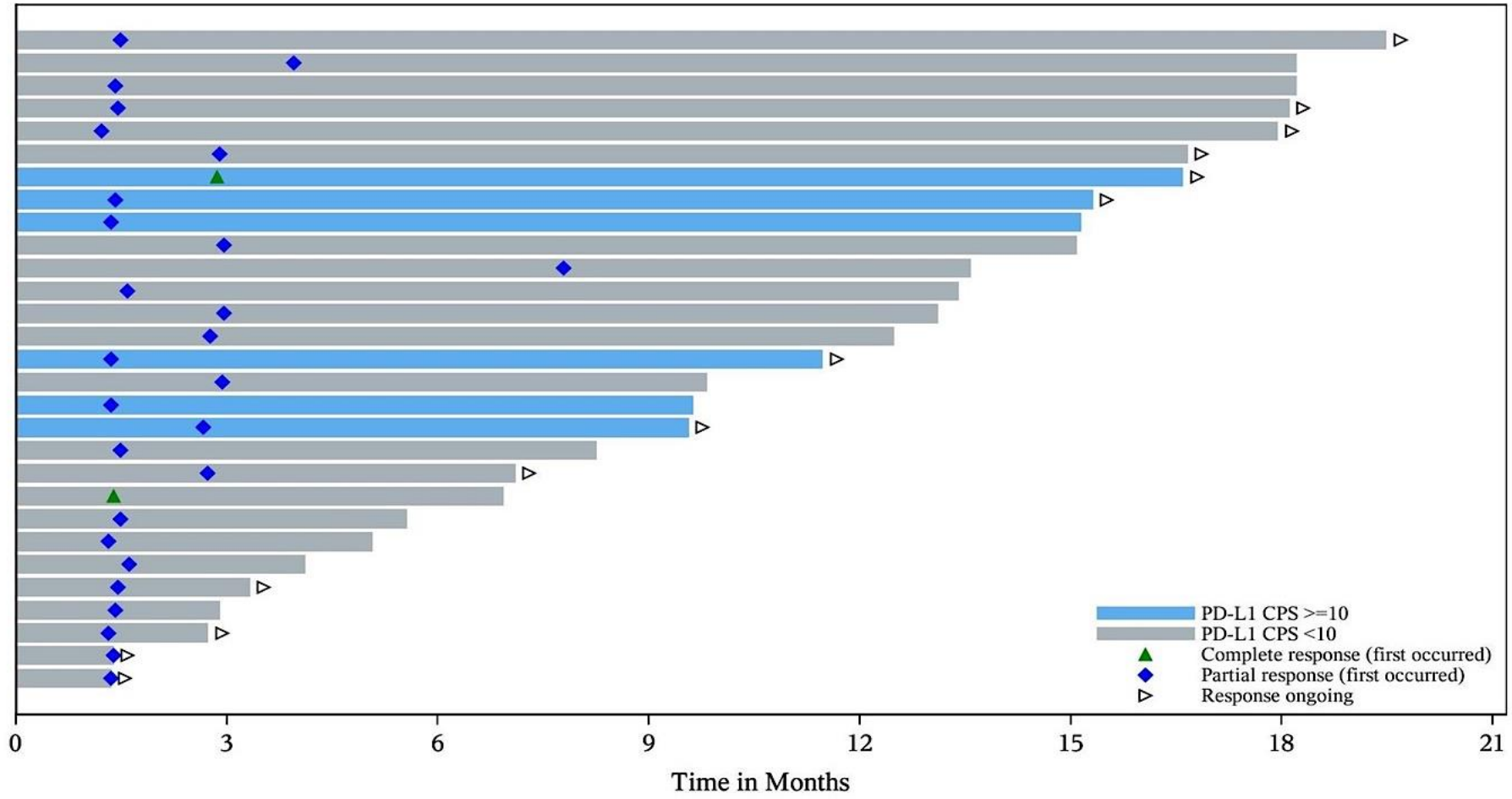
Sac-TMT = sacituzumab tirumotecan

RTP RESEARCH TO PRACTICE

Phase II OptiTROP-Breast05: Duration of Response

Median DOR was 12.2 mo (range: 1.4+-18.0+) and 12-month DOR rate was 50.6% in all patients.



+ indicates there is no progressive disease by the time of last disease assessment.

Yin Y et al. ASCO 2025;Abstract 1019.

Agenda
Metastatic Triple-Negative Breast Cancer

Introduction: Where We Are; Where We're Heading

Module 1: First-Line Treatment of BRCA Wild-Type Disease

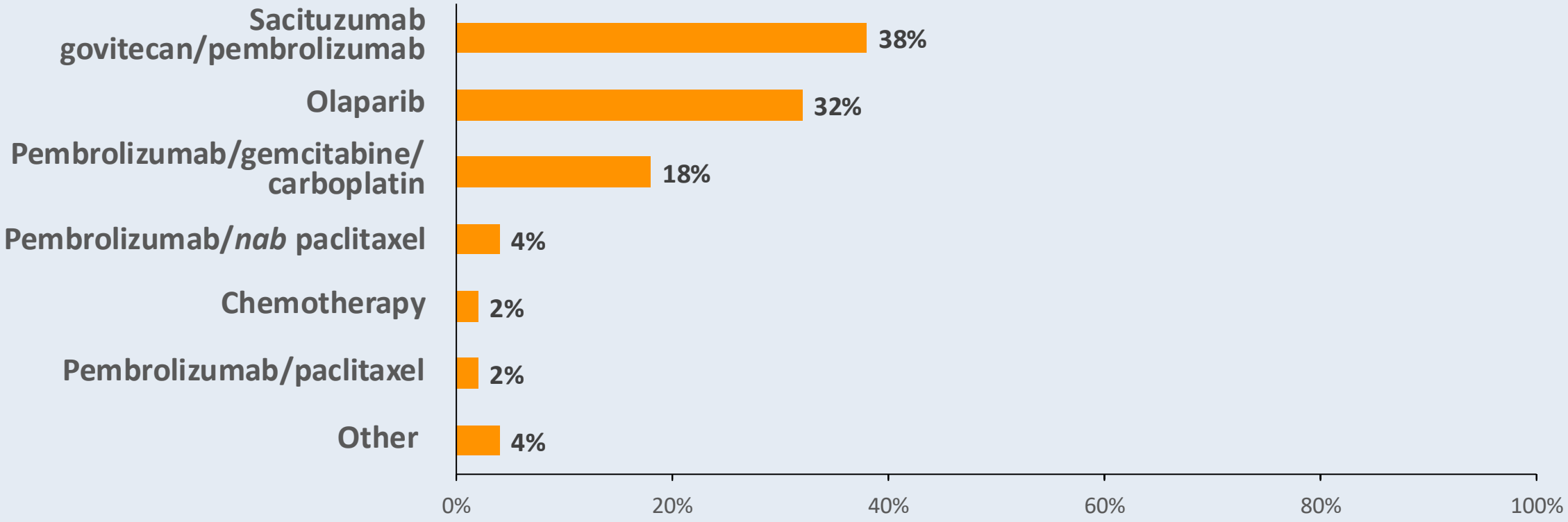
Module 2: First-Line Treatment of BRCA-Mutant Disease

Module 3: Novel Approaches

Module 4: ASCO 2026

A 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?

Age 65, PS 0, asymptomatic bone metastases



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RTP RESEARCH TO PRACTICE

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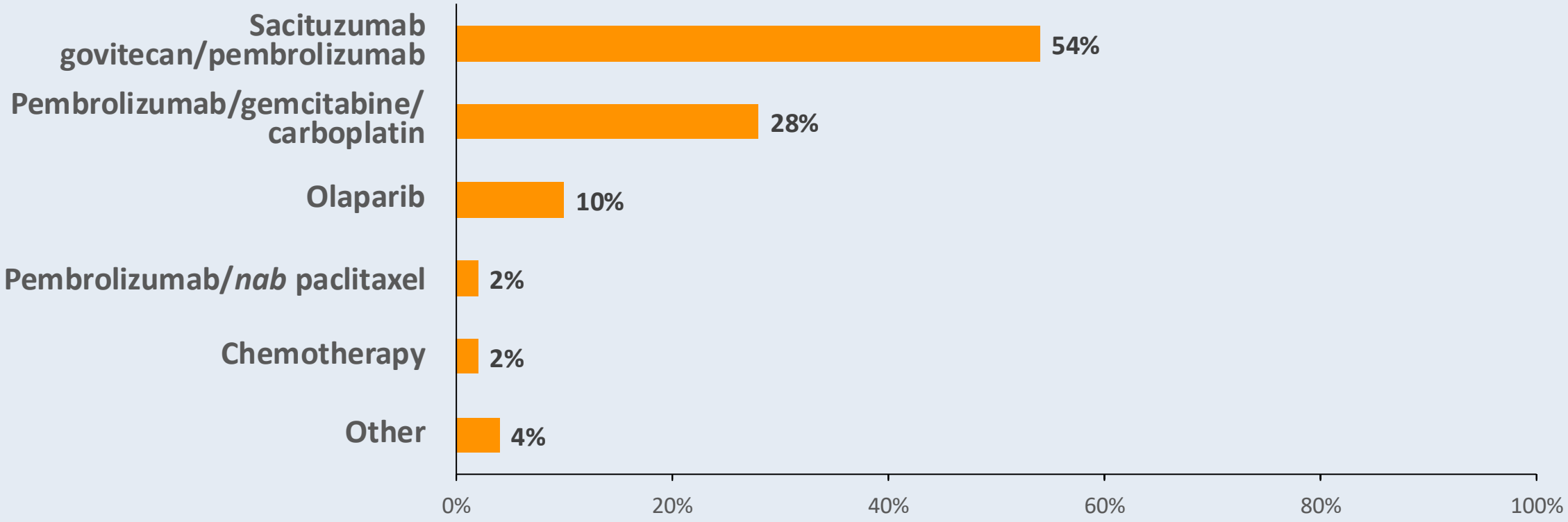
Age 65, PS 0, symptomatic visceral (including liver) metastases



Survey of US-based general medical oncologists

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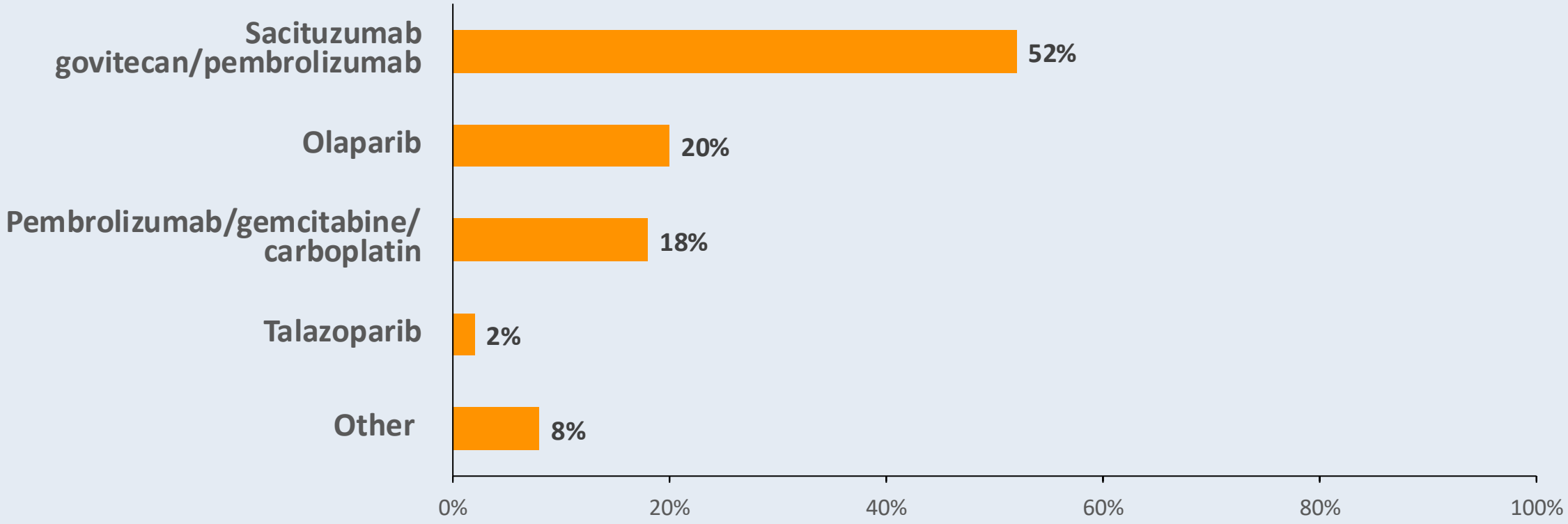
Age 65, PS 0, multiple brain metastases requiring SRS



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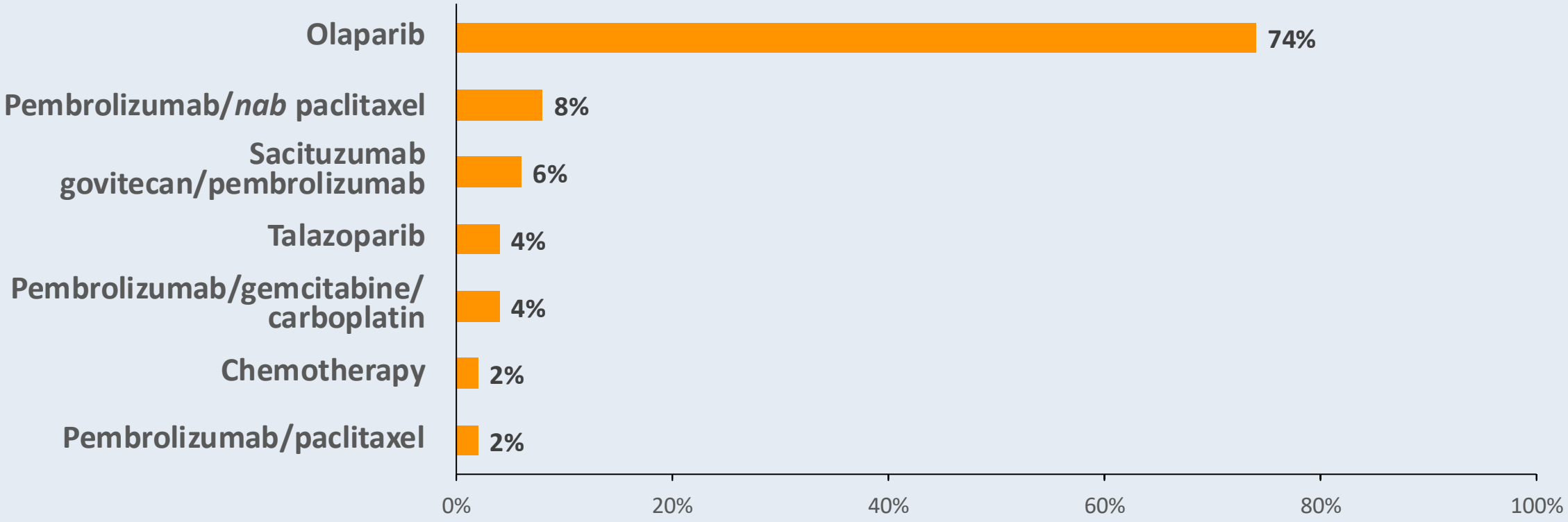
RTP RESEARCH TO PRACTICE

A 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?

Age 80, PS 2, asymptomatic bone metastases



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RTP RESEARCH TO PRACTICE

Cases from General Medical Oncologists

56 yo woman

- **De novo mTNBC, BRCA-mutant, PD-L1 >10, HER2 2+ (FISH neg). Metastases to bone, liver and lymph nodes. History of HTN, HLD.**
- **Recently started SG + pembrolizumab.**
- **How would you decide olaparib vs SG + pembrolizumab? Would you use T-DXd after SG in this case? When do you choose Dato-DXd?**

Cases from General Medical Oncologists

69 yo woman

- **mTNBC with metastases to bone, lungs and LN. PALB2-mutation, HER2-ultra-low. History of HTN.**
- **Triple negative IDC of the R breast cT0N3M0 Stage III/ypT0N0 s/p KN-522 x 1 dose, surgery and RT then developed metastatic disease.**
- **Currently on olaparib for 18 months.**

Should she get SG or T-DXd next line? How do you decide?

Cases from General Medical Oncologists

45 yo woman

- **mTNBC, gBRCA-mutated, PD-L1 CPS 20. Metastases to bone and lung. History of asthma.**
- **Locally advanced stage III, received KN-522 regimen, progressed on pembro maintenance 6 months 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

51 yo woman

- **mTNBC with metastases to brain, liver and lung. PD-L1 high, BRCA-positive. History of diabetes.**
- **TNBC initially stage 3 2018, received AC-T. Diagnosed stage 4 in 2023, received *nab* paclitaxel x 6 with pembrolizumab and achieved a CR, she received maintenance pembrolizumab for 2 yrs with no side effects.**

She is in CR — how long would you continue pembrolizumab? If she has no visible disease, would you offer olaparib?

Role of ctDNA in this patient?

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RTP RESEARCH TO PRACTICE

Novel Approaches

Borresman K, et al. Single arm phase II study with abemaciclib and bicalutamide in locoregionally advanced inoperable or metastatic androgen receptor-positive triple-negative breast cancer (ABBICAR). SABCS 2025;Abstract PS5-08-27.

Traina T et al. TBCRC 058: A randomized phase II study of enzalutamide, enzalutamide with mifepristone, and treatment of physician's choice in patients with androgen receptor-positive metastatic triple-negative or estrogen receptor-low breast cancer (NCT06099769). ASCO 2026; Abstract TPS1162.

Feasibility study of adjuvant enzalutamide for the treatment of early stage AR(+) triple negative breast cancer. NCT02750358. PI: Tiffany Traina

Cases from General Medical Oncologists

74 yo woman

- **mTNBC with metastases to bone and lung. History of diabetes, chronic kidney disease.**
- **Neoadjuvant AC-T chemotherapy 4 years prior to diagnosis of metastatic disease.**
- **On Foundation testing at the time of mets she was found to have androgen receptor positivity.**

Would you consider the use of bicalutamide or enzalutamide in this patient?

PD-L1 80% on NGS so could you also consider a single agent immunotherapy on this person?

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Module 2: First-Line Treatment of BRCA-Mutant Disease

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RTP RESEARCH TO PRACTICE

ASCO 2026 Abstract Titles to Look Out for

- Schmid P et al. **Neoadjuvant pembrolizumab or placebo plus chemotherapy followed by adjuvant pembrolizumab or placebo for high-risk early-stage TNBC: Final analysis results from the phase 3 KEYNOTE-522 study.** Abstract 507.

- Kalinsky K et al. **Progression-free survival after next line of treatment (PFS2) and subsequent therapies (subs tx) in the ASCENT-04 study of participants (pts) with previously untreated PD-L1+ metastatic triple-negative breast cancer (mTNBC) treated with sacituzumab govitecan (SG) plus pembrolizumab (pembro) vs chemotherapy (chemo) plus pembro.** Abstract LBA1000.

- Hurvitz S et al. **Progression-free survival after next line of treatment (PFS2) and subsequent therapies (subs tx) in the ASCENT-03 study of participants (pts) with previously untreated metastatic triple-negative breast cancer (mTNBC) treated with sacituzumab govitecan (SG) vs chemotherapy (chemo).** Abstract 1001.

ASCO 2026 Abstract Titles to Look Out For

- Cescon D et al. **First-line datopotamab deruxtecan (Dato-DXd) vs chemotherapy in patients with locally recurrent inoperable or metastatic triple-negative breast cancer (TNBC) for whom immunotherapy was not an option: Additional efficacy endpoints from the TROPION-Breast02 study.** Abstract 1002.

- Tolaney S et al. **ASCENT-04: Analysis of efficacy by biomarker subgroups with sacituzumab govitecan (SG) + pembrolizumab (pembro) vs chemotherapy (chemo) + pembro in participants (pts) with previously untreated PD-L1+ metastatic triple-negative breast cancer (mTNBC).** Abstract 1013.

- Barrios C et al. **ASCENT-03: Efficacy by biomarker subgroup with sacituzumab govitecan (SG) vs chemotherapy (chemo) in participants (pts) with previously untreated advanced triple-negative breast cancer (TNBC) who are not candidates for PD-(L)1 inhibitors (PD-[L]1i).** Abstract 1014.

RTP RESEARCH TO PRACTICE

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

Non-Muscle-Invasive and Muscle-Invasive Bladder Cancer

A CME/MOC-Accredited Live Webinar

Tuesday, May 5, 2026

5:00 PM – 6:00 PM ET

Faculty

Ashish M Kamat, MD, MBBS

Thomas Powles, MBBS, MRCP, MD

Moderator

Neil Love, MD

RTP Year in Review 2026

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