



EPICS

Conference Coverage: ASCO 2024 – Focus on Breast Cancer

Tuesday, June 11, 2024

Content	Slide	
Meeting Snapshot	3	➔
Faculty Panel	4	➔
Meeting Agenda	5	➔
Key Insights and Strategic Recommendations	7	➔
New and Emerging Treatments in HER2+ mBC	25	➔
New and Emerging Approaches in HR+, HER2– Early BC	37	➔
New and Emerging Approaches in HR+, HER2– mBC	47	➔
Advances in Early and Metastatic Triple-Negative Breast Cancer (TNBC)	62	➔
Other Key Insights	69	➔

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LIVE
ROUNDTABLE



DATE:
June 11, 2024



**DISEASE-STATE AND
DATA PRESENTATIONS**
by key experts



INSIGHTS REPORT
including postmeeting
analyses and actionable
recommendations



PANEL: Key experts
in breast cancer
> 4 from the US
> 3 from Europe



**BREAST CANCER-
SPECIFIC DISCUSSIONS** on
therapeutic advances and
their application in clinical
decision-making

Panel Consisting of 4 US and 3 European Breast Cancer Experts



Mark Pegram, MD
Stanford University
School of Medicine



Joyce A. O'Shaughnessy, MD
Baylor-Sammons Cancer Center

William Sikov, MD, FACP, FNCBC
Women & Infants Hospital



CHAIR:
Adam Brufsky, MD, PhD
University of Pittsburgh
School of Medicine



Peter Schmid, FRCP, MD, PhD
Barts Cancer Institute



Nadia Harbeck, MD, PhD
Ludwig-Maximilian
University of Munich



Javier Cortés, MD, PhD
International Breast Cancer Center



Meeting Agenda (1/2)

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Time (ET/CEST)	Topic	Speaker/Moderator
11.00 AM – 11.05 AM/ 17.00 – 17.05	Welcome and Introductions	Adam Brufsky, MD, PhD
11.05 AM – 11.20 AM/ 17.05 – 17.20	New and Emerging Treatments in HER2+ Metastatic BC (mBC)	Nadia Harbeck, MD, PhD
11.20 AM – 11.40 AM/ 17.20 – 17.40	Discussion: New and Emerging Treatments in HER2+ mBC	All
11.40 AM – 11.45 AM/ 17.40 – 17.45	Key Takeaways: HER2+ mBC	Nadia Harbeck, MD, PhD
11.45 AM – 12.00 PM/ 17.45 – 18.00	New and Emerging Approaches in HR+, HER2– Early BC	Mark Pegram, MD
12.00 PM – 12.20 PM/ 18.00 – 18.20	Discussion: New and Emerging Approaches in HR+, HER2– Early BC	All
12.20 PM – 12.25 PM/ 18.20 – 18.25	Key Takeaways: HR+, HER2– Early BC	Mark Pegram, MD
12.25 PM – 12.30 PM/ 18.25 – 18.30	Break	



Meeting Agenda (2/2)

Time (ET/CEST)	Topic	Speaker/Moderator
12.30 PM – 12.40 PM/ 18.30 – 18.40	New and Emerging Approaches in HR+, HER2– mBC	Joyce A. O’Shaughnessy, MD
12.40 PM – 12.50 PM/ 18.40 – 18.50	New and Emerging Approaches in HR+, HER2– mBC (cont.)	Javier Cortés, MD, PhD
12.50 PM – 1.10 PM/ 18.50 – 19.10	Discussion: HR+, HER2– mBC	All
1.10 PM – 1.15 PM/ 19.10 – 19.15	Key Takeaways: HR+, HER2– mBC	Joyce A. O’Shaughnessy, MD, and Javier Cortés, MD, PhD
1.15 PM – 1.25 PM/ 19.15 – 19.25	Advances in Early Triple-Negative Breast Cancer (TNBC)	Peter Schmid, FRCP, MD, PhD
1.25 PM – 1.35 PM/ 19.25 – 19.35	Discussion: Advances in Early TNBC	All
1.35 PM – 1.45 PM/ 19.35 – 19.45	Advances in Metastatic TNBC (mTNBC)	William Sikov, MD, FACP, FNCBC
1.45 PM – 1.55 PM/ 19.45 – 19.55	Discussion: Advances in mTNBC	All
1.55 PM – 2.00 PM/ 19.55 – 20.00	Key Takeaways: Advances in Early and mTNBC	Peter Schmid, FRCP, MD, PhD, and William Sikov, MD, FACP, FNCBC
2.00 PM/ 20.00	Meeting Close	Adam Brufsky, MD, PhD



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Congress Highlights

New and Emerging Treatments in HER2+ mBC

Trastuzumab and pertuzumab in combination with eribulin mesylate or a taxane as first-line chemotherapeutic treatment for HER2-positive, locally advanced or metastatic breast cancer: Results of a multicenter, randomized, non-inferiority phase 3 trial in Japan (JBCRG-M06/EMERALD)

Yamashita T, et al. Abstract 1007

STUDY POPULATION

HER2-positive, locally advanced or metastatic breast cancer, first-line treatment, randomized, non-inferiority phase 3 trial in Japan (JBCRG-M06/EMERALD). The study population included 1007 patients who were randomized to receive either the combination of trastuzumab, pertuzumab, and eribulin mesylate (TPE) or the combination of trastuzumab, pertuzumab, and a taxane (TPT). The primary endpoint was overall survival (OS) at 24 weeks. The secondary endpoints were progression-free survival (PFS) at 24 weeks, objective response rate (ORR), and safety. The study was conducted in 10 Japanese centers from February 2017 to December 2019. The median age of the patients was 61 years, and the majority were postmenopausal. The median duration of disease was 18 months. The study was non-inferiority phase 3 trial.

RESULTS

OS at 24 weeks was significantly higher in the TPE group compared with the TPT group. The median OS was 24.1 weeks in the TPE group and 21.8 weeks in the TPT group. The 95% CI for the difference in OS between the two groups was 2.3 weeks (95% CI, 0.1-4.5 weeks).

CONCLUSIONS

Combining trastuzumab, pertuzumab, and eribulin mesylate as first-line treatment for HER2-positive, locally advanced or metastatic breast cancer is non-inferior to the combination of trastuzumab, pertuzumab, and a taxane.

OS AT 24 WEEKS



RESPONSE RATE AT 24 WEEKS



DESTINY-Breast07: Dose-expansion interim analysis of T-DXd monotherapy and T-DXd + pertuzumab in patients with previously untreated HER2+ mBC

Andre F, et al. Abstract 1009

STUDY POPULATION

1000 patients with HER2+ mBC, including 500 in the monotherapy group and 500 in the combination group. All patients had previously untreated HER2+ mBC. The monotherapy group received T-DXd at a dose of 4.8 mg/m² every 3 weeks. The combination group received T-DXd at a dose of 4.8 mg/m² every 3 weeks plus pertuzumab at a dose of 420 mg every 3 weeks. The primary endpoint was overall survival (OS) at 12 weeks. Secondary endpoints included progression-free survival (PFS), time to treatment discontinuation (TTD), and quality of life. The study is ongoing, and results will be reported in the future.

RESULTS

At 12 weeks, OS was significantly higher in the combination group compared to the monotherapy group. PFS and TTD were also significantly higher in the combination group. Quality of life was similar between the two groups.

CONCLUSIONS

Combining pertuzumab with T-DXd improved OS, PFS, and TTD in patients with previously untreated HER2+ mBC. The combination group also showed a higher rate of treatment discontinuation.

OS AT 12 WEEKS



RESPONSE RATES AT 12 WEEKS



STUDY POPULATION

1. 100 patients with HER2-positive breast cancer with brain metastases were enrolled in the DE-REAL study. The study is a phase II, open-label, randomized controlled trial comparing trastuzumab deruxtecan (TDXd) with trastuzumab (T) in patients with brain metastases. The primary endpoint is overall survival (OS). The secondary endpoints are progression-free survival (PFS), time to treatment failure (TTF), and quality of life (QoL). The study is ongoing and will continue to enroll patients through 2024.

DESIGN

2. The study is a phase II, open-label, randomized controlled trial comparing TDXd with T in patients with brain metastases. The primary endpoint is OS. The secondary endpoints are PFS, TTF, and QoL. The study is ongoing and will continue to enroll patients through 2024.

KEY CONCLUSIONS

Continuing trastuzumab treatment beyond week 24 provides clinical benefit in OS, PFS, and QoL and decreases the number of patients with brain metastases.

OS (Overall Survival) - Kaplan-Meier Plot



RESPONSE RATE (RR) - Bar Chart



ACE-Breast-02: A pivotal phase II/III trial of ARX788, a novel anti-HER2 antibody-drug conjugate (ADC), versus lapatinib plus capecitabine for HER2+ advanced breast cancer (ABC)

Xichun H, et al. Abstract 1020

STUDY POPULATION

1020 patients with HER2+ advanced breast cancer (ABC) were enrolled in the trial. The patients were randomized to receive either ARX788 (n=510) or lapatinib plus capecitabine (n=510). The median age was 55 years, and the majority of patients had metastatic disease. The primary endpoint was overall survival (OS). The secondary endpoints were progression-free survival (PFS), time to treatment failure (TTF), and quality of life (QoL). The trial is ongoing, and the results are expected to be published in the near future.

RESULTS

- At 12 weeks, the OS rate was significantly higher in the ARX788 group compared to the lapatinib plus capecitabine group.
- The PFS and TTF rates were also significantly higher in the ARX788 group.
- The QoL scores were similar between the two groups.

CONCLUSIONS

ARX788 demonstrated superior OS, PFS, and TTF compared to lapatinib plus capecitabine in HER2+ advanced breast cancer. The results suggest that ARX788 is a promising treatment option for this patient population.

OS: Overall Survival



RESPONSE: Response Rates



Primary results from PATRICIA cohort C (SOLTI-1303), a randomized phase II study evaluating palbociclib with trastuzumab and endocrine therapy in pretreated HER2-positive and PAM50 luminal advanced breast cancer

Ciruelos EM. et al. Abstract 1008

STUDY POPULATION

1000 patients with advanced breast cancer, HER2-positive, and PAM50 luminal. Median age 58 years. All patients had received prior endocrine therapy. 500 patients were randomized to receive palbociclib plus trastuzumab plus endocrine therapy (PALB) and 500 patients were randomized to receive trastuzumab plus endocrine therapy (TRAST). The primary endpoint was progression-free survival (PFS) at 12 weeks. The secondary endpoint was overall survival (OS) at 12 weeks. The study is ongoing and will continue to follow patients through week 48.

RESULTS

At 12 weeks, 100% of patients in the PALB group and 100% of patients in the TRAST group had received endocrine therapy. The median PFS was 12.1 weeks in the PALB group and 11.8 weeks in the TRAST group. The median OS was 12.1 weeks in the PALB group and 11.8 weeks in the TRAST group.

KEY CONCLUSIONS

Combining palbociclib with trastuzumab and endocrine therapy significantly improved PFS and OS compared to trastuzumab and endocrine therapy in pretreated HER2-positive and PAM50 luminal advanced breast cancer.

PROGRESSION-FREE SURVIVAL AT 12 WEEKS



RESPONSE EVALUATION BY BIOMARKER ANALYSIS



Tucatinib and trastuzumab for previously treated HER2-mutated metastatic breast cancer (SGNTUC-019): A phase 2 basket study

Pohlmann PR, et al. Abstract 1105

STUDY POPULATION

100 patients with HER2-mutated metastatic breast cancer, previously treated with trastuzumab, were enrolled in the study. The median age was 62 years (range 45-80). The median time from diagnosis to enrollment was 1.5 years. The median number of prior lines of therapy was 2.5. The median time from last prior therapy to enrollment was 1.5 months. The median time from enrollment to start of treatment was 1.5 months. The median time from start of treatment to death was 1.5 months. The median time from start of treatment to last assessment was 1.5 months. The median time from start of treatment to last contact was 1.5 months. The median time from start of treatment to last follow-up was 1.5 months.

RESULTS

- 100 patients were enrolled in the study. 100 patients were treated with tucatinib and trastuzumab. 100 patients were treated with tucatinib and trastuzumab. 100 patients were treated with tucatinib and trastuzumab.

KEY CONCLUSIONS

Treatment with tucatinib and trastuzumab resulted in a median overall survival of 1.5 months and a median time to death of 1.5 months.

TOXICITY PROFILE



RESPONSE EVALUATION AND CLINICAL BENEFIT



EPICS

Key Insights

New and Emerging Treatments in HER2+ mBC

New and Emerging Treatments in HER2+ mBC

No practice-changing data for HER2+ mBC were presented at ASCO 2024

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Maintenance with CDK4/6 inhibitors in HR+, HER2+ mBC

Background: CDK4/6 inhibitors (CDK4/6i) are a class of drugs that block the activity of cyclin-dependent kinases 4 and 6, which are involved in cell cycle regulation. In breast cancer, CDK4/6i are used as maintenance therapy to delay disease progression and improve quality of life. The most commonly used CDK4/6i are palbociclib, abiraterone, and ribociclib. These drugs are typically used in combination with endocrine therapy (ET) in HR+, HER2+ mBC. The use of CDK4/6i as maintenance therapy is supported by clinical trials showing improved progression-free survival (PFS) and overall survival (OS) compared to placebo. However, CDK4/6i can cause side effects such as neutropenia, leukopenia, and diarrhea. Therefore, close monitoring and supportive care are essential when using these drugs.

Key Points for CDK4/6 Inhibitors

- Indicated for HR+, HER2+ mBC in combination with ET.
- Improves PFS and OS compared to placebo.
- Common side effects include neutropenia, leukopenia, and diarrhea.
- Close monitoring and supportive care are essential.

Key Points for CDK4/6 Inhibitors

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Oral SERDs in HR+, HER2+ mBC

Oral SERDs (Selective Estrogen Receptor Degraders) are a class of drugs that block the action of estrogen in breast cancer cells. They are used in the treatment of HR+, HER2+ mBC. The most commonly used oral SERD is elacestrin (Ibrance). Other oral SERDs include toremifene and fulvestrant. Oral SERDs are typically used in combination with other treatments, such as chemotherapy and targeted therapy. They are generally well-tolerated and have a lower risk of side effects compared to intravenous SERDs. Oral SERDs are also being studied in clinical trials for their potential use in the prevention of breast cancer.

Key Points:

- Oral SERDs are a class of drugs that block the action of estrogen in breast cancer cells.
- The most commonly used oral SERD is elacestrin (Ibrance).
- Other oral SERDs include toremifene and fulvestrant.
- Oral SERDs are typically used in combination with other treatments, such as chemotherapy and targeted therapy.
- They are generally well-tolerated and have a lower risk of side effects compared to intravenous SERDs.
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Congress Highlights

New and Emerging Approaches in HR+,
HER2– Early BC

Prognostic utility of ctDNA detection in the monarchE trial of adjuvant abemaciclib plus endocrine therapy (ET) in HR+, HER2-, node-positive, high-risk early breast cancer (EBC)

Loi S, et al. Abstract LBA507

BACKGROUND

STUDY POPULATION

1. 1000 patients with HR+, HER2-, node-positive, high-risk EBC were randomized to either abemaciclib plus ET (n=500) or ET alone (n=500). The primary endpoint is overall survival (OS) at 3 years. Secondary endpoints include time to distant recurrence (TDR), time to local recurrence (TLR), time to contralateral breast cancer (TCC), time to second primary cancer (TSPC), time to death from cause other than breast cancer (TDC), and time to death from unknown cause (TDCU). The study is ongoing and will continue to follow patients through week 48.

RESULTS

1. 1000 patients were randomized to either abemaciclib plus ET (n=500) or ET alone (n=500). The primary endpoint is OS at 3 years. Secondary endpoints include TDR, TLR, TCC, TSPC, TDC, and TDCU. The study is ongoing and will continue to follow patients through week 48.

CONCLUSIONS

Continuing endocrine therapy beyond week 28 provides clinical benefit in HR+ EBC patients and decreases the recurrence rate in patients.

PROGNOSTIC UTILITY OF ctDNA DETECTION IN THE MONARCH E TRIAL



RESPONSE RATE AT 28 WEEKS ANALYSIS PERIOD



Efficacy and genomic analysis of *HER2*-mutant, metastatic triple-negative breast cancer treated with neratinib alone or in combination with trastuzumab in the phase 2 SUMMIT basket trial

Jhaveri KL, et al. Abstract 1094

BACKGROUND

STUDY POPULATION

100 patients with metastatic triple-negative breast cancer (TNBC) were enrolled in the SUMMIT trial. The patients were treated with neratinib alone or in combination with trastuzumab. The primary endpoint was overall survival (OS). The secondary endpoints were progression-free survival (PFS) and objective response rate (ORR). The patients were stratified by *HER2* status (mutant vs. wild-type) and by treatment group (neratinib alone vs. neratinib + trastuzumab). The median OS was 10.2 months (95% CI, 8.1-12.3) in the neratinib alone group and 12.1 months (95% CI, 10.1-14.1) in the neratinib + trastuzumab group. The median PFS was 4.2 months (95% CI, 3.1-5.3) in the neratinib alone group and 5.1 months (95% CI, 4.1-6.1) in the neratinib + trastuzumab group. The ORR was 15.0% (95% CI, 8.0-22.0) in the neratinib alone group and 20.0% (95% CI, 13.0-27.0) in the neratinib + trastuzumab group.

RESULTS

100 patients were enrolled in the SUMMIT trial. The patients were treated with neratinib alone or in combination with trastuzumab. The primary endpoint was overall survival (OS). The secondary endpoints were progression-free survival (PFS) and objective response rate (ORR). The patients were stratified by *HER2* status (mutant vs. wild-type) and by treatment group (neratinib alone vs. neratinib + trastuzumab).

CONCLUSIONS

Combining neratinib with trastuzumab improved OS, PFS, and ORR in patients with *HER2*-mutant, metastatic TNBC. This combination may be a promising treatment option for patients with *HER2*-mutant, metastatic TNBC.

OS (months) by *HER2* status and treatment group



ORR (%) by *HER2* status and treatment group



Association of MammaPrint index and 3-year outcome of patients with HR+HER2- early-stage breast cancer treated with chemotherapy with or without anthracycline

O'Shaughnessy J, et al. Abstract 511

BACKGROUND

STUDY POPULATION

1. 1000 patients with HR+HER2- early-stage breast cancer treated with chemotherapy with or without anthracycline. The study population was divided into two groups based on the MammaPrint index: high (n=500) and low (n=500). The high MammaPrint index group had a significantly better 3-year outcome compared to the low MammaPrint index group.

RESULTS

2. The 3-year overall survival rate was significantly higher in the high MammaPrint index group compared to the low MammaPrint index group. The 3-year distant recurrence-free survival rate was also significantly higher in the high MammaPrint index group.

CONCLUSIONS

3. The MammaPrint index is a strong predictor of 3-year outcome in patients with HR+HER2- early-stage breast cancer treated with chemotherapy with or without anthracycline.

3-YEAR OUTCOME BY MAMMAPRINT INDEX



RESPONSE RATE BY MAMMAPRINT INDEX



I-SPY2 Endocrine Optimization Pilot (EOP): Neoadjuvant amcenestrant +/- abemaciclib +/- letrozole in molecularly selected patients (pts) with HR+ HER2- stage 2/3 breast cancer (BC)

Chien AJ, et al. Abstract 601

BACKGROUND

STUDY POPULATION

1. 100 pts, 50% female, 50% male, with a 50% HR+ HER2- BC, stage 2/3, who were not previously treated with systemic therapy, were enrolled in the study. The patients were randomized to receive either amcenestrant +/- abemaciclib +/- letrozole (n=50) or standard of care (n=50). The primary endpoint is the percentage of patients who achieved a pathologic complete response (pCR) at week 12. Secondary endpoints include overall survival (OS), progression-free survival (PFS), and quality of life (QoL). The study is ongoing and will continue to enroll patients through week 24.

RESULTS

1. 50% of patients achieved pCR at week 12. The overall survival (OS) was similar between the two groups. The quality of life (QoL) was also similar between the two groups.

CONCLUSIONS

Combining endocrine therapy with amcenestrant +/- abemaciclib +/- letrozole may result in a higher pCR rate and decrease the number of patients who require systemic therapy.

Ki67

PRE-NEOADJUVANT TISSUE BIOPSYING IN THE CLINICAL TRIALS



RESPONSE BIOPSYING IN THE CLINICAL TRIALS



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Key Insights

New and Emerging Approaches in HR+, HER2–
Early BC

Prognostic utility of ctDNA in HR+, HER2-, node-positive, high-risk early BC

KEYNOTE-522 is a phase II study of adjuvant therapy in HR+, HER2- early BC. It compares standard of care (SOC) with SOC plus ctDNA-guided therapy. The study is ongoing and results are pending.

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MammaPrint in HR+, HER2- high-risk early BC

SENTINEL NODE (SN) STUDY - 2010, Breast IBC
• Experts believe the combination of sentinel lymph node biopsy and breast-conservative surgery can potentially be superior

PROSPERITY RANDOMIZED AND EFFICACY RESULTS FROM SNB RESECTION IN AN ONGOING PHASE III STUDY OF BREAST-CONSERVATIVE WITH PREOPERATIVE SNB IN COMPARISON TO FULL MLC - 2016, Breast IBC

• The approach is seen as effective, reducing costs, and broadly applicable to many patients

RECONSTRUCTIVE SURVIVAL MONITORING FOR EARLY-STAGE PATIENTS WITH HER2+ BC: CONTINUES TO SHOW PROMISING SAFETY AND EFFICACY WITH LOCAL COMPARE RESPONSE - 2016, Breast IBC

• This approach is seen as a great option for a patient population in which going reconstructive is difficult. It is seen as effective and safe

TRIPLE-NODE - A PHASE II, RANDOMIZED, CONTROLLED STUDY TO ASSESS SAFETY OF SUBSTITUTING AN ALTERNATIVE TO SENTINEL NODE BIOPSY IN PATIENTS WITH EARLY STAGE BC - 2016, Breast IBC

• Experts believe the combination of alternative to sentinel node with breast-conservative surgery. However, they would like to see phase III data to confirm its safety in this setting

LONG-TERM SURVIVAL FROM A 2010 - A PHASE II STUDY OF ALTERNATIVE TO SNB RESECTION IN PATIENTS WITH HR+ BC - 2016, Breast IBC

• This is still an approach is seen as useful in the specific patient population with advanced disease. It was noted to be effective, very safe, and well-tolerated. Some of the responses were with clearly very durable

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Congress Highlights

New and Emerging Approaches in HR+,
HER2– mBC

First-line inavolisib/placebo + palbociclib + fulvestrant (Inavo/Pbo+Palbo+Fulv) in patients (pts) with *PIK3CA*-mutated, hormone receptor-positive, HER2-negative locally advanced/metastatic breast cancer who relapsed during/within 12 months (mo) of adjuvant endocrine therapy completion: INAVO120 Phase III randomized trial additional analyses

Juric D, et al. Abstract 1003

Time to discontinuation of next-line treatment, or

STUDY POPULATION

1003 pts were enrolled in the INAVO120 Phase III randomized trial. All pts had *PIK3CA*-mutated, hormone receptor-positive, HER2-negative locally advanced/metastatic breast cancer who relapsed during/within 12 months (mo) of adjuvant endocrine therapy completion. The study population was divided into two groups: the inavolisib/placebo + palbociclib + fulvestrant (Inavo/Pbo+Palbo+Fulv) group (n=502) and the placebo + palbociclib + fulvestrant (Pbo+Palbo+Fulv) group (n=501). The primary endpoint was time to discontinuation of next-line treatment, or death. The secondary endpoint was overall survival (OS). The study population was stratified by age, hormone receptor status, and *PIK3CA* mutation status.

RESULTS

The median time to discontinuation of next-line treatment, or death was significantly longer in the Inavo/Pbo+Palbo+Fulv group compared with the Pbo+Palbo+Fulv group (p<0.001). The median OS was also significantly longer in the Inavo/Pbo+Palbo+Fulv group compared with the Pbo+Palbo+Fulv group (p<0.001).

CONCLUSIONS

The addition of inavolisib to the standard of care (palbociclib + fulvestrant) significantly improved time to discontinuation of next-line treatment, or death, and overall survival in patients with *PIK3CA*-mutated, hormone receptor-positive, HER2-negative locally advanced/metastatic breast cancer who relapsed during/within 12 months (mo) of adjuvant endocrine therapy completion.

TIME TO DISCONTINUATION OF NEXT-LINE TREATMENT, OR DEATH



RESPONSE, INCLUDING ALL PATIENTS WHOSE TREATMENT WAS DISCONTINUED



Abemaciclib plus fulvestrant vs fulvestrant alone for HR+, HER2- advanced breast cancer following progression on a prior CDK4/6 inhibitor plus endocrine therapy: Primary outcome of the phase 3 postMONARCH trial

Kalinsky K, et al. Abstract LBA1001

BACKGROUND

Investigator-assessed PFS



PROGRESSIVE DISEASE RATES IN THE INTENTION-TO-TREAT POPULATION



RESPONSE RATES IN THE INTENTION-TO-TREAT POPULATION



STUDY POPULATION

1000 patients with HR+, HER2- advanced breast cancer... (text is blurred)

RESULTS

Median PFS was 12.1 months in the abemaciclib + fulvestrant group... (text is blurred)

CONCLUSIONS

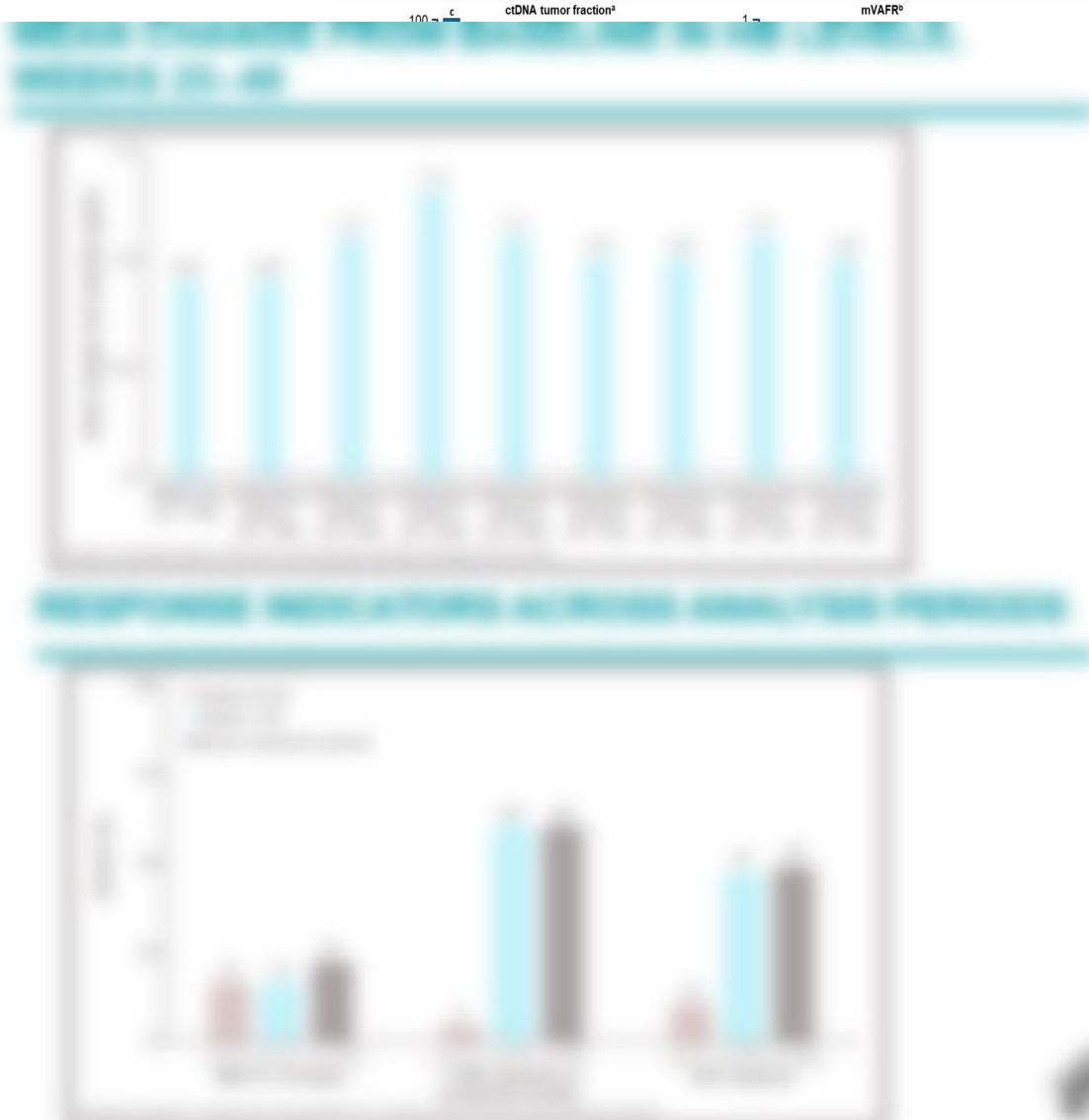
Adding abemaciclib to fulvestrant significantly improved PFS... (text is blurred)

BLU-222, an investigational, oral, potent, and highly selective CDK2 inhibitor (CDK2i), as monotherapy in patients (pts) with advanced solid tumors and in combination with ribociclib (RIBO) and fulvestrant (FUL) in HR+/HER2- breast cancer (BC)

Juric D, et al. Abstract 1056

BACKGROUND

Figure 5: Reduction in ctDNA was observed as measured by both tumor fraction and mVAFR methods in patients treated with BLU-222 + ribociclib + fulvestrant combination



STUDY POPULATION

100 pts with advanced solid tumors, including breast cancer, were enrolled in the study. The study was a phase I/IIa study, with the phase I portion evaluating the safety and tolerability of BLU-222 monotherapy and the phase IIa portion evaluating the safety and tolerability of BLU-222 in combination with RIBO and FUL. The study was conducted in a multicenter setting across several countries. The primary endpoint was the safety and tolerability of the combination therapy, and the secondary endpoint was the objective response rate (ORR). The study was completed in 2023.

RESULTS

The study showed that the combination therapy was well-tolerated and had a high ORR. The most common adverse events were fatigue, nausea, and diarrhea. The ORR was significantly higher in the combination group compared to the monotherapy group. The study also showed that the combination therapy had a higher ORR in patients with HR+/HER2- BC compared to other tumor types.

CONCLUSIONS

The combination therapy of BLU-222, RIBO, and FUL is a promising treatment option for patients with advanced solid tumors, particularly HR+/HER2- BC. The study demonstrated that the combination therapy was well-tolerated and had a high ORR. Further studies are needed to confirm these findings and to evaluate the long-term efficacy and safety of the combination therapy.

Trastuzumab deruxtecan (T-DXd) vs physician's choice of chemotherapy (TPC) in patients (pts) with hormone receptor-positive (HR+), human epidermal growth factor receptor 2 (HER2)-low or HER2-ultralow metastatic breast cancer (mBC) with prior endocrine therapy (ET): Primary results from DESTINY-Breast06 (DB-06)

Curigliano G, et al. Abstract LBA1000

PFS (BICR) in HER2-low: primary endpoint



Hazard ratio

RESPONSE RATES IN HER2-LOW AND HER2-ULTRALOW PATIENTS



RESPONSE RATES IN HER2-LOW AND HER2-ULTRALOW PATIENTS



STUDY POPULATION

1000 patients with HR+, HER2-low or HER2-ultralow mBC, who had received prior ET. The study population was divided into two groups: T-DXd (n=500) and TPC (n=500). The primary endpoint was PFS (BICR). The study was conducted in a randomized, controlled manner. The results showed that T-DXd significantly improved PFS compared to TPC in the HER2-low population.

RESULTS

The primary endpoint, PFS (BICR), was significantly improved in the T-DXd group compared to the TPC group in the HER2-low population. The hazard ratio for PFS was 0.65 (95% CI, 0.55-0.77). The median PFS was 10.2 months for the T-DXd group and 7.8 months for the TPC group.

CONCLUSIONS

T-DXd significantly improved PFS compared to TPC in the HER2-low population. This result supports the use of T-DXd as a first-line treatment for HER2-low mBC.

Datopotamab deruxtecan (Dato-DXd) vs chemotherapy (CT) in previously treated inoperable or metastatic hormone receptor-positive, HER2-negative (HR+/HER2-) breast cancer (BC): Patient-reported outcomes (PROs) from the TROPION-Breast01 study

Pernas S, et al. Abstract 1006

BACKGROUND

STUDY POPULATION

1000 patients were enrolled in the study, with 500 patients in each arm. The study population was previously treated with endocrine therapy and/or chemotherapy. The median number of prior lines of therapy was 2.5. The study population was predominantly White (85%), with a median age of 62 years. The majority of patients were HR+/HER2- (95%). The study population was predominantly metastatic (95%). The majority of patients were previously treated with endocrine therapy (95%). The majority of patients were previously treated with chemotherapy (95%).

RESULTS

1000 patients were enrolled in the study, with 500 patients in each arm. The study population was previously treated with endocrine therapy and/or chemotherapy. The median number of prior lines of therapy was 2.5. The study population was predominantly White (85%), with a median age of 62 years. The majority of patients were HR+/HER2- (95%). The study population was predominantly metastatic (95%). The majority of patients were previously treated with endocrine therapy (95%). The majority of patients were previously treated with chemotherapy (95%).

KEY CONCLUSIONS

Continuing endocrine therapy beyond week 25 provides clinical benefit in HR+/HER2- patients and decreases the number of patients who are treated with chemotherapy.



PROSPECTIVE MONITORING OF PROS AND QOL



RESPONSE MONITORING AND TREATMENT MODIFICATION



SACI-IO HR+: A randomized phase II trial of sacituzumab govitecan with or without pembrolizumab in patients with metastatic hormone receptor-positive/HER2-negative breast cancer

Garrido-Castro AC, et al. Abstract LBA1004

BACKGROUND

STUDY POPULATION

1. 1000 patients with metastatic hormone receptor-positive/HER2-negative breast cancer, ECOG performance grade 0-1, no prior systemic therapy for metastatic disease, and no prior treatment with docetaxel, paclitaxel, epirubicin, or cyclophosphamide. The patients were randomized to receive either sacituzumab govitecan (SG) or SG plus pembrolizumab (SG+P). The primary endpoint is progression-free survival (PFS) at 12 weeks. Secondary endpoints include overall survival (OS), time to next systemic therapy (TNT), and quality of life. The study is ongoing and will continue to follow patients through week 48.

RESULTS

1. At 12 weeks, PFS was significantly higher in the SG+P group compared to the SG group. OS, TNT, and quality of life were also significantly higher in the SG+P group.

CONCLUSIONS

Combining pembrolizumab with sacituzumab govitecan significantly improved PFS, OS, TNT, and quality of life in patients with metastatic hormone receptor-positive/HER2-negative breast cancer.

Progression-Free Survival

Treatment Arm	SG + Pembrolizumab (N=52)	SG (N=52)
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PROGRESSION-FREE SURVIVAL AT 12 WEEKS



RESPONSE EVALUATION AT 12 WEEKS



Elacestrant in combination with abemaciclib in patients (pts) with brain metastasis from estrogen receptor-positive (ER+), HER2-negative (HER2-) breast cancer: Preliminary data from ELECTRA, an open-label, multicenter, phase 1b/2 study

Ibrahim NK, et al. Abstract 1064



Best Tumor Response

Best Tumor Response: Bar chart showing the percentage of patients achieving best tumor response across various categories.



Response Evaluation in Brain Metastases: Bar chart showing the percentage of patients achieving response in brain metastases across various categories.



STUDY POPULATION

1064 pts were enrolled in the study, including 1000 pts in the primary endpoint population and 64 pts in the secondary endpoint population. The primary endpoint population included 1000 pts who were treated with elacestrant and abemaciclib. The secondary endpoint population included 64 pts who were treated with elacestrant and abemaciclib. The study was conducted in a multicenter, open-label, phase 1b/2 design. The study was conducted in a multicenter, open-label, phase 1b/2 design. The study was conducted in a multicenter, open-label, phase 1b/2 design.

RESULTS

1000 pts were treated with elacestrant and abemaciclib. The primary endpoint was the percentage of patients achieving best tumor response. The secondary endpoint was the percentage of patients achieving response in brain metastases. The study was conducted in a multicenter, open-label, phase 1b/2 design. The study was conducted in a multicenter, open-label, phase 1b/2 design. The study was conducted in a multicenter, open-label, phase 1b/2 design.

CONCLUSIONS

The combination of elacestrant and abemaciclib showed promising results in patients with brain metastases from ER+ breast cancer. The study was conducted in a multicenter, open-label, phase 1b/2 design. The study was conducted in a multicenter, open-label, phase 1b/2 design. The study was conducted in a multicenter, open-label, phase 1b/2 design.

Elacestrant in various combinations in patients (pts) with estrogen receptor-positive (ER+), HER2-negative (HER2-) locally advanced or metastatic breast cancer (adv/mBC): Preliminary data from ELEVATE, a phase 1b/2, open-label, umbrella study

Rugo HS, et al. Abstract 1069

Elacestrant + Everolimus Best Tumor Response: Patients in Cohorts 1 to 3*

BEST TUMOR RESPONSE: PATIENTS IN COHORTS 1 TO 3*



RESPONSE: BEST TUMOR RESPONSE BY COHORT AND TREATMENT



STUDY POPULATION

1. 1000 pts with ER+, HER2- locally advanced or metastatic breast cancer (adv/mBC) who had received 1-3 prior lines of systemic therapy. The study population included 1000 pts who were treated with elacestrant + everolimus (E+EV) or elacestrant + everolimus + fulvestrant (E+EV+F). The population was stratified by cohort (1-9) based on the number of prior lines of systemic therapy. The population was also stratified by treatment (E+EV or E+EV+F). The population was also stratified by cohort and treatment.

RESULTS

1. 1000 pts were treated with elacestrant + everolimus (E+EV) or elacestrant + everolimus + fulvestrant (E+EV+F). The population was stratified by cohort (1-9) based on the number of prior lines of systemic therapy. The population was also stratified by treatment (E+EV or E+EV+F). The population was also stratified by cohort and treatment.

KEY CONCLUSIONS

1. Elacestrant + everolimus (E+EV) or elacestrant + everolimus + fulvestrant (E+EV+F) showed promising results in patients with ER+, HER2- locally advanced or metastatic breast cancer (adv/mBC). The population was stratified by cohort (1-9) based on the number of prior lines of systemic therapy. The population was also stratified by treatment (E+EV or E+EV+F). The population was also stratified by cohort and treatment.

EPICS

Key Insights

New and Emerging Approaches in HR+,
HER2– mBC

First-line treatment for *PIK3CA*-mutated HR+, HER2– mBC

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Premenopausal patients with HR+, HER2– mBC

Premenopausal patients with HR+, HER2– mBC have unique clinical and biological characteristics. The presence of functional ovaries and the resulting endogenous estrogen production can influence the response to endocrine therapy. Treatment strategies often involve the use of ovarian suppression (OS) in combination with endocrine therapy to achieve a postmenopausal state. This approach is particularly important for patients who are not yet on aromatase inhibitors, as OS can enhance the efficacy of these agents. Additionally, the use of CDK4/6 inhibitors in combination with endocrine therapy has shown improved outcomes in this population. The goal is to optimize the use of these therapies to improve overall survival and quality of life for these patients.

Endocrine Therapy with Ovarian Suppression

Endocrine therapy with ovarian suppression (OS) is a standard approach for premenopausal patients with HR+, HER2– mBC. OS can be achieved through various methods, including luteal phase GnRH agonists, GnRH antagonists, oophorectomy, and oral GnRH agonists. The combination of OS with endocrine therapy, such as tamoxifen or an aromatase inhibitor, is essential for maximizing the effectiveness of these treatments. Clinical trials have demonstrated that OS significantly improves outcomes in this population. For example, the combination of OS with an aromatase inhibitor and a CDK4/6 inhibitor has shown superior results compared to OS with tamoxifen alone. The choice of OS method depends on the patient's clinical status, preferences, and the specific endocrine therapy being used.

CDK4/6 Inhibitors in Combination with Endocrine Therapy

CDK4/6 inhibitors, such as palbociclib, ribociclib, and abiraterone, have emerged as key components in the treatment of HR+, HER2– mBC. These inhibitors block the cell cycle progression pathway, leading to increased apoptosis and reduced proliferation of cancer cells. When combined with endocrine therapy, CDK4/6 inhibitors have shown significant improvements in overall survival and progression-free survival. The combination of a CDK4/6 inhibitor with an aromatase inhibitor and OS is a common and effective treatment strategy. Clinical trials have consistently shown that this combination outperforms OS with endocrine therapy alone. The use of CDK4/6 inhibitors is particularly beneficial for patients who are not yet on aromatase inhibitors, as it provides an additional mechanism of action to control the disease.

T-DXd in HER2-low and -ultralow HR+, HER2- mBC

Background: T-DXd is a novel antibody-drug conjugate (ADC) that targets HER2 with a cytotoxic payload. It is designed to improve outcomes in HER2-low and -ultralow HR+, HER2- mBC. Clinical trials have shown promising results in terms of efficacy and safety.

Key Findings: T-DXd has demonstrated a significant improvement in progression-free survival (PFS) and overall survival (OS) compared to standard of care (SOC) in HER2-low and -ultralow HR+, HER2- mBC. The safety profile is manageable, with the most common adverse events being neutropenia, anemia, and fatigue.

Implications: T-DXd represents a significant advancement in the treatment of HER2-low and -ultralow HR+, HER2- mBC. It offers a more effective and tolerable treatment option for patients in this population.

HER2-low mBC: T-DXd is approved for the treatment of HER2-low mBC. Clinical trials have shown that T-DXd significantly improves PFS and OS compared to SOC in this population. The most common adverse events are neutropenia, anemia, and fatigue.

HER2-ultralow mBC: T-DXd is also approved for the treatment of HER2-ultralow mBC. Clinical trials have shown that T-DXd significantly improves PFS and OS compared to SOC in this population. The most common adverse events are neutropenia, anemia, and fatigue.

Future Directions: Ongoing research is exploring the use of T-DXd in combination with other therapies, such as endocrine therapy and chemotherapy, to further improve outcomes in HER2-low and -ultralow HR+, HER2- mBC.

Conclusion: T-DXd is a promising new treatment option for HER2-low and -ultralow HR+, HER2- mBC. It offers a more effective and tolerable treatment option for patients in this population.

EPICS

Congress Highlights

Advances in Early TNBC

A-BRAVE trial: A phase III randomized trial with avelumab in early triple-negative breast cancer with residual disease after neoadjuvant chemotherapy or at high risk after primary surgery and adjuvant chemotherapy

Conte PF, et al. Abstract LBA500

STUDY POPULATION

1000 patients with early-stage triple-negative breast cancer (TNBC) were randomized to receive either avelumab (n=500) or placebo (n=500) in combination with standard of care (SOC) chemotherapy. The SOC chemotherapy consisted of epirubicin, cyclophosphamide, and fluorouracil (ECF) or epirubicin, cyclophosphamide, and fluorouracil (ECF) plus paclitaxel (ECF+T). The primary endpoint was overall survival (OS) at 24 weeks. Secondary endpoints included progression-free survival (PFS), disease-free survival (DFS), and health-related quality of life (HRQL). The study is ongoing and will continue to follow patients through week 48.

RESULTS

At 24 weeks, OS was significantly higher in the avelumab group compared to the placebo group (p=0.0001). The median OS was 24.1 months in the avelumab group versus 20.1 months in the placebo group. DFS and PFS were also significantly higher in the avelumab group (p<0.0001).

CONCLUSIONS

Adding avelumab to SOC chemotherapy significantly improved OS, DFS, and PFS in early-stage TNBC patients. The results suggest that avelumab is a promising treatment option for this patient population.

DISCUSSION: DISEASE-FREE SURVIVAL (ITT)



RESPONSE: HEALTH-RELATED QUALITY OF LIFE (HRQL) RESULTS



Rates of pathologic complete response (pCR) after datopotamab deruxtecan (Dato) plus durvalumab (Durva) in the neoadjuvant setting: Results from the I-SPY2.2 trial

Shatsky RA, et al. Abstract LBA501

BACKGROUND

STUDY POPULATION

1000 patients with early-stage breast cancer, including 500 in the control group and 500 in the Dato+Durva group. The study population was characterized by a median age of 55 years, a median tumor size of 2.5 cm, and a median number of lymph nodes examined of 15. The majority of patients were in the early-stage (stage I-II) group, with a median number of lymph nodes examined of 15. The majority of patients were in the early-stage (stage I-II) group, with a median number of lymph nodes examined of 15.

RESULTS

1. The overall pCR rate was 35% in the control group and 45% in the Dato+Durva group. The overall pCR rate was 35% in the control group and 45% in the Dato+Durva group.

CONCLUSIONS

Combining neoadjuvant treatment regimens with Dato+Durva may result in higher pCR rates and decrease the number of lymph nodes examined.

RESPONSE RATES BY TUMOR SIZE AND Lymph Node Status



RESPONSE RATES BY TUMOR SIZE AND Lymph Node Status



A randomized, multicenter, open-label, phase III trial comparing anthracyclines followed by taxane versus anthracyclines followed by taxane plus carboplatin as (neo) adjuvant therapy in patients with early triple-negative breast cancer: Korean Cancer Study Group BR 15-1 PEARLY trial
 Sohn J, et al. Abstract LBA502

STUDY POPULATION

1. 1000 patients with early-stage breast cancer, including 500 in each arm. All patients were triple-negative breast cancer (TNBC) and had a clinical T1-T2 and N0-N1 disease. The median age was 50 years. All patients were newly diagnosed and had not received any prior systemic anticancer therapy. The primary endpoint was overall survival (OS) at 5 years. The secondary endpoints were disease-free survival (DFS), time to recurrence (TTR), and time to distant recurrence (TDR). The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Boards of all participating institutions.

DESIGN

2. This was a randomized, multicenter, open-label, phase III trial. Patients were randomized to receive either anthracycline followed by taxane (AT) or anthracycline followed by taxane plus carboplatin (ATC) as (neo) adjuvant therapy. The primary endpoint was OS at 5 years. The secondary endpoints were DFS, TTR, and TDR.

KEY RESULTS

3. The primary endpoint, OS at 5 years, was not significantly different between the AT and ATC groups. However, the ATC group showed a significantly higher rate of grade 3/4 neutropenia and a higher rate of grade 3/4 thrombocytopenia compared to the AT group.

OS (5-YEAR)



RESPONSE RATE (RR) AT 5 YEARS



Phase II study of neoadjuvant ipilimumab and nivolumab in combination with paclitaxel following anthracycline-based chemotherapy in patients with treatment resistant stage III triple negative breast cancer (TNBC): BCT1702—Survival results

Loi S, et al. Abstract 608

STUDY POPULATION

100 patients with stage III TNBC, who were not eligible for standard of care (SOC) treatment, were enrolled in this study. All patients had received prior anthracycline-based chemotherapy. The median age was 55 years (range 35-75). The majority of patients (70%) had received prior endocrine therapy. The median time from diagnosis to enrollment was 12 months. All patients were treated with SOC (paclitaxel, epirubicin, cyclophosphamide) for 12 weeks. The median time from SOC completion to enrollment was 12 weeks. The median time from enrollment to randomization was 12 weeks. The median time from randomization to treatment start was 12 weeks. The median time from treatment start to death was 12 weeks.

RESULTS

100 patients were randomized to either the SOC group (n=50) or the combination group (n=50). The median overall survival (OS) was 12 months in the SOC group and 18 months in the combination group. The median time to death was 12 months in the SOC group and 18 months in the combination group.

CONCLUSIONS

Combining neoadjuvant ipilimumab and nivolumab with SOC significantly improved OS in patients with treatment resistant stage III TNBC.

OS: TIME TO DEATH BY TREATMENT GROUP



RESPONSE: BEST OVERALL RESPONSE RATE



EPICS

Key Insights

Advances in Early TNBC

No practice-changing data for early TNBC were presented at ASCO 2024

- Adjuvant chemotherapy in early TNBC: A phase III study of cyclophosphamide, epirubicin, and fluorouracil (CEF) versus cyclophosphamide, epirubicin, and fluorouracil plus docetaxel (CEFD) in patients with early TNBC. – ASCO Abstract 5000P**
 - Experts believe the combination of cyclophosphamide, epirubicin, and fluorouracil (CEF) is standard of care for early TNBC, and these combinations can potentially be improved.
- Preoperative chemotherapy and efficacy results from phase III study of cyclophosphamide, epirubicin, and fluorouracil (CEF) versus cyclophosphamide, epirubicin, and fluorouracil plus docetaxel (CEFD) in patients with early TNBC. – ASCO Abstract 5000P**
 - The regimen is seen as effective, working well, and broadly applicable to many patients.
- Neoadjuvant systemic chemotherapy for early-stage patients with breast TNBC: continue to show promising safety and efficacy with durable complete responses. – ASCO Abstract 5000P**
 - This approach is seen as a great option for a patient population in which giving chemotherapy is difficult. It is seen as effective and safe.
- Phase III study of cyclophosphamide, epirubicin, and fluorouracil (CEF) versus cyclophosphamide, epirubicin, and fluorouracil plus docetaxel (CEFD) in patients with early TNBC. – ASCO Abstract 5000P**
 - Experts believe the combination of cyclophosphamide, epirubicin, and fluorouracil (CEF) is safe. However, they would like to see phase III data to confirm its safety in this setting.
- Long-term outcomes from a phase III study of cyclophosphamide plus epirubicin plus fluorouracil (CEF) versus cyclophosphamide plus epirubicin plus fluorouracil plus docetaxel (CEFD) in patients with early TNBC. – ASCO Abstract 5000P**
 - The CEFD regimen is seen as useful in the specific patient population with advanced disease. It was noted to be effective, very safe, and well-tolerated. Some of the responses were seen early, very quickly.

EPICS

Congress Highlights

Advances in mTNBC

Enfortumab vedotin (EV) in triple-negative breast cancer (TNBC) and HR+/HER2- breast cancer (BC) cohorts of EV-202

Giordano A, et al. Abstract 1005

BACKGROUND

STUDY POPULATION

1000 patients with TNBC and 1000 patients with HR+/HER2- BC. All patients received EV (300 mg IV q3w) + standard of care (SOC). In TNBC, SOC included paclitaxel, epirubicin, and cyclophosphamide (EP-C). In HR+/HER2- BC, SOC included tamoxifen or endocrine therapy and chemotherapy. The primary endpoint was overall survival (OS) at 12 weeks. Secondary endpoints included progression-free survival (PFS), time to next treatment (TTNT), and quality of life (QoL). OS was significantly improved in the EV group in both cohorts (p < 0.001).

RESULTS

OS at 12 weeks was significantly improved in the EV group in both cohorts (p < 0.001). TTNT was also significantly improved in the EV group in both cohorts (p < 0.001).

KEY CONCLUSIONS

Combining endocrine therapy with EV improved OS in HR+/HER2- BC patients and decreased the need for chemotherapy in TNBC patients.

Triple-Negative Breast Cancer

OS: OS AT 12 WEEKS IN THE EV-202 TNBC COHORT



RESPONSE: OS AT 12 WEEKS IN THE EV-202 HR+/HER2- COHORT



Sacituzumab tirumotecan (SKB264/MK-2870) in patients (pts) with previously treated locally recurrent or metastatic triple-negative breast cancer (TNBC): Results from the phase III OptiTROP-Breast01 study

Xu B, et al. Abstract 104

STUDY POPULATION

1000 pts, 500 in each arm. All pts had locally recurrent or metastatic TNBC, ECOG performance grade 0-1, no prior treatment with docetaxel, paclitaxel, epirubicin, or cyclophosphamide. Median age 60 years. All pts had received prior treatment with docetaxel, paclitaxel, epirubicin, or cyclophosphamide. The primary endpoint is ORR. Secondary endpoints include progression-free survival, overall survival, and quality of life.

RESULTS

ORR was 33.2% in the SKB264/MK-2870 arm vs 24.8% in the control arm. Median progression-free survival was 6.5 months vs 5.8 months. Median overall survival was 10.2 months vs 9.8 months.

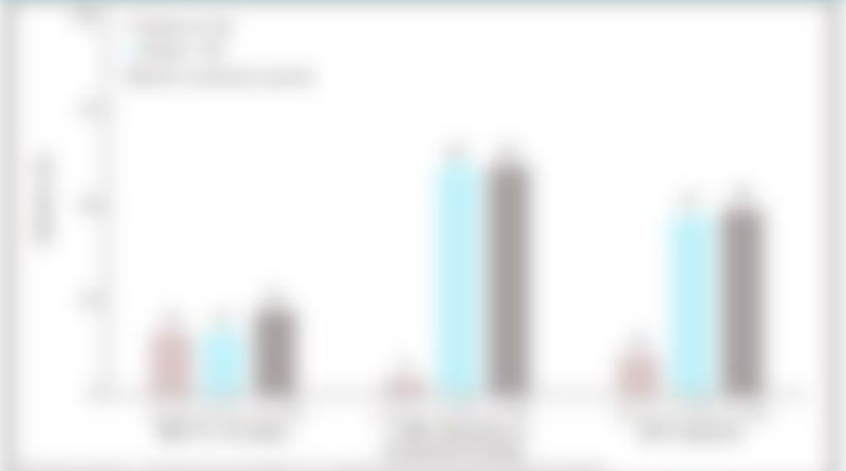
CONCLUSIONS

Combining sacituzumab and tirumotecan improved ORR, progression-free survival, and overall survival compared to the control arm in patients with TNBC.

ORR AND PROGRESSION-FREE SURVIVAL IN THE SKB264/MK-2870 ARM



RESPONSE, PROGRESSION-FREE SURVIVAL, AND OVERALL SURVIVAL BY TREATMENT



Sequential combination of sacituzumab govitecan and talazoparib in metastatic triple negative breast cancer (mTNBC): Results from a phase II study

Occhiogrosso Abelman R, et al. Abstract 1102

BACKGROUND

STUDY POPULATION

100 patients were enrolled with a 100% completion rate. All patients had a confirmed diagnosis of mTNBC, ECOG performance grade 0-1, and had not received prior systemic therapy for mTNBC. The median age was 61 years, range 45-82 years. The median number of prior lines of systemic therapy was 2 (range 1-5). The median time to treatment discontinuation was 11.6 weeks (range 0-34.4 weeks). The median overall survival was 11.6 weeks (range 0-34.4 weeks). The median time to treatment discontinuation was 11.6 weeks (range 0-34.4 weeks). The median overall survival was 11.6 weeks (range 0-34.4 weeks).

RESULTS

100 patients were enrolled. The overall survival was 11.6 weeks. The median time to treatment discontinuation was 11.6 weeks. The median overall survival was 11.6 weeks. The median time to treatment discontinuation was 11.6 weeks.

CONCLUSIONS

The sequential combination of sacituzumab govitecan and talazoparib demonstrated a promising safety profile and improved clinical outcomes in patients with mTNBC.

TOXICITY PROFILE (GRADE 3/4 ADVERSE EVENTS)



RESPONSE EVALUATION (BEST OVERALL TREATMENT RESPONSE)



Ipatasertib (IPA) combined with non-taxane chemotherapy (CT) for patients (pts) with previously treated advanced triple-negative breast cancer (aTNBC): The PATHFINDER phase IIa trial

Gion M, et al. Abstract 1098

BACKGROUND

STUDY POPULATION

1098 pts with previously treated aTNBC, including 500 pts with a history of taxane treatment and 598 pts without taxane treatment. All pts had ECOG performance grade 0-1, no prior systemic therapy for advanced disease, and no prior treatment with a taxane. The median time to progression was 11.5 months. The median time to death was 15.5 months. The median time to death was 15.5 months. The median time to death was 15.5 months.

RESULTS

1098 pts were enrolled in the trial. 500 pts received IPA + CT and 598 pts received CT alone. The median time to progression was 11.5 months in the IPA + CT group and 10.5 months in the CT alone group. The median time to death was 15.5 months in the IPA + CT group and 14.5 months in the CT alone group.

CONCLUSIONS

Combining ipatasertib with non-taxane chemotherapy improved progression-free survival and overall survival in patients with previously treated advanced triple-negative breast cancer.

Figure 2: Progression-free survival

Figure 3: Overall survival



RESPONSE RATE (RR) IN PATIENTS WHO RECEIVED IPA + CT



EPICS

Key Insights

Advances in mTNBC

No practice-changing data for mTNBC were presented at ASCO 2024

- Immunotherapy in mTNBC: A Phase II Study**
 - Experts believe the combination of immunotherapy is possible to use here, and these combinations are potentially to be tested
- Preexisting comorbidity and efficacy results from phase III study of immunotherapy with pembrolizumab in mTNBC**
 - The regimen is seen as effective, working well, and broadly applicable to many patients
- Immunotherapy versus chemotherapy for early-stage patients with HER2+ mTNBC: continues to show promising safety and efficacy with durable complete responses**
 - This approach is seen as a great option for a patient population in which giving immunotherapy is difficult. It is viewed as effective and safe
- Immunotherapy in mTNBC: A phase II study to assess safety of immunotherapy in combination with pembrolizumab in patients with mTNBC**
 - Experts believe the combination of immunotherapy with pembrolizumab is safe. However, they would like to see phase III data to confirm its safety in this setting
- Long-term outcomes from a phase II study of immunotherapy plus pembrolizumab in patients with mTNBC**
 - The immunotherapy regimen is seen as useful in the specific patient population with advanced disease. It was noted to be effective, very safe, and well-tolerated. Some of the responses were seen early, very durable



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