MADRID 2023 ESMO congress

Cancers du sein

Sylvain LADOIRE

MADRID SPAIN
20-24 OCTOBER 2023

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

Cancers du sein triples négatifs

(NEO)ADJUVANT

Pembrolizumab or Placebo + Chemotherapy Followed by Pembrolizumab or Placebo for Early-Stage Triple-Negative Breast Cancer: Updated Event-Free Survival Results from the Phase 3 KEYNOTE-522 Study

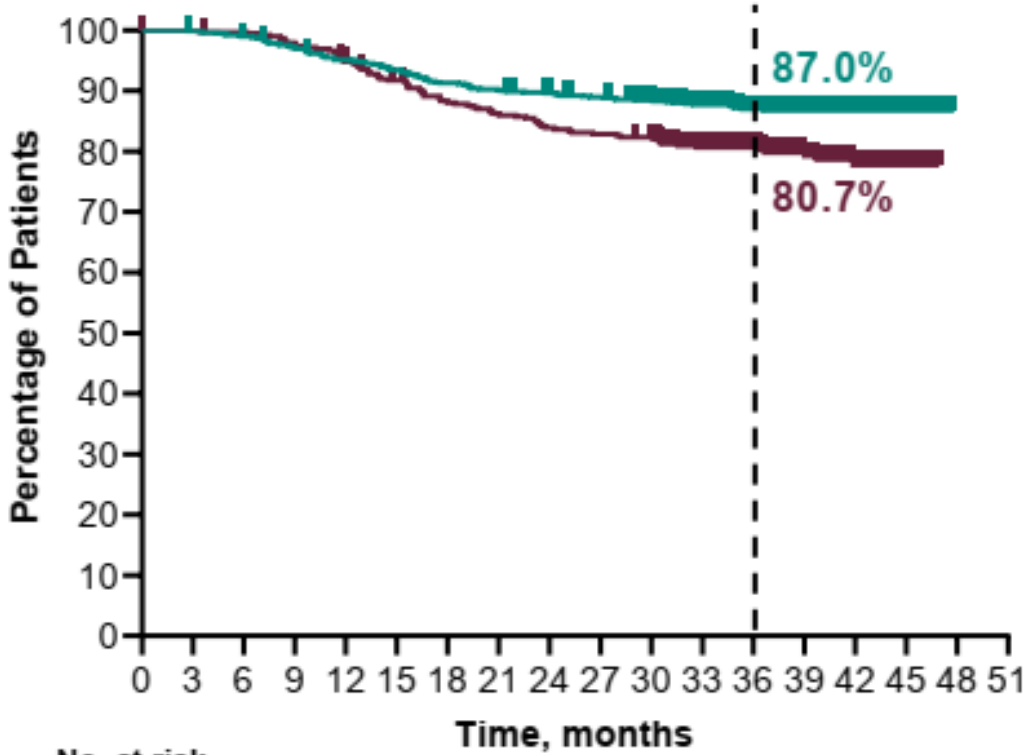
Median FU: 63 months

Peter Schmid[1], Javier Cortes[2], Rebecca Dent[3], Lajos Pusztai[4], Heather McArthur[5], Sherko Kümmel[6], Carsten Denkert[7], Yeon Hee Park[8], Rina Hui[9], Nadia Harbeck[10], Masato Takahashi[11], Theodoros Foukakis[12], Marie-Ange Mouret-Reynier[13], Marta Ferreira[14], Seock-Ah Im[15], Fatima Cardoso[16], Yu Ding[17], Wilbur Pan[17], Konstantinos Tryfonidis[17], Joyce O'Shaughnessy[18]

[1]Centre for Experimental Cancer Medicine, Barts Cancer Institute, Queen Mary University London, London, UK; [2]International Breast Cancer Center, Quironsalud Group, Barcelona, Spain and Universidad Europea de Madrid, Faculty of Biomedical and Health Sciences, Department of Medicine, Madrid, Spain; [3]National Cancer Centre Singapore, Duke – National University of Singapore Medical School, Singapore; [4]Yale School of Medicine, Yale Cancer Center, New Haven, CT, USA; [5]University of Texas Southwestern Medical Center, Dallas, TX, USA; [6]Breast Unit, Kliniken Essen-Mitte, Essen, Germany and Charité – Universitätsmedizin Berlin, Department of Gynecology with Breast Center, Berlin, Germany; [7]Institute of Pathology, Philipps-University Marburg and University Hospital Marburg, Marburg, Germany; [8]Samsung Medical Center, Sungkyunkwan University School of Medicine, Seoul, Republic of Korea; [9]Westmead Breast Cancer Institute, Westmead Hospital and the University of Sydney, Sydney, NSW, Australia and Centre of Cancer Medicine, School of Clinical Medicine, University of Hong Kong, Hong Kong; [10]Breast Center, Dept. OB&GYN, LMU University Hospital, Munich, Germany; [11]Hokkaido University Hospital, Sapporo, Japan; [12]Department of Oncology-Pathology, Karolinska Institutet and Breast Cancer Centre, Cancer theme, Karolinska University Hospital, Solna, Sweden; [13]Centre Jean-Perrin, Clermont-Ferrand, France; [14]Instituto Português de Oncologia do Porto Francisco Gentil (IPO-Porto), Porto, Portugal; [15]Seoul National University, Seoul, Republic of Korea; [16]Breast Unit, Champalimaud Clinical Center/Champalimaud Foundation, Lisbon, Portugal; [17]Oncology, Merck & Co., Inc., Rahway, NJ, USA; [18]Baylor University Medical Center, Texas Oncology, US Oncology Network, Dallas, TX, USA

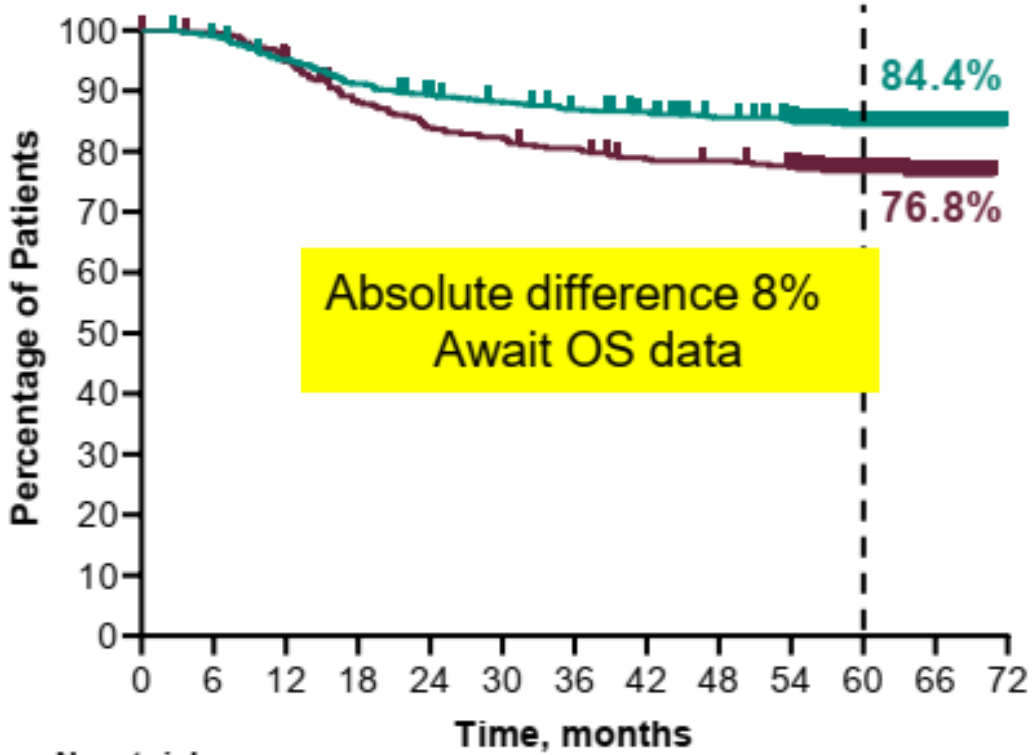
KEYNOTE-544 Distant Recurrence-Free Survival

IA4	Events	HR (95% CI)
Pembro + Chemo/Pembro	12.8%	0.61[a] (0.46-0.82)
Placebo + Chemo/Placebo	20.3%	



Data cutoff date: March 23, 2021.

IA6	Events	HR (95% CI)
Pembro + Chemo/Pembro	15.3%	0.64[a] (0.49-0.84)
Placebo + Chemo/Placebo	23.1%	

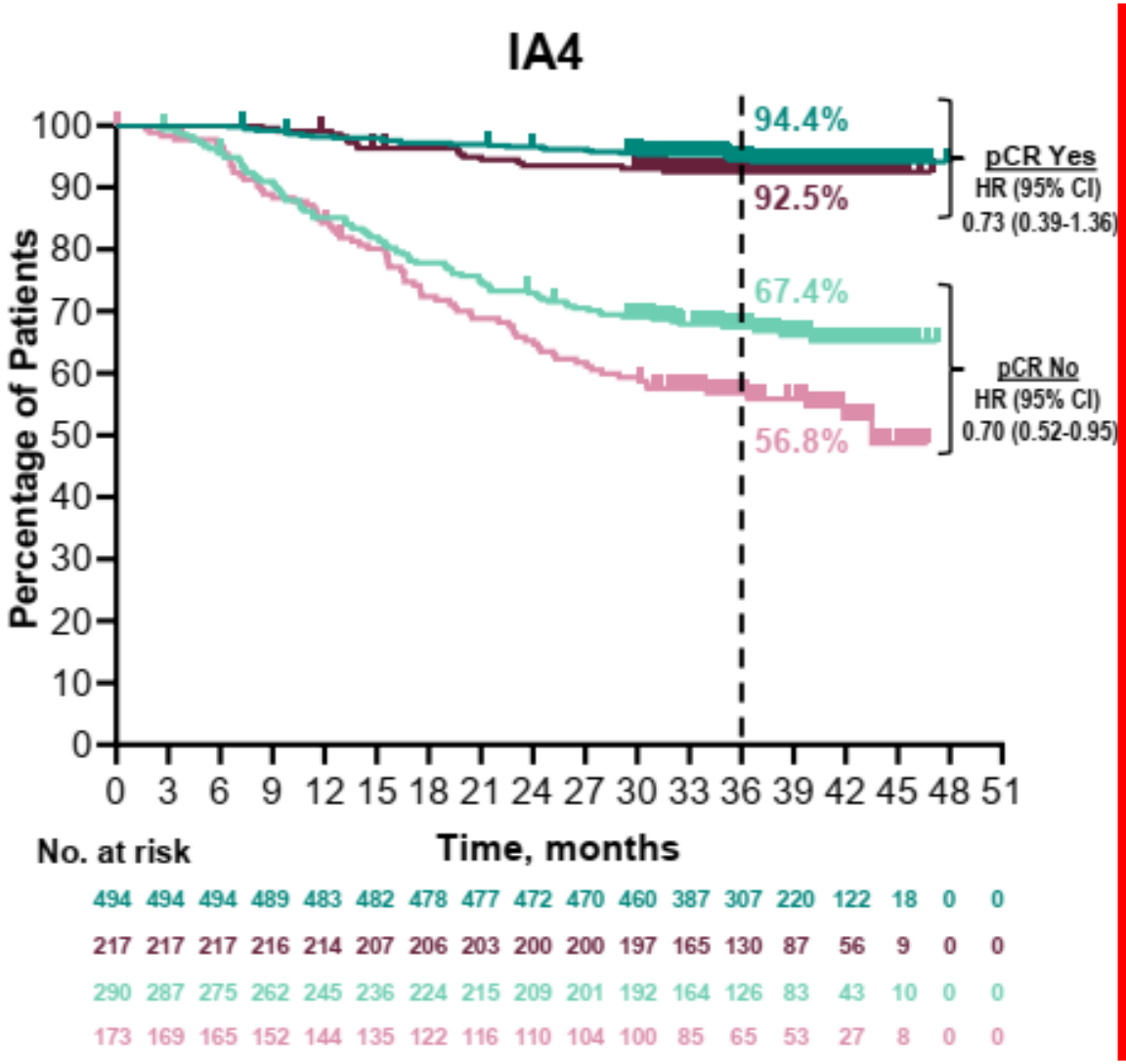


Data cutoff date: March 23, 2023.

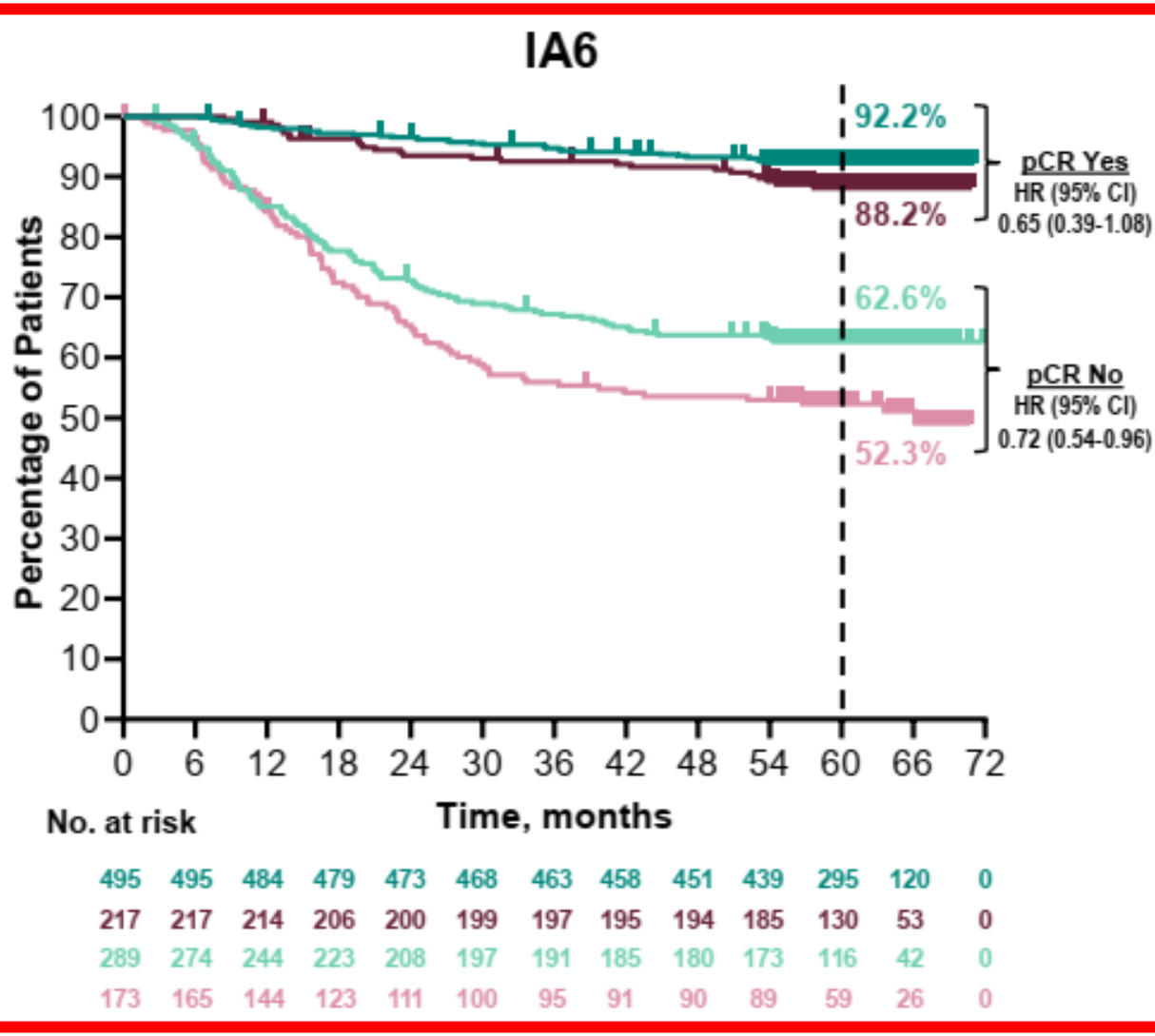
[a]Hazard ratio (CI) analyzed based on a Cox regression model with treatment as a covariate stratified by the randomization stratification factors.

Schmid et al, LBA 18, ESMO 2023

KEYNOTE-522 EFS by pCR (ypT0/Tis ypN0)



Data cutoff date: March 23, 2021.



Data cutoff date: March 23, 2023.

Schmid et al, LBA 18, ESMO 2023

Cancers du sein triples négatifs

METASTATIQUE

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https://bit.ly/45YZac9

Datopotamab Deruxtecan (Dato-DXd) + Durvalumab (D) as First-Line (1L) Treatment for Unresectable Locally Advanced/Metastatic Triple-Negative Breast Cancer (a/mTNBC)

Updated Results From BEGONIA, a Phase 1b/2 Study

Professor Peter Schmid, FRCP, MD, PhD

Barts Cancer Institute, Queen Mary University of London, London, UK

P. J. Wysocki,[1] C. X. Ma,[2] Y. H. Park,[3] R. Fernandes,[4] S. Lord,[5] R. D. Baird,[5] C. Prady,[7] K. H. Jung,[8] J. Asselah,[9] R. Huisden,[10] R. Stewart,[10] K. Heider,[10] P. Vukovic,[10] N. Denduluri,[11] Z. Nowecki[12]

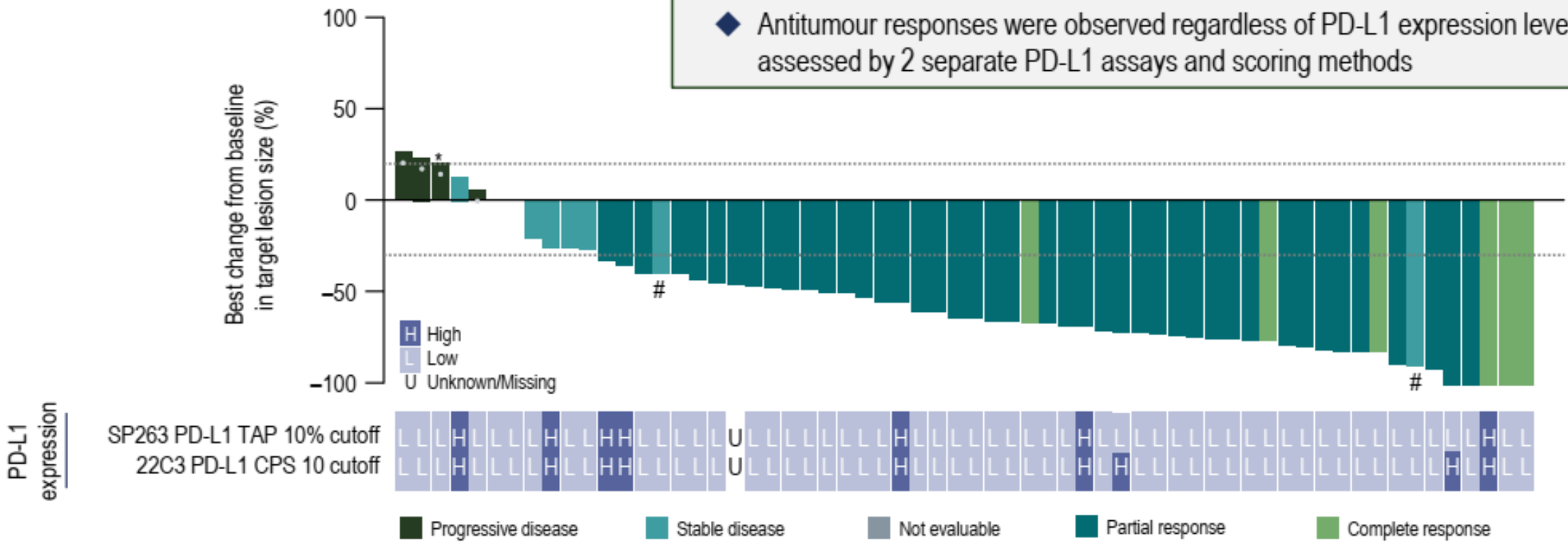
[1]Jagiellonian University Medical College, Krakow, Poland; [2]Washington University School of Medicine, St. Louis, MO, USA; [3]Samsung Medical Center, Sungkyunkwan University School of Medicine, Seoul, Korea; [4]Schulich School of Medicine & Dentistry, Western University, London Health Sciences Centre, London, Ontario, Canada; [5]University of Oxford, Oxford, UK; [6]Cancer Research UK Cambridge Centre, Cambridge, UK; [7]Sherbrooke University, Centre intégré de cancérologie de la Montérégie, CISSS Montérégie Centre, Greenfield Park, Quebec, Canada; [8]Asan Medical Center - University of Ulsan, College of Medicine, Seoul, Korea; [9]McGill University Health Centre, Montreal, Québec, Canada; [10]AstraZeneca, Cambridge, UK; [11]AstraZeneca, Gaithersburg, MD, USA; [12]Maria Skłodowska-Curie National Research Institute of Oncology, Warsaw, Poland

BEGONIA Arm 7: Dato-DXd + Durvalumab

Antitumour Responses in 1L a/mTNBC

Confirmed ORR was **79%** (49/62; 95% CI, 66.8–88.3) with 6 CR and 43 PR

- Antitumour responses were observed regardless of PD-L1 expression level as assessed by 2 separate PD-L1 assays and scoring methods



Dotted lines indicate thresholds for partial response (−30%) and progressive disease (20%). PD-L1 expression was assessed by 1) immunohistochemistry using the VENTANA PD-L1 (SP263) Assay with expression defined as the percentage of the tumour area populated by tumour or immune cells with membranous staining (TAP), or 2) immunohistochemistry using the 22C3 antibody with expression defined as the number of PD-L1–staining tumour cells, lymphocytes, and macrophages, divided by the total number of viable tumour cells, multiplied by 100 (CPS). *If the best percentage change from baseline of target lesions cannot be calculated due to progression, withdrawal, or death, the value is imputed at +20%. *•* Patients with PD as best overall response. #Unconfirmed response.

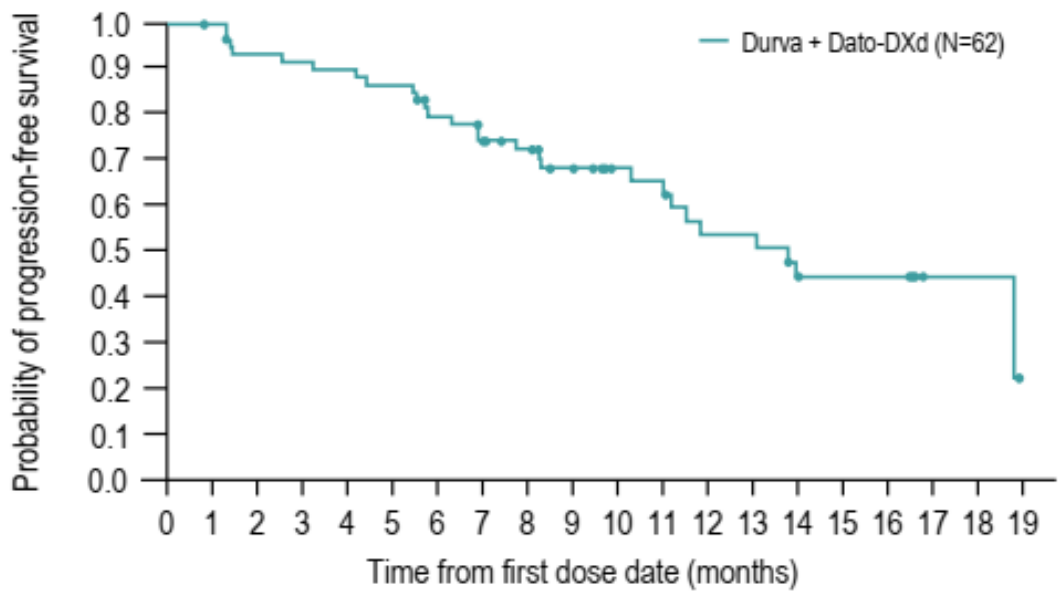
1L, first line; a/m TNBC, advanced/metastatic triple–negative breast cancer; CI, confidence interval; CPS, combined positive score; CR, complete response; Dato-DXd, datopotamab deruxtecan; ORR, objective response rate; PD-L1, programmed cell death ligand-1; PR, partial response; TAP, tumour area positivity.

Data cutoff: 02 Feb 2023

BEGONIA Arm 7: Dato-DXd + Durvalumab

Progression-Free Survival and Duration of Response

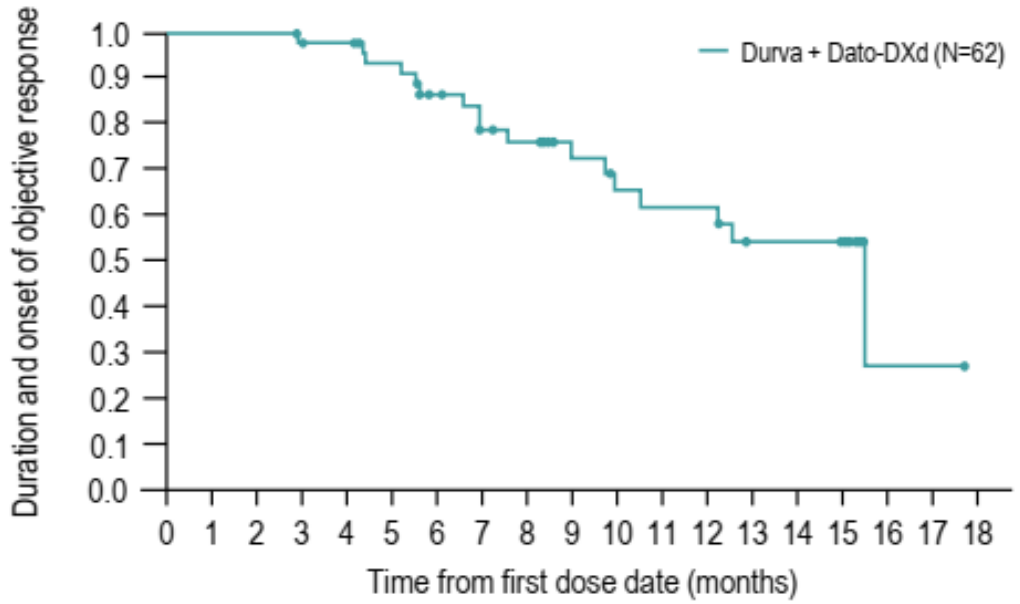
Median PFS was 13.8 months (95% CI, 11.0–NC)



Number of patients at risk

Durva + Dato-DXd	62	61	56	55	54	52	45	40	37	32	24	23	18	18	14	13	13	2	2	0

Median DoR was 15.5 months (95% CI, 9.92–NC)



Number of patients at risk

Durva + Dato-DXd	49	49	49	47	46	42	35	30	28	21	18	17	17	13	13	12	1	1	0

Kaplan-Meier analysis was performed. Circles indicate censored observations.
CI, confidence interval; Dato-DXd, datopotamab deruxtecan; DoR, duration of response; NC, not calculable; PFS, progression-free survival.

Data cutoff: 02 Feb 2023

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A First-in-Human Phase I Trial of HS-20089, a B7-H4 ADC, in Patients with Advanced Solid Tumors

J. Wu[1,2,*], J. Zhang[1,3,*], H. Li[4], X. Wang[5], Q.Y. Zhang[6], Y. Shi[7], M. yan[8], Y. Pan[9], A. Shen[10], Q. Chen[11], Q.Rao[11], H. Wei[12], C. Li[12], L. Yang[12], Q. Huang[12], Z. Cao[12], Q. Wu[12]

[1]Department of Oncology, Shanghai Medical College, Fudan University, Shanghai, China, [2]Department of Breast Surgery, Fudan University Shanghai Cancer Center, Shanghai, China, [3]Phase Ⅰ Clinical Trial Center, Fudan University Shanghai Cancer Center, Shanghai, China, [4]Medical Oncology, Peking University Cancer Hospital and Institute, Beijing, China, [5]Medical Oncology, Zhejiang Cancer Hospital – Cancer Research Institute, Hangzhou, China, [6]Medical Oncology, 3rd Affiliated Hospital of Harbin Medical University, Harbin, China, [7]Medical oncology department of breast cancer, TMUCIH - Tianjin Medical University Cancer Institute and Hospital, Tianjin, China, [8]Medical Oncology, Henan Cancer Hospital/Affiliated Cancer Hospital of Zhengzhou University, Zhengzhou, China, [9]Oncology Dept, Anhui Provincial Hospital, Hefei, China, [10]Clinical Research, The First Affiliated Hospital of USTC/ Anhui Provincial Hospital, Hefei, China, [11]Medical Oncology, Sun Yat-Sen Memorial Hospital, Guangzhou, China, [12]Department of Oncology Medicine, Hansoh Pharma Group CO.,LTD., Shanghai, China

* Contributed equally

Dr Jian Zhang

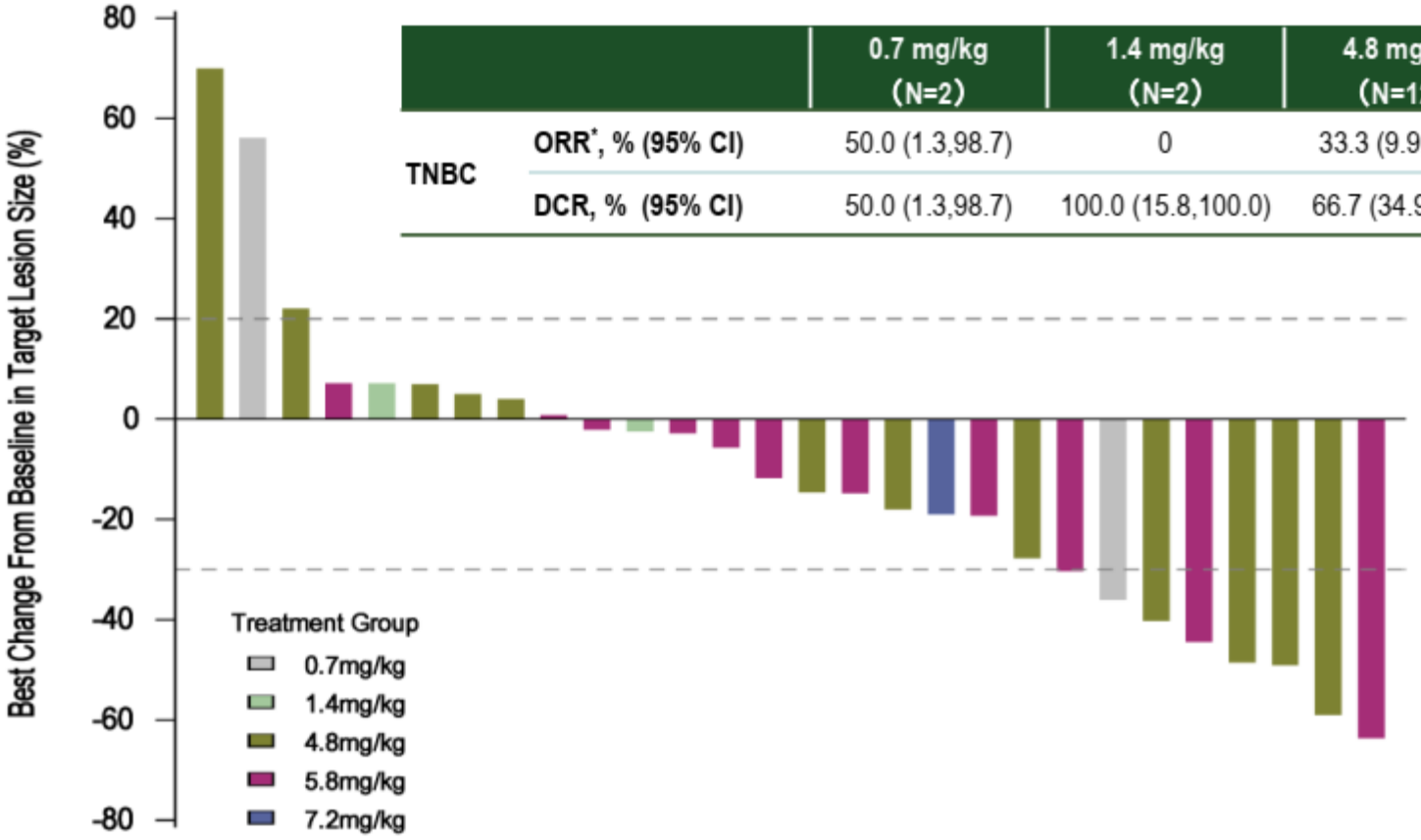
Madrid Spain, 21. 10. 2023

Efficacy - TNBC

- HS-20089 showed promising anti-tumor activity in triple-negative breast cancer (TNBC).
- At potential target therapeutic doses of 4.8 and 5.8 mg/kg, the ORR were 33.3% and 27.3%, respectively.

≥ L3

Figure 5. Best Percent Change of Target Lesions in TNBC



		0.7 mg/kg (N=2)	1.4 mg/kg (N=2)	4.8 mg/kg (N=12)	5.8 mg/kg (N=11)	7.2 mg/kg (N=1)	Total (N=28)
TNBC	ORR*, % (95% CI)	50.0 (1.3,98.7)	0	33.3 (9.9,65.1)	27.3# (6.0,61.0)	0	28.6 (13.2,48.7)
	DCR, % (95% CI)	50.0 (1.3,98.7)	100.0 (15.8,100.0)	66.7 (34.9,90.1)	81.8 (48.2,97.7)	100.0 (2.5,100.0)	75.0 (55.1,89.3)

*Assessed according to RECIST 1.1 by investigators.
#Including 1 confirmed PR and 2 PRs awaiting confirmation. Others were confirmed PRs.
ORR: Objective response rate.
DCR: Disease control rate.
PR: Partial response.

Clinical cutoff: August 17, 2023

Cancers du sein HER2 amplifiés

METASTATIQUE

MADRID 2023 ESMO congress

A Pooled Analysis of Trastuzumab Deruxtecan in Patients With HER2-Positive Metastatic Breast Cancer With Brain Metastases (BMs) from DESTINY-Breast01, -02, and -03

Presentation 3770

Sara A. Hurvitz[1], Shanu Modi, Wei Li, Yeon Hee Park, Wei-Pang Chung, Sung-Bae Kim, Javier Cortes, Toshinari Yamashita, Jose Luiz Pedrini, Seock-Ah Im, Ling-Ming Tseng, Nadia Harbeck, Ian Krop, Giuseppe Curigliano, Elton Mathias, Jillian Cathcart, Antonio Cagnazzo, Shahid Ashfaque, Anton Egorov, Fabrice André

On behalf of the DESTINY-Breast01, -02, and -03 pooled investigators

[1]Fred Hutchinson Cancer Center, University of Washington School of Medicine, Seattle, WA, USA

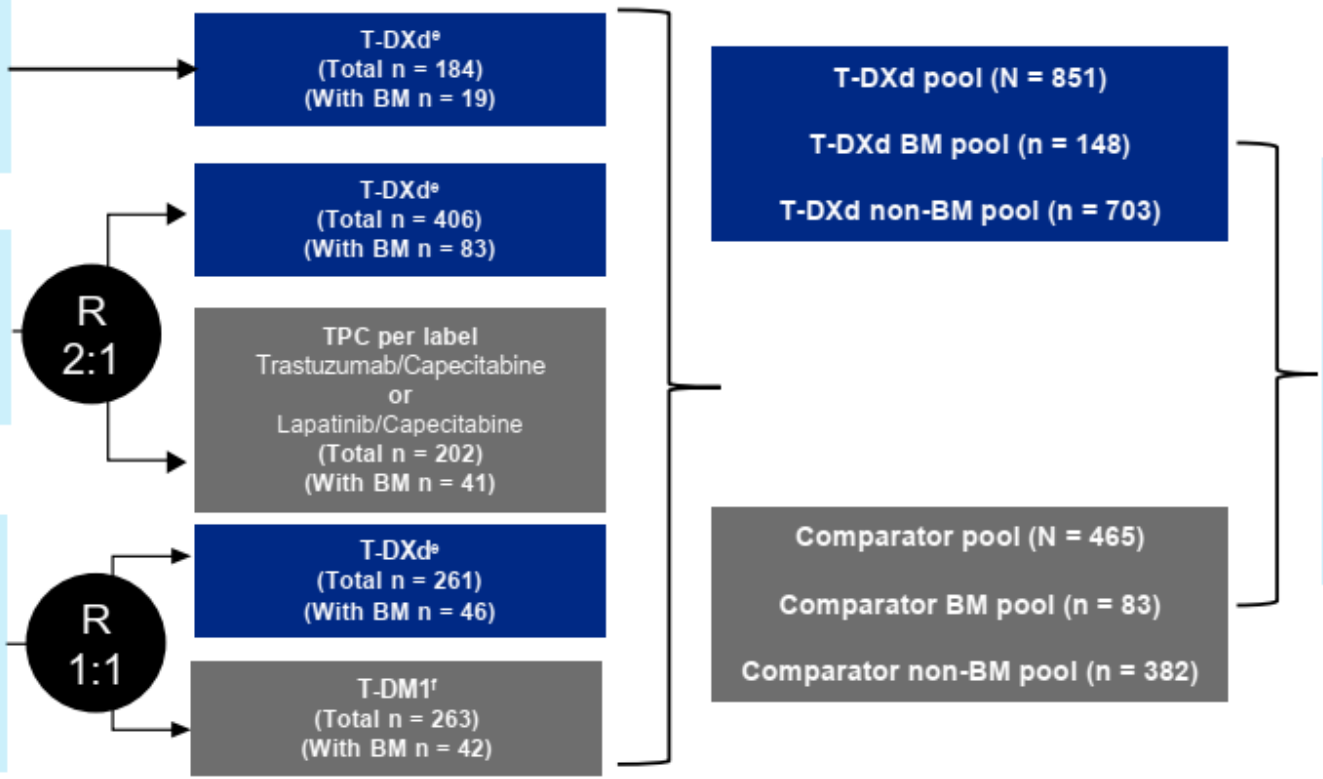
Madrid, Spain, October 20-24, 2023

Retrospective Exploratory Pooled Analysis Plan[1-3]

DESTINY-Breast01 (N = 253)[a,b]
- Phase II study
- Patients previously treated with T-DM1
- Patients with asymptomatic and previously locally treated BM eligible
- Prior BM therapy within 60 days prohibited

DESTINY-Breast02 (N = 608)[a,c]
- Phase III study
- Patients previously treated with T-DM1
- Patients with asymptomatic and previously treated/untreated BM eligible
- Prior BM therapy within 14 days of randomization prohibited

DESTINY-Breast03 (N = 524)[a,d]
- Phase III study
- Patients previously treated with trastuzumab and a taxane in metastatic or (neo)adjuvant setting with recurrence within 6 months of therapy
- Patients with asymptomatic and previously treated/untreated BM eligible
- Prior BM therapy within 14 days of randomization prohibited



Endpoints:
- IC-ORR (CR+PR in brain) per BICR per RECIST v1.1
- IC-DoR per BICR
- CNS-PFS per BICR
- Safety and tolerability

- **The BM and non-BM pools were determined by BICR at baseline among all patients based on mandatory brain CT/MRI screening**

BICR, blinded independent central response; BM, brain metastasis; CNS, central nervous system; CR, complete response; CT, computed tomography; DB, DESTINY-Breast; DoR, duration of response; HER2, human epidermal growth factor receptor 2; IC, intracranial; mBC, metastatic breast cancer; MRI, magnetic resonance imaging; ORR, objective response rate; PFS, progression-free survival; PR, partial response; R, randomization; RECIST v1.1, Response Evaluation Criteria in Solid Tumors version 1.1; T-DM1, trastuzumab emtansine; T-DXd, trastuzumab deruxtecan; TPC, treatment of physician's choice (trastuzumab/capecitabine or lapatinib/capecitabine).
Data for patients in the 5.4 mg/kg T-DXd arms were pooled from the DB-01, DB-02, and DB-03 trials. Comparator data were pooled from the DB-02 and DB-03 trials. All three studies were conducted in unresectable/mBC; HER2 status was confirmed centrally; and a documented radiographic progression after most recent treatment was required.
[a]The presence of BMs was not a stratification factor. [b]Data Cutoff: March 26, 2021. [c]Data Cutoff: June 30, 2022. [d]Data Cutoff: May 21, 2021. [e]5.4 mg/kg Q3W. [f]3.6 mg/kg Q3W.
1. Modi S et al. *N Engl J Med*. 2020; 382:610-621 [article and supplementary appendix]. 2. André F et al. *The Lancet*. 2023. https://doi.org/10.1016/S0140-6736(23)00725-0 [article and supplementary appendix]. 3. Cortes J et al. *N Engl J Med*. 2022; 368(12):1143-1154 [article and supplementary appendix].

Prior Systemic and Local BM Therapies

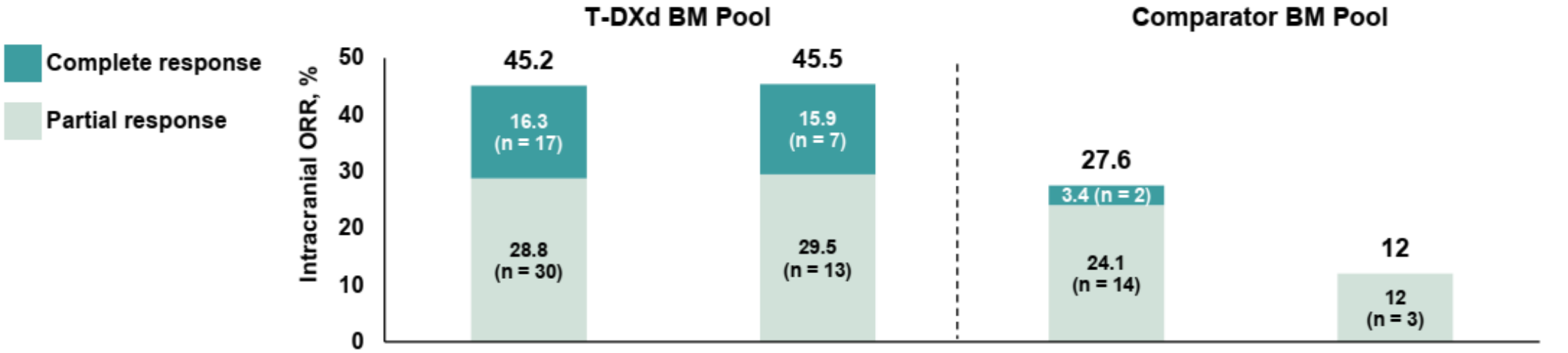
	T-DXd Pool (N = 851)		Comparator Pool (N = 465)	
	BM Pool (n = 148)	Non-BM Pool (n = 703)	BM Pool (n = 83)	Non-BM Pool (n = 382)
Prior regimens in the metastatic setting, Median, (range), n (%)	**3.0 (1.0-14.0)**	**3.0 (0-27.0)**	**3.0 (1.0-15.0)**	**2.0 (0-12.0)**
0	0	2 (0.3)	0	1 (0.3)
1	16 (10.8)	108 (15.4)	14 (16.9)	99 (25.9)
2	41 (27.7)	192 (27.3)	27 (32.5)	110 (28.8)
3	35 (23.6)	156 (22.2)	22 (26.5)	89 (23.3)
4	18 (12.2)	71 (10.1)	9 (10.8)	39 (10.2)
≥5	38 (25.7)	174 (24.8)	11 (13.3)	44 (11.5)
Prior anti-HER2 therapy, n (%)				
Trastuzumab	142 (95.9)	643 (91.5)	83 (100)	381 (99.7)
Pertuzumab	104 (70.3)	497 (70.7)	59 (71.1)	255 (66.8)
T-DM1	102 (68.9)	487 (69.3)	41 (49.4)	161 (42.1)
HER2 TKI	17 (11.5)	51 (7.3)	14 (16.9)	39 (10.2)
Prior treatment for brain metastasis, n (%)				
None (untreated/active)	**44 (29.7)**	642 (91.3)	**25 (30.1)**	359 (94.0)
Any prior treatment for BMs (treated/stable)	**104 (70.3)**	61 (8.7)[a]	**58 (69.9)**	23 (6.0)[a]
RT alone	80 (54.1)	45 (6.4)[a]	44 (53.0)	15 (3.9)[a]
Surgery alone	5 (3.4)	6 (0.9)[a]	5 (6.0)	5 (1.3)[a]
RT and surgery	19 (12.8)	10 (1.4)[a]	9 (10.8)	3 (0.8)[a]

- **Overall, patients with BM were heavily pretreated with a median of 3 prior systemic regimens in the metastatic setting**
- **In both T-DXd and comparator pools, of the patients with BMs at baseline, ~70% had treated/stable BMs and ~30% had untreated/active BMs**
  - **This was balanced between T-DXd and comparator**

BM, brain metastasis; HER2, human epidermal growth factor receptor 2; RT, radiation therapy; T-DM1, trastuzumab emtansine; T-DXd, trastuzumab deruxtecan; TKI, tyrosine kinase inhibitor.
RT includes whole-brain RT, brain-directed stereotactic RT, and brain-directed radiosurgery. Surgery includes any brain-directed surgery (craniotomy, metastasectomy in brain, resection, or removal of brain lesion).
[a]Patients with a reported history of BMs who did not have BMs at baseline.

Exploratory Best IC Response, ORR, and DoR per BICR

Intracranial ORR[a]



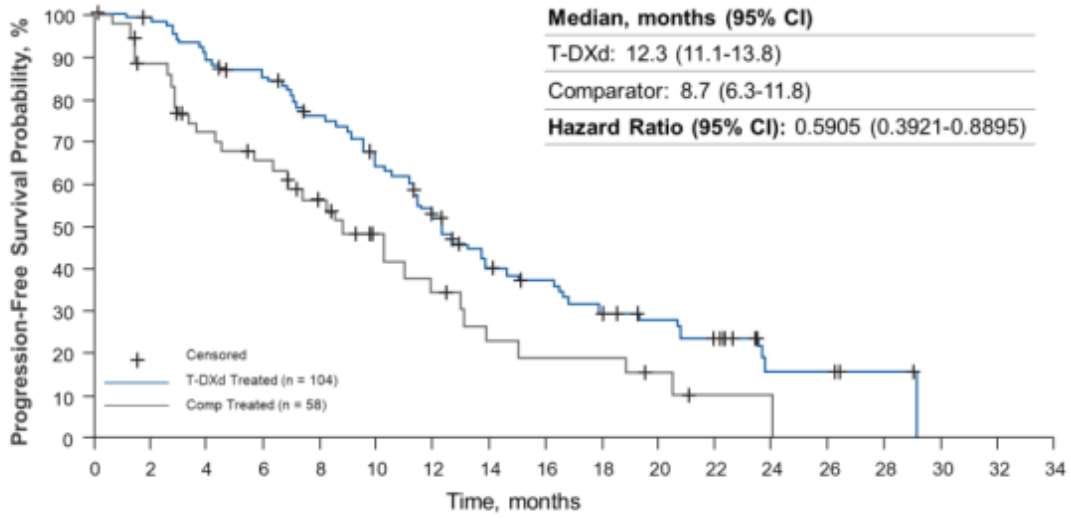
	Treated/stable BMs (n = 104)	Untreated/active BMs (n = 44)	Treated/stable BMs (n = 58)	Untreated/active BMs (n = 25)
Best overall IC response, n (%)				
Stable disease	48 (46.2)	15 (34.1)	28 (48.3)	15 (60.0)
Progressive disease	3 (2.9)	1 (2.3)	7 (12.1)	5 (20.0)
Not evaluable/Missing	6 (5.8)	8 (18.2)	7 (12.1)	2 (8.0)
IC-DoR, median, months (95% CI)	12.3 (9.1-17.9)	17.5 (13.6-31.6)	11.0 (5.6-16.0)	NA[b]

- **T-DXd consistently demonstrated superior rates of IC responses over comparator in patients with treated/stable and untreated/active BMs**
- **A trend in prolonged median IC-DoR was most pronounced in the untreated/active BMs subgroup**

BM, brain metastasis; BICR, blinded independent central review; DoR, duration of response; IC, intracranial; NA, not available; ORR, objective response rate; T-DXd, trastuzumab deruxtecan.
This table considers both target and non-target lesions at baseline. Lesions in previously irradiated areas were not considered measurable target lesions unless there was demonstrated progression in the lesion.
[a]IC-ORR was assessed per RESIST v1.1. [b]IC-DoR NA due to small number of responders (n < 10).

Exploratory CNS-PFS per BICR

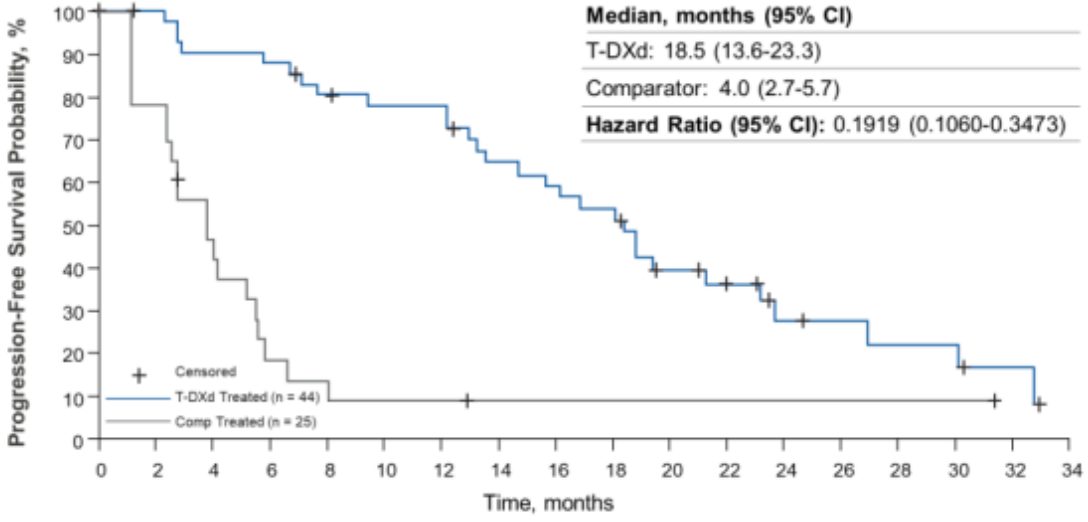
Treated/Stable BMs



Patients still at risk

T-DXd Treated (n = 104)	104	100	89	83	72	58	46	32	28	21	18	12	4	4	2	0	0	0
Comparator Treated (n = 58)	58	44	33	29	22	14	10	6	5	5	3	1	0	0	0	0	0	0

Untreated/Active BMs



Patients still at risk

T-DXd Treated (n = 44)	44	41	37	36	32	30	30	24	22	20	13	11	6	5	4	4	2	0
Comparator Treated (n = 25)	25	18	11	5	3	2	2	1	1	1	1	1	1	1	1	1	0	0

- **T-DXd demonstrated a trend towards prolonged CNS-PFS over comparator, with a noticeably greater advantage for patients with untreated/active BMs**

BICR, blinded independent central review; BM, brain metastasis; CNS, central-nervous system; PFS, progression-free survival; T-DXd, trastuzumab deruxtecan.
CNS-PFS was defined by BICR as only radiological progression.

Cancers du sein RH+/HER2 non amplifié

(NEO)ADJUVANT

MADRID 2023 ESMO congress

Adjuvant abemaciclib plus endocrine therapy for HR+, HER2-, high-risk early breast cancer: results from a preplanned monarchE overall survival interim analysis, including 5-year efficacy outcomes

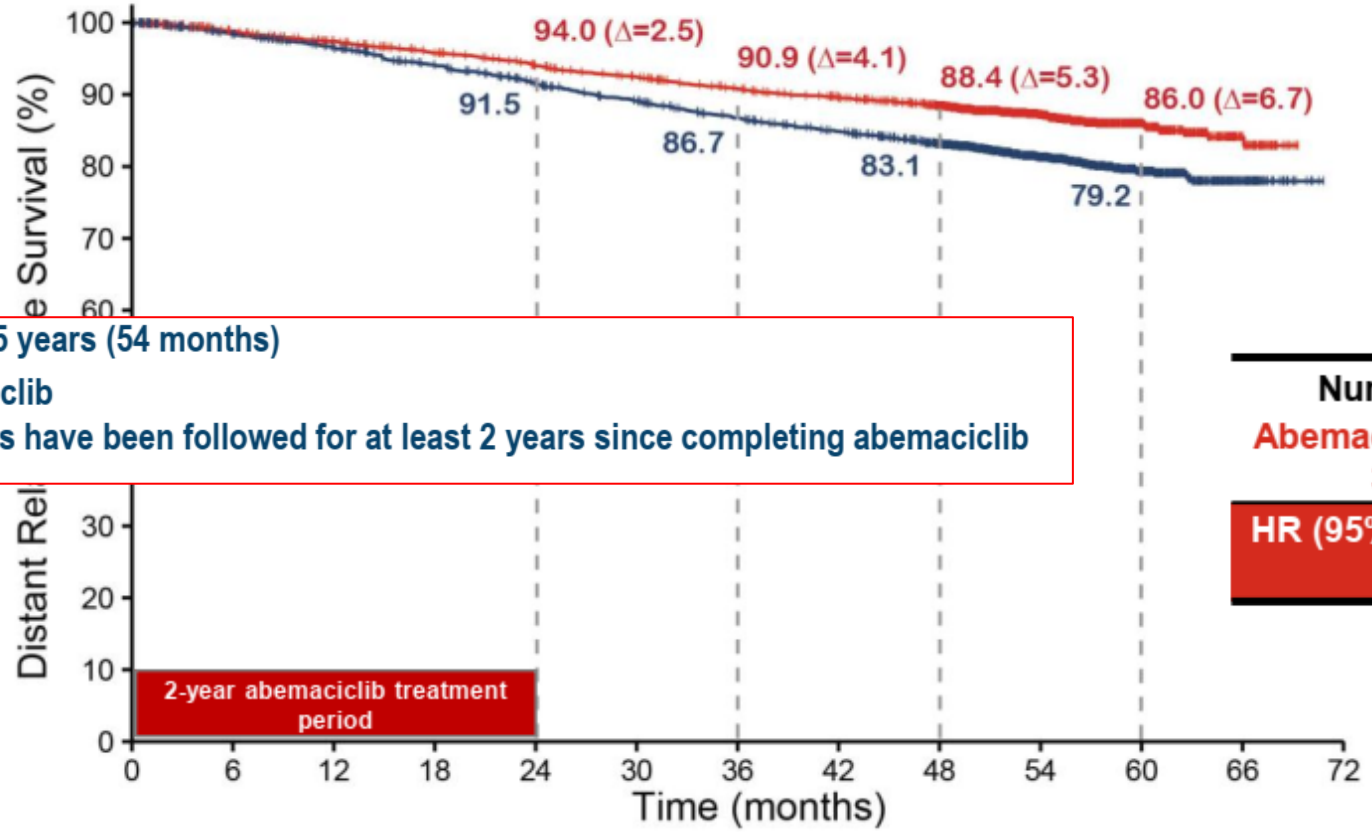
Nadia Harbeck, Priya Rastogi, Joyce O'Shaughnessy, Frances Boyle, Javier Cortes, Hope S. Rugo, Matthew P. Goetz, Erika Hamilton, Chiun-Sheng Huang, Elzbieta Senkus, Alexey Tryakin, Patrick Neven, Jens Huober, Ran Wei, Valérie André, Maria Munoz, Belen San Antonio, Ashwin Shahir, Miguel Martin, Stephen Johnston

Nadia Harbeck, MD

Breast Center, LMU University Hospital, Munich Germany

Madrid, Spain. 20 October 2023

Sustained DRFS Benefit in ITT



Number at risk

Abemaciclib + ET	2808	2630	2567	2500	2434	2375	2313	2258	2141	1202	500	75	0
ET alone	2829	2660	2590	2499	2410	2327	2243	2176	2032	1161	488	72	0

- Median follow-up time is 4.5 years (54 months)
- All patients are off abemaciclib
  - More than 80% of patients have been followed for at least 2 years since completing abemaciclib

Carryover effect !!!

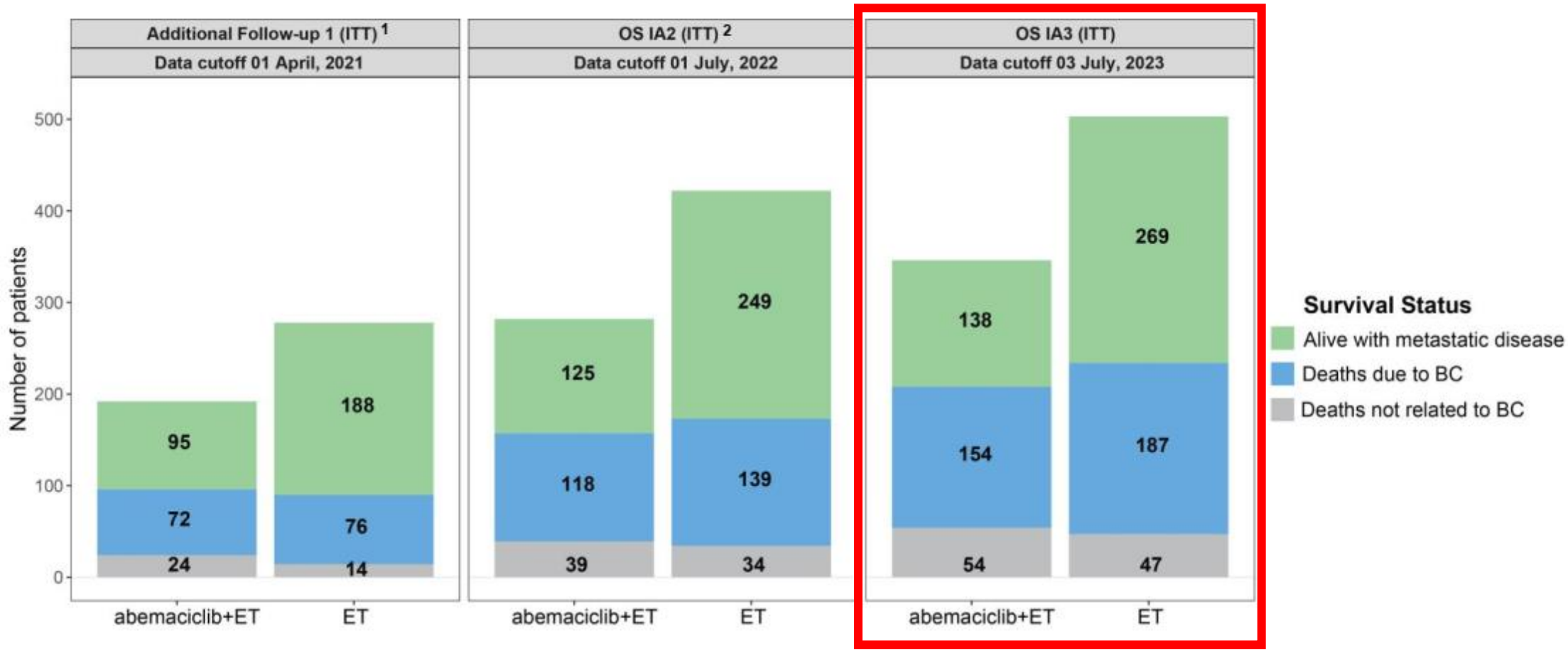
Number of DRFS events

Abemaciclib + ET	ET Alone
345	501

HR (95% CI): 0.675 (0.588, 0.774)
Nominal p <0.001

32.5% reduction in the risk of developing a DRFS event.
The KM curves continue to separate and the absolute difference in DRFS rates between arms was 6.7% at 5 years

Fewer Patients with Metastatic Disease in the Abemaciclib Arm



The imbalance of incurable metastatic recurrence continues to be substantial at OS IA3

[1]Harbeck* N, Rastogi* P, et al. Ann Oncol. 2021;32(12):1571-1581 *co-first authors
[2]Johnston SRD, et al. Lancet Oncol. 2023;24:77-90

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Invasive disease–free survival across key subgroups from the Phase III NATALEE study of ribociclib + a nonsteroidal aromatase inhibitor in patients with HR+/HER2− early breast cancer

Aditya Bardia,[1] Gabriel Hortobagyi,[2] Oleg Lipatov,[3] Nicholas McAndrew,[4] Aleksandra Lacko,[5] Joohyuk Sohn,[6] Lowell Hart,[7] John Crown,[8] Seock-Ah Im,[9] Nadia Harbeck,[10] Joyce O'Shaughnessy,[11] Binghu Xu,[12] Carlos Barrios,[13] Rebecca Moroose,[14] Valeria Gonzalez,[15] Rodrigo Fresco,[15] Farhat Ghaznawi,[16] Sorcha Waters,[17] Arunava Chakravartty,[16] Dennis Slamon[18]

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NATALEE study design

- Adult patients with HR+/HER2− EBC
- Prior ET allowed up to 12 months
- **Anatomic stage IIA**[a]
  - **N0** with:
    - Grade 2 and evidence of high risk:
      - Ki-67 ≥20%
      - Oncotype DX Breast Recurrence Score ≥26 *or*
      - High risk via genomic risk profiling
    - Grade 3
  - **N1**
- **Anatomic stage IIB**[a]
  - N0 or N1
- **Anatomic stage III**
  - N0, N1, N2, or N3

N = 5101[b]

R 1:1[c]

Ribociclib
400 mg/day
3 weeks on/1 week off
for 3 years

NSAI
Letrozole or anastrozole[d] for ≥5 years
+ goserelin in men and premenopausal women

NSAI
Letrozole or anastrozole[d] for ≥5 years
+ goserelin in men and premenopausal women

Primary end point
- iDFS using STEEP criteria

Secondary end points
- Recurrence-free survival
- Distant disease–free survival
- OS
- HRQoL
- Safety and tolerability
- PK

Exploratory end points
- Locoregional recurrence–free survival
- Gene expression and alterations in tumor ctDNA/ctRNA samples

Randomization stratification
Anatomic stage: II vs III
Menopausal status: men and premenopausal women vs postmenopausal women
Prior (neo)adjuvant chemotherapy: yes vs no
Geographic location: North America/Western Europe/Oceania vs rest of world

ctDNA/RNA, circulating tumor DNA/RNA; EBC, early breast cancer; HER2, human epidermal growth factor receptor 2; HR, hormone receptor; HRQoL, health-related quality of life; iDFS, invasive disease-free survival; NSAI, nonsteroidal aromatase inhibitor; OS, overall survival; PK, pharmacokinetics; R, randomized; STEEP, Standardized Definitions for Efficacy End Points in adjuvant breast cancer trials.
[a] Enrollment of patients with stage II disease was capped at 40%. [b] 5101 patients were randomized from January 10, 2019, to April 20, 2021. [c] Open-label design. [d] Per investigator choice.
1. Slamon D, et al. ASCO 2023. Oral; abstract LBA500. 2. Slamon DJ, et al. *J Clin Oncol*. 2019;37(15 suppl). Abstract TPS597.

Consistent iDFS benefit across clinically relevant subgroups

	Treatment	Events, n/N	3-y iDFS rate, %	Δ3-y iDFS rate, %	HR (95% CI)
ITT population	RIB + NSAI	189/2549	90.4	3.3	0.748 (0.618-0.906)
	NSAI alone	237/2552	87.1		
Menopausal status					
Premenopausal women	RIB + NSAI	71/1126	91	2	0.72 (0.53-0.98)
	NSAI alone	93/1132	89		
Postmenopausal women	RIB + NSAI	118/1423	90	4	0.78 (0.61-1.00)
	NSAI alone	144/1420	86		
Anatomic stage					
II	RIB + NSAI	49/1011	94	3	0.76 (0.53-1.10)
	NSAI alone	65/1034	91		
III	RIB + NSAI	140/1528	87	3	0.74 (0.59-0.93)
	NSAI alone	172/1512	84		
Nodal status					
N0	RIB + NSAI	16/285	94	5	0.63 (0.34-1.17)
	NSAI alone	28/328	89		
N1-N3	RIB + NSAI	173/2261	90	3	0.77 (0.63-0.94)
	NSAI alone	208/2219	87		
Age					
<65 y	RIB + NSAI	155/2142	90	3	0.77 (0.62-0.94)
	NSAI alone	195/2186	87		
≥65 y	RIB + NSAI	34/407	90	4	0.72 (0.46-1.14)
	NSAI alone	42/366	86		
Ki-67					
≤20%	RIB + NSAI	76/1199	92	2	0.80 (0.59-1.08)
	NSAI alone	95/1236	90		
>20%	RIB + NSAI	82/920	89	5	0.75 (0.56-1.00)
	NSAI alone	105/938	84		

iDFS, invasive disease-free survival; ITT, intent-to-treat; NSAI, nonsteroidal aromatase inhibitor; RIB, ribociclib.

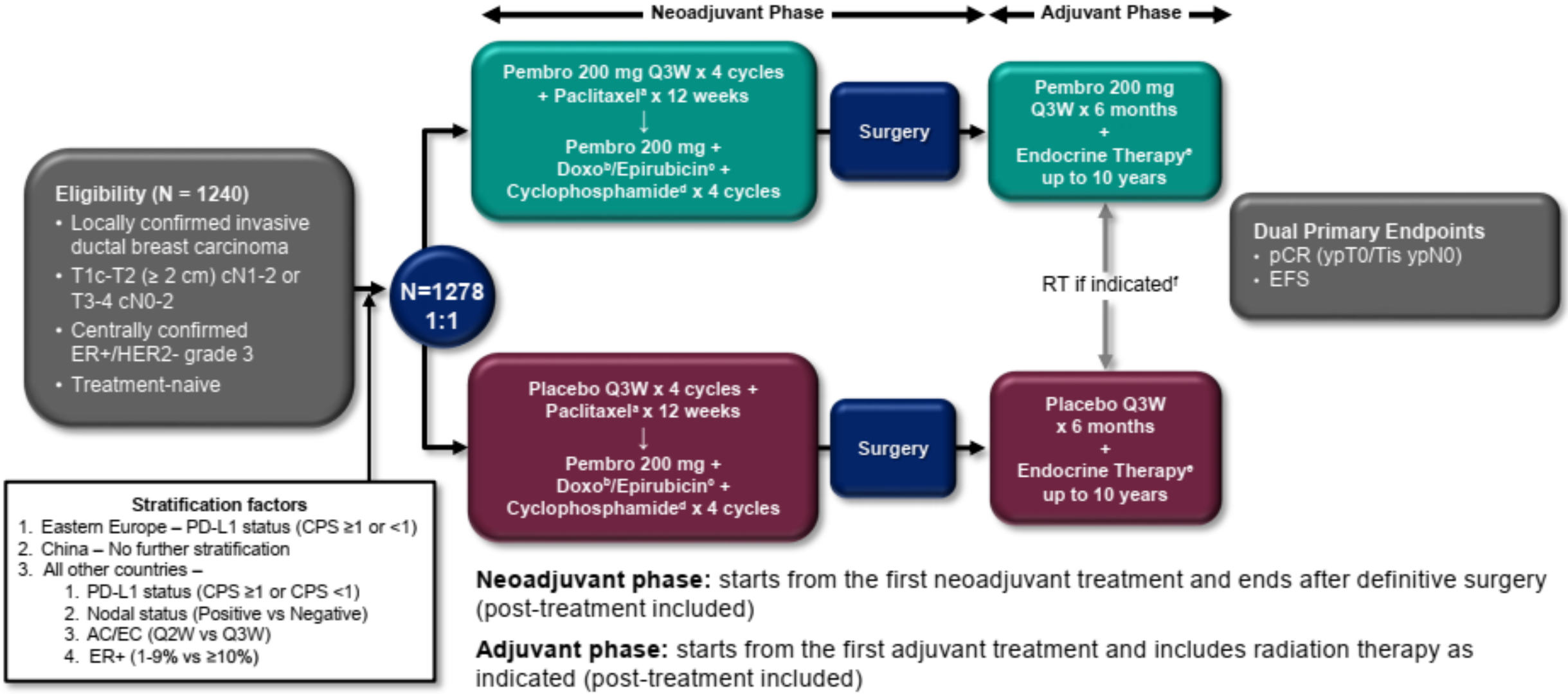
Median FU: 27.7 months

KEYNOTE-756: Phase 3 Study of Neoadjuvant Pembrolizumab or Placebo + Chemotherapy Followed by Adjuvant Pembrolizumab or Placebo + Endocrine Therapy for Early-Stage High-Risk ER+/HER2– Breast Cancer

Fatima Cardoso[1], Heather McArthur[2], Peter Schmid[3], Javier Cortes[4], Nadia Harbeck[5], Melinda L Telli[6], David W. Cescon[7], Joyce O' Shaughnessy[8], Peter A. Fasching[9], Zhimin Shao[10], Delphine Loirat[11], Yeon Hee Park[12], Manuel Gonzalez Fernandez[13], Zhenzhen Liu[14], Hiroyuki Yasojima[15], Yu Ding[16], Liyi Jia[16], Vassiliki Karantza[16], Konstantinos Tryfonidis[16], Aditya Bardia[17]

[1]Champalimaud Clinical Centre/Champalimaud Foundation, Lisbon, Portugal; [2]University of Texas Southwestern Medical Center, Dallas, TX, USA; [3]Centre for Experimental Cancer Medicine, Barts Cancer Institute, Queen Mary University London, London, UK; [4]International Breast Cancer Center, Quironsalud Group, Barcelona, Spain and Universidad Europea de Madrid, Faculty of Biomedical and Health Sciences, Department of Medicine, Madrid, Spain; [5]Breast Center, Dept. OB&GYN, LMU University Hospital, Munich, Germany; [6]Stanford University School of Medicine, Stanford, CA, USA; [7]Princess Margaret Cancer Centre, Toronto, Ontario, Canada; [8]Baylor University Medical Center, Texas Oncology, US Oncology Network, Dallas, TX, USA; [9]University Hospital Erlangen, Comprehensive Cancer Center Erlangen-EMN, Bavarian Cancer Research Center (BZKF), Erlangen, Germany; [10]Department of Breast Surgery, Fudan University Shanghai Cancer Center, Department of Oncology, Shanghai Medical College, Fudan University, Shanghai, China; [11]Institut Curie, Paris, France; [12]Samsung Medical Center, Sungkyunkwan University School of Medicine, Seoul, Republic of Korea; [13]Hemato Oncólogo, IMAT-Oncomedica, Montería, Colombia; [14]Department of Breast Disease, Henan Breast Cancer Center, Affiliated Cancer Hospital of Zhengzhou University & Henan Cancer Hospital, Zhengzhou, Henan, China; [15]Department of Surgery Breast Oncology, NHO Osaka National Hospital, Osaka, Japan; [16]Oncology, Merck & Co., Inc., Rahway, NJ, USA; [17]Massachusetts General Hospital, Harvard Medical School, Boston, MA, USA

KEYNOTE-756 Study Design (NCT03725059)



Neoadjuvant phase: starts from the first neoadjuvant treatment and ends after definitive surgery (post-treatment included)

Adjuvant phase: starts from the first adjuvant treatment and includes radiation therapy as indicated (post-treatment included)

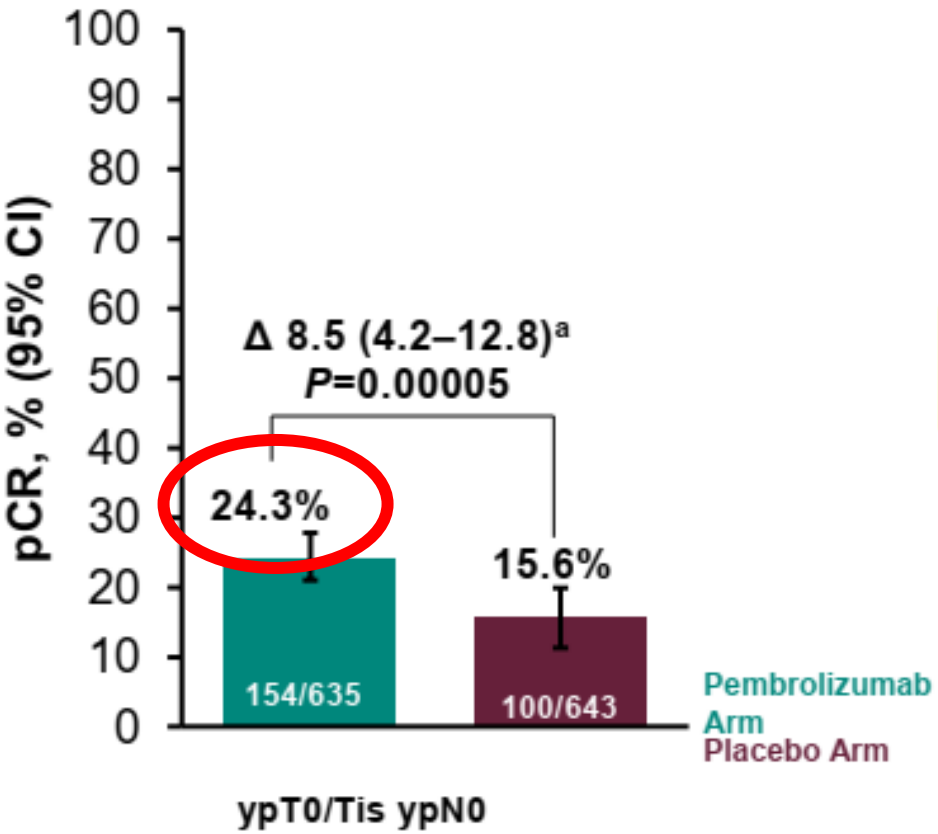
Grade 3, T1c-T2, cN1-2, or T3-4, cN0-2

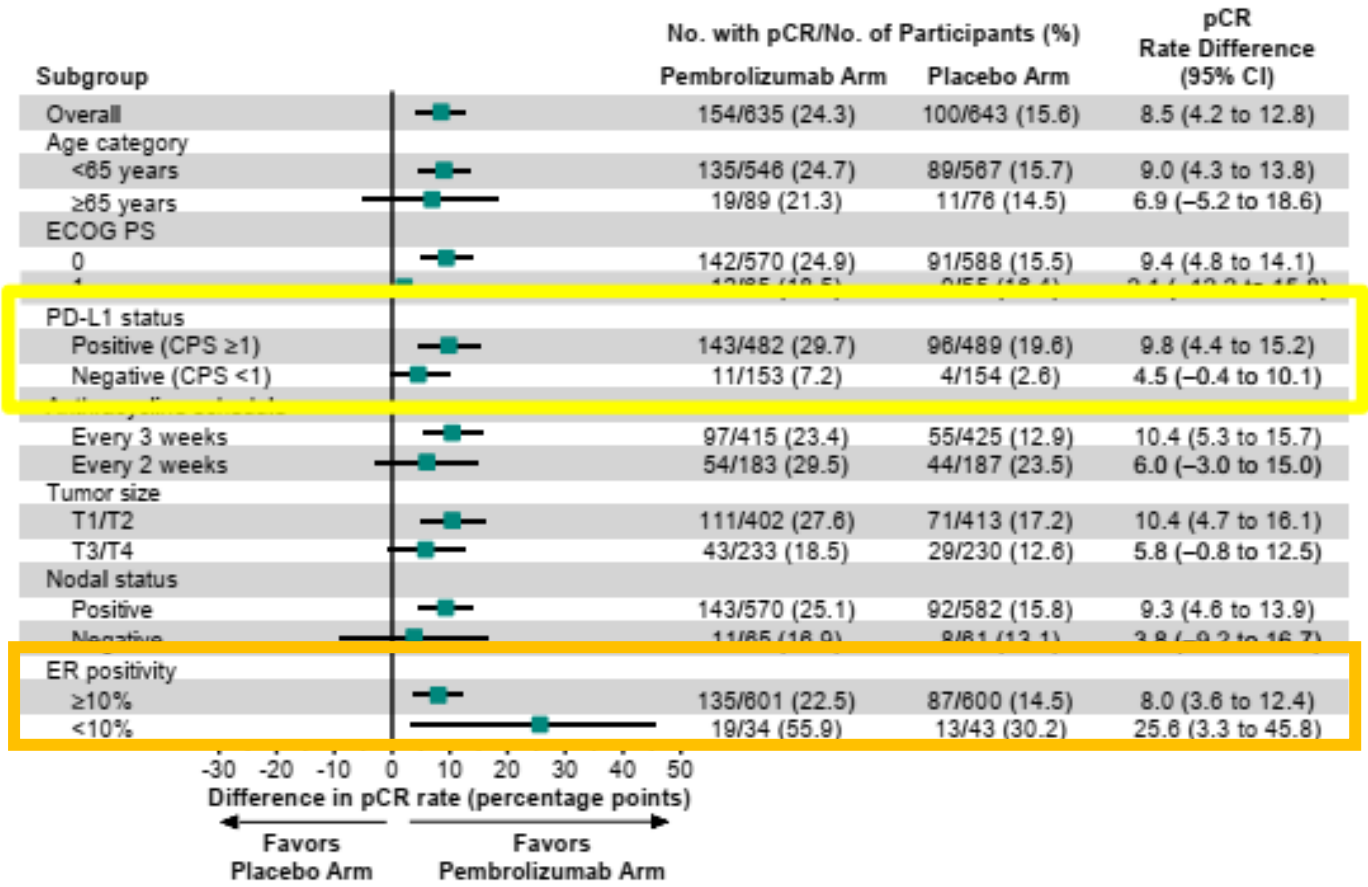
Cardoso, LBA21 ESMO 2023

KEYNOTE-756- Pathological Complete Response (pCR) Rate

Primary Endpoint

ITT N=1278

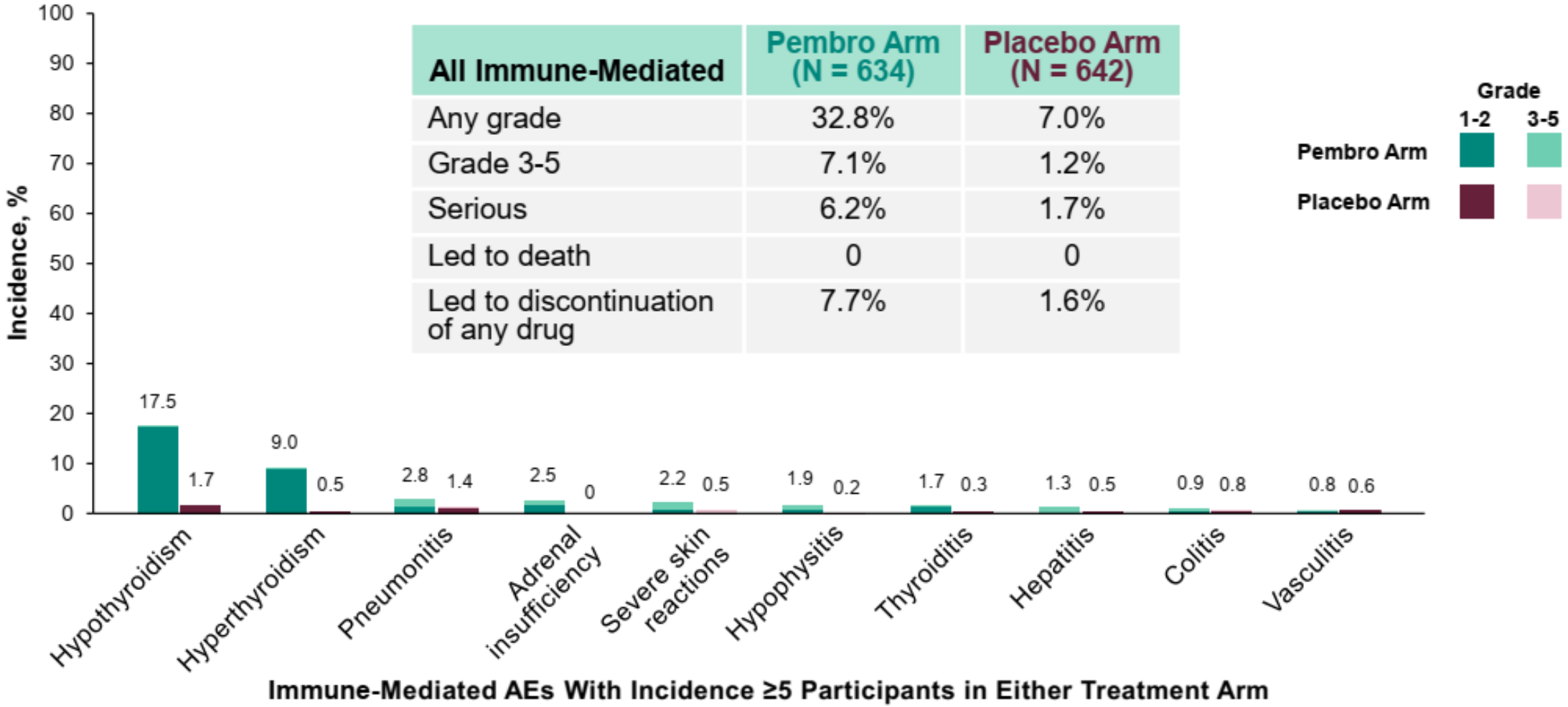




Cardoso, LBA21 ESMO 2023

Immune-Mediated AEs in **Neoadjuvant** Phase

All Immune-Mediated	Pembro Arm (N = 634)	Placebo Arm (N = 642)
Any grade	32.8%	7.0%
Grade 3-5	7.1%	1.2%
Serious	6.2%	1.7%
Led to death	0	0
Led to discontinuation of any drug	7.7%	1.6%



Considered regardless of attribution to treatment or immune relatedness by the investigator. Related terms included in addition to preferred terms listed.
Data cutoff date: May 25, 2023.

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A randomized, double-blind trial of nivolumab vs placebo with neoadjuvant chemotherapy followed by adjuvant endocrine therapy in patients with high-risk, ER+ HER2– primary breast cancer

Sherene Loi,[1] Giuseppe Curigliano,[2,3] Roberto Salgado,[1,4] Roberto Iván Romero Díaz,[5] Suzette Delaloge,[6] Carlos Ignacio Rojas García,[7] Marleen Kok,[8] Cristina Saura,[9] Nadia Harbeck,[10] Elizabeth A. Mittendorf,[11] Denise A. Yardley,[12] Lajos Pusztai,[13] Alberto Suárez Zaizar,[14] Andrei Ungureanu,[15] Felipe Ades,[16] Rajalakshmi Chandra,[16] Raheel Nathani,[16] Misena Pacius,[16] Jenny Qun Wu,[16] Heather McArthur[17]

[1]Peter McCallum Cancer Center, Melbourne, Australia; [2]European Institute of Oncology, IRCCS, Milan, Italy; [3]University of Milan, Milan, Italy; [4]GZA-ZNA Hospitals, Antwerp, Belgium; [5]Consultorio de Oncólogo Médico, Oaxaca, Mexico; [6]Institut Gustave Roussy, Villejuif, France; [7]Bradford Hill Investigación Clinica, Región Metropolitana, Santiago, Chile; [8]Netherlands Cancer Institute, Amsterdam, The Netherlands; [9]Vall d'Hebron University Hospital, Vall d'Hebron Institute of Oncology (VHIO), Barcelona, Spain; [10]Ludwig Maximilians University Hospital, Munich, Germany; [11]Dana Farber Cancer Institute, Boston, MA, USA; [12]Sarah Cannon Research Institute and Tennessee Oncology PLLC, Nashville, TN, USA; [13]Smilow Cancer Hospital at Yale, New Haven, CT, USA; [14]CENEIT Oncológicos, Mexico City, Mexico; [15]Radiotherapy Center CLUJ S.R.L., Florești, Romania; [16]Bristol Myers Squibb, Princeton, NJ, USA; [17]University of Texas Southwestern Medical Center, Dallas, TX, USA

Presentation number LBA20

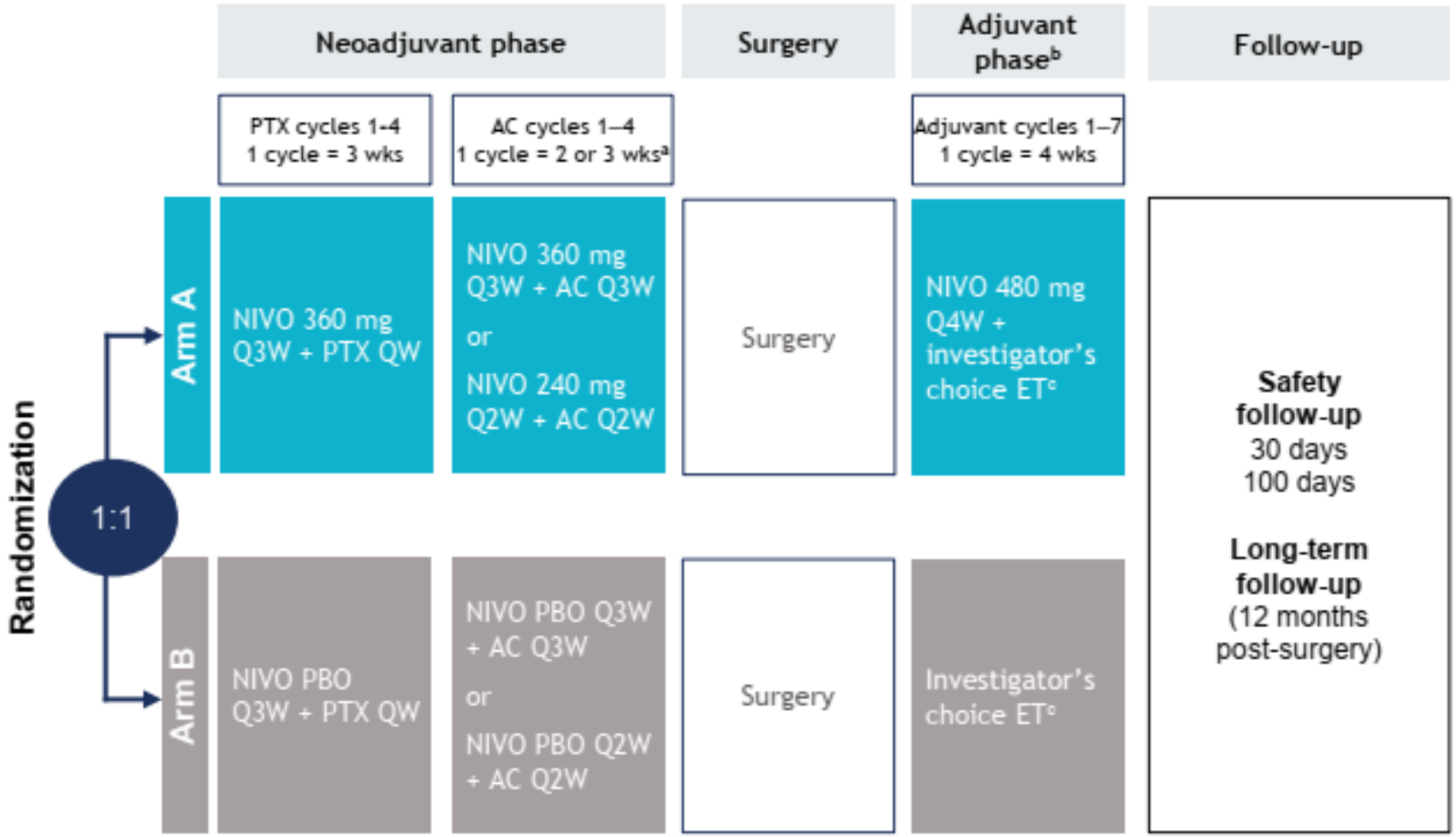
CheckMate-7FL study design (NCT04109066)

Key inclusion criteria

- Newly diagnosed ER+, HER2− BC
- Confirmed ER+ BC
- T1c-T2, cN0-cN2 or T3-T4, cN0-cN2
- Grade 3 or grade 2 with ER 1–10%
- Adequate organ function
- Tissue available for biomarker assessment
- ECOG PS 0–1

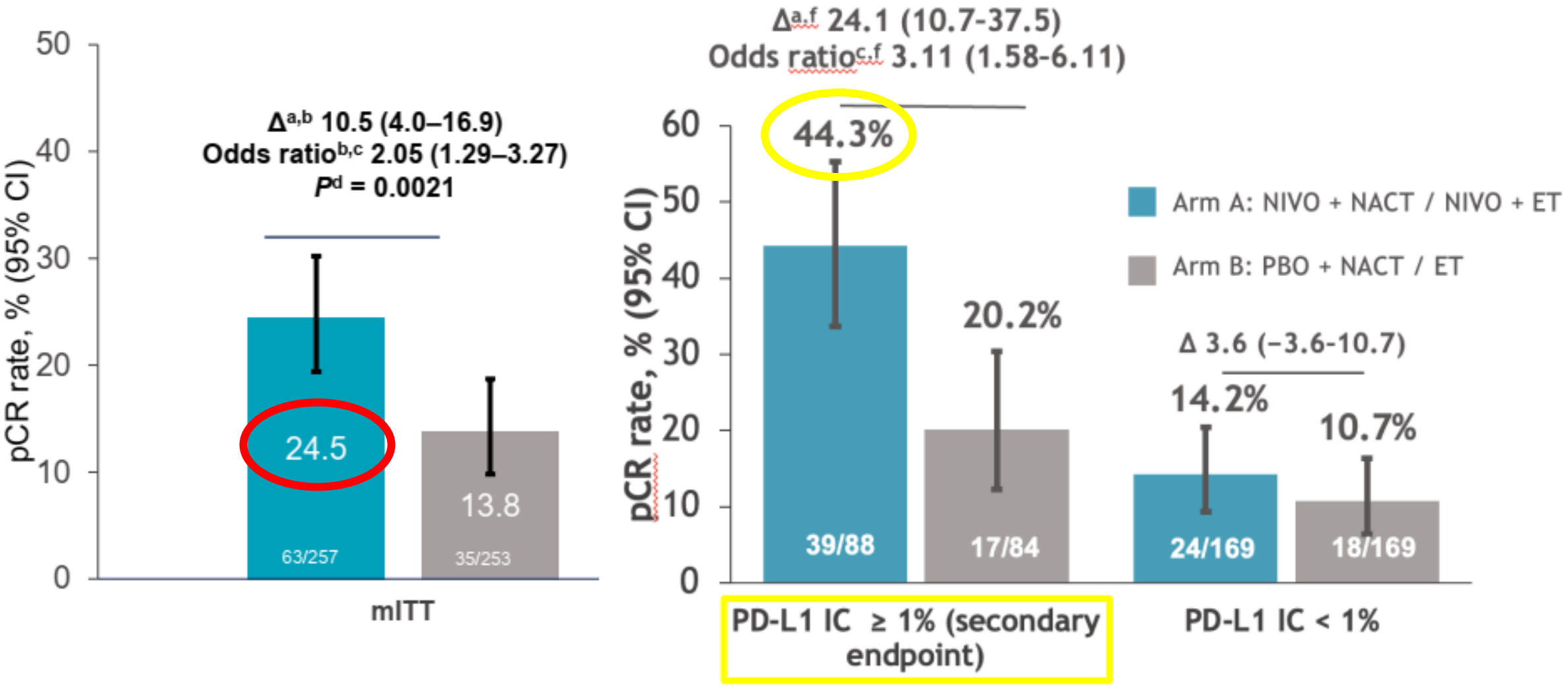
Stratification factors

- PD-L1 IC (≥ 1% or < 1%)
- Tumor grade (3 or 2)
- Axillary nodal status (positive or negative)
- AC (Q3W or Q2W)



Loi, LBA20 ESMO 2023

CheckMate-7FL Pathological Complete Response (pCR) Rate



Loi, LBA20 ESMO 2023

Cancers du sein RH+/HER2 non amplifié

METASTATIQUE

MADRID 2023 ESMO congress

LBA11

Datopotamab deruxtecan (Dato-DXd) vs chemotherapy in previously-treated inoperable or metastatic hormone receptor-positive, HER2-negative (HR+/HER2–) breast cancer: Primary results from the randomised Phase 3 TROPION-Breast01 trial

Aditya Bardia,[1] Komal Jhaveri,[2] Seock-Ah Im,[3] Sonia Pernas,[4] Michelino De Laurentiis,[5] Shusen Wang,[6] Noelia Martínez Jañez,[7] Giuliano Borges,[8] David W. Cescon,[9] Masaya Hattori,[10] Yen-Shen Lu,[11] Erika Hamilton,[12] Qingyuan Zhang,[13] Junji Tsurutani,[14] Kevin Kalinsky,[15] Lu Xu,[16] Neelima Denduluri,[17] Hope S. Rugo,[18] Binghe Xu,[19*] Barbara Pistilli[20*]

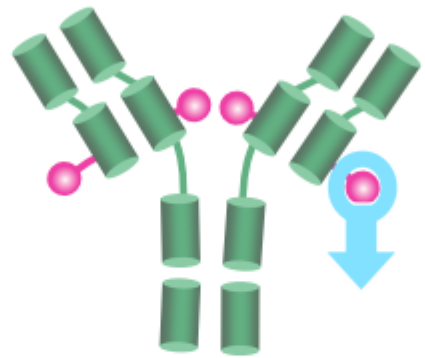
*Contributed equally

[1]Mass General Cancer Center, Harvard Medical School, Boston, MA, USA; [2]Memorial Sloan Kettering Cancer Center, New York, NY, USA, and Weill Cornell Medical College, New York, NY, USA; [3]Seoul National University Hospital, Cancer Research Institute, Seoul National University College of Medicine, Seoul National University, Seoul, Republic of Korea; [4]Institut Català d'Oncologia, IDIBELL, L'Hospitalet, Barcelona, Spain; [5]Istituto Nazionale Tumori Napoli IRCCS "Fondazione Pascale", Napoli, Italy; [6]Cancer Center of Sun Yet-sen University, Guangzhou, China; [7]Ramón y Cajal University Hospital, Instituto Ramón y Cajal de Investigación Sanitaria (IRYCIS), Madrid, Spain; [8]Catarina Pesquisa Clínica, Santa Catarina, Brazil; [9]Princess Margaret Cancer Centre/UHN, Toronto, ON, Canada; [10]Aichi Cancer Center, Nagoya, Japan; [11]National Taiwan University Hospital, National Taiwan University College of Medicine, Taipei, Taiwan; [12]Sarah Cannon Research Institute / Tennessee Oncology, Nashville, TN, USA; [13]Harbin Medical University Cancer Hospital, Harbin, China; [14]Showa University Hospital, Tokyo, Japan; [15]Winship Cancer Institute at Emory University, Atlanta, GA, USA; [16]AstraZeneca, New York, NY, USA; [17]AstraZeneca, Arlington, VA, USA; [18]University of California San Francisco Comprehensive Cancer Center, San Francisco, CA, USA; [19]National Cancer Center / National Clinical Research Center for Cancer / Cancer Hospital, Chinese Academy of Medical Sciences and Peking Union Medical College, Beijing, China; [20]Gustave Roussy Cancer Center, Villejuif, France

Background: Dato-DXd

- **Dato-DXd** is a **TROP2-directed ADC**, that selectively delivers a potent Topo-I inhibitor payload directly into tumor cells,[1] and has several unique properties*:
  - Optimised drug to antibody ratio ≈ 4
  - Stable linker-payload
  - Tumour-selective cleavable linker
  - Bystander antitumour effect
- Dato-DXd previously demonstrated **promising antitumour activity** and a **manageable safety profile** with a convenient Q3W schedule in pre-treated patients with **metastatic HR+/HER2– breast cancer**[2]

Dato-DXd: Humanised anti-TROP2 IgG1 monoclonal antibody



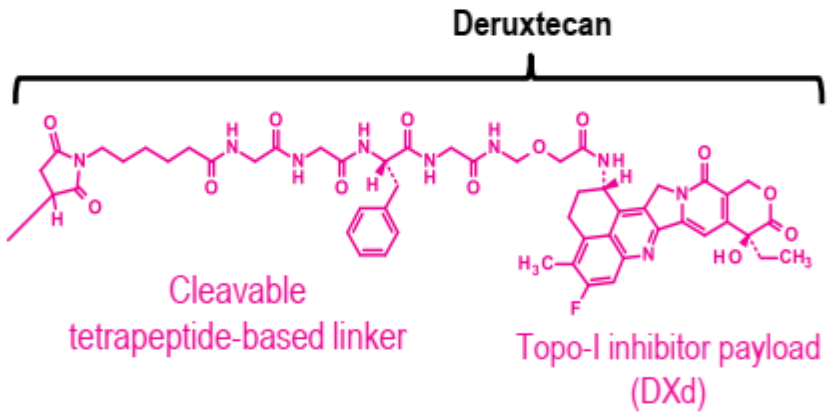


Image is for illustrative purposes only; actual drug positions may vary.

*The clinical relevance of these features is under investigation. Based on animal data.
Dato-DXd, datopotamab deruxtecan; IgG1, immunoglobulin G1; Q3W, every 3 weeks; Topo-I, topisomerase I.

1. Okajima D, et al. *Mol Cancer Ther* 2021;20:2329–40;
2. Meric-Bernstam F, et al. Poster presentation at SABCS 2022: abstract PD13-08.

TROPION-Breast01 Study Design[1]

Randomised, phase 3, open-label, global study (NCT05104866)

Prior CDK4/6 ~ 80%
Prior 2L chemo ~ 37%

Key inclusion criteria:

- Patients with HR+/HER2– breast cancer* (HER2– defined as IHC 0/1+/2+; ISH negative)
- Previously treated with 1–2 lines of chemotherapy (inoperable/metastatic setting)
- Experienced progression on ET and for whom ET was unsuitable
- ECOG PS 0 or 1

1:1

Dato-DXd
6 mg/kg IV Day 1 Q3W
(n=365)

Investigator's choice of chemotherapy (ICC)
as per protocol directions†
(eribulin mesylate D1,8 Q3W; vinorelbine D1,8 Q3W; gemcitabine D1,8 Q3W; capecitabine D1–14 Q3W)
(n=367)

Endpoints:

- **Dual primary**: PFS by BICR per RECIST v1.1, and OS
- **Key secondary**: ORR, PFS (investigator assessed) and safety

Randomisation stratified by:

- **Lines of chemotherapy** in unresectable/metastatic setting (1 vs 2)
- **Geographic location** (US/Canada/Europe vs ROW)
- **Previous CDK4/6 inhibitor** (yes vs no)

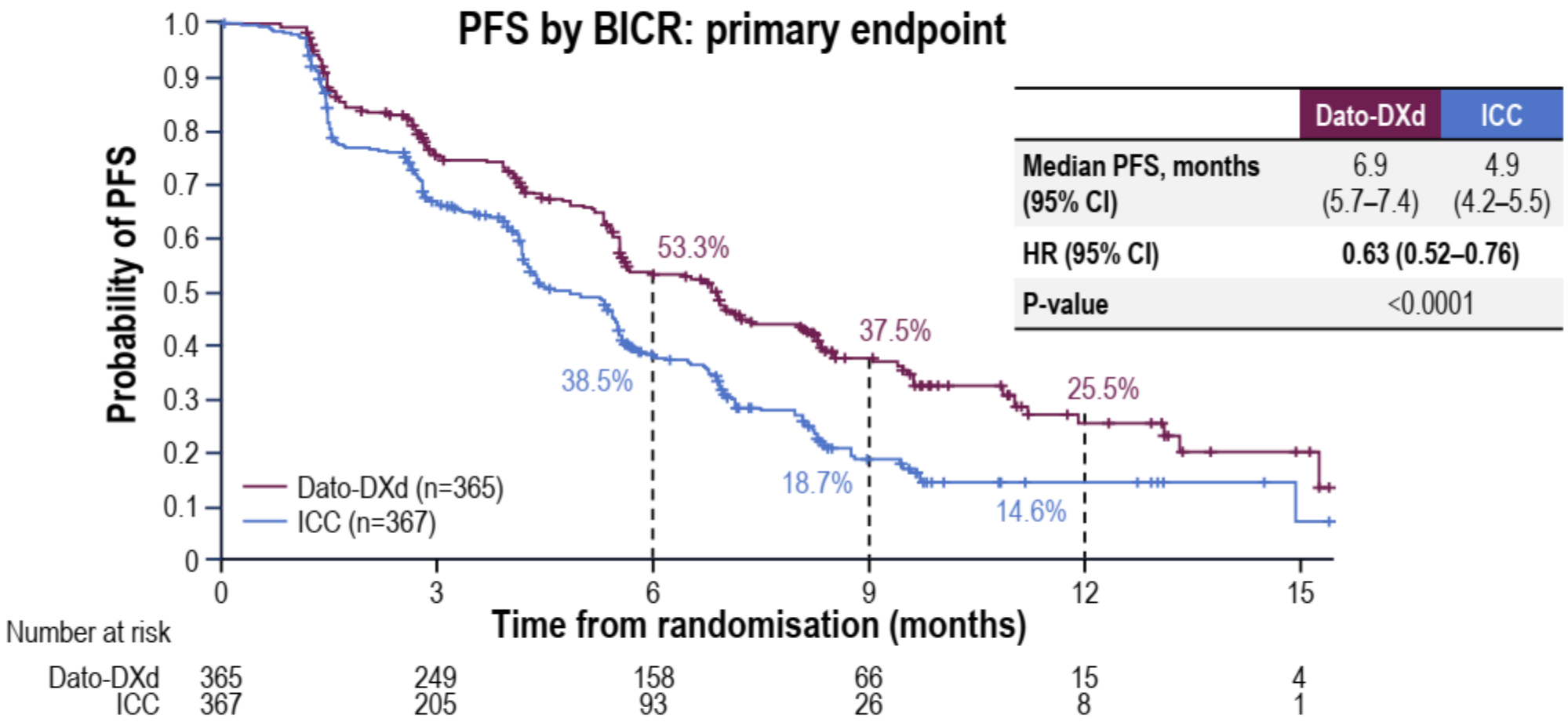
- Treatment continued until PD, unacceptable tolerability, or other discontinuation criteria

Detailed description of the statistical methods published previously.[1] *Per American Society of Clinical Oncology/College of American Pathologists (ASCO/CAP) guidelines. †ICC was administered as follows: eribulin mesylate, 1.4 mg/m² IV on Days 1 and 8, Q3W; capecitabine, 1000 or 1250 mg/m² orally twice daily on Days 1 to 14, Q3W (dose per standard institutional practice); vinorelbine, 25 mg/m² IV on Days 1 and 8, Q3W; or gemcitabine, 1000 mg/m² IV on Days 1 and 8, Q3W. BICR, blinded independent central review; CDK4/6, cyclin-dependent kinase 4/6; ECOG PS, Eastern Cooperative Oncology Group performance status; ET, endocrine therapy; IV, intravenous; ORR, objective response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; RECIST, Response Evaluation Criteria in Solid Tumors; ROW, rest of world.

1. Bardia A, et al. *Future Oncol* 2023; doi: 10.2217/fon-2023-0188.

Progression-Free Survival

ORR: 36% vs 23%



	Dato-DXd	ICC
Median PFS, months (95% CI)	6.9 (5.7–7.4)	4.9 (4.2–5.5)
HR (95% CI)	**0.63 (0.52–0.76)**	
P-value	<0.0001	

PFS by investigator assessment: Median 6.9 vs 4.5 months; HR 0.64 (95% CI 0.53–0.76)

CI, confidence interval; HR, hazard ratio

TRAEs Occurring in ≥15% of Patients and AESIs

System Organ Class Preferred term, n (%)	Dato-DXd (n=360)		ICC (n=351)	
	Any Grade	Grade ≥3	Any Grade	Grade ≥3
Blood and lymphatic system				
Anaemia	40 (11)	4 (1)	69 (20)	7 (2)
Neutropenia*	39 (11)	4 (1)	149 (42)	108 (31)
Eye				
Dry eye	78 (22)	2 (1)	27 (8)	0
Gastrointestinal				
Nausea	184 (51)	5 (1)	83 (24)	2 (1)
Stomatitis	180 (50)	23 (6)	46 (13)	9 (3)
Vomiting	71 (20)	4 (1)	27 (8)	2 (1)
Constipation	65 (18)	0	32 (9)	0
General				
Fatigue	85 (24)	6 (2)	64 (18)	7 (2)
Skin and subcutaneous				
Alopecia	131 (36)	0	72 (21)	0

- Most TRAEs were grade 1–2 and manageable

AESIs

- Oral mucositis/stomatitis:† led to treatment discontinuation in one patient in the Dato-DXd group
- Ocular events:‡ most were dry eye; one patient discontinued treatment in the Dato-DXd group
- Adjudicated drug-related ILD:§ rate was low; mainly grade 1/2

Adjudicated drug-related ILD	Dato-DXd	ICC
All grades, n (%)	9 (3)	0
Grade ≥3, n (%)	2 (1)¶	0

*Neutropenia includes the PTs neutropenia and neutrophil count decreased. †Oral mucositis/stomatitis events included PTs of aphthous ulcer, dysphagia, glossitis, mouth ulceration, odynophagia, oral mucosal blistering, oral pain, oropharyngeal pain, pharyngeal inflammation, stomatitis, tongue ulceration; all grade: 59% with Dato-DXd, 17% with ICC; grade 3: 7% with Dato-DXd, 3% with ICC. ‡Ophthalmologic assessments were required at screening, and then every 3 cycles from C1D1 and at end of therapy; ocular events included selected PTs from Corneal Disorder SMQ and select relevant PTs from Eye Disorder SOC; all grade: 49% with Dato-DXd, 23% with ICC; grade 3: 1% with Dato-DXd (one patient with dry eye, one patient with punctate keratitis, and one patient with dry eye and ulcerative keratitis), 0% with ICC. §ILD includes events that were adjudicated as ILD and related to use of Dato-DXd or ICC (includes cases of potential ILD/pneumonitis, based on MedDRA v23.0 for the narrow ILD SMQ, selected terms from the broad ILD SMQ, and PTs of respiratory failure and acute respiratory failure). ¶One adjudicated drug-related grade 5 ILD event: attributed to disease progression by investigator. ILD, interstitial lung disease; PTs, preferred terms; SMQ, standard MedDRA query; SOC, system organ class.

MADRID 2023 ESMO congress

SKB264 (MK-2870) in previously treated hormone receptor-positive (HR+)/ HER2-negative metastatic breast cancer (mBC): results from a phase I/II, single-arm, basket trial

Quchang Ouyang[1], Yongmei Yin[2], Lihua Song[3], Min Yan[4], Xinhong Wu[5], Zhongsheng Tong[6], YunPeng Liu[7], Xian Wang[8], Xiaoping Jin[9],Yina Diao[9],Gesha Liu[9], Junyou Ge[9], Jin Li[10]

[1]Hunan Cancer Hospital, Changsha, China; [2]Jiangsu Province Hospital, Nanjing, China; [3]Shandong Cancer Hospital, Jinan, China; [4]Henan Cancer Hospital, Zhengzhou, China; [5]Hubei Cancer Hospital, Wuhan, China; [6]Tianjin Cancer Hospital, Tianjin, China; [7]The first Hospital of China Medical University, Shenyang, China; [8]Sir Run Run Shaw Hospital, Hangzhou, China [9]Sichuan Kelun-Biotech Biopharmaceutical Co., Ltd., Chengdu, China; [10]Shanghai East Hospital, Shanghai, China

Presenter: Dr. Yongmei Yin

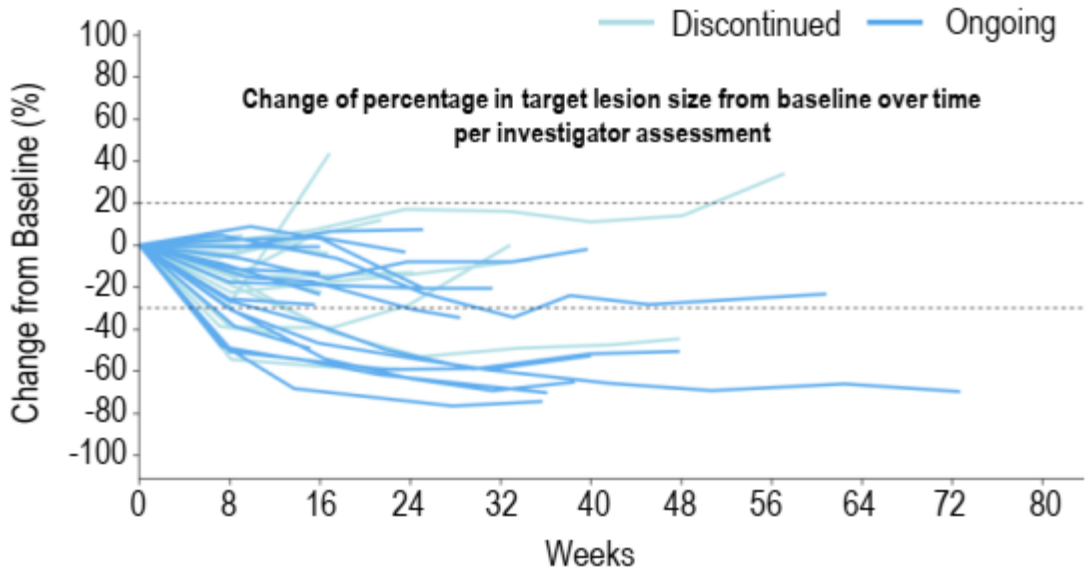
Sunday, October 22, 2023, 08:35-08:40
380MO

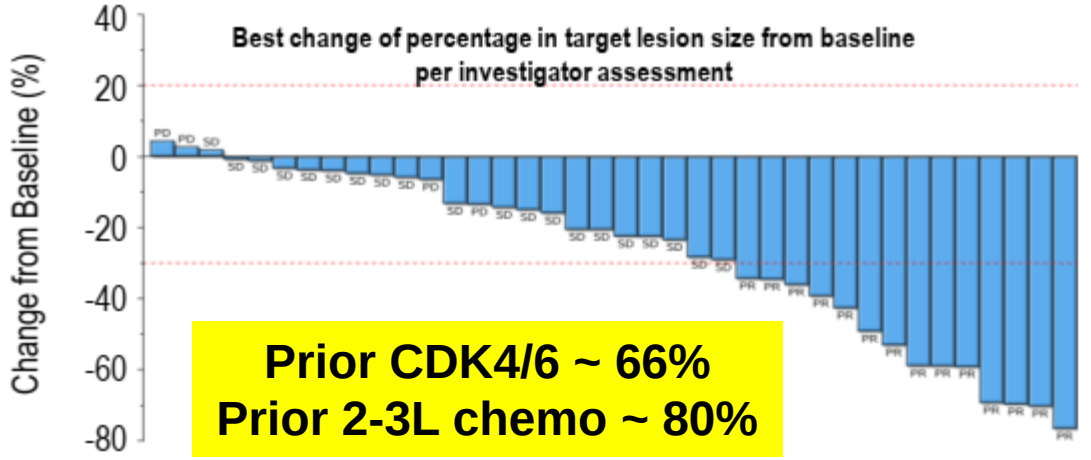
Efficacy of SKB264 (MK-2870) in HR+/HER2- BC

	All patients (N=38)[a]
ORR, n (%)	**14 (36.8)**
Confirmed PR	12
DCR, n (%)	**34 (89.5)**
DoR	
Median (Range), mo	7.4 (4.2~14.9+)
6-mon DoR rate, % (95% CI)	80.0 (40.9, 94.6)
PFS	
Median (95% CI), mo	11.1 (5.4, 13.1)
6-mon PFS rate, % (95% CI)	61.2 (41.3, 76.1)
OS	
Median (95% CI), mo	NE (10.71, NE)
9-mon OS rate (95% CI), %	81.4 (57.1, 92.7)

a. of 41 patients were enrolled, 38 patients were evaluable for response assessment (defined as ≥1 on-study scan).

hematotoxicity





Prior CDK4/6 ~ 66%
Prior 2-3L chemo ~ 80%

Presented by: Dr. Yongmei Yin

MADRID 2023 ESMO congress

Trastuzumab Deruxtecan (T-DXd) Versus Treatment of Physician's Choice (TPC) in Patients With HER2-Low Unresectable and/or Metastatic Breast Cancer: Updated Survival Results of the Randomized, Phase 3 DESTINY-Breast04 Study

Presentation 376O

Shanu Modi,[1] William Jacot, Hiroji Iwata, Yeon Hee Park, Maria Jesus Vidal Losada, Wei Li, Junji Tsurutani, Khalil Zaman, Naoto Ueno, Aleix Prat, Konstantinos Papazisis, Hope S. Rugo, Nadia Harbeck, Seock-Ah Im, Michelino De Laurentis, Cecilia Orbegoso Aguilar, Lotus Yung, Fu-Chih Cheng, Yingkai Cheng, David Cameron

On behalf of the DESTINY-Breast04 investigators

[1]Memorial Sloan Kettering Cancer Center, New York, NY, USA

Madrid, Spain, October 20-24, 2023

PFS2[a] and Post-Study Anticancer Therapies[b]

	HR+ Cohort		All Patients	
	T-DXd (n = 331)	TPC (n = 163)	T-DXd (n = 373)	TPC (n = 184)
Median PFS2 by investigator, mo (95% CI)	15.5 (13.8-17.2)	10.5 (8.3-11.4)	15.4 (13.6-16.5)	9.7 (8.3-10.8)
Hazard ratio (95% CI)	0.51 (0.40-0.64)		0.51 (0.41-0.64)	
Post-study anticancer therapies				
Systemic treatment, n (%)	247 (74.6)	126 (77.3)	282 (75.6)	144 (78.3)
Targeted therapy[c]	119 (36.0)	70 (42.9)	134 (35.9)	75 (40.8)
CDK4/6 inhibitors	47 (14.2)	27 (16.6)	48 (12.9)	27 (14.7)
ADC	**16 (4.8)**	**15 (9.2)**	**18 (4.8)**	**15 (8.2)**
T-DXd	2 (0.6)	4 (2.5)	2 (0.5)	4 (2.2)
Sacituzumab govitecan	9 (2.7)	5 (3.1)	11 (2.9)	5 (2.7)
Endocrine therapy	102 (30.8)	56 (34.4)	103 (27.6)	57 (31.0)
Chemotherapy	222 (67.1)	109 (66.9)	257 (68.9)	126 (68.5)
Radiation, n (%)			37 (9.9)	29 (15.8)
Surgery, n (%)			5 (1.3)	1 (0.5)

ADC sequence

How many had discontinued for ILD/Toxicity?

ADC, antibody drug conjugate; CDK, cyclin-dependent kinase; HR, hormone receptor; PFS, progression-free survival; T-DXd, trastuzumab deruxtecan; TPC, treatment of physician's choice.
[a]Defined as the time from date of randomization to the first documented progression per investigator assessment on next-line of systemic therapy or death due to any cause, whichever occurs first.
[b]Participants may have been treated with more than 1 type of post-study anticancer therapy. [c]Class includes CDK4/6 inhibitor, immunotherapy, antibody drug conjugates, or no subclass specified.

Giuseppe Curigliano, MD PhD

MADRID 2023 ESMO congress

Imlunestrant, with or without everolimus or alpelisib, in ER+, HER2- advanced breast cancer (aBC): Results from the phase 1a/b EMBER study

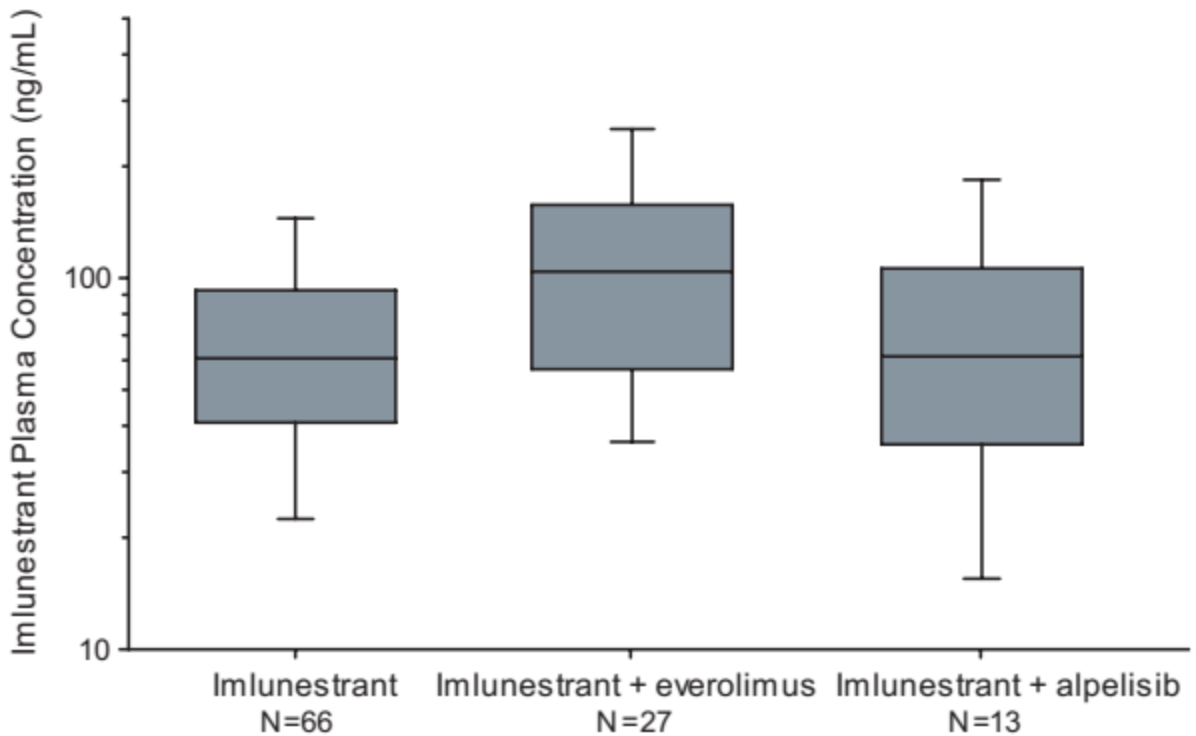
Komal L. Jhaveri, Rinath Jeselsohn, Cynthia X. Ma, Elgene Lim, Kan Yonemori, Erika P. Hamilton, Kathleen Harnden, Seock-Ah Im, J. Thaddeus Beck, Sarah Sammons, Manali Bhave, Peter A. Kaufman, Cristina Saura, Tarek Meniawy, Francesca Bacchion, Roohi Ismail-Khan, Yujia Li, Shawn T. Estrem, Bastien Nguyen, Muralidhar Beeram.

Komal L. Jhaveri

New York, USA. 22nd October 2023

Pharmacokinetics

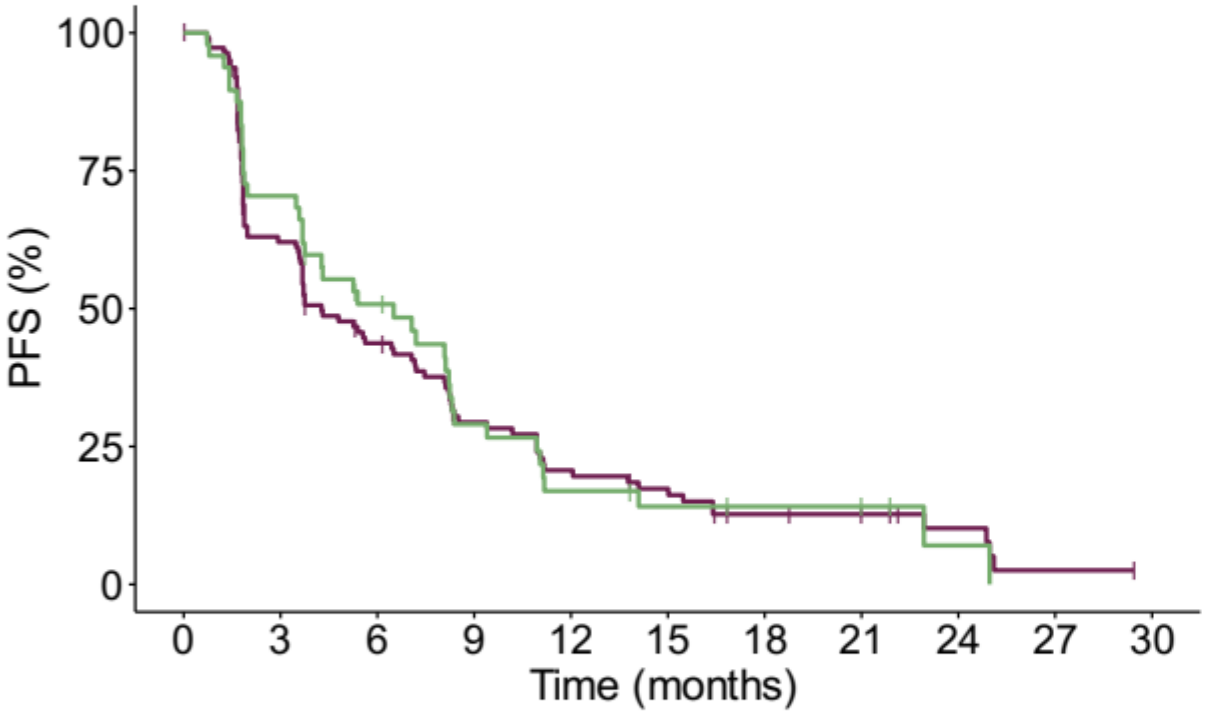
Predose steady state plasma concentrations of imlunestrant as monotherapy or in the presence of everolimus and alpelisib



- **PK analyses showed no drug-drug interaction between imlunestrant and everolimus/alpelisib**

Kaplan-Meier plot of PFS

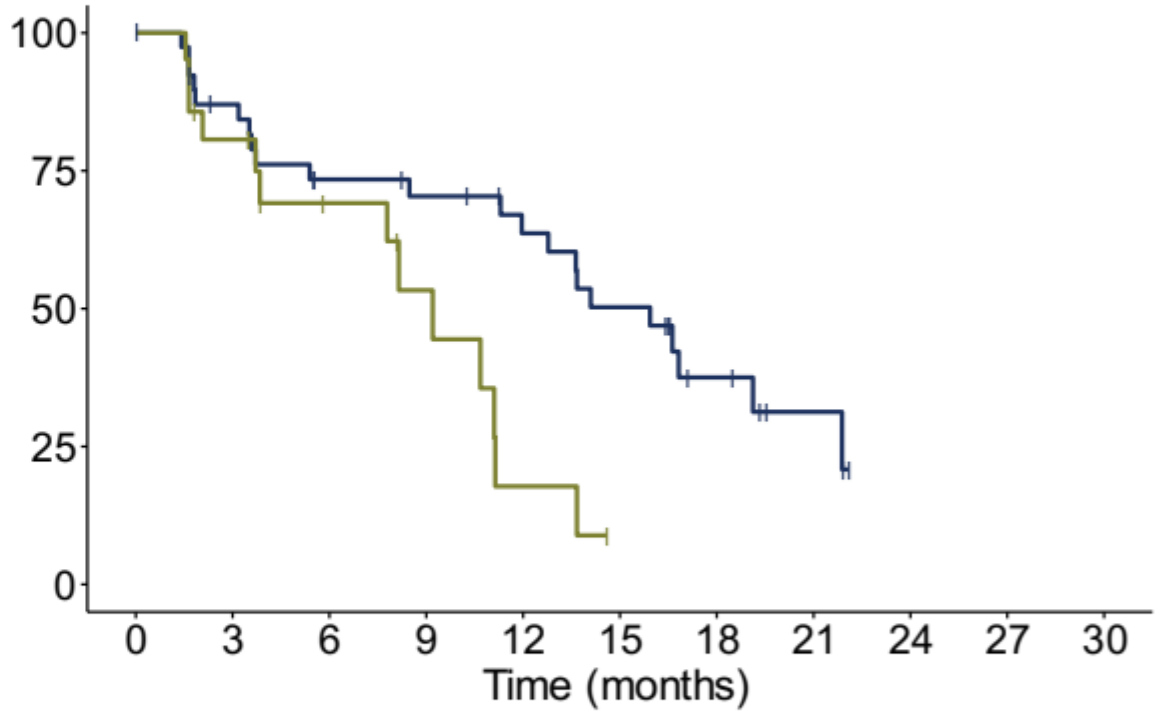
Patient Group	N	Events	Median (95% CI)
Imlunestrant all	114	93	4.3 (3.6, 7.1)
Imlunestrant 2L post-CDK4/6i	48	40	6.5 (3.7, 8.3)



Patients at risk

114	65	44	27	19	15	9	7	4	1	0
48	33	22	12	7	5	4	3	1	0	0

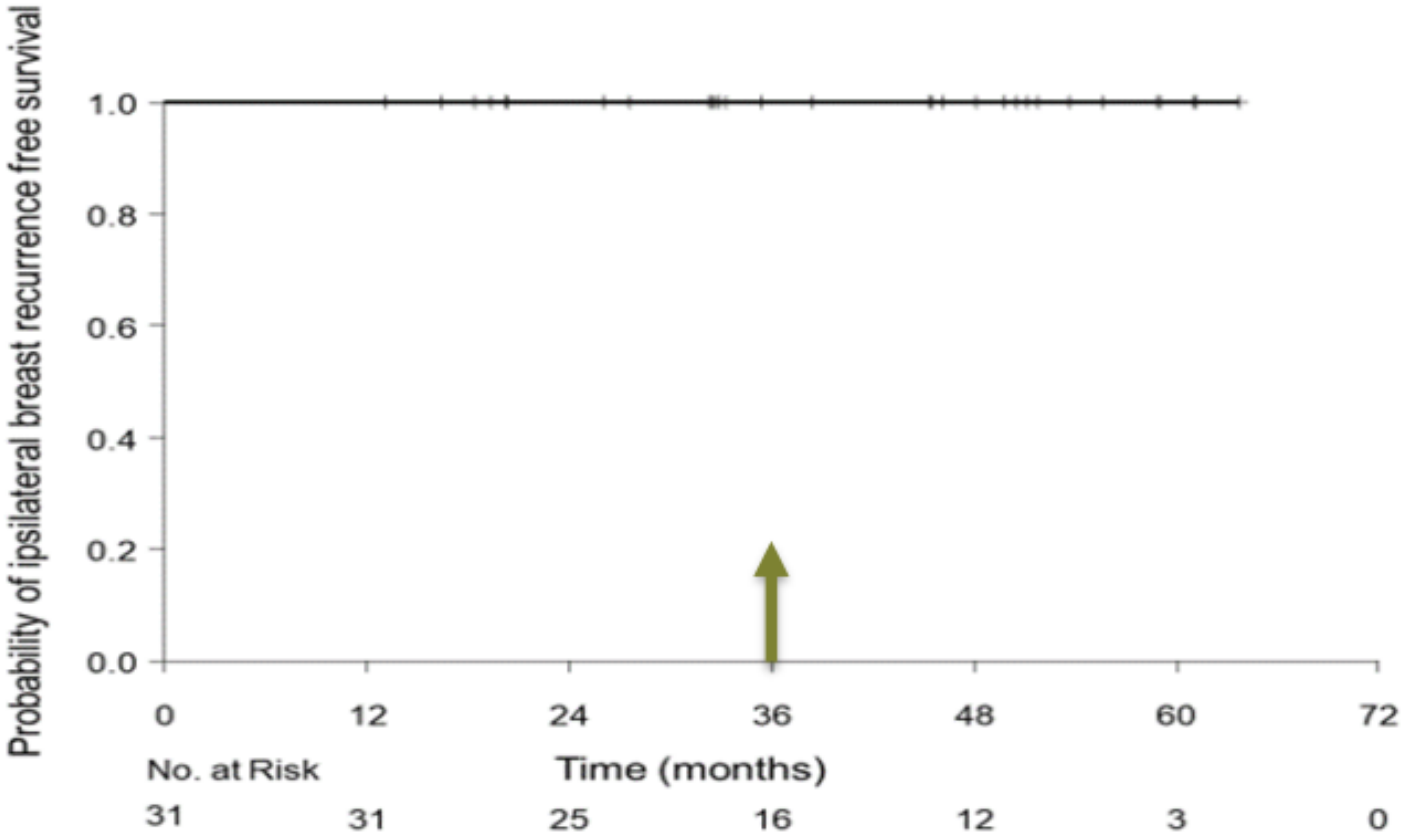
Patient Group	N	Events	Median (95% CI)
Imlunestrant + everolimus	42	22	15.9 (11.3, 19.1)
Imlunestrant + alpelisib	21	13	9.2 (3.7, 11.1)



Patients at risk

42	32	25	23	19	15	7	3	0	0	0
21	16	10	6	2	0	0	0	0	0	0

Une devinette pour terminer !!



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MADRID 2023 ESMO congress

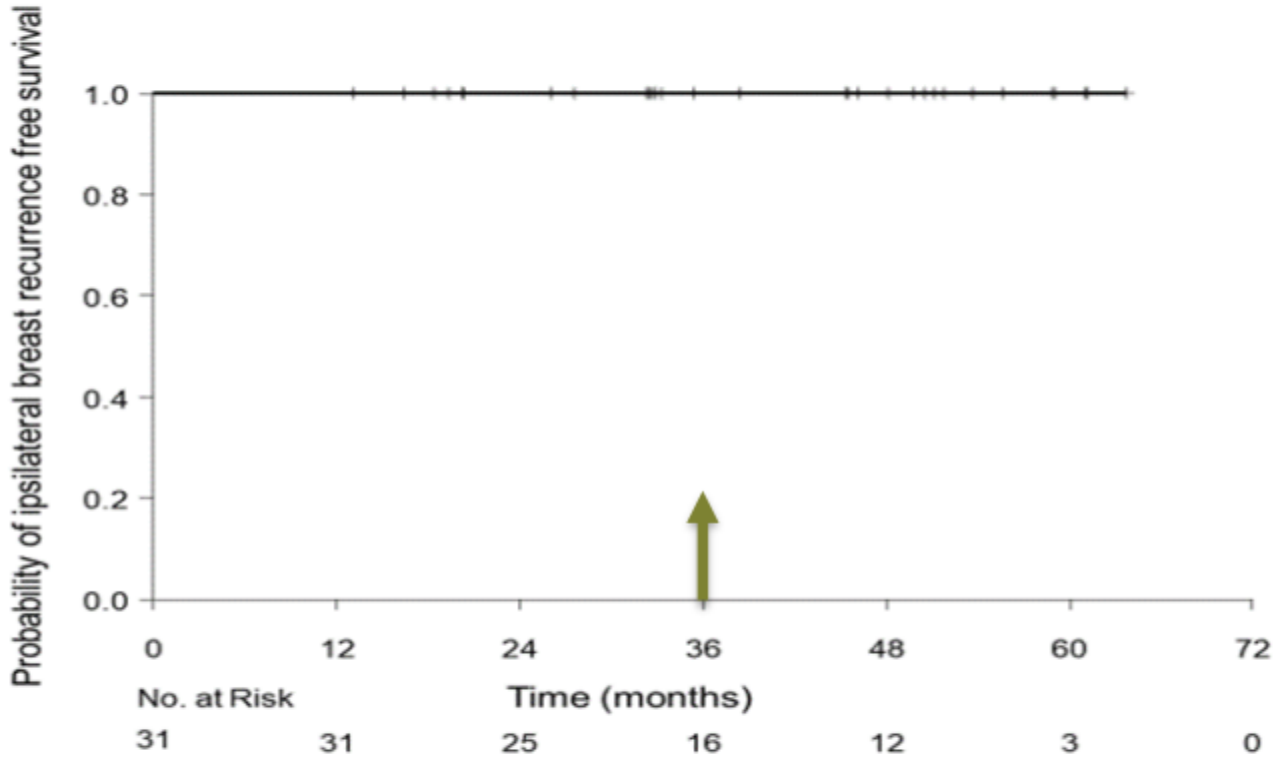
Omission of breast surgery after neoadjuvant systemic therapy for invasive cancer: three-year preplanned primary-endpoint on a phase 2 multicentre prospective trial

Henry M. Kuerer MD, PhD
for the Exceptional Responders Study Group

MD Anderson Cancer Center, Houston, Texas, USA

October 23, 2023

RESULTS: Primary objective IBTR-free survival among patients who did not undergo breast surgery 3-year planned analysis



100% IBTRFS

Secondary
100% OS/DFS

Median follow-up 38.4 months (IQR 27.6–51.8)

Henry M. Kuerer, MD, PhD; hkuerer@mdanderson.org

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Cancers du sein

Sylvain LADOIRE

MADRID SPAIN
20-24 OCTOBER 2023

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