2025

DEBATES AND DIDACTICS in Hematology and Oncology

EMORY WINSHIP CANCER INSTITUTE
National Cancer Institute-Designated Comprehensive Cancer Center

Where Science Becomes Hope

JULY 24 - 27, 2025 • SEA ISLAND, GEORGIA

This activity is jointly provided by Partners for Advancing Clinical Education and Bio Ascend

Triple Negative Breast Cancer
Where We Are and Where Are We Going

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Associate Professor
Winship Cancer Institute of Emory University

Disclosures

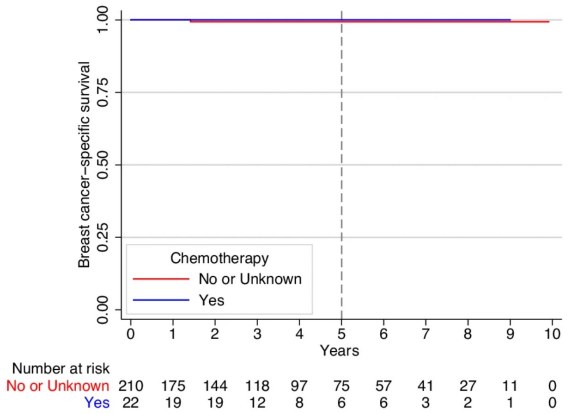
- Consultant/Advisor/Speaker: AstraZeneca

What we will learn today

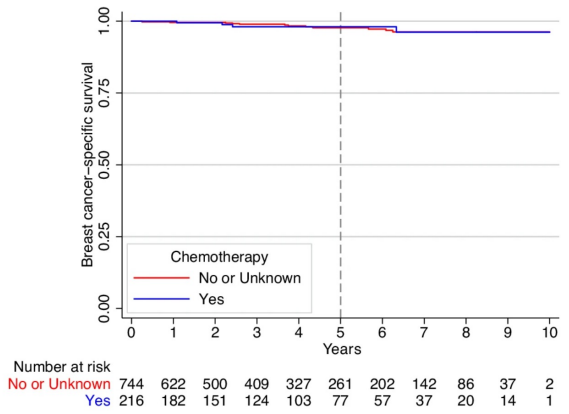
- Contemporary management of TNBC
- Evolving role of antibody drug conjugates
- Emerging biomarkers for treatment selection
- Ongoing clinical trials

How to treat stage I TNBC

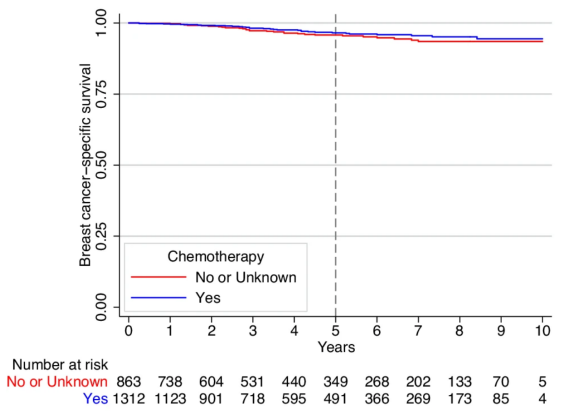
Tmic



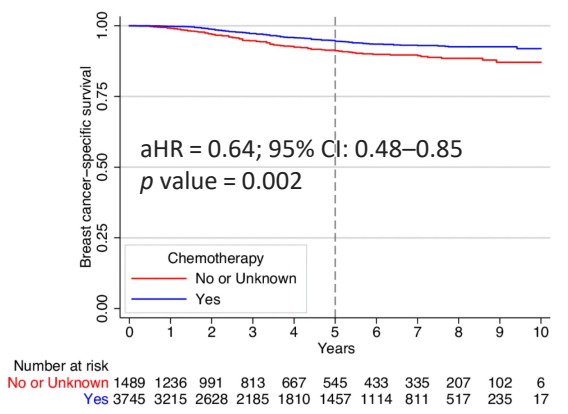
T1a



T1b



T1c



pT1a (≤0.5 cm) → **pN0** → **No adjuvant therapy[ss]**

pT1a (≤0.5 cm) → **pN1mi** → **Consider adjuvant chemotherapy[a,gg,jj] and adjuvant olaparib if germline *BRCA1/2* mutation, see BINV-M for eligibility criteria. Olaparib should be given after completion of RT, see BINV-I.**

pT1b (0.6–1.0 cm) → **Consider adjuvant chemotherapy[a,gg,jj] and adjuvant olaparib if germline *BRCA1/2* mutation, see BINV-M for eligibility criteria. Olaparib should be given after completion of RT, see BINV-I.**

pT1c-pT3 (>1 cm) → **Adjuvant chemotherapy[a,gg,jj] (category 1) and adjuvant olaparib if germline *BRCA1/2* mutation, see BINV-M for eligibility criteria. Olaparib should be given after completion of RT, see BINV-I.**

NCCN Guidelines Version 4.2025; Tarantino P, npj Breast Cancer 2024

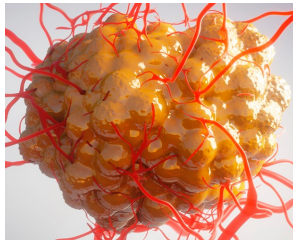
Patient Case

3 cm TNBC
with 2 LN+

?

CT and
bone scan
negative

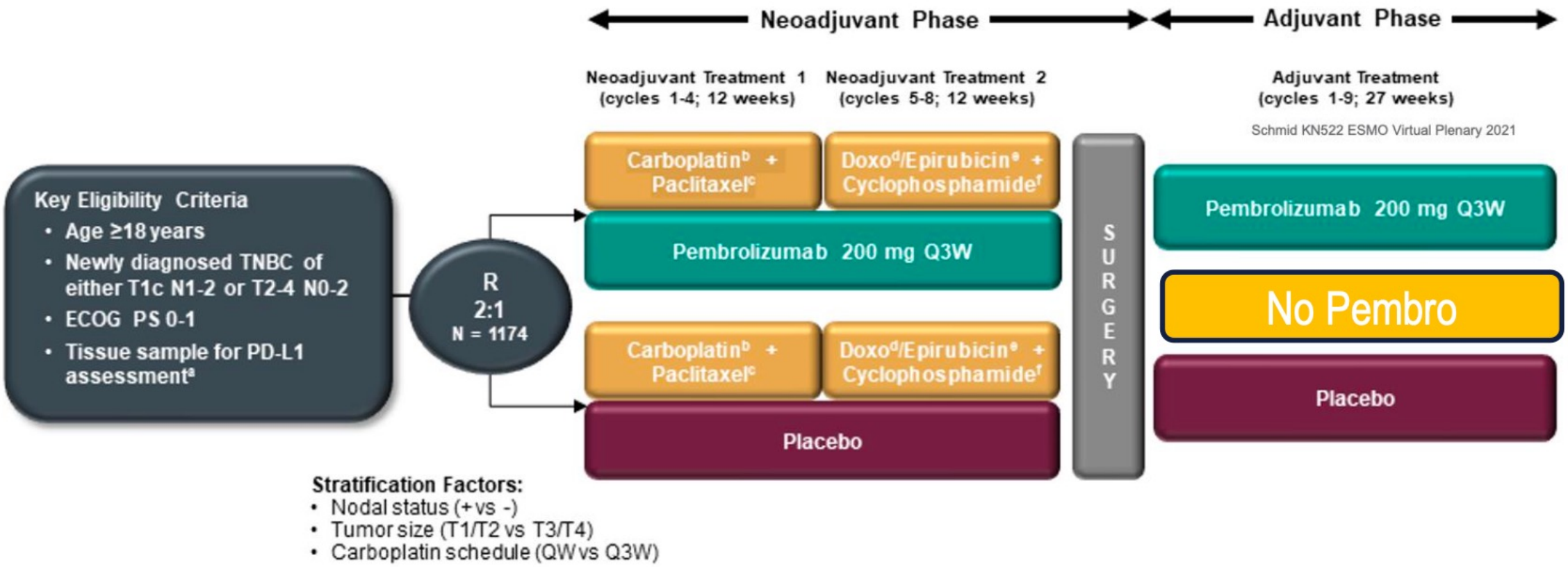
How to treat stage II-III TNBC



KEYNOTE 522

Neoadjuvant	Surgery	Adjuvant
Carboplatin-paclitaxel followed by doxorubicin-cyclophosphamide with pembrolizumab		**Pembrolizumab (pCR)**
		Pembrolizumab + capecitabine/Olaparib (RD)

KEYNOTE 522



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

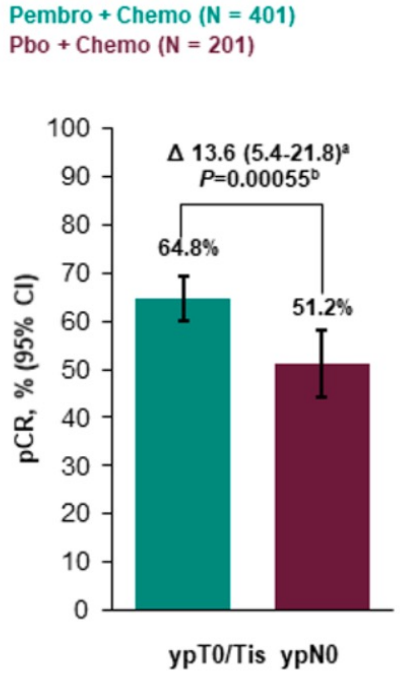
Adjuvant phase: starts from the first adjuvant treatment and includes radiation therapy as indicated (post treatment included)

[a]Must consist of at least 2 separate tumor cores from the primary tumor.
[b]Carboplatin dose was AUC 5 Q3W or AUC 1.5 QW.
[c]Paclitaxel dose was 80 mg/m² QW.
[d]Doxorubicin dose was 60 mg/m² Q3W.
[e]Epirubicin dose was 90 mg/m² Q3W.
[f]Cyclophosphamide dose was 600 mg/m² Q3W.

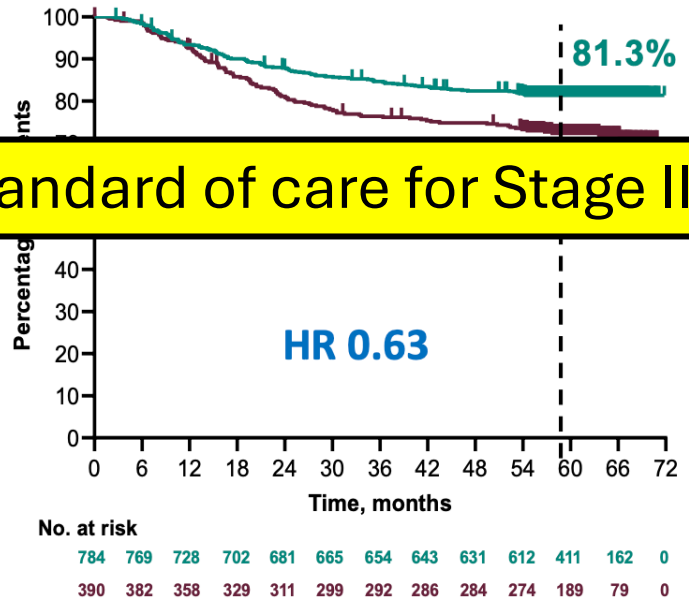
Schmid P et al. NEJM 2020

KEYNOTE 522

Pathological complete response

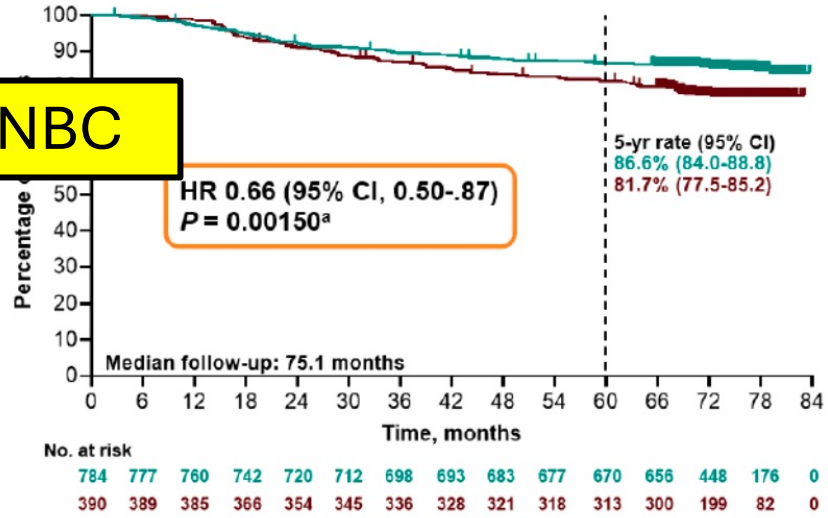


5-year Event Free Survival



Standard of care for Stage II-III TNBC

Overall Survival



Schmid P et al. NEJM 2020

Patient case

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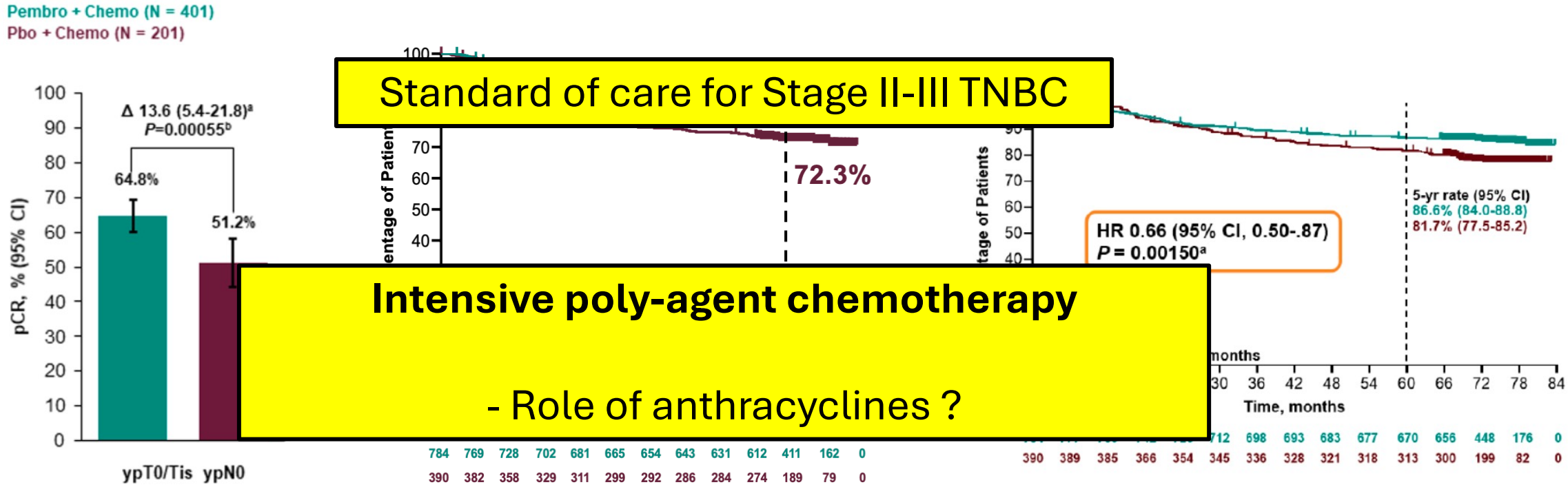


Standard of care for Stage II-III TNBC

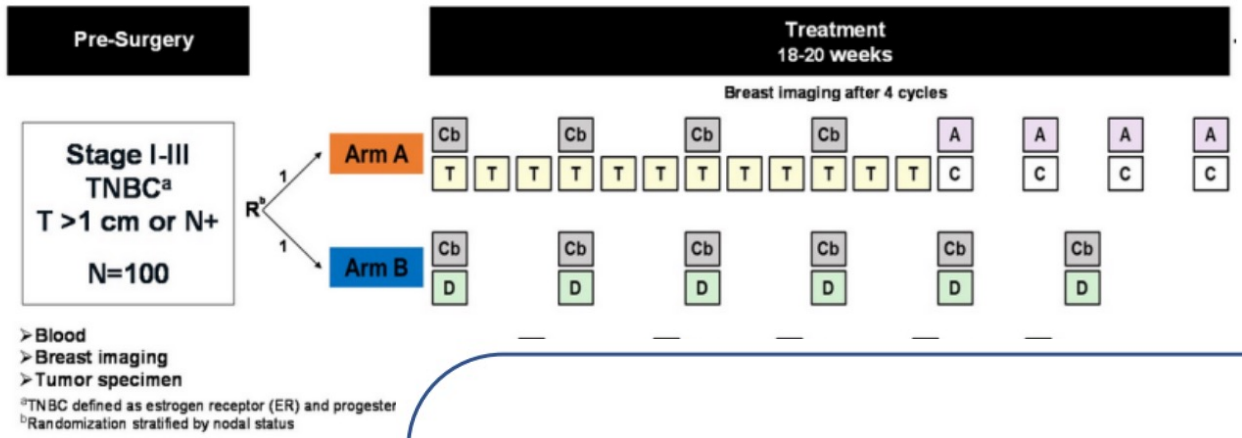
Intensive poly-agent chemotherapy

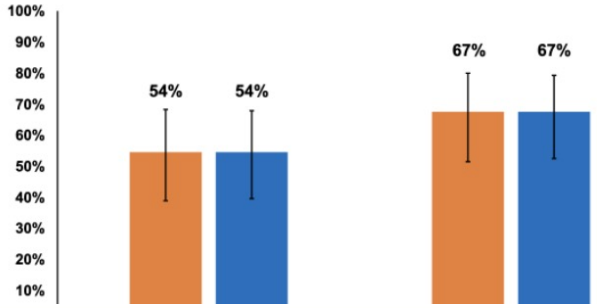
- Role of anthracyclines ?

Schmid P et al. NEJM 2020

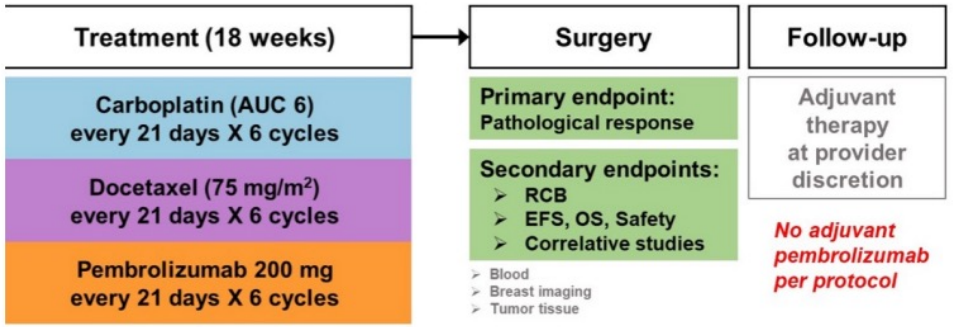
Contraindication to anthracyclines ?

NeoSTOP: Docetaxel + carboplatin shows similar rate of pCR to Paclitaxel + Carboplatin -> AC

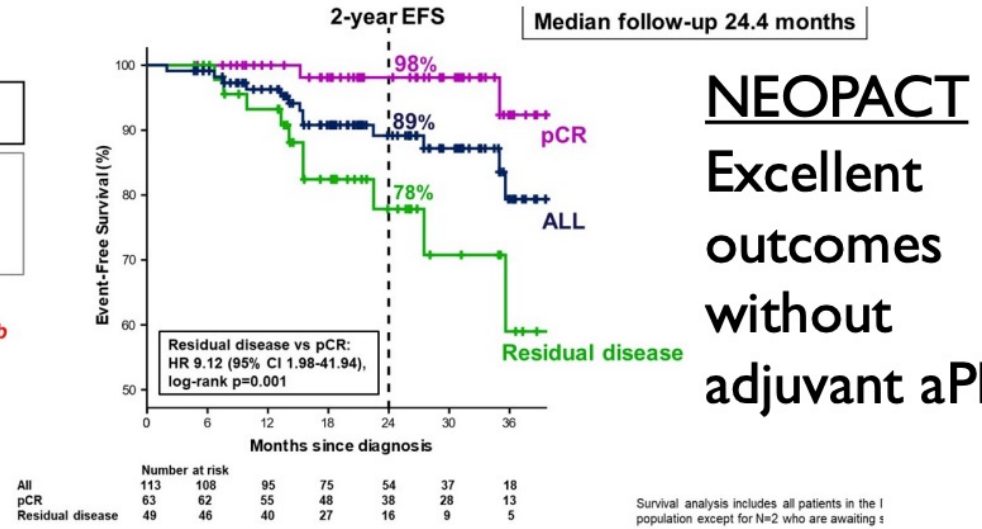




- Docetaxel + Carl
  neutropenia, ane
- Docetaxel + Carl
  regimen of Paclit



pCR 58%

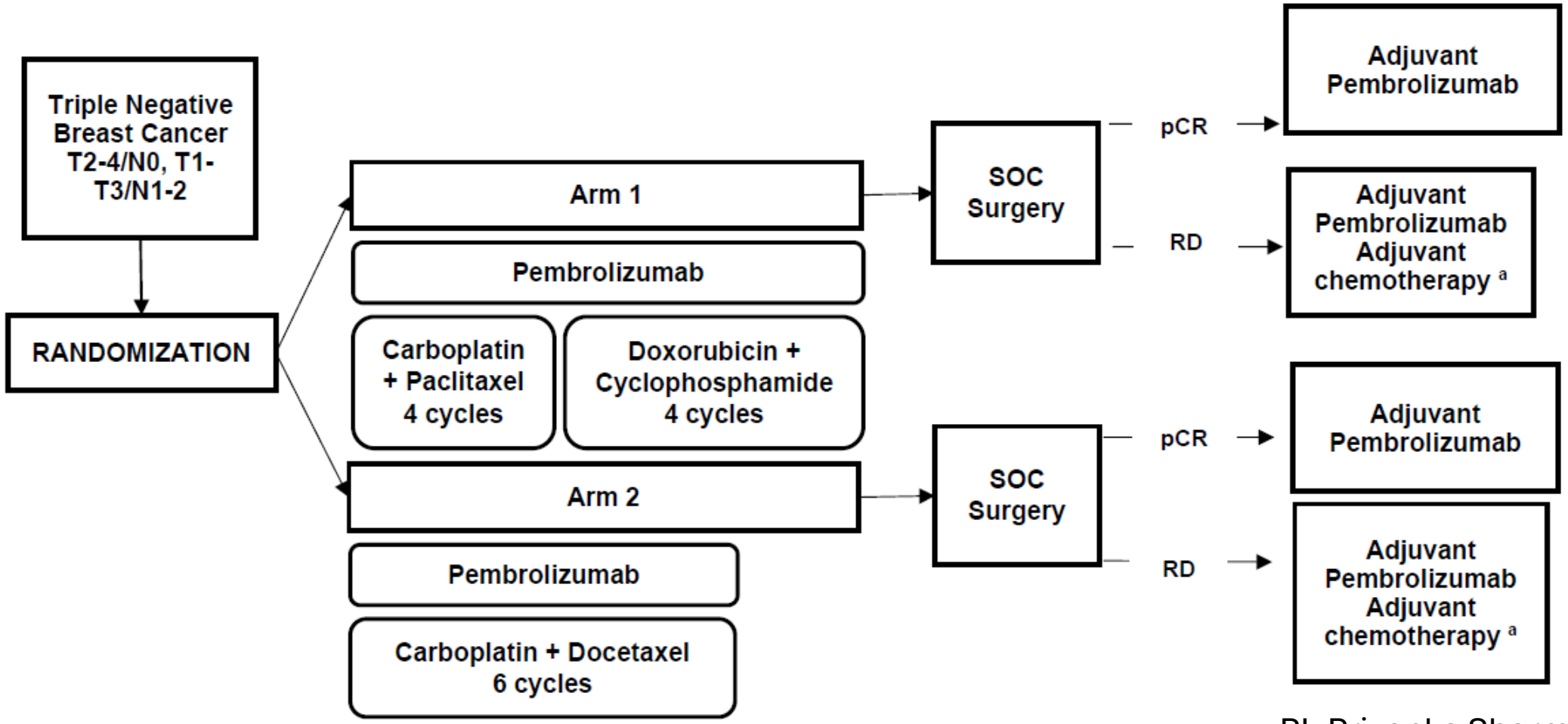


NEOPACT
Excellent outcomes without adjuvant aPD l

Telli M, SABCS 2023; Sharma P et al. JAMA Onc 2023

SCARLET: Non-inferiority of taxane and platinum-based chemotherapy

De-escalation of the chemotherapy backbone

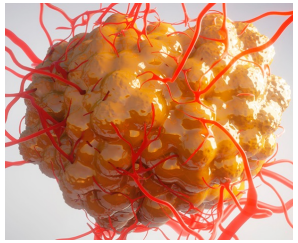


PI: Priyanka Sharma

How to treat stage II-III TNBC

What is the contribution of adjuvant pembrolizumab in pCR?

KEYNOTE 522



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Carboplatin-paclitaxel followed by doxorubicin-cyclophosphamide with pembrolizumab		**Pembrolizumab (pCR)**
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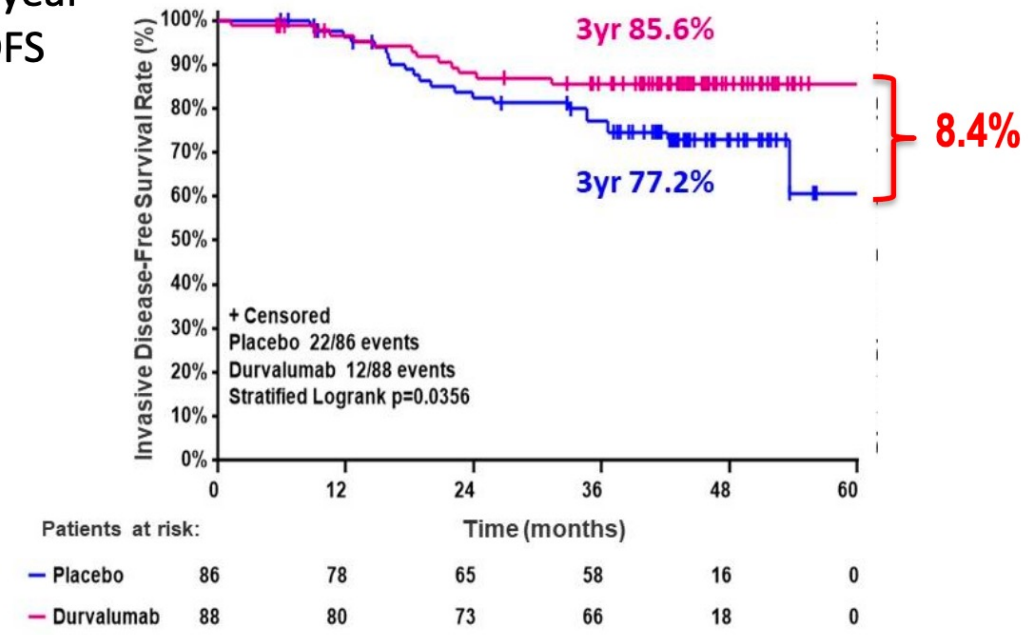
Contribution of adjuvant immunotherapy ?

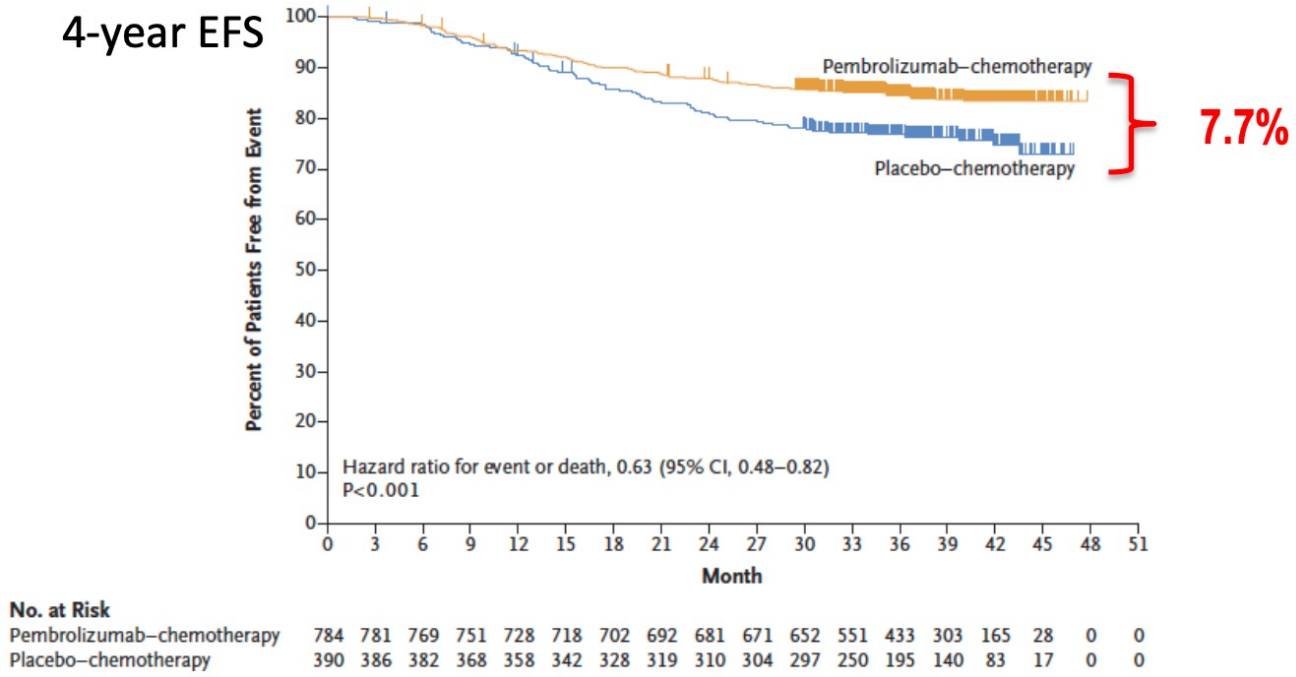
GeparNuevo
Only preop IO, No adjuvant IO

3-year IDFS



KN522
Preop and adjuvant IO

4-year EFS



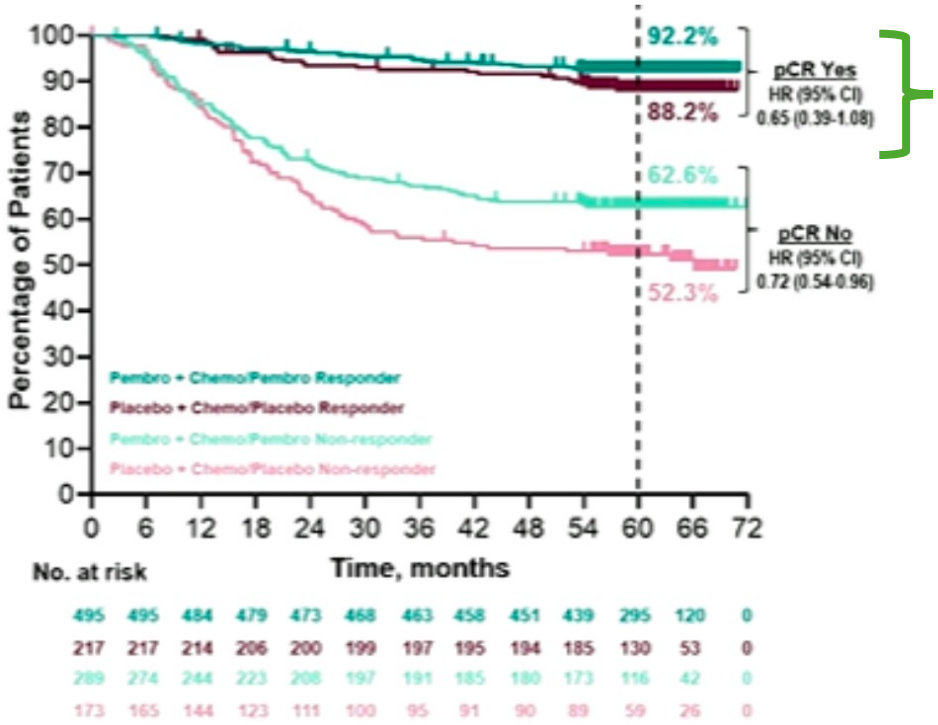
Trials omitting adjuvant immunotherapy showed improved long-term outcomes

Schmid P et al. NEJM 2020; Loibl S et al. Annals of Oncology, 2022

KN522 – Survival by pCR

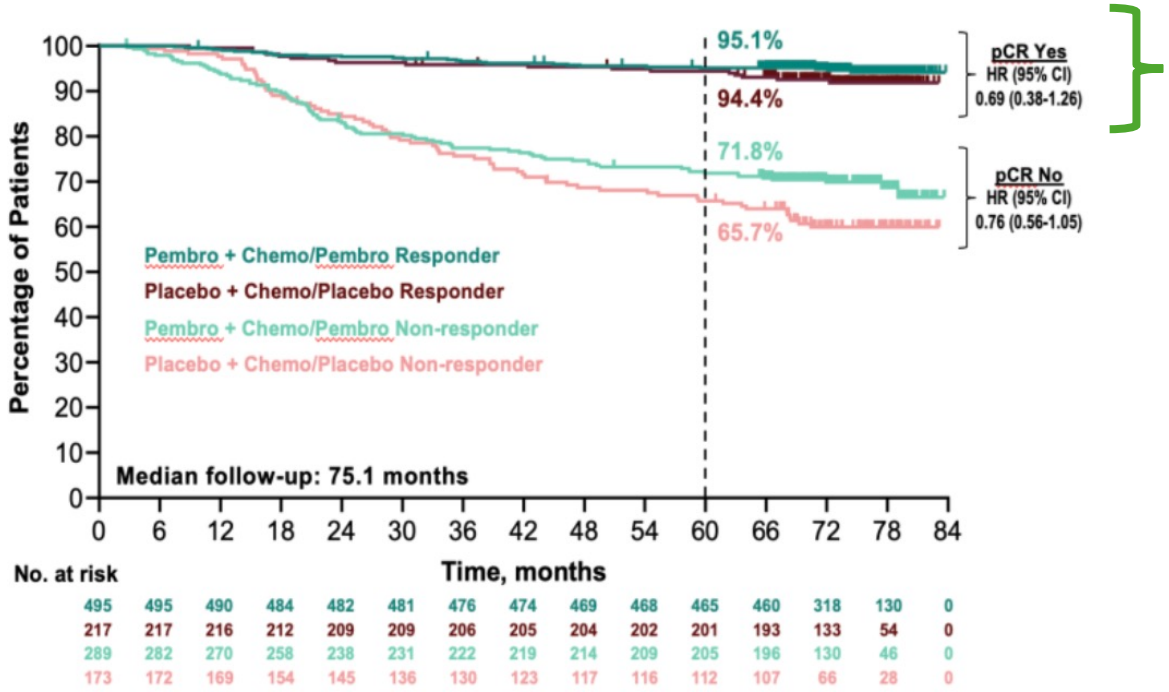
De-escalation

EFS



De-escalation

OS

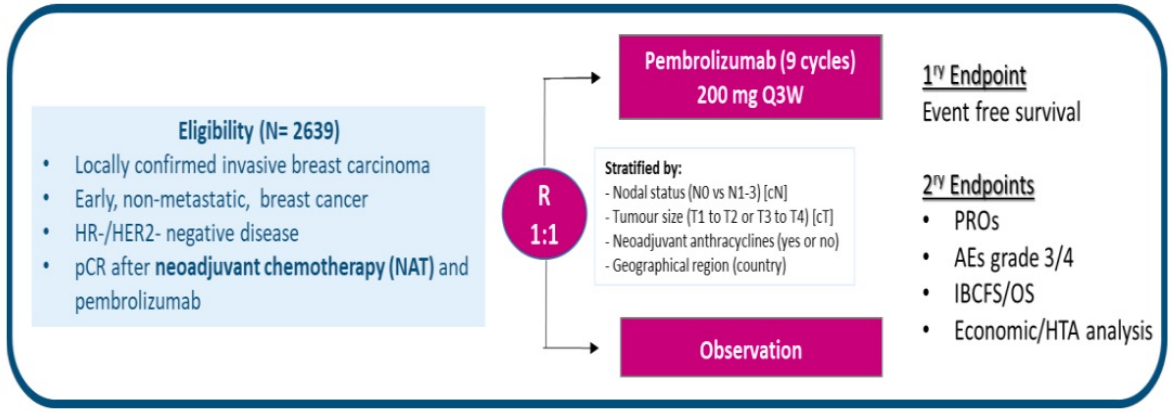


Patients with pCR

Schmid P et al. NEJM 2020

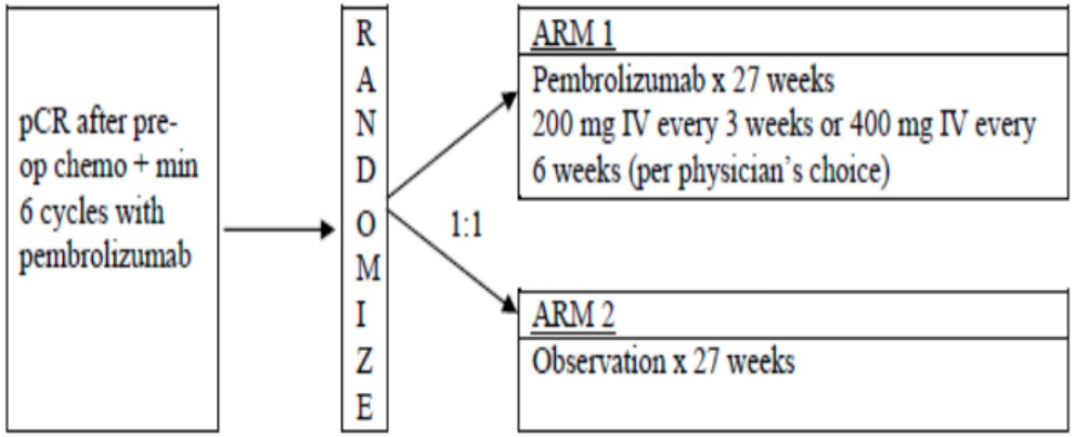
De-escalation of adjuvant pembrolizumab

OPT-PEMBRO



PI: Joana Ribeiro, IGR/unicancer, France

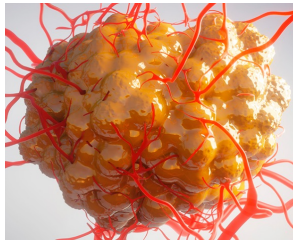
OPTIMICE-pCR



PI: Sara Tolaney, DFCI/ALLIANCE, USA

Ribeiro JM et al. ESMO Breast 2025

How to treat stage II-III TNBC



KEYNOTE 522

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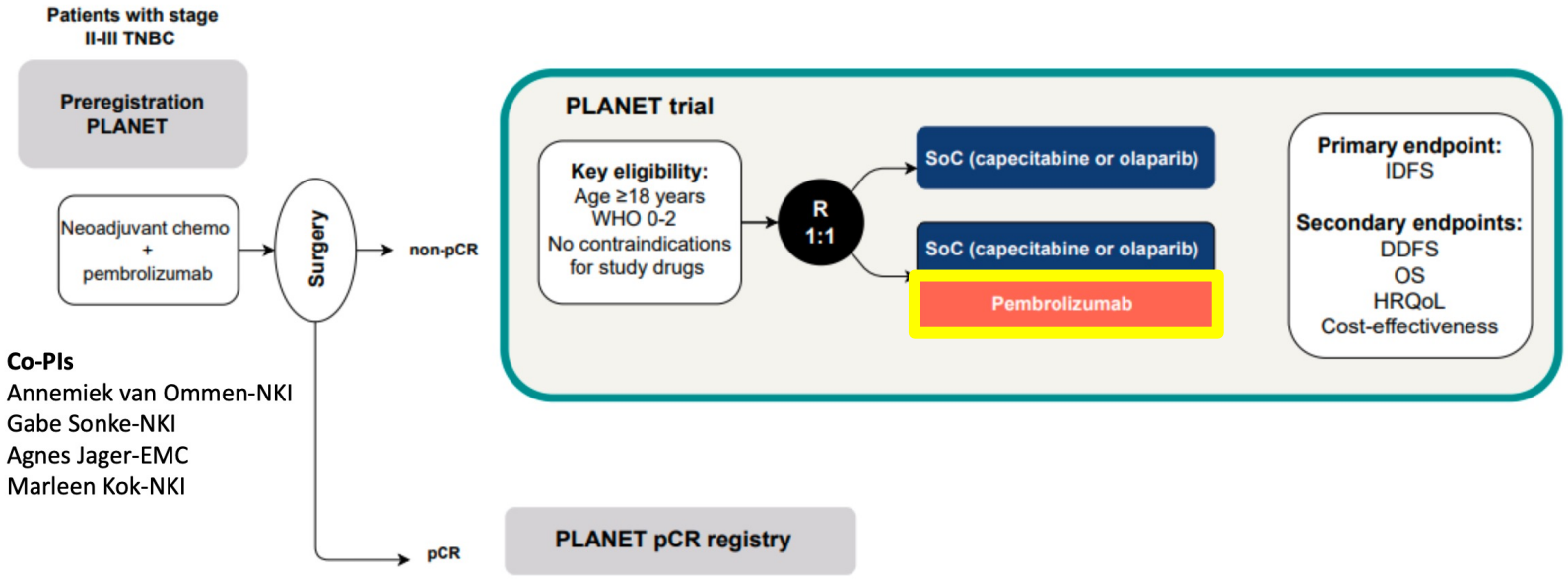
What is the role of adjuvant pembrolizumab or capecitabine in non-pCR?

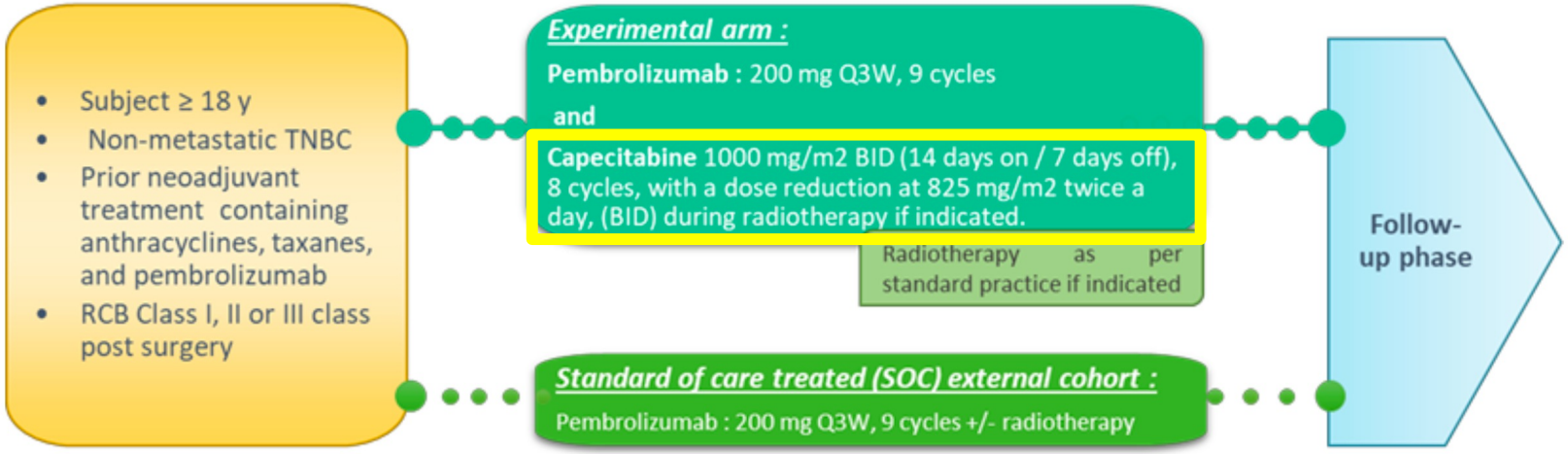
PLANET trial

What is the additional role of pembrolizumab ?



CAPPA trial

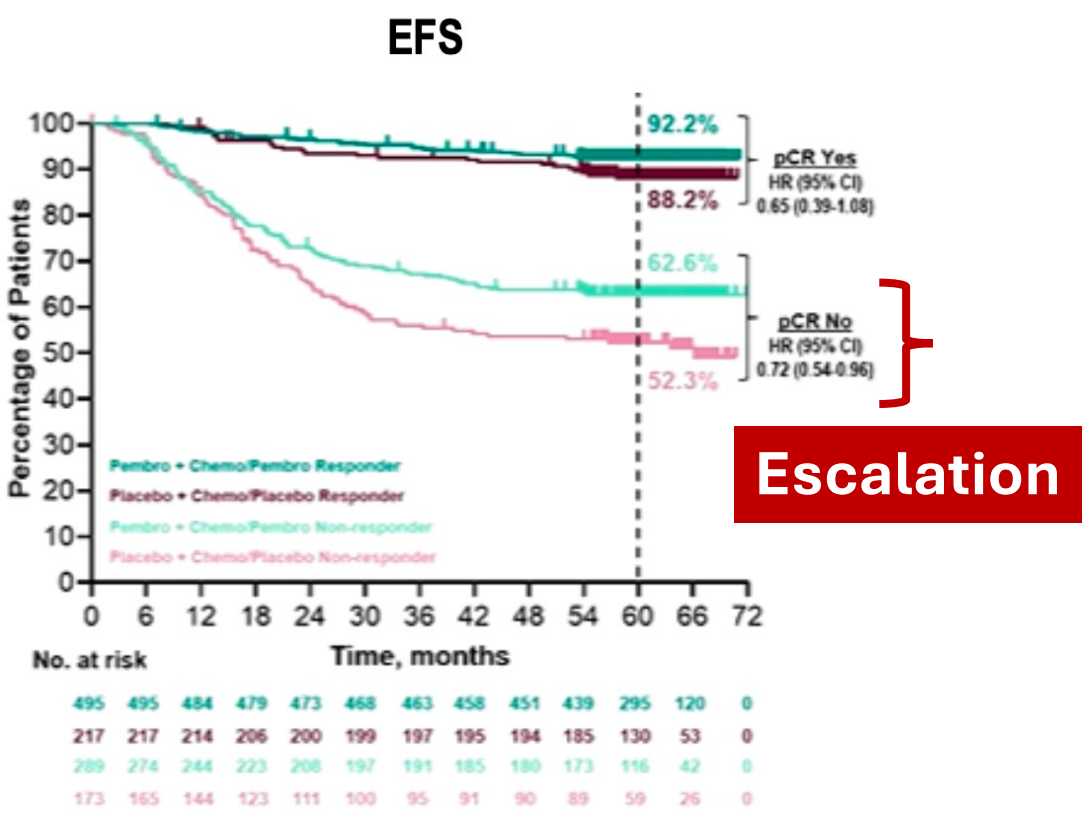
What is the additional role of capecitabine ?



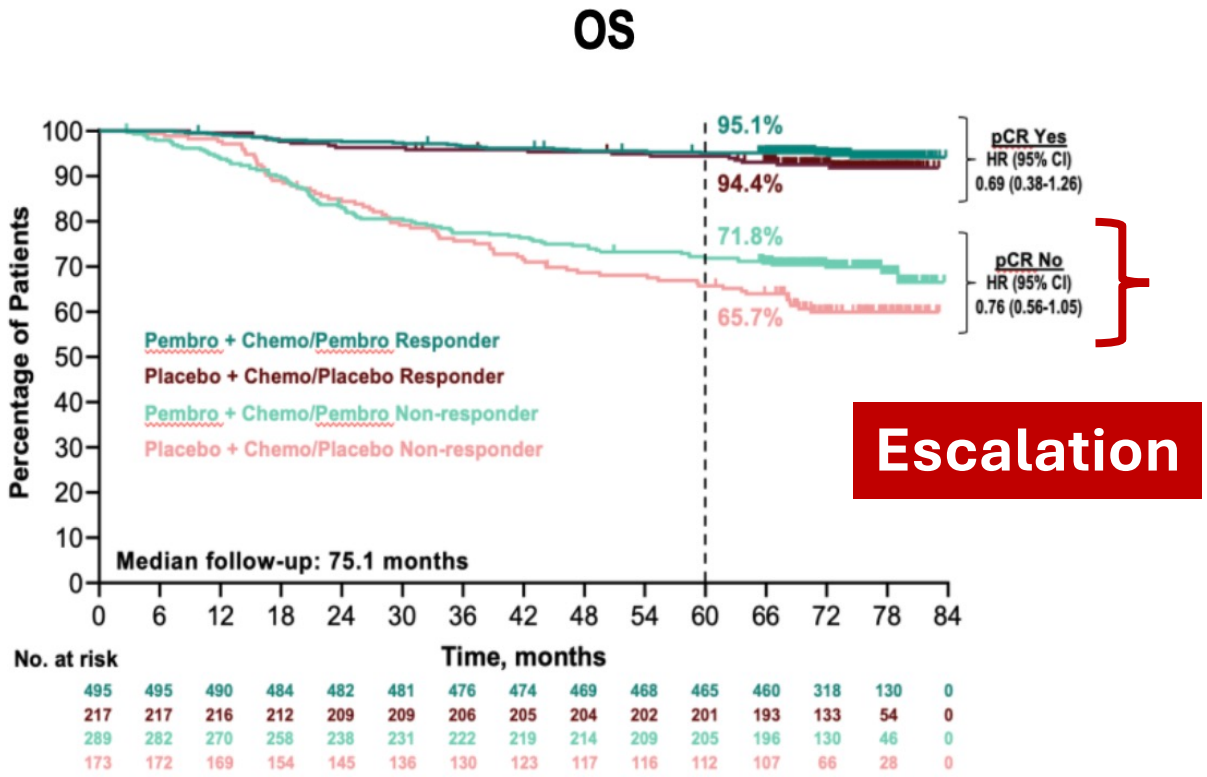
PI: Delphine Loirat, ICurie/Unicancer, France

Ribeiro JM et al. ESMO Breast 2025

KN522– Survival by Residual Disease



Escalation



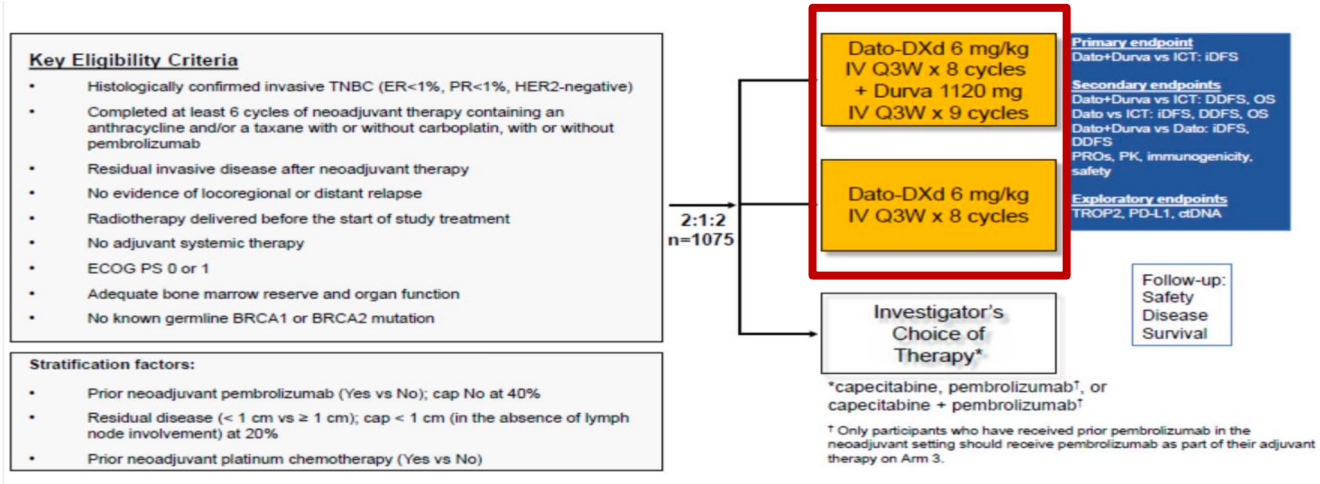
Escalation

Patients with residual disease

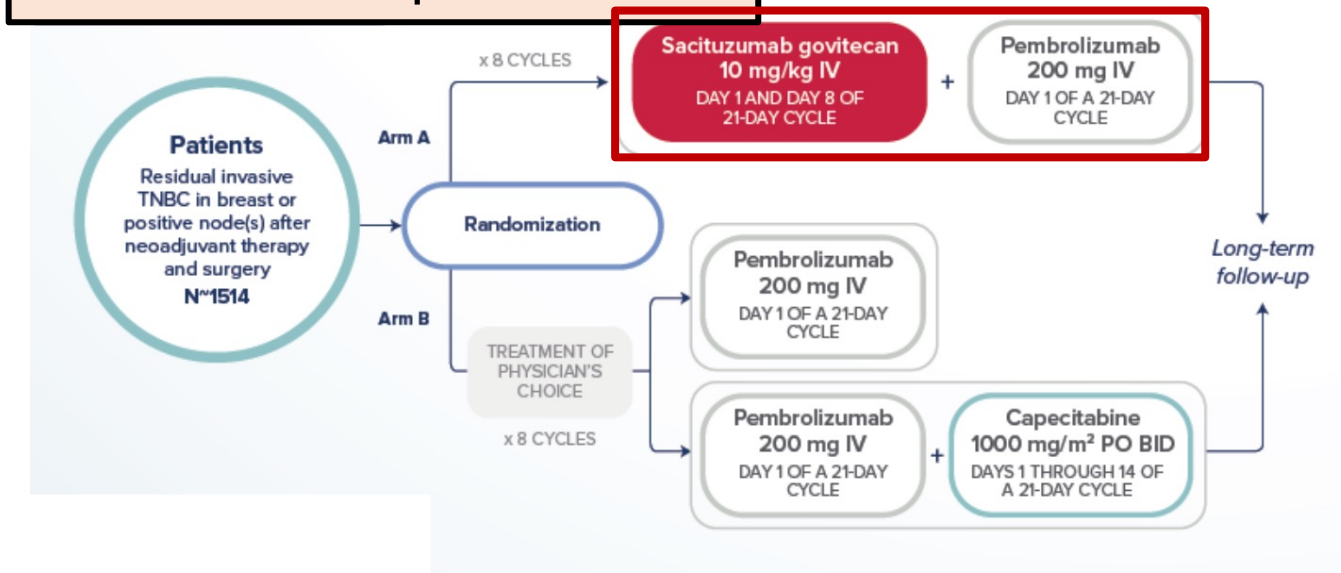
Schmid P et al. NEJM 2020

Escalation of adjuvant treatment for residual disease

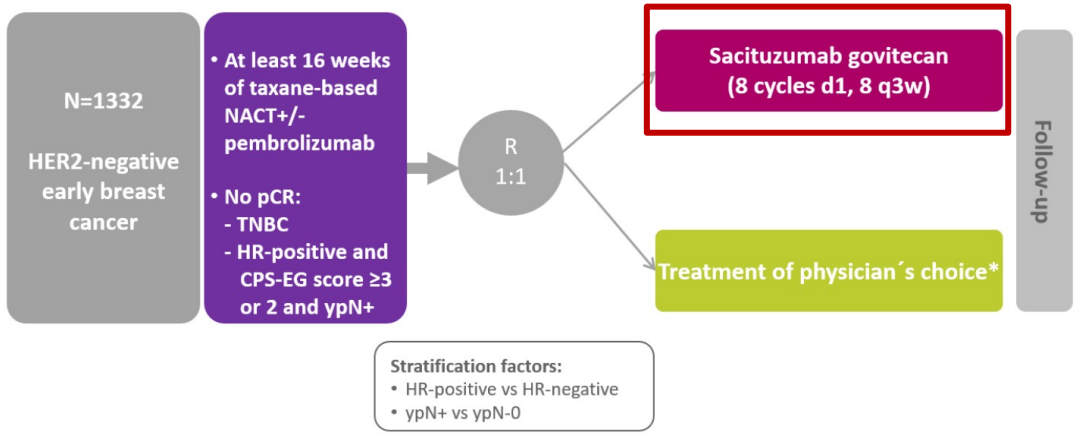
TROPION-Breast03



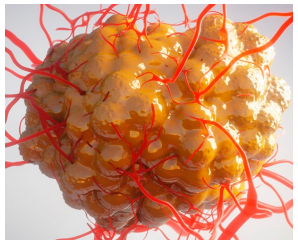
ASCENT 05/OptimICE-RD



SASCIA



How to treat stage II-III TNBC



Chemotherapy + Atezolizumab

IMPASSION 030

Chemotherapy + Avelumab

A-BRAVE

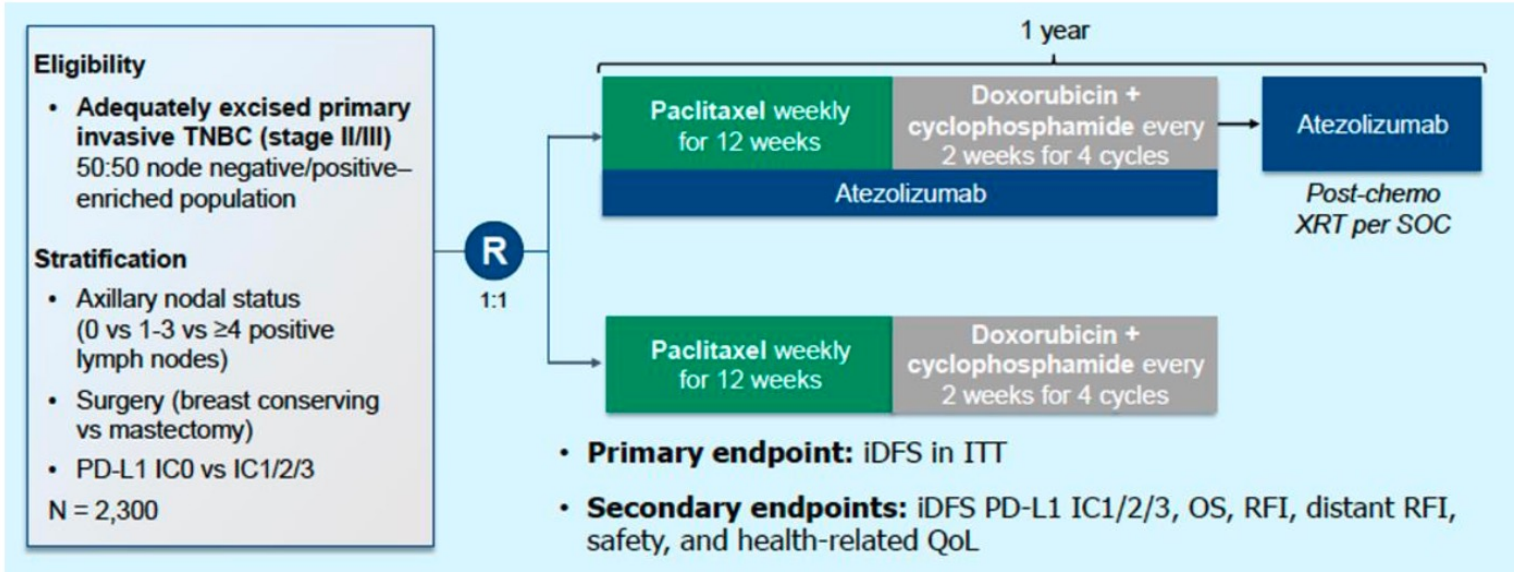
Neoadjuvant chemotherapy

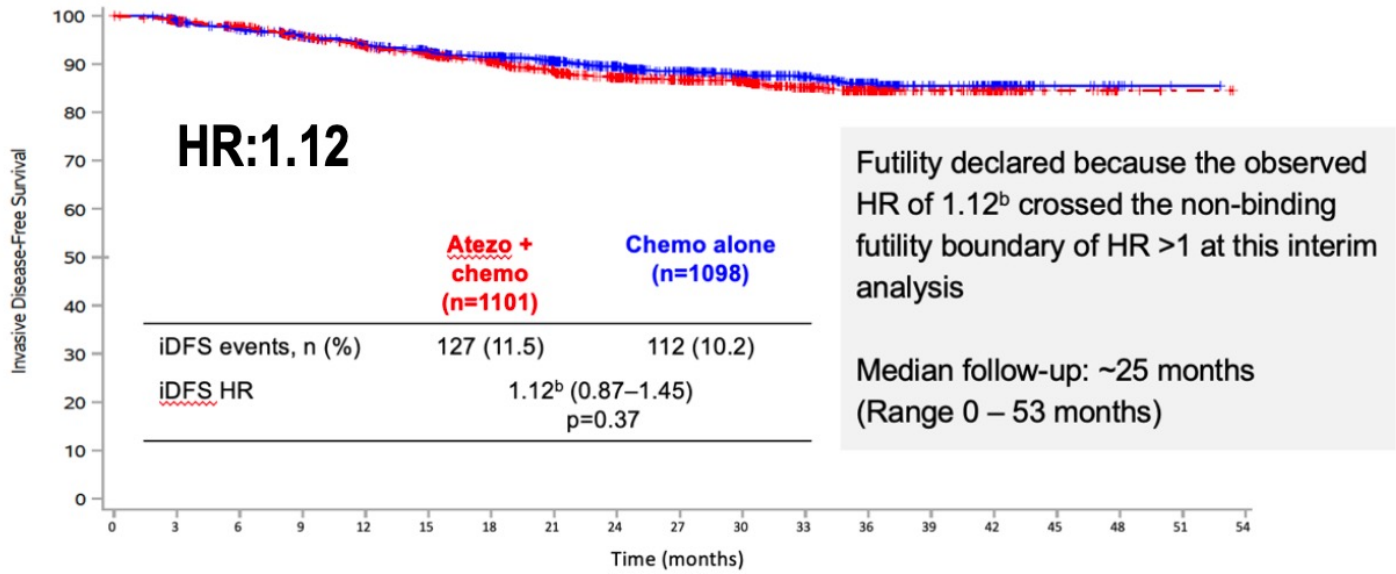
Chemotherapy + Avelumab

What is the contribution of adjuvant ONLY immunotherapy ?

IMPASSION 030 – Adjuvant chemotherapy and atezolizumab

- Concurrent **adjuvant** AC + T chemotherapy and atezolizumab
- **N=2300**
- **No improvement invasive disease-free survival**





Ignatidis et al. SABCS 2023

A-BRAVE

KEY ELIGIBILITY CRITERIA

- ECOG PS 0-1
- TNBC (ER & PR <10%, HER2 IHC 0-1+ or 2+/ISH–)[a]
- Anthracycline and taxane (neo)-adjuvant ChemoRx (no preop IO)
- Randomization <10 weeks from last chemo or surgery

RANDOMIZED 1:1

Avelumab
10 mg/kg, iv, q2w for 52 wks (n=238)

Observation (n=239)

N=477

Stratum A (Adjuvant): pT2N1, pT3-4 N0-3, pN2-3 anyT[b]

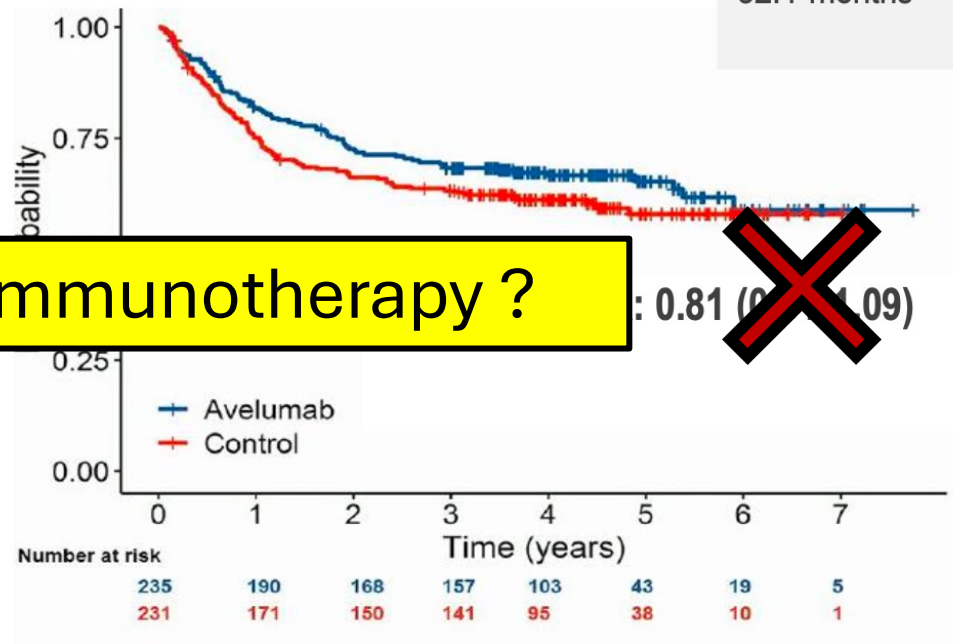
Stratum B (Post-neoadjuvant): residual invasive carcinoma in the breast and/or axillary lymph nodes[c]

PRIMARY OBJECTIVES: DFS, DFS in Stratum B
SECONDARY OBJECTIVES: OS, safety

DFS in ITT

Median follow up:
52.1 months

Is there a role for adjuvant only immunotherapy ?



DFS		Avelumab	Control	Δ	HR (95%, CI)	P value
OS, ITT	Events, n	46	62			
	3-year OS (95%, CI), %	84.8 (79.5-88.8)	76.3 (70.1-81.3)	8.5%	0.66 (0.45-0.97)	0.035
DDFS, ITT	Events, n	66	85			
	3-year DDFS (95%, CI), %	75.4 (69.3-80.4)	67.9 (61.4-73.5)	7.5%	0.70 (0.50-0.96)	0.0277

Conte P et al. ASCO 2024

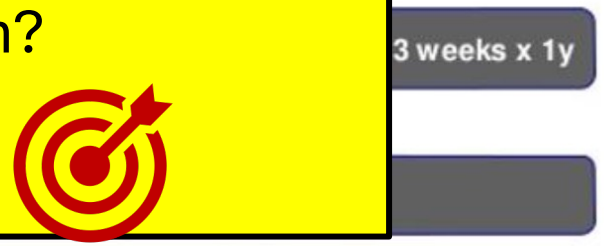
SWOG S1418/NRG BR006

- Await data from SWOG S1418/NRG BR006, a phase 3 trial of pembrolizumab monotherapy for residu
- Large
- Uses pembrolizumab, the currently available agent

SWOG S1418/NRG BR006
Ph 3 Pembrolizumab for Residual TNBC post NAC

Does everyone need checkpoint inhibition?

An unmet need remains: Biomarkers ?



- **Registration:**
  - Central PD-L1 testing
- **Stratification:**
  - Nodal stage ypNo vs ypN+
  - Residual tumor ≥2 vs < 2cm
  - PD-L1 pos vs neg
  - Prior adjuvant chemo yes vs no

PIs: Pusztai/Mamounas

- **Hypothesis:**
  - Pembrolizumab reduces IDFS by 33% c/w observation alone
- **Primary Endpoint:**
  - Invasive DFS in PD-L1-positive and overall cohort
- **Secondary Endpoints:**
  - Toxicity
  - OS
  - DRFS
  - QOL (PROMIS, PRO-CTCAE forms, inflammatory markers)
  - Tissue banking

Biomarkers to predict ICI benefit in early-stage TNBC

GeparDouze

Subgroup	N events/patients	HR (95% CI)	P	P for interaction
Group				0.457
GBG	146/978	0.868 (0.627, 1.202)	0.395	
NSABP	97/572	0.714 (0.478, 1.067)	0.100	
Clinical Nodal Status				0.039
Negative	109/901	1.066 (0.732, 1.552)	0.739	
Positive	134/649	0.623 (0.441, 0.879)	0.007	
AC/EC Schedule				0.401
Every 2 weeks	159/996	0.872 (0.638, 1.191)	0.389	
Every 3 weeks	84/55			
Clinical Size of Primary Tumor				8
> 3.0 cm	128/6			
1.1–3.0 cm	115/9			
PD-L1 status				0.712
Negative/indeterminate/not available	160/853	0.831 (0.609, 1.135)	0.244	
Positive	83/697	0.752 (0.487, 1.160)	0.198	
TIL Category				0.086
<30%	180/960	0.925 (0.690, 1.239)	0.560	
>=30%	63/583	0.551 (0.330, 0.920)	0.023	
Overall	243/1550	0.805 (0.626, 1.037)	0.093	

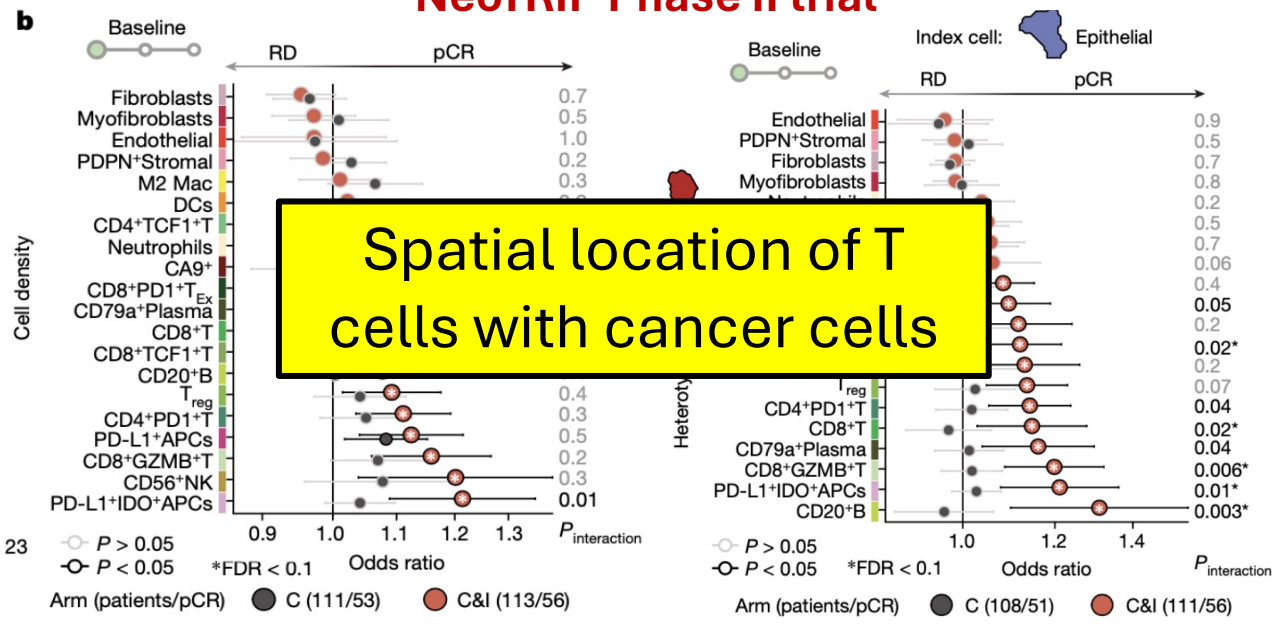
X-axis is under log scale.

0.25 0.5 1 2 4

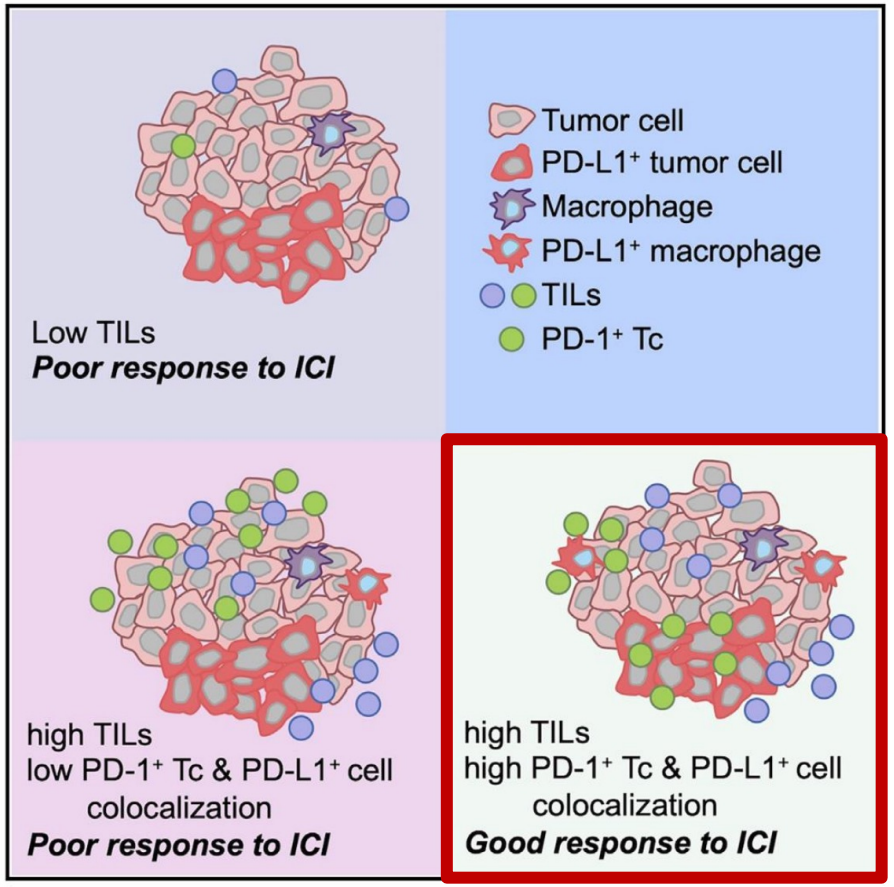
Atezolizumab Better | Placebo Better

TILS ≥ 30%

NeoTRIP Phase II trial



Spatial location of T cells with cancer cells

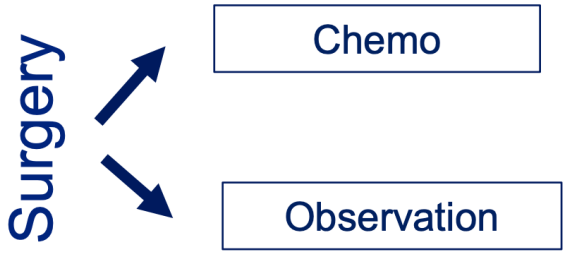


Geyer et al. SABCS 2024; Wang et al. Nature 2023

Personalization of treatment (guided by TILs)

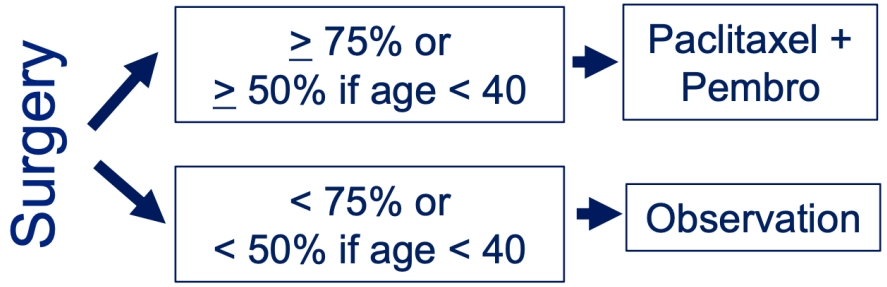
OPTImaL (n=490)

Stage I TNBC: sTIL ≥ 50% or ≥ 75% if < 40 yo



ETNA (n=354)

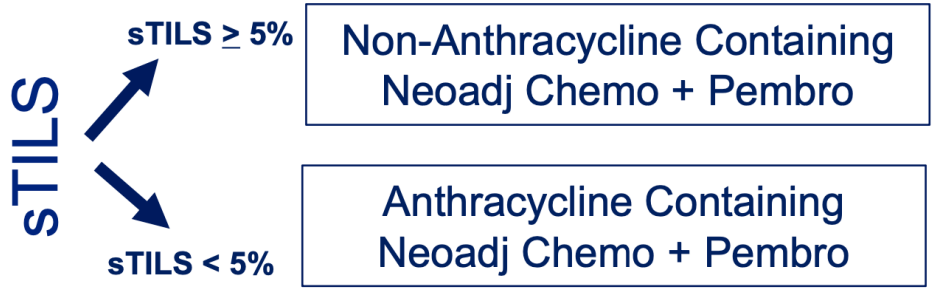
Stage I TNBC: sTIL ≥ 30%



OPTImal: Kok, ETNA: Pistilli/Oliveira

NeoTRACT (n=140)

cT1c-T3, N0-N2 TNBC



NeoTRACT: Sharma

Kalinsky K, ESMO Breast 2025

Patient Case

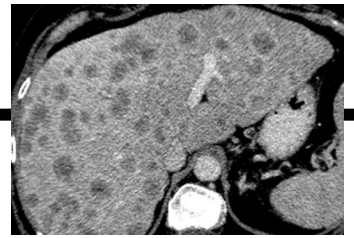
3 cm TNBC
with 2 LN+

CT and
bone scan
negative

Carboplatin-paclitaxel and
doxorubicin-cyclophosphamide
with pembrolizumab

7 months

PD-L1 CPS: 15



IMPASSION 132

Unresectable locally advanced/ metastatic TNBC

Prior anthracycline and taxane for early TNBC

Disease progression <12 months after last treatment for early TNBC with curative intent[a]

No prior chemotherapy for aTNBC

Known PD-L1 status (SP142)

R 1:1

Carboplatin/gemcitabine or capecitabine[b] + atezolizumab 1200 mg q3w

Treatment continued until disease progression or unacceptable toxicity

Stratification factors:

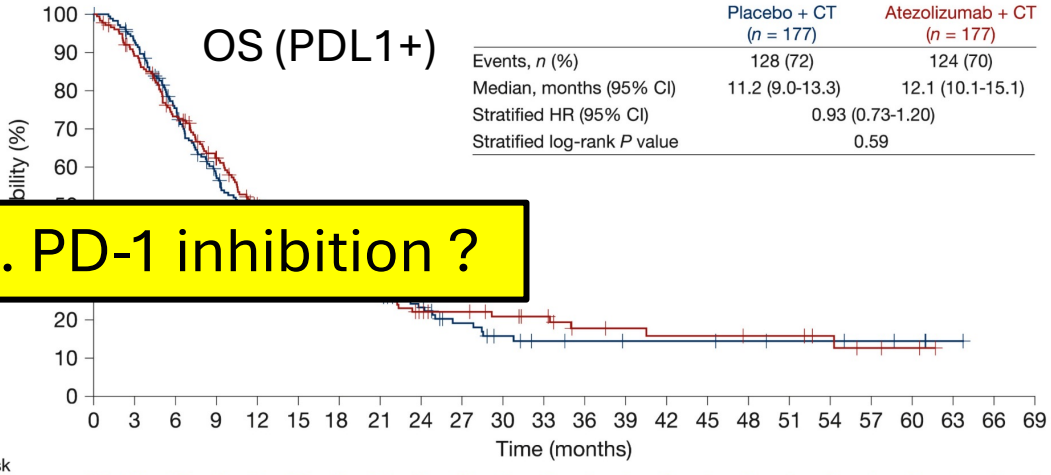
- Visceral (lung and/or liver) metastases
- CT backbone
- PD-L1 status (during all-comer enrolment)

Primary endpoint:

- OS (hierarchical testing: PD-L1+ then if positive, modified ITT[c])

Less benefit with PD-L1 vs. PD-1 inhibition ?

OS (PDL1+)



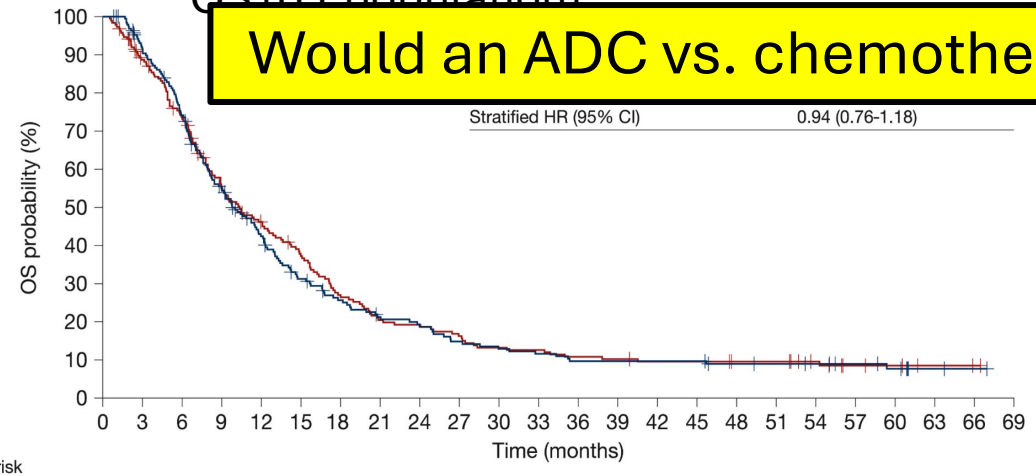
	Placebo + CT (*n* = 177)	Atezolizumab + CT (*n* = 177)
Events, *n* (%)	128 (72)	124 (70)
Median, months (95% CI)	11.2 (9.0-13.3)	12.1 (10.1-15.1)
Stratified HR (95% CI)	0.93 (0.73-1.20)	
Stratified log-rank *P* value	0.59	

Number at risk

Placebo + CT	177	161	125	92	74	57	42	31	25	17	12	9	8	7	7	7	6	5	5	4	3	1	0	0
Atezolizumab + CT	177	153	124	100	75	59	43	30	22	20	17	15	10	9	8	8	7	7	5	3	2	0	0	0

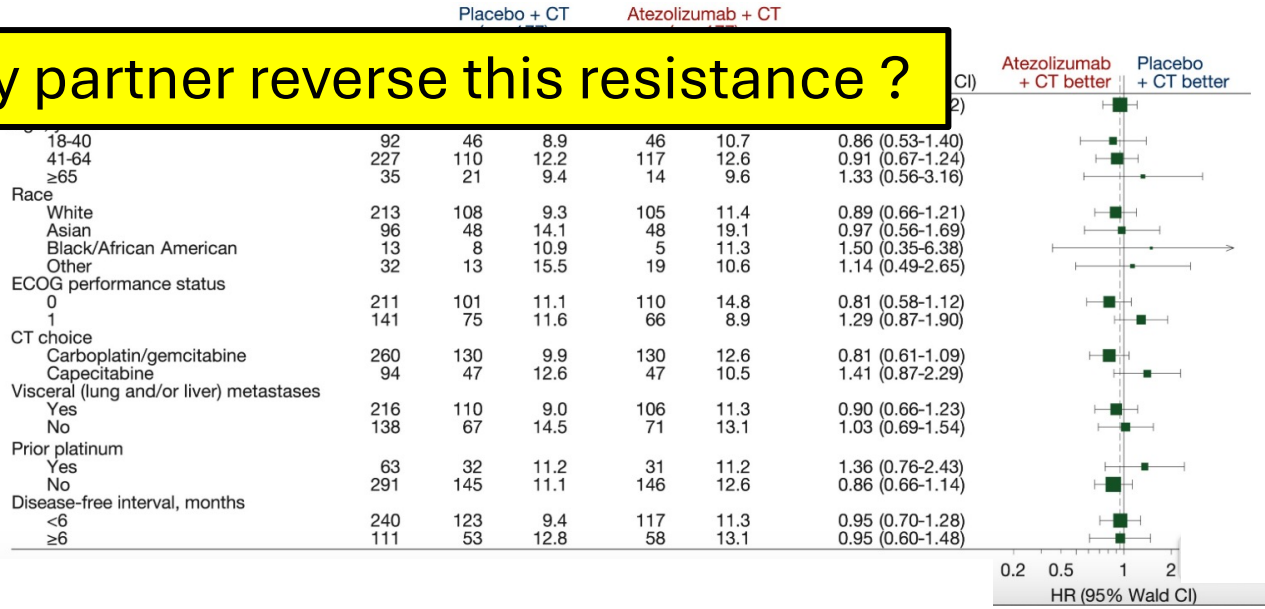
Would an ADC vs. chemotherapy partner reverse this resistance ?

OS (ITT population)



Number at risk

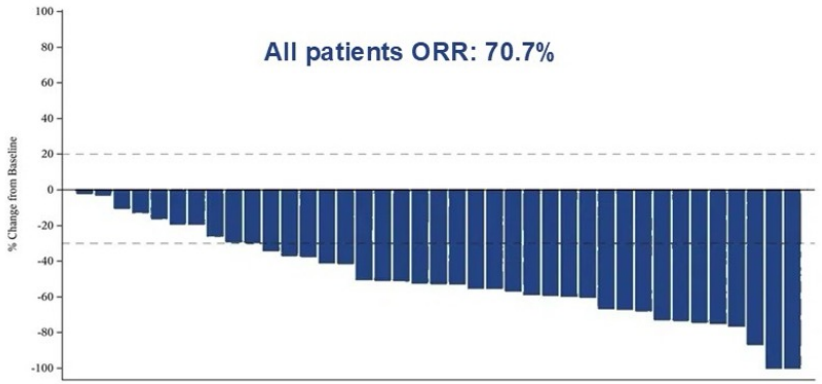
Placebo + CT	192	170	137	99	73	52	41	33	29	23	20	18	15	15	15	15	12	11	10	8	6	2	1	0
Atezolizumab + CT	188	161	132	96	78	62	45	34	32	27	22	21	18	17	15	15	13	13	9	5	4	2	1	0



Dent R et al. Annals of Oncology 2024

OptiTROP-Breast05

PD-L1 CPS <10	78%
PD-L1 CPS ≥ 10	22%



Multicenter, open-label phase II study (NCT05445908)

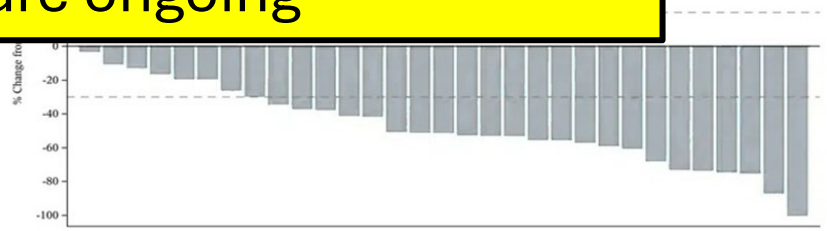
Key eligibility criteria

- No prior systemic therapy for a/m TNBC
- PD-L1 positive or negative[a]
- DFI ≥6 months
- ECOG PS 0–1

Treatment

Primary endpoint[b]

Phase 3 studies of Sac-TMT in 1st line PD-L1 negative (CPS < 10) advanced/ metastatic TNBC are ongoing



Tumor assessment

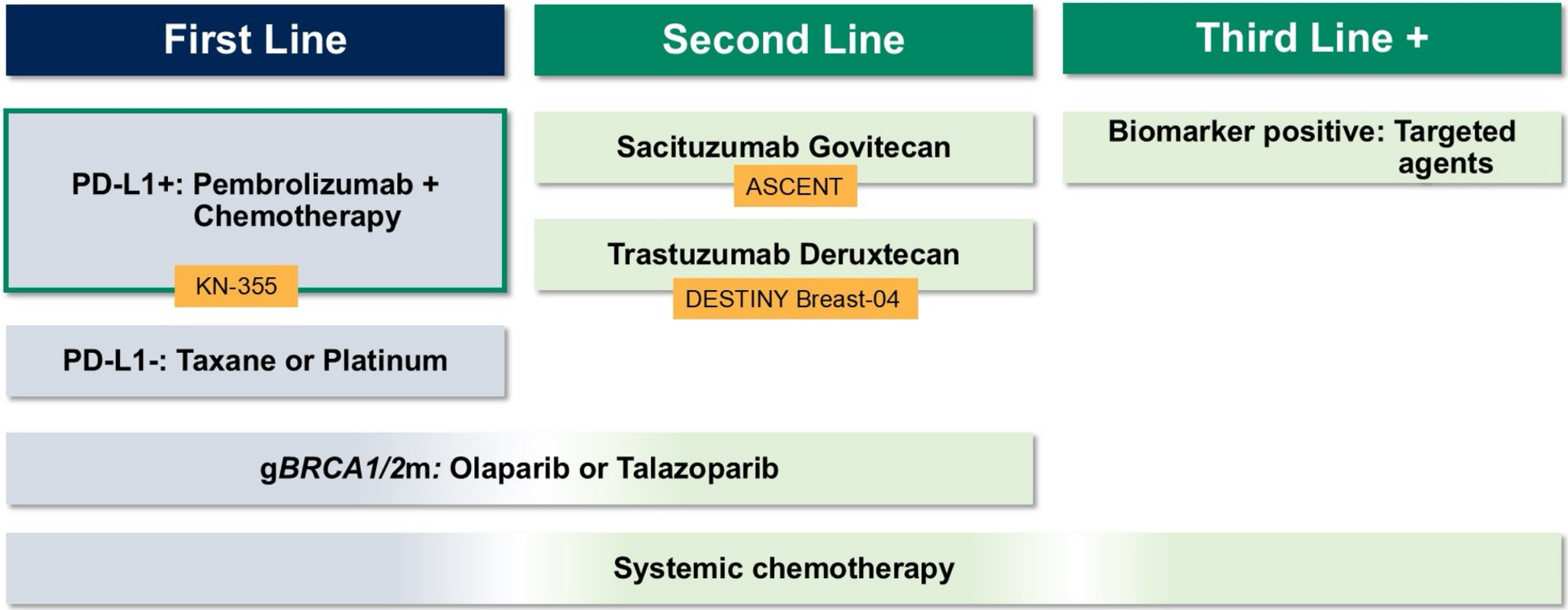
- Every 6 weeks for the first 18 months and every 12 weeks afterward.

	All patients (N = 41)
PFS events, n (%)	20 (48.8)
Median PFS, months (95% CI)	**13.4** (9.9, 18.2)
12-month PFS rate (95% CI), %	**64.6** (45.0, 78.7)

	PD-L1 CPS <10 (N = 32)
PFS events, n (%)	18 (56.3)
Median PFS, months (95% CI)	**13.1** (8.9, 18.2)
12-month PFS rate (95% CI), %	**59.1** (37.1, 75.7)

Yin Y et al. ASCO 2025

Treatment landscape for mTNBC



NCCN Guidelines. Breast Cancer. v4.2025.

Reid S, ASCO 2025

Current Challenge in mTNBC

First Line	Second Line	Third Line +

PD-L1+: Pembrolizumab + Chemotherapy

9.7months Median PFS

23 months Median OS[2,3]

49% Do **not** receive 2L treatment in the real-world[4]

34% **Die** before receiving 2L treatment in the real-world[4]

NCCN Guidelines. Breast Cancer. v4.2025.

1. NCCN Guidelines. Breast Cancer. v4.2025
2. Cortes et al. Lancet 2020 3. Cortes et al. NEJM 2022
4. Punie et al. The Oncologist 2025

Reid S, ASCO 2025 Annual Meeting

New from ASCO

Sacituzumab Govitecan Plus Pembrolizumab vs Chemotherapy Plus Pembrolizumab in Patients With Previously Untreated, PD-L1 Positive, Advanced or Metastatic Triple-Negative Breast Cancer: Primary Results From the Randomized, Phase 3 ASCENT-04/KEYNOTE-D19 Study

Sara M Tolaney[1], Evandro de Azambuja[2], Kevin Kalinsky[3], Sherene Loi[4], Sung-Bae Kim[5], Clinton Yam[6], Bernardo Rapoport[7,8], Seock-Ah Im[9], Barbara Pistilli[10], Wassim McHayleh[11], David W Cescon[12], Junichiro Watanabe[13], Manuel Alejandro Lara Banuelas[14], Ruffo Freitas-Junior[15], Javier Salvador Bofill[16], Maryam Afshari[17], Dianna Gary[17], Lu Wang[17], Catherine Lai[17], Peter Schmid[18]

ASCENT-04/KEYNOTE-D19 Study Design

Previously untreated, locally advanced unresectable, or metastatic TNBC[a]:

- PD-L1-positive (CPS ≥ 10 by the 22C3 assay[b])
- ≥ 6 months since treatment in curative setting (prior anti-PD-[L]1 use allowed)

N = 443

R 1:1

SG + pembro[d]

(SG 10 mg/kg IV, days 1 and 8 of 21-day cycles; pembro 200 mg, day 1 of 21-day cycles)

n = 221

Chemo* + pembro[d]

(paclitaxel 90 mg/m^2 OR nab-paclitaxel 100 mg/m^2 on days 1, 8, & 15 of 28-day cycles, OR gemcitabine 1000 mg/m^2 + carboplatin AUC 2 on days 1 & 8 of 21-day cycles; pembro 200 mg on day 1 of 21-day cycles)

n = 222

***Eligible patients who experienced BICR-verified disease progression were offered to cross-over to receive 2L SG monotherapy**

All treatment, including SG or chemo, was continued until BICR-verified disease progression or unacceptable toxicity

End points

Primary

- PFS by BICR[e]

Secondary

- OS
- ORR, DOR by BICR[e]
- Safety
- QoL

Stratification factors:

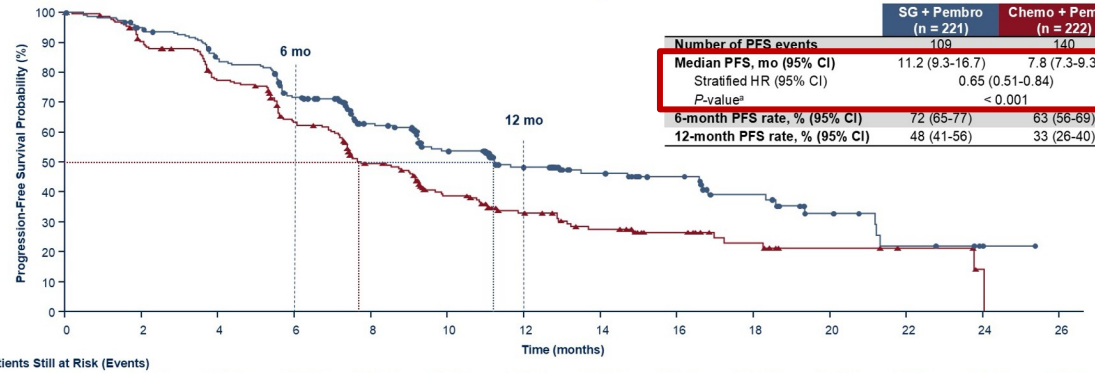
- De novo mTNBC[c] vs recurrent within 6 to 12 months from completion of treatment in curative setting vs recurrent > 12 months from completion of treatment in curative setting
- US/Canada/Western Europe vs the rest of the world
- Prior exposure to anti-PD-(L)1 (yes vs no)

ITT Population	SG + Pembro (n = 221)	Chemo + Pembro (n = 222)
Curative treatment-free interval, n (%)		
De novo	75 (34)	75 (34)
Recurrent within 6-12 mo	40 (18)	40 (18)
Recurrent > 12 mo	106 (48)	107 (48)
Prior anti-PD-(L)1 therapy,[g] n (%)	9 (4)	11 (5)

Tolaney S et al. ASCO 2025 Annual Meeting

ASCENT-04

Progression-Free Survival by BICR

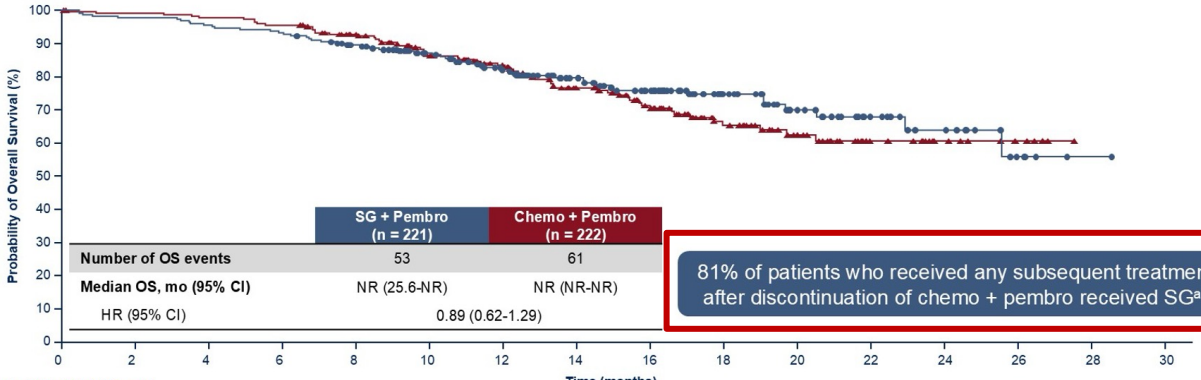


	SG + Pembro (n = 221)	Chemo + Pembro (n = 222)
Number of PFS events	109	140
Median PFS, mo (95% CI)	11.2 (9.3-16.7)	7.8 (7.3-9.3)
Stratified HR (95% CI)	0.65 (0.51-0.84)	
P-value[a]	< 0.001	
6-month PFS rate, % (95% CI)	72 (65-77)	63 (56-69)
12-month PFS rate, % (95% CI)	48 (41-56)	33 (26-40)

No. of Patients Still at Risk (Events)

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

Descriptive Overall Survival at Primary Analysis



	SG + Pembro (n = 221)	Chemo + Pembro (n = 222)
Number of OS events	53	61
Median OS, mo (95% CI)	NR (25.6-NR)	NR (NR-NR)
HR (95% CI)	0.89 (0.62-1.29)	

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

No. of Patients Still at Risk (Events)

SG + Pembro	221 (0)	216 (5)	211 (10)	206 (15)	190 (23)	162 (28)	138 (37)	111 (41)	88 (46)	55 (47)	36 (50)	21 (51)	14 (52)	5 (53)	1 (53)	0 (53)						
Chemo + Pembro	222 (0)	218 (2)	215 (5)	210 (10)	193 (16)	166 (29)	142 (34)	111 (45)	87 (53)	56 (58)	38 (60)	19 (61)	11 (61)	6 (61)	0 (61)							

	SG + Pembro		Chemo + Pembro		Unstratified HR (95% CI)
	n	Median PFS, mo (95% CI)	n	Median PFS, mo (95% CI)	
Curative treatment-free interval					
De novo	75	**8.1** (7.3-18.6)	75	**7.7** (6.1-11.9)	0.89 (0.59-1.34)
Recurrent 6-12 mo	40	**9.9** (5.7-16.8)	40	**7.2** (4.4-9.1)	0.62 (0.36-1.08)
Recurrent > 12 mo	106	**16.6** (11.0-NR)	107	**8.7** (7.3-10.8)	0.52 (0.35-0.76)
Prior (neo)adjuvant anti-PD-(L)1 therapy					
Yes	9	**7.5** (0.9-NR)	11	**6.6** (2.1-NR)	1.08 (0.31-3.75)
No	212	**11.7** (9.3-16.8)	211	**7.8** (7.4-9.3)	0.65 (0.50-0.84)

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

Tolaney S et al. ASCO 2025

Adverse Events of Special Interest

	AESI,[a] n (%)	SG + Pembro (n = 221)		Chemo + Pembro (n = 220)	
		Any Grade	Grade ≥ 3	Any Grade	Grade ≥ 3
SG AESIs	Neutropenia[b]	143 (65)	104 (47)	132 (60)	100 (45)
	Hypersensitivity[b]	43 (19)	4 (2)	51 (23)	5 (2)
Pembro AESIs	Colitis	4 (2)	1 (< 1)	1 (< 1)	1 (< 1)
	Hypothyroidism[b]	4 (2)	0	19 (9)	0
	Hypophysitis[b]	2 (1)	0	2 (1)	0
	Hyperthyroidism[b]	2 (1)	0	5 (2)	0
	Severe skin reactions,[b] including Stevens-Johnson syndrome and toxic epidermal necrolysis	2 (1)	2 (1)	2 (1)	2 (1)
	Hepatitis[b]	1 (< 1)	0	2 (1)	2 (1)
	Adrenal insufficiency[b]	1 (< 1)	0	2 (1)	1 (< 1)
	Pancreatitis[b]	0	0	2 (1)	2 (1)

Results from ASCENT-04/KEYNOTE-D19 su… use of SG + pembro as a potential new standard of care for patients with previously untreat… 1+, locally advanced unresectable or metastatic TNBC

PRACTICE-CHANGING !

No new safety signals

Tolaney S et al. ASCO 2025 Annual Meeting

Patient Case

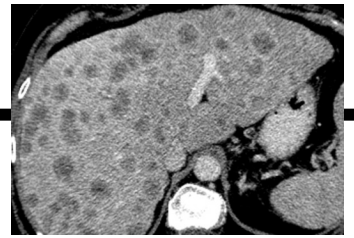
3 cm TNBC
with 2 LN+

CT and
bone scan
negative

Carboplatin-paclitaxel and
doxorubicin-cyclophosphamide
with pembrolizumab

7 months

PD-L1 CPS: 15



Sacituzumab Govitecan
with pembrolizumab

Treatment landscape for mTNBC

First Line	Second Line	Third Line
PD-L1+ : Sacituzumab Govitecan + pembrolizumab	Trastuzumab Deruxtecan	?
PD-L1- : Taxane or platinum	Sacituzumab Govitecan	Trastuzumab Deruxtecan

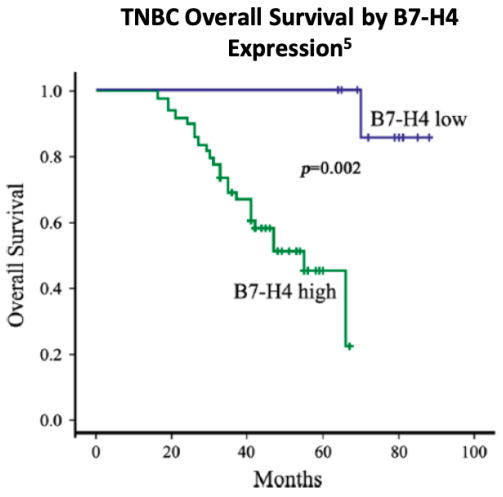
gBRCA1/2 m: Olaparib or Talazoparib

Systemic chemotherapy

Treatment post topo-1 ADC: High unmet need

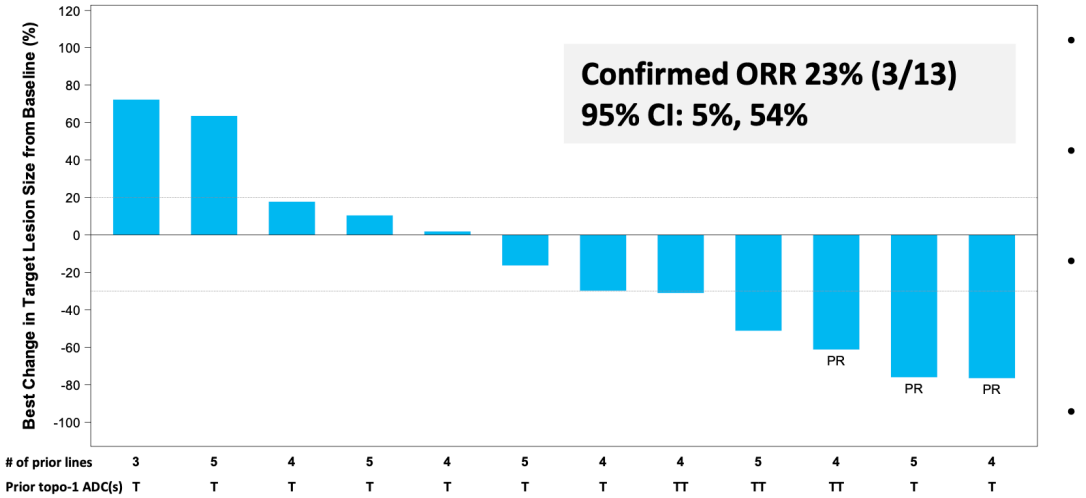
Single agent chemotherapy: ORR: 5%, PFS: 7 weeks, OS: 6.7 months

Emiltatug Ledadotin (Emi-Le): B7-H4-Directed ADC



	TNBC (N=44)
Median age	49.5
Median prior lines in locally advanced/ metastatic setting (range)	4 (1-9)
Prior Topo-1 ADCs received, n (%)	
Prior trastuzumab deruxtecan	14 (31.8%)
Prior sacituzumab govitecan	38 (86.4%)
Prior both	11 (25.0%)
Prior either	41 (93.2%)
B7-H4 expression[1], n (%)	
TPS status known	36 (81.8%)
High (TPS ≥70)	14 (38.9%)
Low (TPS <70)	22 (61.1%)
TPS not yet determined	8 (18.2%)

Intermediate Dose Range (38.1-67.4 mg/m^2)

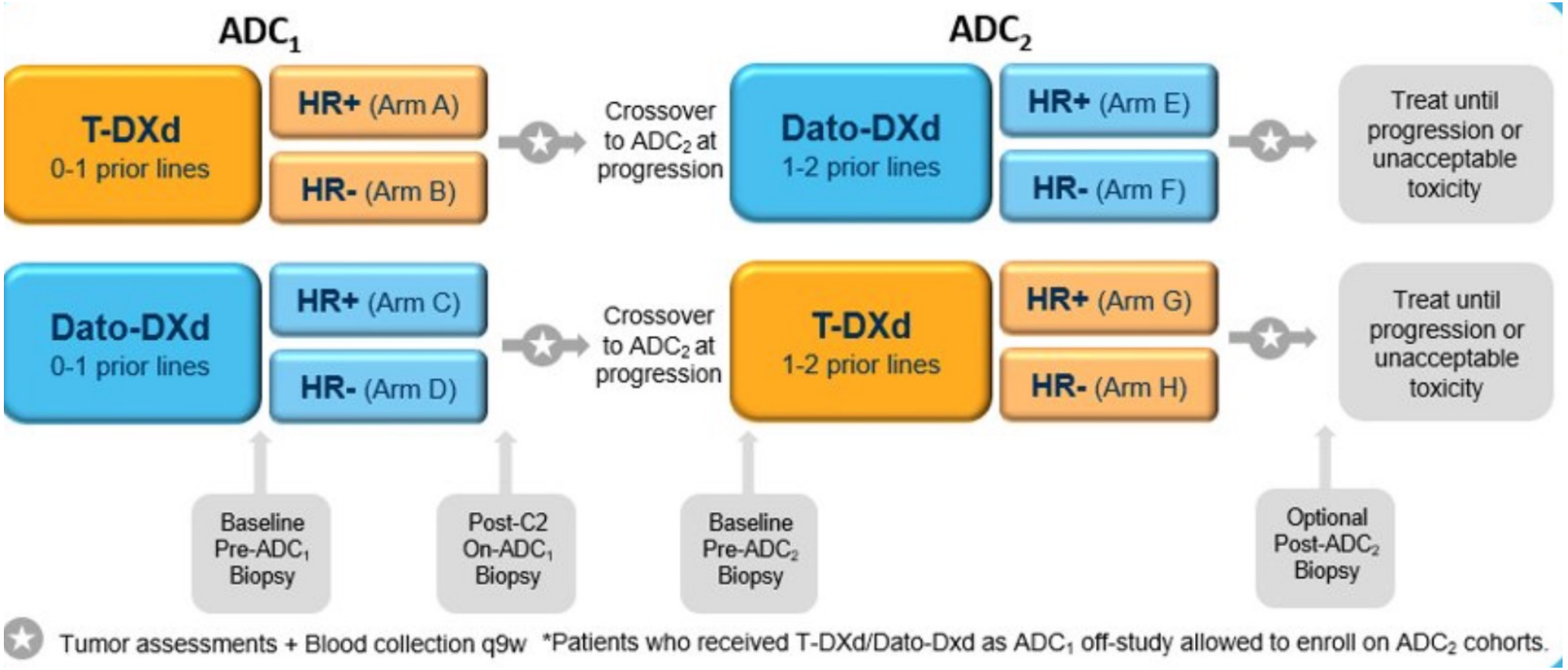


No confirmed responses observed in B7-H4 low patients

Hamilton E et al. ESMO Breast 2025

Ongoing Clinical Trials

TRADE Dxd Trial: Treatment of ADC-Refractory Breast CancEr with Dato-Dxd or T-Dxd



PI: A. Garrido-Castro

Take Home Points

- Chemotherapy is recommended for T1cN0 TNBC
- KEYNOTE 522 remains the standard of care for stage II-III TNBC
- There is no role for adjuvant checkpoint inhibition as monotherapy or with chemotherapy if no ICI in neoadjuvant setting
- Sacituzumab govitecan with pembrolizumab is new standard of care for metastatic PD-L1 positive TNBC

Future Directions

- Precision treatment guided by biomarkers
- With ADCs likely getting approved in early stage: Re-evaluate treatment algorithm for mTNBC