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Insights Into Breast Cancer

September 27, 2025

Columbus, OH

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Report Snapshot

Report Snapshot: Session Overview

On September 27, 2025, disease state and data presentations were led and moderated by **Megan Kruse, MD,** from the Cleveland Clinic, with content developed in conjunction with the Aptitude Health scientific team

The objectives of the meeting were to gain advisors' perspectives on

- **Current treatment practices and recent updates in HER2+ early breast cancer (eBC)**
- **Current treatment practices and recent updates in HER2+ metastatic breast cancer (mBC)**

Data collection was accomplished through use of **audience response system (ARS)** questioning and **moderated discussion**

Insights on the management of breast cancer were obtained from **12 community oncologists** from Ohio

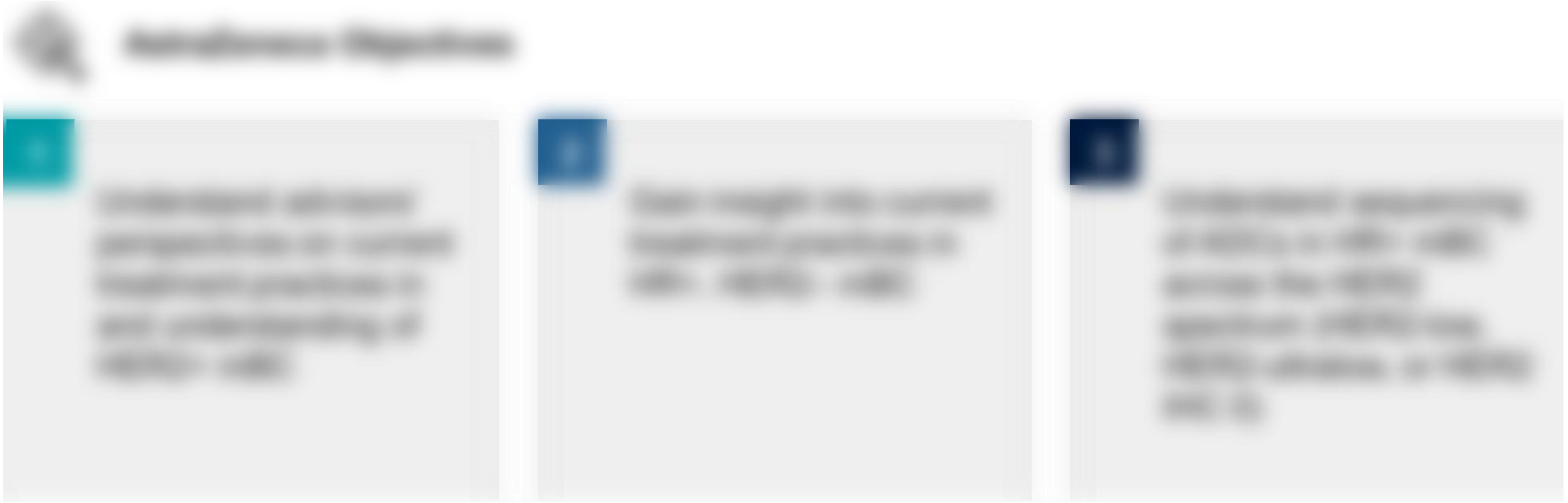
Report Snapshot: Session Agenda

Time (ET)	Topic
9.00 AM – 9.15 AM	**Introduction** • Program overview • Baseline ARS questions
9.15 AM – 10.25 AM	**Treatment of HER2+ eBC** • Overview of current data • Reaction and discussion
10.25 AM – 10.35 AM	**Break**
10.35 AM – 10.40 AM	**ARS Questions**
10.40 AM – 11.50 AM	**Treatment of HER2+ mBC** • Overview of current data • Reaction and discussion
11.50 AM – 12.00 PM	**Key Takeaways and Meeting Evaluation**

Report Snapshot: Attendee Overview

Report Snapshot: Attendee Demographics

Scope of the Report



Topline Takeaways

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Detailed Insights and Strategic Recommendations

Objective 1: Detailed Insights

Objective 1: Supportive Quotes From Discussion (1/2)

Objective 1: Supportive Quotes From Discussion (2/2)

Topic	Advisor Statements
Perspectives on [redacted]	"Yeah, but the data speaks, hazard ratio of 0.36 and 95% confidence interval 0.44 to 0.71. And look at the Kaplan-Meier curve. They're separating. ..... Very impressive data. ..... Which you showed us." "And then when you brought up the impressive results for their control arm, I think we had this study open and what was remarkable, at least in our site, was there was a significant discordance between central review of HER2 and local. And it was a fair amount of patients, like almost all of the patients had discordance. So we actually didn't have a fair amount that was not eligible for [redacted] because of that. I wonder if that's something that just sort of, I guess, concentrated the HER2 population for this, and maybe patients did better. I don't know if that was discussed at all in this." "I mean, they're very impressive results. I'm sure we'll get into the major criticism of the study, which is that the THP CLEOPATRA regimen is so tolerable once you get to the maintenance phase. And I know there are ongoing studies about doing sort of an induction style followed by maintenance. So I think that's what I'm really excited to see. T-DM1 is, I think, well tolerated in general, but it's a lot of monitoring. I'm doing scans every 9 weeks, more or less, to look for ILD. And that's just a lot on patients, especially in long responders. Sometimes I don't restage them for 6 months or do their echoes for 6 months. So it just is like the intensity has increased, for sure." "I think the other factor with this control arm doing better than CLEOPATRA is the volume of patients that did not get trastuzumab or pertuzumab, because half of the patients were de novo. That means the other half had therapy for breast cancer in the past. That's probably not something we saw."

Objective 1: Strategic Recommendations

Objective 2: Detailed Insights

Objective 2: Supportive Quotes From Discussion

Objective 2: Strategic Recommendations

Objective 3: Detailed Insights

Topic	Advisor Statements
Perceptions of SERENA-6	"This is a landmark trial. It came in ASCO. … Plenary session. … Also in New England Journal of Medicine." "We are doing circulating tumor DNA and next-generation sequencing in all metastatic disease. … I think it's a practice-changing data. It's very, very important. The question is, how often you will do it? It means every 3 months, every 6 months. Other thing, PIK3CA mutation. If you found it's a very bad mutation as compared to ESR1 mutation, I will treat with PIK3CA inhibitor initially, because that's a worse mutation as compared to ESR1 mutation. Here you can wait a little bit. But I think this is very important data, which you showed us, and it's a practice-changing. But I don't think camizestrant is available in US yet, this camizestrant with cyclin-D kinase. I think it should be implemented in patient care after 6 months and every 3 to 6 months, check for ESR1 mutation, and change the treatment." "I think the question comes, are we using second line early? Is it a lead time bias also? I think that was another discussion." "Do we know a median time to detect an ESR1 alteration in those that were detected? So, we screened about 3,000 patients or maybe 300 patients. Obviously, at the time, they detected the first ESR1 alteration got randomized. Was that 6 months? Was that a year? Do we know?" "I was skeptical because of the potential for, excuse me, lead time bias as well. And checking every 2 to 3 months certainly is going to increase the cost of what we're doing. But this time to the quality-of-life measure actually sort of changed my mind a little bit. Although I can see what you're saying about the psychological impact. But I don't know how to explain it other than clinical benefit is important, so."

Objective 3: Supportive Quotes From Discussion (1/2)

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[redacted]

Objective 3: Supportive Quotes From Discussion (2/2)

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Objective 3: Strategic Recommendations

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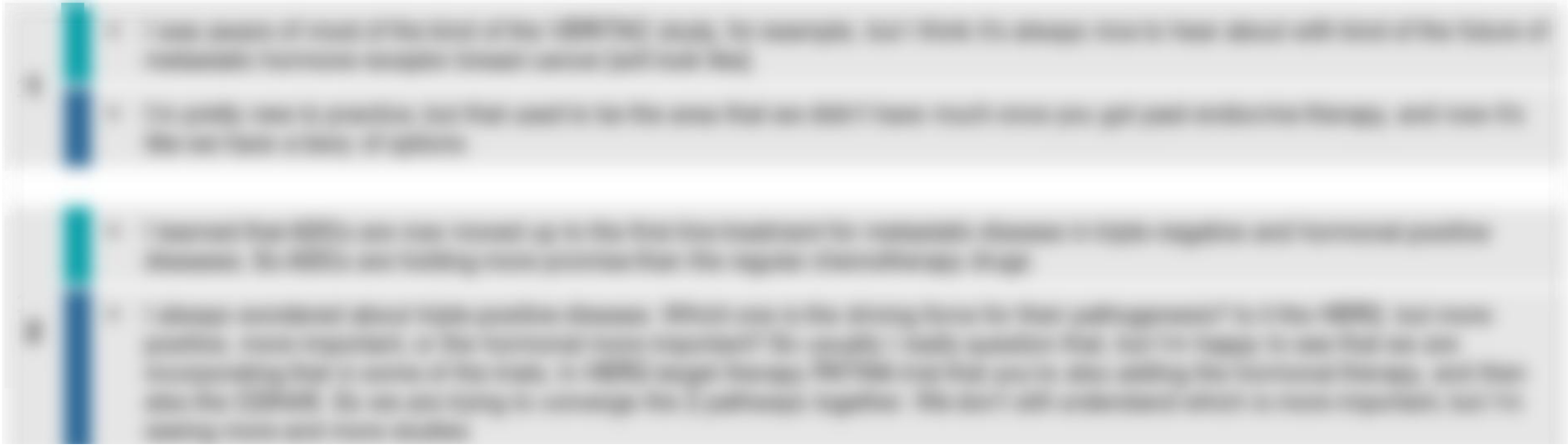
Attendee Key Takeaways

Attendee Key Takeaways (1/4)

Attendee Key Takeaways (2/4)

Attendee Key Takeaways (3/4)

Attendee Key Takeaways (4/4)*



*One advisor did not respond.

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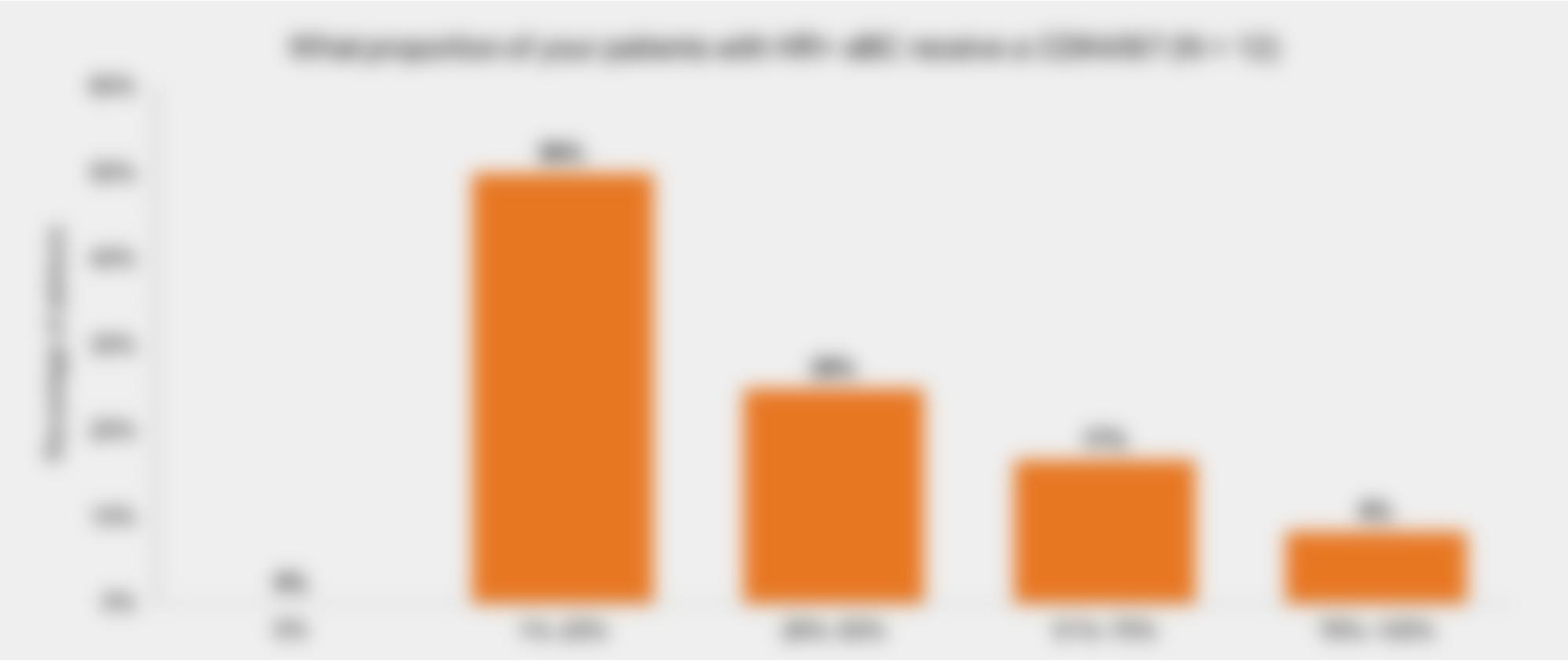
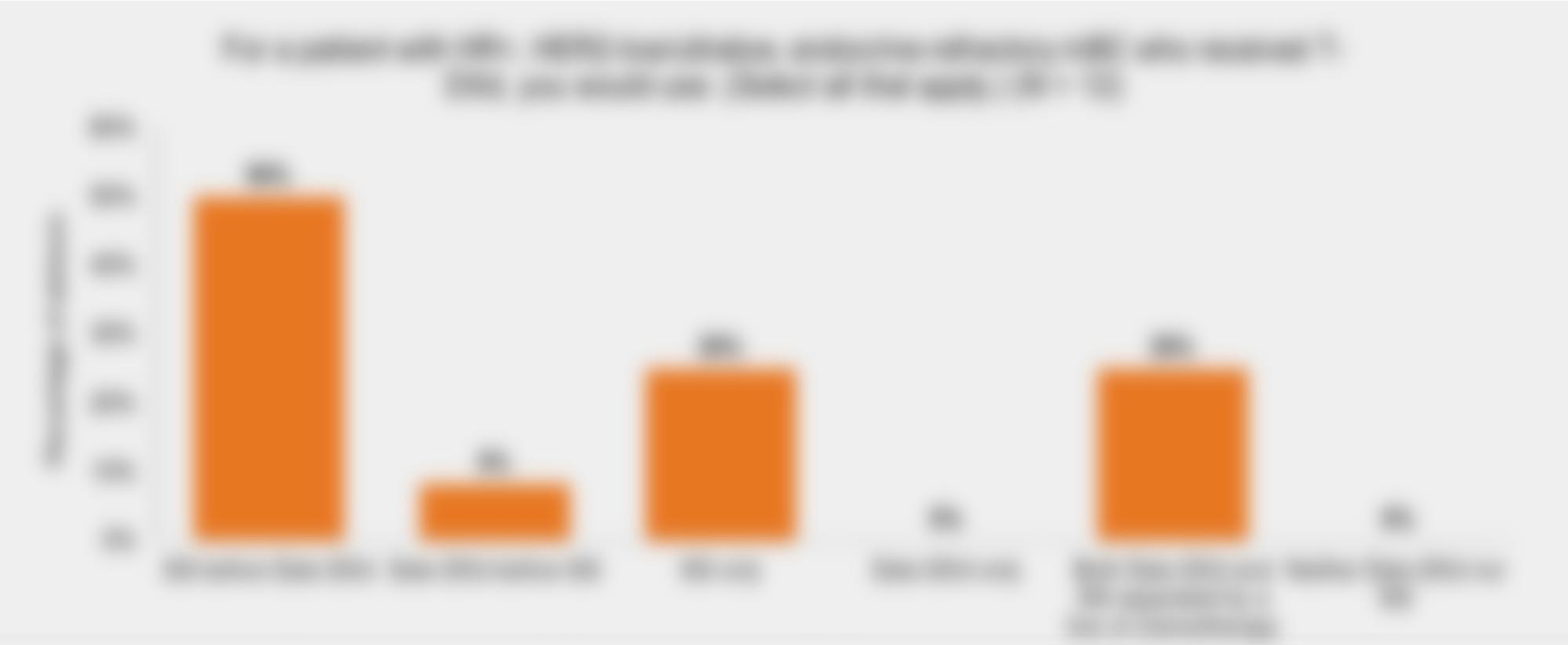
ARS Data

Half of Advisors Treated at Least 4 Patients With Stage II–III HER2+, HR+ eBC in the Past Year

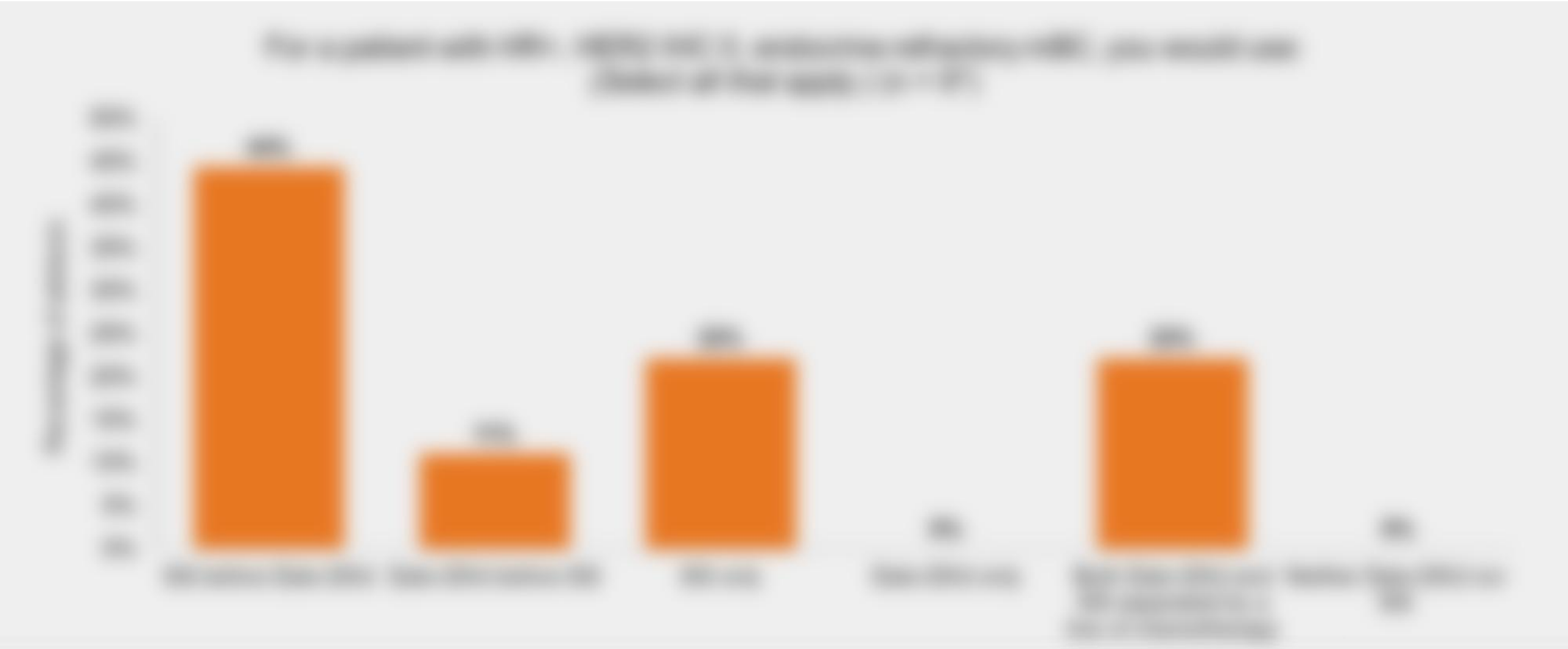


Over Half (58%) of Advisors Treated at Least 6 Patients With HER2+, HR– eBC in the Past Year

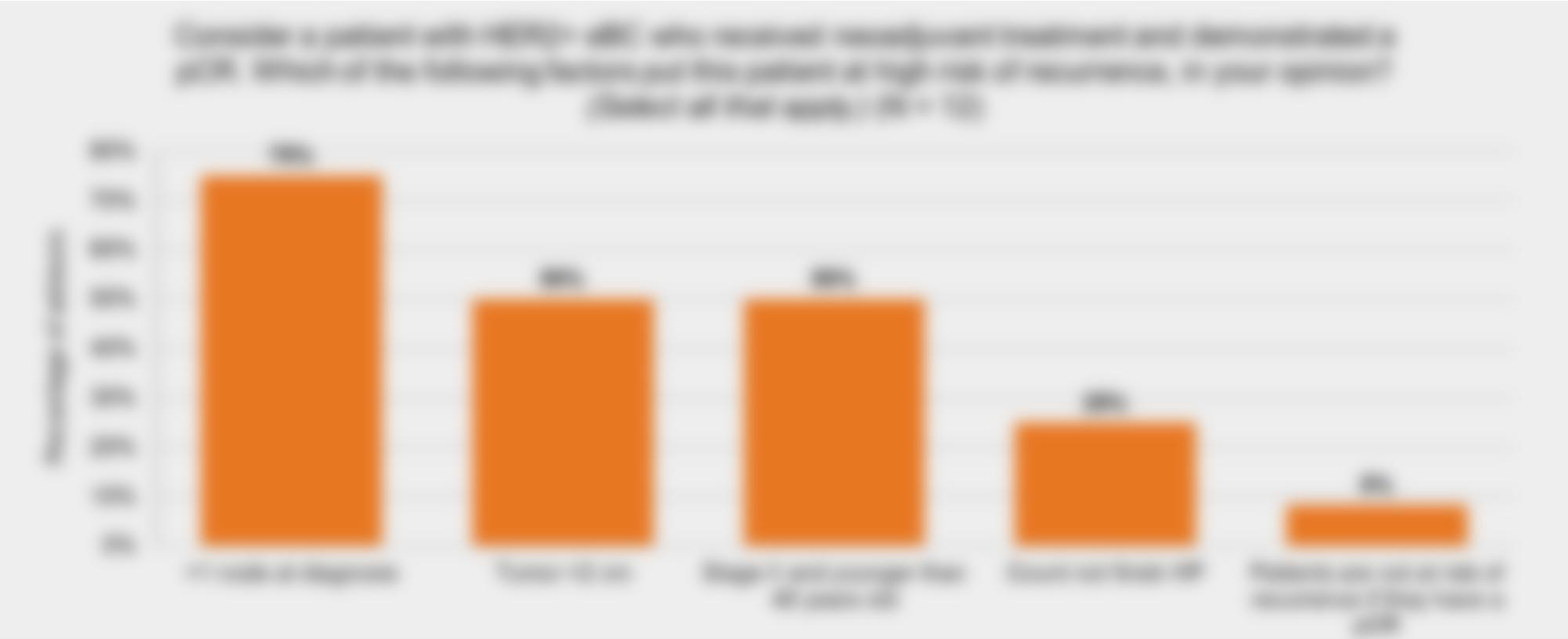


The Majority (73%) of Physicians Had Treated Patients Whose Disease Recurred After a pCR Following Neoadjuvant Treatment

CNS Recurrence Was the Most Common Type of Recurrence After a pCR Following Neoadjuvant Treatment



Presence of >1 Node at Diagnosis Indicates High Risk of Recurrence Despite a pCR, According to 75% of Advisors



Patient Case 1

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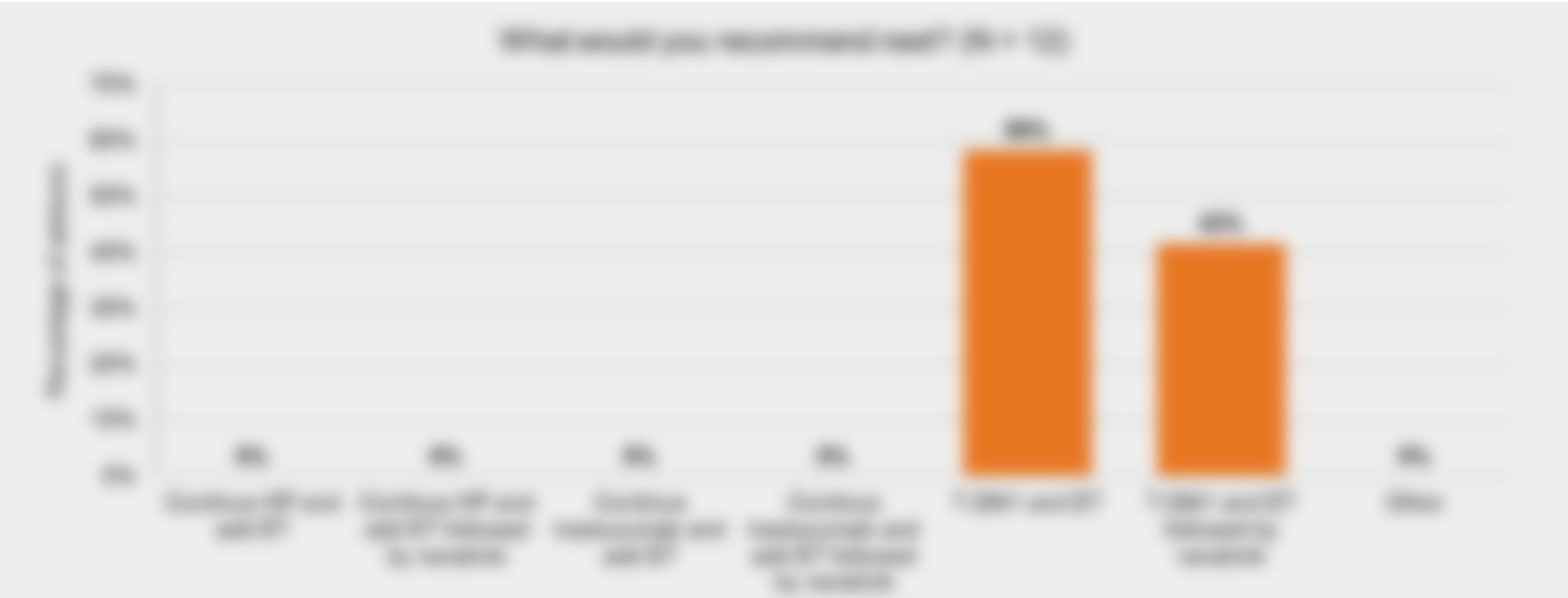
A 40-year-old patient is diagnosed with stage IIA (cT1N1M0), grade 3, ER+, HER2+ (PgR–) eBC. They receive neoadjuvant TCHP and bilateral mastectomy. They have near pCR with 0.3-cm residual tumor in the breast and only fibrosis in axillary lymph nodes. (Residual cancer burden = 1 and tumor remains HER2 3+, weakly ER+, and PgR–).

All Advisors Recommended T-DM1 and ET for a Patient Who Demonstrated Near pCR After Neoadjuvant TCHP in Stage IIA (cT1N1M0), Grade 3, ER+, HER2+ eBC



Patient Case 2

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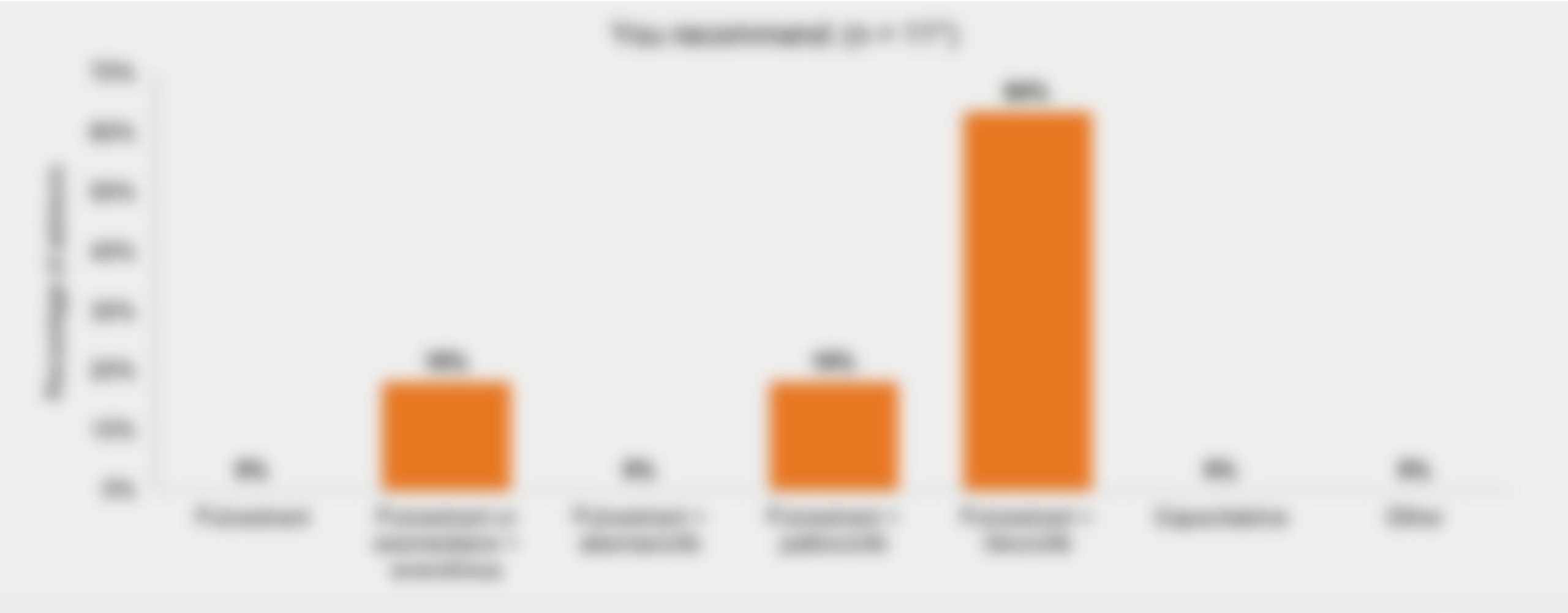
A 38-year-old patient presents with stage II, HER2+, HR+ eBC (2 positive nodes). They receive neoadjuvant TCHP for 6 cycles and have a pCR.

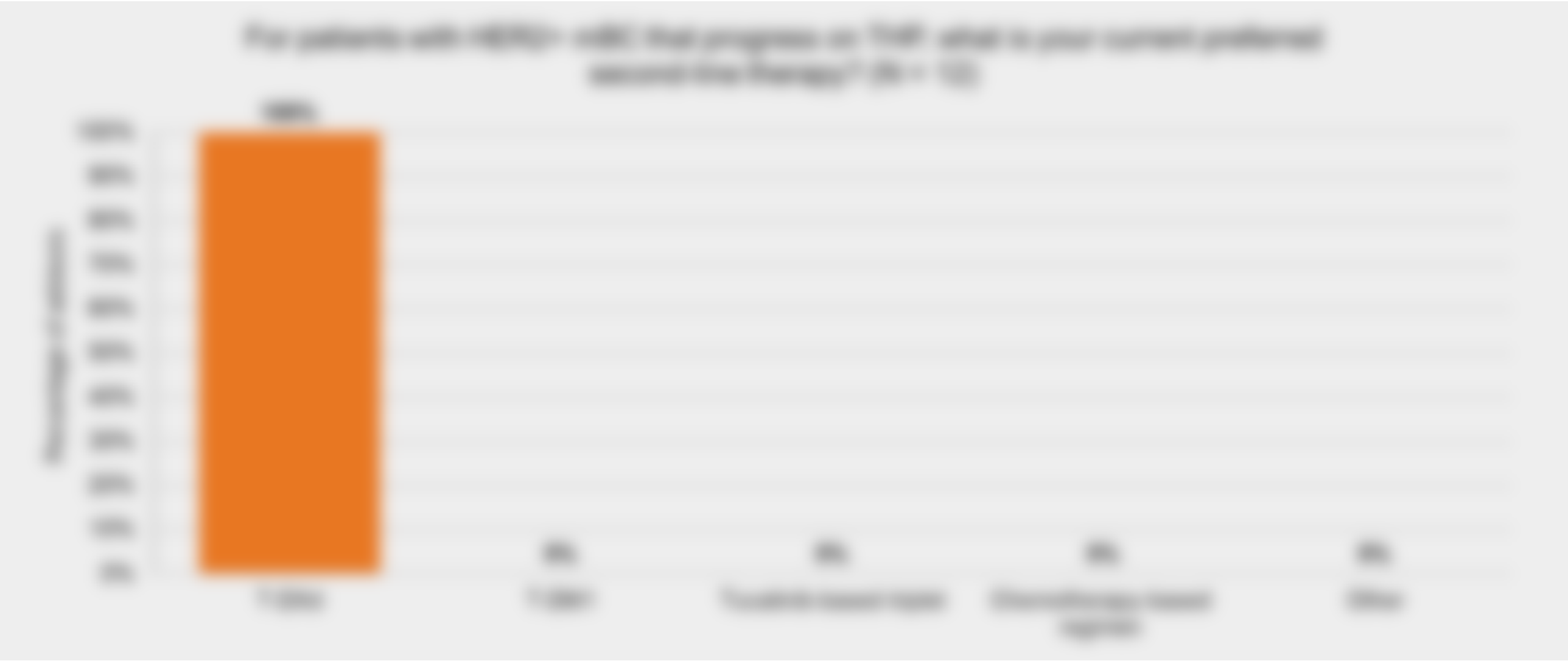
Over Half of Advisors Recommended Adjuvant HP, Neratinib, and ET for a Patient With Stage II, HER2+, HR+ eBC With 2 Positive Nodes and a pCR After Neoadjuvant TCHP



Nearly All Advisors (92%) Treated at Least 1 Patient Who Did Not Demonstrate a pCR Following Neoadjuvant Treatment and Experienced Recurrence Within the Past 3 Years

Half of Advisors Did Not Treat Any Patients With Neratinib in the Extended Adjuvant Setting Within the Past Year

All Advisors Prescribe T-DXd for Patients With HER2+ mBC That Progresses on THP



For 91% of Advisors, Treatment of Brain Metastases Is One of the Most Influential Factors on Second-Line Treatment Selection

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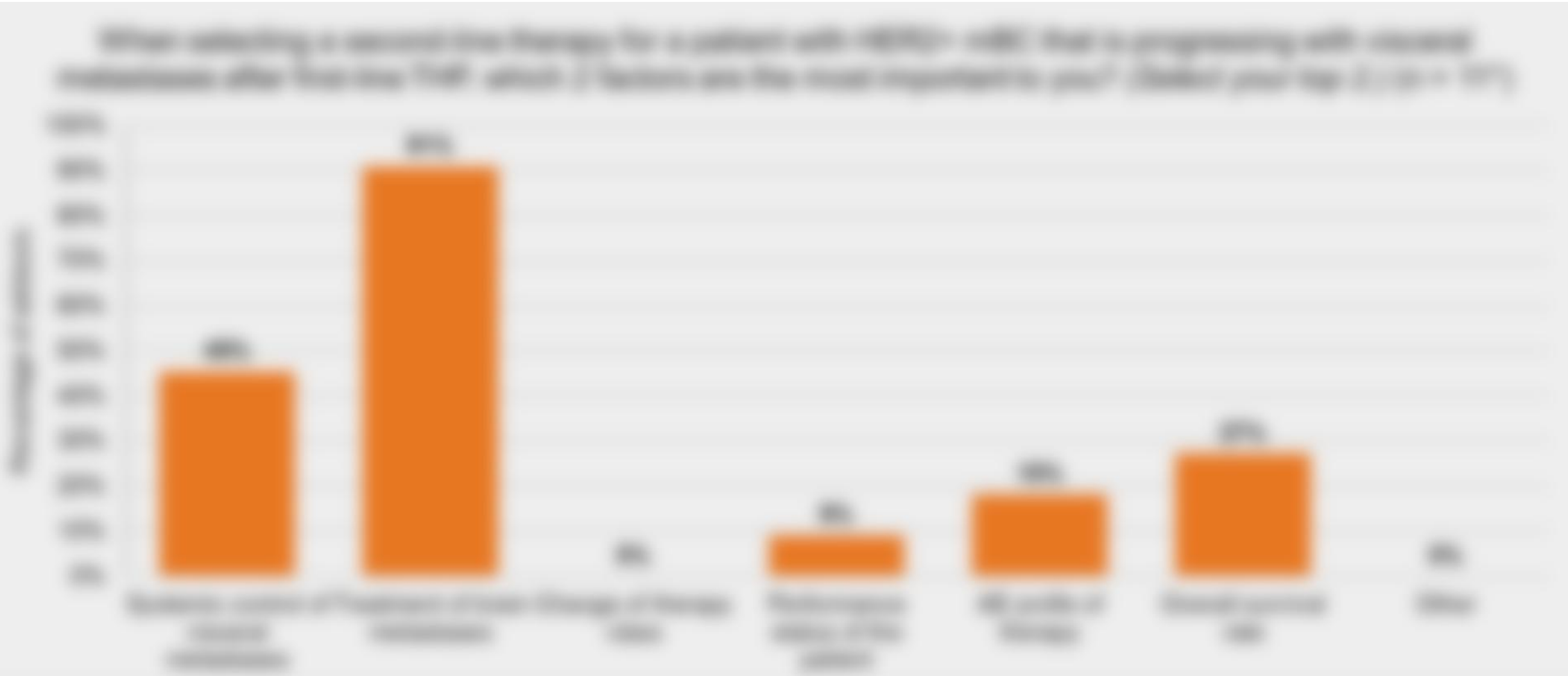

Patient Case 3

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A 55-year-old postmenopausal woman presents with de novo ER+, PR–, HER2+ mBC with bone-only metastasis. She has moderate bone pain requiring intermittent narcotic therapy.

More Than Half (60%) of Advisors Would Choose Trastuzumab Plus Taxane Plus Pertuzumab for a Postmenopausal Patient With De Novo ER+, PR–, HER2+ mBC With Bone-Only Metastasis

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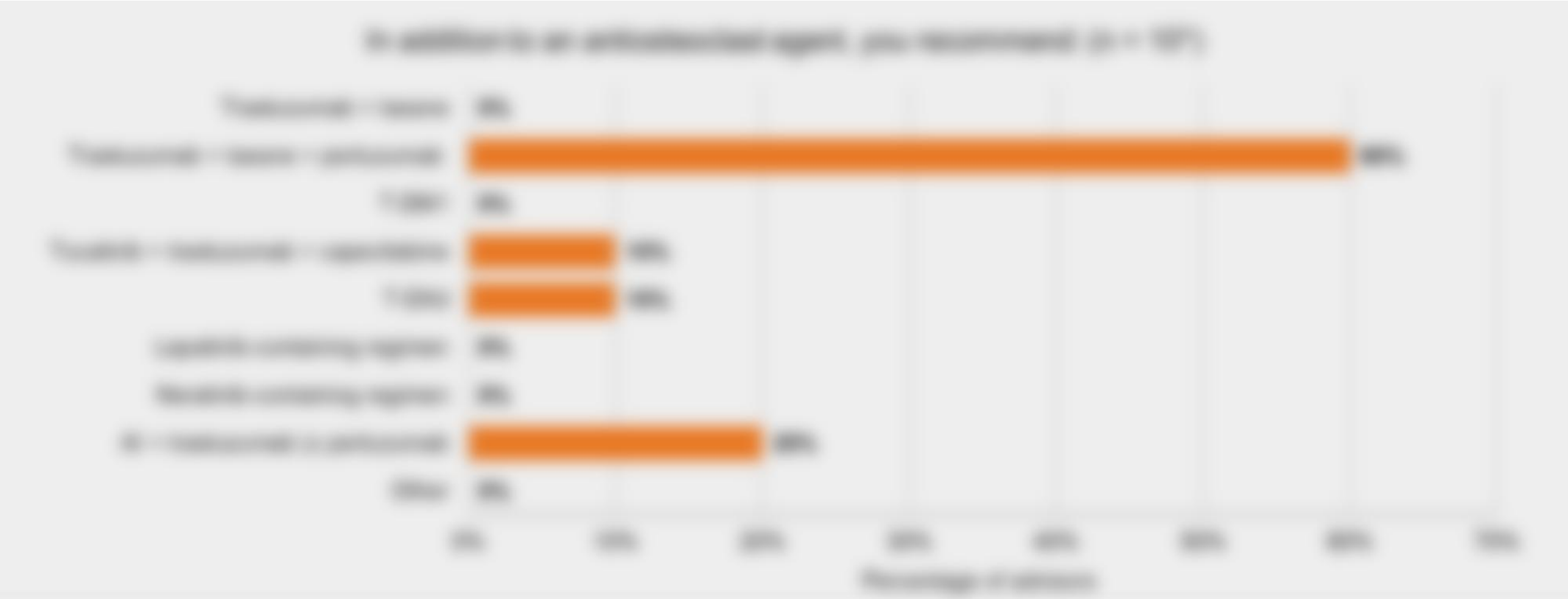

Patient Case 4

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Following 6 cycles of docetaxel + trastuzumab + pertuzumab for her de novo mBC, this same patient receives maintenance therapy with trastuzumab + pertuzumab + an AI for 2 years. She then develops progressive disease into the bone and liver, with a moderate volume of liver disease. She is asymptomatic, and her liver function is normal.

T-DXd Was the Most Common Choice Among Advisors for a Patient With De Novo ER+, PR–, HER2+ mBC Who Develops Progressive Disease In the Bone and Liver Following THP and Maintenance With HP Plus AI

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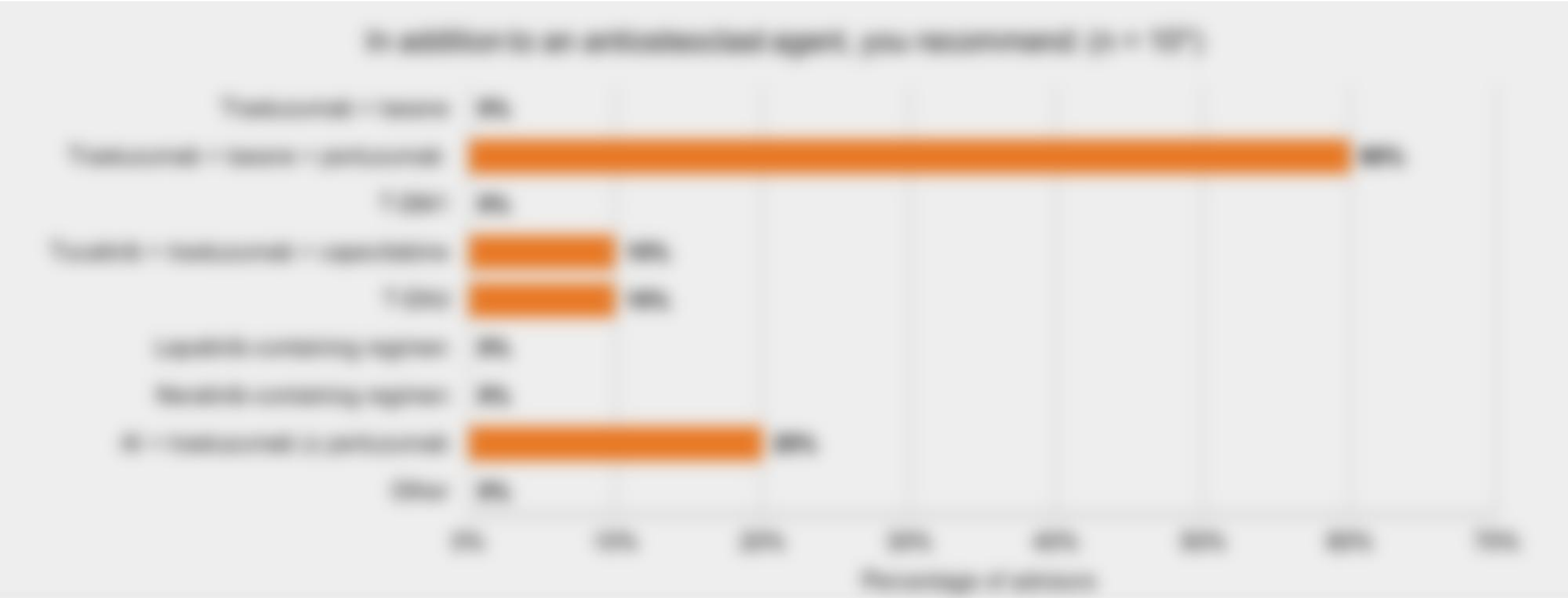

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