



CASES

Insights Into Breast Cancer

September 27, 2025

Columbus, OH

How to Navigate This Report



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Scope of the Report



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Detailed Insights and Strategic Recommendations



Attendee Key Takeaways



ARS Data





Report Snapshot



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



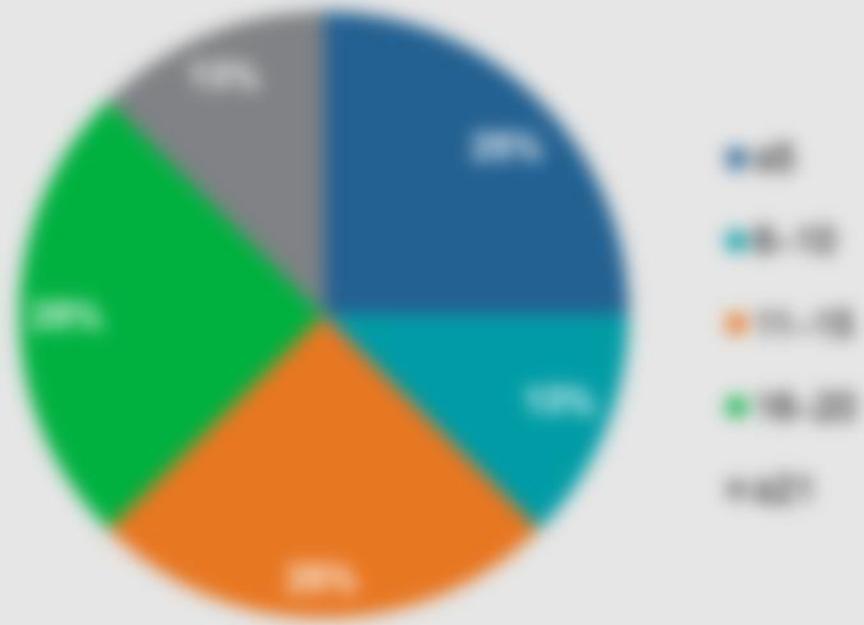
Time (ET)	Topic
9.00 AM – 9.15 AM	Introduction <ul style="list-style-type: none">• Program overview• Baseline ARS questions
9.15 AM – 10.25 AM	Treatment of HER2+ eBC <ul style="list-style-type: none">• Overview of current data• Reaction and discussion
10.25 AM – 10.35 AM	Break
10.35 AM – 10.40 AM	ARS Questions
10.40 AM – 11.50 AM	Treatment of HER2+ mBC <ul style="list-style-type: none">• Overview of current data• Reaction and discussion
11.50 AM – 12.00 PM	Key Takeaways and Meeting Evaluation

Report Snapshot: Attendee Overview



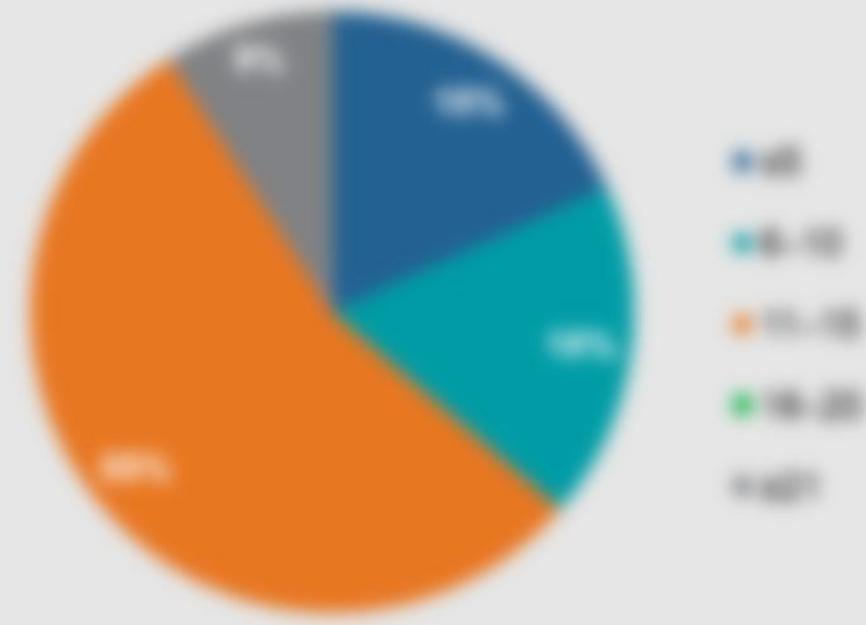
Report Snapshot: Attendee Demographics

83% of attendees treated 211 patients with mTNBC in the past year



Approximately how many patients with metastatic triple-negative breast cancer (mTNBC) have you treated in the past 12 months? (n = 87)

84% of attendees treated 211 patients with HR+/mTNBC in the past year



Approximately how many patients with HR+/mTNBC metastatic breast cancer (mTNBC) have you treated in the past 12 months? (n = 117)



Scope of the Report



Executive Summary

- 1. Introduction
- 2. Methodology
- 3. Findings
- 4. Conclusions
- 5. Recommendations

Topline Takeaways



Key Message	Topline Takeaway
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[Blurred text]	[Blurred text]
[Blurred text]	[Blurred text]



**Detailed Insights and
Strategic Recommendations**

Objective 1: Detailed Insights



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



[The main content of the slide is a large, blurred rectangular area, likely representing a document or discussion text that is intentionally obscured for this objective.]

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



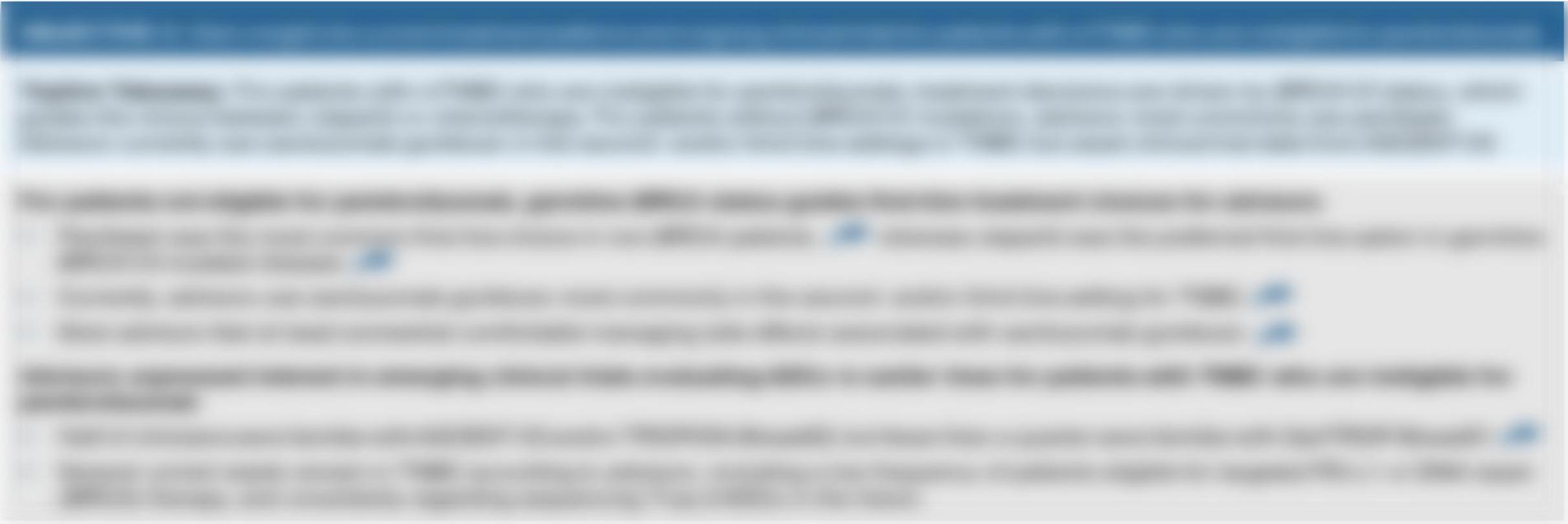
Topic	Supportive Statements
<p>Response to the 2017 ASCO Abstract</p>	<p>"Look, for the data overall, hazard ratio of 0.88 and 95% confidence interval 0.84 to 0.91. And look at the Kaplan-Meier curve. They're separating — very impressive data — which you showed us."</p> <p>"And then when you brought up the impressive results for their control arm, I think we had this study open and what was remarkable, at least in our view, was there was a significant discordance between control versus of 14000 and total that it was a lot amount of patients, the amount of all of the patients that discordance. So we actually didn't have a lot amount that was not eligible for 14000 because of that. I wonder if there's something that just sort of I guess, concentrated the 14000 population for this, and maybe patients did better. I don't know if that was discussed at all."</p> <p>"I mean, they're very impressive results. So you sort of get into the major criticism of the study, which is that the 14000 regimen is an intensive one once you get to the maintenance phase. And I mean there are ongoing studies about doing sort of an induction step followed by maintenance. So I think that's what is really needed to see. Talking I think, well, intended in general, but it's a lot of monitoring. So doing every 2 weeks, more or less, to look for full but that's just a lot of patients, especially in long responders. Sometimes I don't imagine them for 8 months or do that within for 8 months. So it just is like the intensity has increased, for sure."</p> <p>"I think the other factor with this control arm doing better than 14000 is the volume of patients that did not get institutional or performance, because half of the patients were de novo. That means the other half had therapy for breast cancer in the past. There's probably not something we see."</p>

Objective 1: Strategic Recommendations

Work with experts to develop guidelines to address what supporting documents is needed to support a 100% single agent use, while continuing to share information with the 100% single agent use of any first-line approach.

- Develop guidelines early on regarding 100% single agent use.
 - Develop clear evidence-based supporting documents to 100% use to both 100% and 100% patients and the impact of 100% single agent use to help guide treatment choice between 100% and 100%.
- Work with experts to determine feasibility of first-line approach with 100% to 100% use, especially to patients with 100% disease when evidence strongly may favor 100% use.
- As data from 100% single agent use continues to mature, highlight key data outcomes to both the 100% and 100% use 100% use, as the information will be valuable to physicians in guiding treatment decisions.
 - Consider sharing data from the 100% single agent use of 100% single agent use.
- Provide resources or monitoring to help with 100% especially in the early stages to encourage physician comfort in managing the 100% single agent use.

Objective 2: Detailed Insights



Objective 2: Supportive Quotes From Discussion



Objective 2: Strategic Recommendations



Objective 3: Detailed Insights



Topic	Key Statements
<p>Perceptions of AI/ML</p>	<p>"This is a landmark trial... it came in 2020... Primary outcome... Also in the <i>New England Journal of Medicine</i>."</p> <p>"We are doing something called AI/ML and real-time decision support in all metastatic disease... I think it's a practice-changing trial. It's very, very important. The question is, how often you will do it? 2 months every 2 months, every 4 months. Other thing, AI/ML monitor. If you found it's a very bad monitor as compared to AI/ML monitor, I will treat with AI/ML monitor... because that's a worse monitor as compared to AI/ML monitor. Now you can wait a little bit. But I think this is a very important trial, which you showed us, and it's a practice-changing. But I don't think conventional is available in all part. The conventional with cycle of disease... I think it should be implemented in patient care after 4 months and every 2 to 4 months, check to AI/ML monitor, and change the treatment."</p> <p>"I think the question comes, are we using around the world? Is it a trial that has also? I think that was another discussion."</p> <p>"Do we have a monitor that is better as AI/ML alternative to those that were detected? So, we screened about 1,000 patients or maybe 500 patients. Obviously, at the time, they detected the true AI/ML alternative got confirmed after the 4 months? After that a year? Do we know?"</p> <p>"I was skeptical because of the potential for adverse use. But time has so well that checking every 2 to 4 months certainly is going to increase the cost of what we're doing. But this trial is the quality of life measure actually not at changed my mind a little bit. Although I can see what you're saying about the psychological impact. But I don't think that to replace it other than clinical benefit is important, so."</p>

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



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

Supportive Quotes From Discussion (1/2)

Quote 1: In a discussion with a physician, the physician expressed a preference for using T-DMs before other antihypertensive medications in their patients with end-stage renal disease (ESRD). Significant questions remain regarding ESRD management, particularly between agents requiring Type 2.

Quote 2: In a discussion with a physician, the physician expressed a preference for using T-DMs before other antihypertensive medications in their patients with ESRD. Significant questions remain regarding ESRD management, particularly between agents requiring Type 2.

- For patients with ESRD, the physician expressed a preference for using T-DMs before other antihypertensive medications in their patients with ESRD. Significant questions remain regarding ESRD management, particularly between agents requiring Type 2.
- For patients with ESRD, the physician expressed a preference for using T-DMs before other antihypertensive medications in their patients with ESRD. Significant questions remain regarding ESRD management, particularly between agents requiring Type 2.
- During discussion, the physician noted a preference for using T-DMs prior to antihypertensive medications in their patients with end-stage renal disease (ESRD). Significant questions remain regarding ESRD management, particularly between agents requiring Type 2.

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



Topic	Supportive Quotes
<p>Supportive quotes from the discussion</p>	<p>Quote 1: [Faded text]</p> <p>Quote 2: [Faded text]</p> <p>Quote 3: [Faded text]</p>
<p>Supportive quotes from the discussion</p>	<p>Quote 4: [Faded text]</p> <p>Quote 5: [Faded text]</p>

Objective 3: Strategic Recommendations



Strategic Recommendations

1. **Improve operational efficiency**

2. **Enhance patient experience**

3. **Strengthen financial performance**



Attendee Key Takeaways

Attendee Key Takeaways (4/4)*

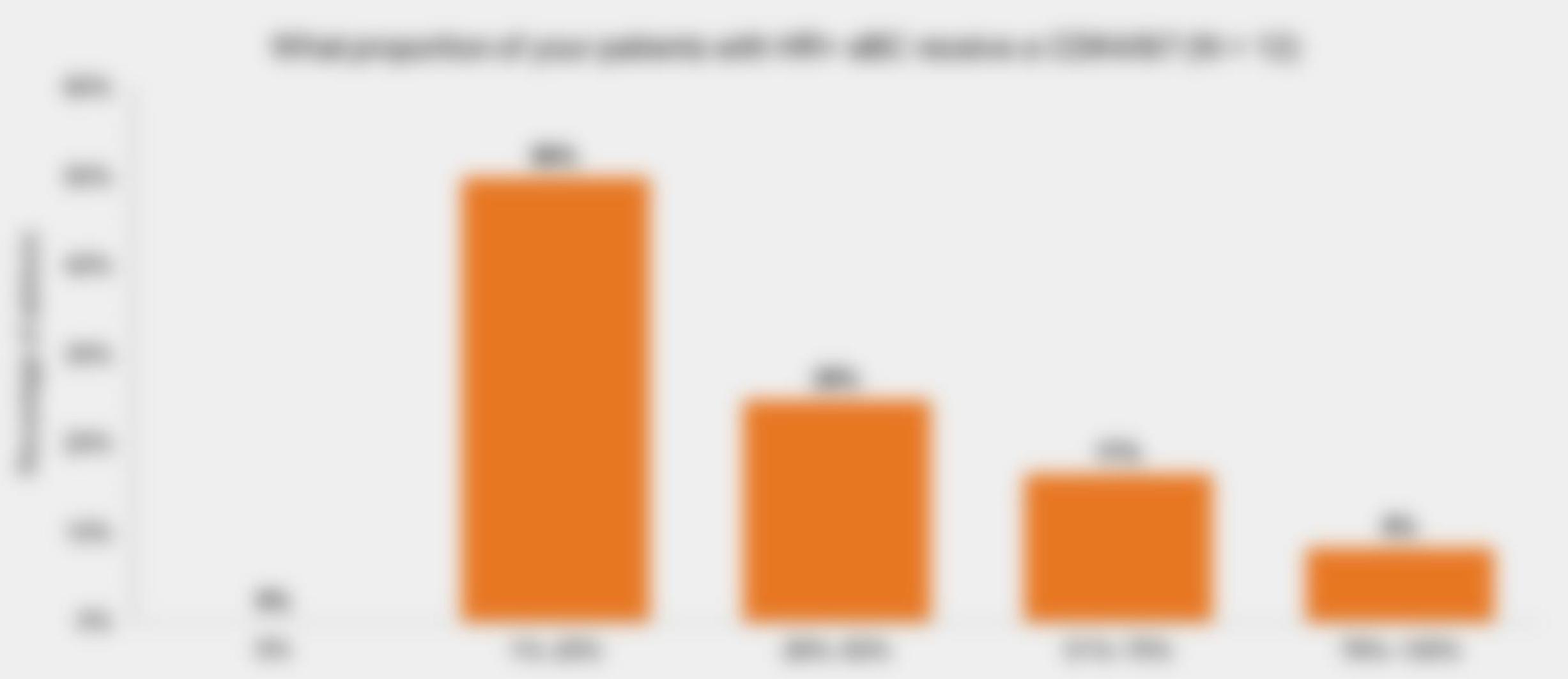


*One advisor did not respond.

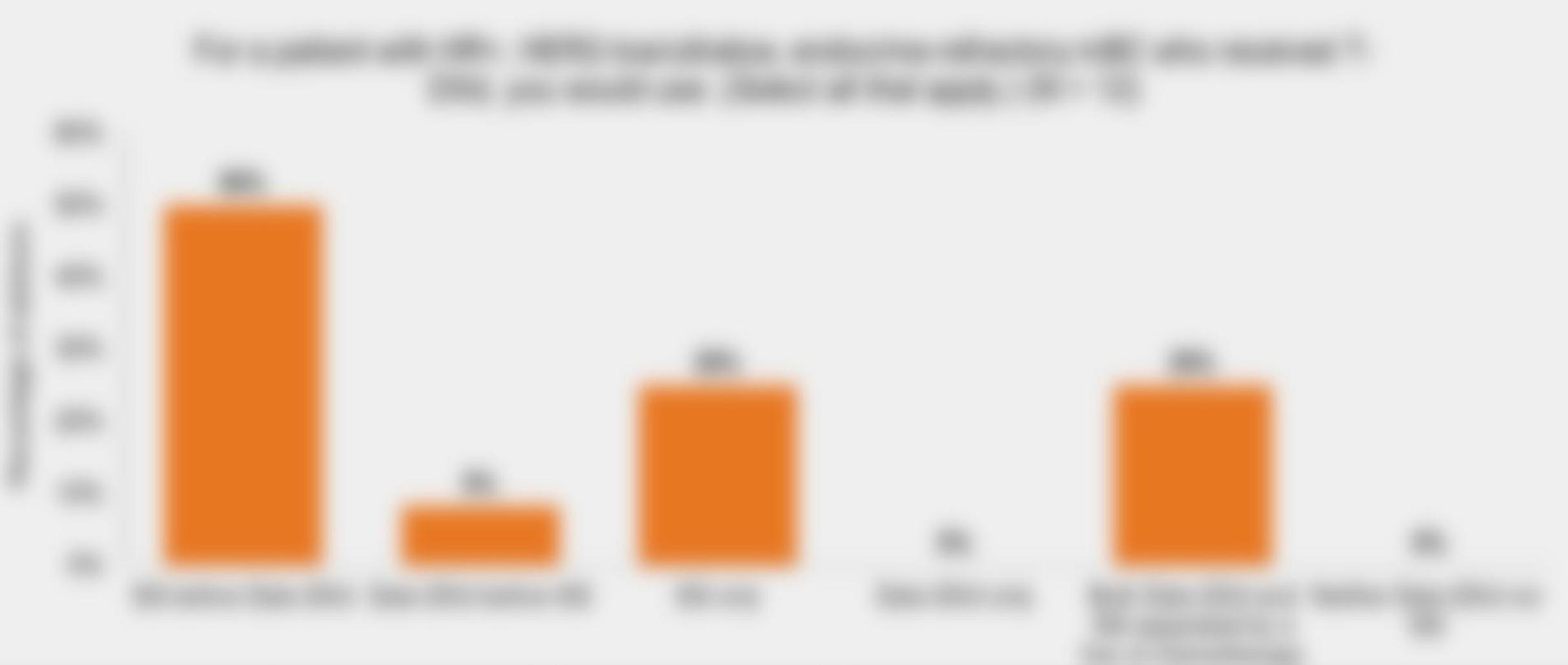


ARS Data

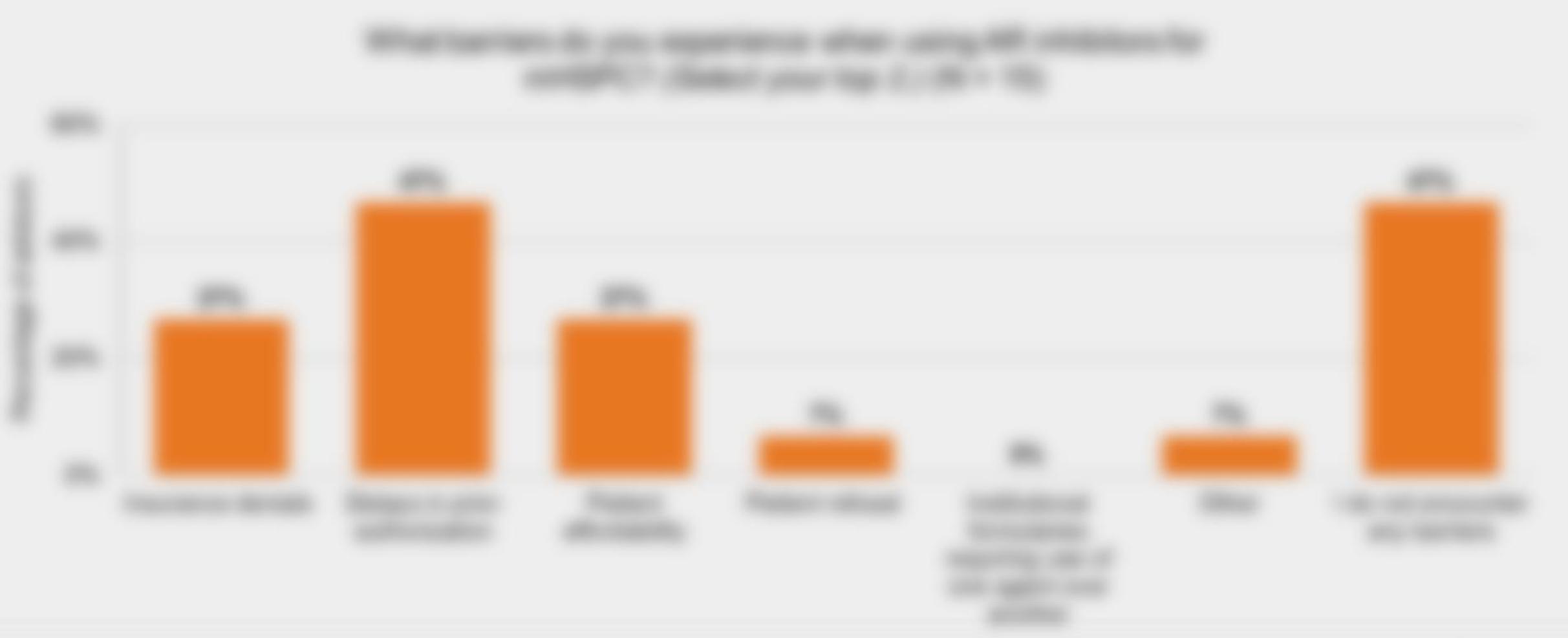
Half of Advisors Treated at Least 4 Patients With Stage II–III HER2+, HR+ eBC in the Past Year



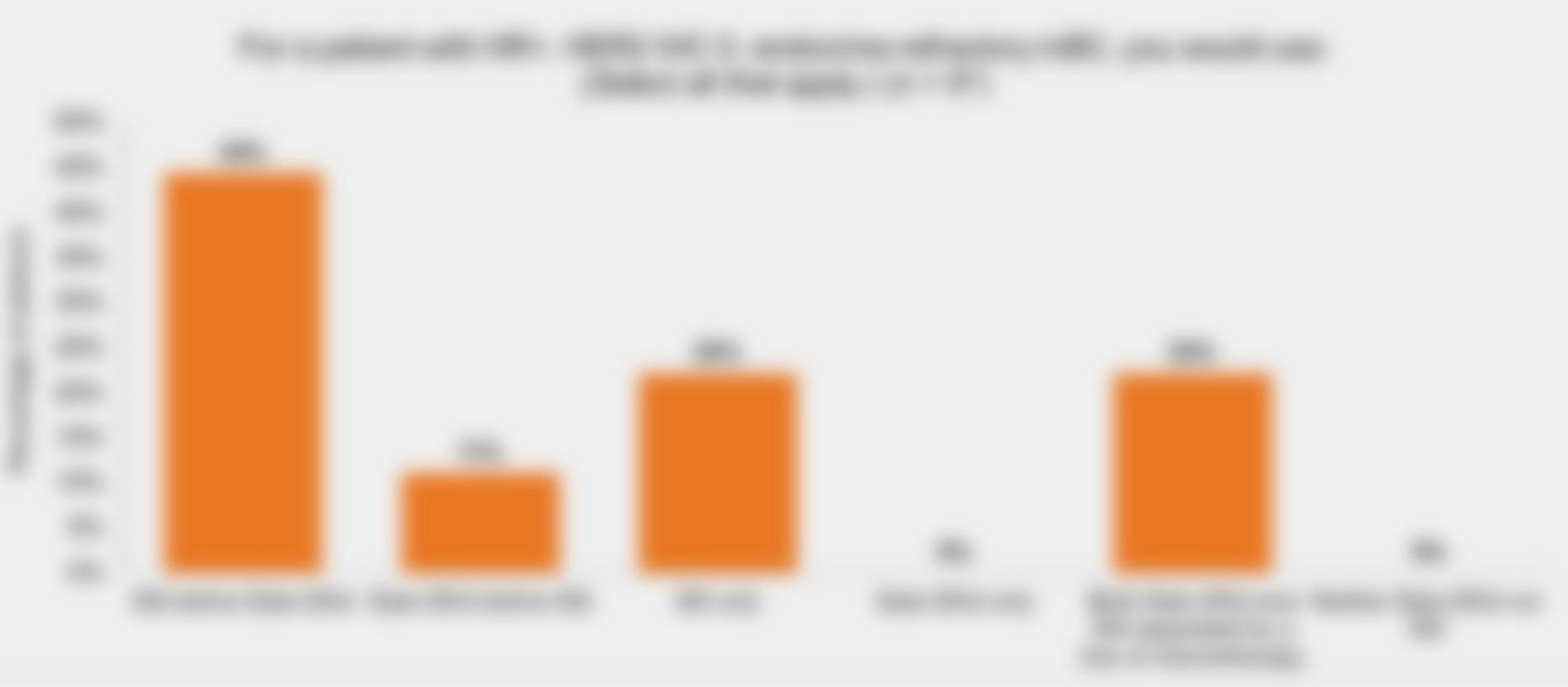
Over Half (58%) of Advisors Treated at Least 6 Patients With HER2+, HR- eBC in the Past Year



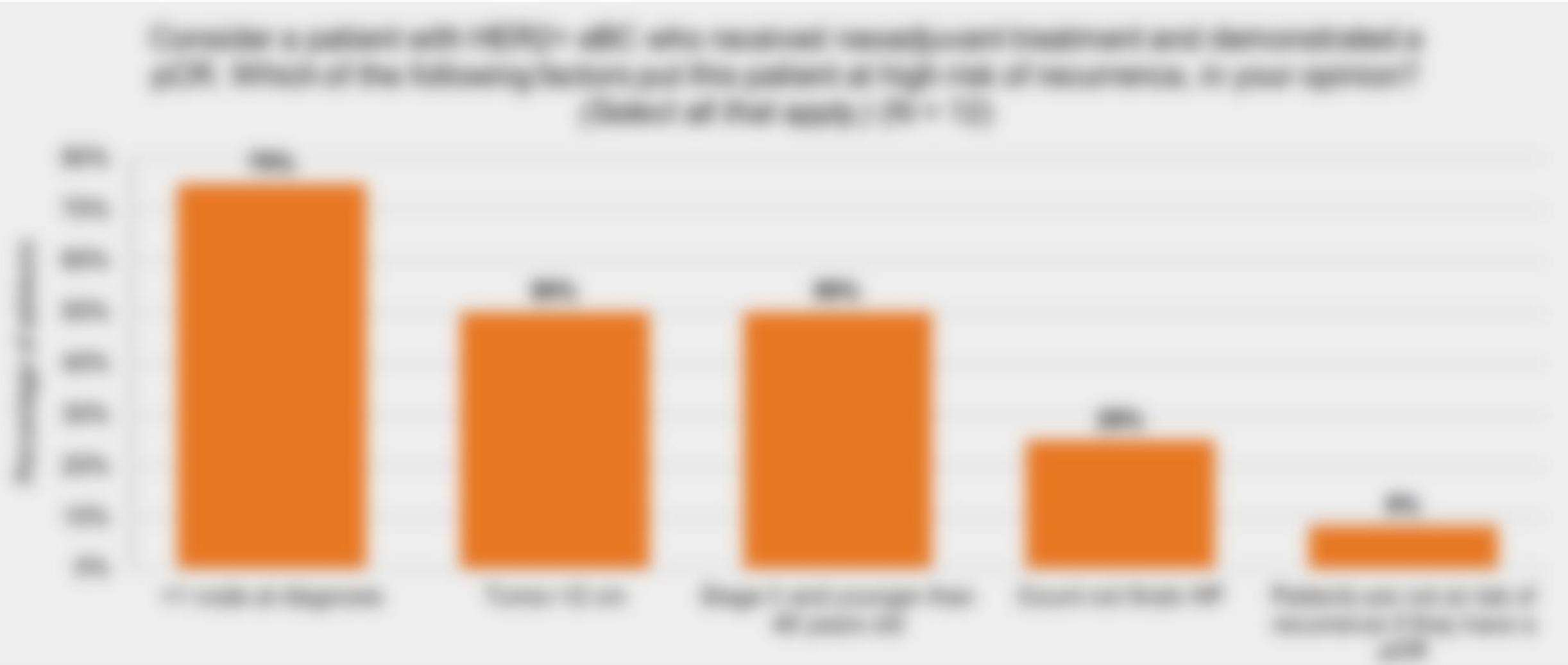
The Majority (73%) of Physicians Had Treated Patients Whose Disease Recurred After a pCR Following Neoadjuvant Treatment

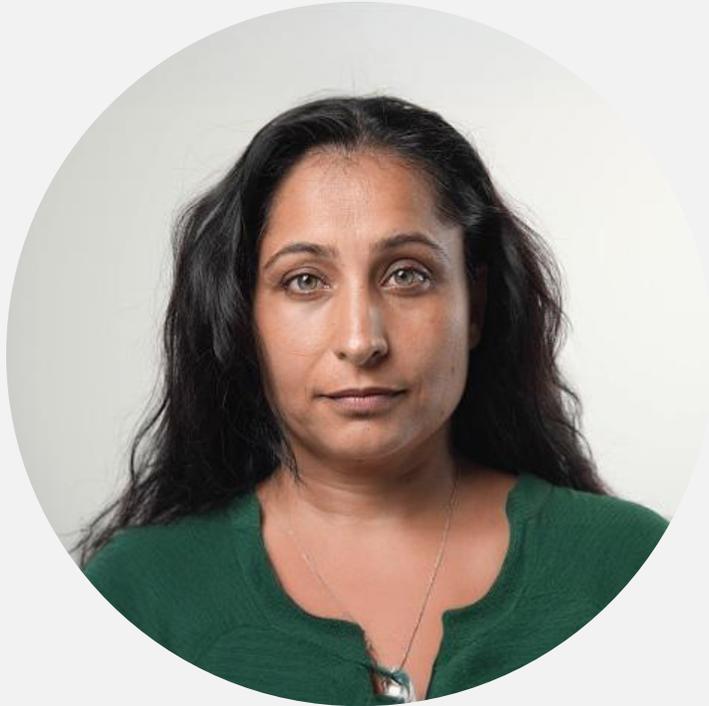


CNS Recurrence Was the Most Common Type of Recurrence After a pCR Following Neoadjuvant Treatment



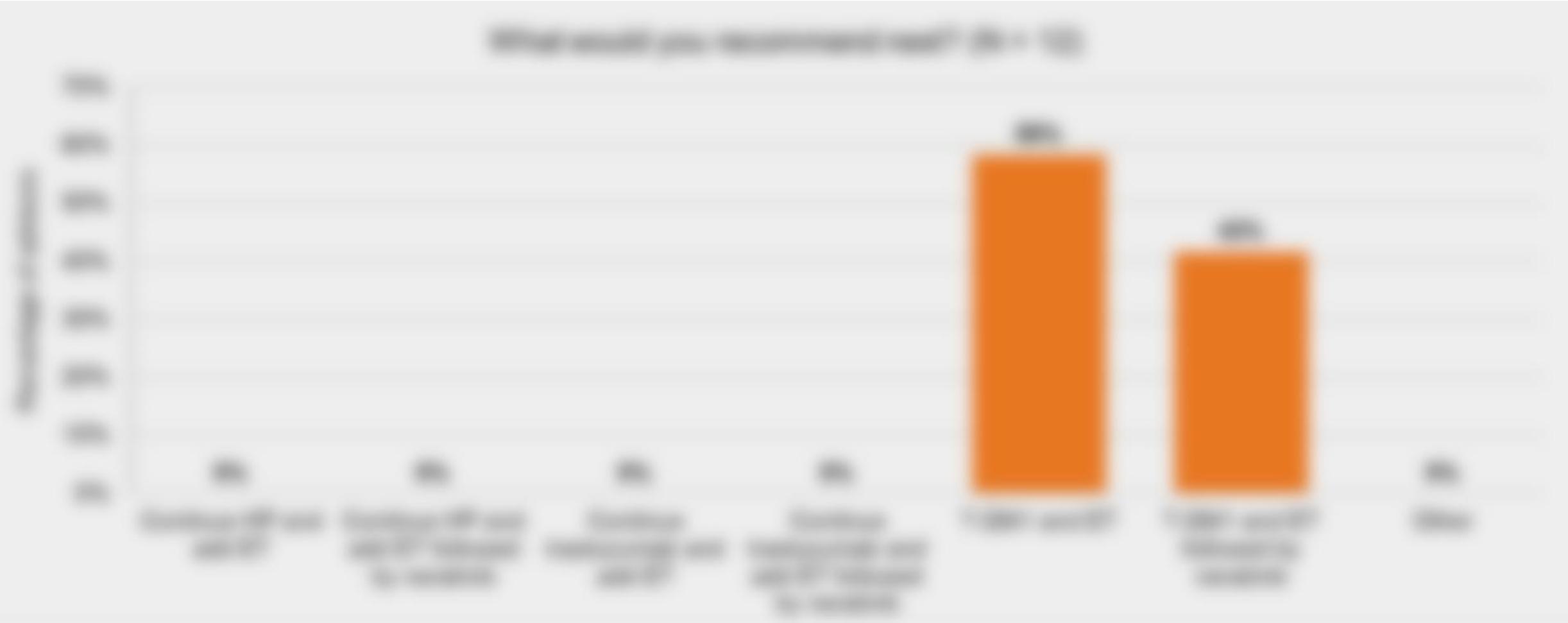
Presence of >1 Node at Diagnosis Indicates High Risk of Recurrence Despite a pCR, According to 75% of Advisors





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-).

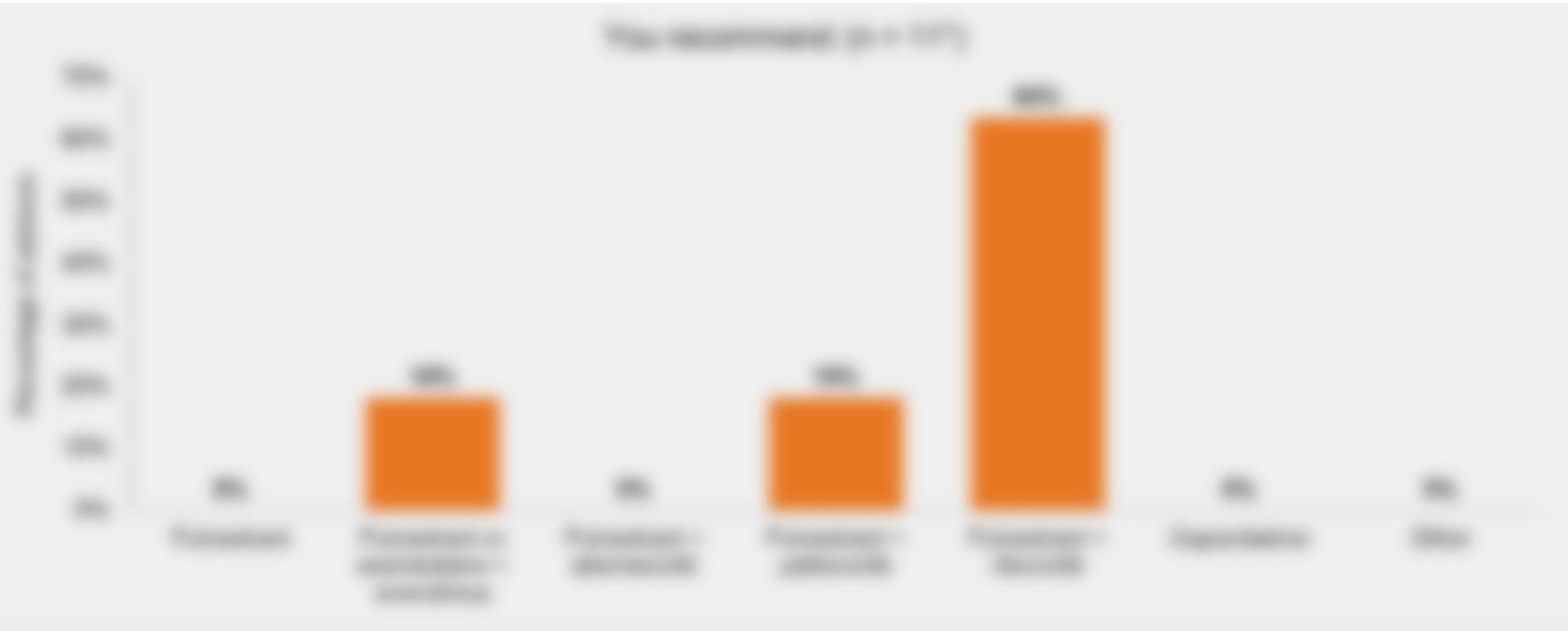
All Advisors Recommended T-DM1 and ET for a Patient Who Demonstrated Near pCR After Neoadjuvant TCHP in Stage IIA (cT1N1M0), Grade 3, ER+, HER2+ eBC



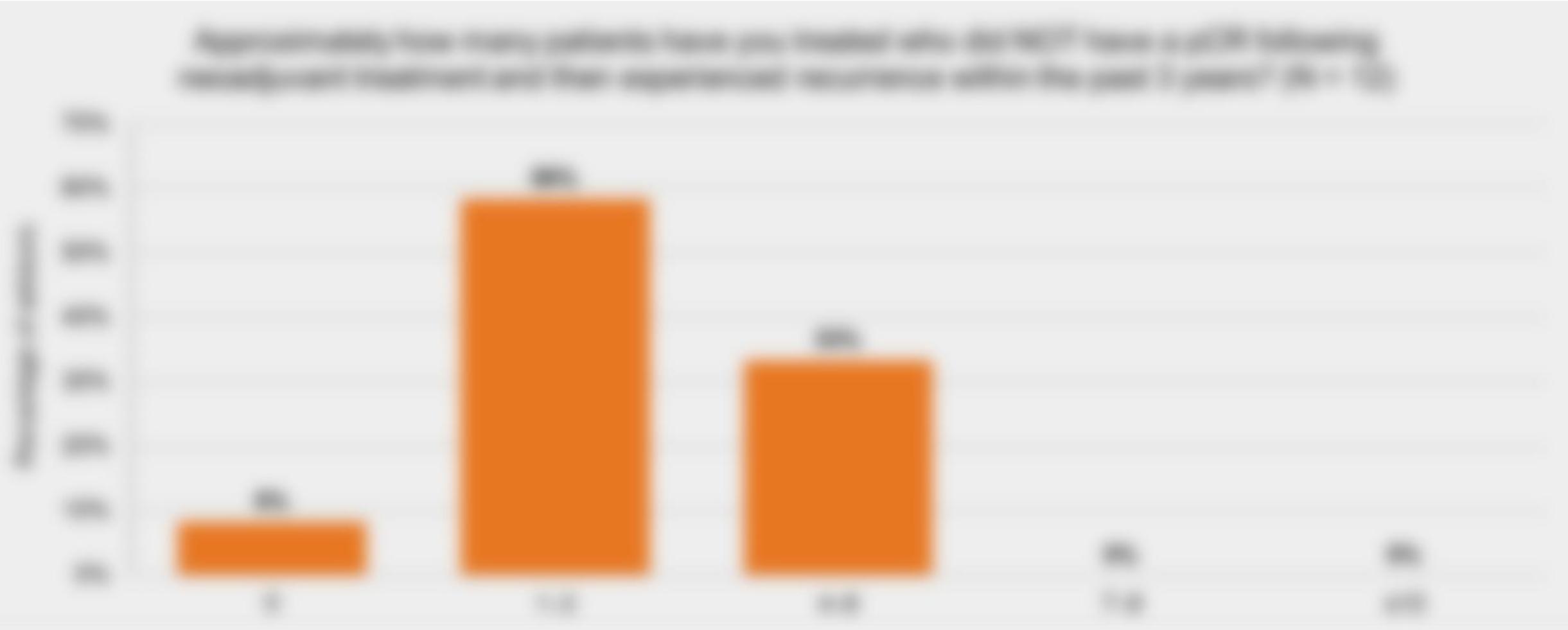


A 38-year-old patient presents with stage II, HER2+, HR+ eBC (2 positive nodes). They receive neoadjuvant TCHP for 6 cycles and have a pCR.

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



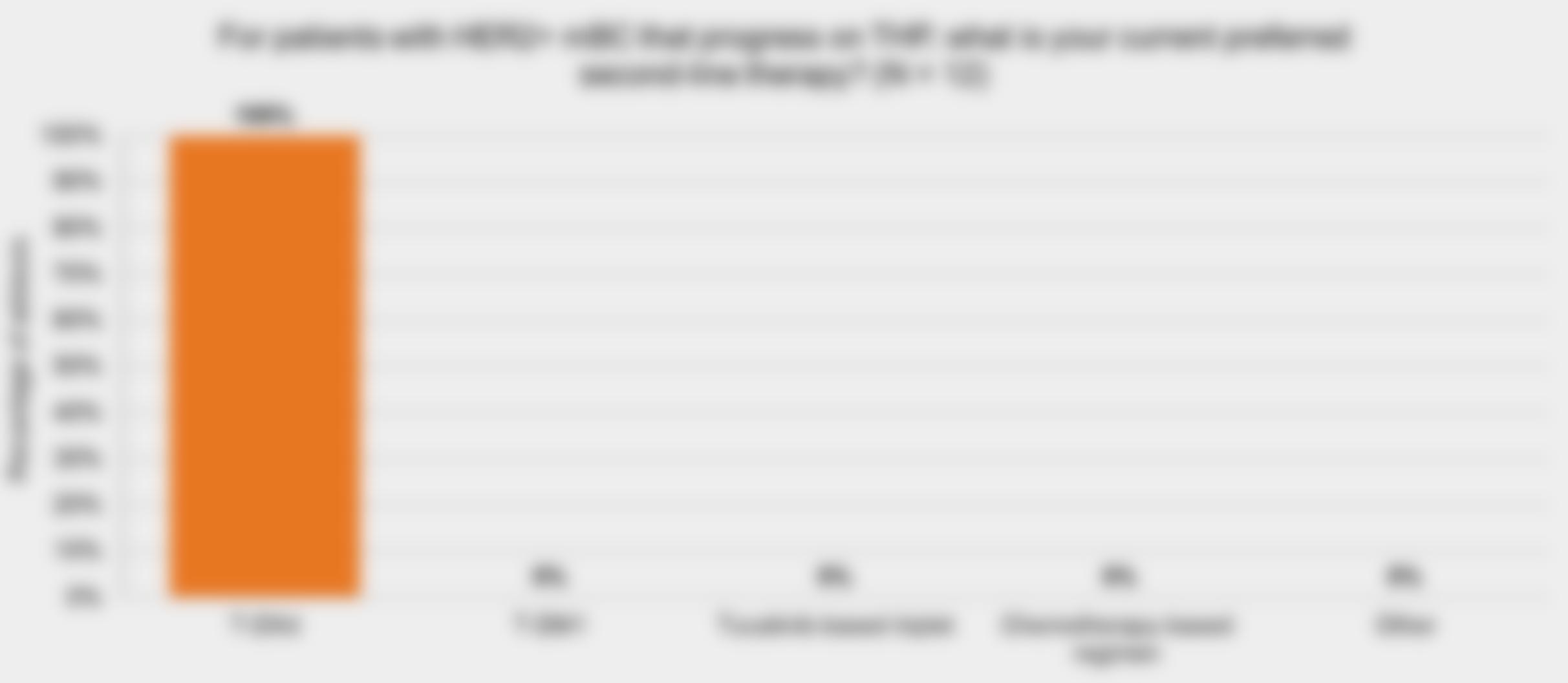
Nearly All Advisors (92%) Treated at Least 1 Patient Who Did Not Demonstrate a pCR Following Neoadjuvant Treatment and Experienced Recurrence Within the Past 3 Years



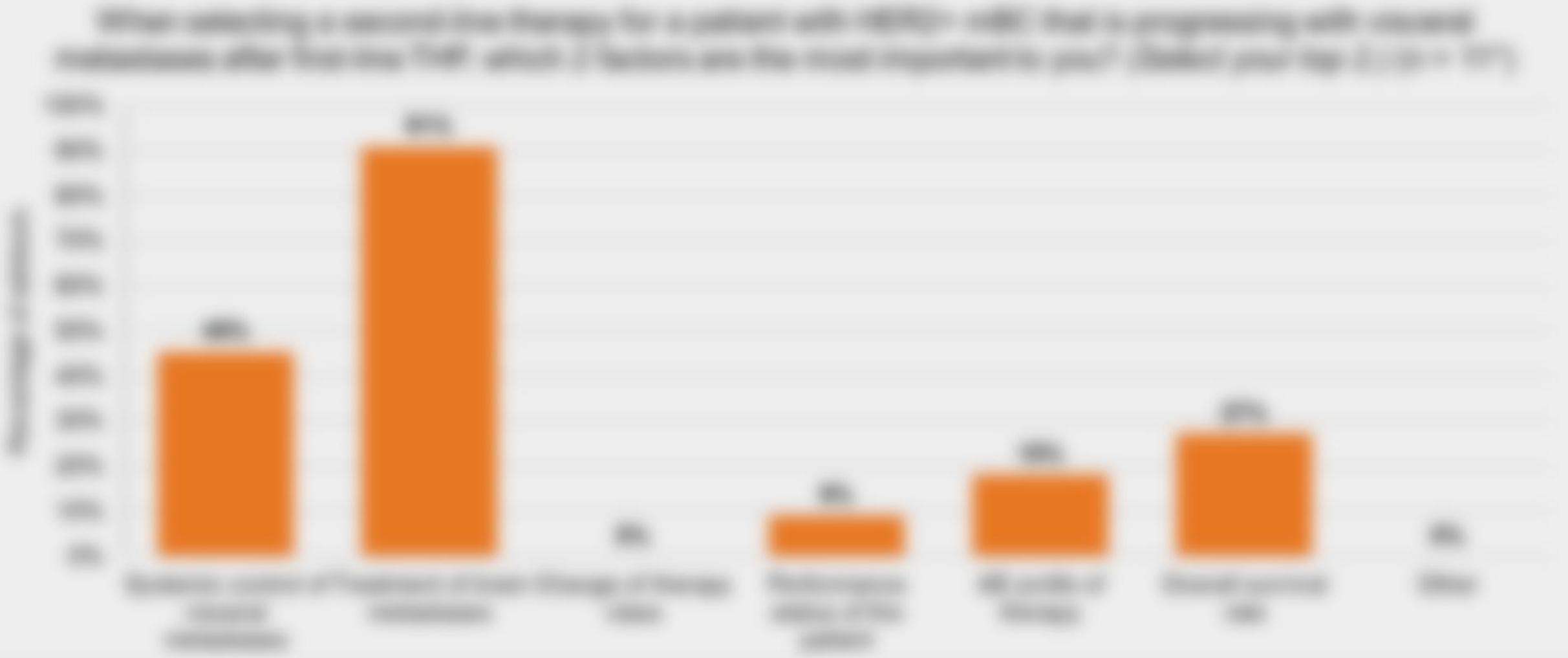
Half of Advisors Did Not Treat Any Patients With Neratinib in the Extended Adjuvant Setting Within the Past Year



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



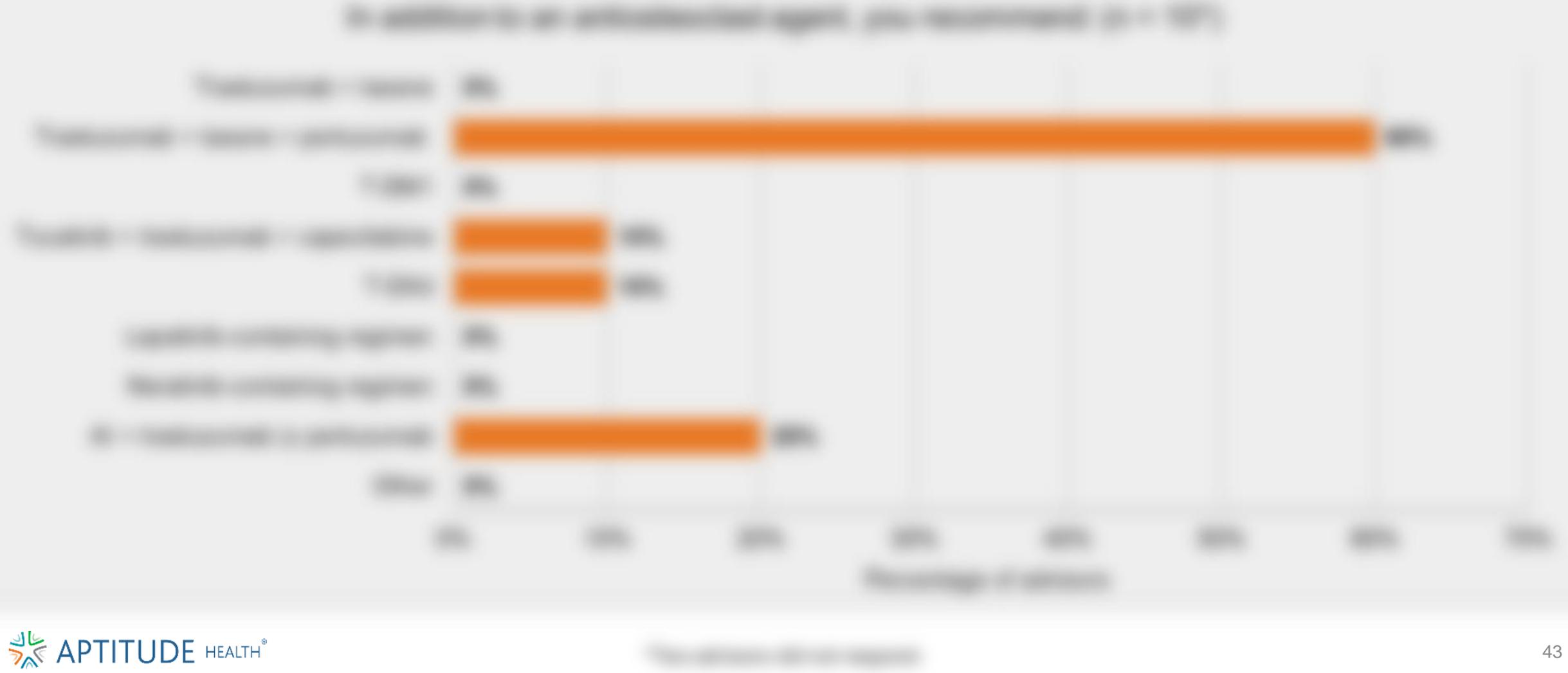
For 91% of Advisors, Treatment of Brain Metastases Is One of the Most Influential Factors on Second-Line Treatment Selection





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.

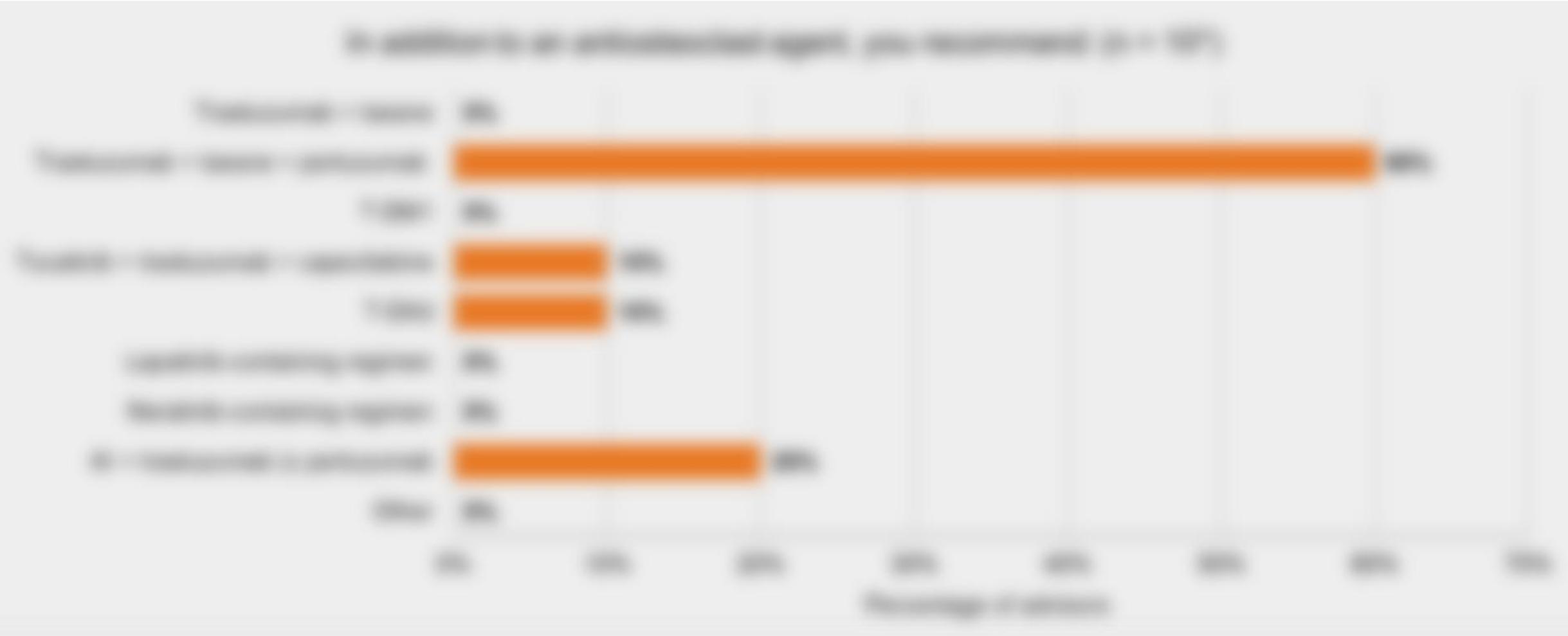
More Than Half (60%) of Advisors Would Choose Trastuzumab Plus Taxane Plus Pertuzumab for a Postmenopausal Patient With De Novo ER+, PR-, HER2+ mBC With Bone-Only Metastasis





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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