



Insights Into Breast Cancer

October 25, 2025

La Jolla, CA

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Report Snapshot



Disease state and data presentations were led on **October 25, 2025**, by **Mark Pegram, MD**, from Stanford University, La Jolla, CA, with content developed in conjunction with the Aptitude Health scientific team



The objectives of the meeting were to gain attendees' perspectives on current treatment practices and recent updates in

- > **HR+ early breast cancer (eBC)**
- > **HR+ metastatic breast cancer (mBC)**



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



Insights on the treatment of HR+ eBC and HR+ mBC were obtained from **13 community oncologists** from California and Nevada

Report Snapshot: Session Agenda



Time (PT)	Topic
1.00 PM – 1.15 PM (15 min)	Introduction <ul style="list-style-type: none">> Program overview> Baseline ARS questions
1.15 PM – 2.15 PM (20-min presentation; 40-min discussion)	Treatment of HR+ Early Breast Cancer (eBC) <ul style="list-style-type: none">> Overview of current data> Reaction and discussion
2.15 PM – 2.30 PM (15 min)	Break
2.30 PM – 2.40 PM (10 min)	ARS Questions
2.40 PM – 3.45 PM (25-min presentation; 40-min discussion)	Treatment of HR+ Metastatic Breast Cancer (mBC) <ul style="list-style-type: none">> Overview of current data> Reaction and discussion
3.45 PM – 4.00 PM (15 min)	3 Key Takeaways and Meeting Evaluation

Report Snapshot: Attendee Overview



Report Snapshot: Attendee Demographics





Detailed Insights

Objective 1: Detailed Insights (1/2)



Objective 1: Detailed Insights (2/2)



Objective 1: Supportive Quotes From Discussion (1/4)



Topic	Relevant Statements
<p>Prognosis on 120/70/80mmHg</p>	<p>"Well, for the data overall, hazard ratio of 0.88 and 95% confidence interval 0.66 to 1.17. 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 regression results for their control arm, I think we had this study open and what was remarkable, at least to our site, was there was a significant difference between control groups of 140/90 and now that I was a lot amount of patients, the amount of all of the patients had hypertension. So we actually didn't have a lot amount that was not eligible for 120/70/80mmHg because of that. I wonder if that's something that just sort of I guess, concentrated the 140/90 population for this, and maybe patients do better. I don't know if that was discussed at all in the."</p> <p>"I mean, there's very impressive results. So you will get into the major criticism of the study, which is that the 120/70/80mmHg regimen is an intensive one you get to the maintenance phase. And I mean there are ongoing studies about doing sort of an induction dose followed by maintenance. So I think that's what we really needed to see. Talking to I think, well, interested in general, but it's a lot of monitoring, the thing every 8 weeks, more or less, to look for full. And that's just a lot of patients, especially in my experience. Sometimes I don't manage them for 8 months or do that follow-up for 8 months. So it just is like the intensity has increased, for sure."</p> <p>"I think the other factor with the control arm doing better than 120/70/80 is the volume of patients that did not get discontinued or hospitalized, because half of the patients were de novo. That means the other half had therapy for several years in the past. There's probably not something we can do."</p>

Objective 1: Supportive Quotes From Discussion (2/4)



Case	Supportive Quotes
Case 1: [Faded]	[Faded text]
Case 2: [Faded]	[Faded text]

Objective 1: Supportive Quotes From Discussion (3/4)



Topic	Supportive Statements
<p>Influence of local networks on decision of highly targeted therapies</p>	<p>"I thought when I saw the [discuss] study I was, but there was a recent study, I think that specifically focused on brain mets. And prior to that date, I think most of us were probably using [medication] for those patients. But now I think there is very good data that this is active in the CNS, including for glioblastoma disease. So knowing that and I think it's much easier than the [medication] regimen, in terms of side effects and multiple medications on the schedule. So I feel comfortable for people with CNS mets."</p> <p>"Yeah, I would agree, I mean, I think there's enough data that that structure has CNS penetration. I think the emphasis in that [medication] data is on the brain metastasis population, but the chemotherapy of that regimen is incredibly difficult, and there's a tremendous amount of GI toxicity and neurotoxicity, and it's very difficult to give. So, I'm pretty comfortable using [medication] in the brain metastasis population. I think there is a cohort showing CNS penetration there."</p> <p>"Yeah, I would agree, I mean, I think that that will be another way of weighing the decision of which one to use as an indication, and with the caveat of being able to control that, that conventional therapy can."</p> <p>"I think that comes up a lot, in the adjacent setting with metastasis. So if you look at the rates, if you had a high-risk patient and they get metastasis, they had less CNS mets, metastases than those that did not get metastasis."</p>

Objective 1: Supportive Quotes From Discussion (4/4)



Case	Supportive Quotes
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Objective 2: Detailed Insights (1/2)

Objective 2: Detailed Insights (1/2)

Key Takeaway: Address practice efficacy, safety, and quality of life (QoL) (HRQoL) with docetaxel as the most preferred CDK4/6 inhibitor currently under treatment-based regimens for advanced breast therapy in the absence of actionable mutations, but they noted a preference for abiraterone in patients with HR234 mutations and enzalutamide in the case of ERPR mutations. Addressed issues with CDK4/6 & competing and were optimistic regarding its future incorporation in HR+ mBC, though concerns remain regarding real-time data and testing costs.

When discussing HR+ disease, address emphasized that safety, toxicity management, quality of life, and efficacy outcomes guide treatment decisions.

- Docetaxel is the most preferred CDK4/6 by HR+ mBC, with half of address recommending docetaxel as their first-line choice, while 47% of address said it depends on the patient.
 - Address pointed to efficacy results and toxicity profiles as the leading reasons behind their choice of CDK4/6 inhibitor; physicians also consider HR234 mutations in their preference.
- According to address, palbociclib is more appealing for their patients, while abiraterone remains effective for higher-risk disease.

Following progression on first-line abiraterone plus docetaxel, most address would recommend subsequent treatment plus docetaxel for a patient with HR+ mBC in the absence of any actionable mutations.

- During discussion, address noted that they typically use abiraterone for their patients with HR234 mutations, citing that it came first as their main strategy for its selection over regimens.
- Address discussed using single-agent docetaxel for their patients with ERPR mutated HR+ mBC.

Address found the data from CDK4/6 & and HR234 highly compelling and expressed interest in the CDK4/6 & and HR234 & trials to expand the arsenal of available treatments for HR+ mBC.

- Physicians cite real-time data and the potential cost of repeated ERPR testing as challenges for incorporation of CDK4/6 &, but they remain optimistic and noted that many patients desire additional testing.
 - One address asked a question on how to proceed for patients who test positive for ERPR mutations at one site but not at another.

Objective 2: Detailed Insights (2/2)

Objective 2: Detailed Insights (2/2)

Key Takeaway: Address provider efficacy, safety, and quality of life with vildagliptin (VILDA) + metformin (MET) with vildagliptin as the most preferred combination. Address currently under-treatment based responses for second-line therapy in the absence of actionable mutations, but they noted a preference for dapagliflozin in patients with HbA1c mutations and dapagliflozin in the case of GPP1 mutations. Address found VILDA/MET compelling and were optimistic regarding its future incorporation in vildagliptin + metformin, though concerns remain regarding real-time data and testing costs.

When discussing vildagliptin + metformin, address emphasized that safety, toxicity management, quality of life, and efficacy outcomes guide treatment decisions.

- Vildagliptin is the most preferred combination by vildagliptin + metformin, with half of address recommending vildagliptin as their first-line choice, while 40% of address said it depends on the patient.
 - Address pointed to efficacy, results and toxicity profiles as the leading reasons behind their choice of combination. Physicians also consider HbA1c reduction in their preference.
- According to address, vildagliptin is more appealing for first patients, while dapagliflozin remains effective for higher risk disease.

Following progression on first-line vildagliptin plus dapagliflozin, most address would recommend follow-up plus vildagliptin for a patient with vildagliptin + metformin in the absence of any actionable mutations.

- During discussion, address noted that they typically use dapagliflozin for their patients with HbA1c mutations, citing that it came first as their first choice for its reduction over vildagliptin.
- Address discussed using single agent dapagliflozin for their patients with GPP1 mutation vildagliptin + metformin.

Address found the data from VILDA/MET and VILDA/MET highly compelling and expressed interest in the VILDA/MET and VILDA/MET trials to expand the arsenal of available treatments for vildagliptin + metformin.

- Physicians cite real-time data and the potential cost of repeated GPP1 testing as challenges for incorporation of VILDA/MET, but they remain optimistic and noted that many patients desire additional testing.
 - One address raised a question on how to proceed for patients who test positive for GPP1 mutations at low allele frequency.

Objective 2: Detailed Insights (3/3)



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



ID	Supportive Quotes
1	<p>...the importance of having a strong support system...</p> <p>...the importance of having a strong support system...</p> <p>...the importance of having a strong support system...</p>
2	<p>...the importance of having a strong support system...</p> <p>...the importance of having a strong support system...</p> <p>...the importance of having a strong support system...</p>

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



Topic	Supportive Statements
<p>Perceptions of clinical use</p>	<p>"Well, I think it's very interesting, I mean, it's also small. It's a small subset of patients who have progressed very well with this regimen, but I think it's a pretty clear improvement in the PDQ."</p> <p>"I think this is the only trial where PDQ versus control is combined with CDK4/6 inhibitor in addition to treatment. So that's the strength, and you can see the response rate in this particular trial."</p> <p>"You would have the response rate with it. This was a trial that had very good patients enrolled. This was a representative... And the fact that these patients are achieving efficacy treatment, and they're all getting a 60% response rate. That's quite high. And PDQ is your program."</p>
<p>Perceptions of CDK4/6 and endocrine</p>	<p>"I think more studies are available, and in CDK4/6 I can see the data of combination with abiraterone, and better results as compared to monotherapy that... So I think that's exciting."</p> <p>"I think it's great to have more options, I mean, all of these PDQs are pretty moderate, but like you said, it's another tool and you're going to improve many, many treatments, hopefully."</p>
<p>Perceptions of CDK4/6 benefits</p>	<p>"Everything depends on the population and the data. So CDK4/6 benefits is a landmark trial, and it's not only in ER, which we had in CDK4/6 benefits. So CDK4/6 is an important strategy. So that's important, and that's practice changing. So we never used to treat these patients. So patients who are hormone refractory after cycle 2 disease ER, and hormone, we can use up front as the first treatment, the treatment. So I think it's practice changing. It's very important. We used to use chemotherapy."</p>

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



ID	Supportive Quotes
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[Blurred]	[Blurred]

Objective 3: Detailed Insights (1/2)



Case 1: [Illegible]

[Illegible text]

[Illegible text]

- [Illegible list item]

[Illegible text]

- [Illegible list item]

[Illegible text]

[Illegible text]

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Objective 3: Detailed Insights (2/2)



Case 1: [Illegible Title]

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- [Illegible bullet point]
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- [Illegible bullet point]
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Objective 3: Supportive Quotes From Discussion (1/5)



Case	Supportive Quotes
Case 1	...the importance of...
Case 2	...the importance of...
Case 3	...the importance of...
Case 4	...the importance of...
Case 5	...the importance of...

Objective 3: Supportive Quotes From Discussion (2/5)



Case	Supportive Quotes
Case 1	Quote 1 Quote 2
Case 2	Quote 1 Quote 2
Case 3	Quote 1 Quote 2

Objective 3: Supportive Quotes From Discussion (3/5)



Case	Supportive Quotes
<p>Case 1</p>	<p>Supportive quote 1</p> <p>Supportive quote 2</p>
<p>Case 2</p>	<p>Supportive quote 3</p> <p>Supportive quote 4</p>

Objective 3: Supportive Quotes From Discussion (4/5)



Case	Supportive Quotes
Case 1	<p>Quote 1: "The results of the study indicate that..."</p> <p>Quote 2: "The findings suggest that..."</p>
Case 2	<p>Quote 3: "The study demonstrates that..."</p> <p>Quote 4: "The research shows that..."</p> <p>Quote 5: "The data reveals that..."</p> <p>Quote 6: "The analysis indicates that..."</p>

Objective 3: Supportive Quotes From Discussion (5/5)



Case	Supportive Quotes
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Attendee Key Takeaways

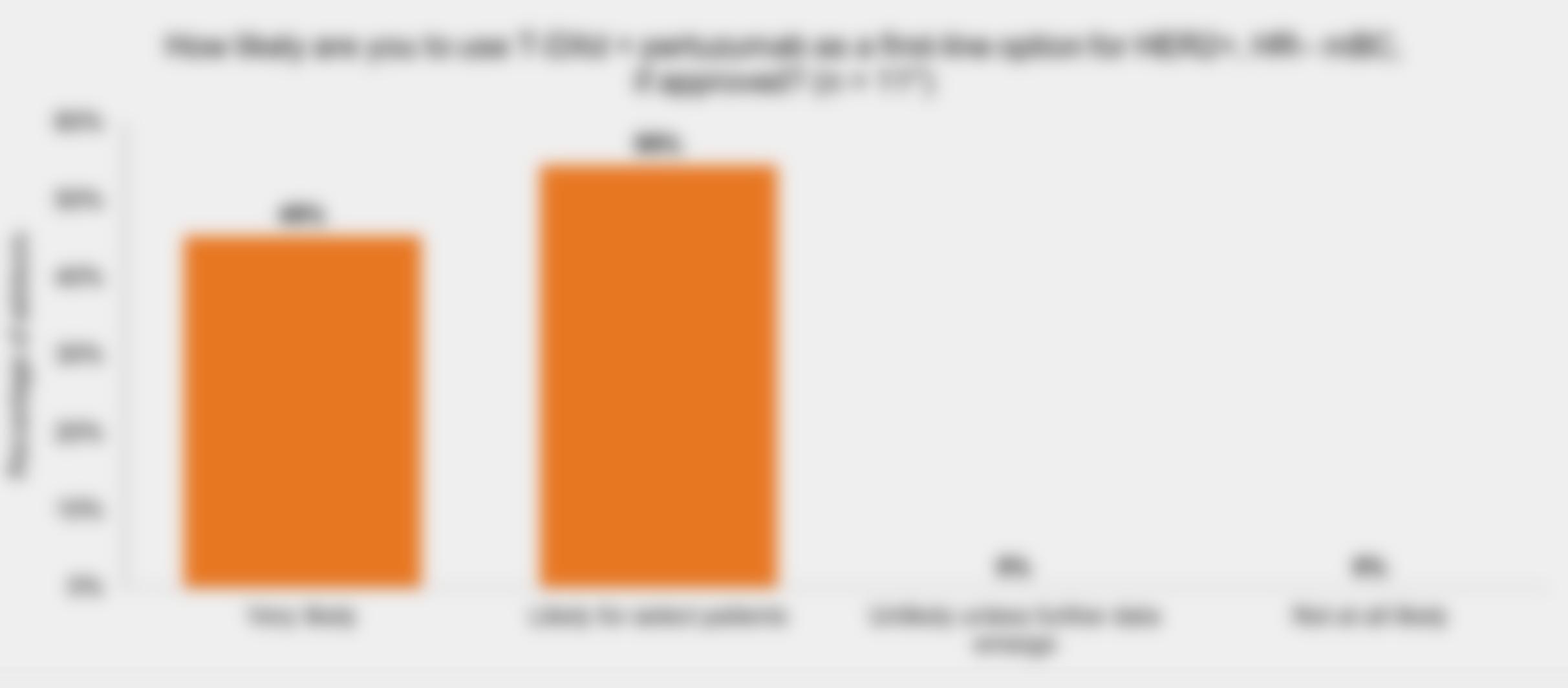


ARS Data

Lymph Node Involvement and Oncotype or Other Tests Are the Disease Factors Most Advisors Use (85% each) to Determine if a Patient With eBC Has High Recurrence Risk



The Majority of Advisors (77%) Use Oncotype DX, But Do Not Use the RSCLin Tool; 23% of Advisors Use Both



Efficacy Data (85%), Safety Profile/Toxicity Management/QOL (62%), and Risk of Recurrence (54%) Most Strongly Drive Advisors' Treatment Decisions in HR+ eBC



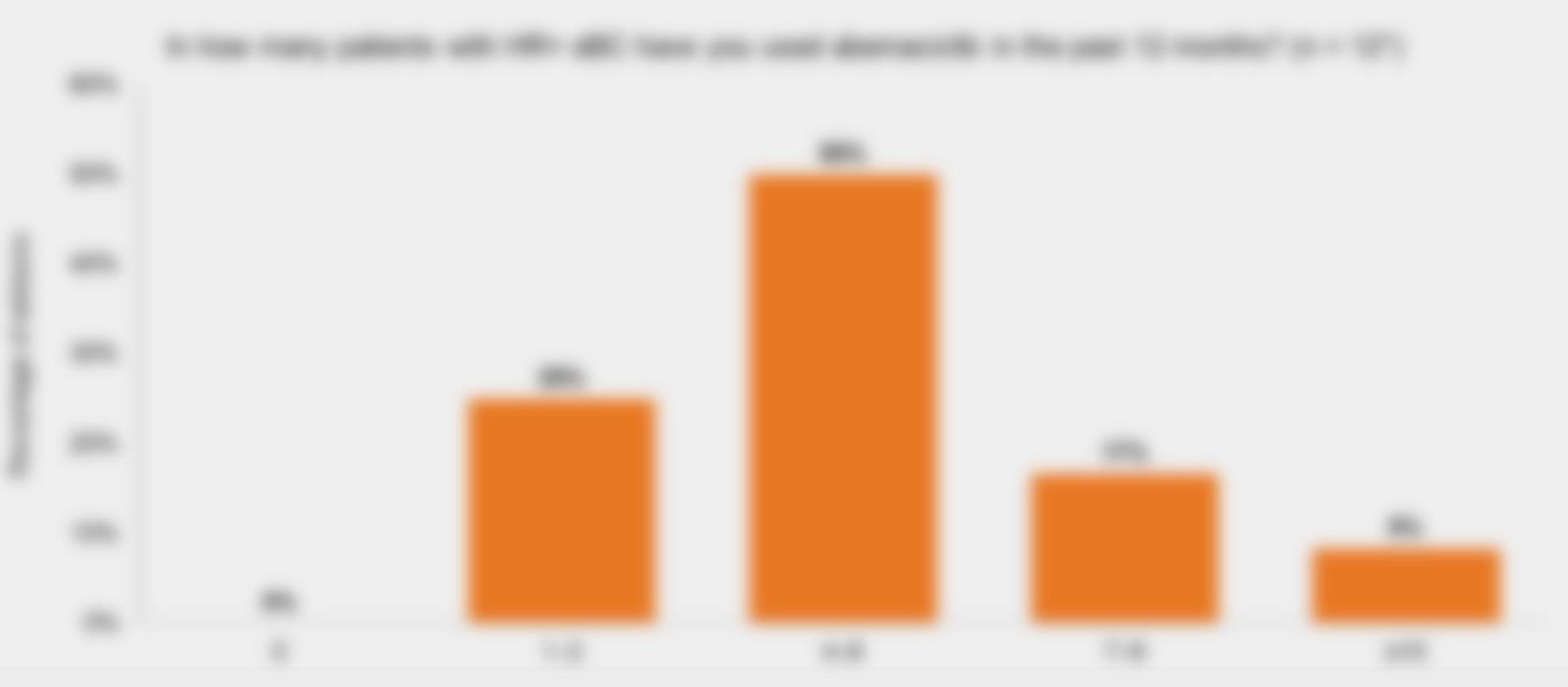
84% of Advisors Estimate That Up to Half Their Patients With HR+ eBC Receive a CDK4/6i



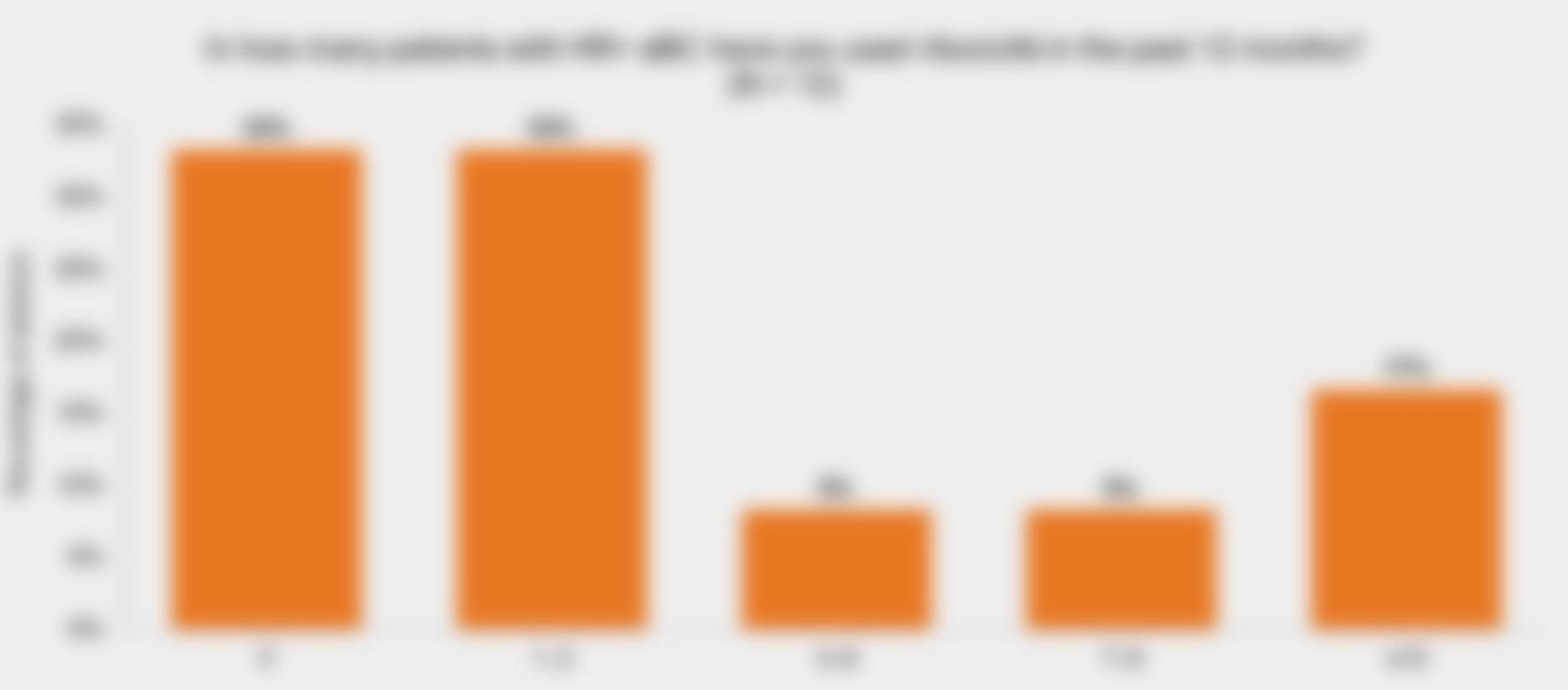
Percentage of HR+ eBC patients receiving CDK4/6i by advisor type



All Advisors Used Abemaciclib in at Least 1 Patient With HR+ eBC in the Last Year



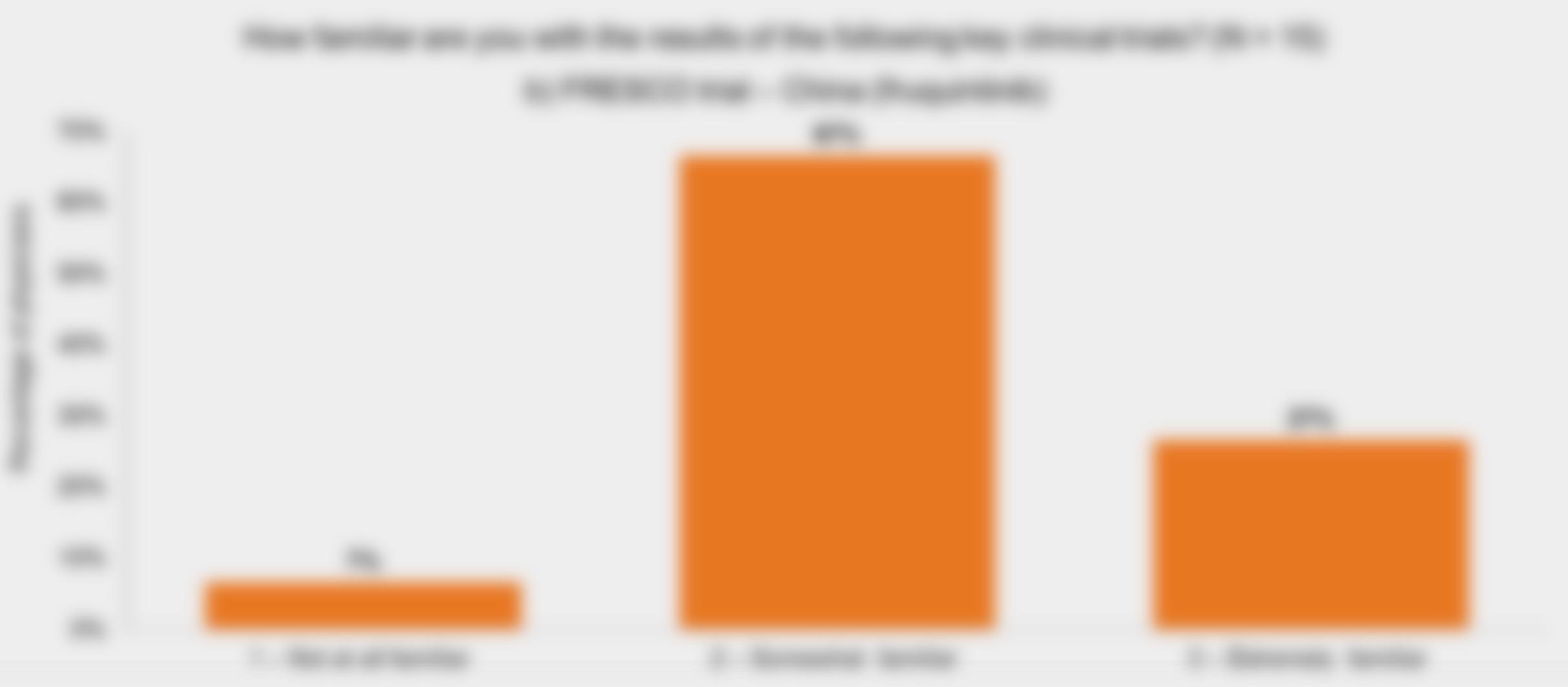
83% of Advisors Prescribed Ribociclib in at Least 1 Patient With HR+ eBC in the Past Year



Overall Survival (92%) Is the Endpoint Advisors Find Most Clinically Relevant in HR+ eBC Trials, Followed by Disease-Free Survival (69%) and Invasive Disease-Free Survival (54%)



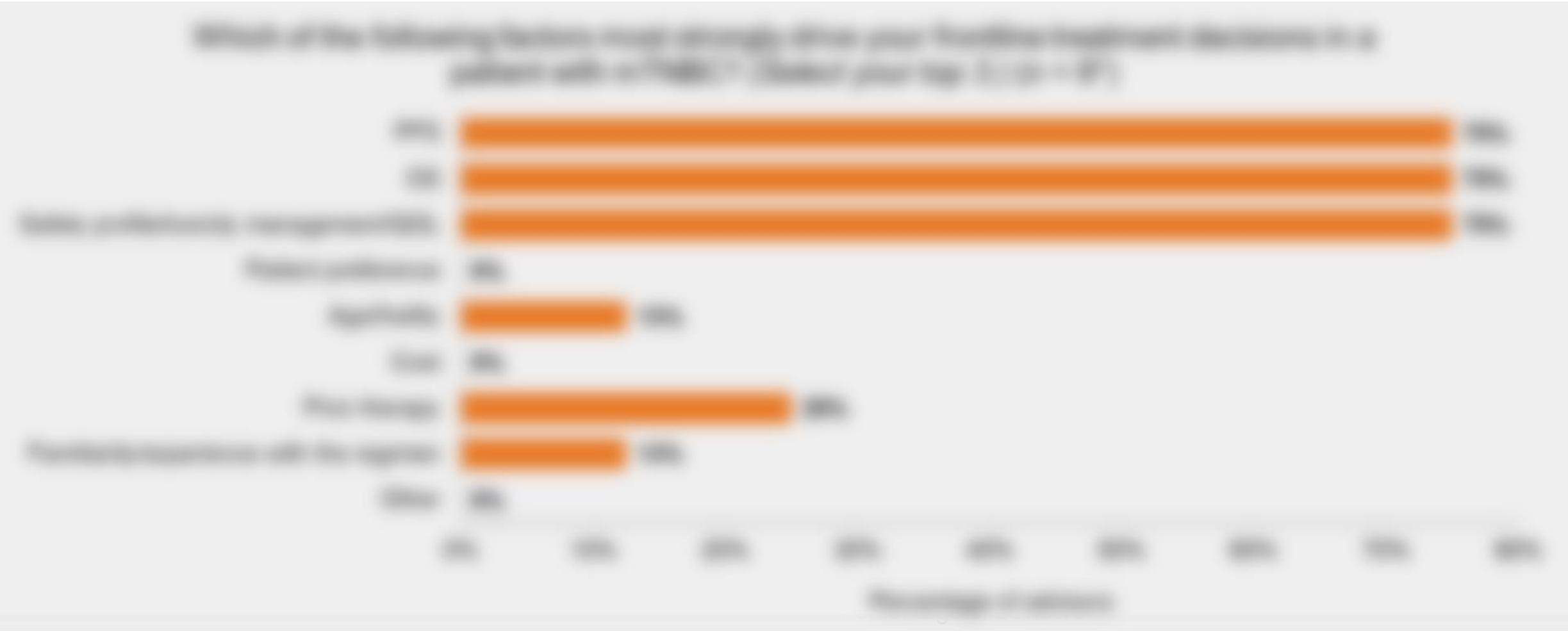
Most Advisors (60%) Utilize CDK4/6i in HR+ mBC in 1 Line of Therapy



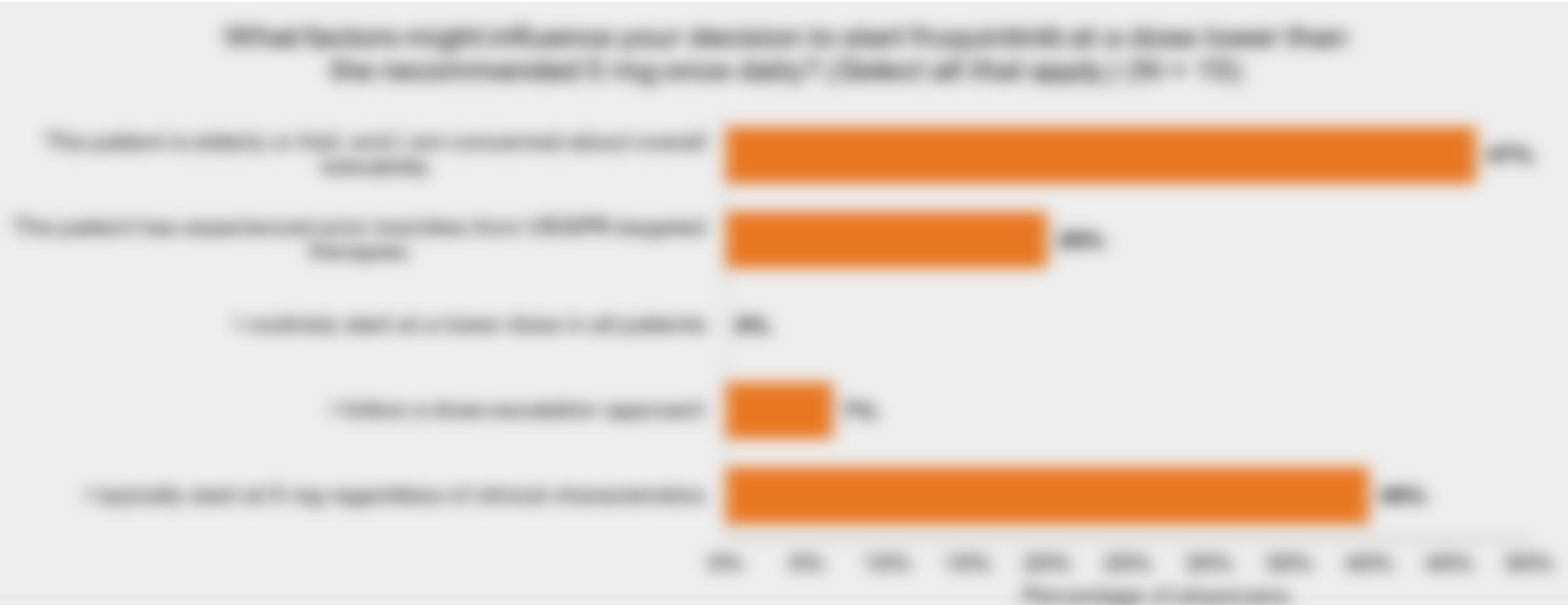
Ribociclib Is the Preferred CDK4/6i in First-Line HR+ mBC for 45% of Advisors



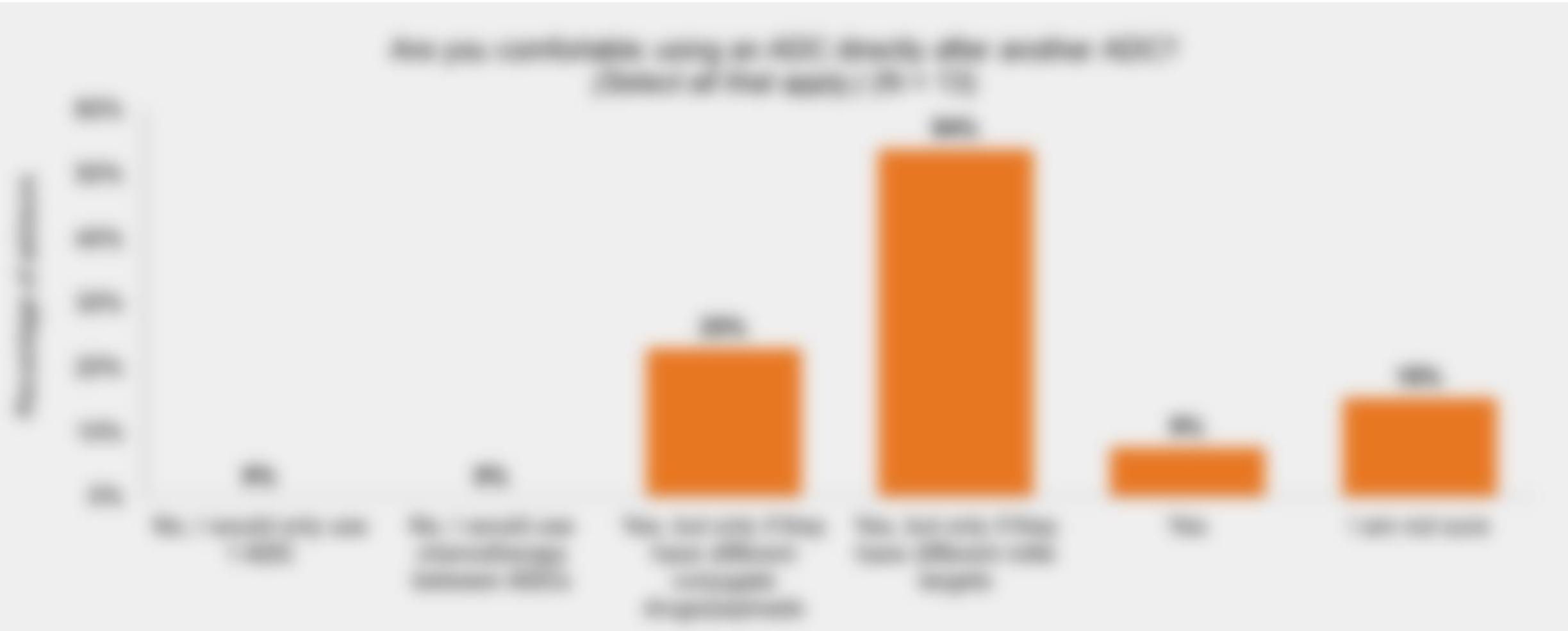
Efficacy Results and Preferred Status in NCCN Guidelines (82% each) Are the Primary Reasons Advisors Prescribe Their Choice of CDK4/6i, Followed by Toxicity Profile (73%)



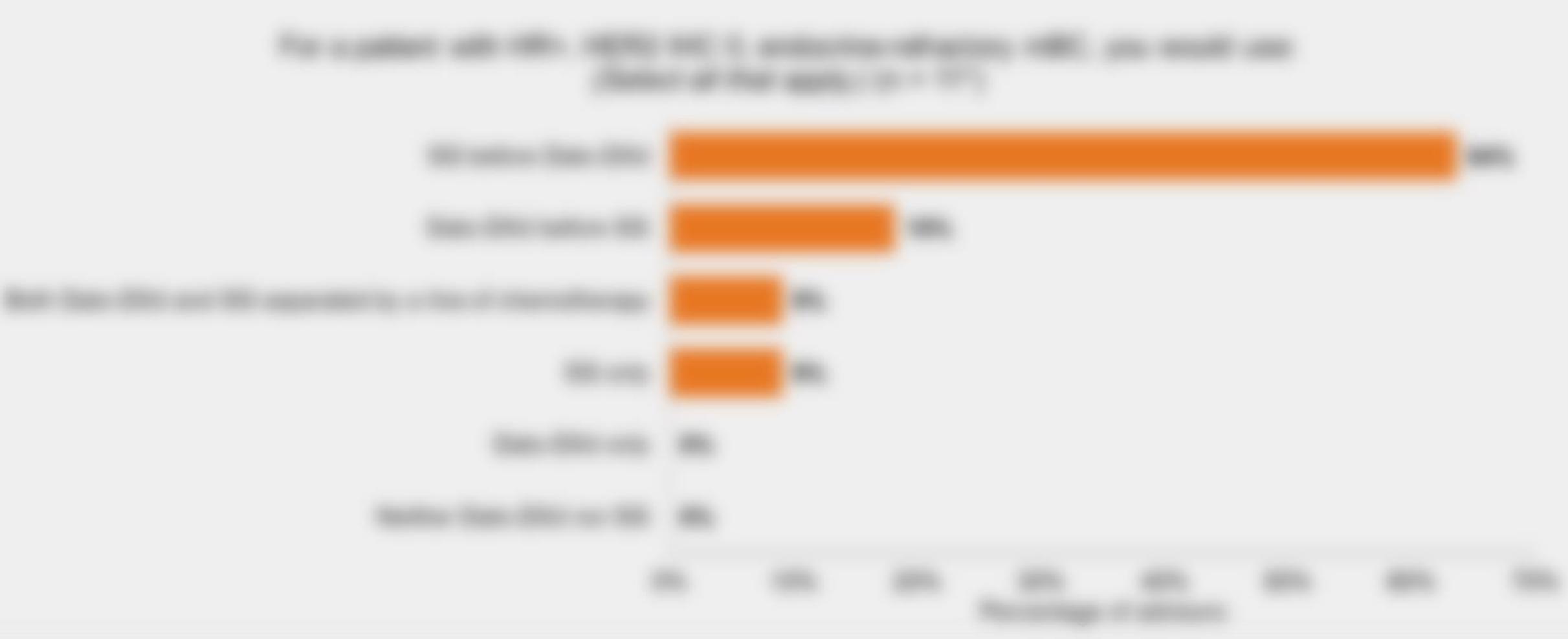
For a Patient With T3N1M1 Grade 2 HR+, HER2– IDC and No Actionable Mutations, 56% of Advisors Recommended Fulvestrant or Exemestane Plus Everolimus After Progression on Letrozole Plus Abemaciclib; 22% Recommended Fulvestrant Plus Abemaciclib



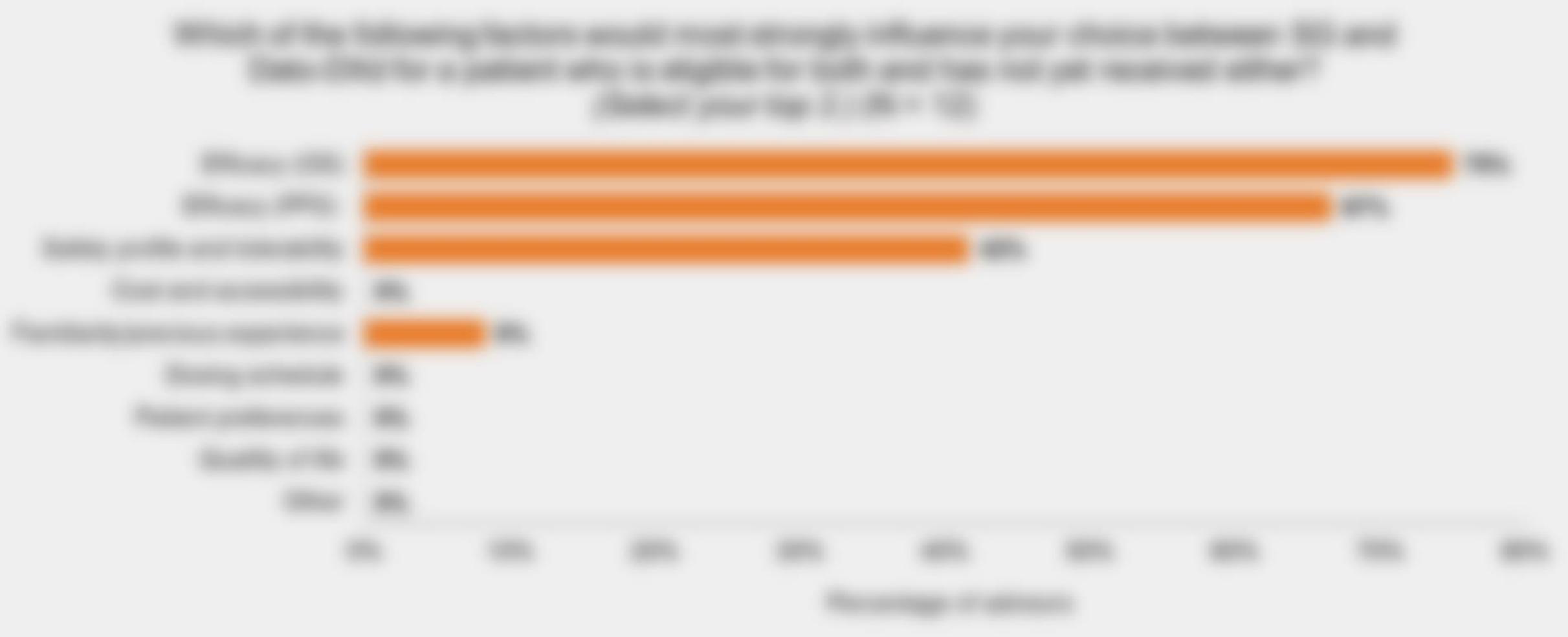
Just Over Half (54%) of the Advisors Would Be Comfortable Using an ADC Directly After Another ADC if They Have Different mAb Targets



For a Patient With HR+, HER2 IHC 0, Endocrine-Refractory mBC, 64% of Advisors Would Use Sacituzumab Govitecan Before Dato-DXd



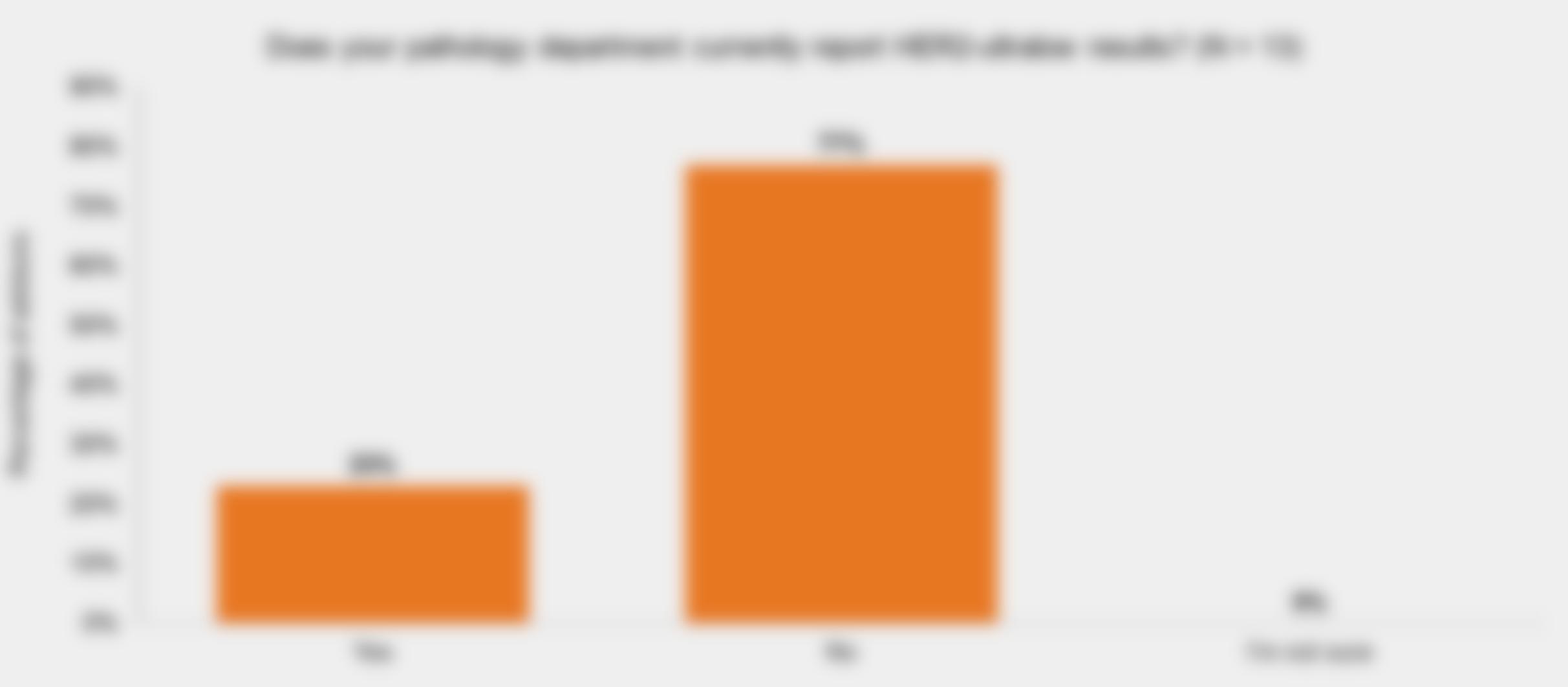
46% of Advisors Would Use SG Before Dato-DXd and 31% Would Use Dato-DXd Before SG for a Patient With HR+, HER2-Low/Ultralow, Endocrine-Refractory mBC



Safety Profile and Tolerability (82%), OS, and PFS (55% each) Most Strongly Influence Choice Between SG and Dato-DXd for Patients Who Are Eligible for Both But Have Not Received Either



For Almost One-Fourth of Advisors, Their Pathology Department Reports HER2-Ultralow Results





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