BC CHAT

The OncoAlert Network:

Hello Dear Colleagues and welcome to day 3 of the OncoAlert Colloquium

Elisa Agostinetto (Moderator):

Hello!

The OncoAlert Network:

Greetings Dr. Agostinetto

Gil Morgan:

Hi Elisa!

Elisa Agostinetto (Moderator):

Dear colleagues, feel free to type your questions in the chat!

The OncoAlert Network:

Absolutely, thank you for reminding everyone Dr. Agostinetto

The OncoAlert Network:

Please don’t forgot that if you are having any technical issues contact us

The OncoAlert Network:

OncoAlertNetwork@OncoAlert360.com

Gil Morgan:

Looks like we are 15 minutes away from our start, looking forward to a great session!

The OncoAlert Network:

Dear All, our session will commence in 5 minutes

Fatima Cardoso Presenter:

Hello. I have just logged in.

The OncoAlert Network:

Hello Dr. Cardoso and welcome

Elisa Agostinetto (Moderator):

Hello Dr Cardoso!

Fatima Cardoso Presenter:

Hello Elisa!

The OncoAlert Network:

Dr. Cardoso, just to remind you that you are welcome through the entire colloquium, but also if you wish to pop out you can

The OncoAlert Network:

your presentation starts approx 8:30pm

The OncoAlert Network: but you are very welcome throughout

the entirety of the colloquium

Gil Morgan:

Hello Fatima, greetings and welcome!

Fatima Cardoso Presenter:

I will listen for a while. Thanks

Gil Morgan:

We love having you here!

Fatima Cardoso Presenter:

Do I need to change anything when it is my time to answer questions?

Gil Morgan:

No, you can just jump in

Fatima Cardoso Presenter:

👆

The OncoAlert Network:

This Chat function is intended to be informal and educational

Elisa Agostinetto (Moderator):

And of course feel free to jump in at any time, not only during your presentation! I echo Gil it is a honor and pleasure to have you here

The OncoAlert Network:

and of course a great opportunity for our participants to talk with great experts like yourself

The OncoAlert Network:

Yes, Exactly like Dr. Agostinetto said

The OncoAlert Network:

Any time, the floor is yours

Fatima Cardoso Presenter:

Thank you!

Gil Morgan:

Dear Colleagues, if you are just joining us

Gil Morgan:

Welcome

Gil Morgan:

We are here with Prof. Fatima Cardoso and Dr. Elisa Agostinetto

Gil Morgan:

We have some great presentations

Elisa Agostinetto (Moderator):

Dear colleagues, feel free to type your questions in the chat!

Gil Morgan: and of course our experts will be in and out of this chat

providing great insight

Gil Morgan:

and taking your questions

Gil Morgan:

We Start off today with Dr. Erika Hamilton

Gil Morgan:

Advanced HR+Her2-BReast Cancer

Gil Morgan:

Abemaciclib plus fulvestrant vs fulvestrant alone for HR+, HER2- advanced breast cancer following progression on a prior CDK4/6 inhibitor plus endocrine therapy: Primary outcome of the phase 3 postMONARCH trial.

Gil Morgan:

https://ascopubs.org/doi/10.1200/JCO.2024.42.17_suppl.LBA1001

Elisa Agostinetto (Moderator):

Dear Dr Hamilton, thank you for taking the time to reply our questions!

Elisa Agostinetto (Moderator):

Interesting

Elisa Agostinetto (Moderator):

Interesting findings from postMonarch - who would you consider CDK 4/6 after CDK4/6 for?

Gil Morgan:

So who would you consider CDK 4/6 after CDK4/6 for?

Elisa Agostinetto (Moderator):

indeed good question

The OncoAlert Network:

This answer coming from Dr. Hamilton: I would be thinking of two things 1) they got adequate benefit from 1st line CDK4/6, at least 12 months. And 2) likely someone who doesn't have a mutation that points me in another direction, such as PI3 for alpelisib, etc.

Elisa Agostinetto (Moderator):

Thank you for your reply! Talking about SERDs: 2. Why do the SERDs only have benefit in those with ESR1 mutations?

Fatima Cardoso Presenter:

I don't use CDK4/6i after CDK4/&i since they have not been compared to ET + everolimus, that does not need a mutation

The OncoAlert Network:

Great Question

The OncoAlert Network:

coming from Dr. Hamilton: I don't think that they do from my experience actually. We don't have a good way to predict who post CDK 4/6 still has endocrine sensitive tumors. It isn't just how well you did on last therapy or how strong the ER is. Some tumors still signal through the estrogen axis and some don't, and we simply put don't have a way to assess that. Selecting those w/ ESR1 mutations is just a way to "enrich" the population with more that are endocrine sensitive, it isn't perfect at all. It's just

The OncoAlert Network:

it isn't perfect at all. It's just the best surrogate we have.

Fatima Cardoso Presenter:

Everolimus is very well tolerated if you use 5 mg and steroid mouthwashes

Elisa Agostinetto (Moderator):

We also do not use much CDK4/6i after CDK4/6i, Dr Cardoso

Elisa Agostinetto (Moderator):

What would you recommend as first line for advanced disease in a patient with distant recurrence during or early after the end of adjuvant CDK4/6i?

Gil Morgan: https://ascopost.com/videos/2017-san-antonio-breast-cancer-symposium/sibylle-loibl-md-phd-on-me tastatic-breast-cancer-the-padma-trial/

Elisa Agostinetto (Moderator):

Another question for Dr Hamilton: Who would you give chemo to in the 1st line for HR+ MBC?

The OncoAlert Network:

Dr Hamilton: Hardly anyone. Seriously. Even those with abnormal LFTs or bili, I often give AI + CDK4/6. WE have multiple randomized trials showing that patients do just as good with endocrine as chemo. So truly only for those with visceral crisis."

Gil Morgan:

Datopotamab Deruxtecan Versus Chemotherapy in Previously Treated Inoperable/Metastatic

Hormone Receptor-Positive Human Epidermal Growth Factor Receptor 2-Negative Breast Cancer: Primary Results From TROPION-Breast01

Gil Morgan:

https://ascopubs.org/doi/10.1200/JCO.24.00920

Elisa Agostinetto (Moderator):

Data on ADCs are interesting, but how do you feel about ADC after ADC? in clinical practice

Gil Morgan:

In Summary: Patients receiving Dato-DXd demonstrated significantly improved progression-free survival and a manageable safety profile, supporting its potential as a novel treatment option for patients with inoperable/metastatic HR+/HER2- breast cancer who have received prior chemotherapy.

The OncoAlert Network:

Dr. Hamilton: Data clearly shows us that the benefit from the 2nd ADC is less than the first. But this shouldn't surprise us. The benefit from a subsequent line of chemo is also much less than the first chemo. Disease becomes refractory the more you treat it. I will use ADC after ADC, the question is will it still beat chemo and I think it may. Ultimately we need to learn more about mechanisms of resistance and if there is an order of ADCs where patients will do better.

Gil Morgan:

Trastuzumab Deruxtecan after Endocrine Therapy in Metastatic Breast Cancer

Gil Morgan:

https://www.nejm.org/doi/abs/10.1056/NEJMoa2407086

Gil Morgan:

in summary: Trastuzumab deruxtecan extended progression-free survival compared to chemotherapy in patients with hormone receptor-positive, HER2-low or ultralow metastatic breast cancer previously treated with endocrine therapy, with no new safety concerns identified.

Kelly Shanahan:

Any difference in AEs between the HER2+ vs HER2-low vs HEr2-ultralow with TdXd? Or are numbers too small

Elisa Agostinetto (Moderator):

I don't believe that a formal comparison has ever been made

Gil Morgan:

Now we have two TROP-2 ADCs, how do you decide between them?

The OncoAlert Network:

Dr. Hamilton: I think they are both great drugs and have similar activity. I think it comes down to schedule and side effects and what works for the individual patient. Saci is D#1,8 every 21 days, where dato is only given once. On the other hand, dato comes with it stomatitis which can be difficult to control if mouth sores occur. Saci has diarrhea and neutropenia which can also be difficult to manage with the D#1,8 schedule. You can already imagine a patient that lives 2 hours away, the convenience

Gil Morgan:

I dont think so either Dr. Shanahan

Gil Morgan:

Thank you very much Dr. Hamilton and we now welcome Dr. Graff

Elisa Agostinetto (Moderator):

Toxicity profile of T-DXd is quite consistent across studies, as I remember

Gil Morgan:

Covering HER2+ Metastatic

Elisa Agostinetto (Moderator):

For those who joined later: Dear colleagues, feel free to type your questions in the chat!

Elisa Agostinetto (Moderator):

Hello Dr Graff!

Elisa Agostinetto (Moderator):

Thank you for taking the time to reply our questions

Elisa Agostinetto (Moderator):

We are all looking forward to the results of Destiny-Breast09. What is your forecast? If T-DXd (+/pertuzumab) will be the winning arm, how do you see the duration of this treatment in first line (until disease progression? A fixed number of cycles followed by a maintenance?)”

Gil Morgan:

Trastuzumab deruxtecan versus treatment of physician's choice in patients with HER2-positive metastatic breast cancer (DESTINY-Breast02): patient-reported outcomes from a randomised, open-label, multicentre, phase 3 trial

Gil Morgan: https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(24)00128-1/fulltext

Elisa Agostinetto (Moderator):

Dr Graff, how do you screen for ILD in your daily clinical practice in patients receiving T-DXd?”

Gil Morgan:

Trastuzumab deruxtecan versus trastuzumab emtansine in HER2-positive metastatic breast cancer: long-term survival analysis of the DESTINY-Breast03 trial

Gil Morgan:

https://www.nature.com/articles/s41591-024-03021-7

Dr. Stephanie Graff:

Thanks for the question, Elisa!

Dr. Stephanie Graff:

For ILD, I think the most important thing is establishing a baseline. Patients should have baseline chest imaging (CT) and PFTs, so if symptoms develop, you can better compare to pre-TDXd

The OncoAlert Network:

HI Dr. Graff, our apologies, had not seen you there to greet you

The OncoAlert Network:

Welcome!

Elisa Agostinetto (Moderator):

That's a great advice. How often do you perform chest imaging during T-DXd?

Dr. Stephanie Graff:

I typically recommend imaging every 9 weeks on T-DXd to monitor for G1 (asymptomatic) ILD, and obviously immediately stop/hold TDXd anytime a patient has symptoms.

Gil Morgan:

Trastuzumab deruxtecan in HER2-positive advanced breast cancer with or without brain metastases: a phase 3b/4 trial

Gil Morgan:

https://www.nature.com/articles/s41591-024-03261-7

Elisa Agostinetto (Moderator):

If a patient has received T-DXd for a long time, can we reduce the frequence of chest imaging?

Dr. Stephanie Graff:

Dr Rugo (OncoAlert faculty!) has a great review in JCO OP on ILD. Find it here: Rugo HS, Crossno CL, Gesthalter YB, Kelley K, Moore HB, Rimawi MF, Westbrook KE, Buys SS. Real-World Perspectives and Practices for Pneumonitis/Interstitial Lung Disease Associated With Trastuzumab Deruxtecan Use in Human Epidermal Growth Factor Receptor 2-Expressing Metastatic Breast Cancer. JCO Oncol Pract. 2023 Aug;19(8):539-546. doi: 10.1200/OP.22.00480. Epub 2023 May 19. Erratum in: JCO Oncol Pract. 2024 Jun;20(6):872. doi:

Elisa Agostinetto (Moderator):

Thank you!

Elisa Agostinetto (Moderator):

Great review

Elisa Agostinetto (Moderator):

I am re-posting another prior question: We are all looking forward to the results of Destiny-Breast09. What is your forecast? If T-DXd (+/- pertuzumab) will be the winning arm, how do you see the duration of this treatment in first line (until disease progression? A fixed number of cycles followed by a maintenance?)

Dr. Stephanie Graff:

That is a really tricky question. ILD can happen at any time, so ?Maybe, but the risk doesn't go to zero after a defined period of time. So it typically comes down to shared decision making.

Dr. Stephanie Graff: oh now I am
answering out of order!

Elisa Agostinetto (Moderator):
sorry I am asking too many questions!

Elisa Agostinetto (Moderator):
But it's a great opportunity to have you here!

Dr. Stephanie Graff:
RE: DB09--I think it will be interesting to see what the median lines of treatment in DB09 is for TDXd and/or Tucatinib and that may be really informative for how we think about de-escalation for patients that respond well (NED for example)

Dimo Manov:
Regarding DB 09, I think it would be really important to look for a reasonable rate of crossover considering the great results of T-Dxd in the 2nd line and the much more toxic treatment that is T-Dxd.

Dr. Stephanie Graff:
The context of the patient's disease and current side effects will likely be really informative.

Elisa Agostinetto (Moderator):
Totally agree

Elisa Agostinetto (Moderator):
The PATINA trial was probably one of the most impacting trials presented at SABCS on this topic: how do you see the implementation in clinical practice of the PATINA’s trial? Did it change your clinical practice yet?

Dr. Stephanie Graff:
Yes! I considered it immediately practice changing.

Dr. Stephanie Graff:
Hey! I just said that! Jinx!

Gil Morgan:
:-)

Elisa Agostinetto (Moderator):

How would this data apply after results of Destiny-Breast09 will be out?

Dr. Stephanie Graff:

I have not yet prescribed (just haven't had a patient in this scenario yet), but will be. I know that Dr. Hamilton has; and I have heard mixed reviews on coverage from insurance providers

Dimo Manov:

Do you consider endocrine therapy during T-Dxd or T-DM1 treatment? ET was not allowed in the trials (DB 03 and EMILIA) but we do it in the adjuvant setting with T-DM1.

Gil Morgan:

Thank you very much Dr. Graff!

Elisa Agostinetto (Moderator):

Great question; I heard a lot of heterogeneity across different centers!

Dr. Stephanie Graff:

Elisa what an great question. I think that again, it is just too early to sort it all out. If we see that XX% of patients on DB09 stop drug A or drug B while staying on the opposite, that may or may not lend itself well to combinations with ET....we just need to see how it all shakes out.

Elisa Agostinetto (Moderator):

Thank you Dr Graff!! Great presentation and thanks for the discussion!

Dr. Stephanie Graff:

Dimo, I tend to follow the trials, but always add back in ET when we (patient & I) de-escalate to trastuzumab alone for whatever reason.

Elisa Agostinetto (Moderator):

Hello Dr. Rugo!

Dr. Stephanie Graff:

Thanks Oncoalert Team!

Elisa Agostinetto (Moderator):

Thank you for taking the time to reply our questions

Dimo Manov:

Thank you!

Gil Morgan:

Great Presentation as always from Dr. Rugo

Elisa Agostinetto (Moderator):

Dr Rugo, what would you advise as first-line in a patient who relapsed during or soon after the end of adjuvant pembrolizumab ? if persistence of PD-L1 positive disease, does it make sense to continue pembro while changing chemotherapy backbone?

Dimo Manov:

I was just asking the same question, Elisa! SG is obviously a very good choice, but in Bulgaria (where I practice) reimbursment of SG requires at least 1 line of chemo in the metastatic setting... What do you consider most appropriate in these situations?

The OncoAlert Network:

Dear Agostinetto and Dr. Manov, Dr. Rugo is actually mid flight right now answering us through her phone, so connectivity is not the best

Elisa Agostinetto (Moderator):

It is indeed a difficult question! In many countries reimbursement plays a major role

The OncoAlert Network: if she does not reply in time, we promise to her answers and send them to you

The OncoAlert Network: just send us and email at OncoAlertNetwork@OncoAlert360.com

Elisa Agostinetto (Moderator):

Thank you OncoAlert! It would be great to have Dr Rugo's insight on this

Gil Morgan:

indeed

Gil Morgan:

We have WhatsApp contact with Hope, but mid-flight there might be difficulties connecting

Gil Morgan:

“LBA20 - First-line carboplatin-cyclophosphamide (CC) versus paclitaxel (P) with or without atezolizumab (atezo) for metastatic triple negative breast cancer (mTNBC): Results from a multicenter, randomized phase IIb trial: The Triple-B study (BOOG 2013-01)”

Elisa Agostinetto (Moderator):

“If you are able to join her, I have another question: we know that TNBC is a very heterogeneous disease; why molecular subtypes (e.g., Lehmans? classification) never made it to the clinics (choice of treatment based on the molecular subtype)?”

Gil Morgan:

https://oncologypro.esmo.org/meeting-resources/esmo-congress-2024/first-line-carboplatin-cyclophosphamide-cc-versus-paclitaxel-p-with-or-without-atezolizumab-atezo-for-metastatic-triple-negative-breast-cance

Fatima Cardoso Presenter:

Maybe I can give my opinion here. An early relapse after KN522 regimen means a very bad prognosis. These cases usually have also no pCR and often Residual Burden class 2 or 3

Gil Morgan:

IMpassion132 double-blind randomised phase III trial of chemotherapy with or without atezolizumab for early relapsing unresectable locally advanced or metastatic triple-negative breast cancer

Gil Morgan:

https://www.annalsofoncology.org/article/S0923-7534(24)00107-8/fulltext

Gil Morgan:

Highlights • Data on outcomes in patients with rapidly relapsing TNBC are scarce. • The phase III IMpassion132 trial enrolled patients with TNBC relapse <12 months after chemotherapy/surgery for early TNBC. • OS was not improved by adding atezolizumab to chemotherapy for rapidly relapsing PD-L1-positive TNBC. • Patients with rapidly relapsing TNBC have a dismal prognosis and represent a population with huge unmet need.

Elisa Agostinetto (Moderator):

Indeed Dr Cardoso; what would you do in such cases?

Fatima Cardoso Presenter:

In those cases, I add capecitabine to pembro in the adjuvant setting. Therefore, you may argue that they have recived alreday a line of Chemo and try to obtain SG

Elisa Agostinetto (Moderator):

This is a very good point

Fatima Cardoso Presenter:

If really impossible to obtain SG, I would give vinorelbine or liposomal anthracycline, depending of the response to taxanes and anthracyclines in the neoadjuvant setting. I monitor carefully and if there is no response, ask SG

Dimo Manov:

Thank you for the suggestion!

Elisa Agostinetto (Moderator):

Thank you so much!

Fatima Cardoso Presenter:

Regarding the question about TNBC subtypes, I also do not understand why they are not used more frequently. Perhaps it is because numbers of patients would be really low. However, there are data very interesting showing that even response to different types of chemo may be different for different TNBC subtypes

The OncoAlert Network:

Dr. Rugo: In 2024, practice-changing data in triple-negative breast cancer (TNBC) supports the use of Olaparib for patients with sBRCA and gPALB2 mutations. Beyond this, no other significant trials have reshaped treatment for metastatic TNBC (mTNBC) this year.

The OncoAlert Network:

However, there is significant potential for future advancements, particularly with the move toward using antibody-drug conjugates (ADCs) in the first-line metastatic setting, with pivotal trial results expected at ASCO 2025.

Elisa Agostinetto (Moderator):

Olaparib for gPALB2 seems really effective, however in many countries is not reimbursed for this indication

Elisa Agostinetto (Moderator):

Hello Dr de Azambuja!

Gil Morgan:

Hello Dear Evandro!

Elisa Agostinetto (Moderator):

Thank you for taking the time to reply our questions!

The OncoAlert Network: A warm

welcome Dr. de Azambuja

The OncoAlert Network:

A pleasure to have such Great talent from Institut Jules Bordet

The OncoAlert Network:

In this session

Gil Morgan:

https://youtu.be/ShNgvoW_264?si=FTLlawGyE1fbwNVn

Gil Morgan:

That is a video we did in San Antonio with Nadia and team

Gil Morgan: going over

FASCINATE

Elisa Agostinetto (Moderator):

Interesting findings from the FASCINATE-N trial from SABCS24

Gil Morgan: and a joint venture between High5Oncology

and OncoAlert

Elisa Agostinetto (Moderator):

Thanks for sharing!

Dimo Manov:

“Maybe controversial, but are anthracyclines a thing of the past for HER2+ eBC? I personally find TCHP quite hard on patients with the diarrhea and taxane-associated pain syndrome... the TRAIN

regimen on the other hand is pretty much 18 cycles of paclitaxel in total. And the old trials did not compare dose-dense anthracycline-regimens which may indeed lead to higher pCR rate and better results.”

Elisa Agostinetto (Moderator):
A question for Dr de Azambuja: how do you see the future development of T-DXd in the early setting? What is your forecast?

Elisa Agostinetto (Moderator):
Great questions on anthracyclines

Elisa Agostinetto (Moderator):
In HER2+ BC are used less and less, usually used in the cases at higher risk

Evandro de Azambuja:
I am here..

The OncoAlert Network:
Hello Dr de Azambuja

Evandro de Azambuja:
can you see me? or will you

Elisa Agostinetto (Moderator):
But it's true that TCHP is not always well tolerated

The OncoAlert Network:
Welcome to the discussion

Evandro de Azambuja:
let me shine later

Elisa Agostinetto (Moderator):
Hello Dr de Azambuja!

Gil Morgan:
A war Welcome Evandro

Gil Morgan:

warm

Evandro de Azambuja:

WAR welcome? I am off hahaha

Gil Morgan:

haa, no promise we are nice

Elisa Agostinetto (Moderator):

Thank you for taking the time to reply our questions!

Elisa Agostinetto (Moderator):

ahahahahha

Gil Morgan:

We are just enjoying your great presentation

Gil Morgan:

if anyone has a question for Dr. de Azambuja

Elisa Agostinetto (Moderator):

Maybe controversial, but are anthracyclines a thing of the past for HER2+ eBC? I personally find TCHP quite hard on patients with the diarrhea and taxane-associated pain syndrome... the TRAIN regimen on the other hand is pretty much 18 cycles of paclitaxel in total. And the old trials did not compare dose-dense anthracycline-regimens which may indeed lead to higher pCR rate and better results.

Evandro de Azambuja:

I have seen few questions here. I can adress

Elisa Agostinetto (Moderator):

I just copy-pasted the question of Dr Manos

The OncoAlert Network:

Thank you Dr. Agostinetto

Elisa Agostinetto (Moderator):

Dr Manov, sorry for the typo!

Dimo Manov:

No worries! :)

Evandro de Azambuja:

A question for Dr de Azambuja: how do you see the future development of T-DXd in the early setting? What is your forecast? my answer is that we have to wait the resutls of neoad TDXD alone or in combination with Pertu... and the psot neadju compataring head to head TDM1 vs TDXD..

Evandro de Azambuja:

should be promising and practicing changing but need to wait the results

Evandro de Azambuja:

Maybe controversial, but are anthracyclines a thing of the past for HER2+ eBC? I personally find TCHP quite hard on patients with the diarrhea and taxane-associated pain syndrome... the TRAIN regimen on the other hand is pretty much 18 cycles of paclitaxel in total. And the old trials did not compare dose-dense anthracycline-regimens which may indeed lead to higher pCR rate and better results.

Evandro de Azambuja:

here I agree Train regimen is hard..

Elisa Agostinetto (Moderator):

Thank you Dr de Azambuja!

Gil Morgan:

Thank you very much Dr. de Azambuja

Evandro de Azambuja:

I use ANtrhaclicnes in T2 NO or T1-2N1.. for those with T3 or N2 I still use anthraculines

The OncoAlert Network:

Thank you very much indeed Dr. de Azambuja!

The OncoAlert Network:

and now we welcome another great BSMO colleague, Dr. Kevin Punie

The OncoAlert Network:

Dr Punie are you with us

Fatima Cardoso Presenter:

I also use anthracyclines. 6 cycles of taxanes are very hard to tolerate.

Kevin Punie:

Hi everyone

Gil Morgan:

Hi Kevin, Greetings!

Gil Morgan:

We have an amazing group of people now

Gil Morgan:

Dr. Cardoso, Dr. de Azambuja, Dr. Punie and Dr. Agostinetto

Evandro de Azambuja:

Interesting findings from the FASCINATE-N trial from SABCS24.. indeed , the single agent ADC did very well.. we need more data on this agent and it may replace heavy chemo regimens

Elisa Agostinetto (Moderator):

I think Dr de Azambuja meant no anthracyclines for T2N0 or T1-2N1.. for those with T3 or N2 he still uses anthracyclines

Elisa Agostinetto (Moderator):

Hello Dr Punie!

Dimo Manov:

Agreed! And once you get the antiemetics right, anthracyclines are reasonably well tolerated in the short term. Thank you, Dr de Azambuja and Dr Cardoso!

Kevin Punie:

HI Dr Agostinetto!

Kevin Punie:

Great moderation

Elisa Agostinetto (Moderator):

I will already make you a question that was also addressed to Dr Rugo: We know that TNBC is a very heterogeneous disease; why molecular subtypes (e.g., Lehmans? classification) never made it to the clinics (choice of treatment based on the molecular subtype)?

The OncoAlert Network:

Might we add, the Belgian Society of Medical Oncology and ABC Global alliance are official collaborators in this 5th OncoAlert COlloquium

Evandro de Azambuja:

Dear Elisa, you are right: I think Dr de Azambuja meant no anthracyclines for T2N0 or T1-2N1.. for those with T3 or N2 he still uses anthracyclines

Elisa Agostinetto (Moderator):

we type too fast!!!?

Kevin Punie:

I think the uptake of molecular profiles as stratification in clinical trials is lagging behind and might explain why clinical utility of defining this subtypes remains to be demonstrated

Gil Morgan:

Overall Survival with Pembrolizumab in Early-Stage Triple-Negative Breast Cancer

Gil Morgan:

https://www.nejm.org/doi/full/10.1056/NEJMoa2409932

Kevin Punie: over the last years we have seen a few early-phase trials emerging investigating in specific TNBC subtypes

Gil Morgan:

Summary: Neoadjuvant pembrolizumab combined with chemotherapy, followed by adjuvant pembrolizumab, significantly improved overall survival compared to neoadjuvant chemotherapy alone in patients with early-stage triple-negative breast cancer.

Kevin Punie:

Also for example for neoadjuvant pembro recently, these subtype classification does not allow to select patients who will benefit from the addition of pembrolizumab

Dimo Manov:

Can't wait for the results of Optim-ICE-RD trial... can't imagine pembro is changing anything for those who achieve a pCR after seeing these curves.

Evandro de Azambuja:

dear all, it was a pleasure to be here today... I wish you a great rest of Oncoalert Colloquium .. and if further questions, please send me an email. Good evening everyone. Thank you Gil for inviting me and Elisa for moderating it. Best

Elisa Agostinetto (Moderator):

A classic question for Dr Punie on the post-neoadjuvant setting after pembro+CT: do you combine capecitabine/pembro/olaparib (where indicated) or how do you choose among them, in case of residual disease?

Dimo Manov:

I meant OptimICE-PCR

Elisa Agostinetto (Moderator):

Yes results of OptimICE are very much awaited

Kevin Punie:

i agree, OptimICE-pCR and also OPT-Pembro will shed light on optimal pembro duration

Gil Morgan:

A-BRAVE trial: A phase III randomized trial with avelumab in early triple-negative breast cancer with residual disease after neoadjuvant chemotherapy or at high risk after primary surgery and adjuvant chemotherapy.

Gil Morgan:

https://ascopubs.org/doi/10.1200/JCO.2024.42.17_suppl.LBA500

Gil Morgan:

Summary: ne year of adjuvant avelumab did not significantly improve DFS in high-risk TNBC patients, but significantly improved OS compared to control, with further analyses on RFS, DMFS, and correlative studies based on centralized collection of tumor tissue, plasma, and feces.

Gil Morgan:

One

Dimo Manov:

Again a bit controversial, but do you think that the difference between GeparDouze and KN522 could be attributed to dose-dense schedule of anthracyclines, the inclusion of olaparib and capecitabine as postneoadjuvant options and other such differences in protocol?

Kevin Punie:

no i don'think this is a likely hypothesis

Gil Morgan:

https://www.onclive.com/view/perioperative-atezolizumab-treatment-does-not-improve-efs-in-tnbc

Gil Morgan:

a report from OncLive on GeparDouze

Kevin Punie:

all data we have on atezo in both early and advanced TNBC suggests that atezo might be not the best checkpoint inhibitor to generate antitumor immunity in breast cancer

Dimo Manov:

Personally, I agree. Just trying to be critical on KN522 as I believe at least capecitabine should have been an option, as well as allowing dd schedules as part of the NACT part.

Kevin Punie: i agree, create x data had been presented before first patient in in KN522 (different than olaparib)

Kevin Punie:

and indeed a pity the question on dose densen with chemoimmunotherapy is still out there (eg also 3 weekly anthracyclines in control arm of Tropion-Breast04)

Elisa Agostinetto (Moderator):

https://www.nature.com/articles/s41523-024-00676-w

Elisa Agostinetto (Moderator): an interesting publication on dose-dense during chemo-immunotherapy for eTNBC

Kevin Punie:

but i think that it is unlikely that patients that benefit from the addition of cape/olaparib are the same as those benefiting from the addition of pembro. I guess it would be unlikely that their potential benefits are mutually exclusive based on biology

Kevin Punie:
Thanks for sharing Elisa!

Dimo Manov:
Thank you, Elisa!

Elisa Agostinetto (Moderator):
Dr Punie, do you use dose-dense in chemoimmunotherapy for eTNBC?

Elisa Agostinetto (Moderator):
in your clinical practice

Kevin Punie:
yes i do use it in clinical practice

Elisa Agostinetto (Moderator):
We also do it

Kevin Punie:
also for dose dense i think it is unlikely that benefit from pembro and benefit from dose dense is mutually exclusive

Kevin Punie: and we do not have good
arguments againts

Elisa Agostinetto (Moderator):
Agree

Dimo Manov:
And how about the q6w schedule of pembro to spare the patients coming to clinic literally every week?

Kevin Punie: even in KN756 this was allowed, so this was just a matter of timing this was not the case in 522

Kevin Punie: we use it in some patients, not in those that come every 3 weeks

for capecitabine

Kevin Punie: in the neoadjuvant setting

always use 3 weekly

Elisa Agostinetto (Moderator):

Thank you Dr Punie!

Kevin Punie:

Thank you everyone

Elisa Agostinetto (Moderator):

Great presentation

Gil Morgan:

Thank you very much Kevin

Elisa Agostinetto (Moderator):

and thanks for the discussion!

The OncoAlert Network:

Thank you very much Dr. Punie and welcome Dr. Lustberg

Dimo Manov:

Thank you for the insightful answers!

Maryam Lustberg:

hello everyone

Elisa Agostinetto (Moderator):

Hello Dr Lustberg!

Kevin Punie:

Great event as usual! Thanks Dr. Manov and Hi Dr. Lustberg

Elisa Agostinetto (Moderator):

Thank you for taking the time to reply our questions

The OncoAlert Network:

Dear Colleagues, we now how a great group of experts on the floor

The OncoAlert Network:

Anu questions and comments you may have please feel free

The OncoAlert Network:

Just jump in

Gil Morgan:

a question for Dr. Lustberg: when do we use anthracyclines in early stage disease?

Dimo Manov:

Are we underutilizing the ADAPT HR+ approach? It could be really informative in the premenopausal patients with cN1 disease, who quite often go on to NACT.

Maryam Lustberg:

We have over the years began to use much less anthracyclines except for the highest risk patients. This new analysis from TailorRx is intriguing for use of recurrence score to identify the pts most likely to benefit from anthracycline use regimens

Maryam Lustberg:

yes I agree with you that we need better adaptive paradigms for premenopausal HR + breast cancer. and I think outside of a trial, many with low nodal burden, should not be treated with NAC. It is hardly effective

Gil Morgan:

Thank you Dr. Lustberg

Elisa Agostinetto (Moderator):

Also the presentation at ASCO from the FLEX study on Mammaprint High 1 vs 2 were intriguing on the question of who benefits from antrhacyclines

Maryam Lustberg:

yes very important was the FLEX study further highlighting the importance of biology in making systemtic therapy decisisons

Maryam Lustberg:

still would use caution re anthracyclines in pateints older than 65 or those with cardiac risk factors

Elisa Agostinetto (Moderator):

Totally agree

Dimo Manov:

A bit of a practical question but necessary when working in a resource-constrained environment... Are you comfortable ommitting adjuvant CT in premenopausal pts with ER/PR-high, Ki67-low, intermediate grade tumors who cannot afford OncoType/MammaPrint?

Dimo Manov:

Lets say pT1 pN1a (1 positive node)

Maryam Lustberg:

her benfit from chemo will be low and much of our data do suggest the benefit from chemo do come from ovarian suppression. so it's a discusison with the patient with the patient and shared decision making. Based on the biological markers you are describing, there is a high probability that patient has low genomic risk (perfect OFSET trial candidate)

Dimo Manov:

Indeed! Thank you.

Gil Morgan:

Dr. Lustberg, can you give us a quick comment on the utilization of ct DNA in late recurrence estimate?

Elisa Agostinetto (Moderator):

I would also highlight that the finding from the sub-analysis of TAILOR-X using the RS cutoff of 31 apply for tumors of 2 cm or more

Maryam Lustberg:

ct DNA for detecting minimal residal disease is an important devlopment that is not quite ready for prime time.

Maryam Lustberg:

We know that patients with detectable ct DNA and HR pos disease are at risk for both early and late recurrence. so it's a negative prognostic marker. However, we need to await data on predictive biomarker applications from ongoing studies (TREAT Ct DNA, CATE and others)

Elisa Agostinetto (Moderator):

A question for Dr Lustberg: How would you choose between adjuvant abema or ribo in cases eligible for both, in your daily clinical practice?

Maryam Lustberg:

if eligible for both, since we have longer maturity data I start with abema

Maryam Lustberg:

however, I do also review both sets of toxicities and sometimes pts have a stron

Maryam Lustberg:

patient can have strong preference over one drug. may not want diarrhea and GI issues for example, in which case we go with ribo

Elisa Agostinetto (Moderator):

Thank you!

Maryam Lustberg:

for high risk node negative, I always of course go with ribo per label

Elisa Agostinetto (Moderator):

Of course

Maryam Lustberg:

I have had several pts who started with abema and had to switch to ribo due to toxicity even after dose reduction

Elisa Agostinetto (Moderator):

Another question: What would you recommend as first line for advanced disease in a patient with distant recurrence during or early after the end of adjuvant CDK4/6i?

Maryam Lustberg:

yes very tough situation -- would interrogate their tumor biology for presence of PIK3 and ESR1 and other actionable pathways

Maryam Lustberg: and then make decisions based on whether they are a trial candidate, PIK3 candidate etc.

Elisa Agostinetto (Moderator): would you consider CDK4/6i after CDK4/6i? Is it something you do in your clinical practice?

Maryam Lustberg:
we do have some data supporting that approach including MAINTAIN, POSTMONARCH and EmBER-3

Maryam Lustberg:
so yes would definitely consider. however, many of the studies were patients who had been on palbo then switched to another Cdk4/6 inhibtor. As palbo use has gone down, application of this sequencing strategy is a bit less clear

Elisa Agostinetto (Moderator):
I agree

Elisa Agostinetto (Moderator):
Thank you for sharing your insight!

Maryam Lustberg:
at this time I do sequencing of CDKs if there is no other pathway to target and patient has relatively low disease burden

Dimo Manov:
Bwel is really interesting... will have to wait for DFS results but do you think the novel GLP-1/GIP agonists will be tested in the adjuvant setting, especially in obese patients?

Maryam Lustberg:
several groups have tried to prosectively test GLP 1 agents. industry support

Maryam Lustberg:
has been the main limitation to date for a large study. I think such a study will be done and needs to be done

Maryam Lustberg:

Retrospective data from Sukumar et al from MD anderson in SABCS24 showed weighloss is less while on AIs with these

Maryam Lustberg: agents but interesting survival
advantage was shown

Elisa Agostinetto (Moderator):
Thank you Dr Lustberg!

The OncoAlert Network: Thank
you very much Dr. Lustberg

The OncoAlert Network:
Great preentation

The OncoAlert Network:
Presentation

Elisa Agostinetto (Moderator):
Hello Dr Lambertini!

The OncoAlert Network: And
now welcome Dr. Lambertini

Gil Morgan:
Welcome Matteo

Matteo Lambertini:
Looking forward to discussing with the OncoAlert colloquium Audience about oncofertility issues !

The OncoAlert Network:
A warm welcome Dr. Lambertini

Elisa Agostinetto (Moderator):
What do we know so far about the gonadotoxicity of the new classes of agents (like ICIs, ADCs etc)?

Elisa Agostinetto (Moderator):
Are pregnancies safe after such treatments?

Matteo Lambertini:

Very little evidence unfortunately, mostly animal data showing their potential gonadotoxicity

Matteo Lambertini:

Same for pregnancies, very limited evidence...mostly with anti-HER2 agents

Matteo Lambertini: always important to consider a proper wash out period after these agents before attempting pregnancy

Elisa Agostinetto (Moderator):

How long should the wash out be?

Matteo Lambertini:

in the absence of data, we propose to consider the half life of these agents...like waiting at least 4 months after completing pembro, 3 months for abema and 1 month for olaparib...but this is based on the. half life...to me the timing of pregnancy depends mostly on the risk of recurrence and age of the patients: the higher the risk, the longer I would wait, the younger the patient the longer che can wait

Deez Nutz:

I do the same in m clinic

Elisa Agostinetto (Moderator):

Thank you! this is very useful

Elisa Agostinetto (Moderator):

Dr Lambertini, could you please comment on the implications on clinical practice of the data you recently presented at SABCS?

Matteo Lambertini:

Sure! We have recently presented data on the important survival benefit of undergoing risk-reducing surgeries (both bilateral sapling-oophorectomy and mastectomy) in young BRCA carriers that were previously diagnosed with their first breast cancer at age 40 years or less

Matteo Lambertini:

Particularly the bilateral sapling-oophorectomy has clear implications on fertility...very important to stick to guidelines to discuss this option between age 35 and 40 years in BRCA1 carriers and 40 to

45 years in BRCA2 carriers, and even more attention to those that were already diagnosed with breast cancer at a young age

Matteo Lambertini: hence, very important to counsel women to try to complete childbearing plans by these ages

Elisa Agostinetto (Moderator):
Thank you Dr Lambertini, very interesting data. Important to highlight that this data applies to women with a prior diagnosis of breast cancer, as you said

Elisa Agostinetto (Moderator):
Hello Dr Volders!

José Volders (presenter):
Thank you, nice to be here, looking forward to awnser some questions!

The OncoAlert Network:
Thank you Dr. Lambertini for that great presentation

The OncoAlert Network:
welcome Dr. Volders

The OncoAlert Network: a
pleasure to have you here

Elisa Agostinetto (Moderator):
Dr Volders, I am a medical oncologist and not a surgeon, so apologies if my questions may be naive :)

Elisa Agostinetto (Moderator):
I would like to ask you in which patients should we first start omitting sentinel lymph node biopsy?

Elisa Agostinetto (Moderator):
If any

José Volders (presenter):
Thank you, that is not a naive question ;)

José Volders (presenter):

“Omitting sentinel lymph node biopsy (SLNB) in low-risk breast cancer patients is an evolving practice, particularly to minimize overtreatment in patients with excellent prognosis and low likelihood of nodal involvement. Based on current guidelines and emerging evidence, SLNB can be safely omitted in the following groups:”

José Volders (presenter):

“Starting Patients aged ≥70 years with clinically node-negative, T1-T2 (≤3 cm) hormone receptor-positive (HR+), HER2-negative breast cancer. Like in the choosing wisely advice from the SSO”

José Volders (presenter):

There should be mentioned that clinical staging of the axilla with ultrasound is very important when starting to omit lymph node biopsy

Elisa Agostinetto (Moderator):

Thank you!

Elisa Agostinetto (Moderator):

“Dr Volders, could you please comment on the SUPREMO study results? I might have missed it, but which patient subgroups derive the greatest benefit from adjuvant radiotherapy?”

José Volders (presenter):

Yes, of course. The supremo study actually learned that adjuvant chest wall irradiation should be omitted in most patients meeting eligibility criteria for SUPREMO. PMRT is most beneficial for pN1 patients (1-3 positive nodes) having additional risk factors (e.g., young age, high grade, lymphovascular invasion).

José Volders (presenter):

So again, room to de-escalate and the decision for PMRT should be individualized based on tumor biology, age, and other high-risk features.

Elisa Agostinetto (Moderator):

Thank you Dr Volders!

The OncoAlert Network:

A Great Presentation Dr. Volders and a huge thanks to our Partners at the Euroean Society of Surgical Oncology!!

Elisa Agostinetto (Moderator):

Hello (again) Dr Cardoso!

The OncoAlert Network:

And thank you so much Dr. Agostinetto for the wonderful moderating

Fatima Cardoso Presenter:

Hi (again) :-)

The OncoAlert Network:

A warm welcome to Dr. Cardoso, who has been with us the entire time

The OncoAlert Network:

Thank you Dr. Cardoso, we love having you here

Gil Morgan:

Greetings Fatima!

Fatima Cardoso Presenter:

Happy to be here

Elisa Agostinetto (Moderator):

Dr Cardoso, what is your opinion (and attitude in clinical practice) on brain screening for patients with metastatic breast cancer and no neurological symptoms?

Fatima Cardoso Presenter:

I do not screen for brain mets in asymptomatic patients but I have a low threshold to ask for imaging, in case of even subtill symptoms

Fatima Cardoso Presenter:

It is true that today we have newer therapies BUT we have never shown better outcomes with the earlier detection of brain mets

Dimo Manov:

What would you suggest to a TNBC patient with early oligorecurrence with a single BM that is resected and treated with SRS and no extracranial disease?

Fatima Cardoso Presenter:

in addition, there are problems associated with earlier diagnosis such as the psychological effect, in some countries patients can no longer drive, the toxicity of treatments and the exclusion from clinical trials

Fatima Cardoso Presenter:

For the cases of isolated brain mets, the addition of chemotherapy is not recommended.

Fatima Cardoso Presenter:

Only for HER2+ ABC, we recommend re-starting trastuzumab. For no other therapies, there is indication to start if there i no extracraneal disease

Dimo Manov:

Thank you!

Elisa Agostinetto (Moderator):

After the recent data of intracranial activity of T-DXd, in which cases would you favor systemic therapy vs RT or viceversa? (in other words, would you recommend to skip RT in patient receiving T-DXd, or would you always give "priority" to RT?

Fatima Cardoso Presenter:

To me, SRS (stereotactic RT) is the best available option for treating limited disease in the brain. There is some activity of T-DXd but SRS is more effective and less toxic

Fatima Cardoso Presenter:

Unless, I need to start T-DXd because of extra-craneal progressive disease, I would choose SRS

Dimo Manov:

Also, while I believe SRS is relatively well tolerated and almost always recommend it, there has been mounting data about increased rate of radionecrosis when ADC are combined with SRS. Is there a recommended interval between the two modalities to minimize this risk?

Fatima Cardoso Presenter:

However, if there is a need to go for whole brain RT, then I would go for systemic therapy (tucatinib or T-DXd) and delay as much as possible whole brain RT

Elisa Agostinetto (Moderator):

Great question Dr Manov, I was about to ask the same

Fatima Cardoso Presenter:

Indeed, we should avoid giving concomitant ADC and RT

Elisa Agostinetto (Moderator):

How long should we wait between T-DXd administration and RT?

Fatima Cardoso Presenter:

I usually wait about 10 to 15 days before re-starting ADC. I do the same also for capecitabine

Fatima Cardoso Presenter: you can skip the day 8 of a cycle and give the SRS and then wait 2 more weeks before re-starting

Elisa Agostinetto (Moderator): thank you, this
is very useful for clinical practice

Elisa Agostinetto (Moderator):

Is there still a subset of patients where you would give tucatinib before T-DXd?

Fatima Cardoso Presenter:

Yes, patients with important brain disease, I prefer tucatinib. You have a phase 3 randomized study for tucatinib and a phae 2 non-randomized trial for T-DXD regarding brain efficacy

Fatima Cardoso Presenter:

I think it is important to remember the options to treat brain mets in HER2 negative disease. Capecitabine is still the chemo agent with more available data

Elisa Agostinetto (Moderator):

Thank you so much Dr Cardoso!

Dimo Manov:

Is there any data on the efficacy of endocrine agents (or combinations with targeted therapy) in luminal BC? Or better go for capecitabine (or T-Dxd in case of HER2-low and availability)?

The OncoAlert Network:

Thank you so very much Dr. Cardoso, a wonderful presentation and an honor to have you as part of our faculty and ABC Global Alliance as an OncoAlert partner!

Fatima Cardoso Presenter:

there are some data for abemaciclib

The OncoAlert Network:

We warmly welcome Dr. Icro meattini

Elisa Agostinetto (Moderator):

Hello Dr Meattini!

Fatima Cardoso Presenter: and less data but also some for ribociclib. Some new SERDS also have some brain efficacy

Dimo Manov:

Really exciting time ahead with all the new SERDs, SERMS and targeted agents! Thank you for the very insightful presentation.

The OncoAlert Network:

WE Would also like to Introduce our OncoAlert Colleague Dr. Elisabetta Bonzano who is also one of the authors of the EUROPA trial that Dr. Meattini will soon be talking about

Gil Morgan:

A warm welcome to the discussion Elisa!

Elisa Agostinetto (Moderator):

Hello Elisabetta!

Elisabetta Bonzano:

Hello everyone, I'm pleased to join this amazing discussion

Elisa Agostinetto (Moderator):

I have a question for Dr Bonzano and Dr Meattini: Are results from the EUROPA trial applicable to clinical practice yet, and would you advise to wait for longer follow-up?

Elisa Agostinetto (Moderator):

could you also comment on the choice of quality of life as primary end point?

Elisa Agostinetto (Moderator):

In EUROPA, but also in general in studies enrolling low risk patients

Elisabetta Bonzano:

The interim analysis suggested that radiation therapy may offer better quality of life and fewer treatment-related adverse events. However, long-term data is necessary before making broad changes to our practice

Dimo Manov:
I really see the EUROPA trial as a win-win data. We should offer (ultra-)hypofractionated RT to patients fitting the criteria and why not give ET a try. If tolerated, great, if not, we have the peace of mind of RT.

Elisa Agostinetto (Moderator):
May I ask you if in EUROPA have you thought about having an arm with ET+RT (as "standard of care")?

Elisabetta Bonzano:
concerning your previous question, especially in older, highly selected patients with luminal A breast cancer and no risk factors, prioritizing quality of life is essential. For this population, it is critical to adopt treatment strategies that minimize therapy impacts on their well-being while maintaining efficacy

Gil Morgan:
To all of our colleagues that have not read the paper

Gil Morgan:
This journal Journals Publish Clinical Global health Multimedia Events About Advanced search ARTICLESVolume 26, Issue 1P37-50January 2025 Download Full Issue Single-modality endocrine therapy versus radiotherapy after breast-conserving surgery in women aged 70 years and older with luminal A-like early breast cancer (EUROPA): a preplanned interim analysis of a phase 3, non-inferiority, randomised trial

Gil Morgan:
out on Lancet Oncology

Gil Morgan:
https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(24)00661-2/abstract

Gil Morgan:

Endocrine therapy was associated with a greater reduction in HRQOL, as measured by GHS, compared with radiotherapy at 24 months. While these interim results suggest radiotherapy might better preserve HRQOL in older women with low-risk early breast cancer, further data on disease control outcomes and final patient accrual are needed to draw definitive conclusions.

Elisabetta Bonzano:

At 24 months, the adjusted mean change from baseline in GHS for the radiotherapy group was -3·40 while for the endocrine therapy group it was -9·79.

Elisa Agostinetto (Moderator):

Thank you Elisabetta!

The OncoAlert Network:

Our Deepest gratitude to Dr Bonzano and Dr. Agostinetto, both a great part of our OncoAlert Breast Cancer Faculty

Elisa Agostinetto (Moderator):

Hello Dr Salgado!

The OncoAlert Network:

as is Dr. Meattini!

The OncoAlert Network:

Welcome Dr. Roberto Salgado

Roberto Salgado:

Thank you Elisa, look forward engaging with the community at this forum.

Gil Morgan:

Bienvenido Roberto!

Elisa Agostinetto (Moderator):

Great presentation as always Dr Salgado. I have a question: Could you please comment on the different prognostic role of TILs in TNBC, HER2+ and luminal breast cancer? How to explain these differences?

Roberto Salgado:

Thank you Elisa, the main determinants are here ER, low ER luminal BC behave clinically as TNBC, and in HER2+ we also see that the prognostic importance of TILs is different in HER2+ ER+ vs ER-. Nevertheless, in both HER2+ as well as TNBC grade is not a prognostic variable when corrected for TILs, so it is the immune-system that determines outcome, not cancer cell characteristics. So, in short ER is a crucial feature in explaining the observed differences.

Elisa Agostinetto (Moderator):

I remembered that quiz!! 😀 Impressive though

Roberto Salgado:

Indeed, we rarely question anymore our own practices. There is a lot of habit in our daily practices. Reflecting more on what we do daily can be an interesting and useful experience to do.

Elisa Agostinetto (Moderator):

this is so true

Elisa Agostinetto (Moderator):

is there a "cut-off" generally used to define low vs high
TILs?

Roberto Salgado:

The prognostic effect is linear, so cut-offs are always arbitrary, but in general cut-offs of 30% to 50% are useful to know, and these are being tested in prospective clinical trials so far. But already knowing today can be very useful to know to clinicians.

Elisa Agostinetto (Moderator):

https://ascopubs.org/doi/abs/10.1200/JCO.24.00372

Elisa Agostinetto (Moderator):

for those who haven't read it yet, I am adding the link to the publication

Elisa Agostinetto (Moderator):

Great paper

Elisa Agostinetto (Moderator):

Congratulations for this great presentation!

Elisa Agostinetto (Moderator): and thank you
for the nice discussion Dr Salgado

The OncoAlert Network: Thank
you very much Dr. Salgado

Elisa Agostinetto (Moderator):
Hello Dr Hodgon!

Roberto Salgado:
Thank you Elisa. If there are questions or remaining concerns, please reach out by e-mail: roberto@salgado.be Thank you again for this kind invitation.

The OncoAlert Network:
Hello Ms. Hodgdon!

The OncoAlert Network:
Welcome

Christine Hodgdon:
Thank you!

Elisa Agostinetto (Moderator):
Great to hear from the Patient advocate perspective

Elisa Agostinetto (Moderator):
“What good is a treatment that is so toxic that you have to skip it?" Important take home message from the patient advocate perspective

Elisa Agostinetto (Moderator):
Thank you so much!

Elisa Agostinetto (Moderator):
Hello Dr Spanic!

The OncoAlert Network:
Welcome Dr Spanic

Tanja Spanic:

Hello! And thank you for the invitation

Elisa Agostinetto (Moderator):

agree, a lot of open questions related to KEYNOTE-522

Elisa Agostinetto (Moderator):

How do you see the role of ctDNA in the early setting from the patient perspective?

Elisa Agostinetto (Moderator):

ctDNA to predict disease relapse

Tanja Spanic:

I'm looking forward to see new results. I some cases it will be great

Tanja Spanic:

exactly for early detection of

relapse

Elisa Agostinetto (Moderator):

I heard concerns related to the stress that can derive from positive ctDNA with negative imaging

Tanja Spanic:

yes, we are not excited about watch and wait period, this is ver hard for

patients

The OncoAlert Network:

Thank you very Much Dr. Spanic!

Elisa Agostinetto (Moderator):

Agree; but I also agree with you that it could be a great tool

Elisa Agostinetto (Moderator):

Thank you so much!

The OncoAlert Network:

Thank you very much Dr. Agostinetto and Dr. Cardoso who was with us the entire time!

The OncoAlert Network:

Thank you Dr. Morgan