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Translating Evidence on TROP2-Directed ADCs Into Global Practice in Metastatic TNBC

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Dr. Cortés:
Welcome. This is CE with GLC. I'm Dr. Javier Cortés.

Dr. Traina:
And I'm Dr. Tiffany Traina.

Dr. Cortés:
Dr. Traina, one of the questions I have on my mind is, what are some of the variations among different geographic regions that might influence first-line treatment decisions in metastatic TNBC?

Dr. Traina:
Oh yeah, that's such a wonderful question, because the trials that we've seen report out just recently are global studies, and we have to think about the sort of practicalities of bringing that data into our clinical practices.

So I think the first thought that comes to mind is clinical guidelines and access to drugs that may vary region by region, country by country. So I mean, the data are incredibly compelling, but we really need to advocate for getting these drugs approved and in communities so that patients can access them.

I think a second really important feature is understanding PD-L1 status of a tumor, so we need to be sure that communities are able to get PD-L1 testing, that folks know how important it is to have that result to guide decision-making. And we need to have reasonable turnaround time on that testing, because often our patients with newly diagnosed advanced triple-negative breast cancer have visceral metastases, are symptomatic from the burden of the disease, and time is really of the essence. So supporting that PD-L1 testing with rapid turnaround time is critical.

I'm wondering how you might share some practical tools or strategies that can help patients improve outcomes in areas that might be resource limited or resource constrained.

Dr. Cortés:
Sure. So I think you pointed out very important aspects. We have to increase the access to the diagnostic tools, it's not good to have great drugs if we cannot diagnose the tumors properly. We have to get access into molecular testing. We were talking about PD-L1, for example. If we cannot look at PD-L1, it's impossible to treat our patients properly. Maybe germline mutations, BRCA1, BRCA2, maybe PALB2 as well. So if we don't have this aspect there, it's difficult to treat our patients in a perfect way.

Or maybe we have to start thinking about building referral pathways to centers of excellence, maybe where clinical trials are there, or

maybe where they can access these diagnostic tools and models we are testing. So we have to also provide multidisciplinary services to patients in need.

Tiffany, based on all these comments, based on all these aspects, in your opinion, what are the best practices for consistent toxicity mitigation and equitable care delivery for patients with metastatic TNBC globally?

Dr. Traina:
Yeah, such a fabulous question, and a great lead-in to your point about relying on our colleagues and our collaborators. So I would say a couple of things.

First is just awareness and education and knowledge of what the typical adverse events are and the toxicities are with these antibody-drug conjugates so that clinicians are prepared and on the lookout and monitoring for those adverse events and educating our patients so they know what to anticipate.

Number 2, there are prophylactic strategies to even prevent those toxicities from developing.

And then we need to work with our colleagues, where we need to recruit in those subspecialists, like optometry or ophthalmology, where that might be a little bit more challenging in some resource-constrained places. Engaging all of those specialists to help care for our patients will mitigate that toxicity.

I'm wondering, with our last moments, if you could share just some final thoughts on how do we bring these TROP2 ADCs into the first-line setting for patients globally

Dr. Cortés:
I think that we were talking all the time about evidence-based strategies, evidence-based treatment, evidence-based guidelines. Anti-TROP2 antibody-drug conjugates have been incorporated in many guidelines already—NCCN Guidelines, ESMO guidelines—they recognize both Dato-DXd and sacituzumab govitecan with Category 1, so these are the preferred strategies for our patients.

Always take into account this individualized patient-centered care. You made very good comments about how to use shared decision-making when we are going to make the final decisions. This is thinking about our patients.

So, dear Tiffany, I think it has been absolutely amazing. But as usual, time is up, so our conversation has to be over here. These type of conversations, this one and other ones, lead to better care decisions.

Thank you very much, Tiffany. Thank you very much for listening to you all.

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