ONCOLOGY GRAND ROUNDS

Actionable Strategies in Community Oncology to Achieve Equity in Triple-negative Breast Cancer

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Learning Objectives

- Employ strategies to promote equitable care and outcomes for all patients with triple-negative breast cancer (TNBC).
- Evaluate clinical trial data for antibody–drug conjugates (ADCs) as part of the evolving and expanding TNBC treatment calculus, including recent FDA approvals and updated guideline recommendations.
- Incorporate evidence-based treatment plans with an emphasis on the placement of novel therapeutics as part of equitable care for patients with TNBC.

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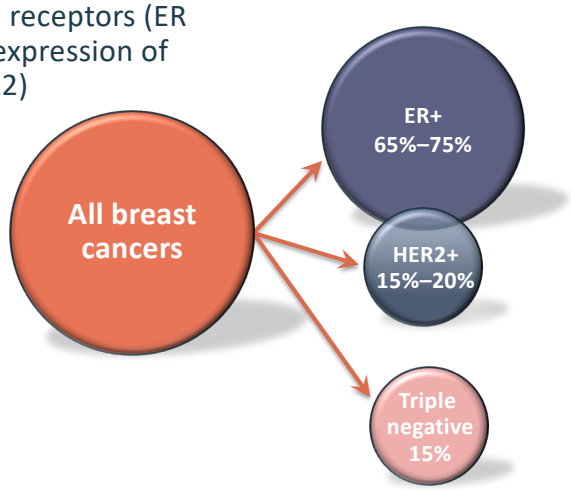
Triple-negative Breast Cancer (TNBC)
Epidemiology and Clinical Gravity

- TNBC lacks estrogen and progesterone hormone receptors (ER and PR, respectively), and does not exhibit overexpression of human epidermal growth factor receptor 2 (HER2)
- TNBC accounts for ~15% of breast cancers
- More common in
  - Young women
  - Individuals of African and Hispanic heritage
  - *BRCA1* germline mutations
- Poorer OS vs other forms of breast cancer (median OS = ~18 months)
- More aggressive disease course
  - Higher risk of both local and distant recurrence
- Historically, limited treatment options



Saha P, Nanda R. *Ther Adv Med Oncol.* 2016; 8(5):351–359.
Lebert JM, et al. *Curr Oncol.* 2018. 25(Suppl 1):S142–S150.

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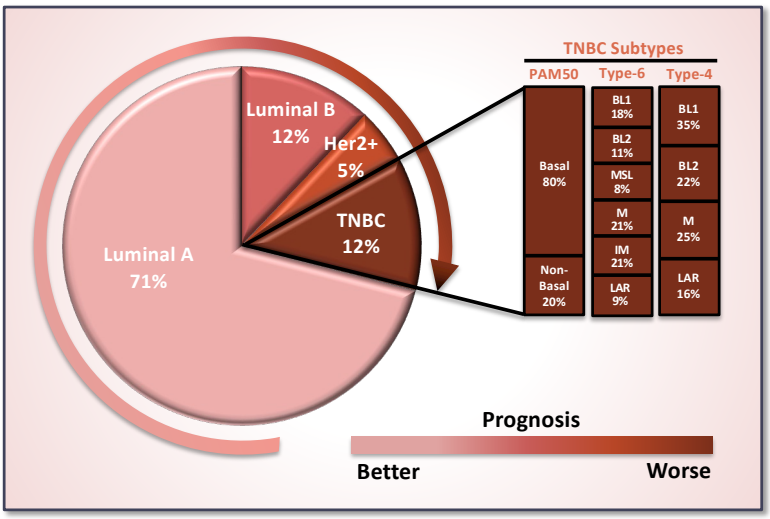
The Intrinsic Heterogeneity of TNBC
Challenge and Opportunity

- Traditional chemotherapy has long been the primary treatment modality for TNBC
- The search for actionable treatment targets has revealed TNBC as a condition with immense molecular heterogeneity



Gatti V, et al. *Int J Mol Sci.* 2019; 20(11):2683.
Bianchini G, et al. *Nat Rev Clin Oncol.* 2016; 13(11):674–690.

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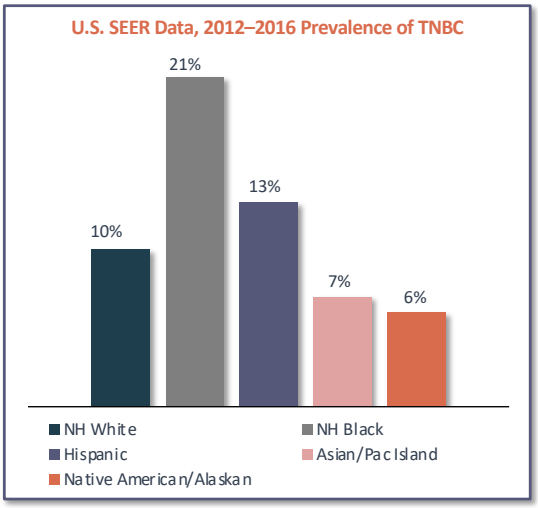
Higher Incidence of TNBC in Black Women

- TNBC is more prevalent in Black women than other ethnicities
  - Worldwide, highest rates found in U.S. and West African Black women (~24%)
  - Contributes to excess breast cancer–related mortality among Black women, but not sole explanation
- Incidence of TNBC is twofold higher for Black women compared to White women
- TNBC disproportionately affects younger, premenopausal women
- Pathogenic variant frequency in 21 cancer-associated genes
  - White: 7.8% BRCA1/BRCA2, 6.2% non-BRCA
  - Black: 9.0% BRCA1/BRCA2, 5.6% non-BRCA



NH, non-Hispanic; Pac Island, Pacific Islander.

https://www.cancer.org/research/cancer-facts-statistics/breast-cancer-facts-figures.html. Dietze EC, et al. *Am J Pathol.* 2018;188:280. Foulkes WD, et al. *N Engl J Med.* 2010;363:1938. Howard FM, et al. Cancer J. 2021;27:8. Prakash O, et al. *Front Public Health.* 2020;8:576964. Sharma P. Oncologist. 2016;21:1050. https://www.cancer.gov/types/breast/hp/breast-ovarian-genetics-pdq#_2723_toc.

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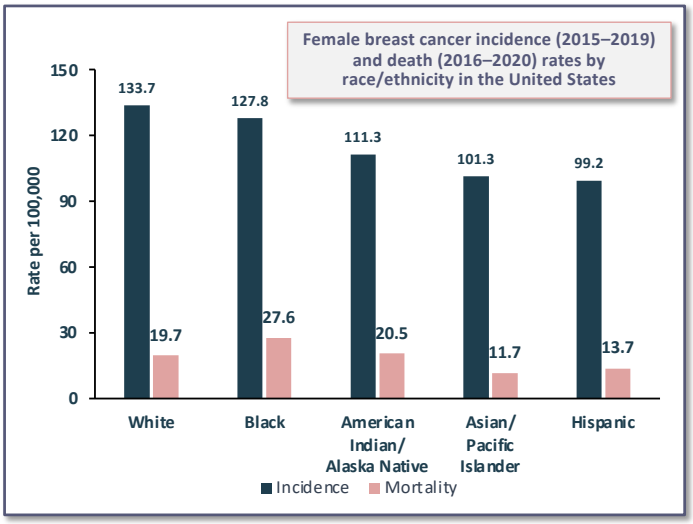
Higher Mortality for Black Women with TNBC

- Median age at death due to breast cancer
  - 68 years all women
  - 70 years White women
  - 63 years Black women



https://www.cancer.org/research/cancer-facts-statistics/breast-cancer-facts-figures.html.
Rebner M, Pai VR. *J Breast Imag*. 2020;2(5):416–421.

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Disparities in Diagnosis and Treatment

- Modifiable risk factors for TNBC may be more prevalent in certain at-risk groups
- Low SES and less-generous insurance associated with diagnosis at advanced stage for all women
- Outcomes in Black women influenced by underlying disease characteristics, as well as SES and patterns of care
- Low SES Black women more likely to receive inadequate treatment in comparison to higher SES NHW women

Risk Factors for TNBC

- Early menarche (age <12 years) and/or later menopause
- African-American and Hispanic ancestry
- Underlying BRCA1 mutation
- Family history
- Obesity (>30 kg/m^2) in premenopausal women
- Moderate/high alcohol consumption
- Low physical activity
- Exogenous hormone use
- Young age at first pregnancy

NHW, non-Hispanic White; SES, socioeconomic status.

NCCN Guidelines. Breast Cancer. v4.2023. Prakash O, et al. *Front Public Health*. 2020;8:576964.
Howard FM, et al. *Cancer J*. 2021;27:8. Silber JH, et al. *Milbank Q*. 2018;96:706.

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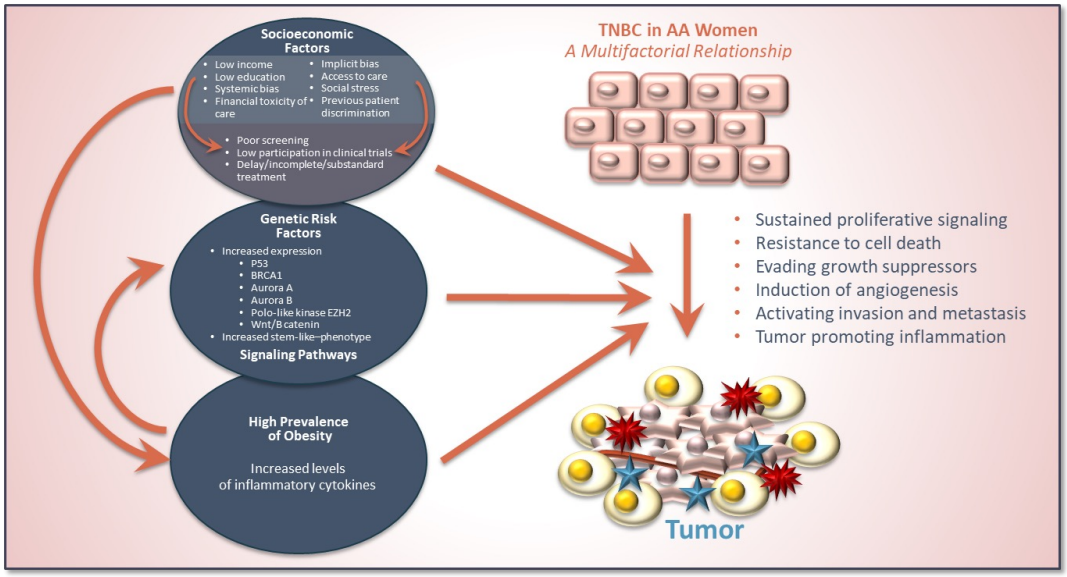
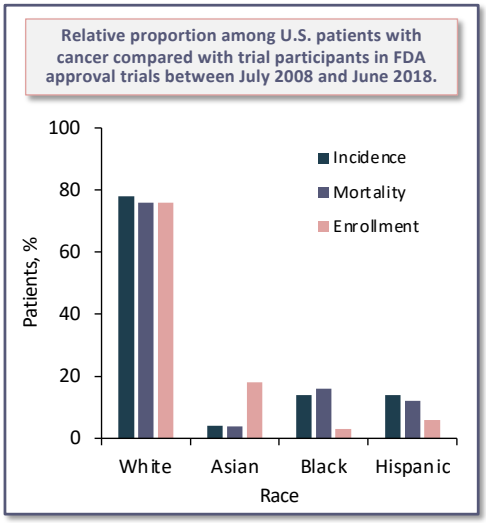
Biological and Socioeconomic Causes of Disparities



Wang F, et al. *Cancer Res*. 2021;81(4):1163–1170. Prakash O, et al. *Front Public Health*. 2020;8:576964. Hossain F, et al. *Front Public Health*. 2019;7:18. Newman LA, Kaljee LM. *JAMA Surg*. 2017;152(5):485–493. Penner LA, et al. *J Clin Oncol*. 2016;34(24):2874–2880. Penner LA, et al. *Soc Sci Med*. 2017;34(24):2874–2880. Siddharth S, Sharma D. *Cancers (Basel)*. 2018;10(12):514.

Clinical Trial Participation

- Trial participation is lowest among Black patients
- In a survey of 358 trials, Black patients represented
  - 12.1% of total cancer population
  - 9.0% of participations in SWOG trials
  - 2.9% of participants in pharmaceutical company sponsored trials
- In study of 230 oncology trials from 2008–2018, only 145 (63%) reported race of participants
- Compared to White participants, Black and Hispanic participants were underrepresented in these trials relative to their proportion among the U.S. cancer population
  - White participants (98% of expected proportion)
  - Black participants (22% of expected proportion)
  - Hispanic participants (44% of expected proportion)

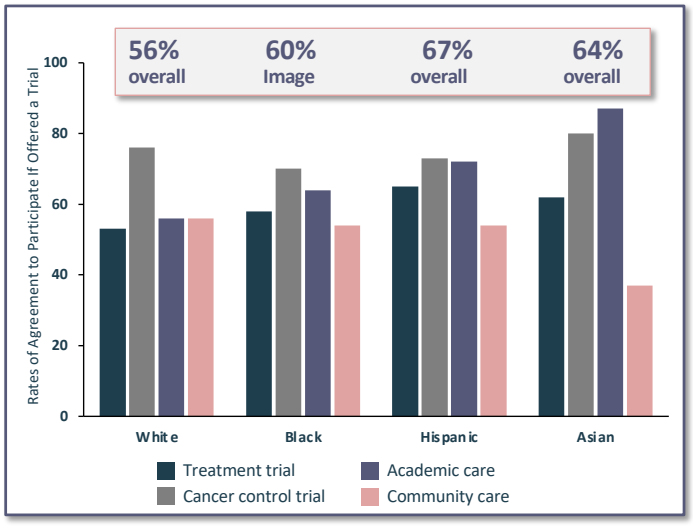


SWOG, Southwest Oncology Group.

Unger JM, et al. *JNCI Cancer Spectr*. 2020;4(4):pkaa034.
Loree JM, et al. *JAMA Oncol*. 2019;5(10):e191870.

"If Offered the Opportunity"

- Meta-analysis (35 studies; 9,759 patients; all cancer types)
  - >Half of patients participate in clinical trials, if they are offered the opportunity
  - No difference by race
- The main reasons for nonparticipation were treatment choice or lack of interest
  - 24% desire for other treatment
  - 20% not interested in trial participation
  - 8% passive refusal
  - 8% fear of side effects
  - 7% financial
  - 7% dislike being part of experiment



Unger JM, et al. *JNCI: J Natl Cancer Inst.* 2020;113(3):244–257.

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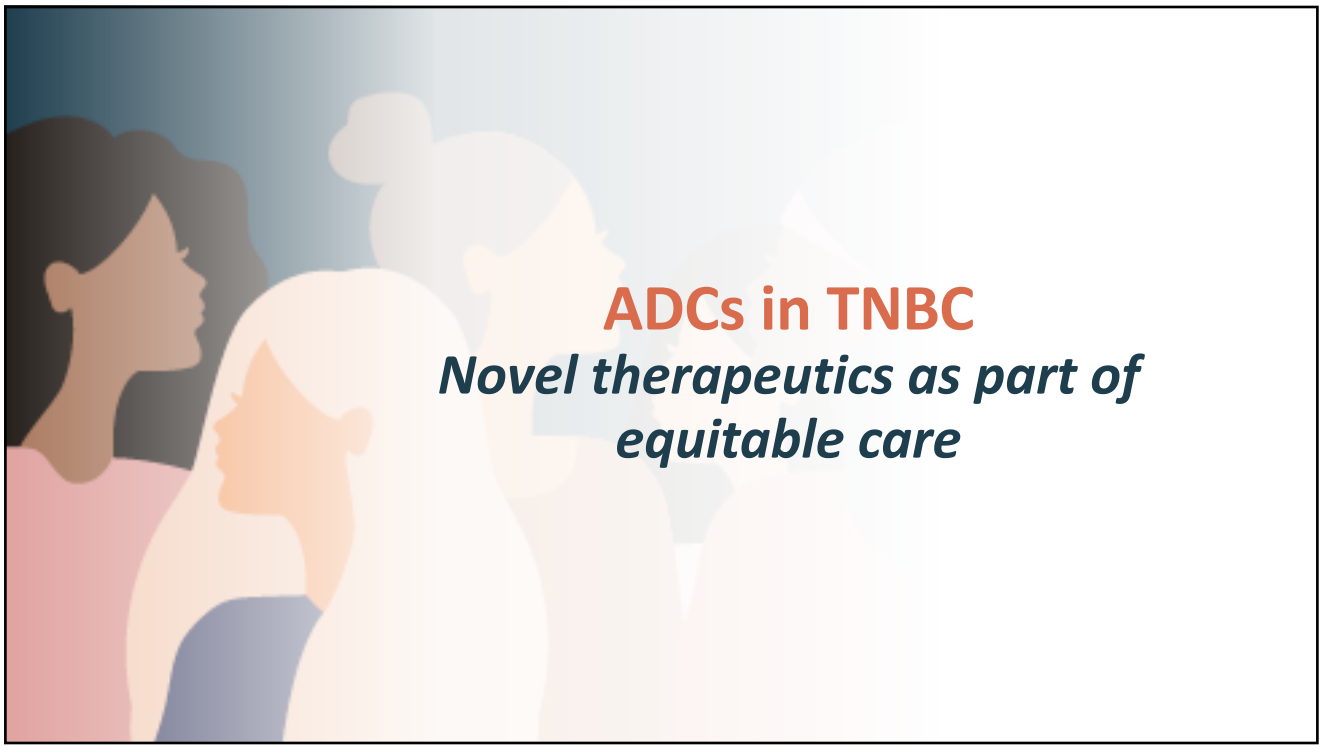

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Evidence-based Management of mTNBC
Evolving Placement of ADCs in the Paradigm

First Line	Second Line	Third Line +
PD-L1 CPS ≥10*: pembrolizumab + chemotherapy†	Sacituzumab govitecan†§	Biomarker positive: targeted agents
	Trastuzumab deruxtecan†‖	
PD-L1 CPS <10‡: taxane or platinum†		
*BRCA1/2*m: olaparib or talazoparib†		
Systemic chemotherapy		

*Regardless of germline *BRCA* status; †Category 1, preferred; ‡no germline *BRCA1/2* pathogenic variant; §Any subtype/biomarker; ‖No germline *BRCA1/2* and *HER2* IHC 1+ or 2+/ISH negative.
CPS, combined positive score.

NCCN Guidelines. Breast Cancer. v4.2023.

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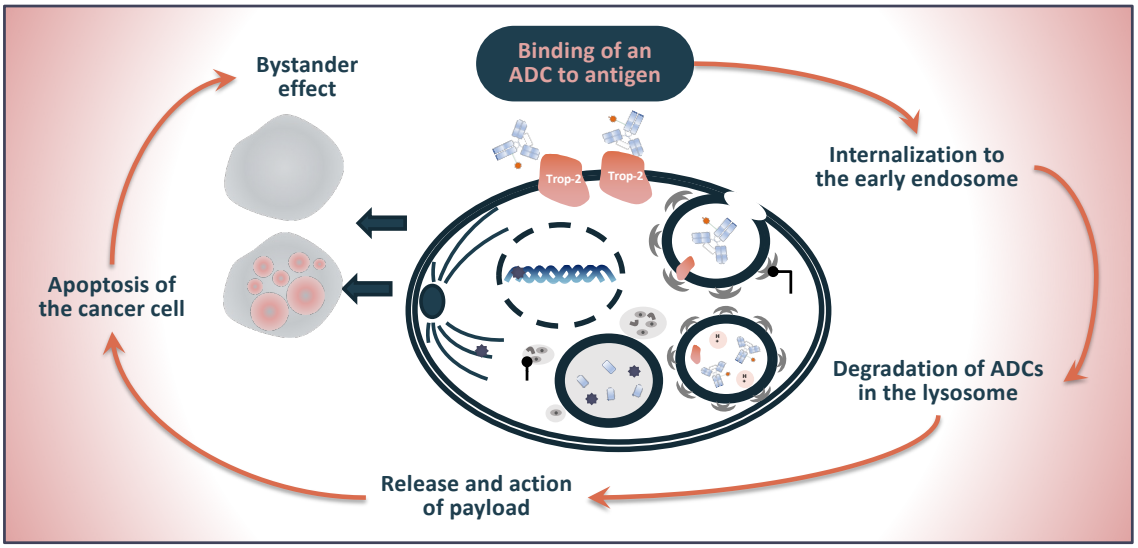
Antibody–drug Conjugates (ADCs)
Selective Delivery of Toxic Payload



Trop-2, trophoblast cell surface antigen 2.

Nagayama A, et al. *Target Oncol.* 2017.

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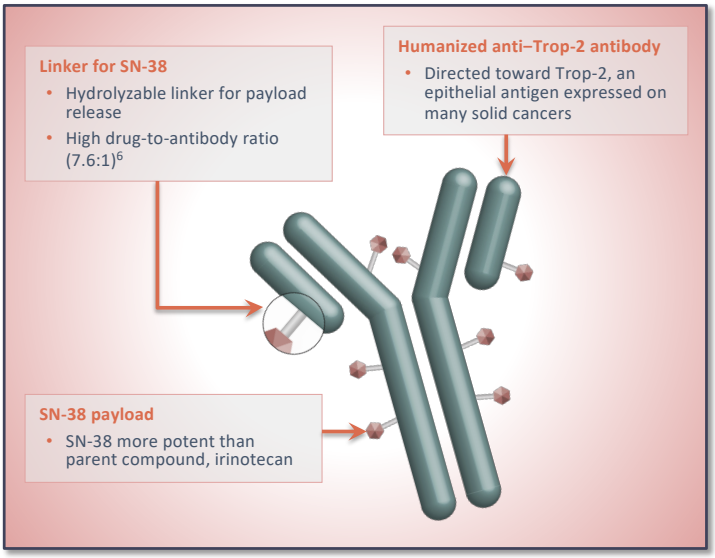
SG Is a First-in-Class Trop-2–directed ADC

- Trop-2 is expressed in all subtypes of breast cancer and linked to poor prognosis
- SG is distinct from other ADCs
  - Antibody highly specific for Trop-2
  - High drug-to-antibody ratio (7.6:1)
- Granted regular approval by the FDA in April 2021 for metastatic TNBC
- Clinical benefit with SG vs treatment of physician's choice (TPC) is irrespective of level of Trop-2 expression, in previously treated mTNBC



[1]Vidula N, et al. *J Clin Oncol.* 2017;35:15(suppl):1075. Ambrogi F, et al. *PLoS One.* 2014;9(5):e96993. Goldenberg DM, et al. *Expert Opin Biol Ther.* 2020;20(8):871–885. Nagayama A, et al. *Ther Adv Med Oncol.* 2020;12:1758835920915980. Cardillo TM, et al. *Bioconjugate Chem.* 2015;26:919–931. Goldenberg DM, et al. *Oncotarget.* 2015;6:22496–224512. https://www.fda.gov/drugs/resources-information-approved-drugs/fda-grants-regular-approval-sacituzumab-govitecan-triple-negative-breast-cancer. Hurvitz S, et al. SABC 2021. Abstract GS3-06.

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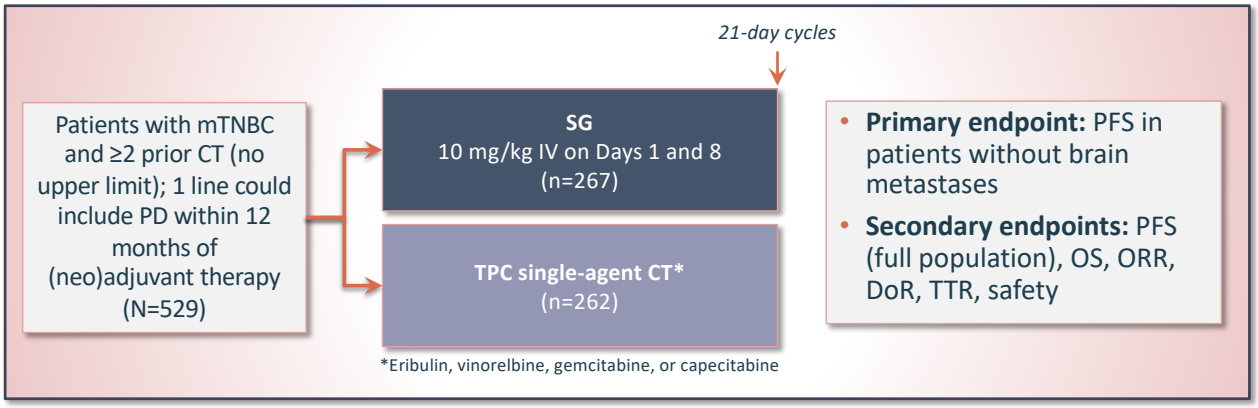
ASCENT

A Phase 3 Confirmatory Study of SG in Second-line and Later mTNBC

- Randomized, open-label phase 3 trial



- **Trial halted early based on efficacy** per unanimous independent DSMC recommendation

CT, chemotherapy; DoR, duration of response; DSMC, data and safety monitoring committee; ORR, objective response rate; OS, overall survival; PD, progressive disease; PFS, progressive-free survival; TTR, time to response.

Bardia A, et al. *N Engl J Med.* 2021;384(16):1529–1541. ClinicalTrials.gov. Identifier: NCT02574455.

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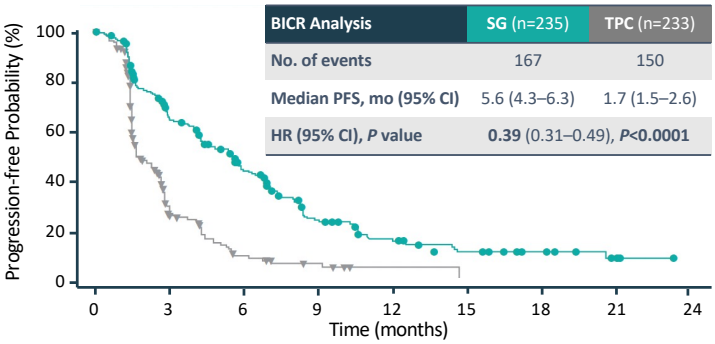
ASCENT Final Analysis

Confirmatory Study of SG in Second-line and Later mTNBC

- Statistically significant and clinically meaningful improvement in PFS and OS over chemotherapy in population without brain metastases (primary study population)

Progression-free Survival
Primary Endpoint



BICR Analysis	SG (n=235)	TPC (n=233)
No. of events	167	150
Median PFS, mo (95% CI)	5.6 (4.3–6.3)	1.7 (1.5–2.6)
HR (95% CI), *P* value	**0.39** (0.31–0.49), ***P*<0.0001**	

Overall Survival
Secondary Endpoint

	SG (n=235)	TPC (n=233)
No. of events	173	199
Median OS, mo (95% CI)	12.1 (10.7–14.0)	6.7 (5.8–7.7)
HR (95% CI), *P* value	**0.48** (0.39–0.59), ***P*<0.0001**	

OS rate at 24 months
22.4% (95% CI, 16.8–28.5)
vs
5.2% (95% CI, 2.5–9.4)

Bardia A, et al. ASCO 2022. Abstract 1071.

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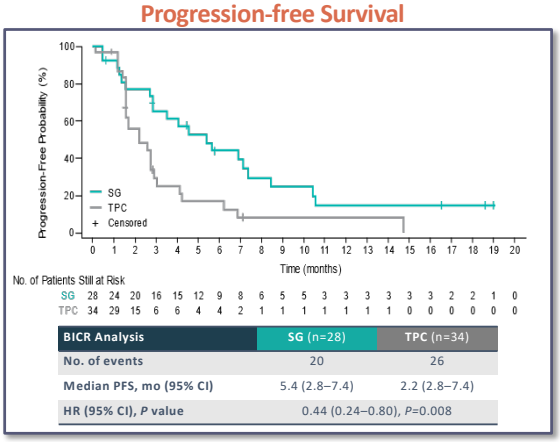
ASCENT

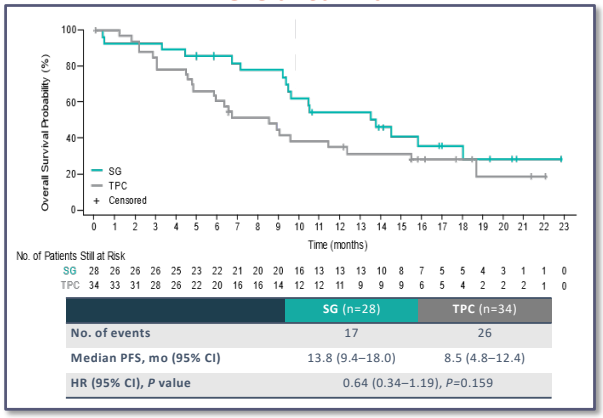
Efficacy in Black Patients

Progression-free Survival



BICR Analysis	SG (n=28)	TPC (n=34)
No. of events	20	26
Median PFS, mo (95% CI)	5.4 (2.8–7.4)	2.2 (2.8–7.4)
HR (95% CI), *P* value	0.44 (0.24–0.80), *P*=0.008	

Overall Survival



	SG (n=28)	TPC (n=34)
No. of events	17	26
Median PFS, mo (95% CI)	13.8 (9.4–18.0)	8.5 (4.8–12.4)
HR (95% CI), *P* value	0.64 (0.34–1.19), *P*=0.159	

- 62/529 patients enrolled in ASCENT were Black (**12%;** 28 SG vs 34 TPC)
- Black patients derived similar benefit in PFS and OS as overall population (PFS 5.6 months and OS 12.1 months)
- The safety profile of SG in this subgroup was consistent with the full trial population

ITT, intention to treat.

Carey L, et al. 2021 SABCS Annual Meeting. Poster P05-16-07.

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SG
Adverse Events from ASCENT

		SG (n=258)			TPC (n=224)		
	TRAE	All grade, %	Grade 3, %	Grade 4, %	All grade, %	Grade 3, %	Grade 4, %
Hematologic	Neutropenia	63	46	17	43	27	13
	Anemia	34	8	0	24	5	0
	Leukopenia	16	10	1	11	5	1
	Febrile neutropenia	6	5	1	2	2	<1
Gastrointestinal	Diarrhea	59	10	0	12	<1	0
	Nausea	57	2	<1	26	<1	0
	Vomiting	29	1	<1	10	<1	0
Other	Fatigue	45	3	0	30	5	0
	Alopecia	46	0	0	16	0	0

Key Toxicity Considerations

- **Black box warnings for neutropenia and diarrhea**
- Dose reductions due to TRAEs were similar (22% SG vs 26% TPC)
- Adverse events (AEs) leading to treatment discontinuation were low for SG and TPC: 4.7% and 5.4%
- No severe cardiovascular toxicity, no grade >2 neuropathy or grade >3 ILD with SG

FDA Prescribing Information: sacituzumab govitecan. Bardia A, et al. ASCO 2022. Abstract 1071.

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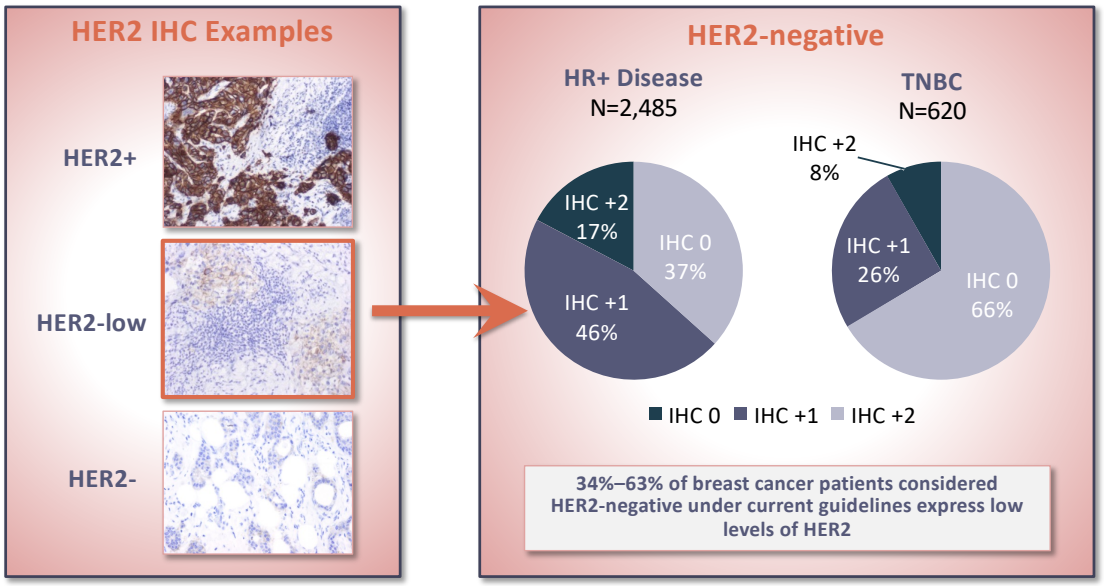
Prevalence of HER2-low by HR-status



Schettini F, et al. 2020 ESMO Breast Cancer Virtual Meeting. Abstract 23P. Slide courtesy of Aleix Prat.

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DESTINY-Breast04

First Randomized Phase 3 Study of T-DXd for HER2-low mBC

- An open-label, multicenter study

Patients*
- HER2-low (IHC 1+ vs IHC 2+/ISH−), unresectable, and/or mBC treated with 1–2 prior lines of chemotherapy in the metastatic setting
- HR+ disease considered endocrine refractory

*If patients had HR+ mBC, prior endocrine therapy was required.

R 2:1

T-DXd
5.4 mg/kg every 3 weeks
(n=373)

HR+ ≈ 480
HR− ≈ 60

TPC
Capecitabine, eribulin, gemcitabine, paclitaxel, nab-paclitaxel
(n=184)

Primary Endpoint
- PFS by BICR (HR+)

Key Secondary Endpoints
- PFS by BICR (all patients)
- OS (HR+ and all patients)

Stratification Factors
- Centrally-assessed HER2 status (IHC 1+ vs IHC 2+/ISH−)
- 1 vs 2 prior lines of chemotherapy
- HR+ (with vs without prior treatment with CDK4/6 inhibitor) vs HR−

BICR, blinded independent central review; CDK, cyclin-dependent kinase; ISH, in situ hybridization; mBC, metastatic breast cancer.

Modi S, et al. *N Engl J Med*. 2022;387(1):9-20; ClinicalTrials.gov. Identifier: NCT03734029.

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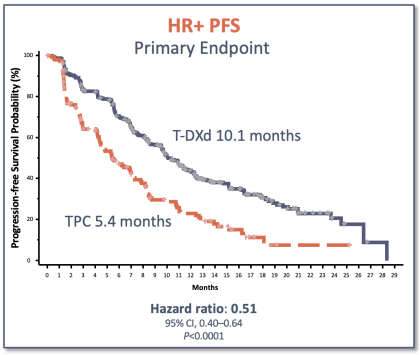
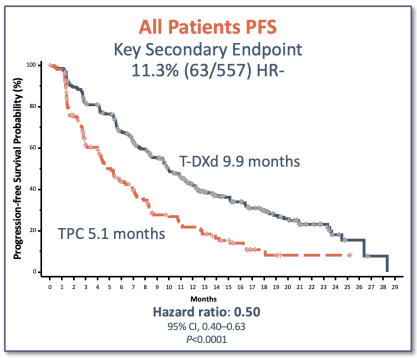
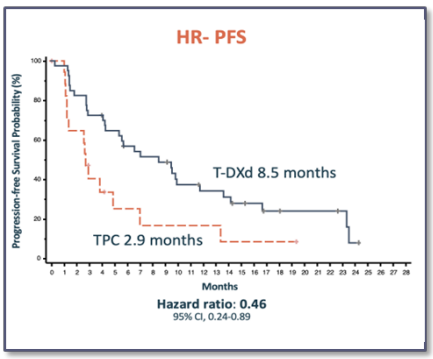
DESTINY-Breast04

Progression-free Survival







Modi S, et al. *N Engl J Med.* 2022;387(1):9–20.

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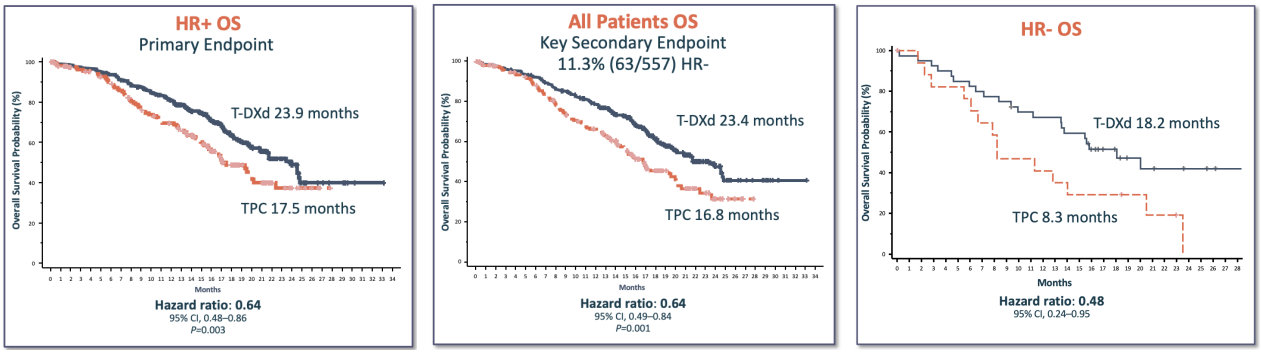
DESTINY-Breast04
Overall Survival



Modi S, et al. *N Engl J Med.* 2022;387(1):9–20.

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T-DXd
AEs from DESTINY-Breast04

		T-DXd (n=371)		TPC (n=172)	
	TRAE	All grade, %	Grade 3, %	All grade, %	Grade 3, %
Hematologic	Neutropenia	33	14	51	41
	Anemia	33	8	23	5
	Leukopenia	23	7	31	19
	Thrombocytopenia	24	5	9	<1
Gastrointestinal	Nausea	73	5	24	0
	Vomiting	34	1	10	0
	Diarrhea	22	1	18	2
Other	Fatigue	50	8	42	5
	Alopecia	38	0	33	0

Key Toxicity Considerations

- **Boxed warnings for ILD and embryo-fetal toxicity**
- ILD occurred in 12% of T-DXd patients (grade 1, 3.5%; grade 2, 6.5%; grade 3, 1.3%; grade 5, 0.8%)
- Left ventricular dysfunction was reported in 17 T-DXd patients (4.6%)
- Dose reductions due to TRAEs: 23% T-DXd vs 38% TPC
- AEs leading to treatment discontinuation: 16% T-DXd vs 8% TPC

FDA Prescribing Information: trastuzumab deruxtecan. Modi S, et al. *N Engl J Med.* 2022;387(1):9–20. Rugo HS, et al. *JCO Oncol Pract*. 2023;00: 1–8. Tarantino P, Tolaney SM. *JCO Oncol Pract*. 2023;00:1–2.

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T-DXd
AEs from DESTINY-Breast04

		T-DXd (n=371)		TPC (n=172)	
	TRAE	All grade, %	Grade 3, %	All grade, %	Grade 3, %
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	Leukopenia	23	7	31	19
	Thrombocytopenia				
Gastrointestinal	Nausea				
	Vomiting				
	Diarrhea				
Other	Fatigue				
	Alopecia				

ILD-related deaths decreased from 2.7% in DB-01 to 0.8% in DB-04.

Strategies to detect and manage T-DXd-related ILD are essential to minimize risk. However, fatal cases are still observed in practice and nonfatal cases can lead to significant patient burden and early treatment discontinuation.

Key Toxicity Considerations

- **Boxed warnings for ILD and embryo-fetal toxicity**
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T-DXd–related Interstitial Lung Disease
The 5 "S" Rules

Screening
Careful patient selection is warranted before initiating T-DXd to optimize the monitoring strategies based on the baseline risk. Screening continues during treatment, with regular clinical assessments to exclude signs/symptoms of ILD.

Scanning
The fundamental diagnostic tools for ILD remain radiological scans, with preference for high-resolution CT scans of the chest. A baseline scan is recommended, with repeat scans to be performed every 6-12 weeks.

Synergy
Minimizing the risk of ILD involves a teamwork, which includes educating patients and all the care team, as well as multidisciplinary management once ILD is suspected.

Suspending Treatment
T-DXd should always be interrupted if ILD is suspected; it can only be restarted in the case of asymptomatic ILD that fully resolves.

Steroids
The mainstay for treating T-DXd–induced ILD remains corticosteroids, with the dose to be adapted to the toxicity grade.

Rugo HS, et al. *JCO Oncol Pract. 2023;00: 1–8.* Tarantina P, Tolaney SM. *JCO Oncol Pract*. 2023;00:1–2.

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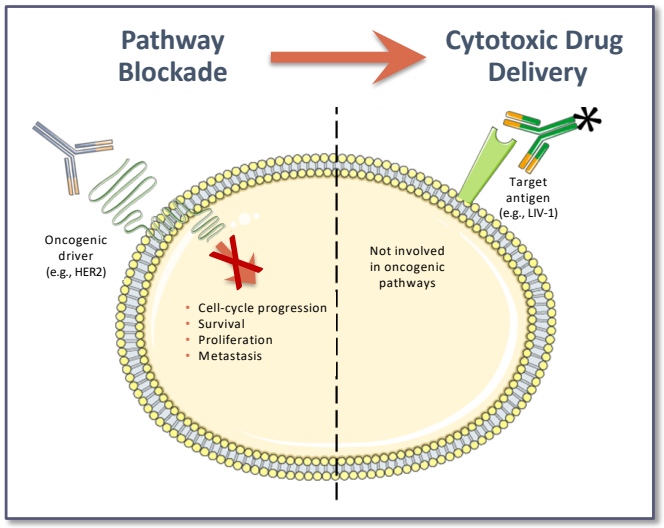
HER2 Low

Activity of HER2-directed ADCs Not Likely Related to Blockade of an Oncogenic Driver

- **No benefit with HER2 blockade**
- Activity is not likely related to the blockade of an oncogenic pathway, but rather to the **targeted delivery of a highly potent payload**
- **HER2-low is not a new subtype characterized by an oncogenic driver, but is rather a biomarker for benefit to ADCs targeting HER2**



Tarantino P, et al. *Expert Opin Biol Ther.* 2020;20:1009–1024.

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ADCs in TNBC

Where Are We Headed?

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ADCs in Development—mTNBC

Datopotamab Deruxtecan (Dato-DXd)

Target: Trop-2

Payload: topoisomerase I inhibitor

Trial: Phase I TROPION-PanTumor01

- ORR in mTNBC cohort (n=44): 32.0%
- ORR in mTNBC cohort who had not received previous topoisomerase I ADC (n=27): 44.0%
- Most common TEAEs ≥grade 3
  - Stomatitis (11%)
  - Decreased lymphocyte count (7%)
  - Fatigue (7%)
  - Vomiting (5%)

Patritumab Deruxtecan (HER3-DXd)

Target: HER3

Payload: topoisomerase I inhibitor

Trial: Phase II (Part A results at ASCO 2023)

- ORR mTNBC cohort (n=19): 21.1%
- ***Clinical activity regardless of HER3 expression***
- Most common grade ≥3 TEAEs
  - Decreased neutrophil count (5.0%)
  - Diarrhea (5.0%)
  - Fatigue (6.7%)
  - Decreased white blood cell count (18.1%)
- 1 experienced treatment-related ILD

Hamilton EP, et al. *J Clin Oncol*. 2023; 41(16_suppl):1004. ClinicalTrials.gov. Identifier: NCT03401385.
Bardia A, et al. SABC 2022. Abstract P6-10-03. ClinicalTrials.gov. Identifier: NCT04699630.

ORR, objective response rate.

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Select Ongoing Trials—ADCs

	Trial	Setting	Experimental Arm	Active Comparator	Primary Endpoint
EARLY	**ASCENT-05** Phase 3 NCT05633654	High-risk early TNBC • Residual invasive TNBC disease in breast or positive node(s) after neoadjuvant therapy	Adjuvant SG + pembrolizumab	Pembrolizumab ± capecitabine	iDFS
EARLY	**SASCIA** NCT04595565	HER2-negative breast cancer with residual disease after neoadjuvant chemotherapy	SG	TPC (capecitabine, platinum-based chemotherapy, or observation)	iDFS
EARLY	**TROPION-Breast03** NCT05629585	Stage I–III TNBC with residual invasive disease in the breast and/or axillary lymph nodes at surgical resection following neoadjuvant systemic therapy	Dato-DXd ± durvalumab	Capecitabine and/or pembrolizumab	iDFS
ADVANCED	**ASCENT-03** Phase 3 NCT05382299	First-line mTNBC • PD-L1– : CPS <10 or • PD-L1+ : CPS ≥10 if treated with PD-1/PD-L1 agent in the curative setting	SG	TPC (gemcitabine + carboplatin, paclitaxel, nab-paclitaxel)	PFS
ADVANCED	**ASCENT-04** Phase 3 NCT05382286	First-line PD-L1+ mTNBC • CPS ≥10, IHC 22C3 assay	SG + pembrolizumab	TPC + pembrolizumab	PFS
ADVANCED	**TROPION-Breast02** NCT05374512	Locally-recurrent inoperable or metastatic TNBC who are not candidates for PD-1/PD-L1 inhibitor therapy	Dato-DXd	Investigators choice of chemotherapy	PFS/OS

iDFS, invasive disease-free survival.

ClinicalTrials.gov. Identifiers: NCT05382299, NCT05382286, NCT05633654, NCT05374512, NCT04595565, NCT05629585.

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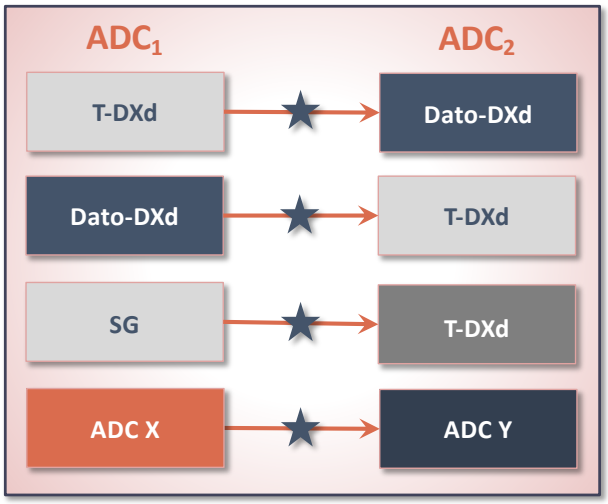
Critical Question
How Will ADCs Work in Sequence?

- Will one ADC work after another if they have non–cross-resistant payloads?
- Will one ADC work after another if they have the same target and different payloads?
- Will there be optimal combination therapies?



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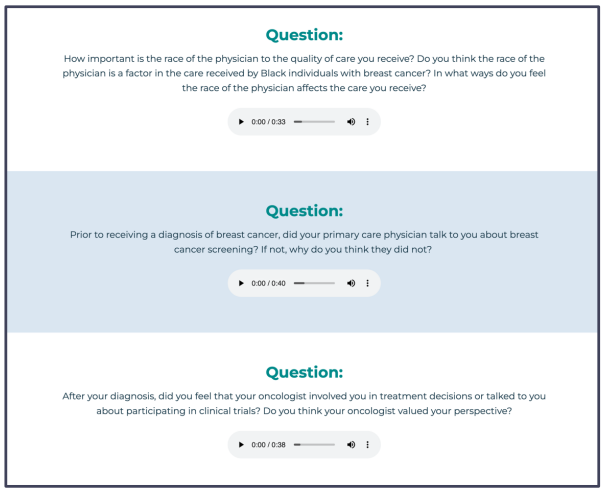
Pause and Listen to Experiences and Perceptions of Black Women with TNBC

TNBC Patient Portal



I feel my oncologist lumped you in a category. If you were African American, you had this type of breast cancer, whatever, this was your treatment. As far as clinical trials, I was involved in a clinical trial, but I think…**I happened to be the person that they needed for the trial. It wasn't so much that he wanted to give that to me. But I could still be in a box.**

So many times, African Americans are close-lipped about chronic diseases—especially cancer. I think that one of the things we, as a community, need to address is our ability to share information about our health situations with our family, with our friends, and with the greater community, if at all possible.

Patient interviews. 2022.

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Improving Breast Cancer Care for Black Patients

- Increased efforts aimed at early detections of breast cancer
  - Review family history of cancer prior to a breast cancer diagnosis to Identify women eligible for genetic testing or high-risk breast cancer screening
- Provide guideline concordant care for all patients, regardless of race (including chemotherapy, radiation, surgery, etc.)
- Avoid treatment delays (work-up of abnormal imaging, time to surgery or radiation, initiation of chemotherapy)
- Ensure accurate assessment of HR, HER2, and BRCA1/2 status, PD-L1 expression, and genetic testing, to facilitate biomarker-guided treatment decisions
- Address structural barriers
  - Promote access to socially, culturally, and linguistically appropriate, respectful, and high-quality cancer care
  - Diversify work force
  - Address social determinants of health (SDoH)

Patel MI, et al. *J Clin Oncol*. 2020;38(29):3439–3448.
Adamson BJS, et al. *J Clin Oncol*. 2019;37(18_suppl):LBA1.

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Addressing Disparities in Access to Care
Increase Participation in Clinical Trials

Actions from the BECOME Project

Better inform: 83% of Black patients with mBC would consider a trial, but 40% reported that no one on care team had discussed this with them

Inspire trust: Black patients were more likely than non-Black patients to want to learn about clinical trials from someone with shared experience.

- Black respondents were more likely than non-Black respondents to value receiving trial information from someone with the same racial/ethnic identity (67% vs 10%)

Ensure access: common barriers reported by Black patients were logistics, finding trials, and expenses

Address concerns: communicate clearly about issues that worry Black patients and reasons that motivate their willingness to participate in clinical trials

BECOME, Black Experience of Clinical Trials and Opportunities for Meaningful Engagement.

Walker S, et al. ASCO 2022. Abstract 1014. https://www.mbcalliance.org/projects/become/.

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Addressing Implicit Bias

IMPLICIT: Steps to Minimize Implicit Bias	
Introspection	Explore and identify your own implicit biases
Mindfulness	Increase awareness and reduce judgmental thoughts
Perspective-taking	Explore different points of view • Engage in diverse media • Directly interact with those different than yourself
Learn to slow down	Pause and reflect on your potential biases before interacting with patients
Individualization	Evaluate a person's individual characteristics instead of leaning on stereotypes • Consider mutual goals (e.g., treating cancer) • Discuss shared interests to build trust and increase patient comfortability
Check your messaging	Use welcoming language that embraces multiculturalism and avoid color-blind statements
Institutionalize fairness	Promote procedural change at the organizational level
Take two	Practice cultural humility, a lifelong process of critical self-reflection to readdress the power imbalances of the clinician-patient relationship

Explore and identify your own implicit biases

Edgoose JYC, et al. *Fam Pract Manag*. 2019;26(4):29–33. Dimarco R, et al. *J Adv Pract Oncol*. 2023;14(3):195–199. https://implicit.harvard.edu/implicit/takeatest.html. https://diversity.nih.gov/sociocultural-factors/implicit-bias-training-course.

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Next Steps/Goals

- Provide guideline concordant care for all patients regardless of race
- Ensure accurate assessment of HR, HER2, and BRCA1/2 status, PD-L1 expression, and genetic testing, to facilitate biomarker-guided treatment decisions
- Identify and address your own implicit biases; reflect on these before each patient interaction
- Listen to your patients and consider their concerns regarding novel therapies and/or clinical trial enrollment
- Speak up when you see explicit or implicit biases affecting cancer care

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Identify a SMART Goal to address Disparities in TNBC Care

Example goal: Identify my own implicit biases as they pertain to TNBC care and utilize available tools to address these biases by the end of 2023.

Specific: *What exactly is the goal?*
To improve care for my patients with TNBC by addressing my own biases

Measurable: *How will I measure progress?*
By taking implicit association tests; take at baseline and track progress by re-taking

Attainable: *Do I have the skills and resources for it?*
Complete online training modules (e.g., NIH Implicit bias training courses), and/or resources provided by my institution

Relevant: *Why is this important?*
Because there are measurable disparities in care for Black women with TNBC, addressing my own implicit biases will improve the level of high-quality care my patients receive

Timely: *When do I want to achieve this?*
By December 2023, reassess implicit association test

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Summary

Incidence and Mortality of TNBC Is Disproportionately Higher for Black Women

- Incidence of TNBC is twofold higher for Black women compared to White women
- Clinical trial participation is lowest among Black patients; however, willingness to participate if offered the opportunity does not differ by race
- There is a complex and multifactorial relationship between the biological and socioeconomic causes of disparities

The Evidence-based Management of mTNBC Is Evolving

- ADCs (SG and T-DXd) have shown potential to extend life in second-line TNBC settings
- SG was similarly efficacious and safe in Black women enrolled in the ASCENT trial
- Strategies to detect and manage T-DXd-related ILD are essential to minimize risk (5 "S" Rules)
- HER2-low is not a new subtype characterized by an oncogenic driver, but is rather a biomarker for benefit to ADCs targeting HER2

Despite Advances in Therapy, Disparities Persist

- As healthcare providers, it is essential to make sure Black patients have equal access to new therapies that can extend life; *actionable items include*
  - Provide guideline concordant care for all patients regardless of race
  - Listen to your patients and consider their concerns regarding novel therapies
  - Better inform patients about participation in clinical trials (actions from the BECOME project)
  - Identify, address, and continually re-address your own implicit biases (IMPLICIT)

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ONCOLOGY GRAND ROUNDS

Actionable Strategies in Community Oncology to Achieve Equity in Triple-negative Breast Cancer

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