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Spotlight on Latin America: Closing the Gap

Dr. Villarreal-Garza:
This is CE on ReachMD, and I'm Dr. Cynthia Villarreal-Garza. Today, I'll provide my perspective on managing HR-positive, HER2-negative breast cancer in Latin America.

Across Latin America, breast cancer is the most frequently diagnosed cancer in women, and our mortality-to-incidence ratios remain higher than in the US and Europe, signals of later stage at diagnosis and gaps in timely effective care. These gaps have recognizable drivers, a persistent share of advanced-stage presentations, especially in socially vulnerable settings, and systemic limitations in access to innovation and clinical research that ultimately shape outcomes.

In practice, we still see comparatively high proportions of stage III at diagnosis and a nontrivial burden of de novo stage IV disease in regional series, which naturally feeds a larger pool of recurrences over time. Within metastatic disease, HR-positive, HER2-negative tumors make up the majority, often around two-thirds. So first-line endocrine therapy with a CDK4/6 inhibitor and anti-hormonal therapy is our foundational approach. Yet, the real-world journey through successive lines can be unforgiving. Many patients will not reach third-line therapy, which is why we should aim to deploy the most effective options as early as biology and access allow.

From second-line onward, biomarkers should steer our decisions. ESR1 mutations, classically emerging under aromatase inhibitor pressure, are a canonical mechanism of endocrine resistance. Current recommendations support testing at each progression, preferably via ctDNA, because liquid biopsy captures heterogeneous resistance clones fast enough to guide real-time choices.

When ESR1 mutations are present, an oral SERD is a rational switch. Elacestrant carries an FDA indication specifically for ESR1-mutated ER-positive, HER2-negative breast cancer after prior endocrine therapy, and now imlunestrant is also FDA-approved.

For patients with qualifying pathway alterations after progression on ET and CDK4/6 inhibitors within the PI3K/AKT/PTEN pathway, capivasertib or alpelisib plus fulvestrant improves outcomes.

More recently, for endocrine-resistant PIK3CA-mutated disease, inavolisib plus palbociclib and fulvestrant demonstrated meaningful benefit. When no actionable mutation is detected, endocrine-based strategies may still be used when appropriate, including everolimus combinations with transitions to chemotherapy or ADCs as biology and clinical status dictate.

All of this only matters if patients can access testing and treatment. Region-wide, CDK4/6 inhibitors are broadly available in private systems and increasingly, but unevenly, in public formularies. Alpelisib is approved in many countries, capivasertib is beginning to enter formularies, and newer agents like elacestrant and inavolisib have variable or pending availability across Latin America.

Comprehensive genomic testing remains concentrated in private care and is often authorized for just once per patient, so teams prioritize profiling at the first progression after CDK4/6 when results most directly inform therapy. These patterns mirror the health system constraints and access lags documented in recent regional analyses.

The science is ready. Now our systems must keep pace. Routine biomarker testing at progression and rapid, equitable access to targeted therapies can narrow Latin Americans' outcome gap. Let's pair clinical precision with policy urgency so every woman has a fair chance at longer survival and a better quality of life.

Well, my time is up. I hope you found my perspective useful. Thanks for listening.