Transcript Details
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Matching TNBC Treatment Intensity to Patient Needs

Announcer:
You're listening to *Project Oncology* on ReachMD. On this episode, we'll hear from Dr. Roberto Leon-Ferre, who's an oncologist at the Mayo Clinic in Rochester, Minnesota. He'll be sharing key insights from his presentation at the 2026 American Society of Clinical Oncology Annual Meeting, which focused on matching the right therapy to the right patient with triple-negative breast cancer. Here's Dr. Leon-Ferre now.

Dr. Leon-Ferre:
Early-stage triple-negative breast cancer has traditionally been seen as an aggressive breast cancer subtype, and for many years, that framing pushed us in the direction of doing more—more drugs, more cycles, and more treatment intensification. And of course, to be fair, that approach has worked for many patients. And because of that, we cure a large proportion of women with stage one to three triple-negative breast cancer with the use of anthracycline, taxanes, platinums, and recently with the adoption of immunotherapy as well. It has made a lot of progress and led to more cures. We've also gotten smarter about how we deliver these treatments. We've moved from giving these medications as an adjuvant regimen after surgery to everyone without real personalization.

Now, to our current preferred approach, which is to give systemic therapy first before surgery, that shift has been very transformative for a few reasons, but primarily because it lets us identify patients who don't respond well upfront. And because of that, they have a higher risk of breast cancer recurrence. We now have other options that can lower that risk. And another reason is that it also lets us identify, on the other hand, patients who respond beautifully to the treatment. And those that achieve a complete response are expected to do very well long term. Those patients can then be spared the toxicities from additional treatments.

Now, that's the good side of the story. The challenge is that almost all of the research efforts in the treatment landscape of triple-negative breast cancer have been focused on treatment intensification. Most patients with early-stage triple-negative breast cancer today get multiple drugs, leading up to five drugs before surgery following the KEYNOTE-522 regimen. And that is one of the main questions that we addressed in the discussion at the ASCO session: how can we right-size the treatment, meaning match the right treatment intensity for patients with more aggressive disease or who need more treatment, but at the same time, try to identify potential patients who may not need as intensive systemic therapy?

I think the clearest example and the one that I focused on at ASCO is stage one triple-negative breast cancer. Guidelines today recommend systemic therapy for essentially any patient with triple-negative breast cancer that has a tumor larger than five millimeters, even when the lymph nodes are negative. But that recommendation has never really been tested prospectively. In a clinical trial focusing specifically or including a large number of patients with stage one triple-negative breast cancer, we extrapolate a lot from stage two and three data and then apply that to this population. We do know that triple-negative disease is highly heterogeneous. There are patients whose tumors are extraordinarily chemo-sensitive while other tumors are intrinsically resistant, and there's a meaningful group of patients that, despite having triple-negative disease, have a generally favorable prognosis even without systemic therapy. So the real question in our clinics is how do we figure out who is who, and, a few controversies stand out that can complicate decision-making in practice in real life.

If there's one take-home, I would say it's that triple-negative breast cancer is aggressive on average, but that is an oversimplification. Triple-negative breast cancer is highly heterogeneous. We need to get better at identifying the subsets with more favorable biology, and we need to stop applying a one-size-fits-all or cookie-cutter approach based on all their data.

We do need new data. We need new biomarkers to be able to make the next step in progress in this disease by personalizing therapy,

not just based on the response that patients have to the neoadjuvant treatment—which we've actually gotten quite good at—but before the first dose of chemotherapy is ever given so we can identify patients who genuinely need chemotherapy in the first place, and for those who do, distinguish who needs one drug, two drugs, three drugs, or all five drugs of the KEYNOTE-522 regimen.

Announcer:
That was Dr. Roberto Leon-Ferre talking about how we can better personalize triple-negative breast cancer care. To access this and other episodes in our series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!