Dott.ssa Silvia Beatrice

Inibitori delle cicline e non solo: dall'adiuvante all'avanzato

3°Edizione

I tumori femminili

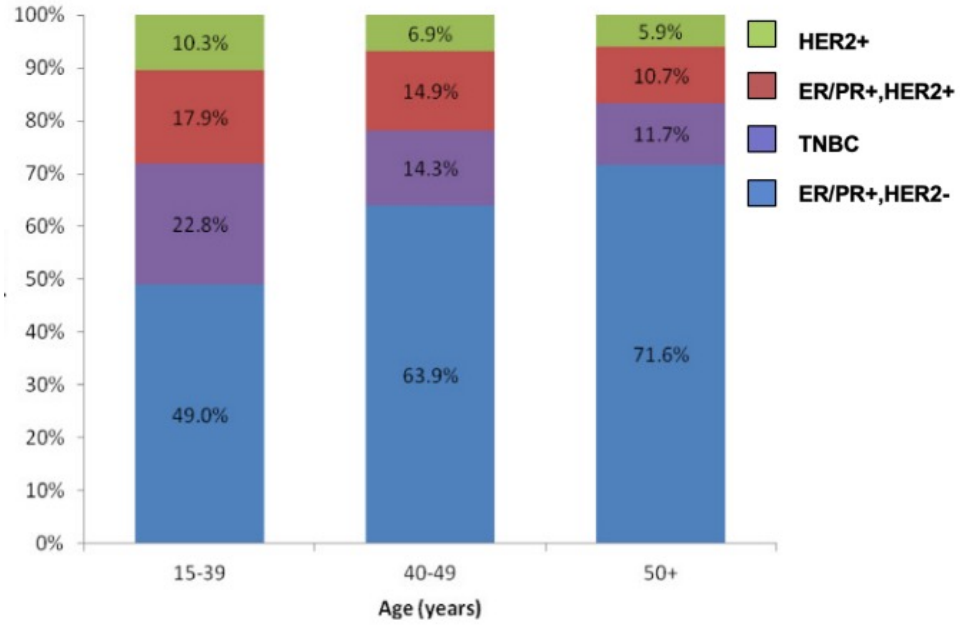
Dal gene profiling alla terapia personalizzata

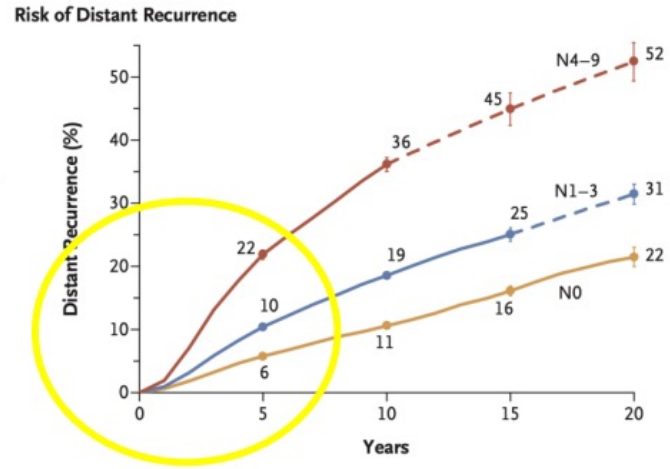
22-23 Novembre 2023

Casale Monferrato, AL

Hotel Candiani

Breast Cancer Incidence by Subtype





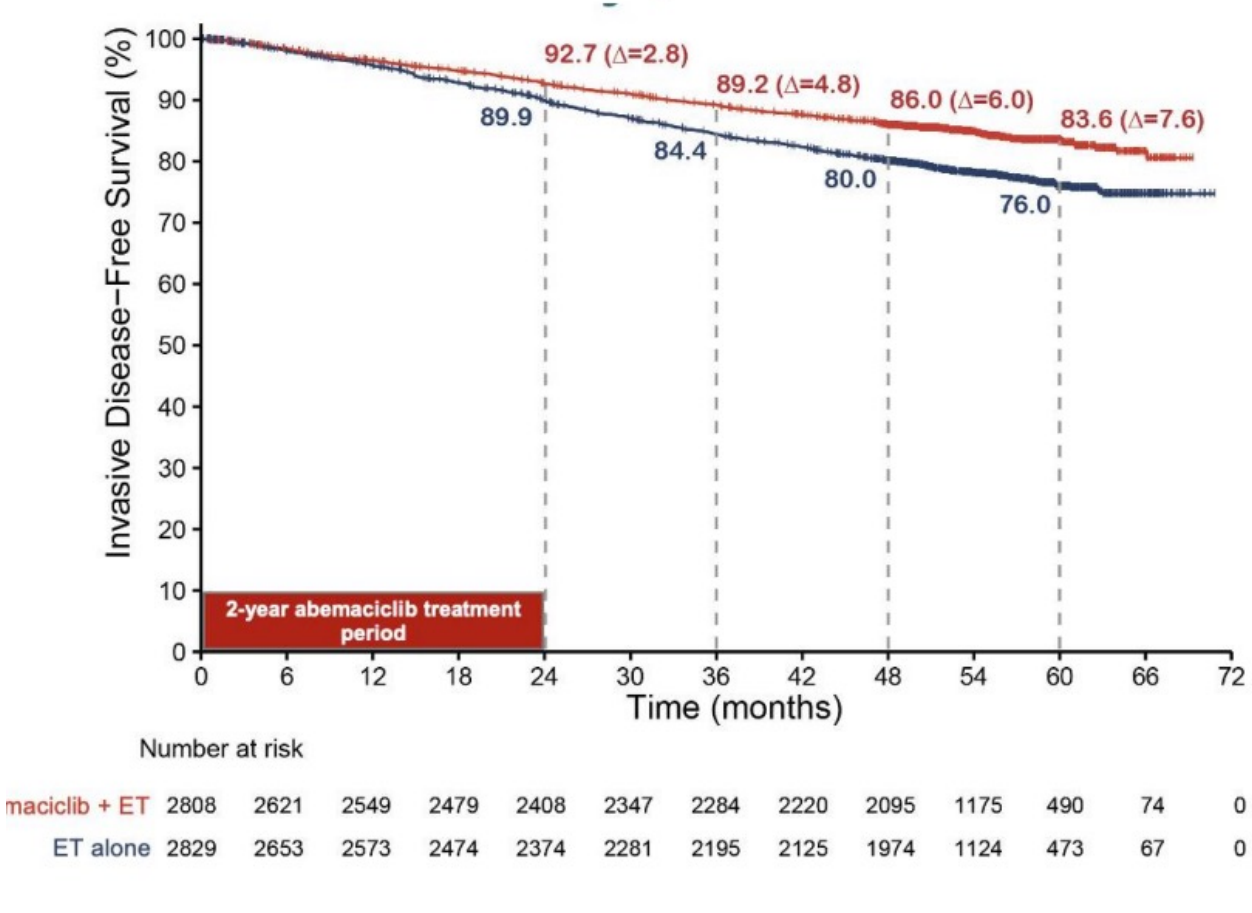
No. at Risk					
N4–9	12,333	8,116	2165	259	52
N1–3	31,936	23,576	7250	949	183
N0	29,925	24,081	8571	1982	414

No. of Events — annual rate (%)				
N4–9	2568 (4.8)	969 (4.0)	121 (3.1)	13 (2.2)
N1–3	3126 (2.2)	1421 (1.9)	241 (1.7)	39 (1.8)
N0	1646 (1.2)	835 (1.1)	272 (1.3)	68 (1.4)

Keegan et al, BCR 2012; Pan et al, NEJM 2017

What else can we do for patients with high risk, ER+ breast cancer?

Sustained Benefits at 5 years in monarchE IDFS & DRFS



Number of IDFS events

Abemaciclib + ET	ET Alone
407	585

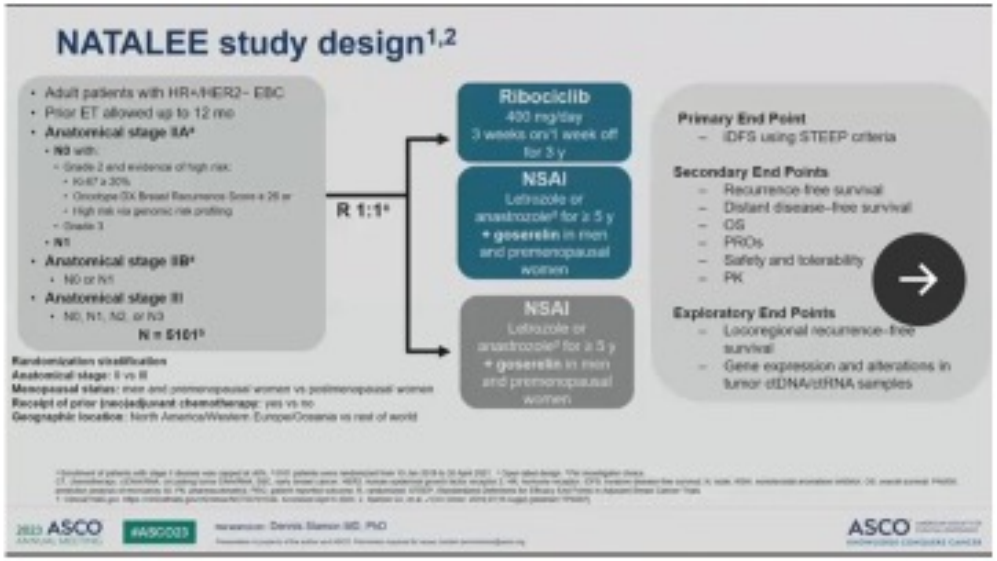
HR (95% CI): 0.680 (0.599, 0.772)
Nominal p <0.001

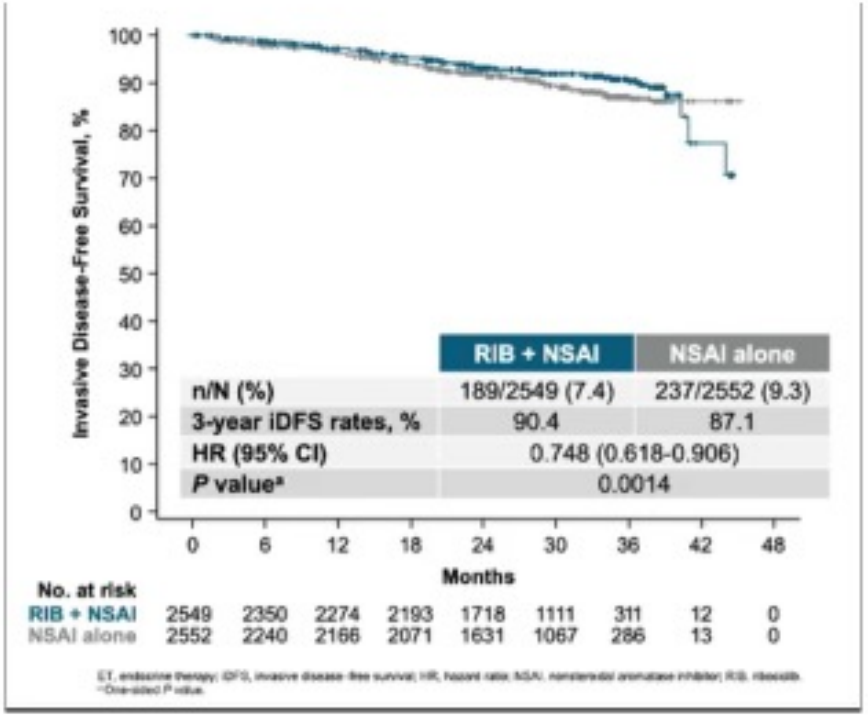
Number of DRFS events

Abemaciclib + ET	ET Alone
345	501

HR (95% CI): 0.675 (0.588, 0.774)
Nominal p <0.001

Harbeck et al, LBA 17, ESMO 2023





The NATALEE results sopport ribociclib + ET as the treatment of choice in a broad population of ptz with stage II or III EBC including ptz with N0

monarchE and NATALEE: IDFS Rate

monarchE (n=5607)

5 year IDFS Rate

Δ 7.6% (HR: 0.68, 0.60-0.77, p<0.001)

NATALEE (n=5101)

3 year IDFS Rate

Δ 3.3% (HR: 0.75, 0.62-0.91, p=0.0014)

Adjuvant CDK4/6i tx substantially improves EFS in eBC

- All subgroups benefit including by Ki67, ER, PR

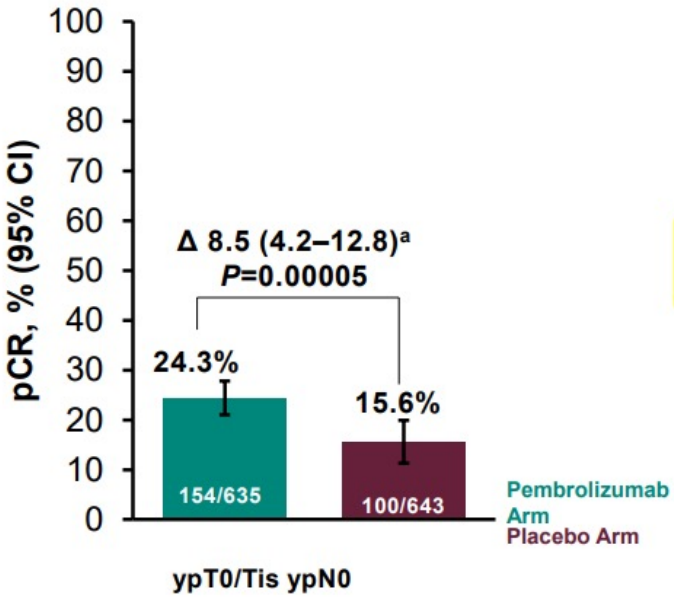
  Goetz et al, ESMO 2023; Bardia et al, ESMO 2023
- Adjuvant abema approved
- Await ribo approval (NATALEE follow-up pending)
- Await OS data and many other unanswered questions
  - Replace chemotherapy?
  - Adherence in real world?

ate: Δ 2.2%

What about ICI's in ER+ Disease?

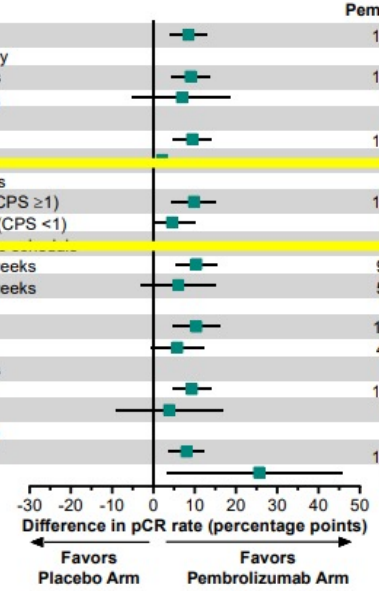
KEYNOTE-756- Pathological Complete Response (pCR) Rate

Primary Endpoint



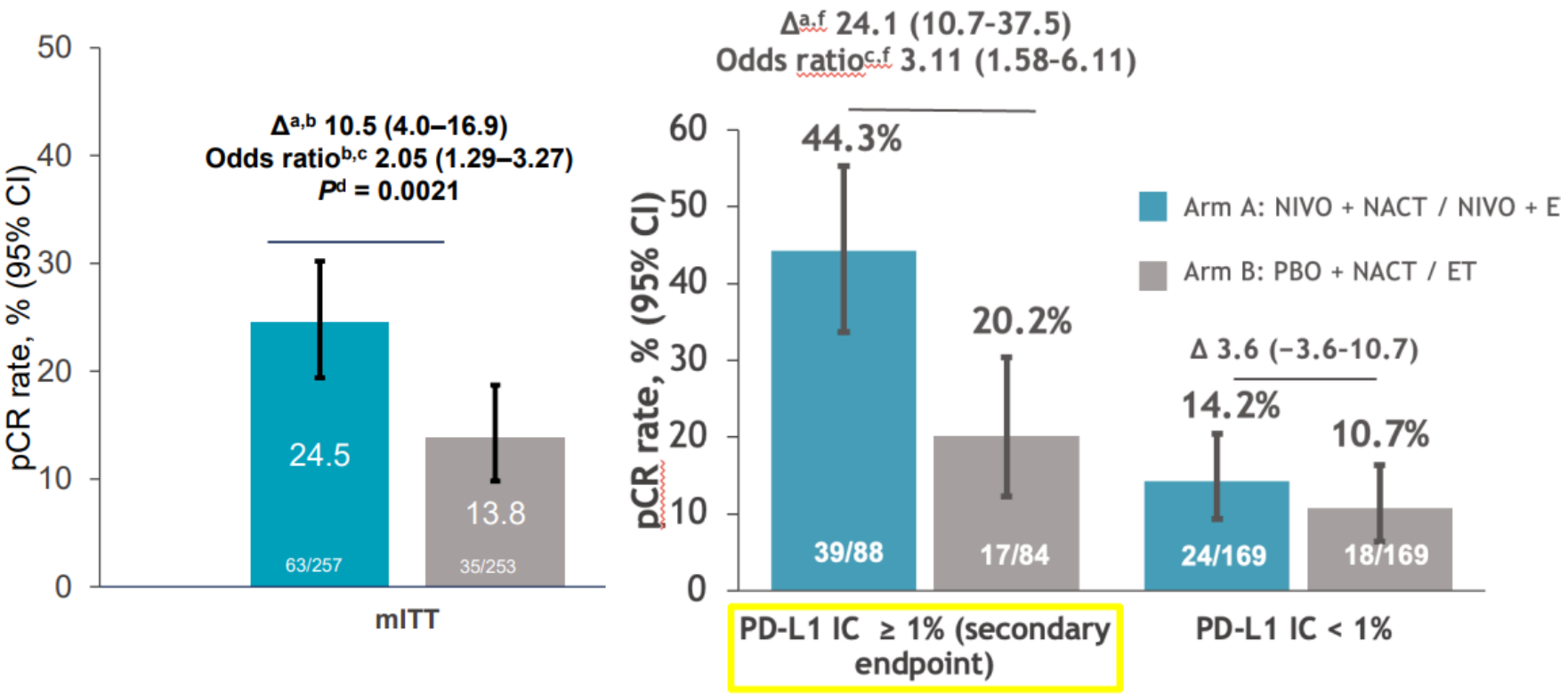
ITT N=1278

Subgroup	No. with pCR/No. of Participants (%) Pembrolizumab Arm	Placebo Arm	pCR Rate Difference (95% CI)
Overall	154/635 (24.3)	100/643 (15.6)	8.5 (4.2 to 12.8)
Age category			
<65 years	135/546 (24.7)	89/567 (15.7)	9.0 (4.3 to 13.8)
≥65 years	19/89 (21.3)	11/76 (14.5)	6.9 (–5.2 to 18.6)
ECOG PS			
0	142/570 (24.9)	91/588 (15.5)	9.4 (4.8 to 14.1)
PD-L1 status			
Positive (CPS ≥1)	143/482 (29.7)	96/489 (19.6)	9.8 (4.4 to 15.2)
Negative (CPS <1)	11/153 (7.2)	4/154 (2.6)	4.5 (–0.4 to 10.1)
Every 3 weeks	97/415 (23.4)	55/425 (12.9)	10.4 (5.3 to 15.7)
Every 2 weeks	54/183 (29.5)	44/187 (23.5)	6.0 (–3.0 to 15.0)
Tumor size			
T1/T2	111/402 (27.6)	71/413 (17.2)	10.4 (4.7 to 16.1)
T3/T4	43/233 (18.5)	29/230 (12.6)	5.8 (–0.8 to 12.5)
Nodal status			
Positive	143/570 (25.1)	92/582 (15.8)	9.3 (4.6 to 13.9)
Negative	11/65 (16.9)	8/61 (13.1)	3.8 (–9.2 to 16.7)
ER positivity			
≥10%	135/601 (22.5)	87/600 (14.5)	8.0 (3.6 to 12.4)
<10%	19/34 (55.9)	13/43 (30.2)	25.6 (3.3 to 45.8)



Cardoso et al, LBA 21, ESMO 2023

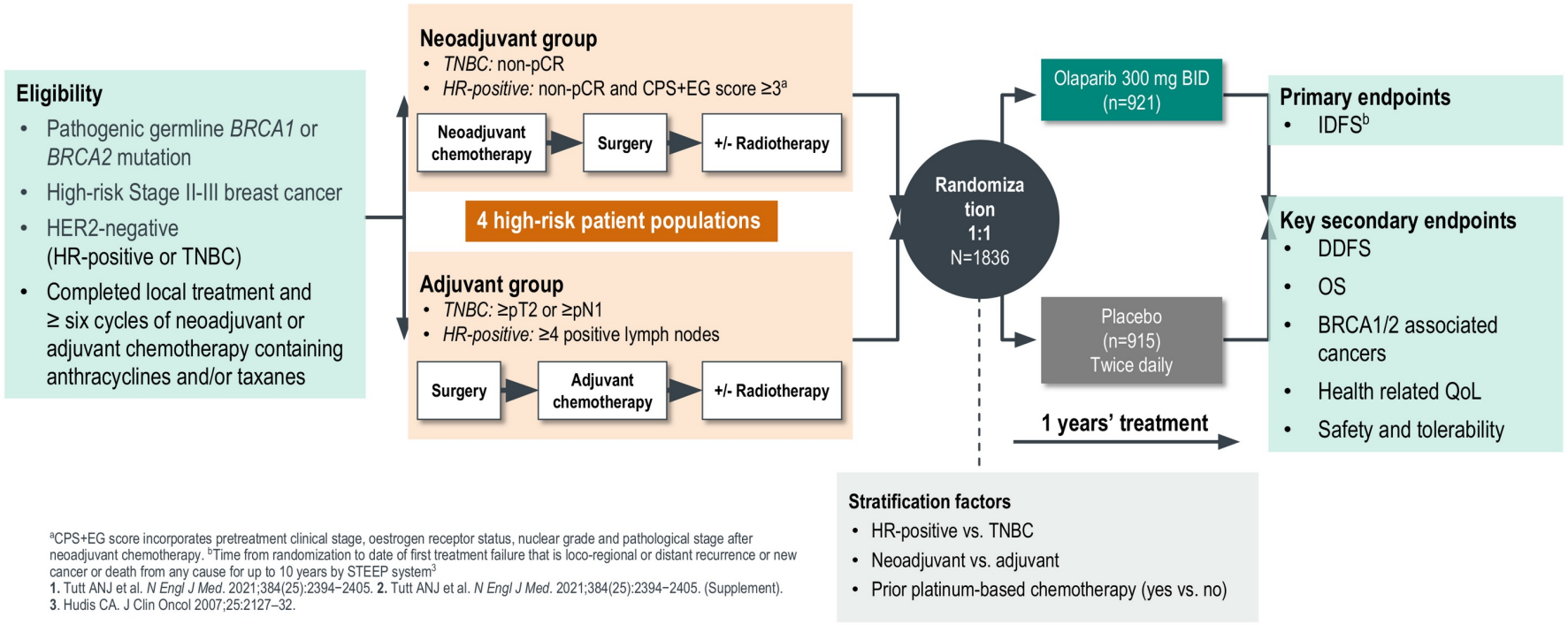
CheckMate-7FL Pathological Complete Response (pCR) Rate



Loi et al, LBA 20, ESMO 2023

What about PARP inhibitors in ER + disease?

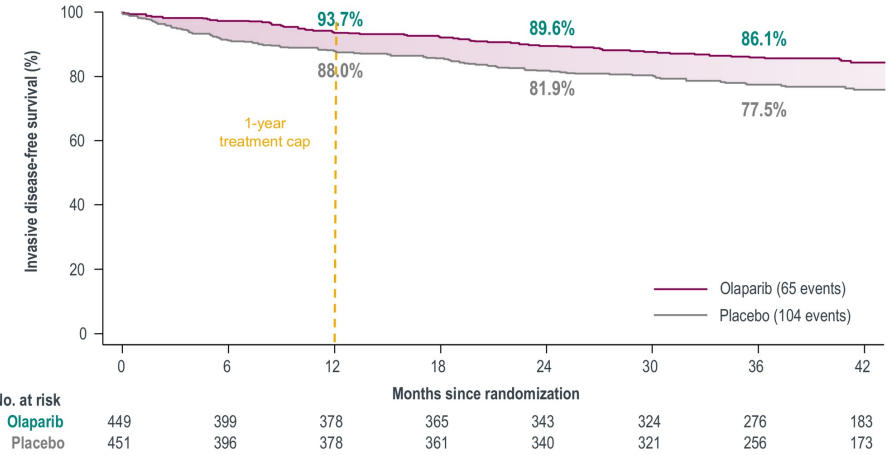
OlympiA Study Design[1,2]



[a]CPS+EG score incorporates pretreatment clinical stage, oestrogen receptor status, nuclear grade and pathological stage after neoadjuvant chemotherapy. [b]Time from randomization to date of first treatment failure that is loco-regional or distant recurrence or new cancer or death from any cause for up to 10 years by STEEP system[3]

1. Tutt ANJ et al. *N Engl J Med*. 2021;384(25):2394−2405. **2.** Tutt ANJ et al. *N Engl J Med*. 2021;384(25):2394−2405. (Supplement).
3. Hudis CA. J Clin Oncol 2007;25:2127–32.

Primary Endpoint: Invasive Disease-Free Survival (Mature Cohort)



IDFS

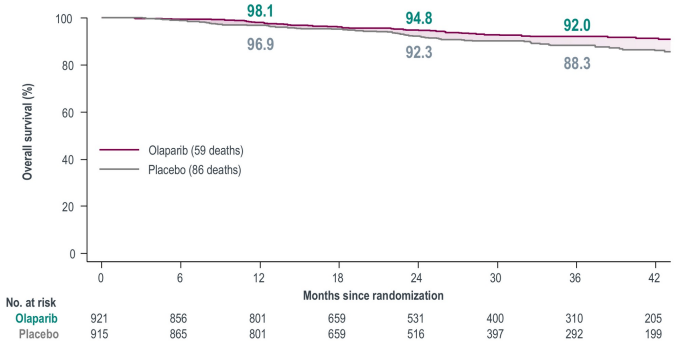
HR 0.61†
99.5% CI, 0.39–0.95

3-year IDFS rate*

Olaparib (n=449)	86.1%
Placebo (n=451)	77.5%

Difference 8.6%
95% CI, 3.3–13.9

Secondary Endpoint: Overall Survival



OS

HR 0.68†
99% CI 0.44–1.05
p=0.02

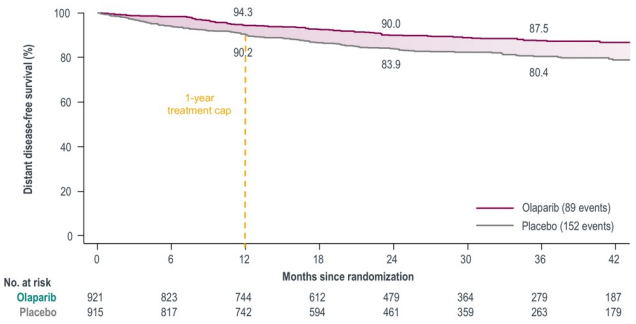
3-year OS rate

Olaparib (n=921)	92.0%
Placebo (n=915)	88.3%

Difference 3.7%
95% CI 0.3–7.1

Difference in OS did not achieve the threshold for statistical significance in the pre-specified multiple testing procedure

Secondary Endpoint: Distant Disease-Free Survival



DDFS

HR 0.57†
99.5% CI, 0.39–0.83
P<0.001

3-year DDFS rate

Olaparib (n=921)	87.5%
Placebo (n=915)	80.4%

Difference 7.1%
95% CI, 3.0–11.1

*Non-proportional hazards; 99.5% CI is shown for the HR for DDFS because p<0.005 was required to indicate statistical significance for this endpoint.

Tutt ANJ et al. *N Engl J Med*. 2021;384(25):2394–2405.

EMBRACA: Phase III Trial Design

Eligibility (N = 431)

Patients with locally advanced or metastatic HER2-negative breast cancer and a germline BRCA1 or BRCA2 mutation

Stratification factors:

- Number of prior chemo regimens (0 or ≥1)
- TNBC or hormone receptor positive (HR+)
- History of CNS mets or no CNS mets

2:1

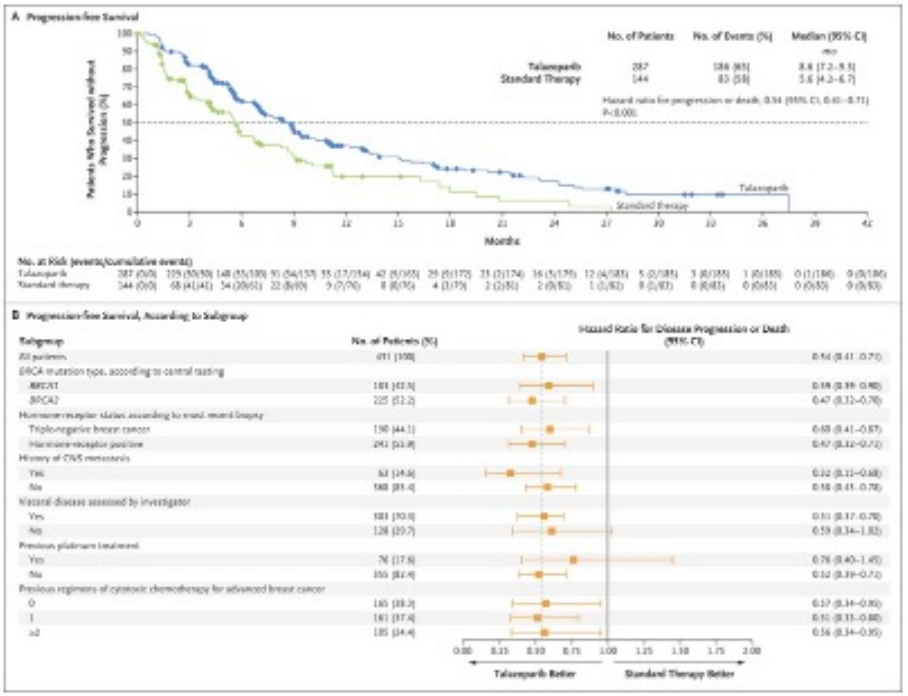
R

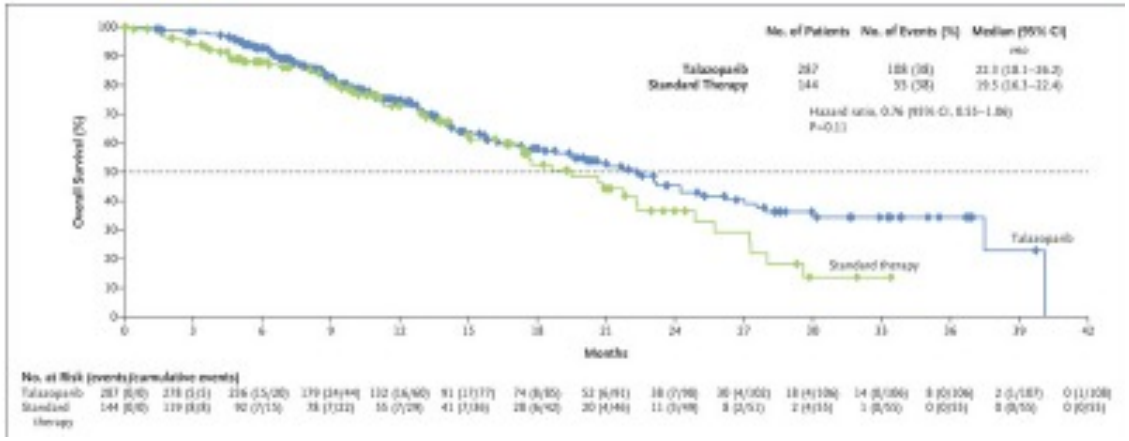
Talazoparib 1 mg PO daily (n = 287)

Treatment (21-day cycles) continues until progression or unacceptable toxicity

Physician's choice of therapy (PCT): capecitabine, eribulin, gemcitabine or vinorelbine (n = 144)

Litton JK et al. *N Engl J Med* 2018;379(8):753-63; Litton J et al. San Antonio Breast Cancer Symposium 2017;Abstract GS6-07.



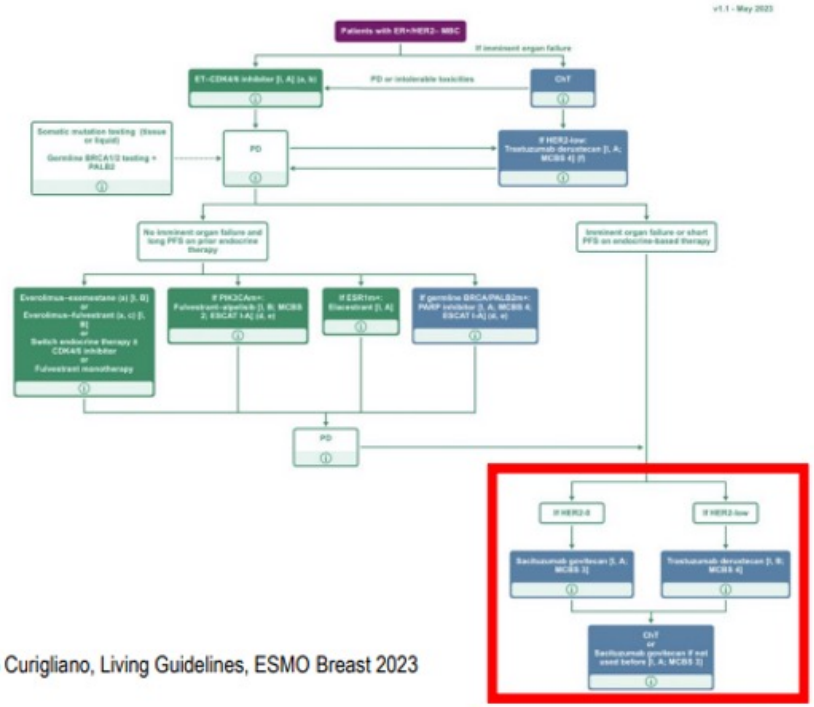


What about ADCs in ER + disease?

HR+/HER2- Metastatic Breast Cancer

Antibody drug-conjugates
in HR+/HER2- mBC

Trastuzumab deruxtecan and **Sacituzumab govitecan** are two ADCs, approved by FDA and EMA for patients with **endocrine-resistant** HR+/HER2- mBC



G Curigliano, Living Guidelines, ESMO Breast 2023

MADRID 2023 ESMO congress

DESTINY-Breast04 Study Design:
An open-label, multicenter study (NCT03734029)[1-3]

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

R 2:1

T-DXd
5.4 mg/kg Q3W
(n = 373)

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

Stratification factors
- Centrally assessed HER2 status[b] (IHC 1+ vs IHC 2+/ISH−)
- 1 vs 2 prior lines of chemotherapy
- HR+ (with vs without prior treatment with CDK4/6i) vs HR−

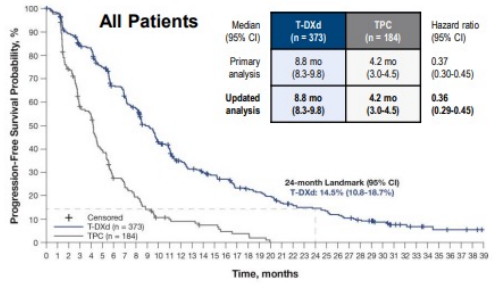
Primary endpoint
- PFS by BICR (HR+)

Key secondary endpoints[d]
- PFS by BICR (all patients)
- **OS (HR+ and all patients)**

Secondary endpoints[d]
- **PFS by investigator**
- ORR by BICR and investigator
- DOR by BICR
- **Safety**
- Patient-reported outcomes (HR+)[e]

At the updated data cutoff (March 1, 2023), median follow-up was 32.0 months (95% CI, 31.0-32.8 months)

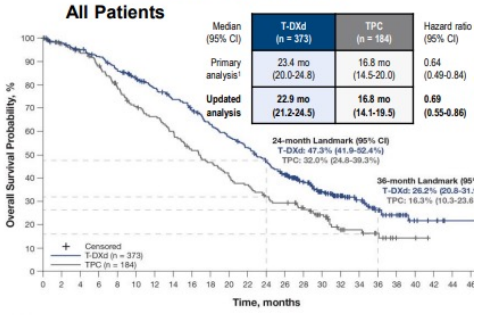
Progression-Free Survival



	Median (95% CI) T-DXd (n = 373)	TPC (n = 184)	Hazard ratio (95% CI)
Primary analysis	8.8 mo (8.3-9.8)	4.2 mo (3.0-4.5)	0.37 (0.30-0.45)
Updated analysis	8.8 mo (8.3-9.8)	4.2 mo (3.0-4.5)	0.36 (0.29-0.45)

nts still at risk:
T-DXd (n = 373)
TPC (n = 184)

Overall Survival



	Median (95% CI) T-DXd (n = 373)	TPC (n = 184)	Hazard ratio (95% CI)
Primary analysis[1]	23.4 mo (20.0-24.8)	16.8 mo (14.5-20.0)	0.64 (0.49-0.84)
Updated analysis	22.9 mo (21.2-24.5)	16.8 mo (14.1-19.5)	0.69 (0.55-0.86)

Patients still at risk:
T-DXd (n = 373)
TPC (n = 184)

Results from the 32-month median follow-up for DESTINY-Breast04 confirm the sustained clinically meaningful improvement for T-DXd vs TPC previously demonstrated in HER2-low (IHC 1+, IHC 2+/ISH−) mBC, regardless of HR status

HR, hormone receptor; mo, month; OS, overall survival; T-DXd, trastuzumab deruxtecan; TPC, treatment of physician's choice.

1. Modi S et al. *N Engl J Med*. 2022;387:9-20.

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Overall Safety Summary

- Exposure-adjusted incidence rates for any-grade TEAEs were 1.2 and 2.6 per patient-year for the T-DXd and TPC arms, respectively
  - This supports that **longer T-DXd exposure does not increase toxicity**
- Overall, the safety profile is consistent with results from the primary analysis (data cutoff, January 11, 2022)
  - **Rates of ILD/pneumonitis remained unchanged with longer follow-up**, and rates of left ventricular dysfunction were consistent with previously observed rates

	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Any Grade
ILD/pneumonitis (adjudicated, drug-related), n (%)						
T-DXd (n = 371)	13 (3.5)	24 (6.5)	4 (1.1)[a]	0	4 (1.1)[a]	45 (12.1)
TPC (n = 172)	1 (0.6)	0	0	0	0	1 (0.6)
Left ventricular dysfunction						
Ejection fraction decreased, n (%)						
T-DXd (n = 371)	2 (0.5)	15 (4.0)	1 (0.3)	0	0	18 (4.9)
TPC (n = 172)	0	0	0	0	0	0

Safety analysis set[a]

n (%)	T-DXd (n = 371)	TPC (n = 172)
TEAEs	369 (99.5)	169 (98.3)
Grade ≥3	202 (54.4)	116 (67.4)
Serious TEAEs	108 (29.1)	44 (25.6)
TEAEs associated with dose discontinuation	62 (16.7)	14 (8.1)
TEAEs associated with dose interruptions	155 (41.8)	73 (42.4)
TEAEs associated with dose reductions	89 (24.0)	65 (37.8)
TEAEs associated with deaths	15 (4.0)	5 (2.9)
Total on-treatment deaths[b]	14 (3.8)	8 (4.7)

ILD, interstitial lung disease; T-DXd, trastuzumab deruxtecan; TEAE, treatment-emergent adverse event; TPC, treatment of physician's choice.
[a]Safety analyses were performed in patients who received ≥1 dose of a study regimen. [b]On-treatment death is defined as death that occurred any time from date of first dose through 47 days after the last dose of the study treatment.

1. Modi S et al. *N Engl J Med*. 2022;387:9-20.

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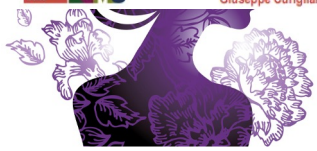


TROPION-Breast01 Study Design[1]

Randomised, phase 3, open-label, global study (NCT05104866)

Key inclusion criteria

Patients with HR+/HER2– breast cancer* (HER2– defined as IHC 0/1+/2+; ISH negative)

Previously treated with 1–2 lines of chemotherapy (inoperable/metastatic setting)

Experienced progression on ET and for whom ET was unsuitable

ECOG PS 0 or 1

1:1

Dato-DXd
6 mg/kg IV Day 1 Q3W
(n=365)

ICC
Q3W as per protocol directions† (eribulin mesylate, vinorelbine, capecitabine, or gemcitabine)
(n=367)

Endpoints:

- **Dual primary:** PFS by BICR per RECIST v1.1, and OS
- **Key secondary:** ORR, PFS (investigator assessed) and safety

Randomisation stratified by:

- **Lines of chemotherapy** in unresectable/metastatic setting (1 vs 2)
- **Geographic location** (US/Canada/Europe vs ROW)
- **Previous CDK4/6 inhibitor** (yes vs no)

- Treatment continued until investigator-assessed PD (RECIST v1.1), unacceptable tolerability, or other discontinuation criteria
- At this data cut-off, the criteria for performing the primary PFS analysis were met (~419 events)

*Per American Society of Clinical Oncology/College of American Pathologists (ASCO/CAP) guidelines. †ICC was administered as follows: eribulin mesylate, 1.4 mg/m² IV on Days 1 and 8, Q3W; capecitabine, 1000 or 1250 mg/m² orally twice daily on Days 1 to 14, Q3W (dose per standard institutional practice); vinorelbine, 25 mg/m² IV on Days 1 and 8, Q3W; or gemcitabine, 1000 mg/m² IV on Days 1 and 8, Q3W.
BICR, blinded independent central review; CDK4/6, cyclin-dependent kinase 4/6; ECOG PS, Eastern Cooperative Oncology Group performance status; ET, endocrine therapy; HR, hazard ratio; ICC, investigator's choice of chemotherapy; IV, intravenous; ORR, objective response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; RECIST, Response Evaluation Criteria in Solid Tumors; Q3W, every 3 weeks; ROW, rest of world.

1. Bardia A, et al. *Future Oncol* 2023; doi: 10.2217/fon-2023-0188.

Demographics and Baseline Characteristics

		Dato-DXd (n=365)	ICC (n=367)
Age, median (range), years		56 (29–86)	54 (28–86)
Female, n (%)		360 (99)	363 (99)
Race, n (%)	Black or African American / Asian / White / Other*	4 (1) / 146 (40) / 180 (49) / 35 (10)	7 (2) / 152 (41) / 170 (46) / 38 (10)
Ethnicity, n (%)	Hispanic or Latino / Not Hispanic or Latino†	40 (11) / 322 (88)	43 (12) / 318 (87)
Prior lines of chemotherapy, n (%)	1 / 2‡	**229 (63)** / 135 (37)	225 (61) / 141 (38)
Prior CDK4/6 inhibitor, n (%)	Yes / No	**299 (82)** / 66 (18)	286 (78) / 81 (22)
Prior taxane and/or anthracycline, n (%)	Taxane alone	80 (22)	71 (19)
	Anthracycline alone	14 (4)	21 (6)
	Both	**236 (65)**	247 (67)
	Neither	35 (10)	28 (8)

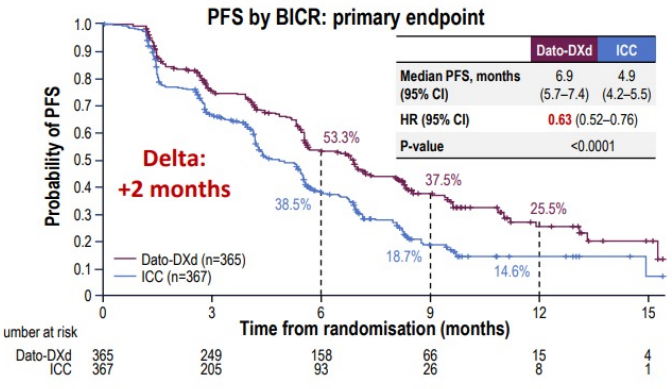
Data cut-off: 17 July 2023. *Including not reported. †Ethnicity missing: 3 patients in Dato-DXd group; 6 patients in ICC group. ‡1 patient in the Dato-DXd group had 3 prior lines of chemotherapy; 1 patient in the ICC group had 4 prior lines.

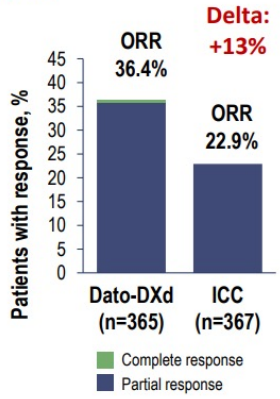
Patient Disposition

Disposition	Dato-DXd (n=360)	ICC (n=351)
Treatment status, n (%)		
Ongoing on study treatment	93 (26)	39 (11)
Discontinued from study treatment	267 (74)	312 (89)
Treatment duration, n (%)		
0–3 months	83 (23)	133 (38)
3–9 months	187 (52)	173 (49)
>9 months	90 (25)	45 (13)
Primary reason for treatment discontinuation, n (%)		
Adverse event	**11 (3)**	**10 (3)**
Progressive disease	229 (64)	240 (68)
Patient decision	13 (4)	32 (9)
Death	2 (1)	7 (2)
Other	12 (3)	23 (7)

- Median study follow-up: **10.8 months**
- Investigator's choice of chemotherapy:
  - **Eribulin mesylate: n=220**
  - Vinorelbine: n=38
  - **Capecitabine: n=76**
  - Gemcitabine: n=33

Progression-Free Survival and Response Rate



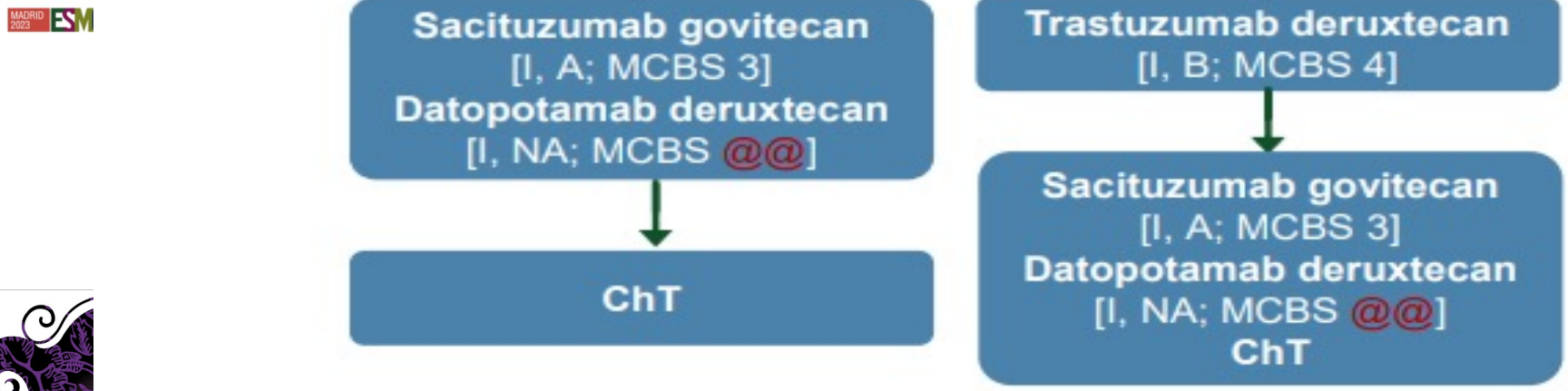


OS data were not mature: a trend favouring Dato-DXd was observed, HR 0.84 (95% CI 0.62–1.14)

TRAEs Occurring in >15% of Patients

System Org Preferred	
Blood and l	
Anaemia	
Neutroper	
Eye disorde	
Dry eye	
Gastrointes	
Nausea	
Stomatiti	
Vomiting	
Constipati	
General dis	
Fatigue	
Skin and su	
Alopecia	

*Includes the preferred t



ty

-DXd 360)	ICC (n=351)
(94)	303 (86)
(21)	157 (45)
(21)	106 (30)
(12)	86 (25)
(3)	9 (3)
0	1 (0.3)
1 (6)	32 (9)
Grade ≥3	17 (5) 31 (8)
Grade 3†	1 (0.3) 0

Data cut-off: 17 July 2023.

What about SERD in ER + disease?

FALCON: a Phase 3, randomised, double-blind, double-dummy international trial (NCT01602380)

Patients with hormone receptor-positive/HER2-negative* locally advanced or metastatic BC

- **Post-menopausal women**
- Endocrine therapy-naïve
- One or more measurable or non-measurable lesions
- No life-threatening, metastatic visceral disease
- No prior systemic therapy for BC, **except for one line of cytotoxic chemotherapy**

Stratification factors

- Locally advanced or metastatic BC
- Previous or no previous treatment with chemotherapy for locally advanced or metastatic BC
- Measurable or non-measurable disease

R 1:1 (N=462)

- **Fulvestrant** — 500 mg, once daily on days 0, 14, 28, and every 28 days thereafter
- **Anastrozole** — 1 mg once daily

The primary endpoint of PFS with fulvestrant vs anastrozole was met[1]

Sub-groups reported:

- Improved PFS in patients with non-visceral disease
- No improvement in patients with visceral disease

1. Robertson JFR et al. *Lancet* 2016;388:2997–3005.

Secondary endpoints (this presentation)

- **OS with fulvestrant vs anastrozole**†
  - Final analysis at 65% maturity and ≥8 years since the last patient was enrolled
  - Data cut-off: 11 July 2022
  - One-sided α for the final OS = 0.01845

†**The FALCON study was not formally powered to detect an OS benefit, and this analysis should be regarded as descriptive with nominal *P* values.**

*Patients with HER2 overexpression or gene amplification, i.e., IHC 3-positive or FISH-positive, where appropriate, were excluded. One patient in the anastrozole arm had hormone receptor-positive/HER2-positive BC.
BC, breast cancer; HER2, human epidermal growth factor receptor 2; FISH, fluorescence *in situ* hybridisation; IHC, immunohistochemistry; OS, overall survival; PFS, progression-free survival; R, randomised.

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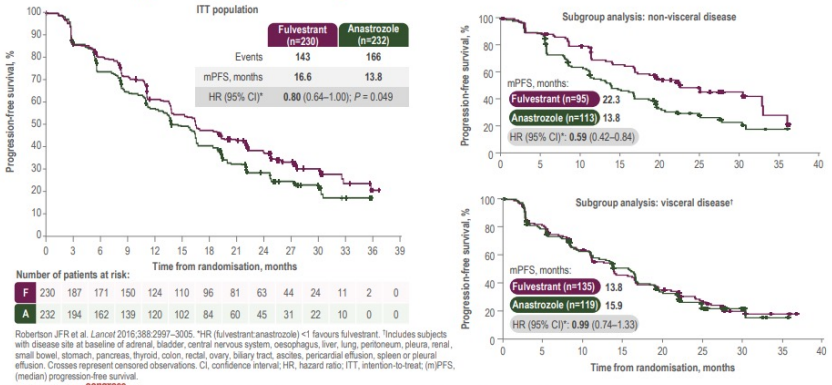
Giuseppe Curigliano, MD PhD

FALCON primary efficacy results: PFS



Robertson JFR et al. *Lancet* 2016;388:2997–3005. *HR (fulvestrant:anastrozole) <1 favours fulvestrant. †Includes subjects with disease site at baseline of adrenal, bladder, central nervous system, oesophagus, liver, lung, peritoneum, pleura, renal, small bowel, stomach, pancreas, thyroid, colon, rectal, ovary, biliary tract, ascites, pericardial effusion, spleen or pleural effusion. Crosses represent censored observations. CI, confidence interval; HR, hazard ratio; ITT, intention-to-treat; (m)PFS, (median) progression-free survival.

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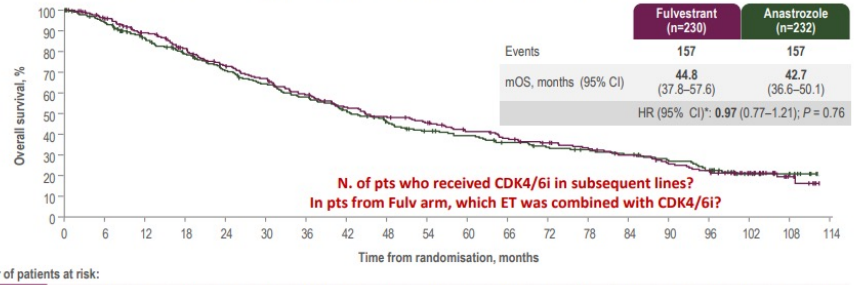
OS in the ITT population (data cut-off 11 July 2022)

The final analysis demonstrated no significant differences in OS between fulvestrant and anastrozole



Number of patients at risk:

Fulvestrant	230	211	190	170	149	137	120	106	96	89	77	70	63	57	50	41	36	24	8	0
Anastrozole	232	214	187	166	146	131	118	104	89	77	71	63	58	53	48	42	35	19	9	0

*HR (fulvestrant:anastrozole) <1 favours fulvestrant. Median follow-up was 37.5 months in the fulvestrant arm and 36.5 months in the anastrozole arm. Crosses represent censored observations.
CI, confidence interval; HR, hazard ratio; ITT, intention-to-treat; (m)OS, (median) overall survival.

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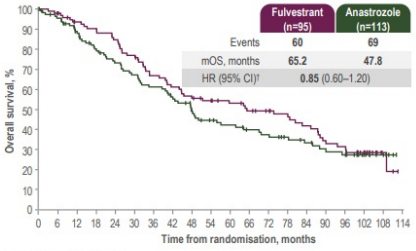
OS in patients with non-visceral and visceral disease

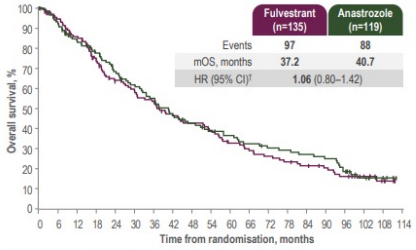
Among patients with **non-visceral disease**, a 15% reduction in risk of death was observed with fulvestrant vs anastrozole



Number of patients at risk:

F	95	92	84	81	76	69	59	54	49	46	42	38	35	32	28	22	21	13	3	0
A	113	104	92	81	73	67	61	55	46	39	36	32	30	26	23	19	18	10	4	0

Among patients with **visceral disease***, OS was comparable between patients who received fulvestrant vs anastrozole



Number of patients at risk:

F	135	119	106	89	73	68	61	52	47	43	35	32	28	25	22	19	15	11	5	0
A	119	110	95	85	73	64	57	49	43	38	35	31	28	27	25	23	17	9	5	0

A trend in favour of OS benefit with fulvestrant was seen in patients with non-visceral vs visceral disease

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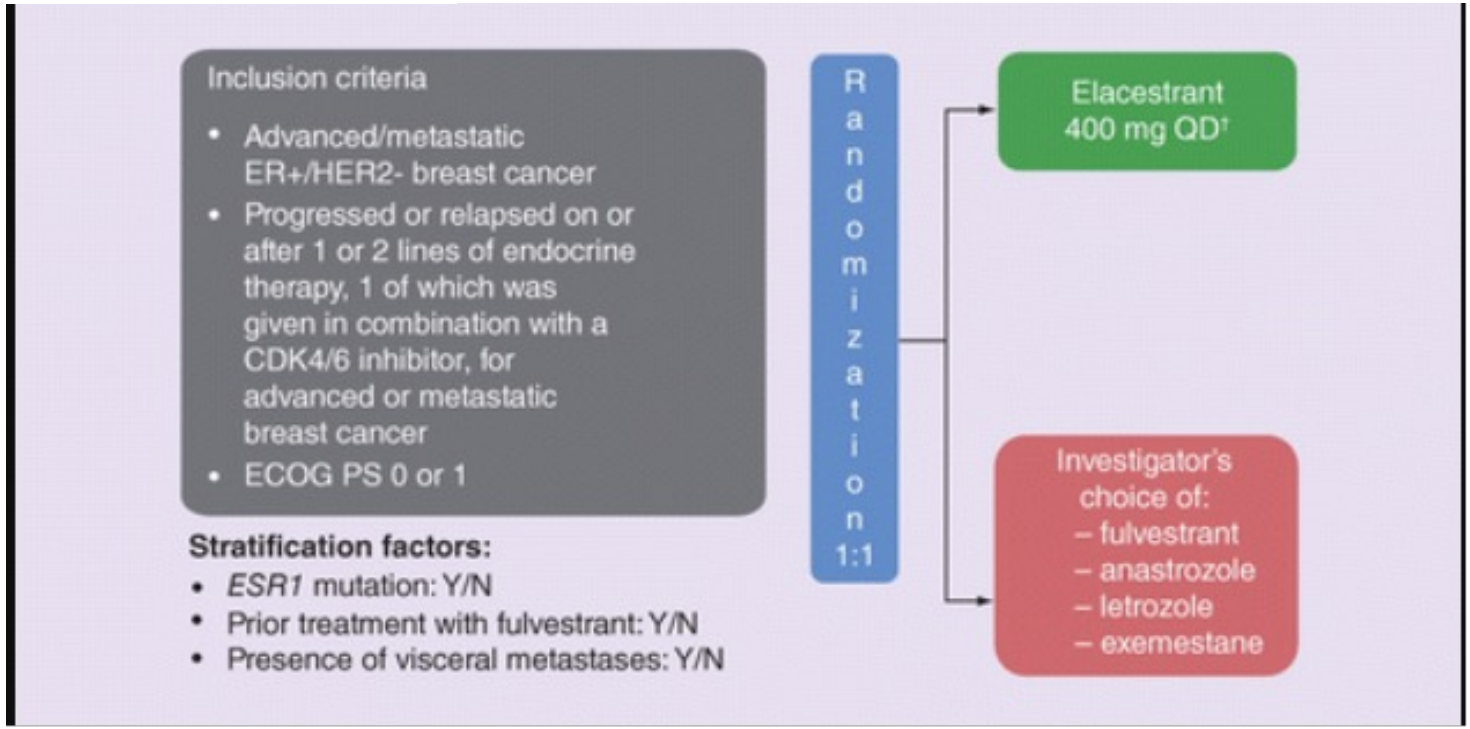
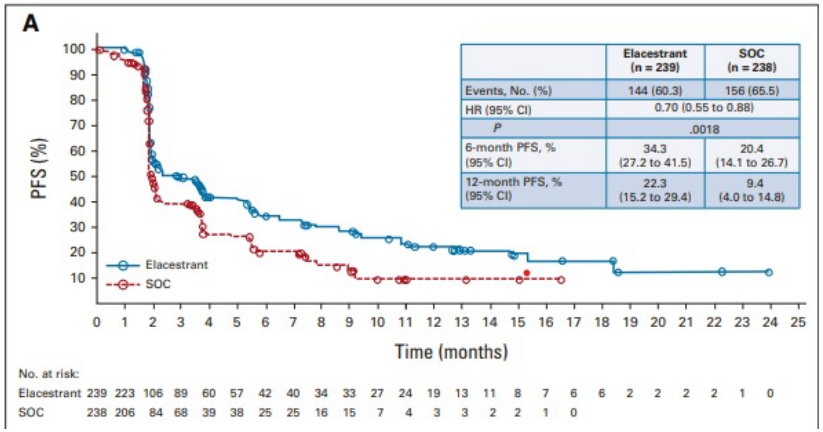
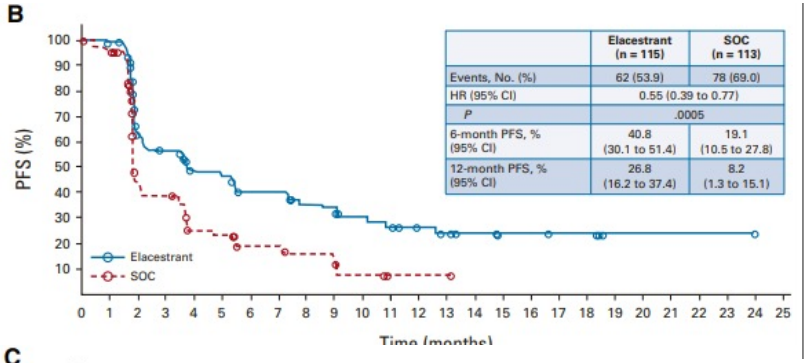
Elacestrant (oral selective estrogen receptor degrader) Versus Standard Endocrine Therapy for Estrogen Receptor–Positive, Human Epidermal Growth Factor Receptor 2–Negative Advanced Breast Cancer: Results From the Randomized Phase III EMERALD Trial

Francois-Clement Bidard, MD[1,2]; Virginia G. Kaklamani, MD[3]; Patrick Neven, MD[4]; Guillermo Streich, MD[5]; Alberto J. Montero, MD[6]; Frédéric Forget, MD[7]; Marie-Ange Mouret-Reynier, MD[8]; Joo Hyuk Sohn, MD[9]; Donatienne Taylor, MD[10]; Kathleen K. Harnden, MD[11]; Hung Khong, MD[12]; Judit Kocsis, MD[13]; Florence Dalenc, MD[14]; Patrick M. Dillon, MD[15]; Sunil Babu, MD[16]; Simon Waters, MD[17]; Ines Deleu, MD[18]; José A. García Sáenz, MD[19]; Emilio Bria, MD[20]; Marina Cazzaniga, MD[21]; Janice Lu, MD[22]; Philippe Aftimos, MD[23]; Javier Cortés, MD[24,25,26,27]; Shubin Liu, MS[28]; Giulia Tonini, PhD[29]; Dirk Laurent, MD[30]; Nassir Habboubi, MD[31]; Maureen G. Conlan, MD[32]; and Aditya Bardia, MD[33]

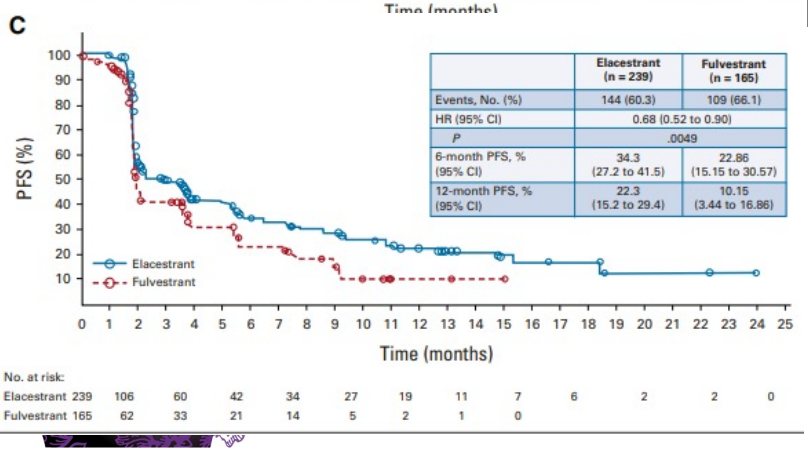




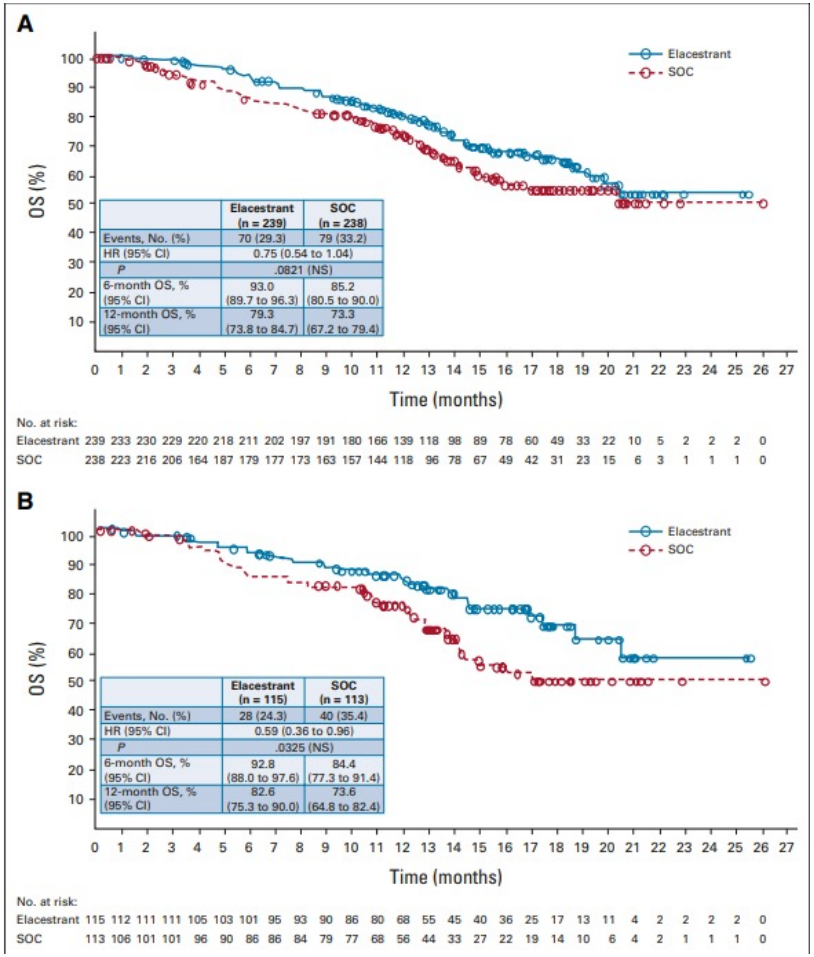
	Elacestrant (n = 239)	SOC (n = 238)
Events, No. (%)	144 (60.3)	156 (65.5)
HR (95% CI)	0.70 (0.55 to 0.88)	
P	.0018	
6-month PFS, % (95% CI)	34.3 (27.2 to 41.5)	20.4 (14.1 to 26.7)
12-month PFS, % (95% CI)	22.3 (15.2 to 29.4)	9.4 (4.0 to 14.8)



	Elacestrant (n = 115)	SOC (n = 113)
Events, No. (%)	62 (53.9)	78 (69.0)
HR (95% CI)	0.55 (0.39 to 0.77)	
P	.0005	
6-month PFS, % (95% CI)	40.8 (30.1 to 51.4)	19.1 (10.5 to 27.8)
12-month PFS, % (95% CI)	26.8 (16.2 to 37.4)	8.2 (1.3 to 15.1)



	Elacestrant (n = 239)	Fulvestrant (n = 165)
Events, No. (%)	144 (60.3)	109 (66.1)
HR (95% CI)	0.68 (0.52 to 0.90)	
P	.0049	
6-month PFS, % (95% CI)	34.3 (27.2 to 41.5)	22.86 (15.15 to 30.57)
12-month PFS, % (95% CI)	22.3 (15.2 to 29.4)	10.15 (3.44 to 16.86)



	Elacestrant (n = 239)	SOC (n = 238)
Events, No. (%)	70 (29.3)	79 (33.2)
HR (95% CI)	0.75 (0.54 to 1.04)	
P	.0821 (NS)	
6-month OS, % (95% CI)	93.0 (89.7 to 96.3)	85.2 (80.5 to 90.0)
12-month OS, % (95% CI)	79.3 (73.8 to 84.7)	73.3 (67.2 to 79.4)

	Elacestrant (n = 115)	SOC (n = 113)
Events, No. (%)	28 (24.3)	40 (35.4)
HR (95% CI)	0.59 (0.36 to 0.96)	
P	.0325 (NS)	
6-month OS, % (95% CI)	92.8 (88.0 to 97.6)	84.4 (77.3 to 91.4)
12-month OS, % (95% CI)	82.6 (75.3 to 90.0)	73.6 (64.8 to 82.4)


GRAZIE PER L’ATTENZIONE!