PS1-08-28

The Use of Oral Selective Estrogen Receptor Degraders (SERDs) by Community-Based General Medical Oncologists (GMOs) in ER-Positive (ER+), HER2-Negative (HER2-neg) Metastatic Breast Cancer (mBC): A Clinician Survey of Practice Patterns and Practical Challenges

Kevin H Pang, PharmD[1], Kathryn A Ziel, PhD[1], Doug Paley[1], Kirsten Miller[1], Seth A Wander, MD, PhD[2], Maxwell R Lloyd, MD[3], Neil Love, MD[1]

[1]Research To Practice, Key Biscayne, Florida. [2]Massachusetts General Hospital, Boston, Massachusetts. [3]Beth Israel Deaconess Medical Center, Boston, Massachusetts.

BACKGROUND:

The rapid pace of cancer research has created a challenging environment in which GMOs are constantly contending with the introduction of multiple novel agents and regimens often indicated for identical or overlapping patient populations. The January 2023 approval of elacestrant (E) for patients with mBC and an ESR1 mutation (ESR1mut) whose disease progresses on endocrine therapy (ET) introduced new treatment considerations into a clinical situation that already had multiple approved therapeutic options. Since that time, several more Phase III reports — including numerous potentially practice-changing trials with novel SERD-based strategies — have added complexity to this space. This initiative sought to better understand GMOs' familiarity with relevant research and their current and potential use of oral SERDs.

METHODS:

In September 2025, 50 US-based GMOs completed a case-based survey on the management of ER+ HER2-neg ESR1mut mBC. For each case, clinical factors (age, sites/extent of metastases, symptom burden, duration of benefit with first-line treatment, PIK3CA mutation status) were varied. The survey also asked GMOs to rate their level of familiarity with and interest in learning more about 12 Phase III trials applicable to the clinical care of patients with ER+ mBC. A modest honorarium was offered.

RESULTS:

In general, GMOs self-reported familiarity with the 12 trials, with a mean overall rating of 3.7 out of 5. They were also very interested in learning more about these studies, with a mean overall rating of 4.5 out of 5 **(Figure 1)**. In terms of selection of therapy, for a 65-year-old patient with ESR1mut disease, progression 2.5 years after starting first-line CDK4/6 inhibitor (CDKi)/aromatase inhibitor (AI) and minimally symptomatic bone-only mets, 84% of GMOs recommend E **(Figure 2)**. For the same patient with symptomatic visceral mets, 62% would deploy the SERD **(Figure 3)**. For the same patient but with a coexisting PIK3CA mutation, E was selected by 36% of GMOs in cases with bone mets **(Figure 4)** and by 30% for symptomatic visceral disease **(Figure 5)**. Other factors, including age (80 y) and shorter duration on CDKi/AI (10 mo), did not substantially affect treatment preferences across various situations. In terms of actual experience, GMOs reported using E a median of 4 times.

Regarding select other oral SERDs (imlunestrant, camizestrant, giredestrant), 46% of GMOs believe data are not sufficient to determine comparative efficacy **(Figure 6)**. However, 68% consider imlunestrant clinically equivalent whenever E is currently employed **(Figure 7)**. In addition, 60% of GMOs would consider using imlunestrant with abemaciclib in select situations in the first-line setting, and 72% would consider using the combination in select situations in the second-line or later setting **(Figure 8)**. A majority (68%) of GMOs currently would utilize serial monitoring for ESR1mut during first-line treatment and early switching to a SERD (camizestrant) for patients with "molecular progression" ahead of overt clinical progression, as in SERENA-6 **(Figure 9)**.

CONCLUSIONS:

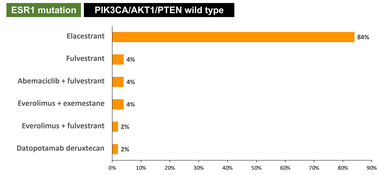
While GMOs are generally familiar with key datasets, they are also highly motivated to learn more. GMOs have rapidly incorporated E into the management of progressive ER+ HER2-neg ESR1mut mBC. Similarities and differences in practice patterns were observed between GMOs and breast cancer research leaders (data available separately) for a number of clinical situations surveyed. In terms of novel SERDs, many GMOs consider the newly approved imlunestrant equivalent to E and would consider using it with abemaciclib in certain circumstances. Many GMOs would use camizestrant for patients found to have an ESR1mut without clinical disease progression, a perspective not shared by the majority of research leaders. This and other differences should be further studied to better understand what is driving the thoughts and recommendations of these different groups of clinicians.

1 FAMILIARITY WITH AND INTEREST IN SELECT CLINICAL TRIALS IN HR-POSITIVE ADVANCED BREAST CANCER

Clinical Trial	Mean Score for Familiarity	Mean Score for Interest
EMERALD (elacestrant vs SOC ET)	4.00	4.42
SERENA-6 (switch to camizestrant + CDKi vs continuing SOC CDKi + AI)	3.74	4.66
EMBER-3 (imlunestrant ± abemaciclib or SOC ET)	3.44	4.60
SOLAR-1 (alpelisib + fulvestrant vs fulvestrant)	3.84	4.12
CAPItello-291 (capivasertib + fulvestrant vs fulvestrant)	4.00	4.48
INAVO120 (inavolisib + palbociclib + fulvestrant vs palbociclib + fulvestrant)	3.70	4.60
DESTINY-Breast04 (trastuzumab deruxtecan vs chemotherapy after prior chemotherapy)	4.20	4.34
DESTINY-Breast06 (trastuzumab deruxtecan vs chemotherapy after prior ET)	4.12	4.38
TROPION-Breast01 (datopotamab deruxtecan vs chemotherapy)	3.60	4.56
TROPICS-02 (sacituzumab govitecan vs chemotherapy)	3.88	4.22
PATINA (maintenance palbociclib + anti-HER2 therapy + ET vs anti-HER2 therapy + ET)	3.58	4.58
VERITAC-2 (vepdegestrant vs fulvestrant)	2.50	4.52
Overall Score	**3.72**	**4.46**

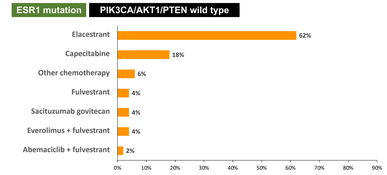
2 SECOND-LINE THERAPY FOR ESR1-MUTANT, PIK3CA WILD-TYPE MBC WITH BONE METASTASES

A 65-year-old woman (PS 0) with ER-positive, HER2-negative (IHC 0/null) de novo mBC receives ribociclib + letrozole for 2.5 years followed by disease progression with multiple minimally symptomatic bone metastases



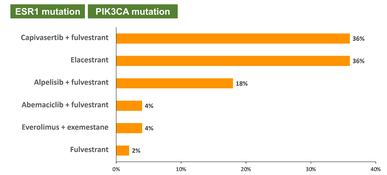
3 SECOND-LINE THERAPY FOR ESR1-MUTANT, PIK3CA WILD-TYPE MBC WITH VISCERAL METASTASES

A 65-year-old woman (PS 0) with ER-positive, HER2-negative (IHC 0/null) de novo mBC receives ribociclib + letrozole for 2.5 years followed by disease progression with multiple symptomatic visceral metastases and normal LFTs



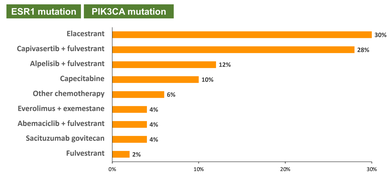
4 SECOND-LINE THERAPY FOR ESR1-MUTANT, PIK3CA-MUTANT MBC WITH BONE METASTASES

A 65-year-old woman (PS 0) with ER-positive, HER2-negative (IHC 0/null) de novo mBC receives ribociclib + letrozole for 2.5 years followed by disease progression with multiple minimally symptomatic bone metastases



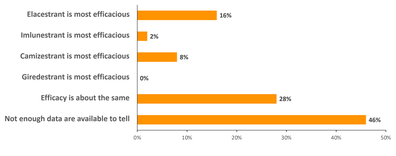
5 SECOND-LINE THERAPY FOR ESR1-MUTANT, PIK3CA-MUTANT MBC WITH VISCERAL METASTASES

A 65-year-old woman (PS 0) with ER-positive, HER2-negative (IHC 0/null) de novo mBC receives ribociclib + letrozole for 2.5 years followed by disease progression with multiple symptomatic visceral metastases and normal LFTs



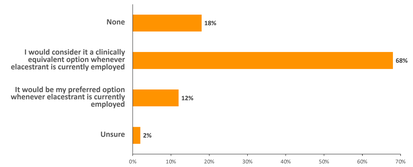
6 COMPARATIVE EFFICACY OF AVAILABLE AND INVESTIGATIONAL ORAL SERDS

Based on published research data and your own clinical experience, how would you indirectly compare the global efficacy of elacestrant, imlunestrant, camizestrant and giredestrant when administered as monotherapy for endocrine therapy-pretreated ER-positive, HER2-negative mBC with an ESR1 mutation?



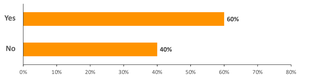
7 POTENTIAL CLINICAL ROLE OF IMLUNESTRANT MONOTHERAPY

If imlunestrant were available, in which situations, if any, would you use this agent as monotherapy?

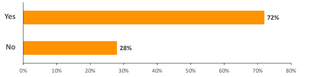


8 POTENTIAL CLINICAL ROLE OF IMLUNESTRANT/ABEMACICLIB

Regulatory and reimbursement issues aside, are there situations in which you would employ the combination of imlunestrant/abemaciclib as first-line treatment for ER-positive, HER2-negative mBC?



Regulatory and reimbursement issues aside, are there situations in which you would employ the combination of imlunestrant/abemaciclib as second- or later-line treatment for ER-positive, HER2-negative mBC?



9 CURRENT ROLE OF SERIAL CTDNA MONITORING DURING FIRST-LINE THERAPY

Regulatory and reimbursement issues aside, do you believe that the results from the SERENA-6 study justify the routine use of serial ctDNA monitoring for early detection of ESR1 mutations in patients with ER-positive, HER2-negative mBC receiving first-line therapy?

