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Applications for Community Oncology

August 20, 2026

Integrated Nursing & Advanced Practice Providers Symposium

Key Oncology FDA Approvals in 2026

Edith A. Perez, MD

6

Breast cancer
(neoadjuvant, adjuvant, metastatic)

4

GU/GI cancers
(pancreatic, prostate, bladder, kidney)

5

Other solid tumors
(lung, ovarian, RET gene fusion)

4

Hematologic malignancies
(chronic lymphocytic leukemia, mantle cell lymphoma, multiple myeloma)

*Recognizing multiple additional FDA approvals occurred in 2025

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Key Clinical Trials, Patient Cases, and AE Management

Meredith Angele
PA-C

Zach Krueger
PA-C, MSPA

Key Clinical Trials and Patient Cases:

Antibody-Drug Conjugates in Breast Cancer and Associated Toxicities	• DESTINY-Breast11, 05, 09
	  ○ ***Patient case: Early-stage ENHERTU and ILD management***
	  ○ ***Patient case: ENHERTU + pertuzumab in metastatic disease***
	• TROPION-Breast02
	• ASCENT-03

Antibody-Drug Conjugate + Immunotherapy Combinations and Associated Toxicities	• ASCENT-04
	  ○ ***Patient case: Growth factor support with TRODELVY***
	• KEYNOTE-869/EV103
	• KEYNOTE-B15/EV304
	  ○ ***Patient case: Managing toxicities with EV + pembrolizumab***

Skin Toxicity With KRAS Inhibitors	• RASOLUTE-302 ○ ***Patient case: Rash management with daraxonrasib***

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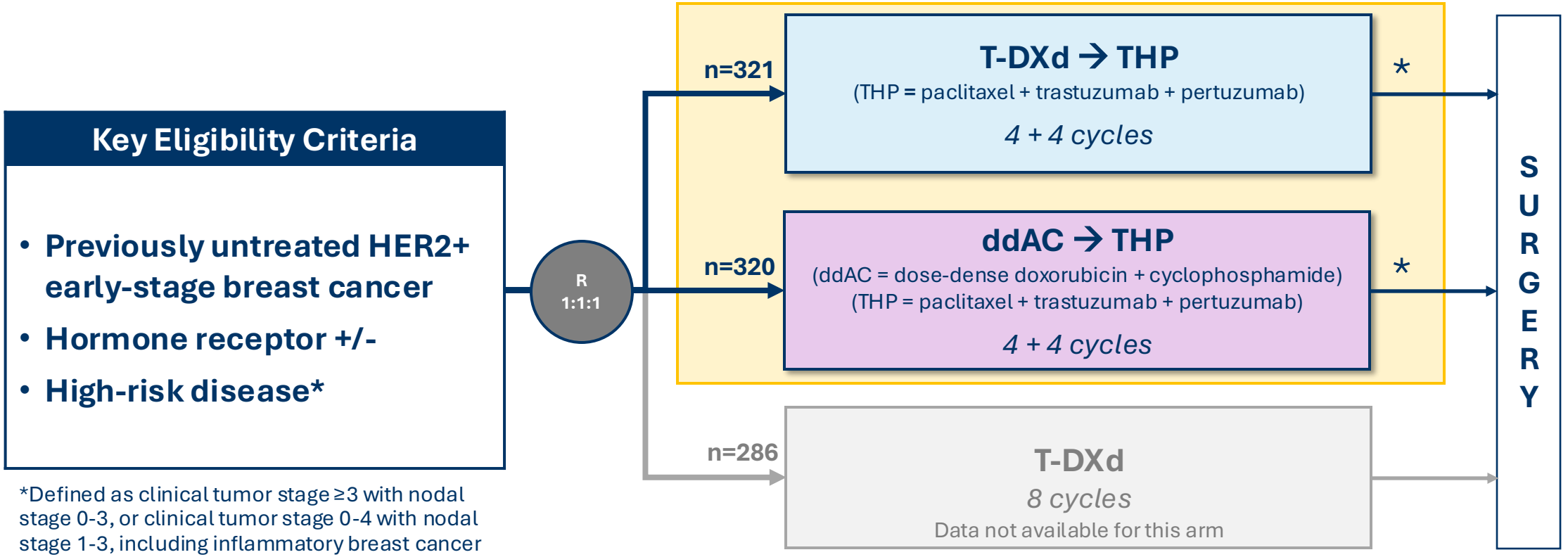
Breast Cancer

DESTINY-Breast11: Evaluating Neoadjuvant Fam-trastuzumab Deruxtecan (T-DXd) for High-risk, Early-stage HER2+ Breast Cancer

Study Design

Phase 3, open-label, randomized trial



*Defined as clinical tumor stage ≥3 with nodal stage 0-3, or clinical tumor stage 0-4 with nodal stage 1-3, including inflammatory breast cancer

Mechanism of action: T-DXd = HER2-directed antibody-drug conjugate (ADC)

***Primary endpoint:** Pathologic complete response†, T-DXd-THP vs ddAC-THP

†By BICR=Blinded Independent Central Review.

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1. Ann Oncol. 2026 Feb;37(2):166-179.2. ESMO 2025. Abstr 291O.

Breast Cancer

DESTINY-Breast11: Evaluating Neoadjuvant Fam-trastuzumab Deruxtecan (T-DXd) for High-risk, Early-stage HER2+ Breast Cancer

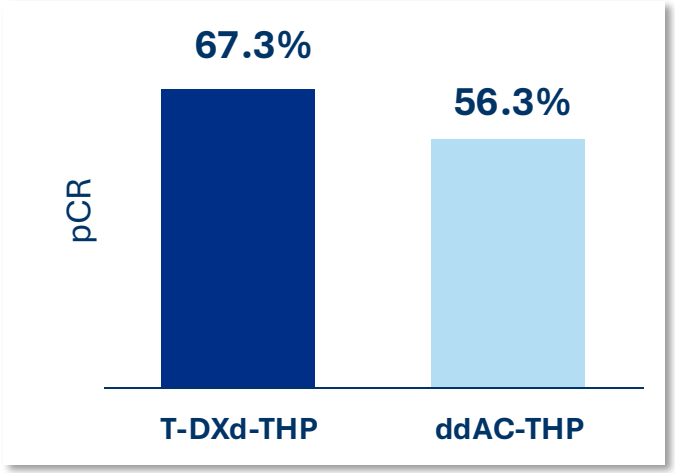
Key Efficacy of Neoadjuvant T-DXd → THP

Primary endpoint

11.2% difference in **pathologic complete response (pCR)** vs ddAC → THP

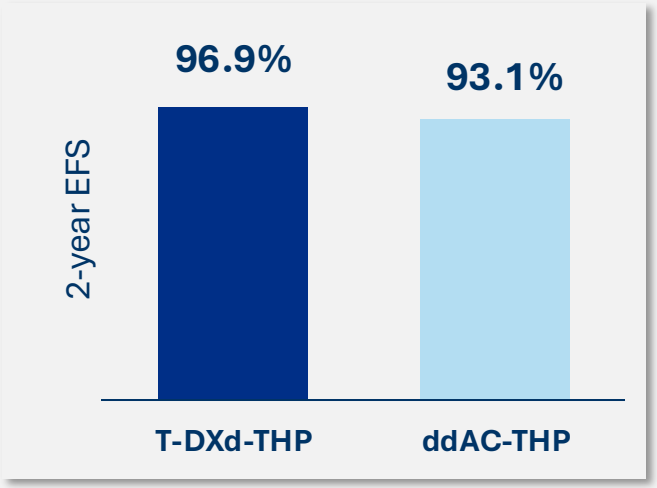
ddAC=dose-dense doxorubicin + cyclophosphamide;

THP=paclitaxel + trastuzumab + pertuzumab.



Key secondary endpoint

Early **positive trends** in **event-free survival (EFS)**, favoring T-DXd → THP



New Adverse Events (AEs) with T-DXd → THP

No new safety signals; T-DXd → THP vs ddAC → THP

- Lower rates of Grade ≥3 AEs (37.5% vs 55.8%) with T-DXd → THP
- Lower rates of hematological AEs, left ventricular dysfunction, and fatigue with T-DXd → THP
- Interstitial lung disease (ILD) and pneumonitis rates similar between arms (4.4% vs 5.1%)

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1. Ann Oncol. 2026 Feb;37(2):166-179.2. ESMO 2025. Abstr 291O.

Breast Cancer

DESTINY-Breast11: Evaluating Neoadjuvant Fam-trastuzumab Deruxtecan (T-DXd) for High-risk, Early-stage HER2+ Breast Cancer

Key Takeaways

1. **T-DXd followed by THP improved pathological complete response (pCR) before surgery vs ddAC-THP**
2. **Event-free survival not yet mature but showed a trend favoring T-DXd followed by THP vs ddAC-THP**
3. **FDA approved: May 15, 2026**

ddAC=dose-dense doxorubicin + cyclophosphamide;
THP=paclitaxel + trastuzumab + pertuzumab.

Key Considerations for Clinical Practice

- **T-DXd x4 → THP x4 should be a new standard of care for neoadjuvant treatment of high-risk HER2+ early breast cancer**
  - Clinically meaningful pCR benefit with reduced toxicity
- Rates of interstitial lung disease (ILD) similar for both arms
  - CT scanning consider at completion of T-DXd for early identification of ILD (Grade 1, asymptomatic); impact on management unclear after 4 cycles of T-DXd unclear
- Optimize supportive care with guideline-based antiemetic prophylaxis strategies

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1. Ann Oncol. 2026 Feb;37(2):166-179.2. ESMO 2025. Abstr 291O.

Breast Cancer

DESTINY-Breast05: Evaluating Post-Neoadjuvant Fam-trastuzumab Deruxtecan (T-DXd) for Residual HER2+ Early Breast Cancer

Study Design

Phase 3, open-label, randomized trial

Key Eligibility Criteria

- **Residual invasive disease in breast and/or axillary lymph nodes** after neoadjuvant chemo with HER2-directed neoadjuvant therapy
- **High risk of recurrence***
- **HER2+** (IHC 3+ or ISH+)

*Defined as inoperable early breast cancer, or operable with axillary node-positive disease after neoadjuvant therapy

R 1:1

n=818

T-DXd
5.4 mg/kg IV q3w
(x14 cycles, ~8 months)

n=817

T-DM1
3.6 mg/kg IV q3w
(x14 cycles, ~8 months)

Mechanism of action: T-DXd and T-DM1 = HER2-targeting antibody-drug conjugates (ADCs), different payloads

Primary endpoint: Invasive disease-free survival

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1. New Eng J Med 2026;394:845-857 2. ASCO 2026. Abstract 516.

Breast Cancer

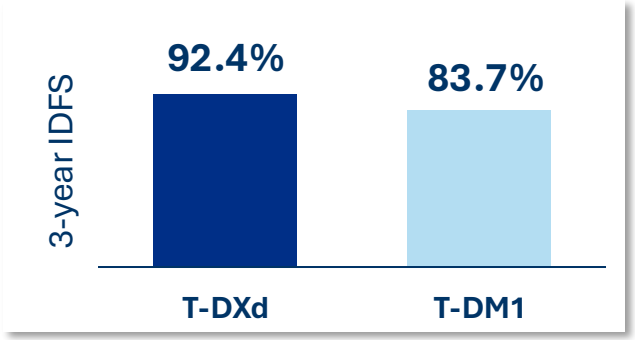
DESTINY-Breast05: Evaluating Post Neoadjuvant Fam-trastuzumab Deruxtecan (T-DXd) for Residual HER2+ Early Breast Cancer

Key Efficacy of Post-Neoadjuvant T-DXd

Primary endpoint

53% relative improvement in **invasive disease-free survival (IDFS)** vs T-DM1

8.7% absolute difference at 3 years



Key Adverse Event (AE) Findings

>72% of patients in each arm completed the planned 14 cycles of therapy

Most Common AEs with T-DXd

- Nausea: 71.3%
- Constipation: 32.0%
- Neutropenia: 31.6%
- Vomiting: 31.0%
- Interstitial lung disease: 9.6%

Most Common AEs with T-DM1

- Increased liver-enzyme levels: AST (50.2%) and ALT (45.3%)
- Thrombocytopenia: 49.8%
- Interstitial lung disease: 1.6%

Investigator-reported radiation pneumonitis (RP):

- Grade 1 or 2
- Similar with concurrent or sequential radiation therapy to antibody-drug conjugate therapy

ALT: alanine aminotransferase, AST: aspartate aminotransferase

1. New Eng J Med 2026;394:845-857 2. ASCO 2026. Abstract 516.

Breast Cancer

DESTINY-Breast05: Evaluating Post Neoadjuvant Fam-trastuzumab Deruxtecan (T-DXd) for Residual HER2+ Early Breast Cancer

Key Takeaways

1. **T-DXd significantly improved invasive disease-free survival after neoadjuvant chemotherapy versus T-DM1**
2. **T-DXd has an overall better efficacy / risk ratio compared to T-DM1 in the post-neoadjuvant HER2+ setting**
3. **FDA approved: May 15, 2026**

Key Considerations for Clinical Practice

- **T-DXd should be a new standard of care for post-neoadjuvant treatment of high-risk HER2+ early breast cancer**
- Timing of adjuvant radiation therapy did not impact incidence or severity of adjudicated drug-related interstitial lung disease
- 14 cycles of T-DXd: consider CT requirements to support early identification of interstitial lung disease and radiation pneumonitis
- Optimize supportive care with guideline-based antiemetic prophylaxis to manage T-DXd's emetogenic profile

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1. New Eng J Med 2026;394:845-857 2. ASCO 2026. Abstract 516.

Has your practice adopted T-DXd in the curative setting?

1. Yes, but in the neoadjuvant setting only
2. Yes, but in the post-neoadjuvant setting only
3. Yes, in both the neoadjuvant and post-neoadjuvant setting
4. No, not yet
5. Unsure

Patient Case Study

T-DXd in Early-Stage Breast Cancer

ILD Management

Real-World Patient Case Study:

Post Neoadjuvant T-DXd and Side Effect Management

Patient Profile and Diagnostic Journey

- 55-year-old woman
- Jan 2026: Diagnosed with Stage IIA ER+ / PR - / HER2+ breast cancer
- Received 6 cycles of neoadjuvant TCHP (docetaxel, carboplatin, trastuzumab, pertuzumab)
- Underwent bilateral total mastectomy with left sentinel lymph node biopsy
- Surgical pathology revealed:
  - Residual invasive ductal carcinoma, Grade 3 (3+3+2)
  - Residual tumor measuring 1.9 cm
  - 1 positive sentinel lymph node
- Due to persistent residual disease and high-risk features, additional adjuvant systemic therapy was recommended.

Treatment

- Historically, this patient would have been considered for ado-trastuzumab emtansine (Kadcyla®) following surgery
- Given evolving treatment options for high-risk HER2-positive disease, the treatment team elected to initiate T-DXd (Enhertu®)
- **08/2026: T-DXd initiated**

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Side Effect Management Implemented for T-DXd

Nausea

- **IV dexamethasone, ondansetron, and fosaprepitant (EMEND®)** administered prior to each treatment
- **Dexamethasone** 8 mg PO daily x 3 days beginning the day after treatment
- **Olanzapine** 5 mg PO nightly x 4 nights beginning the evening of treatment
- **Prochlorperazine** 10 mg PO Q6 hours PRN nausea
- **Ondansetron ODT** 8 mg PO Q8 hours PRN nausea
- This proactive antiemetic strategy has resulted in good nausea control in patients receiving T-DXd

ILD/Pneumonitis

- **Patient educated** on signs and symptoms of interstitial lung disease (ILD)/pneumonitis
- **Instructed to report** new or worsening cough, shortness of breath, fatigue, low-grade fever, or decreased exercise tolerance
- **Vital signs and pulse oximetry (SpO_2)** monitored at every treatment visit
- **Routine symptom assessment** performed throughout therapy
- **Consideration for periodic CT imaging** to monitor for asymptomatic pneumonitis given the known risk associated with fam-trastuzumab Deruxtecan
- Early recognition and prompt evaluation of potential pulmonary symptoms emphasized to minimize treatment-related complications

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The Five "S" Strategy

Detecting and Managing ILD/Pneumonitis in Patients Receiving ENHERTU® (T-DXd)

1. **SCREEN**
   To inform patient selection based on baseline risk, and regularly during treatment
2. **SCAN**
   Radiological scans remain the fundamental diagnostic tool for ILD
3. **SYNERGY**
   Patient counseling and early multidisciplinary engagement
4. **SUSPEND TREATMENT**
   Promptly investigate evidence and **interrupt treatment as soon as ILD is suspected, regardless of which grade is confirmed**
5. **STEROIDS**
   Can be initiated **as soon as ILD is suspected**, before a pulmonologist consultation

Dose Reduction Schedule

	Recommended starting dose	First dose reduction	Second dose reduction	Requirement for further dose reduction
Breast cancer, NSCLC, and IHC 3+ solid tumors	5.4 mg/kg →	4.4 mg/kg →	3.2 mg/kg	Discontinue
Gastric Cancer	6.4 mg/kg →	5.4 mg/kg →	4.4 mg/kg	Discontinue

Full Prescribing Information

1. Tarantino P, Tolaney SM. Detecting and managing T-DXd-related interstitial lung disease: the five "S" rules. JCO Oncol Pract. 2023;19(8):526-527

1. Tarantino P, Tolaney SM. Detecting and managing T-DXd-related interstitial lung disease: the five "S" rules. JCO Oncol Pract. 2023;19(8):526-527

How is your practice monitoring for interstitial lung disease in patients in the curative setting?

1. Baseline chest imaging only with ongoing symptom surveillance
2. Baseline chest imaging and repeat imaging at defined intervals with ongoing symptom surveillance
3. Ongoing symptom surveillance only
4. Not sure – not yet had an eligible patient

Breast Cancer

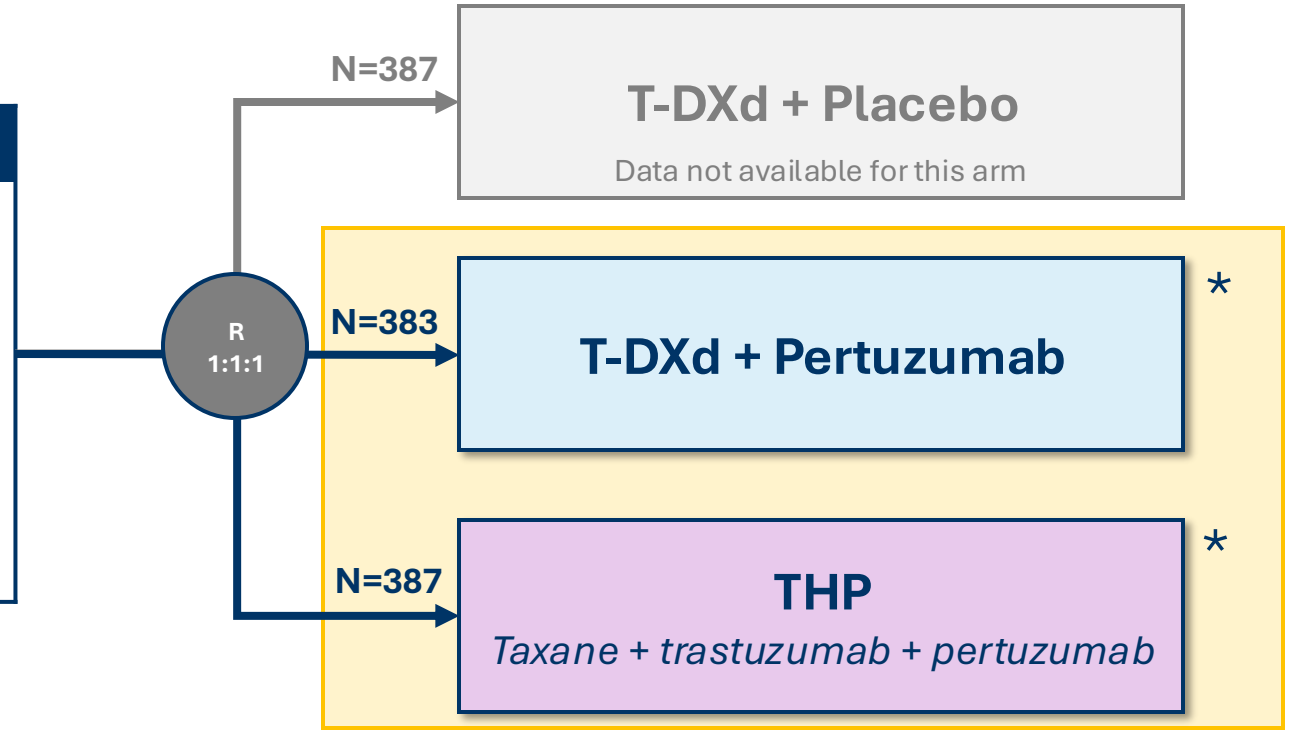
DESTINY-Breast09: Evaluating Fam-trastuzumab Deruxtecan (T-DXd) + Pertuzumab in HER2+ Metastatic Breast Cancer (mBC)

Study Design — Phase 3, randomized trial

Key Eligibility Criteria

- 1L HER2+ mBC
- Hormone receptor +/-
- High-risk disease*

*Defined as tumor stage ≥3 and N0-3, tumor stage 0-4 and N1-3, inflammatory BC



Mechanism of action: T-DXd = HER2-targeting antibody drug conjugate (ADC)

***Primary endpoint:** Progression-free survival†, T-DXd + P vs THP

†By BICR=Blinded Independent Central Review.

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1. N Engl J Med 2026;394:551-562. 2. ESMO 2025 Abstr. LBA18.

Breast Cancer

DESTINY-Breast09: Evaluating Fam-trastuzumab Deruxtecan (T-DXd) + Pertuzumab in HER2+ Metastatic Breast Cancer (mBC)

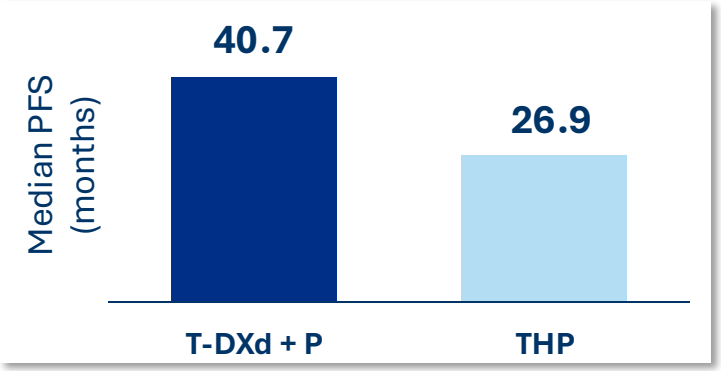
Key Efficacy of T-DXd + Pertuzumab

Primary endpoint

44% relative improvement in **progression-free survival (PFS)** vs THP

THP=taxane + trastuzumab + pertuzumab.

13.8-month absolute difference



Clinically meaningful PFS benefit regardless of **treatment status, hormone receptor status, or PIK3CA mutation status**

Key Adverse Events (AEs)

Most common drug-related AEs

- **Nausea: 71.1%**
  - Grade ≥3: 5.0%
- Diarrhea: 55.9%
  - Grade ≥3: 6.8%
- Neutropenia: 48.8%
  - Grade ≥3: 23.9%

AEs of special interest

- Adjudicated drug-related interstitial lung disease: 12.1%
- Left ventricular dysfunction: 11.0%

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1. N Engl J Med 2026;394:551-562. 2. ESMO 2025 Abstr. LBA18.

Breast Cancer

DESTINY-Breast09: Evaluating Fam-trastuzumab Deruxtecan (T-DXd) + Pertuzumab in HER2+ Metastatic Breast Cancer (mBC)

Key Takeaways

1. **T-DXd + pertuzumab significantly improved progression-free survival vs THP, with no new safety signals**
2. **Benefit observed regardless of prior treatment, hormone receptor status, or PIK3CAm status**
3. **FDA approved: December 15, 2025**

Key Considerations for Clinical Practice

- **T-DXd should be considered a new standard of care for treatment of high-risk HER2+ metastatic breast cancer**
- Coordinate multidisciplinary care (pulmonology, cardiology, and supportive care teams) to optimize management of adverse events during prolonged treatment
  - Complete blood counts and metabolic panel prior to initiation and prior to each dose
  - Counsel patients on signs and symptoms of interstitial lung disease
  - Assess left ventricular ejection fraction prior to initiating therapy and at regular intervals throughout treatment

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THP=taxane + trastuzumab + pertuzumab.

1. N Engl J Med 2026;394:551-562. 2. ESMO 2025 Abstr. LBA18.

Given potential for long term duration of therapy, what adverse events are most challenging for patients?

1. Nausea/Vomiting
2. Diarrhea
3. Neutropenia
4. Fatigue
5. Alopecia
6. Other

Patient Case Studies

T-DXd in Metastatic Breast Cancer

Management of Common Side Effects

Real-World Patient Case Study:

T-DXd + Pertuzumab

Patient Profile

- 46-year-old female
- 07/2025: Presented with right breast swelling and rash
- Mammogram, ultrasound, and biopsies of 2 breast lesions and an axillary lymph node confirmed grade 3 invasive ductal carcinoma:
  - ER-/PR-
  - HER2 3+
  - HER2 amplified by FISH
  - Ki-67 60%
- Staging PET/CT showed metastasis to regional lymph nodes, abdominal/pelvic lymph nodes, bone, and liver

Treatment

- **08/13/2025: Started T-DXd + pertuzumab → stable/improved disease on treatment**
  - **Patient tolerated treatment well with no nausea, ILD, or cardiac toxicity**
  - 04/14/2026: PET/CT imaging showed healing/sclerotic changes in bone lesions and resolution of breast lesions
  - Completed 16 cycles; surgery considered due to excellent response to treatment
- 07/03/2026: Underwent bilateral mastectomy
- **08/05/2026: T-DXd + pertuzumab resumed with cycle 17**

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Continuous Assessment of Lung and Cardiac Function for ENHERTU® (T-DXd) Treatment

Emphasize attention to symptoms related to:

Lung adverse events (e.g., interstitial lung disease)

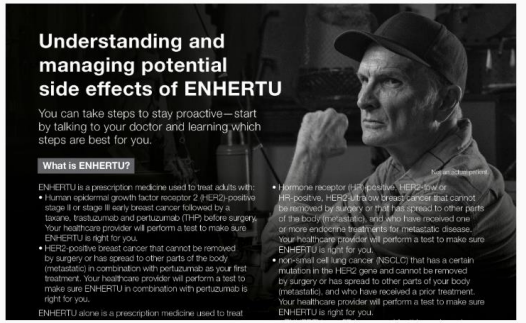
- Cough
- Trouble breathing or shortness of breath
- Fever
- Other new or worsening breathing symptoms such as chest tightness and wheezing

Cardiac adverse events (e.g., left ventricular dysfunction)

- New or worsening shortness of breath
- Coughing
- Feeling tired
- Swelling of ankles or legs
- Irregular heartbeat
- Sudden weight gain
- Dizziness or feeling light-headed
- Loss of consciousness

Assess prior to ENHERTU start and at regular intervals

A Side Effects Awareness and Education Guide is available for ENHERTU:



Scan for ENHERTU management brochure

Shares guidance for patients on how they can work with care team to manage side effects

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Antibody-Drug Conjugates with High Emetic Risk

Multiple approved products for metastatic breast cancer carry a high emetic risk:

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2026
Adult Antiemesis

NCCN Guidelines Index
Table of Contents
Discussion

ADULT PARENTERAL ANTICANCER AGENTS – EMETOGENIC POTENTIAL
HIGH AND MODERATE EMETIC RISK

LEVEL	AGENT		
High emetic risk (>90% frequency of emesis)[g]	• AC combination defined as any chemotherapy regimen that contains an anthracycline and Cyclophosphamide • Busulfan[h] • Carboplatin AUC ≥4 • Carmustine >250 mg/m² • Cisplatin • Cyclophosphamide >1500 mg/m²	• Dacarbazine • Datopotamab deruxtecan-dlnk • Doxorubicin ≥60 mg/m² • Epirubicin >90 mg/m² • Fam-trastuzumab deruxtecan-nxki • Ifosfamide ≥2 g/m² per dose • Mechlorethamine • Melphalan[h]	• Sacituzumab govitecan-hziy • Streptozocin • Thiotepa[h] • Zolbetuximab-clzb[k]

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NCCN Guidelines. Antiemesis. V2.2026.

Nausea Prophylaxis

NCCN Recommendation for nausea prophylaxis is centered around a 4-drug regimen:

olanzapine | NK1 RA | 5-HT3 RA | dexamethasone

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2026
Adult Antiemesis

NCCN Guidelines Index
Table of Contents
Discussion

ADULT PARENTERAL ANTICANCER AGENTS[o] – ACUTE AND DELAYED EMESIS PREVENTION
HIGH EMETIC RISK

DAY 1: Select treatment option A, B, or C **All treatment options are category 1 and should be started before anticancer therapy[p,q,r]**	**DAYS 2, 3, and 4:**
Treatment option A (preferred), use the following combination: 1. Olanzapine 2.5–10 mg PO once daily (bedtime)[s] 2. Neurokinin-1 receptor antagonist (NK1 RA) (choose one): ◊ Aprepitant 125 mg PO once ◊ Aprepitant injectable emulsion 130 mg intravenous (IV) once[t] ◊ Fosaprepitant 150 mg IV once ◊ Fosnetupitant 235 mg/Palonosetron 0.25 mg (available as fixed combination product only) IV once ◊ Netupitant 300 mg/Palonosetron 0.5 mg (available as fixed combination product only) PO once ◊ Rolapitant 180 mg PO once[u] 3. 5-HT3 RA (choose one):[v,w] ◊ Granisetron 10 mg subcutaneous (SQ) once,[x] or 2 mg PO once, or 0.01 mg/kg (max 1 mg) IV once, or 3.1 mg/24-h transdermal patch applied 24–48 h prior to first dose of anticancer therapy ◊ Ondansetron 16–24 mg PO once, or 8–16 mg IV once ◊ Palonosetron 0.25 mg IV once 4. Dexamethasone 12 mg PO/IV once[y,z]	**Treatment option A:** • Olanzapine 2.5–10 mg PO daily (bedtime) on Days 2, 3, and 4[s] • Aprepitant 80 mg PO daily on Days 2 and 3 (if Aprepitant PO is used on Day 1) • ± Dexamethasone 8 mg PO/IV daily on Days 2, 3, and 4[y,z]

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*Bucket strategy for managing therapy with high emetic risk: Pick only one drug from each bucket**

3-drug regimen

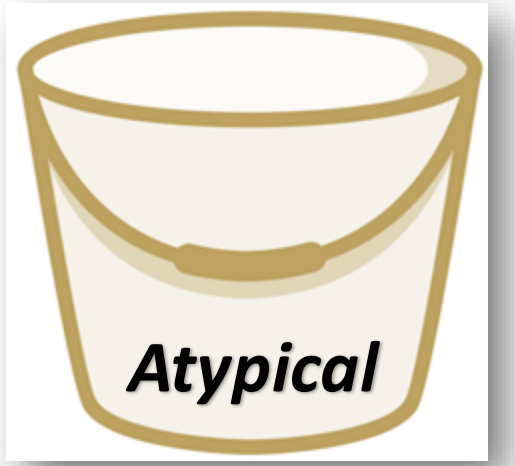
Aprepitant
Rolapitant
Fosaprepitant
Netupitant

Dolasetron
Granisetron
Ondansetron
Palonosetron

Dexamethasone

Additional option

Olanzapine*



2-drug regimen

**Based on NCCN Guidelines*

*Olanzapine is an atypical antipsychotic agent of the thiobenzodiazepine class that has the ability to block many different receptors, which explains its antiemetic properties. Olanzapine targets dopaminergic (D1, D2, D3, D4), serotonergic (5-HT2A, 5-HT2C, 5-HT3, 5-HT6), adrenergic (á1), histaminergic (H1), and muscarinic (m1, m2, m3, m4) receptors. Olanzapine has a benefit over combination CINV regimens in that it can target multiple key receptors with one medication. J Adv Pract Oncol. 2014 Jan-Feb; 5(1): 24–29.

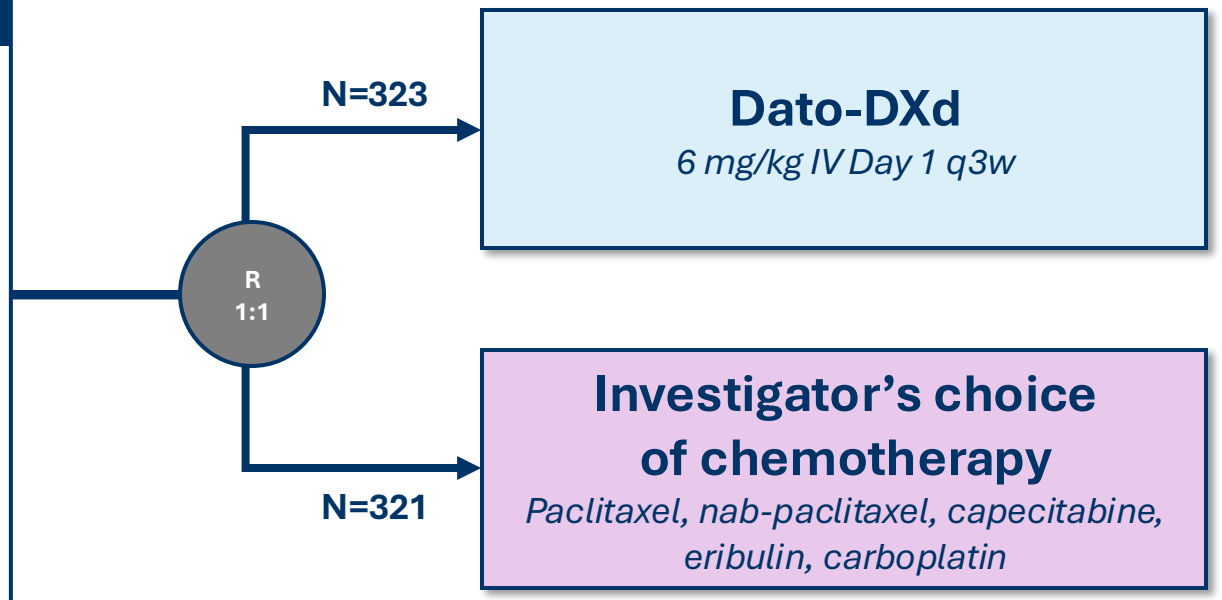
Breast Cancer

TROPION-Breast02: Evaluating Datopotamab Deruxtecan (Dato-DXd) in 1st-line Metastatic Triple Negative Breast Cancer (TNBC), PD-L1-neg or Previously Treated With Anti-PD-L1 Therapy

Study Design | **Phase 3, randomized trial**

Key Eligibility Criteria

- Locally recurrent inoperable or metastatic TNBC
- No prior chemotherapy or targeted systemic therapy in the locally recurrent inoperable or metastatic setting
- ECOG PS 0 or 1
- No minimum disease-free interval (DFI)
- Not eligible for PD-L1 therapy (almost all cases enrolled had PD-L1-negative tumors)



Mechanism of action: Dato-DXd = TROP-2-targeting antibody drug conjugate (ADC)

Dual primary endpoints: Progression-free survival[†]; overall survival

[†]By BICR, Blinded Independent Central Review

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1. Ann Oncol. 2026:S0923-7534(26)00130-4.

Breast Cancer

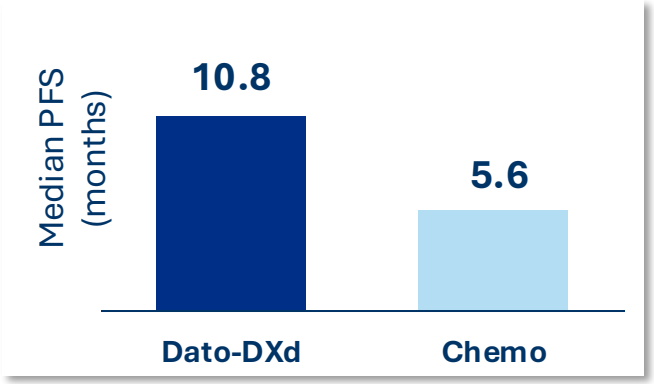
TROPION-Breast02: Evaluating Datopotamab Deruxtecan (Dato-DXd) in 1st-line Metastatic Triple Negative Breast Cancer (TNBC), PD-L1-neg or Previously Treated With Anti-PD-L1 Therapy

Key Efficacy of Dato-DXd

Dual primary endpoint

43% relative improvement in **progression-free survival (PFS)** vs chemotherapy

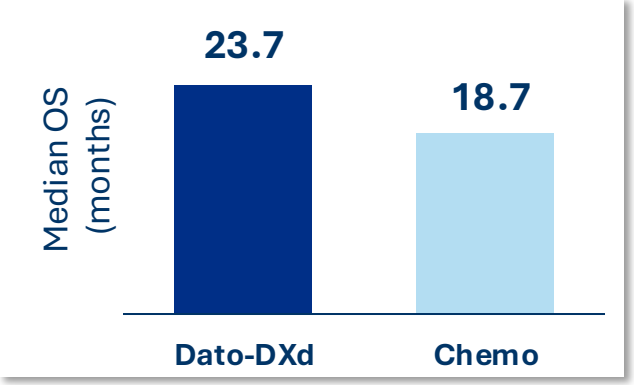
5.2-month absolute difference



Dual primary endpoint

21% relative improvement in **overall survival (OS)** vs chemotherapy

5.0-month absolute difference



Treatment-related Adverse Events (AEs) of Special Interest: Dato-DXd

Ocular events:

- Any: 24% (Grade ≥3: 1%)
- Most common: Dry eye (24%), keratitis (13%), conjunctivitis (7%)

Other selected AEs of special interest:

- Oral mucositis/stomatitis: 60% (Grade ≥3: 8%)
- Adjudicated interstitial lung disease/pneumonitis: 3% (Grade ≥3: 0)

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1. Ann Oncol. 2026:S0923-7534(26)00130-4.

Breast Cancer

TROPION-Breast02: Evaluating Datopotamab Deruxtecan (Dato-DXd) in 1st-line Metastatic Triple Negative Breast Cancer (TNBC), PD-L1-neg or Previously Treated With Anti-PD-L1 Therapy

Key Takeaways

1. **Dato-DXd significantly improved both progression-free survival and overall survival vs chemotherapy**
2. **Supports frontline Dato-DXd in locally recurrent inoperable or metastatic TNBC when immunotherapy is not an option**
3. **FDA approved: May 22, 2026**

Key Considerations for Clinical Practice

- **Datopotamab deruxtecan should be considered a new 1L standard of care for patients with mTNBC with PD-L1- disease**
- Early coordination with optometrist/ophthalmologist is critical for optimal patient management
- Counsel patients on risk and management of ocular toxicity
- Recognize risk of oral toxicity and need for prophylactic and supportive medications
- Limited risk of interstitial lung disease remains; monitor and consider corticosteroid treatment as needed

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1. Ann Oncol. 2026:S0923-7534(26)00130-4.

ADC-Related Ocular Toxicities: How to Recognize and Manage

Advise patients about the potential for ocular toxicities and prepare them for the possibility of dose reductions or discontinuations; *continue to provide education throughout treatment*

Blepharitis: eyelid redness, swelling, crusting

- → Warm compresses

Keratitis: blurred vision, dry eyes, redness or irritation, lacrimation, photophobia

- → Refer to eye care provider
- → Lubricating eye drops

Uveitis: Blurred vision, floaters, photophobia, redness

Conjunctivitis: redness, swelling, irritation, crusting, foreign body sensation

- → Refer to eye care provider
- → Cold compresses

Meibomitis: burning sensation, discharge, vision changes

- → Refer to eye care provider
- → Warm compresses
- → Use lubricating eye drops

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1. ONS Voice. An Oncology Nurse's Guide to Cancer-Related Ocular Toxicities. https://www.ons.org/publications-research/voice/news-views/06-2024/oncology-nurses-guide-cancer-related-ocular

Datopotamab deruxtecan (DATROWAY®) Warnings and Precautions

Interstitial Lung Disease (ILD) and Pneumonitis

can include severe and fatal cases

- Monitor for new or worsening signs and symptoms of ILD/pneumonitis
- If ILD/pneumonitis is suspected, withhold and initiate corticosteroids
- Discontinue if confirmed grade 2 or higher

Ocular Adverse Reactions

can include dry eye, keratitis, blepharitis, meibomian gland dysfunction, increased lacrimation, conjunctivitis, and blurred vision

- **Monitor patients for ocular adverse reactions during treatment**
- **Advise use of preservative-free lubricant eye drops at least 4 times daily and as needed**
- **Avoid using contact lenses unless directed by eye care professional**
- **Withhold, reduce the dose, or permanently discontinue based on severity**
- **Refer to eye care professional for any new or worsening signs/symptoms**

Stomatitis/ Oral Mucositis

- Use a steroid-containing mouthwash when starting treatment and to hold ice chips or ice water in mouth during the infusion
- Withhold, reduce the dose, or permanently discontinue based on severity

Embryo-Fetal Toxicity

- Advise patients of potential risk to a fetus and to use effective contraception

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1. DATROWAY. Prescribing Information.

Coordination With Eye Care Professionals

Refer patients to an eye care professional (optometrist or ophthalmologist) for an ophthalmic exam at treatment initiation, annually while on treatment, at end of treatment, and as clinically indicated

What should exams include?

Exams at initiation, at end of treatment, and as clinically indicated should include:

- ❑ Visual acuity testing
- ❑ Slit lamp examination (with fluorescein staining)
- ❑ Intraocular pressure
- ❑ Fundoscopy

Exams occurring every 3 cycles should include:

- ❑ Visual acuity testing
- ❑ Slit lamp examination

An ocular assessment form can be shared with the patient's optometrist or ophthalmologist to support ocular exams and inform treatment decisions

Available on the DATROWAY website:

Managing Adverse Reactions

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1. DATROWAY HCP website. https://datrowayhcp.com/managing-adverse-reactions

DATROWAY Starter Kit

Designed to support patients and caregivers, offering education and resources to navigate treatment with DATROWAY – needs to be requested by care team

- **Patient Brochure**
- **Care Partner Brochure**
- **$50 Amazon for Eye Drops**
- **Free Oral Care Hygiene Kit**
- **Daily Reminder Card**
- **Wallet Card**

Available on the DATROWAY website:

DATROWAY Getting Started Guide

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Detailed Management Guidance: Keratitis

Nonconfluent superficial keratitis	• Monitor and continue at current dose
Confluent superficial keratitis, cornea epithelial defect, or 3-line or more loss in best corrected visual acuity	• Withhold until improved or resolved, then restart at same dose level or consider dose reduction
Corneal ulcer or stromal opacity or best corrected distance visual acuity 20/200 or worse	• Withhold until improved or resolved, then restart at reduced dose level
Corneal perforation	• Permanently discontinue treatment

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1. DATROWAY. Prescribing Information.

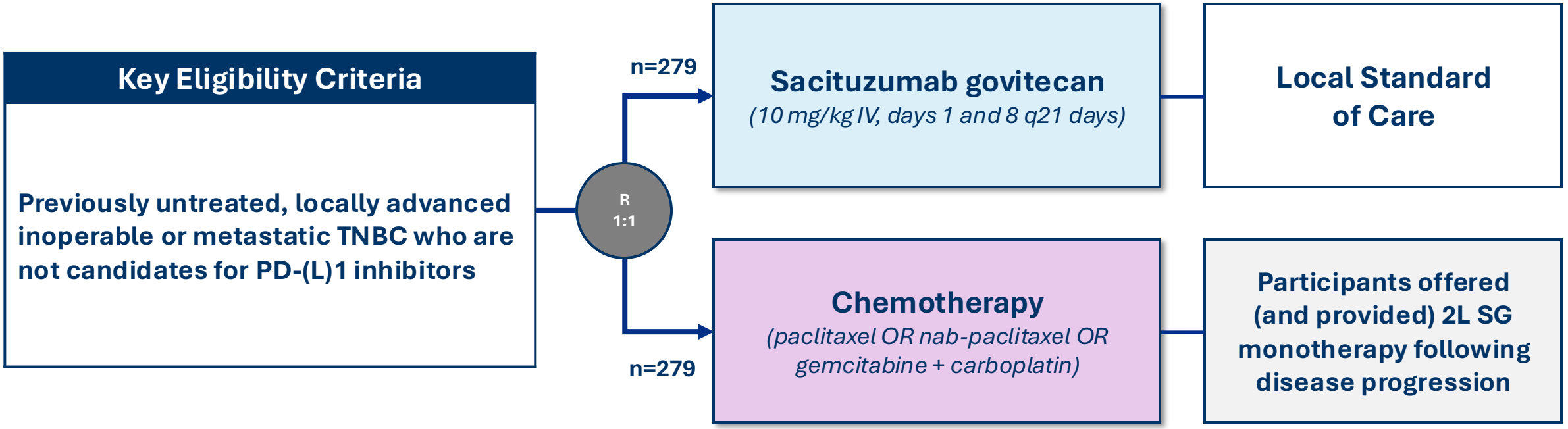
How involved are you in collaborating with eye care professionals on the management of ocular side effects?

1. Very involved – coordinate referrals and communicate ocular examination results
2. Moderately involved – educate patients and alert providers regarding ocular side effects; limited direct interaction with eye care professionals
3. Minimally involved – ocular management is primarily handled by other care team members
4. Not involved

Breast Cancer

ASCENT-03: Evaluating Sacituzumab Govitecan (SG) in 1st-line Metastatic Triple-Negative Breast Cancer (TNBC), PD-L1-Neg or Previously Treated with Anti-PD-L1 Therapy

Study Design | **Phase 3, randomized trial**



Mechanism of action: Sacituzumab govitecan = TROP2-targeting antibody drug conjugate (ADC)

Primary endpoint: Progression-free survival†

†By BICR=Blinded Independent Central Review.

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1. N Engl J Med 2025;393:1912-1925. 2. ASCO 2026. LBA1001.

Breast Cancer

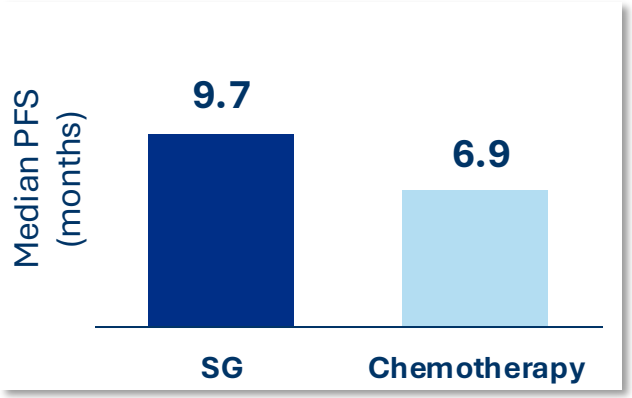
ASCENT-03: Evaluating Sacituzumab Govitecan (SG) in 1st-line Metastatic Triple-Negative Breast Cancer (TNBC), PD-L1-Neg or Previously Treated with Anti-PD-L1 Therapy

Key Efficacy of Sacituzumab Govitecan

Primary endpoint

38% relative improvement in **progression-free survival (PFS)** vs chemotherapy

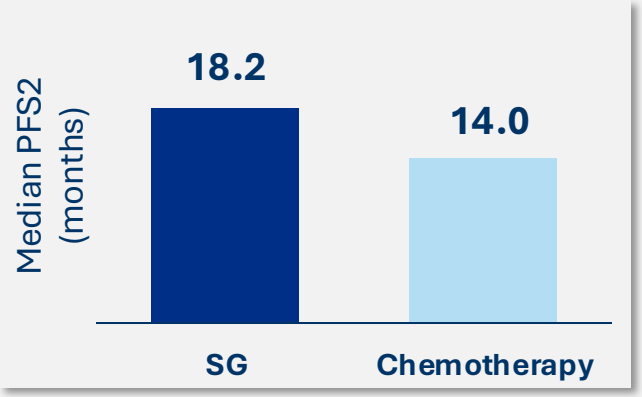
2.8-month absolute difference



Key exploratory endpoint

30% relative improvement in **progression-free survival after next line of treatment (PFS2)** vs chemotherapy

4.2-month absolute difference



Most Common Adverse Events (AEs) including Grade ≥3

Neutropenia:

- Any: 67.0%
  - Grade ≥3: 43.0%

Diarrhea:

- Any: 54.0%
  - Grade ≥3: 9.0%

Leukopenia:

- Any: 25.0%
  - Grade ≥3: 7.0%

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1. N Engl J Med 2025;393:1912-1925. 2. ASCO 2026. LBA1001.

Breast Cancer

ASCENT-03: Evaluating Sacituzumab Govitecan (SG) in 1st-line Metastatic Triple-Negative Breast Cancer (TNBC), PD-L1-Neg or Previously Treated with Anti-PD-L1 Therapy

Key Takeaways

1. **Sacituzumab govitecan significantly improved progression-free survival vs chemotherapy**
2. **Benefits of frontline sacituzumab govitecan extend beyond first disease progression**
3. **FDA approved: June 24, 2026**

Key Considerations for Clinical Practice

- **Sacituzumab govitecan should be considered a new 1L standard of care for patients with mTNBC with PD-L1- disease**
  - Monitor blood counts regularly, educate patients on signs of infection and fever, and consider primary G-CSF prophylaxis inpatients at increased risk of febrile neutropenia
  - Evaluate for infectious causes, initiate antidiarrheal therapy early, provide supportive care as needed, and follow dose-modification recommendations for severe diarrhea
  - Anticipate temporary interruption and dose reduction

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1. N Engl J Med 2025;393:1912-1925. 2. ASCO 2026. LBA1001.

Key Clinical Trials and Patient Cases:

Antibody-Drug Conjugates in Breast Cancer and Associated Toxicities	• DESTINY-Breast11, 05, 09
	  ○ ***Patient case: Early-stage ENHERTU and ILD management***
	  ○ ***Patient case: ENHERTU + pertuzumab in metastatic disease***
	• TROPION-Breast02
	• ASCENT-03

Antibody-Drug Conjugate + Immunotherapy Combinations and Associated Toxicities	• ASCENT-04
	  ○ ***Patient case: Growth factor support with TRODELVY***
	• KEYNOTE-869/EV103
	• KEYNOTE-B15/EV304
	  ○ ***Patient case: Managing toxicities with EV + pembrolizumab***

Skin Toxicity With KRAS Inhibitors	• RASOLUTE-302 ○ ***Patient case: Rash management with daraxonrasib***

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Breast Cancer

ASCENT-04: Evaluating Sacituzumab Govitecan (SG) + Pembrolizumab in 1st-line PD-L1-positive Metastatic Triple-Negative Breast Cancer (TNBC)

Study Design

Phase 3, randomized trial

Key Eligibility Criteria

Previously untreated, locally advanced unresectable or metastatic TNBC

- PD-L1+ (CPS ≥ 10)
- ≥ 6 months since treatment in curative setting (prior anti-PD-[L]1 use allowed)

R 1:1

n=221

Sacituzumab govitecan + pembrolizumab
(SG 10 mg/kg IV, days 1 and 8 q21 days; pembro 200 mg, day 1 q21 days)

Local Standard of Care

n=222

Chemotherapy + pembrolizumab
(paclitaxel OR nab-paclitaxel OR gemcitabine + carboplatin)

Participants offered (and provided) 2L SG monotherapy following disease progression

CPS=Combine Positive Score.

Mechanism of action: Sacituzumab govitecan = TROP-2-targeting antibody drug conjugate (ADC)

Primary endpoint: Progression-free survival†

†By BICR=Blinded Independent Central Review

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1. N Engl J Med 2026;394:354-366 2. ASCO 2026. LBA1000.

Breast Cancer

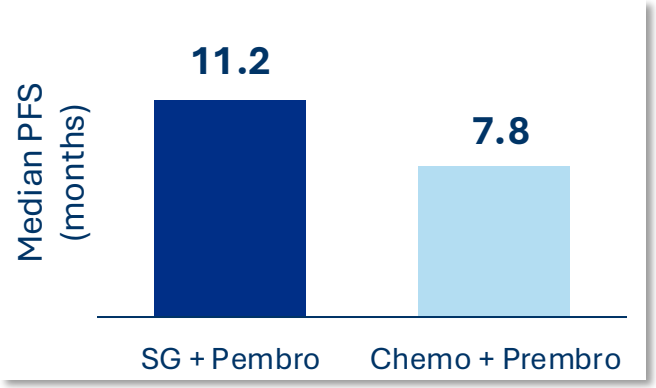
ASCENT-04: Evaluating Sacituzumab Govitecan (SG) + Pembrolizumab in 1st-line PD-L1-positive Metastatic Triple-Negative Breast Cancer (TNBC)

Key Efficacy of Sacituzumab Govitecan + Pembrolizumab

Primary endpoint

35% relative improvement in **progression-free survival (PFS)** vs chemo + pembro

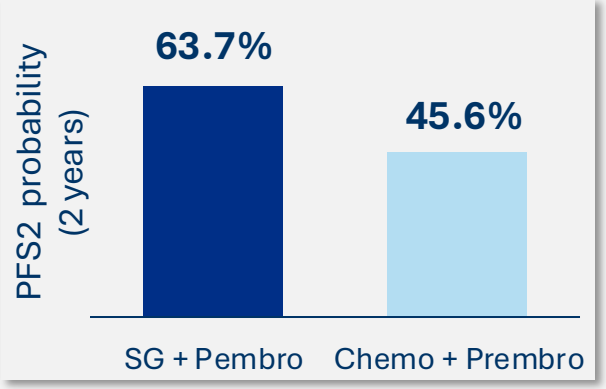
3.4-month absolute difference



Key exploratory endpoint

33% relative improvement in **progression-free survival after next line of treatment (PFS2)** vs chemo + pembro

18.1% absolute difference



Most Common Adverse Events (AEs) of SG + Pembro

Neutropenia:

- Any: 63.0% vs 59
  - Grade ≥3: 43.0%

Diarrhea:

- Any: 70.0%
  - Grade ≥3: 10.0%

Nausea:

- Any: 68.0%
  - Grade ≥3: 3.0%

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1. N Engl J Med 2026;394:354-366 2. ASCO 2026. LBA1000.

Breast Cancer

ASCENT-04: Evaluating Sacituzumab Govitecan (SG) + Pembrolizumab in 1st-line PD-L1-positive Metastatic Triple-Negative Breast Cancer (TNBC)

Key Takeaways

1. **Sacituzumab govitecan + pembrolizumab significantly improved progression-free survival vs chemotherapy + pembrolizumab**
2. **Benefits of frontline sacituzumab govitecan + pembrolizumab extend beyond first disease progression**
3. **FDA approved: June 24, 2026**

Key Considerations for Clinical Practice

- **Sacituzumab govitecan + pembrolizumab should be considered a new 1L standard of care for patients with confirmed PD-L1+ disease (CPS ≥10)**
  - PFS benefit for SG + pembrolizumab maintained across HER2 IHC 0 or HER2-low and BRCA wild-type or mutant
  - Median time to first subsequent treatment after1st line therapy was 17.3 months for SG +pembrolizumab vs 9.8 months for chemo +pembrolizumab
  - SG + pembrolizumab demonstrated a sustained benefit beyond first progression (PFS2), despite high crossover to SG in the control arm

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1. N Engl J Med 2026;394:354-366 2. ASCO 2026. LBA1000.

Patient Case Study

Sacituzumab Govitecan + Pembrolizumab

Growth Factor Support

Real-World Patient Case Study:

SG + Pembrolizumab and Side Effect Management

Patient Profile and Diagnostic Journey

- 43-year-old woman who developed left breast mass
- **May 6, 2026;** biopsies revealed:
  - Grade 3 invasive ductal carcinoma
  - Left breast: 2:00 lesion and left axillary tail lesion
  - ER/PR-negative
  - HER2 IHC 2+, HER2 FISH negative
- **May 14, 2026;** PET scan revealed:
  - Hypermetabolic left breast mass
  - Bulk metastatic left axillary lymphadenopathy
  - Metastatic right hilar and mediastinal lymphadenopathy
  - Multiple subcentimeter right lung nodules
- **May 27, 2026;** Underwent EBUS
  - Cytology positive, confirming Stage IV TNBC
- Molecular profiling (Tempus) identified:
  - BRCA1, CKS1B, MAP3K1 and TP53 mutation
- Immunotherapy biomarker
  - PD-L1 CPS = 10

CPS=Combine Positive Score

Treatment

- **June 2026: 1L Sacituzumab govitecan (SG) + pembrolizumab**

Side effects

- **Fatigue**
- **Diarrhea**
- **Dry skin with occasional rash**
- All responsive to supportive measures (Lomotil, topical moisturizers, Claritin daily)
- No instances of neutropenia notes through start of C4

TRODELVY (Sacituzumab Govitecan) Warnings and Precautions

IMPORTANT SAFETY INFORMATION
BOXED WARNING:
NEUTROPENIA AND DIARRHEA

- TRODELVY can cause severe, life-threatening, or fatal neutropenia. Withhold TRODELVY for absolute neutropenia count below 1500/mm^3 or neutropenic fever. Monitor blood cell counts periodically during treatment. **Primary prophylaxis with G-CSF is recommended for all patients at increased risk of febrile neutropenia.** Initiate anti-infective treatment in patients with febrile neutropenia without delay.
- TRODELVY can cause severe diarrhea. Monitor patients with diarrhea and give fluid and electrolytes as needed. At the onset of diarrhea, evaluate for infectious causes and, if negative, promptly initiate loperamide. If severe diarrhea occurs, withhold TRODELVY until resolved to ≤Grade 1 and reduce subsequent doses.

Infusion-related reactions

- Premedication with antipyretics and H1 and H2 blockers recommended
- For patients who had prior infusion reactions, consider corticosteroids
- **Have medications and emergency equipment to treat infusion-related reactions, including anaphylaxis, available for immediate use**

Nausea and vomiting

Consider premedication with a 2- or 3-drug regimen (e.g., dexamethasone, 5-HT3 receptor antagonist, NK RA)

Scan for TRODELVY Dosing, Administration, and Adverse Reaction Management Guide

1. Gilead Sciences. Trodelvy Dosing & Administration Guide.

Prepare and Monitor for Neutropenia

Prophylaxis With G-CSF

Recommended starting in the first cycle of treatment for patients at increased risk of febrile neutropenia, including patients with:

- Advanced age
- Previous neutropenia
- Poor performance status
- Organ dysfunction
- Multiple comorbidities

Prior to initiating TRODELVY, determine your patient's risk of developing febrile neutropenia

Supported by NCCN Clinical Practice Guidelines in Oncology (NCCN Guideline®)

Different types of G-CSF are available, including various formulations of:

- Filgrastim (short-acting)
- Pegfilgrastim (longer-acting)

If patients do not receive G-CSF prophylaxis, be ready with G-CSF to help patients continue therapy

Monitor

Monitor absolute neutrophil counts (ANC) periodically during treatment.

Encourage patients to report development any of the following signs of infection during treatment with TRODELVY:

- Fever
- Chills
- Cough
- Shortness of breath
- Burning/pain when urinating

NCI CTCAE Version 5.0 Neutropenia Grade Scale	
Grade 1	Grade 1 ANC <LLN to 1500/mm^3
Grade 2	Grade 2 ANC <1500 to 1000/mm^3
Grade 3	Grade 3 ANC <1000 to 500/mm^3
Grade 4	Grade 4 ANC <500/mm^3

LLN: lower limit of normal

1. Gilead Sciences. Trodelvy Dosing & Administration Guide.

Management of Grade 3-4 Neutropenia (ANC <1000/mm^3)

Withhold TRODELVY

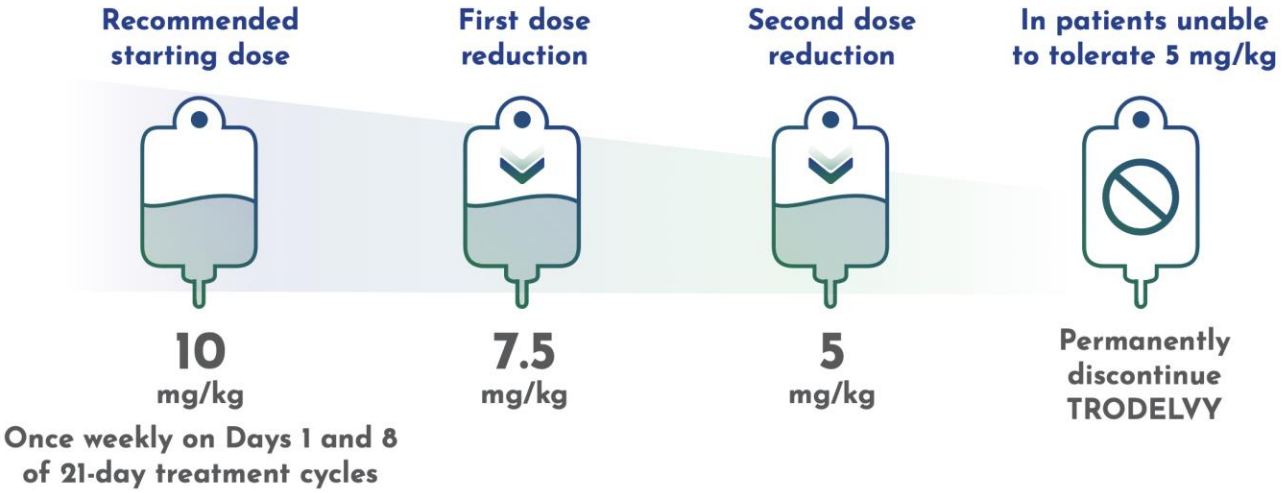
- Until ANC ≥1500/mm^3 for day 1 dose OR
- Until ANC ≥1000/mm^3 for day 8 dose

Administer G-CSF during treatment as clinically indicated

If the patient experiences:

- Febrile neutropenia
- Prolonged Grade 3-4 neutropenia

Reduce one dose level for each occurrence:



Do not re-escalate TRODELVY dose after a dose reduction for adverse reactions has been made.
When administering TRODELVY in combination with pembrolizumab, interrupt or discontinue one or both drugs or reduce TRODELVY dose to manage adverse reactions as appropriate.

1. Gilead Sciences. Trodelvy Dosing & Administration Guide.

Considering sacituzumab govitecan, how does your practice typically manage the associated risk of neutropenia?

1. Prophylactic G-CSFs for every patient receiving sacituzumab govitecan
2. Reactive G-CSFs as needed on a patient-by-patient basis
3. Dose hold or dose reduction as needed
4. All of the above
5. Other

Key Clinical Trials and Patient Cases:

Antibody-Drug Conjugates in Breast Cancer and Associated Toxicities	• DESTINY-Breast11, 05, 09
	  ○ ***Patient case: Early-stage ENHERTU and ILD management***
	  ○ ***Patient case: ENHERTU + pertuzumab in metastatic disease***
	• TROPION-Breast02
	• ASCENT-03

Antibody-Drug Conjugate + Immunotherapy Combinations and Associated Toxicities	• ASCENT-04
	  ○ ***Patient case: Growth factor support with TRODELVY***
	• KEYNOTE-869/EV103 metastatic
	• KEYNOTE-B15/EV304 perioperative
	  ○ ***Patient case: Managing toxicities with EV + pembrolizumab***

Skin Toxicity With KRAS Inhibitors	• RASOLUTE-302 ○ ***Patient case: Rash management with daraxonrasib***

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Bladder Cancer

KEYNOTE-869/EV103: Evaluating Enfortumab Vedotin (EV) Alone or With Pembrolizumab (Pembro) in Metastatic Urothelial Carcinoma

Study Design

Phase 1b/2 Multi-Cohort Study

Cohort K Population*

- Previously untreated, histologically documented metastatic urothelial carcinoma
- Eligible for pembro
- Cisplatin-ineligible due to ≥1 of the following:
  - Glomerular filtration rate ≥30 and <60 mL/min
  - Grade ≥2 hearing loss
  - Class III heart failure

n=76 → **EV + pembro**

n=73 → **EV**

Mechanism of action: Nectin-4-targeted antibody-drug conjugate

Primary endpoint: Confirmed objective response (cORR)

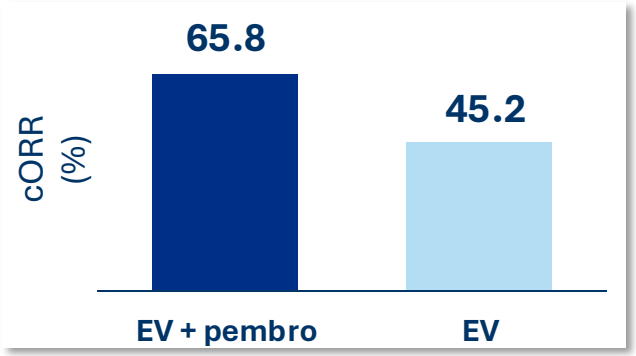
*Additional single-arm cohorts evaluated EV + chemotherapy or pembro as first- or second-line treatment for locally advanced or metastatic urothelial carcinoma.

Key Efficacy of Cohort K at Long-Term Follow-up*

*Median follow-up: ~3.5 years

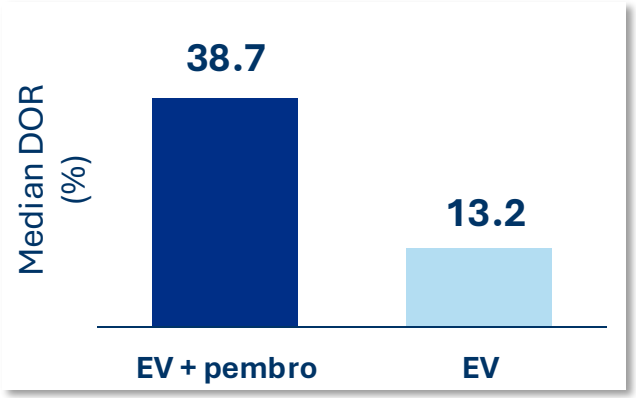
Primary endpoint

21% difference in **cORR** with EV + pembro vs EV alone



Key secondary endpoint

25.5-month difference in median **duration of response (DOR)**



1. ASCO 2020. Abstr. TPS5092. 2. ESMO 2025. Abstr. 3074P.

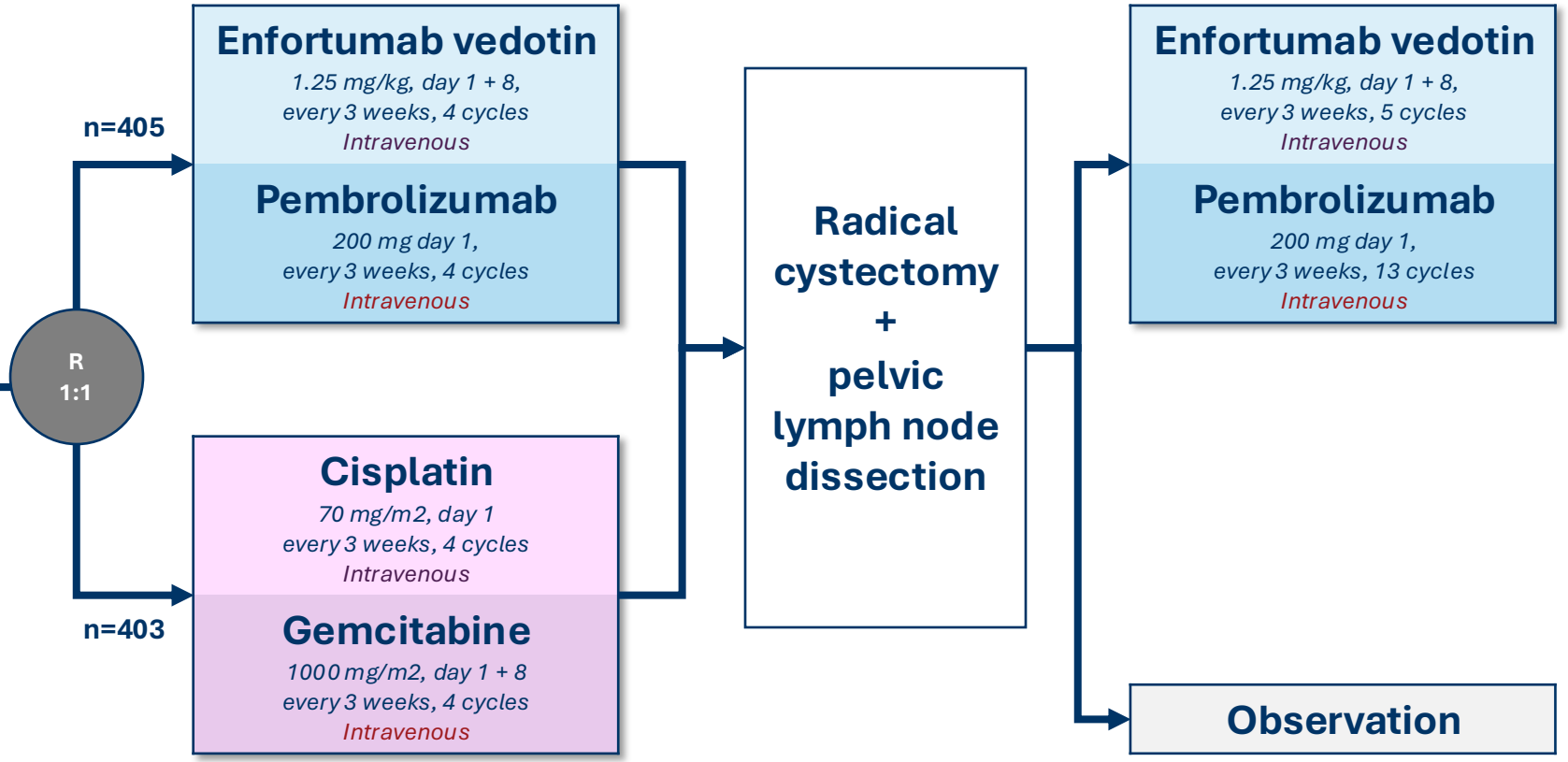
Bladder Cancer

KEYNOTE-B15/EV304: Evaluating Perioperative Enfortumab Vedotin + Pembrolizumab vs Neoadjuvant Chemotherapy in Muscle-Invasive Bladder Cancer (MIBC)

Study Design — Phase 3, Randomized Trial

Key Eligibility Criteria

- MIBC, stage T2-T4a, N0, M0 **OR** T1-T4a, N1, M0
- Cisplatin-eligible
- Radical cystectomy candidate
- Predominantly urothelial (≥50%) bladder cancer



Mechanism of action: Enfortumab vedotin = Nectin-4 targeted ADC (antibody-drug conjugate)

Primary endpoint: Event-free survival

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1. N Engl J Med. 2026;394(13):1257-1269. 2. ASCO GU 2026. LBA630.

Bladder Cancer

KEYNOTE-B15/EV304: Evaluating Perioperative Enfortumab Vedotin + Pembrolizumab vs Neoadjuvant Chemotherapy in Muscle-Invasive Bladder Cancer (MIBC)

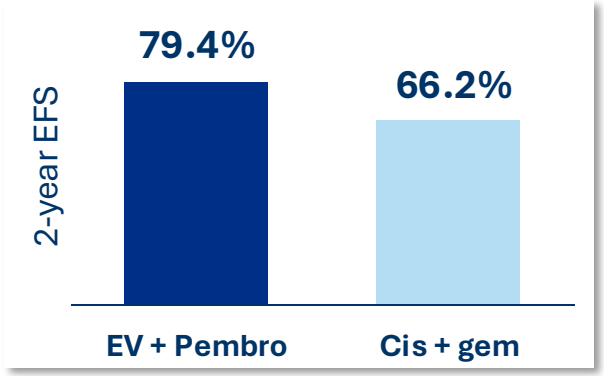
Key Efficacy of Perioperative Enfortumab Vedotin + Pembrolizumab

Primary endpoint

47% relative improvement in **event-free* survival (EFS)** vs neoadjuvant chemotherapy

*Events include recurrence, progression, and death.

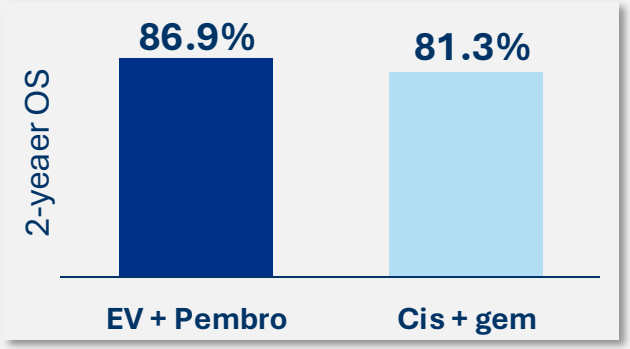
~13% absolute difference



Key secondary endpoint

35% relative improvement in **overall survival (OS)** vs neoadjuvant chemotherapy

5.6% absolute difference



Adverse Events (AEs) of Special Interest

Associated with enfortumab vedotin:

- Skin reactions (63.5%)
- Peripheral neuropathy (36.0%)

Associated with pembrolizumab:

- Severe skin reactions (17.1%)
- Hypothyroidism (12.2%)

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1. N Engl J Med. 2026;394(13):1257-1269. 2. ASCO GU 2026. LBA630.

Bladder Cancer

KEYNOTE-B15/EV304: Evaluating Perioperative Enfortumab Vedotin + Pembrolizumab vs Neoadjuvant Chemotherapy in Muscle-Invasive Bladder Cancer (MIBC)

Key Takeaways

1. **Enfortumab vedotin + pembrolizumab improved pathological response at surgery vs neoadjuvant chemotherapy**
2. **Enfortumab vedotin + pembrolizumab before and after surgery led to significantly improved event-free survival**
3. **FDA approved: July 10, 2026, extending approval of regimen from cisplatin-ineligible to all cystectomy candidates**

Key Considerations for Clinical Practice

- Black Box warning for enfortumab vedotin for severe and fatal cutaneous adverse reactions
  - Closely monitor for skin reactions and consider topical corticosteroids and antihistamines as clinically indicated
  - Referral to specialists recommended for suspected Grade 3 skin reactions
- Monitor for clinical manifestations of underlying immune-mediated reactions
- Monitor for symptoms of new or worsening peripheral neuropathy

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1. N Engl J Med. 2026;394(13):1257-1269. 2. ASCO GU 2026. LBA630. 3. FDA press release. July 10, 2026.

Patient Case Study

Enfortumab Vedotin + Pembrolizumab

Immune-mediated Adverse Events

Peripheral Neuropathy

Real-World Patient Case Study:

Enfortumab Vedotin + Pembrolizumab Side Effects

Patient Profile

- 62-year-old male
- High-grade papillary urothelial carcinoma
- Underwent radical cystectomy; pathology showed locally advanced, node-positive disease
- PET imaging showed thoracic, abdominal, pelvic node metastases

→ **pT3aN2cM1b**

Treatment

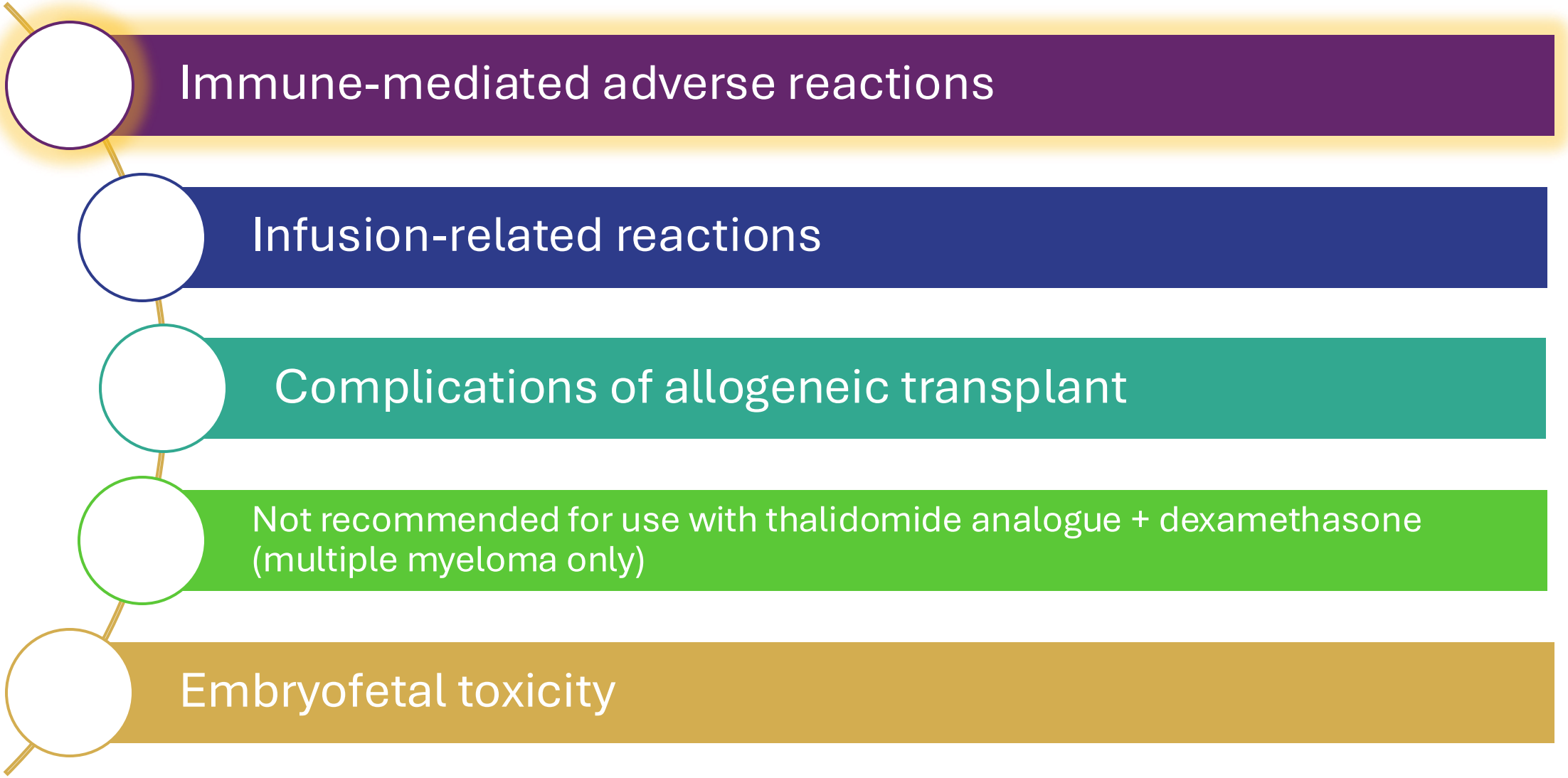
- **09/2023: EV + pembro at tertiary care center; transfer to community at cycle 4**
  - 11/2023: CT imaging showed reduced nodal disease
  - 12/2025: PET imaging showed no evidence of disease

Side Effects

- **Fatigue**
  - Patient's work and overtime contributed
  - 2024: IV iron supplementation helped
  - 06/2025: TSH 230 observed
  - Levothyroxine and collaboration with PCP helped
- **Arthralgias**
  - Elevated ESR/CRP suggested autoimmune arthritis
  - Steroids helped
- **Dry eyes and mouth**
  - Artificial tears, biotene mouthwash, magic mouthwash
- **Neuropathy**

Patient required several treatment holidays and is now completely off treatment in active surveillance

KEYTRUDA® (Pembrolizumab) Warnings and Precautions



1. KEYTRUDA. Prescribing Information.

Immune-Mediated Adverse Reactions

Immune-mediated adverse reactions can affect multiple organ systems

- **Immune-mediated endocrinopathies**
  - **Hypohysitis**
  - **Thyroid disorders**
  - **Adrenal insufficiency**
- **Immune-mediated pneumonitis**
- **Hepatotoxicity and immune-mediated hepatitis**
- **Immune-mediated colitis**
- **Immune-mediated dermatologic adverse events**
- **Immune-mediated nephritis with renal dysfunction**

1. KEYTRUDA. Prescribing Information. 2. Allergol Int. 2022;71(2):169-178.

Monitoring for Immune-Mediated Adverse Reactions

Monitor for symptoms and signs that may be clinical manifestations of underlying immune-mediated adverse reactions:

- ❑ Assess enzymes, creatinine, thyroid function at baseline and periodically during treatment
- ❑ If immune-mediated adverse reaction suspected, initiate workup to exclude alternative etiologies (e.g., infection)
- ❑ Include specialists as appropriate

<u>NCCN Guidelines on the Role of Fatigue</u>:
In patients receiving immunotherapy treatment, **fatigue** may be a presenting symptom of an endocrine disorder secondary to immunotherapy, such as a thyroid or pituitary disorder

Evaluate for and rule out other non-immune checkpoint inhibitor etiologies of fatigue:

Physical exam including vital signs:
- weight
- temperature
- heart rate
- respiratory rate
- blood pressure
- oxygen saturation at rest and walking

Laboratory tests:
- CBC
- CMP
- TSH, FT4 (if not done recently)
- AM cortisol
- AM ACTH (if cortisol suboptimal)
- AM testosterone
- CK and cardiac enzymes

Medication review

Assess for depression (consider PHQ-9)

1. KEYTRUDA HCP website. 2. NCCN Clinical Practice Guidelines in Oncology. Cancer-Related Fatigue. V2.2026. 3. NCCN Guidelines for Management of Immune Checkpoint Inhibitor-Related Toxicities v1.2026.

Management of Immune-Mediated Adverse Reactions

General Guidance for Use of Corticosteroids

- If KEYTRUDA (pembrolizumab) requires interruption or discontinuation, **administer systemic corticosteroids*** until improvement to ≤Grade 1
- Upon improvement to ≤Grade 1, **taper corticosteroids over at least 1 month**
- **Consider other systemic immunosuppressants** if adverse reactions are unresolved

General Guidance for Adverse Reactions Not Requiring Systemic Steroids

- **Dose reductions are not recommended**
- **Withhold** KEYTRUDA for Grade 3 immune-mediated adverse events
- **Permanently discontinue** KEYTRUDA for
  - Grade 4 immune-mediated adverse reactions
  - Recurrent severe Grade 3 immune-mediated reactions that require systemic immunosuppressive treatment
  - Inability to reduce corticosteroid dose to 10 mg or less of prednisone or equivalent per day within 12 weeks of initiating steroids

Scan for specific recommended dose modifications for KEYTRUDA:

Monitoring and Management of Immune-Mediated Adverse Reactions

*1-2 mg/kg/day prednisone or equivalent

1. KEYTRUDA HCP website.

PADCEV® (Enfortumab Vedotin) Warnings and Precautions

WARNING: SERIOUS SKIN REACTIONS

- PADCEV can cause severe and fatal cutaneous adverse reactions, including Stevens-Johnson syndrome (SJS) and Toxic Epidermal Necrolysis (TEN)
- Immediately withhold PADCEV and consider referral for specialized care for suspected SJS or TEN or severe skin reactions
- Permanently discontinue PADCEV in patients with confirmed SJS or TEN; or Grade 4 or recurrent Grade 3 skin reactions.

Hyperglycemia

Ocular Disorders

Pneumonitis/Interstitial Lung Disease

Infusion Site Extravasation

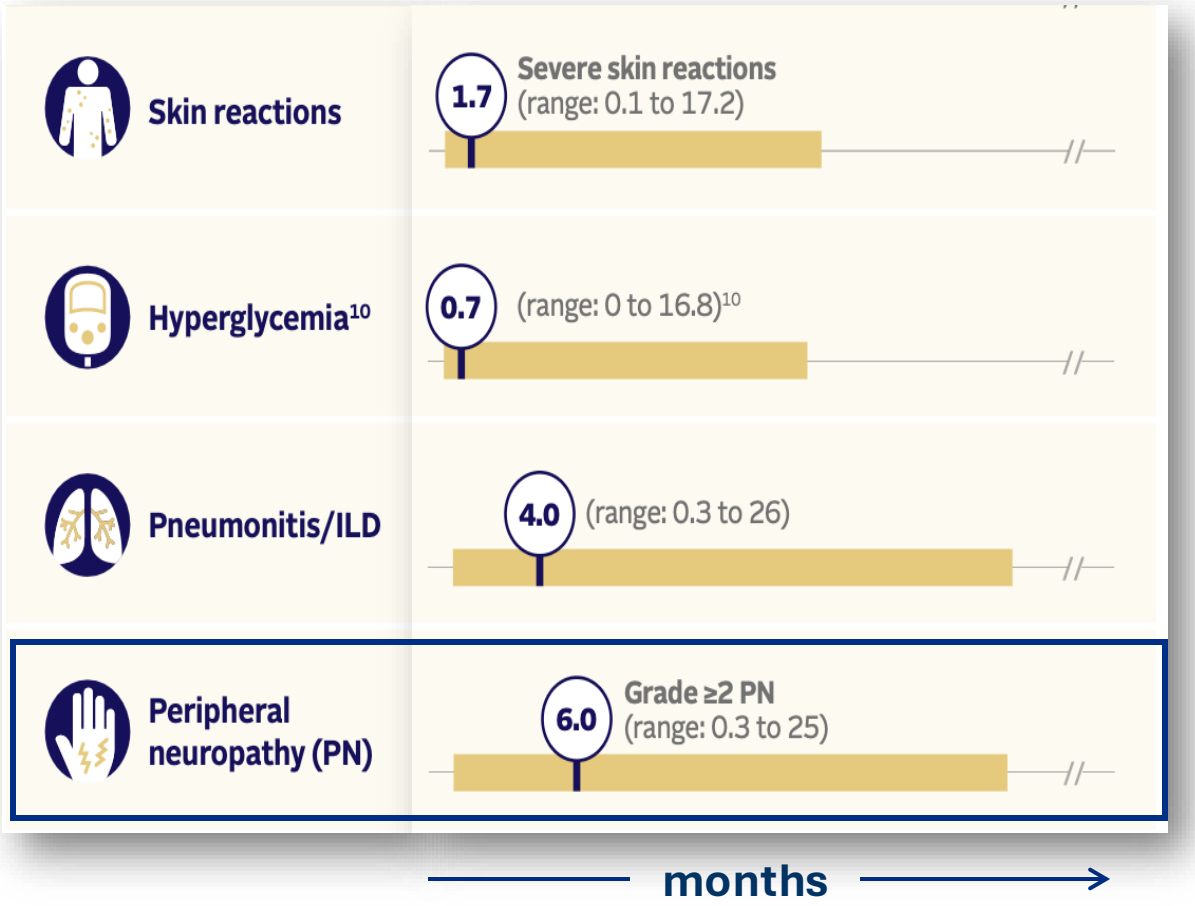
Peripheral Neuropathy

Embryofetal Toxicity

1. PADCEV. Prescribing Information.

Recognizing Peripheral Neuropathy (PN)

Median Time to Side Effect Onset with PADCEV® + Pembrolizumab*



CTCAE v6.0 Grading Scale for PN

	Peripheral motor neuropathy	Peripheral sensory neuropathy
Grade 1	Mild symptoms; clinical or diagnostic observations only	Mild symptoms
Grade 2	Moderate symptoms; limiting instrumental activities of daily living	
Grade 3	Severe symptoms; limiting self-care activities of daily living	
Grade 4	Life-threatening consequences; urgent intervention indicated	

*In first-line locally advanced or metastatic urothelial cancer

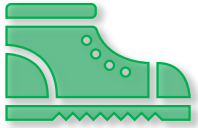
1. Care Team Guide to PADCEV Adverse Reactions.

Monitoring and Management of Peripheral Neuropathy (PN)

Recommend that patients:

Avoid bringing bare hands or feet in direct contact with hot or cold items

Wear shoes at all times when walking, and regularly self-examine feet for injury



Wear clothes and shoes that are not too tight

Ask screening questions to assist in identification of PN

- *"Have you noticed any new or worsening numbness or tingling in your hands or feet?"*
- *"Are you experiencing any muscle weakness?"*

Encourage patients to immediately report any new or worsening symptoms of PN:

- ❑ Numbness in hands or feet
- ❑ Tingling in hands or feet
- ❑ Muscle weakness

Recommended PADCEV dose modifications by PN severity

Grade 2	• If first occurrence, withhold until Grade ≤1, then resume at same dose • For recurrence, withhold until Grade ≤1, then reduce dose by one level
Grade ≥3	• Permanently discontinue

1. Care Team Guide to PADCEV Adverse Reactions.

When considering enfortumab vedotin (EV) + pembrolizumab (pembro) for a patient with pre-existing hyperglycemia and peripheral neuropathy, what would be your practice's general approach to management?

1. Provide interventions to minimize baseline comorbidities prior to EV + pembro initiation
2. Offer increased monitoring and patient education prior to EV + pembro initiation
3. Initiate EV + pembro with standard monitoring and adjust if toxicity develops
4. Consider dose modifications of EV + pembro at treatment initiation
5. Avoid EV + pembro
6. Other

Key Clinical Trials and Patient Cases:

Antibody-Drug Conjugates in Breast Cancer and Associated Toxicities	• DESTINY-Breast11, 05, 09
	  ○ ***Patient case: Early-stage ENHERTU and ILD management***
	  ○ ***Patient case: ENHERTU + pertuzumab in metastatic disease***
	• TROPION-Breast02
	• ASCENT-03

Antibody-Drug Conjugate + Immunotherapy Combinations and Associated Toxicities	• ASCENT-04
	  ○ ***Patient case: Growth factor support with TRODELVY***
	• KEYNOTE-869/EV103
	• KEYNOTE-B15/EV304
	  ○ ***Patient case: Managing toxicities with EV + pembrolizumab***

Skin Toxicity With KRAS Inhibitors	• RASOLUTE-302 ○ ***Patient case: Rash management with daraxonrasib***

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Pancreatic Cancer

RASolute 302: Evaluating Daraxonrasib in Metastatic Pancreatic Adenocarcinoma (mPDAC)

Not yet FDA approved but available through expanded access

Study Design

Phase 3, randomized trial

Key Eligibility Criteria

- Adults with mPDAC
- One prior fluoropyrimidine- or gemcitabine-based regimen in the metastatic setting
- ECOG PS 0-1
- Documented tumor RAS mutational status by local testing
  - Mutated RAS, and no RAS mutation, are both eligible

R 1:1

n=248

Daraxonrasib

300 mg, orally once daily

n=252

Investigator's choice chemotherapy

GnP, mFOLFIRINOX, Nal-IRI + 5-FU/LV, FOLFOX

Novel mechanism of action: Daraxonrasib = RAS(ON) multi-selective inhibitor; targets active, "ON" form of RAS proteins

Dual primary endpoints: Overall survival and progression-free survival* in the RAS G12 population

*By BICR=Blinded Independent Central Review.

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1. ASCO 2026. Abstract LBA5.

Pancreatic Cancer

RASolute 302: Evaluating Daraxonrasib in Metastatic Pancreatic Adenocarcinoma (mPDAC)

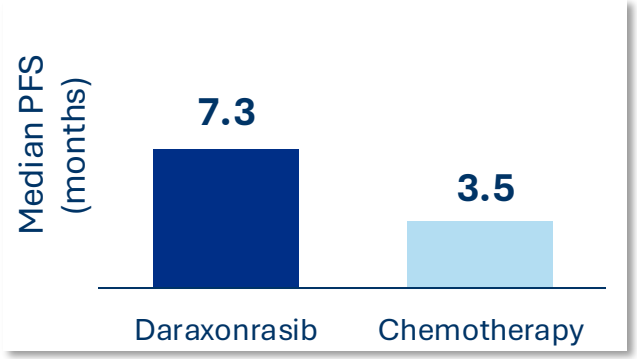
Not yet FDA approved but available through expanded access

Key Efficacy of Daraxonrasib vs Chemotherapy

Dual primary endpoint

55% relative improvement in **progression-free survival (PFS)** in the **RAS G12 population**

3.8-month absolute difference

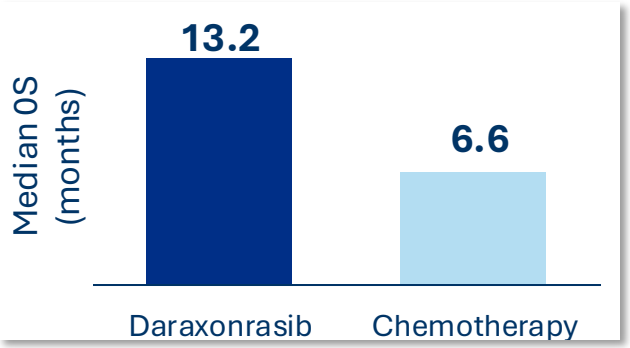


51% improvement (3.6-month absolute difference) in overall population

Dual primary endpoint

60% relative improvement in **overall survival (OS)** in the **RAS G12 population**

6.6-month absolute difference



60% improvement (6.5-month absolute difference) in overall population

Most Common Adverse Events (AEs)

Rash:
- Any: 85%
  - Grade ≥3: 14%

Diarrhea:
- Any: 58%
  - Grade ≥3: 5%

Stomatitis:
- Any: 53%
  - Grade ≥3: 12%

Nausea:
- Any: 46%
  - Grade ≥3: 12%

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1. ASCO 2026. Abstract LBA5.

Pancreatic Cancer

RASolute 302: Evaluating Daraxonrasib in Metastatic Pancreatic Adenocarcinoma (mPDAC)

Not yet FDA approved but available through expanded access

Key Takeaways

1. **Daraxonrasib significantly improved overall survival and progression-free survival vs chemotherapy**
2. **Daraxonrasib provided benefit irrespective of wild-type or mutated RAS**
3. **Not FDA approved yet but granted permission for Revolution Medicines Expanded Access Program** May 1, 2026

Key Considerations for Clinical Practice

- Daraxonrasib should be a new standard of care in the 2L setting when approved by the FDA
- Consider convenient once-daily oral administration
- Establish proactive monitoring and management of common adverse events, including rash, diarrhea, nausea, and stomatitis
- Engage dermatology services early and utilize topical therapies to support management of dermatologic toxicities

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1. ASCO 2026. Abstract LBA5.

Real-World Patient Case Study:

Daraxonrasib and Side Effect Management

Patient Profile and Diagnostic Journey

- 49-year-old woman
- Feb 2025 – Apr 2025: Persistent/worsening abdominal pain
  - Imaging identified gallstone pancreatitis; underwent laparoscopic cholecystectomy
- 06/04/2025: MRI of abdomen revealed 1.9 cm high T2 and low T1 signal at the junction of the body and tail of the pancreas with upstream dilatation of the pancreatic duct as well as a 1.2 cm lesion in segment 5 of the liver
- 06/15/2025: Endoscopic ultrasound → pathology consistent with adenocarcinoma
- **06/20/2025: Liver biopsy → Metastatic adenocarcinoma, compatible with known pancreatic primary**
- **Tempus on original pathology positive for KRAS and TP53 mutations**

Treatment

- Completed 12 cycles of FOLFIRINOX
- Microwave ablation of liver tumor and distal pancreatectomy and splenectomy
- Resumed FOLFIRINOX; oxaliplatin discontinued with cycle 13 due to worsening peripheral neuropathy; chemotherapy continued for a total of 22 cycles
- 07/01/2026: Imaging demonstrated expected post-ablation changes with no evidence of recurrent pancreatic cancer or metastatic disease
- **07/15/2026: Additional FOLFIRINOX held; recommendation to start daraxonrasib**
- **08/03/2026: Daraxonrasib initiated**

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Side Effect Management Implemented for Daraxonrasib

Rash prophylaxis

- **Minocycline** 50 mg BID starting prior to treatment initiation for up to 8 weeks
- **Triamcinolone** 0.1% cream: Apply to the trunk daily for up to 8 weeks
- **Hydrocortisone** 2.5% cream: Apply to face daily for up to 8 weeks
- Gentle lotions, creams, detergents

Nausea

- **Prochlorperazine** 10mg PO Q6 hours PRN mild to moderate nausea
- **Ondansetron** 8mg PO/ODT Q8 hours PRN moderate to severe nausea but ALSO recommended to take this 30 minutes prior to the first 3 doses of daraxonrasib for 3 days when starting. If tolerating well without nausea, OK to discontinue after 3 days.
- Small frequent meals throughout the day, gentle foods (avoid spice) to help with nausea naturally

Diarrhea

- **Loperamide** 2mg capsule. At first instance of diarrhea, take 2 capsules, then take 1 capsule every 4 hours or after each unformed stool. Max: 8 capsules per day.
- Gentle foods (avoid spice), maintain oral hydration

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Clinical Presentation of Rash Associated With KRAS Inhibitors

Most often presents as an erythematous, papulopustular eruption, resembling acneiform lesions, typically on the face, chest, and upper back

Patients may also report pruritus, burning sensations, or tenderness, which can range from mild irritation to severe discomfort

In some cases, rash is accompanied by dry skin, scaling, or secondary infections

CTCAE Grading of Dermatologic Toxicities	
Grade 1	Localized rash or mild pruritus, no impact on daily activities
Grade 2	Widespread eruption or moderate symptoms, some interference with daily living
Grade 3	Severe or generalized rash, intense pruritus, possible superinfection, **requiring medical intervention or treatment interruption**
Grade 4	Life-threatening skin reactions, though rare, necessitating **permanent discontinuation**

Most patients experience Grade 1-2 rashes, which can be effectively managed with supportive care

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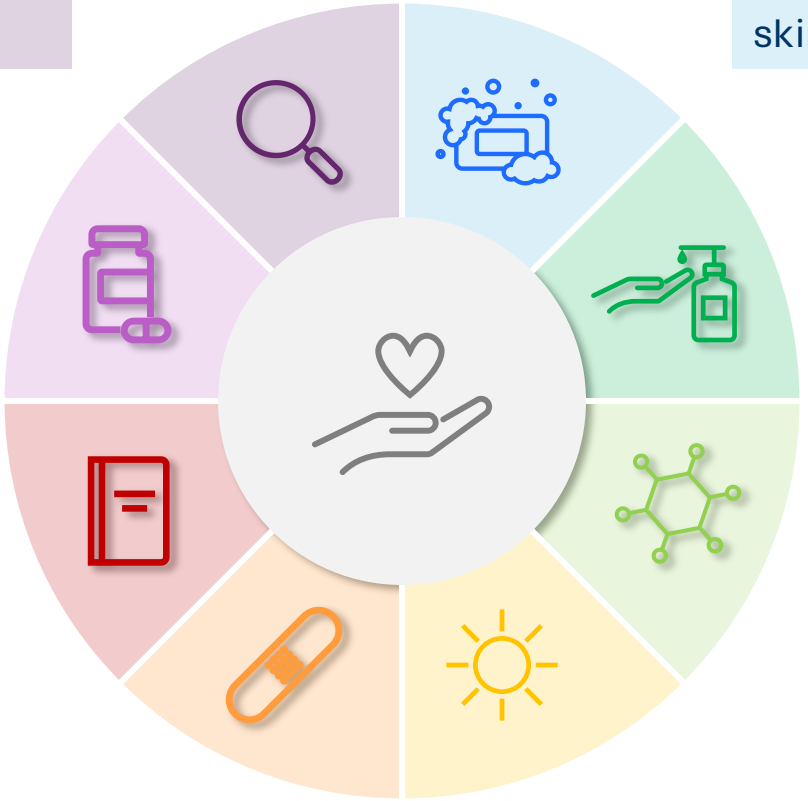
1. HidocDr.com. Managing KRAS Inhibitor Toxicities: Focus on Rash and Beyond.

Supportive Skin Care for Cancer Patients

Regular Monitoring
Critical to identify toxicity early, optimize management, and preserve therapeutic benefits

Gentle Cleansing
Daily cleansing with mild, fragrance-free soaps and lukewarm water help maintain skin integrity without causing irritation

Pharmacologic Therapies
Can include topical corticosteroids, topical antibiotics, and systemic therapies



Moisturizing
Moisturizers containing emollients or ceramides should be applied regularly to prevent dryness and barrier disruption

Patient Education
On early recognition of skin changes and importance of prompt reporting

Avoidance of Irritants
Advise patients to avoid harsh chemicals and abrasive clothing

Prophylactic Treatments
For high-risk patients, preemptive topical corticosteroids or barrier creams may reduce rash incidence and severity

Sun Protection
Advise patients to avoid excessive sun exposure; sunscreen and protective clothing recommended for photosensitive rashes

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1. HidocDr.com. Managing KRAS Inhibitor Toxicities: Focus on Rash and Beyond.

General Strategies for Early Identification and Monitoring of Rash Associated With KRAS Inhibitors

Rash often develops within first 2-4 weeks of treatment with KRAS inhibitor therapy

- Proactive surveillance during this period is critical

Regular follow-up visits help with longitudinal assessment of rash severity

- Standardized grading tools (e.g., CTCAE)
- High-resolution photographs
- Patient-reported outcome measures

Baseline dermatologic assessment should be performed prior to initiating KRAS inhibitor therapy

- Document pre-existing conditions (e.g., eczema, acne, or photosensitivity
- Educate patients on early warning signs (e.g., erythema, pruritus, papulopustular lesions)

Multidisciplinary monitoring involves oncologists, nursing teams, and dermatologists

- Embed structured monitoring protocols into routine oncology practice

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1. HidocDr.com. Managing KRAS Inhibitor Toxicities: Focus on Rash and Beyond.

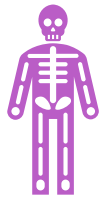
Pharmacologic Management of Rash

Topical corticosteroids

- **Typically given as first-line therapy** to reduce inflammation, erythema, and pruritus
  - **Prophylactic use** may be helpful in high-risk patients
- **Low-to-medium potency:** Typically used for mild-to-moderate rashes
- **Higher-potency:** May be required for severe presentations under careful supervision

Topical antibiotics or antiseptics

- May be added in cases of **secondary bacterial infection**



Systemic therapies

- **Oral antihistamines** are commonly used to control pruritus and improve patient comfort
- Systemic **corticosteroids or immunomodulatory agents** may be indicated in severe or refractory cases

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1. HidocDr.com. Managing KRAS Inhibitor Toxicities: Focus on Rash and Beyond.

How does your practice typically manage the associated risk of rash with select cancer treatments?

1. Supportive care only (topical steroids, antihistamines, moisturizers)
2. Proactive skin-care protocol built into electronic medical records and initiated at treatment start
3. Dose hold or reduction based on severity
4. Dermatology referral for moderate/severe or persistent rash
5. All of the above
6. Unsure

Fatigue and Cancer

Zach Krueger, PA-C, MSPA

General Principles for Management of Cancer-Related Fatigue

NCCN Guidelines definition: *Distressing, persistent, subjective sense of physical, emotional, and/or cognitive tiredness or exhaustion related to cancer or cancer treatment that is not proportional to recent activity and interferes with usual functioning*

Fatigue is rarely an isolated symptom

Fatigue is a subjective experience

Fatigue should be assessed and managed according to clinical practice guidelines

Inform patients and caregivers that fatigue management is an integral part of care and can persist following treatment

Best managed by interdisciplinary teams who can tailor interventions to individual patient needs

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NCCN Guidelines. Cancer-Related Fatigue. V2.2026.

Four Phases of Management of Cancer-Related Fatigue

1

Screening:

Screen for fatigue and, if present, assess intensity level

2

Primary evaluation:

More focused history and physical examination for patients with moderate to severe fatigue

3

Intervention:

For the amelioration of fatigue based on clinical status (e.g., active cancer treatment, post-treatment, end of life)

4

Re-evaluation:

Treatment of fatigue is continuous, leading to iterative loop in screening and management

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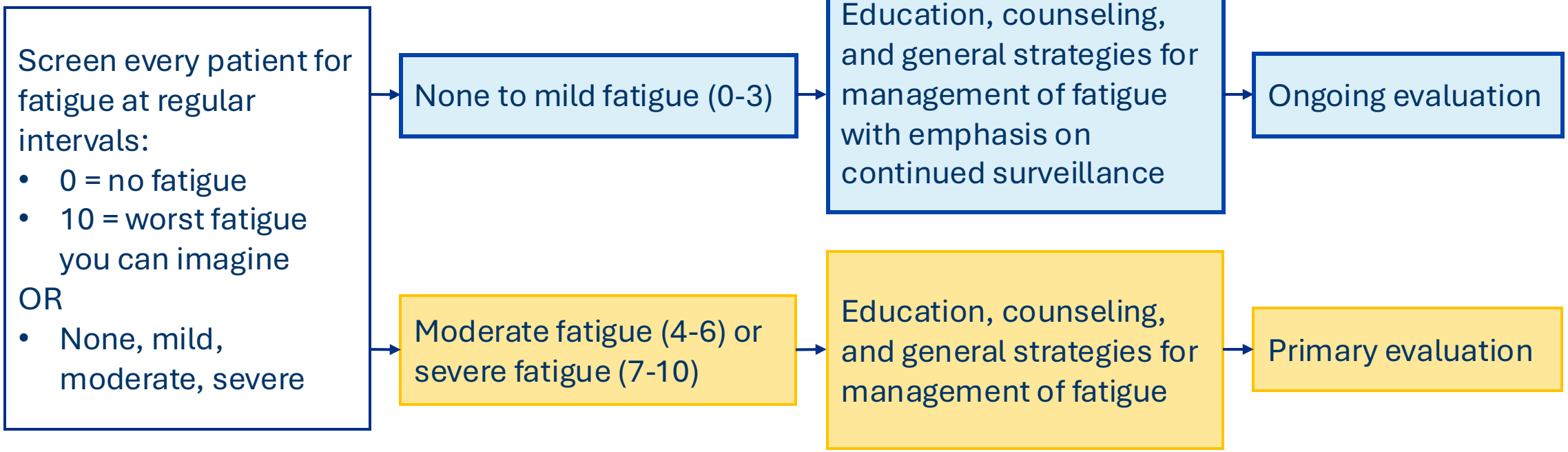
NCCN Guidelines. Cancer-Related Fatigue. V2.2026.

Screening for Cancer-Related Fatigue

Recommended screen and evaluation:

"How would you rate your fatigue on a scale of 0-10 over the past 7 days?"



NCCN Guidelines. Cancer-Related Fatigue. V2.2026.

Primary Evaluation for Cancer-Related Fatigue

Focused history:

- ❑ Disease status, treatments, and recent hospitalizations
- ❑ Medications, including OTC and supplements
- ❑ Functional status prior to cancer diagnosis
- ❑ In-depth fatigue history
- ❑ Social support status/caregiver availability
- ❑ Economic status and resources

Assessment of treatable contributing factors:

- ❑ Pain
- ❑ Emotional distress
- ❑ Psychiatric disorders
- ❑ Anemia
- ❑ Sleep disturbance
- ❑ Nutritional deficits/imbalance
- ❑ Decreased functional status
- ❑ Comorbidities

Used to guide:

→ **Management of concurrent symptoms and treatable contributing factors** → **General strategies for management of fatigue**

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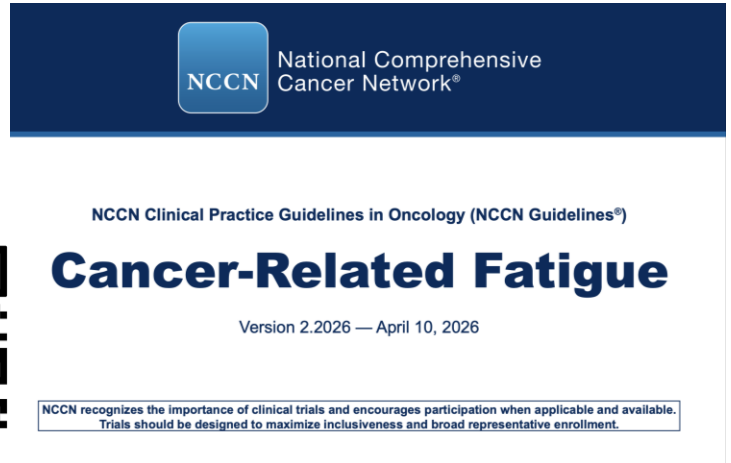
NCCN Guidelines. Cancer-Related Fatigue. V2.2026.

Resources and Interventions for Managing Cancer-Related Fatigue

NCCN Guidelines for Management of Fatigue:



NCCN Guidelines are available for several contributory factors to fatigue

- **Pain**
- **Emotional distress**
- **Anemia**
- **Poor sleep**
- **Comorbidities**

Non-pharmacologic Interventions

Category 1	• Appropriate **activity levels for daily living** • Structured **exercise programs** • Referral to **physical therapy and exercise oncology** specialists • **Psychosocial interventions** • **Massage therapy**
Other	• Bright white light therapy, acupuncture, nutrition consultation

Pharmacologic Interventions

- Consider **short-term steroids** on a patient-by patient basis

NCCN Guidelines. Cancer-Related Fatigue. V2.2026.

Distress and Cancer

Meredith Angele, PA-C

Common Drivers of Distress in Cancer Patients

Understanding What's Behind the Distress

Emotional	**Anxiety, depression, fear of recurrence, uncertainty about treatment outcomes**
Physical	**Pain, fatigue, sleep disturbances, treatment-related adverse events**
Practical	**Financial toxicity, transportation challenges, employment concerns, insurance barriers**
Social & Spirtual	**Caregiver burden, family stress, social isolation, loss of meaning or purpose**

Distress is often multifactorial. Identifying the root cause helps guide appropriate intervention and referral

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NCCN Guidelines for Patients®: Distress During Cancer Care (2026).

Standard of Care for Distress Management

1

Screening:

- Screening tools
- Problem list
- Assessment at key points of care

2

Primary evaluation:

- Evaluate severity of distress
- Identify contributing factors
- Access safety concerns and urgent needs

3

Treatment:

- Symptom management
- Counseling and emotional support
- Referral to specialist
- Coordinate multidisciplinary support

4

Follow-up:

- Re-assess distress regularly
- Monitor response to intervention
- Adjust care plan as needed
- Ensure referrals are completed

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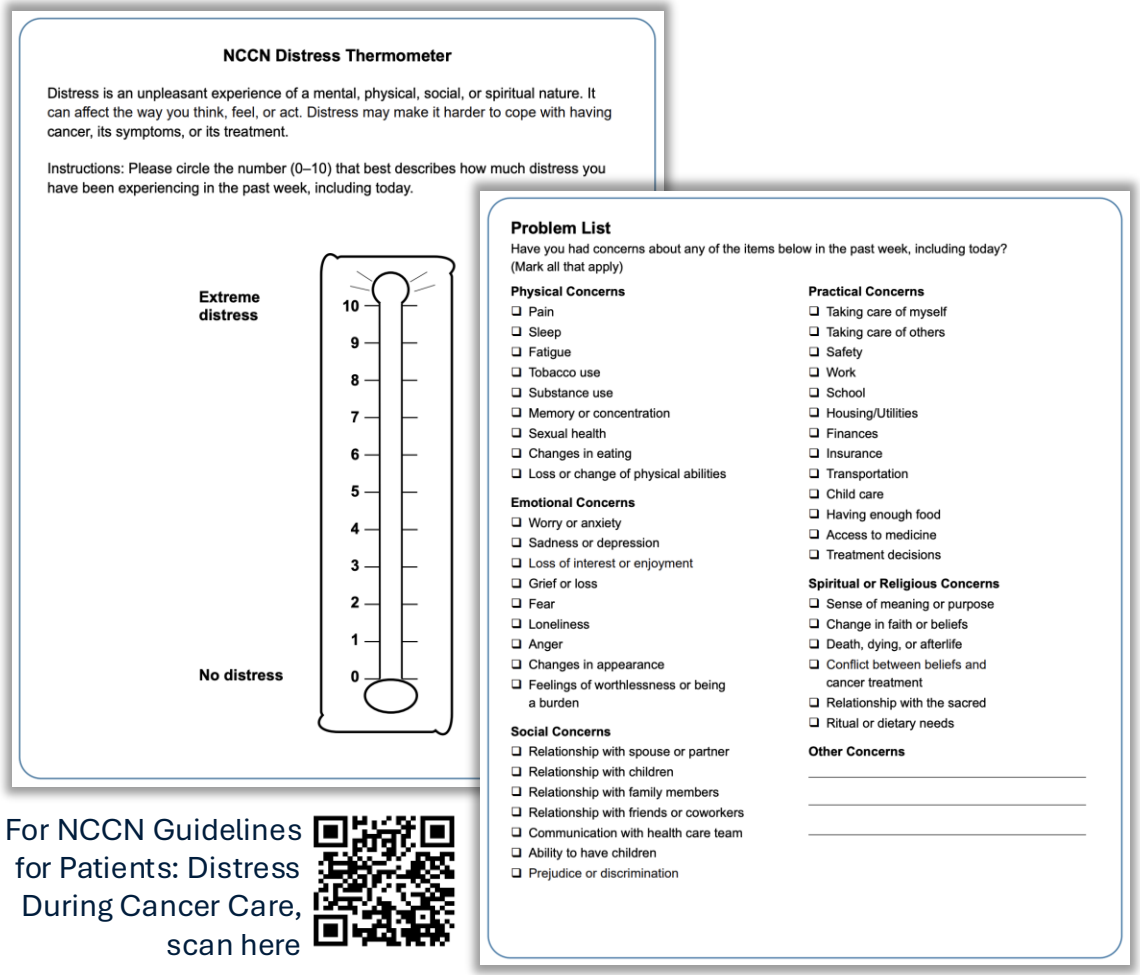
NCCN Guidelines®. Distress Management, Version 2.2026.

Screening and Assessment for Distress

- Several validated approaches to screen for distress exist
- NCCN recommends **routine distress screening** for all patients with cancer
- The **NCCN Distress Thermometer** and **Problem List** provides a quick and validated screening approach
- Screening helps identify the source of distress and facilitates appropriate referrals



NCCN Distress Thermometer

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.

Extreme distress

10 9 8 7 6 5 4 3 2 1

No distress

0

Problem List

Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)

Physical Concerns
- ❑ Pain
- ❑ Sleep
- ❑ Fatigue
- ❑ Tobacco use
- ❑ Substance use
- ❑ Memory or concentration
- ❑ Sexual health
- ❑ Changes in eating
- ❑ Loss or change of physical abilities

Emotional Concerns
- ❑ Worry or anxiety
- ❑ Sadness or depression
- ❑ Loss of interest or enjoyment
- ❑ Grief or loss
- ❑ Fear
- ❑ Loneliness
- ❑ Anger
- ❑ Changes in appearance
- ❑ Feelings of worthlessness or being a burden

Social Concerns
- ❑ Relationship with spouse or partner
- ❑ Relationship with children
- ❑ Relationship with family members
- ❑ Relationship with friends or coworkers
- ❑ Communication with health care team
- ❑ Ability to have children
- ❑ Prejudice or discrimination

Practical Concerns
- ❑ Taking care of myself
- ❑ Taking care of others
- ❑ Safety
- ❑ Work
- ❑ School
- ❑ Housing/Utilities
- ❑ Finances
- ❑ Insurance
- ❑ Transportation
- ❑ Child care
- ❑ Having enough food
- ❑ Access to medicine
- ❑ Treatment decisions

Spiritual or Religious Concerns
- ❑ Sense of meaning or purpose
- ❑ Change in faith or beliefs
- ❑ Death, dying, or afterlife
- ❑ Conflict between beliefs and cancer treatment
- ❑ Relationship with the sacred
- ❑ Ritual or dietary needs

Other Concerns

For NCCN Guidelines for Patients: Distress During Cancer Care, scan here

Many cancer symptoms overlap with depression and anxiety, making formal screening tools especially valuable

NCCN Guidelines for Patients®: Distress During Cancer Care (2026).

Managing Distress in Community Oncology Practice

A Multidisciplinary Approach

Address Physical Contributors

- Optimize symptom management
- Control pain, fatigue, nausea, insomnia
- Refer to palliative care when appropriate

Provide Emotional Support

- Normalize emotional responses
- Encourage coping strategies and resilience
- Offer supportive counseling during visit

Refer to Appropriate Resources

Social Work	**Financial, transportation, caregiver concerns**
Psychology/ Psychiatry	**Anxiety, depression, PTSD**
Chaplaincy	**Spiritual or existential distress**
Support Groups	**Peer connection and shared experience**

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NCCN Guidelines®. Distress Management, Version 2.2026.

Patient Resources for Mental Health & Coping

CancerCare
- Free counseling
- Support groups
- Educational workshops
- Financial assistance

www.cancercare.org

Cancer Support Community
- Support groups
- Educational programs
- Mind-body wellness programs
- Virtual mindfulness and yoga classes

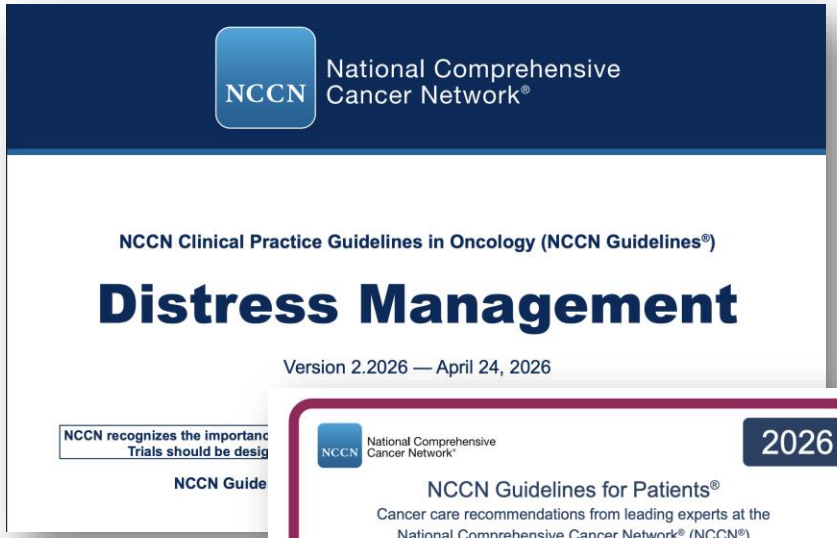
www.cancersupportcommunity.org

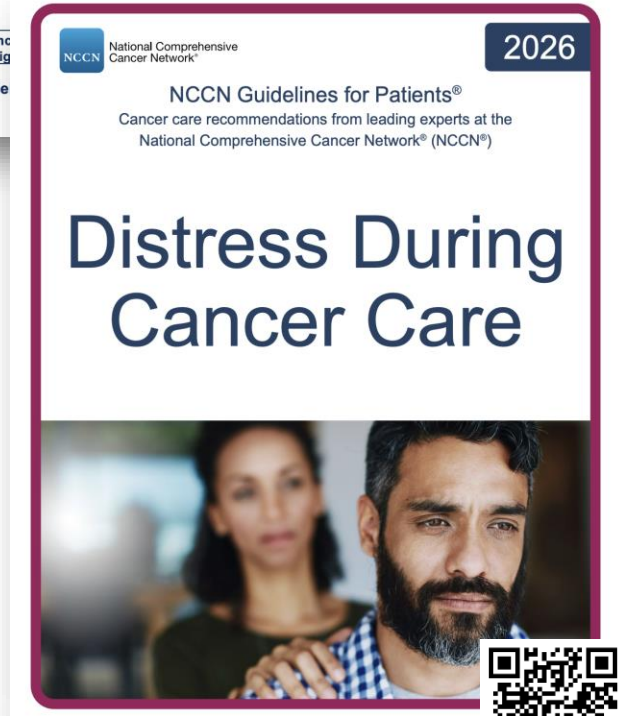
National Cancer Institute
- Coping with Cancer resources
- Caregiver support information
- Mental health resources

www.cancer/gov/about-cancer/coping

American Cancer Society
- Emotional support resources
- Survivorship support
- Caregiver resources

www.cancer.org





Weight, Glucagon-like Peptide-1 Receptor Agonists (GLP-1s) and Cancer

Edith A. Perez, MD

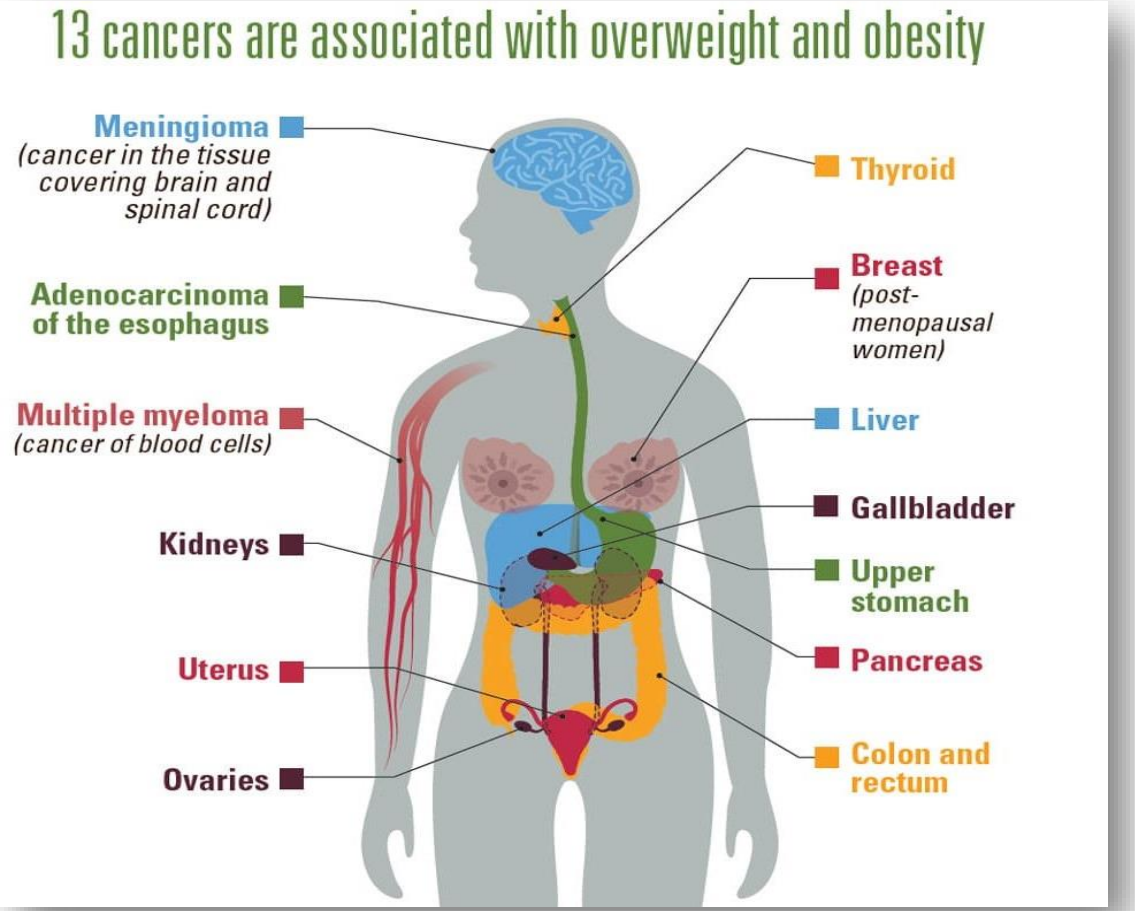
Chief Medical Officer, Cornerstone Specialty Network

Professor Emeritus, Mayo Clinic

6 slides

Why Weight Matters in Oncology Practice?

Obesity and metabolic dysregulation are recognized as major oncogenic drivers across multiple tumor types



Obesity is a modifiable risk factor for development, progression, and resistance to therapy in various cancers

- Reinforces the importance of **metabolic health screening** in oncology care
- Opportunity for **Advanced Practice Provider-led interventions** in weight management and metabolic counseling
- Potential discussion of **GLP-1 therapy** and cancer-risk reduction

https://www.cdc.gov/cancer/risk-factors/obesity.html

What are GLP-1 Receptor Agonists?

GLP-1 receptor agonists (RAs) were originally developed as antidiabetic drugs that mimic the action of glucagon-like peptide-1 (GLP-1), an incretin hormone that enhances insulin secretion in response to meals

4 FDA Approvals for Chronic Weight Management

- **Wegovy (semaglutide)**
  - Initial approval (injectable) 2021
  - December 2025 as an oral
  - March 2026 as a higher dose injectable
- **Zepbound (tirzepatide)**
  - November 2023 (injectable)
- **Saxenda (liraglutide)**
  - August 2025 (injectable)
- **Foundayo (orforglipron)**
  - April 2026 as an oral

Mechanism of Action
GLP-1 RA binds to and activates GLP-1 Receptors
Enhances insulin secretion
Suppresses glucagon secretion
Delays gastric emptying and reduces appetite
Cardiovascular and renal benefits

https://www.drugs.com/medical-answers/glp-1-drug-best-weight-loss-3579236/

Why GLP-1s Matter in Oncology Practice?

Type 2 diabetes is associated with increased cancer risk due to metabolic dysfunction and chronic inflammation

GLP-1s have **anti-inflammatory and immune-modulatory effects** beyond glucose control

GLP-1s may offer dual benefit: metabolic control and potential reduction in metastatic tumor progression in obesity related cancers

Glucagon-like peptide-1 receptor agonists (GLP-1RAs)

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The Lancet Diabetes & Endocrinology, 2025; 141
ASCO 2026; Abstract 3143.
American Cancer Society. *Can GLP-1s Help Reduce the Risk of Cancer?* 2026.

Early Stage Cancer

Can GLP-1 receptor agonists mitigate cancer progression?

Study Design **Retrospective observational cohort**

Population (n=10,225):

- Breast, Lung (NSCLC), Colorectal, Liver (HCC), Prostate, Pancreatic, Kidney (RCC)
- Patients with stage I–III cancer (TriNetX database)

Two types of antidiabetic agents, GLP-1s and gliptins, were evaluated*.

Drugs Compared (1:1):

- **GLP-1s:** liraglutide (Victoza®, Saxenda®), pramlintide (Symlin®), dulaglutide (Trulicity®), tirzepatide Mounjaro®, Zepbound®), lixisenatide (Adlyxin®), semaglutide (Ozempic®, Wegovy®, Rybelsus®)
- **DPP-4 inhibitors (gliptins):** sitagliptin (Januvia®), linagliptin (Tradjenta®), saxagliptin (Onglyza™), alogliptin (Nesina®, Vipidia®)

- ➢ These tumor types represent a large portion of community oncology volume
- ➢ Many patients already use GLP-1s for diabetes or weight management

*GLP-1s are more potent and have stronger anti-inflammatory effects than gliptins.

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ASCO 2026, Abst. 3143; J Clin Oncol 44, 3143(2026)

Early Stage Cancer

Can GLP-1 receptor agonists mitigate cancer progression?

Results of the retrospective comparison of GLP-1s vs. Gliptins on metastatic progression

Reduced Progression to Stage IV disease and improved survival

Cancer Type	Progression to Stage IV	Risk of Death
Lung	**10%** vs 22%	HR: 0.50 (0.43-0.59); *P*-value <0.001
Breast	**10%** vs 20%	HR: 0.57 (0.46-0.71); *P*-value <0.001
Colorectal	**13%** vs 22%	HR: 0.69 (0.54-0.88); *P*-value 0.003
Liver	**19%** vs 28%	HR: 0.62 (0.44-0.89); *P*-value 0.009

- Prostate, pancreatic, kidney: trend toward benefit but **not statistically significant**

➢ GLP-1s resulted in a meaningful reduction in cancer progression across 4 solid tumor types

- ~20 million Americans on GLP-1 receptor antagonist treatments
- Findings are immediately clinically relevant

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ASCO 2026, Abst. 3143; J Clin Oncol 44, 3143(2026)

Other Studies and Future Directions

Many other recent studies on GLP-1s and cancer, with more to come…

Future Directions

- Community-based retrospective or prospective trials to validate anticancer effects of GLP-1s
- Identify if certain tumor types benefit more than others from GLP-1 therapy
- Guidance for GLP-1 continuation/discontinuation during cancer treatment
- Evaluation of GLP-1 RAs benefits in patients without diabetes or obesity

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Wender RC. GLP-1 Receptor Agonists and Cancer—The Promise Is Real. *JAMA Netw Open.* 2026;9(5):e2612143.

Summary: Fatigue, distress, and metabolic health are interconnected in cancer care