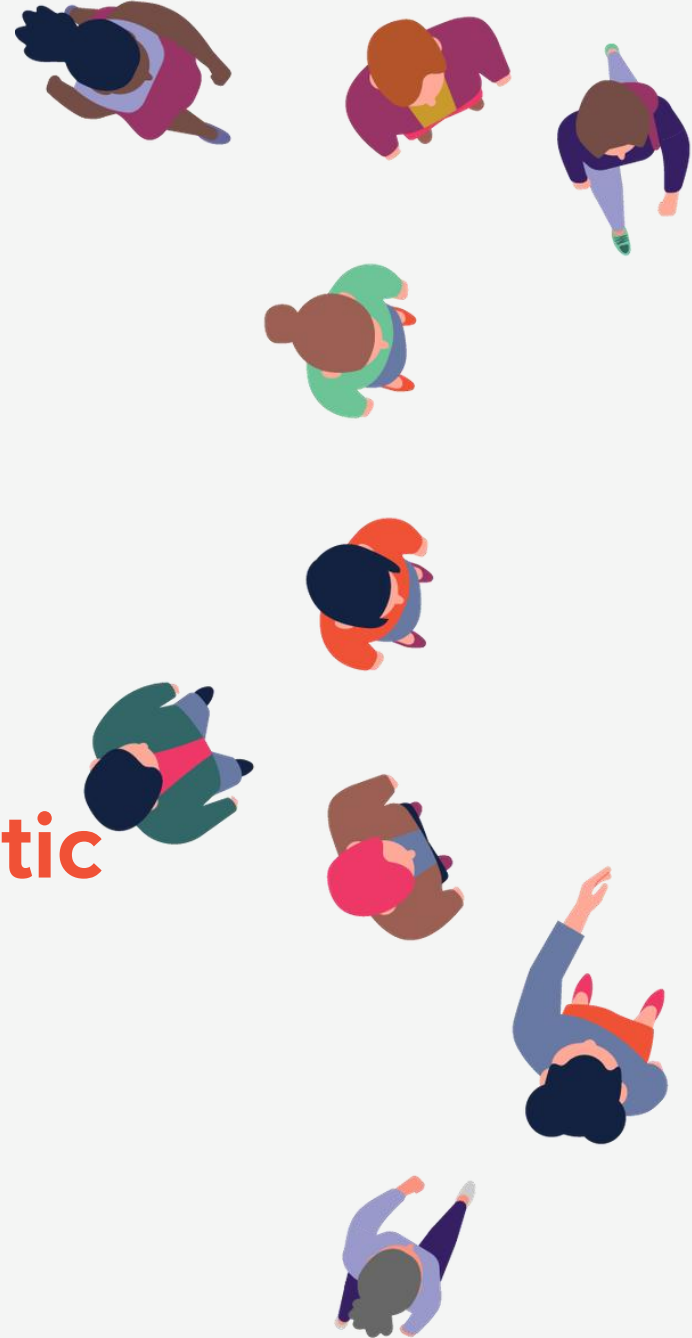


Triple-negative breast cancer

Understanding today's treatment options in early-stage and metastatic breast cancer

Speaker: Monique Gary, DO, MSc, FACS



HOSTED IN PARTNERSHIP WITH THE TRIPLE NEGATIVE BREAST CANCER FOUNDATION

Triple-negative breast cancer: today's treatments and what comes next

Facilitated by Arlene Brothers, Executive Director, TNBC Foundation

Monique Gary, DO, MSc, FACS

Breast Surgical Oncologist- St. Luke's University Health Network

CMO, Bexa Inc

Founder & CEO, Still Rise Farms

What “triple-negative” means

ER

Estrogen receptor

Absent or below 1%

PR

Progesterone receptor

Absent or below 1%

HER2

HER2 protein

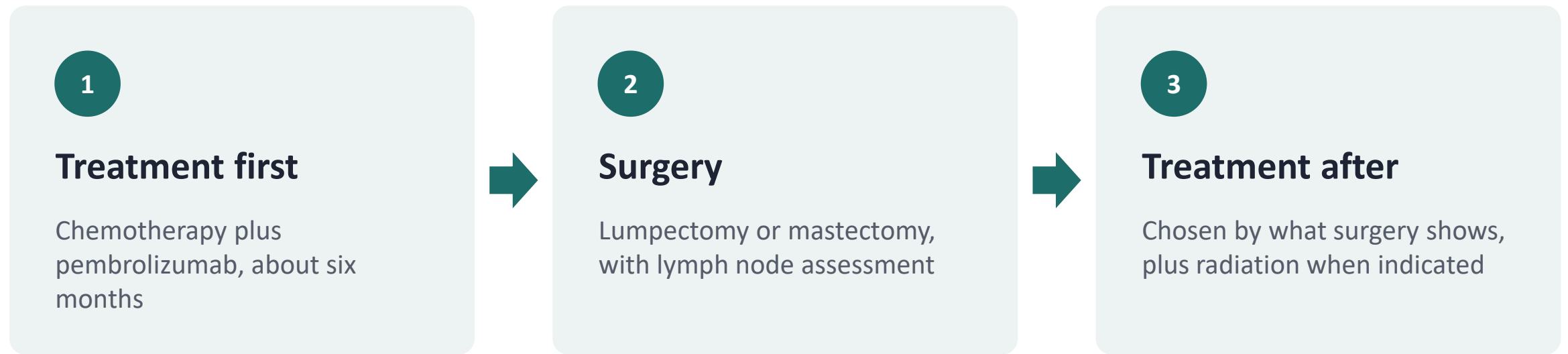
Not overexpressed or amplified

About 10–15% of breast cancers. Diagnosed more often in women under 40, Black women, and people who carry an inherited *BRCA1* variant.

Testing that shapes the plan

Test	What it tells us	When it matters
ER, PR, HER2 (incl. HER2-low)	Confirms TNBC; HER2-low opens trastuzumab deruxtecan	Diagnosis and any recurrence
Germline genetic testing	PARP inhibitor eligibility; surgical and family decisions	Everyone with TNBC, at diagnosis
PD-L1 (22C3, CPS)	Immunotherapy eligibility in metastatic disease	Metastatic diagnosis
Tumor genomic profiling	Rare targets (MSI-high, TMB-high, NTRK) and trial matching	Metastatic diagnosis

Early-stage TNBC: the usual sequence for stage II–III



Small, node-negative (stage I) tumors may start with surgery.

Immunotherapy before and after surgery

63% vs 56%

No cancer left at surgery (pathologic complete response), all 1,174 patients

87% vs 82%

Alive at five years

Chemotherapy plus pembrolizumab compared with chemotherapy plus placebo

Surgery choices in TNBC

Lumpectomy with radiation and mastectomy offer equivalent survival.
Being triple-negative is not, by itself, a reason for mastectomy.

Genetic results

May open a conversation about risk-reducing surgery

Response to treatment

Can spare a full lymph node dissection

Your priorities

Body, recovery, reconstruction, and what matters to you

After surgery, the response guides the next step

No cancer left (pCR)

- Complete one year of pembrolizumab
- Radiation when indicated
- Follow-up and survivorship care

Cancer remaining

- Complete pembrolizumab
- Add capecitabine, or olaparib with a BRCA variant
- Ask about clinical trials now

Immune side effects: tell your team early

Thyroid

Fatigue, weight change, feeling hot or cold

Adrenal and pituitary

Exhaustion, dizziness, headache, nausea

Bowel

Diarrhea, belly pain, blood in stool

Lungs

New cough or shortness of breath

Skin

Rash, itching, blistering

Liver

Yellow skin or eyes, dark urine

These can appear months after treatment ends. Most are treatable; some hormone effects are permanent.

One question splits the road: is immunotherapy an option?

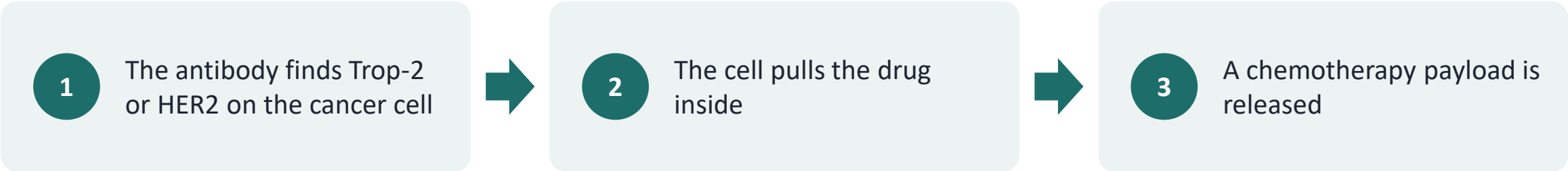
It depends on PD-L1 (CPS ≥ 10), how recently immunotherapy was given, and your overall health.

First-line options for metastatic TNBC in 2026

Situation	Option	Basis
Immunotherapy candidate, PD-L1 CPS ≥10	Sacituzumab govitecan + pembrolizumab	ASCENT-04; FDA, June 2026
	Chemotherapy + pembrolizumab	KEYNOTE-355
Not an immunotherapy candidate	Datopotamab deruxtecan	TROPION-Breast02; FDA, May 2026
	Sacituzumab govitecan	ASCENT-03; FDA, June 2026
Inherited BRCA1/2 variant	Olaparib or talazoparib	OlympiAD; EMBRACA

Later lines include sacituzumab govitecan (ASCENT) and, for HER2-low tumors, trastuzumab deruxtecan.

Antibody–drug conjugates: guided delivery



Drug	Side effects to watch
Sacituzumab govitecan	Low white counts, diarrhea, nausea, hair loss
Datopotamab deruxtecan	Mouth sores, dry or irritated eyes, nausea; rarely lung inflammation
Trastuzumab deruxtecan	Nausea, fatigue; lung inflammation needs prompt reporting

Where research is heading

1

Newer drugs, earlier

ADCs before or after surgery:
TROPION-Breast03 and -04,
ASCENT-05, TroFuse-012

2

Less when less is enough

Anthracycline-free regimens,
stopping immunotherapy after
pCR, MRI and blood tests to guide
timing

3

Better signals

Immune cells in the tumor (TILs)
and circulating tumor DNA after
treatment

A clinical trial can be the best option at any stage, not only the last one.

Ask at diagnosis, after surgery, and whenever treatment changes.

Questions to bring to your team

Early-stage

- Is my tumor ER-negative or ER-low?
- Will genetic results be back before surgery?
- How will my response change the plan?
- How can I protect my fertility first?
- Which side effects need a same-day call?

Metastatic

- What is my PD-L1 score, and on which test?
- Am I a candidate for immunotherapy?
- Is my tumor HER2-low?
- Which ADC first, and what comes after?
- Is there a trial for me now?

TRIPLE NEGATIVE BREAST CANCER FOUNDATION

Questions and conversation

Monique Gary, DO, MSc, FACS

@DrMoniqueGary on IG

info@drmoniquegary.com