Title: Informed Therapy for Black Women with Triple-Negative Breast Cancer: Meeting Them Where They Are and Moving Toward Better Outcomes

Sara Hurvitz:

Hi there. I'm Dr. Sara Hurvitz. On behalf of CME Outfitters, I would like to welcome you to today's educational activity titled: “Informed Therapy for Black Women with Triple-Negative Breast Cancer: Meeting Them Where They Are and Moving Toward Better Outcomes.” Today's program is supported by an educational grant from Merck Sharp & Dohme Corporation. Today's activity is brought to you by CME Outfitters, an award-winning jointly accredited provider of continuing education for clinicians worldwide.

I also want to encourage everyone to join us today on our live Twitter conversation @cmeoutfitters. We'll be monitoring the Twitter feed and responding to your tweets as they come in. One last item I want to note is that we are using an enhanced platform today that allows you to save slides. Also, you can take notes on your slides, answer polling questions, and send us your questions. Please click on the “Ask Questions” tab if you have a question.

Let me now introduce our faculty. Again, I'm Dr. Sara Hurvitz, professor of medicine and director of the Breast Cancer Clinical Trials Program in the division of hematology/oncology at the David Geffen School of Medicine at UCLA. I am very happy to introduce our wonderful faculty for this evening. First is Dr. Rita Nanda. She's associate professor of medicine and director of breast oncology at the University of Chicago in Chicago, Illinois. Hi, Rita. I'm so glad you're here.

Rita Nanda:

Hi, Sara. It's great to be here with you and Dr. Whitaker.

Sara Hurvitz:

Yes. Speaking of which, also here tonight is Dr. Kristen Whitaker, assistant professor in the departments of clinical genetics and medical oncology at Fox Chase Cancer Center in Philadelphia. Welcome, Kristen, so glad you're here.

Kristen Whitaker:

Thank you. I'm so happy to be here with you guys.

Sara Hurvitz:

Excellent. Here are the learning objectives for today's activities. The first one is to evaluate the changing landscape of treatment options for high-risk triple-negative breast cancer to inform therapy plans. The second learning objective is to recognize the disparate impact of triple-negative breast cancer in Black women. Lastly, the third objective is to engage to empower Black women regarding mammography screenings, treatment decisions, and participation in clinical trials.

It's going to be an exciting night. Before we get into more of the interactive discussions, I'd really like to start with some background information on triple-negative breast cancer. Rita, would you be able to walk us through what we know about the incidence and course of triple-negative breast cancer, as well as some recent treatment changes based on recent clinical trials?

Rita Nanda:

Thanks, Sara. I'd love to. I think as many of you know, triple-negative breast cancer is a form of breast cancer that's defined by lack of expression of the estrogen receptor, the progesterone receptor, and the HER2 receptor. About 15% of breast cancers are triple-negative. We know that historically triple-negative breast cancer's been associated with a poor overall survival.

The vast majority of breast cancers in the United States are early-stage, diagnosed in the early stage. We know that up until relatively recently, about a third of individuals with early stage triple-negative breast cancer would experience a recurrence. After a diagnosis of stage four disease, either de novo or a recurrence after early-stage disease, the survival has been on average about a year and a half, again, very aggressive course.

Historically, the options for treatment have been limited to chemotherapy, although that has certainly changed over the last few years. Let's think about some of the biomarkers that we use in breast cancer and how these biomarkers can help us identify what reasonable strategies are for individuals who've been diagnosed with triple-negative breast cancer.

In the interest of time, I'm not going to get into all of this, but we know that individuals who have germline mutations in BRCA1 and 2 can benefit from the PARP inhibitors, either olaparib or talazoparib. We know from the OlympiAD trials and the EMBRACA trials, that both of these therapies are associated with a three- to four-month improvement in median progression-free survival.

In addition to being more effective than chemotherapy of physician's choice, these therapies have also been shown to be associated with a better quality of life. We also know that for those individuals who have advanced triple-negative breast cancer, PD-L1 positivity is an important biomarker and we're going to review some of the data from the KEYNOTE-355 trial subsequently here.

For PD-L1 positive triple-negative breast cancer, we know that pembrolizumab plus chemotherapy is associated with an improved outcome. Now, pembrolizumab also has a monotherapy indication for individuals who have tumors that are characterized by microsatellite instability or mismatch repair, or a high tumor mutational burden, a tumor mutational burden of more than 10 Mbs are associated with an improved outcome with pembrolizumab.

Those are some of the targeted therapies that we've got available, immunotherapy and PARP inhibitors. Then obviously we also have a triple-negative breast cancer-specific approval for sacituzumab. We'll review data from the ASCENT trial as well. The KEYNOTE-355 trial was a randomized phase three trial that enrolled individuals with advanced triple-negative breast cancer.

To be eligible for this trial, patients could have received therapy for early-stage disease, but they had to have a disease-free interval of at least six months. This was a randomized trial. Patients were randomized to pembrolizumab plus chemotherapy of physician's choice versus placebo plus chemotherapy. There were different options for chemotherapy here, either nab-paclitaxel, paclitaxel, or the doublet of carboplatin plus gemcitabine.

Patients were eligible for this trial, regardless of their PD-L1 status. However, patients were stratified based on PD-L1 status, whether or not they'd received prior chemotherapy in the early-stage setting and which chemotherapy they were going to be receiving as part of the trial. There were two primary endpoints for this trial, progression-free survival, as well as overall survival in the overall intent-to-treat population as well as in two groups of patients with PD-L1 positive disease.

Those who had a combined positive score of at least one, and those who had a combined positive score of at least 10. And as you'll recall, a combined positive score looks both at tumor self-staining for PD-L1, as well as immune self-staining. There were a number of other key secondary endpoints.

What you can see here is at the initial presentation, the KEYNOTE-355 trial demonstrated that the addition of pembrolizumab to chemotherapy significantly improved median progression-free survival of about four months in those individuals who had PD-L1 positive disease. In this trial, PD-L1 positivity was defined as having a combined positive score of at least 10. About 40% of patients who participated in this trial did have PD-L1 positive disease.

While there was a trend to improvement in median progression-free survival for the overall intent to treat population and those with a lower level of PD-L1 positivity, these were not statistically significant. It really is that group of individuals with a combined positive score of at least 10 who are the ones who benefit from the addition of pembrolizumab to chemotherapy.

What we saw at the final presentation at ESMO last year is not only was there a significant improvement in progression-free survival, there was also an improvement in overall survival. You can see a really impressive almost seven-month improvement in median overall survival for those individuals who received pembrolizumab plus chemotherapy.

Based on this, pembrolizumab plus chemotherapy was granted full regulatory approval for the treatment of PD-L1 positive metastatic triple-negative breast cancer. Because of the significant survival advantage that was seen, atezolizumab, which did demonstrate an improvement in median progression-free survival when combined with nab-paclitaxel, didn't actually demonstrate an improvement in overall survival.

While atezolizumab plus nab-paclitaxel was granted approval a few years ago, it's now been withdrawn from the market. The only immunotherapy that is approved for metastatic triple-negative breast cancer is pembrolizumab. Shifting gears to briefly review the ASCENT trial, the ASCENT trial was a randomized phase three trial, which randomized individuals with metastatic triple-negative breast cancer to sacituzumab govitecan versus chemotherapy of physician's choice.

The chemotherapy of physician's choice here could be eribulin, vinorelbine, gemcitabine or capecitabine, and patients were treated until the time of unacceptable toxicity or until the time they experienced disease progression. The primary endpoint here was progression-free survival, as well as the secondary endpoint, including overall survival.

Patients were eligible for this trial if they'd received at least two prior lines of chemotherapy for triple-negative breast cancer. One of these lines could be given in the early-stage setting provided patients recurred within 12 months of completing their neoadjuvant or adjuvant therapy. Sacituzumab govitecan is approved in the second-line setting or in the... I'm sorry, in the second-line setting for advanced triple-negative breast cancer.

That approval was based on these results. Sacituzumab was associated with a significant improvement in median progression-free survival of almost four months as compared to chemotherapy of physician's choice. While underpowered to detect a survival advantage, there was also a five-month improvement in median overall survival for those individuals who were randomized to sacituzumab 12 months versus 6.7 months for chemotherapy of physician's choice. Really very impressive results.

About 12% of patients who participated in this trial were of self-reported Black race. What you can see here in the panel on the left was that there was an improvement in median progression-free survival, as well as in the panel on the right overall survival for Black individuals who received sacituzumab versus chemotherapy of physician's choice. The safety profile and the benefit profile was really similar to the overall intent to treat populations. Really exciting data to see.

I just wanted to leave you with this high-level summary of what we've got available for the management of metastatic triple-negative breast cancer. In that frontline setting, we have immunotherapy, pembrolizumab plus chemotherapy, either nab-paclitaxel, paclitaxel, or the carboplatin plus

gemcitabine doublet. For those individuals who have PD-L1 positive disease, taxanes or platinums are widely used in that frontline setting.

Obviously for those 10 or so percent of individuals who have germline mutations in BRCA1 or 2, we want to think about olaparib or talazoparib. We know from the OlympiAD and EMBRACA trials that the earlier we use PARP inhibitors, the more benefit there is. Also, they are associated with a significant improvement in quality of life. We definitely want to think about these for those proportion of patients who have germline alterations.

Obviously in the second-line setting, sacituzumab is my go-to because it's not only associated with a significant improvement in median progression-free survival, but is also associated with significant improvement... I'm sorry, significant improvement in overall survival. We also have approval of pembrolizumab monotherapy for mismatch repair, microsatellite instability, and high tumor mutational burden.

Then there are number of antibody drug conjugates that are looking very promising. We're going to hear results from the DESTINY-Breast04 trial in a plenary session at ASCO this year. Please stay tuned for that really exciting data. We know that trastuzumab deruxtecan is associated with a significant improvement in median progression-free survival, as well as overall survival in HER2 low disease. HER2, one plus and two plus, we know that from a press release, but we have yet to actually see the data. That's really exciting.

Then other antibody drug conjugates targeting HER3 with patritumab deruxtecan and then datopotamab deruxtecan which is another ADC, which targets TROP2, much like sacituzumab, but with a different toxic payload. I know that was a little bit of a whirlwind tour here, but I wanted to give you a very high-level summary of some of these exciting data that have come out in the last few years and are really changing the treatment landscape for individuals with advanced triple-negative breast cancer. I'll give it back to you, Sara.

Sara Hurvitz:

Well, not so fast, Rita. That was wonderful, but we did get a question from the audience that I think would be particularly good to answer right now, before we go into the next part of our presentation. This question is in a patient who received frontline chemotherapy, let's say, doxorubicin alone for metastatic triple-negative disease. Let's assume they have de novo metastases and receive doxorubicin.

Now they need secondline therapy. How do you choose among pembrolizumab plus chemo versus sacituzumab versus more chemotherapy? Of course, for pembro, you need to demonstrate PD-L1 expression based on CPS of at least 10. Let's assume for the purpose of this exercise, patient's PD-L1 positive and is now in the second-line setting, how would you go through this sort of treatment decision-making?

Rita Nanda:

Yes. I think what we do know from the metastatic setting, at least from the monotherapy immunotherapy trials, is that the earlier immunotherapy used, the more likely it is to benefit patients. Ideally we would have that PD-L1 status up front, and we would've then selected pembrolizumab plus chemotherapy. However, now that we know this patient has PD-L1 positive disease, I would really look to a pembrolizumab-based regimen.

There are a number of different chemotherapy agents. I have a tendency to use a lot of CarboGem because patients like to keep their hair for as long as they can. That is certainly a reasonable option. Provided there's a combined positive score of at least 10, I would reach to pembrolizumab plus

chemotherapy, but obviously if there's PD-L1 negative disease, I would really look to sacituzumab in that second-line setting because we know there's a survival advantage and it's pretty impressive.

I would probably use that upfront before other chemotherapies, because I think as all of you know, we don't always get another line of therapy for individuals with metastatic triple-negative breast cancer. We don't want to miss out on that opportunity to give someone something that could enhance survival.

Sara Hurvitz:

Absolutely. Absolutely. Sacituzumab is associated with complete hair loss, so it's something important to discuss, especially in the palliative setting for patients. Thank you so much for that whirlwind overview. It was succinct and yet very thorough. Thank you so much. Now I'd like to turn over to the next part of our discussion, which really is diving deep into disparities among Black women with triple-negative breast cancer.

These disparities continue exist. I'm going to ask Dr. Whitaker Kristen to take us through some data relating to this now.

Kristen Whitaker:

All right. I think one of the important points you guys just heard Dr. Nanda present to you, all of these exciting advances that we've had in the space of triple-negative breast cancer and really in breast cancer in general. But I think a big take-home is that we're seeing that the benefits of these new therapies aren't equally being realized in patients across different racial groups.

Particularly for Black women, they still continue to have poorer outcomes related to their breast cancer compared to other racial groups. Moving on to a little bit more about the details of the disparities related to triple-negative breast cancer with regards to Black women, the first thing we see is that Black women have a higher incidence of triple-negative breast cancer than any other race.

Specifically, we know that in the US and West African populations, the rates are about 24% of triple-negative breast cancer. When we look at the US population, we know that Black women have about a twofold higher risk of triple-negative breast cancer than white women. It's important to note, not only do Black women get diagnosed with triple-negative breast cancer more commonly, they oftentimes are diagnosed at younger ages, many times premenopausal women with these breast cancer diagnoses.

Then I think one of the big questions when we look at the incidence is, well, why do we have this higher incidence of triple-negative breast cancer in Black women? One idea that's been tossed around for years is, well, perhaps it's related to differences in genetic makeup between Black patients and white patients. Until recently, we really didn't have a lot of data related to the genetics of non-white patients.

Most of our studies that looked at genetics really were conducted in white patient populations. But more recently we have started to conduct studies related to genetics in more diverse populations and we can better answer this question of how commonly do we see some of these genetic changes in different racial groups? One that I will point out is the question of, well, how commonly do we see things like BRCA mutation?

I should have said when we think about triple-negative breast cancer, we also know that we more commonly see this in BRCA1 and BRCA2 mutation carriers, particularly BRCA1 mutation carriers. Interestingly, when we start to look at some of our data in more diverse populations, we see that the rates of these mutations are not so different in white patients versus Black patients.

Our most recent estimates are showing that about 9% of Black patients have BRCA1 mutations, about 7.8% have BRCA1 mutations in white populations. Then BRCA2, both groups, whites and Blacks, have

about a 6% prevalence of BRCA2 mutations. This study, I think was very interesting because again, for many, many years, we have not had good estimates of the prevalence of these different mutations across different racial groups.

But just recently the results of this study called the CARRIERS study, which was really a population-based study that looked at the prevalence of germline mutations in 12 breast cancer susceptibility genes. The study was conducted in about 4,000 Black women and about 25,000 white women all with breast cancer. What we found when we boil this data down to look specifically at triple-negative breast cancer, is that although we looked at 12 breast cancer susceptibility genes, we saw that three genes were most commonly associated with triple-negative breast cancer.

75% of mutations in triple-negative breast cancer were in BRCA1, BRCA2, or a gene called PALB2. What I think was probably one of the most interesting findings from this study was that the overall prevalence of germline mutations were actually the same in Black versus white women. About 9% in Black women, 8% in white women, the difference was not statistically significant.

But interestingly, while BRCA1 and BRCA2 rates were the same, PALB2, which is another what we consider moderate risk breast cancer gene, was found in higher rates in Black patients compared to white patients. Then moving onto this really important point to point out is that when we think about triple-negative breast cancer and breast cancer in general, not only are we seeing triple-negative breast cancer diagnosed more commonly in Black women, we also are seeing that death from breast cancer is higher in Black women compared to white women.

If we look at our chart here, if we look at the lighter pink bars, we see we're looking at the rates of death by race. We see that here non-Hispanic white, here non-Hispanic Black. They actually have an incidence that's quite similar, but where we see some differences is again, if we look at our Black patients here compared to our white patients, the mortality from breast cancer is higher, despite a very similar incidence among the two groups.

Then we also see that Black women are diagnosed at younger ages and die at younger ages from their breast cancer. All important points to keep in our mind when we think about how can we help eliminate some of these disparities. I think this was a very interesting study here because when we think about, well, what's driving these disparities in triple-negative breast cancer? There are so many possible factors here.

But one of the obvious ones that comes to mind is, well, is it something that is different in the treatment that Black patients receive as opposed to white patients? This study here actually showed just that. This study essentially looked at Black and white women with early-stage breast cancer. They looked at the receipt of surgery, chemotherapy, and radiotherapy, and looked to see whether there were any differences in these rates of receival.

What they found is that Black patients actually were less likely to receive surgery and chemotherapy, but receive radiation therapy at similar rates as white patients. This really just highlights the point that this is actually a contributing factor that we actually can essentially eliminate and definitely modify if we really are ensuring that all of our patients get the treatment that's recommended for them. That's an important take-home from that.

Then when we think about this whole topic of disparities, just from a bigger picture, again we've highlighted some of these things in the last few slides, but it's important to remember, it really is a complex interplay that is contributing to these disparities that we see in triple-negative breast cancer. There are things like socioeconomic factors that can be things like income level, educational status, access to screening, and even things like participation in clinical trials.

There are also genetic risk factors. I think we still have a lot to learn about our genetic risk factors that may be contributing to disparities, but we know that can be a factor. Then the other thing I think we can more broadly put this category as comorbidity differences. One that we highlight here is obesity, but we certainly know that differences in comorbidities may also be contributing to these disparities that we see.

Then lastly, I just put this slide here just to show you again that where there are modifiable interventions to eliminate these disparities, we really should take note. I think one of the modifiable really are related to making sure that patients have access to high quality cancer care, access to early screening, regardless of their race. I think that's one way to help eliminate some of these disparities. Now I'll let Sara take it from here.

Sara Hurvitz:

Thank you so much, Kristen. That was a terrific overview. I'm involved in a lot of CME activities. I have to say, I've not been involved in one like this, and I think it's such an area of unmet need. We talk about unmet need all the time with breast cancer, and this is a huge area of unmet need. I think our audience agrees because we already have seven questions coming in-

Kristen Whitaker:

That’s really good. Great.

Sara Hurvitz:

... related to the topic. I think it's going to be a very interesting discussion. We've now seen some data showing cancer care disparities do exist among Black patients with triple-negative breast cancer. We've looked at some of the potential contributors to these disparities, but now we're actually going to hear from Black women who were diagnosed with triple-negative breast cancer about the care they received and their perception of bias, if any, in their care.

For this, we reached out to patient networks to identify Black women with triple-negative breast cancer, to give us short recorded answers to questions about screening, diagnosis, and treatment of their disease, and about any barriers to care that they and their peers were presented with. Before we go onto that, we have a polling question that I'm going to show you.

Have you personally witnessed bias in cancer care by fellow clinical staff, doctors, nurses, MPs, Pas, pharmacists, office staff, patient navigators in the past year? Yes, but only once or twice in the past year. Yes, more than once per month. Yes, more than once per week. Yes, seems like daily or no, never. If everybody could please submit a response, that would be terrific.

Wow. Okay. Well, we are not seeing daily and the majority say no, never, which I wonder if that's totally accurate or if we're not tuned in to the signs maybe, but it is interesting to see that 11% are noticing this more than once a week and 11% more than once a month. Truly we are seeing it in the workplace. I wonder, Rita, if you can give me your sort of take from these polling results. What's your take based on this?

Rita Nanda:

I mean, I think they're very interesting. I was expecting to see folks having seen more bias. I have to say I work in a hospital where we have a very large Black population and I think we all try to do what we can to check our own biases and make sure that we are offering patients the best therapy, access to trials,

and doing everything that we can to ensure that everyone has equal access to care. But absolutely, we all see biases in our practice.

I think as health care providers, the onus is on us to make sure that we recognize that biases do exist. They're very commonly seen. I don't know about the 53% of folks here who said they've never witnessed it, but I've definitely witnessed it and multiple times, although certainly not on a daily basis that I can necessarily think to.

But I think a lot of what we can do to break down the barriers and to resolve this issue of health inequity is that we need to recognize that there are biases and recognize our own biases, because without doing that, we really can't do the best that we want to and can do for our patients.

Sara Hurvitz:

Really well stated. Kristen, I'm wondering how these results reflect your observations in clinical practice.

Kristen Whitaker:

Yes. I think similar to Rita, I feel like personally I've definitely witnessed bias in the cancer care of my patients. Again, it's not a daily thing, but I don't actually think it's an infrequent occurrence either. When I see these polling results, I think the thing that really stands out to me is just we're hearing more and more about this concept of unconscious bias.

I think the idea is that unless we really are tuned in like you referenced before, we may not recognize biases that we ourselves are projecting in our care of patients, but also even the biases that our staff members may be projecting on our patients. I think it's just a good time to reflect on this concept of unconscious bias.

Sara Hurvitz:

Absolutely. Great points. I'd like to now turn to our patients and hear from them. Our first question asked about the importance of the race of the physician to the quality of care the patient perceived. Let's now listen to what the patient says.

Speaker 4:

I absolutely feel that the race of the oncologist affects the cancer care.

Speaker 5:

I believe that race can, and is sometimes a factor in care. There's certainly cultural things that go along with being African American that I believe only an African American physician and/or a person of color would be in tune to and recognize that it could have a bearing on care.

Sara Hurvitz:

Wow. Pretty powerful. Powerful for me to hear. I work at a place where there just aren't that many oncologists of color available to see our patients. I'd like to ask you, Kristen, to talk about this in a little bit greater detail for us.

Kristen Whitaker:

Yes. I mean, I think those patient perspectives that we just heard are really, really important. I think they highlight more than anything, the importance of a provider being able to establish rapport and trust with their patients. I think this is true regardless of whether there's racially concordant care or not.

I think when we look at the history in the US of this unethical experimentation and research, things like the Tuskegee syphilis experiment, we can understand why some Black patients actually approach the health care system with some skepticism or misgivings. I think that regardless of your race, it's really important to try to establish trust with your patients.

I also think it really speaks to the point that diversity is so, so important in the workforce, because we've heard directly from patients here that they actually do think it makes a difference having diverse providers. I think that goes across the board from the physicians taking care of them, to the nurses, to the research staff, diversity in the workforce is definitely very, very important.

Sara Hurvitz:

Thank you so much for that. We're going to turn now to another question that our patients answered. Our next question asked about patient-doctor discussions around screening prior to the patient's diagnosis. Let's listen.

Speaker 6:

My physician actually spoke to me about breast cancer screening lots of times. I would say that I was careless.

Speaker 4:

Mine did not talk to me about it, but that is because I was under 40. It was only when I turned 35 and I was having really weird symptoms. I actually went to her and said, "Is there a way that I can get a cancer screening early?" If I hadn't brought it up, it never would've been brought to my attention.

Sara Hurvitz:

Very interesting. Kristen, can you reflect a little bit on this and take us through the next few slides?

Kristen Whitaker:

Yes. I think my biggest take-home from those patient excerpts is that it's just really important that we're identifying our patients who need breast cancer screening. That realizing that even though we have guidelines now that say certain ages or certain risk factors, it's important that we listen to our patients, it's important that we explore odd or unique situations that could prompt earlier diagnosis.

I think one of the biggest areas that I know that I see from part of my clinical practice, which is seeing these high-risk patients, is really this idea of making sure we know our patients' family history so that we're identifying these patients earlier on that need screening. If we look at this study right here, we actually see why it makes a difference when we do mammograms and we diagnose breast cancers on a mammogram, as opposed to a patient coming in with a big lump in their breast or under their armpit.

If we look here at this slide, we actually see that when we look at overall survival for triple-negative breast cancer, that regardless of your race, so we looked at white patients, we also looked at Black patients in this study, women that have their triple-negative breast cancers diagnosed on a screening mammogram actually have improved survival compared to those women who had breast cancers that were not screen detected.

Really just speaking to this point of we really should be making every effort to identify these women that need to have breast cancer screening and making sure: Get that at all costs. Then keeping along with this topic of screening and diagnosis recommendations, I think we really are in a position where we are still learning the best way to screen women across racial groups. There have been some data that have suggested that perhaps Black women actually need to have screening mammograms done at an earlier age.

We do know from some studies that things like triple-negative breast cancer sometimes are not detected very well on mammograms. They get picked up better on things like MRIs. Perhaps we need to be modifying how we screen women to improve some of these outcomes related to triple-negative breast cancer. Then once we diagnose these breast cancers, we hope that they're at early stages because we've been using appropriate screening.

We want to make sure that all of these patients are having accurate assessment of important biomarkers to guide their treatment. Then I think it's very, very key that we avoid delays in treatment when we talk about ensuring the best outcomes for our patients.

Sara Hurvitz:

Thank you so much for that review. Our next question asks whether the patient perceived that the doctor valued her needs and wishes. Let's listen.

Speaker 4:

They never mentioned clinical trials, which would've been ideal for me because my body is intolerant of all the current medications to help prevent a recurrence.

Speaker 7:

I feel my oncologist lumped you in a category. If you were African American, you had this type of breast cancer, whatever, this was your treatment. I happened to be the person that they needed for the trial. It wasn't so much that he wanted to give that to me, but I could still be in a box.

Sara Hurvitz:

Wow. It's really interesting, Rita, the enrollment of Black women on clinical trials in breast cancer it's shockingly low, to be quite honest. We need our trials to enroll patients so that when the results come out, we know that the results can be reliably applied to women in the real world. If fewer than 5% of women enrolled in the study of a drug are Black women, how can we apply the data?

What are your thoughts about this and what measures have you implemented, or have you talked about implementing that might address this unmet need?

Rita Nanda:

No. I think this is a really important point, Sara. We know that women who participate in clinical trials do better. We know that individuals who participate in trials do better. I have to say, I'm very proud. We've done a great job at the University of Chicago. Really, we have a large Black population, probably about 30% of our enrollment to breast cancer trials are Black women, but we have 40% Black women in our catchment area, so we certainly can do better.

What I have to say is we have to take that time talking to patients about trials, especially those actually those who have some reservations about participating in trials because of historical biases. I don't want

to be a guinea pig or I don't want a placebo or things that I very frequently hear when I talk to individuals about trials. Now, I have some patients who come seeking trials, but many are very resistant, and it takes time.

It's really important to spend that time talking to all patients, particularly Black women, about what their options are, what the pros and cons are, and to really take that time and ensure that you don't just take, I don't want to be a guinea pig and stop there. That you really take that time, talk to patients about what trials entail. Sometimes they do take extra procedures, extra visits, maybe research biopsies.

If you explain to patients what the goal of the trial is, and if there are barriers such as childcare issues or transportation or parking, that we develop strategies to help patients with some of those barriers that may prevent them from enrolling in a trial, even if they're interested, but maybe socioeconomically it's a challenge. We really need to do those things to break down these barriers and also make sure that our trials are representative of the US population.

As you mentioned, it's very important. We can't just continue to enroll white women to trials. We really need to do a better job.

Sara Hurvitz:

Thank you for that. Kristen, can you augment this discussion a little bit by taking us through a few more data sets relating to clinical trial participation?

Kristen Whitaker:

Sure. Really just to echo what we've heard just a few minutes prior is trial participation by Black women is exceedingly low. I mean, when we look at cancer clinical trials, we know that less than 5% of the patients that enroll in all cancer clinical trials are self-identified as Black patients. Again, this presents a lot of challenges for making sure that we address some of these disparities and all patients have access to the highest quality of care.

We know our new findings are applicable to all patient populations. We have to do better. Dr. Nanda talked about some of the strategies to do better, but I think one of the things that I've always found very interesting, and I have to tell you, this is something that I hear not uncommonly at my cancer center is that there really is this misconception that either Black patients don't want to participate in clinical trials or that they're not 'good' clinical trial candidates.

I think this study is so important because this study really answered this question of is the reason Black patients aren't participating in trials because they simply don't want to, or there are some other factors that are contributing here? This study essentially... Well, there are multiple studies and this presented here is a meta-analysis of about 35 studies with about 10,000 cancer patients.

What they found is when they looked at rates of agreement to participate in clinical trials when offered among white patients, Black patients, Hispanic, and Asian patients, you actually see that the rates of willingness to participate in clinical trials among minority populations was as high, if not higher than that of white patients.

This really just speaks to that point that like Dr. Nanda said, we really have to make sure that we're taking the time to explain trials to all patients so that everyone has access to clinical trial opportunities.

Sara Hurvitz:

Absolutely. These are great points. Our next question asked about the personal challenges to receiving care, but focused on the challenges faced by their peers. Let's listen.

Speaker 8:

Most of the Black people I know who have breast cancer do complain about the cost of treatment.

Speaker 5:

Logistical challenges as in if the patient is consulted or advised about as an example, clinical trials. Well, if those clinical trials are not close where the individual could stay home and travel back and forth to those clinical trials, it becomes challenging.

Speaker 6:

Many of them went into depression, not having psychosocial tools to take care of their mental issues. Many went into a very dark place during their cancer treatments.

Speaker 4:

It's like no one wants to believe that Black patients are treated differently.

Sara Hurvitz:

Very interesting. On our next slide, we have a nice summary that maybe quickly you could go through, Kristen, talking about the challenges that increase disparities.

Kristen Whitaker:

Yes. I think again, just bringing home this point that the disparities that we see in triple-negative breast cancer, but I think cancers in general really are very much multifactorial. If you just quickly look at this slide here, we can see that we can put these disparities or the drivers of disparities into these four buckets essentially. The first being socioeconomic factors that contribute to these disparities, which are listed here.

I think the historical factors cannot be underestimated. Things like medical mistrust, different cultural practices, lack of access to things like clinical trials. Looking at this third bucket, the biological factors. Things like differences in genetic, things like differences in comorbidities, obesity, hypertension, diabetes.

Then finally we talked about it earlier too, but it's also important that we don't forget about the role that bias actually does play in terms of contributing to some of these disparities we see among our patients.

Sara Hurvitz:

Perfect. Perfect summary of a very complicated topic. Our last question asked to our patients, asked about systemic challenges to receiving care, but as before, the focus was on the challenges faced by their peers. Let's listen to this.

Speaker 6:

You have to now try to find a doctor or hospital that will guide you through the maze because the health care system is a maze in the United States.

Speaker 7:

I think whether you have insurance or not, or the type of insurance that you have does make a difference in the care that you receive.

Sara Hurvitz:

Absolutely important to highlight on top of all these issues relating to bias and biology are these systemic issues relating to insurance and coverage and location. It is just such a complex situation. Thank you again, Kristen, for taking us through that important data and giving us a very good overview of the challenges experienced by Black women with breast cancer.

Now let's finish up with a discussion about what we can do to address disparities in the care of Black women with triple-negative breast cancer specifically, and breast cancer generally. We have a number of questions that's come through. I'm not going to read this to you. I just want to highlight that these are some areas where we could perhaps do better for our patients, early detection, as Kristen went through, providing guideline concordant care.

Concordance among different races and backgrounds for all of our patients. Avoiding treatment delays, avoiding screening delays, and ensuring accurate assessment of hormone receptor status, HER2, getting our patients all genetically tested when appropriate and testing for PD-L1 expression in triple-negative disease specifically. Also, addressing disparities and ensuring as much as we can, as much as in our power, equitable access to high quality care and equitable access to research.

We think patients who are enrolled in clinical trials overall likely do better than patients who do not. It's on us to invite our patients of all colors to participate in clinical research and address structural barriers. In summary, triple-negative breast cancer disproportionately affects Black women with higher incidence, higher stage at diagnosis, and higher mortality. New approvals have expanded the therapeutic options, but they don't help a patient if patients aren't offered them.

Many Black women perceive their care to be different than white peers and many Black women do not have access to, are not offered clinical trials. There continues to be a great need to ensure equitable access to high quality care and research and addressing structural and institutional barriers. These are our specific measurable, attainable, relevant, timely goals listed here.

I won't read it to you because I do want to use the last 10 minutes to go through some questions and to remind you that these slides will be available to you after this program, so you can read through these and refer to these. I think this presentation is just packed with information. I do want to thank Drs. Nanda and Whitaker for this really interesting discussion and all the information that was provided. I would like to move on now to questions because I think this is where we're really going to get to the meat.

One of our patients, and I'll ask Kristen this, is how we talk to patients or ask about social determinants of health. I mean, how do you bring up this concept to a patient, especially if you have discordance in race with the patient you're talking to. Let's say someone like me, a white physician talking to a Black woman about what social determinants may be impacting her access to care, or what she's facing in terms of challenges.

Kristen Whitaker:

Yes. I think it is a challenging bridge sometimes to gap and topic to bring up. I think the way I start these discussions a lot of times is I ask patients, what is their support system like? Do you have someone to help get you to chemotherapy sessions? Do you have someone to help you if you're not feeling well at home? I do think that honestly, I'm very direct with my patients kind of regardless of their race.

I ask out front, I mean, do you foresee financial challenges with your care? Do you foresee transportation? Do you need to talk to the social worker? I think sometimes just asking directly, is there anything that perhaps the social worker could help you with? I know not all places have access to social workers. I think sometimes just asking, is there anything that you can foresee as a barrier to your care?

Maybe you don't see it today, but if it comes up over time, I want you to feel comfortable talking to me about it. I'm going to try my best to help you, but it is a challenging situation for sure.

Sara Hurvitz:

Absolutely. There is a question here, Rita. You talk about the success of your program and enrolling patients of color on clinical trials, which is amazing, but one of our attendees states that in her or his rural areas, access to care is very challenging, distance, financial, lack of insurance, et cetera. Are there any ideas for how this can be improved or addressed in the clinical setting?

Rita Nanda:

Yes. I think that remains a challenge, right? I mean, in rural communities where you travel hours to get care, that can certainly be a challenge. What I will say is one of the good things that has come from the pandemic is that we now have telehealth that is available and that can be an opportunity for patients to feel empowered to access second opinions where they don't need to travel and can potentially get a second opinion about their case via a phone call or a Webex or some sort of a telecommunication system.

Also, I think that programs like this that are done for our providers who are practicing out there in rural communities, who maybe don't have time to go to big meetings, have available to them. The Triple Negative Breast Cancer Foundation has excellent resources on its website for those individuals who have triple-negative disease and can offer resources to patients who are diagnosed with triple-negative breast cancer across the different stages.

There are lots of things that can be tapped into to help enhance the ability of individuals who are in a rural area and providers who care for them to get educated on the current status of treatment options for triple-negative breast cancer.

Sara Hurvitz:

Super. Super. Another question, similar to the one that I was getting at earlier, Kristen, but a slightly different shade to it. This person asked, "Since I'm Caucasian, how can I connect to my Black and non-white patients and let them know I have their best interests at heart, even when their disease is resistant to therapy? I worry that anything I come up with will sound tone-deaf or insincere." Do you have any things that could help here?

Kristen Whitaker:

Yes. I don't know that I have a particular strategy for that, but I think what I feel is most important in these situations is giving it time. I think that regardless of race and there being differences, I think that patients can sense when a provider has their best interest. I know it's hard sometimes, especially with especially aggressive disease and patients maybe not having the outcome that they hope for.

I think over time when patients build rapport with you, regardless of your race, I think you start to develop that trust and they start to realize you do have their best interest at heart. Again, though, I think this comes into the idea of just the importance of diversity in the workplace, because even if their

oncologist is not Black or the same race as them, perhaps they see other Black clinicians in the office setting.

I think that helps to just create this environment of I'm welcome here. I'm supported. They have the best interest of me too, even though I come from a racially different background than my oncologist.

Sara Hurvitz:

Excellent. Excellent. You're right, time I think ties into a lot of this. Slowing down and giving all of our patients the time needed to address their issues. I don't know if either of you know the answer to this, I think it's a great question. Are there tools that can be used to measure bias on the part of myself, my peers and/or my institution? Do either you know of any tools to help measure this? I'm not aware of any.

Rita Nanda:

I'm not aware of any standardized tools, but there are certainly things that can be done to look at quality metrics, right? You can do quality projects where you look at metrics to, what is the time from surgery to starting therapy, for example, for patients who are in adjuvant therapy? Or what is the time from diagnosis to starting neoadjuvant therapy? Or what are the different treatments that are offered to patients?

Looking at that by racial and ethnic groups, I think is a way to start to make sure that the same percentages or that there's the same percentage of patients getting offered genetic testing or having genetic testing. That patients are experiencing... One group isn't experiencing a delay in treatment, that we're screening to the same degree, which I think is a little bit harder for us as oncologists to sort of access.

But making sure patients have equal access to screening because Kristen talked about how important early detection is, and we all know that. There are certain things that you can do. I'm not aware of a standardized tool, but those are definitely key points that can be investigated and improved on, right?

If you're seeing that Black patients aren't getting to radiation in as timely of a fashion as white patients, or aren't getting from diagnosis to starting treatment in as timely as a fashion, is that an opportunity to hire, say a nurse navigator, who can help those patients who may fall through the cracks get to where they need to be? I think those are all things that could be a good start.

Sara Hurvitz:

Yes. We did have one attendee who actually messaged and said the IAT is a tool that could be used. I think it's through Harvard that measures this implicit bias. That's something that also could... But I loved your ideas, looking at your own numbers and metrics at your own center to see how people are measuring up based on race. I think that's a fabulous idea. There are some great questions.

I'm sorry we're not going to get to all of them. Just one quick question back to you, Kristen, and then we're going to have to close out the program, but one of our attendees asked how pharmacists can contribute to reducing disparities in African American women with triple-negative breast cancer. Do you have any ideas here?

Kristen Whitaker:

I mean, I think the role for pharmacists or what could be a role is really helping with this idea of compliance with medication. For example, I know at Fox Chase, we have an oral chemotherapy program

where our pharmacists actually call the patients. They're making sure that they are taking the medications, but also tolerating the medications and then communicating back with their oncologist.

I think that's a great step because I mean, compliance absolutely is going to be really important here in ensuring that patients have similar outcomes regardless of race.

Sara Hurvitz:

Wonderful. That's a great answer. I know I hit you off guard with that, so thank you. I do see our time is up. I want to thank both Drs. Nanda and Whitaker for joining me this evening. It's been such an interesting conversation on a very important topic, and I want to thank you, our audience, for joining us as well. You've done amazing job. I'm sorry we couldn't get to all of the questions, but clearly everyone's hungry for information on this topic.

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