SAN ANTONIO BREAST CANCER SYMPOSIUM®

2025年サンアントニオ報告

がん研究会有明病院
乳腺センター　乳腺外科

木村　優里

SABCS2025　注目topic

➢HER2+ EBC　✓ TILs関連

- CompassHER2, APHINITY

➢HER2+ MBC　✓ MBC治療戦略の変容

- HER2CLIMB-05, PATINA

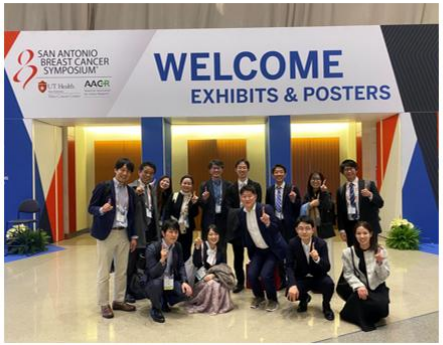
➢ER+ EBC

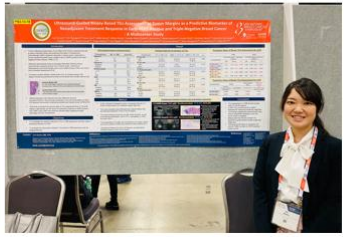
- lidERA, LORETTA

✓ Oral SERD関連

➢ER+ MBC

- ASCENT-7, SERENA-6, EMBER-3, evERA





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内分泌療法の進化
Oral SERD

最新トレンド：
乳がん診療は治療だけでなく
人生全体を支える医療へ

治療のde-escalationと
個別化

サバイバーシップへの
関心の高まり

SAN ANTONIO BREAST CANCER SYMPOSIUM®

本日のtopic

1. lidERA trial　　Oral SERDによるAdjuvant治療の変革
2. LORETTA trial　　低リスクDCISの手術省略の治療戦略
3. YES trial　　AYA世代のサバイバーシップ支援の新形態
4. PREFER trial　　妊孕性温存の現状
5. WISDOM1.0 trial　　リスク別の個別化検診

GS-01-10

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UT Health San Antonio Mays Cancer Center

AACR American Association for Cancer Research

DECEMBER 9–12, 2025

HENRY B. GONZALEZ CONVENTION CENTER • SAN ANTONIO, TX

HR+HER2-早期乳癌の術後内分泌療法において、Oral SERDであるgiredestrantの有効性および安全性を検証したP3ランダム化比較試験

Giredestrant vs standard-of-care endocrine therapy as adjuvant treatment for patients with estrogen receptor-positive, HER2-negative early breast cancer: Results from the global Phase III lidERA Breast Cancer trial

Presenting author: Aditya L. Bardia, MD
University of California, Los Angeles, Los Angeles, CA, USA

Aditya L. Bardia,* Peter Schmid,* Miguel Martín, Sara A. Hurvitz, Kyung Hae Jung, Mothaffar F. Rimawi, Shigehira Saji, Gustavo Werutsky, Nadia Harbeck, Sherene Loi, Akiko Ogiya, Manuel Ruiz-Borrego, Ahmet Alacacıoğlu, Jiong Wu, Chenglin Ye, Mario Liste-Hermoso, Nimali P. Withana, Tanja Badovinac Crnjevic, Mona D. Shah, Pablo Pérez-Moreno, Charles E. Geyer, Jr.*

* Equal contributions

Targeting the Estrogen Receptor in HR+ Disease

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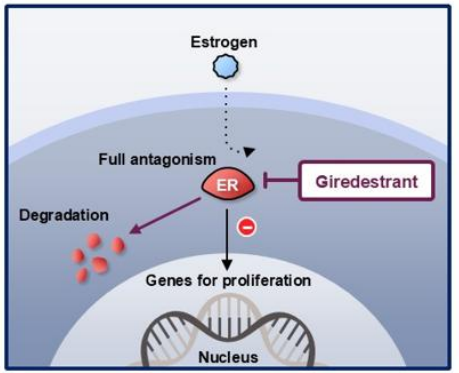
Metastatic breast cancer

1970s	1980s	1990s	2000s	2010s		2020s →	
Selective ER modulator (SERM) tamoxifen		aromatase inhibitors (AI)	Selective ER downregulator (SERD) fulvestrant	mTORi everolimus + AI	CDK4/6i palbociclib, ribociclib, abemaciclib + AI	PI3Ki (PI3K/AKT/PTEN △) alpelisib or capivasertib or inavolisib + fulvestrant	Oral SERD / PROTAC (ESR1m) elacestrant **imlunestrant** camizestrant, giredestrant vepdegestrant …

HR+HER2-進行・再発乳癌において、
次世代経口選択的エストロゲン受容体分解薬(Oral SERD)が登場

<u>Oral SERDとは・・・</u>

- ✓ **ERの働きをブロック+ERをより強力に分解**
- ✓ **Fulvestrantの通院や筋肉注射の負担を軽減**
- ✓ **ホルモン療法後に増悪したESR1m+を有するHR+HER2-進行・再発乳癌に対して、イムルリオ(ilunestrant)が承認**

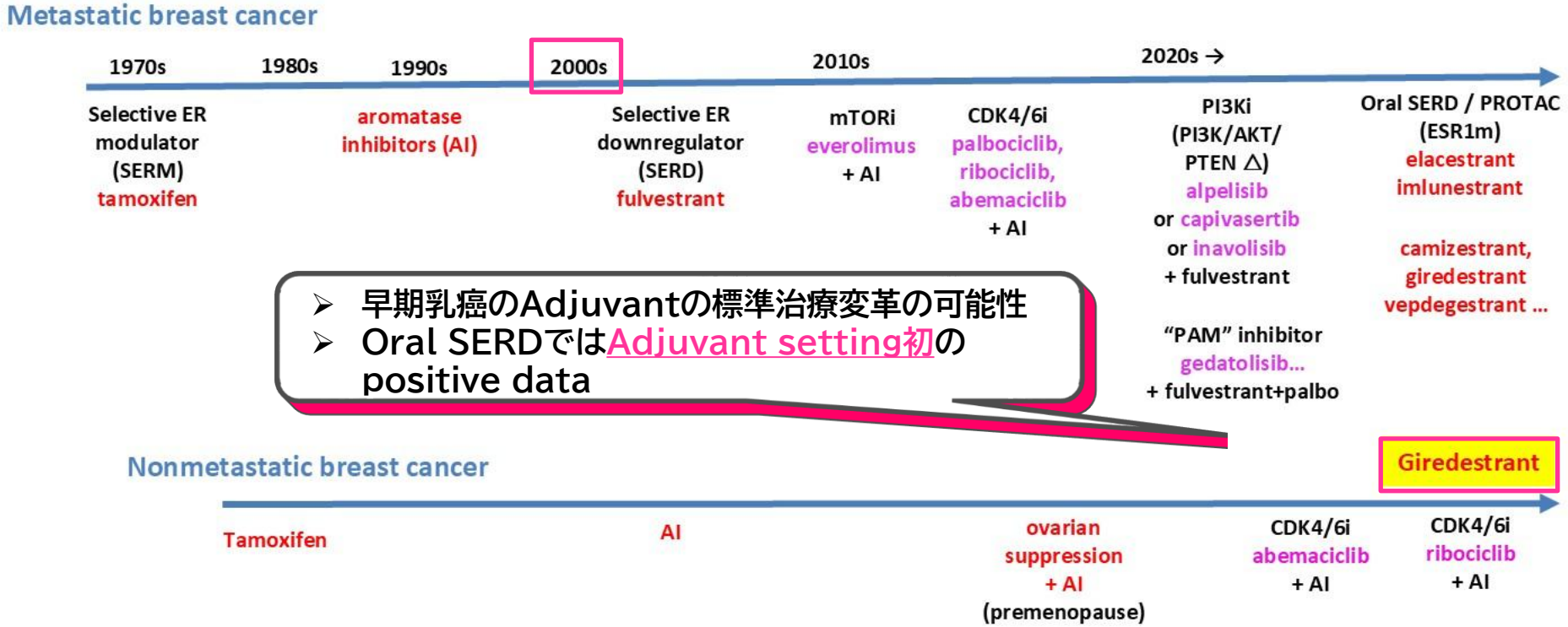


Giredestrant mechanism of action
(selective estrogen receptor antagonist and degrader)

Cancer and Metastasis Reviews 41(1):1-16, 2022

Presented by: Lisa A Carey, MD, ScM.

Targeting the Estrogen Receptor in HR+ Disease



Presented by: Lisa A Carey, MD, ScM.

lidERA Breast Cancer study design

A global, randomized, open-label, multicenter Phase III trial

Key eligibility criteria

- Participants with ER+, HER2-negative early breast cancer
- Stage I–III disease (anatomical)
  - pN0 and pT > 1 cm with Grade 3, or Ki67 ≥ 20%, or high score on genomic assay,* or pT4N0
  - Node-positive
- Pre- or post-menopausal†
- Breast cancer surgery within 12 months
- (Neo)adjuvant chemotherapy if indicated

Stratification factors

- Risk: Medium-‡ vs high-risk§ Stage I–III breast cancer
- Region: USA/Canada/Western Europe vs Asia–Pacific vs RoW
- Previous chemotherapy: No vs yes
- Menopausal status: Pre-menopausal vs post-menopausal

Primary endpoint

- IDFS (excluding second primary non-breast cancer)

Key secondary endpoints

- DFS, DRFI, IDFS (including second primary non-breast invasive cancer with exception of non-melanoma skin cancers and *in situ* carcinomas of any site), LRRFI, OS, safety

Giredestrant is currently also being investigated in combination with abemaciclib in the adjuvant setting (lidERA Breast Cancer substudy 1)

- ➢ **ER+HER2- StageI-III　(n=4170)**
- ➢ **中間~high risk対象**
- ➢ **Giredestrant vs ET　最低5年間内服**
- ➢ **主要評価項目：IDFS　中間解析結果**

ER+ was defined as ≥ 1% positive cells by immunohistochemistry. * OncotypeDx ≥ 26 or high-risk Mammaprint.
ction suppression with an approved luteinizing hormone-releasing hormone agonist. ‡ Medium risk: pN0 and primary tumor
say [if available]) and pN1 with low-risk biologic features (Grade 1/2 and Ki67 < 20% and tumor ≤ 5 cm and low score on genomic
(Grade 3, or Ki67 ≥ 20%, or tumor > 5 cm, or high score on genomic assay [if available]).
rrence-free interval; ER+, estrogen receptor-positive; ET, endocrine therapy; IDFS, invasive disease-free survival;
R, randomization; RoW, rest of the world; SOC, standard-of-care.
16), with permission.

Baseline demographics and characteristics

	Giredestrant n = 2084	SOC ET n = 2086
Median age, years (range)	54.0 (22–91)	54.0 (25–89)
Female sex, n (%)	2073 (99.5)	2075 (99.5)
Race, n (%)		
American Indian or Alaska Native	77 (3.7)	62 (3.0)
Asian	461 (22.1)	467 (22.4)
Black or African American	50 (2.4)	50 (2.4)
Other*	263 (12.6)	232 (11.1)
White	1233 (59.2)	1275 (61.1)
Region, n (%)		
Asia–Pacific	544 (26.1)	544 (26.1)
USA/Canada/Western Europe	860 (41.3)	905 (43.4)
Latin America/Africa/Eastern Europe	680 (32.6)	637 (30.5)
Menopausal status, n (%)†		
Pre-menopausal	849 (41.0)	838 (40.4)
Post-menopausal	1220 (59.0)	1236 (59.6)

	Giredestrant n = 2084	SOC ET n = 2086
ER status, n (%)‡		
Low-positive (1–10% of cells positive)	45 (2.2)	52 (2.5)
Positive (> 10% of cells positive)	2030 (97.8)	2031 (97.5)
AJCC stage at surgery, n (%)§		
I	254 (12.3)	283 (13.6)
II	1013 (49.0)	950 (45.7)
III	799 (38.7)	844 (40.6)
Nodal status, n (%) on surgical specimen‖		
pN0	449 (21.6)	441 (21.2)
pN1	968 (46.6)	953 (45.7)
pN2–3	662 (31.8)	691 (33.1)
Risk, n (%)		
High	1448 (69.5)	1447 (69.4)
Medium	636 (30.5)	639 (30.6)
Previous chemotherapy, n (%)		
No	396 (19.0)	450 (21.6)
Yes	1688 (81.0)	1636 (78.4)

Baseline demographics and characteristics were balanced

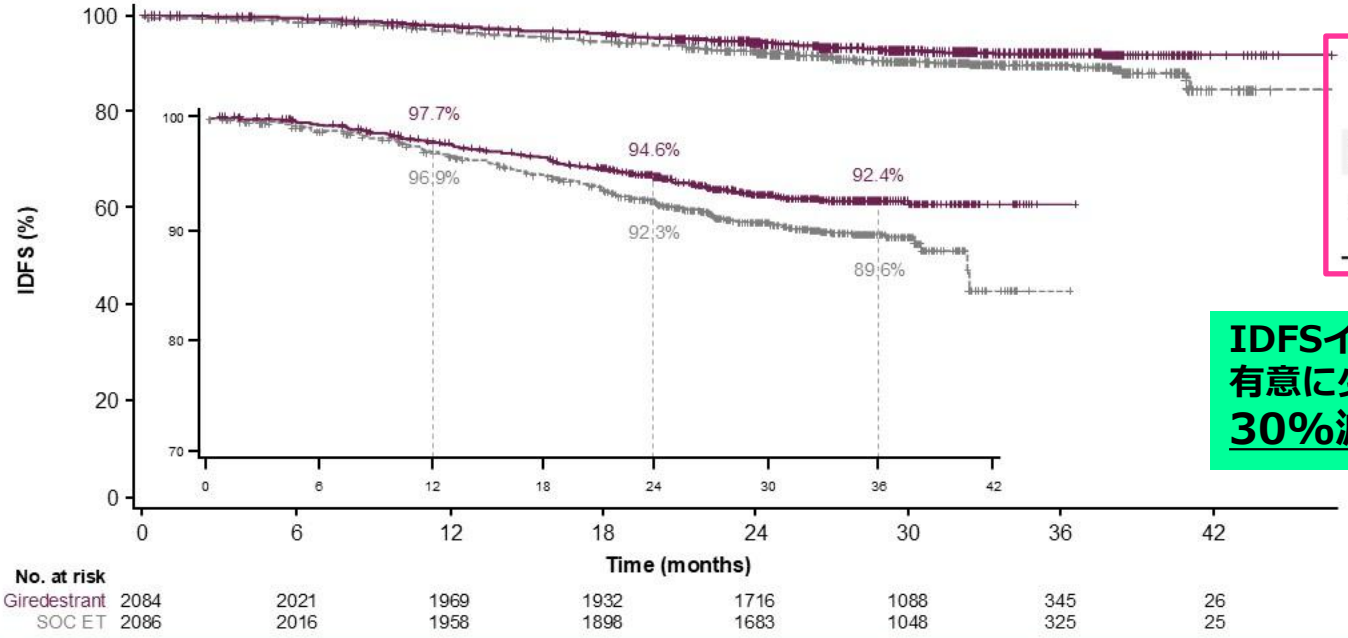
Data cutoff: August 8, 2025. * "Other" refers to "multiple", "Native Hawaiian or Other Pacific Islander", "not reported", or "unknown". † Twenty-seve and 12 in the SOC ET arm). ‡ Twelve patients had unknown ER status (nine in the giredestrant arm and three in the SOC ET arm). § One patient giredestrant arm and eight in the SOC ET arm). ‖ Six patients had unknown nodal status (five in the giredestrant arm and one in the SOC ET arm ET, endocrine therapy; SOC, standard-of-care.

- **StageII-III　約8割**
- **腋窩リンパ節転移陽性　約8割**

Presented by: Aditya L. Bardia, MD.

Primary endpoint: IDFS

- 3年IDFS　92.4% vs 89.6%
- 観察期間中央値　32か月



	Giredestrant n = 2084	SOC ET n = 2086
Events, n (%)	140 (6.7)	196 (9.4)
Stratified HR (95% CI)	**0.70** (0.57, 0.87); **p = 0.0014***	

IDFSイベントはgirdestrant群で有意に少なく、再発や死亡リスクを<u>30%減少</u>させた

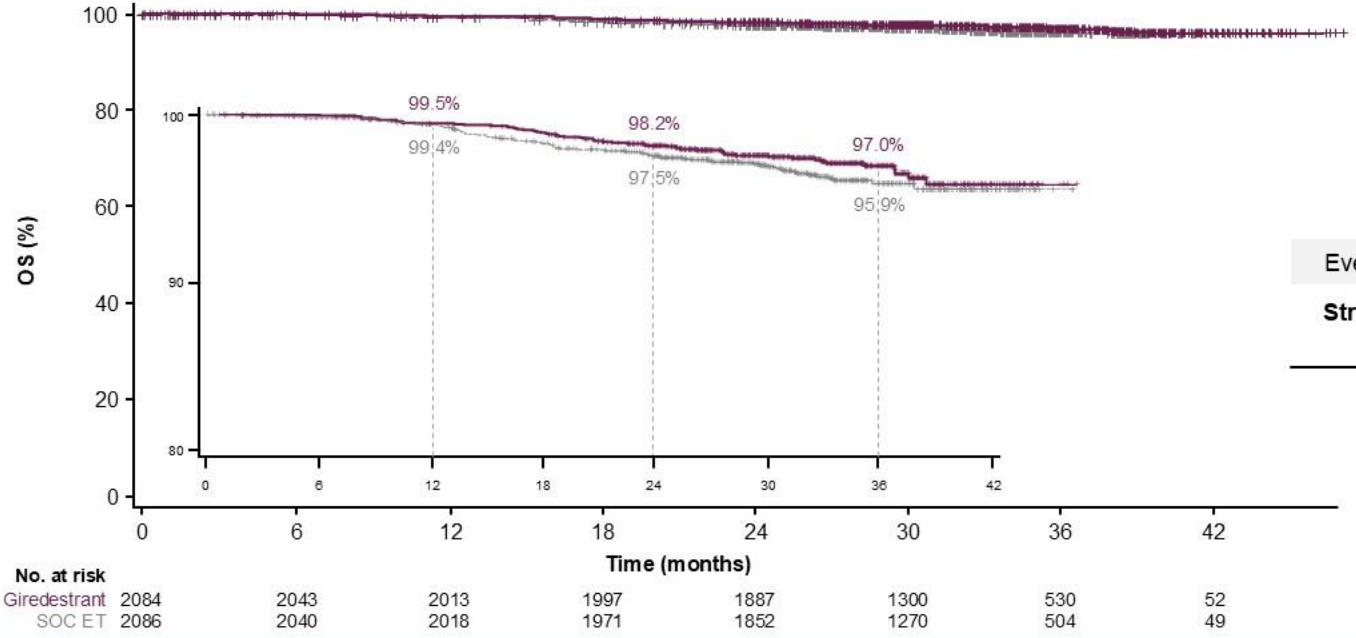
Median follow-up: 32.3 months

Statistically significant and clinically meaningful improvement in IDFS:
Giredestrant reduced the risk of invasive disease recurrence or death by 30% compared with SOC ET

Data cutoff: August 8, 2025. Median follow-up, 32.4 months in the giredestrant arm and 32.3 months in the SOC ET arm; maximum follow-up, 46.6 months and 46.3 months, respectively. * Log-rank (2-sided). p-value boundary for IDFS interim analysis was 0.0217 (2-sided). AI, aromatase inhibitor; CI, confidence interval; ET, endocrine therapy; HR, hazard ratio; IDFS, invasive disease-free survival; SOC, standard-of-care.

Presented by: Aditya L. Bardia, MD.

Interim overall survival



- OSも良好な傾向あり
- 今後の解析に期待

	Giredestrant n = 2084	SOC ET n = 2086
Events, n (%)	57 (2.7)	71 (3.4)
Stratified HR (95% CI)	**0.79** (0.56, 1.12); p = 0.1863*	

Median follow-up: 32.3 months

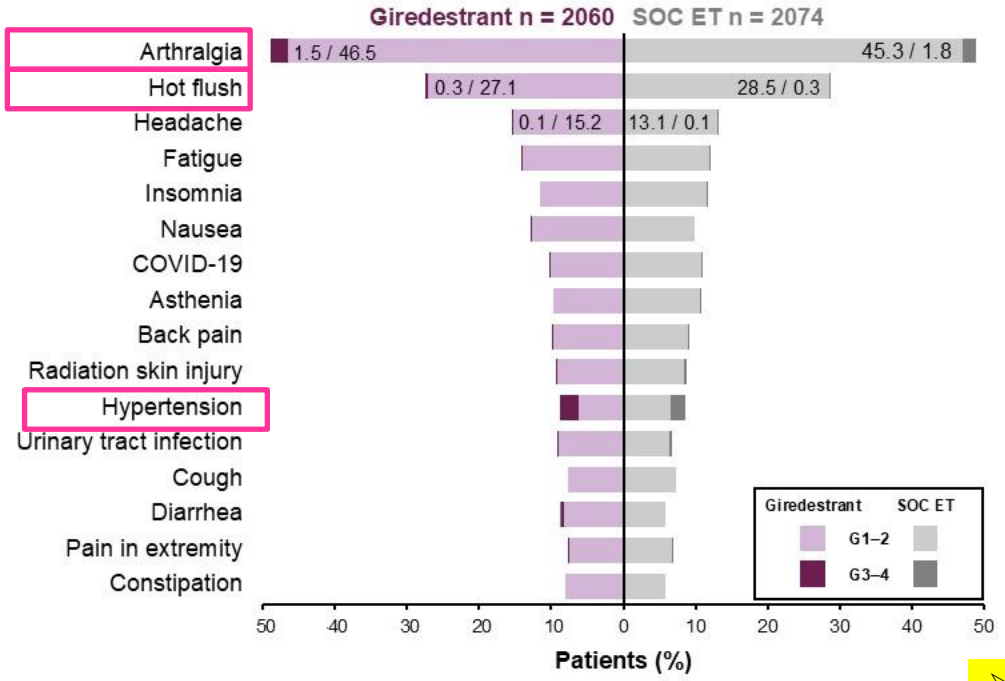
While OS data were immature, a clear positive trend was observed. OS testing will continue at future analyses

Data cutoff: August 8, 2025. Median follow-up, 32.4 months in the giredestrant arm and 32.3 months in the SOC ET arm; maximum follow-up, 46.6 months and 46.3 months, respectively. At the data cutoff, the 1st OS IA was conducted (maturity 31.2% with respect to the final OS analysis). * Log-rank (2-sided). p-value boundary for the 1st OS IA was 0.0001 (2-sided). Includes one death from a patient who was randomized but never dosed. Excludes one death from a patient with missing date of death. CI, confidence interval; ET, endocrine therapy; HR, hazard ratio; IA, interim analysis; OS, overall survival; SOC, standard-of-care.

Presented by: Aditya L. Bardia, MD.

AE overview *(safety-evaluable population)*

Common TEAEs (≥ 7.5% of patients in either arm at any grade)



Selected AEs

	Giredestrant n = 2060	SOC ET n = 2074
Patients, n (%) with treatment discontinuations due to AEs		
Musculoskeletal disorders	38 (1.8)	92 (4.4)
• Arthralgias (PT)	32 (1.6)	76 (3.7)
Vasomotor disorders	2 (< 0.1)	18 (0.9)
• Hot flush (PT)	1 (< 0.1)	16 (0.8)

	Giredestrant n = 2060			SOC ET n = 2074		
Patients, n (%) with selected AEs by medical concept*						
	G1	**G2**	**G3–4**	**G1**	**G2**	**G3–4**
徐脈						
Bradycardia†	217 (10.5)	15 (0.7)	0	64 (3.1)	2 (< 0.1)	0
Venous thromboembolic events	4 (0.2)	12 (0.6)	2 (< 0.1)‡	3 (0.1)	7 (0.3)	7 (0.3)

- **有害事象は関節痛、ホットフラッシュなどがmain**
- **高血圧(Gr2)、徐脈(Gr1)が多く報告**

Data cutoff: August 8, 2025. * Assessed as medical concepts using grouped terms; all other AEs by medical conce
† G2 events occurred in 17 patients; 13 resolved, four patients discontinued treatment and the events resolved. ‡ C
TEAE, treatment-emergent adverse event.

Presented by: Aditya L. Bardia, MD.

Summary of lidERA trial

- 2000年代にAIが承認されて以来、lidERA試験は早期乳癌での新規内分泌療法の有効性を示した初めての試験

- 浸潤癌の再発、死亡リスクを約30%改善（3年IDFS：92.4% vs 89.6% △2.8%）
  →今後拡大する可能性あり

MonarchE 2y IDFS △2.8%
NATALEE 3y IDFS △2.7%

- 安全性プロファイルは良好（関節痛、ホットフラッシュ、徐脈）

- CDK4/6阻害薬の併用、TS-1の選択肢、経済毒性(5年以上)が今後の課題

経口SERDが術後内分泌療法の新しい標準治療の選択肢になる可能性

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GS-02-09
DECEMBER 9–12, 2025
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ER+HER2-の低リスクDCISを対象に手術を省略し、TAM内服を行う有効性と安全性を評価した単群検証的試験 (JCOG1505)

GS2-09. The single-arm confirmatory trial of tamoxifen alone without surgery for low-risk DCIS of the breast with ER-positive HER2-negative (LORETTA trial: JCOG1505)

Hiroji Iwata,[1] Chizuko Kanbayashi,[2] Tatsuya Toyama,[1] Akiyo Yoshimura,[3] Takehiko Sakai,[4] Hiroko Bando,[5] Kenichi Watanabe,[6] Kaori Terata,[7] Takashi Morimoto,[8] Eriko Tokunaga,[9] Takafumi Sangai,[10] Miyuki Kitahara,[11] Takashi Kuwayama,[12] Akira Matsui,[13] Tomomi Fujisawa,[14] Fumikata Hara,[4] Riku Kajikawa,[15] Taro Shibata,[15] Keita Sasaki,[16] Tadahiko Shien[17]

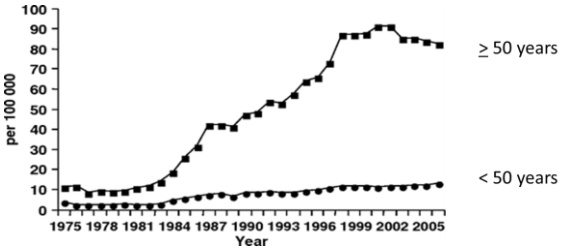
[1] **Nagoya City University,Nagoya, Japan**; [2] Niigata Cancer Center Hospital, Niigata,Japan; [3] Aichi Cancer Center, Nagoya, Japan; [4] The Cancer Institute Hospital of JFCR, Tokyo, Japan; [5] University of Tsukuba Hospital, Ibaraki, Japan; [6] Hokkaido Cancer Center, Sapporo, Japan; [7] Akita University Hospital. Akita, Japan; [8] Yao Municipal Hospital, Osaka, Japan; [9] NHO Kyushu Cancer Center, Fukuoka, Japan; [10] Kitasato University Hospital, Kanagawa, Japan; [11] Ibaraki Prefecture Central Hospital, Ibaraki, Japan; [12]Tokyo Metropolitan Cancer and Infectious diseases Center Komagome Hospital, Tokyo, Japan: [13] National Hospital Organization Tokyo Medical Center, Tokyo, Japan; [14] Gunma Prefectural Cancer Center, Gunma, Japan; [15] JCOG Data Center, Tokyo, Japan; [16] JCOG Operations Office, Tokyo, Japan; [17]Okayama University Hospital, Okayama, Japan.

JCOG Japan Clinical Oncology Group 日本臨床腫瘍研究グループ

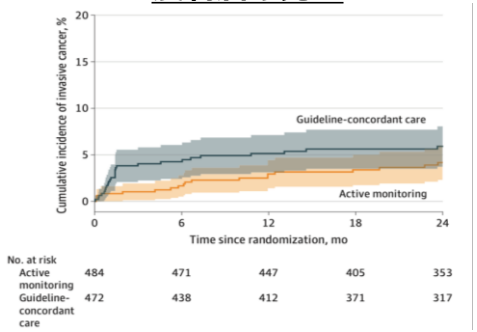
Background

- DICSの標準治療は外科的治療、部分切除の場合は温存乳房への放射線療法
- DCISは特に50歳以上で年々増加
- **CQ：全てのDCISに対して手術を行うことは必要か？**
- COMET試験：低グレードDCISに対する手術省略の有効性を検証
  ガイドライン通りの治療　vs　Active monitoring

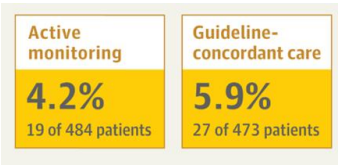
DCISの年齢調整罹患率の推移



浸潤癌の発生



2年での浸潤癌の発生割合



LORETTA試験
ER陽性低リスクDCISに対する内分泌療法単独の有効性を検証する試験

K. Kerlikowske. *J Natl Cancer Inst Monogr*, Volume 2010
JAMA. 2025;333(11):972-980. doi:10.1001/jama.2024.26698

LORETTA (JCOG1505): Prospective Single-arm Confirmatory Trial

Low risk DCIS (N=340)
No comedo necrosis, Nuclear grade:1 or 2, ER+ and HER2-

↓

TAM (20 mg/day) for 5 years

Safety Assessments (5 years until TAM completion)

- The first 6M: every 3M
- Thereafter: every 6M

Efficacy Assessments (10 years)

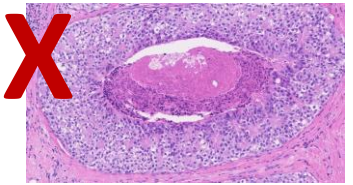
- The first year: every 6M
- Thereafter: annually

➢ **40歳以上、低リスクDCIS**
- **ER強陽性HER2陰性**
- **Comedo壊死なし**
- **画像診断で2.5cmを超えない**
- **VAB　6本以上、CNB　3-5本以上**

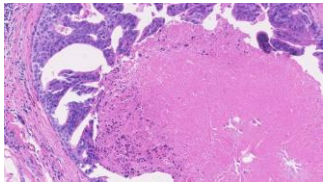
➢ **TAM　5y内服→経過観察**

➢ **主要評価項目：温存乳房内浸潤癌発生割合**

Comedo necrosis



No comedo necrosis



JCOG Japan Clinical Oncology Group 日本臨床腫瘍研究グループ

C.Kanbayashi. H Iwata: JJCO 2017.1-7, H Tsuda, eta l. JJCO 2021, 51(3)434–443

Patient Characteristics

- Grade1　約7割
- 腫瘍径　2.0cm未満が8-9割

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		N=341 (%)
Age	Median (range)	53 (40-85) year
PS	0	340
	1	1
Nuclear Grade (NG)	1	234 (68)
	2	107 (32)
	3	0
Menopausal status	Pre	162 (48)
	Post	173 (51)
	Unknown	6
ER	Negative	0
	Positive (weak)	0
	Positive (strong)	341 (100)
PgR	Negative	11 (3)
	Positive (weak)	17 (5)
	Positive (strong)	313 (92)

		N=341
HER2 status (IHC)	0	66 (19)
	1+	186 (55)
	2+	76 (22)
	3+	0
	Not evaluated*	13 (4)
Tumor size (MMG)	<2.0 cm	315 (93)
	≥2.0 cm	26 (7)
Tumor size (US)	<2.0 cm	319 (94)
	≥2.0 cm	22 (6)
Tumor size (MRI)	<2.0 cm	265 (78)
	≥2.0 cm	76 (22)
Calcification on MMG	absence	111 (33)
	presence	230 (67)

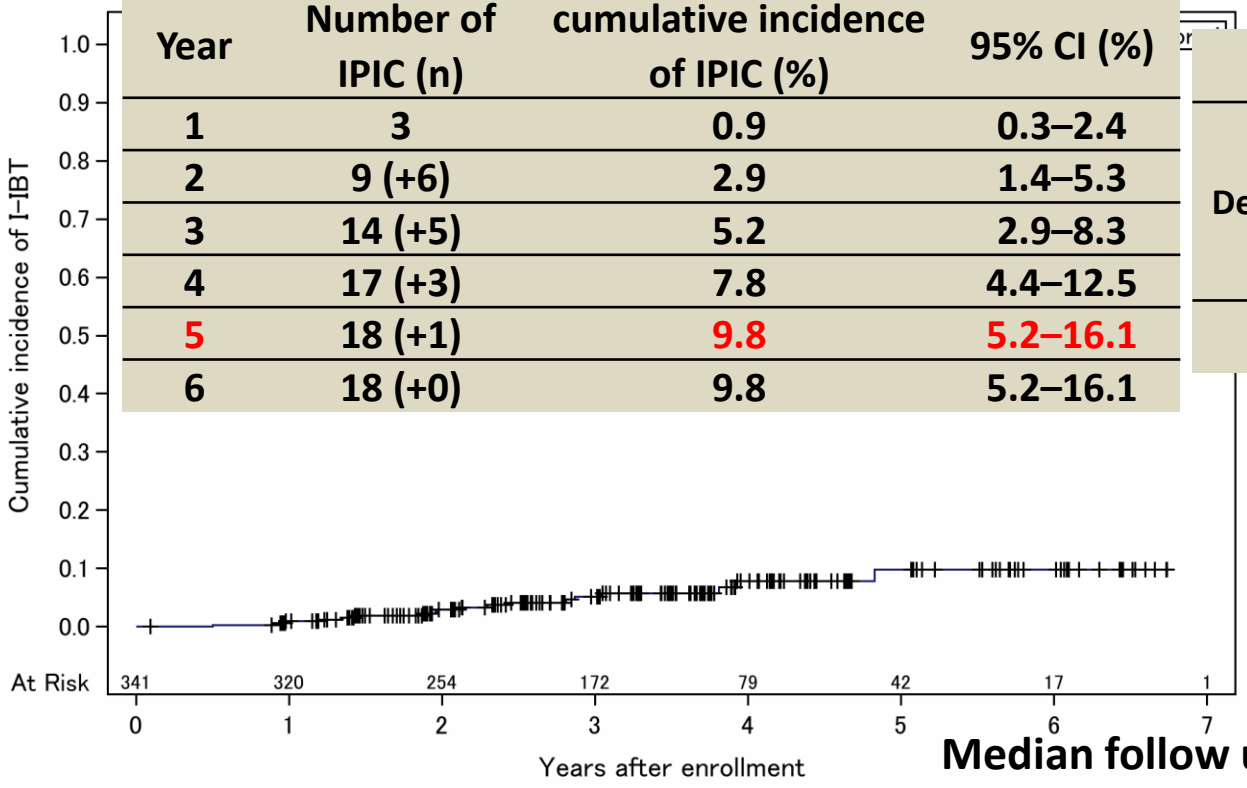
*HER2 status (FISH/DISH) : negative

Primary Endpoint: 5-year IPIC

- 5年の浸潤癌累積発生割合：9.8%
- 当初設定していた閾値(7%)を超えたため主要評価項目は達成されず

Year	Number of IPIC (n)	cumulative incidence of IPIC (%)	95% CI (%)
1	3	0.9	0.3–2.4
2	9 (+6)	2.9	1.4–5.3
3	14 (+5)	5.2	2.9–8.3
4	17 (+3)	7.8	4.4–12.5
5	18 (+1)	9.8	5.2–16.1
6	18 (+0)	9.8	5.2–16.1

Competitive risk (N=16)	
Death (unrelated)	Ipsilateral mastectomy (without invasive cancer)
1	15



Primary endpoint: Not met
(The upper limit of the confidence interval exceeded 7.0%)

Median follow up: 36.0 mo (0.0-80.4 mo)

Subgroup Analysis of the Cumulative Incidence of Invasive Ipsilateral Breast Tumor

SAN ANTONIO BREAST CANCER SYMPOSIUM®

➢ 浸潤癌発生と関連するリスク因子：腫瘍径2.0cm以上

Factor	Level	Events/N	5–year cumulative incidence of IPIC (95% CI)	HR (95% CI)	Two-sided p value
Age	<50	6/117	8.7% (3.0–18.3)	1	
	≥50	12/224	10.9% (4.4–20.8)	1.085 (0.404–2.910)	0.8713
Nuclear grade	NG1	11/234	10.5% (4.4–19.9)	1	
	NG2	7/107	8.8% (3.7–16.7)	1.485 (0.570–3.868)	0.4187
HER2	0	5/66	8.7% (3.1–17.9)	1	
	1+	11/186	10.9% (4.5–20.6)	0.831 (0.288–2.399)	0.7318
	2+	2/76	8.3% (1.4–23.8)	0.343 (0.070–1.684)	0.1876
PgR	negative	1/11	45.5% (0.0–93.7)	1	
	weak	1/17	7.7% (0.4–30.3)	0.691 (0.052–9.191)	0.7798
	strong	16/313	8.1% (4.5–13.2)	0.597 (0.101–3.523)	0.569
Tumor diameter (MMG)	<2.0 cm	14/315	9.0% (4.3–15.9)	1	
	≥2.0 cm	4/26	20.1% (5.2–41.9)	3.579 (1.150–11.140)	0.0278
Tumor diameter (US)	<2.0 cm	15/319	9.0% (4.5–15.6)	1	
	≥2.0 cm	3/22	20.8% (3.7–47.3)	3.630 (1.040–12.676)	0.0433
Tumor diameter (MRI)	<2.0 cm	11/265	8.3% (3.7–15.4)	1	
	≥2.0 cm	7/76	12.9% (5.4–24.0)	2.523 (0.988–6.440)	0.053
Calcification on MMG	absence	2/111	-	1	
	presence	16/230	11.3% (6.1–18.1)	2.939 (0.682–12.670)	0.1481

Secondary Endpoints

➢ 乳癌関連死亡は認めなかった

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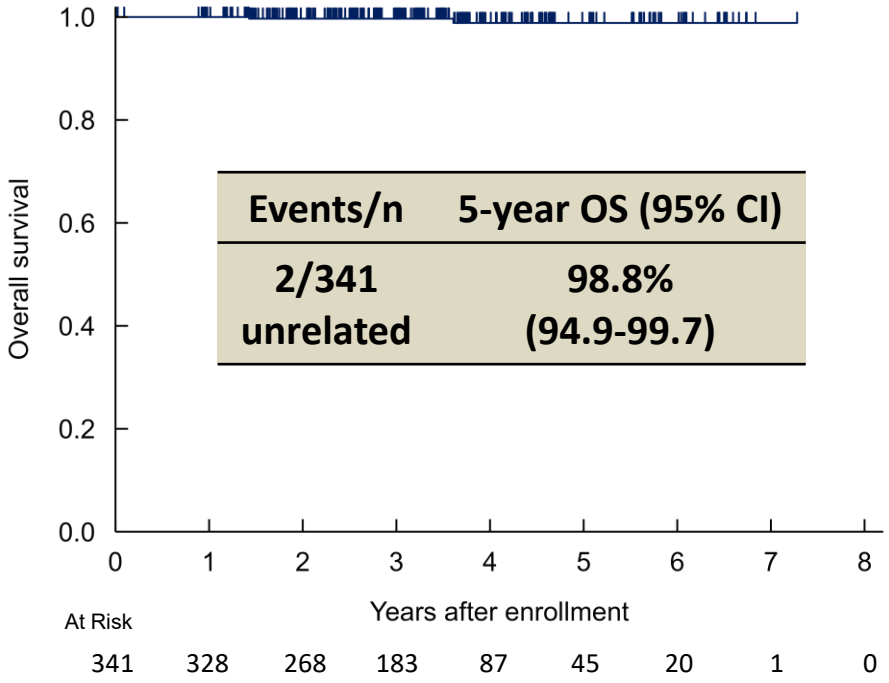
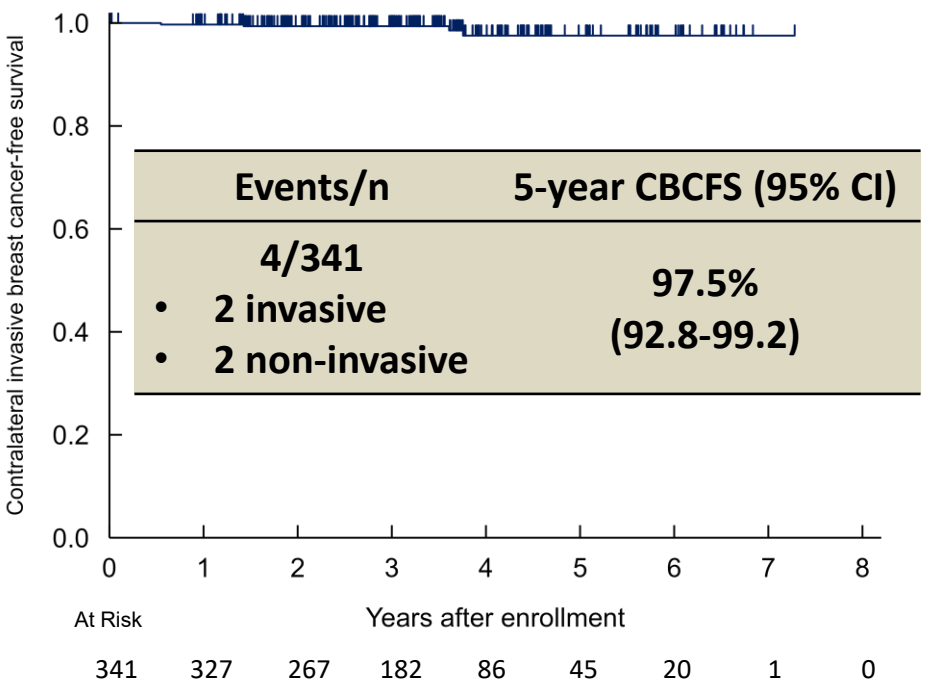
Overall Survival (OS)



Events/n	5-year OS (95% CI)
2/341 unrelated	98.8% (94.9-99.7)

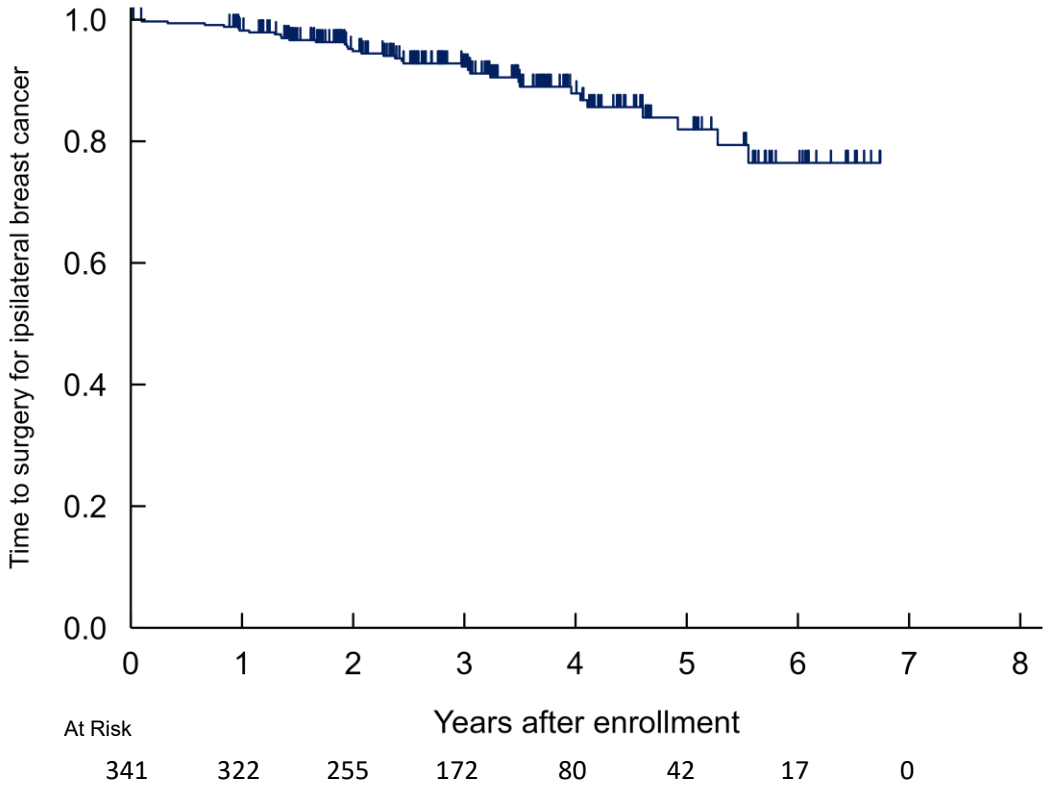
Contralateral breast cancer-free survival (CBCFS)



Events/n	5-year CBCFS (95% CI)
4/341 • 2 invasive • 2 non-invasive	97.5% (92.8-99.2)

Surgery-free Survival

➢ 5年経過時点で8割が手術を回避できた

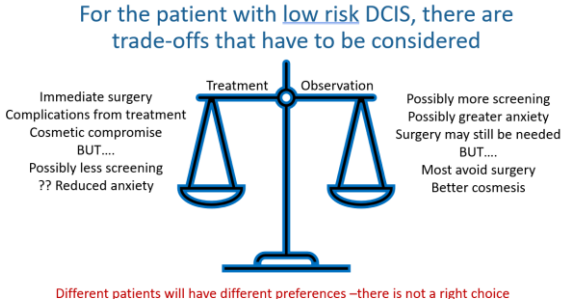


Year	Surgery free survival(%)	95% CI (%)
1	98.2	96.1 – 99.2
2	94.8	91.7 – 96.8
3	92.3	88.4 – 94.9
4	87.9	82.3– 91.8
5	82.0	73.3 – 88.0
6	76.4	64.6 – 84.8

Invasive cancer: 17 cases
Non-invasive cancer: 15 cases
Unrelated death: 2 cases

Summary of LORETTA trial

- 5年累積同側乳房内浸潤癌の発生割合は9.8%で主要評価項目達成ならず
- 5年での手術省略が約8割と一定のbenefitもある
- DCISの過剰診断・過剰治療の可能性もあり
- より長期の観察期間の結果が求められる(COMET試験)



COMET試験
2y浸潤癌発生割合　4.2%

慎重に選択された小さな低リスクDCISでは非手術治療の可能性を示唆
最終的には患者の希望や価値観に基づく治療選択が重要
DCISはすぐ手術から、リスクに応じて治療を考える治療戦略も選択肢

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AYA世代の乳がんサバイバーを対象とした支援アプリによる介入のQOLに関するランダム化比較試験　(YES trial)

Randomized Controlled Trial of Young, Empowered & Strong (YES), an mHealth Intervention for Adolescents and Young Adults with Breast Cancer

Ann H. Partridge, Noah Graham, Kate E. Dibble, Nabihah Tayob, Yue Zheng, Ella J. Johnson, Chloe Hery, Kayla Williams, Sonja Darai, Eric F. Harden, Ashley P. Davenport, Cecilia DeGraffinreid, Timiya S. Nolan, Magnolia Contreras, Noel Roma, Sandra A. Mitchell, Deborah Schrag, Dawn L. Hershman, Shoshana M. Rosenberg*, Michelle J. Naughton* (*Contributed equally)

Dana-Farber Cancer Institute | The Ohio State University | Columbia University

Background

- 乳がんはAYA世代で最も多くみられる悪性腫瘍、罹患率は世界的に増加
- AYA世代の乳がんサバイバーは、不安、妊孕性、社会復帰など、深刻な症状と不安を抱えている
  →長期的なQOLにも影響する問題が多い
- 日常の診療のみでは継続的なサポートが難しい

YES試験
乳癌サバイバーが自分の症状や心理状態を自己管理して、医療従事者の管理なしに教育と支援を受けられるスマートフォンを用いたmHealthツール「YES（Young, Empowered & Strong）」を設計

YES Study Schema

SETTING: 3 sites (Dana-Farber Cancer Institute, The Ohio State University, and Columbia University Medical Center)

- **AYA世代のサバイバー360名対象**
- **YESのePRO導入　vs　通常follow**

ELIGIBILITY:

- Female
- Age 15-39 years at diagnosis of stage 0-III BC
- <3 years from end of active treatment
- No evidence of BC recurrence
- English speaking

STUDY ENDPOINTS:

- Primary outcome – QOL at 6 months
- Secondary outcomes – symptoms at 6 months

Dibble et al, BMC Public Health, 2025

YES Portal Components

- 一人一人に合わせたサポートを提供
  例：不安→マインドフルネスの指導
- 自身の経時的変化の視認
- チャットルームによるサポート

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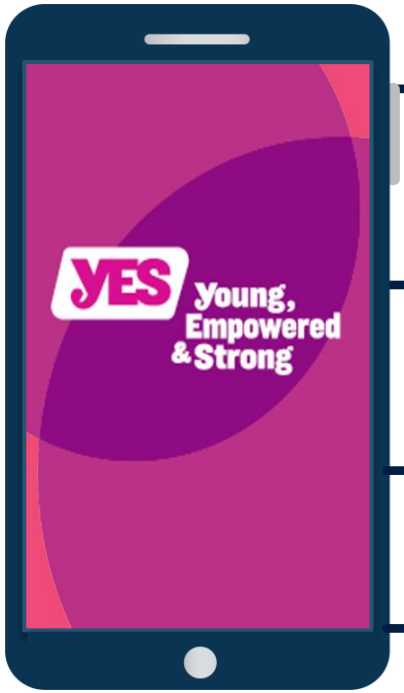


Monthly ePRO Symptom / AYA Concerns Assessments

Chat Room

My Journal

Receipt of Actionable Information Tailored to Individual Concerns / Symptoms

Encouragement to Communicate Severe / Unresolved Symptoms to Clinicians

AYA Peer Support Community Building

Promotion of Regular Expressive Writing

- Engagement / Activation to Self-manage Symptoms / Concerns
- Empowerment to Contact Clinical Team for Unmet Needs / Concerns
- Reduction in Feelings of Isolation
- Stress Reduction

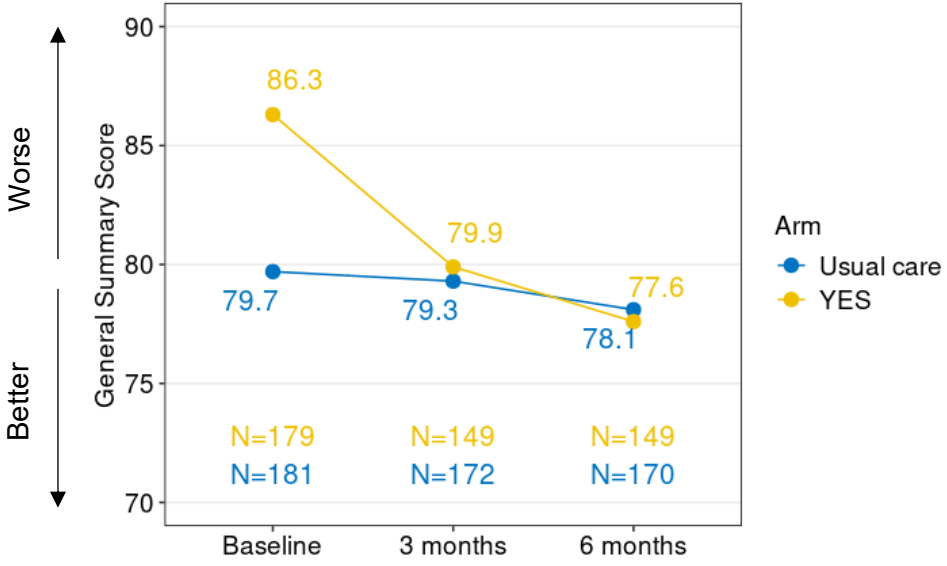
Lower Symptom / Concern Burden

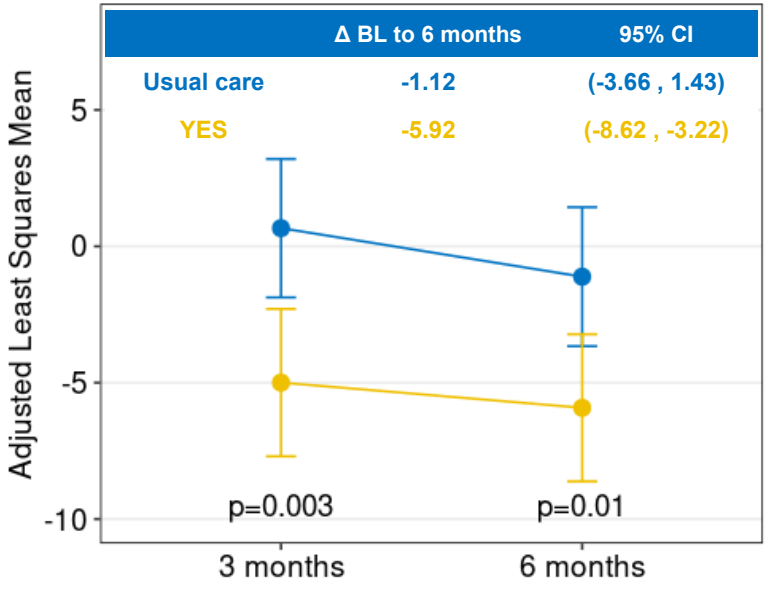
Improved QOL

Dibble et al, BMC Public Health, 2025

YES Study Primary Outcome: General QOL (QLACS)

➢ 3か月後、6か月後の一般的なQOLを有意に大幅に改善

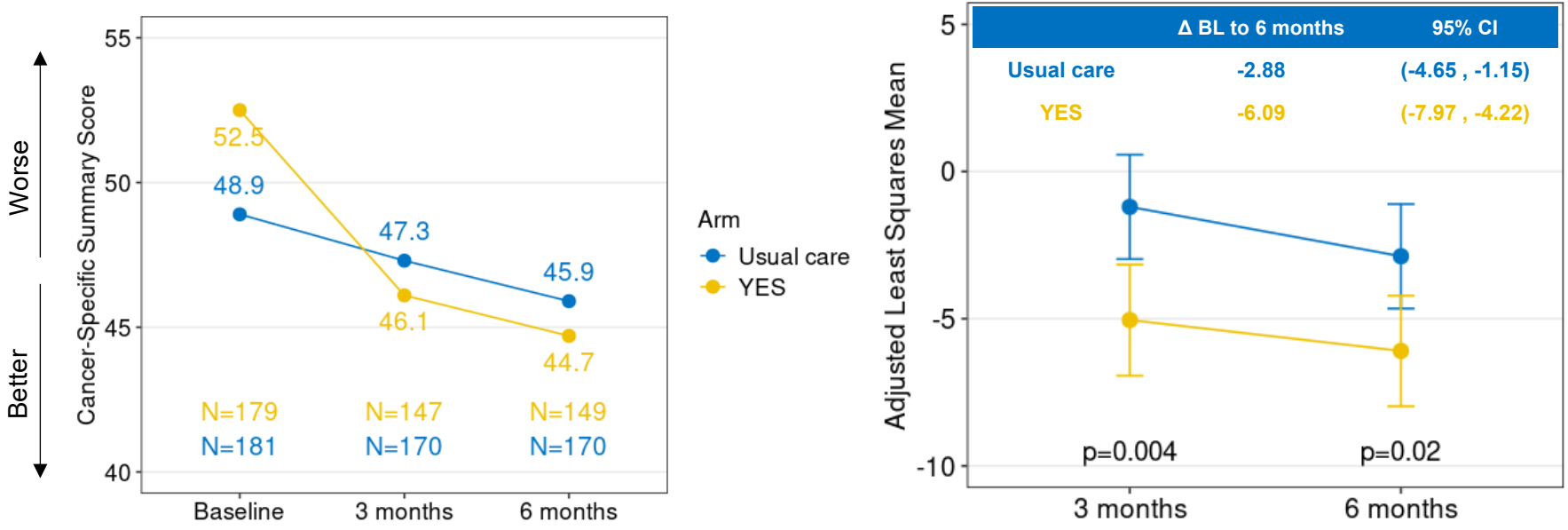




Patients randomized to **YES vs. Usual Care** had significantly greater improvement of General QOL at both 3 and 6 months

YES Study Primary Outcome: Cancer-Specific QOL (QLACS)

➢ 3か月後、6か月後のがん特異的なQOLを有意に大幅に改善



Patients randomized to **YES vs. Usual Care** had significantly greater improvement of Cancer-specific QOL at both 3 and 6 months

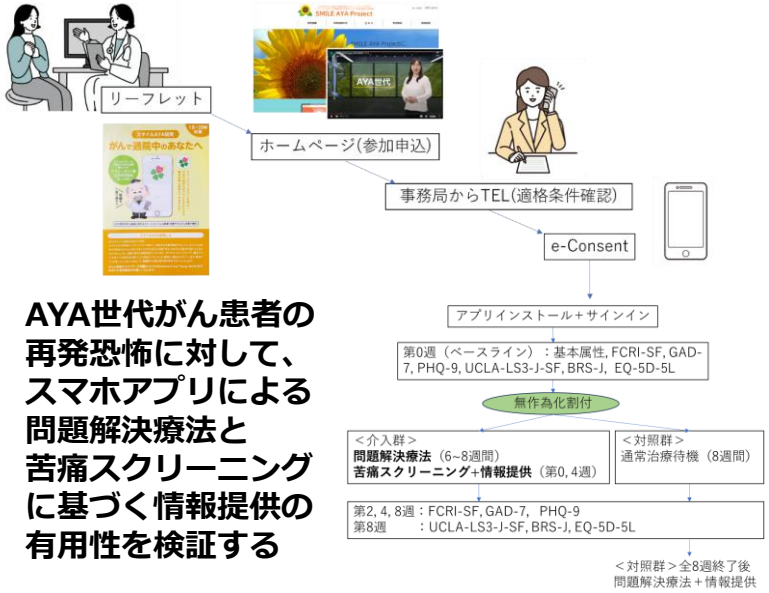
Summary of YES trial

- AYA世代に対するスマートフォンを用いたアプリによる支援介入は6か月時点での全般的/がん特異的なQOLを大幅に改善
- 症状負担も軽減
- AYA世代のサバイバーの不安はつきない
  (妊孕性や仕事、将来、再発不安など)

ロ AYA乳がんサバイバーのQOLを改善するデジタルサポートツールの重要性

ロ 医療従事者が全てを介入するだけでないサバイバーシップケアの新しいモデル

SMILE AYA研究
(当院植弘　奈津恵Dr)



AYA世代がん患者の再発恐怖に対して、スマホアプリによる問題解決療法と苦痛スクリーニングに基づく情報提供の有用性を検証する

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GS-03-02

閉経前EBC患者における妊孕性に関するアプローチ
オンコフェルティリティ・ケアを検討した最大規模の
前向き多施設コホート研究

GS3-02: Fertility and Ovarian Function Preservation in Premenopausal Women with Early Breast Cancer: Results from the Multicenter Prospective PREgnancy and FERtility (PREFER) Study

Matteo Lambertini[1,2], Eva Blondeaux[3], Valeria Fontana[3], Saverio Cinieri[4], Ida Paris[5], Anna Maria Vandone[6], Claudia Andreetta[7], Valentina Sini[8], Icro Meattini[9,10], Carmelo Bengala[11], Maria Vittoria Dieci[12,13], Luca Livraghi[14], Raffaella Cioffi[15], Domenico Bilancia[16], Federico Sottotetti[17], Silvia Mura[18], Angela Denaro[19], Diletta Favero[20], Grazia Arpino[21], Francesca Poggio[2], Maria Grazia Razeti[2], Edoardo Chiappe[1,2], Francesca Bruzzone[1,2], Luca Arecco[22], Claudia Massarotti[23,24], Paola Vanella[6], Francesco Pavese[5], Laura Orlando[4], Fabio Puglisi[25,26], Paola Anserini[23], Luca Boni[3], Lucia Del Mastro[1,2]

[1]Department of Internal Medicine and Medical Specialties (DIMI), School of Medicine, University of Genova, Genoa, Italy; [2]Department of Medical Oncology, U.O. Clinica di Oncologia Medica, IRCCS Ospedale Policlinico San Martino, Genoa, Italy; [3]Clinical Trial Unit, Epidemiologia Clinica, IRCCS Ospedale Policlinico San Martino, Genoa, Italy; [4]Medical Oncology Department and Breast Unit, Perrino Hospital, Brindisi, Italy; [5]Division of Gynecologic Oncology, Department of Woman and Child Health and Public Health, Fondazione Policlinico Universitario Agostino Gemelli IRCCS, Rome, Italy; [6]Breast Unit, Azienda Ospedaliera Santa Croce e Carle, Cuneo, Italy; [7]Department of Oncology, Azienda Sanitaria Universitaria Friuli Centrale, Udine, Italy; [8]Department of Medical Oncology, Centro Oncologico Santo Spirito-Nuovo Regina Margherita, ASL Roma 1, Rome, Italy; [9]Department of Experimental and Clinical Biomedical Sciences "M. Serio", University of Florence, Florence, Italy; [10]Radiation Oncology Unit & Breast Unit, Oncology Department - Florence University Hospital, Florence, Italy; [11]Medical Oncology 1, Azienda Ospedaliero-Universitaria Pisana, Pisa, Italy; [12]Dipartimento di Scienze Chirurgiche, Oncologiche e Gastroenterologiche, Università di Padova, Padova, Italy; [13]Oncologia 2, Istituto Oncologico Veneto IOV-IRCCS, Padova, Italy; [14]Department of Medical Oncology, Hospital of Prato, Azienda USL Toscana Centro, Prato, Italy; [15]Department of Obstetrics and Gynecology, IRCCS San Raffaele Hospital, Milan, Italy; [16]Oncologia Medica, Azienda Ospedaliera S. Carlo, Potenza, Italy; [17]UO Oncologia Medica ICS Maugeri IRCCS, Pavia, Italy; [18]Oncologia Medica, AOU Ospedale SS Annunziata, Sassari, Italy; [19]Oncologia Medica, Ospedale Maggiore di Trieste, Trieste, Italy; [20]Candiolo Cancer Institute, FPO-IRCCS, Candiolo (Turin), Italy; [21]University of Naples "Federico II", Naples, Italy; [22]Université libre de Bruxelles (ULB), Hôpital Universitaire de Bruxelles (H.U.B), Clinical Trials Unit, Institut Jules Bordet, Brussels, Belgium; [23]Clinica Ostetrica e Ginecologica, IRCCS Ospedale San Martino, Genoa, Italy; [24]Dipartimento di Neuroscienze, Riabilitazione, Oftalmologia e Scienze Materno Infantili, University of Genova, Genoa, Italy; [25]Department of Medical Oncology, Centro di Riferimento Oncologico di Aviano (CRO) IRCCS, Aviano, Italy; [26]Department of Medicine, University of Udine, Udine, Italy

December 12th, 2025
San Antonio, TX (USA)

@matteolambe

Background

- **化学療法の適応となる閉経前女性すべてにおいて、オンコフェルティリティ・カウンセリング（がんと妊孕性に関するサポート)が推奨**されている

- 妊孕性温存としては、**卵子／胚凍結／卵巣組織凍結が標準的戦略**であり、**卵巣機能温存目的として化学療法中のGnRHアゴニスト（GnRHa）使用**が推奨されている

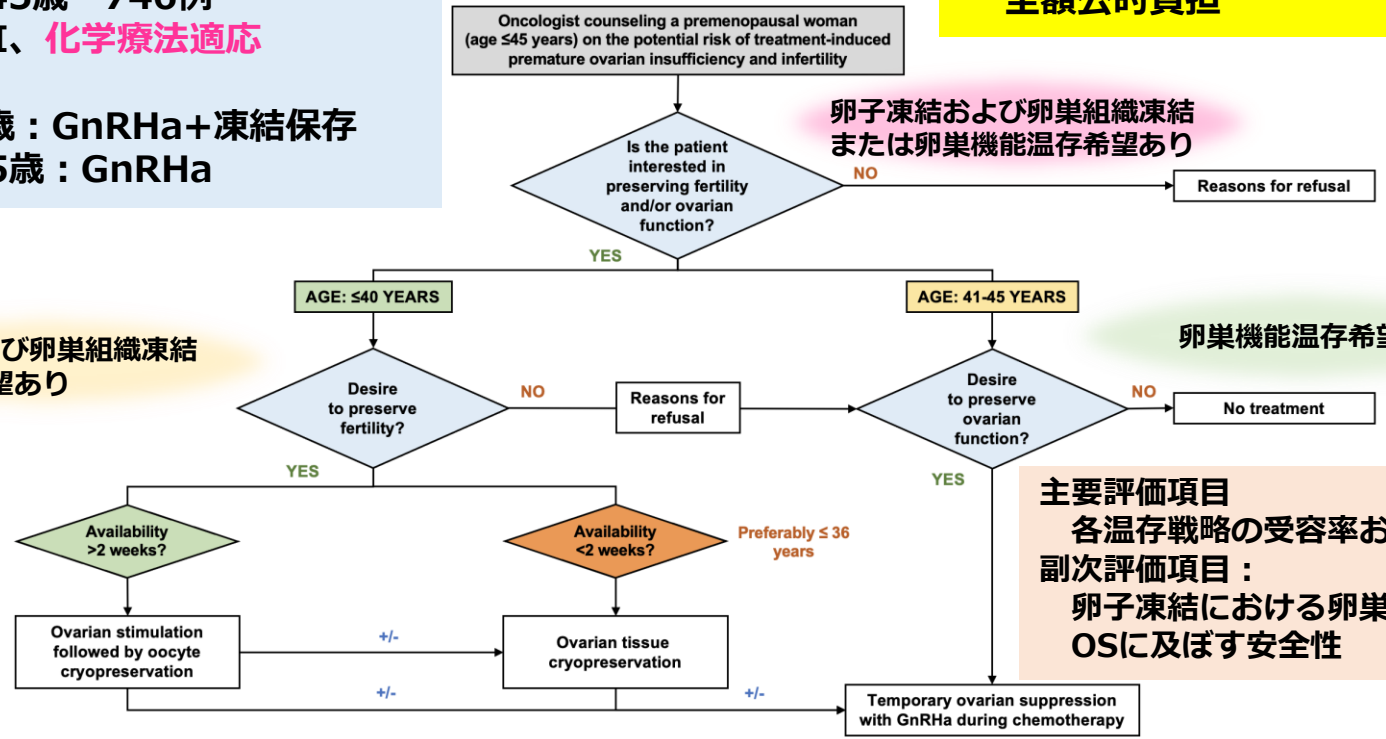
- しかし、卵巣機能および／または妊孕性温存戦略の実臨床における受容率や拒否理由に関するデータ、安全性に関するエビデンスは限られている

PREFER試験（イタリアの試験)
オンコフェルティリティ領域におけるケアの最適化と知見の向上を目的として、2012年に早期乳癌の閉経前女性を対象とした全国プログラムとして立ち上げられた

- GIM study group　2012-2024年
- イタリア23施設　前向きコホート
- 閉経前18-45歳　746例
- StageI-III、化学療法適応

  - ＜40歳：GnRHa+凍結保存
  - 41-45歳：GnRHa

Study flow



卵子凍結および卵巣組織凍結
または卵巣機能温存希望あり

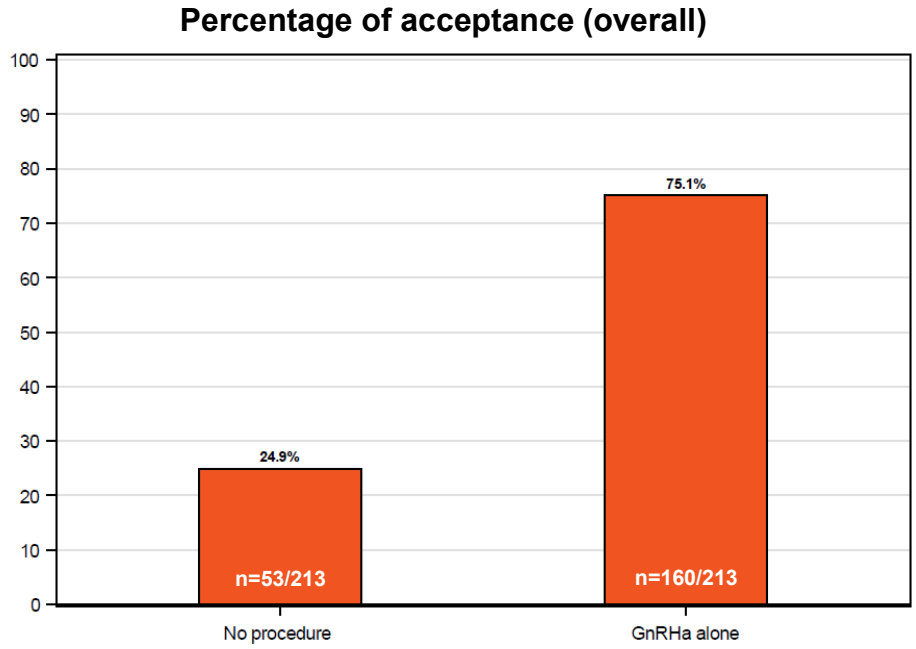
卵子凍結および卵巣組織凍結
希望あり

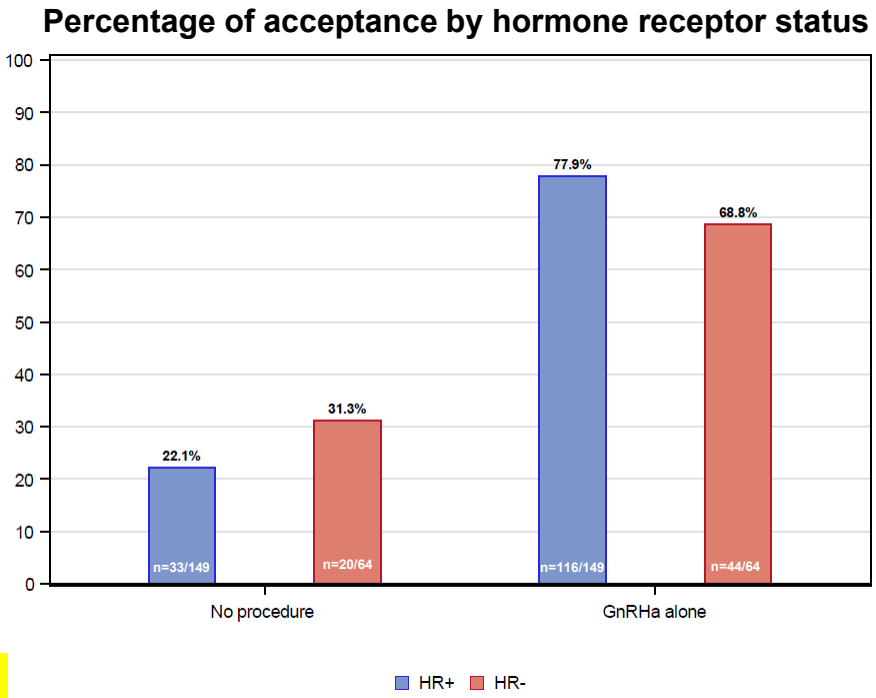
卵巣機能温存希望あり

- イタリアでは胚凍結は法律上禁止
- イタリアの国民保険サービスにより全額公的負担

主要評価項目
　各温存戦略の受容率および拒否理由
副次評価項目：
　卵子凍結における卵巣刺激のDFSやOSに及ぼす安全性

Study Results – Patients with 41 - 45 years



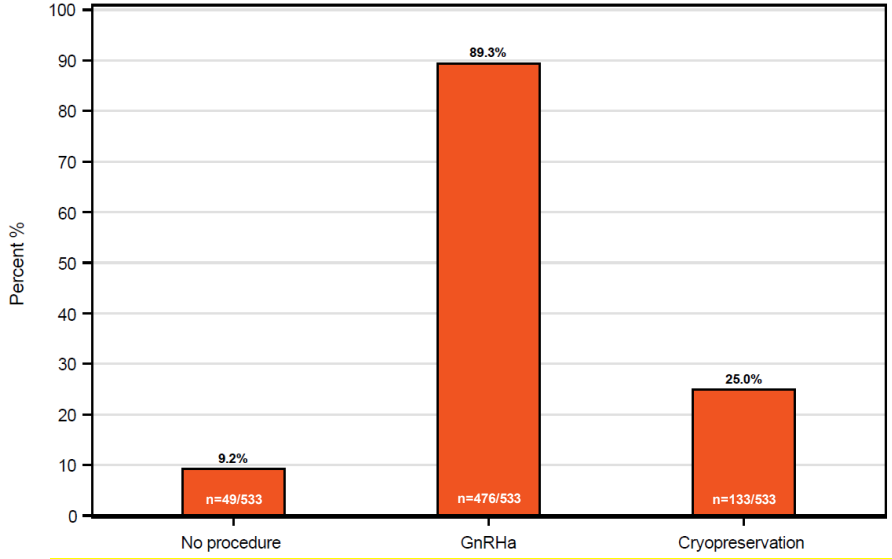


- 41-45歳群では160例（75.1%）がGnRHaを受容
- 拒否理由の多くも家族形成の完了（18例、3.4%）

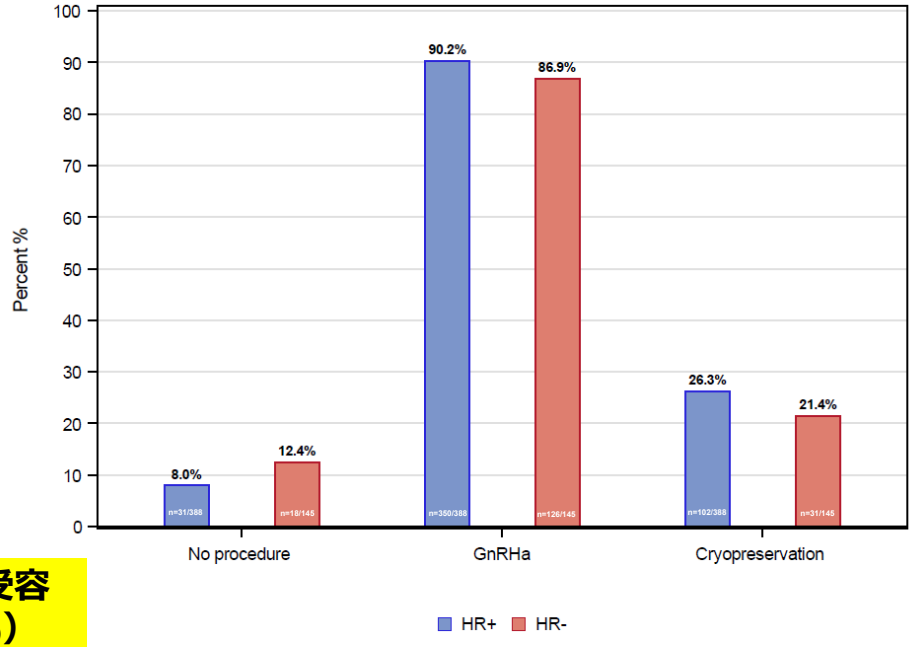
Main reason for refusal: completion of family planning (n=24, 11.3%)

Study Results – Patients with ≤ 40 years

Percentage of acceptance (overall)



Percentage of acceptance by hormone receptor status



- **40歳以下群では476例（89.3%）がGnRHaを受容**
- **拒否理由の多くも家族形成の完了（18例、3.4%）**

Main reason for refusal: completion of family planning (n=18, 3.4%)

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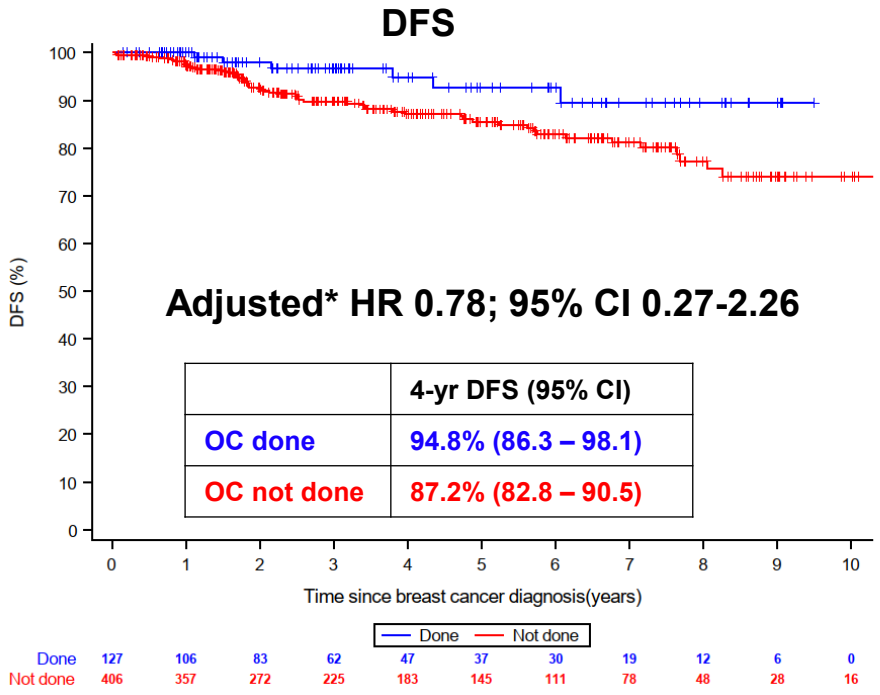
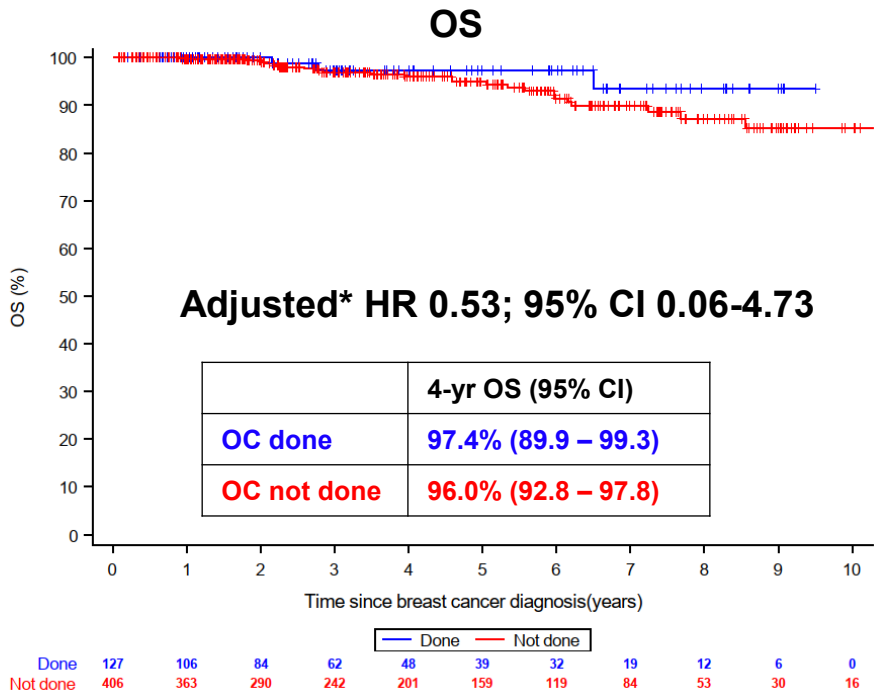
Study Results – Patients with ≤ 40 years



Adjusted* HR 0.78; 95% CI 0.27-2.26

	4-yr DFS (95% CI)
OC done	94.8% (86.3 – 98.1)
OC not done	87.2% (82.8 – 90.5)



Adjusted* HR 0.53; 95% CI 0.06-4.73

	4-yr OS (95% CI)
OC done	97.4% (89.9 – 99.3)
OC not done	96.0% (92.8 – 97.8)

*Strata: age, year of diagnosis, grade, nodal status, timing of chemotherapy

- 追跡期間中央値は3.8年
- 卵巣刺激はDFS、OSのいずれにおいても予後悪化と関連しなかった

Summary of PREFER trial

- 早期乳癌の閉経前女性の大多数が、卵巣機能温存を目的として化学療法中のGnRHアゴニスト投与を受容していた

  40歳以下:89.3%、41–45歳:75.1%

日本　卵子凍結保存：約30-35%
実施数は増加
（Japan Oncofertility Registry, JOFR）

- 40歳以下の4人に1人（25.0%）が卵子凍結による妊孕性温存を選択した

  卵子凍結選択における関連因子：若年、未経産、診断年が新しい、低グレード

- 卵子凍結のための卵巣刺激は、予後を悪化させることはなかった

早めの妊孕性温存に関する情報提供の重要性

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GS-03-07
DECEMBER 9–12, 2025
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乳癌検診にも個人のリスクに応じた検診アプローチが必要ではないかを検証したWISDOM試験

Risk-based breast cancer screening is safe, preferred by women and identifies highest risk individuals: Results from WISDOM 1.0

Laura J. Esserman, MD, MBA
University of California, San Francisco, San Francisco, CA

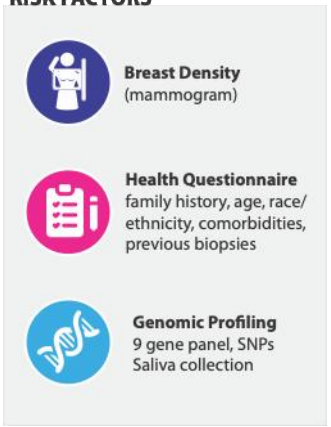
L. J. Esserman[1], A. S. Fiscalini[1], A. Naeim[2], L. J. van 't Veer[1], A. Kaster[3], M. T. Scheuner[1], A. Z. LaCroix[4], A. D. Borowsky[1], H. Anton-Culver[5], O. I. Olopade[6], J. N. Esserman[7], R. Lancaster[8], Y. Shieh[9], E. Ziv[1], J. A. Tice[1], L. Madlensky[4], A. Blanco[1], K. S. Ross[1], D. L. Goodman[5], H. L. Park[5], R. A. Hiatt[1], N. Wenger[2], B. A. Parker[4], D. M. Heditsian[1], S. A. Brain[1], V. Lee[1], K. F.Rhoads[10], K. Fergus[1], K. Blum[1], L. P. Sabacan[1], M. Eklund[11]

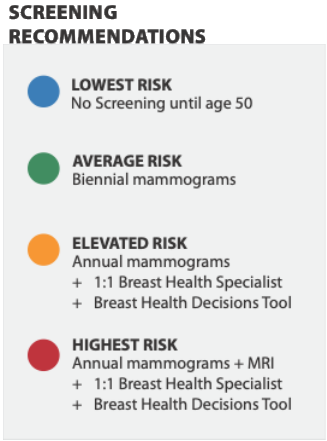
Background and study design

- 現在の乳癌検診は全員が同じ頻度　(40歳以上、2年に1度のMG)
- 乳癌も人それぞれ違いがあるように、乳癌リスクも個人個人で異なる可能性あり
- リスクが低い人→不要な被ばくや疑陽性による精神的負担を回避
  リスクが高い人→検査不足、見逃し、中間期癌のリスク

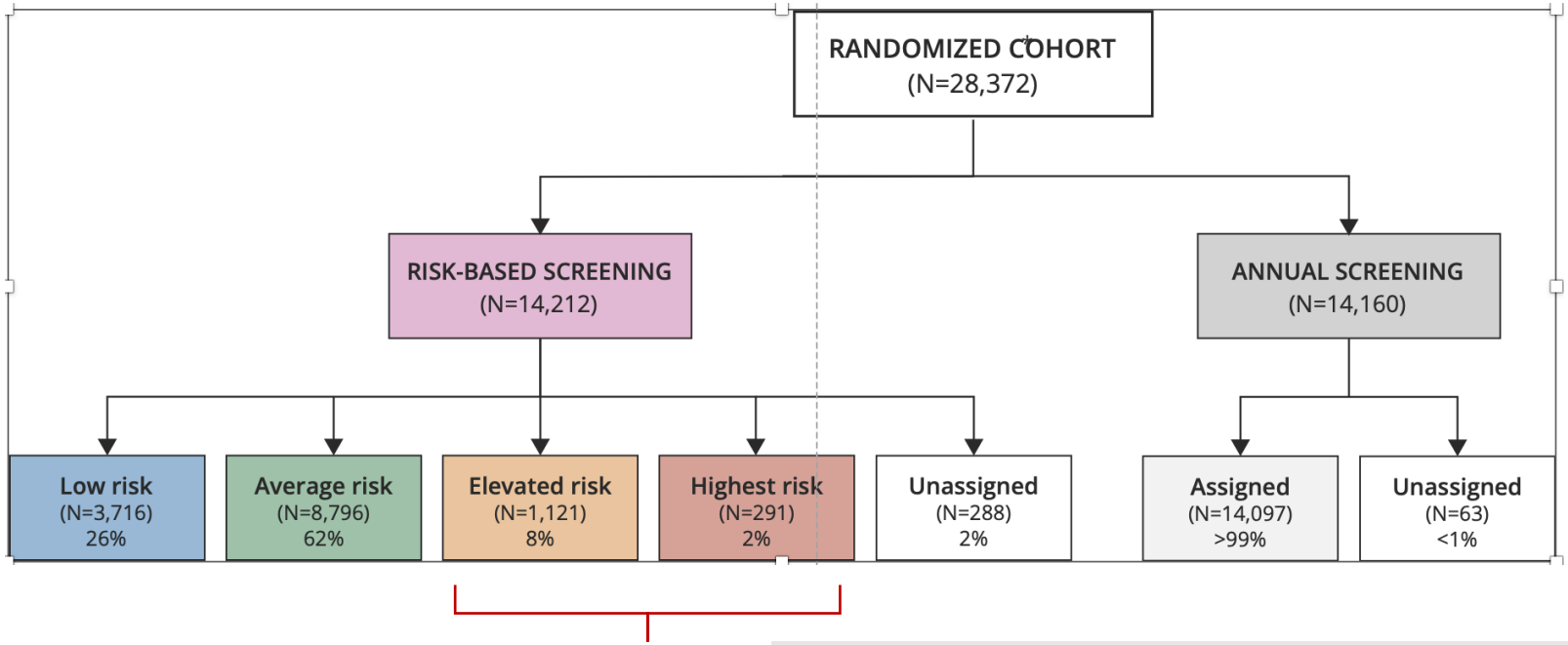
WISDOM試験
個別のリスクに応じた検診は安全か？

- **臨床リスクモデル**
  (背景、乳房濃度など)
- **9遺伝子パネル検査**
  (*BRCA1/2*、*TP53*、*PTEN*など)
- **ポリジェニックリスクスコア**
  (75-126個のSNPを組み合わせたスコア)





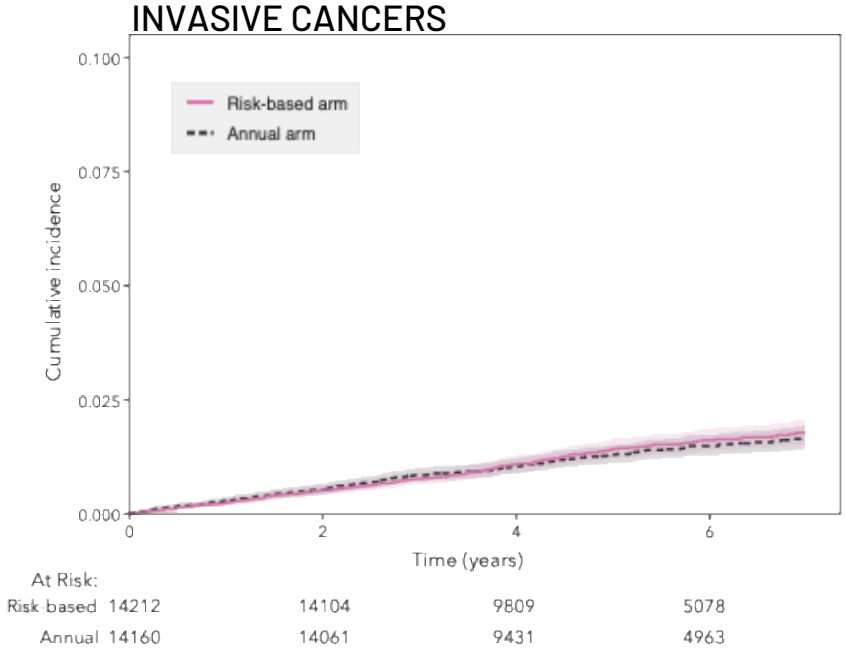
Randomized Cohort Results



- 9割はAverageまたはlow risk

HIGHEST Risk MRI + 6か月ごとのMG+カウンセリング
ELEVATED Risk 毎年MG
AVERAGE Risk 2年に1度のMG
LOW Risk 50歳まで または risk ≥ 1.3%まで不要

Number of cancers are the same but stratified by risk

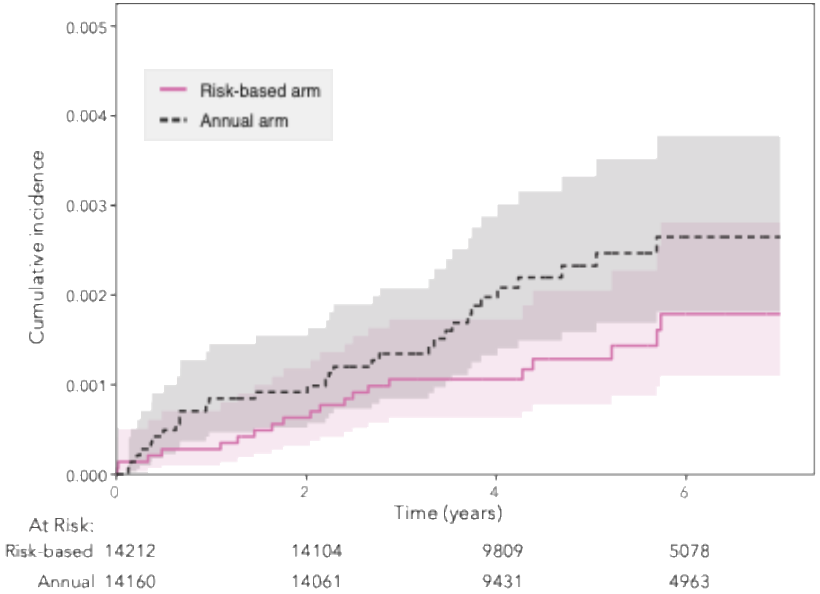


DO NOT POST

Same number of cancers in each arm

- リスクベース群も通常群も同等の癌発生割合

No Increase in Stage ≥2B cancers in Risk-Based Screening



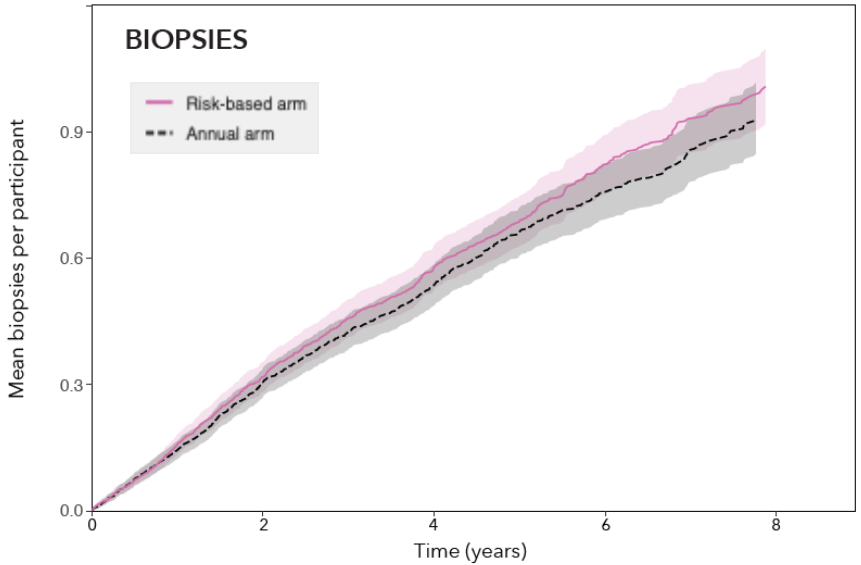
DO NOT POST

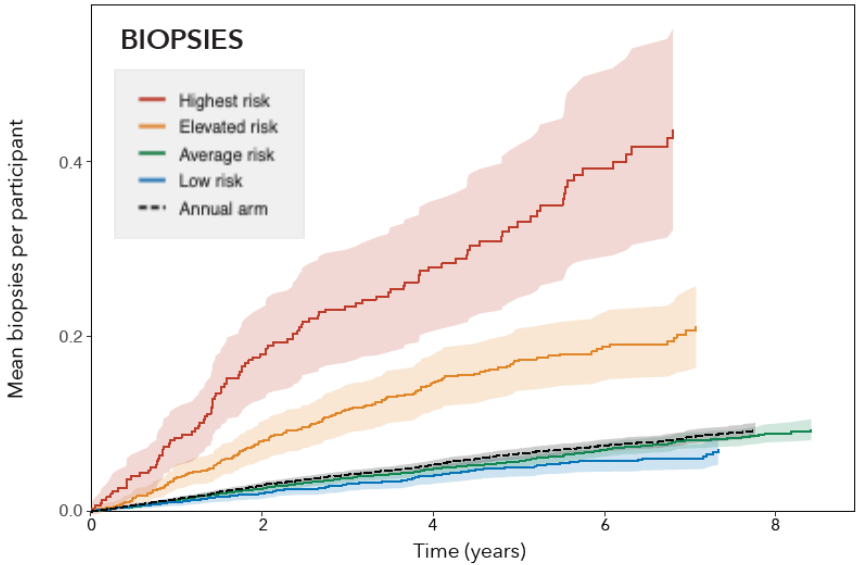
Fewer Stage≥2B cancer in RISK BASED

Clearly met non-inferiority

➢ StageIIB以上の発見率もリスクベース検診は劣らない

Biopsies Similar in Both Groups, varied by risk





Biopsy rates lowest in lower risk groups

- 生検の頻度はリスクベース群も通常群も同程度
- High riskでは生検頻度は増加

Summary of WISDOM1.0 trial

- WISDOM試験では遺伝子や家族歴などを用いたリスク評価に基づく検診が従来の年1回検診と同等に安全であることが示された
- Cost effectivenessも良好であった
- リスクスコアは欧米人のデータに基づいているので、**日本人への適応についてはさらなる研究が必要**

今後はリスクに応じた個別化検診の時代へ進む可能性

Clinical takeaways

- **術後内分泌療法の進化** (lidERA trial)

  再発リスク30%低下、Oral SERDの新たな術後治療への開発に期待

- **低リスクDCIS治療の個別化**（LORETTA trial)

  患者価値観を重視した、手術省略の可能性も含めた治療選択

- **AYA世代サバイバーシップ支援** (YES trial)

  ePROによるQOL改善、サバイバーシップケアの重要性と形態変化

- **妊孕性カウンセリング** (PREFER trial)

  妊孕性温存に対する早めの情報提供とカウンセリング提供

- **乳癌検診の個別化** (WISDOM1.0 trial)

  リスクベース検診の安全性、個別化検診の新時代へ

乳癌診療は
治療、サバイバーシップ、検診
一律の医療から、個別化医療へ