

### LBA<sub>16</sub>

Giredestrant (GIRE), an oral selective oestrogen receptor (ER) antagonist and degrader, + everolimus (E) in patients (pts) with ER-positive, HER2-negative advanced breast cancer (ER+, HER2- aBC) previously treated with a CDK4/6 inhibitor (i): Primary results of the phase III evERA BC trial

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# Background

CDK4/6i + endocrine therapy (ET) is first-line standard of care (SOC) for pts with ER+, HER2- aBC but effective post-CDK4/6i options are limited. GIRE and E target the ER and PI3K/AKT/mTOR pathways, which are implicated in ET resistance. evERA BC (NCT05306340) is a global, randomised, open-label trial.

## Methods

Pts had ER+, HER2- aBC with disease progression (PD) or relapse during/post-CDK4/6i + ET. Randomisation was 1:1 to once-daily oral 30 mg GIRE + 10 mg E or SOC ET (exemestane/fulvestrant/tamoxifen) + E until PD or unacceptable toxicity. Co-primary endpoints: Investigator-assessed progression-free survival (INV-PFS; RECIST v1.1) in pts with detectable ESR1 mutation (m) and the intent-to-treat (ITT) population. Overall survival (OS) was a secondary endpoint.

#### Results

373 pts were randomised; 183 to GIRE + E and 190 to SOC ET + E. Data cutoff was 16 July 2025; median follow-up was 18.6 months.  $\boxtimes 55\%$  of pts had an ESR1m. Efficacy is shown in the Table. The most common adverse events (AEs) were stomatitis (47.3% in the GIRE + E arm [n = 182] vs 48.9% in the SOC ET + E arm [n = 186]), diarrhoea (26.9% vs 22.6%) and anaemia (23.6% vs 21.0%). The most common grade 3/4 AEs were anaemia (6.0% vs 8.6%), hypokalaemia (3.8% vs 2.7%), pneumonia (1.6% vs 4.3%) and stomatitis (2.7% vs 3.2%). Grade 1 bradycardia was reported (3.8% vs 0.5%) with no treatment interruptions/discontinuations. 8.2% and 6.5% of pts withdrew from GIRE and SOC ET, respectively, due to AEs.Table: LBA16

	<i>ESR</i> 1m⊠		ITT	
	GIRE + E	SOC ET + E	GIRE + E	SOC ET + E
INV-PFS				
Median (95% CI), months	s 9.99 (8.08, 12.94)	5.45 (3.75, 5.62)	8.77 (6.60, 9.59)	5.49 (4.01, 5.59)
HR <sup>†</sup> (95% CI)	0.38 (0.27, 0.54) P < 0.0001		0.56 (0.44, 0.71)P < 0.000	1
Interim OS <sup>‡</sup>				
Median (95% CI), months	s NE (20.17, NE)	21.03 (14.78, 26.87	) NE (NE, NE)	26.87 (22.21, NE)
HR <sup>†</sup> (95% CI)	0.62 (0.38, 1.02)P = 0.0566	3	0.69(0.47, 1.00)P = 0.0473	3

CI, confidence interval; HR, hazard ratio; NE, not evaluable. †Stratified by prior fulvestrant (yes vs no), ESR1m (yes vs no/indeterminate) and visceral disease (yes vs no). \*\*Centrally tested via circulating tumour DNA. †Stratified by prior fulvestrant (yes vs no), ESR1m (yes vs

no/indeterminate) and visceral disease (yes vs no).‡At data cutoff, OS maturity was 59% in the ESR1m population and 67% in the ITT population.

### **Conclusions**

GIRE + E showed statistically significant and clinically meaningful improvements in INV-PFS in ER+, HER2- aBC post-CDK4/6i, for both the ESR1 m and ITT pt populations. The safety profile of GIRE + E was manageable with no unexpected findings. GIRE + E may represent a new effective treatment option in the post-CDK4/6i setting.

### Clinical trial identification

NCT05306340, first posted 1 April 2022.

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# Legal entity responsible for the study

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## Disclosure

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