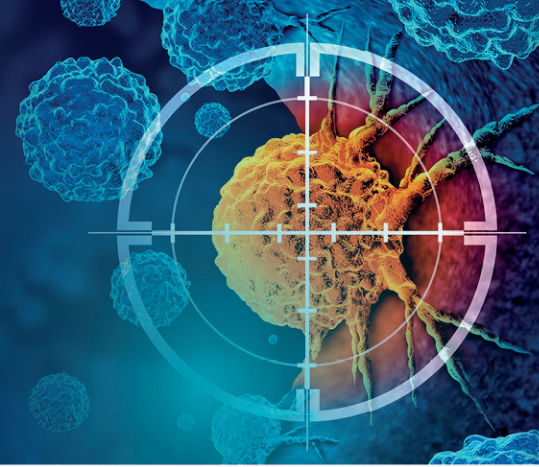
XVIII SIMPOSIUM

BASES BIOLÓGICAS DEL CÁNCER E INNOVACIÓN TERAPÉUTICA

MÁS DE 20 AÑOS A LA VANGUARDIA DE LA FORMACIÓN EN LA BIOLOGÍA Y TRATAMIENTO DEL CÁNCER



De la vida real al estudio Optima. ¿Que hemos aprendido y qué nos queda por aprender?

Francesco Schettini, MD, PhD

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Collaborating Professor, University of Barcelona, Spain
Board Member, SOLTI Young

06/11/2026

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Clínic Barcelona Comprehensive Cancer Center

Translational genomics and targeted therapies in solid tumors

SOLTI young new generation breast

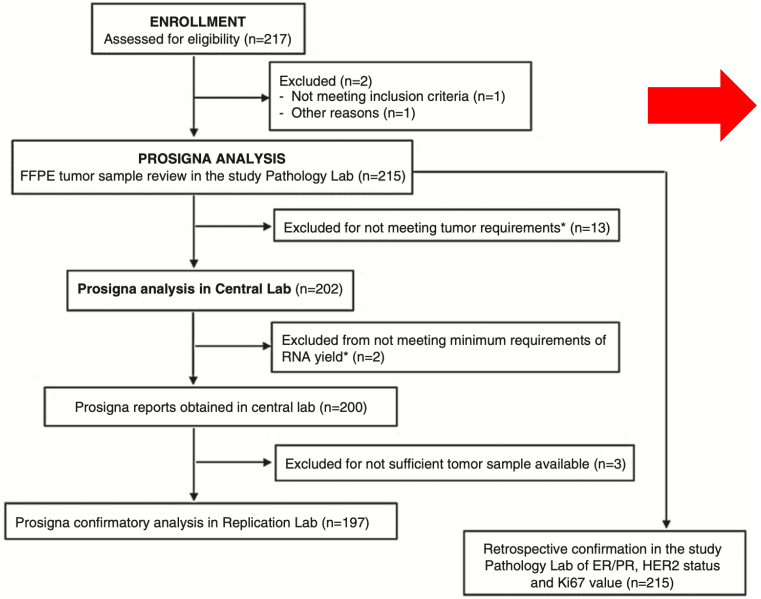
Conflicts of interest

- Honoraria for educational materials/events by Novartis, Gilead, Veracyte, Astra-Zeneca and Daiichy-Sankyo
- Travel expenses by Novartis, Gilead, Astra-Zeneca and Daiichy-Sankyo
- Advisory fees from Pfizer, Daiichy-Sankyo and Veracyte

Prosigna use in Spain: the Spanish experience reported by GEICAM

Prospective study of the impact of the Prosigna assay on adjuvant clinical decision-making in unselected patients with estrogen receptor positive, human epidermal growth factor receptor negative, node negative early-stage breast cancer

Miguel Martín[ab], Milagros González-Rivera[b], Serafín Morales[c], Juan de la Haba-Rodriguez[de], Lucía González-Cortijo[f], Luis Manso[g], Joan Albanell[hij], Antonio González-Martín[k], Sónia González[l], Angels Arcusa[m], Luis de la Cruz-Merino[n], Federico Rojo[o], María Vidal[p], Patricia Galván[q], Elena Aguirre[c], Cristina Morales[d], Sean Ferree[r], Kristen Pompilio[r], Maribel Casas[s], Rosalía Caballero[s], Uxue Goicoechea[s], Eva Carrasco[s], Steven Michalopoulos[t], John Hornberger[tu] & Aleix Prat[pqv]



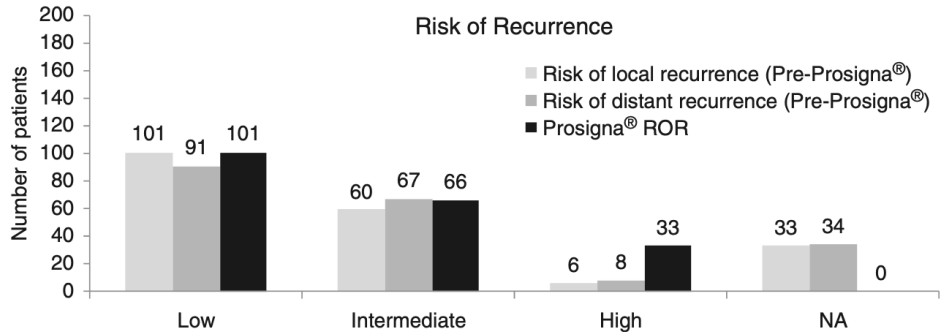
Only postmenopausal women

Table 1. Patient and tumor characteristics.

Characteristic	Type	*N* (%)	ROR low *n* (%)	ROR intermediate *n* (%)	ROR high *n* (%)
Age (years)	<50	2 (1.0)	2 (2.0)	0 (0.0)	0 (0.0)
	≥50	198 (99.0)	99 (98.0)	66 (100.0)	33 (100.0)
Tumor size	T1	162 (81.0)	83 (87.1)	56 (84.8)	18 (54.5)
	T2	38 (19.0)	13 (12.9)	10 (15.2)	15 (45.5)
PR (local)	Positive	166 (83.0)	85 (84.2)	54 (81.8)	27 (81.8)
	Negative	34 (17.0)	16 (15.8)	12 (18.2)	6 (18.2)
Ki67 (local)	<14%	94 (47.0)	70 (69.3)	18 (27.3)	6 (18.2)
	≥14%	96 (48.0)	25 (24.8)	44 (66.6)	27 (81.8)
	Unknown	10 (5.0)	6 (5.9)	4 (6.1)	0 (0.0)
TOTAL		200	101	66	33

ROR, risk of recurrence; PR, progesterone receptor; Ki67, Antigen Ki67.

The **concordance at the individual level** between risk classification based on classical clinicopathological factors and Prosigna results was **51.2%**



Martin M et al. Current Medical Research and Opinion 2015

Prosigna significantly reclassified tumor risk and changed adjuvant treatment choice

Table 2. Changes in physicians' treatment recommendation pre- and post-Prosigna.

Adjuvant treatment recommendation	Prosigna low risk $n=101$ (50.5%)	Prosigna intermediate risk $n=66$ (33.0%)	Prosigna high risk $n=33$ (16.5%)	Total $n=200$ (100%)
Adjuvant treatment recommendations before Prosigna				
CHT	16 (15.9)	24 (36.3)	19 (57.5)	59 (29.5)
CT	0 (0.0)	1 (1.5)[a]	0 (0.0)	1 (0.5)[a]
HT	85 (84.2)	41 (61.75)	14 (42.5)	140 (70.0)
Adjuvant treatment recommendations after Prosigna				
CHT	3 (3.0)	24 (36.4)	28 (84.8)	55 (27.5)
CT	0 (0.0)	1 (1.5)[a]	0 (0.0)	1 (0.5)[a]
HT	98 (97.0)	41 (62.1)	5 (15.2)	144 (72.0)
Change in adjuvant treatment recommendation pre- to post- Prosigna				
Change in treatment type[b]				
HT to CHT	0 (0.0)	9 (13.6)	9 (27.3)	18 (9)
CHT to HT	13 (12.9)	9 (13.6)	0 (0.0)	22 (11)
Change in regimen (at least one agent) within treatment type				
HT to HT	6 (5.9)	2 (3.0)	1 (3.0)	9 (4.5)
CHT to CHT	0 (0.0)	2 (3.0)	4 (12.1)	6 (3)
Any change	19 (18.8)	22 (33.3)	14 (42.4)	55 (27.5)

CHT, chemotherapy and hormonal therapy; CT, chemotherapy; HT, hormone therapy; ROR, risk of recurrence.
[a]One patient was not scheduled for HT pre- and post-Prosigna but had received CHT when assessed in the 6 months follow-up.
[b]The association between changes in physicians' treatment recommendations and Prosigna risk groups was analyzed by Fisher's exact test ($p<0.001$).

Patients reported lower anxiety after GEA-based therapeutic decision

Table 3. Change in physician confidence with knowledge of Prosigna.

	No change in confidence *n* (%)	Increased confidence *n* (%)	Decreased confidence *n* (%)
Confidence with prognosis (subtype, risk of recurrence), $n=185$	101 (54.6)	74 (40.0)	10 (5.4)
Confidence with intended treatment (optimal for the patient), $n=185$	96 (51.9)	77 (41.6)	12 (6.5)

Martin M et al. Current Medical Research and Opinion 2015

The German experience reported by the WGSG

The West German Study Group Breast Cancer Intrinsic Subtype study: a prospective multicenter decision impact study utilizing the Prosigna assay for adjuvant treatment decision-making in estrogen-receptor-positive, HER2-negative early-stage breast cancer

R. Wuerstlein, K. Sotlar, O. Gluz, B. Otremba, R. von Schumann, I. Witzel, C. Schindlbeck, W. Janni, C. Schem, I. Bauerfeind, S. Hasmueller, H. Tesch, A. Paulenz, N. Ghali, E. Orujov, R. E. Kates, W. Cowens, J. Hornberger, E. Pelz & N. Harbeck

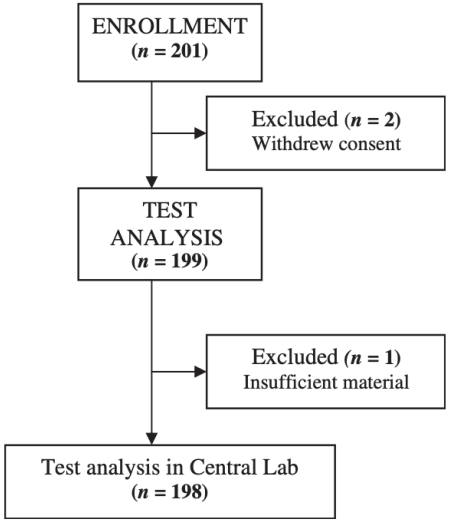


Table 1. Patient and tumor characteristics.

Patient Characteristics	Study Population $N = 198$ (%)
Age in years	
≤50	10 (5.1)
51–69	137 (69.1)
≥70	51 (25.8)
Tumor Stage	
pT1	152 (76.8)
pT2	46 (23.2)
Positive Nodes	
No	197 (99.5)
Yes	1 (0.5)
HER2 Status	
Positive	–
Negative	198 (100)
ER Status (local)	
Negative	1 (0.5)
Positive	197 (99.5)
Unknown	–
PR Status (local)	
Negative	24 (12.12)
Positive	172 (86.87)
Unknown	2 (1.01)
Ki-67 (local)	
Median	15
ECOG Status	
0	179 (90.4)
1	19 (9.6)

HER2, human epidermal growth factor receptor 2; ER, estrogen receptor; PR, progesterone receptor; ECOG, Eastern Cooperative Oncology Group.

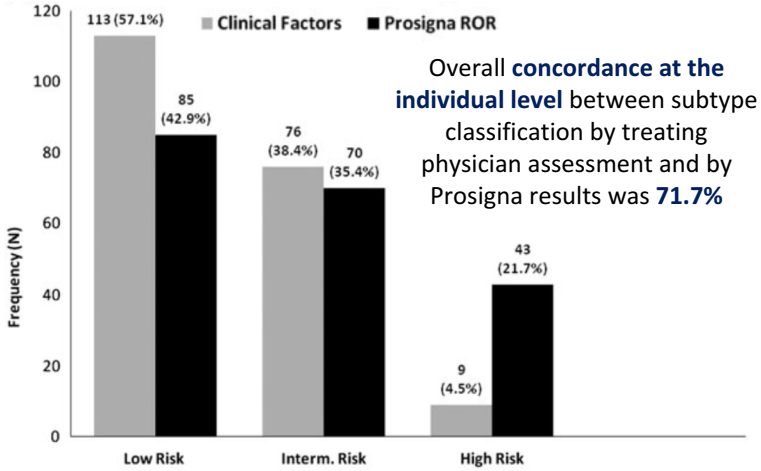
Only postmenopausal women

Wuerstlein R et al. Current Medical Research and Opinion 2016

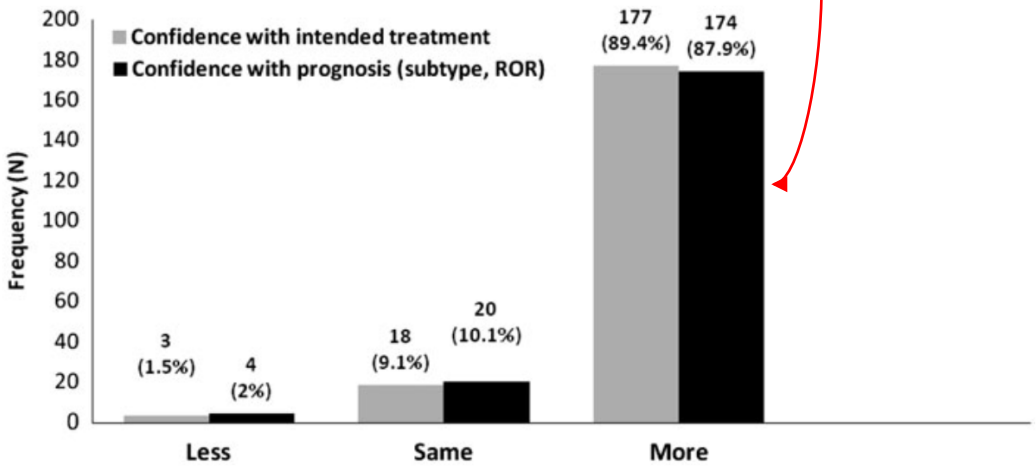
Prosigna significantly reclassified tumor risk and changed adjuvant treatment choice

First scheduled adjuvant therapy recommendation pre- and post Prosigna.

Adjuvant therapy recommendation	Low Risk ($N = 85$)	Intermediate Risk ($N = 70$)	High Risk ($N = 43$)	TOTAL ($N = 198$)
Adjuvant treatment recommendation before Prosigna				
No CT	77	58	18	153
CT	8	12	25	45
Adjuvant treatment recommendation after Prosigna				
No CT	80	53	3	136
CT	5	17	40	62
Adjuvant treatment recommendation pre- and post Prosigna				
No CT to CT	0	7	15	22
CT to no CT	3	2	0	5
No CT to no CT	77	51	3	131
CT to CT (unchanged regimen)	5	5	21	31
CT to CT (changed regimen)	0	5	4	9



Overall **concordance at the individual level** between subtype classification by treating physician assessment and by Prosigna results was **71.7%**



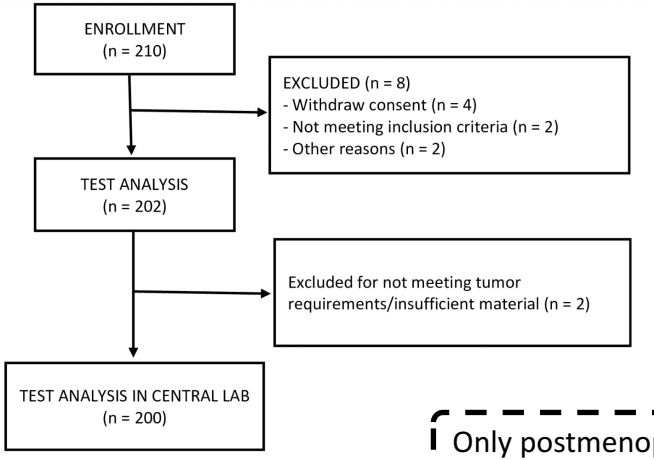
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Wuerstlein R et al. Current Medical Research and Opinion 2016

A multicenter prospective French experience

Prospective, multicenter French study evaluating the clinical impact of the Breast Cancer Intrinsic Subtype-Prosigna® Test in the management of early-stage breast cancers

Delphine Hequet[1,2]*, Céline Callens[3], David Gentien[4], Benoit Albaud[4], Marie-Ange Mouret-Reynier[5], Coraline Dubot[6], Paul Cottu[6], Cyrille Huchon[7], Sonia Zilberman[8], Helene Berseneff[9], Cyril Foa[10], Rémy Salmon[11], Aurélie Roulot[1], Florence Lerebours[6], Anne Salomon[12], Nadeem Ghali[13], Pascale Morel[13], Qianyi Li[14], Anne Cayre[15], Jean-Marc Guinebretière[12], John Hornberger[13,16], Frédérique Penault-Llorca[15], Roman Rouzier[1,2]



Only postmenopausal women

Table 1. Patient and tumor characteristics.

Characteristic	Type	All		ROR low		ROR intermediate		ROR high		p-value*
		N	%	n	%	n	%	n	%	
Age (years)	<50	2	1%	1	1%	1	1%	0	0%	0.75
	> = 50	198	99%	92	99%	66	99%	40	100%	
Tumor size	T1	158	79%	79	85%	56	84%	23	58%	0.001
	T2	42	21%	14	15%	11	16%	17	43%	
PR	Positive	172	86%	84	90%	54	81%	34	85%	0.21
	Negative	28	14%	9	10%	13	19%	6	15%	
Ki67	<14%	97	49%	70	75%	21	31%	6	15%	<0.0001
	> = 14%	98	49%	20	22%	45	67%	33	83%	
	Unknown	5	3%	3	3%	1	1%	1	3%	
TOTAL		200		93		67		40		

* Based on one-way ANOVA

Hequet D et al. PLOS One 2017

Prosigna significantly reclassified tumor risk and changed adjuvant treatment choice

Table 3. Concordance between pre-test physician assessment and Prosigna test results in risk of 10-year distant recurrence.

		Risk according to physician			
		Low	**Intermediate**	**High**	**TOTAL**
Risk according to Prosigna test	Low	78	9	1	88
	Intermediate	33	31	2	66
	High	14	22	4	40
	TOTAL	125	62	7	194

Concordance between physician assessment and Prosigna test: kappa = 0.29.

Table 4. Adjuvant treatment recommendation pre- and post-Prosigna test results, by Prosigna test risk category.

	Low Risk	**Intermediate Risk**	**High Risk**	**TOTAL**	**Fisher's exact test**
Switched type of regimen	**7**	**12**	**15**	**34**	<0.001
%	8%	18%	38%	18%	
No CT to CT	0	10	15	25	
CT to no CT	7	2	0	9	

Only patients for whom both pre- and post-Prosigna test risk assessment were available were included.

Chemotherapy spared thanks to Prosigna

Hequet D et al. PLOS One 2017

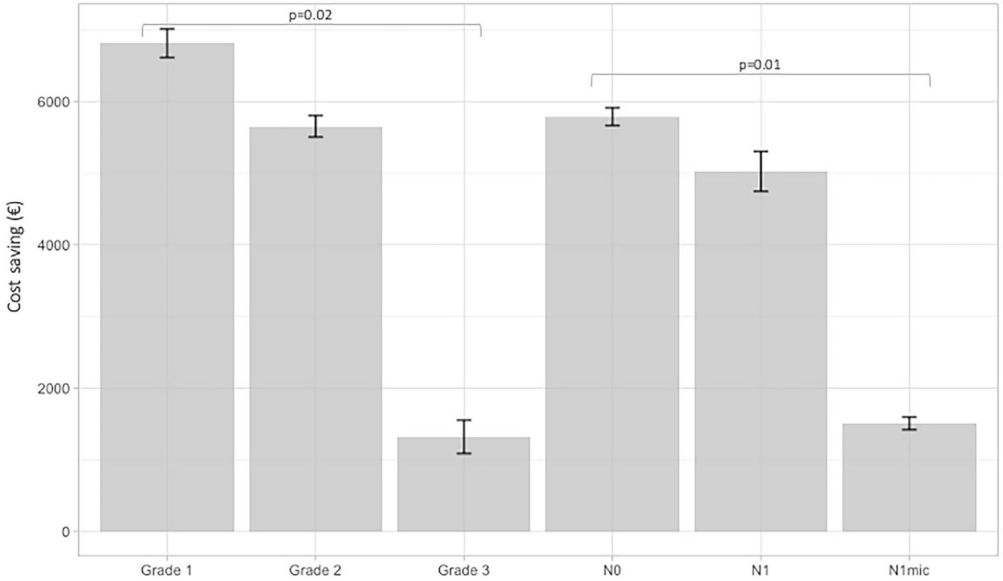
The economic impact of Prosigna in the French public healthcare system

- A total of 809 patients were retrospectively included, at itermediate risk with possible indication to chemotherapy
- The medical and non-medical additional cost of chemotherapy over one year was €9,737 and the cost of Prosigna test was €1,849

Table 1 Patient and tumor characteristics

	n/mean	%/range
Age (years)	57	(26–83)
Tumor characteristics		
Size (mm)	18	(6–50)
Grade		
1	67	8%
2	645	80%
3	97	12%
LVE		
No	663	82%
Yes	146	18%
Lymph node involvement		
pN0	689	85%
pN1mic	79	10%
pN1	41	5%
Ki67	20	(1–100)

Chemotherapy was not indicated by the Prosigna test for 358 patients, resulting in a **44% reduction** of the number of indications for **chemotherapy**



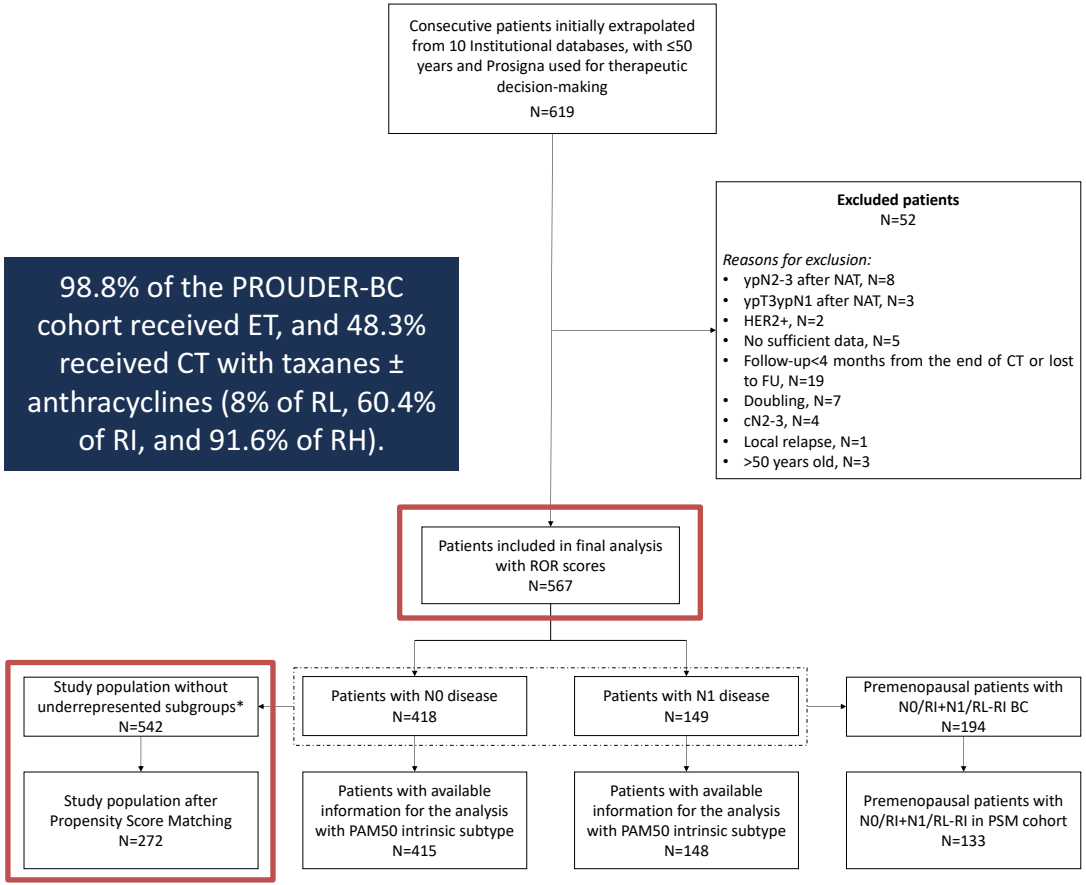
Overall, the **cost saving** related to withholding of adjuvant chemotherapy for one patient on the basis of the Prosigna test results was **€5,485**

Hequet D et al. Breast Cancer Research and Treatment 2021

Prosigna in premenopausal/<50yo women with breast cancer: the Spanish-Italian PROUDER-BC study

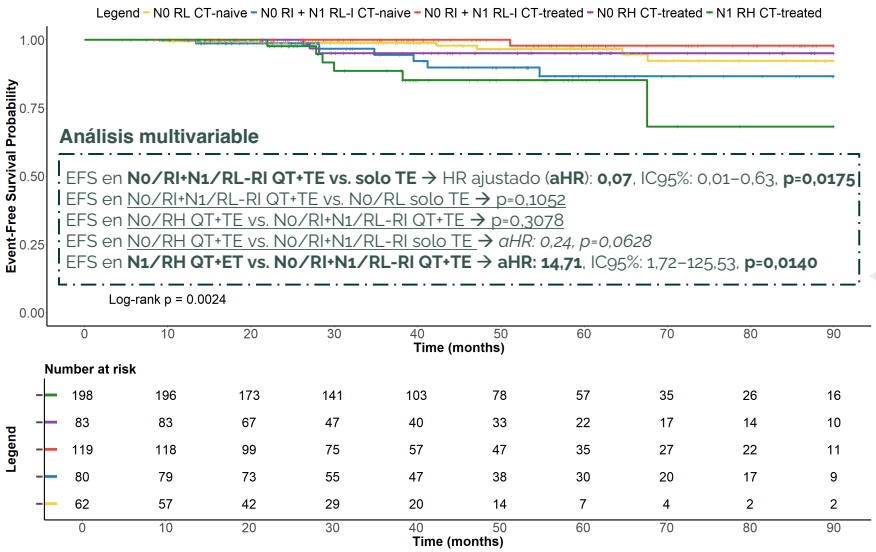
DEMOGRAPHICS	TAILORx N	TAILORx %	RxPONDER N	RxPONDER %	PROUDER-BC N	PROUDER-BC %	P-value (chi-square with Yates correction)
	9719	100.0	5018	100.0	567	100.0	
Age (years)							
≤40	448	4.6	147	2.9	94	16.6	
41-50	2606	26.8	1077	21.5	473	83.4	**<0.0001**
≥51	6665	68.6	3794	75.6	0	0.0	
Menopausal status							
Premenopausal	3300	34.0	1665	33.2	544	95.9	**<0.0001**
Postmenopausal	6419	66.0	3353	66.8	23	4.1	
T at diagnosis							
T1	7271	74.8	2923	58.3	406	71.6	
T2	2445	25.2	1843	36.7	153	27.0	**<0.0001**
T3	0	0.0	252	5.0	8	1.4	
T4	0	0.0	0	0.0	0	0.0	
N at diagnosis							
N0	9719	100.0	0	0.0	418	73.7	**<0.0001**
N1	0	0.0	5018	100.0	149	26.3	
N2-3	0	0.0	0	0.0	0	0.0	
Grade							
1	2512	26.6	1218	24.7	118	21.3	
2	5242	55.6	3215	65.0	378	68.4	**<0.0001**
3	1676	17.8	507	10.3	57	10.3	
Overall	9430	97.0	4940	98.4	553	97.5	
Histology							
IDC/No special type	NR	-	3673	74.6	469	83.9	
ILC and mixed with ILC	NR	-	952	19.3	65	11.6	**<0.0001**
Other	NR	-	299	6.1	25	4.5	
Overall	NR	-	4924	98.1	559	98.6	
Estrogen receptor							
Positive	9665	99.4	4987	100.0	563	99.3	**<0.0001**
Negative	54	0.6	0	0.0	4	0.7	
Progesterone receptor							
Positive	8564	94.0	4701	94.3	543	95.8	0.1808
Negative	551	6.0	286	5.7	24	4.2	
Molecular risk							
Low	1619	16.7	2147	42.8	225	39.7	
Intermediate	6711	69.0	2871	57.2	187	33.0	**<0.0001**
High	1389	14.3	0	0.0	155	27.3	
PAM50 intrinsic subtype							
Luminal A	-	-	-	-	379	67.3	
Luminal B	-	-	-	-	172	30.6	
HER2-enriched	-	-	-	-	2	0.4	NA
Basal-like	-	-	-	-	10	1.7	
Overall	-	-	-	-	563	99.3	

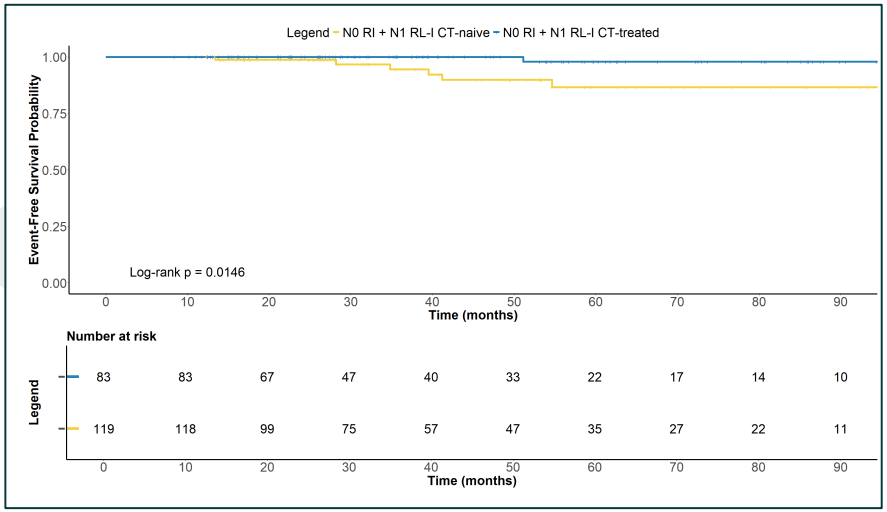
98.8% of the PROUDER-BC cohort received ET, and 48.3% received CT with taxanes ± anthracyclines (8% of RL, 60.4% of RI, and 91.6% of RH).



Di Grazia G et al. Eur J Cancer 2026

Prosigna identified a subgroup of non-high risk patients with stage I-II disease who may gain benefit from CT

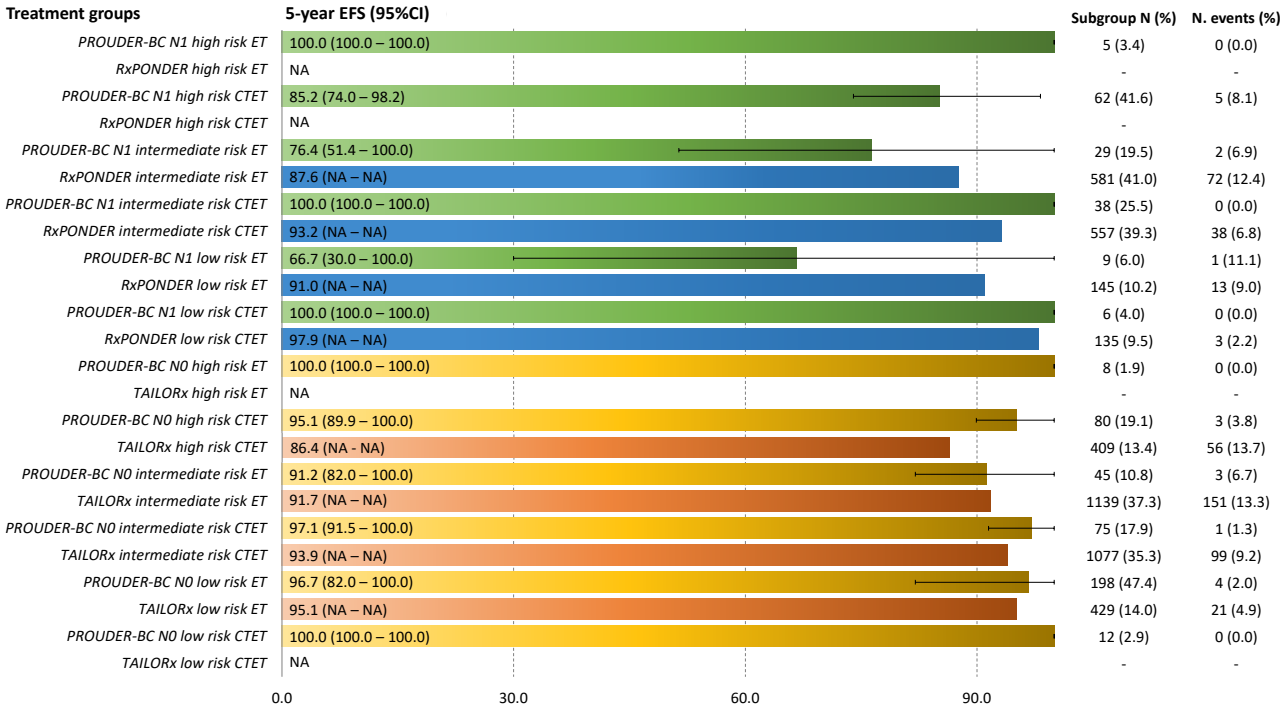




- Multivariable analysis adjusted for **age, Ki-67%, PR%, T stage and grade (G)**, excluding uncommon subgroups not treated according to current SOC (N0/RL treated with CT [n=12, 2.1%], N0/RH treated with ET alone [n=8, 1.4%], and N1/RH treated with ET alone [n=5, 0.9%]).
- N0/RI and N1/RL-RI cases were pooled (n=202, 35.6%) and patients receiving CT+ET were compared with those receiving ET alone.
- The EFS benefit for N0/RI+N1/RL-RI patients receiving CT+ET versus ET alone was maintained after **propensity score matching (PSM)** (aHR: 0.11, p=0.0482).

Di Grazia G et al. Eur J Cancer 2026

5-year EFS rates were consistent with those of similar populations in TailorX and RxPONDER



- **CT+ET-treated** subgroups in PROUDER-BC showed **higher 5y-EFS rates** compared with the corresponding risk subgroups in **TAILORx and RxPONDER**.
- **ET-treated** subgroups in PROUDER-BC showed **similar 5y-EFS** rates to the corresponding risk subgroups in **TAILORx and RxPONDER**.

Di Grazia G et al. Eur J Cancer 2026

Exploratory sub-analysis showed no benefit of CT if GnRHa was administered

Consecutive patients initially extrapolated from 10 Institutional databases, with ≤50 years and Prosigna used for therapeutic decision-making

N=619

Excluded patients
N=52

Reasons for exclusion:
- ypN2-3 after NAT, N=8
- ypT3ypN1 after NAT, N=3
- HER2+, N=2
- No sufficient data, N=5
- Follow-up<4 months from the end of CT or lost to FU, N=19
- Doubling, N=7
- cN2-3, N=4
- Local relapse, N=1
- >50 years old, N=3

Patients included in final analysis with ROR scores
N=567

Study population without underrepresented subgroups*
N=542

Study population after Propensity Score Matching
N=272

Patients with N0 disease
N=418

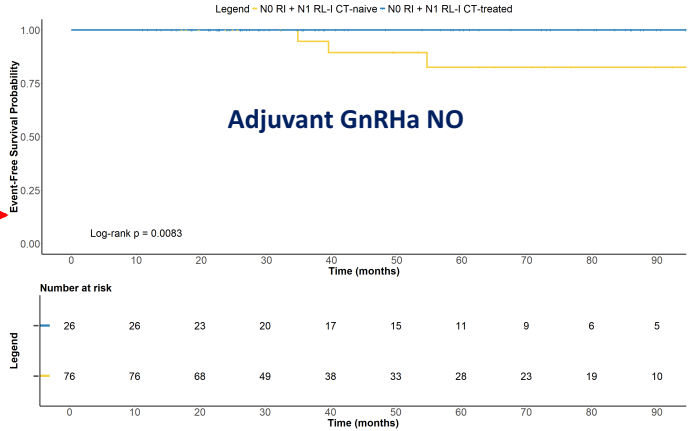
Patients with available information for the analysis with PAM50 intrinsic subtype
N=415

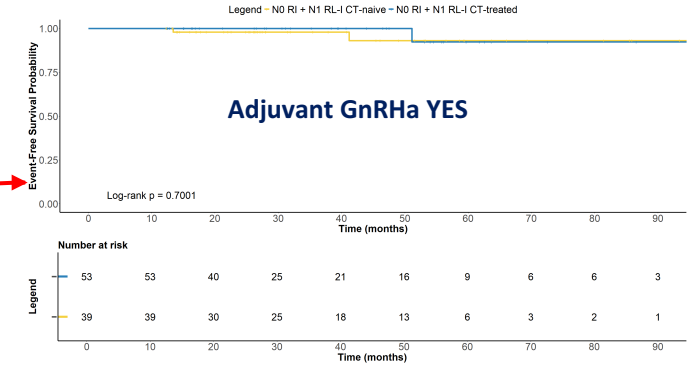
Patients with N1 disease
N=149

Patients with available information for the analysis with PAM50 intrinsic subtype
N=148

Premenopausal patients with N0/RI+N1/RL-RI BC
N=194

Premenopausal patients with N0/RI+N1/RL-RI in PSM cohort
N=133





Di Grazia G et al. Eur J Cancer 2026

Feasibility of Prosigna in core needle biopsy for use in the neoadjuvant setting

Retrospective analysis on 122 FFPE tumor blocks containing CNB samples from 95 patients with newly diagnosed BC

Material from CNB was sufficient to obtain adequate RNA **concentration** and **purity**

N=30 paired CNB and surgical samples (pts untreated between biopsy and surgery)

Similar to what reported in multiple extractions from same surgical sample

SD (Average Standard Deviation)

	ROR	Basal-like	HER2E	LumA	LumB	Proliferation score
Multiple RNA extractions from the same CNB	2.2	0.02	0.02	0.02	0.02	0.05
Multiple CNBs of the same tumor	6.8	0.08	0.09	0.10	0.08	0.22

Subtype calls 98% concordant

Increased variance observed **across multiple CNBs of the same tumor** attributed to molecular heterogeneity within the tumor tissue

Pearson correlation coefficient

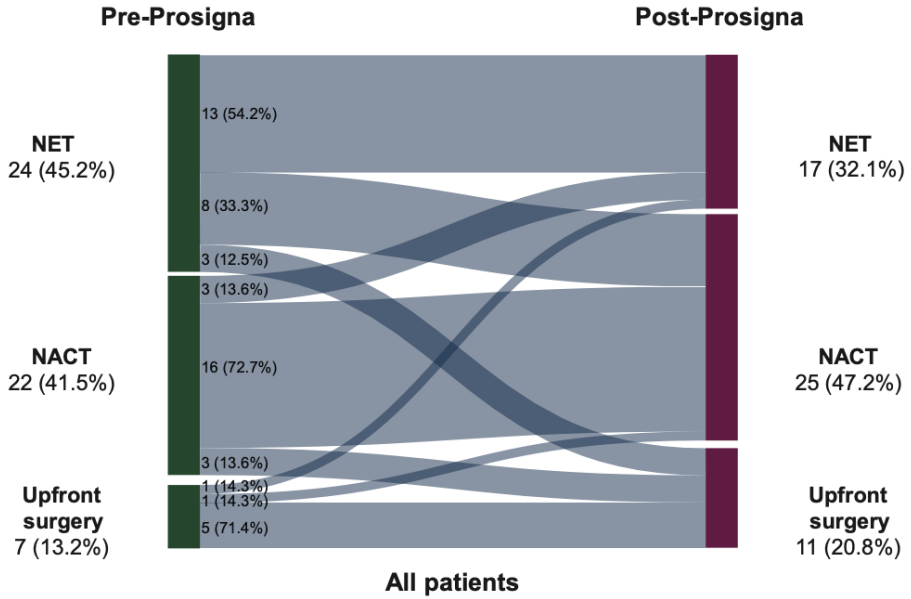
ROR	Basal-like	HER2E	LumA	LumB	Proliferation score
0.90	0.98	0.94	0.96	0.97	0.92

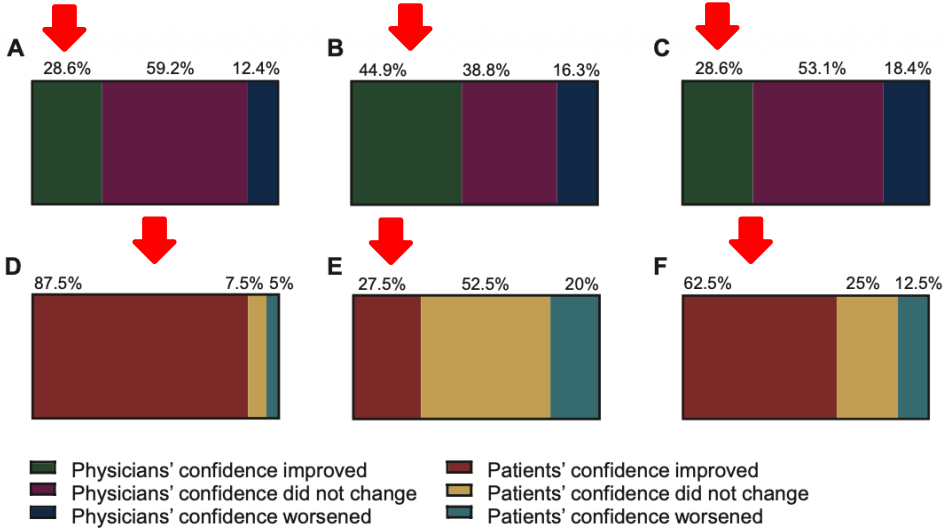
Very strong correlations

Prat A et al. Clin Cancer Res 2016

Prosigna on upfront core biopsies may influence NAT in HR+/HER2- eBC

- Single-center prospective observational study at the DFCI
- 54 patients with early-stage HR+/HER2- BC
- Prosigna test obtained on an upfront CNB
- Prosigna changed the therapeutic approach in several scenarios





A: physicians' **confidence** in their **diagnosis**; B: physicians' confidence in the **treatment plan being optimal** for the patient; C: physicians' confidence in **understanding** how **Prosigna** works; D: patients' **confidence** in the treatment **recommendation**; E: patients' confidence **in understanding** how **Prosigna** works; F: patients' **anxiety** about treatment and disease outcomes.

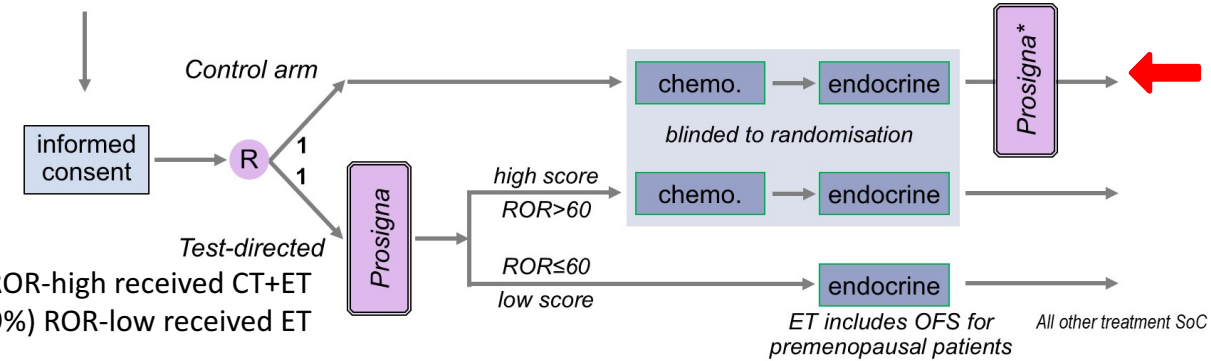
Clínic Barcelona Comprehensive Cancer Center

Corti C et al. Esmo Open 2025

The OPTIMA trial prospectively assessed the clinical utility of Prosigna

Main eligibility criteria

- Women & men age ≥40 with excised breast cancer
- ER-pos (IHC>10%) & HER2-neg
- Nodes: ▸0-9N+, ▸minimum T-size requirement if N0/ N1mi
- Neoadjuvant chemotherapy prohibited



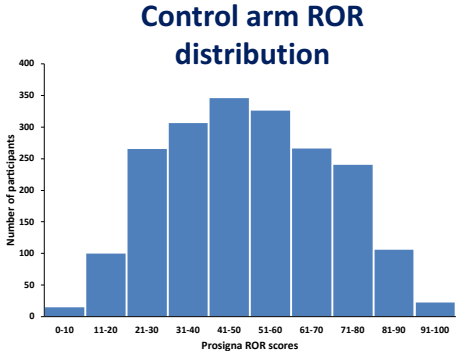
660 (31.5%) ROR-high received CT+ET
1421 (67.9%) ROR-low received ET

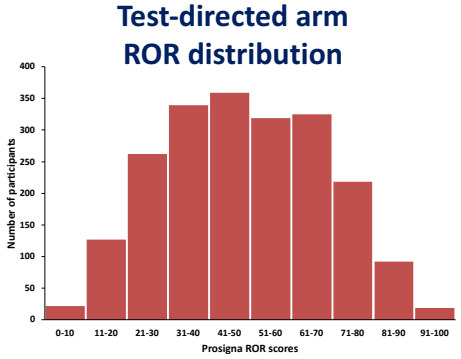
Prosigna carried out in the control arm but investigators blinded to test result

CHARACTERISTIC	CONTROL ARM	TEST DIRECTED ARM	TOTAL
number PP	2059	2094	4153
age (range)	55 (40-84)	56 (40-82)	56 (40-84)
premenopausal	776 (38%)	775 (37%)	1551 (37%)
postmenopausal	1265 (61%)	1302 (62%)	2567 (62%)
men	18 (1%)	17 (1%)	35 (1%)
grade 1-2	1417 (69%)	1465 (70%)	2862 (69%)
grade 3	642 (31%)	629 (30%)	1271 (31%)
tumor size <30 mm	1104 (54%)	1128 (54%)	2232 (54%)
tumor size ≥30 mm	955 (46%)	966 (46%)	3050 (46%)
nodes: 0 / micromets	160 (8%)	167 (8%)	327 (8%)
1-3*	1515 (74%)	1534 (73%)	3049 (73%)
4-9	384 (18%)	393 (19%)	777 (19%)

*39% of pN1 tumors had a sentinel node biopsy only
68% of patients in test directed arm had low ROR score

*Control arm Prosigna testing used for analysis only. U.K. control arm testing performed following recruitment completion

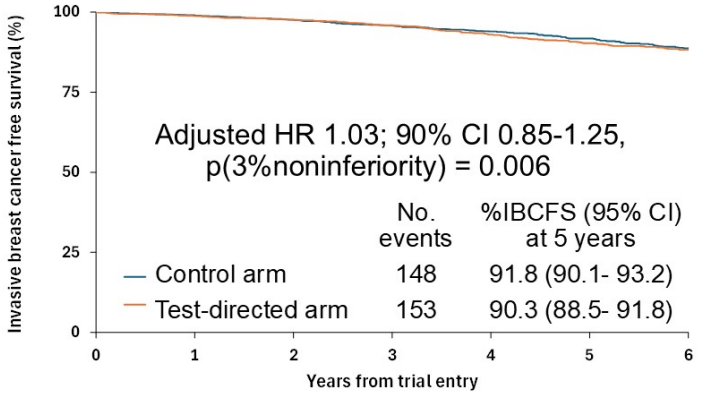




Non-inferiority was met in both the full population and the low-score population

Invasive Breast Cancer-Free Survival

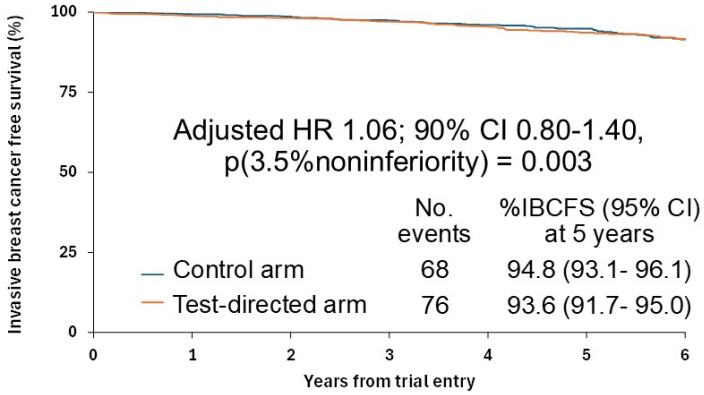
Complete Per Protocol population



Number at risk:							
Control	2059	1818	1563	1283	999	741	485
Test-directed	2094	1857	1591	1303	989	724	481

Demonstrated non-inferiority limit = 2%
No certainty of chemotherapy benefit
1.5% observed 5-year difference –favors chemotherapy

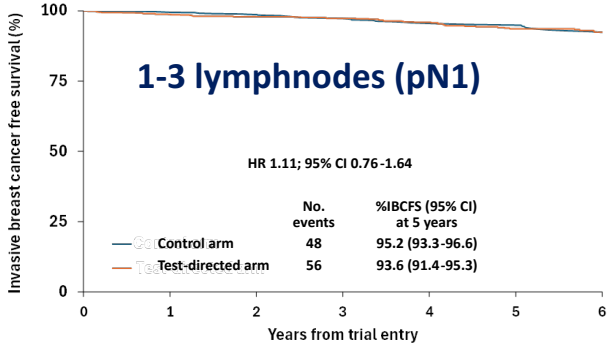
ROR ≤60 subpopulation **(ET only)**



Number at risk:							
Control	1358	1207	1043	862	672	504	337
Test-directed	1421	1257	1086	905	694	503	342

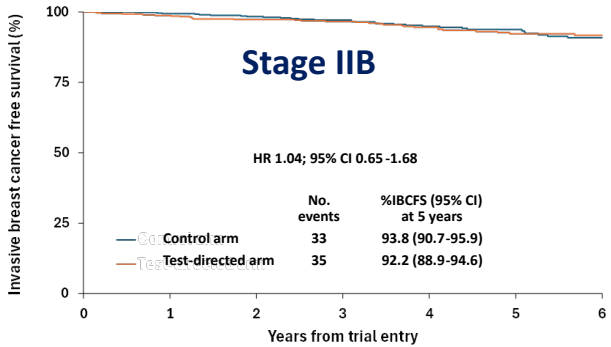
Demonstrated non-inferiority limit = 2%
No certainty of chemotherapy benefit
1.2% observed 5-year difference –favors chemotherapy

Non-inferiority was met in the ROR-low population regardless pN and stage



Number at risk (censored):

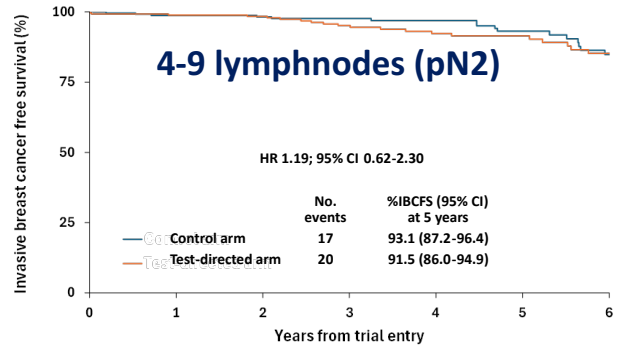
Control	1015 (0)	913 (98)	797 (207)	650 (343)	498 (485)	382 (599)	264 (708)
Test-directed	1063 (0)	953 (97)	828 (214)	700 (338)	539 (490)	389 (629)	270 (744)



Number at risk (censored):

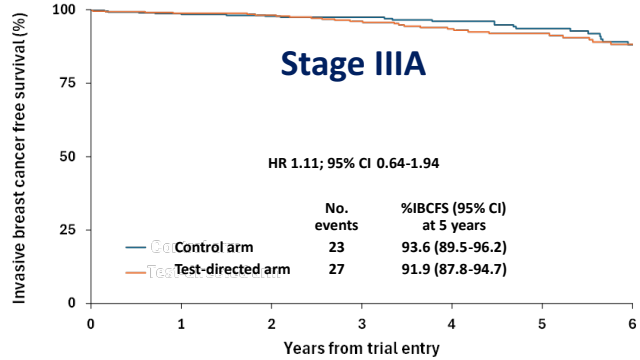
Control	550 (0)	490 (57)	426 (116)	349 (188)	276 (254)	216 (311)	146 (375)
Test-directed	585 (0)	522 (56)	454 (117)	370 (198)	282 (279)	206 (349)	140 (414)

All patients in the test-directed arm received ET, all patients in the control arm received adjuvant CT and subsequent ET



Number at risk (censored):

Control	243 (0)	214 (26)	181 (58)	155 (83)	125 (112)	84 (179)	48 (204)
Test-directed	269 (0)	232 (33)	197 (67)	158 (100)	118 (136)	86 (199)	49 (228)

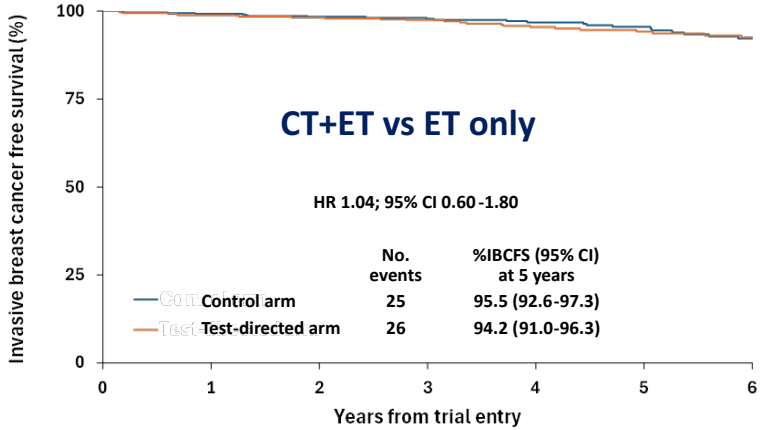


Number at risk (censored):

Control	389 (0)	343 (41)	293 (88)	248 (132)	189 (188)	130 (243)	77 (290)
Test-directed	414 (0)	359 (50)	307 (100)	255 (146)	199 (196)	142 (250)	88 (299)

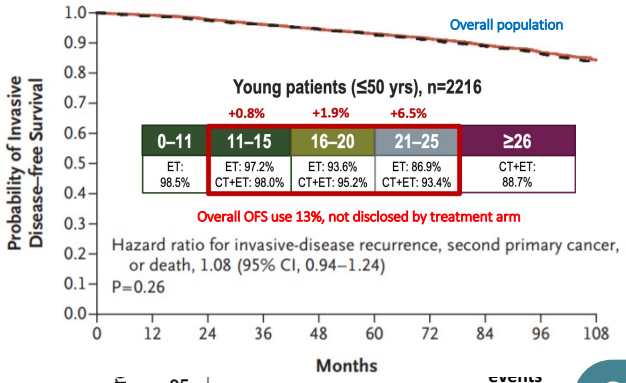
Non-inferiority was met regardless of menopausal status in ROR-low

Premenopausal

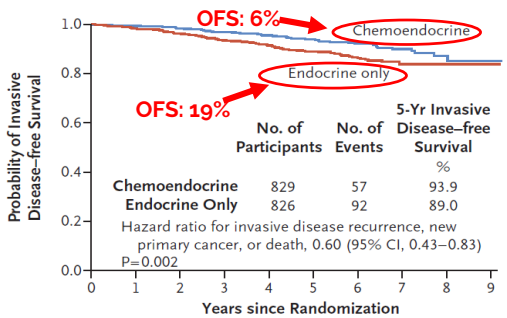


Number at risk (censored):							
Control	561 (0)	481 (76)	409 (144)	338 (213)	258 (290)	200 (345)	140 (399)
Test-directed	559 (0)	487 (66)	409 (141)	347 (200)	256 (285)	195 (343)	135 (400)

CT benefit not observed in premenopausal women with ROR≤60 undergoing **ET+OFS**



iDFS in premenopausal women



No. at Risk										
Chemoendocrine group	829	764	710	642	546	484	312	153	46	5
Endocrine-only group	826	760	703	622	542	463	290	138	44	2

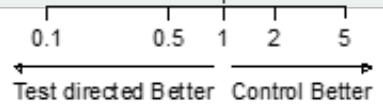
OPTIMA Young focused on premenopausal women (also 35-40yo, no N2) will provide another cohort to pool with that of OPTIMA

413 (352) 304 (457) 197 (555)
437 (391) 307 (512) 207 (606)

Stein RC ASCO 2026; Sparano JA, et al., N Engl J Med 2018. Kalinsky K, et al. N Engl J Med 2021

Non-inferiority was also met regardless tumor grade and pT in the ROR-low subset

Subgroup	Test directed	Control	HR (95% CI)
Overall	76/1421	68/1358	1.06 (0.77 to 1.48)
Menopausual status			
Premenopausal	26/559	25/561	1.04 (0.60 to 1.80)
Postmenopausal	50/858	42/791	1.14 (0.75 to 1.71)
Grade			
1 or 2	60/1184	48/1126	1.22 (0.84 to 1.78)
3	16/237	20/232	0.78 (0.40 to 1.50)
Tumour size			
<30mm	39/809	28/770	1.30 (0.81 to 2.10)
>=30mm	37/612	40/588	0.93 (0.60 to 1.46)
Nodal status			
pN1	56/1063	48/1015	1.11 (0.76 to 1.64)
pN2	20/268	17/243	1.19 (0.62 to 2.29)
Intended Chemotherapy			
Anthracycline containing	6/176	6/163	0.89 (0.29 to 2.76)
Taxane containing	5/163	5/142	1.05 (0.30 to 3.65)
Anthracycline+Taxane	65/1082	57/1053	1.12 (0.79 to 1.60)



Take-home messages

- Datos de **práctica clínica real** (España, Alemania y Francia): Prosigna reclasificó el riesgo, modificó las decisiones sobre tratamiento adyuvante, evitó el uso de quimioterapia y redujo los costes.
- **PROUDER-BC**, una cohorte de práctica clínica real hispano-italiana de más de 500 pacientes premenopáusicas o menores de 50 años: Prosigna permite identificar a pacientes jóvenes con enfermedad en estadio I-II y sin criterios de alto riesgo que podrían necesitar quimioterapia.
- **OPTIMA:** en tumores en estadio II-IIIA con ROR ≤60, la hormonoterapia (ET) sola fue no inferior a quimioterapia seguida de hormonoterapia (CT+ET), incluidos pacientes con pN1-2, estadio IIB-IIIA y mujeres premenopáusicas y posmenopáusicas.
- En **pacientes premenopáusicas con ROR bajo** y cáncer de mama RH+/HER2− en **estadio I-IIIA**, la combinación de hormonoterapia y supresión de la función ovárica (**ET+OFS**) parece anular el beneficio de la quimioterapia.
- Es necesario un **seguimiento más prolongado de OPTIMA**, dado el riesgo de recaídas tardías en la enfermedad RH+, especialmente en pacientes con pN2 y mujeres premenopáusicas.
- **OPTIMA Young** permitirá esclarecer aún más el papel de la supresión de la función ovárica frente a la quimioterapia en mujeres premenopáusicas, ampliando la evidencia a mujeres de 35-40 años.

¡Muchas gracias por la atención!



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