

Riunione Annuale

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**26-27 SETTEMBRE 2025 BERGAMO**

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PIAZZA DELLA REPUBBLICA, 6

*NEOadjuvant therapy with  
ELAcestrant in locally advanced  
lobular breast cancer:  
NEOELA Study*

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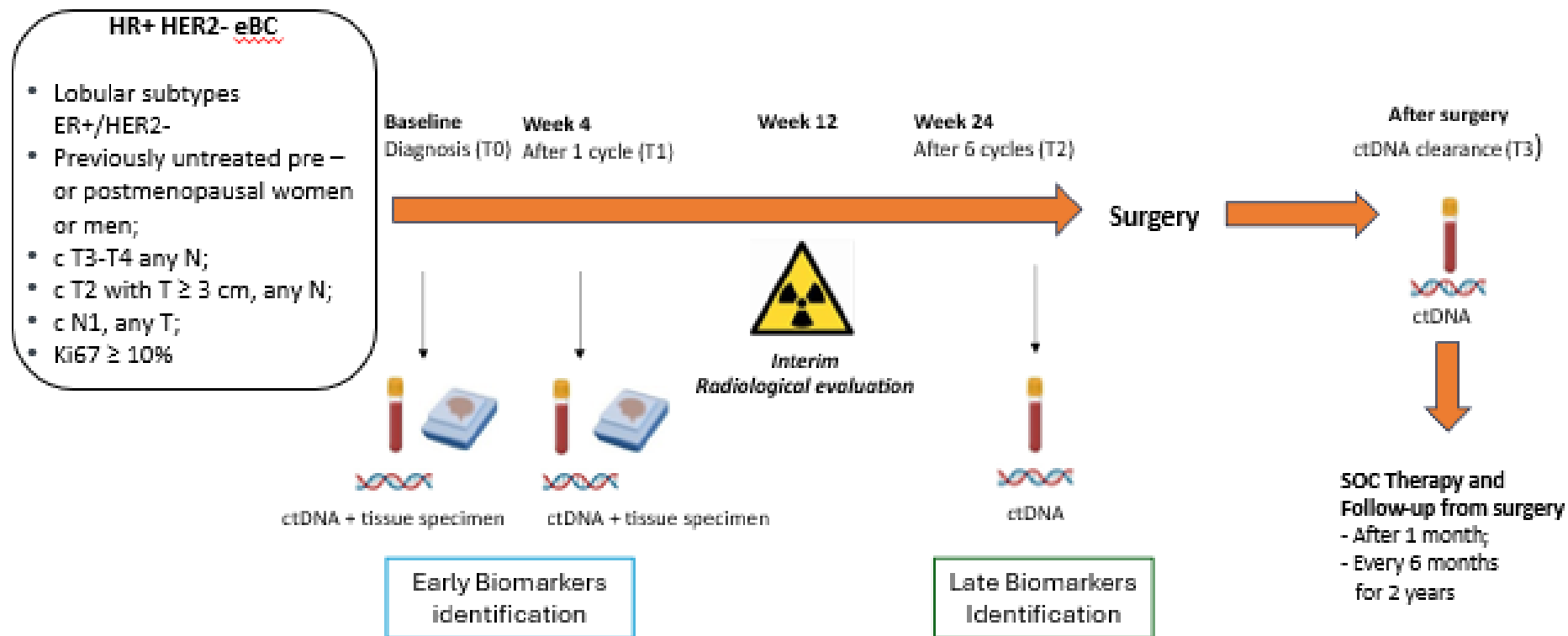


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## Study Background & Rationale

- Neoadjuvant treatment (NT) of breast cancer (BC) is a well-consolidated option for HER2-positive and triple negative histotypes, but data on hormone receptor positive (HR+)/HER2- BC did not gather clear evidence of benefit. Data from CTneoBC pooled analysis suggested that administration of neoadjuvant chemotherapy was associated with clinical benefit only in high grade, aggressive tumour, while the worst outcomes were associated with low grade tumors and lobular histology.
- Moreover, neoadjuvant endocrine therapies (NETs) were considered and compared with chemotherapy-based regimens, with discordant results, and specific data on lobular histology are still lacking.
- Recently, cycline-dependent kinase 4/6 inhibitors (CDK4/6i) were tested in the neoadjuvant setting, investigating overall response rate (ORR), pathological complete response (pCR) and complete cell-cycle arrest (CCCA, defined as  $Ki67 \leq 2.7\%$  at a defined timepoint) or decreased rate of Ki67. However, only studies reporting CCCA met their primary endpoint. A recent meta-analysis showed significant increase in CCCA rates when a CDK4/6i was used in association with endocrine therapy (OR 9.0; 95% CI, 5.42–14.96;  $P < 0.001$ ).
- Regarding new endocrine treatments, Selective Estrogen Receptor Degradors (SERDs) have recently been approved in advanced BC, and there is growing attention at their use in the neoadjuvant setting, alone or in combination with CDK4/6 inhibitors: a post-treatment Ki67 reduction was seen with Giredestrant plus Palbociclib (-81%, coopERA) and Amcenestrant monotherapy (-75.9%, AMEERA-4). Elacestrant, administered as monotherapy, was investigated as NET in the SOLTI-ELIPSE trial, in which 27% of patients showed a CCCA ( $Ki67 < 2.7\%$ ) after 4 weeks of treatment, providing relevant biological and molecular responses.
- Whether these responses will be associated with pCR rates or survival outcomes in HR+/HER2- BC is still under investigation.
- In our study, we propose the use of Elacestrant monotherapy in neoadjuvant setting to investigate the biological and clinical effect on patients with early BC and lobular histology, as data on this particular tumor subtype are strongly needed.

# Study design



# Statistical methods

## Primary Endpoint

Proportion of patients achieving Complete Cell cycle arrest (CCCA), defined as Ki-67 less than or equal to 2.7%, at 1 month

## Secondary Endpoints:

Rate of pCR

- Complete, partial responses, stable disease, progressive disease as per RECIST criteria
- Ki67 rate
- Safety evaluation as per CTCAE v5.0
- Quality of life evaluation through QLQ-C30 and BR42 questionnaires
- Disease-free survival, event-free survival

## Sample Size & Power Calculation

- The primary endpoint of NEOELA trial is the proportion of patients achieving CCCA. From a previous study (SOLTI-1905 ELIPSE) the CCCA rate is 27.3% (95% CI: 10.7-50.2). Considering 10% as a rate of no interest and 30% as a promising rate we need to enroll 25 patients; if, at the end of the study we observe CCCA in at least 6 patients we can reject the null hypothesis (CCCA rate  $\leq 10\%$ ) with a power of 80% at a significance level of 5% (one-sided).

Secondary endpoints are:

- The proportion of patients with a complete response, reported as percentage with its 95% confidence interval
- The proportion of patients according to the type of response, reported as percentage with its 95% confidence interval
- Values of ki67 at surgery reported as absolute values with mean, median, standard deviation and interquartile range as well as the decrease from baseline levels reported as the difference between surgery and baseline levels divided by baseline level
- Safety coded according the NCI-CTCAE v.5.0 system and reported as the worst grade for each type of toxicity event
- Quality of life measured through EORTC questionnaire and analyzed with a linear model with baseline values as covariate
- Survival will be analyzed with the Kaplan-Meier method

# Feasibility

Study Details	
Phase	II
Proposed Sample Size	25
Proposed Countries & No. of Sites	1 country/6 sites

Estimated Timelines	
Anticipated Activation	Q1 2026
Est. Enrollment Duration	24 months (1 pt/month)
Est. Treatment Duration	6 cycles/6 months of therapy per patient
Est. LTFU	24 months after surgery
Est. Total Study Duration	36 months

	Activity / Description	Dates from the ESR submission	Updated milestone dates
Approval	MARC endorsement		
Study set-up	Final protocol	Oct-2026	
	Study agreement signature	Feb-2026	
Study start-up	Regulatory Authority - Institutional Review Board (IRB) / Ethics Committee (EC) approval	Feb-2026	
	First Patient In (FPI)	Mar-2026	
Study execution	25% enrolled patients (expected current vs actual)	Jun-2026	
	50% enrolled patients (expected current vs actual)	Sep-2026	
	75% enrolled patients (expected current vs actual)	Dec-2026	
	Last Patient In (LPI)	Mar 2027	
	Last Patient Out (LPO)	Q1 2028	
Study closure	Database Lock (DBL)	Q2 2028	
	Primary data release	Q3 2027	
	Clinical Study Report (CSR)	Q3 2028	
	Manuscript publication data (actual)	Q4 2028	