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ESMO 2026: ADC Developments Across Solid Tumors—Emerging Efficacy, Treatment Sequencing, and Patient Selection

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ABSTRACT

Antibody–drug conjugates (ADCs) are moving from late-line salvage therapy into first-line combinations, maintenance strategies, and planned treatment sequences. Abstracts presented at the ESMO Congress 2026 in Madrid describe how clinicians currently choose among ADCs, how much activity is lost when one ADC follows another, and whether functional testing can add to conventional biomarkers. Read alongside recent work on resistance biology and new ADC formats, these studies point to one practical conclusion: ADC choice increasingly depends on what kind of therapy the patient has already received, not only on the antigen the tumor expresses.

KEY TAKEAWAYS

- Real-world ADC selection is shaped by tumor biology, disease burden, prior treatment, and brain metastases. These patterns describe clinical decision-making, not comparative efficacy.
- The three most-used ADCs in metastatic breast cancer all carry topoisomerase I payloads. Evidence that switching payload class preserves activity therefore exposes a practical gap that dual-payload and non-topoisomerase I ADCs are being designed to fill.
- Resistance can arise even when the target antigen remains abundant, so antigen testing alone cannot predict whether a subsequent ADC will work. Functional assays may help, but none is yet a validated clinical tool.
- Many patients never reach the next line of therapy. A drug's value in later lines depends on whether patients remain well enough to receive it, which strengthens the case for testing ADCs earlier.

INTRODUCTION

The ESMO Congress 2026, held October 23–27 at IFEMA Madrid, Spain, arrived at a turning point for ADCs[1]. By July 2026, the U.S. Food and Drug Administration (FDA) had approved 15 ADCs[2], and more than 20 had been approved worldwide[3]. Their development is no longer limited to proving activity in heavily pretreated patients. Investigators now test ADCs in first-line combinations, maintenance therapy, and sequences following other targeted agents or other ADCs.

The class's history explains why that matters. Gemtuzumab ozogamicin (Mylotarg®; Pfizer), the first approved ADC, received accelerated approval in acute myeloid leukemia in 2000, was withdrawn in 2010, and returned in 2017 at a lower, fractionated dose[4]. The molecule did not change; how it was given, and to whom, did. That lesson runs through the ESMO 2026 program. Real-world analyses describe how clinicians choose among available ADCs, translational studies ask whether functional testing can complement biomarkers, and ongoing trials test ADCs in settings where patients may receive them for longer.

The central question is how clinicians can determine which ADC suits a particular patient at a particular point in the disease course. The abstracts offer useful observations, but they carry different weights of evidence. Randomized trials, retrospective cohorts, network meta-analyses, and laboratory studies answer different questions, and we interpret their findings accordingly (Table 1.0).

BREAST CANCER: ADC SELECTION IS BECOMING A SEQUENCING QUESTION

Real-world selection in metastatic breast cancer

The DePAS multicenter case series (95eP) examined ADC selection in 215 patients with metastatic breast cancer in Germany[5]. The median age was 59 years. The cohort in-

cluded patients with hormone receptor (HR)-positive/HER2-negative or HER2-low disease and patients with triple-negative breast cancer (TNBC). Nearly half had at least three metastatic sites, and 21.4% had brain metastases.

Sacituzumab govitecan (Trodelvy®; Gilead Sciences) was selected most often (58.1%). Trastuzumab deruxtecan (Enhertu®; Daiichi Sankyo/AstraZeneca) was chosen in 35.3% and datopotamab deruxtecan (Datroway®; Daiichi Sankyo/AstraZeneca) in 6.5%.

Table 1.0. ESMO 2026 abstracts discussed, by level of evidence

Abstract	Tumor type	Design	n	Main finding	Evidence level
95eP (DePAS)	Metastatic breast	Multicenter case series, Germany	215	Sacituzumab govitecan chosen most often (58.1%); brain metastases linked to trastuzumab deruxtecan	Descriptive
61eP	Advanced breast	Bayesian network meta-analysis	9,819 (16 RCTs)	Trastuzumab deruxtecan ranked highest for PFS; payload switch ORR 41% vs 9% same-payload rechallenge (observational sub-analysis)	Indirect comparison
1908eP (REALNESS)	HR+/HER2− metastatic breast	Retrospective cohort, Brazil	171	Attrition rises with each line: ADC use limited	Descriptive
4540eP	NSCLC (*STK11/KRAS*)	Patient-derived organoids, one patient	1	Sac-TMT active (IC50 7.304 nM)	Translational
2775eP	Metastatic NSCLC	*Ex vivo* testing of pleural effusions	5	Genomics alone did not capture responses	Translational
4826eP	Metastatic urothelial	Retrospective cohort, U.S.	248	23.8% received therapy after EV+P; median OS 15.5 months	Descriptive
3875eP	ES-SCLC	Retrospective cohort	285	52.6% received first line only; ECOG ≥2 OR 0.28 for next line	Descriptive
1443eTiP (TroFuse-022)	Recurrent ovarian	Randomized trial in progress	—	Maintenance sac-TMT ± bevacizumab	Trial design
1444eTiP (TroFuse-036)	PD-L1+ cervical	Randomized trial in progress	—	Sac-TMT ± pembrolizumab (trial in progress)	Trial design

Patterns differed by subtype. In TNBC, sacituzumab govitecan accounted for 76.9% of selections. In HR-positive/HER2-negative or HER2-low disease, the split was more even: trastuzumab deruxtecan 44.7%, sacituzumab govitecan 43.9%, and datopotamab deruxtecan 11.4%.

Investigators most often cited tumor biology as the deciding factor, followed by approval or guideline considerations and disease burden. Brain metastases were associated with selection of trastuzumab deruxtecan. That choice has a biological logic: metastatic sites differ in vascular permeability and stroma, and the blood–tumor barrier still limits drug exposure in brain disease[6]. The study was descriptive, however. It does not show that one ADC was more effective than another, nor does it establish a preferred sequence.

Payload history – what the comparative evidence suggests

Goel and colleagues (61eP) pooled 16 randomized trials (9,819 patients) to compare next-generation ADCs with older HER2-directed regimens in advanced breast cancer[7]. Although the title describes a Bayesian network meta-analysis, hazard ratios were pooled with a frequentist random-effects model, and evidence certainty was rated with CINeMA. Despite the title, no bispecific ADC appears among the reported treatment results. In the progression-free survival (PFS) network of 15 studies, trastuzumab deruxtecan ranked highest (HR 0.38 versus treatment of physician's choice; 95% CI 0.25–0.60; P-score 0.93), and sacituzumab govitecan also showed significant benefit (HR 0.57; 95% CI 0.36–0.90). Heterogeneity was substantial (I^2 = 88.2%). In the overall survival (OS) network of 12 studies (I^2 = 65.4%), sacituzumab govitecan (HR 0.64; 95% CI 0.50–0.81) and trastuzumab deruxtecan (HR 0.65; 95% CI 0.50–0.84) showed significant benefit. Trastuzumab emtansine (Kadcyla®; Roche/Genentech) showed a non-significant trend (HR 0.77; 95% CI 0.56–1.06), and datopotamab deruxtecan showed no OS signal (HR 1.01; 95% CI 0.69–1.49). The authors reported the lowest rates of grade ≥3 adverse events and interstitial lung disease (ILD) with datopotamab deruxtecan, the highest rate of grade ≥3 neutropenia with sacituzumab govitecan, and the highest rate of grade ≥3 peripheral neuropathy with datopotamab deruxtecan. ILD occurred in 13.2% of patients with trastuzumab deruxtecan and 3.9% with datopotamab deruxtecan.

A complementary observational sub-analysis examined sequencing. Switching payload class was associated with a 41% objective response rate, compared with 9% for re-

challenge with an ADC carrying the same payload, and a median PFS2 advantage of more than four months. Consecutive TROP2-directed ADCs showed limited benefit. Because these sequencing figures come from observational data rather than the randomized network, they carry less weight than the efficacy estimates.

One detail gives this finding its practical weight. All three ADCs in the DePAS cohort carry topoisomerase I payloads: 7-ethyl-10-hydroxycamptothecin (SN-38) in sacituzumab govitecan, and the exatecan derivative deruxtecan (DXd) in trastuzumab deruxtecan and datopotamab deruxtecan. In current breast cancer practice, a true change of payload class is therefore rarely available (Table 2.0).

Independent evidence points the same way. A systematic review of ADC sequencing in metastatic breast cancer found that, in HER2-low disease, median PFS fell from roughly five to eight months on the first ADC to two to three months on the next, and that switching payload classes preserved more activity than repeating one[8].

Table 2.0. ADCs discussed in this article

ADC (brand; developer)	Target	Payload (class)	Status
Sacituzumab govitecan (Trodelvy®; Gilead Sciences)	TROP2	SN-38 (topoisomerase I inhibitor)	Approved
Trastuzumab deruxtecan (Enhertu®; Daiichi Sankyo/AstraZeneca)	HER2	Deruxtecan, DXd (topoisomerase I inhibitor)	Approved
Datopotamab deruxtecan (Datroway®; Daiichi Sankyo/AstraZeneca)	TROP2	Deruxtecan, DXd (topoisomerase I inhibitor)	Approved
Enfortumab vedotin (Padcev®; Astellas/Pfizer)	Nectin-4	MMAE (microtubule inhibitor)	Approved
Sacituzumab tirumotecan (sac-TMT; Kelun-Biotech/MSD)	TROP2	Topoisomerase I inhibitor	Investigational in trials discussed
Tusamitamab ravtansine (Sanofi)	CEACAM5	DM4 (maytansinoid, microtubule inhibitor)	Investigational
Izalontamab brengitecan (SystImmune/Bristol Myers Squibb)	EGFR × HER3	Topoisomerase I inhibitor	Investigational
KH815 (Chengdu Kanghong)	TROP2	Topoisomerase I inhibitor + RNA polymerase II inhibitor (dual payload)	First-in-human

Sources: ESMO 2026 abstracts [5,7,11,13–15,17–19]; Jukes et al. [4]; Honda and Zhu [10]. An openly accessible overview of approved and investigational conjugates is available in the ADC Review Drug Map [22].

At the 17th World ADC San Diego, CA, held October 12–15, 2026, LIDE Biotech reported that in its payload-resistant models, resistance followed the payload's mechanism largely independent of the target antigen[9]. Resistance is also rarely a single event: in patients progressing on sacituzumab govitecan, separate tumor sites had acquired changes in both the target antigen and the payload's molecular target[10].

These observations are consistent, but network meta-analysis does not replace a direct randomized comparison. Differences in populations, treatment lines, comparators, and follow-up affect indirect estimates, and the reported PFS heterogeneity limits any ranking. The findings are best read as a strong signal that payload history matters, not as a validated sequence.

Treatment after CDK4/6 inhibitor therapy, and the question of access

The REALNESS study (1908eP; NCT06676436) followed 171 patients with HR-positive/HER2-negative metastatic breast cancer after first-line CDK4/6 inhibitor treatment in Brazilian private clinics[11]. Single-agent chemotherapy was the most common second-line approach, followed by fulvestrant and, in selected cases, continued CDK4/6 inhibition. Attrition rose with each line: 14.6% of patients did not proceed beyond first-line treatment, 25.3% beyond second-line treatment, and 35.8% beyond third-line treatment.

Median time to next treatment was 17.94 months, median time to chemotherapy 29.7 months, and median real-world OS 44.88 months. Genetic testing was reported in only 24.7% of patients. ADC use was limited: trastuzumab deruxtecan in 10% of third-line treatment and sacituzumab govitecan in 0.7%.

The results reflect one healthcare setting and should not be generalized. They do show that access to testing and to later-line therapy is part of the treatment pathway. ADCs are among the most complex and costly biologics to manufacture, and their real-world

benefit will depend partly on whether patients outside well-resourced health systems can receive them[6].

LUNG CANCER: FUNCTIONAL TESTING MAY COMPLEMENT BIOMARKER ASSESSMENT

Most ADCs reached the clinic without a validated predictive biomarker, which is unusual for a class described as targeted therapy[12]. Pistilli and colleagues argue that ADC activity depends not only on how much target a tumor displays but also on tumor-cell and microenvironment features, making ADCs therapies aimed at the tumor ecosystem rather than a single receptor[12]. Two ESMO 2026 abstracts test whether measuring drug sensitivity directly can fill that gap.

Patient-derived organoids in STK11/KRAS-mutated lung adenocarcinoma

Abstract 4540eP, presented by Zheng Zhao, PhD, examined sacituzumab tirumotecan (sac-TMT; Kelun-Biotech/MSD), a TROP2-directed ADC with a topoisomerase I payload, in patient-derived organoids (PDOs) from a surgically resected lung adenocarcinoma[13]. The tumor carried *KRAS* G13C and *STK11* G242V alterations, a programmed death-ligand 1 (PD-L1) tumor proportion score of 15%, and strong, diffuse TROP2 expression by immunohistochemistry.

Sacituzumab tirumotecan was active in the organoid model, with a reported IC50 of 7.304 nM. Investigators also tested it with activated autologous T cells and pembrolizumab (Keytruda®; Merck & Co.). Pembrolizumab alone produced modest cytotoxicity, while sacituzumab tirumotecan was the predominant effector.

The limitations are substantial. The organoids came from a single patient, and the study does not establish clinical efficacy in *STK11/KRAS* co-mutated non-small cell lung cancer (NSCLC). It also does not show that TROP2 expression alone predicts response. Functional profiling across a 15-patient PDO series is ongoing.

Ex vivo drug testing in malignant pleural effusions

A separate NSCLC study (2775eP) tested 52 guideline-based therapies or combinations and eight investigational ADCs in malignant pleural effusion samples from five patients with metastatic disease[14]. Genomic findings alone did not fully capture the observed responses, and *ex vivo* responses were consistent with aspects of patients' prior treatment histories. Tumors with *EGFR* exon 19 deletions showed broad sensitivity to tyrosine kinase inhibitors, while tumors with exon 20 insertions showed more selective sensitivity.

Among the ADCs, sacituzumab govitecan and tusamitamab ravtansine (Sanofi), a CEACAM5-directed conjugate carrying the maytansinoid DM4, repeatedly reduced tumor-cell numbers. Antibody-only controls were inactive. The sample was small, and *ex vivo* activity does not necessarily translate into clinical benefit. The study does not establish a validated assay, a response threshold, or a selection algorithm.

Other candidate predictors beyond antigen level

Functional assays are not the only route under study. At World ADC San Diego, Eisai combined genomic and real-world data from patients with metastatic breast cancer treated with trastuzumab deruxtecan and identified *PIK3CA* as a candidate predictor of response in HER2-low disease[9]. Like the organoid and *ex vivo* work, this is hypothesis-generating. For patients, the near-term implication is that a positive antigen test indicates eligibility, not certainty of benefit.

UROTHELIAL CARCINOMA: SEQUENCING AFTER ENFORTUMAB VEDOTIN AND PEMBROLIZUMAB

The real-world study 4826eP used U.S. ConcertAI data to examine treatment after enfortumab vedotin (Padcev®; Astellas/Pfizer), a Nectin-4-directed ADC carrying monomethyl auristatin E (MMAE), plus pembrolizumab in metastatic urothelial carcinoma[15]. Of 248 patients, 69.4% had received the combination first-line, 17.7% second-line, and 12.9% third-line or later. Only 59 patients (23.8%) received subsequent systemic therapy. Platinum-based chemotherapy was the most common regimen, followed by sacituzumab govitecan and erdafitinib (Balversa®; Janssen). Median OS after enfortumab vedotin plus pembrolizumab was 15.5 months.

Observed survival differed between patients who received subsequent treatment

and those who did not. That comparison is subject to selection effects: patients well enough for further therapy differ in disease status and performance status from those who are not. The data do not show that subsequent therapy caused the difference, but they illustrate how few patients reach another systemic regimen after progression.

When the antigen is still there but the drug does not get in

Recent laboratory work offers one reason later-line options may disappoint. In urothelial carcinoma models resistant to enfortumab vedotin, Wang and colleagues identified a resistant population that kept high Nectin-4 on its surface yet failed to internalize the conjugate[16]. Altered membrane trafficking blocked uptake and exported the drug in extracellular vesicles.

This "endocytic evasion" has direct consequences for sequencing. A biopsy showing abundant antigen does not guarantee a second ADC against the same target will reach inside the cell. It reinforces the theme of the breast cancer data: the history of prior ADC exposure may predict activity better than antigen level alone.

SMALL-CELL LUNG CANCER: TREATMENT ATTRITION AND WHERE ADCS FIT

A real-world study of extensive-stage small-cell lung cancer (ES-SCLC; 3875eP) examined treatment after first-line platinum–etoposide plus atezolizumab (Tecentriq®; Roche/Genentech) or durvalumab (Imfinzi®; AstraZeneca)[17]. Of 285 patients, 52.6% received only first-line therapy, and 47.4% received at least second-line therapy. Only 12.6% received third-line or later therapy, and 1.8% fourth-line or later.

Platinum–etoposide rechallenge and topotecan were among the most common second-line approaches. Time to next treatment shortened with each line. Patients with an Eastern Cooperative Oncology Group (ECOG) performance status of 2 or greater were less likely to receive subsequent therapy (odds ratio 0.28).

This is not an ADC study, but it defines the setting ADCs are entering. Izalontamab brengitecan (iza-bren, BL-B01D1; SystImmune with Bristol Myers Squibb), a bispecific ADC that binds EGFR and HER3 and carries a topoisomerase I payload, has produced a 48.1% response rate in ES-SCLC[4]. Such activity matters only if patients are well enough to receive it. When roughly half of patients never reach second-line treatment, and declining performance status sharply reduces the chance of further therapy, the case for testing promising ADCs earlier in the disease course becomes stronger.

MOVING ADCS INTO EARLIER LINES OF TREATMENT

The ESMO 2026 program includes ongoing trials evaluating ADCs in settings where patients may receive longer therapy or after initial treatment has already controlled the disease.

- TroFuse-022/ENGOT-ov84/GOG-3103 (1443eTiP; NCT06824467) is evaluating maintenance sacituzumab tirumotecan (sac-TMT), with or without bevacizumab (Avastin®; Genentech/Roche), against standard of care after second-line platinum-based doublet chemotherapy in platinum-sensitive recurrent ovarian cancer[18].
- TroFuse-036/GOG-3123/ENGOT-cx22 (1444eTiP; NCT07216703) is evaluating sacituzumab tirumotecan plus pembrolizumab, with or without bevacizumab, as first-line maintenance for PD-L1-positive cervical cancer after induction therapy[19].

Both abstracts describe trial designs, not results. Their primary endpoint is PFS, with OS and safety among the secondary measures.

The first phase 3 efficacy data for sacituzumab tirumotecan in a gynecologic cancer came from a different setting. In TroFuse-005/ENGOT-en23/GOG-3095 (LBA11; NCT06132958), presented as part of the Presidential Symposium at ESMO 2026 and published simultaneously in *The Lancet*, 776 patients with advanced or recurrent endometrial cancer previously treated with platinum-based chemotherapy and anti-PD-1/PD-L1 therapy were randomized to sacituzumab tirumotecan or physician's-choice chemotherapy (doxorubicin or paclitaxel)[20]. Sacituzumab tirumotecan extended median overall survival from 12.1 to 19.0 months, reduced the risk of death by 32%, and increased median PFS from 3.9 to 7.2 months,

reducing the risk of progression or death by 41%. Objective responses occurred in 35.1% of patients versus 17.3% with chemotherapy. The FDA has accepted the application for priority review, with a decision expected by June 2027.

These results establish sacituzumab tirumotecan's activity in previously treated disease, but they do not show that the drug works as maintenance. Maintenance poses a different question from treating rapidly progressing disease. Patients may already have responded to chemotherapy, and the ADC may be given for an extended period. Benefit must be weighed against cumulative toxicity, quality of life, treatment duration, and the possibility of delaying later therapy.

That trade-off was a recurring theme at the 17th World ADC San Diego earlier in October[9]. Rita Nanda, MD, of the University of Chicago reviewed I-SPY2 data on trastuzumab deruxtecan and datopotamab deruxtecan in the neoadjuvant setting, with particular attention to monitoring for interstitial lung disease. A patient with early-stage cancer may live for decades after treatment, so lasting lung injury weighs differently than it does in last-line disease. Daiichi Sankyo traced trastuzumab deruxtecan's path from late-line therapy to first-line combination approval in HER2-positive metastatic breast cancer. Natera described how molecular residual disease measured in circulating tumor DNA (ctDNA) could provide earlier readouts than survival endpoints that take years to mature.

Until outcomes are reported for TroFuse-022, TroFuse-036, and the endometrial maintenance trial TroFuse-033 (NCT06952504), sacituzumab tirumotecan maintenance cannot be said to improve outcomes. Earlier readouts such as ctDNA may shorten the wait, but they will need to be validated against the endpoints that matter to patients.

AFTER TOPOISOMERASE I: DUAL PAYLOADS AND NEW MECHANISMS

If payload class drives cross-resistance, the field needs agents that do not share the topoisomerase I mechanism. Most of the work described in this section was presented not at ESMO but at the 17th World ADC conference in San Diego, CA. No efficacy data are yet available for any of these approaches, all of which remain in early-stage development.

Dual-payload ADCs carry two drugs with different mechanisms on one antibody, delivered at a fixed ratio to the same cells[10]. The first to enter human testing was KH815 (Chengdu Kanghong), a TROP2-directed conjugate carrying a topoisomerase I inhibitor and an RNA polymerase II inhibitor[10]. CLIO-8221 (Callio Therapeutics) pairs a topoisomerase I inhibitor with an ATR inhibitor, designed to block the DNA damage response tumors use to survive the first payload. Its Phase 1/2 study (NCT07300943) began dosing in March 2026 and enrolls patients previously treated with trastuzumab deruxtecan[21]. Sutro Biopharma presented preclinical data for STRO-227, its dual-payload conjugate, in resistance models[22], and CanWell Pharma described the path to first-in-human testing of CAN016 for HER2-refractory disease[9].

The limits are clear. A second payload cannot help if the tumor has lost the antigen, stopped internalizing the antibody, or no longer processes it in the lysosome, because both drugs then fail together. The ratio of the two payloads is fixed at manufacture and cannot be tailored to the individual patient[10]. Whether co-delivery outperforms giving two drugs separately is a question only clinical trials can answer.

The opening panel at the 17th World ADC San Diego focused on payloads beyond topoisomerase I, where leaders from Amgen, Daiichi Sankyo, Iksuda, Pfizer, and Regeneron asked whether the field is innovating enough beyond the dominant payload class[9]. Preclinical candidates included degrader (PROTAC) payloads, protein-translation inhibitors, and protein-alkylating agents[9]. For patients whose tumors have progressed after one or more topoisomerase I ADCs, these agents could eventually enable a genuine payload-class change.

WHAT THE FINDINGS MEAN FOR PATIENTS

The ESMO 2026 abstracts offer four patient-relevant observations:

- **ADC selection is becoming more individualized, but the supporting evidence**

varies. Real-world studies describe how clinicians choose; they do not prove those choices are optimal.

- **Treatment sequence matters.** Patients with metastatic disease may receive several systemic therapies, and a later ADC's activity may depend on earlier exposure, payload class, and resistance biology. Prospective trials are now built to answer exactly this. TRADE-DXd (NCT06533826) gives patients one ADC and, at progression, mandates crossover to an ADC against a different antigen, tracking HER2 and TROP2 expression along the way. The National Cancer Institute's ADC MATCH (NCT06311214) assigns ADCs based on RNA and protein testing, and tracks changes in antigen expression and the tumor microenvironment during treatment[6].
- **Availability is not the same as deliverability.** Performance status, prior toxicities, disease burden, and access to care all determine whether a patient can receive the next therapy. In the urothelial and small-cell lung cancer cohorts, most patients never did.
- **New tests may refine selection, but they are not ready for routine use.** Organoid models and *ex vivo* sensitivity assays are promising; the current abstracts do not establish them as validated clinical tools.

Patients themselves have put the point most plainly. At the 17th World ADC San Diego, Kelly Shanahan, MD, president of the metastatic breast cancer organization METAvivor, told an audience of chemists and drug developers that extra time without health-related quality of life (hrQoL) is not a victory, and that trials designed with patient input are better trials[9]. Tolerability is part of efficacy.

DISCUSSION

ESMO 2026 shows ADC development moving beyond whether a construct can shrink tumors. The clinical challenge now is identifying which patients are most likely to benefit, when to use an ADC, and whether earlier treatment can preserve its activity.

The evidence assembled here points in one direction. Real-world cohorts show clinicians already weighing biology, prior treatment, and disease distribution. Comparative and resistance data suggest that payload history, not just antigen status, shapes what a subsequent ADC can achieve, and the dominance of topoisomerase I payloads limits the options for switching. Attrition data show that many patients never reach the next line.

These findings do not yet provide a universal sequencing strategy. Trials such as TRADE-DXd and ADC MATCH aim to provide one, and dual-payload and non-topoisomerase I ADCs may broaden the options after progression. For patients, the central question is not simply which ADC is available, but which treatment offers the most meaningful prospect of disease control at that point in the treatment journey, at a toxicity burden they can live with.

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