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Review

Emerging Trends in Breast Cancer Research: Molecular Mechanisms, Therapeutics, and Clinical Applications

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Abstract

Breast cancer remains the most frequently diagnosed malignancy among women worldwide and a leading cause of cancer-related mortality. The past two decades have witnessed profound advances in understanding its molecular underpinnings, heterogeneity, and therapeutic vulnerabilities. The traditional classification of breast cancer into hormone receptor–positive, HER2-positive, and triple-negative subtypes has expanded into a continuum of molecularly defined entities based on genomic, transcriptomic, and proteomic signatures. Recent discoveries have highlighted the significance of DNA damage repair pathways, immune evasion mechanisms, cancer stem cell niches, and tumor microenvironmental influences in driving disease progression and therapeutic resistance. Parallelly, novel therapeutic strategies, including cyclin-dependent kinase 4/6 (CDK4/6) inhibitors, antibody drug conjugates (ADCs), immune checkpoint inhibitors, PARP inhibitors, and targeted nanomedicine, are transforming clinical outcomes. This review comprehensively explores the molecular mechanisms shaping breast cancer biology, recent advances in therapeutic modalities, and translational applications in clinical practice. Emphasis is placed on bridging preclinical discoveries with patient-centered interventions, evaluating the current limitations of standard therapies, and outlining future perspectives in precision oncology for breast cancer.

Keywords: Breast cancer; Molecular mechanisms; Targeted therapeutics; Tumor microenvironment; Clinical applications.

1. INTRODUCTION

Breast cancer represents a paradigmatic model of tumor heterogeneity and therapeutic innovation. Despite global advances in screening, early diagnosis, and treatment, it remains a formidable public health challenge, accounting for nearly 2.3 million new cases and 685,000 deaths in 2020 according to the GLOBOCAN database [1]. The disease arises through a complex interplay of genetic mutations, epigenetic alterations, hormonal influences, and microenvironmental signals, culminating in uncontrolled proliferation and metastatic spread. The clinical heterogeneity of breast cancer is reflected in its varied molecular subtypes, distinct prognostic outcomes, and differential therapeutic responses [2]. Traditional management with surgery, radiotherapy, and systemic chemotherapy has progressively evolved toward targeted and immune-based therapies, guided by advances in molecular oncology.

Contemporary research highlights the crucial role of molecular biomarkers, such as BRCA1/2 mutations, PI3K/AKT/mTOR pathway activation, and PD-L1 expression, in dictating therapeutic strategies and clinical outcomes [3]. Furthermore, the advent of high-throughput sequencing, single-cell omics, and integrative bioinformatics has deepened our understanding of intratumoral heterogeneity and clonal evolution, leading to the emergence of precision oncology paradigms [4]. This manuscript aims to review the latest molecular insights, therapeutic breakthroughs, and clinical applications in breast cancer research, while critically analyzing challenges and future opportunities for improving patient care.

Global Epidemiology and Disease Burden

The epidemiological burden of breast cancer underscores the pressing need for novel therapeutic approaches and preventive strategies. Breast cancer incidence has risen globally, with significant disparities in outcomes between high-income and low-to-middle-income countries (LMICs). In developed nations, early detection and access to systemic therapies have led to improved survival rates, with five-year relative survival exceeding 85% in North America and parts of Europe [5]. However, in LMICs, late-stage diagnosis, limited access to advanced therapies, and sociocultural barriers contribute to poorer prognoses, with survival rates as low as 40% in some regions [6].

Risk factors include genetic predispositions, such as BRCA mutations, reproductive factors like early menarche and late menopause, lifestyle influences including obesity, alcohol intake, and physical inactivity, as well as environmental exposures [7]. Recent studies emphasize the role of hormonal exposure, endocrine disruptors, and epigenetic alterations in shaping individual risk [8]. Furthermore, disparities in screening practices, mammographic coverage, and healthcare infrastructure significantly influence survival outcomes. The evolving landscape of global breast cancer epidemiology reflects not only the biological complexity of the disease but also the socioeconomic determinants of health. Addressing these disparities requires integrating molecular advances with public health initiatives to ensure equitable access to diagnostics and therapeutics.

Table 1: Comparative Overview of Major Therapeutic Strategies in Breast Cancer

Therapeutic Class	Representative Agents	Target/Mechanism	Clinical Advantages	Limitations
Endocrine Therapy	Tamoxifen, Fulvestrant, Aromatase inhibitors	Blocks ER signaling or estrogen synthesis	Reduces recurrence, long-term survival in HR+ disease	ESR1 mutations, PI3K/AKT-driven resistance
HER2-Targeted Therapy	Trastuzumab, Pertuzumab, Neratinib, T-DXd	HER2 receptor blockade or ADC-mediated cytotoxicity	Dramatic survival improvements in HER2+ and HER2-low cancers	Resistance, cardiac toxicity, cost
CDK4/6 Inhibitors	Palbociclib, Ribociclib, Abemaciclib	Inhibits CDK4/6-Rb axis, halts G1–S transition	Extends survival in HR+/HER2– cancers	Resistance via Rb loss, neutropenia, cost
PARP Inhibitors	Olaparib, Talazoparib	Blocks DNA repair in BRCA/HRD tumors	Effective in BRCA-mutant and HRD tumors	Resistance via HR restoration, hematologic toxicity
Immunotherapy	Pembrolizumab, Atezolizumab	PD-1/PD-L1 blockade restoring immune response	Durable responses in TNBC subsets	Limited responders, immune toxicity
ADCs & Nanomedicine	T-DM1, Nanoparticle formulations	Targeted drug delivery with reduced systemic toxicity	Expands options beyond classic HER2+ tumors	High cost, long-term safety under evaluation

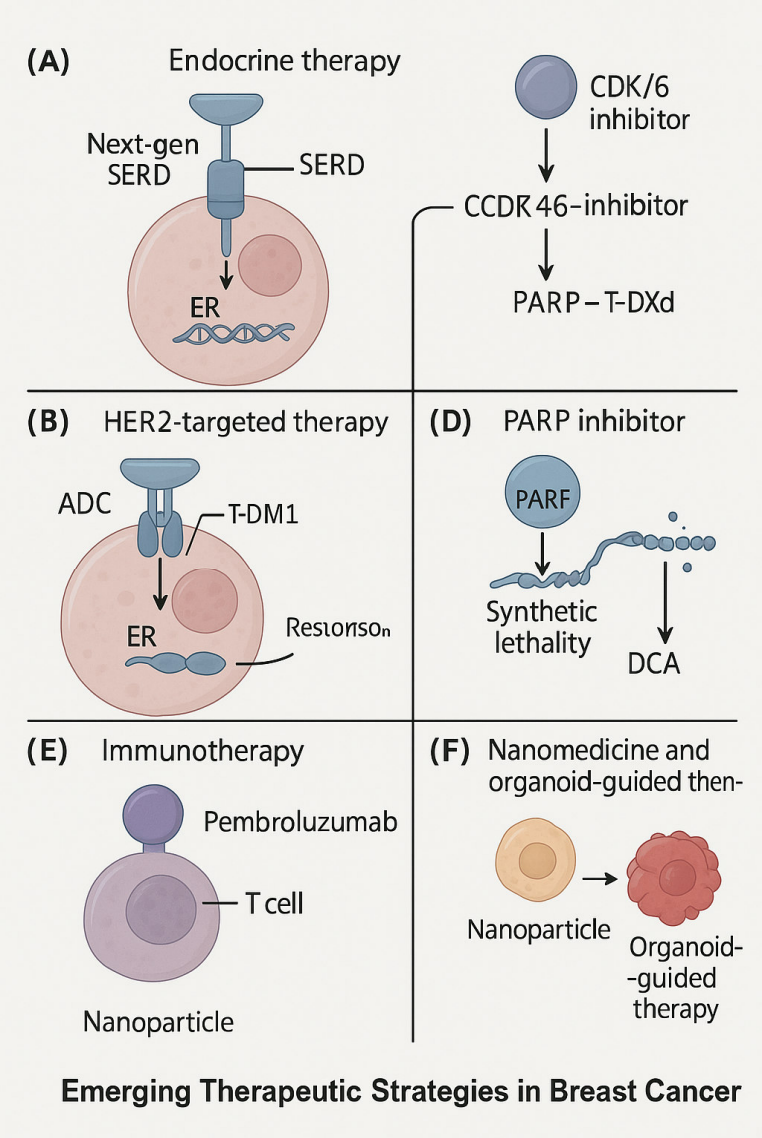

Fig 1: Emerging Therapeutic Strategies in Breast Cancer

Description

A multi-panel schematic integrating new treatment modalities:
(A) Endocrine therapy innovations with next-generation SERDs.
(B) HER2-targeted therapy evolution from trastuzumab to ADCs (T-DM1, T-DXd).
(C) CDK4/6 inhibitors restoring cell-cycle control.
(D) PARP inhibitors inducing synthetic lethality in BRCA-mutated cancers.
(E) Immunotherapy with PD-1/PD-L1 inhibitors enhancing T-cell activity.
(F) Nanomedicine and organoid-guided personalized therapy for precision oncology.

Molecular Classification of Breast Cancer

The molecular classification of breast cancer represents a cornerstone in precision oncology. Beyond the traditional histopathological classification, intrinsic molecular subtypes defined through gene expression profiling namely luminal A, luminal B, HER2-enriched, and basal-like have revolutionized clinical decision-making [9]. Luminal A tumors, characterized by estrogen receptor (ER) positivity, low proliferation indices, and favorable prognosis, contrast sharply with basal-like or triple-negative breast cancers (TNBC), which exhibit aggressive behavior, higher recurrence risk, and limited therapeutic options [10]. HER2-enriched subtypes,

initially associated with poor prognosis, have seen remarkable outcome improvements following the advent of HER2-targeted agents such as trastuzumab and pertuzumab [11].

Recent advances in single-cell sequencing and spatial transcriptomics have revealed further layers of heterogeneity within these broad categories. Subclonal populations within a tumor often exhibit distinct molecular profiles, contributing to drug resistance and metastatic dissemination [12]. Moreover, the recognition of unique subgroups, such as claudin-low breast cancers and HER2-low tumors, has expanded therapeutic possibilities with antibody–drug conjugates [13]. Molecular stratification now not only guides therapy selection but also informs prognosis, surveillance strategies, and trial eligibility. As molecular diagnostics continue to evolve, integrating genomic, proteomic, and metabolomic signatures promises to refine patient-specific treatment paradigms and advance personalized care.

Genomic and Epigenetic Alterations

The pathogenesis and progression of breast cancer are tightly linked to genomic instability and epigenetic modifications. Germline mutations in BRCA1 and BRCA2 genes represent the most recognized hereditary risk factors, predisposing carriers to higher lifetime risks of breast and ovarian cancer [14]. Somatic mutations in TP53, PIK3CA, GATA3, and ESR1 further contribute to tumorigenesis and therapeutic resistance [15]. Notably, TP53 mutations are prevalent in basal-like/TNBC subtypes and are associated with poor prognosis, while ESR1 mutations often emerge under endocrine therapy pressure, leading to acquired resistance [16].

Epigenetic alterations, including DNA methylation, histone modifications, and noncoding RNA dysregulation, play pivotal roles in gene expression reprogramming and tumor plasticity [17]. Aberrant promoter methylation of tumor suppressor genes, such as RASSF1A and CDH1, has been implicated in early breast cancer development [18]. MicroRNAs (miRNAs) and long noncoding RNAs (lncRNAs) have emerged as regulators of oncogenic pathways, influencing proliferation, invasion, and metastasis [19]. Recent research highlights the reversible nature of epigenetic modifications, positioning them as promising therapeutic targets. Epigenetic drugs, such as histone deacetylase inhibitors and DNA methyltransferase inhibitors, are under investigation in combination with standard therapies to overcome resistance [20]. The integration of genomic and epigenomic profiling into routine clinical practice offers the potential for early detection, therapeutic stratification, and monitoring of minimal residual disease, thereby transforming breast cancer management.

Tumor Microenvironment in Breast Cancer Progression

The tumor microenvironment (TME) in breast cancer is increasingly recognized as a dynamic and integral determinant of disease initiation, progression, and therapeutic resistance. Comprising cancer-associated fibroblasts (CAFs), immune cells, endothelial cells, adipocytes, and extracellular matrix (ECM) components, the TME orchestrates a complex interplay of biochemical and mechanical signals that modulate tumor behavior [21]. CAFs, through secretion of cytokines, growth factors, and matrix metalloproteinases, contribute to epithelial–mesenchymal transition (EMT), angiogenesis, and invasive potential [22]. Similarly, tumor-associated macrophages (TAMs), often polarized toward an immunosuppressive M2 phenotype, facilitate immune evasion and metastatic dissemination by releasing interleukin-10 (IL-10), transforming growth factor-β (TGF-β), and vascular endothelial growth factor (VEGF) [23].

Hypoxia within the breast cancer TME further drives malignant progression by activating hypoxia-inducible factors (HIFs), which promote angiogenesis and metabolic reprogramming [24]. Moreover, the ECM undergoes extensive remodeling in breast cancer, with increased stiffness and altered collagen crosslinking enhancing tumor cell motility and mechanotransduction [25]. Adipocytes in the mammary microenvironment also contribute to tumorigenesis through adipokine secretion, lipid transfer, and modulation of metabolic pathways [26]. Importantly, the immunological dimension of the TME has become a therapeutic frontier, as immune checkpoint molecules such as PD-1, PD-L1, and CTLA-4 are upregulated within the breast tumor milieu, limiting effective anti-tumor immunity [27].

Emerging therapeutic strategies now target the TME directly, including inhibitors of stromal signaling, angiogenesis blockers, and immune checkpoint blockade. Nanoparticle-based drug delivery systems capable of selectively modulating the TME are under investigation for enhancing therapeutic efficacy [28]. Understanding the spatial and temporal dynamics of TME components, aided by technologies like spatial transcriptomics and single-cell proteomics, is critical for designing personalized interventions. Thus, the TME is no longer viewed as a passive bystander but as a therapeutic target central to the future of breast cancer management.

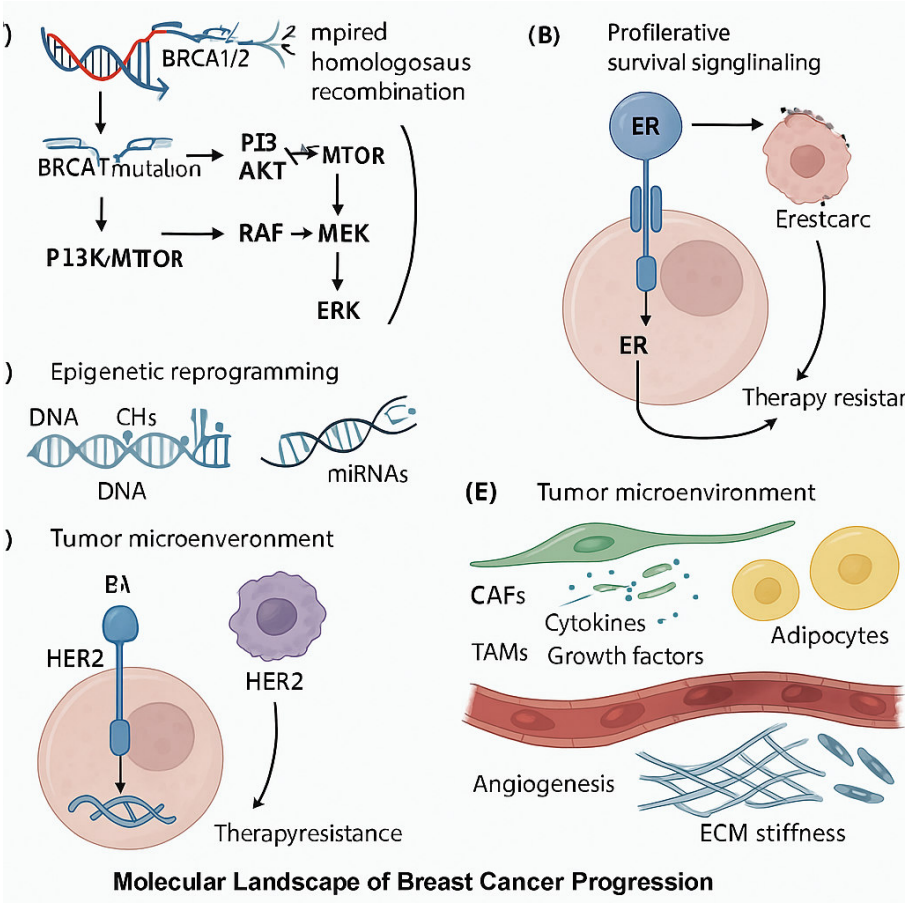

Fig 2: Molecular Landscape of Breast Cancer Progression

Description

A schematic diagram showing the interplay of genetic, epigenetic, and microenvironmental mechanisms:
(A) BRCA1/2 and TP53 mutations driving genomic instability.
(B) PI3K/AKT/mTOR and RAS/RAF/MEK/ERK signaling pathways promoting survival and proliferation.
(C) Crosstalk between estrogen receptor (ER) and HER2 signaling contributing to therapy resistance.
(D) Epigenetic reprogramming via DNA methylation and miRNAs modulating tumor progression.
(E) Tumor microenvironment components (CAFs, TAMs, adipocytes, ECM stiffness) fostering angiogenesis, immune evasion, and metastasis.

Dysregulated Signaling Pathways in Breast Cancer

Breast cancer pathogenesis is profoundly influenced by the dysregulation of key intracellular signaling pathways. The PI3K/AKT/mTOR pathway is among the most frequently altered, with mutations in PIK3CA driving aberrant cell growth, survival, and resistance to endocrine therapy [29]. The clinical relevance of this pathway is underscored by the recent approval of PI3K inhibitors, such as alpelisib, for advanced hormone receptor–positive, PIK3CA-mutated breast cancer [30]. Similarly, the RAS/RAF/MEK/ERK cascade, although less commonly mutated in breast cancer, plays a pivotal role in driving proliferative signals downstream of growth factor receptors, including HER2 [31].

The HER2 signaling axis remains a landmark pathway, with overexpression or amplification of ERBB2 conferring aggressive disease biology but also therapeutic vulnerability to HER2-targeted agents such as trastuzumab, pertuzumab, and T-DM1 [32]. Endocrine signaling through the estrogen receptor (ER) continues to define the majority of breast cancers, with dysregulation arising from ESR1 mutations, ligand-independent receptor activation, and crosstalk with growth factor pathways [33]. Resistance to endocrine therapy is often mediated by such crosstalk, necessitating combined therapeutic approaches.

Notably, aberrant activation of Wnt/β-catenin, Notch, and Hedgehog pathways has been implicated in sustaining cancer stem cell (CSC) populations and facilitating EMT [34]. These developmental signaling cascades contribute to metastatic competence, immune evasion, and resistance to conventional therapies.

Furthermore, the JAK/STAT pathway, activated by cytokines within the TME, enhances tumor growth and modulates immune suppression [35]. Therapies targeting these pathways, including JAK inhibitors and Notch antagonists, are undergoing preclinical and clinical evaluation. A deeper understanding of these interwoven networks underscores the need for combinatorial strategies, as targeting a single pathway often results in compensatory activation of alternative oncogenic circuits [36].

Breast Cancer Stem Cells and Therapeutic Resistance

The concept of cancer stem cells (CSCs) has transformed our understanding of breast cancer biology. CSCs are a subpopulation of tumor cells characterized by self-renewal capacity, multipotency, and resistance to conventional therapies, thereby contributing to disease relapse and metastasis [37]. In breast cancer, CSCs are frequently identified by surface markers such as CD44^high/CD24^low, aldehyde dehydrogenase (ALDH) activity, and epithelial plasticity phenotypes [38]. Functional assays, including mammosphere formation and in vivo tumorigenicity studies, have confirmed their role in sustaining tumor hierarchies and therapeutic resistance. Molecularly, CSC maintenance is regulated by signaling pathways such as Notch, Wnt, and Hedgehog, in addition to hypoxia-induced HIF signaling [39]. Epigenetic mechanisms, including histone modifications and miRNA-mediated regulation, further support CSC plasticity and adaptation under therapeutic pressure [40]. Importantly, breast CSCs exhibit heightened drug efflux activity mediated by ATP-binding cassette (ABC) transporters, enhanced DNA repair capacity, and resistance to apoptosis, which collectively undermine chemotherapy and radiotherapy efficacy [41].

Recent advances have demonstrated that CSCs interact closely with the TME, including niche-like interactions with CAFs, TAMs, and immune suppressive cells, which sustain their stemness and facilitate immune evasion [42]. Targeting CSCs therefore represents a promising strategy to prevent recurrence and improve long-term survival. Current investigational approaches include inhibitors of key signaling pathways, metabolic reprogramming agents, epigenetic modulators, and immunotherapies designed to eradicate CSC populations [43]. Furthermore, novel preclinical models, including patient-derived xenografts and organoids enriched for CSCs, are facilitating translational drug discovery efforts. As therapeutic resistance remains a primary barrier in breast cancer management, the integration of CSC-targeted strategies into multimodal regimens is a pivotal step toward achieving durable remission.

Future Directions and Challenges

The rapid evolution of breast cancer research is ushering in an era where precision, personalization, and prevention will likely dominate clinical paradigms. One of the most pressing future directions involves the integration of multi-omics platforms genomics, epigenomics, transcriptomics, proteomics, and metabolomics into clinical workflows. These tools promise to identify novel biomarkers, stratify patients beyond traditional classifications, and enable real-time tailoring of therapeutic regimens [44]. Technologies such as single-cell sequencing and spatial transcriptomics are expected to further unravel intratumoral heterogeneity and dynamic tumor–immune interactions, thereby illuminating mechanisms of therapeutic resistance [45]. The challenge, however, lies in translating such data-intensive platforms into accessible and affordable solutions, particularly given constraints in cost, infrastructure, and regulatory oversight.

Immunotherapy continues to represent a significant frontier, with immune checkpoint inhibitors offering modest but clinically meaningful outcomes in triple-negative breast cancer (TNBC). The future focus will be on refining predictive biomarkers, such as tumor mutational burden, neoantigen load, and immune infiltrate profiles, and on expanding next-generation modalities like bispecific antibodies, personalized cancer vaccines, and adoptive cell therapies [46,47]. However, immunotherapy-associated toxicities, limited response rates, and the complexity of manufacturing cellular products remain pressing challenges.

Antibody–drug conjugates (ADCs) are redefining HER2 targeting, with trastuzumab deruxtecan (T-DXd) extending clinical benefit into HER2-low populations. Combining ADCs with immune checkpoint inhibitors, PARP inhibitors, or other targeted agents may achieve synergistic responses but introduces concerns about cumulative toxicities and acquired resistance [48]. In parallel, nanomedicine and 3D-bioprinted organoid models are emerging as translational tools for enhancing drug delivery and enabling patient-specific therapeutic testing [49].

Addressing global disparities remains paramount. While patients in developed regions benefit from cutting-edge molecular diagnostics and therapies, those in low- and middle-income countries face barriers including late diagnosis, limited access to advanced therapeutics, and sociocultural determinants [50]. Strategies such as biosimilars, cost-effective screening, and equitable clinical trial enrollment are essential for bridging this gap.

Finally, the ethical and regulatory landscape must evolve alongside scientific progress. The deployment of CRISPR-Cas9 and other gene editing tools, as well as synthetic biology platforms, raises ethical questions regarding safety, long-term outcomes, and appropriate governance [51]. Artificial intelligence and machine learning will likely become integral to pathology, radiomics, and predictive analytics; however, ensuring

transparency, accountability, and equitable implementation is a future challenge [52]. Overall, converging molecular insights with technological innovations, while ensuring ethical and equitable integration, defines the trajectory of breast cancer research.

CONCLUSION

Breast cancer exemplifies the intersection of biological complexity and translational opportunity. Advances in molecular profiling, targeted therapeutics, and immuno-oncology have significantly improved patient outcomes, particularly in aggressive phenotypes such as HER2-positive and triple-negative disease. The recognition of genomic instability, epigenetic alterations, cancer stem cell hierarchies, and the tumor microenvironment's role in therapeutic resistance has broadened therapeutic strategies beyond conventional cytotoxic regimens.

Novel approaches, including CDK4/6 inhibitors, PARP inhibitors, HER2-directed antibody–drug conjugates, and immune checkpoint inhibitors, highlight the transition toward personalized and biology-driven treatment. Nevertheless, significant obstacles remain: resistance mechanisms, intratumoral heterogeneity, and inequitable access to advanced diagnostics and therapies.

The future of breast cancer management will be determined by the successful integration of multi-omics, digital health technologies, and innovative therapeutic modalities into accessible and patient-centered care. Ethical stewardship, global collaboration, and translational efficiency will be critical in ensuring that emerging scientific progress translates into durable clinical benefits. The trajectory of breast cancer research thus offers optimism for a future where precision strategies enable disease control, improved quality of life, and equitable outcomes for patients worldwide.

REFERENCES

1. Sung H, Ferlay J, Siegel RL, Laversanne M, Soerjomataram I, Jemal A, Bray F. Global cancer statistics 2020: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin. 2021;71(3):209–49.
2. Waks AG, Winer EP. Breast cancer treatment: a review. JAMA. 2019;321(3):288–300.
3. Yates LR, Knappskog S, Wedge D, Farmery JHR, Gonzalez S, Martincorena I, et al. Genomic evolution of breast cancer metastasis and relapse. Cancer Cell. 2017;32(2):169–84.
4. Curtis C, Shah SP, Chin SF, Turashvili G, Rueda OM, Dunning MJ, et al. The genomic and transcriptomic architecture of 2,000 breast tumours reveals novel subgroups. Nature. 2012;486(7403):346–52.
5. Allemani C, Matsuda T, Di Carlo V, Harewood R, Matz M, Niksic M, et al. Global surveillance of trends in cancer survival 2000–14 (CONCORD-3): analysis of individual records for 37 million patients. Lancet. 2018;391(10125):1023–75.
6. Cazap E, Anderson BO, Smith RA, Khuhaprema T, Soerjomataram I. Breast cancer in developing countries: opportunities for improved survival. Breast J. 2019;25(2):178–85.
7. Colditz GA, Bohlke K, Berkey CS. Breast cancer risk accumulation starts early: prevention must also. Breast Cancer Res Treat. 2014;145(3):567–79.
8. Brody JG, Rudel RA. Environmental pollutants and breast cancer. Environ Health Perspect. 2003;111(8):1007–19.
9. Perou CM, Sorlie T, Eisen MB, van de Rijn M, Jeffrey SS, Rees CA, et al. Molecular portraits of human breast tumours. Nature. 2000;406(6797):747–52.
10. Bianchini G, Balko JM, Mayer IA, Sanders ME, Gianni L. Triple-negative breast cancer: challenges and opportunities of a heterogeneous disease. Nat Rev Clin Oncol. 2016;13(11):674–90.
11. Swain SM, Baselga J, Kim SB, Ro J, Semiglazov V, Campone M, et al. Pertuzumab, trastuzumab, and docetaxel in HER2-positive metastatic breast cancer. N Engl J Med. 2015;372(8):724–34.
12. Kim C, Gao R, Sei E, Brandt R, Hartman J, Hatschek T, et al. Chemoresistance evolution in triple-negative breast cancer delineated by single-cell sequencing. Cell. 2018;173(4):879–93.
13. Tarantino P, Hamilton E, Tolaney SM, Cortes J, Morganti S, Ferraro E, et al. HER2-low breast cancer: pathological and clinical landscape. J Clin Oncol. 2020;38(17):1951–62.
14. Kuchenbaecker KB, Hopper JL, Barnes DR, Phillips KA, Mooij TM, Roos-Blom MJ, et al. Risks of breast, ovarian, and contralateral breast cancer for BRCA1 and BRCA2 mutation carriers. JAMA. 2017;317(23):2402–16.
15. Bailey MH, Tokheim C, Porta-Pardo E, Sengupta S, Bertrand D, Weerasinghe A, et al. Comprehensive characterization of cancer driver genes and mutations. Cell. 2018;173(2):371–85.
16. Jeselsohn R, Buchwalter G, De Angelis C, Brown M, Schiff R. ESR1 mutations. A mechanism for acquired endocrine resistance in breast cancer. Nat Rev Clin Oncol. 2015;12(10):573–83.

17. Sharma S, Kelly TK, Jones PA. Epigenetics in cancer. Carcinogenesis. 2010;31(1):27–36.
18. Widschwendter M, Siegmund KD, Müller HM, Fiegl H, Marth C, Müller-Holzner E, et al. Association of breast cancer DNA methylation profiles with hormone receptor status and response to tamoxifen. Cancer Res. 2004;64(11):3807–13.
19. Hayes EL, Lewis-Wambi JS. Mechanisms of endocrine resistance in breast cancer: an overview of the proposed roles of noncoding RNA. Breast Cancer Res. 2015;17(1):40.
20. Connolly R, Stearns V. Epigenetics as a therapeutic target in breast cancer. J Mammary Gland Biol Neoplasia. 2012;17(3–4):191–204.
21. Hanahan D, Coussens LM. Accessories to the crime: functions of cells recruited to the tumor microenvironment. Cancer Cell. 2012;21(3):309–22.
22. Kalluri R. The biology and function of fibroblasts in cancer. Nat Rev Cancer. 2016;16(9):582–98.
23. Cassetta L, Pollard JW. Targeting macrophages: therapeutic approaches in cancer. Nat Rev Drug Discov. 2018;17(12):887–904.
24. Rankin EB, Giaccia AJ. Hypoxic control of metastasis. Science. 2016;352(6282):175–80.
25. Pickup MW, Mouw JK, Weaver VM. The extracellular matrix modulates the hallmarks of cancer. EMBO Rep. 2014;15(12):1243–53.
26. Dirat B, Bochet L, Dabek M, Daviaud D, Dauvillier S, Majed B, et al. Cancer-associated adipocytes exhibit an activated phenotype and contribute to breast cancer invasion. Cancer Res. 2011;71(7):2455–65.
27. Emens LA. Breast cancer immunotherapy: facts and hopes. Clin Cancer Res. 2018;24(3):511–20.
28. Rosenblum D, Joshi N, Tao W, Karp JM, Peer D. Progress and challenges towards targeted delivery of cancer therapeutics. Nat Commun. 2018;9(1):1410.
29. Fruman DA, Chiu H, Hopkins BD, Bagrodia S, Cantley LC, Abraham RT. The PI3K pathway in human disease. Cell. 2017;170(4):605–35.
30. André F, Ciruelos E, Rubovszky G, Campone M, Loibl S, Rugo HS, et al. Alpelisib for PIK3CA-mutated, hormone receptor–positive advanced breast cancer. N Engl J Med. 2019;380(20):1929–40.
31. Samatar AA, Poulikakos PI. Targeting RAS–ERK signalling in cancer: promises and challenges. Nat Rev Drug Discov. 2014;13(12):928–42.
32. Baselga J, Swain SM. Novel anticancer targets: revisiting ERBB2 and discovering ERBB3. Nat Rev Cancer. 2009;9(7):463–75.
33. Osborne CK, Schiff R. Mechanisms of endocrine resistance in breast cancer. Annu Rev Med. 2011;62:233–47.
34. Takebe N, Miele L, Harris PJ, Jeong W, Bando H, Kahn M, et al. Targeting Notch, Hedgehog, and Wnt pathways in cancer stem cells: clinical update. Nat Rev Clin Oncol. 2015;12(8):445–64.
35. Yu H, Pardoll D, Jove R. STATs in cancer inflammation and immunity: a leading role for STAT3. Nat Rev Cancer. 2009;9(11):798–809.
36. Chandarlapaty S. Negative feedback and adaptive resistance to the targeted therapy of cancer. Cancer Discov. 2012;2(4):311–9.
37. Batlle E, Clevers H. Cancer stem cells revisited. Nat Med. 2017;23(10):1124–34.
38. Al-Hajj M, Wicha MS, Benito-Hernandez A, Morrison SJ, Clarke MF. Prospective identification of tumorigenic breast cancer cells. Proc Natl Acad Sci USA. 2003;100(7):3983–8.
39. Liu S, Dontu G, Mantle ID, Patel S, Ahn NS, Jackson KW, et al. Hedgehog signaling and Bmi-1 regulate self-renewal of normal and malignant human mammary stem cells. Cancer Res. 2006;66(12):6063–71.
40. Liu C, Kelnar K, Liu B, Chen X, Calhoun-Davis T, Li H, et al. The microRNA miR-34a inhibits breast cancer stem cells and metastasis by repressing Wnt/β-catenin signaling. Proc Natl Acad Sci USA. 2012;109(43):16970–5.
41. Dean M. ABC transporters, drug resistance, and cancer stem cells. J Mammary Gland Biol Neoplasia. 2009;14(1):3–9.
42. Pein M, Insua-Rodriguez J, Hongu T, Riedel A, Meier J, Wiedmann L, et al. Metastasis-initiating cells induce and exploit a fibroblast niche to fuel malignant colonization of the lungs. Nat Commun. 2020;11(1):1494.
43. Phi LTH, Sari IN, Yang YG, Lee SH, Jun N, Kim KS, et al. Cancer stem cells (CSCs) in drug resistance and their therapeutic implications in cancer treatment. Stem Cells Int. 2018;2018:5416923.
44. Hasin Y, Seldin M, Lusis A. Multi-omics approaches to disease. Genome Biol. 2017;18(1):83.
45. Nam AS, Chaligne R, Landau DA. Integrating genetic and non-genetic determinants of cancer evolution by single-cell multi-omics. Nat Rev Genet. 2021;22(1):3–18.
46. Emens LA, Adams S, Barrios CH, Dieras V, Iwata H, Loi S, et al. IMpassion130: efficacy of atezolizumab in combination with nab-paclitaxel in PD-L1–positive metastatic triple-negative breast cancer. J Clin Oncol. 2021;39(3):244–56.

47. Zhang J, Ji Z, Caushi JX, El Asmar M, Anagnostou V, Cottrell TR, et al. Personalized cancer vaccines: targeting the cancer mutanome. Nat Rev Cancer. 2022;22(9):554–71.
48. Cortes J, Kim SB, Chung WP, Im SA, Park YH, Hegg R, et al. Trastuzumab deruxtecan versus trastuzumab emtansine for breast cancer. N Engl J Med. 2022;387(1):9–20.
49. Rosenbluth JM, Schackmann RCJ, Gray GK, Selfors LM, Li CM, Boedicker C, et al. Organoid models for breast cancer therapeutics. Nat Rev Cancer. 2022;22(5):261–80.
50. Ilbawi AM, Gouda HN. Global burden of breast cancer: disparities in survival and access to care. Nat Rev Clin Oncol. 2021;18(6):341–8.
51. Doudna JA, Charpentier E. The new frontier of genome engineering with CRISPR-Cas9. Science. 2014;346(6213):1258096.
52. Topol EJ. High-performance medicine: the convergence of human and artificial intelligence. Nat Med. 2019;25(1):44–56.