Lung Cancer UPDATES
IASLC HIGHLIGHTS
08-14 SEPTIEMBRE 2021

Iniciativa científica de:
GECP lung cancer research

EARLY STAGE DISEASE

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IMPROVING LOCAL CONTROL IN NSCLC SURGERY

PRECONDITIONING WITH MOVE FOR SURGERY SHORTENS HOSPITAL STAY AFTER LUNG CANCER SURGERY

Data from orthopedic, cardiac, and abdominal surgery has shown that **preconditioning** **BEFORE** surgery can:

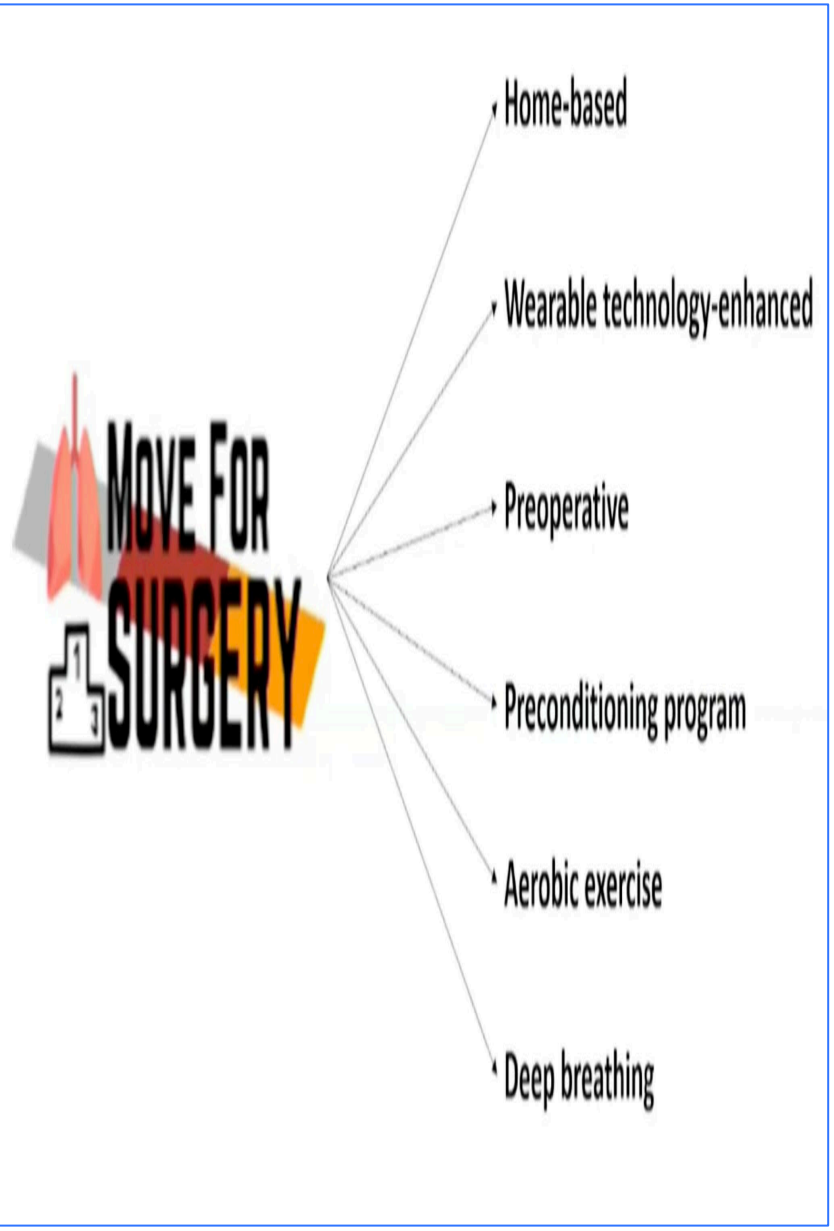
prevent
postoperative complications

shorten
LOS

improve
recovery

enhance
HRQOL[3]

Patel Y, OA04.01



Objectives

Primary:

- Determine if preconditioning with MFS will affect LOS in hospital after surgical lung resection

Secondary:

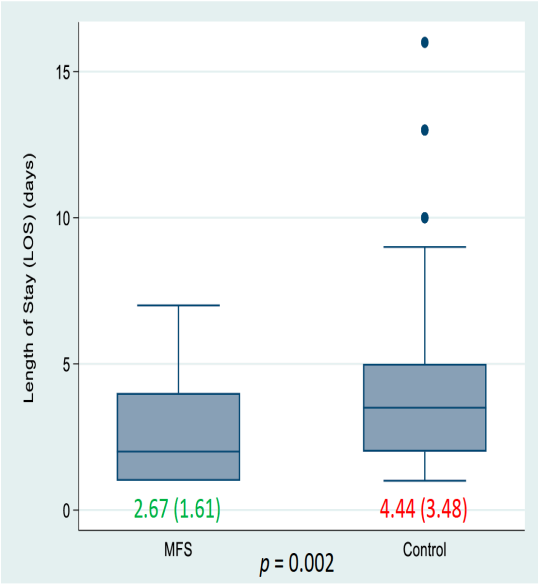
- Compare the differences in the complication rates
- Compare the differences in patient-reported HRQOL outcomes
  - Baseline
  - Day of Surgery
  - Postoperative Day 1 (POD1)
  - 3-Week Follow-Up
  - 12-Week Follow-Up

MFS Preconditioning Program (Intervention)		Usual Preoperative Care (Control)
Provided with a Fitbit, and MFS Booklet, and completed EQ-5D-5L	Baseline	Completed EQ-5D-5L
Baseline average daily step count calculated, and new daily step goal set by increasing baseline average daily step count by 10%	Next 3 Days	
Set new daily step goal each week by increasing previous weeks' daily step goal by the same 10% each week	~ 3-4 Weeks	
Returned Fitbit, and completed EQ-5D-5L	Day of Surgery	Completed EQ-5D-5L
Completed EQ-5D-5L at POD1, 3-Weeks, and 12-Weeks	Follow-Ups	Completed EQ-5D-5L at POD1, 3-Weeks, and 12-Weeks

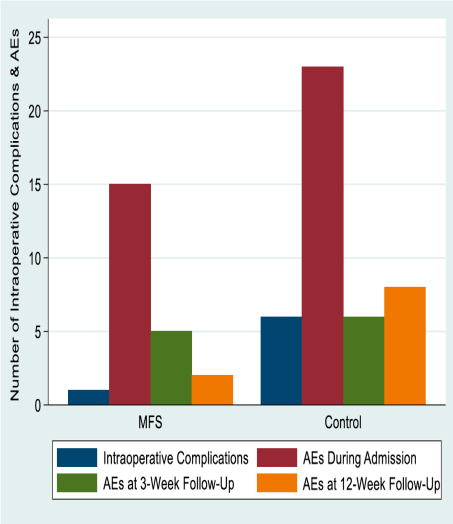
Randomization

Patel Y, OA04.01

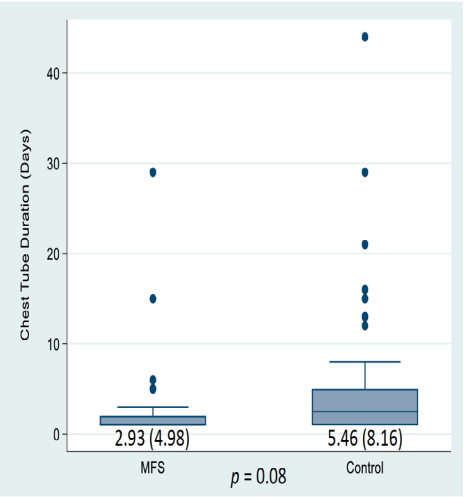
LOS for MFS and Control



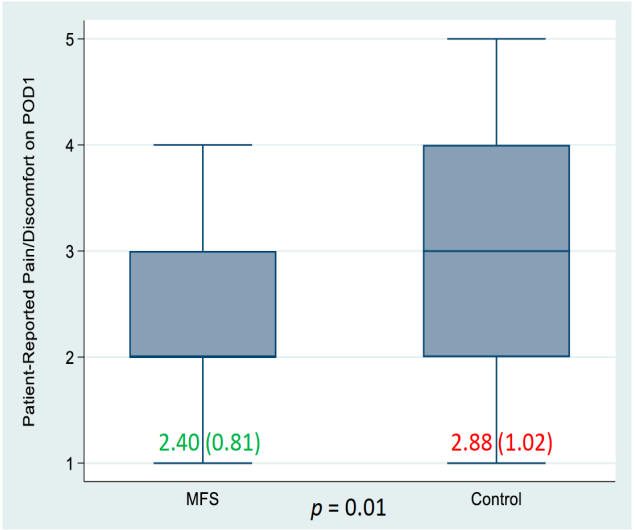
Intraoperative Complications & Adverse Events (AEs)



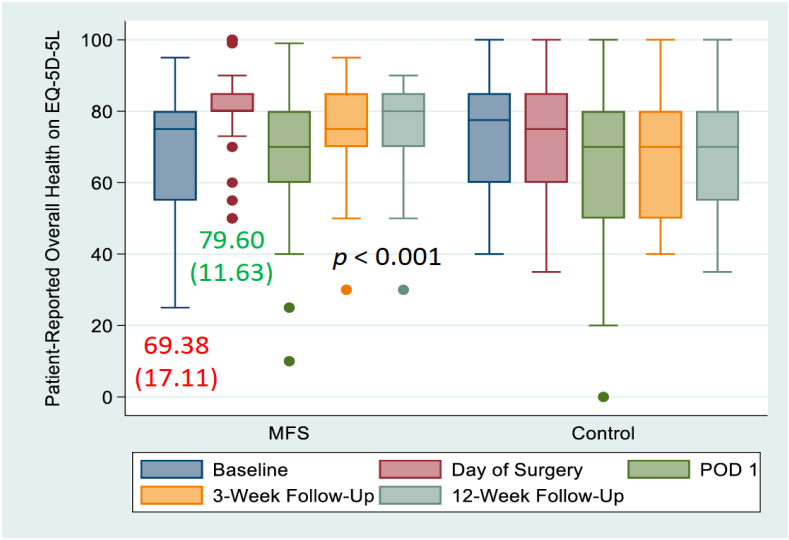
Chest Tube Duration



Patient-Reported Pain/Discomfort on POD1



Overall Health at Different Time Points



Patel Y, OA04.01

ONCOLOGIC OUTCOMES OF PATIENTS WITH RESECTED T3N0M0 NON-SMALL CELL LUNG CANCER

- Notable aspects of their study group:
  - >290 patients (!)
  - Majority received mediastinal staging with EBUS and/or mediastinoscopy (>80%)
  - Majority received lobectomy (>90%)
  - Majority did not go on for adjuvant chemotherapy (85%)

- From this group they analyzed patients by subtype of T3N0 disease:
  - Size >5cm but ≤7cm
  - Chest wall invasion
  - Satellite nodule ≤5cm
  - Parietal pleural invasion
  - Tumors with any combination of the above

Results

Table 1 : Patients, tumor and resection characteristics

Characteristics (n=293)	n (%)
Age	68 ± 8
Sex	
Male	152 (51.9%)
Female	141 (48.1%)
Imaging	
PET scan	231 (78.8%)
IMS	
EBUS/EUS	54 (18.4%)
Mediastinoscopy	155 (52.9%)
Both	37 (12.6%)
None	47 (16.0%)
Surgical resection type	
Lobectomy	268 (91.5%)
Sub lobar	13 (4.4%)
Pneumonectomy	12 (4.1%)
Histology	
Adenocarcinoma	164 (56.0%)
Squamous carcinoma	99 (33.8%)
Others	30 (10.2%)

Single T3 classifying features	n (%)
Size	157 (53.6%)
SN	81 (27.6%)
CWI	15 (5.1%)
PPI	13 (4.4%)
Multiple T3 classifying features	
Size and CWI	12 (4.1%)
Size and PPI	7 (2.4%)
Size and SN	7 (2.4%)
Size, PPI, and parietal pericardium invasion	1 (0.3%)
Completeness of resection	
R0	283 (96.6%)
R1-2	10 (3.4%)
R1-2 resection per T3 feature	
Size and CWI	5 (50 %)
CWI	2 (20 %)
PPI	1 (10 %)
Size and PPI	1 (10 %)
Size	1 (10 %)
Adjuvant Chemotherapy	
Yes	43 (14.7%)
No	250 (85.3%)

Marques E, et al. OA 11.03

Figure 1A: OS and DFS of whole cohort

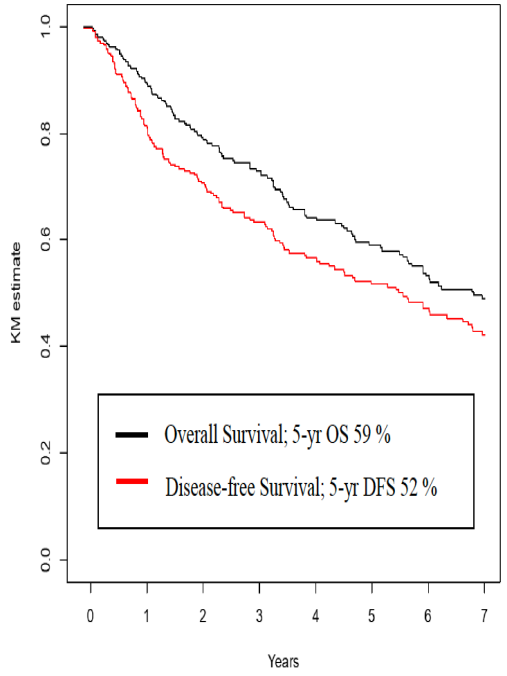
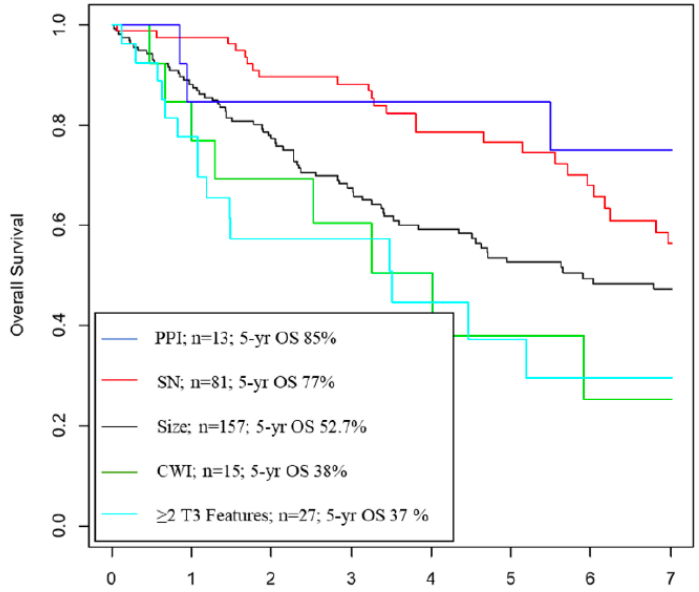


Table 2 : Multivariable analysis of OS and DFS

	OS		DFS	
Variable	HR (95% CI)	p value	HR (95% CI)	p value
Age > 65	1.7 (1.18, 2.46)	0.005	1.46 (1.03, 2.08)	0.033
Male	0.63 (0.44, 0.88)	0.007	0.64 (0.46, 0.89)	0.008
CWI	2.58 (1.41, 4.73)	0.002	3.28 (1.85, 5.79)	<0.001
PPI	1.04 (0.53, 2.02)	0.919	1.32 (0.7, 2.49)	0.387
SN	1.32 (0.74, 2.37)	0.353	1.48 (0.83, 2.66)	0.187
Tumor Size (per cm increase)	1.17 (1, 1.36)	0.048	1.23 (1.05, 1.43)	0.008
Incomplete resection	2.5 (1.09, 5.72)	0.031	2.1 (0.95, 4.64)	0.067
Adjuvant chemotherapy	0.8 (0.46, 1.37)	0.408	0.8 (0.48, 1.34)	0.398

Figure 1B, 1C, 1D :

1B : OS for all individual T3 features



- Male gender, age > 65, CWI, larger tumors and incomplete resection were identified as poorer oncologic factors to OS and DFS ($p < 0,05$). (Except a trend for DFS in R1/R2 resection, $p = 0,067$).
- Patients with CWI T3 feature have a high rate of incomplete resections and recurrences.
- Patients in the SN-PG tumors had a superior OS than patients in the CWI-PG or Size-PG in pair-wise comparisons ($p = 0,036$ and $p < 0,001$).
- Should chest wall invasion be an indication for adjuvant therapy?
- Does pT3 need to be further differentiated in future AJCC staging?

Marques E, et al. OA 11.03

ADJUVANT

WHO WILL BENEFIT FROM ADJUVANT CHEMOTHERAPY/IO

IO + chemotherapy clearly benefits SOME patients with resectable NSCLC.

Understanding who should receive IO in addition to chemo and when remains an unmet need.

IMpower010: Characterization of Stage IB-IIIA NSCLC Patients by Type and Extent of Therapy Prior to Adjuvant Atezolizumab

IMpower010 study design

Completely resected stage IB-IIIA NSCLC per UICC/AJCC v7

- Stage IB tumors ≥4 cm
- ECOG PS 0-1
- Lobectomy/pneumonectomy
- Tumor tissue for PD-L1 analysis

1-4 cycles cisplatin + pemetrexed, gemcitabine, docetaxel or vinorelbine

N=1280

R 1:1

No crossover

Atezolizumab *1200 mg q21d 16 cycles*

N=1005

BSC

Survival follow-up

Stratification factors

- Male vs female
- Stage (IB vs II vs IIIA)
- Histology
- PD-L1 tumor expression status[a]: TC2/3 and any IC vs TC0/1 and IC2/3 vs TC0/1 and IC0/1

Primary endpoints

- Investigator-assessed DFS tested hierarchically:
  1. PD-L1 TC ≥1% (SP263) stage II-IIIA population
  2. All-randomized stage II-IIIA population
  3. ITT (all-randomized stage IB-IIIA) population

Both arms included observation and regular scans for disease recurrence on the same schedule.
IC, tumor-infiltrating immune cells. [a] Per SP142 assay. [b] Two-sided α=0.05.

Hierarchical statistical testing

DFS in PD-L1 TC ≥1% stage II-IIIA population[b]

If positive: → **MET**

DFS in all-randomized stage II-IIIA population[b]

If positive: → **MET**

DFS in ITT population[b] (all-randomized stage IB-IIIA)

If positive: → **TO BE FOLLOWED**

OS in ITT population[b] (all-randomized stage IB-IIIA)

IMMATURE

- Endpoint was met at DFS IA
- Endpoint was not met at DFS IA, and follow-up is ongoing
- OS data were immature, and endpoint was not formally tested

Altorki N, et al. PL 02.05

Patient disposition and reasons for discontinuation prior to randomization

- A total of 1280 patients were enrolled
  - 1269 patients received chemotherapy
  - 275 patients discontinued prior to randomization
  - 1005 patients were subsequently randomized to atezolizumab or BSC

Study discontinuation reason, n (%)	Patients (n=275)
Withdrawal by subject	86 (31.3)
Disease relapse	54 (19.6)
Other	41 (14.9)
Adverse event	34 (12.4)
Death	19 (6.9)
Physician decision	18 (6.5)
Protocol deviation	18 (6.5)
Lost to follow-up	4 (1.5)
Symptomatic deterioration	1 (<1)

Clinical cutoff: January 21, 2021.

Altorki N, et al. PL 02.05

Patient, disease and treatment characteristics (ITT)

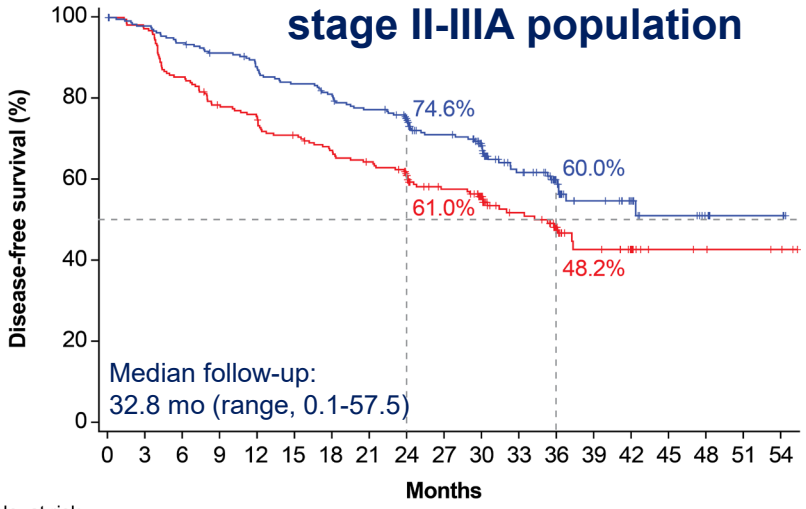
Characteristic	Atezolizumab (n=507)	BSC (n=498)	All patients (n=1005)
Median age (range), y	62 (33-83)	62 (26-84)	62 (26-84)
Sex, male, n (%)	337 (66.5)	335 (67.3)	672 (66.9)
ECOG PS 0 / 1, n (%)	273 (53.8) / 232 (45.8)	283 (56.8) / 214 (43.0)	556 (55.3) / 446 (44.4)
Histology, non-squamous, n (%)	328 (64.7)	331 (66.5)	659 (65.6)
PD-L1 by SP263, TC ≥1%, n (%)[a]	283 (57.4)	252 (51.9)	535 (54.6)
Stage, n (%)			
IB	65 (12.8)	58 (11.6)	123 (12.2)
IIA	147 (29.0)	148 (29.7)	295 (29.4)
IIB	90 (17.8)	84 (16.9)	174 (17.3)
IIIA	205 (40.4)	208 (41.8)	413 (41.1)
Mediastinal lymph node dissection, n (%)	402 (79.3)	409 (82.1)	811 (80.7)
Mediastinal lymph node sampling, n (%)	93 (18.3)	88 (17.7)	181 (18.0)
Regional lymph node status (pN), n (%)			
N0	183 (36.1)	169 (33.9)	352 (35.0)
N1	170 (33.5)	178 (35.7)	348 (34.6)
N2	154 (30.4)	151 (30.3)	305 (30.3)
Type of surgery, n (%)[b]			
Lobectomy	394 (77.7)	391 (78.5)	785 (78.1)
Pneumonectomy	77 (15.2)	83 (16.7)	160 (15.9)
Bilobectomy	31 (6.1)	19 (3.8)	50 (5.0)
Median (range) time from surgery to first atezolizumab treatment or BSC, mo	5.2 (2.4-7.7)	5.1 (2.3-8.0)	5.2 (2.3-8.0)
Chemotherapy treatment, n (%)			
Cisplatin-docetaxel	77 (15.2)	75 (15.1)	152 (15.1)
Cisplatin-gemcitabine	88 (17.4)	77 (15.5)	165 (16.4)
Cisplatin-vinorelbine	152 (30.0)	151 (30.3)	303 (30.1)
Cisplatin-pemetrexed	190 (37.5)	195 (39.2)	385 (38.3)

Clinical cutoff: January 21, 2021. [a] 26 patients in the ITT population had unknown PD-L1 status as assessed by SP263. [b] Subgroups with ≤10 patients are not shown.

Altorki N, et al. PL 02.05

DFS in the PD-L1 TC ≥1%[a] stage II-IIIA, all-randomized stage II-IIIA and ITT populations (primary endpoint)

PD-L1 TC ≥1% stage II-IIIA population

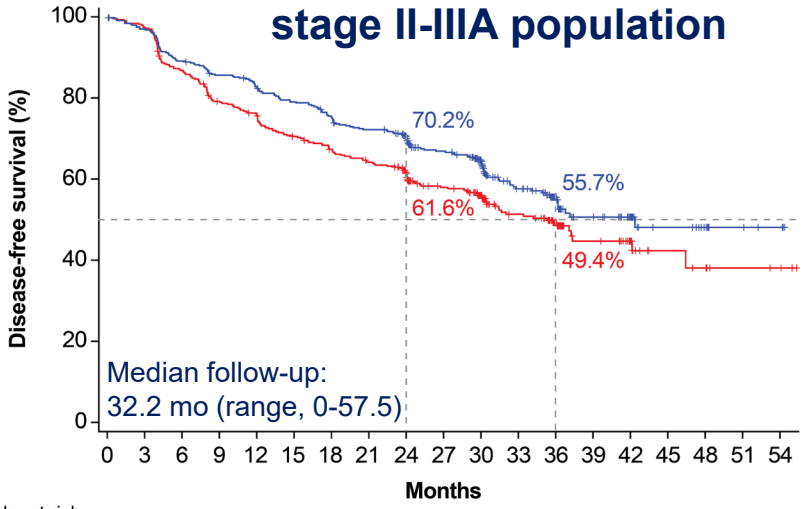


No. at risk

Atezolizumab	248	235	225	217	206	198	190	181	159	134	111	76	54	31	22	12	8	3	3
BSC	228	212	186	169	160	151	142	135	117	97	80	59	38	21	14	7	6	4	3

	Atezolizumab (n=248)	BSC (n=228)
Median DFS (95% CI), mo	NE (36.1, NE)	35.3 (29.0, NE)
Stratified HR (95% CI)	0.66 (0.50, 0.88)	
P value[b]	0.004[c]	

All-randomized stage II-IIIA population

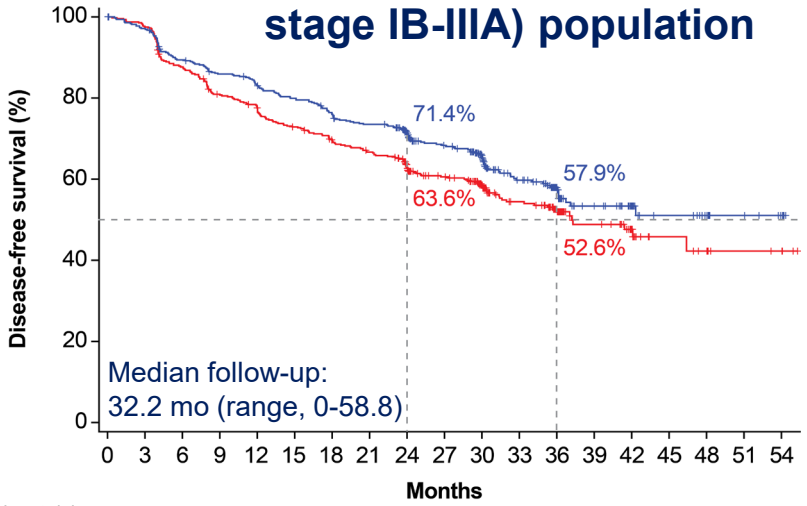


No. at risk

Atezolizumab	442	418	384	367	352	337	319	305	269	225	185	120	84	48	34	16	11	5	3
BSC	440	412	366	331	314	292	277	263	230	182	146	102	71	35	22	10	8	4	3

	Atezolizumab (n=442)	BSC (n=440)
Median DFS (95% CI), mo	42.3 (36.0, NE)	35.3 (30.4, 46.4)
Stratified HR (95% CI)	0.79 (0.64, 0.96)	
P value[b]	0.02[c]	

ITT (randomized stage IB-IIIA) population



No. at risk

Atezolizumab	507	478	437	418	403	387	367	353	306	257	212	139	97	53	38	19	14	8	4
BSC	498	467	418	383	365	342	324	309	269	219	173	122	90	46	30	13	10	5	4

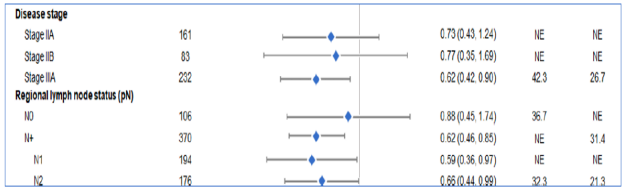
	Atezolizumab (n=507)	BSC (n=498)
Median DFS (95% CI), mo	NE (36.1, NE)	37.2 (31.6, NE)
Stratified HR (95% CI)	0.81 (0.67, 0.99)	
P value[b]	0.04[d]	

Clinical cutoff: January 21, 2021. [a] Per SP263 assay. [b] Stratified log-rank. [c] Crossed the significance boundary for DFS. [d] The statistical significance boundary for DFS was not crossed.

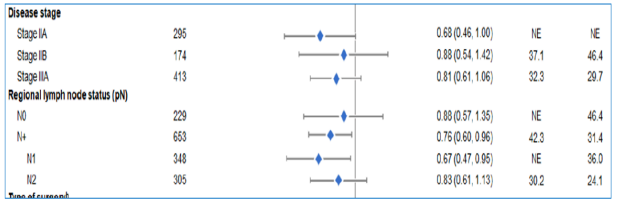
Altorki N, et al. PL 02.05

Stage and nodal status

PD-L1 TC ≥1%[a] stage II-IIIA population



All randomized stage II-IIIA population

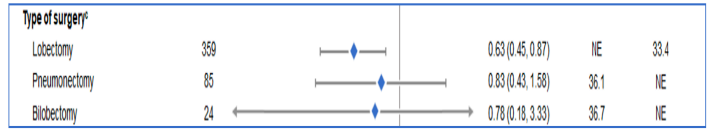


Favors ATZ ← → Favors BSC

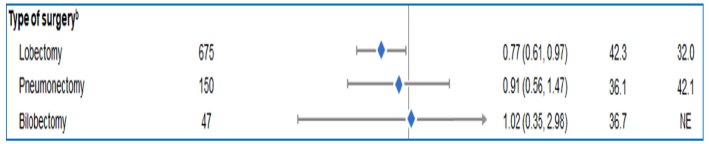
HRs were similar in stage and nodal status
in either PD-L1 TC ≥1%[a] stage II-IIIA, or in all stage II-IIIA population.

Type of surgery

PD-L1 TC ≥1% stage II-IIIA



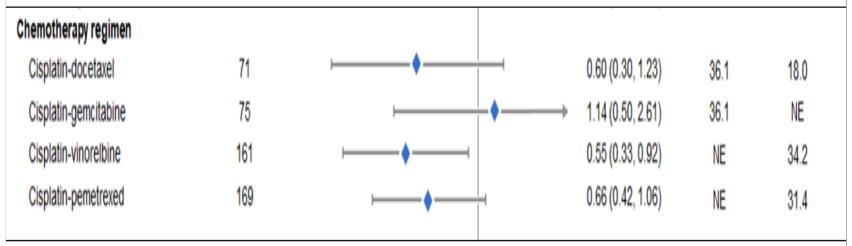
All randomized stage II-IIIA



Favors ATZ ← → Favors BSC

Type of surgery
- Lobectomy (77.7 vs. 78.5%) → Benefit of maintenance of atezolizumab was evident
- Pneumonectomy (15.2 vs. 16.7%)
- Bilobectomy (6.1 vs. 3.8%)

Adjuvant chemotherapy



Favors ATZ ← → Favors BSC

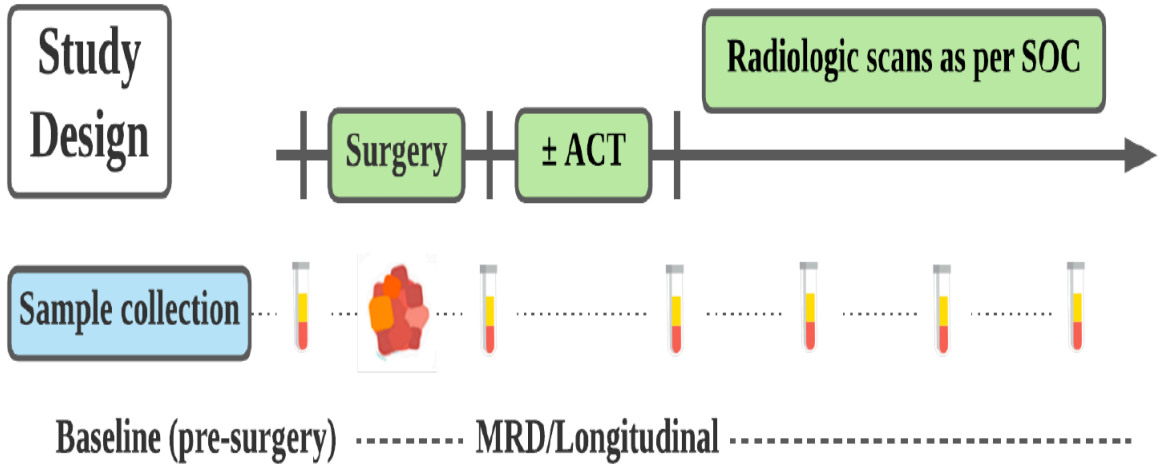
Regimens	Atezo	BSC	
CDDP/DOC	(15.2 vs.	15.1%)	
CDDP/GEM	(17.4 vs.	15.5%)	→ Seems to be BSC favor 'by chance'?
CDDP/VIN	(30.0 vs.	30.3%)	
CDDP/PEM	(37.5 vs.	39.2%)	

WHO BENEFITS FROM THE ADJUVANT IMMUNOTHERAPY ?

- Patients who underwent lobectomy (not pneumonectomy).
- Patients with tumor expressiing PD-L1.
- Patients who received proper regimens of adjuvant chemotherapy…..*to be examined*

Yoshinol. Plenary Session Discussion

Circulating tumor DNA for monitoring minimal residual disease and early detection of recurrence in early-stage lung cancer



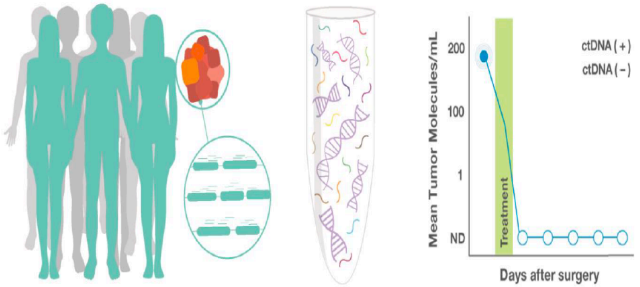
Study Cohort

Patient Characteristics (N=57)	N (%)
Median age – years (range)	60 (43-83)
Male	34 (60)
Non-smoker	31 (54)
Histology	
Adenocarcinoma	48 (84)
Squamous cell	4 (7)
Other*	5 (9)
EGFR mutated	27 (47)
Stage	
I	39 (68)
II	9 (16)
III	9 (16)
Adjuvant chemotherapy	15 (26)
Median follow-up – mths (range)	33.0 (9.8-72.1)
Relapsed	11 (19)

*Sarcomatoid carcinoma, LCNEC, LELC

Tumour-informed ctDNA assay

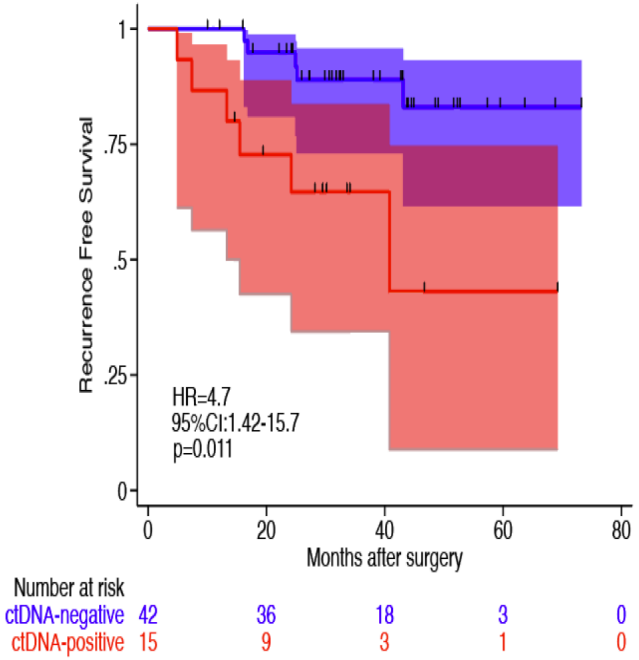
- Resected tumour & PBMC DNA exome sequenced
- Patient-specific multiplex-PCR assays (Signatera™ ctDNA assay) to track 16 clonal SNVs in plasma samples



- Plasma samples total (N=336)
  - Baseline: all (57/57) patients
  - MRD/Longitudinal: median 2 (1-4) per patient

Tan et al. MA 07.06

ctDNA detection pre-surgery associated with shorter RFS



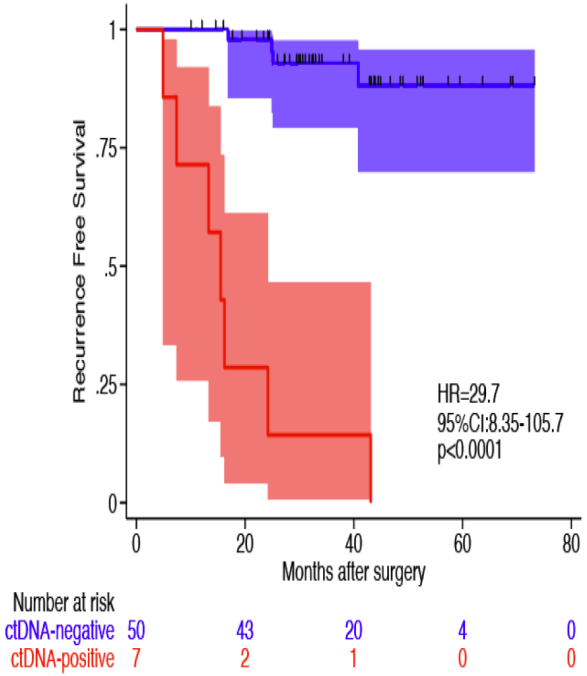
ctDNA status prior to surgery

ctDNA positivity pre-surgery also correlated with

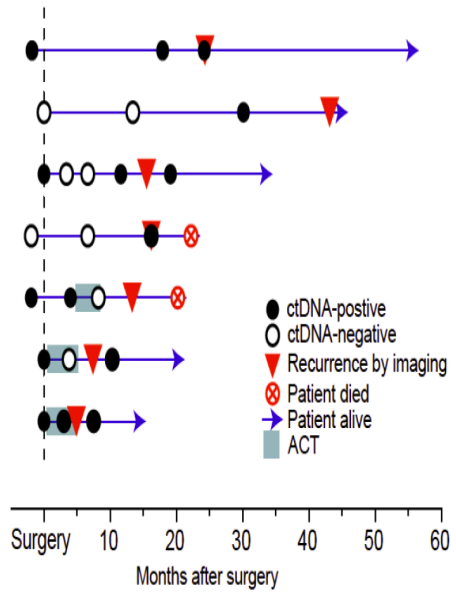
- Higher stage (p<0.0001)
- Lymph node positivity (p<0.0001)

Pre-surgery ctDNA+ (N=15)	N (%)
Stage	
I	7 (47)
II	2 (13)
III	6 (40)
Relapsed	7 (47)
No adjuvant therapy	3 out of 7

Longitudinal ctDNA+ preceded radiological recurrence



Longitudinal ctDNA monitoring



- Median lead time: 3.9 mths
- Longitudinal ctDNA negativity associated with favourable outcomes with NPV of 94% (45/49)

ctDNApositivity (baseline & longitudinal) was associated with relapse in early-stage NSCLC

Molecular recurrence (ctDNA) preceded radiological findings by a median of 3.9 months

NEOADJUVANT

Neoadjuvant pembrolizumab for early stage non-small cell lung cancer

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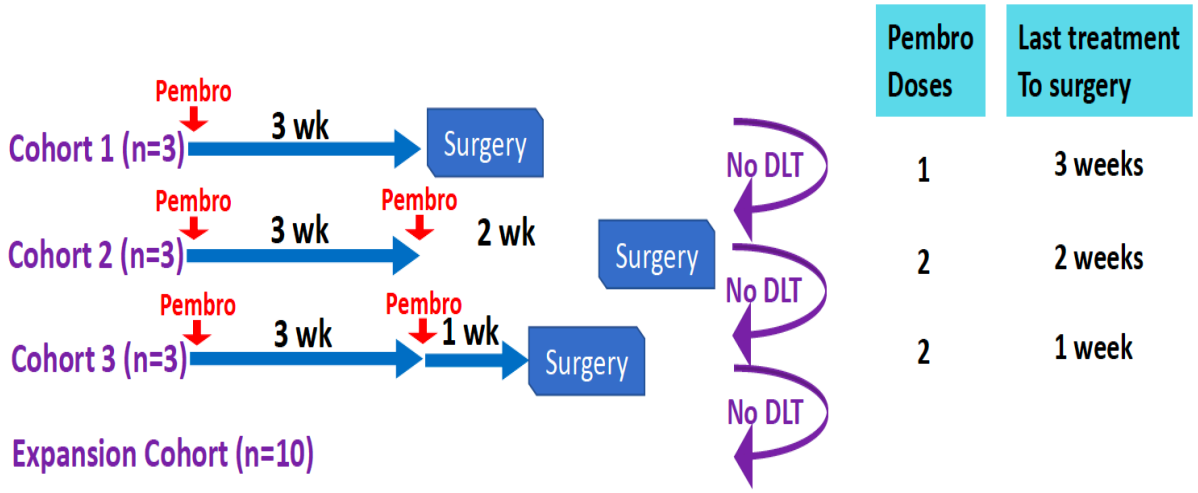
Primary endpoints:

1) Safety, Recommended Phase 2 Dose/Schedule
2) Pathologic response

Secondary endpoints: Recurrence Free Survival, Overall Survival

Exploratory endpoints: Exploration of the mechanism of response and resistance to pembro in early NSCLC



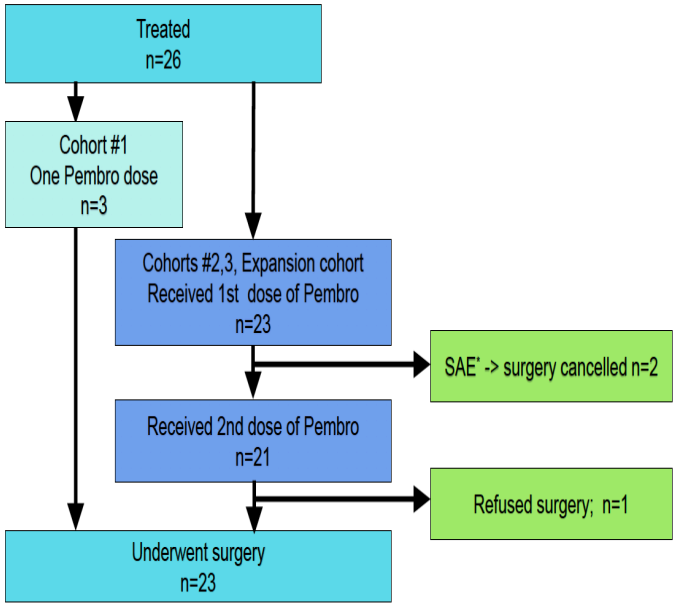
Pembro Doses	Last treatment To surgery
1	3 weeks
2	2 weeks
2	1 week

Study conduct

Study initiation: Janury 2017.

Expansion cohort target increased to 29 total to maximize trial validity (January 2020)

Closed enrolment with 26 patients in November 2020 due to slowed recruitment during COVID-19 pandemic.

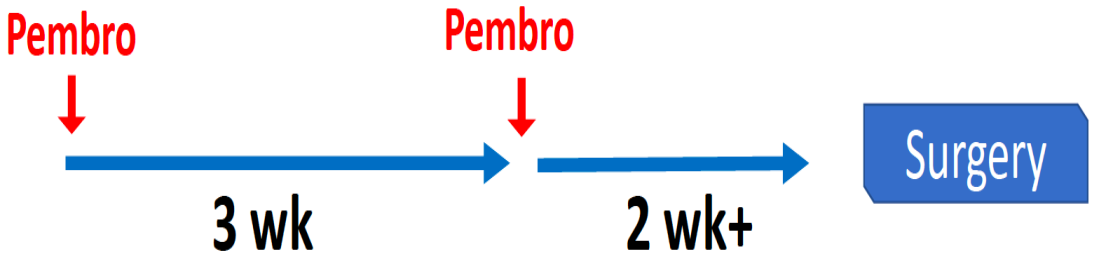


*SAE= Severe Adverse Event; Myositis grade 3 (n=1), Acute cardiac event – not related (n=1)

Bar K, et al. OA 11.01

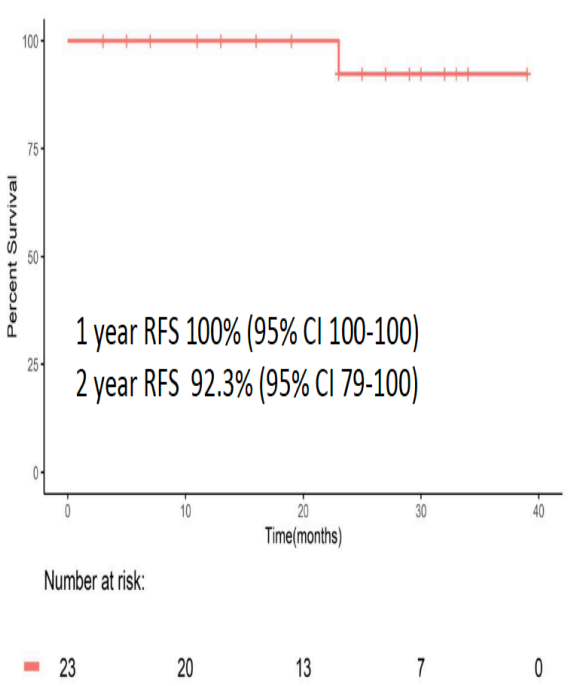
Recommended Phase 2 Dose/Schedule

- No DLT in the escalation cohorts
- MPR was observed only in patients with a time interval from treatment initiation to surgery ≥ 5 weeks
- Recommended dose/schedule:



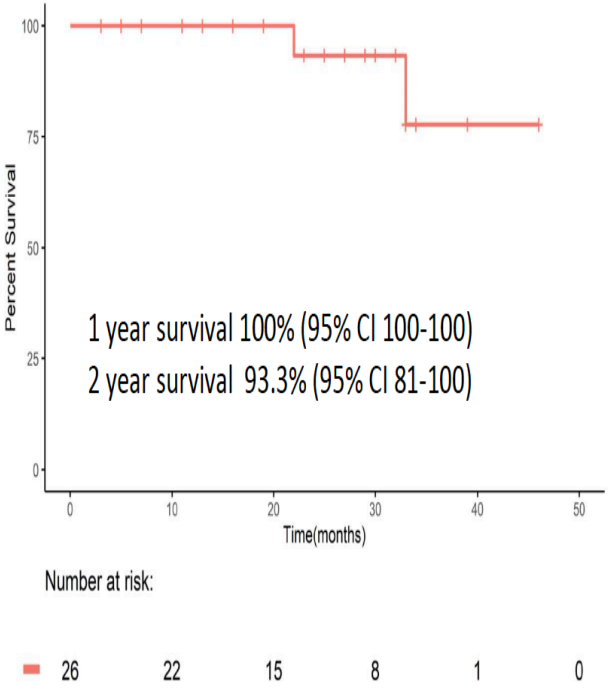
- Exploratory: among the patients treated by this dose/schedule (n=16)
  - MPR 44% (7 of 16)
  - pCR 19% (3 of 16)

Relapse Free Survival



Median follow up: 23 months (95% CI 13-32)

Overall Survival



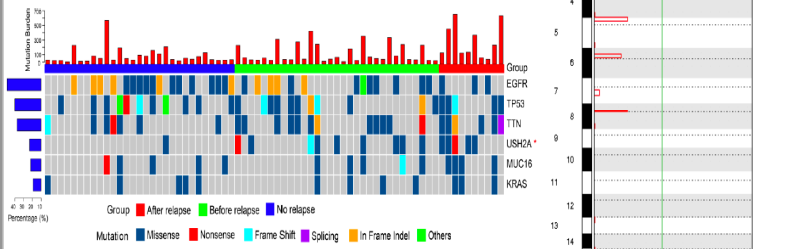
2 deaths: 1 secondary to disease progression (at 21.7 m); 1 from unrelated sepsis (at 32.4 m)

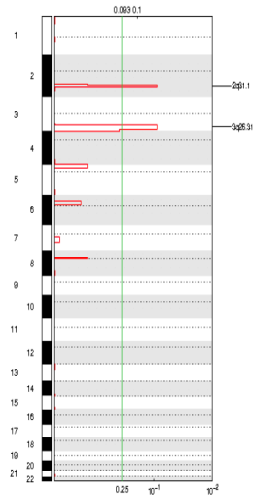
Bar K, et al. OA 11.01

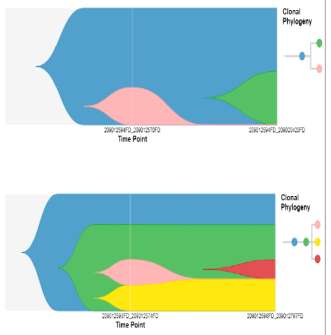
IDENTIFYING EARLY NSCLC POPULATIONS

INTEGRATING GENOMIC AND TRANSCRIPTOMIC FEATURES PREDICT THE RECURRENCE RISK OF STAGE I NON-SMALL CELL LUNG CANCER

Result 1. Autonomous and acquired clonal evolution in recurrent stage I NSCLC



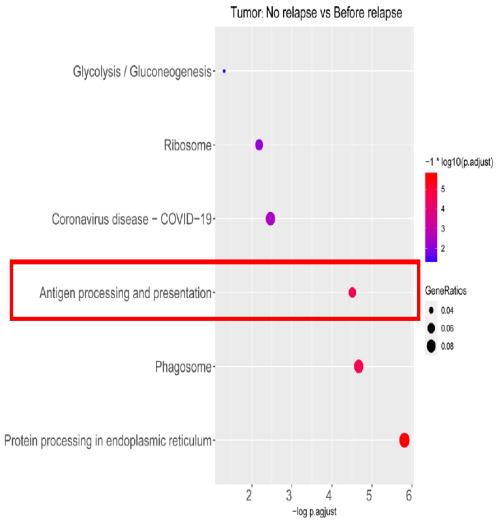


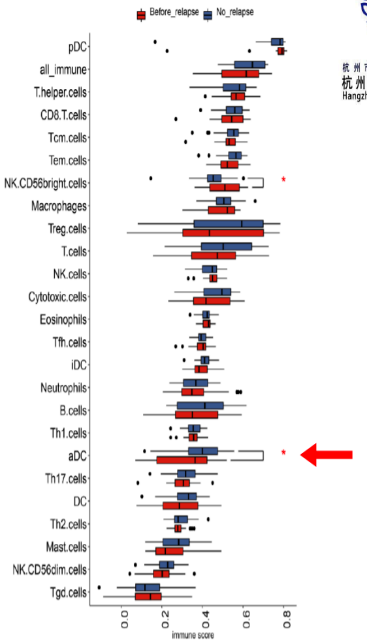


- *USH2A* (28.6% vs 3.4%) was enriched in relapse patients.
- Copy number amplification at 2q31.1 was prevalent in the pre-relapse group.
- Two patterns of clonal evolution : single clonal (6 of 10 patients) and multiple sub-clonal (4 of 10 patients), were identified during the recurrence.

Result 2. DCs in tumor and adjacent normal tissue affect the recurrence of stage I NSCLC

Author's slide





- Only down-regulated pathways were found in relapse tumor. Antigen processing and presentation signaling indicated defective immune function in relapse tumor.
- Lower score of DCs in adjacent normal affects recurrence of stage I NSCLC.

- USH2A mutation and chromosome 2q31.1 amplification might be clinical indicators of recurrent stage I NSCLC.
- Recurrent patients have defected antigen processing and presentation orchestrated by dendritic cells.

Zhang S, et al. MA 08.05

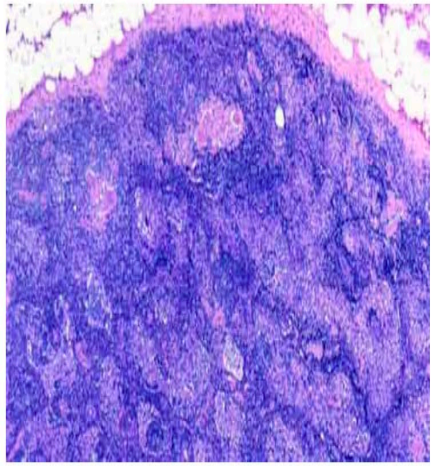
INMUNE CELL PROFILES AS PREDICTORS OF SURVIVAL IN SURGICALLY TREATED NSCLC

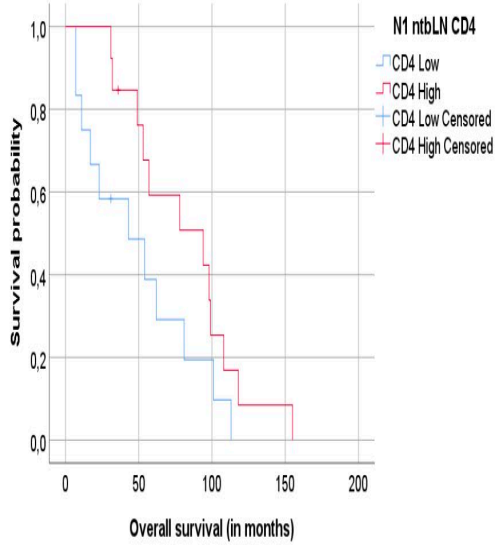
Methods & Outcomes

- Tissues collected:
  - Tumor
  - Affected lymph nodes
  - Unaffected N1 lymph nodes
  - Unaffected N2 lymph nodes
- Investigation of morphology and gene expression analysis
- Outcomes: OS and/or PFS

Source: https://www.minimed.at/medizinische-themen/krebs/lungenkrebs/

Results





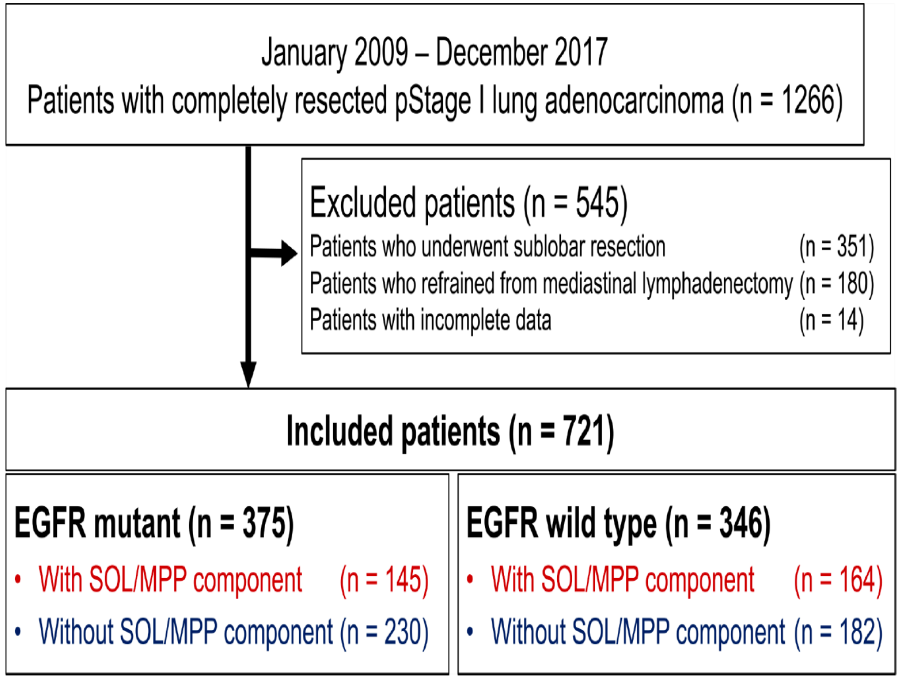
- Sinus histiocytosis and TiL density are associated with PFS and OS, respectively
- CD4 expression in N1 and N2 lymph nodes is associated with PFS and OS, respectively

Sellmer L, et al. MA 08.06

Driver mutations in non-metastatic NSCLC

Presence of High-Grade Subtype Predicts Recurrence of Stage I Lung Adenocarcinoma Only in EGFR-Mutated Patients

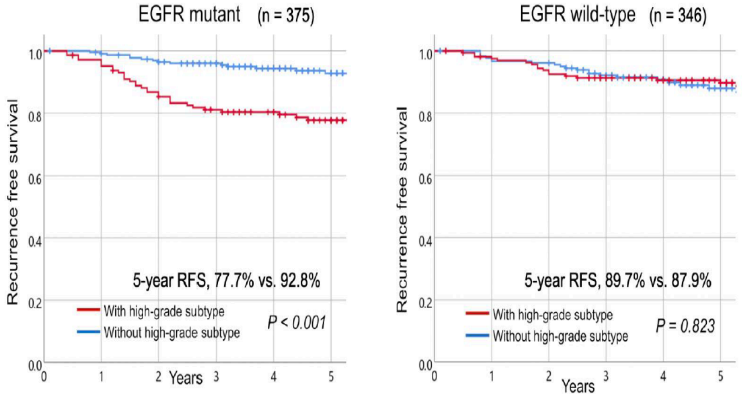
- The OS and RFS of 721 patients with pStage I lung Ad were compared according to EGFR mutation status and presence of > 5% high-grade subtype (solid or micropapillary) component.



'High-grade' subtype associated with worse RFS in pathological stage I, but only in *EGFR*-mutated subgroup

Median follow-up 5.2 years

>5% SOL/MPP N=721	*EGFR*-Mt N=375 (52%)	*EGFR*-Wt N=346 (48%)
+	N=145 (39%)	N=164 (47%)
-	N=230 (61%)	N=182 (53%)

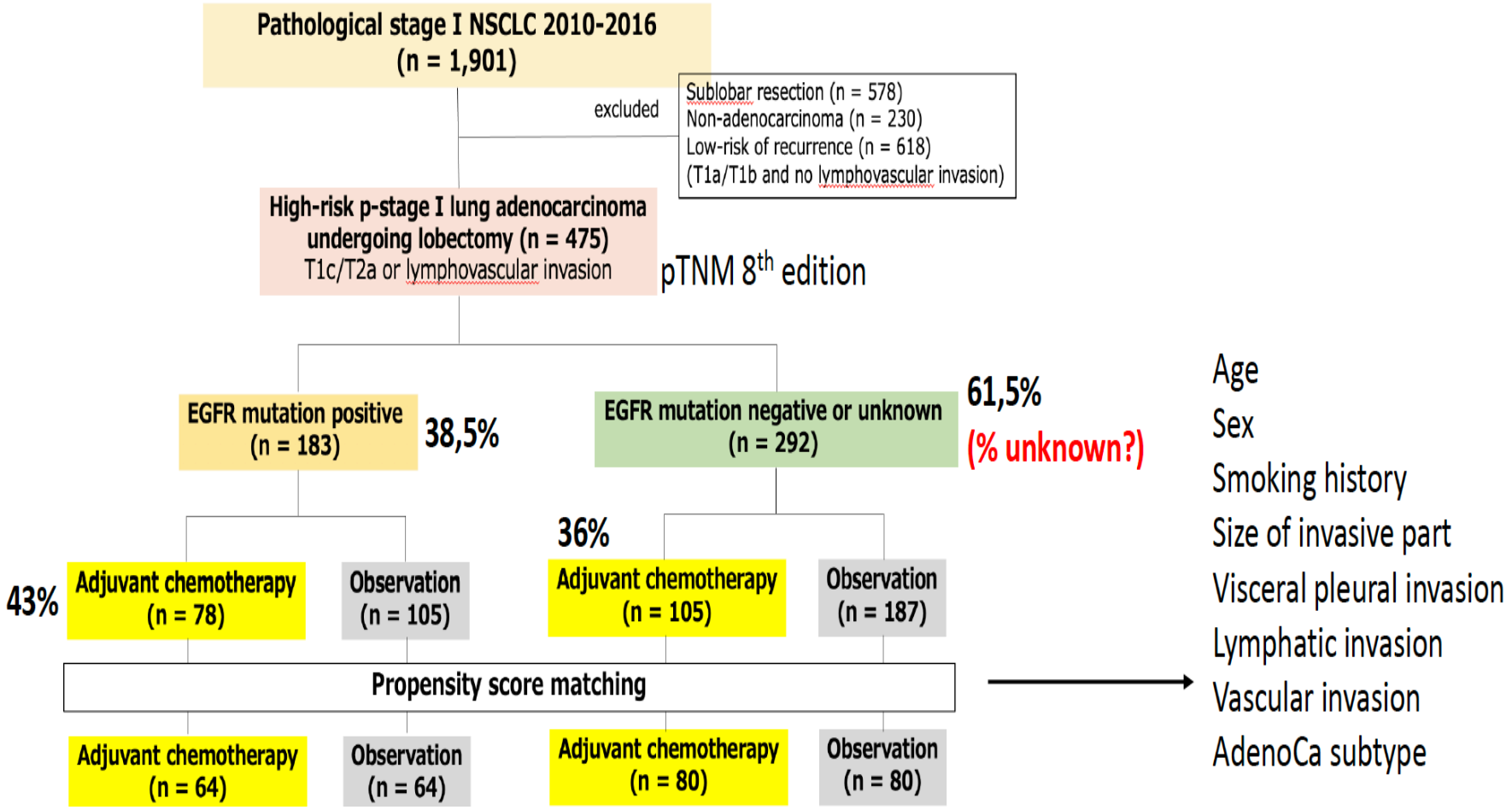


There were no significant differences in OS

- The combination of EGFR mutation and the presence of high-grade subtype predicted recurrence in stage I lung adenocarcinoma.
- Histological subtypes, including minor components, should be considered when evaluating the risk of recurrence in patients with EGFR-mutated lung adenocarcinoma.

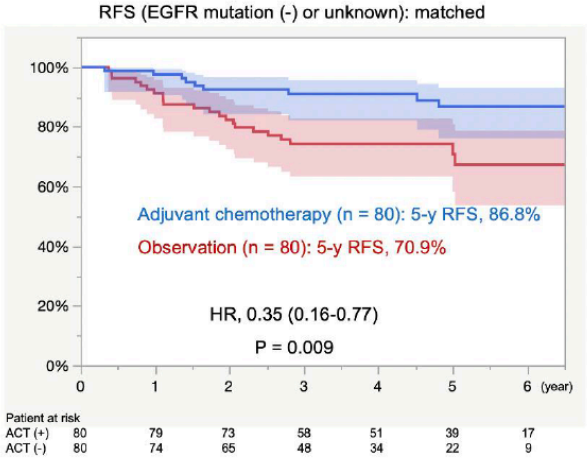
Ichinose J, et al. MA 08.01

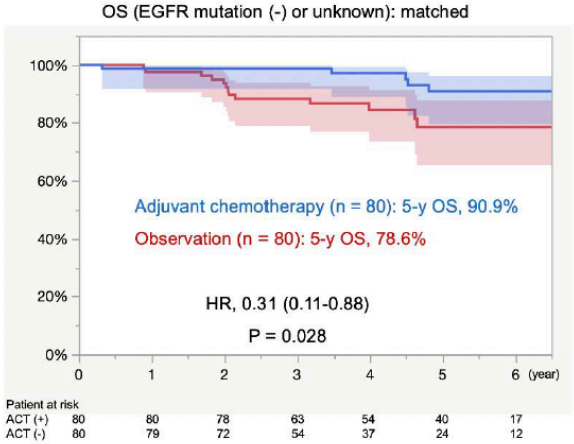
Adjuvant chemotherapy for patients with high-risk stage I lung adenocarcinoma stratified by epidermal growth factor receptor mutation status



Tsutani Y et al. MA 08.03

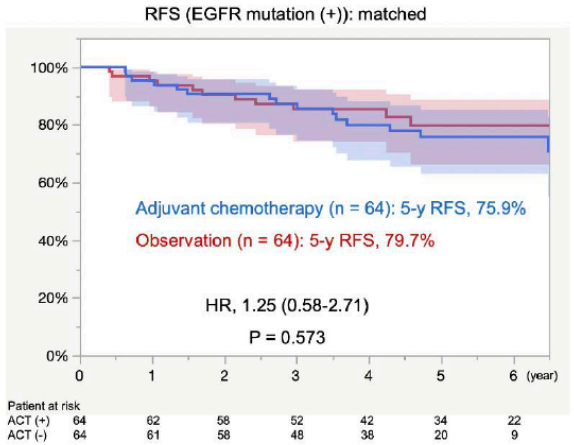
***EGFR* wildtype/?**

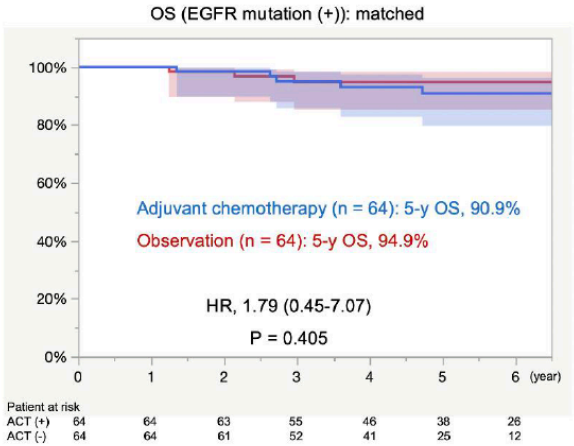




RFS and OS superior with adjuvant chemotherapy

***EGFR* mutant**





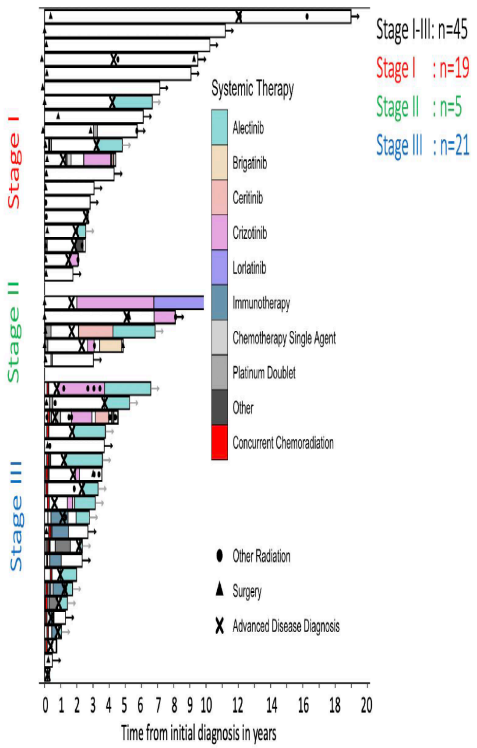
RFS and OS not different with or without adjuvant chemotherapy

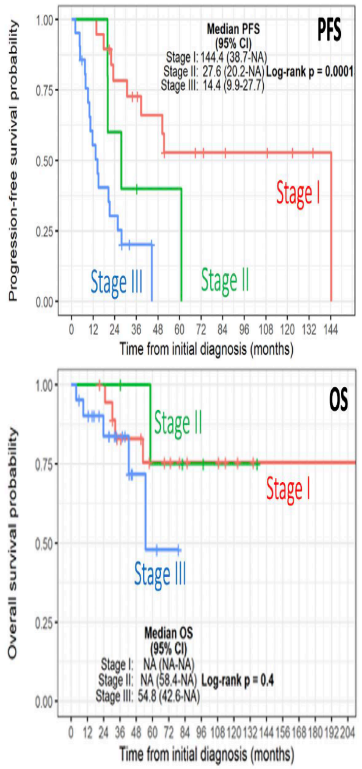
- The role of adjuvant chemotherapy for high-risk stage I lung adenocarcinoma was different by the EGFR mutation status.
- EGFR mutation status should be tested in patients with high-risk stage I lung adenocarcinoma to decide the application of adjuvant chemotherapy.

Tsutani Y, et al. MA 08.03

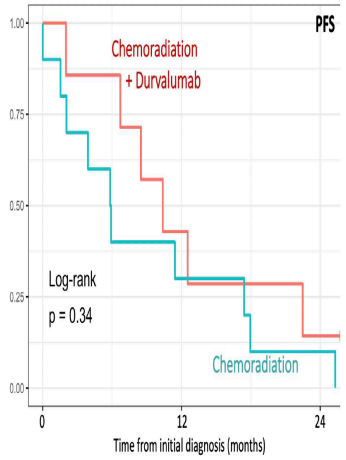
Treatment patterns and outcomes in early stage ALK+ NSCLC

Covariate	Category	Patients with ALK+ NSCLC		
		Overall cohort (100%)	No relapse	Relapse
Total Count (100%)		45	15	30
Age	Median, in years [IQR]	61.2 [13.6]	64.6 (11.7)	61.1 [16.2]
Sex	Male	20 (44)	7 (47)	13 (43)
	Female	25 (56)	8 (53)	17 (57)
Ethnicity	Caucasian	11 (37)	2 (29)	9 (39)
	Asian	15 (50)	5 (71)	10 (44)
	Other	4 (13)	0 (0)	4 (17)
	Missing	15	8	7
Smoking history	Never	31 (66)	11 (73)	20 (67)
	Current/Former	14 (31)	4 (27)	10 (33)
	Missing	0	0	0
Stage at initial diagnosis	I	19 (42)	10 (67)	9 (28)
	II	5 (11)	1 (7)	4 (13)
	III	22 (47)	4 (27)	19 (54)
PDL1	<1%	4 (25.0)	3 (38)	1 (13)
	1-49%	6 (38)	2 (25.0)	4 (50.0)
	>=50	6 (38)	3 (37.5)	3 (37.5)
	Missing	29	7	22
ECOG performance status at initial diagnosis	0	15 (50)	6 (67)	9 (43)
	1	14 (47)	3 (33)	11 (52)
	≥2	1 (3)	0 (0)	1 (5)
	Missing	15	6	9





MA08.02 SChmid Y, et al.



- 10 patients treated with chemoradiation alone
  - 1 patient stopped because of toxicity
- 7 patients received chemoradiation + durvalumab
  - All patients completed chemoradiation
  - Median number of cycles of durva received: 8.5
  - Median time on durvalumab: 9.9 months
- Reasons to stop durvalumab were:
  - Completed treatment n=2
  - Disease progression n=4
  - Durvalumab-related AEs n=1
- 16 of 17 patients relapsed:
  - Median PFS 8.5 (95% CI: 5.8-18.7)
- No suggestion of inceased pulmonary toxicity in patients treated with an ALK TKI after durvalumab

MA08.02 SChmid Y, et al.

- PFS of patients with early stage ALK+ NSCLC after initial curative intent treatment is comparable to molecularly unselected patients with NSCLC
- No significant benefit from addition of durvalumab after concurrent chemoradiation in this small cohort of patients with stage III ALK+ NSCLC was seen
- Durvalumab treatment was not associated with increased toxicity on the first ALK-TKI treatment, as pulmonary toxicity was overall rare
- •16 of 17 unresectable Stage III patients treated with chemoradiation +/-durvalumab relapsed with a short median PFS of 8.5 months.

Schmid S, et al. MA 08.02

GRACIAS