Lung Cancer UPDATES
ASCO HIGHLIGHTS
30 MAYO - 03 JUNIO 2025
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Iniciativa científica de:
GECP lung cancer research

Novedades en CPNCP: Estadios iniciales

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Novedades en CPNCP: Estadios Iniciales

2025 ASCO ANNUAL MEETING

Overall survival with neoadjuvant nivolumab + chemotherapy in patients with resectable NSCLC in CheckMate 816

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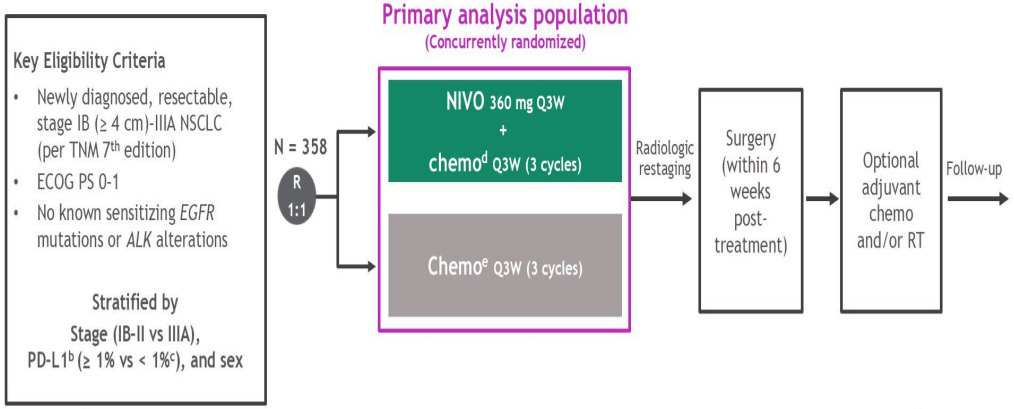
Abstract number LBA8000

CheckMate 816: 5-y OS final analysis

CheckMate 816 study design[a]



Minimum/median follow-up: 59.9/68.4 months

Primary endpoints	Key secondary endpoints	Exploratory analyses
• pCR by BIPR	• OS	• OS by pCR, ctDNA clearance
• EFS by BICR	• MPR by BIPR	• Lung cancer-specific survival
	• TTDM	

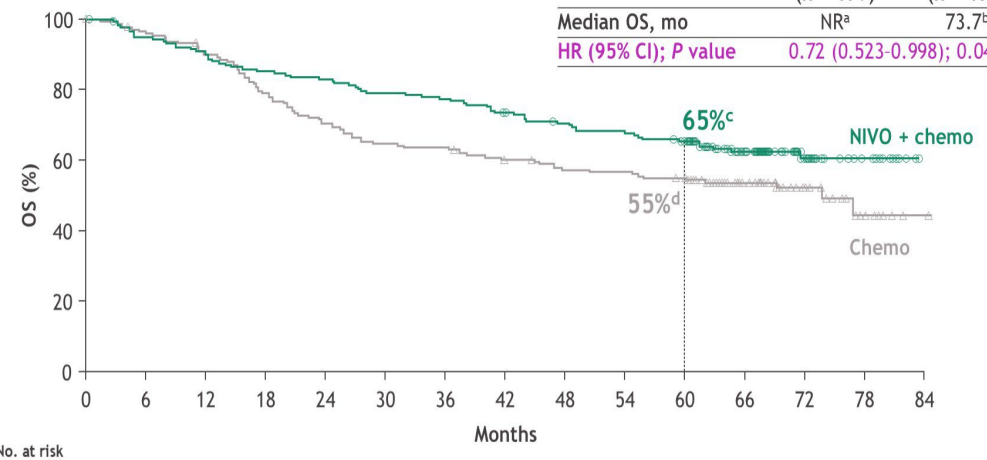
Database lock: January 23, 2025. From *The New England Journal of Medicine*, Forde PM, et al, Neoadjuvant nivolumab plus chemotherapy in resectable lung cancer, 2022;386:1973-1985. Copyright © 2022 Massachusetts Medical Society. Adapted with permission from Massachusetts Medical Society. [a]NCT02998528. [b]Determined by the PD-L1 IHC 28-8 pharmDx assay (Dako). [c]Included patients with PD-L1 expression status not evaluable and indeterminate. [d]Nonsquamous: pemetrexed + cisplatin or paclitaxel + carboplatin; squamous: gemcitabine + cisplatin or paclitaxel + carboplatin. [e]Vinorelbine + cisplatin, docetaxel + cisplatin, gemcitabine + cisplatin (squamous only), pemetrexed + cisplatin (nonsquamous only), or paclitaxel + carboplatin.

Novedades en CPNCP: Estadios Iniciales.

CheckMate 816: 5-y OS final analysis

Final analysis: OS with neoadjuvant NIVO + chemo vs chemo

	NIVO + chemo (n = 179)	Chemo (n = 179)
Median OS, mo	NR[a]	73.7[b]
HR (95% CI); *P* value	0.72 (0.523-0.998); 0.0479	



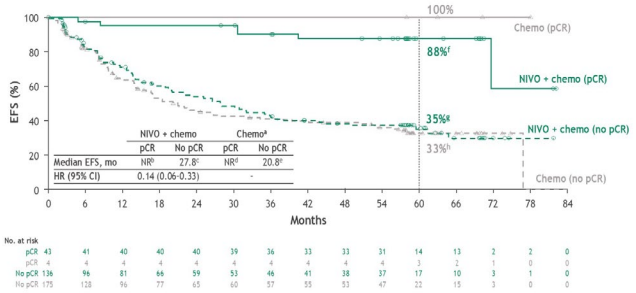
No. at risk

NIVO + chemo	179	168	159	151	147	140	137	129	122	117	111	67	29	9	0
Chemo	179	170	159	139	124	114	112	104	98	97	91	58	29	6	1

Minimum/median follow-up: 59.9/68.4 months.
[a-d]95% CI: [a]NR; [b]47.3-NR; [c]58-72; [d]47-62.

CheckMate 816: 5-y OS final analysis

Exploratory analysis: EFS by pCR status



	NIVO + chemo		Chemo[a]	
	pCR	No pCR	pCR	No pCR
Median EFS, mo	NR[b]	27.8[c]	NR[d]	20.8[e]
HR (95% CI)	0.14 (0.06-0.33)		-	

No. at risk

pCR	43	41	40	40	40	39	36	33	33	31	14	13	2	2	0
pCR	4	4	4	4	4	4	4	4	4	4	3	2	1	0	0
No pCR	136	96	81	66	59	53	46	41	38	37	17	10	3	1	0
No pCR	175	128	96	77	65	60	57	55	53	47	22	15	3	0	0

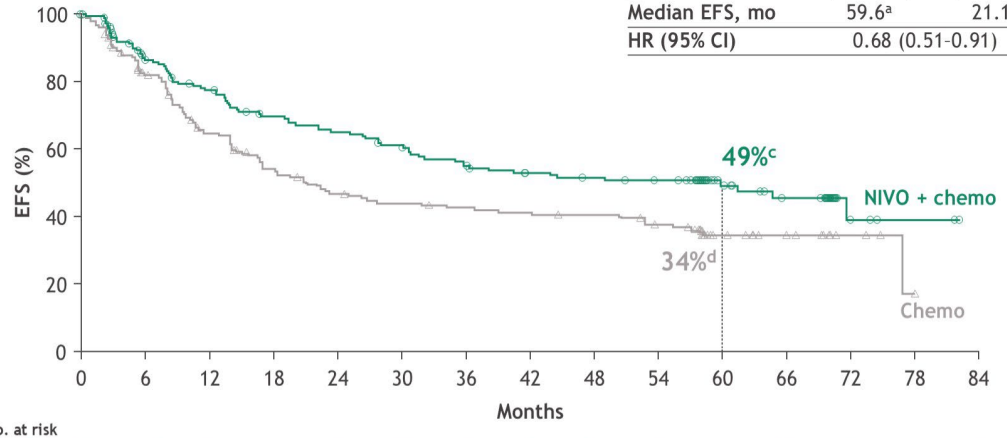
In the NIVO + chemo arm:
- Among patients with pCR, 3 (7.0%) patients had disease recurrence or relapse[i]
- Among patients with no pCR, 57 (41.9%) patients had disease recurrence or relapse

Minimum/median follow-up: 59.9/68.4 months.
HRs were NC if there was an insufficient number of events (< 10 per arm). [i]In the chemo arm, no patients with pCR had disease recurrence or relapse; 84 (48.0%) of patients without pCR had disease recurrence or relapse. [b-i]95% CI: [b]1.1-NR; [c]8.9-38.1; [d]NR; [e]14.8-31.8; [f]73-93; [g]26-44; [h]15-40. [i]Among the 3 patients with recurrence, 1 patient is alive at 5 years on an ALK-directed therapy, the other 2 patients had recurrence by BICR, however, have not received further systemic therapy and are alive at 5 years.

CheckMate 816: 5-y OS final analysis

EFS: 5-year analysis

	NIVO + chemo (n = 179)	Chemo (n = 179)
Median EFS, mo	59.6[a]	21.1[b]
HR (95% CI)	0.68 (0.51-0.91)	



No. at risk

NIVO + chemo	179	137	121	106	99	92	82	74	71	68	31	23	5	3	0
Chemo	179	132	100	81	69	64	61	59	57	51	25	17	4	0	0

Minimum/median follow-up: 59.9/68.4 months.
[a-d]95% CI: [a]31.6-NR; [b]16.5-36.8; [c]41-57; [d]27-42.

Novedades en CPNCP: Estadios Iniciales

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Overall Survival with Neoadjuvant Nivolumab plus Chemotherapy in Lung Cancer

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Quyen Duong, Ph.D.,[20] Stephanie Meadows-Shropshire, Ph.D.,[20]
Joseph Fiore, Pharm.D.,[20] Sumeena Bhatia, Ph.D.,[20] and
Nicolas Girard, M.D., Ph.D.,[21] for the CheckMate 816 Investigators*

Novedades en CPNCP: Estadios Iniciales

Abstract:LBA8010

2025 ASCO ANNUAL MEETING

Perioperative nivolumab vs placebo in patients with resectable NSCLC: updated survival and biomarker analyses from CheckMate 77T

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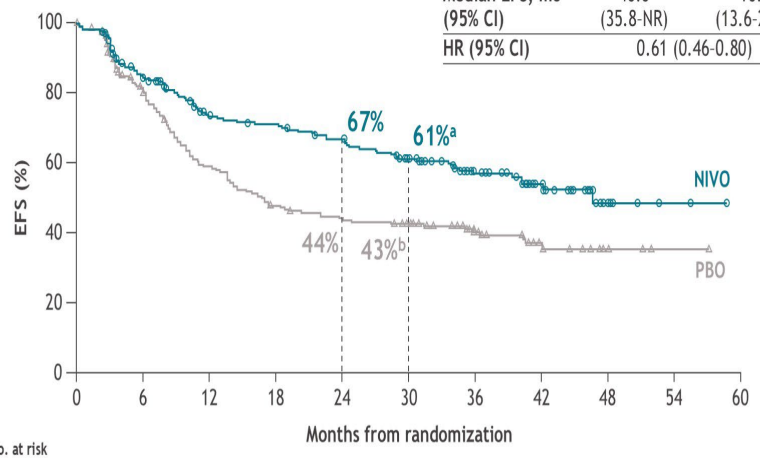
Abstract number LBA8010

EFS per BICR

	NIVO (n = 229)	PBO (n = 232)
Median EFS, mo (95% CI)	46.6 (35.8-NR)	16.9 (13.6-28.2)
HR (95% CI)	0.61 (0.46-0.80)	



No. at risk

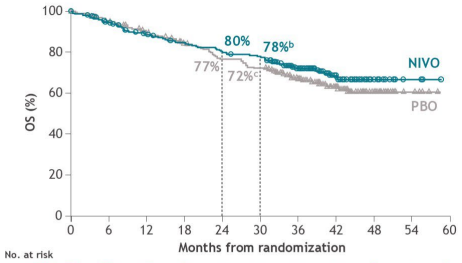
NIVO	229	172	140	133	123	103	69	30	7	3	0
PBO	232	165	118	92	83	76	43	20	5	1	0

CheckMate 77T: survival and biomarker update

OS and lung cancer-specific survival

OS

	NIVO (n = 229)	PBO (n = 232)
Median OS, mo (95% CI)	NR (NR-NR)	NR (NR-NR)
HR (97.63% CI)[a]	0.85 (0.58-1.25)	

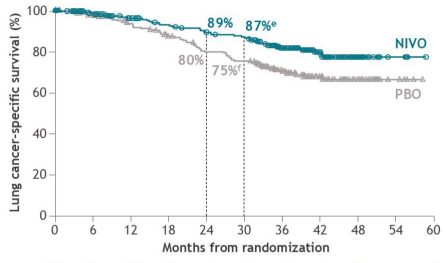


No. at risk

NIVO	229	206	187	176	166	161	114	66	23	6	0
PBO	232	216	197	178	161	152	103	52	20	7	0

Lung cancer-specific survival[d]

	NIVO (n = 229)	PBO (n = 232)
Median lung cancer-specific survival, mo (95% CI)	NR (NR-NR)	NR (NR-NR)
HR (95% CI)	0.60 (0.40-0.89)	



No. at risk

NIVO	229	206	187	176	166	161	114	66	23	6	0
PBO	232	216	197	178	161	152	103	52	20	7	0

Median follow-up (range): 41.0 months (31.3-59.8).
67 (29%) patients in the NIVO arm and 101 (44%) patients in the PBO arm received subsequent therapy of any type; 50 (22%) and 87 (38%) patients, respectively, received subsequent systemic therapy.
[a]HR (95% CI), 0.85 (0.61-1.18). Significance boundary for OS was not met at this interim analysis. [b,c]95% CI: [b]72-83; [c]66-78. [d]Exploratory analysis; events were deaths with noted reason of "disease" per investigator assessment. [e,f]95% CI: [e]82-91; [f]69-81.

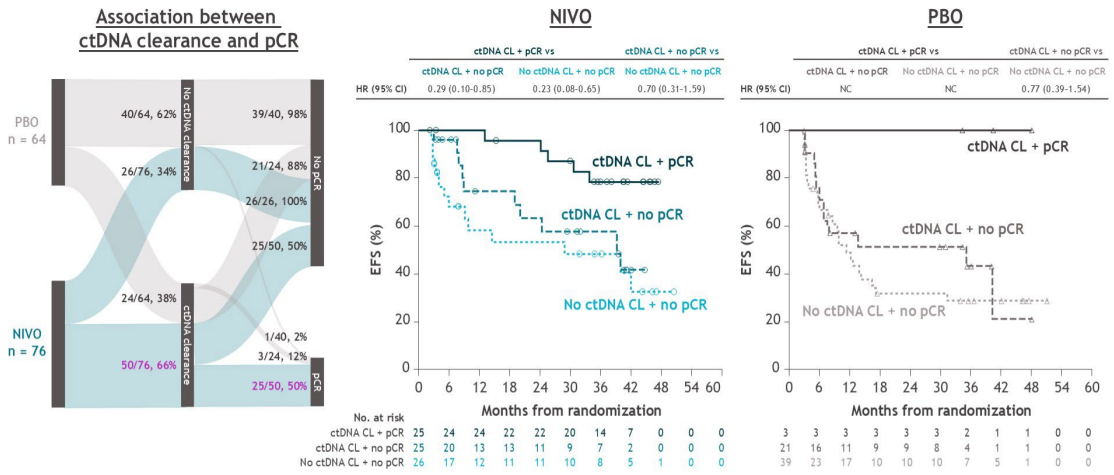
ase lock date: December 16, 2024; median follow-up (range): 41.0 months (31.3-59.8).
: [d]54-68; [e]36-50.

Novedades en CPNCP: Estadios Iniciales

Abstract: LBA8010

CheckMate 77T: survival and biomarker update

EFS by ctDNA clearance[a] and pCR status

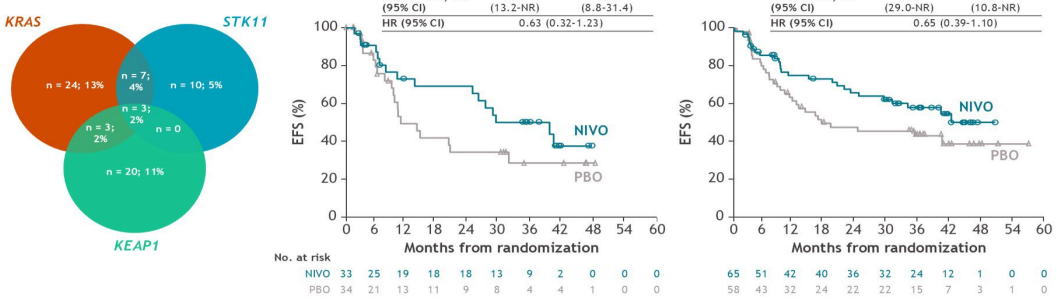


Median follow-up (range): 41.0 months (31.3-59.8).
[a]Change from detectable ctDNA at neoadjuvant treatment initiation (C1D1) to no detectable ctDNA at neoadjuvant treatment completion (end of neoadjuvant treatment or prior to definitive surgery); patients with no detectable ctDNA at neoadjuvant C1D1 were excluded from this analysis. Of randomized patients, 82 (36%) patients in the NIVO arm and 74 (32%) patients in the PBO arm had ctDNA-evaluable samples at both neoadjuvant treatment initiation and completion; 76 (33%) and 64 (28%) patients, respectively, had detectable ctDNA at neoadjuvant treatment initiation.
Landmark EFS from definitive surgery continued to favor NIVO vs PBO in patients with pCR (HR, 0.90; 95% CI, 0.19-4.15) or without pCR (HR, 0.72; 95% CI, 0.50-1.05).

CheckMate 77T: survival and biomarker update

EFS by tumor mutation status

- Of randomized patients, 190 patients had biomarker-evaluable samples (NIVO, 98 [43%]; PBO, 92 [40%])[a]
- Baseline characteristics were generally balanced between treatment arms, including the frequency of *KRAS*, *KEAP1*, and *STK11* tumor mutations



Median follow-up (range): 41.0 months (31.3-59.8).
[a]Tumor mutation status was assessed by whole exome sequencing of pretreatment tumor samples. [b]Percentages are out of all patients with biomarker-evaluable samples across both treatment arms (n = 190). The prevalence of tumor mutations in the NIVO (n = 33) and PBO (n = 34) arms, respectively, was as follows: *KRAS* only, 11 (11%) and 13 (14%); *KRAS* + *KEAP1*, 1 (1%) and 2 (2%); *KRAS* + *STK11*, 1 (1%) and 6 (7%); *KRAS* + *KEAP1* + *STK11*, 2 (2%) and 1 (1%); *KEAP1* only, 11 (11%) and 9 (10%); *STK11* only, 7 (7%) and 3 (3%).

CheckMate 77T: survival and biomarker update

Summary

- In this updated analysis from CheckMate 77T, perioperative NIVO continued to demonstrate EFS benefit vs PBO in patients with resectable NSCLC (HR, 0.61)
- ctDNA clearance and pCR were associated with improved EFS, regardless of treatment
- EFS favored NIVO vs PBO regardless of *KRAS*, *KEAP1*, and/or *STK11* tumor mutation status
- OS showed a trend favoring perioperative NIVO over PBO
  - —NIVO improved lung cancer–specific survival vs PBO
- No new safety signals were observed at this clinical update
- Results of these efficacy and biomarker analyses further support perioperative NIVO as an efficacious treatment option for patients with resectable NSCLC

Abstract:LBA8010

Novedades en CPNCP: Estadios Iniciales

2025 ASCO ANNUAL MEETING

Neoadjuvant osimertinib ± chemotherapy vs chemotherapy alone in resectable epidermal growth factor receptor-mutated (EGFRm) NSCLC: NeoADAURA

Jamie E. Chaft[1], Walter Weder, Jianxing He, Ke-Neng Chen, Maximilian J. Hochmair, Jin-Yuan Shih, Sung Yong Lee, Kang-Yun Lee, Nguyen Viet Nhung, Somcharoen Saeteng, Carlos H.A. Teixeira, Carles Escriu, Alex Martinez-Marti, Collin M. Blakely, Yasushi Yatabe, Sanja Dacic, Xiangning Huang, Yuri Rukazenkov, Anupriya Dayal, Masahiro Tsuboi

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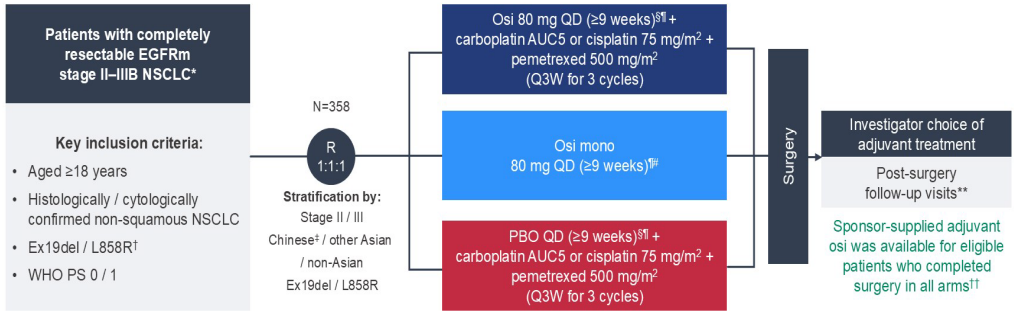
NeoADAURA: global, randomized, Phase 3 controlled study



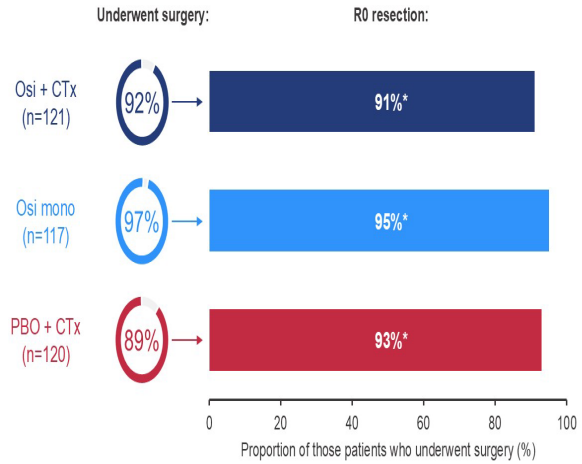
Endpoints:
- **Primary: major pathological response (MPR; by blinded central pathology review)**
- Secondary: event-free survival, pathological complete response, nodal downstaging and safety

NCT04351555. Figure borrowed from "*Neoadjuvant osimertinib with/without chemotherapy versus chemotherapy alone for EGFR-mutated resectable non-small-cell lung cancer: NeoADAURA*", Tsuboi M et al. Published online July 19, 2021 in *Future Oncology* and reprinted by permission of the publisher Informa UK Limited trading as Taylor & Francis Ltd, http://www.tandfonline.com. The figure was adapted with permission from the authors. *AJCC Staging Manual 8th edition.†Confirmed by sponsor pre-approved local or central tissue testing. ‡Chinese living in mainland China. §Double-blind. ¶Osi or PBO could be continued up to the date of surgery, at the discretion of the investigator. #Open-label, sponsor-blinded. **At weeks 12 and 24 post-surgery, then every 24 weeks until 5 years, and then every 48 weeks until disease recurrence or other withdrawal criteria were met. ††Adjuvant osi could be given for a maximum 3-year treatment period, or until unacceptable toxicity or disease recurrence.

AJCC, American Joint Committee on Cancer; AUC, area under the curve; CTx, chemotherapy; del, deletion; EGFRm, epidermal growth factor receptor-mutated; Ex19del, Exon 19 deletion; mono, monotherapy; NSCLC, non-small cell lung cancer; osi, osimertinib; PBO, placebo; Q3W, once every 3 weeks; QD, once daily; R, randomization; WHO PS, World Health Organisation performance status

Novedades en CPNCP: Estadios Iniciales

Surgery summary



In each arm, **91%** of patients who completed surgery received sponsor-supplied adjuvant osi†

- SAEs causally related to surgery occurred in 10%, 5% and 7% of patients
- No patients died within 30 days post-surgery

Data cut-off: October 15, 2024.

*One patient in the osi + CTx arm, two patients in the osi mono arm and one patient in the PBO + CTx arm had missing R status data. One patient in the osi + CTx arm and one patient in the PBO + CTx arm had an R2 resection. †In addition to patients who received sponsor-supplied adjuvant osi, two patients in the osi + CTx arm, one patient in the osi mono arm and two patients in the PBO + CTx arm received commercial supplied osi.

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CTx, chemotherapy; mono, monotherapy; osi, osimertinib; PBO, placebo

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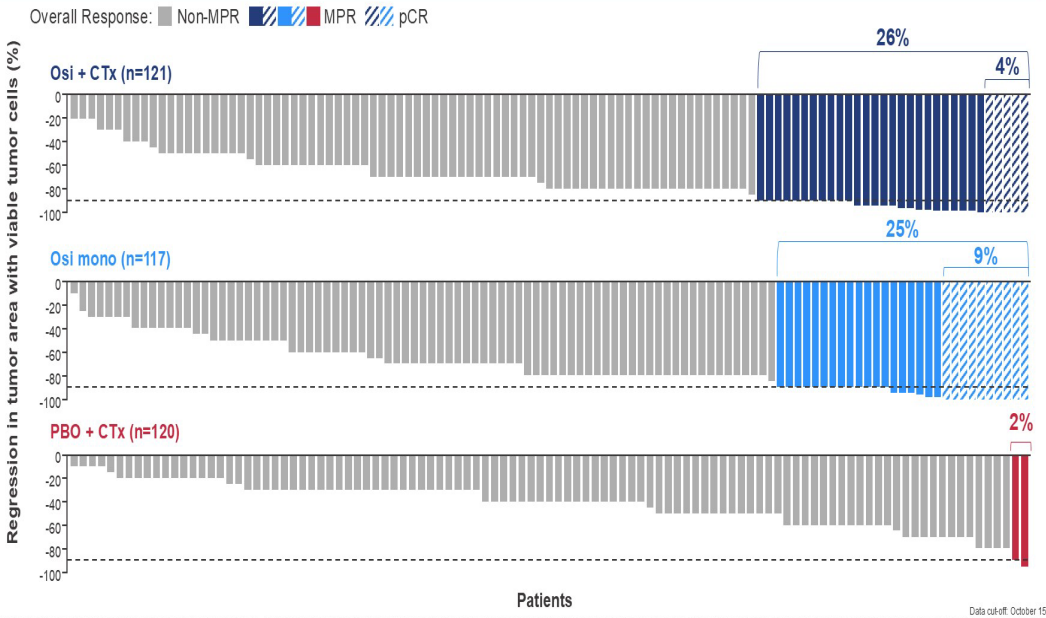
Depth of pathological response

Depth of pathological response was greater with the osi-containing regimens



MPR defined as ≤10% residual viable tumor cells in the lung primary tumor at resection, dotted line at −90% denotes the MPR cut-off. pCR defined as no residual viable tumor in surgical specimens including primary tumors and lymph nodes. Patients had to have an R0 result to be classified as responders. MPR and pCR assessed using the IASLC method. Pathological regression is summarized based on patients with evaluable % residual viable tumor, osi + CTx: n=109; osi mono: n=110; PBO + CTx: n=105. Rates of MPR / pCR are calculated based on the full analysis set.

Data cut-off: October 15, 2024.

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CTx, chemotherapy; mono, monotherapy; IASLC, International Association for the Study of Lung Cancer; MPR, major pathological response; osi, osimertinib; PBO, placebo

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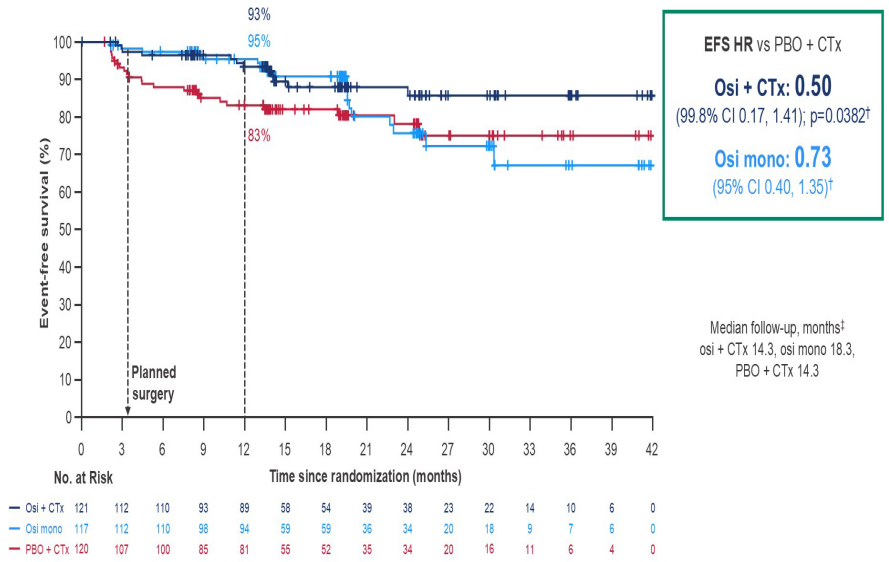
KNOWLEDGE CONQUERS CANCER

Novedades en CPNCP: Estadios Iniciales

Interim EFS analysis (15% maturity)



EFS HR vs PBO + CTx

Osi + CTx: 0.50
(99.8% CI 0.17, 1.41); p=0.0382†

Osi mono: 0.73
(95% CI 0.40, 1.35)†

Median follow-up, months‡
osi + CTx 14.3, osi mono 18.3,
PBO + CTx 14.3

Data cut-off: October 15, 2024.
Tick marks indicate censored data. EFS was investigator assessed. Median follow-up for EFS (censored patients): osi + CTx 15.9 months, osi mono 18.3 months, PBO + CTx 16.8 months. EFS maturity: osi + CTx 10%, osi mono 15%, PBO + CTx 19%.
†EFS analysis performed using a log-rank test stratified by disease stage (II vs III), race (Chinese vs other Asian vs non-Asian) and EGFR mutation type (Ex19del vs L858R). p-value ≤0.002 required for statistical significance at interim analysis. ‡No p-value calculated. The pre-specified sequential multiple testing procedure required a statistically significant improvement in EFS to be demonstrated for the comparison of osi + CTx vs PBO + CTx before formal testing for the comparison of osi mono vs PBO + CTx could be performed. §All patients.

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PRESENTED BY: Dr Jamie E. Chaft

CI, confidence interval; CTx, chemotherapy; EFS, event-free survival; EGFR, epidermal growth factor receptor; Ex19del, Exon 19 deletion; HR, hazard ratio; osi, osimertinib; MPR, major pathological response; PBO, placebo; SAP, statistical analysis plan

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Conclusions

- Neoadjuvant osi, with or without CTx, demonstrated statistically significant improvement in MPR rates vs CTx alone (26% or 25% vs 2%) in resectable EGFRm stage II–IIIB NSCLC
- Interim EFS trends favored the osi-containing arms (osi + CTx HR 0.50; 99.8% CI 0.17, 1.41; osi mono HR 0.73; 95% CI 0.40, 1.35)
- Fewer patients with an MPR had an EFS event vs patients without an MPR (2% vs 18%)
- Over 50% of patients with baseline N2 disease were down-staged at surgery with osi-containing arms vs 21% with CTx alone
- Safety findings were consistent with the known profiles of the individual agents

Neoadjuvant osi, with or without CTx, should be considered when planning treatment for patients with resectable EGFRm stage II–IIIB NSCLC

Novedades en CPNCP: Estadios Iniciales Reordenamiento ALK

Abstract:8015

2025 ASCO ANNUAL MEETING

GOIRC GRUPPO ONCOLOGICO ITALIANO DI RICERCA CLINICA

Alectinib as Neoadjuvant Treatment in Potentially Resectable Stage III ALK-positive NSCLC: Final Analysis of ALNEO Phase II Trial (GOIRC-01-2020-ML42316)

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Study Design

- Resectable locally advanced stage III NSCLC
- Candidate for surgical resection after multidisciplinary discussion
- ALK-positive (IHC/FISH/NGS)
- No Previous treatment
- ECOG PS 0-1

Primary Endpoint: MPR (≤10% viable tumor) by BICR

Secondary Endpoints: pCR by BICR, ORR, EFS, DFS, OS, AEs

Ancillary biological study[a]: correlation of tissue and cell-free biomarkers with MPR and DFS

According to the Simon's two-stage mini-max design, the null hypothesis that the MPR is ≤20% will be tested and will be rejected if 11 or more MPR are observed in 33 patients at the final analysis. This design yields a one-sided type I error rate of 0.05 and power of 0.80 when the true MPR is 40%

Abbreviations: AEs, Adverse Events; BICR, Blinded Independent Central Review; DFS, Disease-Free Survival; EFS, Event-Free Survival; MPR, Major Pathologic Response; ORR, Objective Response Rate; OS, Overall Survival; pCR, Pathologic Complete Response; PD, Progressive Disease

[a]tissue collection at diagnosis and surgery; plasma collection at baseline, after 4 and 8 weeks of neoadjuvant therapy, within 2 weeks of surgery, and at the time of recurrence

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Novedades en CPNCP: Estadios localmente avanzados:

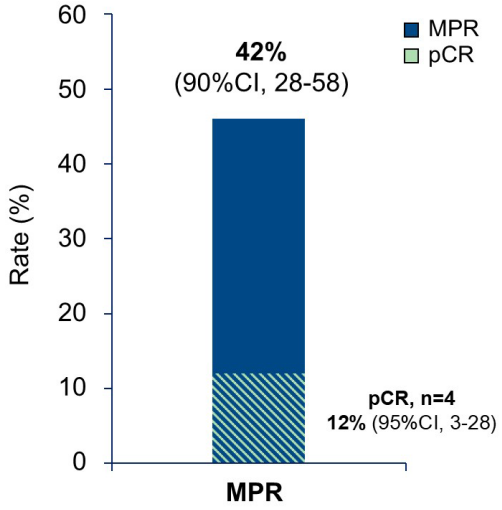
Abstract:8015

GECP lung cancer research

Results – Primary Endpoint: MPR by BICR

Pathologic Response	N=33
MPR (≤10% viable tumor), n (%)	14 (42)
Non-MPR (>10% viable tumor), n (%)	13 (40)
Not assessed, n (%)	6 (18)[a]

[a]5 patients did not undergo surgery, 1 patient underwent explorative thoracotomy



Abbreviations: CI, Confidence Interval; MPR, Major Pathologic Response; pCR, Pathologic Complete Response

Conclusions

- ALNEO phase II trial met its primary endpoint with neoadjuvant alectinib in potentially resectable stage III ALK-positive NSCLC patients
  - **MPR 42%** (90%CI, 28-58); pCR 12% (95%CI, 3-28)
- The treatment was well-tolerated and the safety profile was consistent with previous alectinib studies
- With the limitation of a small phase II non-randomized trial, ALNEO study suggests alectinib as an active and feasible peri-operative option in resectable stage III ALK-positive NSCLC patients
- Molecular sub-study on tissue and liquid biopsies is ongoing

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Novedades en CPNCP: Estadios Iniciales

Abstract 8022 Poster Bd#143

Abstract 8022
Poster 143

IMpower010: Genomic Profiling and Clinical Outcomes With Adjuvant Atezolizumab in Early-Stage Non-Small Cell Lung Cancer (eNSCLC).

Heather A. Wakelee,[1] Enriqueta Felip,[2] Caicun Zhou,[3] Eric Vallières,[4] Martin Reck,[5] Nasser Altorki,[6] Achim Rittmeyer,[7] Tibor Csoszi,[8] Ihor Vynnychenko,[9] Antonio Chella,[10] Velimir Gayevskiy,[11,12] Wei Zou,[11] Barbara Gitlitz,[11] Marcus Ballinger,[11] Elizabeth Bennett,[11] Barzin Y. Nabet,[11] Minu K. Srivastava[11]

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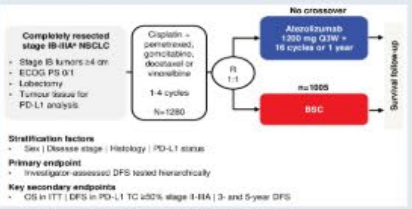
BACKGROUND

- In metastatic non-small cell lung cancer (mNSCLC), genomic alterations are well studied and have led to the development of efficacious new drugs[1,2]
- However, the association of genomic alterations in the adjuvant setting in early-stage NSCLC (eNSCLC) is not as well understood
- Here, we describe an exploratory, retrospective analysis of genomic profiling by whole-exome sequencing and clinical association in IMpower010 (NCT02486718)

METHODS

- IMpower010 is a global, multicenter, open-label, randomized Phase III clinical study evaluating adjuvant atezolizumab vs best supportive care (BSC) in patients with stage IB-IIIA NSCLC after complete resection and platinum-based chemotherapy (**Figure 1**)[3]
- Whole-exome sequencing was performed on baseline tumor samples and germline DNA from whole blood from the Stage II-IIIA biomarker-evaluable population (BEP; n=623)
- Multiple genomic alterations were identified in the full BEP and were assessed by histology
- Disease-free survival (DFS) and overall survival (OS) were assessed in the most common gene subgroups

Figure 1. IMpower010 study design



Treatment arms included observation and regular scans for disease recurrence on the same schedule.
AJCC, American Joint Committee on Cancer; ECOG PS, Eastern Cooperative Oncology Group performance status; R, randomized; PD-L1, programmed death-ligand 1; Q3W, every 3 weeks; TC, tumor cell; UICC, Union for International Cancer Control.
* Per UICC/AJCC staging system; 7th edition.
Figure adapted from: Altorki N, et al. WCLC 2021. Abstract PL02.05.

CONCLUSIONS

- This analysis represents the largest dataset evaluating the genomic profile of patients with eNSCLC who were treated with cancer immunotherapy
- The prevalences of *STK11* and *KEAP1* genomic alterations were lower than in mNSCLC and were enriched for PD-L1–negative TCs in non-squamous NSCLC
- Unlike in mNSCLC, patients with tumors that harbored *KEAP1* genomic alterations did not have poor prognosis in IMpower010
- These data are hypothesis-generating and require validation in independent eNSCLC datasets with larger numbers

ACKNOWLEDGMENTS

REFERENCES

DISCLOSURES

RESULTS

Study population

- Among the evaluable patients, baseline characteristics were generally balanced between arms (**Table 1**)

Table 1. Baseline characteristics for the BEP*

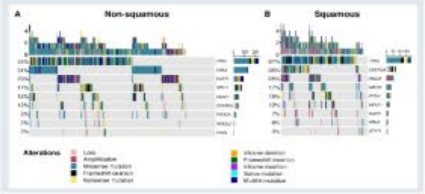
	BEP (n=623)	Atezolizumab (n=315)*	BSC (n=299)*
Age, median (range), years	62 (26-82)	62 (36-82)	63 (26-79)
Sex, n (%)			
Female	197 (31.6)	106 (33.7)	87 (29.1)
Male	426 (68.4)	209 (66.3)	212 (71.0)
Tobacco history, n (%)			
Current	97 (15.6)	42 (13.3)	52 (17.4)
Never	131 (21.0)	64 (20.3)	66 (22.1)
Previous	395 (63.4)	209 (66.3)	181 (60.5)
Histology, n (%)			
Non-squamous	413 (66.3)	207 (65.7)	202 (67.6)
Squamous	210 (33.7)	108 (34.3)	97 (32.4)
Region, n (%)			
Asia-Pacific	143 (23.0)	75 (23.8)	65 (21.7)
Australia	2 (<1.0)	0	1 (<1.0)
Europe and Middle East	403 (64.7)	197 (62.5)	203 (68.0)
North America	75 (12.0)	43 (13.7)	30 (10.0)
SP263, n (%)			
TC <1%	289 (46.4)	134 (42.5)	151 (50.5)
TC 1-49%	177 (28.4)	101 (32.1)	75 (25.1)
TC ≥50%	157 (25.2)	80 (25.4)	73 (24.4)
Stage			
IB	71 (11.4)	39 (12.4)	25 (8.4)
IIA	178 (28.6)	85 (27.0)	91 (30.4)
IIB	106 (17.0)	53 (16.8)	53 (17.7)
IIIA	268 (43.0)	138 (43.8)	127 (42.5)

* All patients had ECOG PS 0.
† The atezolizumab and BSC arms do not add up to n=623 because nine patients who were randomized in the study did not receive any treatment.

Distribution of genomic alterations and co-occurrence patterns

- The distribution of genomic alterations and co-occurrence patterns were similar to expected non-squamous and squamous patterns in mNSCLC, except for lower prevalence of *STK11* (1.7%) and *KEAP1* (12%) genomic alterations (**Figure 2**)

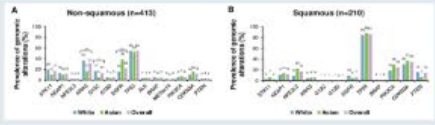
Figure 2. Distribution of genomic alterations and co-occurrence patterns in (A) non-squamous and (B) squamous tumors in eNSCLC



Genomic alterations associated with race by histology

- *KRAS* and *G12C* genomic alterations were associated with the White population while *EGFR* genomic alterations were associated with the Asian population in patients with non-squamous disease (adjusted $P<0.01$; **Figure 3**)

Figure 3. Genomic alterations associated with race by histology

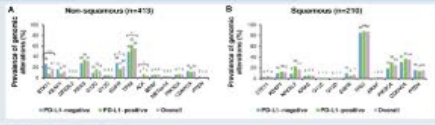


* $P<0.05$; ** $P<0.001$; *** $P<0.0001$.

Genomic alterations associated with PD-L1 TC SP263 status by histology

- In non-squamous disease, *STK11*, *EGFR*, and *KEAP1* genomic alterations were associated with increased prevalence in PD-L1–negative tumors, and *TP53* genomic alterations with PD-L1–positive tumors (adjusted $P<0.1$; **Figure 4**)

Figure 4. Genomic alterations associated with PD-L1 TC SP263 status by histology

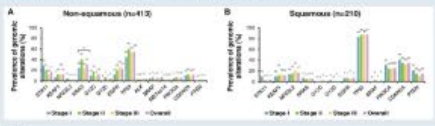


* $P<0.05$; ** $P<0.01$; *** $P<0.0001$.

Genomic alterations associated with disease stage status by histology

- In non-squamous disease, *KRAS* genomic alterations were associated with Stage II; *STK11* genomic alterations were associated with Stage I more than Stages II and III (adjusted $P<0.01$; **Figure 5**)

Figure 5. Genomic alterations associated with disease stage by histology

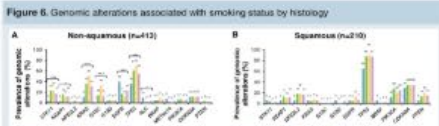


* $P<0.05$.

Genomic alterations associated with smoking status by histology

- In patients with non-squamous disease, increased enrichment of *KRAS*, *STK11*, *KEAP1*, and *TP53* genomic alterations were associated with previous or current smoking status, and *EGFR* gene alterations were enriched in those who never smoked (adjusted $P<0.01$; **Figure 6**)

Figure 6. Genomic alterations associated with smoking status by histology

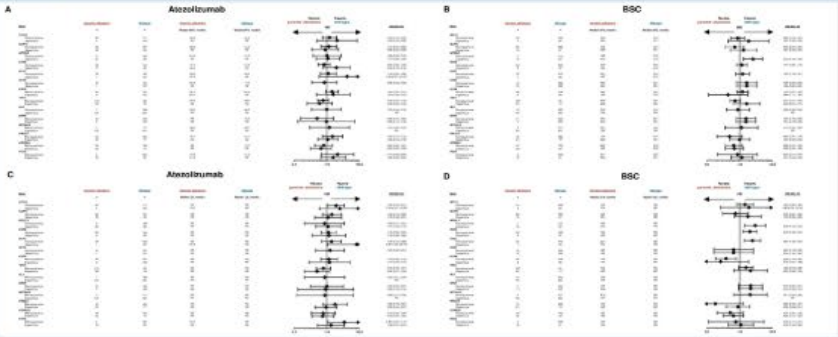


* $P<0.05$; ** $P<0.01$; *** $P<0.0001$.

Genomic alterations associated with survival outcomes in patients with tumors harboring genomic alterations vs patients with wild-type tumours assessed by treatment arm

- In patients with non-squamous disease, *BRAF* alterations were associated with DFS benefit in the atezolizumab arm (**Figure 7**)
- Where genomic alterations were a poor prognostic for both DFS and OS, this occured regardless of histology and in both the atezolizumab and BSC arms

Figure 7. Genomic alterations associated with (A and B) DFS and (C and D) OS in patients with tumors harboring genomic alterations vs patients with wild-type tumors assessed by treatment arm

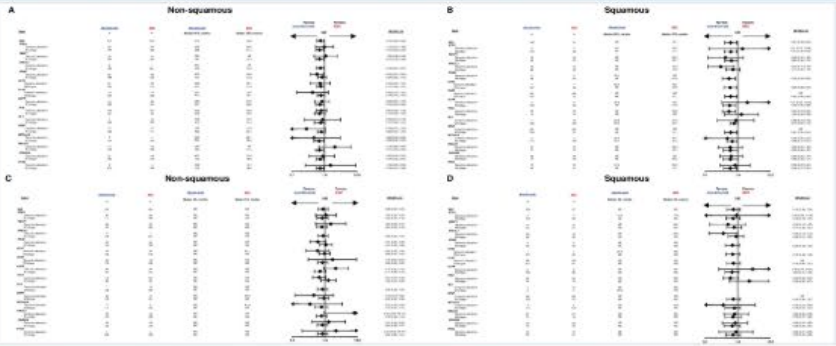


NA, not applicable; NE, not estimable.

Genomic alterations associated with survival outcomes in the atezolizumab vs BSC arms assessed by histology

- Regardless of histology, neither *STK11* or *KEAP1* genomic alterations were significantly associated with differential atezolizumab vs BSC DFS or OS benefit (interaction $P>0.05$; **Figure 8**)

Figure 8. Genomic alterations associated with (A and B) DFS and (C and D) OS in the atezolizumab vs BSC arms assessed by histology



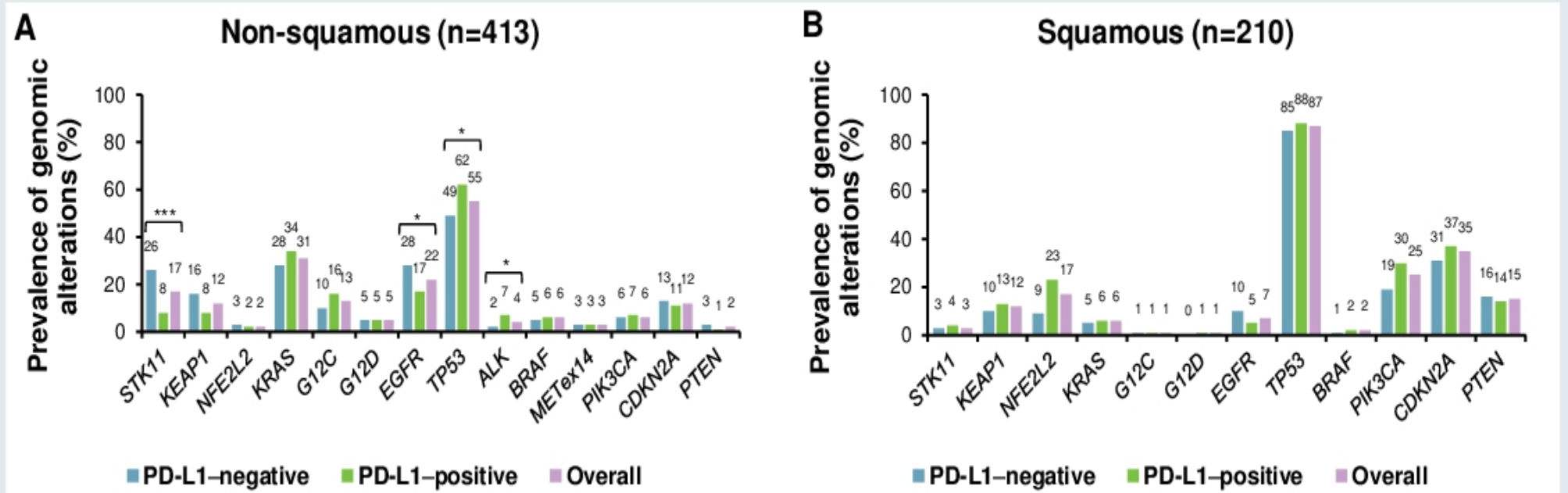
Presented at the American Society for Clinical Oncology (ASCO); May 30-June 3, 2025; Chicago, IL, USA

For more information on this poster, please contact Heather A. Wakelee at: hwakelee@stanford.edu

Novedades en CPNCP: Estadios Iniciales

Abstract: 8022. Poster #143

Genomic alterations associated with PD-L1 TC SP263 status by histology



CONCLUSIONS

- This analysis represents the largest dataset evaluating the genomic profile of patients with eNSCLC who were treated with cancer immunotherapy
- The prevalences of *STK11* and *KEAP1* genomic alterations were lower than in mNSCLC and were enriched for PD-L1–negative TCs in non-squamous NSCLC
- Unlike in mNSCLC, patients with tumors that harbored *KEAP1* genomic alterations did not have poor prognosis in IMpower010
- These data are hypothesis-generating and require validation in independent eNSCLC datasets with larger numbers

Presented at the American Society for Clinical Oncology (ASCO); May 30-June 3, 2025; Chicago, IL, USA

Novedades en CPNCP: Estadios Iniciales

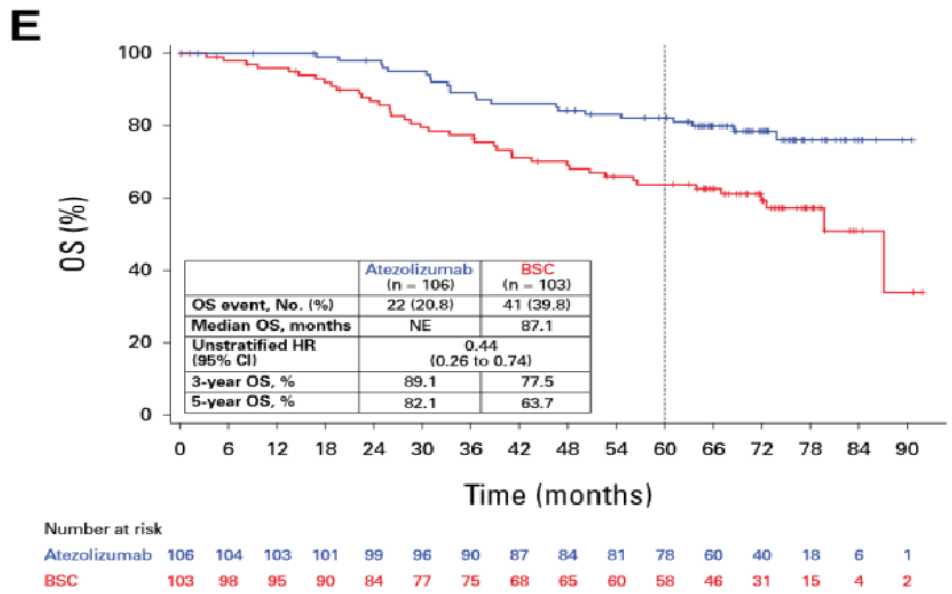
ASCO Journal of Clinical Oncology

Five-Year Survival Outcomes With Atezolizumab After Chemotherapy in Resected Stage IB-IIIA Non-Small Cell Lung Cancer (IMpower010): An Open-Label, Randomized, Phase III Trial

Enriqueta Felip[1], Nasser Altorki[2], Caicun Zhou[3], Eric Vallières[4], Tibor Csoszi[5], Ihor O Vynnychenko[6], Oleksandr Goloborodko[7], Achim Rittmeyer[8], Martin Reck[9], Alex Martinez-Marti[1], Hirotsugu Kenmotsu[10], Yuh-Min Chen[11], Antonio Chella[12], Shunichi Sugawara[13], Chengi Fu[14], Marcus Ballinger[14], Yu Deng[14], Minu K Srivastava[14], Elizabeth Bennett[14], Barbara J Gitlitz[14], Heather A Wakelee[15]; IMpower010 Study Investigators

	SLE	SG
ITT	0.85 (95% CI, 0.71 to 1.01; *P* = .07)	0.97 (95% CI, 0.78 to 1.22)
Estadio II-III-A	HR: 0.83 (95% CI, 0.69 to 1.00)	0.94 (95% CI, 0.75 to 1.19)
Estadio II-III-A PD-L1 ≥ 1%	HR: 0.70 (95% CI, 0.55 to 0.91	0.77 (95% CI, 0.56 to 1.06)
Estadio II-III-A PD-L1 ≥ 50% (EGFR/ALK wt)	HR: 0.49 (95% CI, 0.32 to 0.75)	HR: 0.44 (95% CI, 0.26 to 0.74).

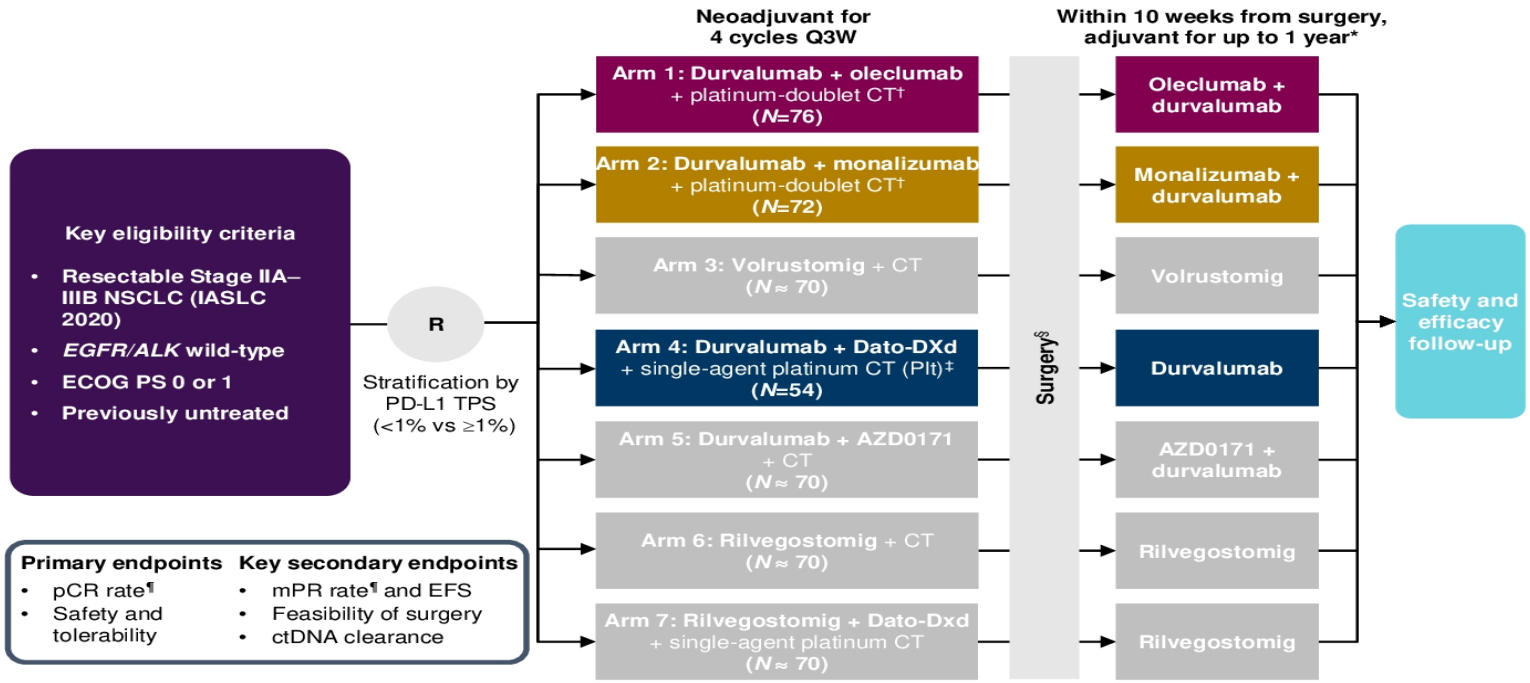
In conclusion, after a 5-year follow-up, atezolizumab did not show a statistically significant improvement in DFS in the ITT population. No improvement in OS was observed in the ITT population at this interim analysis; follow-up is continuing for another OS analysis. Results from the DFS final analysis and second OS interim analysis further support the use of adjuvant atezolizumab in PD-L1–selected patient populations.



Novedades en CPNCP: Estadios Iniciales

NeoCOAST-2 study design

Abstract: 8043. Poster Bd: #167

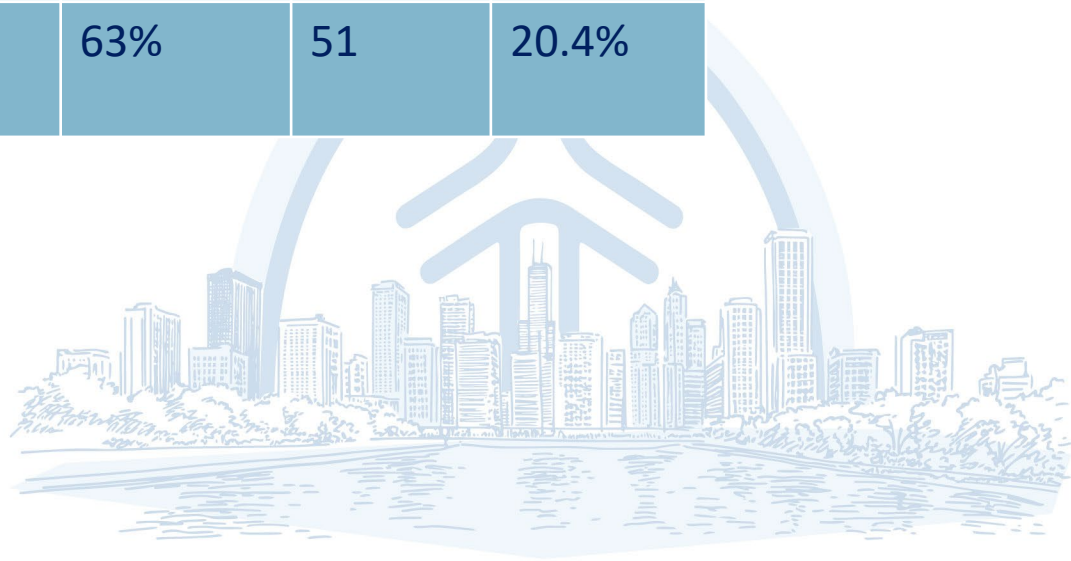


https://doi.org/10.1038/s41591-025-03746-z

Novedades en CPNCP: Estadios Iniciales

Abstract: 8043. Poster Bd: #167

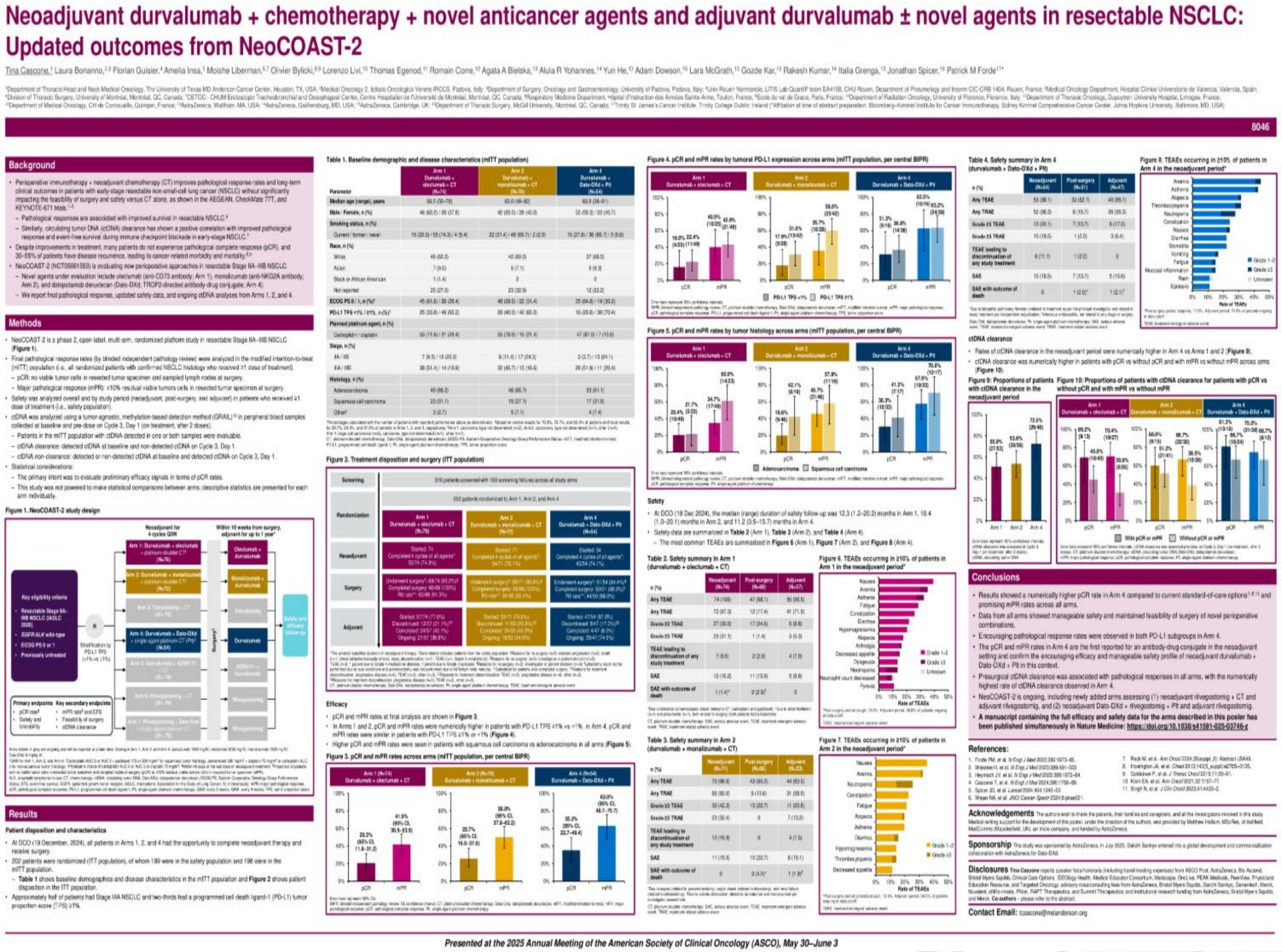
NeoCOAST 2	Fármacos	Mecanismo de acción (nuevo agente)	cPR	mPR	Operados	Seguridad ≥ 3
ARM 1 *n: 74*	N. Durvalumab+Oleclumab+ QT (2 agentes) A. D + O	Inhibidor de CD73	20.3%	41.9%	69	36.5%
ARM 2 *n:* 70	N. Durvalumab+Monalizumab+ QT (2 agentes) A. D +M	Inhibidor de NKG2A	25.7%	50%	66	40.8%
ARM 4 n: 54	N.Durvalumab+Datopotamab-Dxt + **Platino** **A. D**	ADC (TROP-2)	35.2%	63%	51	20.4%



Fuente: https://doi.org/10.1038/s41591-025-03746-z

Novedades en CPNCP: Estadios Iniciales

GeCP lung cancer research

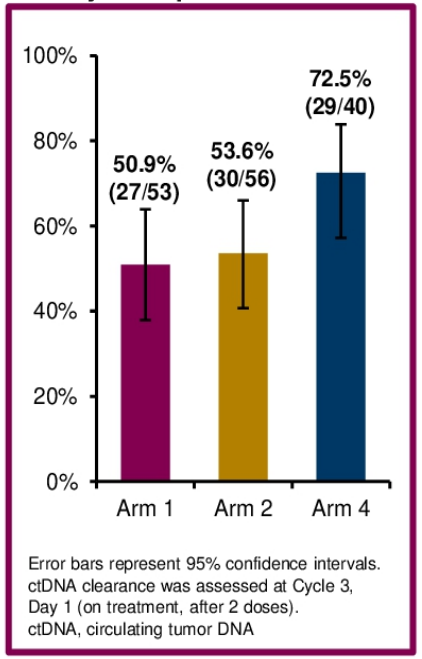


Novedades en CPNCP: Estadios Iniciales

ctDNA clearance

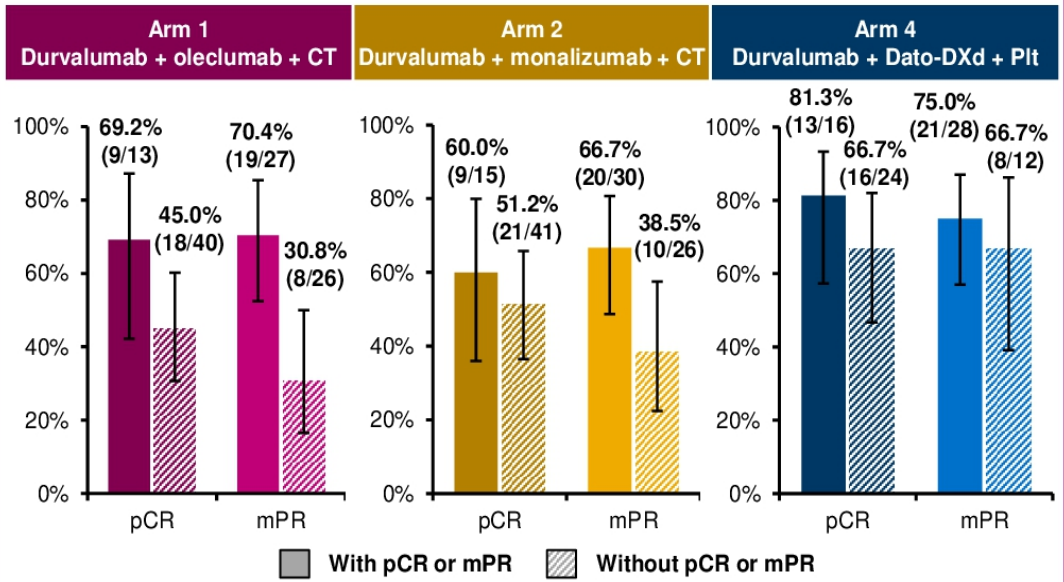
- Rates of ctDNA clearance in the neoadjuvant period were numerically higher in Arm 4 vs Arms 1 and 2 (**Figure 9**).
- ctDNA clearance was numerically higher in patients with pCR vs without pCR and with mPR vs without mPR across arms (**Figure 10**).

Figure 9: Proportions of patients with ctDNA clearance in the neoadjuvant period



Error bars represent 95% confidence intervals. ctDNA clearance was assessed at Cycle 3, Day 1 (on treatment, after 2 doses).
ctDNA, circulating tumor DNA

Figure 10: Proportions of patients with ctDNA clearance for patients with pCR vs without pCR and with mPR vs without mPR



Error bars represent 95% confidence intervals. ctDNA clearance was assessed pre-dose on Cycle 3, Day 1 (on treatment, after 2 doses). CT, platinum-doublet chemotherapy; ctDNA, circulating tumor DNA; Dato-DXd, datopotamab deruxtecan; mPR, major pathological response; pCR, pathological complete response; Plt, single-agent platinum chemotherapy

- Presurgical ctDNA clearance was associated with pathological responses in all arms, with the numerically highest rate of ctDNA clearance observed in Arm 4.
- NeoCOAST-2 is ongoing, including newly added arms assessing (1) neoadjuvant rilvegostomig + CT and adjuvant rilvegostomig, and (2) neoadjuvant Dato-DXd + rilvegostomig + Plt and adjuvant rilvegostomig.

Novedades en CPNCP: Estadios localmente avanzados

NeoCOAST 2	Fármacos	Mecanismo de acción (nuevo agente)	cRP	mPR	Operados	Seguridad ≥ 3	Aclaramiento de ctDNA (d+1 C3)
ARM 1 *n: 74*	Durvalumab+Oleclumab+ QT (2 agentes) ***A. D+ O***	Inhibidor de CD73	20.3%	41.9%	69	36.5%	50.9%
ARM 2 *n:* 70	Durvalumab+Monalizumab + QT (2 agentes) ***A. D+M***	Inhibidor de NKG2A	25.7%	50%	66	40.8%	53.6%
ARM 4 n: 54	Durvalumab+Datopotamab-Dxt+**Platino** ***A. D***	ADC (TROP-2)	35.2%	63%	51	20.4%	72.5%

Fuente: https://doi.org/10.1038/s41591-025-03746-z

Novedades en CPNCP: Estadios Iniciales

En resumen:

- Claro beneficio de la IO en Neoadyuvancia: CM 816 (HR, 0.72)

- Perioperatorio CM 77T: Impacta en SLE (HR, 0.61).

Aclaramiento de ct DNA/Respuesta patológica: impacto en SLE.

- NeoADAURA: Osimertinib en neoadyuvancia: datos inmaduros en cuento a supervivencia, pero mejoría en mPR

- ALNEO: Fase II: Perioperatorio con Alectinib, mejoría en mRP

- IMpower 010: Datos a 5 años, no se alcanzan el número de eventos, beneficio para Atezolizumab adyuvante.

- NeoCOAST-2: ADC: Datopotamab/Deruxtecan + Durvalumab + Platino: Mejora la mPR, pCR, esquema seguro, mayor aclaramiento de ctDNA y respuesta patológica.

Fuente: https://doi.org/10.1038/s41591-025-03746-z

Lung Cancer
UPDATES
ASCO HIGHLIGHTS
30 MAYO - 03 JUNIO 2025
Chicago, USA

Iniciativa científica de:
GECP
lung cancer research

¡GRACIAS !!

Novedades en CPNCP: Estadios Iniciales

Abstract:8009

	Todos los pts	Estadio II	Estadio III	Escamoso	No escamoso	PD-L1 < 1%	PD-L1 ≥ 1%
	NIVO (N = 229) vs PBO(N = 232)	**NIVO (n = 80) vs PBO (n = 81)**	**NIVO (n = 149) vs PBO (n = 149)**	**NIVO (n = 116) vs PBO (n = 118)**	**NIVO (n = 113) vs PBO (n = 114)**	**NIVO (n = 93) vs PBO (n = 93)**	**NIVO (n = 128) vs PBO (n = 128)**
Mediana de EFS, meses	46.6 frente a 16.9	NR vs NR	42.1 frente a 13.4	NR vs 16.4	40,1 frente a 16,9	40,1 frente a 19,8	46,6 frente a 15,1
HR (IC 95%)	0,61 (0,46–0,80)	0,77 (0,46–1,30)	0,54 (0,39–0,74)	0,53 (0,35–0,80)	0,69 (0,48–1,00)	0,79 (0,52–1,21)	0,53 (0,36–0,76)

Fuente: Abstract:LBA8010