Iniciativa científica de:

GECP lung cancer research

Lung Cancer UPDATES

ASCO HIGHLIGHTS

29 MAYO - 02 JUNIO 2026

Chicago, USA

#ASCOUPDATES

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Novedades en Cáncer Microcítico de Pulmón

Carlos Aguado

Hospital Clínico San Carlos

Iniciativa científica de:

GECP lung cancer research

CPCP

- Localizado
- Metastásico
  - 1L: RT, Radiofármacos
  - 2L: ADCs, CAR-T, Tarlatamab, IT
  - Biomarcadores (Imforte)

2026 ASCO ANNUAL MEETING

Iniciativa científica de: GECP lung cancer research

Autologous natural killer cell infusion as consolidation therapy after first-line chemoradiotherapy for limited-stage small-cell lung cancer: A cohort analysis of a randomized phase II study (NCT03410368)

Jiuwei Cui the First Hospital of Jilin University

On behalf of investigators: Xiao Chen, Rilan Bai , Wei Song, Jin Lu, Huimin Tian, Chao Niu, Hua He, Naifei Chen,Ziling Liu, Kewei Ma, Xiaofeng Cong, Xi Li, Dan Li, Xu Wang, Kaidan Chi, Guanran Ding, Ruotong Shi, Yibo Wang, Ruohan Yang, Zehao Li

*All investigators are from the First Hospital of Jilin University

Prof. Jiuwei Cui Email: cuijw@jlu.edu.cn

Iniciativa científica de:

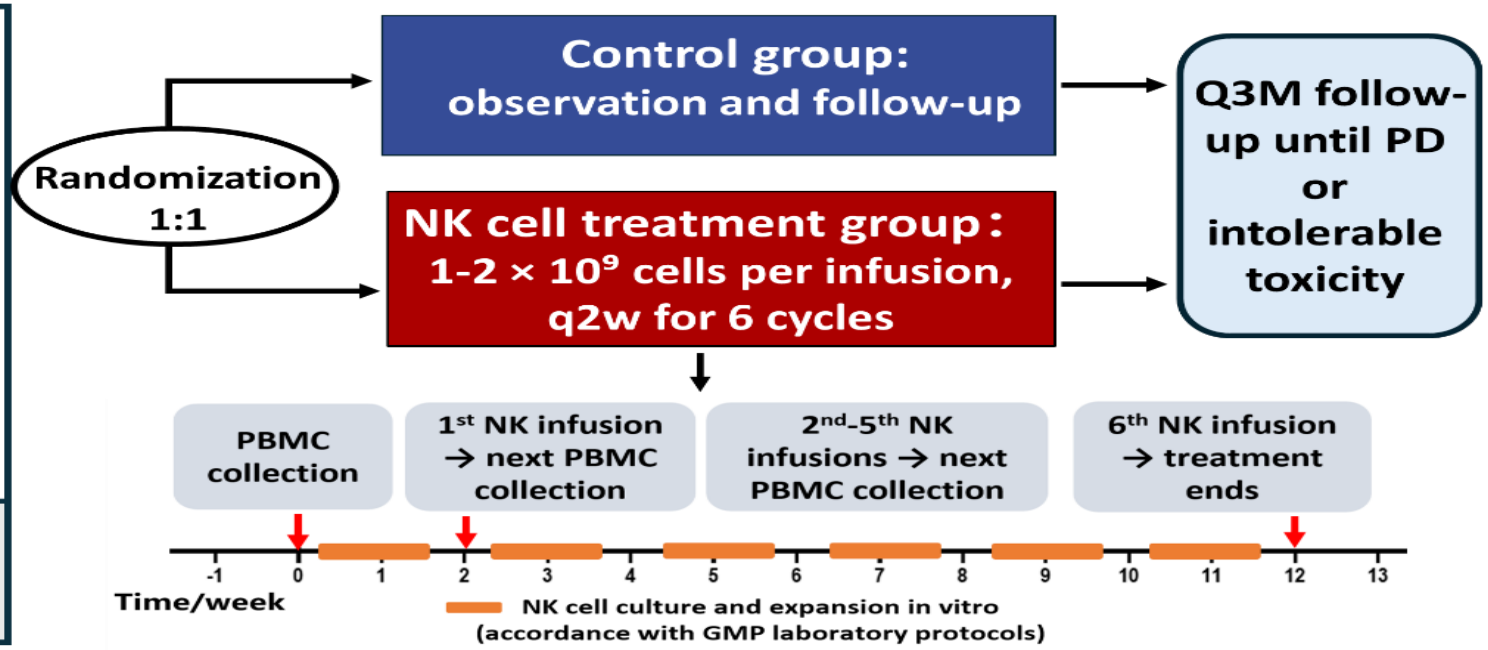
A cohort analysis of limited-stage patients from a randomized, controlled, phase II clinical trial of NK cell-based immunotherapy as consolidation/maintenance therapy for SCLC (NCT03410368)

Key Eligibility Criteria

- Patients with pathologically diagnosed LS-SCLC;
- Patients who have completed standard first-line chemoradiotherapy with efficacy evaluation of CR, PR, or SD;
- Age ≥ 18 years;
- ECOG PS 0 or 1;
- Adequate organ function;
- Hemoglobin (Hgb) ≥ 60 g/L;
- No contraindications for apheresis and cell separation;

Stratification factors

- TNM stage (I-II or III)
- Prophylactic cranial irradiation (yes or no)



End points

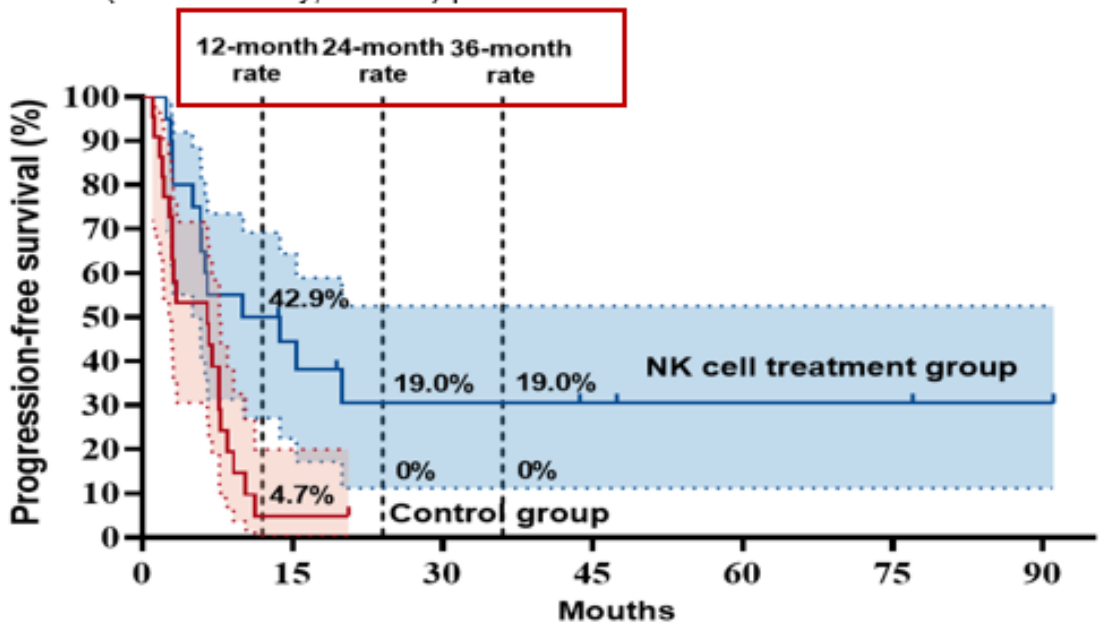
- **Primary:** PFS
- **Secondary:** OS, 12- and 24-month PFS rate, 24- and 36-month OS rates and safety.

PFS, progression-free survival; PD, progressive disease; OS, overall survival; ECOG, Eastern Cooperative Oncology Group; TNM, tumor node metastasis; AEs, adverse events; GMP, Good Manufacturing Practice Laboratory, RECIST v1.1, Response Evaluation Criteria in Solid Tumors version 1.1; ITT, intention-to-treat; PP, per-protocol; NK, natural killer; LS-SCLC, limited-stage small-cell lung cancer; SD, stable disease; CR, complete response; PR, partial response;

Iniciativa científica de:

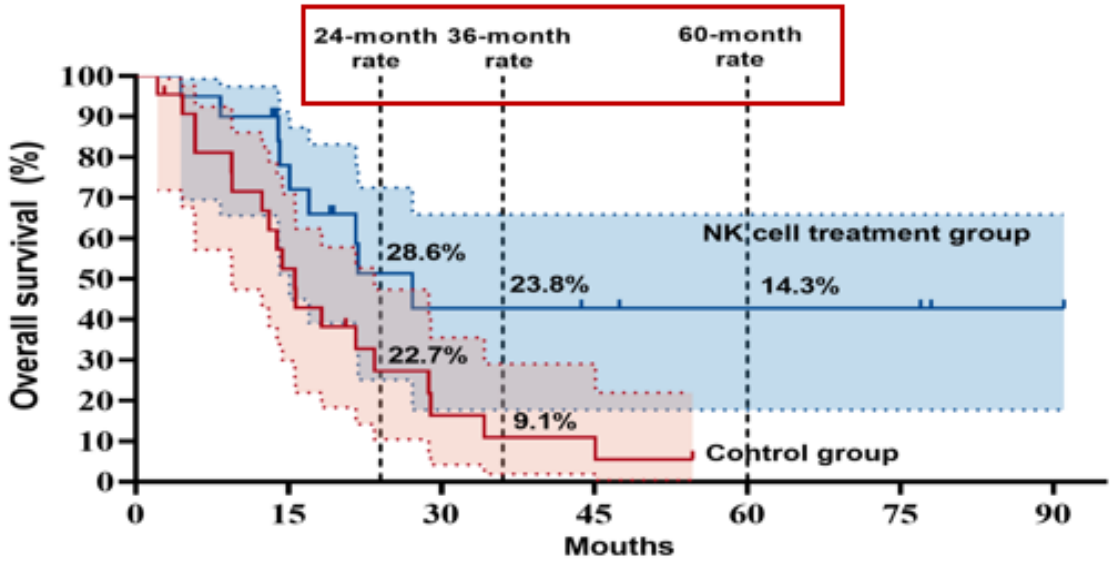
GECP lung cancer research

33/43 (data maturity, 76.7%) patients had PD



	No. of Events/ Total No. (%)	Median, mouths
NK cell treatment group (n=21)	13/21 (61.9)	11.9
Control group (n=22)	20/22 (90.9)	6.5

28 out of 43 (data maturity, 65.1%) patients had died



	No. of Deaths/ Total No. (%)	Median, mouths
NK cell treatment group (n=21)	9/21 (42.9)	27.1
Control group (n=22)	19/22 (86.4)	15.6

* Stratified hazard ratio for death, HR 0.41 (95%CI 0.19-0.87), P = 0.02

Events	NK cell treatment group (N=19)		Control group (N=21)	
	Any Grade	Grade 3 or 4	Any Grade	Grade 3 or 4
	number of patients (percent)			
Any adverse event of any cause	10 (52.6)	2 (10.5)	11 (52.4)	3 (14.3)
Any event leading to discontinuation	0	0	0	0
Abnormal lung function				
Radiation pneumonitis	1 (5.3)	1 (5.3)	2 (9.5)	0
Abnormal liver function				
Hypoalbuminemia	3 (15.8)	0	4 (19.0)	0
Total bile acid increased	1 (5.3)	0	2 (9.5)	0
Aspartate aminotransferase increased	1 (5.3)	0	1 (4.8)	0
Gamma glutamyl transpeptidase increased	1 (5.3)	0	0	0
Abnormal renal function				
Creatinine increased	1 (5.3)	0	1 (4.8)	0
Uric acid increased	1 (5.3)	0	1 (4.8)	0
Urine protein	1 (5.3)	0	0	0
Urinary tract infection	1 (5.3)	0	1 (4.8)	0
Cardiac function abnormal				
Occasional ventricular/atrial extrasystoles	1 (5.3)	0	0	0
Abnormal glucose and lipid metabolism				
Cholesterol increased	1 (5.3)	0	0	0
Triglyceride increased	3 (15.8)	1 (5.3)	2 (9.5)	0
Low-density lipoprotein cholesterol increased	3 (15.8)	0	2 (9.5)	0
Low-density lipoprotein increased	1 (5.3)	0	2 (9.5)	0
Blood system disorders				
Anemia	3 (15.8)	0	6 (28.6)	0
Thrombocytopenia	1 (5.3)	0	1 (4.8)	0
Lymphocyte count decreased	1 (5.3)	0	0	0
Leukopenia/neutropenia	3 (15.8)	0	9 (42.9)	3 (14.3)
Otitis media secretory				
Otitis media with effusion	1 (5.3)	0	0	0

In the safety-analysis set, the incidence of any-grade AEs **52.6% (10/19)** in the treatment group and **52.4% (11/21)** in the observation group, most grade 1–2.

(ITT, 50.0% [11/22] in the observation group and 47.6% [10/21]) in the treatment group;

*The safety-analysis-set included all the patients who had received at least one dose of a trial drug or been followed up at least once. Some patients had more than one adverse event.

2026 ASCO® ANNUAL MEETING

Iniciativa científica de: GECP lung cancer research

Concurrent thoracic radiotherapy, chemotherapy and durvalumab in ES SCLC - a phase III trial

Bjørn Henning Grønberg,[1,2*] Daphne W. Dumoulin,[2] Kersti Oselin,[3] Luigi De Petris,[4] Kirill Neumann,[5] Tesfaye Madebo,[6] Marianne Aanerud,[7] Tarje Onsøien Halvorsen,[1,2] Johan Isaksson,[8] Maria Moksnes Bjaanæs,[9] Daniel Heinrich,[10] Odd Terje Brustugun,[11] Atle Totland,[12] Siv Gyda Aanes,[13] Øyvind Yksnøy,[14] Andreas Hallqvist,[15] Örvar Gunnarsson,[16] Terje Skraastad,[17] Emelie Gezelius,[18] Arne Solberg,[1,2] Kristin Toftaker Killingberg[1,2]

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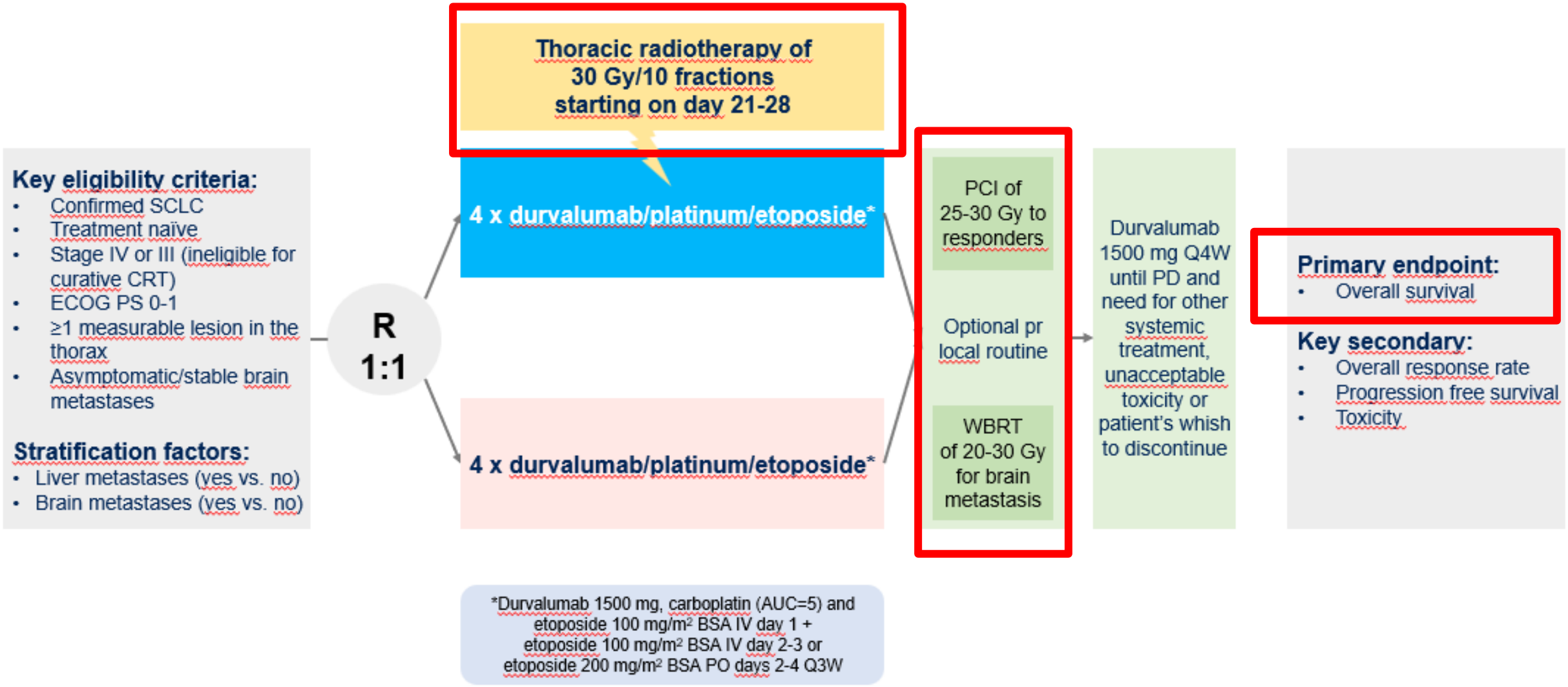
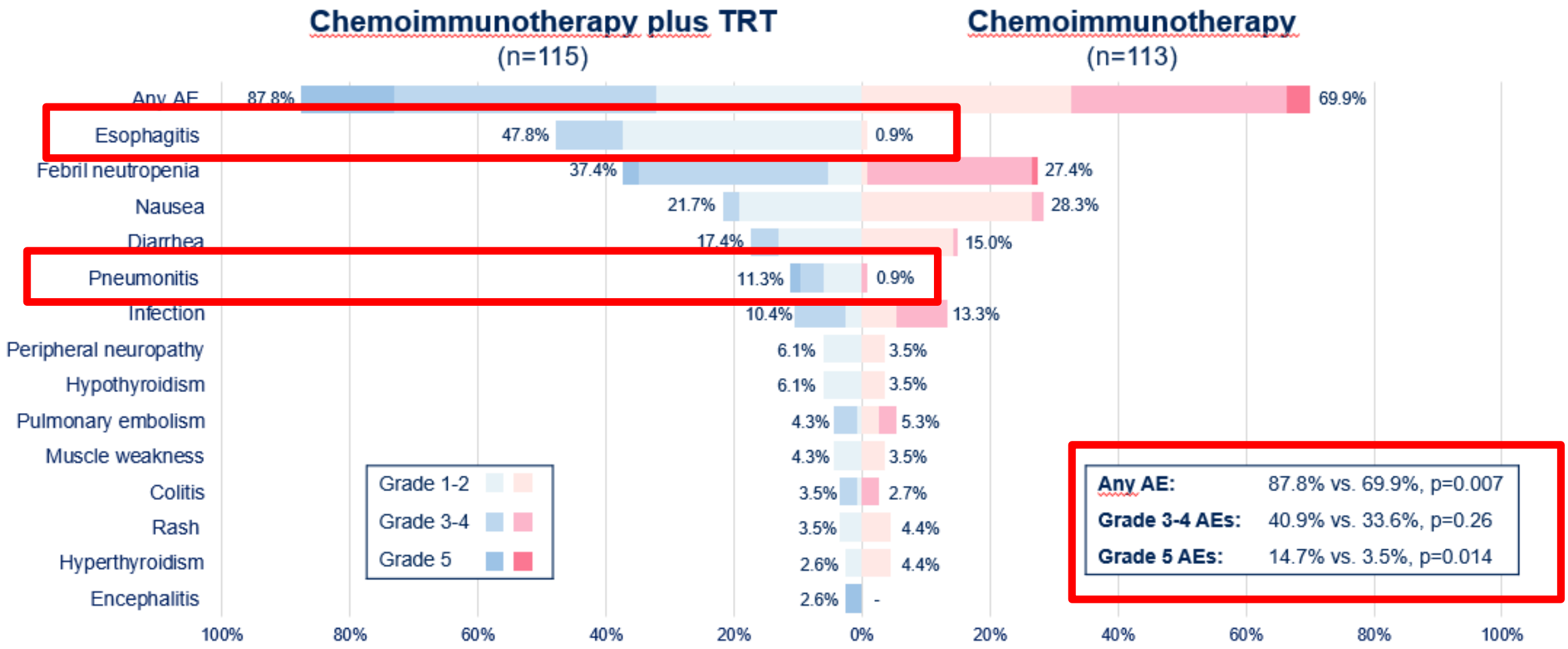
Study design



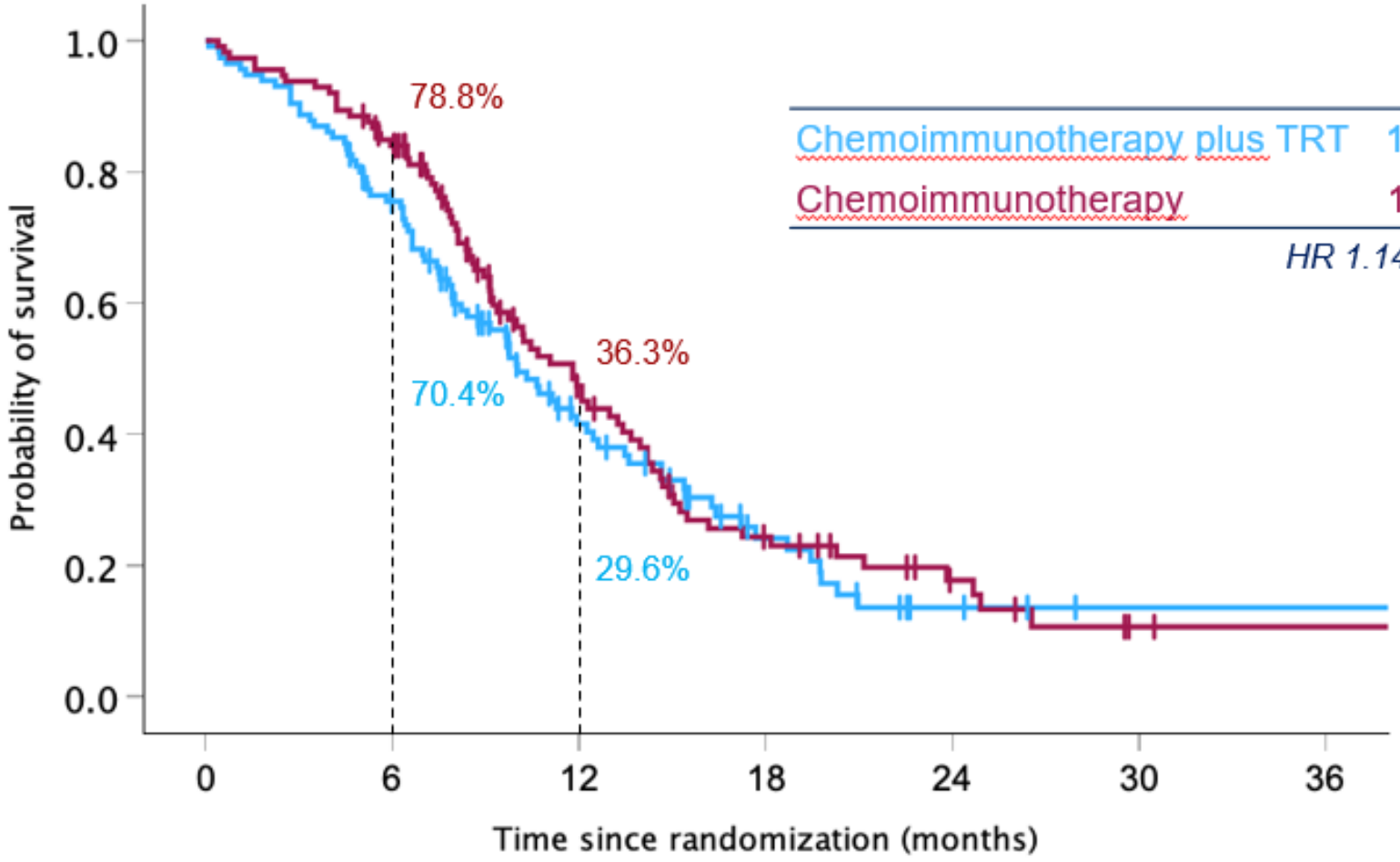
Response rates

	Chemoimmunotherapy plus TRT (n=115)		Chemoimmunotherapy (n=113)		
	n	%	n	%	
Overall response rate	91	79.1%	95	84.1%	p=0.34
Complete response	5	4.3%	3	2.7%	
Partial response	86	74.8%	92	81.4%	
Stable disease	8	7.0%	9	8.0%	
Progressive disease	5	4.3%	2	1.8%	
Not evalutated	11	9.6%	7	6.2%	

Most frequent adverse events



Overall survival



	Median	95% CI
Chemoimmunotherapy plus TRT	10.0 months	8.3 – 11.7
Chemoimmunotherapy	11.8 months	10.0 – 13.6

HR 1.14, 95% CI 0.84 – 1.56, p=0.40

Number at risk (censored)

Chemoimmunotherapy plus TRT	115	83 (4)	35 (18)	14 (26)	4 (30)	1 (33)	1 (34)
Chemoimmunotherapy	113	92 (3)	41 (19)	18 (23)	8 (29)	2 (32)	1 (34)

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Phase Ib results from the Phase Ib/II study of [^{177}Lu]Lu-DOTA-TATE in combination with standard of care as a first-line treatment for patients with extensive-stage small cell lung cancer

Stephen V. Liu MD,[1] Pedro Rocha MD, PhD, MSc,[2] Ken Herrmann MD,[3] Luis G. Paz-Ares MD, PhD,[4] David Planchard MD, PhD,[5] Alexis B. Cortot MD, PhD,[6] Xavier Quantin,[7] Antonio Calles MD, MSc,[8] David Taïeb MD, PhD,[9] Afshin Dowlati MD,[10] Martin Joseph Edelman MD,[11] Inna Ospovat,[12] Martin Gutierrez MD,[13] Ajay Mehta FRCR, MRCP,[14] Medhat Osman MD,[15] Riccardo Belli,[16] Yongmin Liu MSc,[17] Krishna Tulasi Kirla PhD,[18] Zhonglin Hao MD, PhD[19]

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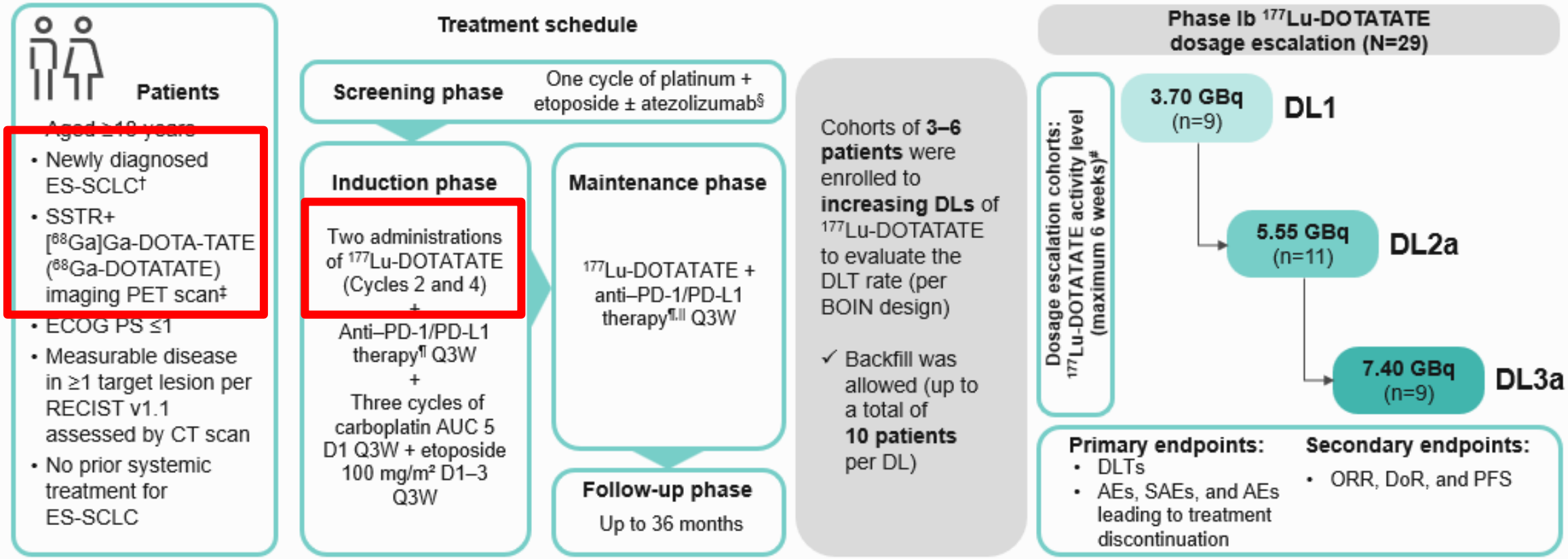
Oral presented at the American Society of Clinical Oncology (ASCO) Annual Meeting 2026 | 29 May–2 June 2026 | Chicago, IL, US.

The Phase Ib part of this Phase Ib/II study aimed to determine the RD* of ^{177}Lu-DOTATATE in patients with ES-SCLC



*Based on the MTD (highest dosage not expected to cause DLTs in >25% of treated patients); †Histologically/cytologically confirmed ES-SCLC per AJCC Cancer Staging Manual 8th edition: Stage IV (T any, N any, M1a/b/c) or T3–4 due to multiple/extensive lung nodules or tumor/nodule/lymph node volume too large for a tolerable radiation plan; ‡SSTR uptake ≥ liver uptake (visual score ≥2 in ≥1 target/non-target lesion); §Atezolizumab was administered during screening only after PA02; ¶Pre-/post-PA02: tislelizumab 200 mg/atezolizumab 1200 mg on D1, respectively; ‖A cumulative maximum dosage of 55.5 GBq was permitted if specific criteria were met; #DLT assessment period was 42 days from ^{177}Lu-DOTATATE initiation.

AE, adverse event; AJCC, American Joint Committee on Cancer; AUC, area under the curve; BOIN, Bayesian Optimal Interval; CT, computed tomography; D, day; DL, dosage level; DLT, dosage-limiting toxicity; DoR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; ES-SCLC, extensive-stage small cell lung cancer; MTD, maximum tolerated dosage; ORR, objective response rate; PA02, protocol amendment 2; PD-1, programmed cell death protein 1; PD-L1, programmed cell death protein ligand 1; PET, positron emission tomography; PFS, progression-free survival; Q3W, every 3 weeks; RD, recommended dosage; RECIST v1.1, Response Evaluation Criteria in Solid Tumors version 1.1; SAE, serious adverse event; SSTR, somatostatin receptor; SSTR+, somatostatin receptor-positive.

Oral presented at the American Society of Clinical Oncology (ASCO) Annual Meeting 2026 | 29 May–2 June 2026 | Chicago, IL, US.

The most frequent AEs were anemia and thrombocytopenia

Preferred term,*,† n (%)	DL1 (n=9)		DL2a (n=11)		DL3a (n=9)		All (N=29)	
	All grades	Grade ≥3	All grades	Grade ≥3	All grades	Grade ≥3	All grades	Grade ≥3
Patients with ≥1 AE, regardless of causality	9 (100)	9 (100)	11 (100)	11 (100)	9 (100)	9 (100)	29 (**100**)	29 (**100**)
Anemia	8 (88.9)	3 (33.3)	6 (54.5)	2 (18.2)	6 (66.7)	5 (55.6)	20 (**69.0**)	10 (**34.5**)
Thrombocytopenia	6 (66.7)	6 (66.7)	7 (63.6)	5 (45.5)	7 (77.8)	7 (77.8)	20 (**69.0**)	18 (**62.1**)
Nausea	6 (66.7)	0	7 (63.6)	0	2 (22.2)	0	15 (**51.7**)	0
Neutropenia	2 (22.2)	0	6 (54.5)	5 (45.5)	6 (66.7)	4 (44.4)	14 (**48.3**)	9 (**31.0**)
Lymphopenia	2 (22.2)	1 (11.1)	3 (27.3)	3 (27.3)	6 (66.7)	5 (55.6)	11 (**37.9**)	9 (**31.0**)
Asthenia	2 (22.2)	0	4 (36.4)	0	4 (44.4)	1 (11.1)	10 (**34.5**)	1 (**3.4**)
Alopecia	3 (33.3)	0	4 (36.4)	0	1 (11.1)	0	8 (**27.6**)	0
Fatigue	3 (33.3)	0	2 (18.2)	0	3 (33.3)	0	8 (**27.6**)	0
Gamma-glutamyltransferase increased	2 (22.2)	0	3 (27.3)	0	2 (22.2)	1 (11.1)	7 (**24.1**)	1 (**3.4**)
Hypomagnesemia	3 (33.3)	0	4 (36.4)	0	0	0	7 (**24.1**)	0
Diarrhea	3 (33.3)	0	1 (9.1)	0	2 (22.2)	0	6 (**20.7**)	0
Dyspnea	1 (11.1)	0	3 (27.3)	0	2 (22.2)	0	6 (**20.7**)	0
Hyponatremia	1 (11.1)	0	1 (9.1)	1 (9.1)	4 (44.4)	4 (44.4)	6 (**20.7**)	5 (**17.2**)
Leukopenia	2 (22.2)	1 (11.1)	3 (27.3)	3 (27.3)	1 (11.1)	1 (11.1)	6 (**20.7**)	5 (**17.2**)
Lymphocyte count decreased	5 (55.6)	5 (55.6)	1 (9.1)	1 (9.1)	0	0	6 (**20.7**)	6 (**20.7**)
Platelet count decreased	1 (11.1)	0	3 (27.3)	1 (9.1)	2 (22.2)	1 (11.1)	6 (**20.7**)	2 (**6.9**)
Pyrexia	2 (22.2)	0	2 (18.2)	0	2 (22.2)	0	6 (**20.7**)	0
White blood cell count decreased	4 (44.4)	3 (33.3)	1 (9.1)	0	1 (11.1)	1 (11.1)	6 (**20.7**)	4 (**13.8**)

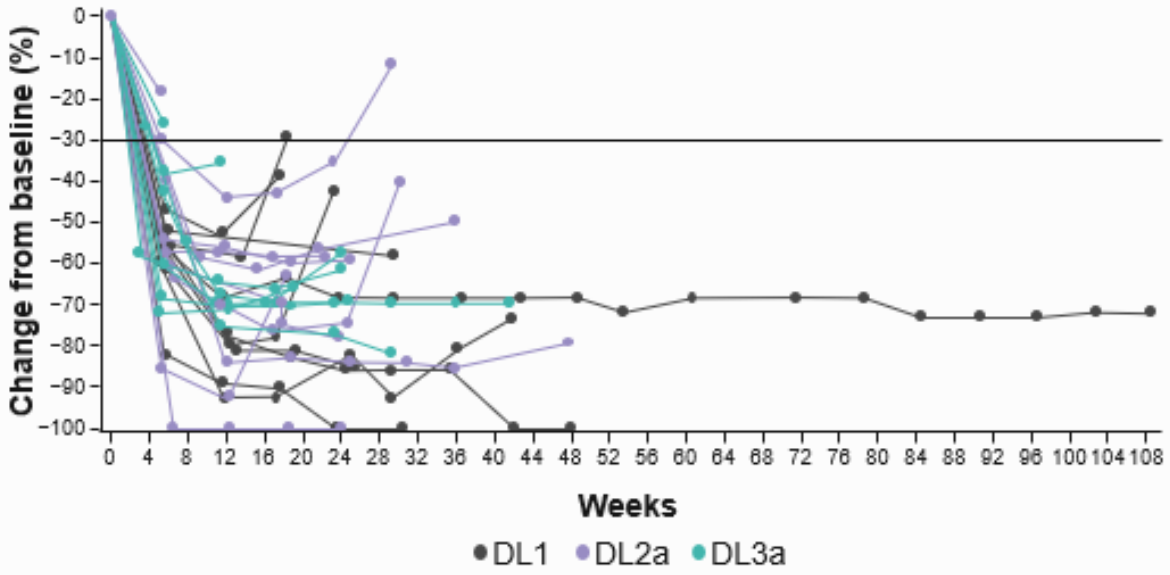
Anemia and thrombocytopenia were also the most common ^{177}**Lu-DOTATATE–related AEs** (44.8% and 58.6%, respectively)

*AEs occurring in >20% of the total patient population during treatment or within 56 days of the last study treatment; †MedDRA v28.1.
AE, adverse event; DL, dosage level; MedDRA, Medical Dictionary for Regulatory Activities.

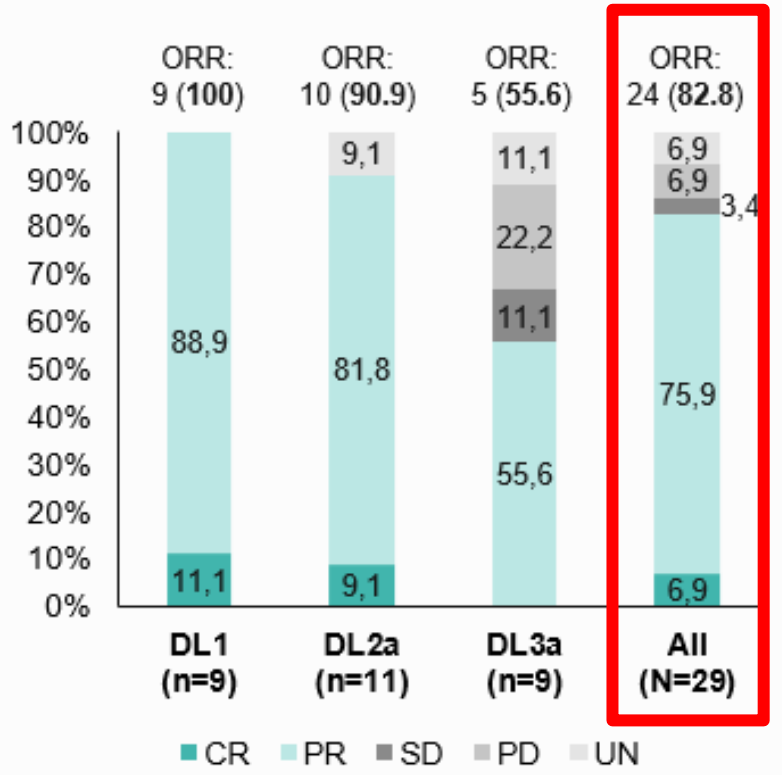
Oral presented at the American Society of Clinical Oncology (ASCO) Annual Meeting 2026 | 29 May–2 June 2026 | Chicago, IL, US.

Preliminary efficacy data of ^{177}Lu-DOTATATE in combination with chemotherapy and immunotherapy in ES-SCLC*

Spider plot of percentage change in total tumor size (sum of target lesions) over time



Confirmed best overall response†



- **6-month PFS rate: 36.1% (95% CI 19.0, 53.6)**
- **6-month DoR rate: 28.5% (95% CI 11.8, 47.7)**

*Data cut-off: 20 Nov 2025; †ORR is presented as n (%).
CI, confidence interval; CR, complete response; DL, dosage level; DoR, duration of response; ES-SCLC, extensive-stage small cell lung cancer; ORR, objective response rate; PD, progressive disease; PFS, progression-free survival; PR, partial response; SD, stable disease; UN, unknown.

Oral presented at the American Society of Clinical Oncology (ASCO) Annual Meeting 2026 | 29 May–2 June 2026 | Chicago, IL, US.

2026 ASCO ANNUAL MEETING

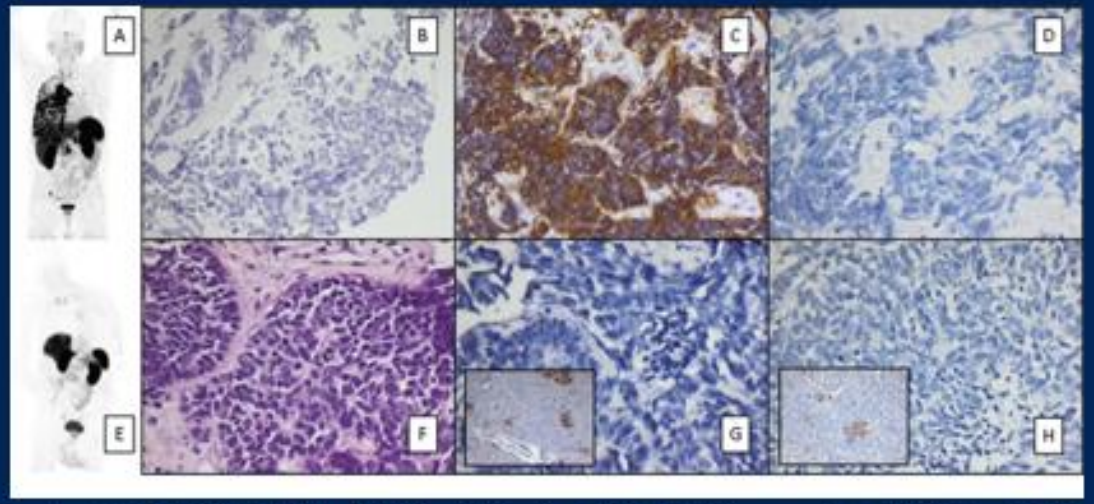
LuSato-1: Phase I study of ^{177}Lu-SSO110 with ^{68}Ga-SSO120 companion imaging in patients with extensive stage small cell lung cancer (ES-SCLC) on maintenance treatment with immune checkpoint inhibition (ICI)

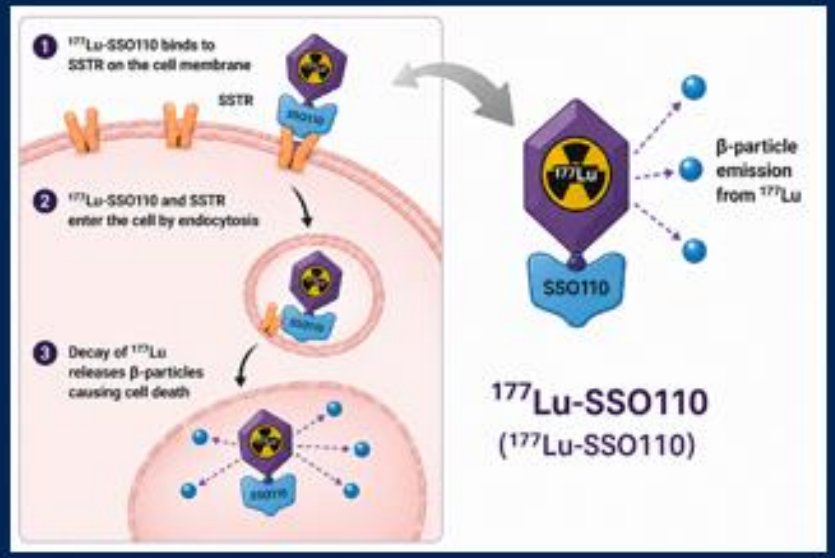
Surein Arulananda, Richard Pham, Aviral Singh, Muhamad Khattak, Peter Lin, Abhijit Pal, Udit Nindra, Chong G Chew, Nimit Singhal, Stanley Ngai, Kenneth O'Byrne, Louise Emmett, Venessa Chin, Shakher Ramdave, Rodney Hicks, Jessica K Preston, Pierre Jordaan, Germo Gericke, Giuseppe Cardaci

Speaker: A/Prof Surein Arulananda, MBBS, PhD, Monash Health, Melbourne, Australia

Background – Radiopharmaceutical Therapy (RPT)

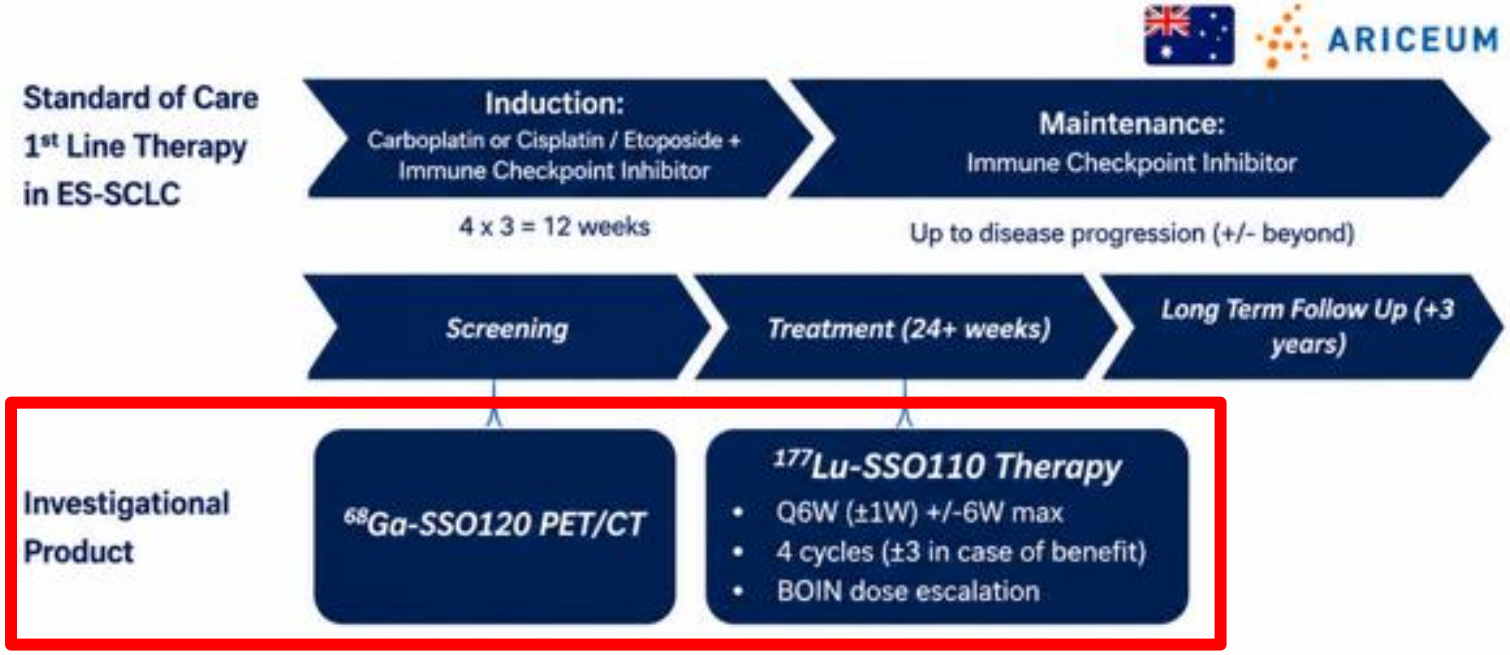
- RPT uses tumour-specific ligands to deliver therapeutic radiation directly to cancer cells
- Lutetium-177 is a β-emitter, and approved for NETs (^{177}Lu-DOTA-TATE) and CRPC (^{177}Lu-PSMA)
- ^{177}Lu-SSO110 (Satreotide tetraxetan) is a novel SSTR antagonist, with a more pronounced cytotoxic treatment effect compared to SSTR agonists (^{177}Lu-DOTA-TATE)[1,2]
- ^{177}Lu-SSO110 had an acceptable safety profile and promising clinical response in patients with SSTR positive NETs[3]





1. Lapa, C et al. Oncotarget, 2016. 2.Wild, D et al. Eur J Nucl Med Mol Imaging, 2024. 3. Reidy-Lagunes D, et al. J Clin Oncol, 2019.

Study Design, Key Eligibility



PRIMARY ENDPOINTS

- Safety and tolerability of ^{177}Lu-SSO110 and ^{68}Ga-SSO120
- RP2D of ^{177}Lu-SSO110

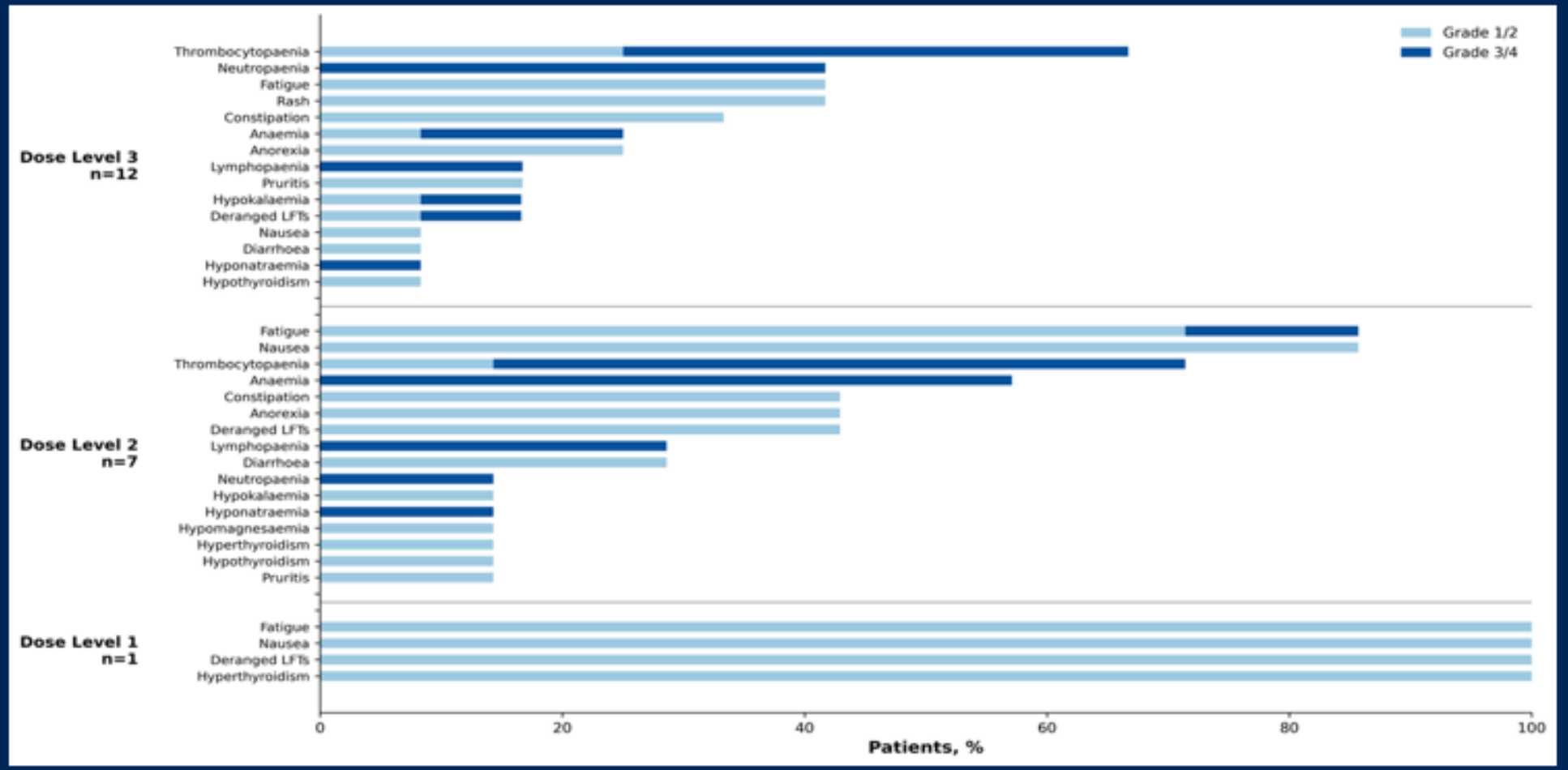
SECONDARY ENDPOINTS

- Efficacy of ^{177}Lu-SSO110 (including PFS and OS)

KEY ELIGIBILITY CRITERIA

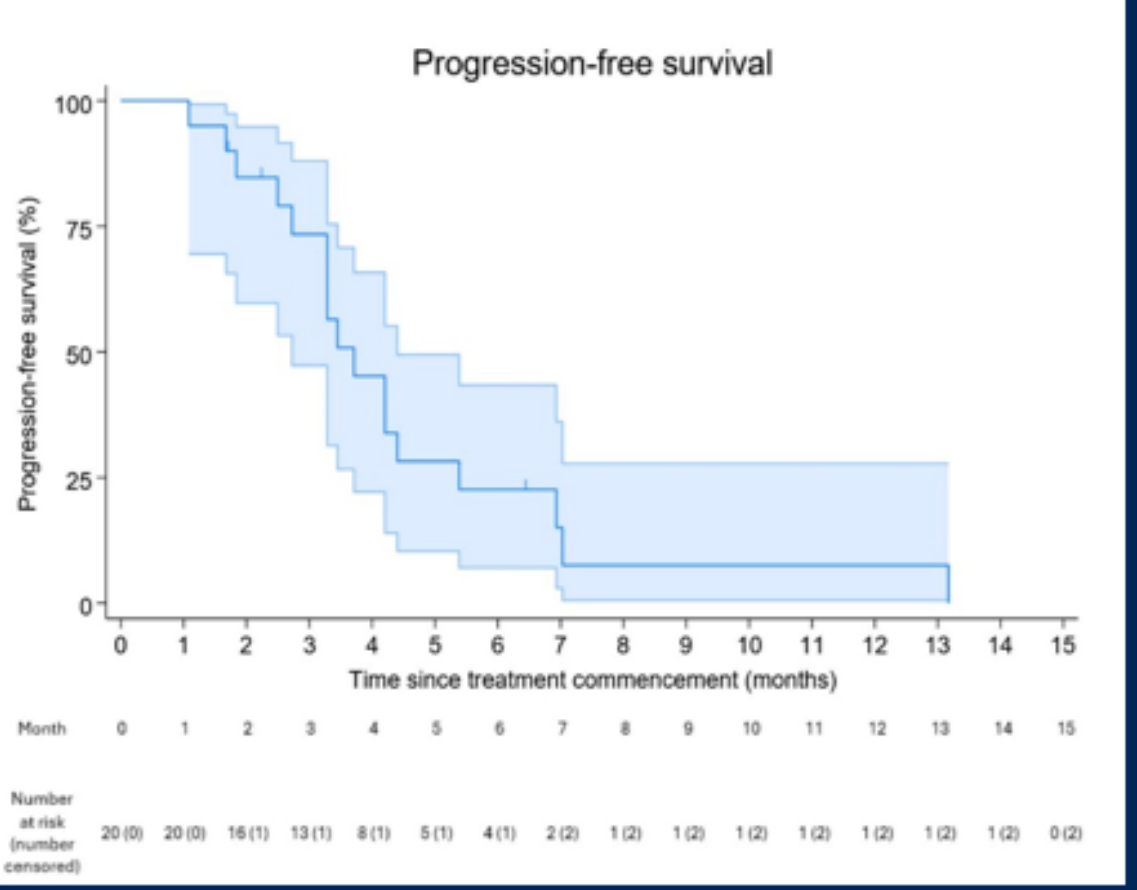
- Histologically or cytologically proven ES-SCLC
- Positive ^{68}Ga-SSO120 scan at screening
- Completed induction therapy with platinum, etoposide and ICI, and be eligible for maintenance ICI therapy
- Brain metastases deemed clinically and radiologically stable
- Excluded any Grade >3 irAE during prior or current therapy
- High risk of bleeding due to uncontrolled coagulopathies or unstable vascular malformations were excluded

AEs by Dose Levels

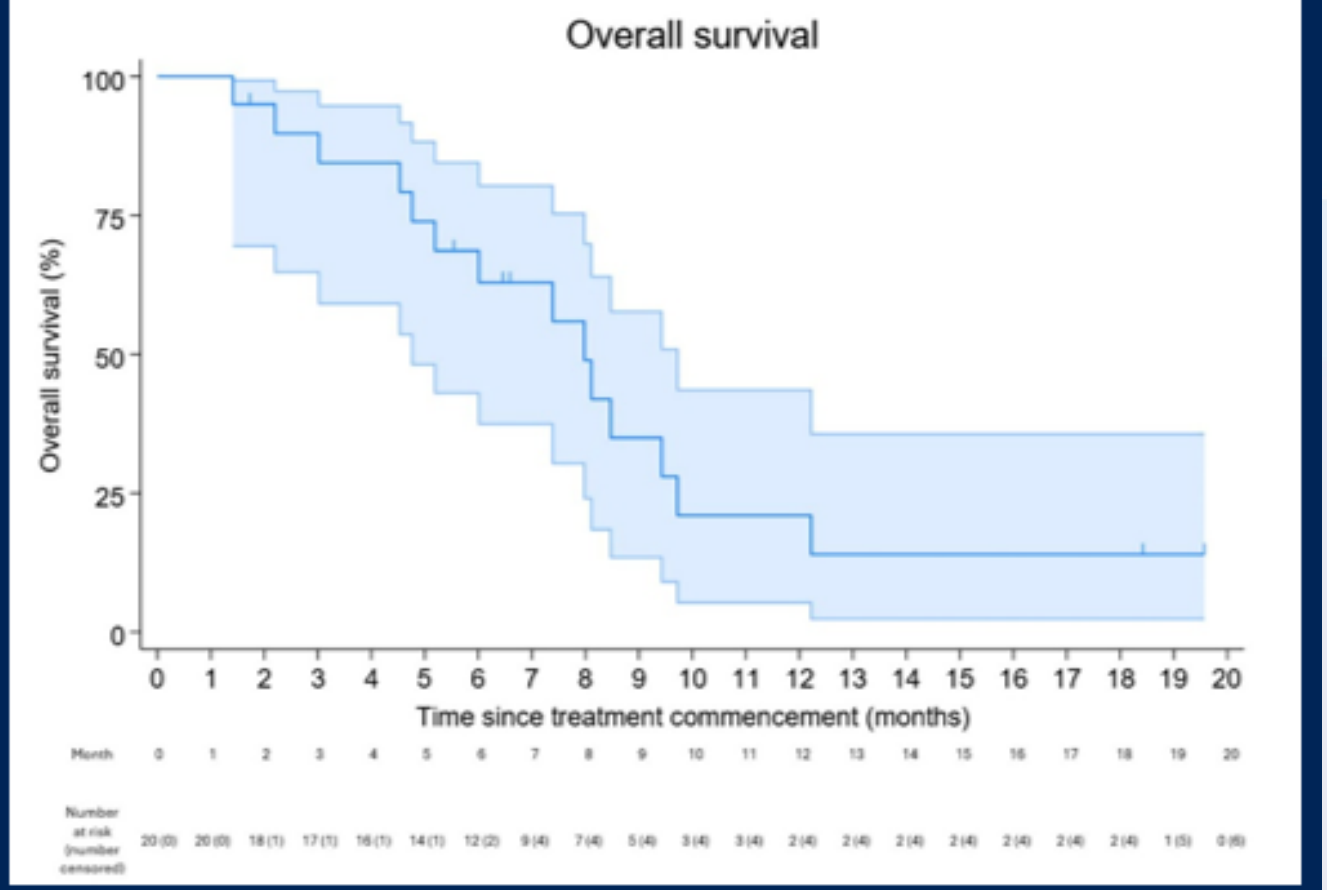


- Thrombocytopenia most common AE (13/20)
- Thrombocytopenia in DL3 – 5/12 patients had G3/4; 3/12 had G1/2
- Fatigue 2nd most common AE (12/20)

Results – PFS and OS



Median PFS (from C1 maintenance): 3.7 months (2.5 – 5.4)



Median OS (from C1 maintenance): 8 months (4.8 – 9.7)

Abstract Number: 8008

Iniciativa científica de: GECP lung cancer research

ABBV-706 as monotherapy and in combination with budigalimab in patients with relapsed/refractory small cell lung cancer

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ABBV-706 targets SEZ6, a neuroendocrine lineage marker overexpressed in SCLC and NEC[1-4]

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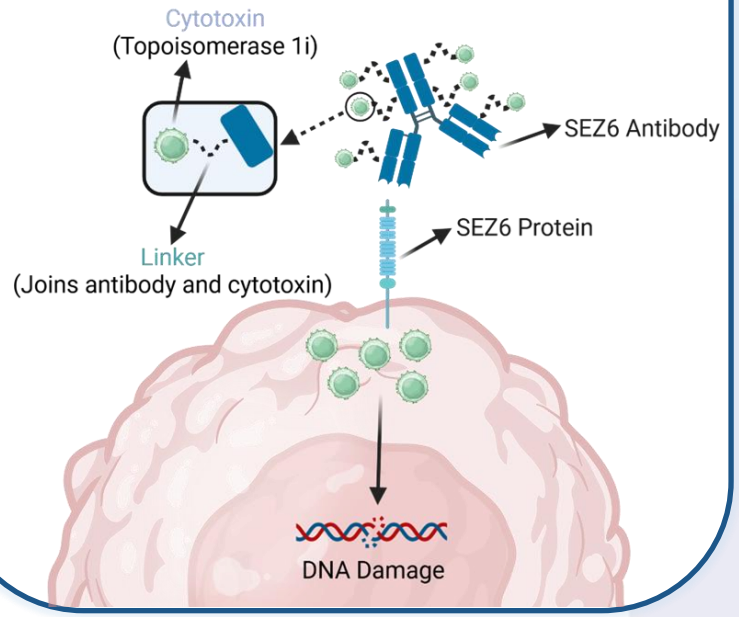
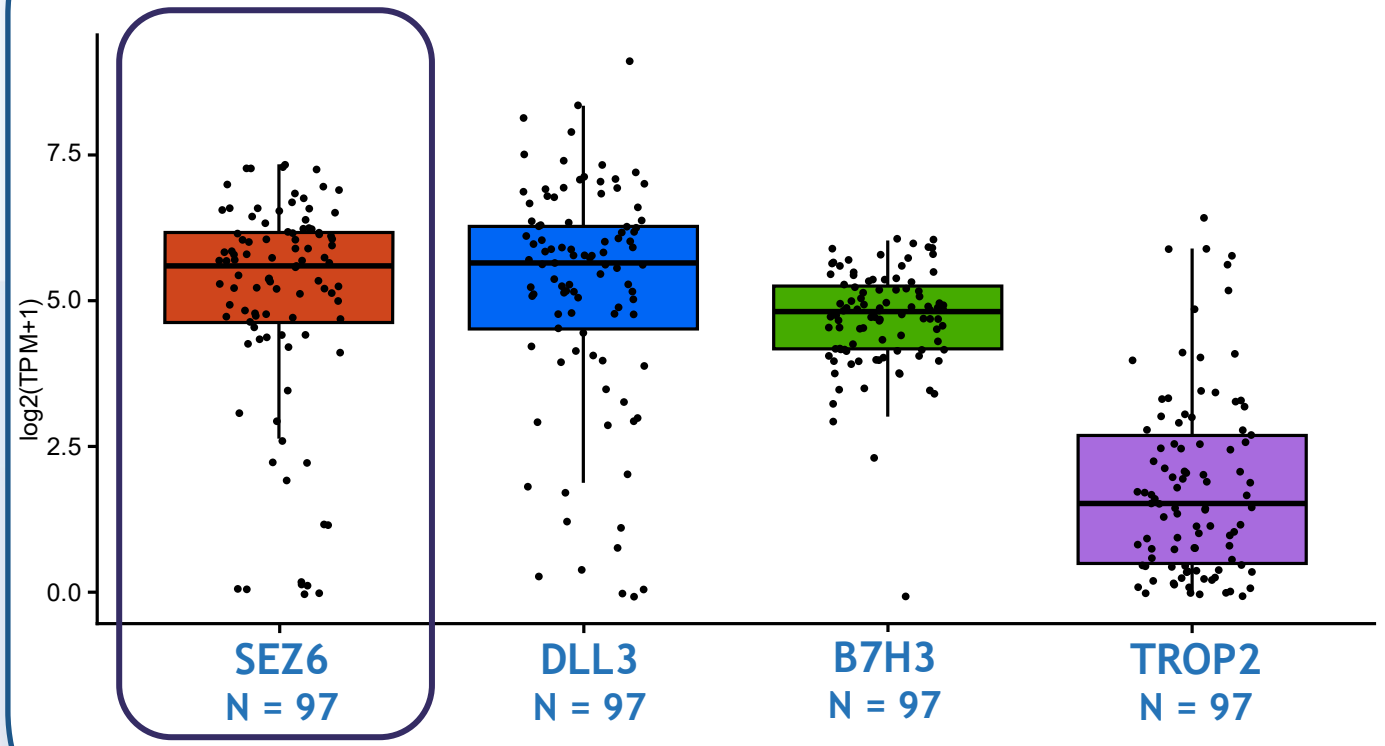
ABBV-706 is a first-in-class ADC[5]

- anti-SEZ6 mAb
- Stable, cleavable linker
- Potent Top1i payload (adizutecan)[5]
- DAR of 6



SEZ6 has high mRNA expression in SCLC
(N = 97; NCT05599984)



SEZ6 tumor expression is prevalent in patients with SCLC (93% of patients above a 1+, 1% cutoff by IHC)[a]

[a]Median cytomembrane H-score: 145.

1. Marks JA, et al. *Journal of Thoracic Oncology*. 2024;10:S364. 2. Chandana SR, et al. *J Clin Oncol*. 2024;42(16_suppl):3001. 3. Cooper AJ, et al. *J Clin Oncol*. 2025;43(16_suppl):105. 4. Wang S, et al. *J Clin Oncol*. 2025;43(16_suppl):3085. 5. Faivre EJ, et al. *Cancer Res*. 2024;84(6_Supplement):3148.

ADC, antibody-drug conjugate; DAR, drug-to-antibody ratio; DLL3, Delta-like ligand 3; mAb, monoclonal antibody; mRNA, messenger RNA; NEC, neuroendocrine carcinoma; SCLC, small cell lung cancer; SEZ6, seizure-related 6 homolog; TROP2, trophoblast cell surface antigen 2; Top1i, topoisomerase 1 inhibitor.

ABBV-706 1.8 mg/kg monotherapy in the 2L setting demonstrated a confirmed ORR of 82%

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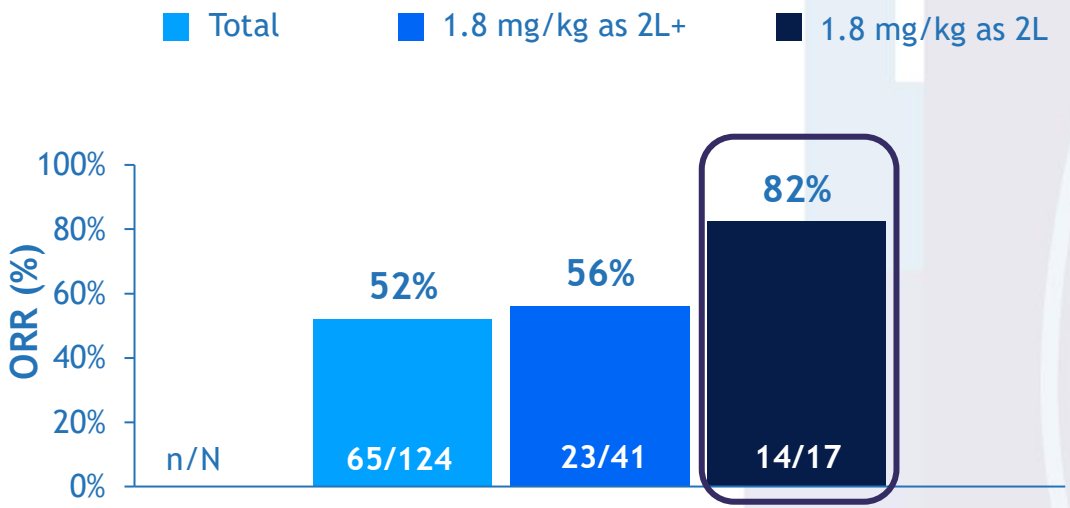
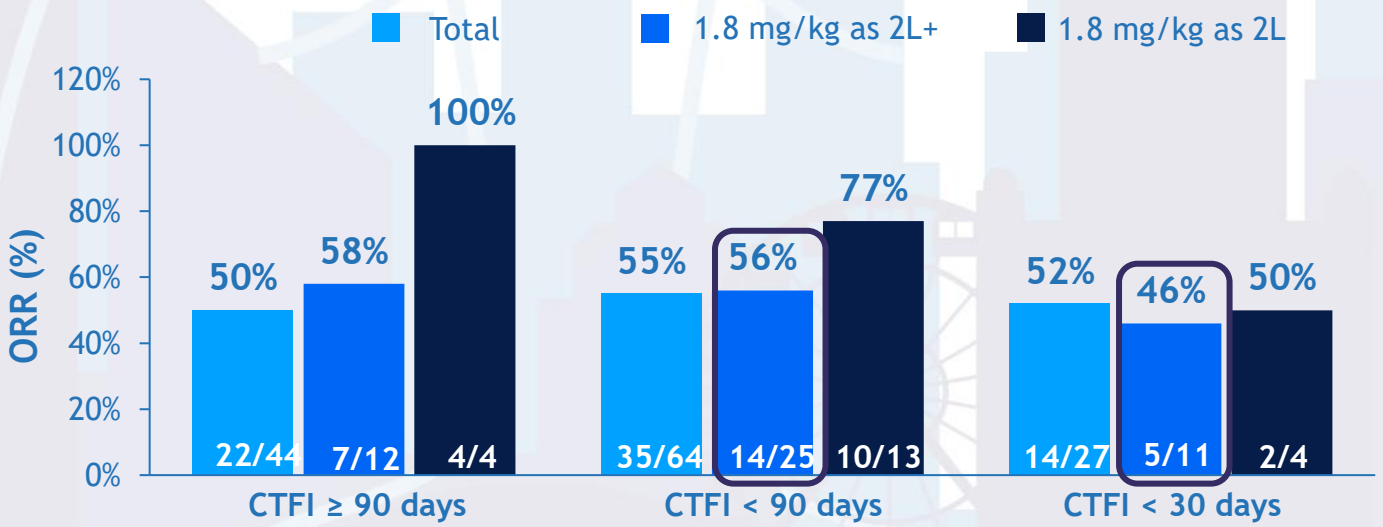
- Strong overall antitumor activity was observed with ABBV-706 monotherapy, and responses were observed in patients with platinum-refractory and resistant disease
- Clinical benefit was high across groups, with a CBR of > 94% in both 1.8 mg/kg subgroups

ORR* Monotherapy by Cohort



ORR* Monotherapy by CTFI



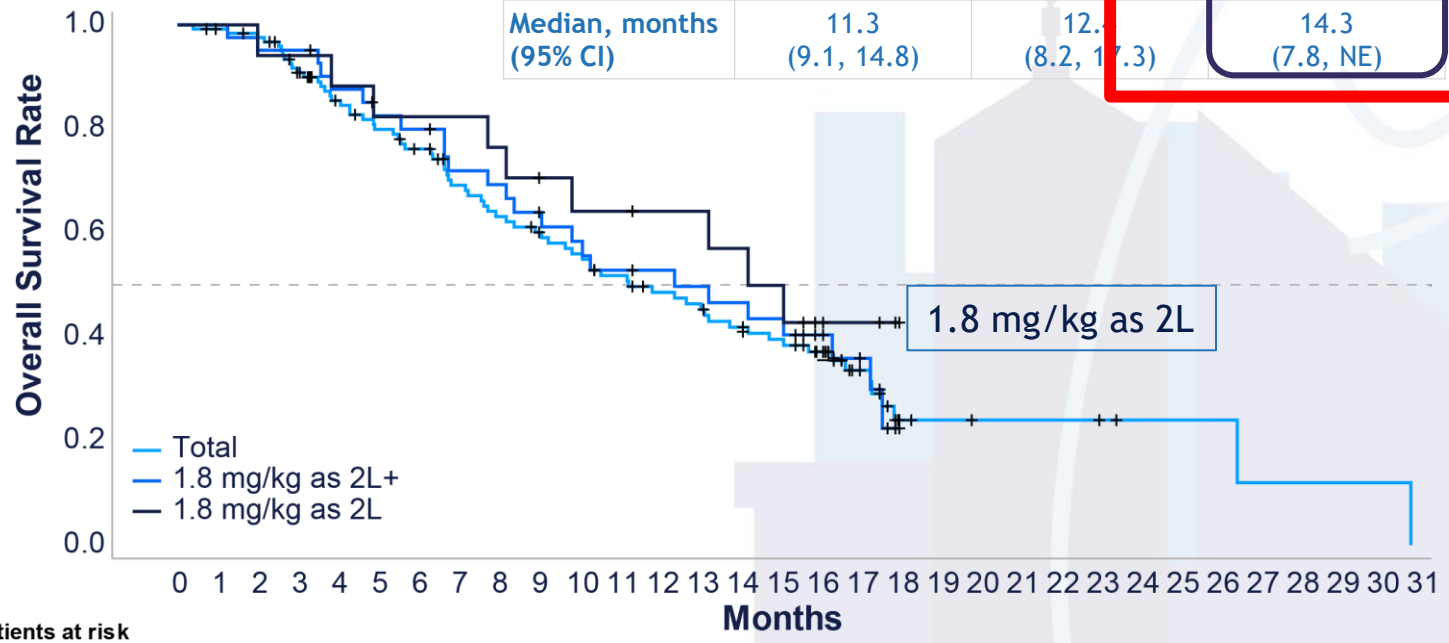
	Total N = 124	1.8 mg/kg as 2L+ n = 41	1.8 mg/kg as 2L n = 17
Confirmed CBR, n (%)	111 (90)	39 (95)	16 (94)
> 6 months	22 (18)	11 (27)	5 (29)

*Investigator-assessed confirmed CR + PR.
2L, second-line treatment; CBR, clinical benefit rate; CTFI, chemotherapy-free interval; ORR, objective response rate; PR, partial response.

ABBV-706 monotherapy demonstrated promising overall survival outcomes of 14.3 months in patients 2L post platinum-based chemotherapy

Overall Survival Rate

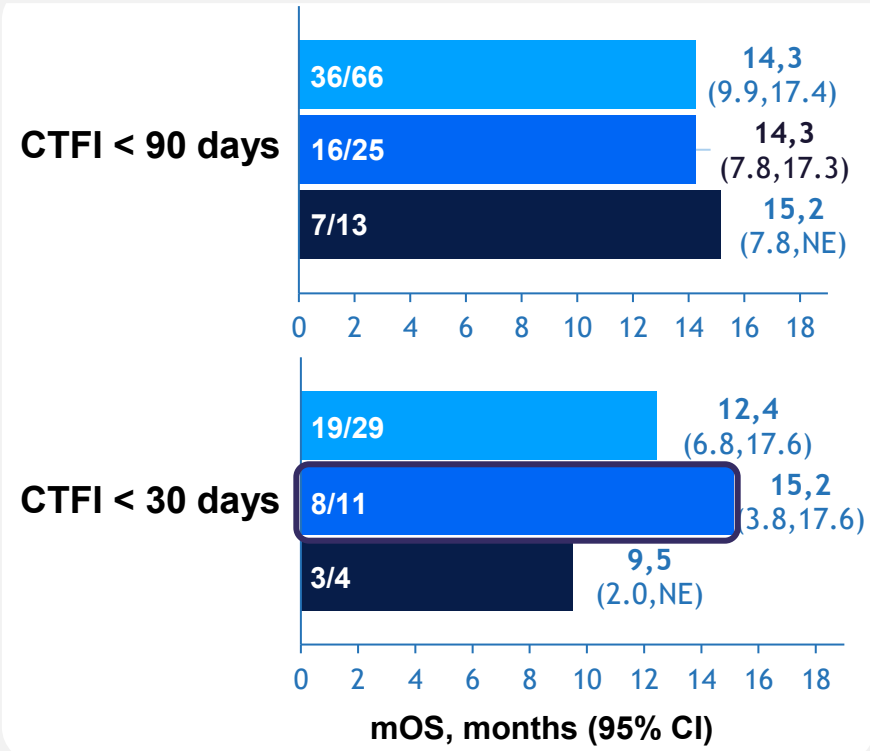
	Total	1.8 mg/kg as 2L+	1.8 mg/kg as 2L
Median, months (95% CI)	11.3 (9.1, 14.8)	12.4 (8.2, 17.3)	14.3 (7.8, NE)



Patients at risk

Total	124	121	119	106	94	85	79	69	63	59	54	49	44	42	37	34	28	16	8	5	4	4	4	4	2	2	2	1	1	1	1	0
1.8 mg/kg as 2L+	41	41	40	39	35	32	31	27	26	24	21	18	17	16	15	14	10	7	1	0	0	0	0	0	0	0	0	0	0	0	0	0
1.8 mg/kg as 2L	17	17	17	16	15	14	14	14	13	12	10	10	9	9	8	7	4	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0

Overall survival

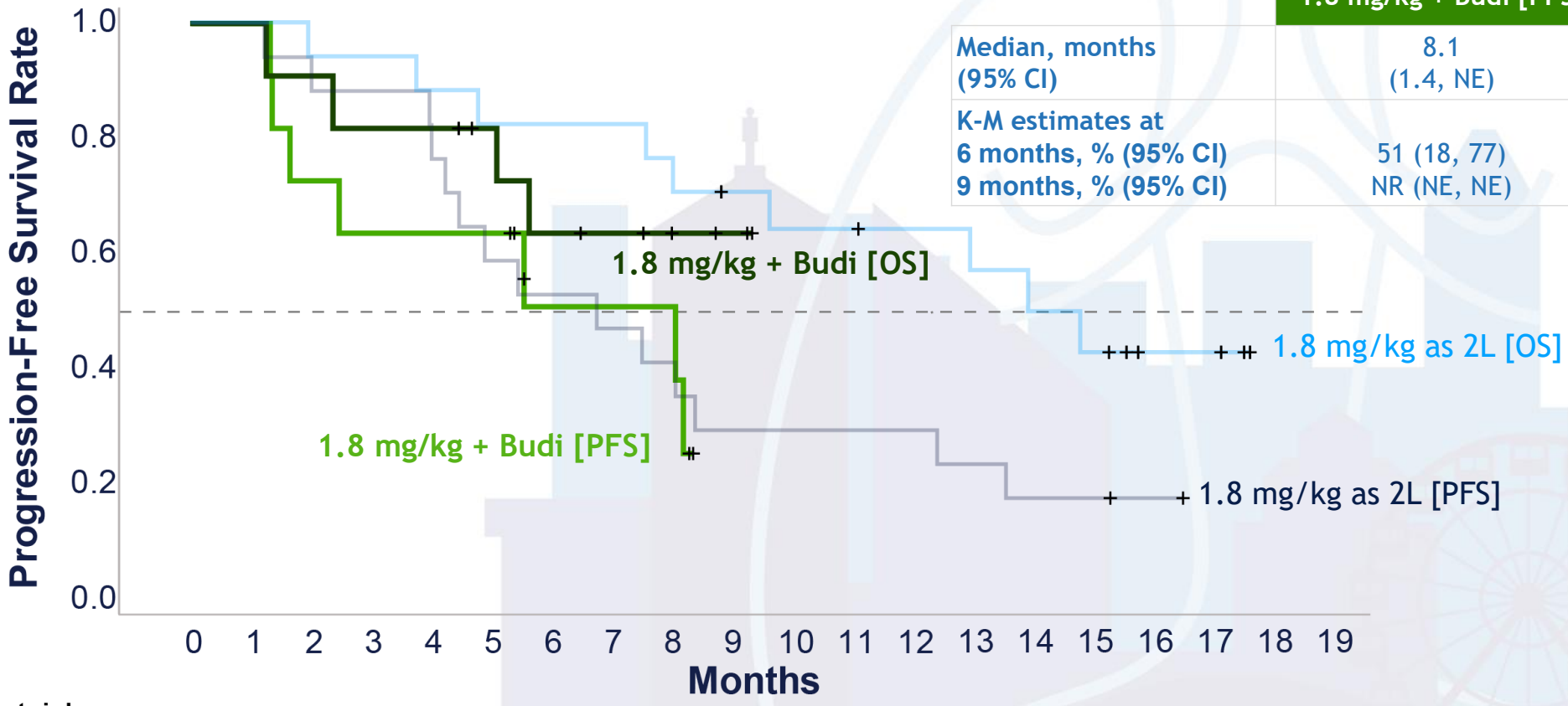


	Total N = 124	1.8 mg/kg as 2L+ n = 41	1.8 mg/kg as 2L n = 17
K-M OS 18-month estimate (95% CI)	0.24 (0.14, 0.35)	0.22 (0.08, 0.42)	0.43 (0.18, 0.65)

Assessed by investigator per RECIST v1.1.
2L, second-line therapy; CTFI, chemotherapy-free interval; K-M, Kaplan-Meier; mOS, median overall survival; RECIST v1.1, Response Evaluation Criteria in Solid Tumors version 1.1.

ABBV-706 + budigalimab combination therapy demonstrated an encouraging median PFS of 8.1 months with median OS not reached

	1.8 mg/kg + Budi [PFS]	1.8 mg/kg + Budi [OS]
Median, months (95% CI)	8.1 (1.4, NE)	NR (2.5, NE)
K-M estimates at 6 months, % (95% CI)	51 (18, 77)	64 (30, 85)
9 months, % (95% CI)	NR (NE, NE)	64 (30, 85)



Patients at risk

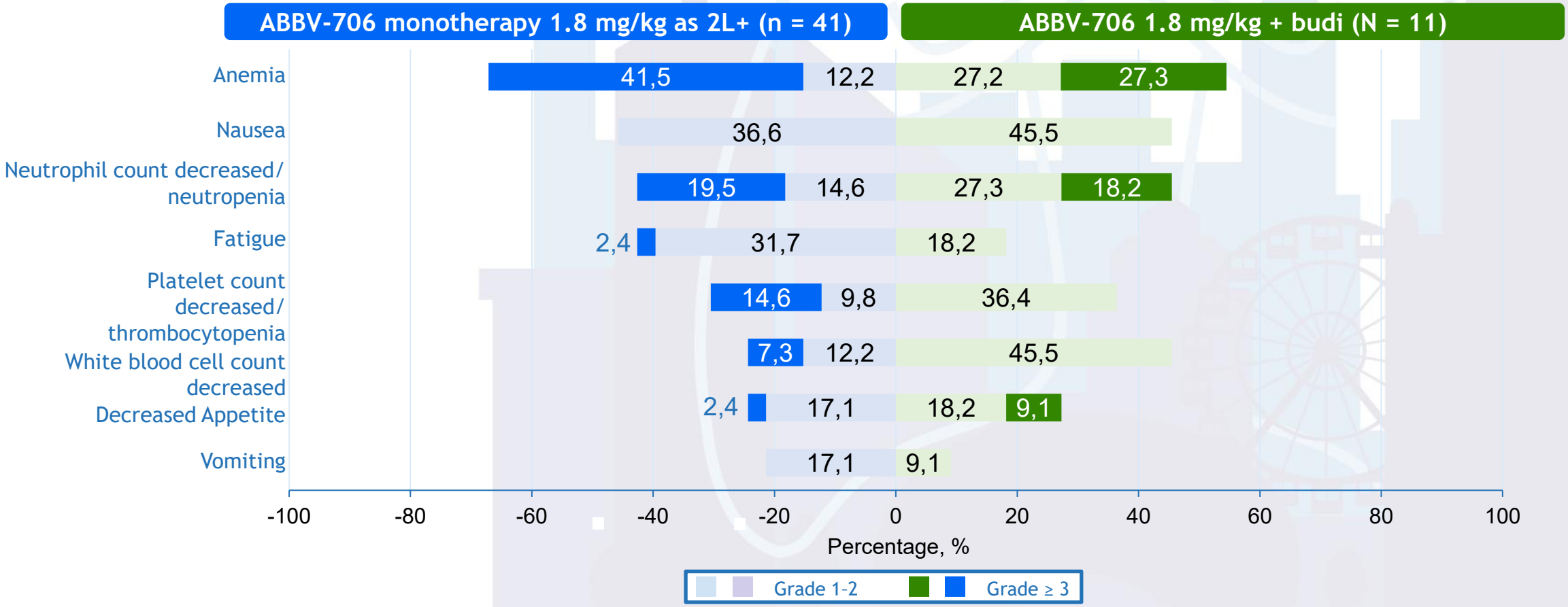
1.8 mg/kg + Budi [PFS]	11	11	8	7	7	7	4	4	4	0	0	0	0	0	0	0	0	0	0	0
1.8 mg/kg + Budi [OS]	11	11	10	9	9	9	7	6	5	4	0	0	0	0	0	0	0	0	0	0
1.8 mg/kg as 2L [PFS]	17	17	16	15	14	10	9	8	7	5	5	5	5	4	2	2	1	0	0	0
1.8 mg/kg as 2L [OS]	17	17	17	16	15	14	14	14	13	12	10	10	9	9	8	7	4	3	1	0

Assessed by investigator per RECIST v1.1.
Budi, budigalimab; PFS, progression-free survival; NE, not evaluable; NR, not reached; OS, overall survival.

Hematologic and GI toxicities were the most common ABBV-706-related AEs, and combination with budigalimab did not alter the safety profile

- Most common Grade ≥ 3 TRAEs were hematologic
- Most GI toxicity events were Grade 1–2
- Rates of dysgeusia, alopecia, and stomatitis were < 5%

- Any-grade treatment-related adjudicated ILD
  - Monotherapy: 7/124 (5.6%) patients
  - Combination: 0/11 patients
- 4/7 patients had grade 1–2 events



TRAEs experienced by ≥ 15% of patients in the ABBV-706 monotherapy 1.8 mg/kg cohort are listed.

AE, adverse event; Budi, budigalimab; GI, gastrointestinal; ILD, interstitial lung disease; TRAE, treatment-related adverse event.

2026 ASCO ANNUAL MEETING

Iniciativa científica de: GECP lung cancer research

Phase I Study of BL-M14D1, a Novel DLL3-Directed Antibody-Drug Conjugate (ADC), in Patients with Locally Advanced or Metastatic Small-Cell Lung Cancer (SCLC), Neuroendocrine Carcinoma (NEC) and Other Solid Tumors

Wei Li[1], Yuping Sun[2], Qi Dang[3], Zhiyong He[4], Ming Lu[5], Yinghua Ji[6], Yongchang Zhang[7], Yan Yu[8], Bihui Li[9], Tao Qin[10], Jian Fang[11], You Lu[12], Longhua Sun[13], Wei Jiang[14], Qitao Yu[15], Jiuwei Cui[16], Sa Xiao[17], Hai Zhu[18], Yi Zhu[19], Caicun Zhou[20]

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Presented by:

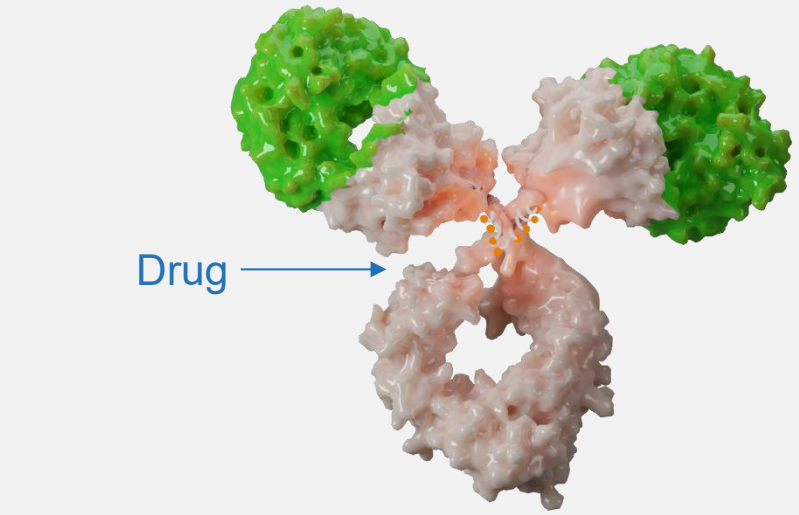
Wei Li, MD

1 June 2026

Background

Iniciativa científica de: GECP lung cancer research

BL-M14D1, DLL3-Directed ADC



- DLL-3 is overexpressed in up to 80% of SCLC and other neuroendocrine neoplasms, with low expression in normal tissues[1].
- BL-M14D1 is a DLL3-directed ADC. The antibody part of BL-M14D1 consists of a human anti-DLL3 monoclonal antibody component (anti-DLL3 mAb), and a linker-payload component (Ex0115). Ex0115 is composed of a topoisomerase I inhibitor (topo1i) Ed-04 payload and a stable enzyme-cleavable linker (IMP042).

Efficacy and safety results of BL-M14D1 in SCLC and NEC patients from phase I study are presented (NCT06505824).

mAb, monoclonal antibody; **DLL3**, delta-like ligand 3.

1. Endocr Pathol. 2025 Mar 28;36(1):9.

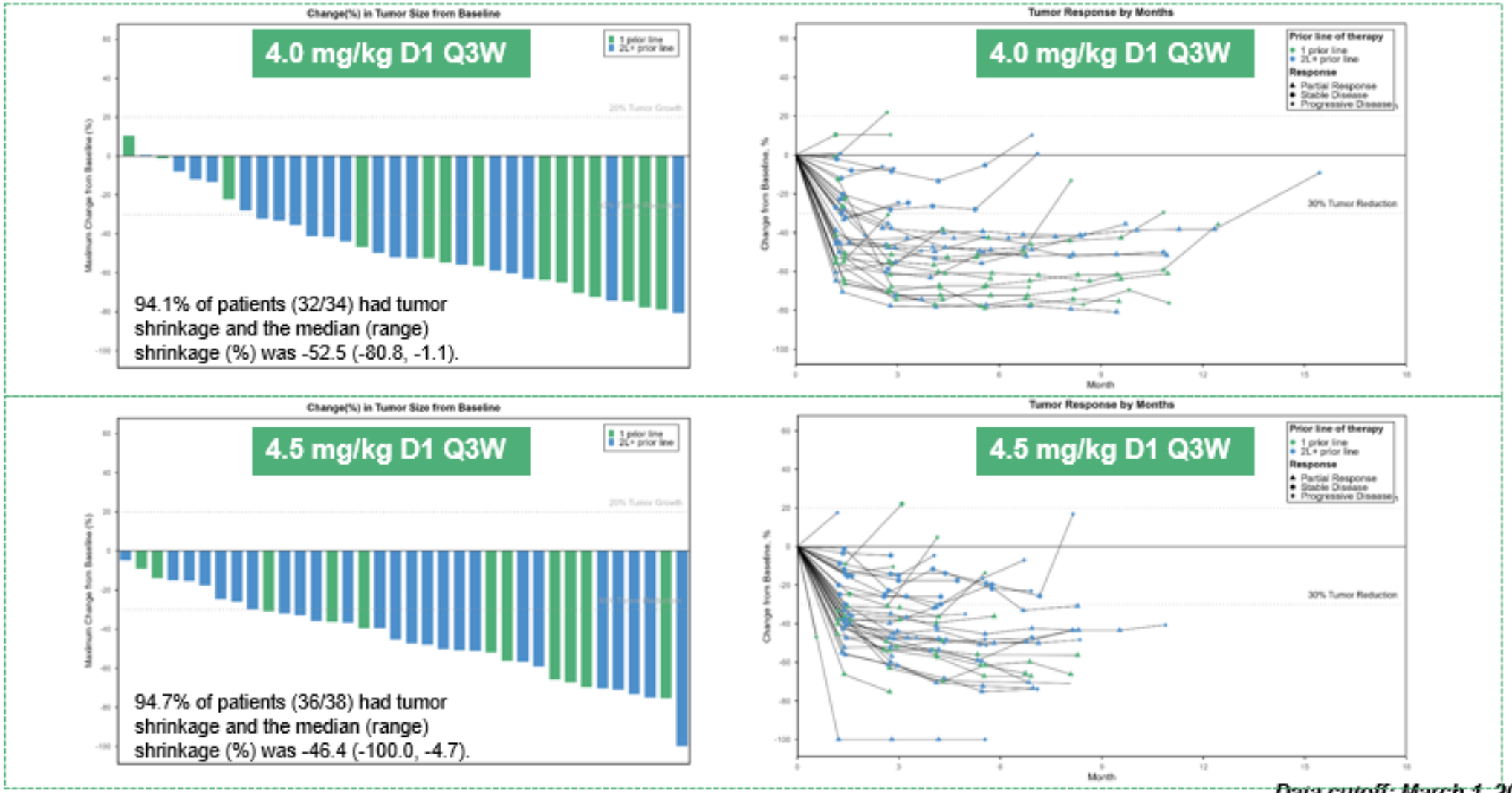
Promising Efficacy in SCLC

	Total (N = 84)	4.0 mg/kg D1 Q3W			4.5 mg/kg D1 Q3W		
		Total (N = 34)	1 prior line (N = 14)	2L+ prior line (N = 20)	Total (N = 38)	1 prior line (N = 12)	2L+ prior line (N = 26)
Median (range) LoT	2 (1, 5)	2 (1, 3)	1 (1, 1)	2 (2, 3)	2 (1, 5)	1 (1, 1)	2 (2, 5)
BOR, n (%)							
PR	60 (71.4)	25 (73.5)	11 (78.6)	14 (70.0)	27 (71.1)	9 (75.0)	18 (69.2)
Confirmed PR	51 (60.7)	21 (61.8)	10 (71.4)	11 (55.0)	23 (60.5)	8 (66.7)	15 (57.7)
PR pending confirmation[1]	1 (1.2)	0	0	0	1 (2.6)	0	1 (3.8)
SD	19 (22.6)	8 (23.5)	3 (21.4)	5 (25.0)	8 (21.1)	1 (8.3)	7 (26.9)
PD	5 (6.0)	1 (2.9)	0	1 (5.0)	3 (7.9)	2 (16.7)	1 (3.8)
ORR, % (95% CI)	71.4 (60.5, 80.8)	73.5 (55.6, 87.1)	78.6 (49.2, 95.3)	70.0 (45.7, 88.1)	71.1 (54.1, 84.6)	75.0 (42.8, 94.5)	69.2 (48.2, 85.7)
cORR, % (95% CI)	60.7 (49.5, 71.2)	61.8 (43.6, 77.8)	71.4 (41.9, 91.6)	55.0 (31.5, 76.9)	60.5 (43.4, 76.0)	66.7 (34.9, 90.1)	57.7 (36.9, 76.6)
DCR, % (95% CI)	94.0 (86.7, 98.0)	97.1 (84.7, 99.9)	100 (76.8, 100)	95.0 (75.1, 99.9)	92.1 (78.6, 98.3)	83.3 (51.6, 97.9)	96.2 (80.4, 99.9)
Median DoR, mo (95% CI)	7.4 (5.8, 9.7)	7.4 (5.7, 9.8)	7.1 (5.4, 11.3)	9.8 (3.2, 9.8)	5.8 (4.1, 9.5)	NR (2.8, NR)	5.6 (3.0, 9.5)
Median PFS, mo (95% CI)	7.1 (5.6, 8.3)	7.1 (4.4, 8.5)	8.1 (2.8, 12.5)	5.6 (3.0, 8.5)	6.2 (4.3, 8.1)	5.6 (1.4, NR)	6.2 (4.3, 8.1)
6-mo PFS rate, % (95% CI)	57.3 (45.6, 67.4)	60.1 (41.4, 74.6)	76.9 (44.2, 91.9)	48.5 (25.4, 68.2)	51.9 (34.3, 66.9)	48.6 (19.2, 73.0)	53.7 (31.9, 71.2)
Median FU for PFS, mo (95% CI)	9.7 (8.3, 11.0)	10.8 (9.5, NR)	11.0 (9.5, NR)	10.8 (9.5, NR)	8.1 (6.8, 8.3)	6.9 (4.3, 8.3)	8.3 (7.0, NR)

Patients received at least one study drug and with at least one post baseline scan were included in the analysis.
[1] Patients still on study with tumor assessment of PR and not reach to the next time point of tumor assessment;
CI: confidence interval; **cORR:** confirmed objective response rate; **CR**, complete response; **PR**, partial response; **SD**, stable disease; **PD**, progressive disease; **NE**, not evaluable.

Data cutoff: March 1, 2026

Depth & Duration of Response in SCLC



Data cutoff: March 1, 2026

2026 ASCO® ANNUAL MEETING

Iniciativa científica de: GECP lung cancer research

Results from the Phase 1 study of LB2102, a dnTGFBR2-armored, DLL3-targeted autologous CAR-T cell therapy, in patients with relapsed or refractory SCLC or LCNEC

AUTHORS: Z Hao, A Chiappori, B Creelan, R Munker, P Schwarzenberger, N Patel, S Vahora, C Davis, C Wang, J Zhang, L Xin, AJ Schoenfeld, and J Sands

Presented by Zhonglin Hao MD PhD

Markey Cancer Center, University of Kentucky, Lexington, KY

ClinicalTrials.gov no: NCT05680922

LB2102 : DLL3-targeted Autologous CAR-T Cells With dnTGFBR2 Armor

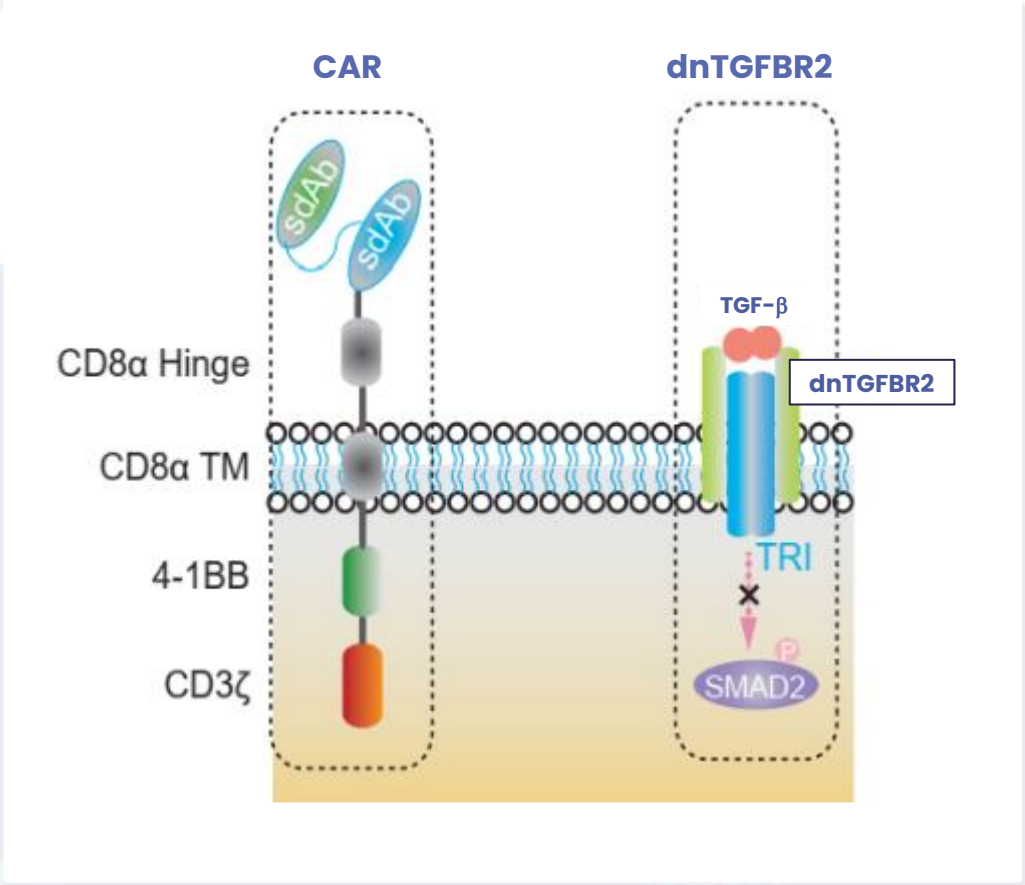
Iniciativa científica de: GECP lung cancer research

DLL3

- An inhibitory Notch ligand highly expressed on the cell surface in SCLC and other neuroendocrine tumors
- Minimal expression in normal tissues

LB2102 CAR-T Cell Design

- Chimeric antigen receptor (CAR): dual single-domain antibodies (sdAb) with high-affinity binding for DLL3
- **dnTGFBR2** blocks TGF-β mediated signaling to SMAD2
- dnTGFBR2 removes the inhibitory effects of TGF-β on the CAR-T cells, leading to their increased activation, proliferation, and anti-tumor effector functions



Oral abstract, **no. 339** ASCGT Congress 2026

At DL3 and Above, the Objective Response Rate (ORR) is 28.6%
Disease Control Rate (DCR) is 78.6%

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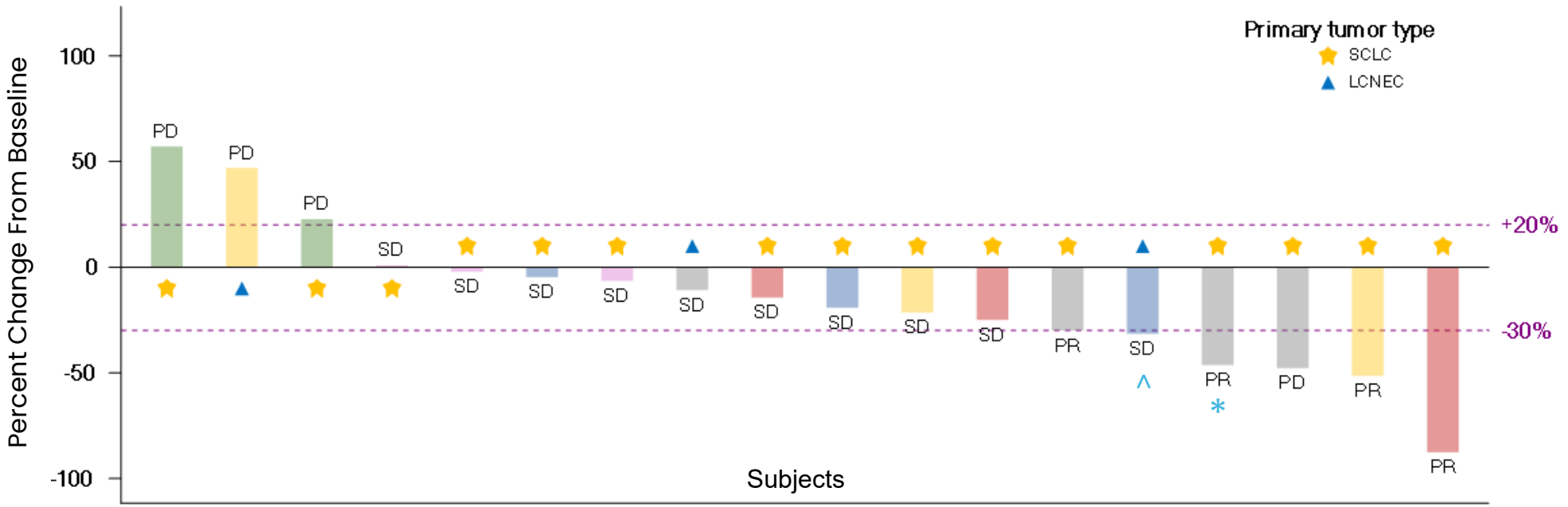
Best Responses (per RECIST 1.1)



Note: 2 subjects with progressing disease (PD) not shown (1 non-measurable at baseline; 1 missing TL data) but included in ORR

^ SD as best response; target lesion reduced by 32% but PD due to new lesion

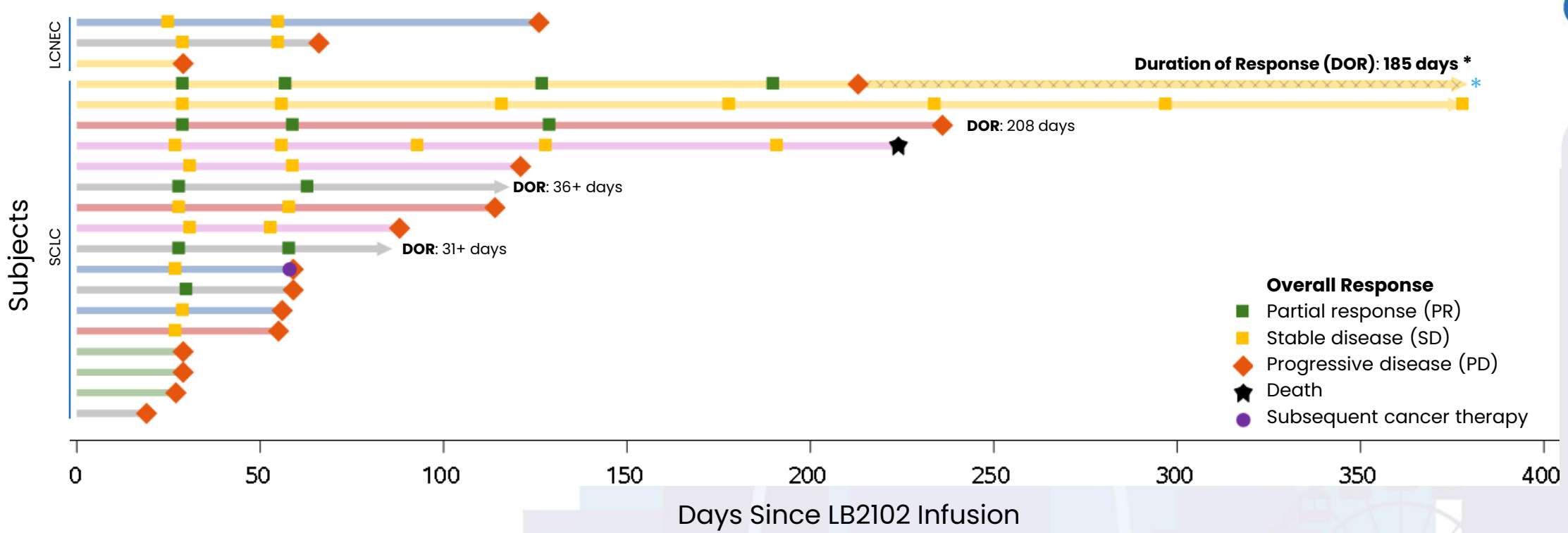
* Unconfirmed PR, tumor lesion reduced by 48%; PD at confirmation

Best Responses Across Dose Levels

	DL1 [N=3] n (%)	DL2 [N=3] n (%)	DL3 [N=3] n (%)	DL4 [N=3] n (%)	DL5 [N=3] n (%)	DL7 [N=5] n (%)	Overall [N=20] n (%)
ORR (PR)	0	0	1 (33.3)	1 (33.3)	0	2 (40.0)	4 (20.0)
DCR (PR+SD)	0	3 (100)	3 (100)	2 (66.7)	3 (100)	3 (60.0)	14 (70.0)

DL, dose level; PR, partial response; SD, stable disease

Responses to LB2101 are Durable



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Dose Level 1
Dose Level 2
Dose Level 3
Dose Level 4
Dose Level 5
Dose Level 7

* PD driven by brain metastases and managed with SBRT; no subsequent systemic antineoplastic therapy (cross-hatched part of arrow)

- Data cut-off April 13 (median follow up 12.5 mo; range 1.1-19.5 mo): median **DOR was 6.5 mo** (95% CI, 6.1-NR), ongoing response in 2 subjects
- **At ≥DL3** (median follow up 9.5 mo; range, 1.1-17.6 mo):
  - Median **duration of disease control was 6.1 mo** (95% CI, 1.3-6.8 mo)
  - DCR was 51.9% at 6 mo and 13.0% at 9 mo

2026 ASCO® ANNUAL MEETING

Iniciativa científica de: GECP lung cancer research

Intracranial efficacy of tarlatamab versus chemotherapy as second-line treatment for small cell lung cancer: DeLLphi-304 phase 3 post hoc analysis

Giannis Mountzios, Byoung Chul Cho, Philip E. Lammers, Longhua Sun, Surein Arulananda, Fiona H. Blackhall, Tatsuya Yoshida, Myung-Ju Ahn, Salman R. Punekar, Bo Zhu, Tudor-Eliade Ciuleanu, Julien Mazieres, Antonio Lugini, Pedro Rocha, Ippokratis Korantzis, Martin Schuler, Wei Shi, Ali Hamidi, Diana Gauto, Charles M. Rudin

Speaker: Giannis Mountzios, MD, MSc, PhD

Henry Dunant Hospital Center, Athens, Greece

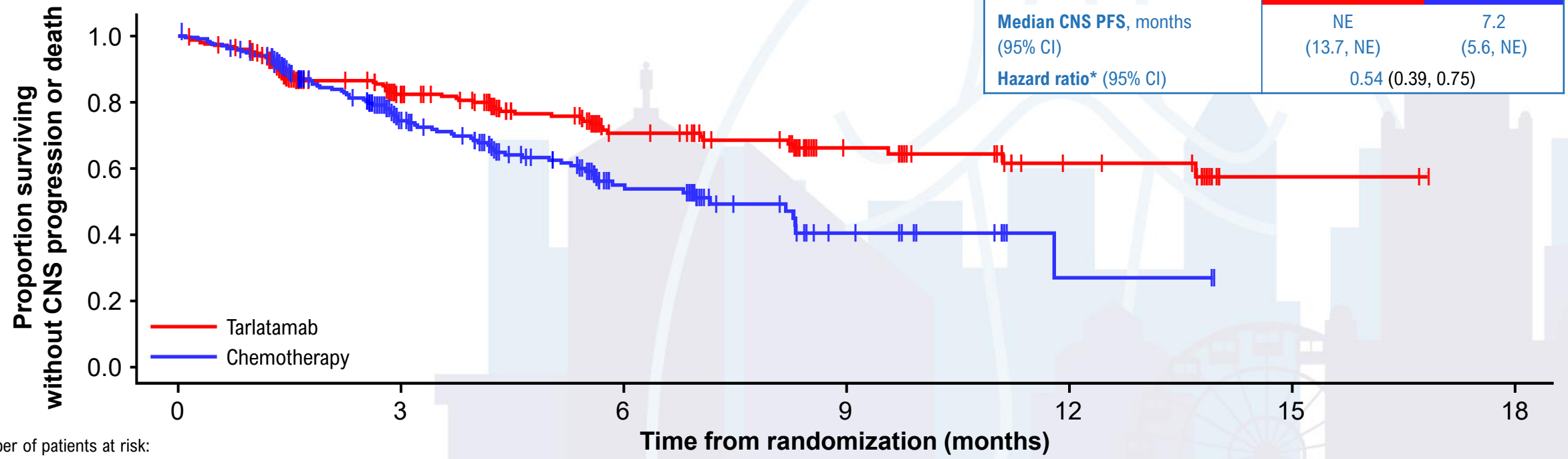
Tarlatamab delayed time to CNS progression or death in all patients

Iniciativa científica de: GECP lung cancer

RECIST assessment per investigator

ITT population

	Tarlatamab (n = 254)	Chemotherapy (n = 255)
Median CNS PFS, months (95% CI)	NE (13.7, NE)	7.2 (5.6, NE)
Hazard ratio* (95% CI)	0.54 (0.39, 0.75)	



Number of patients at risk:

Tarlatamab	254	142	74	36	17	2	0
Chemotherapy	255	119	47	13	2	0	

Patients in the tarlatamab group had a 46% lower risk of CNS disease progression or death compared to those in the chemotherapy group.

*Hazard ratio and 95% CI were estimated using a stratified Cox proportional hazards model.

CI, confidence interval; **CNS**, central nervous system; **ITT**, intention-to-treat; **NE**, not estimable; **PFS**, progression-free survival; **RECIST**, Response Evaluation Criteria in Solid Tumors.

G. Mountzios, Intracranial efficacy of tarlatamab versus chemotherapy in SCLC: Post hoc analysis of DeLLphi-304

Post hoc analysis of intracranial efficacy in the DeLLphi-304 trial

Patients with confirmed SCLC whose disease had progressed following 1L platinum-based chemotherapy +/- anti-PD-(L)1
(Patients with asymptomatic, treated or untreated brain metastases allowed)

1:1 randomization*

Tarlatamab (n = 254)	Chemotherapy† (n = 255)
Patients with BM at baseline per RECIST by investigator (n = 98)	Patients with BM at baseline per RECIST by investigator (n = 99)
Patients with ≥ 1 BM per mRANO-BM/BICR at baseline and ≥ 1 post-baseline scan (n = 67)	Patients with ≥ 1 BM per mRANO-BM/BICR at baseline and ≥ 1 post-baseline scan (n = 56)

Endpoint(s) assessed

- **CNS PFS (investigator-assessed)**
- **OS**
- **Safety/tolerability**

mRANO-BM/BICR analysis group

- **CNS PFS**
- **CNS ORR**
- **CNS DoDC**

*Randomization was stratified by history of brain metastases, prior anti-PD-(L)1 exposure, chemotherapy-free interval, and intended chemotherapy.
†Topotecan was used in all countries except Japan, lurbinectedin in Australia, Canada, Republic of Korea, Singapore and the United States, and amrubicin in Japan
1L, first-line; **BM**, brain metastases; **BICR**, blinded independent central review; **CNS**, central nervous system; **DoDC**, duration of disease control; **mRANO-BM**, modified Response Assessment in Neuro-Oncology Brain Metastases; **ORR**, objective response rate; **OS**, overall survival; **PD-(L)1**, programmed death-(ligand)1; **PFS**, progression-free survival; **RECIST**, Response Evaluation Criteria in Solid Tumors; **SCLC**, small cell lung cancer.

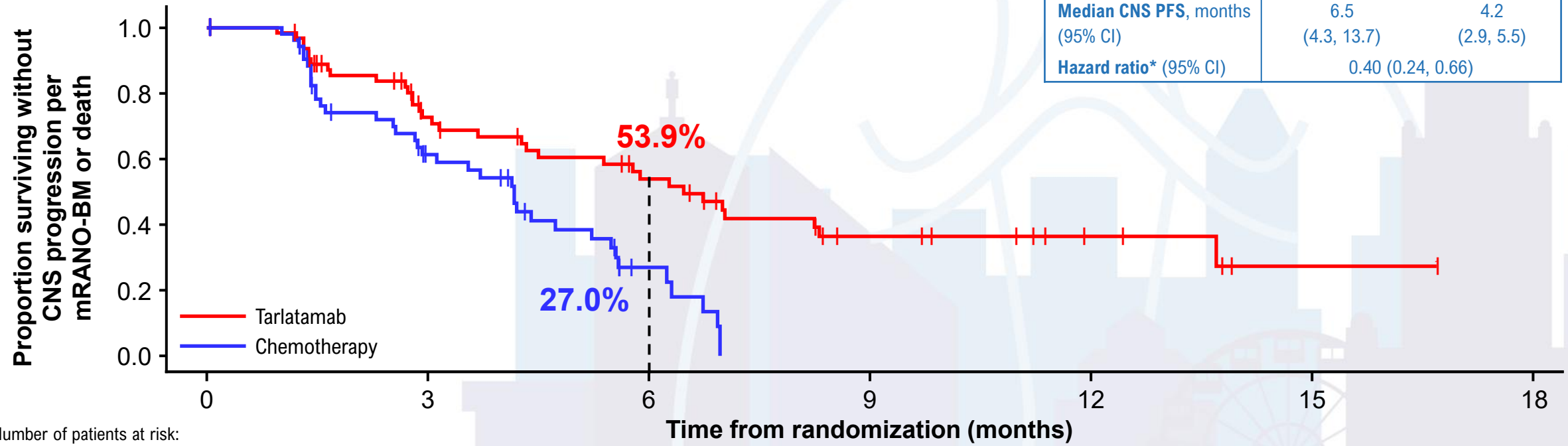
Tarlatamab delayed CNS progression or death in patients with brain metastases

Iniciativa científica de: GECP cancer research

mRANO-BM analysis by BICR

Patients with ≥ 1 brain metastases at baseline per mRANO-BM by BICR and ≥ 1 post-baseline scan

	Tarlatamab (n = 67)	Chemotherapy (n = 56)
Median CNS PFS, months (95% CI)	6.5 (4.3, 13.7)	4.2 (2.9, 5.5)
Hazard ratio* (95% CI)	0.40 (0.24, 0.66)	



Number of patients at risk:

Tarlatamab	67	37	24	11	5	1	0
Chemotherapy	56	26	6	0			

Among patients with brain metastases, treatment with tarlatamab reduced the risk of CNS disease progression or death by 60% compared to chemotherapy.

*Hazard ratio and 95% CI were estimated using an unstratified Cox proportional hazards model.

BICR, blinded independent central review; **CI**, confidence interval; **CNS**, central nervous system; **mRANO-BM**, modified Response Assessment in Neuro-Oncology Brain Metastases; **PFS**, progression-free survival.

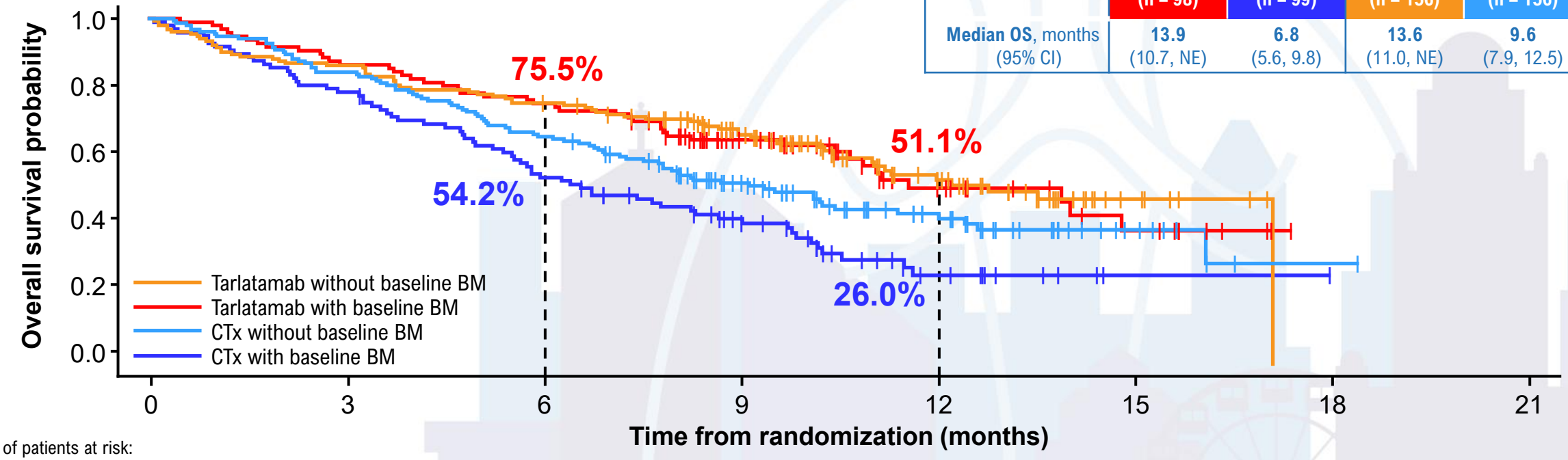
G. Mountzios, Intracranial efficacy of tarlatamab versus chemotherapy in SCLC: Post hoc analysis of DeLLphi-304

Tarlatamab improved overall survival vs chemotherapy regardless of the presence of brain metastases

Iniciativa científica de:

Patients with or without brain metastases at baseline per RECIST by investigator

	Tarlatamab with BM (n = 98)	CTx with BM (n = 99)	Tarlatamab w/o BM (n = 156)	CTx w/o BM (n = 156)
Median OS, months (95% CI)	**13.9** (10.7, NE)	**6.8** (5.6, 9.8)	**13.6** (11.0, NE)	**9.6** (7.9, 12.5)



Number of patients at risk:

Tarlatamab without baseline BM	156	135	118	86	39	8	0
Tarlatamab with baseline BM	98	85	74	45	21	9	0
CTx without baseline BM	156	132	103	64	32	8	1	0
CTx with baseline BM	99	78	53	33	10	1	1	0

Median follow-up: 11.4 months (tarlatamab) and 11.5 months (chemotherapy)

Treatment with tarlatamab reduced the risk of death by 49% in patients with brain metastases vs chemotherapy (HR 0.51 [95% CI: 0.34, 0.74]).

*Hazard ratio and 95% CI were estimated using an unstratified Cox proportional hazards model. †Hazard ratio for death for tarlatamab versus chemotherapy in patients with brain metastases at baseline.
BM, brain metastases; **CTx**, chemotherapy; **CI**, confidence interval; **NE**, not estimable; **OS**, overall survival; **RECIST**, Response Evaluation Criteria in Solid Tumors; **w/o**, without.

G. Mountzios, Intracranial efficacy of tarlatamab versus chemotherapy in SCLC: Post hoc analysis of DeLLphi-304

2026 ASCO ANNUAL MEETING

Efficacy and safety of ivonescimab combined with liposomal irinotecan as second-line treatment for small-cell lung cancer (SCLC) : results from a multicenter phase 2 study (VICTORY)

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Kaiyan Chen, Hui Li, Zhiyu Huang, Jing Qin, Xinmin Yu, Ying Jin, Youzu Xu, Qiong He, Lan Shao, Zhiyong Shi, Sizhe Yu, Shichao Zhou, Yanjun Xu, Lei Gong, Jun Zhao, Cuiping Gu

Study Design

This is a multicenter, single-arm phase 2 study (NCT06478043).

Key Eligibility Criteria:

- Age 18-75 years
- Histologically confirmed SCLC
- ECOG PS 0-1
- Progressed on first-line platinum-based chemotherapy plus PD-1/PD-L1 blockade
- At least one measurable lesion per RECIST 1.1
- Adequate organ function
- Treated/stable brain metastases were eligible

(N=60)

→ Ivonescimab 20 mg/kg, Q3W in a 6-week cycle + Liposomal irinotecan, 56.5 mg/m^2, Q2W in a 6-week cycle

→ Treatment until disease progression or unacceptable toxicity

Primary Endpoint

- 6-month PFS rate per RECIST 1.1

Secondary Endpoints

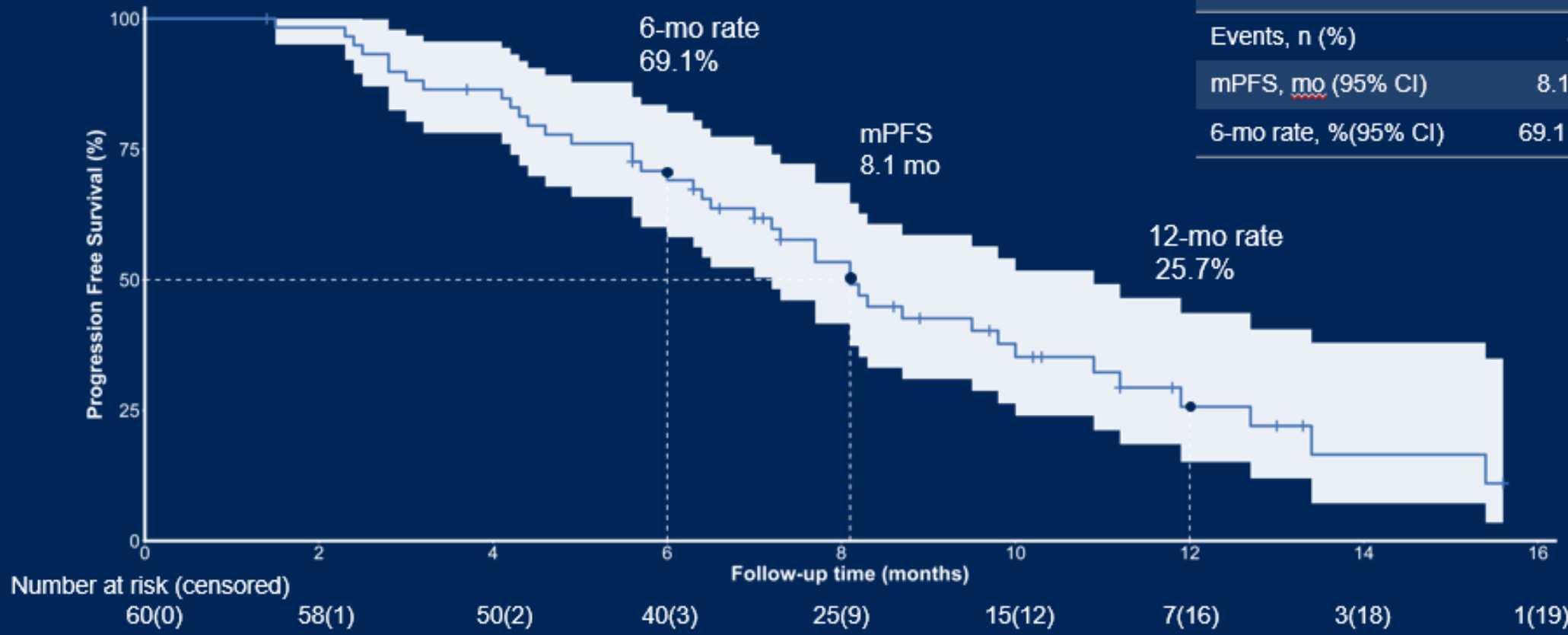
- ORR, PFS, DoR, OS
- Safety

Tumor assessments based on RECIST 1.1 were performed every 6 weeks by investigators

ECOG PS, Eastern Cooperative Oncology Group Performance Status; ORR, Objective Response Rate; DoR, Duration of Response; OS, Overall Survival; PFS, Progression-Free Survival; Q2W, every 2 weeks; Q3W, every 3 weeks; RECIST, Response Evaluation Criteria in Solid Tumors; SCLC, Small-Cell Lung Cancer.

Primary Endpoint: 6-month PFS rate was 69.1%

PFS	Total (N=60)
Events, n (%)	41 (68.3)
mPFS, mo (95% CI)	8.1 (6.5, 10.0)
6-mo rate, %(95% CI)	69.1 (55.5, 79.3)[§]



Data cutoff date: Mar 31, 2026

[§] The estimated 6-month PFS rate was significantly superior to the historical reference of 32.9% ($p < 0.0001$);
mPFS, median Progression-Free Survival; CI, Confidence Interval.

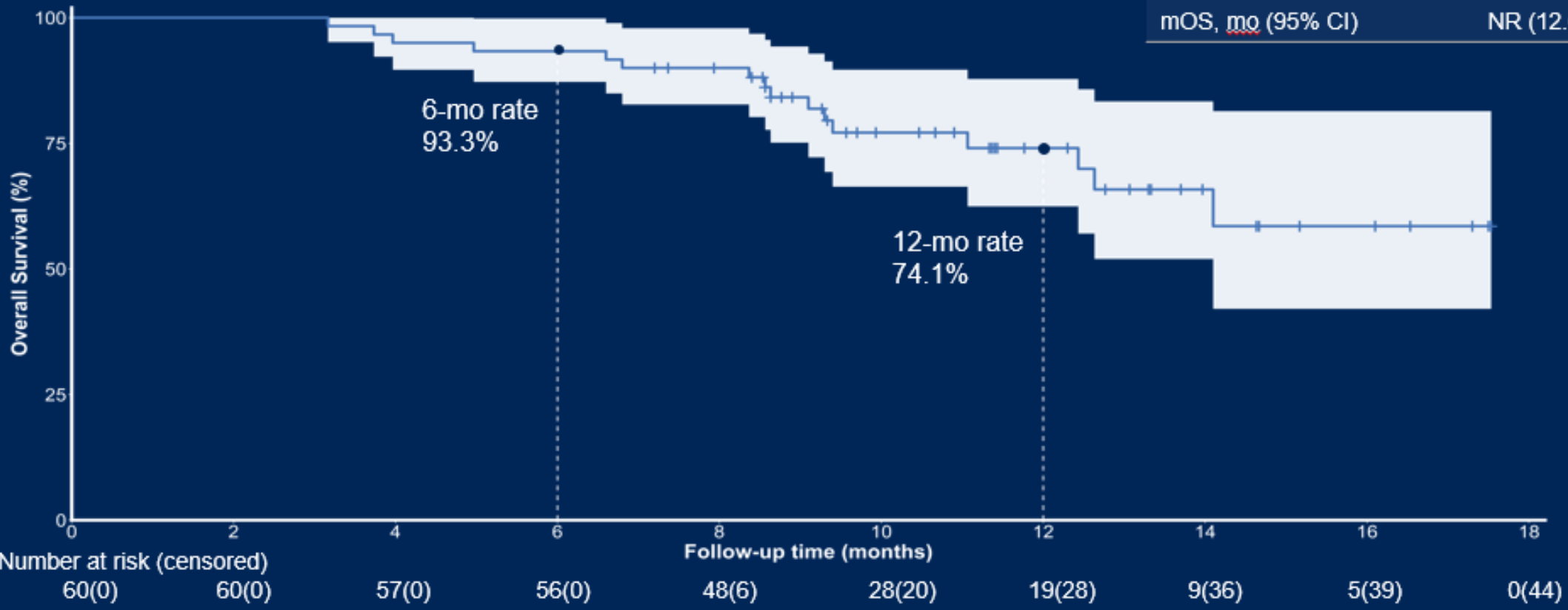
Clinical Efficacy

	Total (N=60)	Platinum-Sensitive CFI ≥90 Days [§] (N=38)	Platinum-Resistant CFI <90 Days [§] (N=22)
Best Overall Response (BOR), n (%)			
PR	39 (65.0)	26 (68.4)	13 (59.1)
Confirmed PR	37 (61.7)	24 (63.2)	13 (59.1)
SD	19 (31.7)	10 (26.3)	9 (40.9)
PD	2 (3.3)	2 (5.2)	0
cORR, % (95% CI)	**61.7 (48.2, 73.9)**	**63.2 (46.0, 78.2)**	**59.1 (36.4, 79.3)**
DCR, % (95% CI)	96.7 (88.5, 99.6)	94.7 (82.3, 99.4)	100 (84.6, 100)
DoR, mo (95% CI)	7.3 (5.9, 10.2)	8.6 (5.9, 10.2)	6.7 (2.8, 13.8)
Median PFS, mo (95% CI)	8.1 (6.5, 10.0)	8.3 (6.3, 11.2)	7.7 (4.4, 9.8)
PFS rate at 6 mo, %(95% CI)	**69.1 (55.5, 79.3)**	**69.5 (51.7, 82.0)**	**68.2 (44.6, 83.4)**
PFS rate at 12 mo, %(95% CI)	25.7 (13.4, 39.8)	25.0 (9.6, 44.1)	24.8 (8.4, 45.7)

Data cutoff date: Mar 31, 2026
Patients received at least one dose of study drug were included;
[§] Refer to the duration from last platinum-based chemotherapy to disease progression;
ORR, Overall Response Rate; cORR, confirmed Overall Response Rate; DCR, Disease Control Rate; DoR, Duration of Response; PFS, Progression-free Survival; CI, Confidence Interval; CFI, Chemotherapy-Free Interval; PR, Partial Response; SD, Stable Disease; PD, Progressive Disease.

Overall Survival (OS)

OS	Total (N=60)
Events, n (%)	16 (26.7)
mOS, mo (95% CI)	NR (12.6, NE)



Data cutoff date: Mar 31, 2026

NR: Not Reached; NE: Not Evaluable; CI: Confidence Interval; OS, Overall Survival.

2026 ASCO ANNUAL MEETING

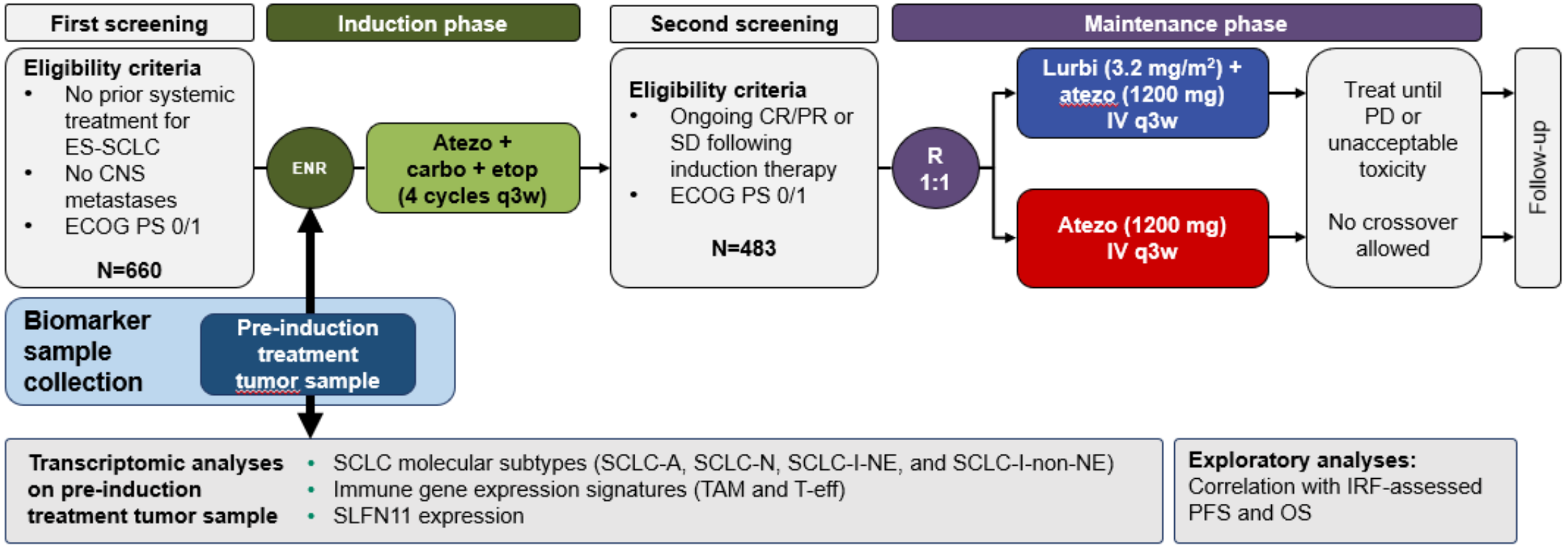
Transcriptomic analyses of molecular subsets and correlations with clinical outcomes from the Phase 3 IMforte study of lurbinectedin + atezolizumab maintenance treatment in extensive-stage small-cell lung cancer

Luis G. Paz-Ares,[1] Hossein Borghaei,[2] Martin Reck,[3] Solange Peters,[4] Roy S. Herbst,[5] Andrzej Kazarnowicz,[6] Aleksandra Szczesna,[7] Erdem Cubukcu,[8] Saadettin Kılıçkap,[9] Jin-Seok Ahn,[10] Raffaele Califano,[11] Yu-Feng Wei,[12] Minu K. Srivastava,[13] Barzin Y. Nabet,[13] Vilma Graupner,[14] Ya-Chen Lin,[13] George Cai,[15] Graham Brock,[15] Kamalnayan Bhatt,[15] Stephen V. Liu[16]

[1]Hospital Universitario 12 de Octubre, Universidad Complutense and Ciberonc, Madrid, Spain; [2]Fox Chase Cancer Center, Philadelphia, PA, USA; [3]Lung Clinic Grosshansdorf, Airway Research Center North, German Center of Lung Research, Grosshansdorf, Germany; [4]Centre Hospitalier Universitaire Vaudois, Lausanne, Switzerland; [5]Yale School of Medicine, New Haven, CT, USA; [6]Tuberculosis and Lung Disease Hospital, Olsztyn, Poland; [7]Mazowieckie Centrum Leczenia Chorób Płuc i Gruźlicy, Otwock, Poland; [8]Uludag University, Bursa, Türkiye; [9]Istinye University, Istanbul, Türkiye; [10]Samsung Medical Center, Sungkyunkwan University School of Medicine, Seoul, Republic of Korea; [11]The Christie NHS Foundation Trust and Division of Cancer Sciences, University of Manchester, Manchester, UK; [12]E-Da Cancer Hospital, I-Shou University, Kaohsiung, Taiwan; [13]Genentech, Inc., South San Francisco, CA, USA; [14]F. Hoffmann-La Roche Ltd, Basel, Switzerland; [15]Jazz Pharmaceuticals, Dublin, Ireland; [16]Lombardi Comprehensive Cancer Center, Georgetown University, Washington, D.C., USA

Study design

IMforte is a Phase 3, multicenter, randomized, open-label study evaluating the efficacy and safety of lurbinectedin in combination with atezolizumab as maintenance therapy for first-line ES-SCLC



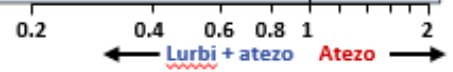
A, ASCL1-positive subtype; Atezo, atezolizumab; carbo, carboplatin; CNS, central nervous system; CR, complete response; ECOG PS, Eastern Cooperative Oncology Group performance status; ENR, enrollment; ES-SCLC, extensive-stage small-cell lung cancer; etop, etoposide; I-NE, inflamed neuroendocrine subtype; I-non-NE, inflamed non-neuroendocrine subtype; IRF, independent-review facility; IV, intravenously; Lurbi, lurbinectedin; N, NEUROD1-positive subtype; NE, neuroendocrine; OS, overall survival; PD, progressive disease; PFS, progression-free survival; PR, partial response; q3w, every 3 weeks; R, randomization; SD, stable disease; SLFN11, Schlafen 11; TAM, tumor-associated macrophage; T-eff, T-effector

IRF-PFS and OS by molecular subtype

- Of 303 tissue samples analyzed, 104 (34.3%) were classified as SCLC-A, 89 (29.4%) as SCLC-N, 46 (15.2%) as SCLC-I-NE, and 64 (21.1%) as SCLC-I-non-NE, similar to the prevalence in the IMpower133 trial*[1]
- Longer IRF-PFS and OS were observed with lurbinectedin + atezolizumab compared with atezolizumab alone, irrespective of molecular subtype
  - The IRF-PFS and OS benefit was comparable between NE and non-NE subtypes

PFS

Subgroup	Group	Event/N	Median survival (months)	HR (CI)
RNAseq BEP	Atezo	125/153	2.37	
	Lurbi + Atezo	105/150	5.49	0.61 (0.47, 0.79)
SCLC-A	Atezo	51/63	2.79	
	Lurbi + Atezo	27/41	4.5	0.64 (0.4, 1.02)
SCLC-I-NE	Atezo	16/22	2.63	
	Lurbi + Atezo	22/24	6.09	0.82 (0.43, 1.58)
SCLC-I-non-NE	Atezo	21/29	2.79	
	Lurbi + Atezo	22/35	4.57	0.73 (0.4, 1.33)
SCLC-N	Atezo	37/39	1.54	
	Lurbi + Atezo	34/50	5.59	0.4 (0.25, 0.65)
NE	Atezo	104/124	2.14	
	Lurbi + Atezo	83/115	5.49	0.58 (0.44, 0.78)
Non-NE	Atezo	21/29	2.79	
	Lurbi + Atezo	22/35	4.57	0.73 (0.4, 1.33)



OS

Subgroup	Group	Event/N	Median survival (months)	HR (CI)
RNAseq BEP	Atezo	81/153	11.66	
	Lurbi + Atezo	64/150	13.47	0.72 (0.52, 1.01)
SCLC-A	Atezo	35/63	11.99	
	Lurbi + Atezo	18/41	14.39	0.73 (0.42, 1.3)
SCLC-I-NE	Atezo	11/22	9.3	
	Lurbi + Atezo	17/24	10.81	1.04 (0.49, 2.23)
SCLC-I-non-NE	Atezo	14/29	11.96	
	Lurbi + Atezo	12/35	NR	0.68 (0.32, 1.48)
SCLC-N	Atezo	21/39	11.47	
	Lurbi + Atezo	17/50	16.13	0.62 (0.33, 1.18)
NE	Atezo	67/124	11.66	
	Lurbi + Atezo	52/115	13.47	0.74 (0.52, 1.07)
Non-NE	Atezo	14/29	11.96	
	Lurbi + Atezo	12/35	NR	0.68 (0.32, 1.48)

*SCLC molecular subtype prevalence in the IMpower133 trial: SCLC-A 89 (33%), SCLC-N 84 (31%), SCLC-I-NE 38 (14%), and SCLC-I-non-NE 60 (22%).
A, ASCL1-positive subtype; Atezo, atezolizumab; BEP, biomarker-evaluable population; CI, confidence interval; HR, hazard ratio; I-NE, inflamed neuroendocrine subtype; I-non-NE, inflamed non-neuroendocrine subtype; IRF, independent review facility; Lurbi, lurbinectedin; N, NEUROD1-positive subtype; NR, not reached; OS, overall survival; PFS, progression-free survival. 1. Liu et al. Lung Cancer 2023.

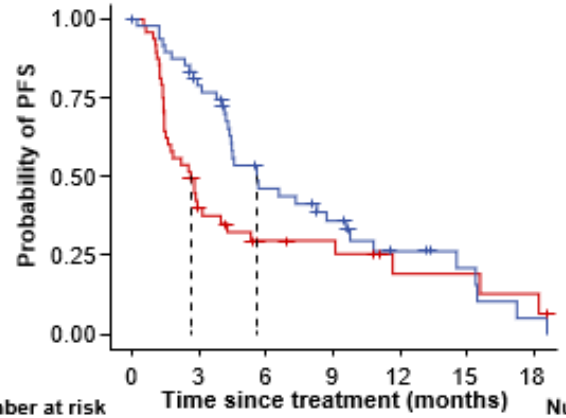
IRF-PFS and OS by TAM/T-eff

- Patients with high TAM/high T-eff in the atezolizumab arm had a numerically shorter IRF-PFS and OS (mPFS: 2.63 months and mOS: 12.25 months) versus those with low TAM/high T-eff (mPFS: 4.76 months and mOS: 16.39 months), reiterating the potential inhibitory effect of TAMs with atezolizumab treatment
- Numerical trends in IRF-PFS and OS suggest that lurbinectedin may overcome TAM-mediated resistance to atezolizumab

IRF-PFS and OS in high TAM/high T-eff

IRF-PFS

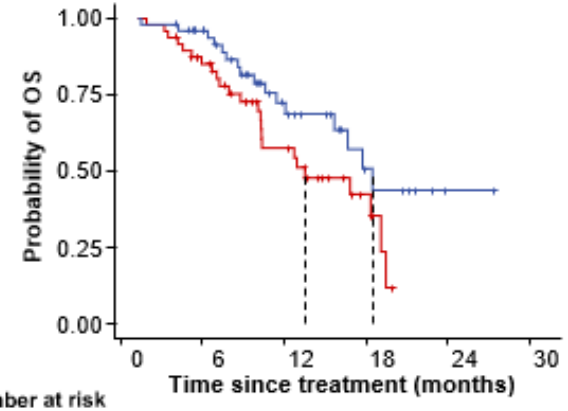
	Atezo	Lurbi+ Atezo
mPFS, months	2.63	5.59
HR, 95% CI	0.64 (0.4, 1.03)	



Number at risk							
Atezo	48	16	8	7	3	3	2
Lurbi + atezo	50	36	19	13	7	4	1

OS

	Atezo	Lurbi+ Atezo
mOS, months	12.25	17.22
HR, 95% CI	0.56 (0.29, 1.05)	

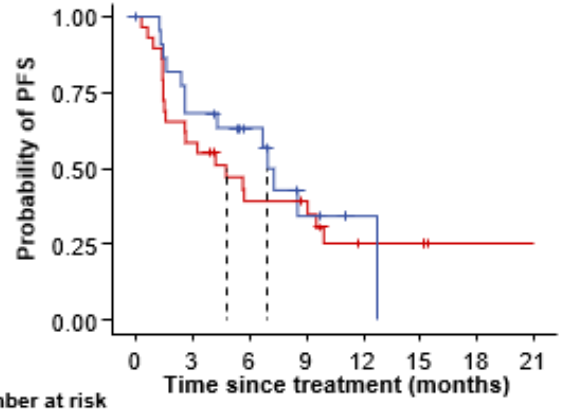


Number at risk							
Atezo	48	32	16	2	0	0	
Lurbi + atezo	50	38	15	6	1	0	

IRF-PFS and OS in low TAM/high T-eff

IRF-PFS

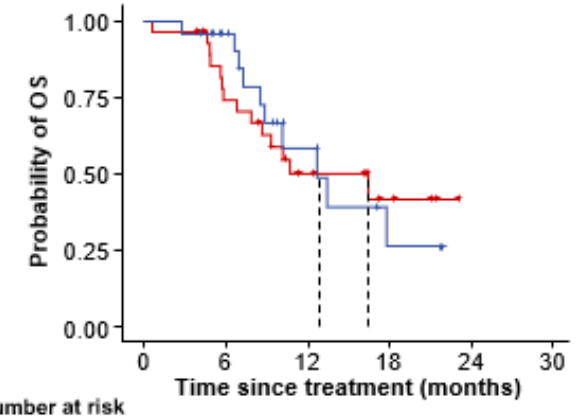
	Atezo	Lurbi+ Atezo
mPFS, months	4.76	6.97
HR, 95% CI	0.82 (0.4, 1.65)	



Number at risk								
Atezo	29	17	10	9	4	4	1	1
Lurbi + atezo	24	15	10	4	1	0	0	0

OS

	Atezo	Lurbi+ Atezo
mOS, months	16.39	12.75
HR, 95% CI	0.95 (0.42, 2.14)	



Number at risk							
Atezo	29	20	10	4	0	0	
Lurbi + atezo	24	18	7	2	0	0	

CI, confidence interval; HR, hazard ratio; IRF, independent review facility; Lurbi, lurbinectedin; m, median; OS, overall survival; PFS, progression-free survival; TAM, tumor-associated macrophage; T-eff, T-effector

CONCLUSIONES

- CPCP 1L:
  - La RT torácica no muestra beneficio en la era QT-IO
  - Resultados iniciales con radiofármacos son prometedores en seguridad y eficacia, pero es necesario un mayor seguimiento

- CPCP 2L:
  - Diferentes tipos de ADC con resultados muy prometedores en seguridad y eficacia
  - Nuevas alternativas terapéuticas: CAR-T, Ac Biespecíficos

Gracias