Lung Cancer UPDATES
ASCO HIGHLIGHTS
31 MAYO-04 JUNIO 2024
Chicago, USA

Iniciativa científica de:
GECP
lung cancer research

CNMP ESTADIOS TEMPRANOS

XABIER MIELGO-RUBIO, MD

Unidad de Oncología

Hospital Universitario Fundación Alcorcón

OUTLINE

ASCO 2024 Lung Cancer Updates GECP

Iniciativa científica de:

GECP lung cancer research

- Perioperative immunotherapy
- Perioperative targeted therapy
- ctDNA – MRD
- Operability parameters changes

PERIOPERATIVE IMMUNOTHERAPY

CHECKMATE-77T : EXPLORATORY ANALYSYS BY NODAL STATUS (N2 vs not-N2)

Iniciativa científica de: GECP lung cancer research

2024 ASCO ANNUAL MEETING

#LBA 8007

Clinical outcomes with perioperative nivolumab by nodal status among patients with stage III resectable NSCLC: results from the phase 3 CheckMate 77T study

Mariano Provencio Pulla,[1] Mark M. Awad,[2] Jonathan D. Spicer,[3] Annelies Janssens,[4] Fedor Moiseyenko,[5] Yang Gao,[6] Yasutaka Watanabe,[7] Aurelia Alexandru,[8] Florian Guisier,[9] Nikolaj Frost,[10] Fabio Franke,[11] T. Jeroen Nicolaas Hiltermann,[12] Jie He,[13] Fumihiro Tanaka,[14] Shun Lu,[15] Cinthya Coronado Erdmann,[16] Padma Sathyanarayana,[16] Phuong Tran,[16] Vipul Devas,[16] Tina Cascone[17]

PERIOPERATIVE IMMUNOTHERAPY

CHECKMATE-77T : EXPLORATORY ANALYSYS BY NODAL STATUS (N2 vs not-N2)

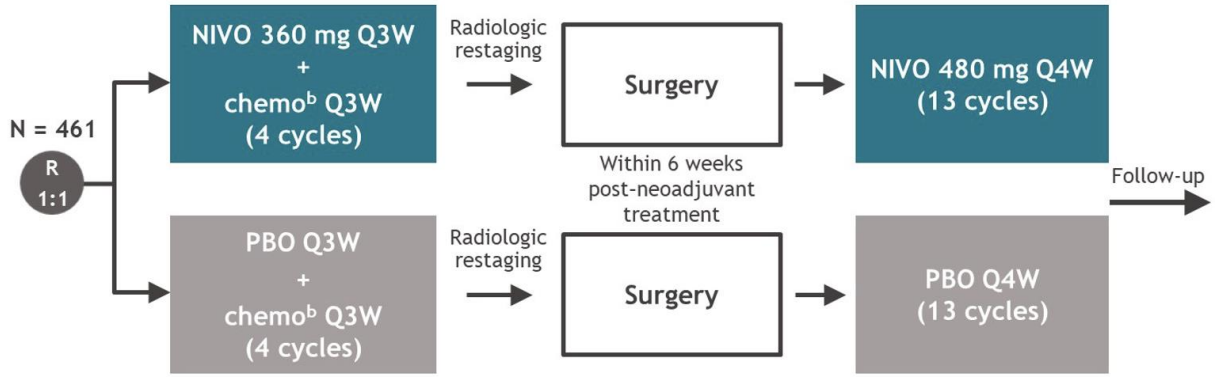
Iniciativa científica de: GECP lung cancer research

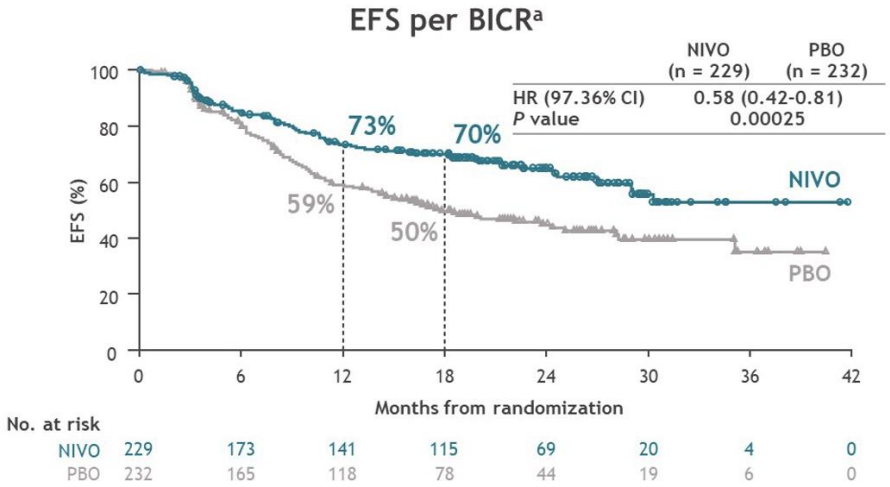
In phase III CM-77T trial, perioperative Nivolumab showed signifcant EFS improvement vs PBO in pts with stage II-IIIB resectable NSCLC. pCR and MPR rates were also improved

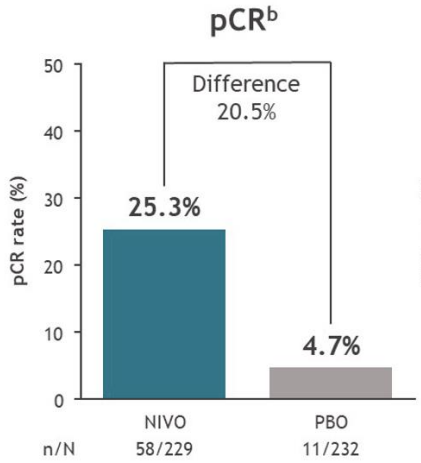
Key eligibility criteria

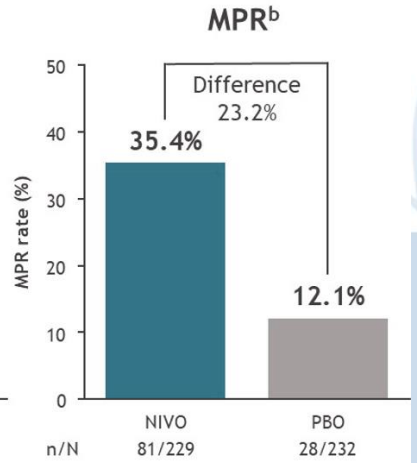
- Resectable, stage IIA (> 4 cm)-IIIB (N2) NSCLC (per AJCC 8th edition)
- No prior systemic anti-cancer treatment
- ECOG PS 0-1
- No *EGFR* mutations/known *ALK* alterations

Stratified by histology (NSQ vs SQ), disease stage (II vs III), and tumor PD-L1 (≥ 1% vs < 1% vs not evaluable/indeterminate)









Cascone, N Eng J Med 2023

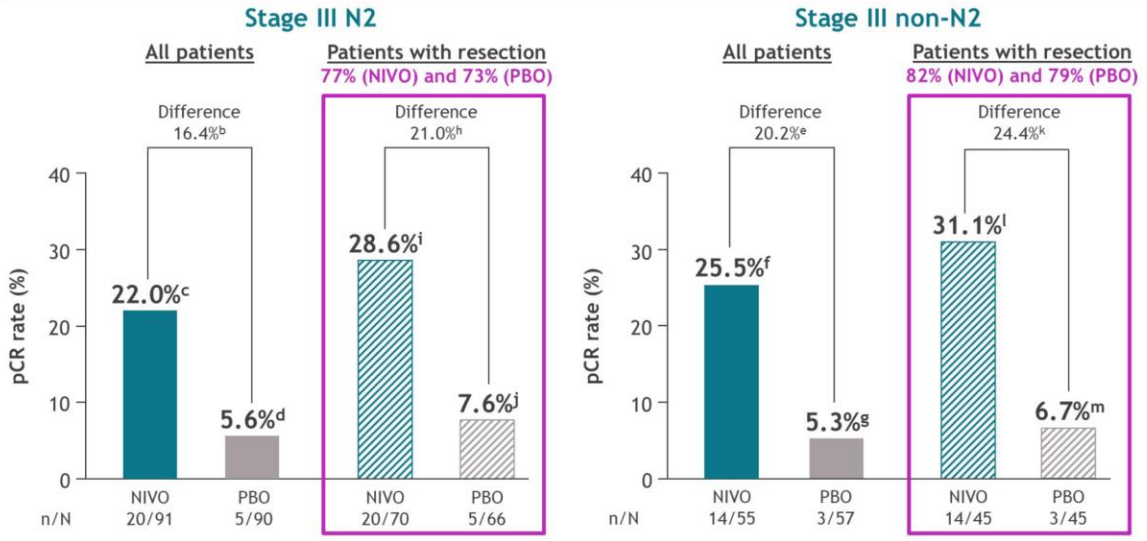
PERIOPERATIVE IMMUNOTHERAPY

#LBA 8007

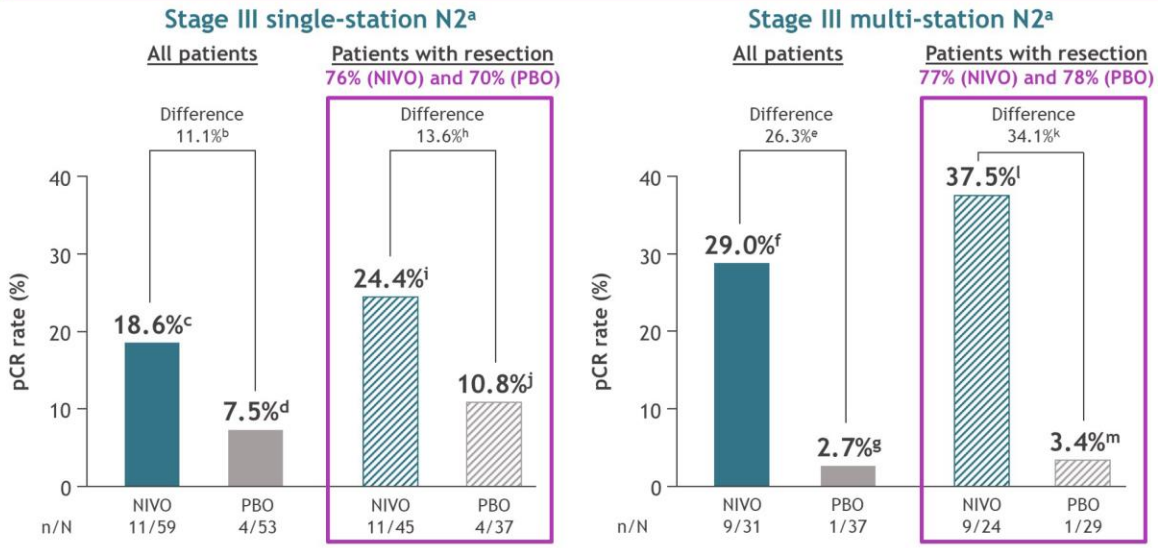
Iniciativa científica de: GECP lung cancer research

CHECKMATE-77T : EXPLORATORY ANALYSIS BY NODAL STATUS (N2 vs not-N2)

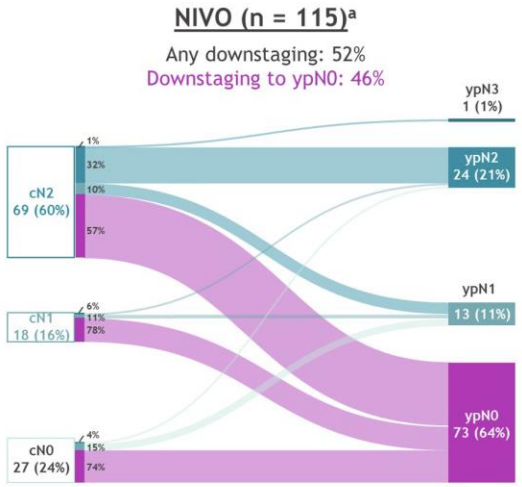
pCR[a] N2 vs non-N2

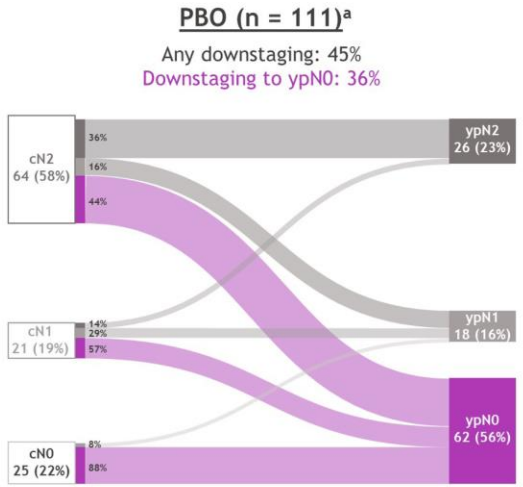


pCR N2 single vs multi-N2



N Downstaging





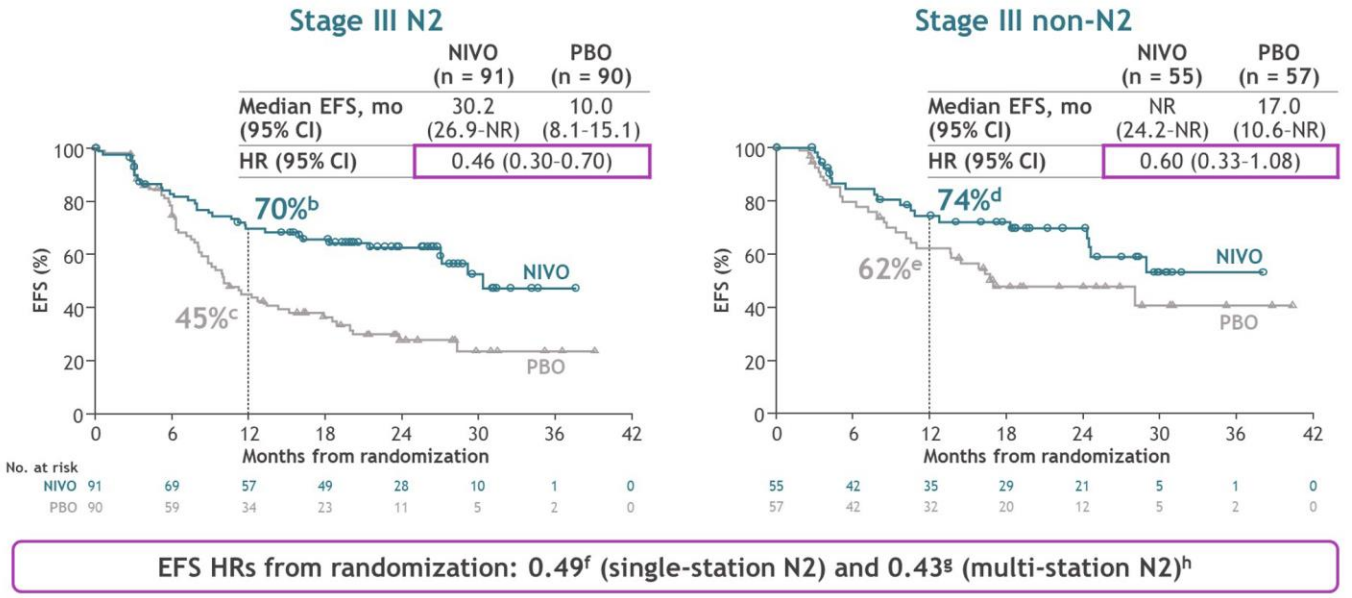
N2
- 67% downstaging
- 57% to N0

PERIOPERATIVE IMMUNOTHERAPY

CHECKMATE-77T : EXPLORATORY ANALYSYS BY NODAL STATUS (N2 vs not-N2)

Iniciativa científica de: GECP lung cancer research

EFS from randomization[a]



EFS HRs from randomization: 0.49[f] (single-station N2) and 0.43[g] (multi-station N2)[h]

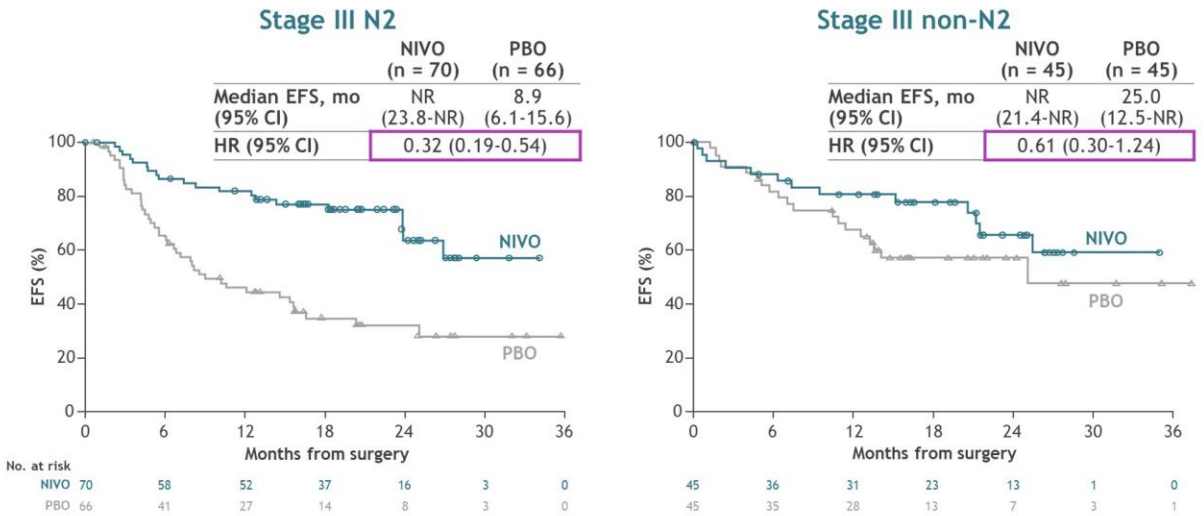
- Beneficio clínico con nivolumab perioperatorio vs placebo tanto en pacientes estadio III N2 como no-N2
- Mejora pCR, downstaging
- Mejora la EFS:
  - HR 0.46 (N2); HR 0.6 (non-N2)
  - HR 0.43 (multi-N2); HR 0.49 (single N2)

PERIOPERATIVE IMMUNOTHERAPY

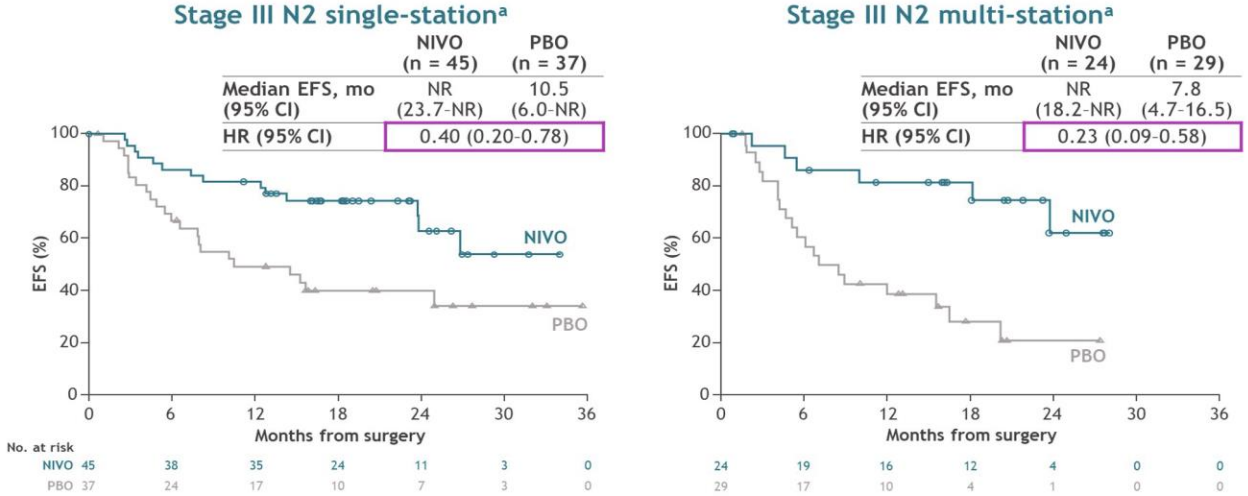
CHECKMATE-77T : EXPLORATORY ANALYSYS BY NODAL STATUS (N2 vs not-N2)

Iniciativa científica de: GECP lung cancer research

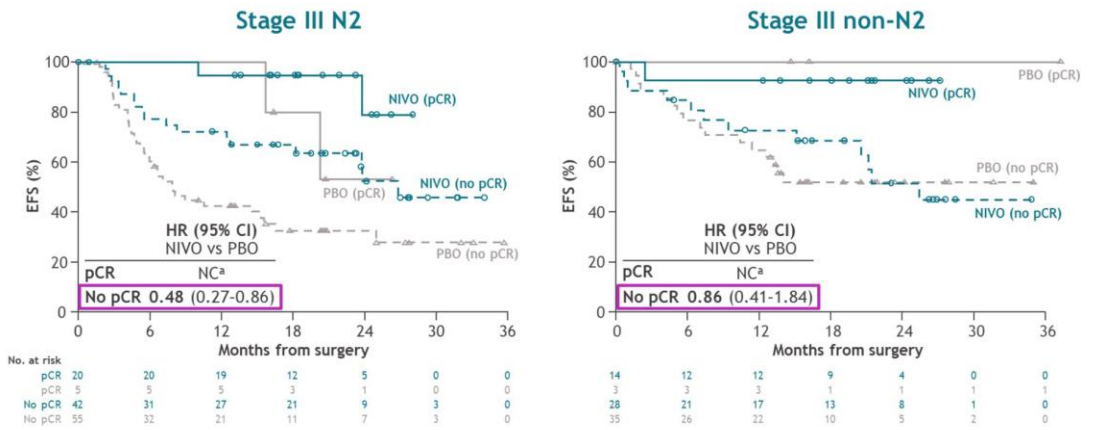
Landmark EFS from definitive surgery



Landmark EFS from definitive surgery



Landmark EFS from definitive surgery by pCR status



Landmark EFS HRs for no pCR[a]: 0.59[b] (single-station N2) and 0.36[c] (multi-station N2)[d]

- Mejoría de la EFS desde la cirugía con mayor reducción de riesgo a más N
  - HR 0.32 N2
  - HR 0.23 multi-N2
- Mejoría de la EFS en pacientes N2 sin pCR
  - HR 0.48

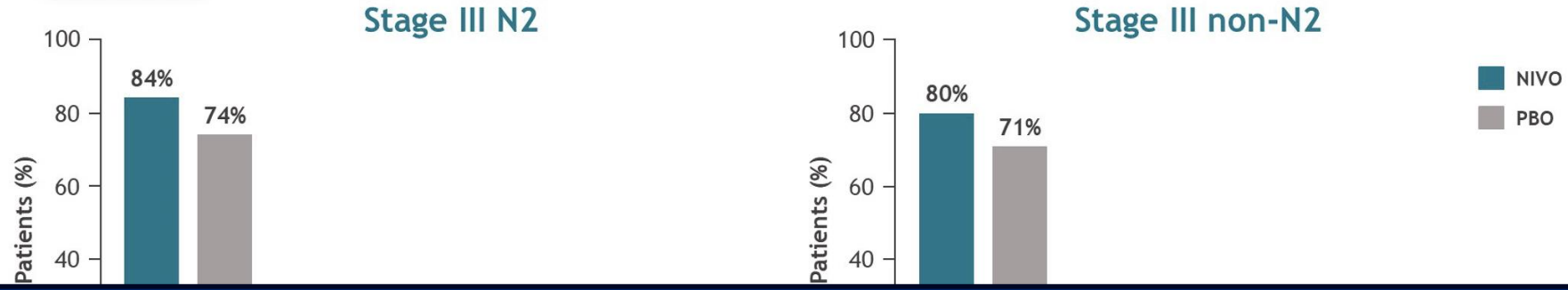
PERIOPERATIVE IMMUNOTHERAPY

CHECKMATE-77T : EXPLORATORY ANALYSYS BY NODAL STATUS (N2 vs not-N2)

Iniciativa científica de: GECP lung cancer research

Extent of resection[a]

Safety summarya



Complete resection (R0), %	86[c]	86[d]
	84[e]	87[f]

Estos resultados avalan el uso de Nivolumab perioperatorio en pacientes con CNMP resecable, también en el subgrupo de peor pronóstico estadio III N2

- La viabilidad quirúrgica fue similar en los pacientes N2 respecto a los no-N2 tras quimio-inmuno neoadyuvante con nivolumab
- 86% de las cirugías fue R0, comparable e incluso mayor numéricamente que en los no-N2

PERIOPERATIVE IMMUNOTHERAPY

CHECKMATE-816 : 4-year update

Iniciativa científica de: GECP lung cancer research

2024 ASCO ANNUAL MEETING

#LBA 8010

Neoadjuvant nivolumab plus chemotherapy vs chemotherapy in patients with resectable NSCLC: 4-year update from CheckMate 816

Jonathan D. Spicer,[1] Nicolas Girard,[2] Mariano Provencio Pulla,[3] Changli Wang,[4] Tetsuya Mitsudomi,[5] Mark M. Awad,[6] Everett E. Vokes,[7] Janis M. Taube,[8] Lorena Lupinacci,[9] Gene B. Saylors,[10] Fumihiro Tanaka,[11] Moishe Liberman,[12] Sung Yong Lee,[13] Aurelia Alexandru,[14] Manolo D'Arcangelo,[15] Phuong Tran,[16] Javed Mahmood,[16] Vishwanath Gharpure,[16] Apurva Bhingare,[16] Patrick M. Forde[8]

[1]McGill University Health Centre, Montreal, Quebec, Canada; [2]Institut du Thorax Curie-Montsouris, Institut Curie, Paris, France; [3]Hospital Universitario Puerta de Hierro, Madrid, Spain; [4]Tianjin Lung Cancer Center, Tianjin Medical University Cancer Institute & Hospital, Tianjin, China; [5]Kindai University Faculty of Medicine, Ohno-Higashi, Osaka-Sayama, Japan; [6]Dana-Farber Cancer Institute, Boston, MA; [7]University of Chicago Medicine, Chicago, IL; [8]The Bloomberg-Kimmel Institute for Cancer Immunotherapy, Johns Hopkins Medicine, The Sidney Kimmel Comprehensive Cancer Center, Baltimore, MD; [9]Hospital Italiano de Buenos Aires, Buenos Aires, Argentina; [10]Charleston Oncology, Charleston, SC; [11]University of Occupational and Environmental Health, Kitakyushu, Japan; [12]Centre Hospitalier de l'Universite de Montreal, Montreal, Quebec, Canada; [13]Korea University Guro Hospital, Korea University College of Medicine, Seoul, Republic of Korea; [14]Institutul Oncologic București Prof. Dr. Alexandru Trestioreanu, Bucharest, Romania; [15]Azienda Unita Sanitaria Locale della Romagna, Ravenna, Italy; [16]Bristol Myers Squibb, Princeton, NJ

Abstract number LBA8010

PERIOPERATIVE IMMUNOTHERAPY

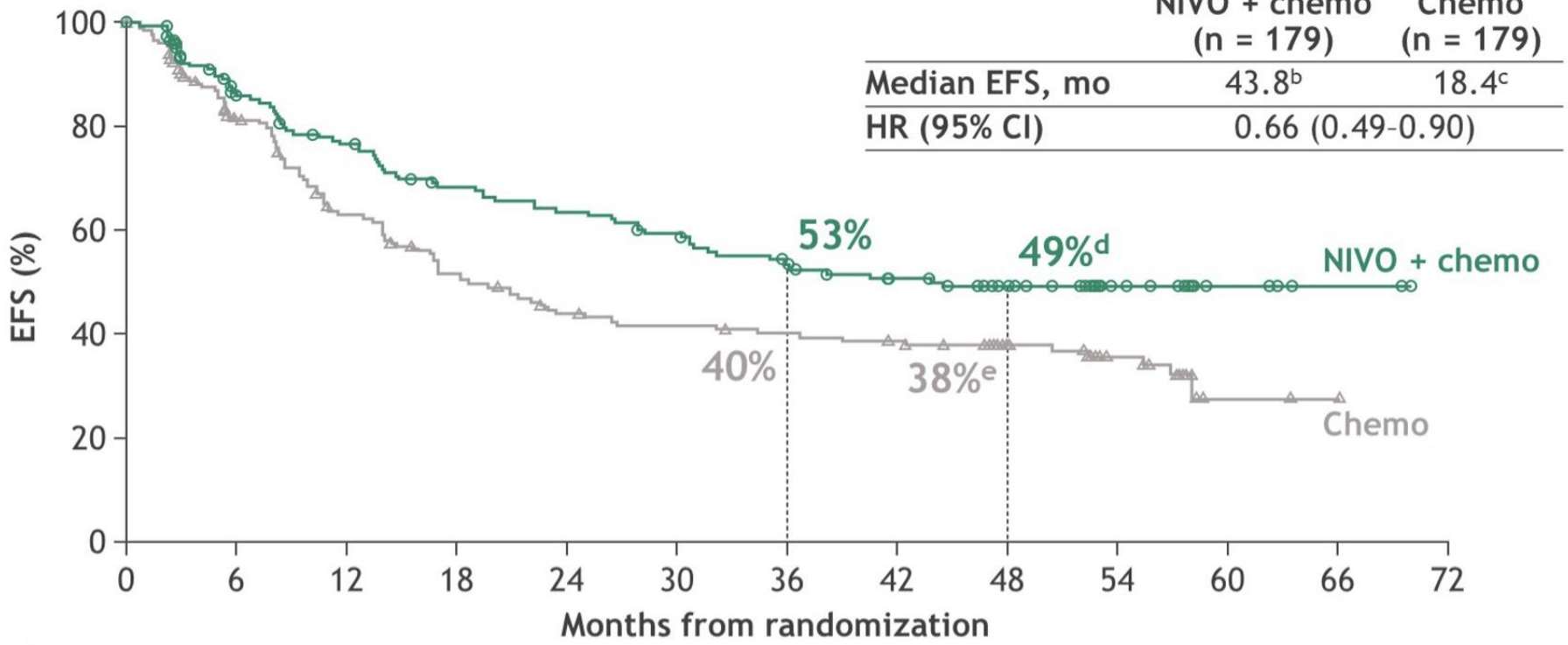
CHECKMATE-816 : 4-year update EFS

Iniciativa científica de: GECP lung cancer research

EFS: 4-year update[a]

- In CheckMate 816, neoadjuvant NIVO + chemo significantly improved the primary endpoints of EFS and pCR vs chemo and demonstrated a favorable OS trend in patients with resectable NSCLC[1,2]

	NIVO + chemo (n = 179)	Chemo (n = 179)
Median EFS, mo	43.8[b]	18.4[c]
HR (95% CI)	0.66 (0.49-0.90)	



No. at risk													
NIVO + chemo	179	130	114	99	92	85	74	64	49	24	5	2	0
Chemo	179	124	92	73	60	56	53	50	37	22	2	1	0

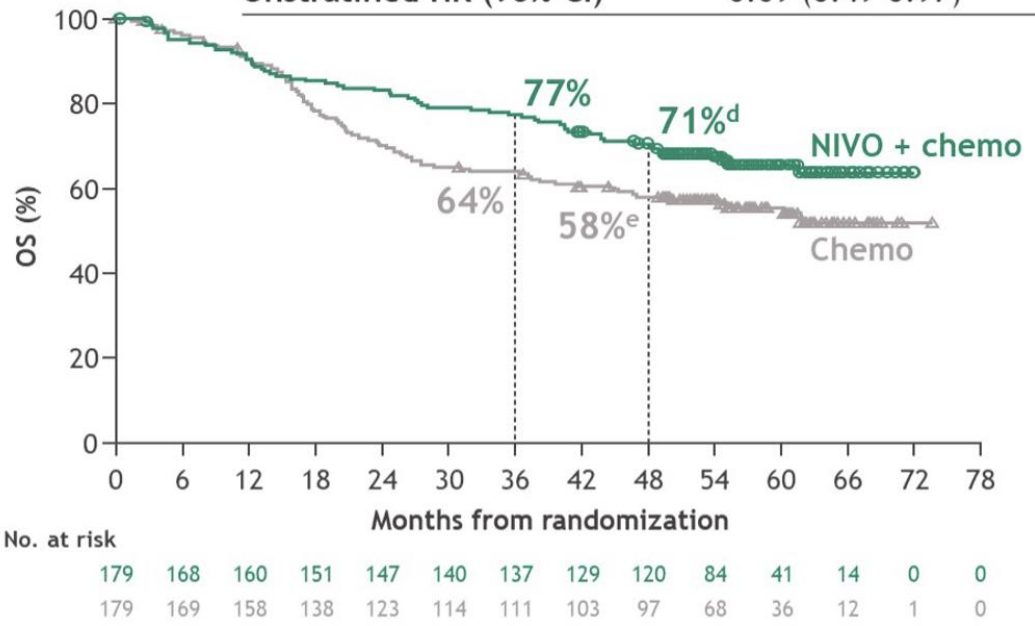
PERIOPERATIVE IMMUNOTHERAPY

CHECKMATE-816 : 4-year update OS and lung cancer-specific survival

Iniciativa científica de: GECP lung cancer research

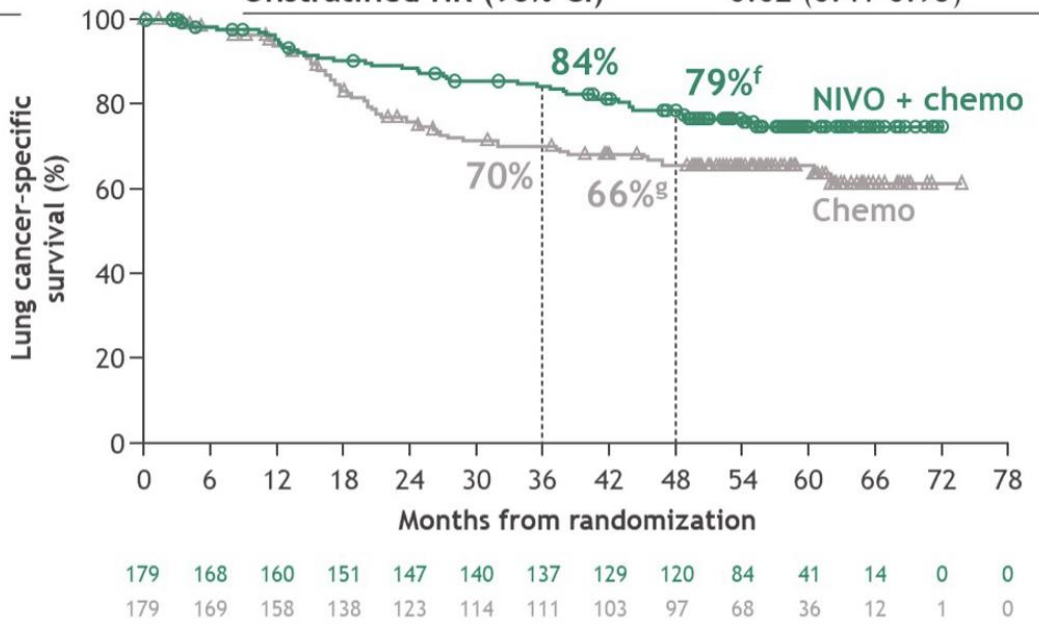
OS

	NIVO + chemo (n = 179)	Chemo (n = 179)
Median OS,[a] mo	NR	NR[c]
HR (98.36% CI); *P* value	0.71 (0.47-1.07); 0.0451[b]	
Unstratified HR (95% CI)	0.69 (0.49-0.97)	



Lung cancer-specific survival[h]

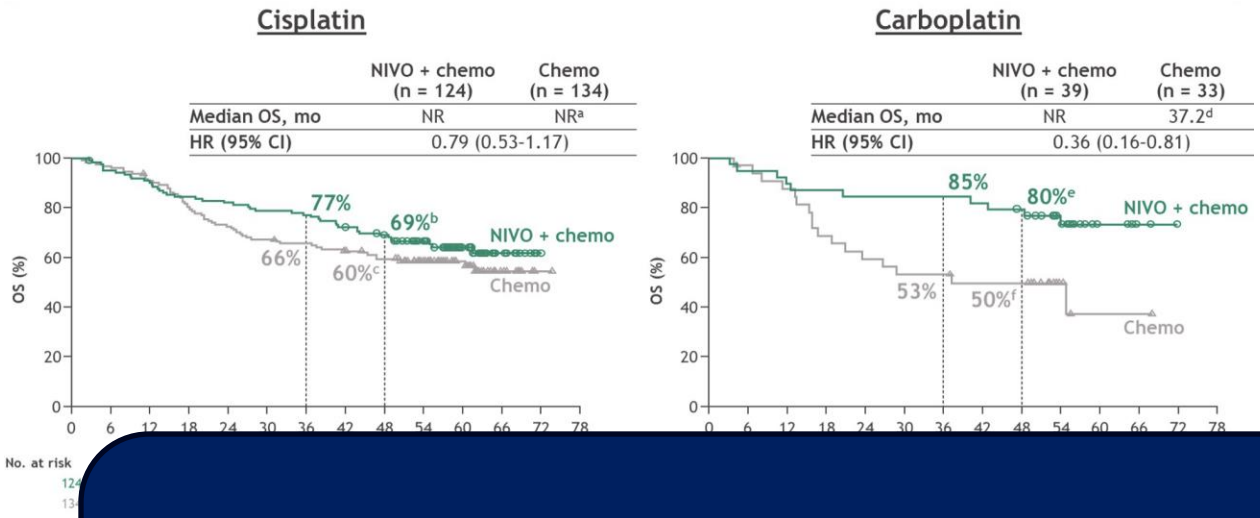
	NIVO + chemo (n = 179)	Chemo (n = 179)
Median lung cancer-specific survival, mo	NR	NR
Unstratified HR (95% CI)	0.62 (0.41-0.93)	



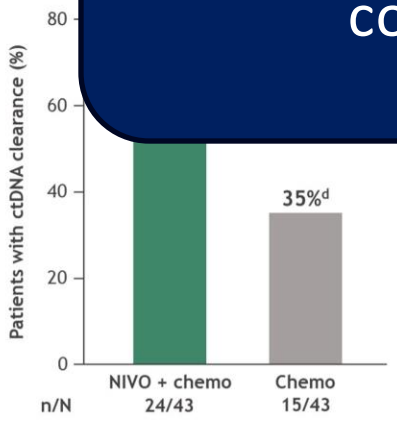
- Patients in the NIVO + chemo arm who had pCR continued to have improved OS vs those who did not (HR [95% CI], 0.08 [0.02-0.34]; **4-year OS rates, 95% vs 63%**)

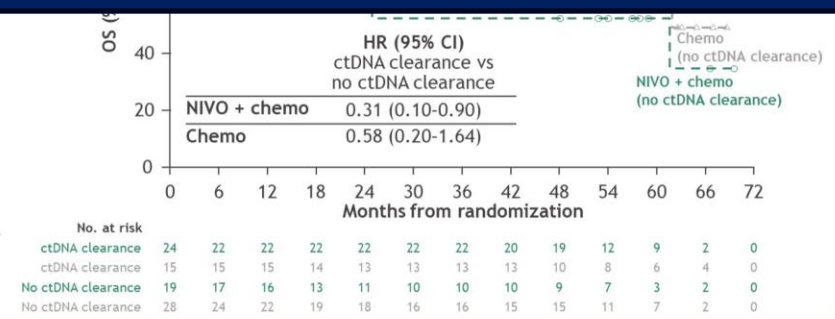
PERIOPERATIVE IMMUNOTHERAPY

CHECKMATE-816 : 4-year update



Estos resultados refuerzan el uso de quimio-inmunoterapia neoadyuvante con nivolumab como SoC de los pacientes con CNMP resecable y nos aporta más conocimiento del beneficio a largo plazo de la QTIO neoadyuvante





- Tendencia a mejor OS independientemente del tipo de platino utilizado (carboplatino HR 0.36) o de la extensión de la cirugía

- El aclaramiento de ctDNA precirugía fue un factor pronóstico de OS

PERIOPERATIVE IMMUNOTHERAPY

AEGEAN : N2 subgroup analysis

Iniciativa científica de: GECP lung cancer research

2024 ASCO ANNUAL MEETING

 # 8011

Outcomes with Perioperative Durvalumab in Patients with Resectable NSCLC and Baseline N2 Lymph Node Involvement (N2 R-NSCLC)

An Exploratory Subgroup Analysis of AEGEAN

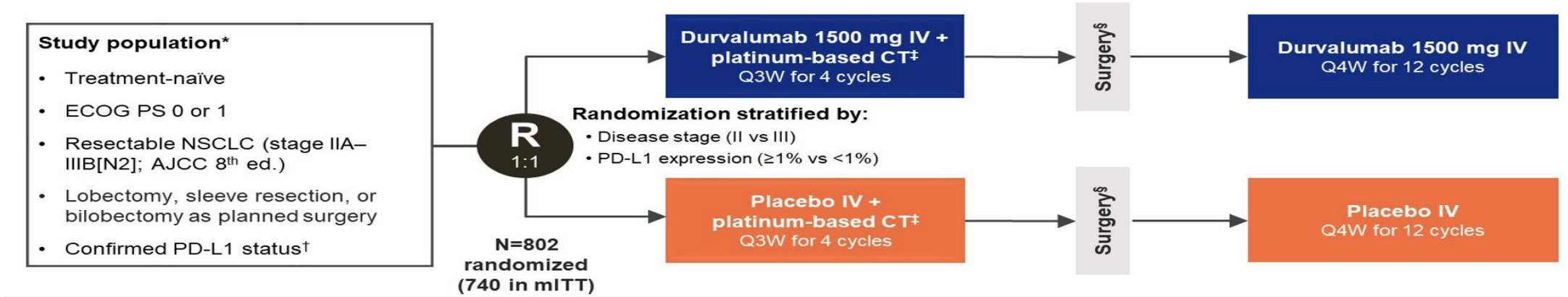
John V. Heymach,[1] Martin Reck,[2] Tetsuya Mitsudomi,[3] Janis M. Taube,[4] Alexander Spira,[5] Jamie Chaft,[6] Gary J. Doherty,[7] Helen Mann,[7] Tamer M. Fouad,[8] David Harpole[9]

[1]Department of Thoracic/Head and Neck Medical Oncology, The University of Texas M.D. Anderson Cancer Center, Houston, TX, USA; [2]Lung Clinic Grosshansdorf, Airway Research Center North, German Center for Lung Research, Grosshansdorf, Germany; [3]Division of Thoracic Surgery, Department of Surgery, Kindai University Faculty of Medicine, Osaka-Sayama, Japan; [4]Bloomberg–Kimmel Institute for Cancer Immunotherapy, Johns Hopkins Kimmel Cancer Center, Baltimore, MD, USA; [5]Virginia Cancer Specialists Research Institute, Fairfax, VA, & US Oncology Research, The Woodlands, TX, USA; [6]Memorial Sloan-Kettering Cancer Center and Weill Cornell Medical College, New York, NY, USA; [7]AstraZeneca, Cambridge, UK; [8]AstraZeneca, New York, NY, USA; [9]Department of Surgery, Duke University Medical Center, Durham, NC, USA

PRESENTED BY: John V. Heymach, MD, PhD; Professor and Chair

PERIOPERATIVE IMMUNOTHERAPY

AEGEAN : N2 subgroup analysis



N2 vs mITT

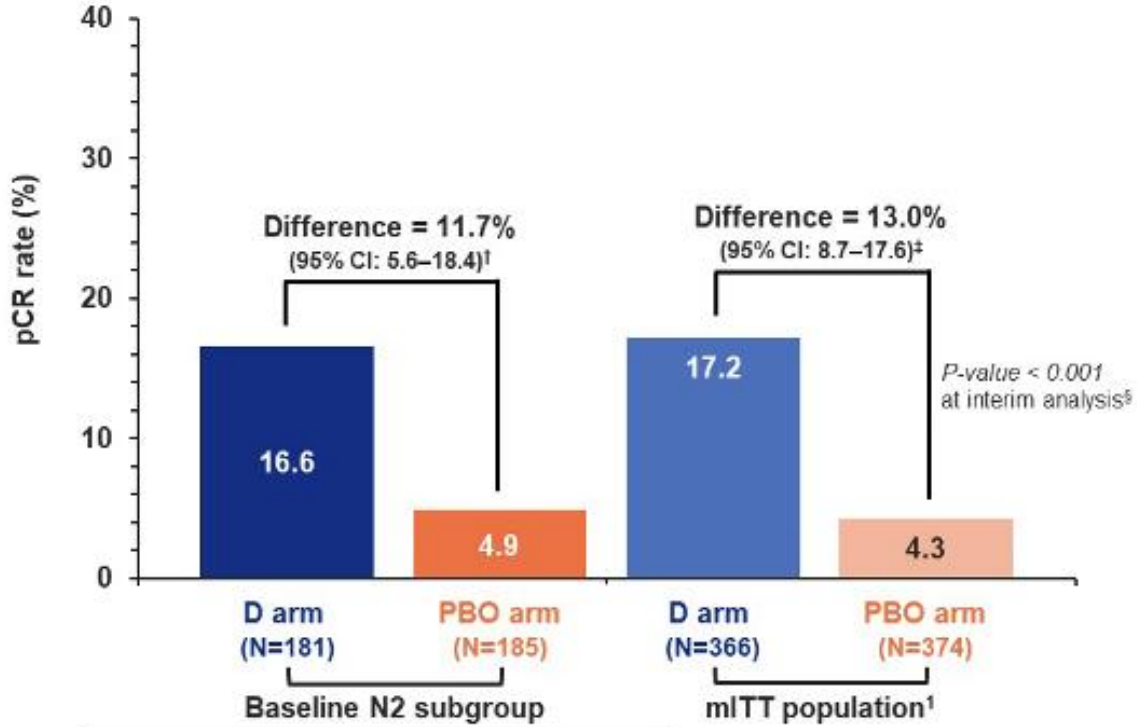
- % 4 ciclos completos neoadyuvancia: similar
- % cirugía de resección ligeramente menor (73,5% N2 vs 77,6% mITT)
- % resección R0 similar (94,7% en ambos) y numéricamente superior que en los que no recibieron durva
- Procedimiento quirúrgico: similar porcentaje cirugía abierta
- Extensión de la cirugía: similar porcentaje de neumonectomías y lobectomías
- % retraso de cirugía similar: 19,9% N2 vs 17,3% mITT

PERIOPERATIVE IMMUNOTHERAPY

AEGEAN : N2 vs mITT

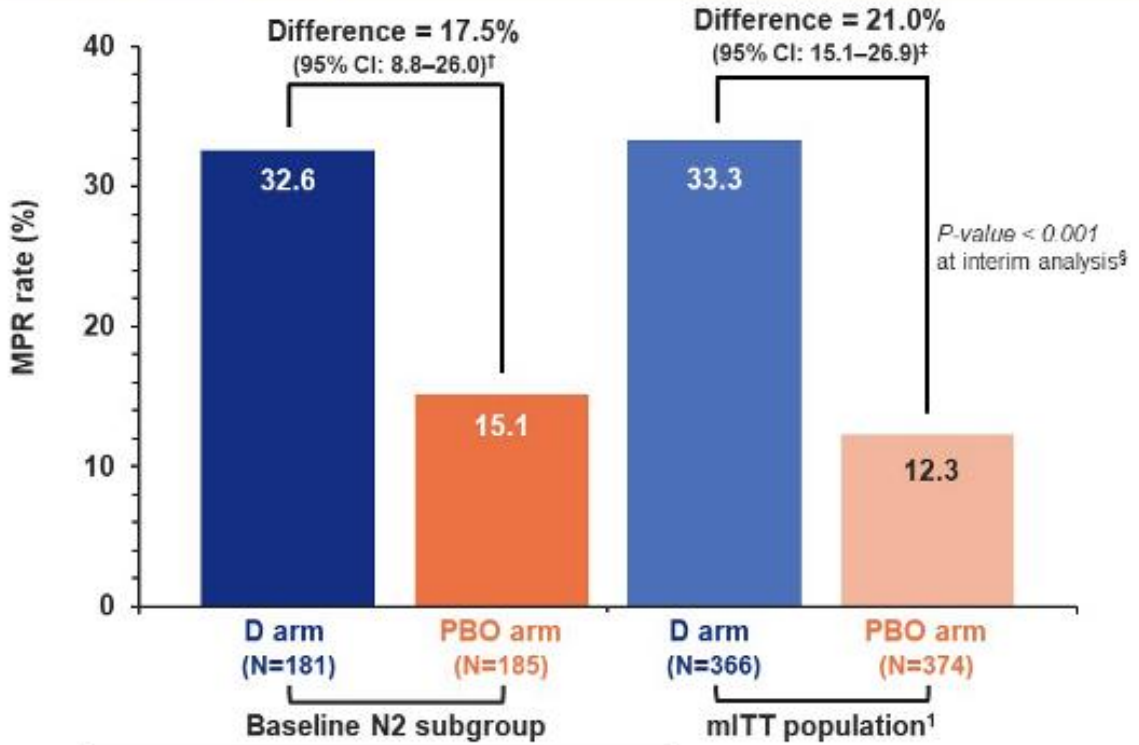
Iniciativa científica de: GECP lung cancer research

pCR (central lab)



	Difference in pCR rates (95% CI)¹
N2 single-station (n=273)	13.9% (6.6–21.7)
N2 multi-station (n=74)	3.8% (-9.2–18.8)

MPR (central lab)



	Difference in MPR rates (95% CI)¹
N2 single-station (n=273)	20.9% (10.5–31.0)
N2 multi-station (n=74)	1.8% (-13.5–18.2)

PERIOPERATIVE IMMUNOTHERAPY

AEGEAN : N2 vs mITT

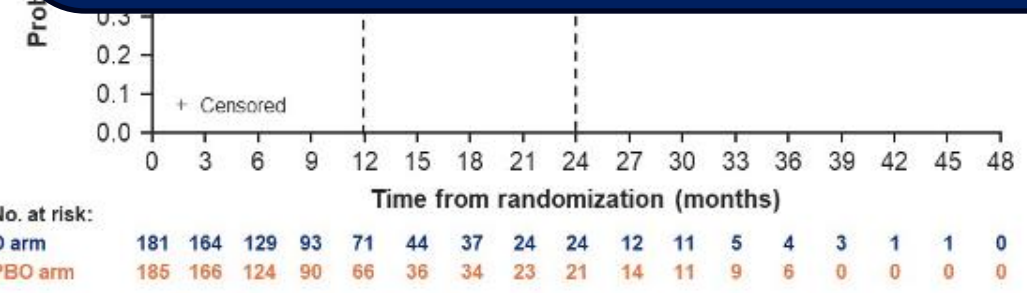
Iniciativa científica de: GECP lung cancer research

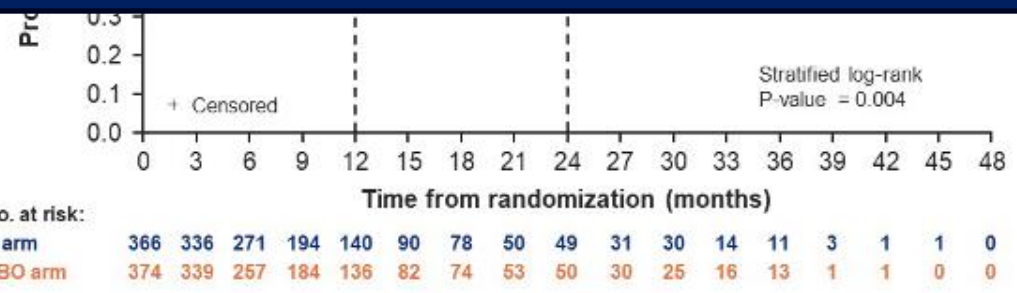
EFS using RECIST v1.1 (BICR) (baseline N2 subgroup and mITT)*

- EFS benefit in this subgroup was consistent with the mITT population and similar among patients with single- and multi-station N2 disease
  - N2 single-station (n=273) HR† (95% CI): 0.61 (0.39–0.94)[1]
  - N2 multi-station (n=74) HR† (95% CI): 0.69 (0.33–1.38)[1]

HR 0.63 in N2 patients

Estos resultados avalan el posible uso de durvalumab perioperatorio en pacientes con CNMP resecable N2 con mejoría estadística y clínicamente significativa de la eficicacia y sin un impacto negativo en los resultado quirúrgicos





PERIOPERATIVE IMMUNOTHERAPY

KEYNOTE-671 : HRQoL

Iniciativa científica de: GECP lung cancer research

2024 ASCO ANNUAL MEETING

 # 8012

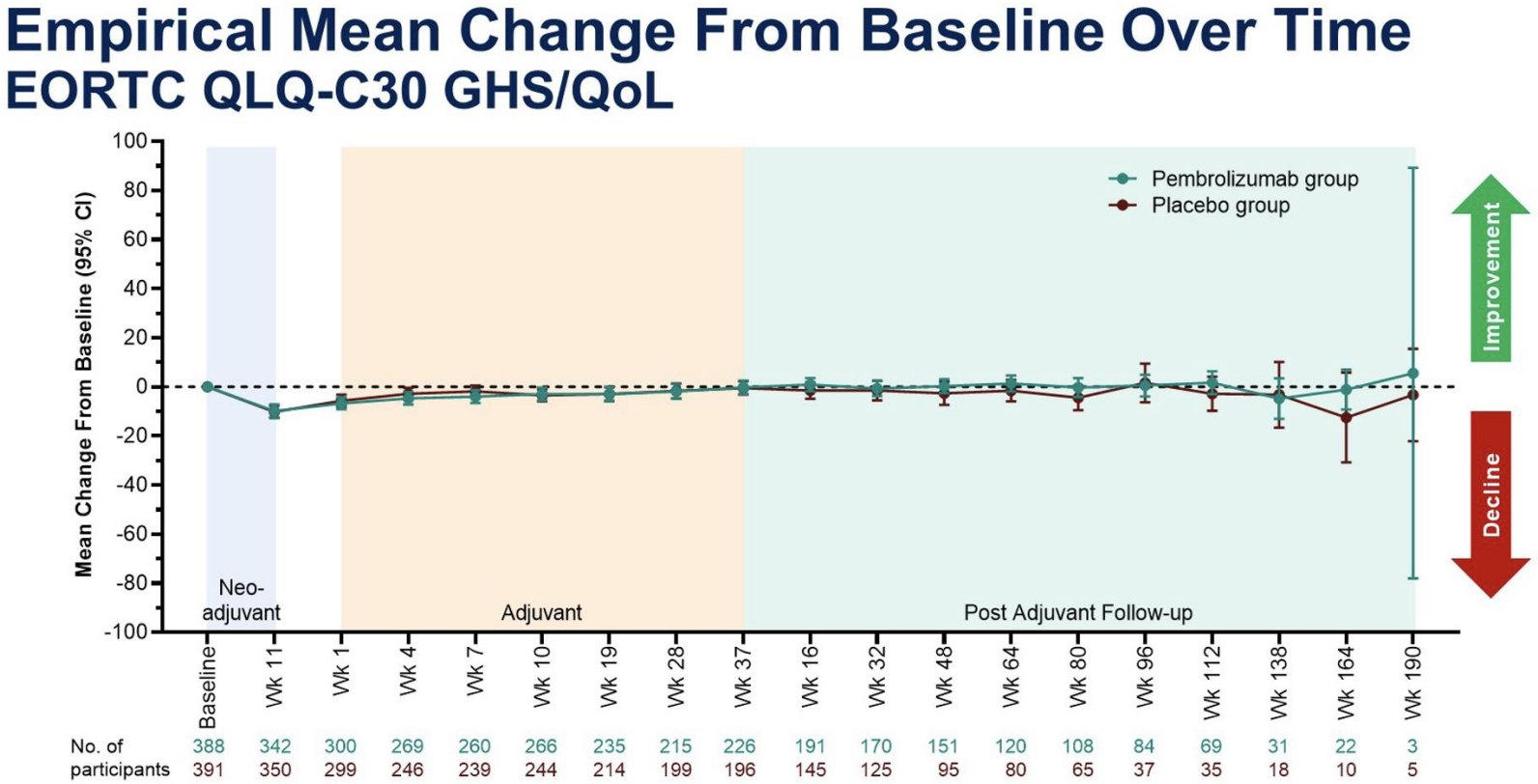
Health-Related Quality of Life Outcomes From the Randomized, Double-Blind Phase 3 KEYNOTE-671 Study of Perioperative Pembrolizumab for Early-Stage NSCLC

Marina C Garassino, Heather Wakelee, Jonathan D Spicer, Moishe Liberman, Terufumi Kato, Masahiro Tsuboi, Se-Hoon Lee, Ke-Neng Chen, Christophe Dooms, Margarita Majem, Ekkehard Eigendorff, Gastón L Martinengo, Olivier Bylicki, Delvys Rodríguez-Abreu, Jamie Chaft, Jing Yang, Ashwini Arunachalam, Josephine M Norquist, Steven M Keller, Shugeng Gao

Presented by Marina C Garassino of the University of Chicago School of Medicine and Biological Sciences, Chicago, IL, USA

PERIOPERATIVE IMMUNOTHERAPY

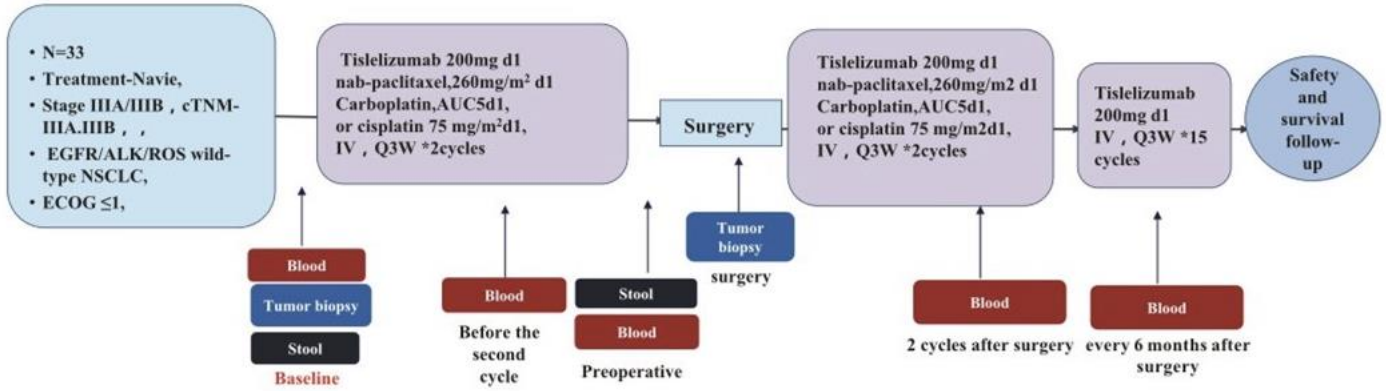
KEYNOTE-671: HRQoL



- El uso de pembrolizumab perioperatorio no deterioró la calidad de vida relacionada con la salud en comparación con la QT neoadyuvante en pacientes con CNMP estadio II-IIIB (N2) resecable
- La calidad de vida empeoró durante el periodo neoadyuvante y posteriormente se restauró hasta la situación basal durante la fase adyuvante en ambos brazos

PERIOPERATIVE IMMUNOTHERAPY #8024

PH. II TISLELIZUMAB + CT PRE AND POST



RATIONALE-315

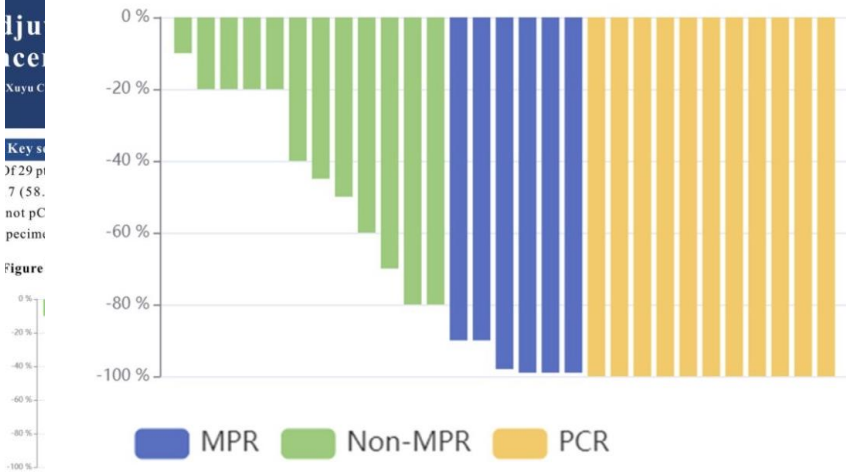


Table5.Pathologic response

Outcomes	Results, n (% , 95% CI); n = 29
MPR	17 (58.6, 38.94-76.48)
PCR	11 (38.0, 20.69-57.74)
Non-MPR	12 (41.4, 23.52-61.06)

Neoadju
advanced stage IIIA/IIIB NSCLC.

Clinical trial identification
Clinical trial information: NCT04865705

Table 6. EFS rate

Outcomes (n = 31)	Results, (% , 95% CI);
12-month EFS rate	82.3 (68.1-96.4)
24-month EFS rate	64.0 (41.8-85.7)

Table 2. R0

Outcomes	
Surgery rate	
Surgical resect	
R0	
R1	

Survival

nalysis Set)

	Events (%)	Median (95% CI), months
TIS arm	58 (25.7)	NR (NE, NE)
PBO arm	83 (36.6)	NR (16.6, NE)

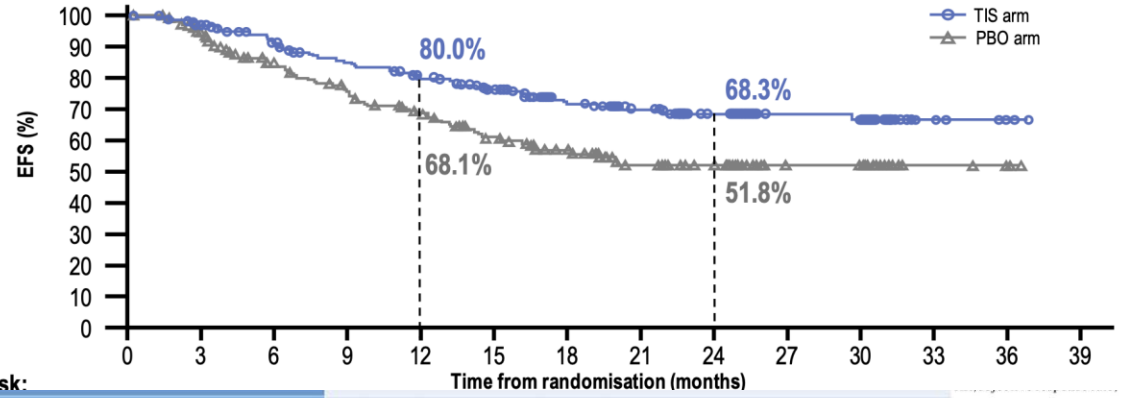


Table3. Dov

Outcomes	
Downstaging r	
clinical	
pathologic	26 (89.7, 72.65-97.82)

PREOPERATIVE IMMUNOTHERAPY + RT # 8054

PHASE IB NEOADJUVANT HYPOFRACTIONATED RT + PEMBRO + CT

Iniciativa científica de: GECP lung cancer research

Neoadjuvant hypofractioned radiotherapy combined with pembrolizumab plus chemotherapy for potentially resectable non-small cell lung cancer: A phase Ib study

Naixin Ding[1], Lijun Zhao[1], Shuai Zhang[2], Ninglei Qiu[2], Xue Song[1], Cheng Kong[1], Ning Jiang[1], Yang Zhao[3], Jianfeng Huang[2], Feng Jiang[2], Ming Jiang[2], Zihao Zhu[1], Rong Yin[4], Binhui Ren[2], Xiangzhi Zhu[1], Ming Li[2]

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Abstract # 8054

Background and Objective

Background:

- Lung cancer is the malignant tumor with the highest incidence rate and mortality in the world[1],and non small cell lung cancer (NSCLC) accounts for approximately 85% of lung cancer[2].
- Neoadjuvant immune checkpoint inhibitors(ICIs) plus chemotherapy in resectable non-small cell lung cancer (NSCLC) has become a standard of care[3, 4].
- More effective neoadjuvant therapy is required for potentially resectable stage III NSCLC to improve surgical resection rate.
- Therefore, there is a need to explore safer and more effective treatment schedules.

Objective:

- To evaluate the safety and feasibility of neoadjuvant hypofractioned radiotherapy (HFRT) with pembrolizumab plus chemotherapy followed by radical resection of lung cancer in patients (pts) with potentially resectable stage III NSCLC with negative driver oncogene.

Methods

- Study design: A single center, single arm exploratory phase Ib trial (Figure1)
- Neoadjuvant Treatment:
  - Radiotherapy: 24Gy / 3 fractions for peripheral primary tumor, D1~D3.
    12Gy / 3 fractions for central primary tumor, D1~D3.
  - Pembrolizumab(100mg) + paclitaxel (135 mg/m²) + carboplatin (AUC=5) on D6, D27
  - Individualized target volume delineation: discussed and determined by both radiation oncologists and thoracic surgeons.
- Radical surgery of lung cancer: within a 4–6 week period after the completion of neoadjuvant treatment.

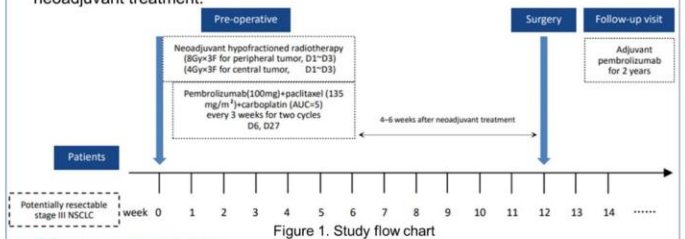

Figure 1. Study flow chart

- Primary endpoint: Safety.
- Secondary endpoint: Feasibility, pathological complete response (pCR),major pathological response(MPR),objective response rate(ORR),progression free survival (PFS),overall survival(OS).
- Study population: cT4N0M0/cT3-4N1M0/cT1-4N2M0 histopathologically confirmed NSCLC patients who were potentially resectable with negative driver oncogene.
- Radiographic response: 64-row spiral CT was used to evaluate the primary tumor regression.
- Pathological response: All surgical specimens were evaluated by two expert oncopathologist (JY Zhang and YN Wu) independently.

Combining HFRT with pembrolizumab and chemotherapy is feasible and effective in patients with potentially resectable NSCLC.

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Results

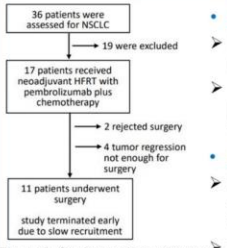


Figure 2. Study enrollment status

- Study enrollment:
  - From Apr 2021 to Nov 2023, 36 pts were screened and 17 pts met the inclusion criteria (Figure 2).
  - 11 pts (64.7%) underwent surgery after the completion of preoperative treatment. The remaining 6 patients were transitioned to definitive chemoradiotherapy.
- General information of patients:
  - Median age was 66 years old(range 54-74) and 15 (88.2%) patients had squamous cell lung cancer. 10 (58.8%) patients had central primary lesion.
  - The majority of them were diagnosed with clinical stage of cT3-T4 (64.7%), cN1-2 (100%), and cTNM IIIB(N2) (70.6%).
- Safety:
  - All 17 pts received HFRT and at least one cycle of immunochemotherapy. Only two pts received chemotherapy alone in the second cycle due to grade 1 nephrotoxicity and grade 2 pulmonary toxicity, respectively.
  - Only one patient died from intraoperative bleeding, and the remaining patients were followed up.
  - The patient with Grade 5 intraoperative AE had coronary heart disease and hypertension as comorbidities, and a history of intracoronary stent implantation. Bleeding occurred at the suturing nail of the pulmonary artery during lymph node traction, resulting in a sudden cardiac arrest. The patient had normal myocardial enzymes, cardiac troponin T, and electrocardiogram performance, so it was uncertain whether his cardiac arrest was related to neoadjuvant therapy.
  - The most common adverse events (AEs) included abnormal hemagglutination(n=10, 58.8%), alopecia (n=10, 58.8%), anemia(n=9, 52.9%), neutropenia(n=8, 47.1%) and hyperlipidemia (n=8, 47.1%).(Table 1)
  - No grade 3 or higher AEs were observed in 17 pts during neoadjuvant therapy.

Grade1~4 AEs	NO.	%
Abnormal Hemagglutination	10	58.8
Alopecia	10	58.8
Anemia	9	52.9
Neutropenia	8	47.1
Hyperlipidemia	8	47.1
Hypoalbuminemia	6	35.3
Lymphopenia	5	29.4
Elevated low-density lipoprotein	5	29.4
Thrombocytopenia	4	23.5
Hyponatremia	4	23.5
Hypochloremia	4	23.5
Reduced high-density lipoprotein	3	17.6
Nausea and vomiting	3	17.6
Hypomagnesemia	3	17.6
Hypokalemia	2	11.8
Hypocalcemia	2	11.8
Fatigue	2	11.8
Cough	2	11.8
Elevated carbamide	2	11.8
Immunologic pneumonitis	1	5.9
Elevated alanine aminotransferase	1	5.9
Elevated serum creatinine	1	5.9
Hiccup	1	5.9
Insomnia	1	5.9
Thoracalgia	1	5.9
Elevated myocardial enzyme	1	5.9

Table 1. AEs during neoadjuvant therapy

Results

- Efficacy:
  - Among the 11 pts, 8 (72.7%) achieved R0 resection, 6 (54.5%) achieved complete pathologic responses in both primary lesions and lymph nodes. 3 (27.3%) achieved pCR in only primary tumor. The primary lesions of the remaining 2 pts did not achieve pCR, including one with remission rate of 87%, the other with remission rate of 47.5% accompanied by residual lymph nodes (Figure 3).
  - No progression was observed during preoperative treatment period. Objective response rate (ORR) was 94.1%.
  - The median PFS was 21.7 months, median OS were not reached, and the 2-year OS rate was 85.6% (Figure 4). The study was terminated early due to slow recruitment.

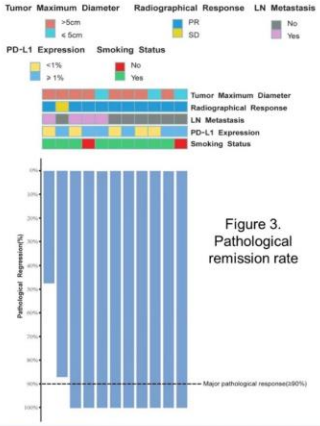
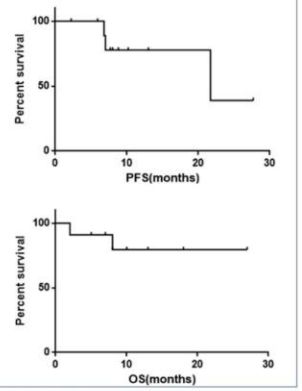


Figure 3. Pathological remission rate

Figure 4. PFS and OS data



Conclusions and future direction

Combining HFRT with pembrolizumab and chemotherapy in neoadjuvant therapy was safe and achieved a pCR rate of 54.5% in pts with potentially resectable NSCLC. We are conducting a phase II trial with an expanded sample size in resectable stage IIA-IIIA NSCLC for further research.

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2024 ASCO Poster Session: Lung Cancer

- 72,7% R0
- 54,5% pCR
- mPFS 21,7 mo
- 2-y-OS 85,6%

ADJUVANT IMMUNOTHERAPY (ATEZOLIZUMAB) # LBA 8035

IMpower 010: updated DFS and OS analysis after ≥5 year follow up

Iniciativa científica de: GECP lung cancer research

IMpower010: Disease-Free Survival Final Analysis and Second Overall Survival Interim Analysis Results After ≥5 years of Follow-up of a Phase III Study of Adjuvant Atezolizumab vs Best Supportive Care in Resected Stage IB-IIIA Non-Small Cell Lung Cancer

Abstract LBA8035
Poster 297

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

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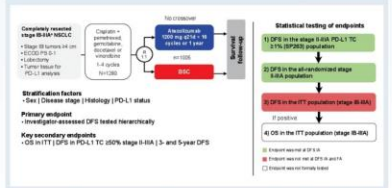
BACKGROUND

- The use of cancer immunotherapy has transformed the treatment of early-stage resectable non-small cell lung cancer (NSCLC)[1-4]
  - Adjuvant cancer immunotherapy treatment options include atezolizumab (anti–PD-L1) and pembrolizumab (anti–PD-1) based on results from the Phase III IMpower010 (NCT02486718) and KEYNOTE-091/PEARLS (NCT02504372) trials, respectively[1,2]
- IMpower010 was the first Phase III cancer immunotherapy study to show statistically significant disease-free survival (DFS) improvement in the adjuvant setting after chemotherapy in patients with resected NSCLC[1]
- At the DFS interim analysis (clinical cutoff, January 21, 2021), the study met its primary endpoint, showing a statistically significant improvement in DFS with adjuvant atezolizumab vs best supportive care (BSC) after resection and chemotherapy in the stage II-IIIA PD-L1 tumor cell (TC) ≥1% (stratified HR, 0.66; 95% CI: 0.50, 0.88) and all-randomized stage II-IIIA (stratified HR, 0.79; 95% CI: 0.64, 0.96) populations but not in the ITT population; DFS benefit with atezolizumab vs BSC was also seen in the subpopulation with stage II-IIIA PD-L1 TC ≥50% disease (unstratified HR, 0.43; 95% CI: 0.27, 0.68)[1]
  - These DFS outcomes led to global approvals of adjuvant atezolizumab after complete resection and platinum-based chemotherapy for stage II-IIIA PD-L1 TC ≥1% NSCLC and stage II-IIIA PD-L1 TC ≥50% NSCLC (excluding *EGFR*/*ALK* alterations in the EU)
- At the first overall survival (OS) interim analysis (clinical cutoff, April 18, 2022), although OS data were immature and not formally tested, there was a trend toward OS improvement in favor of atezolizumab vs BSC in the stage II-IIIA PD-L1 TC ≥1% (stratified HR, 0.71; 95% CI: 0.49, 1.03) and stage II-IIIA PD-L1 TC ≥50% (unstratified HR, 0.43; 95% CI: 0.24, 0.78) populations[3]
  - No OS improvement in favor of atezolizumab vs BSC was seen in the all-randomized stage II-IIIA or ITT populations[3]
- Here we report updated efficacy and safety results from the IMpower010 DFS final analysis and second OS interim analysis, with a minimum follow-up of 60 months

METHODS

- IMpower010 is a global, multicenter, open-label, randomized, Phase III study of adjuvant atezolizumab vs BSC in patients with stage IB-IIIA NSCLC after complete resection and platinum-based chemotherapy (**Figure 1**)
  - Investigator-assessed DFS, the primary endpoint, was hierarchically tested: 1) stage II-IIIA PD-L1 TC ≥1% population, 2) all-randomized stage II-IIIA population and 3) ITT (stage IB-IIIA) population
  - OS in the ITT population, a key secondary endpoint, could be formally tested only when the statistical significance boundary for DFS was crossed in all 3 primary populations
- The DFS final analysis and second OS interim analysis were conducted at the same clinical cutoff (January 26, 2024)

Figure 1. IMpower010 study design and endpoint testing hierarchy



RESULTS

Patients

- The ITT population included 1005 patients (stage IB-IIIA; atezolizumab, n=507; BSC, n=498), the all-randomized stage II-IIIA population included 882 patients (atezolizumab, n=442; BSC, n=440) and the stage II-IIIA PD-L1 TC ≥1% population included 476 patients (atezolizumab, n=248; BSC, n=228)
- Demographics and baseline characteristics were generally balanced between arms across the 3 primary populations, as previously reported[1]
- The median duration of follow-up was 65.0 months (range, 0.0-94.4) in the ITT population, 64.8 months (range, 0.0-93.3) in the all-randomized stage II-IIIA population and 65.2 months (range, 0.1-93.3) in the stage II-IIIA PD-L1 TC ≥1% population
- As of the clinical cutoff date (January 26, 2024), in the ITT population, 59.4% (n=301) and 56.6% (n=282) of patients in the atezolizumab and BSC arms, respectively, remained on study
  - Of the 206 (40.6%) and 216 (43.4%) patients in the respective treatment arms who discontinued from the study, the most common reasons for discontinuation were death (atezolizumab, n=154 [30.4%]; BSC, n=155 [31.1%]) and patient withdrawal (atezolizumab, n=44 [8.7%]; BSC, n=47 [9.4%])

DFS and OS in the ITT, all-randomized stage II-IIIA and stage II-IIIA PD-L1 TC ≥1% populations

- DFS events in the atezolizumab and BSC arms, respectively, occurred in:
  - 47.1% (n=239) and 52.2% (n=260) of the patients in the ITT population
  - 49.5% (n=219) and 54.5% (n=240) of the patients in the all-randomized stage II-IIIA population
- The statistical significance boundary for DFS was not crossed in the ITT population (stratified HR, 0.85; 95% CI: 0.71, 1.01; *P*=0.07)
  - Median DFS was 65.6 months in the atezolizumab arm and 47.8 months in the BSC arm
  - The 3-year DFS rates were 61.4% and 55.5%, and the 5-year DFS rates were 52.0% and 46.5%, respectively
- The stratified DFS HR in the all-randomized stage II-IIIA population was 0.83 (95% CI: 0.69, 1.00)
  - Median DFS was 57.4 months in the atezolizumab arm and 40.8 months in the BSC arm
  - The 3-year DFS rates were 59.3 % and 52.6%, and the 5-year DFS rates were 49.3% and 44.4%, respectively
- DFS in the stage II-IIIA PD-L1 TC ≥1% population is shown in **Figure 2**
  - DFS in key subgroups in the stage II-IIIA PD-L1 TC ≥1% population generally favored atezolizumab vs BSC (**Figure 3**)

Figure 2. DFS in the stage II-IIIA PD-L1 TC ≥1% population

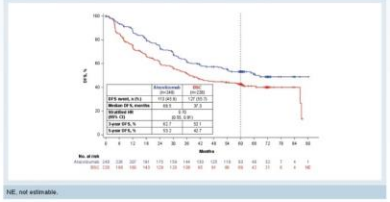


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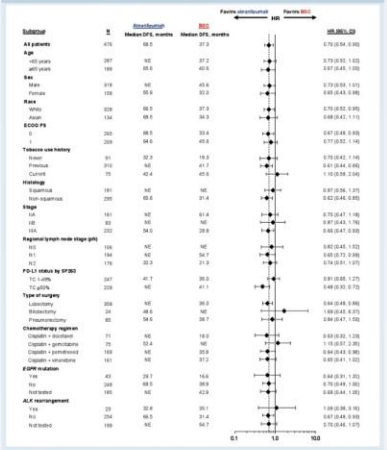
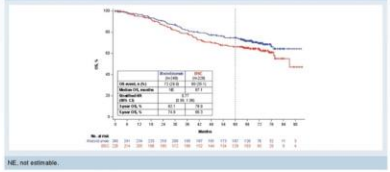
Figure 3. DFS in key subgroups of the stage II-IIIA PD-L1 TC ≥1% population



NE, not estimable.

- OS events in the atezolizumab and BSC arms, respectively, occurred in:
  - 31.4% (n=159) and 31.5% (n=157) of patients in the ITT population
  - 32.4% (n=143) and 33.0% (n=143) of patients in the all-randomized stage II-IIIA population
- Median OS was NE in either treatment arm in the ITT and all-randomized stage II-IIIA populations, with stratified HRs of 0.97 (95% CI: 0.78, 1.22) and 0.94 (95% CI: 0.75, 1.19), respectively
  - In the ITT population, the 3-year OS rates were 79.3% and 81.1%, and the 5-year OS rates were 70.9% and 69.8%, respectively
  - in the all-randomized stage II-IIIA population, the 3-year OS rates were 78.7% and 79.7%, and the 5-year OS rates were 69.8% and 68.6%, respectively
- OS in the stage II-IIIA PD-L1 TC ≥1% population is shown in **Figure 4**

Figure 4. OS in the stage II-IIIA PD-L1 TC ≥1% population



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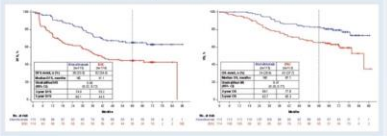
DFS and OS in the stage II-IIIA PD-L1 TC ≥50% population

- DFS and OS in the stage II-IIIA PD-L1 TC ≥50% population are shown in **Figure 5**

Figure 5. DFS and OS in the stage II-IIIA PD-L1 TC ≥50% population



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- When the 20 patients with known *EGFR* mutations or *ALK* rearrangements were excluded from the analysis, DFS and OS data remained similar (**Figure 6**)
  - In general, DFS favored atezolizumab vs BSC in key subgroups of the stage II-IIIA PD-L1 TC ≥50% population without known *EGFR* or *ALK* alterations (**Figure 7**)

Figure 6. DFS and OS in the stage II-IIIA PD-L1 TC ≥50% population without known *EGFR* or *ALK* alterations

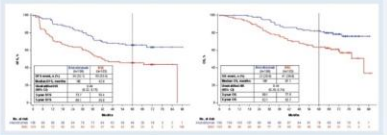

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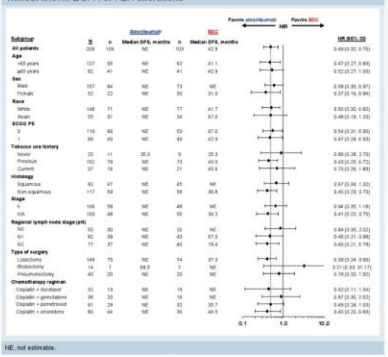
Figure 7. DFS in key subgroups of the stage II-IIIA PD-L1 TC ≥50% population without known *EGFR* or *ALK* alterations



NE, not estimable.

Safety

- Atezolizumab exposure data have not changed since the clinical cutoff for the DFS interim analysis (January 21, 2021) as all patients had completed or withdrawn from treatment at that time[1]
- Overall, 156 patients (31.5%) in the atezolizumab arm and 157 patients (31.7%) in the BSC arm had died (safety-evaluable population)
  - In the respective treatment arms, 91 (18.4%) and 118 (23.8%) patients died due to disease relapse, 9 (1.8%) and 3 (0.6%) died due to AEs and 56 (11.3%) and 36 (7.3%) died due to other reasons (i.e., COVID-19 related death, medical causes unrelated to the study treatment or NSCLC that occurred outside the AE reporting period, death information from public records or death due to unknown causes)
- Since the previous report (clinical cutoff, April 18, 2022),[3] there have been minimal updates to the safety findings, and no new or unexpected signals have been identified
- The incidences of Grade 3/4 and Grade 5 adverse events of special interest (AESIs) remained unchanged in the atezolizumab arm since the previous report.[3] Grade 3/4 AESIs were reported in 4 patients (0.8%) and Grade 5 AESIs in 1 patient (0.2%) in the BSC arm
  - No new medical concept categories developed

CONCLUSIONS

- The data from this DFS final analysis and second OS interim analysis provide the first Phase III cancer immunotherapy data in resectable NSCLC with ≥5 years of follow-up and were consistent with the previous reported analyses[1,3]
- This analysis showed that DFS benefit continues to translate into positive OS outcomes in the stage II-IIIA PD-L1 TC ≥1% and the stage II-IIIA PD-L1 TC ≥50% populations
  - In the stage II-IIIA PD-L1 TC ≥1% population, median DFS in the atezolizumab arm was >30 months longer than in the BSC arm
- The significance boundary for DFS was not crossed in the ITT population, and OS outcomes in the atezolizumab and BSC arms were similar, although OS data were not mature
- In general, atezolizumab's safety profile remained consistent with previous analyses; no new or unexpected safety signals or AESI medical concept categories were reported[1,3]
- After 5 years of follow-up, the updated survival outcomes with atezolizumab in PD-L1–selected populations continue to support the use of adjuvant atezolizumab for stage II-IIIA PD-L1 TC ≥1% and stage II-IIIA PD-L1 TC ≥50% NSCLC

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- The investigators and clinical study sites
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DISCLOSURES

- Dr Heather Wakelee has received consulting fees from IOBiotech and Mirati; is an unpaid advisor for Bristol Meyers Squibb, Genentech/Roche, Merck, and AstraZeneca; has received institutional support for the conduct of clinical trials from AstraZeneca/MedImmune, Bayer, Bristol Meyers Squibb, Genentech/Roche, Helsinn, Merck, SeaGen, and Xcovery; and received writing support for this poster from F. Hoffmann-La Roche Ltd
- Please see published abstract for disclosures of coauthors

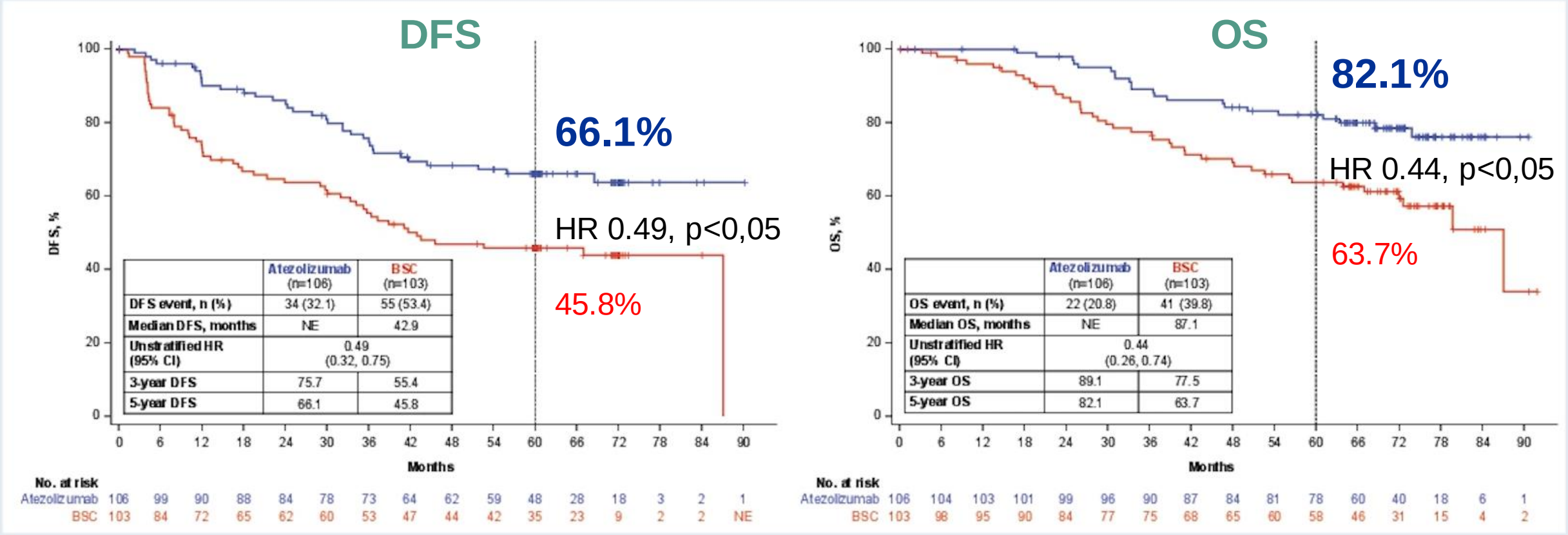
Presented at the American Society of Clinical Oncology, May 31-June 4, 2024, Chicago, IL, USA

ADJUVANT IMMUNOTHERAPY (ATEZOLIZUMAB)

IMpower 010: updated DFS and OS análisis after ≥5 year follow up

Iniciativa científica de: GECP lung cancer research

Figure 6. DFS and OS in the stage II-IIIA PD-L1 TC ≥50% population without known *EGFR* or *ALK* alterations



PERIOPERATIVE TARGETED THERAPY

ICTAN, GASTO1002 STUDY: ADJUVANT ICOTINIB 12 or 6 mo

Iniciativa científica de: GECP lung cancer research

2024 ASCO ANNUAL MEETING

 # 8004

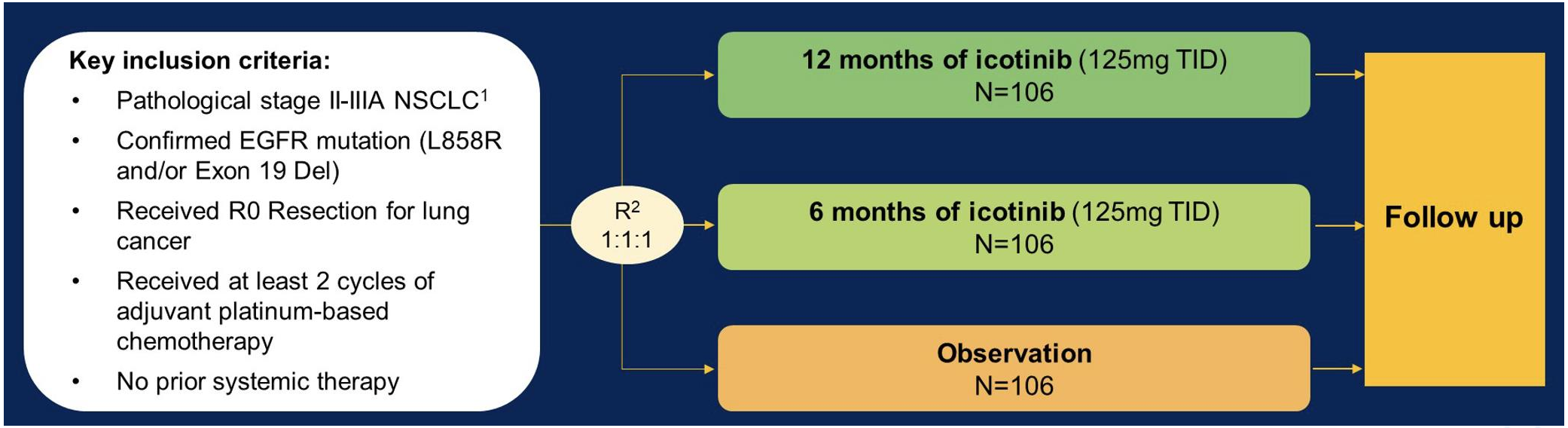
Adjuvant icotinib of 12 months or 6 months versus observation following adjuvant chemotherapy for resected EGFR-mutated stage II–IIIA non-small-cell lung cancer (ICTAN, GASTO1002): a randomized phase 3 trial

Authors: **Si-Yu Wang,** [1], Hao Long[1], Ning Li[1], Chao Cheng[2], Wei Ou[1], Lin Yang[3], Jian You[4], Yi Liang[5], Bao-Xiao Wang[6], on behalf of the ICTAN study investigators

1 Sun Yat-sen University Cancer Center, Guangzhou, China; 2 The First Affiliated Hospital of Sun Yat-sen University, Guangzhou, China; 3 Shenzhen People's Hospital, Shenzhen, China; 4 Tianjin Medical University Cancer Institute and Hospital, Tianjin, China; 5 Zhongshan city people's hospital, Zhongshan, China; 6 Sun Yat-Sen Memorial Hospital, Guangzhou, China.

PERIOPERATIVE TARGETED THERAPY

ICTAN, GASTO1002 STUDY: ADJUVANT ICOTINIB 12 or 6 mo



Primary endpoint:
- DFS

Secondary endpoints:
- OS
- Safety

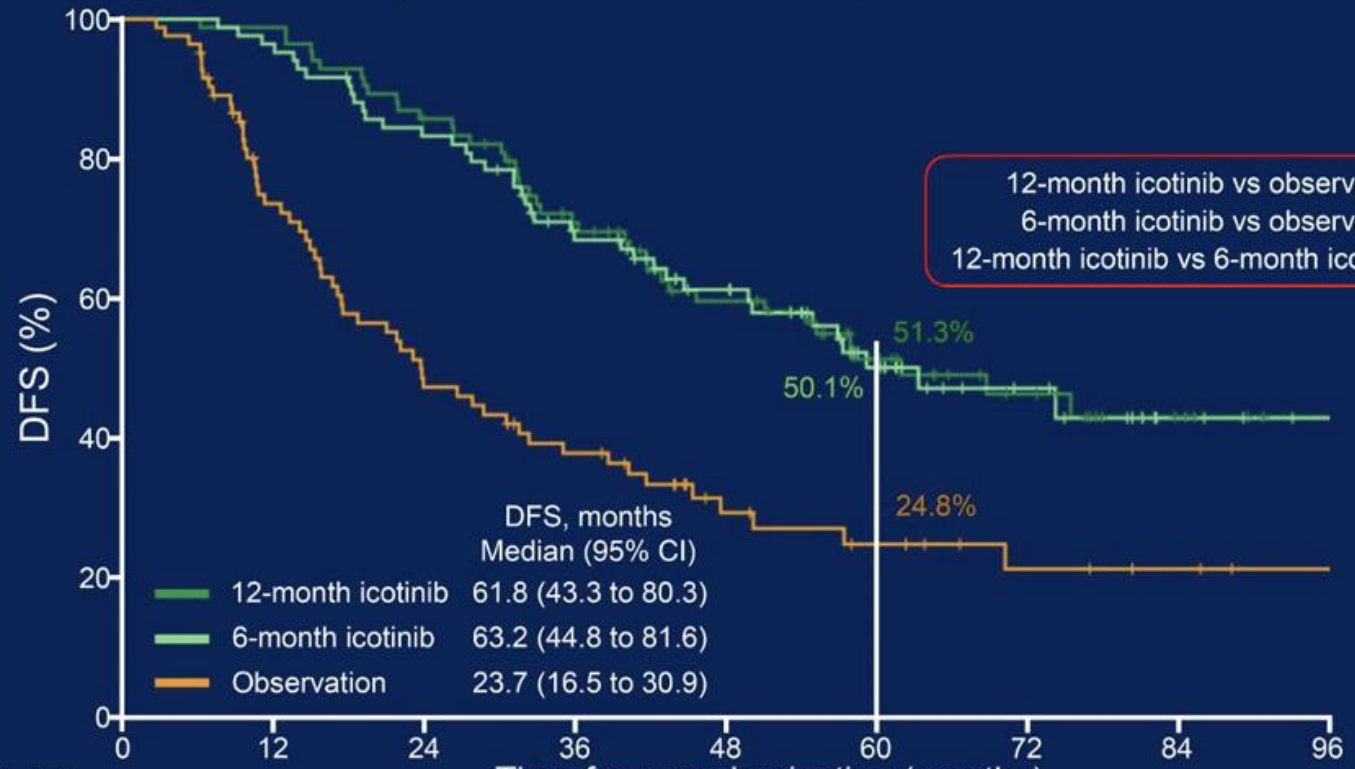
- En torno al 80% completaron 4 ciclos de QT adyuvante
- Siendo carboplatino + pemetrexed el régimen mayoritario (70%)

PERIOPERATIVE TARGETED THERAPY

ICTAN, GASTO1002 STUDY: ADJUVANT ICOTINIB 12 or 6 mo

Iniciativa científica de: GECP lung cancer

DFS by investigator for ITT population



	HR, 95% CI	P value
12-month icotinib vs observation	0.40 (0.27-0.61)	0.000014
6-month icotinib vs observation	0.41 (0.27-0.62)	0.000025
12-month icotinib vs 6-month icotinib	0.97 (0.62-1.51)	0.89

No. at risk

12-month icotinib	84	83	71	54	41	28	16	5	1
6-month icotinib	84	81	69	52	39	23	12	4	1
Observation	83	56	36	27	14	10	6	4	2

DFS comparison summary

12-month icotinib vs. observation	Longer
6-month icotinib vs. observation	Longer
12-month icotinib vs. 6-month icotinib	No difference

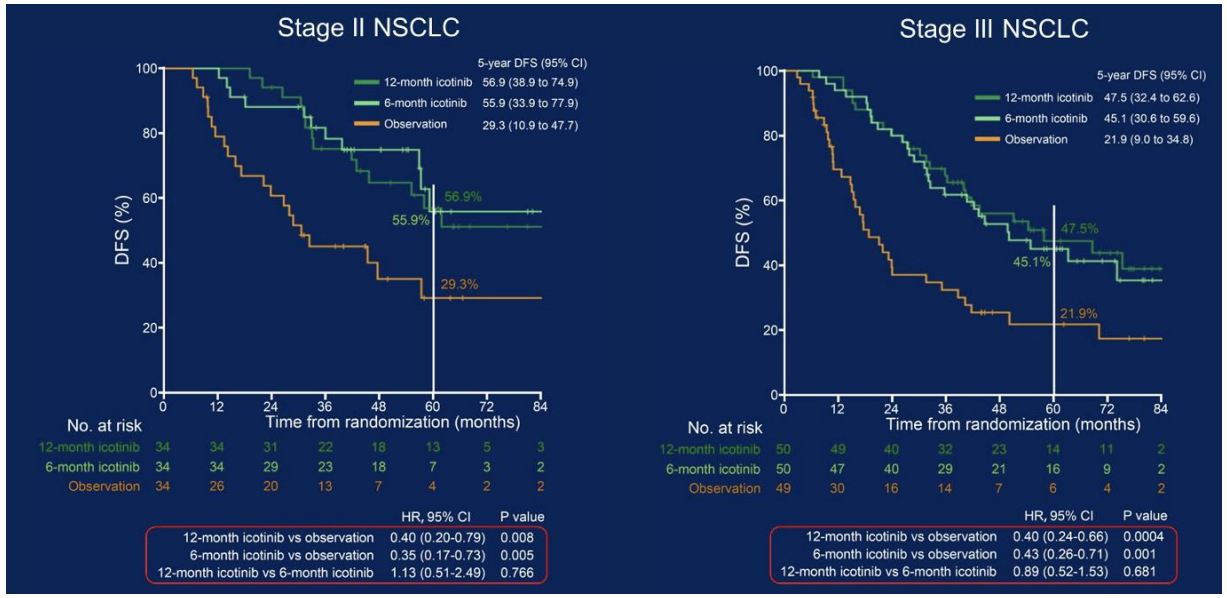
Adjuvant icotinib for 12 months or 6 months provide a significant DFS benefit compared with observation.
12 months of icotinib had no DFS benefit compared with 6 months.

PERIOPERATIVE TARGETED THERAPY

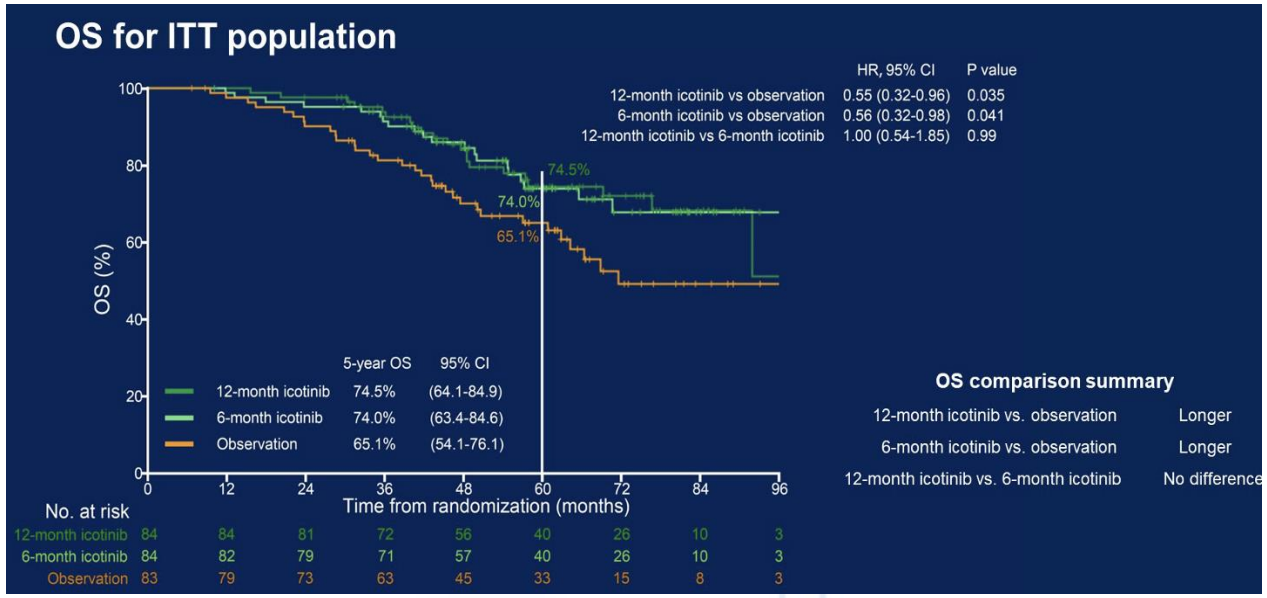
ICTAN, GASTO1002 STUDY: ADJUVANT ICOTINIB 12 or 6 mo

Iniciativa científica de: GECP lung cancer research

DFS by stage



OS



First subsequent treatments	Icotinib of 12 months (n=40)		Icotinib of 6 months (n=39)		Observation (n=56)	
1st generation EGFR-TKI	5	(12.5%)	10	(25.6%)	31	(55.4%)
2nd generation EGFR-TKI	1	(2.5%)	4	(10.3%)	3	(5.4%)
3rd generation EGFR-TKI	17	(42.5%)	12	(30.8%)	9	(16.1%)
Other treatments without EGFR-TKI	6	(15.0%)	3	(7.7%)	1	(1.8%)
No subsequent treatments	11	(27.5%)	10	(25.6%)	12	(21.4%)

<u>AEs leading to discontinuation</u>

- 12 mo: 4,8%
- 6 mo: 3,6%

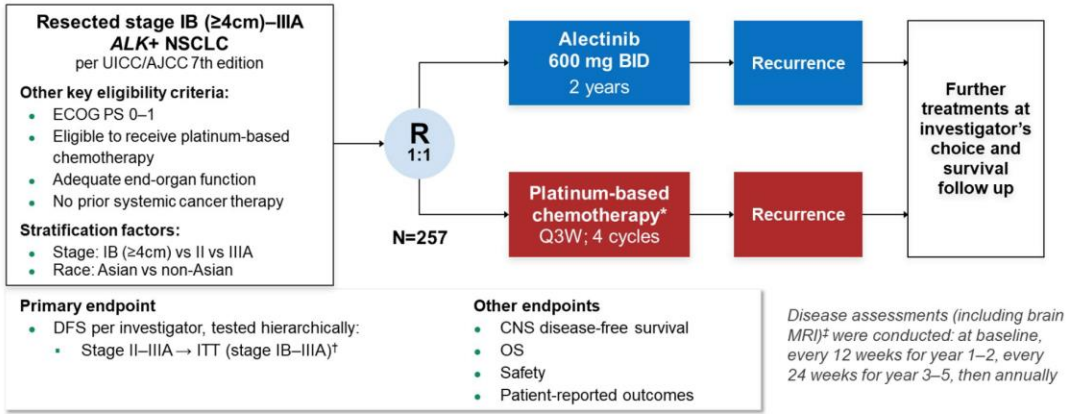
NO dose reduction
NO fatal events

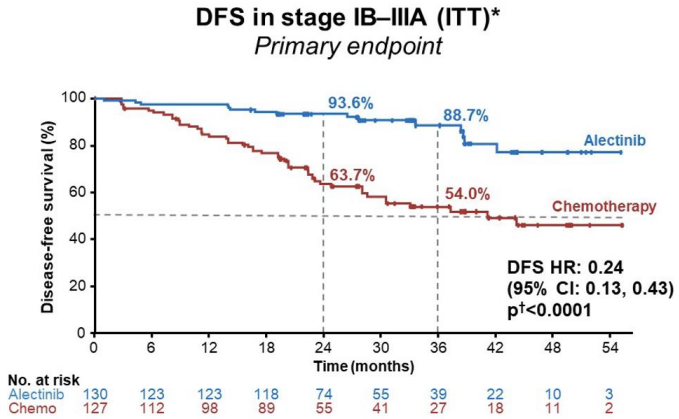
PERIOPERATIVE TARGETED THERAPY

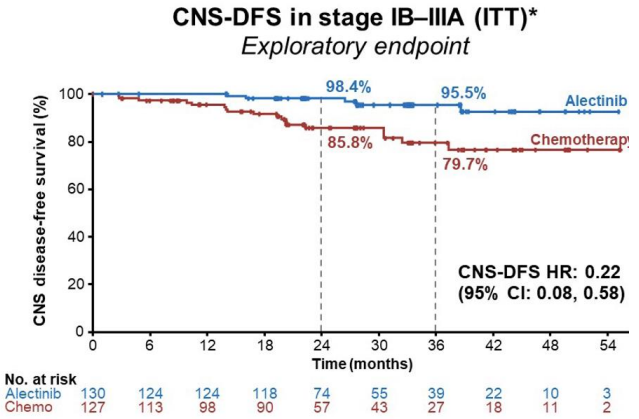
ALINA : HRQoL

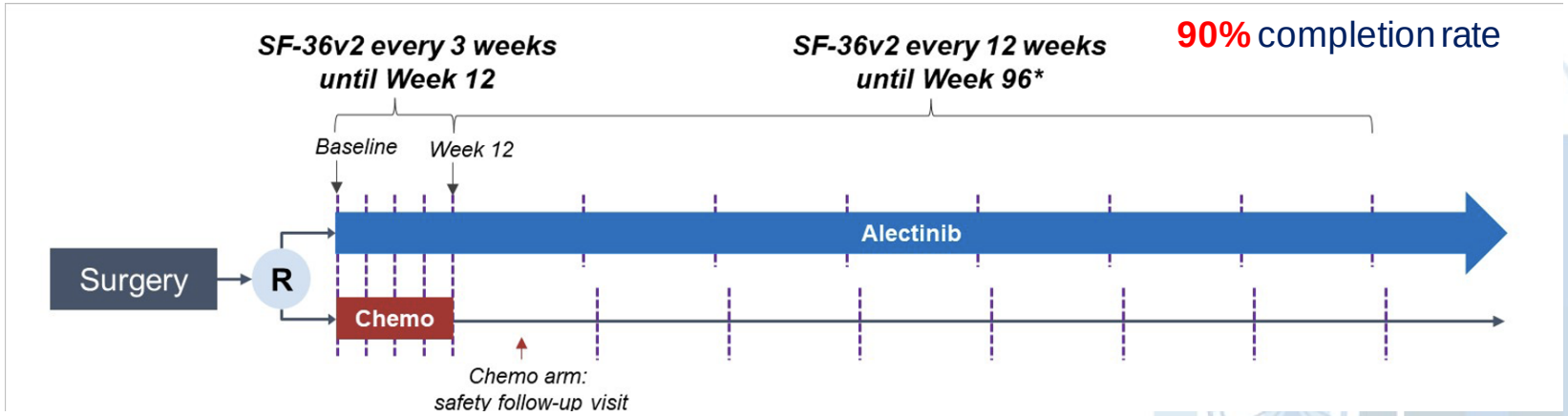
8006

Iniciativa científica de: GECP lung cancer research







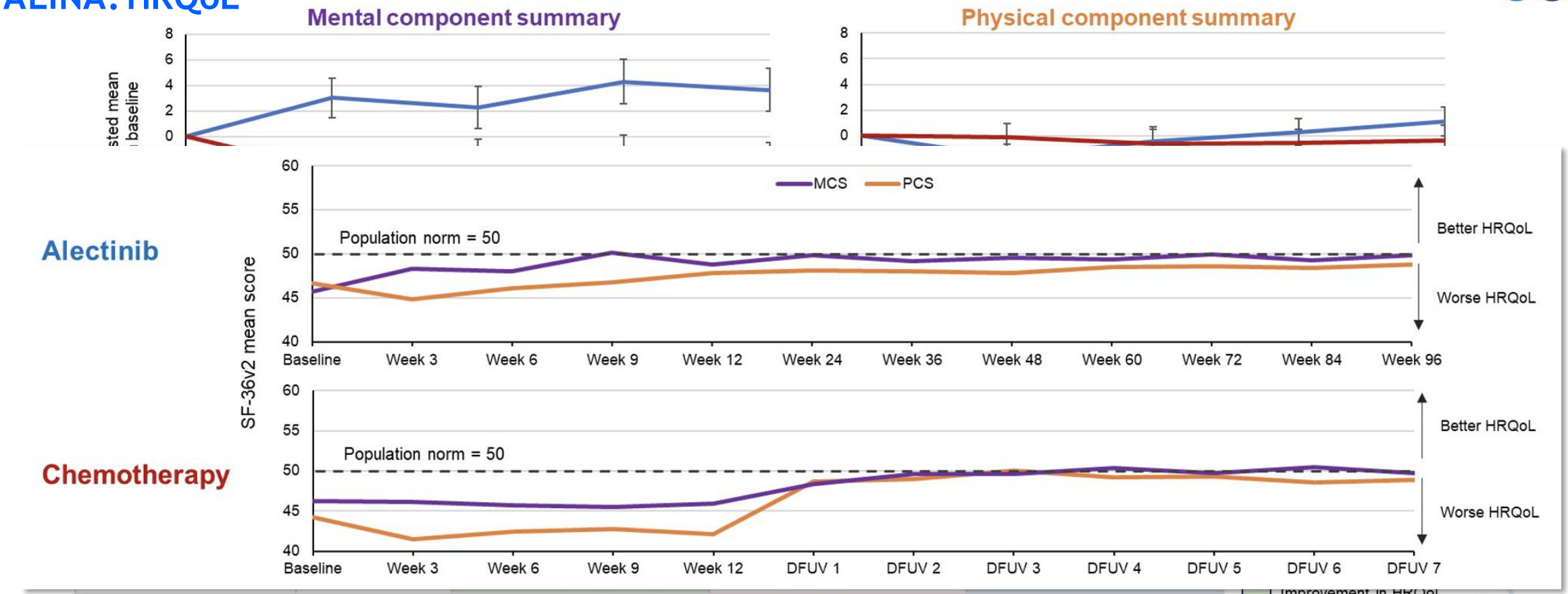


90% completion rate

Solomon, ESMO 2023; Makoto, ASCO 2024

PERIOPERATIVE TARGETED THERAPY

ALINA: HRQoL



General health	± 2	**+ 0.28** (−1.05, 1.62)	**− 2.94** (−4.38, −1.50)	**+ 3.23** (1.26, 5.19)
Physical functioning	± 3	**− 0.86** (−2.15, 0.43)	**− 0.75** (−2.12, 0.62)	**− 0.11** (−1.99, 1.77)
Role physical	± 3	**+ 3.46** (1.89, 5.03)	**− 1.18** (−2.84, 0.47)	**+ 4.64** (2.36, 6.92)
Role emotional	± 4	**+ 2.75** (0.80, 4.69)	**− 2.94** (−5.00, −0.89)	**+ 5.69** (2.86, 8.51)
Mental health	± 3	**+ 3.65** (2.06, 5.24)	**− 0.31** (−1.99, 1.38)	**+ 3.96** (1.64, 6.27)
Social functioning	± 3	**+ 3.88** (2.26, 5.50)	**− 2.17** (−3.91, −0.44)	**+ 6.05** (3.68, 8.43)
Vitality	± 2	**+ 2.39** (0.75, 4.03)	**− 2.03** (−3.76, −0.29)	**+ 4.41** (2.02, 6.80)

Improvement in HRQoL ≥ positive MID

Decline in HRQoL ≥ negative MID

Clinically meaningful difference between arms*

PERIOPERATIVE TARGETED THERAPY - MRD

MRD analysis from ADAURA

Iniciativa científica de: GECP lung cancer research

2024 ASCO ANNUAL MEETING

 # 8005

Molecular residual disease analysis from the ADAURA trial of adjuvant osimertinib in patients with resected EGFR-mutated stage IB–IIIA non-small cell lung cancer

Thomas John,[1] Christian Grohé, Jonathan Goldman, Terufumi Kato, Konstantin Laktionov, Laura Bonanno, Marcello Tiseo, Margarita Majem, Manuel Dómine, Myung-Ju Ahn, Maurice Pérol, Ryan Hartmaier, Jacqulyne Robichaux, Preetida Bhetariya, Aleksandra Markovets, Yuri Rukazenkov, Caitlin Muldoon, Roy S. Herbst, Masahiro Tsuboi, Yi-Long Wu

[1]Department of Medical Oncology, Peter MacCallum Cancer Centre, Melbourne, Australia; Sir Peter MacCallum Department of Oncology, The University of Melbourne, Melbourne, Australia

PERIOPERATIVE TARGETED THERAPY - MRD

MRD analysis from ADAURA

Iniciativa científica de: GECP lung cancer research

Patients with completely resected stage* IB, II, IIIA NSCLC, with or without adjuvant chemotherapy†

Key inclusion criteria:
- ≥18 years (Japan / Taiwan: ≥20 years)
- WHO performance status 0 / 1
- Confirmed primary non-squamous NSCLC Ex19del / L858R‡
- Brain imaging, if not completed pre-operatively
- Complete resection with negative margins§
- Maximum interval between surgery and randomization:
  - 10 weeks without adjuvant chemotherapy
  - 26 weeks with adjuvant chemotherapy

Stratification by stage, EGFRm, and race‖

Randomization 1:1 (N=682)

- **Osimertinib 80 mg QD**
- **Placebo QD**

Planned treatment duration: 3 years

Treatment continued until:
- Disease recurrence
- Treatment completion
- Discontinuation criterion met

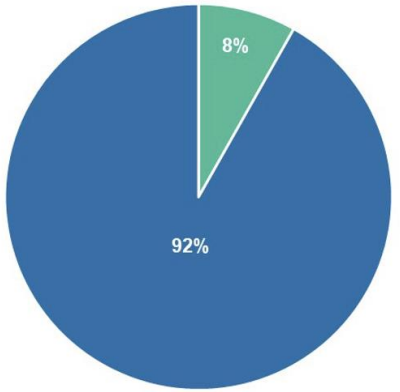
Follow-up:
- Until recurrence: Week 12 and 24, then every 24 weeks to 5 years, then yearly
- After recurrence: every 24 weeks for 5 years, then yearly

	Adjuvant treatment	Post-treatment follow-up	
Scan schedule¶	Weeks 12 & 24 then every 24 weeks	Every 24 weeks	Every 52 weeks
ctDNA sampling (plasma)¶	Every 12 weeks	Weeks 12 & 24 then every 24 weeks	Every 52 weeks

C1D1 / randomization (baseline) — 3 years — 5 years

Exploratory endpoint: Evaluate the feasibility of ctDNA-based MRD detection to predict disease recurrence during adjuvant osimertinib treatment and post-treatment follow-up

Baseline MRD status (MRD analysis set)

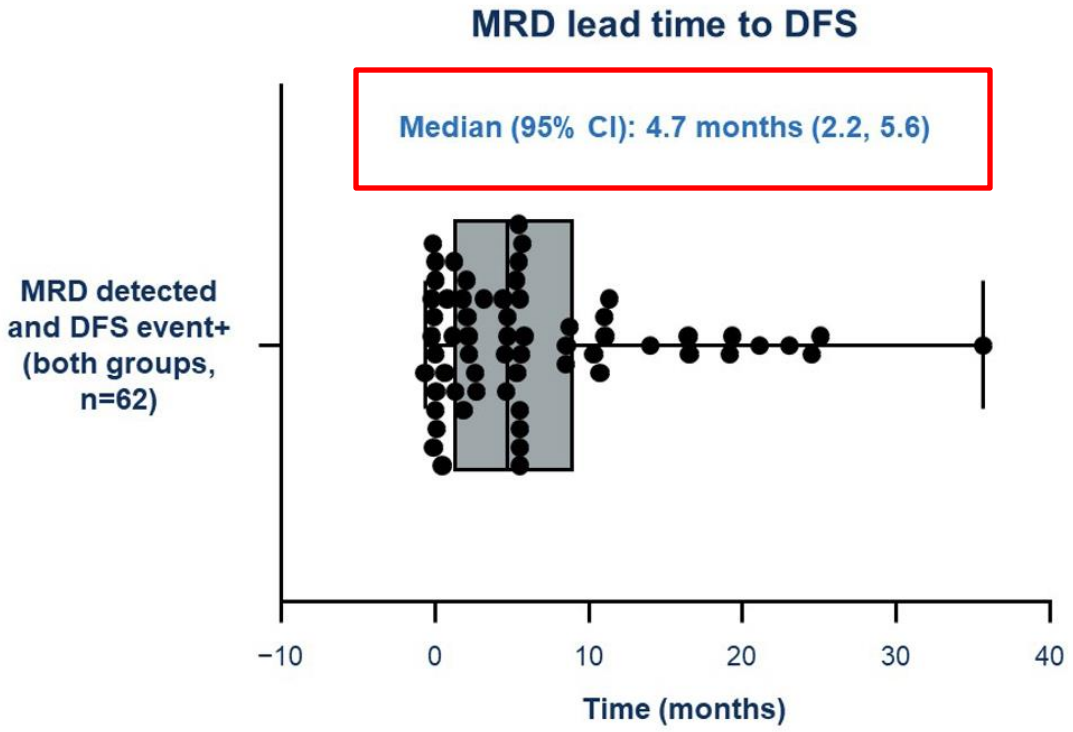


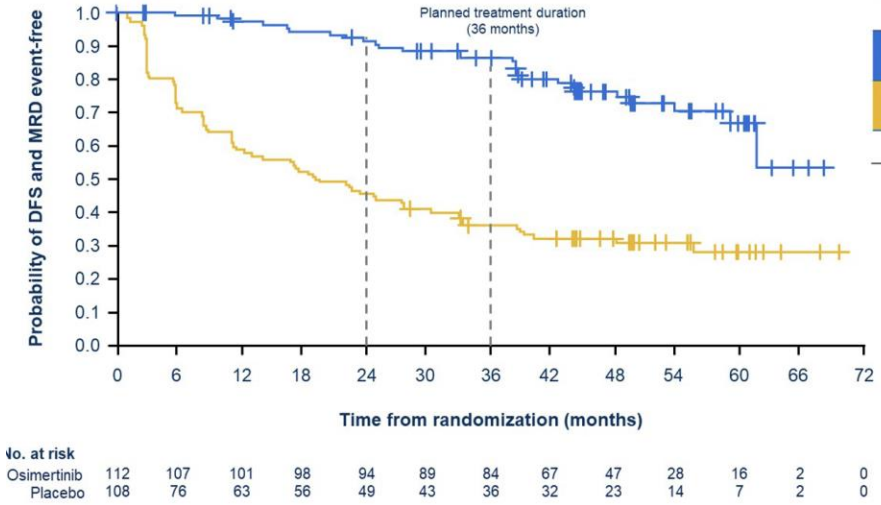
Stage (n=4
Stag (n=9
Stage (n=8

Baseline MRD undetected (n=202) Baseline MRD detected (n=18)

PERIOPERATIVE TARGETED THERAPY - MRD

MRD analysis from ADAURA





% (95% CI)	DFS and MRD event-free rate	
	24 months	36 months
Osimertinib (n=112)	91 (84, 95)	86 (78, 92)
Placebo (n=108)	46 (36, 55)	36 (27, 45)

HR (95% CI) 0.23 (0.15, 0.36)†

Median follow-up time, months (95% CI):
osimertinib 44.2 (42.4, 49.1), placebo 19.1 (11.1, 28.3)

- 75% (84 / 112) patients receiving osimertinib maintained a DFS and MRD event-free status* during treatment and in post-treatment follow-up†
  - Most MRD or DFS events* occurred post-osimertinib; 58% (11 / 19) occurred within 12 months post-osimertinib

La mayoría de eventos de MRD-DFS en el brazo de osimertinib se dan tras su suspensión, el 58% en el primer año post

OPERABILITY PARAMETER CHANGES AFTER NEOADJUVANT CTIO

#8055 Sereno M et al.

Iniciativa científica de: GECP lung cancer research

Abstract 8055#: Operability changes in NSCLC patients after neoadjuvant chemotherapy and anti-PD-1/PD-L1

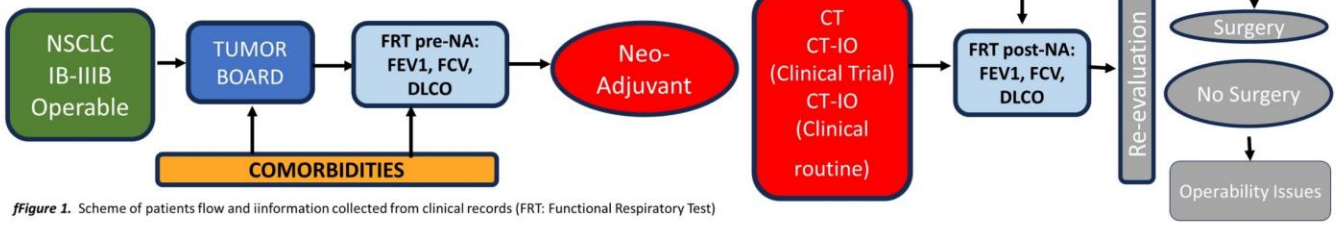
Authors: Garitaonaindia Y [1], Baena J [2], Aguado C [3], Cruz P [4], López-Castro R [5], Rubio J [6], Gomez A [7], Lopez--Martin A [8], Traseira C [9], Mielgo Rubio X [10], Losada B [11], Rogado J [12], Romano I [13], Campo-cañaveral JL [14], Gómez de Antonio D [14], Falagan S [13], Rubio G [13], Montoro FJ [15], Sereno M [15] (1) Puerta de HierroUniversity Hospital, Majadahonda, Madrid, Spain; (2) Hospital Universitario 12 De Octubre, Madrid, Spain; (3)Hospital Clinico San Carlos, Madrid, Spain; (4) Hospital Universitario de Cuidad Real, Cuidad Real, Spain; Medical Oncology Department. (5) Hospital Clínico Universitario de Valladolid,Valladolid, Spain; (6) University Hospital Fundación Jiménez Díaz, Madrid, Spain; (7) Ramon y Cajal University Hospital, Madrid, Spain; (8) Hospital Severo Ochoa, Madrid, Spain; (9)Hospital de Henares, Coslada, Madrid, Spain; (10) Hospital Fundación Alcorcon, Alcorcon, Madrid, Spain; (11) Hospital Universitario de Fuenlabrada, Madrid, Spain; (12) Infanta Leonor University Hospital, Madrid,Spain;(13) Infanta Sofía University Hospital, San Sebastián De Los Reyes, Madrid, Spain (14) Thoracic Surgery Department, Puerta de HierroUniversity Hospital, Majadahonda, Madrid, Spain (15) Pulmunologist Department Infanta Sofía University Hospital, San Sebastián De Los Reyes, Madrid, Spain

Background:

- **Neoadjuvant (NA)** treatment for non-small cell lung cancer (NSCLC) has evolved with the emergence of chemotherapy (CT) and immunotherapy (IO) combinations
- However, limited data exist on the impact of these treatments on respiratory function

Methods:

- We conducted a **multicenter study** of NSCLC pts who underwent NA (CT or CT-IO) and pre- and post-NA respiratory tests from Jan 2021 to Dec 2023.
- Clinical, pathological and surgical variables were also collected (*Figure 1).*
- DLCO (Diffusing Capacity for Carbon Monoxide), FEV1 (Forced Espiratory Volumein first second) and FVC (Forced Vital Capacity) pre- and post-NA in CT/CT-IO subgroups were compared.
- A regression univariate analysis with variables influencing DLCO, FEV1 and FVC variations was also performed



fFigure 1. Scheme of patients flow and iinformation collected from clinical records (FRT: Functional Respiratory Test)

Results:

Figure 2. Global differences among pre and post respiratory test in both groups in pre-NA and post-NA setting

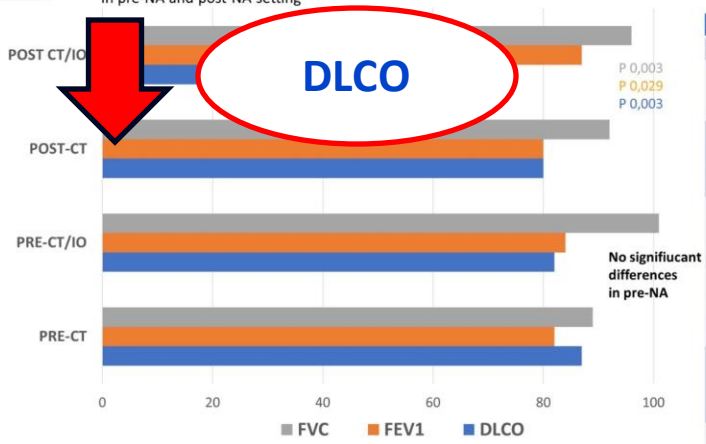


Figure 3. Percentage of reduction in functional tests values before and after NA treatment

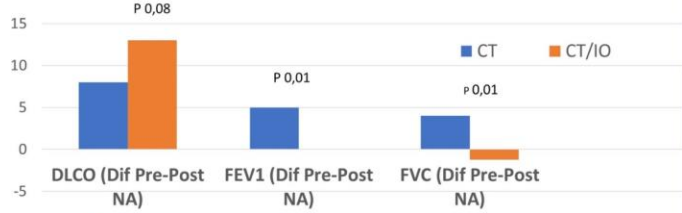


Table 1.. Baseline patients characteristics

Variable	N 159 (%)
Age (median)	70
Gender	
Men	107 (67,3)
Women	52 (32,7)
ECOG at diagnosis	
0	98 (61,6)
1	59 (37,1)
2	2 (1,2)
Comorbidities	
CPDO	43 (27)
Cerebrovascular	10 (6,2)
Cardiovascular	17 (10,6)
Renal	6 (3,7)
Liver	7 (4,4)
Neuromuscular	2 (1,2)
Autoimune	12 (7,5)
Smoking status	
Never	11 (6,9)
Former	86 (54)
Current	62 (38,9)
TNM at diagnosis (8th IASLC classification)	
IB	1 (0,6)
IIA	1 (0,6)
IIB	33 (20,6)
IIIA	113 (71)
IIIB	11 (6,9)
Pathology	
Squamous	80 (50,3)
Adenocarcinoma	70 (44,5)
NOS	9 (5,2)
PDL1 expression	
<1	23 (38)
1-49	19 (31)
>50	19 (30)
NGS	
K-RAS	11 (44)
EGFR	7 (28)
ROS-1	2 (8)
MET	1 (4)
HER2	1 (4)
BRAF	1 (4)
OTHERS (TP53)	2 (8)

Table 2.. Comparative analysis of surgical events between both gropus

Variable	CT N 39 (%)	CT-IO N 117 (%)	P
Surgery			
No	6 (15,4)	12 (10,4)	0,39
Yes	33 (84,6)	103 (89,6)	
Downstaging	20 (51)	72 (62,1)	0,23
Pathological responses	6 (18,1)	53 (51,4)	**0,006**
CPR	4(12,1)	36 (34,9)	
MPR			
VATS-thoracotomy conversion	6 (17,6)	7 (6,7)	0,08
ICU admission	2 (6,1)	6 (5,8)	1,00
Complications after surgery	5(15,2)	23 (22,1)	0,38
Respiratory	2 (6,1)	5 (4,8)	0,67
Cardiovascular	1 (3)	6 (5,8)	1,00
Others			
Re-operation within 90 days	1 (3)	5 (4,8)	1,00
Re-admission within 90 days	2 (6,1)	6 (5,8)	1,00
Inoperability rate	3 (7,7)	6 (5,2)	0,69
Exitus			**0,017**
No	30 (76,9)	108 (92,3)	
Yes	9 (23,1)	9 (7,7)	

Conclusions:

Significant differences in post-NA functional variables were observed between CT-IO and CT subgroups, including lower DLCO and higher FEV1/FVC in the CT-IO group. Prospective validation is essential to confirm these findings.

KEY-HOME MESSAGES

ASCO 2024 Lung Cancer Updates GECP

Iniciativa científica de: GECP lung cancer research

- Perioperative immunotherapy
- Perioperative targeted therapy
- ctDNA – MRD
- Operability parameters changes

ASCO 2024

- **GECP LUNG CANCER UPDATES**