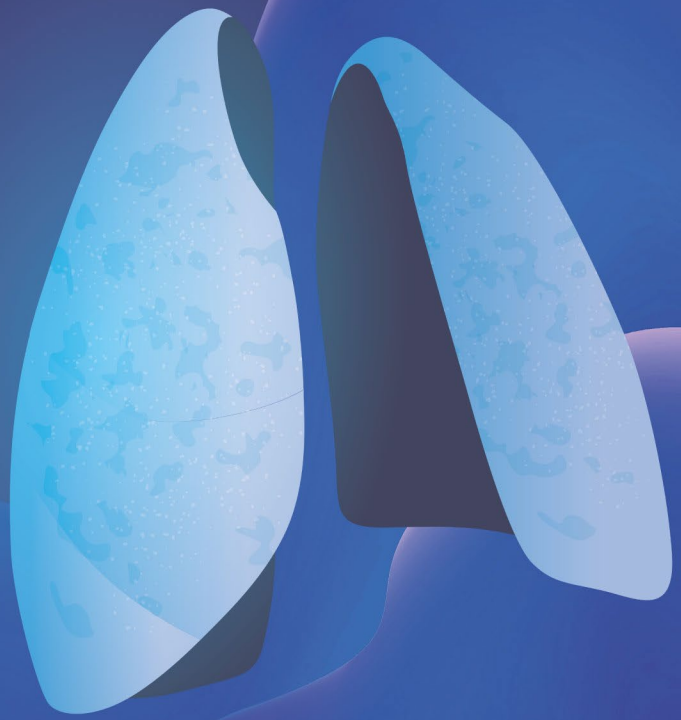

Novedades & Claves en CÁNCER de PULMÓN 2024

Conclusiones

J.L. González Larriba

Hospital Clínico San Carlos. Madrid
Universidad Complutense

Organizado por:

GECP lung cancer research

Patrocinado por:

Bristol Myers Squibb™

Johnson&Johnson

Novedades & Claves en CÁNCER de PULMÓN 2024

Añade esta fecha a tu calendario

21 Enero 2025
16:00h-18:00h

FORMATO **VIRTUAL**

ACCEDER

Programa científico

16:00 - 16:10	Introducción	Dr. Jose Luís González Larriba Hospital Clínico San Carlos, Madrid
16:10 - 16:30	Biomarcadores pronósticos	Dra. Ana Cardeña Hospital Univ. Nuestra Señora de Candelaria, Santa Cruz de Tenerife
16:30 - 16:50	Estadios iniciales y enfermedad localmente avanzada	Dr. Eider Akcona Hospital Univ. de Cruces, Baracaldo, Vizcaya
16:50 - 17:10	Enfermedad metastática (incluyendo inmunoterapia)	Dra. Noelia Vilariño ICO, Hospital Duran i Reynals, L´Hospitalet de Llobregat, Barcelona
17:10 - 17:30	Cáncer de pulmón microcítico y otros tumores	Dr. Juan Luis Martí Hospital General Univ. Dr. Balmis, Alicante
17:30 - 17:45	Debate	
17:45 - 18:00	Conclusiones	Dr. Jose Luís González Larriba Hospital Clínico San Carlos, Madrid

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Biomarcadores (Dra. Cardeña)

¿Qué sabemos?

Índice	Definición	Mal pronóstico
2010		
NLR: Neutrophil-to-Lymphocyte Ratio	Recuento de neutrófilos / Recuento de linfocitos =	NLR ≧3
ALI: Advanced Lung Cancer Inflammation Index.	IMC x Albúmina (g/L) / NLR =	ALI <18
A/G: Albumin-to-Globulin Ratio.	Albúmina(g/L) / Globulina sérica (g/L) =	A/G <1
2018		
LIPI : Lung Immune Prognostic Index	= dNLR LDH (U/L) dNLR = Neutrófilos / Leucociotos - Neutrófilos	Buen pco. dNLR<3 y LDH N Pco. Intermedio: dNLR ≧3 **ó** LDH >250 U/L Mal pco: dNLR ≧3 **y** LDH >250 U/L

PD-L1 y TMB

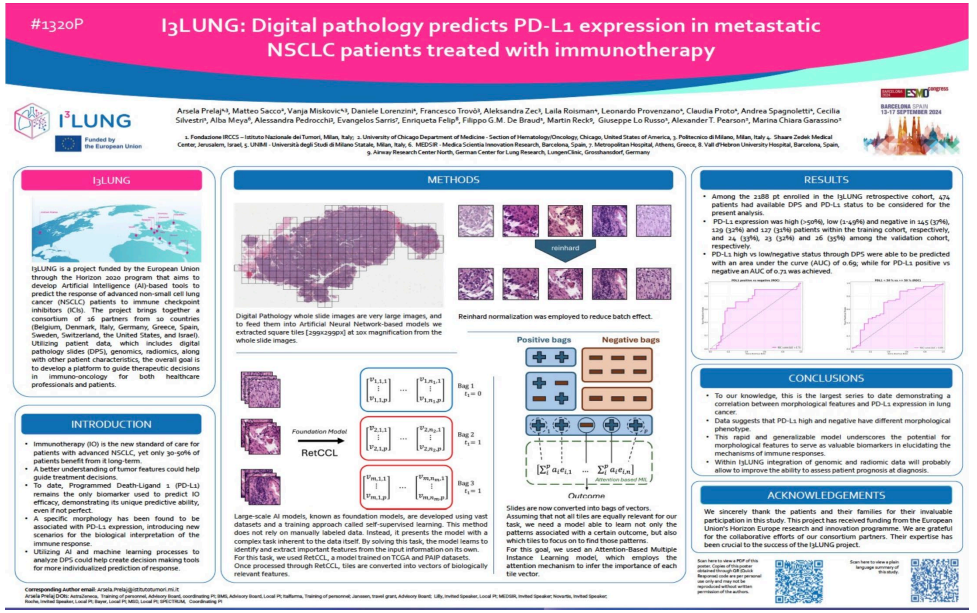
Biomarcadores predictivos

¿Qué sabemos?

- PD-L1: La heterogeneidad intratumoral y la variabilidad en las técnicas de medición pueden afectar su precisión como biomarcador.
- TMB: Aplicación rutinaria limitada debido a la falta de estandarización y consenso sobre los puntos de corte óptimos (aunque ≧10 es el más usado).

¿Novedades?

- Combinación con otros biomarcadores emergentes: radiómica, inteligencia artificial y marcadores séricos y genómicos con valor PRONÓSTICO.



Organizado por:

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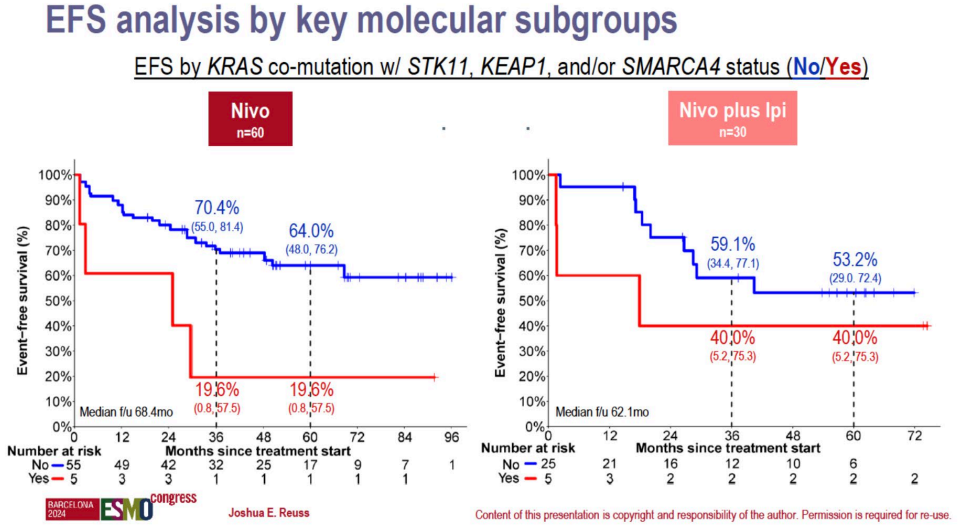
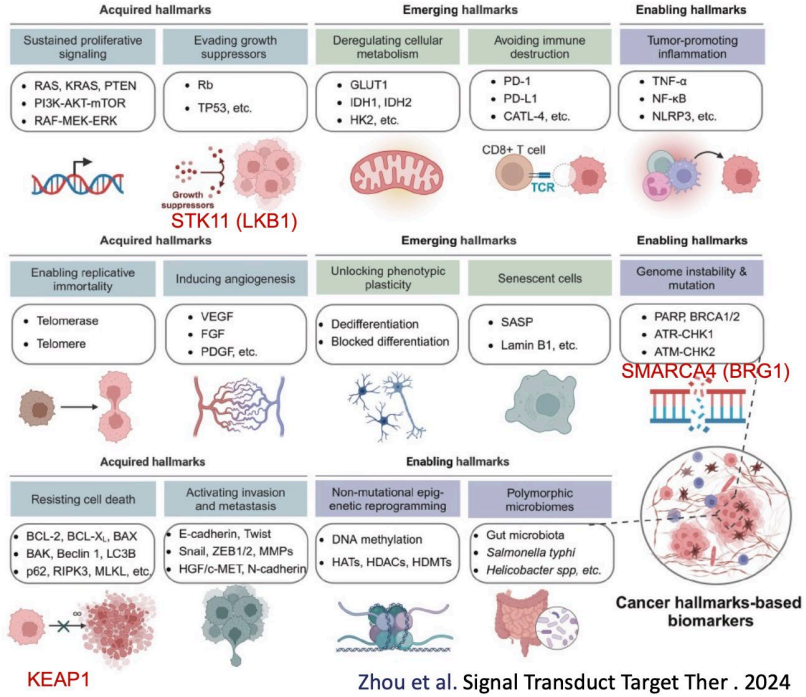
Biomarcadores (Dra. Cardeña)

¿Futuro?



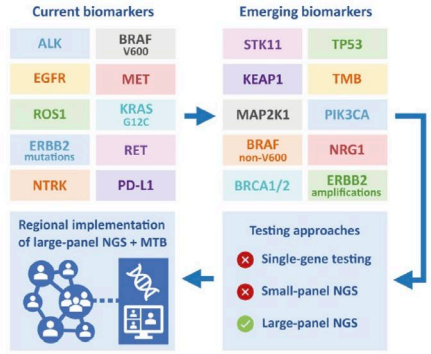
Reuss J. ESMO 2024



Zhou et al. Signal Transduct Target Ther . 2024

NGS

Next-generation sequencing



De Jager VD et al. Lancet Reg Health Eur. 2024

- **Ventajas de ampliar paneles**
  - Detección de múltiples alteraciones de forma simultánea.
  - Facilita la identificación de mutaciones accionables.
  - Mejora la comprensión de la heterogeneidad tumoral.
- **Limitaciones**
  - No identifica alteraciones epigenéticas.
  - Pueden pasar por alto genes no mutados del microambiente tumoral.

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Biomarcadores (Dra. Cardeña)

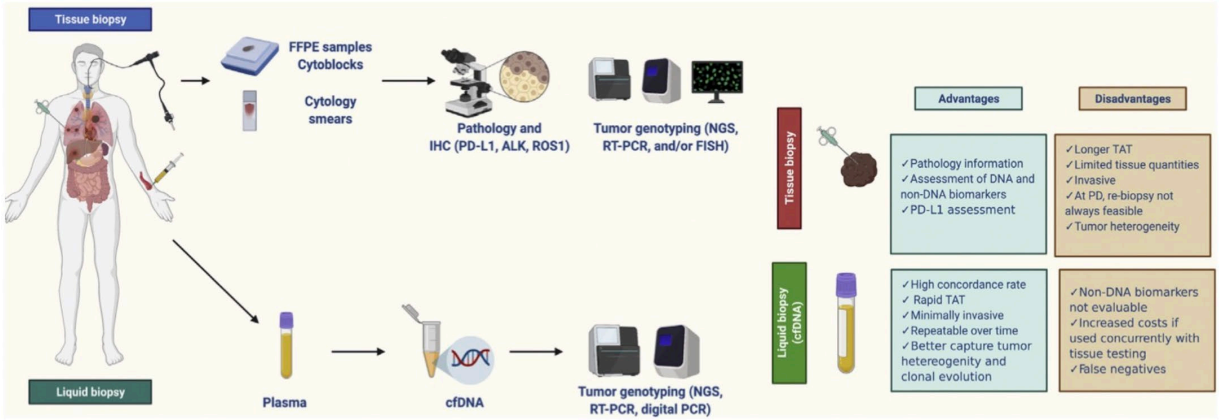
Biopsia líquida

MRD – ctDNA

Exosomas

Perfiles de metilación DNA

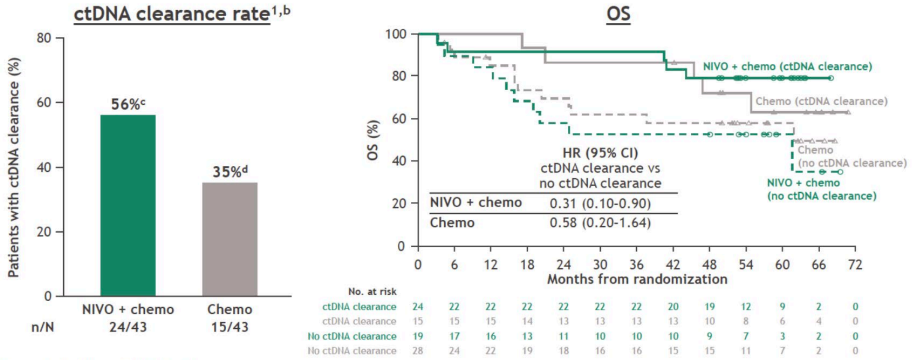
Tasa de mutaciones somáticas (SMR)



CheckMate 816: 4-y survival update

ctDNA clearance rate and OS by ctDNA clearance

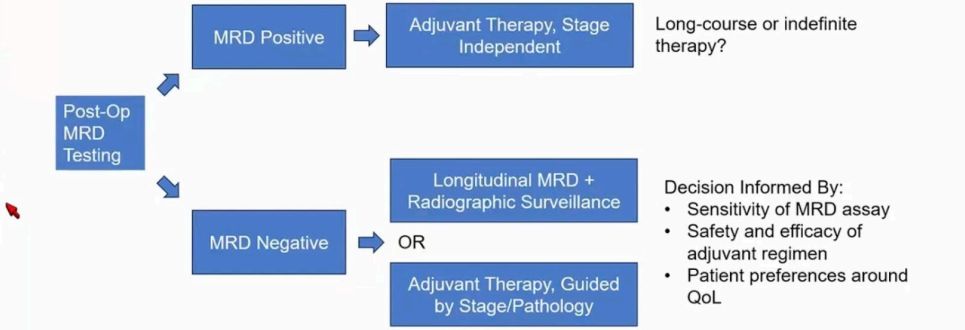
- Among concurrently randomized patients, 89 (25%) had evaluable ctDNA levels, and 86 (24%) had detectable ctDNA levels at baseline[1,a]



Minimum/median follow-up, 49.1/57.6 months.
[a]The main reasons for sample attrition were lack of tissue for WES and lack of quality control pass for tissue and plasma. [b]ctDNA clearance was defined as pre-surgical change from detectable ctDNA levels before cycle 1 to undetectable ctDNA levels before cycle 3. Analysis was performed using a WES tumor-guided personalized ctDNA panel (ArcherDX Personalized Cancer Monitoring). [c]95% CI: [d]40-71; [e]21-51. 1. Fordo PM, et al. *N Engl J Med* 2022;386:1973-1985.

Spicer J. Abstract number LBA8010 (ASCO 2024).

Prospective studies are need to understand how best to modify therapy based on MRD findings



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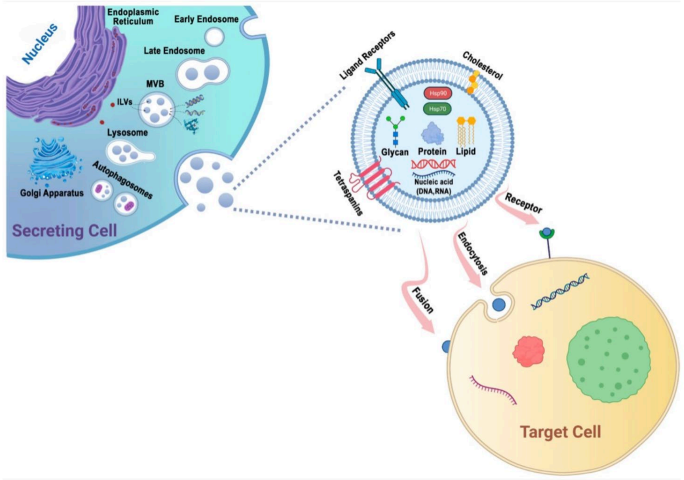
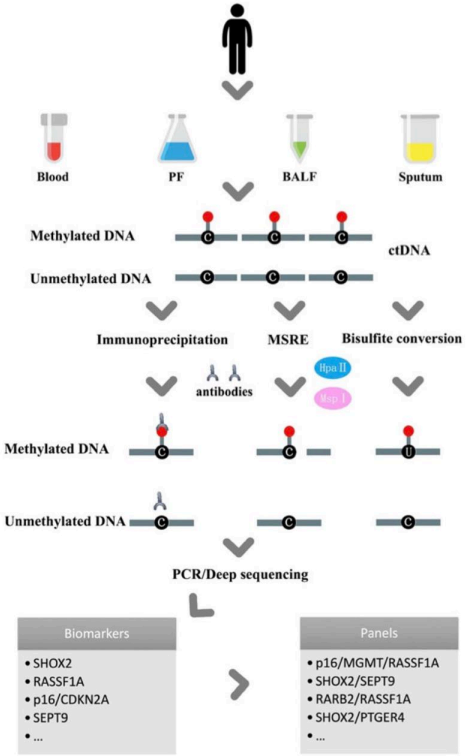
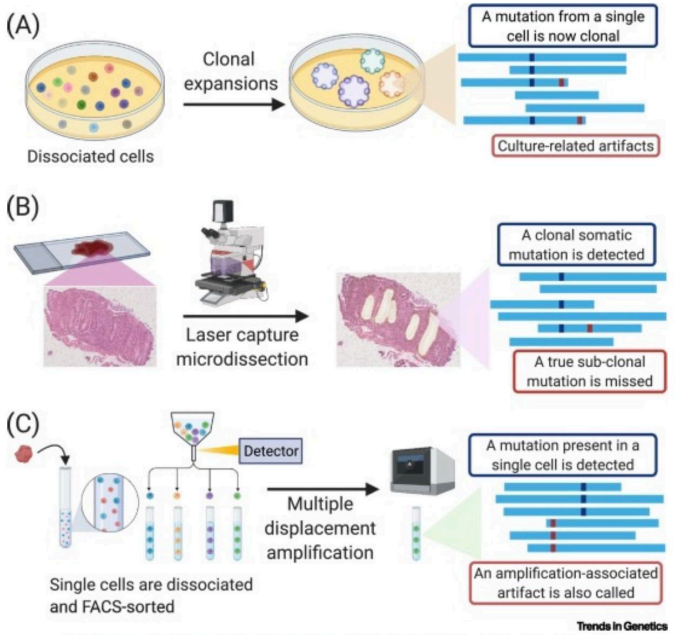
Biomarcadores (Dra. Cardeña)

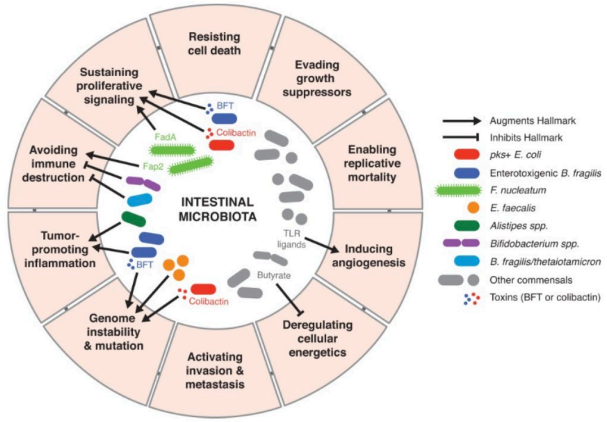


Rahimian S. Biomedicines 2024, 12(1), 123





Olafsson S. Trends in Genetics, October 2021, Vol. 37, No. 10



Fulbright LE PLoS Pathog 13(9): e1006480

Exosomas
Epigenética
SMR
Microbiota

.....

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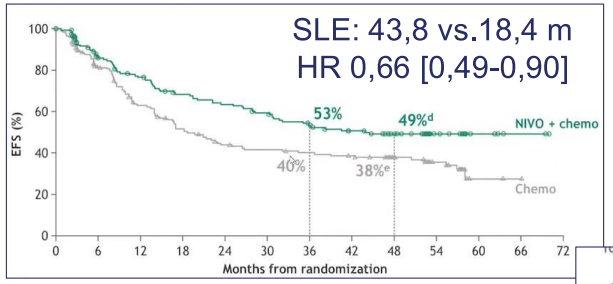
GECP lung cancer research

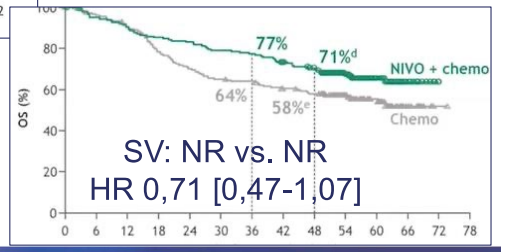
Estudios Iniciales y Enfermedad Localmente Avanzada (Dr. Azkcona)

Neoadyuvant T.

Neoadjuvant nivolumab (NIVO) + chemotherapy (chemo) vs chemo in patients (pts) with resectable NSCLC: 4-year update from CheckMate 816. ASCO 2024. J.Spicer

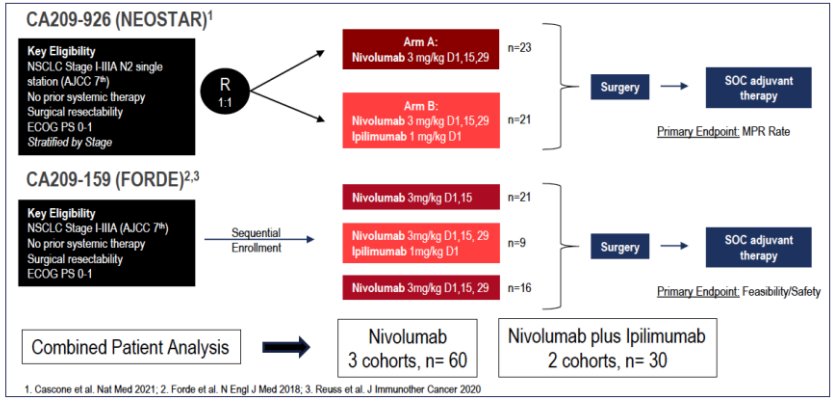


- EIB-IIIA resecable; EGFR y ALK – n=358
- Nivolumab + QT vs. QT → IQ



NEOADYUVANCIA

1209M0 -Neoadjuvant nivolumab and nivolumab plus ipilimumab in resectable non-small cell lung cancer: Combined analysis of 5-year outcomes from NEOSTAR and CA209-159. ESMO 2024. Reuss JE, et al.



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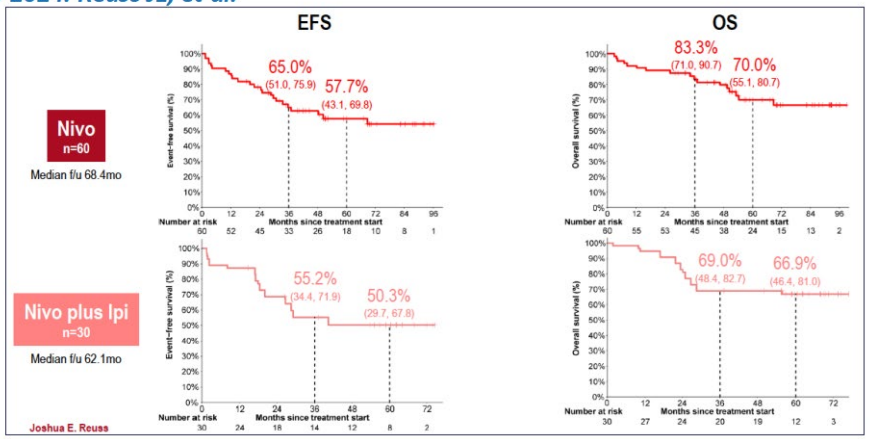


NEOADYUVANCIA

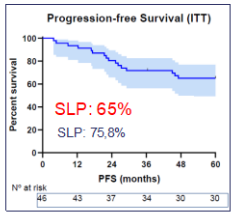
Estudios Iniciales y Enfermedad Localmente Avanzada (Dr. Azkcona)

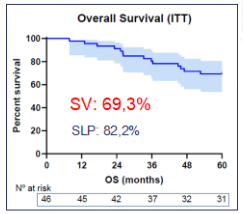
Tratamiento Perioperatorio

5-Year Clinical Outcomes of Perioperative Nivolumab and Chemotherapy in Stage III NSCLC (NADIM trial). WCLC 2024, M. Provencio.

- CNMP EIIIA resecable (AJCC 7ª Ed), EGFR y ALK -
- CBDCA-Taxol + Nivolumab x 3c IQ Nivolumab x1 año

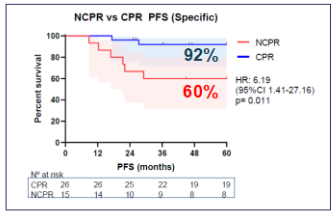
NADIM Patient baseline characteristics	N=46 (ITT)
Age (median, range)	63(41-77)
Co-morbidities, n (%)	43 (93,5)
N2	33 (89,2)
Multiple station	25 (75,8)

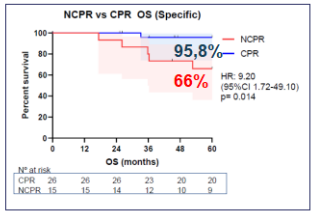




PERIOPERATORIO

5-Year Clinical Outcomes of Perioperative Nivolumab and Chemotherapy in Stage III NSCLC (NADIM trial). WCLC 2024, M. Provencio.



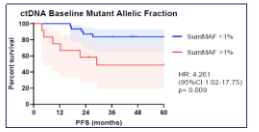


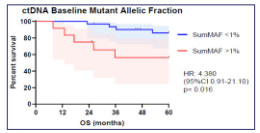
BIOMARCADORES:

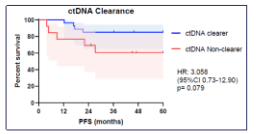
- No diferencias: PD-L1, TMB
- Predictivos: ctDNA basal, aclaramiento ctDNA

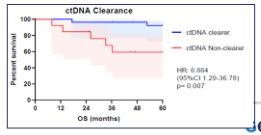
PERIOPERATORIO

5-Year Clinical Outcomes of Perioperative Nivolumab and Chemotherapy in Stage III NSCLC (NADIM trial). WCLC 2024, M. Provencio.





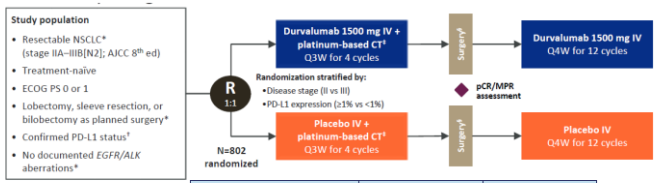




SLP No-ctDNA clearer vs. Si: 60,6 vs. 85,2%

SV No-ctDNA clearer vs. Si: 59,2 vs. 92,3%

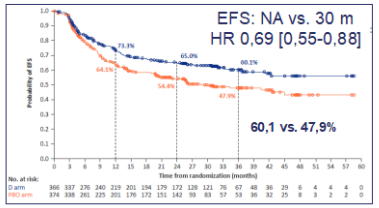
Perioperative Durvalumab for Resectable NSCLC. Updated Outcomes from the Phase 3 AEGEAN Trial. WCLC 2024. JV. Heymach.

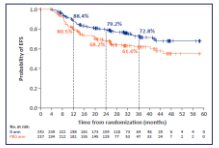


	DURVALUMAB	PLACEBO
Completan 4c neoad	86,9%	88,5%
IQ	77,6%	76,7%
R0	94,7%	91,3%
Completan adyuv	68,6%	63,7%

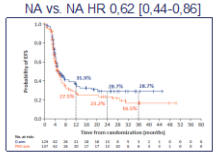
PERIOPERATORIO

Perioperative Durvalumab for Resectable NSCLC. Updated Outcomes from the Phase 3 AEGEAN Trial. WCLC 2024. JV. Heymach.





NA vs. NA HR 0,62 [0,44-0,86]



5,1 vs. 5,2 HR 0,62 [0,60-1,14]

PERIOPERATORIO

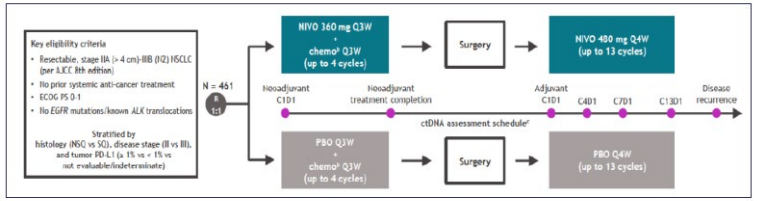
Organizado por:

GECP lung cancer research

Estudios Iniciales y Enfermedad Localmente Avanzada (Dr. Azkcona)

Tratamiento Perioperatorio

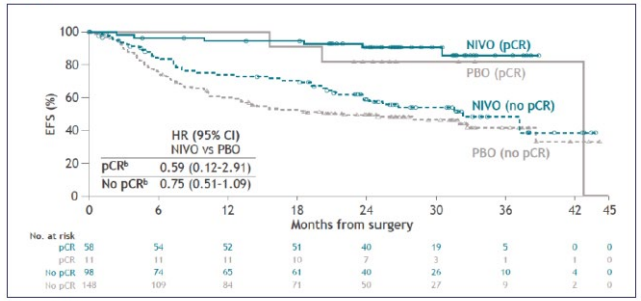
LBA50 - Perioperative nivolumab (NIVO) vs placebo (PBO) in patients (pts) with resectable NSCLC: clinical update from the phase 3 CheckMate 77T study. ESMO 2024. M. Provencio. (Spicer JD)



- Obj 1º: EFS

PERIOPERATORIO

LBA50 - Perioperative nivolumab (NIVO) vs placebo (PBO) in patients (pts) with resectable NSCLC: clinical update from the phase 3 CheckMate 77T study. ESMO 2024. M. Provencio. (Spicer JD)



PERIOPERATORIO

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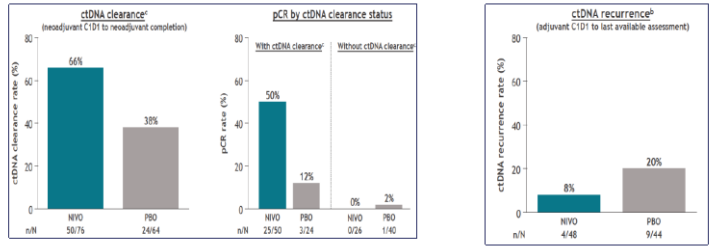
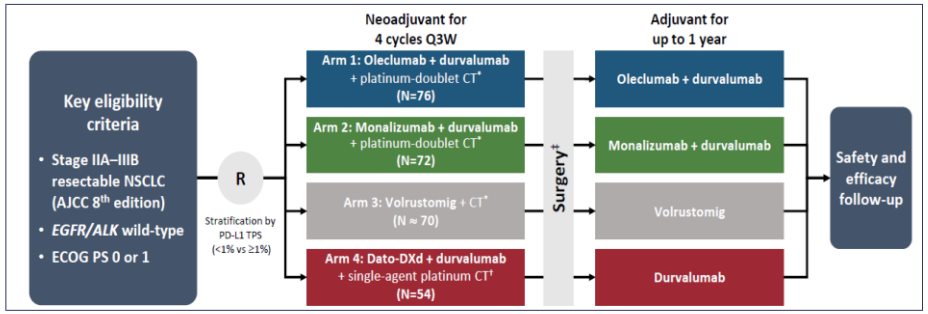


EFS:
- Aclaran ctDNA: 0,38 [0,16-0,88]
- No aclaran ctDNA: 0,74 [0,39-1,42]

PERIOPERATORIO

NeoCOAST-2: Efficacy and Safety of Neoadjuvant Durvalumab (D) + Novel Anticancer Agents + CT and Adjuvant D ±Novel Agents in Resectable NSCLC. WLCLC 2024. T. Cascone.



- Obj 1º: pCR y seguridad

PERIOPERATORIO

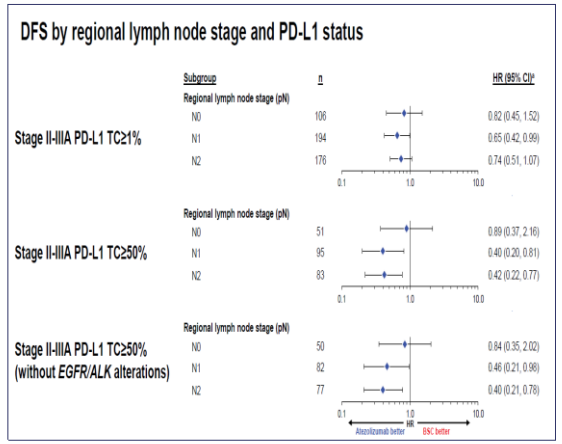
Perioperatory vs Neoadjuvant

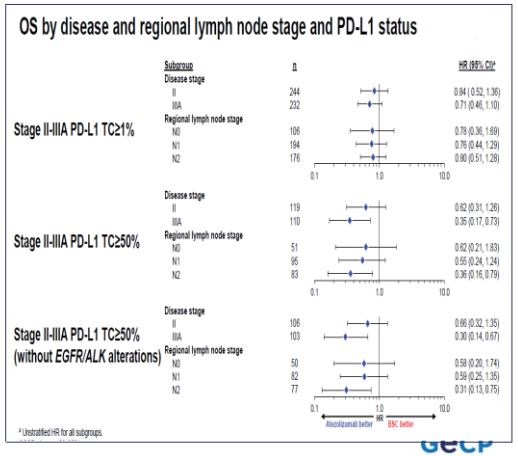
Organizado por: GECP lung cancer research

Estudios Iniciales y Enfermedad Localmente Avanzada (Dr. Azkcona)

Adyuvancia

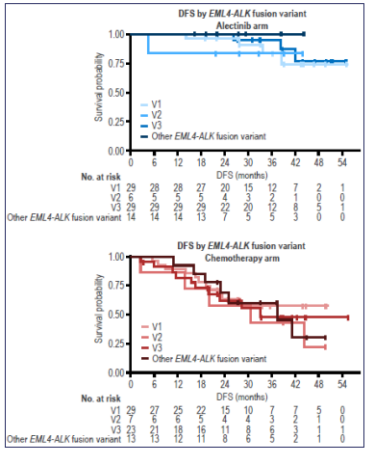
IMpower010 5-y subgroup analysis and relapse patterns: Phase 3 study of atezolizumab vs BSC in stage II-IIIA NSCLC. WCLC 2024. E. Felip.

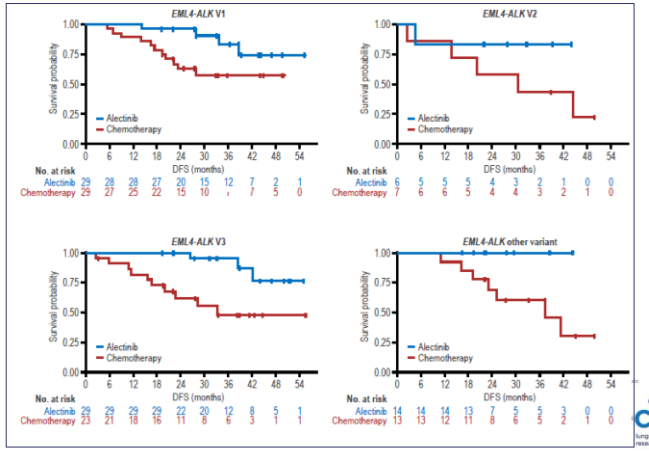




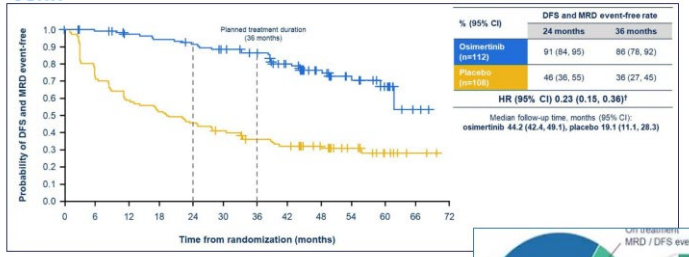
ADYUVANCIA

ALINA: exploratory biomarker analyses in patients with resected *ALK*+ non-small cell lung cancer (NSCLC) treated with adjuvant alectinib vs chemotherapy.ESMO24. BJ. Salomon





Molecular residual disease analysis from the ADAURA trial of adjuvant osimertinib in patients with resected EGFR-mutated stage IB-IIIA non-small cell lung cáncer. ASCO 2024. T. John



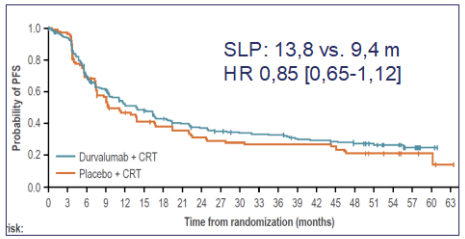
ADYUVANCIA

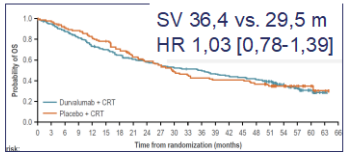
Organizado por:
GECP lung cancer research

Estudios Iniciales y Enfermedad Localmente Avanzada (Dr. Azkcona)

Tumores Irresecables

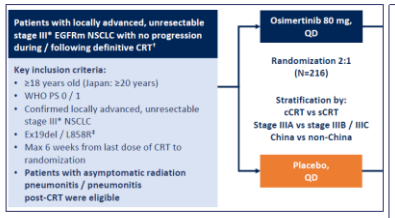
LBA1 –Durvalumab in Combination with Chemoradiotherapy for Patients with Unresectable, Stage III NSCLC: Final Results from PACIFIC-2. ELCC 2024. JD.Bradley



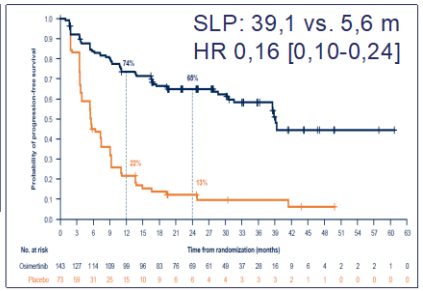


IRRESECABLE

Osimertinib after definitive CRT in patients with unresectable stage III EGFRm NSCLC: Primary results of the phase 3 LAURA study. WCLC 2024. Ramalingan SS.



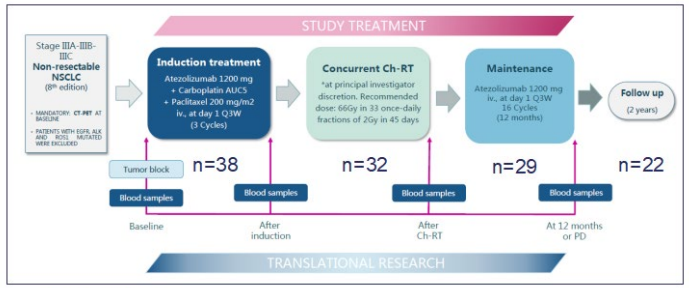
	Osimertinib	Placebo
E IIIA/ B/ C	36/ 47/ 17	33 /52/ 15



- Obj 1º: SLP

IRRESECABLE

Atezolizumab + induction chemotherapy (Ch) + chemo-radiotherapy (Ch-RT) and atezolizumab maintenance in non-resectable stage IIIA-IIIB-IIIC non-small cell lung cancer (NSCLC): APOLO trial. WCLC 2024. M.Provencio



- Obj 1º: SLP 12m

IRRESECABLE

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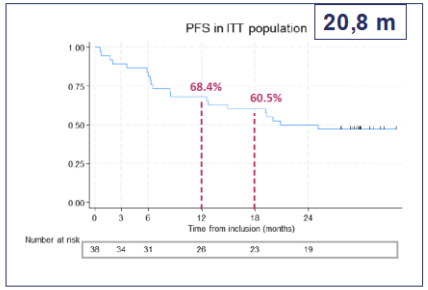
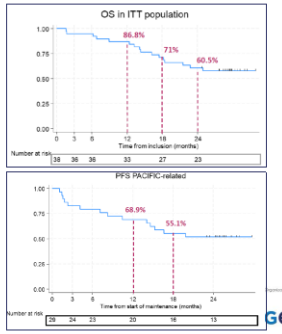




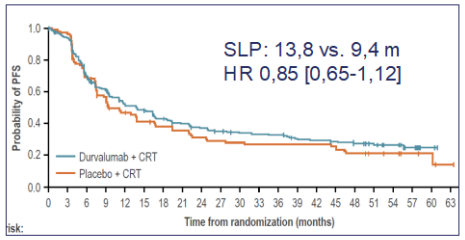
IRRESECABLE

Organizado por: GECP lung cancer research

Estudios Iniciales y Enfermedad Localmente Avanzada (Dr. Azkcona)

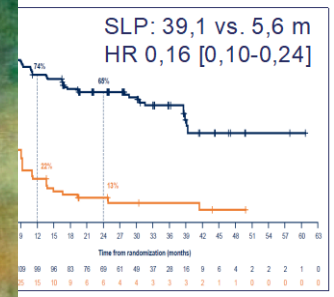
Tumores Irresecables

LBA1 –Durvalumab in Combination with Chemoradiot
Unresectable, Stage III NSCLC: Final Results from PACI



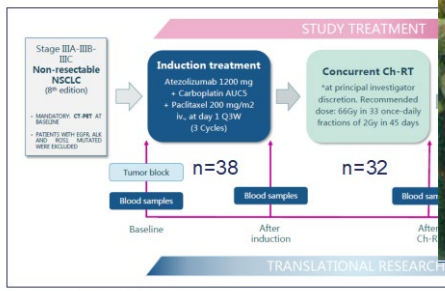
IRRESECABLE

table stage III EGFRm NSCLC:
Ramalingan SS.



IRRESECABLE

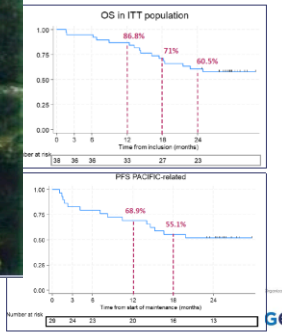
Atezolizumab + induction chemotherapy (Ch) + chemo
atezolizumab maintenance in non-resectable stage III
(NSCLC): APOLO trial. WCLC 2024. M.Provencio



- Obj 1º: SLP 12m

IRRESECABLE

diotherapy (Ch-RT) and
IIB-IIIC non-small cell lung cancer



IRRESECABLE

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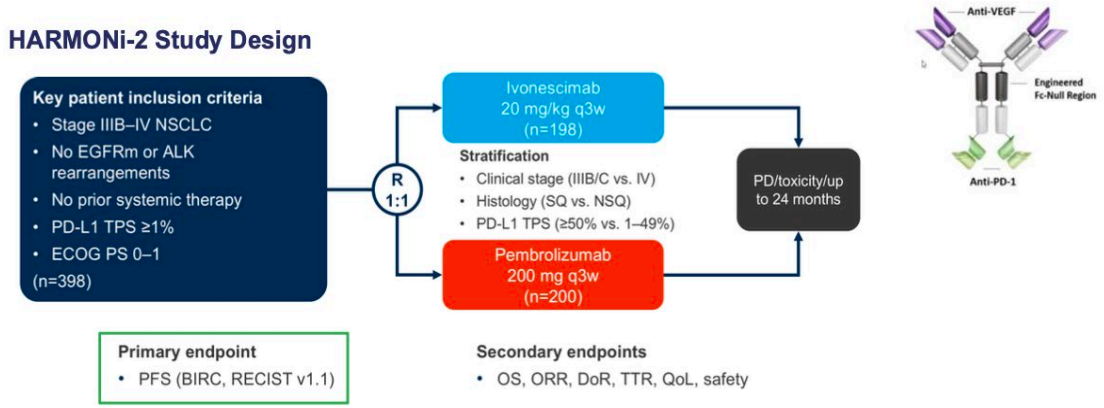
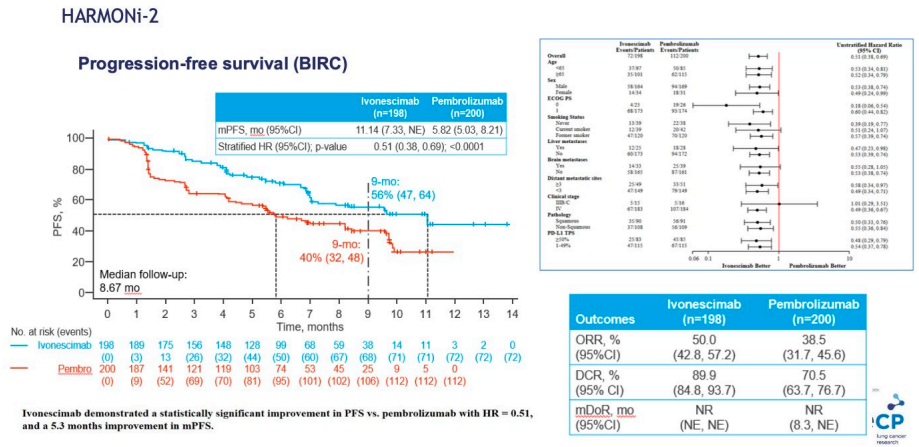
GECP lung cancer research

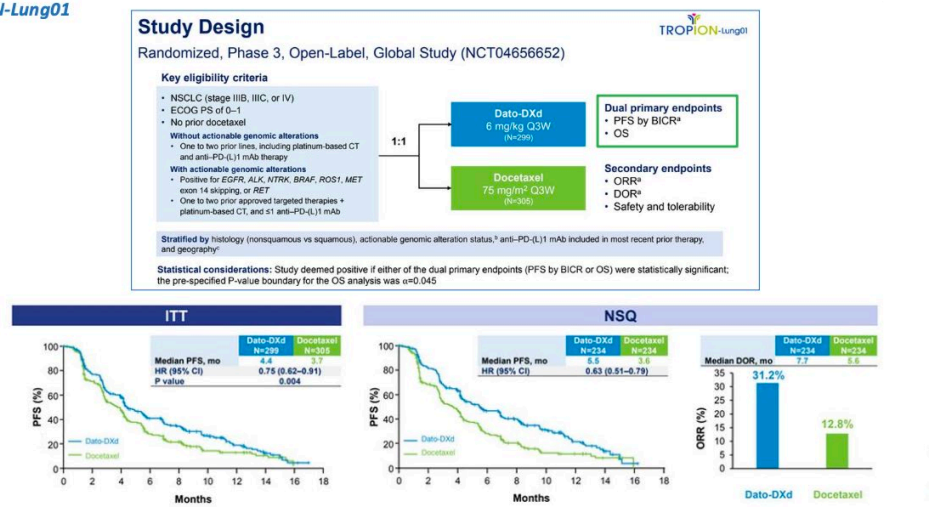
Enfermedad Metastásica (Dra. N. Vilariño)

Sin genes drivers

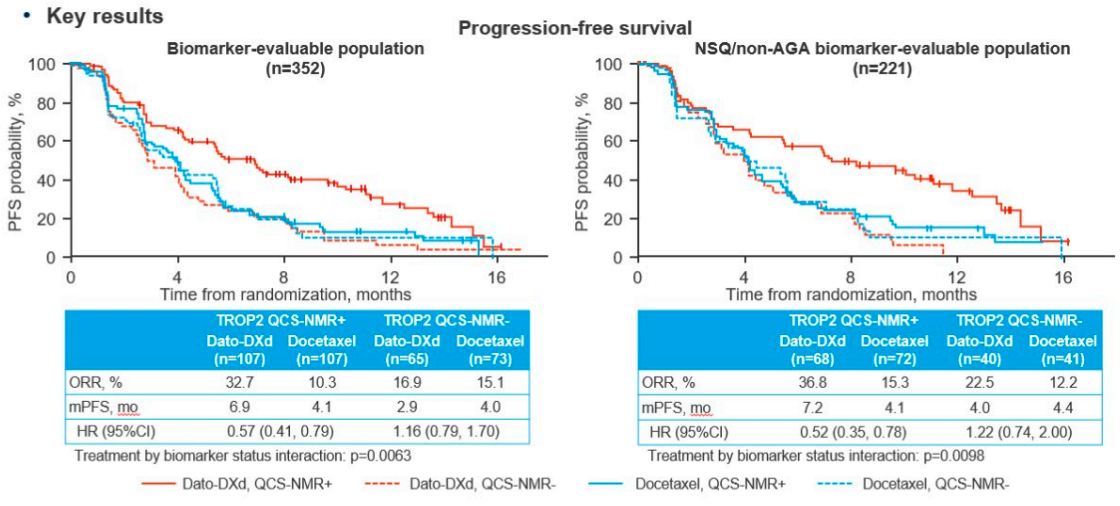




OA08.03: Datopotamab Deruxtecan Vs Docetaxel in Patients with Non-Small Cell Lung Cancer: Final Overall Survival from TROPION-Lung01



• Differential PFS outcomes by histology for Dato-DXd have been independently reported in two other NSCLC trials[5,6]

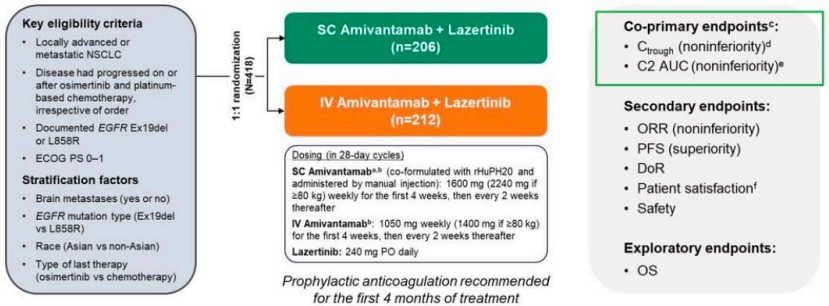


Organizado por: GECP lung cancer research

Enfermedad Metastásica (Dra. N. Vilariño)

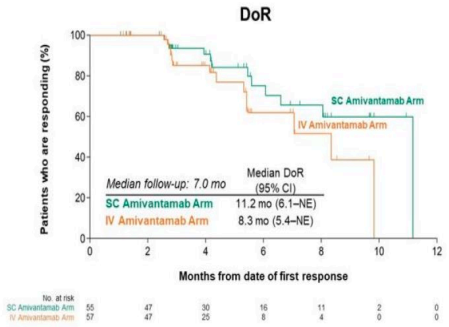
EGFR +

PALOMA-3: Phase 3 Study Design



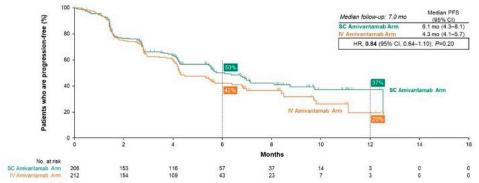
ORR and DoR

	SC Amivantamab Arm (n=206)	IV Amivantamab Arm (n=212)
ORR, % (95% CI)[a]		
All responders	30 (24–37)	33 (26–39)
	Relative risk, 0.92 (95% CI, 0.70–1.23); P=0.001	
Confirmed responders	27 (21–33)	27 (21–33)
	Relative risk, 0.99 (95% CI, 0.72–1.36); P<0.001	
Best response, n (%)		
CR	1 (0.5)	1 (0.5)
PR	61 (30)	68 (32)
SD	93 (45)	81 (38)
PD	37 (18)	42 (20)
Not evaluable	14 (7)	20 (9)
DCR, % (95% CI)[b]	75 (69–81)	71 (64–77)
Median time to response (range), mo	1.5 (1.2–6.9)	1.5 (1.2–9.9)



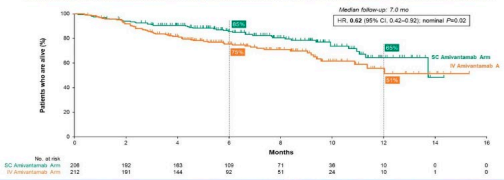
Progression-free Survival

PFS was numerically longer with SC vs IV amivantamab, with an HR of 0.84

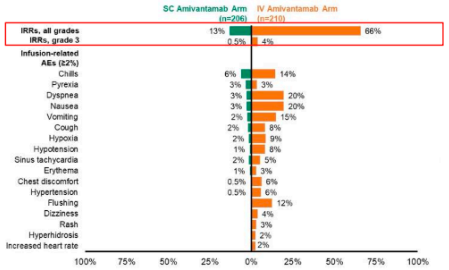


Overall Survival

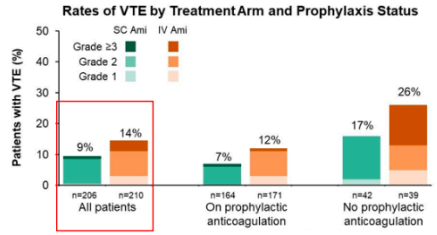
There was an OS benefit associated with SC amivantamab, with an HR of 0.62 compared to the IV amivantamab arm[a]



Incidence of IRR-related Symptoms



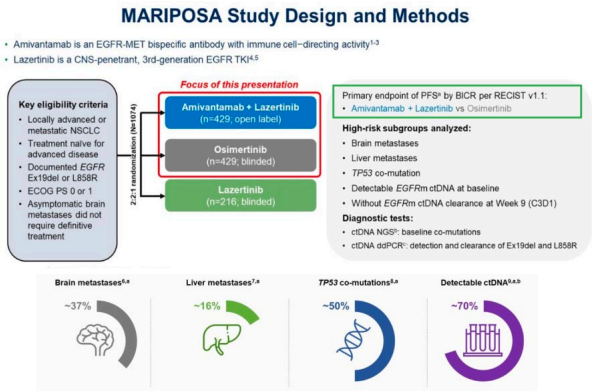
Adverse Event of Special Interest: VTE[a]

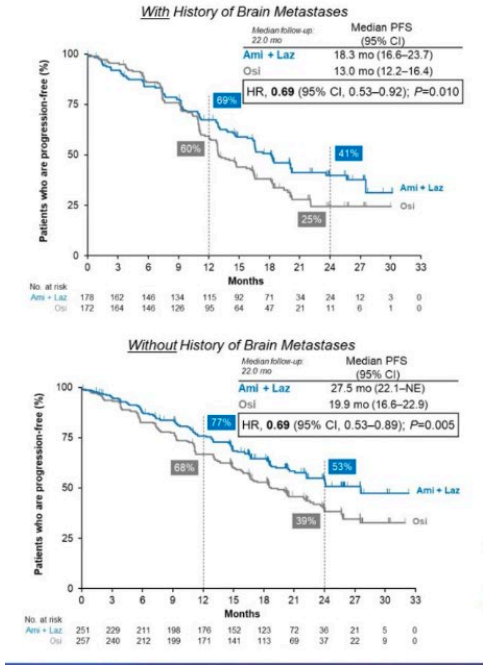


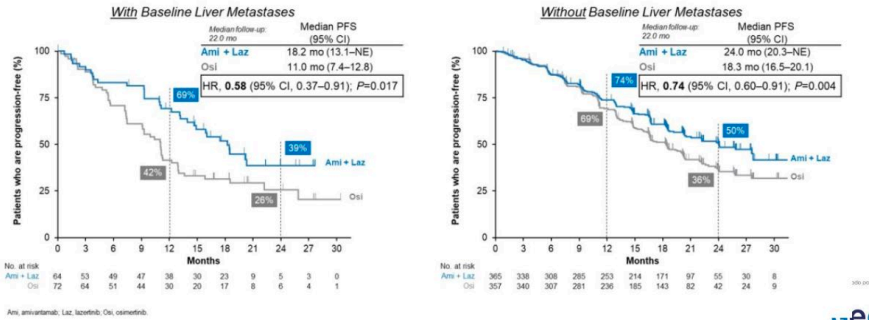
Organizado por: GECP lung cancer research

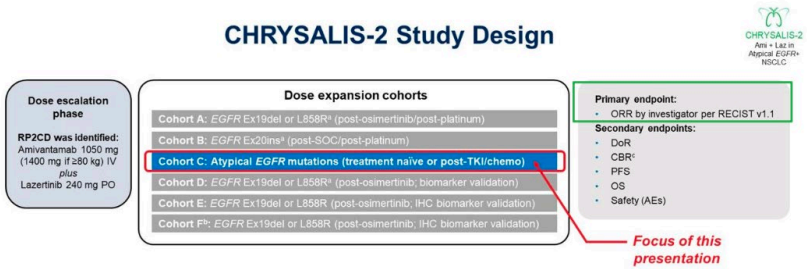
Enfermedad Metastásica (Dra. N. Vilariño)

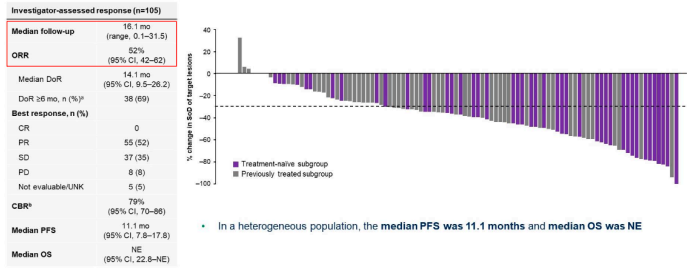
EGFR +

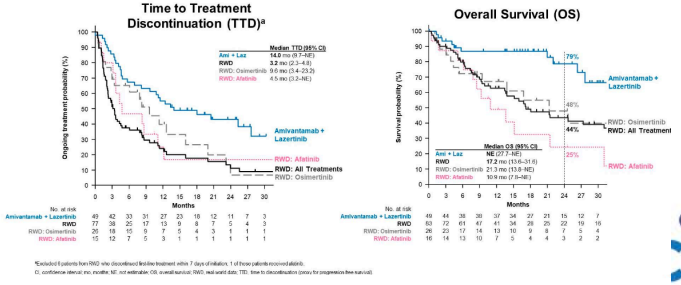










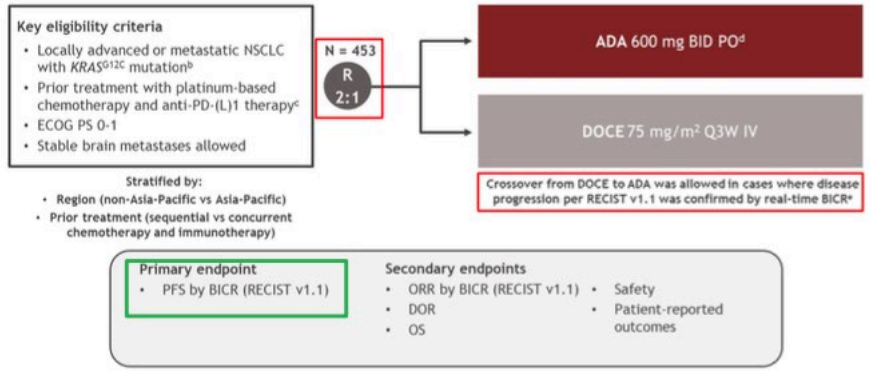


lung cancer research

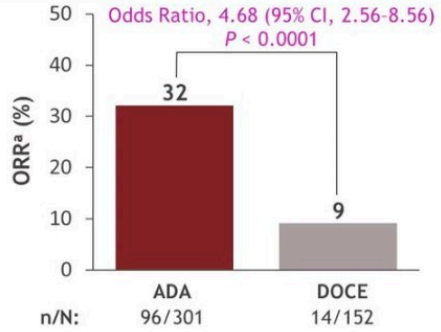
Enfermedad Metastásica (Dra. N. Vilariño)

KRAS +

KRYSTAL-12[a] study design

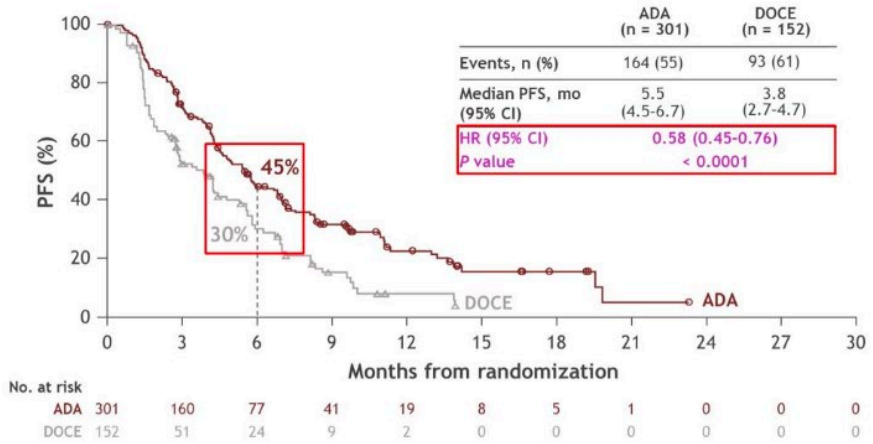


Tumor response per BICR



Tumor response	ADA (n = 301)	DOCE (n = 152)
DCR,[b] n (%)	236 (78)	89 (59)
Median DOR,[c] mo (95% CI)	8.3 (6.1-10.4)	5.4 (2.9-8.5)
Remaining in response at 6 mo, %	64	39

Primary endpoint: PFS[a] per BICR



	ADA (n = 301)	DOCE (n = 152)
Events, n (%)	164 (55)	93 (61)
Median PFS, mo (95% CI)	5.5 (4.5-6.7)	3.8 (2.7-4.7)
HR (95% CI)	0.58 (0.45-0.76)	
P value	< 0.0001	

Organizado por:
GECP lung cancer research

Enfermedad Metastásica (Dra. N. Vilariño)

ALK +

Current Post Hoc Analyses at 5 Years

Endpoint evaluation by BICR stopped after the 3-year analysis

Key eligibility criteria
- Stage IIIB/IV *ALK*+ NSCLC
- No prior systemic treatment for metastatic disease
- ECOG PS 0-2
- Asymptomatic treated or untreated CNS metastases were permitted
- ≥1 extracranial measurable target lesion (RECIST 1.1) with no prior radiation required

Randomized 1:1 N=296

- Lorlatinib 100 mg once daily n=149
- Crizotinib 250 mg twice daily n=147

Stratified by:
- Presence of brain metastases (yes vs no)
- Ethnicity (Asian vs non-Asian)

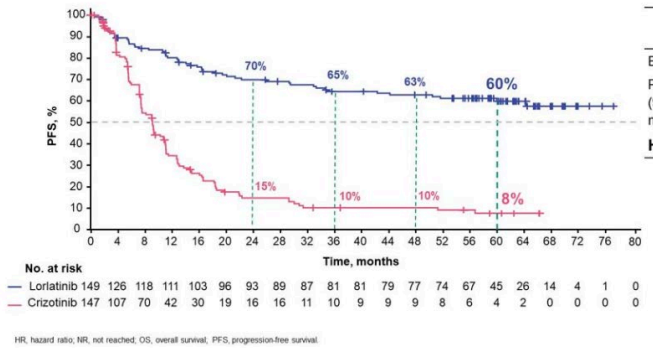
No crossover between treatment arms was permitted

Current analyses
Data cutoff: October 31, 2023
- **Investigator Assessed**
  - PFS[a]
  - ORR and IC ORR
  - DOR and IC DOR
  - IC TTP
- Safety
- Biomarker analyses

Primary Objective:
- PFS by BICR

- The median duration of follow-up for PFS was 60.2 months (95% CI, 57.4-61.6) in the lorlatinib arm and 55.1 months (95% CI, 36.8-62.5) in the crizotinib arm

At 60.2 Months of Median Follow-Up, Median PFS by Investigator Was Still Not Reached With Lorlatinib



	Lorlatinib (n=149)	Crizotinib (n=147)
Events, n	55	115
PFS, median (95% CI), months	NR (64.3-NR)	9.1 (7.4-10.9)
HR (95% CI)	**0.19 (0.13-0.27)**	

At the time of this analysis, the required number of OS events for a protocol-specified second interim analysis **has not been reached**. OS follow up is ongoing

HR, hazard ratio; NR, not reached; OS, overall survival; PFS, progression-free survival.

ALKove-1

A Global First-in-Human Phase 1/2 Clinical Trial of NVL-655 in Advanced ALK-Positive NSCLC and Other Solid Tumors (NCT05384626)

PATIENT POPULATION
- Advanced solid tumors harboring an ALK fusion or activating mutation (by local testing)
- Patients with NSCLC: ≥ 1 prior 2G or 3G ALK TKI
- ≤ 2 prior chemotherapies/immunotherapies
- Excluded: concurrent oncogenic drivers (e.g., EGFR/ROS1/MET/RET/BRAF alterations) [a]
- Evaluable but non-measurable disease allowed [b]

PHASE 1 OBJECTIVES
- Primary: Selection of RP2D and, if applicable, MTD
- Overall safety and tolerability
- PK characterization
- Preliminary antitumor activity
- Intracranial activity

PHASE 1 DOSE-ESCALATION COMPLETED, FOLLOW-UP CONTINUES

Enrollment June 2022 to February 2024 (Data cut-off: 15 June 2024)

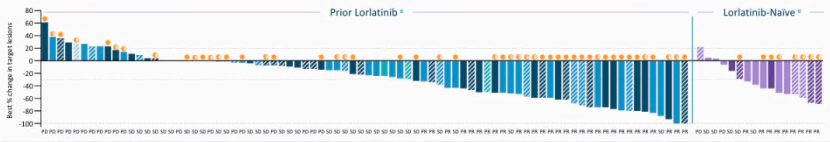
NVL-655 Phase 1	All Doses	15 mg QD	25 mg QD	50 mg QD	100 mg QD	RP2D 150 mg QD	200 mg QD
All-Treated Population	N = 133	3	12	12	32	52	22
NSCLC Response-Evaluable Population	N = 103	3	7	10	27	39	17

2G, 2nd generation ALK TKI (i.e., ceritinib, alectinib, or brigatinib); 3G, 3rd generation ALK TKI (i.e., lorlatinib); MTD, maximum tolerated dose; NSCLC, non-small cell lung cancer; PK, pharmacokinetics; QD, once daily; RP2D, recommended phase 2 dose; TKI, tyrosine kinase inhibitor

[a]Response evaluable population prospectively defined as all NSCLC patients with measurable disease, without concurrent oncogenic driver, and who undergo ≥1 post-baseline response assessment (or discontinue treatment due to clinical progression/death prior to the first response assessment). Patients unevaluable for response: no measurable disease at baseline (n = 18); tumor with alternate oncogenic driver (MET amplification [n = 4], BRAF G469A [n = 2], BRAF fusion [n = 1], NTRK fusion [n = 1]); no post-baseline scan and discontinued treatment for reasons other than progressive disease (n = 2); other solid tumor (n = 2).

Preliminary Activity: Radiographic Tumor Responses Across Previously Treated Patients with ALK+ NSCLC

RECIST 1.1 ORR, % (n/N) All patients ± chemotherapy	NSCLC Response-Evaluable (Any Prior ALK TKI, range 1 – 5) All	NSCLC Response-Evaluable (Any Prior ALK TKI, range 1 – 5) Any ALK mutation [c]	NSCLC Response-Evaluable (Any Prior ALK TKI, range 1 – 5) G1202R [c]	Prior Lorlatinib (≥2 ALK TKIs) All	Prior Lorlatinib (≥2 ALK TKIs) Any ALK mutation	Prior Lorlatinib (≥2 ALK TKIs) Compound ALK mutation	Lorlatinib-naive (≥1 2G ± 1G) All	Lorlatinib-naive (≥1 2G ± 1G) Any ALK mutation
All Doses	38% (39/103)	52% (30/58)	69% (22/32) [d]	35% (30/85)	47% (23/49)	54% (15/28)	53% (9/17)	88% (7/8)
RP2D	38% (15/39)	55% (12/22)	71% (10/14)	35% (11/31)	50% (8/16)	64% (7/11)	57% (4/7)	80% (4/5)



Data cut-off: 15 June 2024. Response-evaluable patients with NSCLC. All responses were confirmed.

NSCLC, non-small cell lung cancer; ORR, objective response rate; PD, progressive disease; PR, partial response; RECIST 1.1, Response Evaluation Criteria in Solid Tumours version 1.1; RP2D, Recommended Phase 2 dose (150 mg QD); SD, stable disease; TKI, tyrosine kinase inhibitor.

[a]Includes all patients with ≥1 identified ALK resistance mutation as per local or central testing of blood (ctDNA) or tissue. Responses observed in patients with ALK I1171N/S, V1180L, L1196Q, L1198F, D1203N, or E1210K mutations, including where multiple mutations co-occur, in addition to those with G1202R.

[b]Includes patients with G1202R single and compound (≥2) mutations.

[c]Cis-allelic configuration has not been confirmed for all patients with compound (≥2) ALK resistance mutations.

[d]ORR = 67% (20/30) for G1202R patients with prior lorlatinib, and ORR= 100% (2/2) for lorlatinib-naïve G1202R patients.

[e]Five response-evaluable patients (4 with no known ALK mutations and 1 with single ALK mutation) not shown due to incomplete or missing post-baseline tumor assessments in the setting of PD or symptomatic deterioration.

KEY: PATIENT DETAILS

Lorlatinib Pre-treated:
- ≥ 3 prior ALK TKIs
- 2 prior, 2G + lorlatinib
- 2 prior, 1G + lorlatinib
- 1 prior (lorlatinib only)

Lorlatinib-naïve:
- ≥ 2 prior ALK TKIs
- 1 prior, alectinib
- Patient treated at RP2D

- ALK single resistance mutation
- ALK compound (≥2) resistance mutation

BARCELONA 2024 ESMO congress

6

Organizado por: GECP lung cancer research

Cáncer de Pulmón Microcítico y otros tumores (Dr. Martí)

Enfermedad Limitada

ADRIATIC study design

Phase 3, randomized, double-blind, placebo-controlled, multicenter, international study (NCT03703297)

- Stage I–III LS-SCLC (stage I/II inoperable)
- WHO PS 0 or 1
- Had not progressed following cCRT*
- PCI* permitted before randomization

N=730

R‡

- **Durvalumab** 1500 mg Q4W N=264
- **Placebo** Q4W N=266
- **Durvalumab + tremelimumab** D 1500 mg Q4W + T 75 mg Q4W for 4 doses, followed by D 1500 mg Q4W N=200

cCRT components
- Four cycles of platinum and etoposide (three permitted†)
- RT: 60–66 Gy QD over 6 weeks or 45 Gy BID over 3 weeks
- RT must commence no later than end of cycle 2 of CT

Stratified by: Disease stage (I/II vs III) PCI (yes vs no)

Treatment until investigator-determined progression or intolerable toxicity, or for a **maximum of 24 months**

Dual primary endpoints:
- Durvalumab vs placebo
  - OS
  - PFS (by BICR, per RECIST v1.1)

Key secondary endpoints:
- Durvalumab + tremelimumab vs placebo
  - OS
  - PFS (by BICR, per RECIST v1.1)

Other secondary endpoints:
- OS/PFS landmarks
- Safety

*cCRT and PCI treatment, if received per local standard of care, must have been completed within 1–42 days prior to randomization.
†If disease control was achieved and no additional benefit was expected with an additional cycle of chemotherapy, in the opinion of the investigator.
‡The first 600 patients were randomized in a 1:1:1 ratio to the 3 treatment arms; subsequent patients were randomized 1:1 to either durvalumab or placebo.
BICR, blinded independent central review; BID, twice daily; CT, chemotherapy; D, durvalumab; PCI, prophylactic cranial irradiation; PS, performance status; Q4W, every 4 weeks; QD, once daily; RECIST, Response Evaluation Criteria in Solid Tumors; RT, radiotherapy; T, tremelimumab; WHO, World Health Organization.

2024 ASCO ANNUAL MEETING #ASCO24 PRESENTED BY: Dr David R. Spigel

ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY KNOWLEDGE CONQUERS CANCER

ORIGINAL ARTICLE

Durvalumab after Chemoradiotherapy in Limited-Stage Small-Cell Lung Cancer

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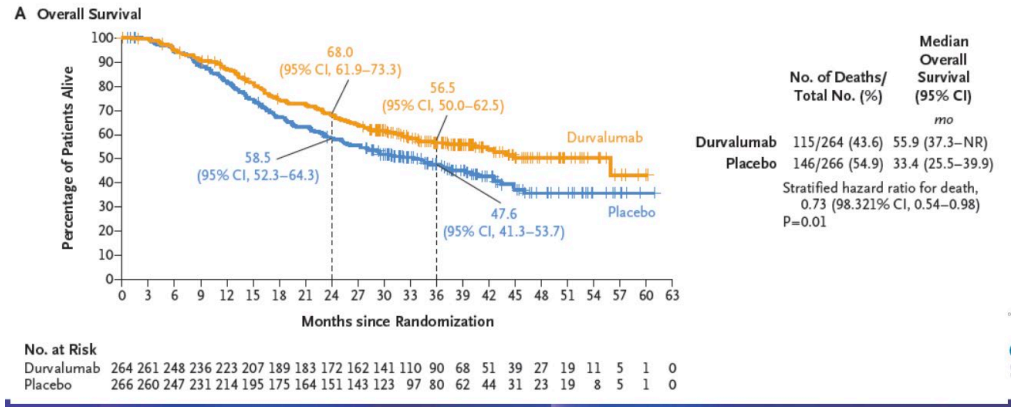
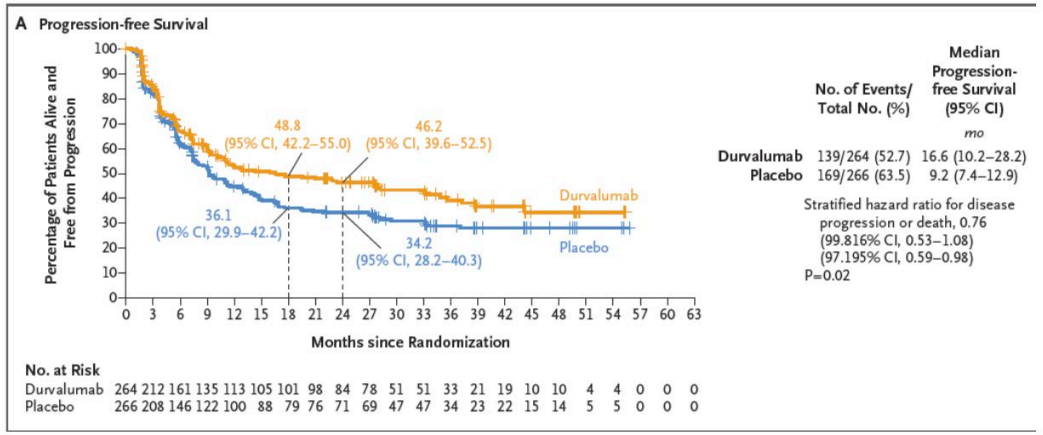


	No. of Deaths/ Total No. (%)	Median Overall Survival (95% CI) mo
Durvalumab	115/264 (43.6)	55.9 (37.3–NR)
Placebo	146/266 (54.9)	33.4 (25.5–39.9)

Stratified hazard ratio for death, 0.73 (98.321% CI, 0.54–0.98) P=0.01



	No. of Events/ Total No. (%)	Median Progression-free Survival (95% CI) mo
Durvalumab	139/264 (52.7)	16.6 (10.2–28.2)
Placebo	169/266 (63.5)	9.2 (7.4–12.9)

Stratified hazard ratio for disease progression or death, 0.76 (99.816% CI, 0.53–1.08) (97.195% CI, 0.59–0.98) P=0.02

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Cáncer de Pulmón Microcítico y otros tumores (Dr. Martí)

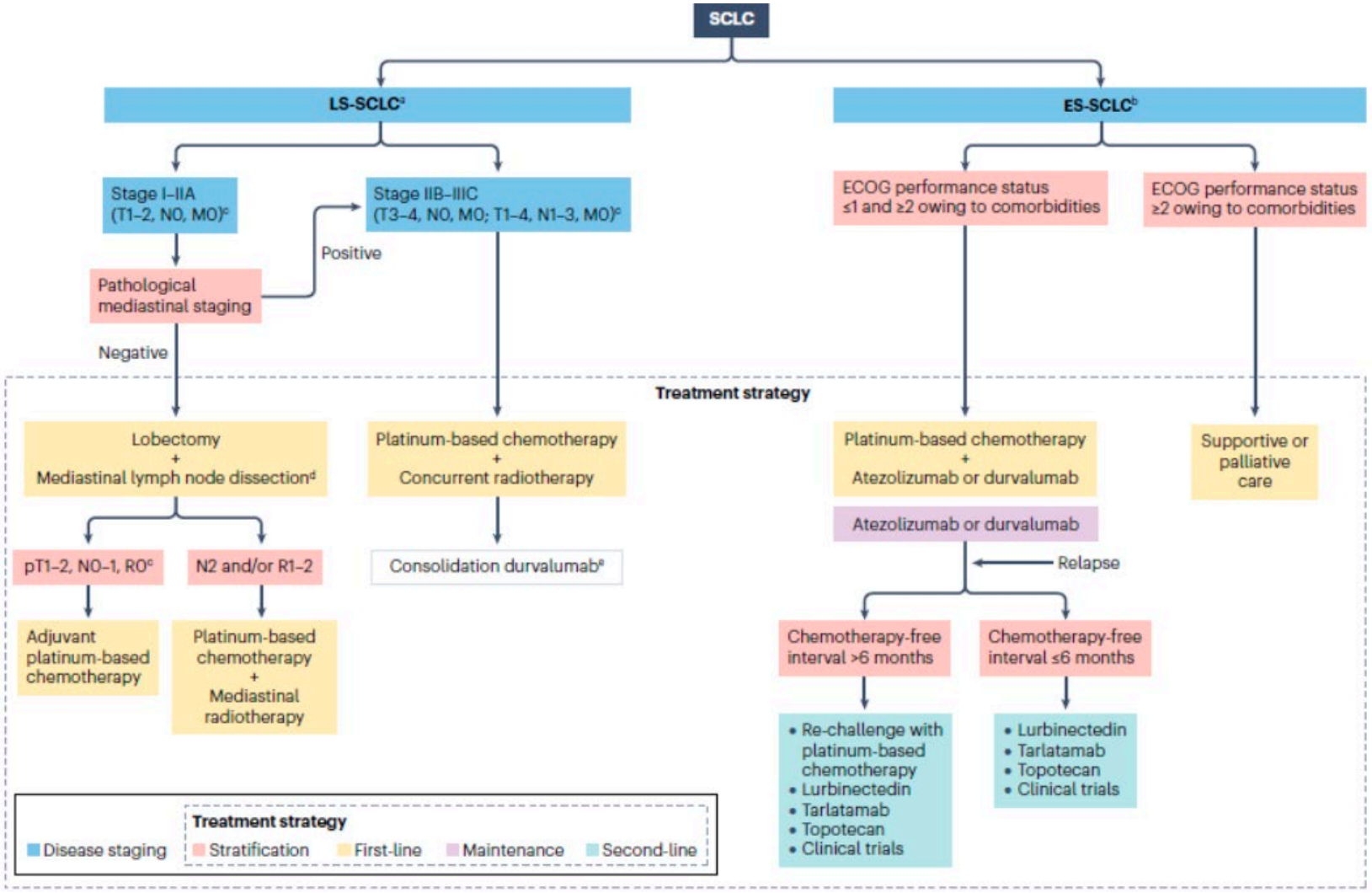

Fig. 4 | Current management strategy for SCLC. Proposed strategy for the management of patients with small-cell lung cancer (SCLC) as of 2024. [a]Limited-plan. [b]Extensive-stage (ES-SCLC) includes stage IV (T any, N any, M 1a/b/c) and T3–4 disease. [c]Defined according to the Eighth Edition of TNM Staging of Lung

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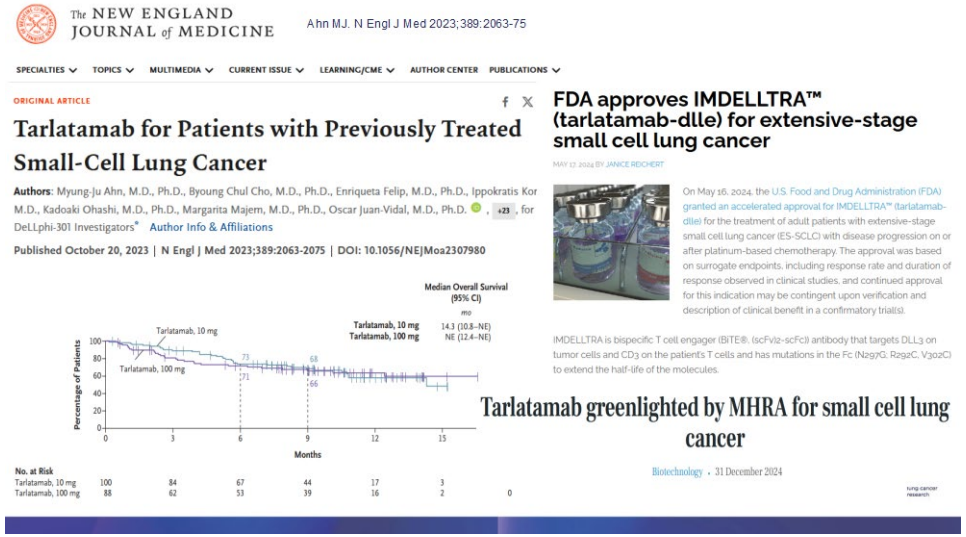
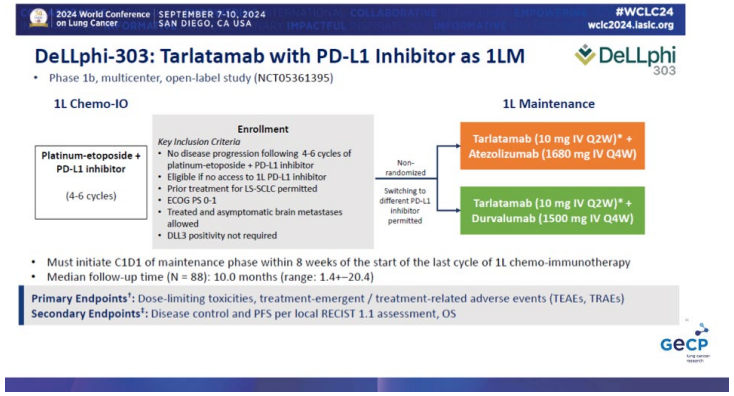
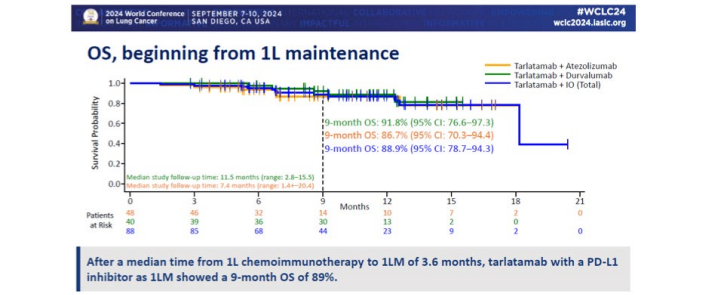
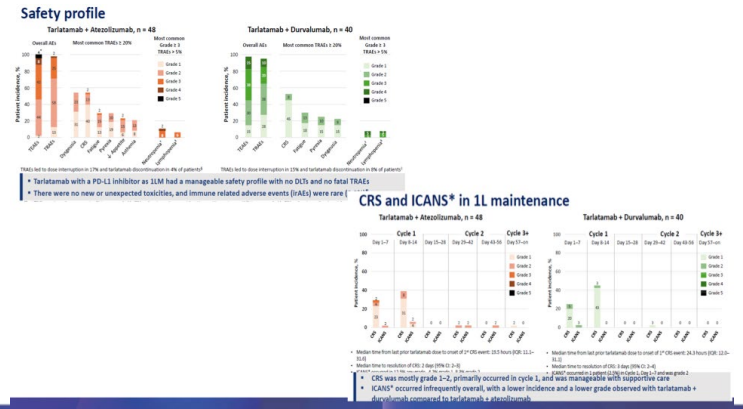
Nuevos fármacos







These results demonstrate a favorable benefit-to-risk profile and support a randomized controlled study of tarlatamab with durvalumab as 1L maintenance, which is underway (Phase 3 DeLLphi-305; NCT06211036)



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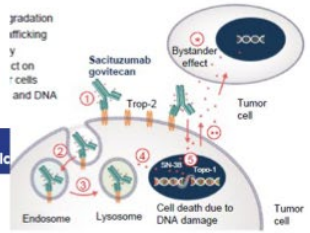
Nuevos fármacos

Sacituzumab Govitecan as Second-Line Treatment in Patients With Extensive-Stage Small Cell Lung Cancer

Afshin Dowlati[1], Anne C. Chiang[2], Andrés Cervantes[3], Sunil Babu[4], Erika Hamilton[5], Shu Fen Wong[6],

2024 World Conference on Lung Cancer | SEPTEMBER 7-10, 2024 | SAN DIEGO, CA USA



TROPiCS-03 Study Design

- The ongoing, open-label, multicohort, phase 2 TROPiCS-03 study (NCT03964727) is evaluating SG in patients with metastatic or locally advanced solid tumors
  - — A preliminary analysis showed SG has promising antitumor activity and a manageable safety profile in an extensive-stage small cell lung cancer (ES-SCLC) cohort[1]
  - — Here, we report updated results with additional patients and longer follow-up from the ES-SCLC cohort

Key eligibility criteria
- Histologically confirmed ES-SCLC
- Disease progression after no more than 1 prior line of platinum-based chemo and anti–PD-(L)-1 therapy
- Measurable disease per RECIST v1.1
- ECOG PS 0–1
- Stable, treated brain metastases allowed[a]

→ **ES-SCLC cohort** (N = 43) → **SG 10 mg/kg** IV on D1 and D8 21-day cycles (until PD or unacceptable toxicity) → **Survival follow-up**

Primary end points
- ORR (INV[b])

Secondary end points
- DOR, CBR, PFS (INV[b])
- ORR, DOR, CBR, PFS (BICR[b])
- OS
- Safety

- At data cutoff (8 March 2024), median follow-up was 12.3 (range, 8.1–20.1) months

[a]Patients with stable CNS disease for ≥4 weeks prior to the first study dose and all neurologic symptoms returned to baseline may be included in the study. All patients with carcinomatous meningitis are excluded from the study, regardless of clinical stability. [b]Per RECIST v1.1.
BICR, blinded independent central review; **CBR**, clinical benefit rate; **chemo**, chemotherapy; **CNS**, central nervous system; **D**, day; **DOR**, duration of response; **ECOG PS**, Eastern Cooperative Oncology Group performance status; **ES-SCLC**, extensive-stage small cell lung cancer; **INV**, investigator-assessed; **IV**, intravenous; **ORR**, objective response rate; **OS**, overall survival; **PD**, progressive disease; **PD-(L)1**, programmed death (ligand) 1; **PFS**, progression-free survival; **RECIST v1.1**, Response Evaluation Criteria in Solid Tumors version 1.1; **SG**, sacituzumab govitecan.
1. Dowlati A, et al. Oral presentation ESMO 2023. Abstract #1096MO.

Ifinatamab deruxtecan (I-DXd) in extensive-stage small cell lung cancer (ES-SCLC): interim analysis of IDeate-Lung01

Charles M. Rudin,[1] Myung-Ju Ahn,[2] Melissa Johnson,[3] Christine L. Hann,[4] Nicolas Girard,[5]

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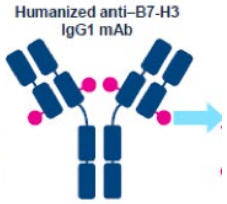

Phase 2 IDeate-Lung01 study (NCT05280470)

Patient eligibility:
- Histologically or cytologically documented ES-SCLC
- Age ≥18 years[a]
- ≥1 prior line of PBC and ≤3 prior lines of systemic therapy
- Radiologically documented PD on or after most recent prior systemic therapy
- ECOG PS 0–1
- ≥1 measurable lesion per RECIST 1.1[b]
- Patients with asymptomatic brain metastases (untreated or previously treated) are eligible

→ **R 1:1**

→ **Arm 1:** I-DXd 8 mg/kg Q3W (n≈40)

→ **Arm 2:** I-DXd 12 mg/kg Q3W (n≈40)

→ Extended enrollment at RP3D (n≈70 3L+)

Stratification:
- 2L CTFI <90 days, 2L CTFI ≥90 days, 3L or 4L
- Prior anti–PD-(L)1 treatment (yes or no)

Primary endpoint:
- ORR by BICR[c]

Secondary endpoints:
- DOR by BICR and inv[c]
- PFS by BICR and inv[c]
- OS
- DCR[c]
- TTR by BICR and inv[c]
- ORR by inv[c]
- Safety
- Pharmacokinetics
- Immunogenicity

Exploratory analysis:
- Intracranial ORR by BICR[d]

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Mesotelioma

Extended pleurectomy decortication and chemotherapy versus chemotherapy alone for pleural mesothelioma (MARS 2): a phase 3 randomised controlled trial

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Summary

Background Extended pleurectomy decortication for complete macroscopic resection for pleural mesothelioma has never been evaluated in a randomised trial. The aim of this study was to compare outcomes after extended pleurectomy decortication plus chemotherapy versus chemotherapy alone.

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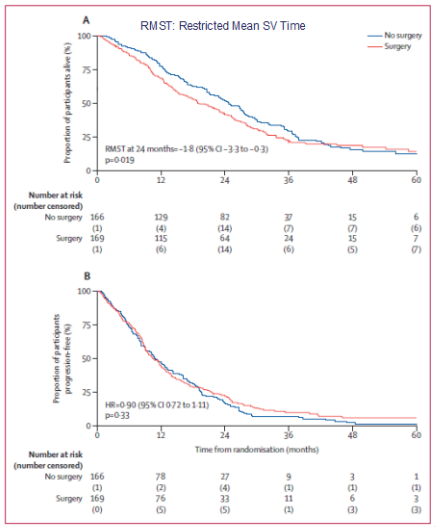

Figure 2: (A) Overall survival and (B) progression-free survival

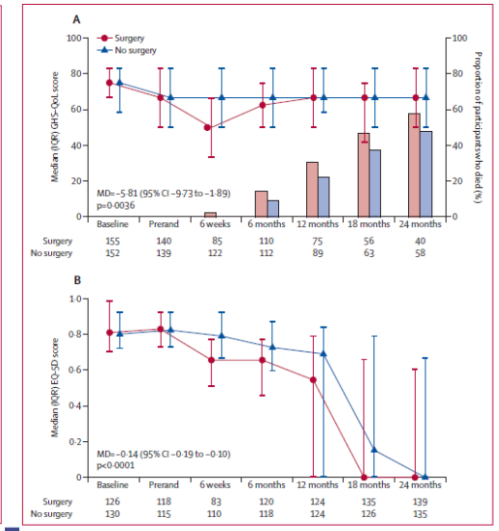

Figure 3: (A) GHS-QoL scores and (B) EQ-5D utility scores over time in survivors

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Novedades y Claves en Cáncer de Pulmón 2024

Comentarios finales

- 2024 ha sido un año muy productivo e inspirador para nuevas estrategias en el diagnóstico y tratamiento del Cáncer de Pulmón
- Un mejor conocimiento de la biología del Cáncer de Pulmón ha permitido trabajar con nuevos biomarcadores predictivos y pronósticos
- Se ha establecido como estándar el uso de las combinaciones de QT + ITP en la aproximación terapéutica del Cáncer de Pulmón Localmente Avanzada
- Los ADC y Ac biespecíficos tienen un futuro prometedor en la enfermedad metastásica, a confirmar su utilidad en 1ª o 2ª línea
- Las combinaciones de anti EGFR de 3ª G y Ac biespecíficos frente a EGFR, pendiente de optimizar su tolerancia, es activa CPCNP con mutaciones habituales de EGFR y en las atípicas (distintas de los exones 19, 20 y 21)
- Se consolidan los excelentes resultados de Lorlatinib en ALK + y aparecen nuevas moléculas que podrían tener un papel en las resistencias y refractariedad al tratamiento estándar
- Asimismo, en CPCP podemos decir que la inmunoterapia, tanto en estadios localizados como diseminados, produce un beneficio limitado pero significativo en nuestros pacientes
- Nuevos agentes, como Tarlatamab y Lurbinectidina, permiten ser optimistas en los progresos terapéuticos de los enfermos con CPCP
- Ha quedado demostrado la no utilidad de grandes cirugías en los Mesoteliomas

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Muchas gracias

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