Meet The Professor

Current and Future Role of Immunotherapy in the Management of Lung Cancer

Stephen V Liu, MD
Associate Professor of Medicine
Georgetown University Hospital
Washington, DC

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Commercial Support

This activity is supported by educational grants from Eisai Inc, Genentech, a member of the Roche Group, and Regeneron Pharmaceuticals Inc and Sanofi Genzyme.

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Dr Love — Disclosures

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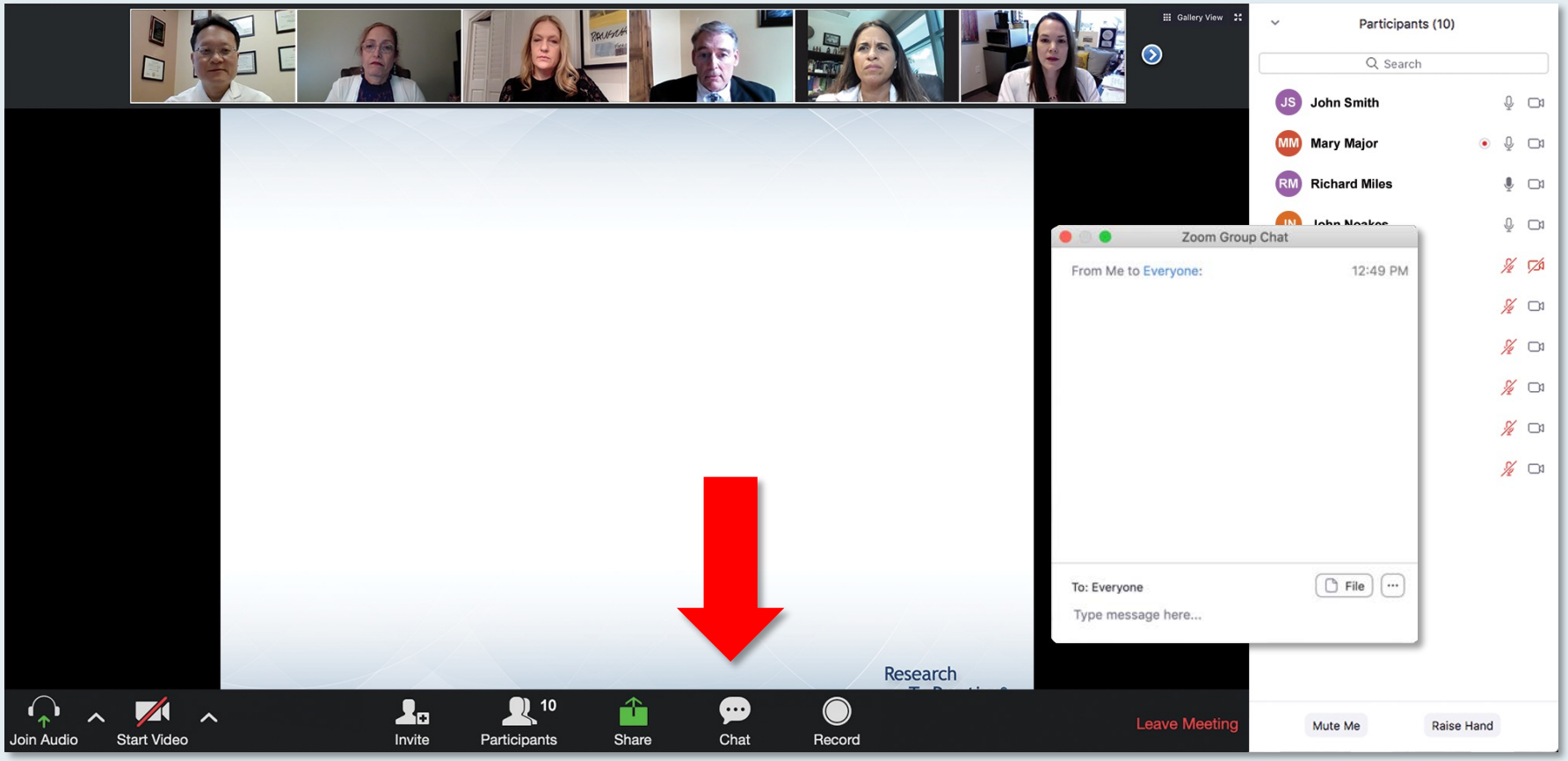
We Encourage Clinicians in Practice to Submit Questions



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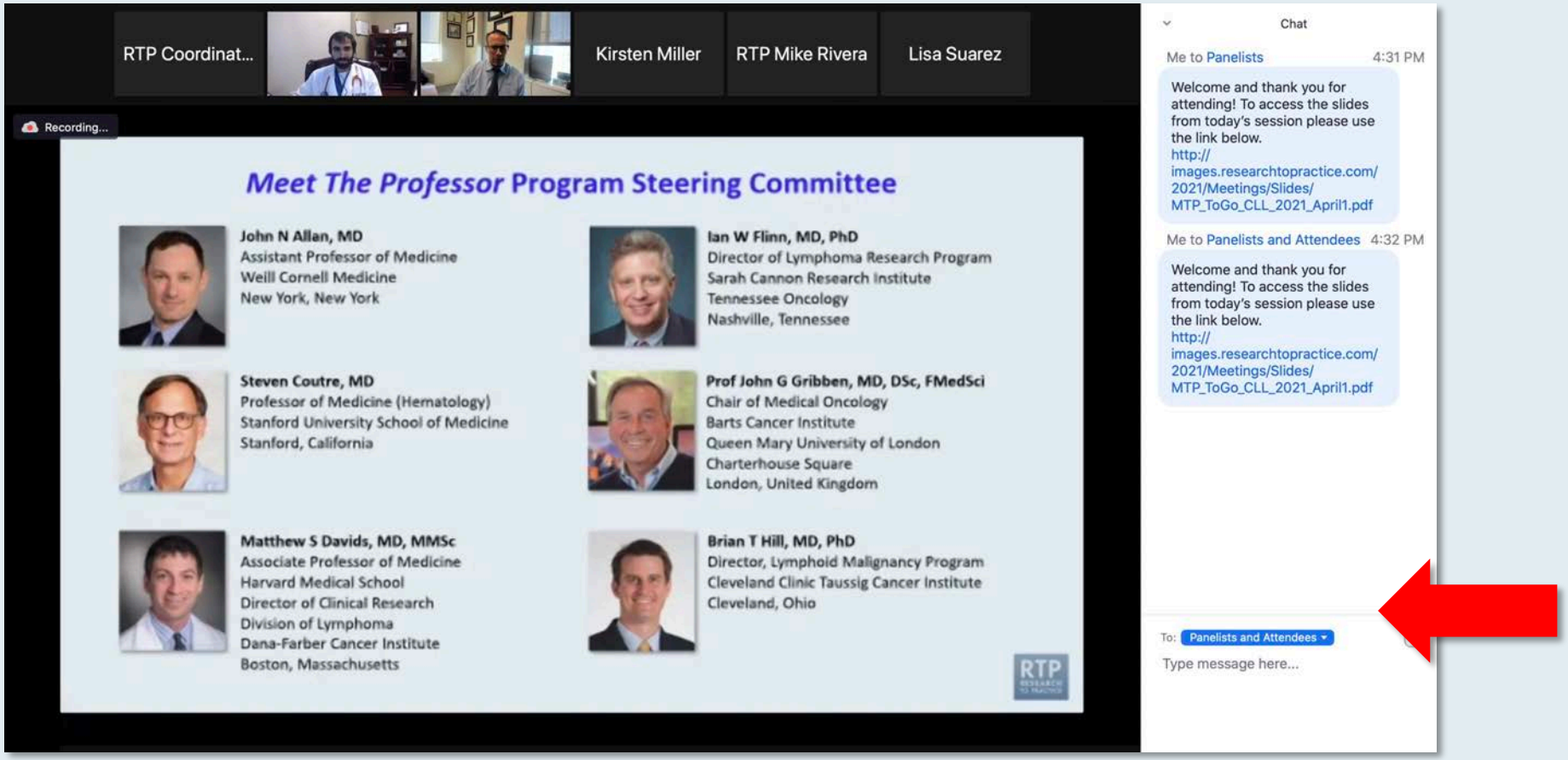

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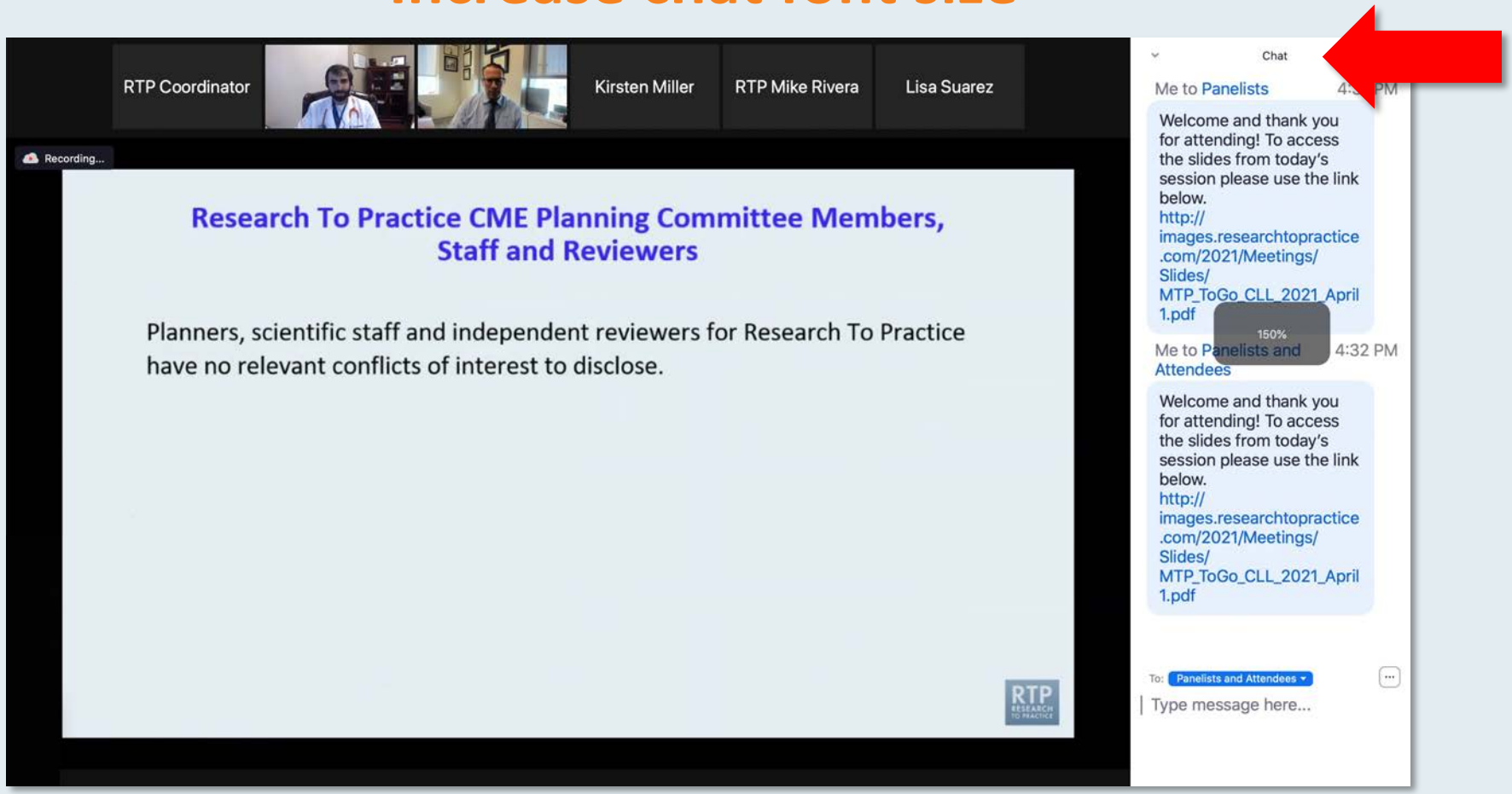

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WITH DR NEIL LOVE

Key Presentations on Lung Cancer from the 2021 ASCO Annual Meeting

DR JOEL NEAL
STANFORD UNIVERSITY

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Meet The Professor

Management of BRAF-Mutant Melanoma

Monday, November 29, 2021
5:00 PM – 6:00 PM ET

Faculty
Jason J Luke, MD

Moderator
Neil Love, MD

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Meet The Professor

Optimizing the Management of Metastatic Castration-Resistant Prostate Cancer

Tuesday, November 30, 2021
5:00 PM – 6:00 PM ET

Faculty

A Oliver Sartor, MD

Moderator

Neil Love, MD

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Meet The Professor

Optimizing the Management of Acute Myeloid Leukemia

Wednesday, December 1, 2021
5:00 PM – 6:00 PM ET

Faculty

Andrew H Wei, MBBS, PhD

Moderator

Neil Love, MD

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Meet The Professor

Optimizing the Selection and Sequencing of Therapy for Patients with HER2-Positive Breast Cancer

Thursday, December 2, 2021
5:00 PM – 6:00 PM ET

Faculty

Hope S Rugo, MD

Moderator

Neil Love, MD

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What Clinicians Want to Know: Addressing Current Questions and Controversies in the Management of ER-Positive Breast Cancer

Tuesday, December 7, 2021
8:00 PM – 9:45 PM ET

Faculty

Aditya Bardia, MD, MPH
Joyce O'Shaughnessy, MD
Kevin Kalinsky, MD, MS

Moderator

Erika Hamilton, MD

RTP RESEARCH TO PRACTICE

What Clinicians Want to Know: Addressing Current Questions and Controversies in the Management of HER2-Positive Breast Cancer

Wednesday, December 8, 2021
8:00 PM – 10:00 PM ET

Faculty

Carey K Anders, MD
Virginia F Borges, MD, MMSc
Sara Hurvitz, MD
Ian E Krop, MD, PhD

Moderator

Lisa Carey, MD

RTP RESEARCH TO PRACTICE

What Clinicians Want to Know: Addressing Current Questions and Controversies in the Management of Triple-Negative Breast Cancer

Thursday, December 9, 2021
8:00 PM – 9:45 PM ET

Faculty

Rita Nanda, MD
Melinda Telli, MD
Peter Schmid, FRCP, MD, PhD

Moderator

Hope S Rugo, MD

RTP RESEARCH TO PRACTICE

What Clinicians Want to Know: Addressing Current Questions and Controversies in the Management of Chronic Lymphocytic Leukemia

Friday, December 10, 2021
7:30 AM – 9:30 AM ET

Faculty

Nitin Jain, MD
Anthony R Mato, MD, MSCE
John M Pagel, MD, PhD
Jennifer Woyach, MD

Moderator

John N Allan, MD

RTP RESEARCH TO PRACTICE

What Clinicians Want to Know: Addressing Current Questions and Controversies in the Management of Hodgkin and Non-Hodgkin Lymphoma

Friday, December 10, 2021
11:30 AM – 1:30 PM ET

Faculty

Jeremy Abramson, MD
Martin Dreyling, MD, PhD
Loretta J Nastoupil, MD
Gilles Salles, MD, PhD

Moderator

Ann S LaCasce, MD, MMSc

RTP RESEARCH TO PRACTICE

What Clinicians Want to Know: Addressing Current Questions and Controversies in the Management of Multiple Myeloma

Friday, December 10, 2021
3:15 PM – 5:15 PM ET

Faculty

Larry D Anderson Jr, MD, PhD
Morie A Gertz, MD, MACP
Irene M Ghobrial, MD
Peter Voorhees, MD

Moderator

Robert Z Orlowski, MD, PhD

RTP RESEARCH TO PRACTICE

What Clinicians Want to Know: Addressing Current Questions and Controversies in the Management of Acute Myeloid Leukemia and Myelodysplastic Syndromes

Friday, December 10, 2021
7:00 PM – 9:00 PM ET

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Alice S Mims, MD, MSCR
Alexander Perl, MD
Richard M Stone, MD
Geoffrey L Uy, MD

Moderator

Harry Paul Erba, MD, PhD

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Thank you for joining us!

CME and MOC credit information will be emailed to each participant within 5 business days.

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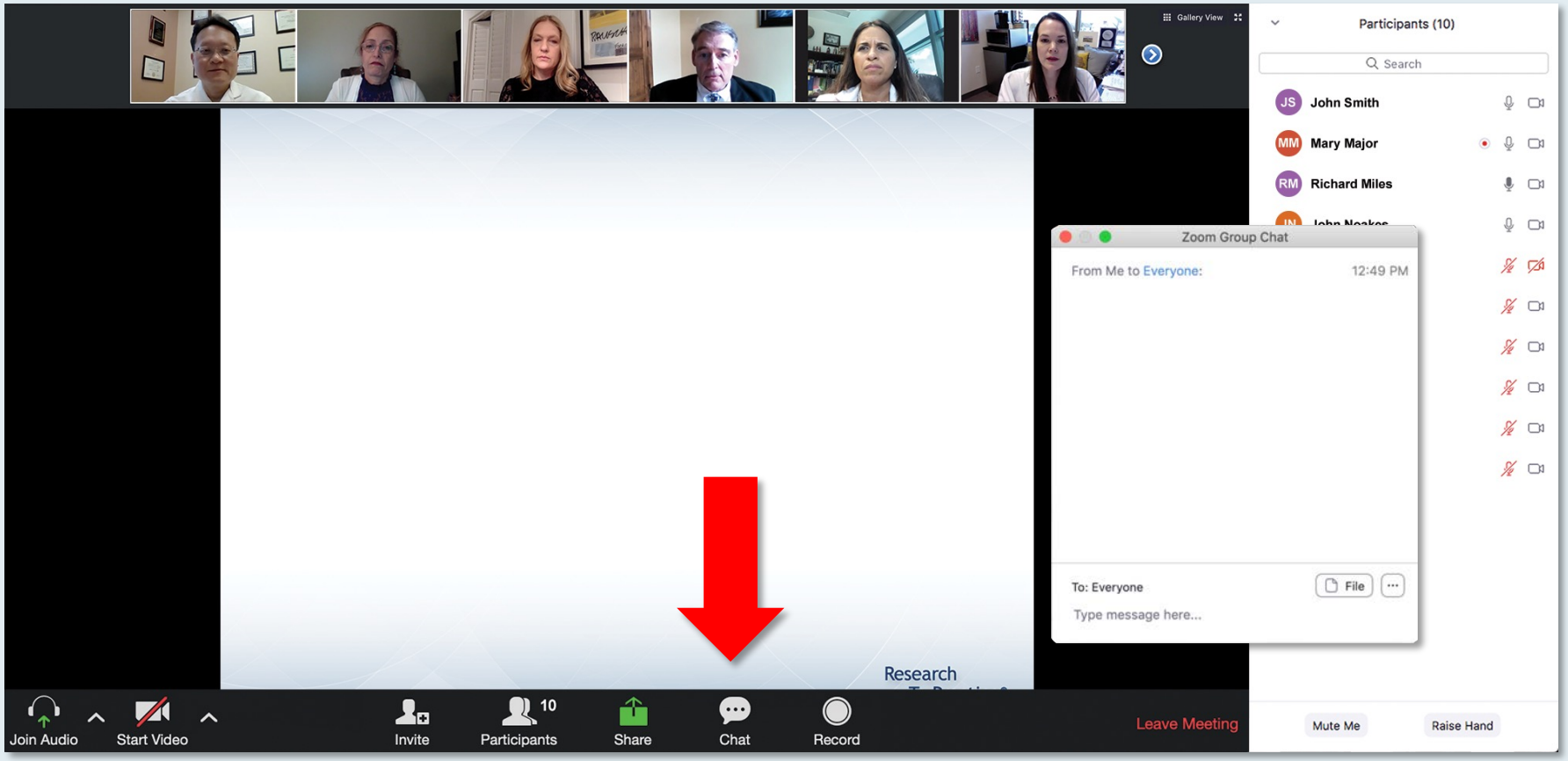

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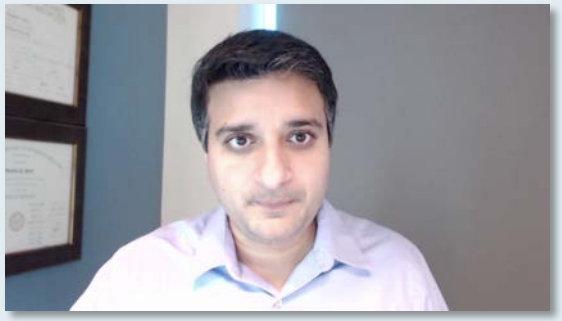
University of California, San Francisco
San Francisco, California



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Meet The Professor with Dr Liu

MODULE 1: Adjuvant and Neoadjuvant Immunotherapy in Non-Small Cell Lung Cancer (NSCLC)

MODULE 2: Case Presentations

- Dr Patel: A 57-year-old man with metastatic NSCLC and no actionable mutations
- Dr Shameem: A 66-year-old woman with newly diagnosed adenocarcinoma of the lung — PD-L1 65%
- Dr Kumar: A 70-year-old man with localized NSCLC and no actionable mutations — PD-L1 90%
- Dr Gupta: A 60-year-old woman with extensive-stage small cell lung cancer
- Dr Gubens: A 72-year-old woman with Stage IIIB adenocarcinoma of the lung and an EGFR L858R tumor mutation — PD-L1 40%
- Dr Kumar: A 75-year-old man with newly diagnosed metastatic NSCLC — MET amplification, PD-L1 90%

MODULE 3: Thoughts for the Future

MODULE 4: Journal Club with Dr Liu

MODULE 5: Appendix – Key Data Sets

Meet The Professor with Dr Liu

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Recent Advances in Adjuvant Systemic Treatment of Solid Tumors

Disease	Agent or regimen			
NSCLC	Atezolizumab (10-15-21)	Osimertinib (12-18-20)	Durvalumab (2-16-18)	Nivolumab/Chemo*
Breast	Abemaciclib (10-13-21)	Olaparib	Pembrolizumab (7-26-21)	T-DM1 (5-3-19)
Upper GI	Nivolumab (5-20-21)			
RCC	Pembrolizumab (11-17-21)			
Bladder	Nivolumab (8-19-21)	Pembrolizumab (1-8-2020)		
Ovarian	Olaparib (12-19-18)	Niraparib (4-29-20)	Olaparib/Bevacizumab (5-8-20)	
Melanoma	Nivolumab (12-20-17)	Pembrolizumab (2-15-19)	Dabrafenib/Trametinib (4-30-18)	
Prostate	Abiraterone (+LHRH)			

*Neoadjuvant therapy

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FDA Approves Atezolizumab as Adjuvant Treatment for NSCLC

Press Release: October 15, 2021

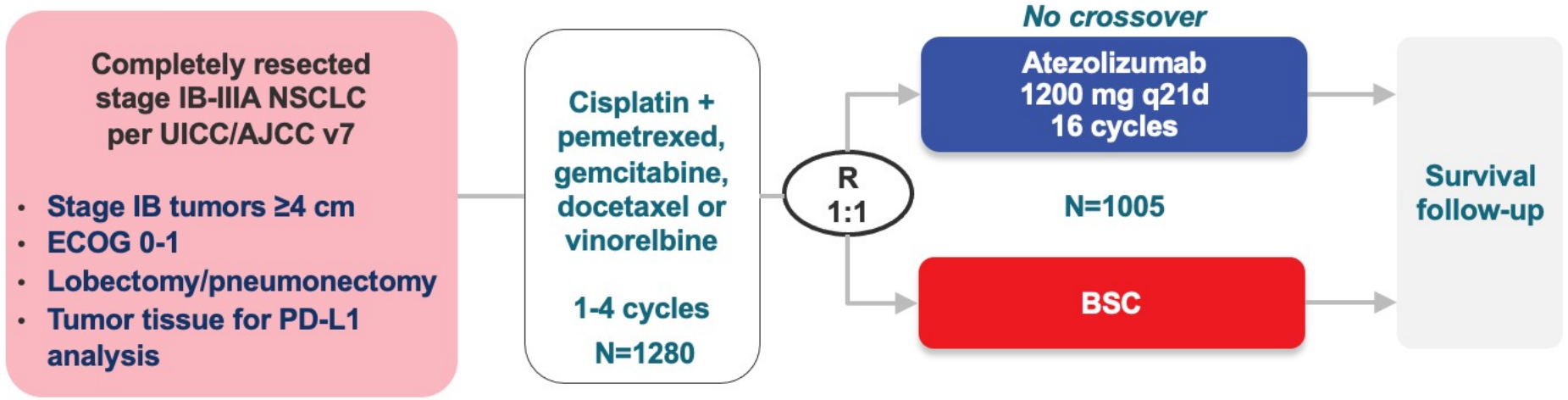
"The Food and Drug Administration approved atezolizumab for adjuvant treatment following resection and platinum-based chemotherapy in patients with stage II to IIIA non-small cell lung cancer (NSCLC) whose tumors have PD-L1 expression on ≥ 1% of tumor cells, as determined by an FDA-approved test.

Today, the FDA also approved the VENTANA PD-L1 (SP263) Assay (Ventana Medical Systems, Inc.) as a companion diagnostic device to select patients with NSCLC for adjuvant treatment with atezolizumab.

The major efficacy outcome measure was disease-free survival (DFS) as assessed by the investigator in the primary efficacy analysis population (n=476) of patients with stage II-IIIA NSCLC with PD-L1 expression on ≥1% of tumor cells (PD-L1 ≥1% TC). Median DFS was not reached (95% CI: 36.1, NE) in patients on the atezolizumab arm compared with 35.3 months (95% CI: 29.0, NE) on the BSC arm (HR 0.66; 95% CI: 0.50, 0.88; p=0.004)."

https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-atezolizumab-adjuvant-treatment-non-small-cell-lung-cancer

IMpower010: Phase III Trial of Adjuvant Atezolizumab After Chemotherapy in Resected Stage IB-IIIA NSCLC



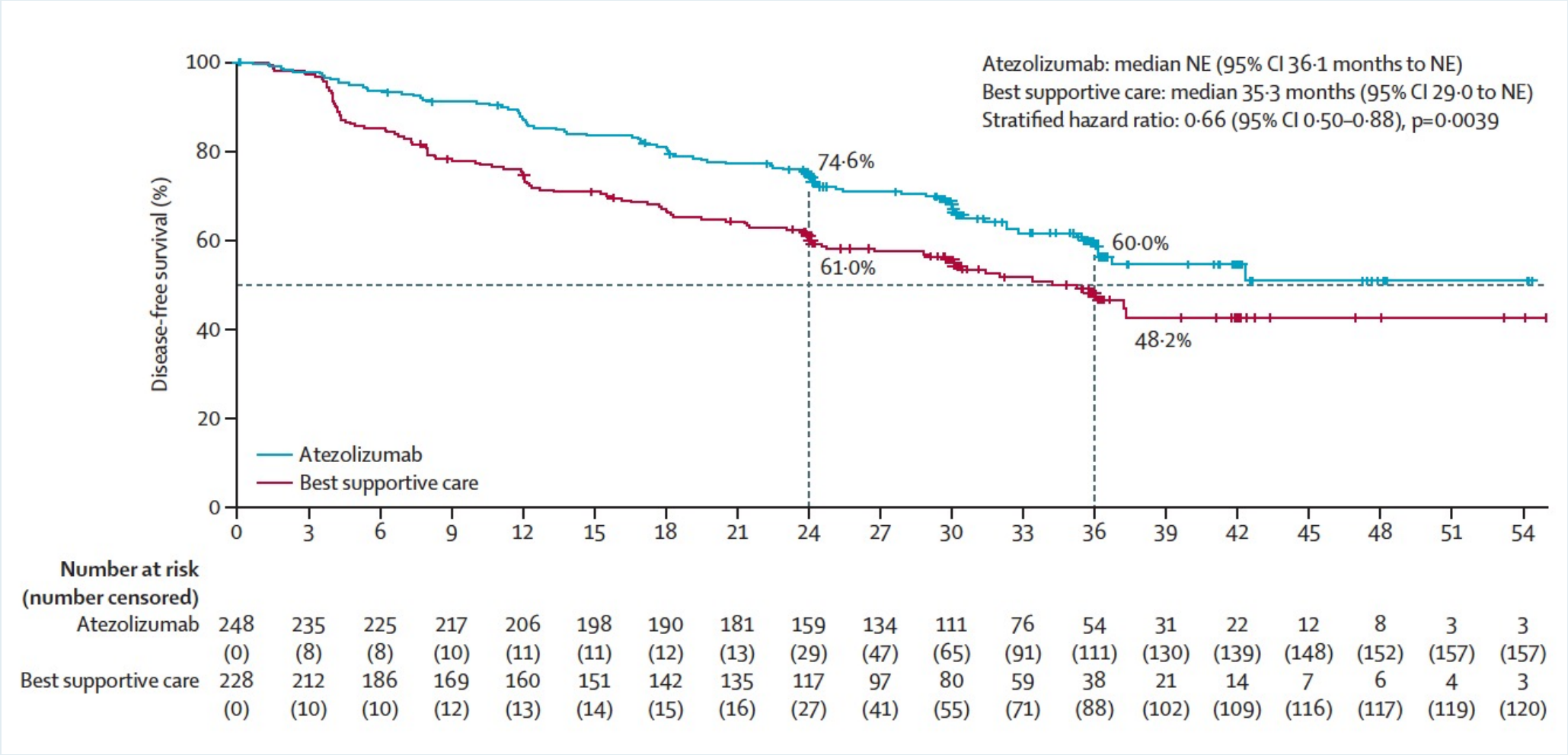
Stratification factors
- Male/female
- Stage (IB vs II vs IIIA)
- Histology
- PD-L1 tumor expression status[a]: TC2/3 and any IC vs TC0/1 and IC2/3 vs TC0/1 and IC0/1

Primary endpoints
- Investigator-assessed DFS tested hierarchically:
  - **PD-L1 TC ≥1% (per SP263) stage II-IIIA population**
  - **All-randomized stage II-IIIA population**
  - **ITT population (stage IB-IIIA)**

Key secondary endpoints
- OS in ITT population
- DFS in PD-L1 TC ≥50% (per SP263) stage II-IIIA population
- 3-y and 5-y DFS in all 3 populations

Wakelee HA et al. ASCO 2021;Abstract 8500.

IMpower010: Disease-Free Survival (DFS) in the PD-L1 TC ≥1% Stage II-IIIA Population (Primary Endpoint)



Felip E et al. *Lancet* 2021;398(10308):1344-57.

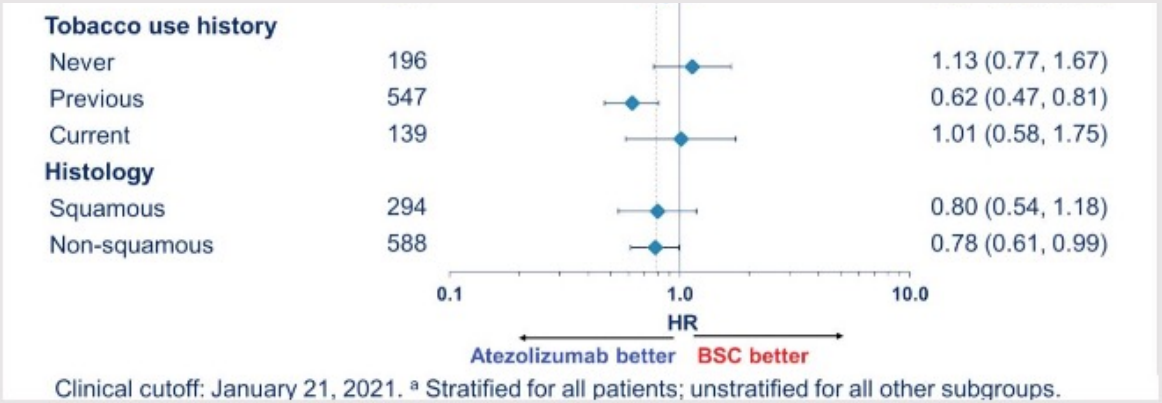
IMpower010: Efficacy Summary

Clinical Endpoint	Atezolizumab	BSC	HR (p-value)
PD-L1 TC ≥ 1%, Stage II-IIIA (n = 248;228)			
Median DFS	Not estimable	35.3 mo	0.66 (0.0039)
2-year DFS rate	75%	61%	-
3-year DFS rate	60%	48%	-
All randomized Stage II-IIIA (n = 442;440)			
Median DFS	42.3 mo	35.3 mo	0.79 (0.020)
2-year DFS rate	70%	62%	-
3-year DFS rate	56%	50%	-
ITT population (n = 507;598)			
Median DFS	Not estimable	37 mo	0.81 (0.040)
2-year DFS rate	71%	64%	-
3-year DFS rate	58%	53%	-

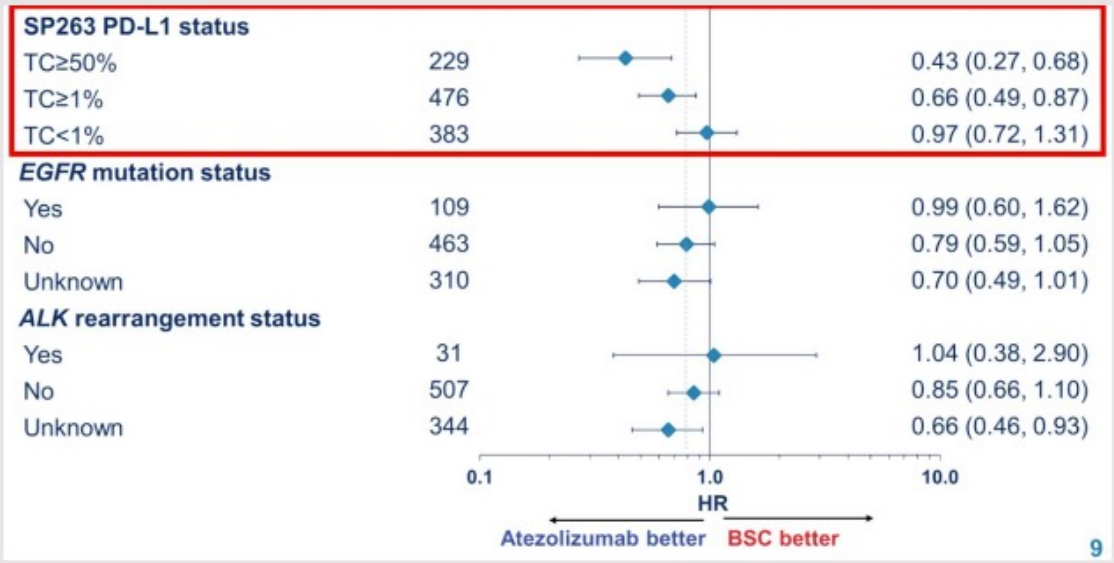
Overall survival data in the ITT population were immature and not formally tested.

Felip E et al. *Lancet* 2021;398(10308):1344-57.

IMpower010: DFS in NSCLC ≥5cm (7th ed. St II-III) Key Subsets



Clinical cutoff: January 21, 2021. [a] Stratified for all patients; unstratified for all other subgroups.



No obvious benefit in:

- Never smokers
- PD-L1 negative
- EGFR/ALK+

Adapted from Wakelee H et al. ASCO 2021;Abstract 8500

Chaft JE. IASLC 2021;Abstract PL05.04

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IMpower010: Safety Summary

	Atezolizumab group (n=495)	Best supportive care group (n=495)
Adverse event		
Any grade	459 (93%)	350 (71%)
Grade 3–4	108 (22%)	57 (12%)
Serious	87 (18%)	42 (8%)
Grade 5	8 (2%)*	3 (1%)†
Led to dose interruption of atezolizumab	142 (29%)	..
Led to atezolizumab discontinuation	90 (18%)	..
Immune-mediated adverse events		
Any grade	256 (52%)	47 (9%)
Grade 3–4	39 (8%)	3 (1%)
Required the use of systemic corticosteroids‡	60 (12%)	4 (1%)
Led to discontinuation	52 (11%)	0

Data are n (%). *Interstitial lung disease, multiple organ dysfunction syndrome, myocarditis, and acute myeloid leukaemia (all four events related to atezolizumab), and pneumothorax, cerebrovascular accident, arrhythmia, and acute cardiac failure. †Pneumonia; pulmonary embolism; and cardiac tamponade and septic shock in the same patient. ‡Atezolizumab-related.

Felip E et al. *Lancet* 2021;398(10308):1344-57.

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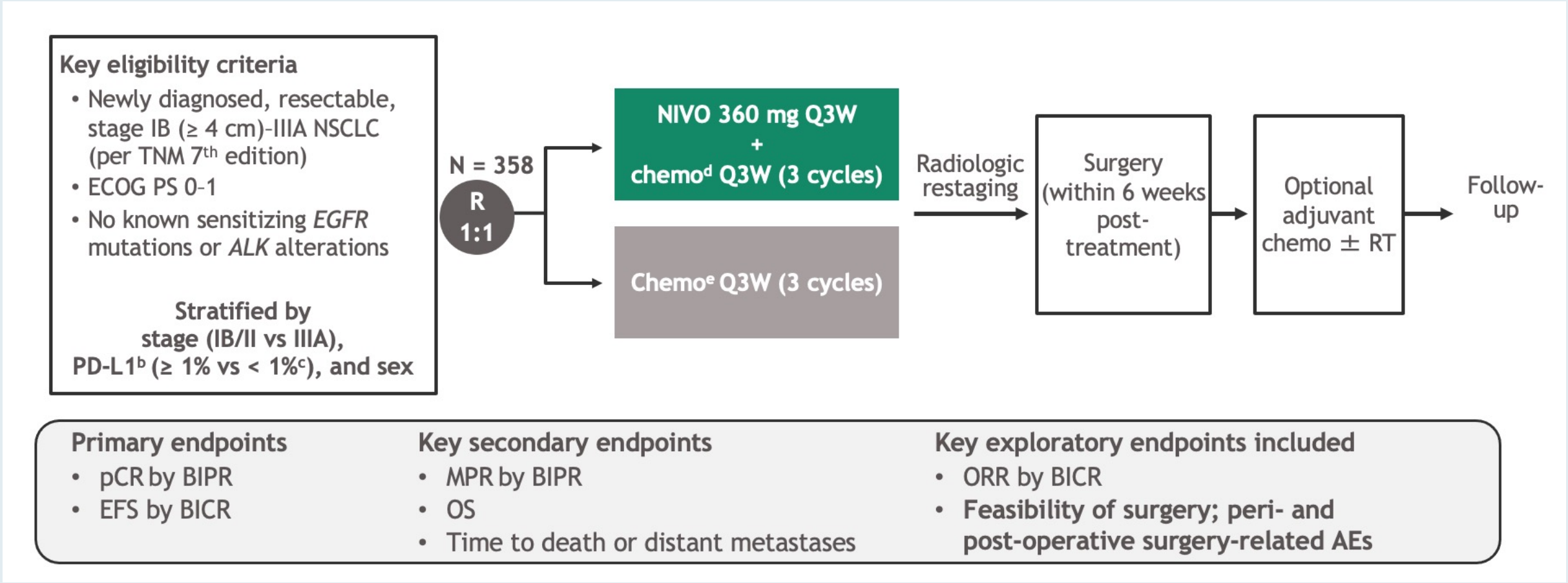
CheckMate 816 Met a Primary Endpoint of Improved Event-Free Survival with Neoadjuvant Nivolumab in Combination with Chemotherapy

Press Release — November 8, 2021

"The Phase 3 CheckMate-816 trial met the primary endpoint of improved event-free survival (EFS) in patients with resectable stage IB to IIIA non-small cell lung cancer (NSCLC). In a prespecified interim analysis, nivolumab plus chemotherapy showed a statistically significant and clinically meaningful improvement in EFS compared to chemotherapy alone when given before surgery. This combination previously showed a significant improvement of pathologic complete response (pCR), the trial's other primary endpoint. The safety profile of nivolumab plus chemotherapy was consistent with previously reported studies in NSCLC. CheckMate-816 is the first Phase 3 trial with an immunotherapy-based combination to demonstrate a statistically significant and clinically meaningful benefit as a neoadjuvant treatment for patients with non-metastatic non-small cell lung cancer."

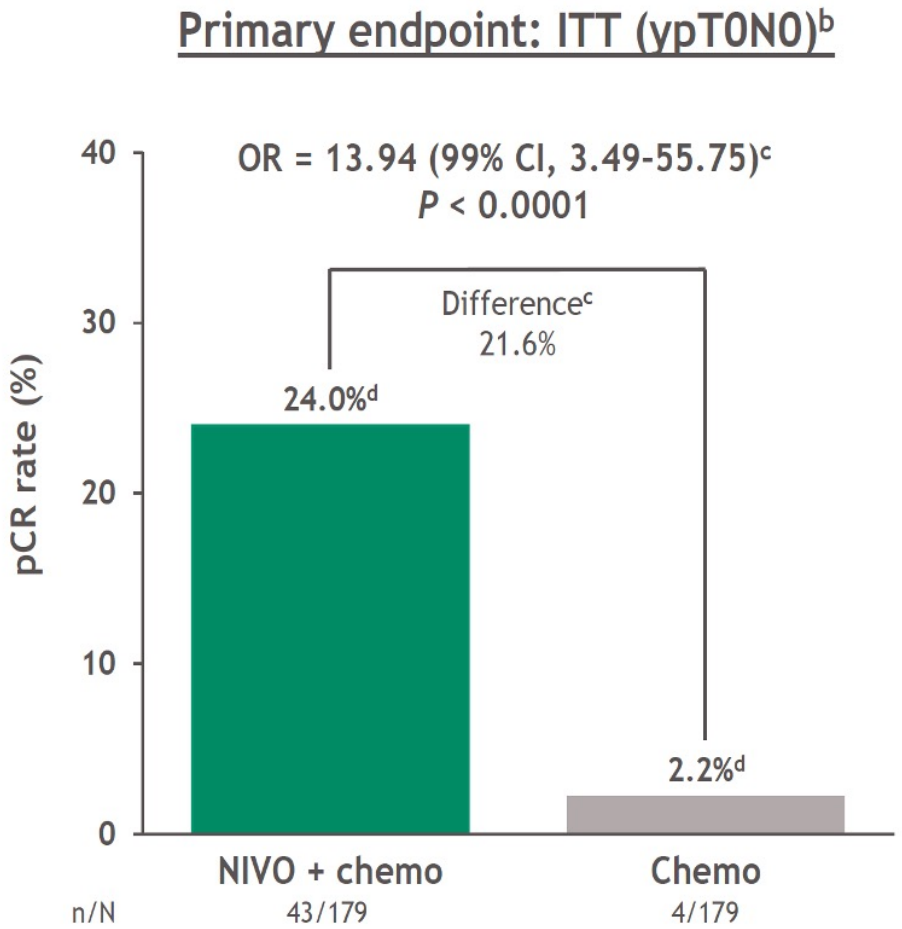
https://news.bms.com/news/details/2021/Neoadjuvant-Opdivo-nivolumab-Plus-Chemotherapy-Significantly-Improves-Event-Free-Survival-in-Patients-with-Resectable-Non-Small-Cell-Lung-Cancer-in-Phase-3-CheckMate--816-Trial/default.aspx

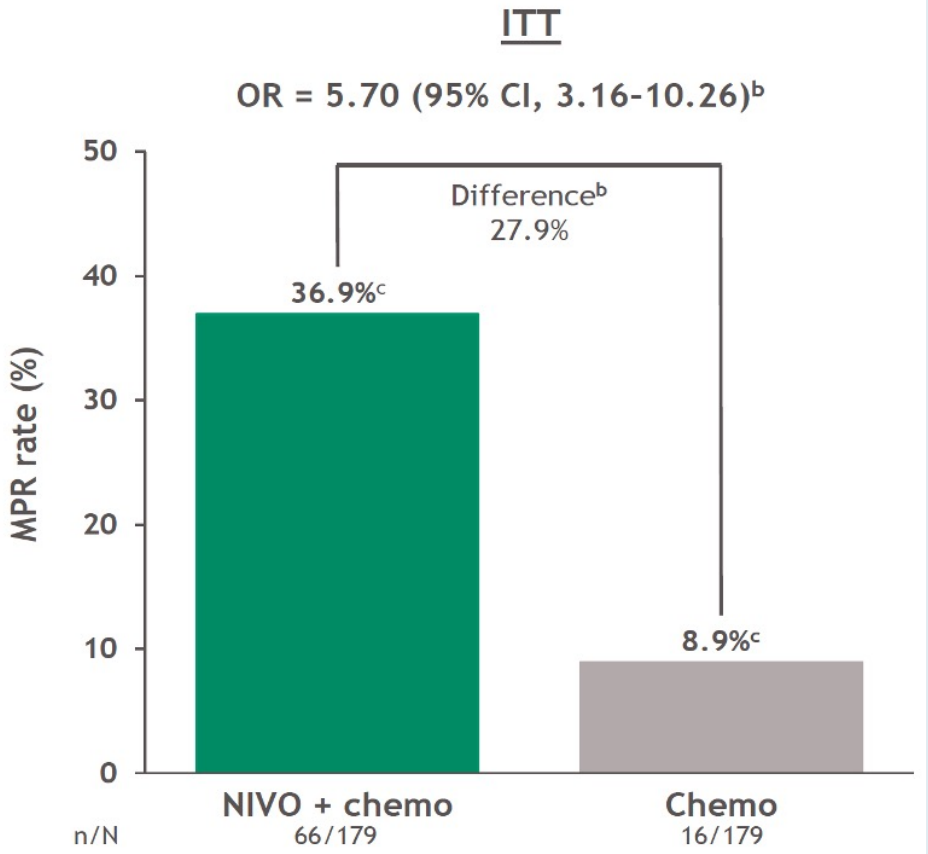
CheckMate 816: Phase III Trial of Neoadjuvant Nivolumab with Chemotherapy for Newly Diagnosed, Resectable, Stage IB-IIIA NSCLC



Spicer J et al. ASCO 2021;Abstract 8503.

CheckMate 816: Coprimary Endpoint pCR





• pCR rate in the exploratory NIVO + IPI arm (ITT) was 20.4% (95% CI, 13.4-29.0)

Forde PM et al. AACR 2021;Abstract CT003.

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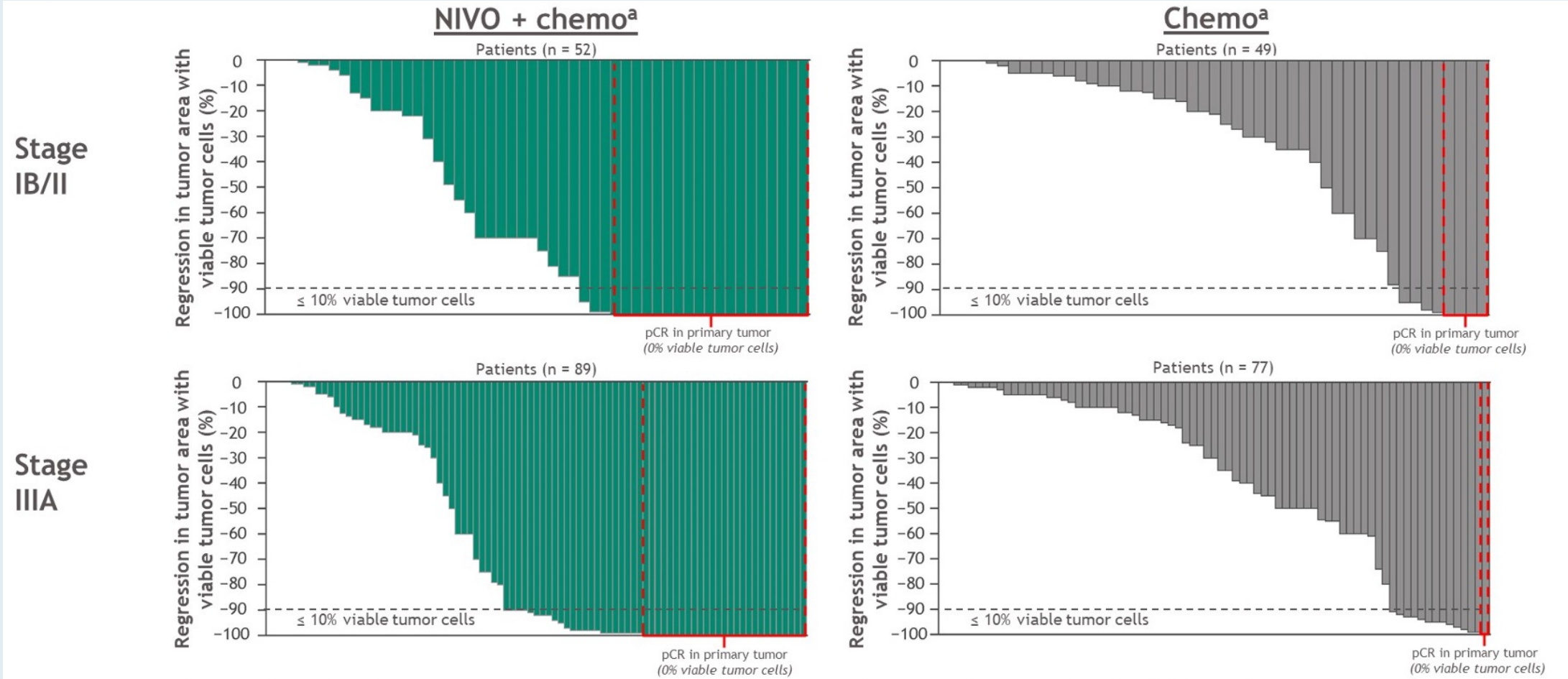
CheckMate 816: Depth of Pathological Regression in Primary Tumor by Stage



- The median residual viable tumor percentage in stage IB/II and IIIA was 28% and 8% with NIVO + chemo vs 79% and 70% with chemo, respectively

[a]Response-evaluable patients.

Spicer J et al. ASCO 2021;Abstract 8503.

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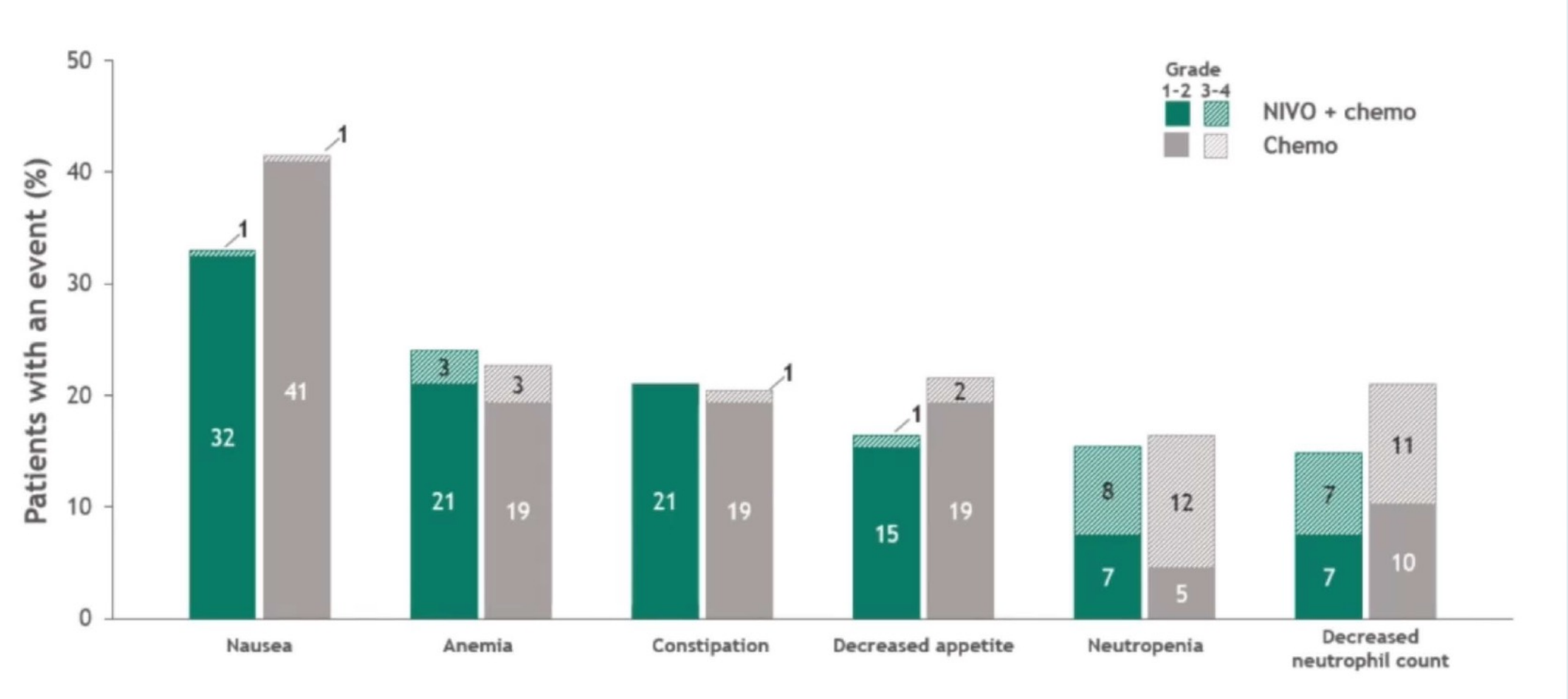
CheckMate 816: Treatment-Related Adverse Events in ≥15% of Patients



Forde PM et al. AACR 2021;Abstract CT003.

RTP RESEARCH TO PRACTICE

In general, what would you estimate to be the 5-year risk of disease recurrence for an otherwise healthy 65-year-old patient with NSCLC and PD-L1 TPS = 50% in each of the following scenarios:

Disease stage	No adjuvant treatment	Adjuvant chemotherapy	Adjuvant chemotherapy + anti-PD-1/PD-L1 antibody	Treatment
IB	25%	25%	20%	None
IIA	35%	30%	20%	Cisplatin/pemetrexed → atezolizumab
IIB	50%	45%	20%	Cisplatin/pemetrexed → atezolizumab
IIIA	60%	55%	30%	Cisplatin/pemetrexed → atezolizumab

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How long have you been in oncology practice (after fellowship)?

1. Less than 5 years
2. 5-10 years
3. 11-20 years
4. 21-30 years
5. 31-40 years
6. 41-50 years
7. More than 50 years

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If you were a patient with Stage IB NSCLC with a PD-L1 TPS of 50% and cost were not an issue, what would be your preference?

1. Chemotherapy
2. Chemotherapy → atezolizumab
3. Atezolizumab
4. No systemic treatment
5. Other

RTP RESEARCH TO PRACTICE

If you were a patient in this situation with a PD-L1 TPS of 50% and cost were not an issue, what would be your preference?

1. Chemotherapy
2. Chemotherapy → atezolizumab
3. Atezolizumab
4. No systemic treatment
5. Other

In what situations, if any, are you currently recommending neoadjuvant chemotherapy (with or without an anti-PD-1/PD-L1 antibody) for your patients with non-small cell lung cancer (NSCLC)?

"Resectable N2+ NSCLC"

Based on available data and your clinical experience, does neoadjuvant immunotherapy (alone or with chemotherapy) increase the risk of surgical complications in patients with NSCLC?

1. Yes
2. ***No***
3. I'm not sure
4. It is too early to tell

Faculty Survey November 2021

RTP RESEARCH TO PRACTICE

Meet The Professor with Dr Liu

MODULE 1: Adjuvant and Neoadjuvant Immunotherapy in Non-Small Cell Lung Cancer (NSCLC)

MODULE 2: Case Presentations

- Dr Patel: A 57-year-old man with metastatic NSCLC and no actionable mutations
- Dr Shameem: A 66-year-old woman with newly diagnosed adenocarcinoma of the lung — PD-L1 65%
- Dr Kumar: A 70-year-old man with localized NSCLC and no actionable mutations — PD-L1 90%
- Dr Gupta: A 60-year-old woman with extensive-stage small cell lung cancer
- Dr Gubens: A 72-year-old woman with Stage IIIB adenocarcinoma of the lung and an EGFR L858R tumor mutation — PD-L1 40%
- Dr Kumar: A 75-year-old man with newly diagnosed metastatic NSCLC — MET amplification, PD-L1 90%

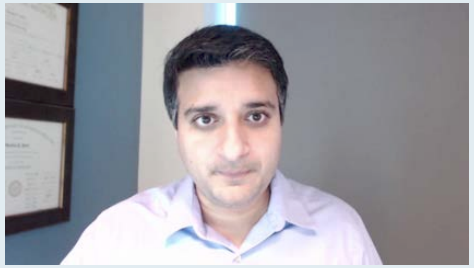
MODULE 3: Thoughts for the Future

MODULE 4: Journal Club with Dr Liu

MODULE 5: Appendix – Key Data Sets

RTP RESEARCH TO PRACTICE

Case Presentation – Dr Patel: A 57-year-old man with metastatic NSCLC and no actionable mutations



Dr Sandip Patel

- Diagnosed with metastatic NSCLC
- On baseline O^2 due to COPD
- Chemoimmunotherapy initiated with decrease in oxygen requirement and improvement in lean muscle mass within 6 weeks
- CT: Nearly 50% increase in size of multiple mediastinal lymph nodes in the chest
- Therapy continued with patient monitoring for 6 to 8 weeks
- Follow-up CT: 50% decrease of multiple mediastinal lymph nodes

Which first-line treatment regimen would you recommend for a 65-year-old patient with metastatic nonsquamous lung cancer, no identified targetable mutations and a PD-L1 TPS of 0%?

1. Chemotherapy
2. Chemotherapy + bevacizumab
3. Pembrolizumab
4. Atezolizumab
5. Cemiplimab
6. ***Carboplatin/pemetrexed/pembrolizumab***
7. Atezolizumab/carboplatin/*nab* paclitaxel
8. Atezolizumab/carboplatin/paclitaxel/bevacizumab
9. Ipilimumab/nivolumab
10. Ipilimumab/nivolumab + chemotherapy
11. Other

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Which first-line treatment regimen would you recommend for a 65-year-old patient with metastatic squamous lung cancer, no identified targetable mutations and a PD-L1 TPS of 0%?

1. Chemotherapy
2. Pembrolizumab
3. Atezolizumab
4. Cemiplimab
5. Carboplatin/paclitaxel/pembrolizumab
6. Carboplatin/*nab* paclitaxel/pembrolizumab
7. Ipilimumab/nivolumab
8. ***Ipilimumab/nivolumab + chemotherapy***
9. Other

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RTP RESEARCH TO PRACTICE

Which first-line treatment regimen would you recommend for a 65-year-old patient with metastatic squamous lung cancer, no identified targetable mutations and a PD-L1 TPS of 10%?

1. Chemotherapy
2. Pembrolizumab
3. Atezolizumab
4. Cemiplimab
5. Carboplatin/paclitaxel/pembrolizumab
6. Carboplatin/*nab* paclitaxel/pembrolizumab
7. Ipilimumab/nivolumab
8. ***Ipilimumab/nivolumab + chemotherapy***
9. Other

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Case Presentation – Dr Shameem: A 66-year-old woman with newly diagnosed adenocarcinoma of the lung – PD-L1 65%

Dr Raji Shameem

- Never smoker presents with progressive shortness of breath
- Chest CT: Right hilar lung mass extending into the mediastinal subcarinal space, large right pleural effusion
- CT guided biopsy: Adenocarcinoma, PD-L1 65%
- Carboplatin/pemetrexed/pembrolizumab with pembrolizumab held after cycle 1
- Liquid and tumor tissue NGS testing ordered
  - ***Liquid NGS: NTRK mutation***
  - ***Tumor tissue: Notable for PD-L1 65%, NTRK fusion reported to be negative***
- ***Chemotherapy plus pembrolizumab continued, patient faring well***

Questions

- *Which NTRK inhibitor would the faculty typically use, entrectinib or larotrectinib? Do any data indicate that one would have better CNS activity?*

Case Presentation – Dr Shameem: A 66-year-old woman with newly diagnosed adenocarcinoma of the lung – PD-L1 65% (continued)

Dr Raji Shameem

Liquid NGS results

BIOMARKER FINDINGS	THERAPIES WITH CLINICAL BENEFIT (IN PATIENT'S TUMOR TYPE)	THERAPIES WITH CLINICAL BENEFIT (IN OTHER TUMOR TYPE)
Blood Tumor Mutational Burden - 13 Muts/Mb	Atezolizumab 1 Cemiplimab 1 Durvalumab 1 Nivolumab 1 Pembrolizumab 1	Avelumab
10 Trials see p. 18		
Microsatellite status - MSI-High Not Detected	MSI-High not detected. No evidence of microsatellite instability in this sample (see Appendix section).	
Tumor Fraction - 47%	Tumor fraction is an estimate of the percentage of circulating-tumor DNA (ctDNA) present in a cell-free DNA (cfDNA) sample based on observed aneuploid instability.	

GENOMIC FINDINGS		VAF %	THERAPIES WITH CLINICAL BENEFIT (IN PATIENT'S TUMOR TYPE)	THERAPIES WITH CLINICAL BENEFIT (IN OTHER TUMOR TYPE)
NTRK3 -	NTRK3-KLHL20 rearrangement	0.86%	Entrectinib 2A Larotrectinib 2A	None
5 Trials see p. 20				

NCCN category

Case Presentation – Dr Shameem: A 66-year-old woman with newly diagnosed adenocarcinoma of the lung – PD-L1 65% (continued)

Dr Raji Shameem

Tumor tissue NGS results

THERAPY CONSIDERATIONS FOR NON-SMALL CELL LUNG CANCER

		Markers	Therapies in Non-Small Cell Lung Cancer	Therapies in Other Tumor Types
FDA (Level 1)		PD-L1 (IHC_22C3) 65% TPS	cemipilimab[1], pembrolizumab[2,3]	None
Guidelines (Level 2)		No markers associated with guideline-indicated therapy considerations for the tumor type tested or other tumor types were identified		
Trial Markers (Level 3)	Targeted	PIK3CA c.2702G>T (C901F) PTEN c.388C>G (R130G) TP53 c.817C>T (R273C)		
	Immuno	ADORA2A 60% CD137 76% CD39 79% IDO1 99% PD-L1 81%	TGFB1 79% TLR8 77%	

PERTINENT NEGATIVE RESULTS FOR NON-SMALL CELL LUNG CANCER

(Tested markers for FDA-approved or guideline-indicated therapies that were not positive)

Negative Results	Targeted	ALK fusion BRAF V600 EGFR exon 19 deletion EGFR exon 20 insertion EGFR mutation	HER2 (ERBB2) mutation KRAS mutation MET amp/exon 14 NTRK fusion RET fusion	ROS1 fusion
	Immuno	MSI Inconclusive TMB 8.6/Mb (Intermediate)		

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Case Presentation – Dr Kumar: A 70-year-old man with localized NSCLC and no actionable mutations – PD-L1 90%

Dr KS Kumar

- Clinically unresectable, received neoadjuvant cisplatin/pemetrexed with good response
- Underwent surgical resection
  - All nodes negative, residual tumor was 0.6 cm
- NGS: No actionable mutations, PD-L1 = 90%

Questions

- Would the faculty consider this patient to be a candidate for anti-PD-L1 therapy?
- If you had seen the patient initially, would you have considered neoadjuvant anti-PD-1/PD-L1 therapy?

Case Presentation – Dr Gupta: A 60-year-old woman with extensive-stage small cell lung cancer

Dr Ranju Gupta

- August 2020: Diagnosed with extensive stage small cell lung cancer, symptomatic with mediastinal adenopathy
- Cisplatin/etoposide/atezolizumab x 4 → atezolizumab maintenance

Questions

- What second-line treatment options are available for this patient when her disease progresses?
- Would there still be a role for prophylactic cranial radiation if the patient had stable disease for 6 months or more?

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In general, what would be your preferred first-line treatment regimen for a 65-year-old patient with extensive-stage small cell lung cancer (SCLC)?

1. Carboplatin/etoposide
2. Carboplatin/etoposide + trilaciclib
3. Cisplatin/etoposide
4. Cisplatin/etoposide + trilaciclib
5. ***Carboplatin/etoposide + atezolizumab***
6. Carboplatin/etoposide + atezolizumab + trilaciclib
7. Carboplatin/etoposide + durvalumab
8. Carboplatin/etoposide + durvalumab + trilaciclib
9. Cisplatin/etoposide + durvalumab
10. Cisplatin/etoposide + durvalumab + trilaciclib
11. Carboplatin/irinotecan
12. Cisplatin/irinotecan
13. Other

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In what situations if any, do you administer trilaciclib to patients with extensive-stage SCLC who are receiving platinum/etoposide- or topotecan-containing regimens to reduce the incidence of chemotherapy-induced myelosuppression?

"I have not used trilaciclib but might consider it if multi-lineage myelosuppression was noted with topotecan."

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The benefits and risks of adding durvalumab to platinum/etoposide and of adding atezolizumab to carboplatin/etoposide are very similar, and from a clinical point of view selecting between the 2 regimens as first-line treatment for a patient with extensive-stage SCLC can be considered a "coin flip."

1. Agree

2. Disagree

3. I'm not sure

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In general, what is your preferred second-line treatment for a patient with extensive-stage SCLC with metastases and disease progression on chemotherapy/atezolizumab?

1. Topotecan or irinotecan
2. ***Lurbinectedin***
3. Nivolumab/ipilimumab
4. Pembrolizumab
5. Nivolumab
6. Other

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RTP RESEARCH TO PRACTICE

Case Presentation – Dr Gubens: A 72-year-old woman with Stage IIIB adenocarcinoma of the lung and an EGFR L858R tumor mutation – PD-L1 40%

Dr Matt Gubens

- Never smoker presents with progressive cough
- RUL mass, 2.4-cm, with R hilar and mediastinal LAD
- CT guided biopsy: Adenocarcinoma, PD-L1 40%
- NGS: EGFR L858R mutation
- Definitive chemoradiation therapy, with good radiographic response

Question

- Would you consider consolidation durvalumab in this patient with an EGFR activating mutation?

Case Presentation – Dr Gubens: A 72-year-old woman with Stage IIIB adenocarcinoma of the lung and an EGFR L858R tumor mutation – PD-L1 40% (continued)

Dr Matt Gubens

- Never smoker presents with progressive cough
- RUL mass, 2.4-cm, with R hilar and mediastinal LAD
- CT guided biopsy: Adenocarcinoma, PD-L1 40%
- NGS: EGFR L858R mutation
- Definitive chemoradiation therapy, with good radiographic response
- ***Discussed PACIFIC data with consolidation durvalumab with patient's 2 physician daughters***
- ***Consolidation durvalumab x 6 months → Abnormal thyroid function tests (TSH: 20, T4: 11)***
  - ***Initiated levothyroxine 88 mcg and continued durvalumab***
  - ***One month later: Fasting glucose 317, A1C 7.3 → Immune-related insuline-dependent diabetes***
- ***Durvalumab discontinued, but 24 months later no evidence of recurrence***

What would you most likely recommend as consolidation treatment for a patient with locally advanced NSCLC who has completed chemoradiation therapy and is found to have an EGFR activating mutation?

1. Durvalumab
2. ***Osimertinib***
3. Durvalumab + osimertinib
4. Durvalumab followed by osimertinib
5. Other

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RTP RESEARCH TO PRACTICE

Case Presentation – Dr Kumar: A 75-year-old man with newly diagnosed metastatic NSCLC – MET amplification, PD-L1 90%

Dr KS Kumar

- Diagnosed with NSCLC with extensive mediastinal lymphadenopathy, TTF1-positive
- Quickly progressed with SVC syndrome
- Palliative radiation initiated with patient's condition improved
- MET amplification detected, PD-L1 90%

Questions

- Should this patient receive the available MET inhibitor given that he has a MET amplification and not a MET exon 14 skipping mutation?
- Should chemotherapy combined with an IO be his first-line therapy?

Meet The Professor with Dr Liu

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MODULE 3: Thoughts for the Future

MODULE 4: Journal Club with Dr Liu

MODULE 5: Appendix – Key Data Sets

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Thoughts for the Future

- **Choice of immunotherapy regimen**
  - Interval between dosing
- **Immunotherapy combinations**
  - Anti-PD-1/PD-L1 antibody/tyrosine kinase inhibitor
  - Immunotherapy/immunotherapy
  - Other investigational approaches

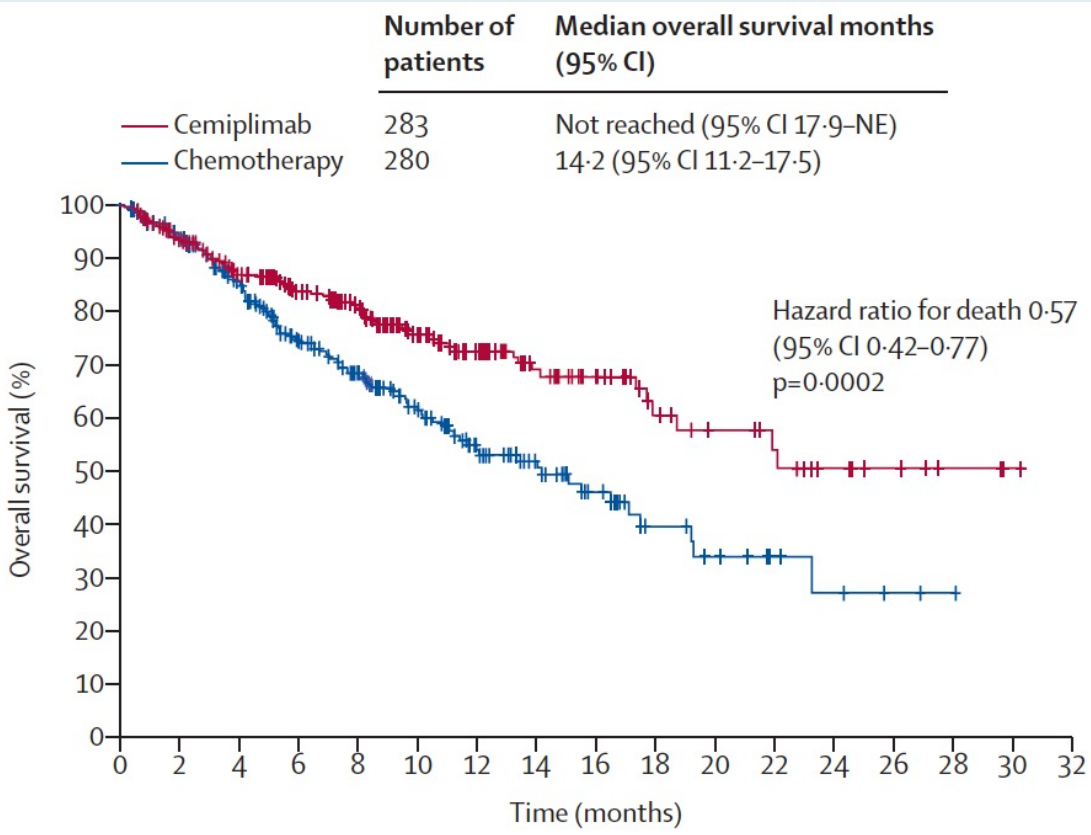
FDA-Approved Immunotherapy Monotherapy Options for First-Line Therapy

Monotherapy	FDA approval	Pivotal study	Histologic type	HR (OS)
Pembrolizumab[1,2] (q3wk or q6wk)	4/11/19 10/24/16	KEYNOTE-042 KEYNOTE-024	PD-L1 TPS ≥1%	0.63
Atezolizumab[3] (q2wk, q3wk or q4wk)	5/18/20	IMpower110	PD-L1 TPS ≥50, EGFR and/or ALK wt	0.59
Cemiplimab[4] (q3wk)	2/22/21	EMPOWER-Lung 1 (Study 1624)	PD-L1 TPS ≥50, EGFR and/or ALK and/or ROS1 wt	0.57

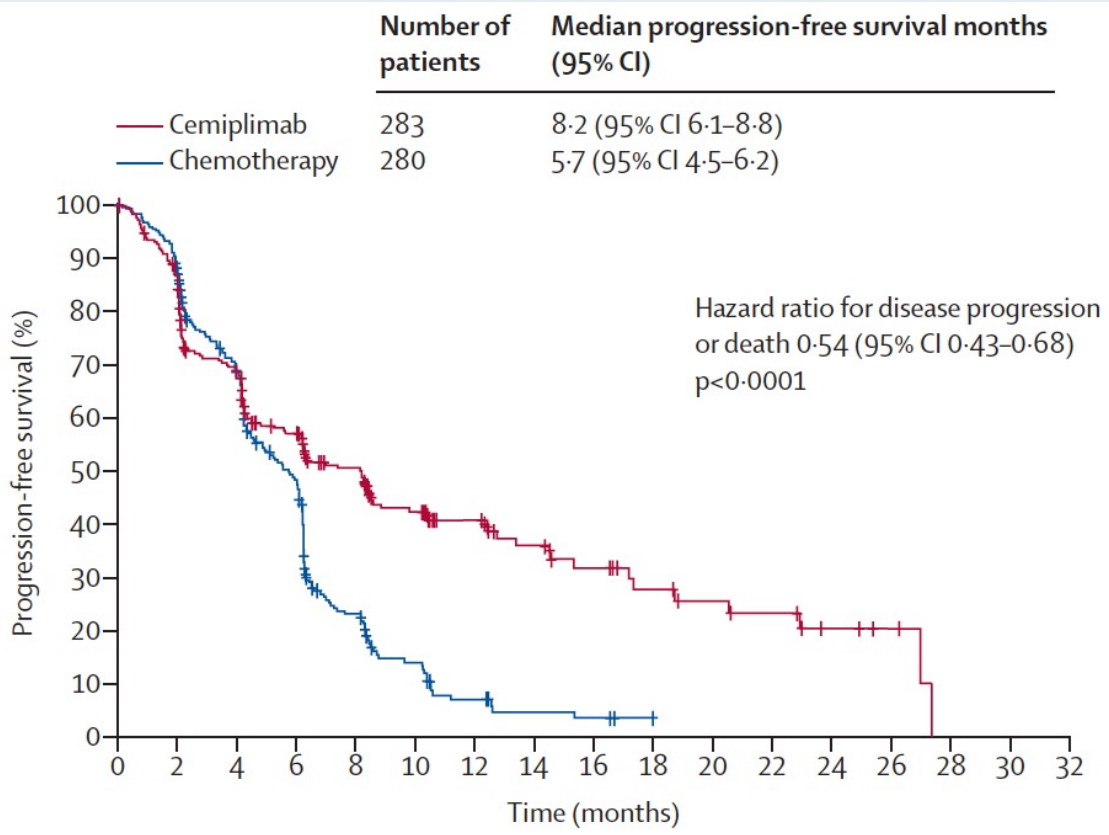
[1] Mok. *Lancet* 2019. [2] Reck. *J Clin Oncol* 2019. [3] Herbst. *N Engl J Med* 2020. [4] Sezer. *Lancet* 2021.

EMPOWER-Lung 1: Phase III Trial of Cemiplimab Monotherapy for First-Line Treatment of NSCLC with PD-L1 ≥50%

Overall Survival



Progression-Free Survival



Sezer A et al. *Lancet* 2021;397:592-604.

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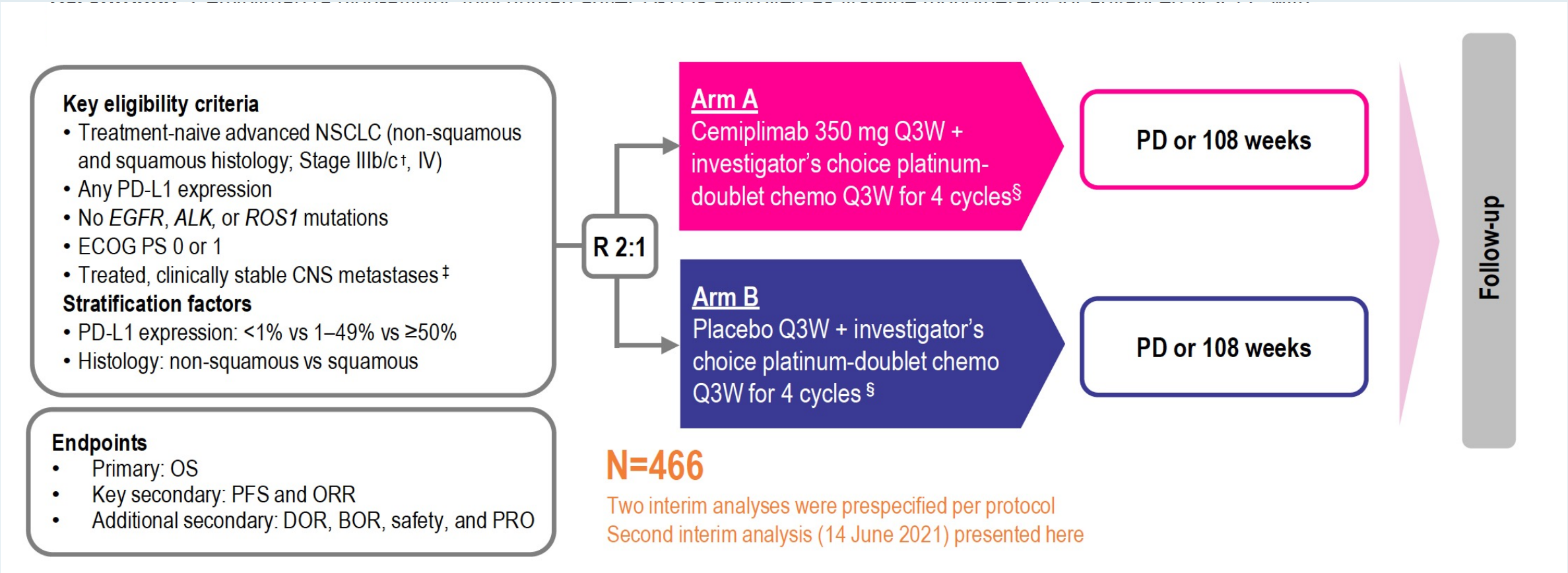
FDA-Approved Immunotherapy Combination Options for First-Line Therapy

Combination regimen	FDA approval	Pivotal study	Histologic type	HR (OS)
Pembrolizumab (q3wk or q6wk) + Platinum and pemetrexed[1]	8/20/18	KEYNOTE-189	Nonsquamous	0.56
Pembrolizumab (q3wk or q6wk) + Carboplatin, paclitaxel or *nab* paclitaxel[2]	10/30/18	KEYNOTE-407	Squamous	0.71
Atezolizumab (q3wk) + Carboplatin and paclitaxel and bevacizumab[3]	12/6/18	IMpower150	Nonsquamous	0.80
Atezolizumab (q3wk) + Carboplatin and *nab* paclitaxel[4]	12/3/19	IMpower130	Nonsquamous	0.79
Nivolumab (q2wk) + Ipilimumab[5]	5/15/20	CheckMate 227	PD-L1 TPS ≥1, EGFR and/or ALK wt	0.76
Nivolumab (q3wk) + Ipilimumab and chemotherapy[6]	5/26/20	CheckMate 9LA	EGFR and/or ALK wt	0.72

[1] Rodriguez-Abreu. *Ann Oncol* 2021. [2] Paz-Ares. *J Thorac Oncol* 2020. [3] Socinski *J Thorac Oncol* 2021. [4] West. *Lancet Oncol* 2019.
[5] Paz-Ares. ASCO 2021;Abstract 9016. [6] Reck. ASCO 2021;Abstract 9000.

EMPOWER-Lung 3: First-Line Cemiplimab with Platinum-Doublet Chemotherapy for Advanced NSCLC



Gogishvili M et al. ESMO 2021;Abstract LBA51.

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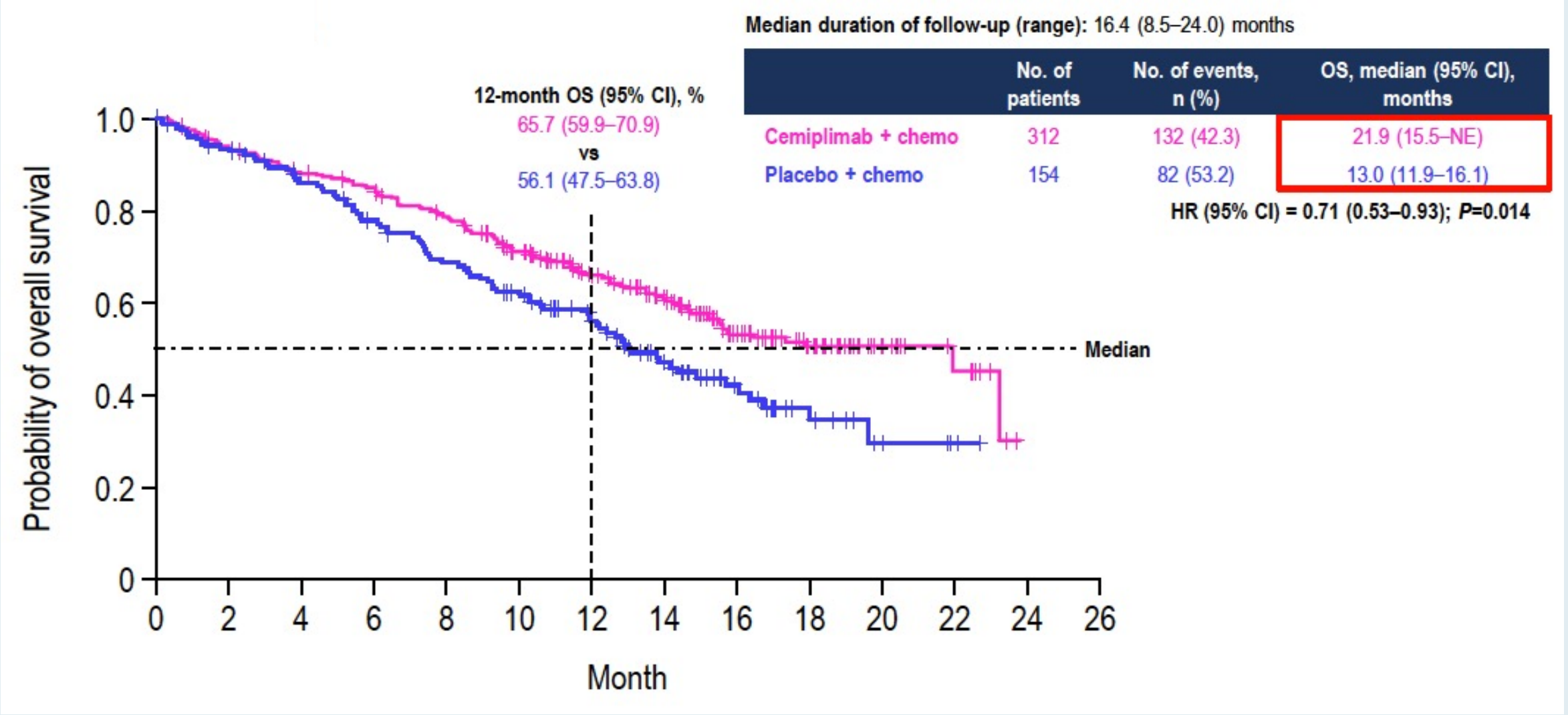
EMPOWER-Lung 3: First-Line Cemiplimab with Platinum-Doublet Chemotherapy for Advanced NSCLC



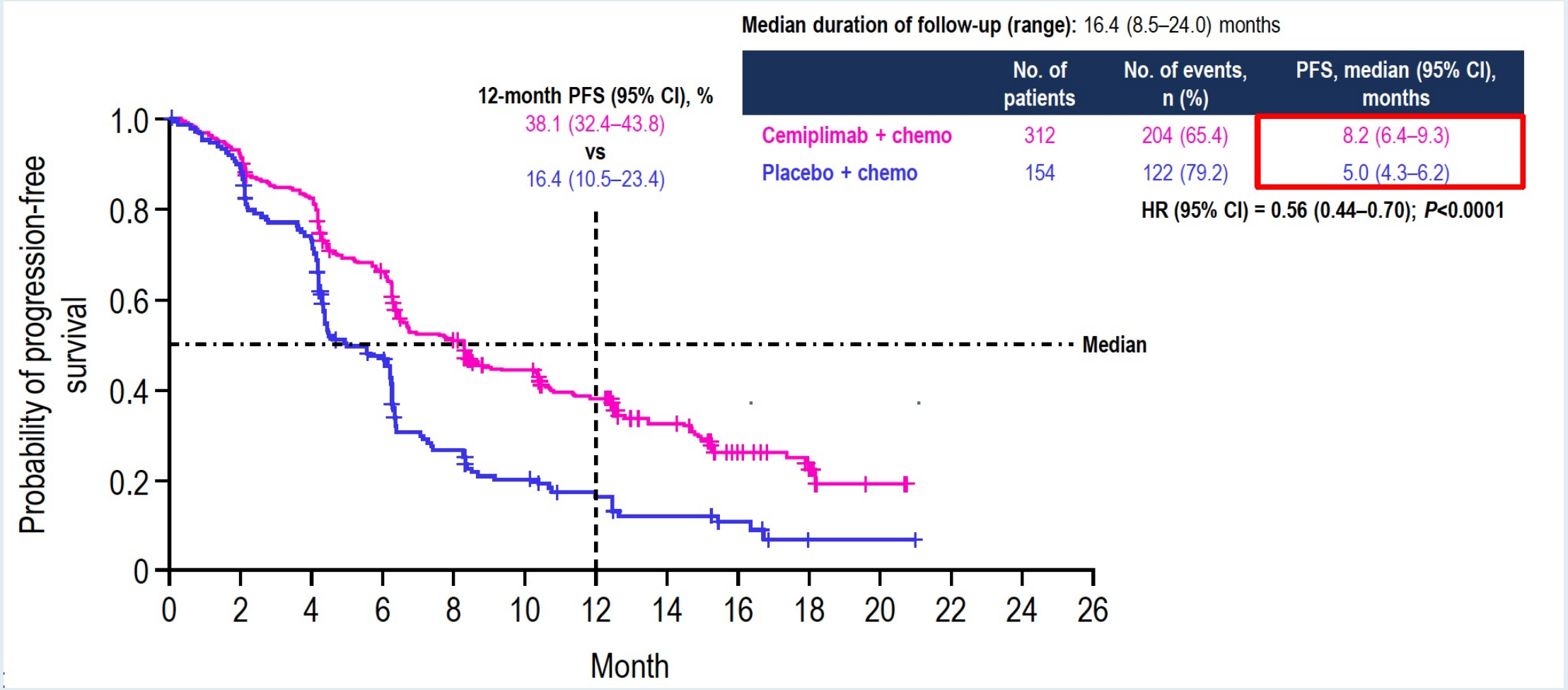
Gogishvili M et al. ESMO 2021;Abstract LBA51.

EMPOWER-Lung 3: Progression-Free Survival

Median duration of follow-up (range): 16.4 (8.5–24.0) months

	No. of patients	No. of events, n (%)	PFS, median (95% CI), months
Cemiplimab + chemo	312	204 (65.4)	8.2 (6.4–9.3)
Placebo + chemo	154	122 (79.2)	5.0 (4.3–6.2)

HR (95% CI) = 0.56 (0.44–0.70); *P*<0.0001



Gogishvili M et al. ESMO 2021;Abstract LBA51.

Thoughts for the Future

- **Choice of immunotherapy regimen**
  - Interval between dosing
- **Immunotherapy combinations**
  - Anti-PD-1/PD-L1 antibody/tyrosine kinase inhibitor
  - Immunotherapy/immunotherapy
  - Other investigational approaches

KEYNOTE-146: Phase IB/II Trial of Lenvatinib/Pembrolizumab in Advanced Solid Cancers

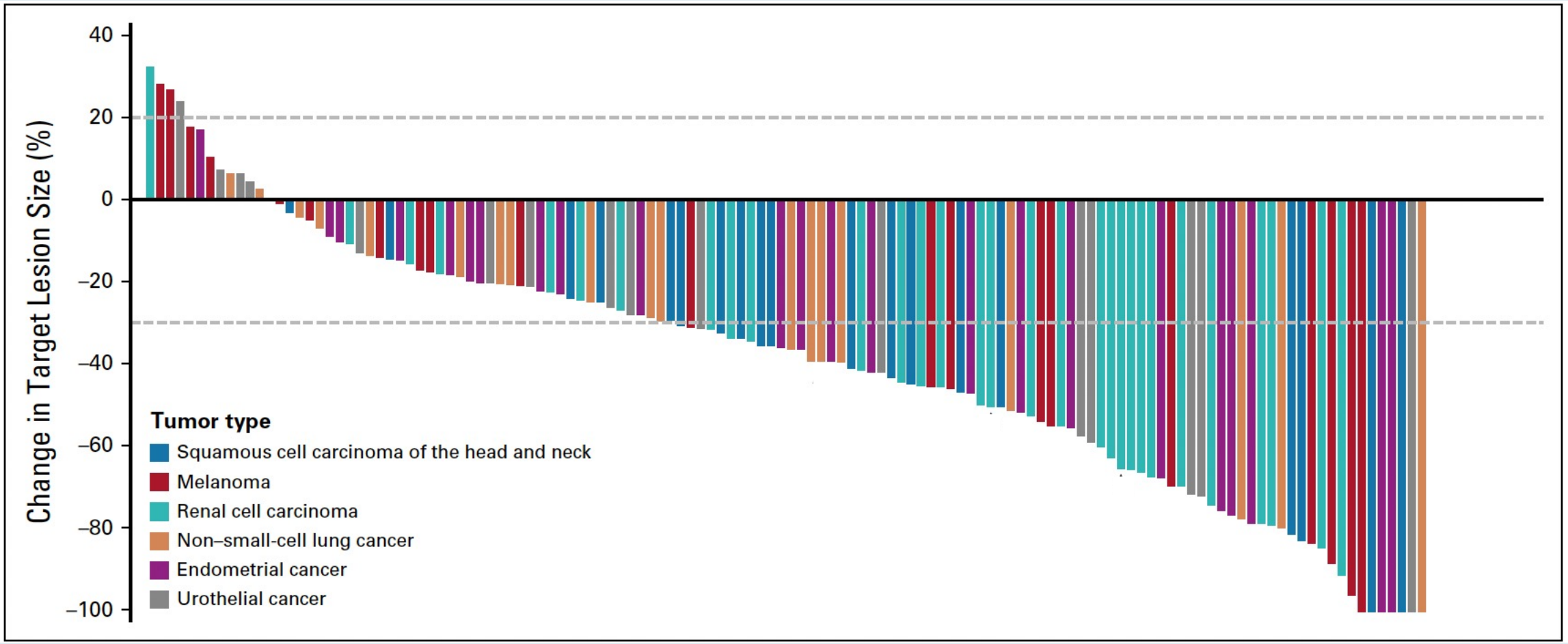
Efficacy in the Metastatic NSCLC Population				
N	**Line of Therapy**	**ORR**	**Median DOR**	**Median PFS**
21	Any	33%	10.9 mo	5.9 mo

DOR = duration of response

Summary of Treatment-Related AEs (TREAs): All Patients	
Parameter	**(N = 137)**
Serious AEs	26%
TREAs leading to pembrolizumab dose interruption	45%
TREAs leading to pembrolizumab discontinuation	15%
TREAs leading to lenvatinib dose reduction and/or interruption	85%
TREAs leading to lenvatinib discontinuation	13%

Taylor MH et al. *J Clin Oncol* 2020;38:154-63.

KEYNOTE-146: Maximum Change in Target Lesion Size (All Patients)



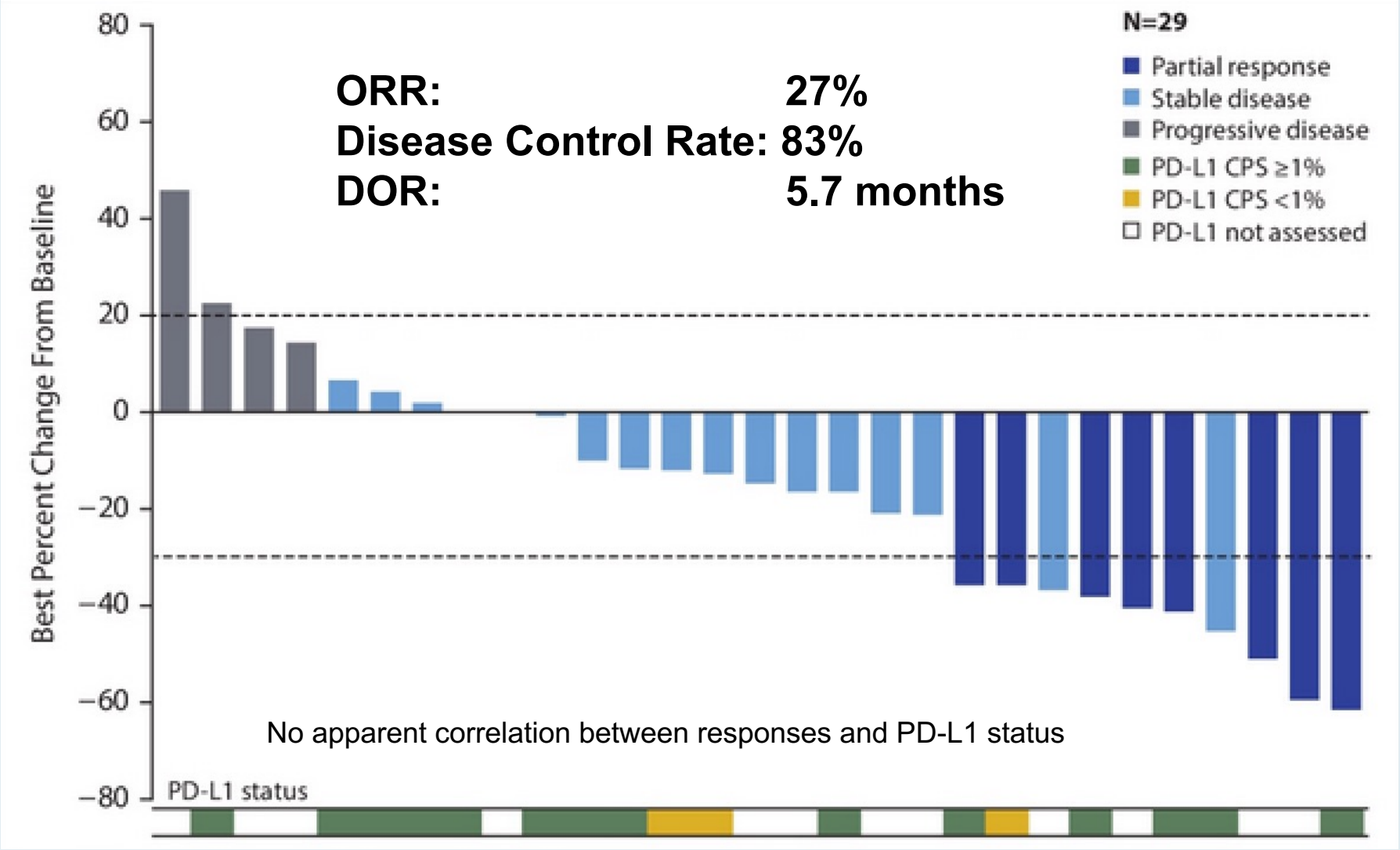
Taylor MH et al. *J Clin Oncol* 2020;38:154-63.

Ongoing LEAP Phase III Trials in NSCLC

Trial ID	N	Patient population	Line of therapy	Treatment
LEAP-006	726	Previously untreated metastatic nonsquamous NSCLC	1L	• Pemetrexed + Platinum chemo + Pembrolizumab + Lenvatinib • Pemetrexed + Platinum chemo + Pembrolizumab + Placebo
LEAP-007	620	Previously untreated, advanced (Stage IV), PD-L1 positive (TPS ≥1%) NSCLC	1L	• Lenvatinib + Pembrolizumab • Placebo + Pembrolizumab
LEAP-008	405	Metastatic NSCLC that progressed during/after platinum doublet chemotherapy or on treatment with anti-PD-1/PD-L1 monoclonal antibody as monotherapy or combination therapy	≥2L	• Lenvatinib + Pembrolizumab • SOC chemo • Lenvatinib

Taylor MH et al. *Futur Oncol* 2021;17(6):637-47. www.clinicaltrials.gov. NCT03829319, NCT03829332, NCT03976375. Accessed November 2021.

COSMIC-021 (Cohort 7): Best Change from Baseline with Cabozantinib/Atezolizumab for Metastatic NSCLC



Patient Population

- Patients with radiographic progression on or after one prior ICI treatment
- ≤2 lines of prior systemic anticancer therapy for metastatic NSCLC
- No EGFR mutations, ALK or ROS1 rearrangements, or BRAF V600E mutation

Neal JW et al. ASCO 2020;Abstract 9610.

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COSMIC-021 (Cohort 7): Immune-Related Adverse Events with Cabozantinib/Atezolizumab for Metastatic NSCLC

	NSCLC Cohort 7 (N=30)	
	Any Grade	Grade 3
Any AE, n (%)	6 (20)	0
Hyperthyroidism	1 (3.3)	0
Hypothyroidism	1 (3.3)	0
Lipase increased	1 (3.3)	0
Myocarditis*	1 (3.3)	0
Pain	1 (3.3)	0
Pneumonitis*	1 (3.3)	0
Rash	1 (3.3)	0

*One patient experienced grade 5 pneumonitis and myocarditis; pneumonitis was assessed as the cause of death

Neal JW et al. ASCO 2020;Abstract 9610.

Enrollment Completed in Phase 3 CONTACT-01 Pivotal Trial of Cabozantinib in Combination with an Immune Checkpoint Inhibitor in Previously Treated Metastatic Non-Small Cell Lung Cancer

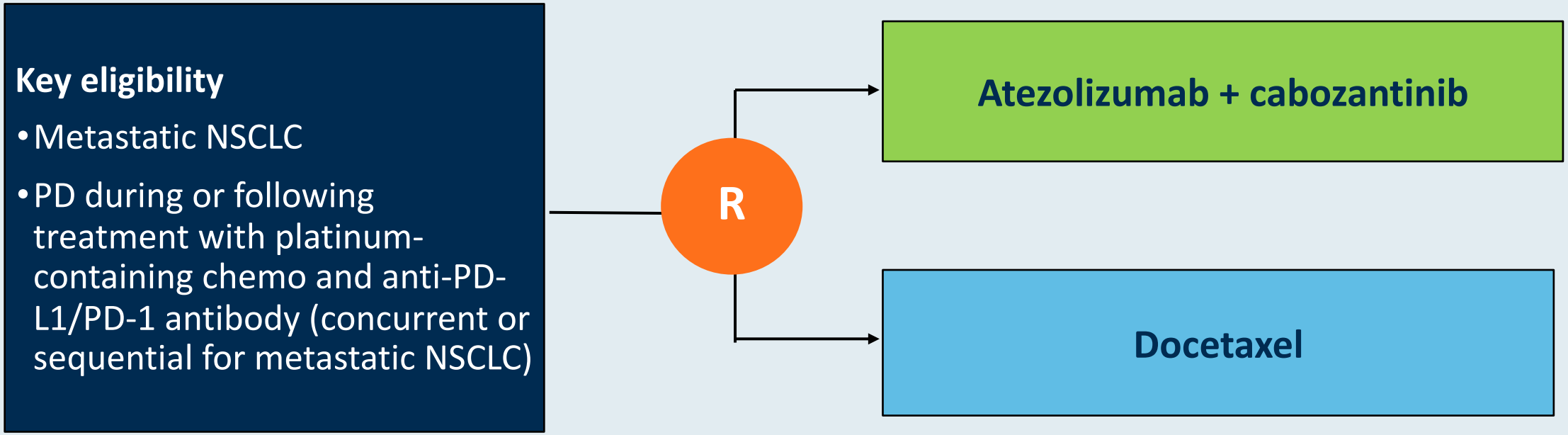
Press Release: November 9, 2021

"Enrollment is now completed for CONTACT-01, the global, phase 3 pivotal trial evaluating cabozantinib in combination with atezolizumab in patients with metastatic non-small cell lung cancer (NSCLC) who have been previously treated with an immune checkpoint inhibitor and platinum-containing chemotherapy.

CONTACT-01 is a global, multicenter, randomized, phase 3, open-label study that enrolled 366 patients who were randomized 1:1 to the experimental arm of cabozantinib in combination with atezolizumab and the control arm of docetaxel. The primary endpoint of the trial is overall survival. Secondary endpoints include progression-free survival, objective response rate and duration of response. Results from cohort 7 of the phase 1b COSMIC-021 trial informed the CONTACT-01 trial design."

https://ir.exelixis.com/news-releases/news-release-details/exelixis-announces-enrollment-completion-phase-3-contact-01

CONTACT-01 Phase III Study Design



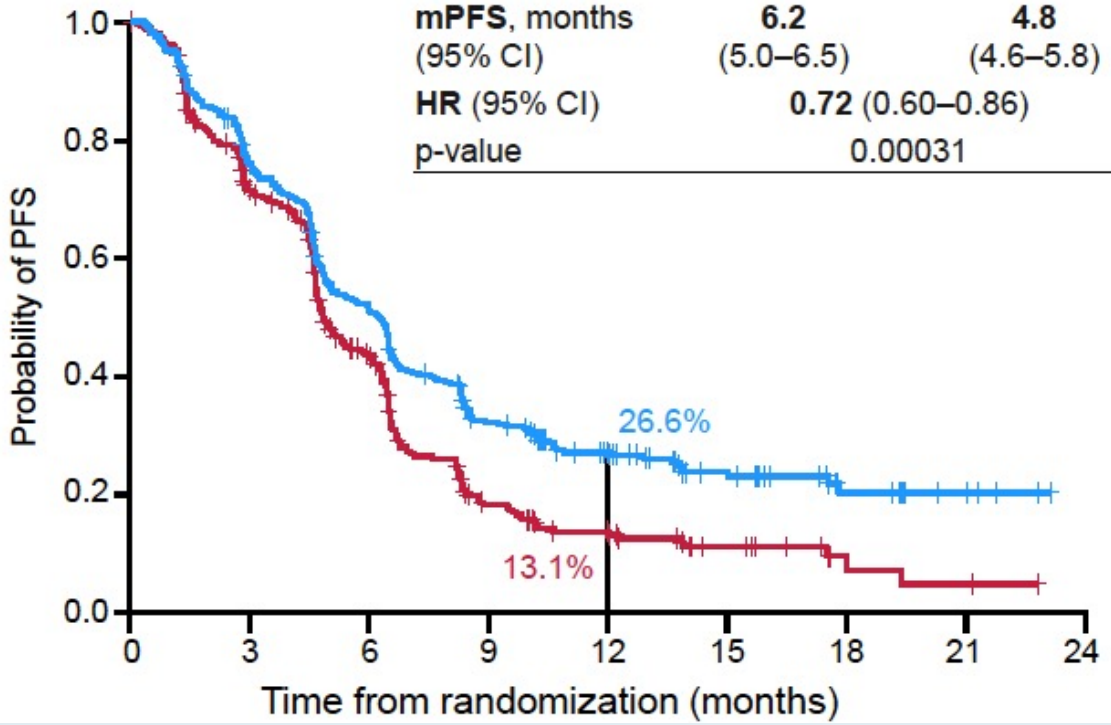
Primary endpoint: Overall survival
Secondary endpoints: PFS, ORR, DOR, others

www.clinicaltrials.gov. NCT04471428. Accessed November 2021.

POSEIDON: First-Line Durvalumab with Tremelimumab and Chemotherapy for Advanced NSCLC

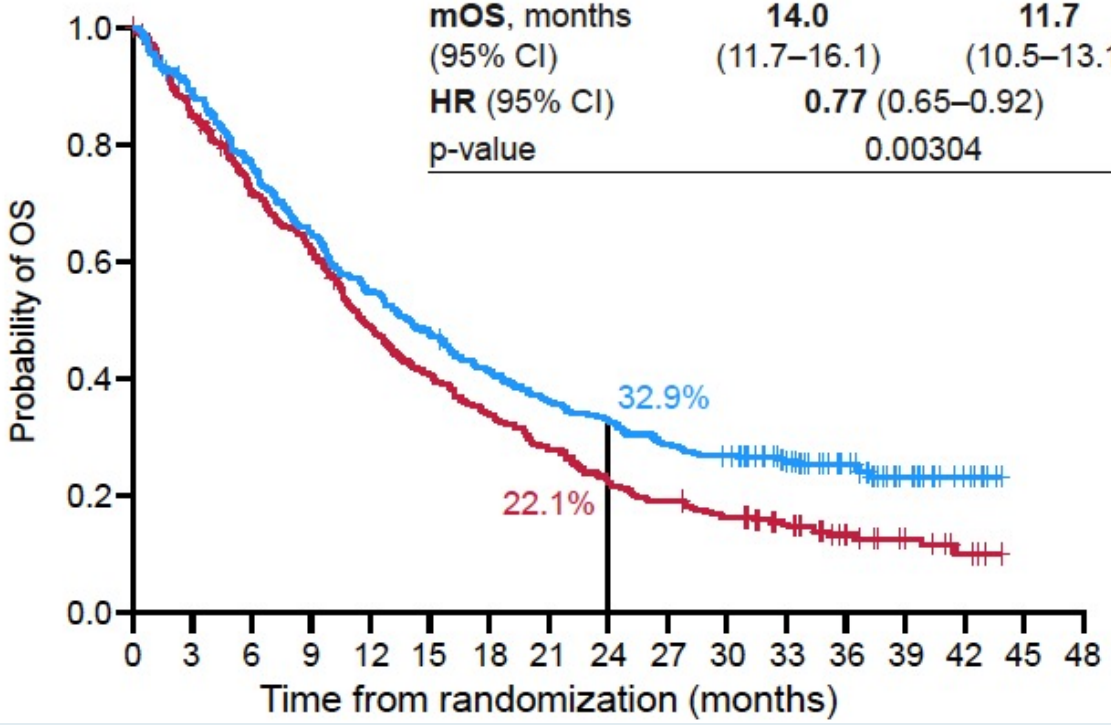
PFS

	D+T+CT	CT
Events, n/N (%)	238/338 (70.4)	258/337 (76.6)
mPFS, months (95% CI)	**6.2** (5.0–6.5)	**4.8** (4.6–5.8)
HR (95% CI)	**0.72** (0.60–0.86)	
p-value	0.00031	



OS

	D+T+CT	CT
Events, n/N (%)	251/338 (74.3)	285/337 (84.6)
mOS, months (95% CI)	**14.0** (11.7–16.1)	**11.7** (10.5–13.1)
HR (95% CI)	**0.77** (0.65–0.92)	
p-value	0.00304	



Johnson ML et al. WCLC 2021;Abstract PL02.01

RTP RESEARCH TO PRACTICE

Background: TIGIT Pathway

- TIGIT (T cell immunoreceptor with Ig and ITIM domains) is a novel inhibitory receptor expressed on multiple immune cells, including T cells and NK cells[1-3]
- TIGIT inhibits T cells and NK cells by binding to its ligand PVR on tumor cells and antigen-presenting cells (APCs)
- TIGIT expression strongly correlates with PD-1 expression, especially in tumor-infiltrating T cells in lung cancer
- *Hypothesis*: Anti-TIGIT antibodies, which prevent TIGIT from binding to its ligand, could restore the anti-tumor response and could complement the activity of anti-PD-L1/PD-1 antibodies

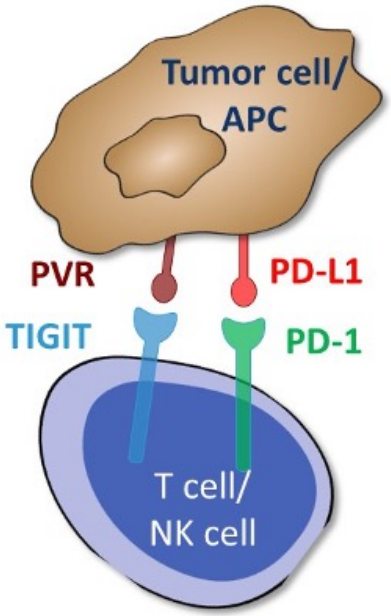


Figure adapted from Manieri et al. *Trends Immunology* 2017

NK, natural killer; PVR, poliovirus receptor

[1] Manieri et al. *Trends Immunology* 2017; [2] Rotte et al. *Annals of Oncology* 2018; [3] Yu et al. *Nature Immunology* 2009

Rodriguez-Abreu D et al. ASCO 2020;Abstract 9503.

Background: Tiragolumab, an Anti-TIGIT Antibody

- Tiragolumab is a fully human IgG1/kappa anti-TIGIT monoclonal antibody with an intact Fc region that blocks the binding of TIGIT to its receptor PVR

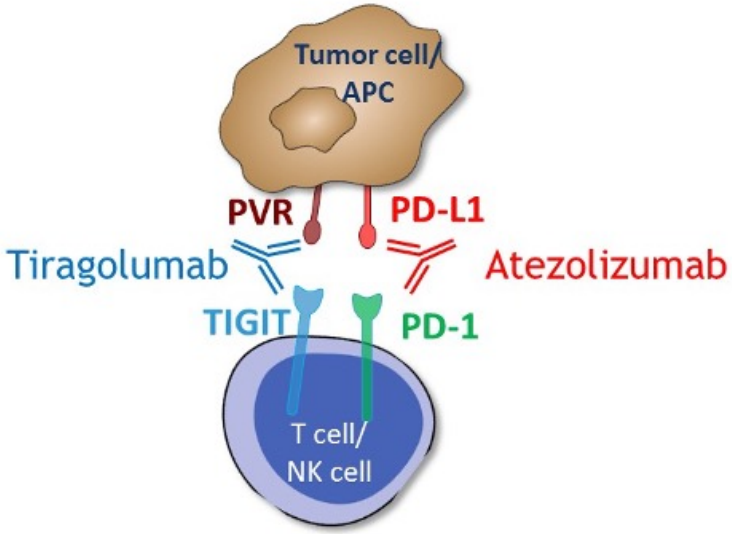
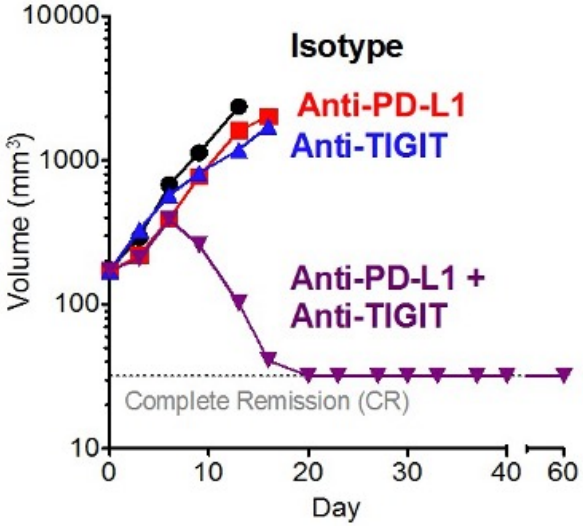


Figure adapted from Manieri et al. *Trends Immunology* 2017

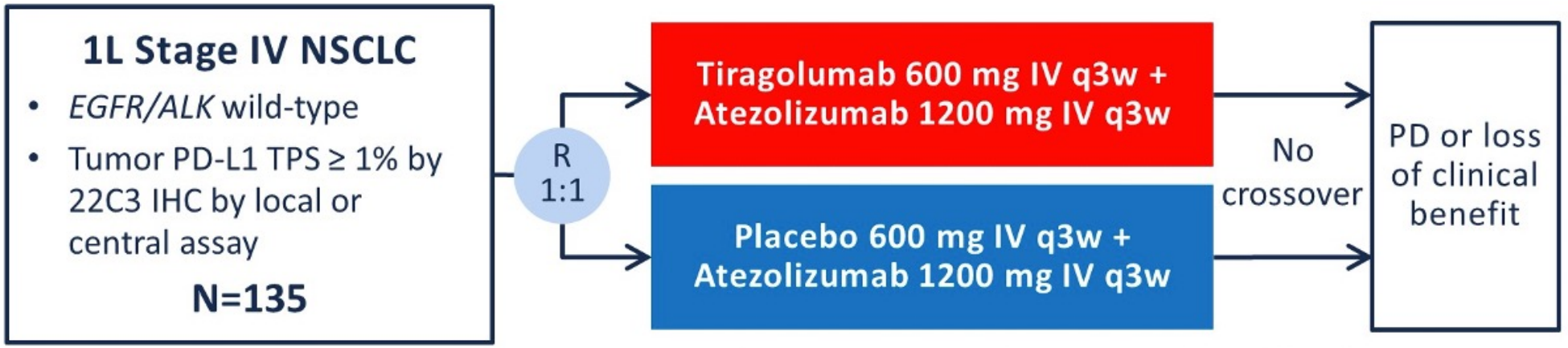
- In preclinical models, combination treatment with anti-TIGIT and anti-PD-L1 antibodies synergistically improves tumor control and prolongs survival in mice[1]



[1] Johnston et al. *Cancer Cell* 2014

Rodriguez-Abreu D et al. ASCO 2020;Abstract 9503.

CITYSCAPE Study Design



Stratification Factors:

- PD-L1 TPS (1-49% vs ≥ 50%)
- Histology (Non-Squamous vs Squamous)
- Tobacco use (yes vs no)

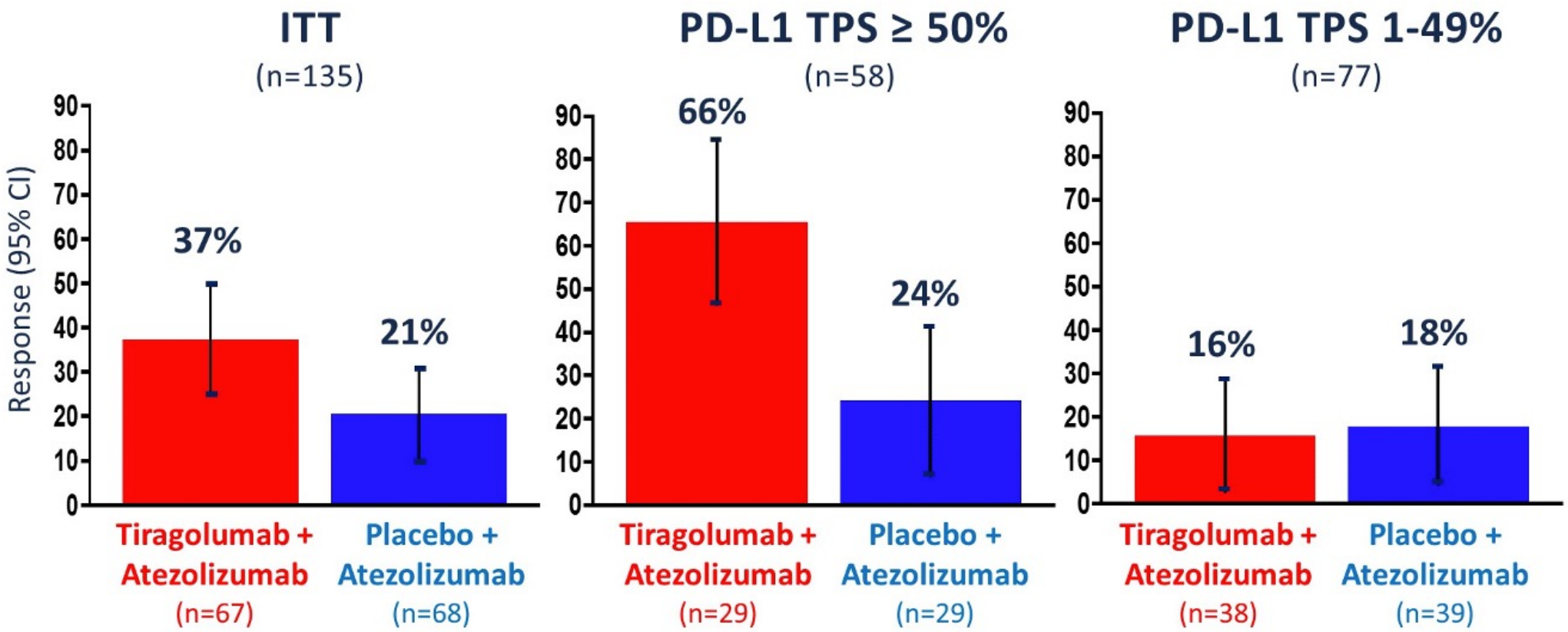
- **Co-Primary Endpoints: ORR** and **PFS**
- **Key Secondary Endpoints: Safety**, DOR, OS, Patient-reported outcomes (PROs)
- **Exploratory Endpoints:** Efficacy analysis by PD-L1 status

DOR = duration of response; IHC = immunohistochemistry; ORR = confirmed overall response rate; OS = overall survival; PD = progressive disease; PFS = progression free survival ; q3w = every 3 weeks; R = randomized; TPS = tumor proportion score

Rodriguez-Abreu D et al. ASCO 2020;Abstract 9503.

CITYSCAPE

Updated Confirmed Overall Response Rate (ORR)



ITT = intention-to-treat; TPS = tumor proportion score

Updated data cutoff: 02 Dec 2019

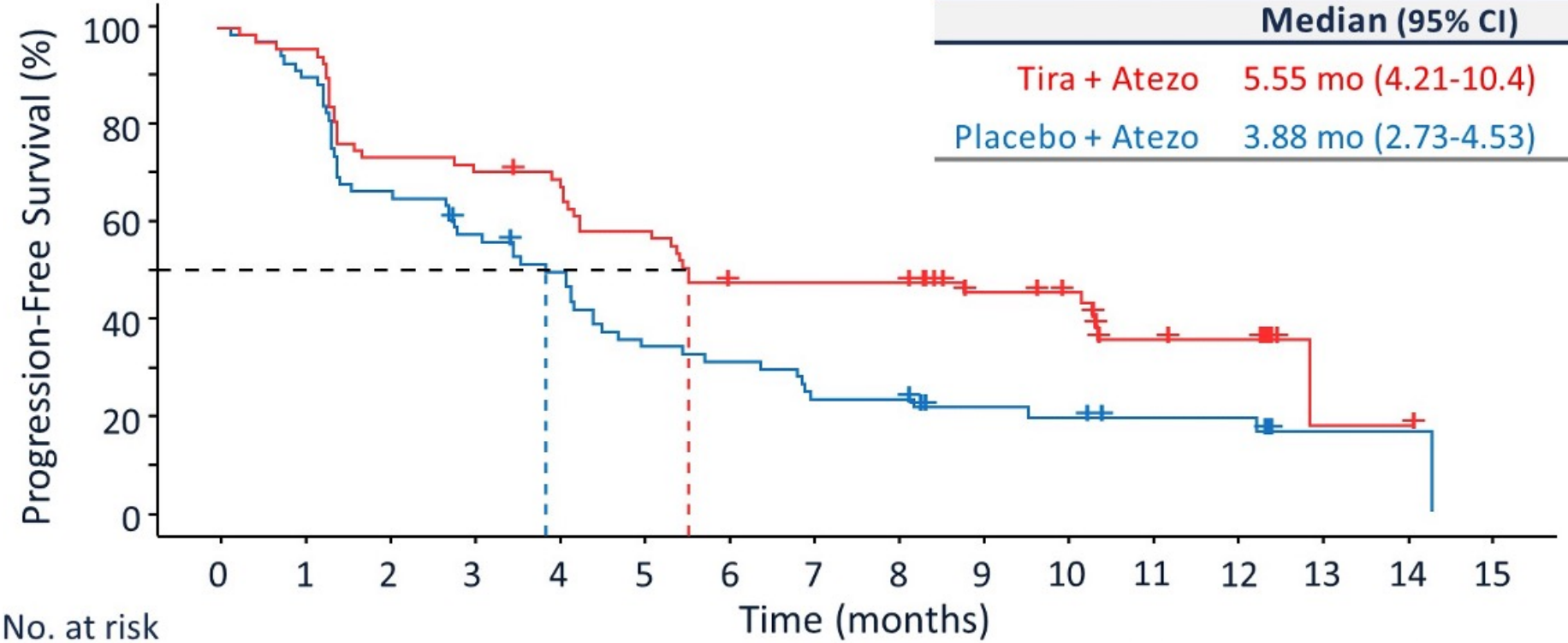
Rodriguez-Abreu D et al. ASCO 2020;Abstract 9503.

CITYSCAPE

Updated Investigator-Assessed PFS: ITT

	Median (95% CI)	HR (95% CI)
Tira + Atezo	5.55 mo (4.21-10.4)	0.58* (0.38-0.89)
Placebo + Atezo	3.88 mo (2.73-4.53)	

*stratified HR



No. at risk																Events
T + A	67	64	49	48	45	38	31	30	30	22	20	10	9	1	1	0	41 (61%)
P + A	68	61	45	38	32	22	20	15	15	10	9	7	7	1	1	0	55 (81%)

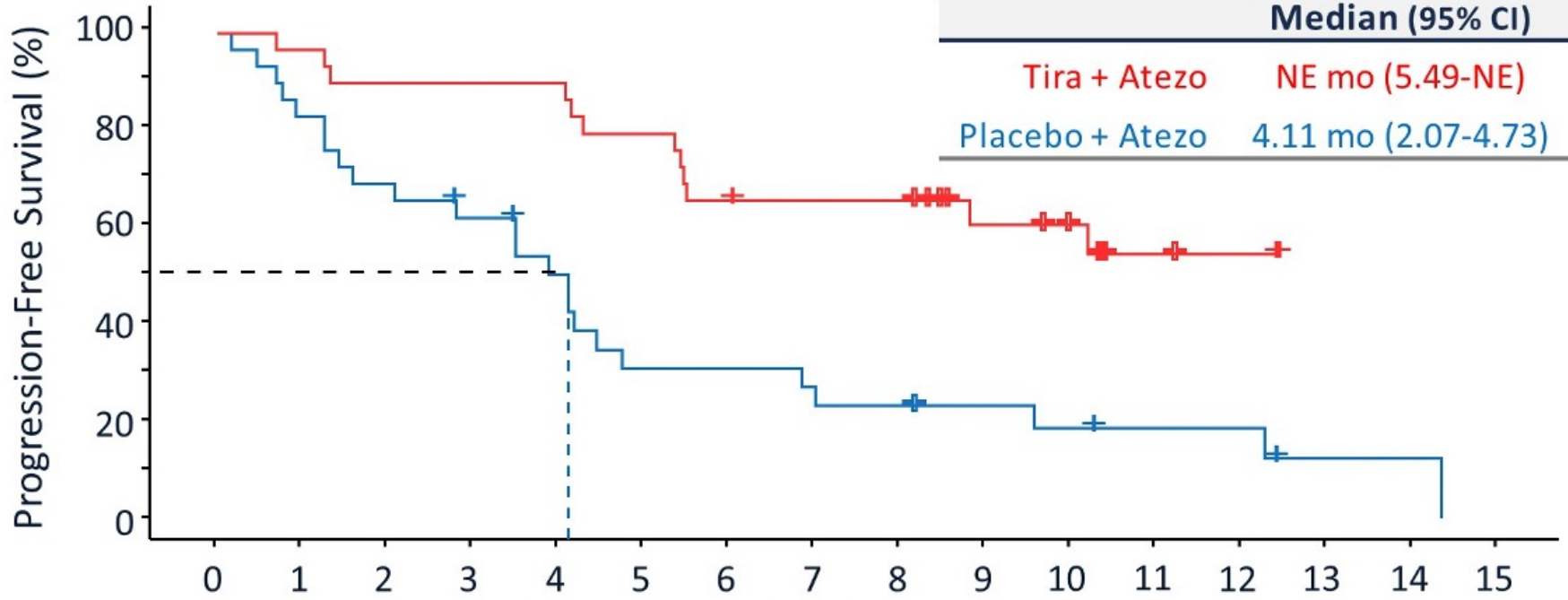
ITT= intention-to-treat; P+A = placebo + atezolizumab; T+A = tiragolumab + atezolizumab

Follow data cutoff: 02 December 2019

Rodriguez-Abreu D et al. ASCO 2020;Abstract 9503.

CITYSCAPE

Updated Investigator-Assessed PFS: PD-L1 TPS ≥ 50%



	Median (95% CI)	HR (95% CI)
Tira + Atezo	NE mo (5.49-NE)	0.30* (0.15-0.61)
Placebo + Atezo	4.11 mo (2.07-4.73)	

*unstratified HR

No. at risk																	Events
T + A	29	28	26	26	26	23	19	18	18	12	10	4	3	0	0	0	12 (41%)
P + A	29	24	20	17	13	8	8	6	6	5	4	3	3	1	1	0	24 (83%)

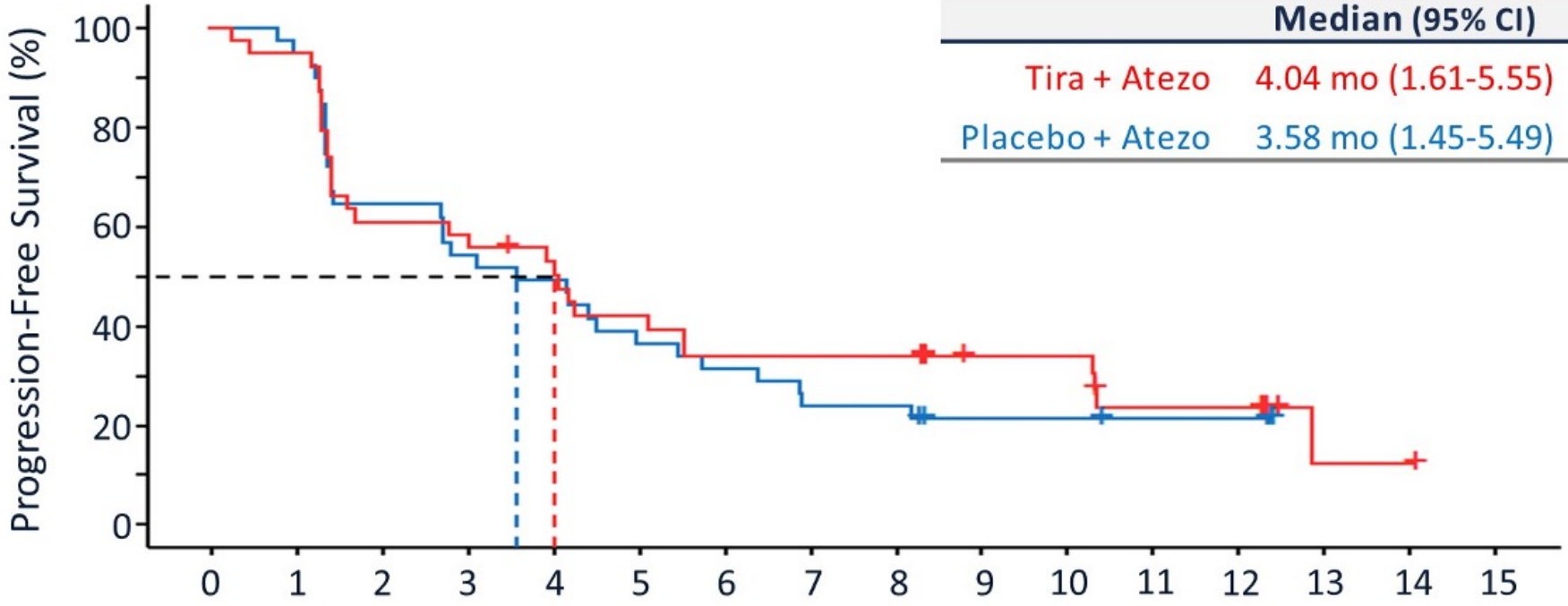
NE = non-evaluable; P+A = placebo + atezolizumab; T+A = tiragolumab + atezolizumab; TPS = tumor proportion score

Follow data cutoff: 02 December 2019

Rodriguez-Abreu D et al. ASCO 2020;Abstract 9503.

CITYSCAPE

Updated Investigator-Assessed PFS: PD-L1 TPS 1-49%



	Median (95% CI)	HR (95% CI)
Tira + Atezo	4.04 mo (1.61-5.55)	0.89* (0.53-1.49)
Placebo + Atezo	3.58 mo (1.45-5.49)	

*unstratified HR

No. at risk																	Events
T + A	38	36	23	22	19	15	12	12	12	10	10	6	6	1	1	0	29 (76%)
P + A	39	37	25	21	19	14	12	9	9	5	5	4	4	0	0	0	31 (80%)

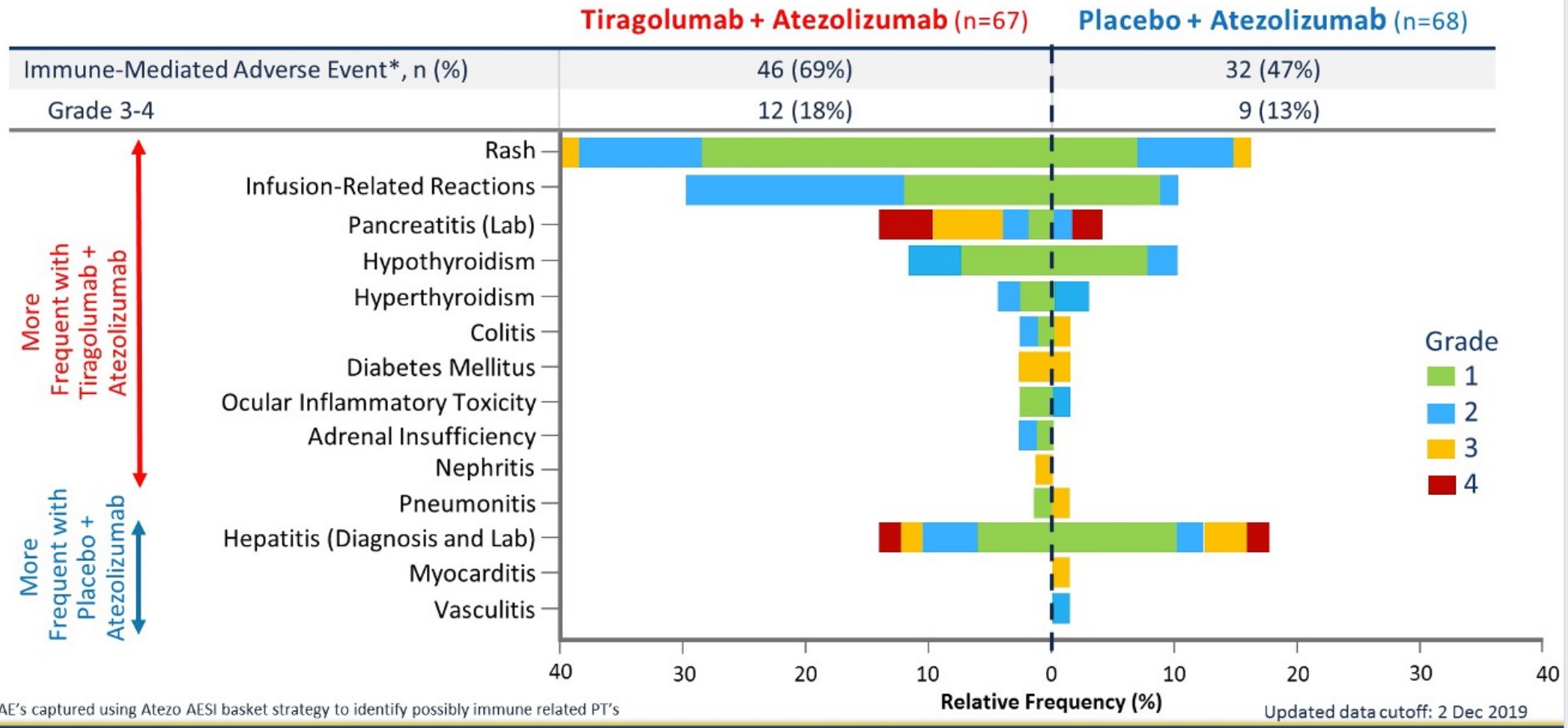
NE = non-evaluable; P+A = placebo + atezolizumab; T+A = tiragolumab + atezolizumab; TPS = tumor proportion score

Follow data cutoff: 02 December 2019

Rodriguez-Abreu D et al. ASCO 2020;Abstract 9503.

CITYSCAPE

Updated Immune-Mediated Adverse Events



*imAE's captured using Atezo AESI basket strategy to identify possibly immune related PT's

Updated data cutoff: 2 Dec 2019

Rodriguez-Abreu D et al. ASCO 2020;Abstract 9503.

Meet The Professor with Dr Liu

MODULE 1: Adjuvant and Neoadjuvant Immunotherapy in Non-Small Cell Lung Cancer (NSCLC)

MODULE 2: Case Presentations

- Dr Patel: A 57-year-old man with metastatic NSCLC and no actionable mutations
- Dr Shameem: A 66-year-old woman with newly diagnosed adenocarcinoma of the lung — PD-L1 65%
- Dr Kumar: A 70-year-old man with localized NSCLC and no actionable mutations — PD-L1 90%
- Dr Gupta: A 60-year-old woman with extensive-stage small cell lung cancer
- Dr Gubens: A 72-year-old woman with Stage IIIB adenocarcinoma of the lung and an EGFR L858R tumor mutation — PD-L1 40%
- Dr Kumar: A 75-year-old man with newly diagnosed metastatic NSCLC — MET amplification, PD-L1 90%

MODULE 3: Thoughts for the Future

MODULE 4: Journal Club with Dr Liu

MODULE 5: Appendix – Key Data Sets

RTP RESEARCH TO PRACTICE

Journal Club with Dr Liu

- Reuss JE et al. **Antibody drug conjugates in lung cancer: State of the current therapeutic landscape and future developments.** *Clin Lung Cancer* 2021;[Online ahead of print]
- Jonna S et al. **Effect of prior therapy on tumor mutational burden in NSCLC.** *Transl Lung Cancer Res* 2021;10(3):1231-8.
- Farid S, Liu SV. **Chemo-immunotherapy as first-line treatment for small-cell lung cancer.** *Ther Adv Med Oncol* 2020;12:175883592098036 5.
- Montenegro GB et al. **Immunotherapy in lung cancer.** *J Surg Oncol* 2021;123(3):718-29.

RTP RESEARCH TO PRACTICE

Meet The Professor with Dr Liu

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RTP RESEARCH TO PRACTICE

Practical Considerations with the Use of Anti-PD-1/PD-L1 Antibodies for the Management of Localized and Locally Advanced NSCLC

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Select Ongoing Phase III Trials of Immunotherapy in the Neoadjuvant Setting

Trial identifier	N	Patient population	Study arms
IMpower030 (NCT03456063)	453	Resectable Stage II, IIIA, or select IIIB (T3N2 only) NSCLC Squamous or non-squamous histology	• Atezolizumab + platinum-based chemotherapy • Placebo + platinum-based chemotherapy
KEYNOTE-671 (NCT03425643)	786	Resectable Stage II, IIIA, and resectable IIIB (T3-4N2) NSCLC	• Pembrolizumab + platinum-based chemotherapy • Placebo + platinum-based chemotherapy
AEGEAN (NCT03800134)	800	Resectable Stage IIA to select (ie, N2) Stage IIIB NSCLC	• Durvalumab + platinum-based chemotherapy • Placebo + platinum-based chemotherapy

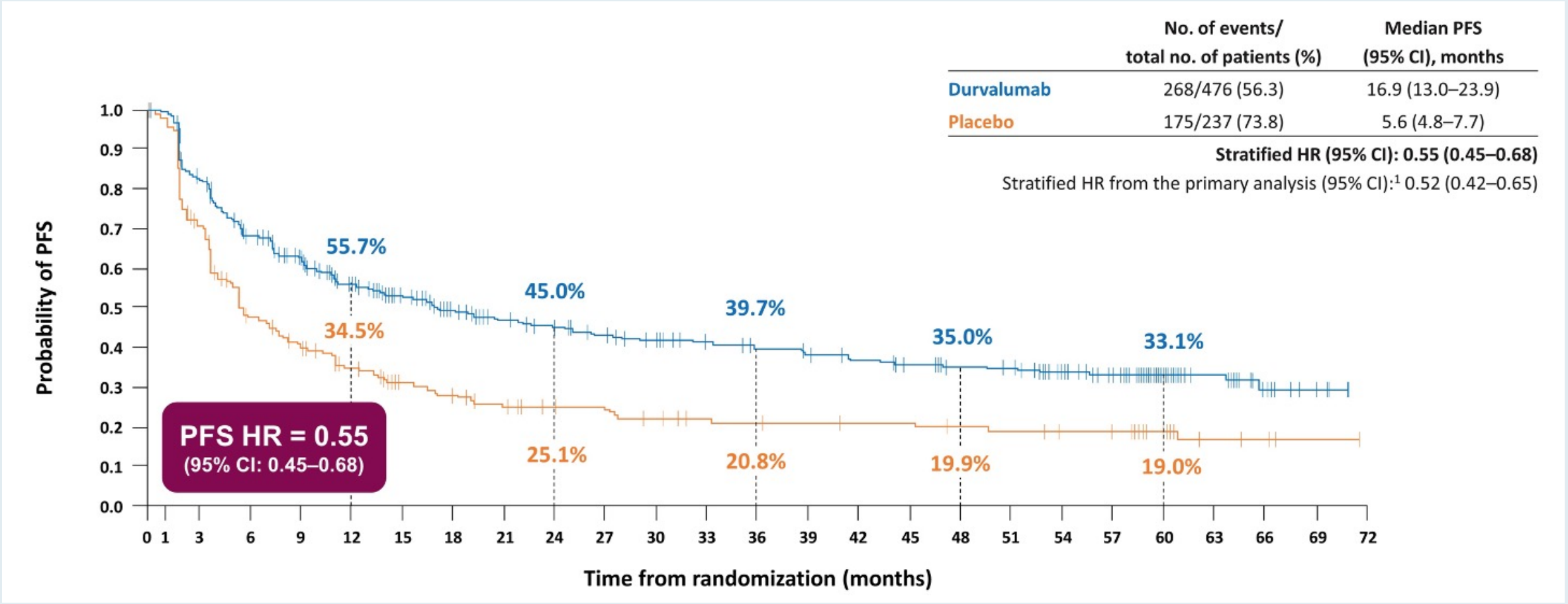
www.clinicaltrials.gov; Accessed November 2021.

Select Ongoing Phase III Trials of Immunotherapy in the Adjuvant Setting

Trial identifier	N	Patient population	Study arms
BR31 (NCT02273375)	1,360	Stage IB (≥ 4cm in the longest diameter), II or IIIA after complete resection	• Durvalumab • Placebo
KEYNOTE-091/ PEARLS (NCT02504372)	1,177	Stage IB with T ≥ 4 cm, II-IIIA NSCLC after complete surgical resection with or without adjuvant chemotherapy	• Pembrolizumab • Placebo
ANVIL (NCT02595944)	903	Complete surgical resection of stage IB (≥ 4 cm), II or IIIA NSCLC with adjuvant chemotherapy Negative for ALK translocation and EGFR exon 19 del or exon 21 L858R mutation	• Nivolumab • Placebo

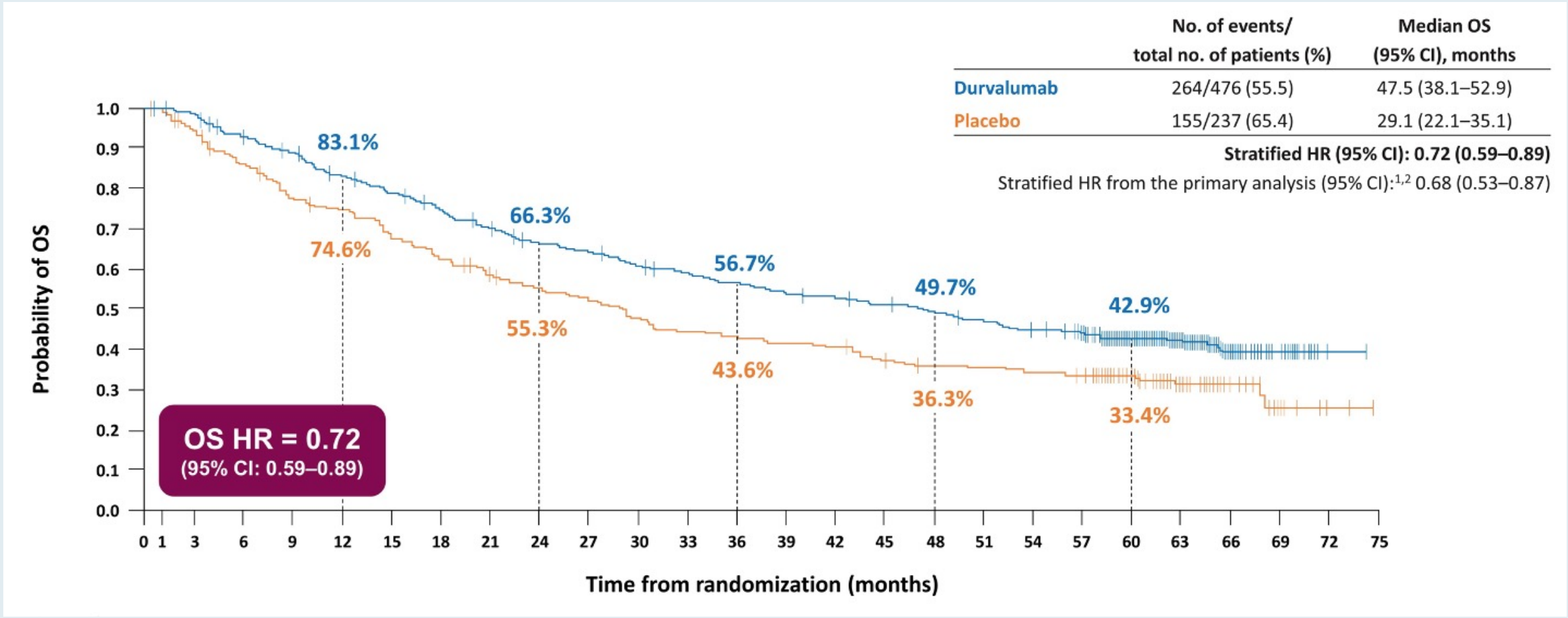
www.clinicaltrials.gov; Accessed November 2021.

PACIFIC: Five-Year Progression-Free Survival (PFS) with Durvalumab After Chemoradiation Therapy for Stage III NSCLC



Spigel DR et al. ASCO 2021;Abstract 8511.

PACIFIC: Five-Year Overall Survival (OS) with Durvalumab After Chemoradiation Therapy for Stage III NSCLC



Spigel DR et al. ASCO 2021;Abstract 8511.

PACIFIC-R: Real-World Study of Durvalumab After Chemoradiation Therapy for Patients with Unresectable Stage III NSCLC

- International observational study (N = 1155)
- Median PFS: 22.5 months
- Median duration of durvalumab treatment: 11 months

Summary of Safety and Pneumonitis	N = 1155
Discontinuation of durvalumab due to AE	17.5%
Discontinuation of durvalumab due to pneumonitis Temporary Permanent	13.8% 5.1% 8.7%
Any-grade pneumonitis and/or ILD Moderate severity Life-threatening Fatal	18.5% 8.8% 0.2% 0.1%

Girard N et al. ESMO 2021;Abstract 1171MO.

RTP RESEARCH TO PRACTICE

FDA Approves Durvalumab for Fixed-Dose Use in NSCLC, Bladder Cancer Indications

Press Release: November 20, 2020

"The FDA has approved durvalumab for an additional dosing option, a fixed dose of 1500 mg every 4 weeks, in the approved indications of unresectable stage III non-small cell lung cancer after chemoradiation and previously treated advanced bladder cancer.

This new dosing option is consistent with the dosing for the agent that has been approved in extensive-stage small cell lung cancer (ES-SCLC); this will serve as an alternative option for patients who weigh more than 30 kg rather than the weight-based dosing of 10 mg/kg that is administered every 2 weeks.

The regulatory decision was based on data from several clinical trials examining the agent, including the phase 3 PACIFIC trial (NCT02125461), which supported the 2-week, weight-based dosing in patients with unresectable stage III NSCLC, and the phase 3 CASPIAN trial (NCT03043872), which examined a 4-week, fixed-dose during maintenance treatment in patients with ES-SCLC."

https://www.onclive.com/view/fda-approves-durvalumab-for-fixed-dose-use-in-nsclc-bladder-cancer-indications

RTP RESEARCH TO PRACTICE

Phase II KEYNOTE-799 Trial of Pembrolizumab with Concurrent Chemoradiation Therapy in Unresectable Stage III NSCLC

— Coprimary Endpoints: Overall Response Rate (ORR) and Grade 3 or Higher Pneumonitis

	Cohort A (Squamous and nonsquamous) (n = 112)	Cohort B (Nonsquamous only) (n = 102)
ORR	70.5%	70.6%
Pts with response ≥12 mo	79.7%	75.6%
≥Grade 3 pneumonitis	8.0%	6.9%

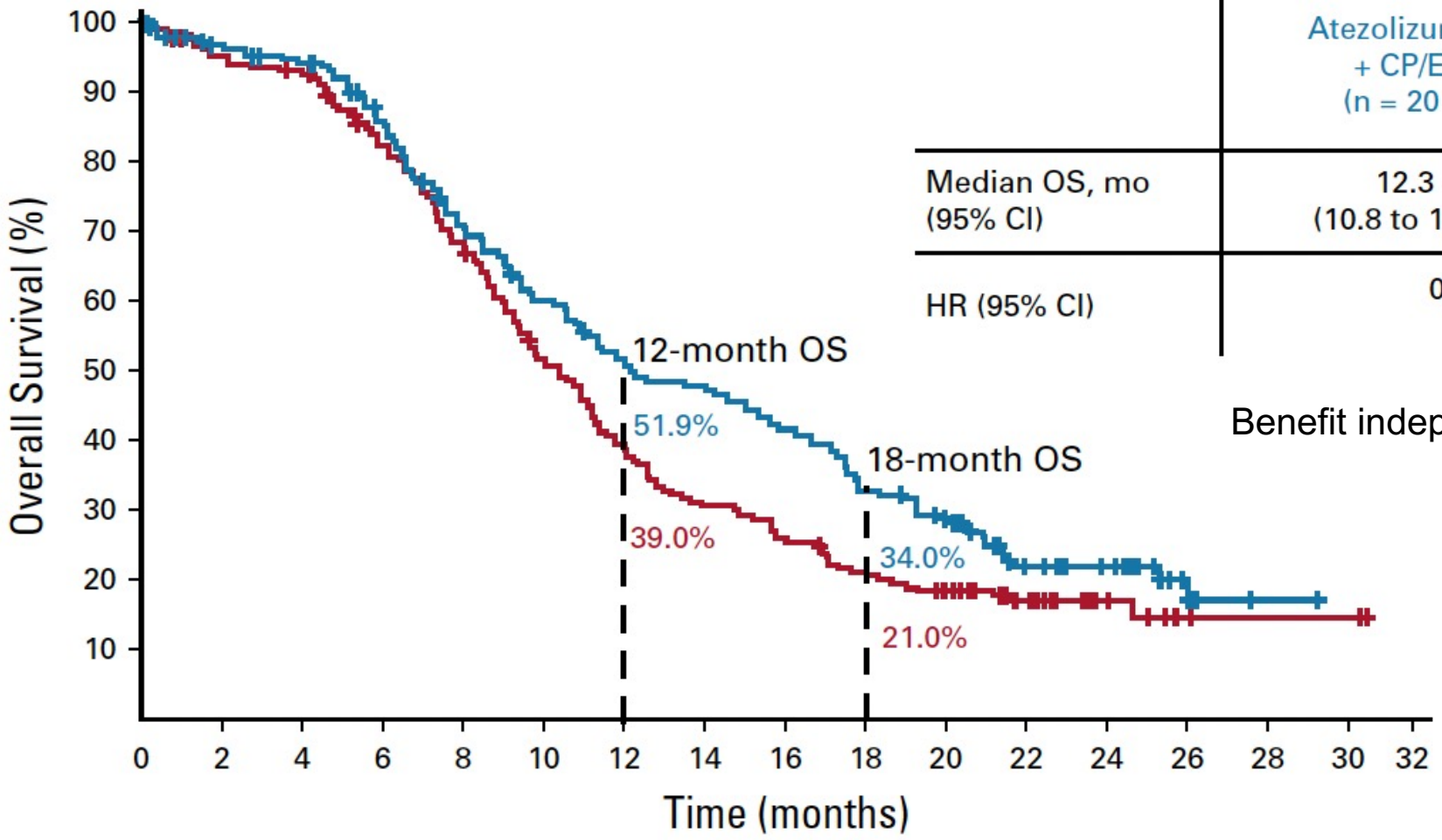
Jabbour SK et al. *JAMA Oncol* 2021;7(9):1351-9.

RTP RESEARCH TO PRACTICE

Role of Immunotherapy in Small Cell Lung Cancer (SCLC)

IMpower133: Updated OS in Extensive-Stage SCLC (ES-SCLC) Treated with First-Line Atezolizumab, Carboplatin and Etoposide

Median follow up: 22.9 mo



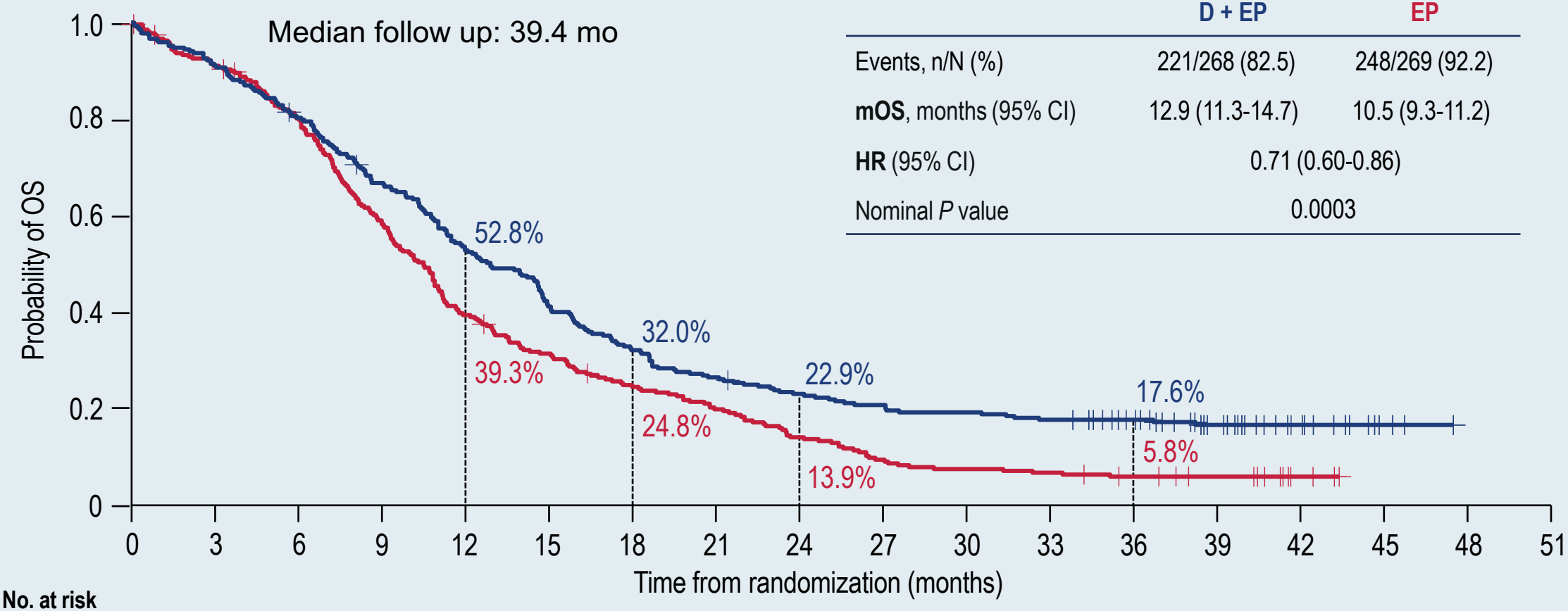
	Atezolizumab + CP/ET (n = 201)	Placebo + CP/ET (n = 202)
Median OS, mo (95% CI)	12.3 (10.8 to 15.8)	10.3 (9.3 to 11.3)
HR (95% CI)	0.76 (0.60 to 0.95) *P* = .0154*	

Benefit independent of PD-L1 status

Liu SV et al. *J Clin Oncol* 2021;39(6):619-30.

CASPIAN: Three-Year Updated OS in ES-SCLC Treated with First-Line Durvalumab, Platinum and Etoposide

	D + EP	EP
Events, n/N (%)	221/268 (82.5)	248/269 (92.2)
mOS, months (95% CI)	12.9 (11.3-14.7)	10.5 (9.3-11.2)
HR (95% CI)	0.71 (0.60-0.86)	
Nominal *P* value	0.0003	



No. at risk

D + EP	268	244	214	177	140	109	85	70	60	54	50	46	39	25	13	3	0	0
EP	269	243	212	156	104	82	64	51	36	24	19	17	13	10	3	0	0	0

Paz-Ares LG et al. *Ann Oncol*. 2021;32(suppl 5):S1283-46.

Meet The Professor

Management of BRAF-Mutant Melanoma

Monday, November 29, 2021
5:00 PM – 6:00 PM ET

Faculty
Jason J Luke, MD

Moderator
Neil Love, MD

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Thank you for joining us!

CME and MOC credit information will be emailed to each participant within 5 business days.

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