Lunch with the Investigators: Gastroesophageal Cancers

A CME Symposium Held in Conjunction with the 2023 ASCO® Annual Meeting

Friday, June 2, 2023

11:45 AM – 12:45 PM CT

Faculty

Yelena Y Janjigian, MD

Manish A Shah, MD

Harry H Yoon, MD, MHS

Moderator

Neil Love, MD

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Faculty

Yelena Y Janjigian, MD
Chief of Gastrointestinal Oncology Service
Department of Medicine
Memorial Sloan Kettering Cancer Center
New York, New York

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Professor of Oncology
Enterprise-Wide Vice-Chair
Gastrointestinal Cancer Disease Group
Mayo Clinic Comprehensive Cancer Center
Rochester, Minnesota

Manish A Shah, MD
Chief, Solid Tumor Oncology Service
Director, Gastrointestinal Oncology Program
Co-Director, Center for Advanced Digestive Care
Bartlett Family Professor of Gastrointestinal Oncology
Weill Cornell Medicine/NewYork-Presbyterian Hospital
New York, New York

Moderator

Neil Love, MD
Research To Practice
Miami, Florida

Dr Janjigian — Disclosures

Advisory Committee and Consulting Agreements	AbbVie Inc, AmerisourceBergen, Arcus Biosciences, AskGene Pharma, Astellas, AstraZeneca Pharmaceuticals LP, Basilea Pharmaceutica Ltd, Bayer HealthCare Pharmaceuticals, Bristol Myers Squibb, Daiichi Sankyo Inc, Geneos Therapeutics, GSK, Guardant Health, Imugene, Lilly, Lynx Health LLC, Merck, Merck Serono, Mersana Therapeutics Inc, Michael J Hennessy Associates Inc, Pfizer Inc, Rgenix, Seagen Inc, Silverback Therapeutics, Zymeworks Inc
Contracted Research	Bayer HealthCare Pharmaceuticals, Bristol Myers Squibb, Genentech, a member of the Roche Group, Lilly, Merck, Rgenix
Data and Safety Monitoring Board/Committee	AstraZeneca Pharmaceuticals LP, Daiichi Sankyo Inc, Merck, Transcenta
Ownership – Private (Nonrelevant)	Rgenix
Nonrelevant Financial Relationship	Clinical Care Options, Cycle for Survival, Fred's Team, Imedex, National Cancer Institute, Paradigm Medical Communications, PeerView Institute, US Department of Defense

Dr Shah — Disclosures

Contracted Research	Bristol Myers Squibb, Merck, Oncolys BioPharma

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Dr Yoon — Disclosures

Advisory Committee	ALX Oncology, Amgen Inc, Astellas, AstraZeneca Pharmaceuticals LP, BeiGene Ltd, Bristol Myers Squibb, Elevation Oncology, MacroGenics Inc, Merck, Novartis, OncXerna Therapeutics, Zymeworks Inc
Consulting Agreements	Amgen Inc, Merck
Contracted Research	Amgen Inc, BeiGene Ltd, Bristol Myers Squibb, CARsgen Therapeutics, MacroGenics Inc, Merck
Travel	BeiGene Ltd

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Commercial Support

This activity is supported by educational grants from Astellas, Bristol Myers Squibb, Jazz Pharmaceuticals Inc, Lilly, and Novartis.

Research To Practice CME Planning Committee Members, Staff and Reviewers

Planners, scientific staff and independent reviewers for Research To Practice have no relevant conflicts of interest to disclose.

Friday June 2	**Gastroesophageal Cancers** 11:45 AM – 12:45 PM CT (12:45 PM – 1:45 PM ET)
	Non-Small Cell Lung Cancer 6:30 PM – 9:00 PM CT (7:30 PM – 10:00 PM ET)
Saturday June 3	**Hepatobiliary Cancers** 6:45 AM – 7:45 AM CT (7:45 AM – 8:45 AM ET)
	Prostate Cancer 7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)
Sunday June 4	**Ovarian Cancer** 6:45 AM – 7:45 AM CT (7:45 AM – 8:45 AM ET)
	Lymphoma, Chronic Lymphocytic Leukemia and Multiple Myeloma 7:00 PM – 9:30 PM CT (8:00 PM – 10:30 PM ET)
Monday June 5	**Urothelial Bladder Cancer** 6:45 AM – 7:45 AM CT (7:45 AM – 8:45 AM ET)
	Breast Cancer 7:00 PM – 9:30 PM CT (8:00 PM – 10:30 PM ET)
Tuesday June 6	**Renal Cell Carcinoma (Webinar)** 7:00 AM – 8:00 AM CT (8:00 AM – 9:00 AM ET)

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Exciting CME Events in Chicago You Do Not Want to Miss

A CME Hybrid Symposium Series Held in Conjunction with the 2023 ASCO® Annual Meeting

Gastroesophageal Cancers

Friday, June 2, 2023
11:45 AM – 12:45 PM CT (12:45 PM – 1:45 PM ET)

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Yelena Y Janjigian, MD
Manish A Shah, MD
Harry H Yoon, MD, MHS

Hepatobiliary Cancers

Saturday, June 3, 2023
6:45 AM – 7:45 AM CT (7:45 AM – 8:45 AM ET)

Faculty
Anthony El-Khoueiry, MD
Robin K (Katie) Kelley, MD
Professor Arndt Vogel, MD

Non-Small Cell Lung Cancer

Friday, June 2, 2023
6:30 PM – 9:00 PM CT (7:30 PM – 10:00 PM ET)

Faculty
Edward B Garon, MD, MS
John V Heymach, MD, PhD
Corey J Langer, MD
Ticiana Leal, MD
David R Spigel, MD
Helena Yu, MD

Prostate Cancer

Saturday, June 3, 2023
7:00 PM – 9:00 PM CT (8:00 PM – 10:00 PM ET)

Faculty
Emmanuel S Antonarakis, MD
Prof Karim Fizazi, MD, PhD
Rana R McKay, MD
Alicia K Morgans, MD, MPH
A Oliver Sartor, MD

Exciting CME Events in Chicago You Do Not Want to Miss

A CME Hybrid Symposium Series Held in Conjunction with the 2023 ASCO® Annual Meeting

Ovarian Cancer

Sunday, June 4, 2023
6:45 AM – 7:45 AM CT (7:45 AM – 8:45 AM ET)

Faculty
Philipp Harter, MD, PhD
David M O'Malley, MD
Shannon N Westin, MD, MPH

Urothelial Bladder Cancer

Monday, June 5, 2023
6:45 AM – 7:45 AM CT (7:45 AM – 8:45 AM ET)

Faculty
Matthew D Galsky, MD
Andrea Necchi, MD
Scott T Tagawa, MD, MS

Lymphoma, Chronic Lymphocytic Leukemia and Multiple Myeloma

Sunday, June 4, 2023
7:00 PM – 9:30 PM CT (8:00 PM – 10:30 PM ET)

Faculty
John N Allan, MD
Shaji K Kumar, MD
Ann S LaCasce, MD, MMSc
Sagar Lonial, MD
Loretta J Nastoupil, MD
Susan O'Brien, MD

Breast Cancer

Monday, June 5, 2023
7:00 PM – 9:30 PM CT (8:00 PM – 10:30 PM ET)

Faculty
Komal Jhaveri, MD
Kevin Kalinsky, MD, MS
Ian E Krop, MD, PhD
Joyce O'Shaughnessy, MD
Hope S Rugo, MD
Professor Peter Schmid, FRCP, MD, PhD

Exciting CME Events in Chicago You Do Not Want to Miss

A CME Hybrid Symposium Series Held in Conjunction with the 2023 ASCO® Annual Meeting

Renal Cell Carcinoma Webinar

Tuesday, June 6, 2023

7:00 AM – 8:00 AM CT (8:00 AM – 9:00 AM ET)

Faculty

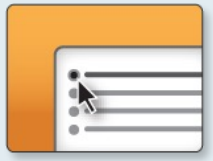
David F McDermott, MD

Sumanta Kumar Pal, MD

Clinicians in the Meeting Room

Networked iPads are available.

Review Program Slides: Tap the Program Slides button to review speaker presentations and other program content.



Answer Survey Questions: Complete the pre- and postmeeting surveys.

Ask a Question: Tap Ask a Question to submit a challenging case or question for discussion. We will aim to address as many questions as possible during the program.

Complete Your Evaluation: Tap the CME Evaluation button to complete your evaluation electronically to receive credit for your participation.

For assistance, please raise your hand. Devices will be collected at the conclusion of the activity.

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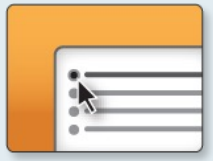
Clinicians Attending via Zoom

Review Program Slides: A link to the program slides will be posted in the chat room at the start of the program.



Answer Survey Questions: Complete the pre- and postmeeting surveys.

Ask a Question: Submit a challenging case or question for discussion using the Zoom chat room.

Get CME Credit: A CME credit link will be provided in the chat room at the conclusion of the program.

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PREMEETING SURVEY – Available Now

Clinicians in Attendance: If you have not already done so, please take a moment to complete the premeeting survey on the iPads for attendees in the room and on Zoom for those attending virtually. Your input on this survey will be integral to the program today.

A postmeeting survey will be posted toward the end of the session.

Thank you for your input.

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About the Enduring Program

- The live meeting is being video and audio recorded.
- The proceedings from today will be edited and developed into an enduring web-based video/PowerPoint program.
  An email will be sent to all attendees when the activity is available.
- To learn more about our education programs, visit our website, **www.ResearchToPractice.com**

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RTP RESEARCH TO PRACTICE

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- Adjuvant immunotherapy for GE cancers
- First-line anti-PD-1/PD-L1 antibody-based regimens for metastatic HER2-negative GE cancer
- Future role of novel immunotherapies/checkpoint inhibitors

Module 2 – Optimal Management of HER2-Positive GE Cancers

- Selection of first-line therapy for metastatic HER2-positive GE cancer
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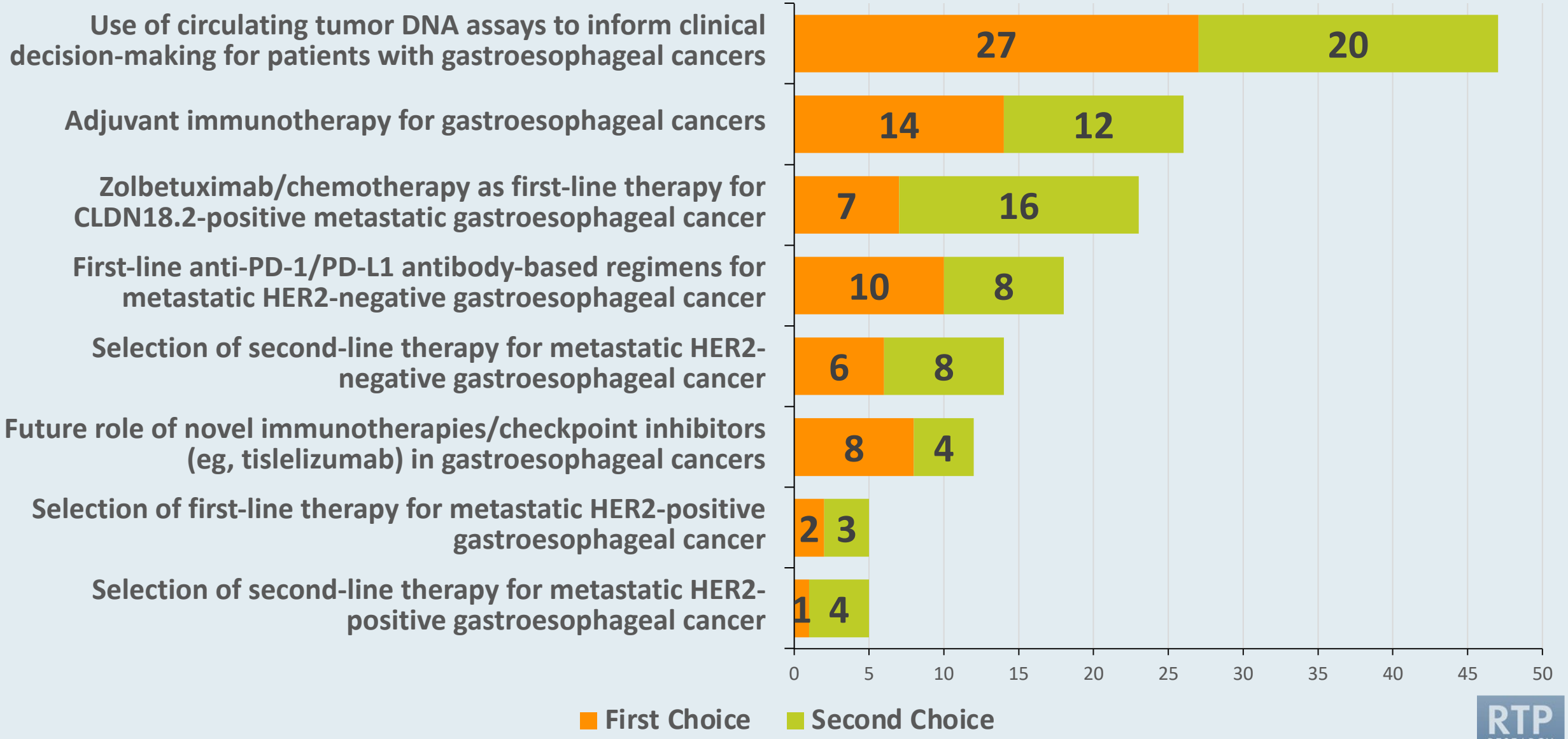
Module 3 – Therapeutic Options for Relapsed/Refractory GE Cancers; Novel Investigational Approaches

- Selection of second-line therapy for metastatic HER2-negative GE cancer
- Zolbetuximab/chemotherapy as first-line therapy for CLDN18.2-positive metastatic GE cancer
- Use of circulating tumor DNA assays in patients with GE cancers

Topics of Interest for Future CME Programs



Survey of US-based general medical oncologists, May 2023. N = 75

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Agenda

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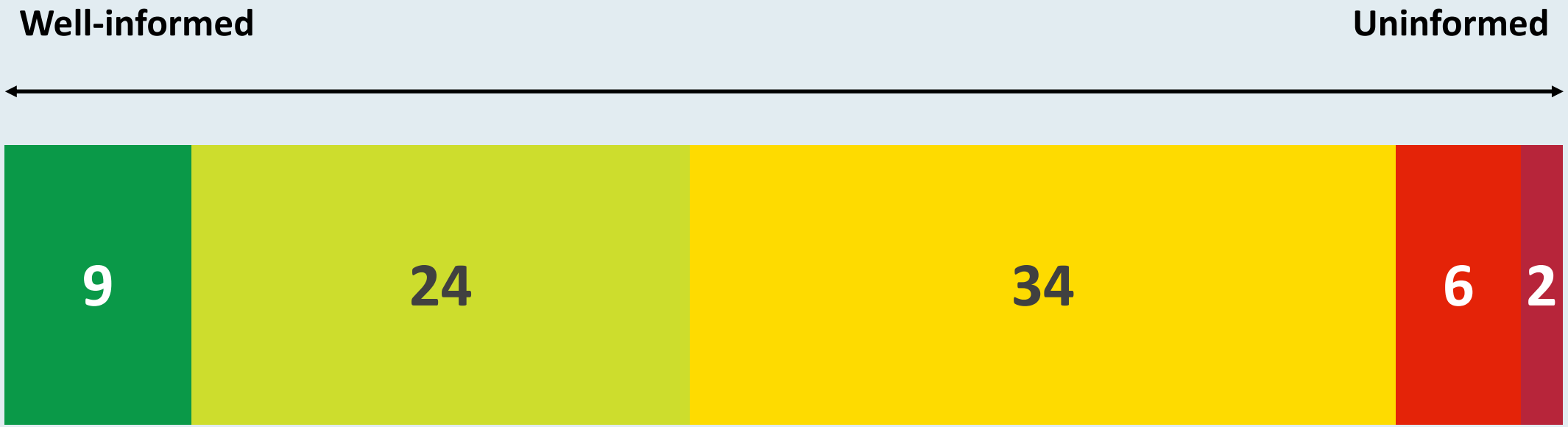
How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to adjuvant immunotherapy for localized gastroesophageal cancers?



Survey of US-based general medical oncologists, May 2023. N = 75

RTP RESEARCH TO PRACTICE

Adjuvant immunotherapy for GE cancers

- Andre T, et al. **Neoadjuvant nivolumab plus ipilimumab and adjuvant nivolumab in localized deficient mismatch repair/microsatellite instability-high gastric or esophagogastric junction adenocarcinoma: The GERCOR NEONIPIGA phase II study**. J Clin Oncol 2023;41(2):255-65
- Kelly RJ, et al. **Adjuvant nivolumab in resected esophageal or gastroesophageal junction cancer following neoadjuvant chemoradiotherapy: Expanded efficacy and safety analyses from CheckMate 577**. ASCO 2021;Abstract 4003
- Manji GA, et al. **Phase II clinical trial of perioperative pembrolizumab and chemotherapy followed by adjuvant pembrolizumab for resectable gastric/GEJ adenocarcinoma**. AACR 2022;Abstract CT009
- Terashima M et al. **ATTRACTION-5: A Phase 3 Study of Nivolumab plus Chemotherapy as Postoperative Adjuvant Treatment for Pathological Stage III (pStage III) Gastric or Gastroesophageal Junction (G/GEJ) Cancer.** ASCO 2023; Abstract 4000.

Questions from General Medical Oncologists

- **How have you changed your approach to treatment due to the recent 5-FU/capecitabine and carboplatin/cisplatin shortages?**

Survey of US-based general medical oncologists, May 2023. N = 75

Questions from General Medical Oncologists

- **73 yo male with Dx of GEJ adenocarcinoma and past med history of follicular lymphoma. Now s/p chemoradiotherapy w/ carboplatin/paclitaxel. Not surgical candidate so unsure of response to therapy. What would you do next?**

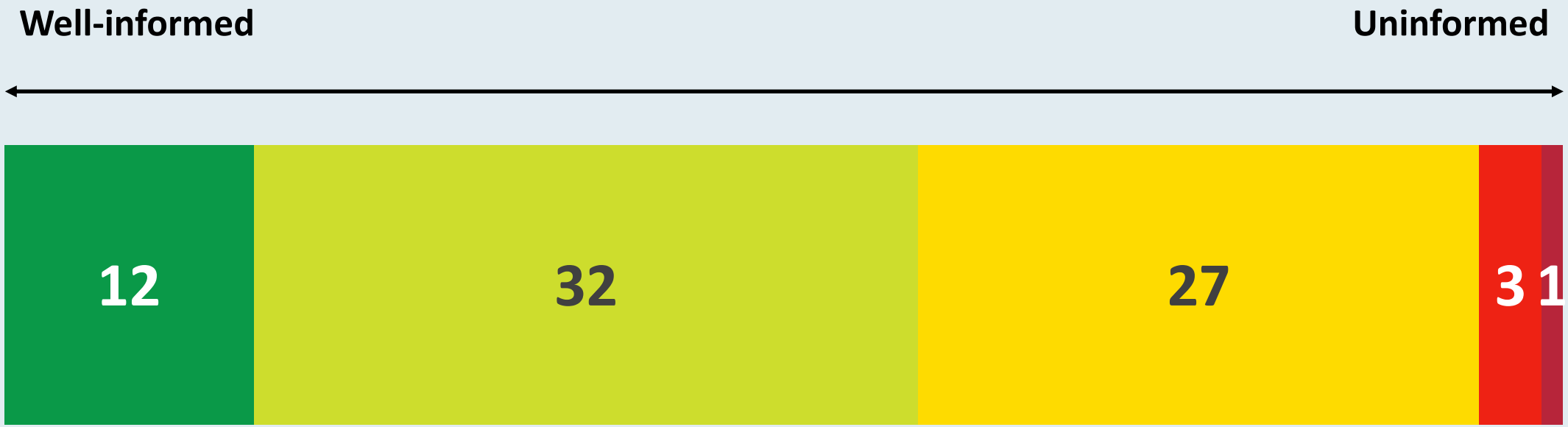
- **72 yo male has CRT for localized esophageal cancer. Pathology from surgery shows 2 nodes positive and a positive margin. The tumor is HER2-neg, Claudin 75%, PD-L1 0. What would be your suggestion for postop treatment?**

- **65 yo patient with ypT3N1 GEJ adenoCa, HER2-positive, PD-L1-negative**

- **Patient with locally advanced esophageal cancer progresses during adjuvant immunotherapy, is immunotherapy doublet an option?**

Survey of US-based general medical oncologists, May 2023. N = 75

How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to first-line anti-PD-1/PD-L1 antibody-based regimens for metastatic HER2-negative gastroesophageal cancer?



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First-line anti-PD-1/PD-L1 antibody-based regimens for metastatic HER2-negative GE cancer

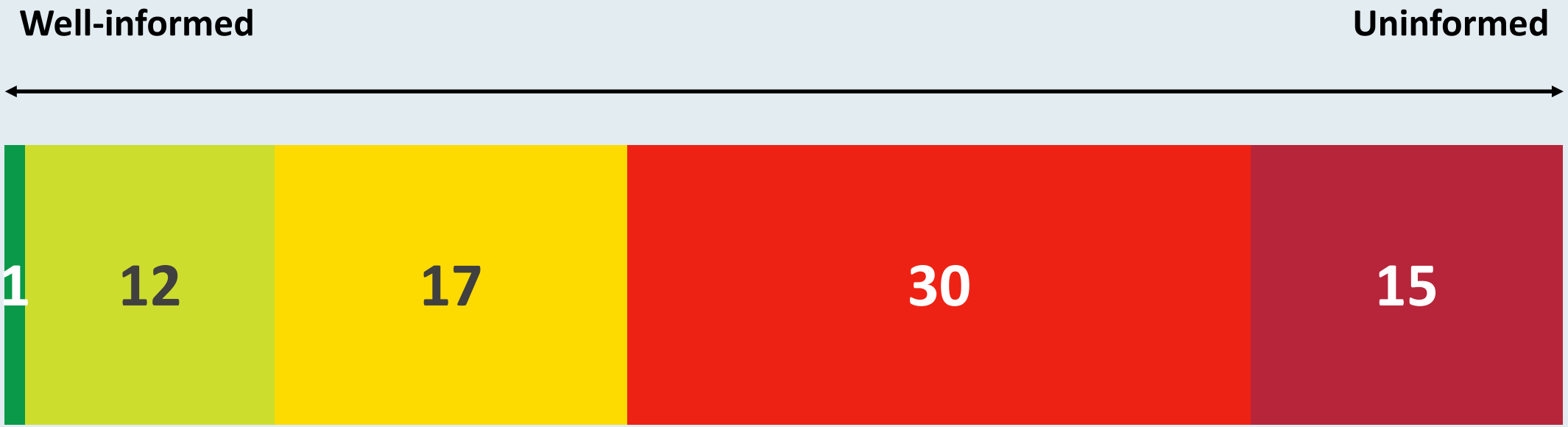
- Janjigian YY, et al. **Nivolumab plus chemotherapy vs chemotherapy as first-line treatment for advanced gastric cancer/gastroesophageal adenocarcinoma: 3-year follow-up from CheckMate 649.** ASCO GI 2023;Abstract 291
- Lei M, et al. **Nivolumab plus chemotherapy vs chemotherapy as first-line treatment for advanced gastric cancer/gastroesophageal junction cancer/esophageal adenocarcinoma: CheckMate 649 biomarker analyses.** AACR 2022;Abstract CT023
- Kato K, et al. **Nivolumab plus chemotherapy or ipilimumab vs chemotherapy as first-line treatment for advanced esophageal squamous cell carcinoma: 29-month follow-up from CheckMate 648.** ASCO GI 2023;Abstract 290
- Rah SY, et al. **Pembrolizumab plus chemotherapy as first-line therapy for advanced HER2-negative gastric or gastroesophageal junction cancer: Phase 3 KEYNOTE-859 study.** ESMO 2023;Abstract VP1-2023
- Metges JP, et al. **First-line pembrolizumab plus chemotherapy versus chemotherapy in advanced esophageal cancer: Longer-term efficacy, safety, and quality-of-life results from the phase 3 KEYNOTE-590 study.** ASCO GI 2022;Abstract 241

Questions from General Medical Oncologists

- **A 67 yo with advanced gastric cancer and a PD-L1 CPS of 3%, HER2-negative, treatment recommended**
- **65 yo patient with HER2-negative, PD-L1-negative metastatic GEJ adenoCa**
- **In someone with MMR deficiency, how much does chemotherapy add to IO alone?**
- **What is your "threshold" for omission in patients with autoimmune disorders/post-transplant on immunosuppressive meds?**
- **Could you comment on PD-L1 testing? Are all PD-L1 assays interchangeable amongst each other?**

Survey of US-based general medical oncologists, May 2023. N = 75

How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to the future role of novel immunotherapies/checkpoint inhibitors (eg, tislelizumab) in gastroesophageal cancers?



Survey of US-based general medical oncologists, May 2023. N = 75

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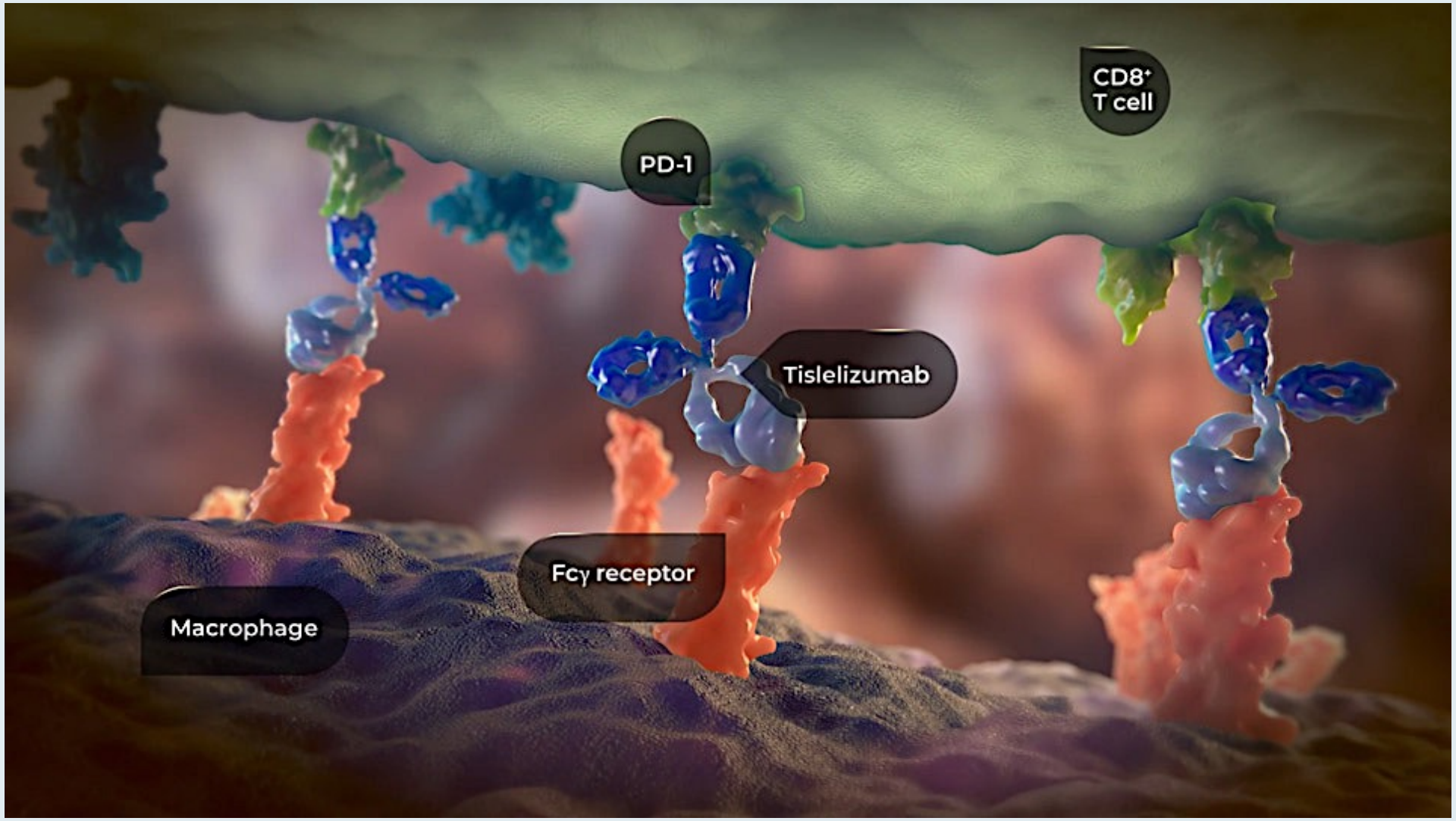
Future role of novel immunotherapies/checkpoint inhibitors

- Moehler M, et al. **RATIONALE-305: Phase 3 study of tislelizumab + chemotherapy vs placebo + chemotherapy as first-line treatment of advanced gastric or gastroesophageal junction adenocarcinoma.** ASCO GI 2023;Abstract 286
- **BeiGene Announces Positive Phase 3 Tislelizumab Trial in Advanced Gastric or Gastroesophageal Junction Adenocarcinoma. [Press Release] April 20, 2023. Available at https://ir.beigene.com/news/beigene-announces-positive-phase-3-tislelizumab-trial-in-advanced-gastric-or-gastroesophageal-junction-adenocarcinoma/dc7ae8df-dbbb-4de2-834f-0f74feaaa519/**
- Xu J, et al. **Tislelizumab plus chemotherapy versus placebo plus chemotherapy as first-line treatment for advanced or metastatic oesophageal squamous cell carcinoma (RATIONALE-306): A global, randomised, placebo-controlled, phase 3 study.** Lancet Oncol 2023;24(5):483-95

Tislelizumab: Mechanism of Action



https://www.hcp.novartis.com/virtual-congress/disease-areas/gastrointestinal-gi-cancers/

Positive Phase 3 Tislelizumab Trial in Advanced Gastric or Gastroesophageal Junction Adenocarcinoma

Press Release: April 20, 2023

"Today the manufacturer announced the global RATIONALE 305 trial met its primary endpoint of overall survival, with tislelizumab in combination with chemotherapy demonstrating superior overall survival (OS) compared with chemotherapy in patients with advanced unresectable or metastatic gastric or gastroesophageal junction (G/GEJ) adenocarcinoma, regardless of PD-L1 status. No new safety signals were identified for tislelizumab.

The manufacturer previously announced superior OS for the combination compared with chemotherapy in the PD-L1 high group at a planned interim analysis1 and the trial continued according to pre-specified statistical hierarchy testing. At the final analysis, tislelizumab, in combination with chemotherapy, demonstrated superior OS compared with chemotherapy in the intent-to-treat (ITT) population. Results will be submitted for presentation at an upcoming medical conference."

https://ir.beigene.com/news/beigene-announces-positive-phase-3-tislelizumab-trial-in-advanced-gastric-or-gastroesophageal-junction-adenocarcinoma/dc7ae8df-dbbb-4de2-834f-0f74feaaa519/

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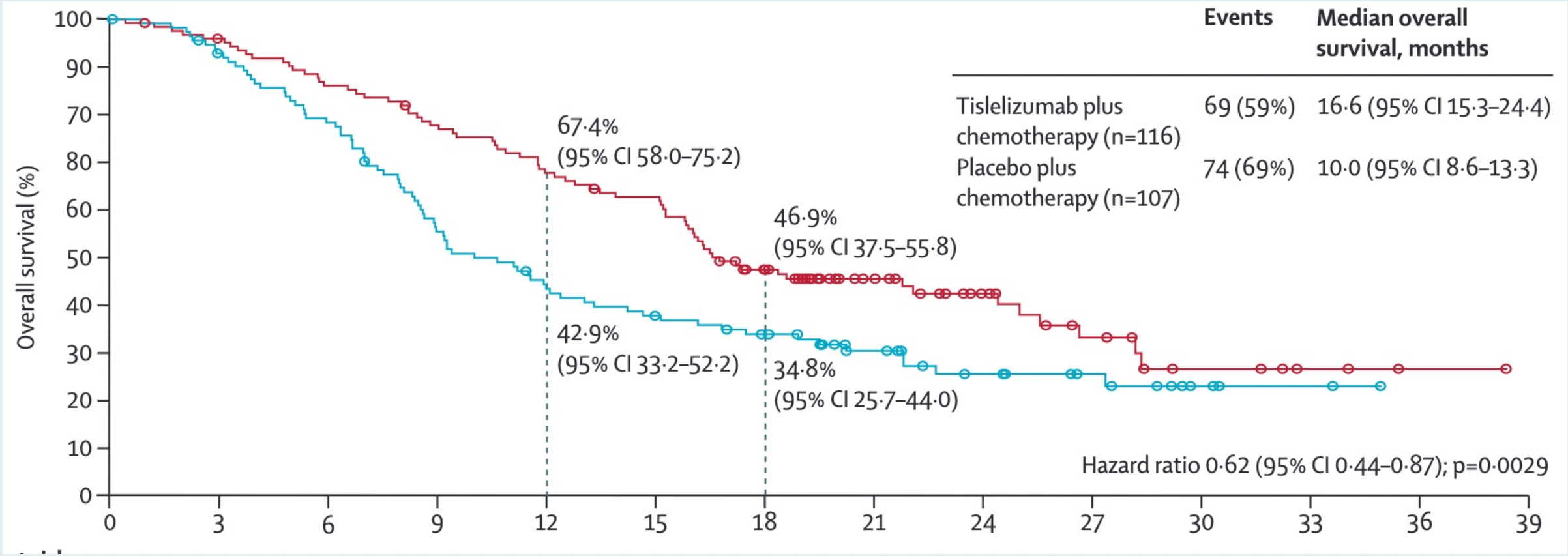
Tislelizumab plus chemotherapy versus placebo plus chemotherapy as first-line treatment for advanced or metastatic oesophageal squamous cell carcinoma (RATIONALE-306): a global, randomised, placebo-controlled, phase 3 study

Jianming Xu, Ken Kato, Eric Raymond, Richard A Hubner, Yongqian Shu, Yueyin Pan, Sook Ryun Park, Lu Ping, Yi Jiang, Jingdong Zhang, Xiaohong Wu, Yuanhu Yao, Lin Shen, Takashi Kojima, Evgeny Gotovkin, Ryu Ishihara, Lucjan Wyrwicz, Eric Van Cutsem, Paula Jimenez-Fonseca, Chen-Yuan Lin, Lei Wang, Jingwen Shi, Liyun Li, Harry H Yoon

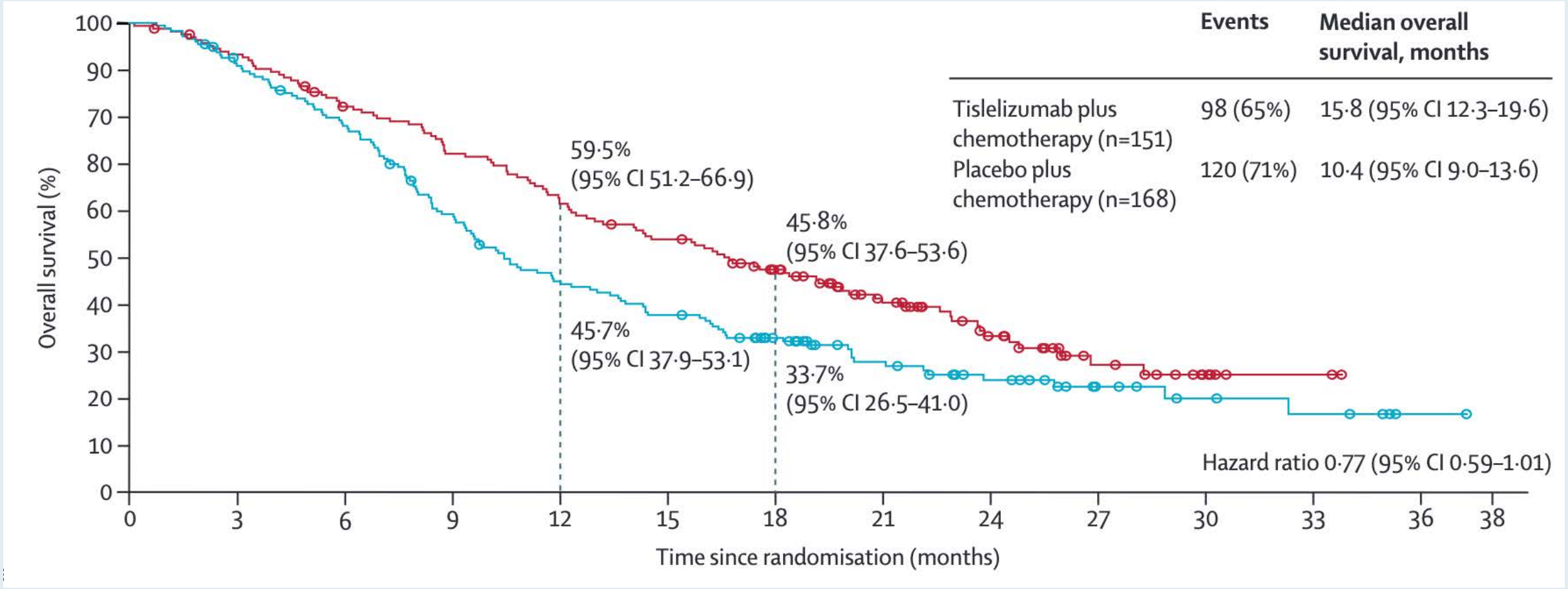
Xu J et al. *Lancet Oncol,* 2023; 24(5):483-495.

RATIONALE-306: Overall Survival in Patients with PD-L1 TAP ≥10%



Xu J et al. *Lancet Oncol,* 2023; 24(5):483-495.

RATIONALE-306: Overall Survival in Patients with PD-L1 TAP <10%



Xu J et al. *Lancet Oncol,* 2023; 24(5):483-495.

RATIONALE-306: Safety

	Tislelizumab plus chemotherapy group (n=324)				Placebo plus chemotherapy group (n=321)			
	Grade 1–2	Grade 3	Grade 4	Grade 5*	Grade 1–2	Grade 3	Grade 4	Grade 5*
Any event	97 (30%)	153 (47%)	56 (17%)	7 (2%)	102 (32%)	148 (46%)	53 (17%)	6 (2%)
Anaemia	126 (39%)	46 (14%)	1 (<1%)	0	114 (36%)	41 (13%)	0	0
Decreased white blood cell count	108 (33%)	31 (10%)	4 (1%)	0	107 (33%)	45 (14%)	5 (2%)	0
Decreased appetite	107 (33%)	9 (3%)	0	0	108 (34%)	7 (2%)	0	0
Nausea	104 (32%)	8 (2%)	0	0	125 (39%)	5 (2%)	0	0
Peripheral sensory neuropathy	63 (19%)	10 (3%)	0	0	54 (17%)	7 (2%)	0	0
Alopecia	58 (18%)	0	0	0	63 (20%)	0	0	0
Diarrhoea	54 (17%)	9 (3%)	0	0	54 (17%)	5 (2%)	0	0
Decreased neutrophil count	54 (17%)	72 (22%)	27 (8%)	0	47 (15%)	70 (22%)	35 (11%)	0
Vomiting	53 (16%)	4 (1%)	0	0	67 (21%)	6 (2%)	1 (<1%)	0
Decreased platelet count	51 (16%)	8 (2%)	1 (<1%)	0	51 (16%)	3 (1%)	0	0
Stomatitis	45 (14%)	10 (3%)	3 (1%)	0	40 (12%)	7 (2%)	0	0
Decreased weight	45 (14%)	1 (<1%)	0	0	45 (14%)	0	0	0
Increased blood creatinine	42 (13%)	1 (<1%)	0	0	27 (8%)	1 (<1%)	0	0
Constipation	42 (13%)	0	0	0	40 (12%)	1 (<1%)	0	0
Increased aspartate aminotransferase	37 (11%)	4 (1%)	1 (<1%)	0	27 (8%)	1 (<1%)	1 (<1%)	0
Increased alanine aminotransferase	36 (11%)	5 (2%)	0	0	28 (9%)	4 (1%)	1 (<1%)	0
Hypoalbuminaemia	36 (11%)	0	0	0	25 (8%)	0	0	0
Fatigue	35 (11%)	13 (4%)	0	0	45 (14%)	8 (2%)	0	0
Malaise	35 (11%)	5 (2%)	1 (<1%)	0	47 (15%)	3 (1%)	0	0
Pruritis	34 (10%)	0	0	0	19 (6%)	0	0	0
Asthenia	33 (10%)	4 (1%)	0	0	38 (12%)	1 (<1%)	0	0
Hypoaesthesia	33 (10%)	1 (<1%)	0	0	39 (12%)	1 (<1%)	0	0
Hypothyroidism	31 (10%)	0	0	0	14 (4%)	0	0	0
Neutropaenia	29 (9%)	16 (5%)	7 (2%)	0	15 (5%)	19 (6%)	12 (4%)	0
Hypokalaemia	22 (7%)	17 (5%)	1 (<1%)	0	15 (5%)	7 (2%)	2 (1%)	0
Hyponatraemia	19 (6%)	17 (5%)	5 (2%)	0	23 (7%)	9 (3%)	1 (<1%)	0

Xu J et al. *Lancet Oncol,* 2023; 24(5):483-495.

Questions from General Medical Oncologists

- **In absence of comparative data, how will we decide between checkpoint pathway inhibitor classes?**
- **Does this antibody with its alternative mechanism of action have greater efficacy than currently approved antibodies in conjunction with chemotherapy?**
- **I wonder about response rate of tislelizumab after having used IOs before.**
- **I have a 53 yo man who has been on FOLFOX/nivo followed by capecitabine/nivo for 15 months. He is now slowly progressing. Should I continue his IO and switch the chemo backbone or stop the IO altogether?**
- **What do alternative immune response inhibitors such as for LAG3 and TIM show in GE ca?**

Survey of US-based general medical oncologists, May 2023. N = 75

Agenda

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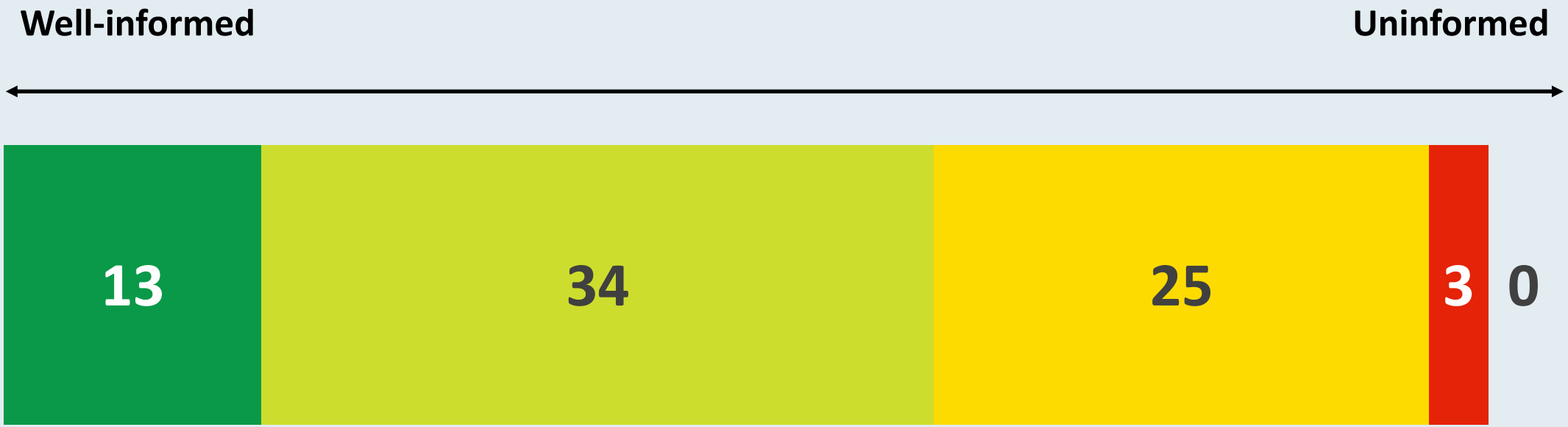
- Use of circulating tumor DNA assays in patients with GE cancers

How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to selection of first-line therapy for metastatic HER2-positive gastroesophageal cancer?



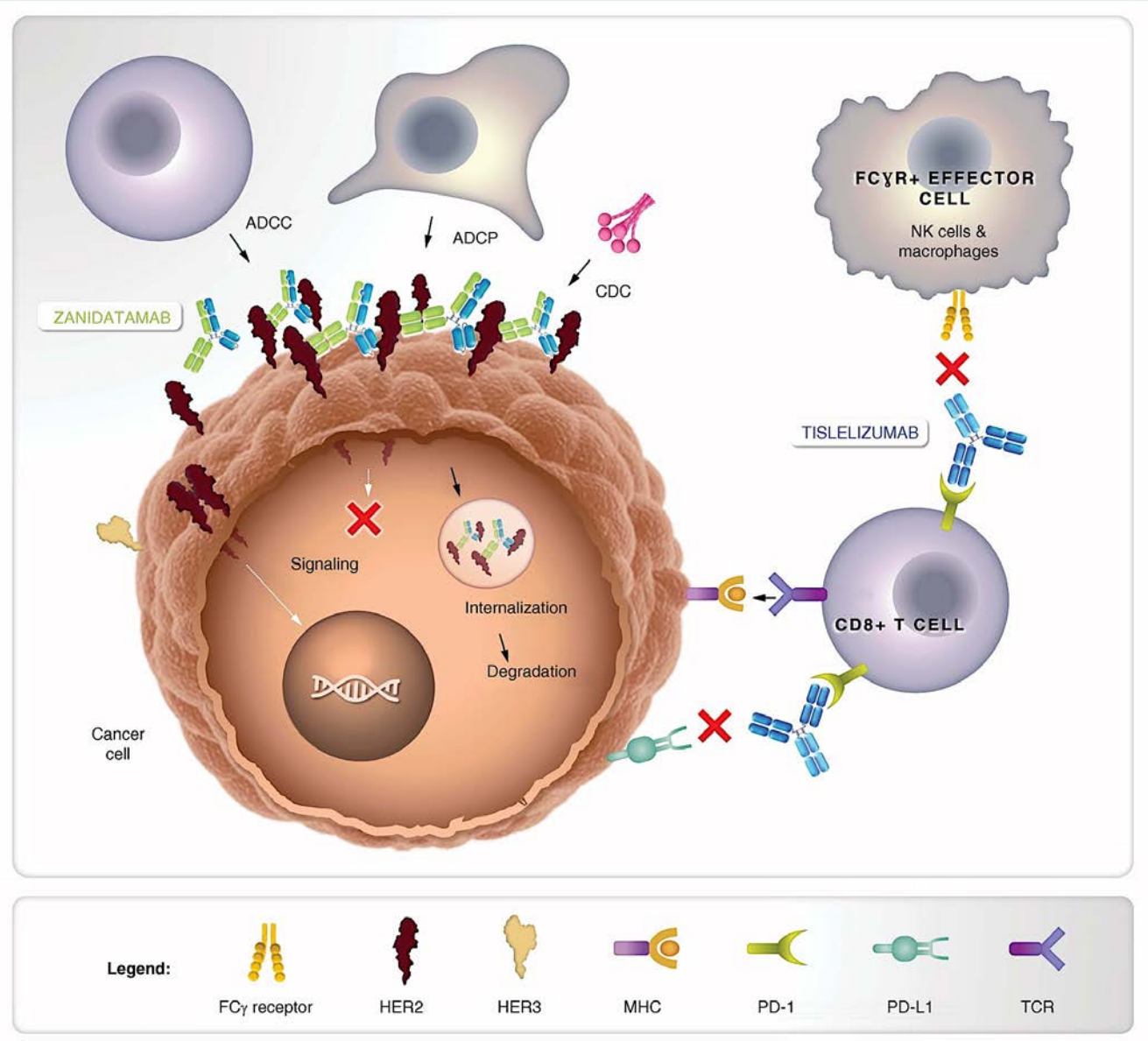
Survey of US-based general medical oncologists, May 2023. N = 75

RTP RESEARCH TO PRACTICE

Selection of first-line therapy for metastatic HER2-positive GE cancer

- Janjigian YY, et al. **Pembrolizumab plus trastuzumab and chemotherapy for HER2+ metastatic gastric or gastroesophageal junction cancer: Initial findings of the global phase 3 KEYNOTE-811 study.** ESMO GI 2021;Abstract LBA4
- Yamaguchi K, et al. **Trastuzumab Deruxtecan in anti-human epidermal growth factor receptor 2 treatment-naïve patients with human epidermal growth factor receptor 2-low gastric or gastroesophageal junction adenocarcinoma: Exploratory cohort results in a phase II trial.** J Clin Oncol 2023;41(4):816-25
- Elimova E, et al. **Zanidatamab + chemotherapy as first line treatment for HER2-expressing metastatic gastroesophageal adenocarcinoma (mGEA).** ASCO GI 2023;Abstract 347

Zanidatamab: Mechanism of Action



Tabernero J et al. *Future Oncol* 2022;18(29):3255-66.

Zanidatamab + Chemotherapy as First-Line Treatment for HER2-Expressing mGEA: Response

Table 2: Response Rates and DOR in Patients with HER2-Expressing mGEA (Response-evaluable)

	Zanidatamab + CAPOX (n =18)	Zanidatamab + mFOLFOX6 (n = 18)	Zanidatamab + FP (n = 2)	Total (N = 38)
Confirmed objective response rate[a], % (95% CI)	89 (65, 99)	67 (41, 87)	100 (16, 100)	79 (63, 90)
Confirmed best overall response, n (%)				
Complete response	2 (11)	1 (6)	0	3 (8)
Partial response	14 (78)	11 (61)	2 (100)	27 (71)
Stable disease	2 (11)	3 (17)	0	5 (13)
Progressive disease	0	3 (17)	0	3 (8)
Disease control rate, % (95% CI)	100 (82, 100)	83 (59, 96)	100 (16, 100)	92 (79, 98)
Median duration of response (95% CI), months	10.4 (5.7, NE)	NE (2.8, NE)	NE (6.8, NE)	20.4 (8.3, NE)

a. Based on a baseline scan and a confirmatory scan obtained ≥4 weeks following initial documentation of objective response.
CI = confidence interval; DOR = duration of response; NE = not estimable.

FP = 5-FU/cisplatin

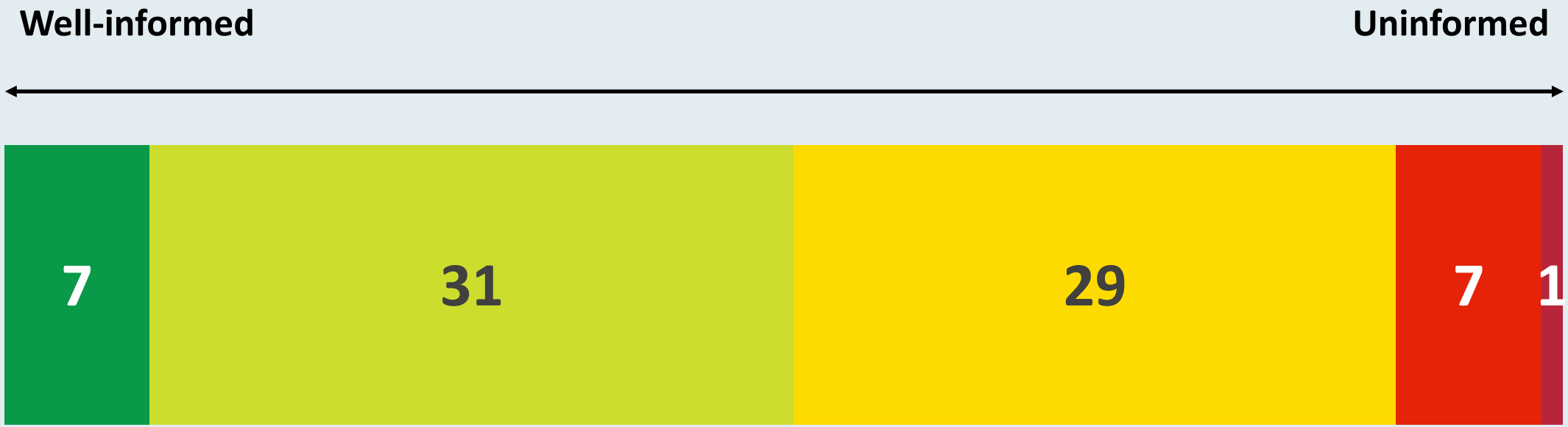
Elimova E et al. Gastrointestinal Cancers Symposium 2023;Abstract 347.

Questions from General Medical Oncologists

- **Should all HER2+ patients receive pembrolizumab in addition to chemotherapy/trastuzumab?**
- **Use of HER2 agents in neoadjuvant setting**
- **I have a 76 yo man with COPD with HER2+ adenoCa of GE junction. He is not on oxygen, but he can only walk one block. Is trastuzumab deruxtecan contraindicated? Would you defer it to third line?**
- **78 yo PS 2, advanced gastric cancer HER2+, PD-L1 14%, refuses chemotherapy**
- **Any role for T-DXd in 1st line?**
- **Do you avoid HER2-directed therapies in patients with underlying heart failure? If not, how do you manage such patients?**

Survey of US-based general medical oncologists, May 2023. N = 75

How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to selection of second-line therapy for metastatic HER2-positive gastroesophageal cancer?



Survey of US-based general medical oncologists, May 2023. N = 75

RTP RESEARCH TO PRACTICE

Selection of second-line therapy for metastatic HER2-positive GE cancer

- Ku G, et al. **Updated analysis of DESINTY-Gastric02: A phase 2 single-arm trial of trastuzumab deruxtecan (T-DXd) in Western patients with HER2-positive unresectable/metastatic gastric/gastroesophageal junction (GEJ) cancer who progressed on or after trastuzumab-containing regimen.** ESMO 2023;Abstract 1205MO
- Yamaguachi K, et al. **Trastuzumab Deruxtecan (T-DXd; DS-8201) in patients with HER2-positive advanced gastric or gastroesophgeal junction (GEJ) adenocarcinoma: Final Overall Survival (OS) results from a randomized, multicenter, open-label, phase 2 study (DESTINY-Gastric01).** ASCO GI 2022;Abstract 242

Questions from General Medical Oncologists

- **72 yo advanced gastric cancer, 28 mo post FOLFOX/trastuzumab/pembro with lung mets, rebiopsy HER2 Fish 2, IHC 1+, history of bypass 7 months ago**
- **For 2L HER2-positive adenocarcinoma, do you prefer trastuzumab deruxtecan or ramucirumab and paclitaxel?**
- **Role of T-DXd in HER2-low GI cancers? What about HER2-mutated pts?**
- **Do you repeat HER2neu testing on new biopsy? If so, how often?**
- **Your experience with cardiotoxicity and pneumonitis for deruxtecan**

Survey of US-based general medical oncologists, May 2023. N = 75

Questions from General Medical Oncologists (con't)

- **What would be your second line for patients who developed autoimmune pneumonitis on FOLFOX + nivo + trastuzumab and progressed after 10 months from starting the above therapy?**
- **How and how often are you monitoring pulmonary function in patients receiving trastuzumab deruxtecan?**
- **What would be your go-to regimen for recurrence of HER2 GE cancer with brain mets?**
- **Any clinical trials looking at other combination options with tucatinib?**

Survey of US-based general medical oncologists, May 2023. N = 75

Agenda

Module 1 – Integration of Immune Checkpoint Inhibitors into the Management of HER2-Negative Gastroesophageal (GE) Cancers

- Adjuvant immunotherapy for GE cancers
- First-line anti-PD-1/PD-L1 antibody-based regimens for metastatic HER2-negative GE cancer
- Future role of novel immunotherapies/checkpoint inhibitors

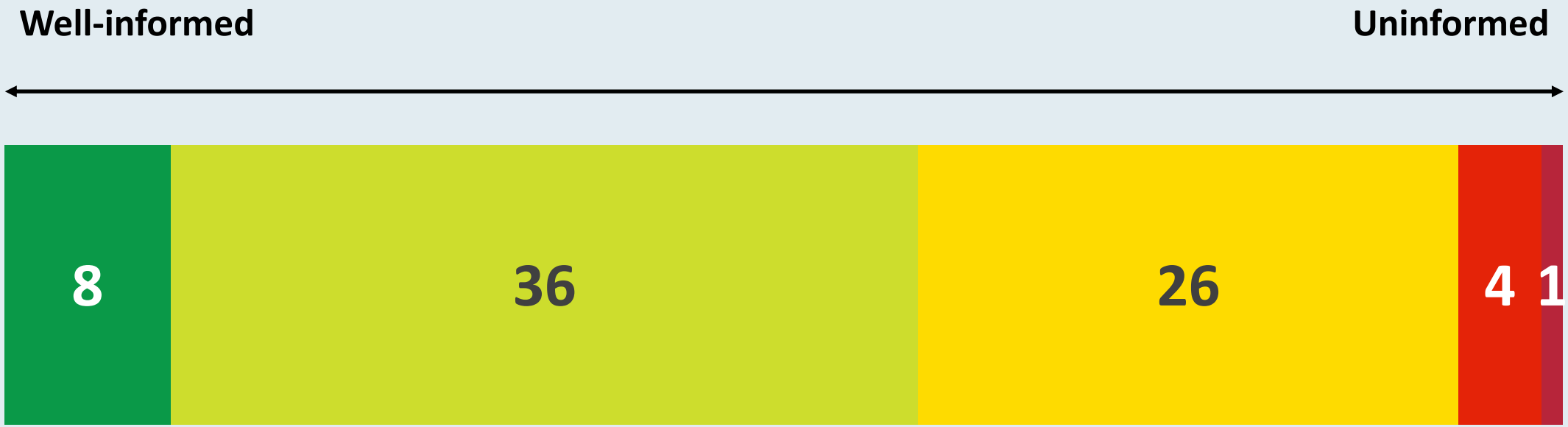
Module 2 – Optimal Management of HER2-Positive GE Cancers

- Selection of first-line therapy for metastatic HER2-positive GE cancer
- Selection of second-line therapy for metastatic HER2-positive GE cancer

Module 3 – Therapeutic Options for Relapsed/Refractory GE Cancers; Novel Investigational Approaches

- Selection of second-line therapy for metastatic HER2-negative GE cancer
- Zolbetuximab/chemotherapy as first-line therapy for CLDN18.2-positive metastatic GE cancer
- Use of circulating tumor DNA assays in patients with GE cancers

How comfortable/familiar are you with the published data sets, available guidelines, investigator perspectives and ongoing research studies pertaining to selection of second-line therapy for metastatic HER2-negative gastroesophageal cancer?



Survey of US-based general medical oncologists, May 2023. N = 75

RTP RESEARCH TO PRACTICE

Selection of second-line therapy for metastatic HER2-negative GE cancer

- Lorenzen S, et al. **FOLFIRI plus ramucirumab versus paclitaxel plus ramucirumab as second-line therapy for patients with advanced or metastatic gastroesophageal adenocarcinoma with or without prior docetaxel – Results from the phase II RAMIRIS study of the German Gastric Cancer Study Group at AIO.** Eur J Cancer 2022;165:48-57
- Goetze TO et al. **Ramucirumab beyond progression plus TAS 102 in patients with advanced or metastatic adenocarcinoma of the stomach or the gastroesophageal junction, after treatment failure on a ramucirumab-based therapy: Final results of the phase II RE-ExPEL study.** ASCO GI 2023;Abstract 359

Questions from General Medical Oncologists

- **How would you treat a 69 yo, no comorbidities, ECOG 0, HER2-negative GE cancer patient, who had received preoperative chemotherapy for a locally advanced resectable tumor and underwent surgery, and progressed 4 months post-surgery while on adjuvant immunotherapy?**

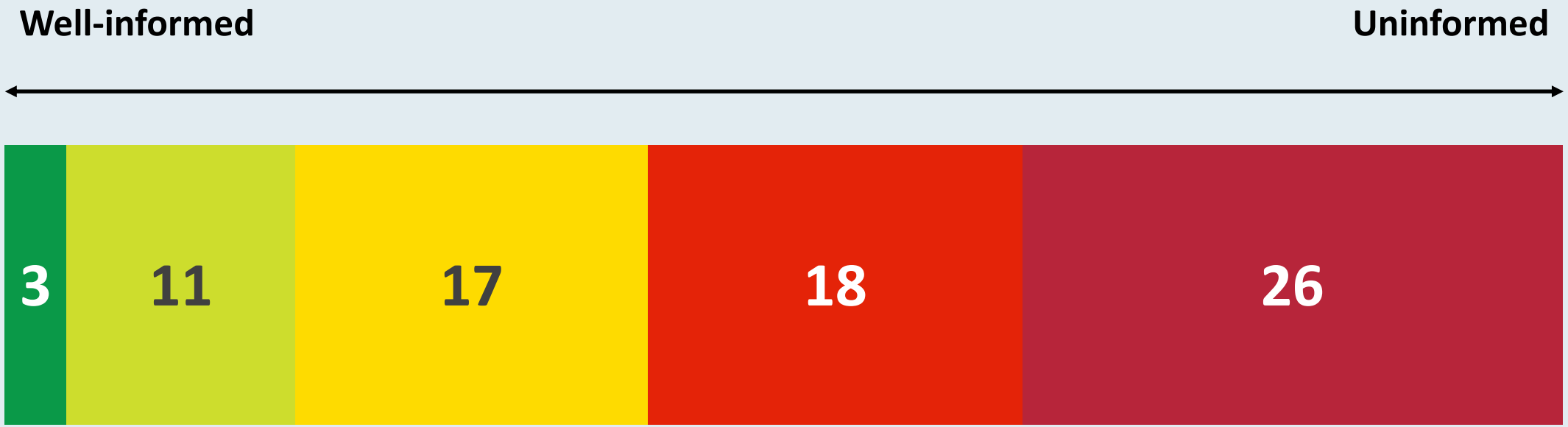
- **How do you select patients to receive taxane alone vs taxane + ramucirumab?**

- **For patients who have progressed within six months after chemoradiotherapy, curative intent surgery and adjuvant immunotherapy, is there a role for re-challenge with immunotherapy?**

- **For a patient with Grade 2 neuropathy or higher, which second-line regimen?**

Survey of US-based general medical oncologists, May 2023. N = 75

How comfortable/familiar are you with the published data sets, investigator perspectives and ongoing research studies pertaining to zolbetuximab/chemotherapy as first-line therapy for CLDN18.2-positive metastatic gastroesophageal cancer?



Survey of US-based general medical oncologists, May 2023. N = 75

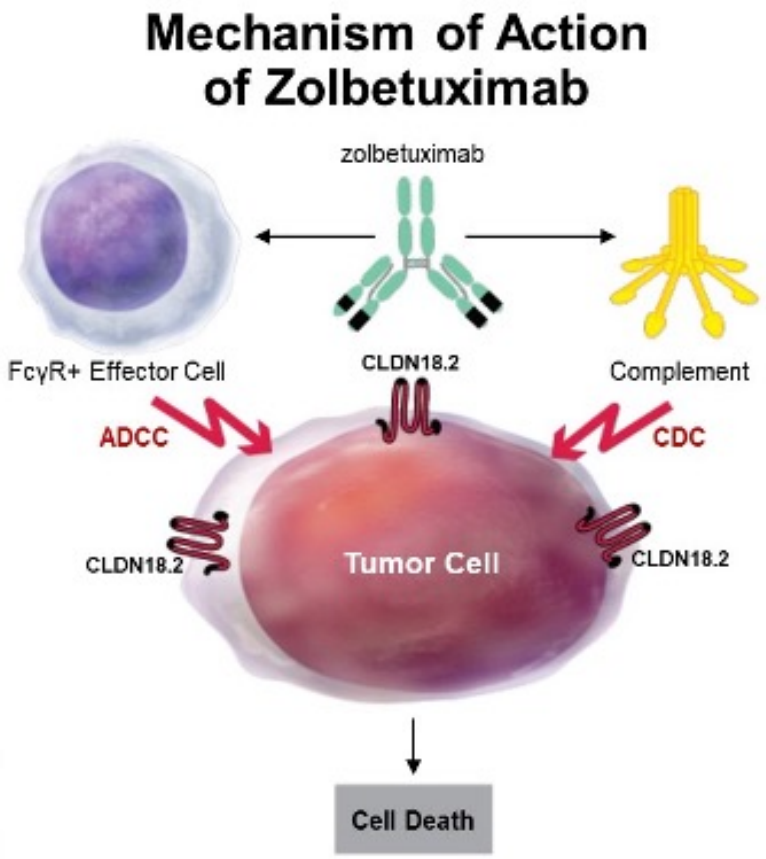
RTP RESEARCH TO PRACTICE

Zolbetuximab/chemotherapy as first-line therapy for CLDN18.2-positive metastatic GE cancer

- Shitara K, et al. **Zolbetuximab + mFOLFOX6 as 1L treatment for patients with CLDN18.2+/HER2- locally advanced (LA) unresectable or metastatic gastric or gastroesophageal junction (mG/GEJ) adenocarcinoma: Primary phase 3 results from SPOTLIGHT.** ASCO GI 2023;Abstract LBA292
- Shah M et al. **Zolbetuximab + CAPOX in 1L claudin-18.2+ (CLDN18.2+)/HER2– locally advanced (LA) or metastatic gastric or gastroesophageal junction (mG/GEJ) adenocarcinoma: Primary phase 3 results from GLOW.** ASCO Plenary Series 2023;Abstract 405736

Mechanism of Action of Zolbetuximab

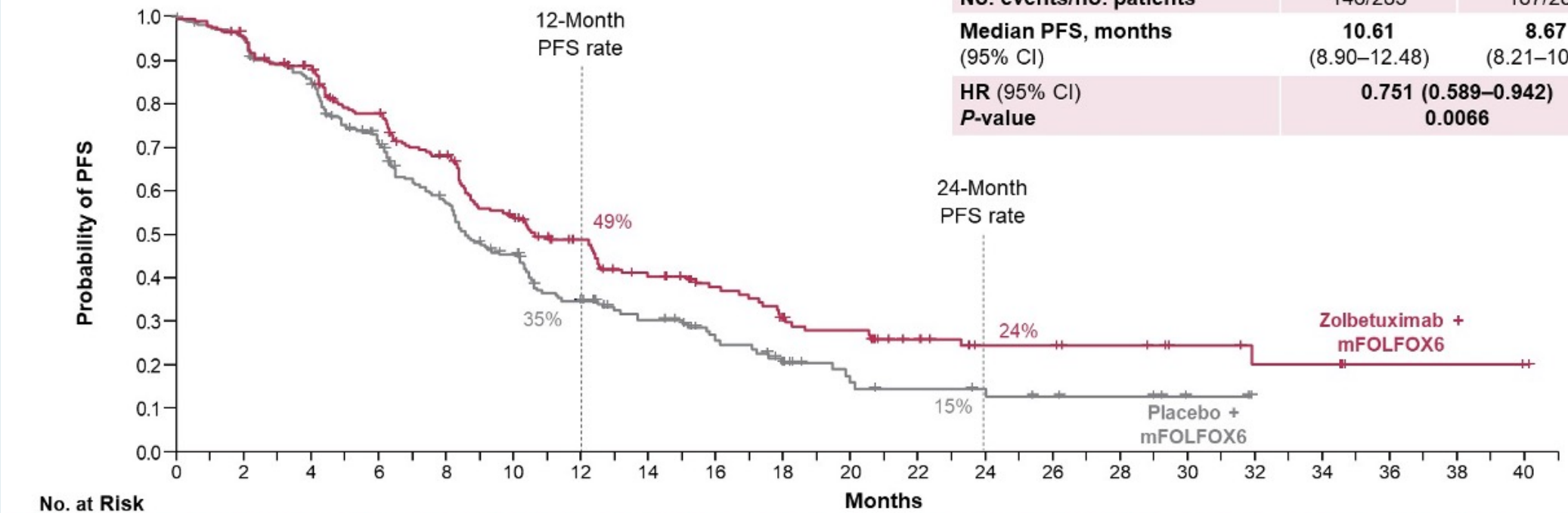
- CLDN18.2 is a tight junction protein normally expressed in gastric mucosa cells and retained in G/GEJ adenocarcinoma[1–8]
- CLDN18.2 may become exposed on the surface of G/GEJ adenocarcinoma cells, making it a promising target[2–8]
- Zolbetuximab is a first-in-class chimeric IgG1 monoclonal antibody that targets CLDN18.2 and induces ADCC/CDC[4–8]
- In the phase 2b FAST study, EOX ± zolbetuximab prolonged survival in a subgroup of patients with higher expression of CLDN18.2 in tumor cells[8]
  - mPFS: 9.0 vs 5.7 months with zolbetuximab + EOX vs EOX alone
  - mOS: 16.5 vs 8.9 months with zolbetuximab + EOX vs EOX alone



Shitara K et al. Gastrointestinal Cancers Symposium 2023;Abstract LBA292.

SPOTLIGHT: Progression-Free Survival (Primary Endpoint)

	Zolbetuximab + mFOLFOX6	Placebo + mFOLFOX6
No. events/no. patients	146/283	167/282
Median PFS, months (95% CI)	**10.61** (8.90–12.48)	**8.67** (8.21–10.28)
HR (95% CI)	**0.751 (0.589–0.942)**	
***P*-value**	**0.0066**	



No. at Risk

Zolbetuximab + mFOLFOX6	283	263	254	232	226	190	187	148	143	108	102	84	78	59	56	53	43	40	33	28	28	21	19	17	12	12	12	10	10	9	7	7	5	5	5	2	2	2	2	2	1	0
Placebo + mFOLFOX6	282	273	260	237	226	183	168	136	122	91	83	60	56	43	40	38	26	25	19	14	12	9	9	9	8	7	6	5	5	4	2	2	0	0	0	0	0	0	0	0	0	0

- PFS was significantly longer in patients treated with zolbetuximab + mFOLFOX6 vs placebo + mFOLFOX6

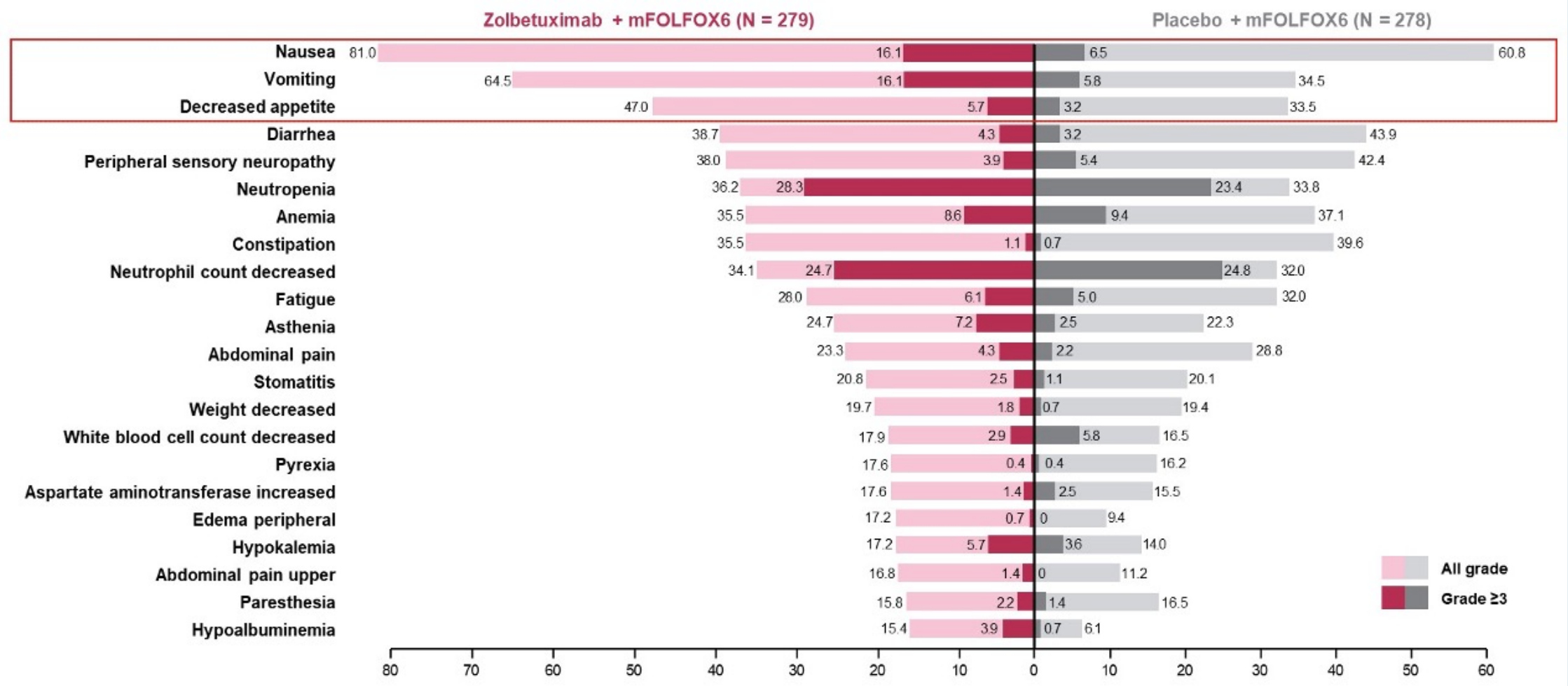
Data cutoff: September 9, 2022; Median follow-up = 12.94 months (zolbetuximab + mFOLFOX6) vs 12.65 months (placebo + mFOLFOX6).

[a]Per RECIST version 1.1.

Shitara K et al. Gastrointestinal Cancers Symposium 2023;Abstract LBA292.

RTP RESEARCH TO PRACTICE

SPOTLIGHT: TEAEs Occurring in ≥15% of All Patients Who Received Treatment



- The most common TEAEs with zolbetuximab + mFOLFOX6 were nausea and vomiting as on-target effects

Shitara K et al. Gastrointestinal Cancers Symposium 2023;Abstract LBA292.

Questions from General Medical Oncologists

- **What is the mechanism of action of this drug, and how does it synergize with traditional chemotherapy? How well is the drug tolerated?**
- **Presuming zolbetuximab becomes FDA approved, how would you factor in its use first line with a CPI?**
- **Why did both arms in the SPOTLIGHT trial have similar response rates with differences in overall survival? Is 2 months' absolute increase in overall survival beneficial with a 20% increase in toxicity? [Higher rate of GI side effects]**
- **The issue with "zolbie" is claudin 18.2 testing at the time of diagnosis. This is not a test that NGS tests for, given that it is IHC testing. How do we get pathologists on board that this needs to be tested as standard of care?**

Survey of US-based general medical oncologists, May 2023. N = 75

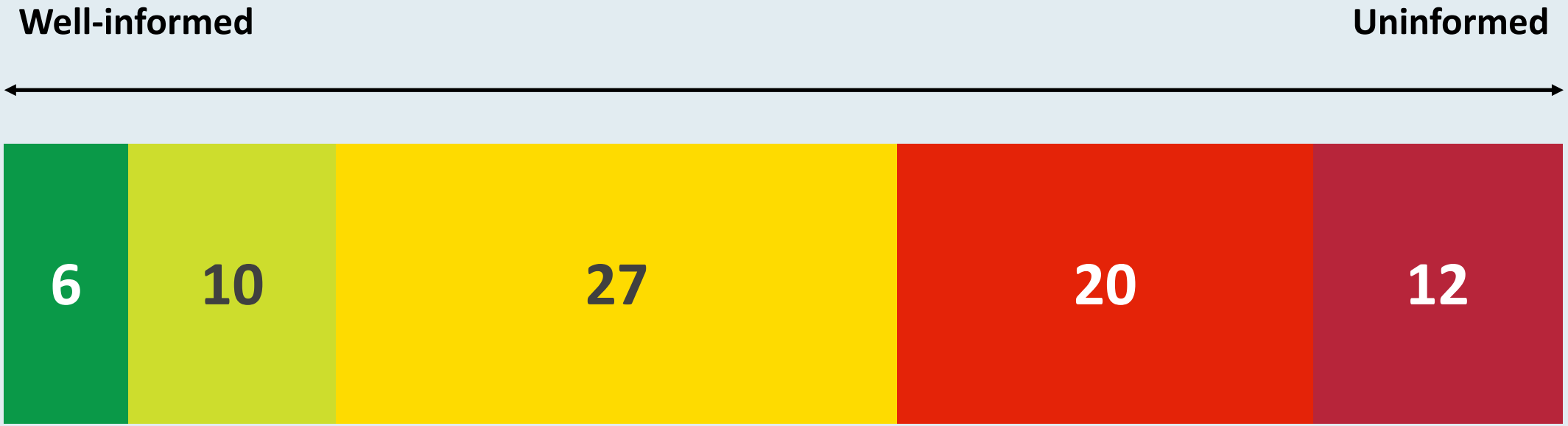
Questions from General Medical Oncologists (con't)

- **A 68 yo presented with metastatic HER2-neg gastric cancer. He progresses on FOLFOX. He has a CPS of 10 and a claudin level of 70% and presuming zolbetuximab is approved, what would be your treatment?**

- **67 yo with metastatic HER2-positive GE junction cancer has CPS of 30 and Claudin 75 (presuming zolbetuximab is FDA approved) What would be your recommended treatment and sequence?**

Survey of US-based general medical oncologists, May 2023. N = 75

How comfortable/familiar are you with the published data sets, investigator perspectives and ongoing research studies pertaining to the use of circulating tumor DNA assays to inform clinical decision-making for patients with gastroesophageal cancers?



Survey of US-based general medical oncologists, May 2023. N = 75

RTP RESEARCH TO PRACTICE

Questions from General Medical Oncologists

- **What stages of gastroesophageal cancer would you use CT DNA in?**
- **70 yo with locally advanced esophageal cancer s/p definitive chemoradiation and surgery with complete pCR. Pt is clinically well but ctDNA starts to rise after 6 months. Imaging is negative for any suspicious mass. How do you proceed?**
- **A 63 yo male with node-positive GE junction cancer has neo-adj CRT and then surgery. The tumor is fully resected. At one month after surgery, his Signatera test is negative. How would this affect your treatment plan?**

Survey of US-based general medical oncologists, May 2023. N = 75

Impediments you have encountered in delivering high-quality care to patients with gastroesophageal cancers

- **Decisions need to be made fast; info is needed within enough time to start treatment before they deteriorate**
- **Patients with Stage 4 GE junction cancers tend to decline pretty quickly after progression with first-line therapy. It's a bit of a challenge.**
- **Molecular testing often slow.**
- **One barrier continues to be ensuring adequate nutritional support for chemoradiotherapy-based regimens, even in those with gastrostomy or jejunostomy tubes. We have a long way to go to minimize toxicities, especially for those needing large radiotherapy treatment fields.**

Survey of US-based general medical oncologists, May 2023. N = 75

RTP RESEARCH TO PRACTICE

APPENDIX

Localized Gastric/GEJ Cancers

original reports

Neoadjuvant Nivolumab Plus Ipilimumab and Adjuvant Nivolumab in Localized Deficient Mismatch Repair/Microsatellite Instability–High Gastric or Esophagogastric Junction Adenocarcinoma: The GERCOR NEONIPIGA Phase II Study

Thierry André, MD[1]; David Tougeron, MD, PhD[2]; Guillaume Piessen, MD, PhD[3]; Christelle de la Fouchardière, MD[4]; Christophe Louvet, MD, PhD[5]; Antoine Adenis, MD, PhD[6]; Marine Jary, MD[7]; Christophe Tournigand, MD, PhD[8]; Thomas Aparicio, MD, PhD[9]; Jérôme Desrame, MD[10]; Astrid Lièvre, MD, PhD[11]; Marie-Line Garcia-Larnicol, MD[12]; Thomas Pudlarz, MD[1]; Romain Cohen, MD, PhD[1]; Salomé Memmi, MD, PhD[13]; Dewi Vernerey, PhD[14,15]; Julie Henriques, MSc[14,15]; Jérémie H. Lefevre, MD, PhD[16]; and Magali Svrcek, MD, PhD[13]

J Clin Oncol 2023 January 10;41(2):255-65.

NEONIPIGA: Efficacy

N = 32		
Underwent surgery	**R0 resection**	**pCR**
29/32*	29/29 (100%)	17/29 (58.6%)

* Three patients did not have surgery and had a complete endoscopic response with tumor-free biopsies and normal CT scans

André T et al. *J Clin Oncol* 2023 January 10;41(2):255-65.

NEONIPIGA: Safety

TRAE	All Patients (N = 32)	
	Any Grade, No. (%)	Grade 3-4, No. (%)
Any TRAE max/patients	24 (75)	6 (19)
Any TRAE leading to discontinuation	5 (16)	5 (16)
Diarrhea	4 (13)	1 (3)
Colitis/ileitis	2 (6)	2 (6)
Fatigue	5 (16)	0 (0)
Pruritus	8 (25)	0 (0)
Pyrexia/fever/chills	1 (3)	0 (0)
Hepatitis (increased AST/ALT)	3 (9)	2 (6)
Adrenal insufficiency/ hypophysitis	1 (3)	0 (0)
Vomiting	1 (3)	1 (3)
Nausea	1 (3)	0 (0)
Rash	4 (13)	0 (0)
Hypothyroidism	3 (9)	0 (0)
Hyperthyroidism	7 (22)	0 (0)
Pancreatitis	1 (3)	0 (0)
Others	9 (28)	2 (6)[a]

TRAE = treatment-related adverse event

André T et al. *J Clin Oncol* 2023 January 10;41(2):255-65.

2021 ASCO ANNUAL MEETING

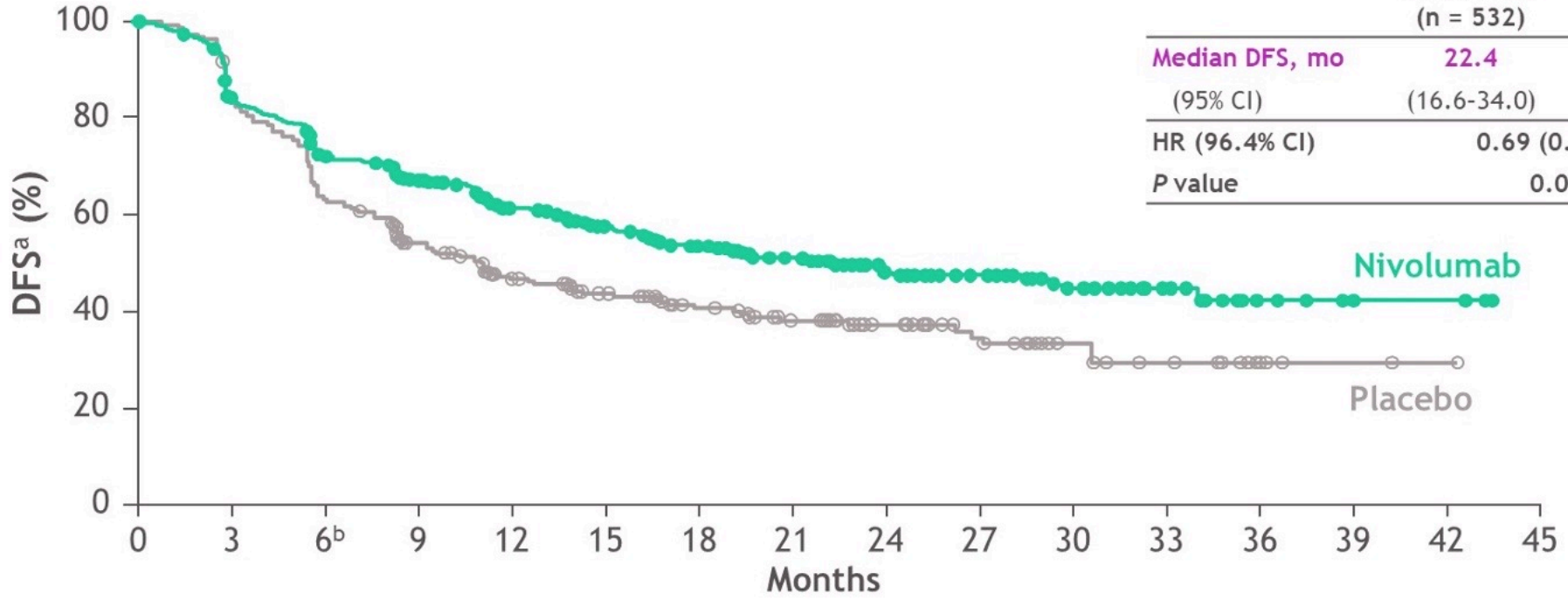
Adjuvant nivolumab in resected esophageal or gastroesophageal junction cancer following neoadjuvant chemoradiotherapy: expanded efficacy and safety analyses from CheckMate 577

Ronan J. Kelly,[1] Jaffer A. Ajani,[2] Jaroslaw Kuzdzal,[3] Thomas Zander,[4] Eric Van Cutsem,[5] Guillaume Piessen,[6] Guillermo Mendez,[7] Josephine Feliciano,[8] Satoru Motoyama,[9] Astrid Lièvre,[10] Hope Uronis,[11] Elena Elimova,[12] Cecile Grootscholten,[13] Karen Geboes,[14] Jenny Zhang,[15] Samira Soleymani,[15] Ming Lei,[15] Prianka Singh,[15] James M. Cleary,[16] Markus Moehler[17]

[1]The Charles A. Sammons Cancer Center at Baylor University Medical Center, Dallas, TX; [2]The University of Texas MD Anderson Cancer Center, Houston, TX; [3]Jagiellonian University, John Paul II Hospital, Cracow, Poland; [4]University Hospital of Cologne, Cologne, Germany; [5]University Hospitals Gasthuisberg, Leuven and KULeuven, Leuven, Belgium; [6]University of Lille, Claude Huriez University Hospital, Lille, France; [7]Fundacion Favaloro, Buenos Aires, Argentina; [8]Johns Hopkins Sidney Kimmel Comprehensive Cancer Center, Baltimore, MD; [9]Akita University Hospital, Akita, Japan; [10]CHU Pontchaillou, Rennes 1 University, Rennes, France; [11]Duke Cancer Institute, Durham, NC; [12]Princess Margaret Cancer Centre, Toronto, ON, Canada; [13]Netherlands Cancer Institute-Antoni van Leeuwenhoek Hospital, Amsterdam, Netherlands; [14]UZ Gent, Gent, Belgium; [15]Bristol Myers Squibb, Princeton, NJ; [16]Dana Farber Cancer Institute, Boston, MA; [17]Johannes-Gutenberg University Clinic, Mainz, Germany

Abstract number 4003

CheckMate 577: Disease-Free Survival (DFS)



	Nivolumab (n = 532)	Placebo (n = 262)
Median DFS, mo	22.4	11.0
(95% CI)	(16.6-34.0)	(8.3-14.3)
HR (96.4% CI)	0.69 (0.56-0.86)	
P value	0.0003[c]	

No. at risk																
Nivolumab	532	430	364	306	249	212	181	147	92	68	41	22	8	4	3	0
Placebo	262	214	163	126	96	80	65	53	38	28	17	12	5	2	1	0

- Nivolumab provided superior DFS with a 31% reduction in the risk of recurrence or death and a doubling in median DFS versus placebo

Kelly RJ et al. ASCO 2021;Abstract 4003.

Phase II Clinical Trial of Perioperative Pembrolizumab and Chemotherapy followed by Adjuvant Pembrolizumab for Resectable Gastric/GEJ Adenocarcinoma

Gulam Abbas Manji, MD PhD[1], Shing Lee, PhD[1], Michael May, MD[1], Armando Del Portillo, MD[1], Naomi Sender, BS[1], Sarah Sta Ana, MS[1], Katarzyna Gautier, BS[1], Emily Alouani, MD[1], Mengyu Xie, PhD[2], Amrita Sethi, MD[1], Beth Schrope, MD PhD[1], MD, Aik Choon Tan, PhD[2], Haeseong Park, MD[3], Paul E. Oberstein, MD[4], Manish A. Shah, MD[5], Alexander G. Raufi MD[6].

[1]Columbia University Irving Medical Center – NewYork-Presbyterian, [2]Moffitt Cancer Center, [3]Washington University, [4]New York University, [5]Weill Cornell Medical College – NewYork-Presbyterian, [6]Brown University

Presented by

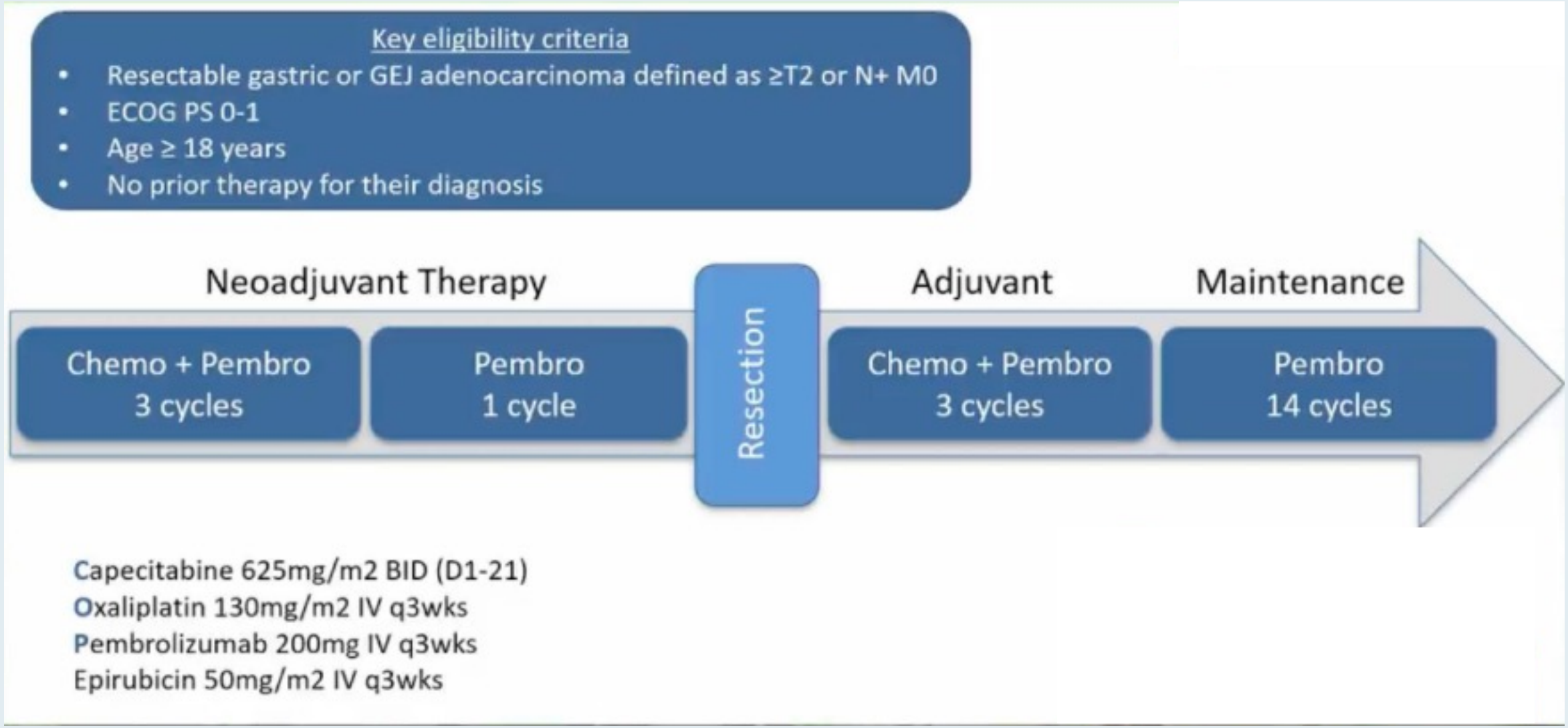
Gulam Abbas Manji, MD PhD

Columbia University – NewYork-Presbyterian

Abstract CT009

RTP RESEARCH TO PRACTICE

Phase II Study Design: Perioperative Pembrolizumab with Chemotherapy Followed by Adjuvant Pembrolizumab for Resectable Gastric Cancer or GEJ Adenocarcinoma



Manji GA et al. AACR 2022;Abstract CT009.

Pathologic Complete Response Rate (Primary Endpoint)

Pathological Response (Central Review)	Evaluable – 34 (%)	Underwent Curative Resection – 28 (%)
Complete	**7 (20.6%)** (10.1%, 100%)	7 (25%)
Near-complete	6 (17.6%)	6 (21%)
Partial	8 (23.5%)	8 (29%)
Treatment effect present, NOS	1 (2.9%)	1 (4%)
No or minimal/poor	7 (20.6%)	7 (25%)

Pathological Complete Response
No viable cancer cells

Near-complete Pathological Response
Single/rare small groups of cancer cells

Partial Response
Residual cancer with regression
(> single/rare small groups of cancer cells)

No or Minimal/Poor Response
Treatment effect absent

The study successfully met its primary endpoint of achieving a complete pathologic response (20.6%)

Manji GA et al. AACR 2022;Abstract CT009.

Advanced Gastric Cancer: HER2-Negative

ASCO Gastrointestinal Cancers Symposium 2023

Nivolumab plus chemotherapy vs chemotherapy as first-line treatment for advanced gastric cancer/gastroesophageal junction cancer/esophageal adenocarcinoma: 3-year follow-up from CheckMate 649

Yelena Y. Janjigian,[1] Kohei Shitara,[2] Markus Moehler,[3] Marcelo Garrido,[4] Carlos Gallardo,[5] Lin Shen,[6] Kensei Yamaguchi,[7] Lucjan Wyrwicz,[8] Tomasz Skoczylas,[9] Arinilda Bragagnoli,[10] Tianshu Liu,[11] Mustapha Tehfe,[12] Elena Elimova,[13] Ricardo Bruges,[14] James M. Cleary,[15] Michalis Karamouzis,[16] Samira Soleymani,[17] Ming Lei,[17] Carlos Amaya Chanaga,[17] Jaffer A. Ajani[18]

[1]Memorial Sloan Kettering Cancer Center and Weill Cornell Medical College, New York, NY; [2]National Cancer Center Hospital East, Kashiwa, Japan; [3]Johannes-Gutenberg University Clinic, Mainz, Germany; [4]Clinica San Carlos de Apoquindo, Pontificia Universidad Católica, Santiago, Chile; [5]Fundación Arturo López Pérez, Providencia, Chile; [6]Department of Gastrointestinal Oncology, Key Laboratory of Carcinogenesis and Translational Research (Ministry of Education/Beijing), Peking University Cancer Hospital & Institute, Beijing, China; [7]The Cancer Institute Hospital of JFCR, Tokyo, Japan; [8]Klinika Onkologii i Radioterapii, Narodowy Instytut Onkologii, Warszawa, Poland; [9]II Klinika Chirurgii Ogólnej, Gastroenterologicznej i Nowotworów Układu Pokarmowego, Medical University of Lublin, Lublin, Poland; [10]Fundacao Pio Xii Hosp Cancer De Barretos, Barretos, Brazil; [11]Zhongshan Hospital Fudan University, Shanghai, China; [12]Oncology Center-Centre Hospitalier de l'Universite de Montreal, Montreal, Canada; [13]Princess Margaret Cancer Centre, Toronto, Canada; [14]Instituto Nacional de Cancerologia E.S.E., Bogotá, Colombia; [15]Dana Farber Cancer Institute, Boston, MA; [16]Laiko General Hospital of Athens, Athens, Greece; [17]Bristol Myers Squibb, Princeton, NJ; [18]The University of Texas MD Anderson Cancer Center, Houston, TX

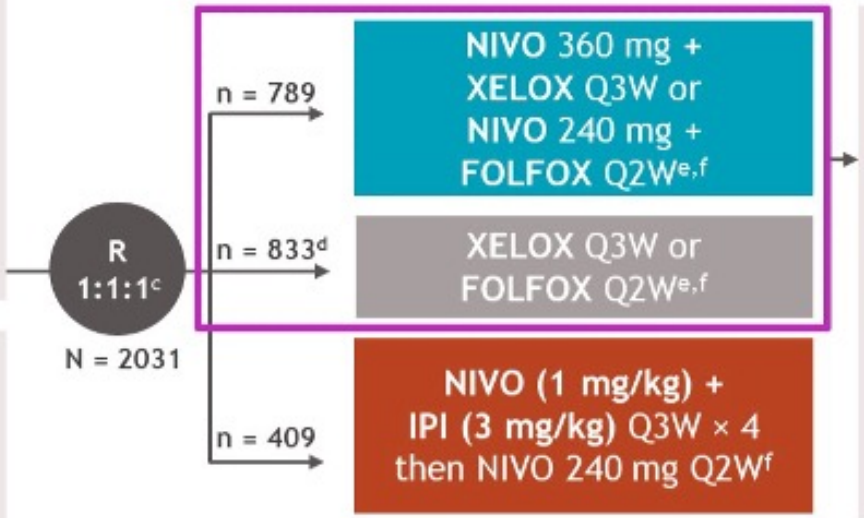
Abstract number 291

CheckMate 649 Study Design

- CheckMate 649 is a randomized, open-label, global phase 3 study[1,a]

Key eligibility criteria
- Previously untreated, unresectable, advanced or metastatic gastric/GEJ/esophageal adenocarcinoma
- No known HER2-positive status
- ECOG PS 0-1

Stratification factors
- Tumor cell PD-L1 expression (≥ 1% vs < 1%[b])
- Region (Asia vs United States/Canada vs ROW)
- ECOG PS (0 vs 1)
- Chemo (XELOX vs FOLFOX)



Dual primary endpoints:
- OS and PFS[g] (PD-L1 CPS ≥ 5)

Secondary endpoints:
- OS (PD-L1 CPS ≥ 1, all randomized)
- OS (PD-L1 CPS ≥ 10)
- PFS[g] (PD-L1 CPS ≥ 10, ≥ 1, all randomized)
- ORR[g]

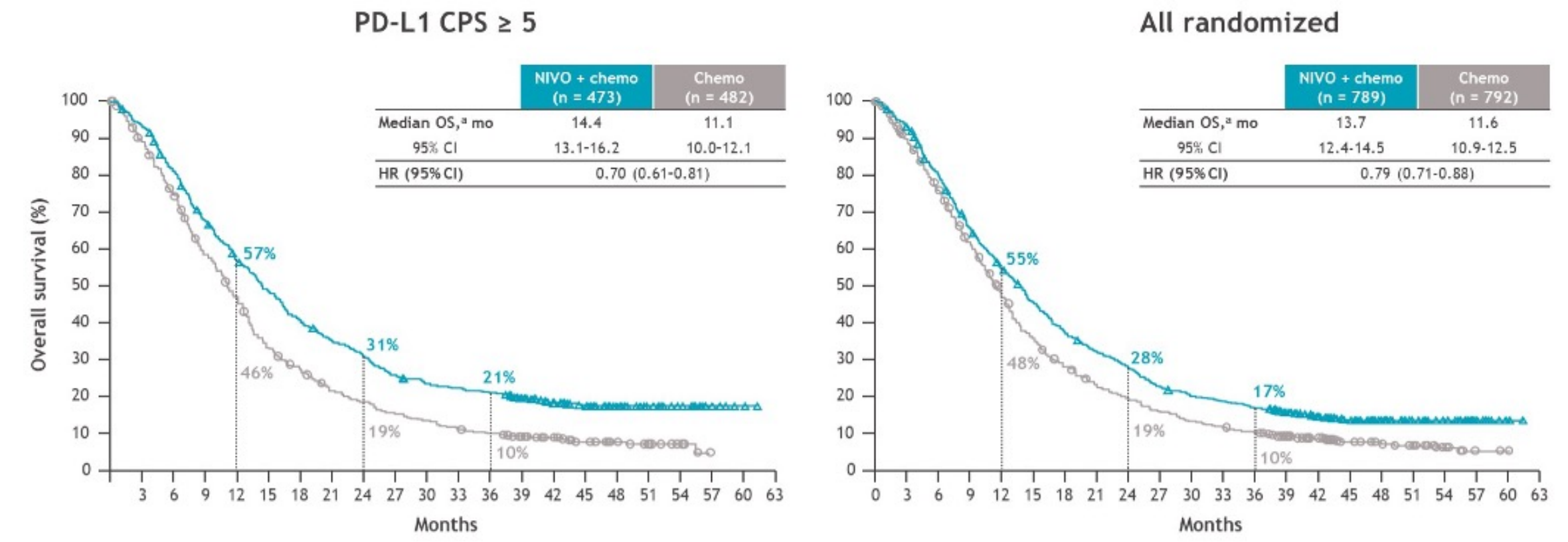
Exploratory endpoints:
- Safety
- QoL

- Patients were enrolled from 175 hospitals and cancer centers in 29 countries
- At data cutoff (May 31, 2022), the minimum follow-up[h] was 36.2 months

NIVO = nivolumab; IPI = ipilimumab; CPS = combined positive score

Janjigian YY et al. Gastrointestinal Cancers Symposium 2023;Abstract 291.

CheckMate 649: Overall Survival with Nivolumab and Chemotherapy versus Chemotherapy Alone — 36-Month Follow-Up



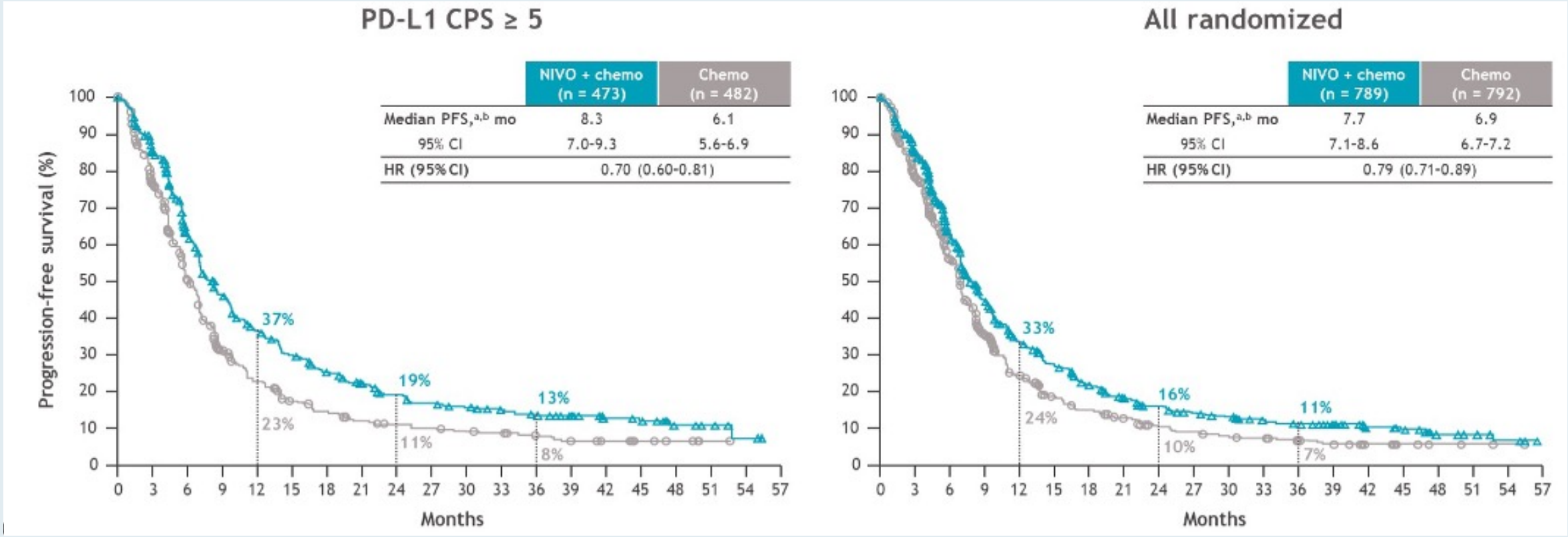
- Clinically meaningful improvement in OS with NIVO + chemo vs chemo was maintained with longer follow-up in PD-L1 CPS ≥5 and all randomized populations

CPS = combined positive score

Janjigian YY et al. Gastrointestinal Cancers Symposium 2023;Abstract 291.

RTP RESEARCH TO PRACTICE

CheckMate 649: Progression-Free Survival with Nivolumab and Chemotherapy versus Chemotherapy Alone — 36-Month Follow-Up



- PFS with NIVO + chemo vs chemo was maintained with longer follow-up in PD-L1 CPS ≥5 and all randomized populations

Janjigian YY et al. Gastrointestinal Cancers Symposium 2023;Abstract 291.

RTP RESEARCH TO PRACTICE

AACR American Association for Cancer Research ANNUAL MEETING 2022 New Orleans

Nivolumab plus chemotherapy vs chemotherapy as first-line treatment for advanced gastric cancer/gastroesophageal junction cancer/esophageal adenocarcinoma: CheckMate 649 biomarker analyses

Ming Lei,[1] Yelena Y. Janjigian,[2] Jaffer A. Ajani,[3] Markus Moehler,[4] Xuya Wang,[1] Lin Shen,[5] Marcelo Garrido,[6] Carlos Gallardo,[7] Kensei Yamaguchi,[8] Lucjan Wyrwicz,[9] Tomasz Skoczylas,[10] Arinilda Bragagnoli,[11] Tianshu Liu,[12] Mustapha Tehfe,[13] Elena Elimova,[14] Mingshun Li,[1] Valerie Poulart,[1] Yu Wang,[1] Parul Doshi,[15] Kohei Shitara[16]

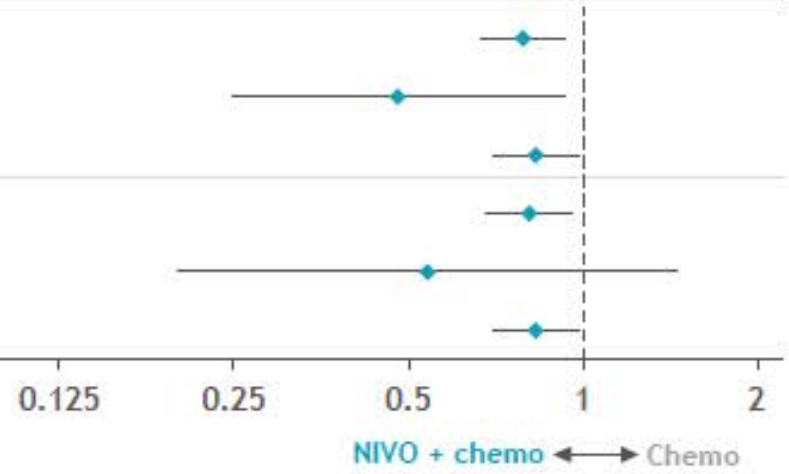
[1]Bristol Myers Squibb, Princeton, NJ; [2]Memorial Sloan Kettering Cancer Center and Weill Cornell Medical College, New York, NY; [3]The University of Texas MD Anderson Cancer Center, Houston, TX; [4]Johannes-Gutenberg University Clinic, Mainz, Germany; [5]Department of Gastrointestinal Oncology, Key Laboratory of Carcinogenesis and Translational Research (Ministry of Education/Beijing), Peking University Cancer Hospital and Institute, Beijing, China; [6]Clinica San Carlos de Apoquindo, Pontificia Universidad Católica, Santiago, Chile; [7]Fundacion Arturo Lopez Perez, Santiago, Chile; [8]Cancer Institute Hospital of JFCR, Tokyo, Japan; [9]Klinika Onkologii i Radioterapii, Narodowy Instytut Onkologii, Warszawa, Poland; [10]II Klinika Chirurgii Ogólnej, Gastroenterologicznej i Nowotworów Układu Pokarmowego, Medical University of Lublin, Lublin, Poland; [11]Fundacao Pio Xii Hosp Cancer De Barretos, Barretos, Brazil; [12]Zhongshan Hospital Fudan University, Shanghai, China; [13]Oncology Center - Centre Hospitalier de l'Universite de Montreal, Montreal, QC, Canada; [14]Princess Margaret Cancer Centre, Toronto, ON, Canada; [15]Bristol Myers Squibb, Princeton, NJ (at the time the study was conducted); [16]National Cancer Center Hospital East, Kashiwa, Japan

Presentation number CT023

RTP RESEARCH TO PRACTICE

CheckMate 649: Overall Survival by Tumor Mutational Burden (TMB)

Population	Status	Median OS, months		Unstratified HR (95% CI)
		NIVO + chemo	Chemo	
All TMB-evaluable	All evaluable (n = 685)	14.3	12.1	0.79 (0.67-0.93)
	TMB-high (n = 57)	24.6	12.6	0.48 (0.25-0.93)
	TMB-low (n = 628)	13.7	12.1	0.83 (0.70-0.99)
All TMB-evaluable (excluding MSI-H)[a]	All evaluable (n = 651)	14.0	12.1	0.81 (0.68-0.96)
	TMB-high (n = 26)	20.1	13.5	0.54 (0.20-1.45)
	TMB-low (n = 625)	13.7	12.1	0.83 (0.70-0.99)



- OS benefit with NIVO + chemo vs chemo was observed regardless of TMB status
  - Benefit was enriched in patients with TMB-high tumors, although sample size was small and the CI was wide
  - Results were consistent when patients with MSI-H tumors, which accounted for more than half of patients with TMB-high tumors, were excluded

Lei M et al. AACR 2022;Abstract CT023.

CheckMate 649 Biomarker Analyses: Summary

- OS benefit with NIVO + chemo vs chemo was observed regardless of TMB status, although the magnitude of benefit appeared to be higher in the small number of patients with TMB-high tumors, more than half of whom also had MSI-H tumors
- OS benefit with NIVO + chemo vs chemo was observed across 4-gene inflammatory GES subgroups with no apparent association between 4-gene inflammatory GES status and magnitude of OS benefit
- Lower stroma-related and angiogenesis GES appeared to be associated with numerically lower HRs with NIVO + chemo vs chemo
- OS benefit with NIVO + chemo vs chemo was observed in multiple subgroups of patients with low PD-L1 CPS expression, particularly in patients with low angiogenesis GES
- The clinical utility of the biomarkers reported in these exploratory analyses will need to be validated in future prospective studies

GES = gene expression signature

Lei M et al. AACR 2022;Abstract CT023.

ESMO VIRTUAL PLENARY 2023;Abstract VP1-2023.

Pembrolizumab Plus Chemotherapy as First-Line Therapy for Advanced HER2-Negative Gastric or Gastroesophageal Junction Cancer: Phase 3 KEYNOTE-859 Study

S.Y. Rha,[1] L.S. Wyrwicz,[2] P.E. Yañez Weber,[3] Y. Bai,[4] M.-H. Ryu,[5] J. Lee,[6] F. Rivera,[7] G. Vasconcelos Alves,[8] M. Garrido,[9] K.-K. Shiu,[10] M. González Fernández,[11] J. Li,[12] M.A. Lowery,[13] T. Çil,[14] F.J. Silva Melo Cruz,[15] S. Qin,[16] L. Yin,[17] S. Bordia,[17] P. Bhagia,[17] D.-Y. Oh[18] on behalf of the KEYNOTE-859 Investigators

[1]Yonsei Cancer Center, Yonsei University Health System, Seoul, Republic of Korea; [2]Maria Sklodowska-Curie National Research Institute of Oncology, Warsaw, Poland; [3]Universidad de La Frontera, James Lind Cancer Research Center, Temuco, Chile; [4]Harbin Medical University Cancer Hospital, Harbin, China; [5]Asan Medical Center, University of Ulsan College of Medicine, Seoul, South Korea; [6]Samsung Medical Center, Seoul, South Korea; [7]University Hospital Marqués de Valdecilla, IDIVAL, Santander, Spain; [8]Hospital Nossa Senhora da Conceição, Porto Alegre, Brazil; [9]Pontificia Universidad Católica de Chile, Santiago, Chile (currently at Universidad Mayor, Santiago, Chile); [10]University College Hospital, NHS Foundation Trust, London, UK; [11]IMAT-Oncomedica, Montería, Colombia; [12]Shanghai East Hospital, Tongji University School of Medicine, Shanghai, China; [13]Trinity St. James Cancer Institute, Dublin, Ireland; [14]Health and Science University, Adana City Hospital, Adana, Turkey; [15]Nucleo de Pesquisa e Ensino da Rede São Camilo, São Paulo, Brazil; [16]Cancer Center of People's Liberation Army, Nanjing, China; [17]Merck & Co., Inc., Rahway, NJ, USA; [18]Seoul National University College of Medicine, Seoul, Republic of Korea

KEYNOTE-859 Study Design

Randomized, Double-Blind, Phase 3 Trial

Key Eligibility Criteria

- Histologically or cytologically confirmed adenocarcinoma of the stomach or GEJ
- Locally advanced unresectable or metastatic disease
- No prior treatment
- Known PD-L1 status (assessed centrally using PD-L1 IHC 22C3)
- HER2-negative status (assessed locally)
- ECOG PS 0 or 1

R 1:1

Pembrolizumab 200 mg IV Q3W for ≤35 cycles (~2 yr) + Chemotherapy[a] (FP or CAPOX)

Placebo IV Q3W for ≤35 cycles (~2 yr) + Chemotherapy[a] (FP or CAPOX)

Stratification Factors

- Geographic region (Europe/Israel/North America/ Australia vs Asia vs rest of world)
- PD-L1 CPS (<1 vs ≥1)
- Choice of chemotherapy[a] (FP vs CAPOX)

- **Primary End Point:** OS
- **Secondary End Points:** PFS,[b] ORR,[b] DOR,[b] and safety

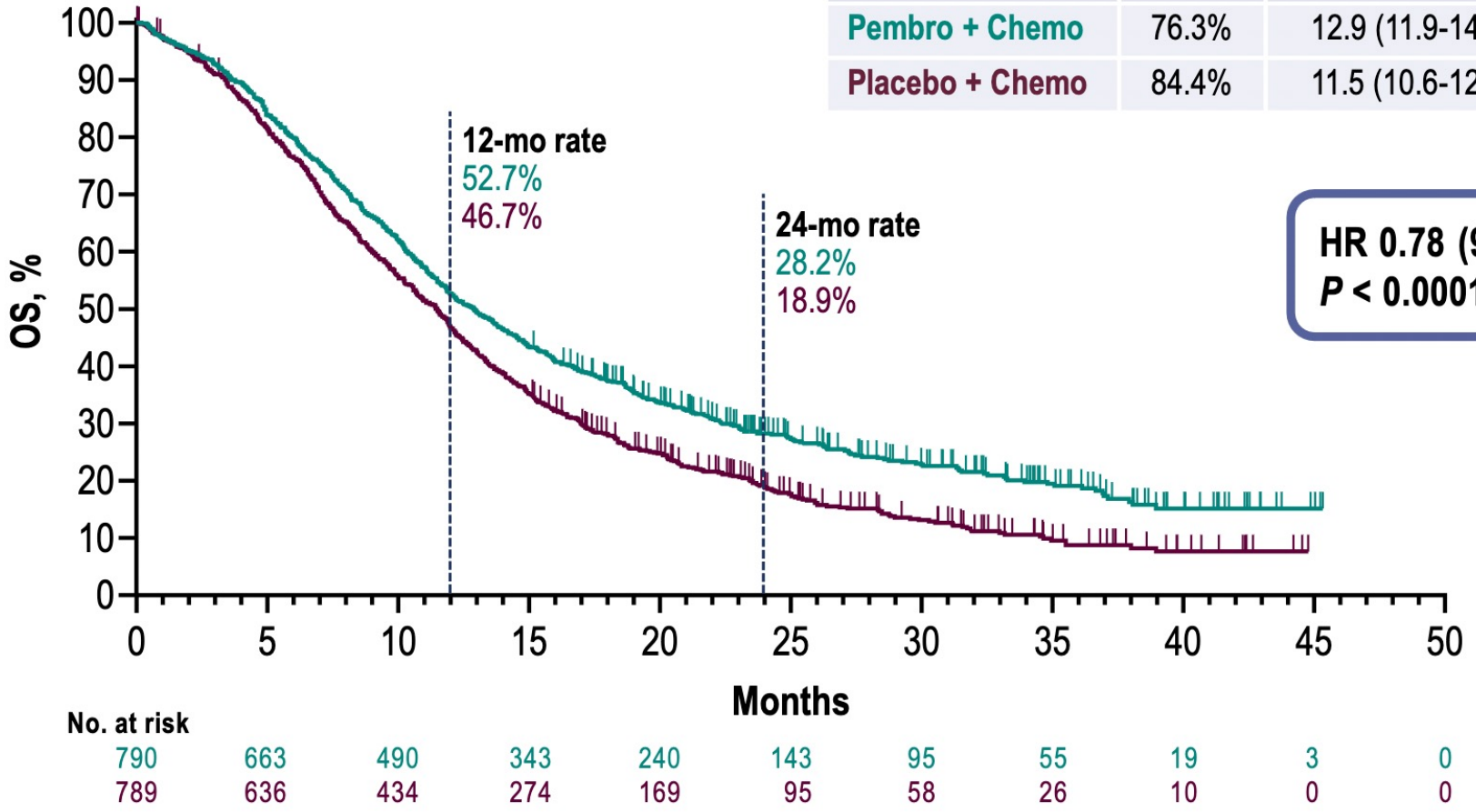
ESMO VIRTUAL PLENARY

[a] FP: 5-fluorouracil 800 mg/m^2/day IV continuous on days 1-5 Q3W + cisplatin 80 mg/m^2 IV Q3W. CAPOX: capecitabine 1000 mg/m^2 orally twice daily on days 1-14 Q3W + oxaliplatin 130 mg/m^2 IV Q3W. Cisplatin and oxaliplatin could have been limited to 6 cycles as per local country guidelines.
[b] Assessed per RECIST v1.1 by blinded, independent central review.
ClinicalTrials.gov number, NCT03675737.

Rha SY et al. ESMO Virtual Plenary 2023;Abstract VP1-2023.

OS, ITT Population

	Pts w/ Event	Median, mo (95% CI)
Pembro + Chemo	76.3%	12.9 (11.9-14.0)
Placebo + Chemo	84.4%	11.5 (10.6-12.1)



HR 0.78 (95% CI, 0.70-0.87)
P < 0.0001

ESMO VIRTUAL PLENARY

Data cutoff date: October 3, 2022.

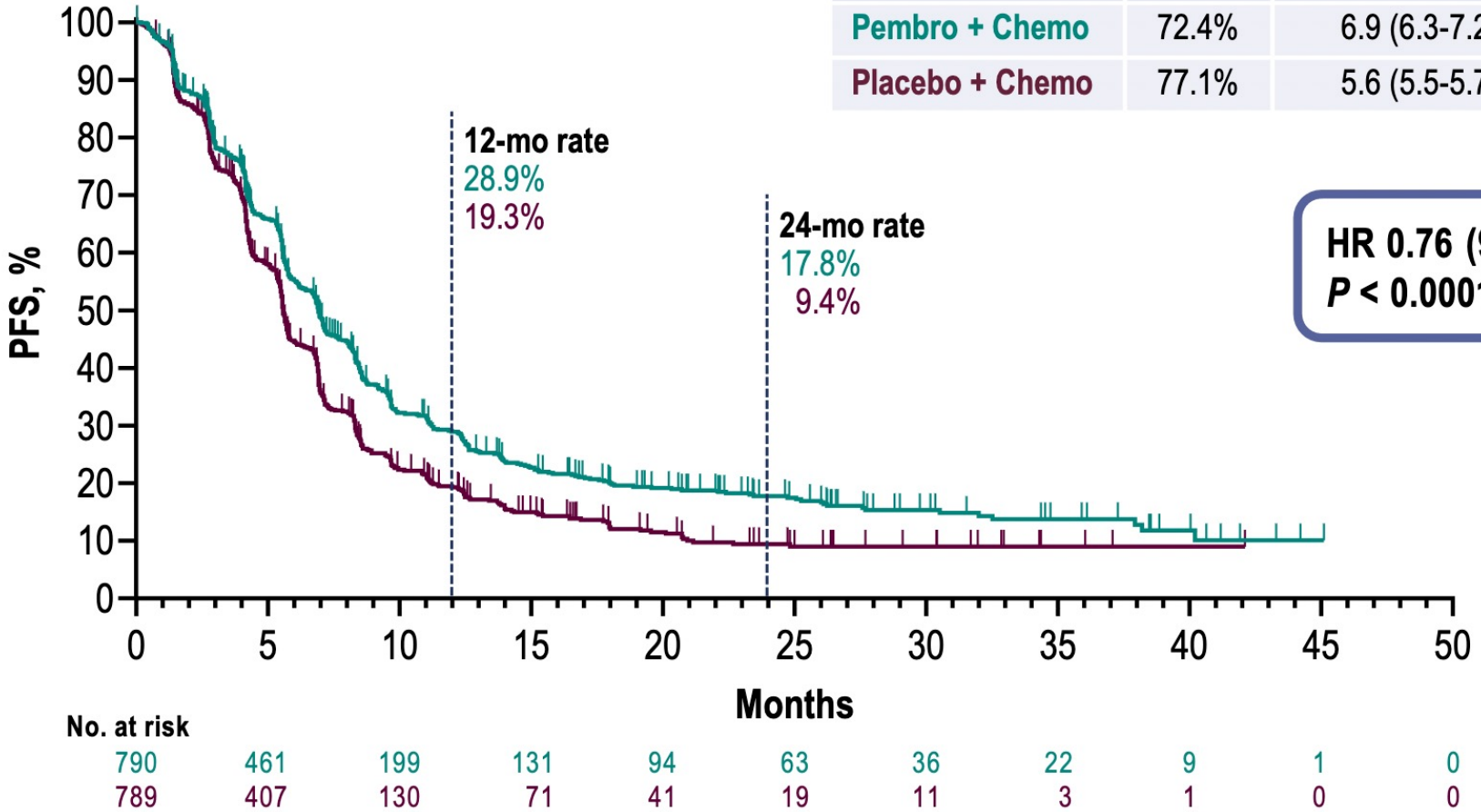
OS = overall survival; ITT = intent to treat

Rha SY et al. ESMO Virtual Plenary 2023;Abstract VP1-2023.

RTP RESEARCH TO PRACTICE

PFS, ITT Population

	Pts w/ Event	Median, mo (95% CI)
Pembro + Chemo	72.4%	6.9 (6.3-7.2)
Placebo + Chemo	77.1%	5.6 (5.5-5.7)



HR 0.76 (95% CI, 0.67-0.85)
***P* < 0.0001**

ESMO VIRTUAL PLENARY

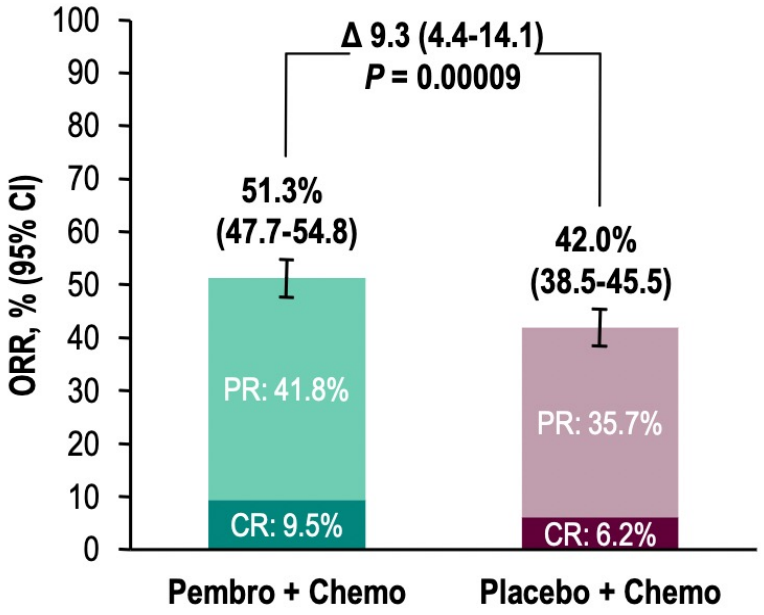
Response assessed per RECIST v1.1 by blinded, independent central review..
Data cutoff date: October 3, 2022.

Rha SY et al. ESMO Virtual Plenary 2023;Abstract VP1-2023.

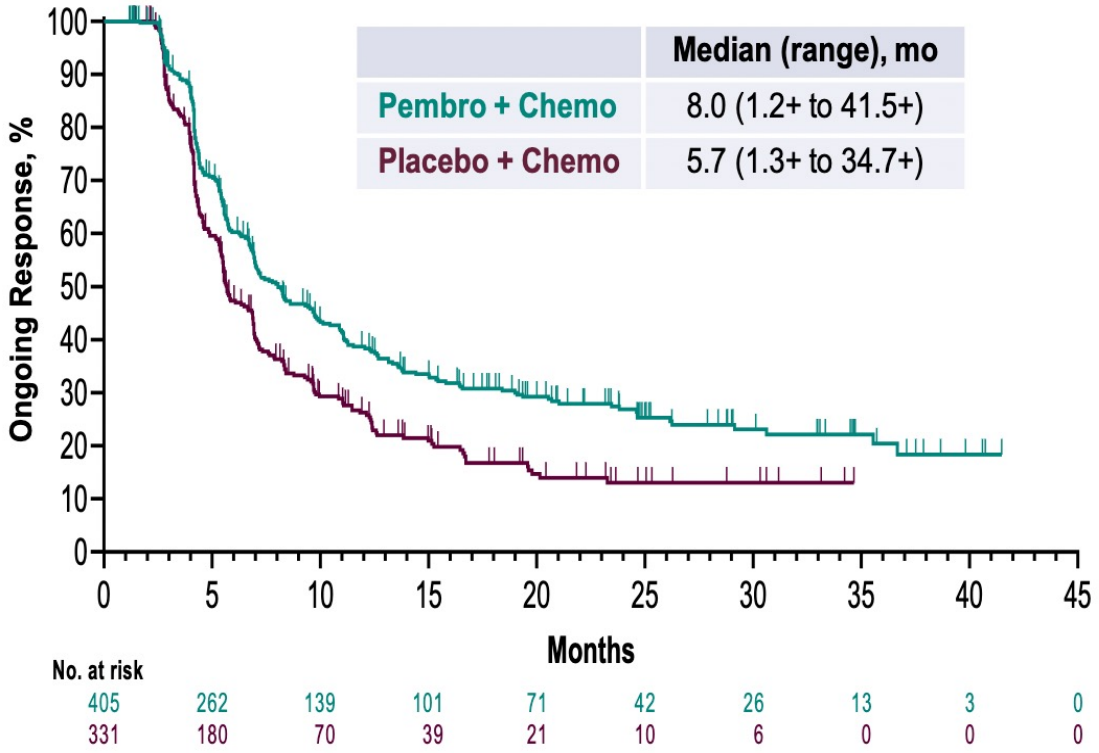
RTP RESEARCH TO PRACTICE

ORR and DOR, ITT Population

ORR



DOR



ESMO VIRTUAL PLENARY

Response assessed per RECIST v1.1 by blinded, independent central review..
Data cutoff date: October 3, 2022.

ORR = overall response rate; DOR = duration of response

Rha SY et al. ESMO Virtual Plenary 2023;Abstract VP1-2023.

ASCO Gastrointestinal Cancers Symposium 2023

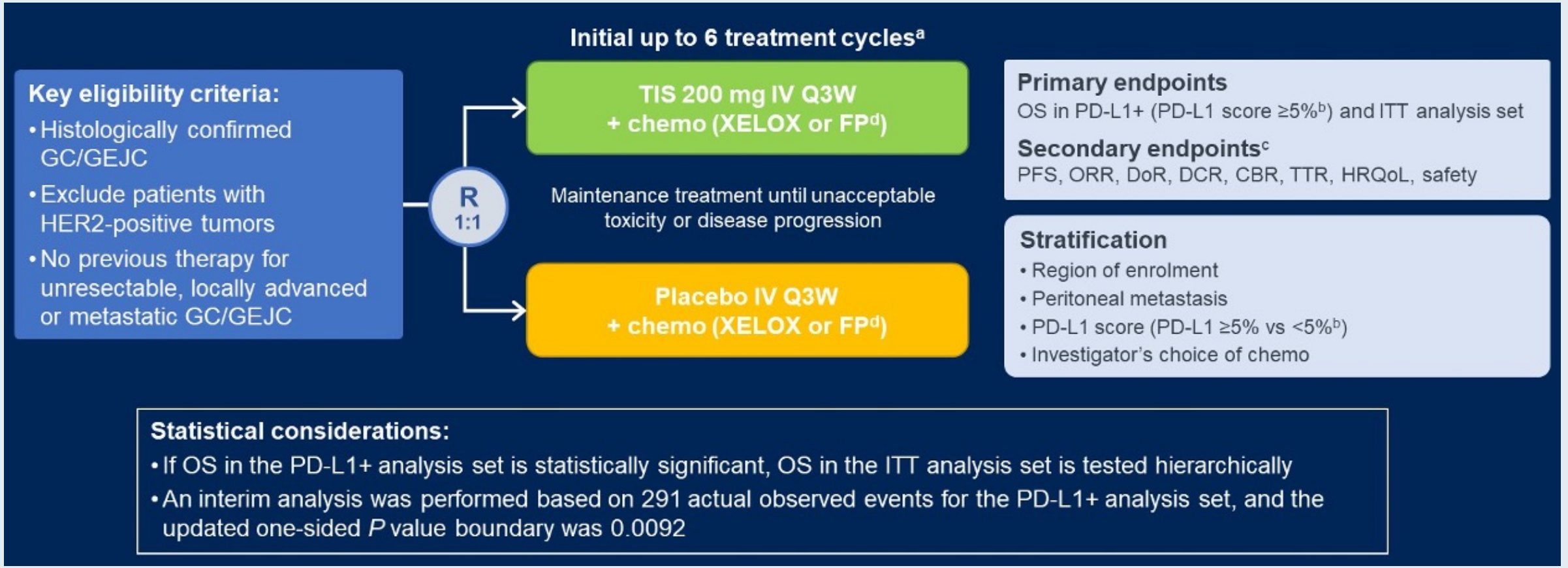
Abstract 286

RATIONALE-305: Phase 3 Study of Tislelizumab + Chemotherapy vs Placebo + Chemotherapy as First-line Treatment of Advanced Gastric or Gastroesophageal Junction Adenocarcinoma

Markus Moehler,[1] Ken Kato,[2] Tobias Arkenau,[3] Do-Youn Oh,[4] Josep Tabernero,[5] Marcia Cruz Correa,[6] Hongwei Wang,[7] Hui Xu,[8] Jiang Li,[9] Silu Yang,[8] Gisoo Barnes,[10] Rui-Hua Xu[11]

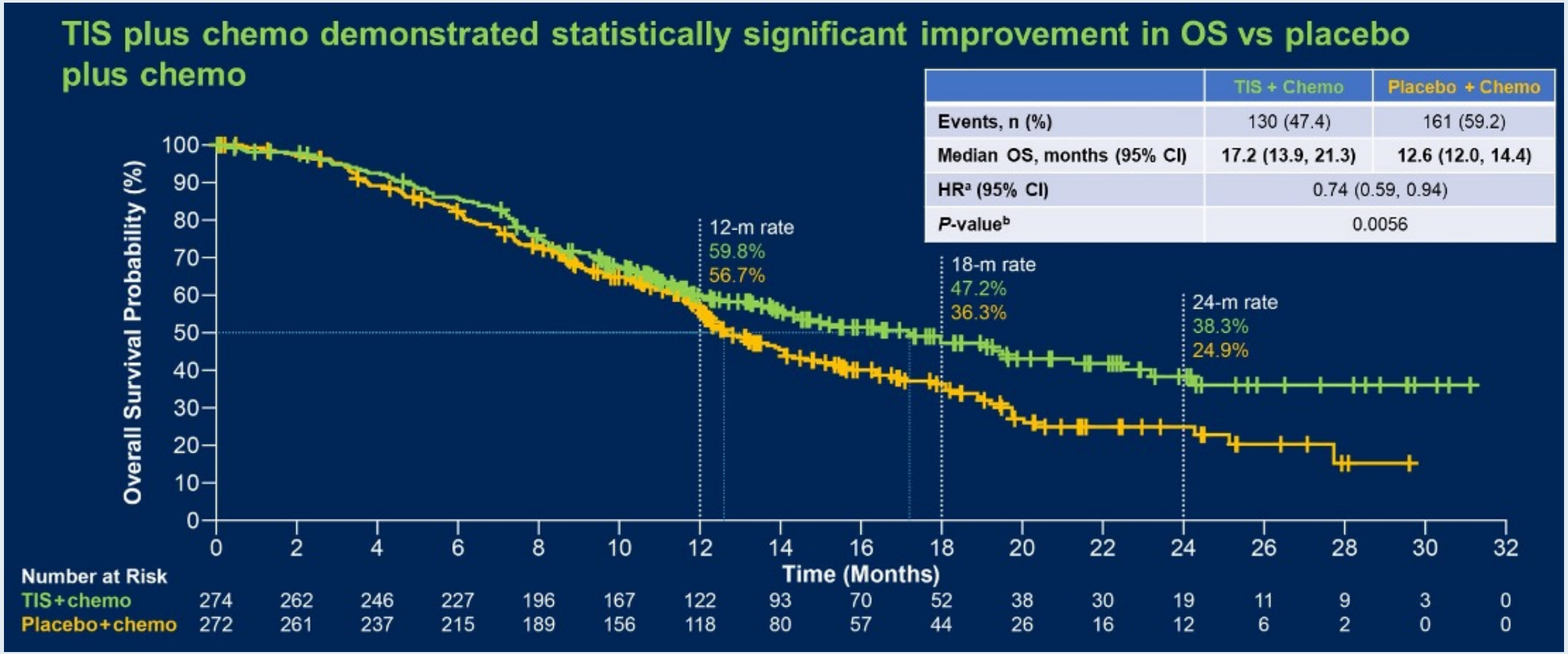
[1]Johannes Gutenberg-University Clinic, Mainz, Germany; [2]National Cancer Center Hospital, Tokyo, Japan; [3]Sarah Cannon Research, London, England; [4]Seoul National University Hospital, Cancer Research Institute, Seoul National University College of Medicine; [5]Vall d'Hebron University Hospital, Barcelona, Spain; [6]University of Puerto Rico, San Juan, Puerto Rico; [7]BeiGene, Ltd., Boston, MA, United States; [8]BeiGene (Beijing) Co., Ltd., Beijing, China; [9]BeiGene, Ltd., Ridgefield Park, NJ, United States; [10]BeiGene, Ltd., Emeryville, CA, United States; [11]Sun Yat-sen University Cancer Center State Key Laboratory of Oncology in South China, Collaborative Innovation Center of Cancer Medicine, Guangzhou, China

RATIONALE-305: Phase III Study Design



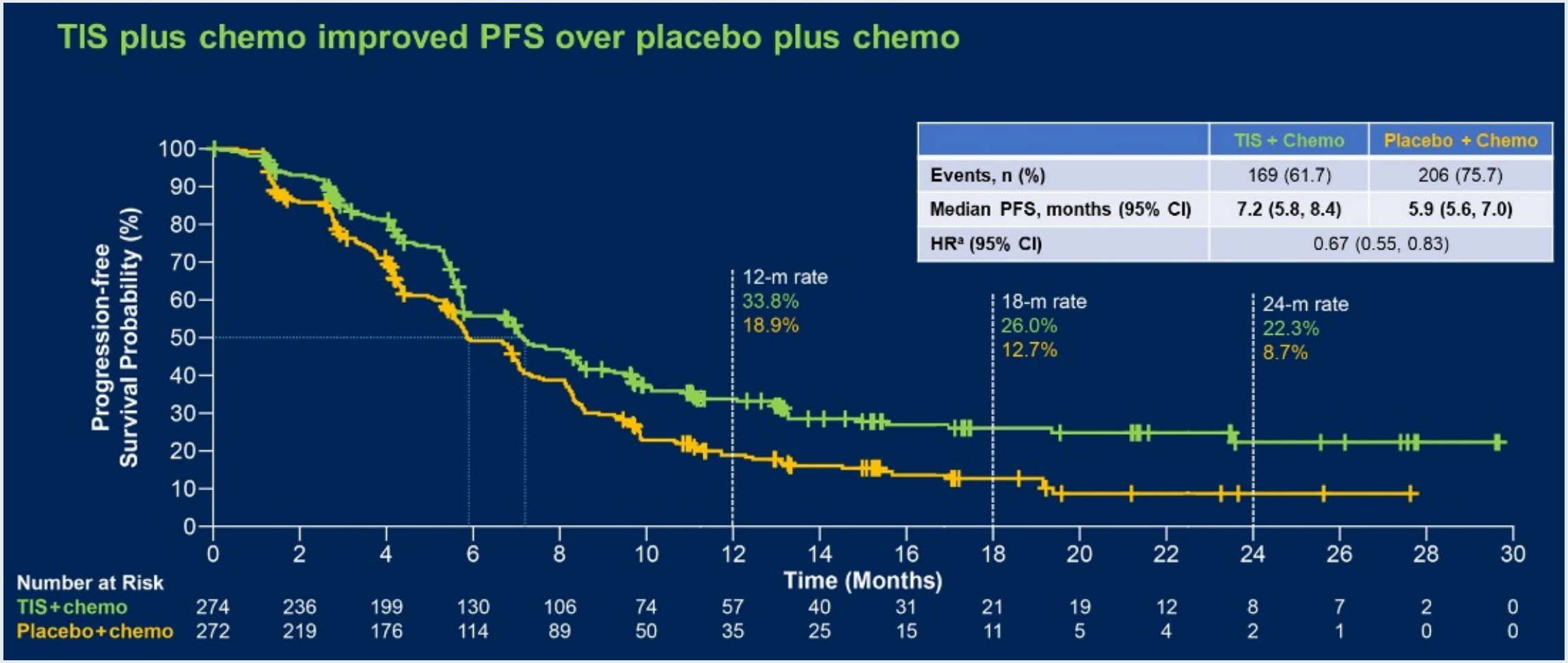
Moehler M et al. Gastrointestinal Cancers Symposium 2023;Abstract 286.

RATIONALE-305: Overall Survival in PD-L1-Positive Analysis Set (Primary Endpoint)



Moehler M et al. Gastrointestinal Cancers Symposium 2023;Abstract 286.

RATIONALE-305: Progression-Free Survival in PD-L1-Positive Analysis Set (Key Secondary Endpoint)



	TIS + Chemo	Placebo + Chemo
Events, n (%)	169 (61.7)	206 (75.7)
Median PFS, months (95% CI)	7.2 (5.8, 8.4)	5.9 (5.6, 7.0)
HR[a] (95% CI)	0.67 (0.55, 0.83)	

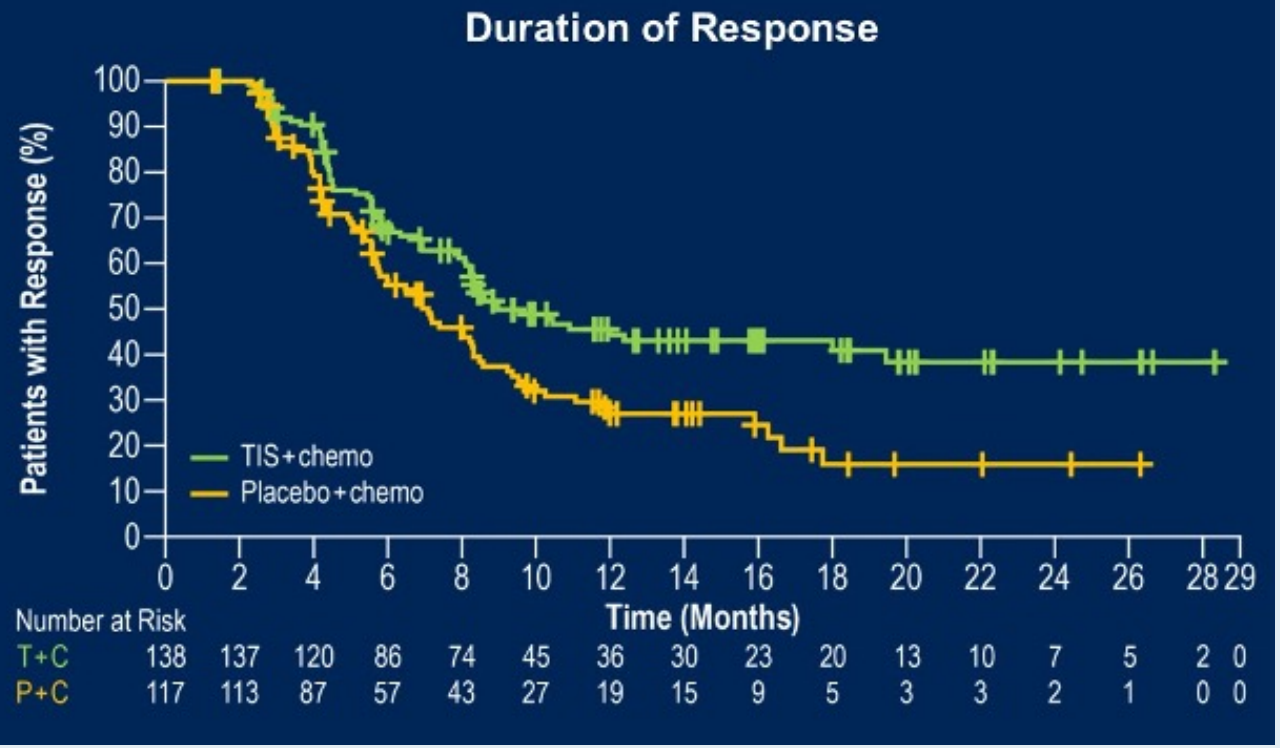
Moehler M et al. Gastrointestinal Cancers Symposium 2023;Abstract 286.

RTP RESEARCH TO PRACTICE

RATIONALE-305: Antitumor Response in PD-L1-Positive Analysis Set (Key Secondary Endpoint)

TIS plus chemo was associated with a numerically higher ORR and more durable response vs placebo plus chemo

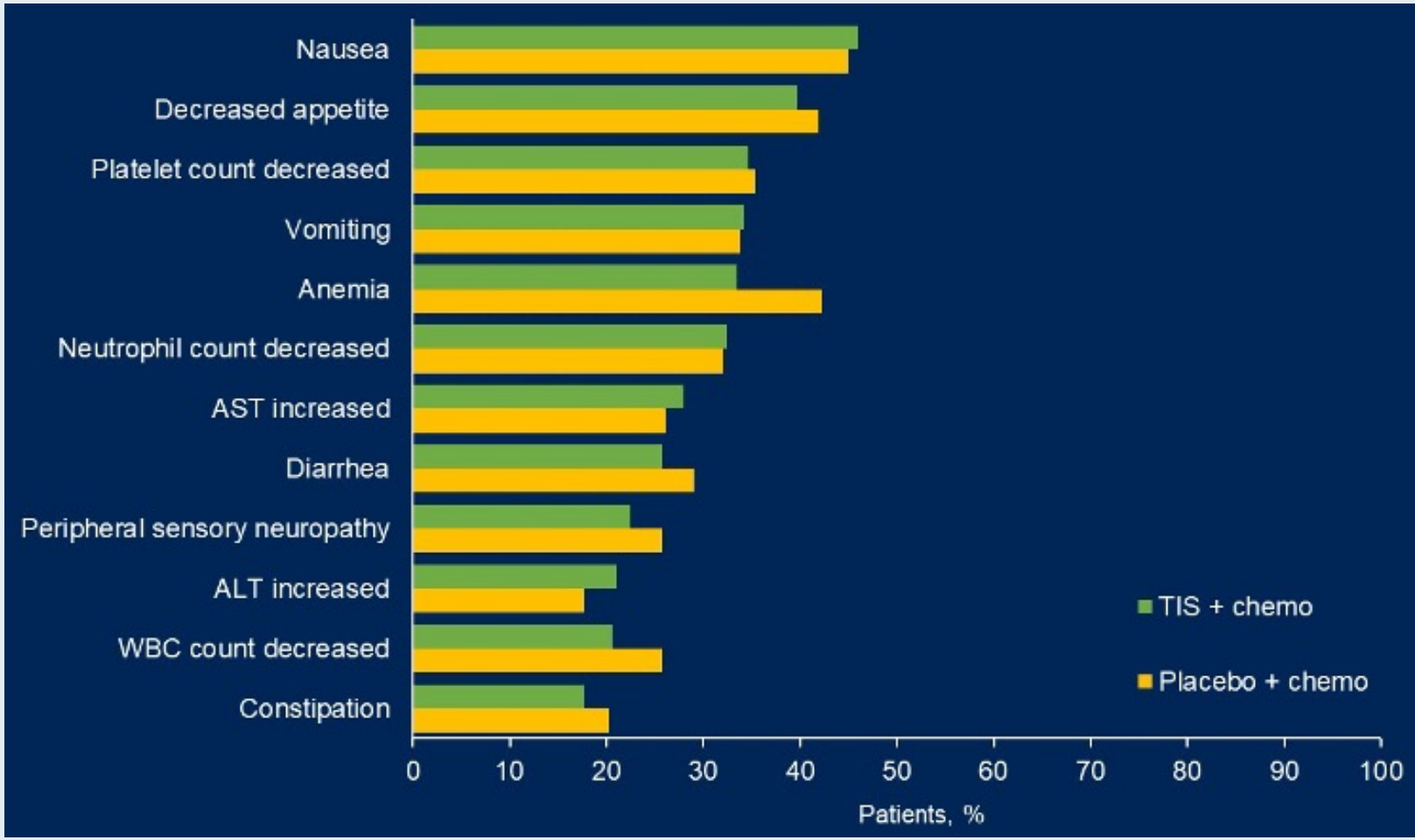
	TIS + Chemo (n=274)	Placebo + Chemo (n=272)
ORR[a], % (95% CI[b])	**50.4** (44.3, 56.4)	**43.0** (37.1, 49.1)
Best overall response, % (n)		
CR	**3.3** (9)	**1.8** (5)
PR	**47.1** (129)	**41.2** (112)
SD[c]	**38.0** (104)	**40.1** (109)
PD	**4.4** (12)	**11.8** (32)
Undetermined[d]	**7.3** (20)	**5.1** (14)
Disease control rate, % (95% CI[a])	**88.3** (83.9, 91.9)	**83.1** (78.1, 87.3)
Median DoR, months (95% CI)	**9.0** (8.2, 19.4)	**7.1** (5.7, 8.3)



Moehler M et al. Gastrointestinal Cancers Symposium 2023;Abstract 286.

RTP RESEARCH TO PRACTICE

RATIONALE-305: Treatment-Emergent Adverse Events Reported in ≥20% of Patients



The profile of TEAEs with tislelizumab plus chemo was consistent with the known profile of each treatment agent, with no new safety signals identified

Moehler M et al. Gastrointestinal Cancers Symposium 2023;Abstract 286.

RTP RESEARCH TO PRACTICE

European Journal of Cancer 165 (2022) 48–57

Available online at www.sciencedirect.com

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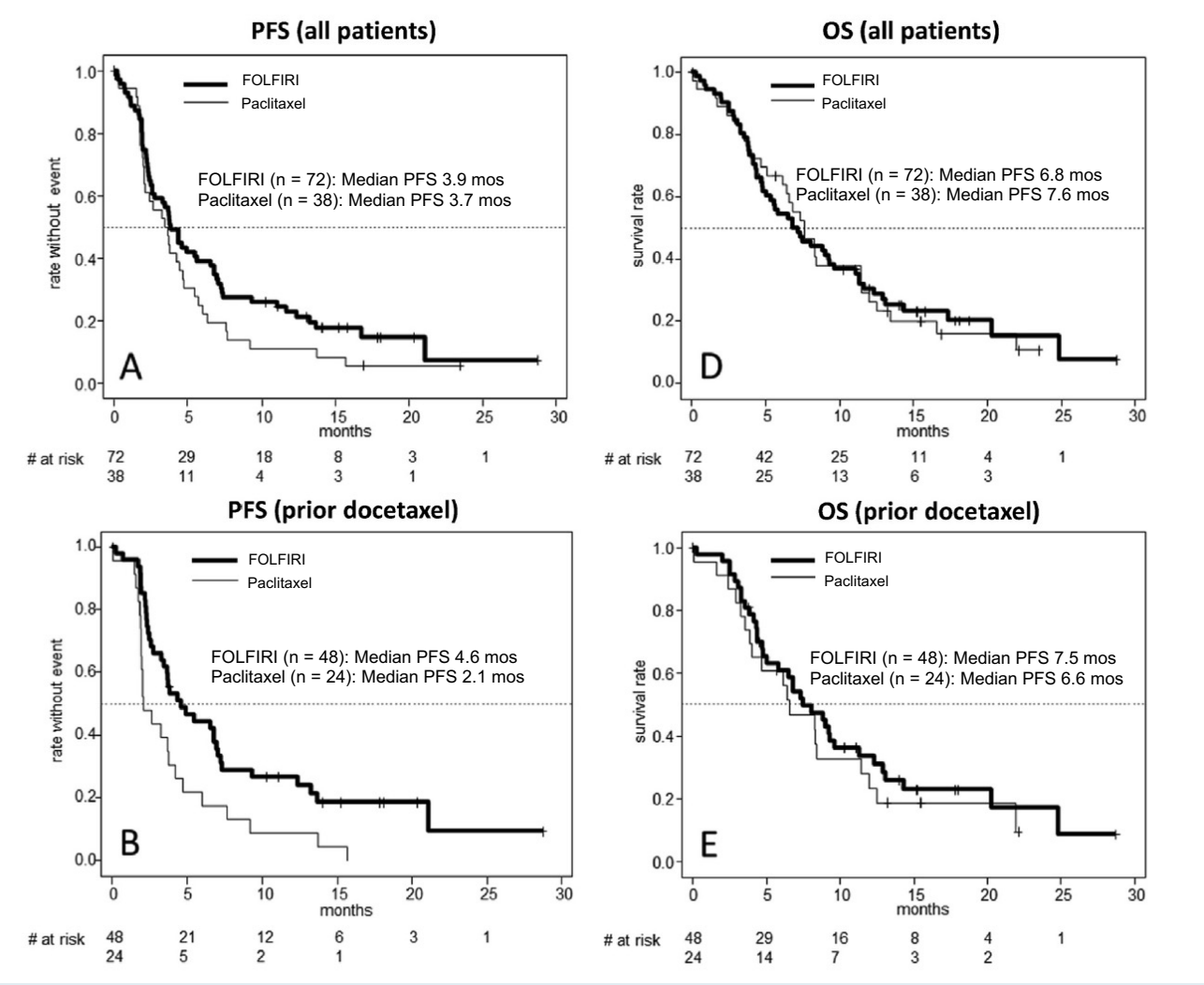
Original Research

FOLFIRI plus ramucirumab versus paclitaxel plus ramucirumab as second-line therapy for patients with advanced or metastatic gastroesophageal adenocarcinoma with or without prior docetaxel – results from the phase II RAMIRIS Study of the German Gastric Cancer Study Group at AIO

Sylvie Lorenzen [a,*], Peter Thuss-Patience [b], Claudia Pauligk [c], Eray Gökkurt [d], Thomas Ettrich [e], Florian Lordick [f], Michael Stahl [g], Peter Reichardt [h], Martin Sökler [i], Daniel Pink [j,k], Stefan Probst [l], Axel Hinke [m], Thorsten O. Goetze [c,n,1], Salah E. Al-Batran [c,n,1]

Phase II RAMIRIS Trial of Second-Line Ramucirumab with FOLFIRI: Patients with Advanced or Metastatic Gastroesophageal Adenocarcinoma with or without Prior Docetaxel



PFS = progression-free survival; OS = overall survival

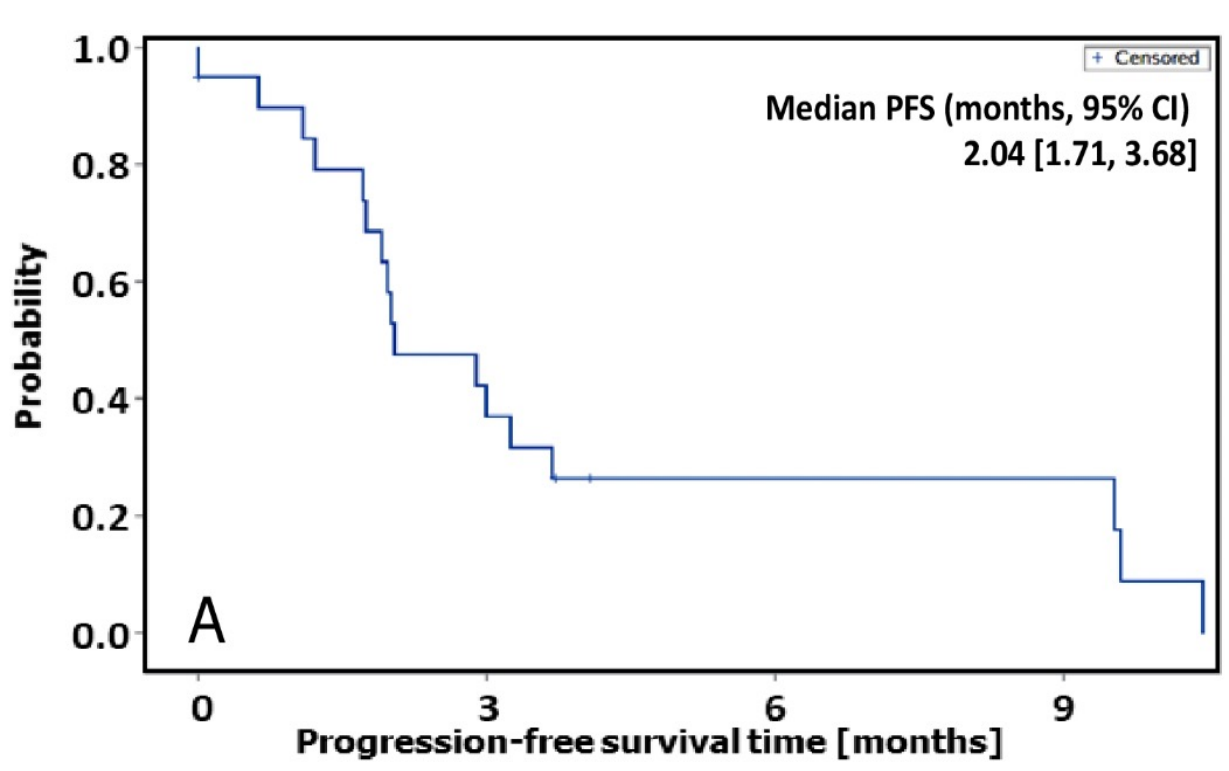
Lorenzen S et al. *Eur J Cancer* 2022;165:48-57.

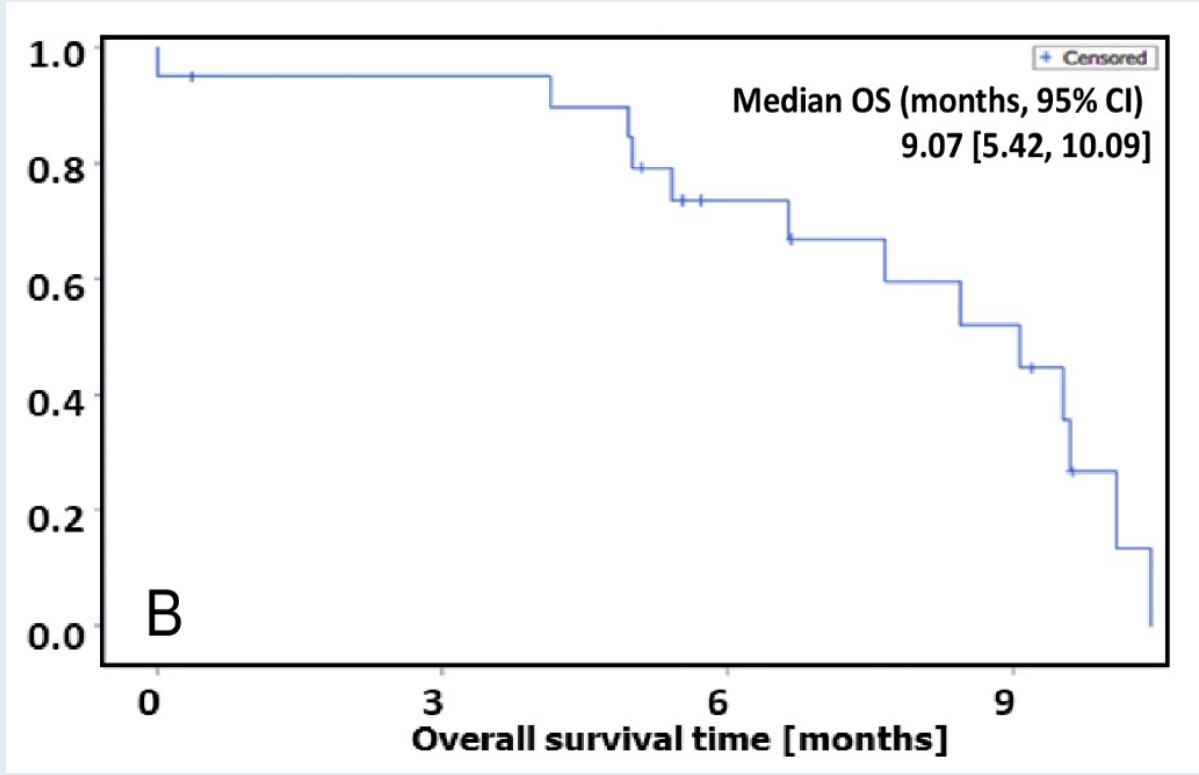
Ramucirumab Beyond Progression plus TAS 102 in Patients with Advanced or Metastatic Adenocarcinoma of the Stomach or the Gastroesophageal Junction, After Treatment Failure on a Ramucirumab-Based Therapy: Final Results of the Phase II RE-ExPEL Study

Goetze TO et al.

Gastrointestinal Cancers Symposium 2023;Abstract 359.

Phase II RE-ExPEL Study: Progression-Free and Overall Survival





Goetze TO et al. Gastrointestinal Cancers Symposium 2023;Abstract 359.

Phase II RE-ExPEL Study: Summary of Serious Adverse Events

Term	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
Bronchitis		1			
Cholangitis			1		
Fever	1				
(Sub)Ileus		2			
Malaise			1		
Respiratory failure					1
Salivary gland infection			1		
Worsening of Enterothorax			1		

Goetze TO et al. ASCO GI 2023;Abstract 359.

Advanced Gastric Cancer: HER2-Positive

ESMO WORLD CONGRESS ON Gastrointestinal Cancer

Pembrolizumab Plus Trastuzumab and Chemotherapy for HER2+ Metastatic Gastric or Gastroesophageal Junction Cancer: Initial Findings of the Global Phase 3 KEYNOTE-811 Study

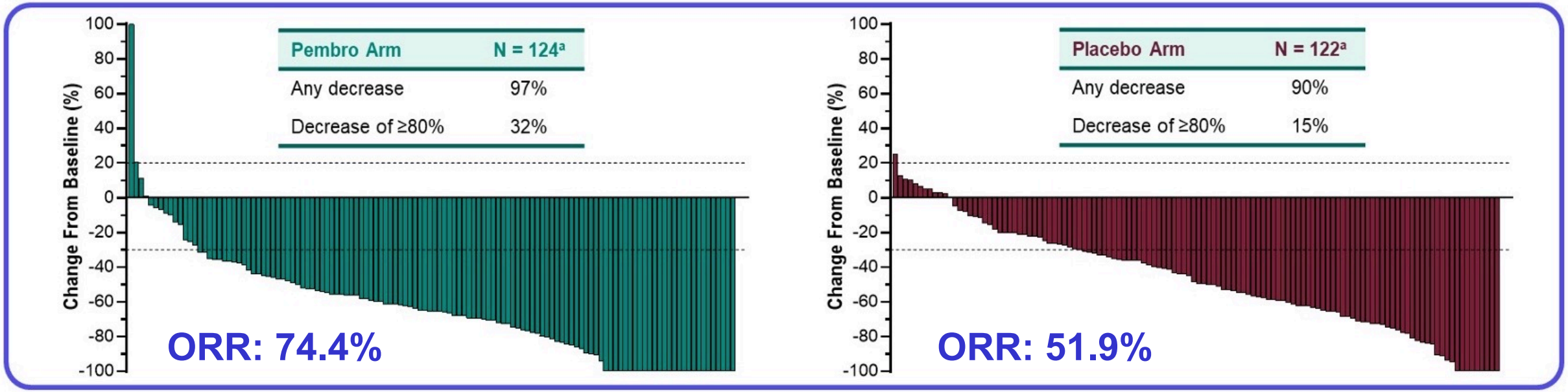
Yelena Y. Janjigian,[1] Akihito Kawazoe,[2] Patricio Yañez,[3] Suxia Luo,[4] Sara Lonardi,[5] Oleksii Kolesnik,[6] Olga Barajas,[7] Yuxian Bai,[8] Lin Shen,[9] Yong Tang,[10] Lucjan S. Wyrwicz,[11] Kohei Shitara,[2] Shukui Qin,[12] Eric Van Cutsem,[13] Josep Tabernero,[14] Lie Li,[15] Chie-Schin Shih,[15] Pooja Bhagia,[15] Hyun Cheol Chung,[16] on behalf of the KEYNOTE-811 Investigators

[1]Memorial Sloan Kettering Cancer Center, New York, NY, USA; [2]National Cancer Center Hospital East, Kashiwa, Japan; [3]Universidad de La Frontera, James Lind Cancer Research Center, Temuco, Chile; [4]Henan Cancer Hospital, the Affiliated Cancer Hospital of Zhengzhou University, Zhengzhou, China; [5]Istituto Oncologico Veneto IOV-IRCCS, Padova, Italy; [6]Medical Center "Oncolife", Zaporizhzhia, Ukraine; [7]Arturo López Pérez Foundation, Santiago, Chile; [8]Harbin Medical University Cancer Hospital, Harbin, China; [9]Key Laboratory of Carcinogenesis and Translational Research (Ministry of Education/Beijing), Peking University Cancer Hospital & Institute, Beijing, China; [10]Cancer Hospital Affiliated to Xinjiang Medical University, Xinjiang, China; [11]Maria Sklodowska-Curie Memorial Cancer Center and Institute of Oncology, Warsaw, Poland; [12]Cancer Center of People's Liberation Army, Nanjing, China; [13]University Hospitals Gasthuisberg and KU Leuven, Leuven, Belgium; [14]Vall d'Hebron Hospital Campus and Institute of Oncology (VHIO), IOB-Quiron, UVic-UCC, Barcelona, Spain; [15]Merck & Co., Inc., Kenilworth, NJ, USA; [16]Yonsei Cancer Center, Yonsei University College of Medicine, Seoul, South Korea

ESMO World Congress on Gastrointestinal Cancer 2021;Abstract LBA4.

RTP RESEARCH TO PRACTICE

KEYNOTE-811: Confirmed Response at First Interim Analysis



ORR = objective response rate

Janjigian YY et al. ESMO World Congress on Gastrointestinal Cancer 2021;Abstract LBA4.

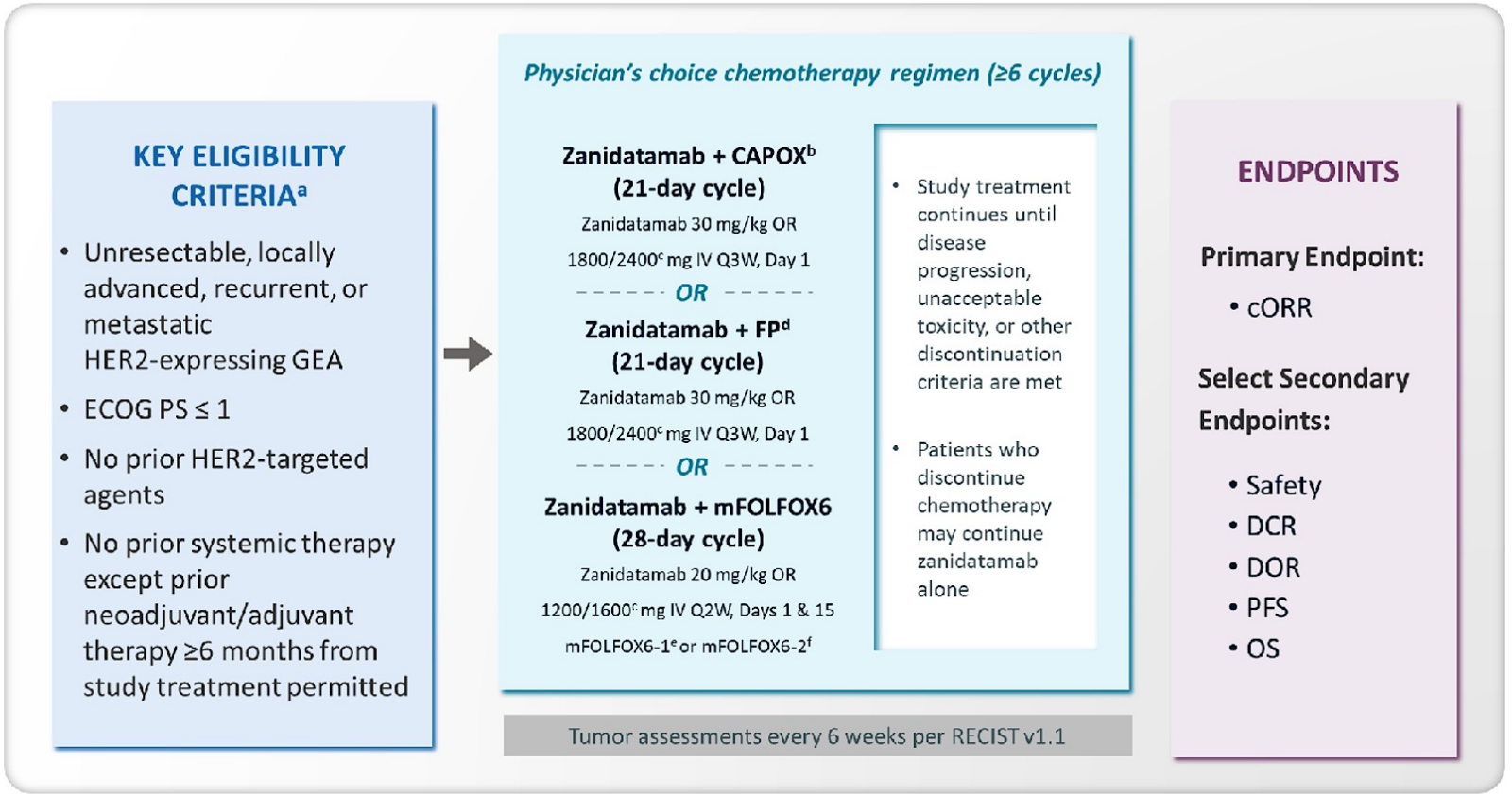
Zanidatamab + Chemotherapy as First Line Treatment for HER2-expressing Metastatic Gastroesophageal Adenocarcinoma (mGEA)

Elena Elimova[1], Jaffer Ajani[2], Howard Burris[3], Crystal S. Denlinger[4], Syma Iqbal[5], Yoon-Koo Kang[6], Yeul Hong Kim[7], Keun-Wook Lee[8], Bruce Lin[9], Rutika Mehta[10], Do-Youn Oh[11],

[1]Princess Margaret Cancer Center, Toronto, ON, Canada; [2]The University of Texas MD Anderson Cancer Center, Houston, TX, USA; [3]Sarah Cannon Research Institute, Nashville, TN, USA; [4]Fox Chase Cancer Center, Philadelphia, PA, USA; [5]University of Southern California, Los Angeles, CA, USA; [6]Asan Medical Center, Seoul, South Korea; [7]Korea University Anam Hospital, Seoul, South Korea; [8]Seoul National University College of Medicine, Seoul National University Bundang Hospital, Seongnam, South Korea; [9]Virginia Mason Medical Center, Seattle, WA, USA; [10]H. Lee Moffitt Cancer Center and Research Institute, Tampa, FL, USA; [11]Seoul National University Hospital, Seoul National University College of Medicine, Seoul, South Korea; [12]Yonsei Cancer Center, Yonsei University College of Medicine, Seoul, South Korea; [13]Pusan National University Hospital, Busan, South Korea; [14]Zymeworks BC Inc., Vancouver, BC, Canada; [15]Memorial Sloan Kettering Cancer Center, New York, NY, USA

ASCO Gastrointestinal Cancers Symposium.
January 19-21, 2023
Abstract #347
Presented by: Elena Elimova, MD, MSc

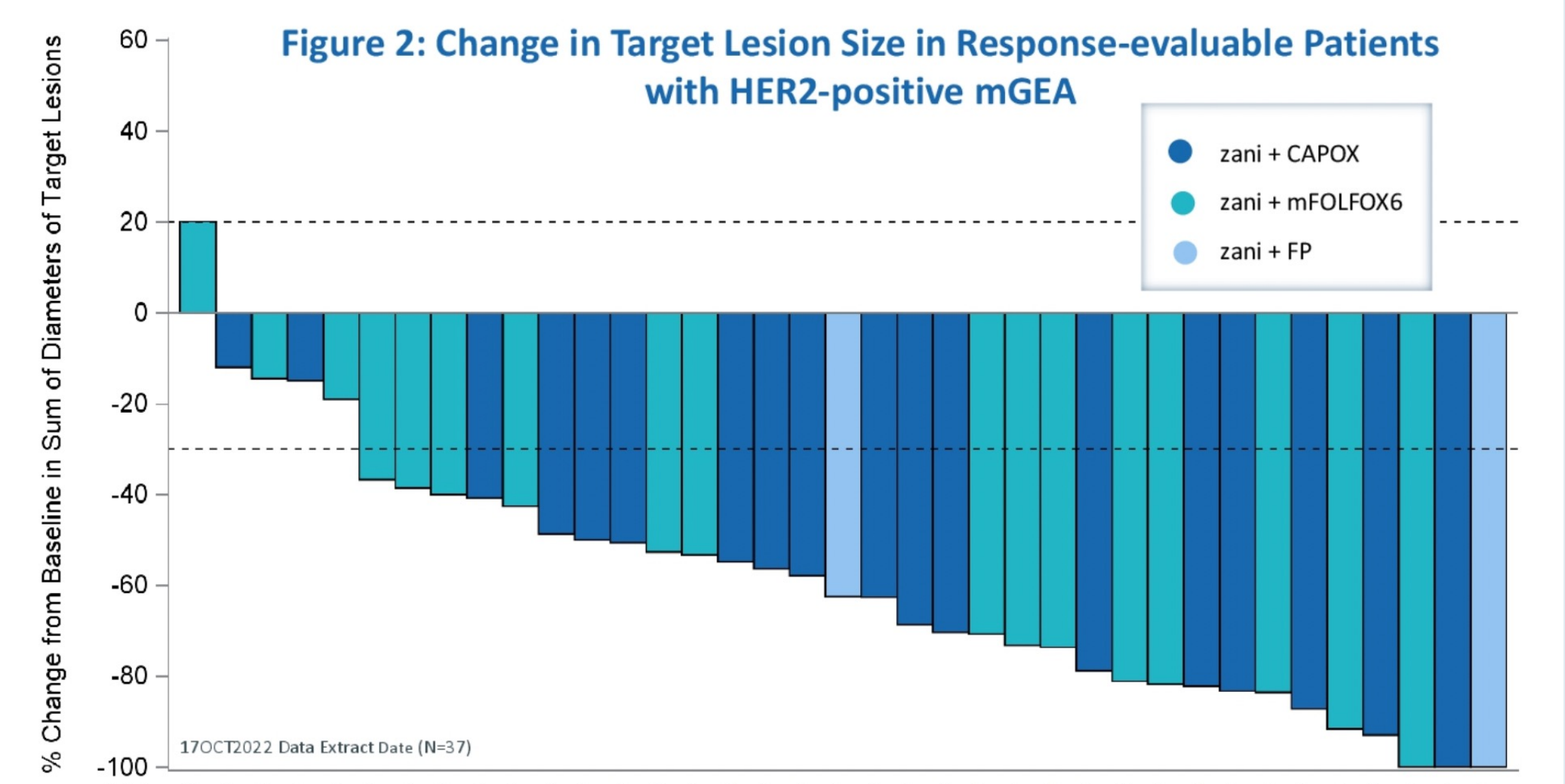
Zanidatamab + Chemotherapy as First-Line Treatment for HER2-Expressing mGEA: Study Design



Note: All patients received prophylaxis with acetaminophen, diphenhydramine, and corticosteroid with each infusion to prevent or attenuate infusion-related reactions.
a.The initial safety cohort used local or central assessment of HER2 status and allowed HER2 IHC 3+ or IHC 2+ regardless of HER2 FISH status. Part 2 included only patients with HER2-positive cancer (IHC 3+ or IHC 2+/FISH+); b.CAPOX: capecitabine 1,000 mg/m^2 PO BID, Days 1-15; oxaliplatin 130 mg/m^2 IV Q3W, Day 1; c. Two-tiered flat dose for subjects <70 kg/≥70 kg; d.FP: cisplatin 80 mg/m^2 IV Q3W, Day 1; 5-fluorouracil (5-FU) 800 mg/m^2/day IV, continuous Days 1-5; e.mFOLFOX6-1: leucovorin 400 mg/m^2 IV Q2W, Days 1 and 15; oxaliplatin 85 mg/m^2 IV Q2W, Days 1 and 15; 5-FU 1200 mg/m^2/day IV continuous Days 1-2 and 15-16, and 400 mg/m^2 IV Q2W, Days 1 and 15; f.mFOLFOX6-2 is the same as mFOLFOX6-1 but omits the 5-FU 400 mg/m^2 IV Q2W dose on Days 1 and 15.
cORR = confirmed objective response rate; CR = complete response; DCR = disease control rate (defined as best response of CR, PR, or SD); DOR = duration of response (defined as time from first objective response that is subsequently confirmed until documented PD or death from any cause ≤ 30 days of last study treatment); ECOG PS = Eastern Cooperative Oncology Group performance status; OS = overall survival (defined as the time from the first dose of study treatment to the date of death from any cause); PD = progressive disease; PFS = progression-free survival (defined as the time from the first dose of study treatment to the date of documented disease progression, clinical progression, or death from any cause); PR = partial response; SD = stable disease.

Elimova E et al. Gastrointestinal Cancers Symposium 2023;Abstract 347.

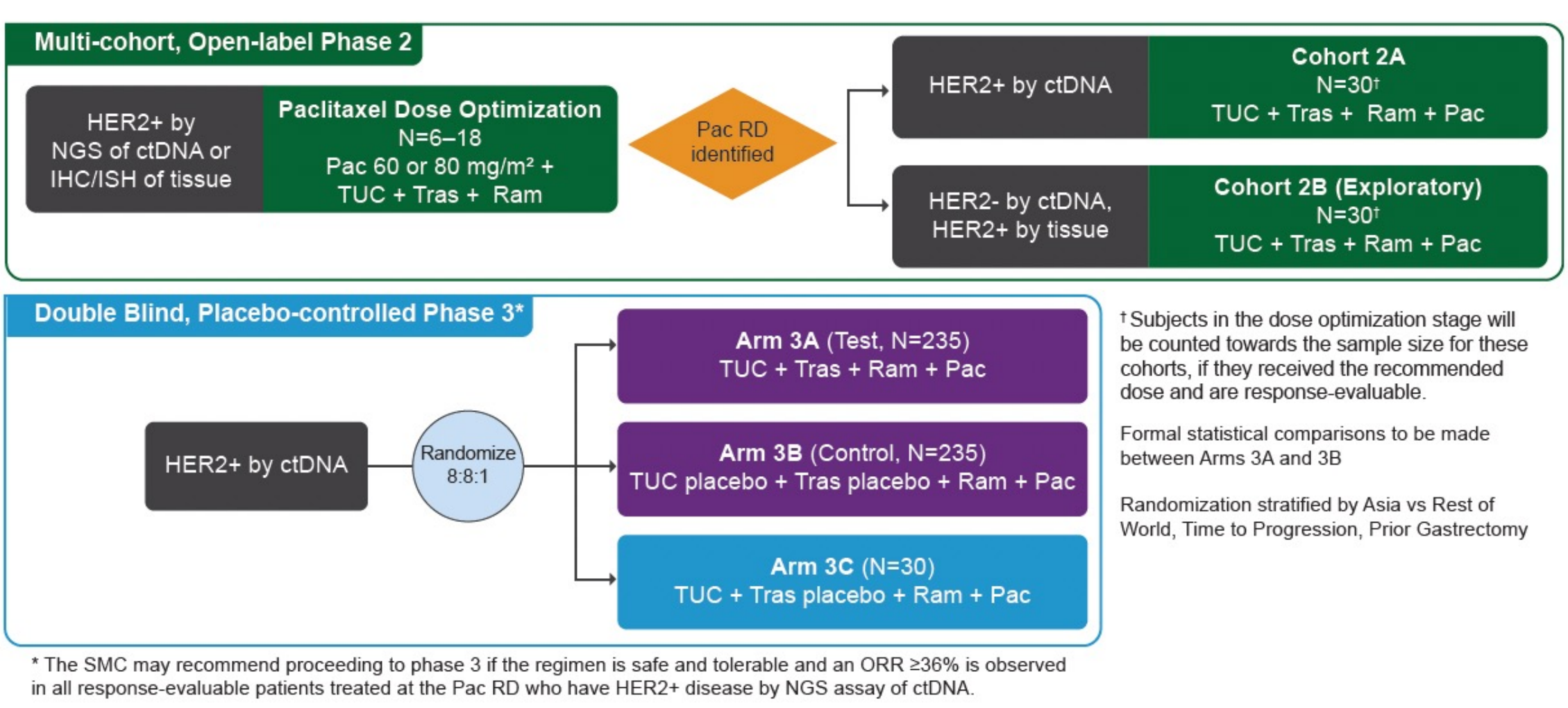
Zanidatamab + Chemotherapy as First-Line Treatment for HER2-Expressing mGEA: Change in Target Lesion Size



Elimova E et al. ASCO GI 2023;Abstract 347.

RTP RESEARCH TO PRACTICE

MOUNTAINEER-02 Phase II/III Study Design



NGS = next-generation sequencing; TUC = tucatinib; Tras = trastuzumab; Ram = ramucirumab; Pac = paclitaxel; RD = recommended dose; ctDNA = circulating tumor DNA

Catenacci DV et al. ESMO 2021;Abstract 1434TiP.

Poster 242

ASCO Gastrointestinal Cancers Symposium 2022

Trastuzumab Deruxtecan (T-DXd; DS-8201) in Patients With HER2–Positive Advanced Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma: Final Overall Survival (OS) Results From a Randomized, Multicenter, Open-Label, Phase 2 Study (DESTINY-Gastric01)

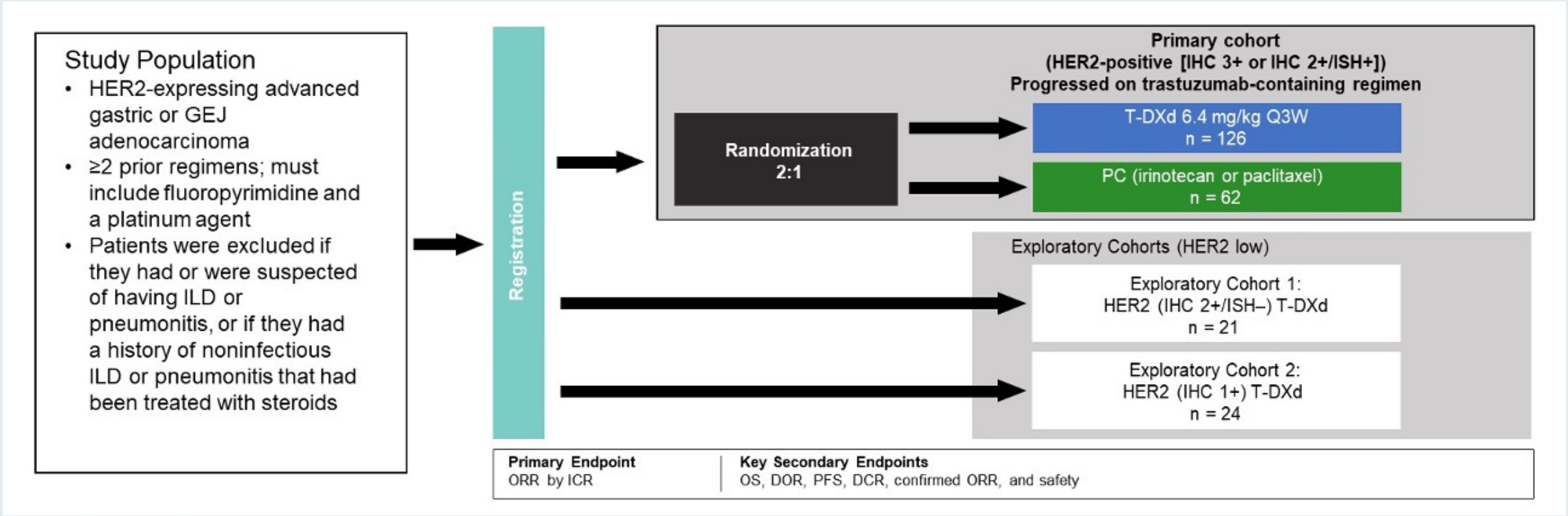
Kensei Yamaguchi

The Cancer Institute Hospital of JFCR, Tokyo, Japan

ON BEHALF OF THE DESTINY-GASTRIC01 INVESTIGATORS

Additional authors: Yung-Jue Bang, Satoru Iwasa, Naotoshi Sugimoto, Min-Hee Ryu, Daisuke Sakai, Hyun Cheol Chung, Hisato Kawakami, Hiroshi Yabusaki, Jeeyun Lee, Kaku Saito, Yoshinori Kawaguchi, Takahiro Kamio, Akihito Kojima, Masahiro Sugihara, Kohei Shitara

DESTINY-Gastric01 Randomized, Phase II Study Design

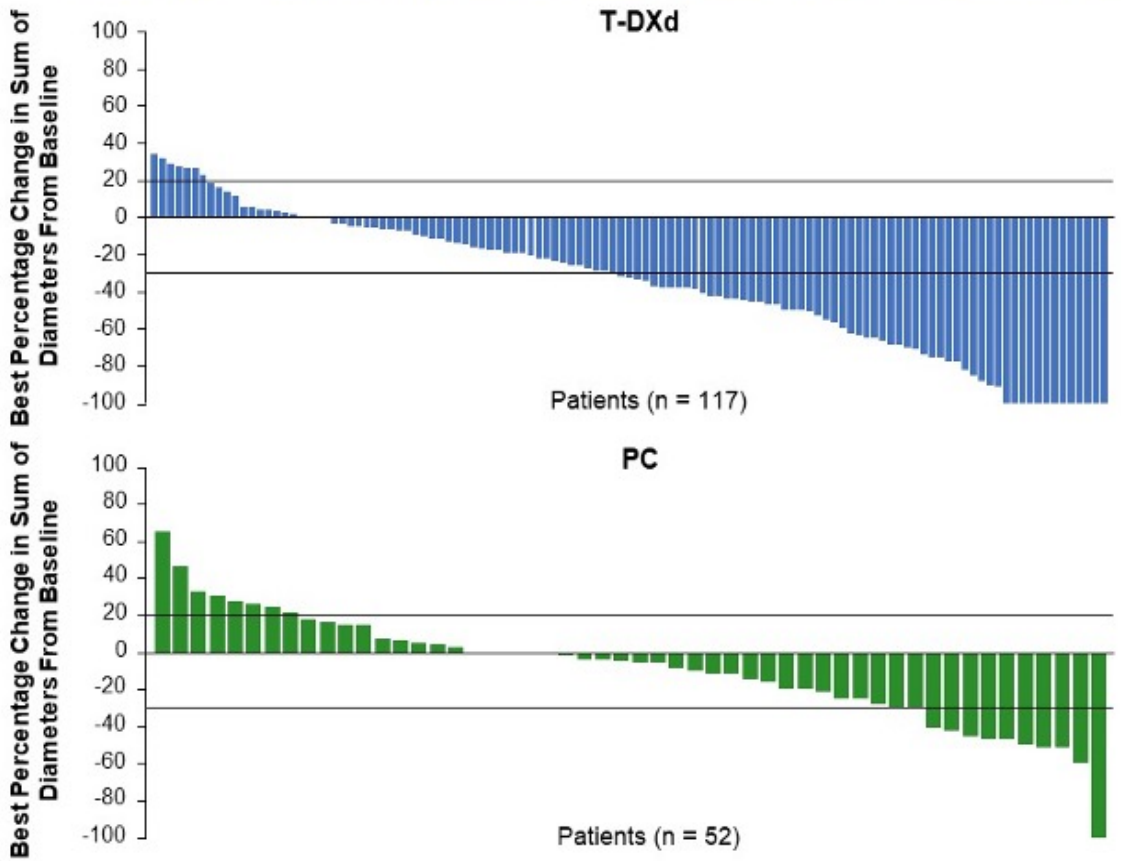


Yamaguchi K et al. Gastrointestinal Cancers Symposium 2022;Abstract 242.

DESTINY-Gastric01: Antitumor Activity

	T-DXd n = 119	PC Overall n = 56
ORR (CR + PR) by ICR, n (%)[a]	**61 (51.3) 95% CI, 41.9-60.5**	**8 (14.3) 95% CI, 6.4-26.2**
	P < 0.0001[b]	
CR	11 (9.2)	0
PR	50 (42.0)	8 (14.3)
SD	42 (35.3)	27 (48.2)
PD	14 (11.8)	17 (30.4)
Not evaluable	2 (1.7)	4 (7.1)
Confirmed ORR (CR + PR) by ICR, n (%)[a]	50 (42.0) 95% CI, 33.0-51.4	7 (12.5) 95% CI, 5.2-24.1
CR	10 (8.4)	0
PR	40[c] (33.6)	7 (12.5)
SD	52 (43.7)	28 (50.0)
PD	14 (11.8)	17 (30.4)
Not evaluable	3 (2.5)	4 (7.1)
Confirmed DCR (CR + PR + SD), n (%)[a]	102 (85.7) 95% CI, 78.1-91.5	35 (62.5) 95% CI, 48.5-75.1
Confirmed DOR, median, months	12.5 95% CI, 5.6-NE	3.9 95% CI, 3.0-4.9
TTR, median, months	1.5 95% CI, 1.4-1.7	1.6 95% CI, 1.3-1.7

Best Percentage Change from Baseline in Tumor Size for Individual Patients

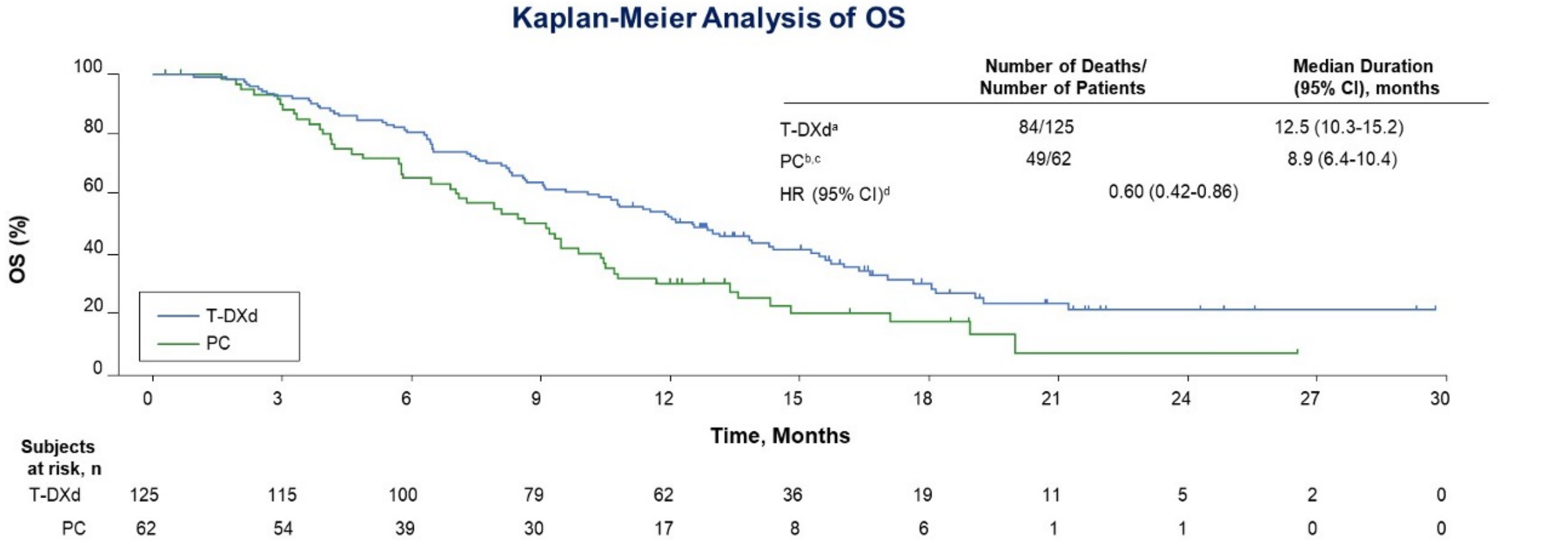


PC = physician's choice of chemotherapy; ORR = objective response rate; CR = complete response; PR = partial response; ICR = independent central review; DCR = disease control rate; DOR = duration of response; TTR = time to response

Yamaguchi K et al. Gastrointestinal Cancers Symposium 2022;Abstract 242.

RTP RESEARCH TO PRACTICE

DESTINY-Gastric01: Final Overall Survival (OS)



As in the primary analysis (101 OS events; 54.0% maturity), in this updated analysis (133 OS events; 71.1% maturity), T-DXd showed superior antitumor activity compared to PC

Yamaguchi K et al. Gastrointestinal Cancers Symposium 2022;Abstract 242.

RTP RESEARCH TO PRACTICE

DESTINY-Gastric01: Select Adverse Events

Adverse event	T-DXd (n = 125)		PC overall (n = 62)	
	Any grade	Grade ≥3	Any grade	Grade ≥3
Neutrophil count decrease	65%	51%	36%	24%
Nausea	63%	6%	47%	2%
Decreased appetite	61%	17%	45%	13%
Anemia	58%	38%	31%	23%
Platelet count decrease	40%	11%	7%	3%
WBC count decrease	38%	21%	36%	11%
Lymphocyte count decrease	23%	12%	3%	2%

16 patients (13%) had T-DXd-related interstitial lung disease/pneumonitis:

- 13/16 were Grade 1 or 2
- Median time to first onset: 102.5 days

Yamaguchi K et al. Gastrointestinal Cancers Symposium 2022;Abstract 242.

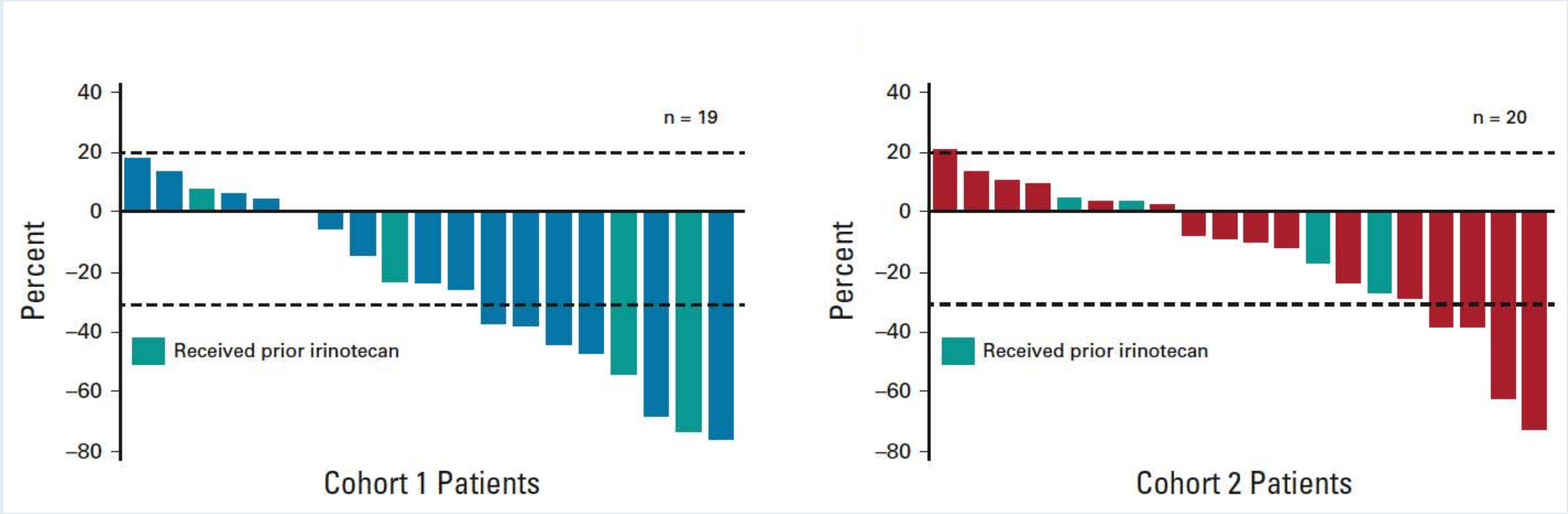
original reports

Trastuzumab Deruxtecan in Anti–Human Epidermal Growth Factor Receptor 2 Treatment–Naive Patients With Human Epidermal Growth Factor Receptor 2–Low Gastric or Gastroesophageal Junction Adenocarcinoma: Exploratory Cohort Results in a Phase II Trial

Kensei Yamaguchi, MD[1]; Yung-Jue Bang, MD, PhD[2]; Satoru Iwasa, MD[3]; Naotoshi Sugimoto, MD[4]; Min-Hee Ryu, MD, PhD[5]; Daisuke Sakai, MD[6]; Hyun Cheol Chung, MD, PhD[7]; Hisato Kawakami, MD, PhD[8]; Hiroshi Yabusaki, MD[9]; Jeeyun Lee, MD[10]; Tatsu Shimoyama, MD[11]; Keun-Wook Lee, MD, PhD[12]; Kaku Saito, MSc, MBA[13]; Yoshinori Kawaguchi, MSc, MBA[13]; Takahiro Kamio, MD[13]; Akihito Kojima, MSc[14]; Masahiro Sugihara, PhD[14]; and Kohei Shitara, MD[15]

J Clin Oncol 2023 February 1;41(4):816-25.

DESTINY-Gastric01: Best Percent Change from Baseline Tumor Size in Patients with Treatment-Naïve HER2-Low Advanced Gastric or GEJ Adenocarcinoma



Yamaguchi K et al. *J Clin Oncol* 2023 February 1;41(4):816-25.

RTP RESEARCH TO PRACTICE

PARIS 2022 ESMO congress

Updated Analysis of DESTINY-Gastric02: a Phase 2 Single-Arm Trial of Trastuzumab Deruxtecan (T-DXd) in Western Patients with HER2-Positive Unresectable/Metastatic Gastric/Gastroesophageal Junction (GEJ) Cancer Who Progressed on or After Trastuzumab-Containing Regimen

Presentation 1205MO

Geoffrey Ku,[a] Maria di Bartolomeo, Elizabeth Smyth, Ian Chau, Haeseong Park, Salvatore Siena, Sara Lonardi, Zev A. Wainberg, Jaffer Ajani, Joseph Chao, Ferdous Barlaskar, Yoshinori Kawaguchi, Amy Qin, Jasmeet Singh, Aashima Puri, Gerold Meinhardt, Eric Van Cutsem

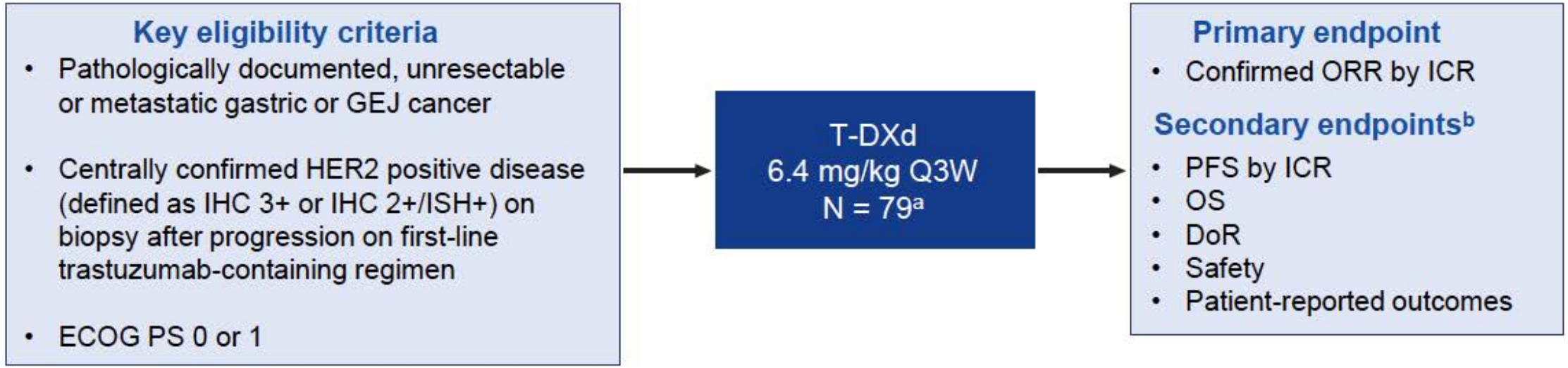
On behalf of the DESTINY-Gastric02 investigators

[a]Memorial Sloan Kettering Cancer Center, New York, NY, USA

Paris, France, September 9-13, 2022

Abstract 1205MO

DESTINY-Gastric02 Phase II Study Design



- Primary results of DESTINY-Gastric02 (data cutoff, April 9, 2021; median follow up 5.9 months) demonstrated a cORR of **38.0%** (95% CI, 27.3-49.6), and safety consistent with the established T-DXd safety profile[1]
- Here, we report OS and updated efficacy and safety results, with 7 additional months of follow-up (data cutoff, November 8, 2021)

cORR, confirmed ORR; DoR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; GEJ, gastroesophageal junction; HER2, human epidermal growth factor receptor 2; ICR, independent central review; IHC, immunohistochemistry; ISH, in situ hybridization; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; T-DXd, trastuzumab deruxtecan; Q3W, every 3 weeks.
[a]Enrollment of 80 patients was planned; actual enrollment was 79 patients. [b]Other secondary endpoints were ORR, PFS, and DoR by investigator assessment, pharmacokinetics, and anti-drug antibodies.
1. Van Cutsem E et al. *Ann Oncol*. 2021 32(suppl_5):S1283-S346.

Ku G et al. ESMO 2022;Abstract 1205MO.

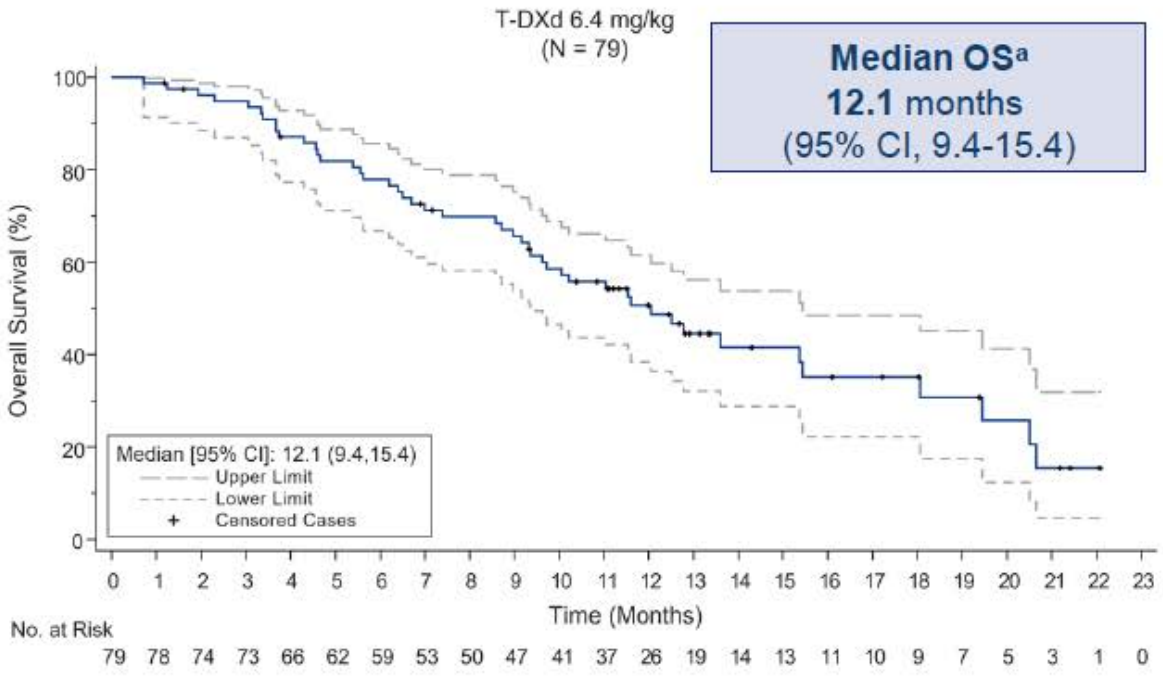
DESTINY-Gastric02: Efficacy Endpoints

Response Assessment by ICR	April 9, 2021 Data Cutoff[a] Patients (N = 79)	November 8, 2021 Data Cutoff[b] Patients (N = 79)
Confirmed ORR,[c] % (n)	**38.0** (30) (95% CI, 27.3-49.6)	**41.8** (33) (95% CI, 30.8-53.4)
Confirmed best overall response, % (n)		
CR	**3.8** (3)	**5.1** (4)
PR	**34.2** (27)	**36.7** (29)
SD	**43.0** (34)	**39.2** (31)
PD	**16.5** (13)	**16.5** (13)
Not evaluable	**2.5** (2)	**2.5** (2)
Confirmed DCR,[d] % (n)	**81.0** (64) (95% CI, 70.6-89.0)	**81.0** (64) (95% CI, 70.6-89.0)
Median DoR, months	8.1 (95% CI, 4.1-NE)	8.1 (95% CI, 5.9-NE)[e]
Median TTR, months	1.4 (95% CI, 1.4-2.6)	1.4 (95% CI, 1.4-2.7)

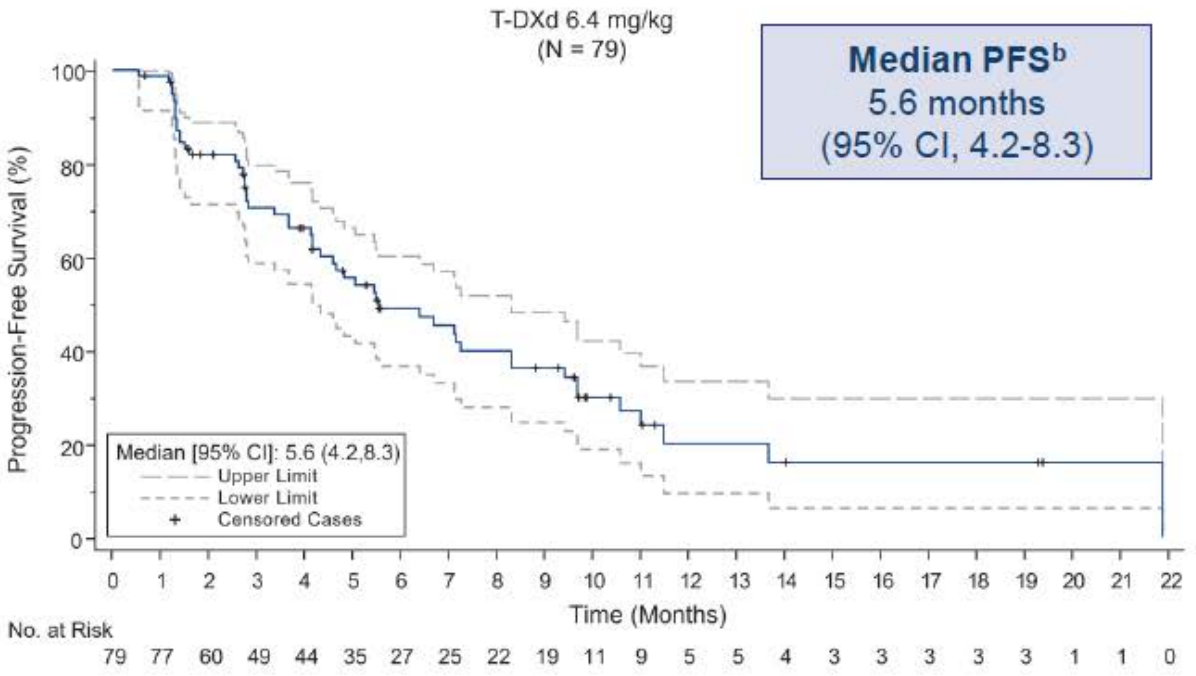
Ku G et al. ESMO 2022;Abstract 1205MO.

DESTINY-Gastric02: PFS and OS

Kaplan-Meier Plot of OS



Kaplan-Meier Plot of PFS by ICR



Ku G et al. ESMO 2022;Abstract 1205MO.

RTP RESEARCH TO PRACTICE

DESTINY-Gastric02: Overall Safety Summary and ILD/Pneumonitis

% (n)	Patients (N = 79)
Any TEAE	100 (79)
Drug-related	94.9 (75)
TEAE grade ≥3	55.7 (44)
Drug-related	30.4 (24)
Serious TEAE	41.8 (33)
Drug-related	12.7 (10)
TEAE associated with study drug discontinuation	19.0 (15)
Drug-related	12.7 (10)
TEAE associated with dose reduction	21.5 (17)
Drug-related	17.7 (14)
TEAE associated with an outcome of death	13.9 (11)
Drug-related	2.5 (2)
Adjudicated drug-related ILD/pneumonitis	10.1 (8)[a]
Adjudicated drug-related ILD/pneumonitis grade 5	2.5 (2)

- Median treatment duration was 4.3 months (range, 0.7-22.1 months)
- The most common TEAEs were nausea (67.1%), vomiting (44.3%), and fatigue (41.8%)
- Grade 1 adjudicated drug-related ILD/pneumonitis occurred in 2 patients (2.5%), grade 2 in 4 patients (5.1%), and grade 5 in 2 patients (2.5%)
- Median time to onset of adjudicated drug-related ILD/pneumonitis was 80.5 days (range, 42-344 days), with a median duration of 36.0 days (range, 15-142 days)
- Of the 2 fatal ILD/pneumonitis cases, 1 occurred 171 days after drug initiation and the second after 353 days

ILD, interstitial lung disease; TEAE, treatment-emergent adverse event.
Cutoff date: November 8, 2021.
[a]Of the 6 grade 1/2 ILD/pneumonitis cases, 3 patients had recovered or were recovering at the time of data cutoff, 1 had recovered with sequelae, 1 had not recovered, and 1 had an outcome that was unknown.

Ku G et al. ESMO 2022;Abstract 1205MO.

Conclusions

- T-DXd is currently FDA approved for use in patients with locally advanced or metastatic HER2+ gastric or GEJ adenocarcinoma who have received a trastuzumab-based regimen[1]
- With longer follow-up, T-DXd continues to demonstrate clinical benefit and a tolerable safety profile, as well as maintained QoL, in second-line Western patients with HER2+ unresectable/metastatic gastric/GEJ cancer
  - Median follow up was **10.2** months
  - Confirmed ORR was **41.8%** and median OS was **12.1** months
  - Safety profile was generally consistent with the established safety profile of T-DXd
  - Observed mean scores at baseline and up to cycle 7,[a] as assessed by EQ-5D VAS and FACT-Ga Physical Wellbeing and Gastric Cancer Subscales, suggest that HRQoL did not worsen
    - Together with the improved clinical efficacy and a manageable safety profile, these PRO results provide additional support for the benefit of T-DXd in this patient population

Ku G et al. ESMO 2022;Abstract 1205MO.

Esophageal Cancers

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RESEARCH
TO PRACTICE

ASCO Gastrointestinal Cancers Symposium 2023

Nivolumab plus chemotherapy or ipilimumab vs chemotherapy as first-line treatment for advanced esophageal squamous cell carcinoma: 29-month follow-up from CheckMate 648

Ken Kato,[1] Jaffer Ajani,[2] Yuichiro Doki,[3] Jianming Xu,[4] Lucjan Wyrwicz,[5] Satoru Motoyama,[6] Takashi Ogata,[7] Hisato Kawakami,[8] Chih-Hung Hsu,[9] Antoine Adenis,[10] Farid El Hajbi,[11] Maria Di Bartolomeo,[12] Maria Ignez Braghiroli,[13] Eva Holtved,[14] Mariela Blum Murphy,[2] Apurva Patel,[15] Nan Hu,[15] Yasuhiro Matsumura,[16] Ian Chau,[17] Yuko Kitagawa[18]

[1]National Cancer Center Hospital, Tokyo, Japan; [2]The University of Texas MD Anderson Cancer Center, Houston, TX; [3]Osaka University Graduate School of Medicine, Osaka, Japan; [4]Affiliated Hospital Cancer Center, Academy of Military Medical Sciences, Beijing, China; [5]Klinika Onkologii i Radioterapii, Narodowy Instytut Onkologii, Warszawa, Poland; [6]Japanese Red Cross Akita Hospital, Akita, Japan; [7]Kanagawa Cancer Center, Kanagawa, Japan; [8]Kindai University Faculty of Medicine, Osakasayama, Japan; [9]National Taiwan University Hospital, Taipei, Taiwan; [10]Institut du Cancer de Montpellier, Montpellier, France; [11]Centre Oscar Lambret, Lille, France; [12]Fondazione IRCCS Istituto Nazionale dei Tumori, Milan, Italy; [13]Institute of Cancer of São Paulo, University of São Paulo, São Paulo, Brazil; [14]Odense University Hospital, Odense, Denmark; [15]Bristol Myers Squibb, Princeton, NJ; [16]Ono Pharmaceutical Company Ltd., Osaka, Japan; [17]Royal Marsden Hospital, London & Surrey, UK; [18]Keio University School of Medicine, Tokyo, Japan

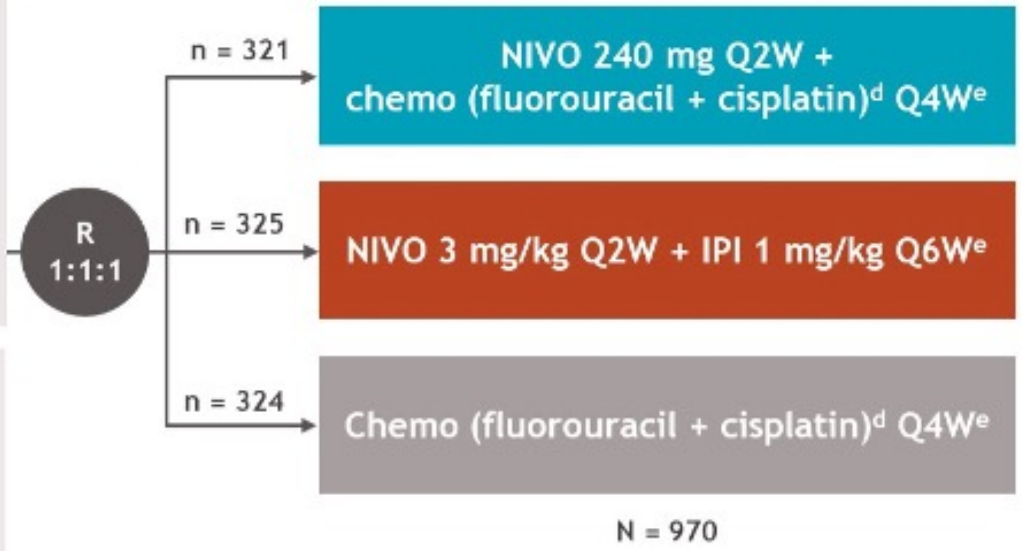
Abstract number 290

CheckMate 648 Study Design

- CheckMate 648 is a global, randomized, open-label phase 3 study[a]

Key eligibility criteria
- Unresectable advanced, recurrent or metastatic ESCC
- ECOG PS 0-1
- No prior systemic treatment for advanced disease
- Measurable disease

Stratification factors
- Tumor cell PD-L1 expression (≥ 1% vs < 1%[b])
- Region (East Asia[c] vs rest of Asia vs ROW)
- ECOG PS (0 vs 1)
- Number of organs with metastases (≤ 1 vs ≥ 2)



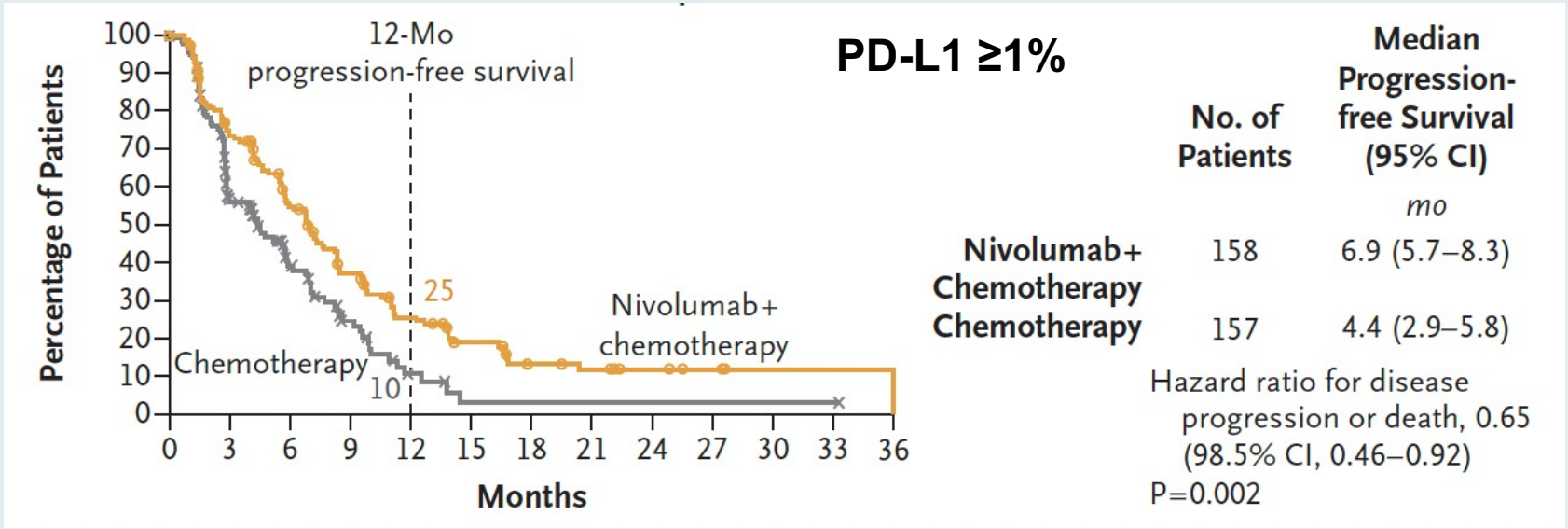
Primary endpoints:
- OS and PFS[f] (tumor cell PD-L1 ≥ 1%)

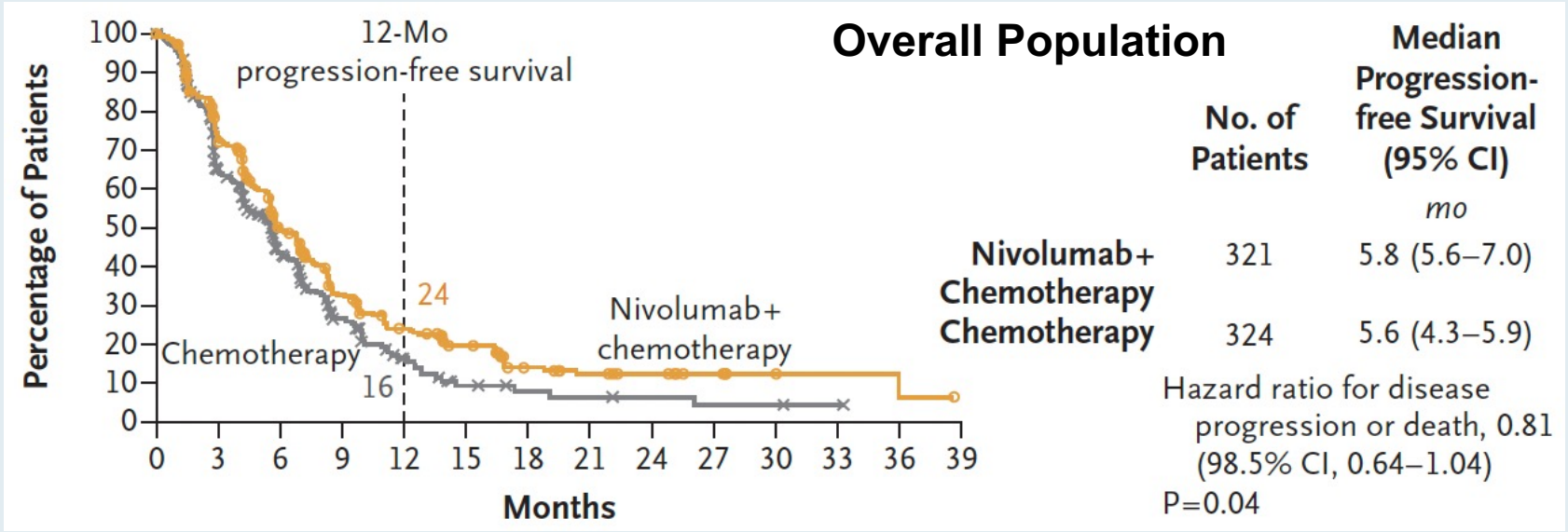
Secondary endpoints:
- OS and PFS[f] (all randomized)
- ORR[f] (tumor cell PD-L1 ≥ 1% and all randomized)

- At data cutoff (May 17, 2022), the minimum follow-up[g] was 28.8 months

Kato K et al. Gastrointestinal Cancers Symposium 2023;Abstract 290.

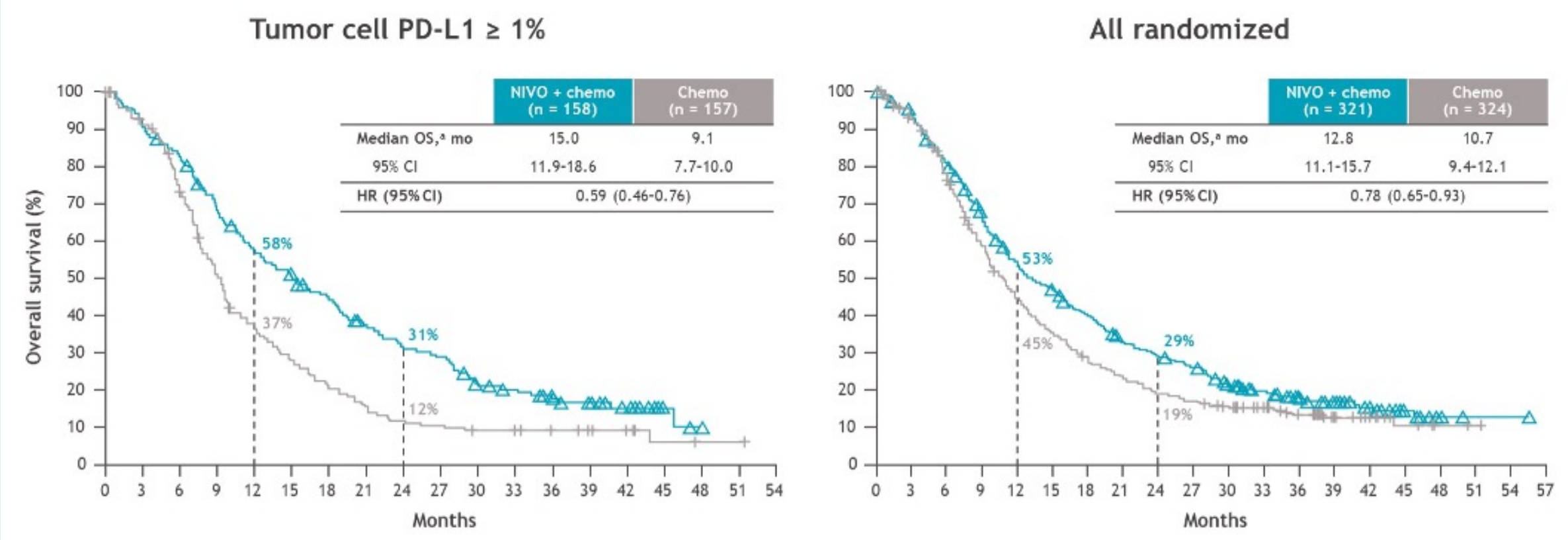
CheckMate 648: Progression-Free Survival for PD-L1 ≥1% and in the Overall Population – Nivolumab with Chemotherapy





Doki Y et al. *N Engl J Med* 2022;386(5):449-62.

CheckMate 648: Overall Survival with Nivolumab and Chemotherapy versus Chemotherapy Alone at 29-Month Follow-Up



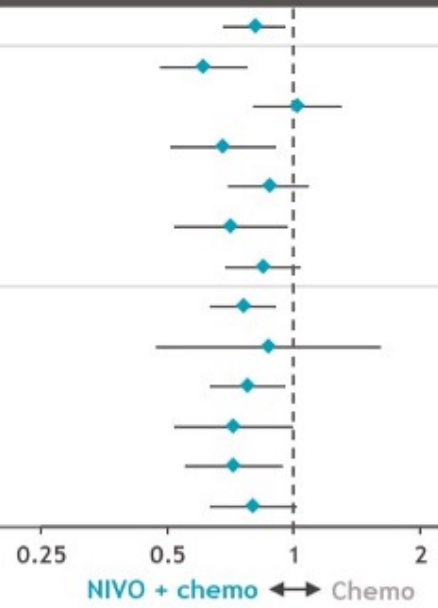
- Clinically meaningful improvement in OS with NIVO + chemo vs chemo in the tumor cell PD-L1 ≥1 and all randomized populations was maintained with longer follow-up:
  - Tumor cell PD-L1 ≥1: 41% reduction in the risk of death and a 5.9-month improvement in median OS
  - All randomized: 22% reduction in the risk of death and a 2.1-month improvement in median OS

Kato K et al. Gastrointestinal Cancers Symposium 2023;Abstract 290.

RTP RESEARCH TO PRACTICE

CheckMate 648: Overall Survival by Baseline PD-L1 Status with Nivolumab and Chemotherapy versus Chemotherapy Alone at 29-Month Follow-Up

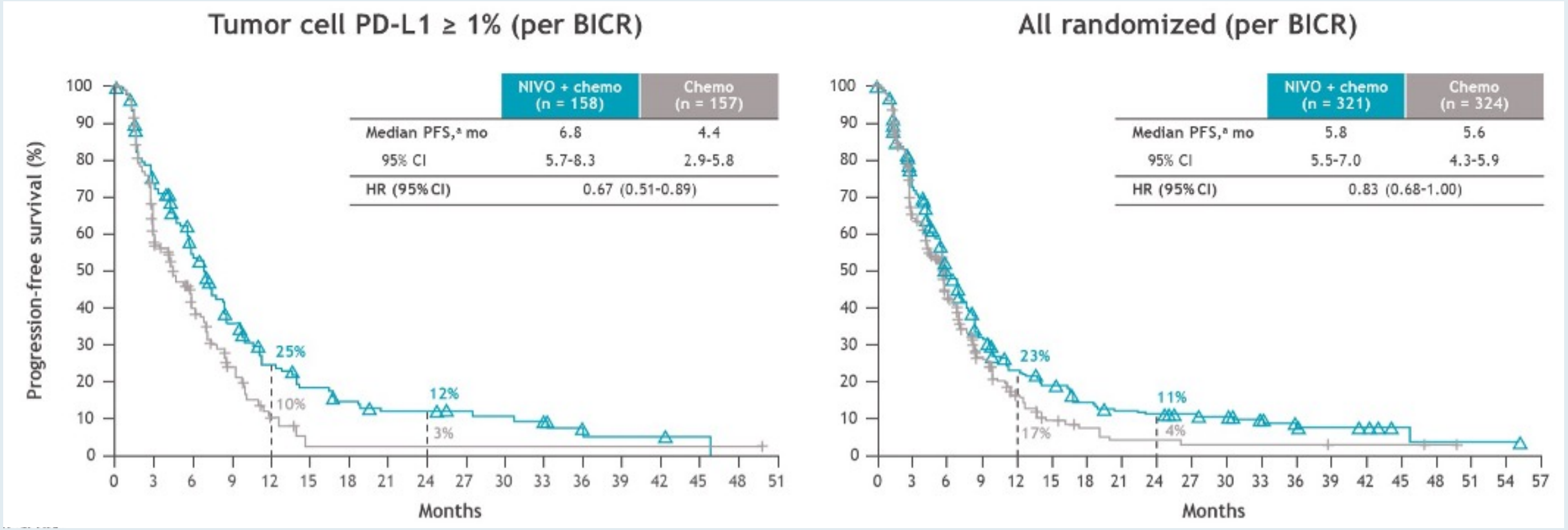
Category (all randomized)	Subgroup	Median OS, months		Unstratified HR for death	Unstratified HR (95% CI)
		NIVO + chemo	Chemo		
Overall (N = 645)		12.8	10.7	0.81	
Tumor cell PD-L1 expression[a]	≥ 1% (n = 314)	15.0	9.2	0.61	
	< 1% (n = 329)	12.0	12.2	1.02	
	≥ 5% (n = 235)	13.7	9.5	0.68	
	< 5% (n = 408)	12.5	11.1	0.88	
	≥ 10% (n = 199)	14.7	9.6	0.71	
	< 10% (n = 444)	12.1	10.8	0.85	
PD-L1 CPS[b,c]	≥ 1 (n = 558)	13.7	9.9	0.76	
	< 1 (n = 51)	9.9	12.1	0.87	
	≥ 5 (n = 421)	14.9	11.1	0.78	
	< 5 (n = 188)	11.7	9.4	0.72	
	≥ 10 (n = 280)	15.5	11.6	0.72	
	< 10 (n = 329)	12.0	9.7	0.80	



- Results across baseline PD-L1 status subgroups were generally consistent with those previously reported:
  - HRs were below 1 across most PD-L1 expression subgroups, favoring NIVO + chemo
  - The largest magnitude of OS benefit was observed among patients with tumor cell PD-L1 ≥1%, with no further enrichment in subgroups with higher tumor cell PD-L1 expression

Kato K et al. Gastrointestinal Cancers Symposium 2023;Abstract 290.

CheckMate 648: Progression-Free Survival with Nivolumab and Chemotherapy versus Chemotherapy Alone at 29-Month Follow-Up

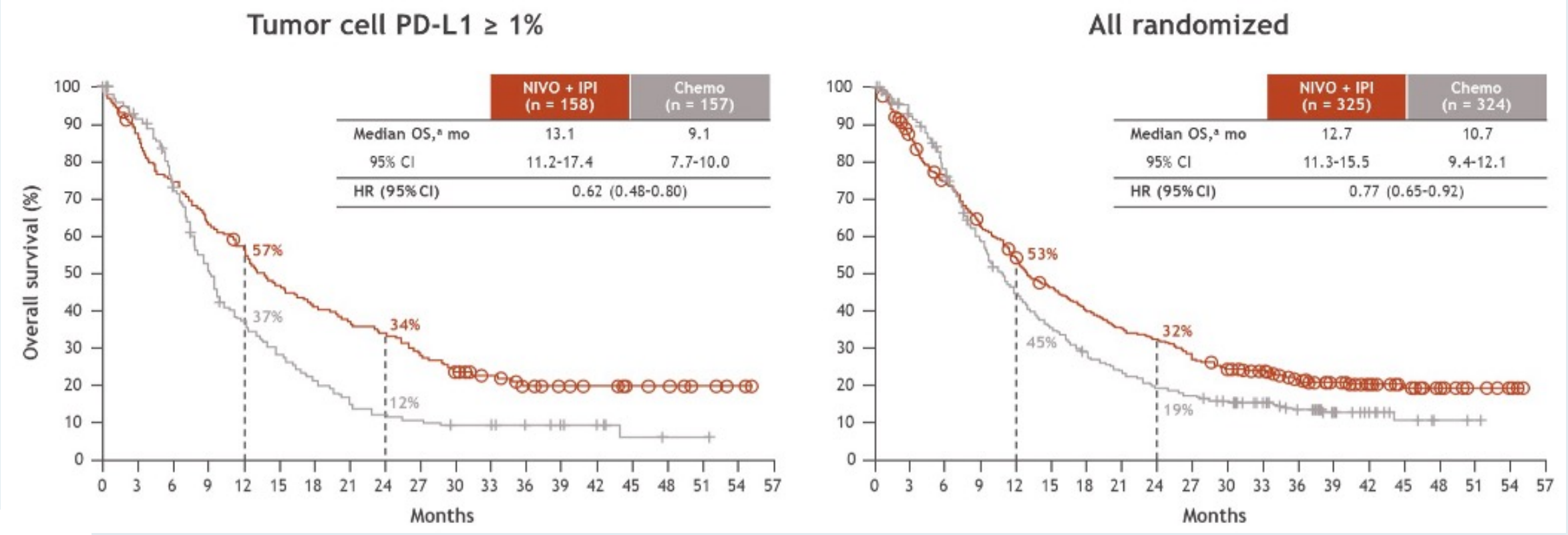


- PFS benefit with NIVO + chemo vs chemo was maintained with longer follow-up

BICR = blinded independent central review

Kato K et al. Gastrointestinal Cancers Symposium 2023;Abstract 290.

CheckMate 648: Overall Survival with Nivolumab/Ipilimumab versus Chemotherapy at 29-Month Follow-Up

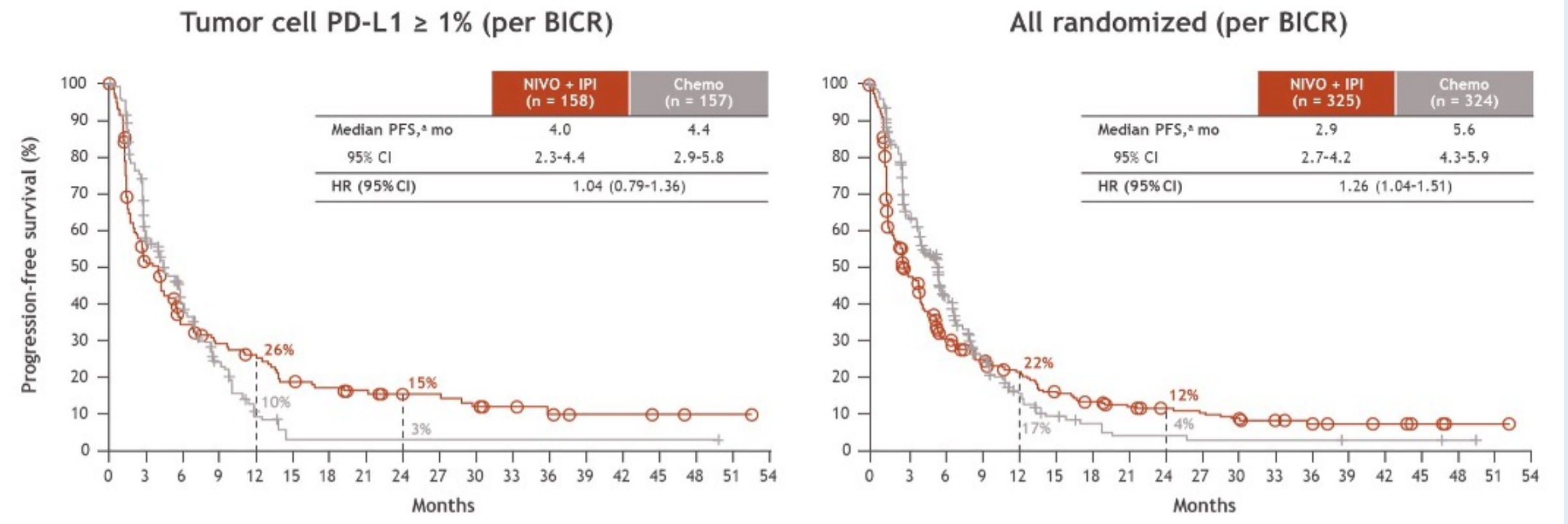


- Clinically meaningful improvement in OS with NIVO + IPI vs chemo in the tumor cell PD-L1 ≥1 and all randomized populations was maintained with longer follow-up:
  - Tumor cell PD-L1 ≥1: 38% reduction in the risk of death and a 4.0-month improvement in median OS
  - All randomized: 23% reduction in the risk of death and a 2.0-month improvement in median OS

Kato K et al. Gastrointestinal Cancers Symposium 2023;Abstract 290.

RTP RESEARCH TO PRACTICE

CheckMate 648: Progression-Free Survival with Nivolumab/Ipilimumab versus Chemotherapy at 29-Month Follow-Up



- No PFS benefit was observed with NIVO + IPI vs chemo with longer follow-up in either the tumor cell PD-L1 ≥1 population or all randomized populations, consistent with previously reported results

Kato K et al. Gastrointestinal Cancers Symposium 2023;Abstract 290.

First-line Pembrolizumab Plus Chemotherapy Versus Chemotherapy in Advanced Esophageal Cancer: Longer-term Efficacy, Safety, and Quality-of-life Results From the Phase 3 KEYNOTE-590 Study

Jean-Philippe Metges,[1] Ken Kato,[2] Jong-Mu Sun,[3] Manish A. Shah,[4] Peter Enzinger,[5] Antoine Adenis,[6] Toshihiko Doi,[7] Takashi Kojima,[7] Zhigang Li,[8] Sung-Bae Kim,[9] Byoung Chul Cho,[10] Wasat Mansoor,[11] Shau-Hsuan Li,[12] Patrapim Sunpaweravong,[13] Maria Alsina Maqueda,[14] Gary L. Buchschacher, Jr,[15] Wu Jimin,[16] Sukrut Shah,[16] Pooja Bhagia,[16] Lin Shen[17]

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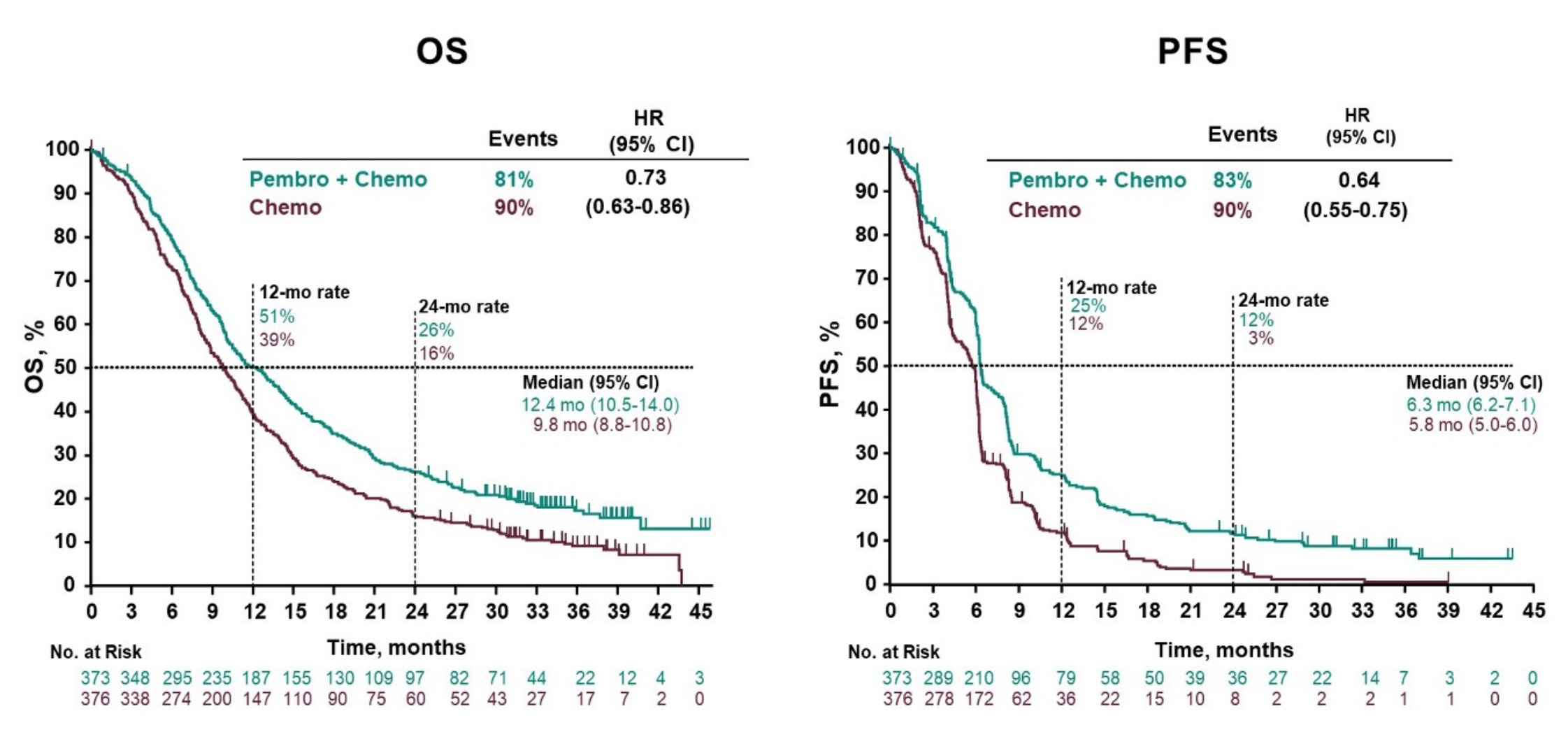
Gastrointestinal Cancers Symposium 2022;Abstract 241.

KEYNOTE-590: Survival Analyses (All Patients)



Metges JP et al. Gastrointestinal Cancers Symposium 2022;Abstract 241.

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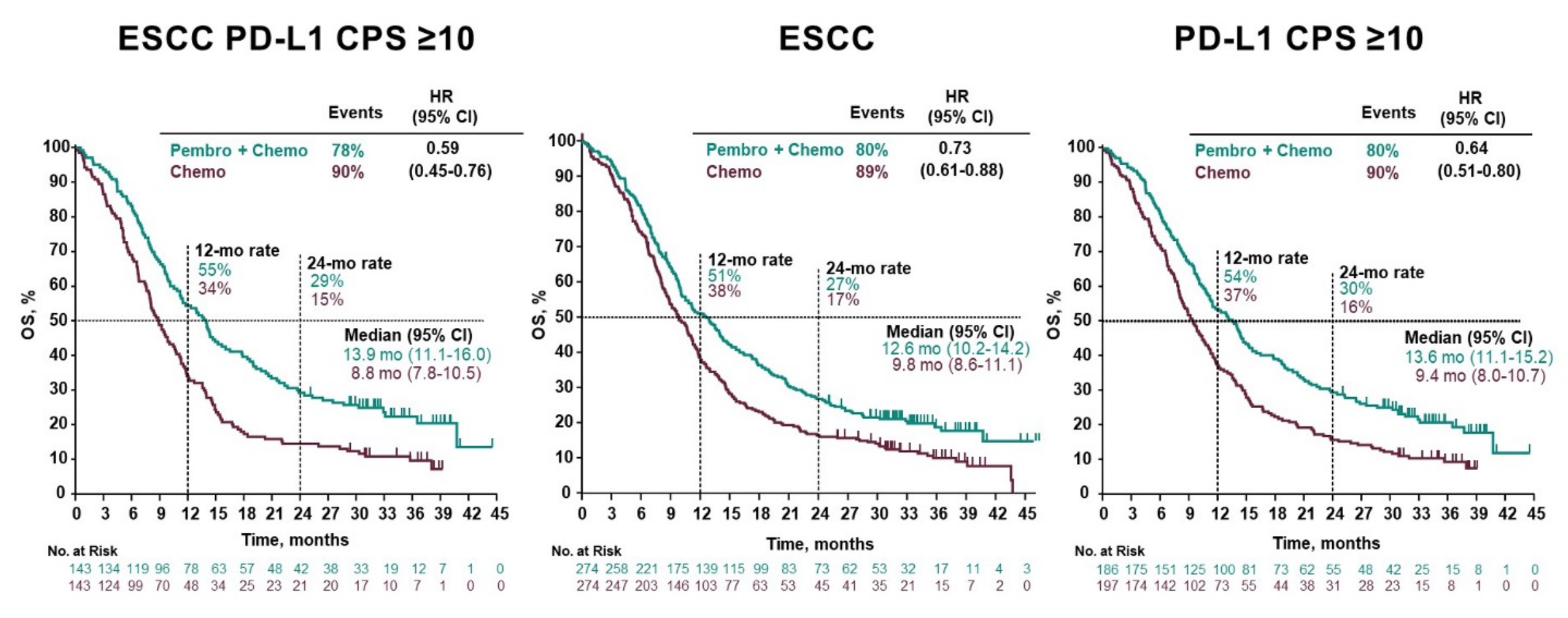
KEYNOTE-590: Overall Survival (OS) in Prespecified Subgroups



Metges JP et al. Gastrointestinal Cancers Symposium 2022;Abstract 241.

RTP RESEARCH TO PRACTICE

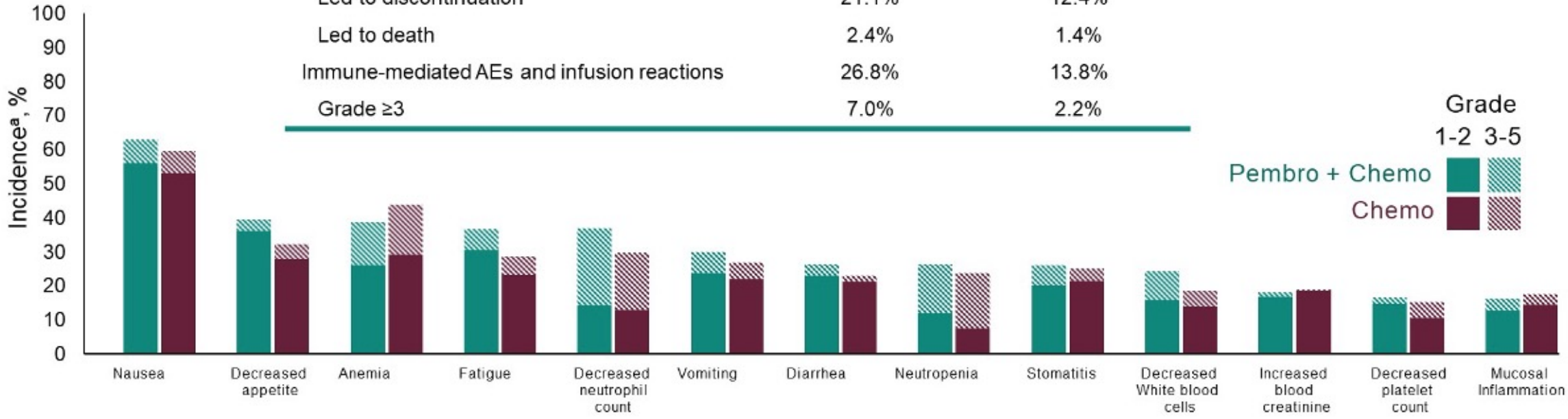
KEYNOTE-590: Antitumor Response

Best response, n (%)	Pembro + Chemo N = 373	Chemo N = 376
ORR, n (%)	**168 (45.0)**	**110 (29.3)**
Complete response	25 (6.7)	9 (2.4)
Partial response	143 (38.3)	101 (26.9)
Stable disease	126 (33.8)	174 (46.3)
Disease control rate	294 (78.8)	284 (75.5)
Progressive disease	43 (11.5)	59 (15.7)
Not evaluable/no assessment	36 (9.6)	33 (8.7)
Median DOR (range), mo	8.3 (1.2+ to 41.7+)	6.0 (1.5+ to 34.9+)
≥ 24 months response duration, %	**20.4**	**6.2**

Metges JP et al. Gastrointestinal Cancers Symposium 2022;Abstract 241.

KEYNOTE-590: Adverse Events Summary

Events, n (%)	Pembro + Chemo N = 373	Chemo N = 376
Any	100%	99.5%
Treatment-related	98.4%	97.3%
Grade ≥3	71.9%	67.6%
Led to discontinuation	21.1%	12.4%
Led to death	2.4%	1.4%
Immune-mediated AEs and infusion reactions	26.8%	13.8%
Grade ≥3	7.0%	2.2%



Metges JP et al. Gastrointestinal Cancers Symposium 2022;Abstract 241.

RTP RESEARCH TO PRACTICE

Novel Agents and Strategies

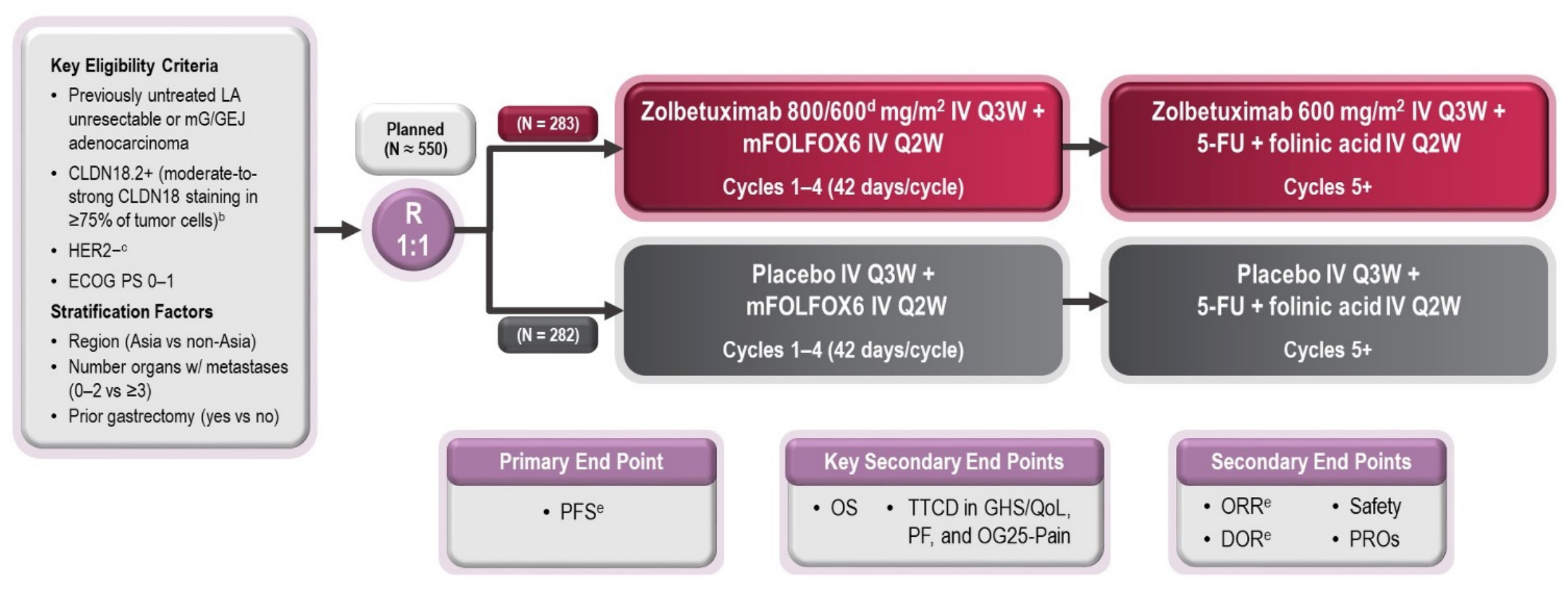
ASCO Gastrointestinal Cancers Symposium 2023

Zolbetuximab + mFOLFOX6 as 1L treatment for patients with CLDN18.2+/ HER2− locally advanced (LA) unresectable or metastatic gastric or gastroesophageal junction (mG/GEJ) adenocarcinoma: Primary phase 3 results from SPOTLIGHT

Kohei Shitara, Florian Lordick, Yung-Jue Bang, Peter Enzinger, David Ilson, Manish A. Shah, Eric Van Cutsem, Rui-Hua Xu, Giuseppe Aprile, Jianming Xu, Joseph Chao, Roberto Pazo-Cid, Yoon-Koo Kang, Jianning Yang, Diarmuid Moran, Pranob Bhattacharya, Ahsan Arozullah, Jung Wook Park, Jaffer A. Ajani

Abstract LBA292

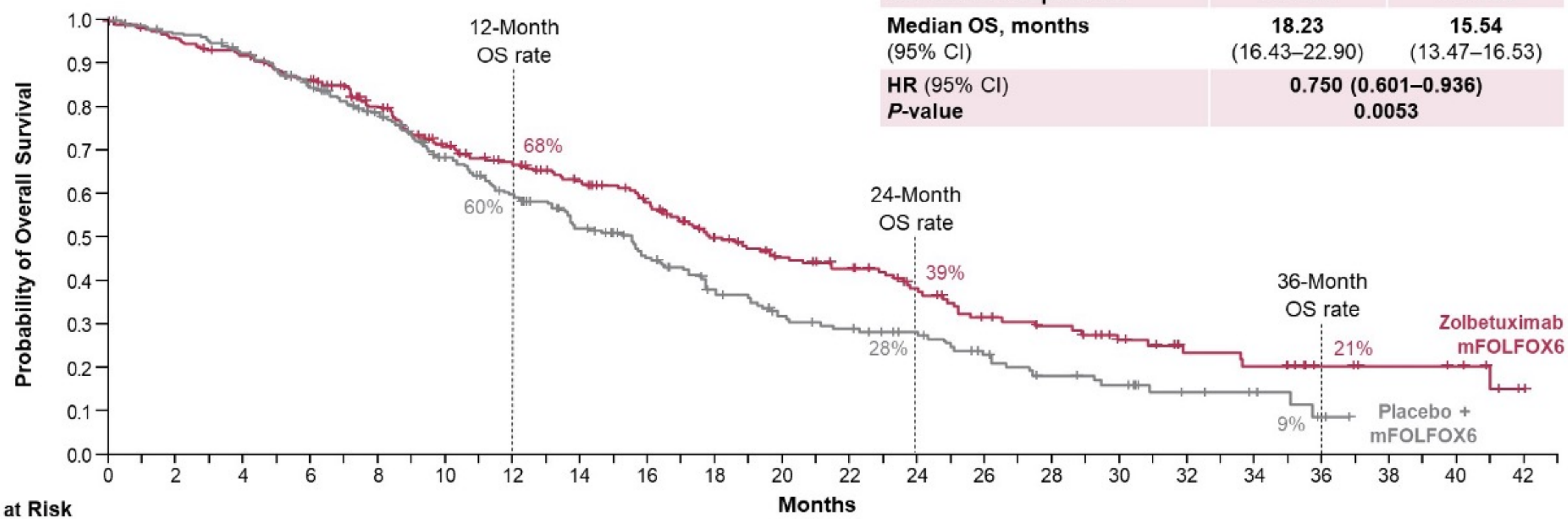
SPOTLIGHT: Phase III Study Design



Shitara K et al. Gastrointestinal Cancers Symposium 2023;Abstract LBA292.

SPOTLIGHT: Overall Survival (Key Secondary Endpoint)

	Zolbetuximab + mFOLFOX6	Placebo + mFOLFOX6
No. events/no. patients	149/283	177/282
Median OS, months (95% CI)	**18.23** (16.43–22.90)	**15.54** (13.47–16.53)
HR (95% CI) *P*-value	**0.750 (0.601–0.936)** **0.0053**	



No. at Risk

Zolbetuximab + mFOLFOX6	283	270	264	255	251	241	233	217	196	178	164	152	146	135	125	117	107	93	83	75	70	67	62	58	49	42	34	32	30	27	23	20	15	15	13	13	9	8	7	7	6	4	1	0
Placebo + mFOLFOX6	282	277	271	266	253	242	224	210	197	183	164	152	139	129	108	101	85	77	64	60	49	42	40	36	34	30	25	21	18	17	15	9	8	7	6	5	2	0	0	0	0	0	0	0

- OS was significantly longer in patients treated with zolbetuximab + mFOLFOX6 vs placebo + mFOLFOX6

Data cutoff: September 9, 2022; Median follow-up = 22.14 months (zolbetuximab + mFOLFOX6) vs 20.93 months (placebo + mFOLFOX6).

Shitara K et al. Gastrointestinal Cancers Symposium 2023;Abstract LBA292.

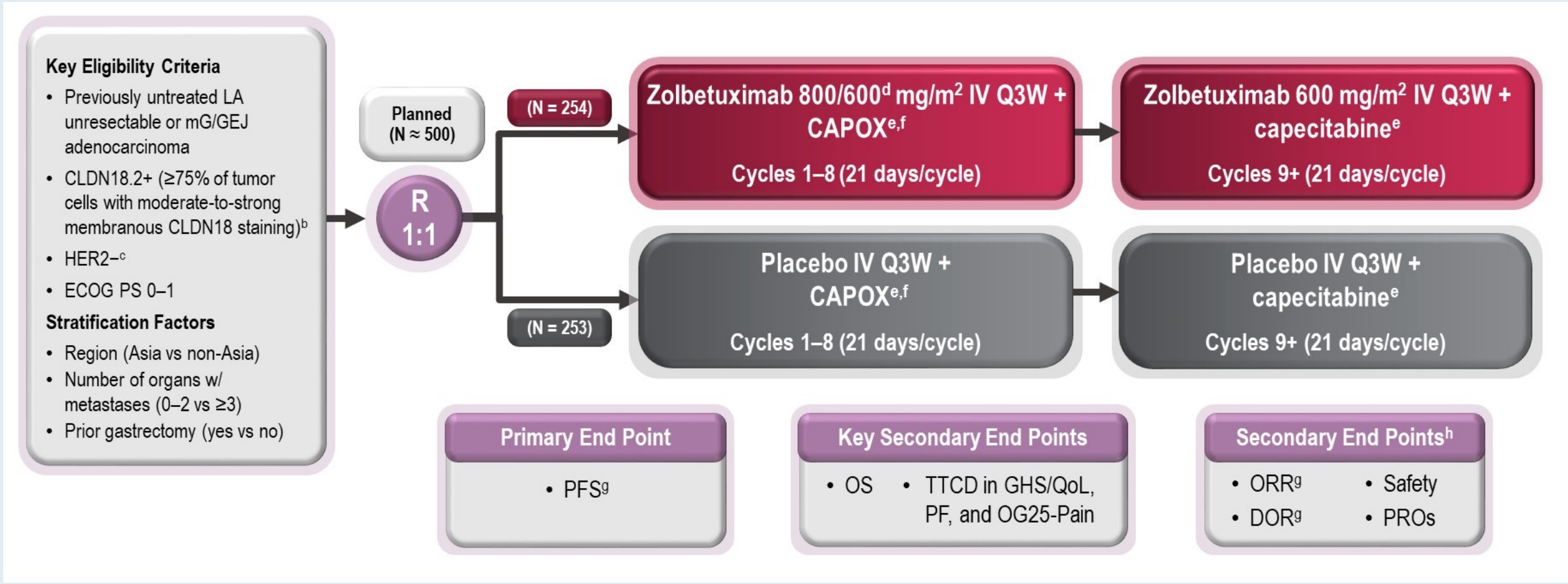
SPOTLIGHT: Response Rates (Key Secondary Endpoint)

	Zolbetuximab + mFOLFOX6 (N = 211)	Placebo + mFOLFOX6 (N = 211)
Patients[a], n	128	131
ORR[b], % (95% CI)	60.7 (53.72–67.30)	62.1 (55.17–68.66)
BOR[c,d], n (%)		
CR	12 (5.7)	7 (3.3)
PR	116 (55.0)	124 (58.8)
SD	45 (21.3)	52 (24.6)
PD	14 (6.6)	14 (6.6)
Median DOR[b], months, (95% CI)	8.51 (6.80–10.25)	8.11 (6.47–11.37)
3rd quartile, months (95% CI)	29.9 (10.41–NE)	15.5 (13.27–NE)

- Response rates were similar between treatment arms
- Formal analysis of PROs is pending
  - Initial descriptive analysis did not indicate differences between treatment arms

Shitara K et al. Gastrointestinal Cancers Symposium 2023;Abstract LBA292.

GLOW: A Phase III Study of First-Line Zolbetuximab and CAPOX for Claudin 18.2-Positive, HER2-Negative Advanced Gastric or Gastroesophageal Junction Adenocarcinoma



Shah M et al. ASCO Plenary Series, March 22, 2023;Abstract 405736.

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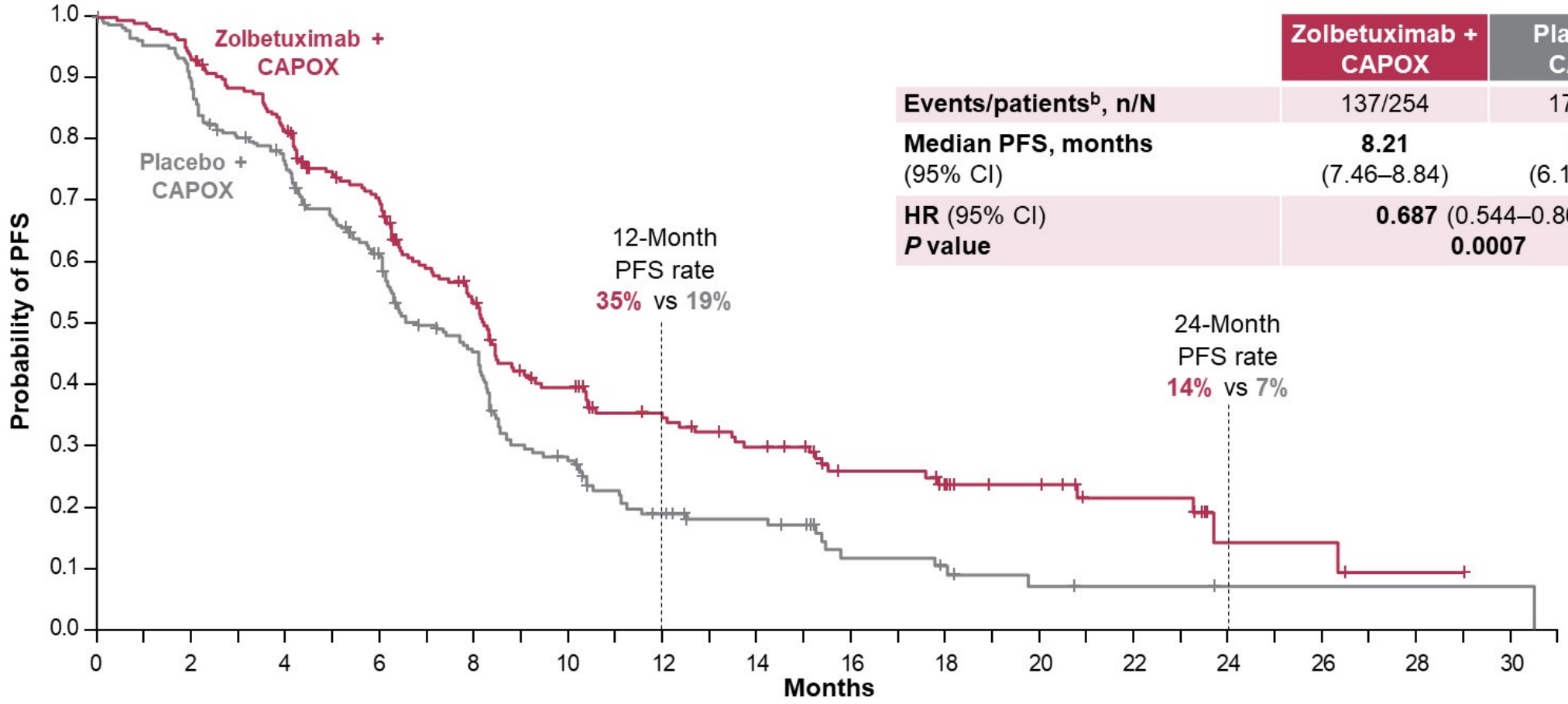
GLOW: PFS by Independent Review Committee (Primary Endpoint)



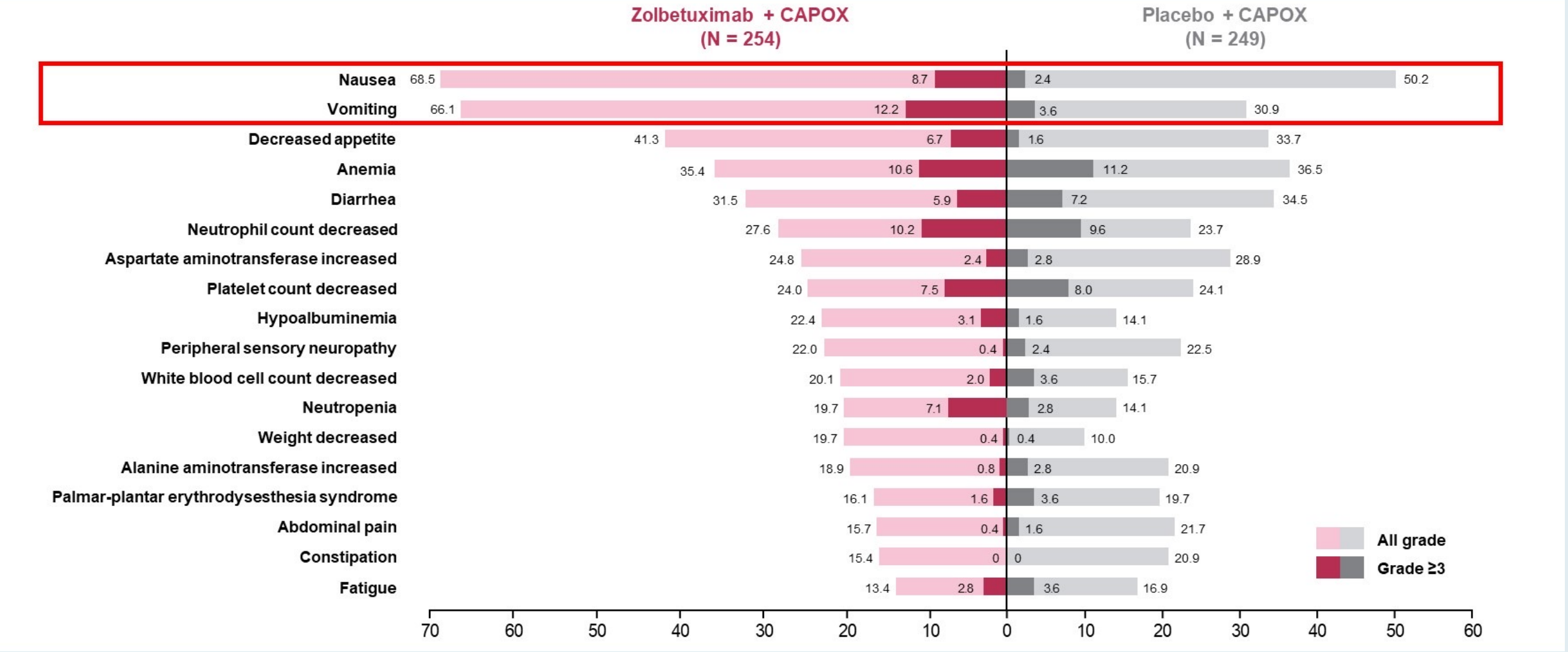
	Zolbetuximab + CAPOX	Placebo + CAPOX
Events/patients[b], n/N	137/254	172/253
Median PFS, months (95% CI)	**8.21** (7.46–8.84)	**6.80** (6.14–8.08)
HR (95% CI)	**0.687** (0.544–0.866)	
***P* value**	**0.0007**	

No. at Risk

Zolbetuximab + CAPOX	254	223	205	187	171	141	132	104	91	66	61	47	45	41	37	35	24	24	19	14	14	9	9	9	3	3	3	1	1	1	0	0
Placebo + CAPOX	253	233	215	188	175	146	127	93	84	48	43	30	24	19	19	17	9	9	7	5	4	2	2	2	1	1	1	1	1	1	1	0

Shah M et al. ASCO Plenary Series, March 22, 2023;Abstract 405736.

GLOW: TEAEs Occurring in ≥15% of All Patients Who Received Treatment



Shah M et al. ASCO Plenary Series, March 22, 2023;Abstract 405736.

Lunch with the Investigators: Gastroesophageal Cancers

A CME Symposium Held in Conjunction with the 2023 ASCO® Annual Meeting

Friday, June 2, 2023

11:45 AM – 12:45 PM CT

Faculty

Yelena Y Janjigian, MD

Manish A Shah, MD

Harry H Yoon, MD, MHS

Moderator

Neil Love, MD

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POSTMEETING SURVEY – Available Now

Clinicians in Attendance: The postmeeting survey is now available on the iPads for attendees in the room and on Zoom for those attending virtually. We appreciate your completing this survey before the end of the program.

Thank you for your input.

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Video Consensus or Controversy? Clinical Investigators Provide Perspectives on the Current and Future Management of Non-Small Cell Lung Cancer

A CME Symposium Held in Conjunction with the 2023 ASCO® Annual Meeting

Friday, June 2, 2023

6:30 PM – 9:00 PM CT

Faculty

Edward B Garon, MD, MS
John V Heymach, MD, PhD
Corey J Langer, MD
Ticiana Leal, MD
David R Spigel, MD
Helena Yu, MD

Moderator

Neil Love, MD

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Thank you for joining us!
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Please complete the survey currently up on the iPads for attendees in the room and on Zoom for those attending virtually. The survey will remain open up to 5 minutes after the meeting ends.

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Online/Zoom attendees: The CME credit link is posted in the chat room.

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