2ND LINE TREATMENT FOR ADVANCED NSCLC

A moving field

Name

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DECLARATION OF INTERESTS

Martin Reck

Honoraria for lectures and consultancies (self fee) from:

Amgen, AstraZeneca, Beigene, BMS, Boehringer-Ingelheim, Daiichi-Sankyo, Lilly, Merck, Mirati, MSD, Novartis, Pfizer, Roche, Sanofi

Institutional Support for clinical trials from:

BMS, Boehringer-Ingelheim

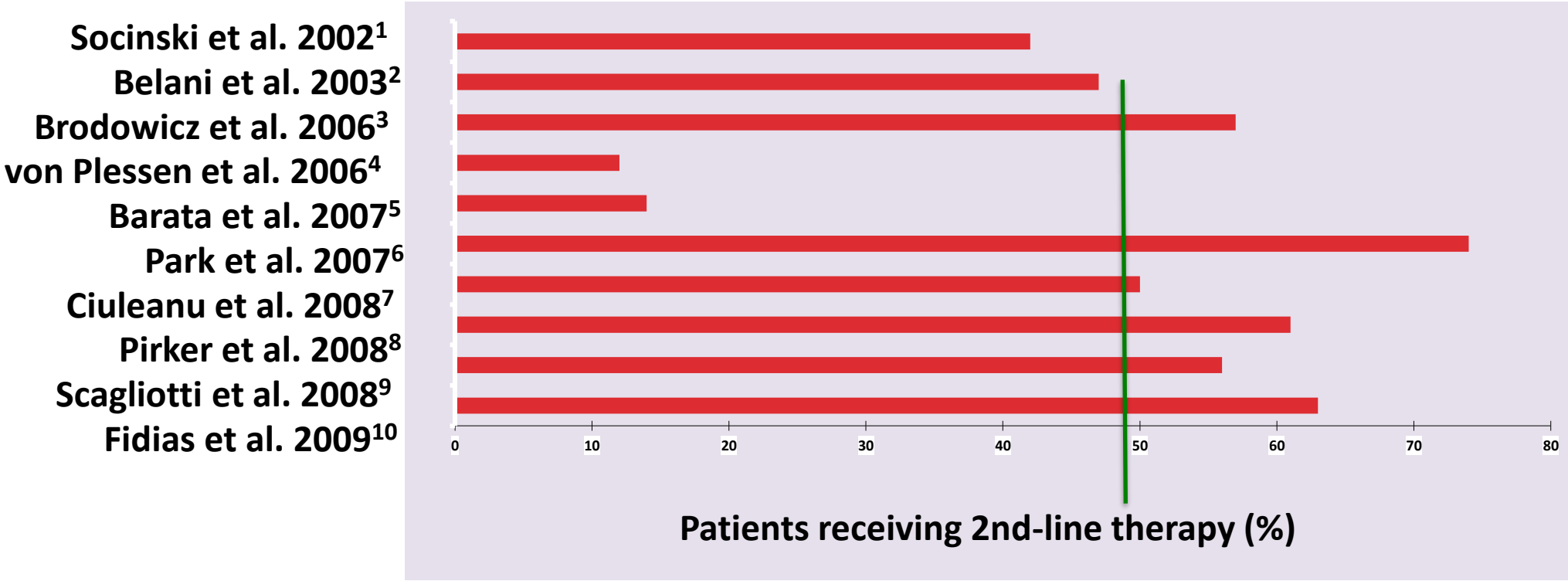
Research funding for clinical trials paid to my institution by:

Amgen, AstraZeneca, Beigene, BMS, Boehringer-Ingelheim, Daiichi-Sankyo, Lilly, Merck, Mirati, MSD, Novartis, Pfizer, Roche, Gilead

CHALLENGES IN SECOND-LINE TREATMENT I

- Pretreated Patients
- Reduced performance status: Tolerability becomes more important.
- Low response rates: Tumor control becomes important.
- More symptomatic patients: Symptom control and symptom improvement become important .
- It is hard to show any improvement in efficacy...

SECOND-LINE TREATMENT – CHALLENGES II



In recent studies, approximately 50% of patients did not receive second-line therapy

[1]J Clin Oncol 2002;20:1335–43; [2]J Clin Oncol 2003;21:2933–39; [3]Lung Cancer 2006;52:155–63; [4]Br J Cancer 2006;95:966–73; [5]J Thoracic Oncol 2007;2(Suppl. 4):S666 Abs. P2-235; [6]J Clin Oncol 2007;25:5233–39; [7]J Clin Oncol 2008;26(Suppl. 15S):426s Abs. 8011; [8]J Clin Oncol 2008;26(Suppl. 15S):6s Abs. 3; [9]J Clin Oncol 2008;26:3543–51; [10]J Clin Oncol 2009;27:

THE THREE PERIODS OF SECOND-LINE TREATMENT

- Before Immunotherapy

SECOND LINE TREATMENT NSCLC – FIRST RESULTS

	Docetaxel	Pemetrexed	Erlotinib
RR, %	5.0–12.0	7.1–11.8	7.9–9.0
Median PFS, m	2.0–3.1	2.6–2.9	2.2–3.6
Median OS, m	5.7–8.0	6.7–8.9	6.7–7.9
1-year OS,%	28.7–37.0	29.7–38.5	31.0–35.7

Shepherd, et al. JCO 2000; Fossella, et al. JCO 2000; Ramlau, et al. JCO 2006; Paz-Ares, et al. BJC 2008
Kim, et al. Lancet 2008; Krzakowski, et al. JCO 2010; Hanna, et al. JCO 2004, Cullen, et al. Ann Oncol 2008
Shepherd, et al. NEJM 2005; Vamvakas, et al. ASCO 2010; Ciuleanu, et al. IASLC Chicago 2010; Reck M , et al, Lancet Oncology 2014; Garon E et al, Lancet 2014; Soria JC, Lancet Oncology 2015

SECOND LINE TREATMENT NSCLC – UPDATED RESULTS

	Docetaxel	Pemetrexed	Erlotinib	Afatinib (SCC)	Docetaxel + Ramucirumab (NSCLC)	Docetaxel + Nintedanib (NSCLC)
RR, %	5.0–12.0	7.1–11.8	7.9–9.0	6	23	4.4 Central Review
Median PFS, m	2.0–3.1	2.6–2.9	2.2–3.6	2.4	4.5	3.4
Median OS, m	5.7–8.0	6.7–8.9	6.7–7.9	7.9	10.5	10.1
1-year OS,%	28.7–37.0	29.7–38.5	31.0–35.7	nr	nr	nr

Shepherd, et al. JCO 2000; Fossella, et al. JCO 2000; Ramlau, et al. JCO 2006; Paz-Ares, et al. BJC 2008
Kim, et al. Lancet 2008; Krzakowski, et al. JCO 2010; Hanna, et al. JCO 2004, Cullen, et al. Ann Oncol 2008
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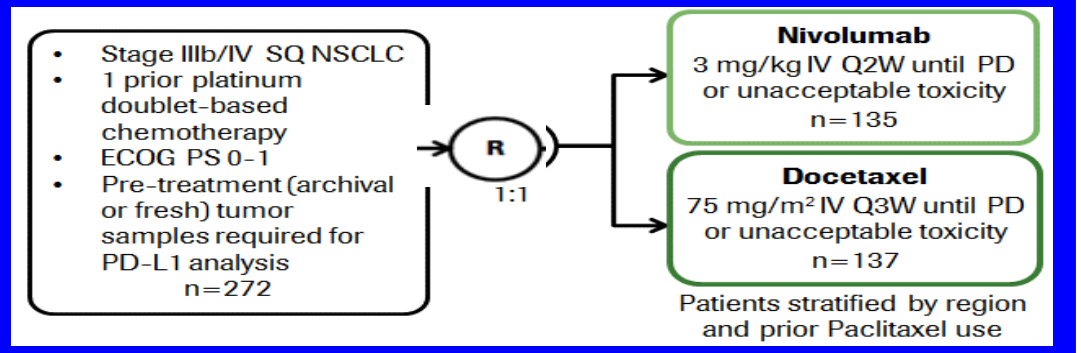
THE THREE PERIODS OF SECOND-LINE TREATMENT

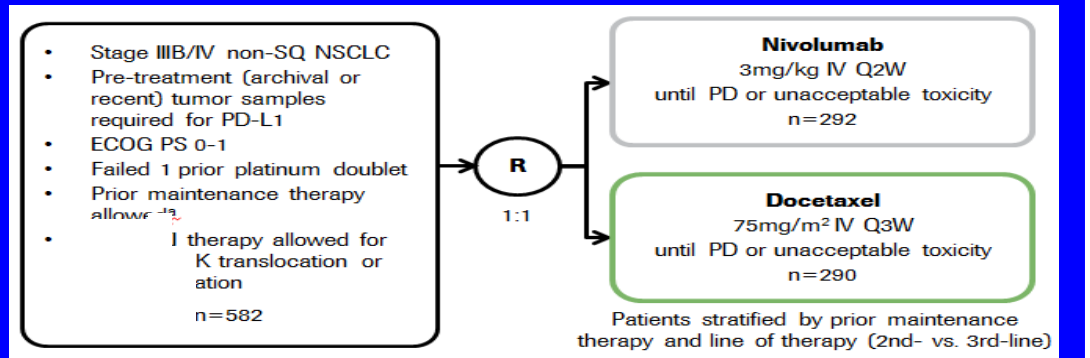
- Before Immunotherapy
- During Immunotherapy

ANTI – PD-1 MONOTHERAPY IN PRETREATED PATIENTS
PRIMARY ENDPOINT: OS!

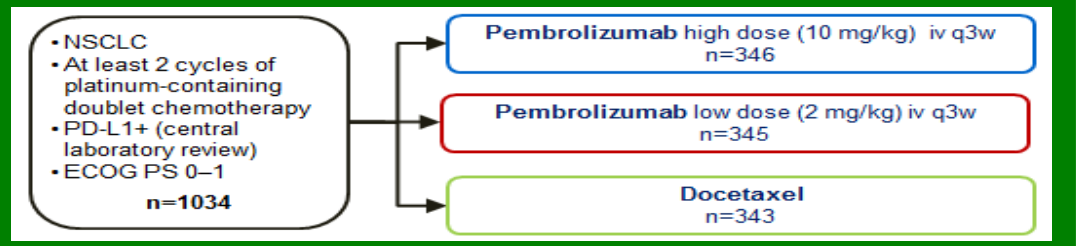
Nivolumab – CheckMate 017 (PIII)[1]
2nd Line, squamous, PD-L1 All-Comer



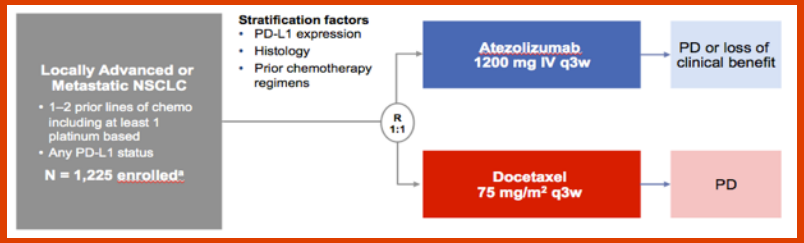
Nivolumab – CheckMate 057 (PIII)[2]
2nd Line, non-squamous, PD-L1 All-Comer



Pembrolizumab - Keynote 010 (PII/III)[3]
2nd+ Line, PD-L1 TPS ≥1%



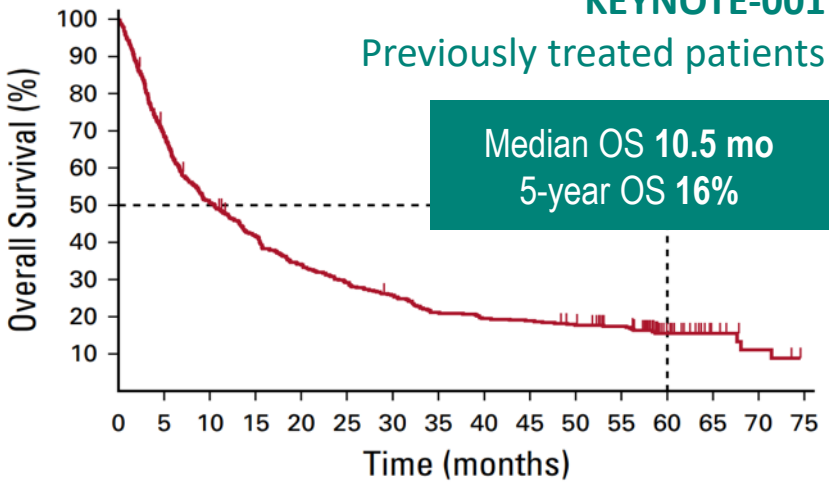
Atezolizumab – OAK (PIII)[4]
2nd+ Line, PD-L1 All-Comer



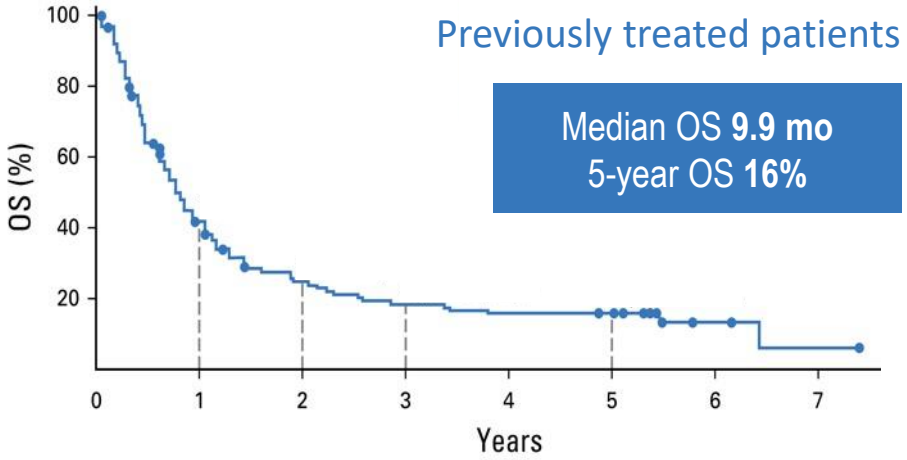
1. Borghaei H et al. Poster presentation at ASCO 2016. 9025. 2. Brahmer JR et al. Oral presentation at AACR 2017. CT077. 3. Herbst RS et al. Poster presentation at ASCO 9090. 4. Rittmeyer A et al. *Lancet.* 2017;389(10066):255-265.

IMMUNOTHERAPIES – 5-YEAR OS IN PHASE I–III TRIALS
A 'TASTE' OF CHRONIC DISEASE

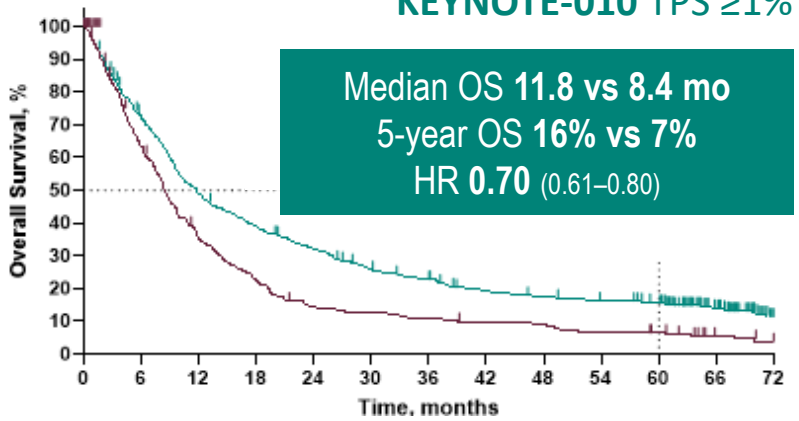
KEYNOTE-001
Previously treated patients



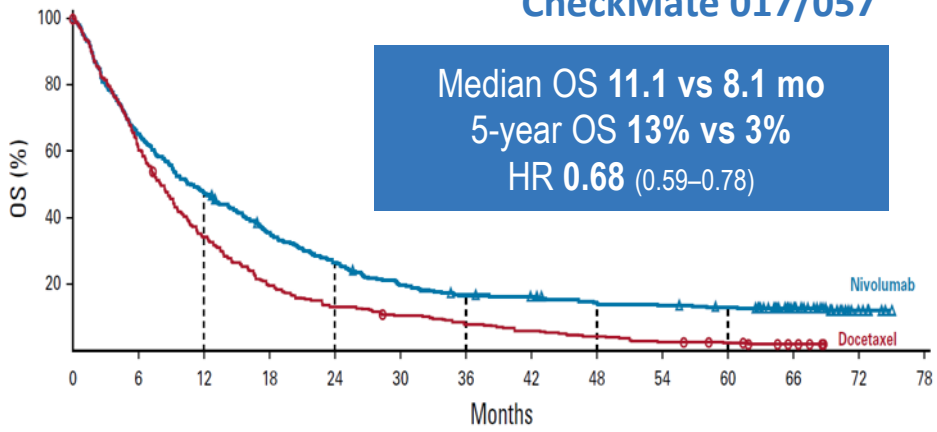
CheckMate 003
Previously treated patients



KEYNOTE-010 TPS ≥1%



CheckMate 017/057

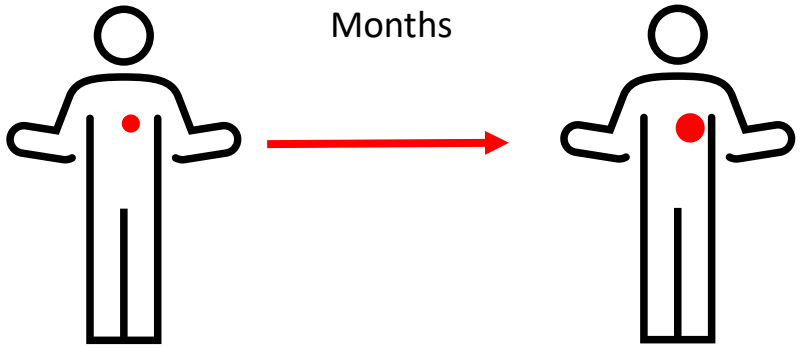


Garon E et al. *J Clin Oncol.* 2019;37(28):2518-2527. Gettinger S et al. *Lancet Oncol.* 2019;36(17):1675-1684. Herbst R et al. Presented at WCLC 2020; abstract FP13.01. Borghaei H et al. *J Clin Oncol.* 2021; DOI: 10.1200/JCO.20.01605.

THE THREE PERIODS OF SECOND-LINE TREATMENT

- Before Immunotherapy
- During Immunotherapy
- After Immunotherapy (the reality of today!)

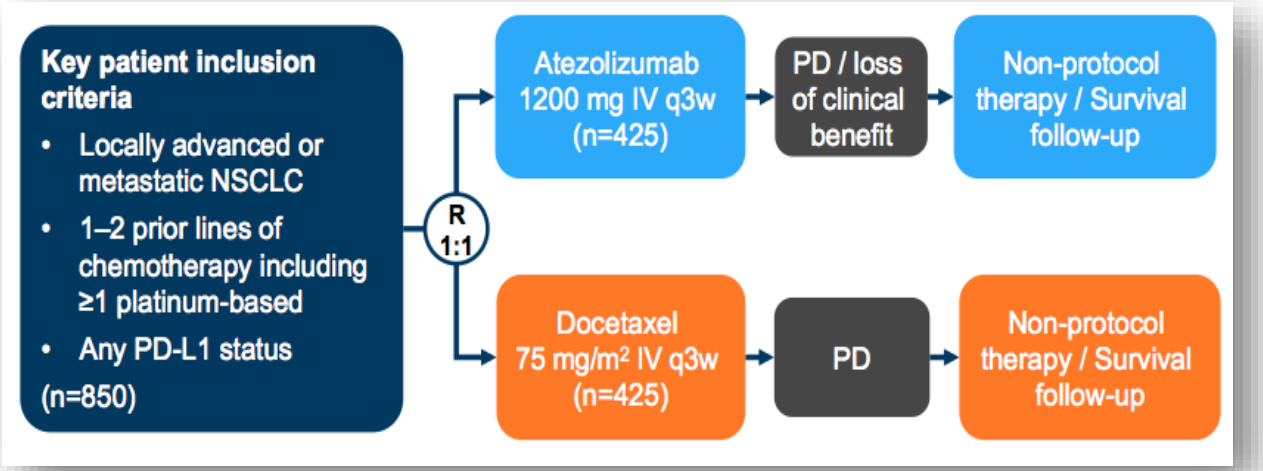
THE CLINICAL (PRAGMATIC) VIEW ON PD AFTER IO AND POTENTIAL TREATMENT IMPLICATIONS



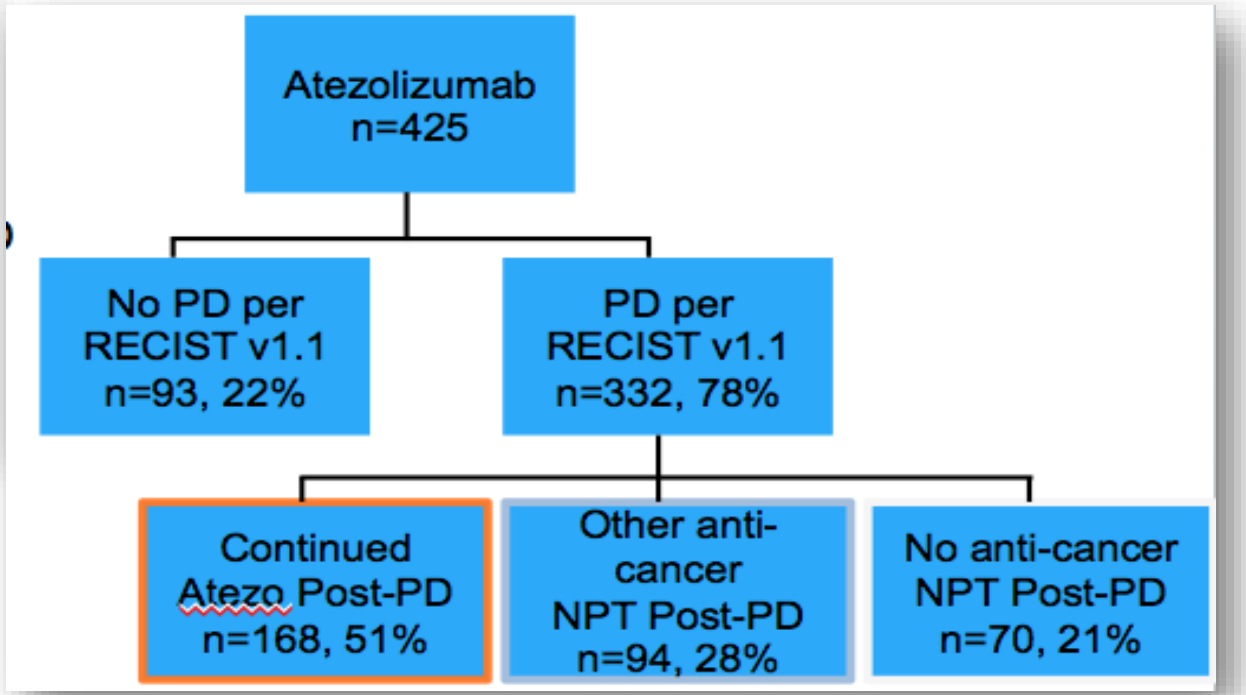
Type 1:

- Slow, asymptomatic PD
- No new tumor related symptoms
- Good tolerability of IO
- *Continuation of IO?*

Oak – Exploratory Analysis



	Atezo Post-PD	Other Post PD	No Treatment Post PD
Number	168 (51%)	94 (28%)	70 (21%)
Median OS	12.7 m (9.3 ; 14.9)	8.8 m (6.0 ; 12.1)	2.2 m (1.9 ; 3.4)
18 m OS	37%	20%	9%



Gandara D et al, ASCO 2017; abstract 9001

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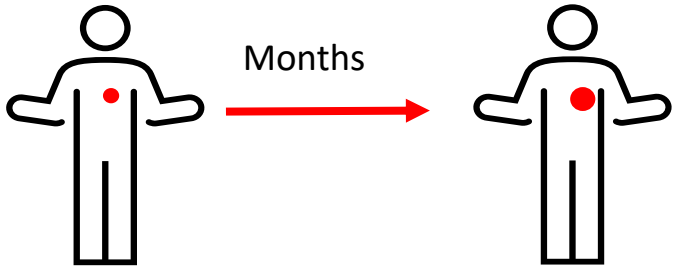

Type 1 / Slow - PD:

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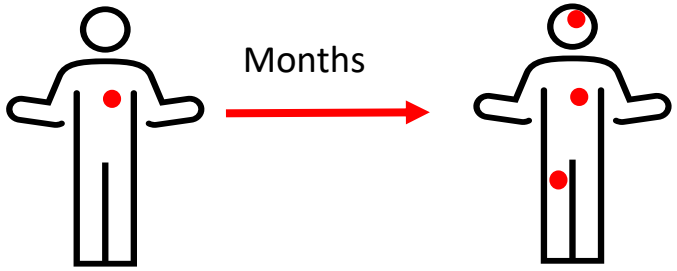
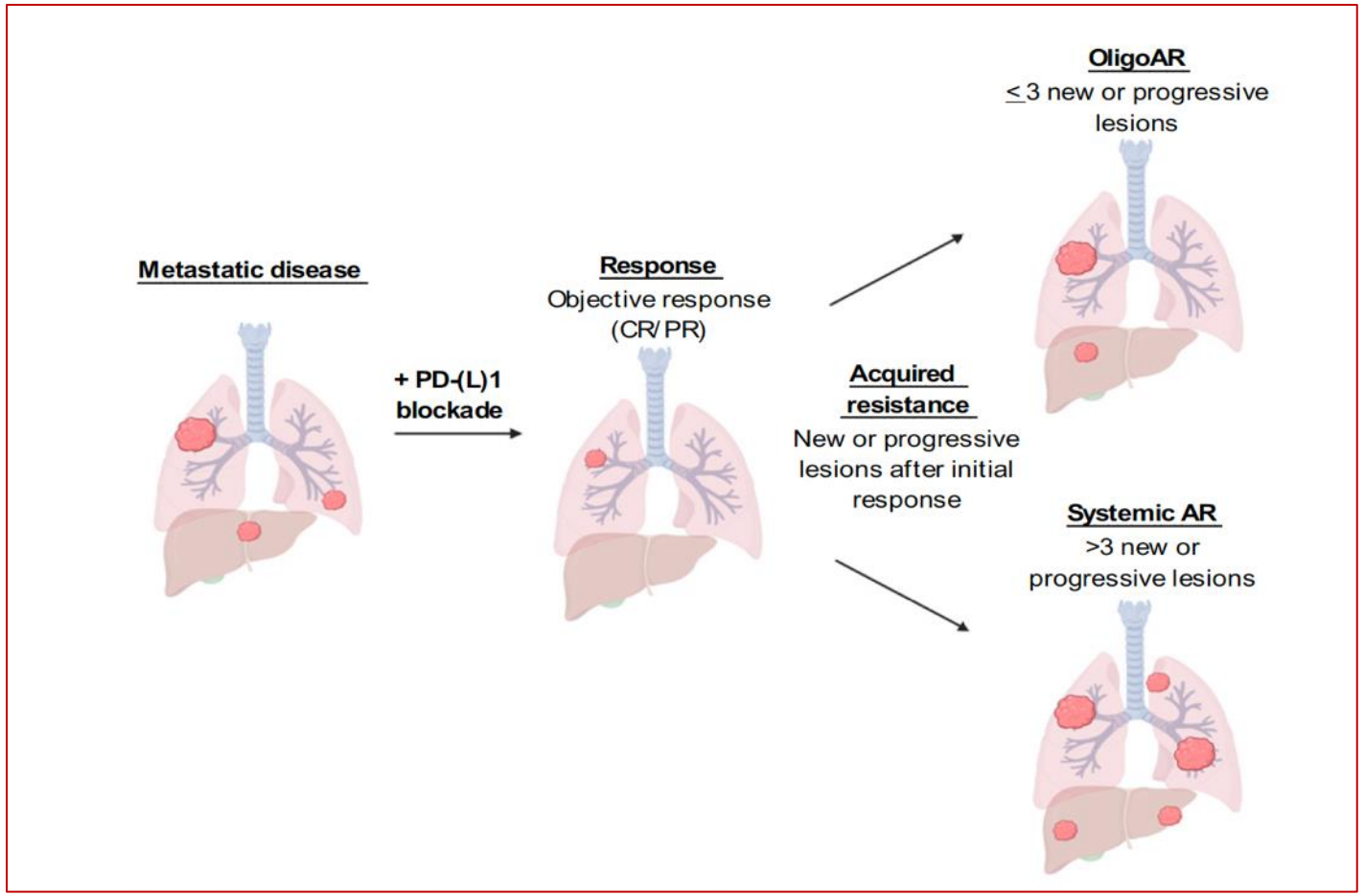


Type 2 / Oligo-PD:

- Stabilization/Response of primary tumor
- 1-2 new metastases
- Good tolerability of IO
- *Continuation of IO and local therapy?*

OLIGO PD / OLIGORESISTANCE

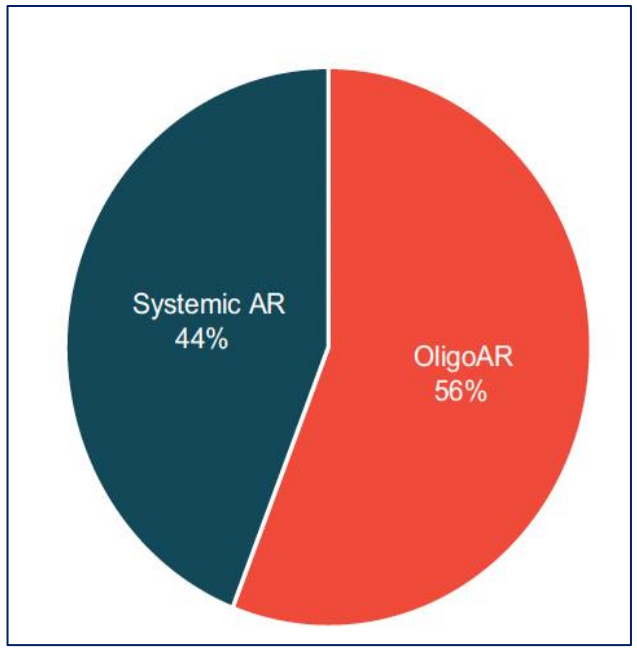
1536 patients, 312 patients with initial response, 143 patients with acquired resistance

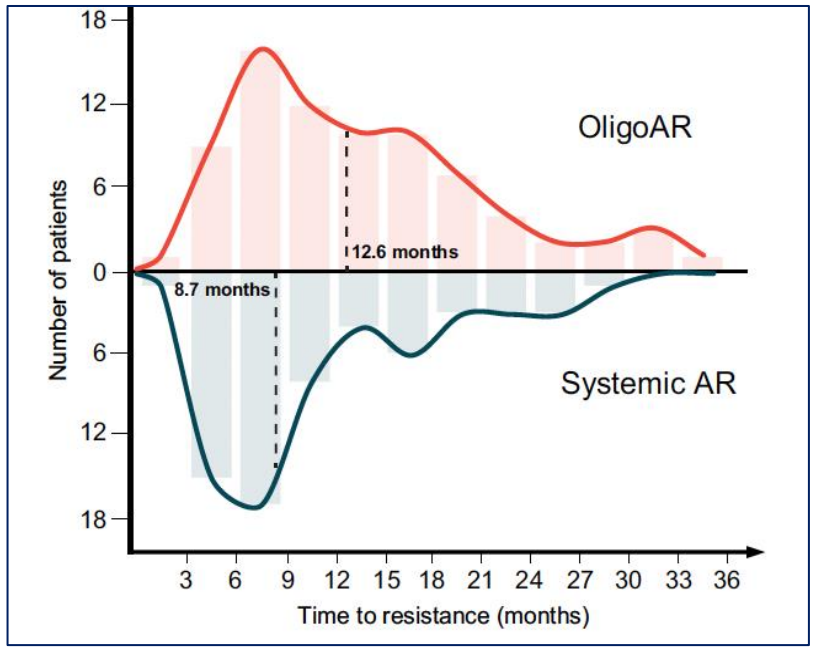


Schoenfeld A et al, Clinical Cancer Research 2022

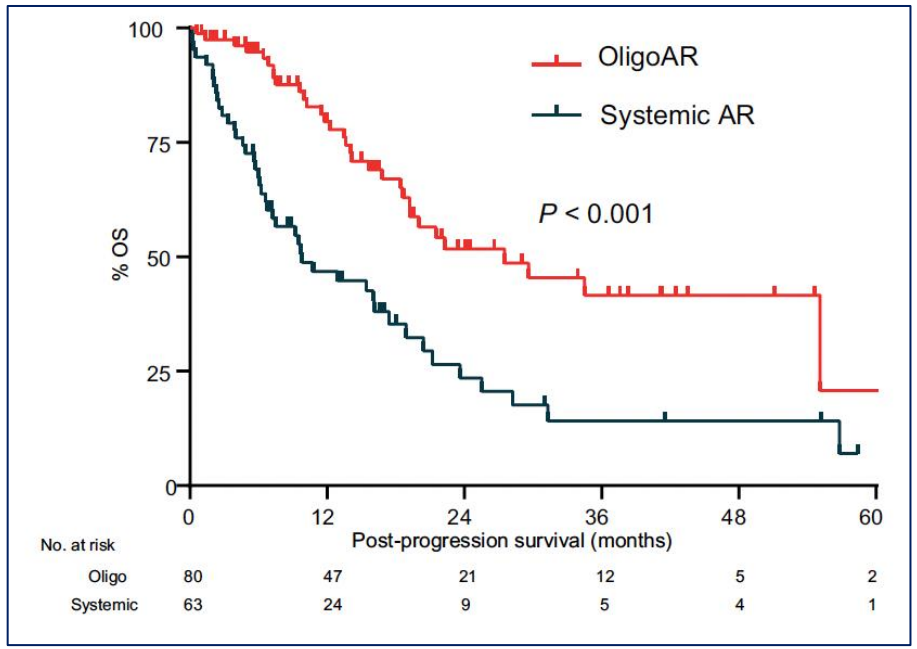
DIFFERENT CHARACTERISTICS OF OLIGO PD

Oligo PD: No difference in clinical characteristics or PD-L1 expression but higher TMB





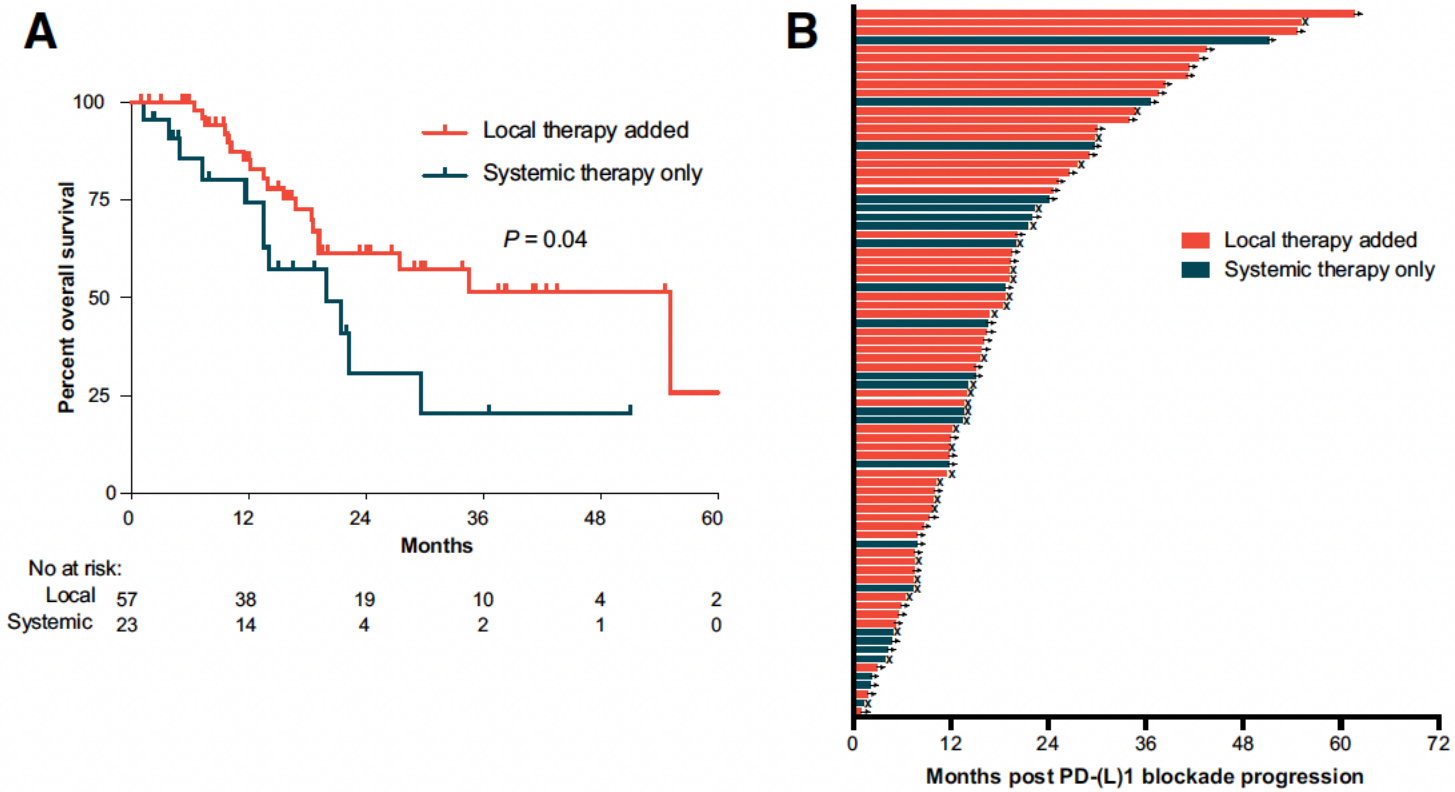
Median time to resistance 12.6 vs 8.7 m



Postprogression survival: 28 vs 10 m

Schoenfeld A et al, Clinical Cancer Research 2022

IMPACT OF LOCAL TREATMENT IN OLIGO PD



Schoenfeld A et al, Clinical Cancer Research 2022

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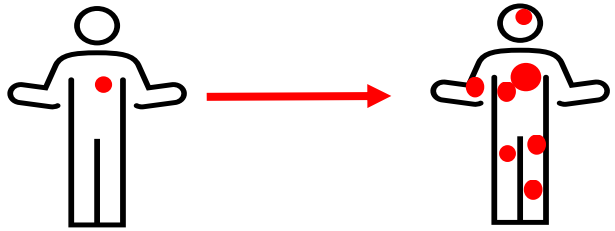
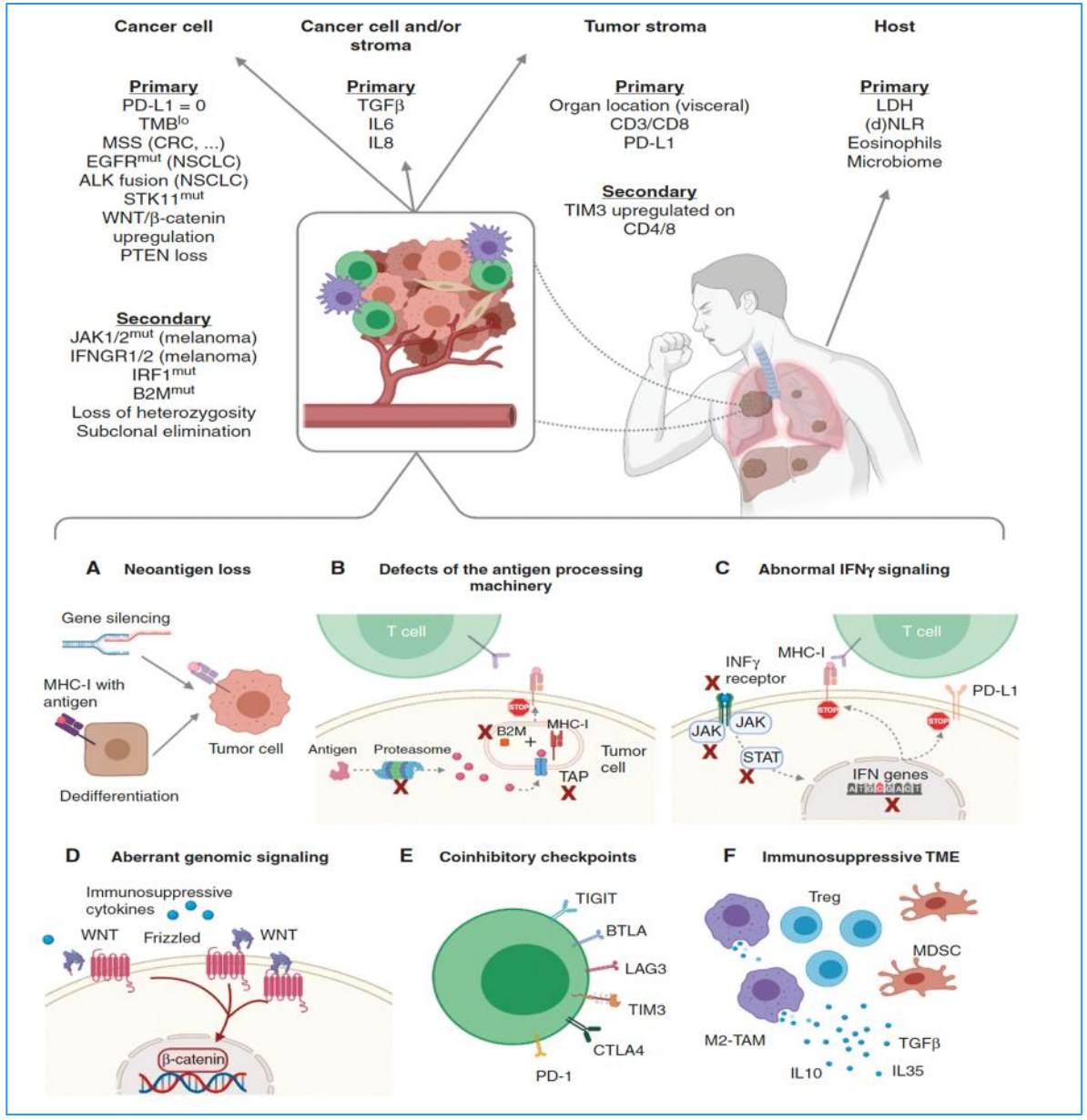


Type 3 / Systemic PD

- General PD
- Clinical Symptoms
- Change of treatment?



Do we have a standard of resistance?

Resistence after Immunotherapy
A really complex event

Aldea M et al, Cancer Discovery 2021

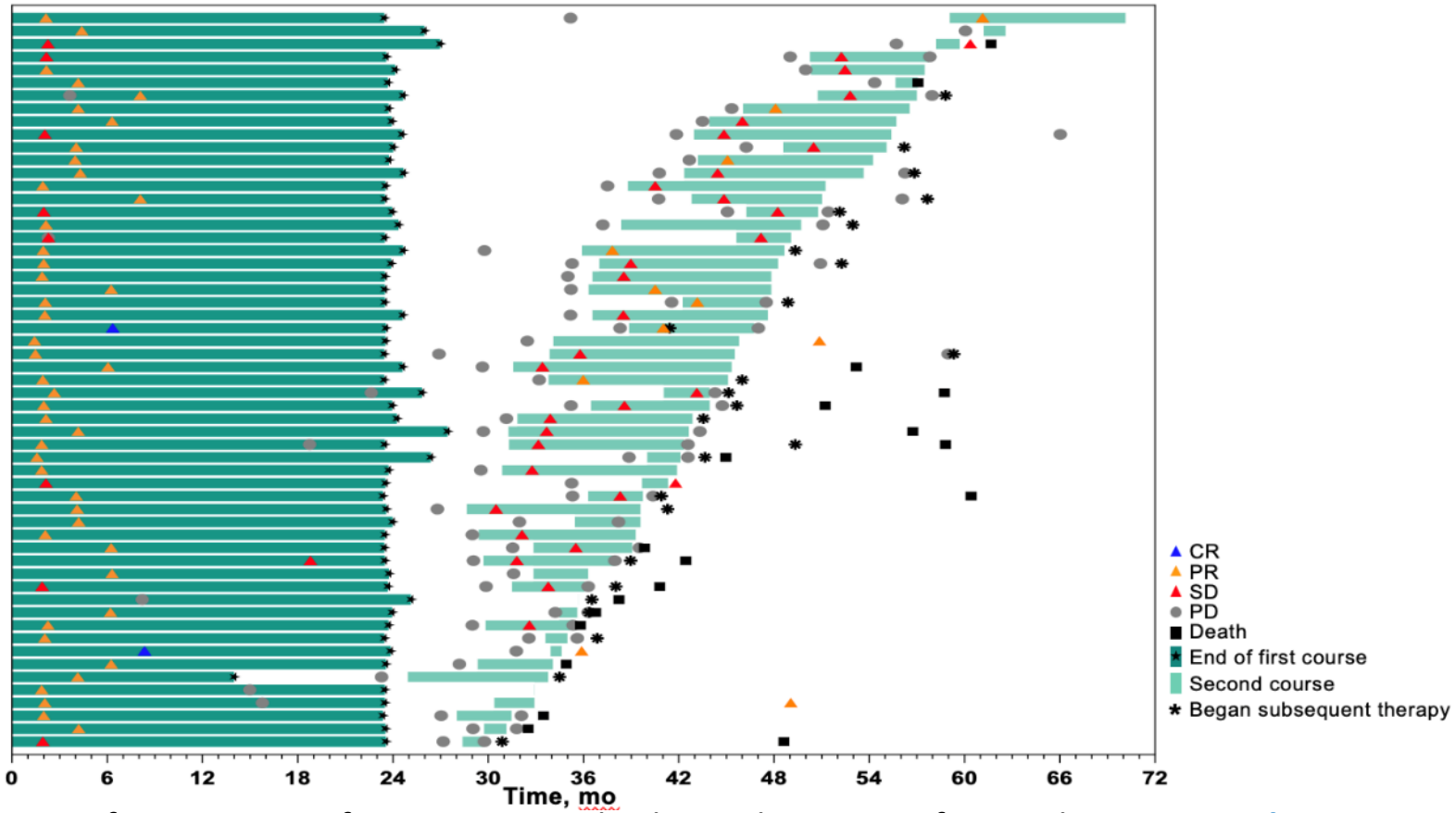
MANAGEMENT - POTENTIAL STRATEGIES

- Re Challenge?

POOLED ANALYSIS REEXPOSITION PEMBROLIZUMAB
KN 024, KN 042, KN 598, KN 189, KN 407

Rodriguez Abreu D, Reck M, WCLC 2022

Monotherapy Cohort



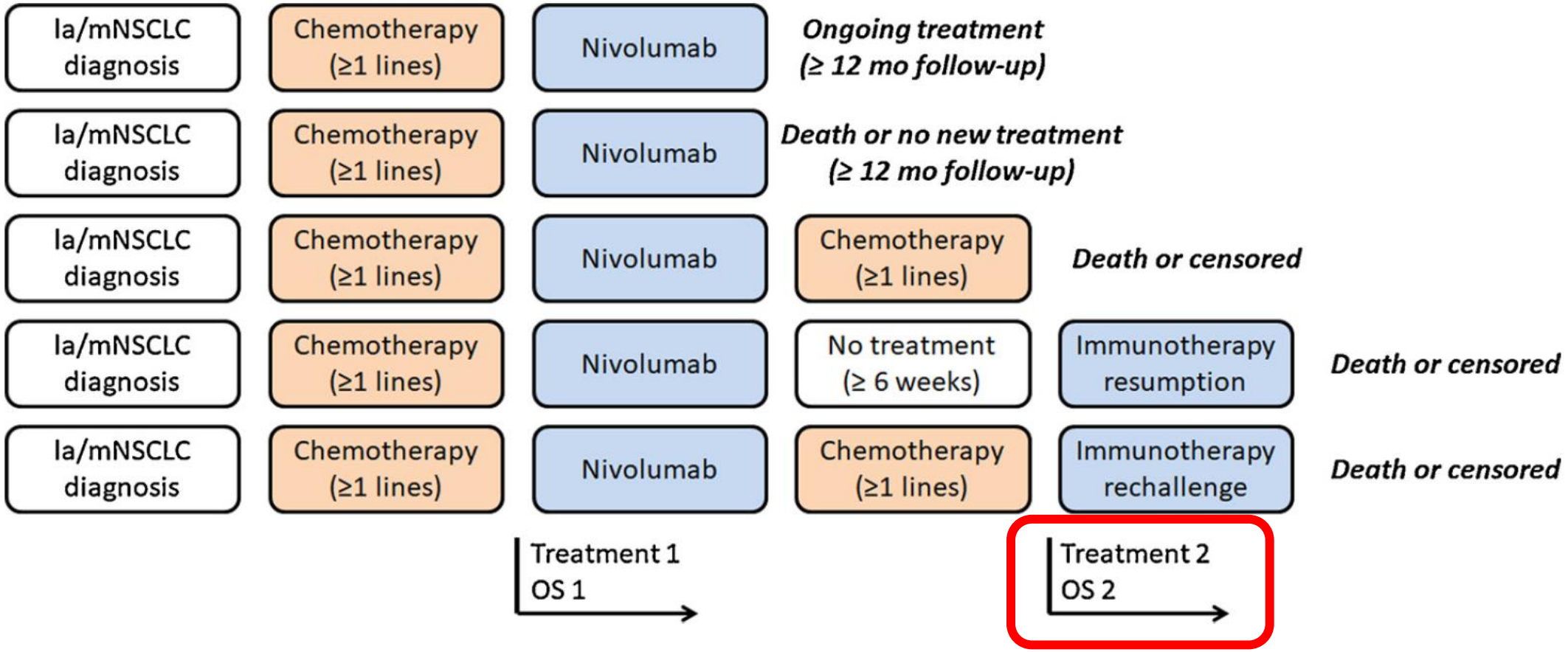
	Cohort 1 (pembro monotherapy) N = 57
ORR[a] (95% CI), %	19 (10–32)
DCR[a] (95% CI), %	74 (60–85)
Best overall response,[a] n (%)	
CR	0
PR	11 (19)
SD	31 (54)
PD	8 (14)
NA[b]	7 (12)
DOR,[a] median (range), mo	NR (0.0+ to 20.0+)
DOR ≥6 mo, %	79
PFS,[a,c] median (95% CI), mo	10.3 (5.6–14.0)
6-mo rate (95% CI), %	61 (46–73)
OS,[c] median (95% CI), mo	27.5 (21.7–NR)
6-mo rate (95% CI), %	85 (72–92)

Time from stopping first course pembrolizumab to start of second course: **Median 12.0 m (3.8 - 35.6m)**

Time from starting second course pembrolizumab to cut off: **Median 21.5 m (0.6 - 46.5 m)**

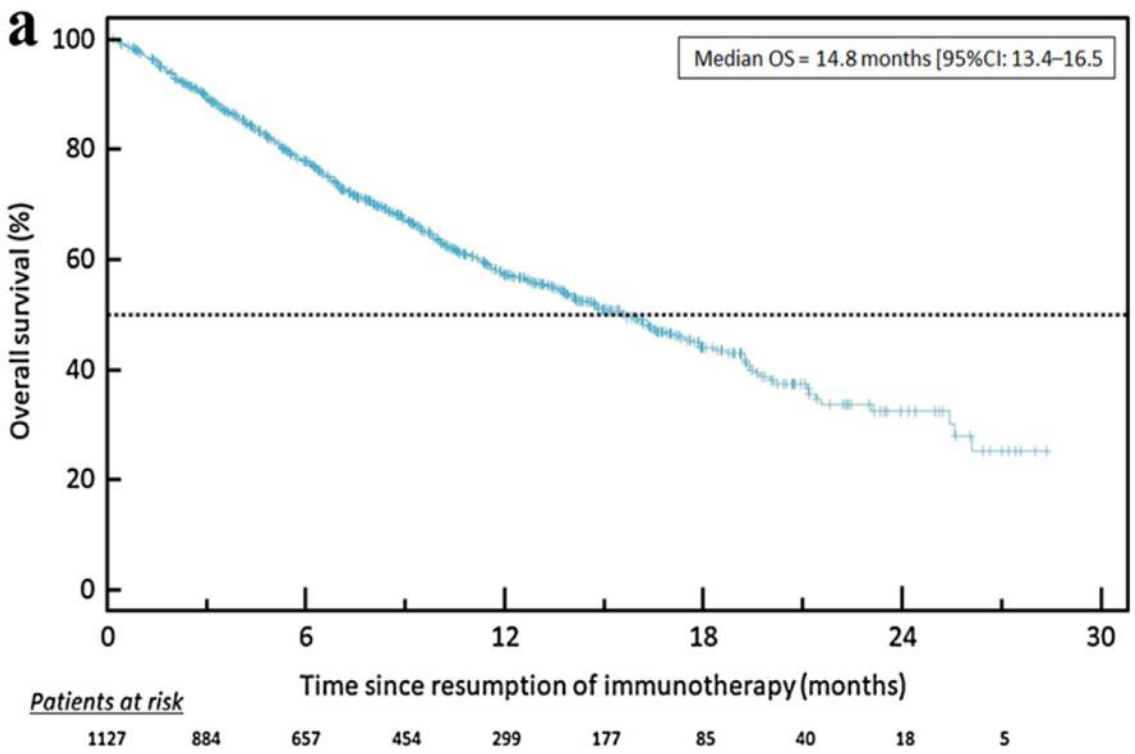
REEXPOSITION IN PRETREATED PATIENTS SOME INTERESTING DATA FROM FRANCE

10.452 patients with advanced NSCLC

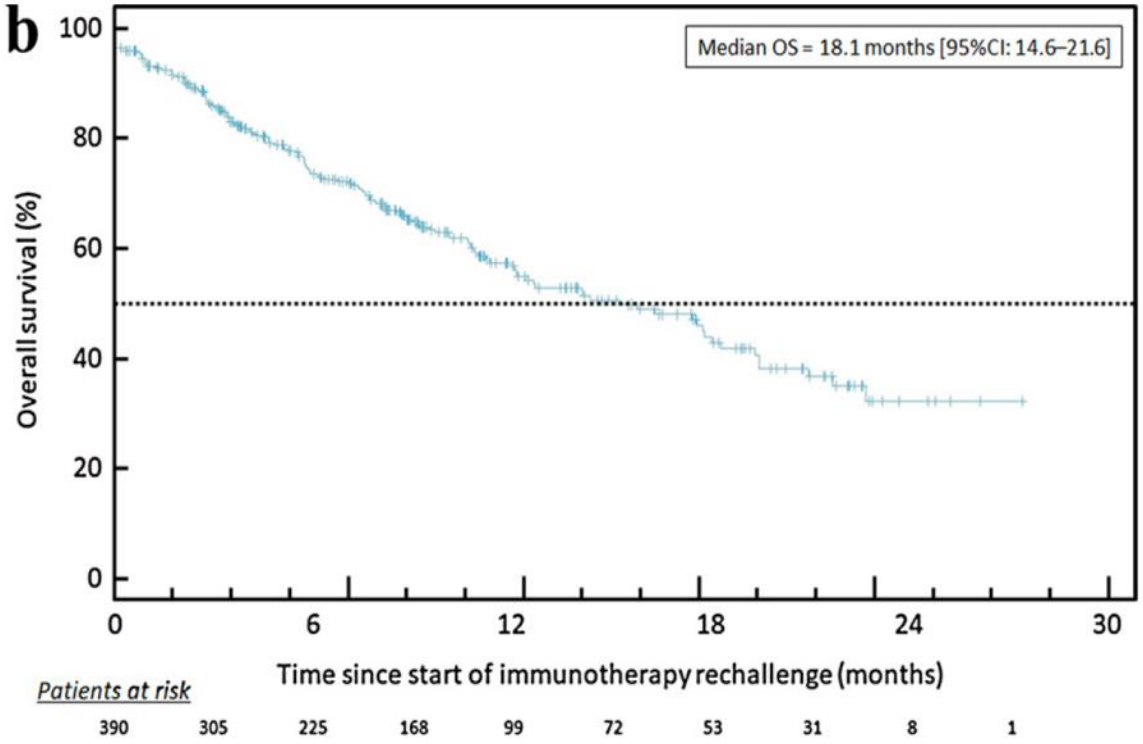


Levra MG et al, Lung Cancer 2020

MEDIAN OS2 EVEN BETTER THAN OS1!



Median OS2 / Resumption: 14.8 m



Median OS2 / Rechallenge: 18.1m

Levra MG et al, Lung Cancer 2020

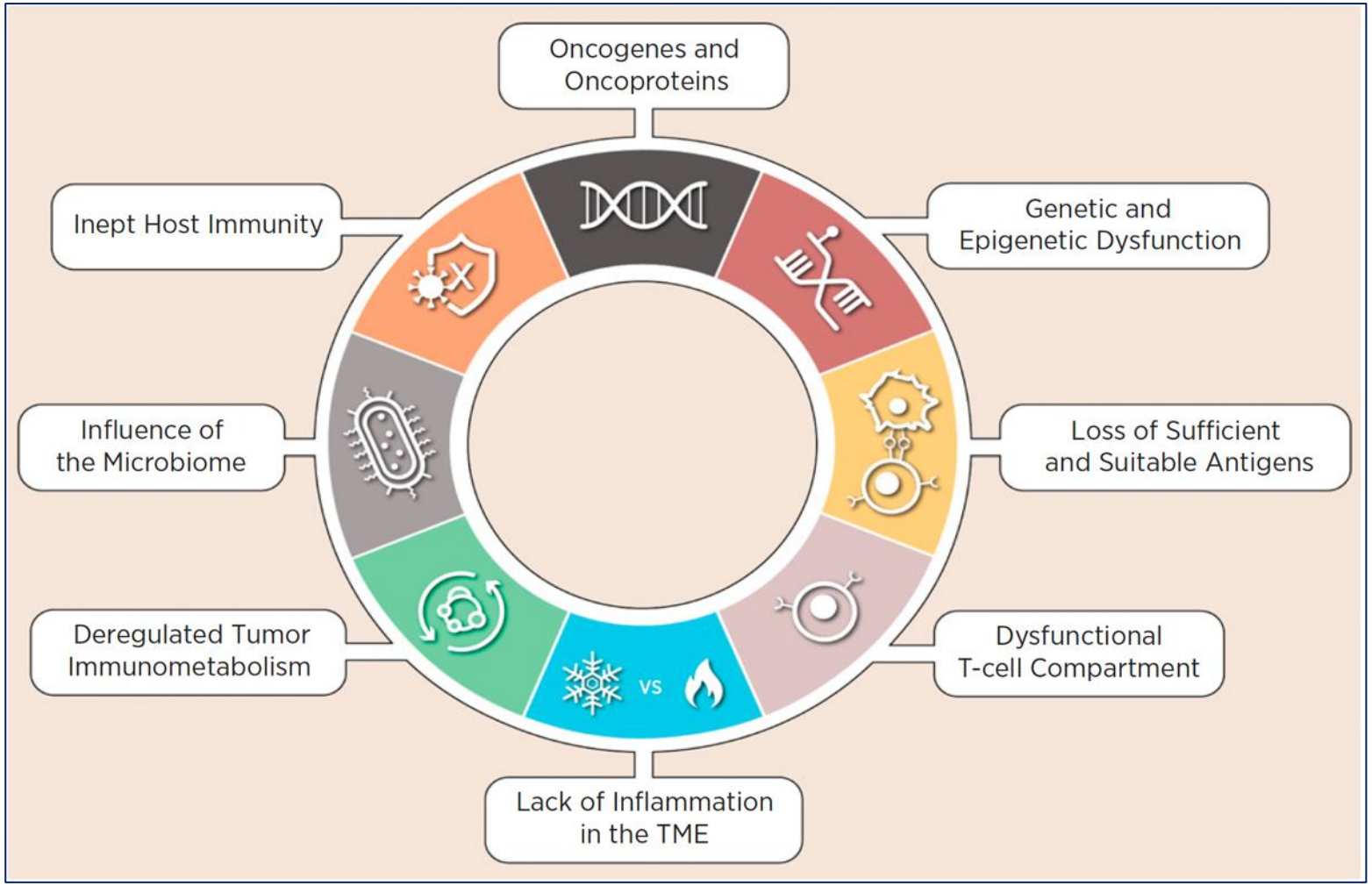
RELEVANT FACTORS DRIVING THE BENEFIT

Univariate and multivariate logistic regression analysis of factors of receiving a second PD-1 inhibitor.

Patients' characteristics	All patients with 2nd PD-1 inhibitor course (N = 1517)	All patients with post-nivolumab chemotherapy only (N = 3601)	Univariate analysis		Multivariate analysis	
			OR (95 % CI)	P value	OR (95 % CI)	P value
Age (mean ± SD; years)	63.5 ± 9.7	63.4 ± 9.4	1.00 (0.99–1.01)	0.634	–	–
Gender (men: n, %)	1057 (69.7 %)	2526 (70.2 %)	1.02 (0.90–1.17)	0.737	–	–
Histology (non-squamous; n, %)	810 (53.4 %)	2047 (56.9 %)	**1.15 (1.02–1.30)**	**0.023**	**NS**	**NS**
Cancer duration						
Less than 1 year	689 (45.4 %)	1729 (48.0 %)	Reference		–	–
1 to 5 years	741 (48.9 %)	1678 (46.6 %)	1.11 (0.98–1.25)	0.103	–	–
5 years and more	87 (5.7 %)	194 (5.4 %)	1.13 (0.86–1.47)	0.388	–	–
Cerebral metastases	254 (16.7 %)	562 (15.6 %)	1.09 (0.93–1.28)	0.310	–	–
Duration of initial nivolumab course						
< 3 months	695 (45.8 %)	1888 (52.4 %)	**Reference**		**Reference**	
3 – 6 months	390 (25.7 %)	912 (25.3 %)	**1.16 (1.00–1.35)**	**0.046**	**1.17 (1.01–1.36)**	**0.035**
≥6 months	432 (28.5 %)	801 (22.2 %)	**1.47 (1.27–1.70)**	**< 0.001**	**1.48 (1.28–1.71)**	**< 0.001**
Comorbidities (yes vs. no)						
Hypertension	297 (19.6 %)	592 (16.4 %)	**1.24 (1.06–1.44)**	**0.007**	**1.21 (1.03–1.42)**	**0.019**
Diabetes	138 (9.1 %)	289 (8 %)	1.15 (0.93–1.42)	0.206	–	–
Renal failure	68 (4.5 %)	147 (4.1 %)	1.10 (0.82–1.48)	0.515	–	–
COPD	222 (14.6 %)	425 (11.8 %)	**1.28 (1.08–1.53)**	**0.005**	**1.24 (1.03–1.48)**	**0.021**
Pulmonary insufficiency	24 (1.6 %)	42 (1.2 %)	1.36 (0.82–2.26)	0.230	–	–
Other chronic pulmonary disease	147 (9.7 %)	274 (7.6 %)	**1.30 (1.06–1.61)**	**0.014**	NS	NS

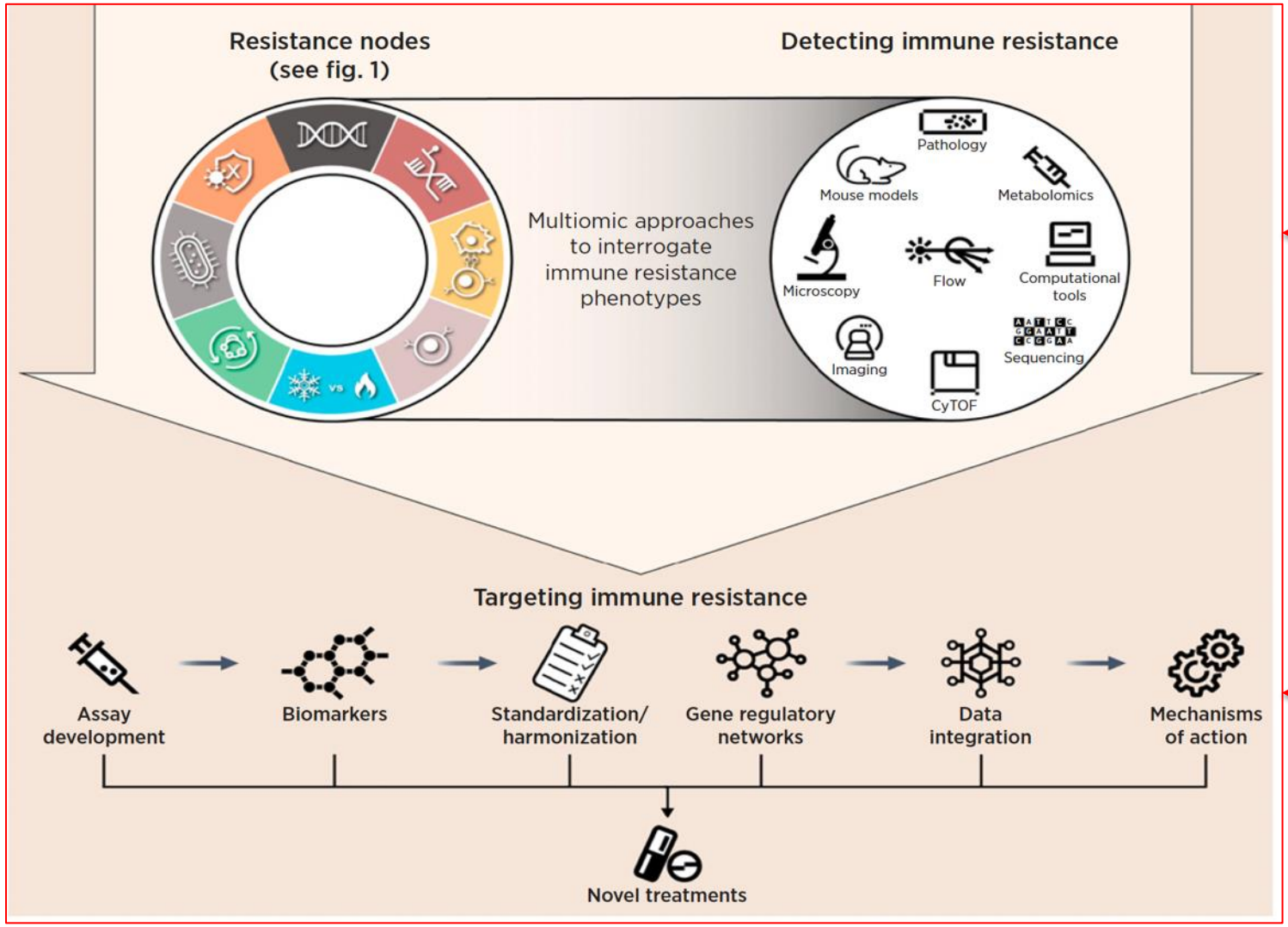
Levra MG et al, Lung Cancer 2020

MULTIPLE HALLMARKS OF RESISTANCE TO IMMUNOTHERAPY



Karasarides M et al, Cancer Immunol Res 2022

CHALLENGES IN DIAGNOSIS AND THERAPY



Identification of resistance mechanism

Development of treatments to overcome resistance

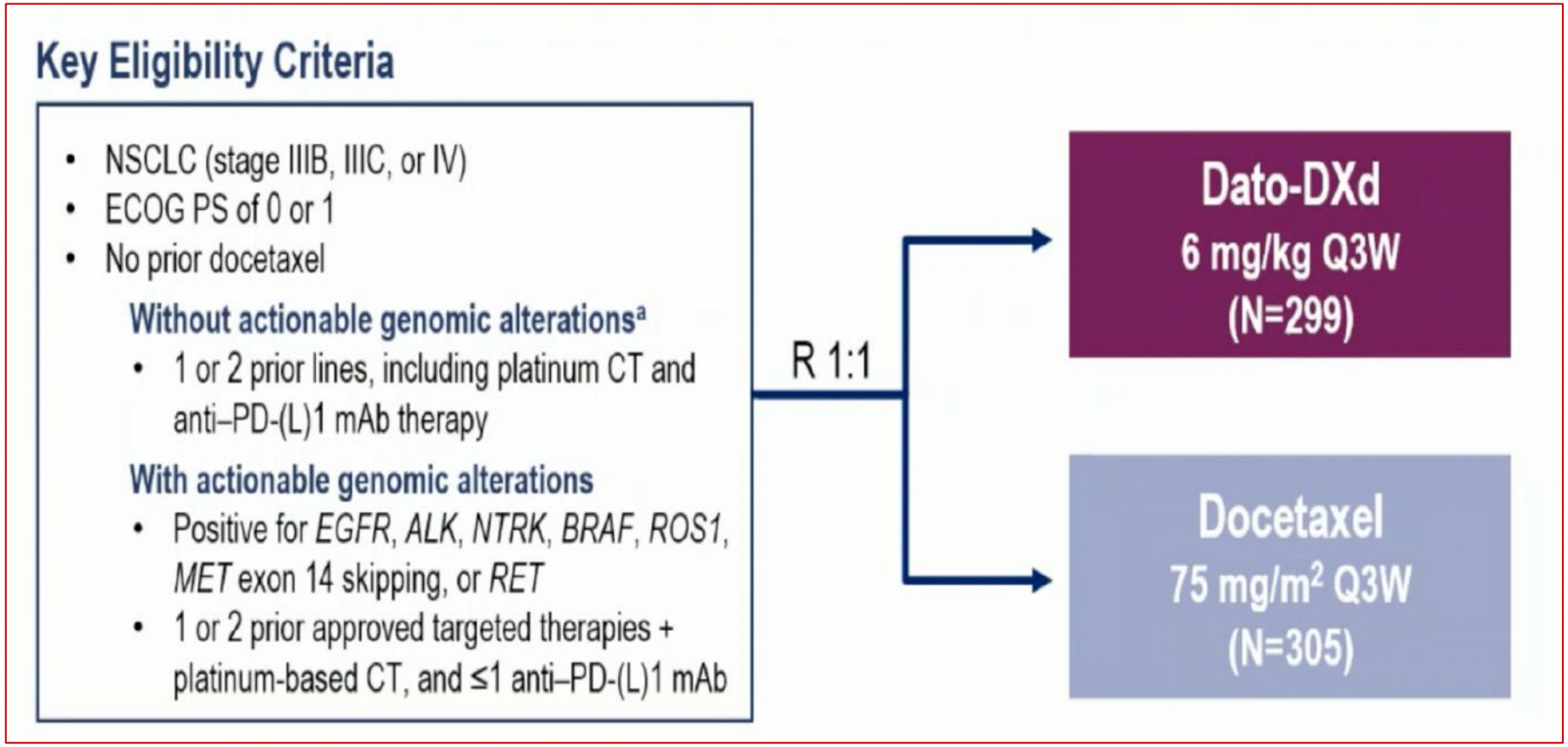
Karasarides M et al, Cancer Immunol Res 2022

POTENTIAL APPROACHES

- ADCs - the new weapon for everything?
- Antiangiogenic compounds?
- Different approaches?
- Vaccines?
- Cellular therapies? (will be covered later)

TROPION LUNG 01 TRIAL

SECOND-LINE TREATMENT AFTER FAILURE OF CT AND CIT

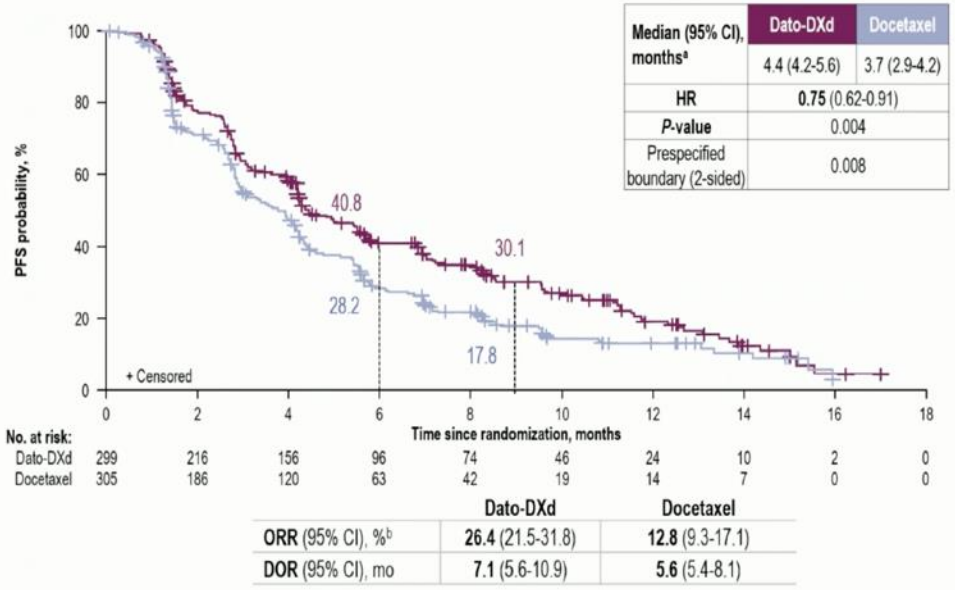


Prim EP: PFS & OS
Results of Interim Analysis

Lisberg A et al, LBA12, ESMO 2023

TROPION LUNG 01 - RESULTS

Progression-Free Survival: ITT

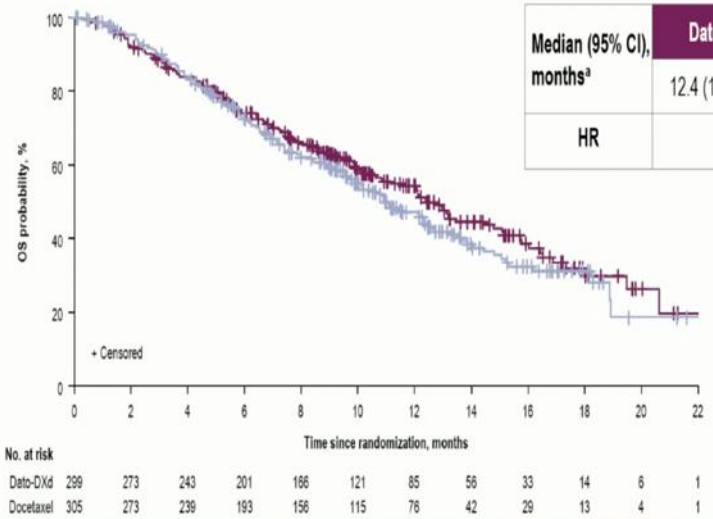


Median (95% CI), months[a]	Dato-DXd	Docetaxel
	4.4 (4.2-5.6)	3.7 (2.9-4.2)
HR	**0.75** (0.62-0.91)	
P-value	0.004	
Prespecified boundary (2-sided)	0.008	

	Dato-DXd	Docetaxel
ORR (95% CI), %[b]	**26.4** (21.5-31.8)	**12.8** (9.3-17.1)
DOR (95% CI), mo	**7.1** (5.6-10.9)	**5.6** (5.4-8.1)

- Med PFS: 4.4 vs 3.7 M (HR 0.75, p 0.004)
- PFS Squamous: HR 1.38, Non Squamous: HR 0.63
- RR: 26.4 vs 12.8%

Interim Overall Survival: ITT



Median (95% CI), months[a]	Dato-DXd	Docetaxel
	12.4 (10.8-14.8)	11.0 (9.8-12.5)
HR	**0.90** (0.72-1.13)	

Information fraction at interim analysis (events/total events required): **74%**.

Non-squamous HR (95% CI): **0.77** (0.59-1.01); **Squamous HR** (95% CI): **1.32** (0.87-2.00)

- OS data not mature

Lisberg A et al, LBA12, ESMO 2023

TROPION LUNG 01 - ADVERSE EVENTS

TRAEs Occurring in ≥10% of Patients

System organ class Preferred term, n (%)	Dato-DXd N=297		Docetaxel N=290	
	Any grade	Grade ≥3	Any grade	Grade ≥3
Blood and lymphatic system				
Anemia	43 (15)	11 (4)	59 (20)	11 (4)
Neutropenia[a]	12 (4)	2 (1)	76 (26)	68 (23)
Gastrointestinal				
Stomatitis	140 (47)	19 (6)	45 (16)	3 (1)
Nausea	100 (34)	7 (2)	48 (17)	3 (1)
Vomiting	38 (13)	3 (1)	22 (8)	1 (0.3)
Constipation	29 (10)	0	30 (10)	0
Diarrhea	28 (9)	1 (0.3)	55 (19)	4 (1)
General				
Asthenia	55 (19)	8 (3)	55 (19)	5 (2)
Fatigue	34 (11)	2 (1)	40 (14)	6 (2)
Metabolism and nutrition				
Decreased appetite	68 (23)	1 (0.3)	45 (16)	1 (0.3)
Skin and subcutaneous				
Alopecia	95 (32)	0	101 (35)	1 (0.3)[b]
Rash	36 (12)	0	18 (6)	0
Pruritus	30 (10)	0	12 (4)	0

Characteristic AEs:

- Mucositis
- Stomatitis
- Pneumonitis / ILD
- Skin toxicity
- Eye Toxicity

Lisberg A et al, LBA12, ESMO 2023

NEGATIVE TRIALS

EVOKE-01
Sacituzumab Govitecan vs Docetaxel

January 22, 2024

Gilead Provides Update on Phase 3 EVOKE-01 Study

FOSTER CITY, Calif.--(BUSINESS WIRE)-- Gilead Sciences, Inc. (Nasdaq: GILD) today announced that the Phase 3 EVOKE-01 study did not meet its primary endpoint of overall survival (OS) in previously treated metastatic non-small cell lung cancer (NSCLC). EVOKE-01 is evaluating Trodelvy® (sacituzumab govitecan-hziy; SG) vs. docetaxel in patients with metastatic or advanced NSCLC that had progressed on or after platinum-based chemotherapy and checkpoint inhibitor therapy.

CARMEN-LC03
Tusamitamab Ravtansine vs Docetaxel

Press Release

sanofi

Sanofi announces end of program evaluating tusamitamab ravtansine after a 2L NSCLC Phase 3 trial did not meet a primary endpoint

- CARMEN-LC03 trial did not meet dual primary endpoint of improving progression-free survival; tusamitamab ravtansine clinical development program will be discontinued
- Sanofi reinforces commitment to broader oncology development program including CEACAM5-directed antibody drug conjugates (ADC) with additional anticipated trials

PARIS, December 21, 2023. Sanofi is discontinuing the global clinical development program of tusamitamab ravtansine. The decision is based on the outcome of a prespecified interim analysis of the Phase 3 CARMEN-LC03 trial evaluating tusamitamab ravtansine as monotherapy compared to docetaxel in previously treated patients with metastatic non-squamous (NSq) non-small cell lung cancer (NSCLC) whose tumors express high levels of carcinoembryonic antigen-related cell adhesion molecule 5 (CEACAM5).

ESMO

VEGF ACTS AS A KEY MEDIATOR OF AN IMMUNOSUPPRESSIVE TUMOR MICROENVIRONMENT (TME)

VEGF creates an immunosuppressive (pro-tumour) microenvironment[1]

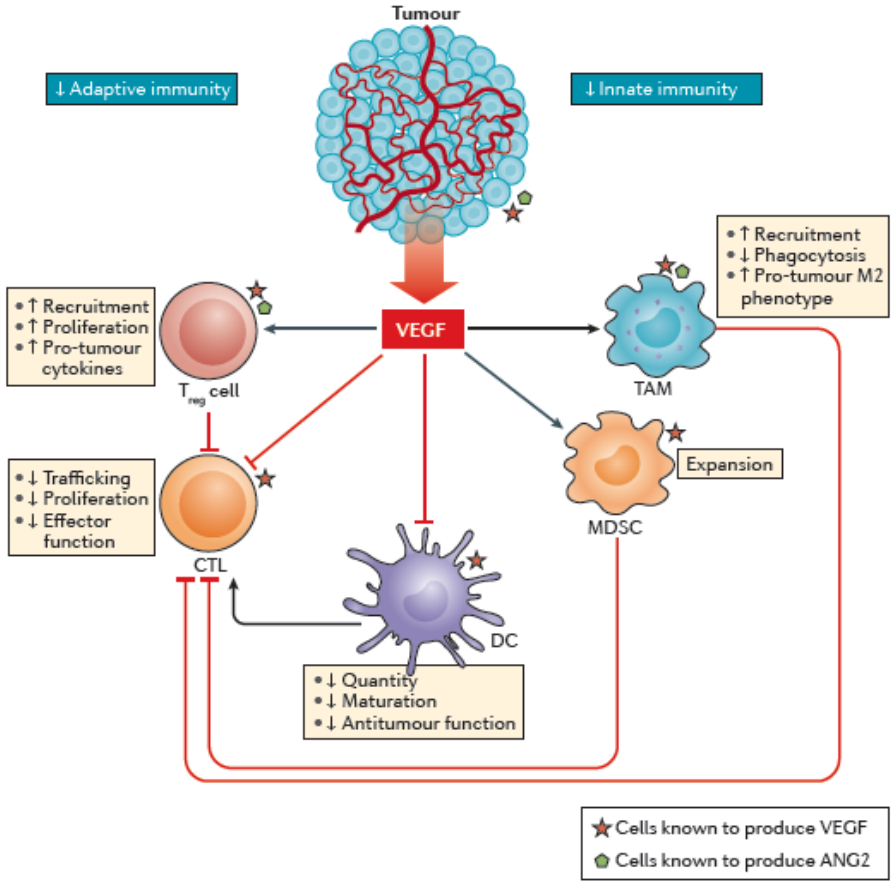
Upregulation of immunosuppressive cells:

- **Regulatory T-cells (T-regs)**
- **Myeloid-Derived Suppressor Cells (MDSCs)**

Impaired antigen presentation:

- **Suppression of dendritic cell (DC) maturation, macrophages (TAMs)**
- **Impaired T-cell function (CTLs)**

Direct effects of angiogenic factors on immune cells[1]



1. Fukumura D et al. *Nat Rev Clin Oncol*. 2018;15(5):325-340

COMBINATION TRIALS - MISSING CONFIRMATION IN PHASE III TRIALS

	COSMIC-021 Cohort 7	LUNG-MAP S1800A	MRTX-500	Phase II	Retrospective	Phase I
Schedule	Cabozantinib Atezolizumab	Ramucirumab Pembrolizumab	Sitravatinib Nivolumab	Bevacizumab Atezolizumab	Ramucirumab Atezolizumab	Lenvatinib Pembrolizumab
N	80	69	68	24	21	21
ORR (%)	19*	22	18	13	4.8	33**
PFS (mo.)	4.5*	4.5	5.7	5.6	3.4	NR
OS (mo.)	13.8*	14.5	14.9	14.0	16.5	NR
G≥3 TRAE (%)	53	42	66	4.2	43	42
Phase III	~~CONTACT1~~	Pragmatica-lung	~~SAPPHIRE~~			~~LEAP-007~~

*RR: PD-L1<1%: 11% ; PD-L1≥1%: 20%. PFS: PD-L1<1%: 4.7; PD-L1≥1%: 5.4. OS: PD-L1<1%: 10.4 ; PD-L1≥1%: 17.8

** Includes treatment naïve population.

Slide courtesy J Remon, Hendricks L adapted

Neal - ASCO 2022 * Reckamp –JCO 2022 * Leal –ESMO 2021 * Lee –JTO 2022 * Herzog –Lung Cancer 2022* Brose – ASCO 2019 * Taylor –JCO 2020 *Borghaei Ann Oncol 2023 *Neal ELCC 2023

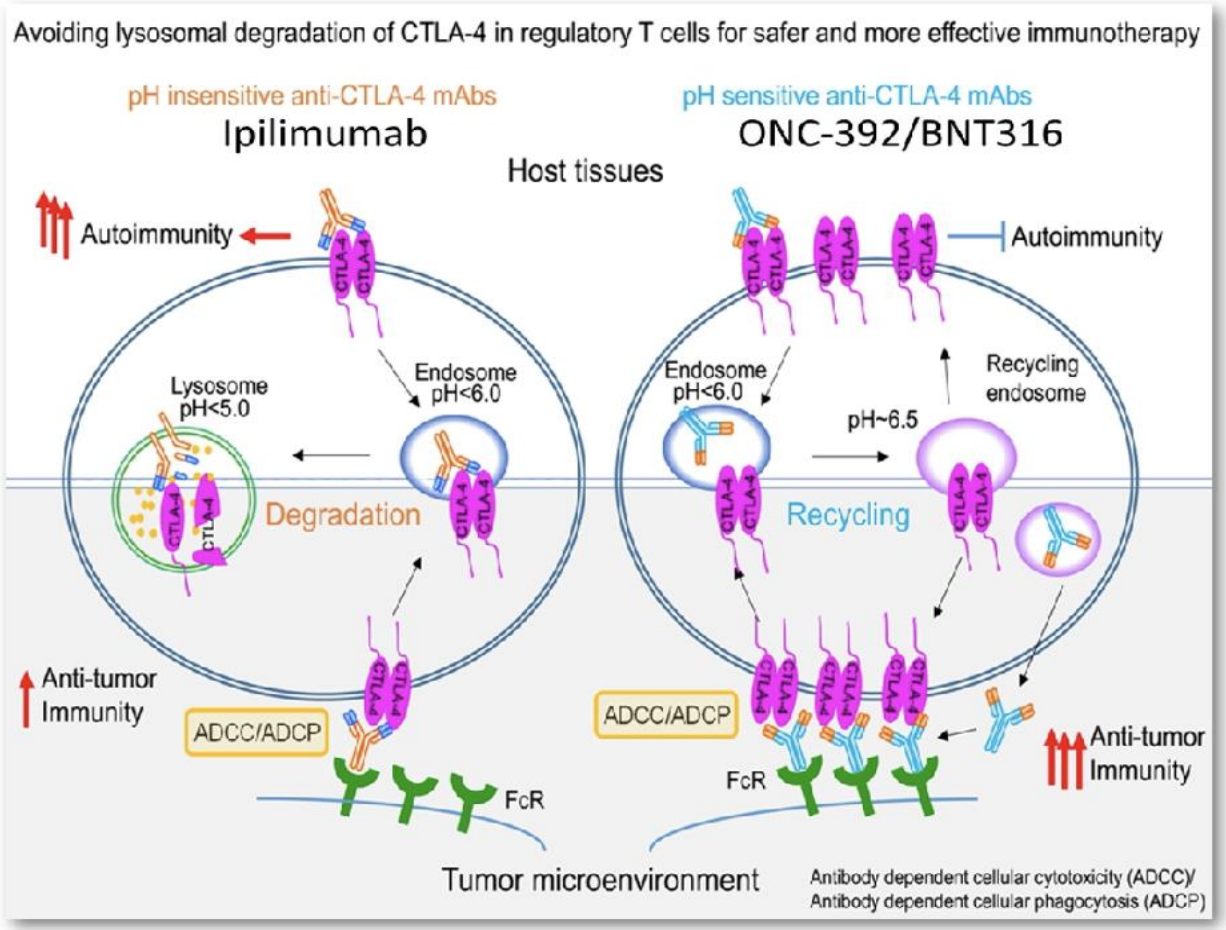
(There is no intention of cross trial comparison)

SELECTED POTENTIAL CONCEPTS

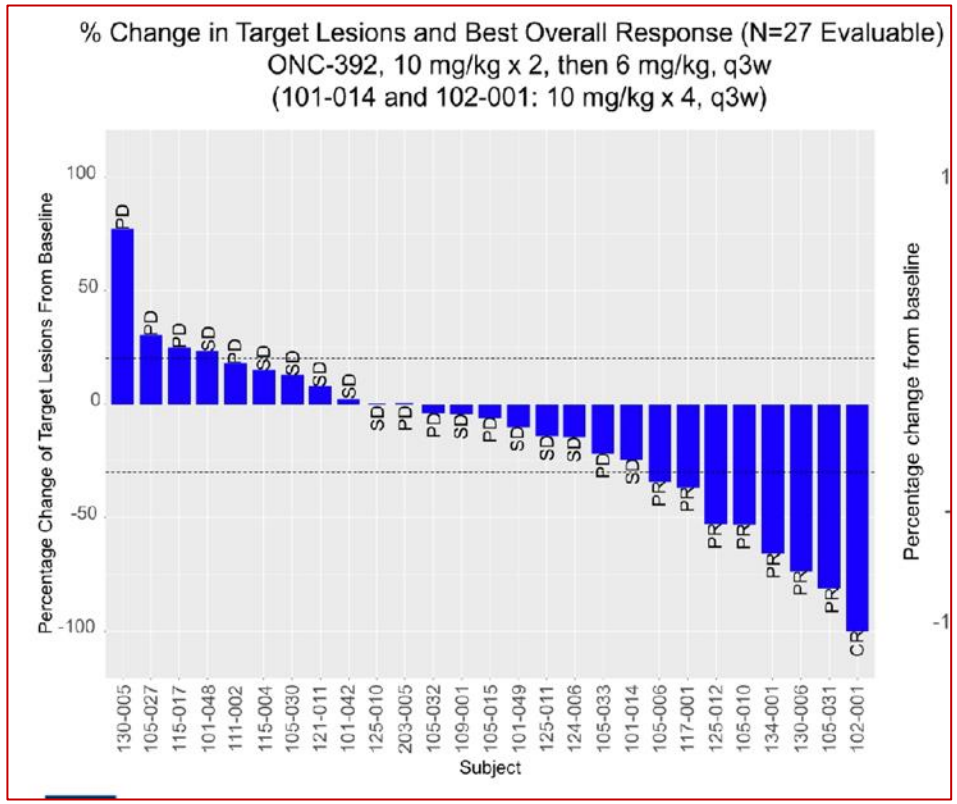
ONC-392/BNT316

He K et al, abstract 9024, ASCO 2023

Mechanism of action



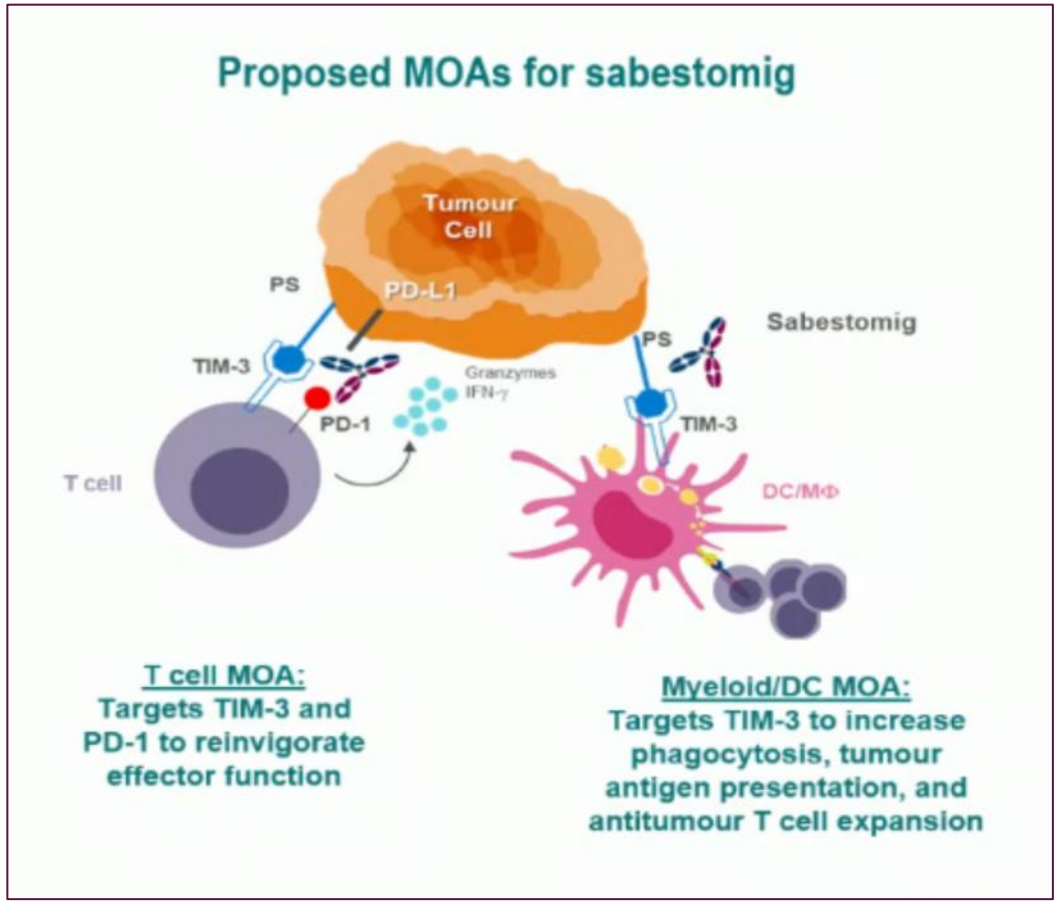
Liu Y, Zheng P. Preserving the CTLA-4 Checkpoint for Safer and More Effective Cancer Immunotherapy. *Trends Pharmacol Sci*. 2020;41(1):4-12. doi:10.1016/j.tips.2019.11.003



- Long treatment duration despite extensive first-line immunotherapy in some patients
- GI Tox CTC Grade 3/4: 43%, irAE CTC Grade 3/4: 34%
- Moving to phase III trial

SELECTED POTENTIAL CONCEPTS

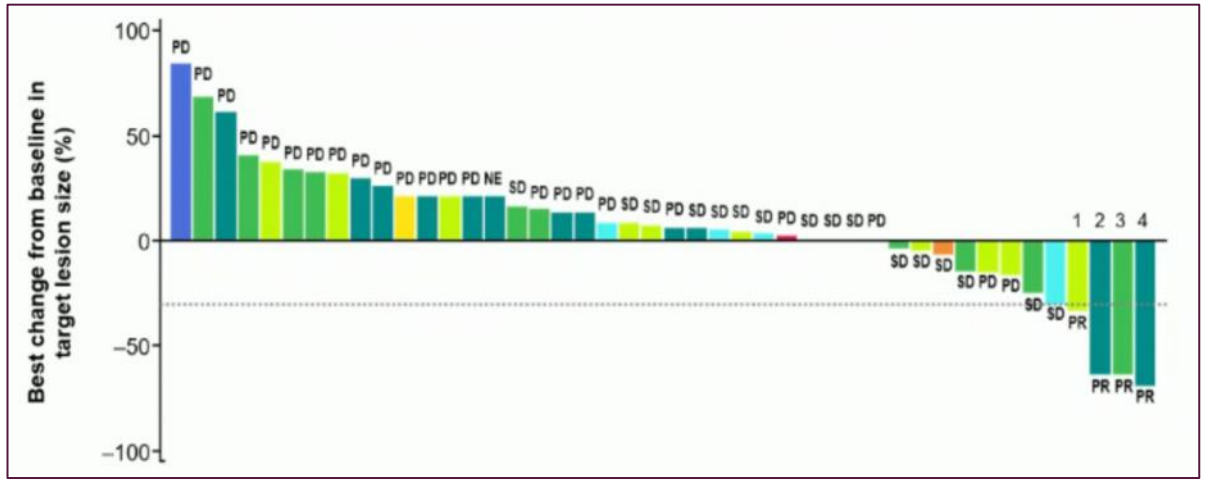
SABESTOMIG - AZD7789 (ANTI PD-1 & ANTI TIM)



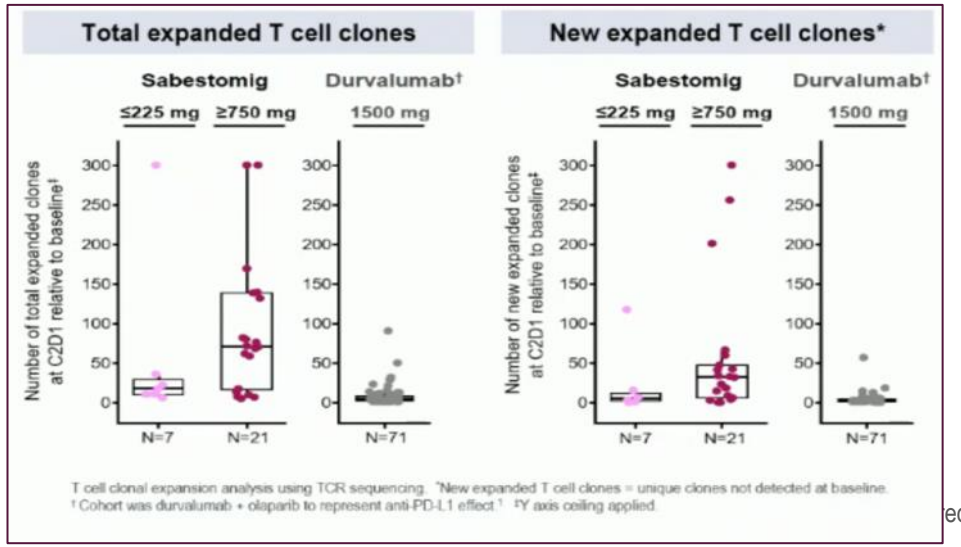
45 patients, prior treatment with anti PD(L)-1
Median 2 lines of prior therapy (1-6)

Martin Reck

Besse B et al, ESMO 2023



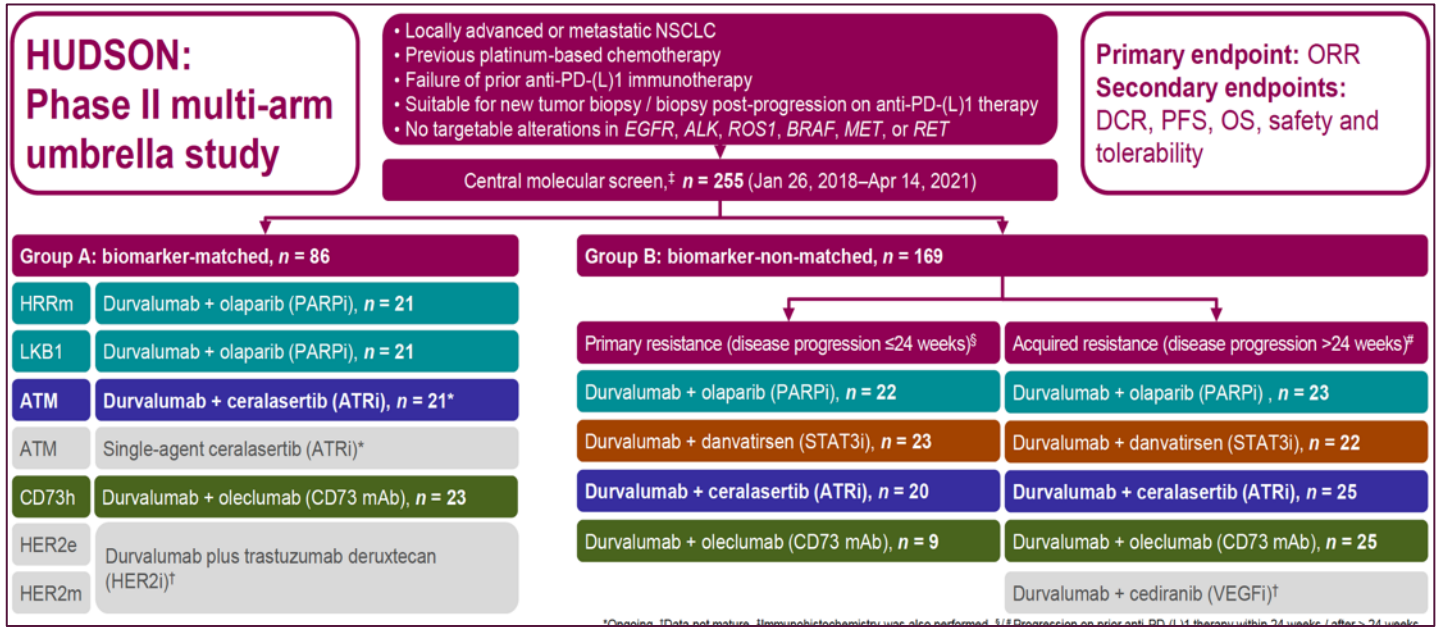
Response: 4/36 (11%) (Dose =/> 750 mg)



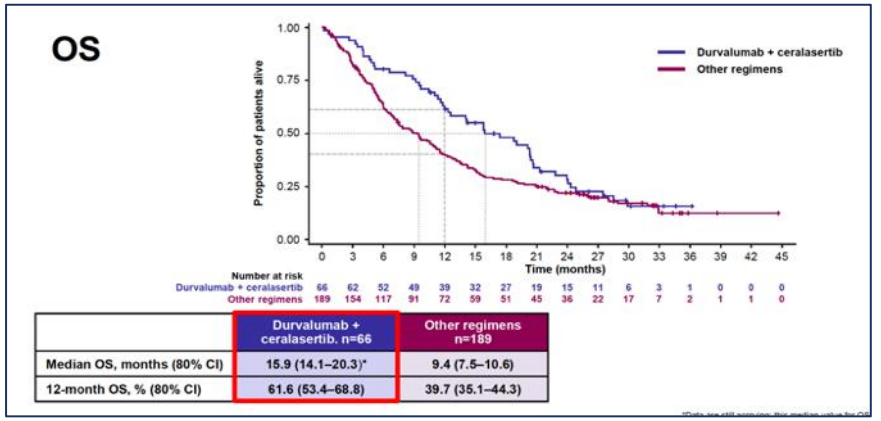
Expansion of T-Cell Clones

SELECTED POTENTIAL CONCEPTS
HUDSON - PLATFORM STUDY

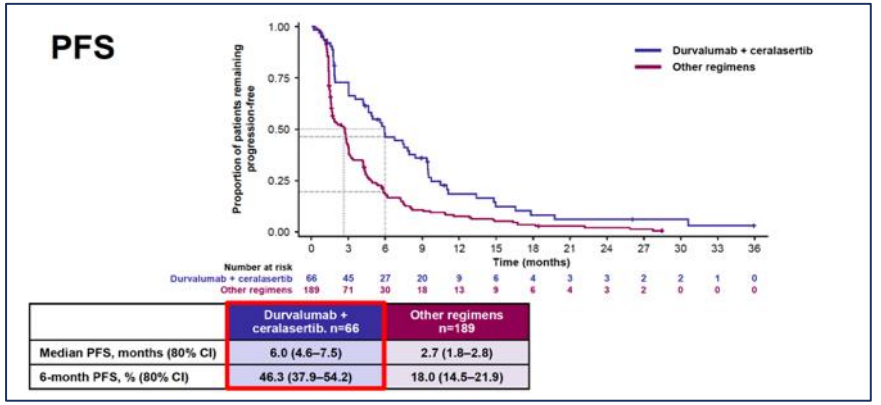
Besse B et al, WCLC 2022



Ceralasertib + Durvalumab



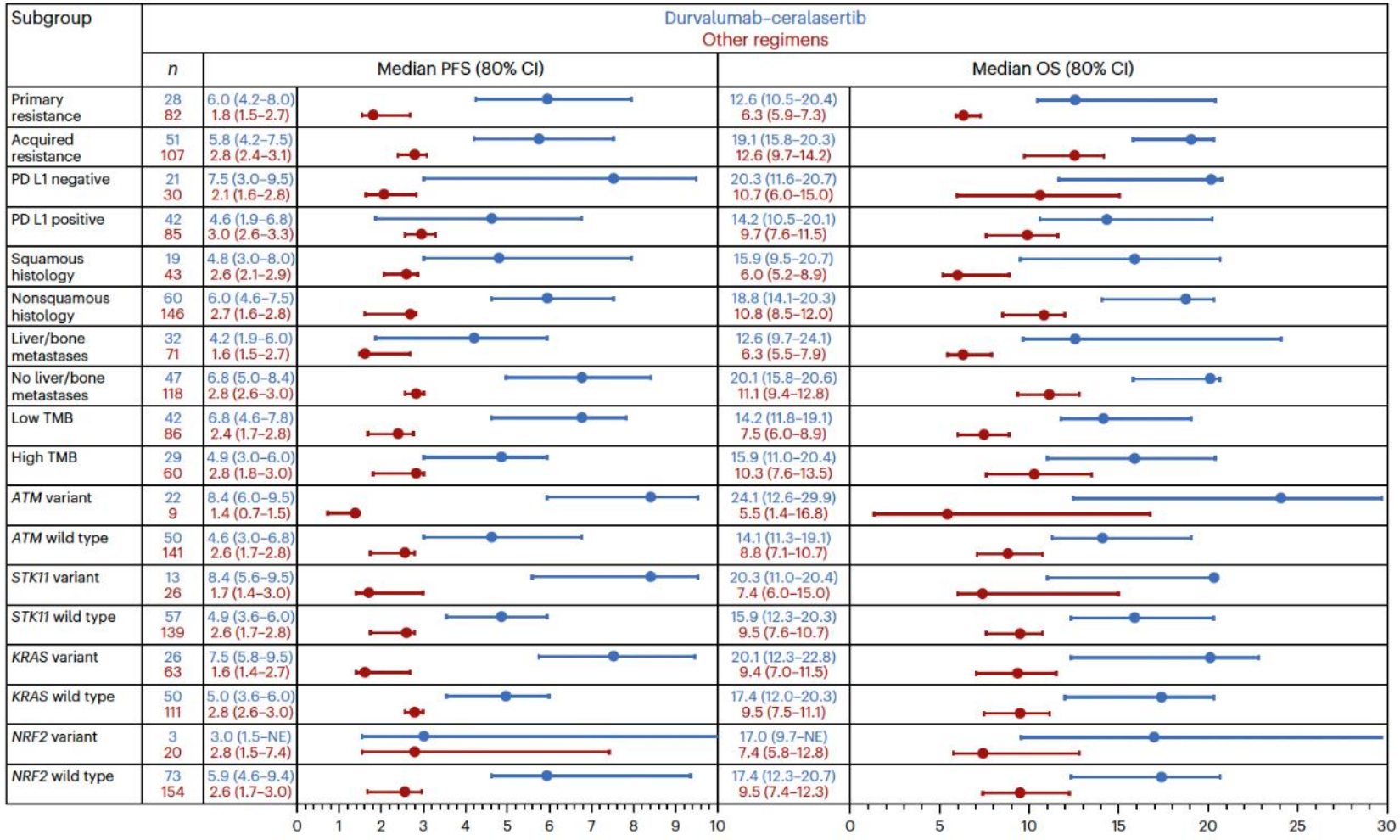
	Durvalumab + ceralasertib, n=66	Other regimens n=189
Median OS, months (80% CI)	15.9 (14.1–20.3)*	9.4 (7.5–10.6)
12-month OS, % (80% CI)	61.6 (53.4–68.8)	39.7 (35.1–44.3)



	Durvalumab + ceralasertib, n=66	Other regimens n=189
Median PFS, months (80% CI)	6.0 (4.6–7.5)	2.7 (1.8–2.8)
6-month PFS, % (80% CI)	46.3 (37.9–54.2)	18.0 (14.5–21.9)

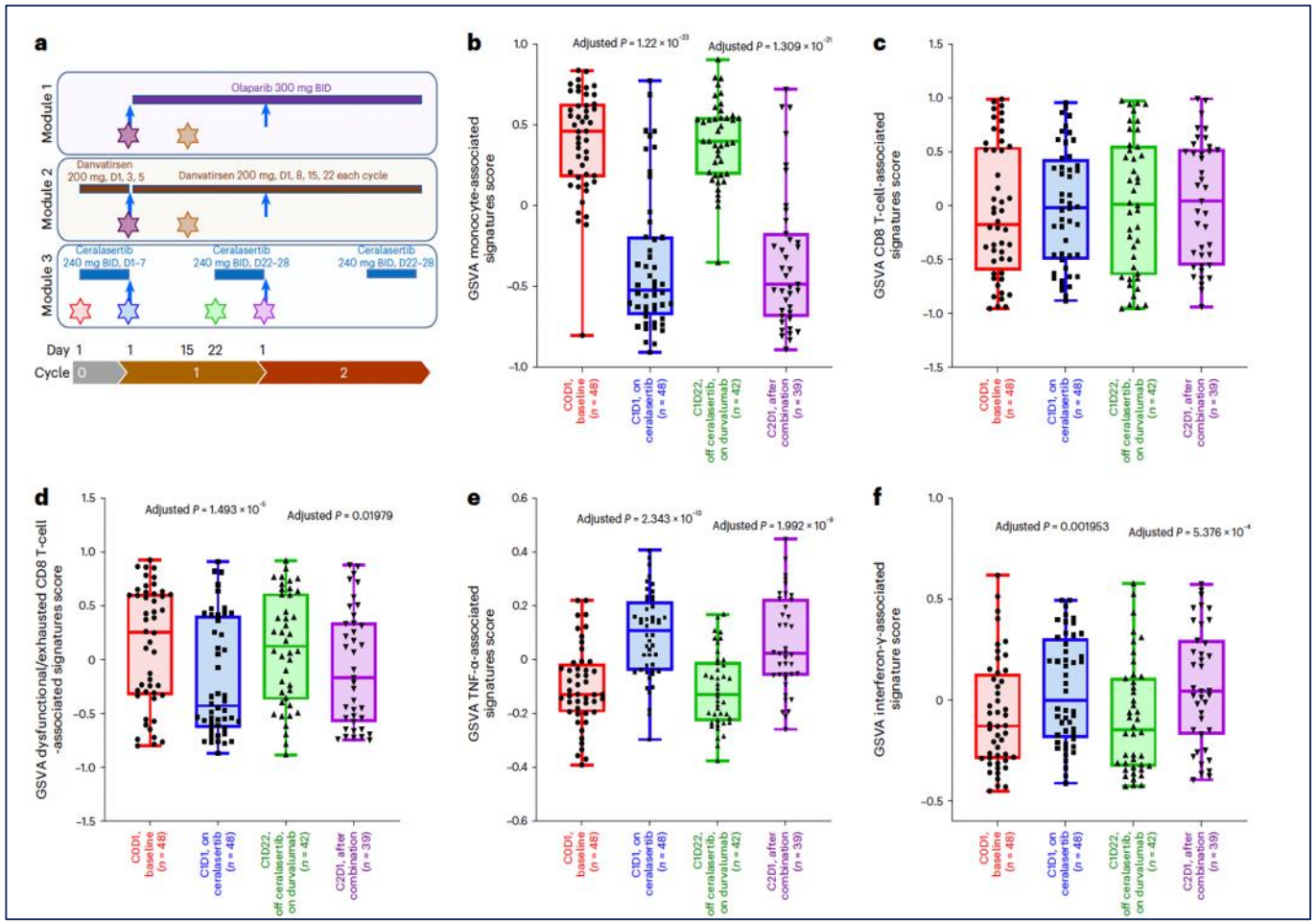
OS (median/1 y OS): 15.9 m/62% - 9.4 m/39.7% (other)
PFS (median/1 y PFS): 6.0 m/46.3% - 2.7 m/18.9% (other)

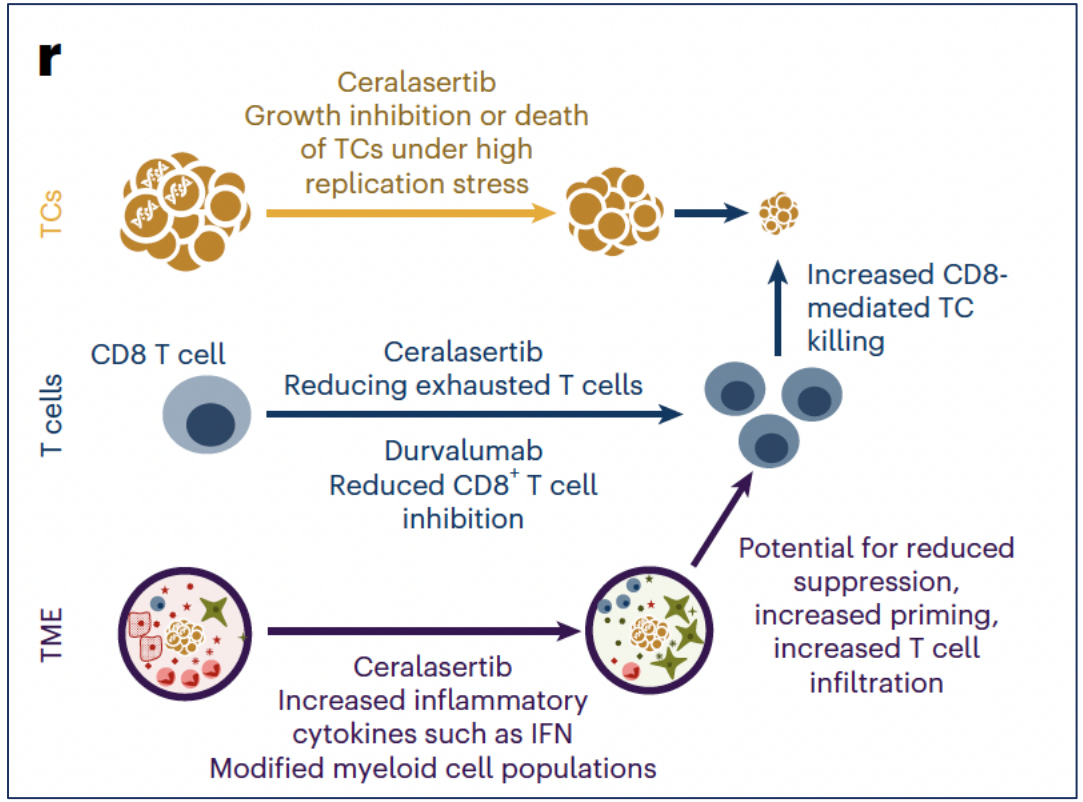
HUDSON - EFFICACY ACROSS SUBGROUPS



Besse B et al, Nature Medicine 2024

HUDSON - CHANGES IN TME AND CLONALITY

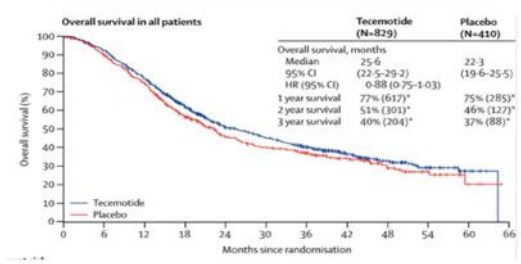




Besse B et al, Nature Medicine 2024

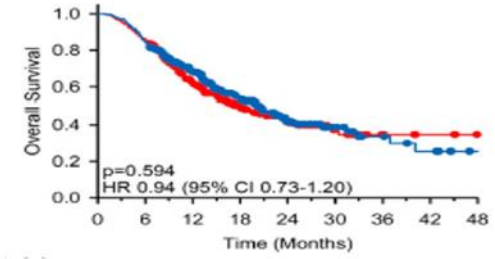
VACCINATION IN NSCLC - SO FAR NOT A SUCCESS STORY

Tecemotide (L-BLP25)
MUC 1 peptide



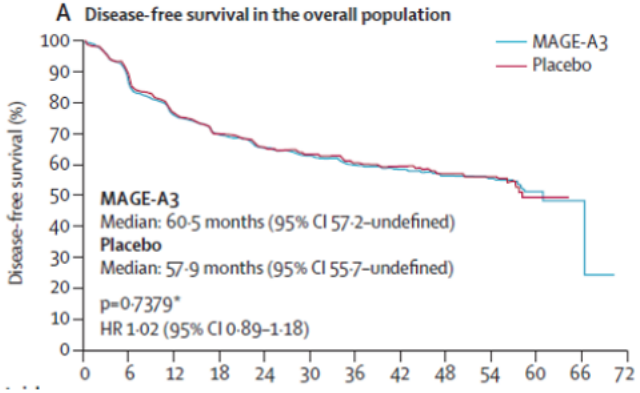
Butts, Lancet Onc, 2013

Belagenpumatucel-L
Whole cell vaccine



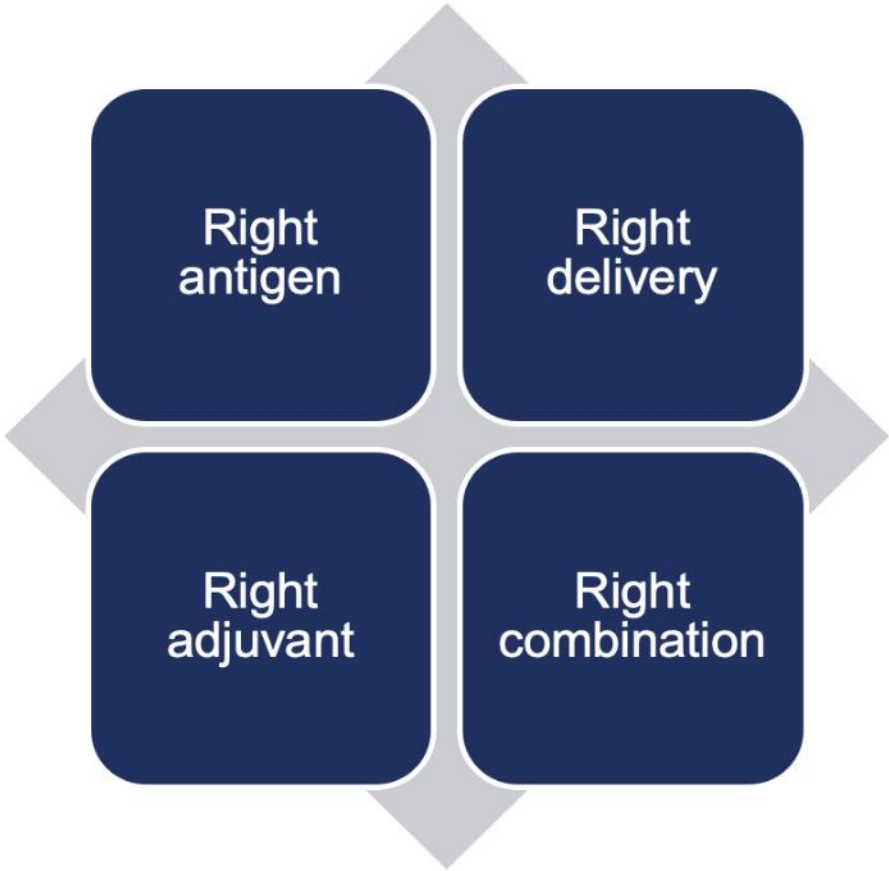
Giaccone, European Journal of cancer_2015

(MAGE-A3) peptide



Vansteenkiste JF, et al. Lancet Oncol 2016

Relevant steps in optimization



Courtesy of Lyudmila Bhazenova

VACCINES – PH III ATALANTE TRIAL

- Advanced/metastatic NSCLC
- EGFRwt, ALK-negative, all PD-L1 status
- HLA-A2+ (blood)
- Failure to platinum-based CT and IO, combined or sequenced
- IO last line with primary or secondary resistance*
- Brain metastases allowed if asymptomatic & treated
- ECOG PS 0 to 1

R 2:1

Arm A: OSE2101 Q3W for 6 subcutaneous injections, then Q8W up to Year 1, then Q12W until progression or toxicity

Arm B: SoC (docetaxel or pemetrexed) Q3W until progression or toxicity

Primary endpoint: OS

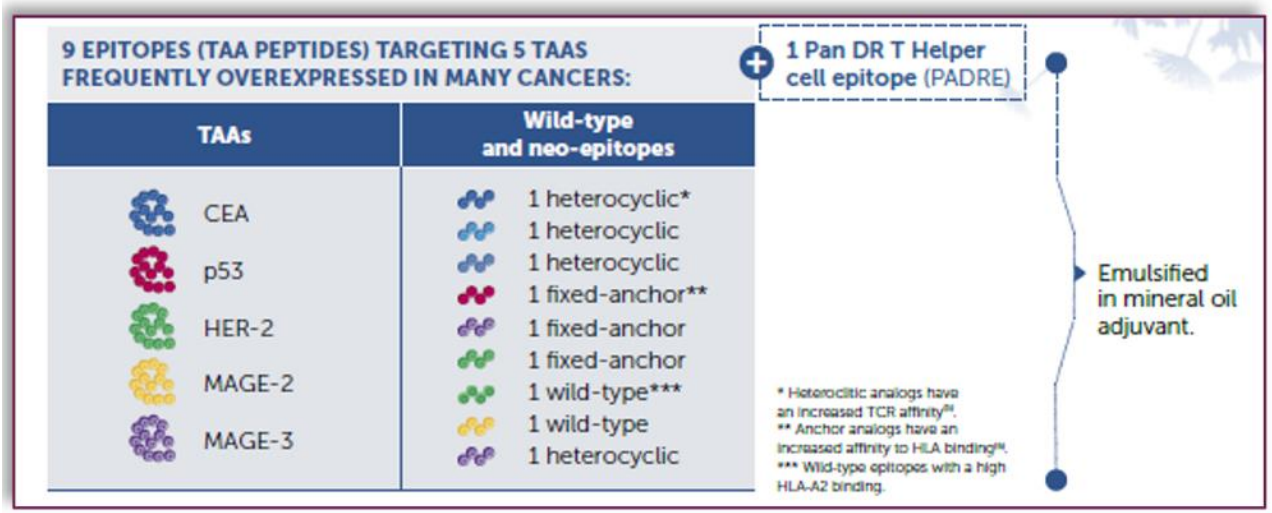
Stratification:
- Histology
- Best response to 1st line
- Line rank of prior IO

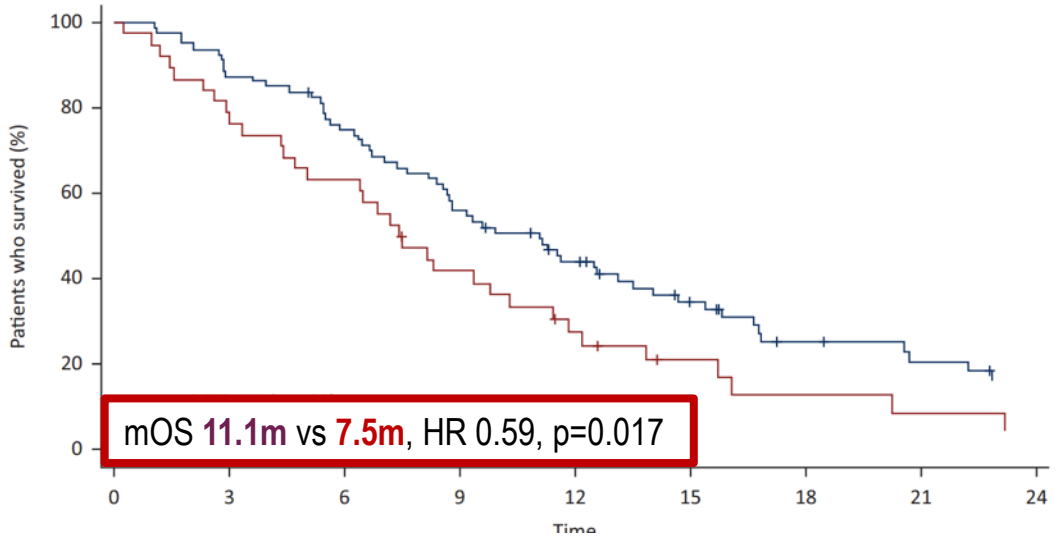
COVID: prematurely closed (219/400 enrolled)

Final primary analysis in IO secondary resistance

(>12 weeks IO, N=118, 68% of total)

Stats revised: HR 0.55, power 80%, 2-sided level 5%



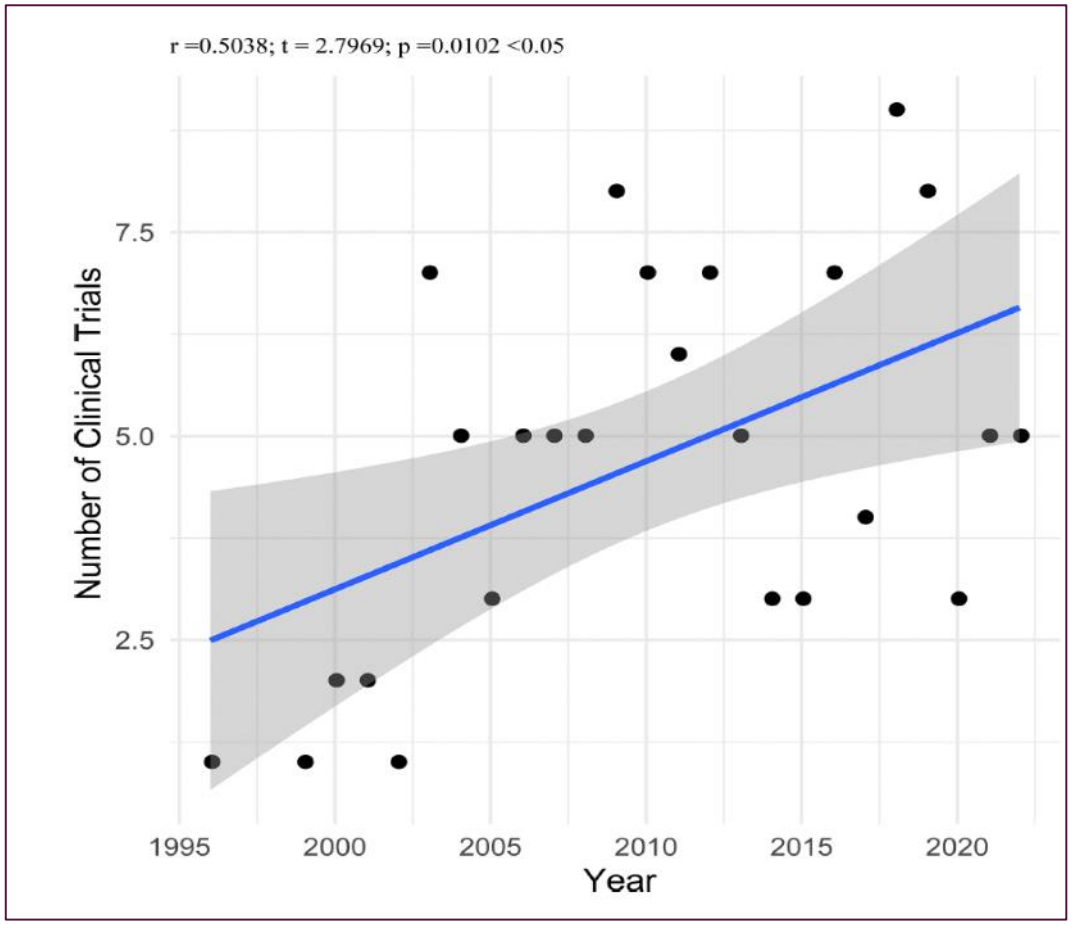


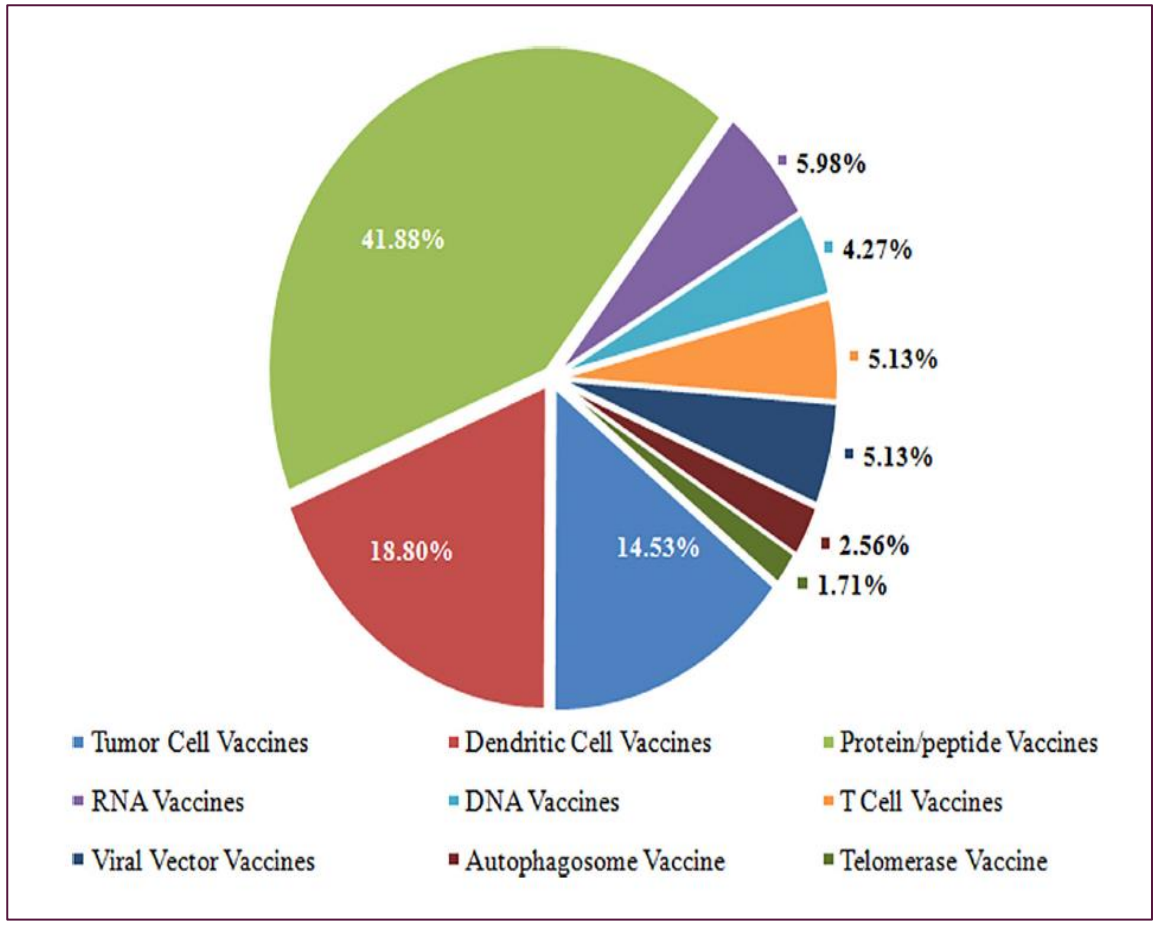
Besse Ann Oncol 2023

Courtesy of L Hendriks

Evolution of NSCLC Vaccines studies

(www.trial.gov registered)





Gu W et al, Frontiers Immunology 2022

CONCLUSIONS

- Second Line Treatment represents an effective and important part of lung cancer treatment
- Second Line Treatment should be offered to all eligible patients (we should be able to beat the 50%)
- Second Line Treatment has undergone signficant changes with the implementation of immunotherapies
- Second Line Treatment will have to undergo significant changes with the introduction of immunotherapies in first-line treatment

Thank you!

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