STATE OF THE ART IMMUNOTHERAPY FOR NON-AGA ADVANCED NSCLC

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DECLARATION OF INTERESTS

Interest	Company/organisation
Grants/research support	Roche, Boehringer Ingelheim, AstraZeneca, Takeda, Merck, Pfizer, Novartis, Gilead (institution)
Honoraria or consultation fees	Advisory boards (all institution): Amgen, Boehringer Ingelheim, Lilly, Novartis, Pfizer, Takeda, Merck, Janssen, MSD, Anheart, Bayer, AstraZeneca, Summit Therapeutics, BMS, Pierre Fabre, Daiichi
Participation in a company-sponsored bureau	Not applicable
Stock shareholder	Not applicable
Spouse/partner	Not applicable
Other support/potential conflict of interest	Speaker educationals/webinars: AstraZeneca, Bayer, Lilly, MSD, high5oncology, Takeda, Janssen, GSK, Sanofi, Pfizer (Inst), Medtalks, Benecke, VJOncology, Medimix (self) Member guideline committees: Dutch guidelines on NSCLC, brain metastases and leptomeningeal metastases (self), ESMO guidelines on metastatic NSCLC and SCLC (non-financial) Local PI pharma studies (Inst): MSD, AstraZeneca, GSK, Novartis, Merck, Roche, Takeda, Blueprint, Mirati, Abbvie, Gilead, MSD, Boehringer, Pfizer, Amgen Other (non-financial): secretary NVALT studies foundation, subchair EORTC metastatic NSCLC systemic therapy, vice-chair scientific committee Dutch Thoracic Group

OVERVIEW

Whats in the ESMO guidelines?

First line monotherapy immune checkpoint blocker (ICB)

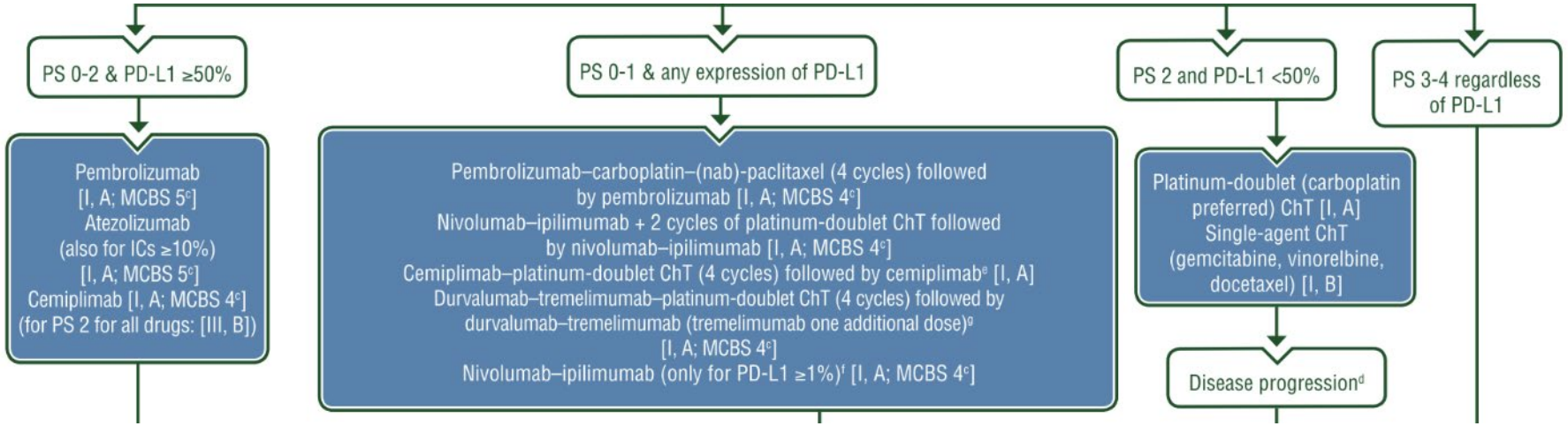
First line chemo-ICB

First line dual ICB combinations

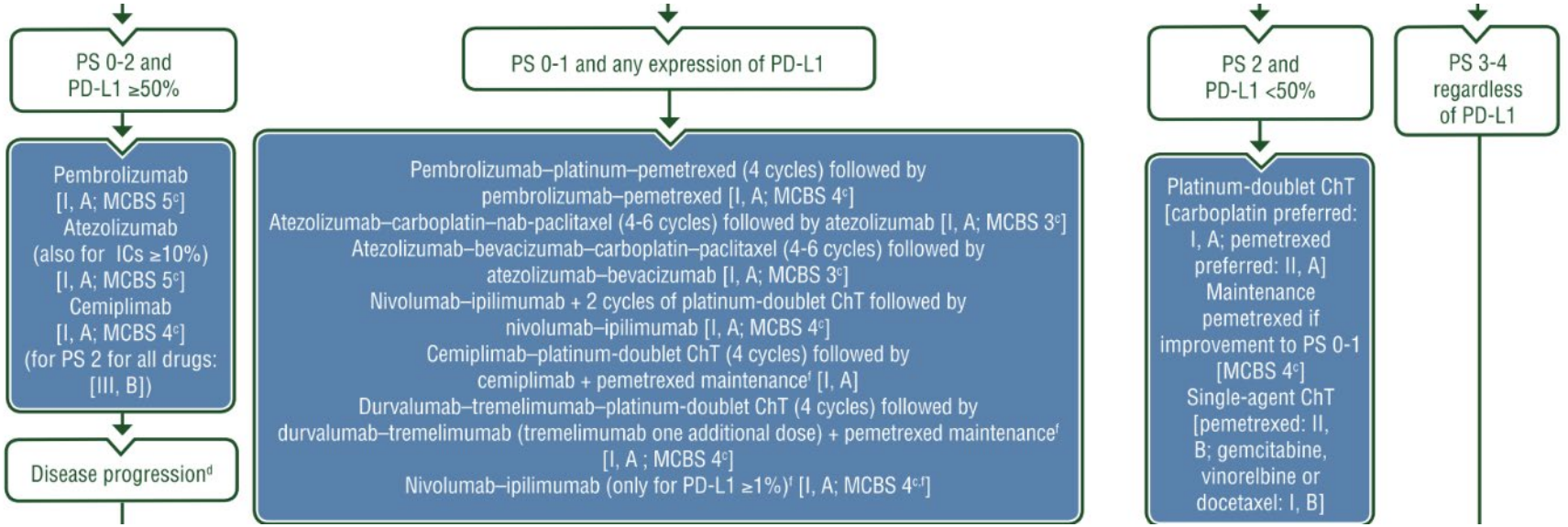
Second line and beyond

Conclusions and take home messages

ESMO CPG FIRST LINE ICB METASTATIC NON-ONCOGENE ADDICTED NSCLC



squamous



Non-squamous

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Hendriks Ann Oncol 2023

ESMO LIVING GUIDELINE CURRENTLY UPDATED

ESMO Non-Oncogene-Addicted Metastatic Non-Small-Cell Lung Cancer Living Guideline

Version:
v1.1 - March 2024

To cite this living guideline, please include the original Clinical Practice Guideline citation "Ann Oncol. 2023;34(4):358-376" and this online publication, including date and version number: "ESMO Non-Oncogene-Addicted Metastatic Non-Small-Cell Lung Cancer Living Guidelines, v1.1 March 2024"

This living guideline was prepared by L Hendriks, F Cortiula, E Mariamidze, L Castelo-Branco, D Martins-Branco, C Sessa, G Pentheroudakis and M Reck, on behalf of the Clinical Practice Guideline author group.

FIRST LINE MONOTHERAPY ICB

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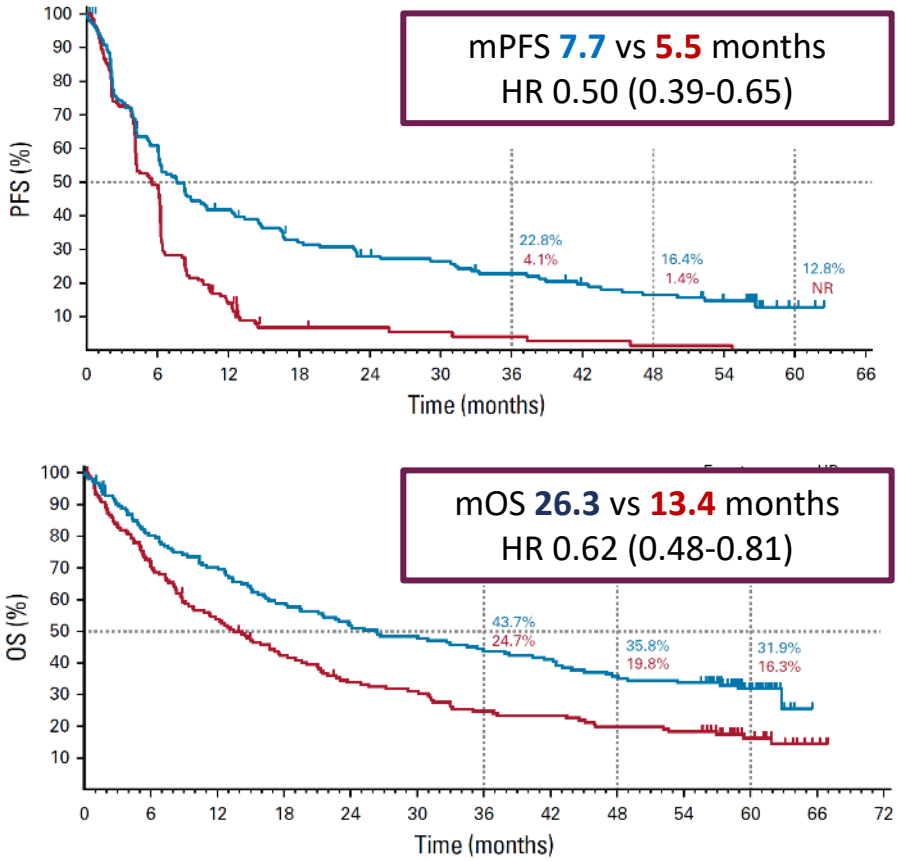
FIRST LINE MONO ICB DATA

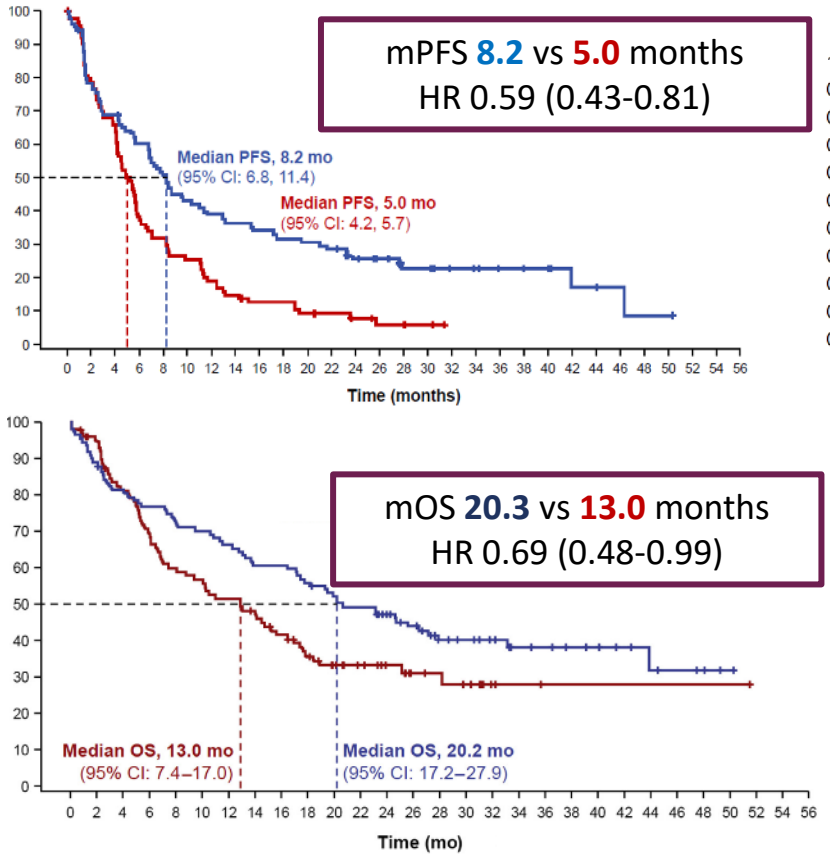
KEYNOTE-024



mPFS **7.7** vs **5.5** months
HR 0.50 (0.39-0.65)

mOS **26.3** vs **13.4** months
HR 0.62 (0.48-0.81)

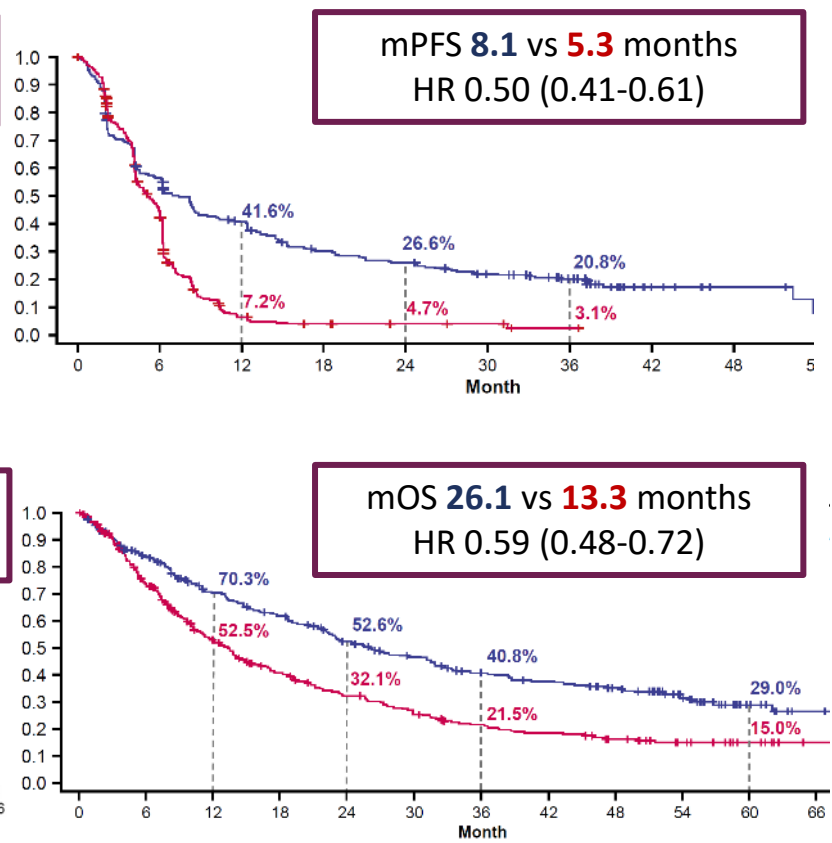
IMPOWER110 WT



mPFS **8.2** vs **5.0** months
HR 0.59 (0.43-0.81)

mOS **20.3** vs **13.0** months
HR 0.69 (0.48-0.99)

EMPOWER LUNG1



mPFS **8.1** vs **5.3** months
HR 0.50 (0.41-0.61)

mOS **26.1** vs **13.3** months
HR 0.59 (0.48-0.72)

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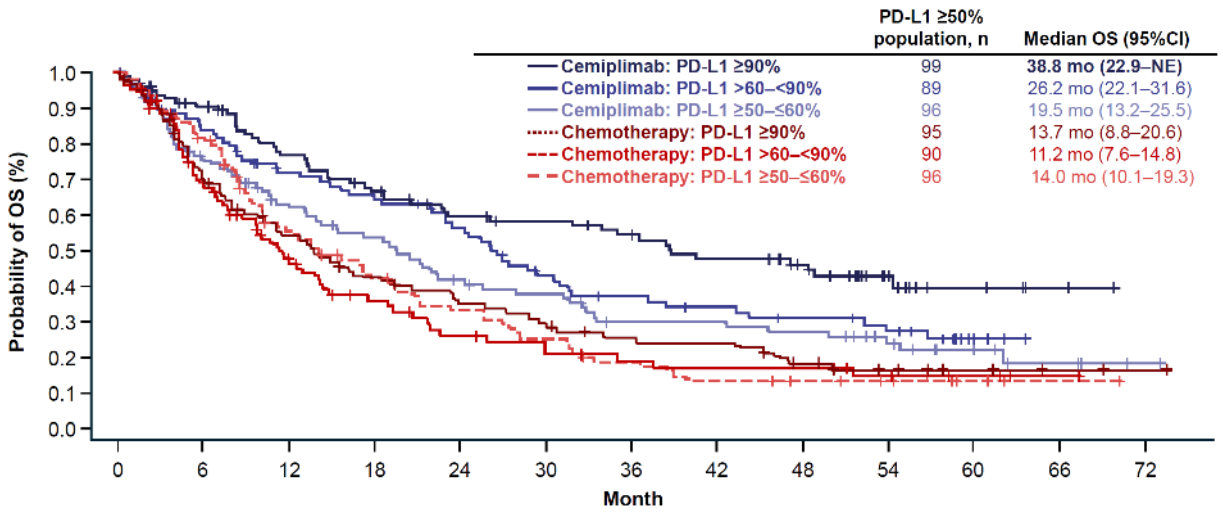
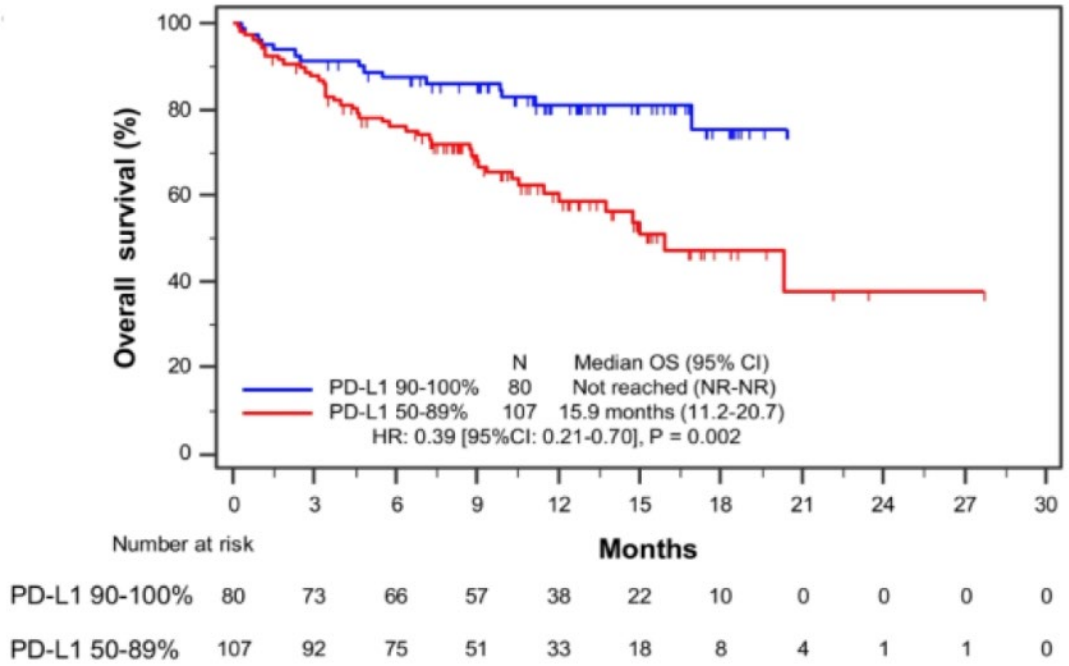
Reck JCO 2021 ; Jassem JTO 2021; Kilickap WCLC 2024

HIGHER PD-L1 = MORE BENEFIT

EMPOWER LUNG1



Pembro data

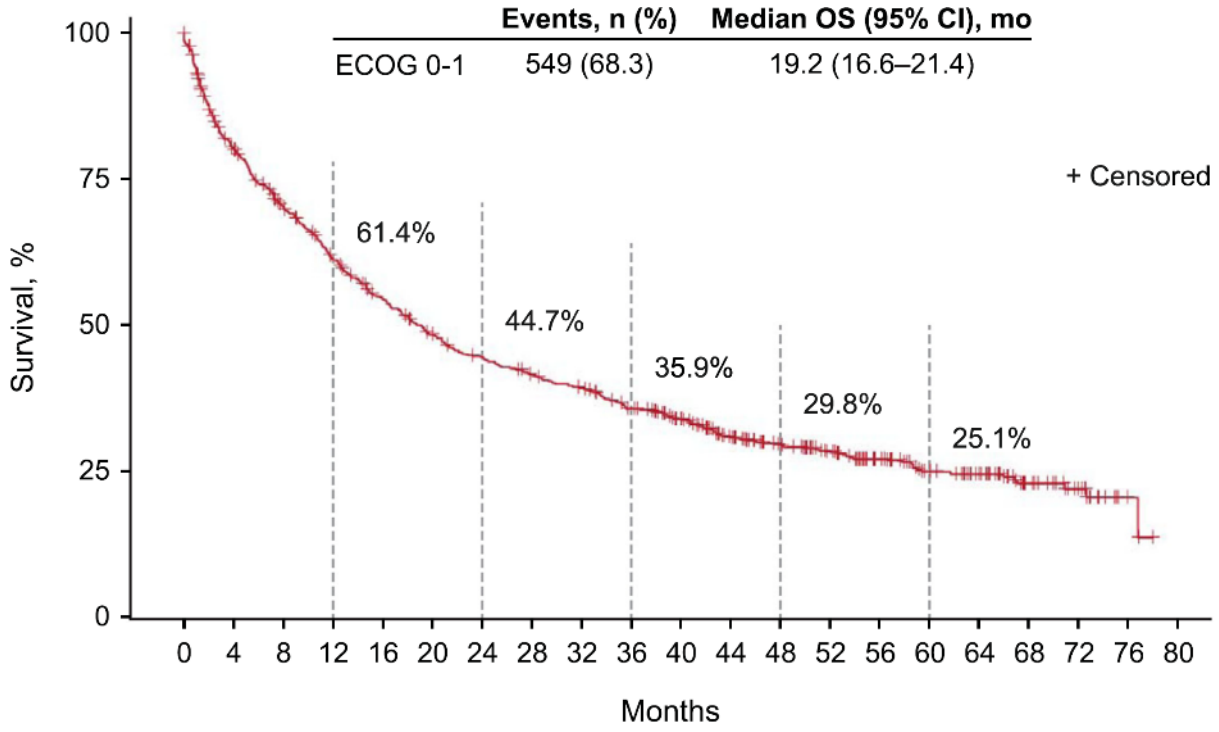


Kilickap WCLC 2024; Aguilar Ann Oncol 2019

REAL WORLD DATA

Pembrolizumab PD-L1 ≥50%

N = 804 ECOG PS 0-1



mOS slightly lower vs trials

5y OS comparable – slightly lower

FIRST LINE CHEMO-ICB COMBOS

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CHEMO-ICB VS CHEMO PHIII TRIALS

Non-squamous

Anti-PD-L1 + ChT		Patients	PFS (months)	OS (months)
Keynote 189 (pembrolizumab)	CisP/CbP + pemetrexed	616	9 vs 4.9, HR 0.50	5 years OS 19.4%
IMPower 150 (atezolizumab)	CbP-paclitaxel ± bevacizumab	800	8.3 vs 6.8, HR 0.62	19.5 vs 14.7, HR 0.80
IMPower 130 (atezolizumab)	CbP + nab-paclitaxel	679	7.0 vs 5.5, HR 0.64	18.6 vs 13.9, HR 0.79
IMPower 132 (atezolizumab)	CisP/CbP + pemetrexed	578	7.7 vs 5.2, HR 0.56	17.5 vs 13.6, HR 0.86
ORIENT-11 (sintilimab)	CisP/CbP + pemetrexed	397	9.2 vs 5.0, HR 0.49	24.2 vs 16.8, HR 0.65
Camel-Nsq (camrelizumab)	CbP + pemetrexed	412	11.3 vs 8.3, HR 0.60	NR vs 20.9, HR 0.73
Rationale-304 (tislelizumab)	Cis-CbP + pemetrexed	332	9.8 vs 7.6, HR 0.61	21.4 vs 21.3, HR 0.9

All PD-L1 levels eligible

Outcomes ↓ with ↓ PD-L1

Slide S Peters

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ChT, chemotherapy; HR, hazard ratio; OS, overall survival; PD-L1, programmed death-ligand 1; PFS, progression-free survival.
Gandhi KN189, NEJM 2018; Rodriguez-Abreu, ASCO 2020; Socinski, NEJM 2018 and AACR 2020; Papadimitrakopoulou, WCLC 2018; Cappuzzo, ESMO 2018; Yang, JTO 2021; Nishio, ESMO Asia 2020 and JTO 2020; Gray, WCLC 2020; Zhou, Lancet Respir Med 2020; Lu, JTO 2021; Yang, ELCC 2022.

CHEMO-ICB VS CHEMO PHIII TRIALS

Squamous

Anti-PD-L1 + ChT		Patients	PFS (months)	OS (months)
Keynote 407 (pembrolizumab)	CisP/CbP + paclitaxel or nab-paclitaxel	559	8.0 vs 5.1, HR 0.59	5 years OS 18.4%
IMPower 131 (atezolizumab)	CisP/CbP + paclitaxel or nab-paclitaxel	684	6.3 vs 5.6, HR 0.71	14.2 vs 13.5, HR 0.88
Orient-12 (sintilimab)	CisP/CbP + gemcitabine	357	5.5 vs 4.9, HR 0.54	NR vs NR, HR 0.57
Camel-Sq (camrelizumab)	CbP-paclitaxel	389	8.5 vs 4.9, HR 0.37	NR vs 14.5, HR 0.55
Rationale-307 (tislelizumab)	CbP-(nab)paclitaxel	355	7.7 vs 9.9 vs 5.5 HR 0.45 and 0.43	22.8 vs NE vs 20.2 HR 0.68 and 0.75

All PD-L1 levels eligible

Outcomes ↓ with ↓ PD-L1

Slide S Peters

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ChT, chemotherapy; HR, hazard ratio; OS, overall survival; PD-L1, programmed death-ligand 1; PFS, progression-free survival.
Paz-Ares, NEJM 2018 and JTO 2020; Jotte, JTO 2020; Zhou, ESMO 2020; Robinson, ELCC 2021; Zhou, ELCC 2021; Wang, JAMA Oncol 2021. Ren, JTO 2021.

WHO NEEDS CHEMO IN THE HIGH PD-L1 SUBGROUP?

FDA pooled analysis

Pooled Analysis Population

- Advanced NSCLC
- PD-L1 TPS ≥50%
  - Excluded staining by tumor-infiltrating immune cells
- No sensitizing *EGFR* mutations or *ALK* alterations
- Clinical trial supported FDA approval of IO-based regimen

Chemo-IO

IO-only

Exploratory Primary Outcome measure

- OS

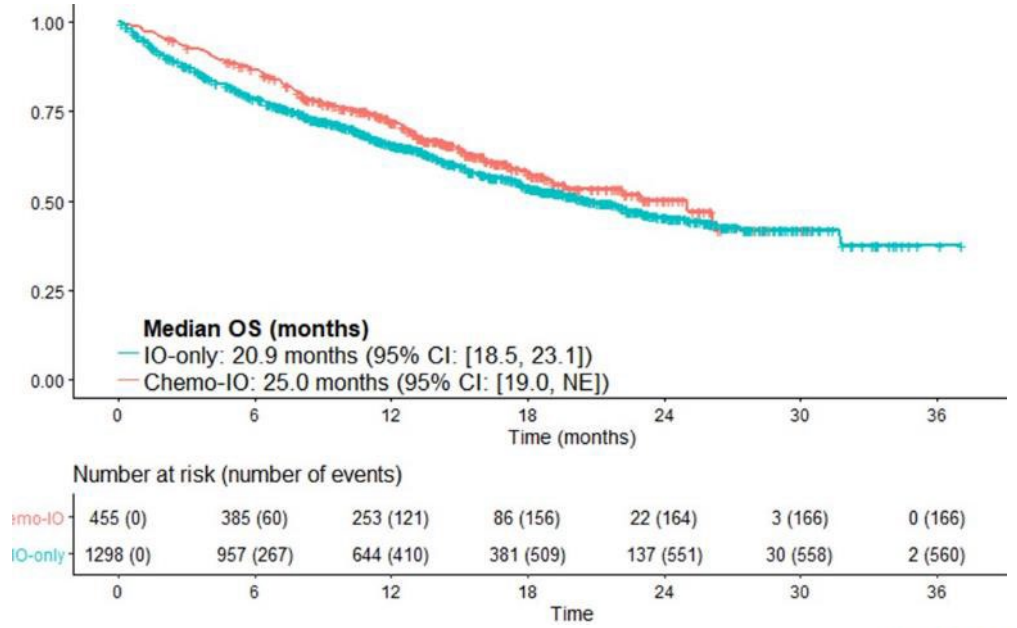
Other exploratory outcome measures

- PFS
- ORR

Sub-group analyses

- Age (yrs): *<65 vs 65-75 vs ≥75*
- ECOG PS: *0 vs. ≥ 1*
- Smoking history: *Never vs. Ever*

N = 455 chemo-ICB
N = 1298 ICB
N = 1436 chemo
Baseline characteristics similar



Similar findings retrospective RWD (HR 1.04)

Esp 75+ NO benefit Chemo-ICB
(similar data in Japanese retrosp series N=1245)

Esp never smokers BENEFIT chemo-ICB

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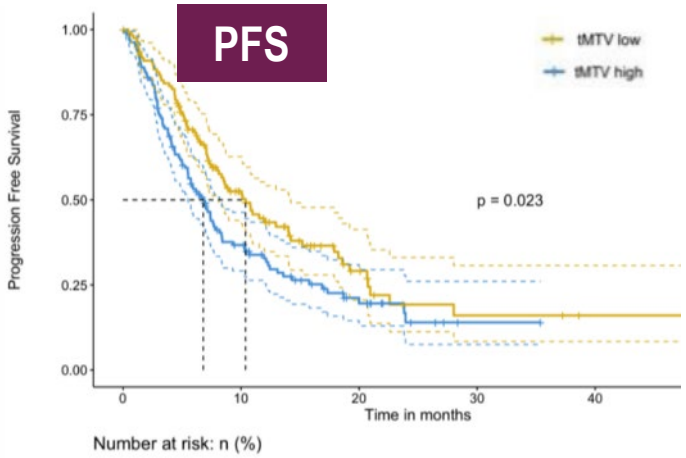
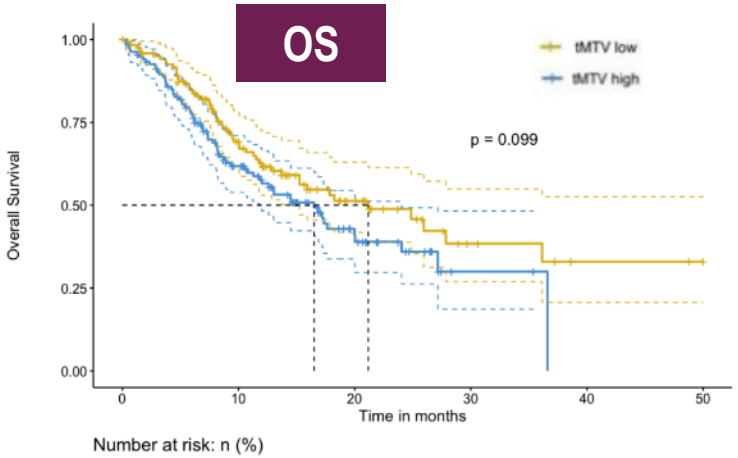
Akinboro ASCO 22; Perol Ann Oncol 2022; Tsukita JAMA Oncol 2024

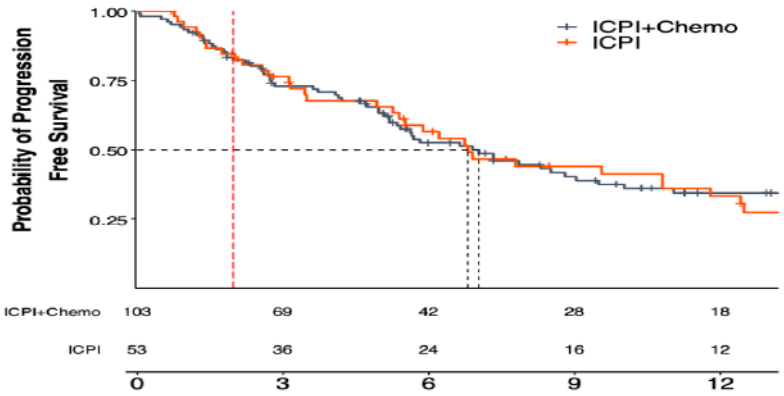
WHO NEEDS CHEMO IN THE HIGH PD-L1 SUBGROUP?

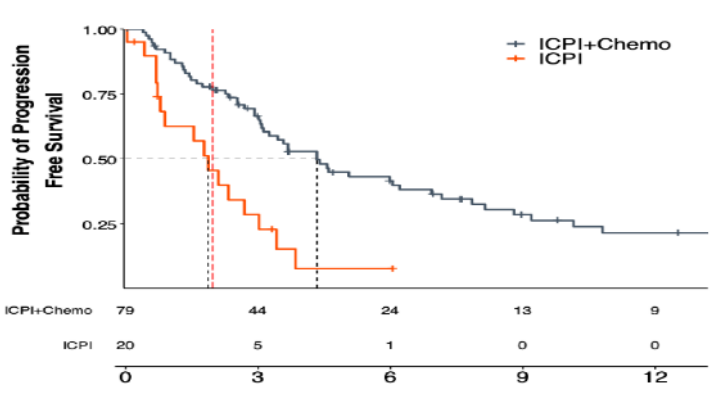
Radiological / tumor-related biomarkers? – data not specifically for PD-L1 high





N = 257 PD-L1+
tMTV ↑ with ↓ survival in ICB mono, but not chemo-ICB





N = 255
High, but not low tumor fraction associated with ↓ PFS on ICB mono vs chemo-ICB

In other series (N=) lower PD-L1, disease burden (liver mets), JAK2 and STK11 mutations associated with early PD on ICB mono, but no OS difference

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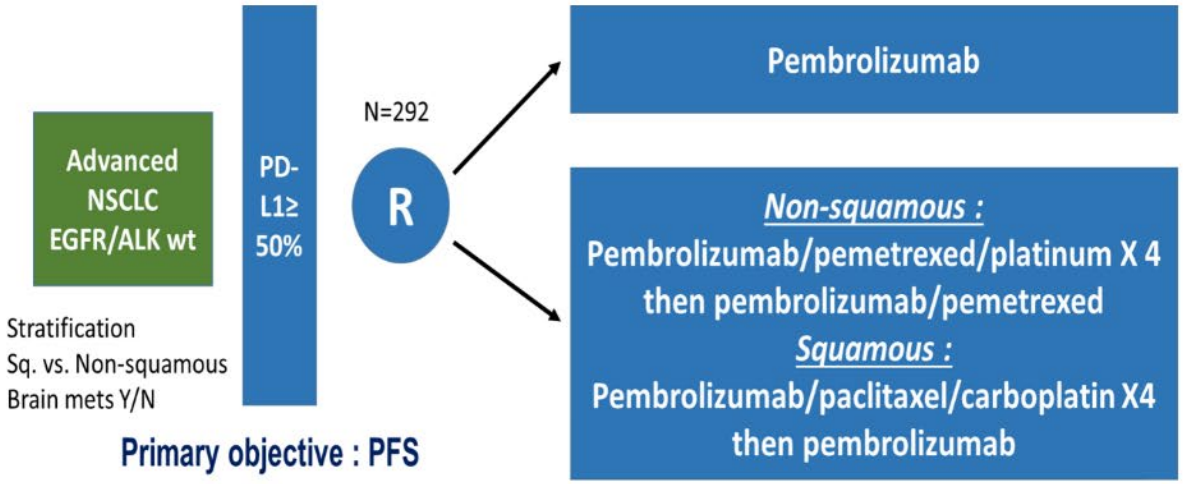
Dall Olio CCR 2024; Hong Nat Comm 2023; Besse ASCO 2022

PROSPECTIVE TRIALS ICI VS CHEMO-ICI ONGOING

PERSEE

NCT04547504

PD-L1≥50%



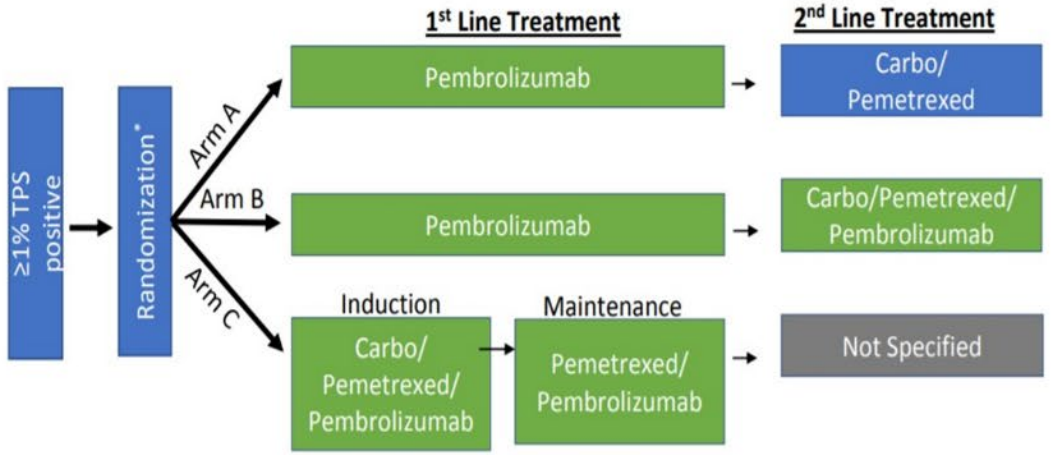
Primary objective : PFS

INSIGNA

NCT03793179

PD-L1≥1%

INSIGNA: A Randomized, Phase III Study of Firstline **I**mmunotherapy alone or in Combination with Chemotherapy in Induction/Maintenance or Post-progression in Advanced **N**onsquamous Non-Small Cell Lung Cancer (NSCLC) with Immunobiomarker **SIGN**ature-driven **A**nalysis



(Slide courtesy of Dr. Planchard)

DUAL ICB COMBOS

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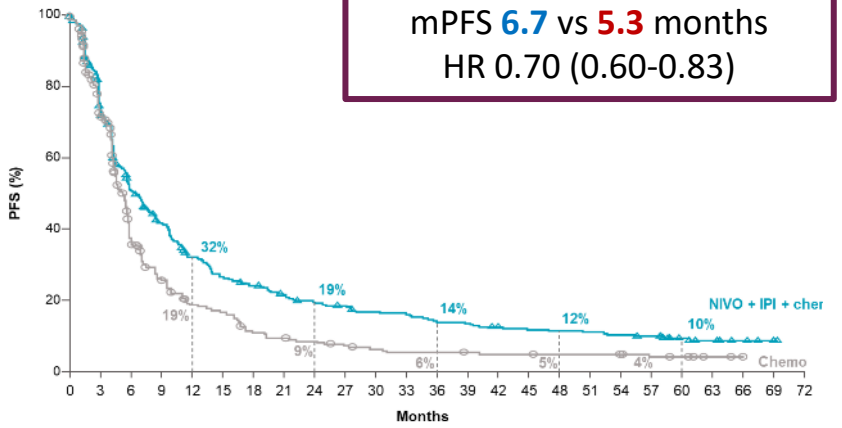
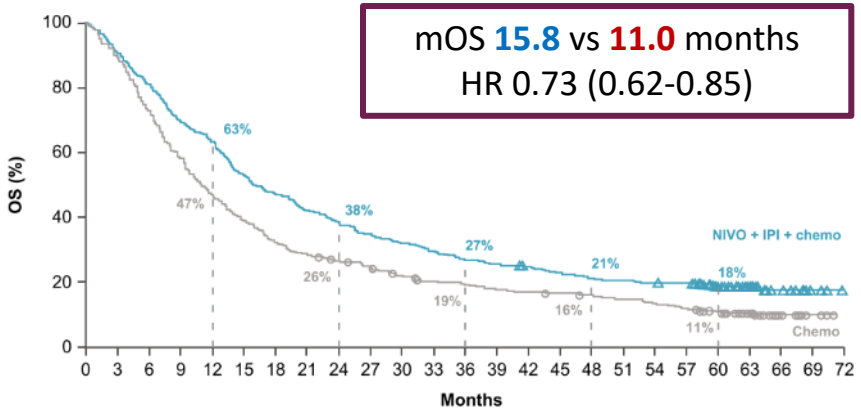
DUAL ICB +/- CHEMO PHIII TRIAL DATA

CM9LA

mPFS **6.7** vs **5.3** months
HR 0.70 (0.60-0.83)

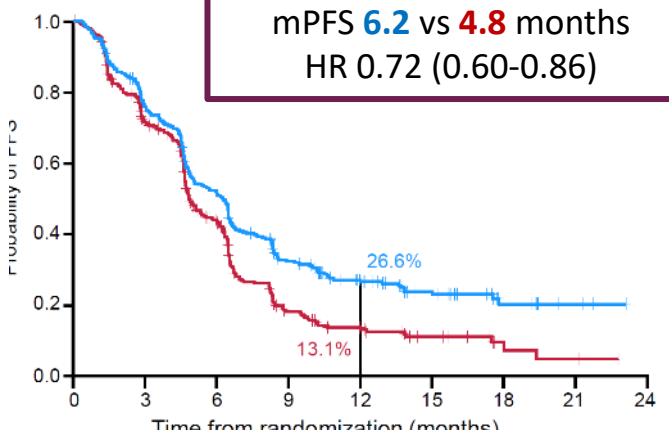


mOS **15.8** vs **11.0** months
HR 0.73 (0.62-0.85)

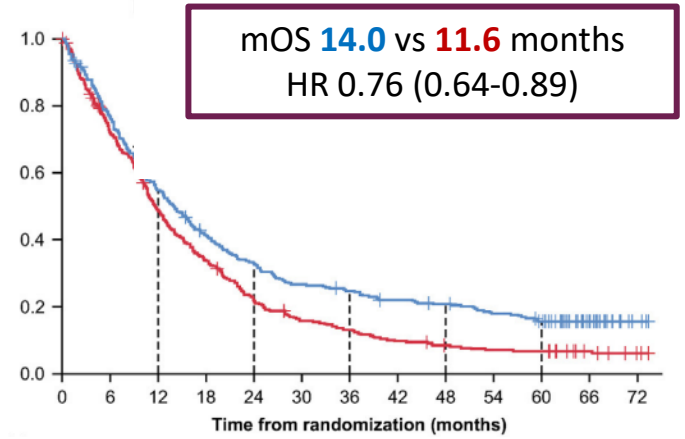


POSEIDON

mPFS **6.2** vs **4.8** months
HR 0.72 (0.60-0.86)

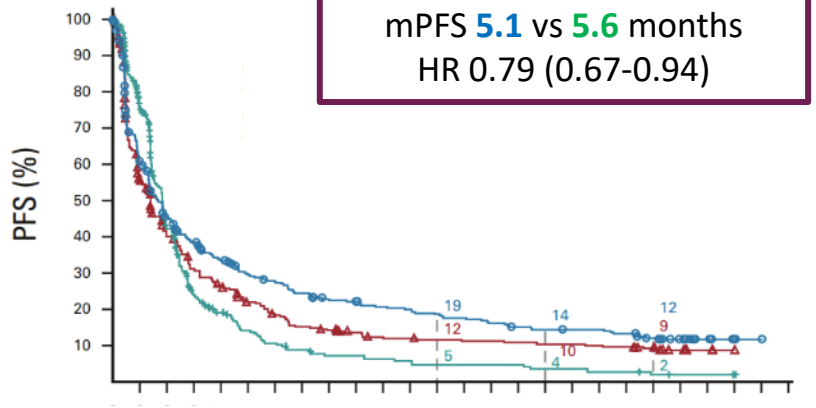


mOS **14.0** vs **11.6** months
HR 0.76 (0.64-0.89)

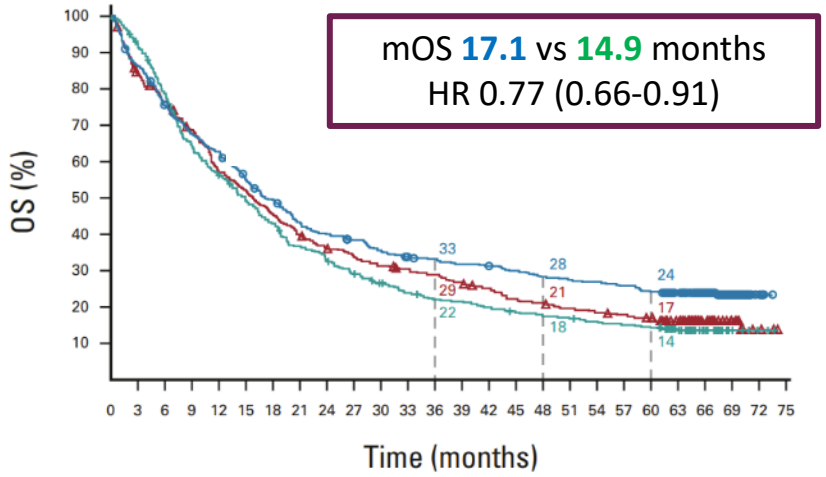


CM227 PD-L1+

mPFS **5.1** vs **5.6** months
HR 0.79 (0.67-0.94)



mOS **17.1** vs **14.9** months
HR 0.77 (0.66-0.91)



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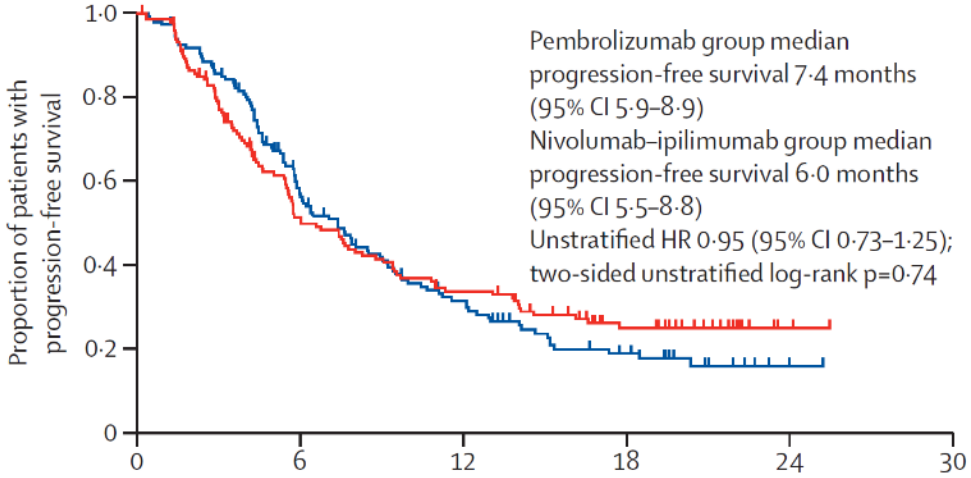
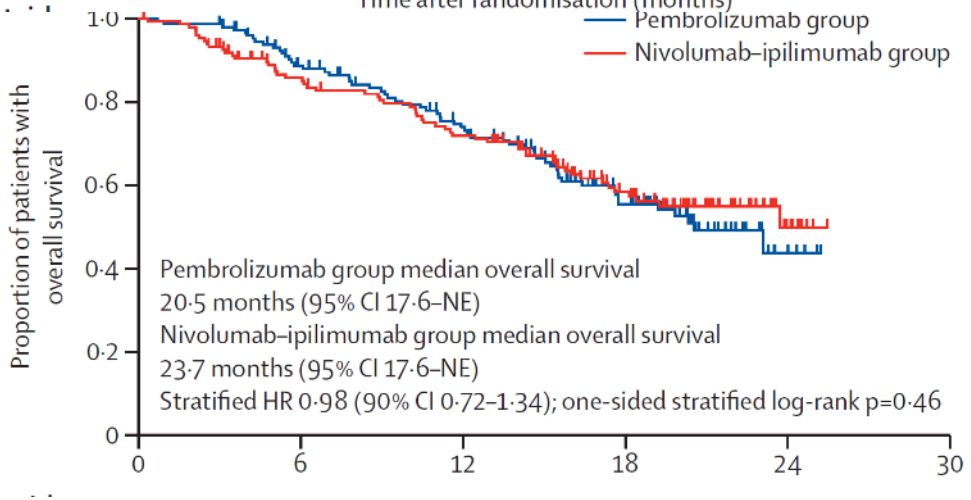
Reck EJC 2024; Brahmer JCO 2022; Peters JTO 2024; Johnson JCO 2021

DUAL ICB + CHEMO OR MONO ICB + CHEMO?

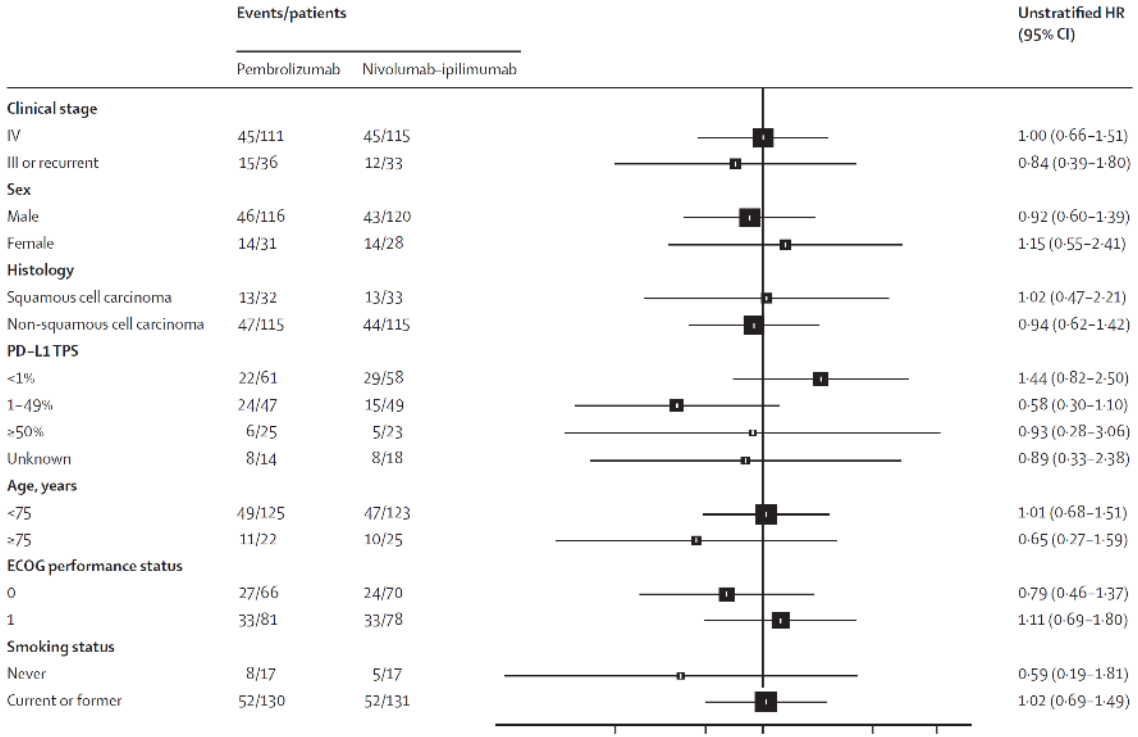
NIPPON (JCOG2007): CM9LA vs KEYNOTE





Prematurely closed because of ↑ tox in CM9LA arm
N=295/planned 414

OS



	Events/patients		Unstratified HR (95% CI)
	Pembrolizumab	Nivolumab-ipilimumab	
Clinical stage			
IV	45/111	45/115	1·00 (0·66–1·51)
III or recurrent	15/36	12/33	0·84 (0·39–1·80)
Sex			
Male	46/116	43/120	0·92 (0·60–1·39)
Female	14/31	14/28	1·15 (0·55–2·41)
Histology			
Squamous cell carcinoma	13/32	13/33	1·02 (0·47–2·21)
Non-squamous cell carcinoma	47/115	44/115	0·94 (0·62–1·42)
PD-L1 TPS			
<1%	22/61	29/58	1·44 (0·82–2·50)
1–49%	24/47	15/49	0·58 (0·30–1·10)
≥50%	6/25	5/23	0·93 (0·28–3·06)
Unknown	8/14	8/18	0·89 (0·33–2·38)
Age, years			
<75	49/125	47/123	1·01 (0·68–1·51)
≥75	11/22	10/25	0·65 (0·27–1·59)
ECOG performance status			
0	27/66	24/70	0·79 (0·46–1·37)
1	33/81	33/78	1·11 (0·69–1·80)
Smoking status			
Never	8/17	5/17	0·59 (0·19–1·81)
Current or former	52/130	52/131	1·02 (0·69–1·49)

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Shiraishi Lancet Resp Med 2024

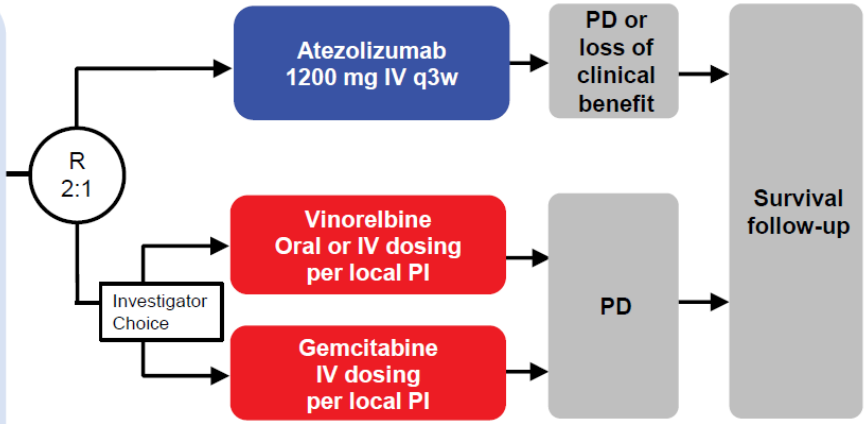
OPEN QUESTIONS IN (FIRST LINE) ICB TREATMENT

WHAT ABOUT THE ELDERLY / POOR PS? – IPSOS PHIII

Treatment-naive stage IIIB[a]/IV (AJCC 7th edition) NSCLC

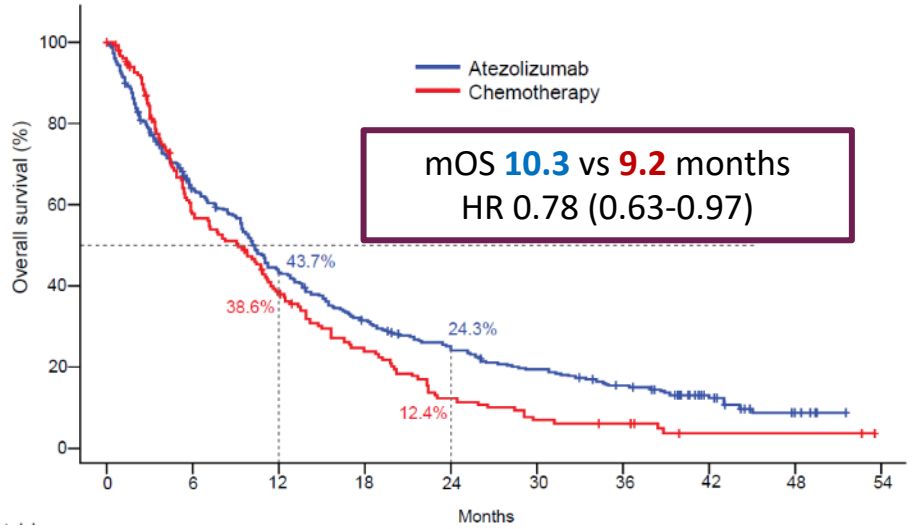
- Squamous or non-squamous histology
- Platinum ineligible because of:
  - ECOG PS 2 or 3
  - ECOG PS 0 or 1 permitted if ≥70 years of age with substantial comorbidities or other contraindictions to platinum chemotherapy
- *EGFR*+ (L858R or exon 19 deletion) or *ALK*+ excluded
- Patients with treated asymptomatic brain metastases permitted

n=453



Primary endpoint: OS

Baseline characteristics
Majority PS 2



Benefit regardless of PD-L1 level
PS 0-1 > benefit (HR 0.64) vs PS 2/3 (HR 0.86-0.74)

EMA approval+

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Lee Lancet 2023

WHAT ABOUT COMBINATION REGIMENS IN ELDERLY/PS2? PHIII ENERGY

Key Eligibility Criteria
- Stage IV or recurrent
- Squamous or Non-Squamous
- No prior systemic therapy for advanced disease
- No known EGFR mutations or ALK or ROS1 alteration
- Age ≥ 70 ECOG PS 0-1 or PS 2

Stratified by :
· Age ≥ versus < 70 years
· PS 0/1 versus 2
· Histology : squamous/non-squamous

R 1:1

n = 109 → **NIVO** 240 mg Q2W + **IPI** 1 mg/kg Q6W

n = 107 → **Chemo** Q3W (**4 cycles**)
Platinum doublet with optional pemetrexed maintenance (NSQ)

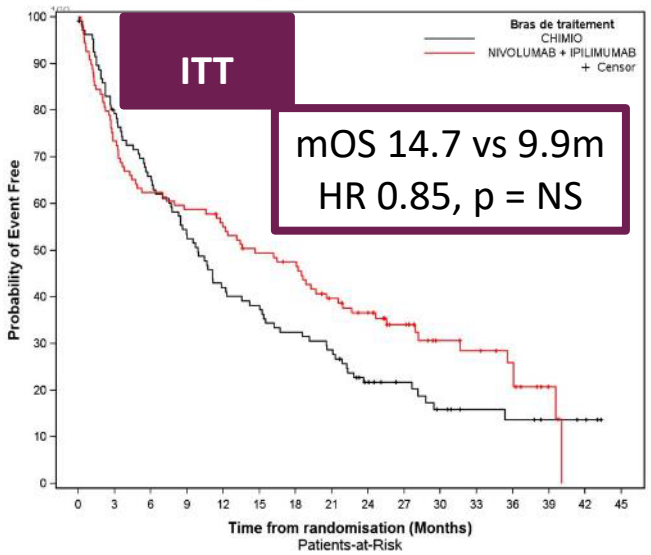
Until disease progression, unacceptable toxicity, *or* for 2 years for immunotherapy

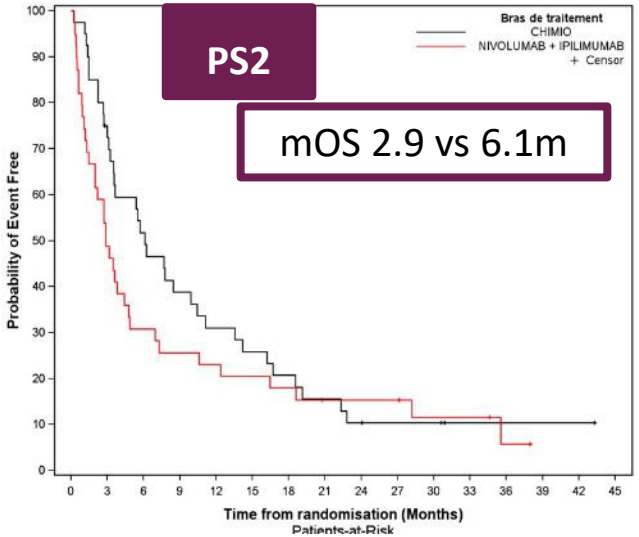
Almost 80% 70+

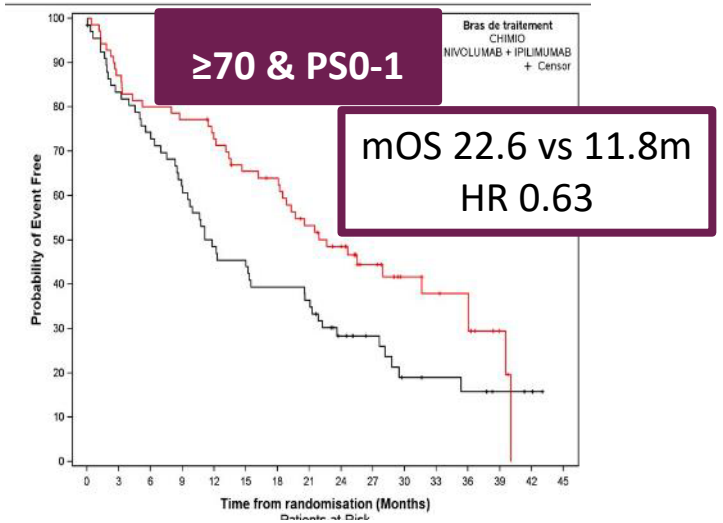
Over 1/3 PS2

Primary endpoint
- OS

Secondary endpoints
- PFS
- ORR
- Efficacy by tumor PD-L1 expression
- QOL, geriatric mini dataset







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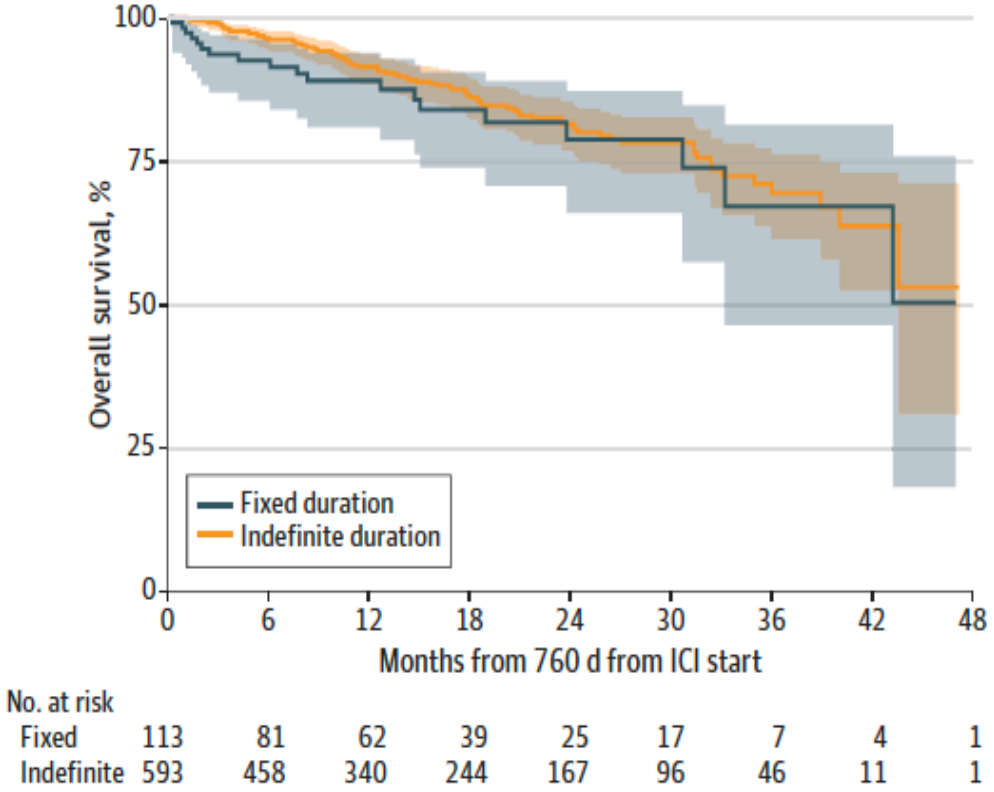
Lena Lancet Resp Med 2024

ESMO

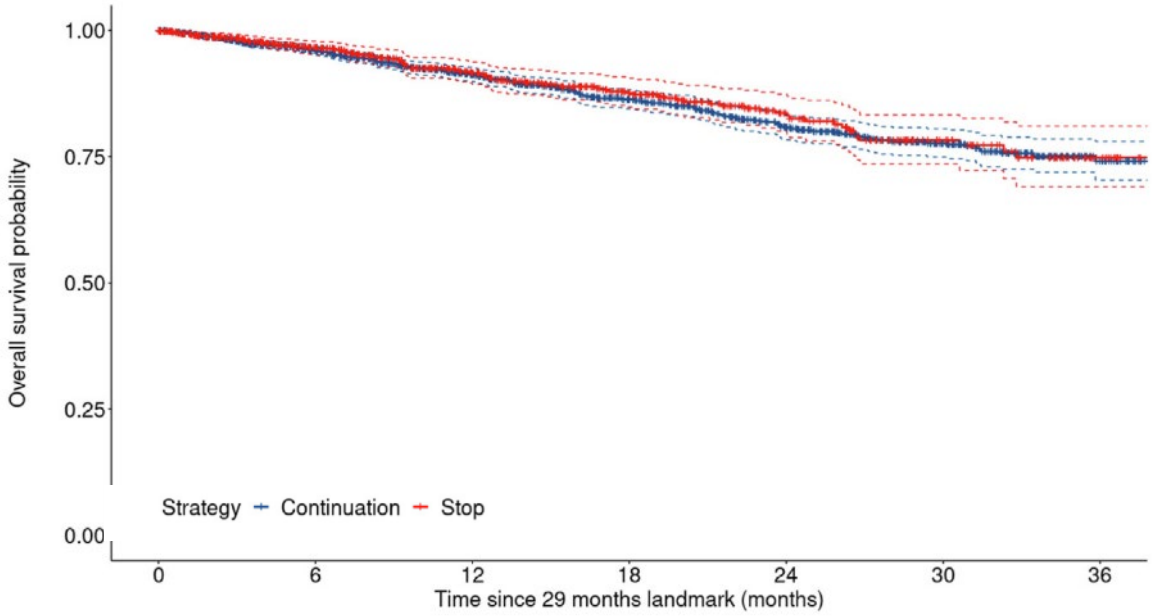
CAN WE SAFELY STOP AFTER 2 YEARS OF TREATMENT?

No difference in OS for continue vs stop

US data (N-=706): only 20% stops after 2y



French data (N=3075): 30% stops after 2y



L Hendriks

Sun – JAMA Oncol 2023; Rousseau Lancet Reg Health 2024

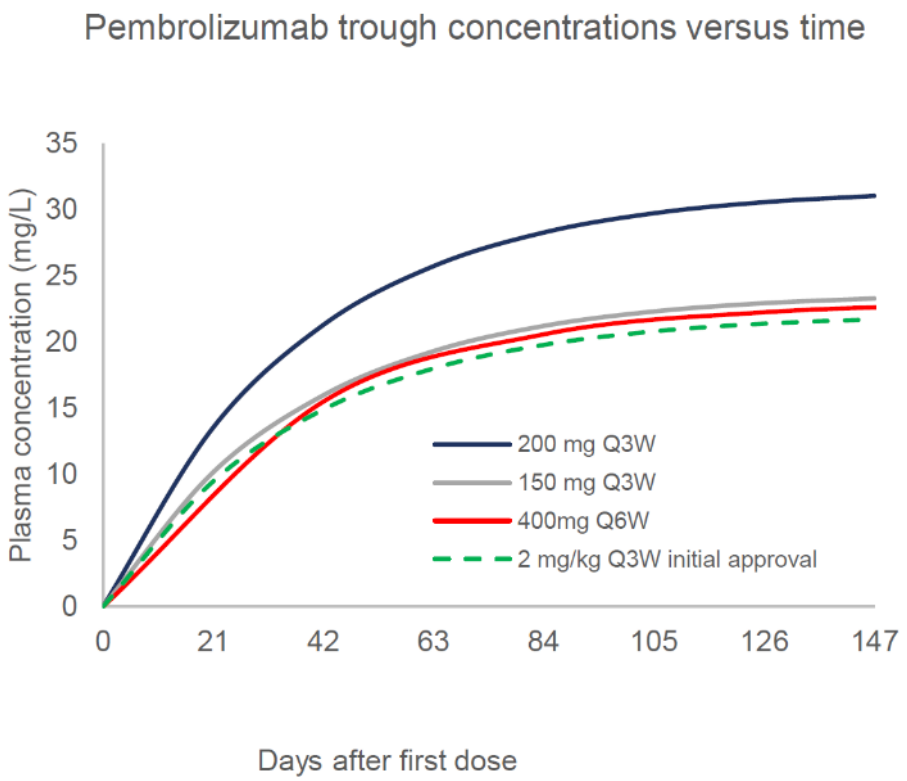
CAN WE GIVE A LOWER DOSE OF ICB?

No MTD with a-PD(L1) blockers

Dose-response & exposure response curves flatton

Sustained mean occupancy 70% of PD-1 on T-cells
Maintained for 2 months after single infusion

We overdose with current (flat) dose

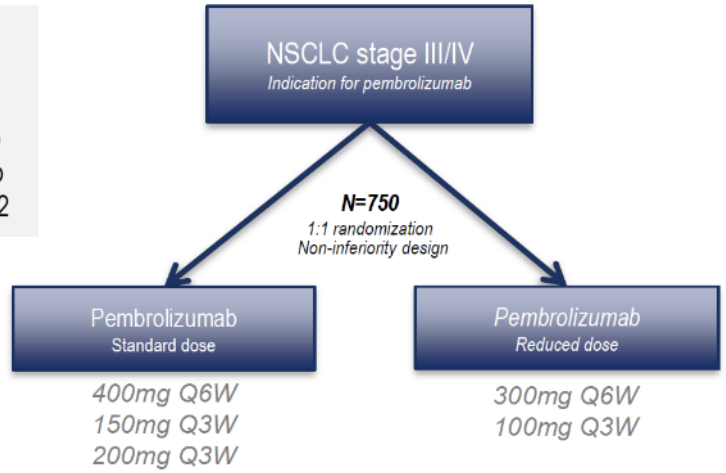


Reviewed in Bortolol, under revision JCO

NVALT30 – DEDICATION TRIAL

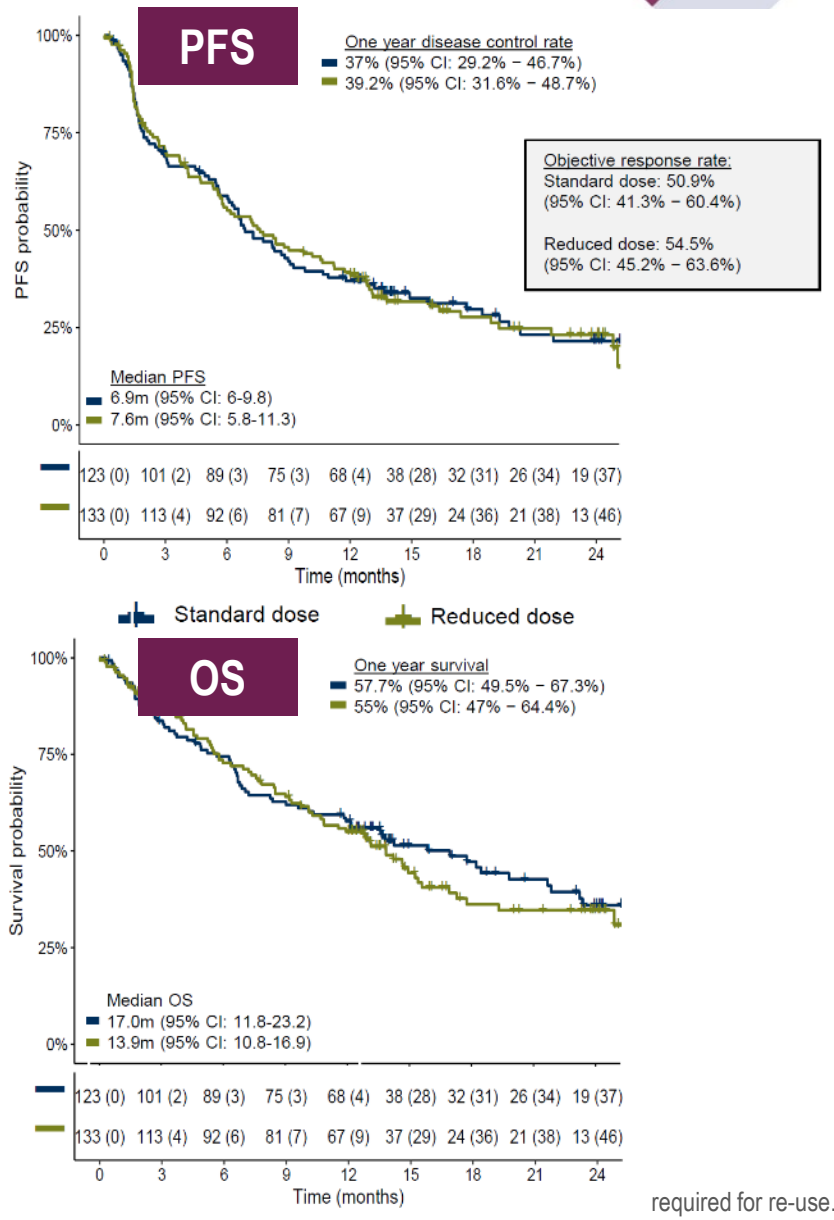
Interim analysis

Stratification factors:
- Type of treatment:
  - Pembrolizumab
  - Pemetrexed / platinum / pembrolizumab
  - Carboplatin / paclitaxel / pembrolizumab
- Smoking, PDL1 status, Gender, PS 0/1 vs 2



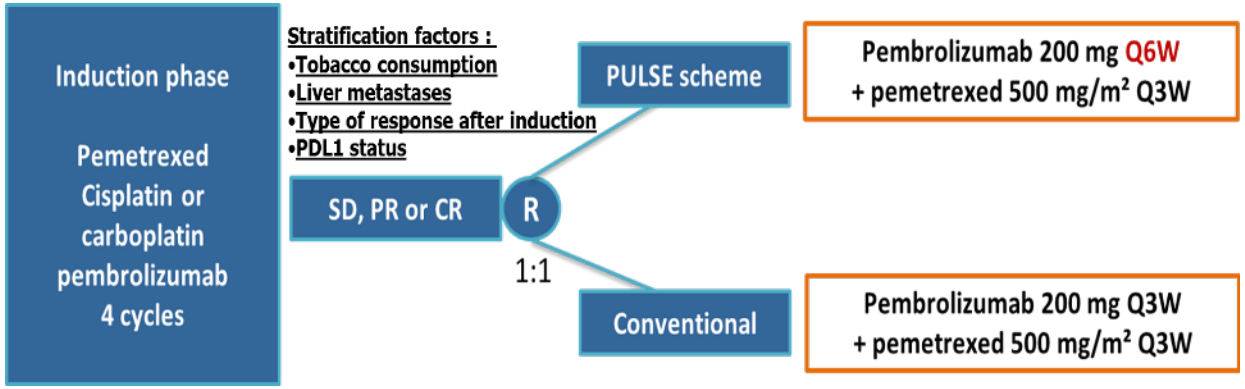
Primary endpoint: OS (non-inferiority)

Interim analysis: ≥10% difference between arms in 1-y OS = stopping criterium



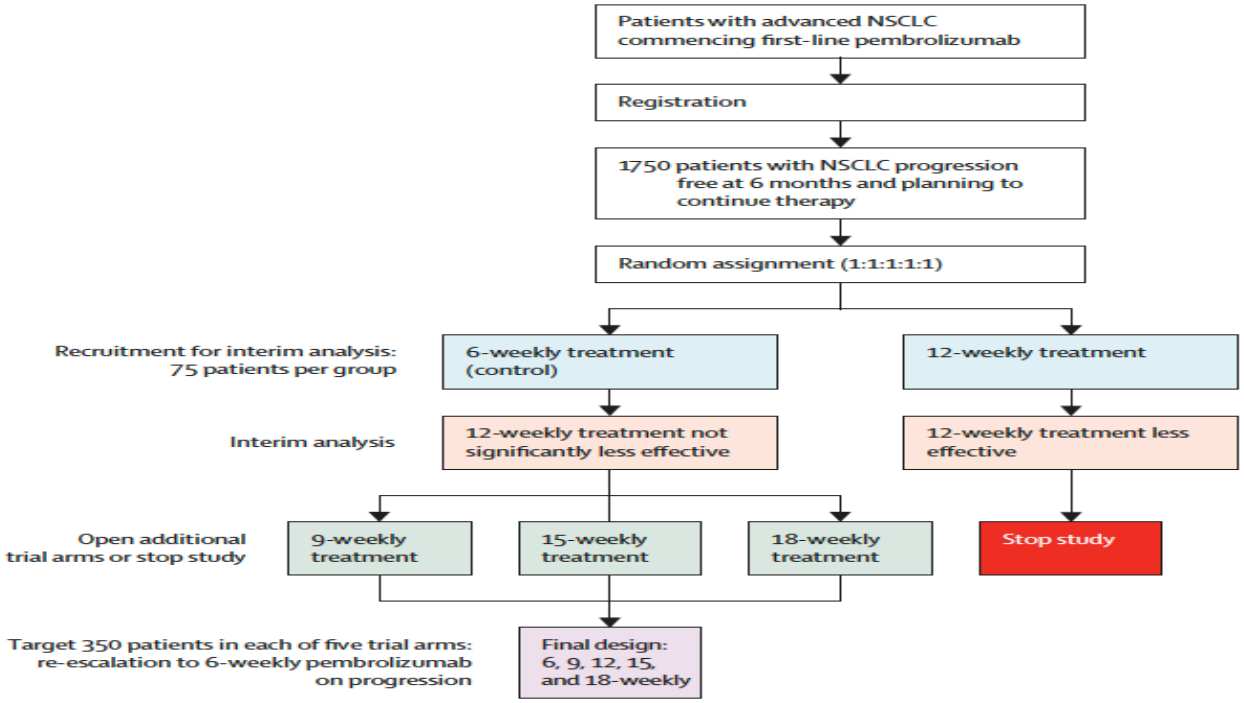
OTHER TRIALS WITH ICB DOSE REDUCTION ONGOING

PULSE (NCT05692999), non-inferiority study



Primary endpoint: Overall survival

REFINE LUNG (NCT05085028)

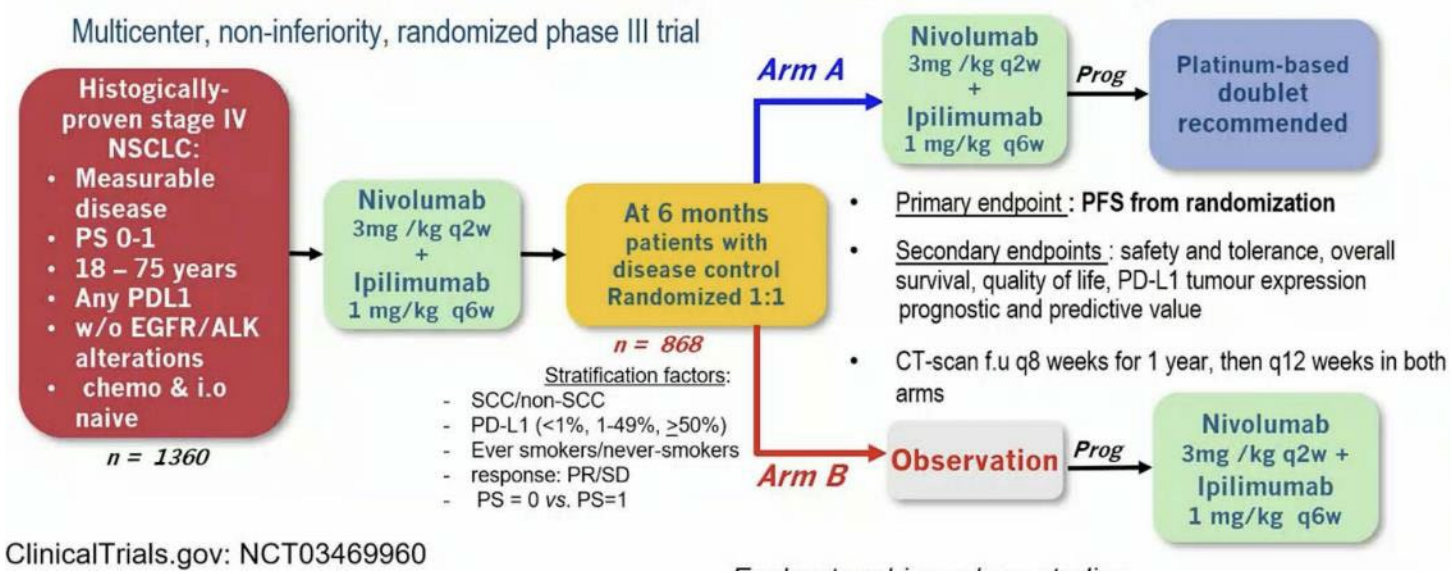


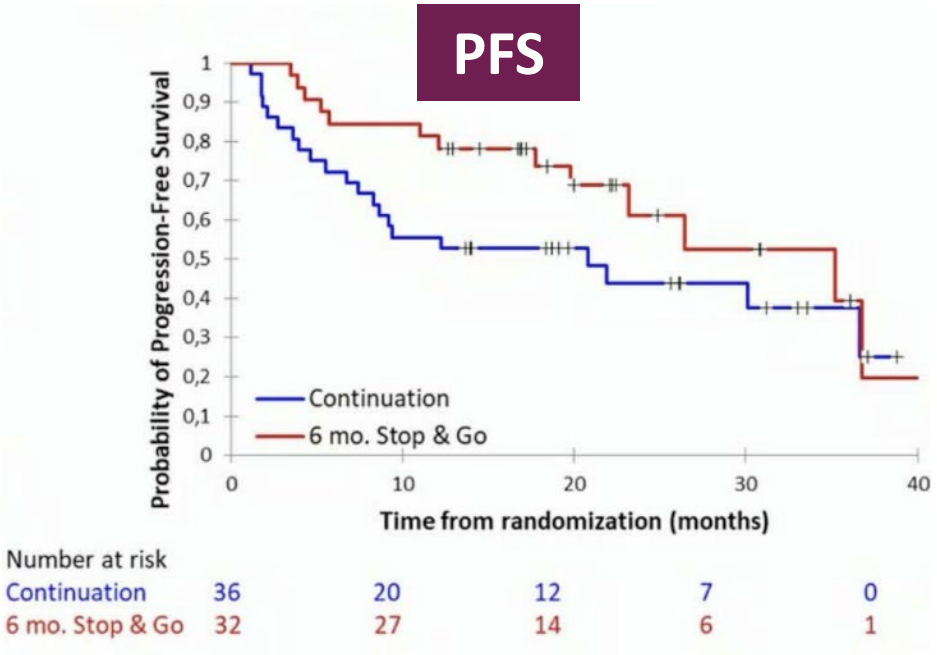
Primary endpoint: Overall survival @2Y

PULSE design courtesy of Prof. Besse, PI; Ghorani Lancet Oncol 2023

SHORTER DURATION?

DICIPLE phIII non-inferiority trial





816 patients/651 events needed for 80% power – 1-sided error 0.025, non-inferiority margin HR 1.25
Accrual stopped early: nivo-ipi no EMA approval

Continuation vs stop & go
mPFS 20.8 vs 35.2 months
12m PFS 56 vs 81% p = 0.12

PhII/III DIAL (IFCT-2103, NCT05255302) ongoing and Dutch trial will start

CAN WE IMPROVE THE FIRST LINE REGIMEN?

CAN WE IMPROVE FIRST LINE THERAPY?

DESPITE PROMISING PHASE I OR II DATA, GLOBAL PHASE III TRIALS NEGATIVE

Trial	Phase	Drugs	N	PFS, HR	OS, HR
KEYNOTE 598 PD-L1≥50%	III	Pembrolizumab ± Ipilimumab	568	1.06 (0.86-1.30)	1.08 (0.85-1.37)
INTREPID-Lung 037 PD-L1 ≥80% (73-10)	III	Pembrolizumab *vs*. M7824 (bifunct fusion protein targeting TGF-beta & PD-L1)	304	1.23 (0.89-1.71)	1.20 (0.89-1.81)
LEAP007 PD-L1 ≥1%	III	Pembrolizumab ± Lenvatinib (multikinase inhibitor)	623	0.78 (0.64-0.95)	1.10 (0.87-1.39)
SKYSCRAPER-01 PD-L1 ≥50%	III	Atezolizumab ± Tiragolumab (aTIGIT)	135	Press release: NEG for co-primary endpoint PFS OS still immature	
KEYLYNK-006/008 Non-Sqcc / Sqcc	III	Maint pembro + Olaparib (PARPi) vs pembro + pem/PCB, after 4 cycles ChT-ICB	672 591	1.12 (0.92-1.36) 0.77 (0.63-0.93)	1.04 (0.87-1.25) 1.01 (0.83-1.24)

Boyer JCO 2021 – Cho JTO 2023 - Csoszi ESMO IO 2021 – Gray AACR 2024; Hochmair AACR 2024

CAN WE IMPROVE FIRST LINE THERAPY?

HARMONI-2 Chinese PhIII RCT

Patient Population
- Stage IIIB-IV aNSCLC
- No prior systemic therapy
- No *EGFR* mutations or *ALK* rearrangements
- ECOG PS 0 or 1
- PD-L1 TPS ≥1%

R 1:1

N=398

Ivonescimab
20 mg/kg Q3W (N=198)

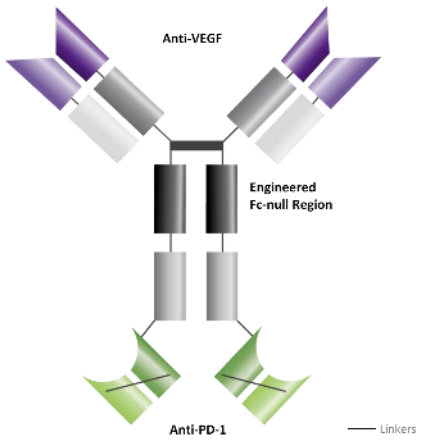
Pembrolizumab
200 mg Q3W (N=200)

Treatment until no clinical benefit, unacceptable toxicity or up to 24 months

Stratification
- Clinical stage (IIIB/C vs. IV)
- Histology (SQ vs. non-SQ)
- PD-L1 TPS (≥50% vs. 1-49%)

Endpoints

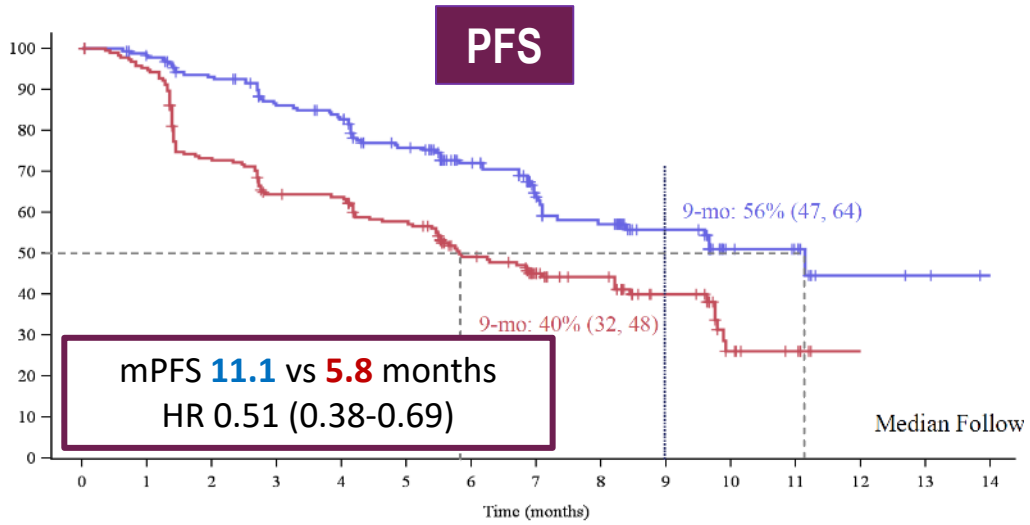
Primary: PFS by blind IRRC per RECIST v1.1
Secondary: OS, PFS assessed by INVs, ORR, DoR, TTR and safety
Exploratory: QoL



Cooperative Binding

Presence of VEGF increases binding of PD-1 by >10-fold in-vitro[6]

VEGF dimer leads to potential interconnection of multiple ivonescimab molecules, which may lead to increased binding of T-cells in-vitro[6]



PFS benefit regardless of PD-L1
≥50% HR 0.48, 1-49% HR 0.54

Will data be similar in global population?

Will OS be positive with adding angiogenesis inhibition?

Tox profile favourable, low high grade bleeding events

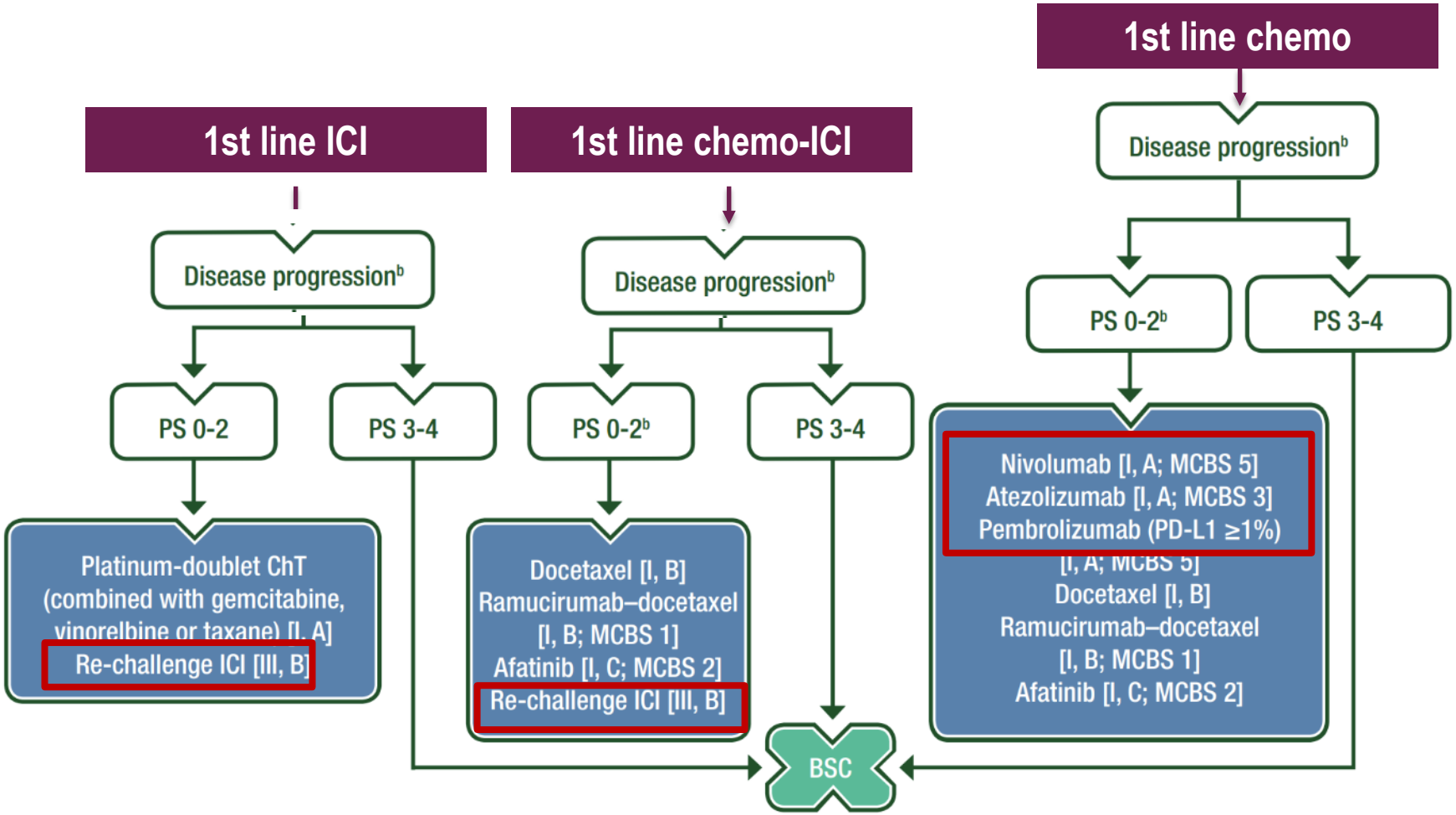
L Hendriks

Zhou WCLC 2024

ESMO

SECOND LINE AND BEYOND

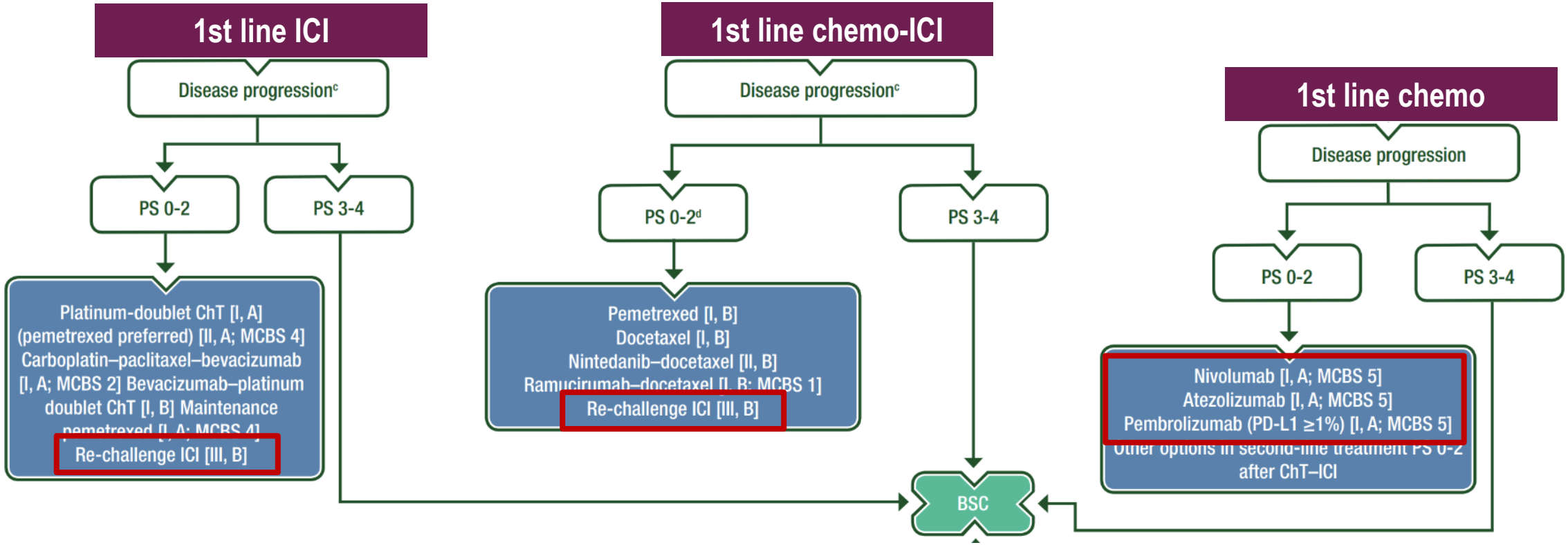
SECOND LINE ICB OPTIONS FOR SQUAMOUS NSCLC



Hendriks – Ann Oncol 2023

SECOND LINE OPTIONS FOR NON-SQUAMOUS NSCLC

Non-oncogene addicted



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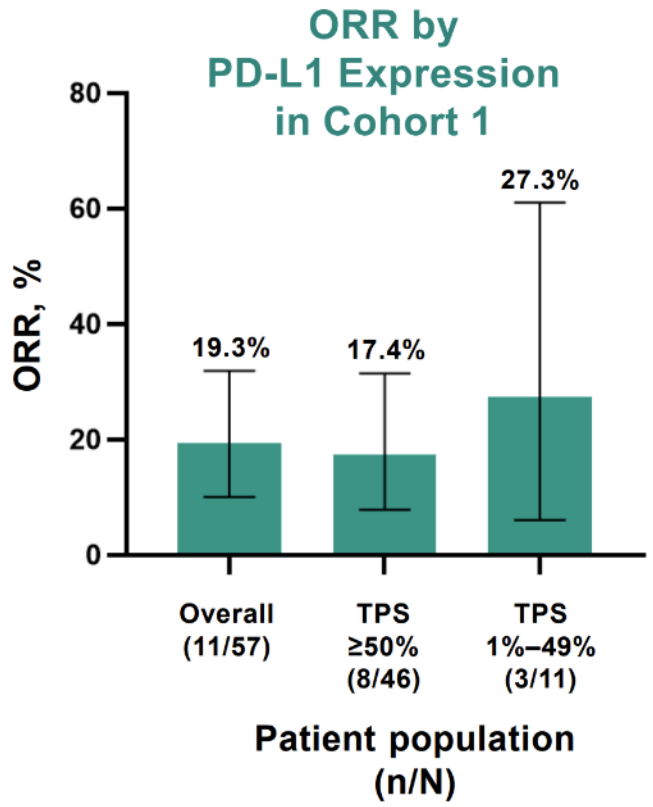
CAN I RECHALLENGE ICB?

Pooled analysis phIII KEYNOTE trials: 2nd line pembro after completing 2y in 1st line OR ≥6 months pembro and confirmed CR and minimally 2 cycles after CR

	Cohort 1 (pembro monotherapy) N = 57	Cohort 2 (pembro + chemo) N = 14
ORR[a] (95% CI), %	19.3 (10.0–31.9)	0 (0.0–23.2)
DCR[a] (95% CI), %	73.7 (60.3–84.5)	50.0 (23.0–77.0)
Best overall response,[a] n (%)		
CR	0	0
PR	11 (19.3)	0
SD	31 (54.4)	7 (50.0)
PD	8 (14.0)	2 (14.3)
NA[b]	7 (12.3)	5 (35.7)
DOR,[a] median (range), mo	NR (0.0+ to 20.0+)	–
DOR ≥6 mo, %	78.8	–
OS,[c] median (95% CI), mo	27.5 (21.7–NR)	NR (NR–NR)
6-mo rate (95% CI), %	85.1 (72.4–92.3)	85.1 (52.3–96.1)
PFS,[a,c] median (95% CI), mo	10.3 (5.6–14.0)	7.7 (1.8–NR)
6-mo rate (95% CI), %	60.8 (46.0–72.7)	54.5 (22.9–78.0)



Rodrigeuz-Abreu WCLC 2022

CAN I ADD OTHER DRUG TO THE ICB?

Phase III trials so far negative

	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

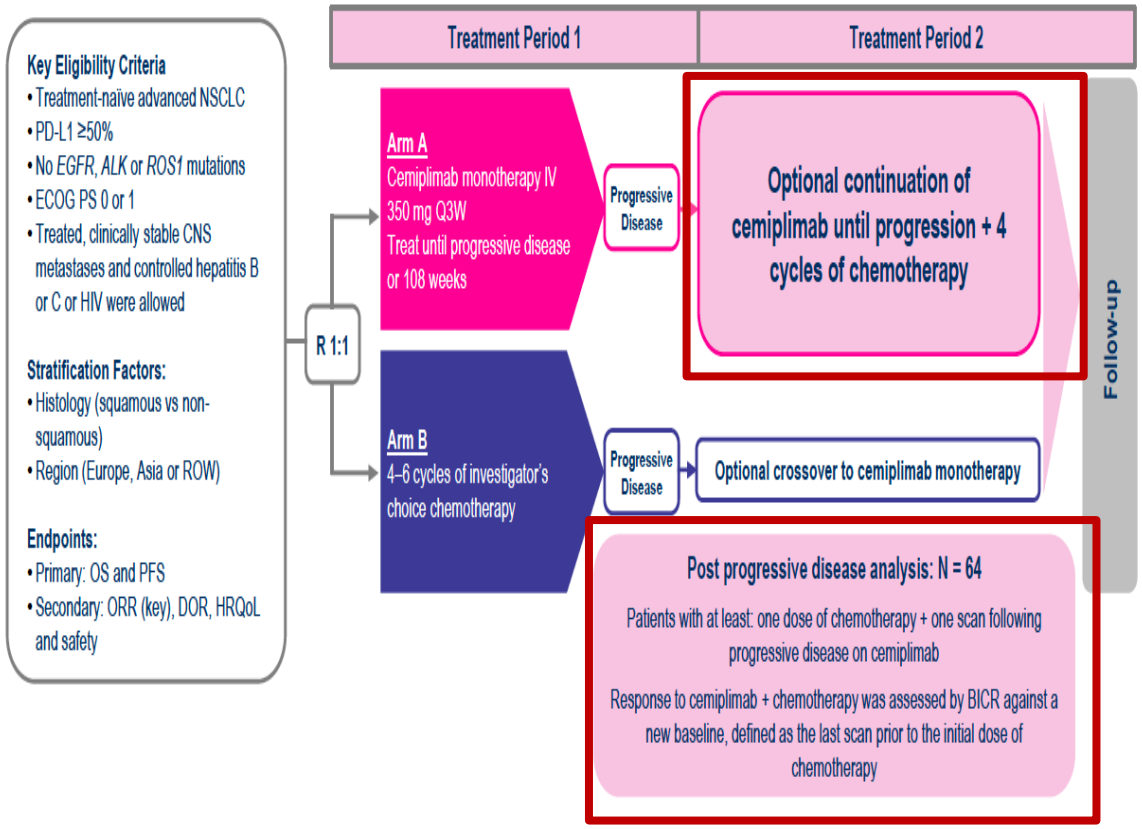
** Includes treatment naïve population.

Slide courtesy J Remon, 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)

CAN WE CONTINUE ICB BEYONG PD ON FIRST LINE?

EMPOWER-LUNG1 data



	Period 1	Period 2
RR	29.7% (CR: 0%; PD: 20%)	31.3% (CR: 5%; PD: 14%)
PFS	6.2 1-year PFS: 24.1%	6.6 1-y PFS: 31.2%
OS		15.1 1-year OS: 56.8% Period 1+2: 27.4 mo.
G≥3		35.9%

PhII RCT: NO benefit of continuing ICB with next line of ChT if PD on 2nd/3th line ICB

L Hendriks

Ozguruglu ESMO 2022; Jung CCR 2022

DOES A VACCINE WORK?

PhIII 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

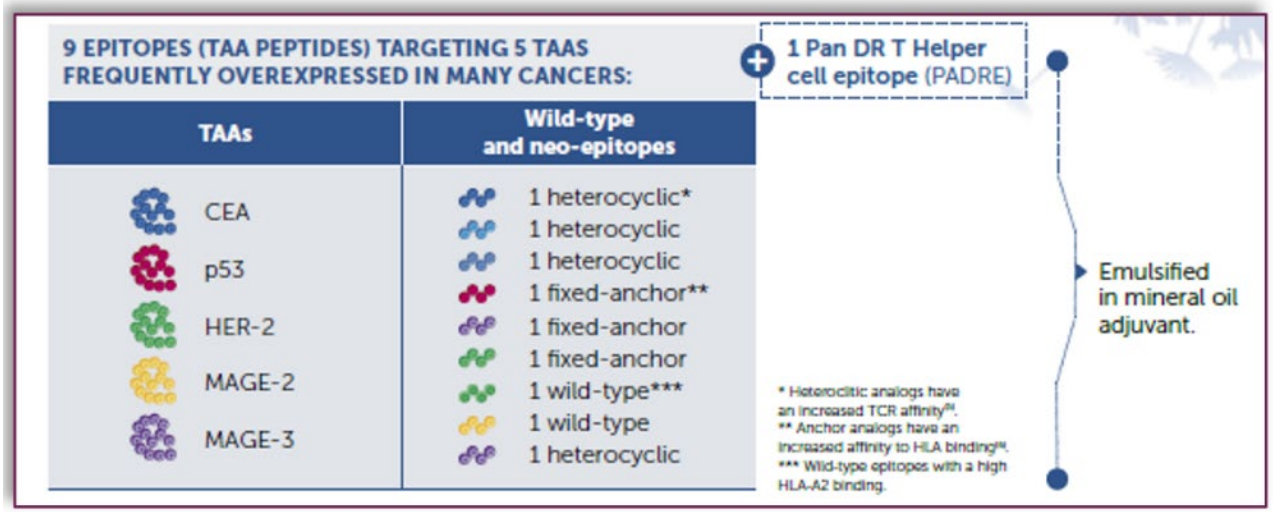
Primary endpoint: OS

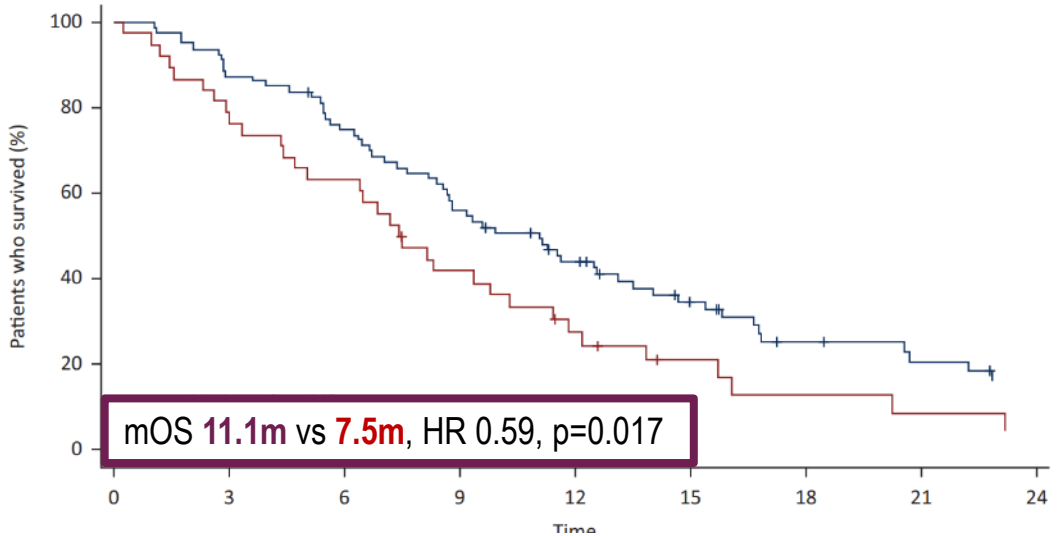
Stratification:
- Histology
- Best response to 1st line
- Line rank of prior IO

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%





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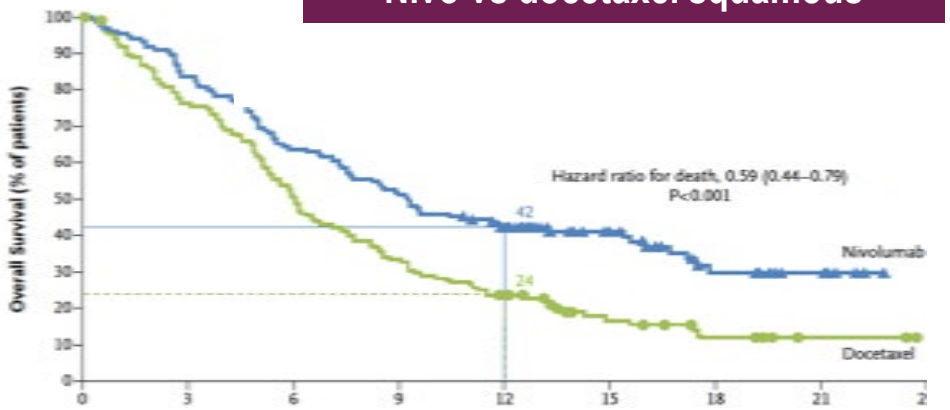
Besse Ann Oncol 2023

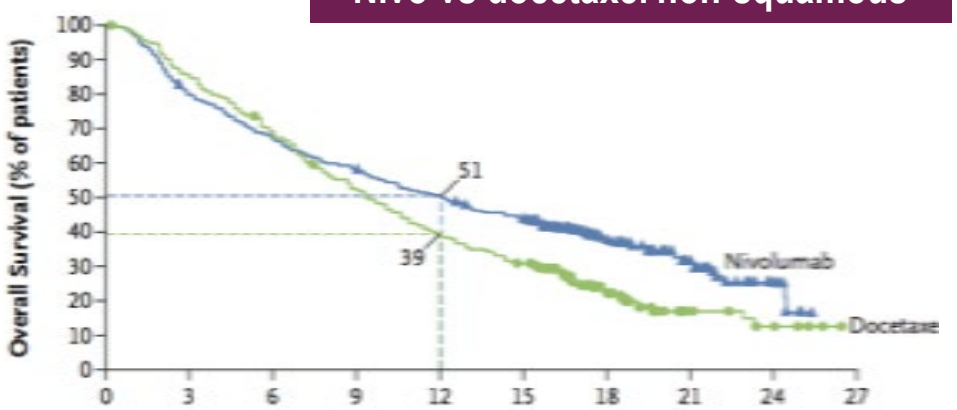
ESMO

SECOND LINE ICI MONO AFTER FIRST LINE CHEMO

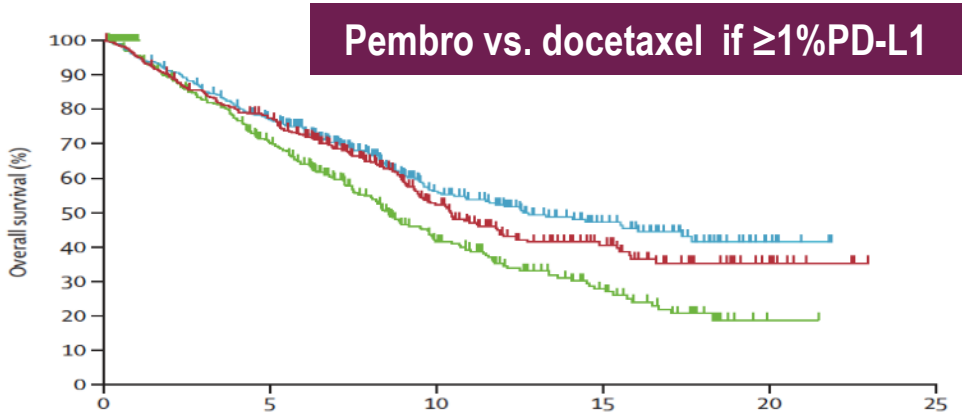
Nivo vs docetaxel squamous



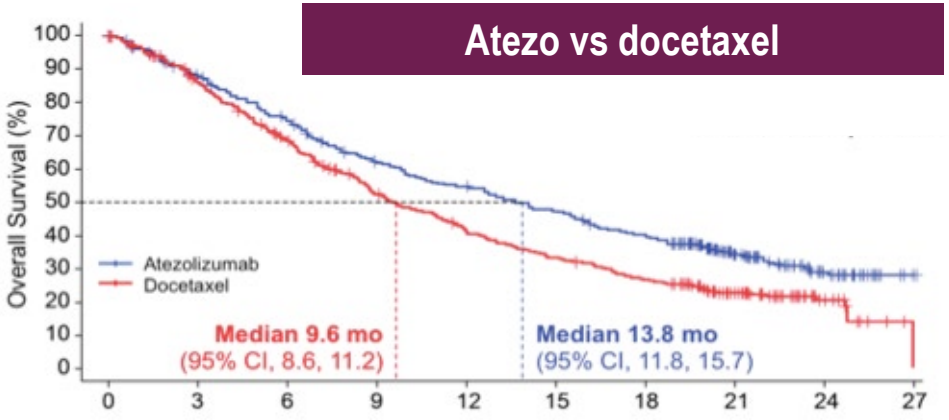
Nivo vs docetaxel non-squamous



Pembro vs. docetaxel if ≥1%PD-L1



Atezo vs docetaxel



L Hendriks

Brahmer - NEJM 2015; Borghaei - NEJM 2015; Herbst- Lancet Oncol 2016; Rittmeyer – Lancet 2017

CONCLUSIONS AND TAKE HOME MESSAGES

ICB have revolutionized the treatment landscape of metastatic NSCLC

However, majority will not obtain long-term benefit

PD-L1 main criterium in 1st line for treatment decisions, and predictive biomarker

Second line: no approved new ICB, rechallenge is option

GOOD SCIENCE
BETTER MEDICINE
BEST PRACTICE

THANK YOU!

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