So, I think there is already a state set of key 067 study that is a periopsetting pamilizumab and now we will be moving to the periopneo adjuvant and adjuvant immunotherapy
in resectable lung cancer.
The most important point here is we are discussing about resectable lung cancer.
If a patient is unresectable at the baseline and you are giving chemo IO as a newer treatment
then it is a different.
All the trials for resectable lung cancer.
So this should be at the back of mind that you are not down saging the disease to make
it resectable.
This is all the trials are being done to improve the outcomes in even in resectable setting.
So that is one of the most important point which I wanted to highlight.
So, we are just highlighting the relevant points related to this key 067 trial.
This is what we have seen.
This is Pembro plus chemotherapy with pam or germ setabinor pametrexate versus placebo
with pametrexate or germ setabinor pametrexate along with cisplatin.
And the patients you can see were included having stage 2, 3A, 3B as it was being highlighted
by doctors with already.
Most patients were in stage 3.
Stage 2 there are few patients but they should be resectable and the surgery was performed
within 20 weeks after first new adjuvant dose and adjuvant periopneo.
This was a periopne trial so pamro was continued for up to 13 cycles.
We had a very good discussion by in the previous discussion about 2 years of treatment in metastatic
setting.
So, that is also important.
We have a good data set which is available extending treatment beyond to us is not adding
to the survival.
So, then why to continue treatment.
Another point is that here what we are looking at actually the data is already very strong.
We are seeing even all the trials were designed for event free survival like in breast cancer
we discussed IDFS, invasive disease free survival, in lung cancer, all the new adjuvant treatments
are designed to check event free survival benefit.
This is the 2 year data set with this periopneo, 2 year outcomes with EFS was 40% versus 62%.
So, seems to be a quite robust benefit.
It is not a very small benefit of 1 month, 2 months, 3 months.
This is a robust benefit and the percentage difference is very significant.
And also what is the major pathological response in lung cancer again why wanted to keep the
students busy so I am asking this question why what is major pathological response in
lung cancer anybody less than 10.
So, residual viable tumor less than 10% is called major pathological response.
So, that is very important to understand and the path CR is we all know from due to breast
we are so much pro about path CR.
So, path CR was improved from 4 to 18% major pathological response MPI was improved from

11 to 30% so that is quite significant.
Now, what happens if patient does not have major pathological response that is what we
want to see.
So, what was done in this analysis this is RBT that means residual viable tumor it was
0 to 5% 5 to 30% 30 to 60% more than 60%.
So, the data was analyzed according to percentage of residual viable tumor can anybody state
what which cancer you become a reminded of by this type of classification anybody.
You are a good very good it is you was grading for osteosarcoma and even for even sarcoma
the percentage residual tumor becomes prognostic.
So, that is the same analogy which is being implied here.
So, try to correlate it and try to cross relate the same thing which was seeing in osteosarcoma
and even sarcoma is now being translated into lung cancer also with this analysis.
So, what we see if the residual viable tumor is between 0 to 5% 12% outcomes with placebo
while 31% this is the data set which is got with pathological available tumors and if
you see Pembrova median percentage residual viable tumor was 29.5% it was double 52%
with placebo.
So, this is about the downstaging this plot gives you an idea what was the downsizing
the tumor and it is you can compare with the placebo it is much different and it was 52%
in placebo versus 29.5%.
So, it is nearly double chances of reduction in with your utilizing perio Pembrova.
And if you see again even free survival data as per the percentage of residual viable
tumor the same concept I was telling about evings the when the residual viable tumor
is 0 to 5% you are seeing the curve is at the top that means the best possible outcomes
are being achieved between 5 to 30 you can see it is slightly below that but above 30
to 60 and if it is more than 60% the similarly what we see for evings the curves are much
down.
So, it is clear that the percentage of residual viable tumor is a very good prognostic marker
now you want achieve you want to achieve paths here you want to achieve major pathological
response but beyond that also you can look at and have a prognostic idea in your mind
whether you can do anything to change in the adjuvant setting that remains uncertain even
in evings are coming osteosarcoma there is clear data till now that the patient did not
have a very good fibrosis or necrosis post-neurium treatment whether do you change the effect
of the treatment and achieve anything better this is not established yet.
Similar thing will be for lung cancer as well but I think in lung there is so much explosion
of the data so many targeted treatments there might be some thing which will be coming up
that you change the treatment in the adjuvant setting as per the responses in the

new adjuvant
setting so that thing is also being planned and under witnesses.
So, this is about the evings free survival outcomes so to conclude and summarize the percentage
of residual viable tumor is also becoming important when you are using periop approach
and your pathologist again the importance of these things should be communicated by to
the pathologist so that they are able to give this data to you when you are utilizing periop
chemo IO in your patients.
So periop emburo has already demonstrated a significant OS benefit so it was also discussed
in the previous talk this is till now this is the only data which has shown periop OS
benefit because of its longer duration of follow at 3 years the OS difference is 64
percent versus 71 percent all other trials have follow up in terms of EFS but this first
time periop emburo has a data because it was the first trial one of the first trials and
it has shown OS benefit so that is a very important MCQ equation keep in mind these
questions because you will have participate in MCQ on the third day first session thank
you for the patient listening.