Good afternoon everybody and thank you for this opportunity.
I'm going to talk about data portamap, direct stecan, versus docetexilant patients with metastatic non-small cell lung cancer,
or final overall survival from the tropon lung trial.
So, background, the standard of care is of now is a second-line chemotherapy for metastatic lung cancer,
is a chemotherapy in second-line, which has very modest benefit in substantial toxicity.
So, data DxD is a tropodirected ADC that is anti-body drug conjugate,
with a payload as a tropoisomerase 1 inhibitor.
So, the background, this is the original tropon lung 0-1 study design,
and this was published last year in SMO.
And what we can see here, it was a randomized phase 3 study, a global study,
with where they have taken all the patients who have either actionable gene mutation
or without any actionable gene mutations, with prior 1-2 lines of therapy,
which should include a platinum therapy, as well as NTP-D L1 therapy, if required.
And after these discussions, where the standard of care is of now is docetexil,
this study, the randomization of 1 is to 1, with docetexil versus DxD.
Both were given as a three-weekly cycles,
and the primary endpoint here was the PFS by a blinded, independent central review, as well as overall survival.
These both were the primary endpoints, and the secondary endpoints were overall response rate,
duration of response and safety.
These were stratified based on histology, actionable genomic alteration,
and NTP-D L1 antibody therapy, included in most recent prior therapy or not.
So, this was already published last year, where the baseline characteristic was similar
in both the arms, and histology-wise, almost 80% patients were non-scromosal carcinoma in both the groups.
I mean, all other parameters were also similar on the both sides.
And this was presented last year, where the primary endpoint of PFS was presented,
and what we can see here is there is a benefit of DxD with hazard ratio of 0.75,
and median OAS of 4.4 months versus 3.7 months.
This is for intention-to-treat population, so overall population was taken.
If we see, this was a positive outcome, as well, if we see the overall response rates,
that was also positive from 13 months to 26 months, as well as duration of response was from 5.6 months to 7 months.
If we see the subgroup analysis of the study for PFS at that time,
it was similar for majority of randomization criteria, stratification criteria,
but specifically, if we see the histology, the majority of benefit was seen
because of non-scromosal histology, and not because of this commercial histology.
So, that was further tested, and if we see the median PFS for non-scromosystology,
what we see here, it is positive for non-scromosystology in form of hazard ratio, which is 0.63,
and 37 reduction in the risk of progression, the median is also better 5.6 months versus 3.7 months.
The overall response rate is also almost double from 13 months to 31 months.
So, this was a positive study for PFS for non-scromosystology.
It included both patients who had actionable genetic alteration or non-actionable genetic alteration.
If we see the squamosal, the results are actually opposite to the non-scromosin.
There is a determinant seen with the data dxd, where hazard ratio is 1.38,
and if we see the median as well as overall response rate, it is better for docile in comparison to data dxd.
So, the main major benefit was mainly seen with the non-scromosystology.
Now, this year they have published the final overall survival analysis of the same

study in San Diego US,
and the overall survival this was presented this year.
So, now this is the second primary endpoint that is overall survival for intention-to-date population.
Now, this is not a positive in the form that hazard ratio of 0.94 and P value is also 0.5.
The median are also 13 months versus 12 months, so there is not a major benefit of data dxd
over docile for intention-to-date population.
Again, if we see by the histology, the major benefit was seen for non-scromosystology only,
and the squamos was actually on the favoring docile-to-date arm.
This was seen in this non-scromosystology PFS cow,
when we can see that the median is 14.6 months versus 12.3 months,
that is slightly better for data dxd, as well as hazard ratio of 0.84.
So, there is a 16% reduction in risk for death or progression,
as well as 2.3 month improvement in median OS.
However, the hazard ratio is crossing the level of equality that is 1,
and that is going up to 1.05.
So, that is not statistically significant, but numerically,
there is a benefit of data dxd in non-scromosyst arm for overall survival.
The squamos is expected, it was detrimental,
and the benefit of docile-to-date arm was better over the data dxd arm.
The overall survival improvement in the non-scromosystology,
regardless of the actionable genomic mutation,
so even if the mutations were present,
the benefit was there for non-scromosystology,
or if it was absent, then also it was beneficial for non-scromosystology.
The safety, this was already published last year,
and that was confirmed here, that the safety is better for data dxd over docile-to-date arm,
and the more than greater than the three-toxicities were seen in almost 42% patients with docile,
which was seen in 26% patients,
30% patients required dose reduction in docile-to-date muscle versus 20%,
as well as treatment-discantrogen also seen with 12% versus 8%.
The overall safety was consistent, that was seen when last year it was published,
and no late-toxicities were observed.
If we see for more than 15% of what treatment-related adverse event,
the stromatitis in nausea is much higher for data dxd than docile-to-date.
However, majority of them were grade 1 and 2,
and only 7% or 2% were for grade 3 or more.
The neutropenia in Leucopinia is more with docile-to-date arm in comparison to the data dxdm.
So the conclusion of take-home message,
tropion-lung-0-1 study first primary endpoint of PFS was met for overall population,
and the number of patients in the population was not seen in the population.
But the majority of benefit was seen for non-scomosestology.
For OS, there is a numerical improvement, but that was not statistically significant.
The majority of benefit for efficacy was seen for non-scomosestology only.
However, the tolerability was manageable,
and there were no new safety signals seen during this further follow-up.
The data dxd has a potential new therapeutic option.
Maybe it will not completely replace docile, but there is a better option.
There is a tolerability-wise better option available now for docile-to-date axial.
Thank you.