Next speaker is Dr. Abhinay Zauer from Aurangabad and he will be talking today morning on Osimartanib
with or without several little nib in first line in D. Novo Met aberrant EJFR mutated
advanced in NSCLC. Over to you Abhinav.
Yes. Good morning everyone. I will be speaking about Osimartanib with or without several
little nib in D. Novo Metastatic aberrant EJFR mutated adenosia lung. The last study.
So the background is like limited data shows that D. Novo Metastatic Met amplified or
Met overexpression which is the Met aberrant C is seen in 2 to 5% and 11 to 15% of the treatment
naive EJFR mutated advanced in NSCLC and the preclinical studies have demonstrated that
coexistence of both EJFR mutated and Met amplification or overexpression has shown reduced efficacy
to Osimartanib. So and that is the primary reason that there is Osimartanib does not work
that well with Met amplification or Met overexpression. So some clinical studies have shown that EJFR
mutated advanced NSCLC with Met aberrant C treated with first line EJFR TKs have shown poor prognosis
and now the aim is to do dual targeted therapy with both Osimartanib plus severaletanib which is a highly
selective type 1 Met TKI inhibitor and it has shown potent endotumae activity in the lung cancers.
So that is why the study was designed. It is an open label to cohort randomized multi-center
clinical trial which was done in China and it had 44 patients both arms recruited 22-22 patients
and the eligibility criteria was metastatic or locally advanced NSCLC and treatment they should be treatment naive EKOC PS1
and the how was the Met aberrant C explained or they were included is Met overexpression by IHC which is 3 plus
and 75% of the cells or Met amplification which is the gene copy number being more than or equal to 5
and it was a study design which with the primary endpoint being overall response rate and the second end point being disease controlled
duration of response PFS, OS and 12-month OS and safety analysis the exploratory end point was overall response rate
who had from cohort 1 who were going to cohort 2 and to look for the resistance mechanism and the CTD and EC clearance.
So baseline demographics were matched around median age being 60 years males were 60% 38% were females and PS1 smoking almost 60% of them had non-smoker history
and if you look at the brain metastasis one-third of them had brain metastasis in this study
so and 90-95% by EGFR deleted and L8-8 are mutated and uncommon mutation were 2 which were screened later out and that was in the uncommon in the osmotenibam
so and so the overall response rate if you look at this it was quite good 90-90.5% versus osmotenib only 60%
and this was at a median cut off of 8 months and if you look at this the partial response was just 60% in the osmotenib and 90% in the combination arm
and if you look at the objective response rate and the disease controlled rate so it was 87% versus 95%
and if you look at the change in the sum of the target lesions so approximately the reduction in the tumor size was minus 42 in the osmotenib versus
minus 47.5% in the combination arm and so suggesting a more deeper response and durable response if you look at the median duration of response it was just 8.4 in

the osm versus 18.6 in the combination arms
so showing a better durable and a deeper response so this is the typical case which was seen in China so in the 62 year male advanced metastatic adenocarcinoma lung
I see proven met amplification and tissue injury showed EJFR so if you look at this it was in the month of November 23 it was started with osmotenib
then after that if you look at this there was brain mates and there was PD and rebipsey was done it showed met gene copy number was 5.2
to begin with it was gene copy number was 5.6 so crossover was allowed and it showed a better response with if you look at this there was a confirmed PR even after osmotenib failure
after that there was crossover to the cohort number or combination cohort and if you look at the PFS benefit PFS benefit was approximately 9 months versus 19 months in the combination arm
although overall survival the data still yet to mature and if you look at the overall safety of this so mainly the treatment related adverse events were higher in the osmotenib plus servoletenibarm it was approximately 60% hard side effects but if you look at the great 3 adverse events they were 10 to 15% and the most common side effect which could be seen in the servoletenibarm was rashes, diarrhea and deranged LFT and pudil edema which were reasonably well manageable but no fatal adverse events neither there was any mortality
so flower study is a first phase 2 prospective randomized study to study the efficacy and safety of combination osmotenib with servoletenib in only denobo metastatic aberrant EJFR mutated advanced NACLC and it has shown a clinically meaningful improvement in primary endpoint overall response rate and if you look at the response rate 90 versus 60 and PFS of 9 months versus 19 months and the safety profile if you look at this it was tolerable and manageable and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so on and so
so this is probably the provider novel first line therapy in a specific subset of EJFR mutated with metaberency mutation and so what next so I think we need more data for that overall response rate is awaited and the other thing is the met amplification it did not correlate the met by fish analysis and the IHC base it did not correlate so probably we need more
robust clinical markers for that thank you thank you very much Abhinav