Next speaker is Dr. Pradeep Vintra Pathy from WISAC and he will be talking to us about
real world outcomes of BEMP, Platinom chemo plus sociomultinib after progression on first
line of the biopsy.
Good morning everyone.
I am Dr. Pradeep Vintra Pathy.
So today I will be discussing the study real world outcomes of BEMP, PEMP, PEMP, PEMP,
Pathy plus sociomultinib after progression on first line of sematinev when advanced TGF are mutated in the CLC.
We know from the florida to study findings that there was significant PFS improvement
with the combination of first line BEMP, PEMP, OC, PEMP, to a tune of 25.5 months which is
the longest to date versus OC, PEMP, PEMP, PEMP, PEMP, PEMP, PEMP, PEMP, PEMP, PEMP,
however this was at the expense of increased toxicities mainly chemotherapy related especially
myelose operation and also it required the patient to come every three weeks for intravenous
infections.
So this led to an impact on the quality of life leading to more healthcare resources and
hospital visits.
Hence there was a real world hesitancy to come and chemotherapy upfront both by the patients
and the doctors.
Coming to post-ociomultinib progression there are already very limited options which we
have seen.
One of the options is platinum PEMP, PEMP, PEMP, PEMP with or without MEMP and TNAB.
And continuing OC-MATNib beyond progression on OC-MATNib is always a controversy but
there are especially when there are phase three trials with first generation EGFRT case
which were negative.
So now there is emerging evidence from retrospective studies which has shown that CFTA and efficacy
of the combination of OC-MATNib with chemotherapy after progression and there seems to be a
potential PFS benefit also.
Overall the data of the efficacy remains very unclear.
So this study was done to evaluate the outcomes of PEMP, OC following first-line OC-MATNib
progression in EGFR-metated NACLs in the real world setting.
The primary endpoint was time to treatment failure and the second end points were OS,
radiological response and toxicities.
So this is a retrospective multicenter cohort analysis spanning from July 2018 to September
2023.
It was conducted at the National Cancer Center Singapore, Prince of Wales Hospital and the
Chinese University of Hong Kong.
The patients who were histologically confirmed with NACLC and advanced EGFR mutation were
included in this study and they had needed to have a documented progression on

first-line
OC-MATNib.
Any histological transformation after progression on OC-MATNib was excluded.
So a total of 60 patients were included in this study.
Coupline males were well-cursed for TTF and were used to evaluate the TTF and OS and the
baseline characteristics in this study revealed a median age of 62 years.
53% were males, 76.7% were never smokers and exon 19 deletion was 56 and L85 was 43%.
Overall 66% of the patients already had baseline CNS mitts, which was quite high.
Coming to the outcomes with first-line OC-MATNib in this study, the best response, partial
response was 90%, almost 54 patients had partial response and 5% age had stable disease and
progressive disease.
The median time to treatment failure that is TTF1 on OC-MATNib was 14.4 months with a content interval of 11.7 to 17 months.
The patients who had progressed, most of them had extracranial failure, 57 had extracranial
failure and only 10 patients had CNS failure.
The lungs were the most common site of progression.
So at progression, repeat molecular profiling was done for 27 patients and 22 with a tissue
biopsy and 5 with a liquid biopsy.
Only one patient had an EGFR C797S mutation.
Coming to the combination of pamplat OC after progression on OC-MATNib, at the time of
evaluation, 10 patients were still on treatment.
The median follow-up was 31.2 months.
The median TTF2, that is with pamplat OC was 6.6 months.
And combined TTF1 plus TTF2 was 23.4 months.
The OS was 34.2 months.
Here also, patients who had partial response or stable disease was 81%.
Patients who progressed on this combination, again, most of them failed extracranial failure,
47 out of 50, and only 9 patients had intracranial failure.
Out of these 9 patients, already 5 patients had D-NOBO meds at diagnosis, 2 had CNS meds
on OC-MATNib monotherapy, and only 2 patients developed new CNS meds on the pamplat OC combination.
CNS outcomes at pamplat OC initiation, they found that there were 43 patients who already
had CNS meds and out of that 34 patient, that is 79% stable or responding CNS disease and
9 had progressive.
And brain imaging was performed by the initiation of this chemotherapy plus OC-MATNib, and out
of that, there were 32 patients who had measurable CNS disease, 5 patients also received prior
radiotherapy, and out of those 32 patients, again, 31.3, that is 10 patients had complete
or partial response after starting chemotherapy again.
Only 3 patients had progressive disease intracranial failure.
And also, 3 of 4 patients who skipped radiotherapy also achieved partial response of stable disease
with chemotherapy.
Subgroup analysis, based on the mutations, both the mutations were comparable, either
with TTF or OS.

On multivariate analysis for TTF2 and OS, the significant predictors of improved TTF2
mainly were timed to chemotherapy initiation.
Those who had chemotherapy initiation within 20 days of progression had a better survival,
a better TTF2, and also patients who had partial response and stable disease had a better TTF2.
For overall survival, the TTF1, if it is more than 12 months, they did better, and patients
who had baseline levements did worse.
So the authors found that PEMPLAT OC is effective after OC-MATNib progression.
The intracranial control is also very high of 90%, the outcomes were comparable across
all groups, and early chemotherapy initiation is critical for improved TTF2.
So the study strength is that it is the first real world multi-center dataset and demonstrates
efficacy for chemotherapy eligible patients, but it's a retrospective study design and
small dataset.
So my take is that first-line ocementib alone is very convenient for patients with a good
QL and reasonably good PFS.
Fluorative is yet to show OS benefit.
Ammon term is associated with high-cost toxicity and available tissues.
Those of PEMPLATNib with OC after progression on first-line OC also seems to show similar
efficacy as we saw.
So this approach should be considered strongly to at least avoid unnecessary chemotherapy
for a major part of the patient's life.
Thank you.
Thank you very much, Dr. Pradid.