So good afternoon everyone. So the previous all talks have discussed everything about law and law and law and law. So this is the real world evidence and that is from India only. So this is the compassionate access of the law and law which we got during the second line therapies and this data has been now been published in the BJC reports this year after a prolonged follow up. So the introduction as we know that it's a Alke's presence in something from 3 to 5 percent with few centers having 8 percent data with young age, females, expiridominants with never or light smokers and great propensity for brain meds. Resotenive is the initial molecule which we use and maximum patients are on this whether they are on if we are able to arrange the rest in drug with a PFS of 10.9 months where serotonin and electinif other improves this PFS further as we know.

Lawlatinib is the new molecule which came with the third generation highly potent and the importance of it that it penetrates the blood brain barrier by decreasing the GP1 and the blood brain barrier. So this audit was made at TMS Mumbai and all patients who were started on lawlatinib for all positive lung cancer before 31 December 2019 has been included in this and basically the patients with those who were initially started on crosotenib then switched to second generation as a serotonin and thereafter gone to lawlatinib or there are few patients who directly switched from crosotenib to lawlatinib in this subset of the patient and the few patients with those who were started initially on crosotenib and electinib and then on progression or intolerance to another therapies has switched to lawlatinib.

Important is we have got a regular follow up of these patients at every two to three one Lee interval and the response has been evaluated with the recess criteria. So if we see the baseline demographics of these patients so they were out of 38 patients were there and the median age in Indian our setting it was 48 years, 52% were male, como-bities was something around 36% the previous lines of therapies these patients have received we've say one line therapy 13% 45% of the patients are those who have received two lines of therapy and then four it is around 18% crosotenib has been received by around 85% of the patient and second generation TKI is by 76% of the patient in this subset. Maximum patients have had a co-op of one with 79% and brainmates 55% of the patients have brainmates I say and all brainmates patients except one have received prior whole brain atty and four of the patients have also he read it twice but no one were given SRS due to the heavy burden of disease

at that time. So the median PFS and OS in this second line and beyond we say was the median follow-off of 49 months so it's a very good follow-up of around 49 months we have for these patients and the median PFS was 16 months in the second line setting and the median overall survival is 22 months. If we see the response comparison in different real world settings so this is a basically an expanded access program so the trial data was of the second line is from the Solomon Nittin where the others were from Asia Germany France and other so in our study the overall response rate was something around 19% which was less than all other studies which was 45% to 50% but the disease control rate was 84% significant to others it is because maximum patient in our study has stable disease as compared to the partial response which we have seen in the other settings. The median PFS was more of its slightly higher in our study it was 16 months as compared to the other studies in the second line where Lola Teneb was used in the real world setting varying from 6 month to 9 months so this increase in the PFS was mostly because maximum patients were transformed to Lola Teneb post first line chryzoteneb so that may explain that we may have a more greater PFS in the subset of the patient. The median OS which we have calculated from the initial diagnosis for all those patients who received Lola Teneb is with a median follow up of around 80 months in this patient it was median OS was 55 months so if we see this median OS from the date of diagnosis was they calculated for 55 months but if we compare with this with the French real world study which shows that they have initially used most patients with serotonin and electinib had this median OS of around 89 months so our PFS was lower as compared to the other real world studies it is mostly because most patients they have excluded patients with the poor performance status and they are heavily pretreated patients and those who have a poor response to therapy so might be the selection bias that may lead to this study. Best response in our study we say progression on second line Lola Teneb as the best response was documented basically we have out of 38 patients 7% patients were non-evaluable because this can could not be performed for the next 31% the progressive disease was seen in 16% else all patients have a disease control 12 patients have died without any documented progression and 5 out of this 12 patients who have a documented progression has a brain involvement so even on Lola Teneb something around 5 patients develops brain meds and while 6 had lung involvement at that time and 12 out of 24 patients who have progressed

received names of subsequent liking of chemotherapy so post progression we have also continued
Lola Teneb in something 6 patients with ablation of the site of the progression and 2 of these
patients shown some short duration clinical response and one stable disease. If we compare
Lola Teneb based on the brain meds and without brain meds and those who received one or two
lines so the data was very strong since the number is very small we cannot exactly comment
the median OS was slightly different those with brain meds as 36 month and those without
was 16 month but since the number is very small so it was non-significant but number
of previous TKI use definitely affects the median OS of patients receiving more than
one TKI was only 16 months as compared to the patient who have received only one TKI
where the median PFS was not reached so in this study 55% brain meds patients before
starting Lola Teneb was similar as compared to other 60% patients in other studies but
there is no statistically significant difference in the PFS and OS in this subset one patient
with prior brain meds who had not received radio therapy is continued on Lola Teneb
for 41 months when she expired due to pneumonitis and the outcome for the previous TKI as already
said as compared to the Lola Teneb French cohort study it was 11.7 months as compared
to 5.8 months if we have used only one line of therapy so this is the swimmer plot which
shows that the duration of therapy so all the patients have received PCTI or seratinib
or chemotherapy so at present also 12 patients out of these 38 patients are surviving and
they are doing good on this therapy.
Toxity in our setting we say in our setting the most common grade 3 and above toxicity
were hypercholesteremia and 13% hypertriglyceridemia 11% two patient develops anemia hyponatremia
nausea and hyperglycemia neurological manifestation was seen in 6 patients that is 16% and these
patients under ways are dose reduction to 75 milligram either due to anemia, delirium
or hallucination so we have compared with this all the studies the important thing is
the major grade 3 adverse events were 12% similar to the previous reported 15% and the
most common toxicities were hypothyroidism hyponatremia anemia and pidellarima.
Hypothyroidism and anemia were slightly higher might be due to our population which is predisposed
to anemia and thyroid disease electrolyte imbalance was also seen in 14% though not severe pidellarima
is seen in 34% and we can manage it well but less than the other we have 51% fatigue
and area seen in less than 10% of the patient, 3 patients required that is 7% required dose
reduction, 2 patients on dose reduction progressed within 2 and 6 months of starting law latinium

and 1 continued for 2 and 8 years and 8 months before progression and 18% of the patient
have neurological toxicity as compared to 23% reported earlier because asian population
seems to have only 12% as compared to non asian so this cognitive impairment and other
toxicities are less than this asian population and that is also depicted in our study peripheral
neuropathy something around 8% as compared to the previous reported pool date of 41%
which we cannot explain weight gain only 5% of the patient we have seen less patient
as compared to 30% which has already been discussed so if we demographic comparison
has been it is more or less same the treatment post progression on law latinium most patient
receives chemotherapy and few success has continued on law latinium and few have received
whole minority and the site of progression on law latinium is something around documented
progression was in 12, 5 patients in brain, 6 in lung, plura, 4 in plura, 3 in node and
3 in bone so the limitation retrospective design was there, cohort included patients
both on disease progression and those were intolerant to previous drug, further few patients
with advanced disease and heavily pre-treated died within the first 3 month of starting
law latinium so we cannot assess the response, no biopsy has been done prior to studying
law latinium in this and post law latinium only 6 ribapses we can do and L can is domain
at other we have not done.
The strength of this study was extended follow up of the patient with regular imaging and
extensive documentation of toxicities has been done so this real world that it clearly
shows its benefits in second line as being shown in the initial trial registrines and
this lipidemia and pidellidym are the common side effects and which are usually manageable
in our setting.
Thank you.