When we discuss about limited stage small cell lung cancer, I think we all will agree
The disease responds very well, but the problem is that it comes back rapidly. So the cancer your comment
What is been your experience for treatment of limited stages CLC first?
It is much less in our country, but overall if whenever we see what's the experience
Yeah, very right. Thanks dr. Akil for the question. It was wonderful to witness the quiz
Well lung cancer is a disease with the high proliferation rate very
Great tendency for metastasis. So it's a systemic disease even it's even the name is limited stage
It is it can it continues to be a systemic disease and it responds well and comes back rapidly
So treat limited stage like a systemic disease and there is a need for increasing systemic
therapy
Yeah, so it's a systemic disease and we need to treat it systematically that is why
We are trying to add something to it and we will see the results. We are aware of the results
Do you incorporate PCI in all the patients routinely for limited stage?
It's a topic of debate I think earlier the answer used to be yes
Because the earlier studies did show that there was some benefit however there were some caveats to those studies where
They did not really do MRI at the baseline and people thought it's probably because they were
Radiating brain lesions in a therapeutic way, right?
Then there was one study that came I think it was a Japanese study where
The practice all those studies are for extensive stage for limited. Yeah agreed. So few studies also took limited stage into account
The dictum so far was that yes, we do radiate the brain in limited stage disease
But that paradigm is kind of changing right based on these old trials, right?
There are studies which are ongoing which are phase three randomized studies and we hope to get some more answers once the results of those studies come out
It was a very established practice in limited stage, but with the incorporation fire
I think that might change in the future, but we don't know what will happen till now
I think we keep on utilizing PCI in limited stage for the time we have more data
the point that I would like to mention here is that
If you are not giving PCI then you have to be very sure that your patient will be coming to you in close follow-up
If you cannot do MRI imaging
Frequently every three months or so then it's better to go ahead and give them PCI
There was some data which said that elderly patients with poor cognitive function
You can try to put them under maintenance. I mean close observation instead of giving them PCI because there are long-term
neurological issues with PCI
So I think the crux is that you need to either do a very strict follow or you have to give PCI and it seems that in our settings
Most time we end up keeping PCI in this
So these have been advances in limited stage small cell
But since limited stage is not so common with us most of the time
We don't discuss in panels or anything because that was not a very common topic of discussion, but with the
Trial becoming available and having a very important trial which is showing some
Benefit in terms of overalls level it becomes very useful
So this has been the paradigm which we have just covered either give surgery
Which is done very rarely stage one cases?

Hardly we'll get and then we'll give kimoth happy with sister to both follow with thoracic radiation and then go ahead with
PCI
If we see this trial
I think that was made very clear in the quiz also quiz actually helped us to understand the trial also that
We have significant data. Let's see this is outcome. This is
Limited stage small cell lung cancer median OS data is to the tune of 25 to 32 months
So even if it's limited stage, we are talking about 25 months OS
This is the data which has coming up and which has changed some more data's are Expected in the subsequent years
Lungmate and key link trials are expected in 2027
Adriatic data which came this year which we are discussing now and one energy trial was negative. So it's
Needs to and we need to understand why some trials are coming as negative via some are positive. This is the
Adriatic trial design
Chansh Khan's I was to highlight the important points which you saw in the trial design
Right so
Adriatic is basically post
chemo radiation
If they had not had progression they were randomized to
Something like that. Yeah within 42 days you need to randomized to the rule of map versus placebo the third arm is
Not yet reported right now. So arm A versus arm B is the present comparison and
It was continued
For two for until progression for a maximum. Yeah for two years
And again this trial at dual primary endpoint which is a very important statistical consideration
And
And some it is reasonably
pragmatic trial because platinum's well out so she sent carbo both for a lot they allowed PCI on
discretion of
Investigator so it is something which which is very close to what we practice the inclusion criteria as we would be
Able to take a lot of patience only the performance data's part is something which is
Zero and one but you expect that post CTRT even if patients PS was not good
Initially most of them would respond to your CT RT and they would have good performance status
So I think it is something which is close to what we practice and
applicable to real world patients also
The trial designs need to be pragmatic and this is one of the trials which we are already practicing day
In our daily practice. So that's a good point about this trial as I let you add up to Russia first
Let's see the baseline characteristics
Stage three as we know it's the maximum chances and it's for 85 to 27 percent both arms
Around 65 percent patient receives this platinum while 35 percent received the carbo-platin
So on the same your opinion
When the patients are receiving
treatment for CT RT for small cell in limited stage
What's been the percentage in your practice rough percentage?
So it's very occasionally that we give carbo-platin unless there is an absolute

I mean we usually prefer giving sis platinum, but there are those elderly patients
With hearing issues where we don't really want to give sis platinum in terms of
real toxicity cardiac
Issues where we don't want to overload them with fluid. We do give carbo-platin
The dictum so far for limited stage has been again that we prefer to use sis
platinum
But again, I mean if you look at the trial and like Dr. Roushov also said, you know
It's very broad based about how we practice in the real world setting
So they it's a good thing that they included that led to some issues later, which I
guess we will be discussing
but
But yeah, so we prefer sis platinum unless and until
There is a
I think that's a very fair point in
limited stage, I think more and more patients are affected
So the problem is carbo may cause marrow suppression with RT. So maybe that is a
reason why
So most of the time we prefer giving sis platinum wherever it is feasible
In extensive state, I think most of us will go with carbo-platin because we want we
don't want any other
toxicity bus here it is different
so
Another thing is about radiation schedule
So if we see the trial design that allowed two types of radiation schedule that was
60 to 66 grey over six weeks
But says 45 grey BID over three weeks which of the schedule is being commonly
utilized in the practice
I have not seen patients treated with BDC deals
I completely agree OD and
Later on we had a data there was some controversy that BD would be better
But later on we have a data that both are equivalent. So I think we are not missing
on it. So
Practically speaking also for a patient to come twice a day. It is not that very
They have to come twice a day. They can't stay in the hospital
So if you are giving radiation you have to give in the morning
It becomes difficult for the patient and also the institutes
The use of a JATAS is too much with the BTD. So they cannot tolerate and you cannot
Change the schedule also the moment it is great
So for JATAS you can't even change and you have to complete so the people
completing the whole
Treatment is at stake if you give a BD dose in especially now a set of patients
Another point is about the prior PCI as month him I'm highlighted that
Sometimes we give sometimes we may not give and there was a equipoise here around
55% receive prior PCI
Well, 45% didn't receive so it's very close in the trip. So yeah, so because you
you saw the median overall survival
It is so long. So if you give a PCI and if these people are living long they they
like to develop
Cognitive problems. So therefore it is wise to avoid PCI provided you do that MRI
follow-up, which is difficult for us to do in our practice
Completely agree as we discussed PCI is being utilized in our setup much more than
compared to the other setups
If we come to the overall survival data, I think that's the most important part as
a clinician which we see and get
Entimate also now we have high cost committees which look at the OS data not any
other data
So if we don't have OS data
We have difficulty in getting the drug approved for the patients now the situation
has changed from previous practice

So the OS data is strongly positive and OS was one of the dual primary end point and this data shows a
significant difference of close to 20 months in terms of overall survival and has our ratio
0.73 any comment on the duration the benefit
Magnitude
It's great, you know like I mean
The OS is better than the pacific trial overall survival. So small cell looks more promising
Than non-small cell. So very important is the control arm is also
Having a fantastic overall survival the reason is for I think 30 35% patients did receive immunotherapy in head progression. So
Great overall survival and small cell crossing five years or four years is something we never heard of so even a therapy has become a game changer
And this patient
Survival even in
Classic control arm is because of this 50% patients having
PS0 and
Rasp 50 having PS1 so that's one of the reason we get control arms also being good actually in such trials
Which are not applicable directly in the real world practice data. So but that even well selected patients. It is clearly showing around
Significant improvement and 10% OS benefit at three years
So this is a good benefit and what more we can expect in this patients in these patients who are not doing it coming to OS subgroup analysis any comments
Point which you see to be concerning or of very significant use
so
as discussed we
Kind of see the benefit in either of the radiation schedule either of the platinum
Or whether there was PCI or not again
when you divide it too much
The numbers are small so some of them would cross unity, but I think
Based on the subgroup analysis, I think it is reasonably okay for all the subgroups which were pre-planned
The only thing is the 28 day like if you're giving it
About 28 days you start you starting it beyond 28 days the benefit is marginal. So the reason why this is
For who for which patient do we differ for patients or not that good for patients
We have pneumonia it is or not recovering so that bias is there
So whether a bad patient is receiving about 28 days or whether 28 days above is making bad we do not know but
The take home is dry and as early as possible if you can start so that is probably
But most of time some amount of pneumonitis and other components held us
So also the radiation if you are starting when it was start at least with the second cycle of
platinum at the site
In the CT
Important point would be in routine practice if this drug was not there
We would have done response assessment quite late here
We need to do a scan early to start IO to see whether the disease or
Maybe probably the last radiation dose at that point of time even when you are doing image guided
Radiation you can have a look that at least it is not progressed
Okay, so I agree with this is an important point and this is actually a very difficult
When we are recruiting patients in trial as well example if we are recruiting pacificates which is ongoing at both of our centers
What's the point what's the difficulty you see them? So it's it's it's actually difficult to randomize patients before 14 days

I mean
Realistically speaking especially if you want to give PCI also I mean the immediately the moment
You know your CT RT stops then you do a response assessment
Then you decide for PCI then you go ahead with PCI and then you decide to randomize the patient
So it's a little challenging again
You know the subgroups. I mean almost 50% of patients are PS 0
Which is I would say in a real world every day setting with very few patients who have received CT RT
With it opposite and cisplatin were actually PS 0 by the end of it, you know, especially in the Indian scenario
So so I think I think we'll be coming to that but I think for the 28 day cut off
I think we need more data because
Pacific also did that earlier and then there was data that came in which said no you can give it a little later also
And there is some benefit so
early days
Definitely seems to be some benefit
I think that there should be some scope or some room to you know tweak these a little bit
But long-term data would be better
Completely I give him so that is a very important point and which we learned from Pacific as well
And now we are utilizing
Pacific it as well as a part of the trial
This is the PFS due to end point and it was expected. It is also positive and
9 versus 16 months and this is the subgroup which is the similar if we see the subgroup PCI versus no PCI
I think there's no very strong difference in the overall outcomes
But if the PCI was not received as our ratio was just under the
Point one margin of one that was point 99 and if PCI was yes, you can see some close curves are closing down
Then separating it again that doesn't make too much of sense to me anything to add from anyone
Sensing yeah completely there are a lot of sensing at three years which is making a difficult to have a direct answer
If we see the cis versus carbo data again, there is a problem here
you can see the there is so much of sensing at three years and
The cisplatin arm I first thought
Cisplatin might be there a lower number of patient, but it is not like that caroplatin had lower number of patients
91 versus 88 and there was significant separation in the curve while the cisplatin arm
173 patient both them and curves were quite close to each other at three years
But again, there was some separation later on but again merging so I don't think there is a direct answer from the subgroup analysis
But it seems that caroplatin patient was getting somewhat better better bit benefit from the drug
You would expect cover platinum people to live short there, but here I mean greater people are surviving. So, you know
anyways
So BD versus QD doses
Not much difference is now outcome as expected
Coming to the safety. So that's the most important part
Let's come to directly the new minute spot which I wanted to discuss actually
So in the case of your highlighting about the new one at this which the data
Percent it's you would like to highlight it to it. So we need to figure out whether it is radiation immunitis or whether it is

I.O induced
Edition immunitis. I think it's almost comparable not some 10% difference not much difference
So can be easily managed we should be vigilant in picking up early that said yeah
About radiation. It is there is a study of inhaled bacalomethazone, which seems to be quite interesting
I think it will be practiced ending because we see that patients are not able to receive adjuvant
I owe in a significant number of patients are in 30% of the patient will not be candidate of adjuvant
I do to read pre-existing radiation immunitis in those we are not very comfortable and it's so I think inhaled bacalomethazone might be a game changer for adjuvant I owe and
this is a note for
the pharma companies who are making these adjuvant drugs to
promote inhaled strikes as well during the
Radiation so that will change the situation other toxic seems to be quite similar and they were not much different
And we see immunitis on set. This is drug rated 55 as a 66 days
I think in the interest of time we'll have to stop it here
And just on the median PFS of 16 and median OS of 55 that is something which we never see clinically
So obviously data is good, but that is something which we are not able to replicate in real world situation completely
After first progression
Thank you, thank you to all the panelists and let's move ahead with the next talk.
Thank you