Durvalumab in Stage III NSCLC

Panel Discussion

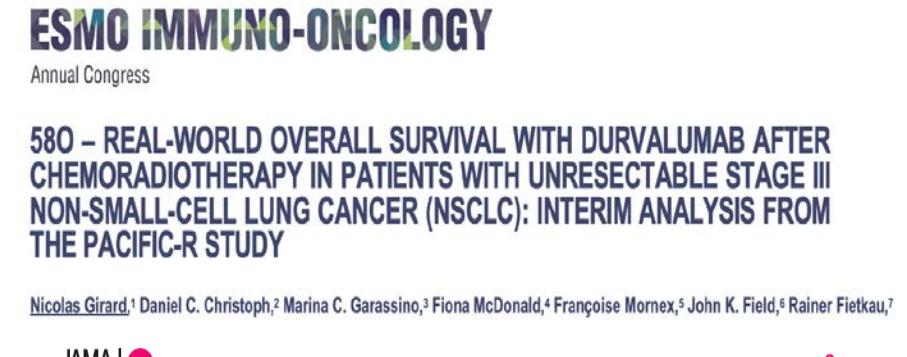
Dr Randeep Singh

Medical Oncologist

NARAYANA HEALTH , GURUGRAM

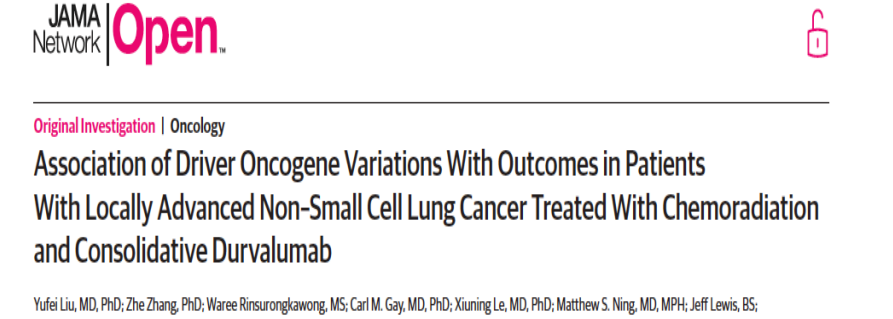
PANELIST

- **Dr Bharat Chauhan**
- **Dr Shashank Das**
- **Dr Prahlad Elamarthi**
- **Dr Dipalee Borade**
- **Dr Biren**
- **Dr Vipul Doshi**


ESMO IMMUNO-ONCOLOGY
Annual Congress

580 – REAL-WORLD OVERALL SURVIVAL WITH DURVALUMAB AFTER CHEMORADIOTHERAPY IN PATIENTS WITH UNRESECTABLE STAGE III NON-SMALL-CELL LUNG CANCER (NSCLC): INTERIM ANALYSIS FROM THE PACIFIC-R STUDY

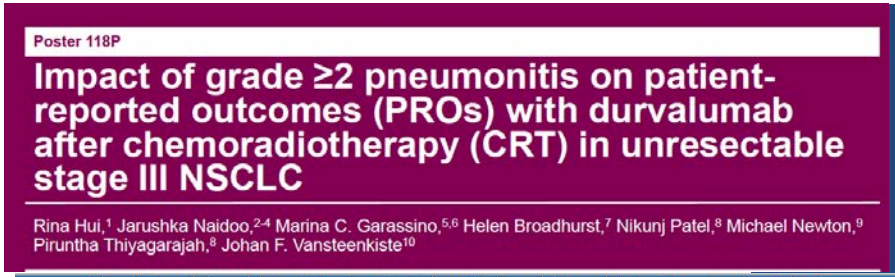
Nicolas Girard,[1] Daniel C. Christoph,[2] Marina C. Garassino,[3] Fiona McDonald,[4] Françoise Mornex,[5] John K. Field,[6] Rainer Fietkau,[7]


JAMA Network Open

Original Investigation | Oncology

Association of Driver Oncogene Variations With Outcomes in Patients With Locally Advanced Non-Small Cell Lung Cancer Treated With Chemoradiation and Consolidative Durvalumab

Yufei Liu, MD, PhD; Zhe Zhang, PhD; Waree Rinsurongkawong, MS; Carl M. Gay, MD, PhD; Xiuning Le, MD, PhD; Matthew S. Ning, MD, MPH; Jeff Lewis, BS;


Poster 118P

Impact of grade ≥2 pneumonitis on patient-reported outcomes (PROs) with durvalumab after chemoradiotherapy (CRT) in unresectable stage III NSCLC

Rina Hui,[1] Jarushka Naidoo,[2-4] Marina C. Garassino,[5,6] Helen Broadhurst,[7] Nikunj Patel,[8] Michael Newton,[9] Piruntha Thiyagarajah,[8] Johan F. Vansteenkiste[10]

Maastro in de beste handen

Proton-therapy and concurrent chemotherapy in stage III NSCLC:

Effects on Durvalumab eligibility and safety profile

elcc

#113P

Francesco Cortiula[1], Dirk De Ruysscher[2], Safiye Dursun[3], Michelle Steens[4], Gerben Bootsma[4], Richard Canters[2], Ilaria Rinaldi[2], Vicki Taasti[2], Ruud Houben[2], Kobe Reynders[3], Stéphanie Peeters[2], Antonio Angrisani[2], Djoya Hattu[2] and Lizza Hendriks[3]

LMU KLINIKUM DER UNIVERSITÄT MÜNCHEN


Concurrent versus sequential immune checkpoint inhibition in stage III NSCLC patients treated with chemoradiation

Poster: #115

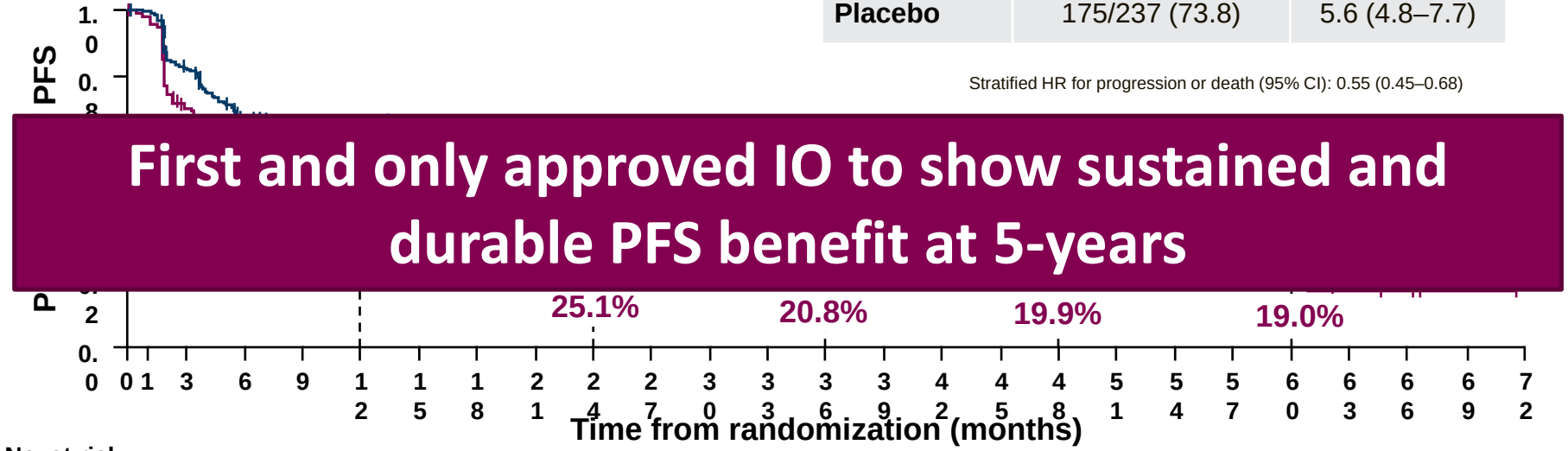
Authors:

Primary Endpoints: Progression-Free Survival by BICR (ITT)

	No. of events / No. of patients (%)	Median PFS (95% CI) months
Durvalumab	268/476 (56.3)	16.9 (13.0–23.9)
Placebo	175/237 (73.8)	5.6 (4.8–7.7)

Stratified HR for progression or death (95% CI): 0.55 (0.45–0.68)

First and only approved IO to show sustained and durable PFS benefit at 5-years



No. at risk

Durva.	47	37	30	26	21	19	16	14	13	12	11	11	10	9	9	8	8	7	6	5	3	2	1	5	0
Placebo	6	7	1	7	5	0	5	7	7	8	9	0	3	7	2	5	1	8	7	7	4	2	1	1	0
	23	16	10	87	68	56	48	41	37	36	30	27	26	2	2	2	2	2	1	1	1	6	4		
	7	4	5											5	4	4	2	1	9	9	4				

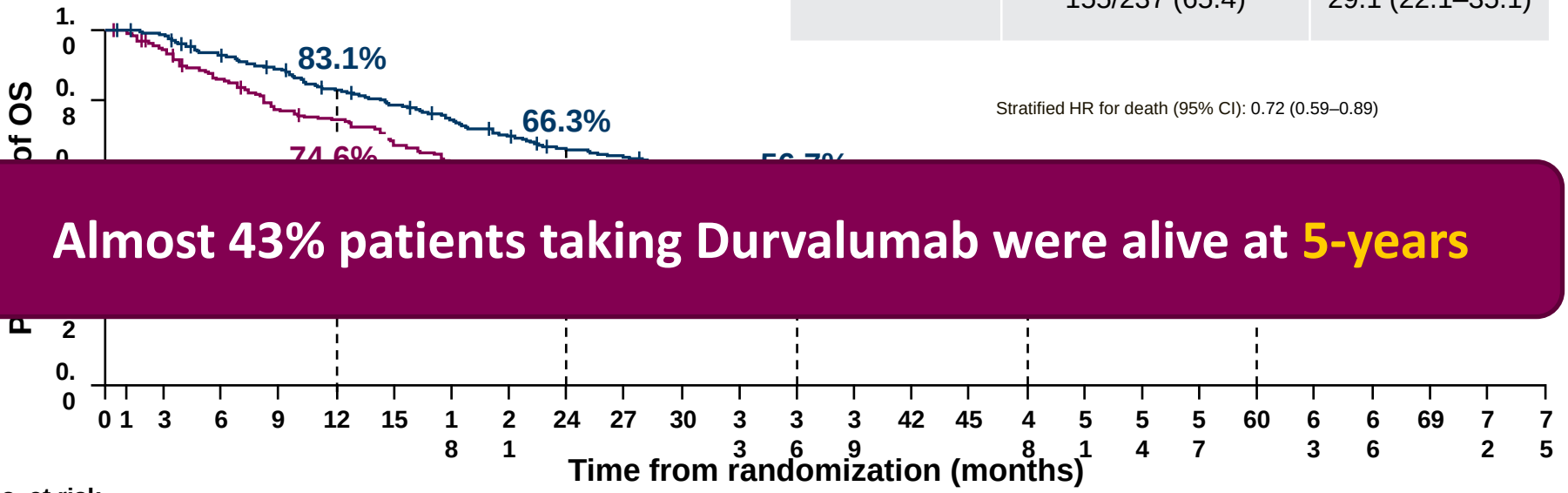
- DCO5: January 11, 2021; median follow-up: all patients, 34.2 months [range, 0.2–74.7]; censored patients, 61.6 months [range, 0.4–74.7].
- BICR = blinded independent central review; CI = confidence interval; DCO = data cutoff; HR = hazard ratio; ITT = intent-to-treat; PFS = progression-free survival
- Spigel DR, et al. Poster presented at: ASCO Virtual Meeting; June 4-8, 2021.

First and only approved IO to show 5 year OS

	No. of events / No. of patients (%)	Median OS (95% CI) months
Durvalumab	264/476 (55.5)	47.5 (38.1–52.9)
Placebo	155/237 (65.4)	29.1 (22.1–35.1)

Stratified HR for death (95% CI): 0.72 (0.59–0.89)

Almost 43% patients taking Durvalumab were alive at 5-years



No. at risk

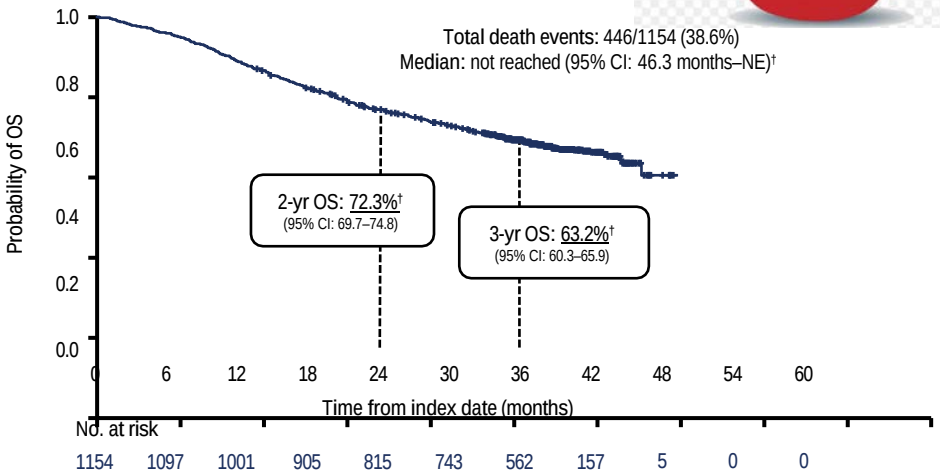
Durva.	47	46	43	41	38	36	34	31	29	28	27	26	25	24	236	227	218	207	196	18	134	9	4	1	2	0
Placebo	6	4	1	4	5	4	3	9	8	9	3	4	2	1	91	83	78	77	74	3	56	1	0	8	2	0
	23	22	19	17	17	15	14	13	12	11	10	99	97	93						72		3	1	7		
	7	0	9	9	1	6	3	3	3	6	7											3	6			

- DCO5: January 11, 2021; median follow-up: all patients, 34.2 months [range, 0.2–74.7]; censored patients, 61.6 months [range, 0.4–74.7].
- CI = confidence interval; DCO = data cutoff; HR = hazard ratio; ITT = intention-to-treat; OS = overall survival.
- Spigel DR, et al. Poster presented at: ASCO Virtual Meeting; June 4-8, 2021.

Do you still wish to see RWE ??

OVERALL SURVIVAL*

- Median OS had not matured at the time of this analysis
  - More than 60% of patients were estimated to be alive at 3 years
- OS outcomes were numerically better among patients who received durvalumab within 42 days of finishing RT



	cCRT	
Outcome	**PACIFIC-R*** (N=900)	**PACIFIC[1]†** (N=476)
2-yr OS rate, % (95% CI)	**73.8** (70.8–76.6)	**66.3** (61.8–70.4)
3-yr OS rate, % (95% CI)	**64.8** (61.5–67.9)	**56.7** (52.0–61.1)

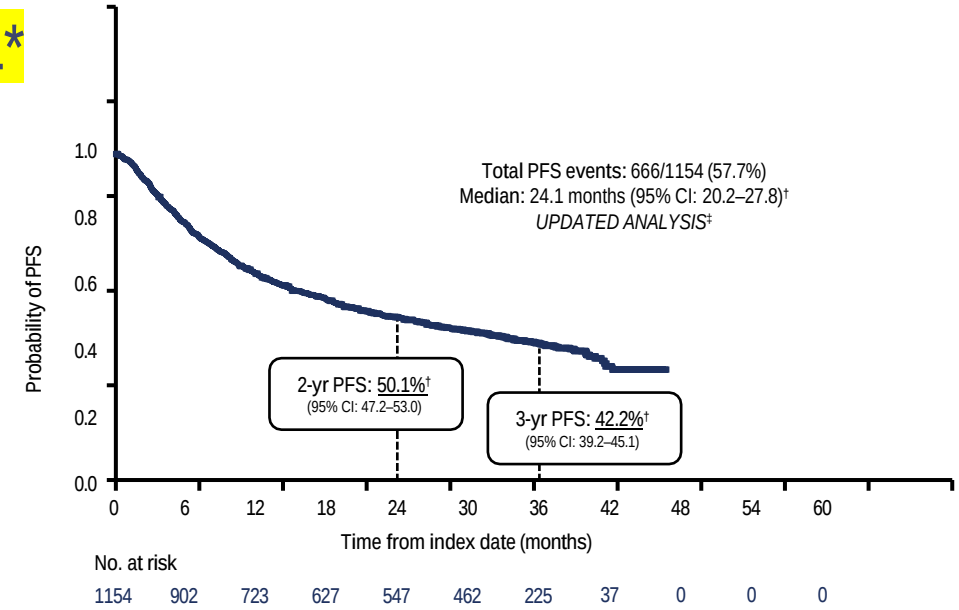
	Time from end of RT to durva. initiation	
Outcome	**≤42** days (N=398)	>42 days (N=732)
2-yr OS rate, % (95% CI)†	*74.8* (70.2–78.8)	*71.2* (67.8–74.4)
3-yr OS rate, % (95% CI)†	*66.0* (61.1–70.5)	*61.8* (58.1–65.2)

*Analyses are based on the 3rd chart extraction from PACIFIC-R (end date: 30 Nov 2021).
†Calculated using the Kaplan–Meier method.

CI, confidence interval; NE, not estimable;
OS, overall survival; RT, radiotherapy; yr, year

PROGRESSION-FREE SURVIVAL*

- Median PFS was 24.1 months (95% CI: 20.2–27.8)
  - More than 40% of patients were estimated to be alive and free of progression at 3 years
- PFS outcomes were numerically better among patients who received durvalumab within 42 days of finishing RT



Outcome	cCRT	
	PACIFIC-R* (N=900)	PACIFIC[1†] (N=476)
mPFS, months (95% CI)	**25.6** (20.7–31.1)	**16.9** (13.0–23.9)

Outcome	Time from end of RT to durva. initiation	
	≤42 days (N=398)	>42 days (N=732)
2-yr PFS rate, % (95% CI)†	*52.3* (47.3–57.1)	*48.9* (45.3–52.5)
3-yr PFS rate, % (95% CI)†	*45.5* (40.4–50.4)	*40.3* (36.5–44.0)

CI, confidence interval; PFS, progression-free survival; RT, radiotherapy; yr, year

*Analyses are based on the 3rd chart extraction from PACIFIC-R (end date: 30 Nov 2021). †Calculated using the Kaplan–Meier method. ‡The original PFS analysis was based on the 2nd chart extraction (end date: 30 Nov 2020) and is published elsewhere.[1,2] [1]Girard N et al,. Ann Oncol 2021;32(suppl_5):S939–48; [2]Girard N et al,. J Thorac Oncol; doi: https://doi.org/10.1016/j.jtho.2022.10.003 (ePub ahead of print)

COMPARISON WITH CLINICAL TRIAL DATA – PD-L1 STATUS

- Outcomes in PD-L1 subgroups from PACIFIC-R were numerically better than those observed in the PACIFIC trial[1]

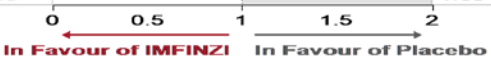
Outcome	PD-L1 TC ≥1%	
	PACIFIC-R* (N=573)	PACIFIC[1†] (N=212)
2-yr OS rate, % (95% CI)	*76.0* (72.3–79.3)	*72.9* (66.2–78.4)
3-yr OS rate, % (95% CI)	*67.0* (63.0–70.8)	*61.9* (54.8–68.2)
mPFS, months (95% CI)	*25.3* (19.1–31.6)	*24.9* (16.9–38.7)

Outcome	PD-L1 TC <1%	
	PACIFIC-R* (N=138)	PACIFIC[1†] (N=90)
2-yr OS rate, % (95% CI)	*64.3* (55.6–71.7)	*56.1* (45.0–65.8)
3-yr OS rate, % (95% CI)	*54.4* (45.7–62.4)	*47.5* (36.5–57.6)
mPFS, months (95% CI)	*16.3* (10.7–28.1)	*10.7* (7.3–20.6)

- Outcomes from RWE studies and clinical trials should be compared with caution owing to differences in study design and methods of data collection/analysis

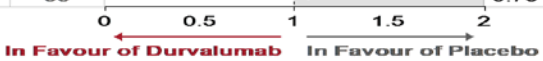
OS in Retrospective Exploratory PD-L1 Subgroups

Subgroup		Patients		Unstratified HR for Death (95% CI)
		Durva	Placebo	
PD-L1 Status	All patients	476	237	0.68 (0.53–0.87)
	≥1%	212	91	0.53 (0.36–0.77)
	1–24%	97	47	0.60 (0.35–1.03)
	<1%	90	58	1.36 (0.79–2.34)



PFS in Retrospective Exploratory PD-L1 Subgroups

Subgroup		Patients		Unstratified HR for Disease Progression or Death (95% CI)
		Durva	Placebo	
PD-L1 Status	All patients	476	237	0.52 (0.42–0.65)
	≥1% [41]	212	91	0.46 (0.33–0.64)
	1–24%	97	47	0.49 (0.30–0.80)
	<1%	90	58	0.73 (0.48–1.11)



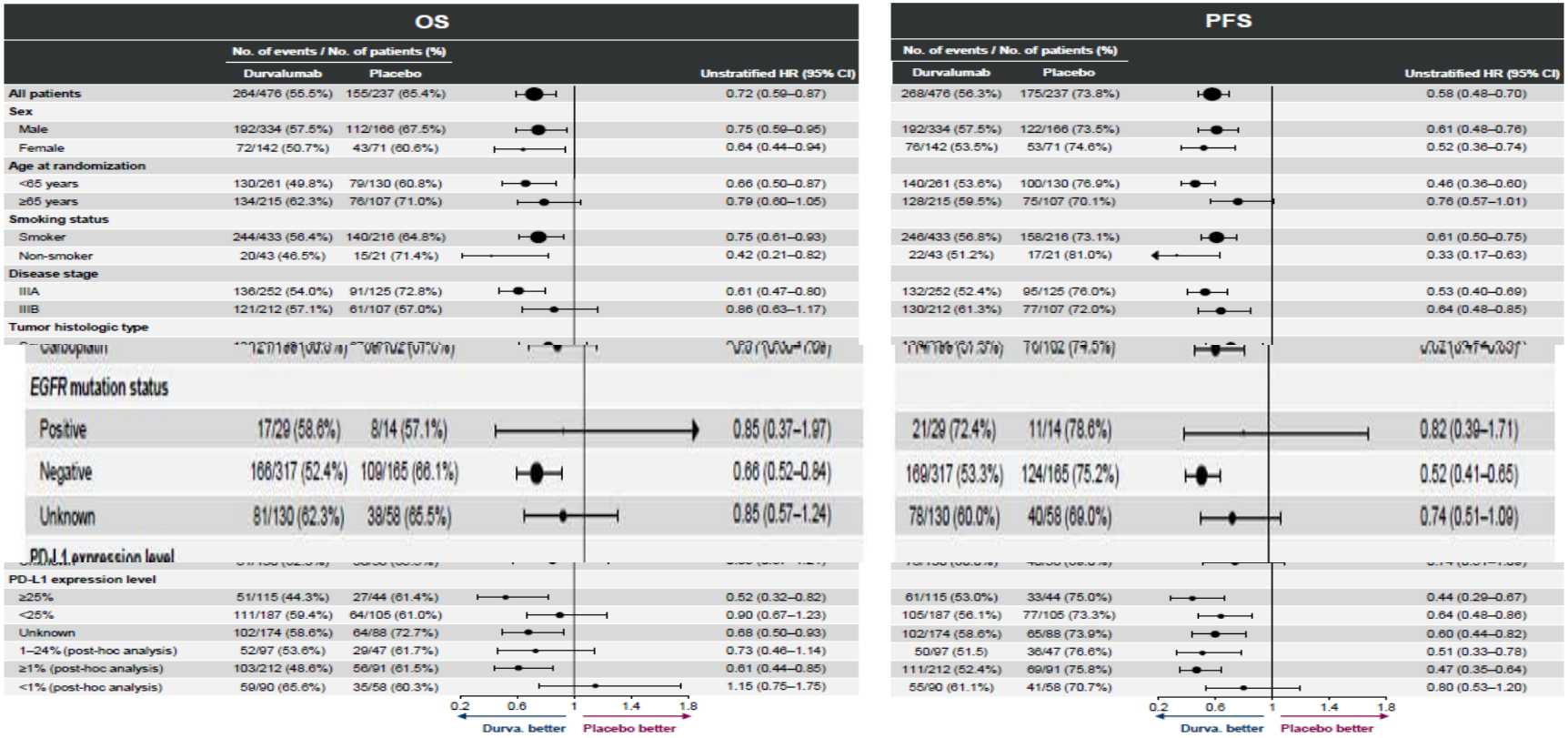
Antonia S, et al. N Eng J Med 2018

CI, confidence interval; EAP, early access programme; (m)PFS, (median) progression-free survival; OS, overall survival; RWE, real-world evidence; yr, year

*Data based on the 3rd chart extraction (30 Nov 2021). †Data shown is for the durva of PACIFIC (DCO: 11 Jan 2021). [1]Spigel DR et al., J Clin Oncol 2022;40:130

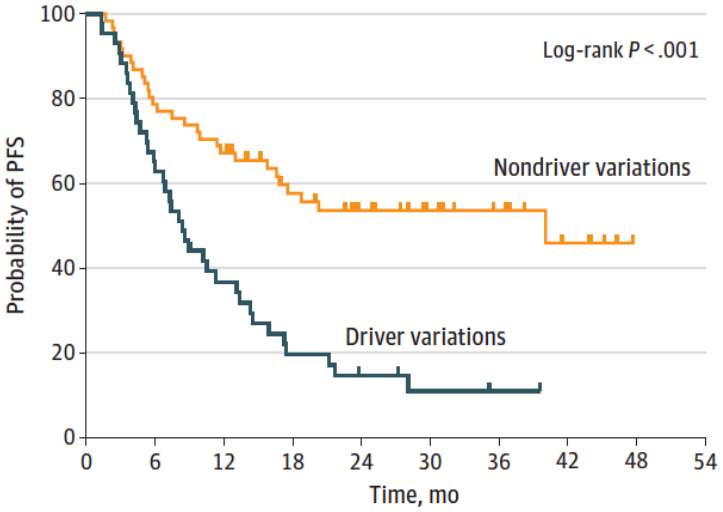
Would you consider Durva for EGFR mNSCLC Stage III

Imfinzi has shown efficacy across all sub-groups



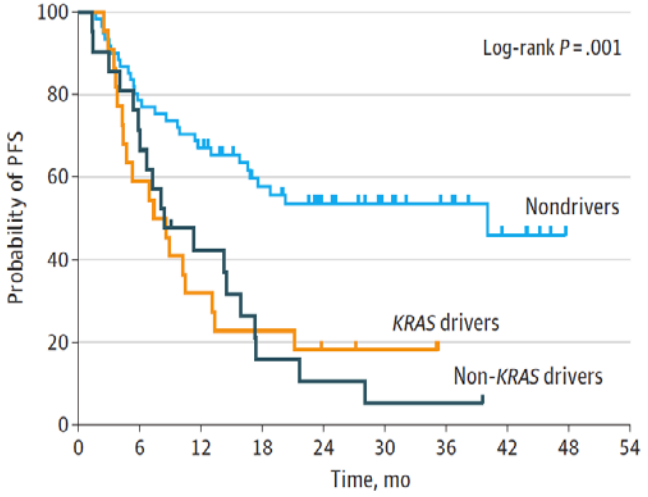
*HRs and 95% CIs were not calculated if the subgroup had <20 events.

A PFS of driver variations and nondriver variations



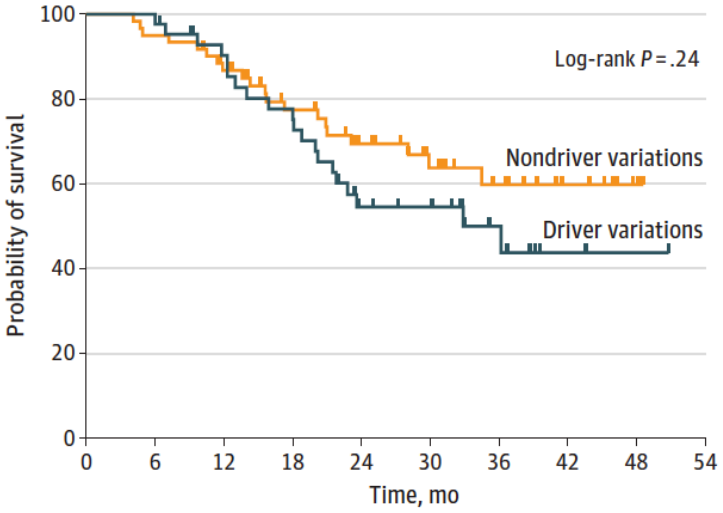
No. at risk										
Driver variations	43	28	15	8	5	3	1	0	0	0
Nondriver variations	61	48	40	29	21	15	10	5	0	0

B PFS of nondriver variations, *KRAS* drivers, and non-*KRAS* drivers



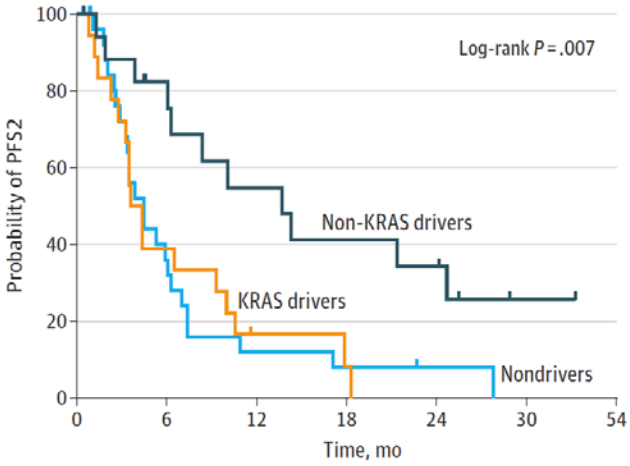
No. at risk										
Non-*KRAS* drivers	21	15	8	3	2	1	1	0	0	0
KRAS drivers	22	13	7	5	3	2	0	0	0	0
Nondriver variations	61	48	40	29	21	15	10	5	0	0

C Overall survival of driver variations and nondriver variations



No. at risk										
Driver variations	43	43	36	31	18	16	8	2	1	0
Nondriver variations	61	58	51	40	30	21	14	8	2	0

B PFS2 for non-KRAS drivers, KRAS drivers, and nondrivers



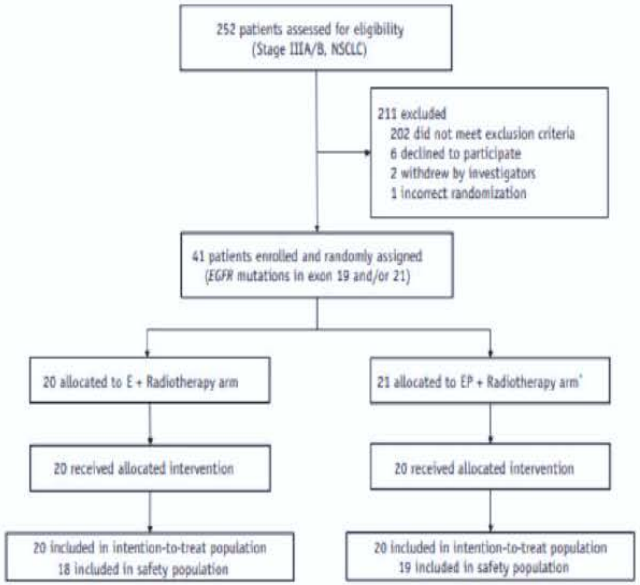
No. at risk							
Non-KRAS drivers	18	12	8	6	5	1	0
KRAS drivers	18	7	2	0	0	0	0
Nondrivers	27	9	3	2	1	0	0

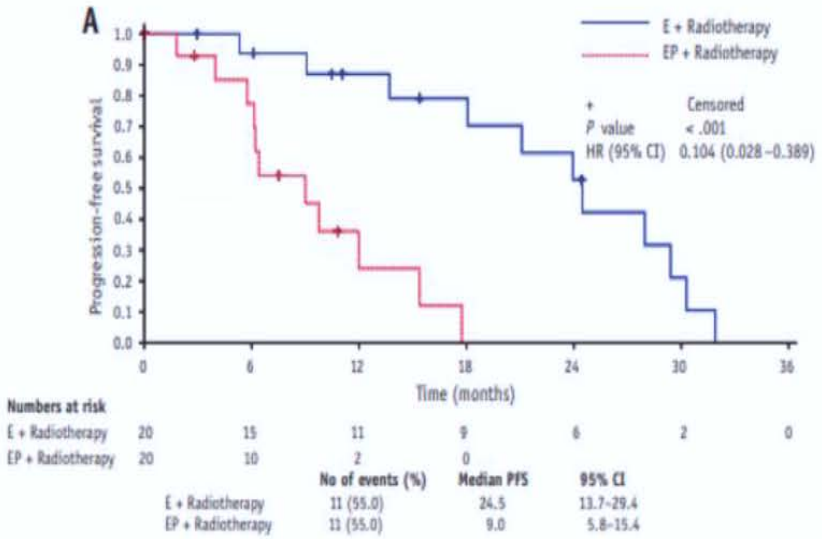
Stage III NSCLC : Driver +

	Author	Type	Time	Pathol	N	Regimen	%ORR	2-yrPFS	LRR	DMR	BMR	2-yrOS
EGFR+ population	Tanaka	Retrosp	06-13	ADK	28	P-based CTRT	72.4		14	76	35	
	Yagishita	Retrosp	01-10	Non Squam	34	P-based CTRT	79		4	80	16	
	Nakamura	Retrosp	06-16	Non Squam	34	P-based CTRT	-	10-25	53	85	29	~80
	Akamatsu	Retrosp	02-09	ADK	13	P-based CTRT	76.9		15	69	46	
	Hotta	Phase 2	11-17	NSCLC	20	Gefitinib....+CTRT	85	36.9	10	65	30	90
EGFR unselected population	OLCSG0007	Phase 3	00-05	NSCLC	101	DPccTRT	78.8		38	37	35	60.3
	Proclaim	Phase 3	08-12	Non Squam	301	PP or EPccTRT	35.9	20-30	58	50	19	52
	WJTOG0105	Phase 3	01-05	NSCLC	156	PCccTRT	63					*45
	Pacific	Phase 3	14-16	NSCLC	473	CTRT_Durval	30	45	-	-	5	66.3
					236	CTRT_Placebo	17.8	20	-	-	12	55.6

Erlotinib Versus Etoposide/Cisplatin With Radiation Therapy in Unresectable Stage III Epidermal Growth Factor Receptor Mutation-Positive Non-Small Cell Lung Cancer: A Multicenter, Randomized, Open-Label, Phase 2 Trial

Ligang Xing, MD, PhD • Gang Wu, MD, PhD • Luhua Wang, MD • ... Baolin Qu, MD • Wanqi Zhu, MD •





Median PFS of E + RT significantly > EP+RT (24.5 vs 9.0 mo) [hazard ratio, 0.104; 95% confidence interval, 0.028-0.389; P < .001]).

Xing, Red J, 2021

Slide credit : ESMO ASIA 22 RESOURCES

TOXICITY DATA

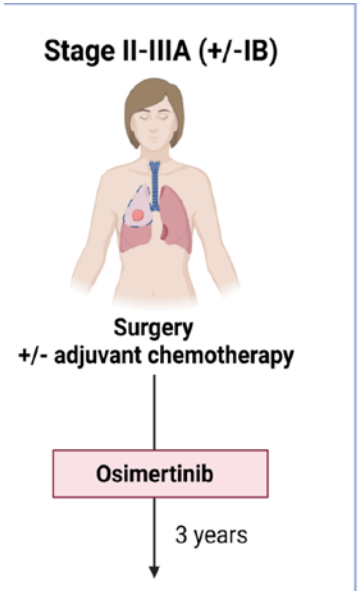
Table 3. Treatment Toxic Effects by Variation Status

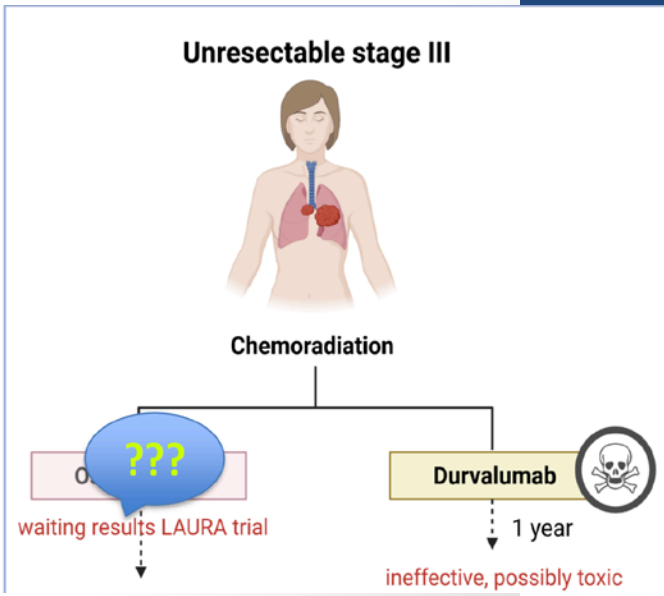
Toxic Effects	No. (%) All patients (n = 104)	Non-*KRAS* driver variations (n = 21)	*KRAS* driver variations (n = 22)	Nondriver variations (n = 61)	*P* value
All toxicities					
Grade 2 or higher	78 (75.0)	17 (81.0)	17 (77.3)	44 (72.1)	.78
Grade 3 or higher	24 (23.1)	6 (28.6)	5 (22.7)	13 (21.3)	.77
Pneumonitis					
Grade 2 or higher	44 (42.3)	13 (61.9)	10 (45.5)	21 (34.4)	.09
Grade 3 or higher	17 (16.3)	4 (19.0)	3 (13.6)	10 (16.4)	.87
Dysphagia					
Grade 2 or higher	30 (28.8)	4 (19.0)	6 (27.3)	20 (32.8)	.53
Grade 3 or higher	0	0	0	0	> .99
Esophagitis					
Grade 2 or higher	48 (46.2)	9 (42.9)	9 (40.9)	30 (49.2)	.80
Grade 3 or higher	2 (1.9)	0	0	2 (3.3)	> .99
Pain					
Grade 2 or higher	25 (24.0)	4 (19.0)	3 (13.6)	18 (29.5)	.30
Grade 3 or higher	3 (2.9)	0	0	3 (4.9)	.57
Dermatitis					
Grade 2 or higher	12 (11.5)	2 (9.5)	2 (9.1)	8 (13.1)	> .99
Grade 3 or higher	2 (1.9)	1 (4.8)	0	1 (1.6)	.41
Arthritis					
Grade 2 or higher	1 (1.0)	1 (4.8)	0	0	.202
Grade 3 or higher	0	0	0	0	> .99
Diarrhea					
Grade 2 or higher	2 (1.9)	1 (4.8)	1 (4.5)	0	.169
Grade 3 or higher	2 (1.9)	1 (4.8)	1 (4.5)	0	.17
Anorexia					
Grade 2 or higher	6 (5.8)	0	1 (4.5)	5 (8.2)	.62
Grade 3 or higher	1 (1.0)	0	0	1 (1.6)	> .99
Dehydration					
Grade 2 or higher	3 (2.9)	0	0	3 (4.9)	.57
Grade 3 or higher	1 (1.0)	0	0	1 (1.6)	> .99
Fatigue					
Grade 2 or higher	9 (8.7)	0	2 (9.1)	7 (11.5)	.38
Grade 3 or higher	0	0	0	0	> .99

JAMA Network Open. 2022;5(6):e2215589. doi:10.1001/jamanetworkopen.2022.15589

Would you consider Durva for Driver positive mNSCLC Stage III

- Would you consider NGS for all driver mutation before considering consolidation Durva or only EGFR/ALK/ROS
- Would you consider mEGFR positive and other mutations separately for DURVA consolidation.
- Toxicity of Durva in Driver mut + mNSCLC ??
- FOR EGFR + mNSCLC
  - Observation after CTRT
  - Durva for 1 year
  - Osimertinib /Targeted after CTRT for 2 yrs (Laura Trial)





Poster 118P

Impact of grade ≥2 pneumonitis on patient-reported outcomes (PROs) with durvalumab after chemoradiotherapy (CRT) in unresectable stage III NSCLC

Rina Hui,[1] Jarushka Naidoo,[2-4] Marina C. Garassino,[5,6] Helen Broadhurst,[7] Nikunj Patel,[8] Michael Newton,[9] Piruntha Thiyagarajah,[8] Johan F. Vansteenkiste[10]

Figure 3. Changes in Scores for Prespecified PROs at Weeks 16 and 24 (from Baseline)

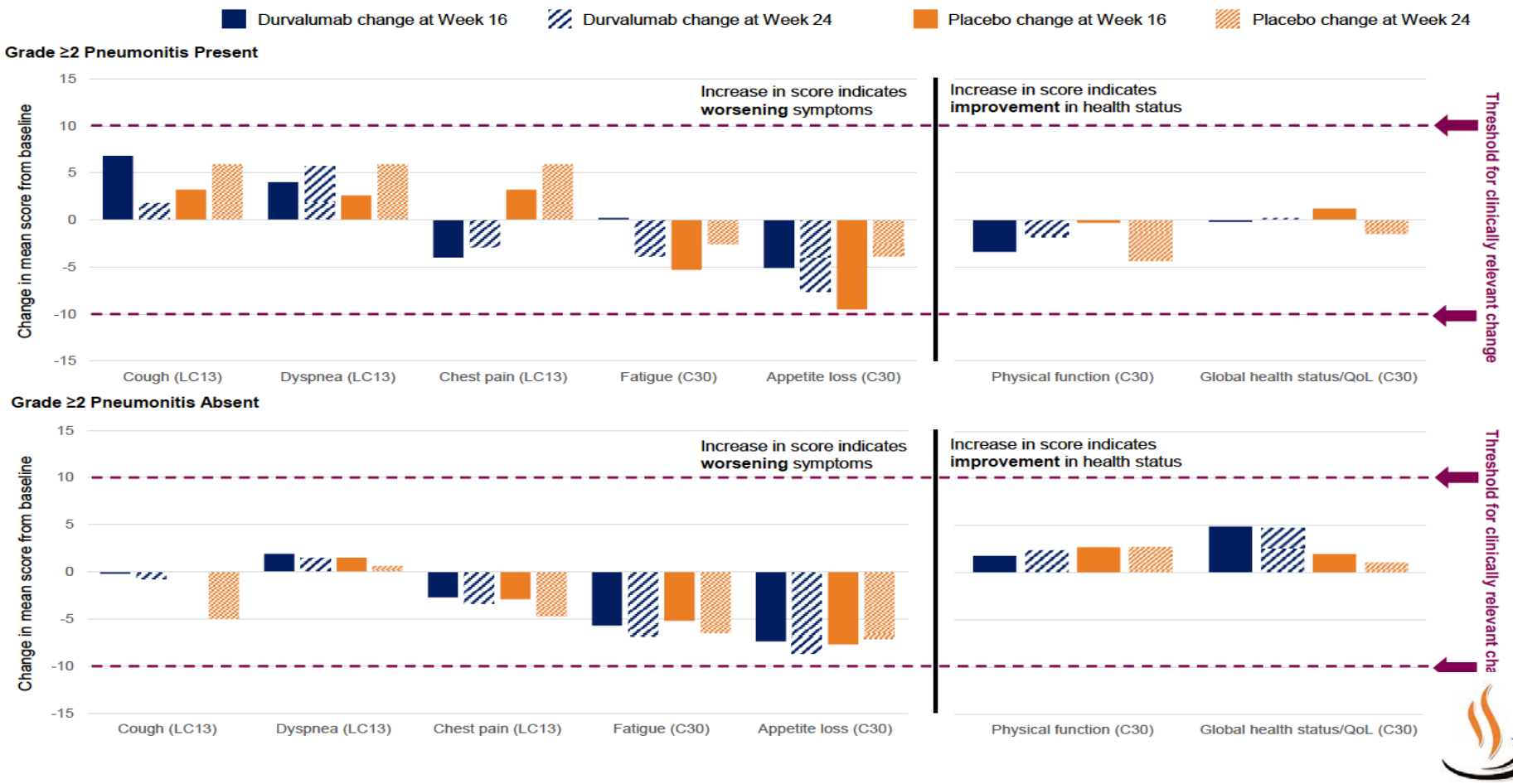
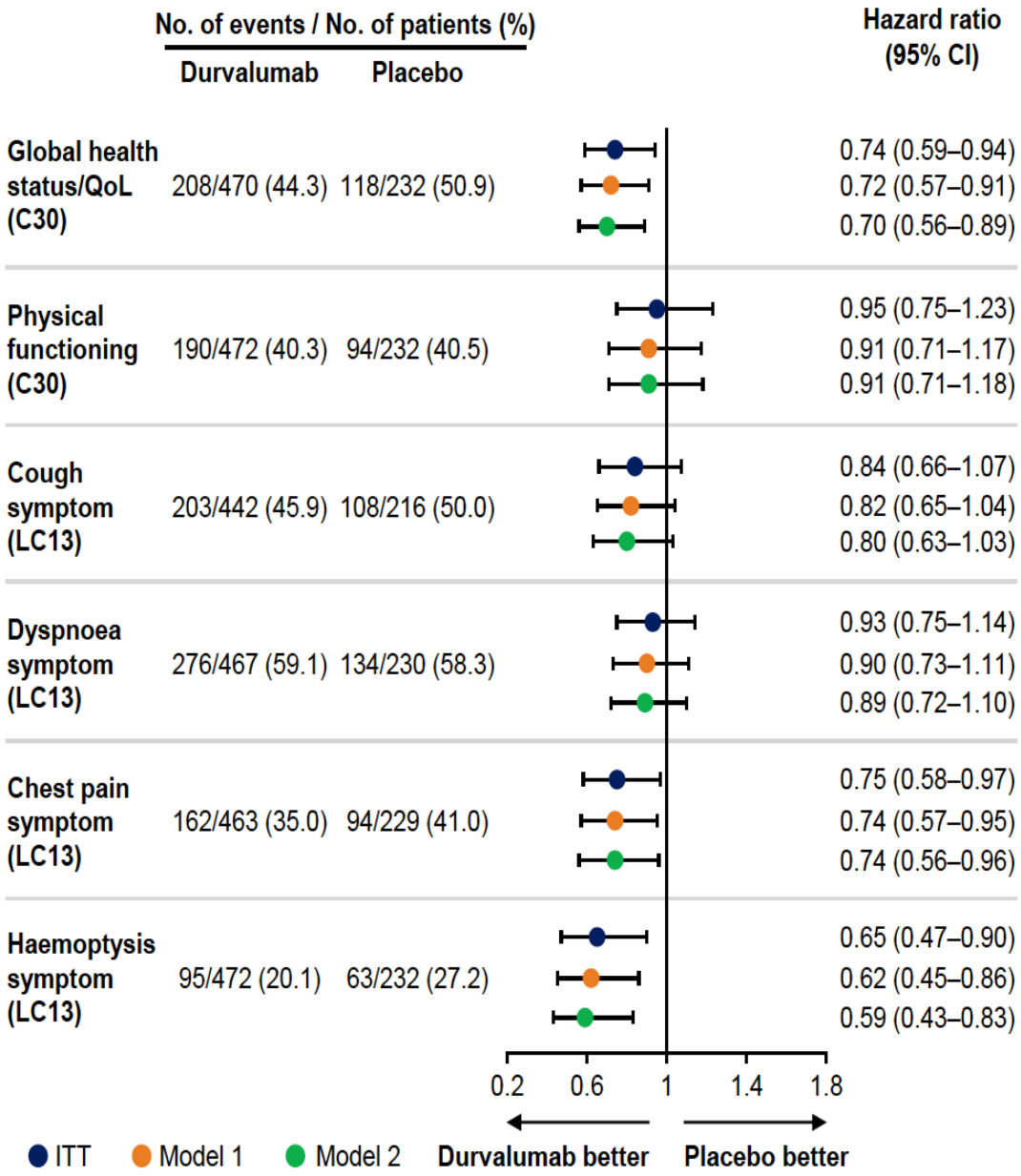


Figure 4. Confirmed TTD for PROs of Interest Adjusted for Time-dependent Grade ≥2 Pneumonitis



Model 1 (the base model) is a multivariable Cox model accounting for trial stratification factors (as used for the ITT analyses) and the time-dependent occurrence of grade ≥2 pneumonitis.

Model 2 is the base model plus additional factors :

stage
histology
best response to prior therapy
PS
region
race

PACIFIC Study – IO Pneumonitis or Radiation Pneumonitis

Pneumonitis (grouped terms)/radiation pneumonitis, n (%)*	Durvalumab (N=475)	Placebo (N=234)
Any grade	**161 (33.9)**	**58 (24.8)**
Grade 3/4	16 (3.4)	6 (2.6)
Grade 5	5 (1.1)	4 (1.7)
Leading to discontinuation	30 (6.3)	10 (4.3)

Safety analysis set (all-causality). *Pneumonitis/radiation pneumonitis was assessed by investigators with subsequent review and adjudication by the study sponsor.
In addition, pneumonitis, as reported in the table, is a grouped term, which includes acute interstitial pneumonitis, interstitial lung disease, pneumonitis, and pulmonary fibrosis.

1. Antonia SJ, Villegas A, Daniel D, Vicente D, Murakami S, Hui R, et al. Durvalumab after Chemoradiotherapy in Stage III Non–Small-Cell Lung Cancer. New England Journal of Medicine [Internet]. 2017 Nov 16 [cited 2018 Mar 30];377(20):1919–29. Available from: https://doi.org/10.1056/NEJMoa1709937

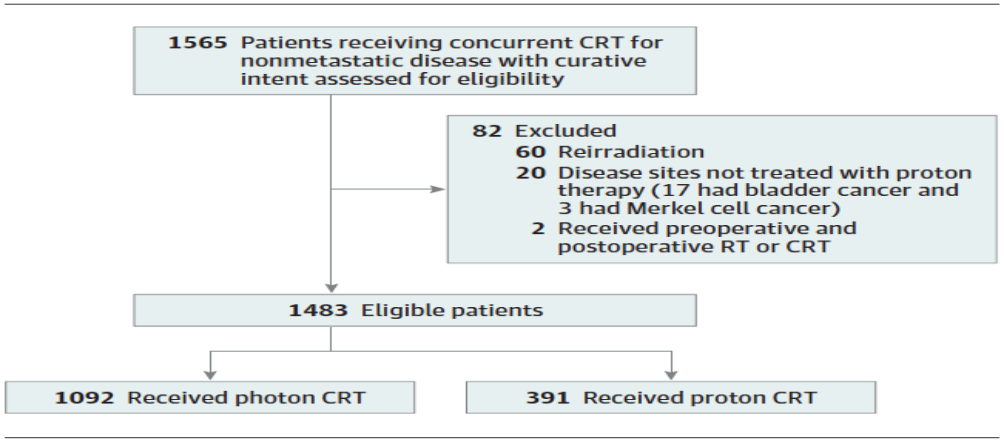
How do you diagnose and manage pneumonitis on Durva maintenance

JAMA Oncology | Original Investigation

JAMA Oncology February 2020 Volume 6, Number 2

Comparative Effectiveness of Proton vs Photon Therapy as Part of Concurrent Chemoradiotherapy for Locally Advanced Cancer

Brian C. Baumann, MD; Nandita Mitra, PhD; Joanna G. Harton, MS; Ying Xiao, PhD; Andrzej P. Wojcieszynski, MD;

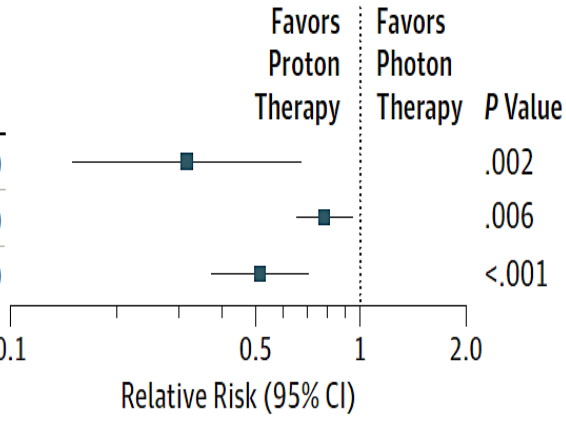


Retrospective nonrandomized comparative effectiveness study

PRIMARY END PT

Figure 3. Adverse Events and Decline in Eastern Cooperative Oncology Group (ECOG) Performance Status for Proton vs Photon Chemoradiotherapy (CRT) and Propensity Analysis Results

Outcome	Proton CRT Group (n = 391) No. of Events	Proton CRT Group (n = 391) Percentage (95% CI)	Photon CRT Group (n = 1092) No. of Events	Photon CRT Group (n = 1092) Percentage (95% CI)	Relative Risk (95% CI)
90-day Grade ≥3 adverse events	45	11.5% (8.3%-14.7%)	301	27.6% (24.9%-30.2%)	0.31 (0.15-0.66)
90-day Grade ≥2 adverse events	290	74.2% (69.8%-78.5%)	926	84.8% (82.7%-86.9%)	0.78 (0.65-0.93)
ECOG performance status decline	145	37.1% (32.3%-41.9%)	434	42.4% (39.4%-45.4%)	0.51 (0.37-0.71)



JAMA Oncology | Original Investigation

Comparative Effectiveness of Proton vs Photon Therapy as Part of Concurrent Chemoradiotherapy for Locally Advanced Cancer

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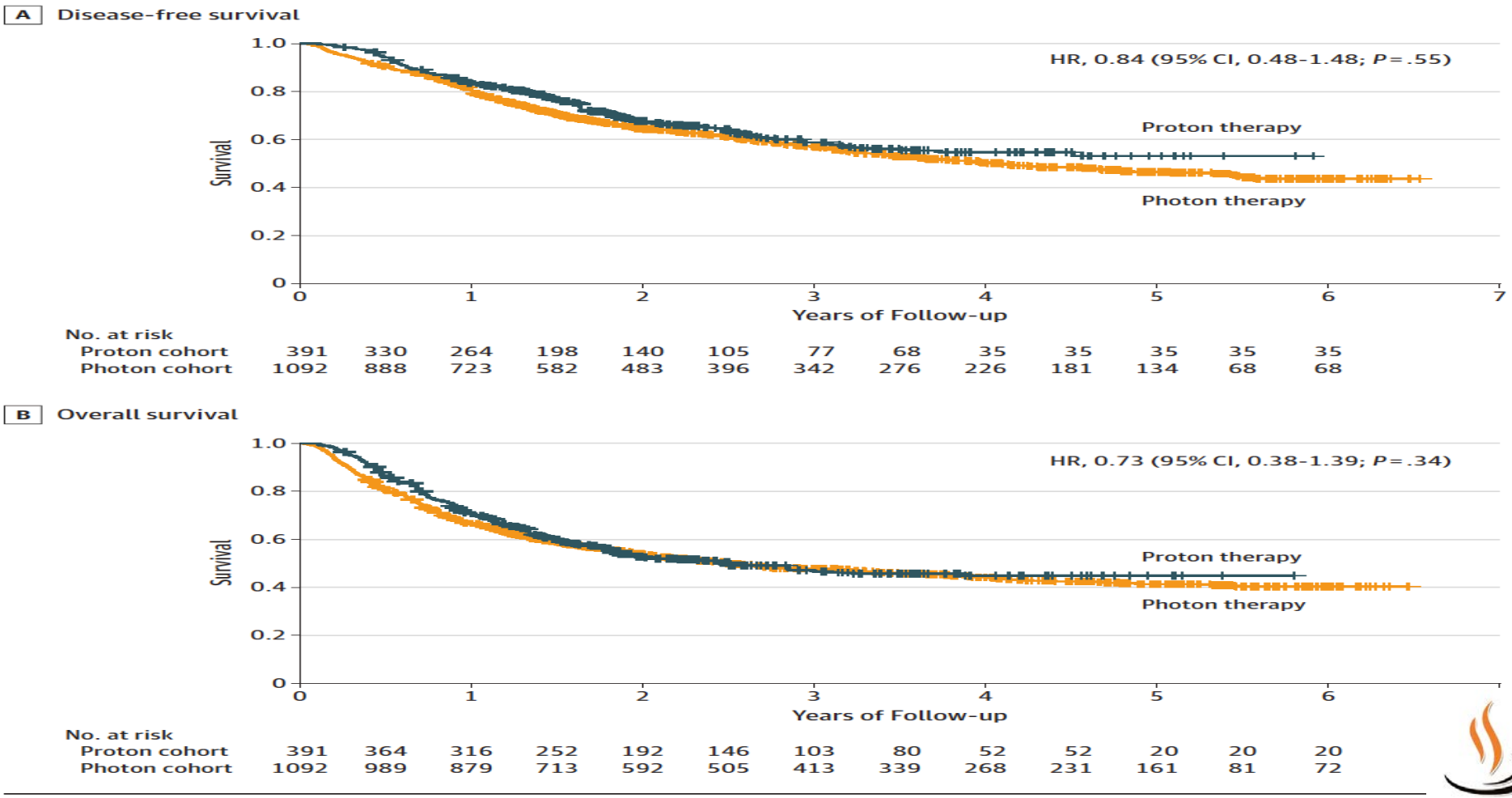
Figure 4. Adjusted Disease-Free and Overall Survival for the Proton vs Photon Chemoradiotherapy Cohorts



Proton-therapy and concurrent chemotherapy in stage III NSCLC: Effects on Durvalumab eligibility and safety profile

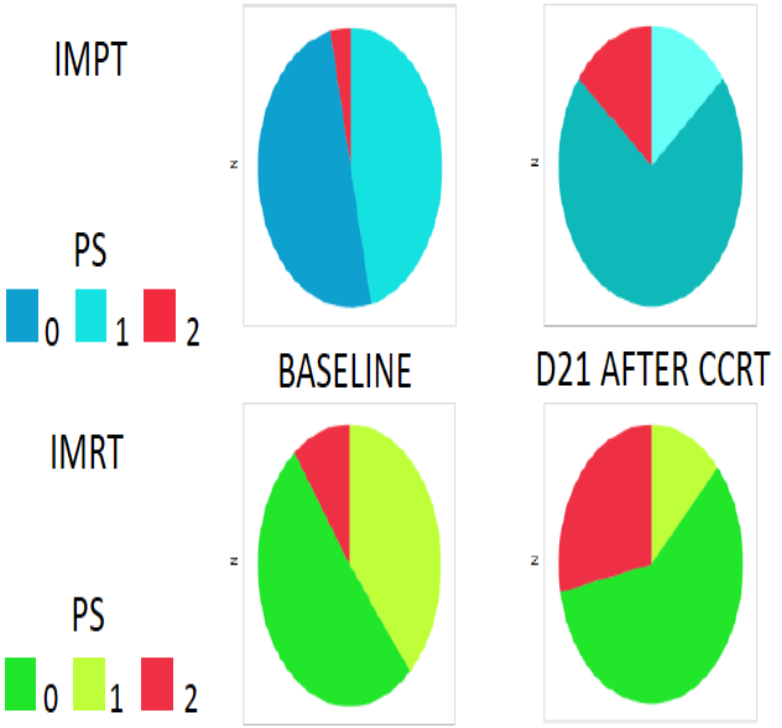
elcc European Lung Cancer Congress

#113P

Francesco Cortiula[1], Dirk De Ruysscher[2], Safiye Dursun[3], Michelle Steens[4], Gerben Bootsma[4], Richard Canters[2], Ilaria Rinaldi[2], Vicki Taasti[2], Ruud Houben[2], Kobe Reynders[2], Stéphanie Peeters[2], Antonio Angrisani[2], Djoya Hattu[2] and Lizza Hendriks[3]

1 Department of Radiation Oncology (MAASTRO), Maastricht University Medical Center+, Maastricht, The Netherlands; Department of Medical Oncology, University Hospital of Udine, Udine, Italy 2 Department of Radiation Oncology (MAASTRO), GROW School for Oncology, Maastricht University Medical Center+, Maastricht, The Netherlands. 3 Department of Pulmonary Diseases, GROW - School for Oncology and Developmental Biology, Maastricht University Medical Center+, Maastricht, the Netherlands 4 Department of Pulmonary Diseases, Zuyderland Medical Centre, 6162 BG Geleen, The Netherlands

Variable	Overall (n=67)	Protons (n= 28)	Photons (n=39)	p. value
Age – years Median (Range)	66 (35-79)	66 (35-77)	67 (49-79)	0.9
Male (%)	52.2	57.1	48.7	0.49
Tumor Stage - no. (%) IIIA IIIB IIIC	25 (37.3) 38 (56.7) 4 (6)	10 (35.7) 17 (60.7) 1 (3.6)	15 (38.5) 21 (53.8) 3 (7.7)	0.7
PD-L1 % 0-49 ≥ 50% Unknown	31 (46) 20 (30) 16 (24)	10 (35.7) 8 (28.8) 10 (35.7)	21 (53) 13 (33) 5 (12)	0.2
WHO PS after CCRT At day 21 (0-1/≥2)	**80.6%/ 19.4%**	**92.9%/ 7.1%**	**71.8%/ 28.2%**	**0.032**
Immune related adverse events - no. (%) Any grade Grade ≥ 3	18 (26.9) 5 (7.4)	6 (21.4) 3 (10)	12 (30.8) 2 (5)	0.062
Pneumonitis rate during Durvalumab - no. (%) Any grade Grade ≥ 3	16 (26) 4 (6)	7 (25) 2 (7)	9 (23) 2 (5.1)	0.8
Median FU - months	14	9.5	19.5	<0.001



IMPT Vs IMRT : Stage III NSCLC

- **Any experience ?**
- **Any particular scenario : Old age , large mass , bulky mediastinum etc ?**
- **Prime time or would like more data to mature ?**

Concurrent versus sequential immune checkpoint inhibition in stage III NSCLC patients treated with chemoradiation

Poster: #115

Authors: Lukas Käsmann[1,2,3], Julian Taugner[1], Chukwuka Eze[1], Julian Guggenberger[1], Benedikt Flörsch[1], Saskia Kenndoff[1], Amanda Tufman[4], Niels Reinmuth[5], Claus Belka[1,2,3], Farkhad Manapov[1,2,3]

SIM-1 n = 11 : Nivo conc + seq for 1 yr
SEQ-1:n= 28 : Durva seq for 1 yr

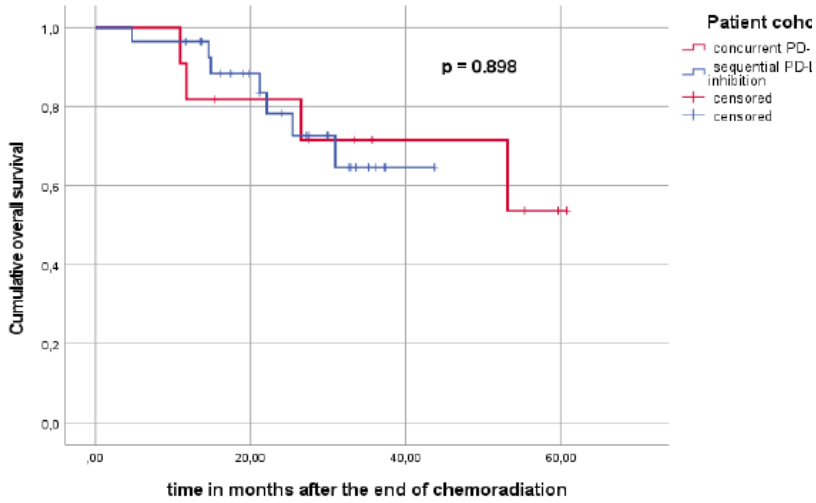


Figure I: Kaplan-Meier curves for overall survival according to concurrent versus sequential checkpoint in

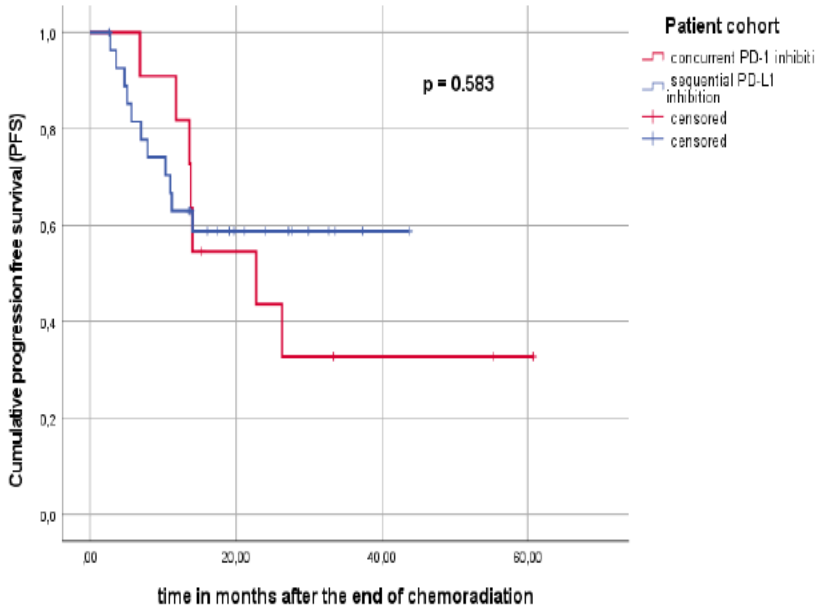
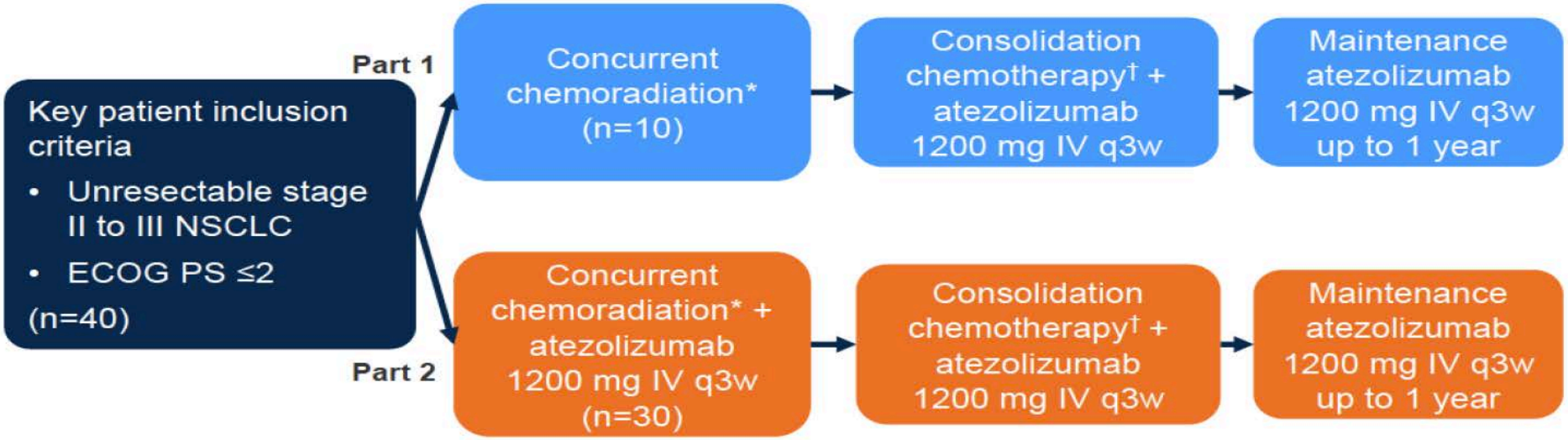


Figure II: Kaplan-Meier curves for progression free survival according to concurrent versus sequential checkpoint inhibitio

In the SIM-I cohort, 18.2% of patients showed grade III radiogenic pneumonitis and in the SEQ-I cohort 14.3% (p=0.765). Grade 4 and 5 toxicities did not occur.

PFS at 12/24 months was 82 and 44% in the SIM-I cohort, respectively, and 63 and 59% in the SEQ-I cohort (p=0.583)

ATEZO /CTRT IN STAGE III NSCLC



Primary endpoint

- Safety

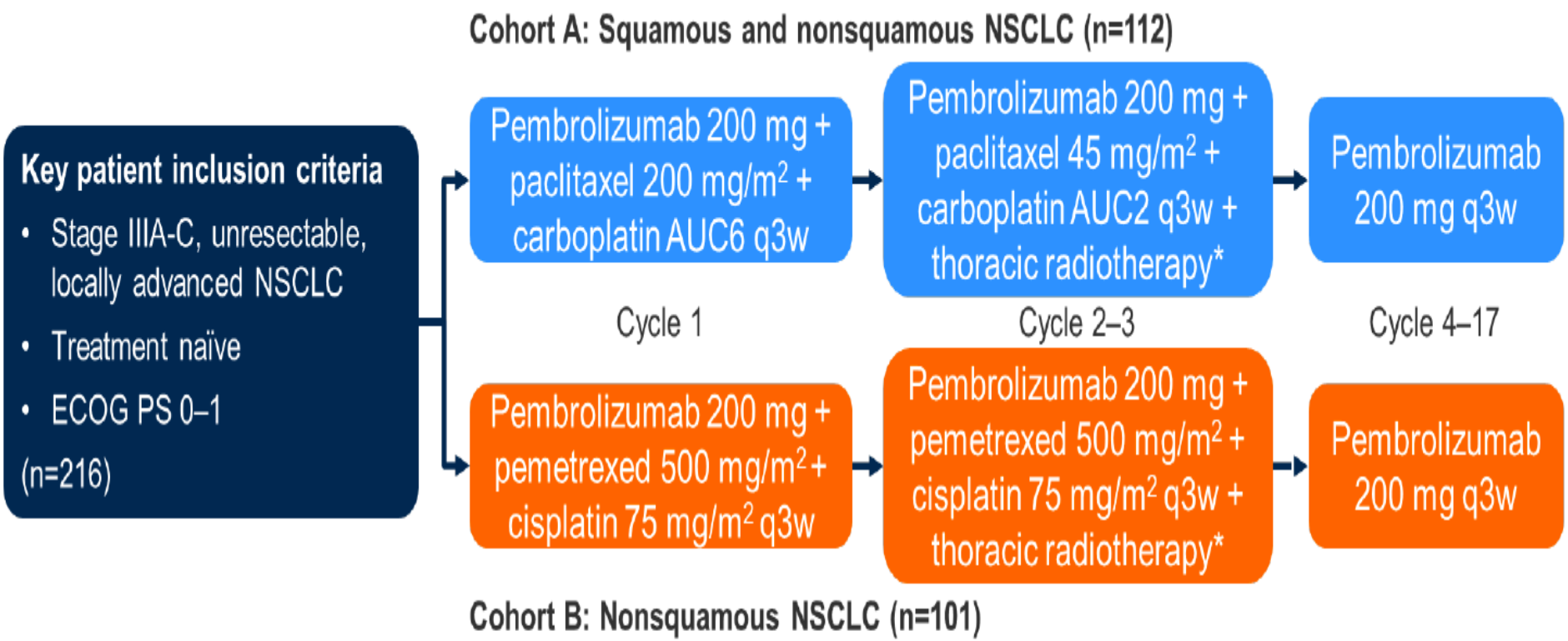
Secondary endpoints

- PFS, OS

Grade ≥3 AEs, n (%)			
Part 1 (n=10)		**Part 2 (n=30)**	
Dyspnea (G3)	1 (10)	Diarrhea (G3); radiation pneumonitis (G3)	1 (3)
Arthralgia (G3)	1 (10)	Nephritis (G3), fatigue (G3)	1 (3)
Lung infection (G5); tracheoesophageal fistula (G5)	1 (10)	Fatigue (G3)	2 (7)
		Heart failure (G3)	1 (3)
		Respiratory failure NOS (G4)	1 (3)

Lin SH, et al. J Thorac Oncol 2020

PEMBRO /CTRT IN STAGE III NSCLC



Primary endpoints

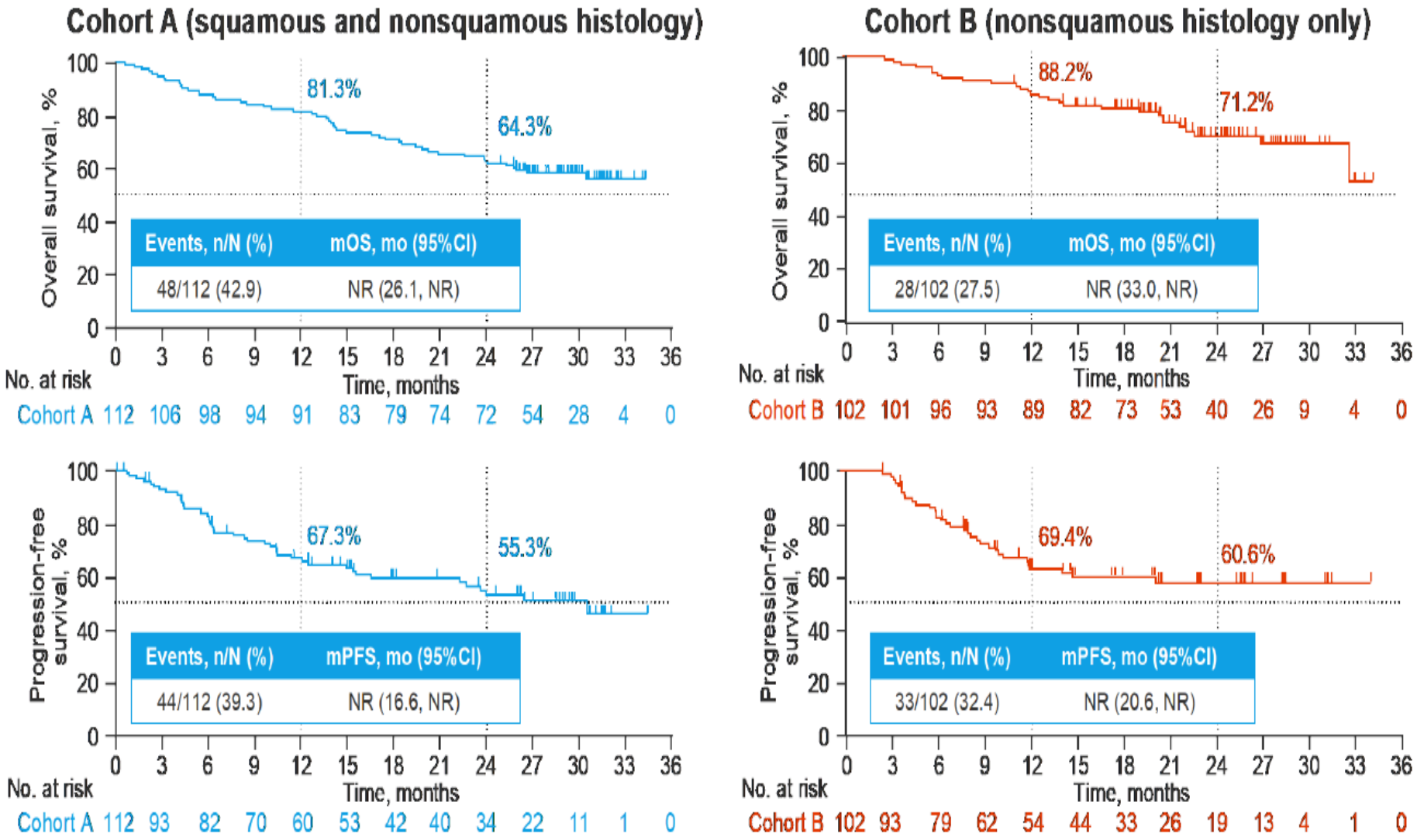
- ORR (BICR, RECIST v1.1)
- Proportion developing grade ≥3 pneumonitis

Secondary endpoints

- PFS, OS, safety

Reck M, et al. J Thorac Oncol 2021;16(suppl):Abstr OA02.03; update at 2 years, ASCO 2022

PEMBRO /CTRT IN STAGE III NSCLC



Reck M, et al. J Thorac Oncol 2021;16(suppl):Abstr OA02.03; update at 2 years, ASCO 2022

PEMBRO /CTRT IN STAGE III NSCLC

AEs, n (%)	Cohort A (n=112)	Cohort B (n=102)
Grade ≥3 pneumonitis	9 (8.0)	7 (6.9)
TRAEs	105 (93.8)	99 (97.1)
Grade 3–5	72 (64.3)	52 (51.0)
Occurring in >10%		
Neutropenia	18 (16.1)	10 (9.8)
Anemia	12 (10.7)	4 (3.9)
Led to death	4 (3.6)	1 (1.0)
Led to discontinuation	38 (33.9)	21 (20.6)
irAEs	58 (51.8)	46 (45.1)
Grade 3–5	18 (16.1)	9 (8.8)
Occurring in >10%		
Pneumonitis	7 (6.3)	6 (5.9)
Led to death	4 (3.6)	1 (1.0)
Led to discontinuation	21 (18.8)	12 (11.8)

Reck M, et al. J Thorac Oncol 2021;16(suppl):Abstr OA02.03; update at 2 years, ASCO 2022

TAKE HOME MESSAGE: Monday Morning

Stage 3 CTRT WITH IO

1: For Driver mutated mNSCLC : DURVA Yes or no , what all mutations would you consider for or against Durva

2: Would you continue Durva maintenance for GARDE I/II pneumonitis

3: Will you consider IMPT in any patient of yours with CTRT

4: Any concerns regarding Durva maintenance for patients undergoing IMPT based CTRT

5:What will be the best way to combine IO with CTRT for the future

International Journal of Molecular & ImmunoOncology

Online ISSN: 2456-3994

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