XXIV

# Simposio de Revisiones en Cáncer

*"Tratamiento médico del cáncer en el año 2022"*

## Retos del abordaje del paciente con CPNM metastásico para garantizar la supervivencia a largo plazo y calidad de vida

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ARÁN

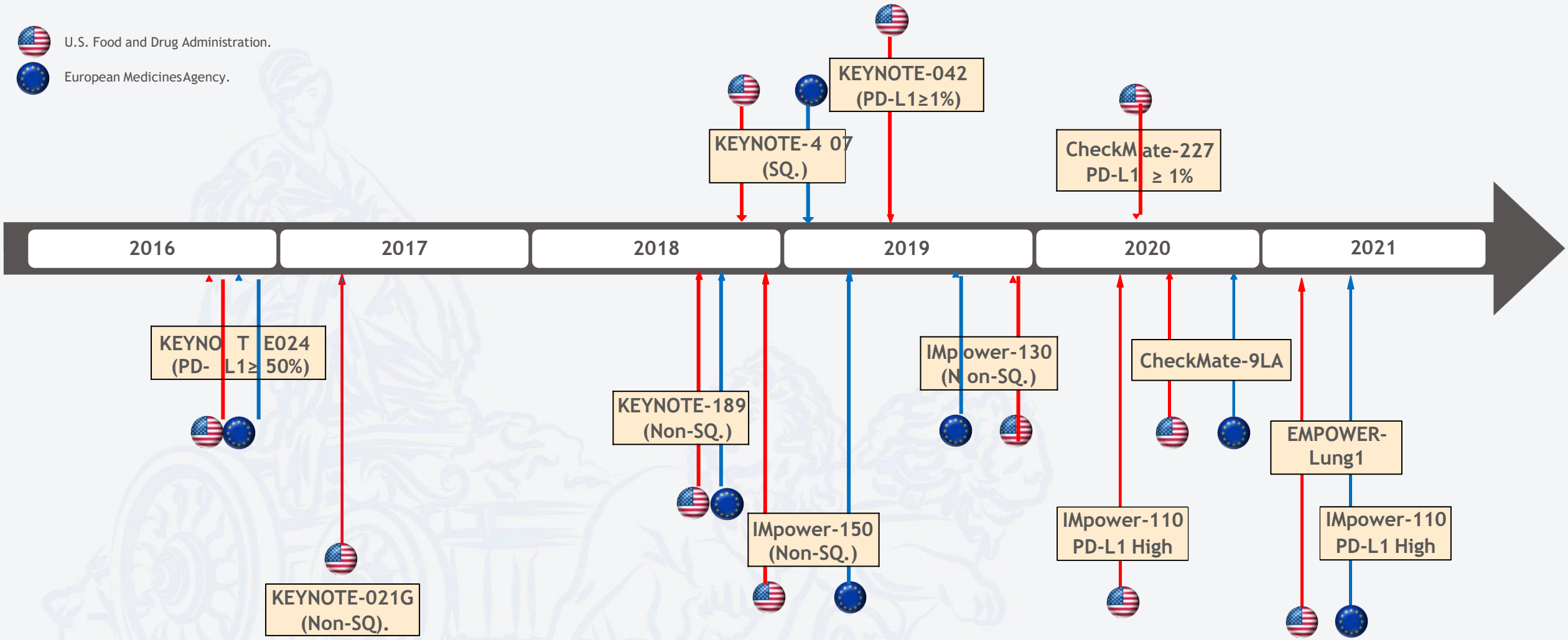
# Conflictos de interés

- Honoraria: AstraZeneca, Boehringer-Ingelheim, Pfizer, Roche, Novartis, Merck Sharp & Dohme, and Bristol-Myers Squibb.
- Consulting or advisory role: AstraZeneca, Boehringer-Ingelheim, Pfizer, Roche/Genentech, Eli Lilly and Company, Novartis, Takeda, Merck Sharp & Dohme, and Bristol-Myers Squibb.
- Research funding: Merck Sharp & Dome.
- Travel financial support: Roche, Boehringer-Ingelheim, Merck Sharp & Dohme, and Bristol-Myers Squibb.

# The rapidly evolving immunotherapy landscape in 1st line NSCLC

U.S. Food and Drug Administration.

European Medicines Agency.



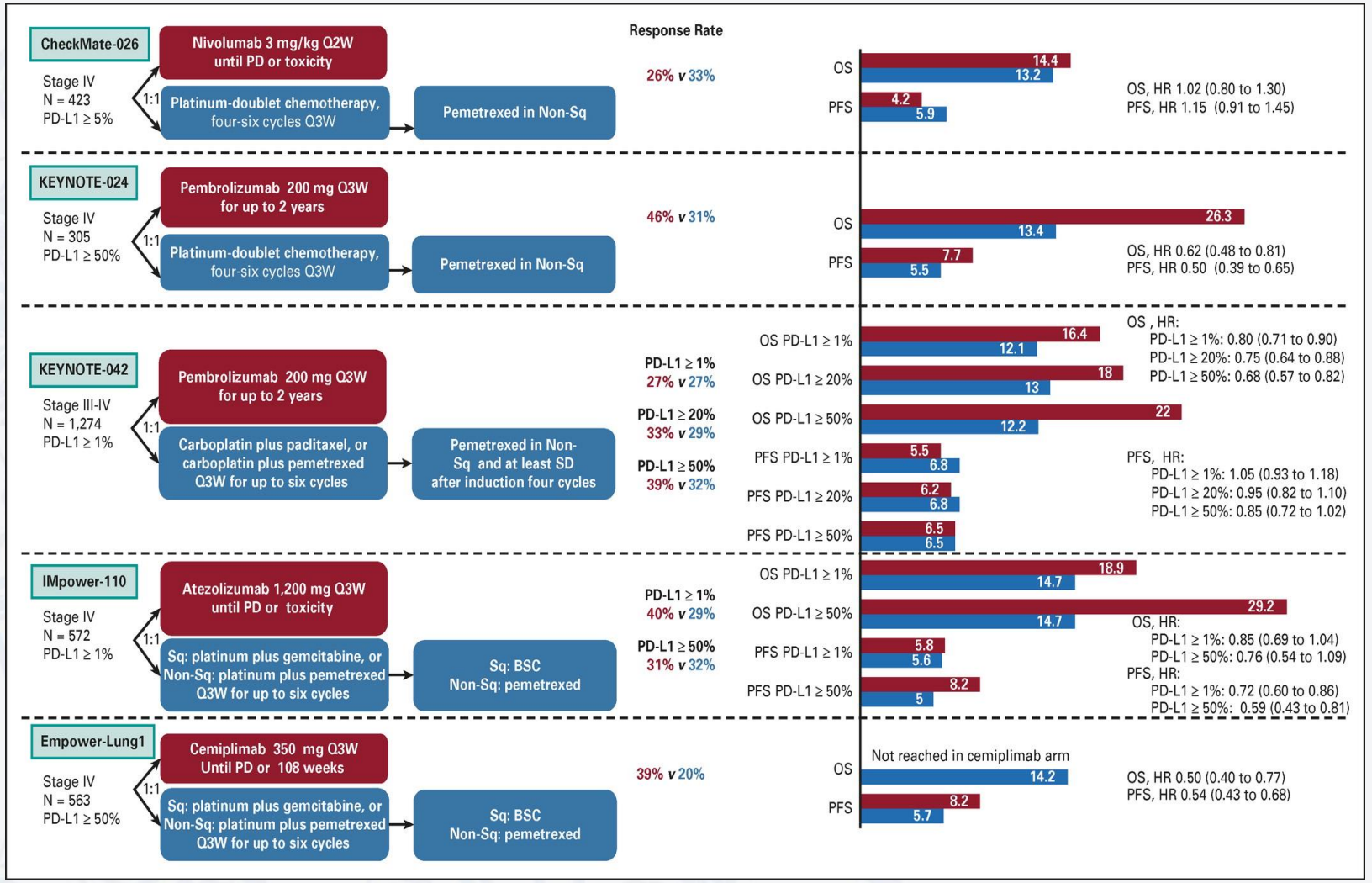

*IMpower 150, is approved in EGFR/ALK wild-type tumours by FDA, whereas EMA includes this subgroup after failure to TKII

Reck –JCO 2022

# Esquema de la presentación

1. IO en monoterapia
2. IO en combinación
3. Selección de la terapia por histología y PD-L1
4. Metástasis cerebrales
5. Largos supervivientes
6. Conclusiones

# ICI alone in 1L NSCLC (Squamous & Non-Squamous)




Reck, JCO 2022

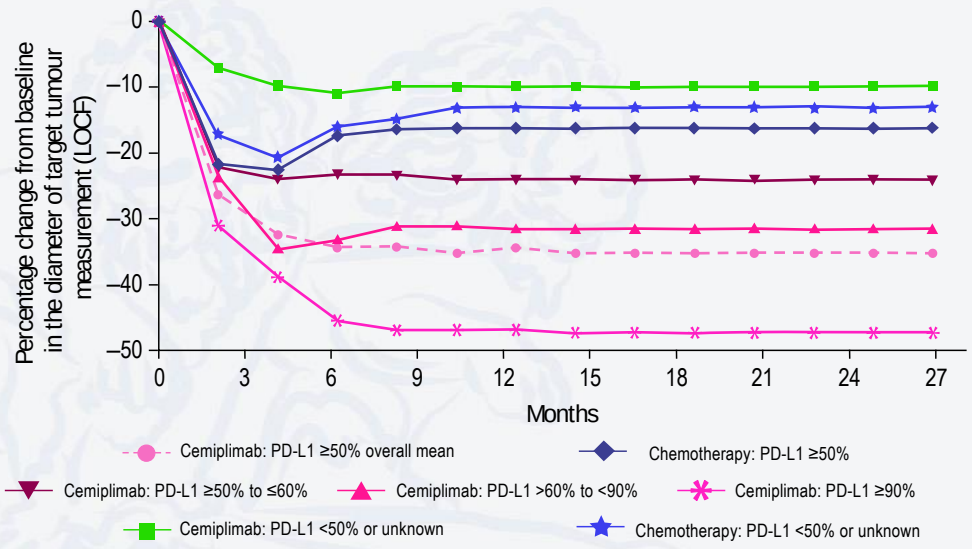
# The Benefit of I-O Monotherapy Is Established in NSCLC With High PD-L1 Expression

## Outcomes in NSCLC With High PD-L1 Expression

| Trial | Treatment | PD-L1 | ORR | Median PFS | Median OS |
|---|---|---|---|---|---|
| KEYNOTE-024[1,2] | Pembrolizumab (n=154) | ≥50% | 44.8% | 10.3 mo | 30 mo |
| IMpower110[3] | Atezolizumab (n=107) | TC3; IC3 | 38.3% | 8.1 mo | 20.2 mo |
| EMPOWER-Lung 1[4,5] | Cemiplimab (n=283) | ≥50% | 39.2% | 8.2 mo | NR |

- Most PD-L1 IHC clones interchangeable for TC score (TPS)
- PD-L1 levels of expression matter
- Never-smoker: wait for tumor genotype, lack of efficacy or sequential toxicity if driver mutation
- Benefit seen in KRASmut LUAC or hTMB
- Benefit in previously treated CNS mets, unresectable stage III not amenable for radiotherapy, elderly, or PS2

- Correlation of Change in Target Tumour Volume and ORR with Baseline PD-L1 Levels




| PD-L1 levels | ORR, % (95% CI) |
|---|---|
| ≥90% | 45.9 (35.8–56.3) vs 18.1 (10.9–27.4) |
| >60 to <90% | 39.3 (29.1–50.3) vs 20.0 (12.3–29.8) |
| ≥50 to ≤60% | 32.3 (23.1–42.6) vs 22.9 (15.0–32.6) |
| 50% or unknown | 26.0 (16.5–37.6) vs 21.6 (12.9–32.7) |

Cemiplimab vs Chemotherapy

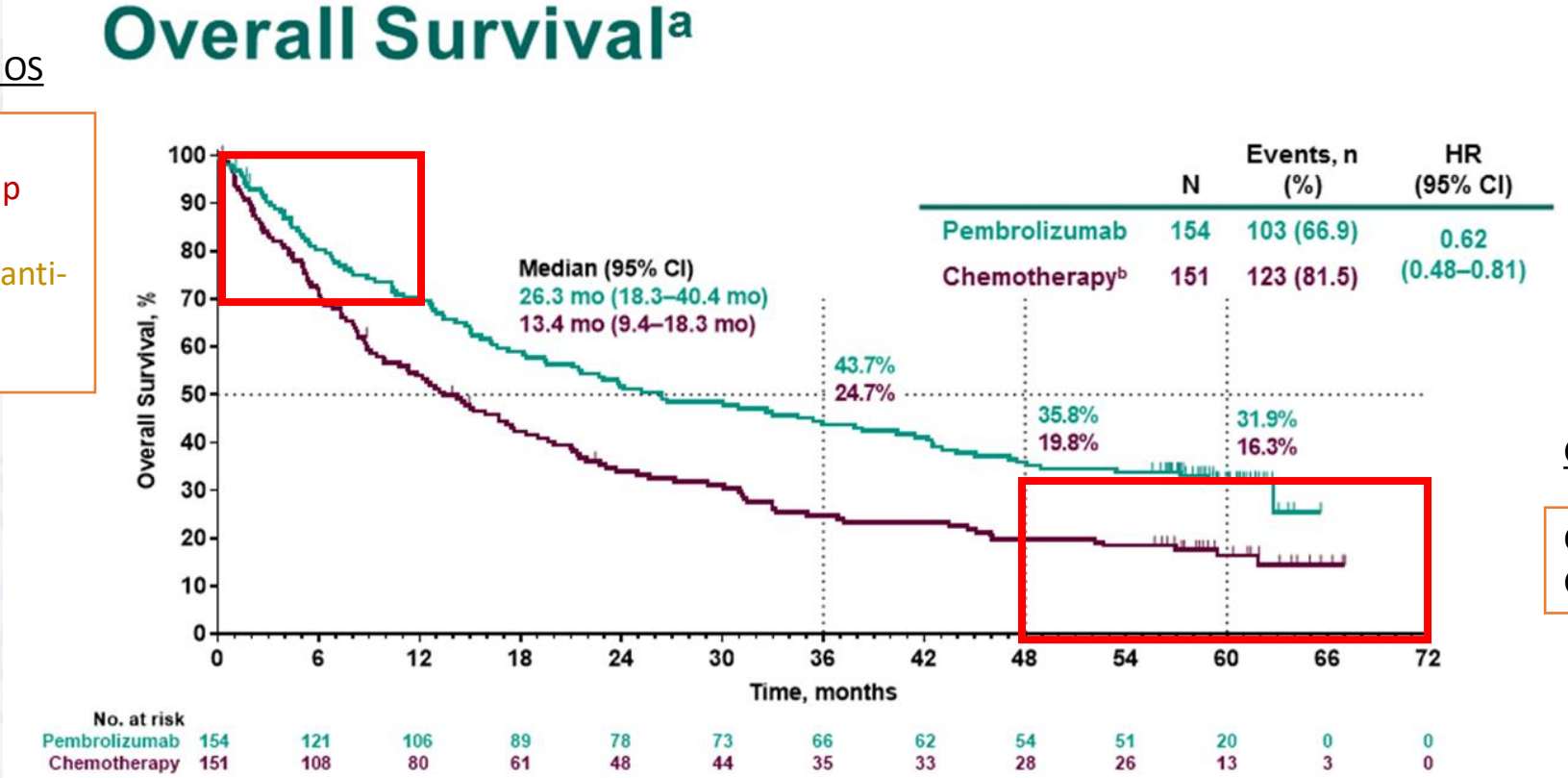
•CI, confidence interval; LOCF, last observation carried forward; ORR, objective response rate; PD-L1, programmed cell death-ligand 1.

Data cut-off date: 1 March 2020 (interim analysis #2)

# Long-term survival achieved in 1/3 pts with IO monotherapy… but another 1/3 die during the 1st year

## KN-024, 5-year OS update

J Brahmer. ESMO 2020




Strategies to improve OS

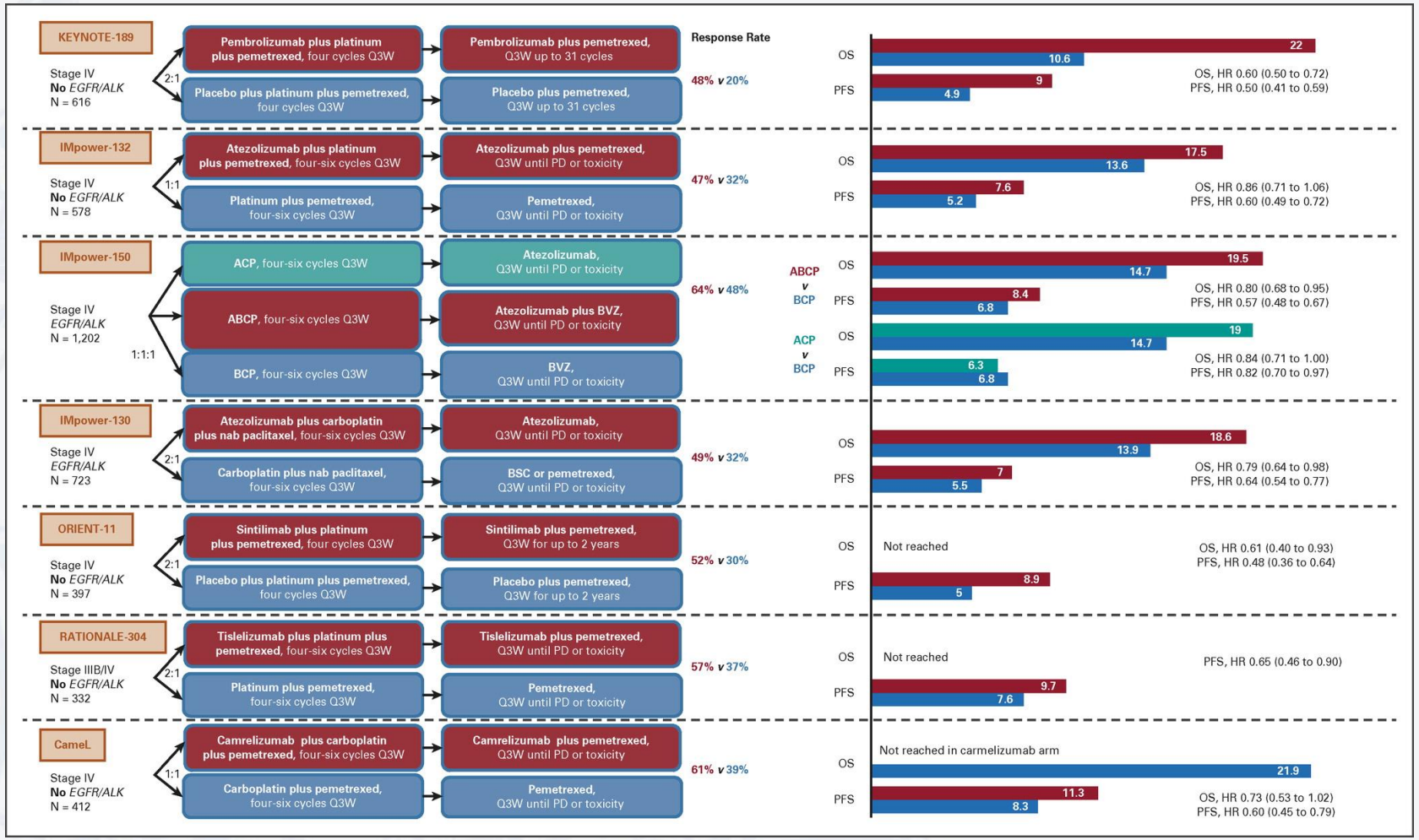
anti-CTLA4, TGF-b trap (bintrafusp alfa), anti-TIGIT, chemotherapy, anti-VEGF

- Failed
- No ph3 RCT

Characteristics of LT survivors

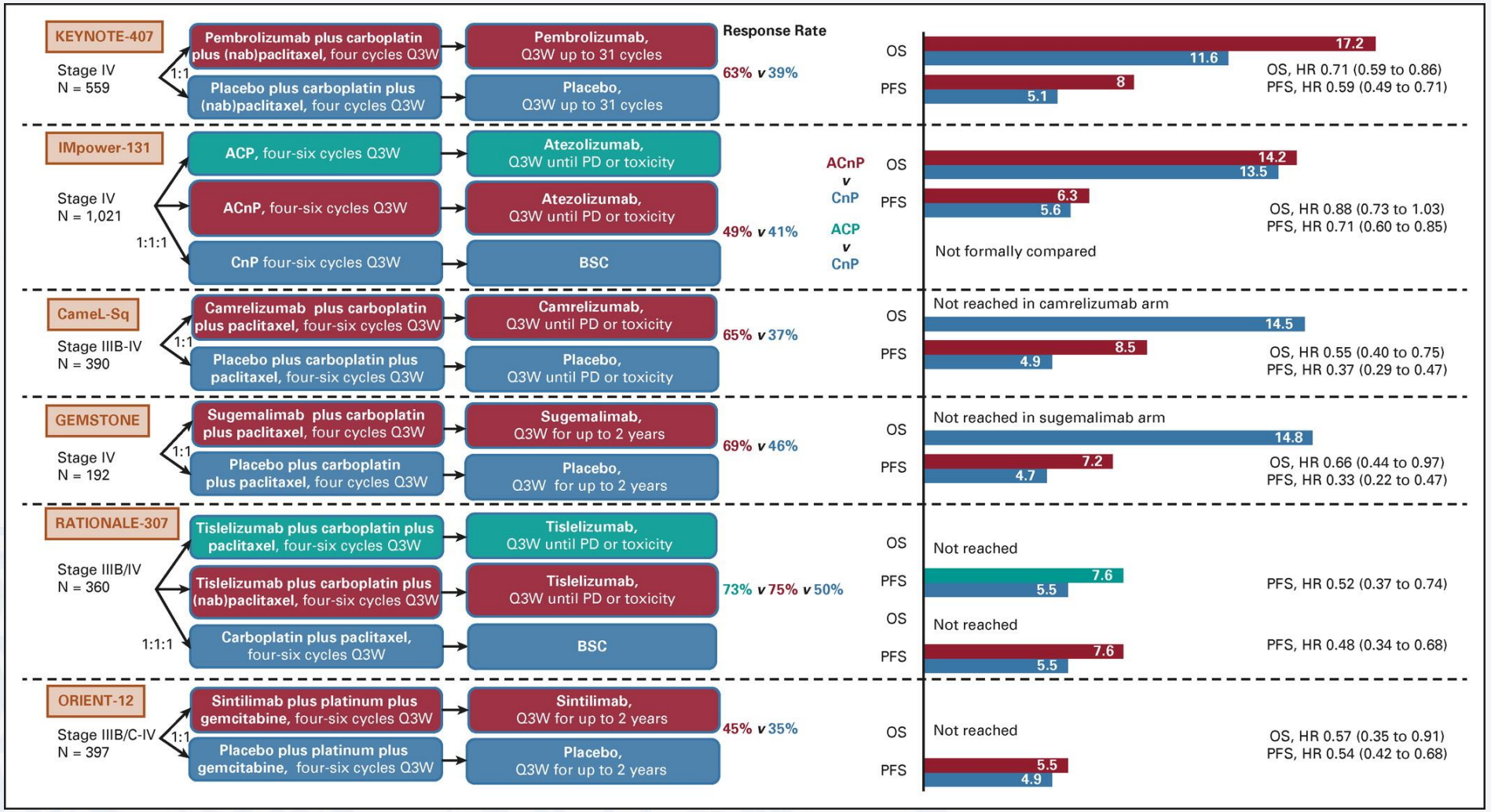
Completion of 2y of treatment
CR/RP as best response

# Inmuno-chemotherapy in 1L Non-Squamous NSCLC



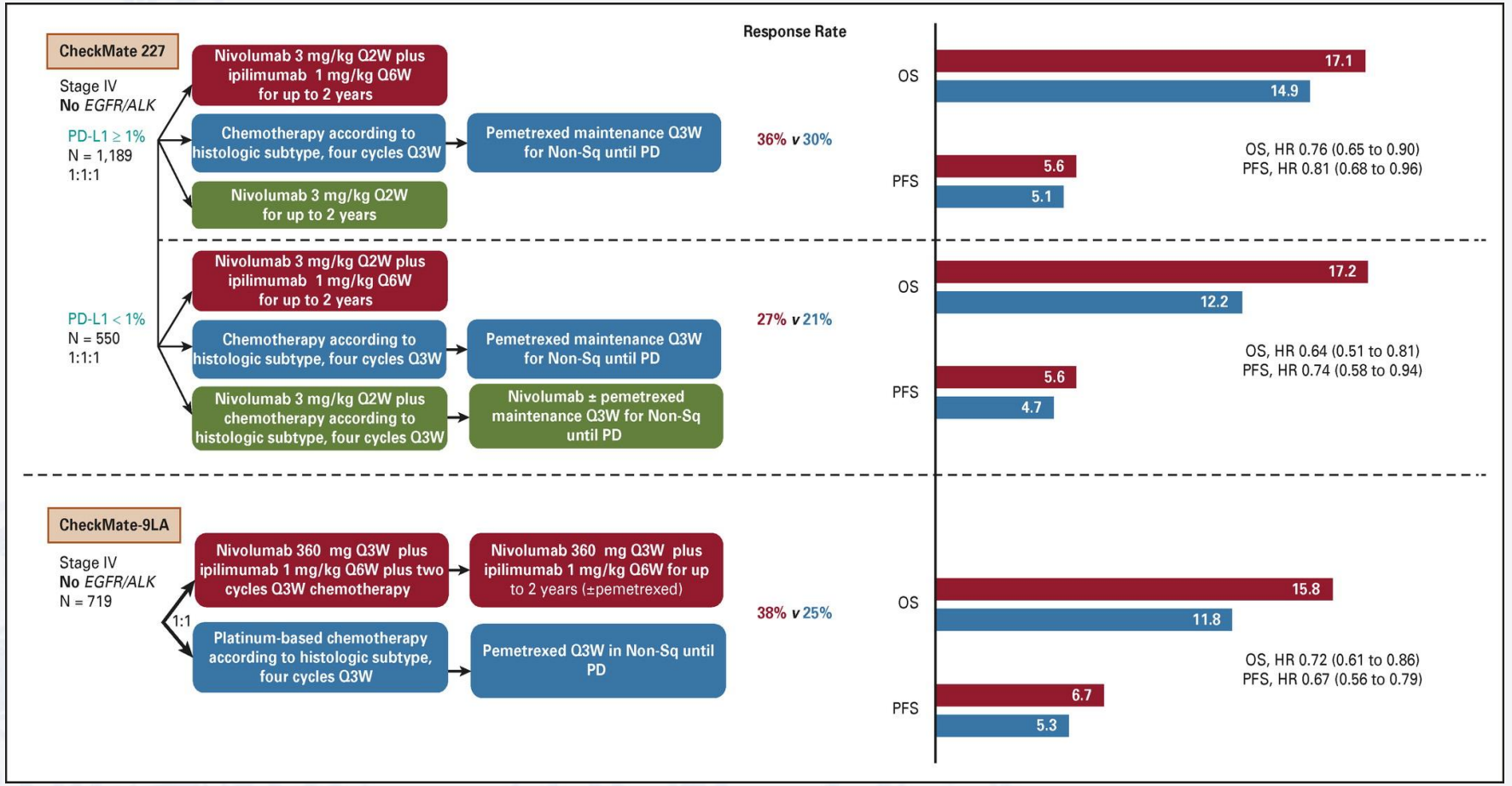

Reck, JCO 2022

# Inmuno-chemotherapy in 1L Squamous NSCLC




Reck, JCO 2022

# Inmuno+Inmuno +/- chemotherapy in 1L NSCLC

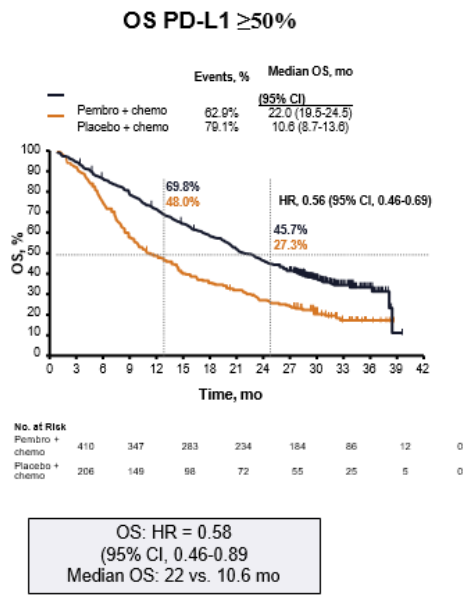


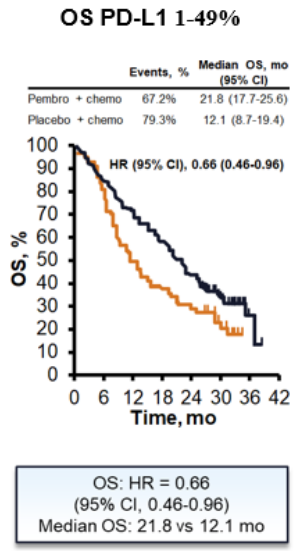

Reck, JCO 2022

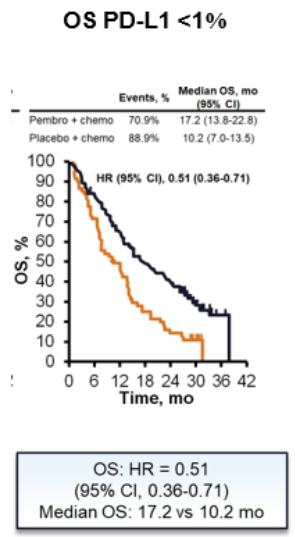
# The Benefit of I-O Combinations Is Established in NSCLC regardless of PD-L1 expression

- Evita riesgo de progresión precoz/HPD
- Beneficio menos dependiente de PD-L1, TMB, carga tumoral o biología
- Incremento toxicidad asociado a quimioterapia o anti-CTLA4
- 2 ciclos de quimioterapia + IO podría ser suficiente
- Suspensión de IO por irAE no tiene por qué impactar negativamente en OS
- Largos supervivientes: CR/PR, completar tratamiento

KEYNOTE-189 Final Analysis: OS by PD-L1 status[1]



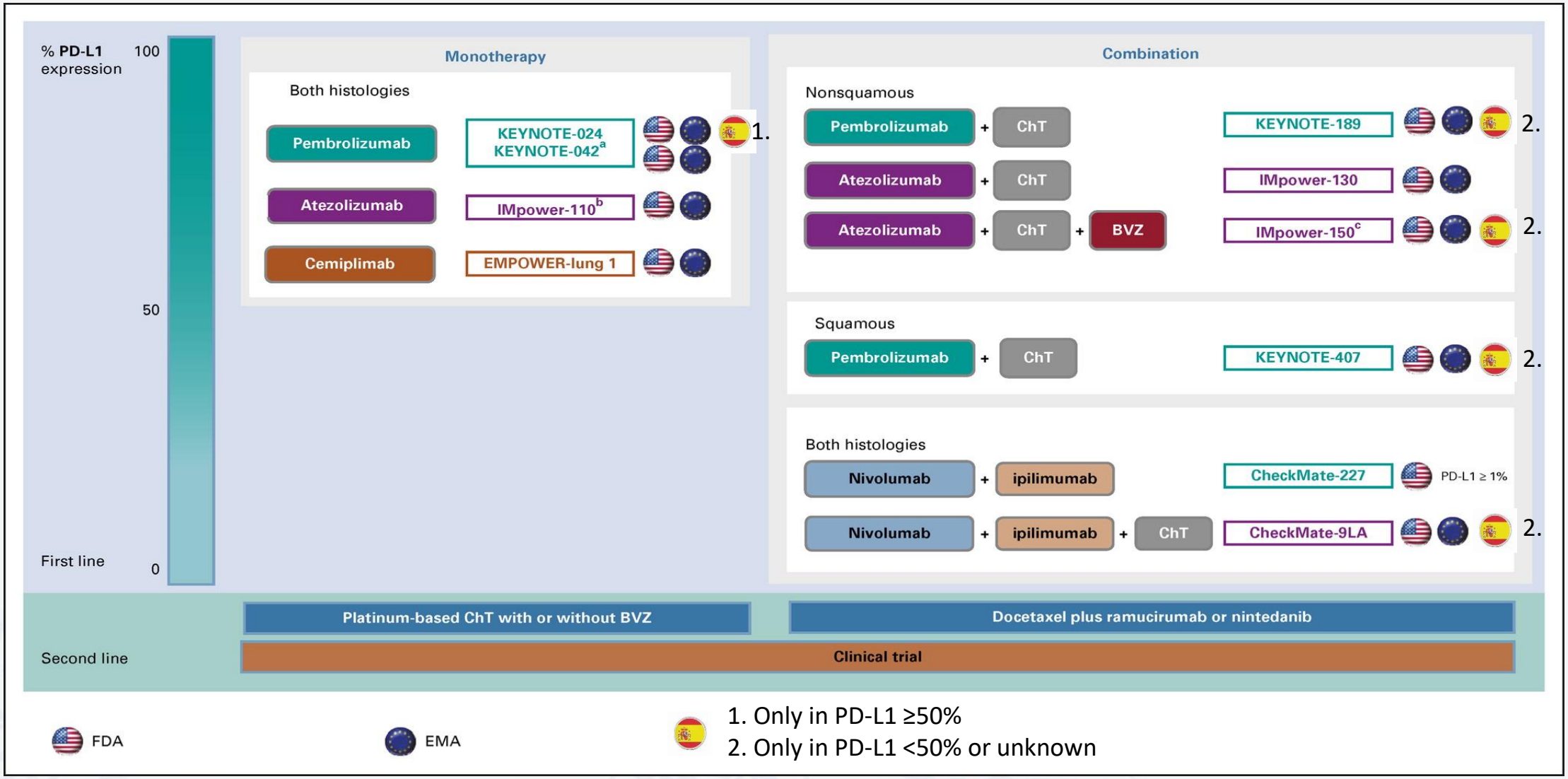




Forde, WCLC 2021

1. Rodriguez-Abreu D et al. ASCO 2020. Abstract 9582.

# First-line IO in Stg IV NSCLC by histology & PD-L1 …and availability




1. Only in PD-L1 ≥50%
2. Only in PD-L1 <50% or unknown

Modified from Reck, JCO 2022

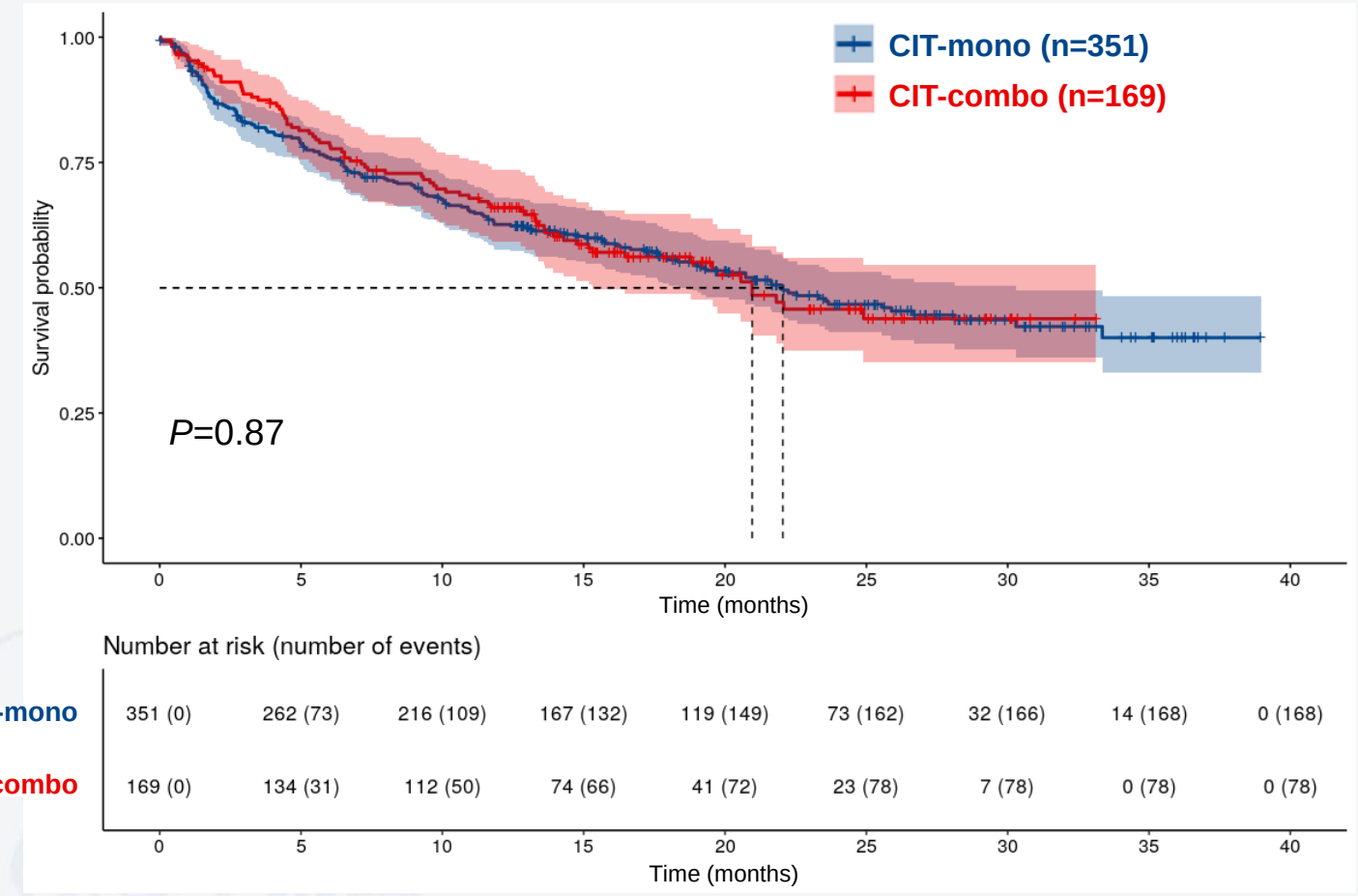
# PD-L1 ≥50% NSCLC, IO alone is sufficient

**Unadjusted analysis**

| | CIT-mono (n=351) | CIT-combo (n=169) |
|---|---|---|
| Events, n (%) | 168 (49) | 78 (46) |
| **OS, mo** Median (95% CI) | 22.05 (18.33, 30.29) | 20.96 (15.31, NA) |
| **Follow-up, mo** Median (IQR) | 23.46 (15.74, 28.71) | 19.92 (14.92, 26.25) |

| CIT-combo vs CIT-mono (reference) | Hazard ratio (95% CI) | *P* value |
|---|---|---|
| Unadjusted analysis | 0.98 (0.75, 1.28) | 0.868 |
| Adjusted analysis | 1.03 (0.77, 1.39) | 0.833 |

**PD-L1 ≥ 50%**

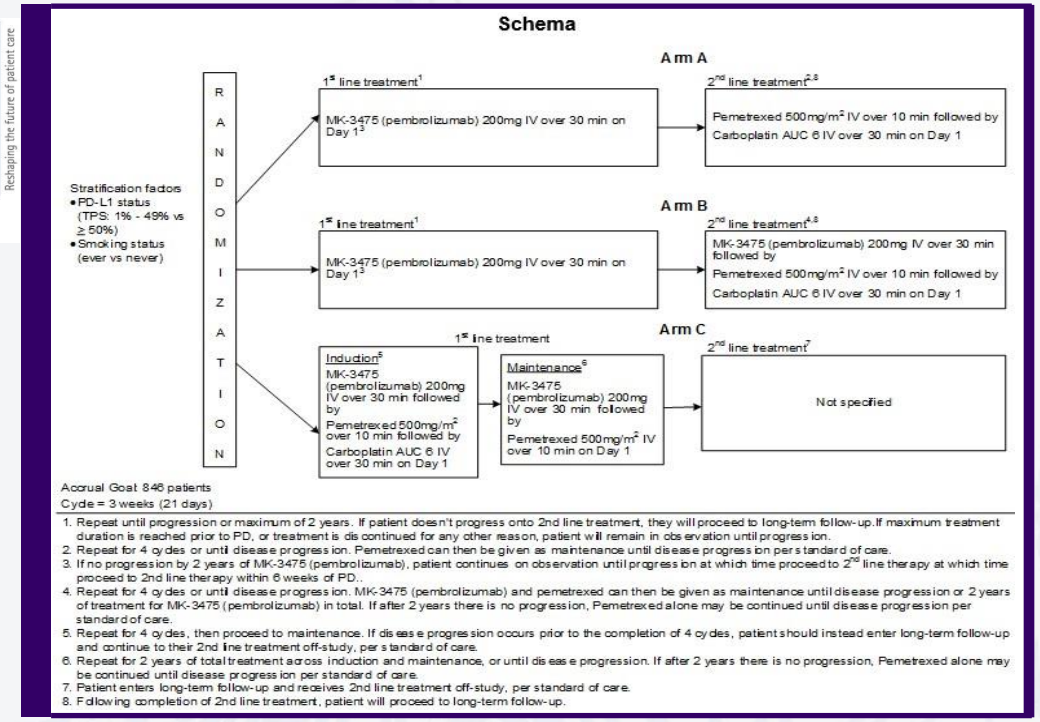



Peters S; ESMO 2020

# PD-L1 ≥50%: Pembrolizumab vs. Pembrolizumab + Chemotherapy?

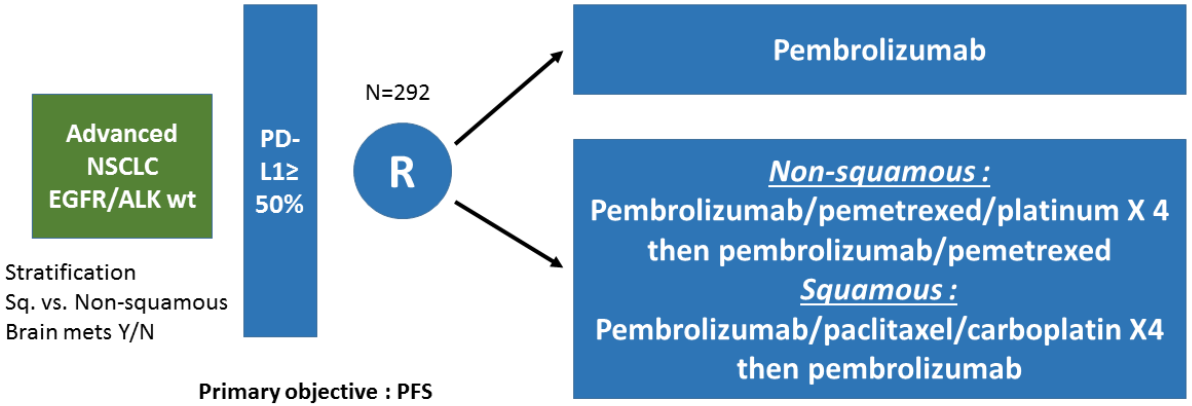
## EA5163/S1709/INSIGNA

ECOG-ACRIN cancer research group — Reshaping the future of patient care




## PERSEE Trial ongoing

*NCT04547504*



# PD-L1 1-49% NSCLC, combos are better

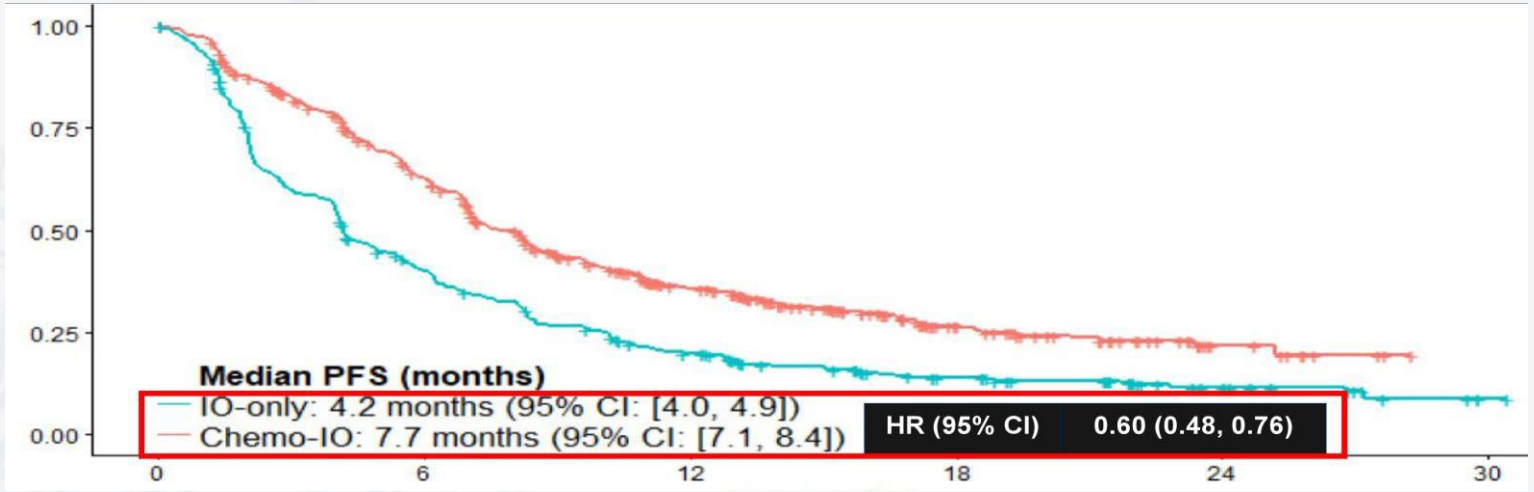
FDA

| Trial* |
|---|
| **Immunotherapy-only (PD-L1 ≥1%)** |
| KEYNOTE-042 |
| CHECKMATE-227 |
| **Chemo-immunotherapy** |
| KEYNOTE-189 |
| KEYNOTE-407 |
| KEYNOTE-021 (cohort G) |
| IMPOWER-150** |
| IMPOWER-130 |
| CA2099LA |

**Chemo-IO, N=530.**
**IO-only, N=239**

**OS**


**PFS**




Akinboro – ASCO 2021

# What IO-combo is better?

**Median OS (HR)**

| Study | PD-L < 1% | PD-L1 1-49% | PD-L1 ≥ 50% |
|---|---|---|---|
| CM-227 | 17.2 (0.62) | 15.1 (0.94) | 21.2 (0.66)* |
| 9LA | 16.8 (0.62) | 15.4 (0.61) | 18.9 (0.67) |
| KN-189, 021, 407# | 19 (0.63) | - | - |
| KN-189 | 17.2 (0.51) | 21.8 (0.66) | 22 (0.58) |
| KN-024 | - | - | 26.3 (0.62)$ |

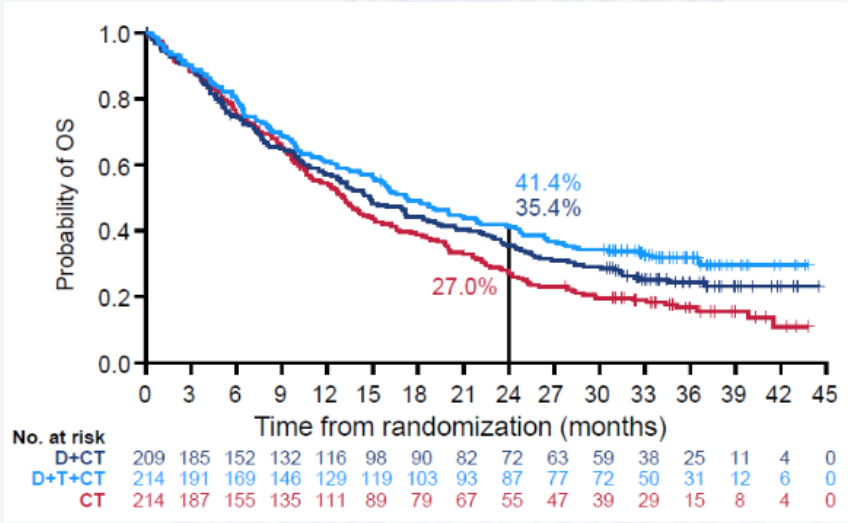
# Pooled analysis; *Four Year FU; $ Five yr OS

Hellman, NEJM, 2019; Paz-Ares. Lancet Onc, 2021; Borghaei, Cancer 2020; Gandhi, NEJM 2018, Brahmer ESMO 2020, Paz-Ares, ASCO 2021; Rodrigues-Abreu ASCO 2020

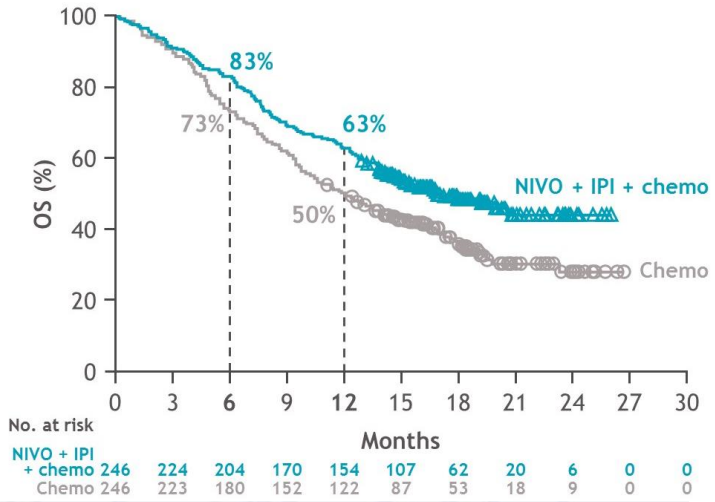
# OS in Patients With Nonsquamous NSCLC

| | POSEIDON[1,a] | CM9LA[2,b] | KN189[3,c] |
|---|---|---|---|
| OS HR (95% CI) | D + T + CTx: 0.70 (0.56-0.87) | 0.69 (0.55-0.87) | 0.56 (0.46-0.69) |
| OS median, m | 17.2 vs 13.1 | 17.0 vs 11.9 | 22.0 vs 10.6 |

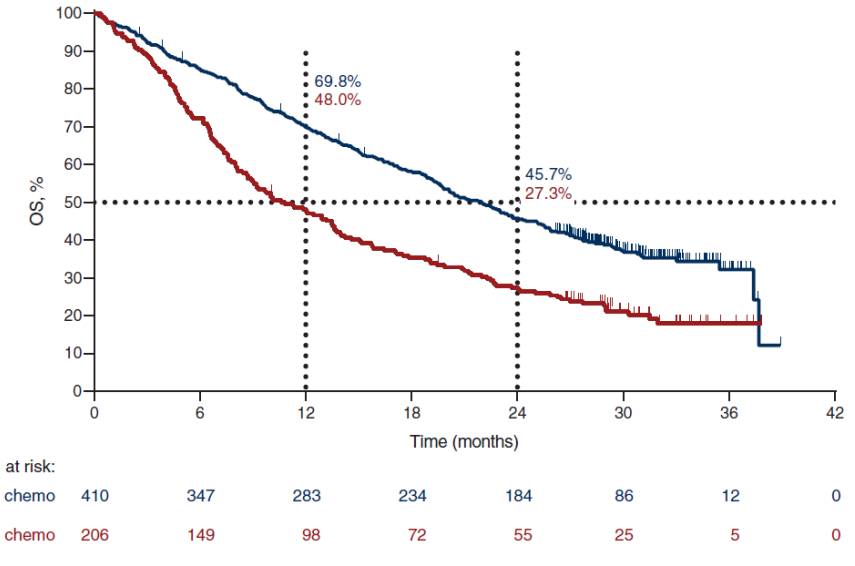
## POSEIDON




## CheckMate 9LA




## KEYNOTE-189




[a]Median follow-up in censored patients at data cutoff: 34.9 months (range: 0-44.5).[1] [b]Minimum follow-up of 12.7 months.[2] [c]Median follow-up of 31.0 months.[3]

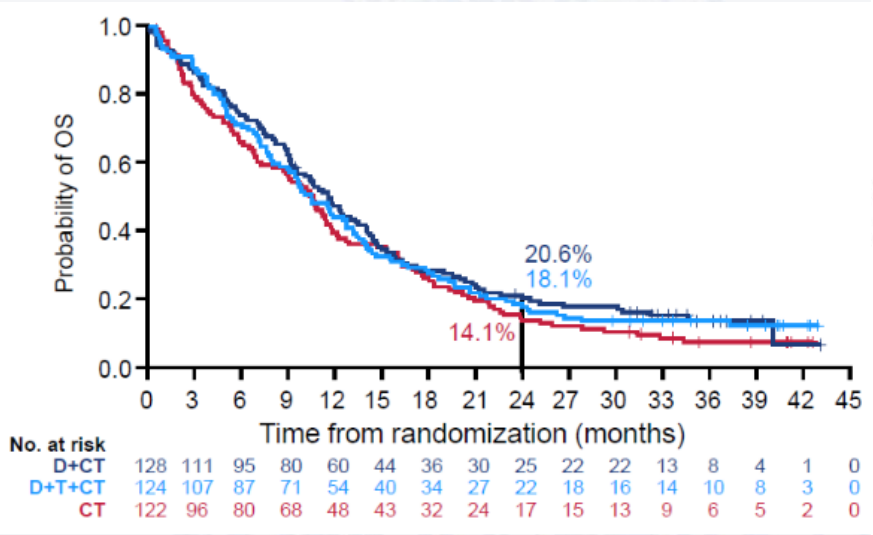
D, durvalumab; CI, confidence interval; CM9LA, CheckMate 9LA; CT/CTx/chemo, chemotherapy; HR, hazard ratio; KM, Kaplan-Meier; KN189, KeyNote 189; NSCLC, non-small cell lung cancer; OS, overall survival; pembro, pembrolizumab.

1. Johnson ML, et al. Presented at: 2021 World Conference on Lung Cancer; September 8-14, 2021; virtual. 2. Reck M, et al. Presented at: ASCO 2020; May 29-June 2, 2020; virtual. Abstract 9501000. 3. Rodríguez-Abreu D. *Ann Oncol.* 2021;32(7):881-895.

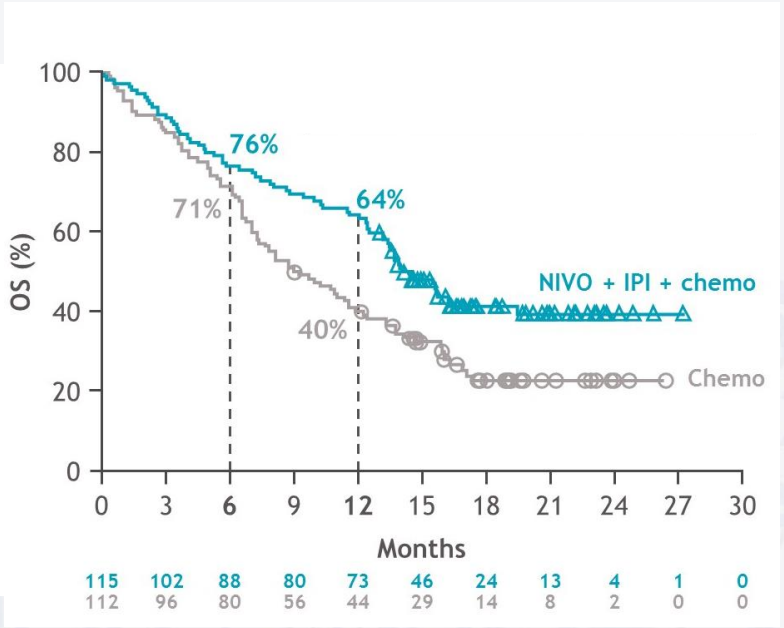
# OS in Patients With Squamous NSCLC

| | POSEIDON[1,a] | CM9LA[2,b] | KN407[3,c] |
|---|---|---|---|
| OS HR (95% CI) | D + T + CTx: 0.88 (0.68-1.16) | 0.62 (0.45-0.86) | 0.71 (0.58-0.88) |
| OS median, m | 10.4 vs 10.5 | 14.5 vs 9.1 | 17.1 vs 11.6 |

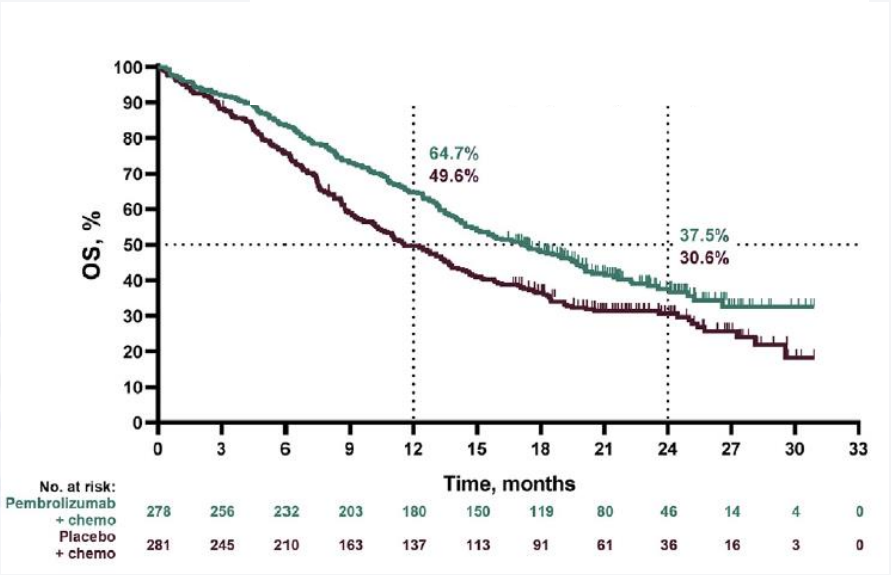
## POSEIDON




## CheckMate 9LA




## KEYNOTE-407




[a]Median follow-up in censored patients at data cutoff: 34.9 months (range: 0-44.5).[1] [b]Minimum follow-up of 12.7 months.[2] [c]Median follow-up of 14.3 months (range: 0.1-31.3).[3]

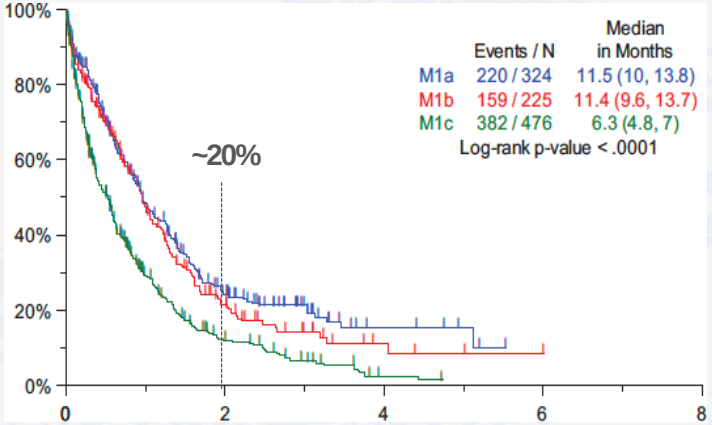
CI, confidence interval; CM9LA, CheckMate 9LA; CT/CTx/chemo, chemotherapy; D, durvalumab; HR, hazard ratio; KN407, KeyNote 407; NSCLC, non-small cell lung cancer; OS, overall survival; T, tremelimumab.

1. Johnson ML, et al. Presented at: 2021 World Conference on Lung Cancer; September 8-14, 2021; virtual. Reck M, et al. Presented at: ASCO 2020; May 29-June 2, 2020; virtual. 3. Paz-Ares L, et al. *J Thorac Oncol*. 2020;15(10):1657-1669.

# Combos improve outcomes, long-term survivors

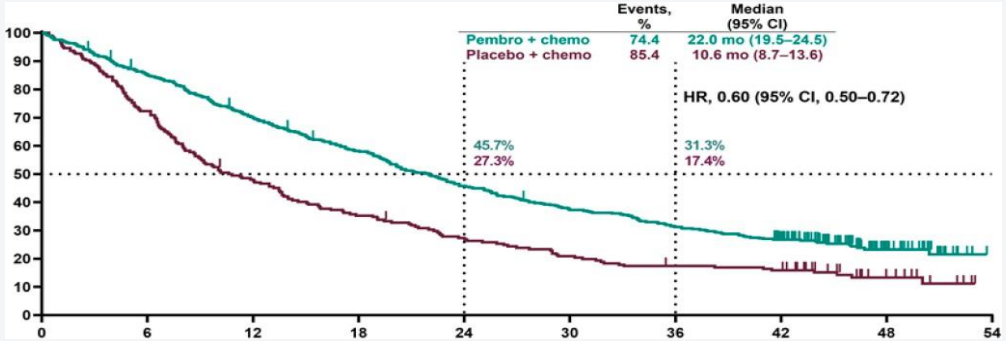
## 2-year OS in Stage IV 8th TNM is ~20%

| Proposed | Events / N | MST | 24 Month | 60 Month |
|---|---|---|---|---|
| IA1 | 68 / 781 | NR | 97% | 92% |
| IA2 | 505 / 3105 | NR | 94% | 83% |
| IA3 | 546 / 2417 | NR | 90% | 77% |
| IB | 560 / 1928 | NR | 87% | 68% |
| IIA | 215 / 585 | NR | 79% | 60% |
| IIB | 605 / 1453 | 66.0 | 72% | 53% |
| IIIA | 2052 / 3200 | 29.3 | 55% | 36% |
| IIIB | 1551 / 2140 | 19.0 | 44% | 26% |
| IIIC | 831 / 986 | 12.6 | 24% | 13% |
| IVA | 336 / 484 | 11.5 | 23% | 10% |
| IVB | 328 / 398 | 6.0 | 10% | 0% |



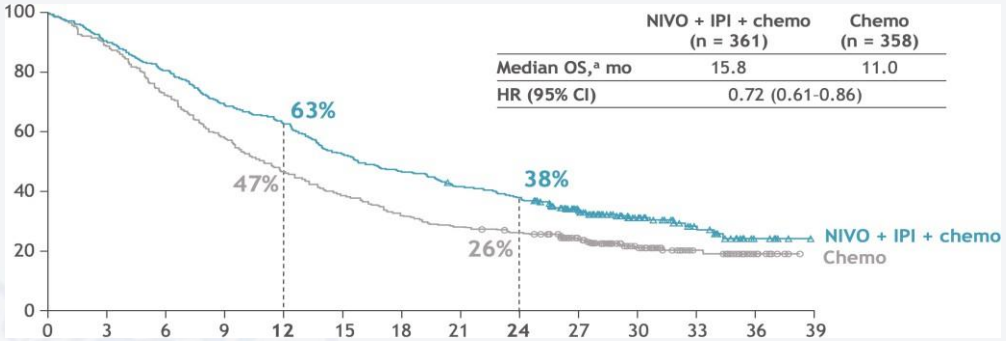

## KEYNOTE 189

**2-yOS: 46%**



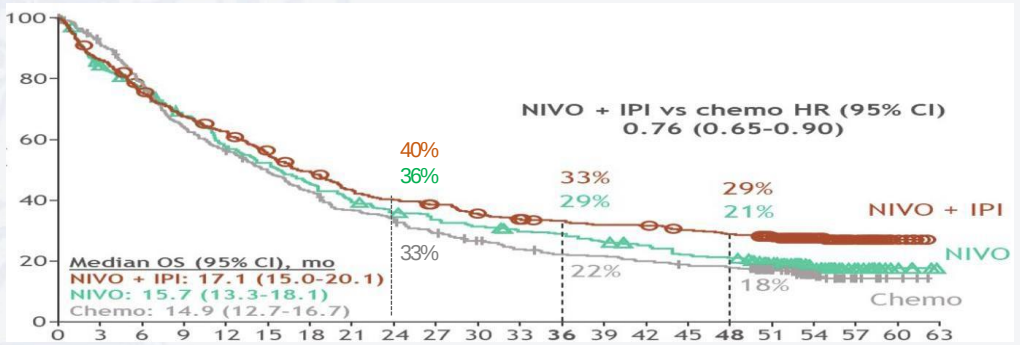

## CheckMate9LA

**2-yOS: 38%**



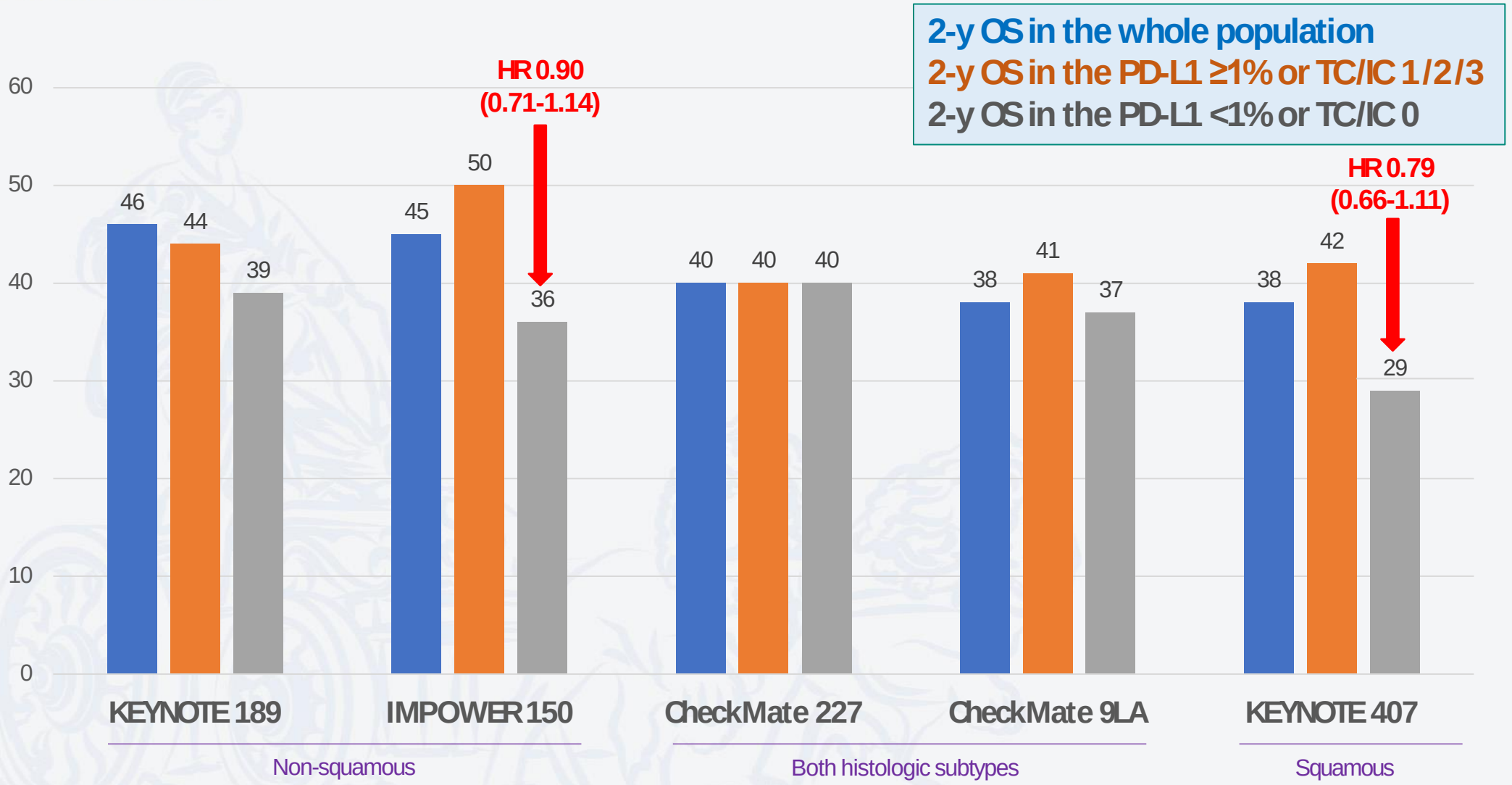

## CheckMate227 (PD-L1≥1%)

**2-yOS: 40%**




Goldstraw – JTO 2015 * Gray – WCLC 2020 * Reck – ASCO 2020 * Paz-Ares – JTO 2021

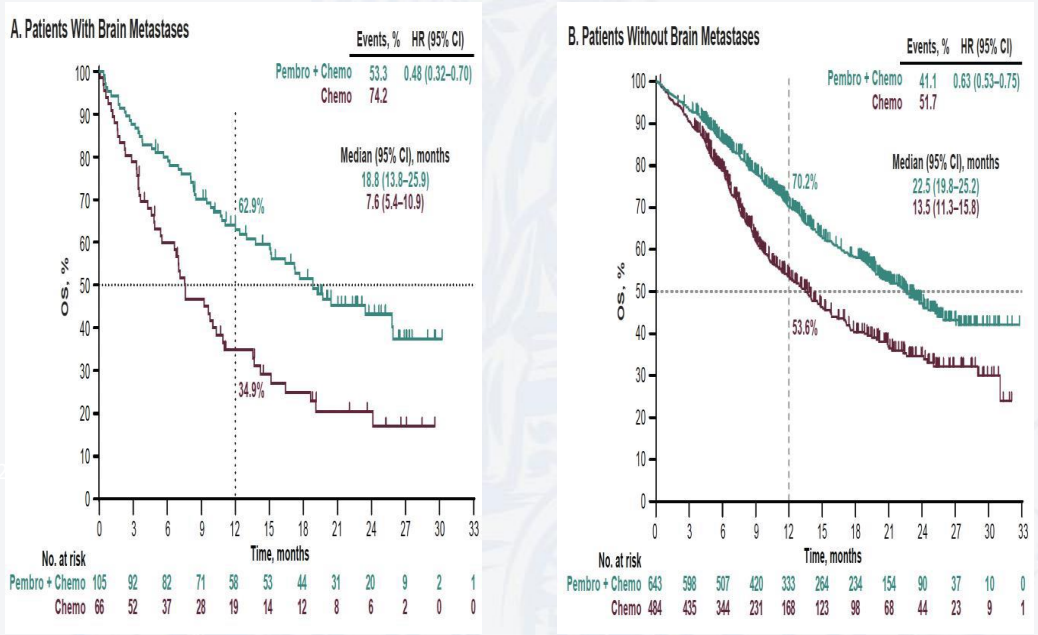
# Similar 2-year OS regardless of the strategy




Rodriguez- Abreu – Ann Oncol 2021 * Socinski – JTO 2021 * Ramalingam –ASCO 2020 * Reck – ASCO 2021 * Paz-Ares –JTO 2021

# Brain metastases and chemo-immunotherapy (selected population)

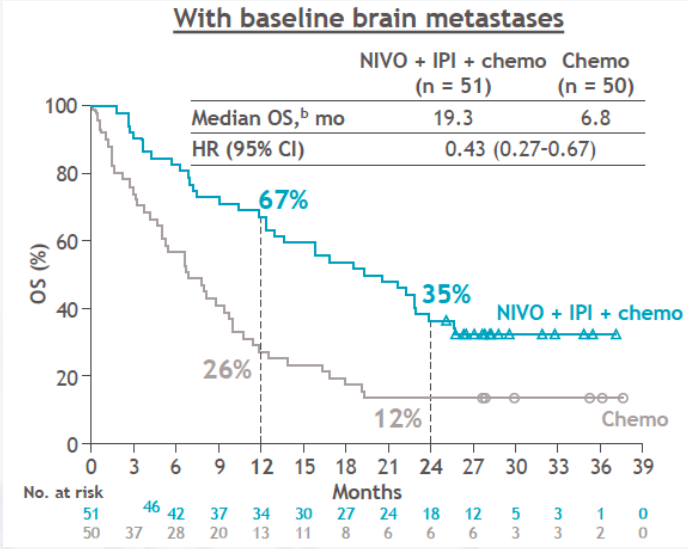
Pooled analyses KN021, KN189, KN407

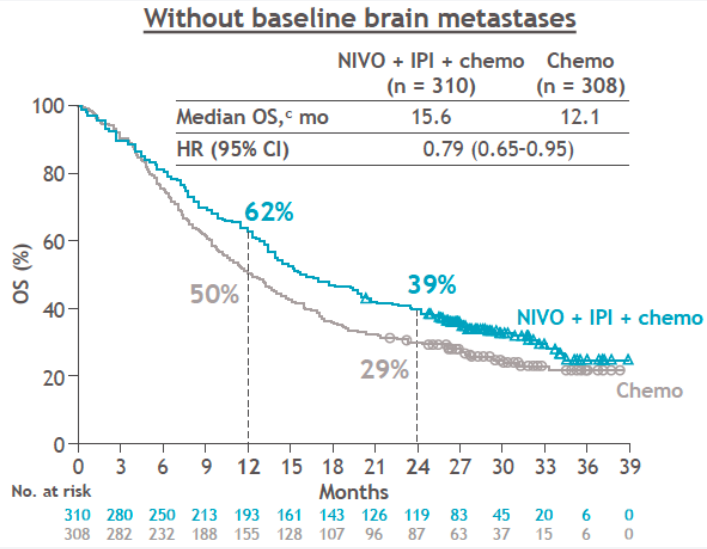






CM-9LA




Powell –ESMO 2019; Gadgeel–JCO 2020 ; Carbonne–WCLC 2021

# Untreated brain metastasis and chemo-immunotherapy
## *ATEZOBRAIN TRIAL (SLCG-GECP)*

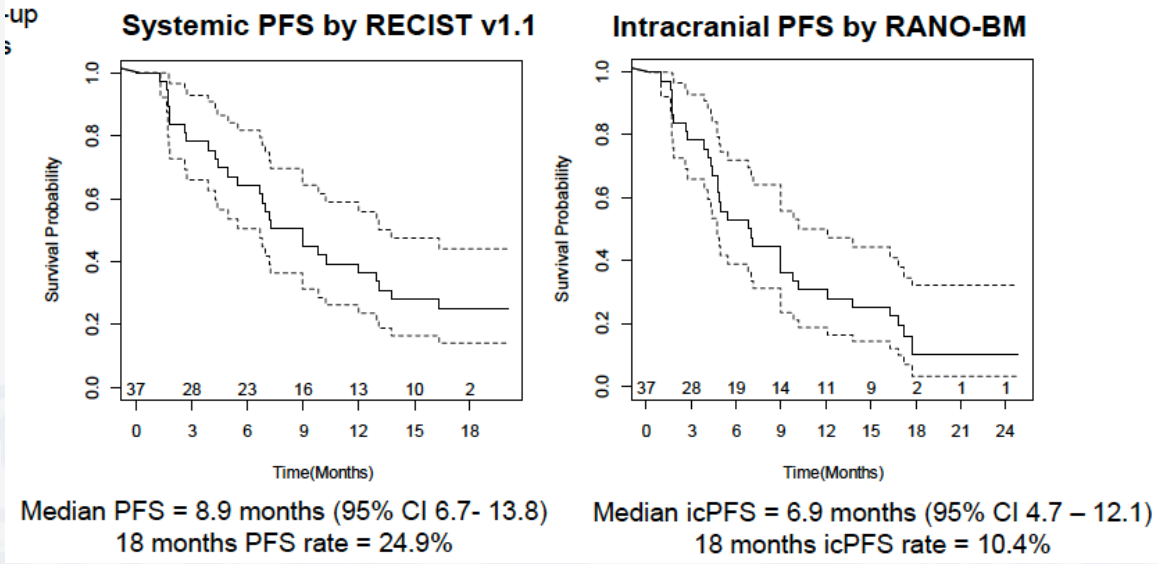
**Single arm phase II clinical trial**

**Key Elegibility Criteria:**
Stage IV non-squamous NSCLC
Untreated brain metastases
Treatment naïve
*EGFR/ALK* negative, any PD-L1
ECOG PS 0-1
Anticonvulsivants and dexamethasone ≤ 4 mg qd allowed
Measurable systemic and brain lesion/s

**Carboplatin (5 AUCs) + Pemetrexed 500mg/m² + Atezolizumab 1200mg Q3W for 4-6 cycles** → **Pemetrexed 500mg/m2 + Atezolizumab 1200mg Q3W until tumor progression (*), unacceptable toxicity or 2 years**

Tumor evaluation by body CT scan and brain MRI Q6W until the 12th week and thereafter Q9W until PD

(*) If exclusive CNS PD, patients could continue on study after brain RT

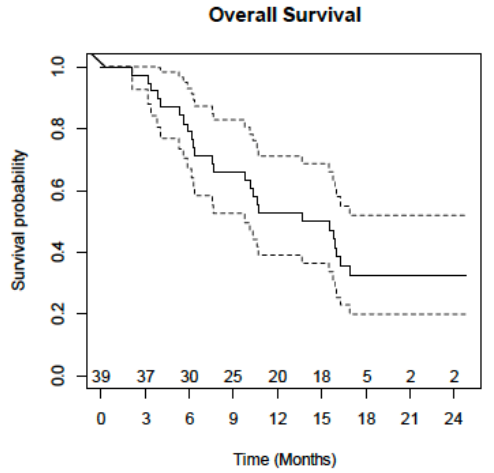



Median PFS = 8.9 months (95% CI 6.7- 13.8)
18 months PFS rate = 24.9%

Median icPFS = 6.9 months (95% CI 4.7 – 12.1)
18 months icPFS rate = 10.4%

| | Best Intracranial Response (RANO-BM) | Best Systemic Response (RECIST v1.1) |
|---|---|---|
| CR | 4 (10%) | 0 |
| PR | 12 (30%) | 19 (47.5%) |
| SD | 19 (47.5%) | 16 (40%) |
| PD | 4 (10%) | 3 (7.5%) |
| NE | 1 (2.5%) | 2 (5%) |
| **ORR** | **16 (40%)** | **19 (47.5%)** |

Only 4 patients had discordance among systemic and CNS response:
- 2 with PD in body and SD in brain
- 2 with PD in brain and PR in body

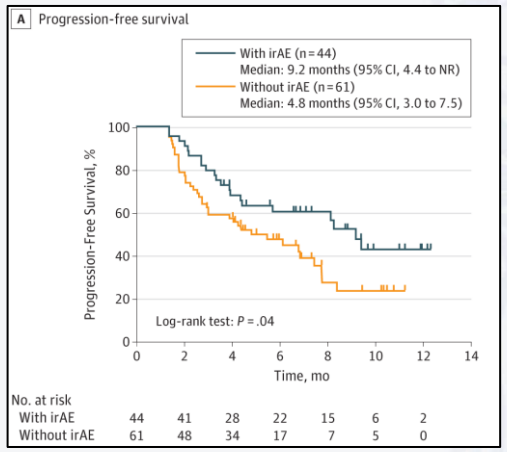


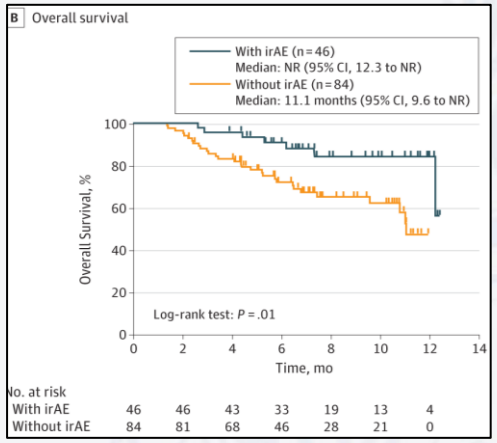

Median OS = 13.6 (95% CI 9.7 – NR)
2y OS rate = 32%

Nadal E. et al. WCLC 2021

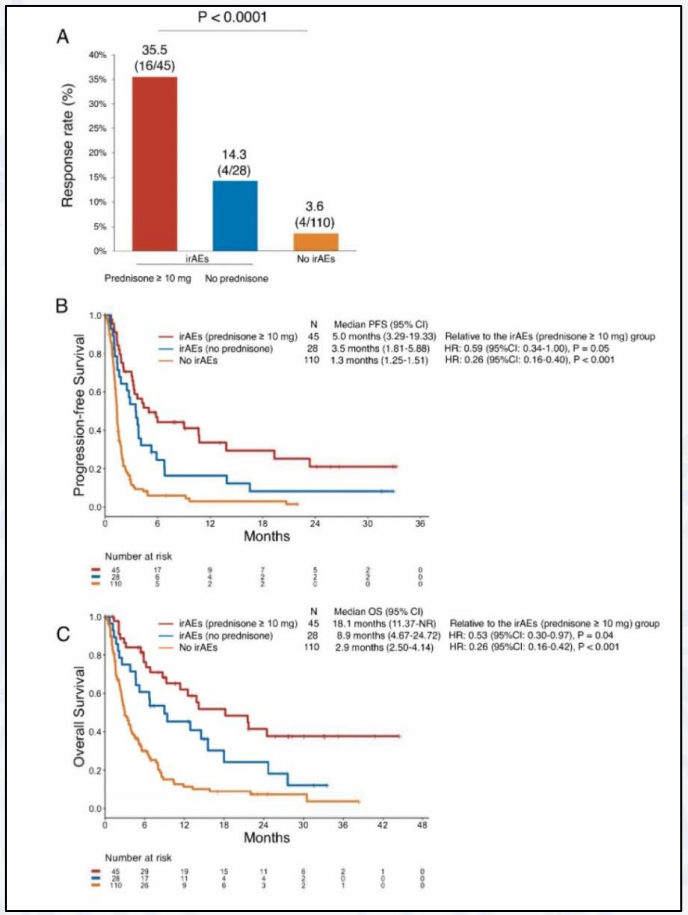
# irAEs and Response to Immunotherapy Associated with PFS and OS benefit

## NSCLC

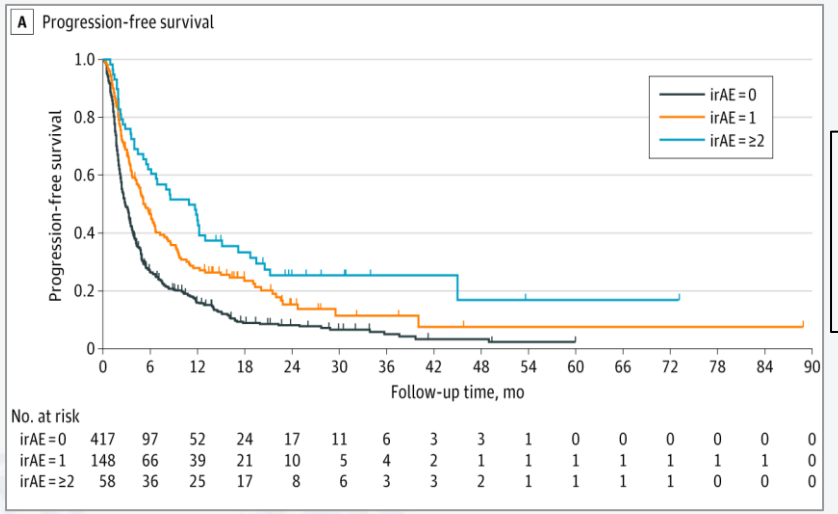


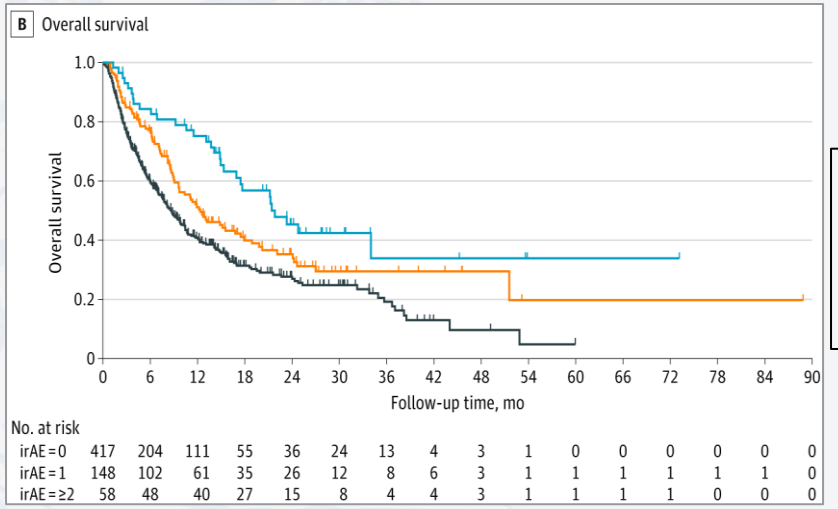

## SCLC




## Multisystem irAEs (NSCLC)




1 irAE: HR 0.67
**p=0.001**
≥2 irAEs: HR 0.38
**p<0.001**

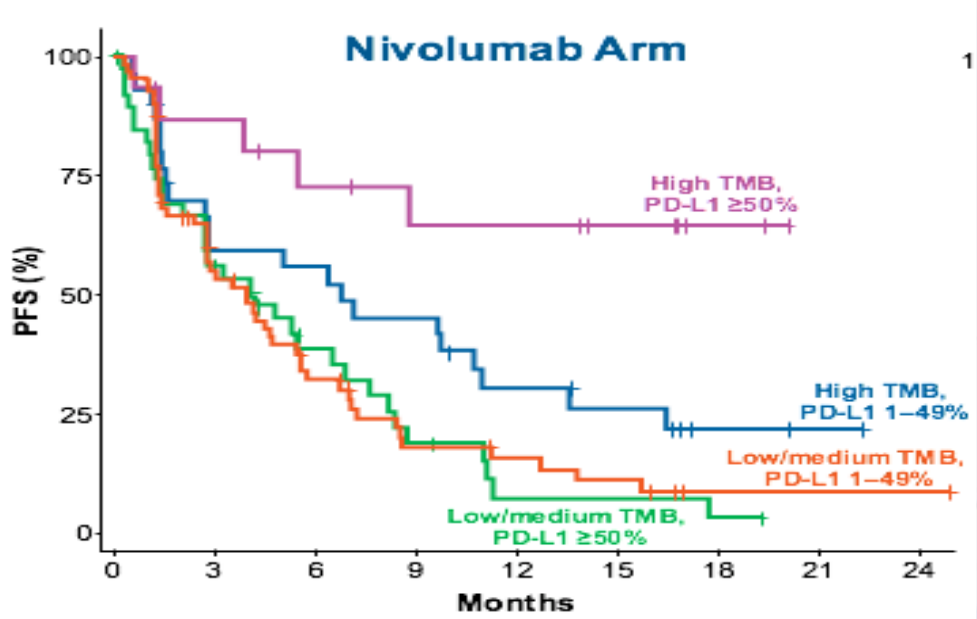



1 irAE: HR 0.86
p = 0.253
≥2 irAEs: HR 0.56
**p=0.005**

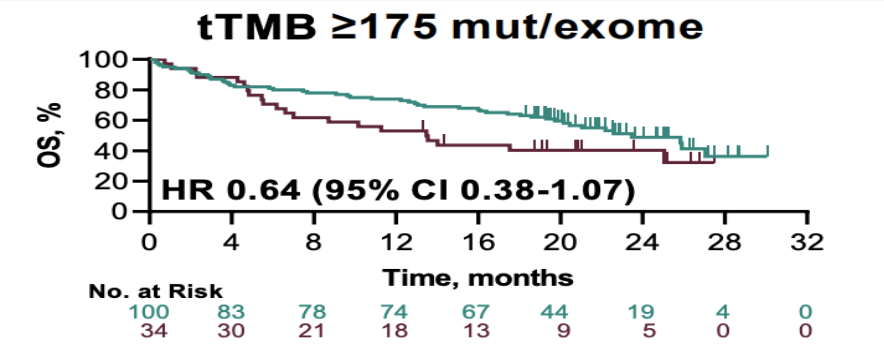
Haratani et al, JAMA Oncol 2018
Ricciuti et al, JTO CRR 2021
Shankar, Naidoo et al, JAMA Oncol 2020

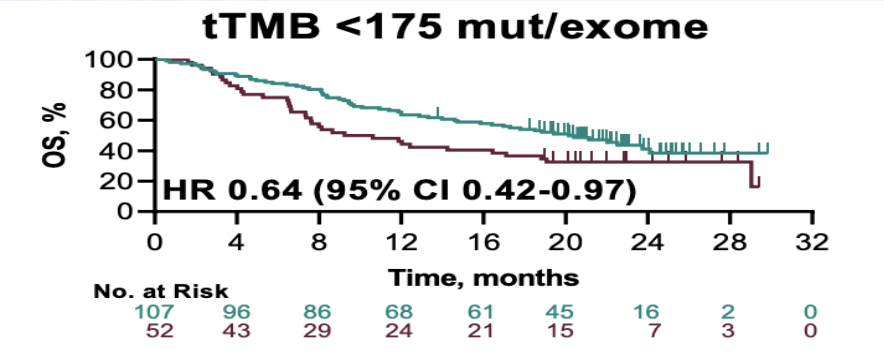
# Tumor Mutational Burden (TMB) to predict benefit from ICI

## In combination with anti-CTLA4
## CM-227




## In combination with chemotherapy
## KN-189




Peters AACR 2019
Garassino et al WCLC 2019

# ctDNA in IMpower 150 trial

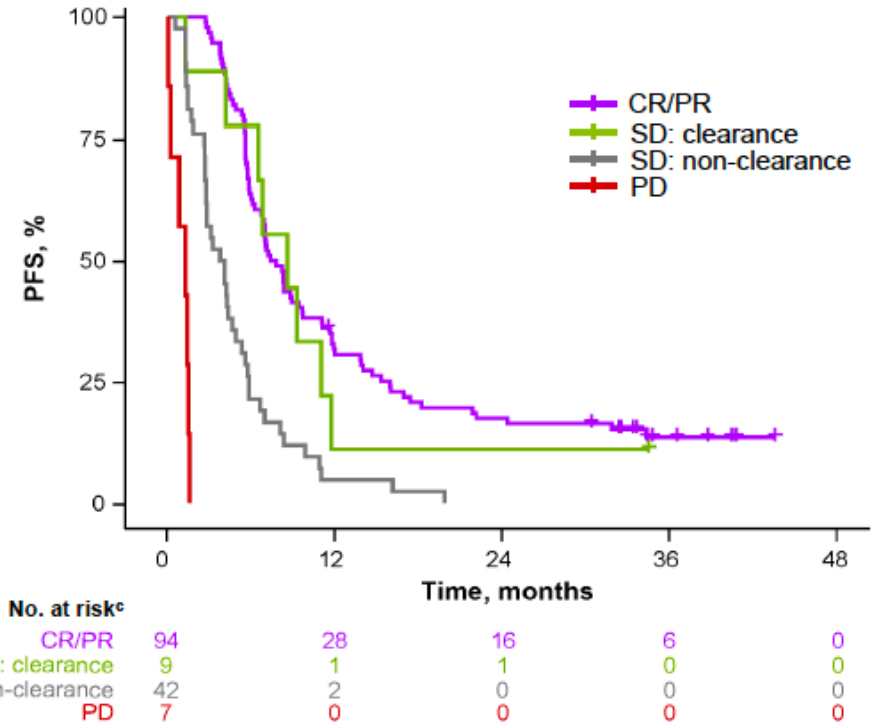
## ctDNA clearance[a] can risk stratify patients with SD

- 30.4% of patients clear pathogenic driver ctDNA mutations with treatment
- Clearance of ctDNA at Cycle 3 can risk stratify patients with SD

**ctDNA clearance at Cycle 3 identifies patients with SD who have improved PFS**

| | All patients | CR/PR | SD | PD |
|---|---|---|---|---|
| **PFS HR[b,c] (95% CI)** | 0.79 (0.54, 1.17) | 1.08 (0.67, 1.76) | 0.41 (0.19, 0.89) | <0.01 (0, infinity) |
| **Median PFS for Cycle 3 non-clearance vs clearance, months** | 5.7 vs 7.2 | 8.2 vs 7.2 | 3.9 vs 8.5 | 0.8 vs 1.5 |

**PFS by treatment response and ctDNA clearance at Cycle 3**




[a] ctDNA clearance was assessed in patients who were ctDNA+ at baseline; "clearance" was defined as becoming ctDNA− at a later on-treatment time point, and "non-clearance" was defined as remaining ctDNA+ at all on-treatment time points. [b] Reference population: patients with no ctDNA clearance. [c] Data in training dataset from all 3 IMpower150 treatment arms were pooled.

Assaf et al WCLC

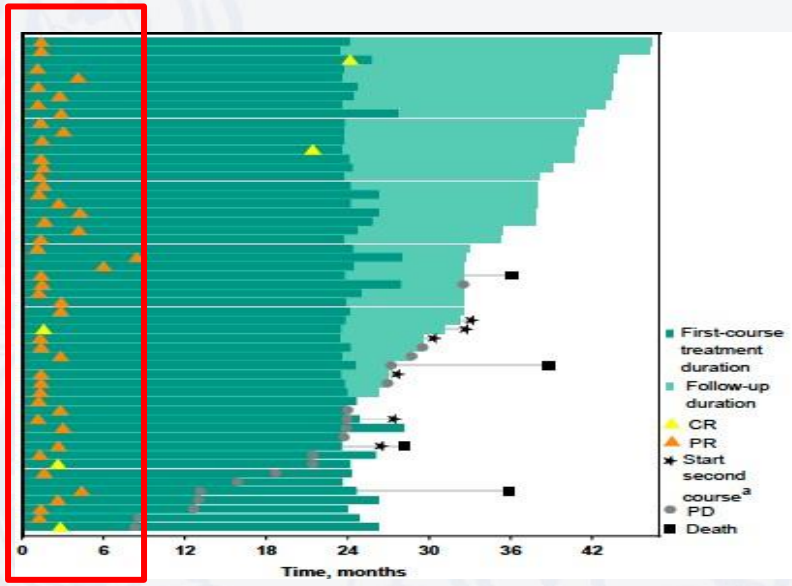
# Patients who completed treatment, better outcome

## KEYNOTE 189

| Best response | N = 56 |
|---|---|
| Objective response, n (%) | 49 (87.5) |
| Best objective response, n (%) | |
| CR | 6 (10.7) |
| PR | 43 (76.8) |
| SD | 7 (12.5) |

- 2-year OS rate from completion of 35 cycles (2 years) was 79.6%
- At data cutoff, 45/56 patients (80.4%) were alive, 28 without PD
- 7 patients started second-course pembrolizumab
  - 2 had a second-course best response of SD by investigator assessment
  - 2 had best response of PD, and 3 were not assessed as of data cutoff

## KEYNOTE 407




**35 Cycles of pembrolizumab completed**

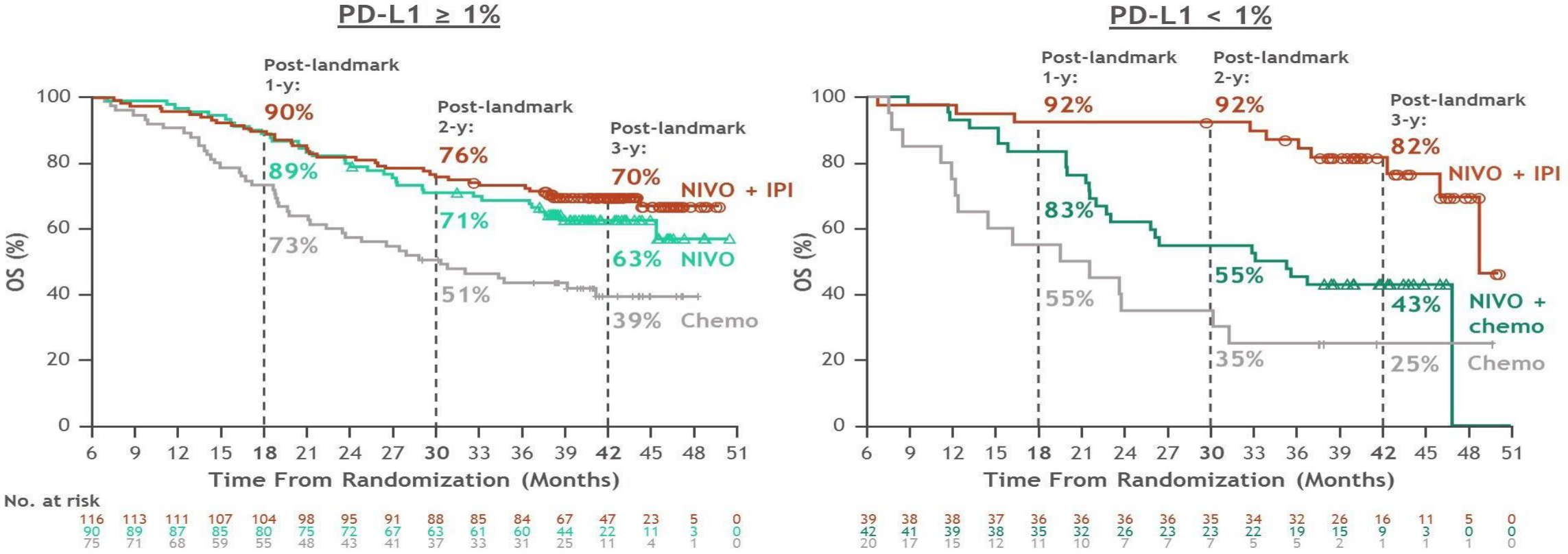
| | n = 55 |
|---|---|
| ORR[b], n (%) | 51 (92.7) |
| Best overall response, n (%) | |
| Complete response | 5 (9.1) |
| Partial response | 46 (83.6) |
| Stable disease | 4 (7.3) |
| Progressive disease | 0 |
| DOR, median (range), mo | NR (7.1–45.0+) |
| 1-y OS rate from completion of pembro, % | 96.0 |
| 1-y PFS rate from completion of pembro[c], % | 82.6 |

- Median (range) time from completion of 35 cycles of pembrolizumab to data cutoff was 16.1 (6.0–24.6) mo
- 7 patients initiated a second course of pembrolizumab
  - 6 patients (86%) were alive at data cutoff

Gray – WCLC 2020 * Robinson – ELCC 2021

# Patients who completed treatment, better outcome

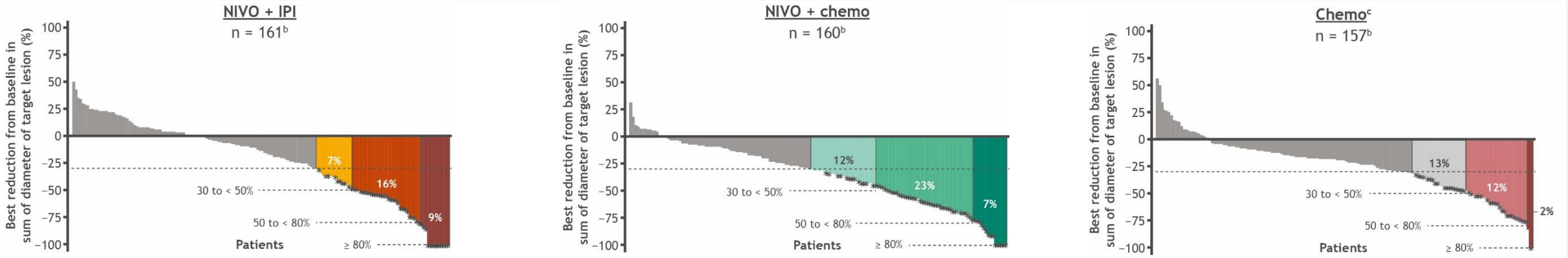
## CM227: Post-landmark OS in CR/PR PD-L1≥ 1% and PD-L1< 1%




Ramalingam – ASCO 2020 * Reck – JCO 2021 * Remon – JCO 2021

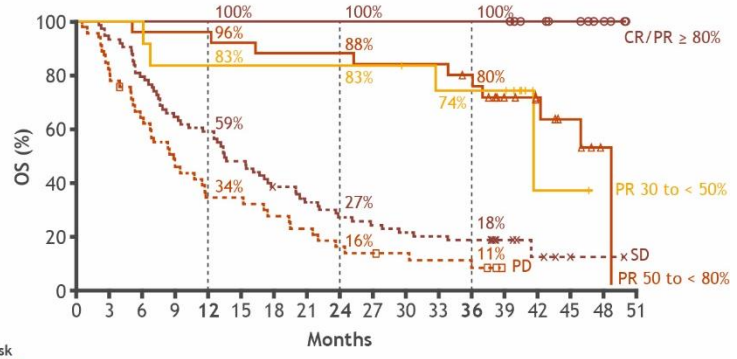
# OS by response[a] and tumor burden reduction with NIVO + IPI, NIVO + chemo and chemo (PD-L1 < 1%)

A




B

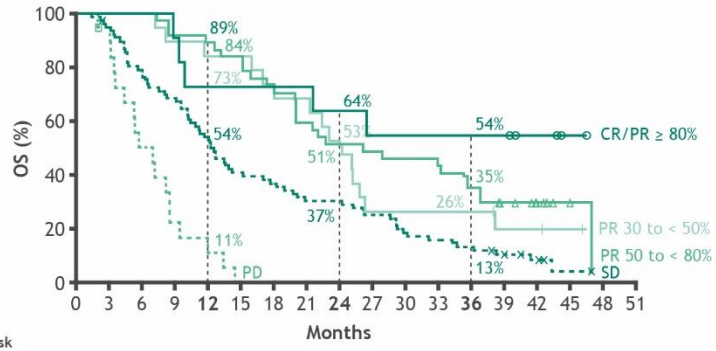
| | ≥ 80% (n = 14) | 50 to < 80% (n = 25) | 30 to < 50% (n = 12) | SD (n = 73) | PD (n = 45) |
|---|---|---|---|---|---|
| Median OS, mo | NR | 48.8 | 41.7 | 13.5 | 8.9 |
| 95% CI | | 37.1-48.8 | 6.8-NR | 9.5-17.8 | 5.9-11.8 |
| HR vs SD/PD[d] | < 0.01 | 0.23 | 0.15 | | |
| 95% CI | < 0.01-NR | 0.12-0.45 | 0.05-0.40 | | |




No. at risk

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CR/PR ≥ 80% | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 9 | 7 | 4 | 0 |
| PR 50 to < 80% | 25 | 25 | 24 | 24 | 24 | 23 | 22 | 22 | 22 | 21 | 21 | 21 | 19 | 13 | 9 | 6 | 1 | 0 |
| PR 30 to < 50% | 12 | 12 | 12 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 9 | 8 | 8 | 8 | 1 | 1 | 0 | 0 |
| SD | 73 | 68 | 58 | 47 | 43 | 35 | 27 | 23 | 19 | 17 | 15 | 14 | 13 | 8 | 4 | 2 | 1 | 0 |
| PD | 45 | 37 | 28 | 21 | 15 | 15 | 12 | 10 | 7 | 6 | 5 | 4 | 4 | 0 | 0 | 0 | 0 | 0 |

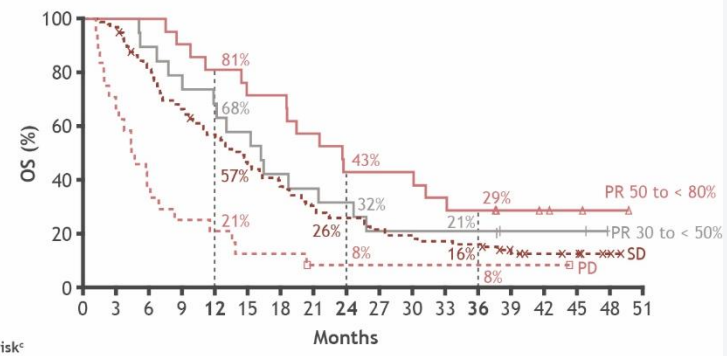
| | ≥ 80% (n = 11) | 50 to < 80% (n = 37) | 30 to < 50% (n = 19) | SD (n = 77) | PD (n = 19) |
|---|---|---|---|---|---|
| Median OS, mo | NR | 26.2 | 24.2 | 12.6 | 7.0 |
| 95% CI | 9.4-NR | 19.9-36.8 | 17.0-26.3 | 10.2-17.0 | 3.6-8.5 |
| HR vs SD/PD[d] | 0.31 | 0.42 | 0.45 | | |
| 95% CI | 0.12-0.77 | 0.27-0.66 | 0.26-0.77 | | |




No. at risk

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CR/PR ≥ 80% | 11 | 11 | 11 | 10 | 8 | 8 | 8 | 8 | 7 | 6 | 6 | 6 | 6 | 6 | 3 | 1 | 0 | 0 |
| PR 50 to < 80% | 37 | 37 | 37 | 34 | 33 | 31 | 27 | 22 | 19 | 18 | 17 | 16 | 13 | 9 | 5 | 1 | 0 | 0 |
| PR 30 to < 50% | 19 | 19 | 19 | 17 | 16 | 16 | 14 | 13 | 10 | 5 | 5 | 5 | 5 | 3 | 3 | 1 | 0 | 0 |
| SD | 77 | 72 | 60 | 52 | 41 | 31 | 28 | 23 | 23 | 19 | 14 | 12 | 10 | 7 | 4 | 1 | 0 | 0 |
| PD | 19 | 17 | 9 | 4 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | 50 to < 80% (n = 21) | 30 to < 50% (n = 19) | SD (n = 97) | PD (n = 24) |
|---|---|---|---|---|
| Median OS, mo | 23.7 | 16.2 | 14.2 | 4.6 |
| 95% CI | 15.0-33.2 | 9.1-24.7 | 10.4-17.8 | 2.4-7.0 |
| HR vs SD/PD[d] | 0.59 | 0.74 | | |
| 95% CI | 0.34-1.01 | 0.43-1.26 | | |



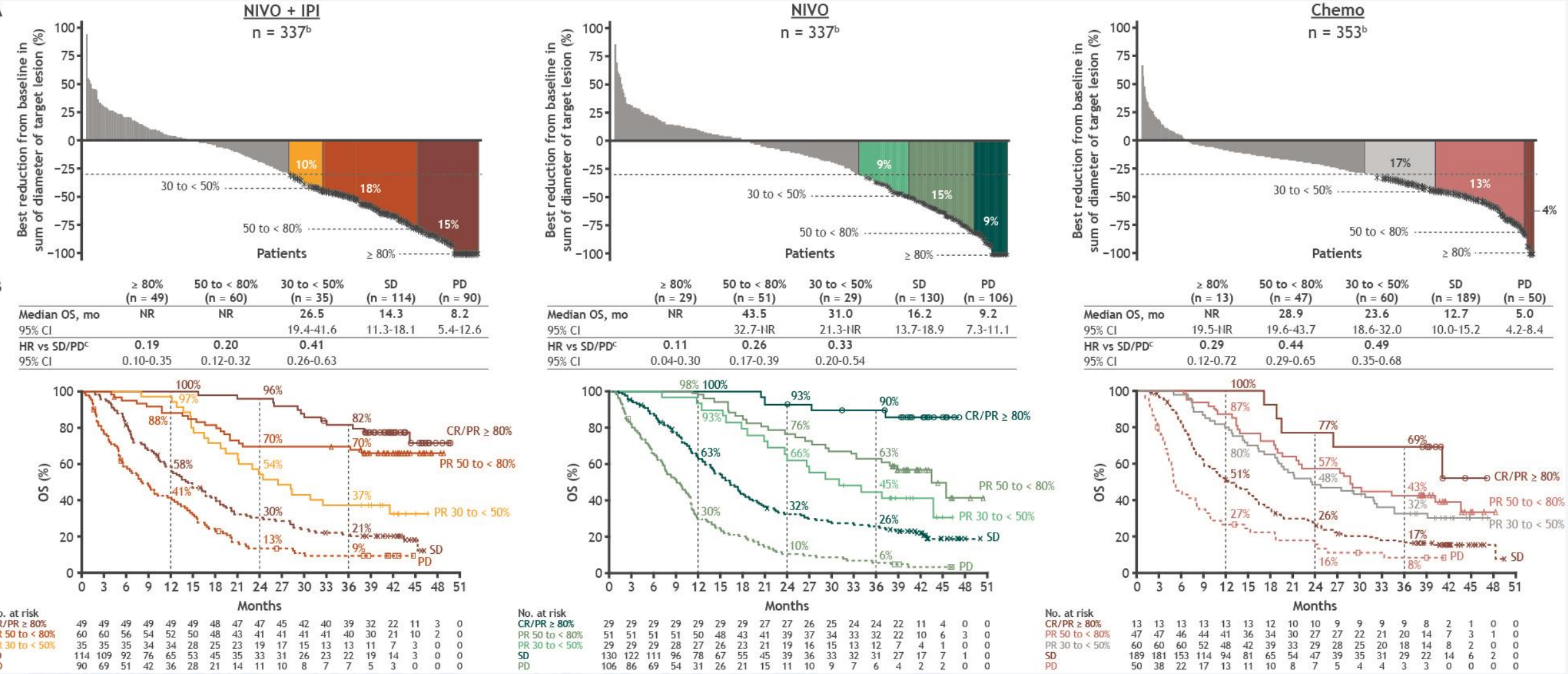

No. at risk[c]

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PR 50 to < 80% | 21 | 21 | 21 | 19 | 17 | 15 | 15 | 12 | 9 | 9 | 9 | 7 | 6 | 4 | 3 | 2 | 1 | 0 |
| PR 30 to < 50% | 19 | 19 | 17 | 15 | 13 | 11 | 8 | 7 | 6 | 4 | 4 | 4 | 4 | 2 | 2 | 2 | 0 | 0 |
| SD | 97 | 94 | 77 | 63 | 53 | 44 | 35 | 28 | 24 | 20 | 18 | 16 | 15 | 10 | 6 | 5 | 2 | 0 |
| PD | 24 | 17 | 9 | 6 | 5 | 3 | 3 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 |

Brahmer; ESMO 2020

# OS by response and tumor burden reduction with NIVO + IPI, NIVO and chemo (PD-L1 ≥ 1%)

A




B

| | ≥ 80% (n = 49) | 50 to < 80% (n = 60) | 30 to < 50% (n = 35) | SD (n = 114) | PD (n = 90) |
|---|---|---|---|---|---|
| Median OS, mo | NR | NR | 26.5 | 14.3 | 8.2 |
| 95% CI | | | 19.4-41.6 | 11.3-18.1 | 5.4-12.6 |
| HR vs SD/PD[c] | 0.19 | 0.20 | 0.41 | | |
| 95% CI | 0.10-0.35 | 0.12-0.32 | 0.26-0.63 | | |

| | ≥ 80% (n = 29) | 50 to < 80% (n = 51) | 30 to < 50% (n = 29) | SD (n = 130) | PD (n = 106) |
|---|---|---|---|---|---|
| Median OS, mo | NR | 43.5 | 31.0 | 16.2 | 9.2 |
| 95% CI | | 32.7-NR | 21.3-NR | 13.7-18.9 | 7.3-11.1 |
| HR vs SD/PD[c] | 0.11 | 0.26 | 0.33 | | |
| 95% CI | 0.04-0.30 | 0.17-0.39 | 0.20-0.54 | | |

| | ≥ 80% (n = 13) | 50 to < 80% (n = 47) | 30 to < 50% (n = 60) | SD (n = 189) | PD (n = 50) |
|---|---|---|---|---|---|
| Median OS, mo | NR | 28.9 | 23.6 | 12.7 | 5.0 |
| 95% CI | 19.5-NR | 19.6-43.7 | 18.6-32.0 | 10.0-15.2 | 4.2-8.4 |
| HR vs SD/PD[c] | 0.29 | 0.44 | 0.49 | | |
| 95% CI | 0.12-0.72 | 0.29-0.65 | 0.35-0.68 | | |




Brahmer; ESMO 2020

# Conclusiones

- The treatment landscape is changing: More options, more ability to tailor treatment.
- Biomarkers other than PD-L1 might be helpful in deciding how to treat patients.
- Patient preferences must be taken into account given multiple options.
- Single agent checkpoint inhibitor for PD-L1 high expressing tumors seems to be the best option given clinical efficacy and side effect profile. Improvements are needed, however.
- Combination of chemotherapy and a checkpoint inhibitor is a good option for most patients. IO/IO combination are intriguing and offer another options for some patients.

XXIV

# Simposio de Revisiones en Cáncer

*"Tratamiento médico del cáncer en el año 2022"*

# Gracias

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ARÁN