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Clinical evidence driving guidelines for immunotherapy in the neoadjuvant and adjuvant settings of NSCLC

Announcer:
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Dr. Yu:
This is CME on ReachMD, and I'm Dr. Helena Yu.

Dr. Paz-Ares:
And I'm Luis Paz-Ares.

Dr. Yu:
Welcome. In recent years, immunotherapy has been incorporated into the treatment paradigm for early-stage non-small cell lung cancer.

Luis, what can you tell me about the clinical evidence that's driving guidelines for immunotherapy, both in the neoadjuvant and adjuvant settings?

Dr. Paz-Ares:
Okay. So, I mean, it started by historical order. We first showed that adjuvant immunotherapy has a role in this setting. Those patients actually resected after chemotherapy, they really benefit from immunotherapy with PD-L1 inhibitors such as atezolizumab, and this had been shown in the IMpower010 trial showing a clear improvement in DFS with a hazard ratio of about 0.71 for stage II and III with PD-L1-positive expression, and that seems to impact, actually, survival, particularly for those patients with high PD-L1 expression in more than 50% of the cells with a hazard ratio of 0.42.

I have to say that pembrolizumab has showed consistent data in this very setting, but there were not that clear benefit depending on the PD-L1 expression. In the neoadjuvant setting, we have also very substantial data. Indeed, the benefit for those patients treated before starting with 3 cycles of chemotherapy plus nivolumab resulted in a better rate of pathological completed remission, 24% as compared to only 2% when treated with chemotherapy alone. And that actually also confirms a benefit in terms of EFS with a hazard ratio in the range of 0.62. And those data seem also to really associate into an improvement in overall survival.

Important to say that the benefit is related to the PD-L1 expression, so those patients with positive expression in their tumors of PD-L1, they seem to benefit more as compared to those patients with negative expression, but it's still some benefit is actually there.

So the truth is that after those approaches have been studied, adjuvant and neoadjuvant, it had been a number of trials actually looking in the perioperative setting what is the role of immunotherapy. So what is the evidence driving guidelines for immunotherapy in these very contexts, Helena?

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Dr. Yu:
Yeah. So we do have a lot of new data in the perioperative setting. As you mentioned, Luis, we had initially adjuvant immunotherapy and then there was neoadjuvant immunotherapy, and then more recently we've had approvals in the perioperative space. And so there really are 3 agents that we can use in this space, pembrolizumab, durvalumab, and now, most recently, nivolumab as well. And so all of these studies really focus on the same backbone in terms of study schema, where patients receive neoadjuvant chemotherapy with the respective PD-1 inhibitors and then go on to receive surgical resection and then do get approximately a year of adjuvant immunotherapy with either pembrolizumab, durvalumab, or nivolumab.

And really, all 3 of these regimens have shown excellent efficacy where we see clear, marked improvements in the major pathologic response rate and in the complete pathologic response rate and improvements in event-free survival. And so I think these are all good options to consider. I think we don't have yet head-to-head data to really suggest whether neoadjuvant alone versus perioperative therapy really is superior. And there is some question for patients who have complete pathologic responses, whether that adjuvant therapy is necessary. But all of these certainly remain options, and I think moving forward, we are likely to see new studies that will take into account pathologic responses to help us dictate care in the adjuvant setting.

Well, that's all the time that we have today. Thank you for a great discussion, Luis, and thanks to our audience for listening.

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