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Unresectable Stage III NSCLC: Highlights From the Oncology Meeting in Chicago 2024

Announcer:
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Dr. Gray:
This is CME on ReachMD, and I'm Dr. Jhanelle Gray. Here with me today is Dr. Joshua Reuss.

There are some interesting data in unresectable stage III non-small cell lung cancer that were presented at the recent ASCO 2024 meeting in Chicago.

Joshua, what did you think of the data? What do you find is the most compelling?

Dr. Reuss:
Yeah, thanks, Jhanelle. I mean, it was really a lung-heavy ASCO this year. And I would say that headlining that was the phase 3 LAURA trial. So just as a little backdrop on the LAURA study, we know that osimertinib has cemented itself in patients with metastatic EGFR mutation-positive non-small cell lung cancer, as well as as an adjuvant therapy following resection of EGFR-positive non-small cell lung cancer. And what this study did was looked at patients with unresectable stage III non-small cell lung cancer who received definitive chemoradiotherapy.

Patients who received osimertinib had a median progression-free survival of 39.1 months, compared to 5.6 months with placebo, with a whopping hazard ratio of 0.16, and this was at a median follow-up of about 22 months.

So when looking at those, who had recurrence in the placebo group, 29% actually had new disease in the CNS [central nervous system], as well as 29% also had new disease in the lungs, compared to 8% and 6% for those treated with osimertinib.

So really, my key takeaways from this dataset was this is definitely practice-changing. I think this cemented, really, a new role for osimertinib in those with unresectable stage III non-small cell lung cancer who received chemoradiotherapy.

Dr. Gray:
The study results, I agree, are definitive. They are changing our current standard of care and that those patients who are diagnosed with unresectable stage III locally advanced non-small cell lung cancer who harbor a common EGFR mutation should be placed on osimertinib.

So this is something that is very exciting. I don't think that we can just automatically take patients off the IO [immunotherapy] and immediately start the osimertinib. We do have to be thoughtful in that setting.

Dr. Reuss:
I completely agree. And I think that's a great point, specifically if we're seeing, you know, second opinion referrals and patients are on durvalumab, that's been our tried and true for so long, including, in many cases, for those with driver mutations. So I think it's important

to be cognizant of that.

So, Jhanelle, can you take us through some of these studies that you found more interesting in this space?

Dr. Gray:
Yes, absolutely, happy to. So we know that the PACIFIC trial looked at patients with concurrent chemoradiation, randomized them in a 2:1 fashion to durvalumab versus placebo as consolidation.

And one of the key studies that has completed is a phase 2 study looking at adding 2 medications. And the study did show that it improved not only PFS [progression-free survival] and overall survival, but overall response rate. This is now going to undergo further interrogation in the PACIFIC-9 study, a phase 3 study

There is also Abstract 8061 which looked at maintenance durvalumab following definitive concurrent chemoradiation. And just for the key take-home points here for that study, we did show that durvalumab in the maintenance or consolidative setting, including in patients who harbored the EGFR/ALK mutation, had very comparable clinical outcomes to those with wild-type. And it almost aligned very nicely with those patients who had a PD-L1 status of greater than or equal to 1%.

There's also Abstract 8079. So when you look at the results of the AI [artificial intelligence] tool, you'll see that it was able to identify those patients who are more likely to progress on the PACIFIC regimen than those who are unlikely to progress. And this appears to have outperformed the PD-L1-negative cohort. I think AI is here. I think we really have to start to figure out best ways to incorporate this into our treatment landscape for our patients. I don't think that this is ready for prime time, but we certainly look forward to more data in this space so we can make the best personalized decisions for all of our patients.

Dr. Reuss:
Yeah, and I would say that, you know, for things like the AI-assisted study and the COAST study, I think this shows that there's ways that we can innovate.

Dr. Gray:
Josh, do you think you can briefly review for us the updates of the KEYNOTE-799 study?

Dr. Reuss:
Sure, absolutely. So the KEYNOTE-799 study, this was a phase 2 noncomparative cohort trial, 2-cohort trial that enrolled patients into 1 of 2 cohorts. Now what this study showed was a 5-year update on the full cohort. And in cohort A, that pembro/carbo/pac population saw a median survival of 35.6 months. And in cohort B, the cis/pem/pembro cohort, median survival not reached.

And an interesting sub-cohort here, they looked at the ctDNA population. And these were small subsets.

Now, how this goes into clinic, it's hard for me to say. Like, I will say I don't typically get on-treatment circulating tumor DNA assessment in patients receiving definitive chemoradiotherapy.

But what would you say about that, Jhanelle?

Dr. Gray:
I agree with you, though that would definitely be something that's experimental at this time frame and not something that's ready for prime time. I do not do on-treatment ctDNA collections in patients off a clinical trial. But I do have to say I like where the field is moving.

Well, thank you guys for listening. We hope you found this discussion useful to your clinical practice.

Dr. Reuss:
Thank you.

Announcer:
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