Adjuvant/Neo-Adjuvant Systemic Therapy

PL02.07

PL02.08

P3.08F.08

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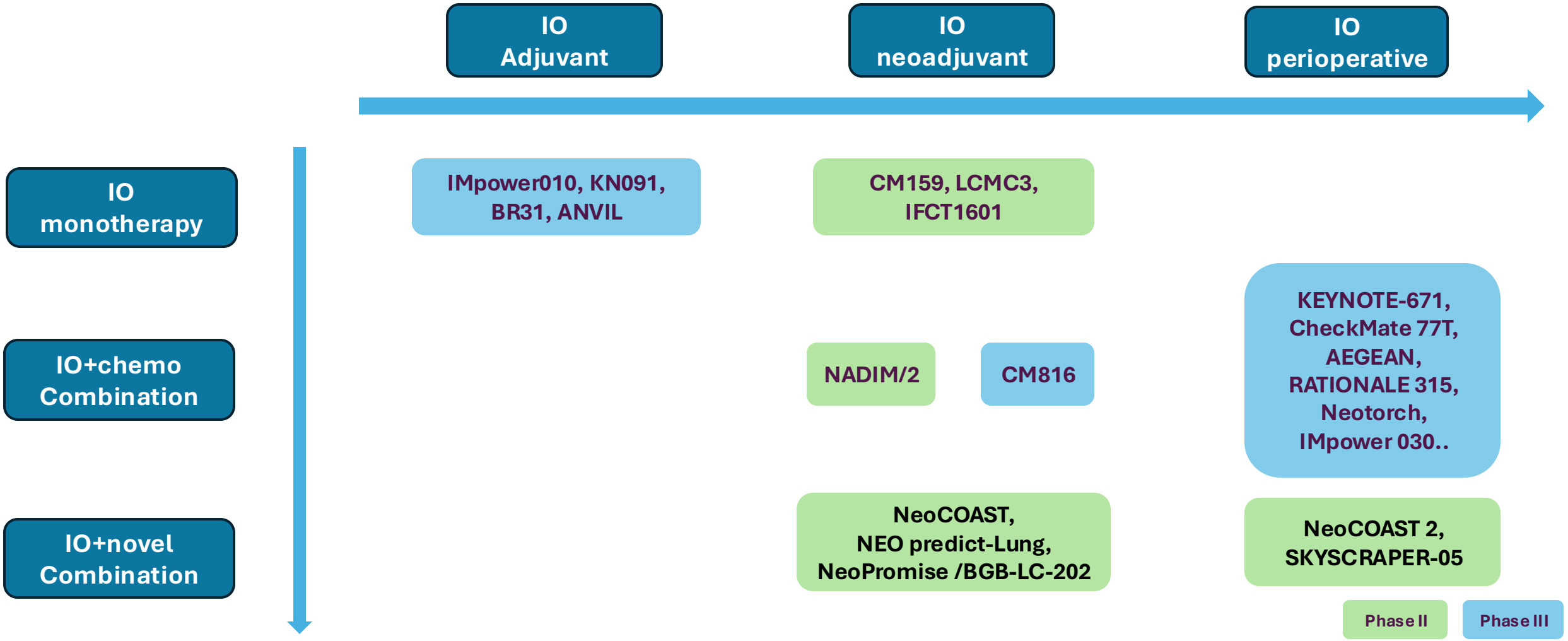
- **Neo-Adjuvant, Adjuvant and Peri-operative IO therapy improves EFS/DFS and with peri-operative OS for resectable early stage NSCLC**
- **At WCLC: Many trials with 5 year outcomes (NADIM, IMpower010)**
- **Durable Benefit demonstrated**
- **Many trials showing that pCR and degree of pathologic response correlates with outcomes (KN671)**
- **Really Novel Data with PL02.07 and PL02.08 focused on Novel Agents and Adjuvant question**

IO treatment paradigms in early-stage NSCLC



Slide Courtesy Nan Wu

All major neoadjuvant/perioperative IO trials have revealed a similar trend around surgical outcomes and pathological response

	Checkmate-816	KEYNOTE-671	AEGEAN	Checkmate-77T	NEOTORCH	RATIONALE-315
Patients received neo-IO	179	397	366	229	202	226
Cancelled surgery	15.6%	17.9%	19.4%	20.0%	17.8%	15.9%
Surgical delay	20.8%	4.9%	14.5%	-	-	16.3%
R0	83.2%	92.0%	94.7%	89.0%	95.8%	95.0%
MPR rate	36.9%	30.2%	33.3%	35.4%	48.5%	56.2%
PCR rate	24.0%	18.1%	17.2%	25.3%	24.8%	40.7%
PD-L1<1%	43.3%	36.3%	33.4%	40.3%	26.0%	38.2%
PD-L1 1-49%	27.4%	30.4%	37.4%	34.5%	33.9%	28.5%
PD-L1≥50%	22.3%	33.4%	29.2%	21.0%	31.7%	29.4%

Unmet needs

Risk of surgical cancellation and delay

40.1%
25.0%

Low response

36.3%
32.0%

Large proportion of lower PD-L1 expression

Forde PM, et al. N Engl J Med. 2022;386:1973; Wakelee H, et al. N Engl J Med. 2023;389:491; Heymach JV, et al. N Engl J Med. 2023;389:1672; Tina Cascone, et al. N Engl J Med 2024;390:1756; Lu S, et al. JAMA. 2024;331:201; Yue D, et al. Annals of Oncology. 2024;35:332.

PL02.07

NeoCOAST-2: Efficacy and Safety of Neoadjuvant Durvalumab (D) + Novel Anticancer Agents + CT and Adjuvant D ± Novel Agents in Resectable NSCLC

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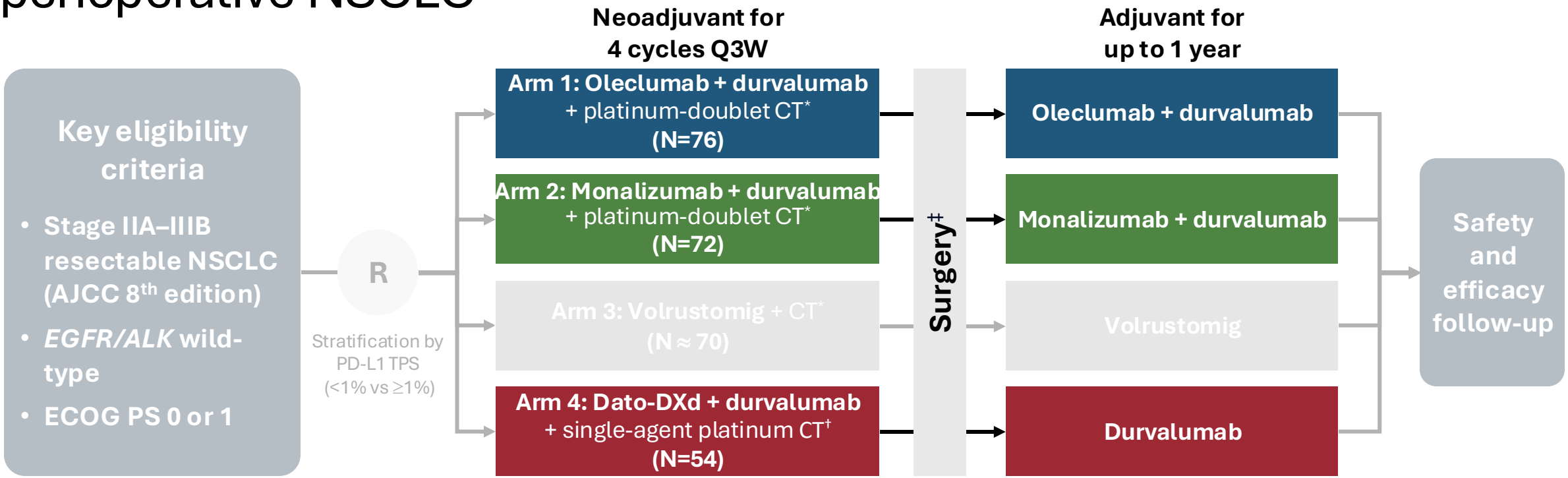
Background

- Durvalumab + oleclumab (anti-CD73) or monalizumab (anti-NKG2A) have demonstrated improved efficacy in COAST and NeoCOAST, two phase 2 studies in patients with early-phase NSCLC.[1,2]
- Datopotamab deruxtecan (Dato-DXd), a TROP2-directed antibody-drug conjugate, significantly improved PFS versus docetaxel in patients with locally advanced or metastatic NSCLC in the phase 3 TROPION-Lung01 study.[3]
- Perioperative anti-PD-(L)1 therapies + neoadjuvant CT have demonstrated improvements in EFS compared with CT alone, as reported by the phase 3 studies AEGEAN, KEYNOTE-671 and Checkmate 77T.[4–6]
- The phase 2 NeoCOAST-2 platform study (NCT05061550) is evaluating the efficacy and tolerability of novel perioperative treatment combinations in patients with resectable NSCLC.

1. Herbst RS, et al. *J Clin Oncol* 2022;40:3383–93; 2. Cascone T, et al. *Cancer Discov* 2023;13;2394–411; 3. Ahn M-J, et al. *Ann Oncol* 2023;34;S1305–6;
4. Heymach JV, et al. *N Engl J Med* 2023;389:1672–84; 5. Wakelee H, et al. *N Engl J Med* 2023;389:491–503; 6. Cascone T, et al. *N Engl J Med* 2024;390:1756–69.

NeoCOAST-2: Open-label, multi-arm platform study in perioperative NSCLC



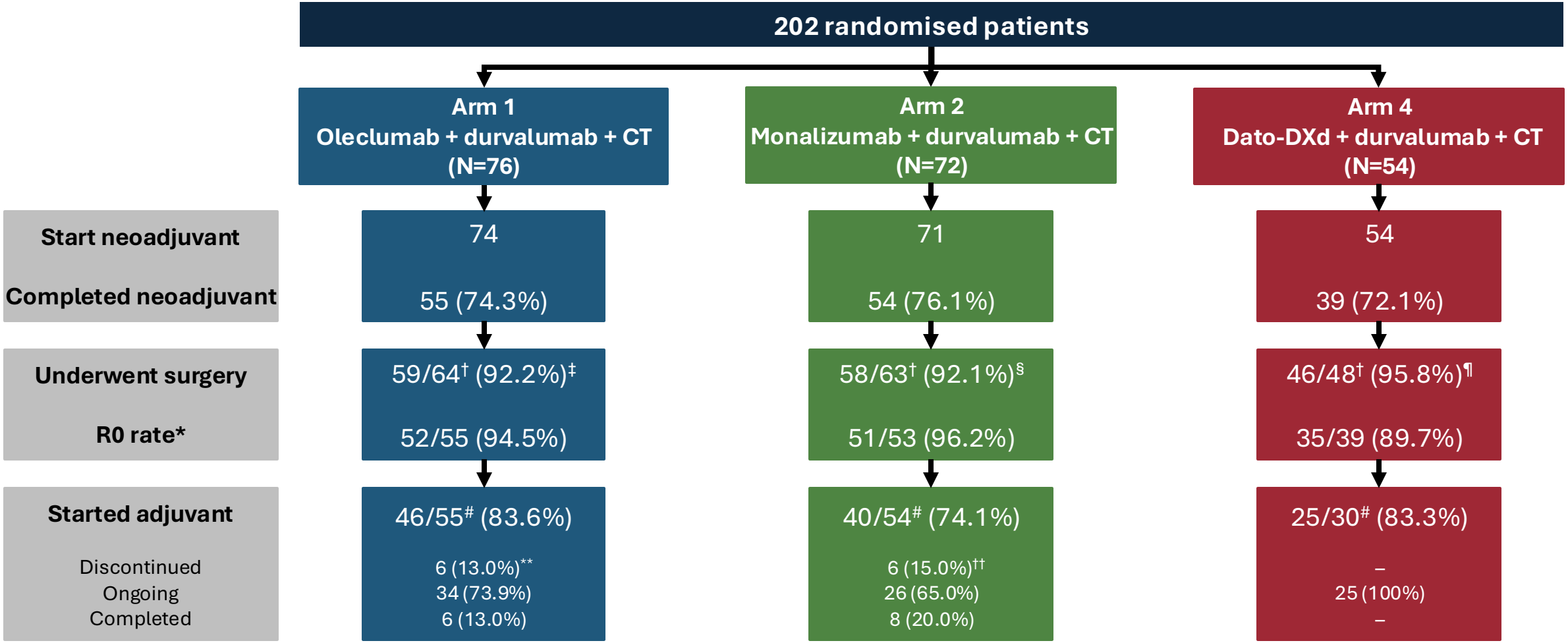
Primary endpoints
- pCR rate§
- Safety and tolerability

Key secondary endpoints
- mPR rate§ and EFS
- Feasibility to surgery

Statistical considerations
- This study was not powered to make direct statistical comparisons between arms.
- Descriptive statistics are summarised and presented.
- The primary intent was to look for preliminary efficacy signals by calculating pCR rates.

*Carboplatin + paclitaxel for squamous tumour histology, pemetrexed + cisplatin or carboplatin for non-squamous tumour histology. †Physician's choice of carboplatin or cisplatin. ‡Within 40 days of the last dose of neoadjuvant treatment. §Proportion of patients with no viable tumour cells and ≤10% residual viable tumour cells, respectively, in resected

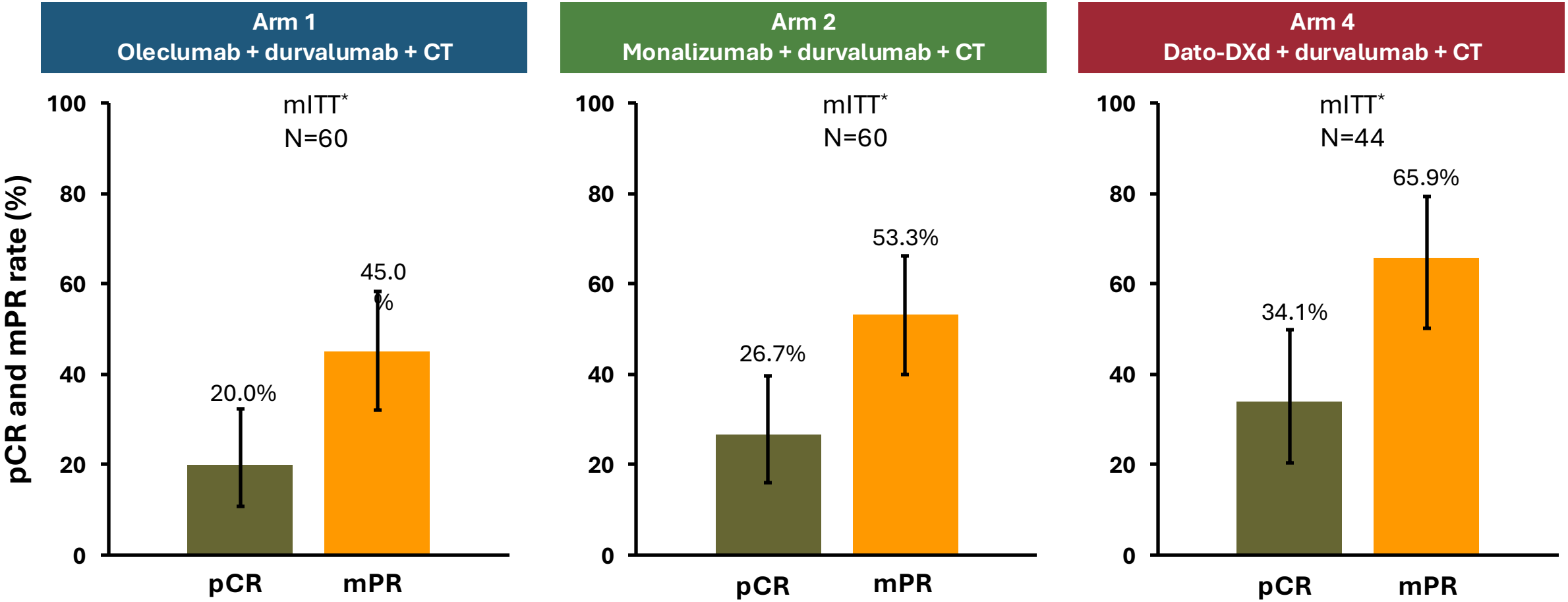
Summary of treatment disposition and surgery



Data cut-off: 17 June 2024. Median (range) of number of adjuvant cycles completed in Arm 1, 2, and 4 are 6 (1–12), 7.5 (1–12) and 2 (1–6), respectively. *Margins are calculated from patients who completed surgery and had data available at data cut-off. †Denominator includes patients who underwent surgery or were ineligible for surgery at data cut-off. ‡No surgery: AE=1, PD=2, other=2. §No surgery: AE=2, other=3. ¶No surgery: investigator decision=1, other=1. #Denominator includes patients who underwent surgery and had

Reason for discontinuation of IP: AE=2, PD=3, other=1. Reason for discontinuation of IP: AE=3, PD=2, other=1. progressi

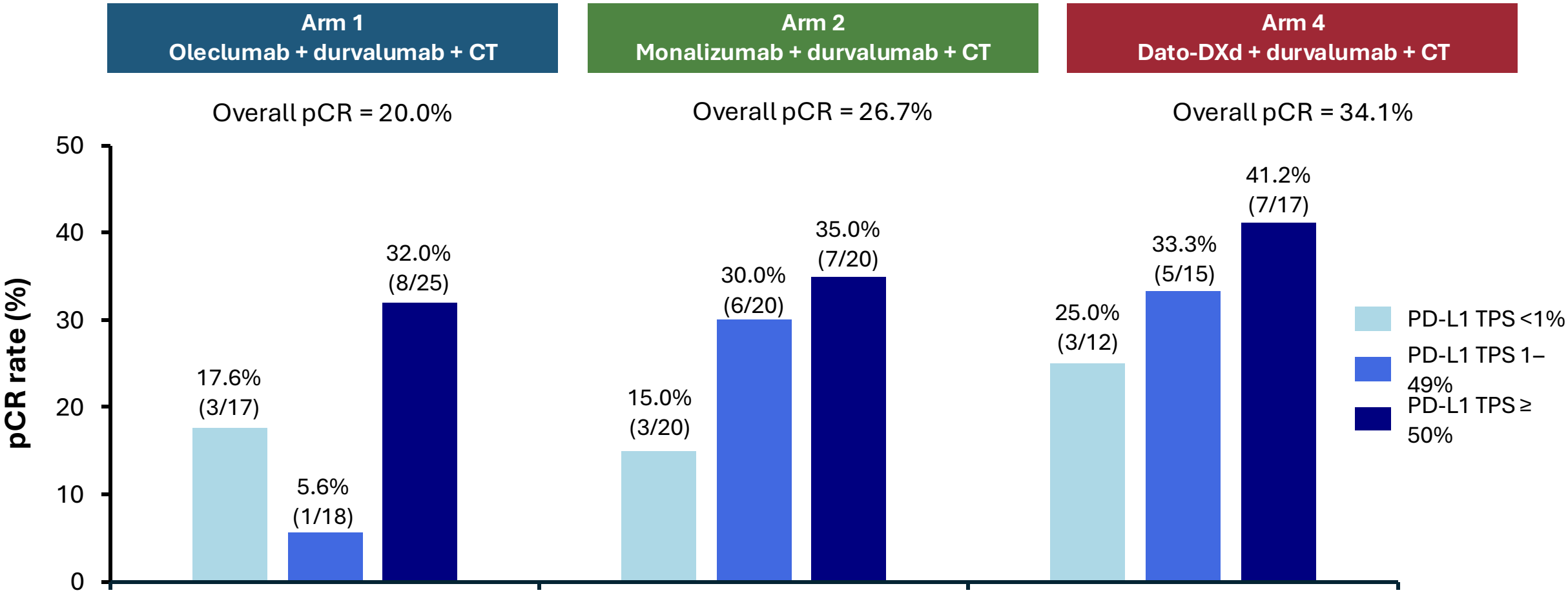
NeoCOAST-2: pCR and mPR rates across treatment arms



Pathological assessment performed locally or centrally†

Data cut-off: 17 June 2024. Error bars represent 95% confidence intervals.
*The mITT population includes all randomised patients with confirmed NSCLC histology who received at least 1 dose of study treatment and had central or local data available at the data cut-off, including those who were unable to receive or complete surgery. Some patients who underwent surgery did not have pathology results available at data cut-off. †Blind independent pathological review was used where available; proportion of local results were Arm 1: 9/55 (16.3%); Arm 2: 6/55 (11%); Arm 4: 16/41 (39%). Denominator includes only those patients who had surgery. CT, chemotherapy;

pCR rates across baseline PD-L1 expression subgroups



Data cut-off: 17 June 2024. Based on the modified intention-to-treat population which includes all randomised patients with confirmed NSCLC histology who received at least 1 dose of study treatment and had data available at data cut-off, including those who were unable to receive or complete surgery.
Baseline PD-L1 status is assessed using central (Ventana SP263) or local testing (Ventana SP263, pharmDx 28-8, or pharmDx 22C3). Proportion of central results were

Safety profile of NeoCOAST2 showed comparable data with other combination in same platform

	NeoCOAST			NeoCOAST2			AEGEAN	
	Ole + Durva	Mona + Durva	Danva + Durva	Ole + Durva + CT	Mona + Durva + CT	Dato + Durva + CT	Durva + CT	CT
Neoadjuvant								
Any TEAE	90.5%	75.0%	81.3%	97.3%	98.6%	98.1	91.0%	89.7%
Any TRAE	57.1%	50.0%	43.8%	94.6%	90.1%	96.3	82.3%	78.6%
Grade ≥3 TEAE	14.3%	10.0%	31.3%	35.1%	40.8%	24.1	32.4%	36.4%
Grade ≥3 TRAE	4.8%	0	6.3%	31.1%	29.6%	18.5	19.2%	32.4%
AE leading to discontinuation	4.8%	5.0%	6.3%	8.1%	12.7%	7.4	13.5%	7.8%
SAE	9.5%	5.0%	31.3%	16.2%	16.9%	18.5	20.7%	16.6%
Any SAE with outcome of death	0	0	6.3%	1.4%	0	0.0%	2.0%	1.0%
Adjuvant								
Any TEAE				78.3%	72.5%	44.0%	83.8%	74.8%
Any TRAE				63.0%	40.0%	20.0%	48.1%	29.1%
Grade ≥3 TEAE				8.7%	20.0%	4.0%	15.4%	10.6%
Grade ≥3 TRAE				4.3%	12.5%	0.0%	7.5%	3.5%
AE leading to discontinuation				6.5%	7.5%	0	9.8%	3.9%
SAE				6.5%	12.5%	4.0%	15.0%	10.2%
Any SAE with outcome of death				0.0%	2.5%	0.0%	1.5%	0.8%

Direct comparison of novel combos with durva+chemo is needed in one RCT trial.

Heymach JV, et al. N Eng J Med 2023;389:1672; Cascone T, et al. Cancer Discov 2023;13:2394

Conclusions

- In perioperative NSCLC, novel combinations demonstrated promising efficacy, with numerically higher pCR and/or mPR rates compared to historical benchmarks.
  - Oleclumab + durvalumab + CT: pCR rate 20.0%; mPR rate 45.0%
  - Monalizumab + durvalumab + CT: pCR rate 26.7%; mPR rate 53.3%
  - Dato-DXd + durvalumab + CT: pCR rate 34.1% ; mPR rate 65.9%
- Treatments in all arms demonstrated a manageable safety profile and surgical rates comparable to currently approved regimens.[1–3]
- **This is the first global phase 2 study showing encouraging efficacy and manageable safety profile of an antibody-drug conjugate in the neoadjuvant setting for patients with resectable NSCLC.**

1. Wakelee H, et al. *N Engl J Med* 2023;389:491–503; 2. Forde PM, et al. *N Engl J Med* 2022;386:1973–85; 3. Heymach JV, et al. *N Engl J Med* 2023;389:1672–84.

Novel IO combinations trials in neoadjuvant setting

Trial	NeoCOAST	NeoCOAST-2	NEO predict-Lung	NeoPromise /BGB-LC-202
NCT number	NCT03794544	NCT05061550	NCT04205552	NCT05577702
Phase	2	2	2	2
Patient number	84	490	60	120
Stage	IA3–IIIA	II-IIIB	IB-IIIA	II-IIIA
Neoadjuvant treatment arm(s)	Arm 1: Durvalumab Arm 2: Oleclumab (CD73) + Durvalumab Arm 3: Monalizumab (NKG2A) + Durvalumab Arm 4: Danvatirsen (STAT3) + Durvalumab	Arm 1: Oleclumab (CD73)+ Durvalumab + PDC* Arm 2: Monalizumab (NKG2A)+ Durvalumab + PDC Arm 3: Volrustomig (dual PD-1 and CTLA-4)+ PDC Arm 4: Dato-DXd (TROP2 ADC)+ durvalumab + platinum Arm 5: AZD0171 (LIF)+ durvalumab + PDC	Arm 1: Nivolumab Arm 2: Nivolumab + relatlimab (LAG-3)	Sub-study-1 PD-L1 TC≥50%: Arm 1a: Tislelizumab Arm 1b: Tislelizumab + Ociperlimab (TIGIT) Arm 1c: Tislelizumab + LBL-007 (LAG-3) Sub-study-2 PD-L1 TC<50%: Arm 2a: Tislelizumab + PDC Arm 2c: Tislelizumab + LBL-007 (LAG-3) +PDC
Neoadjuvant cycles	One 28-Day treatment cycle	4	2	2-4
Adjuvant treatment arm(s)	NA	Arm 1: Oleclumab + Durvalumab Arm 2: Monalizumab + Durvalumab Arm 3: Volrustomig Arm 4: Durvalumab Arm 5: AZD0171 + Durvalumab	NA	NA
Adjuvant cycles	NA	12	NA	NA
Primary endpoint(s)	Locally-assessed MPR	pCR, Safety	Feasibility of surgery within 43 days (met by all 60 randomized patients)	Central pathology laboratory-assessed MPR
Readout or Completion	MPR: Durva: 12.5%; Durva + Ole: 22.2% Durva + Mona: 33.3% Durva + Danva: 33.3%	Completion estimated in 2028	pCR: 13%, 17% (Arm 1, Arm2) MPR: 27%, 30% (Arm 1, Arm 2)	Primary readout in 2025 H1

1. Cancer Discov 2023;13 : 2394. 2. ASCO 2023; Abstract TPS8604. 3.Nat Med. 2024 ;30:1602. 4. ESMO Asia Congress 2023; 489TiP. *PDC: Platinum doublet chemotherapy

2024 World Conference on Lung Cancer
SEPTEMBER 7-10, 2024 | SAN DIEGO, CA USA

Perioperative vs neoadjuvant nivolumab for resectable NSCLC: patient-level data analysis of CheckMate 77T vs CheckMate 816

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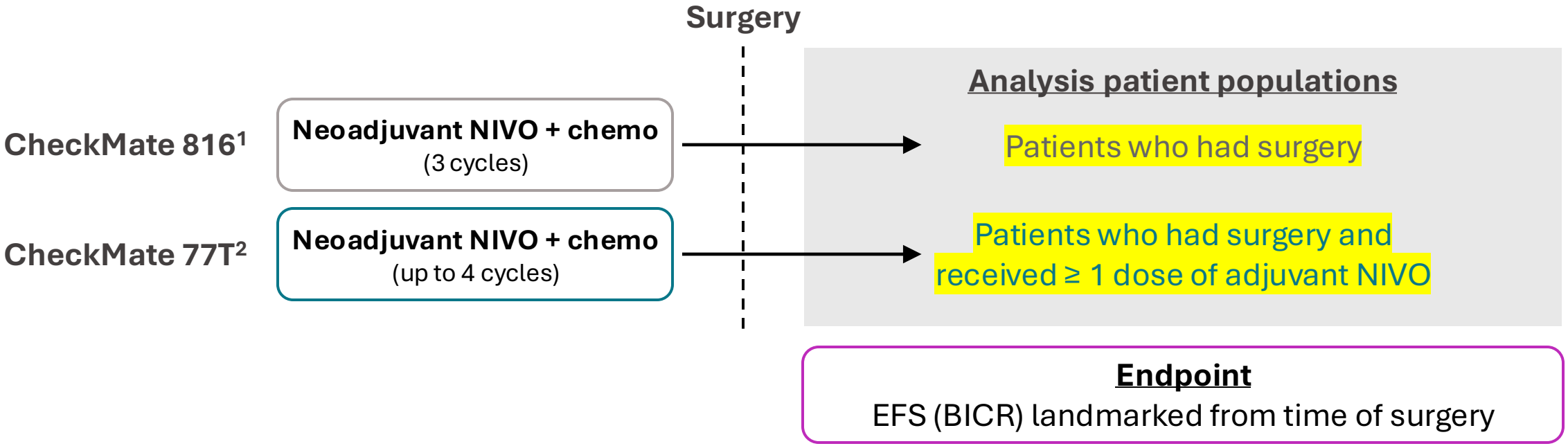
[1]The Bloomberg–Kimmel Institute for Cancer Immunotherapy, The Sidney Kimmel Comprehensive Cancer Center, Johns Hopkins Medicine, Baltimore, MD, USA; [2]Lausanne University Hospital, Lausanne, Switzerland; [3]The University of Chicago, Chicago, IL, USA; [4]Bristol Myers Squibb, Princeton, NJ, USA; [5]Bristol Myers Squibb, Uxbridge, UK; [6]Bristol Myers Squibb, Boudry, Switzerland; [7]The University of Texas MD Anderson Cancer Center, Houston, TX, USA

Presentation number 3589

Methods: perioperative NIVO vs neoadjuvant NIVO + chemo



- In lieu of a head-to-head trial, exploratory propensity score weighting analyses (ATT[a] and ATE[b]) were performed to allow simplified reproduction of a randomized trial by adjusting for clinically relevant baseline demographics and disease characteristics[c] between study populations and reducing the confounding effects of these factors
- Subgroup analyses were not weighted due to smaller sample sizes
- Median duration of follow-up[d]: 29.5 months (CheckMate 816) and 33.3 months (CheckMate 77T)

[a]Average treatment effect for the treated (ATT): a weight of 1 was applied to patients in the perioperative NIVO arm of CheckMate 77T; varying weights were applied to patients in the CheckMate 816 NIVO + chemo arm to make them comparable to those in the perioperative NIVO arm in CheckMate 77T based on propensity scores. [b]Average treatment effect (ATE): varying weights were applied to all patients in the populations of interest from CheckMate 77T and CheckMate 816 to make them comparable to one another based on propensity scores. [c]Sex, race, clinical stage, tumor histology, PD-L1 expression, age, ECOG PS, and smoking status. [d]Database locks: CheckMate 816, October 20, 2021; CheckMate 77T, April 26, 2024. 1. Forde PM, et al. *N Engl J Med* 2022;386:1973–1985. 2. Cascone T, et al. *N Engl J Med* 2024;390:1756–1769.

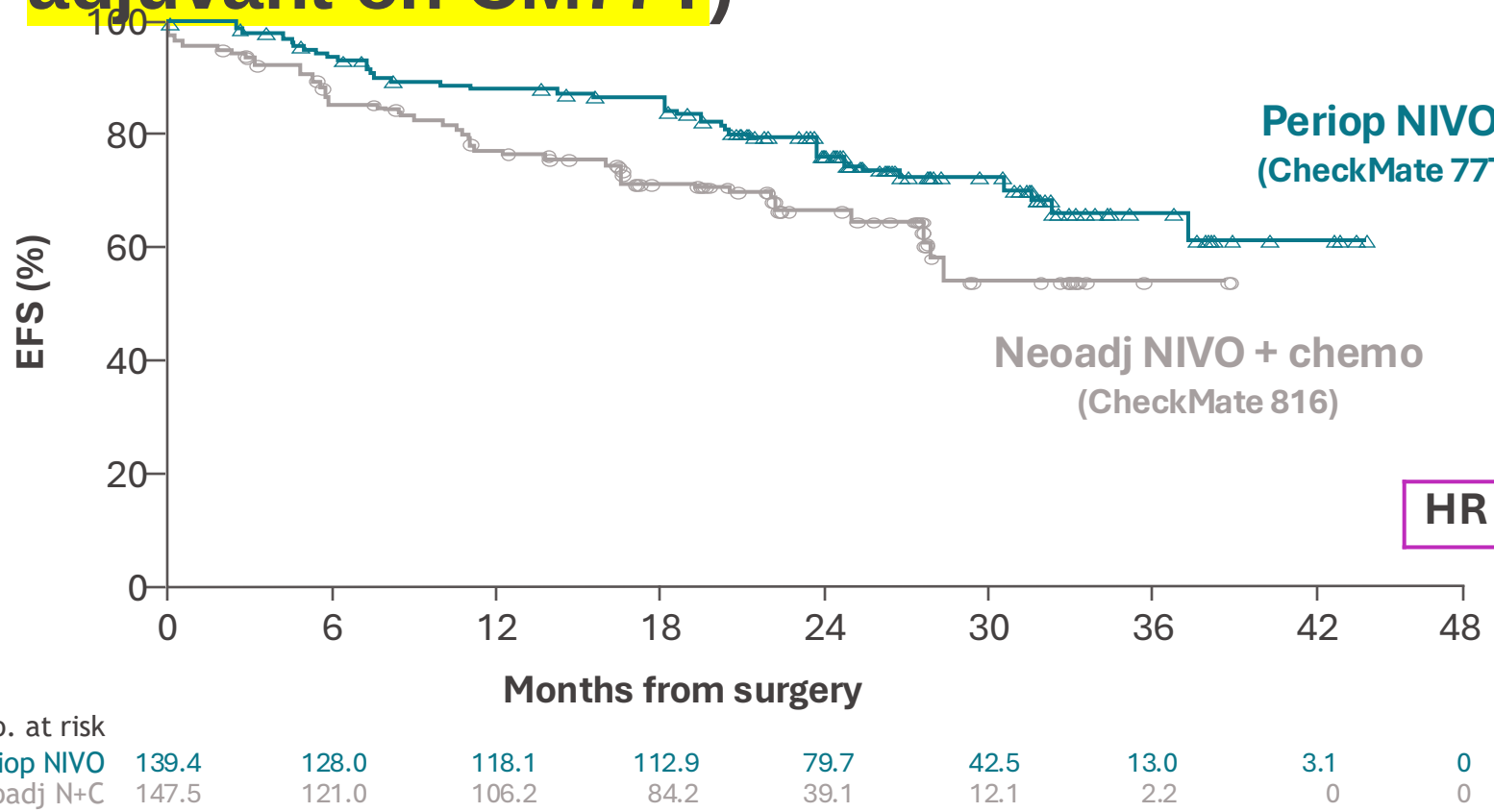
Baseline characteristics: analysis populations[a]

	Unweighted	
	Perioperative NIVO (n = 139), %	Neoadjuvant NIVO + chemo (n = 147), %
Age < 65 years	48	52
Male	73	69
Asian	27	50
ECOG PS ≥ 1	33	25
Disease stage		
Stage IB–II	35	37
Stage III non-N2	24	16
Stage III N2	40	47
Squamous NSCLC	50	46
Current/former smoker,[b]	94	90
Tumor PD-L1 expression ≥ 1%	58	50

- Baseline characteristics between patients who received perioperative NIVO or neoadjuvant NIVO + chemo were generally balanced after propensity score weighting (ATT and ATE)[c]

[a]Patients missing any variable used in propensity score computation were excluded from analyses; includes only patients with an EFS time at least up to the surgery. [b]Includes patients with unknown smoking status. [c]ATT: varying weights were applied to patients in the neoadjuvant NIVO + chemo arm (CheckMate 816) to make them comparable to those in the perioperative NIVO arm (CheckMate 77T); ATE: varying weights were applied to all patients in both neoadjuvant NIVO + chemo arm (CheckMate 816) and perioperative NIVO (CheckMate 77T) to make them comparable to one another.

Landmark EFS (BICR) from definitive surgery (and 1 cycle adjuvant on CM77T)



No. at risk

Periop NIVO	139.4	128.0	118.1	112.9	79.7	42.5	13.0	3.1	0
Neoadj N+C	147.5	121.0	106.2	84.2	39.1	12.1	2.2	0	0

Weighted (ATE)[b]

	Periop NIVO[a] (n = 139.4[c])	Neoadj NIVO + chemo (n = 147.5[c])
HR (95% CI)	0.61 (0.39–0.97)	

- HR (95% CI): ATT[d] weighted analysis, 0.56 (0.35–0.90); unweighted analysis, 0.59 (0.38–0.92)

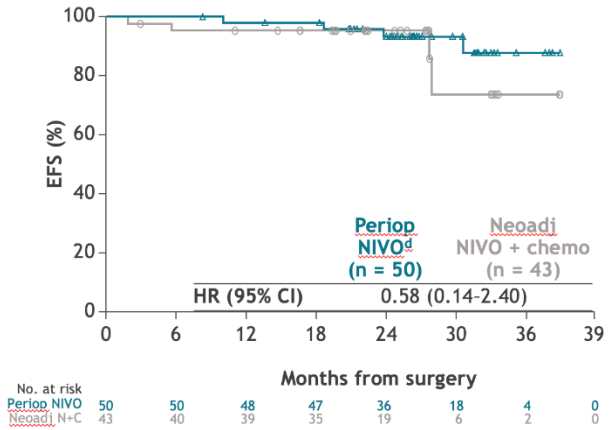
Median follow-up: CheckMate 816, 29.5 months; CheckMate 77T, 33.3 months. [a]Includes only patients who received ≥ 1 dose of adjuvant NIVO. [b]ATE: varying weights were applied to all patients in both neoadjuvant NIVO + chemo arm (CheckMate 816) and perioperative NIVO (CheckMate 77T) to make them comparable to one another. [c]N values fractional due to weighting. [d]ATT: varying weights were applied to patients in the neoadjuvant NIVO + chemo arm (CheckMate 816) to make them comparable to those in the perioperative NIVO arm (CheckMate 77T).

In the unweighted analysis population, 89 patients (64%) completed adjuvant therapy, and median number of doses (range) was 13.0 (1–13). Unweighted landmark EFS from surgery among all patients who had surgery (regardless of whether they received adjuvant NIVO in CheckMate 77T) for periop NIVO vs neoadj NIVO + chemo: HR = 0.82 (95% CI, 0.55–1.21).

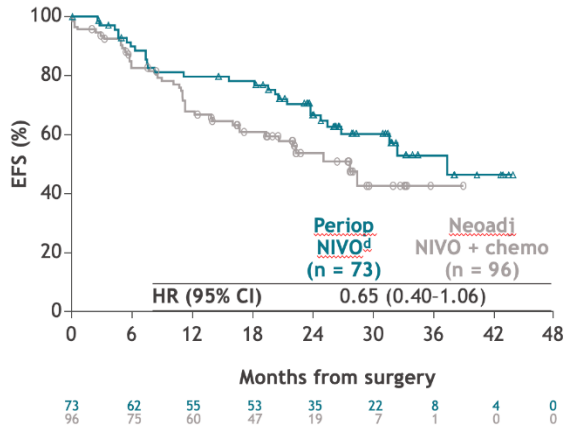
CheckMate 77T vs CheckMate 816: Periop vs neoadj nivolumab

Landmark EFS (analysis population) by PCR status

pCR[c]

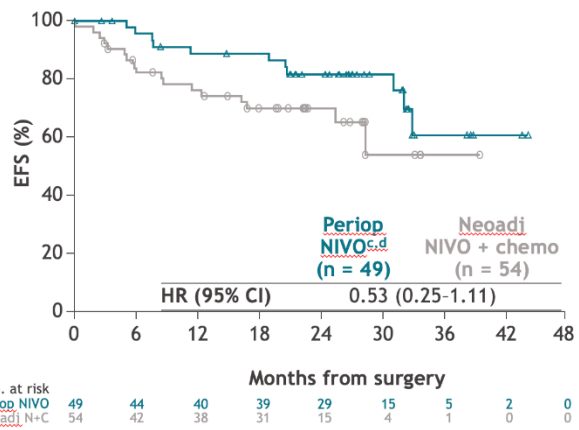


No pCR

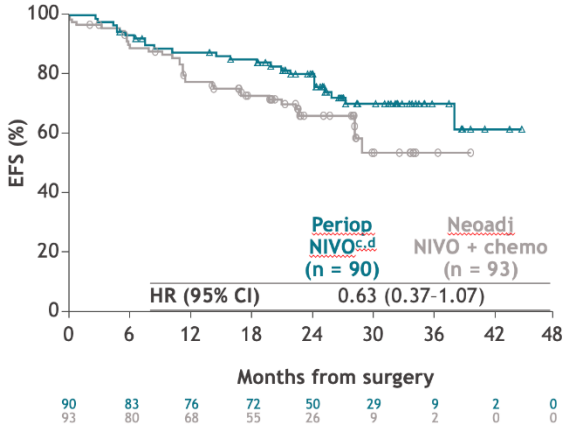


Landmark EFS (analysis population) by clinical stage

Stage IB-II

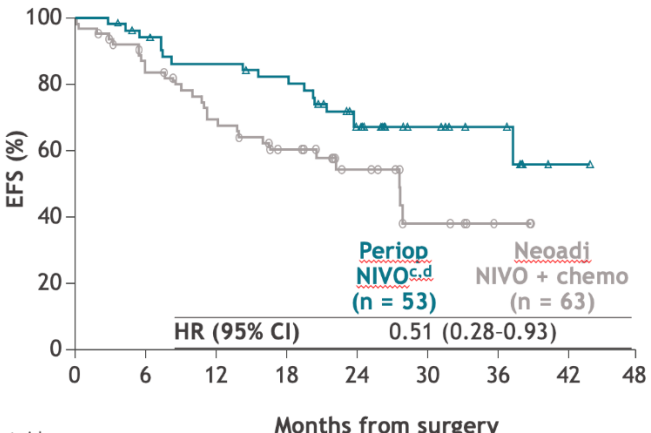


Stage III

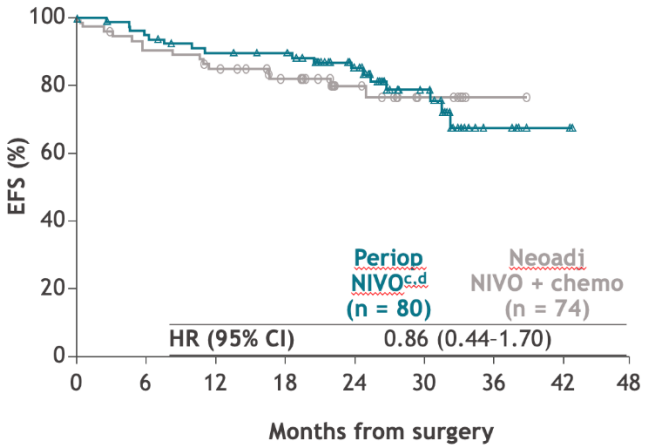


Landmark EFS (analysis population) by tumor PD-L1 expression

PD-L1 < 1%



PD-L1 ≥ 1%



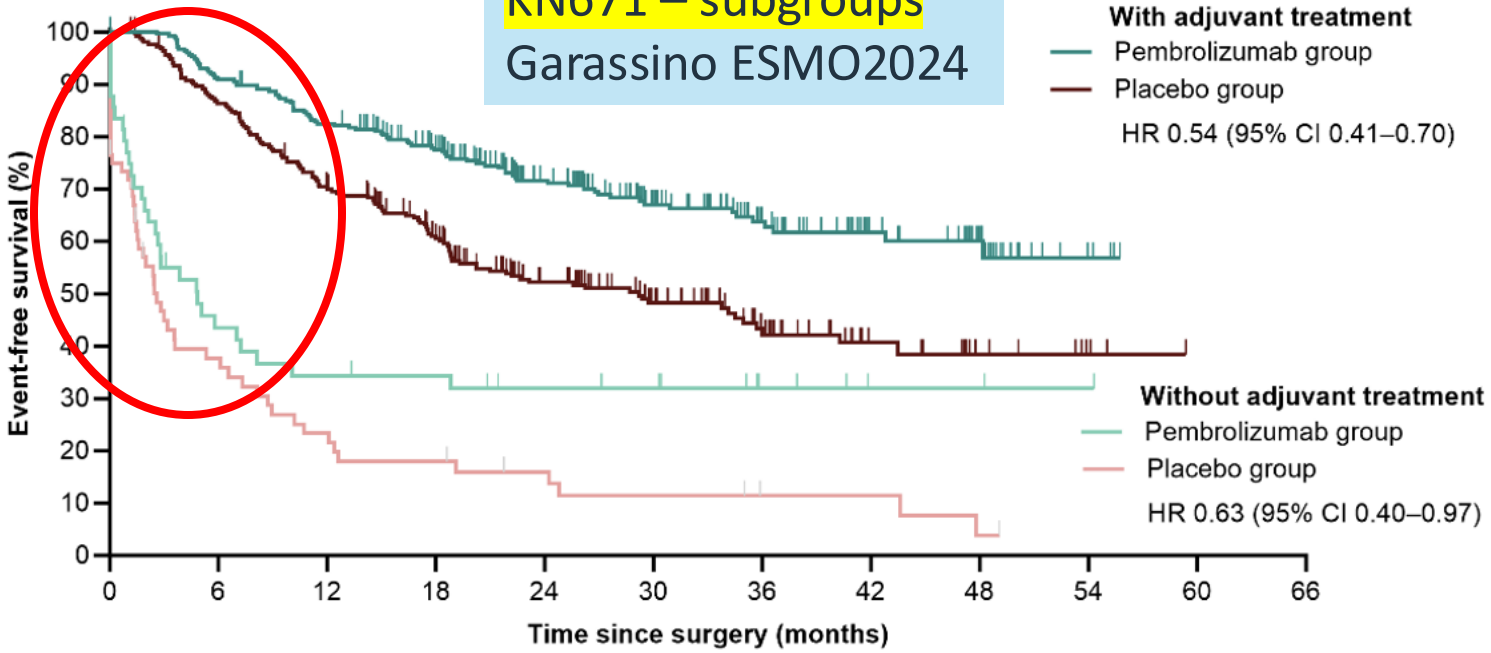
Forde PM, et al. WCLC 2024; Abstract PL02.08.

CheckMate 77T vs CheckMate 816: Periop vs neoadj nivolumab

Beware the patients who do not get adjuvant therapy – small numbers but poor outcomes

KN671 – subgroups
Garassino ESMO2024

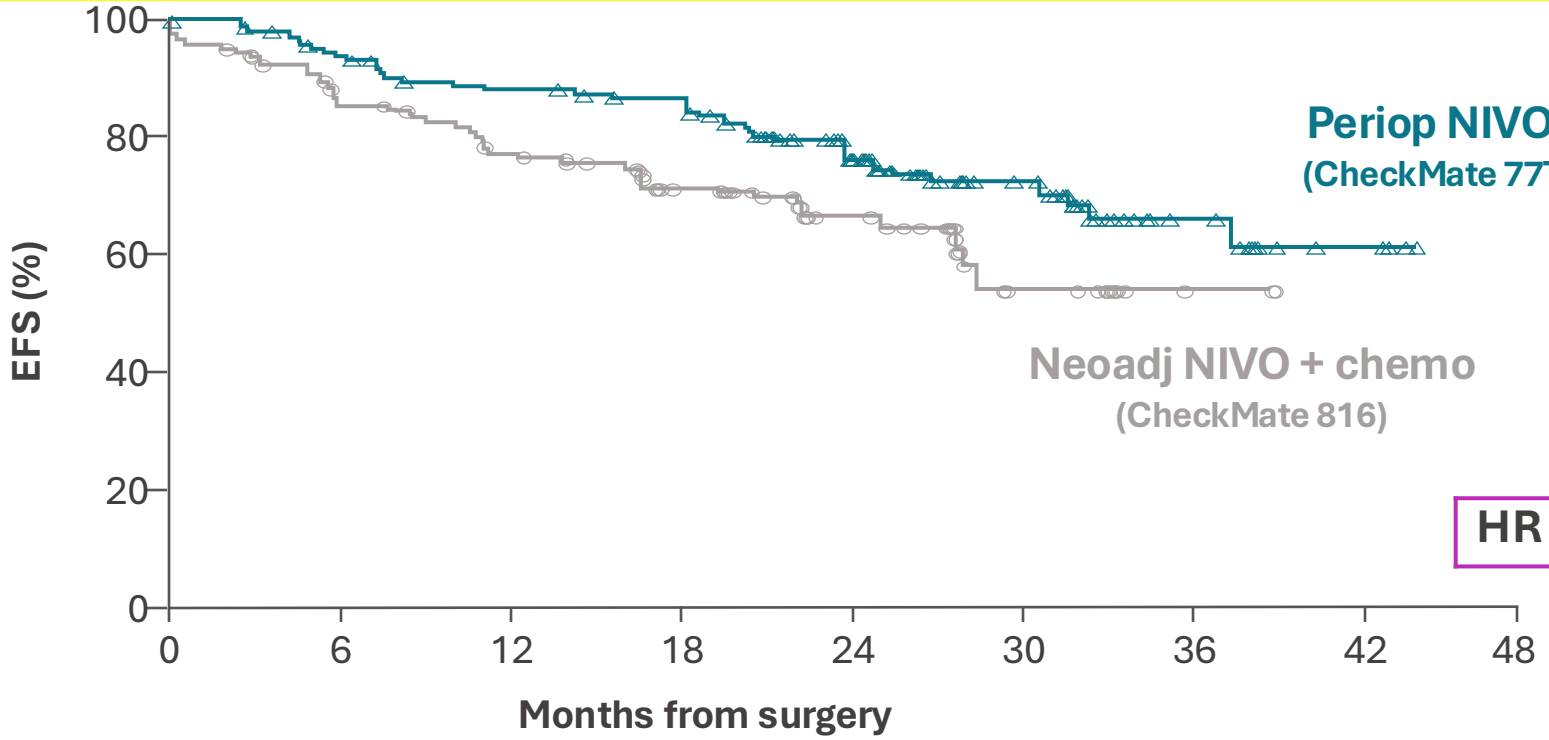
EFS in patients who did or did not receive adjuvant therapy



Number at risk (number censored)													
With adjuvant treatment	Pembrolizumab group	276 (0)	250 (1)	225 (3)	191 (24)	139 (63)	99 (95)	64 (126)	38 (150)	24 (163)	4 (182)	0 (186)	0 (186)
	Placebo group	253 (0)	216 (3)	173 (5)	136 (21)	91 (48)	64 (69)	39 (89)	18 (108)	8 (117)	3 (122)	0 (125)	0 (125)
Without adjuvant treatment	Pembrolizumab group	49 (0)	19 (4)	15 (4)	14 (5)	11 (7)	10 (8)	5 (13)	2 (16)	2 (16)	1 (17)	0 (18)	0 (18)
	Placebo group	64 (0)	21 (5)	13 (5)	10 (5)	7 (7)	5 (7)	3 (9)	3 (9)	1 (9)	0 (10)	0 (10)	0 (10)

Landmark EFS (BICR) from definitive surgery

Comparing ALL who had surgery on 816 and EXCLUDING those who had surgery but did NOT get a dose of Adjuvant chemotherapy on 77T : Not Apples to Apples instead is Apples to Shiny Apples comparison



No. at risk

Periop NIVO	139.4	128.0	118.1	112.9	79.7	42.5	13.0	3.1	0
Neoadj N+C	147.5	121.0	106.2	84.2	39.1	12.1	2.2	0	0

Weighted (ATE)[b]

	Periop NIVO[a] (n = 139.4[c])	Neoadj NIVO + chemo (n = 147.5[c])
HR (95% CI)	0.61 (0.39–0.97)	

- HR (95% CI): ATT[d] weighted analysis, 0.56 (0.35–0.90); unweighted analysis, 0.59 (0.38–0.92)

Median follow-up: CheckMate 816, 29.5 months; CheckMate 77T, 33.3 months. [a]Includes only patients who received ≥ 1 dose of adjuvant NIVO. [b]ATE: varying weights were applied to all patients in both neoadjuvant NIVO + chemo arm (CheckMate 816) and perioperative NIVO (CheckMate 77T) to make them comparable to one another. [c]N values fractional due to weighting. [d]ATT: varying weights were applied to patients in the neoadjuvant NIVO + chemo arm (CheckMate 816) to make them comparable to those in the perioperative NIVO arm (CheckMate 77T).

In the unweighted analysis population, 89 patients (64%) completed adjuvant therapy, and median number of doses (range) was 13.0 (1–13). Unweighted landmark EFS from surgery among all patients who had surgery (regardless of whether they received adjuvant NIVO in CheckMate 77T) for periop NIVO vs neoadj NIVO + chemo: HR = 0.82 (95% CI, 0.55–1.21).

Safety summary[a]: analysis populations

Patients, n (%)	Perioperative NIVO (n = 139)		Neoadjuvant NIVO + chemo (n = 147)	
	Any grade[b]	Grade 3–4[b]	Any grade[c]	Grade 3–4[c]
All AEs	137 (99)	64 (46)	138 (94)	63 (43)
TRAEs	130 (94)	38 (27)	125 (85)	52 (35)
All AEs leading to discontinuation	29 (21)	10 (7)	16 (11)	8 (5)
TRAEs leading to discontinuation	22 (16)	9 (6)	16 (11)	8 (5)
All SAEs	57 (41)	37 (27)	23 (16)	16 (11)
Treatment-related SAEs	23 (16)	14 (10)	17 (12)	13 (9)
Surgery-related AEs[d]	53 (38)	15 (11)	61 (42)	17 (12)
Treatment-related deaths[e]	0		0	

[a]AEs per CTCAE v4.0 and MedDRA v24.0 (CheckMate 816) or v26.1 (CheckMate 77T). [b]Includes events reported between the first dose and 30 days after the last dose of study treatment. [c]Includes events reported between the first neoadjuvant dose and 30 days after the last dose of neoadjuvant study treatment. [d]Includes events reported within 90 days after definitive surgery. [e]Treatment-related deaths occurring at any time after the first dose of neoadjuvant study treatment.

Summary: 816 vs 77T (what does the adjuvant add)

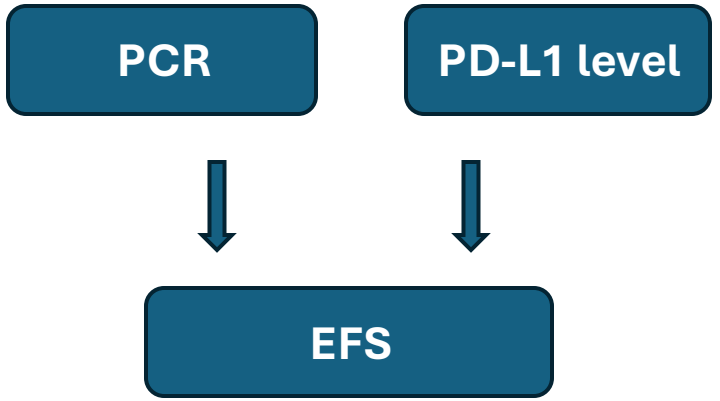
- Author Conclusions
- In the absence of a randomized-controlled trial, this analysis represents the only comparison of perioperative vs neoadjuvant-only immunotherapy treatments for patients with resectable NSCLC, using individual patient-level data from 2 randomized phase 3 trials
- Approximately 40% reduction in risk of disease recurrence or death after surgery was observed in patients who received ≥ 1 dose of adjuvant NIVO following neoadjuvant NIVO + chemo treatment and surgery compared with those who did not receive adjuvant NIVO
  - Similar benefit was seen regardless of baseline stage, with a greater magnitude of benefit in patients with tumor PD-L1 expression < 1%

- My Conclusions:
- Important comparison where we have little data
- FLAWED by excluding those who did not get adjuvant therapy in CM77T (versus all who had surgery on 816)
- We still need to do the the trial to ask the question about the benefit of adjuvant after neo-adjuvant, but this is supportive data

pCR and PD-L1 level influence the survival benefit from neoadj/periop chemoimmunotherapy

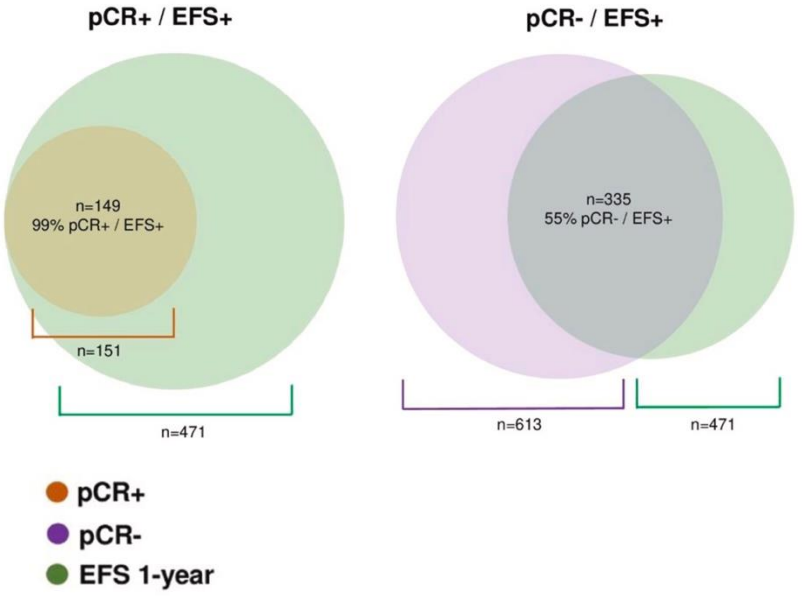
EFS/PFS by PCR

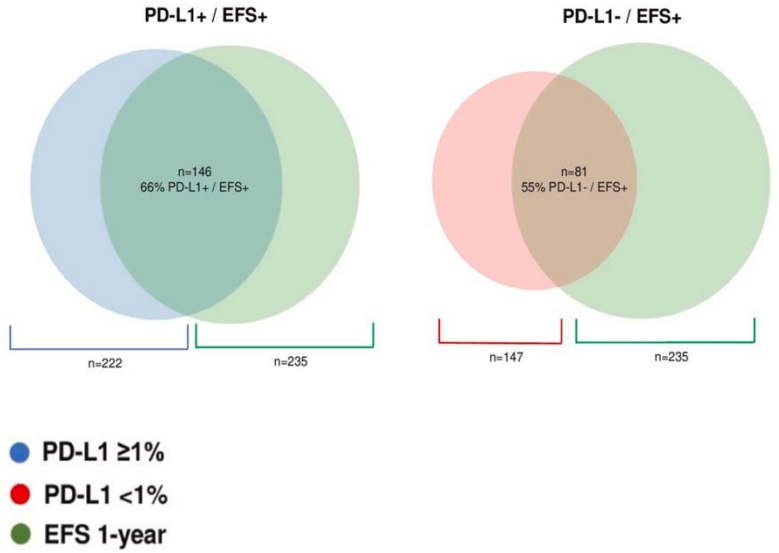
	HR	95%CI
PCR	0.17	0.09-0.33
Non-PCR	0.73	0.62-0.88



DFS/PFS by PD-L1 TPS

PD-L1	HR	95%CI
<1%	0.76	0.62-0.94
1-49%	0.52	0.37-0.72
≥ 50%	0.41	0.29-0.57





Need to answer: Which one would be a better prognostic marker for both treatment approaches?

Nuccio A, et al. Eur J Cancer 2023; 195: 113404

Association of Pathologic Regression With Event-Free Survival in the KEYNOTE-671 Study of Perioperative Pembrolizumab for Early-Stage NSCLC

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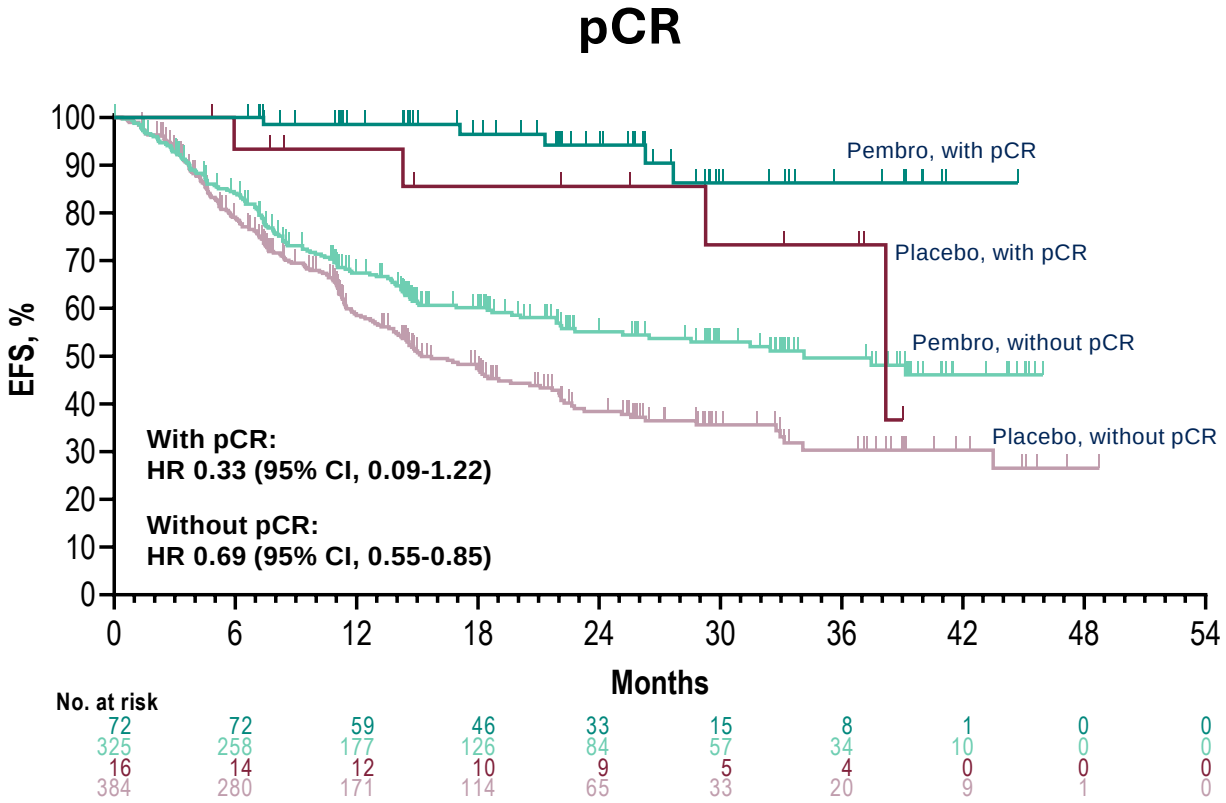
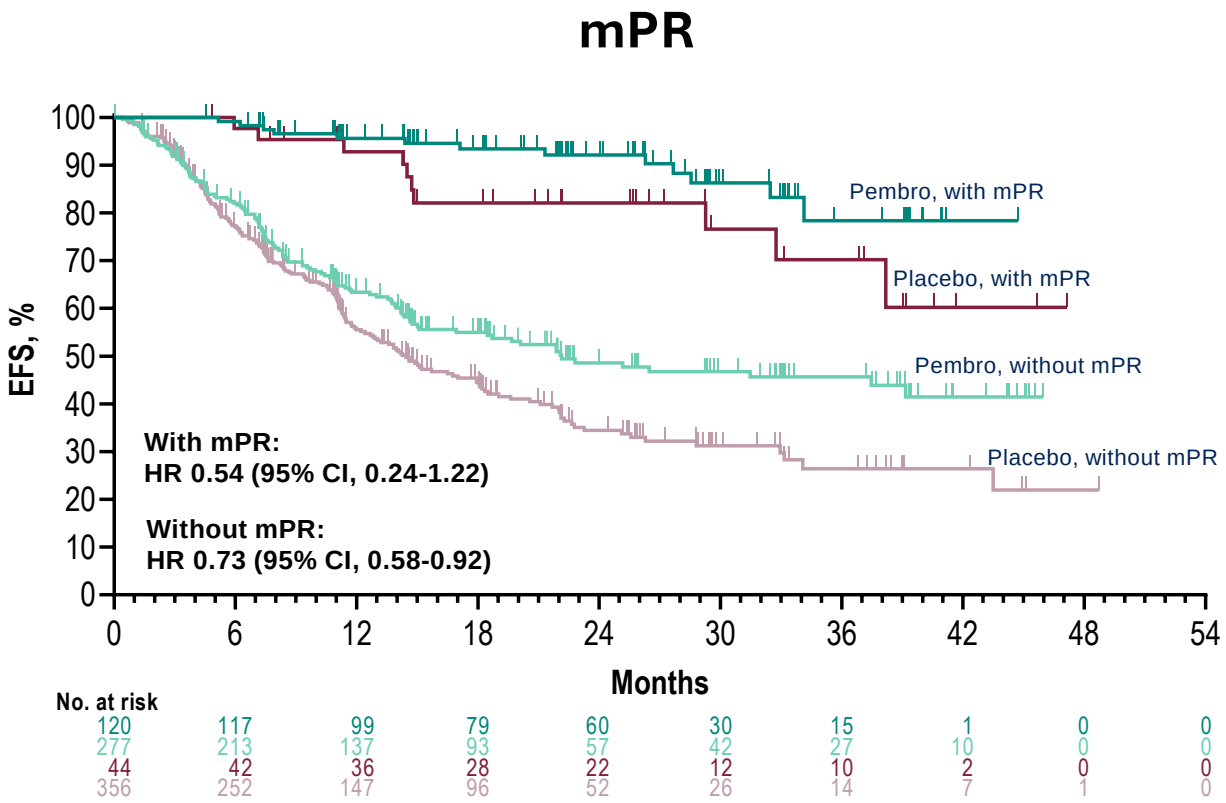
Event-Free Survival Among Patients With pCR or mPR[a,1]



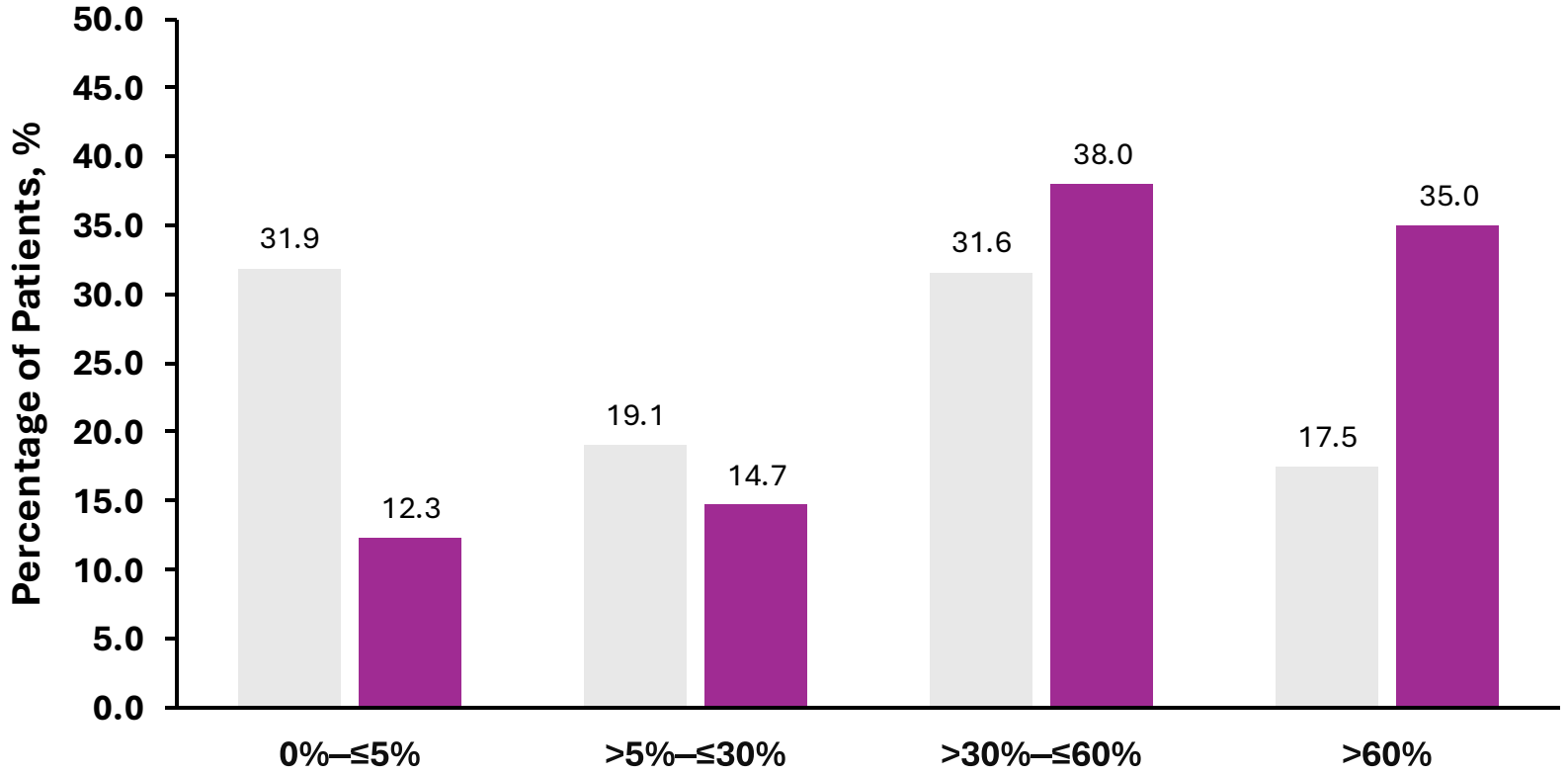


Objective of this analysis was to evaluate efficacy of perioperative pembrolizumab across different RVT cutpoints, beyond pCR and mPR

[1]Wakelee H et al. *N Engl J Med* 2023;389:491–503.

[a]Exploratory analysis. pCR defined as absence of residual invasive cancer in resected primary tumor and lymph nodes (ypT0/Tis ypN0). [b]mPR defined as ≤10% viable tumor cells in resected primary tumor and lymph nodes. EFS defined as time from randomization to first occurrence of local progression precluding planned surgery, unresectable tumor, progression or recurrence per RECIST v1.1 by investigator

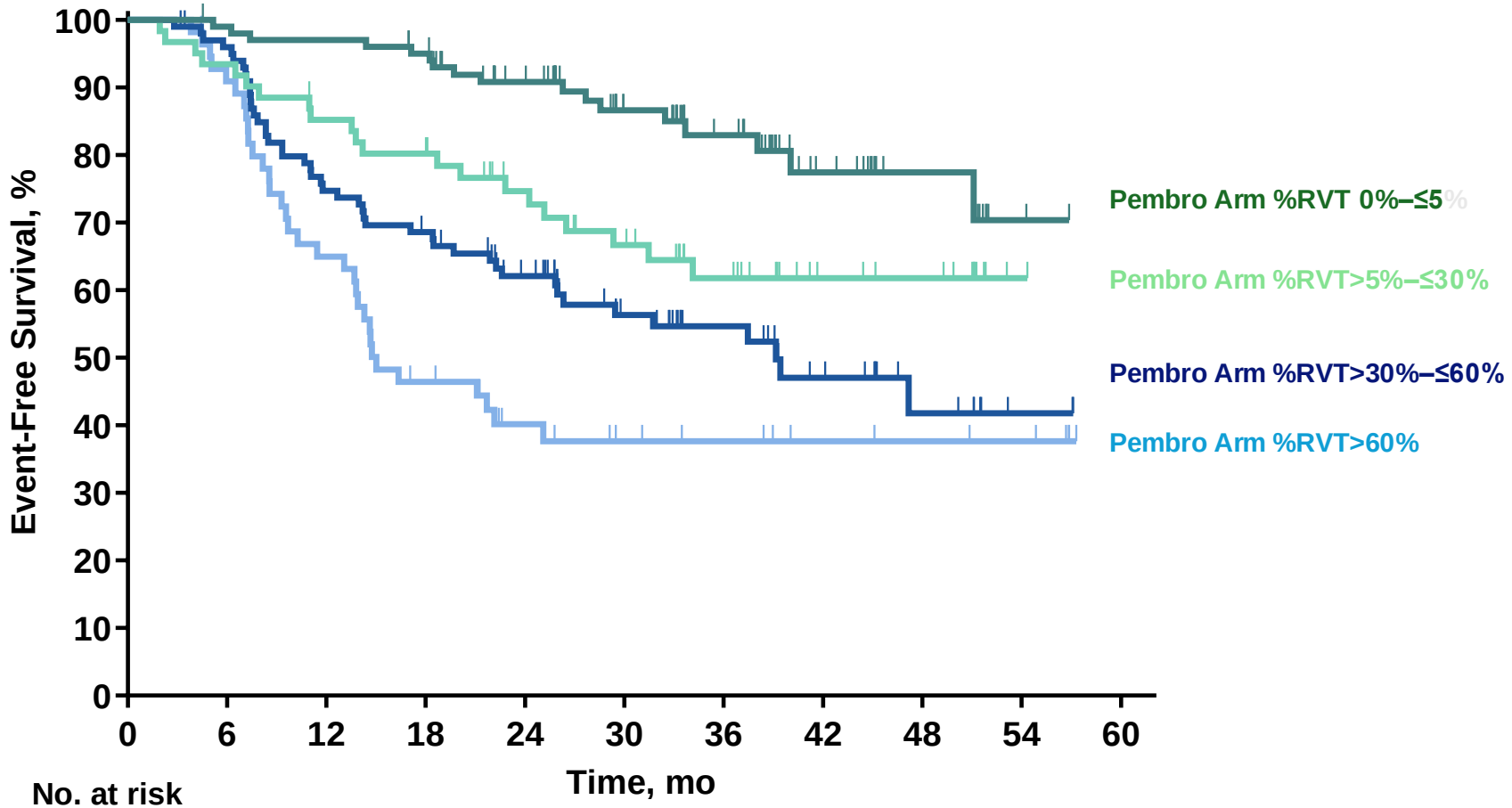
%RVT Categorization of Patients With Pathologically Evaluable Tumors



	n	Median %RVT (IQR), %
Pembro Arm	320	29.5 (1.0–56.0)
Placebo Arm	300	52.0 (29.0–68.0)

Event-Free Survival

According to %RVT Categorization in the Pembrolizumab Arm



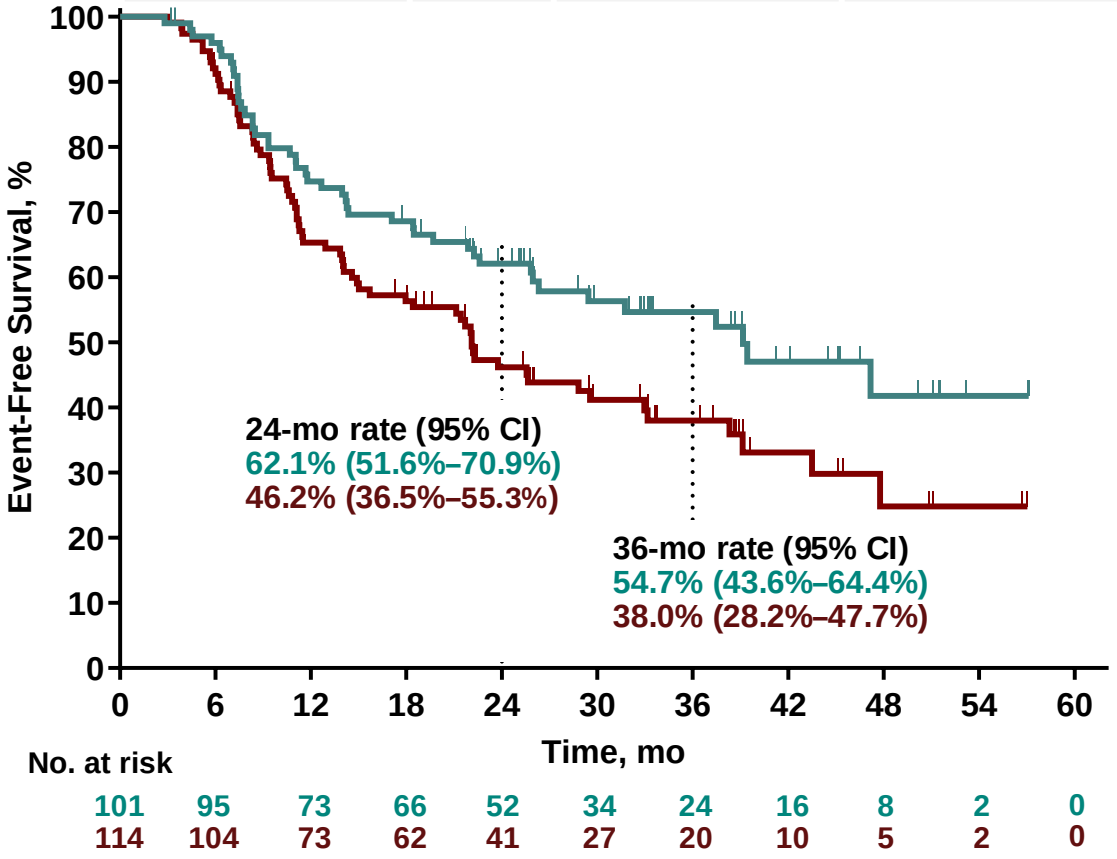
No. at risk											
%RVT 0%–≤5%	102	100	98	94	77	54	39	21	11	2	0
%RVT >5%–≤30%	61	57	51	48	38	32	23	13	11	1	0
%RVT >30%–≤60%	101	95	73	66	52	34	24	16	8	2	0
%RVT >60%	56	50	35	24	16	12	10	7	6	5	0

Event-Free Survival

Patients Who Underwent Surgery and Had RVT >30%–≤60% or >60%

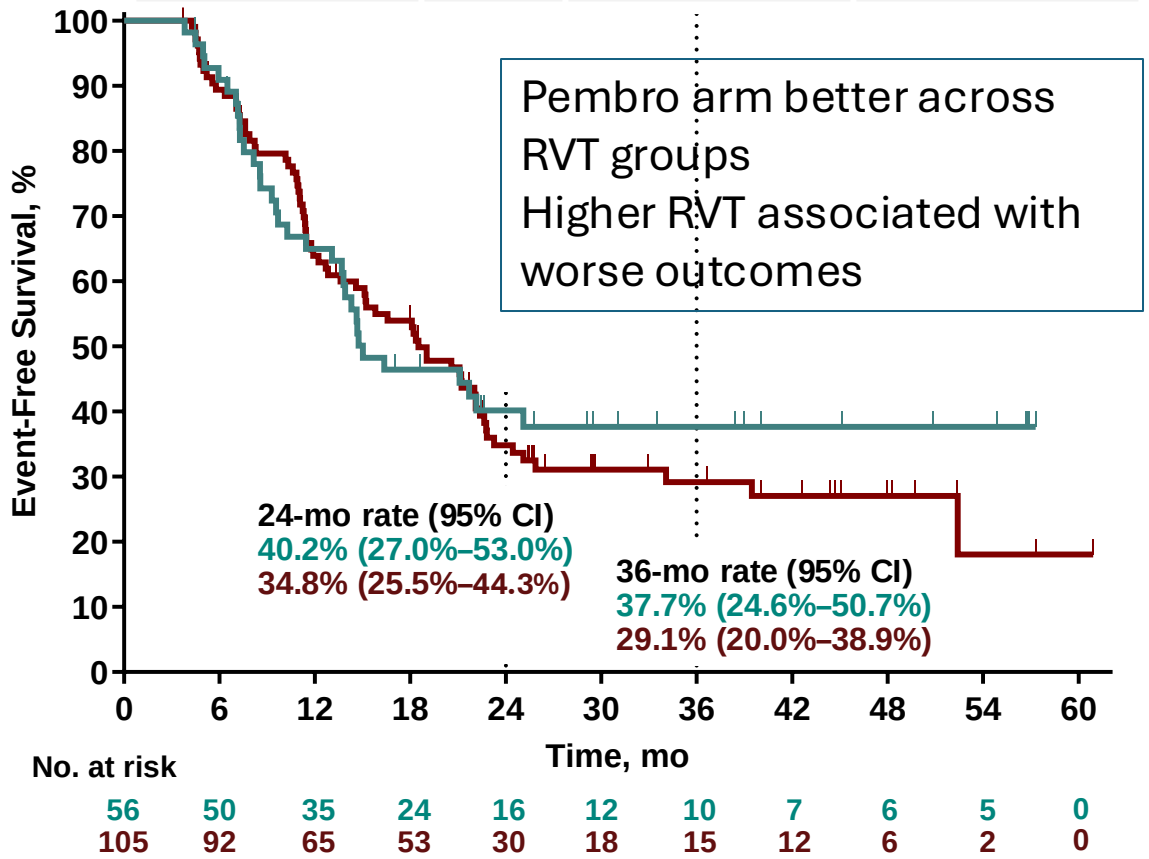
%RVT >30%–≤60%

	Pts w/ Event	Median, mo (95% CI)	HR (95% CI)
Pembro Arm	45.5%	39.2 (26.0–NR)	0.65 (0.45–0.94)
Placebo Arm	60.5%	22.1 (14.9–33.0)	



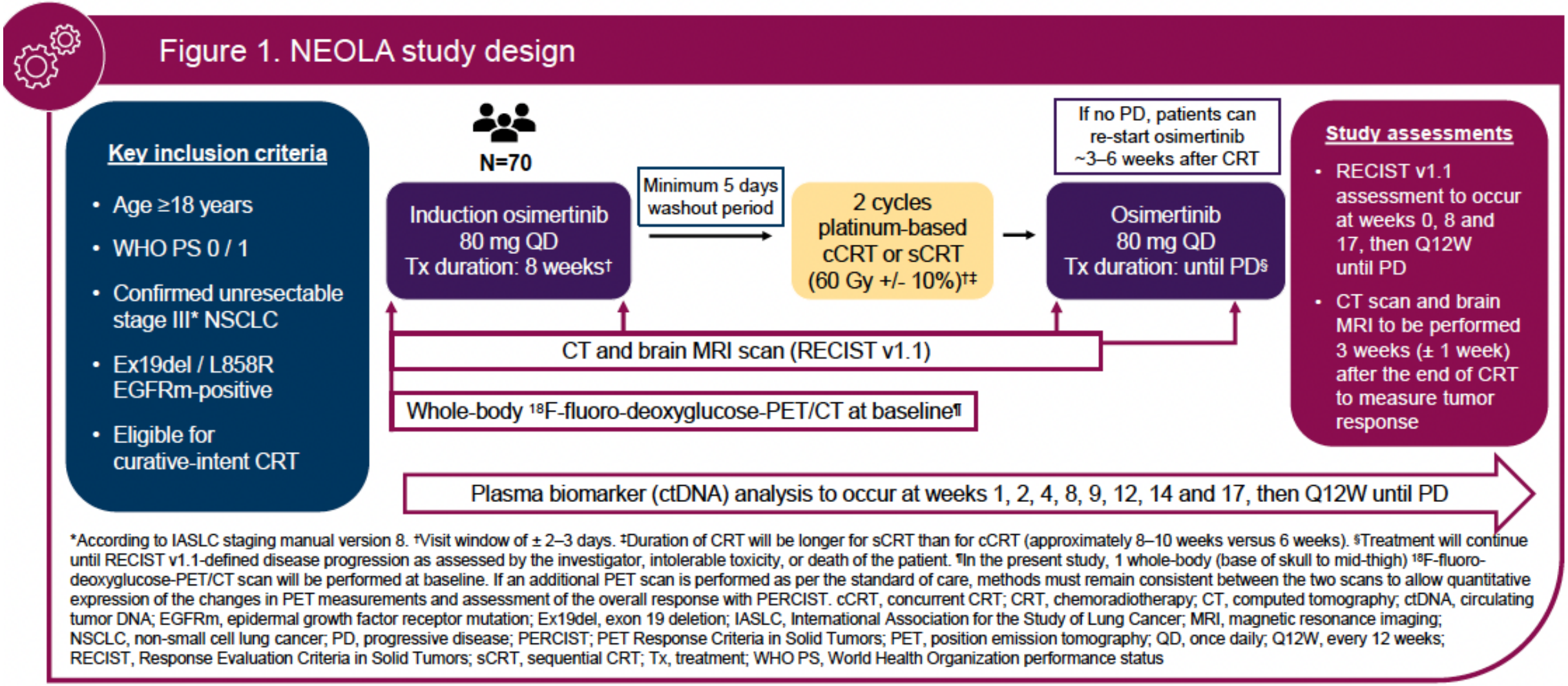
%RVT >60%

	Pts w/ Event	Median, mo (95% CI)	HR (95% CI)
Pembro Arm	58.9%	15.0 (13.1–NR)	0.90 (0.60–1.36)
Placebo Arm	67.6%	18.5 (13.6–22.1)	



Neola Poster P3.08F.08 Wakelee….Aredo

Figure 1. NEOLA study design



*According to IASLC staging manual version 8. †Visit window of ± 2–3 days. ‡Duration of CRT will be longer for sCRT than for cCRT (approximately 8–10 weeks versus 6 weeks). §Treatment will continue until RECIST v1.1-defined disease progression as assessed by the investigator, intolerable toxicity, or death of the patient. ¶In the present study, 1 whole-body (base of skull to mid-thigh) ^{18}F-fluoro-deoxyglucose-PET/CT scan will be performed at baseline. If an additional PET scan is performed as per the standard of care, methods must remain consistent between the two scans to allow quantitative expression of the changes in PET measurements and assessment of the overall response with PERCIST. cCRT, concurrent CRT; CRT, chemoradiotherapy; CT, computed tomography; ctDNA, circulating tumor DNA; EGFRm, epidermal growth factor receptor mutation; Ex19del, exon 19 deletion; IASLC, International Association for the Study of Lung Cancer; MRI, magnetic resonance imaging; NSCLC, non-small cell lung cancer; PD, progressive disease; PERCIST; PET Response Criteria in Solid Tumors; PET, position emission tomography; QD, once daily; Q12W, every 12 weeks; RECIST, Response Evaluation Criteria in Solid Tumors; sCRT, sequential CRT; Tx, treatment; WHO PS, World Health Organization performance status

- **Neo-Adjuvant, Adjuvant and Peri-operative IO therapy improves EFS/DFS and with peri-operative OS for resectable early stage NSCLC**
- **5 year outcomes showing durable benefit**
- **NeoCoast2 shows promise with Dato-DXD and other novel agents with neo-adjuvant durvalumab**
- **Comparison on CM77T and CM816 shows ? Benefit of the Adjuvant component**
- **Many trials show degree of pathologic response correlates with outcomes (KN671)**
- **Targeted Therapy uses expanding in early stage NSCLC**