

VIII SIMPOSIO NACIONAL
de ONCOLOGÍA de PRECISIÓN

Vigo, 19 y 20 de febrero de 2026



Lo mejor del 2025 en cáncer de pulmón

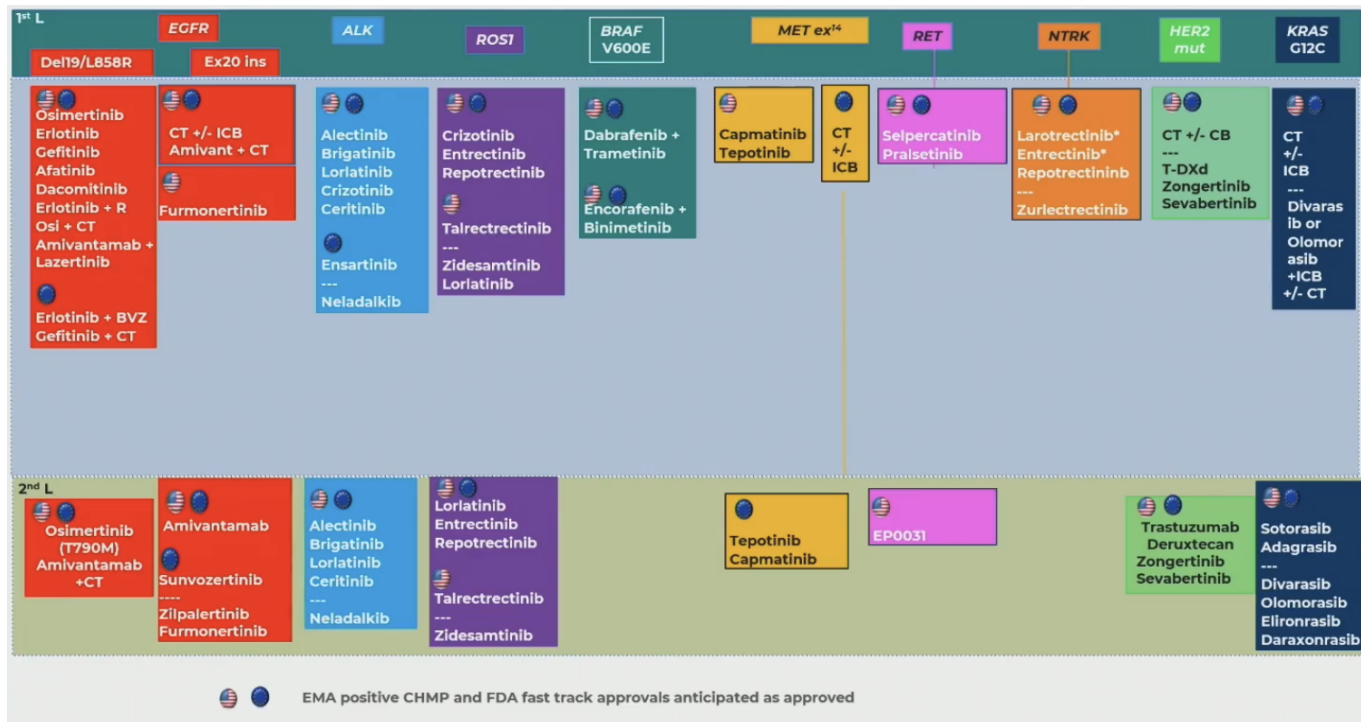
(en 20 diapos...imposible)

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Disclosures

- Consultant or Advisor: MSD, Bristol-Myers, Roche, Boehringer Ingelheim, Pfizer, Novartis, AstraZeneca, Lilly, Takeda
- Speaker: MSD, Bristol-Myers, Roche, Boehringer Ingelheim, Pfizer, Novartis, AstraZeneca, Lilly, Takeda, Jansenn, Thermo Fisher, Guardant Health
- Co-founder: Trialing Health S.L

NSCLC with actionable genomic alterations

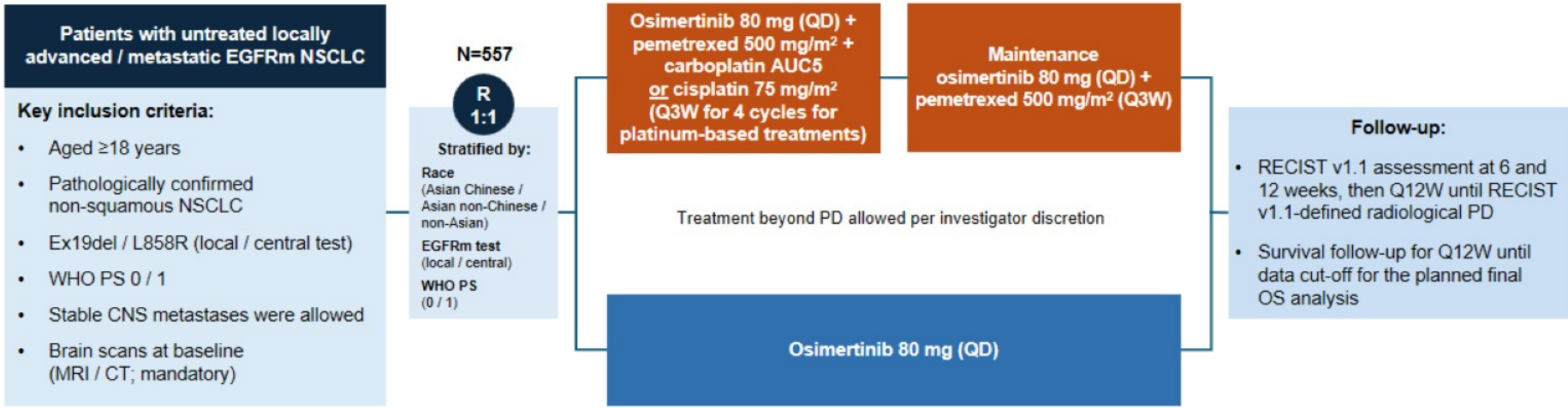


NSCLC with AGAs

Actionable genomic alterations

- *EGFR* in advanced 1L and preoperative settings
- *BRAF* V600E
- *Reimbursement for alectinib in the adjuvant setting*

FLAURA2 phase III study¹



• **Primary endpoint:** Investigator-assessed PFS (RECIST v1.1)¹

• **Secondary endpoints included:** OS, TFST, DoR, DCR, PFS2, TSST, HRQoL

OS was a key secondary endpoint*

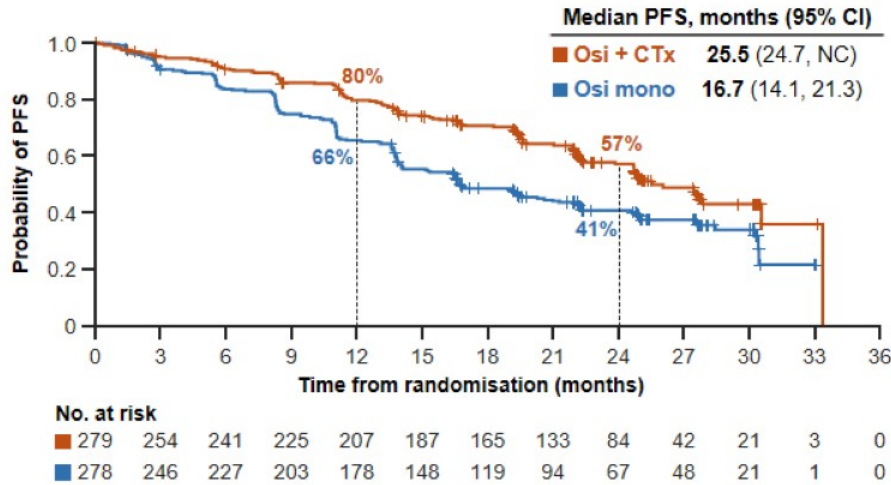
Final OS analysis performed at 57% maturity

D. Planchard. First-line Osimertinib + Chemotherapy Versus Osimertinib Monotherapy in EGFRm Advanced NSCLC: FLAURA2 Final Overall Survival

NCT04035486
 1. Planchard D, et al. N Engl J Med 2023;369:1936-1948
 *For statistical significance of OS, a two-sided p-value of less than 0.04953, as determined by the O'Brien-Fleming spending rule, was required
 AUC, area under the curve; CNS, central nervous system; CT, computed tomography; DCR, disease control rate; DoR, duration of response; EGFRm, epidermal growth factor receptor-mutated; Ex19del, exon 19 deletion; HRQoL, health-related quality of life; MRI, magnetic resonance imaging; NSCLC, non-small cell lung cancer; OS, overall survival; PD, progressive disease; PFS, progression-free survival; PFS2, time from randomisation to second progression on a subsequent treatment; QD, once daily; QXW, every X weeks; RECIST, Response Evaluation Criteria in Solid Tumors; TFST, time to first subsequent treatment or death; TSST, time to second subsequent treatment or death; WHO PS, World Health Organization performance status

Primary analysis: Progression-free survival¹

Investigator-assessed PFS: HR=0.62 (95% CI: 0.49, 0.79); p<0.001



Subgroup		Osi + CTx (Events / patients)	Osi mono (Events / patients)	HR (95% CI)
All patients	Stratified log-rank	120 / 279	166 / 278	0.62 (0.49, 0.79)
	Unadjusted Cox PH	120 / 279	166 / 278	0.62 (0.49, 0.78)
Sex	Male	51 / 108	73 / 109	0.54 (0.37, 0.77)
	Female	69 / 173	93 / 169	0.67 (0.49, 0.92)
Race*	Asian Chinese	26 / 71	43 / 69	0.49 (0.30, 0.81)
	Asian non-Chinese	54 / 107	65 / 107	0.76 (0.53, 1.09)
	Non-Asian	40 / 101	58 / 102	0.55 (0.37, 0.83)
EGFR mutation test method	Central	52 / 121	67 / 119	0.73 (0.51, 1.05)
	Local	68 / 158	99 / 159	0.55 (0.40, 0.74)
Age at screening	<65 years	73 / 174	97 / 166	0.59 (0.44, 0.80)
	≥65 years	47 / 105	69 / 112	0.68 (0.47, 0.98)
Smoking history	Yes	43 / 91	57 / 97	0.63 (0.42, 0.94)
	No	77 / 188	109 / 181	0.61 (0.46, 0.82)
EGFR mutation type†	Ex19del	65 / 172	94 / 169	0.60 (0.44, 0.83)
	L858R	55 / 106	70 / 107	0.63 (0.44, 0.90)
WHO PS	0	48 / 101	57 / 102	0.79 (0.54, 1.16)
	1	72 / 178	109 / 176	0.53 (0.39, 0.72)
CNS mets at baseline	Yes	52 / 116	79 / 110	0.47 (0.33, 0.66)
	No	68 / 163	87 / 168	0.75 (0.55, 1.03)

0.1 ← Favours osi + CTx | Favours osi mono → 2

Osi + CTx showed a statistically significant and clinically meaningful improvement in PFS versus osi mono; PFS benefit was consistent across predefined subgroups

Figures from N Engl J Med, Planchard D, Jänne PA, Cheng Y, et al., Osimertinib with or without Chemotherapy in EGFR-Mutated Advanced NSCLC, 389:1935-48. Copyright © (2023) Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society.

D. Planchard. First-line Osimertinib + Chemotherapy Versus Osimertinib Monotherapy in EGFRm Advanced NSCLC: FLAURA2 Final Overall Survival

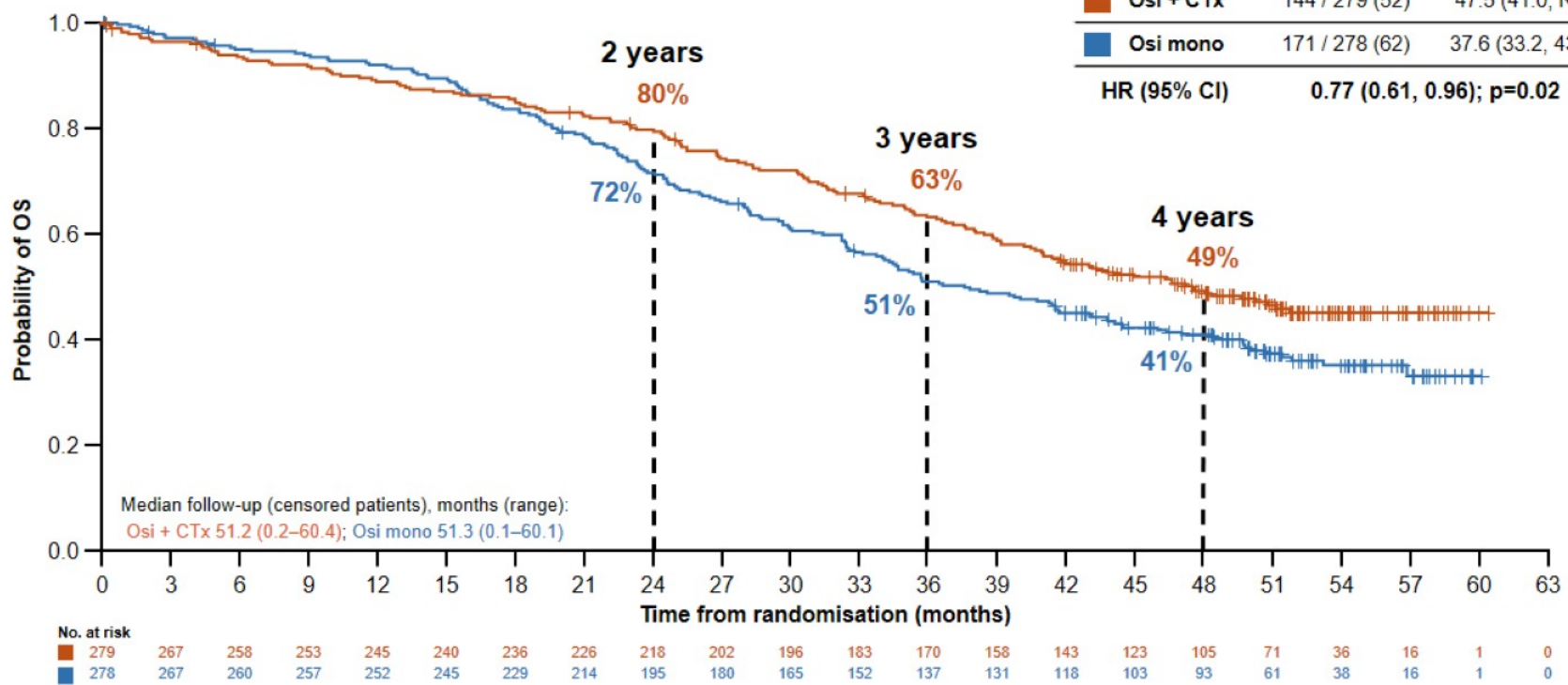
Data cut-off: 03 April 2023
 1. Planchard D, et al. N Engl J Med 2023;389:1935-1948
 *Race was reported by the patient. †For EGFR mutation type, patients with both Ex19del and L858R mutations were included in the Ex19del group
 CI, confidence interval; CNS, central nervous system; CTx, chemotherapy; EGFR, epidermal growth factor receptor; HR, hazard ratio; mets, metastases; mono, monotherapy; NC, not calculable; osi, osimertinib; PFS, progression-free survival; PH, proportional hazard; WHO PS, World Health Organization performance status



FLAURA2: Overall survival

Median OS with osi + CTx was 47.5 months

	No. Events / no. patients (%)	Median OS, months (95% CI)
Osipi + CTx	144 / 279 (52)	47.5 (41.0, NC)
Osipi mono	171 / 278 (62)	37.6 (33.2, 43.2)
HR (95% CI)	0.77 (0.61, 0.96); p=0.02	



Safety

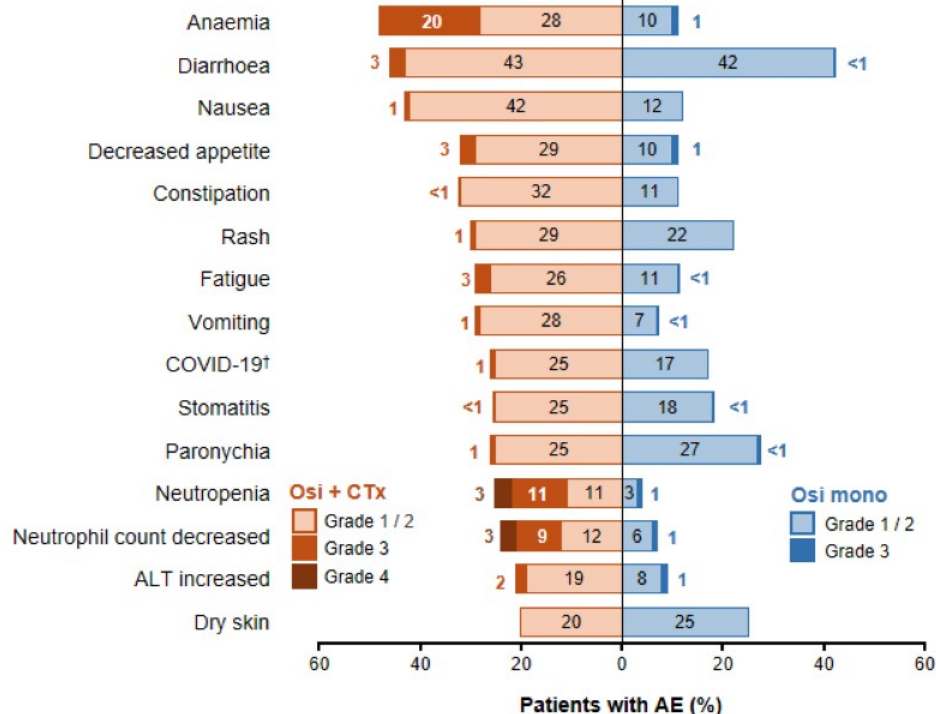
Since the primary analysis¹ (>2 years additional follow-up):

- No new safety signals observed
- AEs leading to discontinuation of osi remained low
- No new treatment-related deaths observed with osi + CTx (vs 1 with osi mono)

AE summary

	Osi + CTx (n=276)	Osi mono (n=275)
AE any cause, n (%)		
Any grade	276 (100)	269 (98)
Grade ≥3	193 (70)	94 (34)
Serious	126 (46)	75 (27)
Outcome of death	22 (8)	10 (4)
Considered possibly related to treatment	5 (2)	2 (1)
Leading to discontinuation of osi	34 (12)	20 (7)
Leading to discontinuation of pemetrexed	137 (50)	NA
Leading to discontinuation of platinum	46 (17)	NA

Most common AEs*





Amivantamab Plus Lazertinib vs Osimertinib in First-line *EGFR*-mutant Advanced NSCLC

Final Overall Survival from the Phase 3 MARIPOSA Study

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Shun Lu⁶, Adlinda Alip⁷, Ernesto Korbenfeld⁸, Josiane Mourão Dias⁹, Pongwut Danchaivijitr¹⁰,
Nicolas Girard¹¹, Enriqueta Felip¹², Hidetoshi Hayashi¹³, Alexander I Spira¹⁴, Benjamin Besse¹⁵,
Tao Sun¹⁶, Mariah Ennis¹⁷, Seema Sethi¹⁷, Joshua M Baum¹⁷, Byoung Chul Cho¹⁸

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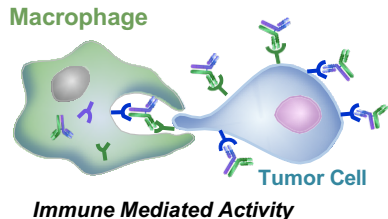
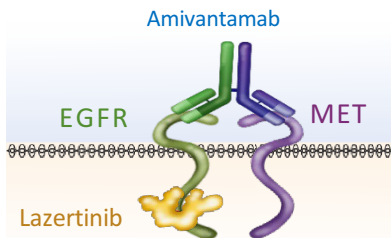
Organisers



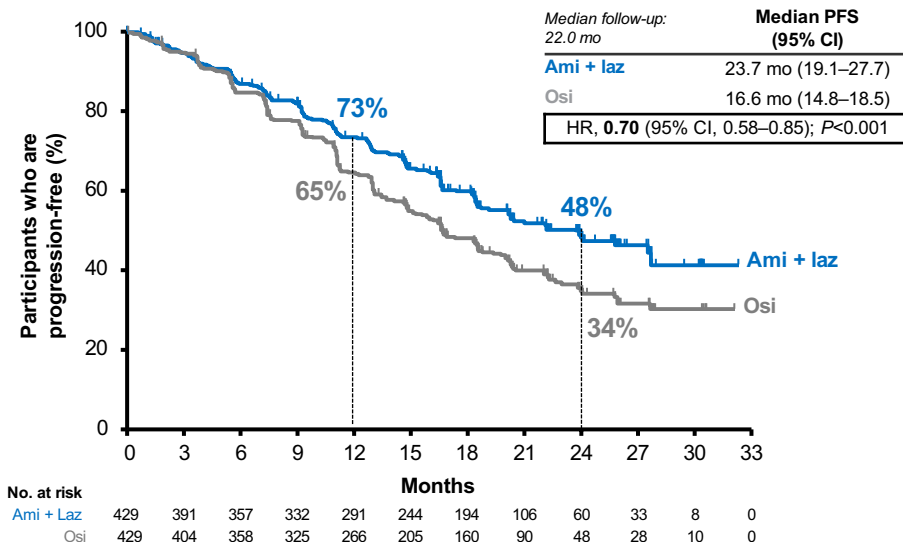
Partners



- In MARIPOSA, 1L amivantamab + lazertinib significantly improved PFS vs osimertinib^{1,2}
- Amivantamab + lazertinib is approved for patients with 1L EGFR-mutant advanced NSCLC^{3,4}
- 1L amivantamab + lazertinib exhibits a triple mechanism of action with a reduction in the spectrum and complexity of acquired resistance⁵



1L Amivantamab + Lazertinib Primary Endpoint: PFS by BICR^{1,2}



Here, we report the protocol-specified final overall survival results of 1L amivantamab + lazertinib vs osimertinib from MARIPOSA

1. From *New England Journal of Medicine*, Cho BC, et al., Amivantamab plus Lazertinib in Previously Untreated EGFR-Mutated Advanced NSCLC, Volume No. 391 (16), Pages 1486-1498. Copyright © (2024) Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society. 2. Cho BC, et al. Presented at the European Society for Medical Oncology (ESMO) Congress; October 20-24, 2023; Madrid, Spain. 3. RYBREVANT® (amivantamab-vmjw) injection for intravenous use [package insert]. Horsham, PA: Janssen Biotech, Inc.; 2025. 4. Johnson & Johnson. European Commission approves LAZCLUZE® (lazertinib) in combination with RYBREVANT® (amivantamab) for the first-line treatment of patients with EGFR-mutated advanced non-small cell lung cancer. January 21, 2025. Accessed January 27, 2025. 5. Besse B, et al. Presented at the European Society for Medical Oncology (ESMO) Congress; September 13-17, 2024; Barcelona, Spain.



Key Eligibility Criteria

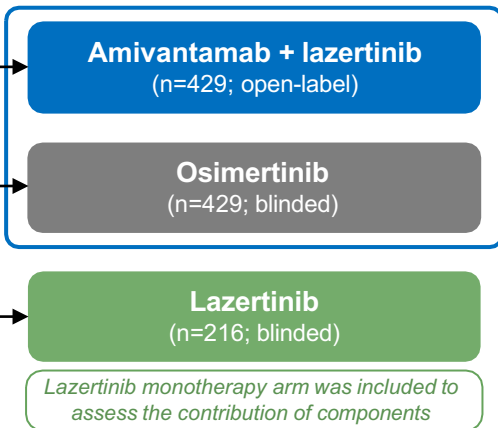
- Locally advanced or metastatic NSCLC
- Treatment-naïve for advanced disease
- Documented *EGFR* Ex19del or L858R
- ECOG PS 0 or 1

Stratification Factors

- *EGFR* mutation type (Ex19del or L858R)
- Asian race (yes or no)
- History of brain metastases (yes or no)

2:2:1 Randomization
(N=1074)

Focus of this presentation



Primary endpoint:

- PFS by BICR per RECIST v1.1

Key secondary endpoint:

- Protocol-specified final overall survival^b

Other endpoints reported in this presentation:

- Intracranial PFS (icPFS)
- Intracranial ORR (icORR)
- Intracranial DoR (icDoR)
- Time to symptomatic progression (TTSP)
- Safety

Serial brain MRIs were required for all participants
MARIPOSA did not allow treatment crossover^a

OS was a key secondary endpoint with prespecified alpha to assess significance

- Protocol-specified final OS analysis was planned for when ~390 deaths had occurred in the amivantamab + lazertinib and osimertinib arms
- OS was tested with a 2-sided alpha of 0.05, determined by O'Brien-Fleming alpha spending approach as implemented by the Lan-DeMets method
 - In the prespecified interim analysis, a 2-sided alpha of 0.005 was allocated for OS
 - The protocol-specified final analysis of overall survival was subsequently evaluated at a 2-sided significance level of 0.0484

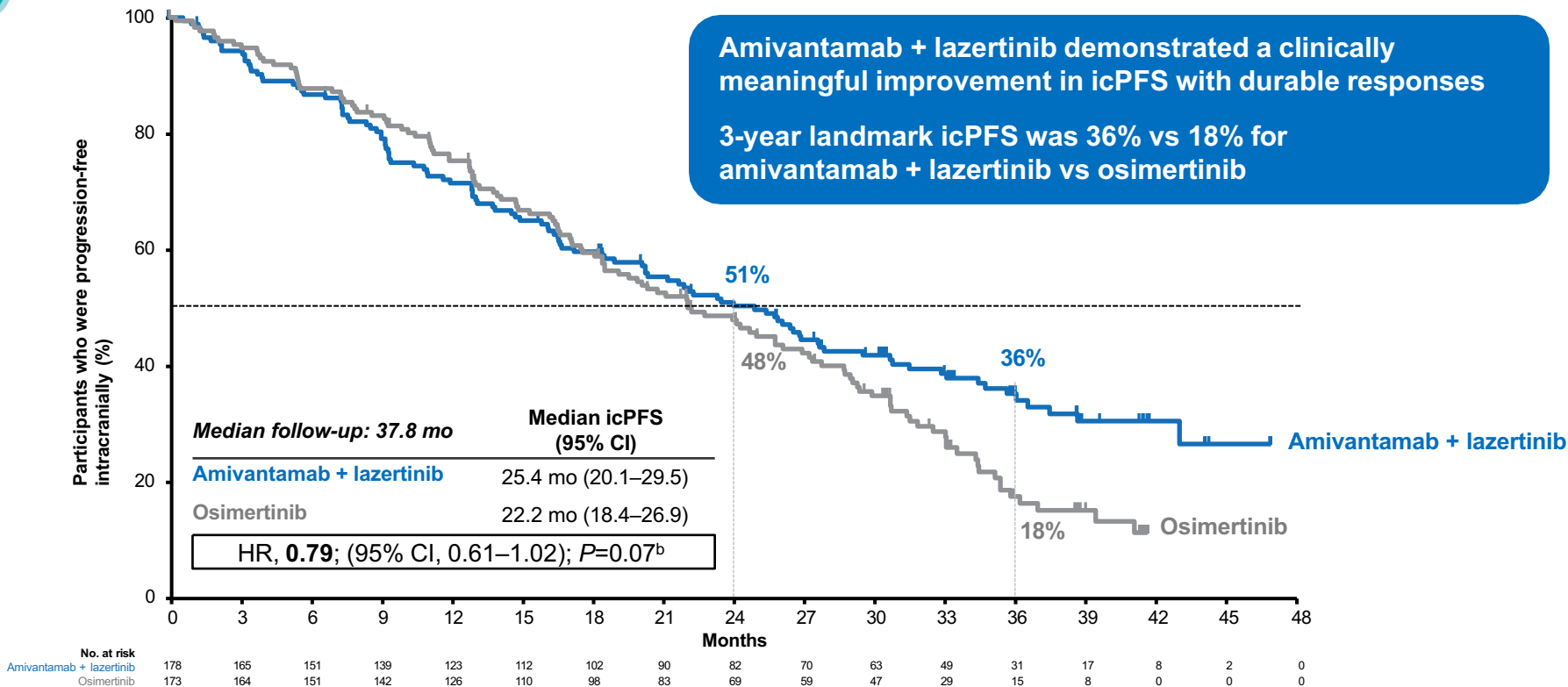
MARIPOSA (ClinicalTrials.gov Identifier: NCT04487080) enrollment period: November 2020 to May 2022; clinical cut-off: 04 December 2024. OS analysis was evaluated by means of the *P*-value generated from the stratified log-rank test, with *EGFR* mutation type, Asian race, and history of brain metastases as stratification factors. HRs and 95% CIs were calculated using the stratified Cox regression model with treatment as the sole explanatory variable. Dosing (in 28-day cycles): amivantamab: 1050 mg (1400 mg if ≥80 kg) weekly for the first 4 weeks, then every 2 weeks; lazertinib: 240 mg daily; osimertinib: 80 mg daily.

^aMARIPOSA did not allow crossover as amivantamab-based regimens were not approved in the 2L setting during MARIPOSA enrollment. ^bContinued follow-up is planned to evaluate long-term overall survival.



Amivantamab + lazertinib demonstrated a clinically meaningful improvement in icPFS with durable responses

3-year landmark icPFS was 36% vs 18% for amivantamab + lazertinib vs osimertinib



- Median duration of treatment was **27.0 mo** for amivantamab + lazertinib and **22.4 mo** for osimertinib
- Safety profile was consistent with the primary analysis¹
 - AEs were mostly EGFR- and MET-related and grades 1–2^{1,2}
- A minority of participants were prescribed antibiotics for rash (21%) at study initiation²
- Few were on anticoagulation (**5%**) at baseline², with VTE^a occurring in **40%** in the amivantamab + lazertinib arm and **11%** in the osimertinib arm

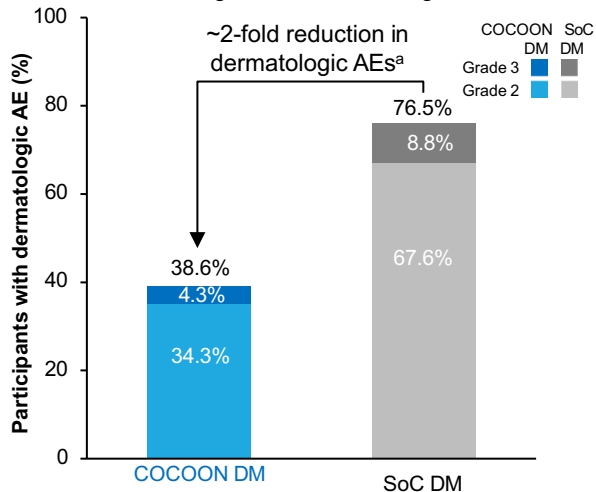
AEs by preferred term (≥20% of participants in either group)	Amivantamab + lazertinib (n=421)		Osimertinib (n=428)	
	Any grade	Grade ≥3	Any grade	Grade ≥3
Related to EGFR inhibition				
Paronychia	291 (69)	49 (12)	127 (30)	2 (<1)
Rash	271 (64)	73 (17)	136 (32)	3 (<1)
Diarrhea	133 (32)	9 (2)	200 (47)	4 (<1)
Dermatitis acneiform	127 (30)	37 (9)	55 (13)	0
Stomatitis	126 (30)	5 (1)	92 (21)	1 (<1)
Pruritus	107 (25)	2 (<1)	75 (18)	1 (<1)
Related to MET inhibition				
Hypoalbuminemia	216 (51)	26 (6)	29 (7)	0
Peripheral edema	162 (38)	8 (2)	29 (7)	1 (<1)
Other				
Infusion-related reaction	275 (65)	27 (6)	0	0
ALT increased	170 (40)	28 (7)	66 (15)	8 (2)
AST increased	139 (33)	15 (4)	68 (16)	6 (1)
Constipation	130 (31)	0	70 (16)	0
COVID-19	125 (30)	8 (2)	112 (26)	9 (2)
Anemia	114 (27)	20 (5)	112 (26)	10 (2)
Decreased appetite	114 (27)	4 (1)	84 (20)	7 (2)
Nausea	99 (24)	5 (1)	65 (15)	1 (<1)
Hypocalcemia	96 (23)	11 (3)	37 (9)	0
Asthenia	84 (20)	13 (3)	54 (13)	7 (2)
Muscle spasms	84 (20)	3 (<1)	36 (8)	0
Thrombocytopenia	74 (18)	4 (1)	92 (21)	6 (1)

^aVTE is a grouped term, which included pulmonary embolism, deep vein thrombosis, limb venous thrombosis, venous thrombosis, thrombosis, superficial vein thrombosis, thrombophlebitis, embolism, venous embolism, jugular vein thrombosis, sigmoid sinus thrombosis, axillary vein thrombosis, pulmonary infarction, vena cava thrombosis, central venous catheterization, portal vein thrombosis, post thrombotic syndrome, pulmonary thrombosis, superior sagittal sinus thrombosis, transverse sinus thrombosis, pelvic vein thrombosis, and superior vena cava syndrome. 1. Cho BC, et al. *N Engl J Med.* 2024;391(16):1489-1498. 2. Spira AI, et al. Presented at: 2023 North America Conference on Lung Cancer (NACLC); December 1–3, 2023; Chicago, IL, USA.

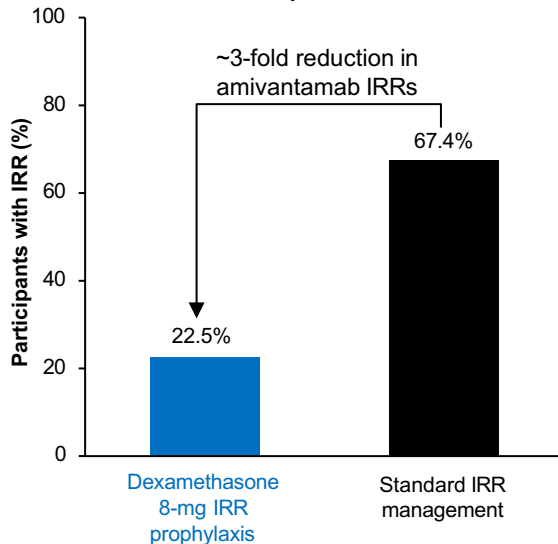


Early Onset AEs can be Significantly Reduced with Prophylactic Approaches

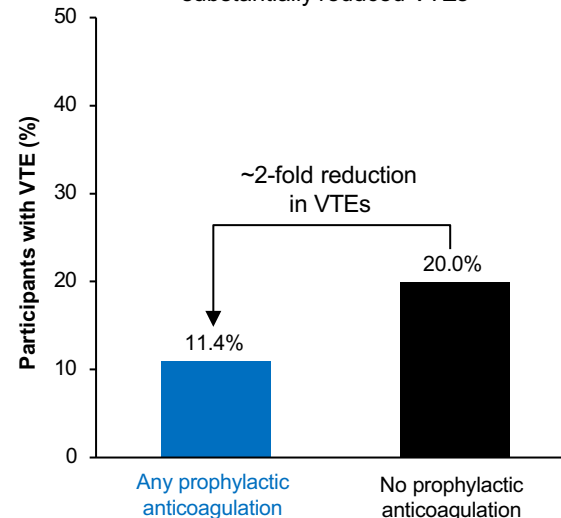
COCOON DM regimen substantially reduced grade ≥2 dermatologic AEs¹



SKIPPirr regimen substantially reduced IRRs²



Prophylactic anticoagulation substantially reduced VTEs³



Data from COCOON will be presented on Thursday, 27 March 2025 at 16:50–16:55 CET

Early onset AEs can be reduced using simple and accessible preventative approaches

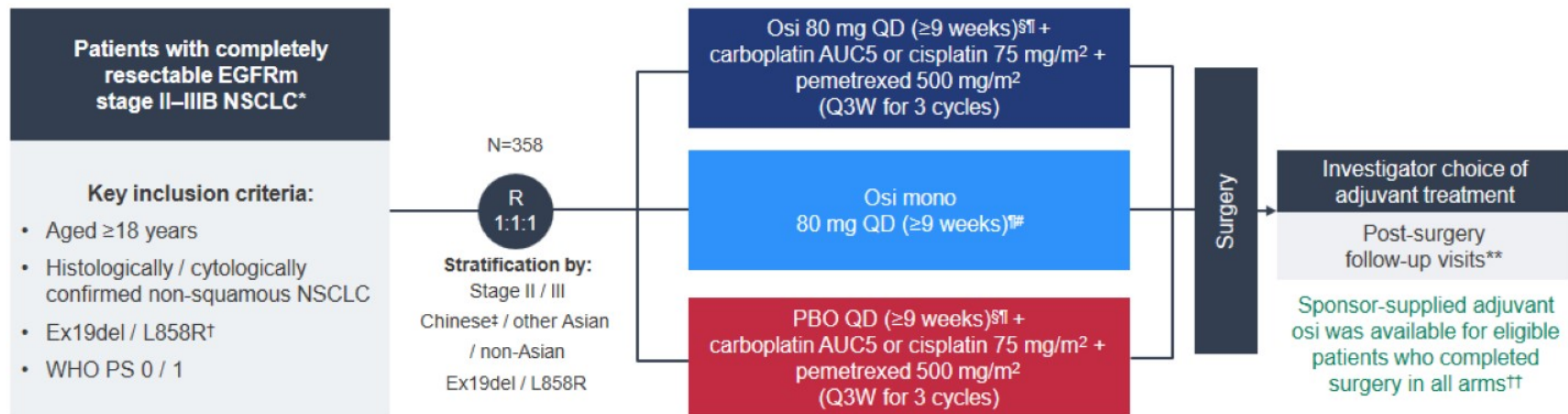
*OR: 0.19 (95% CI, 0.09–0.40); P<0.0001.

1. Girard N, et al. To be presented at: The European Lung Cancer Congress (ELCC), March 26–29, 2025, Paris, France. 2. Spira AI, et al. *J Thorac Oncol.* 2025;S1556-0864(25)00051-6. 3. Scott SC, et al. Presented at: American Society for Clinical Oncology

(ASCO) Annual Meeting, May 31–June 4, 2024, Chicago, IL, USA reproduced without written permission of the authors.



NeoADAURA: global, randomized, Phase 3 controlled study



Endpoints:

- **Primary: major pathological response (MPR; by blinded central pathology review)**
- **Secondary: event-free survival, pathological complete response, nodal downstaging and safety**

NCT04351555. Figure borrowed from "Neoadjuvant osimertinib with/without chemotherapy versus chemotherapy alone for EGFR-mutated resectable non-small-cell lung cancer: NeoADAURA", Tsuboi M et al. Published online July 19, 2021 in *Future Oncology* and reprinted by permission of the publisher Informa UK Limited trading as Taylor & Francis Ltd, <http://www.tandfonline.com>. The figure was adapted with permission from the authors.

*AJCC Staging Manual 8th edition. †Confirmed by sponsor pre-approved local or central tissue testing. ‡Chinese living in mainland China. §Double-blind; ¶Osi or PBO could be continued up to the date of surgery, at the discretion of the investigator. *Open-label, sponsor-blinded. **At weeks 12 and 24 post-surgery, then every 24 weeks until 5 years, and then every 48 weeks until disease recurrence or other withdrawal criteria were met. ††Adjuvant osi could be given for a maximum 3-year treatment period, or until unacceptable toxicity or disease recurrence.

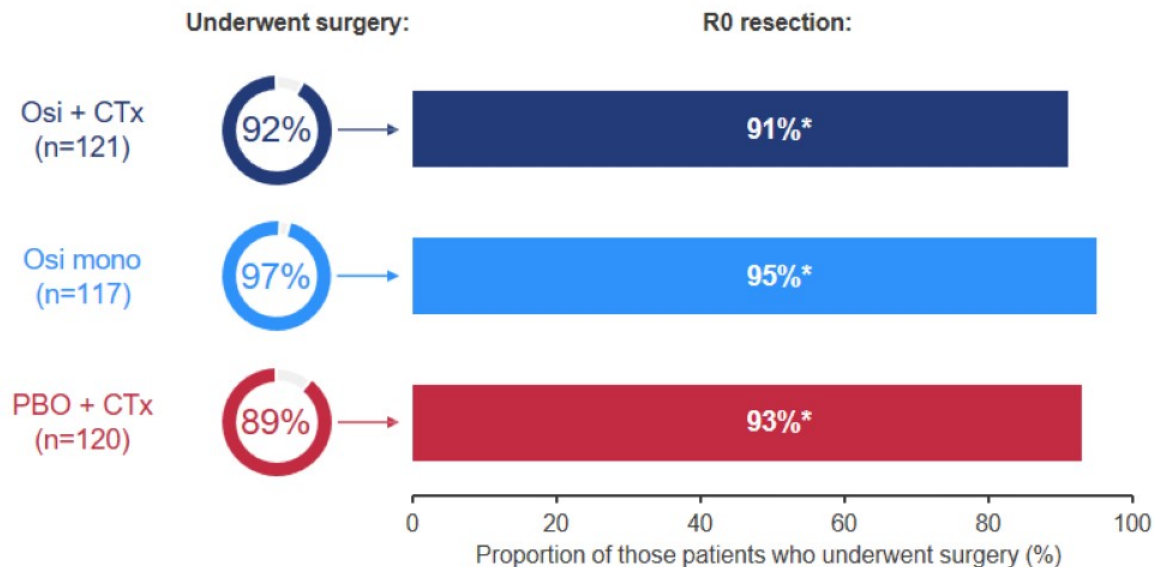
Baseline characteristics

Characteristic, %	Osi + CTx (n=121)	Osi mono (n=117)	PBO + CTx (n=120)
Sex: male / female	40 / 60	35 / 65	25 / 75
Age: median (range), years	63 (31–82)	66 (42–83)	65 (36–86)
Smoking history: former or current / never	32 / 68	34 / 66	22 / 78
Race: * Chinese [†] / other Asian / non-Asian	24 / 49 / 27	23 / 50 / 26	26 / 49 / 25
WHO PS: 0 / 1	80 / 20	79 / 21	83 / 17
Histology: adenocarcinoma / other	98 / 2	100 / 0	100 / 0
EGFR mutation at randomization: * Ex19del / L858R	50 / 50	51 / 49	51 / 49
AJCC staging (8th edition) at diagnosis: * II / III	49 / 51	50 / 50	51 / 49
Regional lymph nodes: N0 / N1 / N2	26 / 35 / 39	26 / 38 / 35	29 / 37 / 34
Baseline tumor size, mean (SD), cm	4.2 (1.4)	4.0 (1.5)	4.3 (1.6)

Data cut-off: October 15, 2024.

*Reported by Investigators using interactive voice response. [†]Chinese living in mainland China.

Surgery summary



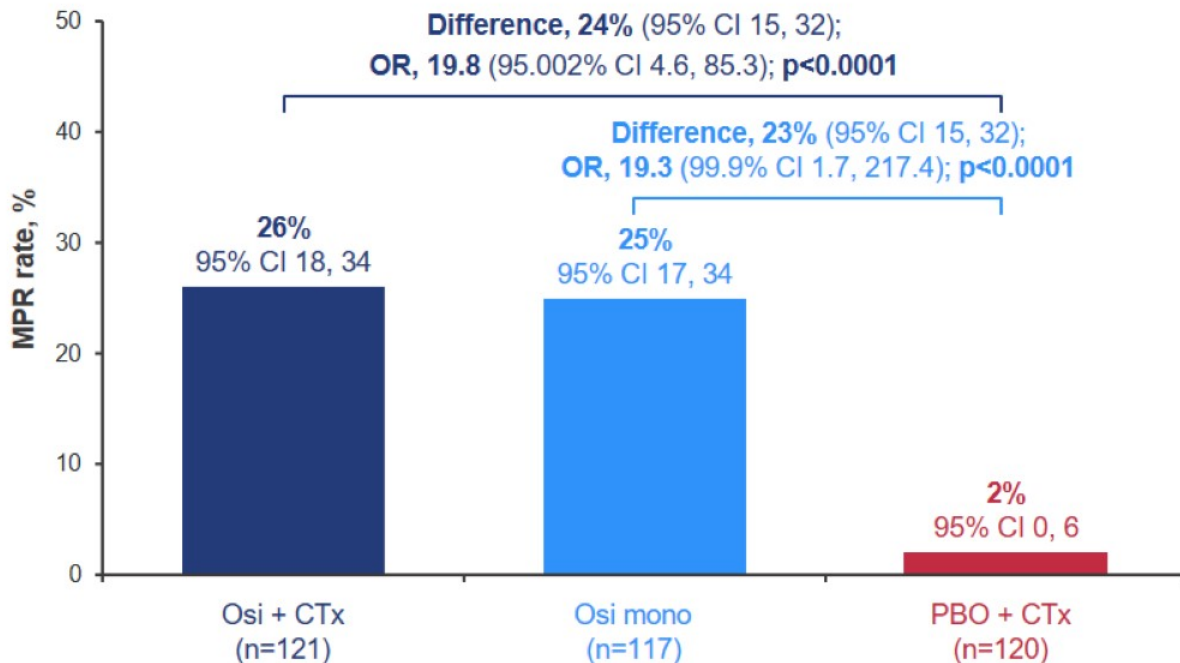
In each arm, **91%** of patients who completed surgery received sponsor-supplied adjuvant osi†

- SAEs causally related to surgery occurred in 10%, 5% and 7% of patients
- No patients died within 30 days post-surgery

*One patient in the osi + CTx arm, two patients in the osi mono arm and one patient in the PBO + CTx arm had missing R status data. One patient in the osi + CTx arm and one patient in the PBO + CTx arm had an R2 resection. †In addition to patients who received sponsor-supplied adjuvant osi, two patients in the osi + CTx arm, one patient in the osi mono arm and two patients in the PBO + CTx arm received commercial supplied osi.

MPR

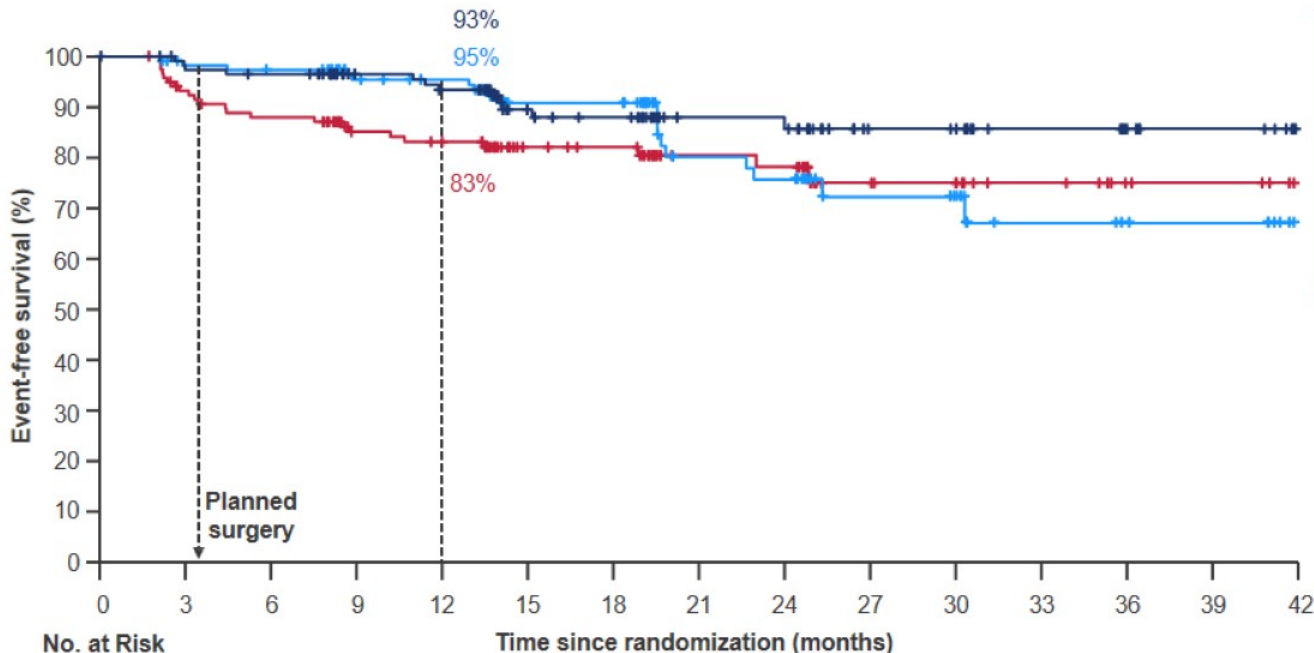
The MPR rate was statistically significantly higher with both osi-containing regimens



MPR defined as $\leq 10\%$ residual viable tumor cells in the lung primary tumor at resection. Patients had to have an R0 result to be classified as responders. MPR assessed using the IASLC method. MPR was analyzed using the Cochran-Mantel-Haenszel test stratified by disease stage (II vs III), race (Chinese vs other Asian vs non-Asian) and EGFR mutation type (Ex19del vs L858R).

Data cut-off: October 15, 2024.

Interim EFS analysis (15% maturity)



EFS HR vs PBO + CTx

Osi + CTx: 0.50
(99.8% CI 0.17, 1.41); p=0.0382†

Osi mono: 0.73
(95% CI 0.40, 1.35)†

Median follow-up, months‡
osi + CTx 14.3, osi mono 18.3,
PBO + CTx 14.3

	No. at Risk														
	0	3	6	9	12	15	18	21	24	27	30	33	36	39	42
— Osi + CTx	121	112	110	93	89	58	54	39	38	23	22	14	10	6	0
— Osi mono	117	112	110	98	94	59	59	36	34	20	18	9	7	6	0
— PBO + CTx	120	107	100	85	81	55	52	35	34	20	16	11	6	4	0

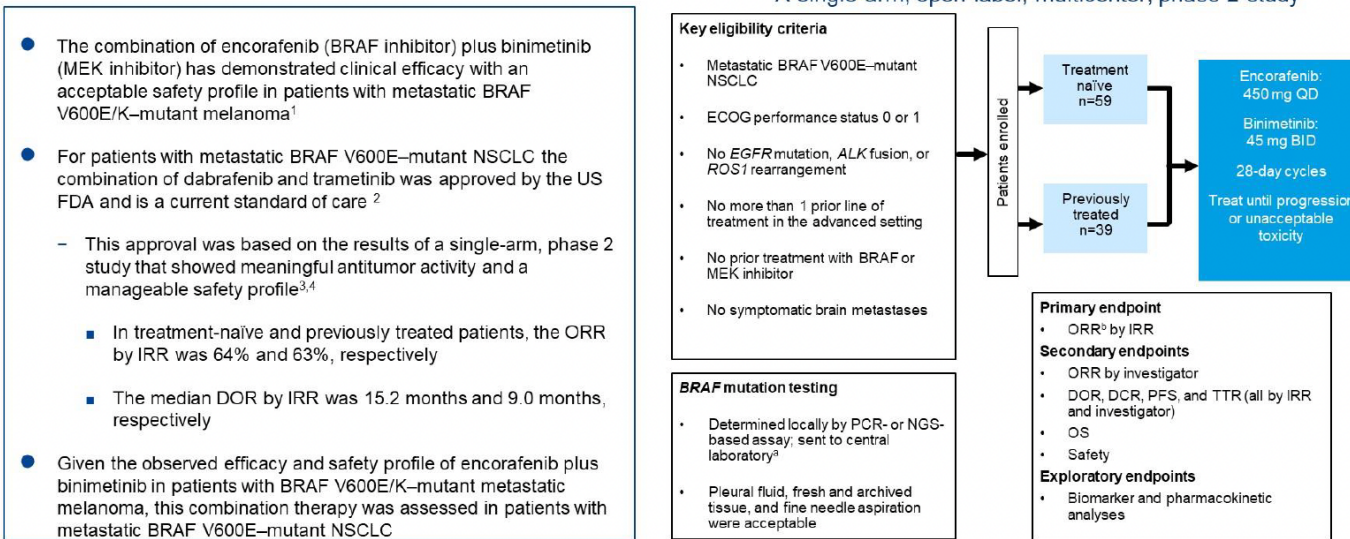
Tick marks indicate censored data. EFS was investigator assessed. Median follow-up for EFS (censored patients): osi + CTx 15.9 months, osi mono 18.3 months, PBO + CTx 18.8 months. EFS maturity: osi + CTx 10%, osi mono 15%, PBO + CTx 19%.
†EFS analysis performed using a log-rank test stratified by disease stage (II vs III), race (Chinese vs other Asian vs non-Asian) and EGFR mutation type (Ex19del vs L858R). p-value ≤0.002 required for statistical significance at interim analysis. †No p-value calculated. The pre-specified sequential multiple testing procedure required a statistically significant improvement in EFS to be demonstrated for the comparison of osi + CTx vs PBO + CTx before formal testing for the comparison of osi mono vs PBO + CTx could be performed. †All patients.

Data cut-off: October 15, 2024.

Approval and reimbursement for BRAFm targeted therapy-PHAROS

Encorafenib plus binimetinib in patients with metastatic BRAF V600E NSCLC

PHAROS (NCT03915951):
A single-arm, open-label, multicenter, phase 2 study



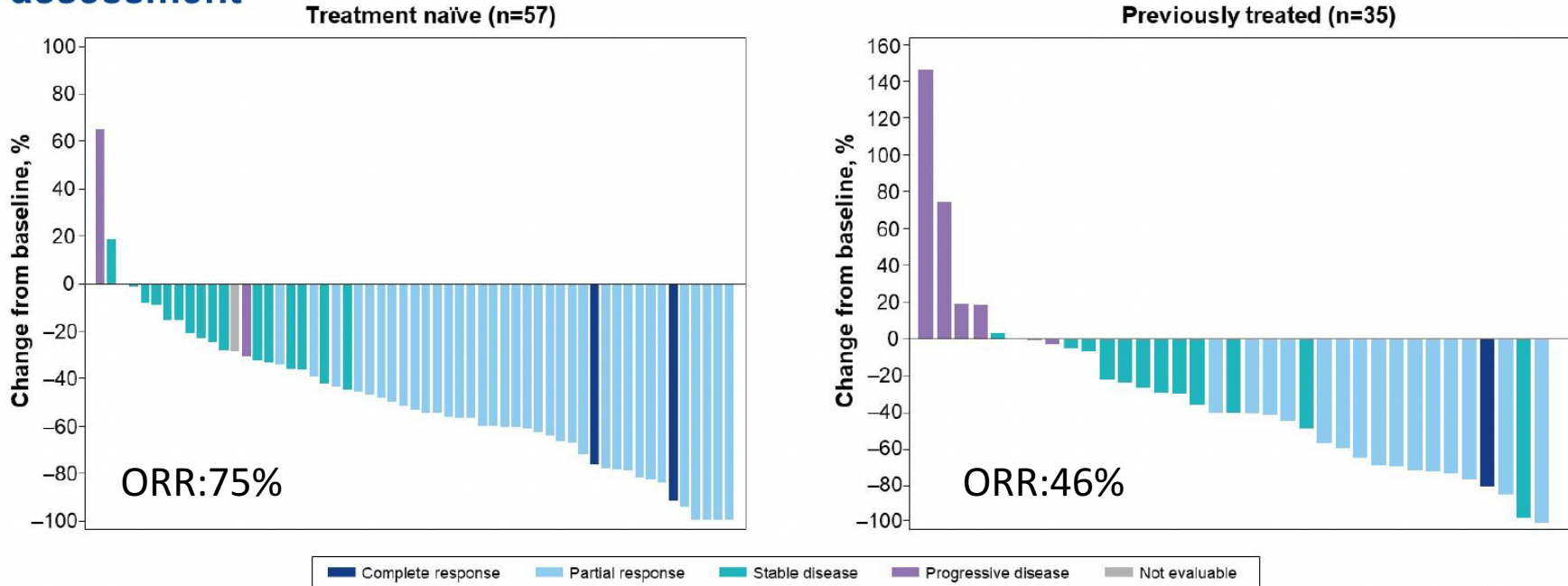
BID, twice daily; DCR, disease control rate; DOR, duration of response; ECOG, Eastern Cooperative Oncology Group; IRR, independent radiology review; ORR, objective response rate; NGS, next-generation sequencing; OS, overall survival; PCR, polymerase chain reaction; PFS, progression-free survival; QD, once daily; TTR, time to response.

²BRAF V600 mutations were retrospectively confirmed by FoundationOne CDx (Foundation Medicine, Cambridge, MA). ³According to RECIST 1.1.

1. Dummer R, et al. *Lancet Oncol*. 2018;19(5):603-615. 2. Dabrafenib prescribing information. June 2022. 3. Planchard D, et al. *Lancet Oncol*. 2016;17(7):984-993. 4. Planchard D, et al. *Lancet Oncol*. 2017;18(10):1307-1316.

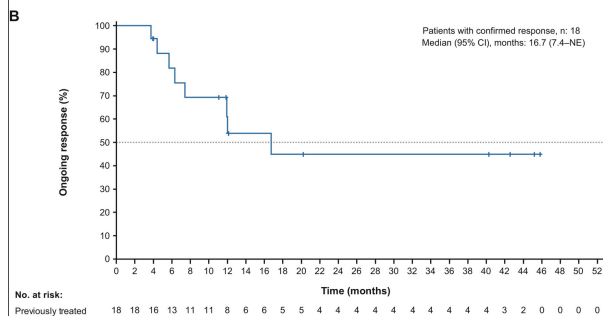
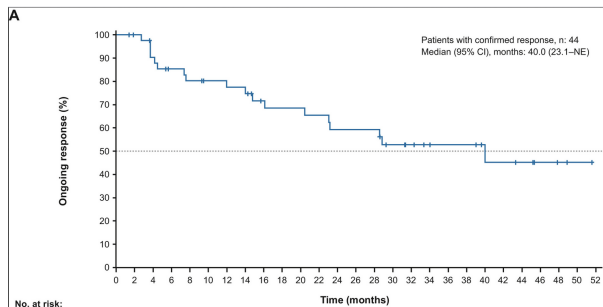
Encorafenib plus binimetinib in metastatic BRAF-V600E mutant NSCLC

Change from baseline in the sum of diameters of target lesions by investigator assessment^a

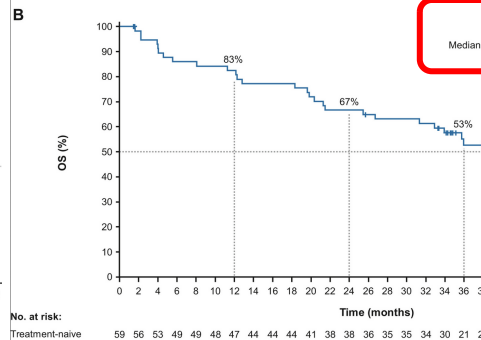
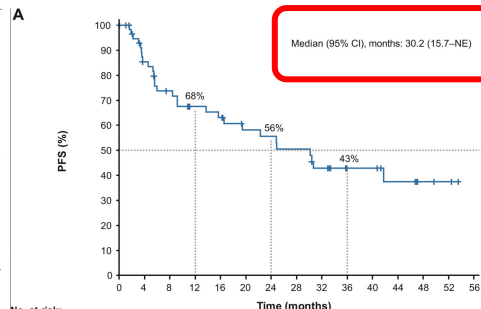


^aPatients for whom an assessment response was not evaluable at all tumor assessments were not included in this analysis.

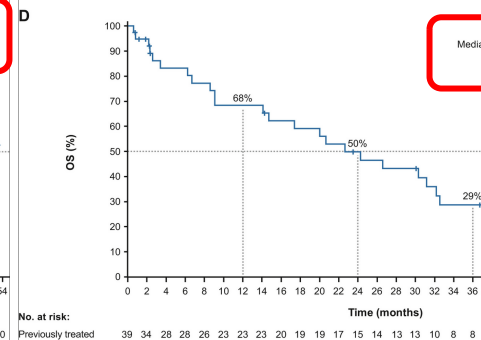
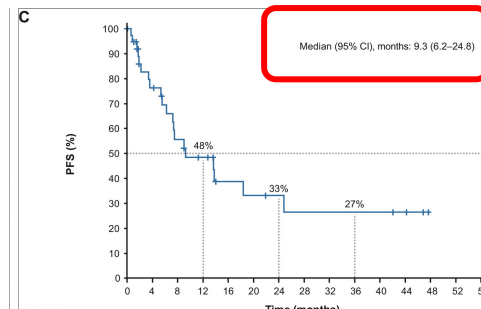
Duración de respuesta



Treatment naive



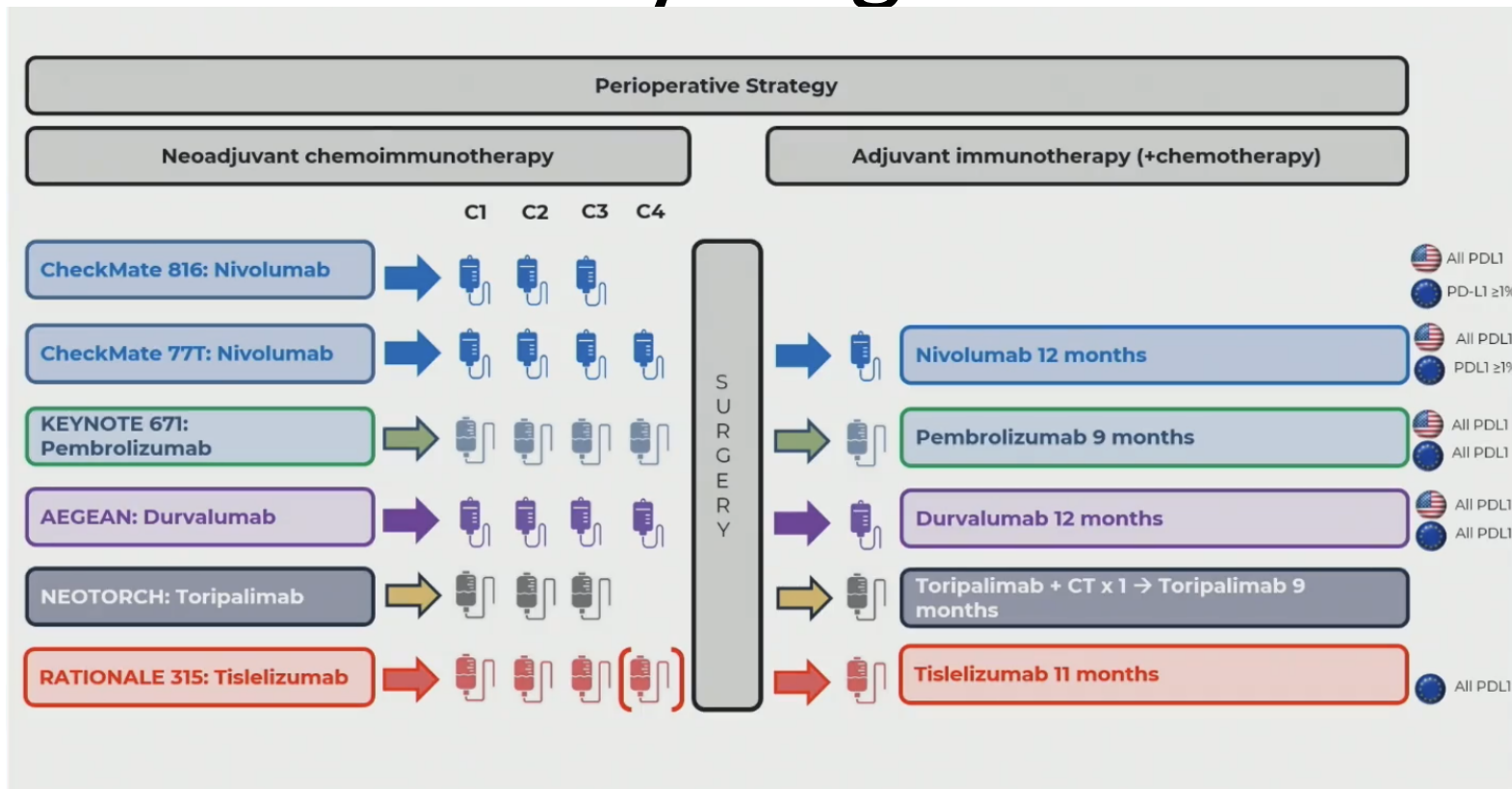
Pretreated



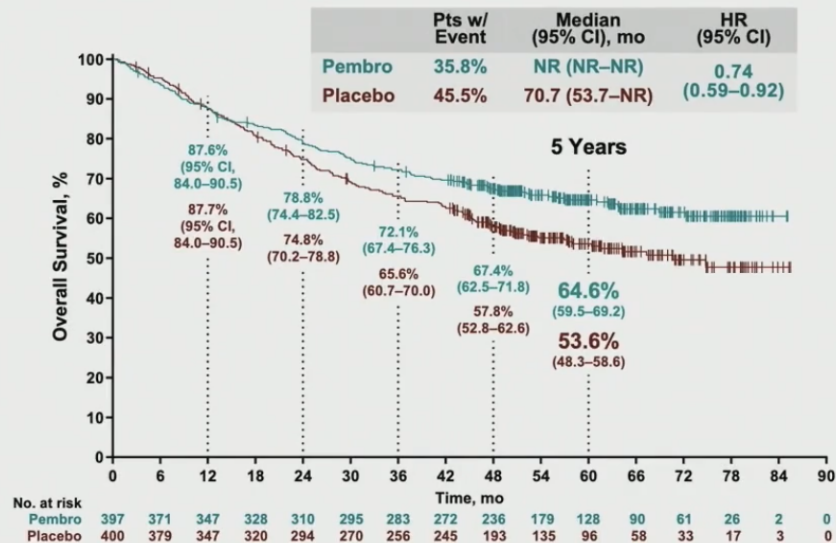
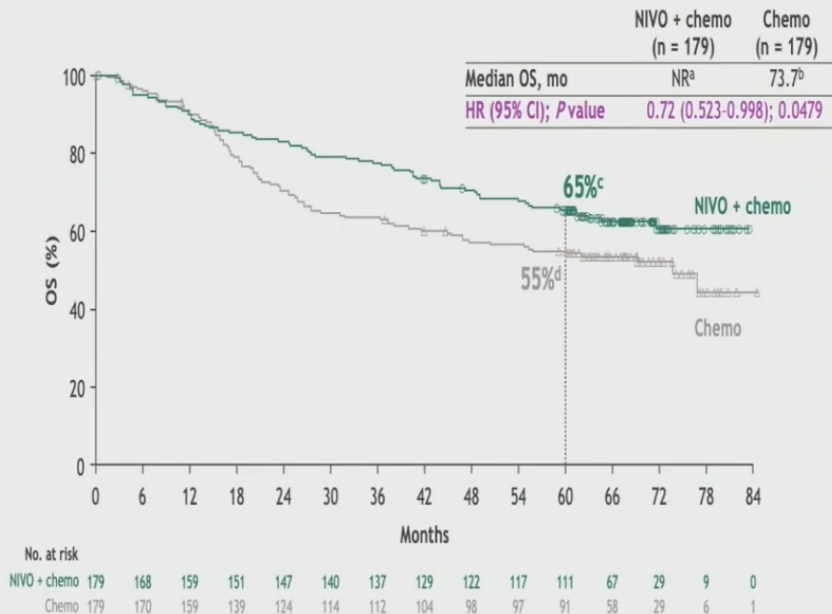
Immunotherapy combinations

- Early stage
 - Perioperative strategies with 5 y OS results
- *Advanced disease*
 - *New anti-PD1-L1 agents with similar results*
 - *Preliminary promising data on new molecules*

Early stage



5 year survival of CM816 and KN-671



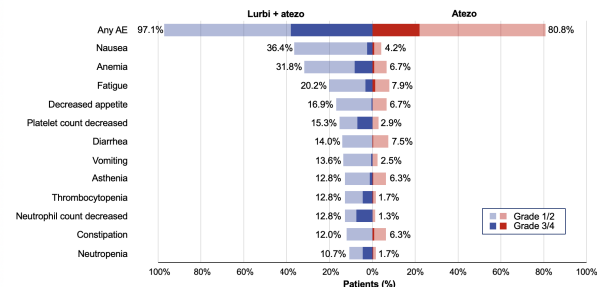
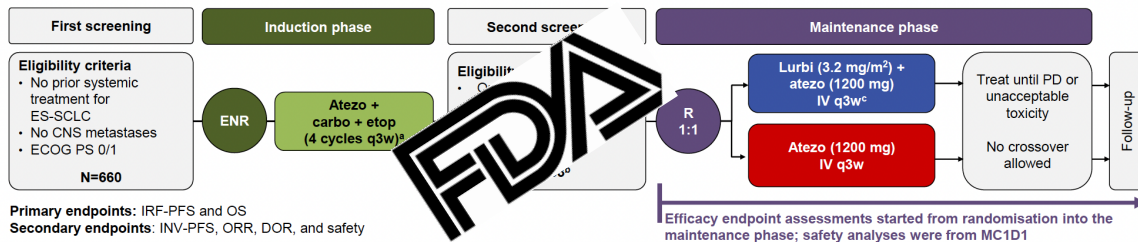
SCLC in 2025

- Extensive stage
 - Maintenance
 - 2nd line
- *Limited stage*
 - *Consolidation immunotherapy ADRIATIC trial (approval expected soon)*

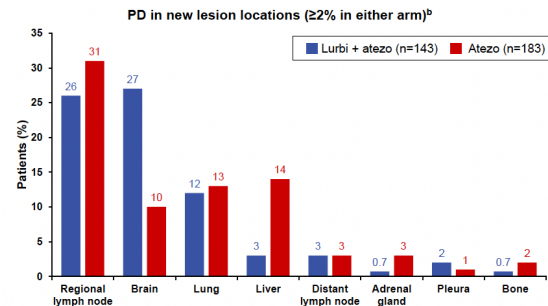
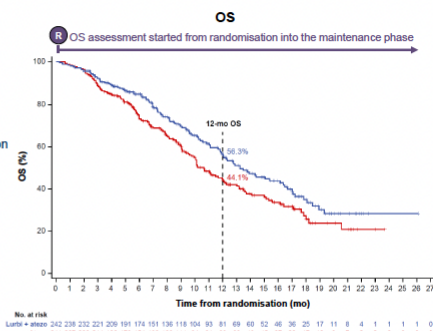
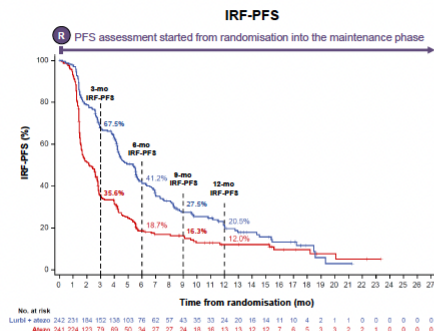
Changes to SoC-Imforte-Lurbinectedine in maintenance

Background and study design

- IMforte is the first Phase 3 study to demonstrate statistically significant and clinically meaningful improvements in PFS and OS with lurbi + atezo vs atezo for 1L maintenance treatment of ES-SCLC



IRF-PFS and OS from randomisation into maintenance phase



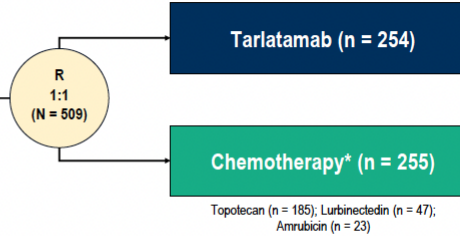
Changes to SoC in SCLC– Dellphi-304- Tarlatamab in 2nd line

Key inclusion criteria

- Histologically or cytologically confirmed SCLC
- Progression after 1L platinum-based chemotherapy +/- anti-PD-(L)1
- ECOG PS 0 or 1
- Asymptomatic, treated or untreated brain metastases

Randomization stratified by

- Prior anti-PD-(L)1 exposure (yes/no)
- Chemotherapy-free interval (< 90 days vs ≥ 90 to < 180 days vs ≥ 180 days)
- Presence of (previous/current) brain metastases (yes/no)
- Intended chemotherapy (topotecan/amrubicin vs lurbinectedin)

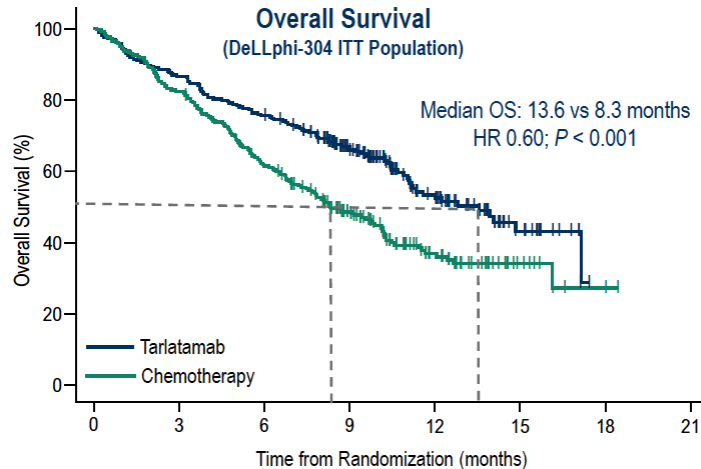


Practical management of adverse events in patients receiving tarlatamab, a delta-like ligand 3–targeted bispecific T-cell engager immunotherapy, for previously treated small cell lung cancer

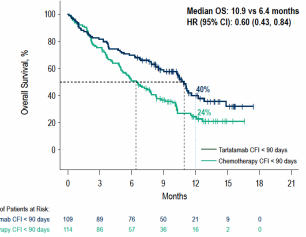
Jacob M. Sands MD¹ | Stéphane Champiat MD, PhD² | Horst-Dieter Hummel MD³ | Kelly G. Paulson MD, PhD⁴ | Hossein Borghaei DO⁵ | Jean Bustamante Alvarez MD⁶ | David P. Carbone MD, PhD⁷ | Jennifer W. Carlisle MD⁸ | Noura J. Choudhury MD⁹ | Jeffrey M. Clarke MD¹⁰ | Shirish M. Gadgeel MD¹¹ | Hiroki Izumi MD, PhD¹² | Alejandro Navarro MD¹³ | Sally C. M. Lau MD¹⁴ | Philip E. Lammers MD¹⁵ | Shuang Huang PhD¹⁶ | Ali Hamidi MD¹⁴ | Sujoy Mukherjee MD¹⁴ | Taofeek K. Owonikoko MD, PhD¹⁷ ●

Primary Endpoint: Overall survival

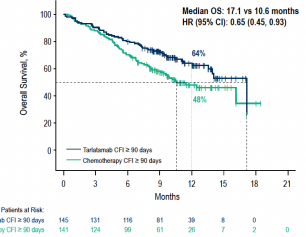
Secondary Endpoints: Progression-free survival, patient-reported outcomes, objective response rate, safety



CFI < 90 days (platinum-resistant disease)



CFI ≥ 90 days (platinum-sensitive disease)



Reflexiones de 2025

- Ha sido un año de aprobaciones esperadas y resultados con impacto en supervivencia global muy importantes para tumores con AGAs
- En los pacientes candidatos a inmunoterapia con tumores resecables, se han consolidado resultados a mayor seguimiento, estableciendo la estrategia neoadyuvante/perioperatoria como un estándar sólido
- En CPCP, hay 3 cambios de estándar, tanto en enfermedad limitada como extensa y se han presentado muchos estudios con resultados que parece que cambiarán nuevamente el estándar en los próximos años

VIII SIMPOSIO NACIONAL
de ONCOLOGÍA de PRECISIÓ

Vigo, 19 y 20 de febrero de 2026



Gracias
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