Navigating the Treatment Landscape

Dr Kevin Franks

Consultant Clinical Oncologist, The Leeds Teaching Hospitals NHS Trust

Prescribing information is available at this meeting and can be accessed from the links at the end of this deck.
This is a promotional meeting funded and organised by AstraZeneca for UK HCPs only.

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk/ or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to AstraZeneca by visiting https://contactazmedical.astrazeneca.com or by calling 0800 783 0033.

GB-56122
Date of preparation: June 2024

THINK AGAIN LUNG SUMMIT

Disclosures

Dr Kevin Franks: I have received honoraria for consultancy and my participation in advisory boards from AstraZeneca, Amgen, BioNTech, Boehringer-Ingelheim, Bristol Myers Squibb, Lilly, Roche, and Takeda, and for my participation in the 2024 Think Again Lung Summit from AstraZeneca.

IMFINZI™ ▼ (durvalumab) and TAGRISSO® (osimertinib) therapeutic indications in NSCLC:

THINK AGAIN LUNG SUMMIT

IMFINZI™ (durvalumab) as monotherapy is indicated for[1,2]:

- The treatment of locally advanced, unresectable NSCLC in adults whose tumours express PD-L1 on ≥1% of tumour cells and whose disease has not progressed following platinum-based chemoradiation therapy

TAGRISSO® (osimertinib) as monotherapy is indicated[3,4]:

- The adjuvant treatment after complete tumour resection in adult patients with Stage IB-IIIA non-small cell lung cancer (NSCLC) whose tumours have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations
- The first-line treatment of adult patients with locally advanced or metastatic NSCLC with activating EGFR mutations
- The treatment of adult patients with locally advanced or metastatic EGFR T790M mutation-positive NSCLC

NSCLC, non-small cell lung cancer; PD-L1, programmed cell death ligand-1; URTI, upper respiratory tract infection.

1. EMC. IMFINZI SmPC. Available at: https://www.medicines.org.uk/emc/product/9495 (Accessed June 2024); 2. EMC Northern Ireland. IMFINZI SmPC. Available at: https://www.emcmedicines.com/en-gb/northernireland/medicine?id=ebfb0ef2-3f0b-4d5d-8e7b-353a0176b147&type=smpc (Accessed June 2024); 3. EMC. Tagrisso SmPC. Available at: https://www.medicines.org.uk/emc/product/7615/smpc (Accessed June 2024). 4. EMC Northern Ireland. Tagrisso SmPC. Available at: https://www.emcmedicines.com/en-gb/northernireland/medicine?id=31fc5f4c-3e57-45dc-a9ab-39ea9213601c&type=smpc (Accessed June 2024).

Overview

Current UK landscape in curable NSCLC for Stage III disease

Operable vs. inoperable

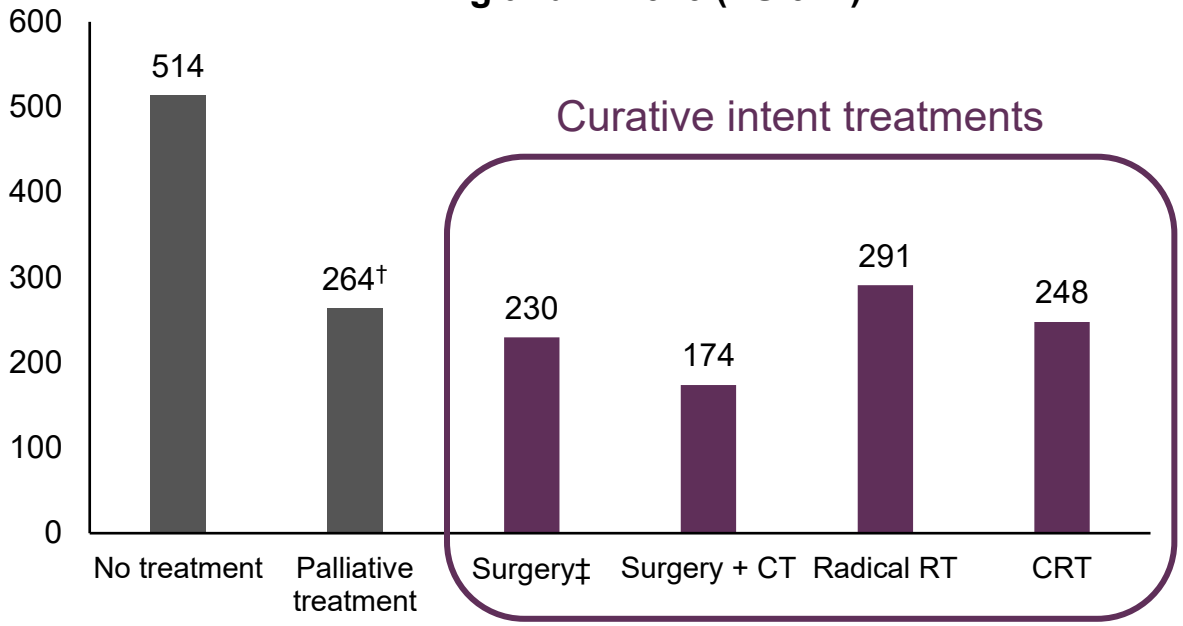
Focus on inoperable – PACIFIC and Real-World Data (CODAK)

NSCLC, non-small cell lung cancer.

Historical UK Stage III NSCLC treatments[1]

60% of patients with NSCLC (stage IIIA, PS 0–2) across England & Wales received treatment with curative intent[2]

Breakdown of treatment of Stage IIIA patients in England in 2020 (PS 0–2)[1]



The lack of curative intent treatment may reflect:

- The significant weight loss, decline in performance status, stage evolution, and serious intercurrent events that often occur during the diagnostic and evaluation process in this patient group[3]
- Variability in clinical practice and expertise across the UK[4]

[1] The figure shows the treatment received by Stage IIIA NSCLC patients in the UK in 2020. Curative intent treatments include surgery, surgery + chemotherapy, radical radiotherapy, and chemoradiotherapy. †This figure relate to the proportion of patients receiving palliative RT (228) and palliative systemic therapy (36). ‡This relates to surgery alone

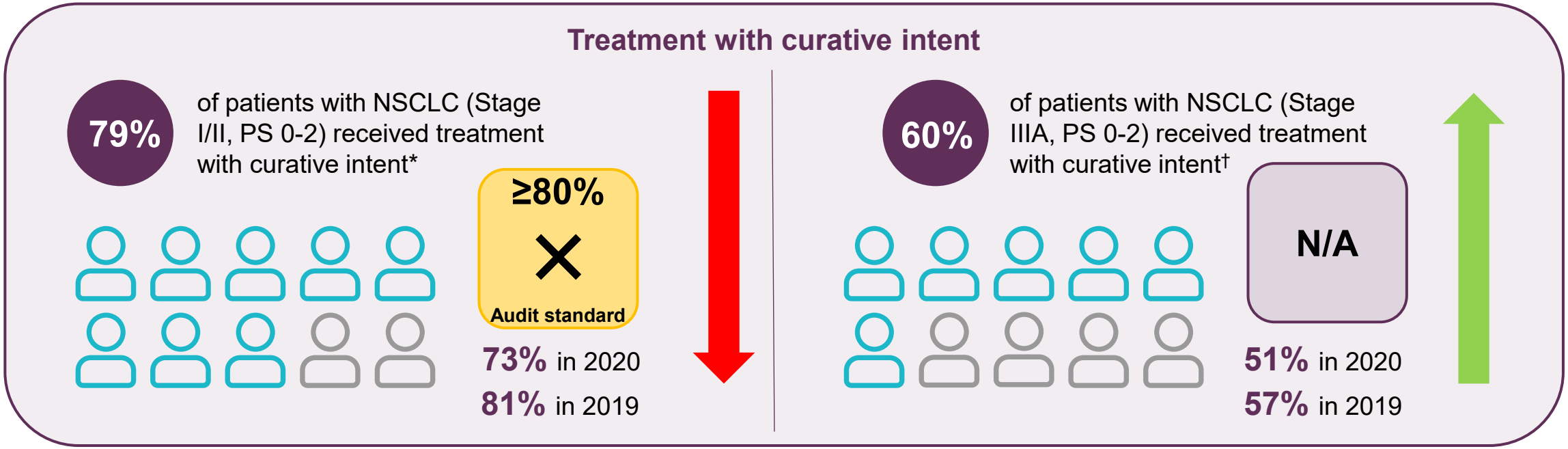
CRT, chemoradiotherapy; CT, chemotherapy; NLCA, National Lung Cancer Audit; NSCLC, non-small cell lung cancer; PS, performance status; RT, radiotherapy.

1. Royal College of Physicians. 2022. National Lung Cancer Audit annual report for the audit period 2019 England, Wales and Guernsey and 2020 England only (including data spreadsheet); 2. Roy Castle Lung Cancer Foundation. (2023) National Lung Cancer Audit. Available at https://roycastle.org/research/national-lung-cancer-audit/#:~:text=60%25%20of%20patients%20with%20NSCLC,received%20treatment%20with%20curative%20intent Accessed June 2024; 3. Robinson AG, et al. *Curr Oncol*. 2015 Dec; 22(6):399-404; 4. Sethi T, et al. *Thorax*. 2013 Dec;68(12):1181-5.

Curative treatment rates in the UK

NLCA | National Lung Cancer Audit
State of the Nation Report 2023

Results of the National Lung Cancer Audit for patients in England during 2021 and Wales during 2020-2021
Version 3: November 2023



*Surgery or radical radiotherapy. †Surgery, radical radiotherapy or multimodal combination with chemotherapy.
NSCLC, non-small cell lung cancer; PS, performance status; N/A, not applicable

Stage III disease – resectable and non-resectable What are our curative options?

THINK AGAIN LUNG SUMMIT

Resectable:[1,2,3]

- Upfront surgery followed by adjuvant chemotherapy
- Upfront surgery followed by adjuvant chemotherapy and immunotherapy
- Upfront surgery followed by adjuvant chemotherapy and osimertinib (*EGFR* Exon 19 Del/Exon 21 L858R +ve)
- Neo-adjuvant/adjuvant chemotherapy/immunotherapy and surgery

Unresectable:[1,2]

- Concurrent chemoradiotherapy +/- durvalumab (PD-L1 ≥1%)
- Sequential chemotherapy and radiotherapy
- Radical radiotherapy alone

EGFR, epidermal growth factor receptor; PD-L1, programmed death ligand-1.

1. Wu, Y-L et al. *N Engl J Med* 2020;383:1711-1723; 2. Herbst, R.S et al, *J Clin Oncol*. 2023; 1;41(22):3877; 3. Ferrari V and Helissey C, *J Clin Med.* 2024; 13(9): 2715.

Navigating the Treatment Landscape

Neo-adjuvant/adjuvant chemotherapy/immunotherapy and surgery

THINK AGAIN LUNG SUMMIT

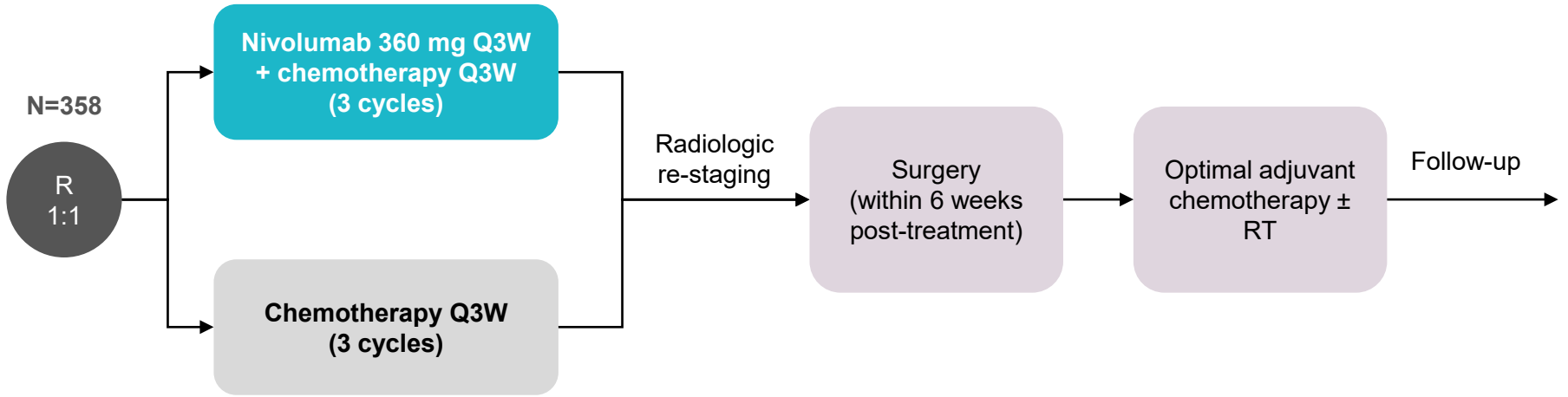
Focusing on Stage III disease – RESECTABLE

Neo-adjuvant chemo-immunotherapy and surgery – Checkmate 816 schema

Key eligibility criteria

- Newly diagnosed, resectable, Stage IB (≥4cm)-IIIA NSCLC (per TNM 7th edition)
- ECOG PS 0–1
- No known sensitising *EGFR* mutations or *ALK alterations*

Stratified by Stage (IB/II vs. IIIA), PD-L1 (≥1% vs. <1%), and sex



Primary endpoints
- pCR by BIPR
- EFS by BICR

Key secondary endpoints
- MPR by BIPR
- OS
- Time to death or distance metastases

Key exploratory endpoints included
- ORR by BICR
- Feasibility of surgery and post-operative surgery-related AEs
- Predictive biomarkers (PD-L1, TMB ,ctDNA)

AE, adverse events; ALK, anaplastic lymphoma kinase; BICR, blinded independent central review; BIPR, blinded independent pathological review; ctDNA, circulating tumour DNA; ECOG, Eastern Cooperative Oncology Group; EFGR, epidermal growth factor receptor; EFS, event free survival; MPR, major pathological response; NSCLC, non-small cell lung cancer; ORR, objective response rate; OS, overall survival; pCR, pathological complete response; PD-L1, programmed death ligand-1; Q3W, once every 3 weeks; RT, radiotherapy; TMB, tumour mutation burden; TNM, tumour node metastasis.

Forde P.M. et al. N Engl J Med; 386(21):1973-1985 (incl. Suppl).

Focusing on Stage III disease – RESECTABLE

THINK AGAIN LUNG SUMMIT

Neo-adjuvant chemo-immunotherapy and surgery – Checkmate 816 key points

Key eligibility criteria:

- Stage IB to Stage IIIA (TNM Version 7)
- Any enlarged/PET positive nodes needed sampling before treatment
- Had to be deemed RESECTABLE by a thoracic surgeon before treatment
- PET/CT and CT at baseline then next CT 14 days before surgery
- Optional adjuvant chemotherapy +/- radiotherapy
- No UK centre in this trial

CT, chemotherapy; PET, positron emission tomography; TNM, tumour node metastasis.

Forde P.M. et al. N Engl J Med; 386(21):1973-1985 (incl. Suppl).

Concurrent chemoradiotherapy +/- durvalumab (PD-L1 ≥1%)

Focusing on Stage III disease – UNRESECTABLE

Concurrent chemoradiotherapy +/- immunotherapy – PACIFIC trial[1-3]

Treatments of patients with Stage III unresectable NSCLC who have not progressed following platinum-based cCRT
Patients randomised=713

Randomisation 2:1
1–42 days post-cCRT

Durvalumab IV 10 mg/kg Q2W up to 12 months (N=476)

Placebo IV Q2W up to 12 months (N=237)

Stratification factors

1. Age at randomisation (<65 vs ≥65 years of age)
2. Sex (male vs female)
3. Smoking history (smoker vs non-smoker)

Co-primary endpoints	Secondary endpoints	
• OS • PFS*	• OS24 • DoR (per BICR) • ORR (per BICR) • APF12 and APF18	• TTDM • Safety profile and tolerability • Health-related QoL • PK and immunogenicity

*Response Evaluation Criteria In Solid Tumours v1.1.

APF12, proportion of patients alive and progression-free at 12 months; APF18, proportion of patients alive and progression-free at 18 months; BICR, blinded independent central review; cCRT, concurrent chemoradiotherapy; DoR, duration of response; IV, intravenously; NSCLC, non-small cell lung cancer; ORR, objective response rate; OS, overall survival; OS24, number (%) of patients who are alive at 24 months; PFS, progression-free survival; PK, pharmacokinetics; QoL, quality of life; Q2W, every 2 weeks; TTDM, time to death or distant metastasis.

1. Antonia SJ, et al. *N Engl J Med*. 2017;377(20):1919-1929; 2. Antonia SJ, et al. *N Engl J Med* 2018;379:2342−2350; 3. Faivre-Finn et al. *Journal of Thoracic Oncology* Vol. 16 No.5.

Focusing on Stage III disease – UNRESECTABLE

Concurrent chemoradiotherapy +/- immunotherapy – PACIFIC key points[1-3]

Non-operable patients Stage IIIA (~53%) and IIIB (45%) (TNM Version 7) randomised to durvalumab or placebo post CRT if:

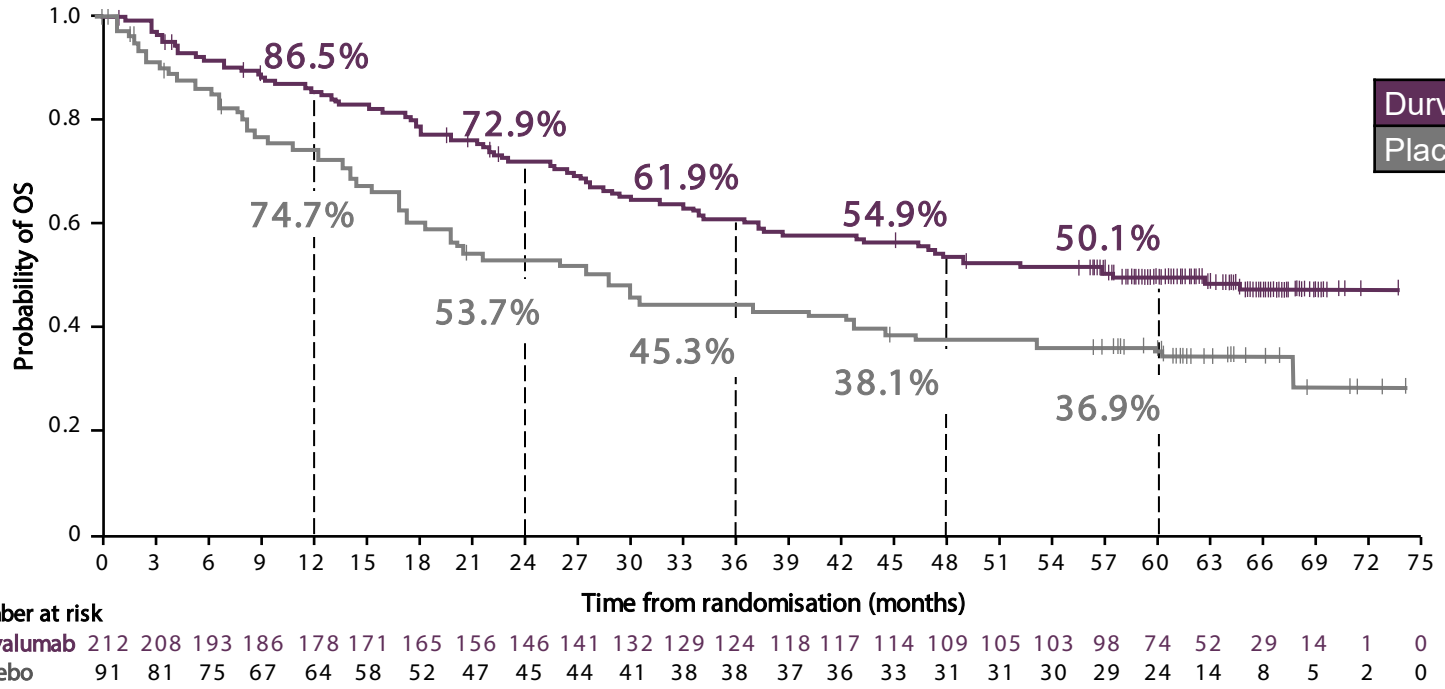
- Good Performance Status 0–2
- No evidence of progression post CRT
- No unresolved toxicity CTCAE ≥ G2 post CRT
- Commenced durvalumab treatment within 42 days of completing CRT

CTCAE, Common Terminology Criteria for Adverse Events; CRT, chemoradiotherapy; TNM, tumour node metastasis.

1. Antonia SJ, et al. *N Engl J Med*. 2017;377(20):1919-1929; 2. Antonia SJ, et al. *N Engl J Med* 2018;379:2342−2350 (incl. Suppl.); 3. Faivre-Finn C, et al. *J Thorac Oncol.* 2021;16(5):860–867.

PACIFIC results

PACIFIC OS in patients with PD-L1 ≥1% (licensed population, post-hoc exploratory analysis)[1*]



	No. of events/total no. of patients (%)	Median OS, months (95% CI)
Durvalumab	103/212 (48.6)	63.1 (43.7–NR)
Placebo	56/91 (61.5)	29.6 (17.7–44.7)

OS HR=0.61
(95% CI: 0.44–0.85)†

*Post-hoc exploratory analysis in patients with PD-L1 ≥1%. Not intended to show statistical significance. Data cut off 11th January 2021; †Treatment effect estimated using an unstratified Cox proportional hazards model.

CI, confidence interval; HR, hazard ratio; OS, overall survival; NR, not reached; PD-L1, programmed cell death receptor ligand-1.

Spigel DR, et al. *J Clin Oncol.* 2022;40(12):1301–1311 (including supplementary appendix).

Stage III treatment choices

Neo-adjuvant//immunotherapy and surgery

vs

Concurrent chemoradiotherapy +/- immunotherapy

- Not a battle and are complementary
- Different populations RESECTABLE vs NON-RESECTABLE
- Both show positive results with clear benefits

We are fortunate that we have the addition of immunotherapy to offer all suitable Stage IIB–III patients

Speaker's clinical expertise.

THINK AGAIN LUNG SUMMIT

Navigating the Treatment Landscape

Is PACIFIC deliverable in the UK?

THINK AGAIN LUNG SUMMIT

CODAK: real-world clinical outcomes of patients with unresectable, Stage III NSCLC treated with durvalumab after chemoradiotherapy in the United Kingdom

Kevin Franks,[1] Daniel Smith,[2] Paul Shaw,[3] Giuseppe Luigi Banna,[4] Mathilda Cominos,[5] Toby Talbot,[6] Betina T Blak,[7] Linnéa Lindqvist-Brown,[7] Merina Ahmed[8]

[1]Leeds Cancer Centre, St James's University Hospital, Leeds, UK; [2]Guy's and St Thomas' NHS Foundation Trust, London, UK; [3]Velindre Cancer Centre, Cardiff, UK; [4]Portsmouth Hospitals University NHS Trust, Faculty of Science and Health, School of Pharmacy and Biomedical Sciences, University of Portsmouth, Portsmouth, UK; [5]Kent Oncology Centre, Kent and Canterbury Hospital, Canterbury, UK; [6]Royal Cornwall Hospital, Truro, UK; [7]AstraZeneca UK, London, UK; [8]Institute of Cancer Research, The Royal Marsden NHS Foundation Trust, London, UK

Objective:

- To describe the characteristics and real-world clinical outcomes of patients with locally advanced, unresectable, Stage III NSCLC receiving durvalumab in the UK

CODAK enrolled patients irrespective of tumour PD-L1 expression. Durvalumab is licensed only in patients with locally advanced unresectable NSCLC whose tumours express PD-L1 on ≥1% of tumour cells.

NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1.

K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

CODAK: real-world clinical outcomes of patients with unresectable, Stage III NSCLC treated with durvalumab after chemoradiotherapy in the United Kingdom

THINK AGAIN LUNG SUMMIT

Background:

- Durvalumab is a fully human monoclonal antibody that selectively blocks the interaction of PD-L1 with PD-1 and CD80 (B7.1)[1]
- Following the randomised, double-blind, phase III PACIFIC trial (NCT02125461), the PACIFIC regimen of CRT followed by durvalumab has become a SOC for the treatment of unresectable, Stage III NSCLC[2–4]
- Despite the inclusion of some UK patients (n=54; 3.9% of total enrolled) in the ongoing, international, observational PACIFIC-R study (NCT03798535), there is a need for additional real-world data on the tolerability and effectiveness of durvalumab in UK patients with NSCLC[5,6]
- The retrospective observational CODAK study (NCT04667312) addresses this gap[5,6]

CRT, chemoradiotherapy; NSCLC, non-small cell lung cancer; PD-1, programmed cell death protein-1; PD-L1, programmed death ligand-1; SOC, standard of care.

1. Imfinzi 50 mg/mL concentrate for solution for infusion. Summary of Product Characteristics. AstraZeneca UK Ltd. 2024; 2. Antonia SJ, et al. *N Engl J Med*. 2017;377:1919–29.
3. AstraZeneca. European Commission approves Imfinzi for locally-advanced, unresectable NSCLC. 2018. Available at: https://www.astrazeneca.com/media-centre/press-releases/2018/european-commission-approves-imfinzi-for-locally-advanced-unresectable-nsclc-24092018.html#. (Last accessed June 2024); 4. Antonia SJ, et al. *N Engl J Med*. 2018;379:2342–50; 5. Girard N, et al. *J Thorac Oncol*. 2023;18:181–93; 6. K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

CODAK: real-world clinical outcomes of patients with unresectable, Stage III NSCLC treated with durvalumab after chemoradiotherapy in the United Kingdom

THINK AGAIN LUNG SUMMIT

Methods:

- CODAK was a multicentre, non-interventional, cohort study of patients (N=114) with locally advanced, unresectable, Stage III NSCLC initiated on durvalumab between 1 September 2017 and 31 December 2019 following concurrent or sequential CRT in the UK
- In the UK, before being reimbursed, durvalumab was initially made available to patients through an EAP from September 2017 to March 2019. Of these EAP patients, 76 were enrolled in CODAK
- Patients were excluded if they were participating in the PACIFIC-R trial or any clinical study with an investigational product at the time of durvalumab initiation or during the observational period
- Data on demographic and clinical characteristics of patients, treatment with durvalumab and clinical outcomes were extracted from medical records of eligible patients from 10 participating centres by direct care teams
- Subject to sufficient group size (n≥25), the primary and secondary outcomes were subject to subgroup analyses, stratified according to PD-L1 status (<1%, ≥1–49%, ≥50%, unknown)*

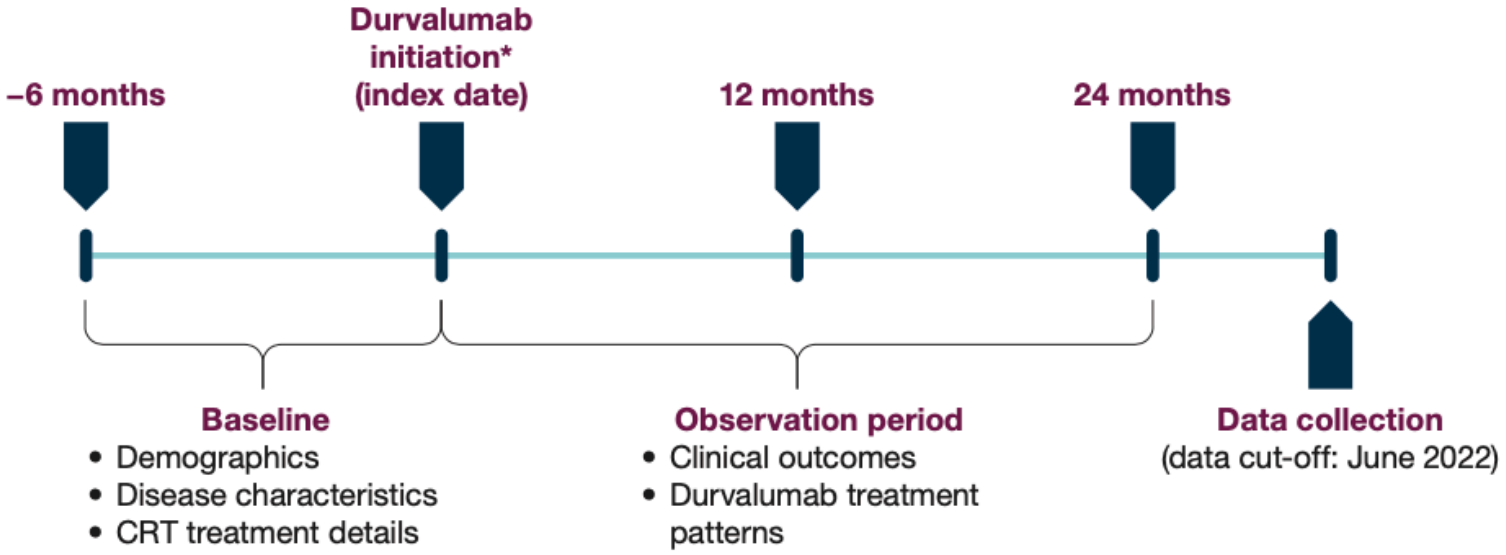
***Durvalumab is licensed only in patients with locally advanced unresectable NSCLC whose tumours express PD-L1 on ≥1% of tumour cells.**

CRT, chemoradiotherapy; EAP, early access programme; NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1.

K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

CODAK: real-world clinical outcomes of patients with unresectable, Stage III NSCLC treated with durvalumab after chemoradiotherapy in the United Kingdom

Study design:



Primary outcome: rwOS rate at 12 and 24 months post-durvalumab initiation†

Second outcomes included rwPFS and rwPFS2 rate at 12 and 24 months post-durvalumab initiation, time to first subsequent therapy, best overall response (CR, PR, SD, absence of progression, PD, death and not recorded) and TTD†

Interim analysis:
47 patients (data cut-off: March 2022)

Final enrolment:
114 patients from 10 centres across the UK

*All patients received 10 mg/kg as the durvalumab starting dose. †Dependent on sufficient group size (n≥25), the primary and secondary outcomes were subject to subgroup analyses, stratified according to PD-L1 status (<1%, ≥1–49%, ≥50%, unknown).

CR, complete response; CRT, chemoradiotherapy; PD, progressive disease; PR, partial response; rwOS, real-world overall survival; rwPFS, real-world progression-free survival; rwPFS2, real-world second progression-free survival; SD, stable disease; TTD, time to treatment discontinuation.

K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

CODAK: real-world clinical outcomes of patients with unresectable, Stage III NSCLC treated with durvalumab after chemoradiotherapy in the United Kingdom

Results:

- In total, 114 patients with NSCLC from 10 centres across the UK were included in the final analysis
- The median follow-up time from durvalumab initiation was 22 months (interquartile range: 12.9–27.5 months)
- Most patients were male (58.7%) and 41.2% were aged ≥70 years
- Most patients (64.0%) reported that they were not smoking during the 6-month baseline period before initiating durvalumab
- Of patients with a known PD-L1 status, 8 patients (8.9%) had PD-L1 <1%, 36 (40.0%) had PD-L1 ≥1–49% and 46 (51.1%) had PD-L1 ≥50%. PD-L1 status was unknown in 24 patients
- The mean radiotherapy dose and number of fractions per patient was 61.7 Gy and 29.1, respectively
- The median (range) time from NSCLC diagnosis to initiation of durvalumab was 135.5 (113.0–168.0) days, and the mean (range) time from last CRT to initiation of durvalumab was 41.0 (33.0-54.8) days

CRT, chemoradiotherapy; Gy, gray; NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1.

Durvalumab is licensed only in patients with locally advanced unresectable NSCLC whose tumours express PD-L1 on ≥1% of tumour cells.

K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

CODAK: real-world clinical outcomes of patients with unresectable, Stage III NSCLC treated with durvalumab after chemoradiotherapy in the United Kingdom

THINK AGAIN LUNG SUMMIT

Patient demographics and baseline characteristic:

	Overall (N=114)	PD-L1 <1% (n=8)	PD-L1 ≥1–49% (n=36)	PD-L1 ≥50% (n=46)	PD-L1 unknown (n=24)
Age at index date, years, n (%)					
40–49	7 (6.1)	1 (2.5)	2 (5.6)	3 (6.5)	1 (4.2)
50–59	19 (16.7)	2 (25.0)	5 (13.9)	7 (15.2)	5 (20.8)
60–69	41 (36.0)	1 (12.5)	16 (44.4)	15 (32.6)	9 (37.5)
70–79	40 (35.1)	3 (37.5)	11 (30.6)	21 (45.7)	5 (20.8)
80–89	7 (6.1)	1 (12.5)	2 (5.6)	0 (0.0)	4 (16.7)
Sex, n (%)					
Female	47 (41.2)	1 (12.5)	13 (36.1)	24 (52.2)	9 (37.5)
Male	67 (58.7)	7 (87.5)	23 (63.9)	22 (47.8)	15 (62.5)
Histology at NSCLC diagnosis, n (%)					
Squamous	61 (53.5)	6 (75.0)	22 (61.1)	21 (45.7)	12 (50.0)
Non-squamous	42 (36.8)	1 (12.5)	9 (25.0)	21 (45.7)	11 (45.8)
Not recorded	11 (9.6)	1 (12.5)	5 (13.9)	4 (8.7)	1 (4.2)
CRT prior to durvalumab, n (%)					
Concurrent	97 (85.1)	4 (50.0)	33 (91.7)	42 (91.3)	18 (75.0)
Sequential	15 (13.2)	4 (50.0)	3 (8.3)	3 (6.5)	5 (20.6)
Type not recorded	2 (1.8)	0 (0.0)	0 (0.0)	1 (2.2)	1 (4.2)
Time from NSCLC diagnosis to durvalumab initiation, days					
Median (IQR)	135.5 (113.0–168.0)	146.0 (103.0–178.2)	135.0 (111.0–165.8)	133.0 (116.2–155.0)	164.5 (124.2–217.0)
Time from last day of CRT to initiation of durvalumab, days					
Median (IQR)	41.0 (33.0–54.8)	67.5 (24.8–75.2)	40 (32.0–46.8)	41.5 (31.8–49.5)	41.5 (37.5–71.8)

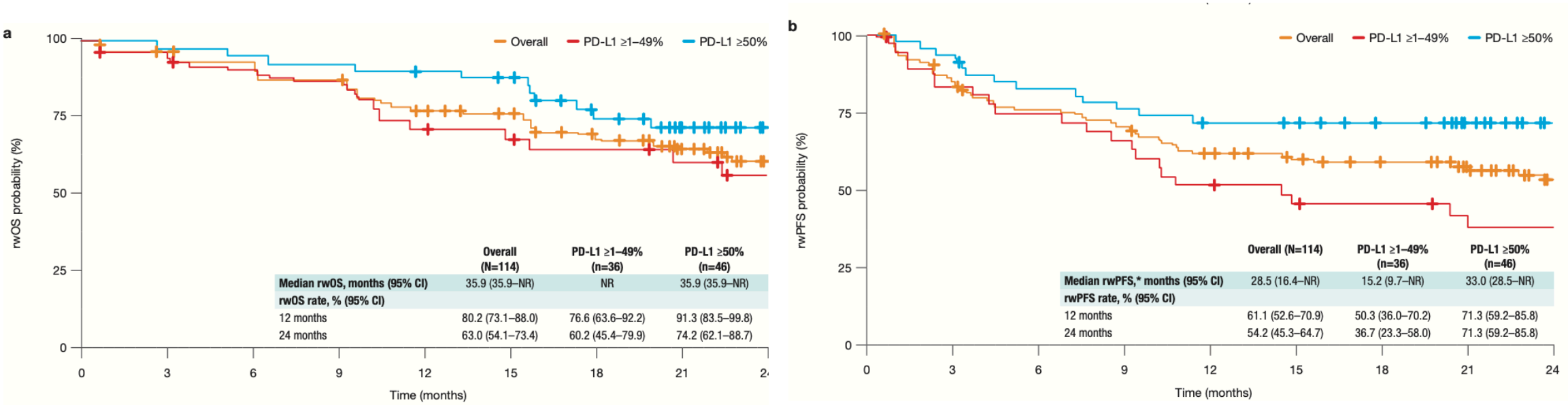
Percentage data may not total 100% due to rounding.

CRT, chemoradiotherapy; IQR, interquartile range; NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1.

K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

CODAK: real-world clinical outcomes of patients with unresectable, Stage III NSCLC treated with durvalumab after chemoradiotherapy in the United Kingdom

Real world overall survival (a) and progression free survival (b)



	Overall (N=114)	PD-L1 ≥1–49% (n=36)	PD-L1 ≥50% (n=46)
Median rwOS, months (95% CI)	35.9 (35.9–NR)	NR	35.9 (35.9–NR)
rwOS rate, % (95% CI)			
12 months	80.2 (73.1–88.0)	76.6 (63.6–92.2)	91.3 (83.5–99.8)
24 months	63.0 (54.1–73.4)	60.2 (45.4–79.9)	74.2 (62.1–88.7)

	Overall (N=114)	PD-L1 ≥1–49% (n=36)	PD-L1 ≥50% (n=46)
Median rwPFS,* months (95% CI)	28.5 (16.4–NR)	15.2 (9.7–NR)	33.0 (28.5–NR)
rwPFS rate, % (95% CI)			
12 months	61.1 (52.6–70.9)	50.3 (36.0–70.2)	71.3 (59.2–85.8)
24 months	54.2 (45.3–64.7)	36.7 (23.3–58.0)	71.3 (59.2–85.8)

The crosses represent censored observations. *Two patients had their follow-up data censored at the end of their durvalumab treatment. The first patient did not experience any progression events but initiated second-line treatment and subsequently died. The second patient did not experience any progression events, initiated second-line treatment and no death was recorded thereafter.

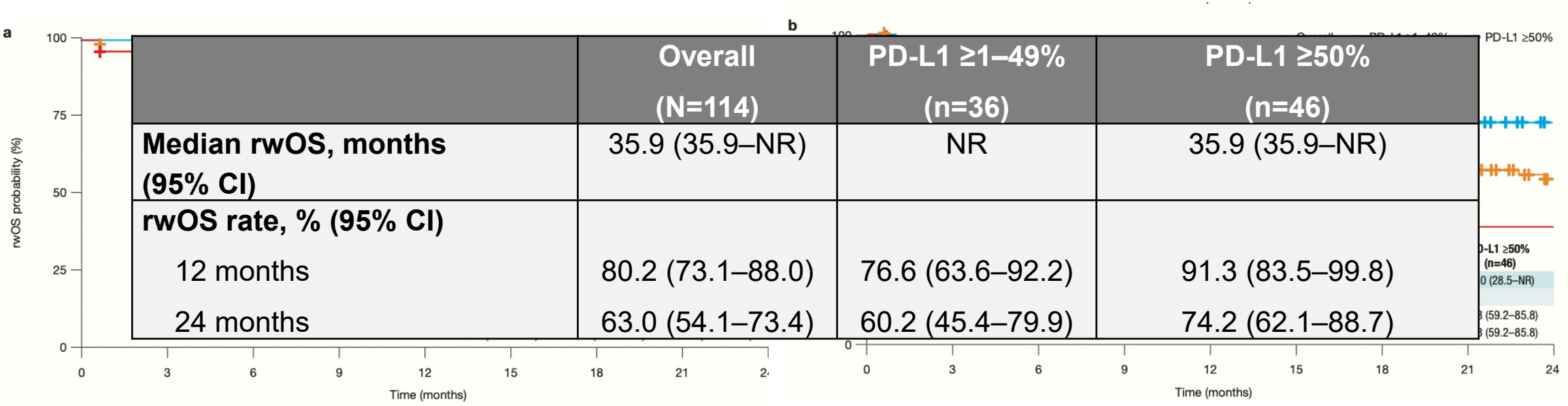
Durvalumab is licensed only in patients with locally advanced unresectable NSCLC whose tumours express PD-L1 on ≥1% of tumour cells.
CI, confidence interval; NB, not reached; PD-L1, programmed cell death ligand-1; rwOS, real-world overall survival; rwPFS, real-world progression free survival.

K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

CODAK: real-world clinical outcomes of patients with unresectable, Stage III NSCLC treated with durvalumab after chemoradiotherapy in the United Kingdom

Real world overall survival (a) and progression free survival (b)

	Overall (N=114)	PD-L1 ≥1–49% (n=36)	PD-L1 ≥50% (n=46)
Median rwOS, months (95% CI)	35.9 (35.9–NR)	NR	35.9 (35.9–NR)
rwOS rate, % (95% CI)			
12 months	80.2 (73.1–88.0)	76.6 (63.6–92.2)	91.3 (83.5–99.8)
24 months	63.0 (54.1–73.4)	60.2 (45.4–79.9)	74.2 (62.1–88.7)



The crosses represent censored observations.

Durvalumab is licensed only in patients with locally advanced unresectable NSCLC whose tumours express PD-L1 on ≥1% of tumour cells.

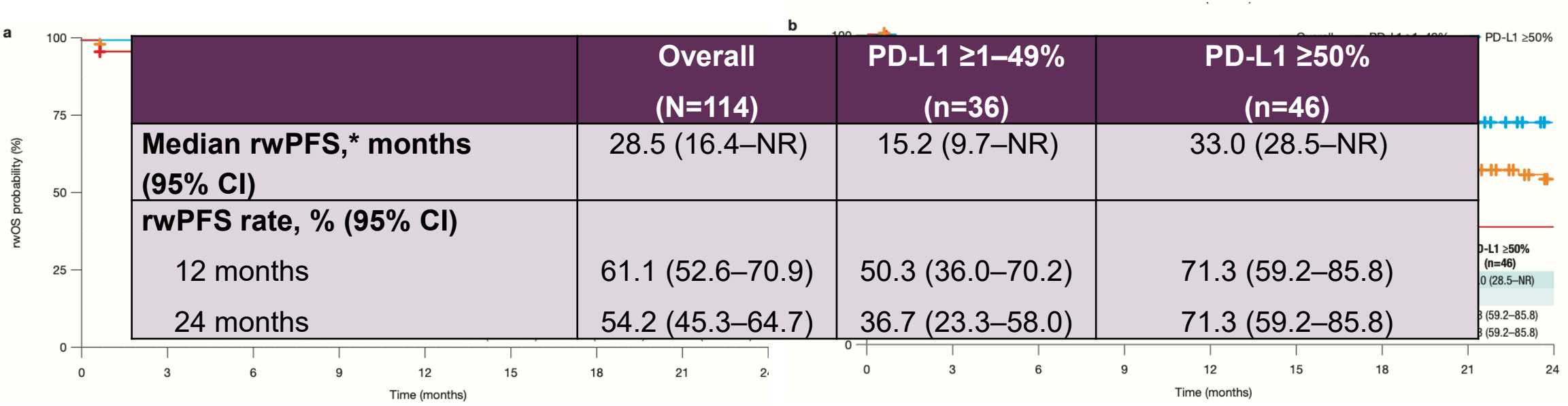
CI, confidence interval; NB, not reached; PD-L1, programmed cell death ligand-1; rwOS, real-world overall survival; rwPFS, real-world progression free survival.

K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

CODAK: real-world clinical outcomes of patients with unresectable, Stage III NSCLC treated with durvalumab after chemoradiotherapy in the United Kingdom

Real world overall survival (a) and progression free survival (b)

	Overall (N=114)	PD-L1 ≥1–49% (n=36)	PD-L1 ≥50% (n=46)
Median rwPFS,* months (95% CI)	28.5 (16.4–NR)	15.2 (9.7–NR)	33.0 (28.5–NR)
rwPFS rate, % (95% CI)			
12 months	61.1 (52.6–70.9)	50.3 (36.0–70.2)	71.3 (59.2–85.8)
24 months	54.2 (45.3–64.7)	36.7 (23.3–58.0)	71.3 (59.2–85.8)



The crosses represent censored observations.

Durvalumab is licensed only in patients with locally advanced unresectable NSCLC whose tumours express PD-L1 on ≥1% of tumour cells.

CI, confidence interval; NB, not reached; PD-L1, programmed cell death ligand-1; rwOS, real-world overall survival; rwPFS, real-world progression free survival.

K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

CODAK: real-world clinical outcomes of patients with unresectable, Stage III NSCLC treated with durvalumab after chemoradiotherapy in the United Kingdom

Treatment patterns:

- Across all patients in the study, the mean time to treatment discontinuation was 8.7 months (IQR 2.8-12.0)
- Patients in the overall cohort received a mean of 14.0 durvalumab infusions
- The main reasons for treatment discontinuation were the end of treatment (n=39; 34.2%), toxicity or AE (n=33; 28.9%) and disease progression (n=27; 23.7%)
- A total of 258 treatment interruptions occurred in 70 patients; 121 interruptions occurred due to changes in the frequency of cycles related to the coronavirus disease 2019 (COVID-19) pandemic (46.9%), 86 due to toxicity or AEs (33.3%) and 20 due to patient choice (7.8%)
- Pneumonitis/interstitial lung disease was the most common AE leading to treatment interruption (reported in 11 patients [9.6%]) and discontinuation (reported in 19 patients [16.7%])

Patients should be monitored for signs and symptoms of pneumonitis/radiation pneumonitis. Please refer to the durvalumab SmPC for a full list of special warnings/precautions and adverse events.

AE, adverse events.

K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

CODAK: real-world clinical outcomes of patients with …with durvalumab …Kingdom

Durvalumab treatment patterns	
	Overall (N=114)
Number of durvalumab infusion per patient, mean (range)	14.0 (1.0–27.0)
Number of durvalumab interruptions* per patient, mean (range)	2.3 (0.0–11.0)
Reasons for treatment interruption (N=258 interruptions)†, n(%)	
Change in frequency of cycles due to COVID-19	121 (46.9)
Toxicity/AE	86 (33.3)
Patient choice	20 (7.8)
Other	19 (7.4)
Progression	1 (0.4)
Not recorded	11 (4.3)
Patients having ≥1 episode of pneumonitis or ILD resulting in interruption of treatment, n (%)	11 (9.6)
Reason for treatment discontinuation (at site of enrolment), n (%)	
End of treatment	39 (34.2)
Toxicity or AE	33 (28.9)
Disease progression	27 (23.7)
Patient choice	5 (4.4)
Death	3 (2.6)
Patient transferred to another hospital or continuation of treatment	3 (2.6)
Other	3 (2.6)
Not recorded	1 (0.9)

AEs resulting in durvalumab treatment discontinuation	
AE, n (%)	**Overall (N=114)**
Pneumonitis/ILD	19 (16.7)
Diarrhoea/colitis and intestinal perforation	3 (2.6)
Endocrinopathies	0 (0.0)
Hepatitis or transaminase increases	3 (2.6)
Nephritis or blood creatinine increases	1 (0.9)
Neuropathy/neuromuscular toxicity	2 (1.8)
Other inflammatory responses	2 (1.8)
Rash or dermatitis	2 (1.8)
Myositis/polymyositis	1 (0.9)
Pancreatitis or serum lipase and amylase increases	0 (0.0)
Myocarditis	0 (0.0)

Percentage data may not total 100% due to rounding.

*An interruption is a delay of ≥ 1 week of the planned dose; †A total of 258 interruptions occurred in 70 patients.

AE, Adverse event; COVID-19, Coronavirus disease 2019; ILD, Interstitial lung disease.

Please refer to the durvalumab SmPC for further information on adverse events and their management.

K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

CODAK: real-world clinical outcomes of patients with unresectable, Stage III NSCLC treated with durvalumab after chemoradiotherapy in the United Kingdom

THINK AGAIN LUNG SUMMIT

Conclusions:

- This final analysis of CODAK demonstrates the effectiveness of consolidation durvalumab after CRT in a real-world cohort of UK patients with unresectable, Stage III NSCLC
- rwOS rates 12 and 24 months were comparable to the results seen in the phase III PACIFIC study
- Safety data were comparable to results from PACIFIC
- Limitations of CODAK include the retrospective chart review for data collection and the lack of standardisation for response and progression evaluation which may have led to an overestimation of rwPFS estimates compared to PACIFIC
- **Despite its limitations, CODAK's results support evidence from other real-world studies that the PACIFIC regimen is an effective SOC for patients with unresectable, Stage III NSCLC in real-world UK clinical practice**

CRT, chemoradiotherapy; NSCLC, non-small cell lung cancer, rwOS, real-world overall survival; rwPFS, real-world progression free survival; SOC, standard of care.

1. Speaker's clinical expertise. 2. K Franks, et al. CODAK real-world study (NCT04667321). Presented at BTOG Annual Meeting, April 2024, Poster 78.

Conclusions[1,2]

We are catching up in the UK – in 2017 only 32% of Stage III NSCLC had curative treatment

Stage III is curable and we need to offer our eligible patients the optimal treatment – for both operable and inoperable Stage III NSCLC patients

CODAK shows that we can deliver concurrent chemoradiotherapy and adjuvant durvalumab in the UK

NSCLC, non-small cell lung cancer.

1. Speaker's clinical expertise; 2. Royal College of Physicians. 2018 NLCA information sheet. Available at: https://www.rcplondon.ac.uk/projects/outputs/nlca-annual-report-2018 (last accessed June 2024).

Thank you

Prescribing information is available at this meeting, and at the following links:
IMFINZI GB , IMFINZI NI , TAGRISSO GB , TAGRISSO NI

THINK AGAIN LUNG SUMMIT

Navigating the Treatment Landscape

Q&A

Dr Kevin Franks
Consultant Clinical Oncologist, The Leeds Teaching Hospitals NHS Trust

THINK AGAIN LUNG SUMMIT