Small Cell Lung Cancer: New Therapeutic Advances in 2024

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COMPREHENSIVE CANCER CENTER

Disclosures

- **Paid Advisory Board:** Novartis; Lilly; Amgen; AstraZeneca; Boehringer Ingelheim; EMD Serono; Bayer; Roche/Genentech, Inc.; Merck; Jazz Pharmaceuticals; Daiichi Sankyo; Janssen; Genentech; Coherus Biosciences; GenCART; Heat Biologics; Meryx; Puma Biosciences; GSK, Gilead, Regeneron, Betta Pharmaceuticals; OncoHost; Boehringer Ingelheim
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- **IRC/DSMB**: EMD Serono, Roche/Genentech
- **Co-founder or Stock Ownership**: Cambium Oncology; Taobob LLC/Coherus Biosciences; GenCART;

Paradigm or practice change in SCLC

Therapeutic Advances in SCLC: Yes (✓) or No (X)?

Years	LS-SCLC Frontline induction	LS-SCLC Maintenance/ Consolidation	ES-SCLC Frontline induction	ES-SCLC Maintenance/ Consolidation	Relapsed SCLC
2019	X	X	✓ Atezolizumab	✓Atezolizumab	X
2020	X	X	✓ Durvalumab	✓Durvalumab	✓Lurbinectedin
2021	X	X	X	X	X
2022	X	X	X	X	X
2023	X	X	X	X	X
2024	X	✓Durvalumab	X	✓Lurbinectedin	✓Tarlatamab

Phase 3 ADRIATIC trial

Ongoing, randomised, double-blind, placebo-controlled, multicentre, international study

- Stage I–III LS-SCLC (stage I/II inoperable)
- WHO PS 0 or 1
- Had not progressed following cCRT*
- PCI* permitted before randomisation

N=730

R†

Stratified by:
Disease stage (I/II vs III)
PCI (yes vs no)

- **Durvalumab** N=264
- **Placebo** N=266
- **Durvalumab + tremelimumab** N=200

Treatment until investigator-determined PD or intolerable toxicity, or for a **maximum of 24 months**

Dual primary endpoints:
- D vs P
  - PFS,‡ OS

Key secondary endpoints:
- D+T vs P
  - PFS,‡ OS

Other secondary endpoints:
- PFS/OS landmarks, safety

At the first interim analysis:[1]

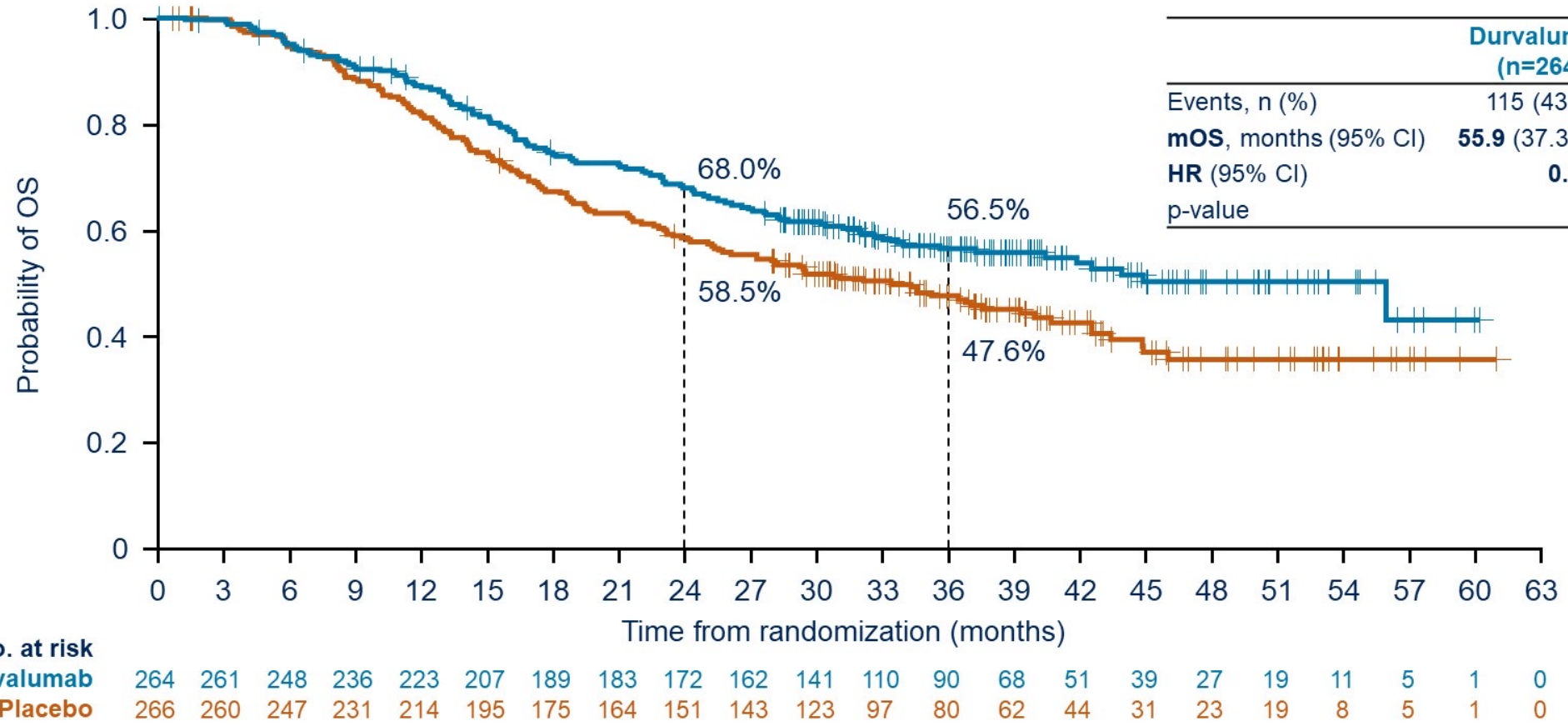
- Consolidation durvalumab significantly improved the dual primary endpoints of OS and PFS versus placebo; generally consistent treatment benefit across predefined patient subgroups
- Treatment well tolerated; safety consistent with known safety profile of durvalumab in the post-cCRT setting
- Durvalumab + tremelimumab arm remained blinded

BICR, blinded independent central review; cCRT, concurrent chemoradiotherapy; D, durvalumab; LS-SCLC, limited-stage small-cell lung cancer; OS, overall survival; P, placebo; PCI, prophylactic cranial irradiation; PD, progressive disease; PFS, progression-free survival; R, randomisation; RECIST, Response Evaluation Criteria in Solid Tumors; T, tremelimumab; WHO PS, World Health Organization performance status.

1. Spigel D, et al. J Clin Oncol 2024;42(17_suppl):LBA5.
*cCRT and PCI treatment, if received per local standard of care, must have been completed within 1–42 days prior to randomisation. †The first 600 patients were randomised in a 1:1:1 ratio to the 3 arms; subsequent patients were randomised 1:1 to either durvalumab or placebo. ‡PFS assessed by BICR, per RECIST v1.1.

Overall survival (dual primary endpoint)

- Median duration of follow up in censored patients: 37.2 months (range 0.1–60.9)



	Durvalumab (n=264)	Placebo (n=266)
Events, n (%)	115 (43.6)	146 (54.9)
mOS, months (95% CI)	**55.9** (37.3–NE)	**33.4** (25.5–39.9)
HR (95% CI)	**0.73** (0.57–0.93)	
p-value	0.0104	

No. at risk																						
Durvalumab	264	261	248	236	223	207	189	183	172	162	141	110	90	68	51	39	27	19	11	5	1	0
Placebo	266	260	247	231	214	195	175	164	151	143	123	97	80	62	44	31	23	19	8	5	1	0

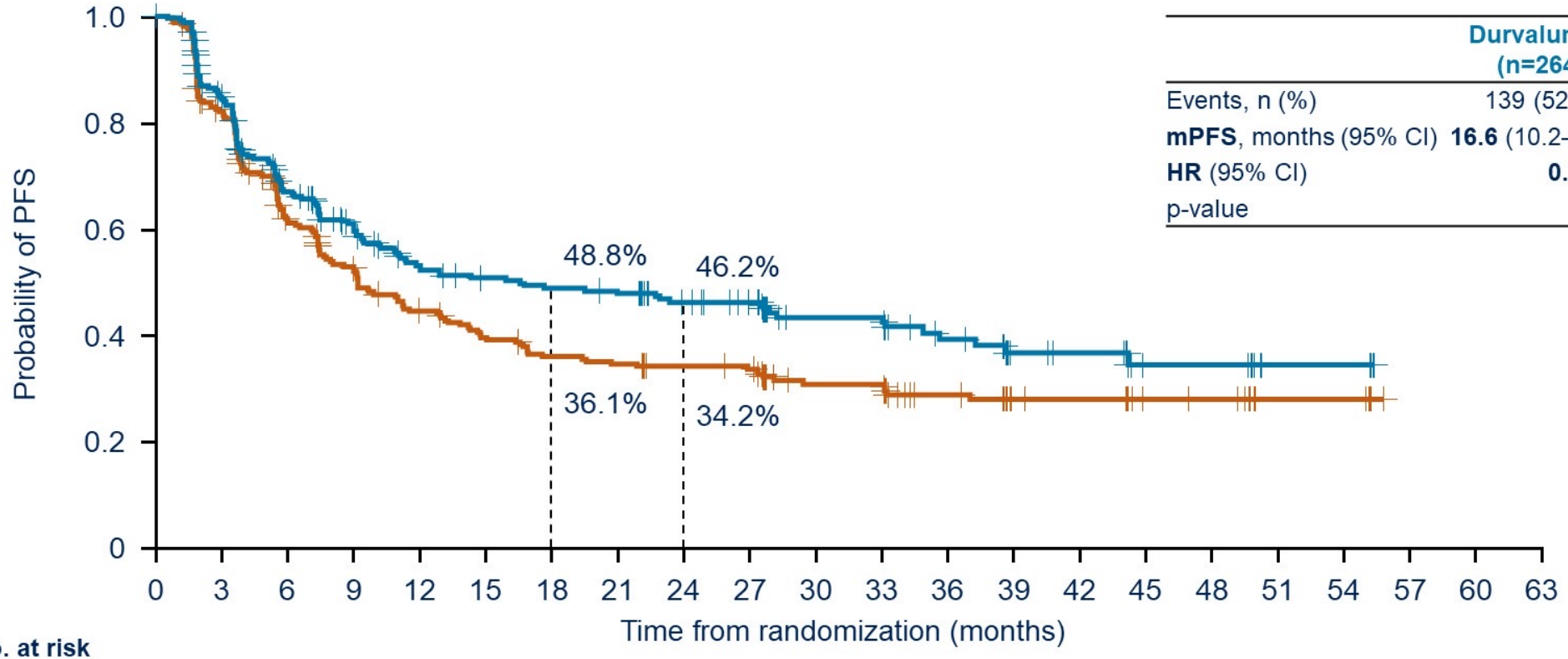
OS was analyzed using a stratified log-rank test adjusted for receipt of PCI (yes vs no). The significance level for testing OS at this interim analysis was 0.01679 (2-sided) at the overall 4.5% level, allowing for strong alpha control across interim and final analysis timepoints.

PRESENTED BY: Dr David R. Spigel

CI, confidence interval; mOS, median OS; NE, not estimable.

Progression-free survival* (dual primary endpoint)

- Median duration of follow up in censored patients: 27.6 months (range 0.0–55.8)



	Durvalumab (n=264)	Placebo (n=266)
Events, n (%)	139 (52.7)	169 (63.5)
mPFS, months (95% CI)	**16.6** (10.2–28.2)	**9.2** (7.4–12.9)
HR (95% CI)	**0.76** (0.61–0.95)	
p-value	0.0161	

No. at risk																						
Durvalumab	264	212	161	135	113	105	101	98	84	78	51	51	33	21	19	10	10	4	4	0	0	0
Placebo	266	208	146	122	100	88	79	76	71	69	47	47	34	23	22	15	14	5	5	0	0	0

*By BICR per RECIST v1.1.

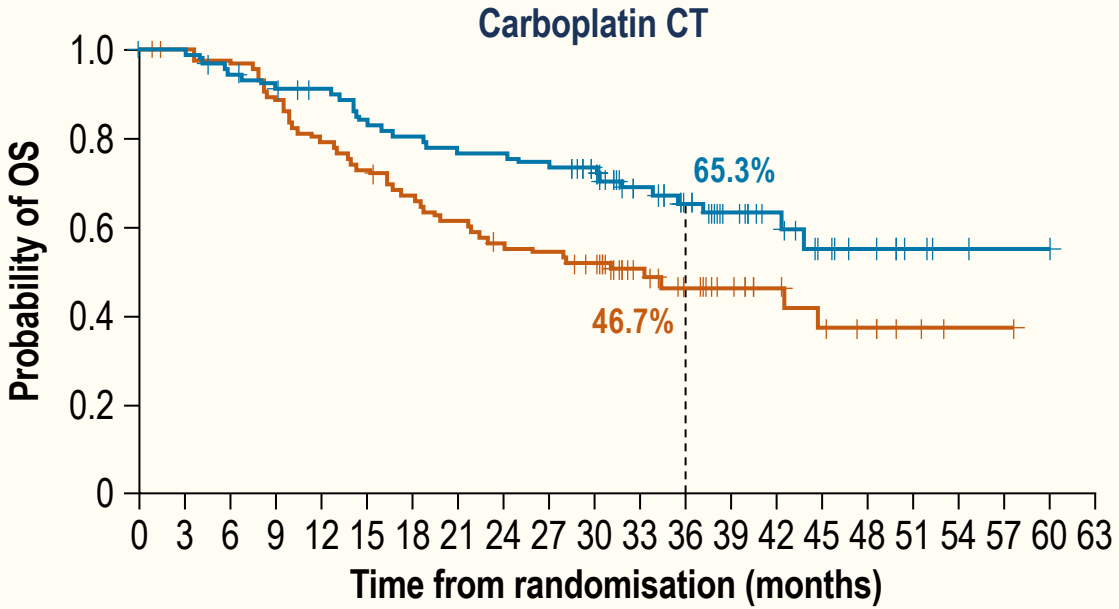
PFS was analyzed using a stratified log-rank test adjusted for disease stage (I/II vs III) and receipt of PCI (yes vs no). The significance level for testing PFS at this interim analysis was 0.00184 (2-sided) at the 0.5% level, and 0.02805 (2-sided) at the overall 5% level. Statistical significance for PFS was achieved through the recycling multiple testing procedure framework and testing at the 5% (2-sided) alpha level (adjusted for an interim and final analysis).

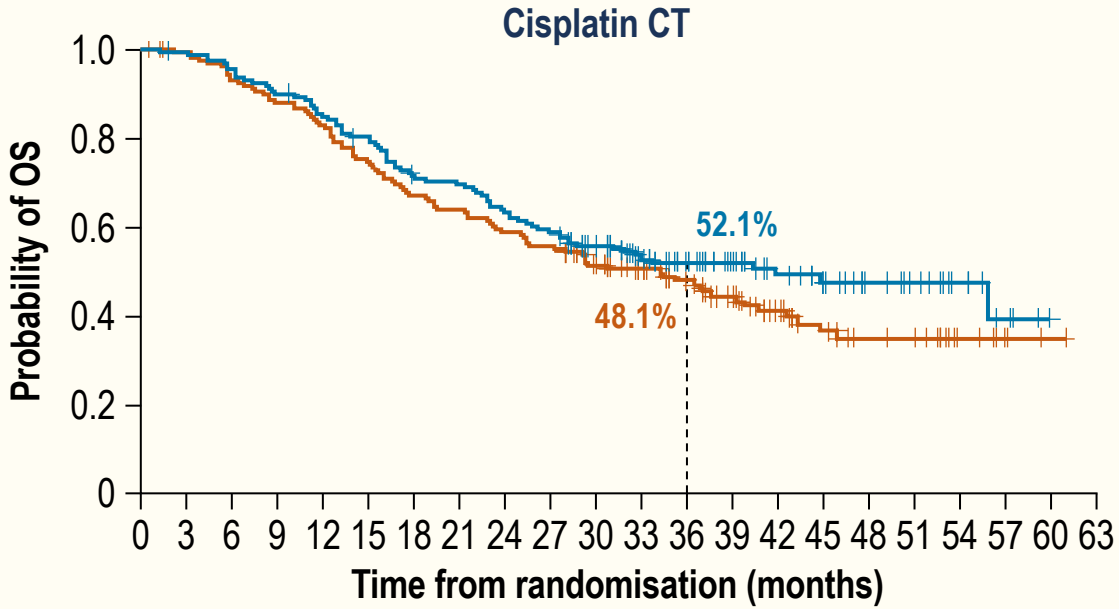
PRESENTED BY: Dr David R. Spigel

mPFS, median PFS.

Carboplatin and cisplatin CT subgroups – OS

	Carboplatin CT		Cisplatin CT		ITT	
	D (n = 91)	P (n = 88)	D (n = 173)	P (n = 178)	D (n = 264)	P (n = 266)
Median OS (95% CI), months	NR (42.5–NE)	33.4 (21.7–NE)	41.9 (27.7–NE)	34.3 (25.4–40.7)	55.9 (37.3–NE)	33.4 (25.5–39.9)
3-year OS, %	65.3	46.7	52.1	48.1	56.5	47.6
HR (95% CI)	0.56 (0.35–0.89)*		0.82 (0.61–1.10)*		0.73 (0.57–0.93)†	
Multivariable HR (95% CI)	0.55 (0.35–0.87)‡		0.81 (0.60–1.08)‡		–	





No. at risk:

D, carboplatin	91	90	84	81	77	71	68	66	65	63	55	40	32	23	17	11	8	4	2	1	1	0
P, carboplatin	88	86	84	77	69	63	57	52	47	45	41	28	22	16	11	8	6	3	1	1	0	0

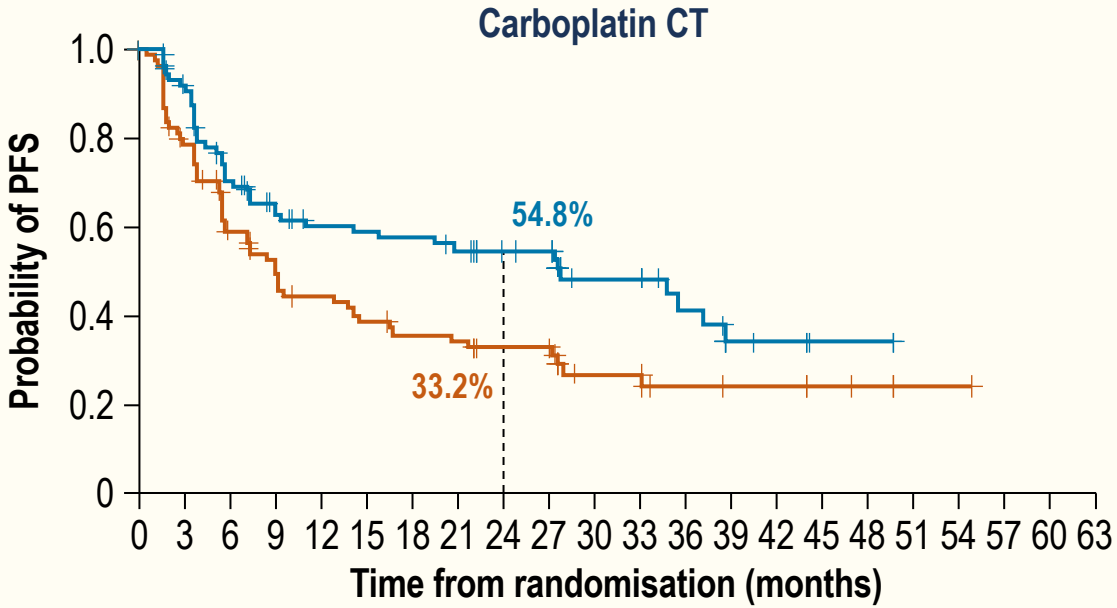
No. at risk:

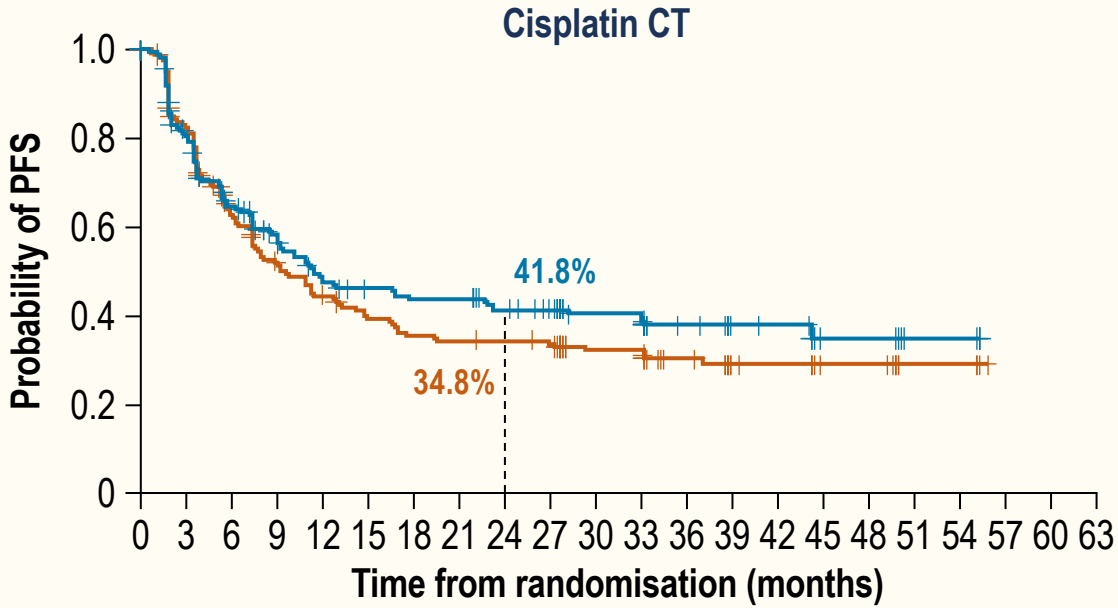
D, cisplatin	173	171	164	155	146	136	121	117	107	99	86	70	58	45	34	28	19	15	9	4	0	0
P, cisplatin	178	174	163	154	145	132	118	112	104	98	82	69	58	46	33	23	17	16	7	4	1	0

*Subgroup HRs and CIs calculated using an unstratified Cox proportional hazards model.
†ITT HR and CIs calculated using a Cox proportional hazards model stratified by receipt of PCI.
‡Multivariable analysis interaction p-value 0.17.

Carboplatin and cisplatin CT subgroups – PFS

	Carboplatin CT		Cisplatin CT		ITT	
	D (n = 91)	P (n = 88)	D (n = 173)	P (n = 178)	D (n = 264)	P (n = 266)
Median PFS (95% CI), months	27.9 (11.1–38.7)	9.2 (5.8–14.6)	11.4 (9.0–23.4)	9.7 (7.4–13.3)	16.6 (10.2–28.2)	9.2 (7.4–12.9)
2-year PFS, %	54.8	33.2	41.8	34.8	46.2	34.2
HR (95% CI)	0.61 (0.41–0.90)*		0.86 (0.65–1.13)*		0.76 (0.61–0.95)†	
Multivariable HR (95% CI)	0.60 (0.40–0.88)‡		0.89 (0.67–1.17)‡		–	





No. at risk:

D, carboplatin	91	79	59	50	43	42	41	38	33	32	18	18	12	6	5	2	2	0	0	0	0	0
P, carboplatin	88	67	46	39	32	28	25	24	20	20	11	11	7	6	6	4	3	1	1	0	0	0

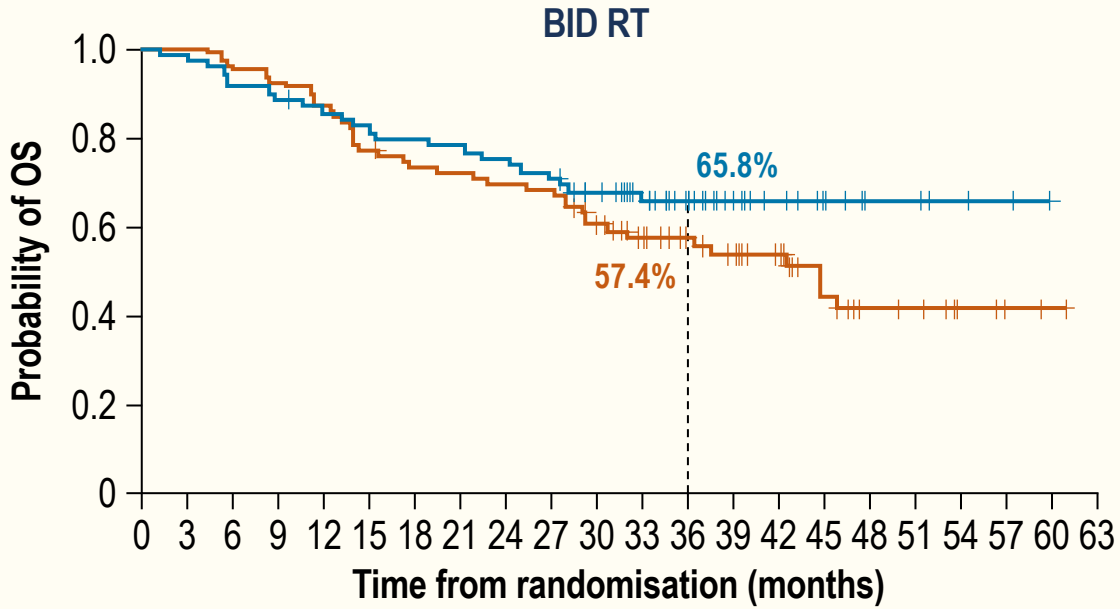
No. at risk:

D, cisplatin	173	133	102	85	70	63	60	60	51	46	33	33	21	15	14	8	8	4	4	0	0	0
P, cisplatin	178	141	100	83	68	60	54	52	51	49	36	36	27	17	16	11	11	4	4	0	0	0

*Subgroup HRs and CIs calculated using an unstratified Cox proportional hazards model.
†ITT HR and CIs calculated using a Cox proportional hazards model stratified by TNM stage and receipt of PCI.
‡Multivariable analysis interaction p-value 0.11.

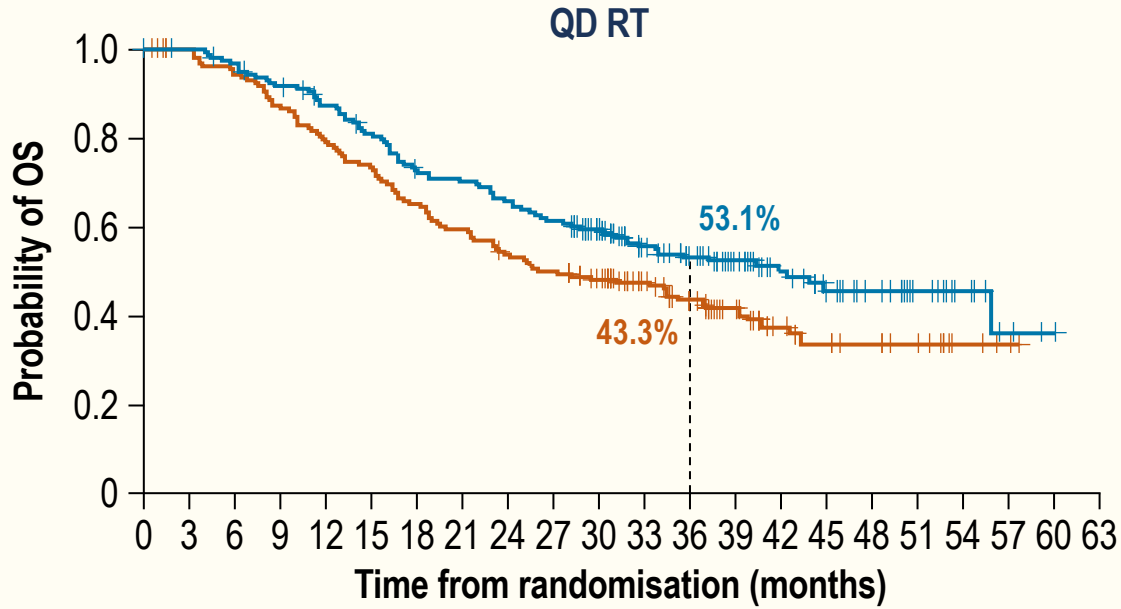
BID and QD RT subgroups – OS

	BID RT		QD RT		ITT	
	D (n = 69)	P (n = 79)	D (n = 195)	P (n = 187)	D (n = 264)	P (n = 266)
Median OS (95% CI), months	NR (NE–NE)	44.8 (29.4–NE)	41.9 (32.0–NE)	26.1 (21.7–36.8)	55.9 (37.3–NE)	33.4 (25.5–39.9)
3-year OS, %	65.8	57.4	53.1	43.3	56.5	47.6
HR (95% CI)	0.68 (0.40–1.14)*		0.72 (0.55–0.96)*		0.73 (0.57–0.93)†	
Multivariable HR (95% CI)	0.71 (0.42–1.18)‡		0.73 (0.55–0.96)‡		–	



No. at risk:

D, BID	69	68	63	61	59	56	54	53	51	48	42	35	27	18	13	10	5	5	3	2	0	0
P, BID	79	79	76	73	69	61	57	56	54	53	45	37	32	27	22	14	9	8	4	3	1	0



No. at risk:

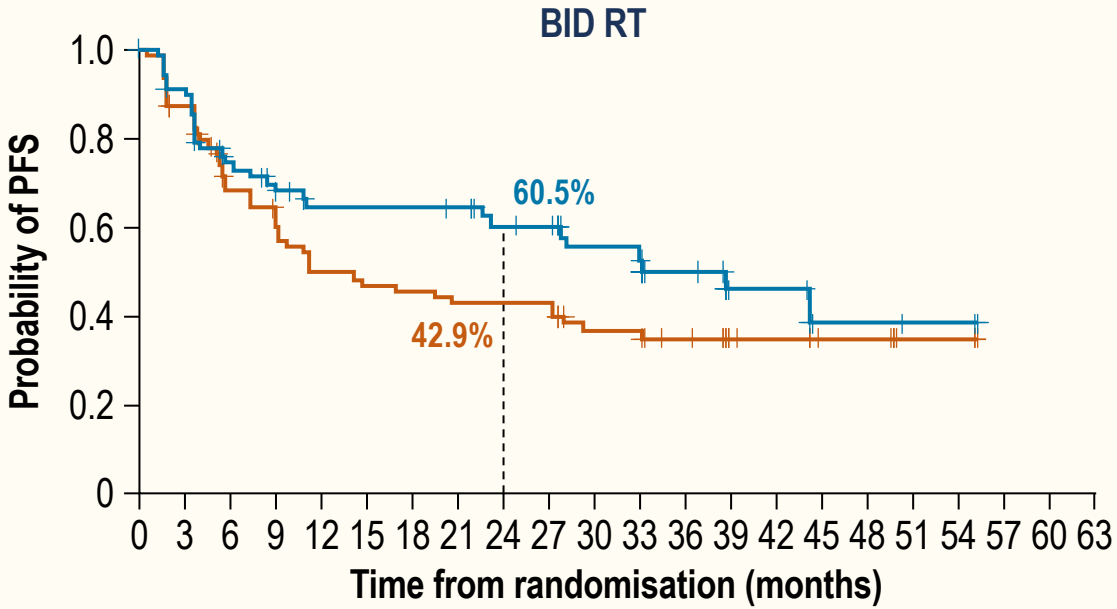
D, QD	195	193	185	175	164	151	135	130	121	114	99	75	63	50	38	29	22	14	8	3	1	0
P, QD	187	181	171	158	145	134	118	108	97	90	78	60	48	35	22	17	14	11	4	2	0	0

*Subgroup HRs and CIs calculated using an unstratified Cox proportional hazards model.
†ITT HR and CIs calculated using a Cox proportional hazards model stratified by receipt of PCI.
‡Multivariable analysis interaction p-value 0.95.

Senan S et al. ESMO 2024 (abstr LBA81)

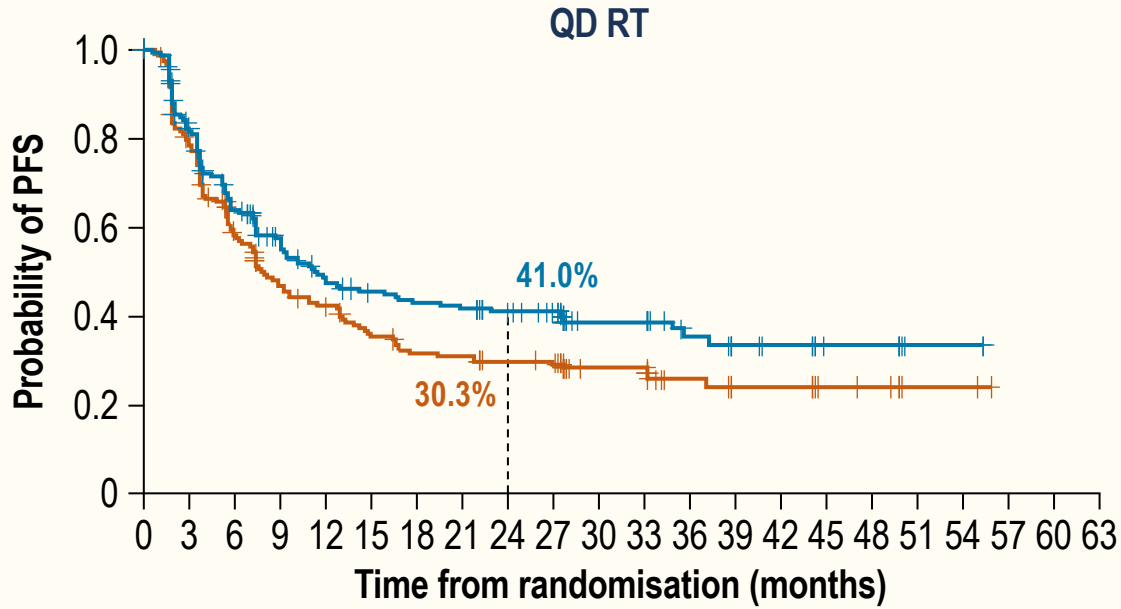
BID and QD RT subgroups – PFS

	BID RT		QD RT		ITT	
	D (n = 69)	P (n = 79)	D (n = 195)	P (n = 187)	D (n = 264)	P (n = 266)
Median PFS (95% CI), months	38.7 (22.7–NE)	14.3 (9.1–28.1)	11.4 (9.0–19.5)	7.8 (6.4–11.5)	16.6 (10.2–28.2)	9.2 (7.4–12.9)
2-year PFS, %	60.5	42.9	41.0	30.3	46.2	34.2
HR (95% CI)	0.72 (0.45–1.13)*		0.77 (0.60–1.00)*		0.76 (0.61–0.95)†	
Multivariable HR (95% CI)	0.73 (0.46–1.14)‡		0.79 (0.61–1.03)‡		–	



No. at risk:

D, BID	69	61	47	42	36	36	36	35	30	29	22	22	14	7	7	3	3	2	2	0	0	0
P, BID	79	67	49	46	35	33	32	30	30	30	23	23	19	12	11	8	8	3	3	0	0	0



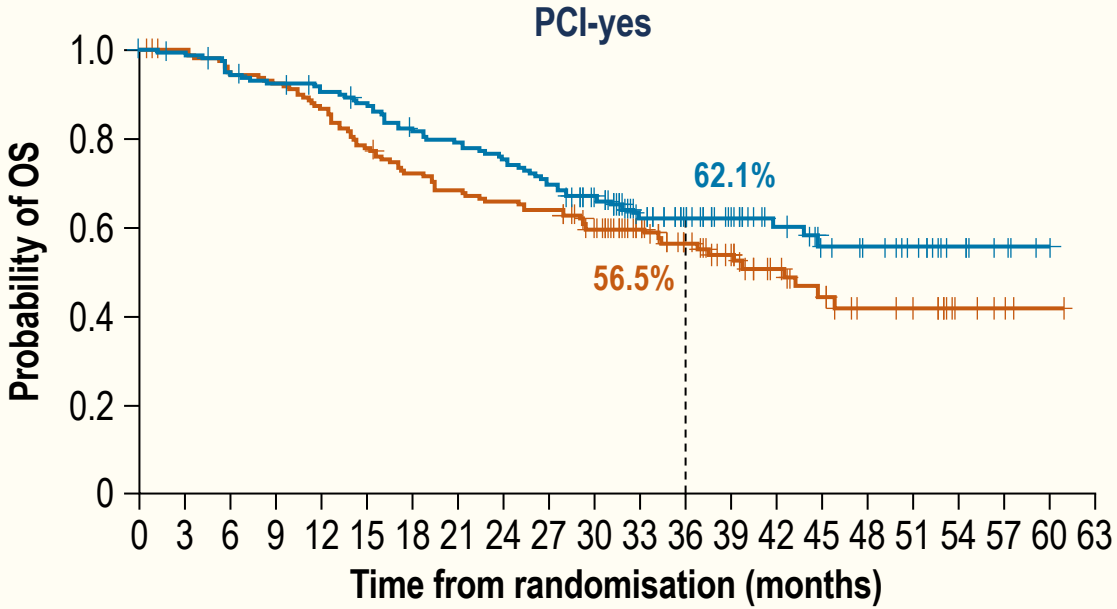
No. at risk:

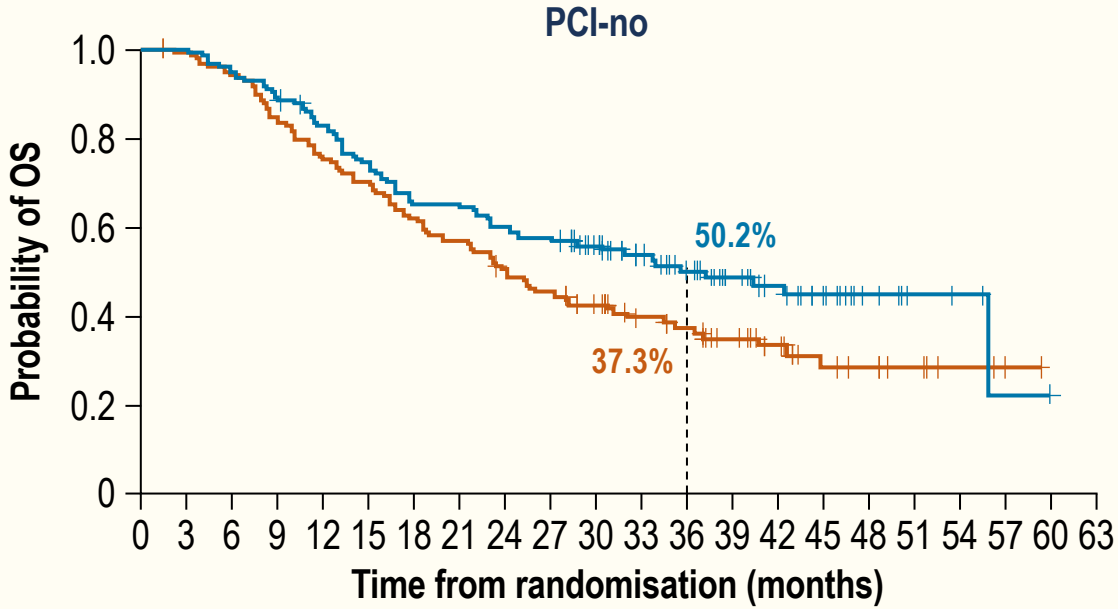
D, QD	195	151	114	93	77	69	65	63	54	49	29	29	19	14	12	7	7	2	2	0	0	0
P, QD	187	141	97	76	65	55	47	46	41	39	24	24	15	11	11	7	6	2	2	0	0	0

*Subgroup HRs and CIs calculated using an unstratified Cox proportional hazards model.
†ITT HR and CIs calculated using a Cox proportional hazards model stratified by TNM stage and receipt of PCI.
‡Multivariable analysis interaction p-value 0.75.

PCI-yes and PCI-no subgroups – OS

	PCI-yes		PCI-no		ITT	
	D (n = 142)	P (n = 143)	D (n = 122)	P (n = 123)	D (n = 264)	P (n = 266)
Median OS (95% CI), months	NR (43.9–NE)	42.5 (33.4–NE)	37.3 (24.3–NE)	24.1 (18.8–31.1)	55.9 (37.3–NE)	33.4 (25.5–39.9)
3-year OS, %	62.1	56.5	50.2	37.3	56.5	47.6
HR (95% CI)	0.75 (0.52–1.07)*		0.71 (0.51–0.99)*		0.73 (0.57–0.93)†	
Multivariable HR (95% CI)	0.72 (0.50–1.03)‡		0.73 (0.52–1.02)‡		–	





No. at risk:

D, PCI-yes	142	139	132	127	124	118	110	105	100	93	82	63	51	40	29	23	19	15	8	4	1	0
P, PCI-yes	143	140	133	129	122	110	100	95	91	89	77	61	48	37	26	20	14	13	5	3	1	0

No. at risk:

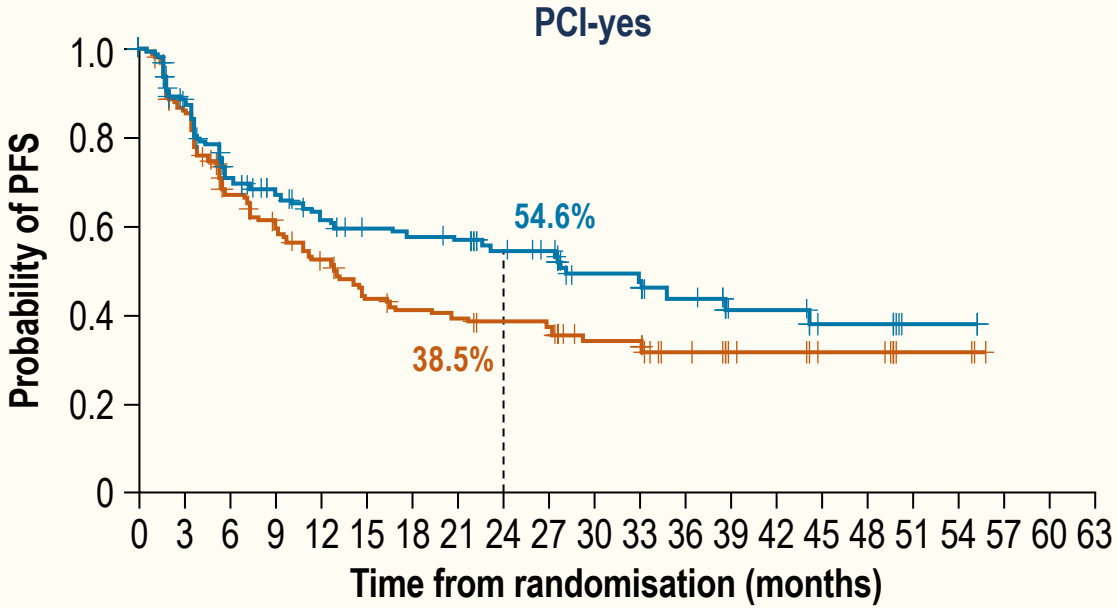
D, PCI-no	122	122	116	109	99	89	79	78	72	69	59	47	39	28	22	16	8	4	3	1	0	0
P, PCI-no	123	120	114	102	92	85	75	69	60	54	46	36	32	25	18	11	9	6	3	2	0	0

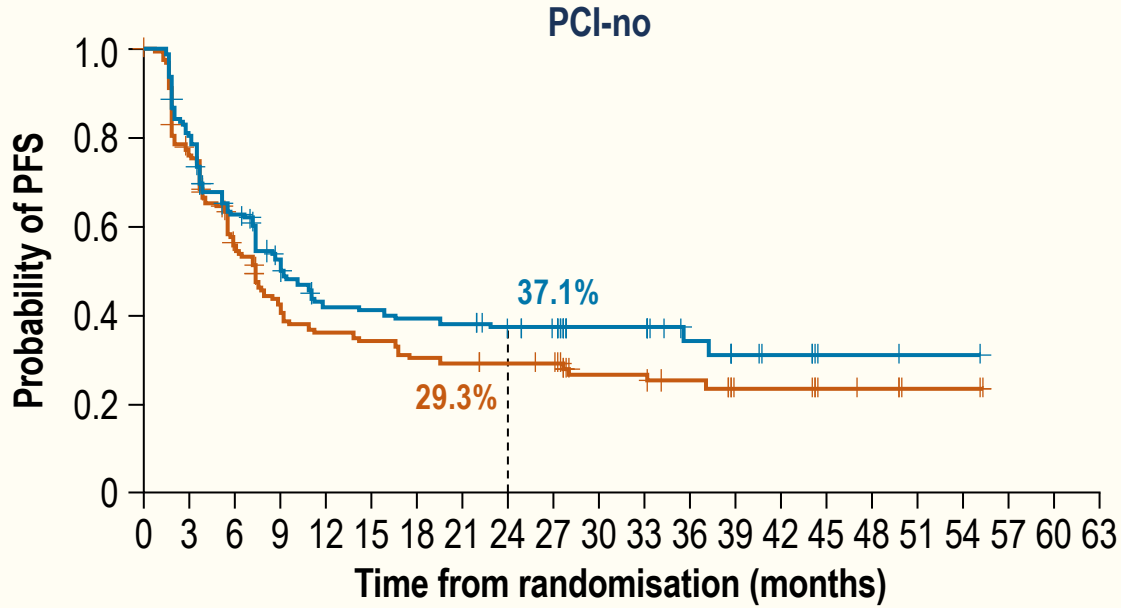
*Subgroup HRs and CIs calculated using an unstratified Cox proportional hazards model.
†ITT HR and CIs calculated using a Cox proportional hazards model stratified by receipt of PCI.
‡Multivariable analysis interaction p-value 0.96.

CI, confidence interval; NE, not estimable; NR, not reached; yr, year.

PCI-yes and PCI-no subgroups – PFS

	PCI-yes		PCI-no		ITT	
	D (n = 142)	P (n = 143)	D (n = 122)	P (n = 123)	D (n = 264)	P (n = 266)
Median PFS (95% CI), months	28.2 (16.8–44.2)	13.0 (9.2–17.0)	9.1 (7.3–14.3)	7.4 (5.7–9.2)	16.6 (10.2–28.2)	9.2 (7.4–12.9)
2-year PFS, %	54.6	38.5	37.1	29.3	46.2	34.2
HR (95% CI)	0.73 (0.52–1.00)*		0.80 (0.59–1.09)*		0.76 (0.61–0.95)†	
Multivariable HR (95% CI)	0.72 (0.52–0.99)‡		0.84 (0.61–1.15)‡		–	





No. at risk:

D, PCI-yes	142	114	89	79	70	63	61	59	50	47	31	31	21	13	13	8	8	3	3	0	0	0
P, PCI-yes	143	116	84	76	62	52	47	45	42	41	28	28	18	13	12	9	9	3	3	0	0	0

No. at risk:

D, PCI-no	122	98	72	56	43	42	40	39	34	31	20	20	12	8	6	2	2	1	1	0	0	0
P, PCI-no	123	92	62	46	38	36	32	31	29	28	19	19	16	10	10	6	5	2	2	0	0	0

*Subgroup HRs and CIs calculated using an unstratified Cox proportional hazards model.
†ITT HR and CIs calculated using a Cox proportional hazards model stratified by TNM stage and receipt of PCI.
‡Multivariable analysis interaction p-value 0.50.

TNM, Tumour-Node-Metastasis.

NRG ONCOLOGY

Advancing Research. Improving Lives.™

Concurrent Chemoradiation +/- Atezolizumab (atezo) in limited-stage small cell lung cancer (LS-SCLC): Results of NRG Oncology/Alliance LU005

Kristin A. Higgins, Chen Hu, Helen J. Ross, Salma K. Jabbour, David E. Kozono, Taofeek K. Owonikoko, Kyoichi Kaira, Amit K. Gupta, Pranshu Mohindra, Elie G. Dib, Jeremy Brownstein, Stephen Chun, Charles S. Kuzma, Rupesh R. Kotecha, Adedayo A. Onitilo, Yuhchyau Chen, Tom Stinchcombe, Xiaofei F. Wang, Rebecca Paulus, Jeffrey D. Bradley

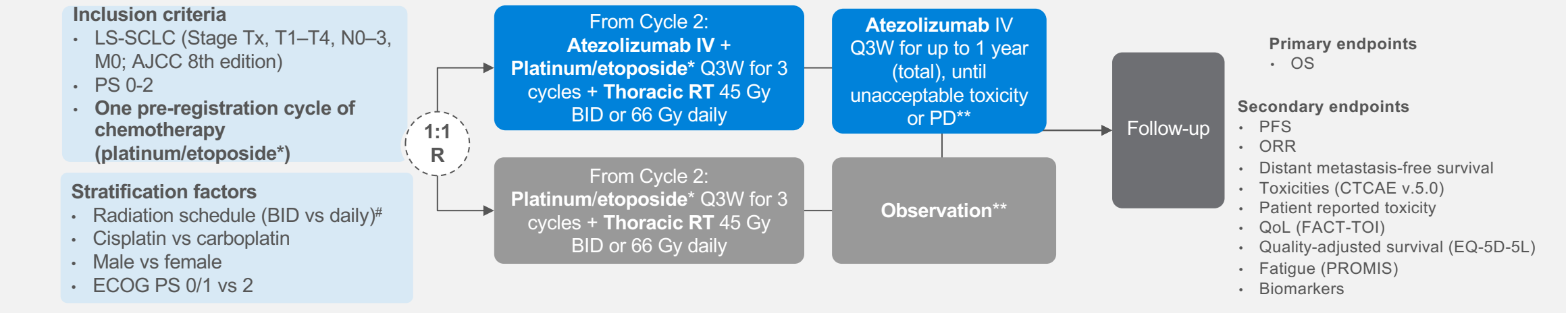
ASTRO 2024
September 30, 2024

NCI National Clinical Trials Network — a National Cancer Institute program

NCI Community Oncology Research Program — A program of the National Cancer Institute of the National Institutes of Health

NRG LU005 Schema

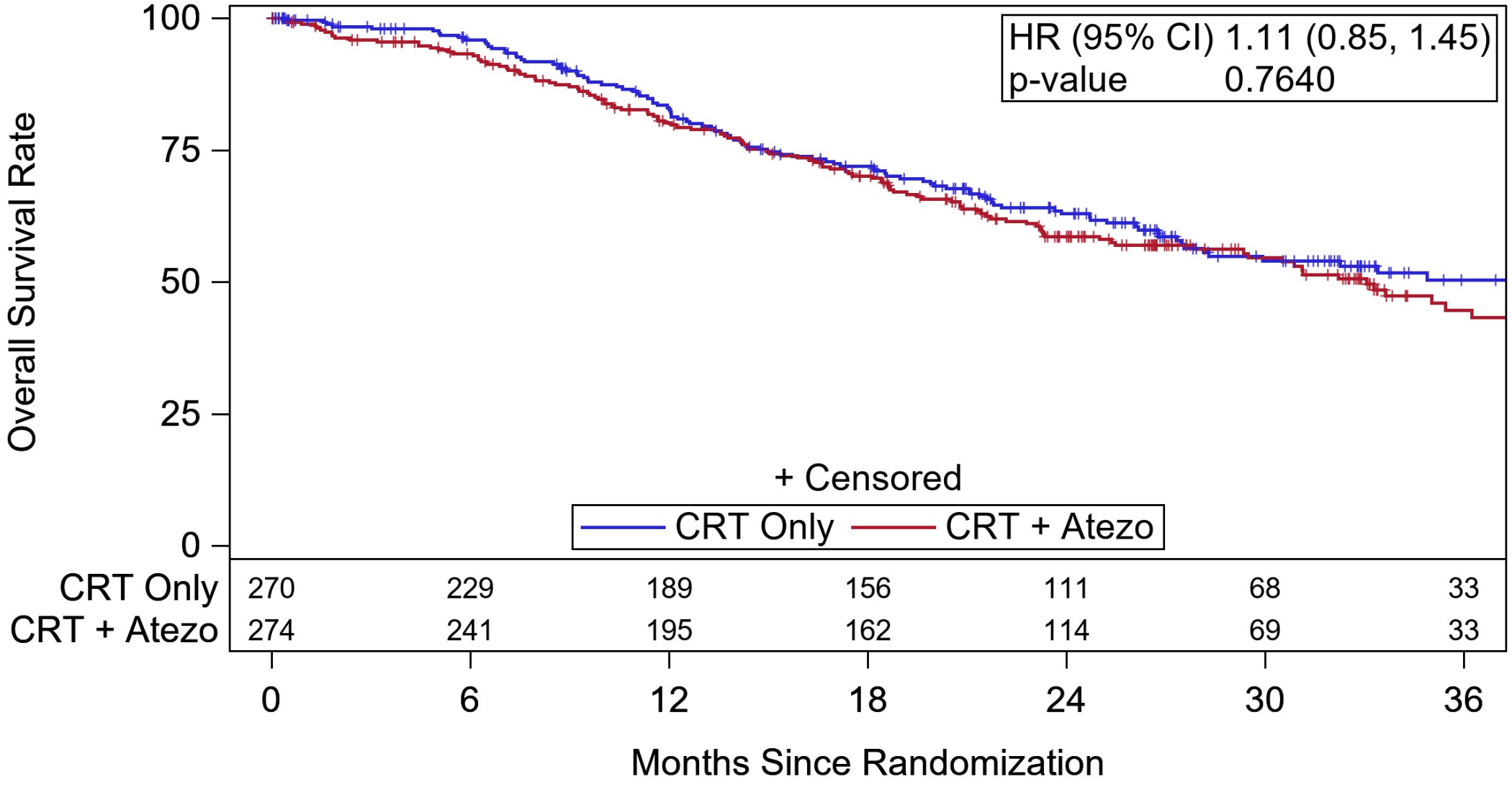
Phase III (N = 544; US & Japanese sites**)** NCT03811002



#Thoracic RT 45 Gy BID (1.5 Gy x 30 fractions ->3 weeks) or 66 Gy daily (2 Gy x 33 fractions ->6.5 weeks) beginning with cycle 2 of chemotherapy; *cisplatin (preferred) or carboplatin; first cycle of chemotherapy given prior to study entry, 3 given on study (for a total of 4 cycles); **All patients with a CR or near CR are strongly recommended to receive prophylactic cranial irradiation (PCI; 25 Gy)

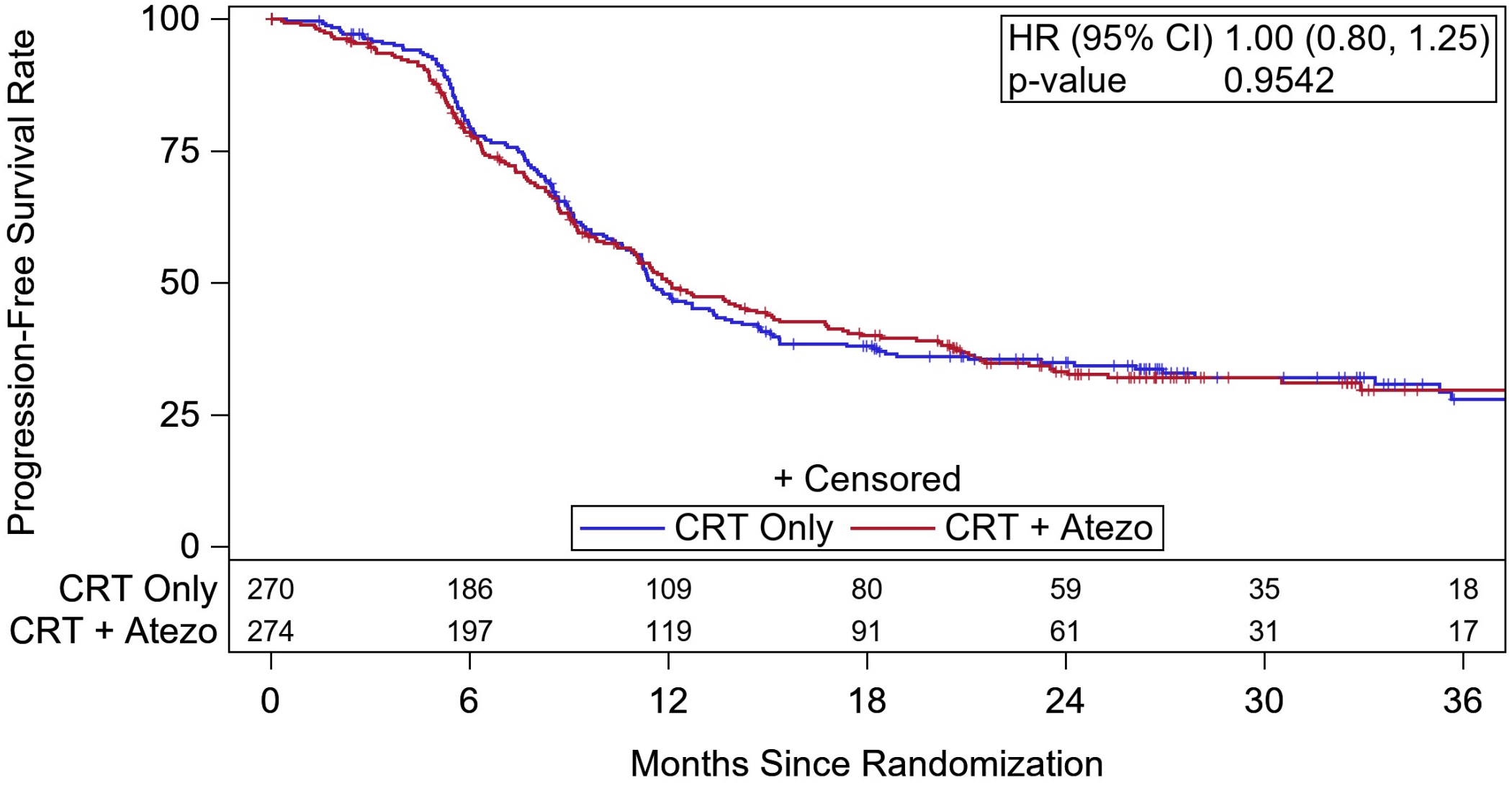
NRG ONCOLOGY™

Overall Survival



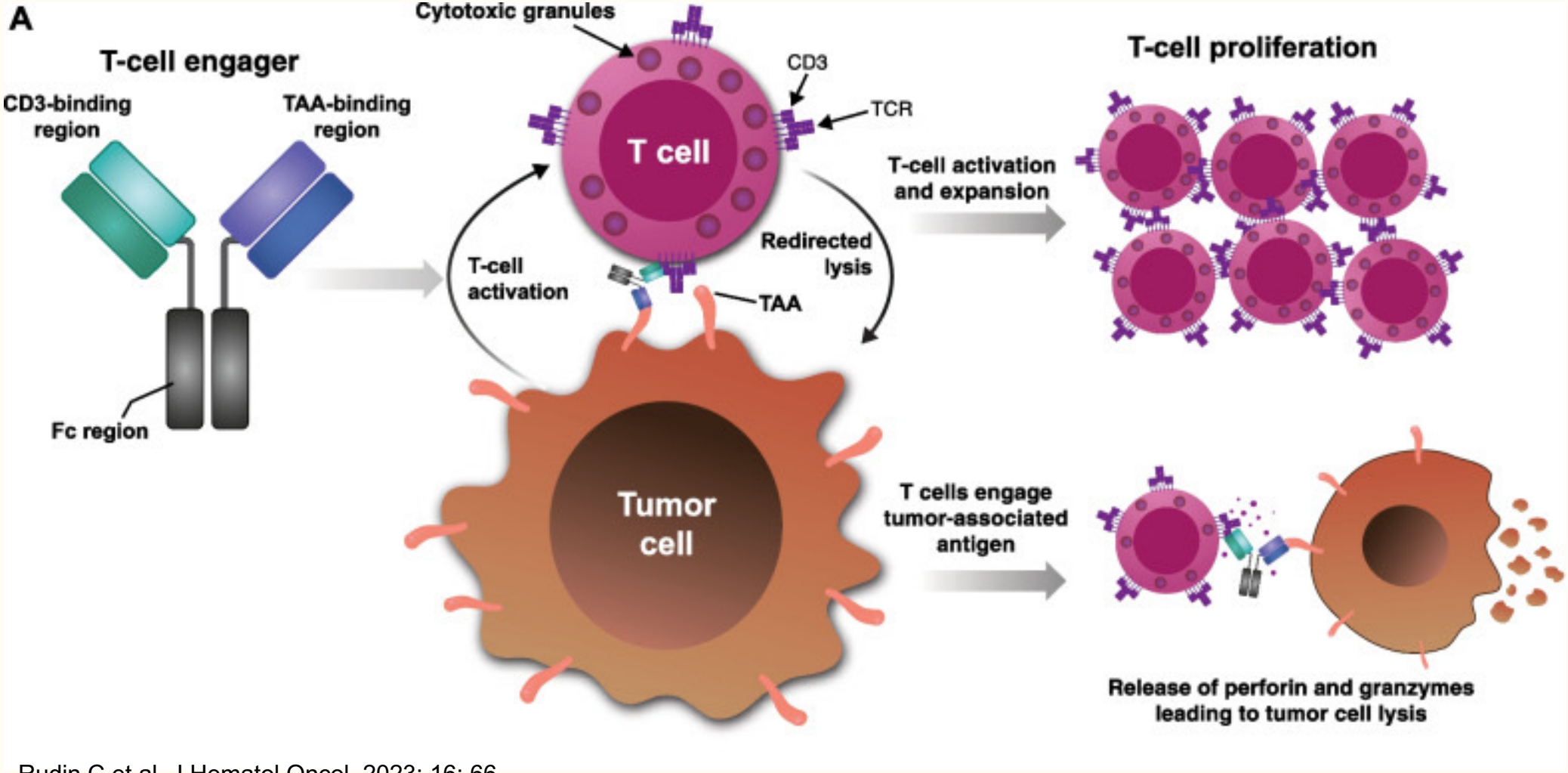
Hazard ratio and one-sided p-value stratified by RT schedule, chemotherapy, and sex

Progression Free Survival



Hazard ratio and p-value stratified by RT schedule, chemotherapy, and sex

Basic construct and mechanism of antitumor efficacy



Rudin C et al. J Hematol Oncol. 2023; 16: 66.

Tarlatamab Sustained Clinical Benefit and Safety in Previously Treated SCLC: DeLLphi-301 Phase 2 Extended Follow-Up

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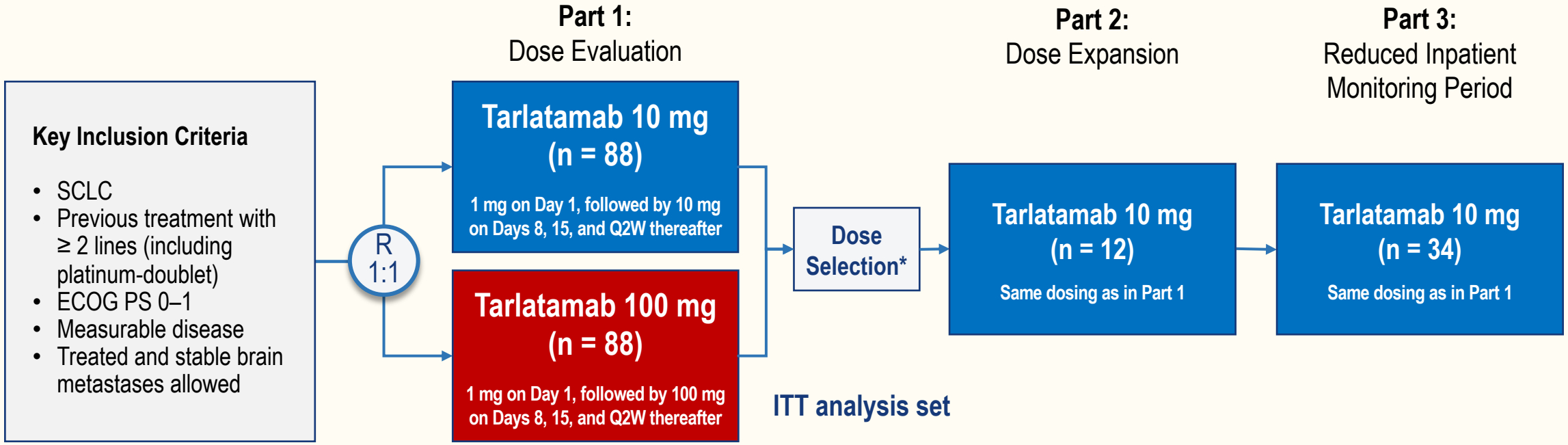
DeLLphi-301 Study Design

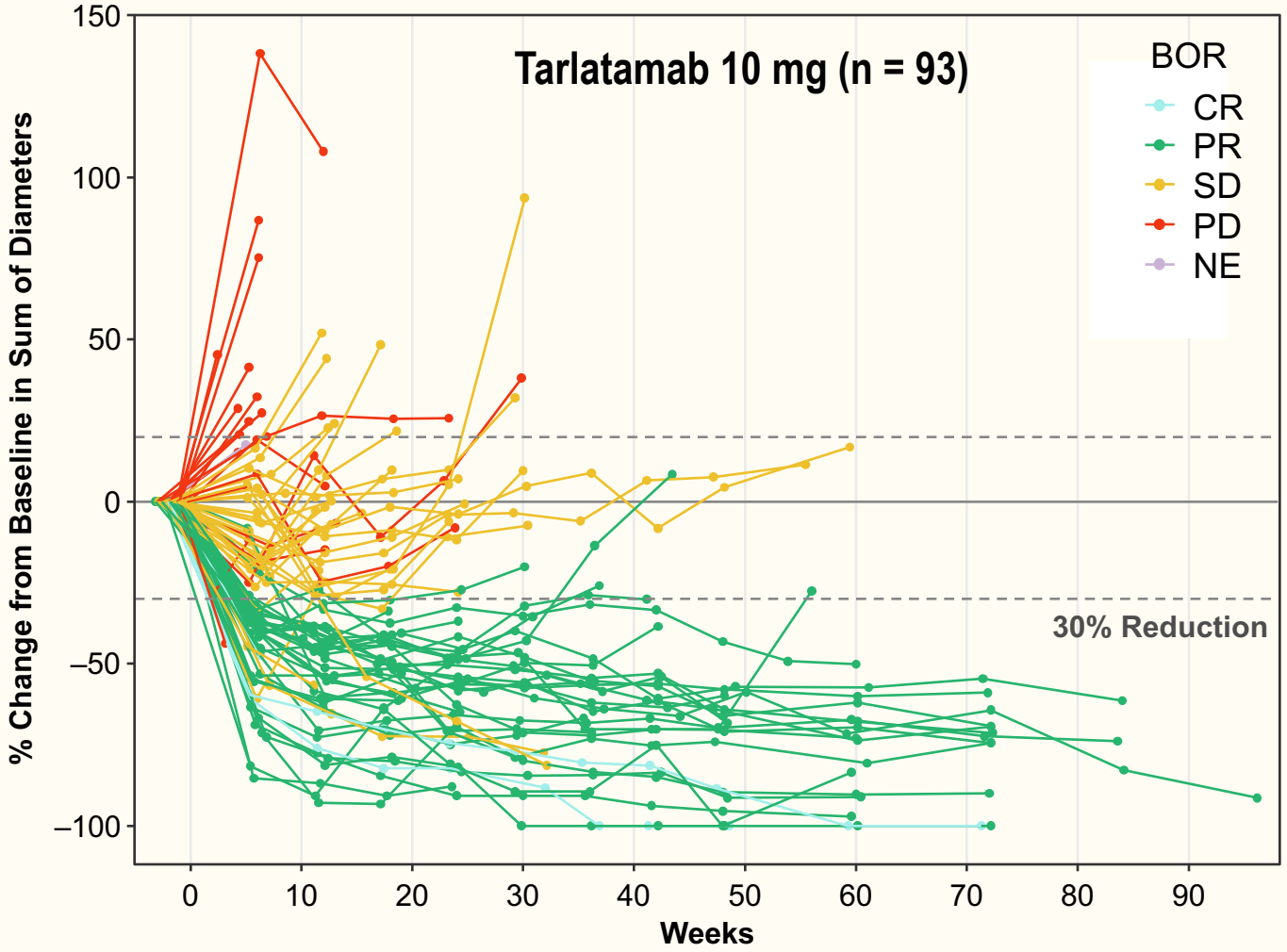
- Phase 2, open-label study (NCT05060016)



Primary Endpoint: ORR per RECIST 1.1 by BICR
Secondary Endpoints Included: DOR, DCR, PFS per RECIST 1.1 by BICR, OS, TEAEs, tarlatamab serum concentrations

Data cutoff was January 12, 2024 for all efficacy and safety outcomes, except for OS. For OS, the data cutoff was May 16, 2024 to obtain mature OS data with a median follow-up of 20.7 months.
*Once 30 patients per dose level had the opportunity to confirm an objective response after the first post-treatment scan or ≥ 13 weeks of follow-up, whichever occurred first.
BICR, blinded independent central review; **DCR**, disease control rate; **DOR**, duration of response; **ECOG PS**, Eastern Cooperative Oncology Group performance status; **ITT**, intention-to-treat; **ORR**, objective response rate; **OS**, overall survival; **PFS**, progression-free survival; **Q2W**, every 2 weeks; **R**, randomization; **RECIST**, Response Evaluation Criteria in Solid Tumors; **SCLC**, small cell lung cancer; **TEAE**, treatment-emergent adverse event.

Sustained Disease Control*

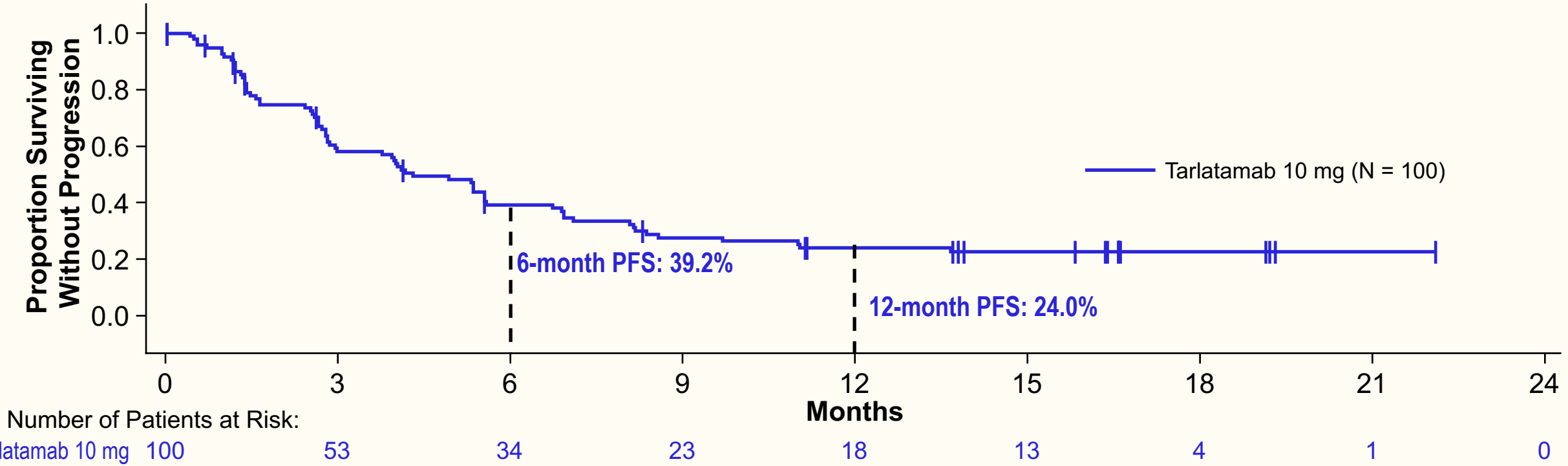


- Tumor shrinkage was seen in 72% of patients
- The median duration of disease control was 6.9 months (95% CI, 5.4–8.6)

26 patients (26%; 3 CR, 20 PR, 3 SD) had sustained disease control ≥ 52 weeks

Data cutoff, January 12, 2024. The efficacy analysis set consists of patients in Parts 1 and 2 (N = 100). One patient did not receive tarlatamab 10 mg but was included in the ITT analysis. Part 3 was a safety substudy and was not included in this response analysis.
*Sustained disease control was defined as disease control (CR, PR, or SD) with time on treatment ≥ 52 weeks.
BOR, best overall response; **CR,** complete response; **ITT,** intention-to-treat; **NE,** not evaluable; **PD,** progressive disease; **PR,** partial response; **SD,** stable disease.

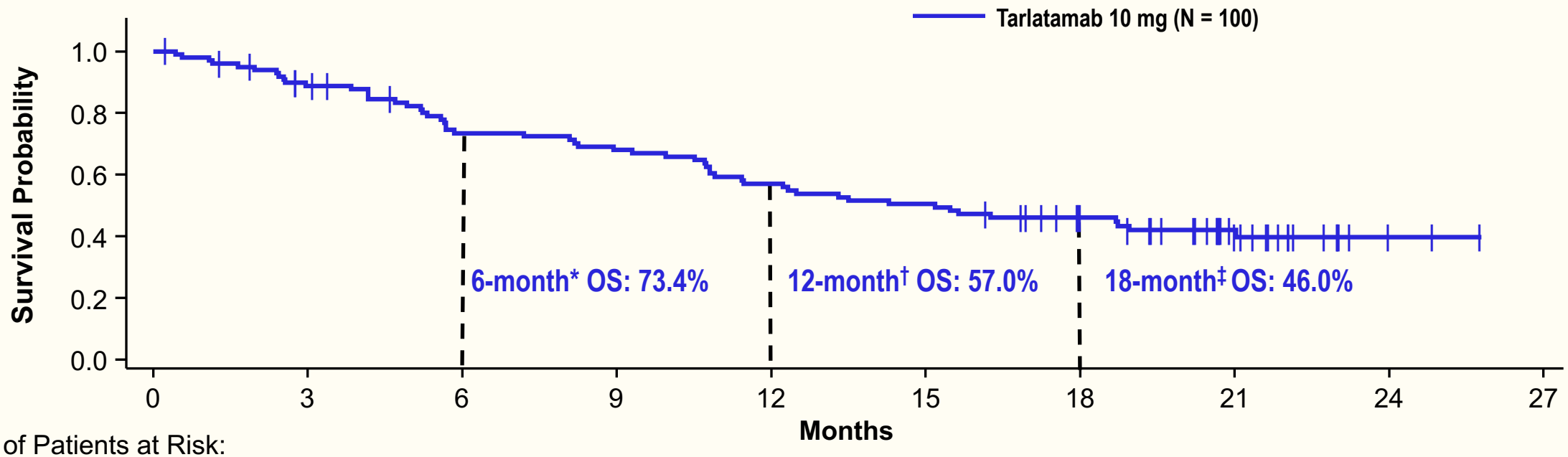
Progression-Free Survival



- **Median PFS was 4.3 months (95% CI, 2.9–5.6)**

Data cutoff, January 12, 2024. Median follow-up for PFS was 16.4 months. The efficacy analysis set consists of patients in Parts 1 and 2 (N = 100). One patient did not receive tarlatamab 10 mg but was included in the ITT analysis. Part 3 was a safety substudy and was not included in this response analysis. **ITT,** intention-to-treat; **PFS**, progression-free survival.

Overall Survival



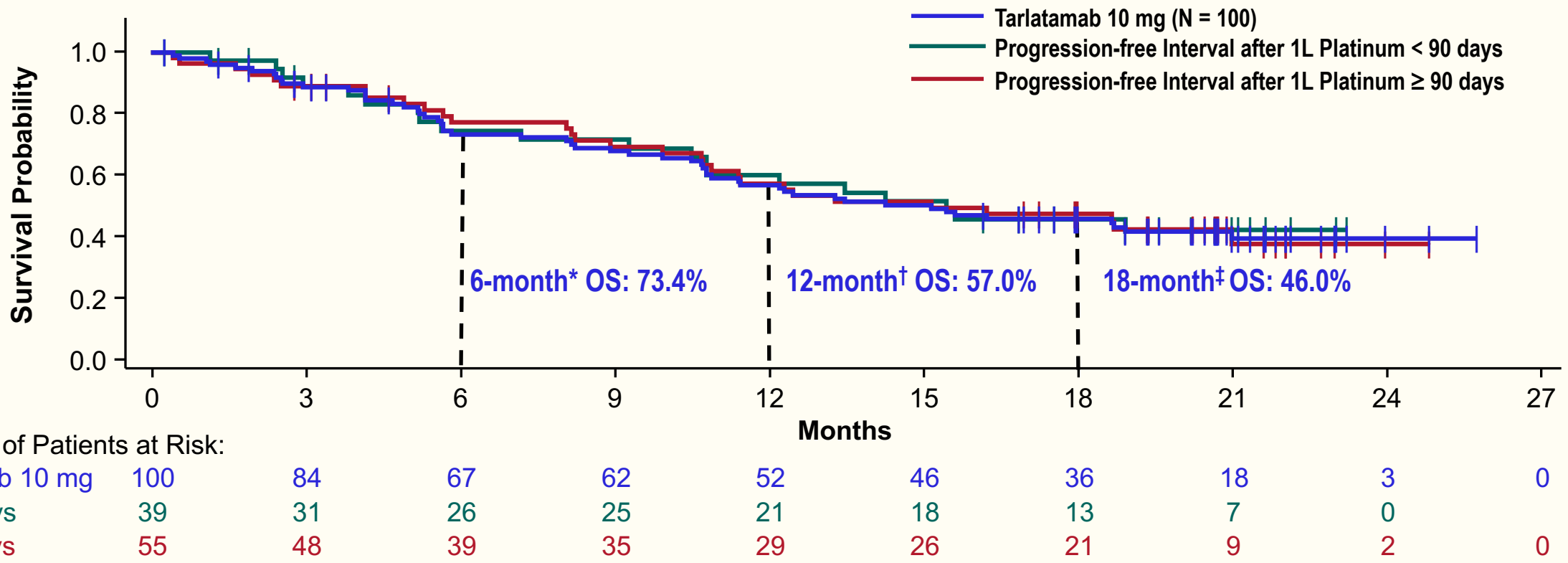
Number of Patients at Risk:

Tarlatamab 10 mg	100	84	67	62	52	46	36	18	3	0

Median OS was 15.2 months (95% CI, 10.8–NE)

Median follow-up for OS was 20.7 months. Data cutoff, May 16, 2024. The efficacy analysis set consists of patients in Parts 1 and 2 (N = 100). One patient did not receive tarlatamab 10 mg but was included in ITT analysis. Part 3 was a safety substudy and was not included in this response analysis. *95% CI, 63.2–81.2. †95% CI, 46.3–66.3. ‡95% CI, 35.6–55.8. Progression-free interval after first line platinum treatment is defined as days from the last first line platinum treatment to disease progression or start of second line treatment, whichever is earlier. **ITT,** intention-to-treat; **NE**, not estimable; **OS**, overall survival.

Overall Survival



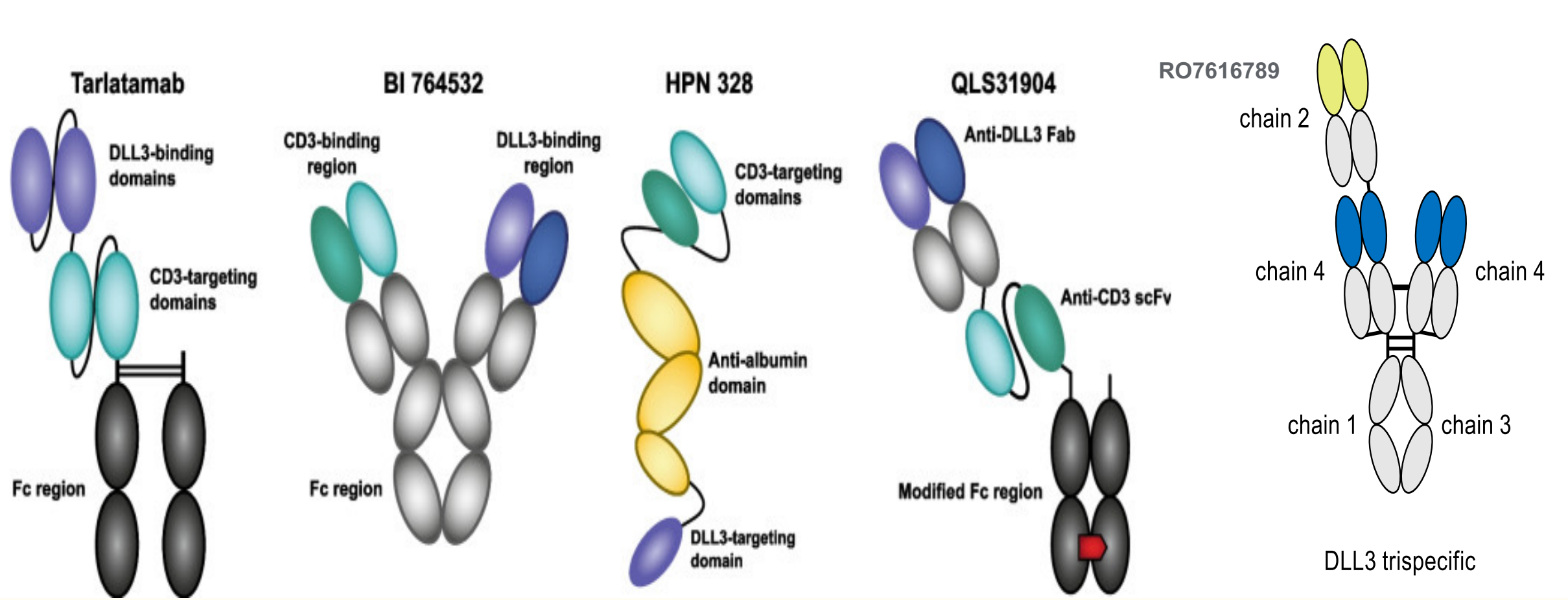
Number of Patients at Risk:

Tarlatamab 10 mg	100	84	67	62	52	46	36	18	3	0
< 90 days	39	31	26	25	21	18	13	7	0	
≥ 90 days	55	48	39	35	29	26	21	9	2	0

OS was similar regardless of progression-free interval after 1L platinum treatment (< 90 d vs ≥ 90 d)

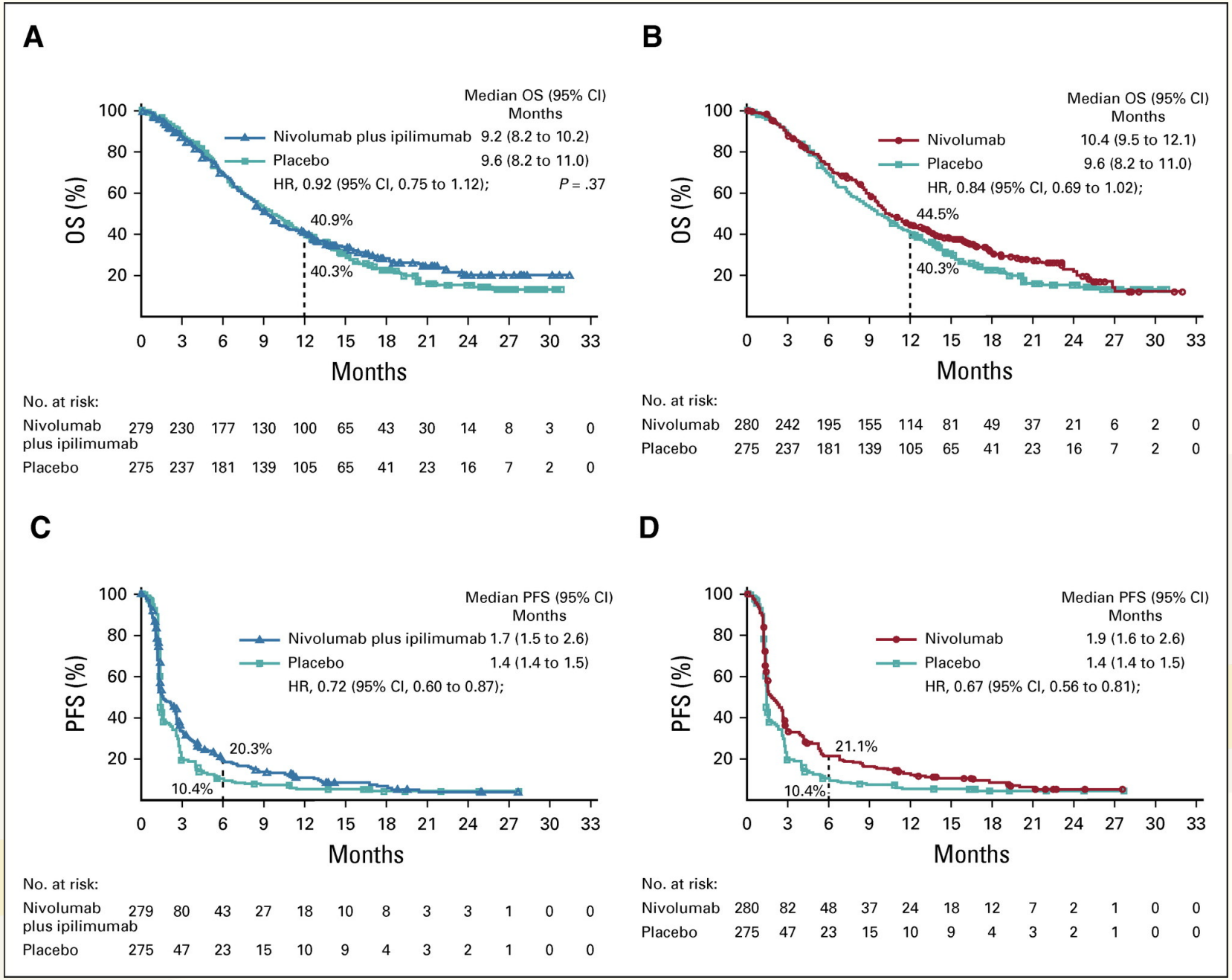
Median follow-up for OS was 20.7 months. Data cutoff, May 16, 2024. The efficacy analysis set consists of patients in Parts 1 and 2 (N = 100). One patient did not receive tarlatamab 10 mg but was included in ITT analysis. Part 3 was a safety substudy and was not included in this response analysis. *95% CI, 63.2–81.2. †95% CI, 46.3–66.3. ‡95% CI, 35.6–55.8. Progression-free interval after first line platinum treatment is defined as days from the last first line platinum treatment to disease progression or start of second line treatment, whichever is earlier. **ITT,** intention-to-treat; **NE**, not estimable; **OS**, overall survival.

T-Cell engagers in clinical development



Rudin C et al. J Hematol Oncol. 2023; 16: 66; Mikami H et al. Cancer Immunol Res (2024) 12 (6): 719–730.

Maintenance treatment



Owonikoko TK et al. Journal of Clinical Oncology, Volume 39, Number 12

DeLLphi 303

Tarlatamab with a PD-L1 Inhibitor as First-Line Maintenance After Chemo-Immunotherapy for ES-SCLC: DeLLphi-303 Phase 1b Study

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University of Maryland
Marlene and Stewart Greenebaum
Comprehensive Cancer Center

DeLLphi-303: Tarlatamab with PD-L1 Inhibitor as 1LM

- Phase 1b, multicenter, open-label study (NCT05361395)

1L Chemo-IO

Platinum-etoposide + anti-PD-L1 therapy

(4-6 cycles)

Enrollment

Key Inclusion Criteria

- No disease progression following 4-6 cycles of platinum-etoposide + PD-L1 inhibitor
- Eligible if no access to 1L PD-L1 inhibitor
- Prior treatment for LS-SCLC permitted
- ECOG PS 0-1
- Treated and asymptomatic brain metastases allowed
- DLL3 positivity not required

Non-randomized

Switching to different PD-L1 inhibitor permitted

1L Maintenance

Tarlatamab (10 mg IV Q2W) + Atezolizumab (1680 mg IV Q4W)

Tarlatamab (10 mg IV Q2W) + Durvalumab (1500 mg IV Q4W)

- Must initiate C1D1 of maintenance phase within 8 weeks of the start of the last cycle of 1L chemo-immunotherapy
- Median follow-up time (N = 88): 10.0 months (range: 1.4–20.4)

Primary Endpoints*: Dose-limiting toxicities, treatment-emergent / treatment-related adverse events (TEAEs, TRAEs)
Secondary Endpoints†: Disease control and PFS per local RECIST v1.1 assessment, OS

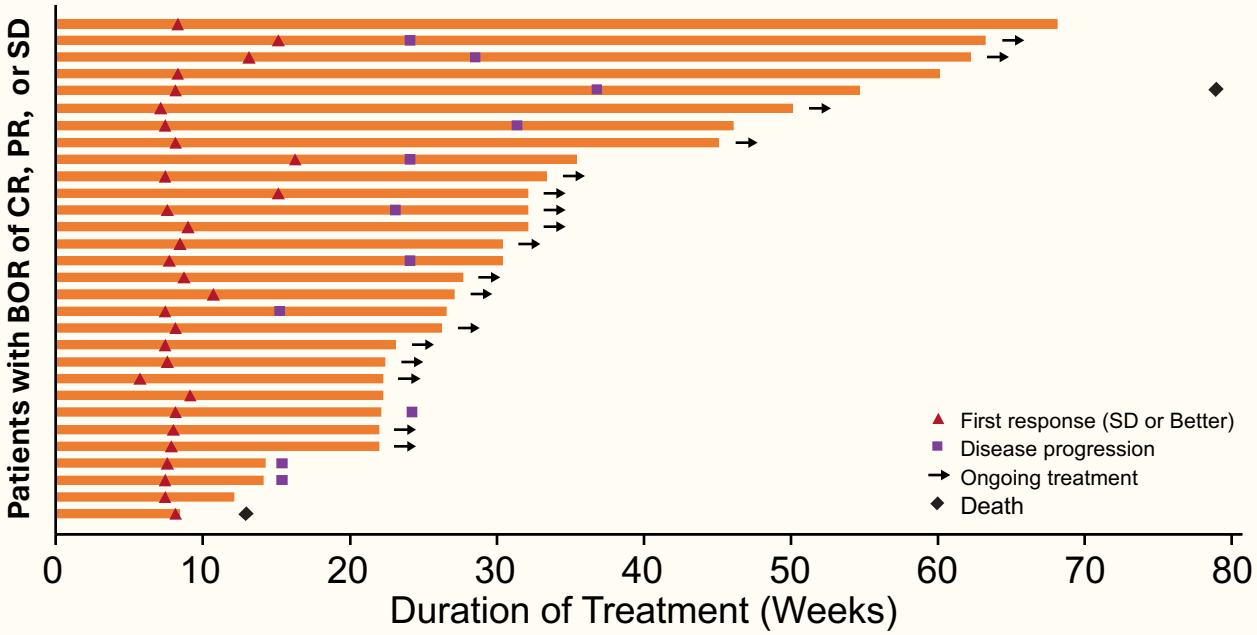
Data cutoff was May 31, 2024. *Also includes vital signs, electrocardiograms, and clinical laboratory tests. †Also includes objective response, duration of response, serum concentrations of tarlatamab, quantification of biomarker expression, and incidence of anti-tarlatamab antibody formation. **1L,** first-line; **1LM,** first-line maintenance; **C1D1,** cycle 1 day 1; **DLL3,** delta-like ligand 3; **ECOG PS,** Eastern Cooperative Oncology Group performance status; **ES**, extensive-stage; **IO,** immuno-oncology agent; **IV**, intravenous; **LS**, limited-stage; **PD-L1**, programmed death-ligand 1; **Q2W**, once every two weeks; **Q4W**, once every four weeks; **RECIST,** response evaluation criteria in solid tumors; **SCLC**, small cell lung cancer.

DCR and duration of disease control, beginning from 1L maintenance

Given study eligibility required non-PD to 1L chemo +/- IO, DCR and mDoDC were favored over ORR and mDOR in assessing clinical benefit.

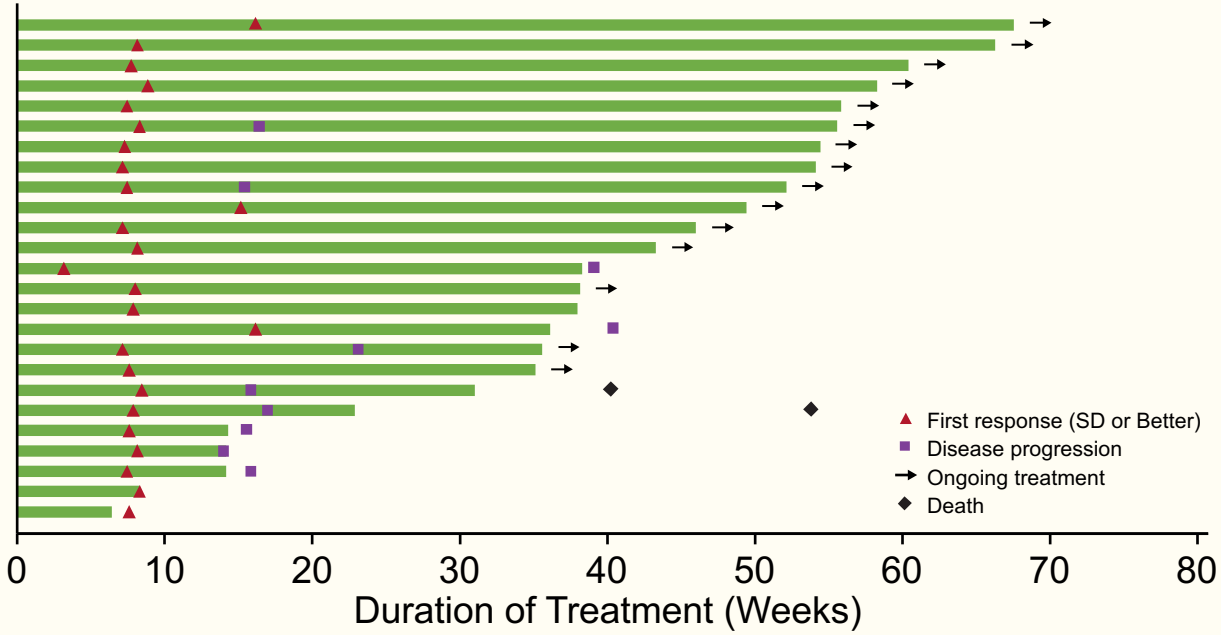
Tarlatamab + Atezolizumab

- DCR: 30/48 = 62.5% (95% CI: 47.4-76.0)
- Median duration of DC = 7.2 months (95% CI: 5.6, NE)



Tarlatamab + Durvalumab, n = 25

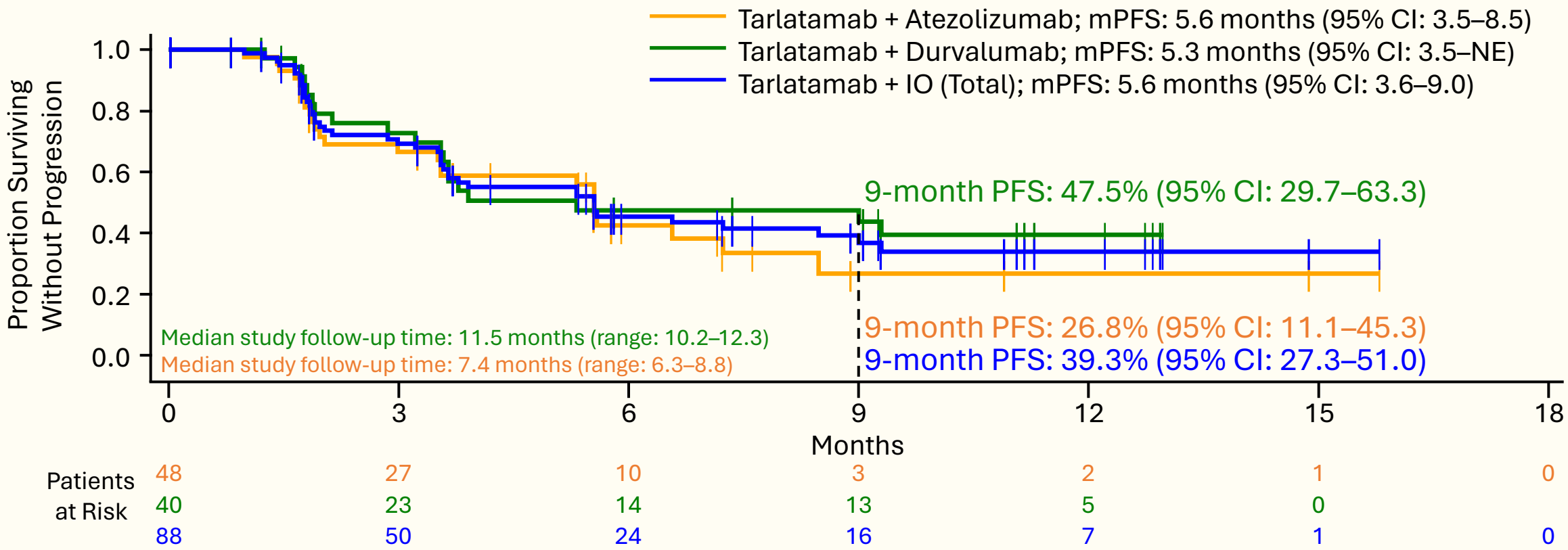
- DCR: 25/40 = 62.5% (95% CI: 45.8, 77.3)
- Median duration of DC = NE (95% CI: 3.9, NE)



- **Tarlatamab with a PD-L1 inhibitor as 1LM demonstrated sustained disease control**
- **For tarlatamab + PD-L1 inhibitor, DCR was 62.5% (95% CI: 51.5–72.6) and mDoDC was 9.3 months (95% CI: 5.6, NE)**

1L, first-line; **1LM,** first-line maintenance; **CI,** confidence interval; **DC**, disease control; **DCR,** disease control rate; **IO,** immuno-oncology agent; **mDoDC**, median duration of disease control; **mDOR**, median duration of response; **NE,** not estimable; **ORR**, objective response rate; **PD**, progressive disease; **PD-L1,** programmed cell death ligand-1; **Q4W,** once every four weeks.

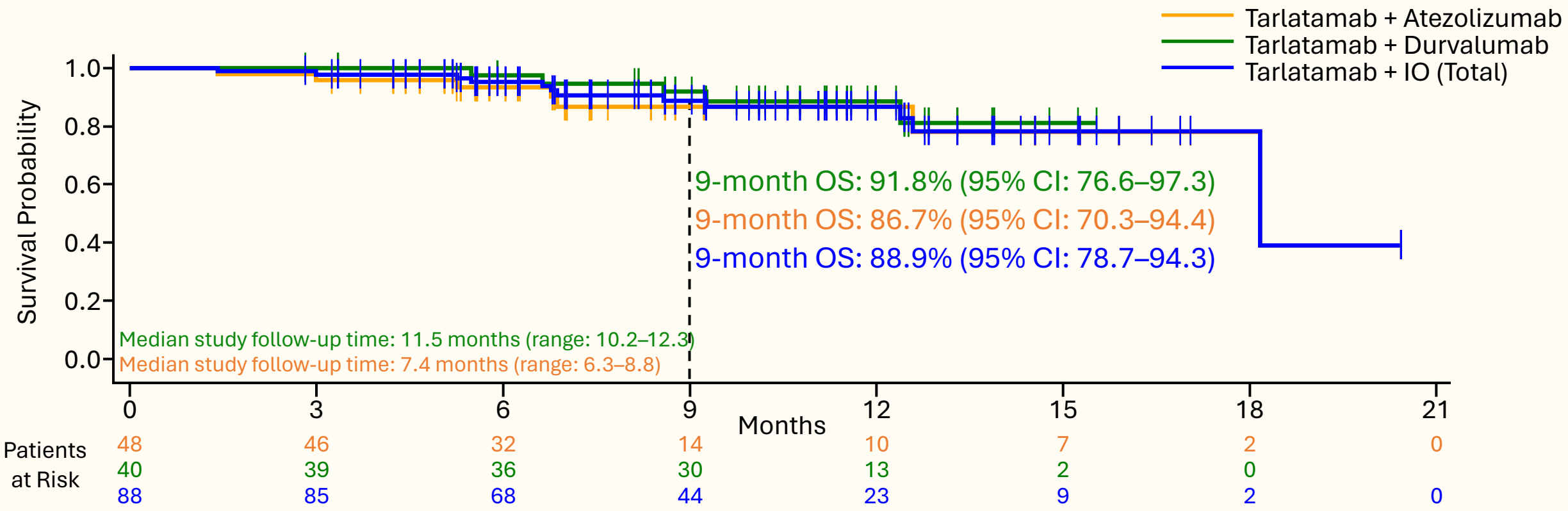
PFS, beginning from 1L maintenance



After a median time from 1L chemoimmunotherapy to 1LM of 3.6 months, tarlatamab with a PD-L1 inhibitor as 1LM showed promising PFS, with mPFS of 5.6 months.

1L, first-line; **1LM,** first-line maintenance; **CI,** confidence interval; **IO,** immuno-oncology agent; **NE,** not estimable; PD-L1, programmed death-ligand 1;**PFS,** progression-free survival.

OS, beginning from 1L maintenance



After a median time from 1L chemoimmunotherapy to 1LM of 3.6 months, tarlatamab with a PD-L1 inhibitor as 1LM showed a 9-month OS of 89%.

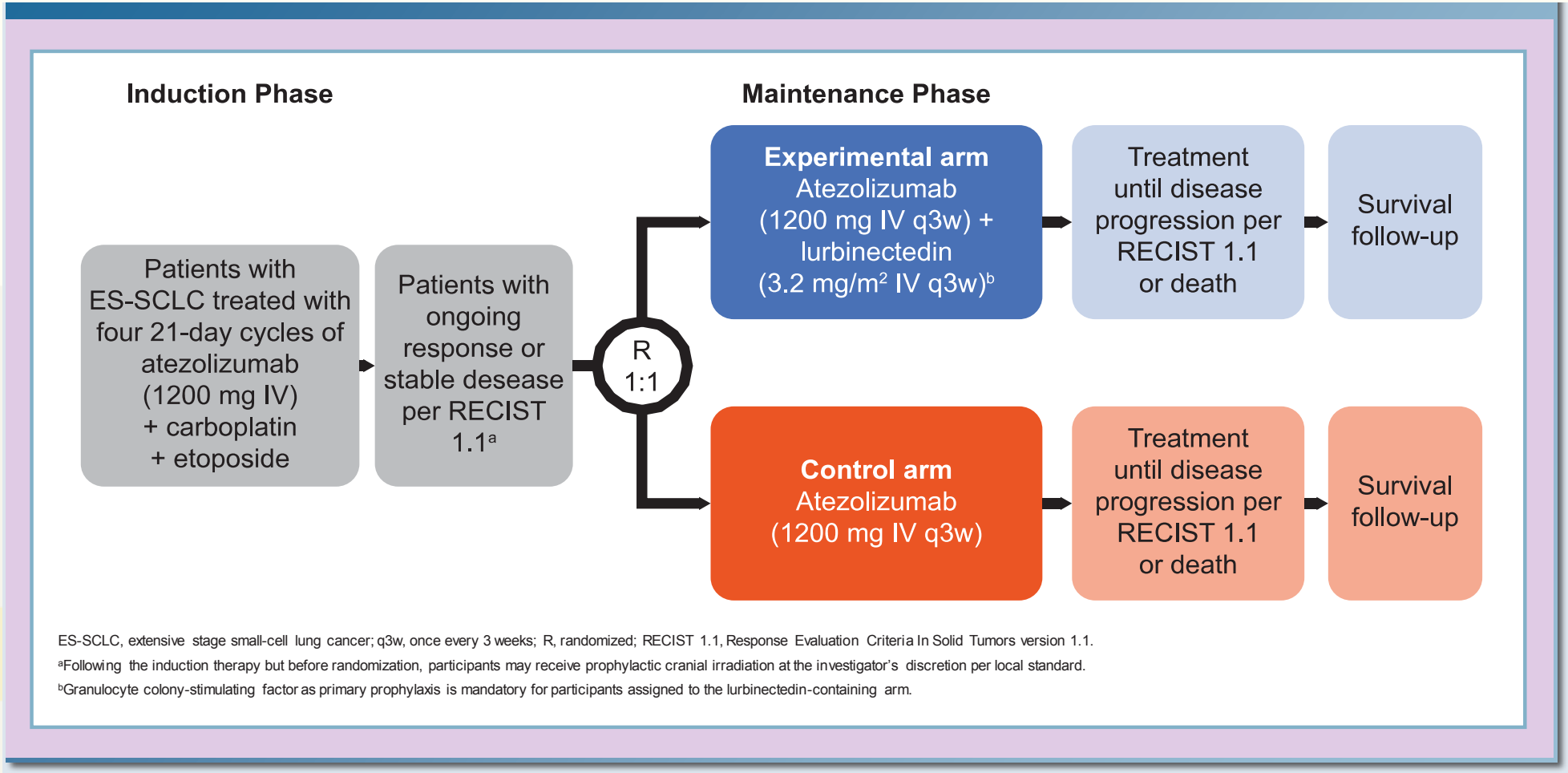
1L, first-line; **1LM,** first-line maintenance; **CI,** confidence interval; **IO,** immuno-oncology agent; **OS,** overall survival.

ImFORTE Trial:

Home > Small Cell Lung Cancer > IMforte Trial: Maintenance With Lurbinectedin Plus Atezolizumab Shows OS, PFS Benefit in ES-SCLC

IMforte Trial: Maintenance With Lurbinectedin Plus Atezolizumab Shows OS, PFS Benefit in ES-SCLC

By Cecilia Brown - Last Updated: October 17, 2024



ES-SCLC, extensive stage small-cell lung cancer; q3w, once every 3 weeks; R, randomized; RECIST 1.1, Response Evaluation Criteria In Solid Tumors version 1.1.

[a]Following the induction therapy but before randomization, participants may receive prophylactic cranial irradiation at the investigator's discretion per local standard.

[b]Granulocyte colony-stimulating factor as primary prophylaxis is mandatory for participants assigned to the lurbinectedin-containing arm.

Conclusions

- Major changes in the treatment of SCLC witnessed in 2024
- ADRIATIC trial established a role for durvalumab as consolidation post chemorad in LS-SCLC
- ImFORTE trial also demonstrated clinical benefit and a new paradigm of maintenance therapy with a cytotoxic agent in ES-SCLC
- Tarlatamab offers both a new option and a new treatment paradigm for BiTE as salvage therapy in relapsed SCLC