



8th Annual

LEAD 2026

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EMPOWERMENT

DEVELOPMENT

**SEPT
18-19,
2026**

Enriching Experiences for Leaders in Hematology and Oncology

Small Cell Lung Cancer: 30 Years of Stagnation, Two Years of Change

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Disclosures

Ad Boards: AstraZeneca, BMS, MJH Life Science, Pfizer

Speaking Opportunities: Total Health Conferencing

SCLC

10–15%

of lung cancers

4.7 / 100k

incidence, declining

~95%

smoking history

Chemotherapy was essentially unchanged from the 1990s - 2018.

The last two years delivered more practice-changing data than the prior three decades.

The realities SCLC until 2024

Stage

Limited: ~30%
Extensive: ~70%

~15% brain mets at
diagnosis

Relapse

Near universal relapse

Survival

LS mOS: ~25-30 mo
ES mOS: ~12 mo

5-year OS: 29–34% LS;
<5% ES

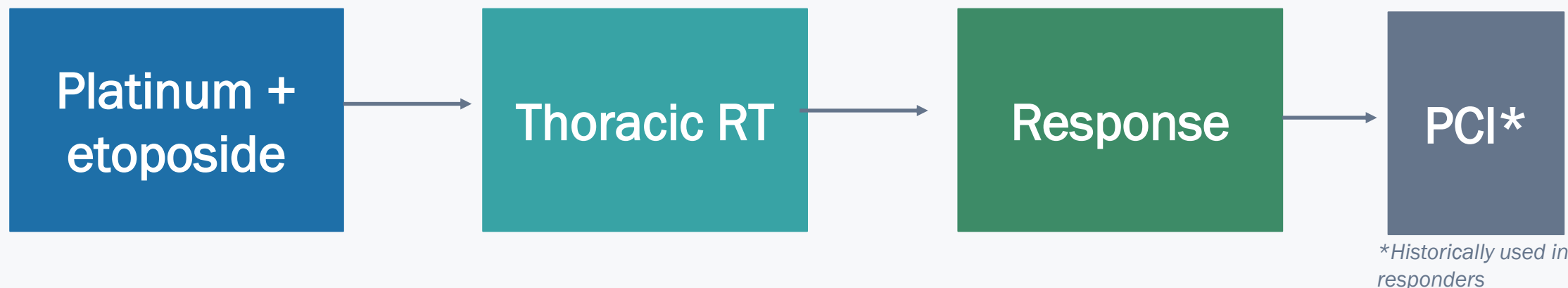
These are the numbers the next decade of trials had to move.

HOW WE TREAT LIMITED-STAGE SCLC

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Up until 2024, the regimen consisted of this



The gap before 2024: No consolidation immunotherapy after curative-intent chemoradiotherapy — a striking contrast with stage III NSCLC.

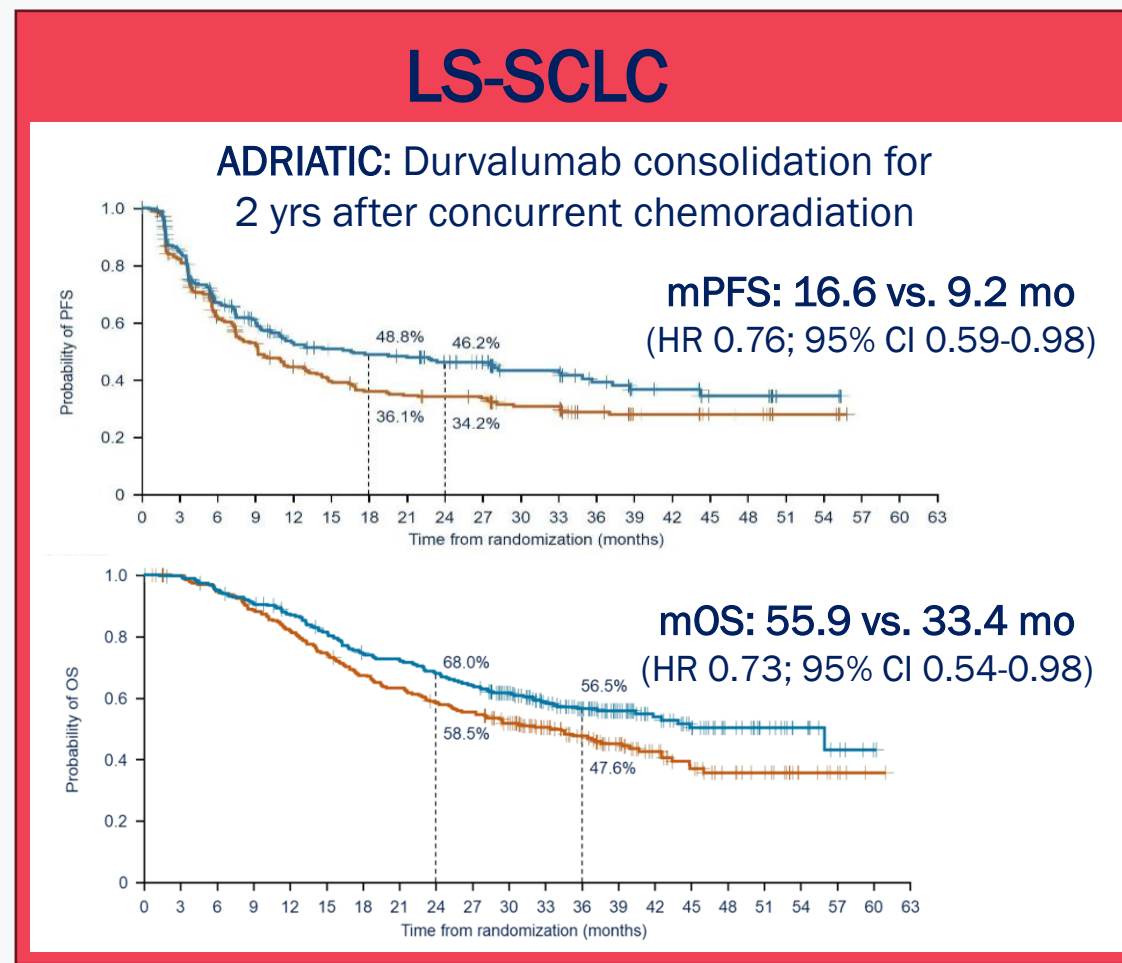
ADRIATIC: consolidation durvalumab changes LS-SCLC

Phase 3 design

No progression after concurrent CRT
→ durvalumab for up to 24 months vs placebo.

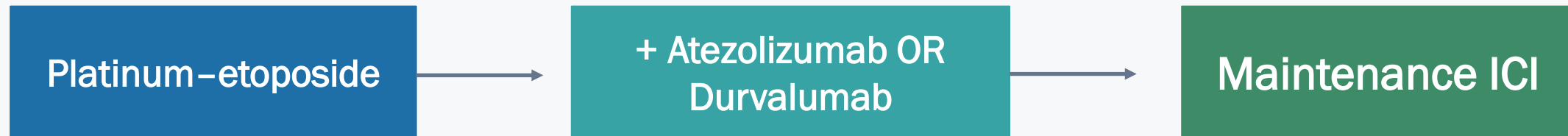
+22.5 months median OS

A generational advance in a curative-intent setting



HOW WE TREAT EXTENSIVE-STAGE SCLC

Extensive Stage: the first break in the wall in 2018-2019



Modest median gain

~2–3 months improvement in mOS

From ~10m → 12 – 13m

A new tail of the curve

Durvalumab 3-year OS: 17.6% (3x increase)

Meaningful long-term survivors where there were almost none.

THE SHIFT: chemoimmunotherapy created the first meaningful survival tail in decades.

Relapsed SCLC: the unmet need remains brutal

Near-universal

relapse

15–35%

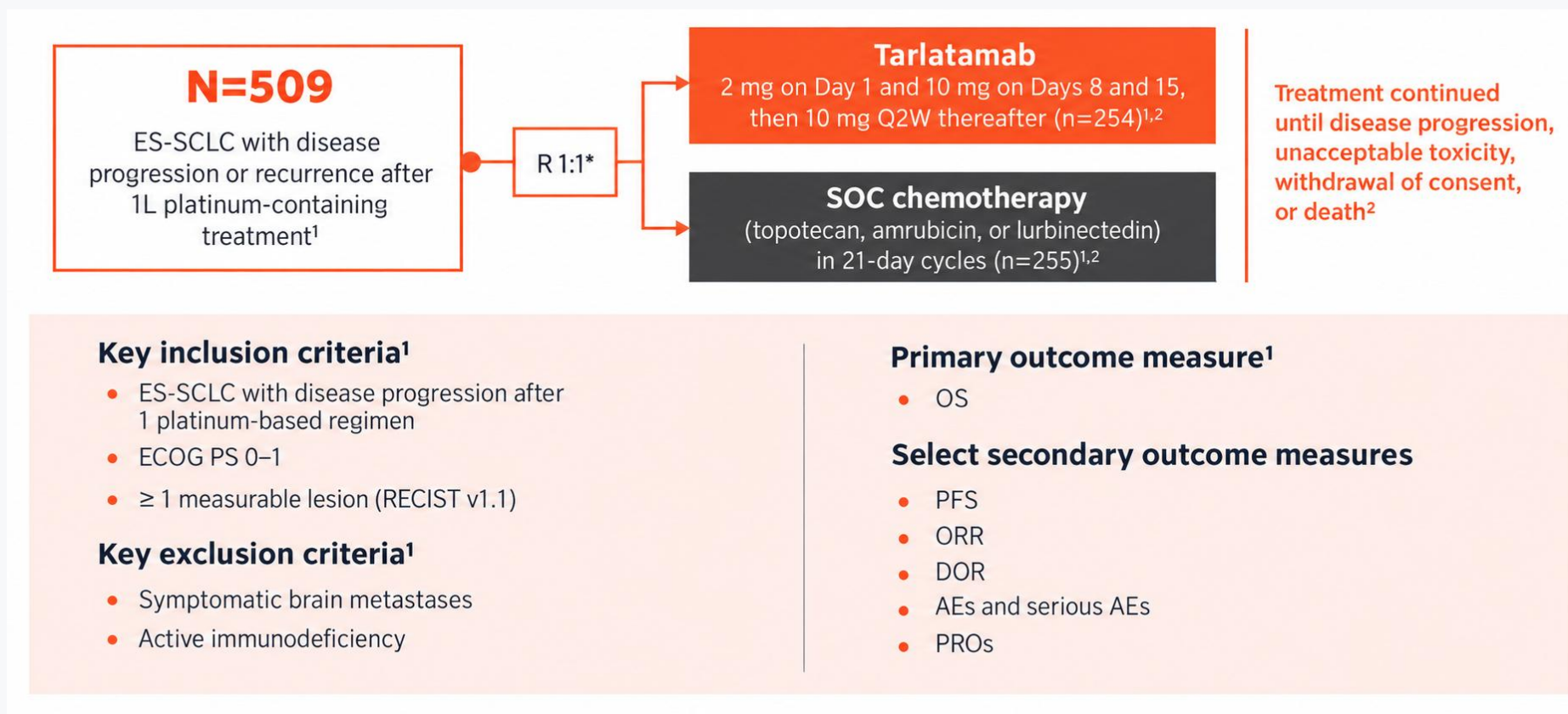
historical ORR

Short

response duration

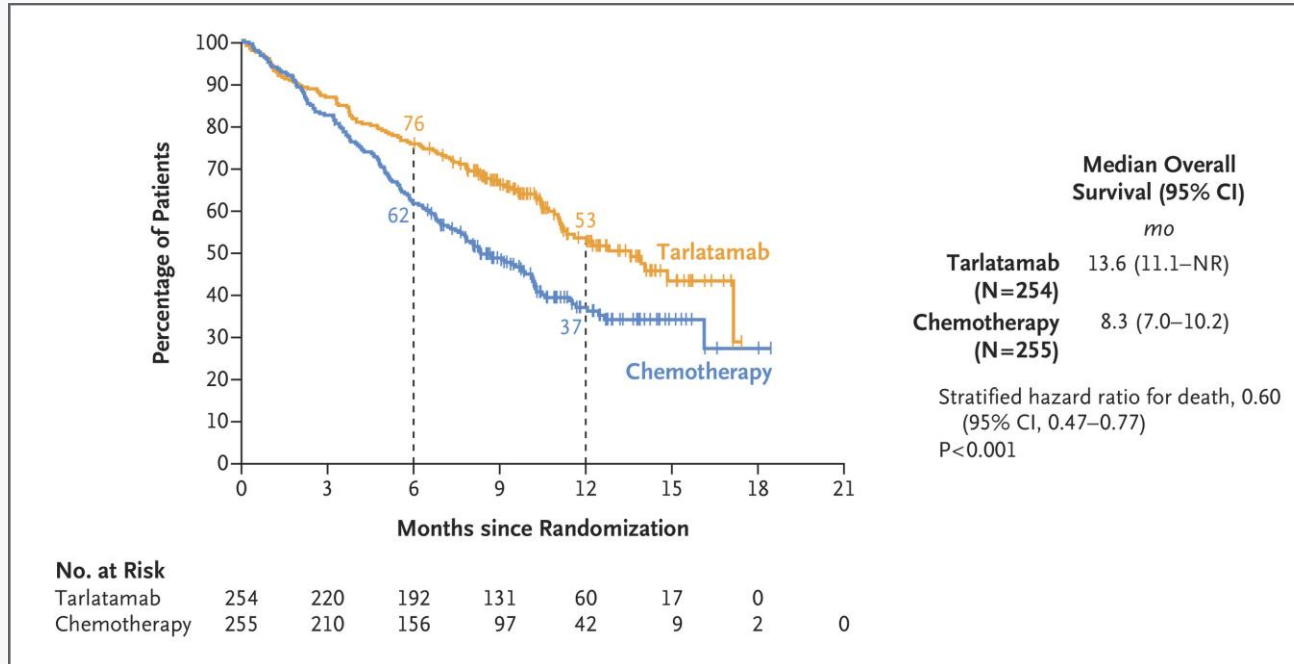
Historical second line: Topotecan and lurbinectedin provide activity, but durable disease control is uncommon.

DeLLphi-304: Tarlatamab turning DLL3 into a therapeutic target



THE SHIFT: DLL3 becomes a clinically actionable target in relapsed SCLC.

Survival benefit but with a new toxicity workflow



THE TRADE-OFF: less severe hematologic toxicity, but a new CRS/ICANS workflow.

Practice impact

Fewer all-cause grade ≥ 3 events: 54% vs 80%
 TRAEs grade ≥ 3 events: 27% vs 62%

CRS

Boxed warning; step-up dosing and monitoring change where and how therapy is delivered.

Neurologic toxicity / ICANS

Must be recognized early and incorporated into site workflows and patient counseling.

Second-line management of ES-SCLC



National
Comprehensive
Cancer
Network®

NCCN Guidelines Version 2.2026 Small Cell Lung Cancer

SCLC SUBSEQUENT SYSTEMIC THERAPY (PS 0–2)⁹ Consider dose reduction or growth factor support for patients with PS 2

Preferred

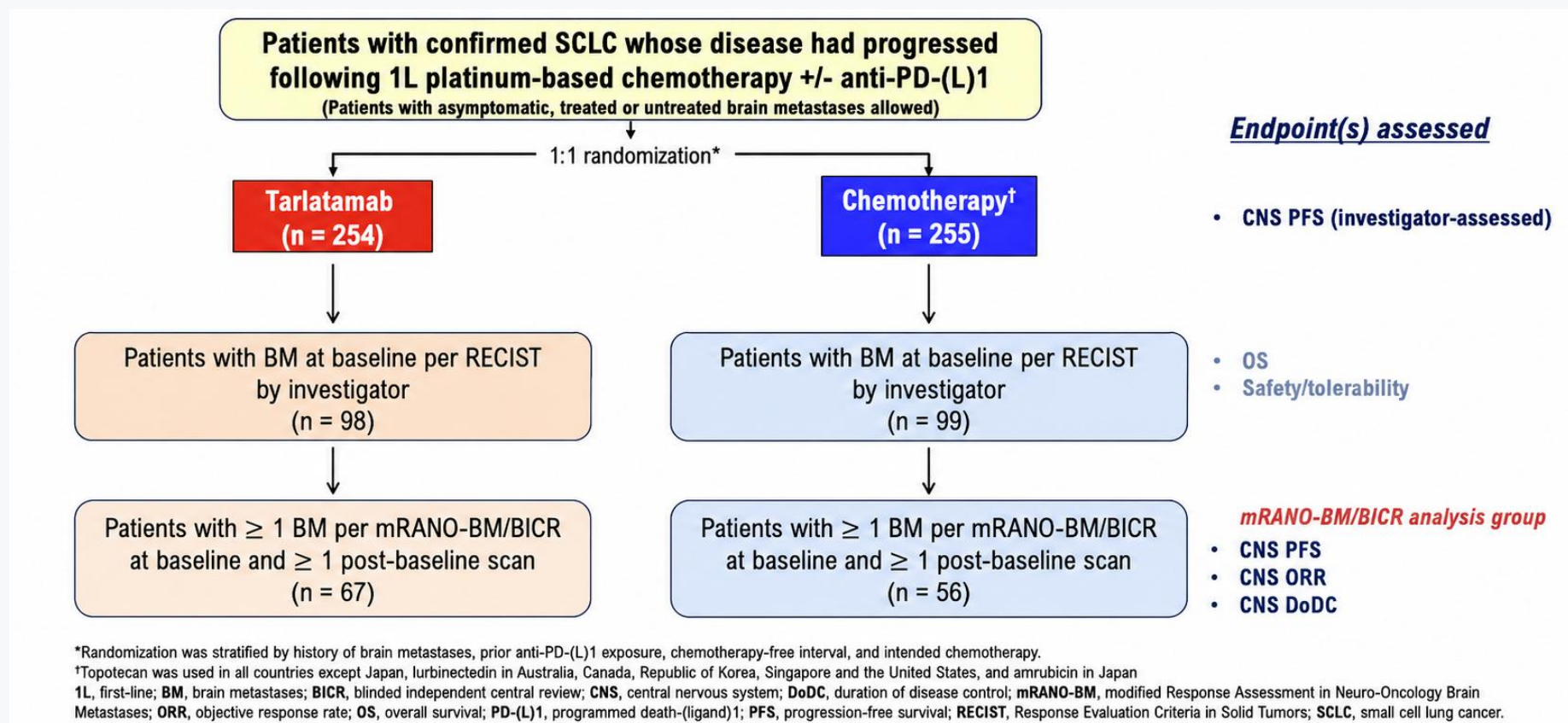
- Tarlatamab-dlle^{j,27} (category 1)
- Clinical trial enrollment
- Irinotecan^{1,25,26}
- Lurbinectedin (if not previously used)^{20,21}
- If prolonged disease free time, re-treatment with platinum-based doublet with or without immunotherapy¹⁵⁻¹⁹
- Topotecan Oral (PO) or Intravenous (IV)^{17,22-25}

Other Recommended

- CAV (Cyclophosphamide/Doxorubicin/Vincristine)²²
- Docetaxel³⁶
- Gemcitabine^{37,38,39}
- Nivolumabⁿ or Pembrolizumab (if not previously treated with an ICI)^{d,28-31}
- Oral Etoposide^{40,41}
- Paclitaxel^{32,33}
- Temozolomide^{34,35}

FDA approval on November 19, 2025

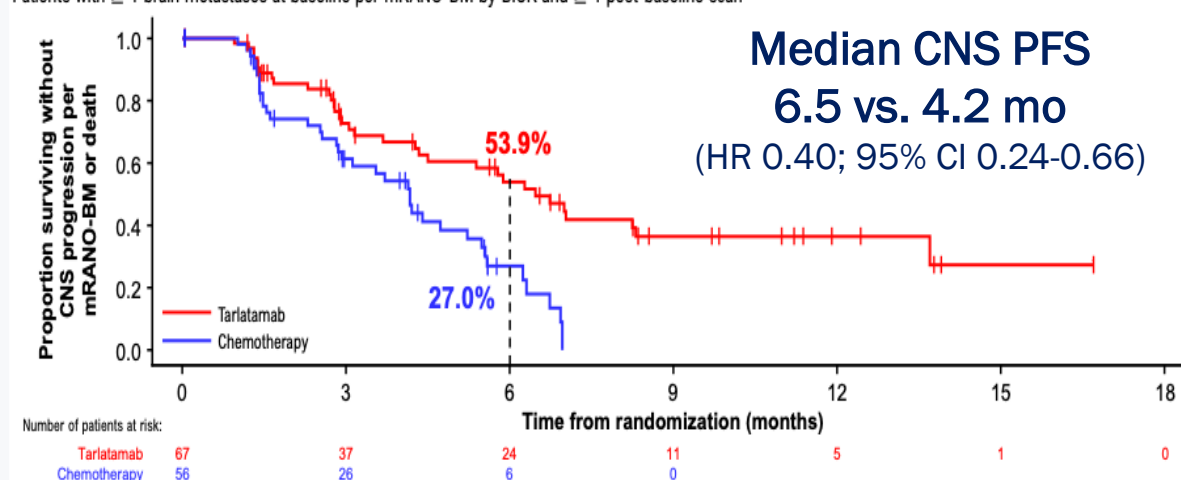
Post hoc analysis from DeLLphi-304: What is the intracranial efficacy of Tarlatamab vs chemo?



DeLLphi-304 CNS efficacy in patients with baseline brain metastases

mRANO-BM analysis by BICR

Patients with ≥ 1 brain metastases at baseline per mRANO-BM by BICR and ≥ 1 post-baseline scan



Among patients with brain metastases, treatment with tarlatamab reduced the risk of CNS disease progression or death by 60% compared to chemotherapy.

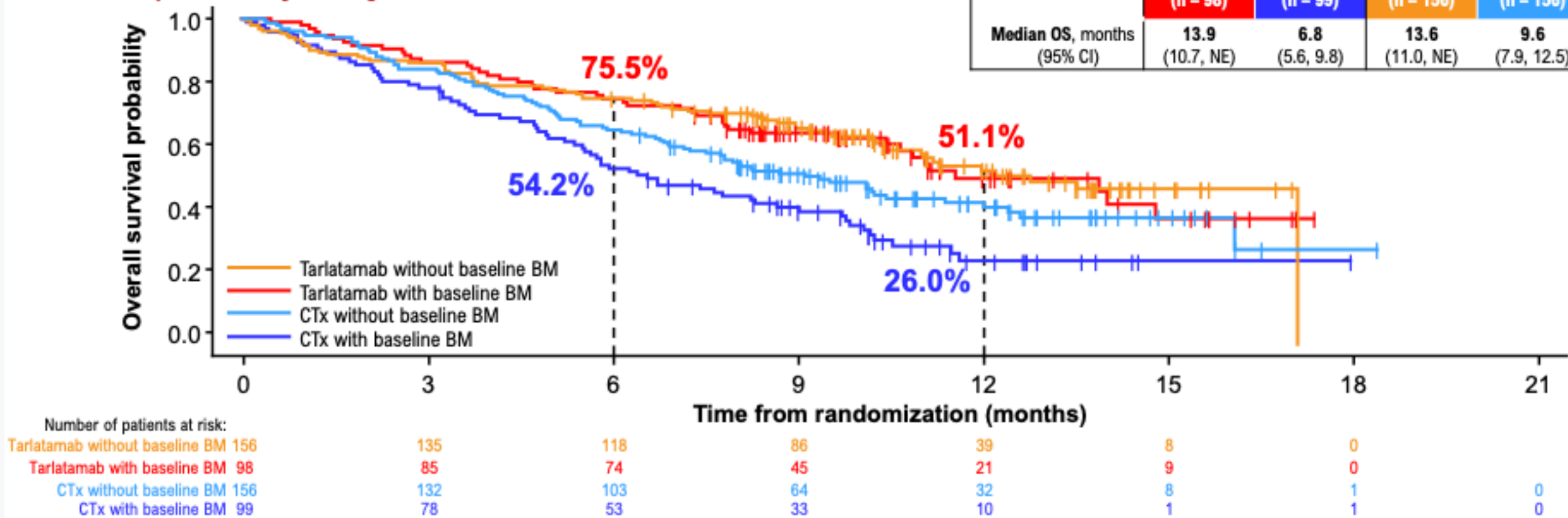
	Tarlatamab (n = 67)	Chemotherapy (n = 56)
Best overall CNS response*, n (%)		
Complete response (95% CI)	10 (14.9) (7.4, 25.7)	3 (5.4) (1.1, 14.9)
Non-CR/Non-PD	42 (62.7)	37 (66.1)
Progressive disease	13 (19.4)	16 (28.6)
Not evaluable	2 (3.0)	0
Median duration of CNS complete response, months (range) (95% CI)	NE (1.3+, 13.6+) (2.9, NE)	3.6 (1.3+, 4.2) (3.1, NE)
CNS disease control rate, n (%) (95% CI)	52 (77.6) (65.8, 86.9)	40 (71.4) (57.8, 82.7)
Median duration of CNS disease control, months (range) (95% CI)	8.2 (1.2+, 16.7+) (6.3, NE)	5.2 (1.2+, 7.0) (4.2, 6.2)
CNS tumor shrinkage of $\geq 30\%^{\dagger}$, n/N1	56.3% (9/16)	38.5% (5/13)
Ongoing CNS response at data cutoff, n (%)	5 (50.0)	0

WHY IT MATTERS: intracranial activity strengthens the case for DLL3-directed therapy

Tarlatamab improved overall survival vs chemotherapy regardless of the presence of brain metastases

Patients with or without brain metastases at baseline per RECIST by investigator

	Tarlatamab with BM (n = 98)	CTx with BM (n = 99)	Tarlatamab w/o BM (n = 156)	CTx w/o BM (n = 156)
Median OS, months (95% CI)	13.9 (10.7, NE)	6.8 (5.6, 9.8)	13.6 (11.0, NE)	9.6 (7.9, 12.5)



Median follow-up: 11.4 months (tarlatamab) and 11.5 months (chemotherapy)

Treatment with tarlatamab reduced the risk of death by 49% in patients with brain metastases vs chemotherapy (HR 0.51 [95% CI: 0.34, 0.74]).

Mountzios G, et al. ASCO 2026.

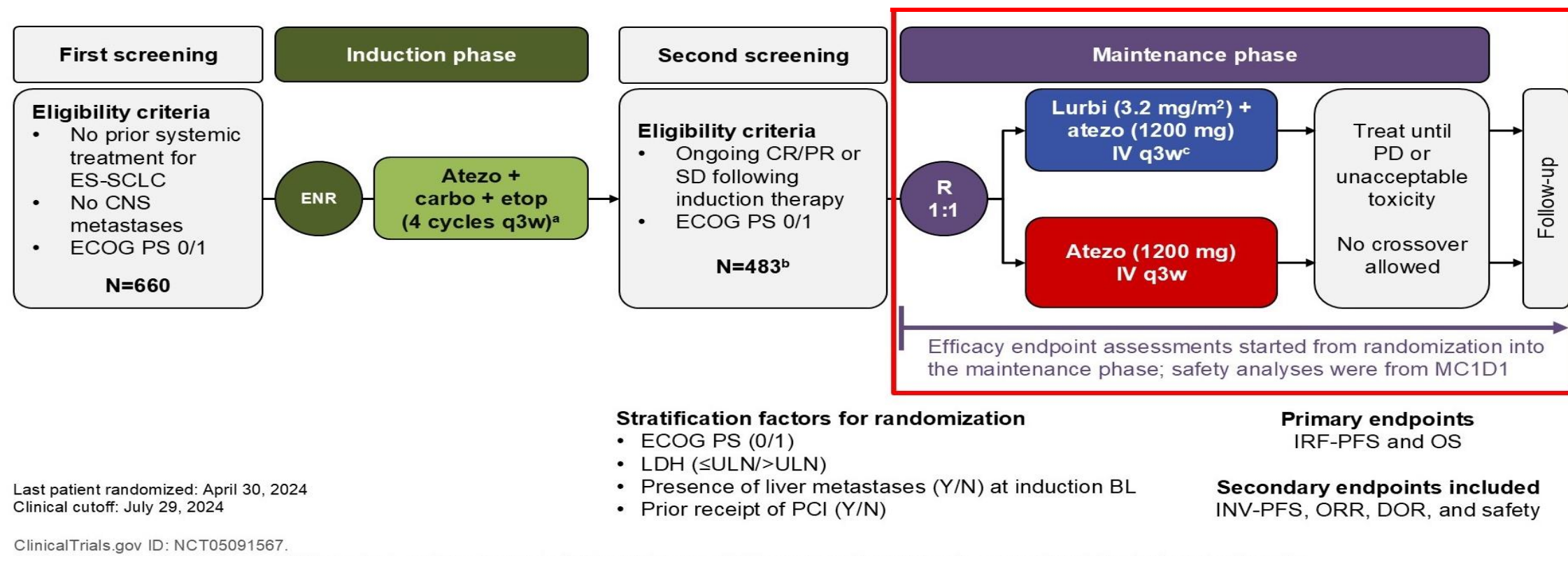
BUILDING ON CHEMOIMMUNOTHERAPY CAN WE INTENSIFY ES-SCLC TREATMENT?

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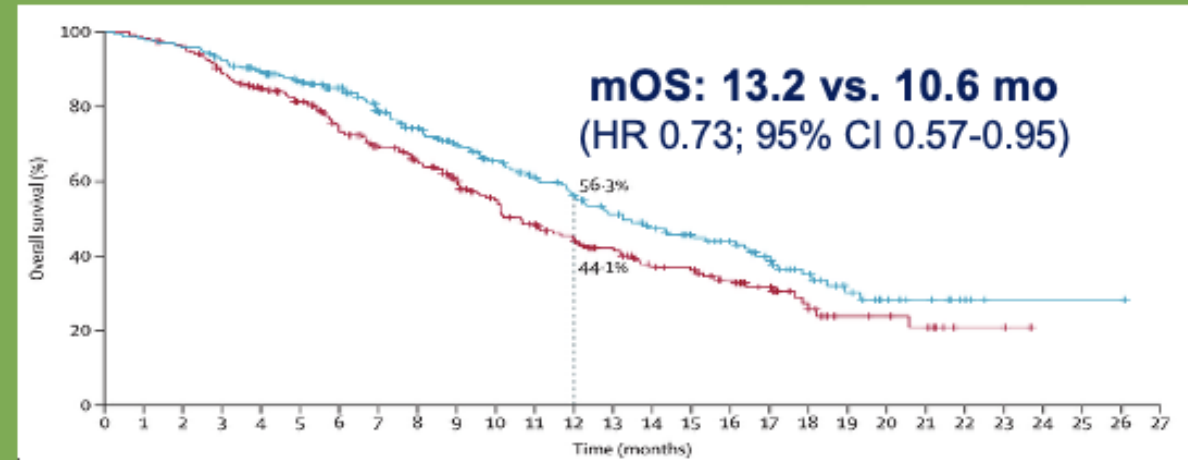
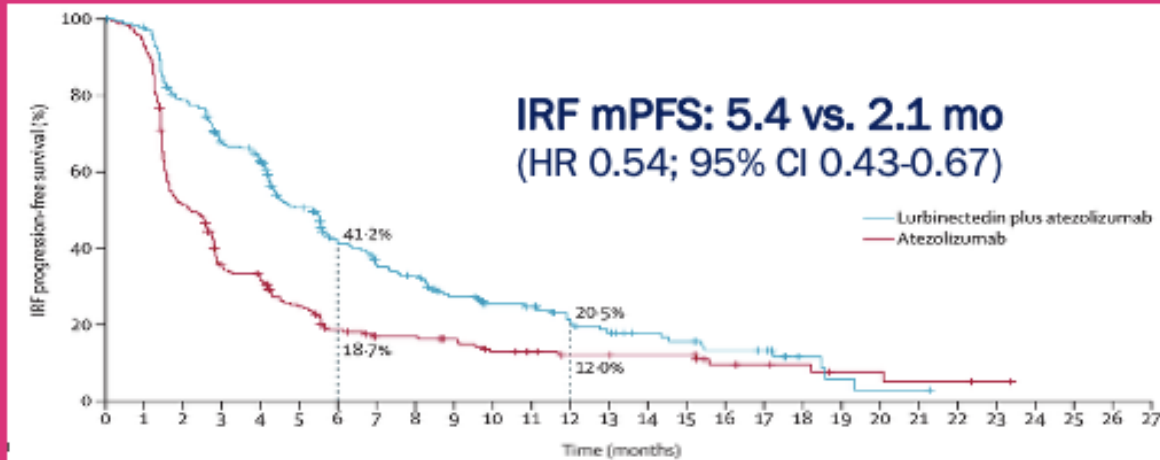


IMforte asks: can we intensify maintenance?

International, open-label, randomized phase III study



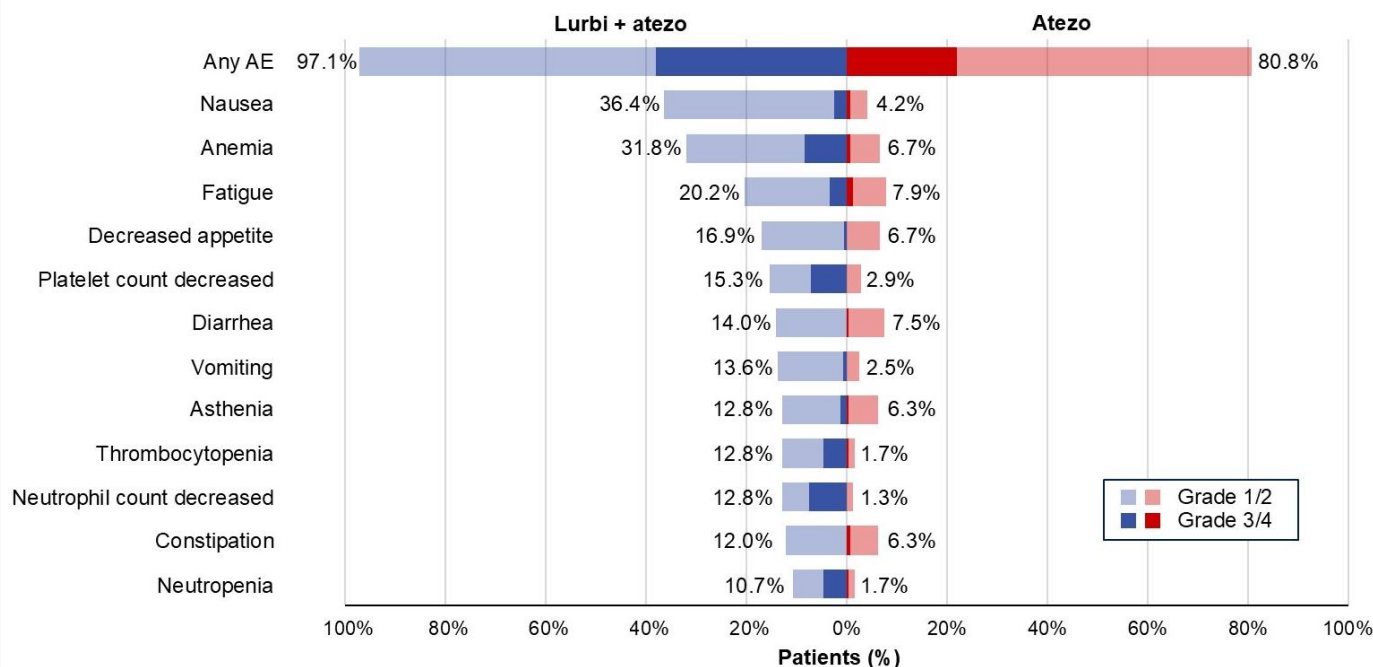
IMforte: the maintenance phase becomes active therapy



THE SHIFT: maintenance becomes an active treatment phase—not simply observation.

The cost of intensification

All –cause AE's with incidence $\geq 10\%$

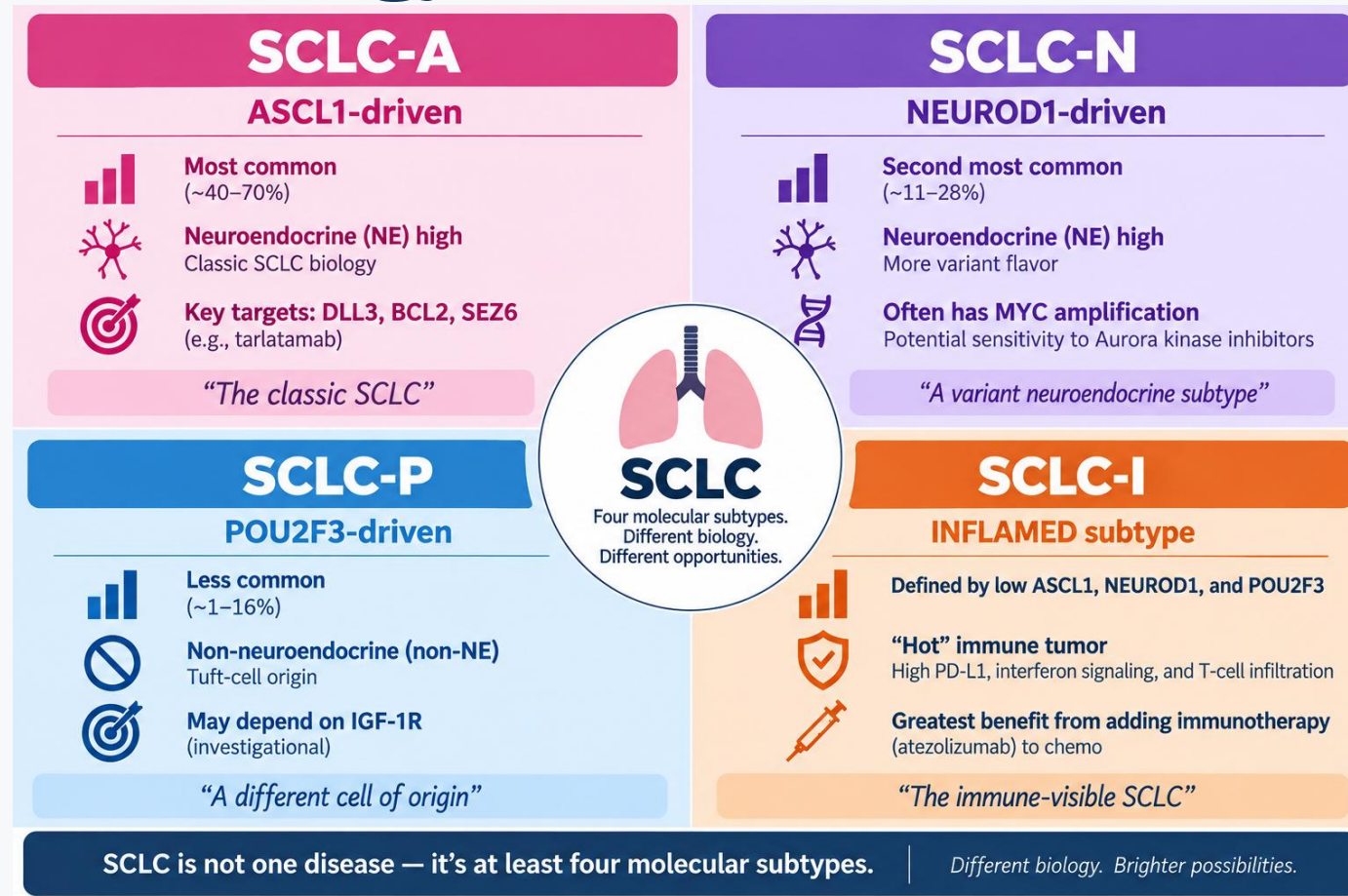


- ⚠ More pancytopenia
- ⚠ More fatigue
- ⚠ More nausea
- ⚠ More treatment discontinuation

THE QUESTION: how much added toxicity is acceptable for maintenance intensification?

WHAT COMES NEXT? CAN BIOLOGY GUIDE TREATMENT SELECTION?

Biology that now matters



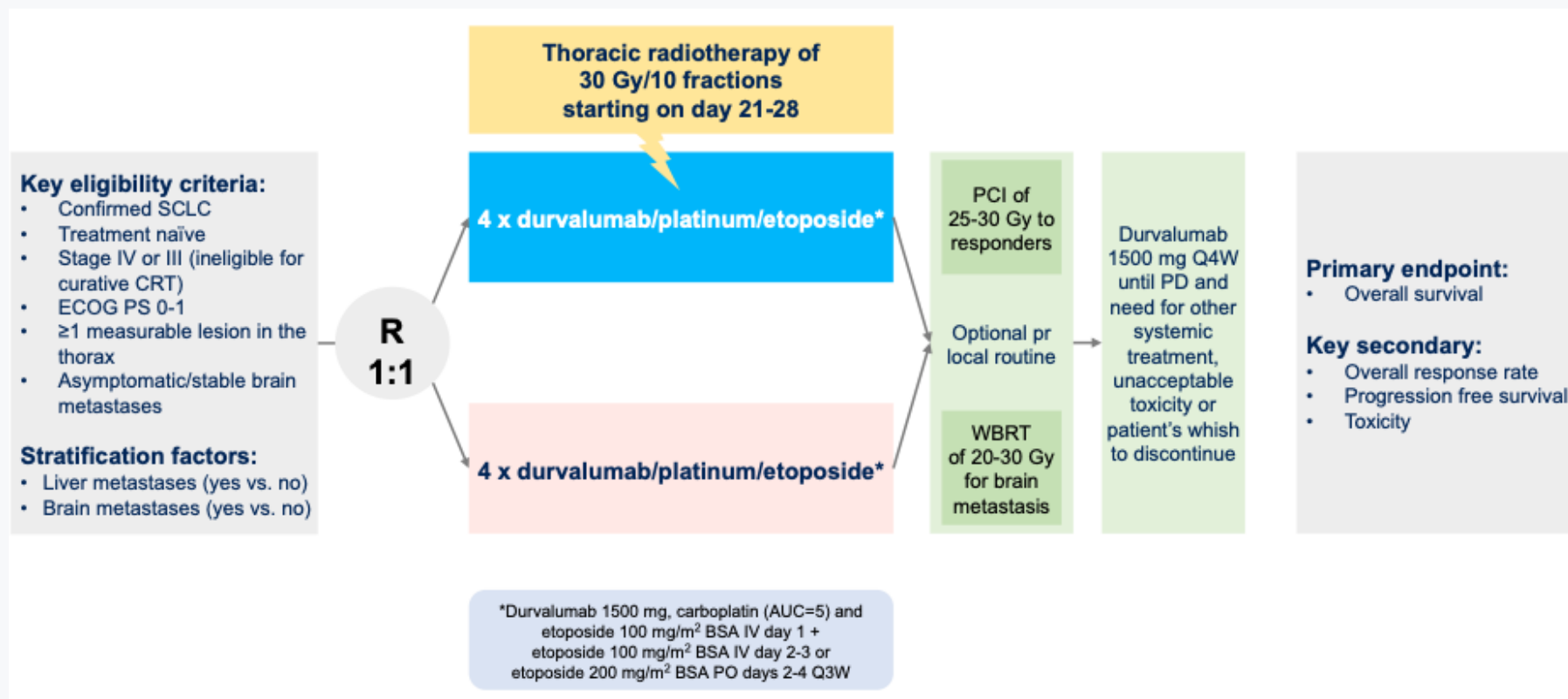
THE FUTURE: SCLC is moving from one disease toward biologic segmentation.

Gay et al., *Cancer Cell*, 2021; Thomas et al., *Nature Cancer*, 2025

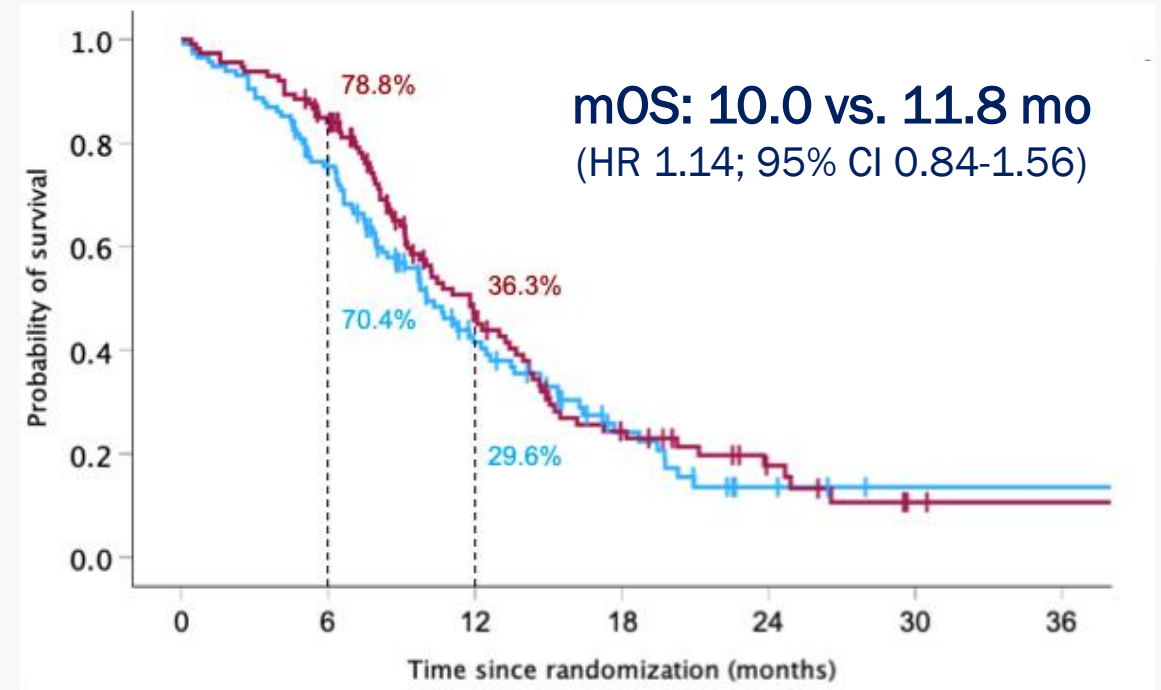
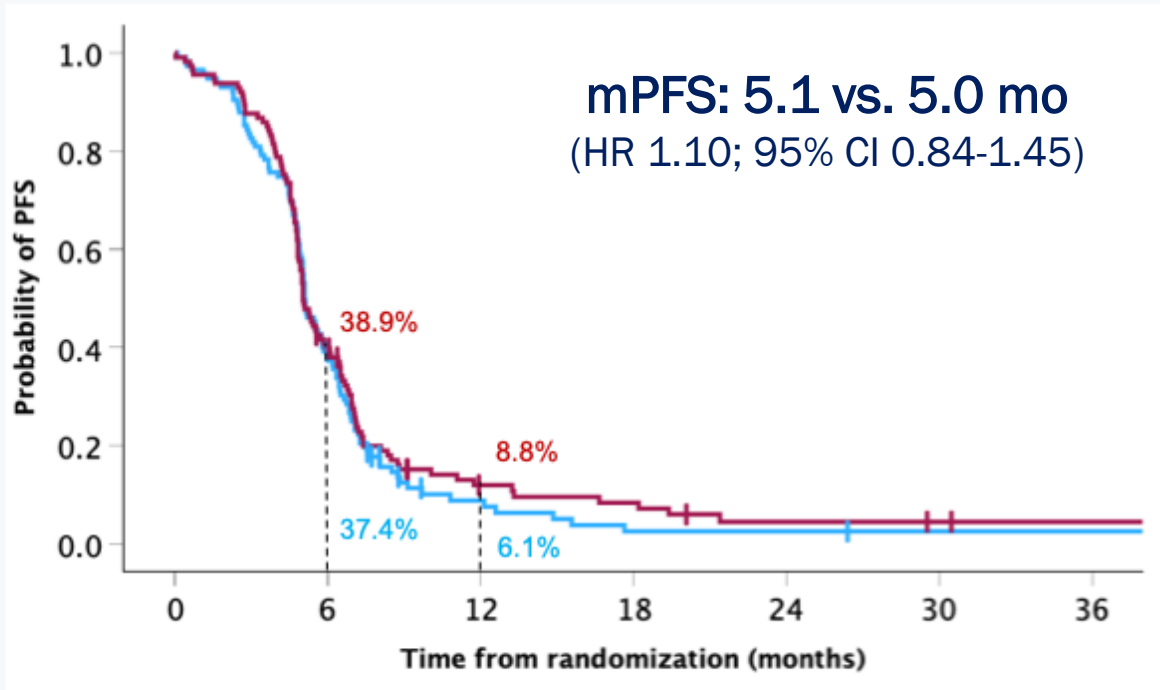
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CAN LOCAL THERAPY IMPROVE ES-SCLC OUTCOMES?

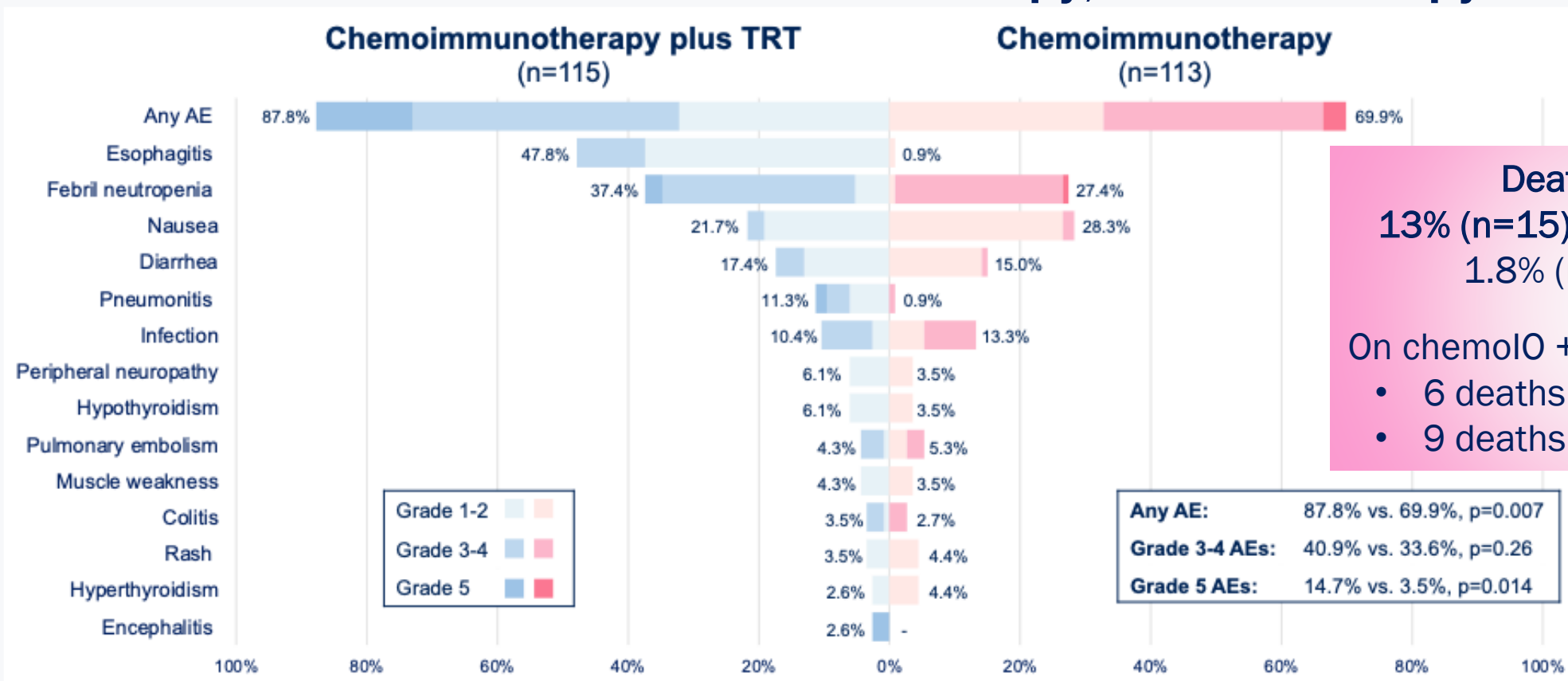
Concurrent thoracic radiotherapy, chemotherapy and durvalumab in ES SCLC - a phase III trial



Concurrent Thoracic Radiotherapy, Chemotherapy + Durvalumab



Concurrent Thoracic Radiotherapy, Chemotherapy + Durvalumab



Deaths due to AEs:
 13% (n=15) on chemoIO + TRT vs.
 1.8% (n=2) on chemoIO

On chemoIO + TRT arm:

- 6 deaths prior to TRT
- 9 deaths after start of TRT

Concurrent TRT *did not* improve survival among ES-SCLC patients receiving chemoIO and led to *more* AEs and treatment related deaths

HOT OFF THE PRESS FROM WCLC 2026

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ARTEMIS-008: Phase 3 randomized study of Risvutatug Rezetecan (Ris-Rez) vs Topotecan in Relapsed SCLC

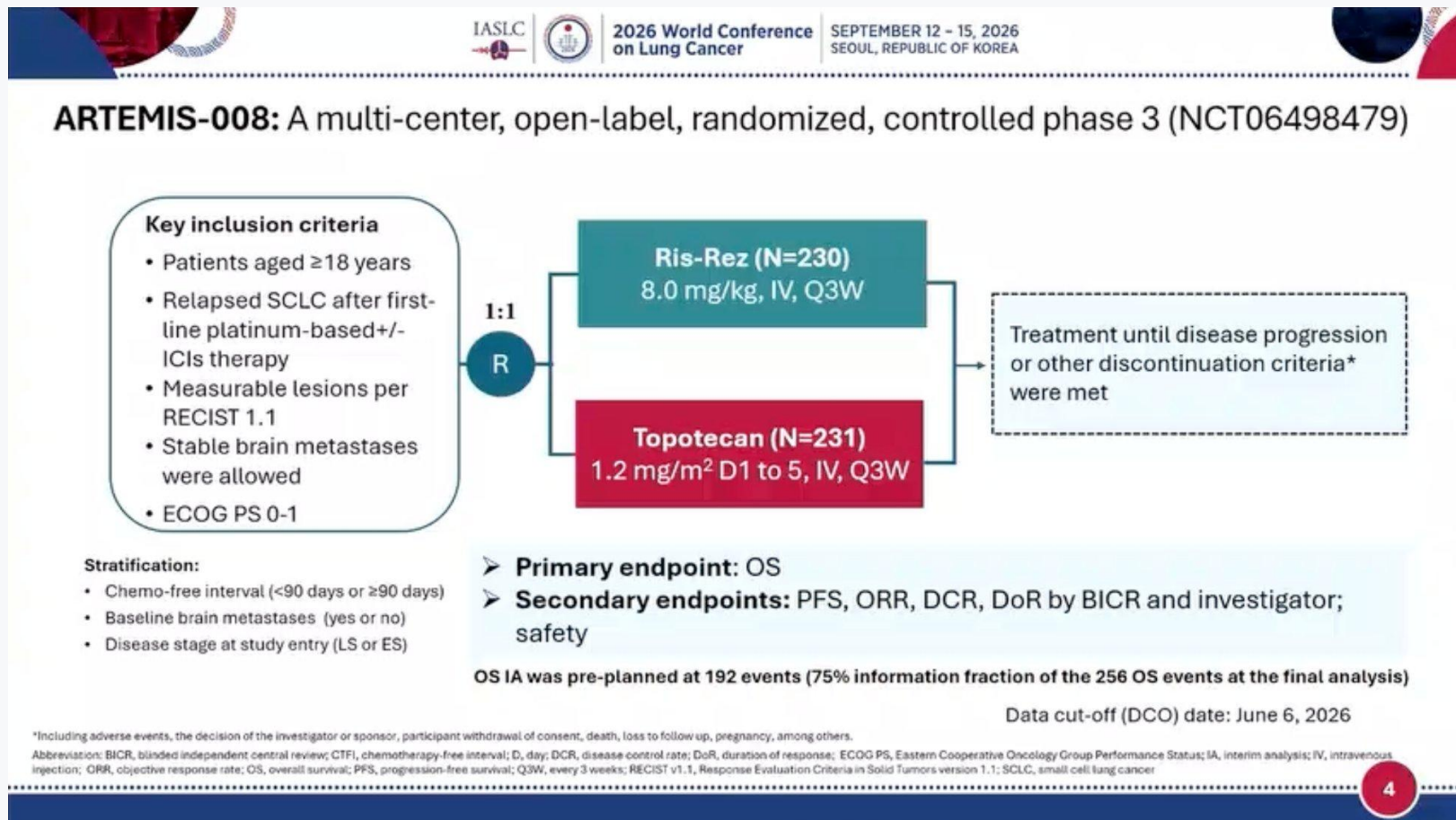


Photo source: @stephenliu twitter

Wang Jie, WCLC 2026.

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ARTEMIS-008: Phase 3 randomized study of Risvutatug Rezetecan (Ris-Rez) vs Topotecan in Relapsed SCLC



Ris-Rez showed substantial activity vs topotecan, but interim evidence and in China only

TAISHAN-302: Phase 3 randomized study of Tambotatug Pelitecan (Tam-Peli) versus Topotecan in Relapsed SCLC

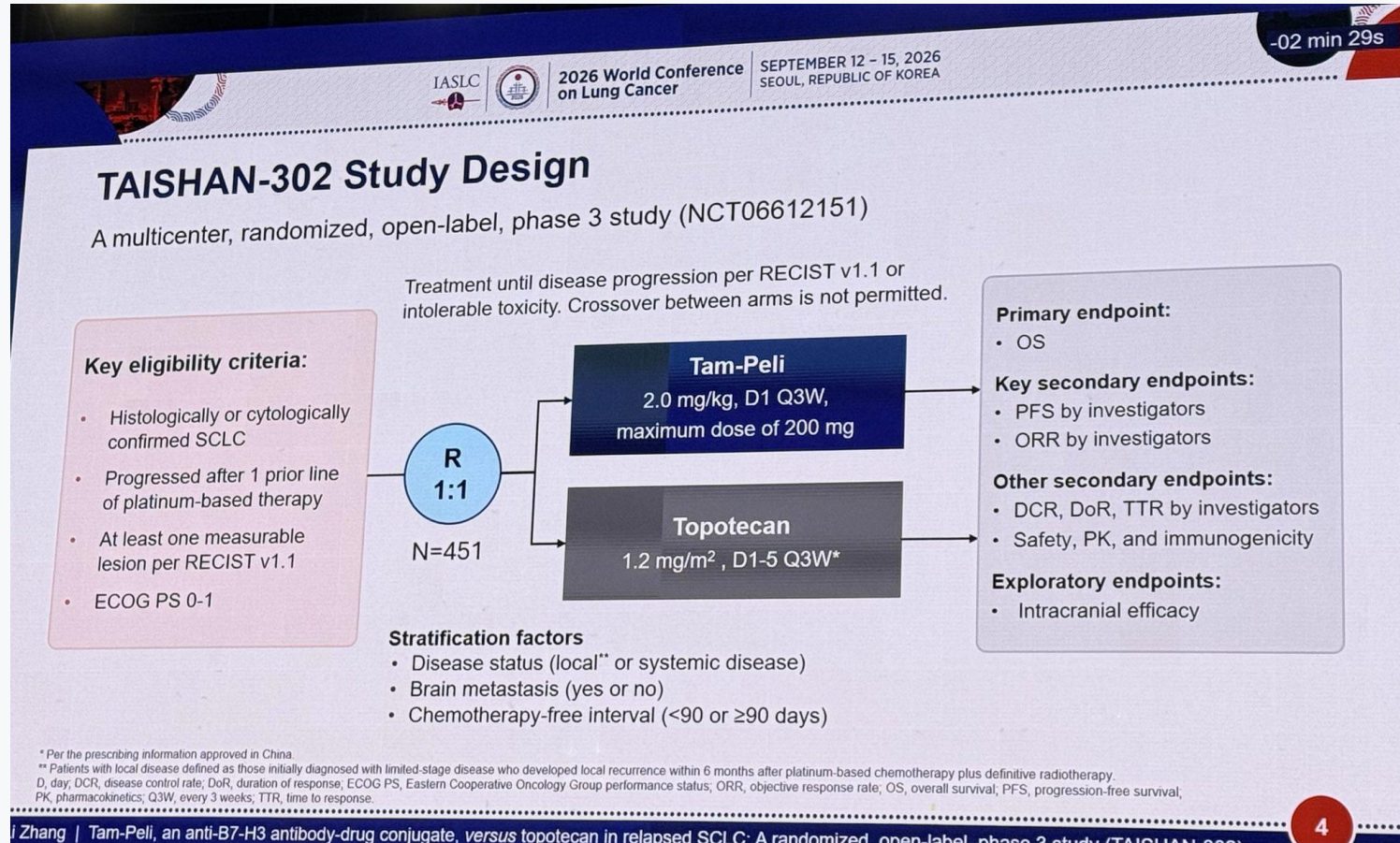
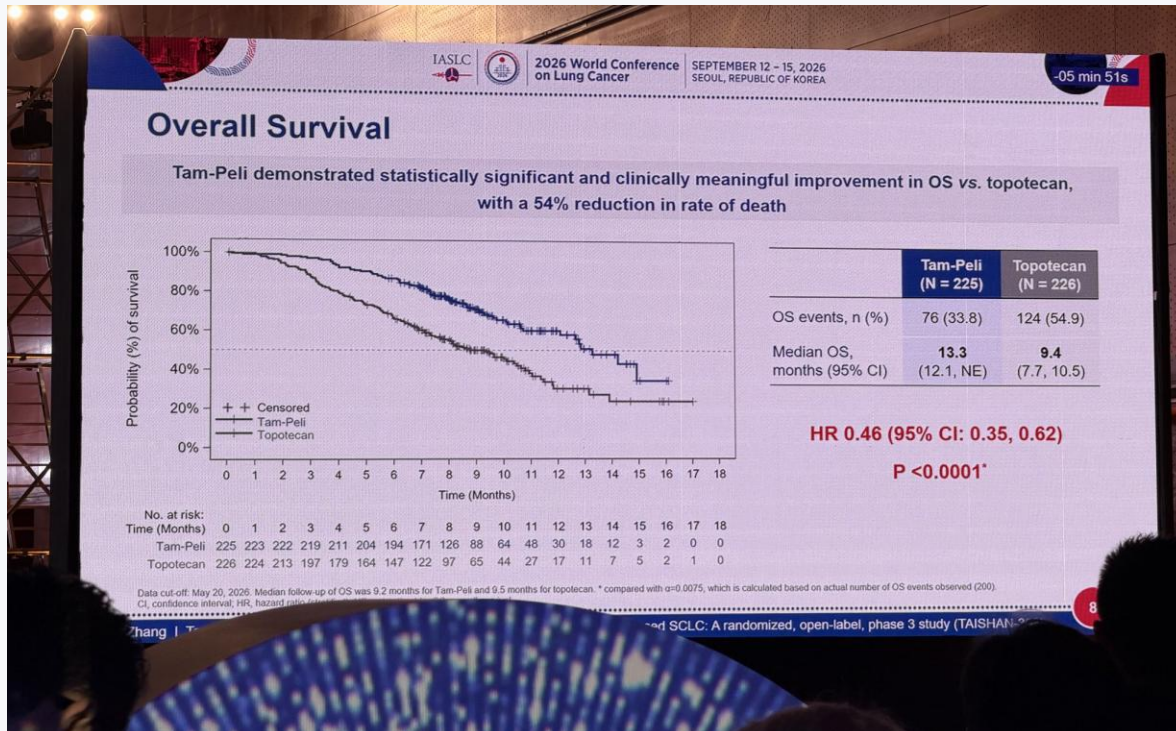


Photo source: @latinamd twitter

Zhang Li, WCLC 2026.

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TAISHAN-302: Phase 3 randomized study of Tambotatug Pelitecan (Tam-Peli) versus Topotecan in Relapsed SCLC



IASLC 2026 World Conference on Lung Cancer SEPTEMBER 12 - 15, 2026 SEOUL, REPUBLIC OF KOREA -08 min 16s

Safety Summary

	Tam-Peli (N = 224)	Topotecan (N = 217)
Median duration of exposure, weeks (range)	31.1 (3, 72.9)	10.1 (3, 70.4)
TRAEs, n (%)		
All grades	221 (98.7)	216 (99.5)
Grade ≥ 3	104 (46.4)	162 (74.7)
Serious TRAEs	58 (25.9)	79 (36.4)
Leading to dose interruption	78 (34.8)	80 (36.9)
Leading to dose reduction	58 (25.9)	80 (36.9)
Leading to discontinuation	13 (5.8)	6 (2.8)
Leading to death	0	1 (0.5)

- Fewer grade ≥ 3 TRAEs, serious TRAEs and TRAEs leading to dose reduction were observed with Tam-Peli compared with topotecan (46% vs 74% and 25% vs 36%).
- No treatment-related deaths were reported in the Tam-Peli arm.
- The incidences of all-grade TRAEs and dose interruptions were similar between arms.

Data cut-off: May 20, 2026.
TRAEs, treatment-related adverse events.

Li Zhang | Tam-Peli, an anti-B7-H3 antibody-drug conjugate, versus topotecan in relapsed SCLC: A randomized, open-label, phase 3 study (TAISHAN-302)

Photo source: @glopes twitter

Zhang Li, WCLC 2026.

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Photo source: @latinamd twitter

B7-H3 ADCs in Relapsed SCLC

Descriptive cross trial comparison: ARTEMIS-008 (Ris-Rez) vs TAISHAN-302 (Tam-Peli)

1 TRIAL SNAPSHOT

	ARTEMIS-008 (Ris-Rez)	TAISHAN-302 (Tam-Peli)
Investigation drug	Ris-Rez (B7-H3-directed TOP1 ADC)	Tam-Peli (B7-H3-targeted ADC with TMALIN linker and topoisomerase-I inhibitor payload)
Study design	Phase 3, open-label randomized controlled trial	Phase 3, open-label randomized controlled trial
ClinicalTrials.gov ID	NCT06498479	NCT06612151
Randomized (n)	230 vs 231	225 vs 226
Geographic scope	China-only (100% Asian cohort)	China-only cohort
Data cut-off	June 6, 2026	May 20, 2026
Median follow-up	12.2 months	9.2 months (Tam-Peli arm) 9.5 months (topotecan arm)

2 ELIGIBILITY / POPULATION / BASELINE DIFFERENCES

(Experimental arms shown; control arms were similar within each study)

	ARTEMIS-008 (Ris-Rez, N=230)	TAISHAN-302 (Tam-Peli, N=225)
Prior PD-(L)1 exposure, n (%)	190 (82.6)	194 (86.2)
Brain metastases at baseline, n (%)	44 (19.1)	78 (34.7)
Liver metastases at baseline, n (%)	49 (21.3)	72 (32.0)
Chemotherapy-free interval <90 days, n (%)	83 (36.1)	110 (48.9)
Disease extent, n (%)	Extensive-stage 200 (87.0)	Systemic disease 218 (96.9)
Brain metastases eligibility	Stable brain metastases allowed	Stratified by brain metastases (yes or no)

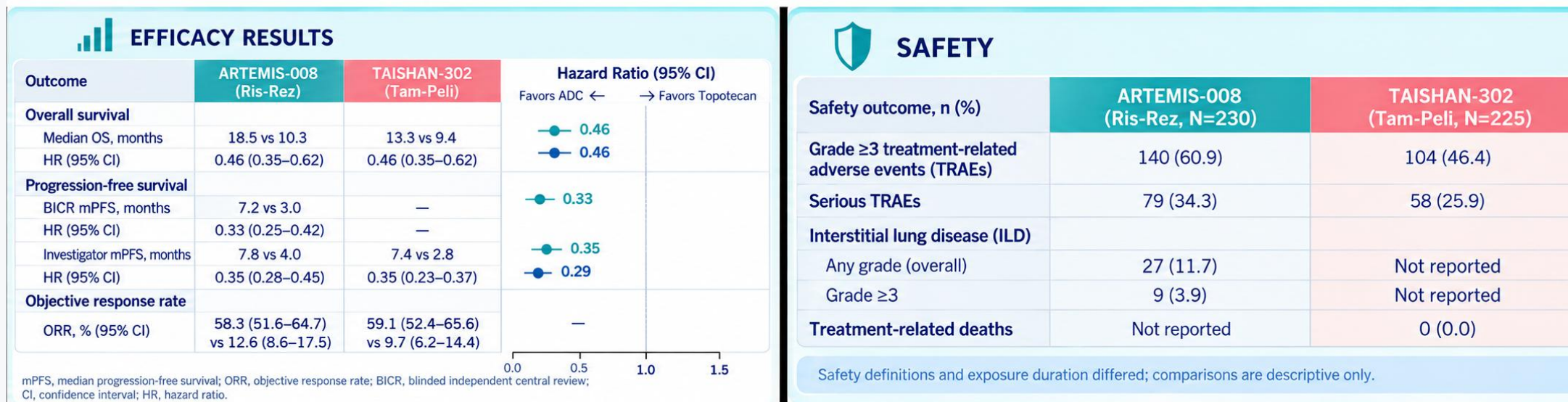


Interpretation: TAISHAN-302 appears to have enrolled a somewhat higher-risk population, especially for CNS and liver metastatic burden and shorter chemotherapy-free interval.

NOT a head to head comparison. Differences in eligibility, case mix, follow up, endpoint, and trial conduct limits cross trial inference.

B7-H3 ADCs in relapsed SCLC

Descriptive cross trial comparison: ARTEMIS-008 (Ris-Rez) vs TAISHAN-302 (Tam-Peli)



THE SIGNAL: two B7-H3 ADC phase III programs show substantial activity vs topotecan—without a head-to-head ranking.

2026 World Conference
on Lung Cancer

SEPTEMBER 12 - 15, 2026
SEOUL, REPUBLIC OF KOREA

06 min 35s

SWOG S1827/MAVERICK

MRI Brain Surveillance Alone Versus MRI Surveillance and Prophylactic Cranial Irradiation (PCI): A Randomized Phase III Trial in Small-Cell Lung Cancer

**Small-cell lung cancer
(Limited OR Extensive)**

- No prior brain metastases
- No brain metastases on MRI after 1st line therapy

R

Prophylactic cranial irradiation (PCI)

→ MRI brain surveillance

Stratify: 1. Limited vs Extensive stage
2. Immunotherapy (y/n) 3. Performance Status (0-1 vs 2)

No PCI

→ MRI brain surveillance

- MRI brain surveillance and cognitive testing at 3, 6, 9, 12, 18, and 24 months
- PCI was 25 Gy / 10 FX, hippocampal-avoidance (HA) PCI allowed at physician discretion

Primary Endpoint:
Cognitive Failure Free Survival (CFFS)
(time to cognitive decline or death)

7

Photo source: @larinamd twitter
Rusthoven, Chad WCLC 2026

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Bio Ascend™

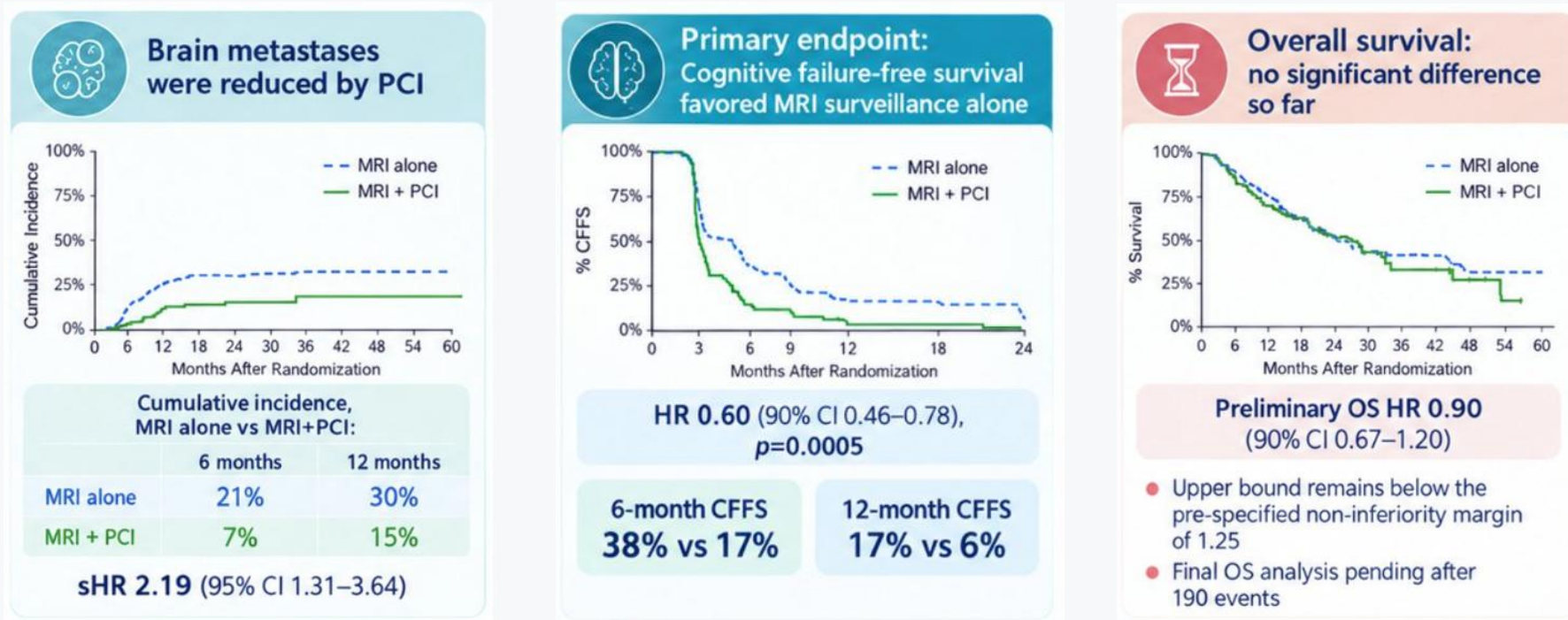
A Vaniam Group Company

University of Nebraska
Medical Center

Olazagasti • 2026

MAVERICK: What are the clinical implications?

MRI surveillance alone vs prophylactic cranial irradiation (PCI) in SCLC



THE PRACTICAL QUESTION: can MRI surveillance replace routine PCI for many patients?

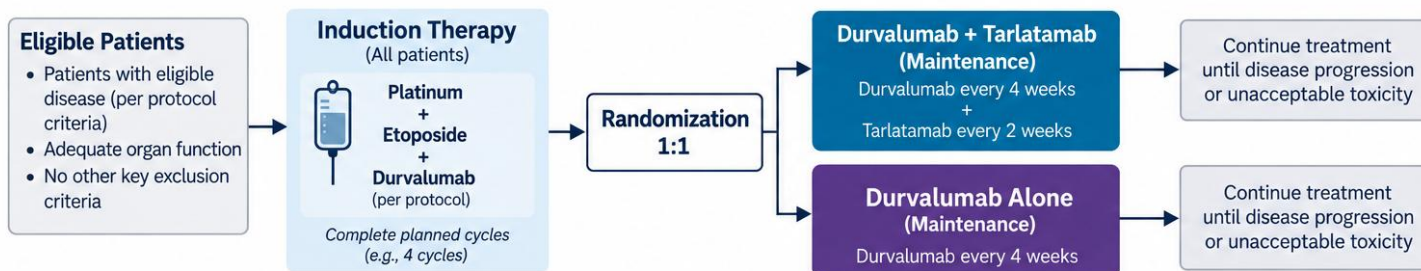


STILL TO COME...

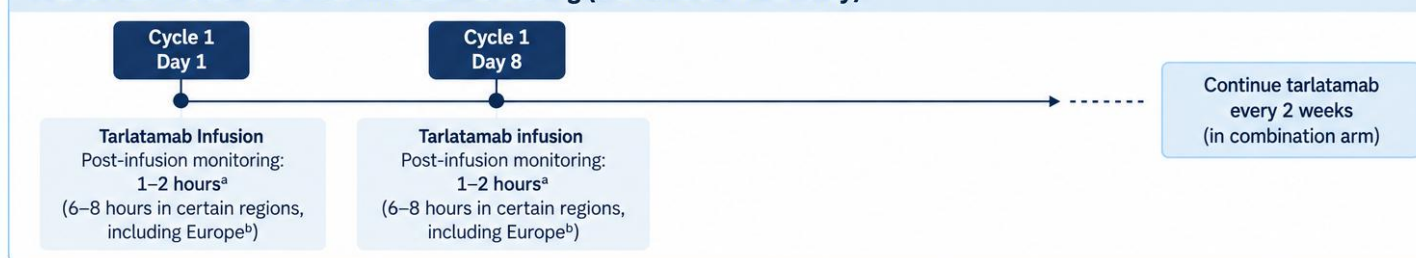
Eagerly awaiting DeLLphi-305 results

Study Schema

Induction, Randomization, and Maintenance Treatment



Tarlatamab Infusion and Post-infusion Monitoring (Combination Arm Only)



Study End Points

Primary End Point

- Overall survival (OS)

Key Secondary End Points

- Progression-free survival (PFS)
- Objective response rate (ORR)
- Disease control rate (DCR)
- Duration of response (DOR)

Each assessed by investigators per RECIST 1.1 criteria.^{2,3}

^a Patients were monitored in a healthcare setting for 1 to 2 hours after tarlatamab infusions on day 1 and day 8 of cycle 1.

^b In certain regions, including Europe, patients were monitored for 6 to 8 hours.

^{2,3} Per study protocol.

DeLLphi-305 in Frontline ES-SCLC Maintenance: Key Takeaways

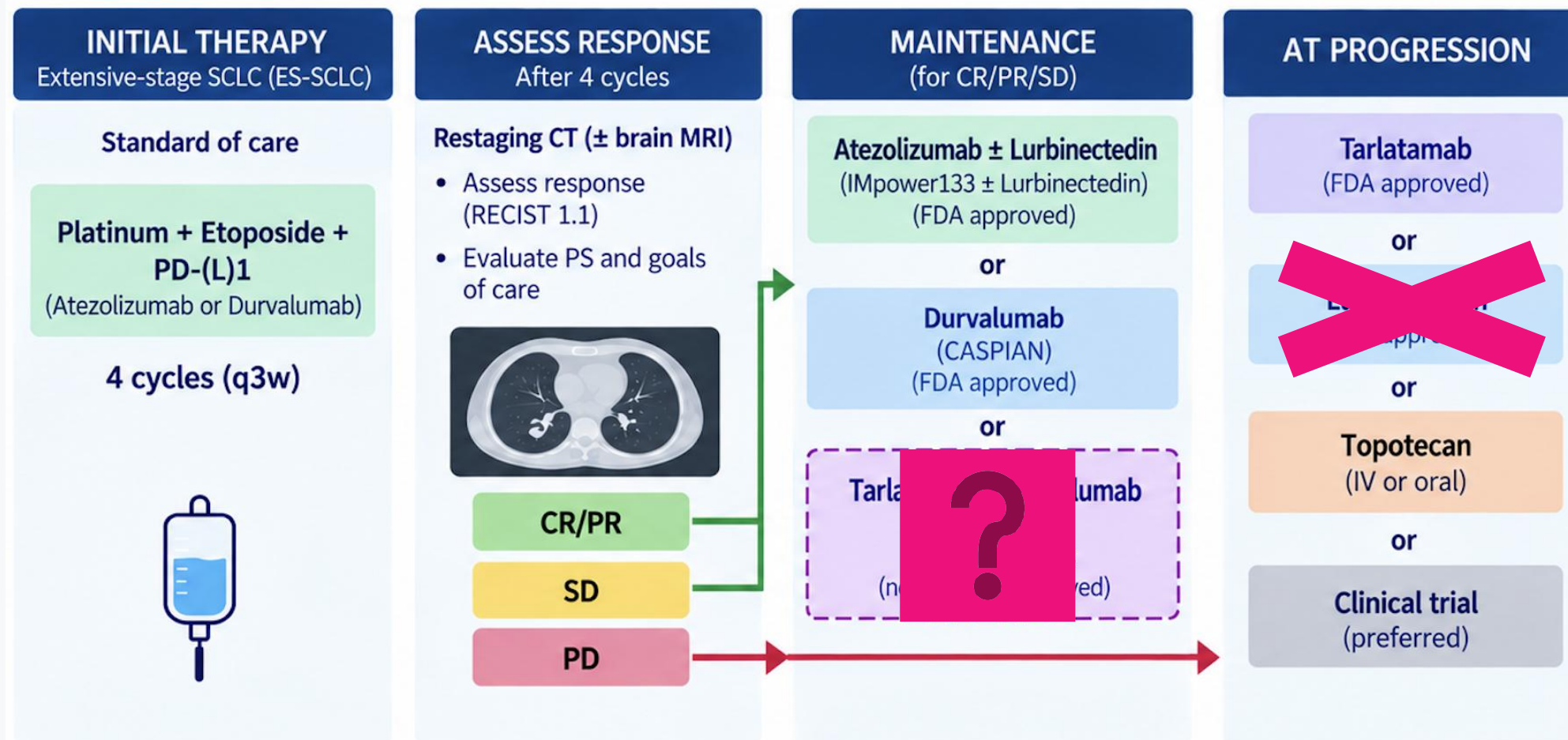
- Durvalumab plus tarlatamab met the primary end point of OS at a planned interim analysis of the phase 3 DeLLphi-305 trial, marking the first survival benefit reported for an immunotherapy plus bispecific T-cell engager combination in this setting.

Source: OncLive

Source: OncLive

HOW I TREAT ES-SCLC IN 2026

Bringing the evidence back to the clinic



¡Gracias!