20th ANNUAL



ATLANTA LUNG CANCER SYMPOSIUM

November 7th, 2026

Partners for Advancing Clinical Education

Bio Ascend™

20th ANNUAL ATLANTA LUNG CANCER SYMPOSIUM

Locally Advanced NSCLC

Have We Hit the Ceiling?

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Partners for Advancing Clinical Education

Bio Ascend™

Disclosures

Company Name	*Honoraria/ Expenses*	*Consulting/ Advisory Board*	*Funded Research*	*Royalties/ Patent*	*Stock Options*	*Ownership / Equity Position*	*Employee*	*Other (please specify)*
Varian/Siemens Healthineers			x					
Genentech		x						
Merck (RTOG Foundation)	x	x						
Emory University							x	
Castle Biosciences		x						
BioAscend	x							

PACIFIC: STUDY DESIGN

Phase 3, randomized, double-blind, placebo-controlled, multicenter, international study

- **Unresectable, Stage III NSCLC without progression and without G2+ toxicity after definitive platinum-based cCRT (≥2 cycles)**
- **18 years or older**
- **WHO PS score 0 or 1**
- **If available, archived pre-cCRT tumor tissue for PD-L1 testing***

All-comers population (i.e. irrespective of PD-L1 status)

N=713 randomized

1-42 days post-cCRT

R

Durvalumab
10 mg/kg q2w for up to 12 months
N=476

2:1 randomization, stratified by age, sex, and smoking history

Placebo
for up to 12 months
N=237

Primary endpoints
- PFS by BICR using RECIST v1.1†
- OS

Key secondary endpoints
- ORR, DoR and TTDM by BICR
- PFS2 by investigator
- Safety
- PROs

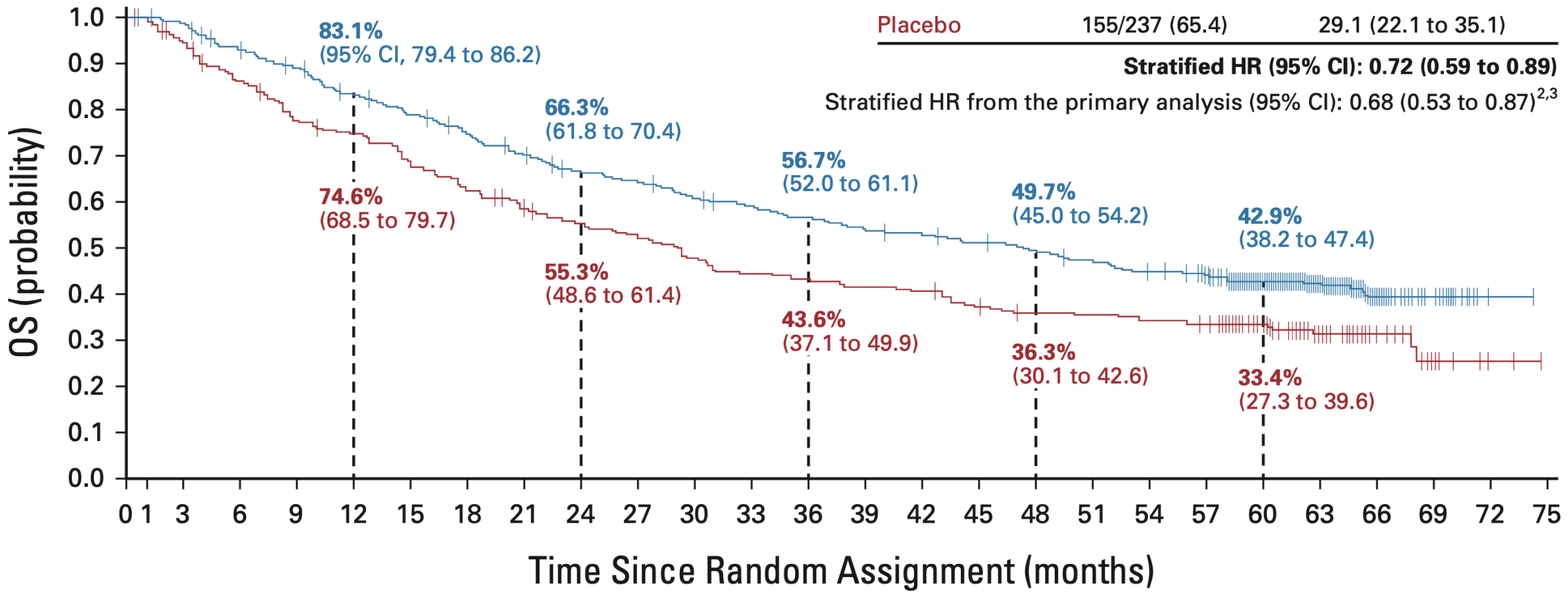
†Defined as the time from randomization until the date of objective disease progression or death by any cause in the absence of progression. BICR, blinded independent central review; cCRT, concurrent CRT; PFS2, time to second progression;
RECIST, Response Evaluation Criteria in Solid Tumors; TTDM, time to death or distant metastasis.

Antonia et al. NEJM 2017 & 2018

Arm	No. of Events/ Total No. of Patients (%)	Median OS (95% CI), Months
Durvalumab	264/476 (55.5)	47.5 (38.1 to 52.9)
Placebo	155/237 (65.4)	29.1 (22.1 to 35.1)

Stratified HR (95% CI): 0.72 (0.59 to 0.89)

Stratified HR from the primary analysis (95% CI): 0.68 (0.53 to 0.87)[2,3]



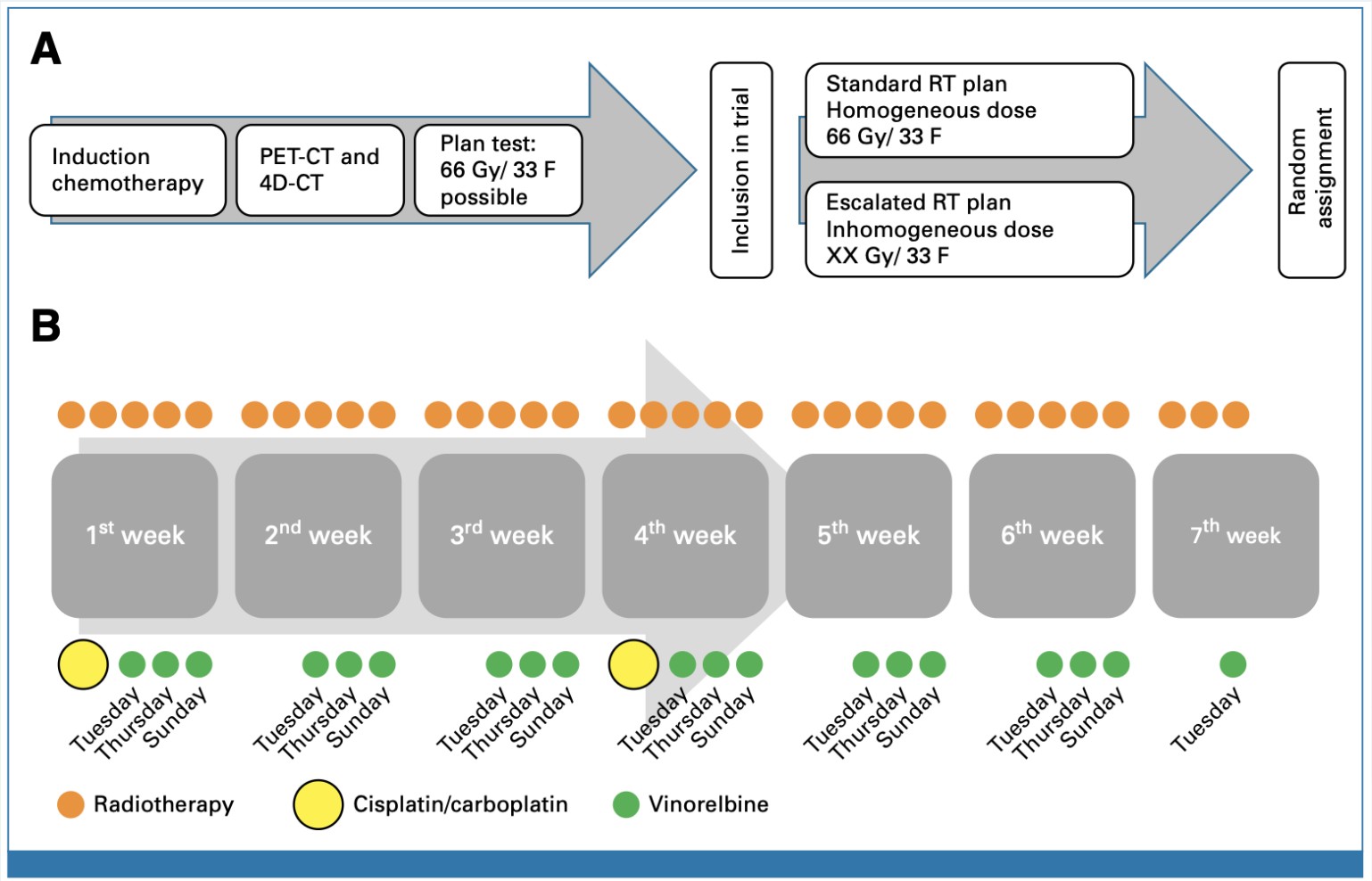
No. at risk:

Durvalumab	476	464	431	414	385	364	343	319	298	289	273	264	252	241	236	227	218	207	196	183	134	91	40	18	2	0
Placebo	237	220	199	179	171	156	143	133	123	116	107	99	97	93	91	83	78	77	74	72	56	33	16	7	2	0

Spigel et al. *J Clin Oncol*. 2022;40(12):1301-1311.

NARLAL 2

Novel **A**pproach to **R**adiotherapy for **LA**-NSC**L**C - phase III randomized trial on dose escalation



N = 350 randomized

Primary:
Locoregional control

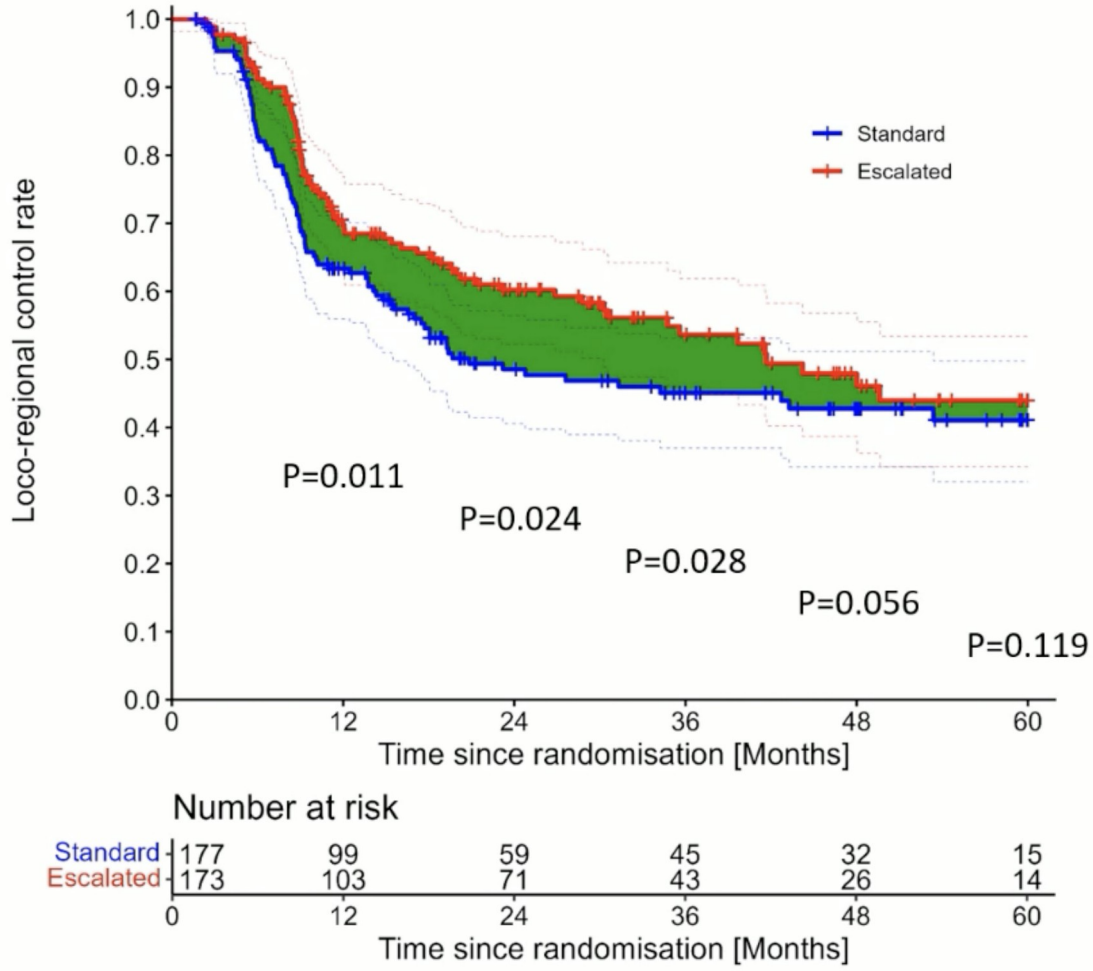
Modern radiotherapy
- 4D-CT
- Daily CBCT
- Adaptive RT

Dose-escalated RT
- Target dose
  - 95 Gy to GTV-p
  - 74 Gy to GTV-n
- 2 plans with equal lung dose created before randomization

Schytte et al. *J Clin Oncol*. 2025;43(17):1972-1983.

Dose Escalation Improves Locoregional Control

RESULTS



20% received durvalumab

G3 esophagitis
- 9 vs 5.8%

G3 pneumonitis
- 3.4 vs 6.4%

No G4+ acute AEs

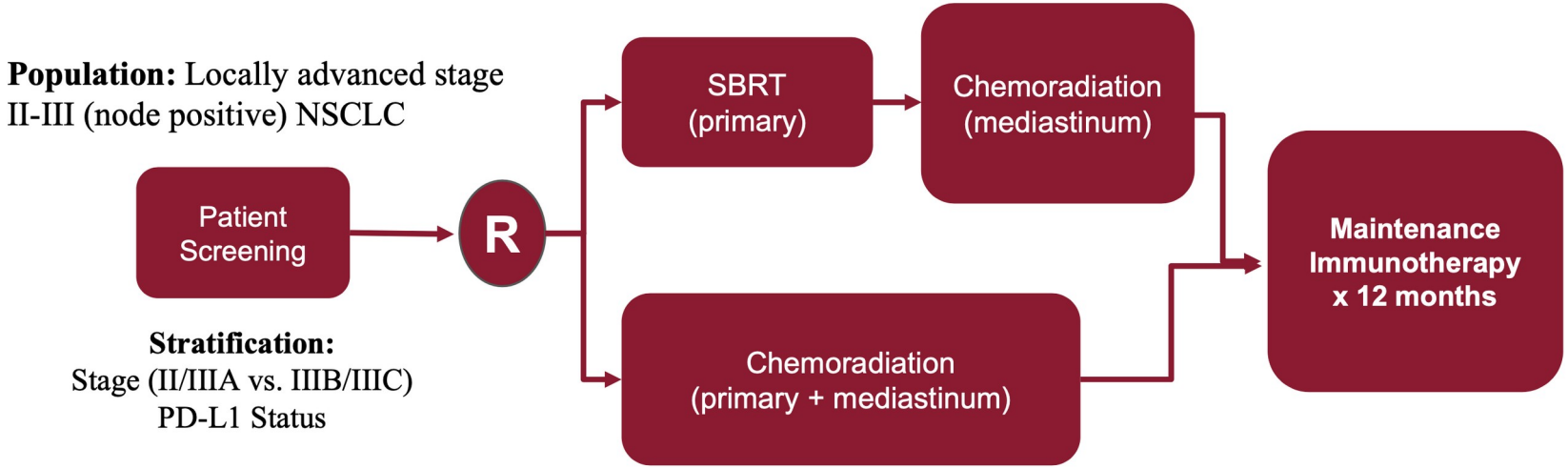
Three G5 events in each arm (1.7%)

OS immature

Schytte et al. Abstract 3531 ESTRO 2024

NRG-LU008

Phase III Prospective Randomized Trial of Primary Lung Tumor Stereotactic Body Radiation Therapy Followed by Concurrent Mediastinal Chemoradiation for Locally-Advanced NSCLC



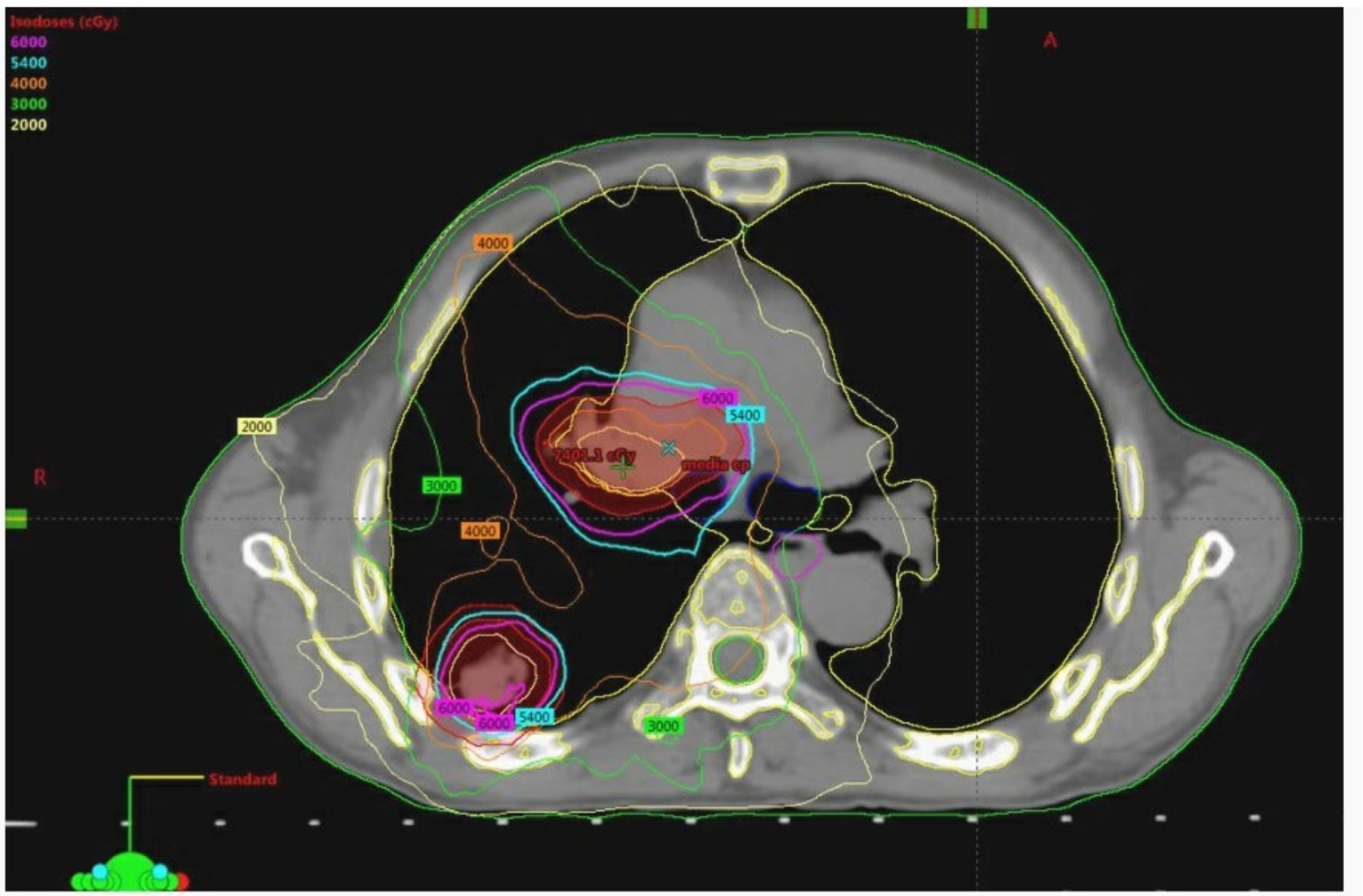
- Control arm: chemoradiation to the primary and mediastinal disease (60 Gy/2 Gy) → immunotherapy maintenance x 12 months
- Experimental arm: SBRT to the primary (standard BED ≥100 Gy dose regimen) → chemo
  Gy) → immunotherapy maintenance x 12 months
  - SBRT to primary tumor:
    - 3 fractions to 54 Gy (BED10 of 151.2 Gy) [peripheral]
    - 4 fractions to 50 Gy (BED10 of 112.5 Gy) [peripheral]
    - 5 fractions to 50 Gy (BED10 of 100 Gy) [peripheral or central]
  - Radiation to involved hilar/mediastinal lymph nodes: 2 Gy x 30 fx to 60 Gy, IMRT or proton therapy
  - Concurrent chemotherapy: carboplatin + paclitaxel, cisplatin + etoposide, cisplatin + pemetrexed or carboplatin + pemetrexed
  - Maintenance immunotherapy: durvalumab x 12 months [if durvalumab is NOT given, carbo/paclitaxel pts receive 2 cycles of consolidation]

Co-primary: OS and PFS
Activated 5/10/23

NRG ONCOLOGY™

NCT05624996

NRG-LU008 Representative Case



Total volume of lung receiving 40 Gy= 332 cc (compared to 590 cc, 44% reduction)
Total volume of lung receiving 20 Gy=922 cc (compared to1300 cc, 29% reduction)
Total volume of lung receiving 10 Gy=2168 cc (compared to 2360, 8% reduction)

NCT05624996

NRG RTOG 1308

Phase III Randomized Trial Comparing Overall Survival After Photon vs Proton Chemoradiotherapy for Inoperable Stage II-IIIB NSCLC

STRATIFY	Stage 1.II 2.IIIA 3.IIIB Histology 1.Squamous 2.Non-Squamous Concurrent Chemotherapy Doublet Type 1.Carboplatin/paclitaxel 2.Cisplatin/etoposide 3. carboplatin/ pemetrexed	RANDOMIZE	Arm 1: Photon dose—70 Gy*, at 2 Gy (RBE) once daily plus platinum-based doublet chemotherapy** Arm 2: Proton dose—70 Gy (RBE), at 2 Gy once daily plus platinum-based doublet chemotherapy**	Both Arms: Durvalumab or Consolidation chemotherapy x 2 cycles required for patients who receive concurrent carboplatin and paclitaxel***

Co-Primary:
OS,
Cardiac AE + lymphocyte reduction
2/3/14
Activated

9/26/23
Closed to accrual

Primary endpoint result anticipated late 2026

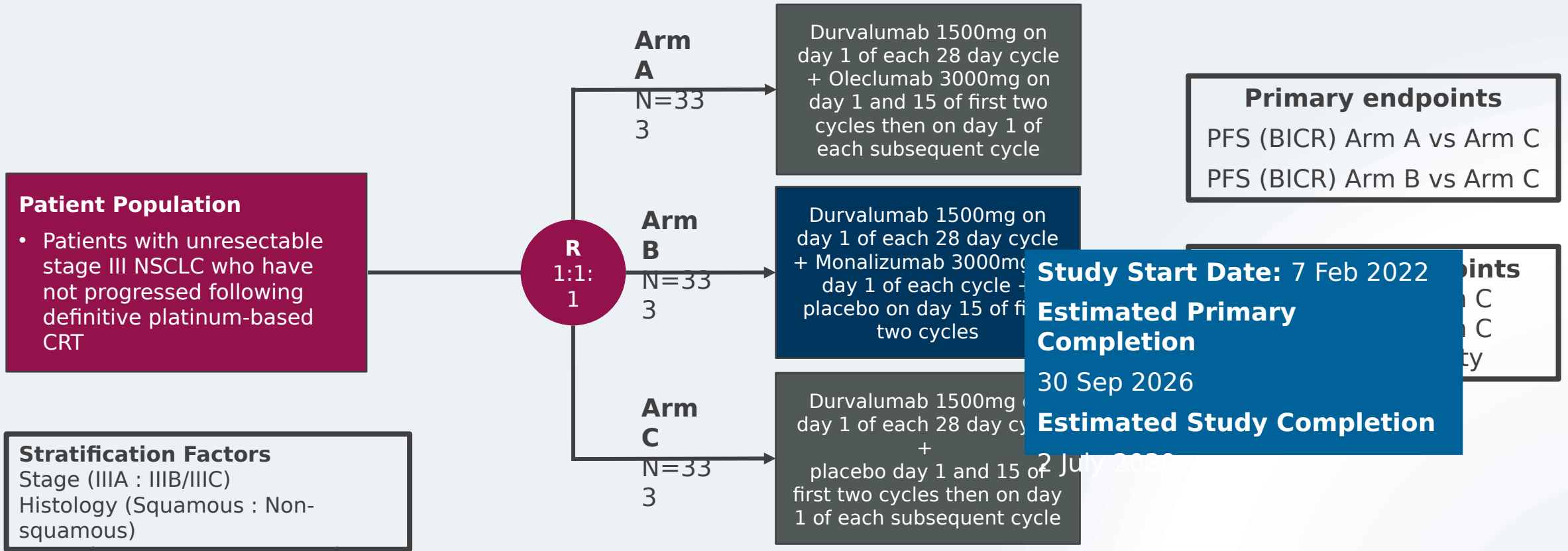
PI: Zhongxing Liao

*The highest total prescribed dose will be 70 Gy (Relative Biological Effectiveness (RBE)) **without exceeding tolerance dose-volume limits of all critical normal structures**. The dose range can be 60-70Gy provided the dose constraints of OARs are met.

NCT01993810

PACIFIC-9

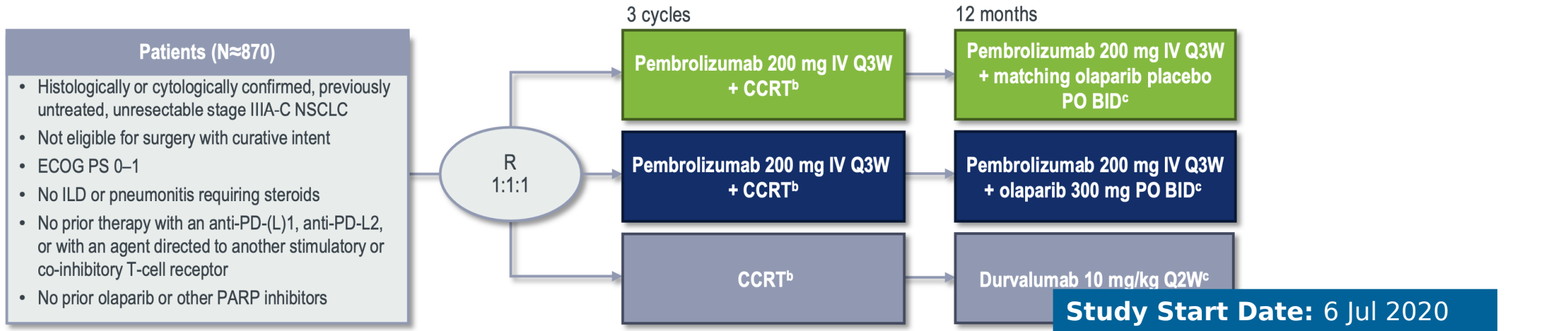
Phase III, double-blind, multicenter international study of durvalumab + oleclumab and durvalumab + monalizumab for the treatment of patients who have not progressed following concurrent chemoradiation treatment for locally-advanced, unresectable NSCLC



NCT05221840

KEYLYNK-012

Phase 3, randomized, double-blind, placebo-controlled study of pembrolizumab in combination with concurrent CRT followed by pembrolizumab ± olaparib vs CCRT followed by durvalumab in patients with unresectable, locally advanced, stage III NSCLC



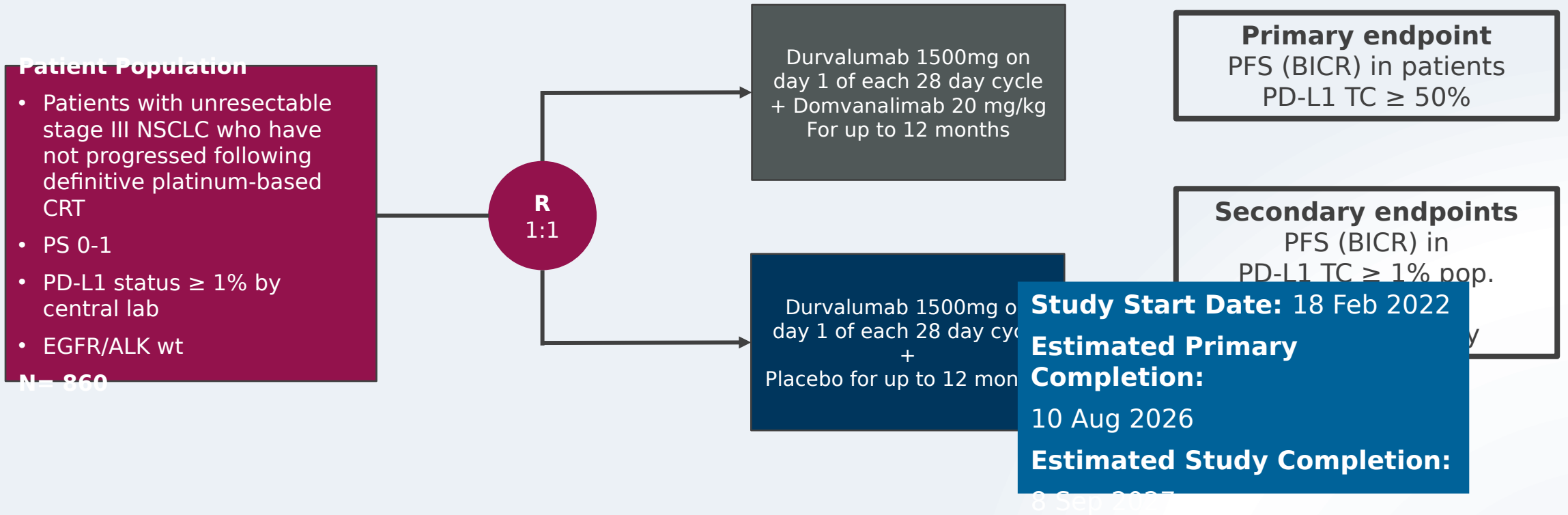
[a]Stratification occurs at randomization. [b]Platinum doublet chemotherapy and concurrent standard thoracic radiotherapy (60 Gy in 2 Gy fractions; during cycles 2 and 3). [b]Platinum doublet options (per investigator's choice) include cisplatin + pemetrexed (NSQ histology only), cisplatin + etoposide, and carboplatin + paclitaxel. [c]Patients in Groups A and B may receive a maximum of 20 cycles of pembrolizumab (Q3W) and patients in Group C may receive a maximum of 26 cycles of durvalumab (Q2W). [d]Assessed per RECIST v1.1 by BICR. [e]Subject to change.

ClinicalTrials.gov. https://clinicaltrials.gov/ct2/show/NCT04380636. Accessed June 22, 2022. Jabbour et al. Presented at ASCO 2021. Abstract TPS8580. Jabbour et al. *Clin Lung Cancer*. 2022;23(6):e342-e346.

NCT04380636

PACIFIC-8

A Phase III, Randomized, Double blind, Placebo-controlled, Multicentre, International Study of Durvalumab plus Domvanalimab (AB154) in Participants with Locally Advanced (Stage III), Unresectable NSCLC



Domvanalimab (AB154) is a Fc-silent humanized IgG1 monoclonal antibody that blocks interaction of the T cell immunoreceptor with Ig and ITIM domains (TIGIT; upregulated by immune cells) with CD112 and CD155

NCT05211895

LAURA

Patients with locally advanced, unresectable stage III* EGFRm NSCLC with no progression during / following definitive CRT† treatment

Key inclusion criteria:
- ≥18 years (Japan: ≥20)
- WHO PS 0 / 1
- Confirmed locally advanced, unresectable stage III* NSCLC
- Ex19del / L858R‡
- Maximum interval between last dose of CRT and randomization: 6 weeks

Osimertinib 80 mg, once daily

Randomization 2:1 (N=216)

Stratification by:
Concurrent vs sequential CRT
Stage IIIA vs stage IIIB/IIIC
China vs non-China

Placebo, once daily

Treatment duration until BICR-assessed progression (per RECIST v1.1), toxicity, or other discontinuation criteria

Open-label osimertinib after BICR-confirmed progression offered to both treatment arms§

Tumor assessments:
- Chest CT / MRI and brain MRI
- At baseline, every 8 weeks to Week 48, then every 12 weeks until BICR-assessed progression

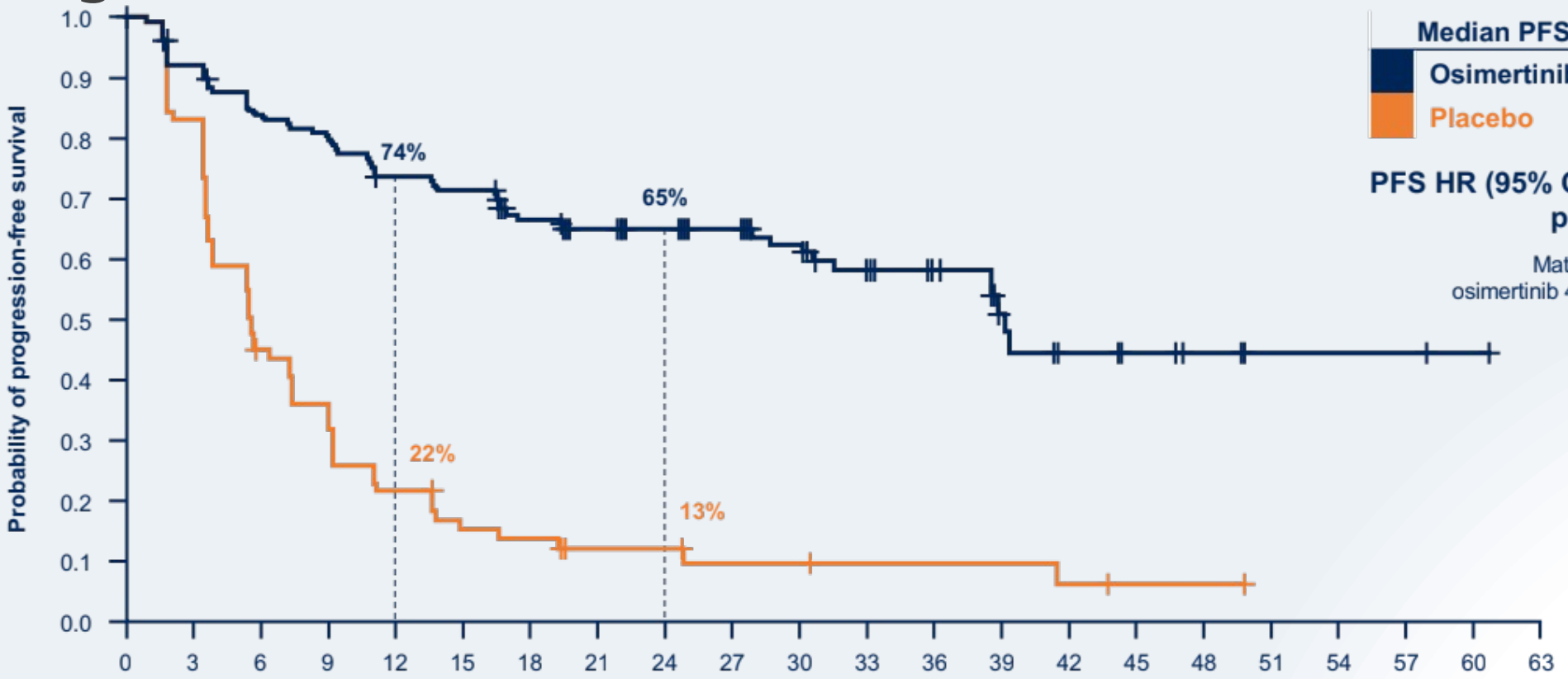
Endpoints

- **Primary endpoint:** PFS assessed by BICR per RECIST v1.1 (sensitivity analysis: PFS by investigator assessment)
- **Secondary endpoints included:** OS, CNS PFS, safety

*According to AJCC / UICC staging (8th edition);
†Concurrent or sequential CRT comprising ≥2 cycles of platinum-based chemotherapy (or 5 doses of weekly platinum-based chemotherapy) and a total dose of radiation of 60 Gy ±10%;
‡Central or FDA-approved local testing (from a CLIA-approved laboratory, or accredited local laboratory for sites outside of USA) based on tissue;
§If deriving clinical benefit (osimertinib arm); by the judgement of treating physician (placebo arm).

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Progression-Free Survival (BICR)



Median PFS, months (95% CI)	
Osimertinib	39.1 (31.5, NC)
Placebo	5.6 (3.7, 7.4)

PFS HR (95% CI): 0.16 (0.10, 0.24), p<0.001

Maturity 56%:
osimertinib 40%, placebo 86%

No. at risk																						
Osimertinib	143	127	114	109	99	96	83	76	69	61	49	37	28	16	9	6	4	2	2	2	1	0
Placebo	73	59	31	25	15	10	9	6	6	4	4	3	3	3	2	1	1	0	0	0	0	0

Data cut-off: January 5, 2024.

Tick marks indicate censored data. Median follow-up for PFS (all patients): osimertinib 22.0 months, placebo 5.6 months. Median follow-up for PFS (censored patients): osimertinib 27.7 months, placebo 19.5 months.

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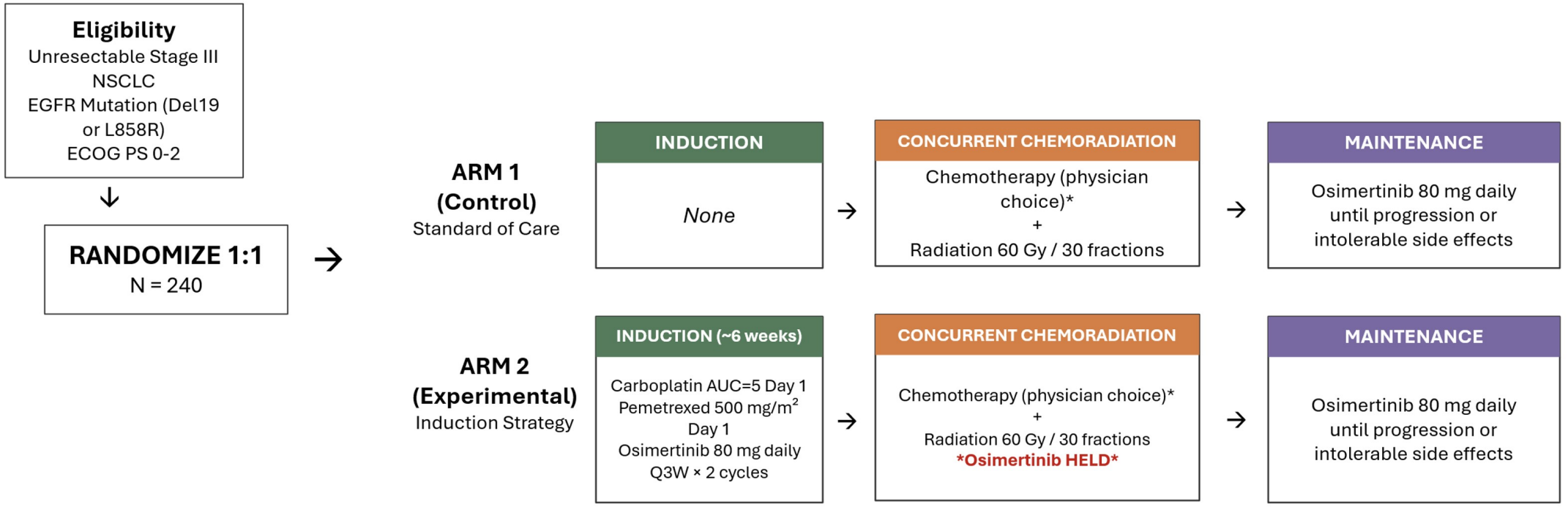
Overall Survival (OS)

ELCC 2025 Update	Interim OS results (20% maturity)		Updated OS results (31% maturity)	
	Osimertinib	Placebo	Osimertinib	Placebo
Events, n (%)	28 (20%)	15 (21%)	40 (28%)	26 (36%)
Median OS	54mo	NR	58.8	54
HR (95% CI)	**0.81** (0.42-1.56); P = 0.530*		**0.67** (0.40-1.14); P = 0.140	
36-mo OS	84%	74%	82%	73%
48-mo OS	-	-	**70%**	**52%**

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NRG-LU013 SORT

A Randomized Phase III Study of **S**equencing **O**simertinib, **R**adiation, and Chemo**t**herapy in Stage III NSCLC with activating EGFRT mutations

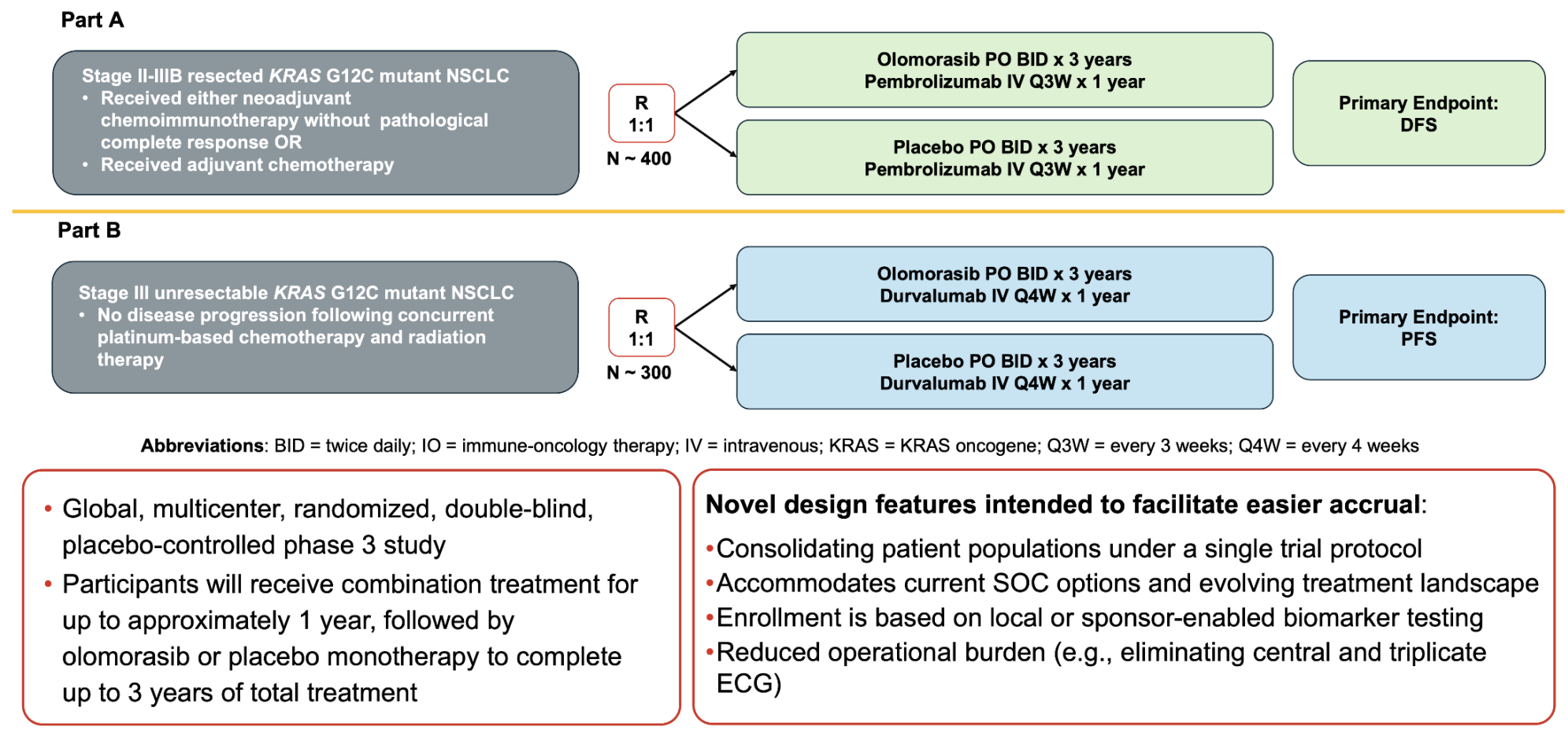


Study Design
Primary Endpoint: Progression-Free Survival | **Secondary Endpoints:** Overall Survival, Safety, Patterns of Failure | **Statistical Design:** HR=0.64,

*Control arm chemo options: Carboplatin/Pemetrexed, Cisplatin/Pemetrexed, Cisplatin/Etoposide, or Carboplatin/Paclitaxel

SUNRAY-02

A Phase 3 Study of Olomorasib and Immunotherapy in Stage II-III KRAS G12C-Mutant NSCLC After Definitive Therapy



Abbreviations: BID = twice daily; IO = immune-oncology therapy; IV = intravenous; KRAS = KRAS oncogene; Q3W = every 3 weeks; Q4W = every 4 weeks

- Global, multicenter, randomized, double-blind, placebo-controlled phase 3 study
- Participants will receive combination treatment for up to approximately 1 year, followed by olomorasib or placebo monotherapy to complete up to 3 years of total treatment

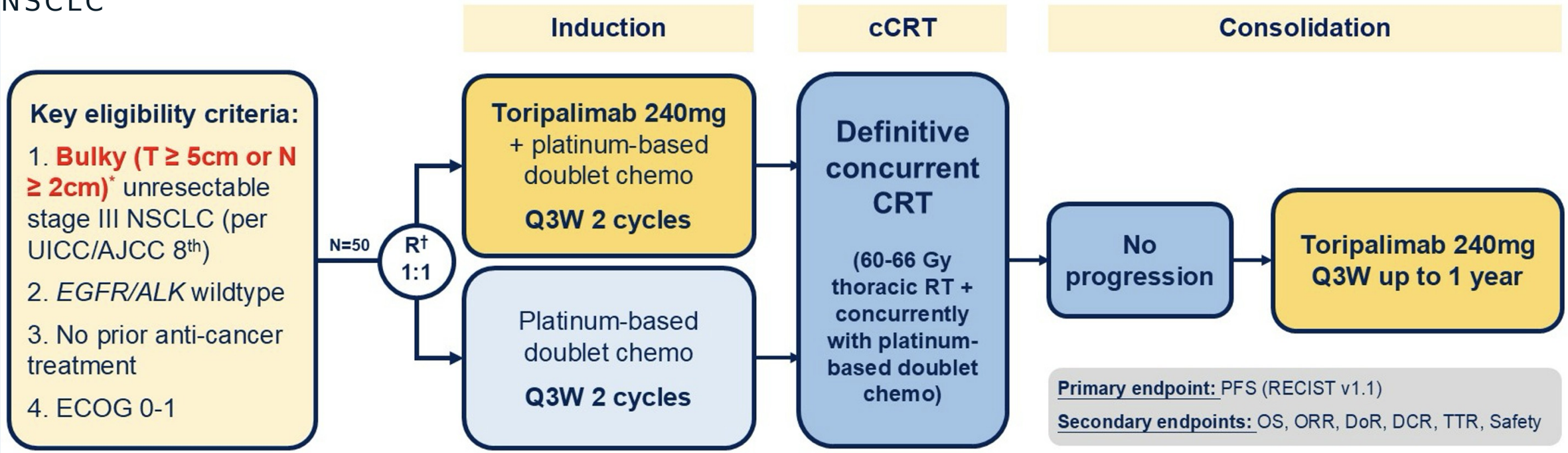
Novel design features intended to facilitate easier accrual:

- Consolidating patient populations under a single trial protocol
- Accommodates current SOC options and evolving treatment landscape
- Enrollment is based on local or sponsor-enabled biomarker testing
- Reduced operational burden (e.g., eliminating central and triplicate ECG)

Nadal et al. Abstract 1953 P3.18.09 WCLC 2025

InTRist (GCOG0074)

Randomized Phase II trial evaluating induction toripalimab plus chemotherapy followed by concurrent chemoradiotherapy and consolidation toripalimab in bulky unresectable stage III NSCLC



* Primary tumor ≥5 cm in the greatest dimension, or metastatic lymph nodes ≥2 cm in the shortest diameter
† Stratification factor: squamous vs non-squamous

cCRT, concurrent CRT; RT, radiotherapy; PFS, progression-free survival; OS, overall survival; ORR, objective response rate; DoR, duration of response; DCR, disease control rate; TTR, time to response

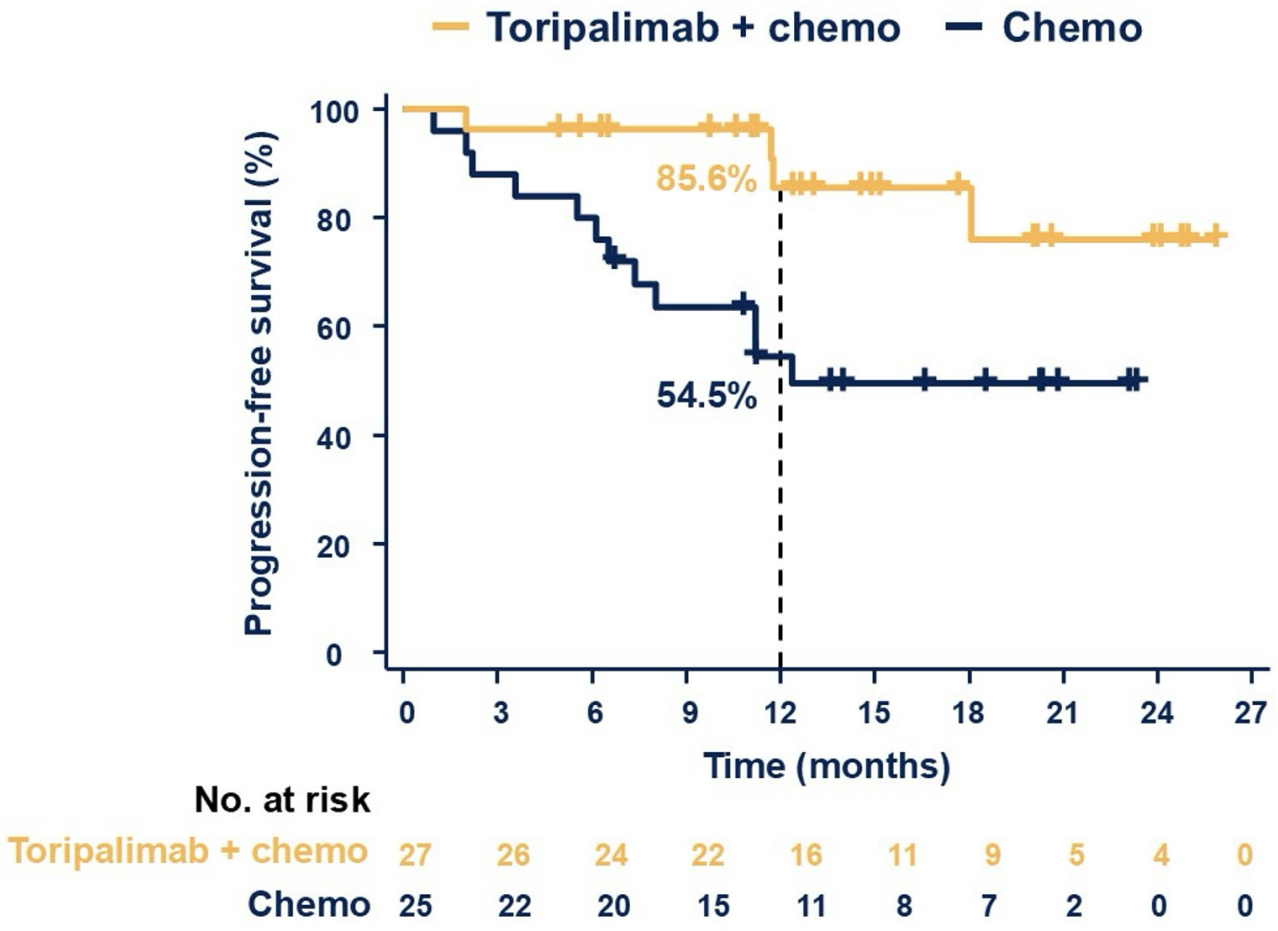
2025 ASCO ANNUAL MEETING #ASCO25

PRESENTED BY: Yu Wang, MD

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NCT05888402

Primary Endpoint – PFS



	Toripalimab + chemo	Chemo
Median PFS, mo (95% CI)	NR (NR-NR)	12.4 (8.0-NR)
1-yr PFS, % (95% CI)	85.6 (71.6-100.0)	54.5 (37.7-78.7)
HR (95% CI)	0.26 (0.08-0.81)	
Log		

ORR after induction tx

77.8 vs 40 % (p=0.006)

G3+ pneumonitis

11.1 vs 4%

2025 ASCO ANNUAL MEETING #ASCO25

PRESENTED BY: Yu Wang, MD

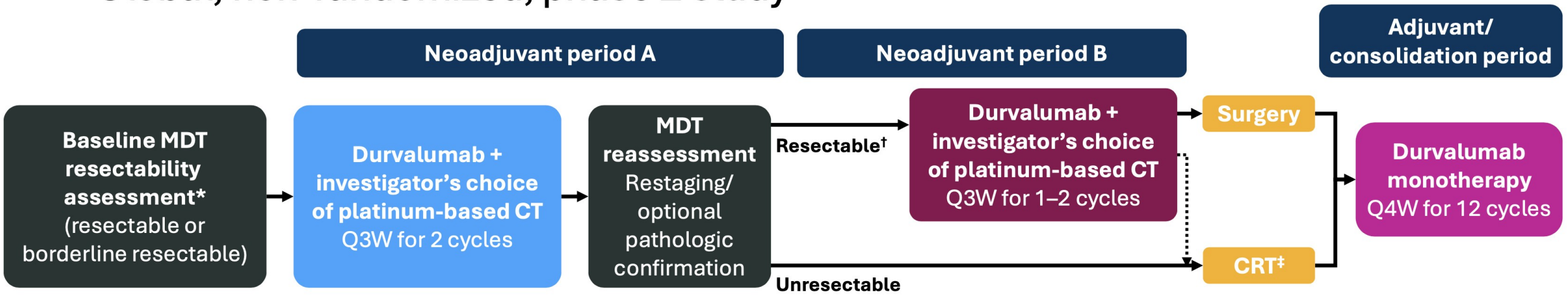
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Selected Induction Chemoimmunotherapy (ICIO) Studies

Study	N	Treatment	Arm (s)	1º Endpoint	Outcome
APOLO	38	ICIO -> CRT -> IO (1yr atezo)		PFS	12-mo PFS 68.4%
PACIFIC-BRAZIL	49	ICIO -> CRT + IO -> IO (1yr durva)		PFS	12-mo PFS 68.1%
InTRist	52	IC -> CRT -> IO	ICIO -> CRT -> IO	PFS	12mo PFS 85.6 vs 54.5%

MDT-BRIDGE study design

Global, non-randomized, phase 2 study



Key inclusion criteria and study requirements

- Aged ≥18 years
- Previously untreated
- Pathologically confirmed, resectable or borderline resectable stage IIB–IIIB NSCLC (AJCC 8th edition[1])
- *EGFR*/*ALK* wild type (per local test)
- WHO/ECOG PS 0–1
- At least 1 target lesion not previously irradiated
- Pre-operative RT not allowed

Primary endpoint

- Resection rate, defined as proportion of all patients (FAS) who underwent definitive surgery

Secondary endpoints¶

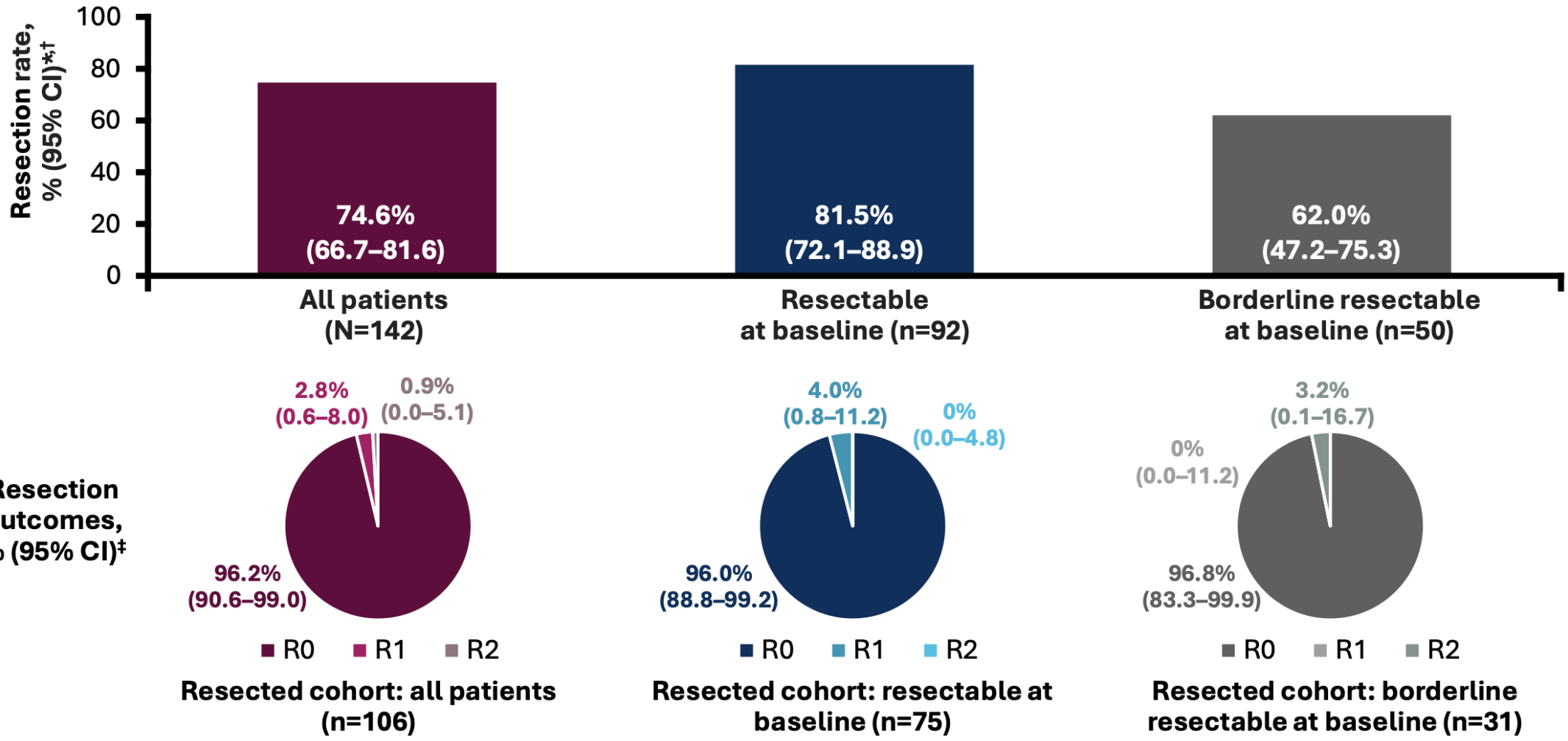
- Resection rate in patients deemed resectable/borderline resectable at baseline
- Surgical outcomes in patients who underwent surgery
- ORR in patients deemed resectable/unresectable at MDT reassessment
- pCR and EFS in all patients (FAS) and patients deemed resectable at MDT reassessment
- PFS in patients deemed unresectable at MDT reassessment
- Safety

*MDT comprised a medical/pulmonary oncologist, thoracic surgeon, radiation oncologist, and pathologist at a minimum; resectable/borderline resectable status determined per MDT decision based on baseline available assessments. †Patients who were deemed eligible for surgery at MDT evaluation but then deemed unresectable/progressed locally at the pre-surgery assessments entered the unresectable cohort. ‡Five fractions/week for ~6 weeks (± 3 days) (total 60 Gy ± 10%). ¶Efficacy outcomes are reported, unless otherwise indicated, according to prespecified analysis populations except for pCR (assessed per local pathology review), which was not prespecified for analysis in all patients. AJCC, American Joint Committee on Cancer; ECOG, Eastern Cooperative Oncology Group; FAS, full analysis set (i.e., all patients who received at least one dose of study intervention); Gy, gray; ORR, objective response rate; PS, performance status; QXW, once every X weeks; RT, radiotherapy; WHO, World Health Organization.

1. Amin MB, et al. *AJCC Cancer Staging Manual*. 8th ed. New York, NY: Springer; 2017.

Resection rates and outcomes (FAS)

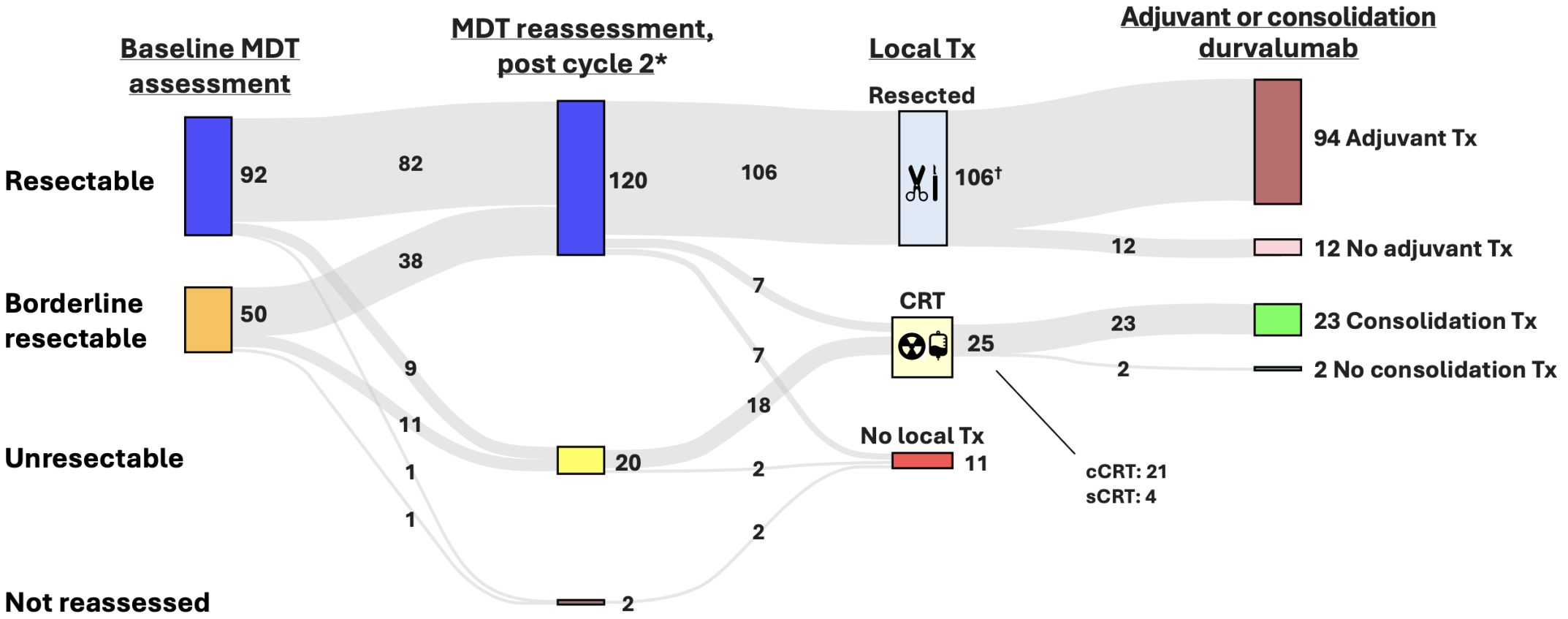
- The overall resection rate was 74.6% and most patients had R0 resection



Reck et al. Abstract 5042 WCLC 2026

Changes in resectability assessments and local treatment (FAS)

- After 2 cycles of neoadjuvant durvalumab + CT, most patients, including those who were borderline resectable at baseline, were deemed resectable at MDT reassessment



92.3% had either surgery or CRT after neoadjuvant durvalumab + CT

Reck et al. Abstract 5042 WCLC 2026

Patients Who Did Not Receive Local Treatment

- Patients did not receive local treatment (surgery or CRT) for varied reasons, with no common characteristics identified
- The most frequent reason for discontinuation was AE

Age ≥75 years	Histology	Stage	TNM	Baseline MDT assessment	MDT reassessment after 2 cycles	Pre-surgery evaluation	Reason for discontinuation of study Tx
Yes	Non-squamous	IIIA	T2aN2M0	Resectable	Not performed	No	AE (Sepsis)
No	Non-squamous	IIIA	T1cN2M0	Resectable	Resectable	No	AE (Asthenia)
Yes	Non-squamous	IIB	T3N0M0	Resectable	Resectable	No	PD
No	Squamous	IV	T4N0M1b	Resectable	Unresectabl		riteria
Yes	Squamous	IIIA	T4N1M0	Borderline	Not performe		rhea)
No	Non-squamous	IIIB	T4N2M0	Borderline	Resectable		nonitis)
Yes	Squamous	IIB	T3N0M0	Borderline	Resectable		neutropenia)
No	Non-squamous	IIIA	T2aN2M0	Borderline	Resectable	No	PI decision (Patient frailty)
No	Non-squamous	IIIB	T3N2M0	Borderline	Resectable	Yes	PD
No	Non-squamous	IIIA	T4N0M0	Borderline	Resectable	Yes	AE (Cardiac decompensation)
No	Squamous	IIIA	T4N1M0	Borderline	Unresectable	No	PD

54.5% (6/11) from AE
27.3% (3/11) from PD
18.2% (2/11) from other

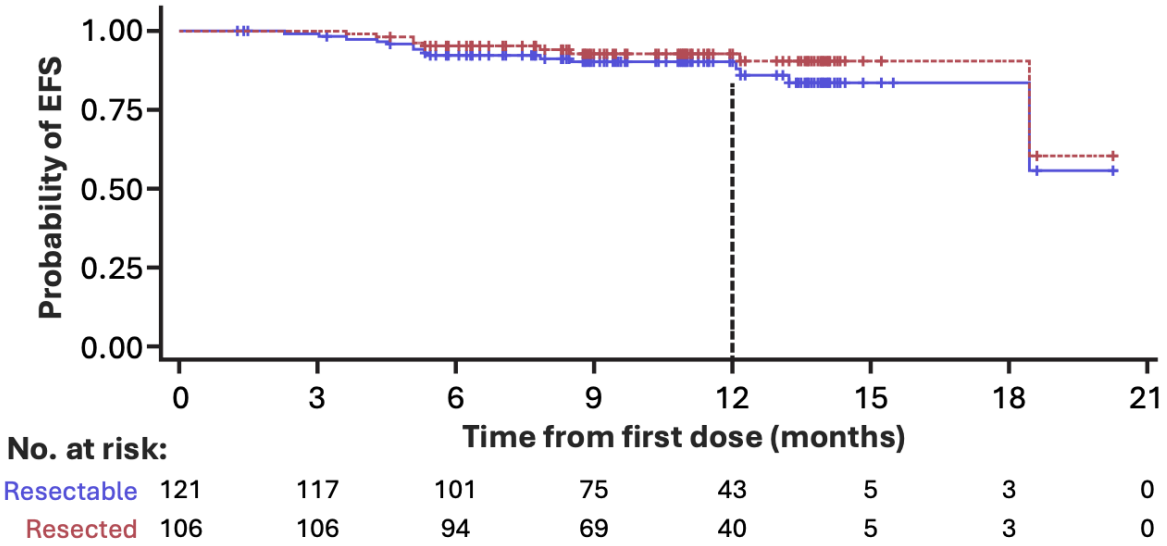
DCO, 12 January 2026. AE, adverse event; imAE, immune-mediated AE; PD, progressive disease; PI, principal investigator.

Filippi et al. Abstract LBA 05 ASTRO 2026

EFS and PFS in subgroups of interest

EFS in patients resectable at MDT reassessment and in resected patients

	Resectable	Resected
No. events / no. patients (%)	15/121 (12.4)	9/106 (8.5)
12-month EFS, % (95% CI)*	90.1 (82.8–94.4)	92.9 (85.5–96.6)

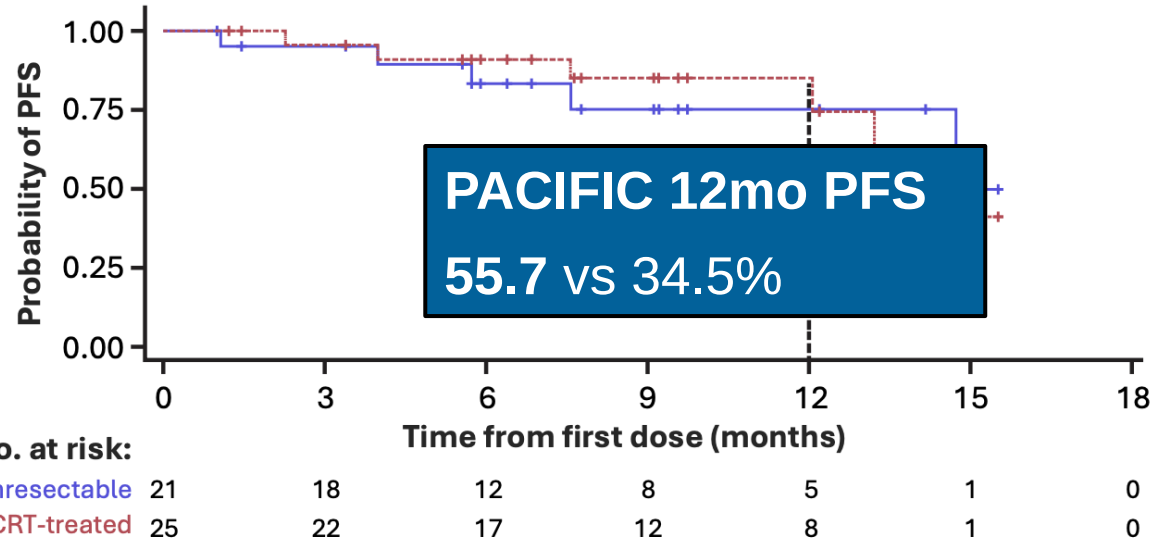


No. at risk:

Resectable	121	117	101	75	43	5	3	0
Resected	106	106	94	69	40	5	3	0

PFS in patients unresectable at MDT reassessment and in CRT-treated patients

	Unresectable	CRT-treated
No. events / no. patients (%)	5/21 (23.8)	6/25 (24.0)
12-month PFS, % (95% CI)*,†	75.1 (45.2–90.2)	85.0 (59.8–95.0)



No. at risk:

Unresectable	21	18	12	8	5	1	0
CRT-treated	25	22	17	12	8	1	0

Reck et al. Abstract 5042 WCLC 2026

Safety during CRT period (CRT-treated cohort)*

- Proportionally few patients had AEs leading to discontinuation in the CRT period
- imAEs and pneumonitis were uncommon in the CRT period

CRT period, n (%)	CRT-treated patients (n=25)
Any-grade, all-cause AEs	22 (88.0)
Maximum grade 3 or 4	7 (28.0)
Serious AE	
Outcome of death	
Leading to discontinuation of any study treatment	
Leading to dose interruption of any study treatment	
Leading to delay in RT	
Any-grade AEs, possibly related to study treatment	
Any AE possibly related to standard of care	
Any AE possibly related to RT	11 (44.0)
Any-grade immune-mediated AEs	1 (4.0)
Maximum grade 3 or 4†	0
Any-grade pneumonitis‡	2 (8.0)
Maximum grade 3 or 4¶	0

Morbidity and Mortality Conference

A Case for Caution in a New Era of Managing Patients with Locally Advanced Non-Small Cell Lung Cancer: Fatal Bronchial-Esophageal Fistula After Neoadjuvant Chemo-Immunotherapy Followed by Definitive Chemoradiation Therapy

Kaitlyn Heintzelman, BS,[a,1] John C. Knoth, MD,[a,1] Casey Mozingo, MSN, FNP-C,[a] Adrienne Duckworth, MSN, AOCNP,[b] Cody Kilar, DO, PhD,[a] David A. Clump, MD, PhD,[a] Jason Lamb, MD,[c] Mohammed Almubarak, MD,[b] and Phillip M. Pifer, MD, PhD[a,*]

Reck et al. Abstract 5042 WCLC 2026

Safety during adjuvant/consolidation durvalumab period (FAS)*

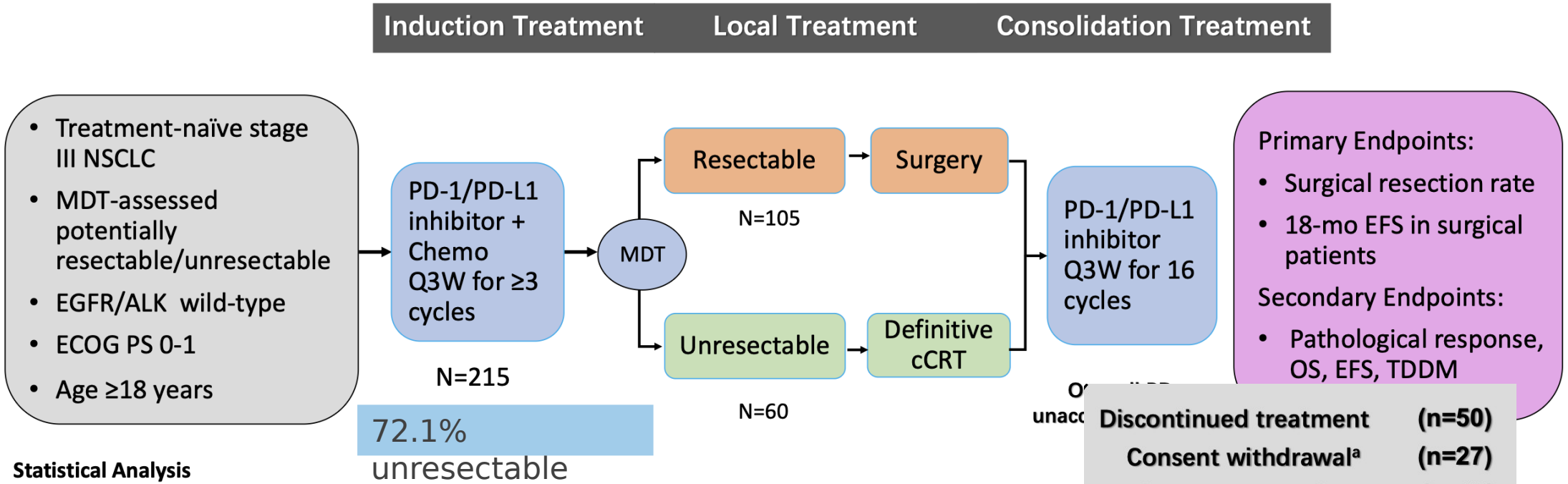
- 7.4% and 17.4% had maximum grade 3/4 AEs in the adjuvant and consolidation durvalumab periods, respectively; 8.5% and 13.0% had AEs leading to durvalumab discontinuation
- Maximum grade 3/4 imAEs and pneumonitis were uncommon in the adjuvant and consolidation periods

Adjuvant/consolidation period, n (%)	Received adjuvant durvalumab after surgery (n=94)	Received consolidation durvalumab after CRT (n=23)
Any-grade, all-cause AEs	83 (88.3)	19 (82.6)
Maximum grade 3 or 4	7 (7.4)	4 (17.4)
Serious AE	10 (10.6)	4 (17.4)
Outcome of death	0	1 (4.3)†
Leading to discontinuation of durvalumab	8 (8.5)	3 (13.0)
Any-grade AEs, possibly related to study treatment	53 (56.4)	11 (47.8)
Maximum grade 3 or 4	1 (1.1)	0
Serious AE	0	0
Outcome of death	0	0
Any-grade immune-mediated AEs	14 (14.9)	3 (13.0)
Maximum grade 3 or 4‡	1 (1.1)	0
Any-grade pneumonitis¶	6 (6.4)	2 (8.7)
Maximum grade 3 or 4§	0	0

Reck et al. Abstract 5042 WCLC 2026

CTONG 1804 Part 3

Surgical Conversion and Survival Outcomes After Induction Chemoimmunotherapy in Potentially Resectable or Unresectable Stage III NSCLC



Statistical Analysis

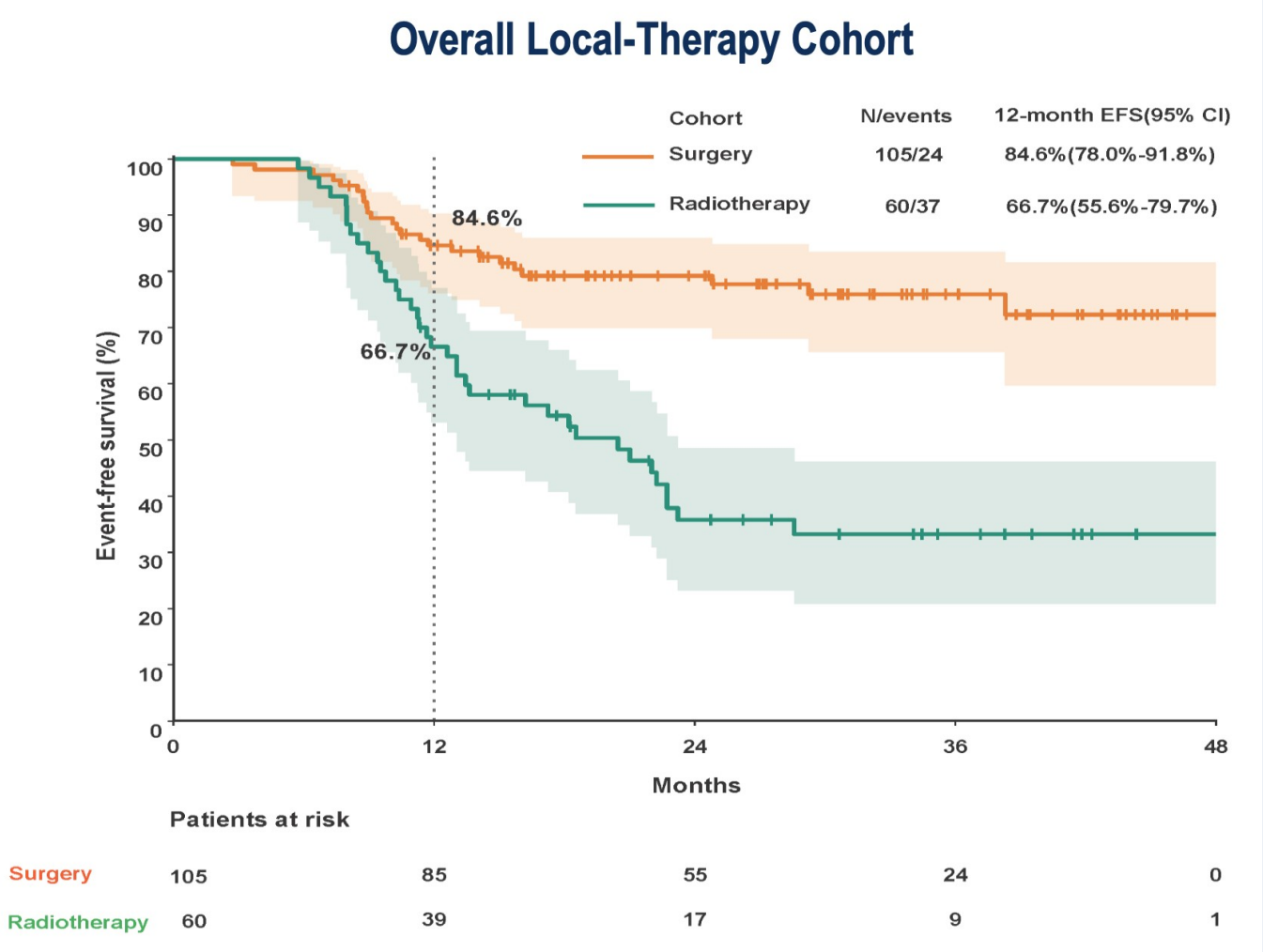
- 18-mo EFS assumption: 50% (H_0) vs 68% (H_1)*; one-sided α=0.025, power=90%; 75 surgical patients / 29 event
- Assuming a **35% resection rate**, the target enrollment was **215 patients**.

*EFS assumptions informed by PACIFIC and CheckMate 816.

NSCLC, Non-small Cell Lung Cancer; EGFR, Epidermal Growth Factor Receptor; ALK, Anaplastic Lymphoma Kinase; ECOG, Eastern Cooperative Oncology Group Performance Status; Chemo, Chemotherapy; Q3W, once every 3 weeks; MDT, Multidisciplinary Team; cCRT, Concurrent Chemoradiotherapy; EFS, Event-Free Survival; OS, Overall Survival; TDDM, Time to Death or Distant Metastasis.

Pan et al. Abstract LBA65 ESMO 2026

CTONG 1804 Part 3 – Results



Surgical conversion rate: 48.8%

R0 resection rate: 98.1%

Pneumonectomy: 1.9%

Post-op complications: 30.5.%

Grade 3+ AEs: 27.4%

Tx-related deaths: 1.9%

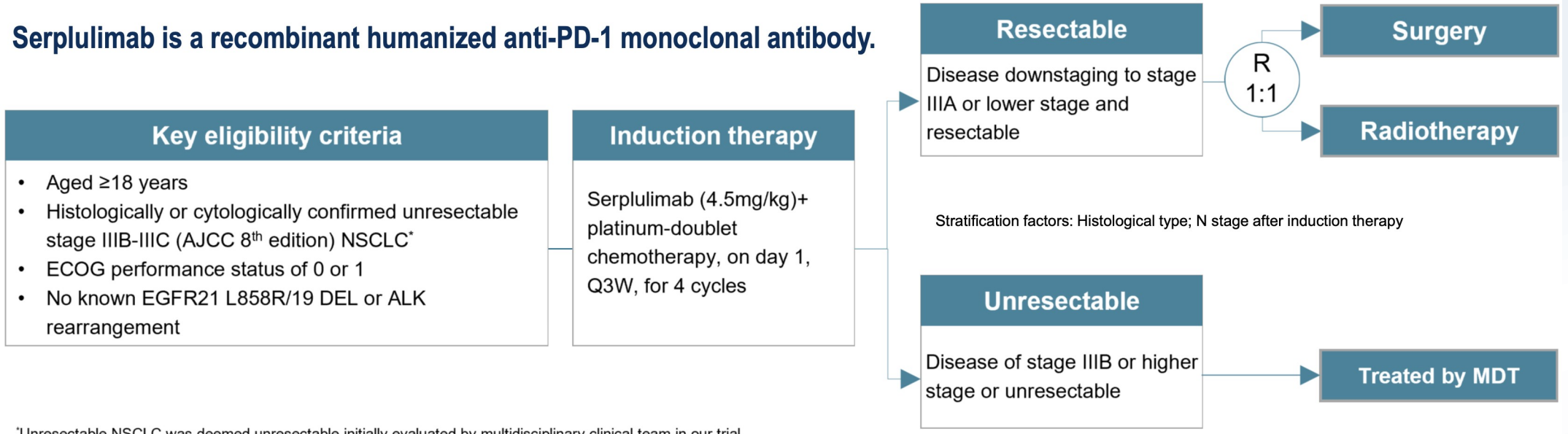
Grade 3+ pneumonitis: 3.7%

Pan et al. Abstract LBA65 ESMO 2026

LungMate-013

Surgery versus radiotherapy after induction therapy with serplulimab combined with chemotherapy for unresectable stage IIIB-IIIC NSCLC: a randomized controlled, open-label, phase 2 trial

Serplulimab is a recombinant humanized anti-PD-1 monoclonal antibody.



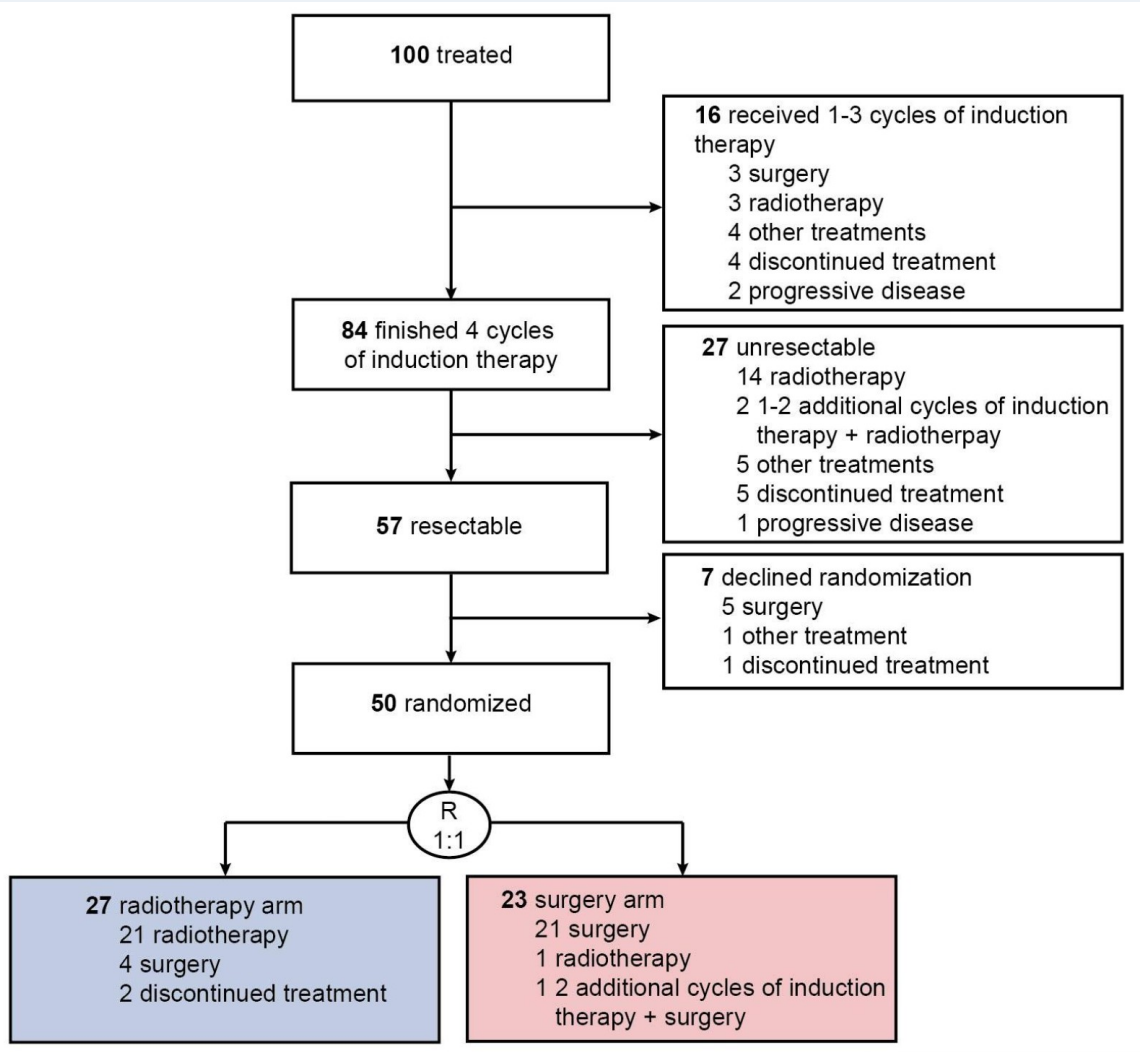
*Unresectable NSCLC was deemed unresectable initially evaluated by multidisciplinary clinical team in our trial.
#Adenocarcinoma: carboplatin AUC 5 and pemetrexed 500 mg/m^2 on day 1; Squamous cell carcinoma or other NSCLCs: carboplatin AUC 5 on day 1 and nab-paclitaxel 260 mg/m^2 on day 1(or liposomal paclitaxel 135 mg/m^2 on day 1).

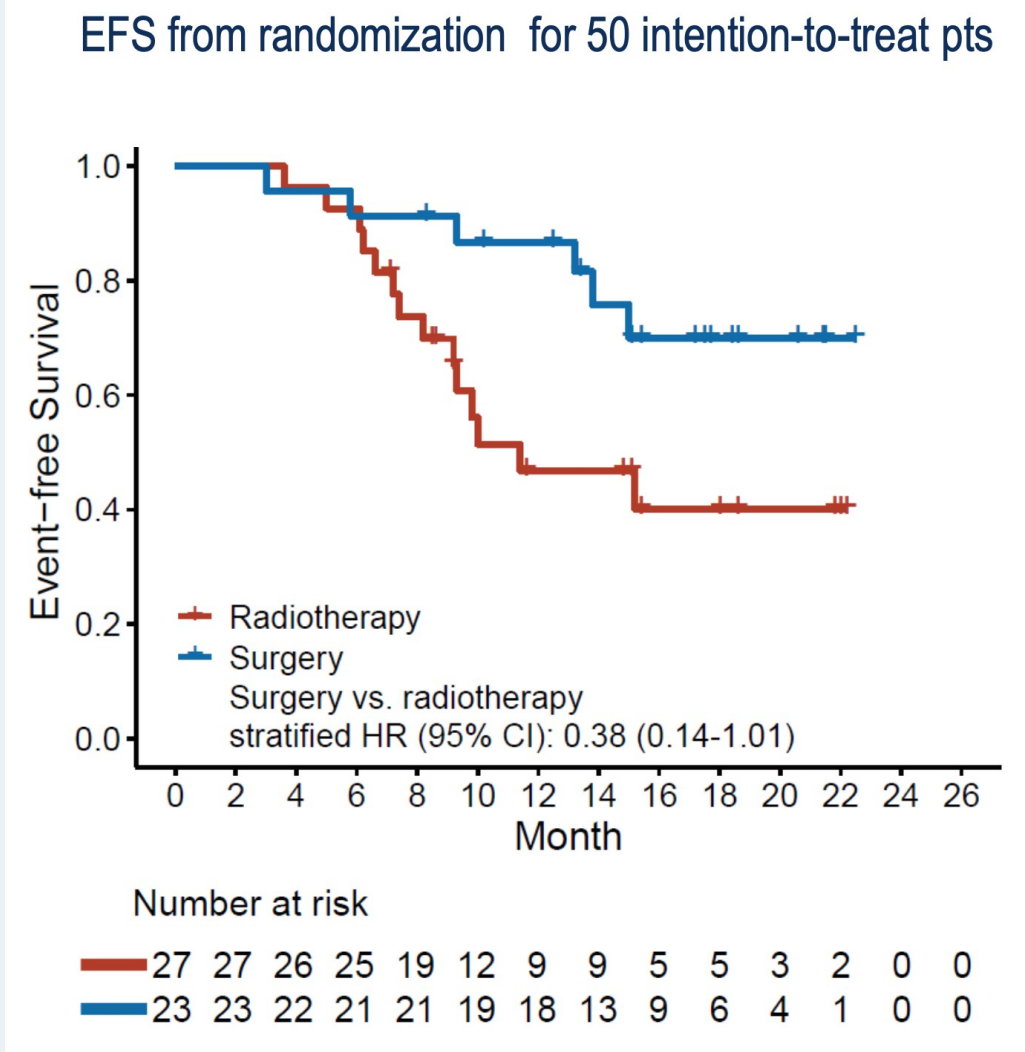
Primary endpoint: Event-free-survival (EFS)

Second endpoints: EFS-from-randomization (EFS-FR) and OS-from-randomization (OS-FR) in randomized population; objective response rate (ORR) after induction therapy; major pathological response (MPR) in the surgery population; overall survival (OS); resectable conversion rate; R0 resection rate; safety; Health-Related Quality of Life (HRQoL).

Wang et al. Abstract 1818 ESMO 2025

LungMate-013 Results





Wang et al. Abstract 1818 ESMO 2025

Take Home Points

- PACIFIC regiment is standard of care for locally-advanced unresectable stage III NSCLC without driver mutations
- Investigations on advanced radiotherapy technology are ongoing
  - Dose escalation with modern techniques, SBRT, proton therapy
- Novel targets are being evaluated by building upon the PACIFIC regiment
  - Monalizumab (NKG2A), oleclumab (CD73), olaparib (PARPi), domvanalimab (TIGIT), olomorasib (KRAS G12C)
- Induction chemoimmunotherapy with or without re-assessment for resectability is an emerging strategy under active investigation



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