ELCC 2026 Industry Satellite Symposium

# Collaborate to innovate in the MDT: Unlocking the potential of immunotherapy in resectable NSCLC

Friday, March 27, 2026 | 16:45–17:45 CET
Copenhagen, Denmark


ELCC, European Lung Cancer Congress; MDT, multidisciplinary team; NSCLC, non–small cell lung cancer.
March 2026 | 0126-BGB-A317-MRC-024

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# Disclosures

**Consultancy and speaker fees**

- AstraZeneca, BeOne Medicines, Boehringer Ingelheim, Daiichi Sankyo, Gilead, Pfizer, Regeneron, Takeda

**Meeting or travel support**

- Daiichi Sankyo, Pfizer, Takeda

**Grants**

- AstraZeneca, Gilead

# Faculty

## Chair

**Martin Sebastian**
Medical oncologist
*Frankfurt University Hospital, Germany*

## Speakers

**Jean Y Perentes**
Thoracic surgeon
*Lausanne University Hospital (CHUV), Switzerland*

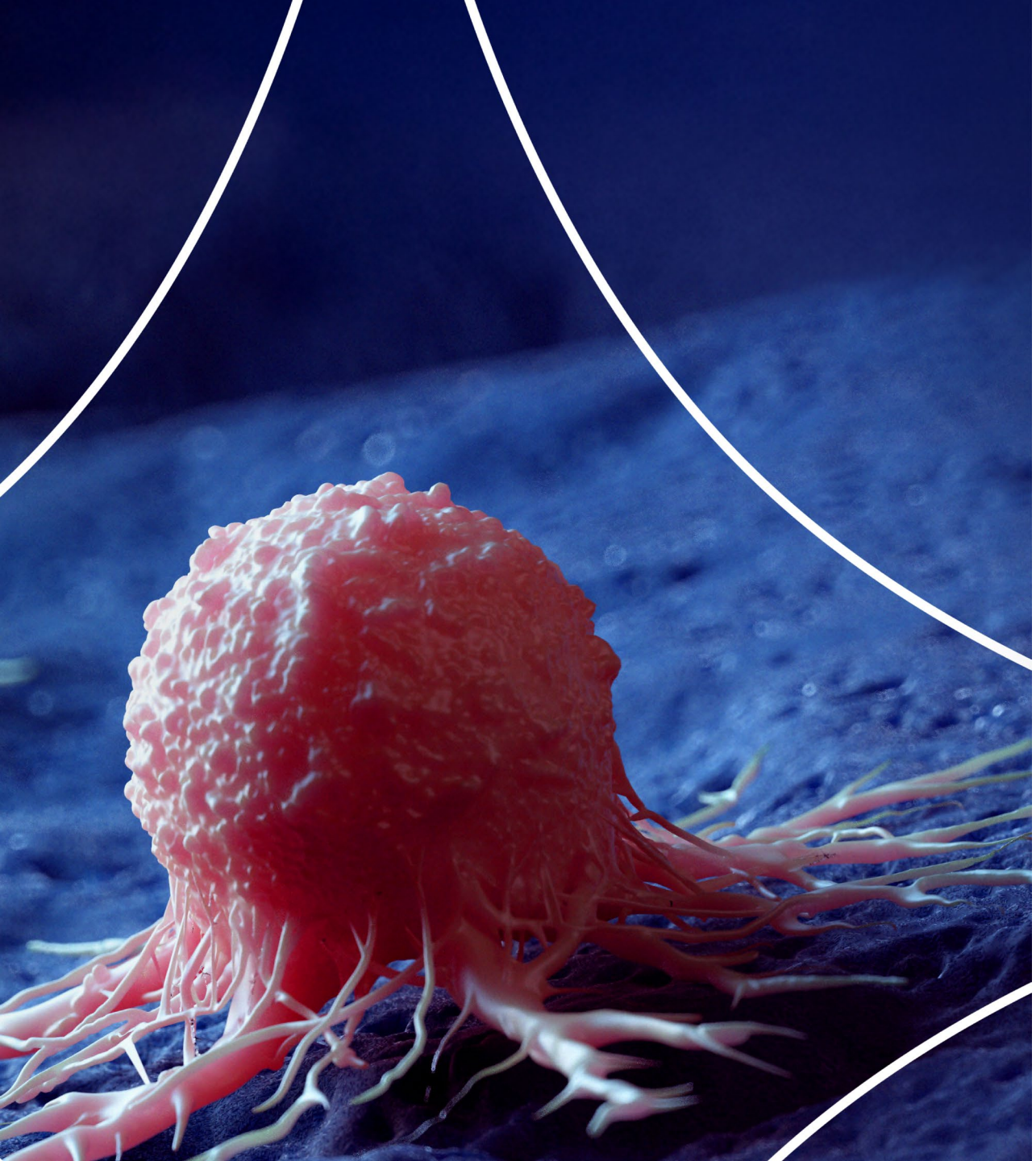
**Umberto Malapelle**
Molecular pathologist
*University of Naples Federico II, Italy*

# Agenda

## Collaborate to innovate in the MDT: Unlocking the potential of immunotherapy in resectable NSCLC

| Time (CET) | Session | Faculty |
|---|---|---|
| 16:45–17:05 | **How do advances in the treatment landscape inform treatment selection?** | Martin Sebastian **(Chair)** |
| 17:05–17:20 | **How do the latest data inform the surgical approach?** | Jean Y Perentes |
| 17:20–17:35 | **Which key factors may inform the de-escalation/escalation of treatment?** | Umberto Malapelle |
| 17:35–17:45 | **MDT perspectives: How may the optimal treatment approach evolve in the future?** | All faculty |

MDT, multidisciplinary team; NSCLC, non–small cell lung cancer.



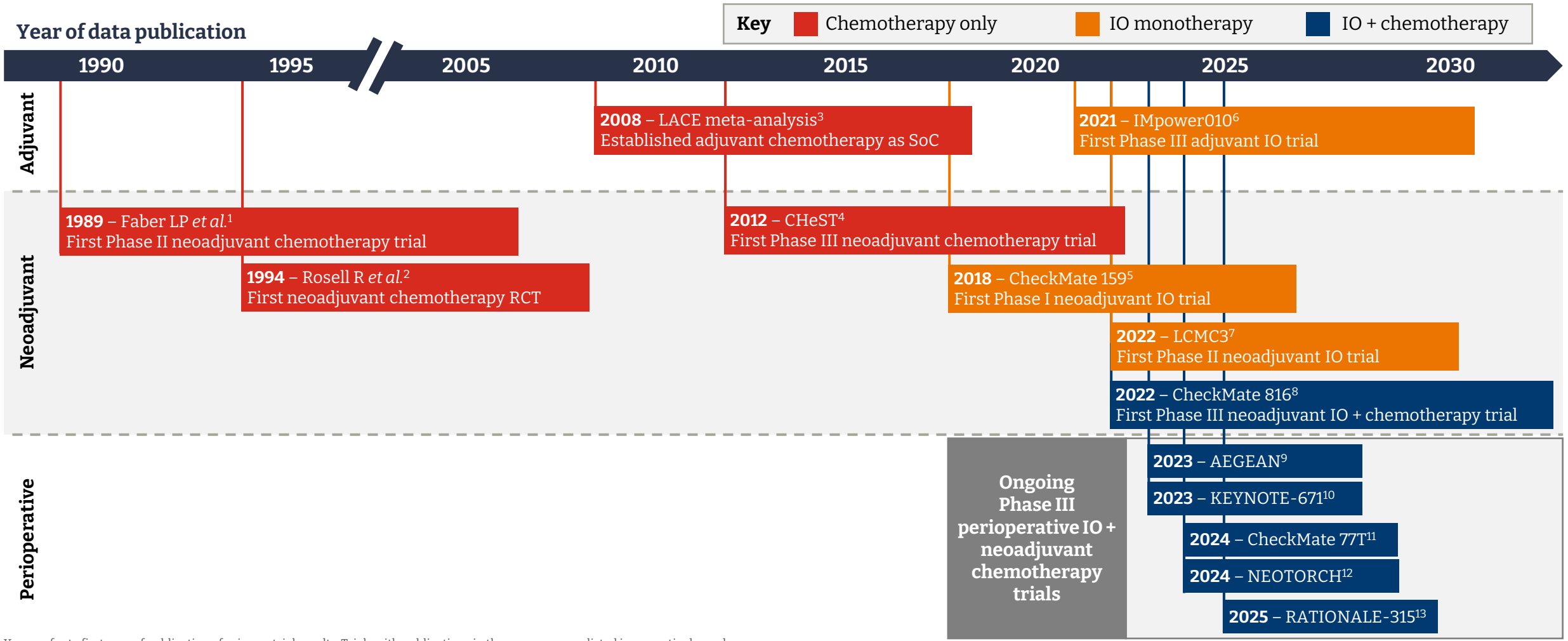
COLLABORATE TO INNOVATE IN THE MDT: UNLOCKING THE POTENTIAL OF IMMUNOTHERAPY IN RESECTABLE NSCLC

# How do advances in the treatment landscape inform treatment selection?

Martin Sebastian
Frankfurt University Hospital, Germany

MDT, multidisciplinary team; NSCLC, non–small cell lung cancer.

# Neoadjuvant chemotherapy was first investigated in lung cancer in 1989, laying the foundation for IO in the neoadjuvant and perioperative settings



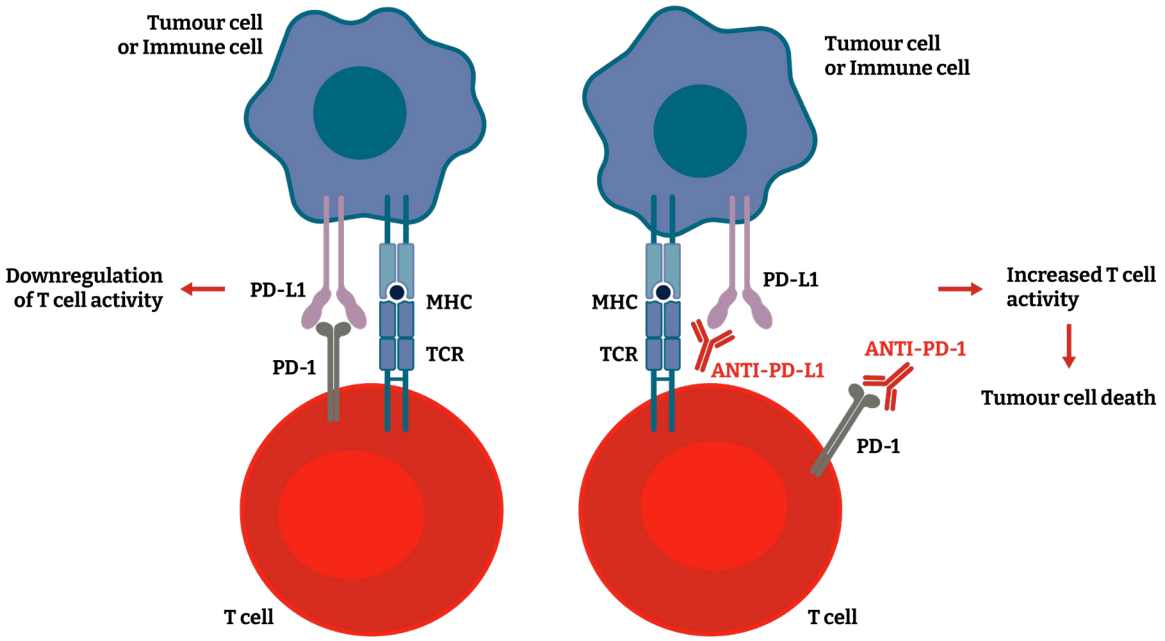

Years refer to first year of publication of primary trial results. Trials with publications in the same year are listed in no particular order.

IO, immunotherapy; RCT, randomized controlled trial; SoC, standard of care.

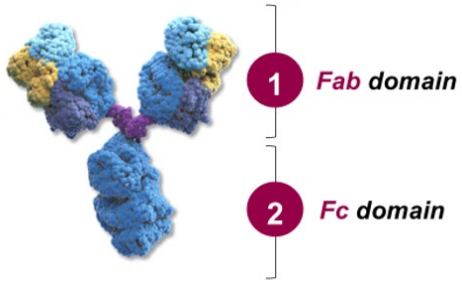

1. Faber LP *et al. Ann Thorac Surg* 1989; 47 (5): 669–675. 2. Rosell R *et al. N Engl J Med* 1994; 330 (3): 153–158. 3. Pignon JP *et al. J Clin Oncol* 2008; 26 (21): 3552–3559. 4. Scagliotti GV *et al. J Clin Oncol* 2012; 30 (2): 172–178. 5. Forde PM *et al. N Engl J Med* 2018; 378 (21): 1976–1986. 6. Felip E *et al. Lancet* 2021; 398 (10308): 1344–1357. 7. Chaft JE *et al. Nat Med* 2022; 28 (10): 2155–2161. 8. Forde PM *et al. N Engl J Med* 2022; 386 (21): 1973–1985. 9. Heymach JV *et al. N Engl J Med* 2023; 389 (18): 1672–1684. 10. Wakelee H *et al. N Engl J Med* 2023; 389 (6): 491–503. 11. Cascone T *et al. N Engl J Med* 2024; 390 (19): 1756–1769. 12. Lu S *et al. JAMA* 2024; 331 (3): 201–211. 13. Yue D *et al. Lancet Respir Med* 2025; 13 (2): 119–129.

# PD-1/PD-L1 inhibitors block PD-1/PD-L1 binding, increasing T cell activity

## PD-1/PD-L1 inhibitor mechanism of action[1]




## Tislelizumab was designed to continuously block PD-1/PD-L1 and reduce macrophage binding*,[2,3]




1. Tislelizumab completely blocks PD-L1 binding to PD-1 and has demonstrated **high target affinity and slow dissociation rate** from PD-1 in mouse models[2]

2. Tislelizumab was specifically engineered to **minimize binding to FcγR on macrophages,** which may abrogate T cell clearance, allowing T cells to remain activated and maintain effector functions[3,4]

*Results from preclinical studies using mouse models.

Fab, antigen-binding fragment; Fc, fragment crystallizable; FcγR, Fc-gamma receptor; MHC, major histocompatibility complex; PD-1, programmed cell death protein-1; PD-L1, programmed death-ligand 1; TCR, T-cell receptor.

1. Modified from: Alard E *et al. Cancers (Basel)* 2020; 12 (7): 1826. 2. Hong Y *et al. FEBS Open Bio* 2021; 11 (3): 782–792. 3. Dahan R *et al. Cancer Cell* 2015; 28 (3): 285–295. 4. Arlauckas SP *et al. Sci Transl Med* 2017; 9 (389): eaal3604.



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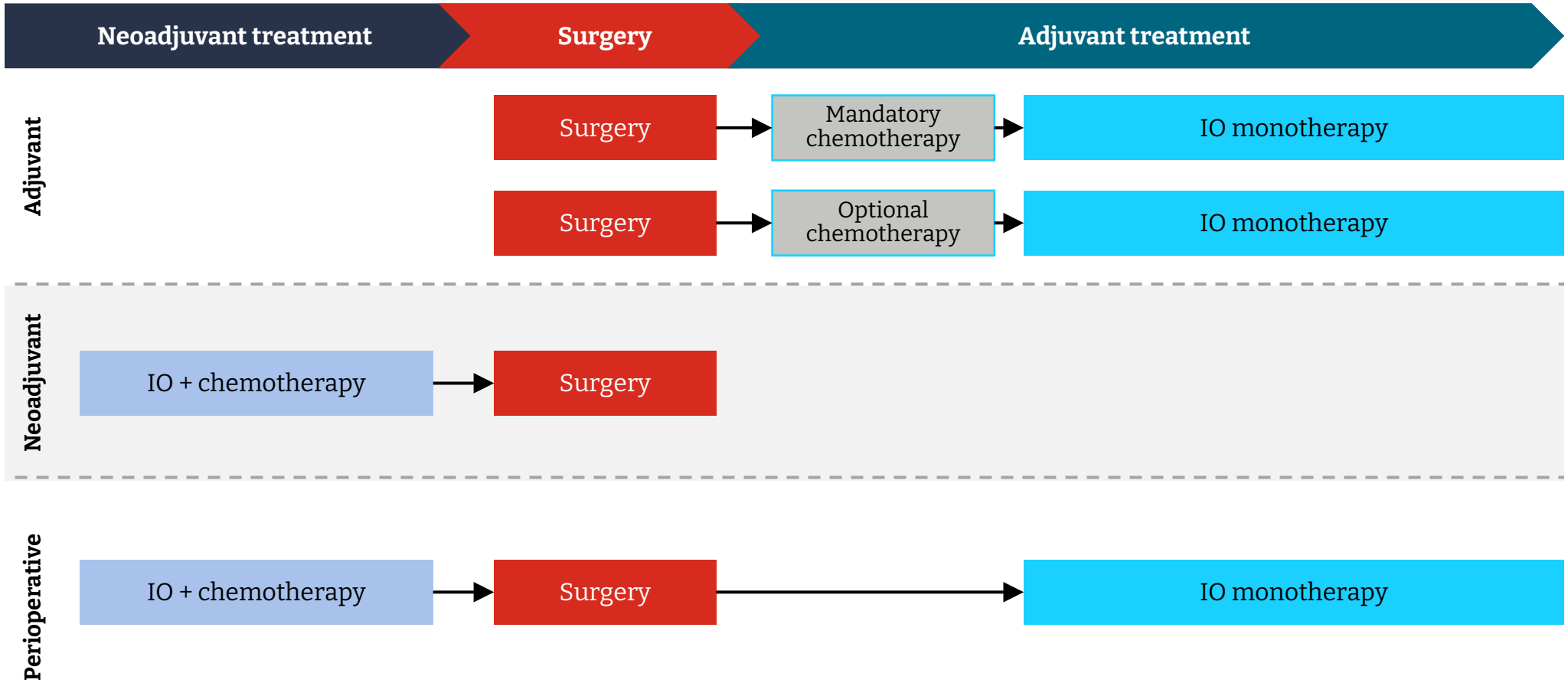
# The optimal timing of IO is currently being investigated for resectable NSCLC

**Key** ✓ Positive readout × Negative readout

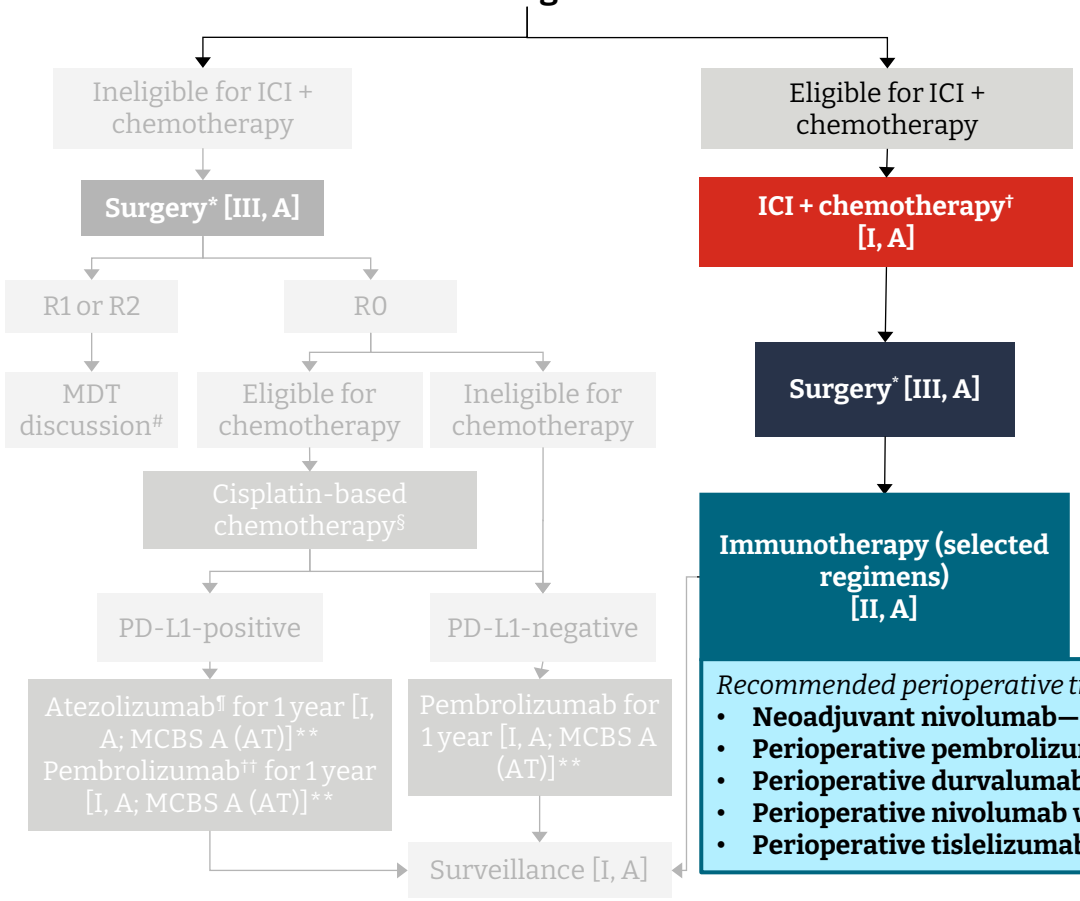



IO, immunotherapy; NSCLC, non–small cell lung cancer.

1. Felip E *et al. Lancet* 2021; 398 (10308): 1344–1357. 2. O'Brien M *et al. Lancet Oncol* 2022; 23 (10): 1274–1286. 3. AstraZeneca press release. Update on ADJUVANT BR.31 Phase III trial of Imfinzi in non–small cell lung cancer. Available at: https://www.astrazeneca.com/media-centre/press-releases/2024/update-on-imfinzi-adjuvant-br31-trial.html. Accessed January 2026. 4. Forde PM *et al. N Engl J Med* 2022; 386 (21): 1973–1985. 5. Heymach JV *et al. N Engl J Med* 2023; 389 (18): 1672–1684. 6. Cascone T *et al. N Engl J Med* 2024; 390 (19): 1756–1769. 7. Wakelee H *et al. N Engl J Med* 2023; 389 (6): 491–503. 8. Lu S *et al. JAMA* 2024; 331 (3): 201–211. 9. Yue D *et al. Lancet Respir Med* 2025; 13 (2): 119–129.

# ESMO treatment guidelines recommend neoadjuvant and perioperative IO regimens for the treatment of resectable NSCLC

**ESMO guidelines for treatment of resectable Stage II–III NSCLC without actionable genomic markers**




## Key decision points for MDT discussion

1. Eligibility for neoadjuvant IO + chemotherapy
2. Eligibility for surgery
3. Eligibility for adjuvant IO

*Recommended perioperative treatment options:*

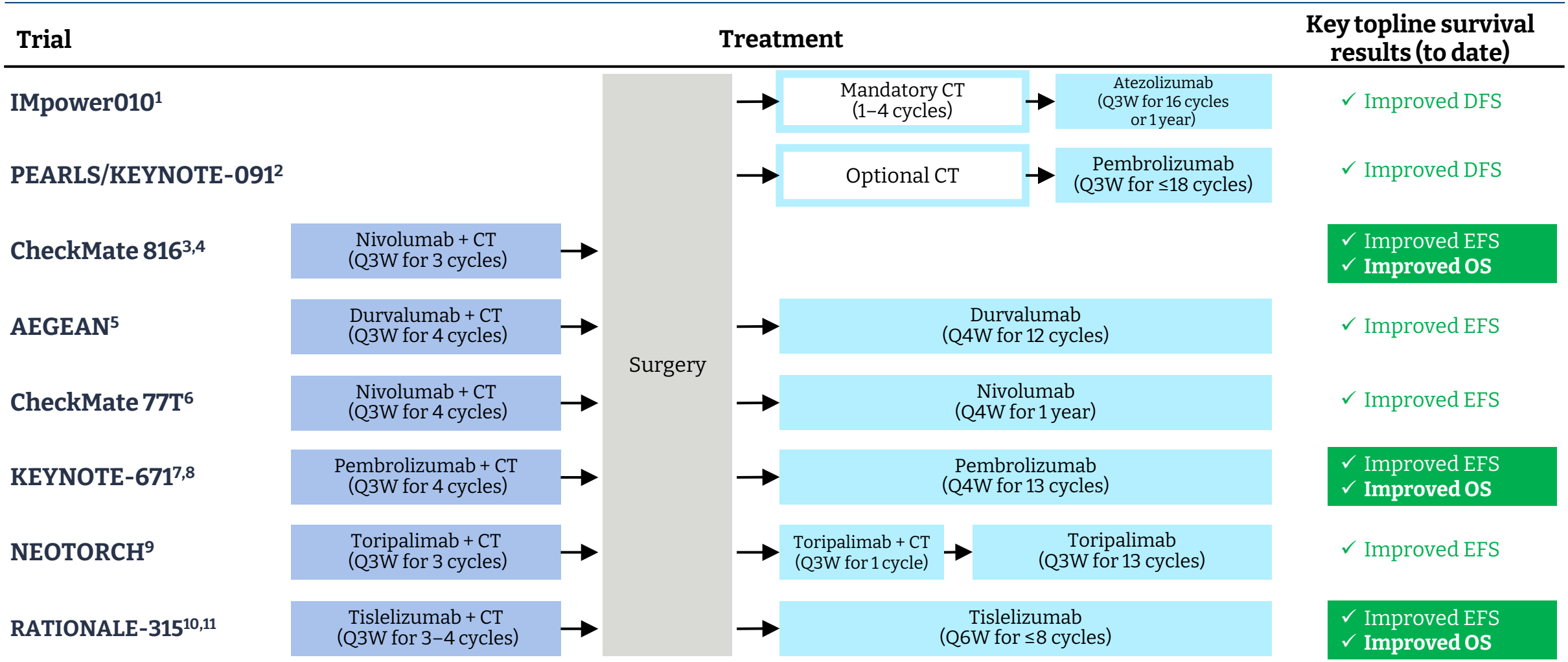
- **Neoadjuvant nivolumab—ChT** [I, A; ESMO-MCBS v2.0 score: A (AT); FDA approved, EMA approved for PD-L1 TC ≥1%]
- **Perioperative pembrolizumab with neoadjuvant ChT** [I, A; ESMO-MCBS v2.0 score: A (AT); EMA and FDA approved]
- **Perioperative durvalumab with neoadjuvant ChT** [I, A; ESMO-MCBS v2.0 score: A (AT) ; EMA and FDA approved]
- **Perioperative nivolumab with neoadjuvant ChT** [I, A; ESMO-MCBS v2.0 score: A (AT); FDA approved, EMA approved for PD-L1 TC ≥1%]
- **Perioperative tislelizumab with neoadjuvant ChT** [I, A; ESMO-MCBS v2.0 score: A (AT); EMA approved, not FDA approved]

*Anatomical resection is preferred over wedge resection [I, A]; three mediastinal and three hilar lymph node stations should be dissected [III, A]; VATS or RATS is recommended for Stage II tumors [I, A]; minimally invasive approaches may be considered for resectable Stage III tumors, according to the surgeon's experience [V, C]. †Options: neoadjuvant nivolumab—ChT [I, A; ESMO-MCBS v2.0 score: A (AT); FDA approved, EMA approved for PD-L1 TC ≥1%]; neoadjuvant pembrolizumab—ChT followed by adjuvant pembrolizumab [I, A; ESMO-MCBS v2.0 score: A (AT)]; neoadjuvant durvalumab—ChT followed by adjuvant durvalumab [I, A; ESMO-MCBS v2.0 score: A (AT)]; neoadjuvant nivolumab—ChT followed by adjuvant nivolumab [I, A; ESMO-MCBS v2.0 score: A (AT); FDA approved, EMA approved for PD-L1 TC ≥1%]; neoadjuvant tislelizumab—ChT followed by adjuvant tislelizumab [I, A; ESMO-MCBS v2.0 score: A (AT); EMA approved, not FDA approved]. #In R1 and R2 resections, an MDT discussion is indicated for consideration of re-resection or incorporation of adjuvant ChT, PORT or definitive CRT. §Carboplatin-based regimens can be recommended for patients who are not eligible for cisplatin (e.g. renal, neurological or other contraindication) [II, B]. ¶FDA approved for tumors with PD-L1 TC ≥1%, EMA approved for tumors with PD-L1 TC ≥50%. **ESMO-MCBS v2.0 was used to calculate scores for therapies/indications approved by the EMA or FDA. The scores have been calculated and validated by the ESMO-MCBS Working Group and reviewed by the authors (https://www.esmo.org/guidelines/esmo-mcbs/esmo-mcbs-evaluation-forms). ††EMA and FDA approved after platinum-based ChT.

ChT, chemotherapy; CRT, chemoradiotherapy; EMA, European Medicines Agency; ESMO, European Society for Medical Oncology; FDA, Food and Drug Administration; ICI, immune checkpoint inhibitor; IO, immunotherapy; MCBS, magnitude of clinical benefit scale; MDT, multidisciplinary team; NSCLC, non–small cell lung cancer; PD-L1, programmed death-ligand 1; PORT, postoperative radiotherapy; R0, no tumor at the margin; R1, microscopic tumor at the margin; R2, macroscopic tumor at the margin; RATS, robotic-assisted thoracoscopic surgery; TC, tumor cell; VATS, video-assisted thoracoscopic surgery.

Zer A *et al. Ann Oncol* 2025; 36 (11): 1245–1262.

# To date, the CheckMate 816, KEYNOTE-671, and RATIONALE-315 trials have reported positive OS results

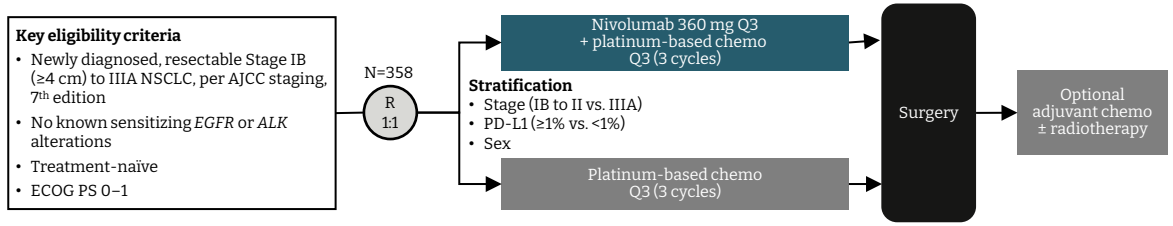



CT, chemotherapy; DFS, disease-free survival; EFS, event-free survival; OS, overall survival; PFS, progression-free survival; QXW, every X weeks.

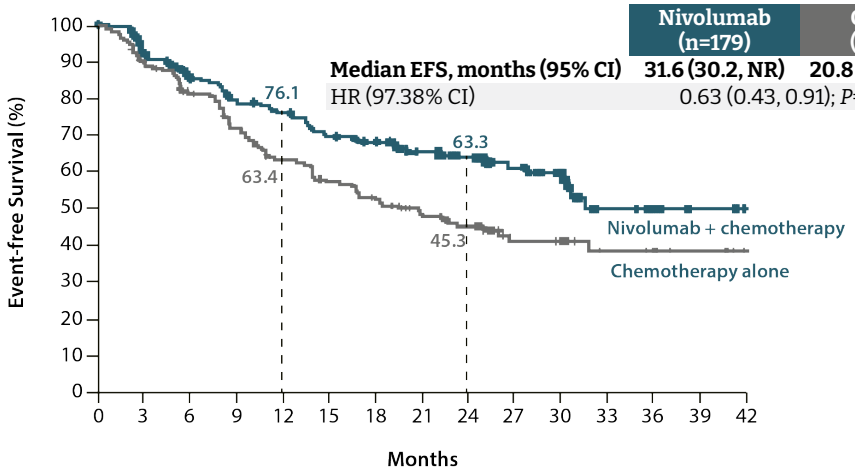
1. Felip E *et al. Lancet* 2021; 398 (10308): 1344–1357. 2. O'Brien M *et al. Lancet Oncol* 2022; 23 (10): 1274–1286. 3. Forde PM *et al. N Engl J Med* 2022; 386 (21): 1973–1985. 4. Forde PM *et al. N Engl J Med* 2025; 393 (8): 741–752. 5. Heymach JV *et al. N Engl J Med* 2023; 389 (18): 1672–1684. 6. Cascone T *et al. N Engl J Med* 2024; 390 (19): 1756–1769. 7. Wakelee H *et al. N Engl J Med* 2023; 389 (6): 491–503. 8. Spicer J *et al. Lancet* 2024; 404 (10459): 1240–1252. 9. Lu S *et al. JAMA* 2024; 331 (3): 201–211. 10. Yue D *et al. Lancet Respir Med* 2025; 13 (2): 119–129. 11. Wang C *et al. Ann Oncol* 2025; Digital ahead of print. DOI: https://doi.org/10.1016/j.annonc.2025.11.017.

# The neoadjuvant approach: CheckMate 816 investigated neoadjuvant IO in resectable NSCLC

## CheckMate 816 study design[1]




## CheckMate 816: EFS at primary analysis*,[1]

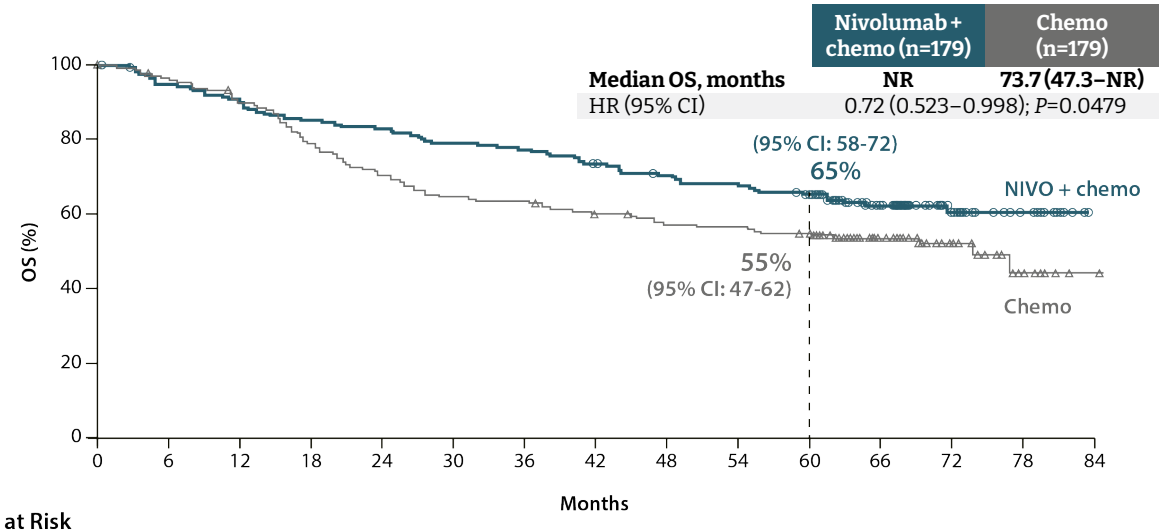



| | Nivolumab (n=179) | Chemo (n=179) |
|---|---|---|
| **Median EFS, months (95% CI)** | **31.6 (30.2, NR)** | **20.8 (14.0, 26.7)** |
| HR (97.38% CI) | 0.63 (0.43, 0.91); *P*=0.005 | |

No. at Risk

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nivolumab plus chemotherapy | 179 | 151 | 136 | 124 | 118 | 107 | 102 | 87 | 74 | 41 | 34 | 13 | 6 | 3 | 0 |
| Chemotherapy alone | 179 | 144 | 126 | 109 | 94 | 83 | 75 | 61 | 52 | 26 | 24 | 13 | 11 | 4 | 0 |

## CheckMate 816: Final (5-year) OS†,[2]




| | Nivolumab + chemo (n=179) | Chemo (n=179) |
|---|---|---|
| **Median OS, months** | **NR** | **73.7 (47.3–NR)** |
| HR (95% CI) | 0.72 (0.523–0.998); *P*=0.0479 | |

No. at Risk

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nivo+ chemo | 179 | 168 | 159 | 151 | 147 | 140 | 137 | 129 | 122 | 117 | 111 | 67 | 29 | 9 | 0 |
| Chemo | 179 | 170 | 159 | 139 | 124 | 115 | 112 | 104 | 98 | 97 | 91 | 58 | 29 | 6 | 1 |

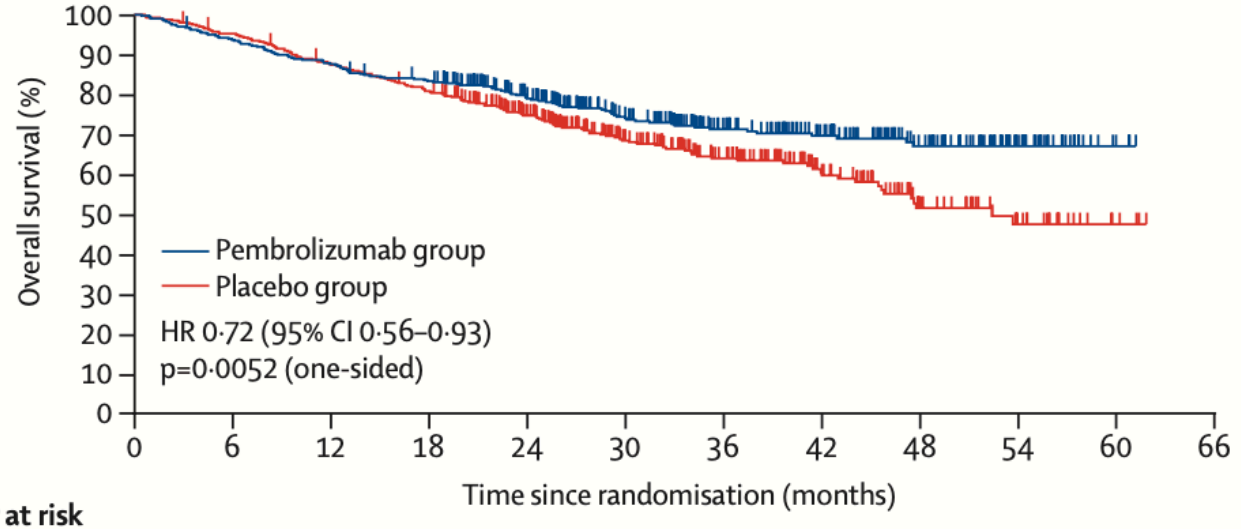
*Median follow-up: 29.5 months. †Minimum/median follow-up: 59.9/68.4 months.

AJCC, American Joint Committee on Cancer; chemo, chemotherapy; CI, confidence interval; ECOG PS, Eastern Cooperative Oncology Group Performance Status; EFS, event-free survival; HR, hazard ratio; IO, immunotherapy; NR, not reached; NSCLC, non–small cell lung cancer; OS, overall survival; PD-L1, programmed death-ligand 1; Q3, every 3 weeks; R, randomization.

1. Forde PM *et al. N Engl J Med* 2022; 386 (21): 1973–1985. 2. Forde PM et al. Oral presentation at ASCO 2025; Chicago, IL, USA, May 30 – June 3, 2025.

# The perioperative approach: KEYNOTE-671 was the first trial to demonstrate improved OS with perioperative IO + chemotherapy

## KEYNOTE-671: OS in the ITT population (second interim analysis)




| Number at risk (number censored) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pembrolizumab group | 397 (0) | 371 (1) | 347 (1) | 327 (4) | 277 (38) | 205 (95) | 148 (145) | 108 (182) | 69 (218) | 32 (255) | 4 (283) | 0 (287) |
| Placebo group | 400 (0) | 379 (2) | 347 (4) | 319 (5) | 256 (45) | 176 (106) | 125 (147) | 77 (190) | 39 (219) | 20 (236) | 4 (252) | 0 (256) |

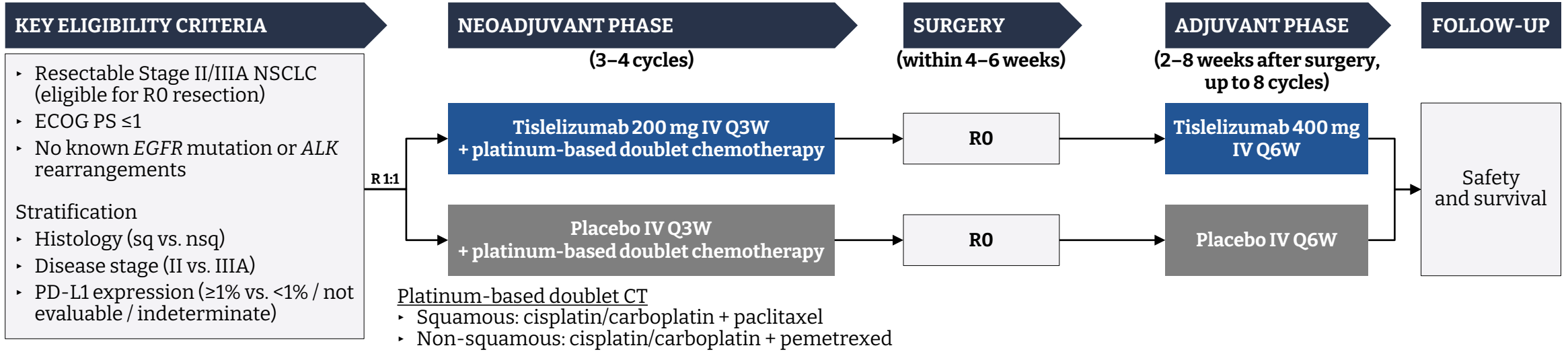
Median follow-up: 36.6 months. Tick marks indicate censored data.
CI, confidence interval; HR, hazard ratio; IO, immunotherapy; ITT, intention-to-treat; OS, overall survival.
Spicer JD *et al. Lancet* 2024; 404 (10459): 1240–1252.

# RATIONALE-315 is a Phase III trial of perioperative tislelizumab + neoadjuvant chemotherapy in resectable Stage II–IIIA NSCLC

## RATIONALE-315 trial design[1,2]

**Study identifier:**
RATIONALE-315,
NCT04379635

**Primary endpoint:** MPR rate by BIPR and EFS by BICR in ITT set
**Key secondary endpoints:** pCR, OS, ORR, INV-assessed EFS, HRQOL, safety
**Exploratory endpoint:** Surgical outcomes

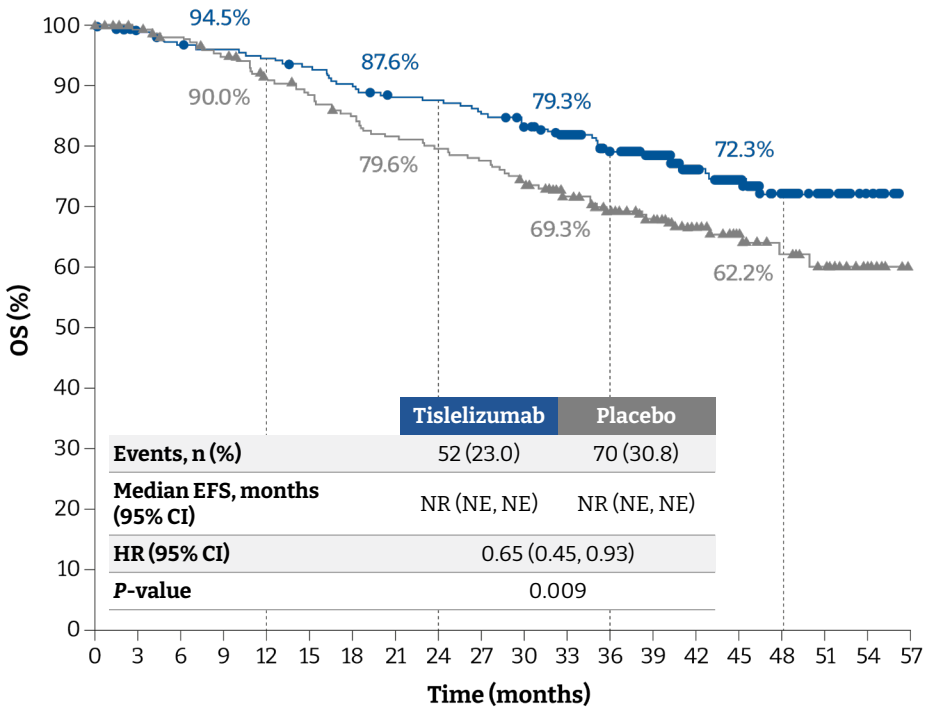



BICR, blinded independent central review; BIPR, blinded independent pathology review; CT, chemotherapy; ECOG PS, Eastern Cooperative Oncology Group Performance Status; EFS, event-free survival; HRQOL, health-related quality of life; INV, investigator; ITT, intention-to-treat; IV, intravenous; MPR, major pathologic response; NSCLC, non–small cell lung cancer; nsq, non-squamous; ORR, objective response rate; OS, overall survival; pCR, pathologic complete response; PD-L1, programmed death-ligand 1; QXW, every X weeks; R, randomized; R0, no tumor at the margin; ; sq, squamous.

1. ClinicalTrials.gov. Available at: https://clinicaltrials.gov/ct2/show/NCT04379635. Accessed April 2025; 2. Yue D *et al.* Oral presentation at ESMO 2023; Madrid, Spain, October 20–24, 2023.

# In RATIONALE-315, tislelizumab + chemotherapy led to statistically significant and clinically meaningful improved OS

## OS in the ITT population (final analysis)*

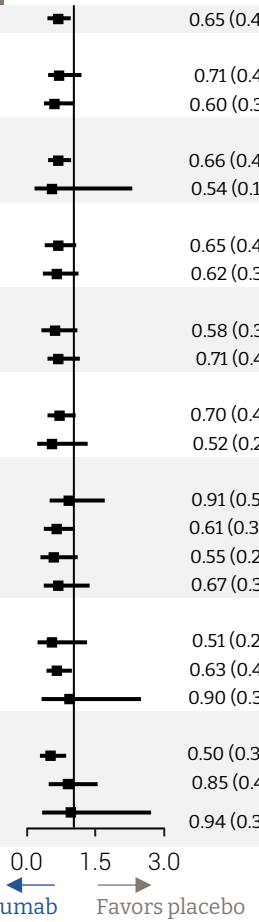



| | Tislelizumab | Placebo |
|---|---|---|
| **Events, n (%)** | 52 (23.0) | 70 (30.8) |
| **Median EFS, months (95% CI)** | NR (NE, NE) | NR (NE, NE) |
| **HR (95% CI)** | 0.65 (0.45, 0.93) | |
| ***P*-value** | 0.009 | |

**No. at risk**

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Tislelizumab | 226 | 218 | 212 | 209 | 206 | 202 | 195 | 189 | 188 | 183 | 176 | 163 | 143 | 121 | 91 | 69 | 47 | 36 | 15 | 0 |
| Placebo | 227 | 214 | 207 | 199 | 186 | 180 | 172 | 165 | 161 | 157 | 148 | 131 | 117 | 98 | 73 | 51 | 34 | 26 | 9 | 0 |

| | Tislelizumab, n/N | Placebo, n/N | Tislelizumab, median (95% CI) | Placebo, median (95% CI) | Hazard ratio (95% CI) |
|---|---|---|---|---|---|
| Overall | 52/226 | 70/227 | NR (NE, NE) | NR (NE, NE) | 0.65 (0.45, 0.93) |
| Age group | | | | | |
| <65 years | 31/143 | 34/129 | NR (NE, NE) | NR (NE, NE) | 0.71 (0.44, 1.16) |
| ≥65 years | 21/83 | 36/98 | NR (NE, NE) | NR (38.3, NE) | 0.60 (0.35, 1.03) |
| Sex | | | | | |
| Male | 49/205 | 65/205 | NR (NE, NE) | NR (NE, NE) | 0.66 (0.45, 0.95) |
| Female | 3/21 | 5/22 | NR (NE, NE) | NR (49.8, NE) | 0.54 (0.13, 2.26) |
| ECOG Performance Status | | | | | |
| 0 | 28/142 | 41/154 | NR (NE, NE) | NR (NE, NE) | 0.65 (0.40, 1.05) |
| 1 | 24/83 | 29/73 | NR (NE, NE) | NR (30.9, NE) | 0.62 (0.36, 1.07) |
| Disease stage at baseline | | | | | |
| II | 17/92 | 26/91 | NR (NE, NE) | NR (NE, NE) | 0.58 (0.31, 1.06) |
| IIIA | 35/132 | 43/133 | NR (NE, NE) | NR (49.8, NE) | 0.71 (0.46, 1.11) |
| Histologic subtype | | | | | |
| Squamous | 45/179 | 55/175 | NR (NE, NE) | NR (47.7, NE) | 0.70 (0.47, 1.04) |
| Non-squamous | 7/45 | 13/50 | NR (NE, NE) | NR (49.8, NE) | 0.52 (0.21, 1.30) |
| PD-L1 TC expression | | | | | |
| <1% (excluding NE/indeterminate) | 22/89 | 22/84 | NR (NE, NE) | NR (NE, NE) | 0.91 (0.50, 1.64) |
| ≥1% | 29/130 | 41/132 | NR (NE, NE) | NR (47.7, NE) | 0.61 (0.38, 0.98) |
| 1%-49% | 14/59 | 23/70 | NR (NE, NE) | NR (40.4, NE) | 0.55 (0.28, 1.08) |
| ≥50% | 15/71 | 18/62 | NR (NE, NE) | NR (47.7, NE) | 0.67 (0.34, 1.34) |
| Smoking status | | | | | |
| Current | 7/45 | 13/52 | NR (NE, NE) | NR (47.7, NE) | 0.51 (0.20, 1.28) |
| Former | 38/148 | 49/138 | NR (NE, NE) | NR (42.9, NE) | 0.63 (0.41, 0.96) |
| Never | 7/33 | 8/37 | NR (42.6, NE) | NR (49.8, NE) | 0.90 (0.33, 2.48) |
| Neoadjuvant platinum chemotherapy | | | | | |
| Cisplatin | 23/120 | 40/124 | NR (NE, NE) | NR (47.7, NE) | 0.50 (0.30, 0.83) |
| Carboplatin | 22/80 | 23/76 | NR (45.2, NE) | NR (NE, NE) | 0.85 (0.47, 1.52) |
| Switched from cisplatin to carboplatin | 7/25 | 7/25 | NR (35.0, NE) | NR (40.4, NE) | 0.94 (0.33, 2.69) |




Median follow-up: 38.5 months (range: 0.1–57.0).

*Kaplan–Meier curve: HRs and their 95% CIs were estimated using a Cox regression model stratified by histology (squamous vs. non-squamous), disease stage (Stage II vs. Stage IIIA), and PD-L1 TC expression (≥1% vs. <1% / not evaluable / indeterminate) per interactive response technology. The circle and triangle symbols indicate censored patients.

CI, confidence interval; ECOG, Eastern Cooperative Oncology Group; EFS, event-free survival; HR, hazard ratio; ITT, intention-to-treat; NE, not estimable/evaluable; NR, not reached; OS, overall survival; PD-L1, programmed death-ligand 1; TC, tumor cell.

Yue D *et al.* Presented at WCLC 2025; Barcelona, Spain, September 6–9, 2025.



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# The safety profile of perioperative IO + chemotherapy was manageable across both the KEYNOTE-671 and RATIONALE-315 trials

## KEYNOTE-671: Safety summary (second interim analysis; median follow-up: 36.6 months)[1]

| n (%) | Pembrolizumab arm (n=396) | Placebo arm (n=399) |
|---|---|---|
| Any TRAE | 383 (97) | 381 (95) |
| Serious TRAE | 73 (18) | 58 (15) |
| TRAE that led to death* | 4 (1.) | 3 (1) |
| TRAE that led to discontinuation of all trial treatment | 54 (14) | 21 (5) |

**Most frequently reported TRAEs:**

- **Nausea**
  n=216 (54.5%) vs. n=205 (51.8%)
- **Decreased neutrophil count**
  n=169 (42.7%) vs. n=168 (42.4%)

## RATIONALE-315: Safety summary (final analysis; median follow-up: 38.5 months)[2]

| n (%) | Tislelizumab arm (n=226) | Placebo arm (n=226) |
|---|---|---|
| Any TRAE | 224 (99.1) | 225 (99.6) |
| Serious TRAE | 35 (15.5) | 20 (8.8) |
| TRAE that led to death† | 4 (1.8) | 2 (0.9) |
| TRAE that led to discontinuation | 29 (12.8) | 21 (9.3) |

**Most frequently reported TRAEs:**

- **Decreased neutrophil count**
  n=178 (78.8%) vs. n=177 (78.3%)
- **Decreased white blood cell count**
  n=143 (63.3%) vs. n=152 (67.3%)

**This slide includes data from different clinical trials. These data are meant for demonstration purposes only and not meant for cross-trial comparison purposes.**

The safety analysis set included all randomized patients who received ≥1 dose of any study drug. AEs were classified based on MedDRA v26.0. AEs were graded for severity using Common Terminology Criteria for AEs v5.0.

*TRAEs leading to death (n=1 each): pembrolizumab arm: atrial fibrillation, immune-mediated lung disease, pneumonia, sudden cardiac death; placebo arm: acute coronary syndrome, pneumonia, pulmonary hemorrhage.
†TRAE leading to death (n=1 each): tislelizumab arm: infection, pneumonia, pneumonitis, immune-mediated lung disease; placebo arm: respiratory hemorrhage, cardiac failure.

AE, adverse event; IO, immunotherapy; MedDRA, Medical Dictionary for Regulatory Activities; TRAE, treatment-related adverse event.

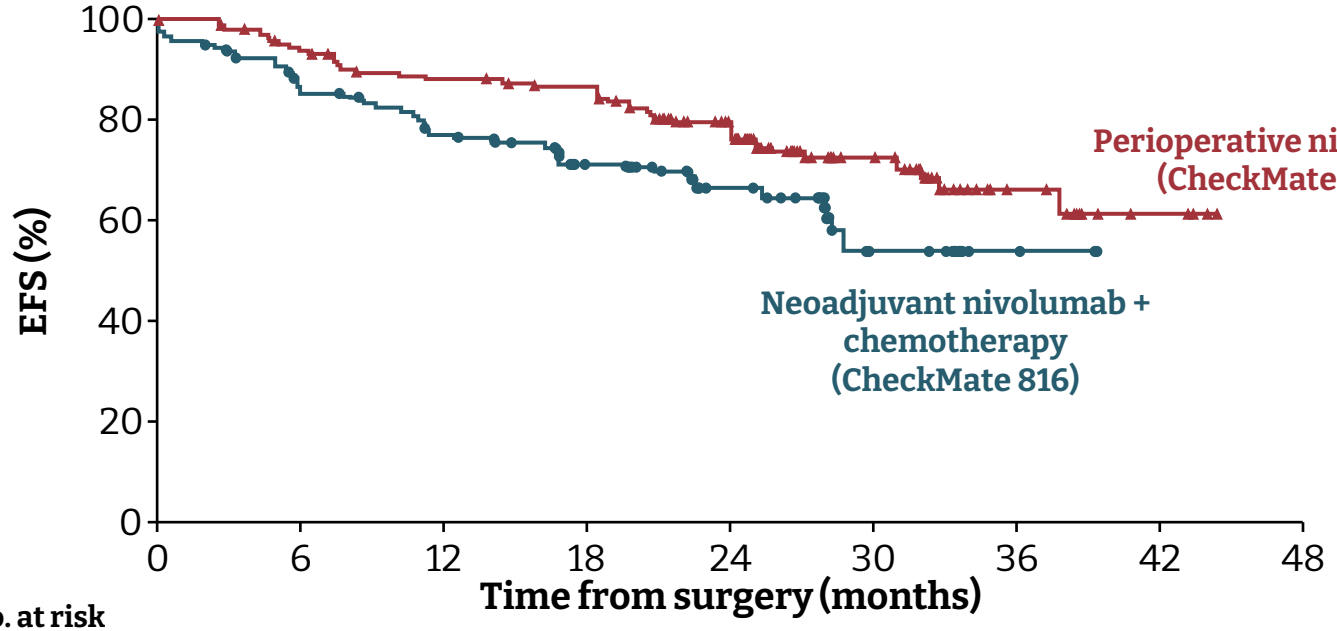
1. Spicer JD *et al. Lancet* 2024; 404 (10459): 1240–1252. 2. Yue D *et al.* WCLC 2025; Barcelona, Spain, September 6–9, 2025.



BeOne

# How can we best select patients who will benefit from treatment with perioperative IO?

## CheckMate 77T vs. CheckMate 816: EFS (final analysis)




| No. at risk | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Perioperative nivolumab | 139.4 | 128.0 | 118.1 | 112.9 | 79.7 | 42.5 | 13.0 | 3.1 | 0 |
| Neoadjuvant nivolumab + chemotherapy | 147.5 | 121.0 | 106.2 | 84.2 | 39.1 | 12.1 | 2.2 | 0 | 0 |

| | Weighted (ATE)* | |
|---|---|---|
| | Perioperative nivolumab† (n=139.4#) | Neoadjuvant nivolumab + chemotherapy (n=147.5#) |
| HR (95% CI) | 0.61 (0.39–0.97) | |

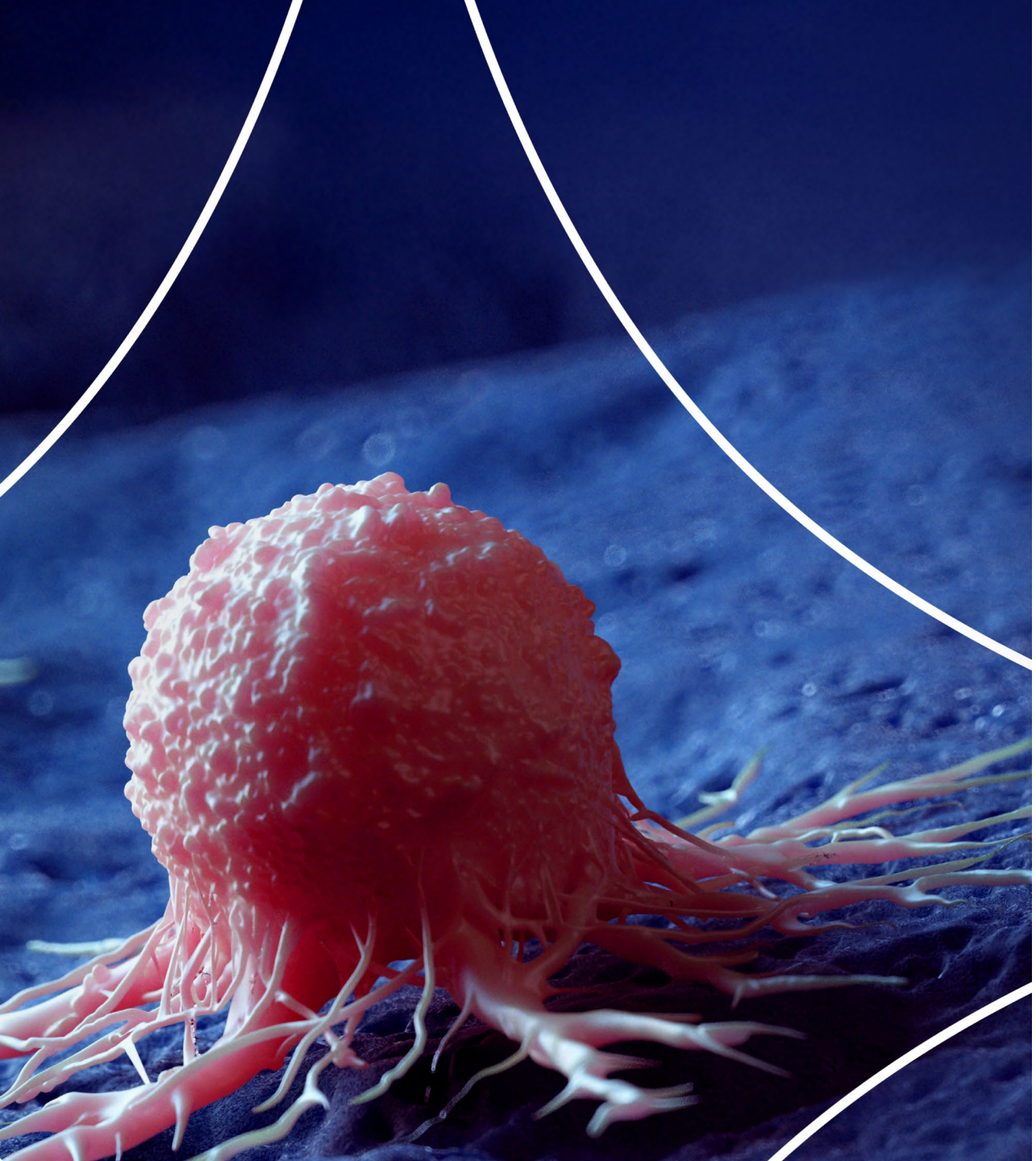
**HR (95% CI):** ATT§ weighted analysis, 0.56 (0.35–0.90); unweighted analysis, 0.59 (0.38–0.92)

In the absence of head-to-head data, an **indirect, treatment-matched comparison** suggested benefit with perioperative vs. neoadjuvant IO

Median follow-up: CheckMate 816, 29.5 months; CheckMate 77T, 33.3 months. *ATE: varying weights were applied to all patients in both neoadjuvant NIVO + chemo arm (CheckMate 816) and perioperative NIVO (CheckMate 77T) to make them comparable to one another. †Includes only patients who received ≥ 1 dose of adjuvant NIVO. #N values fractional owing to weighting. §ATT: varying weights were applied to patients in the neoadjuvant NIVO + chemo arm (CheckMate 816) to make them comparable to those in the perioperative NIVO arm (CheckMate 77T).

ATE, average treatment effect; ATT, average treatment effect for the treated; CI, confidence interval; EFS, event-free survival; HR, hazard ratio; IO, immunotherapy; NIVO, nivolumab.

Forde PM *et al*. Presented at WCLC 2024; San Diego, CA, USA, September 7–10, 2024.





# MDT discussion:

# How do advances in the treatment landscape inform treatment selection?

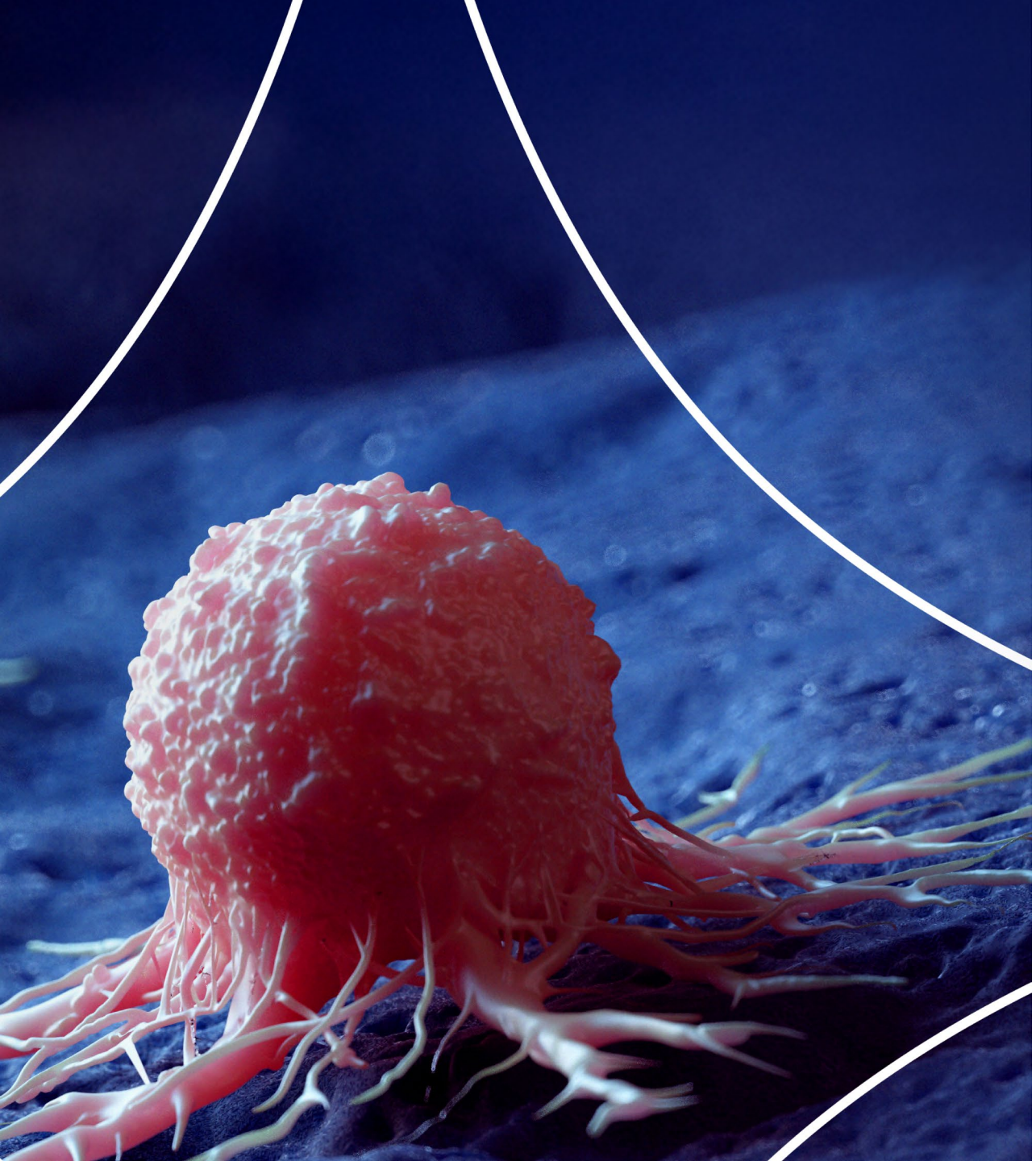
All faculty

✦ ✦ ✦

MDT, multidisciplinary team; NSCLC, non–small cell lung cancer.



BeOne



COLLABORATE TO INNOVATE IN THE MDT: UNLOCKING THE POTENTIAL OF IMMUNOTHERAPY IN RESECTABLE NSCLC

# How do the latest data inform the surgical approach?

Jean Y Perentes
Lausanne University Hospital (CHUV), Switzerland

MDT, multidisciplinary team; NSCLC, non–small cell lung cancer.

March 2026 | 0226-BGB-A317-MRC-017

# Disclosures

**Honoraria or advisory role and travel grants**

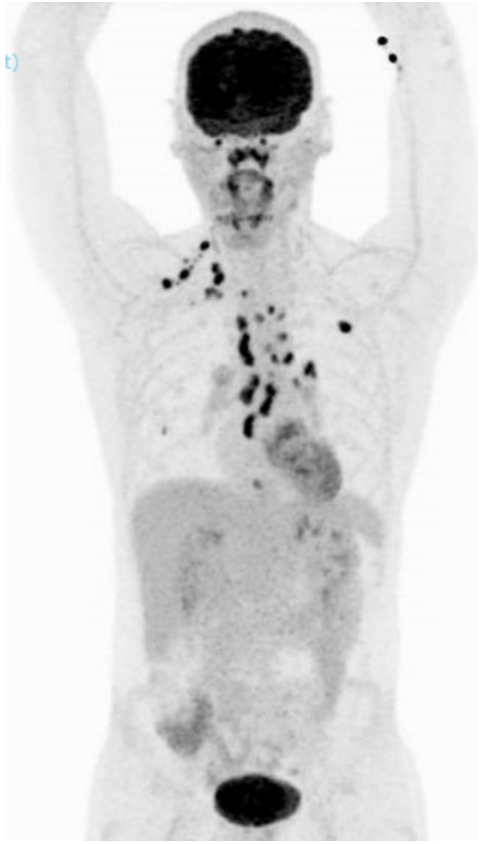
- AstraZeneca, BeOne Medicines, BMS, Embion, Johnson & Johnson, Medtronic, MSD, Roche

**Grants/research funding**

- VATS teaching and VATS immersion courses: Johnson & Johnson, Medtronic, Scanlan

# MDT discussion

- Male
- 42 years old
- Good general health
- Former smoker (20 pack-years)
- Self-palpated cervical mass
- PET-CT: Left upper lobe mass (2.5 cm) with bilateral mediastinal, subclavian and cervical adenopathies



Biopsy: NSCLC *Kras* mut, PD-L1=50%
Brain MRI: negative

**Final stage: cT2N3M0**

c, clinical; CT, computed tomography; M, metastasis; MDT, multidisciplinary team; MRI, magnetic resonance imaging; mut, mutated; N, node; NSCLC, non–small cell lung cancer; PD-L1, programmed death-ligand 1; PET, positron emission tomography; T, tumor.

Case study provided by Jean Perentes.

# MDT discussion

- Male
- 42 years old
- Good general health
- Former smoker (20 pack-years)
- 
- 

What do we do

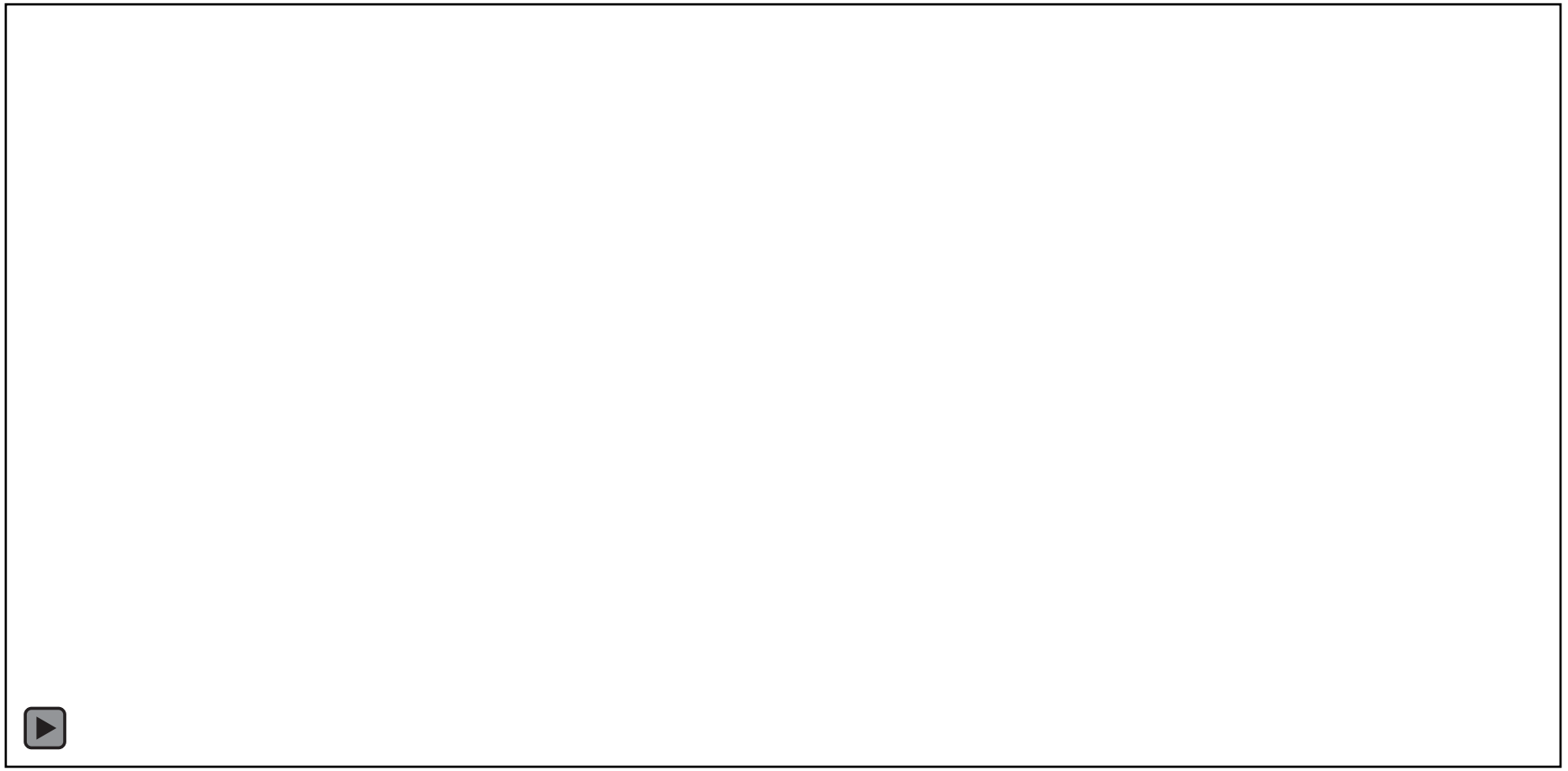
Brain MRI: negative

**Final stage: cT2N3M0**

c, clinical; CT, computed tomography; M, metastasis; MDT, multidisciplinary team; MRI, magnetic resonance imaging; mut, mutated; N, node; NSCLC, non–small cell lung cancer; PD-L1, programmed death-ligand 1; PET, positron emission tomography; T, tumor.

Case study provided by Jean Perentes.

# Post-induction CT scan



CT, computed tomography.
Case study provided by Jean Perentes.

# Decision to undergo surgery

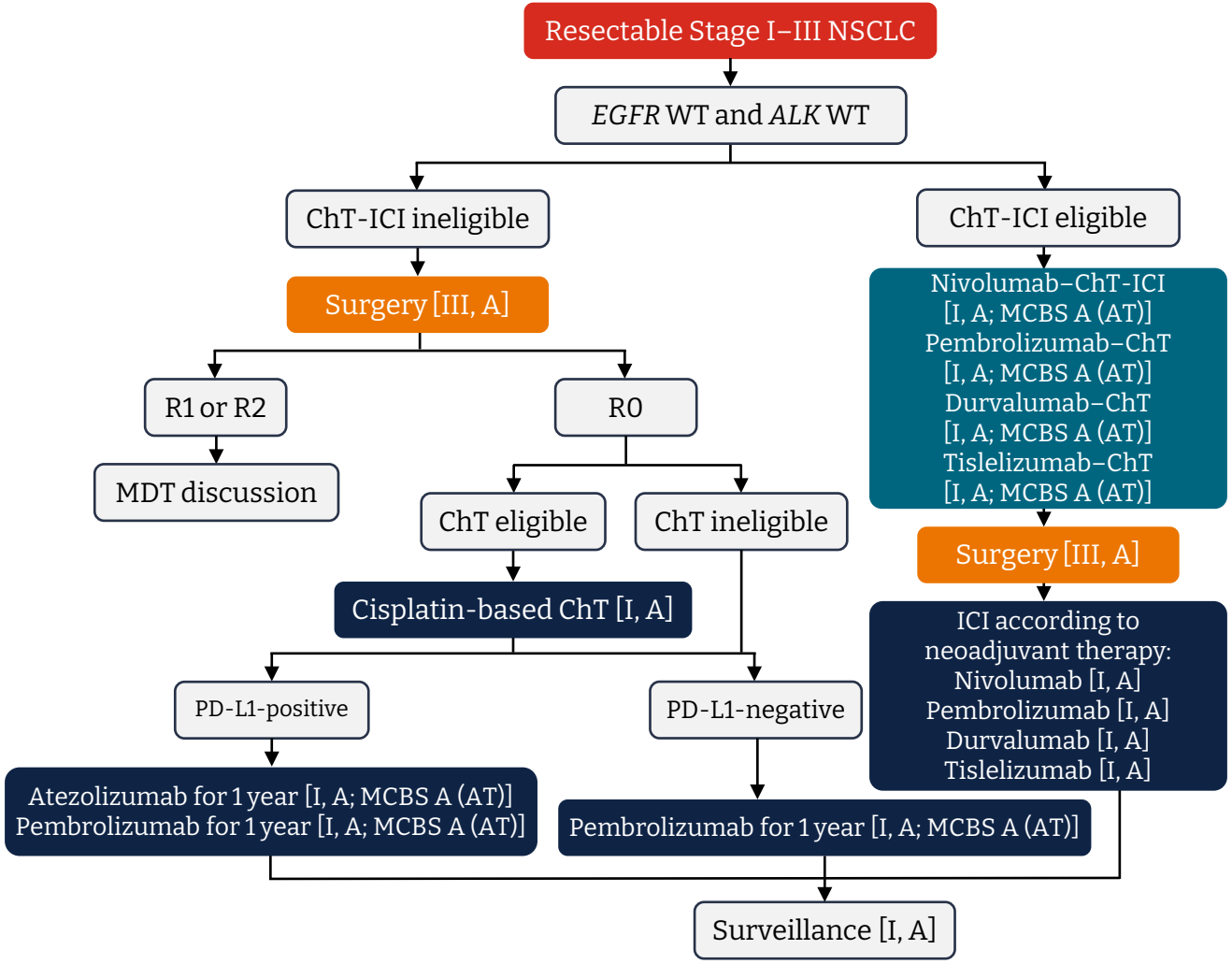
Left upper lobectomy
Complete LN dissection
Resection of N3 on the right side

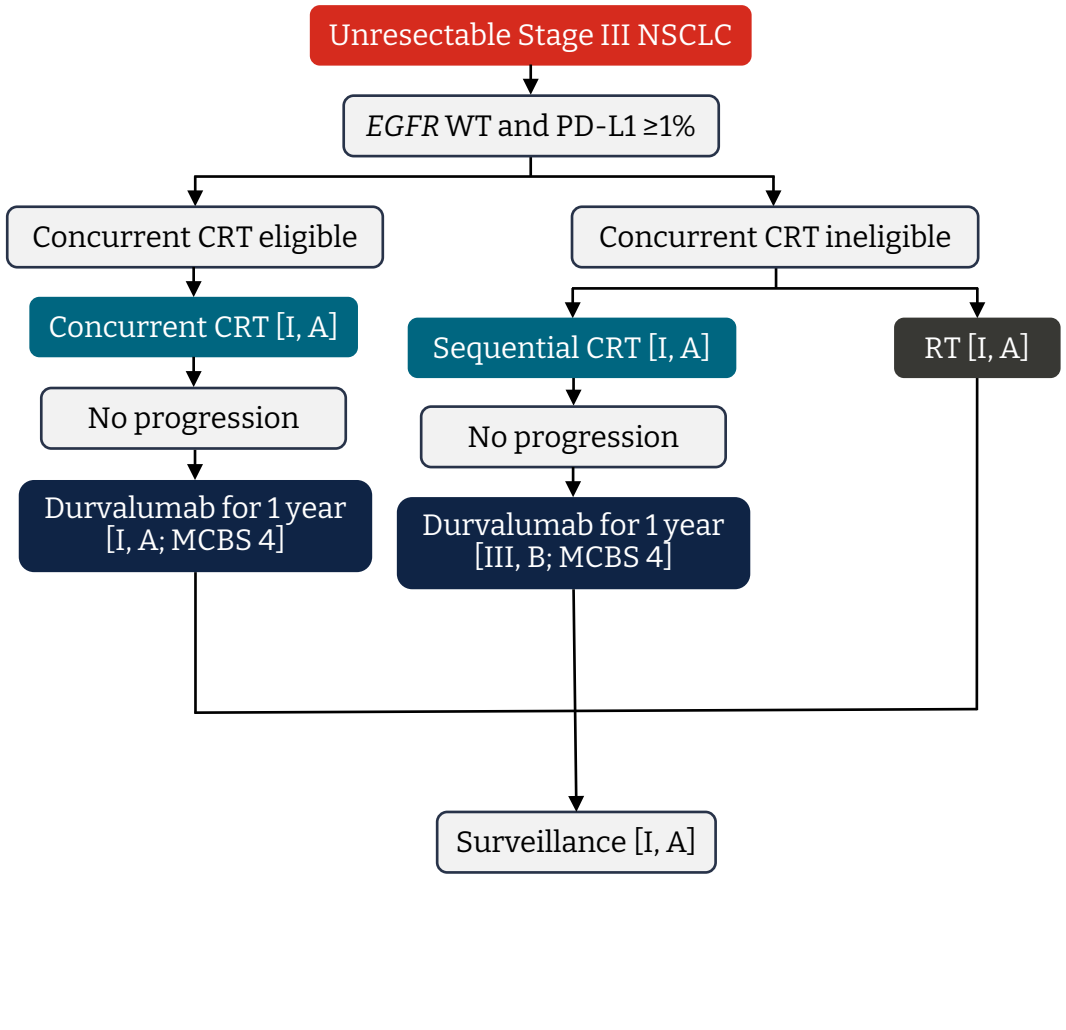
Anatomopathology
pCR ypT0N0M0

Surveillance

LN, lymph node; M. metastasis; N, node; pCR, pathologic complete response; T, tumor; yp, post-treatment pathological.
Case study provided by Jean Perentes.

# ESMO guidelines: Management of resectable Stage I–III NSCLC and unresectable Stage III NSCLC[1,2]




ChT, chemotherapy; CRT, chemoradiotherapy; ESMO, European Society for Medical Oncology; ICI, immune checkpoint inhibitor; MCBS, magnitude of clinical benefit scale; MDT, multidisciplinary team; NSCLC, non–small cell lung cancer; PD-L1, programmed death-ligand 1; R0, no tumor at the margin; R1, microscopic tumor at the margin; R2, macroscopic tumor at the margin; RT, radiotherapy; WT, wild-type.

1. Zer A *et al. Ann Oncol* 2025; 36 (11): 1245-1262. 2. ESMO Early and Locally Advanced Non-small-cell Lung Cancer Living Guideline, v1.0 December 2025.

# What is resectable?

| | |
|---|---|
| **Problem:** | Stage III disease represents a highly heterogenous group |
| | Many clinical trials now incorporate neoadjuvant ChT–IO |
| | Definitions of resectability differ between centers |
| | There is a need for standardized language |
| **Approach:** | Systematic review of the literature |
| | International survey |
| | Multidisciplinary discussions of 105 clinical cases |

**Consensus meeting at WCLC 2023**

This slide reflects the opinion of the speaker.
ChT, chemotherapy; IO, immunotherapy; WCLC, World Conference on Lung Cancer.

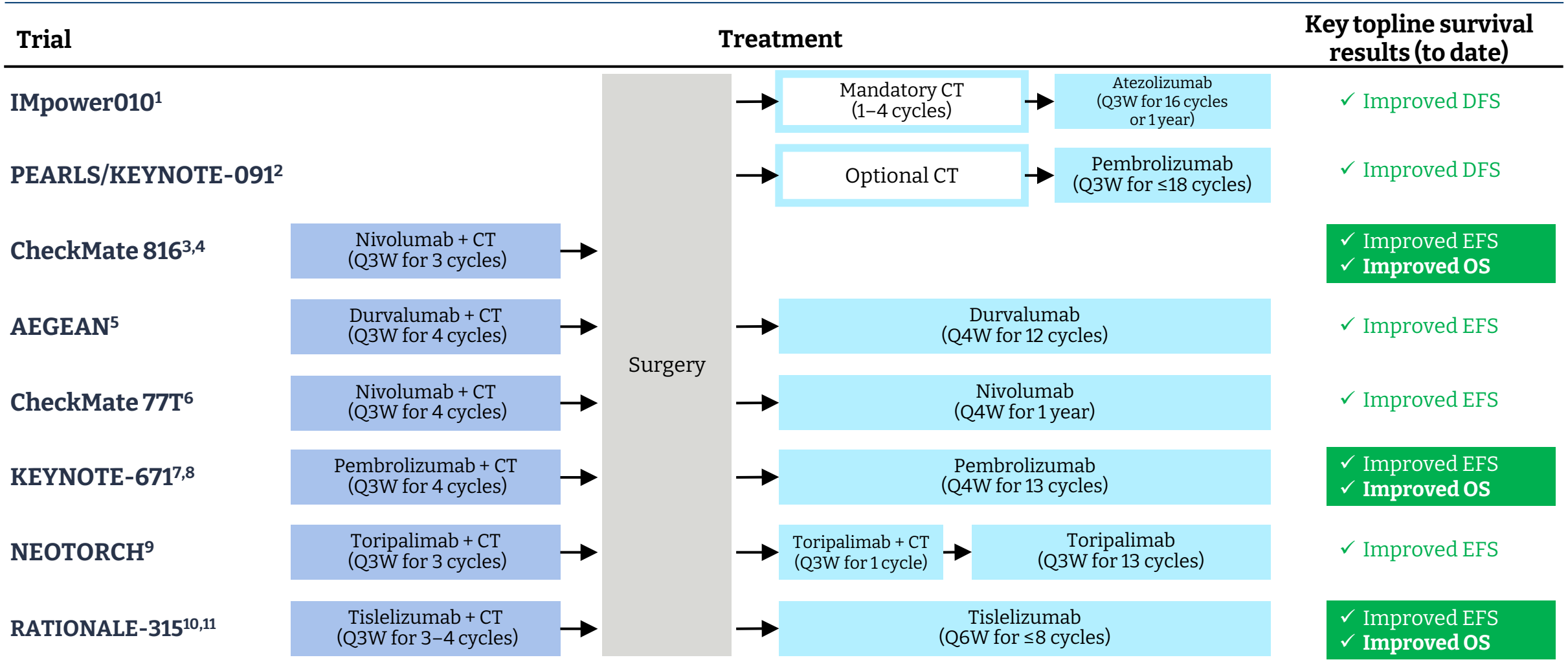
# What is resectable?

## EORTC, ESTS, ETOP consensus on resectability in Stage III NSCLC

| | N0 | N1 | N2 SINGLE (non-bulky, non-invasive) | N2 MULTI (non-bulky, non-invasive) | N2 BULKY | N2 INVASIVE | N3 |
|---|---|---|---|---|---|---|---|
| **T1–2** | Not Stage III disease | Not Stage III disease | Resectable | Potentially resectable | Unclear | Unresectable | Unresectable |
| **T3 size / satellite / invasion** | Not Stage III disease | Resectable | Resectable | Potentially resectable | Unresectable | Unresectable | Unresectable |
| **T4 size / satellite** | Resectable | Resectable | Resectable | Potentially resectable | Unresectable | Unresectable | Unresectable |
| **T4 invasion** | Potentially resectable | Potentially resectable | Potentially resectable | Potentially resectable | Unresectable | Unresectable | Unresectable |

EORTC, European Organisation for Research and Treatment of Cancer; ESTS, European Society of Thoracic Surgeons; ETOP, European Thoracic Oncology Platform; N, node; NSCLC, non–small cell lung cancer; T, tumor.
Houda I *et al. Lung Cancer* 2025; 199: 108061.

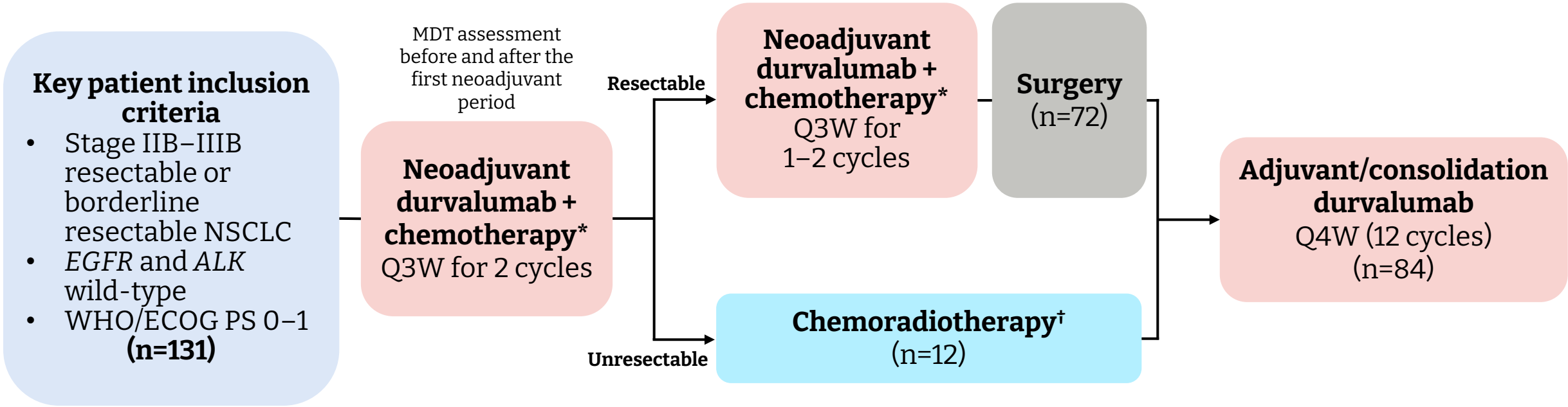
# To date, the CheckMate 816, KEYNOTE-671, and RATIONALE-315 trials have reported positive OS results




CT, chemotherapy; DFS, disease-free survival; EFS, event-free survival; OS, overall survival; PFS, progression-free survival; QXW, every X weeks.

1. Felip E *et al. Lancet* 2021; 398 (10308): 1344–1357. 2. O'Brien M *et al. Lancet Oncol* 2022; 23 (10): 1274–1286. 3. Forde PM *et al. N Engl J Med* 2022; 386 (21): 1973–1985. 4. Forde PM *et al. N Engl J Med* 2025; 393 (8): 741–752. 5. Heymach JV *et al. N Engl J Med* 2023; 389 (18): 1672–1684. 6. Cascone T *et al. N Engl J Med* 2024; 390 (19): 1756–1769. 7. Wakelee H *et al. N Engl J Med* 2023; 389 (6): 491–503. 8. Spicer J *et al. Lancet* 2024; 404 (10459): 1240–1252. 9. Lu S *et al. JAMA* 2024; 331 (3): 201–211. 10. Yue D *et al. Lancet Respir Med* 2025; 13 (2): 119–129. 11. Wang C *et al. Ann Oncol* 2025; Digital ahead of print. DOI: https://doi.org/10.1016/j.annonc.2025.11.017.

# MDT-BRIDGE study: A Phase II study to determine the resection rate in resectable and borderline resectable patients treated with neoadjuvant ChT–IO




## Primary endpoint

- Resection rate (in patients who had definitive surgery)

## Secondary endpoints

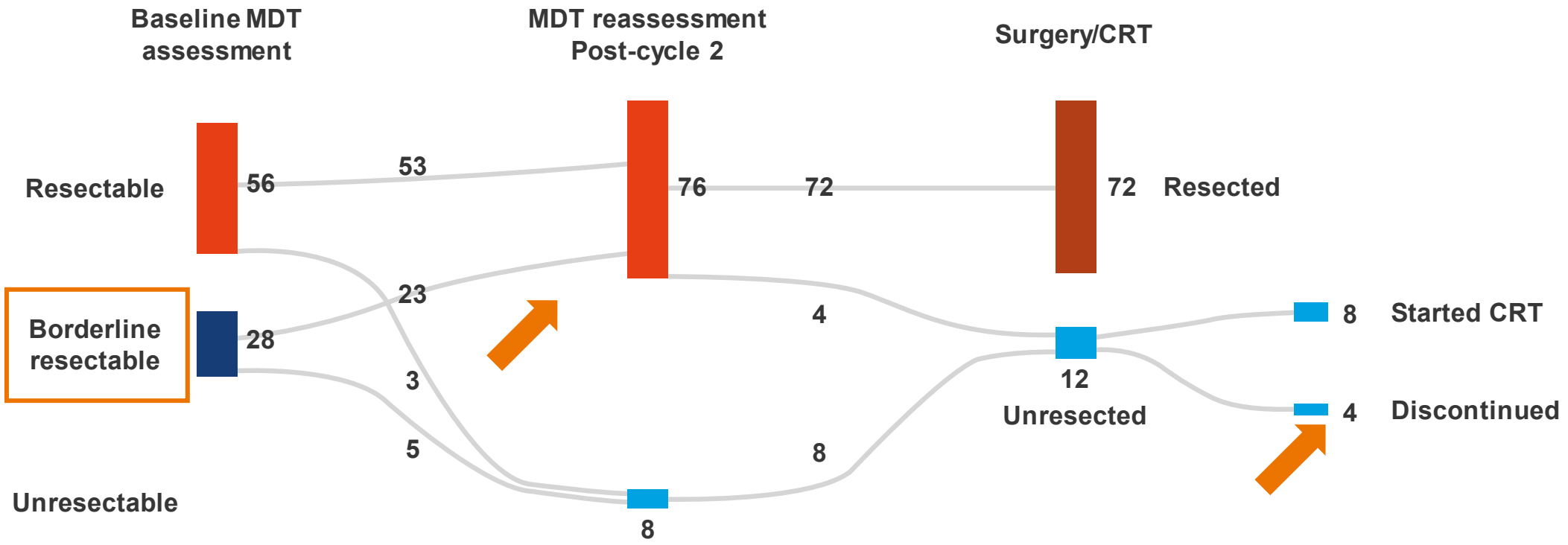
- Resection rate (all patients), surgical outcomes, ORR, pCR and safety

*Investigator's choice platinum-based. †60 Gy ±10% (five fractions/week for 6 weeks).

ChT, chemotherapy; ECOG PS, Eastern Cooperative Oncology Group Performance Status; IO, immunotherapy; MDT, multidisciplinary team; NSCLC, non–small cell lung cancer; ORR, overall response rate; pCR, pathological complete response; QXW, every X weeks; WHO, World Health Organization.

Reck M *et al.* Oral presentation LBA65 at ESMO 2025; Berlin, Germany, 17–21 October 2025.

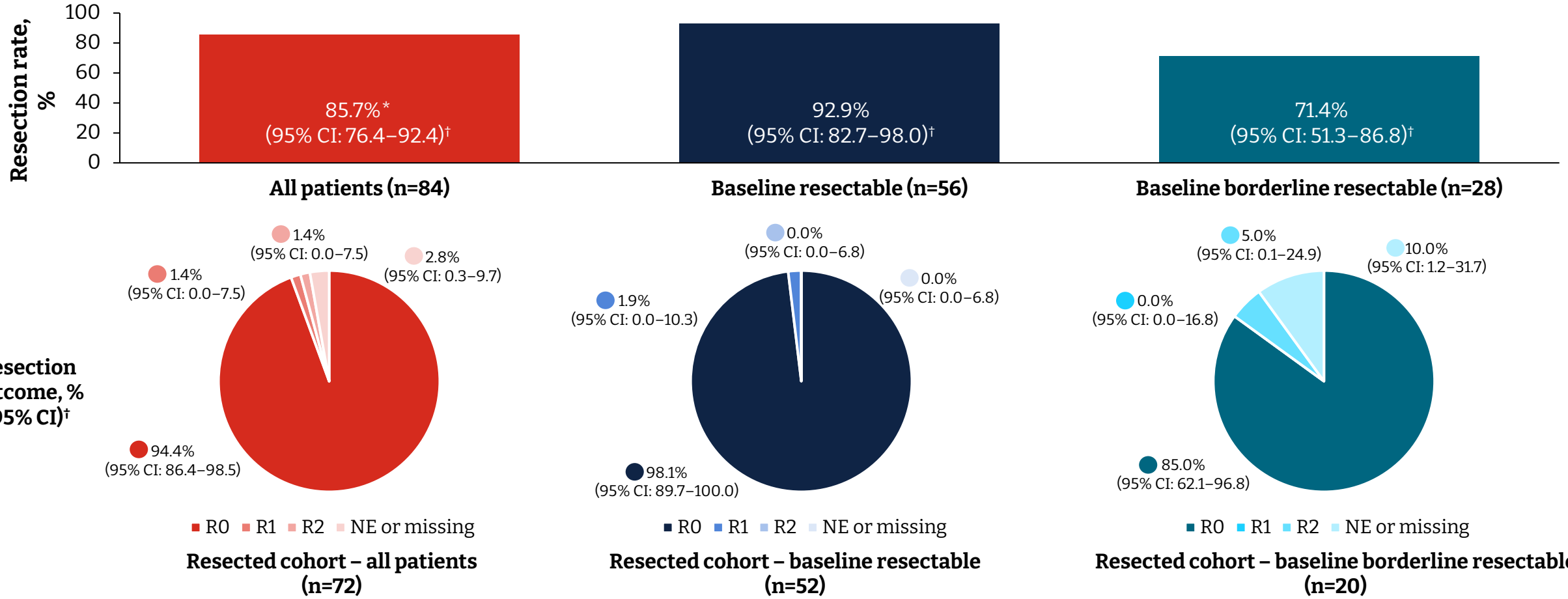
# MDT-BRIDGE: Following two cycles of neoadjuvant ChT–IO, most cases of borderline resectable disease were reassessed as resectable




**95.2% of patients had definitive local therapy after two cycles of ChT–IO**

ChT, chemotherapy; CRT, chemoradiotherapy; IO, immunotherapy; MDT, multidisciplinary team.
Reck M *et al.* Oral presentation LBA65 at ESMO 2025; Berlin, Germany, 17–21 October 2025.

# MDT-BRIDGE: Complete (R0) resection rates were high in both baseline resectable and borderline resectable patients




## Resection rate of 85.7% with a majority of R0 resections

Data cutoff: May 8, 2025.

*One patient did not complete surgical resection as intended. †95% CIs calculated using the Clopper-Pearson exact method.

CI, confidence interval; NE, not evaluable; R0, no tumor at the margin; R1, microscopic tumor at the margin; R2, macroscopic tumor at the margin.

Reck M *et al.* Oral presentation LBA65 at ESMO 2025; Berlin, Germany, 17–21 October 2025.

# PANDA-1: Tislelizumab plus chemotherapy followed by surgery or radiotherapy and adjuvant tislelizumab in unresectable stage III NSCLC

**Inclusion Criteria**

- Histologically confirmed stage III NSCLC (per AJCC 8th edition), deemed **initially unresectable based on at least one of the following criteria as assessed by MDT**:
  1. **T4** tumors invade vital organ*, precluding R0 resection
  2. multi-station/bulky **N2** metastases
  3. **N3** metastases
- No prior systemic therapy
- ECOG PS 0–1
- Without known EGFR/ALK mutation

**N=55**

**Induction therapy**

Tislelizumab 200 mg d1
+
Nab-paclitaxel 260 mg/m² d1
+
Cisplatin 75 mg/m² or carboplatin AUC 5 d1,
Q3W for 2–4 cycles

**MDT†**

**Local therapy**

**Definitive Surgery**

**Definitive RT ± Chemo**

**Adjuvant therapy**

**Tislelizumab ± chemo Q3W for 17 cycles***

Or until PD or unacceptable toxicity

**Tislelizumab Q3W for 17 cycles**

**Primary endpoint**

- 1-year EFS rate (assessed in radical treatment analysis set)

**Secondary endpoints:**

- EFS, OS, TTDM, TTLR, ORR, DCR, clinical downstaging rate, and surgery rate (based on safety analysis set and radical treatment analysis set)
- R0 resection rate, pCR, MPR, and pathological downstaging rate (based on surgery analysis set)
- Safety (based on safety analysis set)

**Analysis set**

- **Safety analysis set:** includes all patients who received at least one dose of any study drug
- **Radical treatment analysis set:** includes all patients who underwent surgery or radiotherapy after completing induction therapy
- **Surgery analysis set:** includes all patients who underwent surgical resection after completing induction therapy

*Lesions invading vital organs, including diaphragm, mediastinum, major blood vessels, trachea, recurrent laryngeal nerve, esophagus, or satellite nodules in the different lobe of the primary tumor. †The resectability of the lesions will be re-evaluated by MDT after two cycles of induction therapy and each subsequent induction cycle. ‡Postoperative radiotherapy is allowed for patients with ypN2+ or ypN3+ after surgery, at the discretion of investigator.

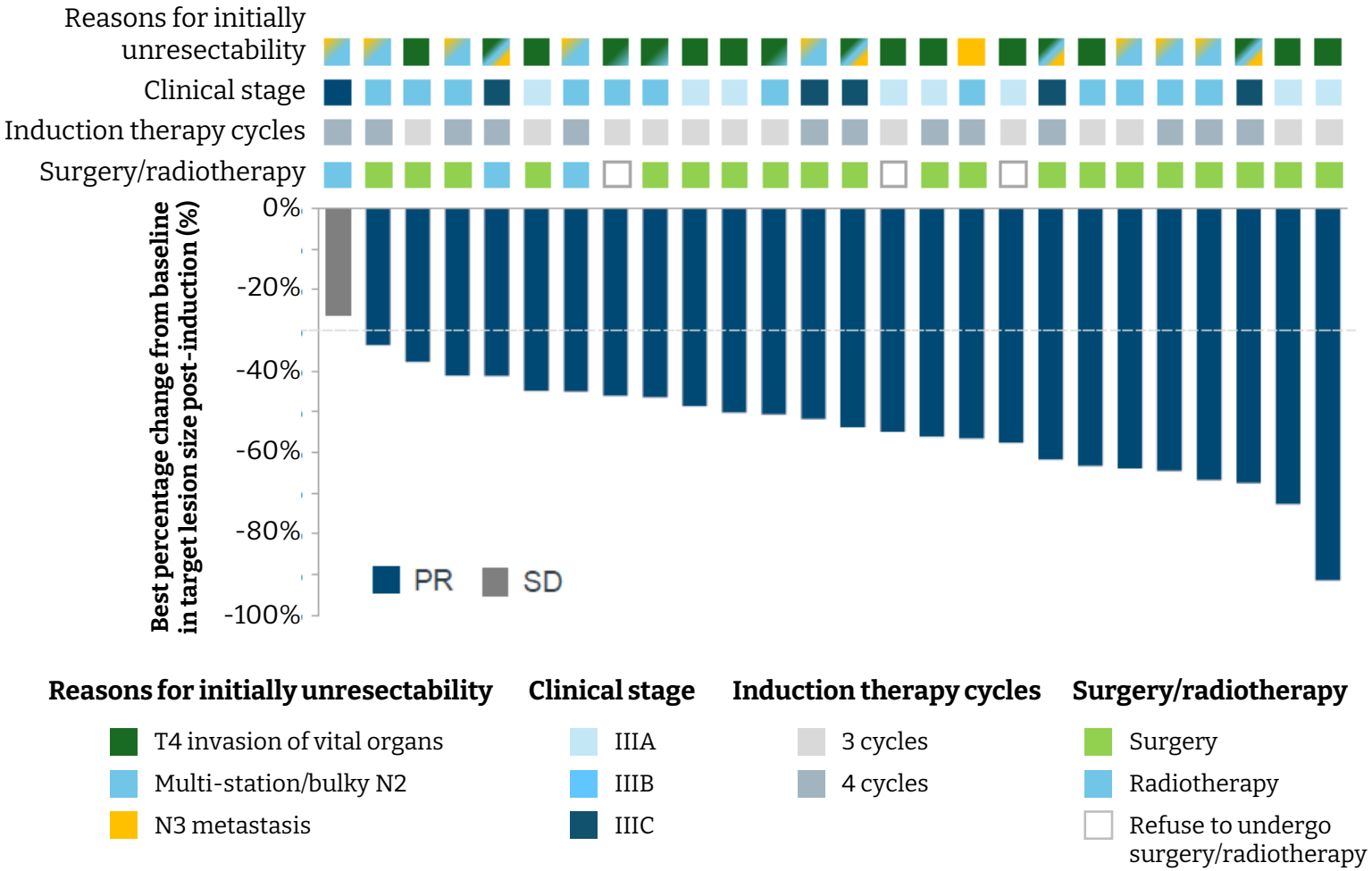
AUC, area under the plasma or serum concentration–time curve; DCR, disease control rate; ECOG PS, Eastern Cooperative Oncology Group performance status; EFS, event-free survival; MDT, multidisciplinary team; MPR, major pathological response; NSCLC, non-small cell lung cancer; OS, overall survival; ORR, objective response rate; pCR, pathological complete response; PD, disease progression; Q3W, every 3 weeks; RT, radiotherapy; TTDM, time to distant metastasis; TTLR, time to loco regional recurrence.

Liu J *et al.* Oral presentation MA04.08. at WCLC 2025; Barcelona, Spain, September 6–9 2025.



BeOne

# PANDA-1: 96.2% patients achieved tumor response post-induction, with a markedly high surgery conversion rate



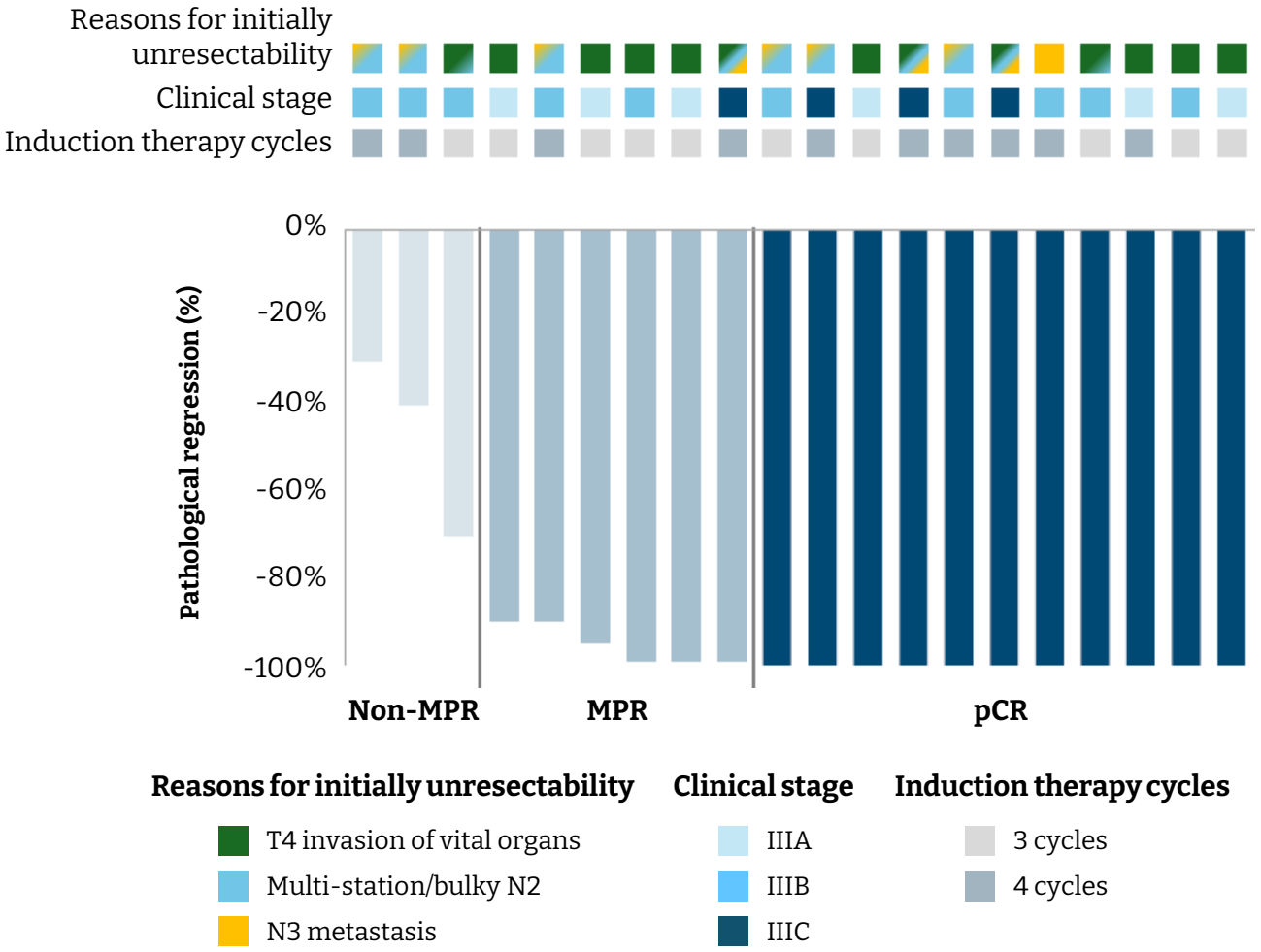

Among 26 patients who completed induction therapy and post-induction MDT assessment:

- **ORR was 96.2%** (n=25/26)
- **Surgery conversion rate was 76.9%** (n=20/26)

| | Surgical patients (n=20) |
|---|---|
| R0 resection rate* | 20 (100%) |
| Surgical approach, n (%) | |
| Minimally invasive | 14 (70%) |
| Thoracotomy | 6 (30%) |
| Minimally invasive to thoracotomy | 0 |
| Type of surgery, n (%) | |
| Lobectomy | 20 (100%) |

*R0 resection rate was defined as the proportion of patients with margin-negative resection.
ORR, objective response rate; PR, partial response; R0, no tumor at the margin; SD, stable disease.
Liu J *et al.* Oral presentation MA04.08. at WCLC 2025; Barcelona, Spain, September 6–9 2025.

# PANDA-1: High pCR and MPR rates were attained in surgical patients



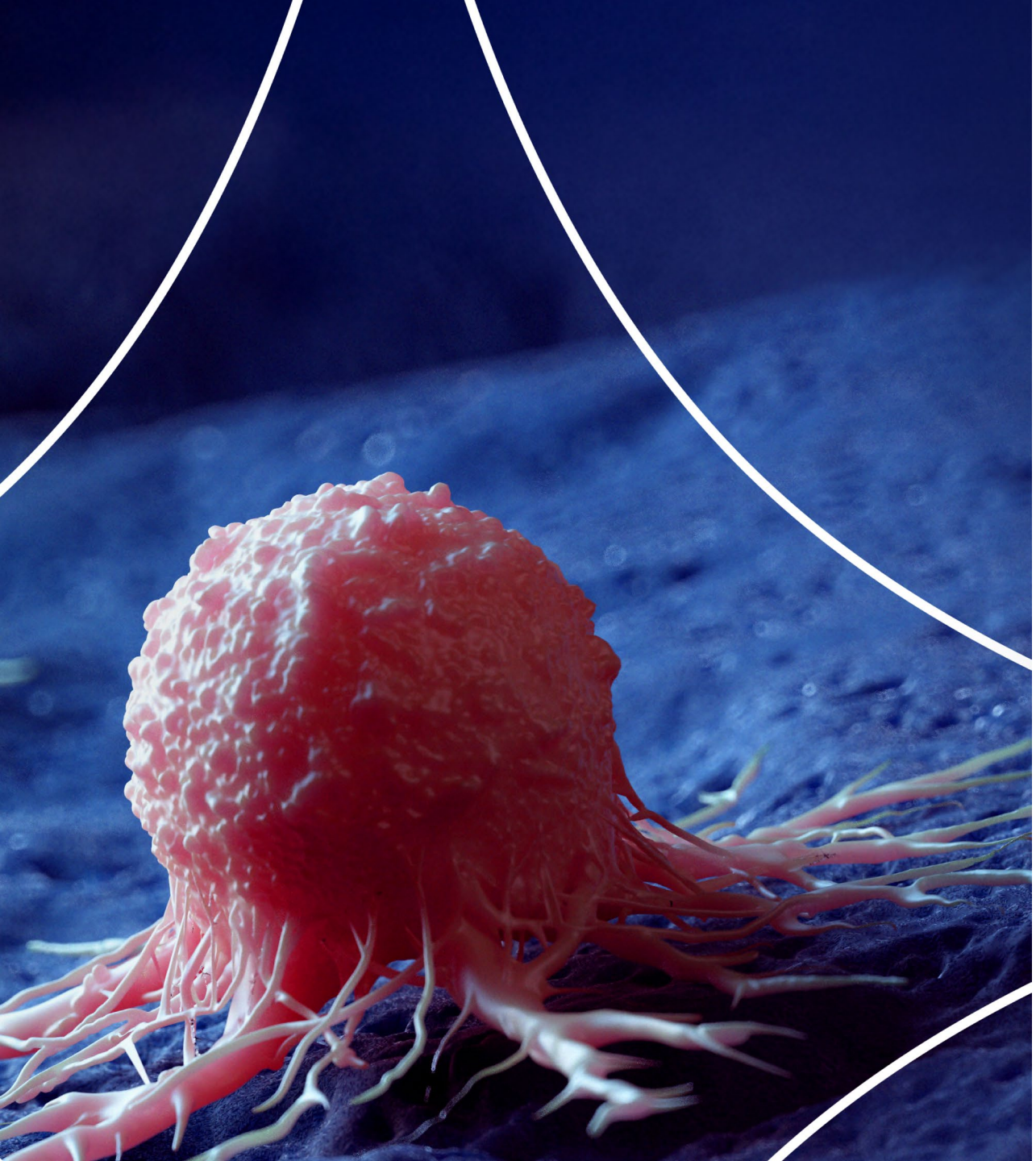

Among 20 patients who underwent surgery:

- **pCR** and **MPR** rates were **55.0%** and **85.0%**, respectively
- pCR and MPR in patients receiving 3 cycles and those receiving 4 cycles of induction therapy were summarized in the below table

| | Surgical patients (n=20) | Cycles of induction therapy | |
|---|---|---|---|
| | | 3 cycles (n=10) | 4 cycles (n=10) |
| pCR, n (%) | 11 (**55.0%**) | 5 (50.0%) | 6 (60.0%) |
| MPR, n (%) | 17 (**85.0%**) | 9 (90.0%) | 8 (80.0%) |

MPR, major pathologic response; pCR, pathological complete response.

Liu J *et al.* Oral presentation MA04.08. at WCLC 2025; Barcelona, Spain, September 6–9 2025.





# Conclusions

Jean Y Perentes
Lausanne University Hospital (CHUV), Switzerland

MDT, multidisciplinary team; NSCLC, non–small cell lung cancer.

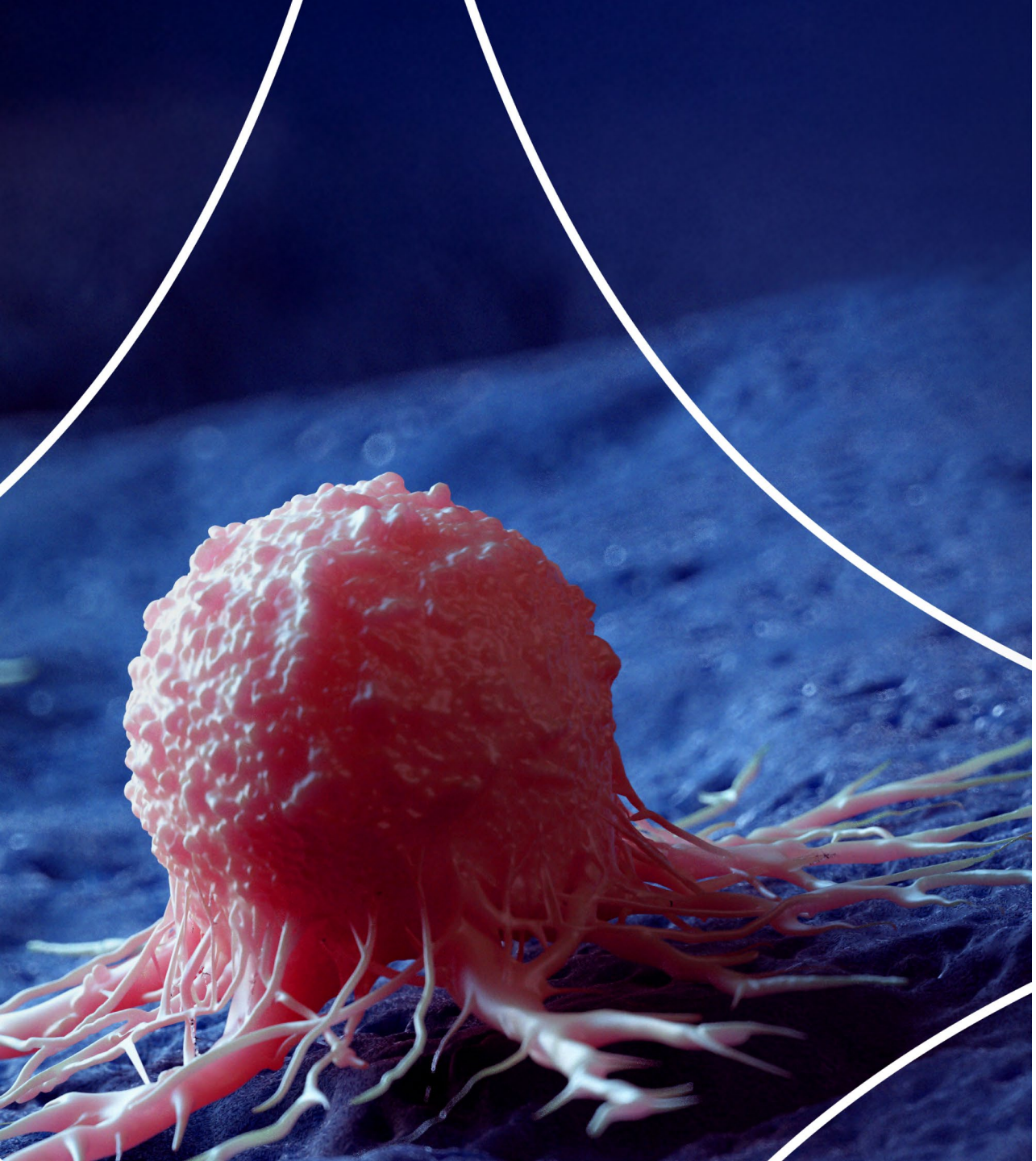
# Conclusions

- ChT–IO in the neoadjuvant and adjuvant settings is transforming the management of resectable Stage III NSCLC

- Achieving an R0 resection following ChT–IO is a key goal for improving long-term outcomes

- Based on data from the MDT-BRIDGE and PANDA-1 trials, will the concept of resectability change and be assessed **after** induction ChT–IO?

This slide reflects the opinion of the speaker.
ChT, chemotherapy; IO, immunotherapy; NSCLC, non–small cell lung cancer; R0, no tumor at the margin.





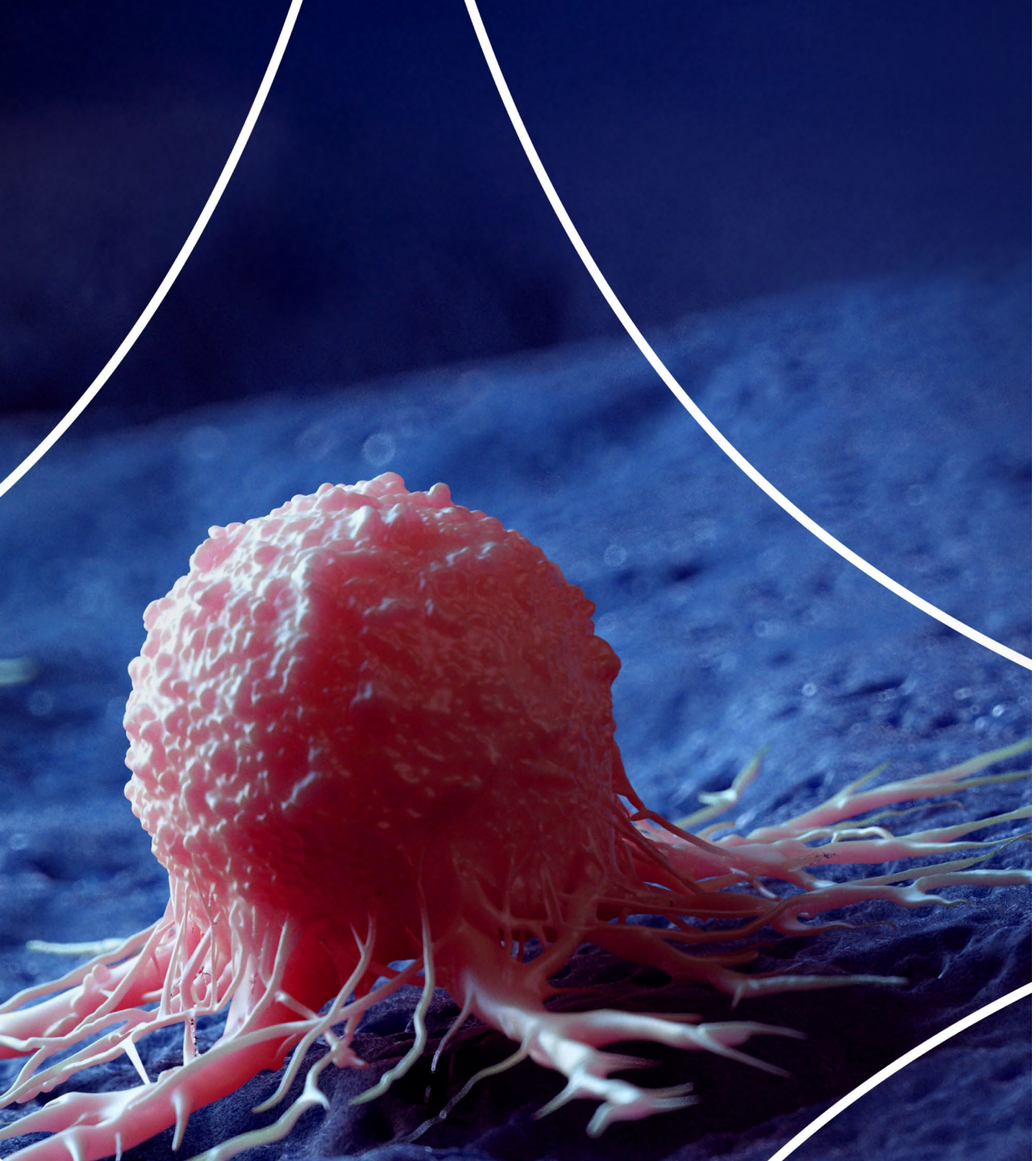
# MDT discussion:

# How do the latest data inform the surgical approach?

All faculty

✦ ✦ ✦

MDT, multidisciplinary team; NSCLC, non–small cell lung cancer.



COLLABORATE TO INNOVATE IN THE MDT: UNLOCKING THE POTENTIAL OF IMMUNOTHERAPY IN RESECTABLE NSCLC

# Which key factors may inform the de-escalation/escalation of treatment?

Umberto Malapelle
University of Naples Federico II, Italy

MDT, multidisciplinary team; NSCLC, non-small cell lung cancer.

March 2026 | 0126-BGB-A317-MRC-020

# Disclosures

**Employment**

- International Society of Liquid Biopsy (Board of Directors)

**Consulting fees**

- Amgen, AstraZeneca, BeOne Medicines, Boehringer Ingelheim, Diaceutics, Diatech, Eli Lilly, GlaxoSmithKline plc, Hedera, Janssen, Merck, Merck Sharp & Dohme, Novartis, Roche, Thermo Fisher Scientific

**Grants/funding**

- AstraZeneca, Menarini Stemline, Thermo Fisher Scientific

**Non-financial conflicts**

- Scientific President of the International Society of Liquid Biopsy, membership of AIOM, ESMO, IASLC, and SIAPEC

**Spousal employment**

- Roche

AIOM, Italian Association of Medical Oncology; ESMO, European Society for Medical Oncology; IASLC, International Association for the Study of Lung Cancer; SIAPEC, Italian Society of Anatomic Pathology and Diagnostic Cytopathology.

# Pathologic outcomes are assessed based on the proportion of viable tumor on a post-treatment specimen

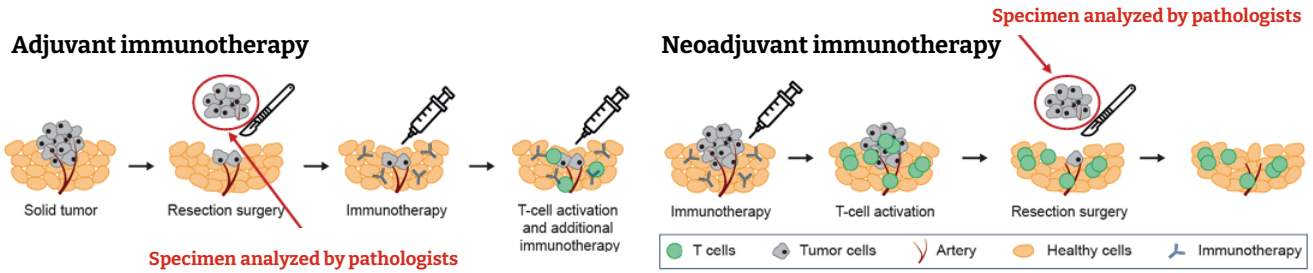
**MPR** = **reduction of viable tumor** to **below a clinically significant cutoff***

- The historical definition of MPR is **≤10% of viable tumor**
- Recent data suggest the MPR in the conventional chemotherapy setting may **differ according to histologic type** (i.e. adenocarcinoma versus squamous cell carcinoma)

**pCR** = **lack of any viable tumor cells**, including **all sampled regional lymph nodes**†

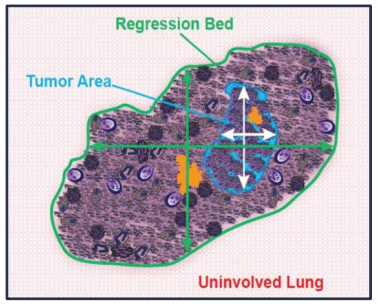
- **ypT0N0** per AJCC-UICC 8th edition

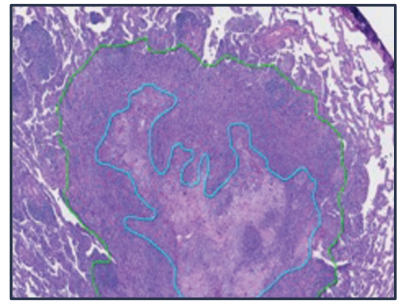
## Specimen sampling following immunotherapy




## Residual viable tumor assessment

**% RVT** $= \frac{\text{Total area involved by viable tumor}}{\text{Total tumor bed area}} \times 100$



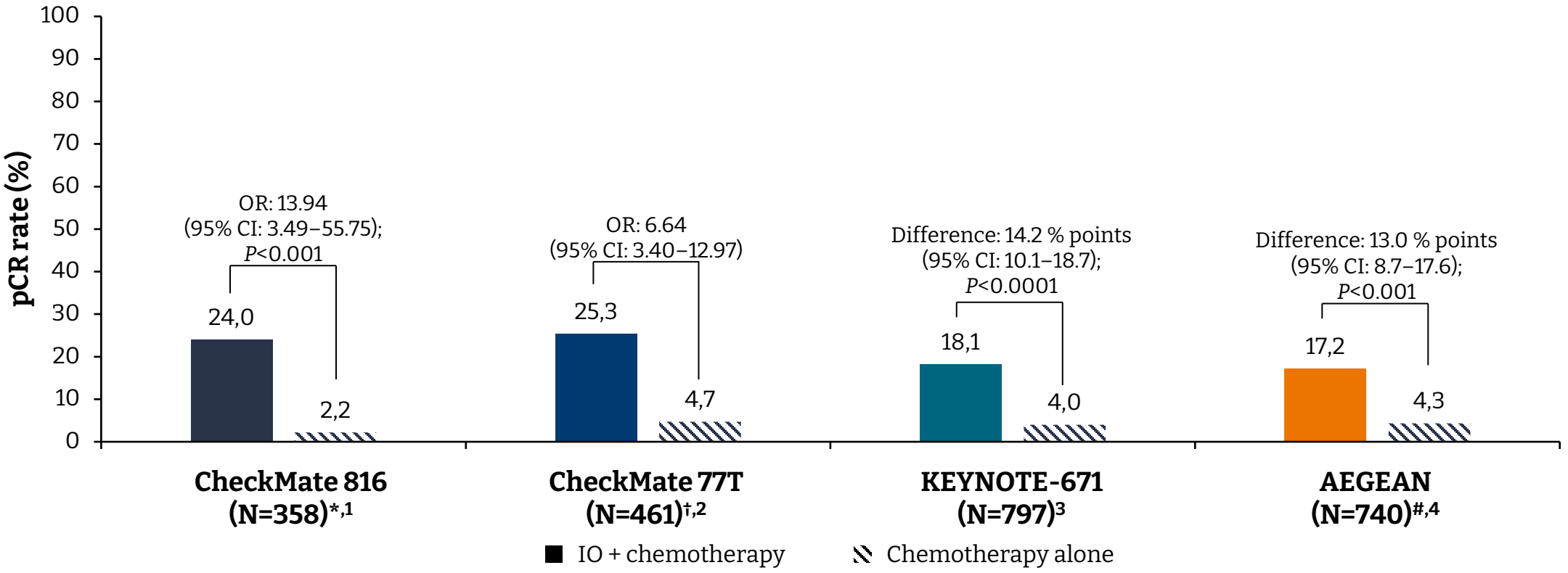
*Established cutoff based on prior evidence according to the individual histologic type of lung cancer and a specific therapy. †On review of H&E slides after complete evaluation of a resected lung cancer specimen.

AJCC, American Joint Committee on Cancer; H&E, hematoxylin and eosin; M, metastasis; MPR, major pathologic response; N, node; pCR, pathologic complete response; RVT, residual viable tumor; T, tumor; UICC, Union for International Cancer Control; yp, post-treatment pathological.

PeerView Pathology practice aid: IASLC Multidisciplinary Recommendations for Pathologic Assessment of Lung Cancer Specimens Following Neoadjuvant Therapy. Available at: https://c.peerview.com/onDemand/programs/150208306-2/downloads/PVI_practiceaids_GNU.pdf. Accessed February 2026.

# Neoadjuvant IO + chemotherapy improves pCR rate in Phase III resectable NSCLC trials

## pCR in selected neoadjuvant/perioperative IO + chemotherapy trials in resectable NSCLC




**This slide includes data from different clinical trials. These data are meant for demonstration purposes only and not meant for cross-trial comparison purposes.**

*Pathologic complete response was defined as 0% residual viable tumor cells in both primary tumor (lung) and sampled lymph nodes. According to the intention-to-treat principle, patients who did not undergo surgery were counted as not having had a response for the primary analysis. Between-group difference was calculated by means of a stratified Cochran–Mantel–Haenszel method. †The pathologic response was measured as the number of residual viable tumor cells after surgery in the primary tumor and sampled lymph nodes; the response was defined as complete if there were no residual viable tumor cells. The confidence intervals have not been adjusted for multiplicity and should not be used for hypothesis testing. #Pathologic response was assessed by central review with the use of recommendations from the International Association for the Study of Lung Cancer (2020). Pathologic complete response was defined as a lack of viable tumor cells after complete evaluation of the resected lung cancer specimen and all sampled regional lymph nodes. Patients were considered to have had no response if they were not eligible for assessment (including those with R2 resection margins by local assessment) or if a surgical specimen was not available. *P*-value based on interim analysis (n=402).

CI, confidence interval; IO, immunotherapy; NSCLC, non–small cel lung cancer; OR, odds ratio; pCR, pathologic complete response; R2, macroscopic tumor at the margin.

1. Forde PM *et al. N Engl J Med* 2022; 386 (21): 1973–1985. 2. Cascone T *et al. N Engl J Med* 2024; 390 (19): 1756–1769. 3. Wakelee H *et al. N Engl J Med* 2023; 389 (6): 491–503. 4. Heymach JV *et al. N Engl J Med* 2023; 389 (18): 1672–1684.



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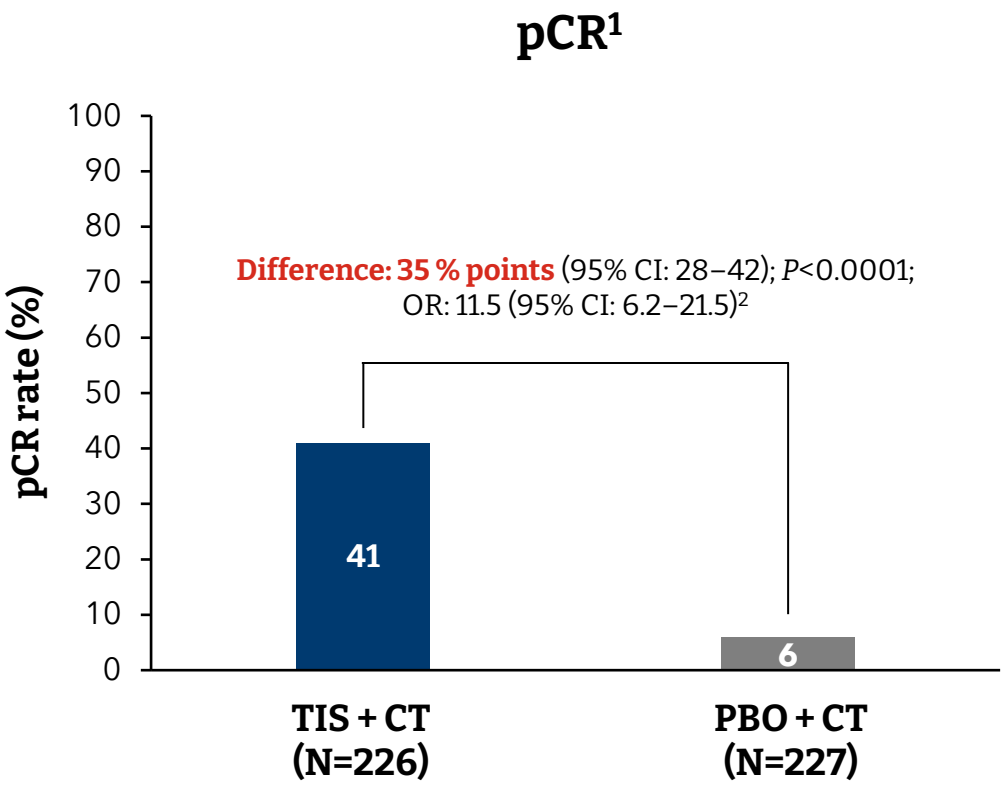
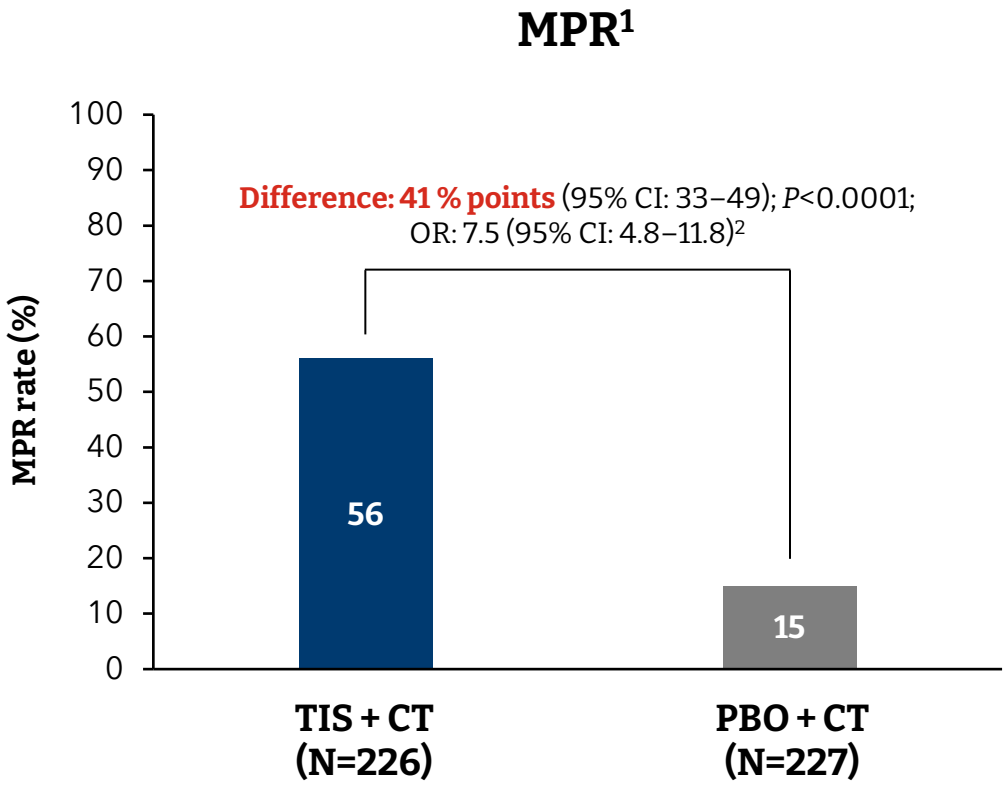
# In RATIONALE-315, tislelizumab + chemotherapy improved rates of pCR and MPR compared with chemotherapy alone



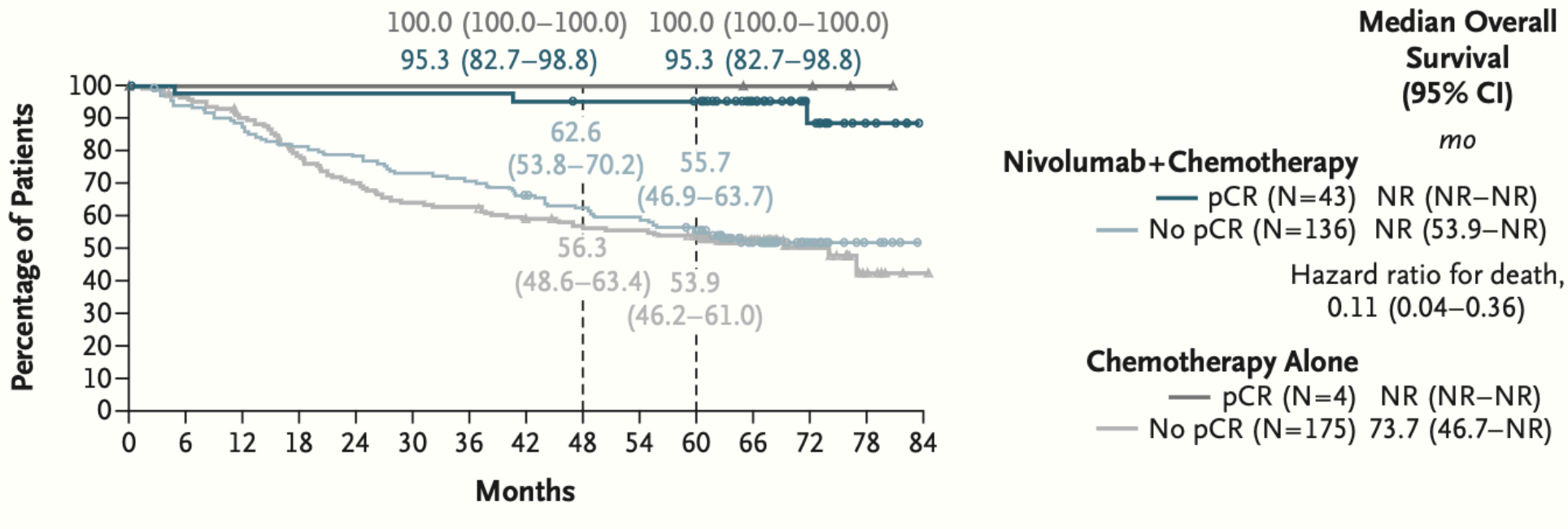

MPR and pCR response were compared between treatment groups using the Cochran–Mantel–Haenszel test. pCR rate was defined as the proportion of patients without residual viable tumour in the resected primary tumour and all resected lymph nodes after completion of neoadjuvant treatment, as assessed by masked independent pathology review in the ITT population. MPR rate was defined as the proportion of patients with 10% or less residual viable tumour in the resected primary tumour and all resected lymph nodes after completion of neoadjuvant treatment, as assessed by masked independent pathology review in the ITT population. Patients were considered as non-responders in the analysis if they did not receive surgical resection or if a surgical specimen was not available.

CI, confidence interval; CT, chemotherapy; ITT, intention-to-treat; MPR, major pathologic response; OR, odds ratio; PBO, placebo; pCR, pathologic complete response; TIS, tislelizumab.

1. Yue D *et al. Lancet Respir Med* 2025; 13 (2): 119–129. 2. Yue D *et al. Ann. Oncol.* 2025; 34 (S2): S1299.

# Longer-term data from CheckMate 816 suggest an association with pCR and 5-year OS

## CheckMate 816: OS by pCR status*




*Median follow-up: 68.4 months.

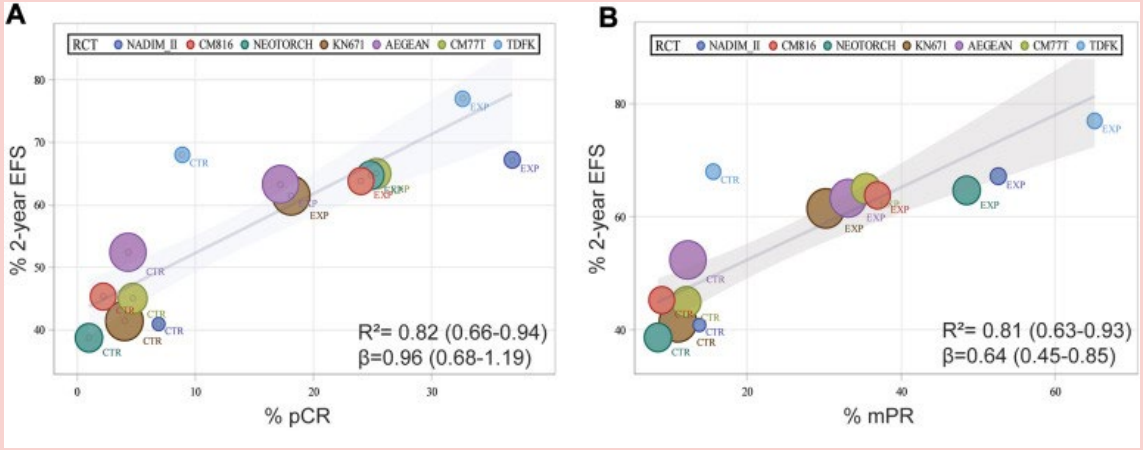
CI, confidence interval; NR, not reached; OS, overall survival; pCR, pathologic complete response.

Forde PM *et al. N Engl J Med* 2025; 393 (8): 741–752.

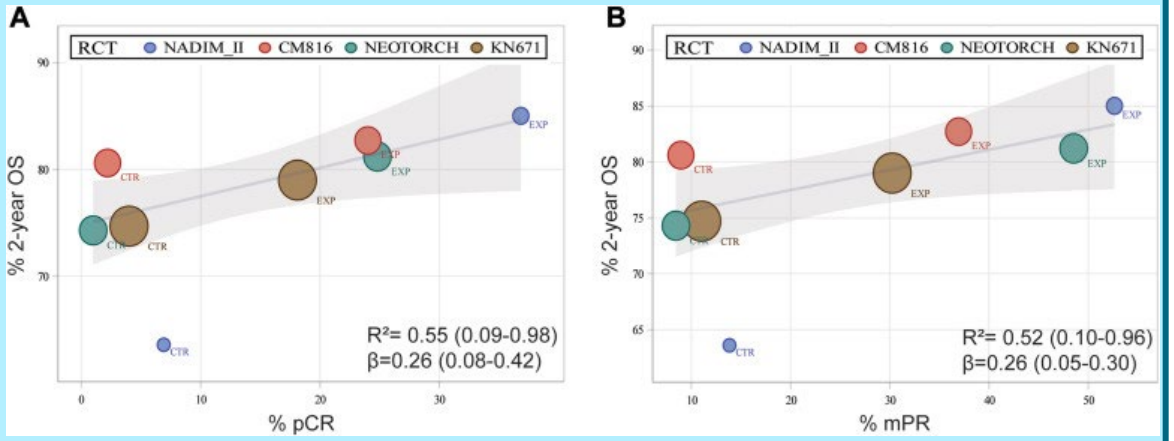
# Meta-analysis suggests achieving pCR or MPR may be associated with improved EFS following neoadjuvant IO

- 2024 meta-analysis of **seven RCTs** of **neoadjuvant IO ± chemotherapy**
  - NADIM II, CheckMate 816, NEOTORCH, KEYNOTE-671, AEGEAN, CheckMate 77T, and TD FOREKNOW
- Total patient population: **N=2,940**

**Association between A) pCR status and B) MPR status with 2-year EFS**




**Association between A) pCR status and B) MPR status with 2-year OS**




CTR, control; EFS, event-free survival; EXP, experimental; IO, immunotherapy; MPR, major pathologic response; OS, overall survival; pCR, pathologic complete response; RCT, randomized controlled trial.

Hines JB *et al. J Thoracic Oncol* 2024; 19 (7): 1108–1116.

# SACTION01: Evaluating whether SBRT improves outcomes with neoadjuvant tislelizumab + chemotherapy

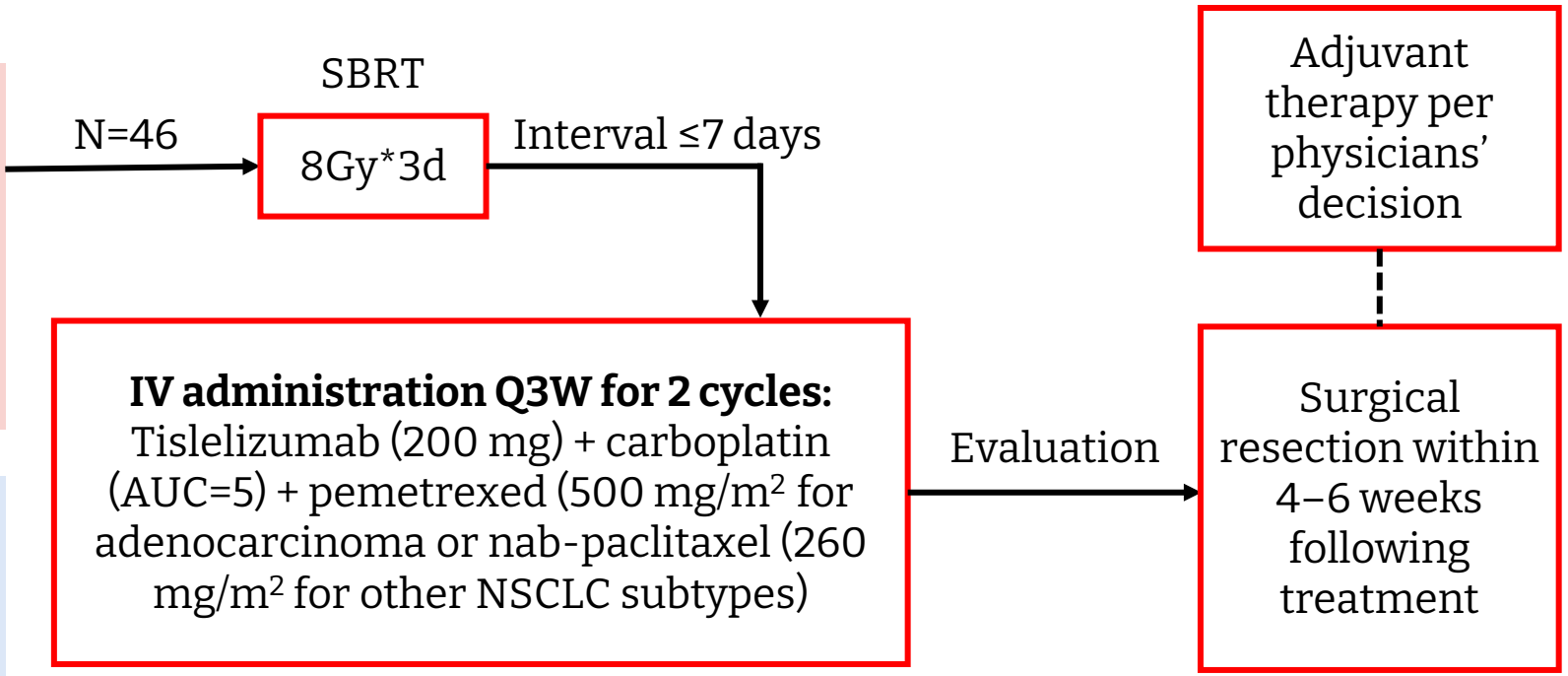
**Study design: Prospective, single-center, single arm, Phase II clinical trial to study SBRT & sequential tislelizumab and chemotherapy as neoadjuvant therapy in patients with resectable NSCLC**

**Key eligibility criteria:**

- Clinical stage IIA-IIIB (T3-4N2) NSCLC[a]
- Age ≥18
- ECOG PS 0–1
- No known *EGFR*/*ALK* alteration

**Primary endpoint:** MPR[b]

**Secondary endpoints:** pCR, R0 resection rate, event-free survival[c]




[a]According to the eighth edition of the American Joint Committee on Cancer staging system. [b]MPR defined as the presence of 10% or fewer RVT in the primary tumor and resected lymph nodes. [c]Event-free survival was defined as the time from initiation of neoadjuvant treatment to the first occurrence of disease progression precluding surgical resection, disease progression in the absence of surgery, progression or recurrence after surgery, or death from any cause.

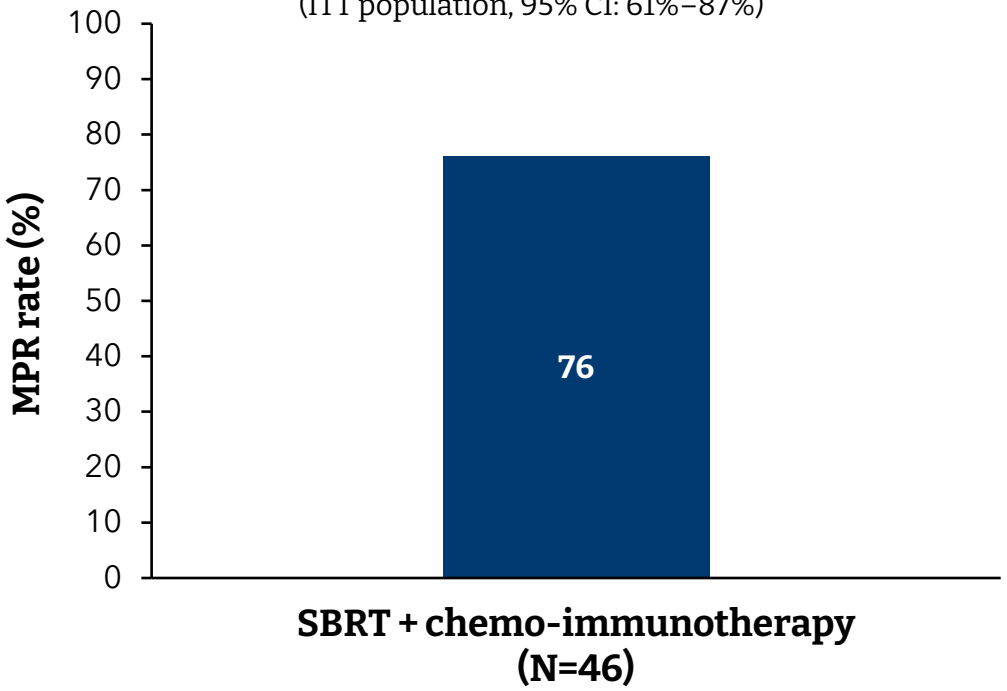
ECOG, Eastern Cooperative Oncology Group performance status; IV, intravenous; MPR, major pathological response; NSCLC, non-small cell lung cancer; pCR, pathological complete response; Q3W, every 3 weeks; SBRT, stereotactic body radiotherapy; T3-4N2, tumor stage T3–T4 with N2 nodal involvement.

Zhao ZR *et al. Lancet Respir Med* 2024;12(12):988–996.

# SACTION01: Early findings indicate positive MPR and pCR results

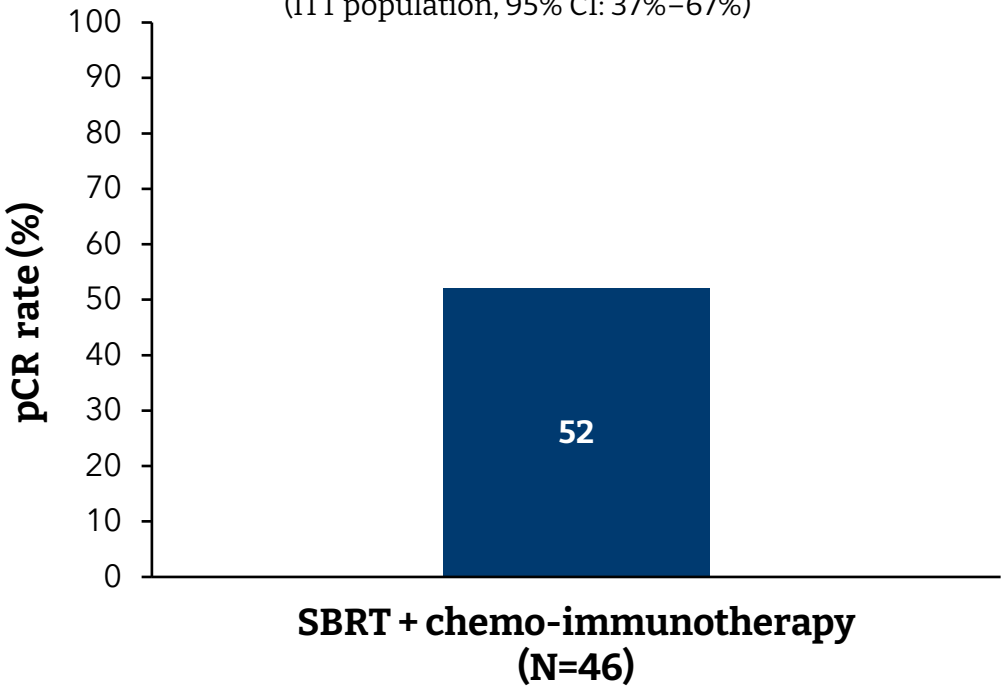
## Primary endpoint: MPR

(ITT population, 95% CI: 61%–87%)




## Secondary endpoint: pCR

(ITT population, 95% CI: 37%–67%)




SBRT followed by neoadjuvant Tislelizumab + chemotherapy was generally well tolerated and resulted in a **clinically meaningful increase in MPR and pCR rates** compared with previously reported outcomes following neoadjuvant IO + Ch

IO, immunotherapy; MPR, major pathological response; NSCLC, non-small cell lung cancer; pCR, pathological complete response; SBRT, stereotactic body radiotherapy.
Zhao ZR et al. Lancet Respir Med 2024;12(12):988–996.

# SACTION2401: RCT to compare neoadjuvant tislelizumab + chemotherapy with or without SBRT

## Study design: Multicenter, Phase III clinical trial to evaluate SBRT followed by tislelizumab plus platinum doublet chemotherapy vs standard immune chemotherapy in the peri-operative setting

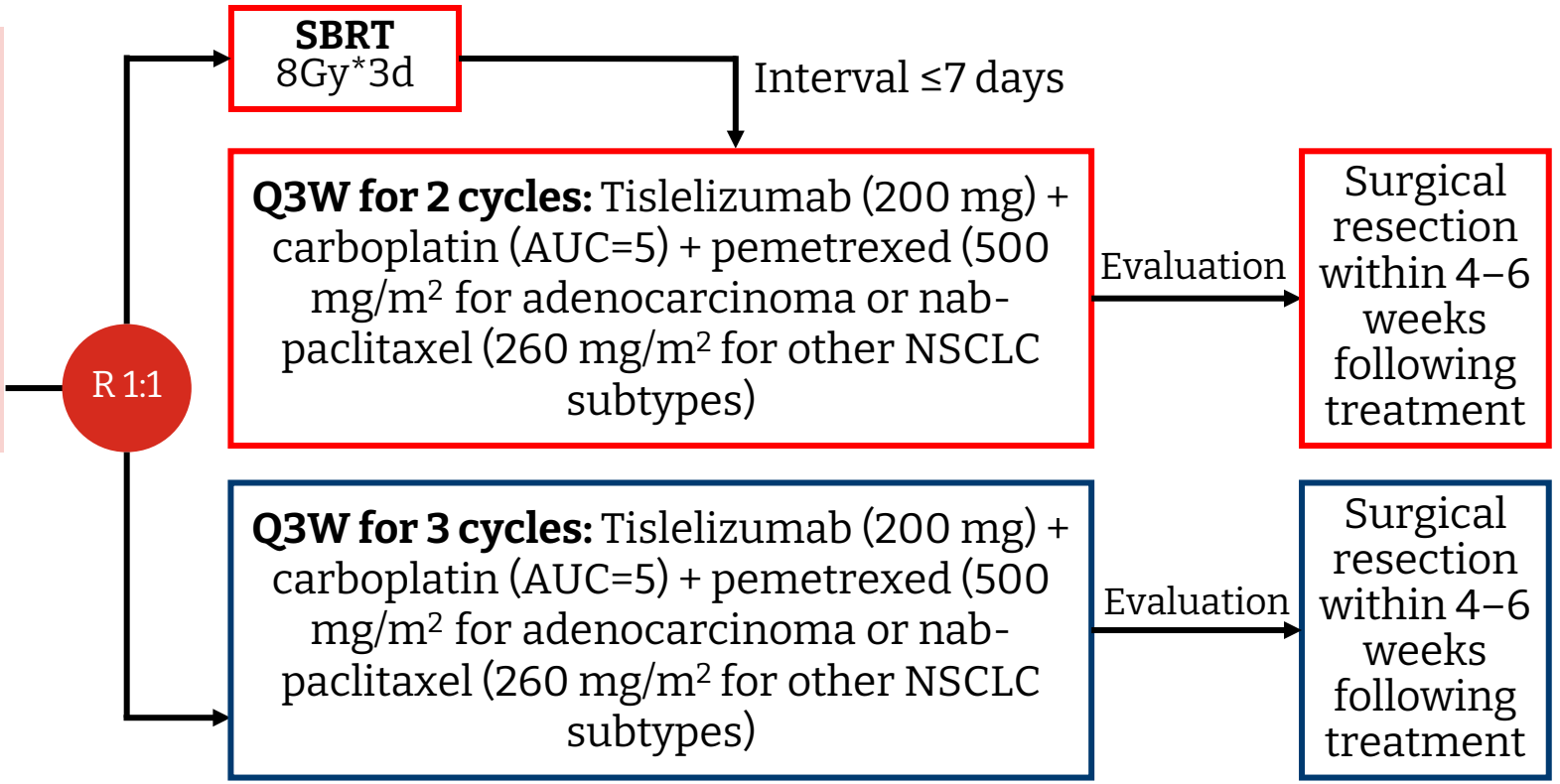
**Key eligibility criteria:**

- Resectable stage II–IIIA or potentially resectable T3-4N2 IIIB NSCLC[a]
- Age ≥18
- ECOG PS 0–1
- No known *EGFR*/*ALK* alteration
- N=360

**Primary endpoint:** Event-free survival

**Secondary endpoints:** OS, pCR, R0 resection rate, MPR, safety

**Stratification factors:** Disease stage, histology and study center



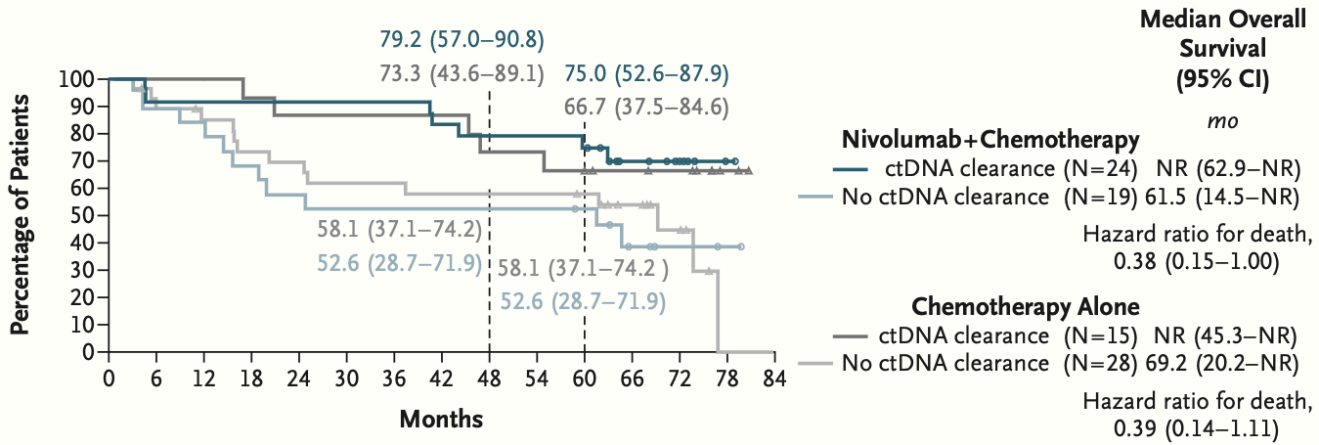

[a]According to the eighth edition of the American Joint Committee on Cancer staging system.

ECOG, Eastern Cooperative Oncology Group performance status; MPR, major pathological response; NSCLC, non-small cell lung cancer; OS, overall survival; pCR, pathological complete response; Q3W, every 3 weeks; RCT, randomized controlled trial; SBRT, stereotactic body radiotherapy; T3-4N2, tumor stage T3–T4 with N2 nodal involvement.

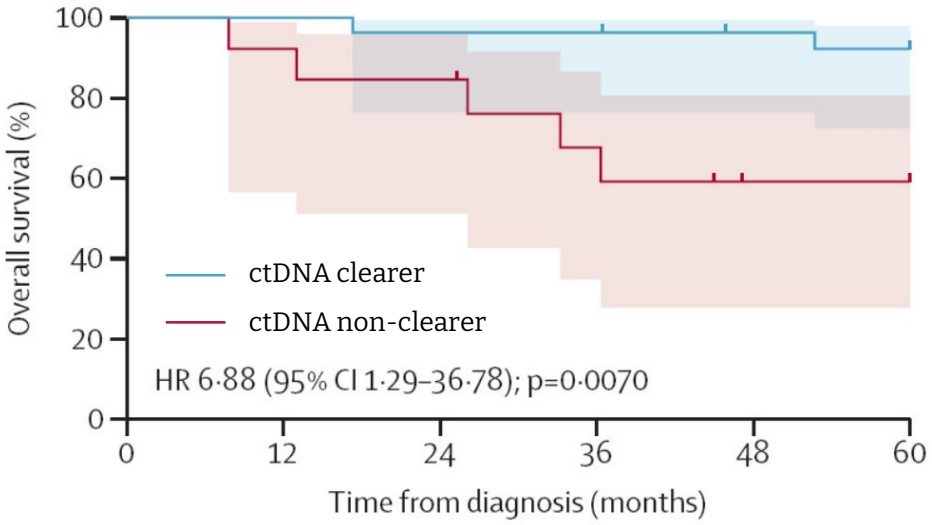
NCT06598527. Available at: https://clinicaltrials.gov/study/NCT06598527. Accessed March 2026.

# ctDNA detection following neoadjuvant IO + chemotherapy may be associated with poorer patient outcomes

## CheckMate 816: OS by ctDNA clearance*,1




## NADIM: 5-year OS by ctDNA clearance†,2




**OS ctDNA clearer: 92.3% (95% CI: 72.5%–98%)**

**OS ctDNA non-clearer: 59.2% (95% CI: 27.9%–80.7%)**

**This slide includes data from different clinical trials. These data are meant for demonstration purposes only and not meant for cross-trial comparison purposes.**

*Median follow-up: 68.4 months. †Median follow-up: 60.0 months.

CI, confidence interval; ctDNA, circulating tumor DNA; HR, hazard ratio; IO, immunotherapy; NR, not reached; OS, overall survival.

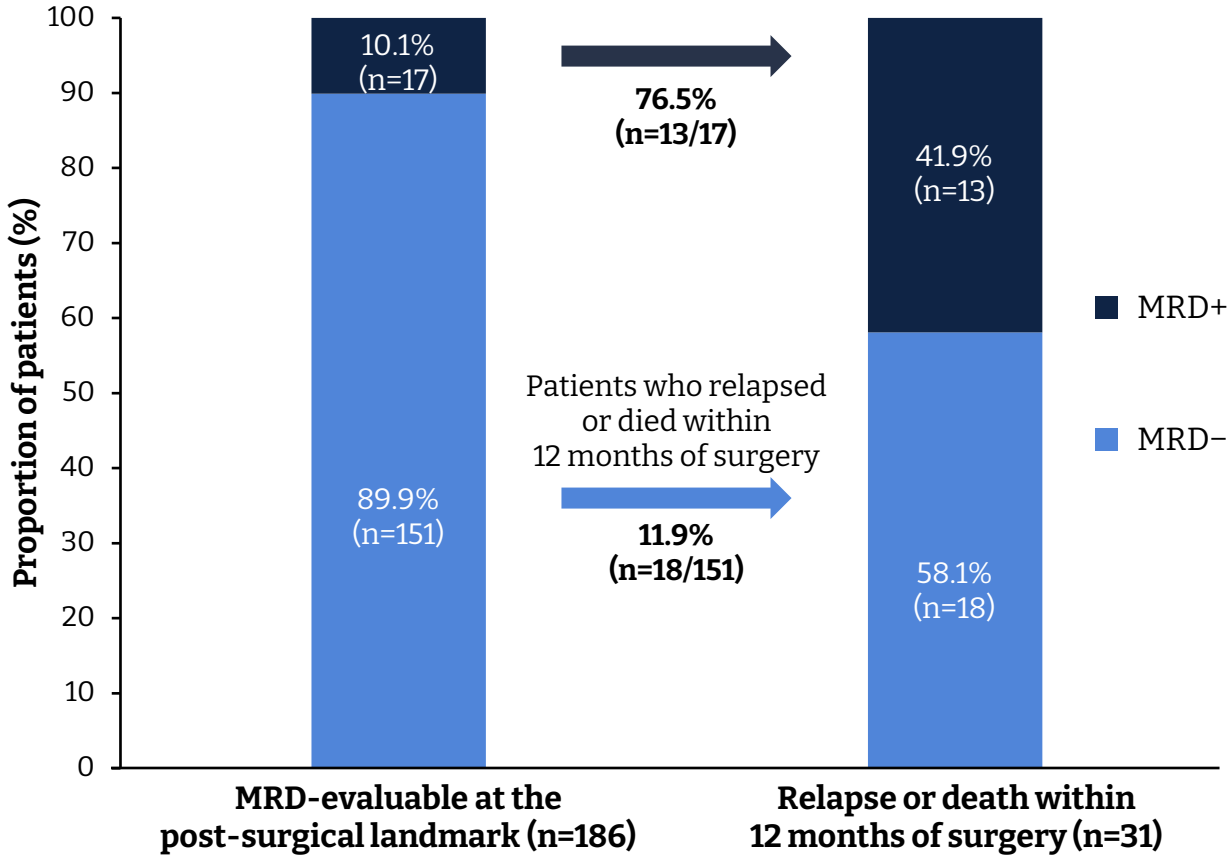
1. Forde PM *et al. N Engl J Med* 2025; 393 (8): 741–752. 2. Provencio M *et al. Lancet Oncol* 2024; 25 (11): 1453–1464.

# Based on exploratory data from AEGEAN, MRD status may help to identify patients at higher risk of relapse or death

## Proportion of patients achieving pCR and MPR by MRD status

| Response, n (%) | Durvalumab arm | | Placebo arm | |
|---|---|---|---|---|
| | MRD+ (n=10) | MRD− (n=78) | MRD+ (n=7) | MRD− (n=73) |
| pCR | 0 | 25 (32.1) | 1 (14.3) | 3 (4.1) |
| No pCR | 10 (100) | 53 (67.9) | 6 (85.7) | 70 (95.9) |
| MPR | 0 | 42 (53.8) | 2 (28.6) | 14 (19.2) |
| Non-MPR | 10 (100) | 36 (46.2) | 5 (71.4) | 59 (80.8) |

## MRD clearance in patients who experienced relapse or death within 12 months of surgery




Exploratory analysis.
MRD(+/−), minimal residual disease(−positive/−negative); MPR, major pathologic response; pCR, pathologic complete response.
Reck M *et al.* Oral presentation (abstract 8009) at ASCO 2025; Chicago, IL, USA, May 30 – June 3, 2025.

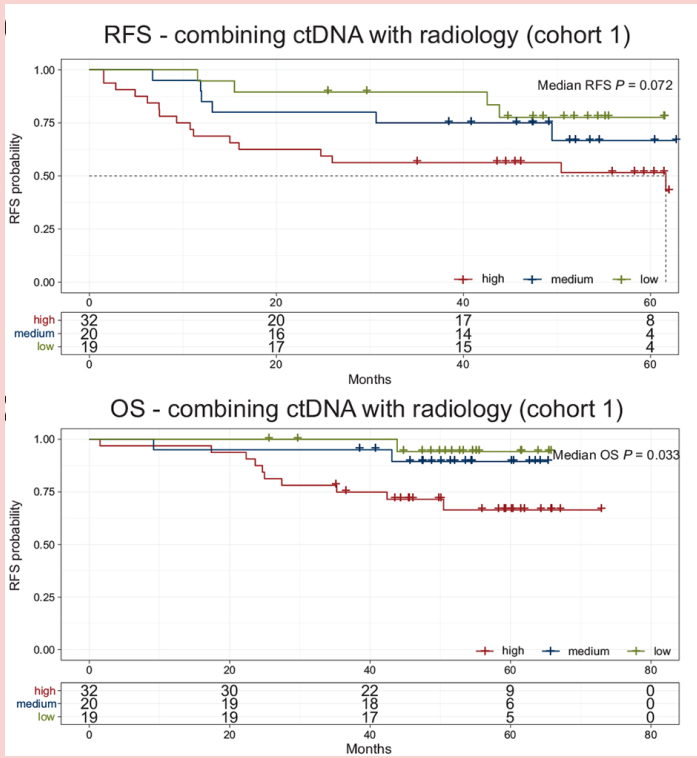
# In the future, a combination of ctDNA assessment and imaging data may help predict risk of relapse

## Validation of a risk model with combination of ctDNA and radiologic tumor volume

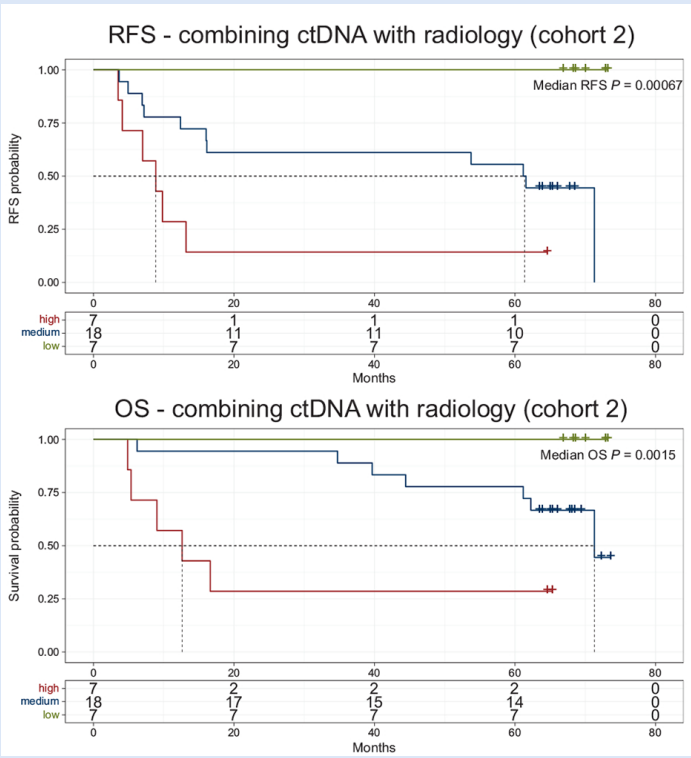
**Patients were stratified based on the following risk categories to test the combination risk model:**

- **High risk:** detectable ctDNA and radiological tumor volume above the computed threshold
- **Medium risk:** detectable ctDNA but tumor volume below the calculated threshold, or patients with undetectable ctDNA but tumor volume above the calculated threshold
- **Low risk:** undetectable ctDNA and radiological tumor volume below the computed threshold

### Development cohort

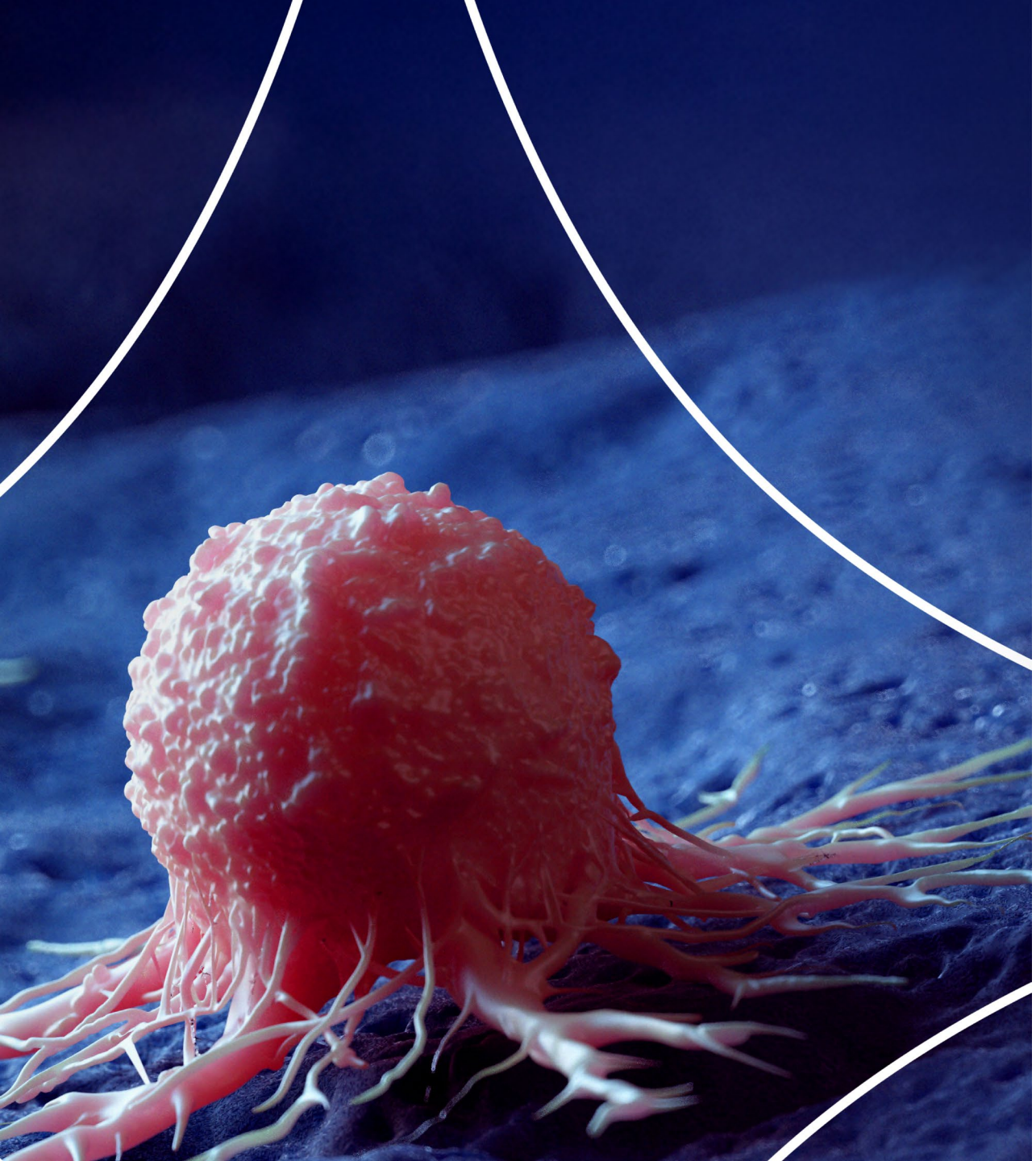



### Validation cohort




ctDNA, circulating tumor DNA; OS, overall survival; RFS, relapse-free survival.

Tran HT *et al. Ann Oncol* 2023; 35 (2): 183–189.





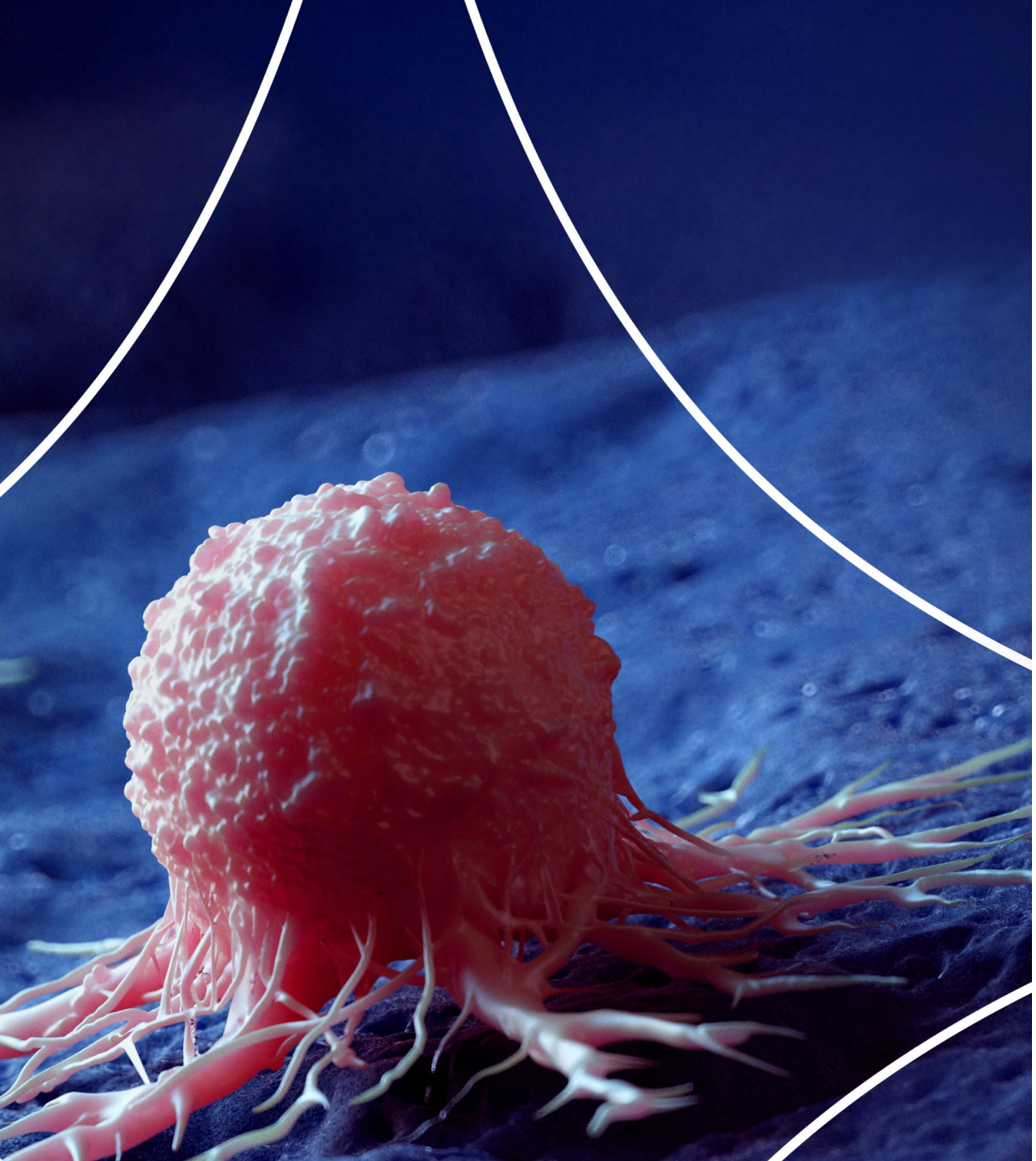
# MDT discussion:

## Which key factors may inform the de-escalation/escalation of treatment?

All faculty

✦ ✦ ✦

MDT, multidisciplinary team; NSCLC, non–small cell lung cancer.





# MDT perspectives: How may the optimal treatment approach evolve in the future?

All faculty

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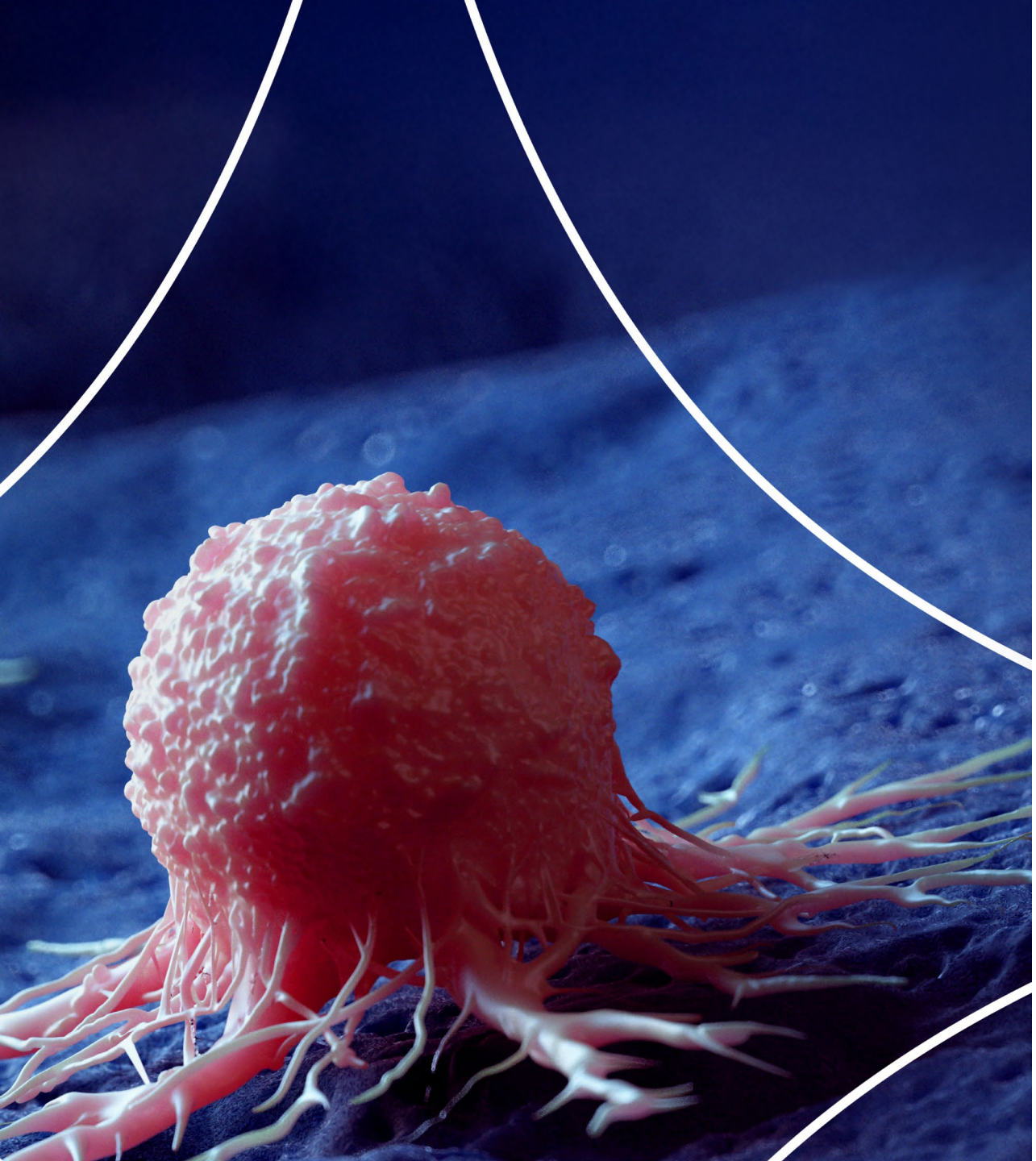
MDT, multidisciplinary team; NSCLC, non–small cell lung cancer.





# Conclusions

Martin Sebastian
Frankfurt University Hospital, Germany

MDT, multidisciplinary team; NSCLC, non–small cell lung cancer.

# Conclusions

- Neoadjuvant and perioperative IO regimens have demonstrated improved OS for the treatment of patients with resectable NSCLC[1–3]
- There remains a need to refine patient selection criteria for each approach to optimize patient outcomes[4]

- Neoadjuvant IO does not appear to affect surgical feasibility in resectable NSCLC[5–9]
- Determination of resectability should be based on both patient and disease factors, as assessed by the treating surgeon[10]

- Based on meta-analyses and data from Phase III IO trials, pCR, MPR, and ctDNA may be correlated with survival outcomes in resectable NSCLC[11–13]
- There remains a need for more reliable biomarkers to inform determination of the optimal treatment approach[14]

This slide reflects the opinion of the speaker.

ctDNA, circulating tumor DNA; IO, immunotherapy; MPR, major pathologic response; NSCLC, non–small cell lung cancer; OS, overall survival; pCR, pathologic complete response.

1. Forde PM *et al.* Oral presentation at ASCO 2025; Chicago, IL, USA, May 30 – June 3, 2025. 2. Spicer JD *et al. Lancet* 2024; 404 (10459): 1240–1252. 3. Yue D *et al.* Presented at WCLC 2025; Barcelona, Spain, September 6–9, 2025. 4. Guerrera F *et al. Lung Cancer* 2025; 209: 108760. 5. Forde PM *et al. N Engl J Med* 2022; 386 (21): 1973–1985. 6. Cascone T *et al. N Engl J Med* 2024; 390 (19): 1756–1769 – supplementary appendix. 7. Wakelee H *et al. N Engl J Med* 2023; 389 (6): 491–503. 8. Heymach JV *et al. N Engl J Med* 2023; 389 (18): 1672–1684. 9. Yue D *et al.* Oral presentation at ELCC 2024; Prague, Czech Republic, March 20–23, 2024. 10. Kim SS *et al. Ann Thoracic Surg* 2025; 119 (1): 16–33. 11. Forde PM *et al. N Engl J Med* 2025; 393 (8): 741–752. 12. Provencio M *et al. Lancet Oncol* 2024; 25 (11): 1453–1464. 13. Hines JB *et al. J Thoracic Oncol* 2024; 19 (7): 1108–1116. 14. Jeon H *et al. Pathol Oncol Res* 2024; 30: 1611817.



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# Questionnaire and Survey

# Thank you for your attendance and participation!