Herlev og Gentofte Hospital
Afdeling for Kræftbehandling

REGION

Nyeste fremskridt indenfor behandling af lungekræft i Danmark

Jon Lykkegaard Andersen

Overlæge

Afdeling for Kræftbehandling Herlev/Gentofte Hospital

Disclosure

- Jeg har rådgivet, undervist, deltaget i advisory boards mod honorar og fået betalt kongresudgifter fra følgende firmaer:
- Abbvie, Amgen, AstraZeneca, Boehringer-Ingelheim, Bristol-Myers Squibb, Clovis, Eli Lilly, Merck Sharp and Dohme, Merck KGaA, Novartis, Pfizer, Pierre Fabre, Sanofi, Roche & Takeda.
- Ingen interessekonflikter i det følgende foredrag.

Herlev Hospital

REGION

Platinum-Based Doublets for NSCLC

North American Experience (SWOG + ECOG)

SWOG[1]	N	ORR, %	Median Survival, Months	1-Year Survival, %
Cisplatin + vinorelbine	202	28	8.6	36
Paclitaxel + carboplatin	206	25	8.1	38
ECOG[2]				
Paclitaxel + carboplatin	290	17	8.1	34
Gemcitabine + cisplatin	288	22	8.1	36
Paclitaxel + cisplatin	288	21	7.8	31
Docetaxel + cisplatin	289	17	7.4	31

ECOG, Eastern Cooperative Oncology Group; ORR, overall response rate; SWOG, Southwest Oncology Group

1. Kelly K, et al. J Clin Oncol. 2001;19(13):3210-3218. 2. Schiller JH, et. al. N EnglJ Med. 2002;346(2):92-98.

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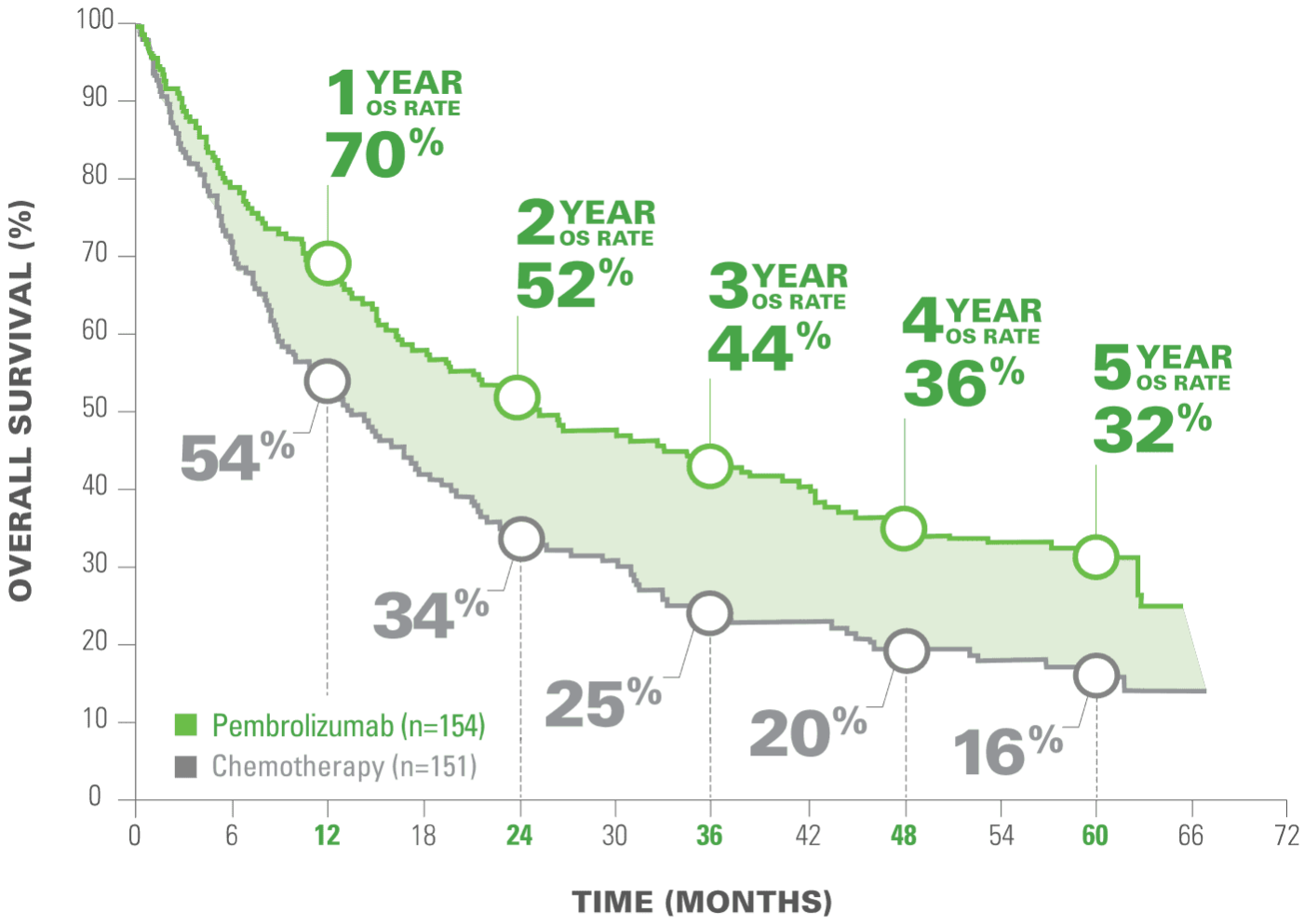
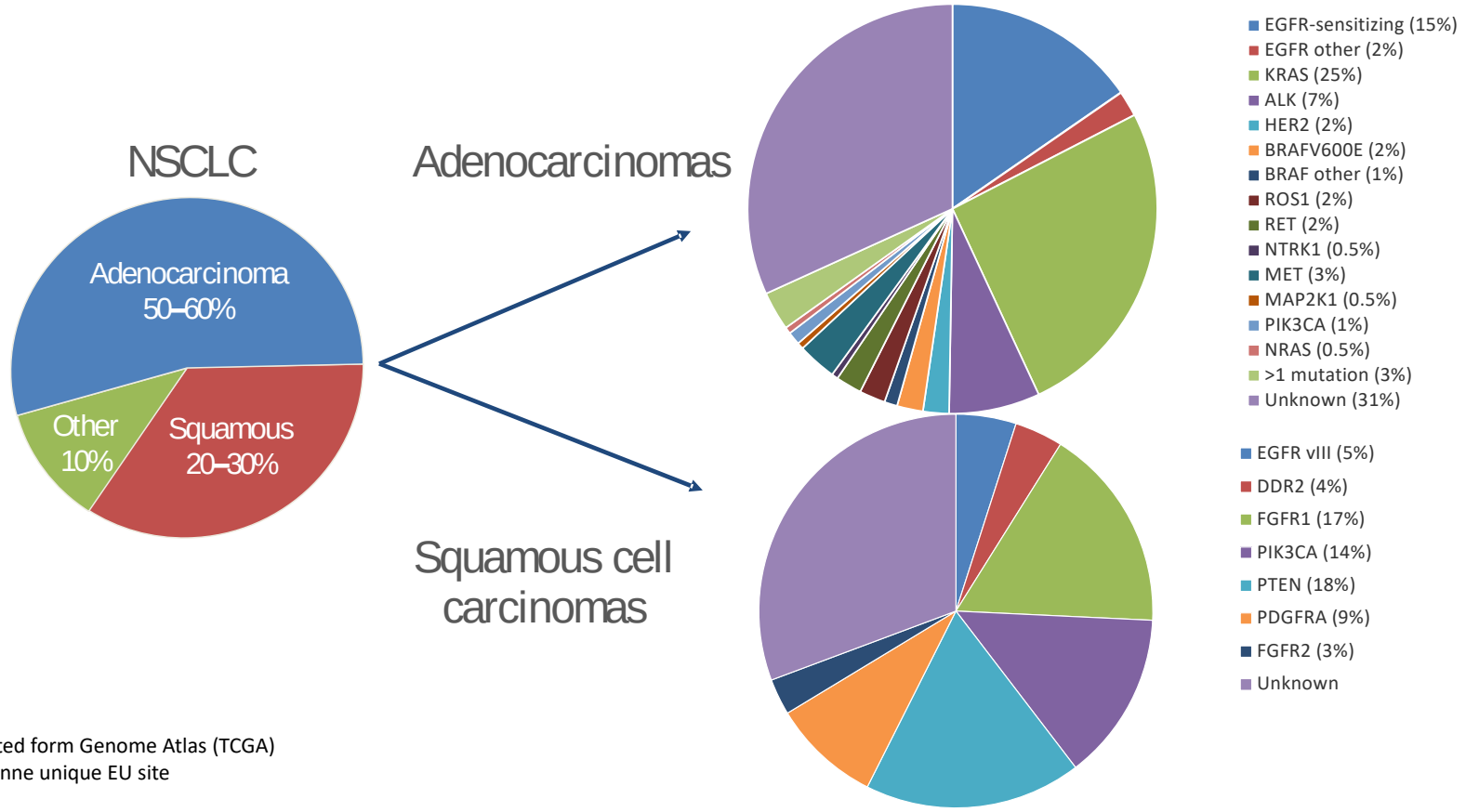


NUMBER AT RISK

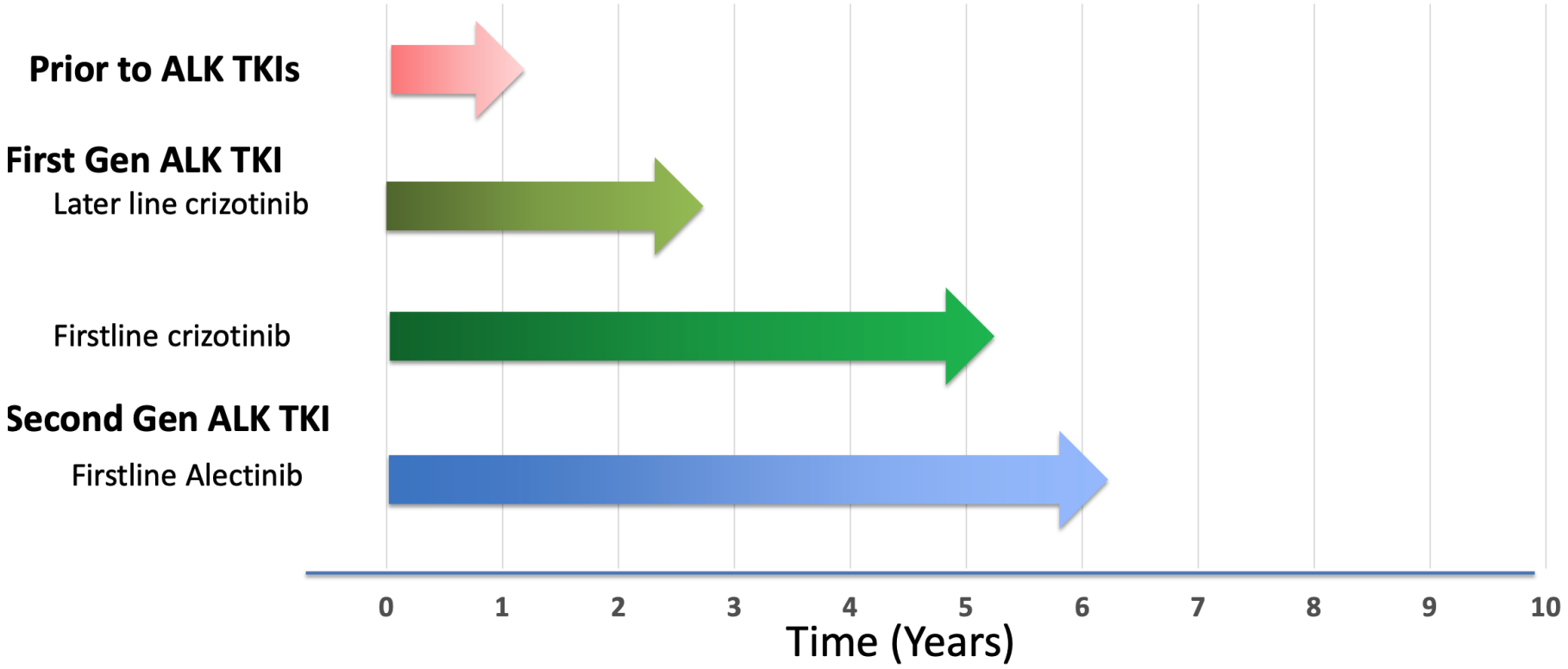
154	121	106	89	78	73	66	62	54	51	20	0	0
151	108	80	61	48	44	35	33	28	26	13	3	0

Drivers alterations in NSCLC



Adapted form Genome Atlas (TCGA)
Lausanne unique EU site

Improving survival in ALK+ NSCLC



Shaw Lancet Oncology 2011; Solomon JCO 2018; Mok Annals Oncol 2020

Dansk Lunge Cancer Gruppes Visionskonference 2023

2030-VISION FOR LUNGEKRÆFT I DANMARK

Et længere og bedre liv med lungekræft.
Gennem tidligere og fokuseret diagnosticering skal vi i 2030 kunne tilbyde kurativ behandling til 50 % af patienter med lungekræft.

Hvor helbredelse ikke er mulig, skal lungekræft transformeres fra en sygdom med hurtig progression og død til en kronisk sygdom med fortsat livskvalitet.

Kan man øge overlevelsen efter kirurgen sagde jeg var rask….

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5-års overlevelse for pt opereret for NSCLC

Indikator IId: Overlevelse 5 år efter første resektion
(Standardværdi ≥58% (målsætning))

Tabel 3.2.7: Resultater for indikator IId, for hele landet og efter behandlende afdeling,

Indikator IId: Andel, som overlever 5 år fra først registrerede resektion

	Standard ≥ 58% opfyldt	Tæller/ nævner	Uoplyst antal (%)	Aktuelle år 01.01.2017 - 31.12.2017 Andel	95% CI	2016 Andel
Danmark	Ja	663 / 1.054	0 (0)	62,9	(59,9-65,8)	62,1

Dansk Lunge Cancer Register

Årsrapport 2022

Rapporten dækker perioden 1. januar 2022 – 31. december 2022

Offentlig version
Per 29. juni 2023

Tabel 8.2.1.4 pTNM stadie overlevelser – total

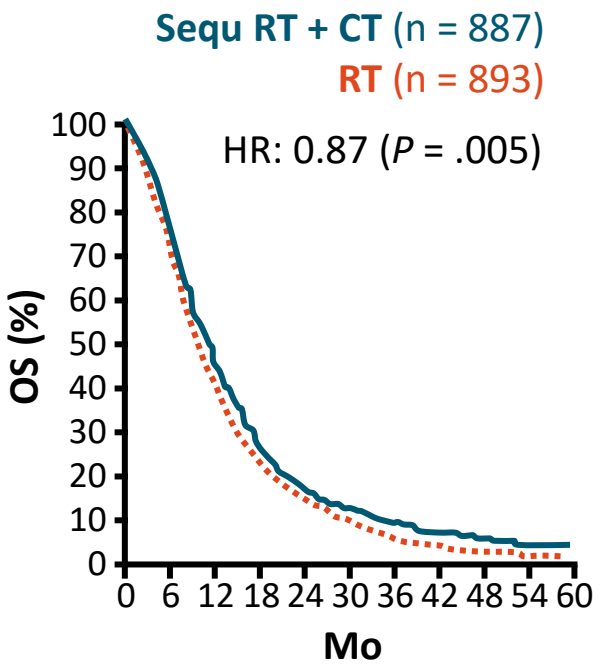
Postoperativt stadie	2017
IA	72.4
IB	58.7
IIA	59.2
IIB	55.2
IIIA	53.3
IIIB	38.5

Dansk Lunge Cancer Gruppe/Register

rkkp
regionernes kliniske kvalitetsudviklingsprogram

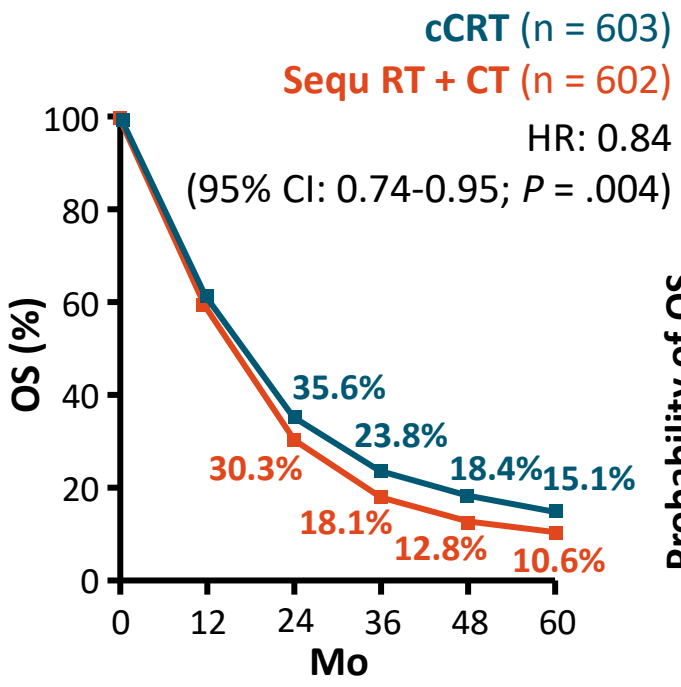
Unresectable Stage III NSCLC: Evolution of Treatment

RT vs Sequential RT + CT*[1]

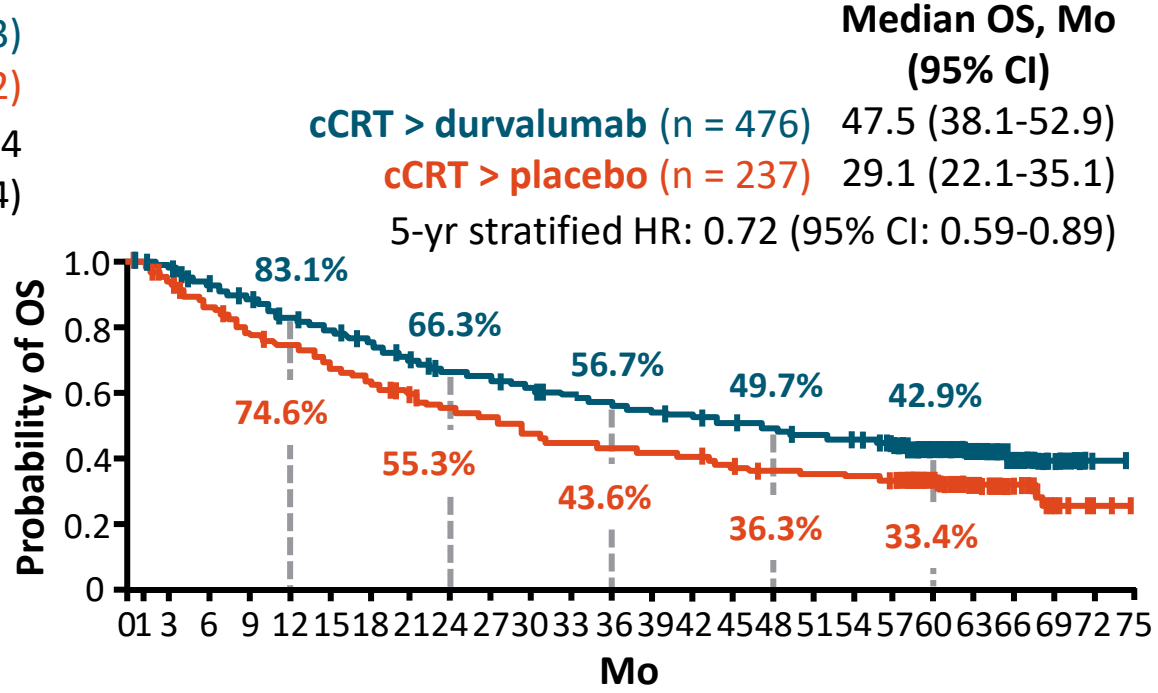


*Cisplatin-based regimens.

Sequential RT + CT vs Concurrent CRT[2]



PACIFIC: Concurrent CRT ± Immunotherapy[3]



In February 2018, FDA approved durvalumab for treatment of unresectable stage III NSCLC without disease progression following concurrent CRT

1. NSCLC Collaborative Group. BMJ. 1995;311:899. 2. Aupérin. JCO. 2010;28:2181. 3. Spigel. JCO. 2022;40:1301.

Slide credit: clinicaloptions.com
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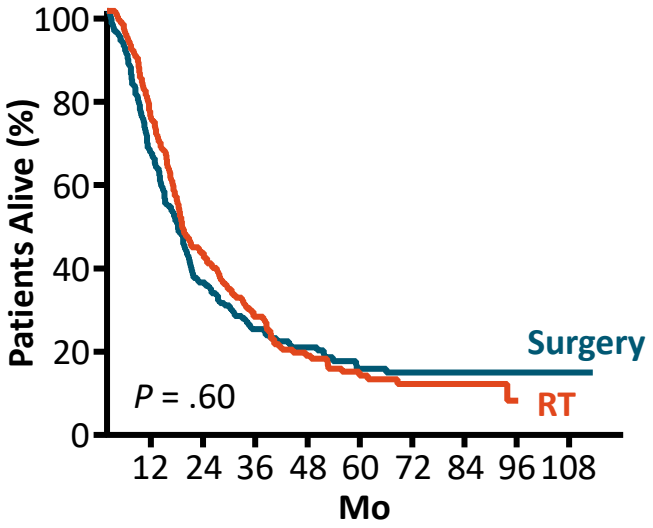
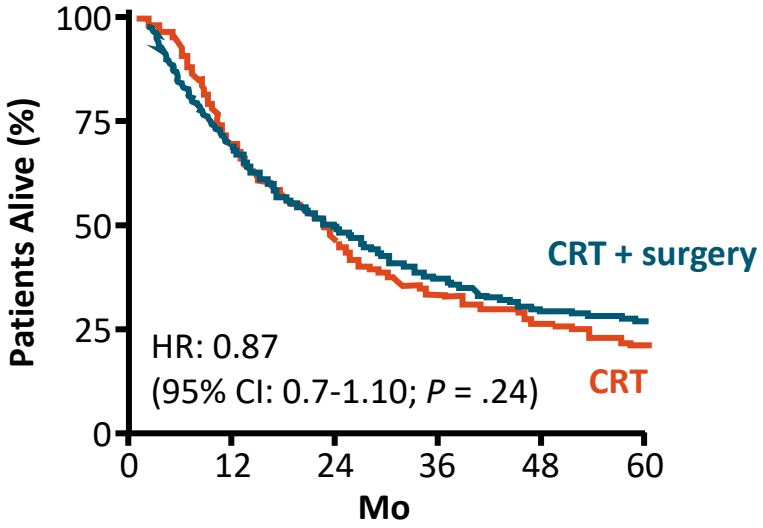
Stage III-N2 Resectable NSCLC: Should We Operate or Radiate?

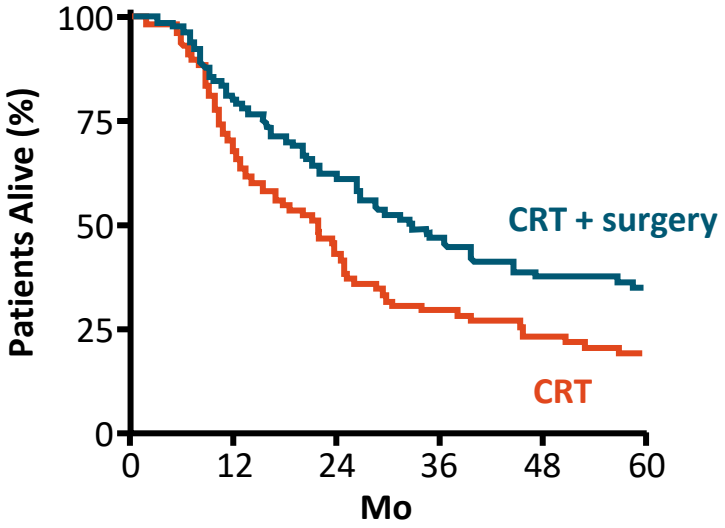
EORTC 80941: Induction CRT > Response > Resection vs RT (60 Gy)[1]



INT0139: Induction CRT (45 Gy) + Resection vs Radical CRT (61 Gy)[2]



INT0139 Subgroup Analysis: Lobectomy as Trimodality Tx vs Bimodality CRT[2]



- No universal definition of "resectable" stage III-N2 disease; case-by-case multidisciplinary determination[3]
  - Tend to consider single station, smaller (≤1.5 cm) N2 nodal involvement, better operative risk
- Resection and radical RT, combined with systemic tx, provide benefit in resectable stage III-N2 disease
- Adding surgical resection (trimodality) did not increase PFS, OS compared with CRT alone
- Patient selection (lobectomy, low operative risk) may identify subgroup that may benefit from trimodality tx

1. Van Meerbeeck. J Natl Cancer Inst. 2007;99:442. 2. Albain. Lancet. 2009;374:379. 3. Patel. Oncologist. 2005;10:335.

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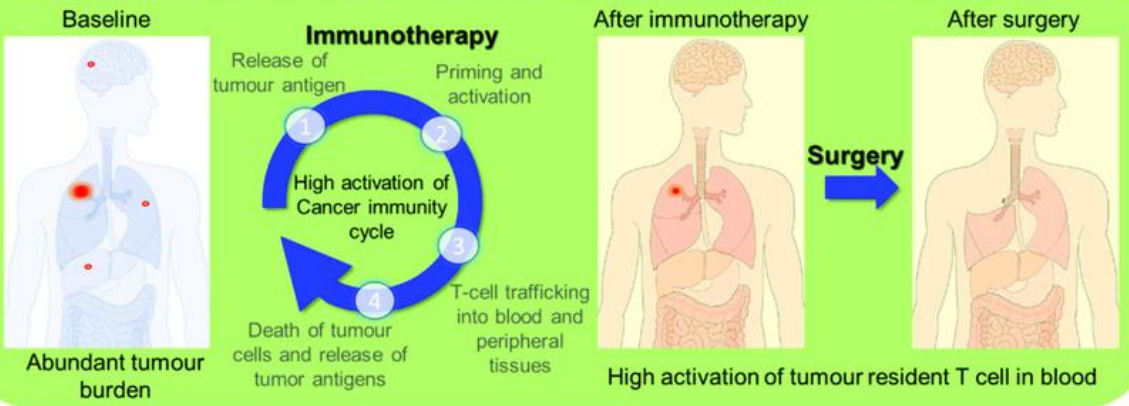
Neoadjuverende versus adjuverende

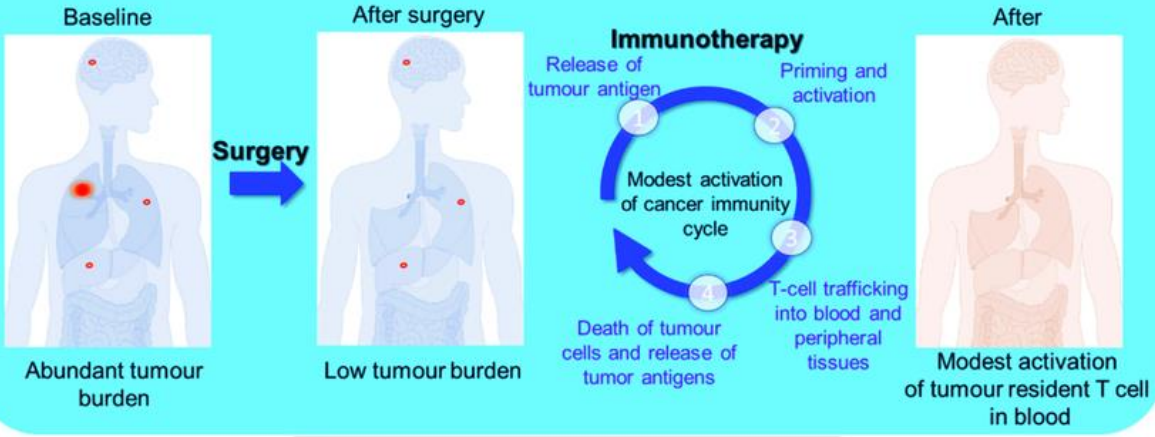
Neoadjuvant

Advantage	Maintains lymphatic and blood flow between the tumor and its lymph nodes (T-cell activation) Offers the earliest treatment of micrometastases, especially for distant metastases Allows patients with good compliance Increases resectability due to tumour shrinkage Increases opportunity to implement preoperative smoking cessation and pulmonary rehabilitation Increases opportunity for preoperative assessment of anticipated metastases and comorbidities
Disadvantage	Opportunities for resection are delayed or missed due to neoadjuvant therapy-related adverse events Decreases haematopoiesis and wound healing (increases postoperative complications)



Adjuvant

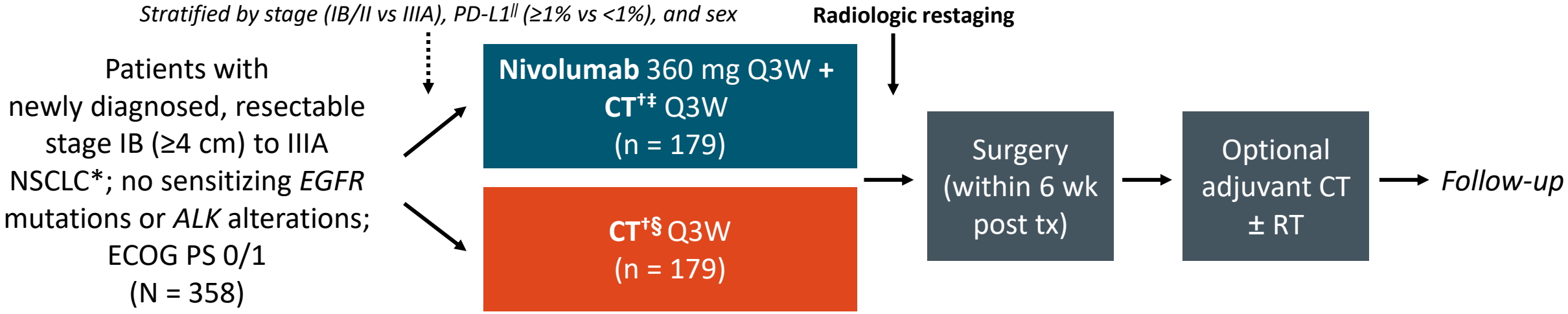
Advantage	Allows for treatment strategies to be determined according to the final pathological stage Increases the number of biomarkers examined using abundant resected tumour samples
Disadvantage	Implemented in a disrupted immune environment. Takes place when compliance is reduced due to the surgical invasiveness.



Primary tumour • undetectable metastasis by imaging

CheckMate 816: Neoadjuvant Nivolumab + Platinum Chemotherapy for Resectable Stage IB-IIIA NSCLC

- Randomized, open-label phase III trial (data cutoff: September 16, 2020; min f/u: 7.6 mo)



*By TNM 7th edition. †3 cycles. ‡NSQ: cisplatin/pemetrexed or carboplatin/paclitaxel; SQ: cisplatin/gemcitabine or carboplatin/paclitaxel. §NSQ: cisplatin/pemetrexed; SQ: cisplatin/vinorelbine, cisplatin/docetaxel, cisplatin/gemcitabine; both: carboplatin/paclitaxel. ‖PD-L1 28-8 pharmDx IHC assay.

- **Primary endpoints:** pCR (by BIPR) and EFS (by BICR)
- **Key secondary endpoints:** OS, MPR (by BIPR), time to death or distant metastasis
- **Key exploratory endpoints:** ORR (by BICR), feasibility of surgery, peri- and postoperative surgery-related AEs

Spicer. ASCO 2021. Abstr 8503. Forde. NEJM. 2022;386:1973. Girard. AACR 2022. Abstr CT012.

Slide credit: clinicaloptions.com

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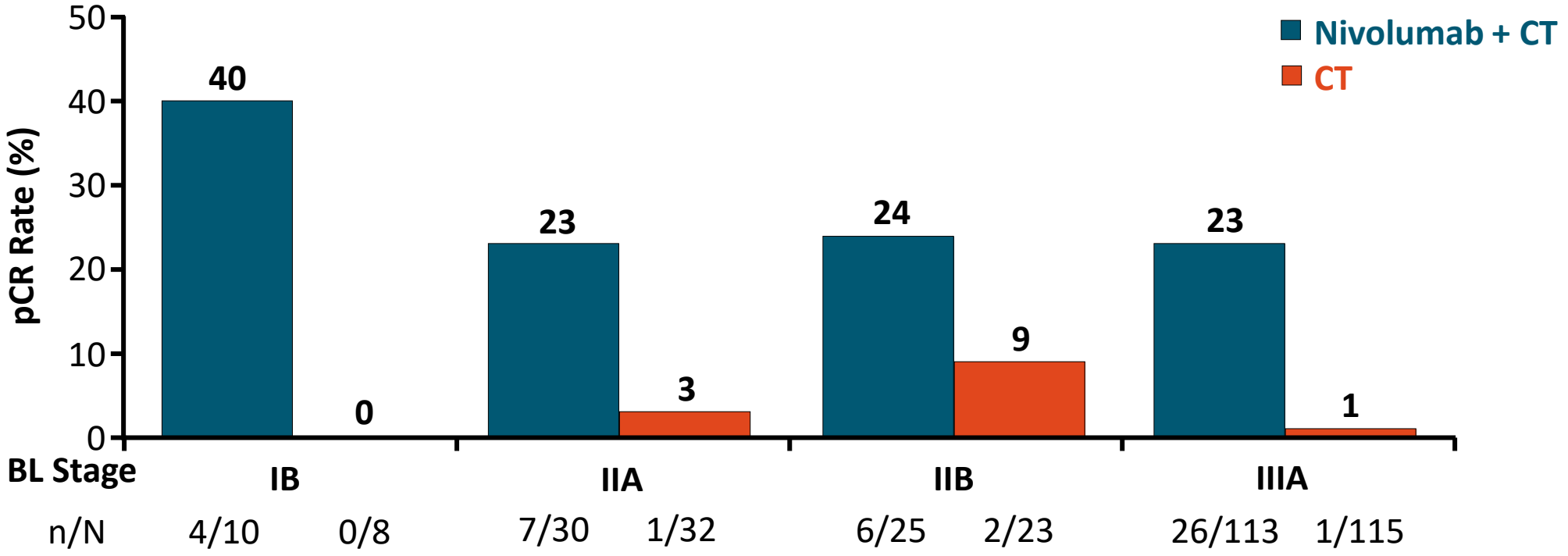
CheckMate 816: pCR by Disease Stage at Baseline (Coprimary Endpoint)

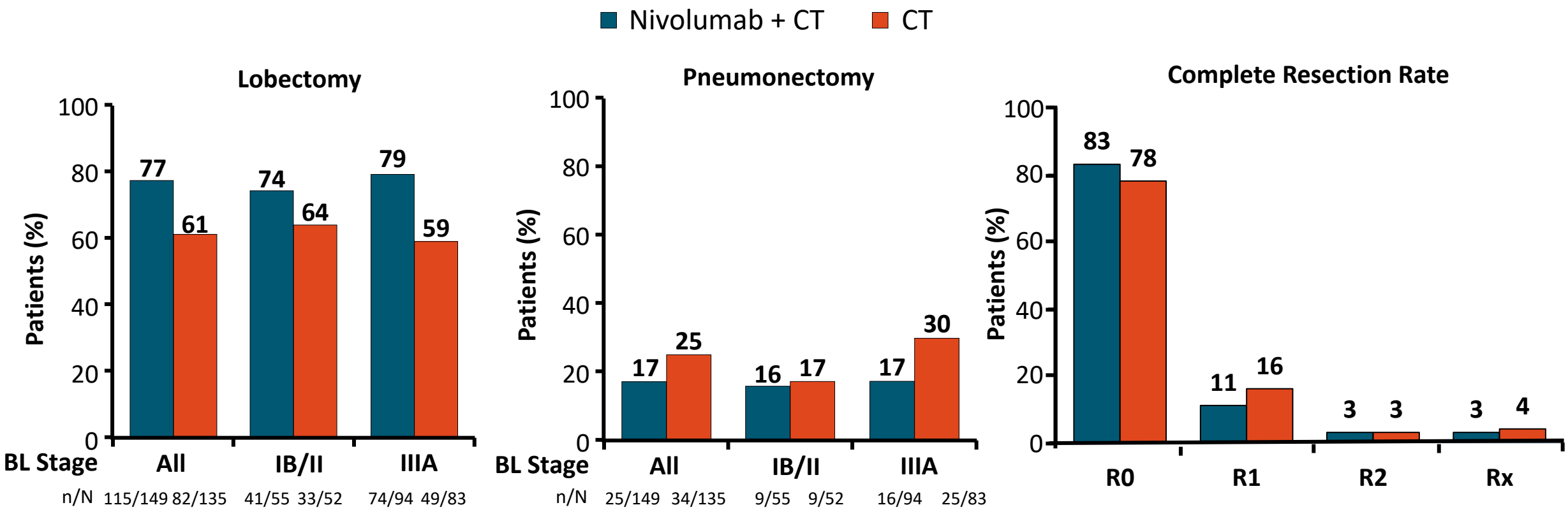


- Overall pCR rate: 24% with nivolumab + CT vs 2.2% with CT alone (OR: 13.94; 99% CI: 3.49-55.75; *P* <.001); improvement evident regardless of radiologic downstaging
- In March 2022, nivolumab was approved by the FDA for adult patients with resectable (tumors ≥4 cm or node positive) NSCLC in the neoadjuvant setting, in combination with platinum-doublet CT

Spicer. ASCO 2021. Abstr 8503. Forde. NEJM. 2022;386:1973. Nivolumab PI.

Slide credit: clinicaloptions.com

CheckMate 816: Nivolumab + Chemotherapy Showed Benefit in Surgical Outcomes vs Chemotherapy

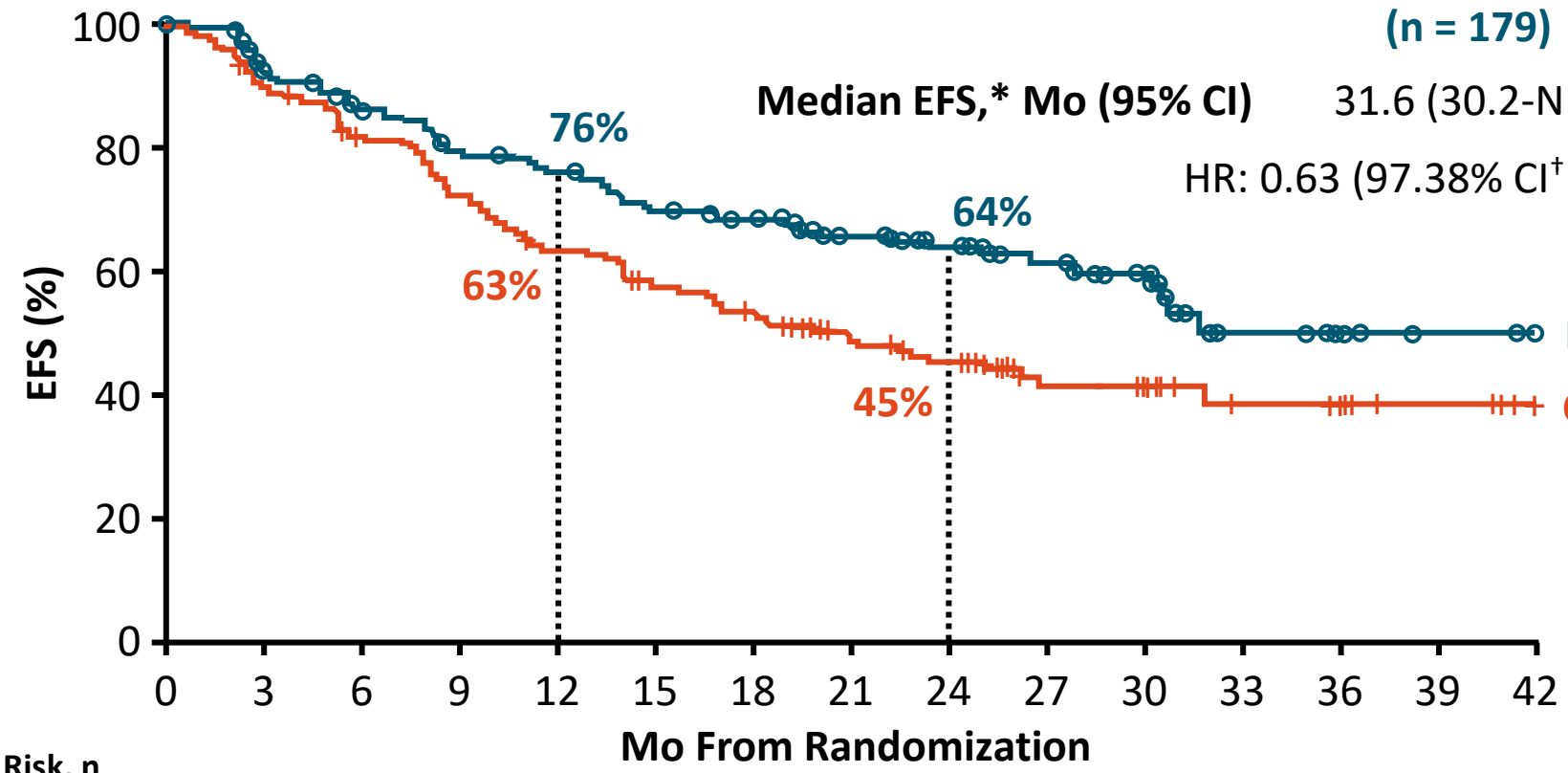


- Lower pneumonectomy rates were evident with nivolumab + chemotherapy
- Complete resection rates (R0) were similar across treatment arms

Spicer. ASCO 2021. Abstr 8503. Forde. NEJM. 2022;386:1973.

Slide credit: clinicaloptions.com

CheckMate 816: EFS (Coprimary Endpoint)



	Nivolumab + CT (n = 179)	CT (n = 179)
Median EFS,* Mo (95% CI)	31.6 (30.2-NR)	20.8 (14.0-26.7)

HR: 0.63 (97.38% CI[†]: 0.43-0.91; *P* = .0052[‡])

Patients at Risk, n

Nivolumab + CT	179	151	136	124	118	107	102	87	74	41	34	13	6	3	0
CT	179	144	126	109	94	83	75	61	52	26	24	13	11	4	0

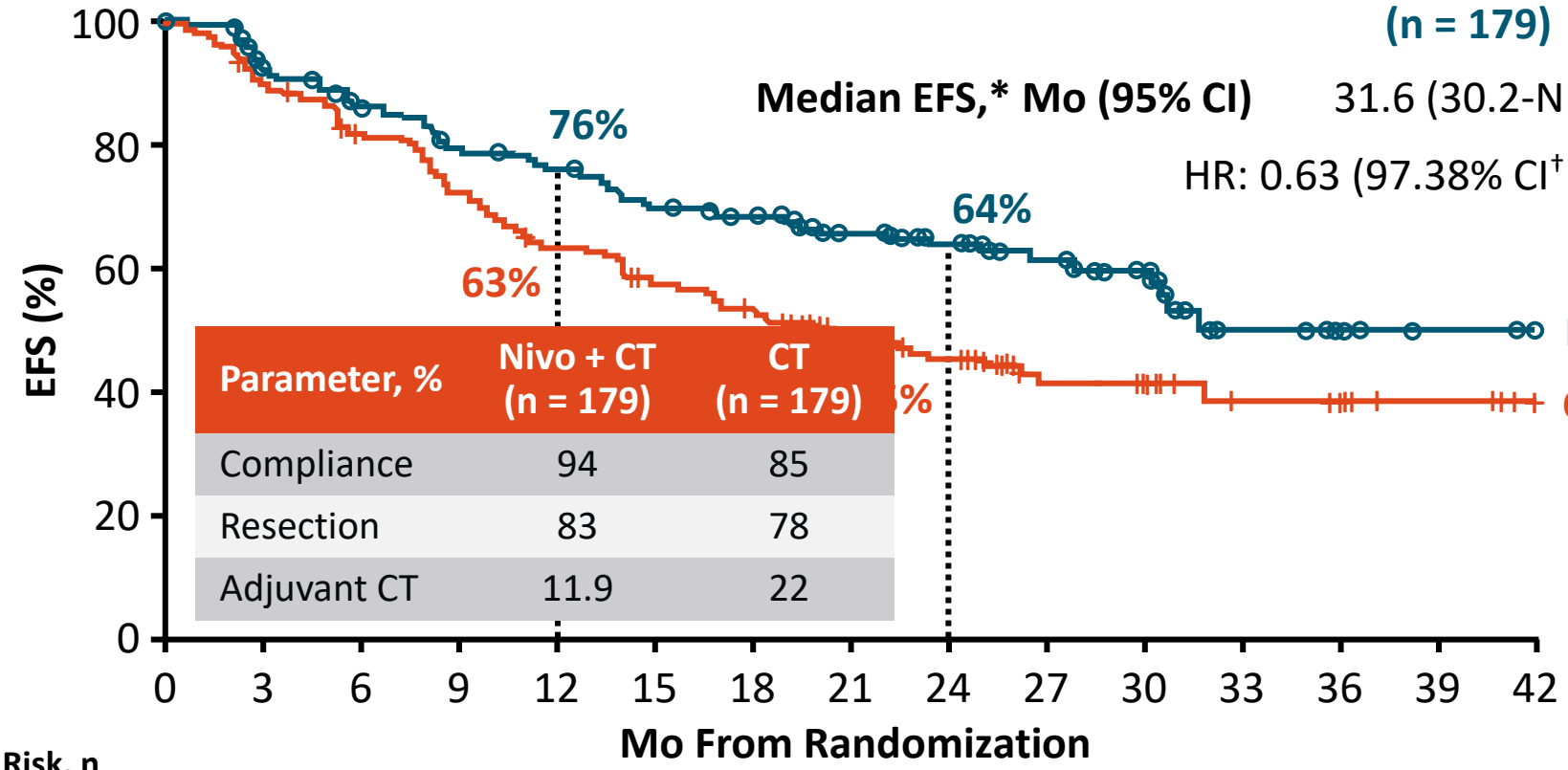
Minimum follow-up: 21 mo. Median follow-up: 29.5 mo.

*Per BICR. [†]95% CI: 0.45-0.87. [‡]Significant boundary for EFS at time of interim analysis: 0.0262.

Girard. AACR 2022. Abstr CT012. Forde. NEJM. 2022;386:1973.

Slide credit: clinicaloptions.com

CheckMate 816: EFS (Coprimary Endpoint)



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HR: 0.63 (97.38% CI†: 0.43-0.91; *P* = .0052‡)

Parameter, %	Nivo + CT (n = 179)	CT (n = 179)
Compliance	94	85
Resection	83	78
Adjuvant CT	11.9	22

Patients at Risk, n

Nivolumab + CT	179	151	136	124	118	107	102	87	74	41	34	13	6	3	0
CT	179	144	126	109	94	83	75	61	52	26	24	13	11	4	0

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Girard. AACR 2022. Abstr CT012. Forde. NEJM. 2022;386:1973.

Slide credit: clinicaloptions.com

Ongoing and reported Phase III Periadjuvant Studies in Resectable NSCLC

The current neoadjuvant and perioperative ICI-based treatment landscape in NSCLC

Completed and Ongoing Select Phase 3 Trials

Resectable NSCLC

Neoadjuvant

Trial	Regimen
CheckMate 816[1]	Nivolumab + Chemotherapy
CheckMate 816[2]	Nivolumab + Ipilimumab

Adjuvant

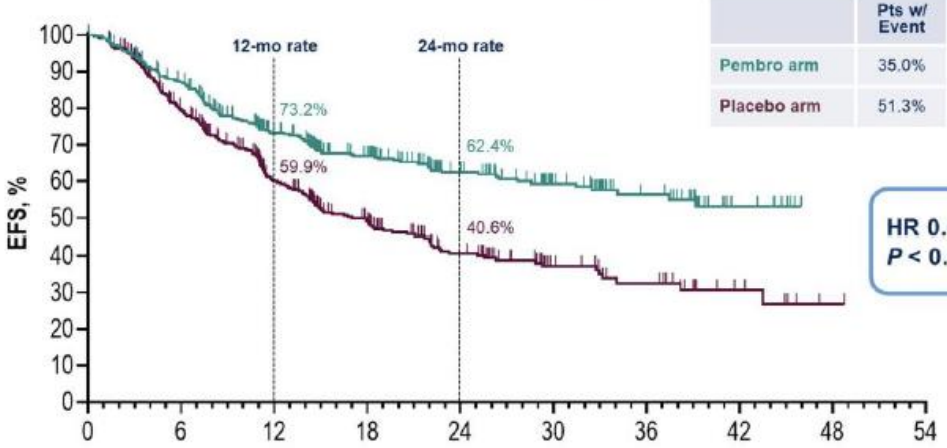
Trial	Regimen
KEYNOTE-091/PEARLS[3]	Pembrolizumab
IMpower010[4]	Atezolizumab
CCTC BR31[5]	Durvalumab
ANVIL[6]	Nivolumab
NADIM-ADJUVANT[7]	Nivolumab + Chemotherapy

Perioperative

Trial	Regimen
CheckMate 77T[8]	Nivolumab + Chemotherapy → Nivolumab
IMpower030[9]	Atezolizumab + Chemotherapy → Atezolizumab
AEGEAN[10]	Durvalumab + Chemotherapy → Durvalumab
KEYNOTE-671[11]	Pembrolizumab + Chemotherapy → Pembrolizumab
Neotorch[12]	Toripalimab + Chemotherapy → Toripalimab + Chemotherapy → Toripalimab

Similar EFS signal across perioperative/neoadjuvant trials

KEYNOTE-671

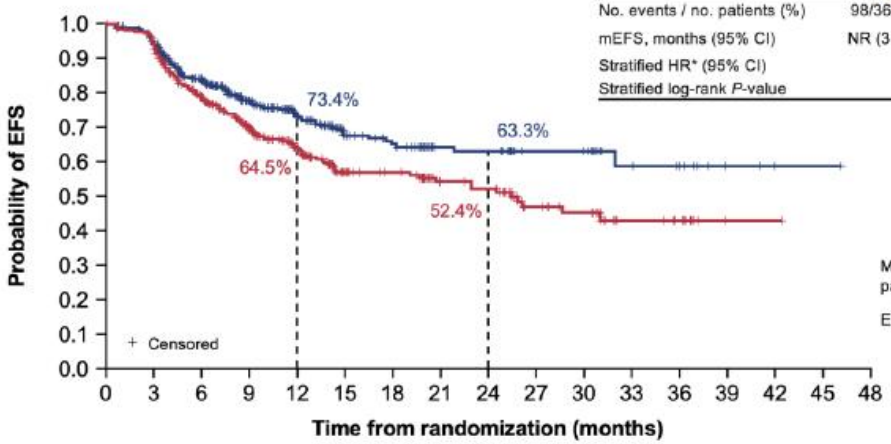


	Pts w/ Event	Median (95% CI), mo
Pembro arm	35.0%	NR (34.1-NR)
Placebo arm	51.3%	17.0 (14.3-22.0)

HR 0.58 (95% CI, 0.46-0.72)
P < 0.00001

AEGEAN

	D arm	PBO arm
No. events / no. patients (%)	98/366 (26.8)	138/374 (36.9)
mEFS, months (95% CI)	NR (31.9–NR)	25.9 (18.9–NR)
Stratified HR* (95% CI)	0.68 (0.53–0.88)	
Stratified log-rank *P*-value	0.003902	

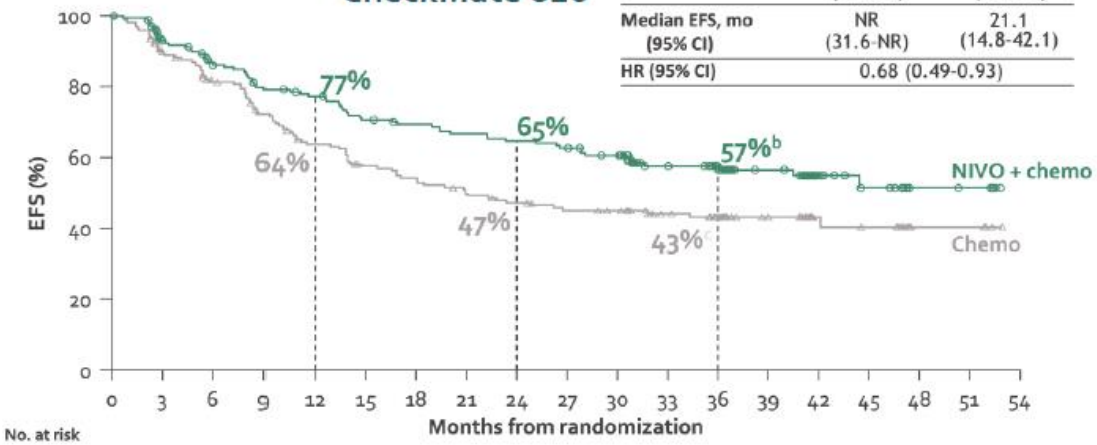


Median follow-up (range) in censored patients: 11.7 months (0.0–46.1)

EFS maturity: 31.9%

CheckMate 816

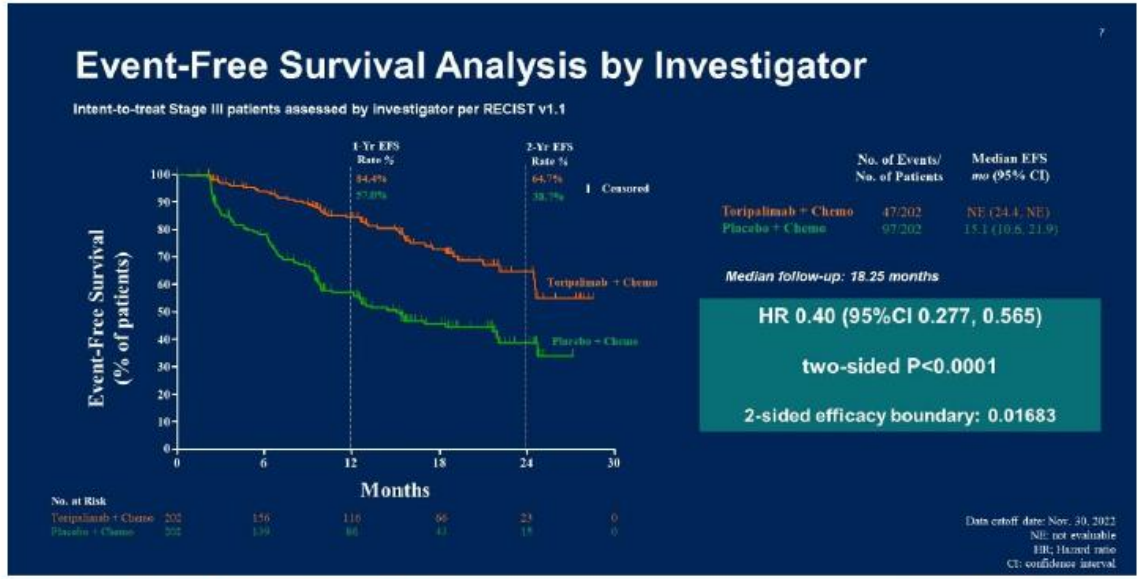
	NIVO + chemo (n = 179)	Chemo (n = 179)
Median EFS, mo (95% CI)	NR (31.6-NR)	21.1 (14.8-42.1)
HR (95% CI)	0.68 (0.49-0.93)	



No. at risk

NIVO + chemo	179	152	136	125	119	108	104	100	97	94	88	69	57	38	20	13	6	5	0
Chemo	179	146	128	110	95	84	79	72	67	62	60	48	39	27	15	13	4	4	0

Neotorch



How Do We Decide?

Neoadjuvant	Adjuvant
Better treatment compliance	
Can add further therapy postoperatively	More commonly used in routine practice (>95%)
In vivo test of drug sensitivity	No risk of surgical delay
Better antigen priming?	No increased perioperative risks due to preop therapy
Potential downstaging	Complete pathologic staging

→ **Multidisciplinary and Patient Discussion**

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Antistof lægemiddel konjugater
Er den smarte kemoterapi på vej?
Håb eller hype på en regnvejrsdag?

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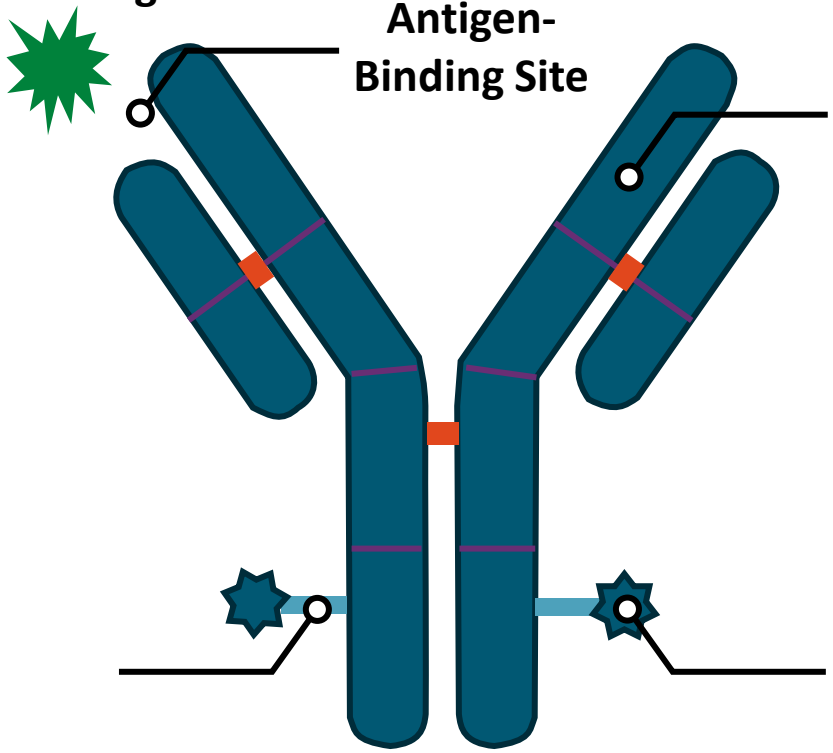
What Are Antibody–Drug Conjugates?

- Monoclonal antibody linked to cytotoxic drug designed to widen therapeutic window by focusing delivery to specific cells



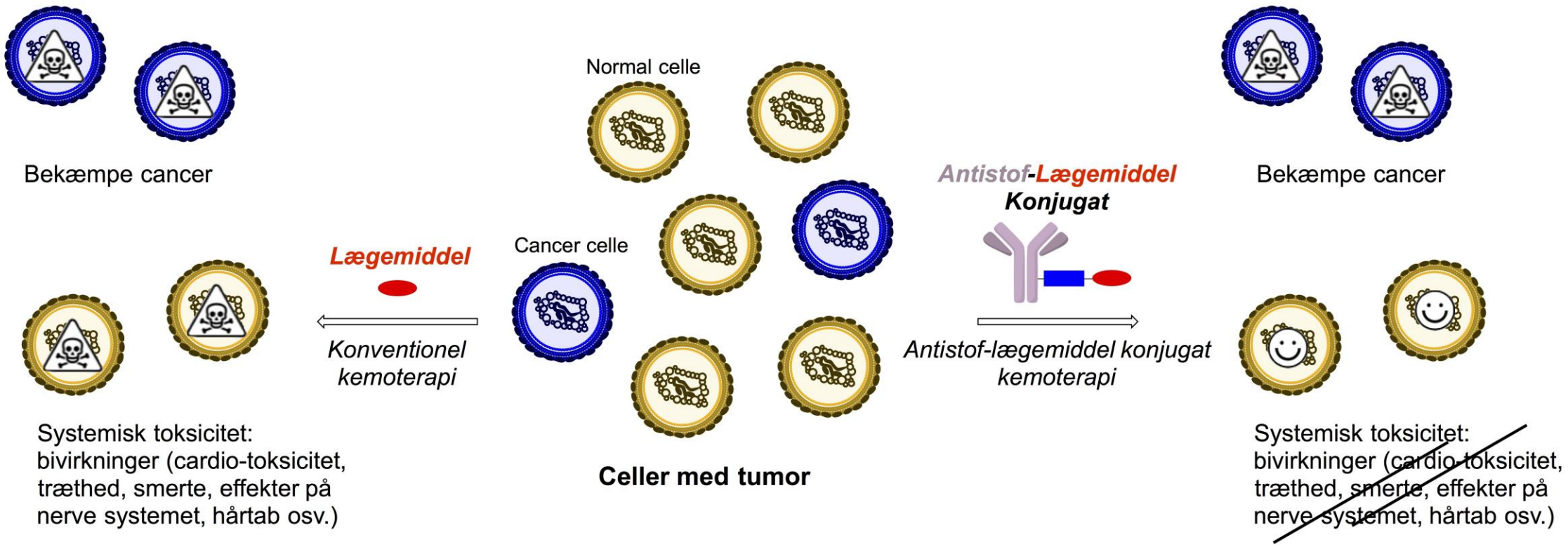
Monoclonal Antibody
Selective for antigen with high copy numbers on target tumor cell and with minimal immunogenic response

Stable Linker
Releases payload only in target cell

Cytotoxic Drug Payload
With potent subnanomolar activity

Drago. Nat Rev Clin Oncol. 2021;18:327.

Slide credit: clinicaloptions.com



Lånt af: Katrine Qvortrup, Senior research scientist, Ph.d.
Institut for Kemi, Danmarks Tekniske Universitet
Modtaget støtte til Carlsbergfondet internationaliseringstipendier: Design and Synthesis of New Warheads and Linkers for Antibody-Drug Conjugate

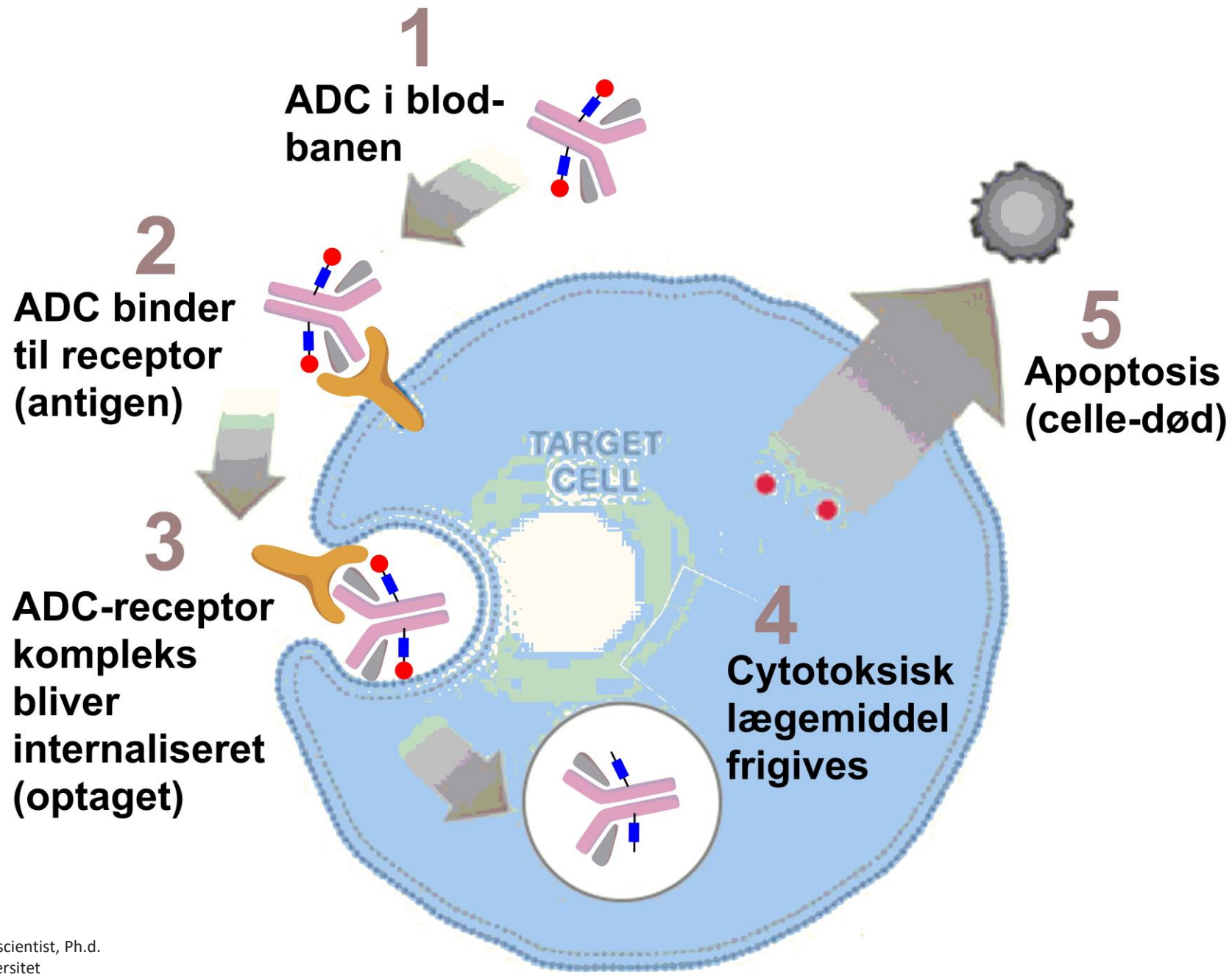
Antistof-lægemiddel konjugater

- ***Specifik levering af cytotoksisk lægemiddel til tumorcellen: Mål-specifik kemoterapi, nedsat toksicitet***

Antistof Tumor-specifik binding

Linker Stabil i cirkulation
Antistof konjugations-site skal ikke have indflydelse på stabilitet, binding, celle-optag: *Site-specifik konjugation*
Selektiv intracellulær frigivelse af lægemiddel: *enzymatisk kløvning*, *pH-afhængig kløvning*

Lægemiddel Meget potent



Lånt af: Katrine Qvortrup, Senior research scientist, Ph.d.
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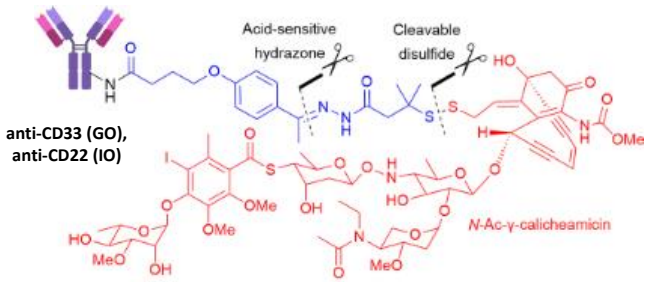
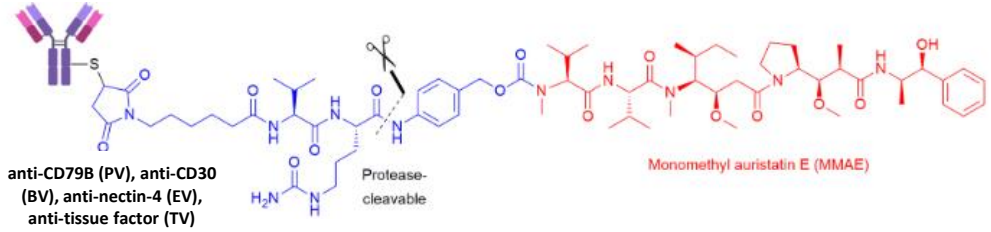
FDA Approved ADCs

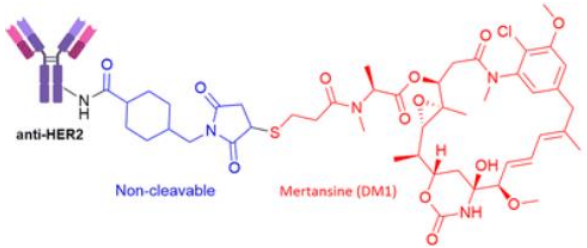
Gemtuzumab ozogamicin (AML/2000/2017)
Inotuzumab ozogamicin (ALL/2017)



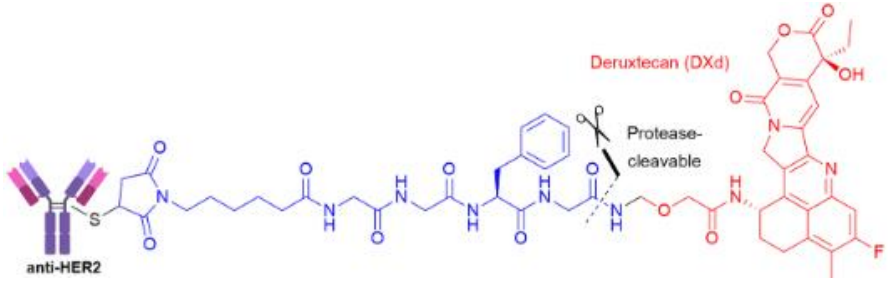
Brentuximab vedotin (lymphomas/2011) **Polatuzumab vedotin** (lymphoma/2019)
Enfortumab vedotin (urothelial/2019) **Tisotumab vedotin** (cervical/2021)



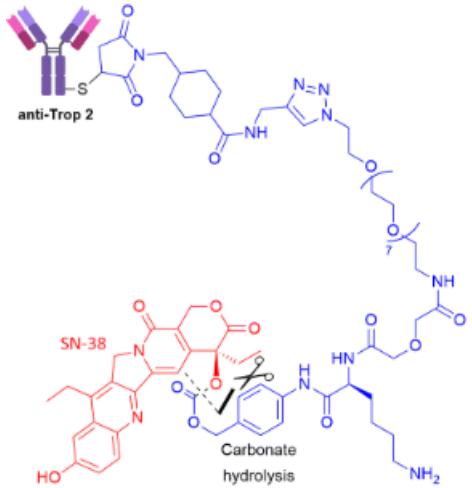
Trastuzumab emtasine (breast/2013)



Trastuzumab deruxtecan (breast/lung/gastric/2019)



Sacituzumab govitecan
(breast/urothelial/2020)

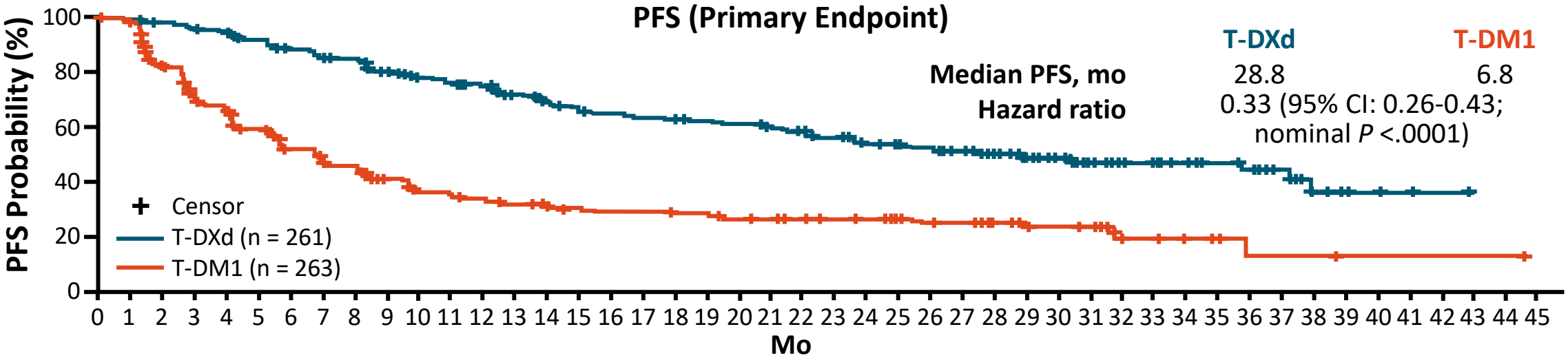


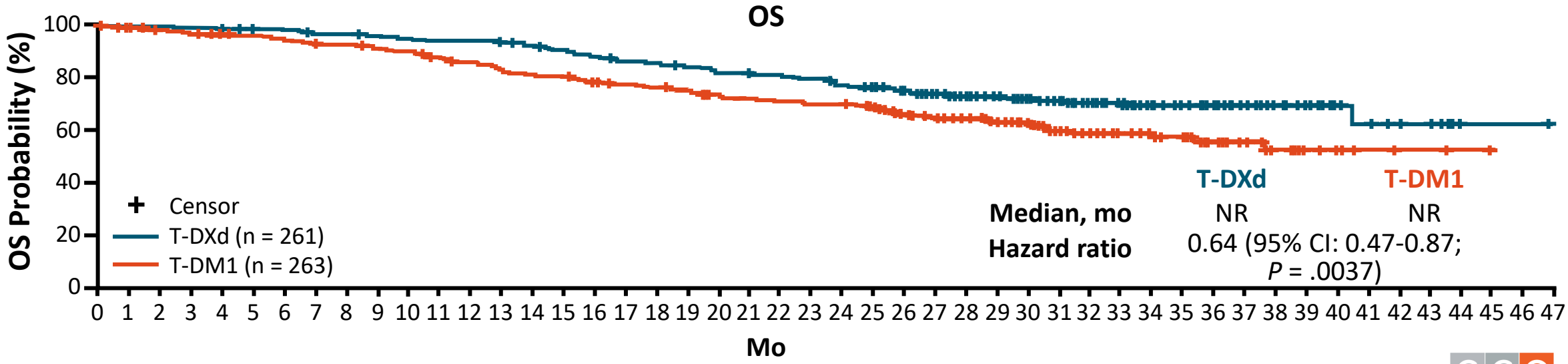
- Others: moxetumomab (leukemia/2018/withdrawn), belantumab mafodotin (MM/2020/withdrawn), mirvetuximab soravtansine (ovarian/2022)

Ashman. Chem Soc Rev. 2022;51:9182.

Slide credit: clinicaloptions.com

DESTINY-Breast03: Updated PFS and OS



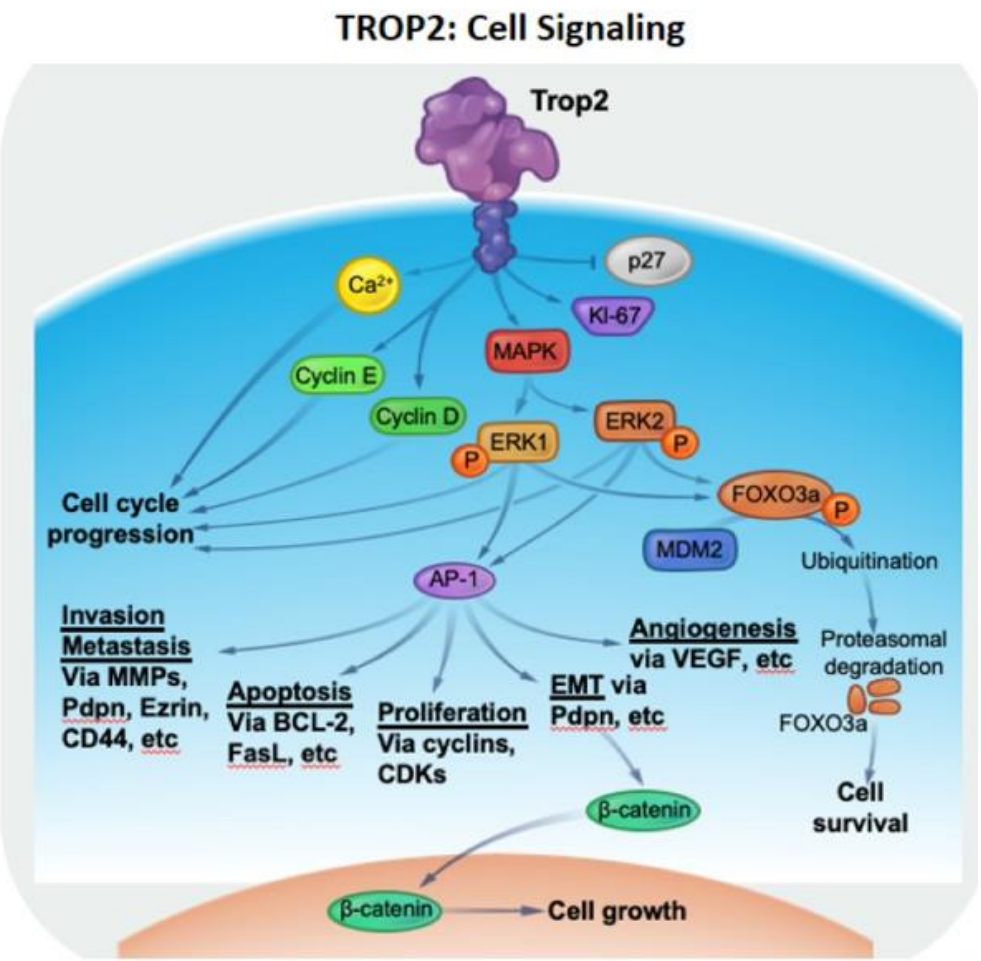


Hurvitz. Lancet. 2023;401:105.

Slide credit: clinicaloptions.com

TROP-2 as a Therapeutic Target

- TROP-2 is a transmembrane glycoprotein overexpressed in solid tumors including TNBC and NSCLC
- TROP-2 is an epithelial adhesion molecule and regulates stem cell marker–associated cell regeneration

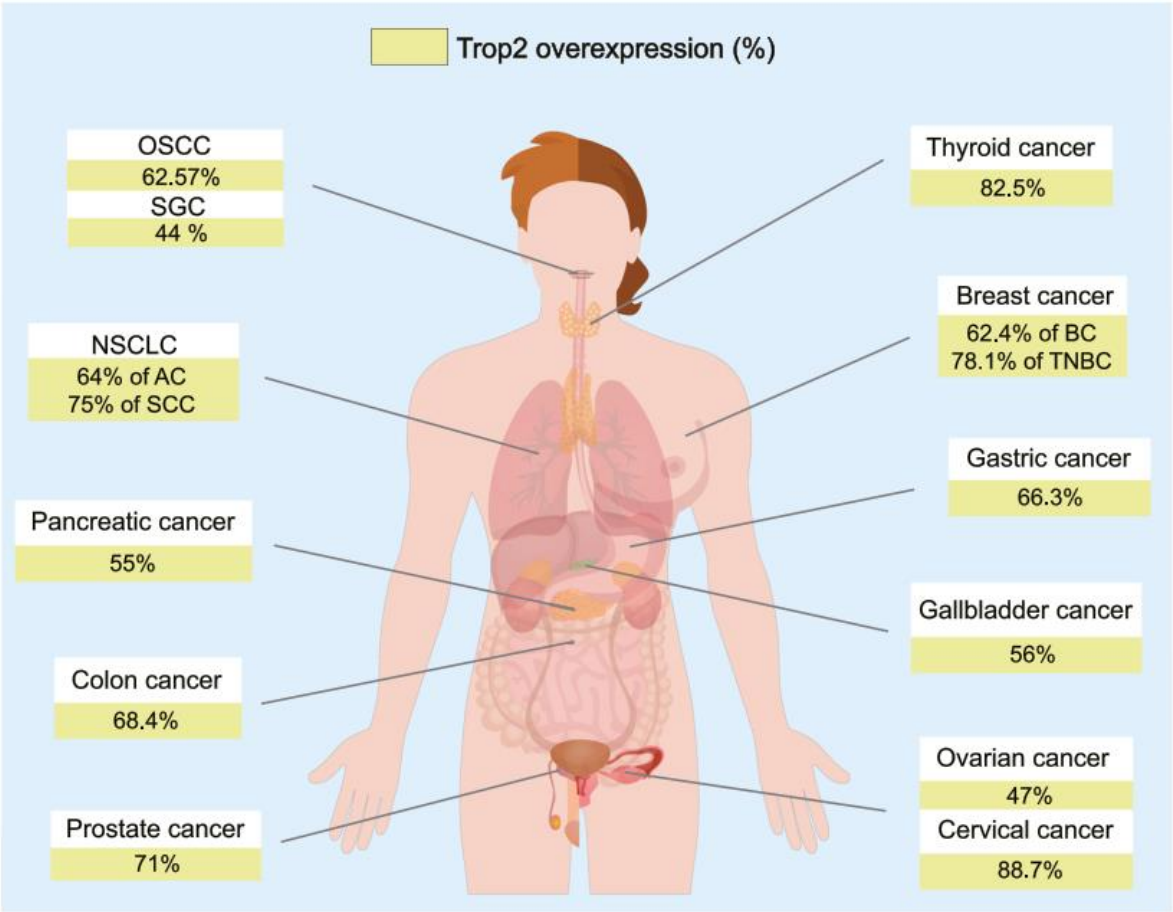


Jiang. Oncol Lett. 2013;6:375. Shvartsur. Genes Cancer. 2015;6:84.

Figure modified from Shvartsur. Genes Cancer. 2015;6:84 under the terms and conditions of the Creative Commons Attribution 4.0 International license (CC BY 4.0 https://creativecommons.org/licenses/by/4.0/)

Slide credit: clinicaloptions.com

TROP-2 Overexpression in NSCLC and Other Cancers

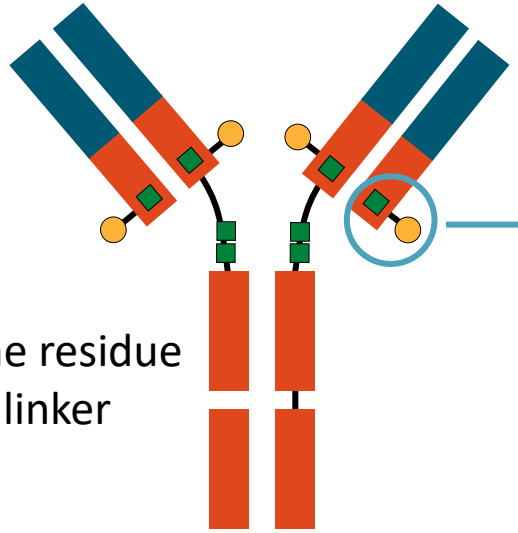


Liu. Pharmacol Ther. 2022;239:108296. Figure 3 of given citation is used in its original form under the terms and conditions of the Creative Commons Attribution 4.0 International license (CC BY 4.0 https://creativecommons.org/licenses/by/4.0/)

Slide credit: clinicaloptions.com

Datopotamab Deruxtecan: TROP-2–Targeted ADC

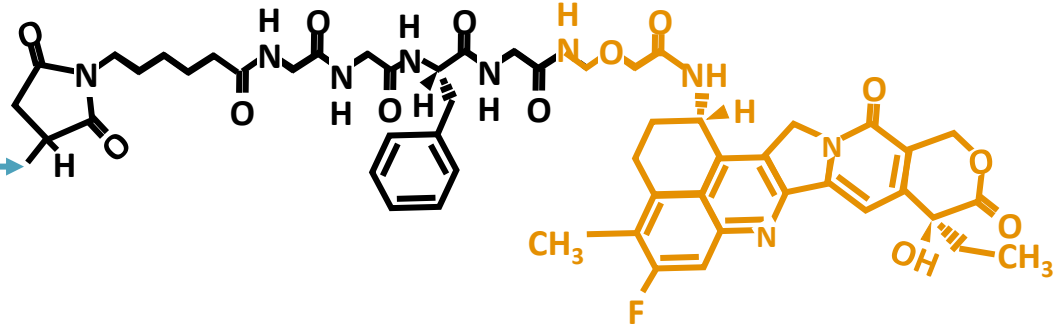
Datopotamab
Humanized
anti–TROP-2 mAb



Cysteine residue
Drug + linker

Conjugation Chemistry
Drug + linker conjugated to
cysteine residues of mAb

Tetrapeptide-Based
Cleavable Linker



Topoisomerase I Inhibitor
Payload (DXd)
Exatecan derivative

- High-potency, membrane-permeable payload with short systemic half-life
- Optimized DAR: ~4:1
- Stable linker–payload
- Tumor-selectable cleavable linker
- Bystander killing effect

Okajima. Mol Cancer Ther. 2021;20:2329. Shastry. Breast. 2022;66:169.
Bardia. SABCS 2022. Abstr P6-10-03. Yasuda. AACR 2023. Abstr 4893.

Slide credit: clinicaloptions.com
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TROPION-PanTumor01 NSCLC Cohort With Datopotamab Deruxtecan

- Multicohort, dose-escalation/dose-expansion phase I trial

Adults* with R/R advanced/metastatic NSCLC; measurable disease by RECIST v1.1; stable, treated brain mets permitted; pretreatment biopsy required, but patients unselected for TROP-2 expression; ECOG PS 0/1 (N = 180)

→

Dose Escalation†

8 mg/kg Q3W established as MTD

6 mg/kg Q3W chosen for future development

Dato-DXd
0.27 mg/kg to 10 mg/kg Q3W

→

Dose Expansion‡

Dato-DXd
4 mg/kg Q3W
(n = 50)

Dato-DXd
6 mg/kg Q3W
(n = 50)

Dato-DXd
8 mg/kg Q3W
(n = 80)

- **Primary objectives:** MTD, safety, tolerability
- **Secondary objectives:** efficacy, pharmacokinetics, antidrug antibodies

*In US, ≥18 yr of age; in Japan, ≥20 yr of age. †Dose levels 4, 6, and 8 mg/kg under further study for safety and efficacy.
‡Includes patients from dose-escalation and dose-expansion phases of trial.

Shimizu. JCO. 2023;[Epub].

Slide credit: clinicaloptions.com

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TROPION-PanTumor01—Updated NSCLC Cohort: Antitumor Activity

Best Overall Response by BICR per RECIST v1.1	Datopotamab Deruxtecan		
	4 mg/kg (n = 50)	6 mg/kg (n = 50)	8 mg/kg (n = 80)
ORR, n (%)	11 (22)	13 (26)	19 (24)
▪ CR	0	0	1 (1)
▪ PR	11 (22)	13 (26)	18 (23)
SD, n (%)	26 (52)	20 (40)	42 (53)
Non-CR/PD, n (%)	1 (2)	2 (4)	2 (3)
PD, n (%)	7 (14)	10 (20)	8 (10)
Not evaluable, n (%)	5 (10)	5 (10)	9 (11)
Median DoR, mo (95% CI)	12.7 (2.8-NE)	10.5 (5.6-26.5)	9.6 (5.8-NE)
Median PFS, mo (95% CI)	4.3 (2.9-6.9)	6.9 (2.7-8.8)	5.2 (4.1-7.1)
Median OS, mo (95% CI)	12.9 (9.4-NE)	11.4 (7.1-20.6)	10.5 (8-12)

Shimizu. JCO. 2023;[Epub].

Slide credit: clinicaloptions.com

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TROPION-Lung01 Study Design

Randomized, Phase 3, Open-Label, Global Study (NCT04656652)

Key Eligibility Criteria

- NSCLC (stage IIIB, IIIC, or IV)
- ECOG PS of 0 or 1
- No prior docetaxel

Without actionable genomic alterations[a]

- 1 or 2 prior lines, including platinum CT and anti–PD-(L)1 mAb therapy

With actionable genomic alterations

- Positive for *EGFR*, *ALK*, *NTRK*, *BRAF*, *ROS1*, *MET* exon 14 skipping, or *RET*
- 1 or 2 prior approved targeted therapies + platinum-based CT, and ≤1 anti–PD-(L)1 mAb

R 1:1

Dato-DXd
6 mg/kg Q3W
(N=299)

Docetaxel
75 mg/m^2 Q3W
(N=305)

Dual Primary Endpoints

- PFS by BICR
- OS

Secondary Endpoints

- ORR by BICR
- DOR by BICR
- Safety

Stratified by: histology,[b] actionable genomic alteration,[c] anti–PD-(L)1 mAb included in most recent prior therapy, geography[d]

Enrollment period: 19 February 2021 to 7 November 2022.
BICR, blinded independent central review; CT, chemotherapy; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; mAb, monoclonal antibody; NSCLC, non-small cell lung cancer; ORR, objective response rate; OS, overall survival; PD-(L)1, programmed cell death 1 (ligand 1); PFS, progression-free survival; Q3W, every 3 weeks; R, randomized.
[a]Patients with *KRAS* mutations in the absence of known actionable genomic alterations are eligible; must meet prior therapy requirements for patients without actionable genomic alterations. [b]Squamous vs non-squamous. [c]Presence vs absence. [d]United States/Japan/Western Europe vs rest of world.

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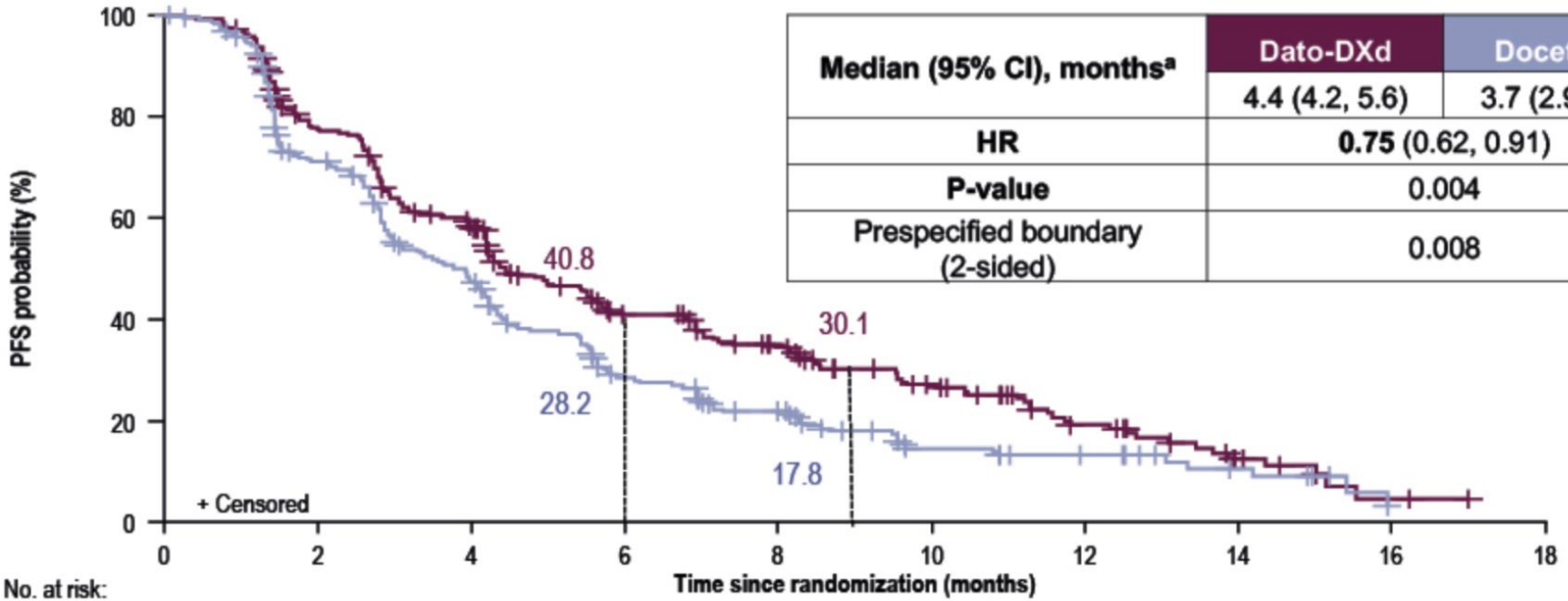
Progression-Free Survival - ITT



Median (95% CI), months[a]	Dato-DXd	Docetaxel
	4.4 (4.2, 5.6)	3.7 (2.9, 4.2)
HR	**0.75** (0.62, 0.91)	
P-value	0.004	
Prespecified boundary (2-sided)	0.008	

No. at risk:

Dato-DXd	299	216	156	96	74	46	24	10	2	0
Docetaxel	305	186	120	63	42	19	14	7	0	0

	Dato-DXd	Docetaxel
ORR, % (95% CI)[b]	26.4 (21.5, 31.8)	12.8 (9.3, 17.1)
DOR, mo. (95% CI)	7.1 (5.6, 10.9)	5.6 (5.4, 8.1)

CI, confidence interval; CR, complete response; Dato-DXd, datopotamab deruxtecan; DOR, duration of response; HR, hazard ratio; ITT, intention-to-treat; mo., months; ORR, objective response rate; PFS, progression-free survival; PR, partial response.

[a]Median PFS follow-up time was 10.9 months (95% CI: 9.8, 12.5) and 9.6 months (95% CI: 8.2, 11.9) for Dato-DXd and docetaxel, respectively. [b]Included four CRs and 75 PRs for Dato-DXd and 39 PRs for docetaxel.

Select Ongoing Trials of Datopotamab Deruxtecan in Advanced or Metastatic NSCLC

Trial	Phase	Planned N	Treatment Arms	Population	Primary Endpoint
TROPION-Lung01* (NCT04656652)	III	590	Dato-DXd vs docetaxel	Adv/metastatic NSCLC: (1) without AGAs previously treated with platinum CT and PD-1/PD-L1 inhibitor or (2) with AGAs previously treated with 1-2 targeted therapies or CT and ≤1 PD-1/PD-L1 inhibitor (± CT)	PFS by BICR, OS
TROPION-Lung07† (NCT05555732)	III	975	Dato-DXd + pembrolizumab + platinum CT vs Dato-DXd + pembrolizumab vs pembrolizumab + platinum/pemetrexed CT	1L adv/metastatic NSCLC without AGAs; PD-L1 <50%	PFS by BICR, OS
TROPION-Lung08† (NCT05215340)	III	740	Dato-DXd + pembrolizumab vs pembrolizumab	1L adv/metastatic NSCLC without AGAs; PD-L1 ≥50%	PFS by BICR, OS
TROPION-Lung05* (NCT04484142)	II	137‡	Dato-DXd	Adv/metastatic NSCLC with AGAs previously treated with targeted tx and platinum CT	ORR by BICR
TROPION-Lung04† (NCT04612751)	Ib	232	Dato-DXd + durvalumab or AZD2936 or MEDI5752 ± carboplatin	Adv/metastatic NSCLC without AGAs; 1L or previously treated with platinum CT	DLT, safety

Status as of July 2023: *Active, not recruiting. †Recruiting. ‡Actual enrollment.

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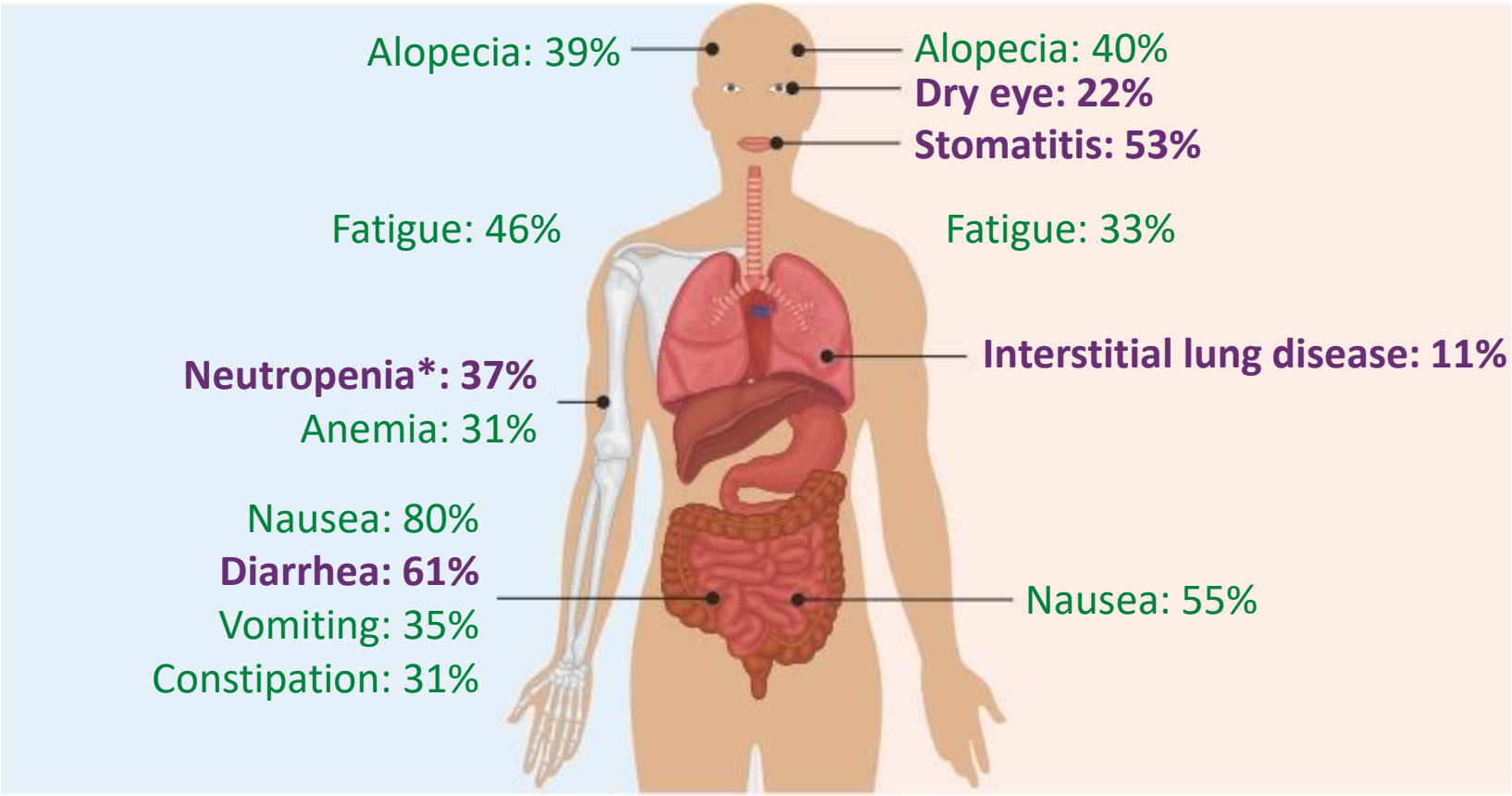
Common and Notable Toxicities Associated With TROP-2–Directed ADCs



*Most common severe AE.

Heist. JCO. 2017;35:2790. Shimizu. JCO. 2023;[Epub].

Slide credit: clinicaloptions.com

Questions that can be answered by cancer biomarkers

Prognostic
Is it likely to develop this cancer?

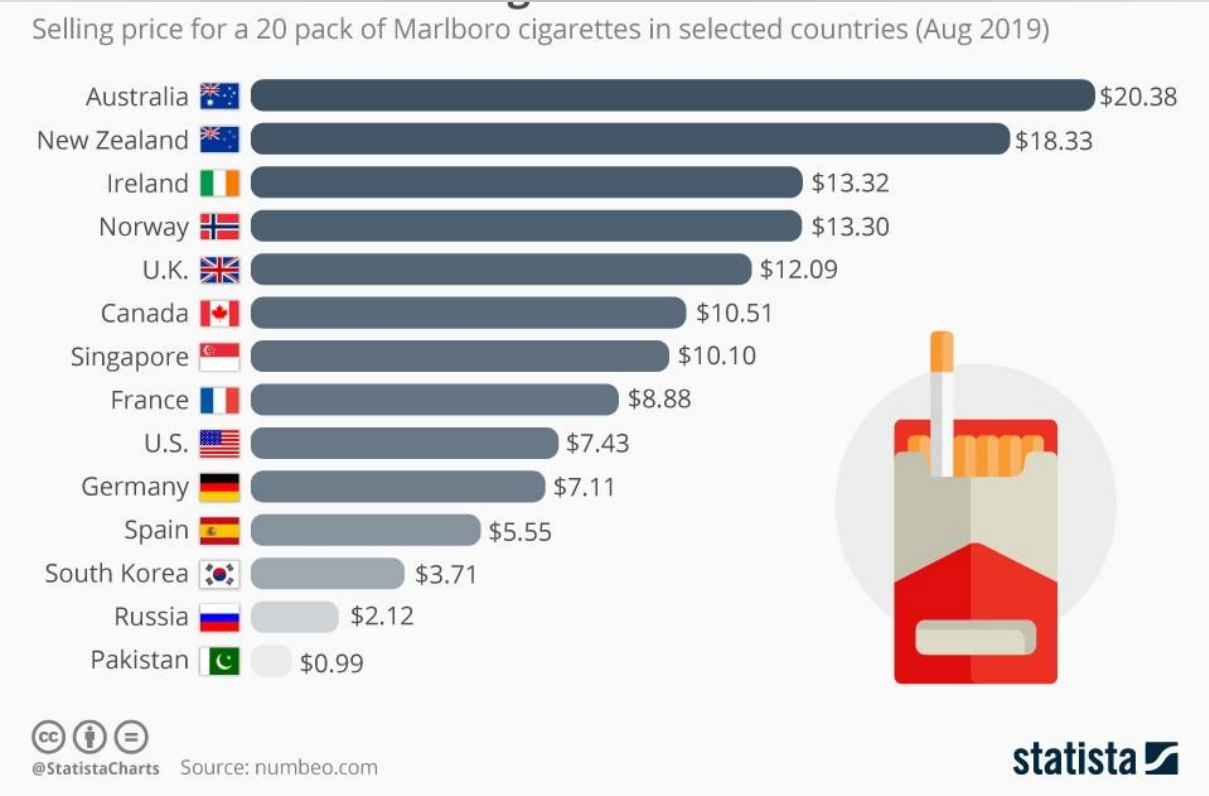
Diagnostic
What type of cancer is it?

Predictive
Is this the optimal drug for my cancer?

Pharmacodynamics
What's the optimal dose for my body?

Recurrence
Will the cancer return?

BIOMARKØRER er gentiske sladrehanke, som findes i blod eller væv og kan blive fremtidens værktøj til at diagnosticere, forudsige sygdomsforløb og finde den bedste behandling til hver enkelt patient


Selling price for a 20 pack of Marlboro cigarettes in selected countries (Aug 2019)
Australia $20.38
New Zealand $18.33
Ireland $13.32
Norway $13.30
U.K. $12.09
Canada $10.51
Singapore $10.10
France $8.88
U.S. $7.43
Germany $7.11
Spain $5.55
South Korea $3.71
Russia $2.12
Pakistan $0.99
@StatistaCharts
Source: numbeo.com
statista

QUIT
SMOKING

STOP

”MEN DET KOSTER 5 MIA I STATSKASSEN…..”

- 15920 tobaksrelaterede dødsfald om året
- 50000 indlæggelser om året
- Rygning koster årligt sundhedsvæsenet 13.2 milliarder kr.
- Og… 33.9 milliarder kr. i tabt produktion.

Partier har ikke råd til at hæve prisen på cigaretter

13. okt kl. 07.42
Opd. 13. okt kl. 09.33

Del artikel

Mest set

En pakke cigaretter stiger nu i pris. Arkivfoto. Foto: Emil Helms / Ritzau Scanpix

Kilde: Sundhedsstyrelsen og Lægeforeningen

Tak