NCCN 2025
Lung Cancer Congress

Systemic Therapy in Early-Stage, Wild-Type Non-Small Cell Lung Cancer: Current Standards and Practical Applications

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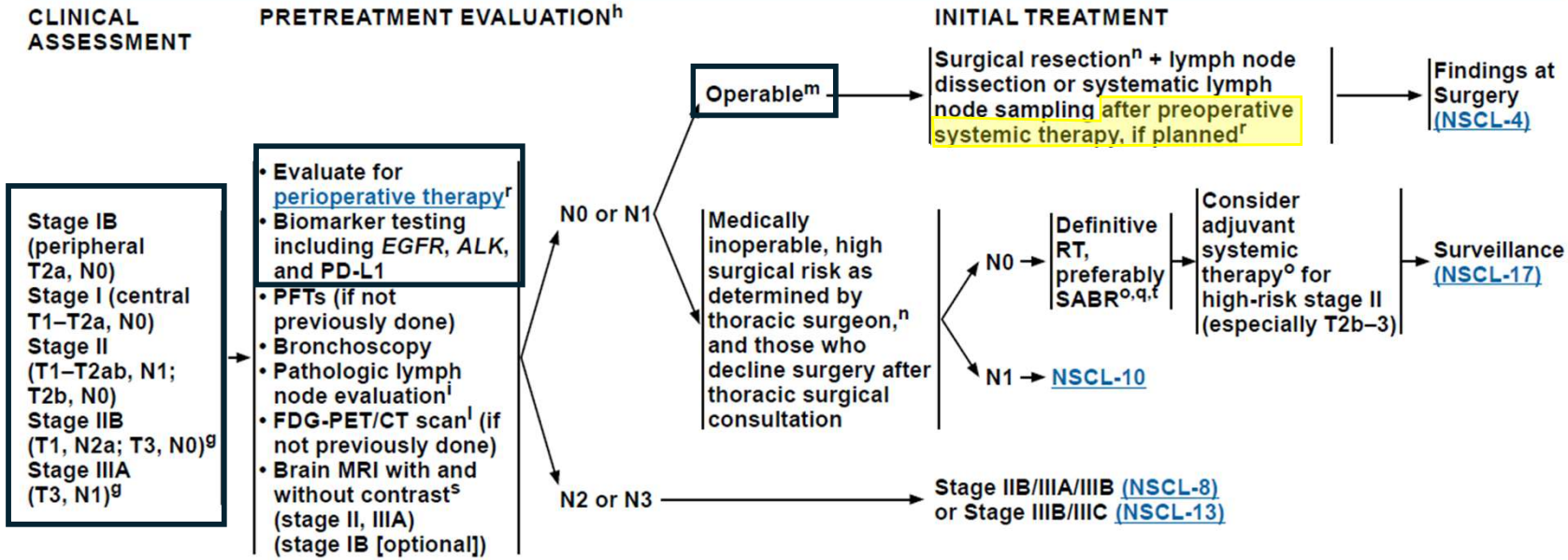
NCCN National Comprehensive Cancer Network®

Goals

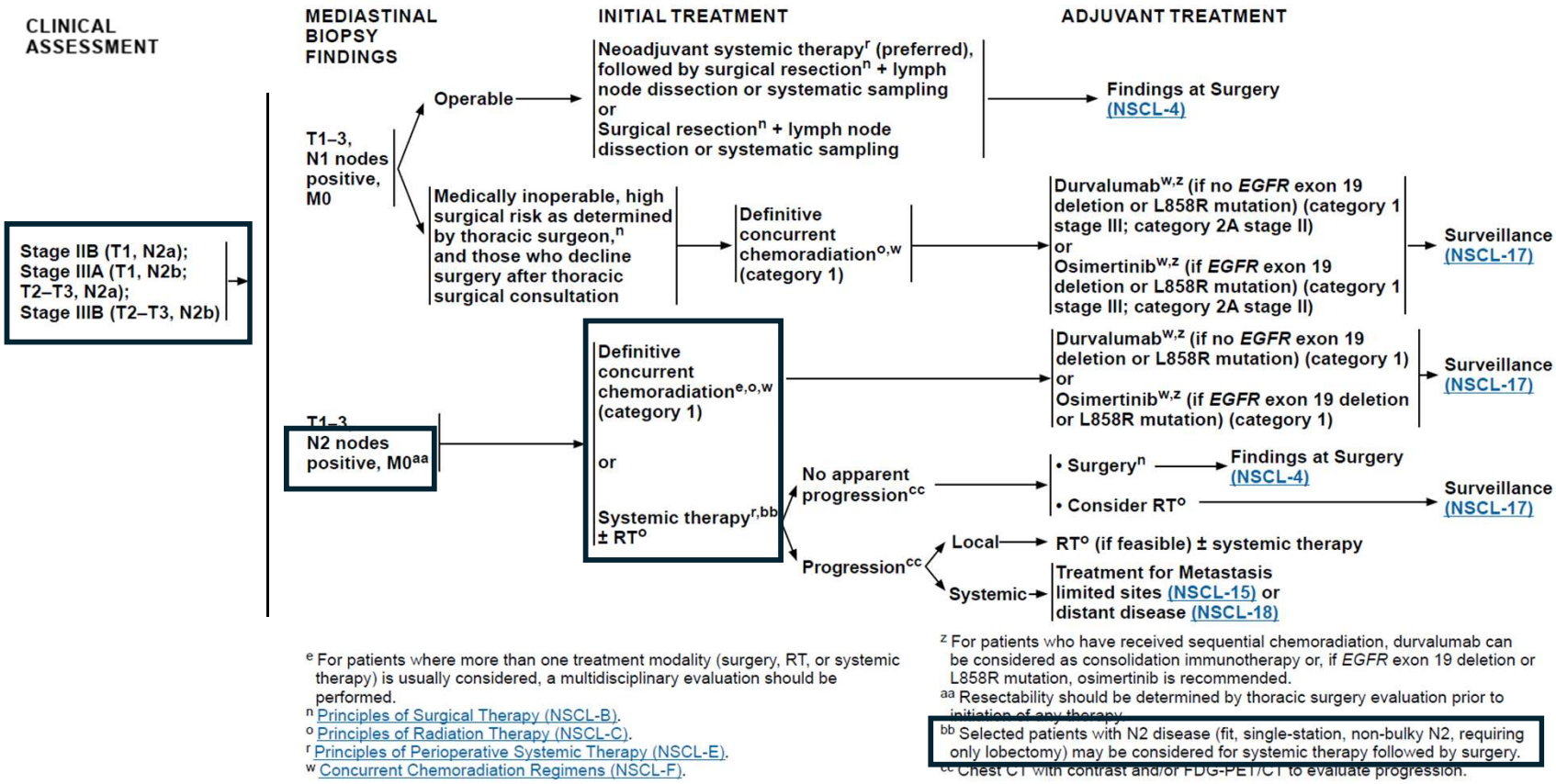
- Describe current NCCN Guidelines recommendations for systemic therapy in early-stage, wild-type non-small cell lung cancer.
- Evaluate clinical trial evidence supporting the use of neoadjuvant and adjuvant immunotherapy.
- Apply practical, team-based strategies for integrating immunotherapy into treatment planning for early-stage wild-type NSCLC.

Recommendations for early-stage NSCLC



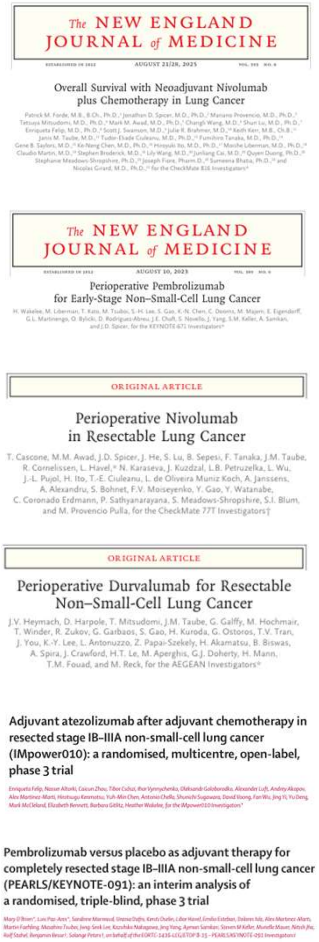
[q] Prior to treatment, multidisciplinary evaluation that includes treating physicians and specialists in obtaining tissue diagnosis (thoracic surgery, interventional pulmonology, and interventional radiology) is required to determine the safest and most efficient approach for biopsy, or to provide consensus that a biopsy is too risky or difficult, that a clinical diagnosis of lung cancer is appropriate, and that treatment is warranted.

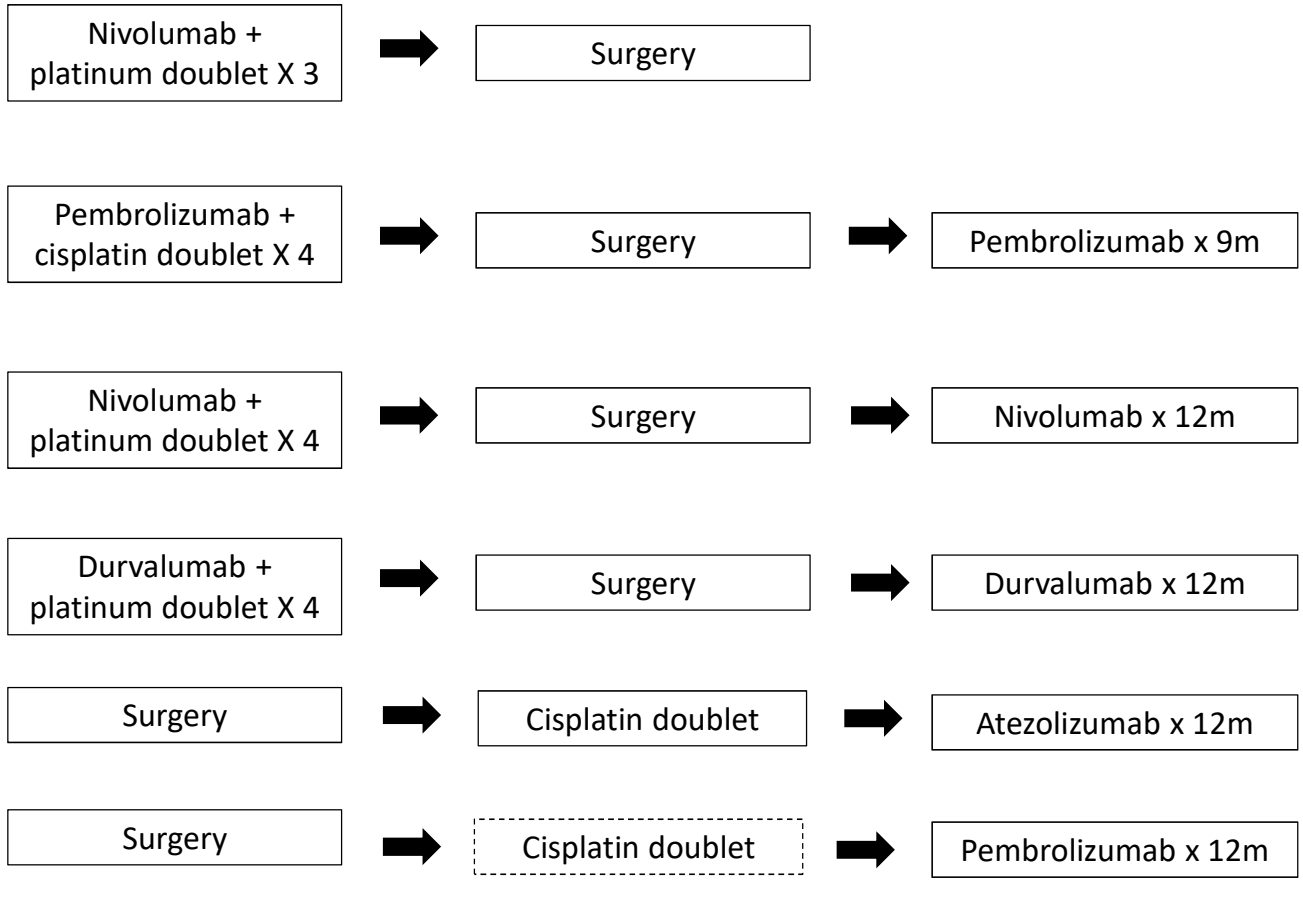
NSCL-3. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Non-Small Cell Lung Cancer (V1.2026).



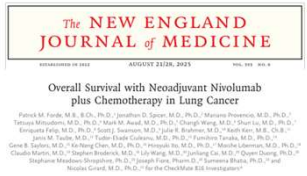
[e] For patients where more than one treatment modality (surgery, RT, or systemic therapy) is usually considered, a multidisciplinary evaluation should be performed.
[n] Principles of Surgical Therapy (NSCL-B).
[o] Principles of Radiation Therapy (NSCL-C).
[r] Principles of Perioperative Systemic Therapy (NSCL-E).
[w] Concurrent Chemoradiation Regimens (NSCL-F).

[z] For patients who have received sequential chemoradiation, durvalumab can be considered as consolidation immunotherapy or, if *EGFR* exon 19 deletion or L858R mutation, osimertinib is recommended.
[aa] Resectability should be determined by thoracic surgery evaluation prior to initiation of any therapy.
[bb] Selected patients with N2 disease (fit, single-station, non-bulky N2, requiring only lobectomy) may be considered for systemic therapy followed by surgery.
[cc] Chest CT with contrast and/or FDG-PET/CT to evaluate progression.

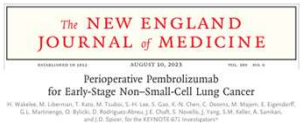




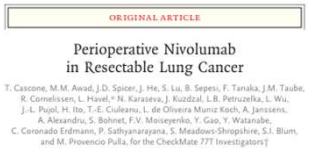
Forde PM et al, N Engl J Med 2022; Forde PM et al NEJM 2025; Wakelee H et al N Engl J Med 2023; Spicer JD et al Lancet 2024; Cascone T et al N Engl J Med 2024 ;JV Heymach et al N Engl J Med 2023 Felip et al Lancet 2021; Felip et al Ann Oncol 2023; O'Brien M et al Lancet Oncol 2022



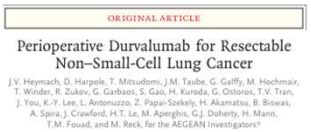
Nivolumab + platinum doublet X 3 → Surgery



Pembrolizumab + cisplatin doublet X 4 → Surgery → Pembrolizumab x 9m

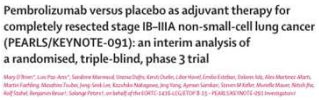


Nivolumab + platinum doublet X 4 → Surgery → Nivolumab x 12m



Durvalumab + platinum doublet X 4 → Surgery → Durvalumab x 12m

Surgery → Cisplatin doublet → Atezolizumab x 12m



Surgery → Cisplatin doublet → Pembrolizumab x 12m

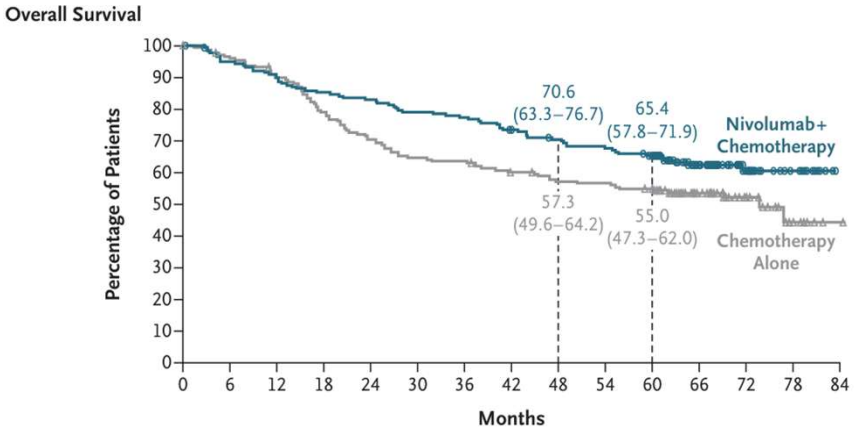
Forde PM et al, N Engl J Med 2022; Forde PM et al NEJM 2025; Wakelee H et al N Engl J Med 2023; Spicer JD et al Lancet 2024; Cascone T et al N Engl J Med 2024 ;JV Heymach et al N Engl J Med 2023 Felip et al Lancet 2021; Felip et al Ann Oncol 2023; O'Brien M et al Lancet Oncol 2022

Phase 3 trials with regulatory approval for resectable NSCLC

Trial	Intervention	N	pCR Rate	EFS (HR, median)	OS (HR; median)	FDA Approval Status
CheckMate 816	Neoadjuvant Nivo + CT vs CT	358 (IB–IIIA)	24%	EFS: 0.68; 59.6 mo vs 21.1 mo	OS: 0.72; 65% vs 55% (5-yr)	FDA Approved
KEYNOTE-671	Perioperative Pembro + CT vs CT	797 (II–IIIB)	20.9%	EFS: 0.59; 47.2 mo vs 18.3 mo	OS: 0.72; 71% vs 64% (3-yr)	FDA Approved
AEGEAN	Perioperative Durva + CT vs CT	740 (IIA–IIIB)	17.2%	EFS: 0.68; NR vs 25.9 mo	OS: 0.89; NR vs 53.2 mo	FDA Approved
CheckMate 77T	Perioperative Nivo + CT vs CT	461 (IIA – IIIB)	25.3%	EFS: 0.61; 46.6 mo vs 16.9 mo	OS: 0.85; 78% vs 72% (30 mo)	FDA Approved

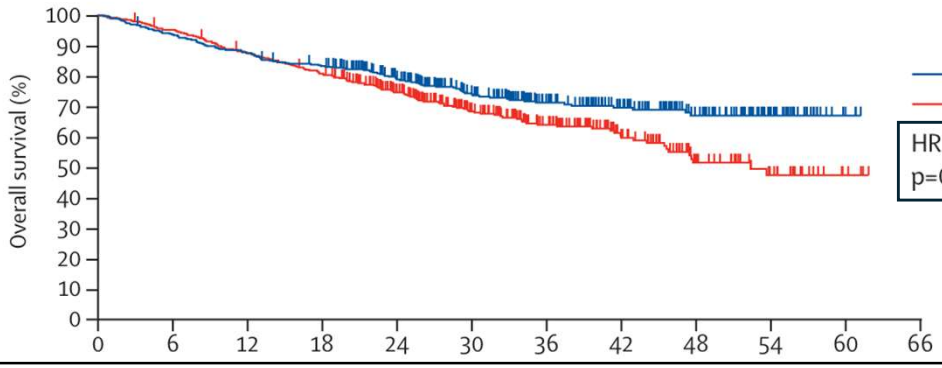
Forde P, NEJM 2022; Forde P, NEJM 2025; Wakelee H, NEJM 2023; Spicer JD, Lancet 2024; Heymach J, NEJM 2023; Heymach JTO 2024; Cascone T, NEJM 2024; Cascone T, ASCO 2025

Overall survival



	Median Overall Survival (95% CI)
	mo
Nivolumab+Chemotherapy (N=179)	NR (NR–NR)
Chemotherapy Alone (N=179)	73.7 (47.3–NR)

Hazard ratio for death, 0.72 (95% CI, 0.523–0.998)
P=0.048



Overall Survival with Neoadjuvant Nivolumab plus Chemotherapy in Lung Cancer

Forde et al, N Engl J Med 2025;393:741-52

Neoadjuvant pembrolizumab plus chemotherapy followed by adjuvant pembrolizumab compared with neoadjuvant chemotherapy alone in patients with early-stage non-small-cell lung cancer (KEYNOTE-671): a randomised, double-blind, placebo-controlled, phase 3 trial

Spicer et al, Lancet 2024; 404: 1240–52

Narrowing the focus

- How to approach N2 positivity in the current era
- Role of PD-L1 expression
- What about earlier stage, node negative tumors?
- Pathological response implications
- A look at adjuvant chemotherapy
- How biomarker testing should guide decisions

Adjuvant, neoadjuvant, or perioperative?

- Surgical resection upfront

  VS

- In patients who completed neoadjuvant therapy

- Should we consider these separately?

Adjuvant, neoadjuvant, or perioperative?

- Surgical resection upfront

  VS

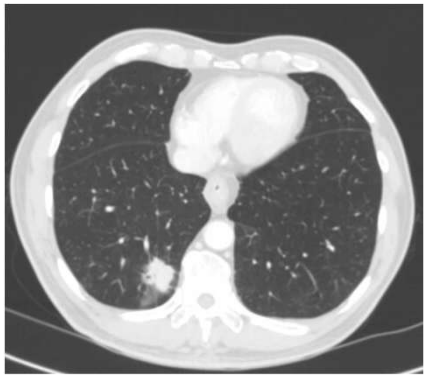
- In patients who completed neoadjuvant therapy
  - With pathCR? Without pCR? What about MPR? RVT?

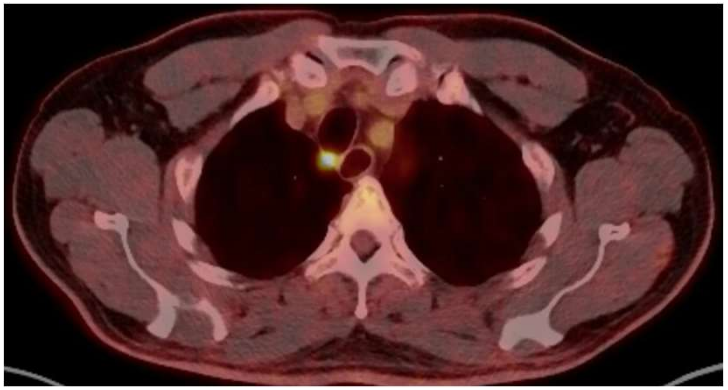
- Should we consider these separately?

Clinical Scenario/Case: Role of N2

77 yo man with DM and abnormal LFTs prompted imaging

- **CT abd revealed 2.7 cm RLL lesion**
- **PET shows RLL lesion and retro tracheal LN uptake**
- **EBUS confirms N2 positive disease, NSCLC, adenocarcinoma**
- **NGS: *CDKN2A*; PD-L1 50%**
- **What data do we have for N2 in peri-operative NSCLC?**





Trial ID	Stage III (%)	Stage III HR (95% CI)	Outcome
Adjuvant ICI			
IMpower 010	47%	0.62 (0.42, 0.90)	DFS
IMpower 010	47%	0.71 (0.44, 1.15)	OS
KEYNOTE-091	30%	0.92 (0.69, 1.24)	DFS
Neoadjuvant/Perioperative			
KEYNOTE-671	70%	0.74 (0.55, 0.98)	OS
KEYNOTE-671	70%	0.58 (0.46, 0.72)	EFS
CheckMate 816	63%	0.54 (0.37, 0.80)	EFS
CheckMate 816	63%	0.70 (0.47, 1.05)	OS
CheckMate 77T	64%	0.51 (0.36, 0.72)	EFS
AEGEAN	71%	IIIA 0.57 (0.39, 0.83) IIIB 0.83 (0.52, 1.32)	EFS
Adjuvant TKI			
ADAURA	35%	0.12 (0.07, 0.20)	DFS
ADAURA	35%	0.37 (0.20, 0.64)	OS
ALINA	53%	0.25 (0.12, 0.53)	DFS

Felip et al Lancet 2021; Felip et al Ann Oncol 2023; O'Brien M et al Lancet Oncol 2022; Wakelee H et al N Engl J Med 2023; Spicer JD et al Lancet 2024; Forde PM et al, N Engl J Med 2022; Forde PM et al NEJM 2025; Cascone T et al N Engl J Med 2024; JV Heymach et al N Engl J Med 2023; YL Wu et al N Engl J Med 2022; M Tsuboi et al N Engl J Med 2023; YL Wu et al N Engl J Med 2024

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Trial ID	Stage III (%)	Stage III HR (95% CI)	Outcome	N2 (%)
Adjuvant ICI				
IMpower 010	47%	0.62 (0.42, 0.90)	DFS	37%
IMpower 010	47%	0.71 (0.44, 1.15)	OS	37%
KEYNOTE-091	30%	0.92 (0.69, 1.24)	DFS	21%
Neoadjuvant/Perioperative				
KEYNOTE-671	70%	0.74 (0.55, 0.98)	OS	42%
KEYNOTE-671	70%	0.58 (0.46, 0.72)	EFS	42%
CheckMate 816	63%	0.54 (0.37, 0.80)	EFS	NR
CheckMate 816	63%	0.70 (0.47, 1.05)	OS	NR
CheckMate 77T	64%	0.51 (0.36, 0.72)	EFS	40%
AEGEAN	71%	IIIA 0.57 (0.39, 0.83) IIIB 0.83 (0.52, 1.32)	EFS	50%
Adjuvant TKI				
ADAURA	35%	0.12 (0.07, 0.20)	DFS	31%
ADAURA	35%	0.37 (0.20, 0.64)	OS	31%
ALINA	53%	0.25 (0.12, 0.53)	DFS	49%

Felip et al Lancet 2021; Felip et al Ann Oncol 2023; O'Brien M et al Lancet Oncol 2022; Wakelee H et al N Engl J Med 2023; Spicer JD et al Lancet 2024; Forde PM et al, N Engl J Med 2022; Forde PM et al NEJM 2025; Cascone T et al N Engl J Med 2024; JV Heymach et al N Engl J Med 2023; YL Wu et al N Engl J Med 2022; M Tsuboi et al N Engl J Med 2023; YL Wu et al N Engl J Med 2024

Trial ID	Stage III (%)	Stage III HR (95% CI)	Outcome	N2 (%)	N2 HR (95%CI)
Adjuvant ICI					
IMpower 010	47%	0.62 (0.42, 0.90)	DFS	37%	0.66 (0.44, 0.99)
IMpower 010	47%	0.71 (0.44, 1.15)	OS	37%	0.74 (0.51, 1.07)
KEYNOTE-091	30%	0.92 (0.69, 1.24)	DFS	21%	NR
Neoadjuvant/Perioperative					
KEYNOTE-671	70%	0.74 (0.55, 0.98)	OS	42%	0.74 (0.51, 1.07)
KEYNOTE-671	70%	0.58 (0.46, 0.72)	EFS	42%	0.63 (0.48, 0.82)
CheckMate 816	63%	0.54 (0.37, 0.80)	EFS	NR	NR
CheckMate 816	63%	0.70 (0.47, 1.05)	OS	NR	NR
CheckMate 77T	64%	0.51 (0.36, 0.72)	EFS	40%	0.46 (0.30, 0.70)
AEGEAN	71%	IIIA 0.57 (0.39, 0.83) IIIB 0.83 (0.52, 1.32)	EFS	50%	NR
Adjuvant TKI					
ADAURA	35%	0.12 (0.07, 0.20)	DFS	31%	NR
ADAURA	35%	0.37 (0.20, 0.64)	OS	31%	NR
ALINA	53%	0.25 (0.12, 0.53)	DFS	49%	0.21 (0.09, 0.47)

Felip et al Lancet 2021; Felip et al Ann Oncol 2023; Felip et al JCO 2025; O'Brien M et al Lancet Oncol 2022; Wakelee H et al N Engl J Med 2023; Spicer JD et al Lancet 2024; Forde PM et al, N Engl J Med 2022; Forde PM et al NEJM 2025; Cascone T et al N Engl J Med 2024; JV Heymach et al N Engl J Med 2023; YL Wu et al N Engl J Med 2022; M Tsuboi et al N Engl J Med 2023; YL Wu et al N Engl J Med 2024

Trial ID	Stage III (%)	Stage III HR (95% CI)	Outcome	N2 (%)	N2 HR (95%CI)	N2a(%)	N2a HR (95% CI)	N2b (%)	N2b HR (95% CI)
Adjuvant ICI									
IMpower 010	47%	0.62 (0.42, 0.90)	DFS	37%	0.66 (0.44, 0.99)				
IMpower 010	47%	0.71 (0.44, 1.15)	OS	37%	0.84 (0.50, 1.40)				
KEYNOTE-091	30%	0.92 (0.69, 1.24)	DFS	21%	NR				
Neoadjuvant/Perioperative									
KEYNOTE-671	70%	0.74 (0.55, 0.98)	OS	42%	0.74 (0.51, 1.07)				
KEYNOTE-671	70%	0.58 (0.46, 0.72)	EFS	42%	0.63 (0.48, 0.82)				
CheckMate 816	63%	0.54 (0.37, 0.80)	EFS	NR	NR				
CheckMate 816	63%	0.70 (0.47, 1.05)	OS	NR	NR				
CheckMate 77T	64%	0.51 (0.36, 0.72)	EFS	40%	0.46 (0.30, 0.70)	26%	0.49 (0.29, 0.84)	14%	0.43 (0.21, 0.88)
AEGEAN	71%	IIIA 0.57 (0.39, 0.83) IIIB 0.83 (0.52, 1.32)	EFS	50%	NR	39%	0.61 (0.39, 0.94)	9%	0.69 (0.33, 1.38)
Adjuvant TKI									
ADAURA	35%	0.12 (0.07, 0.20)	DFS	31%	NR				
ADAURA	35%	0.37 (0.20, 0.64)	OS	31%	NR				
ALINA	53%	0.25 (0.12, 0.53)	DFS	49%	0.21 (0.09, 0.47)				

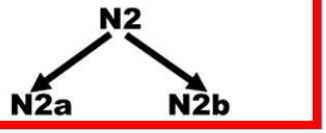
Felip et al Lancet 2021; Felip et al Ann Oncol 2023; O'Brien M et al Lancet Oncol 2022; Wakelee H et al N Engl J Med 2023; Spicer JD et al Lancet 2024; Forde PM et al, N Engl J Med 2022; Forde PM et al NEJM 2025; Cascone T et al N Engl J Med 2024; JV Heymach et al N Engl J Med 2023; YL Wu et al N Engl J Med 2022; M Tsuboi et al N Engl J Med 2023; YL Wu et al N Engl J Med 2024

The IASLC Lung Cancer Staging Project: Proposals for Revision of the TNM Stage Groups in the Forthcoming (Ninth) Edition of the TNM Classification for Lung Cancer

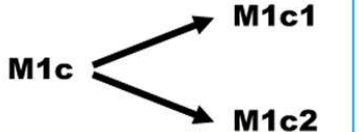
Journal of Thoracic Oncology

Changes in the 9th Edition

N2 involvement is split into:
N2a (single station)
N2b (multiple stations)



M1c involvement is split into:
M1c1 (single organ system)
M1c2 (multiple organ systems)



T/M category	Subcategory, Descriptor	N0	N1	N2		N3
				N2a	**N2b**	
T1	T1a T1b T1c	IA	**IIA**	**IIB**	**IIIA**	IIIB
T2	T2a	IB	IIIB	**IIIA**	**IIIB**	IIIB
	T2b	IIA				
T3	Size Invasion Nodule	IIB	IIIA	**IIIA**	**IIIB**	IIIC
T4	Size Invasion Nodule	IIIA	IIIA	**IIIB**	**IIIB**	IIIC
M1	M1a, M1b	IVA				
	M1c1, M1c2	**IVB**				

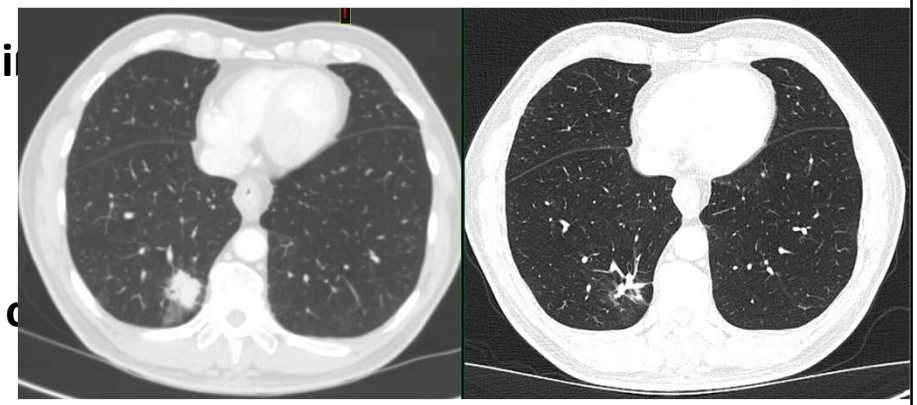
CONCLUSION: The proposed changes improve the granularity of nomenclature of anatomic extent that has benefits as treatment becomes increasingly differentiated and complex.

IASLC

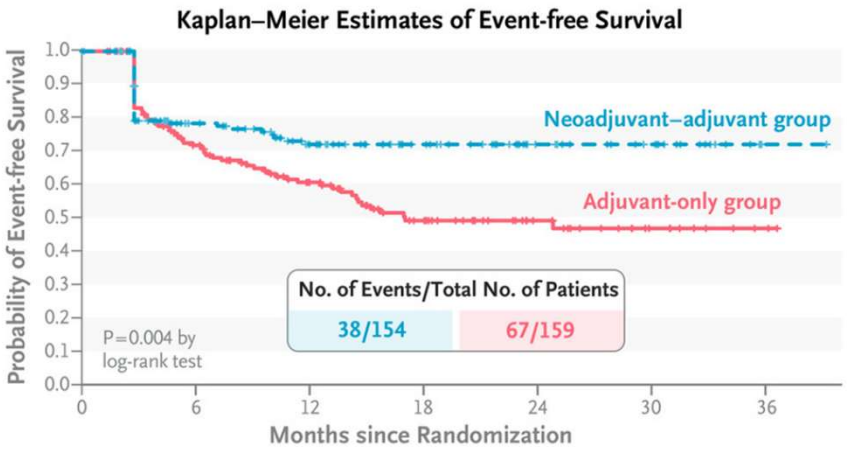
Rami-Porta et al. *J Thorac Onc* (2024)

Clinical Scenario/Case

- **Patient planned for neoadjuvant chemoimmunotherapy**
- **CT after three cycles shows response i primary**
- **PET confirms improvement in mediastinal uptake**
- **Taken to OR: non-pCR with clearance o N2 nodes**
- **What to offer as adjuvant therapy?**



The Dream



Patel et al, N Engl J Med 2023; 388:813-823

The Reality

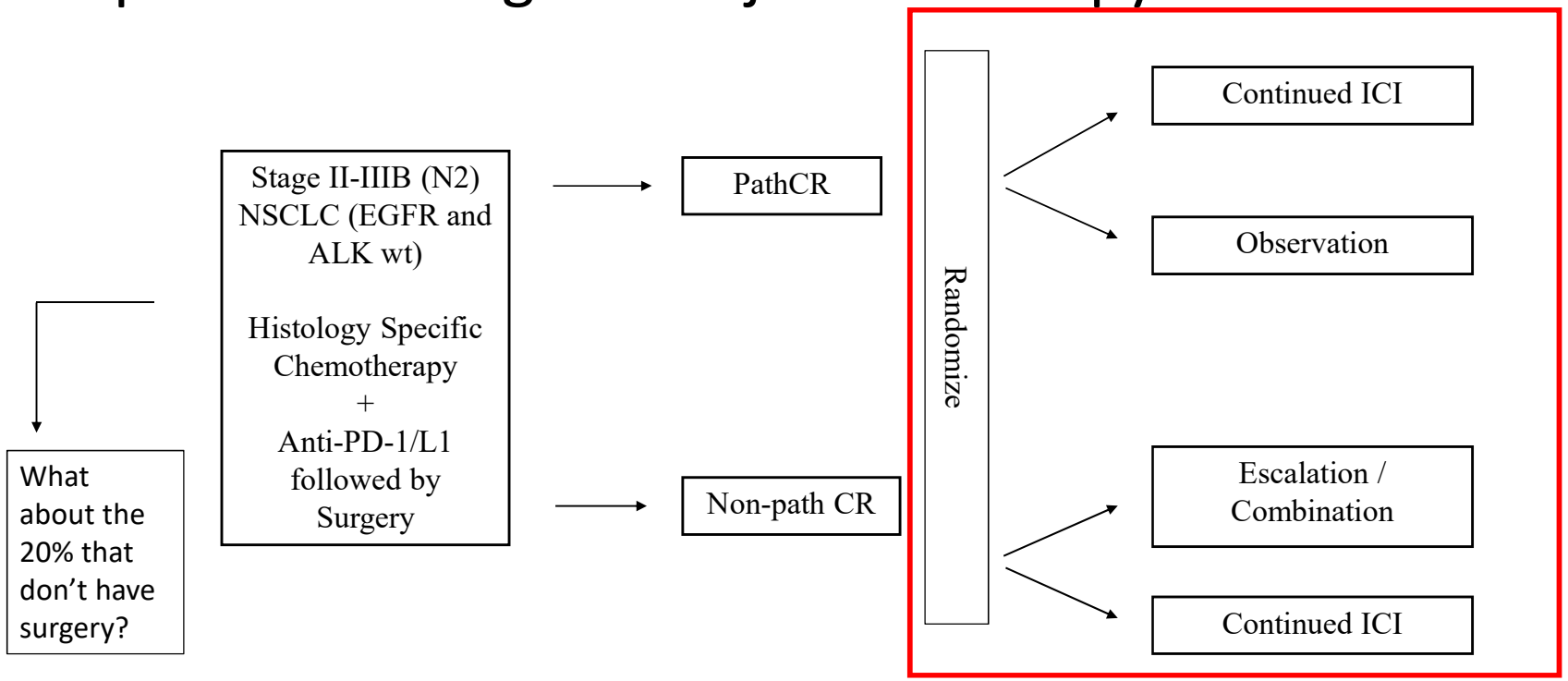
Trial	Regimen	N
Neoadjuvant only		
CheckMate 816	Nivo + chemo → surgery	358
Peri-operative		
CheckMate 77T	Nivo + chemo → nivo	452
KEYNOTE-671	Pembro + chemo → pembro	786
IMpower030	Atezo + chemo → atezo	453
AEGEAN	Durva + chemo → durva	802
Adjuvant		
ANVIL	Surgery → nivo	903
ACCIO	Surgery → chemo → pembro Surgery → chemo + pembro	1210
KEYNOTE-091	Surgery → pembro	1177
IMpower010	Surgery → atezo	1280
BR.31	Surgery → durva	1360

Source: clinicaltrials.gov

Challenges

- Many of the perioperative studies require enrollment during neoadjuvant phase
- Locked in choice of neoadjuvant ICI based on sponsor
- Need for real world enrollment of patients without pCR regardless of neoadjuvant ICI/chemo combination
- While awaiting results of these studies, how do we interpret the available data?

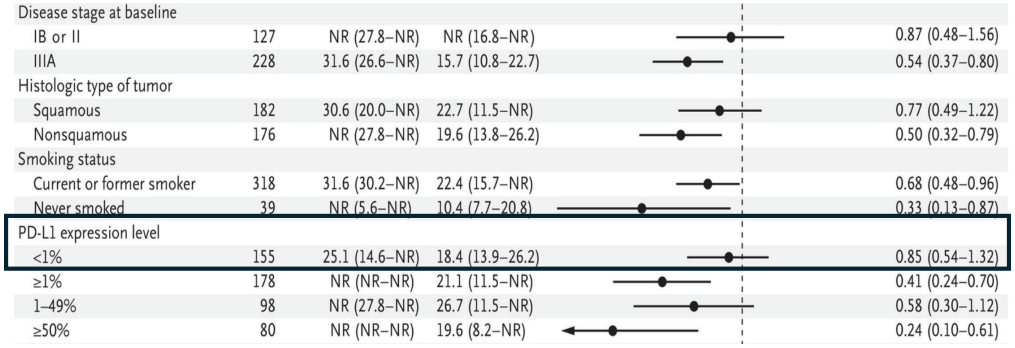
Ideal approach for perioperative trials leveraging pCR status to guide adjuvant therapy



Role of PD-L1 in treatment decisions

CheckMate 816

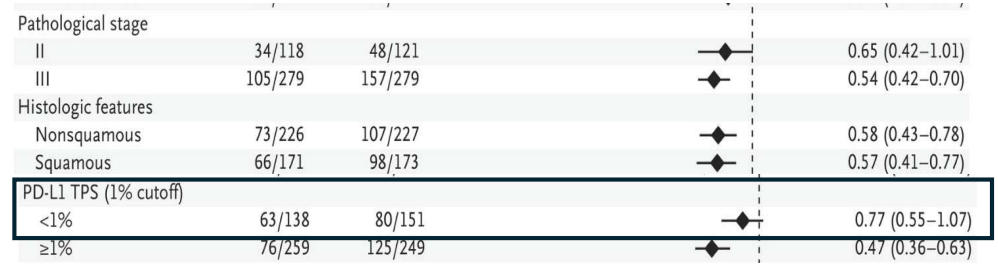
Forde PM et al, N Engl J Med 2022; 386:1973-1985



Disease stage at baseline				
IB or II	127	NR (27.8–NR)	NR (16.8–NR)	0.87 (0.48–1.56)
IIIA	228	31.6 (26.6–NR)	15.7 (10.8–22.7)	0.54 (0.37–0.80)
Histologic type of tumor				
Squamous	182	30.6 (20.0–NR)	22.7 (11.5–NR)	0.77 (0.49–1.22)
Nonsquamous	176	NR (27.8–NR)	19.6 (13.8–26.2)	0.50 (0.32–0.79)
Smoking status				
Current or former smoker	318	31.6 (30.2–NR)	22.4 (15.7–NR)	0.68 (0.48–0.96)
Never smoked	39	NR (5.6–NR)	10.4 (7.7–20.8)	0.33 (0.13–0.87)
PD-L1 expression level				
<1%	155	25.1 (14.6–NR)	18.4 (13.9–26.2)	0.85 (0.54–1.32)
≥1%	178	NR (NR–NR)	21.1 (11.5–NR)	0.41 (0.24–0.70)
1–49%	98	NR (27.8–NR)	26.7 (11.5–NR)	0.58 (0.30–1.12)
≥50%	80	NR (NR–NR)	19.6 (8.2–NR)	0.24 (0.10–0.61)

KEYNOTE-671

Wakelee H et al N Engl J Med 2023; 389:491-503

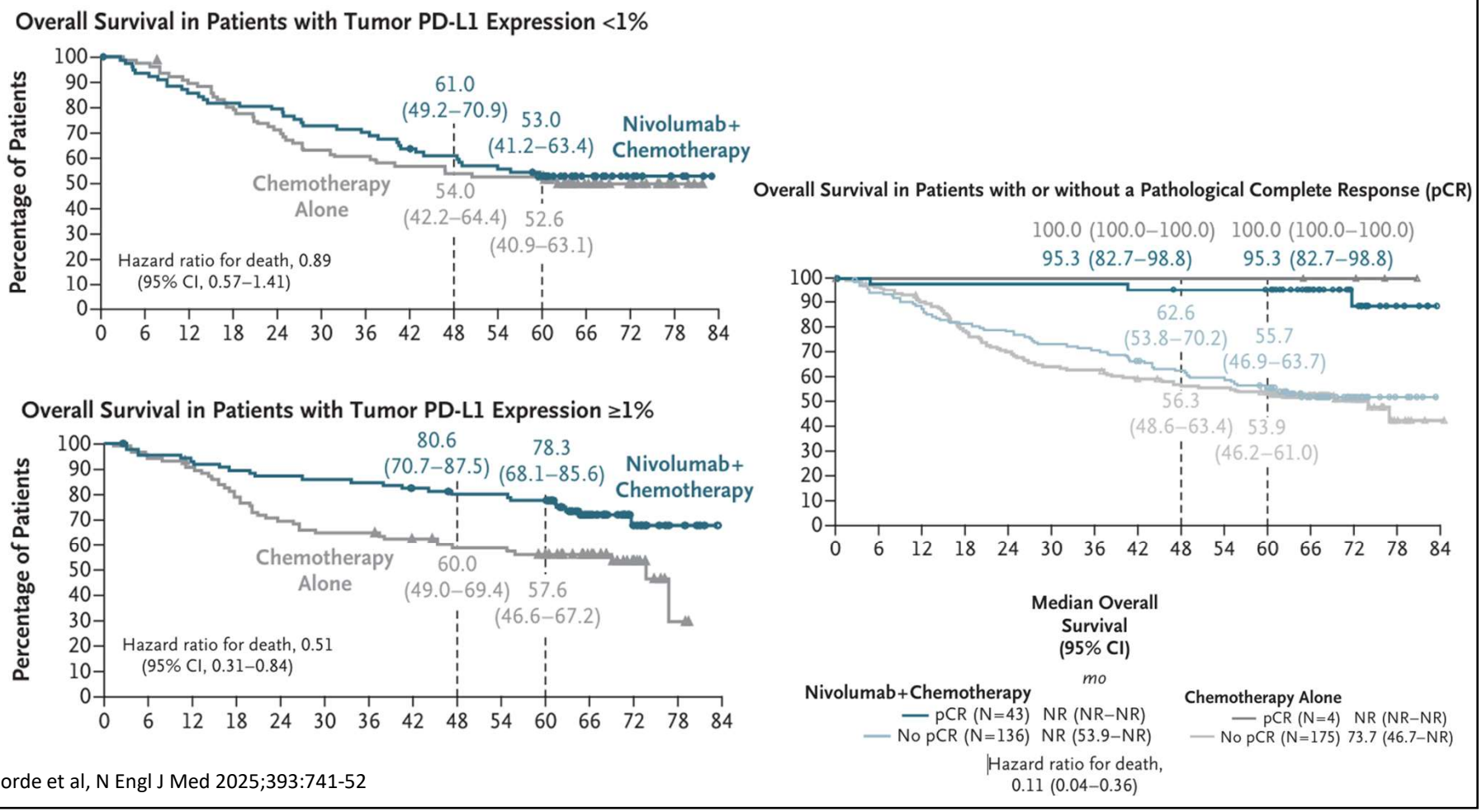


Pathological stage			
II	34/118	48/121	0.65 (0.42–1.01)
III	105/279	157/279	0.54 (0.42–0.70)
Histologic features			
Nonsquamous	73/226	107/227	0.58 (0.43–0.78)
Squamous	66/171	98/173	0.57 (0.41–0.77)
PD-L1 TPS (1% cutoff)			
<1%	63/138	80/151	0.77 (0.55–1.07)
≥1%	76/259	125/249	0.47 (0.36–0.63)

KEYNOTE-091

O'Brien M et al Lancet Oncol 2022; 1274-1286

Received adjuvant chemotherapy			
No	35/84	29/83	1·25 (0·76-2·05)
Yes	177/506	231/504	0·73 (0·60-0·89)
Histology			
Non-squamous	146/398	184/363	0·67 (0·54-0·83)
Squamous	66/192	76/224	1·04 (0·75-1·45)
PD-L1 TPS			
<1%	89/233	106/232	0·78 (0·58-1·03)*
1-49%	69/189	91/190	0·67 (0·48-0·92)*
≥50%	54/168	63/165	0·82 (0·57-1·18)*



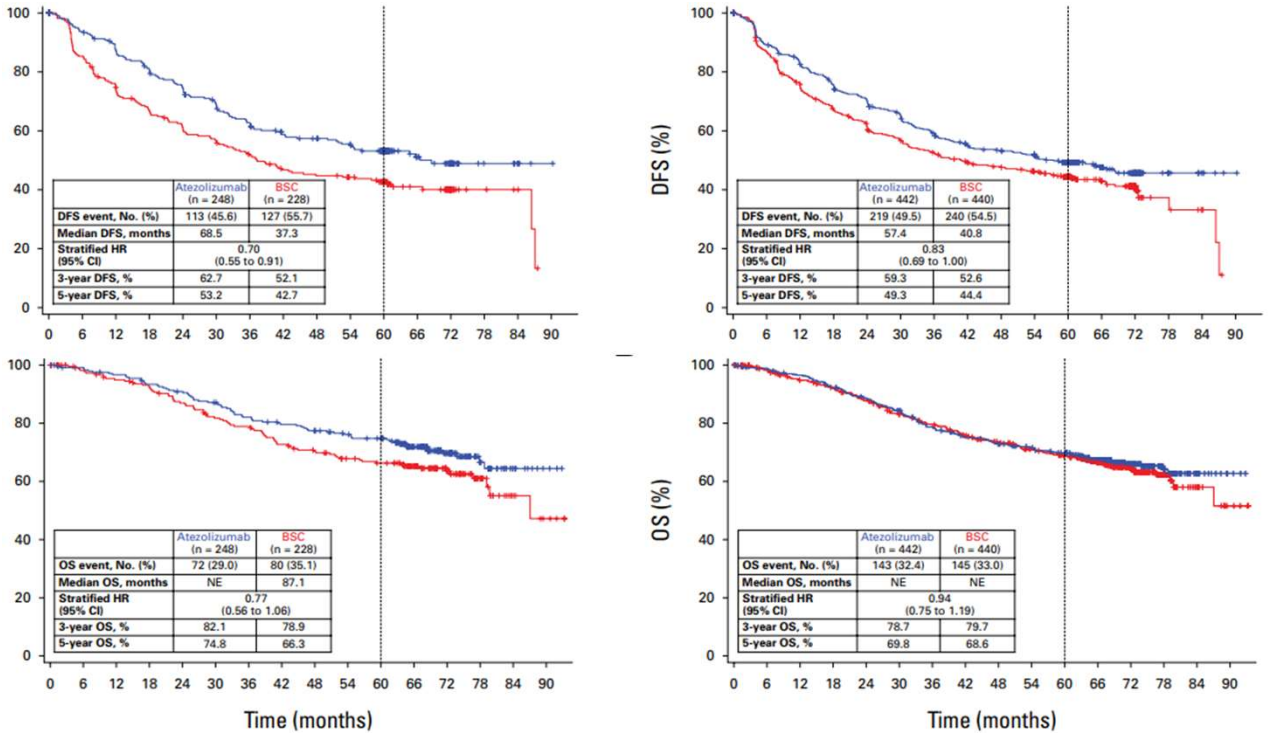
Forde et al, N Engl J Med 2025;393:741-52

Adjuvant atezolizumab after adjuvant chemotherapy in resected stage IB–IIIA non-small-cell lung cancer (IMpower010): a randomised, multicentre, open-label, phase 3 trial

Surgery → Cisplatin doublet → Atezolizumab x 12m

Five-year overall survival: IMpower 010

- DFS improvement in both PD-L1 positive and negative cohorts



	Atezolizumab (n = 248)	BSC (n = 228)
DFS event, No. (%)	113 (45.6)	127 (55.7)
Median DFS, months	68.5	37.3
Stratified HR (95% CI)	0.70 (0.55 to 0.91)	
3-year DFS, %	62.7	52.1
5-year DFS, %	53.2	42.7

	Atezolizumab (n = 442)	BSC (n = 440)
DFS event, No. (%)	219 (49.5)	240 (54.5)
Median DFS, months	57.4	40.8
Stratified HR (95% CI)	0.83 (0.69 to 1.00)	
3-year DFS, %	59.3	52.6
5-year DFS, %	49.3	44.4

	Atezolizumab (n = 248)	BSC (n = 228)
OS event, No. (%)	72 (29.0)	80 (35.1)
Median OS, months	NE	87.1
Stratified HR (95% CI)	0.77 (0.56 to 1.06)	
3-year OS, %	82.1	78.9
5-year OS, %	74.8	66.3

	Atezolizumab (n = 442)	BSC (n = 440)
OS event, No. (%)	143 (32.4)	145 (33.0)
Median OS, months	NE	NE
Stratified HR (95% CI)	0.94 (0.75 to 1.19)	
3-year OS, %	78.7	79.7
5-year OS, %	69.8	68.6

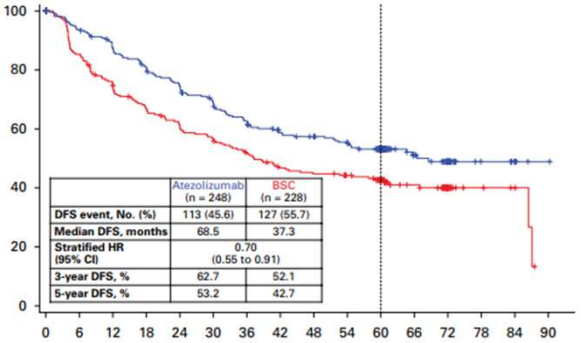
Felip E et al JCO 2025

Adjuvant atezolizumab after adjuvant chemotherapy in resected stage IB–IIIA non-small-cell lung cancer (IMpower010): a randomised, multicentre, open-label, phase 3 trial

Surgery → Cisplatin doublet → Atezolizumab x 12m

Five-year overall survival: Impower 010

- DFS improvement in both PD-L1 positive and negative cohorts
- But OS benefit only in PD-L1 positive, driven by PD-L1 high



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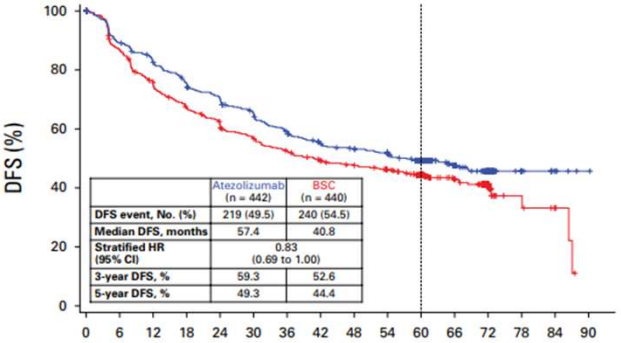
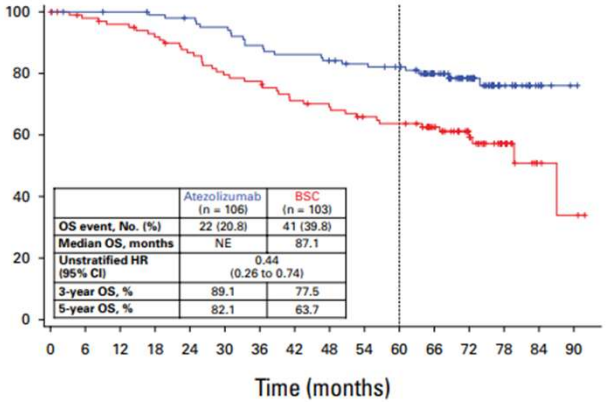


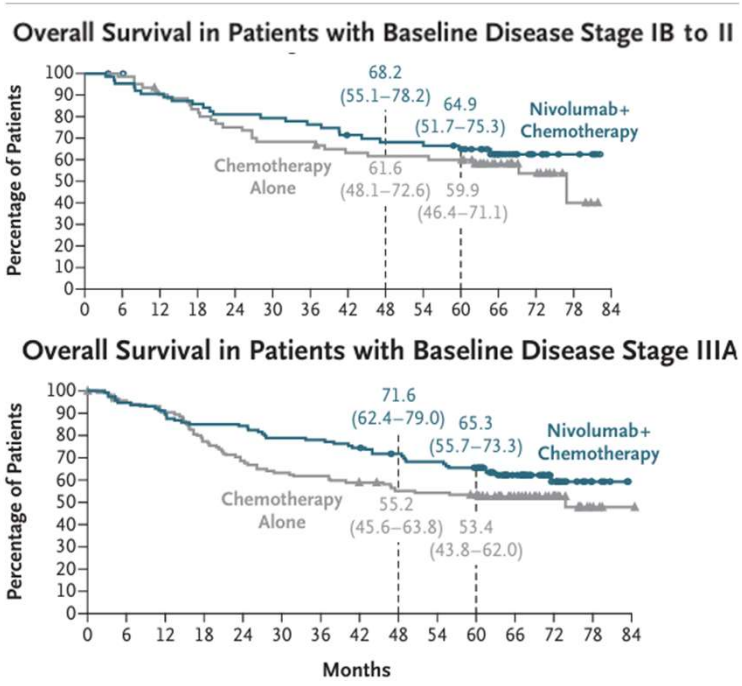
	Atezolizumab (n = 442)	BSC (n = 440)
DFS event, No. (%)	219 (49.5)	240 (54.5)
Median DFS, months	57.4	40.8
Stratified HR (95% CI)	0.83 (0.69 to 1.00)	
3-year DFS, %	59.3	52.6
5-year DFS, %	49.3	44.4



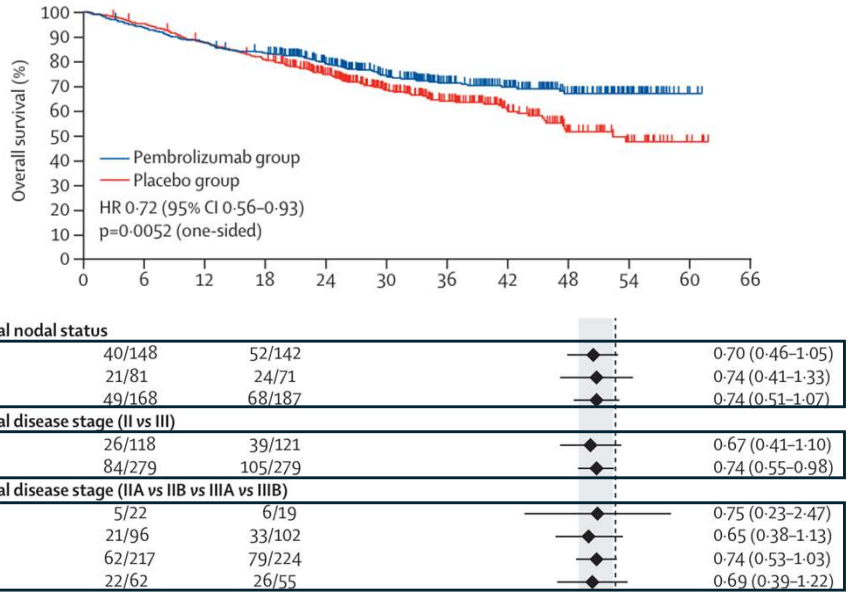
	Atezolizumab (n = 106)	BSC (n = 103)
OS event, No. (%)	22 (20.8)	41 (39.8)
Median OS, months	NE	87.1
Unstratified HR (95% CI)	0.44 (0.26 to 0.74)	
3-year OS, %	89.1	77.5
5-year OS, %	82.1	63.7

Felip E et al JCO 2025

What about patients with node negative NSCLC?



Forde et al, N Engl J Med 2025;393:741-52



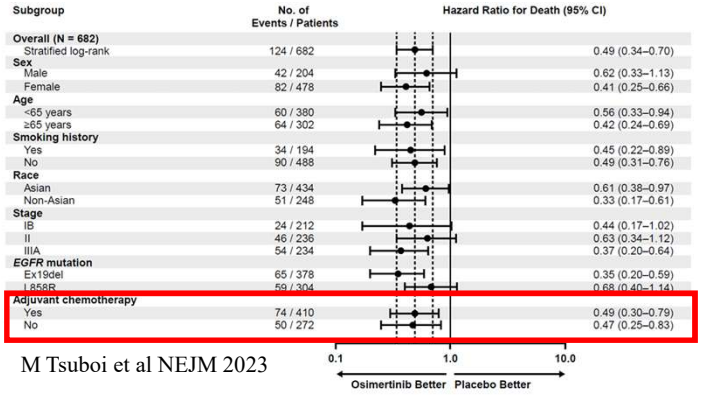
Clinical nodal status			
N0	40/148	52/142	0·70 (0·46–1·05)
N1	21/81	24/71	0·74 (0·41–1·33)
N2	49/168	68/187	0·74 (0·51–1·07)
Clinical disease stage (II *vs* III)			
II	26/118	39/121	0·67 (0·41–1·10)
III	84/279	105/279	0·74 (0·55–0·98)
Clinical disease stage (IIA *vs* IIB *vs* IIIA *vs* IIIB)			
IIA	5/22	6/19	0·75 (0·23–2·47)
IIB	21/96	33/102	0·65 (0·38–1·13)
IIIA	62/217	79/224	0·74 (0·53–1·03)
IIIB	22/62	26/55	0·69 (0·39–1·22)

Spicer et al, Lancet 2024; 404: 1240–52

Still a role for adjuvant chemotherapy?

- IMpower010: required at least one cycle of chemo prior to atezolizumab
- KEYNOTE-091: chemotherapy optional
- ADAURA: chemotherapy optional
- ALINA: alectinib vs chemotherapy

O'Brien M et al Lancet Oncol 2022; 1274-1286



M Tsuboi et al NEJM 2023

Importance of ruling out *EGFR*/*ALK*

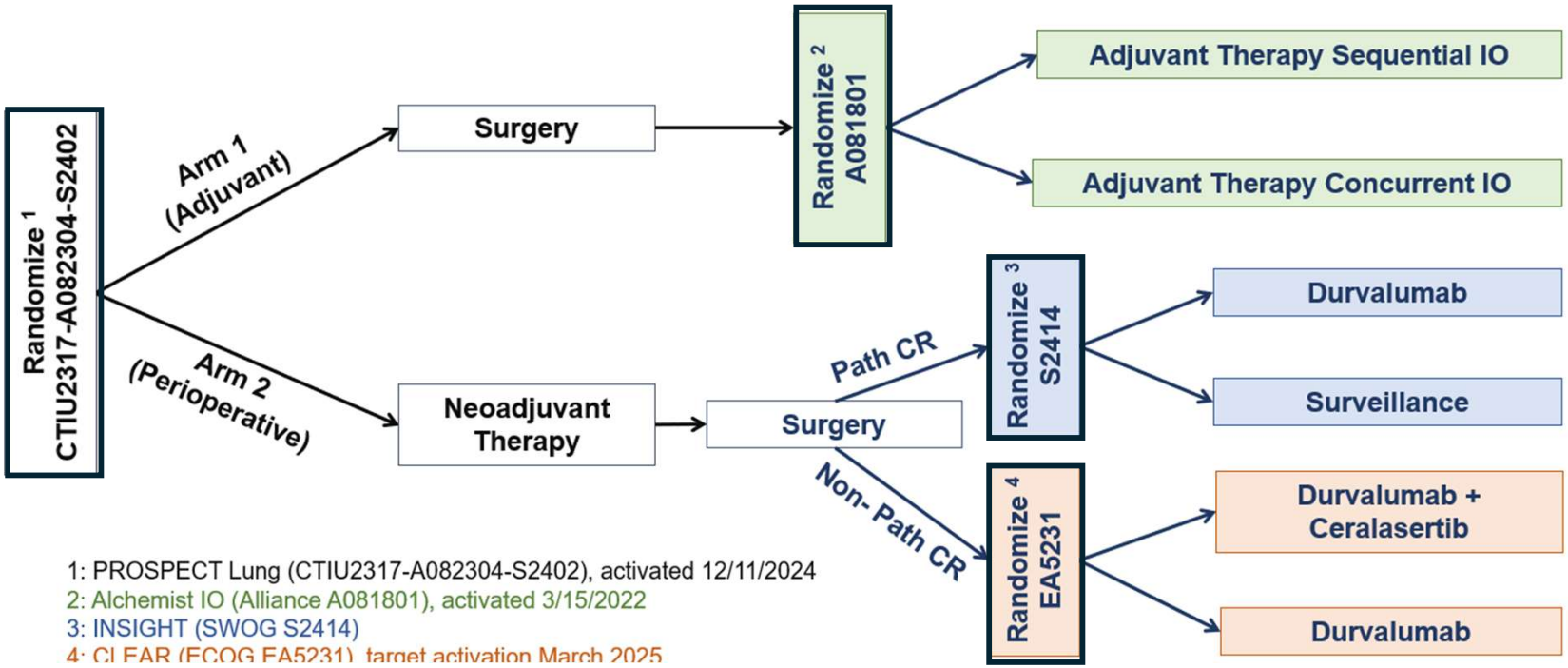
- Biomarker testing drives clinical decision-making in perioperative NSCLC
  - Identify logistics for streamlining testing in the clinic among the multidisciplinary team
- PD-L1 TPS, *EGFR* and *ALK* at a minimum:
  - ALL patients planned for neoadjuvant therapy
  - ALL patients with Stage IB-IIIA NSCLC after surgery
- *EGFR* and *ALK* positive: *excluded* from most perioperative trials
  - IO + TKIs have been shown to be toxic without a consistent benefit
  - These patients should get **adjuvant** targeted therapy
  - It is important to have all biomarker testing done **upfront**
  - **Sequential ICI then TKI may predispose patients to toxicities**

Lisberg A et al J Thorac Oncol. 2018
Adderly H et al, Cancer Immunol Immunother. 2020

Future directions

- Need to develop approaches for both adjuvant and perioperative therapies.
  - Adaptive trials to incorporate both
- Utilizing pathCR status (+/- ctDNA) to tailor adjuvant therapy
- Does non-path CR really = non-responder? MPR? RVT?
- Unmet need for patients with PD-L1 negative NSCLC in both perioperative and adjuvant therapies

NCTN-wide Trial Options



1: PROSPECT Lung (CTIU2317-A082304-S2402), activated 12/11/2024
2: Alchemist IO (Alliance A081801), activated 3/15/2022
3: INSIGHT (SWOG S2414)
4: CLEAR (ECOG EA5231), target activation March 2025

National Comprehensive Cancer Network®

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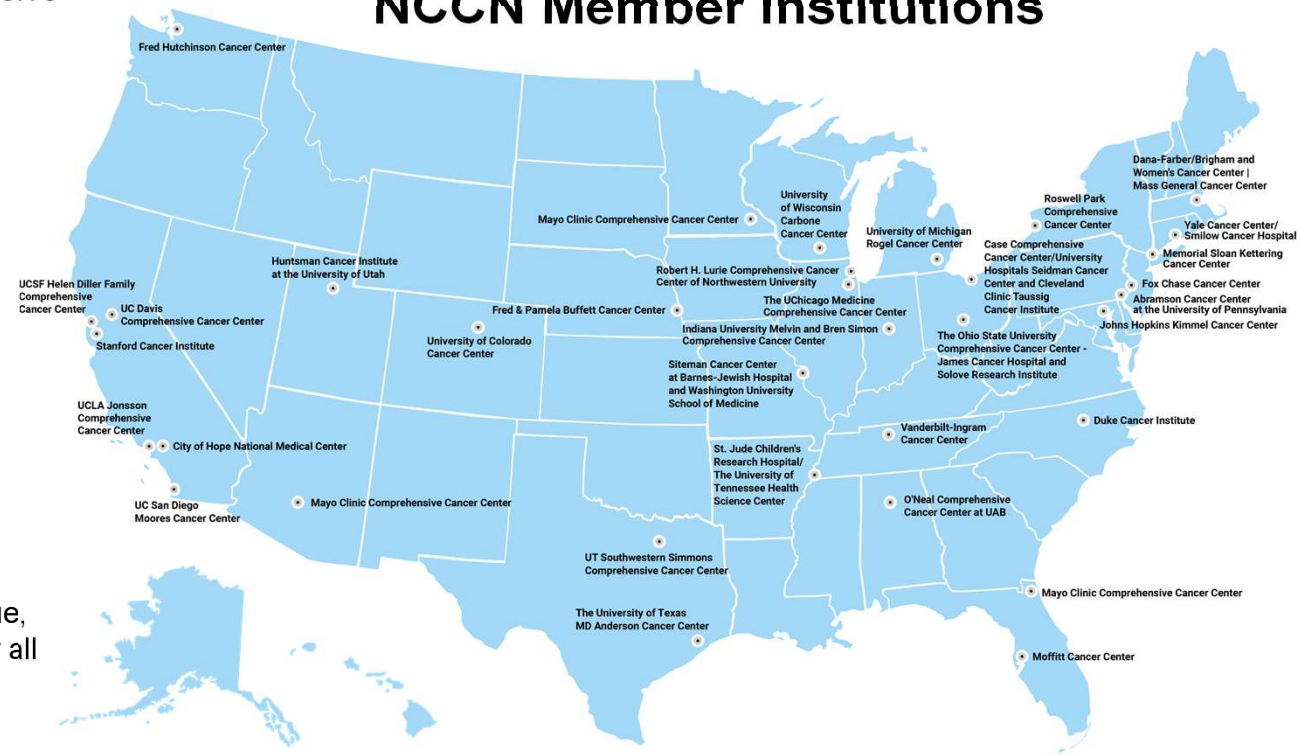

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An alliance of leading cancer centers devoted to patient care, research, and education

Our Mission

To define and advance quality, effective, equitable, and accessible cancer care and prevention so all people can live better lives

Our Vision

Access to high-quality, high-value, patient-centered cancer care for all people globally

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