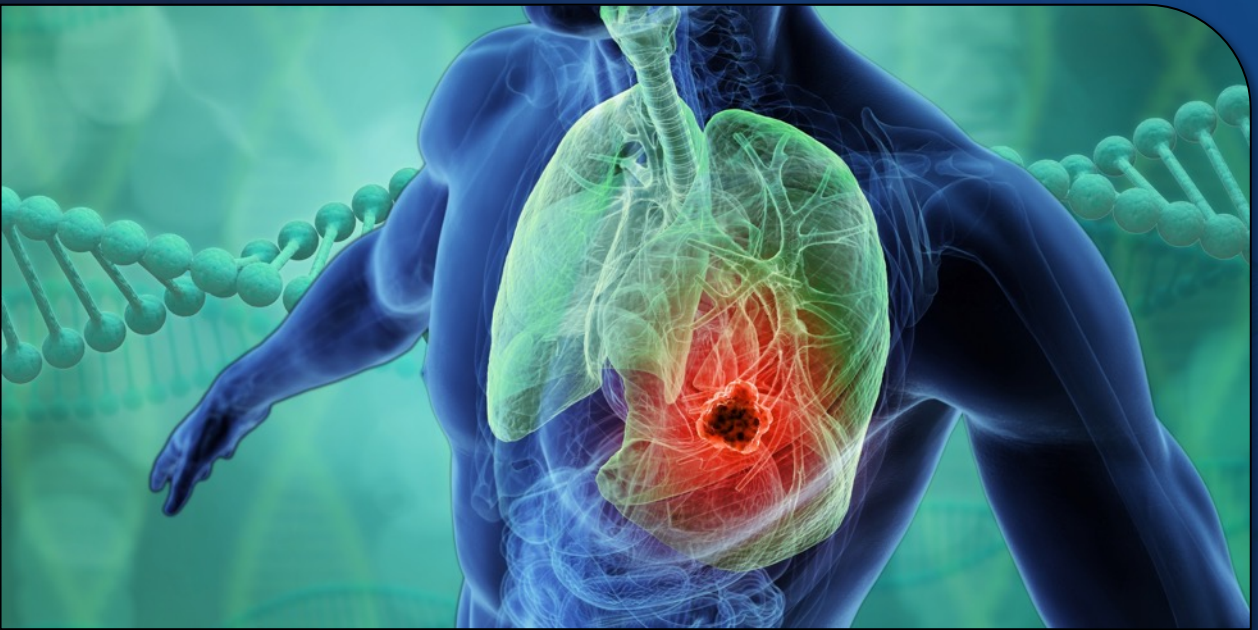
Refining the First Strike Against *EGFR*-Mutated Advanced NSCLC

PeerView Live

Personalizing Frontline Treatment Decisions Amid Increasing Complexity



Today's Faculty

PeerView

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Our Goals for Today

- **Augment your knowledge** of the evidence supporting the use of different first-line treatment options for *EGFR*-mutated advanced/metastatic NSCLC
- **Equip you with skills** for developing individualized first-line treatment plans with EGFR-targeted therapies or combinations for patients with *EGFR*-mutated advanced/metastatic NSCLC

Gaps and Opportunities for Improvement:

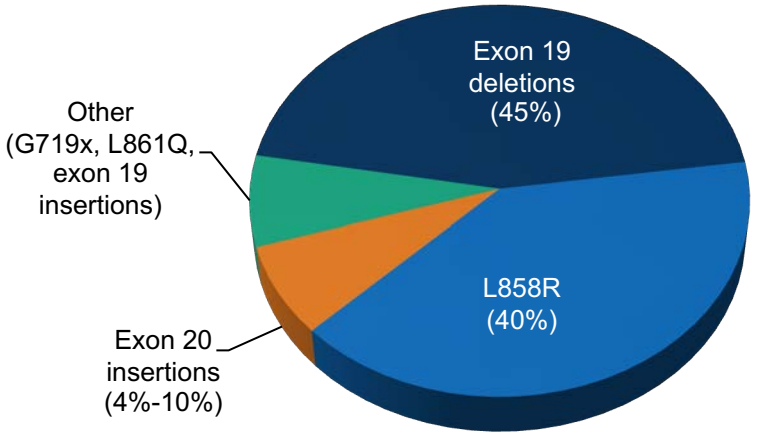
Spotlight on *EGFR*-Mutated mNSCLC

Necessary Biomarker Testing in Lung Cancer: *EGFR* and Beyond

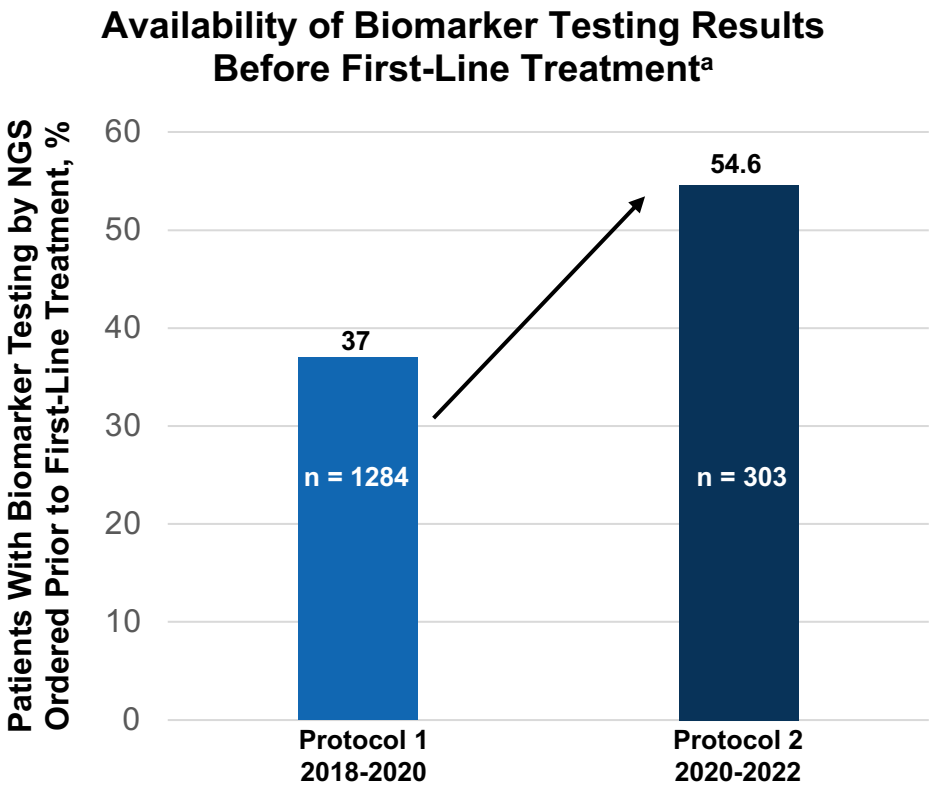
Complete biomarker testing prior to therapy is needed to optimize care

- PD-L1 tumor expression, genomic alterations (*EGFR*, *ALK*, *ROS1*, *BRAF*, *NTRK*, *MET*, *RET*, *KRAS*, *ERBB2*)
- Guides therapy in advanced NSCLC and now in earlier stages of disease
- Type of testing matters (NGS, DNA vs RNA)
- Interpretation of results is just as important
  - Know what you're looking for (mutation vs amplification/overexpression)
  - *EGFR* or biomarker "positive" is not enough → more granularity needed

Different Subtypes of *EGFR* Mutations



Gaps in Biomarker Testing Persist… MYLUNG Study Update[1]



Patients in Advanced Cohort (N = 582) With Any Biomarker Testing Results Prior to First-Line Treatment (N = 461)	
ALK , n (%)	355 (77.0)
BRAF, n (%)	335 (72.7)
EGFR, n (%)	371 (80.5)
KRAS, n (%)	294 (63.8)
MET, n (%)	328 (71.1)
NTRK, n (%)	253 (54.9)
PD-L1, n (%)	388 (84.2)
RET, n (%)	305 (66.2)
ROS1, n (%)	344 (74.6)

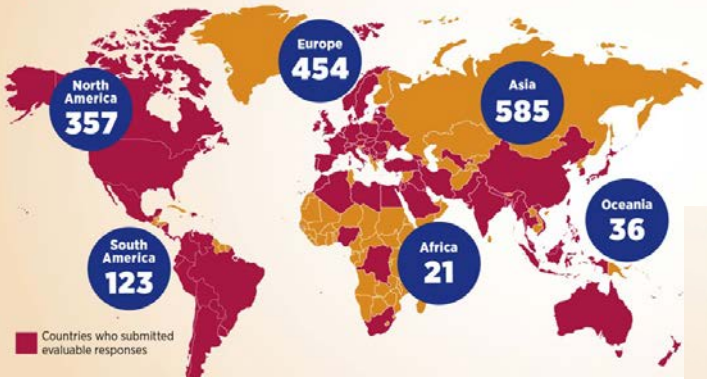
[a] Denominator: Protocol = 3474; protocol 2, N = 555.

1. Evangelist M et al. ASCO 2023. Abstract 9109.

2024 IASLC Global Survey on Biomarker Testing[1]

Found improvements in the perception of testing rates vs 2018, but continued and substantial barriers in testing persist

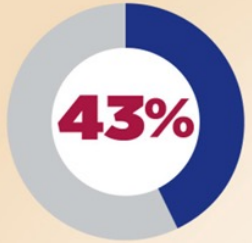
1,677 responses across 90 countries and 14 disciplines.



67% estimate more than half of individuals with lung cancer are biomarker tested in their country, up from **39%** in the 2018 survey (p-value<0.0001)

LATE STAGE ranked highly important to perform comprehensive biomarker testing in respective stage

63% | **EARLY STAGE 29%**



Sometimes or often treat patients prior to receiving biomarker results

The Highest Ranked Barriers

- COST
- TIME
- SAMPLE QUALITY
- ACCESS
- AWARENESS

Key Solutions Identified

- IMPLEMENT TESTING PROTOCOLS
- ADVOCATE FOR GOVERNMENT LEVEL INTERVENTIONS
- DECREASE COST & IMPROVE REIMBURSEMENT STRATEGIES
- INCREASE AWARENESS & EDUCATION
- PROVIDE SUPPORT
- EXPAND ACCESS & BROADEN AVAILABILITY
- PROMOTE RESEARCH

1. Evangelist M et al. ASCO 2023. Abstract 9109.

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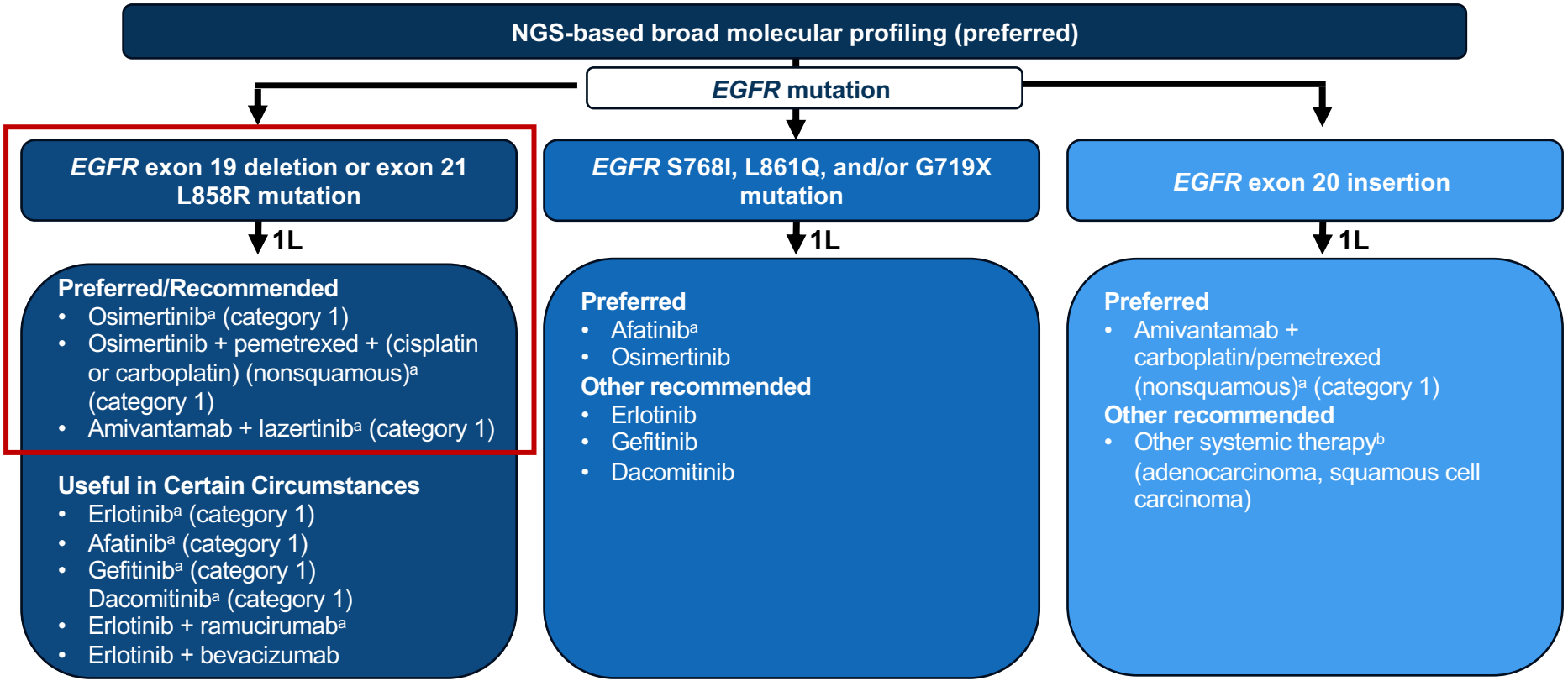
Increasing Complexity of First-Line EGFR-Targeted Therapy Options for *EGFR*-Mutated mNSCLC: NCCN Guidelines[1]



[a] FDA approved. [b] Please consult NCCN Guidelines for details on systemic therapy options.

1. NCCN Clinical Practice Guidelines in Oncology. Non-Small Cell Lung Cancer. Version 11.2024. https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf.

Candid Conversations and Clinical Consults:

How to Interpret the Evidence and Make Multifactorial Clinical Decisions in First-Line Treatment of *EGFR*-Mutated Advanced NSCLC

Let's Consider Case #1

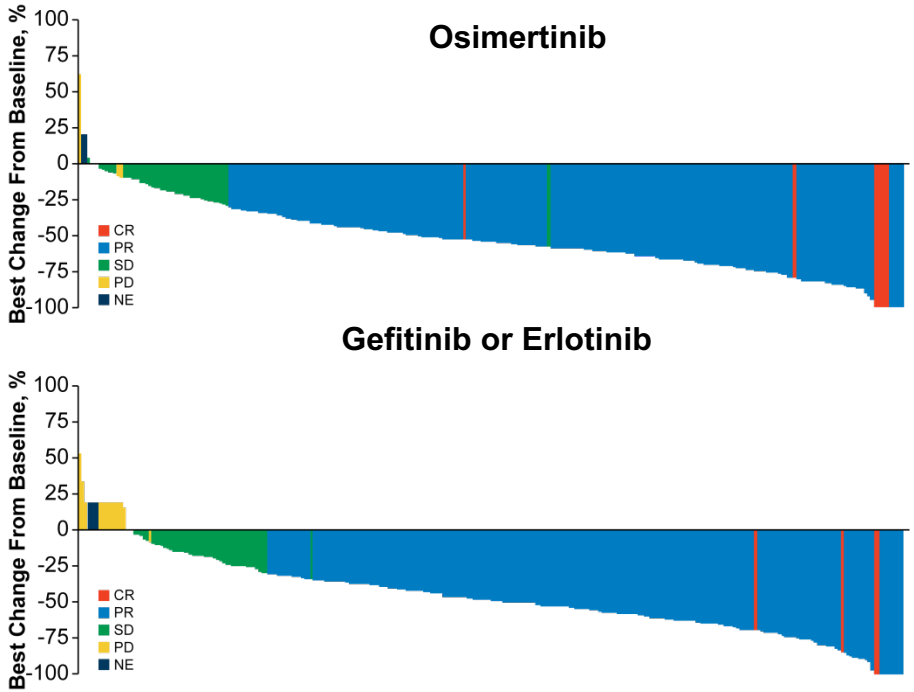
A 61-year-old woman with no history of smoking presents with cough, dyspnea, and generalized fatigue x 3 months

- Initial CXR: LUL opacity → PET/CT: 3-cm LLL lung nodule and enlarged mediastinal nodes + multiple FDG-avid hepatic hypodensities and extensive bone marrow uptake c/w skeletal metastasis
- MRI of the brain: 4 subcentimeter parenchymal lesions consistent with metastases and without perilesional edema
- FNA of the lung lesion shows adenocarcinoma (TTF-1+)
- Biomarker testing reveals *EGFR* exon 21 L858R mutation; PD-L1 TPS <1%
- Comes to your clinic to discuss first-line treatment options

We will come back to this case and discuss it shortly, but please answer the following question and share what you would do.

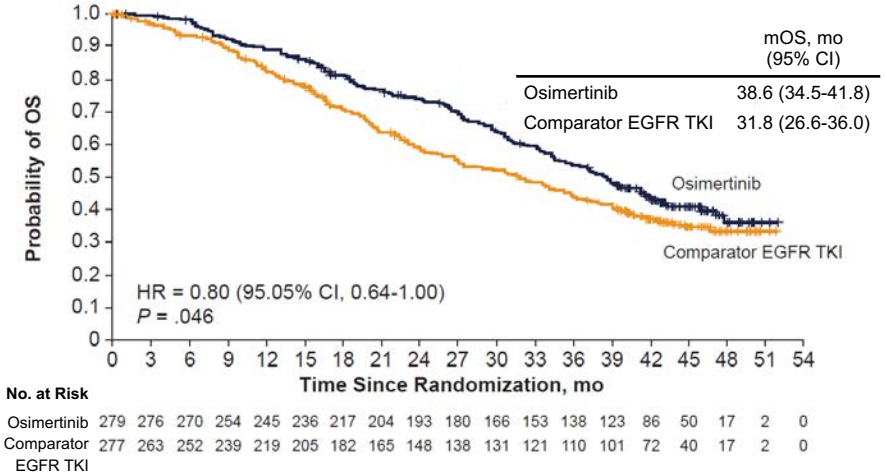
FLAURA: Phase 3 Study of First-Line Osimertinib in *EGFR*-Mutated mNSCLC[1,2]

Best Change From Baseline in Target Lesions



- mPFS = 18.9 mo
- Improved intracranial penetration vs 1G TKIs
- Toxicities: rash, diarrhea, paronychia (low grade), QTc prolongation, and ILD (rare)

OS

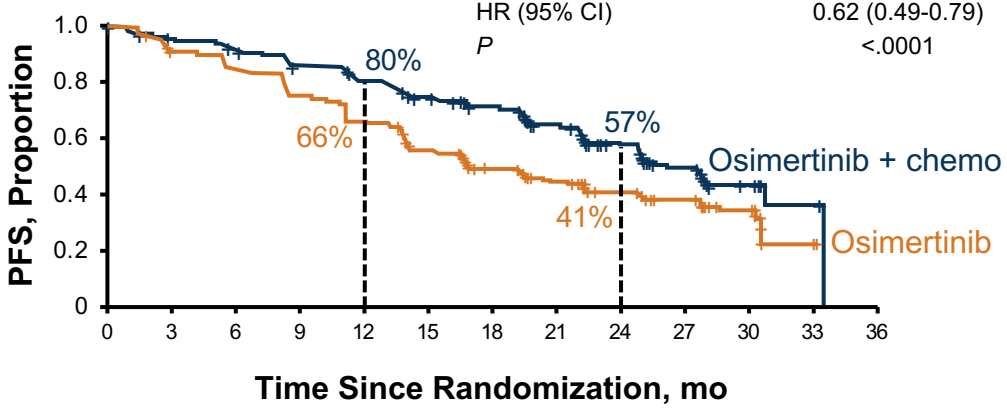


1. Soria JC et al. *N Engl J Med.* 2018;378:113-125. 2. Ramalingam SS et al. *N Engl J Med*. 2020;382:41-50.

FLAURA2: PFS With First-Line Osimertinib ± Chemotherapy in *EGFR*-Mutated mNSCLC[1-4]

PFS per Investigator Assessment

	Median PFS, mo (95% CI)
Osimertinib + chemo	25.5 (24.7-NC)
Osimertinib	16.7 (14.1-21.3)
HR (95% CI)	0.62 (0.49-0.79)
P	<.0001



No. at Risk

Osimertinib + chemo	279	254	241	225	207	187	165	133	84	42	21	3	0
Osimertinib	278	246	227	203	178	148	119	94	67	48	21	1	0

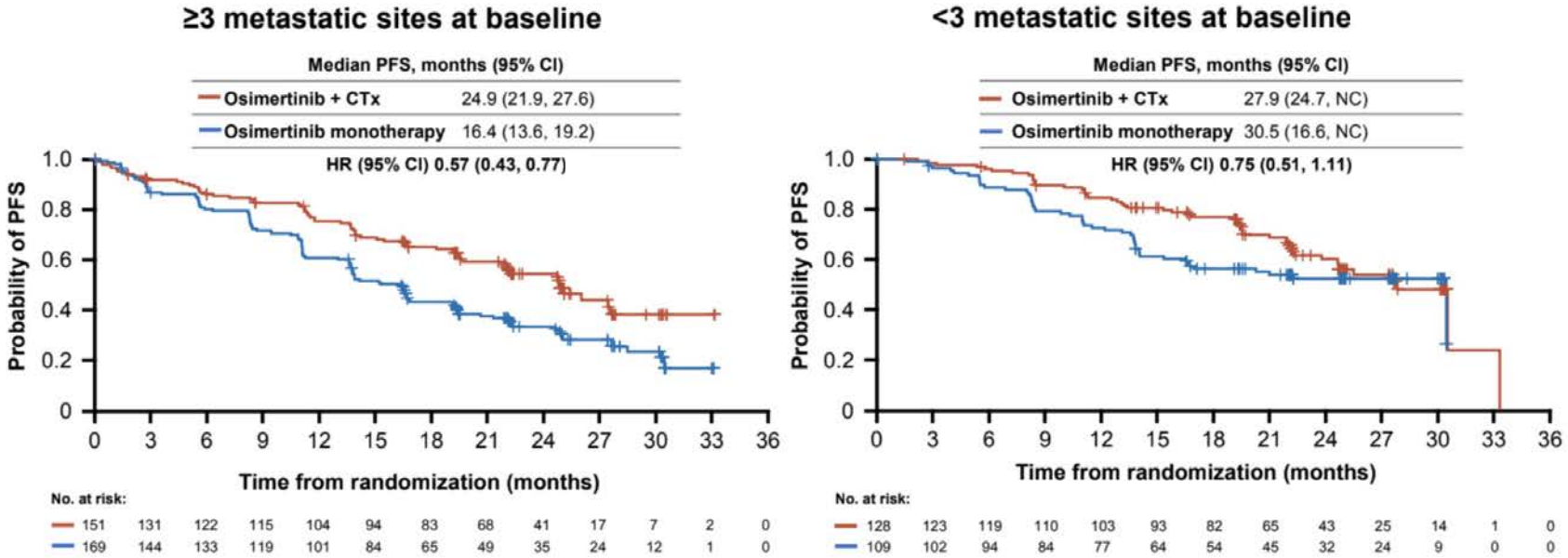
- Clinically meaningful PFS benefit observed across predefined subgroups, including patients with CNS metastases and *EGFR* L858R mutations
- mOS (2nd interim analysis): NR vs 36.7 mo, HR, 0.75 (95% CI, 0.57-0.97; *P* = .0280)
- Toxicities: myelosuppression, diarrhea, nausea, anorexia, rash

Data cutoff: April 3, 2023.

1. Janne P et al. WCLC 2023. Abstract PL03.13. 2. Planchard D et al. ESMO 2023. Abstract LBA68. 3. Planchard D et al. *N Engl J Med.* 2023;389:1935-1948.
4. Valdiviezo N et al. *Ann Oncol*. 2024;9:1-53.

FLAURA2: Impact of Tumor Burden on Outcomes of First-Line Osimertinib ± Chemotherapy in *EGFR*-Mutated mNSCLC[1]

Osimertinib + Chemo Showed PFS Benefit in Patients With ≥3 Metastatic Anatomical Sites at Baseline vs Osimertinib Alone

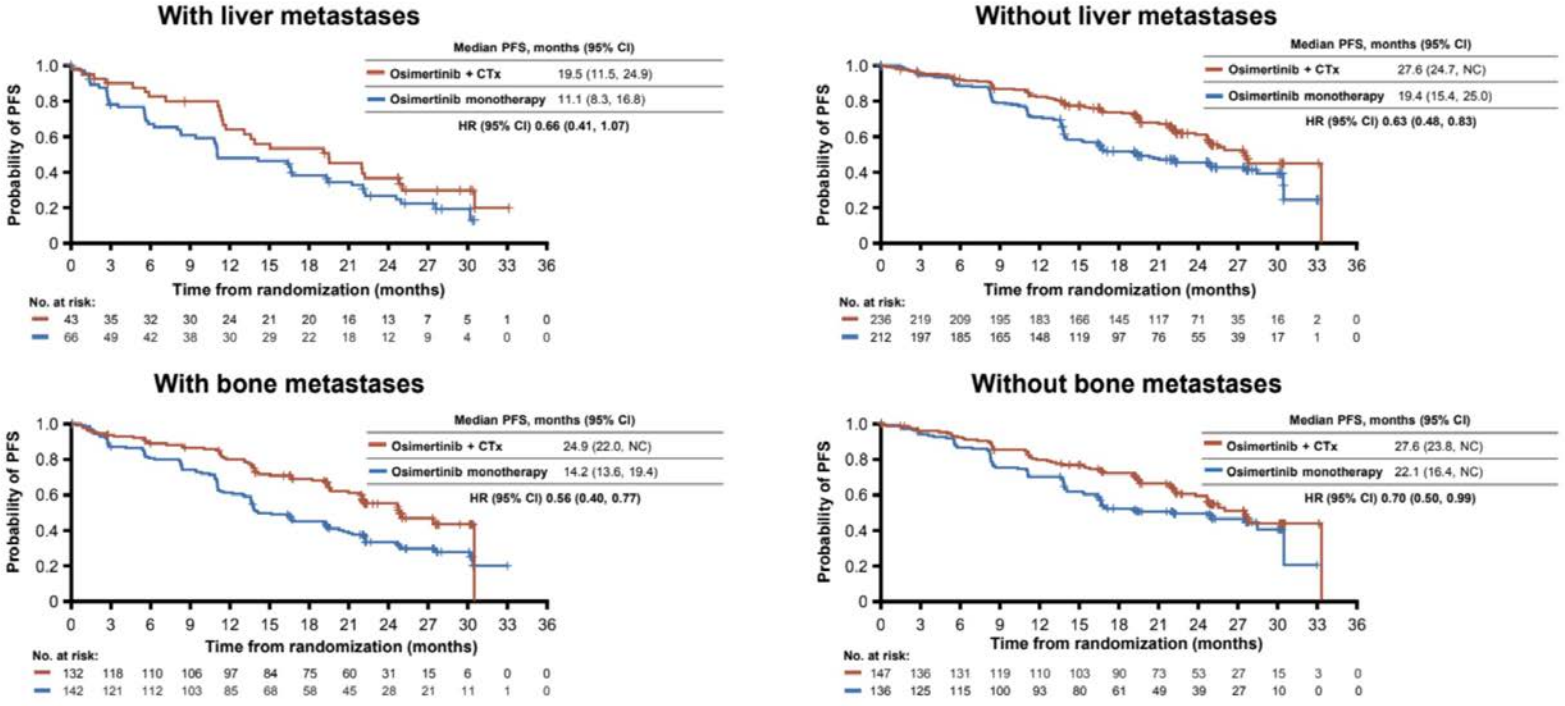


- A PFS benefit with osimertinib plus chemotherapy vs osimertinib alone was observed in patients with extra-thoracic metastases at baseline:
  - Intra-thoracic: median PFS (95% CI) was 26.0 months (21.9, NC) vs NC (16.7, NC), respectively; HR 0.97 (95% CI 0.59, 1.60)
  - Extra-thoracic: median PFS (95% CI) was 25.1 months (22.2, NC) vs 16.4 months (13.6, 19.4), respectively; HR 0.54 (95% CI 0.41, 0.71)

1. Valdiviezo N et al. WCLC 2024. Abstract MA12.04.

FLAURA2: Impact of Tumor Burden on Outcomes of First-Line Osimertinib ± Chemotherapy in *EGFR*-Mutated mNSCLC[1]

Osimertinib + Chemo Showed PFS Benefit in Patients With or Without Liver or Bone Metastases at Baseline vs Osimertinib Alone



1. Valdiviezo N et al. WCLC 2024. Abstract MA12.04.

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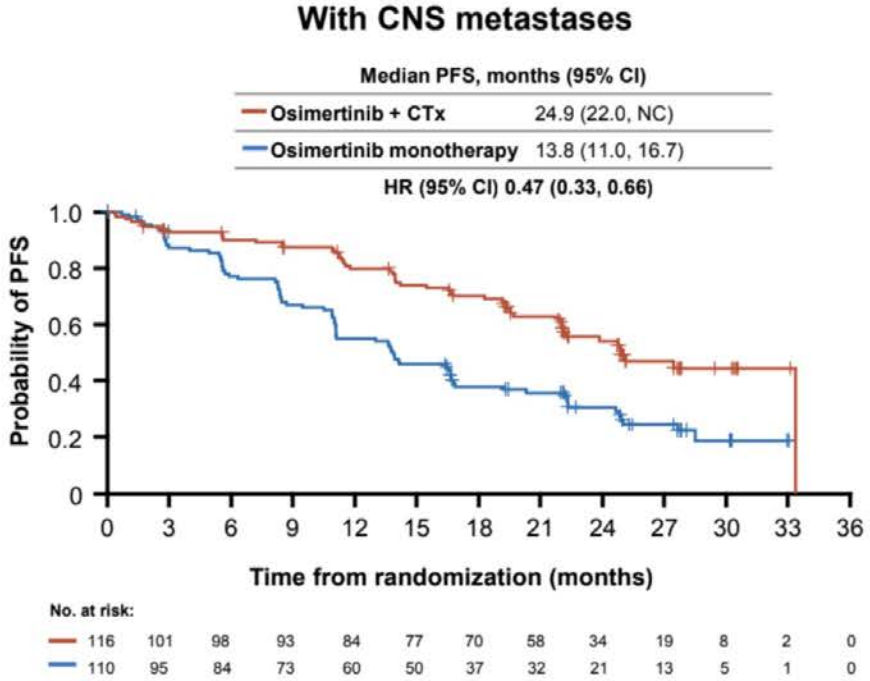
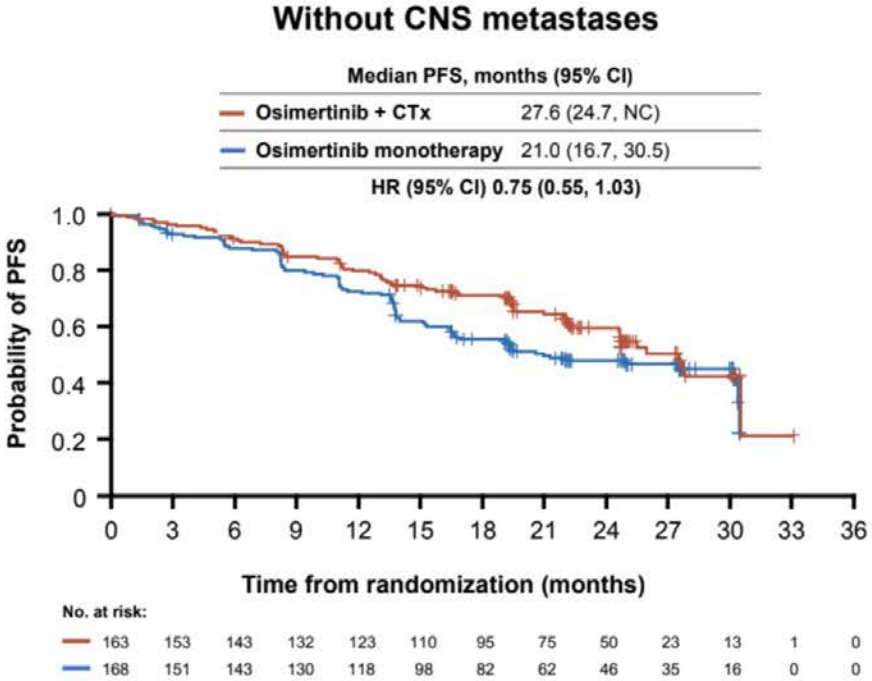
FLAURA2: Impact of Tumor Burden on Outcomes of First-Line Osimertinib ± Chemotherapy in *EGFR*-Mutated mNSCLC[1]

Osimertinib + Chemo Showed PFS Benefit in Patients With or Without CNS Metastases at Baseline vs Osimertinib Alone

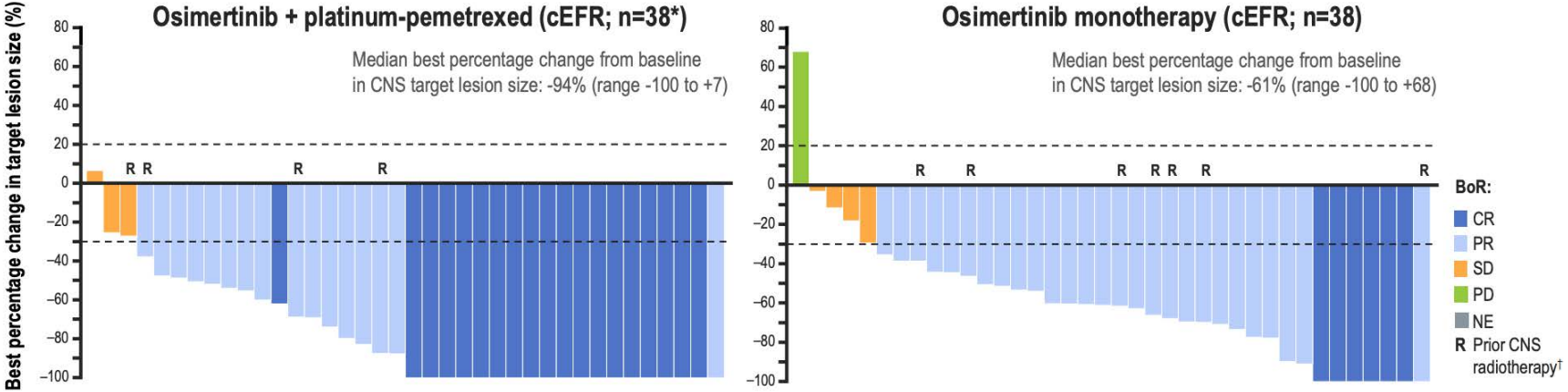




1. Valdiviezo N et al. WCLC 2024. Abstract MA12.04.

FLAURA2: CNS Outcomes With First-Line Osimertinib ± Chemotherapy in *EGFR*-Mutated mNSCLC[1]

Osimertinib + Chemo Showed a High Proportion of CRs in the CNS by CNS BICR



	cFAS (n=222) Measurable + non-measurable BM		cEFR (n=78) Measurable BM	
CNS response‡	**Osi + CTx (n=118)**	**Osi mono (n=104)**	**Osi + CTx (n=40)**	**Osi mono (n=38)**
CNS ORR, % (95% CI)	**73 (64 to 81)**	**69 (59 to 78)**	**88 (73 to 96)**	**87 (72 to 96)**
Complete response, n (%)	70 (59)	45 (43)	19 (48)	6 (16)
Partial response, n (%)	16 (14)	27 (26)	16 (40)	27 (71)
CNS DCR, % (95% CI)	91 (84 to 95)	93 (87 to 97)	95 (83 to 99)	97 (86 to 100)
Median DoR, months (95% CI)§	**NR (23.8, NC)**	**26.2 (19.4, NC)**	**NR (21.6, NC)**	**20.9 (12.6, NC)**

*Two pts had ≥1 measurable CNS lesion at baseline by CNS BICR but died before the follow-up CNS BICR scan; † In the cEFR, 4/40 pts (10%) in the osimertinib + platinum-pemetrexed arm and 7/38 pts (18%) in the osimertinib arm had received prior CNS radiotherapy; stable neurological status for ≥2 weeks after completion of definitive treatment and steroids was required before study entry, if received; ‡Responses did not require confirmation, per RECIST guidance on randomized studies; §Kaplan–Meier estimates

1. Planchard D et al. ESMO 2023. Abstract LBA68.

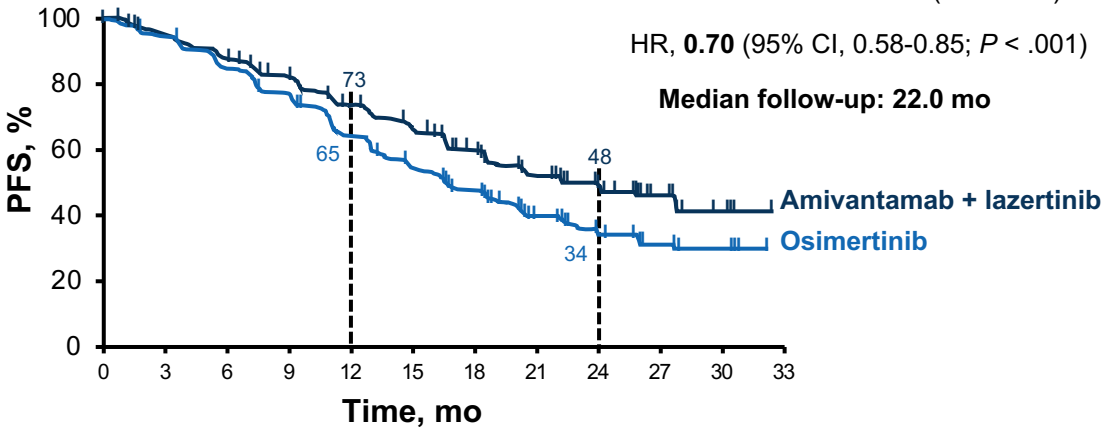
MARIPOSA: PFS of First-Line Amivantamab + Lazertinib in *EGFR*-Mutated mNSCLC[1-3]

Primary Endpoint: PFS by BICR[a]

	Median PFS, mo (95% CI)
Amivantamab + lazertinib	23.7 (19.1-27.7)
Osimertinib	16.6 (14.8-18.5)

HR, **0.70** (95% CI, 0.58-0.85; *P* < .001)

Median follow-up: 22.0 mo



No. at Risk

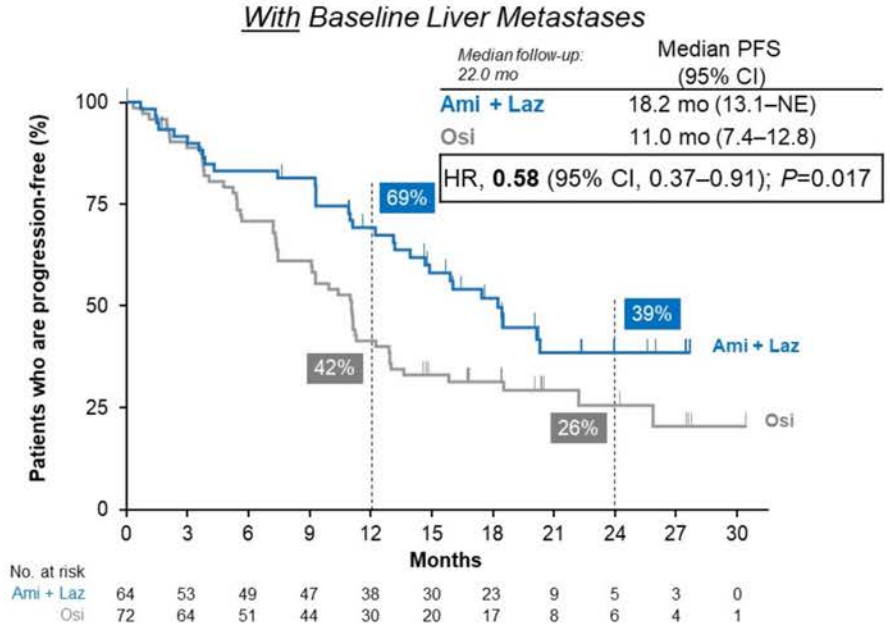
Amivantamab + lazertinib	429	391	357	332	291	244	194	106	60	33	8	0
Osimertinib	429	404	358	325	266	205	160	90	48	28	10	0

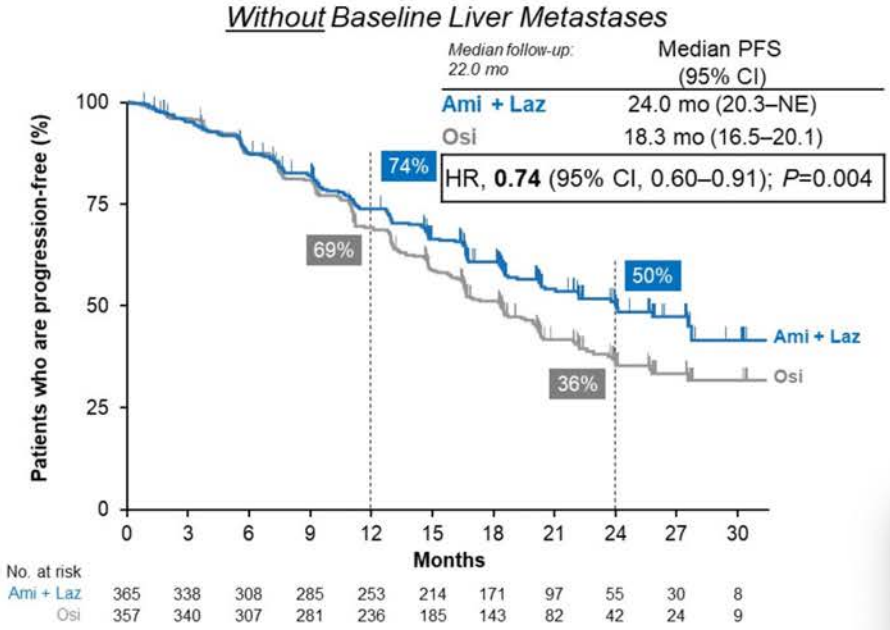
- mOS (interim analysis): HR, 0.77 (95% CI, 0.61-0.96; *P* = .019); did not reach prespecified level of statistical significance
- Toxicities: paronychia, IRR, rash, VTE

[a] At the time of prespecified final PFS analysis, there were a total of 444 PFS events in the amivantamab + lazertinib and osimertinib arms combined.

1. Cho BC et al. ESMO 2023. Abstract LBA14. 2. Cho BC et al. *N Engl J Med.* 2024;391:1486-1498. 3. Gadgeel S et al. WCLC 2024. Abstract OA02.03.

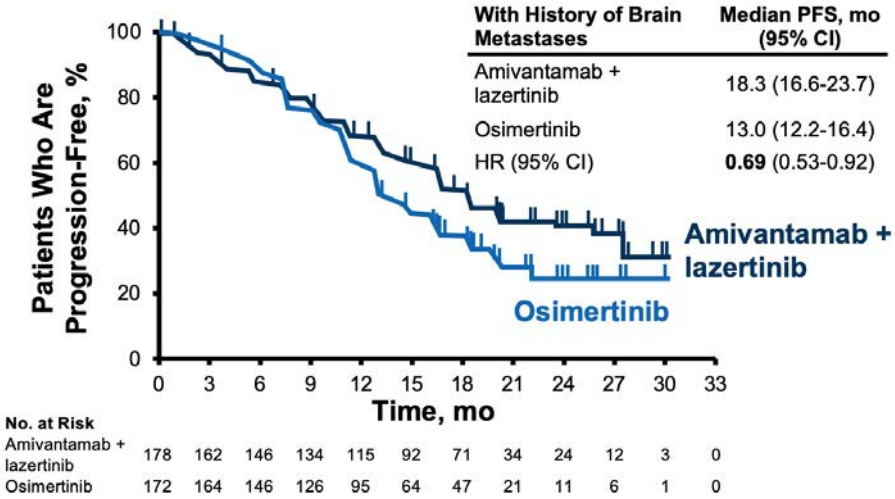
MARIPOSA: PFS by Baseline Liver Metastases With First-Line Amivantamab + Lazertinib in *EGFR*-Mutated mNSCLC[1]

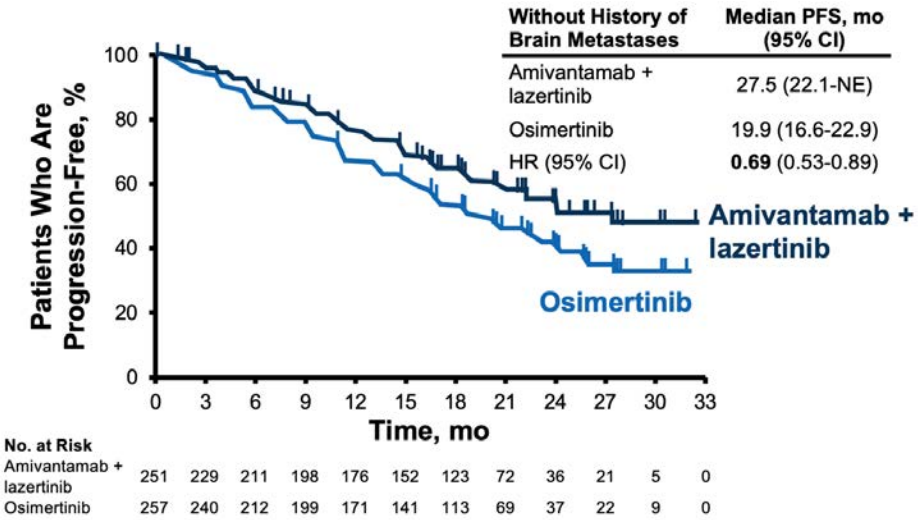




1. Felip E et al. ASCO 2024. Abstract 8504.

MARIPOSA: PFS Benefit With/Without CNS Metastases With First-Line Amivantamab + Lazertinib in *EGFR*-Mutated mNSCLC[1-3]





1. Cho BC et al. ESMO 2023. Abstract LBA14. 2. Cho BC et al. *N Engl J Med.* 2024;391:1486-1498. 3. Felip E et al. ASCO 2024. Abstract 8504.

PALOMA-3: SC vs IV Amivantamab (Both in Combination With Lazertinib) in Refractory *EGFR*-Mutated mNSCLC[1,2]

- SC amivantamab + lazertinib demonstrated PK and ORR noninferiority to IV amivantamab + lazertinib in patients with *EGFR*-mutated advanced NSCLC with disease progression on or after osimertinib and chemotherapy
- Compared with the IV arm, SC amivantamab also showed:
  - Numerically longer DOR (11.2 vs 8.3 mo) and PFS (6.1 vs 4.3 mo)
  - Significant improvement in OS (HR = 0.62; nominal *P* = .02)

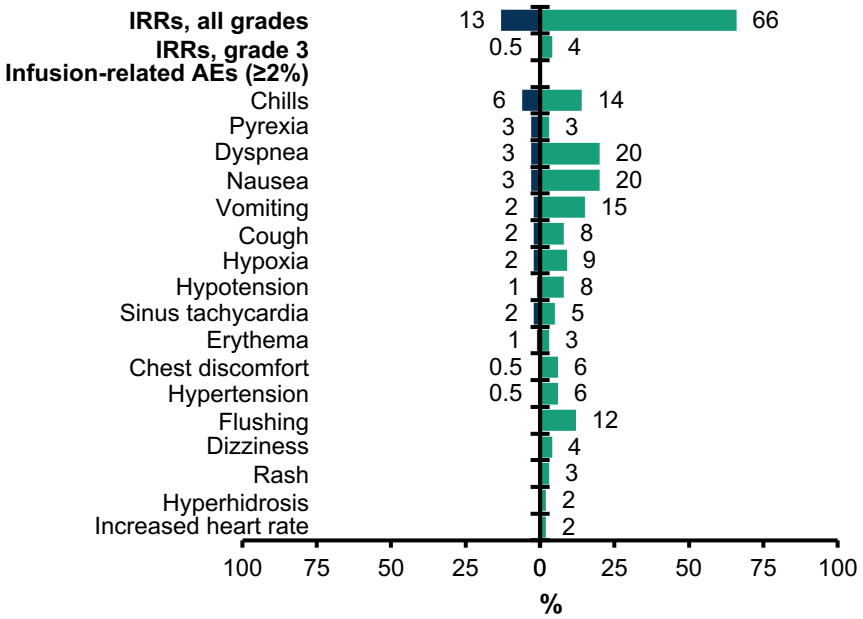
	SC Amivantamab (n = 206)	IV Amivantamab (n = 212)
ORR, % (95% CI)		
All responders	**30 (24-37)**	**33 (26-39)**
	Relative risk, 0.92 (0.70-1.23); *P* = .001	
Confirmed responders	**27 (21-33)**	**27 (21-33)**
	Relative risk, 0.99 (0.72-1.36); *P* < .001	
Best response, n (%)		
CR	1 (0.5)	1 (0.5)
PR	61 (30)	68 (32)
SD	93 (45)	81 (38)
PD	37 (18)	42 (20)
NE	14 (7)	20 (9)
DCR, % (95% CI)	**75 (69-81)**	**71 (64-77)**
Median TTR (range), mo	**1.5 (1.2-6.9)**	**1.5 (1.2-9.9)**

1. Leighl N et al. ASCO 2024. LBA8505. 2. Leighl NB et al. *J Clin Oncol*. 2024;42:3593-3605.

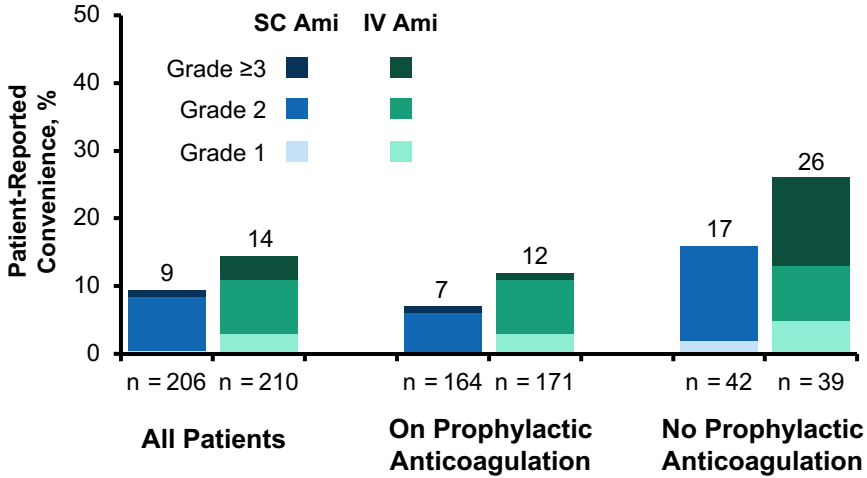
PALOMA-3: SC vs IV Amivantamab (Both in Combination With Lazertinib) in Refractory *EGFR*-Mutated mNSCLC[1,2]

- The safety profile of SC amivantamab was consistent with IV, with fewer IRRs (13% vs 66%) and VTE (9% vs 14%)

Incidence of IRR-Related Symptoms



Rates of VTE by Treatment Arm and Prophylaxis Status



1. Leighl N et al. ASCO 2024. LBA8505. 2. Leighl NB et al. *J Clin Oncol*. 2024;42:3593-3605.

Let's Come Back to Case #1

A 61-year-old woman with no history of smoking presents with cough, dyspnea, and generalized fatigue x 3 months

- Initial CXR: LUL opacity → PET/CT: 3-cm LLL lung nodule and enlarged mediastinal nodes + multiple FDG avid hepatic hypodensities and extensive bone marrow uptake c/w skeletal metastasis
- MRI of the brain: 4 subcentimeter parenchymal lesions consistent with metastases and without perilesional edema
- FNA of the lung lesion shows adenocarcinoma (TTF-1+)
- Biomarker testing reveals *EGFR* exon 21 L858R mutation; PD-L1 TPS <1%
- Comes to your clinic to discuss first-line treatment options

Let's Discuss

✓ What first-line treatment would you recommend and why?

Let's Consider Case #1 Variations

A 61-year-old woman with no history of smoking presents with cough, dyspnea, and generalized fatigue x 3 months

- Initial CXR: LUL opacity → PET/CT: 3-cm LLL lung nodule and enlarged mediastinal nodes + multiple FDG avid hepatic hypodensities and extensive bone marrow uptake c/w skeletal metastasis
- MRI of the brain: 4 subcentimeter parenchymal lesions consistent with metastases and without perilesional edema
- FNA of the lung lesion shows adenocarcinoma (TTF-1+)
- Biomarker testing reveals *EGFR* exon 21 L858R mutation; PD-L1 TPS <1%
- Comes to your clinic to discuss first-line treatment options

Let's Discuss

What if…

- ✓ The patient is 85 years of age?
- ✓ The patient is 45 years of age?
- ✓ The patient lives in a remote area 6 hours away from your clinic?

Let's Consider Case #2

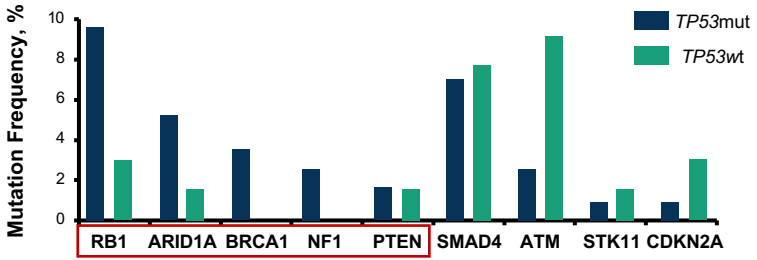
A 58-year-old man with no history of smoking noticed a nonproductive cough

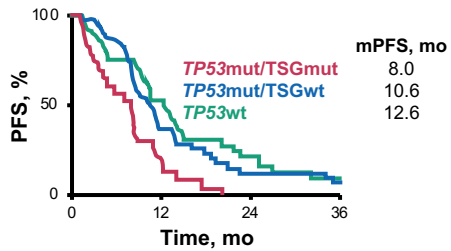
- Symptoms persisted, and he went to his PCP → chest x-ray → left lung nodule detected
- CT identified a 3-cm LLL lung nodule, enlarged mediastinal nodes, and multiple lytic bone lesions c/w skeletal metastasis; no other areas of uptake
- MRI of the brain: negative
- FNA of the lung lesion shows adenocarcinoma (TTF-1+)
- Biomarker testing reveals *EGFR* exon 21 L858R mutation and *TP53*mut/*TSG*mut
- PD-L1 IHC: TPS 80%
- Comes to your clinic to discuss first-line treatment options

We will come back to this case and discuss it shortly, but please answer the following question and share what you would do.

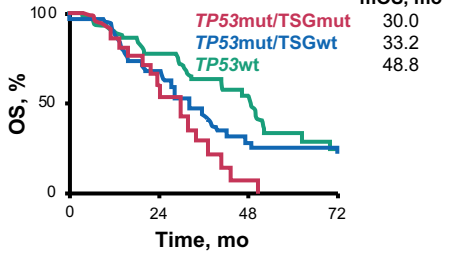
Relevance of *TP53* Status in Guiding Patient Selection for First-Line Combination Therapy in *EGFR*-Mutated mNSCLC

Can co-mutations be used as prognostic biomarkers?[1]





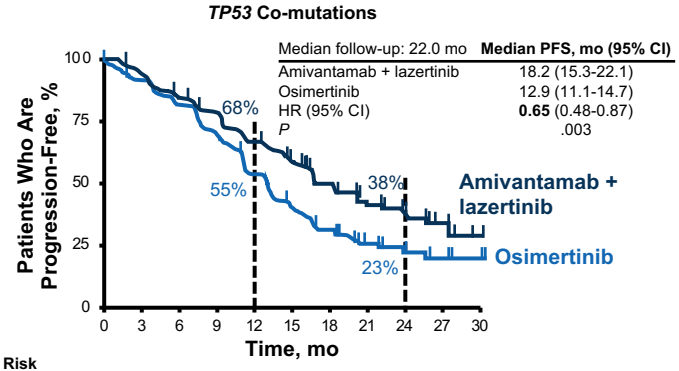
No. at Risk							
*TP53*mut/TSGmut	23	13	5	1	0	0	0
*TP53*mut/TSGwt	42	35	14	9	5	5	3
*TP53*wt	36	27	19	11	8	4	3



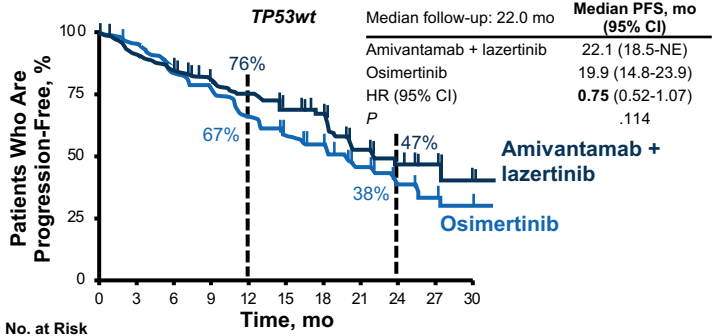
No. at Risk							
*TP53*mut/TSGmut	23	19	10	5	1	0	0
*TP53*mut/TSGwt	42	34	26	16	9	7	6
*TP53*wt	36	33	28	22	17	8	6

- Co-mutations in *TP53* and tumor suppressor genes are associated with worse TKI outcomes

MARIPOSA: PFS by *TP53* Status[2]



No. at Risk												
Ami + laz	149	136	121	111	95	78	60	33	23	12	2
Osi	429	132	116	101	76	49	34	17	11	7	2



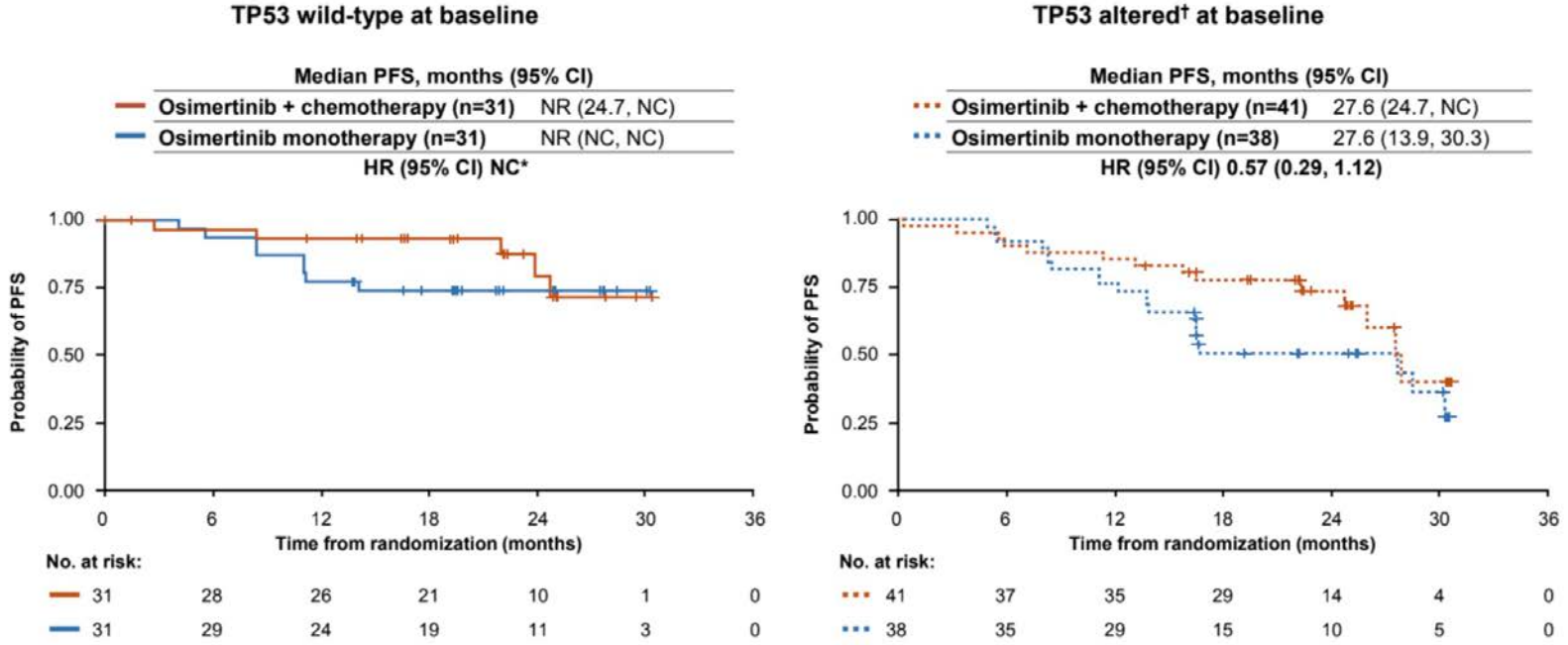
No. at Risk												
Ami + laz	117	104	95	87	79	64	53	30	18	13	4
Osi	130	125	108	101	85	69	59	35	20	12	4

1. Stockhammer P et al. *J Thorac Oncol*. 2024;19:240-251. 2. Felip E et al. ASCO 2024. Abstract 8504.

Relevance of *TP53* Status in Guiding Patient Selection for First-Line Combination Therapy in *EGFR*-Mutated mNSCLC (Cont'd)

FLAURA2: Impact of Baseline *TP53* Alterations on Outcomes[1]

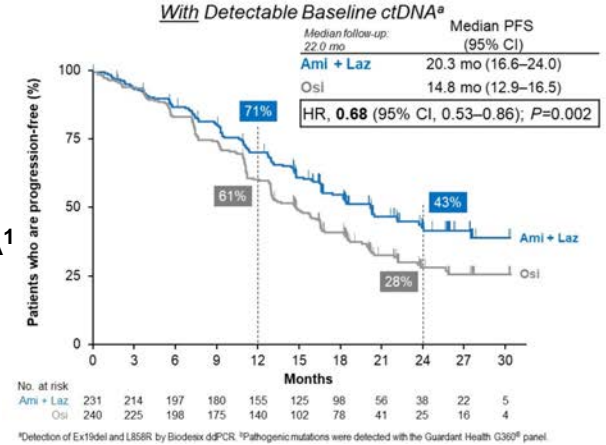
- *TP53* alterations may be prognostic for PFS benefit with osimertinib + platinum-pemetrexed over osimertinib monotherapy

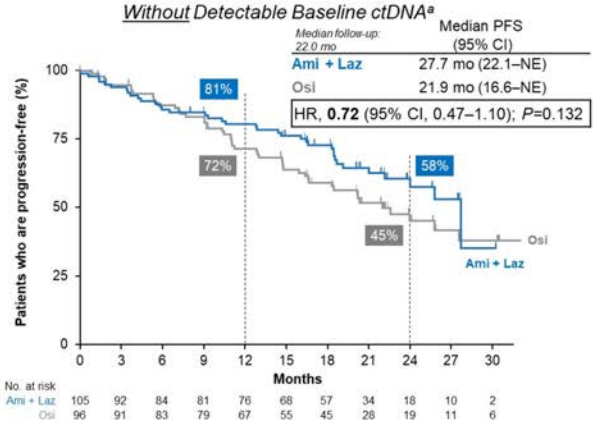


1. Yang JC et al. WCLC 2024. Abstract MA12.03.

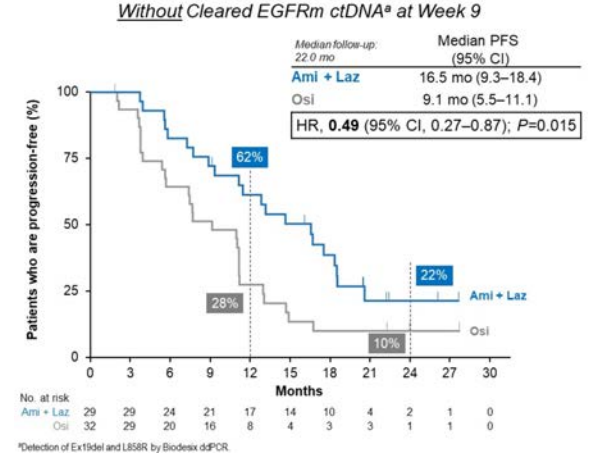
Value of Monitoring ctDNA Dynamics in *EGFR*-Mutated mNSCLC

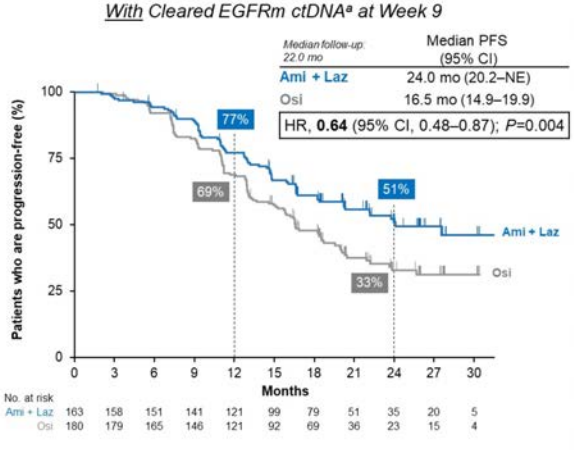
MARIPOSA:
PFS by Detectable Baseline *EGFR*mut ctDNA[1]





MARIPOSA:
PFS Without/With Cleared *EGFR*mut ctDNA at Week 9[1]

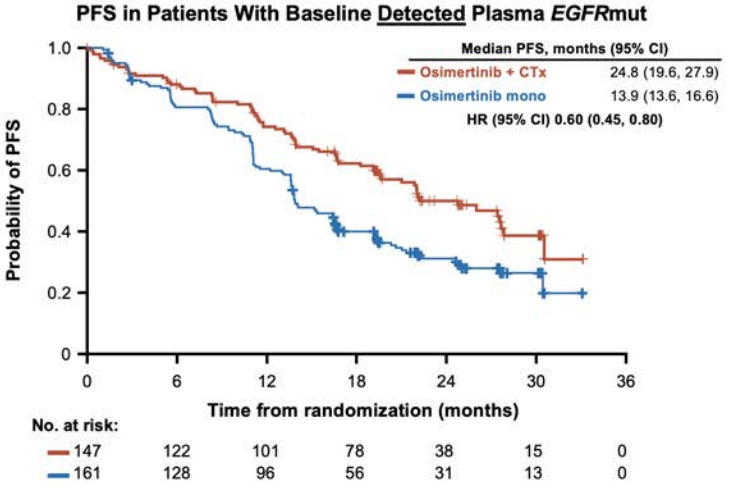


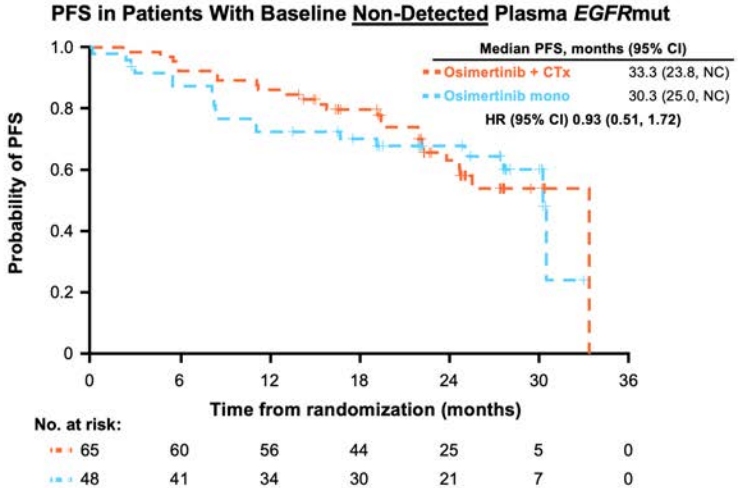


1. Felip E et al. ASCO 2024. Abstract 8504.

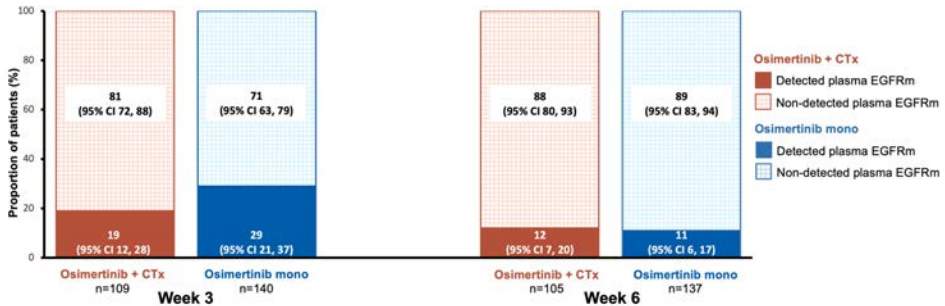
Value of Monitoring ctDNA Dynamics in *EGFR*-Mutated mNSCLC (Cont'd)

- FLAURA2: baseline detected plasma *EGFR*mut was prognostic and may select for a higher degree of clinical benefit with osimertinib plus chemotherapy versus osimertinib alone[1]





- FLAURA2: on-treatment plasma *EGFR*mut clearance was prognostic but not predictive of benefit with osimertinib plus chemotherapy versus osimertinib alone[1]



1. Jänne PA et al. AACR 2024. Abstract CT017.

Let's Come Back to Case #2

A 58-year-old man with no history of smoking noticed a nonproductive cough

- Symptoms persisted, and he went to his PCP → chest x-ray → left lung nodule detected
- CT identified a 3-cm LLL lung nodule, enlarged mediastinal nodes, and multiple lytic bone lesions c/w skeletal metastasis; no other areas of uptake
- MRI of the brain: negative
- FNA of the lung lesion shows adenocarcinoma (TTF-1+)
- Biomarker testing reveals *EGFR* exon 21 L858R mutation and *TP53*mut/*TSG*mut
- PD-L1 IHC: TPS 80%
- Comes to your clinic to discuss first-line treatment options

Let's Discuss

✓ What first-line treatment would you recommend and why?

Let's Consider Case #2 Variations

A 58-year-old man with no history of smoking noticed a nonproductive cough

- Symptoms persisted, and he went to his PCP → chest x-ray → left lung nodule detected
- CT identified a 3-cm LLL lung nodule, enlarged mediastinal nodes, and multiple lytic bone lesions c/w skeletal metastasis; no other areas of uptake
- MRI of the brain: negative
- FNA of the lung lesion shows adenocarcinoma (TTF-1+)
- Biomarker testing reveals *EGFR* exon 21 L858R mutation and *TP53*mut/*TSG*mut
- PD-L1 IHC: TPS 80%
- Comes to your clinic to discuss first-line treatment options

Let's Discuss

What if…

- ✓ ctDNA was detectable at baseline and cleared?
- ✓ ctDNA was detectable at baseline, but did not clear?

Let's Consider Case #3

A 63-year-old man with no history of smoking is incidentally found to have lung nodules on x-ray; no symptoms

- PET scan: multiple bilateral pulmonary nodules; no other areas of uptake
- MRI of the brain: negative
- FNA of the lung lesion shows adenocarcinoma (TTF-1+)
- Biomarker testing reveals *EGFR* exon 19 deletion
- Comes to your clinic to discuss first-line treatment options

We will come back to this case and discuss it shortly, but please answer the following question and share what you would do.

Summary of Key Trials and Factors to Consider

FLAURA[1-2]

- Osimertinib vs 1G TKI
- mPFS = 18.9 mo
- mOS = 38.6 mo

Toxicities: rash, diarrhea, paronychia (low grade), QTc prolongation, and ILD (rare); generally, a well tolerated treatment

Key Factors

- Improved intracranial penetration vs 1G TKIs
- Oral only administration with few clinic visits

1. Soria JC et al. *N Engl J Med*. 2018;378:113-125.
2. Ramalingam SS et al. *N Engl J Med*. 2020;382:41-50.

FLAURA2[1-3]

- Osimertinib/platinum-pemetrexed vs osimertinib
- mPFS = 25.5 mo (HR vs osimertinib = 0.62)
- mOS (2nd interim analysis): NR vs 36.7 mo, HR, 0.75 (95% CI, 0.57-0.97; *P* = .0280); did not reach prespecified level of statistical significance

Toxicities: myelosuppression, diarrhea, nausea, anorexia, and rash

Key Factors

- Requires IV administration Q21D
- Median pemetrexed exposure 8.3 mo
- More intracranial CRs and lower risk of intracranial progression with osimertinib + chemo suggests potential benefit in patients with CNS disease

1. Planchard D et al. ESMO 2023. Abstract LBA68. 2. Planchard D et al. *N Engl J Med*. 2023;389:1935-1948. 3. Valdiviezo N et al. *Ann Oncol*. 2024;9:1-53.

MARIPOSA[1-3]

- Lazertinib + amivantamab vs osimertinib
- mPFS = 23.7 months (HR vs osimertinib = 0.70)
- mOS (interim analysis): HR, 0.77 (95% CI, 0.61-0.96, *P* = .019); did not reach prespecified level of statistical significance

Toxicities: paronychia, IRR[a], rash, and VTE

Key Factors

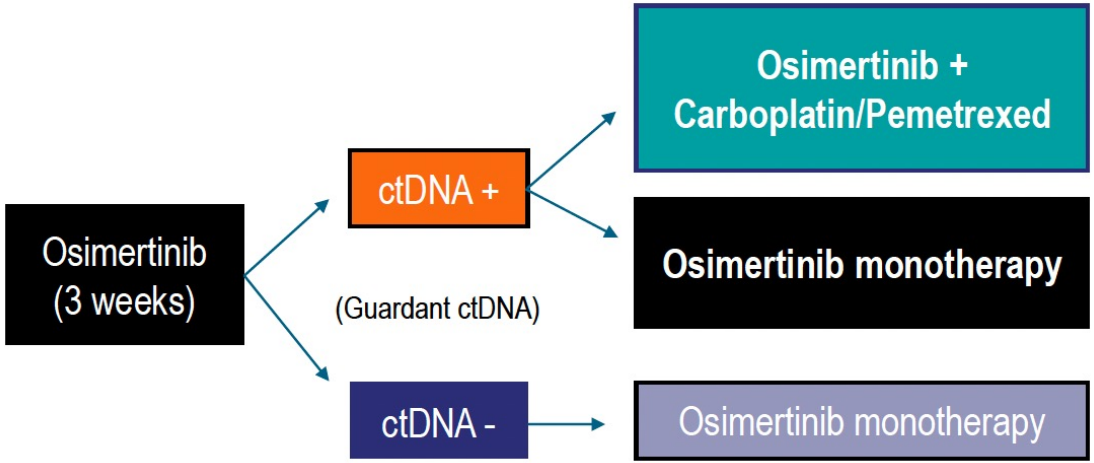
- IV administration with frequent initial visits[a]
- Significant dermatologic toxicities (rash, scalp irritation, and paronychia)
- Benefit observed across high risk subgroups
  - Detectable baseline ctDNA, HR = 0.68
  - *TP53* co-mutations, HR = 0.65
  - Brain metastases, HR = 0.69

[a] IRR less frequent with subcutaneous formulation.
1. Cho BC et al. *N Engl J Med*. 2024. 2. Felip E et al. ASCO 2024. Abstract 8504. 3. Gadgeel S et al. WCLC 2024. Abstract OA02.03.

Novel Approaches Under Investigation in Clinical Trials

Regimen	Trial Name	Clinicaltrials.gov #
Osimertinib + amivantamab	OSTARA	NCT05801029
Osimertinib +/- bevacizumab	EA5182	NCT04181060
Osimertinib +/- datopotamab deruxtecan	TROPION-Lung14	NCT06350097
Osimertinib + patritumab deruxtecan		NCT04676477

Risk-adaptive trial design:
eg, EGFR Shedders Trial
NCT04410796; PI: H. Yu



Let's Come Back to Case #3

A 63-year-old man with no history of smoking is incidentally found to have lung nodules on x-ray; no symptoms

- PET scan: multiple bilateral pulmonary nodules; no other areas of uptake
- MRI of the brain: negative
- FNA of the lung lesion shows adenocarcinoma (TTF-1+)
- Biomarker testing reveals *EGFR* exon 19 deletion
- Comes to your clinic to discuss first-line treatment options

Let's Discuss

✓ What first-line treatment would you recommend and why?

Let's Consider Case #3 Variations

A 63-year-old man with no history of smoking is incidentally found to have lung nodules on x-ray; no symptoms

- PET scan: multiple bilateral pulmonary nodules; no other areas of uptake
- MRI of the brain: negative
- FNA of the lung lesion shows adenocarcinoma (TTF-1+)
- Biomarker testing reveals *EGFR* exon 19 deletion
- Comes to your clinic to discuss first-line treatment options

Let's Discuss

What if…

- ✓ The tumor had an *EGFR* exon 21 L858R mutation instead?
- ✓ The tumor had an *EGFR* exon 19 deletion, but MRI of the brain had shown a solitary brain metastasis?
- ✓ The tumor had an *EGFR* exon 19 deletion and also a *TP53* co-mutation?

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- Complete and submit your post-test and evaluation for credit
- Download the slides and Practice Aids
- Watch the replay of this event in the next 24 hours and the online activity in the coming weeks

Thank you for joining us!

Join the conversation on
𝕏 @PeerView

Abbreviations

1L: first line
Ami: amivantamab
ASCO: American Society of Clinical Oncology
BICR: blinded independent central review
C2D1: cycle 2, day 1
CR: complete response
ctDNA: circulating tumor DNA
CXR: chest x-ray
DCR: disease control rate
DOR: duration of response
ESMO: European Society for Medical Oncology
FDG: F-18-Fluorodeoxyglucose
FNA: fine needle aspiration
IHC: immunohistochemistry
ILD: interstitial lung disease
IRR: incidence rate ratio
LLL: lower left lobe
LUL: left upper lobe
mNSCLC: metastatic non–small cell lung cancer
mOS: median overall survival
mPFS: median progression-free survival
NC: no change
NCCN: National Comprehensive Cancer Network
NE: not evaluable
NGS: next-generation sequencing
NR: not reached
ORR: objective response rate
PD-L1: programmed death-ligand 1
PD: progressive disease
PK: pharmacokinetics
PR: partial response
Q21D: every 21 days
SC: subcutaneous
SD: stable disease
TAT: turnaround time
TM: transmembrane
TPS: tumor proportion score
TTF-1: thyroid transcription factor 1
TTR: time to response
WCLC: World Conference on Lung Cancer