ORAL PRESENTATIONS

S1 – ADJUVANT CHEMOTHERAPY IN HR+ BREAST CANCER, TO GIVE IT OR TO OMIT?

SIMONIDA BOBIC

Department for Medical Oncology, Institute for Oncology and Radiology of Serbia, Belgrade, Serbia

Breast cancer is the most frequently diagnosed cancer and the leading cause of cancer death in females. Hormone receptor (HR)-positive breast cancer is the most common subtype of breast cancer, and it represents up to 80 percent of all breast cancers. For women with early, estrogen receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer, adjuvant endocrine therapy is the most important systemic treatment, but some patients may also benefit from adjuvant chemotherapy. Adjuvant chemotherapy is use of cytotoxic chemotherapy after breast cancer surgery, and its goal is to eradicate microscopic remains of cancer cells that, if untreated, could grow and recur as metastatic cancer. The decision to use adjuvant chemotherapy takes into account a great number of factors, such as tumor histology, expression of estrogen (ER) and/or progesterone (PR) receptors, tumor stage and grade, patient age, as well as high-risk features such as lymphovascular invasion. All cancers ≤0.5 cm and most of breast cancer <1 cm that are ER-positive, HER2-negative and node-negative have a sufficiently good prognosis with endocrine therapy alone, and they do not usually require adjuvant chemotherapy. At the other end of the risk spectrum, most women with stage III breast cancer are candidates for adjuvant chemotherapy because of their risk of recurrence and the likely benefits of chemotherapy treatment. The majority of cases of HR-positive breast cancer fall in between these two extremes, and decisions regarding the addition of chemotherapy to adjuvant endocrine therapy are individualized based on patient and disease factors. For these patients the genomic analysis and benefit-risk calculators, such as Oncotype DX 21-gene Recurrence Score (RS), EndoPredict (EP) and MammaPrint, are helpful to determine appropriate candidates for adjuvant chemotherapy. For most patients in whom chemotherapy is recommended doxorubicin and cyclophosphamide (AC) followed by paclitaxel or docetaxel is preferred regimen, and it should be administered on a dose-dense schedule. Non-anthracycline-based regimens may be an appropriate strategy for certain groups of patients such as patients with lower-risk disease or patients with a history of cardiac disease.

Having in mind all the side effects of chemotherapy it is of the most significance to identify the patients where we can it safely omit.

Keywords: breast cancer, chemotherapy, genomic testing, prognosis

REFERENCES

1. Berry DA, Cronin KA, Plevritis SK, et al. Effect of screening and adjuvant therapy on mortality from breast cancer. N Engl J Med 2005; 353:1784.
2. Early Breast Cancer Trialists Collaborative Group (EBCTCG), Peto R, Davies C, et al. Comparisons between different polychemotherapy regimens for early breast cancer: meta-analyses of long-term outcome among 100,000 women in 123 randomised trials. Lancet 2012;379:432.
3. Acs B, Fredriksson I, Rönnlund C, et al. Variability in breast cancer biomarker assessment and the effect on oncological treatment decisions: a nationwide 5-year population-based study. Cancers (Basel) 2021; 13(5):1166.

S2 – WHO IS THE CANDIDATE FOR ADJUVANT TREATMENT WITH CDK4/6 INHIBITOR AND WHAT CDK4/6 INHIBITOR TO CHOOSE?

TAJANA SILOVSKI[1,2]

[1]*Department of Oncology, University Hospital Center Zagreb, Zagreb, Croatia*
[2]*School of Medicine, University of Zagreb, Zagreb, Croatia*

Hormone receptor-positive/HER2-negative (HR+/HER2-) is most often diagnosed breast cancer (BC) subtype usually diagnosed in early stage (eBC). Despite advances in (neo)adjuvant treatment strategies, many patients with HR+/HER2– eBC experience disease recurrence, even many years after primary surgery, displaying bimodal curve with two peaks followed by long-lasting tail. Throughout the period of 5-20 years, the long-term risk of recurrence is about 1-2% per year. Therefore, there is significant need to optimize stratification according to the risk of disease recurrence which is important to be done at the time of diagnosis to increase number of cured patients by tailoring optimal therapeutic approach. Histological tumor grade, axillary lymph node involvement, genomic scoring, proliferation index and tumor size are factors commonly considered most important when defining risk of reoccurrence in patients with HR+/HER2– eBC.

According to monarchE study, it was shown, that combination of abemaciclib and ET significantly improved invasive disease-free survival (iDFS) (for 4.8% at 3 and 7.6% at 5 years) in comparison to ET alone in patients with node positive, high-risk, HR+/HER2– eBC. NATALEE study included somewhat broader study population, including even node negative patients (stage II and III HR+/HER2– eBC), and it confirmed an absolute improvement in iDFS with combination of ribociclib and ET over ET alone for 3.3% at 3 years.

Therefore, abemaciclib for 2 years in combination with ET ≥5 years may be offered to patients meeting monarchE criteria – having ≥4 positive axillary lymph (ALN) nodes or 1-3 positive ALN together with grade 3, tumor greater than 5 cm or Ki67 of 20% or more. Adjuvant ribociclib 400 mg daily over 3 weeks, followed with one week off, for 3 years, in combination with ET, can be offered, according to NATALEE study to high-risk patients with stage II and III HR+/HER2– eBC. When reviewing literature, there are still some uncertainties considering benefit gained by the addition of ribociclib in node negative patients.

Among patients who would have been eligible for both monarchE and NATALEE study, majority of experts still prefer abemaciclib over ribociclib due to longer follow-up and shorter duration of treatment. There are, although, experts who believe that better tolerability and longer therapy duration is in fact ribociclib advantage. When choosing preferable adjuvant CDK4/6 inhibitor, patients' preference as well as potential side effect should be taken into consideration.

Keywords: ribociclib, abemaciclib, optimal adjuvant therapy, HR+/HER2– early breast cancer

REFERENCES

1. Morganti S, Marra A, Crimini E, et al. Refining risk stratification in HR– positive/HER2-negative early breast cancer: how to select patients for treatment escalation? Breast Cancer Res Treat. 2022 Apr;192(3):465-484.
2. Caswell-Jin JL, Freedman RA, Hassett MJ, et al. Optimal adjuvant chemotherapy and targeted therapy for early breast cancer-CDK4/6 inhibitors: ASCO rapid guideline update clinical insights. JCO Oncol Pract. 2025 Mar;21(3):287-291.
3. Rastogi P, O'Shaughnessy J, Martin M, et al. Adjuvant abemaciclib plus endocrine therapy for hormone receptor-positive, human epidermal growth factor receptor 2-negative, high-risk early breast cancer: results from a preplanned monarchE overall survival interim analysis, including 5-year efficacy outcomes. J Clin Oncol. 2024 Mar 20;42(9):987-993.
4. Slamon D, Lipatov O, Nowecki Z, et al. Ribociclib plus endocrine therapy in early breast cancer. N Engl J Med. 2024 Mar 21;390(12):1080-1091.

S3 – PERIOPERATIVE THERAPY OF ESOPHAGEAL CANCER – ARE THE STANDARDS CHANGING?

FEĐA ĐORĐEVIĆ

Institute of Oncology and Radiology of Serbia, Belgrade, Srbija

Perioperative chemotherapy and neoadjuvant chemoradiation are standard approaches for managing early resectable gastroesophageal adenocarcinoma, whereas the integration of immunotherapy into the treatment paradigm is emerging to enhance the efficacy of surgical interventions and improve patient outcomes.Targeted therapies beyond PD-1 inhibitors, such as anti–human epidermal growth factor receptor 2 agents, Claudin 18.2 inhibitors, and FGFR2 inhibitors, are reshaping frontline management strategies for advanced gastroesophageal cancers (GECs), offering patients more effective and personalized treatment options. Ongoing trials and emerging technologies with bispecific antibodies, antibody-drug conjugates, and adoptive cell therapies like chimeric antigen receptor T cells hold promise for further refining treatment approaches in GEC.These advancements signal a shift toward more personalized and immunotherapy-based treatment regimens, paving the way for tailored therapies that target specific molecular aberrations and immune checkpoints in patients with GEC. The integration of circulating tumor DNA as a prognostic biomarker for treatment response and residual disease detection has the potential to enable more precise monitoring and early intervention strategies in GEC management.

REFERENCES

1. Al-Batran SE, Hofheinz RD, Pauligk C, et al. Perioperative chemotherapy with fluorouracil plus leucovorin, oxaliplatin, and docetaxel versus fluorouracil or capecitabine plus cisplatin and epirubicin for locally advanced, resectable gastric or gastro-oesophageal junction adenocarcinoma (FLOT4): a randomised, phase 2/3 trial. Lancet. 2019;393(10184):1948-1957. doi:10.1016/S0140-6736(18)32557-1.
2. Wu D, Yang L, Yan Y, Jiang Z, Liu Y, Dong P, et al. Neoadjuvant immunotherapy improves outcomes for resectable gastroesophageal junction cancer: A systematic review and meta-analysis. Cancer Med. 2024 May;13(9):e7176. doi: 10.1002/cam4.7176.
3. Shitara K, Bang YJ, Iwasa S, Sugimoto N, Ryu MH, Sakai D,eet.al., DESTINY-Gastric01 Investigators. Trastuzumab deruxtecan in previously treated HER2-positive gastric cancer. N Engl J Med. 2020 Jun 18;382(25):2419-2430. doi: 10.1056/NEJMoa2004413.
4. Iden CR, Mustafa SM, Øgaard N, Henriksen T, Jensen SØ, Ahlborn LB, et al. Circulating tumor DNA predicts recurrence and survival in patients with resectable gastric and gastroesophageal junction cancer. Gastric Cancer. 2025 Jan;28(1):83-95. doi: 10.1007/s10120-024-01556-9.

S4 – LONG-TERM TREATMENT IN PATIENT WITH SQUAMOUS CELL ESOPHAGEAL CARCINOMA

NIKOLA PEULIĆ, Nikola Milašević

Institute of Oncology, Clinical Center of Montenegro, Podgorica, Montenegro

Esophageal cancer is a disease with high mortality. This is mainly due to late presentation with non-specific symptoms. Despite advances in surgery and chemo-radiotherapy, it is the eighth most common cancer but the sixth deadliest. It is reportedly common in older patients but rare in young ones.

In this case report, we present a 30-year-old male (at the moment of diagnosis) patient with no prior medical condition who presented with pain and difficulty at swallowing and was found to have esophageal cancer with the biopsy and re-biopsy. He was treated with perioperative chemotherapy and surgery. One year after adjuvant chemotherapy patient relapsed, recurrence appeared at site of surgical anastomosis with bulky right – sided neck lymphadenopathy. In metastatic setting he was treated with chemo and immunotherapy after diagnosis of CPS of 12. Within a year, patient had near complete response to treatment and he is currently on mono-immunotherapy as consolidation therapy.

Keywords: esophageal cancer, chemo-radiotherapy, surgery, recurrence, immunotherapy

REFERENCES

1. Ludmir EB, Stephens SJ, Palta M, Willett CG, Czito BG. Human papillomavirus tumor infection in esophageal squamous cell carcinoma. J Gastrointest Oncol. 2015 Jun;6(3):287-95.
2. Boerner T, Carr RA, Hsu M, Michel A, Tan KS, Vos E, et al. Incidence and management of esophageal cancer recurrence to regional lymph nodes after curative esophagectomy. Int J Cancer. 2023 May 15;152(10):2109-2122.
3. Helai Husseini et all; Efficacy of pembrolizumab in advanced esophageal carcinoma: A systematic review and meta-analysis, JCO 2025;43:438-438.

S5 – THERAPEUTIC APPROACH IN THE TREATMENT OF LOCALLY ADVANCED CERVICAL CANCER AT THE KCCG INSTITUTE OF ONCOLOGY (M INTERLACE)

NEVENKA LUKOVAC-JANJIĆ

Institute of Oncology and Radiotherapy of the Clinical Center of Montenegro, Podgorica, Montenegro

The INTERLACE trial was a multicentre, randomised phase 3 trial done at 32 medical centres in Brazil, India, Italy, Mexico, and the UK. Adults (aged ≥18 years) with locally advanced cervical cancer (FIGO 2008 stage IB1 disease with nodal involvement, or stage IB2, IIA, IIB, IIIB, or IVA disease) were randomly assigned (1:1), by minimisation, using a central electronic system, to standard cisplatin-based chemoradiotherapy (once-a-week intravenous cisplatin 40 mg/m2 for 5 weeks with 45·0–50·4 Gy external beam radiotherapy delivered in 20–28 fractions plus brachytherapy to achieve a minimum total 2 Gy equivalent dose of 78–86 Gy) alone or induction chemotherapy (once-a-week intravenous carboplatin area under the

receiver operator curve 2 and paclitaxel 80 mg/m2 for 6 weeks) followed by standard cisplatin-based chemoradiotherapy. Stratification factors were recruiting site, stage, nodal status, three-dimensional conformal radiotherapy or intensity modulated radiotherapy, age,tumour size, and histology (squamous vs non-squamous). Primary endpoints were progression-free survival and overall survival within the intention-to-treat population. This trial is registered with ClinicalTrials.gov, NCT01566240, and EUDRACT, 2011-001300-35.

In Montenegro, cervical cancer ranks fourth in terms of frequency in the category of women. In front of him are breast, colorectal and lung cancers.

In 2023, 93 women were presented to the gynecological-oncological council as new cases. It mainly affects young women. About 50% of patients are women aged 30 to 50. Two thirds of women are in an inoperable stage of the disease and can be treated with combined chemo-radiotherapy. These data make cervical cancer a very big public health problem.

Faced with advanced stages, we gave patients 3 cycles of induction chemotherapy Paclitaxel + Carboplatin for 3 weeks, which is the standard protocol for metastatic disease, with the aim of primarily reducing the side effects of chemo-radiotherapy, as well as a better response to it, and before officially entering the guidelines.

We presented the experiences of 13 female patients and compared the differences between our experience (M INTERLACE) and INTERLACE.

Keywords: cervical cancer, real world data, Interlace trial

REFERENCES

1. McCormak M, Eminowiz G, Gallardo D, Diez P, Farrelly L, Kent C, et al. Induction chemotherapy followed by standard chemoradiotherapy versus standard chemoradiotherapy alone in patients with locally advanced cervical cancer (GCIG INTERLACE): an international, multicentre, randomised phase 3 trial. Lancet 2024;404(10462):1525-1535.

S6 – SCREENING FOR LUNG CANCER IN THE REGION

URŠKA JANŽIČ[1,2]

[1]*Medical Oncology Unit, University Clinic Golnik, Golnik, Slovenija.*
[2]*Medical Faculty, University of Ljubljana, Ljubljana, Slovenija*

Lung cancer has reached the top rank for both incidence and mortality across the globe in recent years. In the region, there are over 16 million inhabitants combines in Bosnia and Herzegovina, Croatia, Montenegro, Serbia and Slovenia and the cumulative incidence and mortality are reaching above 15 000 and 12 000, respectively. Preventative measures such as lung cancer screening programs are required to discover more patients in early stages and to reduce mortality in the next decade or two as was shown in other large lung cancer screening trials, where 10-year mortality was decreased by an amazing 20%.

The only country that managed to implement nationwide lung cancer screening program is Croatia, where the program is ongoing since 2020. The program is fully reimbursed by National Health Insurance Fund and smoking cessation program is included as well. Heavy smokers between 50 and 75 years of age

are invited to attend the low dose CT scans (LDCT) by their general practitioners and in case of suspected nodules, they are again the point of reference to further diagnostics. In the first 3 years over 40 000 LDCT scans were performed for over 30 000 people, and 347 lung cancer cases were confirmed (1.43%). Sixty percent of patients were found in early stages that were manageable by surgery. Another pilot project is ongoing in the region of Vojvodina in Serbia. They were mainly following Croatia's example in terms of inclusion criteria and both including primary care physicians as the junction for identifying suitable candidates and referring them to LDCTs and then to further diagnostics in case of positive radiologic findings. They have screened over 2000 people in the 2-year period and lung cancer detection rate was 1.8% with 58% of them found in stage I or II.

There was a feasibility trial ongoing in Montenegro about a decade ago in which 120 participants were included, older than 50 years with at least 20-year smoking history. There were 3.3% positive findings in this cohort, all in stages I–III. National lung cancer screening plan is still pending.

Slovenia is lagging behind and preparing to launch a pilot project in 2026 and Bosnia and Herzegovina, divided by its socio-economic and political differences, will probably launch a pilot project in Sarajevo canton first in the next few years.

In conclusion, lung cancer screening programs have shown benefit in finding early-stage patients and reducing mortality over and over again. That is why implementing them in a region that is still burdened with high rates of heavy smokers is urgent.

Keywords: lung cancer, screening programs, implementation

REFERENCES

1. Globocan. Cancer incidence and mortality. Accessed on April 29th 2025. Available from: Chromeextension://efaidnbmnnnibpcajpcglclefindmkaj/https://gco.iarc.who.int/media/globocan/factsheets/cancers/15-trachea-bronchus-and-lung-fact-sheet.pdf
2. Lung cancer screening in Croatia: leading the way for earlier detection in Europe – The Lung Cancer Policy Network. https://www.lungcancerpolicynetwork.com/lung-cancer-screening-in-croatia/ Accessed on April 29th 2025
3. Djekic Malbasa J, Kovacevic T, Zaric B, et al. Results and challenges of lung cancer screening in Serbia. European Respiratory Journal. 2023;62(suppl 67):PA1116. Doi: 10.1183/13993003.congress-2023.PA1116
4. Račeta-Mašić D, Nikolić G. Low dose CT in detection of lung cancer –preliminary raport. Medical Journal of Montenegro, 2015;3(4):27-29. doi: 10.5937/cma3-9686

S7 – IMMUNOTHERAPY IN RESECTABLE NON-SMALL-CELL LUNG CANCER

KATJA MOHORČIČ

Medical Oncology Unit, University Clinic Golnik, Golnik, Slovenia

Surgery remains the standard treatment for early-stage non-small-cell lung cancer (NSCLC) stages I–IIIA. However, only about 25% of patients present with resectable disease at diagnosis, and 30–55% experience recurrence after surgery. Until 2022, treatment for high– risk resectable NSCLC (tumors >4 cm or with nodal involvement) involved neoadjuvant or adjuvant cisplatin-based chemotherapy, which reduces mortality by only ~5%. Although neoadjuvant chemotherapy offers comparable benefits, the risk

of tumor progression prior to surgery often favours the adjuvant approach, despite significant toxicity. Treatment decisions must therefore be individualized. Improved outcomes are associated with earlier diagnosis, accurate staging, advanced surgical techniques, and especially modern systemic therapies(1).

Immune checkpoint inhibitors (ICIs) targeting PD-1, PD-L1, and CTLA-4—administered alone or with chemotherapy—have shown superior response rates, improved survival, and reduced toxicity compared to chemotherapy alone in metastatic disease. This success has led to their investigation in earlier stages. Several phase 3 trials are evaluating ICIs in adjuvant (postoperative), neoadjuvant (preoperative), and perioperative (combined) settings. Evidence suggests neoadjuvant ICIs may be more effective than adjuvant therapy due to enhanced T-cell activation in the presence of residual tumour, leading to deeper responses and fewer recurrences(2). Trials include patients with resectable NSCLC, good performance status, and no contraindications to chemoimmunotherapy. Importantly, ICIs are largely ineffective in tumors with targetable mutations such as EGFR or ALK, and most trials exclude these patients. As a result, immunotherapy is not recommended for this subgroup in early-stage disease.

Adjuvant Immunotherapy: Two EMA-approved phase 3 trials—IMpower010 and KEYNOTE-091 (PEARLS)—evaluated one year of adjuvant immunotherapy (atezolizumab or pembrolizumab) versus best supportive care or placebo in completely resected stage IB–IIIA (AJCC 7th edition) NSCLC. Atezolizumab significantly improved disease-free survival (DFS) in all tested groups and showed overall survival (OS) benefit in stage II–IIIA patients with PD-L1 ≥50%. Pembrolizumab improved DFS in the overall population, but not in the PD-L1 ≥50% subgroup. OS data for pembrolizumab remain immature.

Neoadjuvant Chemoimmunotherapy: The CheckMate 816 trial, the only EMA-approved phase 3 study in this setting, evaluated three cycles of neoadjuvant chemoimmunotherapy (nivolumab plus chemotherapy) versus chemotherapy alone in stage IB–IIIA NSCLC. It met both primary endpoints—pathologic complete response (pCR) and event-free survival (EFS)—with the greatest benefit observed in stage III and PD-L1 ≥1% patients. OS was improved as a secondary endpoint (HR 0.72).

Perioperatice Chemoimmunotherapy: This approach combines four cycles of neoadjuvant chemoimmunotherapy with one year of postoperative immunotherapy. Five randomized phase 3 trials—AEGEAN, KEYNOTE-671, CheckMate-77T, Neotorch, and Rationale-315—have reported positive results in resectable stage IB–IIIB (N2) NSCLC. All met primary endpoints (pCR, EFS, or MPR). KEYNOTE-671 is the only study to show a statistically significant OS improvement (HR 0.72, p = .005), OS data from the remaining trials are still maturing. Neotorch and Rationale-315 were conducted exclusively in China(3-5).

Despite promising findings, key questions remain—such as the optimal number of neoadjuvant cycles, the necessity of adjuvant therapy, the potential to omit chemotherapy, and whether surrogate endpoints will ultimately translate into long-term survival benefits.

Keywords: NSCLC (Non-Small-Cell Lung Cancer), neoadjuvant/adjuvant treatment, checkpoint inhibitors (ICIs), survival outcomes

REFERENCES

1. Burdett S. Preoperative chemotherapy for non-small-cell lung cancer: A systematic review and meta-analysis of individual participant data. Lancet [Internet]. 2014;383(9928):1561–71. Available from: http://dx.doi.org/10.1016/S0140–6736(13)62159-5
2. Versluis JM, Long GV, Blank CU. Learning from clinical trials of neoadjuvant checkpoint blockade. Nat Med [Internet]. 2020;26(4):475–84. Available from: http://dx.doi.org/10.1038/s41591-020-0829-0

3. Phillips WJ, Jackson A, Kidane B, Lim G, Navani V, Wheatley-price P. Immunotherapy for early-stage non – small cell lung cancer : a practical guide of current controversies. Clin Lung Cancer [Internet]. 2025;26(3):179–90. Available from: https://doi.org/10.1016/j.cllc.2025.01.006
4. Banna GL, Hassan MA, Signori A, Giunta EF, Maniam A, Anpalakhan S, et al. Neoadjuvant chemo-immunotherapy for early-stage non-small cell lung cancer: a systematic review and meta-analysis. JAMA Netw Open. 2024;E246837.
5. Sorin M, Prosty C, Ghaleb L, Nie K, Katergi K, Shahzad MH, et al. Neoadjuvant Chemoimmunotherapy for NSCLC: A Systematic Review and Meta-Analysis. JAMA Oncol. 2024;10(5):621–33.

S8 – IMMUNOTHERAPY IN SMALL CELL LUNG CANCER

JELENA SPASIĆ

Institute of Oncology and Radiology of Serbia, Belgrade, Srbija

Small cell lung cancer (SCLC) accounts for about 15% of all lung cancers, with almost 2/3 of patients presenting in metastatic disease (extensive-stage, ES). For more than 30 years, platinum-based chemotherapy was the only first-line option in metastatic disease, yielding high response rates of 70-80%, but with most patients relapsing within a few months and median survival in metastatic disease of about 8 to 12 months. Second line options were also limited, with topotecan being the only option for many years, and only in the past few years lurbinectedin getting approval in this setting.

Immunotherapy has revolutionised the treatment landscape of many solid tumours, including SCLC. Two pivotal trials, CASPIAN and IMpower133, showed a statistically and clinically significant improvement in overall survival (OS) in metastatic SCLC in patients treated with combination platinum chemotherapy and immunotherapy, when compared to chemotherapy alone. In the CASPIAN study, the programmed death ligand-1 (PD-L1) inhibitor durvalumab in combination with etoposide-platinum chemotherapy significantly improved the OS (hazard ratio (HR), 0.73; 95% confidence interval (CI) 0.59–0.91) of patients with ES-SCLC, with median OS (mOS) of 13.0 months compared with 10.3 in the chemotherapy group. Similar results were seen in the Impower133 study, where patients treated with the combination of PD-L1 inhibitor atezolizumab and platinum chemotherapy had a mOS of 12.3 months compared to 10.3 months in the group receiving chemotherapy alone, also statistically and clinically significant (HR 0.70; 95% CI 0.54-0.91). Long term follow-up of Impower133 (IMbrella A study) showed that 12% of patients treated with atezolizumab-chemotherapy combination were alive after 5 years, which represents a significant and until that time, an unheard-of result. Several other studies have shown similar results of median progression– free survival (mPFS) of 5-6 months, and mOS of 12-15 months.

A major breakthrough was achieved in limited-disease (LD) SCLC. In the randomised, phase 3 ADRIATIC study, patients were randomised to receive durvalumab or placebo after chemoradiotherapy for LD-SCLC for a maximum of 2 years. Both co-primary end-points were met. Durvalumab therapy significantly improved OS, with a median of 55.9 months (95% CI 37.3 to not reached) vs. 33.4 months (95% CI, 25.5 to 39.9); HR of 0.73; 98.321% CI, 0.54 to 0.98; P=0.01), as well as PFS (median 16.6 months [95% CI, 10.2 to 28.2] vs. 9.2 months [95% CI, 7.4 to 12.9]; HR 0.76; 97.195% CI, 0.59 to 0.98; P=0.02). This improvement is also highly clinically significant, as the improvement in OS is about 2 years.

At the moment, it is not clear which patients will benefit most from chemo-immunotherapy in SCLC, as there are no predictive biomarkers currently used in clinical practice. Also, even though the improve-

ment in survival is consistent and significant, it is modest in ED-SCLC, and new strategies are needed to further improve outcomes. To achieve this, new combination therapies, new targets and new molecules are being investigated in this setting.

Even so, immunotherapy has definitely made a big impact on outcomes in SCLC, and represents a new standard of care.

Keywords: small cell lung cancer, immunotherapy, atezolizumab, durvalumab

REFERENCES

1. Dolkar T, Gates C, Hao Z, et al New developments in immunotherapy for SCLC. Journal for ImmunoTherapy of Cancer 2025;13:e009667. doi: 10.1136/jitc-2024– 009667
2. Paz-Ares L, Chen Y, Reinmuth N, et al. Durvalumab, with or without tremelimumab, plus platinum-etoposide in first-line treatment of extensive-stage small-cell lung cancer: 3-year overall survival update from CASPIAN. ESMO Open 2022;7(2):100408. doi: 10.1016/j.esmoop.2022.100408
3. Liu SV, Reck M, Mansfield AS, et al. Updated overall survival and PD-L1 subgroup analysis of patients with extensive-stage small-cell lung cancer treated with atezolizumab, carboplatin, and etoposide (IMpower133). J Clin Oncol. 2021 Feb 20;39(6):619-630. doi: 10.1200/JCO.20.01055.
4. Reck M, Dziadziuszko R, Sugawara S, et al. Five-year survival in patients with extensive-stage small cell lung cancer treated with atezolizumab in the Phase III IMpower133 study and the Phase III IMbrella A extension study. Lung Cancer. 2024 Oct;196:107924. doi: 10.1016/j.lungcan.2024.107924.
5. Cheng Y, Spigel DR, Cho BC, et al. Durvalumab after chemoradiotherapy in limited-stage small-cell lung cancer.N Engl J Med. 2024 Oct 10;391(14):1313– 1327. doi: 10.1056/NEJMoa2404873.