Congress Introduction

Congress Review

Review of the American Society of Clinical Oncology (ASCO) Annual Meeting 2026

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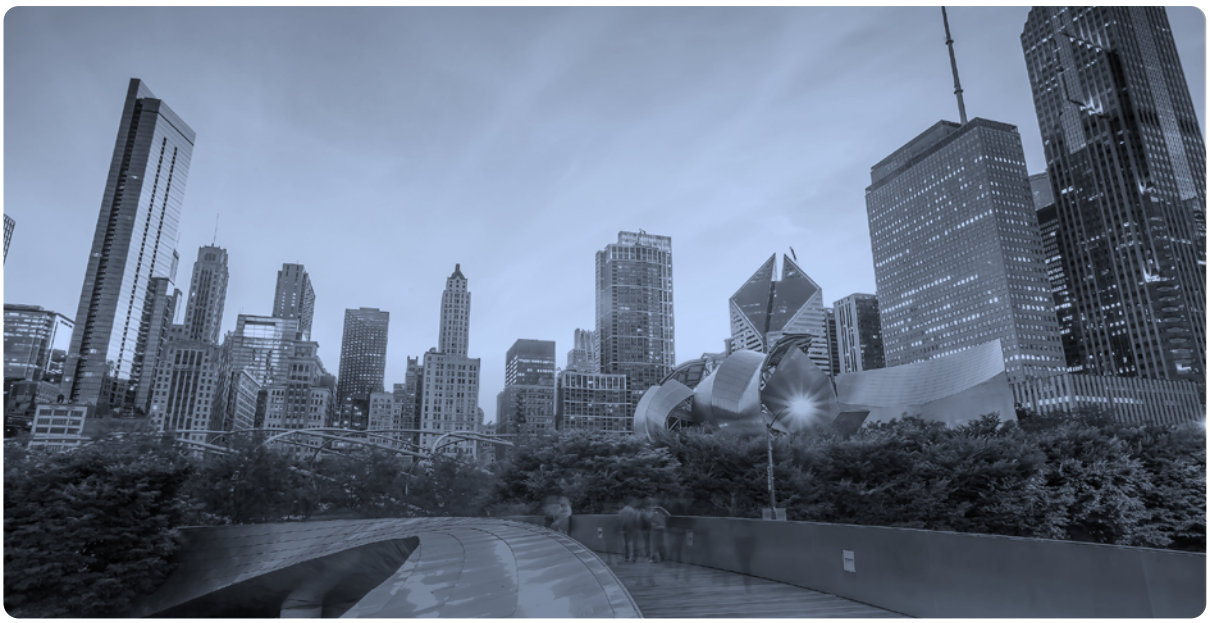
THE 2026 Annual Meeting of the American Society of Clinical Oncology (ASCO) returned to Chicago, Illinois, USA, from May 29–June 2, bringing together the global oncology community for one of the most influential meetings in cancer research and care. Held at McCormick Place and online, this year's congress centered on the presidential theme: 'The Science and Practice of Translation: Improving Cancer Outcomes Worldwide'. The program featured more than 200 sessions, with more than 7,000 abstracts presented or published as part of the meeting.

Chicago provided a fitting backdrop for a meeting focused on translating discovery into practice. Situated on Lake Michigan, the city is known for its architecture, cultural institutions, food scene, and long history as a hub for medical research and clinical care.

Its major academic medical centers and cancer programs have contributed to advances across oncology, making the city an apt host for discussions spanning prevention, diagnosis, treatment, survivorship, and global access.



FROM DISCOVERY TO MEANING

Opening the Meeting, ASCO President Eric J. Small framed translation as the central responsibility of the oncology community. Speaking to delegates, he emphasized that the value of scientific discovery lies not only in the generation of new knowledge but also in its ability to improve patient outcomes across settings and populations.

Small described three dimensions of translation: moving laboratory science into the clinic, translating clinical trial evidence into real-world patient-centered care, and ensuring innovation reaches every patient. His remarks connected the scientific program to a broader ethical and practical challenge: ensuring that breakthroughs presented at the Meeting are ultimately reflected in better care.

The congress program reflected this theme through oral abstract sessions, posters, lectures, educational sessions, symposia, plenaries, and digital content. Topic areas included immunotherapy, targeted therapies, liquid biopsies, novel imaging, biomarkers, early detection, survivorship, quality of life, cancer disparities, global oncology, supportive care, and health policy.

> **Because discovery alone is not enough, it's about what becomes of what we discover**

SCIENCE, ACCESS, AND EQUITY

A recurring message from the opening session was that progress in oncology must be measured not only by new treatments but also by whether patients can access them. Small highlighted the need for diverse clinical trial representation, stronger bonds of trust between patients and community oncologists, and systems that reduce barriers to timely, evidence-based care.

He also brought a deeply personal dimension to the theme, reflecting on the death of his partner, Amy Lin, from metastatic clear-cell ovarian cancer. Her experience, he said, reinforced the importance of placing what matters to patients at the center of oncology advances.

That patient-centered focus shaped the tone of the opening ceremony, with speakers repeatedly linking innovation to responsibility. Small noted that translation must occur across languages, cultures, geographies, resources, and practice settings so that scientific advances can benefit patients everywhere.

FUNDING THE FUTURE OF CANCER RESEARCH

The opening session also featured remarks from Anthony Letai, Director of the National Cancer Institute (NCI), who addressed the current cancer research landscape and emphasized stability in the U.S. cancer research infrastructure. He acknowledged concerns around funding delays and planning uncertainty, particularly among early-career investigators, but stated that the NCI remained committed to supporting high-quality research across the community.

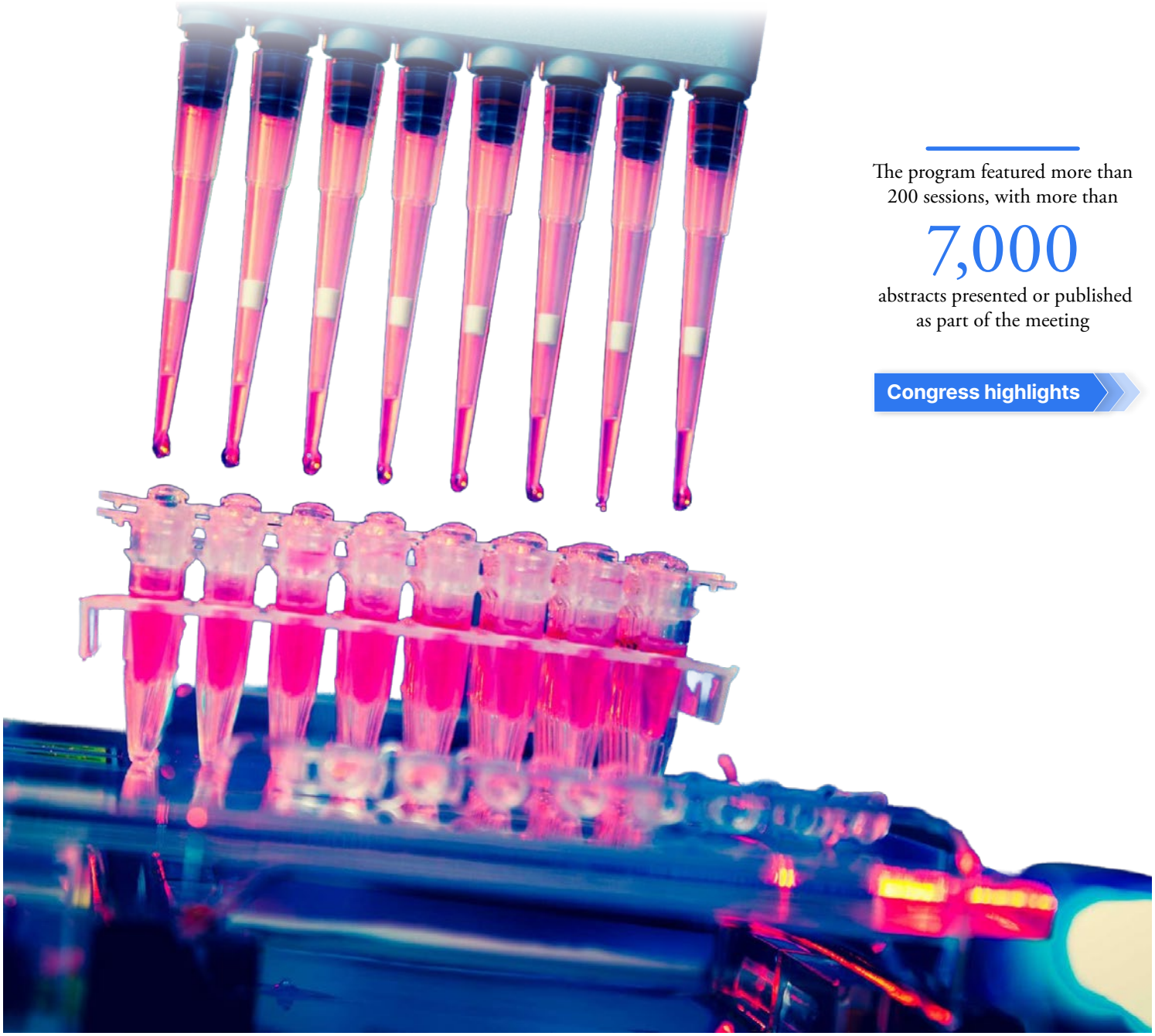
Letai underscored the long-term progress made in reducing cancer mortality in the U.S., while cautioning that cancer remains a leading cause of death and continues to affect millions of Americans. He described the NCI's priorities as focused on reducing friction in the system, accelerating progress for patients, and funding the best science.

The opening ceremony also recognized the next generation of cancer researchers through the Conquer Cancer grant and award recipients, including acknowledgment of the Young Investigator Award established in honor of Felix Feng.

A GLOBAL ONCOLOGY PLATFORM

ASCO's global reach was evident throughout the opening session. Small noted that ASCO has more than 50,000 members, with approximately 40% international membership, representing more than 170 countries. This global scale shaped the Meeting's central message: oncology innovation must move beyond discovery and become meaningful, accessible progress for patients worldwide.

As the congress opened, the message from ASCO 2026 was clear: the future of cancer care will depend not only on scientific breakthroughs, but on how effectively the oncology community translates them into practice, access, and improved outcomes for every patient.



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7,000

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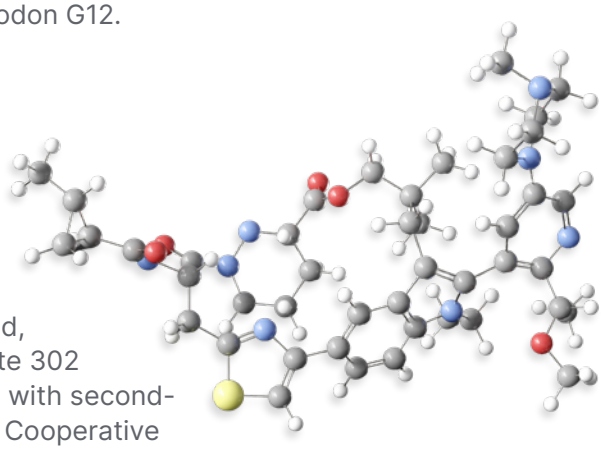
Congress highlights

1

Daraxonrasib Extends Survival in Metastatic Pancreatic Cancer

PROMISING Phase 3 data (NCT06625320), presented at ASCO 2026, suggest that daraxonrasib could offer a new treatment option for patients with second-line metastatic pancreatic adenocarcinoma (mPDAC), a highly aggressive cancer that has spread beyond the pancreas and is associated with poor survival outcomes.[1]

Current second-line therapies provide limited clinical benefit, with reported median progression-free survival (PFS) of 3–4 months and a median overall survival (OS) of 6–7 months. Aberrant RAS pathway activation is a key driver of the disease, with RAS mutations found in more than 90% of cases, most commonly at codon G12.



Daraxonrasib, an oral RAS(ON) multi-selective, tri-complex inhibitor, targets the active, guanosine triphosphate (GTP)-bound state of both mutant and wild-type RAS. The global, randomized, open-label Phase 3 RASolute 302 study enrolled 500 patients with second-line mPDAC and an Eastern Cooperative Oncology Group (ECOG) performance status of 0–1. Participants were randomized to receive either daraxonrasib or investigator's choice of standard-of-care chemotherapy.

The trial met all primary and key secondary endpoints, with statistically significant improvements in OS and PFS observed with daraxonrasib compared with chemotherapy. In patients with RAS G12 mutations, median OS reached 13.2 months with daraxonrasib versus 6.6 months with chemotherapy (hazard ratio [HR]: 0.40; 95% CI: 0.30–0.54; p<0.0001). In the overall population, median OS was 13.2 months versus 6.7 months, respectively (HR: 0.40; 95% CI: 0.30–0.53; p<0.0001).

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Median PFS in the RAS G12 subgroup was 7.3 months with daraxonrasib compared with 3.5 months with chemotherapy (HR: 0.45; 95% CI: 0.34–0.59; p<0.0001). In the overall population, median PFS was 7.2 months versus 3.6 months (HR: 0.49; 95% CI: 0.38–0.64; p<0.0001). Objective response rates were also higher with daraxonrasib, reaching 33.2% versus 11.8% in the RAS G12 group and 31.6% versus 11.2% overall.

At the data cutoff point (February 10, 2026), treatment discontinuations were also lower with daraxonrasib. Grade 3 or higher treatment-related adverse events occurred in 43.6% of patients receiving daraxonrasib compared with 57.5% receiving chemotherapy. Treatment-related serious adverse events occurred in 10.8% versus 18.7%, while discontinuations due to treatment-related adverse events were reported in 1.2% and 11.2% of patients, respectively. No new safety signals were reported.

Although the open-label design should be considered when interpreting the findings, efficacy outcomes were assessed through blinded independent central review.

These findings support daraxonrasib as a potential new standard-of-care option for second-line mPDAC, and longer follow-up could help further define the durability of benefit across patient populations.

2

STRIDE-Based Combinations Improve PFS in EMERALD-3 HCC Trial

THE PHASE 3 EMERALD-3 study (LBA4000), presented at ASCO 2026, evaluated whether adding systemic therapy to transarterial chemoembolization (TACE) improves outcomes in patients with embolization-eligible unresectable hepatocellular carcinoma.[2] TACE is a global standard of care in this setting, and is thought to enhance tumor antigen release, potentially synergizing with immunotherapy.

EMERALD-3 randomized approximately 760 patients with confirmed unresectable disease into three arms: TACE alone; STRIDE-based immunotherapy plus TACE; and STRIDE plus TACE combined with lenvatinib. STRIDE consisted of a priming dose of tremelimumab followed by regular dosing of durvalumab. Patients were stratified by region, prior embolization, and tumor burden.

The primary endpoint was progression-free survival (PFS) comparing STRIDE + lenvatinib + TACE versus TACE alone, with overall survival (OS) as a key secondary endpoint across both STRIDE-containing arms.

At interim analysis (February 2026), STRIDE + lenvatinib + TACE significantly improved PFS versus TACE alone, reducing the risk of progression or death by 30% (hazard ratio [HR]: 0.70; 95% CI: 0.57–0.86; p=0.0007). A favorable but non-significant trend in OS was observed (HR: 0.84; 95% CI: 0.65–1.09; p=0.18). The STRIDE + TACE arm also demonstrated consistent benefit, improving both PFS (HR: 0.71) and OS (HR: 0.70) compared with TACE.

Survival rates at 24 months were higher in both combination arms versus TACE alone, suggesting potential durability of benefit, although follow-up remains immature.

Safety findings were consistent with known profiles of immune checkpoint inhibitors, tyrosine kinase inhibition, and locoregional therapy. Grade 3/4 treatment-related adverse events occurred in 62.7% of patients receiving STRIDE + lenvatinib + TACE, 48.6% with STRIDE + TACE, and 18.6% with TACE alone.

Overall, EMERALD-3 demonstrates that integrating STRIDE-based immunotherapy, with or without lenvatinib, into TACE significantly improves disease control in unresectable hepatocellular carcinoma, with encouraging early survival trends and manageable safety signals.

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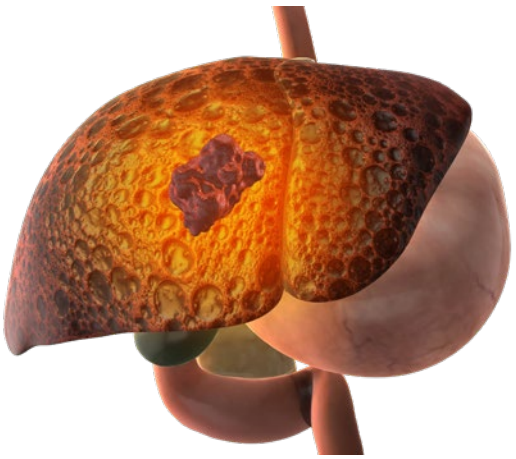


> **Survival rates at 24 months were higher in both combination arms versus TACE alone**

Ivonescimab Improves Survival in Advanced Squamous Lung Cancer

NEW PHASE III trial results presented at ASCO 2026 have shown that ivonescimab combined with chemotherapy significantly improved overall survival (OS) compared with tislelizumab plus chemotherapy in patients with previously untreated advanced squamous non-small cell lung cancer (NSCLC), marking the first time a regimen has demonstrated superiority over an active programmed cell death protein 1 (PD-1) inhibitor control in the first-line setting.[3]

The findings come from the HARMONi-6 trial, an international Phase III randomized study evaluating ivonescimab, a dual-targeted immunotherapy, in patients with Stage III–IV squamous NSCLC who had not previously received systemic treatment. Earlier analyses had already demonstrated a progression-free survival benefit with ivonescimab; the latest results now confirm a significant OS advantage.

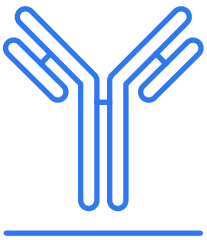
A total of 532 patients were randomly assigned to receive either ivonescimab plus paclitaxel and carboplatin chemotherapy or tislelizumab plus the same chemotherapy regimen. Following four treatment cycles, patients continued on maintenance therapy with either ivonescimab or tislelizumab alone. The analysis was conducted after a median follow-up of 21.4 months.

Researchers reported a median OS of 27.9 months in the ivonescimab arm compared with 23.7 months in the tislelizumab arm (hazard ratio [HR]: 0.66; 95% CI: 0.50–0.87; p=0.0017). The result met the trial's prespecified boundary for statistical significance and represents a 34% reduction in the risk of death.

Importantly, the survival benefit was observed across key patient subgroups regardless of programmed death-ligand 1 (PD-L1) expression status. Among patients with PD-L1 tumor proportion scores below 1%, median OS had not yet been reached in the ivonescimab group, compared with 18.6 months in the control group (HR: 0.64; 95% CI: 0.43–0.96). Similarly, among those with PD-L1 expression of 1% or higher, median OS was not yet reached with ivonescimab versus 27.3 months with tislelizumab (HR: 0.68; 95% CI: 0.46–0.99).

The safety profile of ivonescimab plus chemotherapy was reported to be manageable and consistent with previous studies, with no new safety concerns identified during follow-up.

Investigators concluded that ivonescimab delivers clinically meaningful improvements in survival while maintaining a favorable risk–benefit profile. The findings position the regimen as a potential new standard of care for patients with advanced squamous NSCLC, a population that continues to face limited treatment options despite recent advances in immunotherapy.



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4

Gene Test Safely Spares Many Patients Chemotherapy

NEW FINDINGS from the Phase III OPTIMA trial, presented at ASCO 2026, suggest that thousands of patients with high-risk early breast cancer could safely avoid chemotherapy when treatment decisions are guided by a tumor gene expression test.[4]

The international RCT evaluated whether Veracyte, Inc's (South San Francisco, California, USA) Prosigna (PAM50) gene expression test could be used to direct chemotherapy decisions in patients with estrogen receptor-positive (ER-positive), human epidermal growth factor receptor 2 (HER2)-negative early breast cancer who would traditionally be recommended chemotherapy based on clinical features alone.

The study enrolled 4,429 patients between 2017–2025, including predominantly node-positive patients considered at relatively high risk of recurrence (ROR). Participants were randomized to receive either standard chemotherapy followed by endocrine therapy or a treatment strategy guided by the Prosigna test. Patients with a low ROR score of 60 or below received endocrine therapy alone, while those with higher scores received chemotherapy in addition to endocrine treatment.

Among patients whose tumors had low ROR scores, representing 68% of the study population, outcomes were comparable regardless of whether chemotherapy was given. After a median follow-up of 3.9 years, the 5-year invasive breast cancer-free survival rate was 94.9% in the standard treatment group and 93.7% in the test-directed group. Statistical analysis confirmed that omitting chemotherapy in these patients met the trial's predefined criteria for non-inferiority.

Across the overall study population, 5-year invasive breast cancer-free survival was 91.5% in the control arm and 90.4% in the test-directed arm, with no meaningful difference in outcomes. Researchers also found no evidence that the results varied according to menopausal status or the extent of lymph node involvement.

Importantly, the findings extend to groups that have historically been underrepresented in studies evaluating chemotherapy omission, including premenopausal patients receiving ovarian function suppression and those with more extensive nodal involvement. The results therefore provide some of the strongest evidence to date supporting a personalized approach to adjuvant treatment in ER-positive, HER2-negative early breast cancer.

The researchers concluded that patients with low-ROR tumors can safely avoid chemotherapy without compromising cancer outcomes, potentially sparing many individuals the short- and long-term toxicities associated with treatment.

While follow-up remains relatively short for a breast cancer trial and longer-term results will be important, the OPTIMA study represents a significant step towards more individualized treatment decisions and reducing unnecessary chemotherapy in early breast cancer.

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5

Senomac Trial Supports Omission of Axillary Dissection in Selected Patients with Breast Cancer

AVOIDING completion axillary lymph node dissection (ALND) in patients with breast cancer and limited sentinel lymph node involvement does not compromise survival outcomes and significantly reduces long-term arm morbidity, according to results from the SENOMAC trial presented at ASCO 2026.[5]

ALND has long been a standard component of surgical management for patients with positive sentinel lymph nodes. However, the procedure is associated with substantial postoperative complications, including pain, reduced arm mobility, and lymphedema. The SENOMAC trial was designed to determine whether completion ALND can be safely omitted in patients with one or two sentinel lymph node macrometastases.

The international, randomized non-inferiority study enrolled 2,766 patients with clinically node-negative T1–3 invasive breast cancer across five countries between 2015–2021. Patients were randomized to either undergo completion ALND or omit further axillary surgery following identification of up to two sentinel lymph node macrometastases. The per-protocol population included 2,540 patients, with a median follow-up of 60 months.

During follow-up, 196 deaths were recorded, including 75 attributable to breast cancer. Five-year overall survival was 93.4% in the ALND group and 94.4% among patients who omitted the procedure. Similarly, 5-year breast cancer-specific survival reached 97.3% and 97.8%, respectively. Both endpoints met the predefined criteria for non-inferiority, demonstrating that omission of completion ALND did not adversely affect survival outcomes.

The omission strategy also resulted in meaningful improvements in patient-reported arm function.

Using the Lymphoedema Functioning, Disability and Health (Lymph-ICF) questionnaire, investigators found significantly better physical arm function among patients who avoided ALND at both 3 and 5 years after surgery. Arm-related symptoms measured using the 23-item European Organization for Research and Treatment of Cancer Quality of Life Questionnaire - Breast Cancer Module (EORTC QLQ-BR23) questionnaire were likewise substantially lower in the omission group throughout follow-up.

While overall health-related quality of life did not differ significantly between treatment groups, the reduction in long-term arm morbidity represents an important patient-centered benefit.

Notably, SENOMAC expands upon previous studies by including patients with larger tumors and those undergoing mastectomy, broadening the applicability of the findings to contemporary clinical practice.

The investigators concluded that omission of completion ALND following a positive sentinel lymph node biopsy is oncologically safe in appropriately selected patients and offers a significant reduction in long-term arm morbidity, supporting continued de-escalation of axillary surgery in early breast cancer.

6

NHS-Galleri: Mixed Verdict on Multi-cancer Screening Blood Test

A BLOOD test designed to catch many cancers early failed to hit its main target in a landmark 140,000-person NHS trial, yet still quadrupled screen-detected cancers and cut the most advanced, Stage IV diagnoses by 14%, according to results presented at ASCO 2026.[6]

Multi-cancer early detection (MCED) tests spot a shared cancer signal in circulating cell-free DNA in the blood. The NHS-Galleri trial tested whether adding the Galleri MCED test (GRAIL, Inc., Menlo Park, California, USA) to routine care could catch cancers earlier, when they are more treatable, across asymptomatic older adults in England.

The RCT enrolled 142,924 asymptomatic participants aged 50–79 years. After an initial draw, they were randomized 1:1 to an intervention arm tested with the MCED test, or an untested control arm, with samples taken at up to three annual visits. Those with a detected cancer signal entered NHS urgent suspected-cancer pathways.

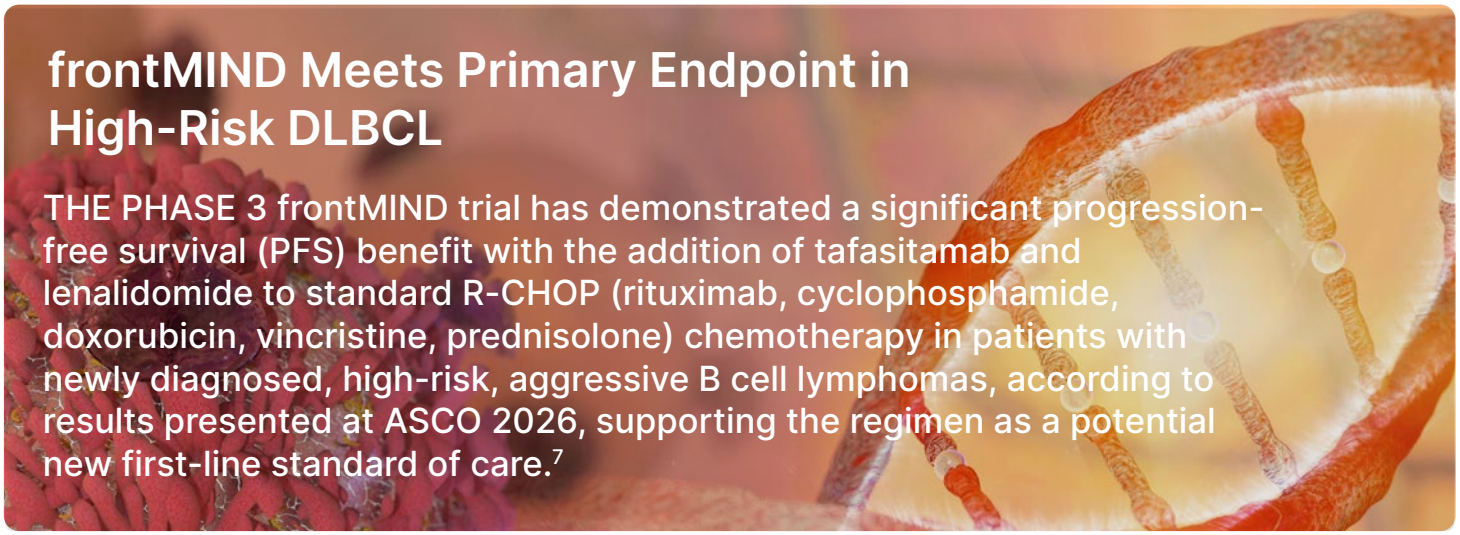
The arms were well balanced, but the primary endpoint was not met: Stage III/IV cancers numbered 706 in the intervention arm versus 688 in the control arm (incidence rate ratio: 1.03). However, Stage IV cancers fell by 14% (342 versus 397) over 3 screening years, with the reduction growing from 9% in Year 1 to 26% by Year 3. Earlier-stage detection rose correspondingly, with Stage I/II cancers up 16% (647 versus 559; relative risk: 1.16 [1.03–1.30]). The test quadrupled screen-detected cancers (1,173 versus 290), cut clinically-detected cancers by 21% (2,464 versus 3,110), and reduced emergency presentations by 21% (225 versus 286). Specificity was 99.55%, and positive predictive value was 52.0%, with no related serious adverse events.

The authors acknowledged that the primary endpoint was not met, but argued that adding annual MCED testing to standard screening boosted early detection while lowering Stage IV diagnoses and emergency presentations. Combined with the test's safety profile and strong specificity, they suggested that integrating MCED into population screening could help cut late-stage cancer, though longer follow-up is needed to confirm whether earlier detection means fewer cancer deaths.

> **"Adding annual MCED testing to standard screening boosted early detection while lowering Stage IV diagnoses"**

7

frontMIND Meets Primary Endpoint in High-Risk DLBCL



THE PHASE 3 frontMIND trial has demonstrated a significant progression-free survival (PFS) benefit with the addition of tafasitamab and lenalidomide to standard R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisolone) chemotherapy in patients with newly diagnosed, high-risk, aggressive B cell lymphomas, according to results presented at ASCO 2026, supporting the regimen as a potential new first-line standard of care.[7]

Approximately 40% of patients with diffuse large B cell lymphoma (DLBCL) are not cured with first-line R-CHOP, highlighting the need for more effective treatment approaches. frontMIND evaluated whether adding tafasitamab and lenalidomide to R-CHOP could improve outcomes in patients with high-intermediate or high-risk DLBCL or high-grade B cell lymphoma.

In this double-blind, placebo-controlled study, 899 patients aged 18–80 years were randomized to receive tafasitamab-lenalidomide-R-CHOP (Tafa-Len-R-CHOP; n=448) or standard R-CHOP (n=451). Eligible patients had newly diagnosed disease with high-risk clinical features, including International Prognostic Index (IPI) scores of 3–5. Baseline characteristics were balanced between treatment arms.

At the primary analysis, conducted after a median follow-up of 35.2 months, Tafa-Len-R-CHOP significantly improved investigator-assessed PFS compared with R-CHOP, reducing the risk of disease progression or death by 25% (hazard ratio [HR]: 0.75; 95% CI: 0.59–0.96; p=0.019). In the subgroup of 773 patients with centrally confirmed lymphoma subtypes, the benefit was even greater, with a 32% reduction in risk (HR: 0.68; 95% CI: 0.52–0.88). The 24-month PFS rate was 72.7% with Tafa-Len-R-CHOP versus 62.2% with R-CHOP, representing an absolute improvement of 10.5%.

The PFS advantage was observed across both cell-of-origin subtypes, activated B cell and germinal center B cell, suggesting broad applicability of the regimen. The combination also significantly improved event-free survival, while complete response and overall response rates were similar between treatment groups. Overall survival data remain immature, although a favorable trend was observed (HR: 0.85), with final analysis planned after 5 years of follow-up.

Safety findings were consistent with expectations for an intensified treatment regimen. Any-grade treatment-emergent adverse events occurred at similar rates in both arms, although Grade 3 or higher events were more frequent with Tafa-Len-R-CHOP (86.7% versus 76.1%). Treatment discontinuations and adverse event-related deaths were also higher in the experimental arm. Despite this, fewer deaths from any cause were reported with Tafa-Len-R-CHOP than with R-CHOP (18.5% versus 21.7%).

Investigators concluded that frontMIND met its primary endpoint and that Tafa-Len-R-CHOP offers a clinically meaningful improvement in disease control for patients with high-risk DLBCL and high-grade B cell lymphoma, potentially establishing a new first-line treatment standard across both molecular subtypes.

Approximately **40%** of patients with diffuse large B cell lymphoma (DLBCL) are not cured with first-line R-CHOP

8

Apalutamide Regimen Improves Outcomes Before Prostate Surgery

ADDING apalutamide to androgen deprivation therapy (ADT) before and after radical prostatectomy significantly improved pathological responses and metastasis-free survival in patients with high-risk localized or locally advanced prostate cancer, according to findings from the Phase 3 PROTEUS trial presented at ASCO 2026.[8]

While radical prostatectomy can be curative for patients with high-risk localized or locally advanced disease, around half of patients experience disease recurrence after surgery, highlighting the need for more effective treatment strategies.

In the PROTEUS trial, 2,109 patients with high-risk localized or locally advanced prostate cancer were randomized to receive either apalutamide plus ADT or placebo plus ADT for 6 months before surgery, followed by a further 6 months of assigned treatment after recovery. The dual primary endpoints were pathological complete response/minimal residual disease (pCR/MRD) and metastasis-free survival.

Patients receiving apalutamide plus ADT were significantly more likely to achieve pCR/MRD than those receiving placebo plus ADT, with rates of 8.9% versus 1.0% (odds ratio: 10.17; 95% CI: 5.27–19.64; p<0.0001). This represented a more than 10-fold increase in the odds of achieving pCR/MRD. As highlighted by the findings, adding apalutamide substantially improved pathologic responses at surgery.

The combination regimen also significantly improved metastasis-free survival (hazard ratio: 0.80; 95% CI: 0.67–0.96; p=0.0169). Five-year metastasis-free survival rates were 78.2% and 73.5%, respectively. Investigator-assessed metastasis-free survival also favored apalutamide plus ADT (hazard ratio: 0.74; 95% CI: 0.62–0.87; nominal p=0.0004).

Additional efficacy measures, including event-free survival, time to first subsequent treatment, and time to distant metastasis, all favored the apalutamide-based approach. Using a more stringent residual cancer burden definition, MRD rates were significantly higher with apalutamide plus ADT, at 30.6% versus 11.7% (odds ratio: 3.36; 95% CI: 2.67–4.23; nominal p<0.0001). The findings were supported by favorable results across multiple efficacy endpoints.

Higher rates of Grade 3/4 treatment-emergent adverse events and treatment discontinuations were observed with apalutamide plus ADT than with placebo plus ADT. Grade 3 or 4 treatment-emergent adverse events occurred in 39.6% of patients receiving apalutamide plus ADT and 31.0% of those receiving placebo plus ADT, while treatment discontinuation due to adverse events occurred in 7.4% and 2.7%, respectively.

The findings support the use of perioperative apalutamide plus ADT alongside radical prostatectomy in patients with high-risk localized or locally advanced prostate cancer.

MRD rates were significantly higher with apalutamide plus ADT, at 30.6% versus 11.7%

9

Adjuvant Selpercatinib in Stage IB–IIIA *RET*+ NSCLC Associated with Improvement in EFS

PATIENTS with early-stage *RET* fusion-positive (*RET*+) non-small cell lung cancer (NSCLC) experienced a significant improvement in event-free survival (EFS) after treatment with adjuvant selpercatinib according to the primary results of the Phase III LIBRETTO-432 trial presented at ASCO 2026.[9]

RET-targeted therapy has not previously been studied in patients with Stage IB–IIIA *RET*+ NSCLC, a group with high recurrence rates after definitive locoregional treatment and no approved adjuvant targeted therapy. Selpercatinib is a selective, brain-penetrant *RET* inhibitor approved for *RET*+ NSCLC. This study investigated selpercatinib against a placebo to determine its safety and effectiveness in improving EFS in patients with Stage IB–IIIA *RET*+ NSCLC.

Researchers evaluated selpercatinib 160 mg twice a day against a placebo in patients with Stage IB–IIIA *RET*+ NSCLC after definitive locoregional treatment for up to 3 years in a double-blind, Phase III randomized (1:1) controlled trial.

The primary endpoint was investigator-assessed EFS in patients with Stage II–IIIA disease. A key secondary endpoint was investigator-assessed EFS in the overall population (Stage IB–IIIA). Other secondary endpoints included EFS by blinded independent central review, overall survival, and safety.

Patients were randomly assigned to receive selpercatinib (n=75) or placebo (n=76), with median follow-up times of 24 and 27 months, respectively.

EFS in patients with Stage II–IIIA disease after treatment with selpercatinib was significantly improved (n=109; hazard ratio [HR]: 0.172; 95% CI: 0.058–0.509; p=0.0003). The median EFS for placebo was 31.8 months, while the median EFS was not reached in the selpercatinib arm. The investigator-assessed EFS results aligned with EFS by blinded independent central review (HR: 0.125; 95% CI: 0.028–0.552; p=0.0011). Selpercatinib had a 2-year EFS rate of 91.5% compared with 61.1% for placebo. In the overall population, error-controlled EFS HR was 0.165 (95% CI: 0.056–0.485; p=0.0002), and median EFS was not reached for either of the treatment arms.

With selpercatinib, increased alanine aminotransferase and aspartate aminotransferase levels were the most common adverse events, and overall adverse events were comparable to those reported in metastatic *RET*+ NSCLC.

These data demonstrated that adjuvant selpercatinib significantly increased EFS in comparison to placebo in patients with early-stage *RET*+ NSCLC. Utilizing selpercatinib for adjuvant NSCLC treatment adds to the existing evidence for targeted therapy, including the use of epidermal growth factor receptor (EGFR) and anaplastic lymphoma kinase (ALK) inhibitors. Moreover, researchers noted that providing optimal therapeutic decision-making requires comprehensive genomic testing across disease stages at diagnosis of NSCLC.

> **Adjuvant selpercatinib significantly increased EFS in comparison to placebo in patients with early-stage *RET*+ NSCLC**

10

Sacituzumab Govitecan Extends Benefit Beyond Progression

RESEARCH presented at ASCO 2026 found that sacituzumab govitecan plus pembrolizumab improved progression-free survival (PFS) after next-line treatment compared with chemotherapy plus pembrolizumab in patients with previously untreated programmed-death ligand 1 (PD-L1)-positive metastatic triple-negative breast cancer. The benefit was observed despite crossover, with most patients in the chemotherapy arm who went on to receive subsequent therapy receiving sacituzumab govitecan.[10]

The findings come from ASCENT-04, a randomized Phase 3 study evaluating first-line sacituzumab govitecan plus pembrolizumab versus investigator's choice chemotherapy plus pembrolizumab in 443 patients with previously untreated PD-L1-positive metastatic triple-negative breast cancer. Earlier results from the study showed a statistically significant and clinically meaningful improvement in PFS with sacituzumab govitecan plus pembrolizumab versus chemotherapy plus pembrolizumab, with median PFS of 11.2 months versus 7.8 months, respectively.

In this analysis, investigators assessed PFS after next-line therapy (PFS2), which can provide insight into longer-term clinical benefit when overall survival data remain immature or may be affected by treatment crossover. PFS2 was defined as the time from randomization to first documented progression on next-line therapy, as assessed by investigators, or death from any cause.

At a median overall survival follow-up of 14.0 months, 43% of patients in the sacituzumab govitecan plus pembrolizumab group and 23% in the chemotherapy plus pembrolizumab group remained on study treatment. PFS2 events occurred in 25% of patients receiving sacituzumab govitecan plus pembrolizumab compared with 37% of those receiving chemotherapy plus pembrolizumab.

Median PFS2 was not reached in the sacituzumab govitecan plus pembrolizumab group, compared with 21.0 months in the chemotherapy plus pembrolizumab group. The stratified hazard ratio was 0.67, with a 95% CI of 0.48–0.95, and the nominal stratified log-rank p value was 0.0224. PFS2 rates also favored sacituzumab govitecan plus pembrolizumab at 12, 18, and 24 months, reaching 63.7% at 24 months compared with 45.6% for chemotherapy plus pembrolizumab.

Time to first subsequent treatment was also longer with sacituzumab govitecan plus pembrolizumab, at 17.3 months versus 9.8 months. Among patients who discontinued treatment and received subsequent therapy, the most common treatments were taxanes, platinum chemotherapy, and capecitabine in the sacituzumab govitecan arm, and sacituzumab govitecan in the chemotherapy arm.

Overall, the data support sacituzumab govitecan plus pembrolizumab as a potential first-line standard of care for patients with previously untreated PD-L1-positive metastatic triple-negative breast cancer.

PFS2 rates also favored sacituzumab govitecan plus pembrolizumab at 12, 18, and 24 months, reaching 63.7% at 24 months compared with 45.6% for chemotherapy plus pembrolizumab

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