

1. INTRODUCTION

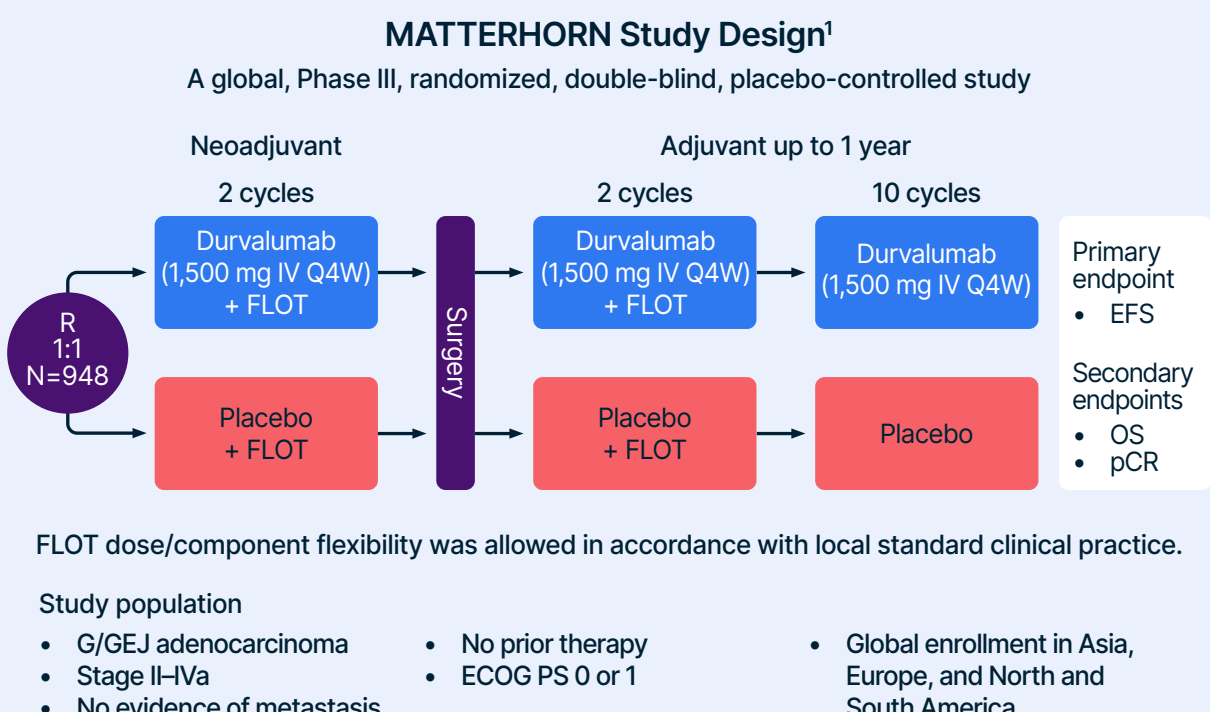
Globally, G/GEJ adenocarcinomas are among the leading causes of cancer-related deaths.¹

In locally advanced resectable disease, surgery and perioperative FLOT is the primary treatment approach, but recurrence is common.¹

Durvalumab is an anti-PD-L1 antibody, approved for the treatment of a range of solid tumors.¹

MATTERHORN trial data show that, compared to placebo + perioperative FLOT, perioperative durvalumab + FLOT:

- Significantly improved EFS and OS overall, with a generally consistent OS treatment effect across PD-L1 TAP subgroups and FLOT dosing flexibility.¹⁻³
- Did not delay surgical management or increase SAEs.^{1,4}



2. RESULTS

When comparing durvalumab + FLOT to placebo + FLOT, the results of the MATTERHORN trial showed:

Statistically significant improvements in OS (HR: 0.78; 95% CI: 0.63–0.96; p=0.021). At 36 months, OS was 68.6% in the durvalumab group and 61.9% in the placebo group.²

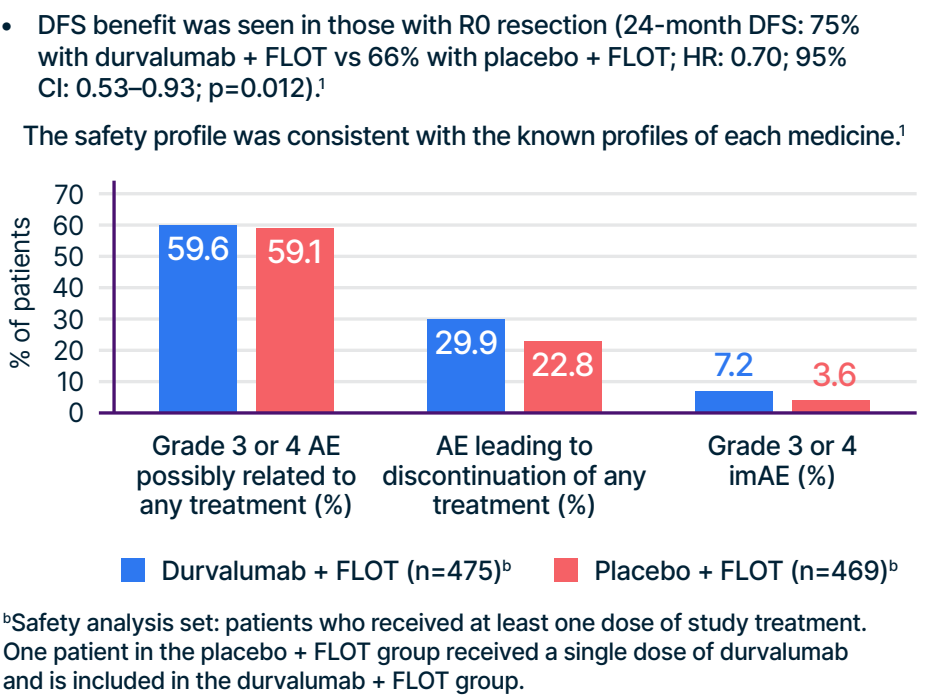
Consistent benefit observed in most key subgroups^a including:

- PD-L1 status by TAP score (TAP ≥1%: HR: 0.79; 95% CI: 0.63–0.99; TAP <1%: HR: 0.79; 95% CI: 0.41–1.50).^{1,2}
- Histology type (diffuse: HR: 0.98; 95% CI: 0.68–1.40; indeterminate: HR: 0.61; 95% CI: 0.38–0.96).²

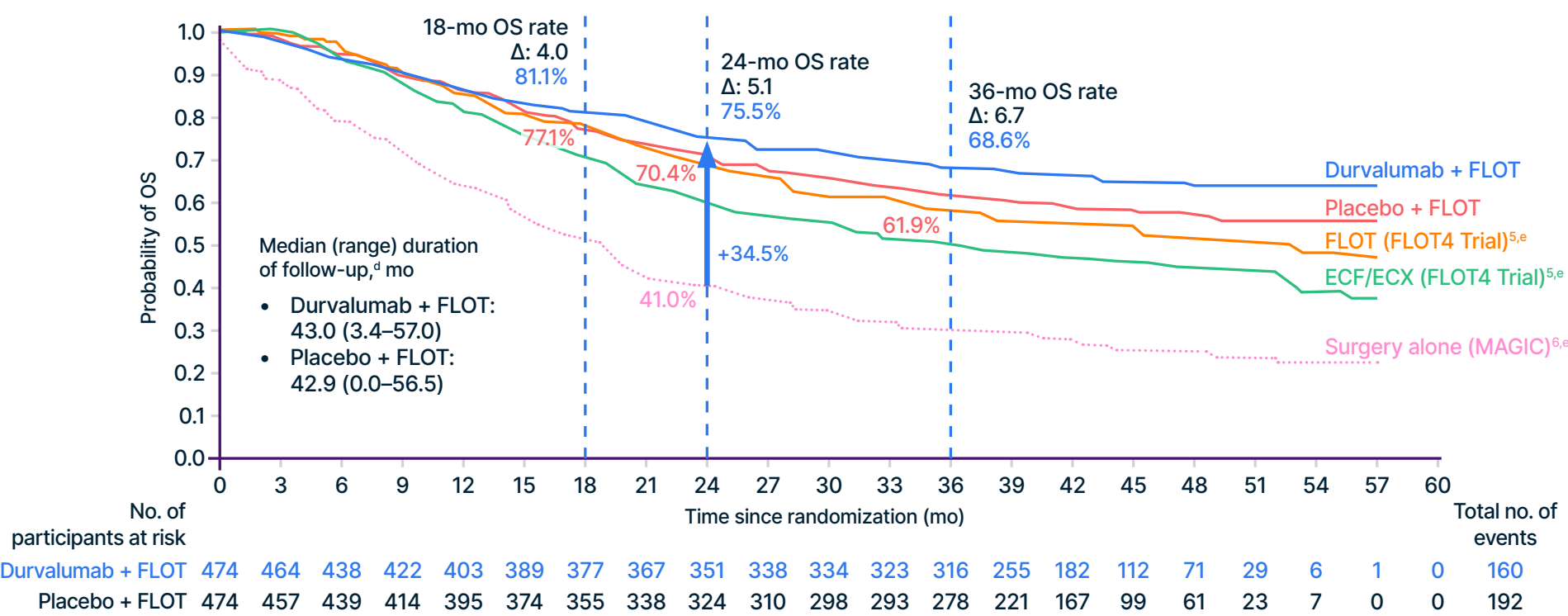
^aThe OS subgroup analysis was not powered to show differences between or within individual subgroups.

Statistically significant improvements in EFS. At 24 months, 67.4% of the participants in the durvalumab and 58.5% of those in the placebo group remained event free (HR: 0.71; 95% CI: 0.58–0.86; p<0.001).¹

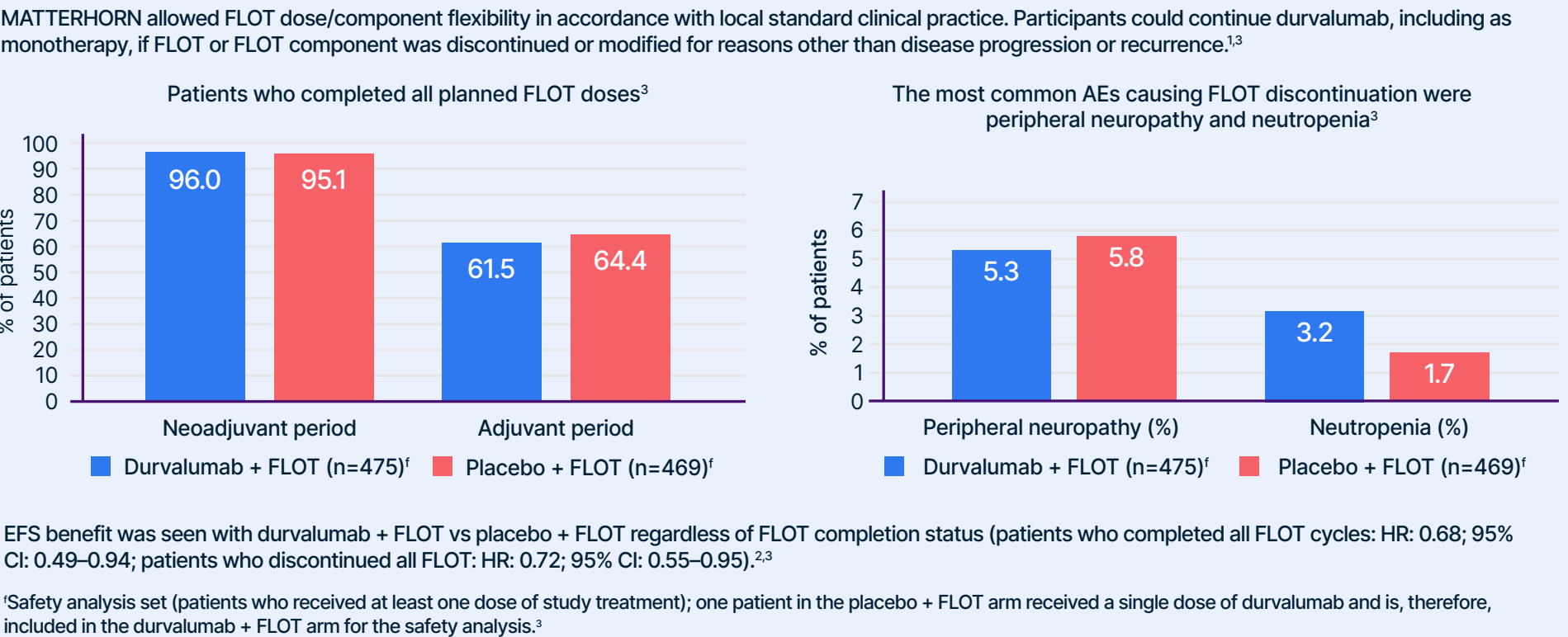
EFS benefits were seen among participants with any degree of pathological response (HR: 0.60; 95% CI: 0.46–0.79).^{2,3}



Durvalumab + FLOT improves OS vs SoC FLOT and surgery^c | 2006–2025: Achievements in 19 years of perioperative treatment²



3. FLOT FLEXIBILITY



4. SURGICAL OUTCOMES

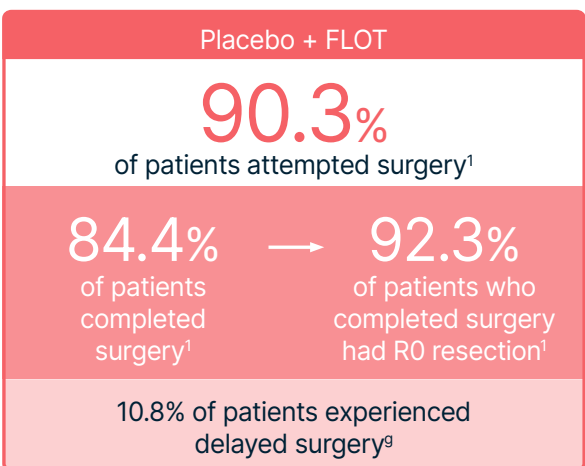
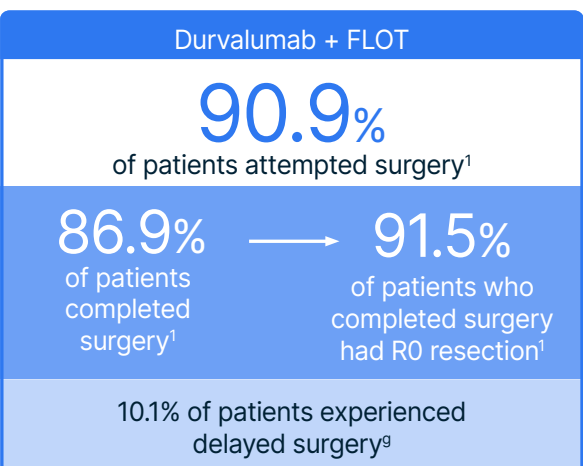
Crucially, durvalumab + FLOT did not impact the surgical journey, compared to placebo + FLOT.¹

There was an EFS benefit with durvalumab + FLOT vs placebo + FLOT regardless of:

- tumor location (GC: HR: 0.70; 95% CI: 0.52–0.94; GEJC: HR: 0.64; 95% CI: 0.43–0.95);⁴
- resection margin (R0: HR: 0.67; 95% CI: 0.51–0.86; R1: HR: 0.58; 95% CI: 0.28–1.19);⁴
- lymphadenectomy type (D1: HR: 0.75; 95% CI: 0.33–1.70; D2/D3: HR: 0.67; 95% CI: 0.52–0.86).⁴

Higher pCR and near-pCR rates were observed with durvalumab + FLOT than with placebo + FLOT.¹

SAE and mortality rates were similar across both arms.^{1,4}



Outcome	Durvalumab + FLOT n (%)	Placebo + FLOT n (%)
R0 resection rates ^h	377 (91.5)	369 (92.3)
Patients undergoing D2/D3 lymphadenectomy ^h	375 (91.0)	373 (93.3)
Any SAE possibly related to surgery ⁱ	61 (12.8)	61 (13.0)
Death within 90 days of surgery ⁱ	13 (3.1)	8 (2.0)

^aDelay defined as surgery occurring more than 8 weeks after the final dose of neoadjuvant treatment.

^bPercentages are of participants who completed surgery (durvalumab + FLOT: n=412; placebo + FLOT: n=400).

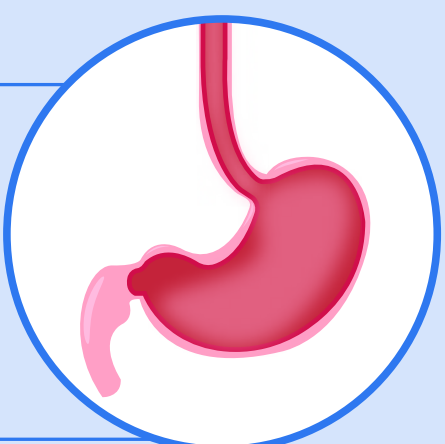
^cPercentages are of the safety analysis set (participants who received at least one dose of study treatment; durvalumab + FLOT: n=475; placebo + FLOT: n=469). One participant in the placebo + FLOT group received a single dose of durvalumab and is, therefore, included in the durvalumab + FLOT group for the safety analysis.

^dPercentages are of participants in the safety analysis set who completed surgery (durvalumab + FLOT: n=413; placebo + FLOT: n=399).

5. CONCLUSION

Results from the MATTERHORN trial demonstrate that adding durvalumab to perioperative FLOT significantly improves OS and EFS in patients with G/GEJ adenocarcinoma, without increasing surgical risk or SAEs.¹

- Benefits were consistent across clinically relevant subgroups, including PD-L1 status and histology type.¹⁻³
- The addition of durvalumab to FLOT did not impact the surgical journey; EFS benefit seen regardless of FLOT completion status.³
- Together, these findings support perioperative durvalumab + FLOT as a potential new SoC for patients with resectable G/GEJ adenocarcinoma.



Abbreviations:

AE: adverse event; D1: dissection level 1; D2: dissection level 2; D3: dissection level 3; DFS: disease-free survival; ECF/ECX: epirubicin, cisplatin, 5-fluorouracil/epirubicin, cisplatin, capecitabine; ECOG PS: Eastern Cooperative Oncology Group Performance Status; EFS: event-free survival; FLOT: fluorouracil, leucovorin, oxaliplatin, and docetaxel; GC: gastric cancer; GEJC: gastroesophageal junction cancer; G/GEJ: gastric/gastroesophageal junction; HR: hazard ratio; imAE: immune-mediated adverse event; IV: intravenous; mo: months; OS: overall survival; pCR: pathologic complete response; PD-L1: programmed death-ligand 1; Q4W: every 4 weeks; R0: no residual tumor; R1: microscopic residual tumor; SAE: serious adverse event; SoC: standard of care; TAP: tumor area positivity; vs: versus.

References:

- Janjigian YY et al. N Engl J Med. 2025;393(3):217–30.
- Tabernero J et al. Abstract LBA81. ESMO Congress, October 17–21, 2025.
- Smyth E et al. Abstract 343. ASCO Gastrointestinal Cancers Symposium, January 8–10, 2026.
- Molena D et al. Abstract 353. ASCO Gastrointestinal Cancers Symposium, January 8–10, 2026.
- Al-Batran SE et al. Lancet. 2019;393(10184):1948–57.
- Cunningham D et al. N Engl J Med. 2006;355(1):11–20.