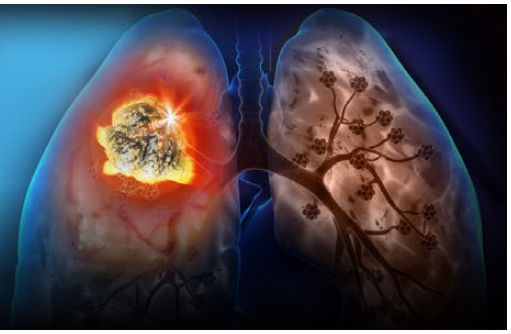
Lung Cancer Research Review™



Making Education Easy

Issue 61 - 2021

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Abbreviations used in this issue:

AE = adverse event; **DFS** = disease-free survival; **ECOG** = Eastern Cooperative Oncology Group; **HR** = hazard ratio; **ICI** = immune checkpoint inhibitor; **NSCLC/SCLC** = (non-)small-cell lung cancer; **ORR** = overall/objective response rate; **OS** = overall survival; **PD-1/PD-L1** = programmed cell death (ligand)-1; **PFS** = progression-free survival; **SABR** = stereotactic ablative body radiotherapy.

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Welcome to issue 61 of Lung Cancer Research Review.

Research published in the Lancet begins this issue, reporting the results of the Impower 011 trial, which compared adjuvant atezolizumab with best supportive care following adjuvant platinum-based chemotherapy in patients who had undergone complete surgical resection of early-stage NSCLC. We follow this with an Australasian randomised trial reporting that single-fraction SABR was as effective and easier to deliver than multifraction SABR in the treatment of patients with pulmonary oligometastases. There is also research showing that sparing the hippocampus during prophylactic cranial irradiation helps to preserve cognitive function when managing patients with SCLC. This issue concludes with a pooled analysis of three KEYNOTE trials of pembrolizumab added to platinum-doublet chemotherapy for advanced NSCLC reporting that the clinical benefits of adding pembrolizumab were not impacted by different levels of PD-L1 expression.

We hope you enjoy the research selected, and we look forward to receiving your comments and feedback.

Kind regards,

Dr Divyanshu Dua

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Adjuvant atezolizumab after adjuvant chemotherapy in resected stage IB–IIIA non-small-cell lung cancer (IMpower010)

Authors: Felip E et al., for the IMpower010 Investigators

Summary: Adults with completely resected stage IB–IIIA NSCLC were randomised to receive 16 cycles of adjuvant atezolizumab 1200mg every 21 days for 1 year (n=507) or best supportive care (n=498) following 1–4 cycles of adjuvant platinum-based chemotherapy in the open-label phase 3 IMpower010 trial; 495 participants from each group received treatment. Compared with best supportive care, atezolizumab was associated with improved DFS after median follow-up of 32.2 months in participants with stage II–IIIA disease (HR 0.79 [95% CI 0.64–0.96]) including those with ≥1% PD-L1 expression on tumour cells (0.66 [0.50–0.88]); a DFS benefit was also evident in the intent-to-treat population (0.81 [0.67–0.99]). The incidence of grade 3–4 AEs related to atezolizumab use was 11%, and the incidence of grade 5 AEs was 1%.

Comment: IMpower010 trial participants had lung cancers ranging from stage IB through IIIA. In these patients, the tumours have only spread locally and not metastasised to distant locations in the body. In stage IIIA, for example, the cancer has spread to lymph nodes on the same side of the chest as the primary, or original, tumour. Most patients in the trial received standard adjuvant chemotherapy as planned. Those assigned to the atezolizumab group then went on to receive it every 3 weeks, for up to a year. After a median follow-up of nearly 3 years, more participants in the atezolizumab group than the best supportive care group were alive without any evidence of their cancer returning or of a new primary NSCLC developing. The improvement in 3-year DFS with immunotherapy versus supportive care overall (56% vs. 49%) was even greater when looking at just patients whose tumours expressed PD-L1 on ≥1% of tumour cells (60% vs. 48%). The median DFS was 35.3 months in the supportive care group, but had not been reached in the atezolizumab group translating into a 34% reduction in the risk of a DFS event. When all patients with stage II–IIIA disease were considered together, regardless of PD-L1 expression level, the median DFS was 42.3 months for the patients in the atezolizumab group and 35.3 months for the supportive care group; a 21% reduction in risk of a DFS event. The IMpower010 trial sets the scene for the use of immunotherapy in the adjuvant setting for the treatment of lung cancer. The long-term follow-up data as well as OS data are still awaited. There were no new safety issues with atezolizumab.

Reference: Lancet 2021;398:1344–57
Abstract

Single-fraction vs multifraction stereotactic ablative body radiotherapy for pulmonary oligometastases (SAFRON II)

Authors: Siva S et al., for the Stereotactic Ablative Fractionated Radiotherapy Versus Radiosurgery for Oligometastatic Neoplasia to the Lung (SAFRON) II Study Investigators

Summary: Eighty-seven patients each with 1–3 lung oligometastases (total 133) ≤5cm from any nonhaematological malignant tumour located away from the central airways (ECOG performance status 0–1) and all primary and extrathoracic disease controlled with local therapy were randomised to receive single-fraction 28Gy or four fractions of 12Gy SABR to each oligometastasis in this phase 2 trial from the Trans Tasman Radiation Oncology Group. After a median 36.5 months of follow-up, the 1-year treatment-related grade ≥3 AE rates in the respective single-fraction and multifraction arms were 5% and 3%, with no significant between-group difference; there was one grade 5 AE in the multifraction arm. There was also no significant difference between the multifraction and single-fraction arms for freedom from local failure, OS, DFS or patient-reported outcomes.

Comment: This study is more reassuring in clinical practice, and will be widely adopted across the radiation oncology practice, despite a small number of patients in the study. Single-fraction SABR is the standard of care, and multifractional provides no benefit for the patient over a single fraction in either efficacy or AEs.

Reference: JAMA Oncol 2021;7:1476–85
Abstract

Gemcitabine with or without ramucirumab as second-line treatment for malignant pleural mesothelioma (RAMES)

Authors: Pinto C et al.

Summary: Adults with progressive malignant pleural mesothelioma during or after first-line treatment with pemetrexed plus platinum (ECOG performance status 0–2) were randomised to receive intravenous gemcitabine 1000 mg/m^2 on days 1 and 8 every 3 weeks plus either intravenous ramucirumab 10 mg/kg (n=80) or placebo (n=81) on day 1 every 3 weeks until tumour progression or unacceptable toxicity in this phase 2 trial from Italy with a median 21.9 months of follow-up. Compared with placebo, ramucirumab recipients had longer median OS (primary endpoint; 13.8 vs. 7.5 months; HR 0.71 [70% CI 0.59–0.85]). The incidences of grade 3–4 treatment-related AEs in the ramucirumab and placebo arms were 44% and 30%, respectively, with the most common being neutropenia (20% and 12%) and hypertension (6% and 0%), and the respective incidences of serious treatment-related AEs were 6% and 5%, with the most common being thromboembolism (4% and 2%). No treatment-related deaths were recorded.

Comment: These results are promising; however, there is a need for a bigger phase 3 study as well as evidence for the durability of the outcomes achieved with this combination. The comparison for this regimen will be combination immunotherapy with ipilimumab and nivolumab based on the randomised phase 3 CheckMate-743 trial, which included 605 patients with untreated malignant pleural mesothelioma, stratified according to sex and histology (epithelioid versus nonepithelioid). The results showed the immunotherapy regimen continued to confer an OS benefit compared with chemotherapy after minimum follow-up of 35.5 months (median OS, 18.1 vs. 14.1 months; HR 0.73 [95% CI 0.61–0.87]). The researchers reported 3-year OS rates of 23.2% among patients who received nivolumab plus ipilimumab vs. 15.4% among patients who received chemotherapy, and 3-year PFS rates by blinded independent central review of 13.6% vs. 0.8% (median PFS, 6.8 vs. 7.2 months; HR 0.92 [95% CI 0.76–1.11]).

Reference: Lancet Oncol 2021;22:1438–47
Abstract

Stereotactic ablative radiotherapy for operable stage I non-small-cell lung cancer (revised STARS)

Authors: Chang JY et al., on behalf of The STARS Lung Cancer Trials Group

Summary: Eighty adults with newly diagnosed NSCLC with N0M0 disease (squamous cell, adenocarcinoma, large cell or NSCLC not otherwise specified) and a tumour diameter of ≤3cm (Zubrod performance status of 0–2) received three fractions of SABR 54Gy to peripheral lesions or four fractions of 50Gy to central tumours with simultaneous integrated boost to gross tumour totalling 60Gy in this trial. After a median 5.1 years of follow-up, the respective 3-year (primary endpoint) and 5-year OS rates were 91% and 87%; the respective rates in a propensity score matched cohort who had undergone video-assisted thoracoscopic surgical lobectomy with mediastinal lymph node dissection were 91% and 84%, with no significant difference between the two cohorts for 3-year OS (adjusted HR 0.86 [95% CI 0.45–1.65]) and the criterion for noninferiority between the two cohorts met. There were no serious or grade 4–5 AEs in the study participants, and grade 3 dyspnoea, grade 2 pneumonitis and grade 2 lung fibrosis each occurred in one participant.

Comment: This study highlights the need for the option of surgery versus SABR for operable stage IA NSCLC. It remains very important for all patients with operable stage IA NSCLC to be discussed in a multidisciplinary setting, and where needed, both options need to be considered. It is highly unlikely there will be a large study in this space, and hence despite the limitations with regard to a single-centre experience, the results are important and will influence clinical practice in the multidisciplinary management of operable stage IA NSCLC.

Reference: Lancet Oncol 2021;22:1448–57
Abstract

Once-daily savolitinib in Chinese patients with pulmonary sarcomatoid carcinomas and other non-small-cell lung cancers harbouring *MET* exon 14 skipping alterations

Authors: Lu S et al.

Summary: In this open-label phase 2 study, 70 *MET* inhibitor-naïve adults with locally advanced or metastatic *MET*ex14-positive pulmonary sarcomatoid carcinoma or other NSCLC subtypes who had disease progression or were intolerant to or unsuitable for standard treatment received oral savolitinib 600mg or 400mg once daily according to bodyweight (≥50 and <50 kg) until disease progression, death, intolerable toxicity, initiation of other antitumour therapy, noncompliance, withdrawal or discontinuation. After a median 17.6 months of follow-up, the ORR was 49.2% in 61 participants assessed to be evaluable for tumour response by an independent review committee and 42.9% for the full study population. All participants experienced ≥1 treatment-related AE, 46% experienced grade ≥3 treatment-related AEs (most commonly increased aminotransferase levels and peripheral oedema) and 24% experienced treatment-related serious AEs (most commonly abnormal hepatic function and hypersensitivity). There was one death due to tumour lysis syndrome, which was assessed to be probably related to savolitinib.

Comment: Pulmonary sarcomatoid carcinoma is a rare subtype of NSCLC with treatment resistance and a poor prognosis. This study is a phase 2 study showing the efficacy of savolitinib in locally advanced or metastatic *MET*ex14-positive pulmonary sarcomatoid carcinoma or other NSCLC subtypes. The results are promising and need to be validated in a bigger study outside of China. The AEs of liver function test impairment and hypersensitivity are as expected, but tumour lysis needs to be monitored for in future studies in this space.

Reference: Lancet Respir Med 2021;9:1154–64
Abstract

Randomized phase III trial of prophylactic cranial irradiation with or without hippocampal avoidance for small-cell lung cancer (PREMER)

Authors: de Dios NR et al.

Summary: Patients with SCLC (n=150; 71.3% with limited disease) received standard prophylactic cranial irradiation (25Gy in ten fractions) or hippocampal avoidance-prophylactic cranial irradiation in this phase 3 study, with a median 40.4 months of follow-up among survivors. Compared with standard prophylactic cranial irradiation, hippocampal avoidance-prophylactic cranial irradiation was associated with smaller declines from baseline in Free and Cued Selective Reminding Test scores for delayed free recall at 3 months (primary objective; 5.8% vs. 23.5%; OR 5 [95% CI 1.57 to 15.86]) and 6 months (11.1% vs. 33.3%), total recall at 3, 6 and 24 months (8.7% vs. 20.6%, 20.3% vs. 38.9% and 14.2% vs. 47.6%, respectively) and total free recall at 6 months (14.8% vs. 31.5%). There were no significant changes in the incidences of brain metastases, OS and quality of life measures.

Comment: This study is a phase 3 study involving 150 patients but it will change practice. The decline in cognitive function is a serious issue after whole-brain radiotherapy. Hippocampal sparing will help preserve the cognitive function and improve quality of life.

Reference: J Clin Oncol 2021;39:3118–27
Abstract

KEYTRUDA®
(pembrolizumab)

For patients with non-squamous mNSCLC and no EGFR or ALK genomic tumour aberrations[1]

HELP MAKE MORE TOMORROWS POSSIBLE[1]*

*KEYTRUDA + plat-pem in first-line non-squamous mNSCLC vs. placebo + plat-pem: **OVERALL SURVIVAL**; number of events were 127/410 (31%) vs. 108/206 (52%), respectively: HR 0.49, 95% CI: 0.38-0.64, p<0.00001; median follow-up of 10.5 months. Co-primary endpoint PFS was also met.[1]

The most common treatment-related adverse events of any grade in the KEYTRUDA combination group of KEYNOTE-189 (occurring in ≥20% of patients and at a higher incidence than with the placebo combination group) were nausea, fatigue, constipation, diarrhoea, neutropenia, vomiting, and rash.[1]

CONSIDER KEYTRUDA FIRST-LINE IN COMBINATION WITH CHEMOTHERAPY FOR YOUR PATIENTS WITH mNSCLC.

KEYNOTE-189 STUDY DESIGN: Phase 3, randomised, multicentre, double-blind, placebo-controlled trial; treatment-naïve, non-squamous mNSCLC, no EGFR or ALK genomic tumour aberrations; no autoimmune disease that required systemic therapy within 2 years of treatment; no medical conditions that required immunosuppression; no patients who had received > 30 Gy of thoracic radiation within prior 26 weeks. Patients received: KEYTRUDA 200 mg + pem + plat Q3W for 4 cycles followed by KEYTRUDA 200 mg and pem Q3W for up to 24 months (n=410); OR placebo (n=206), pem + plat Q3W for 4 cycles followed by placebo + pem Q3W. Treatment continued until progression or unacceptable toxicity. Primary efficacy outcomes: OS and PFS.[1]

Please review the Product Information before prescribing. Product Information is available at www.msdinfo.com.au/keytrudapi.
PBS Listed. PBS information can be viewed at www.pbs.gov.au.

KEYTRUDA (Pembrolizumab) Minimum Product Information (v38.3) NSCLC Indications

Indications: As monotherapy for first-line treatment of patients with NSCLC whose tumours express PD-L1 tumour proportion score (TPS) ≥1% on a validated test, with no EGFR or ALK genomic tumour aberrations and are either; metastatic, or stage III where patients are not candidates for surgical resection or definitive chemoradiation. As monotherapy for advanced NSCLC patients with a PD-L1 TPS level ≥1% and who have received platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumour aberrations should have received prior therapy for these aberrations before receiving KEYTRUDA. In combination with pemetrexed and platinum chemotherapy for first-line treatment of metastatic non-squamous NSCLC in patients with no EGFR or ALK genomic tumour aberrations. In combination with carboplatin and either paclitaxel or nab-paclitaxel for the first-line treatment of patients with metastatic squamous NSCLC. **Contraindications:** None. **Precautions:** Immune-mediated adverse reactions, including pneumonitis, colitis (including gastrointestinal perforation), hepatitis, hepatotoxicity (in combination with axitinib), nephritis, adrenal insufficiency, hypophysitis, type 1 diabetes mellitus, hyperthyroidism, hypothyroidism, thyroiditis, uveitis, myositis, Guillain-Barre syndrome, myasthenic syndrome/myasthenia gravis (incl. exacerbation), myelitis, vasculitis, pancreatitis, sarcoidosis, encephalitis, myocarditis, pericarditis and pericardial effusion, peripheral neuropathy, sclerosing cholangitis, solid organ transplant rejection, severe skin reactions (including Stevens-Johnson syndrome, toxic epidermal necrolysis, and bullous pemphigoid), severe infusion reactions (hypersensitivity, anaphylaxis), and complications of allogeneic HSCT including fatal graft-versus-host-disease and hepatic veno-occlusive disease. Severe and fatal cases of immune-mediated adverse reactions have occurred. Limited experience in paediatrics (only indicated in PMBCL and MSI-H/dMMR cancers). Monitor thyroid and liver function. Limited data in combination with axitinib and in combination with chemotherapy in patients ≥75 years. Increased mortality when in combination with dexamethasone and a thalidomide analogue in multiple myeloma (not indicated). Immune-mediated adverse reactions affecting more than one body system can occur simultaneously. For management of immune-mediated adverse events, see full PI. Limited information in patients with active infection and patients with on-going adverse reaction to ipilimumab – use caution. Increased deaths observed in previously-treated UC patients in first two months of treatment compared to chemotherapy. Pregnancy (Category D). See full PI for further information. **Interactions:** None expected. Avoid corticosteroids or immunosuppressants prior to treatment (except as premedication in combination with chemotherapy). **Adverse events:** Monotherapy: fatigue, pruritus, rash, diarrhoea, nausea, hypothyroidism, hyperthyroidism, pneumonitis, colitis, arthralgia, cough, back pain, vitiligo, abdominal pain, hyponatremia, asthenia, neutropenia, dyspnoea, upper respiratory tract infection, pyrexia, febrile neutropenia, musculoskeletal pain, decreased appetite, constipation, elevated LFTs, urinary tract infection, acute kidney injury, haematuria, sepsis, urosepsis, anaemia, vomiting, increased creatinine, peripheral oedema, pneumonia, decreased weight, other laboratory abnormalities, mucosal inflammation, dysphagia, stomatitis, headache, dizziness, peripheral sensory neuropathy, myalgia, neck pain, insomnia, thrombocytopenia, nasopharyngitis, pulmonary embolism. Combination (where not already listed under Monotherapy) *with chemotherapy:* nephritis, alopecia; *with lenvatinib:* gastrointestinal perforation, reversible posterior leukoencephalopathy syndrome with intraventricular haemorrhage, intracranial haemorrhage, haemorrhage, confusional state, pleural effusion, adrenal insufficiency, pancreatitis, muscular weakness, renal impairment, increased lipase, increased blood alkaline phosphatase, headache, skin ulcer, increased amylase, hypocalcaemia, syncope, hypertension, haemorrhagic events, stomatitis, hypomagnesemia, dysphonia, palmar-plantar erythrodysesthesia syndrome; *with axitinib:* hypertension, hepatotoxicity, palmar-plantar erythrodysesthesia syndrome, stomatitis/mucosal inflammation, dysphonia. (see full PI). **Dosage:** Adults: 200 mg every 3 weeks in combination or monotherapy, OR 400 mg every 6 weeks as monotherapy in NSCLC. Administered as an intravenous infusion over 30 minutes. Treat with KEYTRUDA until disease progression or unacceptable toxicity, or up to 24 months or the equivalent number of treatment cycles for NSCLC. KEYTRUDA should be administered first when used in combination with intravenous chemotherapy. Atypical responses (i.e. an initial transient increase in tumour size or small new lesions followed by shrinkage) have been observed. Clinically stable patients (i.e. asymptomatic and not requiring urgent intervention) with initial evidence of progression can remain on treatment until confirmed. See full PI for further information.

Reference: 1. KEYTRUDA Australian Approved Product Information, www.msdinfo.com.au/keytrudapi.

HR: hazard ratio; **mNSCLC:** metastatic non-small cell lung cancer; **PFS:** progression-free survival; **pem:** pemetrexed; **plat:** platinum-based therapy; **Q3W:** every 3 weeks.

RELAY subgroup analyses by EGFR Ex19del and Ex21L858R mutations for ramucirumab plus erlotinib in metastatic non-small cell lung cancer

Authors: Nakagawa K et al., for the RELAY study investigators

Summary: The phase 3 RELAY study randomised patients with metastatic NSCLC, an *EGFR* ex19del or ex21L858R mutation and no CNS metastases to receive erlotinib 150 mg/day plus either ramucirumab 10 mg/kg or placebo every 2 weeks until progression or unacceptable toxicity. Among participants with ex19del mutations, the respective 1-year PFS rates (primary endpoint) in the ramucirumab and placebo arms were 74% and 54%, and for participants with ex21L858R mutations, they were 70% and 47%. Ramucirumab was also associated with benefits for ORR, duration of response, PFS2 and time-to-chemotherapy in both mutational subgroups. A *TP53* comutation at baseline was associated with superior outcomes in the ramucirumab arm for both the ex19del and ex21L858R mutation subgroups. The rate of *EGFR T790M* mutation at progression was similar between treatment arms and between mutation types.

Comment: This study shows that patients with *EGFR* ex19del and ex21L858R NSCLC derive clinical benefit with the use of erlotinib (150 mg/day) and ramucirumab (10 mg/kg). However, this needs further validation and it is not clear how it will fit into the current treatment paradigm.

Reference: Clin Cancer Res 2021;27:5258–71
Abstract

Antibiotic-exposed patients with non-small-cell lung cancer preserve efficacy outcomes following first-line chemo-immunotherapy

Authors: Cortellini A et al.

Summary: Associations of prior and current antibiotic therapy with the outcomes of OS, PFS and ORR in stage IV NSCLC were explored in 302 patients who received first-line chemoimmunotherapy; 71.5% and 20.2% of the patients were former and current smokers, respectively, and PD-L1 tumour expression was ≥50%, 1–49% and <1% in 25.2%, 27.9% and 37.5% of assessable patients, respectively. A multivariable analysis revealed that compared with patients who had not been exposed to antibiotics, those with prior exposure had similar OS and PFS (respective HRs 1.42 [95% CI 0.91–2.22] and 1.12 [0.76–1.63]), irrespective of performance status, and also similar ORRs (42.6% vs. 57.4% [p=0.1794]). Neither prior antibiotic therapy exposure duration (≥7 vs. <7 days) nor oral versus intravenous administration had any significant differential impact. When evaluated as a time-varying covariate in multivariable analysis, current antibiotic therapy had no significant impact on OS or PFS (respective HRs 1.29 [95% CI 0.91–1.84] and 1.20 [0.89–1.63]).

Comment: This study adds further information into the evolving area of antibiotic use and outcomes for chemoimmunotherapy. This study showed no response for immunotherapy with response from chemoimmunotherapy for patients with NSCLC. In a previous study, which was a retrospective analysis, Kim et al. showed that the use of antibiotics may affect the clinical outcomes of patients with solid cancers treated with ICIs (BMC Cancer 2021;19:1100). In summary, the data are based on multiple retrospective analyses and hence clinical correlation is warranted.

Reference: Ann Oncol 2021;32:1391–9
Abstract

Pretreatment Glasgow prognostic score predicts survival among patients with high PD-L1 expression administered first-line pembrolizumab monotherapy for non-small cell lung cancer

Authors: Imai H et al.

Summary: The abilities of the Glasgow prognostic score, neutrophil-to-lymphocyte ratio and BMI for evaluating the effect of first-line pembrolizumab monotherapy in patients with advanced NSCLC with high-level PD-L1 expression were assessed by reviewing data from 142 such patients. The Glasgow prognostic score was found to independently predict first-line pembrolizumab monotherapy efficacy, with scores of 0–1 associated with significantly better PFS and OS compared with a score of 2 (11.8 vs. 2.9 months and not reached vs. 8.3 months, respectively [p<0.0001 for both]). BMI was also found to be an independent predictor for efficacy, with values ≥21.4 kg/m^2 associated with significantly better OS than lower values (not reached vs. 14.1 months [p=0.006]).

Comment: This is another approach to ascertain and identify the patients who will derive a response from the use of single-agent immunotherapy (ICI). In view of increasing use of ICIs in lung cancer, either as a single agent or as combination immunotherapy, it is essential for clinicians to predict which patients will have a response from the treatment. The score needs further validation in a bigger cohort before it can be implied in routine practice.

Reference: Cancer Med 2021;10:6971–84
Abstract

Outcomes with pembrolizumab plus platinum-based chemotherapy for patients with NSCLC and stable brain metastases

Authors: Powell SF et al.

Summary: This pooled analysis of the KEYNOTE-021, KEYNOTE-189 and KEYNOTE-407 trials sought to determine of baseline brain metastases, present in 171 of 1127 participants, influenced the efficacy of first-line platinum-doublet chemotherapy with versus without 35 cycles of pembrolizumab 20mg every 3 weeks in participants with advanced NSCLC. Median follow-up durations were 10.9–11.0 months. For participants with and without brain metastases, the OS benefits seen with pembrolizumab plus chemotherapy versus chemotherapy alone were similar (respective HRs 0.48 [95% CI 0.32–0.70] and 0.63 [0.53–0.75]), as were the PFS benefits (0.44 [0.31–0.62] and 0.55 [0.48–0.63]); for participants with brain metastases, the respective median OS durations in the pembrolizumab plus chemotherapy and chemotherapy-only arms were 18.8 and 7.6 months, and their median PFS durations were 6.9 and 4.1 months. In addition, ORR and response duration benefits with pembrolizumab plus chemotherapy versus chemotherapy alone occurred irrespective of brain metastasis status. Treatment-related AE incidences in the pembrolizumab plus chemotherapy versus chemotherapy alone arm were 88.2% and 82.8%, respectively, among participants with brain metastases and they were 94.5% and 90.6% in those without brain metastases.

Comment: This study is a retrospective analysis that reassures us that using pembrolizumab with platinum-based chemotherapy is equally effective in patients with or without brain metastases. This will be useful in day-to-day clinical practice when managing patients with *de novo* brain metastases.

Reference: J Thorac Oncol 2021;16:1883–92
Abstract

Independent commentary by Dr Divyanshu Dua

Dr Divyanshu 'Divy' Dua graduated from the Manipal Academy of Higher Education, India, followed by a fellowship at the Royal Australasian College of Physicians.

He trained in internal medicine and medical oncology in Australia, followed by a clinical fellowship in drug development, early-phase trials and thoracic malignancies at Guys Hospital in London as well as the Sarah Cannon Research Institute. He has worked as a consultant medical oncologist in Australia across various sites.

His main tumour stream interests include thoracic malignancies (lung, mesothelioma and thymoma), malignant melanoma, breast, genitourinary, sarcomas and central nervous system tumours. He is keenly involved in geriatric (older persons') oncology.

Divy has published several articles in peer-reviewed international journals. He is actively involved in teaching and research. His past academic affiliations include the University of Adelaide, Flinders University, Kings College, London, Monash Rural School of Medicine and currently the Australian National University.

Correction notice

In issue 60, in the commentary for the article 'Pembrolizumab plus concurrent chemoradiation therapy in patients with unresectable, locally advanced, stage III non-small cell lung cancer' by Jabbour SK et al., we incorrectly stated that "In Australia, the PBS support chemoradiation only, but globally best practice using maintenance immunotherapy is now possible via Pharma-facilitated special access schemes based on the result of the PACIFIC trial, presented at ASCO 2021." It should read "In Australia, the PBS support chemoradiation followed by consolidation durvalumab in stage III unresectable NSCLC patients who have not progressed following CRT, which is consistent with global best practice of using maintenance immunotherapy based on the result of the PACIFIC trial."

