Society for Immunotherapy of Cancer

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Immunotherapy for the Treatment of Lung Cancer

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AAEM AMERICAN ACADEMY OF EMERGENCY MEDICINE CHAMPION OF THE EMERGENCY PHYSICIAN

ACCC Association of Community Cancer Centers

HOPA Hematology/Oncology Pharmacy Association

sitc Society for Immunotherapy of Cancer

Disclosures

- Consulting Fees:
  - Amgen, AstraZeneca, Merck, Genentech-Roche, Bayer, BMS, Pfizer, Tesaro, KisoJi
- Contracted Research:
  - Genentech-Roche
- I will be discussing non-FDA approved indications during my presentation.

Lung cancer

- 80-85% non-small cell lung cancer (NSCLC)
- 10-15% small cell lung cancer (SCLC)
- NSCLC has relatively long and extensive history of immunotherapy use

Estimated Deaths

Male		
Lung & bronchus	76,650	24%
Prostate	31,620	10%
Colon & rectum	27,640	9%
Pancreas	23,800	7%
Liver & intrahepatic bile duct	21,600	7%
Leukemia	13,150	4%
Esophagus	13,020	4%
Urinary bladder	12,870	4%
Non-Hodgkin lymphoma	11,510	4%
Brain & other nervous system	9,910	3%
All sites	**321,670**	

Female		
Lung & bronchus	66,020	23%
Breast	41,760	15%
Colon & rectum	23,380	8%
Pancreas	21,950	8%
Ovary	13,980	5%
Uterine corpus	12,160	4%
Liver & intrahepatic bile duct	10,180	4%
Leukemia	9,690	3%
Non-Hodgkin lymphoma	8,460	3%
Brain & other nervous system	7,850	3%
All sites	**285,210**	

American Cancer Society

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Immune checkpoint inhibitors in lung cancer

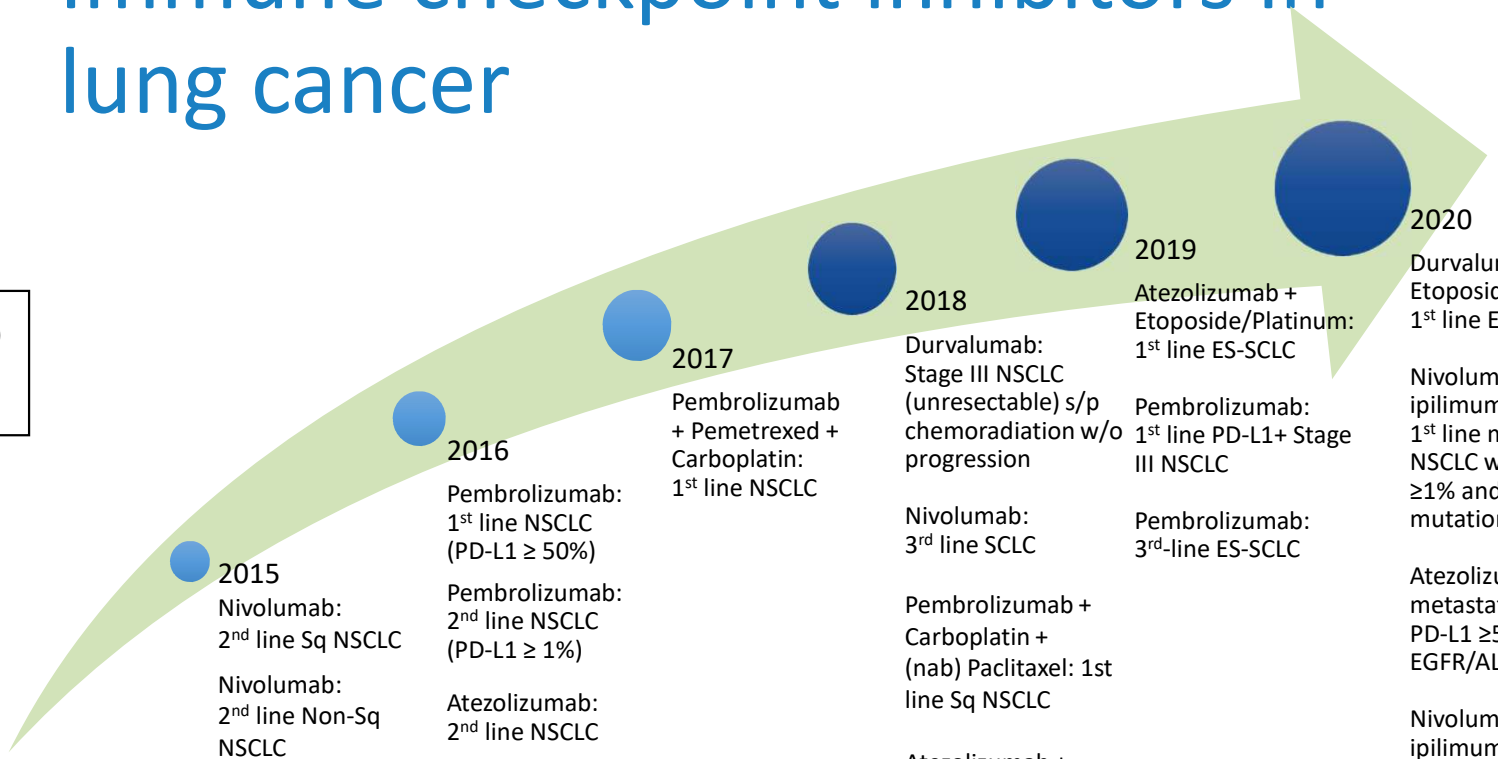
Nivolumab — **PD-1**

Pembrolizumab — **PD-1**

Atezolizumab — **PD-L1**

Durvalumab — **PD-L1**

Ipilimumab — **CTLA-4**



2015

Nivolumab: 2nd line Sq NSCLC

Nivolumab: 2nd line Non-Sq NSCLC

Pembrolizumab: 2nd line NSCLC (PD-L1 ≥ 50%)

2016

Pembrolizumab: 1st line NSCLC (PD-L1 ≥ 50%)

Pembrolizumab: 2nd line NSCLC (PD-L1 ≥ 1%)

Atezolizumab: 2nd line NSCLC

2017

Pembrolizumab + Pemetrexed + Carboplatin: 1st line NSCLC

2018

Durvalumab: Stage III NSCLC (unresectable) s/p chemoradiation w/o progression

Nivolumab: 3rd line SCLC

Pembrolizumab + Carboplatin + (nab) Paclitaxel: 1st line Sq NSCLC

Atezolizumab + Bevacizumab + Carboplatin + Paclitaxel: 1st line Non-Sq NSCLC

2019

Atezolizumab + Etoposide/Platinum: 1st line ES-SCLC

Pembrolizumab: 1st line PD-L1+ Stage III NSCLC

Pembrolizumab: 3rd-line ES-SCLC

2020

Durvalumab + Etoposide/Platinum: 1st line ES-SCLC

Nivolumab + ipilimumab: 1st line metastatic NSCLC with PD-L1 ≥1% and no EGFR/ALK mutations

Atezolizumab: 1st line metastatic NSCLC with PD-L1 ≥50% and no EGFR/ALK mutations

Nivolumab + ipilimumab + chemotherapy: 1st line NSCLC with no EGFR/ALK mutations

#LearnACI

AAEM American Academy of Emergency Medicine · ACCC Association of Community Cancer Centers · HOPA Hematology/Oncology Pharmacy Association · sitc Society for Immunotherapy of Cancer

Immunotherapy for first-line treatment of metastatic NSCLC

Drug	Indication	Dose
Pembrolizumab	1st line metastatic NSCLC with **PD-L1 TPS ≥ 1%** and no EGFR/ALK mutations	200 mg Q3W or 400 mg Q6W
Atezolizumab	1st line metastatic NSCLC with **PD-L1 ≥ 50% of tumor cells or ≥ 10% of immune cells** with no EGFR/ALK mutations	840 mg Q2W, 1200 mg Q3W, or 1680 mg Q4W
Nivolumab + ipilimumab	1st line metastatic NSCLC with **PD-L1 ≥1%** and no EGFR/ALK mutations	Nivolumab 3 mg/kg Q2W + ipilimumab 1 mg/kg Q6W
Nivolumab + ipilimumab + platinum-doublet chemotherapy	1st line metastatic NSCLC with no EGFR/ALK mutations	Nivolumab 360 mg Q3W + ipilimumab 1 mg/kg Q6W + 2 cycles of chemotherapy
Pembrolizumab + pemetrexed + platinum	1st line metastatic non-squamous NSCLC with no EGFR/ALK mutations	200 mg Q3W or 400 mg Q6W
Pembrolizumab + carboplatin + paclitaxel/nab-paclitaxel	1st line metastatic squamous NSCLC	200 mg Q3W or 400 mg Q6W
Atezolizumab + bevacizumab + paclitaxel + carboplatin	1st line metastatic non-squamous NSCLC with no EGFR/ALK mutations	For 4-6 cycles: atezolizumab 1200 mg Q3W + chemotherapy + bevacizumab; Maintenance: 840 mg Q2W, 1200 mg Q3W, or 1680 mg Q4W
Atezolizumab + nab-paclitaxel + carboplatin	1st line metastatic non-squamous NSCLC with no EGFR/ALK mutations	For 4-6 cycles: atezolizumab 1200 mg Q3W + chemotherapy Maintenance: 840 mg Q2W, 1200 mg Q3W, or 1680 mg Q4W

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Immunotherapy for relapsed/refractory NSCLC

Drug	Indication	Dose
Nivolumab	Metastatic squamous or non-squamous NSCLC with progression after chemotherapy (2nd line)	240 mg Q2W or 480 mg Q4W
Pembrolizumab	Metastatic NSCLC with progression after chemotherapy and **PD-L1 ≥ 1%**	200 mg Q3W or 400 mg Q6W
Atezolizumab	Metastatic NSCLC with progression after Pt-chemotherapy and targeted therapy if EGFR/ALK mutation-positive	840 mg Q2W, 1200 mg Q3W, or 1680 mg Q4W

Treatment Naïve Regimens: Competing Strategies in NSCLC

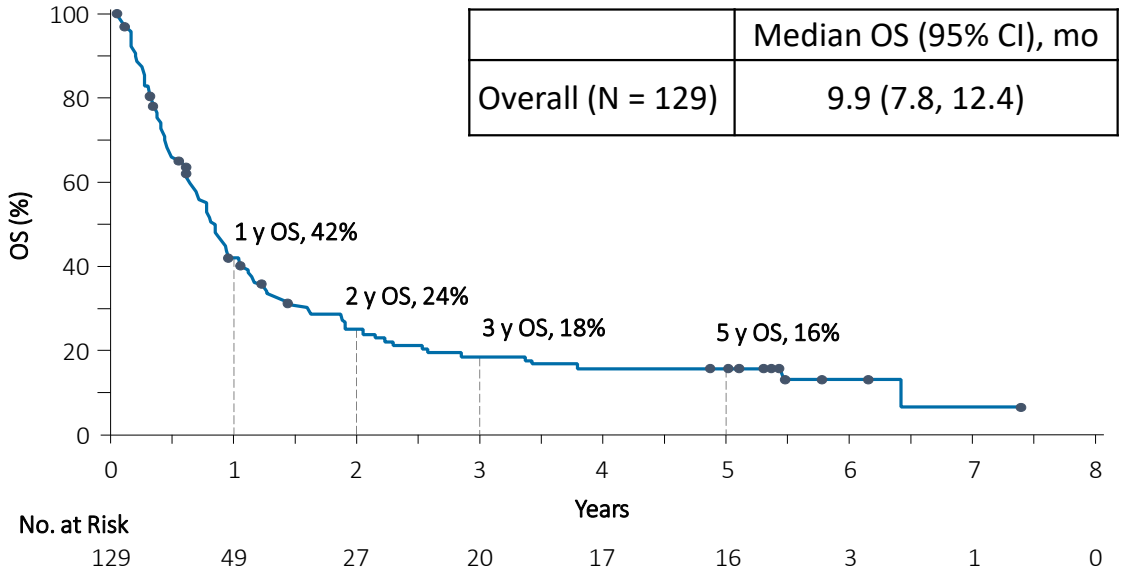
- **KEYNOTE 024** – Pembrolizumab vs. Chemotherapy in PD-L1 ≥ 50%
- **KEYNOTE 042** – Pembrolizumab vs. Chemotherapy in PD-L1 ≥ 1%
- **KEYNOTE 189** – Pembrolizumab + Chemotherapy vs. Chemotherapy alone in advanced non-squamous NSCLC
- **IMPOWER150** – Atezolizumab + Chemotherapy (Bev) vs. Chemotherapy (Bev) in advanced non-squamous NSCLC
- **KEYNOTE 407** – Pembrolizumab + Chemotherapy vs. Chemotherapy in advanced squamous cell lung cancer
- **CHECKMATE 227** – Ipilimumab + Nivolumab vs. Chemotherapy in advanced NSCLC with high TMB
- **IMPOWER110** – Atezolizumab vs. chemotherapy in PD-L1 ≥ 1%
- **CHECKMATE 9LA –** Nivolumab/ipilimumab with limited chemotherapy vs. chemotherapy in squamous and nonsquamous NSCLC

CA209-003: Nivolumab in Heavily-pretreated Advanced NSCLC (NCT00730639)

Phase 1, 5-Year Update

- First report of long-term survival rate in patients with metastatic NSCLC treated with an immune checkpoint inhibitor
- According to the National Cancer Institute's SEER data, 5-year survival rate for patients with advanced NSCLC is 4.9%

5-Year Survival

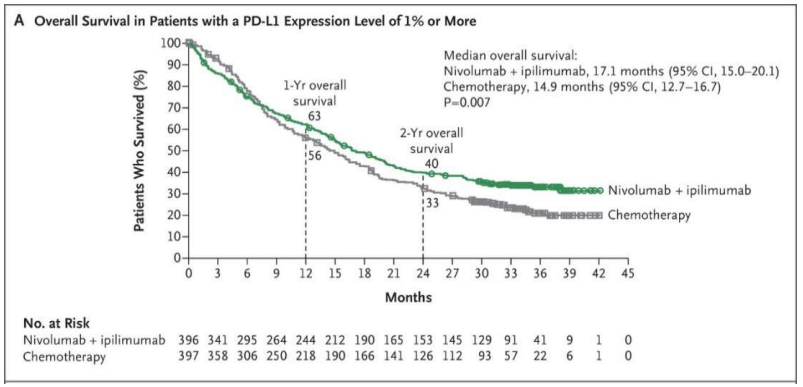


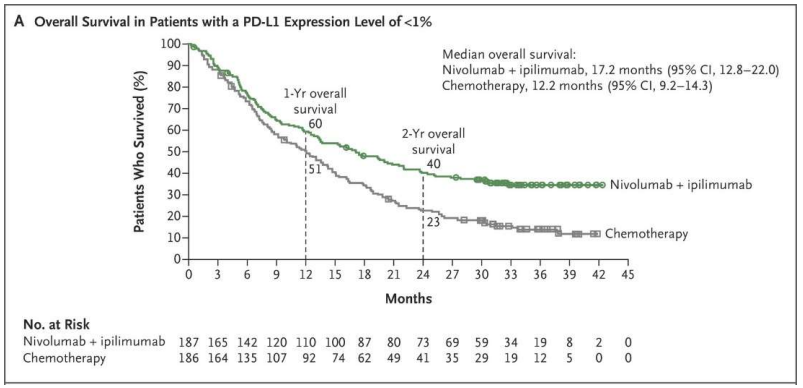
	Median OS (95% CI), mo
Overall (N = 129)	9.9 (7.8, 12.4)

Gettinger et al. JCO 2018
Brahmer et al, AACR 2017
NCI SEER data, Lung and Bronchus Cancer, 2014

CheckMate 227

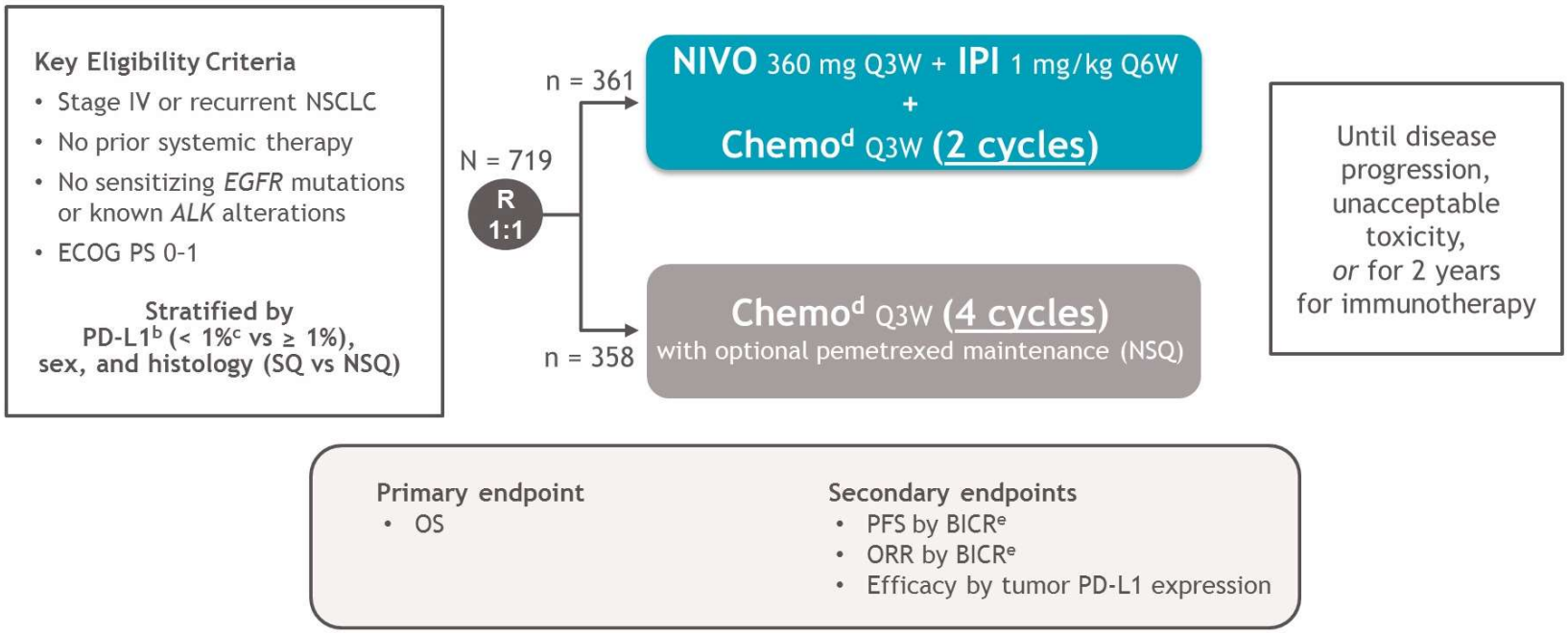
- Primary endpoint: OS in PD-L1 ≥ 1% (tumor cells)
  - Nivo/ipi: 17.1 months
  - Chemo: 14.9 months
- Longer duration of response with nivo/ipi over chemo
- Benefit of nivolumab + ipilimumab seen regardless of PD-L1 status in this study





Hellmann, NEJM 2019.

CheckMate 9LA: Nivolumab/Ipilimumab + limited chemo

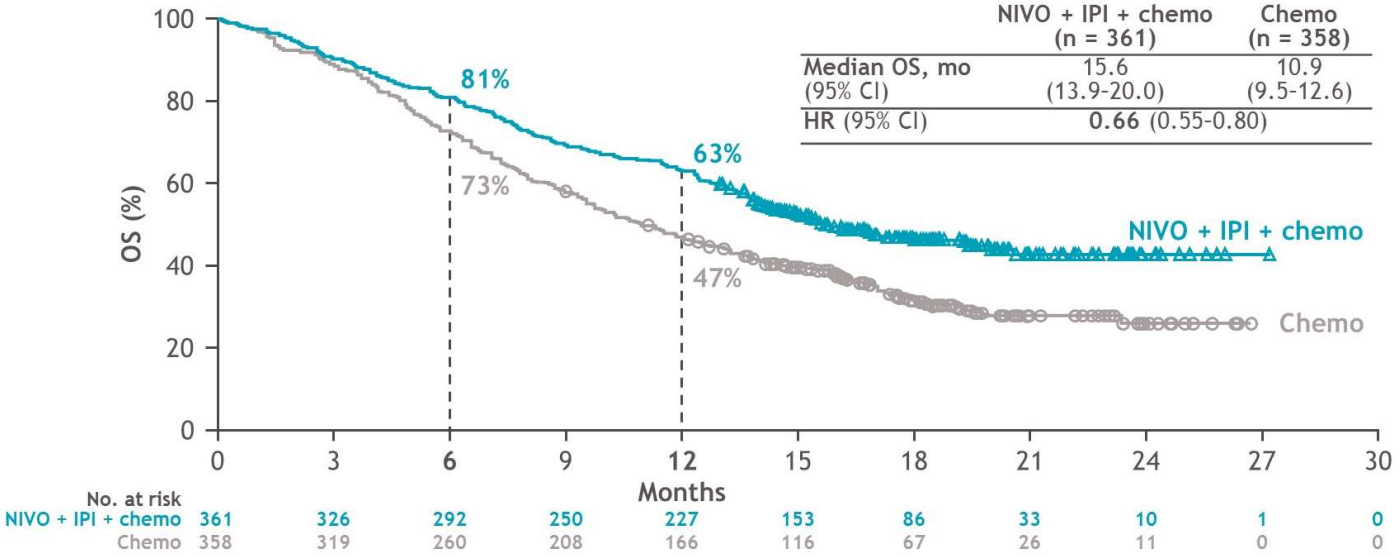


Interim database lock: October 3, 2019; minimum follow-up: 8.1 months for OS and 6.5 months for all other endpoints.
Updated database lock: March 9, 2020; minimum follow-up: 12.7 months for OS and 12.2 months for all other endpoints.

[a]NCT03215706; [b]Determined by the PD-L1 IHC 28-8 pharmDx assay (Dako); [c]Patients unevaluable for PD-L1 were stratified to PD-L1 < 1% and capped to 10% of all randomized patients; [d]**NSQ**: pemetrexed + cisplatin or carboplatin; SQ: paclitaxel + carboplatin; [e]Hierarchically statistically tested.

Reck M et al, ASCO 2020.

CheckMate 9LA: Nivolumab/Ipilimumab + limited chemo



	NIVO + IPI + chemo (n = 361)	Chemo (n = 358)
ORR, n (%)	138 (38)	89 (25)
Odds ratio (95% CI)	1.9 (1.4-2.6)	
BOR, n (%)		
CR	8 (2)	4 (1)
PR	130 (36)	85 (24)
SD	164 (45)	185 (52)
PD	32 (9)	45 (13)
DCR, n (%)	302 (84)	274 (76)

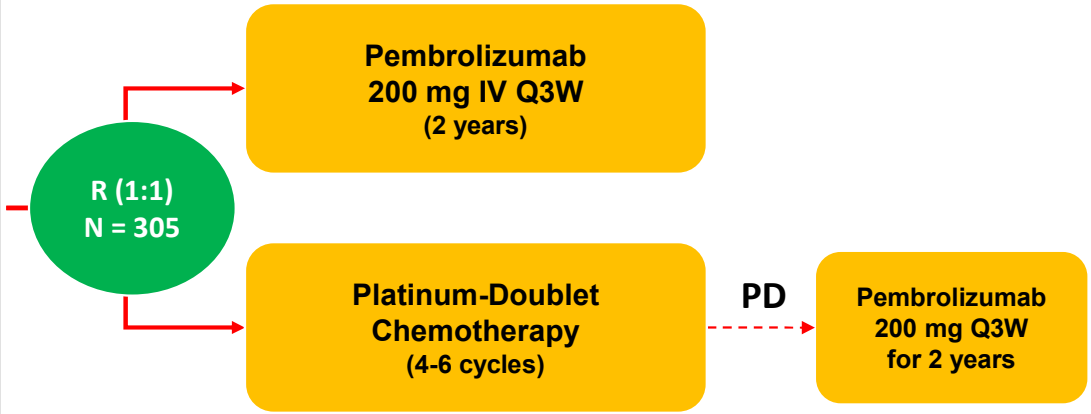
Reck M et al, ASCO 2020.

KEYNOTE-024: Pembrolizumab vs. Chemotherapy for PD-L1 Positive (≥ 50%)

NSCLC Study Design (NCT021427389)

Key Eligibility Criteria

- ***Untreated*** stage IV NSCLC
- PD-L1 TPS ≥50%
- ECOG PS 0-1
- No activating *EGFR* mutation or *ALK* translocation
- No untreated brain metastases
- No active autoimmune disease requiring systemic therapy

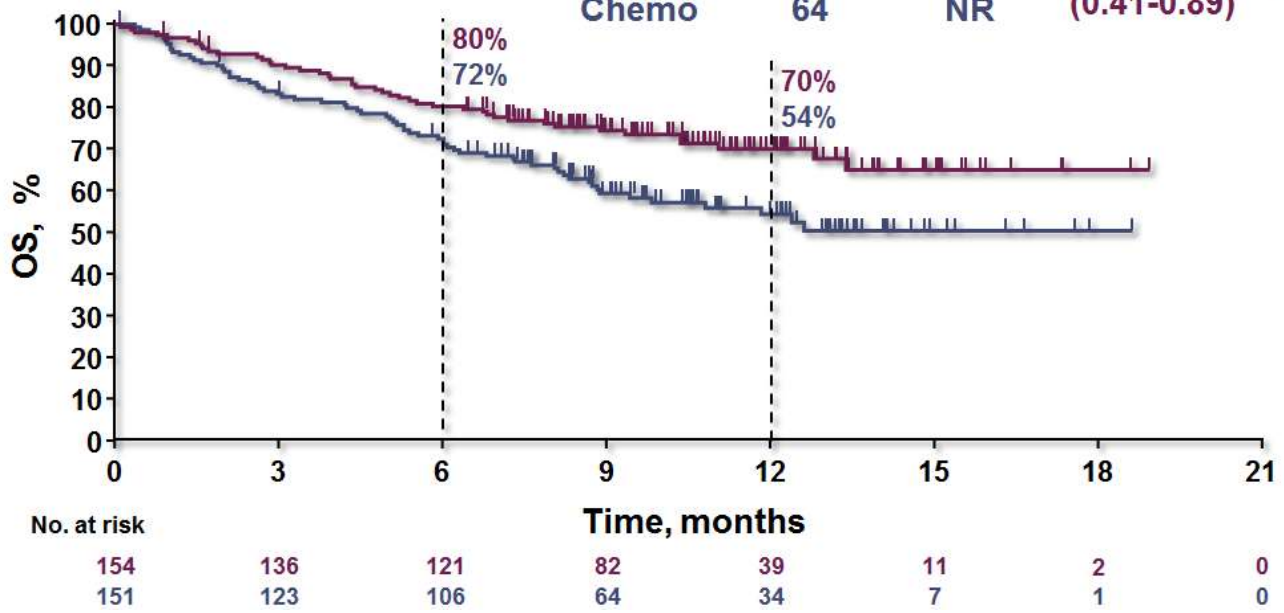


Reck M et al, ESMO 2016, NEJM 2016

KEYNOTE-024: Pembrolizumab vs. Chemotherapy for PD-L1 ≥ 50% NSCLC

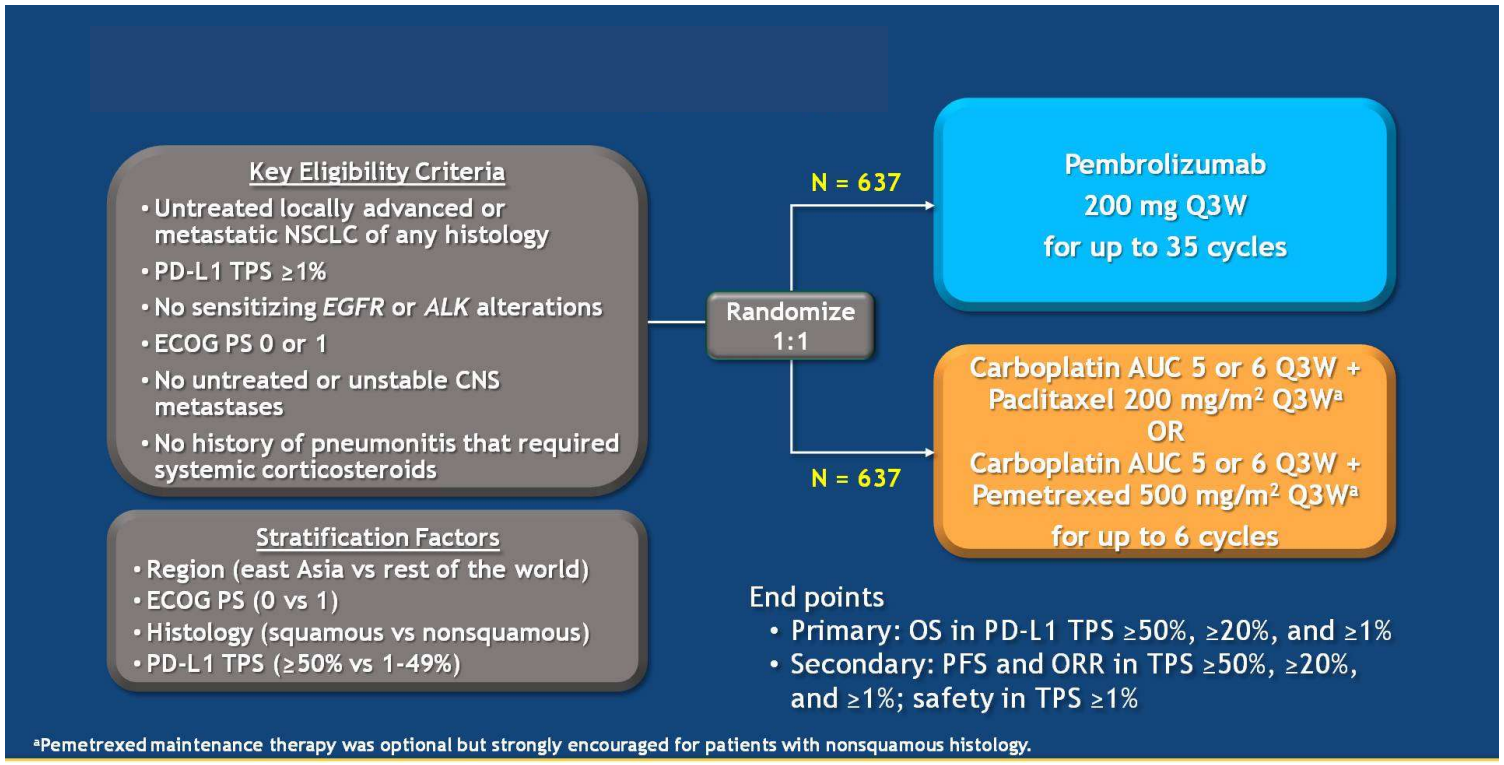
Overall Survival

	Events, n	Median, mo	HR (95% CI)	*P*
Pembro	44	NR	0.60 (0.41-0.89)	0.005
Chemo	64	NR		



Reck M et al, ESMO 2016, NEJM 2016

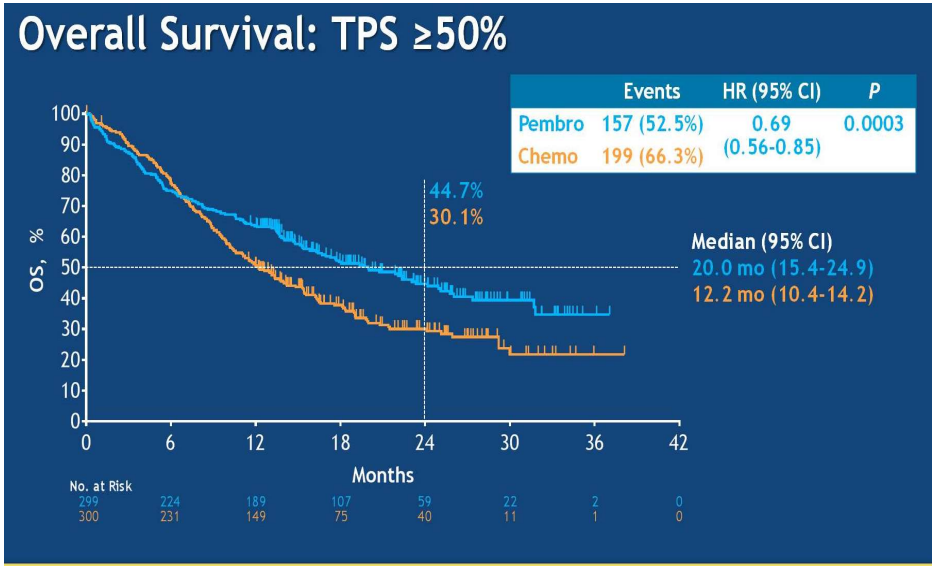
KEYNOTE-042: Pembrolizumab vs. Chemotherapy for PD-L1 ≥ 1% NSCLC

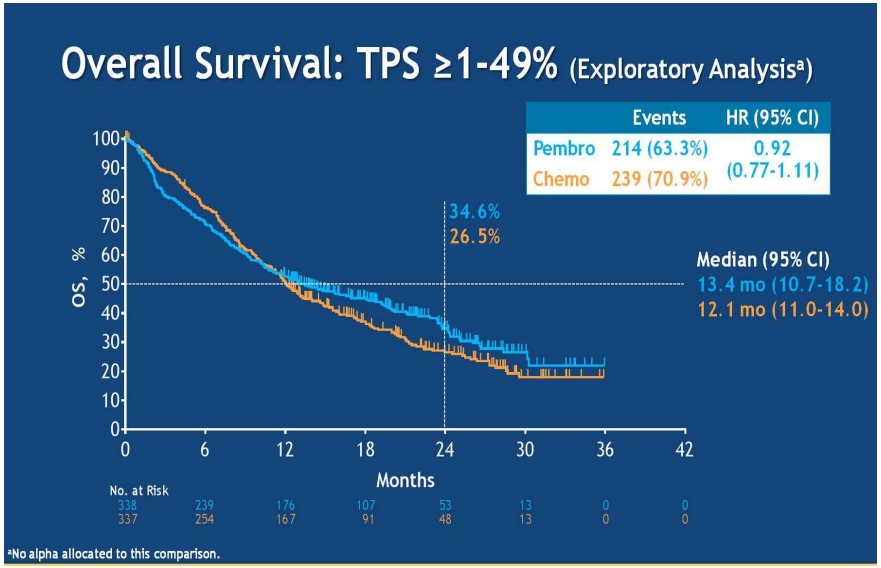


Lopes et al, ASCO 2018

KEYNOTE-042: Pembrolizumab vs. Chemotherapy for PD-L1 ≥ 1% NSCLC

Overall Survival

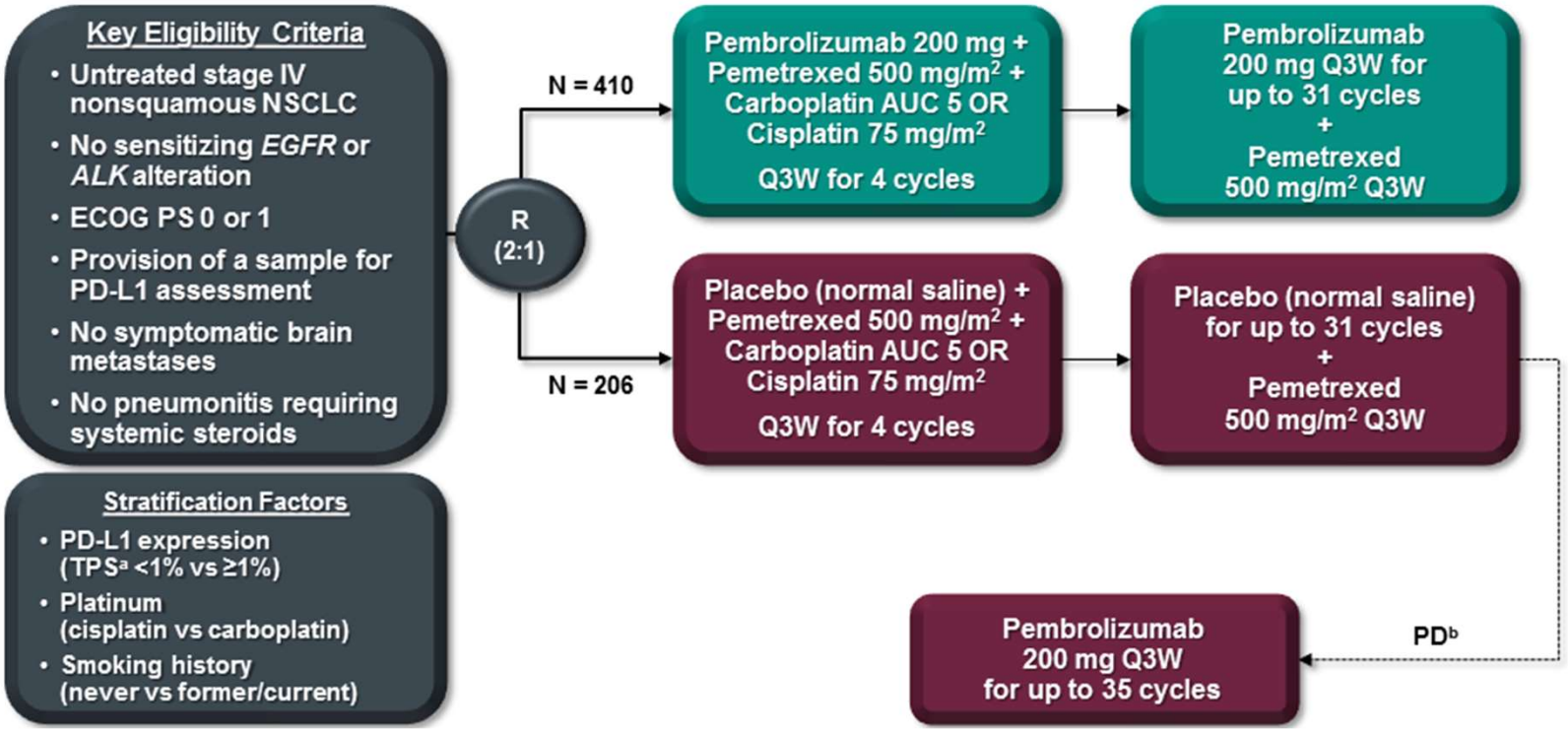




Survival benefit seemed to be driven by the TPS ≥ 50% subset with little benefit witnessed in the subset TPS = 1 - 49%

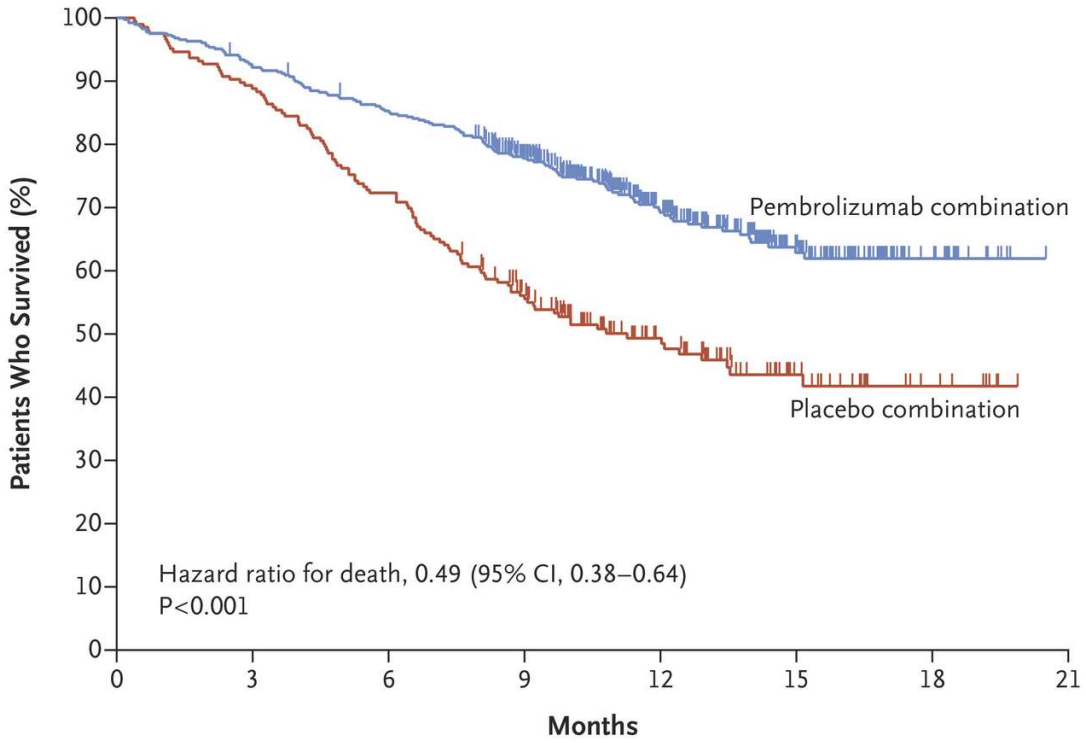
Lopes et al, ASCO 2018

KEYNOTE-189: Pembrolizumab/Platinum /Pemetrexed vs Chemotherapy Alone for Advanced Non-Squamous NSCLC



Ghandi et al, NEJM 2018

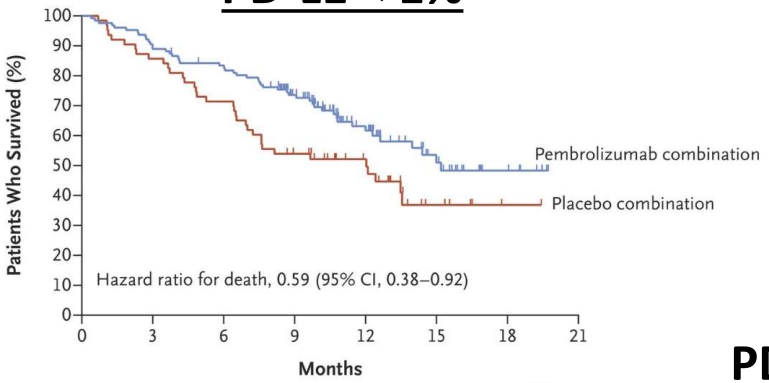
KEYNOTE-189: Pembrolizumab/Platinum /Pemetrexed vs Chemotherapy Alone for Advanced Non-Squamous NSCLC



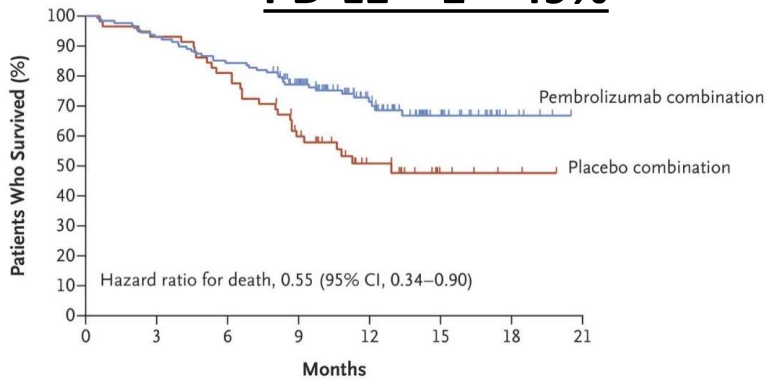
Ghandi et al, NEJM 2018

KEYNOTE-189: Pembrolizumab/Platinum /Pemetrexed vs Chemotherapy Alone for Advanced Non-Squamous NSCLC

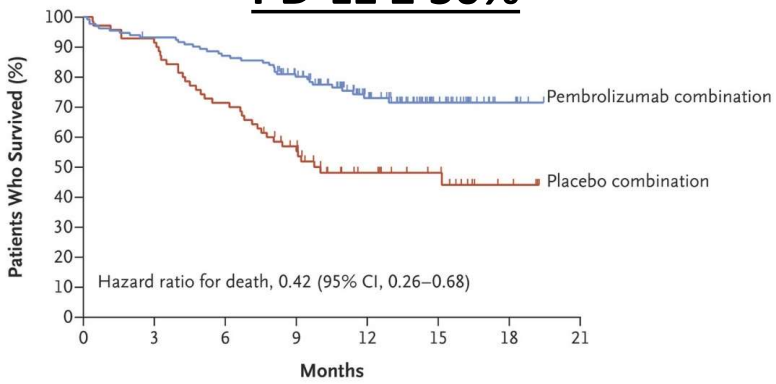
PD-L1 < 1%



PD-L1 = 1 – 49%

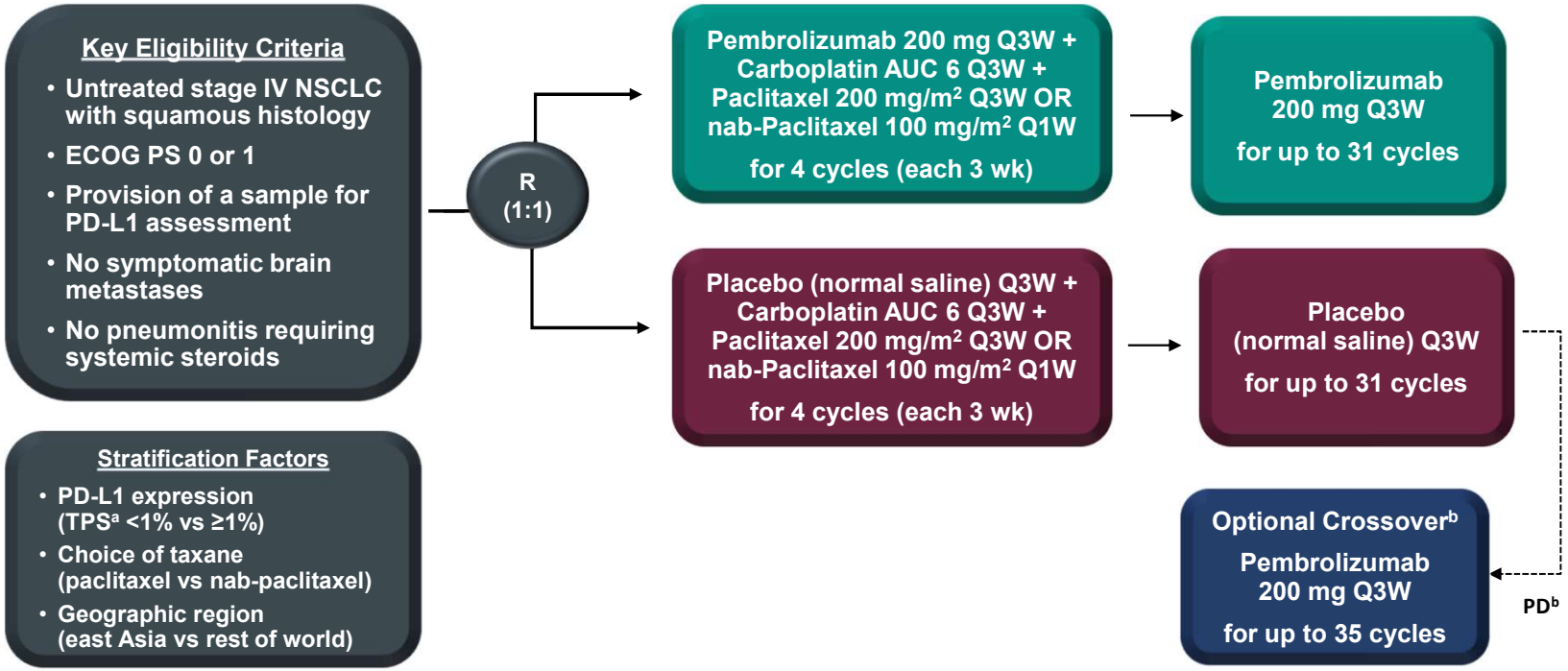


PD-L1 ≥ 50%



Ghandi et al, NEJM 2018

KEYNOTE-407: Pembrolizumab/Chemotherapy vs Chemotherapy Alone for Advanced Squamous-Cell NSCLC

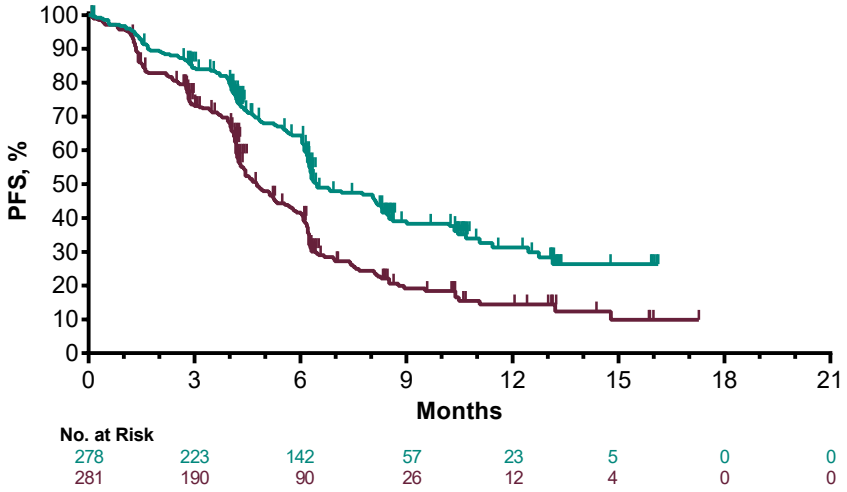


Paz-Ares et al, ASCO 2018

KEYNOTE-407: Pembrolizumab/Chemotherapy vs Chemotherapy Alone for Advanced Squamous-Cell NSCLC

PFS (RECISTv1.1, BICR)

	Events	HR (95% CI)	*P*
Pembro + Chemo	54.7%	0.56 (0.45-0.70)	<0.0001
Placebo + Chemo	70.1%		

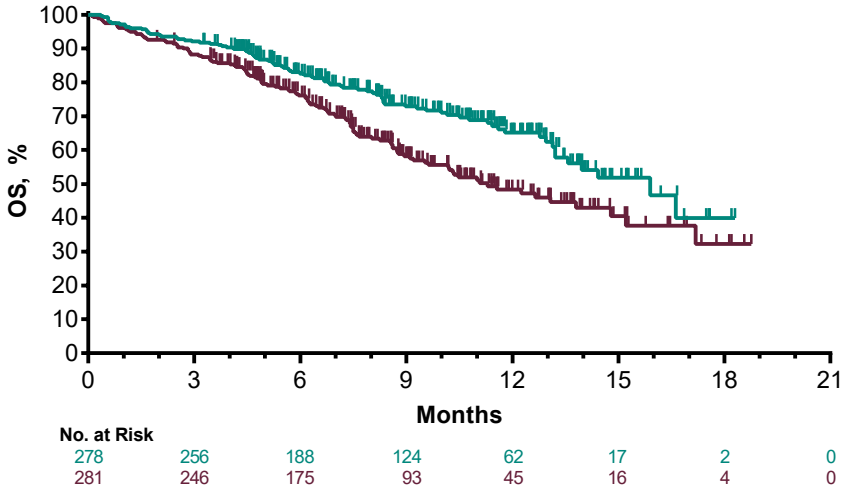


No. at Risk

278	223	142	57	23	5	0	0
281	190	90	26	12	4	0	0

Overall Survival

	Events	HR (95% CI)	*P*
Pembro + Chemo	30.6%	0.64 (0.49-0.85)	0.0008
Placebo + Chemo	42.7%		

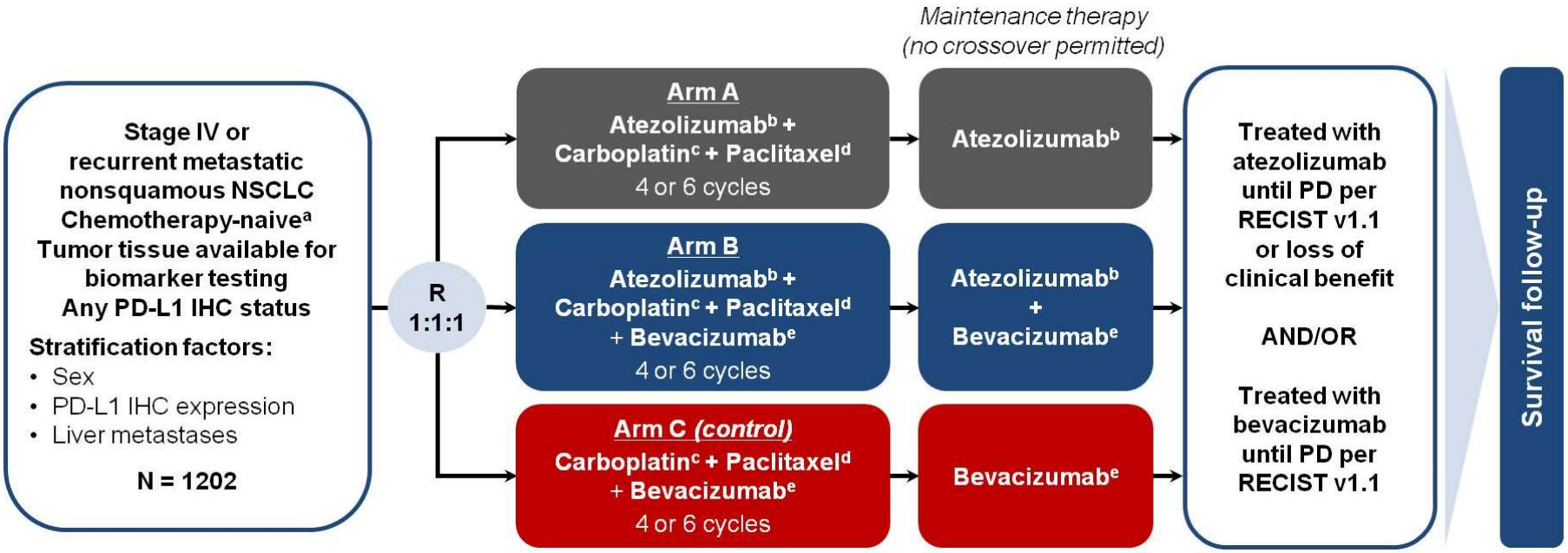


No. at Risk

278	256	188	124	62	17	2	0
281	246	175	93	45	16	4	0

Paz-Ares et al, ASCO 2018

IMPOWER 150: Atezolizumab/Carboplatin/ Paclitaxel/Bevacizumab vs Carboplatin/Paclitaxel/ Bevacizumab in Advanced Non-Squamous NSCLC

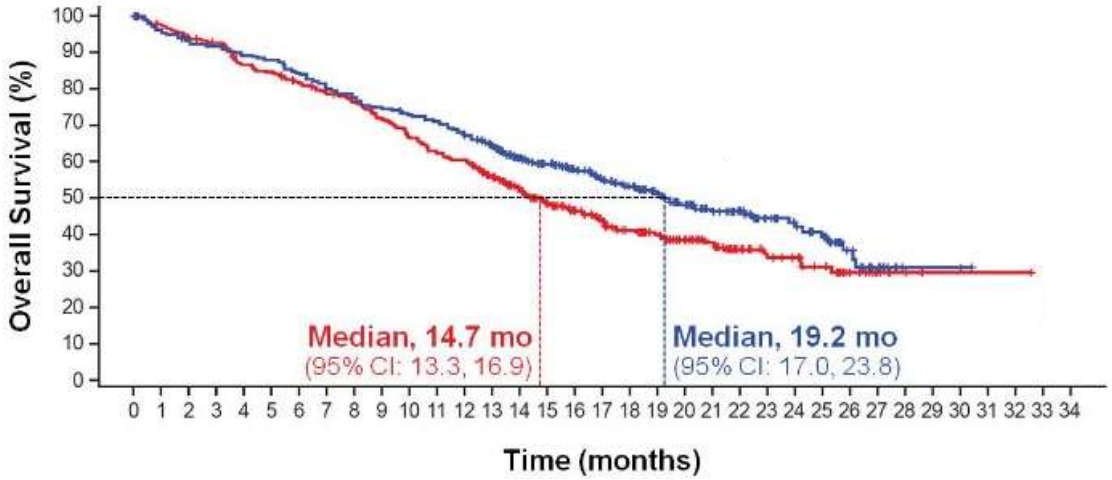


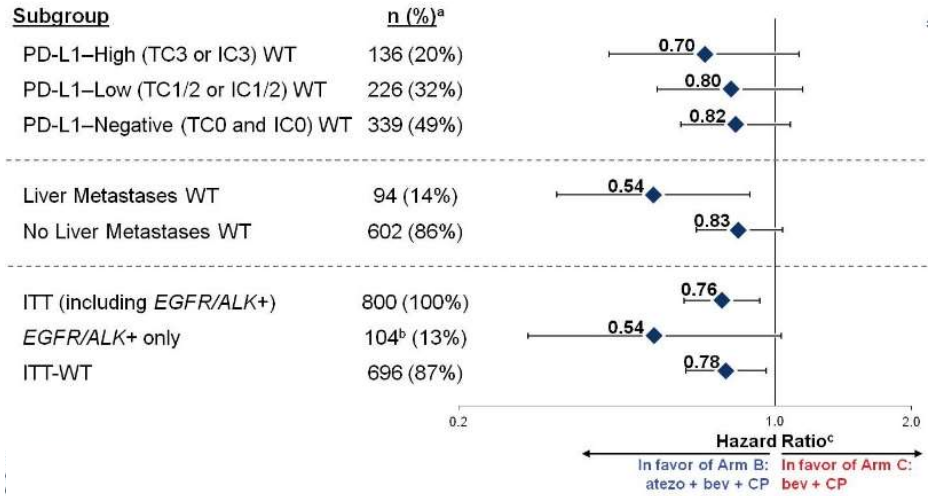
Socinski et al, NEJM 2018

IMPOWER 150: Atezolizumab/Carboplatin/ Paclitaxel/Bevacizumab vs Carboplatin/Paclitaxel/ Bevacizumab in Advanced Non-Squamous NSCLC

Landmark OS, %	Arm B: atezo + bev + CP	Arm C: bev + CP
12-month	67%	61%
18-month	53%	41%
24-month	43%	34%

HR[a], 0.78
(95% CI: 0.64, 0.96)
***P* = 0.0164**
Median follow-up: ~20 mo

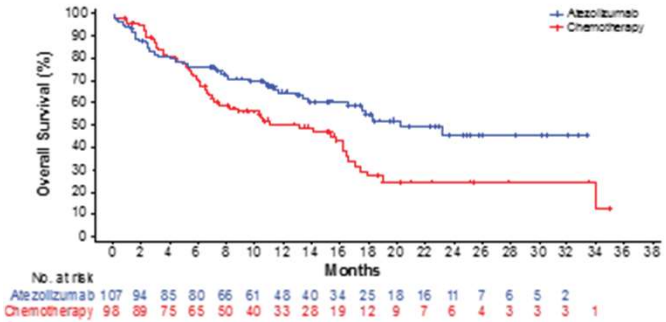




Socinski et al, NEJM 2018

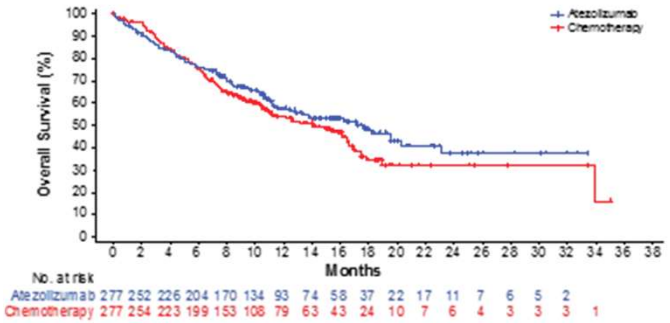
IMpower110: Atezolizumab vs chemotherapy in 1L NSCLC

SP142 (TC3 or IC3-WT)[a]



	Atezo (n = 107)	Chemo (n = 98)
mOS, mo	20.2	13.1
HR[b] (95% CI)	0.59 (0.40, 0.89)	

SP142 (TC1/2/3 or IC1/2/3-WT)[a]

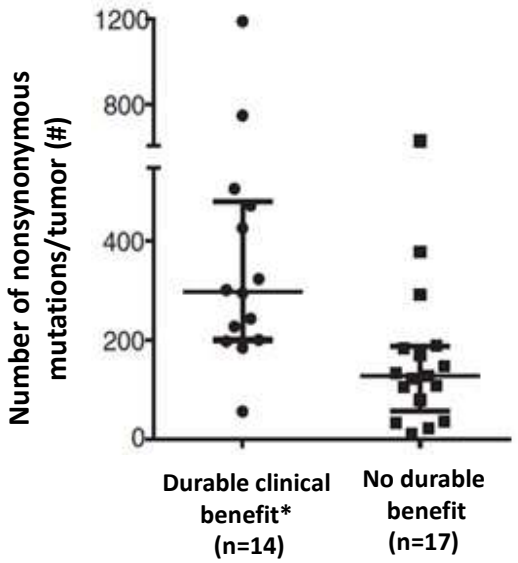


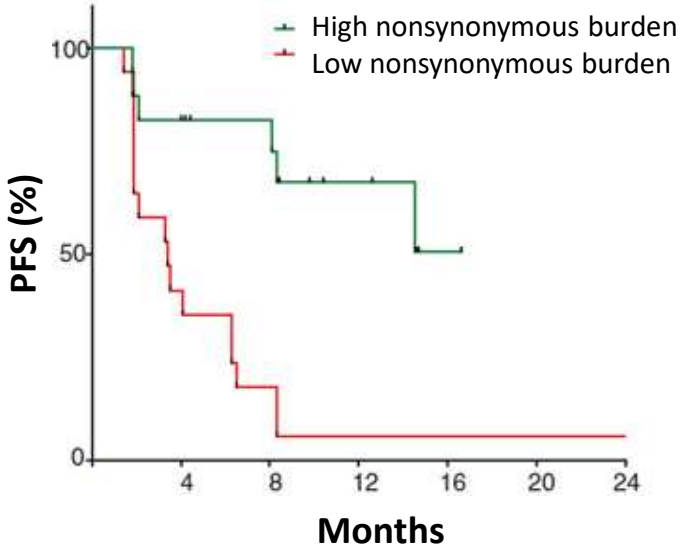
	Atezo (n = 277)	Chemo (n = 277)
mOS, mo	17.5	14.1
HR[b] (95% CI)	0.83 (0.65, 1.07)	

Herbst, ESMO-IO 2019.

Tumor Mutational Burden (TMB) may Determine Sensitivity to PD-1 Blockade in NSCLC

In two independent cohorts, higher nonsynonymous tumor mutational burden (TMB) was associated with improved objective response, durable clinical benefit, and PFS.

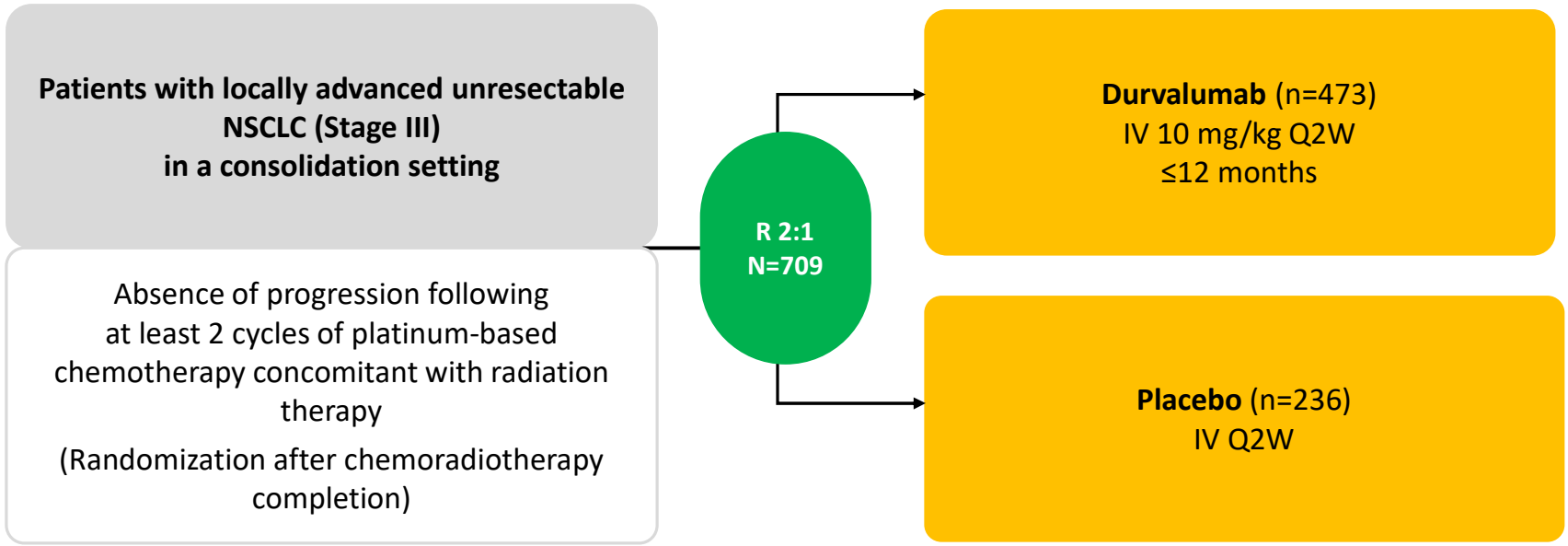




***Partial or stable response lasting > 6 mo**

Rizvi N et al, Science, 2015

PACIFIC (NCT02125461): Durvalumab after chemoradiotherapy in Stage III NSCLC

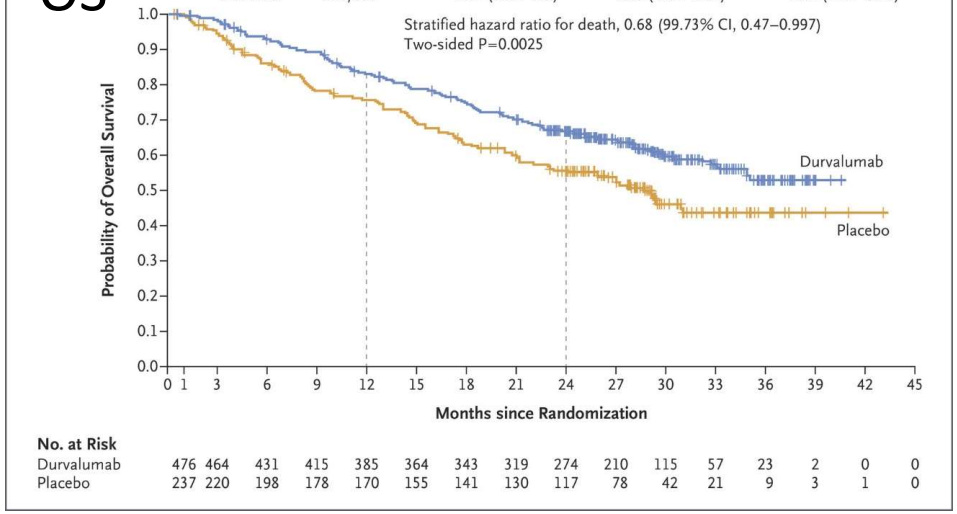


Antonia et al, NEJM 2018

PACIFIC (NCT02125461): Durvalumab after chemoradiotherapy in Stage III NSCLC

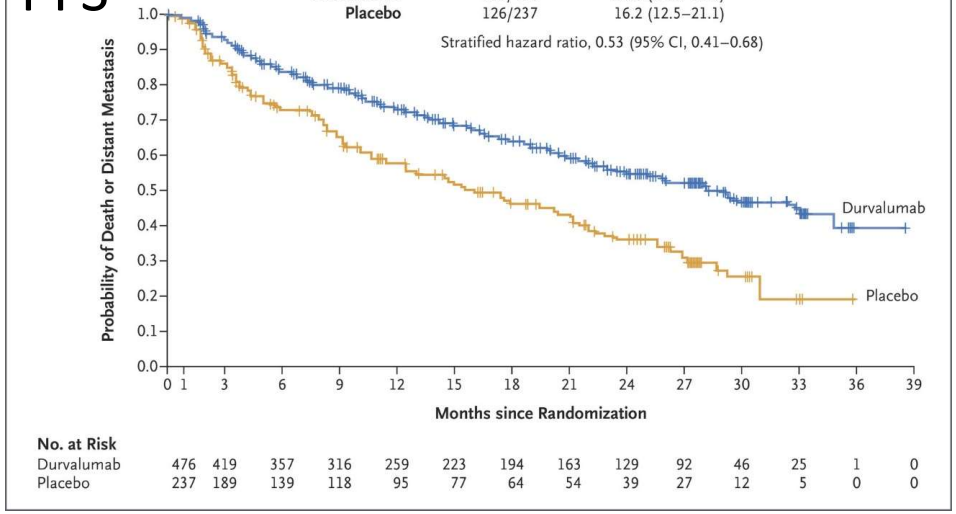
OS

	No. of Events/ Total No. of Patients	Median Overall Survival (95% CI)	12-Mo Overall Survival Rate (95% CI)	24-Mo Overall Survival Rate (95% CI)
		mo	%	%
Durvalumab	183/476	NR (34.7–NR)	83.1 (79.4–86.2)	66.3 (61.7–70.4)
Placebo	116/237	28.7 (22.9–NR)	75.3 (69.2–80.4)	55.6 (48.9–61.8)



PFS

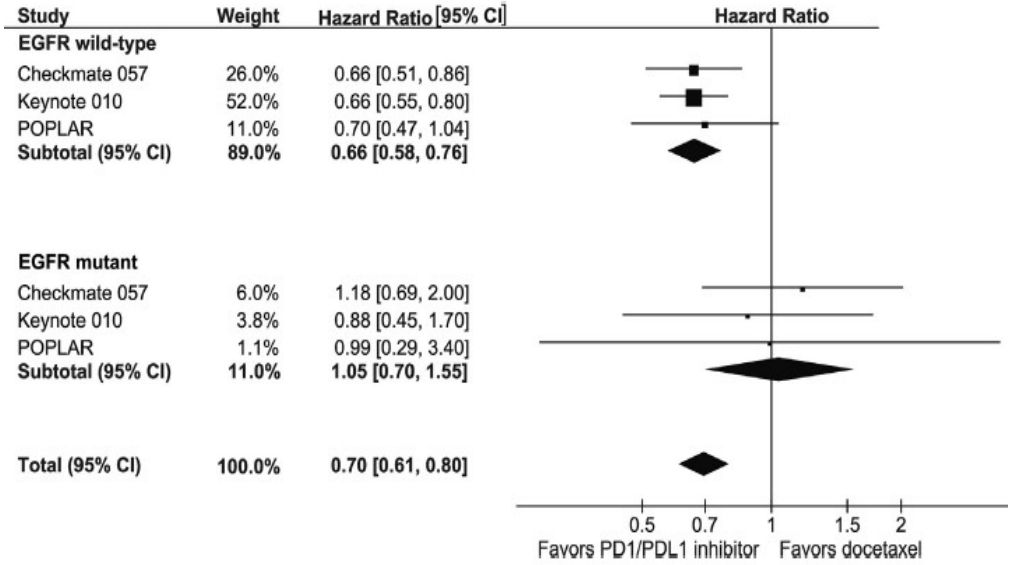
	No. of Events/ Total No. of Patients	Median Time to Death or Distant Metastasis (95% CI)
		mo
Durvalumab	182/476	28.3 (24.0–34.9)
Placebo	126/237	16.2 (12.5–21.1)



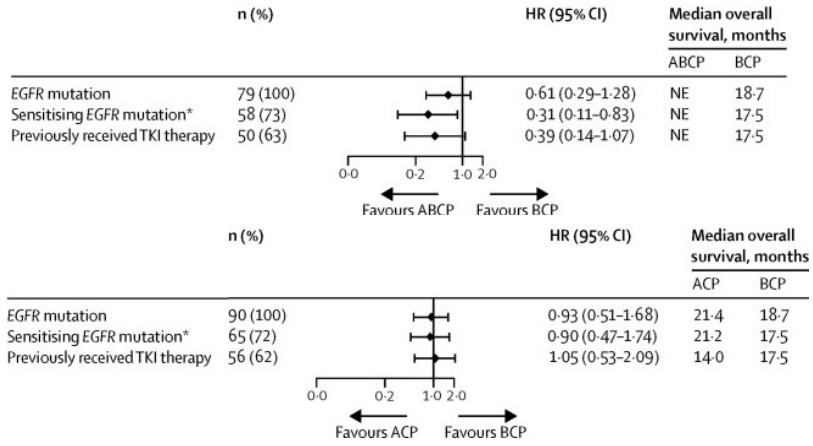
Antonia et al, NEJM 2018

Checkpoint Inhibitors in Metastatic EGFR-Mutated NSCLC

Meta-Analysis: CM-057, KN-010, POPLAR; IMPOWER-150



IMPOWER-150



CK Lee et al., JTO 2016
M Reck et al., Lancet Resp Med 2019

PD-1/PD-L1 Inhibitors Increase *Overall Survival* in 2L Advanced NSCLC

CHECKMATE 017 (nivolumab)

	Median Overall Survival *mo (95% CI)*	1-Yr Overall Survival *% of patients (95% CI)*	No. of Deaths
Nivolumab (N–135)	9.2 (7.3–13.3)	42 (34–50)	86
Docetaxel (N–137)	6.0 (5.1–7.3)	24 (17–31)	113

CHECKMATE 057 (nivolumab)

	Nivolumab (n = 292)	Docetaxel (n = 290)
mOS, mo	12.2	9.4
HR = 0.73 (96% CI: 0.59, 0.89); *P* = 0.0015		

KEYNOTE 010 (TPS ≥ 1%) (pembrolizumab)

Treatment Arm	Median (95% CI), mo	HR* (95% CI)	P
Pembro 2 mg/kg	14.9 (10.4-NR)	0.54 (0.38-0.77)	0.0002
Pembro 10 mg/kg	17.3 (11.8-NR)	0.50 (0.36-0.70)	<0.0001
Docetaxel	8.2 (6.4-10.7)	--	--

OAK (atezolizumab)

HR, 0.73[a]
(95% CI, 0.62, 0.87)
P = 0.0003

Minimum follow up = 19 months

Brahmer NEJM 2015
Borghaei, NEJM 2015
Herbst Lancet 2016
Rittmeyer Lancet 2017

Small cell lung cancer

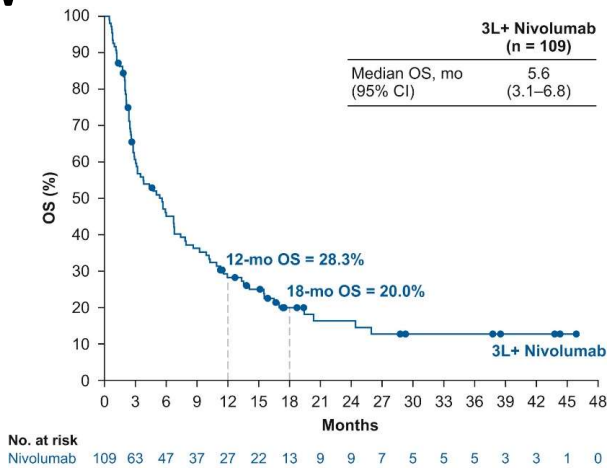
- 10-15% of lung cancers
- Almost exclusively former/current smokers
- Median survival 1-2 years after diagnosis
- Until recently, only one FDA-approved 2nd line option: topotecan – DOR: 3.3 months
- Recent approvals of immunotherapies mark the first progress in decades

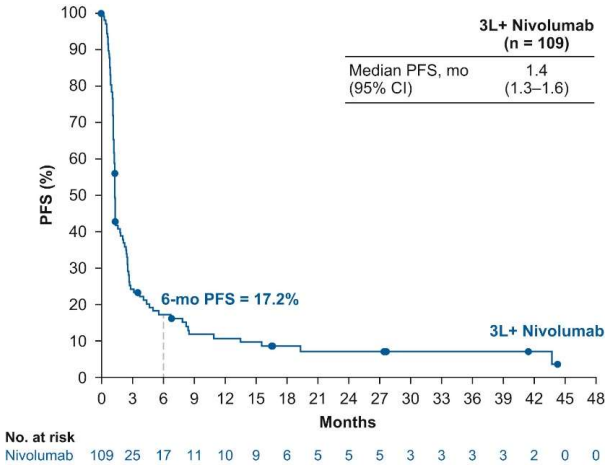
Approved checkpoint inhibitors in SCLC

Drug	Indication	Dose
Nivolumab	Metastatic small cell lung cancer with progression on Pt-chemotherapy and one other therapy (**3rd line**)	240 mg Q2W
Pembrolizumab	Metastatic small cell lung cancer with progression on Pt-chemotherapy and one other therapy (**3rd line**)	200 mg Q3W or 400 mg Q6W
Atezolizumab + carboplatin + etoposide	**1st line** extensive stage SCLC	For 4 cycles: atezolizumab 1200 mg + carboplatin + etoposide Q3W Maintenance: 840 mg Q2W, 1200 mg Q3W, or 1680 mg Q4W
Durvalumab + etoposide + carboplatin/cisplatin	**1st line** extensive stage SCLC	For 4 cycles: 1500 mg durvalumab Q3W + chemotherapy; Maintenance: 1500 mg durvalumab Q4W

CheckMate-032: Nivolumab in 3rd line SCLC

- Nivolumab in SCLC with progression on platinum chemotherapy and another therapy
- Nivolumab 3 mg/kg Q2W
- @28.3 months:
  - ORR: 11.9%
  - mDOR: 17.9 months

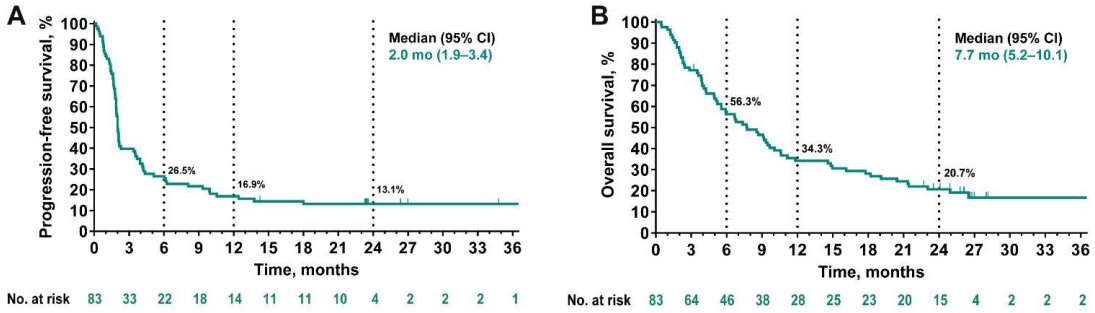




Ready, J Thorac Oncol 2019

Pembrolizumab in 3rd-line SCLC

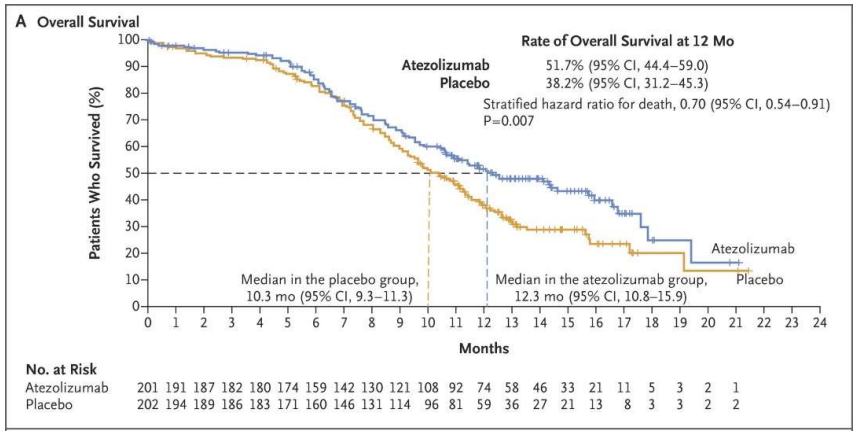
- KEYNOTE-028: PD-L1+ only (Cohort C1)
- KEYNOTE-158: PD-L1 +/- (Cohort G)
- Combined analysis:
- ORR: 19.3%
  - 2 CR, 14 PR
  - 14/16 responders were PD-L1+
  - 9/16 responders had response ≥18 mo.
- mOS: 7.7 months



Chung, J Thor Oncol 2020
Ott, J Clin Oncol 2017.

IMpower133: Atezolizumab + chemo in 1st-line SCLC

- Induction phase: four 21-day cycles of carboplatin and etoposide + atezolizumab (1200 mg once per cycle) or placebo
- Maintenance phase: either atezolizumab or placebo
- @13.9 mo:
  - mOS = 12.3 vs 10.3 mo
  - mPFS = 5.2 vs 4.3 mo



Horn, NEJM 2018.

Immunotherapy for mesothelioma

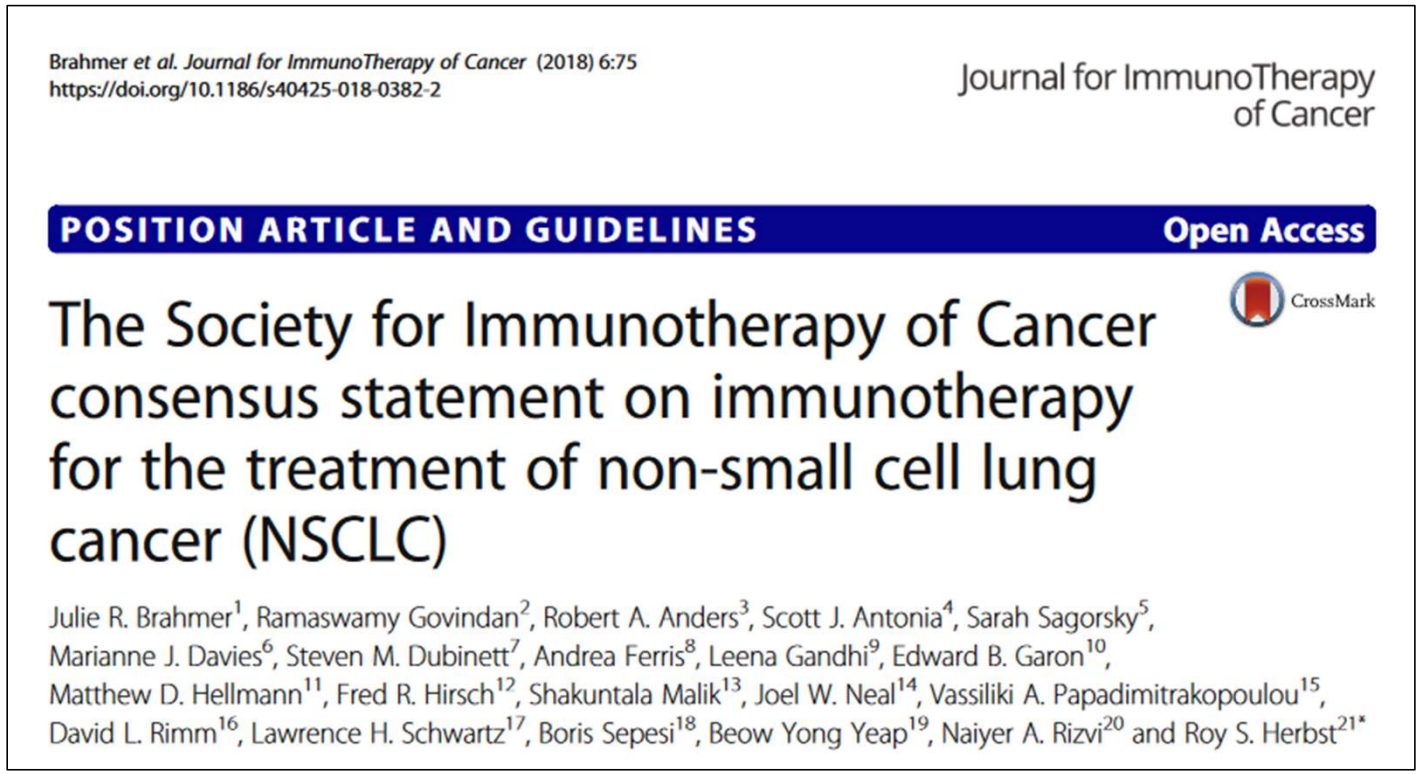
Drug	Indication	Dose
Nivolumab + ipilimumab	Frontline unresectable malignant pleural mesothelioma	Nivolumab 360 mg Q3W + ipilimumab 1 mg/kg Q6W

- Approval based on CheckMate 743
  - Nivolumab + ipilimumab vs platinum-based chemotherapy
  - Median OS: 18.1 months vs 14.1 months
  - 2-year OS: 41% vs 27%
  - Median PFS: 6.8 months vs 7.2 months
- First FDA approval for mesothelioma since 2004

Conclusions

- NSCLC has been a proving ground for checkpoint inhibitors
- Moving from 2nd/3rd line options to the front line
- Optimal initial immunotherapy is rapidly evolving
- Clear-cut biomarkers still lacking

Resources



Brahmer *et al. Journal for ImmunoTherapy of Cancer* (2018) 6:75
https://doi.org/10.1186/s40425-018-0382-2

Journal for ImmunoTherapy of Cancer

POSITION ARTICLE AND GUIDELINES Open Access

The Society for Immunotherapy of Cancer consensus statement on immunotherapy for the treatment of non-small cell lung cancer (NSCLC)

Julie R. Brahmer[1], Ramaswamy Govindan[2], Robert A. Anders[3], Scott J. Antonia[4], Sarah Sagorsky[5], Marianne J. Davies[6], Steven M. Dubinett[7], Andrea Ferris[8], Leena Gandhi[9], Edward B. Garon[10], Matthew D. Hellmann[11], Fred R. Hirsch[12], Shakuntala Malik[13], Joel W. Neal[14], Vassiliki A. Papadimitrakopoulou[15], David L. Rimm[16], Lawrence H. Schwartz[17], Boris Sepesi[18], Beow Yong Yeap[19], Naiyer A. Rizvi[20] and Roy S. Herbst[21*]

Society for Immunotherapy of Cancer
ADVANCES IN Cancer IMMUNOTHERAPY™

Case Studies

Case Study 1

- A 65 y.o. gentleman is referred to you with newly diagnosed metastatic lung adenocarcinoma.
- The patient initially presented with a chronic cough and subsequently underwent a CXR and CT chest with his family MD. This revealed a large RLL mass which was biopsied revealing lung adenocarcinoma. Subsequent reflex NGS was negative and PDL1 was 15%.
- The patient has undergone a recent MRI brain and PET/CT which reveals a 4 cm RLL mass, mediastinal LN, bone and liver metastases. The patient has no significant pain associated with bone metastases and is ECOG 1.
- Physical examination and bloodwork are unremarkable.
- What initial therapy would you recommend to this patient and why?

Case Study 1

- What initial therapy would you recommend to this patient and why?
  - Pembrolizumab
  - Carboplatin-Pemetrexed-Pembrolizumab
  - Ipilimumab-Nivolumab with initial Carboplatin-Pemetrexed
  - Carboplatin-Paclitaxel-Atezolizumab-Bevacizumab

Case Study 1

- The patient undergoes 3 cycles of carboplatin-pemetrexed-pembrolizumab with an excellent radiographic response on subsequent restaging CT CAP.
- The patient subsequently completes 4 cycles of carboplatin-pemetrexed-pembrolizumab and then transitions to pemetrexed-pembrolizumab maintenance.
- 6 months after beginning treatment, he develops blisters over his hands, arms and feet. He does not have associated fever or involvement of any mucosal surfaces.
- What is the most likely diagnosis and appropriate management?

Case Study 1

- What is the most likely diagnosis and appropriate management?
  - SJS/TEN – hold drug, obtain skin biopsy, admit to burn unit and treat with cyclosporine + prednisone
  - Bullous Pemphigoid – hold drug, obtain skin biopsy, treat with topical steroids + rituximab or omalizumab
  - Cellulitis exacerbated by immunotherapy – admit for IV antibiotics
  - Pemetrexed rash – discontinue pemetrexed and treat supportively

Case Study 2

- A 54 y.o. woman is referred to you with newly diagnosed Stage IIIA squamous cell lung cancer (T2N2M0).
- She initially presented with a chronic cough and small volume hemoptysis. She subsequently underwent a CT chest and bronchoscopy revealing a 4.3 cm RLL mass with biopsy consistent with squamous cell carcinoma (PDL1 5%). EBUS biopsy revealed multi-station N2 disease.
- Subsequent MRI brain and PET/CT did not reveal evidence of distant metastases or LN involvement beyond the aforementioned N2 stations.
- What would you recommend as initial management?

Case Study 2

- What would you recommend as initial management?
  - Surgical resection then adjuvant chemotherapy and PORT
  - Neoadjuvant chemotherapy, surgical resection then PORT
  - Chemoradiotherapy then surgical resection
  - Chemoradiotherapy then durvalumab

Case Study 2

- The patient completes chemoradiotherapy complicated by esophagitis. She undergoes a repeat CT CAP after completion of chemoradiotherapy revealing no evidence of disease progression.
- She then completes 1 year of durvalumab without complication.
- Ongoing surveillance imaging at 2 years reveals no evidence of disease recurrence.