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ONCOLOGY COMPASS
# Digest

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*Breast cancer cells, photo credit by National Cancer Institute*

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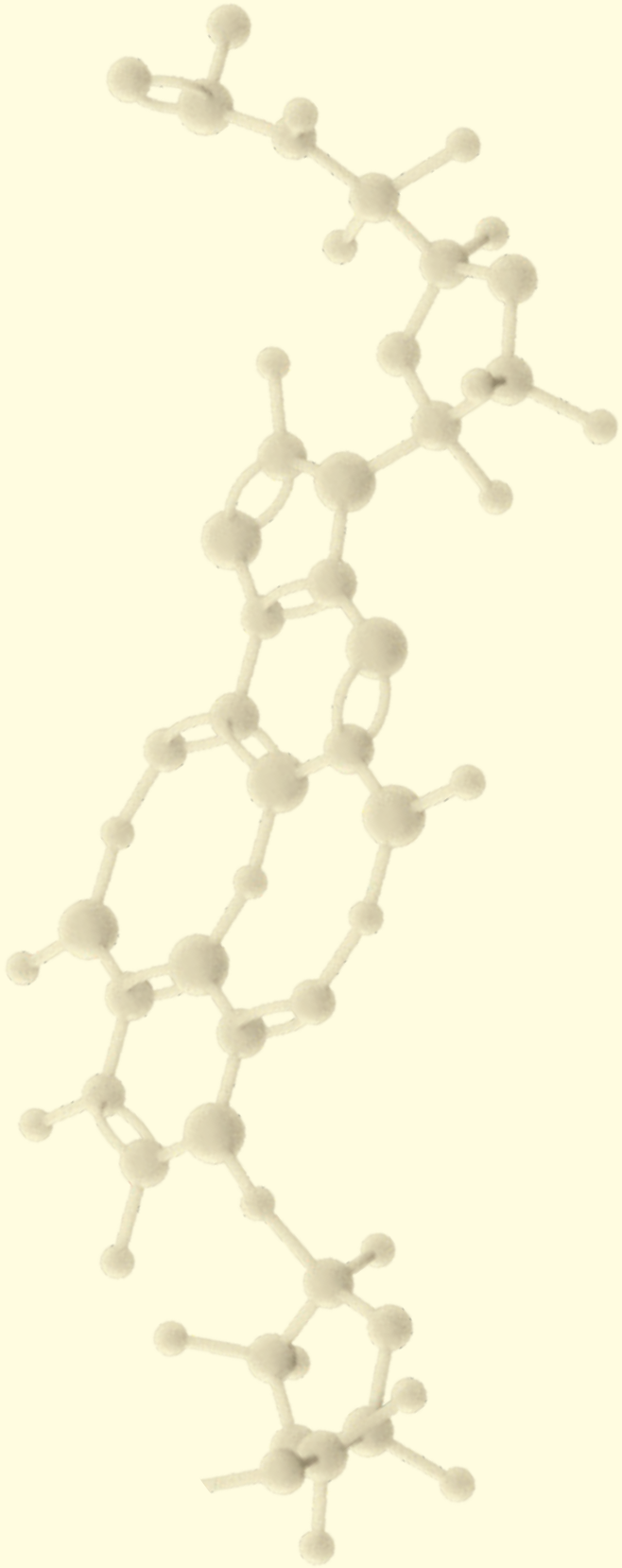


RAISING AWARENESS

# FIGHTING FOR BREAST CANCER JUSTICE IN SWITZERLAND: CHRISTINA CHRISTEN INTERVIEW

BY ANNE JÄKEL

**Christina Christen, President of Europa Donna Switzerland, has made it her mission to raise awareness of breast cancer and the importance of early detection in Switzerland.**

**Her passion and commitment go far beyond what one would expect from a volunteer leadership role.**

**Since taking office, she has launched numerous projects that not only support patients, but also initiate political and social changes.**

As an advocate for greater justice and equal opportunities in early breast cancer detection, Christina Christen faces challenges every day. But with a clear goal in mind – establishing a comprehensive, quality-assured mammography screening program – she is determined to overcome these hurdles.

Her work also includes strengthening initiatives such as Tavola Rosa, a network that connects and supports those affected.

*Photo credit: Photo courtesy of Europa Donna Switzerland*

In the following interview, Christina shares her accomplishments, the challenges of her presidency, and her vision for the future.

## Milestones of her presidency

**Ms. Christen, what have been your most significant achievements in your presidency so far?**

My greatest success was the Pink Cube awareness campaign in September and October 2024, which, according to our media analysis, achieved an impressive reach across various media channels such as print, web, and TV, thereby raising awareness among many people about the importance of early breast cancer detection.

Since 2022, Europa Donna Switzerland has been the patron of this initiative, and this year, we were finally heard.

The results speak for themselves. Additionally, during my term, we have been able to establish three more Tavole Rose in Switzerland.

These gatherings provide a safe space for affected women to share experiences and find support.

**In which areas would you particularly like to drive change during your term?**

My greatest goal is to implement a comprehensive, quality-assured mammography screening program in all Swiss cantons. Additionally, I aim to establish a Tavola Rosa in every canton. These networks are essential for supporting women on their personal breast cancer journey.

**What barriers stand in the way of implementing such programs?**

During the Pink Cube campaign, I had the pleasure of speaking with government representatives from the cantons of Zurich and Lucerne.

A major issue that became evident is the deeply rooted misunderstandings


*Photo credit: Christina Christen at the Pink Cube event in Lucerne, photo courtesy of Credo GmbH*

or lack of awareness about early detection programs, which have been ingrained in people's minds since 2009.

It is often argued that overdiagnoses are a problem, but these assumptions have long been disproven.

However, it is easier and cheaper not to make a decision. Structural challenges, such as the lack of tumor boards or insufficient experience among radiologists, also slow progress.

Fortunately, the canton physician of Zurich listened to me attentively, which gives hope that the situation might improve in the future. Conversations like these are essential to fostering dialogue and developing long-term solutions.

## Collaboration as the key to success

**In keeping with the motto "Stronger together" – how do you promote collaboration with other healthcare organizations?**

Our collaboration with the Swiss Cancer League through the Pink Cube project was a great success. We informed the Cancer League about our project, which led to them joining our initiative and actively supporting us.

Additionally, we are promoting the newly founded Metastatic Breast Cancer association, which recently

gained guest status in our delegates' assembly.

We support the association as much as possible, for example by using our channels to amplify their concerns. Furthermore, we are a member of the new umbrella organization Swiss Capa, which unites various cancer patient organizations under one roof.

These partnerships give us a stronger voice in shaping the Swiss Cancer Plan, as they help us bring our messages and demands more effectively into the political discussion.

**Bettina Borisch is a Professor of Public Health at the University of Geneva and a former president of Europa Donna. Her scientific work focuses on breast cancer and neoplastic diseases of the immune system, and she has been committed for years to breast cancer early detection and education. What makes your collaboration with Bettina Borisch particularly valuable?**

Bettina and I share a common goal: promoting early detection programs. I have known Bettina Borisch since I joined Europa Donna Switzerland, when she was still president, around 2006.

She not only brings valuable expertise and knowledge from European countries, but also understands the complex situation and challenges in Switzerland very well. The country's federalism and often hesitant approach toward early detection programs are not unfamiliar to her.

Her support is essential to our mission, as her international focus and experience strengthen us, while I concentrate on the work within Switzerland.

Together, we are strong: she operates on a European level, and I seek allies within the country, with whom I have been pursuing a shared political goal since October 2023.
Bettina Borisch not only advises me but also provides valuable data and analyses on mammography screening programs from European countries and Switzerland, which greatly support our arguments and efforts.

Her expertise and our shared commitment are crucial to making progress in Switzerland.

## Results and impact

**How do you evaluate the impact of the Pink October initiatives?**

The results of Pink Cube are impressive. We reached a broad audience and were able to highlight important topics. The campaign achieved a reach of over 1.59 million people through radio and TV, as well as 0.83 million in online media, underscoring the significance of such initiatives.

I personally participated in several events to encourage women and promote the establishment of additional Tavole Rose. However, it remains a challenge to accomplish all of this on a voluntary basis alongside my 80% job.

## Looking ahead

**How has the conversation around early detection changed since you took office, and where is it heading?**

Since I took office, several cantons have announced plans to introduce a quality-assured mammography screening program by 2026. This puts pressure on other cantons and increasingly holds them accountable to take action as well. I hope to achieve my goal of a nationwide program in Switzerland by 2027.

A key concern for me is ensuring that all women in Switzerland have equal rights and equal access to cancer early detection programs.

It is unacceptable to shift the responsibility to the cantons, thereby tolerating inequalities in access to these essential programs. I am fighting resolutely for this – equal rights for all.

**What message would you like to share with women and men in Switzerland?**

Dear women and men, take responsibility for your health. Use the opportunity to get a mammogram at certified centers – it can save lives. One in eight women in Switzerland will be diagnosed with breast cancer during her lifetime, and about 50 men are also affected every year.

The key is detecting breast cancer as early as possible. The earlier the diagnosis, the less aggressive the treatment and the significantly higher the chances of survival. Unfortunately, in Switzerland, one person still dies from breast cancer every six hours.

Be vigilant and pay attention to changes. Partners can play an important role by noticing and addressing any changes. Young women are not exempt – one in five breast cancer diagnoses affects a woman under 50.

Get to know your body, perform regular self-examinations, and never delay seeing a doctor if you notice something unusual. If you are currently affected by breast cancer or have been in the past, do not hesitate to reach out to a Tavola Rosa. These networks provide a safe space to connect informally with others affected – whether through personal meetings or online chats.

It is a community created by those affected, for those affected, showing that no one has to face this diagnosis alone.

Together, we can support and empower one another.

**Ms. Christen, we thank you for this interview.**

*This article was kindly supported by Gilead Sciences Switzerland (CH-UNB-0856, Jan 25)*

PATIENTS' PERSPECTIVES

# JO KNIGHT'S MISSION TO TRANSFORM THE LIVES OF CANCER PATIENTS

BY ANNE JÄKEL

**For millions of cancer patients around the world, the diagnosis is just the beginning of an arduous journey. Beyond the physical and emotional toll of the disease and its treatment, cancer patients often face challenges that extend into their identity, self-esteem, and daily lives. One of these profound challenges is hair loss due to chemotherapy.**

**For many, it's not just hair; it's a piece of their identity that chemotherapy strips away. Enter Jo Knight—a breast cancer survivor from the United Kingdom turned advocate and innovator, whose relentless drive to bring dignity and comfort to fellow cancer patients is nothing short of transformative.[1]**

*Photo credit: Jo Knight, photo courtesy of Jo Knight*

### Persistent chemotherapy-induced alopecia

Hair loss from chemotherapy, or chemotherapy-induced alopecia (CIA), is one of the most visible and distressing side effects of cancer treatment.[2]

While some patients experience regrowth after treatment, others face persistent chemotherapy-induced alopecia (pCIA), a condition that leaves them without their hair for years or even permanently.

This condition isn't just cosmetic; it affects patients' mental health, social interactions, and even their ability to feel like themselves.[2]

Despite advances in treatment, pCIA remains under-discussed in oncology care, leaving patients to navigate this deeply personal issue on their own. Many turn to wigs, scarves, or hats as coping mechanisms, but these solutions often feel insufficient. Jo Knight knows this struggle firsthand. Her experiences with breast cancer and pCIA shaped her mission to bring change to the way patients approach hair loss and their overall recovery journey.[1]

### Turning pain into purpose

Jo Knight's journey began as a patient, grappling with the aftermath of chemotherapy and the toll it took on her sense of self. As she rebuilt her life, she noticed a glaring gap in how the healthcare system addressed long-term side effects like hair loss. Rather than accepting this gap, Jo became a voice for change.

Her first step was advocacy. Jo started speaking openly about pCIA, sharing her story to raise awareness about the issue. She wanted oncologists and patients alike to recognize pCIA not just as a side effect, but as a legitimate quality-of-life issue that deserved attention.[3]

But Jo didn't stop at awareness. She founded initiatives to provide tangible solutions for patients struggling with hair loss. Through her work

with Preloved Reloved, Jo began distributing preloved headscarves to patients who couldn't afford them.[1] She launched a fundraising campaign to cover postage costs, ensuring that financial barriers wouldn't prevent anyone from accessing this support.[4] What began as a small act of kindness quickly grew into a lifeline for countless patients.

**Innovation through community and social media**

Jo also harnessed the power of social media to expand her reach and build a supportive community. Her work with Novo Cabelo highlighted the emotional transformations that come with finding the right solutions for hair loss.[5]

Her own hair loss transformation garnered over 1 million views, underscoring the profound impact her advocacy had on patients seeking to reclaim their confidence.

This visibility wasn't just about spreading awareness; it was about normalizing the conversation around hair loss and pCIA. By sharing success stories and practical resources, Jo gave patients the tools they needed to advocate for themselves in their own cancer journeys. In doing so, she turned what is often an isolating experience into a shared, empowering one.

**Bringing scalp cooling technology to the forefront**

Beyond advocacy and community-building, Jo has been a staunch supporter of scalp cooling technology as a preventative measure against hair loss during chemotherapy. Scalp cooling involves reducing the temperature of the scalp during treatment to minimize hair follicle damage. While not a perfect solution, it has shown promise in reducing the severity of CIA for many patients.[2]

Jo collaborated with organizations like Paxman Scalp Cooling to promote this technology and ensure that more patients had access to it.[6]

*Photo credit: Jo Knight, photo courtesy of Jo Knight*

She emphasized the need for oncologists to discuss scalp cooling as an option during treatment planning, arguing that patients deserved the chance to make informed choices about their care. Jo's and other affected women's advocacy has been instrumental in pushing for wider adoption of this technology in oncology clinics.

**The bigger picture: redefining survivorship care**

Jo's work underscores a larger issue in oncology: the need to redefine survivorship care. Too often, the focus remains on treating the cancer itself, with less attention paid to the long-term effects on patients' quality of life. Advocates like Jo Knight remind us that survivorship isn't just about living after cancer; it's about living well.

Through her initiatives, Jo has shown that small, thoughtful interventions can make an enormous difference. Whether it's a headscarf, a scalp cooling cap, or simply knowing they aren't alone, cancer patients deserve care that addresses their whole being—not just their diagnosis.

**The ripple effect of advocacy**

Jo Knight's impact goes beyond the patients she directly supports. Her work has inspired other survivors to advocate for themselves and their peers, creating a ripple effect in the cancer care community. By raising awareness about pCIA and lobbying for practical solutions, Jo has helped shift the narrative around hair loss from one of shame to one of empowerment.

Jo's story is a powerful reminder of the role health care providers play in shaping patients' experiences. Addressing issues like pCIA doesn't just improve individual outcomes; it fosters trust, empathy, and a more holistic approach to care.

Her work reminds us that even the most overlooked aspects of cancer care, like hair loss, can have profound implications for patients' well-being.

As more healthcare professionals embrace this perspective, the hope is that patients like Jo will no longer have to fight for solutions—because they'll already be part of the standard of care.

ROBOTICS AND REALITY

# TACKLING THE SHORTAGE OF SKILLED SURGEONS IN GYNECOLOGICAL ONCOLOGY THROUGH INNOVATIVE TRAINING

BY ANNE JÄKEL

**Dr. Laila Najjari is an experienced physician and expert in gynecological oncology and urogynecology, with a particular focus on robotic-assisted surgery. She leads the Department of Robotic Gynecology at the University Hospital Aachen, Germany, and has extensive practical experience with the Da Vinci Xi system. Her expertise encompasses the use of minimally invasive techniques to treat complex gynecological conditions, particularly tumors and pelvic floor disorders. Dr. Najjari has been deeply involved in the advancement and integration of robotics into clinical practice and education.**

**Through her work, she significantly contributes to improving patient care and establishing innovative surgical procedures. Her leadership role and dedication to training the next generation of medical professionals highlight her prominent position in the ongoing development of medical robotics. Oncology Compass Digest discussed with Dr. Najjari her views on the impending shortage of skilled surgeons in gynecologic oncology, and how robotics simulation training can play a crucial role in addressing this challenge.**

**Dr. Najjari, how do you see the current challenge of the shortage of skilled surgeons in oncology, especially in the field of gynecological oncology?**

I see the shortage of proficient surgeons in gynecological oncology as extremely critical. There are many factors that have contributed to this, the shortage of qualified professionals has developed insidiously and it will take decades to remedy this shortage without innovative solutions.

A key aspect is the generational change and the changed attitude of the younger generation to work, combined with new expectations of the profession. In addition, there are considerable deficits in training, especially in gynecological oncology in Germany. Training is often insufficient, and there is a lack of structured training programs and operational standards.

Special gynecological oncology is only covered by an oral examination, without surgical skills being tested centrally. In addition, we have been poorly prepared for the transition from open surgery to laparoscopy, which has led to a significant loss of expertise. Now we are facing the next big change, the transition from laparoscopy to robotics. This process must be better planned and accompanied in order to avoid a further loss of expertise.

**What specific measures are being implemented in your robotics simulation training to prepare future gynecologic oncologists for their tasks, and how has this training impacted the competence and safety of the young doctors you train?**

To address the shortage of proficient surgeons in gynecological oncology, we rely on comprehensive robotics simulation training that incorporates several key measures. We offer a structured curriculum covering both theoretical and practical aspects of robotic surgery, tailored to the special requirements of gynecological oncology.

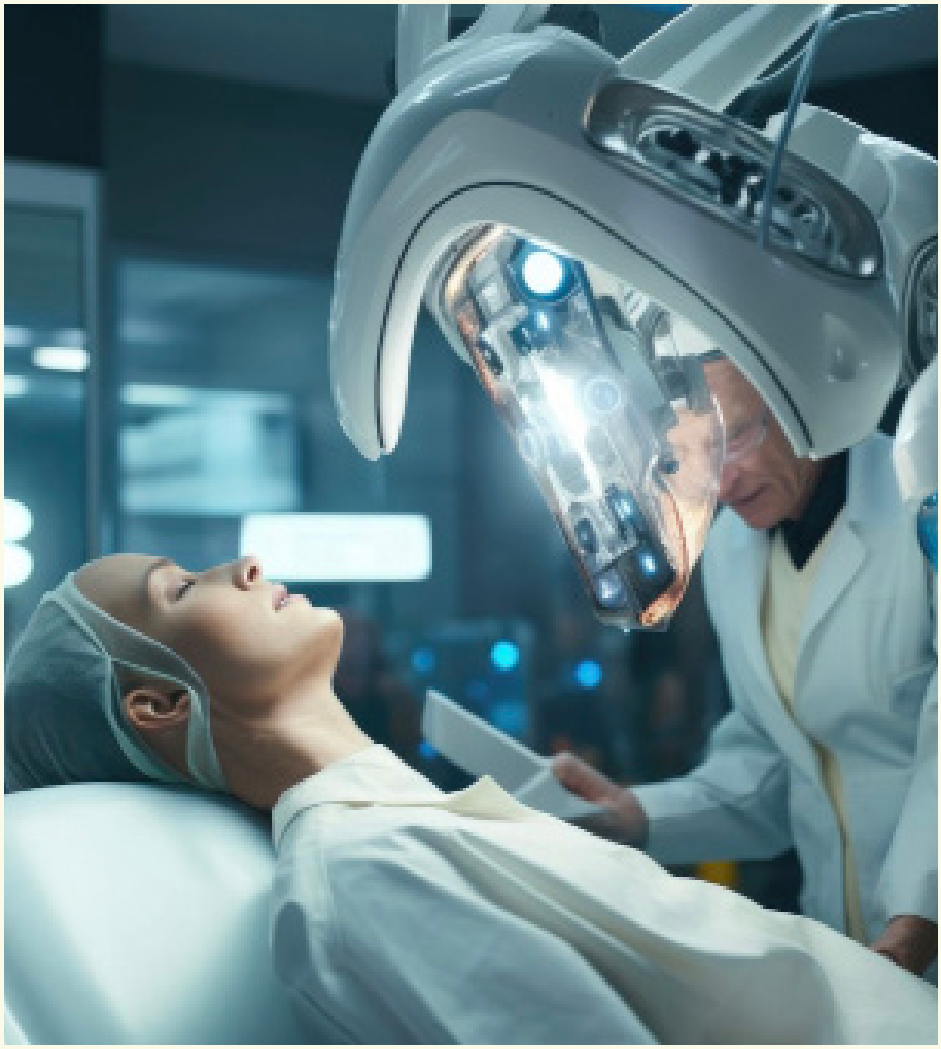


*Photo credit: Freepik*

Our training programs are based on established operational standards, and we use state-of-the-art Virtamed simulators to provide realistic operational scenarios. Participants receive individual feedback, mentoring, and coaching from experienced surgeons, with regular assessments to monitor progress.

We also emphasize the seamless integration of robotic technology into training, minimizing the loss of knowledge during the transition from laparoscopy to robotics. The introduction of double consoles allows experienced surgeons to guide trainees in real-time, significantly enhancing their competence and safety.

Simulation of real cases before actual operations further prepares trainees for complex scenarios, allowing them to refine their skills in a controlled environment. Through these measures, we actively prepare future gynecologists and contribute to addressing the shortage in this critical medical field.

**What are the current obstacles to the integration of robotics simulation training in medical education, and how can these challenges be addressed to advance its implementation at the national level?**

Several barriers hinder the integration of robotics simulation training into medical education. The high costs of robotic systems and simulation software limit accessibility for many institutions.

There is also a lack of standardized training programs and clear guidelines, and a shortage of experienced trainers to provide the necessary skills. Additionally, the importance of robotics technology is not always fully recognized, resulting in insufficient support from political and institutional levels.

To overcome these challenges, we focus on collaborating with other medical institutions to pool resources and create joint training programs. We also work on developing more cost-effective simulation solutions and advocating for the benefits of robotics training to gain policy support and funding.

Nationally, the integration of robotics simulation can be advanced by ensuring financial backing from policymakers, promoting equal access across disciplines, and addressing the cost discrepancies between robotic surgery and traditional laparoscopy.

**How does interdisciplinary cooperation play a role in expanding the use of robotics and advanced simulation technologies, and what political support is needed to facilitate this?**

Interdisciplinary cooperation is essential for expanding the use of robotics and advanced simulation technologies in medical training.

At Aachen University Hospital, we are working with departments such as urology and surgery to build an interdisciplinary network, including setting up a simulation laboratory in the women's clinic.

However, limited resources, such as having only one robotic system shared by multiple departments, pose significant challenges.

Politically, robotic surgery in gynecology, particularly gynecologic oncology, faces hurdles due to the

limited indications for its use, such as primarily in endometrial cancer and lymph node dissection. Stronger political support is necessary not only for training more specialists but also for ensuring that entire teams, including nurses and caregivers, are adequately trained and supported.

Addressing the shortage of skilled nursing staff and the need for a holistic approach is critical to improving the effectiveness and quality of care in robotic surgery.

**How can targeted advocacy and political action help increase financial support and the adoption of robotics simulation training in medical education, while addressing the shortage of skilled workers in oncology?**

Targeted advocacy can play a crucial role in increasing financial support and the broader adoption of robotics simulation training by emphasizing the long-term benefits, such as improved surgical outcomes and enhanced patient safety.

Well-organized lobbying can raise awareness among decision-makers and policymakers, highlighting the necessity of investment in this technology for the future of medical education and healthcare.

Evidence-based reports and studies proving the effectiveness of robotics simulation training could strengthen the case for securing funding
Additionally, raising public awareness through outreach could further pressure policymakers to allocate more resources.

Regarding the shortage of skilled workers in oncology, current political efforts appear insufficient.
Sustainable measures are needed to attract young doctors to the field and improve training conditions, ensuring a motivated workforce for the future.

*Dr. Laila Najjari, photo courtesy of Dr. Laila Najjari*

**How do you envision the future of robotics simulation training in gynecological oncology, and what role does the political environment play in realizing this vision?**

My long-term vision for robotics simulation training in gynecological oncology focuses on creating a more collaborative, interdisciplinary approach, particularly between gynecology, surgery, and urology.

The use of robotics allows specialists from different fields to work together efficiently, improving patient outcomes and reducing time during procedures. However, to fully realize this vision, political and policy support is crucial.  Policymakers must recognize gynecology as an equal partner in robotics, ensuring that resources such as robotic systems are distributed fairly among all relevant disciplines.

Additionally, financial backing for acquiring advanced robotic technologies and establishing comprehensive, standardized training programs is essential.

While political support is necessary, my team and I are doing everything within our power to advance this field. We are developing structured curricula, introducing innovative simulation training, and fostering collaborations with other departments. Still, to make a broader impact, more policy-driven support is needed.

This includes funding for research and development, as well as creating frameworks for innovations like telemedicine, robotic navigation systems, and automated surgical reports.

With these changes, we can ensure that robotics becomes a cornerstone of medical education and clinical practice, but the journey requires a united effort from both the medical and political sectors.

ADVANCES IN RCC TREATMENT

# STREAMLINED THERAPIES AND BROADER EFFICACY ACROSS TUMOR SIZES

BY ANNE JÄKEL

**The CheckMate 67T study, led by Dr. Saby George, explored whether subcutaneous (SC) administration of nivolumab could match the efficacy and safety of intravenous (IV) administration in patients with advanced clear cell RCC (ccRCC).**

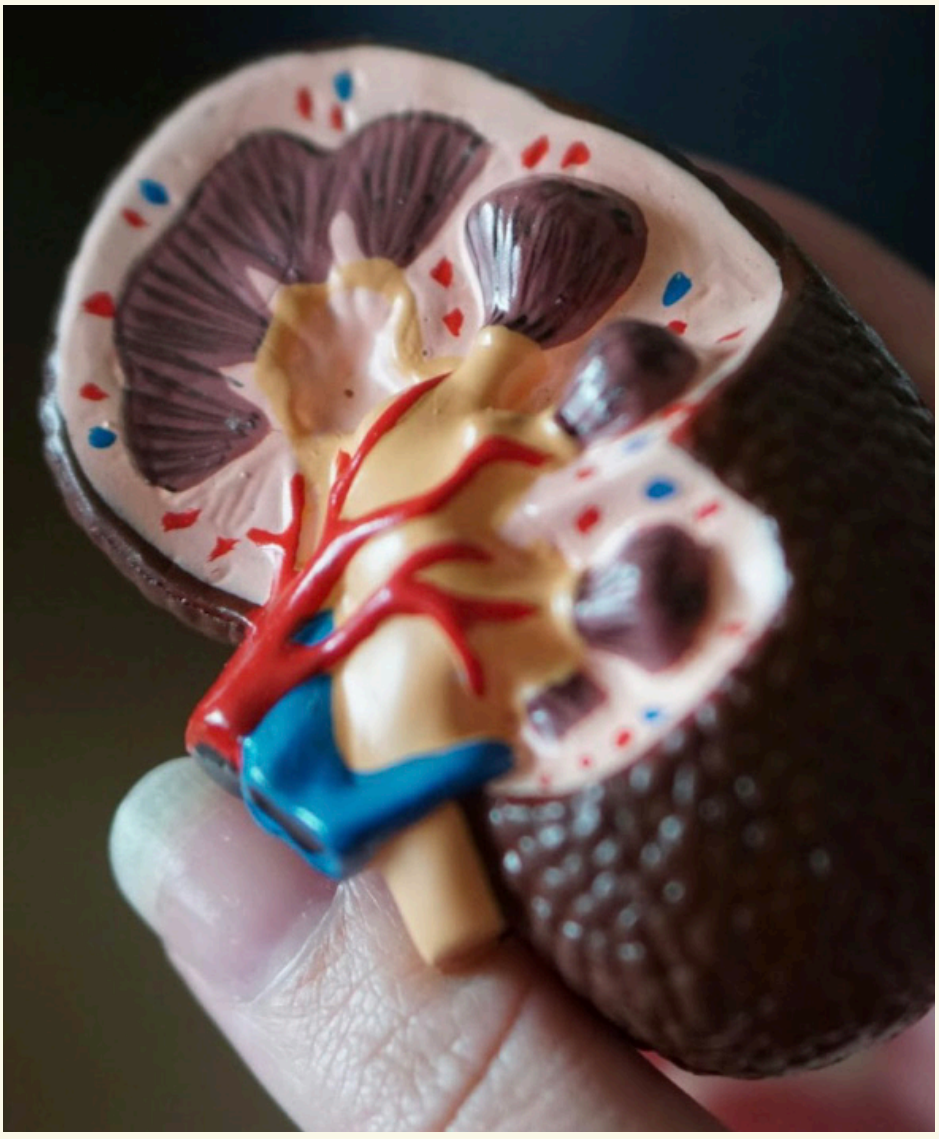
Renal cell carcinoma (RCC) represents one of the most challenging cancers, with advanced cases often requiring complex treatment regimens that can be taxing on both patients and healthcare systems. Ongoing research aims to improve the effectiveness of RCC therapies while making treatments more patient-friendly. Two significant studies, the CheckMate 67T and CLEAR trials, represent important steps forward.[1,2]

CheckMate 67T investigates an alternative administration method for nivolumab, aiming to make this effective therapy easier to administer. [1]

Meanwhile, the CLEAR trial examines the efficacy of lenvatinib and pembrolizumab across different tumor sizes, helping refine treatment for patients with a variety of tumor characteristics.[2]

### Streamlining treatment delivery: the CheckMate 67T study on SC nivolumab

The CheckMate 67T study, led by Dr. Saby George, explored whether subcutaneous (SC) administration of nivolumab could match the efficacy and safety of intravenous (IV) administration in patients with advanced clear cell RCC (ccRCC). Nivolumab has shown positive



*A 3D representation of a kidney, photo by Robina Weermeijer on Unsplash*

outcomes for RCC and other cancers, yet its standard IV delivery can be time-intensive for patients and healthcare providers alike. SC administration offers a faster, more patient-friendly approach, potentially reducing the treatment burden and improving healthcare efficiency.[1]

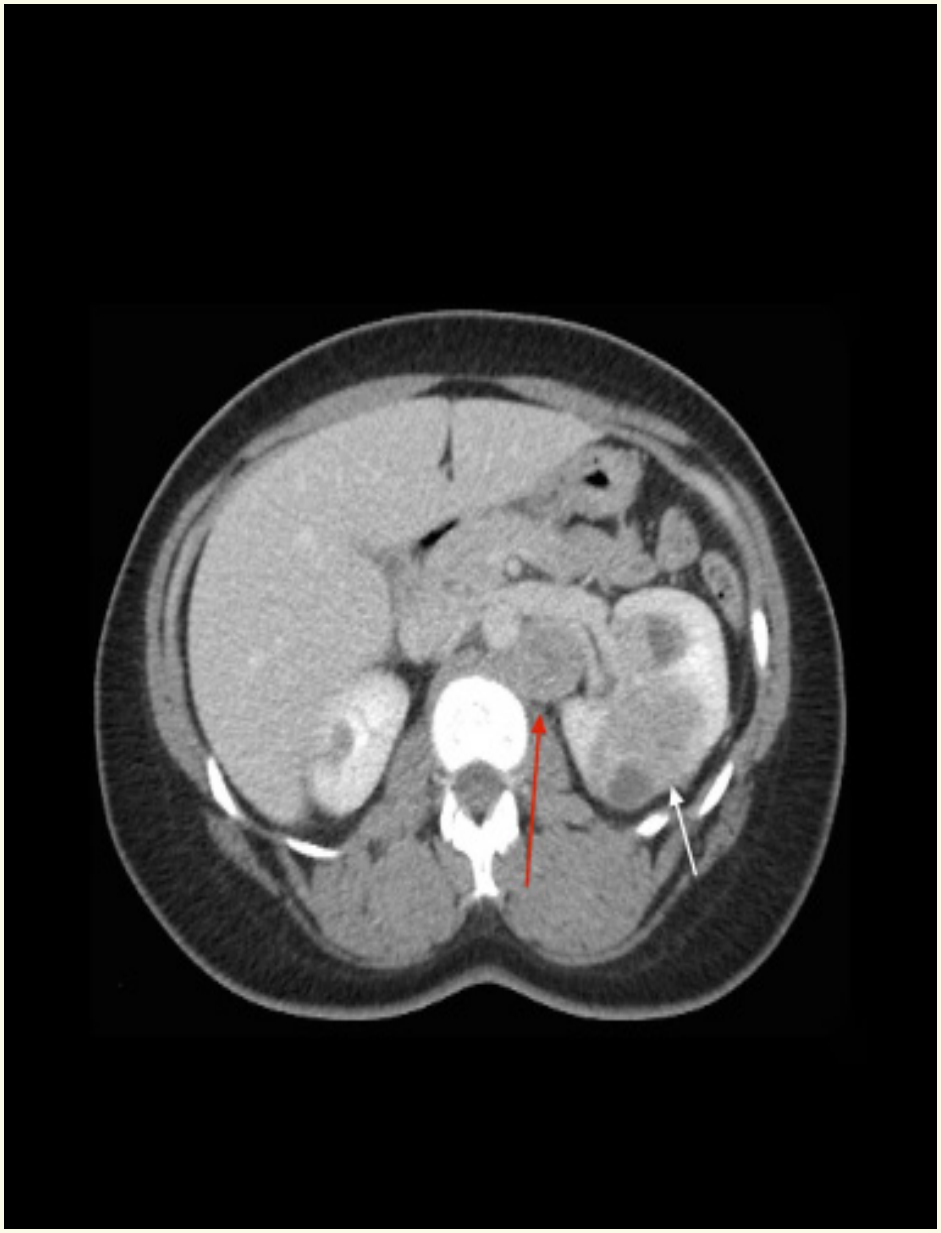
CheckMate 67T, a phase III, randomized trial, enrolled 495 ccRCC patients who had experienced disease progression after one to two prior systemic regimens and had a Karnofsky performance score of at least 70. Patients were assigned in a 1:1 ratio to receive either SC nivolumab (1200 mg every four weeks) or IV nivolumab (3 mg/kg every two weeks). Both groups continued treatment until disease progression, intolerable toxicity, patient withdrawal, or up to two years.[1]

The trial's co-primary endpoints centered on pharmacokinetic (PK) comparisons between SC and IV nivolumab, focusing on two PK measures: the time-averaged serum concentration over the first 28 days (Cavgd28) and the minimum serum concentration at steady state (Cminss). Secondary endpoints included the objective response rate (ORR) to confirm that the SC administration was noninferior to the IV delivery method. The study also tracked additional PK exposure measures, safety, efficacy, and immunogenicity.[1]

**Key findings**

Pharmacokinetics (PK): SC nivolumab achieved noninferiority, with PK values similar to IV nivolumab, meeting the primary endpoint. The PK results demonstrated a close match in drug concentration, with a geometric mean ratio (GMR) for Cavgd28 of 2.098 (90% CI: 2.001–2.200) and for Cminss of 1.774 (90% CI: 1.633–1.927), validating SC nivolumab as a viable alternative. [1]

Efficacy: SC administration showed a slightly higher ORR of 24.2% compared to 18.2% in the IV group, with median progression-free survival



*Axial view of an individual's midsection showing tumors in both kidneys, photo credit: Brian Shuch, MD, Yale University School of Medicine, National Cancer Institute*

(PFS) at 7.23 months for SC and 5.65 months for IV. This data supports SC administration's comparable efficacy to the traditional IV route. 1

Safety: The safety profiles were consistent across both arms, with slightly fewer grade 3/4 adverse events (AEs) in the SC group (35.2%) compared to the IV group (40.8%). Local injection-site reactions were reported in 8.1% of SC patients, all of which were mild and transient, highlighting SC administration as a safe alternative.[1]

These findings suggest that SC nivolumab could simplify treatment delivery for ccRCC patients, making therapy more accessible and convenient without compromising outcomes.

**Broadening treatment efficacy: the CLEAR trial's subgroup analysis on lenvatinib + pembrolizumab**

The CLEAR trial examined the effectiveness of lenvatinib plus pembrolizumab (L+P) in patients with advanced RCC, particularly across varying baseline

tumor sizes. Led by researchers from the University Hospital Essen and Memorial Sloan Kettering Cancer Center, this subgroup analysis sought to determine if the size of the baseline tumor affected treatment outcomes in terms of overall survival (OS), progression-free survival (PFS), and objective response rate (ORR).[2]

CLEAR, an open-label phase III study, randomized patients with untreated advanced RCC to one of three treatment arms: L+P, lenvatinib plus everolimus, or sunitinib. Patients were categorized into quartiles based on tumor size at baseline to evaluate the efficacy of L+P across different tumor sizes.[2]

**Findings by tumor size**

Efficacy Across Tumor Size Quartiles: L+P demonstrated high ORR across all tumor size groups, with the highest ORR (80%) in patients with moderate-sized tumors (Q2, >34.72 mm to ≤60.06 mm). Even in the largest tumor size group (Q4, >108.56 mm), L+P showed strong responses, underscoring its efficacy across tumor profiles.[2]

Survival Outcomes: Patients with the smallest baseline tumors (Q1, ≤34.72 mm) had the longest OS, with an estimated lower bound of 49.9 months, while the largest tumor group (Q4) had a median OS of 39.5 months. These findings illustrate that L+P provides robust survival benefits, with a slight advantage for patients with smaller baseline tumors.[2]

This data confirms that L+P offers consistent benefits across tumor sizes, establishing it as a potent first-line treatment option for a broad range of RCC patients. Its efficacy in larger tumors highlights L+P's capacity to meet the needs of patients with different tumor characteristics.

**Implications for RCC treatment and patient care**

These two studies highlight RCC treatment advancements through two distinct approaches. The CheckMate

*Photo credit: Freepik*

67T findings suggest that SC nivolumab could be a practical alternative to IV administration, potentially simplifying the treatment process and making it more manageable for patients and healthcare providers. SC nivolumab's noninferior efficacy and similar safety profile to IV make it a promising option for reducing patient time spent in clinics, improving convenience, and reducing treatment burdens.

The CLEAR trial's subgroup analysis of lenvatinib plus pembrolizumab confirms the versatility of L+P as a first-line therapy, demonstrating its effectiveness across a range of tumor sizes. This flexibility allows clinicians to confidently recommend L+P for advanced RCC patients with diverse tumor characteristics, supporting a more personalized approach to RCC care.

**Conclusion**

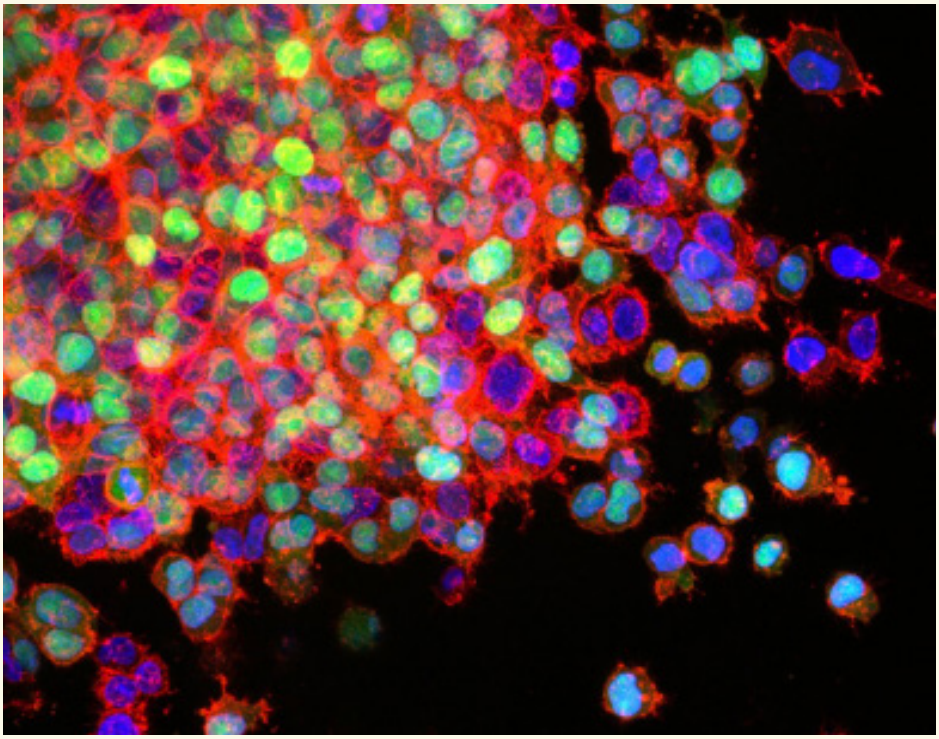
The CheckMate 67T and CLEAR trials reflect significant advancements in RCC treatment, each contributing to a more flexible, effective approach to managing this complex disease. SC nivolumab presents a viable alternative to traditional IV administration, enhancing patient comfort and healthcare efficiency. Meanwhile, lenvatinib plus pembrolizumab provides reliable efficacy across different tumor sizes, establishing itself as a robust option for RCC patients with varying baseline tumor characteristics. As these therapies continue to be optimized, the promise of improved outcomes and better quality of life for RCC patients becomes ever closer to reality.

TARGETED THERAPIES IN STAGE III NSCLC

# INSIGHTS FROM THE PACIFIC-2 TRIAL ON DURVALUMAB WITH CHEMORADIATION

BY KRISTINA OLUJIĆ MILOŠEVIĆ

**In the pursuit of better treatments for non-small cell lung cancer (NSCLC), particularly in advanced, unresectable cases, targeted therapies have shown great promise.[1] The recent PACIFIC-2 trial explored the efficacy of combining durvalumab, an immunotherapy, with concurrent chemoradiation in patients with stage III unresectable NSCLC.[2] While preclinical evidence suggested a potential synergistic benefit, the results showed no significant improvement in progression-free survival (PFS) or overall survival (OS) compared to chemoradiation alone. These findings add to the growing understanding that the success of targeted therapies in NSCLC can vary considerably based on factors like cancer stage and mutational profile, and they underscore the importance of evaluating each therapy in a specific clinical context.[2]**



*Lung Cancer Metastasis, photo credit: Scott Wilkinson, Adam Marcus, National Cancer Institute \ Winship Cancer Institute of Emory University*

## PACIFIC-2 trial overview

The PACIFIC-2 trial was the first phase III trial designed to evaluate the concurrent use of immunotherapy and chemoradiation followed by immunotherapy consolidation in stage III unresectable NSCLC. The trial followed the successful PACIFIC study, which had shown that durvalumab as a consolidation therapy following chemoradiotherapy significantly improved survival outcomes in this patient group. However, PACIFIC-2 aimed to assess if concurrent use of durvalumab and chemoradiotherapy would offer additional benefits.[2]

The randomized, double-blind, placebo-controlled study enrolled patients with advanced NSCLC who were randomly assigned to receive either 1500 mg durvalumab plus chemoradiotherapy or a placebo plus chemoradiotherapy every 4 weeks. The study's primary endpoint was PFS, while secondary endpoints included OS and response rate. [2]

As lead investigator Dr. Jeffrey Bradley noted, "There's preclinical evidence that supports using immunotherapy concurrently with chemoradiation because it may have a synergistic effect when added to radiation therapy, potentially benefiting patients during chemoradiotherapy and increasing eligibility for immunotherapy".[3]

## Efficacy results: no significant benefit with concurrent durvalumab

Contrary to expectations, PACIFIC-2 found that combining durvalumab with chemoradiotherapy did not significantly improve

survival outcomes compared to chemoradiotherapy alone. In the intention-to-treat population, median PFS was 13.8 months in the durvalumab arm versus 9.4 months in the placebo arm (HR = 0.85; P = 0.247). Median OS was similarly modest, at 36.4 months with the combination versus 29.5 months for the placebo plus chemoradiotherapy (HR = 1.03; P = 0.823). Response rates were also similar across both groups, with an overall response rate of around 60.[2]

These findings confirm that for stage III NSCLC, concurrent durvalumab plus chemoradiotherapy does not outperform sequential treatment, reaffirming the consolidation-only approach as the current standard of care.

## Safety profile: increased toxicities with concurrent treatment

The PACIFIC-2 trial highlighted a higher incidence of early toxicity with concurrent durvalumab and chemoradiation, leading to treatment discontinuation or death in more cases than chemoradiation alone. Any-grade adverse events (AEs) occurred in nearly all patients in both the durvalumab (98.6%) and placebo (100%) arms, with severe grade 3 or 4 AEs occurring in over half of the patients in each group. Common toxicities in the durvalumab arm included anaemia (42.0%), pneumonitis (28.8%), and neutropenia (27.4%).[4]

Notably, the durvalumab group saw a higher incidence of AEs leading to death, largely due to infections early in treatment. Fatal AEs were reported in 6.8% of patients receiving durvalumab compared to 4.6% in the placebo arm.[4]

These findings underscore the importance of carefully balancing treatment benefits and potential toxicities when considering concurrent immunotherapy in advanced NSCLC cases, as well as the potential risks in certain patient populations.

*Photo credit: CDC on Unsplash*

## Comparison with PACIFIC-1 and implications for stage III NSCLC

The original PACIFIC trial established durvalumab as the standard of care following chemoradiation, showing a 5-year OS rate of 42.9% versus 33.4% for placebo, with a substantial PFS benefit as well. By contrast, PACIFIC-2 shows that adding durvalumab concurrently does not yield further survival gains.

This difference illustrates that while immunotherapy can be effective as a consolidation treatment, its concurrent use with chemoradiotherapy might not provide additional benefit in certain clinical scenarios, such as stage III NSCLC.[3,4]

This finding is valuable in understanding how the efficacy of targeted therapies varies by the timing and combination of treatments.

The success of durvalumab in PACIFIC-1 could be attributed to the immune system's ability to engage effectively after the initial tumour burden was reduced by chemoradiation. In contrast, the higher toxicity in PACIFIC-2 might have offset any potential benefits of concurrent treatment, possibly due to an overtaxed immune response when simultaneously managing the demands of both therapies.

## Future perspectives: personalizing treatment based on cancer stage and mutation profile

The PACIFIC-2 trial results reaffirm the importance of tailoring treatments to specific cancer stages and patient profiles. For patients with stage III unresectable NSCLC, sequential chemoradiotherapy followed by immunotherapy remains the optimal strategy.

As research continues, refining patient selection criteria based on mutational and immune profiles may help identify subgroups that could benefit from concurrent treatments without the added toxicity burden.

Moreover, future research could explore alternative dosing schedules or targeted therapies to maximize efficacy while minimizing adverse effects. For instance, combination regimens may be more beneficial in earlier or later stages of the disease, or in patients with distinct mutational profiles, such as EGFR mutations or PD-L1 expression.

Identifying biomarkers and further exploring personalized medicine approaches will be crucial for optimizing treatment and improving outcomes for NSCLC patients across all stages.

## Conclusion

The PACIFIC-2 trial underscores the complexity of treating stage III NSCLC, revealing that concurrent durvalumab with chemoradiotherapy does not outperform the sequential approach established in PACIFIC-1.

These findings highlight that while targeted immunotherapies offer new avenues for treatment, their success can vary greatly depending on cancer stage and treatment timing.

As the field of oncology continues to evolve, understanding these nuances will be essential in optimizing treatment strategies for NSCLC, guiding the development of future trials and personalized approaches to cancer care.

NEW FRONTIERS IN EGFR-TARGETED NSCLC THERAPIES

# INSIGHTS FROM THE PAPILLON AND BECOME TRIALS

BY KRISTINA OLUJIĆ MILOŠEVIĆ

**Non-small cell lung cancer (NSCLC) is one of the leading causes of cancer-related deaths worldwide, with many patients presenting advanced stages of the disease.[1] Within the diverse landscape of NSCLC, a specific subset harbors EGFR exon 20 insertion mutations, which account for around 4-10% of EGFR-mutant lung cancers.[2] Unfortunately, this mutation renders patients less responsive to conventional EGFR-targeted therapies, highlighting a pressing need for effective treatment options. Two pivotal studies, the PAPILLON and BECOME trials, have shown promising results with novel combination therapies that target EGFR exon 20 mutations, offering renewed hope for improved outcomes in NSCLC.[3,4]**

*Photo credit: Freepik*

## Targeting EGFR Exon 20 Insertions: The PAPILLON and BECOME trials

The PAPILLON and BECOME trials represent significant advancements in therapies for EGFR exon 20 insertion-positive NSCLC.

These studies provide insights into combination treatment approaches using targeted therapies to manage progression and improve quality of life for patients with advanced disease.

PAPILLON tested amivantamab, an EGFR-MET bispecific antibody, with chemotherapy in untreated patients, while BECOME evaluated the combination of becotarug and osimertinib in patients who had progressed on platinum-based chemotherapy.[3,4]

## PAPILLON trial overview

The phase III PAPILLON trial assessed the effectiveness of amivantamab, a bispecific antibody targeting both EGFR and MET, combined with carboplatin and pemetrexed chemotherapy.3 The goal was to evaluate this combination as a first-line treatment for locally advanced or metastatic EGFR exon 20 insertion-mutated NSCLC.

In this randomized, open-label, multicenter study, 308 patients were divided into two groups: 153 received amivantamab with carboplatin and pemetrexed, while 155 were treated with chemotherapy alone.

This structure allowed researchers to directly compare the efficacy of the new combination with standard chemotherapy.[3]

## PAPILLON trial results and implications

Results from the PAPILLON trial demonstrated that amivantamab plus chemotherapy significantly extended the time to treatment discontinuation (TTD).

Patients in the combination group experienced a median TTD of 13.2 months compared to 7.5 months for chemotherapy alone (HR = 0.38; P < .0001). Notably, 58% and 35% of patients on amivantamab and chemotherapy remained on treatment at 12 and 18 months, respectively, versus only 21% and 5% in the chemotherapy-only group.[3]

These results underscored the potential of amivantamab as a powerful first-line therapy option.

Moreover, progression rates were notably lower among patients receiving the combination, with decreased metastasis in areas such as lymph nodes, soft tissue, bone, and abdominal viscera compared to the chemotherapy-only group.

Following these results, the FDA approved amivantamab with chemotherapy as a frontline treatment for EGFR exon 20 insertion-positive NSCLC.[5]

## BECOME trial overview

In the phase II BECOME trial, researchers investigated the efficacy of becotarug, a humanized monoclonal antibody targeting EGFR, in combination with osimertinib, an EGFR tyrosine kinase inhibitor.[4]

This trial was specifically designed for patients with advanced EGFR exon 20 insertion-positive NSCLC who had already undergone platinum-based chemotherapy.

The open-label, single-arm study involved 126 patients, and the primary endpoints included objective response rate (ORR) and disease control rate (DCR) by an independent review committee.[4]

## BECOME trial results and implications

The results from the BECOME trial were equally promising. The ORR reached 50%, with a DCR of nearly 80%, suggesting strong antitumor activity.

Median progression-free survival (PFS) stood at 6.9 months, with 57.7% of patients remaining progression-free at six months and 31.0% at twelve months.[4]

The treatment's safety profile was manageable, with common adverse effects linked to EGFR inhibition, such as rash, diarrhea, and decreased appetite, all of which were deemed tolerable with proper management.[7]

BECOME's findings solidify the combination of becotarug and osimertinib as a valuable second-line therapy for patients with EGFR exon 20 insertion-positive NSCLC, extending the range of effective treatment options for those who progress on platinum-based chemotherapy.

## Comparison and clinical significance

Both trials contribute valuable data that underscore the efficacy of combination therapies in treating EGFR exon 20 insertion-positive NSCLC. While the PAPILLON trial positions amivantamab plus chemotherapy as a first-line therapy, the BECOME trial offers a viable option for patients needing a second-line treatment.

Taken together, these studies illustrate the potential of targeting EGFR exon 20 insertions with tailored, multi-drug regimens that significantly extend treatment efficacy, progression-free survival, and overall disease control.

These results also reflect a shift in the treatment paradigm for NSCLC with EGFR mutations, highlighting the importance of personalized treatment strategies and multi-drug approaches for improved outcomes.

By understanding the nuances of individual mutations like EGFR exon 20, oncologists can more effectively tailor therapies to patient-specific genetic profiles.

## FDA approval and future perspectives

As of March 1, 2024, the FDA approved amivantamab plus chemotherapy as a first-line treatment for patients with advanced NSCLC harboring EGFR exon 20 insertions.

This approval marks a major step forward in establishing new standards for personalized treatment in oncology. Becotarug plus osimertinib, while currently investigational, shows immense promise as a viable future treatment, especially in cases where the disease progresses following initial chemotherapy.[5,6]

The success of these trials underscores the growing trend of combining therapies to target complex mutations, a strategy that continues to gain traction in cancer treatment.

Looking forward, these promising outcomes lay the groundwork for additional studies and potentially pave the way for even more targeted and effective therapies for EGFR-mutant NSCLC.

## Conclusion

The PAPILLON and BECOME trials represent significant advancements in treating NSCLC with EGFR exon 20 insertion mutations. By combining targeted agents with chemotherapy, these studies offer a novel approach to manage disease progression and extend survival rates in a previously hard-to-treat patient population.

As personalized medicine continues to evolve, the findings from these trials underscore the potential of mutation-specific treatments and multi-drug regimens in changing the landscape of cancer care, especially for NSCLC patients with specific genetic profiles.

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LOBBYING FOR CHANGE

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# UPCOMING ONCOLOGY CONFERENCES THIS WINTER / SPRING

**Oncology Compass Digest presents a selection of medical conferences happening this winter and spring. The Oncology Compass Calendar is the most comprehensive calendar of global oncology conferences.**

Be sure to check out the whole calendar on
www.oncologycompass.com/calendar
and find more conferences.

## FEBRUARY 2025

### ASCO Genitourinary Cancers

Location:
San Francisco, California

Date:
13 Feb - 15 Feb

Cancer Indication:
Genitourinary cancer

www.oncologycompass.com/calendar/european-lung-cancer-congress-2025

### 29th Annual International Congress on Hematologic Malignancies: Focus on Leukemias, Lymphomas, and Myeloma

Location:
Miami, Florida

Date:
27 Feb - 02 Mar

Cancer Indication:
Hematologic malignancies

www.oncologycompass.com/calendar/29th-annual-international-congress-on-hematologic-malignancies-focus-on-leukemias-lymphomas-and-myeloma

## MARCH 2025

### 15th European Breast Cancer Conference (EBCC-15) 2025

Location:
Barcelona, Spain

Date:
25 Mar - 27 Mar

Cancer Indication:
Breast cancer

www.oncologycompass.com/calendar/15th-european-breast-cancer-conference-ebcc-15-2025

## APRIL 2025

### European Lung Cancer Congress 2025

Location:
Paris, France

Date:
26 Mar - 29 Mar

Cancer Indication:
Lung cancer

www.oncologycompass.com/calendar/european-lung-cancer-congress-2025

### ESMO Summit Latin America 2025

Location:
Lima, Peru

Date:
11 Apr - 12 Apr

Cancer Indication:
General

www.oncologycompass.com/calendar/esmo-summit-latin-america-2025

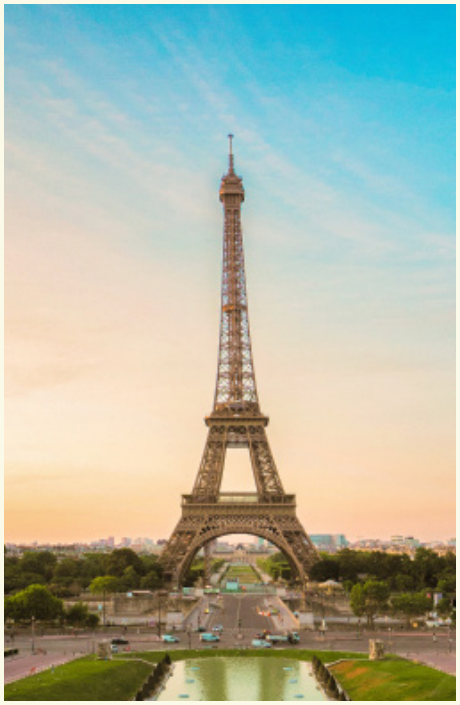
### AACR Annual Meeting 2025

Location:
Chicago, Illinois

Date:
25 Apr - 30 Apr

Cancer Indication:
General

https://oncologycompass.com/calendar/aacr-annual-meeting-2025



# INSIGHTS FOR YEAR 2024

ONCOLOGY COMPASS IS GLOBALLY BECOMING AN INCREASINGLY IMPORTANT PLATFORM FOR ONCOLOGISTS

## 17 SCIENTIFIC LEADERS

selected practice-relevant publications for lung, renal, gastro-esophageal, melanoma, multiple myeloma, prostate cancer and triple-negative breast cancer




## 426 ACTIVE USERS

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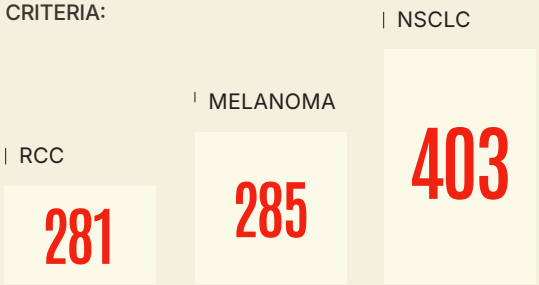


*Total number of clicks on filter criteria over time

| | |
|---|---|
| WEBSITE VISITORS | 42,557 |
| PAGEVIEWS | 85,629 |
| SESSIONS | 49,654 |
| AVG. SESSION | 01:51 |
| PAGES PER SESSION | 1.72 |

VISITORS BY DEVICES

| DEVICE CATEGORY | TOTAL VISITORS | PAGEVIEWS |
|---|---|---|
| *Desktop* | 58,990 | 32,296 |
| *Mobile* | 24,244 | 15,157 |
| *Tablet* | 1,661 | 1,229 |

VISITORS BY GENDER

| | |
|---|---|
| *Total female* | 60.7% |
| *Total male* | 39.3% |

TOP 10 COUNTRIES WHERE VISITORS COME FROM:

| COUNTRY | VISITORS | SESSIONS |
|---|---|---|
| 1. United States | 22,449 | 25,510 |
| 2. United Kingdom | 3,798 | 4,092 |
| 3. India | 3,432 | 3,685 |
| 4.Ireland | 1,577 | 1,670 |
| 5. Germany | 1,206 | 1,364 |
| 6. Switzerland | 949 | 1,267 |
| 7. Poland | 656 | 740 |
| 8. Malta | 631 | 680 |
| 9. Italy | 554 | 589 |
| 10. Netherlands | 493 | 562 |

*The number of Visitors represents all visitors to Oncology Compass, both registered and non-registered users. The metrics for Users relate to the Registered Users data who have full access to the Oncology Compass platform.*

VISITORS BY AGE / GENDER

| AGE | VISITORS | PAGEVIEWS |
|---|---|---|
| 1. 65+ | 1,894 | 2,050 |
| 2. 55-64 | 1,015 | 1,146 |
| 3. 45-54 | 1,031 | 1,266 |
| 4. 35-44 | 962 | 1,192 |
| 5. 25-34 | 1,236 | 1,614 |
| 6. 18-24 | 732 | 1,002 |

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ONCOLOGY COMPASS
# Digest

# THE NEXT ISSUE WILL BE PUBLISHED IN APRIL 2025

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