23rd Advances in Oncology: Updates in GI Cancers

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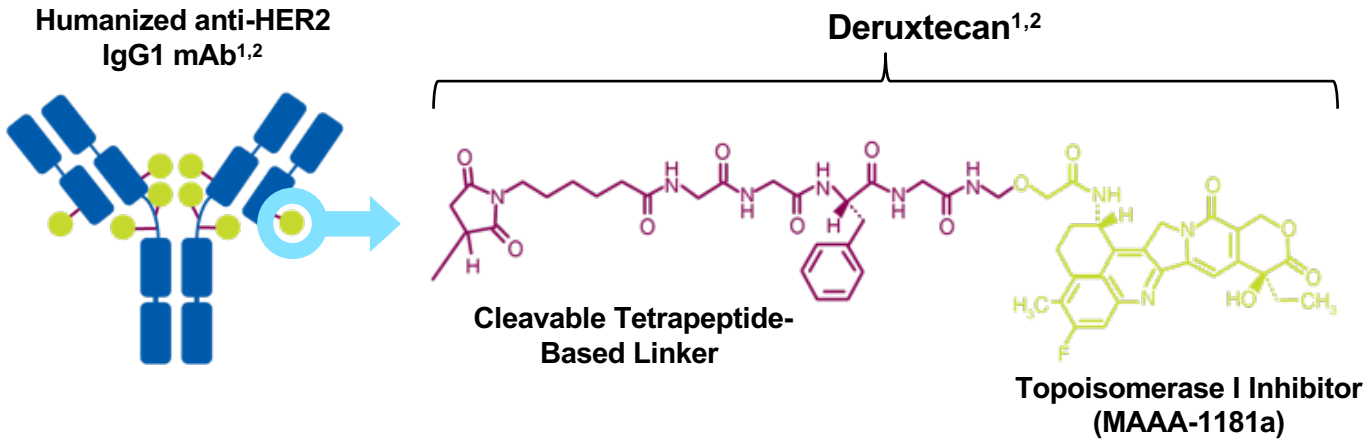
VANDERBILT-INGRAM CANCER CENTER

T-DXd Was Designed With 7 Key Attributes

An ADC composed of 3 components[1,2]:

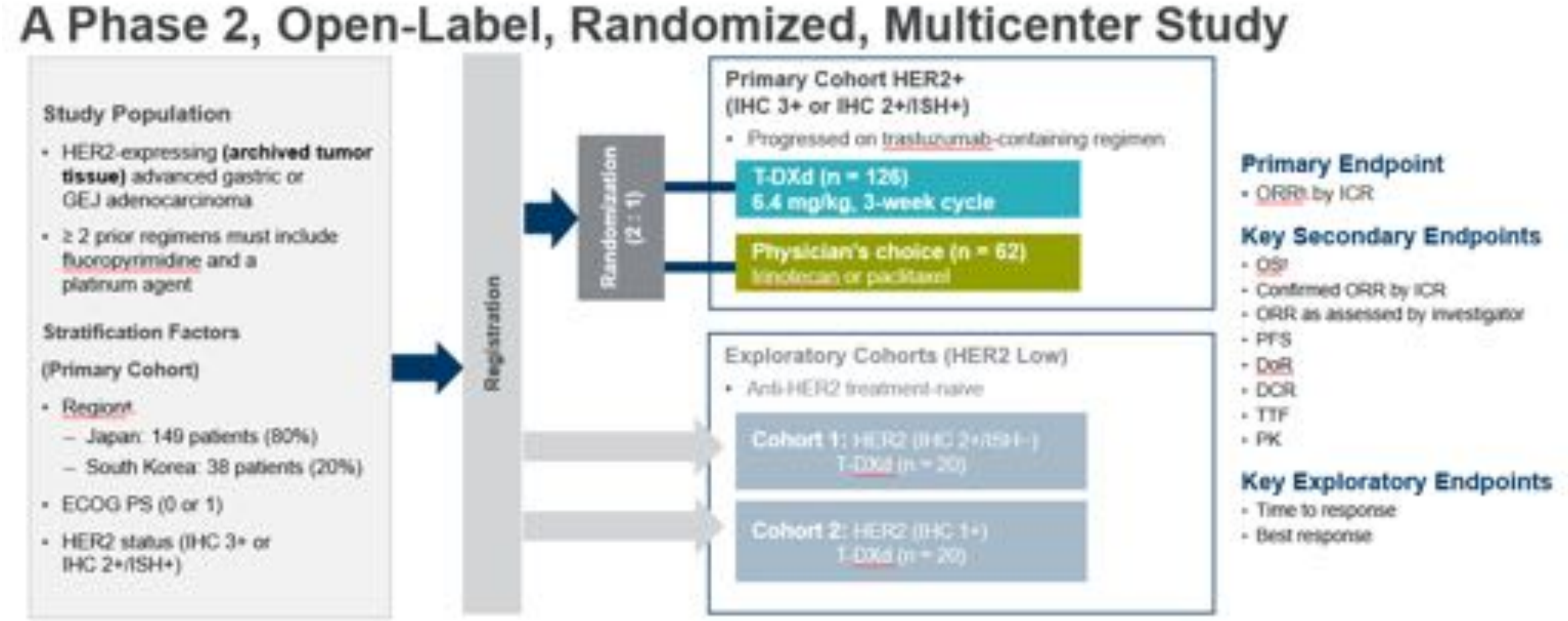
- A humanized anti-HER2 IgG1 mAb with the same amino acid sequence as trastuzumab, covalently linked to:
  - A topoisomerase I inhibitor, an exatecan derivative, via
  - A tetrapeptide-based cleavable linker



- Payload MOA: topoisomerase I inhibitor
- High potency of payload
- High DAR ≈ 8
- Payload with short systemic half-life
- Stable linker-payload
- Tumor-selective cleavable linker
- Membrane permeable payload

Yamaguchi et al; ASCO GI 2022

Overview of the Safety and Efficacy From the DESTINY-Gastric01 Clinical Trial



Yamaguchi et al; ASCO GI 2022

Overview of the Safety and Efficacy From the DESTINY-Gastric01 Clinical Trial

DESTINY-Gastric01 Primary Cohort

Baseline Demographics and Clinical Characteristics

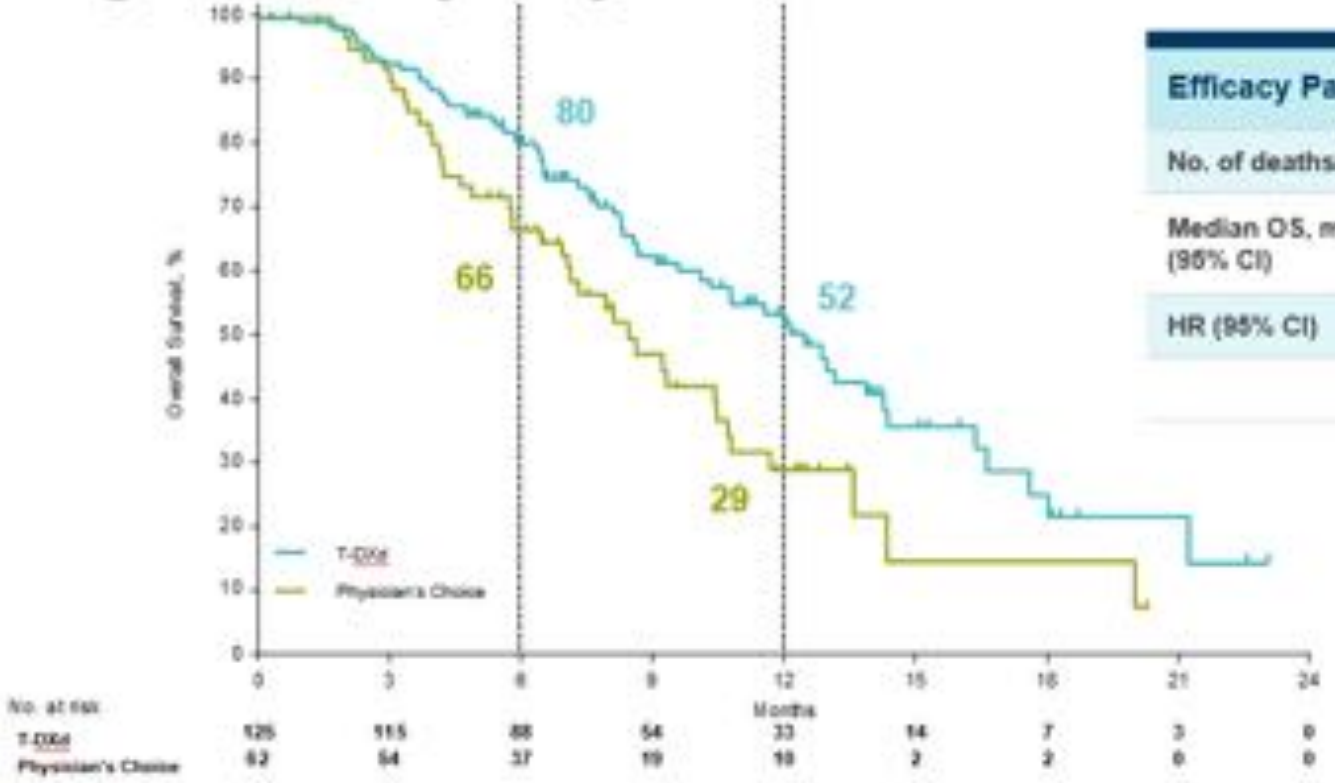
Characteristic for All Treated Patients	T-DXd (n = 125)	Physician's Choice (n = 62)
Age, median (range), years[a]	65 (34-82)	66 (28-82)
Female, n (%)	30 (24%)	15 (24%)
Region, n (%)		
Japan	99 (79%)	50 (81%)
Korea	26 (21%)	12 (19%)
ECOG PS, n (%)		
0	62 (50%)	30 (48%)
1	63 (50%)	32 (52)
Primary site, n (%)		
Gastric	108 (86%)	55 (89%)
GEJ	17 (14%)	7 (11%)
Histological subtype, n (%)		
Intestinal	89 (71%)	38 (61%)
Diffuse	28 (22%)	18 (29%)
Other	8 (6%)	6 (10%)
HER2 expression, n (%)[b]		
IHC 3+	96 (77%)	47 (76%)
IHC 2+ or ISH+	29 (23%)	15 (24%)

Yamaguchi et al; ASCO GI 2022

Overview of the Safety and Efficacy From the DESTINY-Gastric01 Clinical Trial

DESTINY-Gastric01 Primary Cohort

Significantly Improved Overall Survival With T-DXd



Efficacy Parameter	T-DXd	Physician's Choice
No. of deaths/no. of patients	62 / 125	39 / 62
Median OS, months (95% CI)	12.5 (9.6 - 14.3)	8.4 (6.9 - 10.7)
HR (95% CI)	0.59 (0.39 - 0.88)	
	P = 0.01	

Yamaguchi et al; ASCO GI 2022

TOPAZ-1 study design

TOPAZ-1 is a double-blind, multicenter, global, Phase 3 study

Key eligibility
- Locally advanced or metastatic BTC (ICC, ECC, GBC)
- Previously untreated if unresectable or metastatic at initial diagnosis
- Recurrent disease >6 months after curative surgery or adjuvant therapy
- ECOG PS 0 or 1

Stratification factors
- Disease status
  - (initially unresectable versus recurrent)
- Primary tumor location
  - (ICC versus ECC versus GBC)

R (1:1)
N=685

Durvalumab 1500 mg Q3W + GemCis (up to 8 cycles) → Durvalumab 1500 mg Q4W until PD

Placebo Q3W + GemCis (up to 8 cycles) → Placebo Q4W until PD

Primary objective
- Overall survival

Secondary objectives
- Progression-free survival
- Objective response rate
- Duration of response
- Efficacy by PD-L1 status
- Safety

GemCis treatment: gemcitabine 1000 mg/m2 and cisplatin 25 mg/m2 on Days 1 and 8 Q3W administered for up to 8 cycles.

BTC, biliary tract cancer; ECC, extrahepatic cholangiocarcinoma; ECOG, Eastern Cooperative Oncology Group; GBC, gallbladder cancer; GemCis, gemcitabine and cisplatin; ICC, intrahepatic cholangiocarcinoma; PD, progressive disease; PD-L1, programmed cell death ligand-1; PS, performance status; Q#W, every # weeks; R, randomization.

Presented by: Do-Youn Oh, MD, PhD

NEJM, 2022

Patient demographics and baseline characteristics

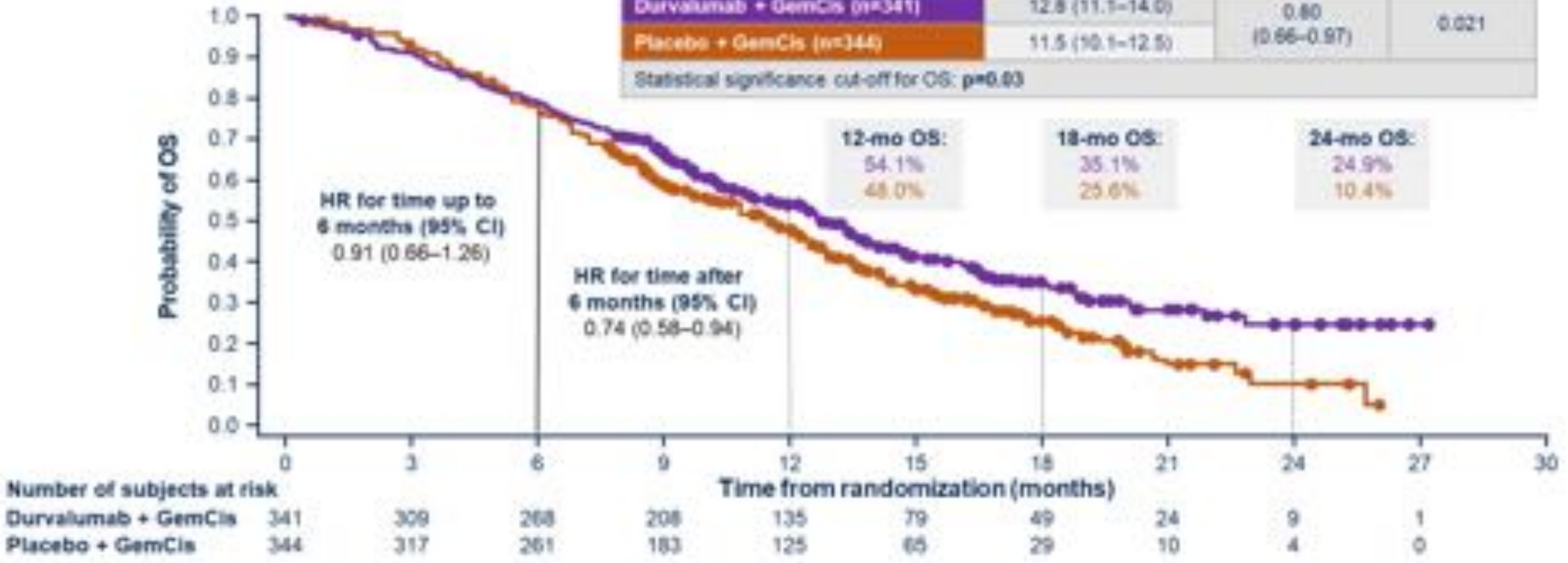
	Durvalumab + GemCis (n=341)	Placebo + GemCis (n=344)
Median age (range), years	64 (20–84)	64 (31–85)
Sex, female, n (%)	172 (50.4)	168 (48.8)
Race, n (%)		
Asian	185 (54.3)	201 (58.4)
White	131 (38.4)	124 (36.0)
Black or African American	8 (2.3)	6 (1.7)
American Indian or Alaska Native	0	1 (0.3)
Other	17 (5.0)	12 (3.5)
Region, n (%)		
Asia	178 (52.2)	196 (57.0)
Rest of the world	163 (47.8)	148 (43.0)
ECOG PS 0 at screening, n (%)	173 (50.7)	163 (47.4)
Primary tumor location at diagnosis, n (%)		
Intrahepatic cholangiocarcinoma	190 (55.7)	193 (56.1)
Extrahepatic cholangiocarcinoma	66 (19.4)	65 (18.9)
Gallbladder cancer	85 (24.9)	86 (25.0)
Disease status at randomization, n (%)		
Initially unresectable	274 (80.4)	279 (81.1)
Recurrent	67 (19.6)	64 (18.6)
Disease classification at diagnosis,* n (%)		
Metastatic	303 (88.9)	286 (83.1)
Locally advanced	38 (11.1)	57 (16.6)
PD-L1 expression,* n (%)		
TAP ≥1%	197 (57.8)	205 (59.6)
TAP <1%	103 (30.2)	103 (29.9)

*Data missing for remaining patients. Unless otherwise indicated, measurements were taken at baseline.

ECOG, Eastern Cooperative Oncology Group; GemCis, gemcitabine and cisplatin; PD-L1, programmed cell death ligand-1; PS, performance status; TAP, tumor area positivity.

Primary endpoint: OS

	Median OS (95% CI), months	Hazard ratio (95% CI)	p-value
Durvalumab + GemCis (n=341)	12.8 (11.1–14.0)	0.80 (0.66–0.97)	0.021
Placebo + GemCis (n=344)	11.5 (10.1–12.5)		
Statistical significance cut-off for OS: p=0.03			



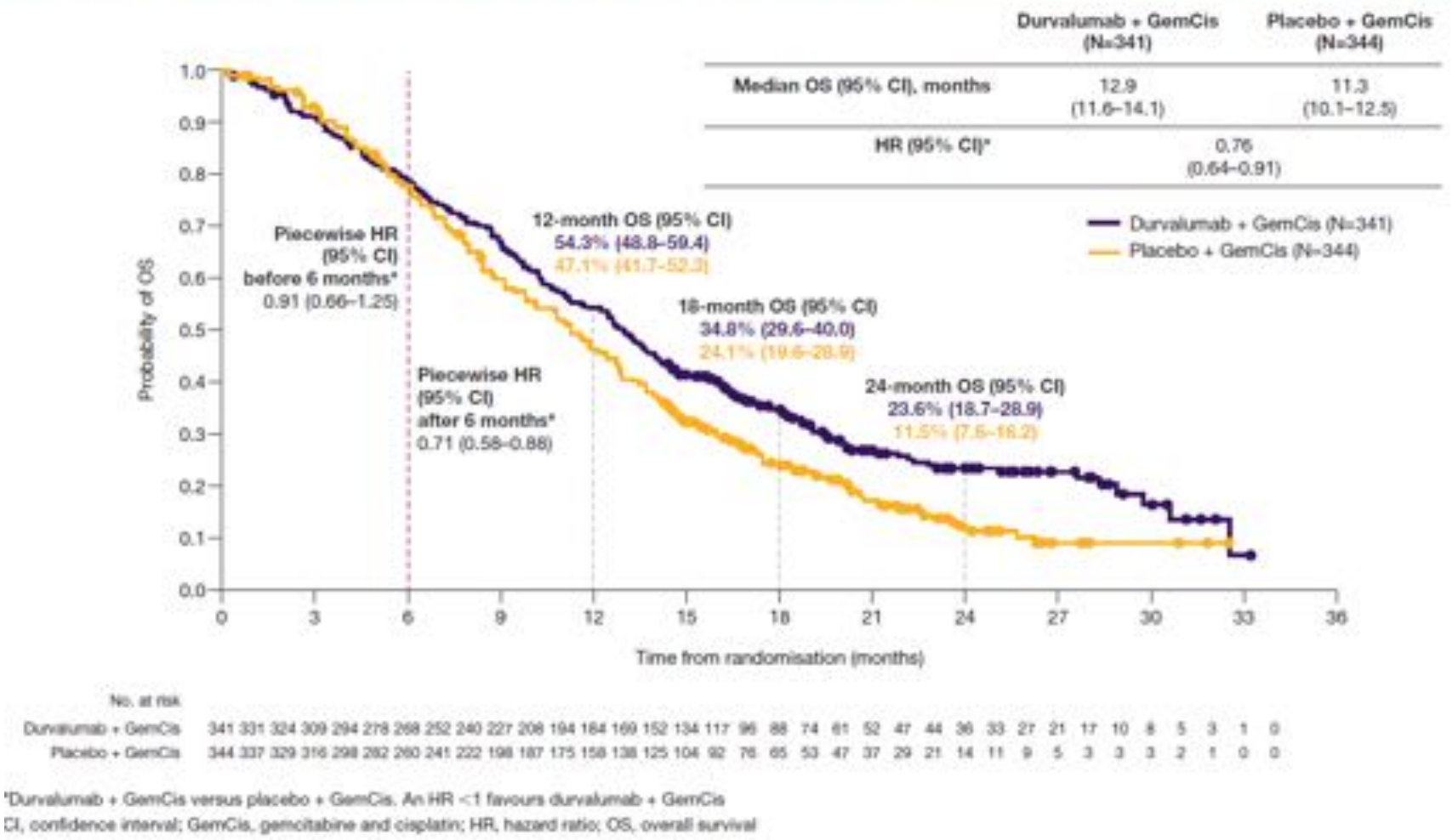
Median duration of follow-up (95% CI) was 16.8 (14.8–17.7) months with durvalumab + GemCis and 15.9 (14.9–16.8) months with placebo + GemCis.
CI, confidence interval; GemCis, gemcitabine and cisplatin; HR, hazard ratio; mo, month; OS, overall survival.

Presented by: Do-Youn Oh, MD, PhD

NEJM, 2022

ESMO 2022: Median 23M of Follow-Up

Figure 2. Kaplan-Meier curve of overall survival



*Durvalumab + GemCis versus placebo + GemCis. An HR <1 favours durvalumab + GemCis
CI, confidence interval; GemCis, gemcitabine and cisplatin; HR, hazard ratio; OS, overall survival

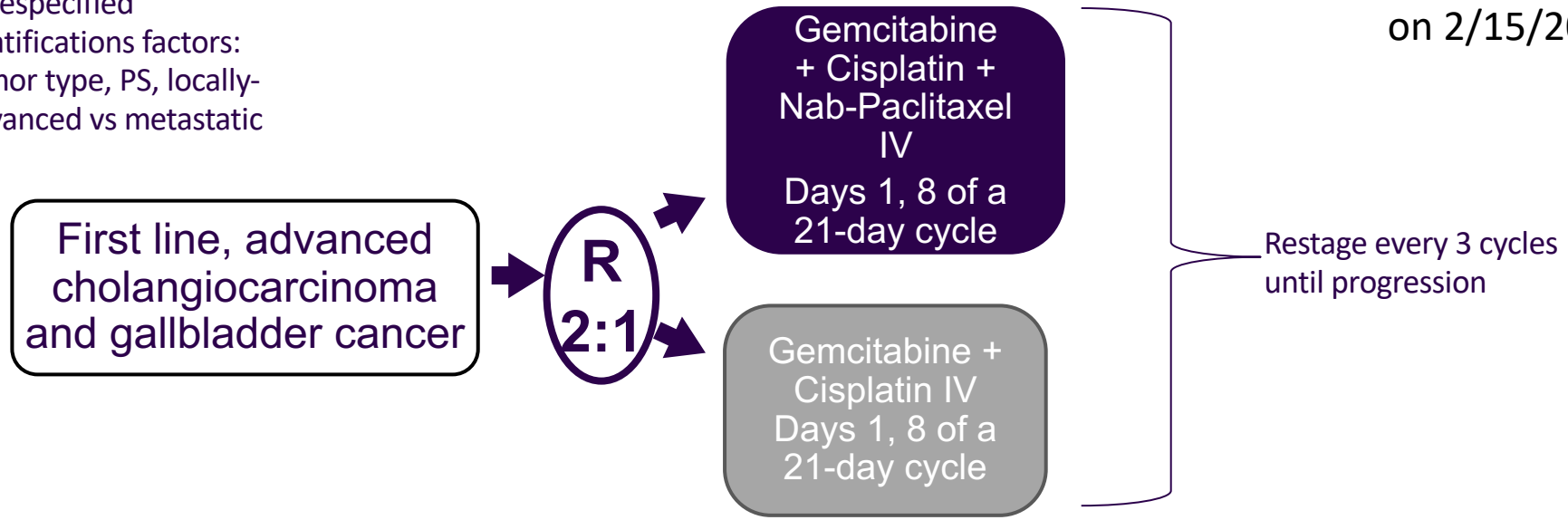
Oh et al: ESMO 2022

S1815: Gemcitabine Hydrochloride and Cisplatin With or Without Nab-Paclitaxel in Treating Patients With Newly Diagnosed Advanced Biliary Tract Cancers NCT03768414

N = 268 → NOW 441

CLOSED TO ACCRUAL on 2/15/2021!!

*Prespecified stratifications factors: tumor type, PS, locally-advanced vs metastatic



Primary EP: OS; Target HR 0.7
Secondary: ORR, PFS, DCR, safety, CA 19-9 changes

Archival blood and tissue specimens to be banked

PI: R. Shroff

HIMALAYA study design

HIMALAYA was an open-label, multicenter, global, Phase 3 trial

Study population
- Patients with confirmed uHCC
- BCLC B (not eligible for locoregional therapy) and C
- No prior systemic therapy
- ECOG PS 0–1
- Child-Pugh A
- No main portal vein thrombosis
- EGD was not required

Stratification factors
- Macrovascular invasion: Y / N
- Etiology of liver disease: HBV / HCV / others
- Performance status: ECOG 0 / 1

R
N=1324

- **T300+D (n=393):** Tremelimumab 300 mg × 1 dose + durvalumab 1500 mg Q4W*
- **Durvalumab (n=389):** Durvalumab monotherapy 1500 mg Q4W*
- **Sorafenib (n=389):** Sorafenib 400 mg BID*
- **T75+D (n=153): *arm closed*†** Tremelimumab 75 mg Q4W × 4 doses + durvalumab Q4W*

Primary objective
- OS for T300+D vs sorafenib

Key secondary objective
- OS for durvalumab vs sorafenib

Additional secondary objectives
- PFS, ORR, and DoR as assessed by investigator per RECIST v1.1
- Safety

Multiple testing procedure

OS *superiority* for T300+D vs sorafenib

↓

OS *noninferiority* for durvalumab vs sorafenib
Noninferiority margin: 1.08

↓

OS *superiority* for durvalumab vs sorafenib

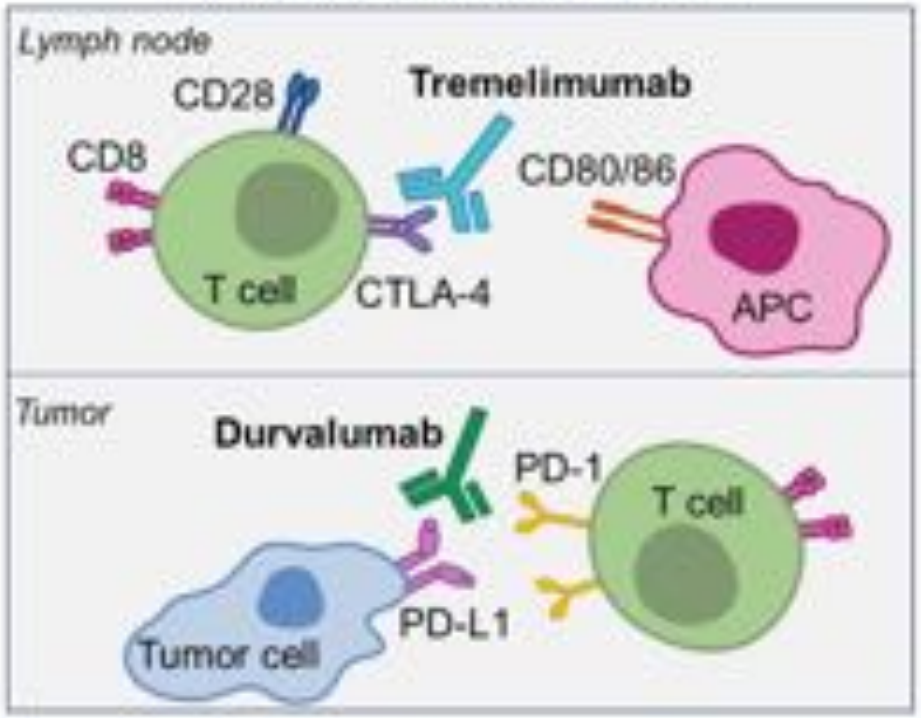
*Treatment continued until disease progression. Patients with progressive disease who, in the investigator's opinion, continued to benefit from treatment and met the criteria for treatment in the setting of progressive disease could continue treatment. †The T75+D arm was closed following a preplanned analysis of a Phase 2 study. Patients randomized to this arm (n=153) could continue treatment following arm closure. Results from this arm are not reported in this presentation.

BID, twice a day; EGD, esophagogastroduodenoscopy; Q4W, every 4 weeks

Background

- Until recently, first-line treatment options for uHCC were limited to the multi-kinase inhibitors sorafenib and lenvatinib, which have been associated with median OS of approximately one year and toxicities that impact quality of life[1,2]
- Atezolizumab (anti-PD-L1) plus bevacizumab (anti-VEGF) showed significant survival benefit vs sorafenib in IMbrave150[3] and has become a standard of care following approval in 2020[4,5]
- The STRIDE (Single Tremelimumab Regular Interval Durvalumab; T300+D) regimen, a novel combination featuring a single high-priming dose of tremelimumab (anti-CTLA-4) and regular interval durvalumab (anti-PD-L1), showed encouraging clinical activity and was well tolerated in a Phase 2 trial in uHCC[6]

Mechanism of action of T300+D[7]



Here, we present results from the final analysis of the Phase 3 HIMALAYA trial (NCT03298451), evaluating the STRIDE (T300+D) regimen and durvalumab monotherapy versus sorafenib for the first-line treatment of patients with uHCC

T300+D, tremelimumab 300 mg + 1 dose + durvalumab 1500 mg Q4W; uHCC, unresectable hepatocellular carcinoma.

1. Llovet et al. *N Engl J Med* 2008;359:378–390. 2. Kudo et al. *Lancet* 2018;391:1163–1173. 3. Finn et al. *N Engl J Med* 2020;382:1894–1905. 4. AVASTIN [prescribing information]. South San Francisco, CA: Genentech, Inc.; 2020. 5. Benson et al. *J Natl Compr Canc Netw* 2021;19:541–565. 6. Kelley et al. *J Clin Oncol* 2021;39:2991–3001. 7. Kudo. *Liver Cancer* 2019;8:413–426.

Presented by: Ghassan K. Abou-Alfa, MD, MBA

Baseline characteristics

Characteristic	T300+D (n=393)	Durvalumab (n=389)	Sorafenib (n=389)
Male sex, n (%)	327 (83.2)	323 (83.0)	337 (86.6)
Median age (range), years	65.0 (22–86)	64.0 (20–86)	64.0 (18–88)
Region, n (%)			
Asia (excluding Japan)	156 (39.7)	167 (42.9)	156 (40.1)
Rest of world (including Japan)	237 (60.3)	222 (57.1)	233 (59.9)
Viral etiology,*† n (%)			
HBV	122 (31.0)	119 (30.6)	119 (30.6)
HCV	110 (28.0)	107 (27.5)	104 (26.7)
Nonviral	161 (41.0)	163 (41.9)	166 (42.7)
ECOG PS, n (%)			
0	244 (62.1)	237 (60.9)	241 (62.0)
1	148 (37.7)	150 (38.6)	147 (37.8)
BCLC,† n (%)			
B	77 (19.6)	80 (20.6)	66 (17.0)
C	316 (80.4)	309 (79.4)	323 (83.0)

Characteristic	T300+D (n=393)	Durvalumab (n=389)	Sorafenib (n=389)
Child-Pugh classification,† n (%)			
A	392 (99.7)	388 (99.7)	386 (99.2)
B	0	1 (0.3)	3 (0.8)
Missing	1 (0.3)	0	0
ALBI grade, n (%)			
1	217 (55.2)	198 (50.9)	203 (52.2)
2	174 (44.3)	189 (48.6)	185 (47.6)
3	1 (0.3)	2 (0.5)	1 (0.3)
MVI,† n (%)	103 (26.2)	94 (24.2)	100 (25.7)
EHS,† n (%)	209 (53.2)	212 (54.5)	203 (52.2)
PD-L1 positive,‡ n (%)	148 (37.7)	154 (39.6)	148 (38.0)
AFP ≥400 ng/ml,† n (%)	145 (36.9)	137 (35.2)	124 (31.9)

*HBV: patients who tested positive for HBsAg or anti-HBc with detectable HBV DNA; HCV: patients who tested positive for HCV or had history of HCV infection; Nonviral: no active viral hepatitis identified. †Determined at screening. ‡Defined as tumor area positivity score ≥1%.

T300+D: tremelimumab 300 mg + 1 dose + durvalumab 1500 mg Q4W.

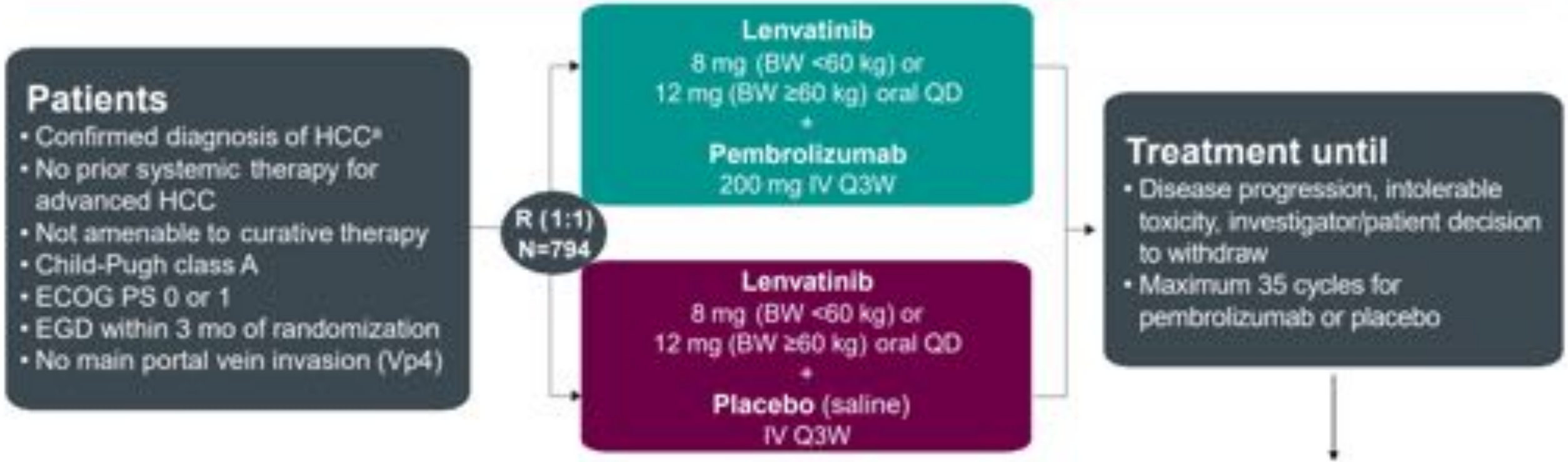
Primary objective: overall survival for T300+D vs sorafenib

	T300+D (n=393)	Sorafenib (n=389)
OS events, n (%)	262 (66.7)	293 (75.3)
Median OS (95% CI), months	16.4 (14.2–19.6)	13.8 (12.3–16.1)
HR (96.02% CI)	0.78 (0.65–0.92)	
p-value (2-sided)	0.0035	

Data cut-off: August 27, 2021. Median duration of follow-up was 33.18 (95% CI: 31.74–34.53) months for T300+D and 32.23 (95% CI: 30.42–33.71) months for sorafenib.
CI: confidence interval; HR: hazard ratio; OS: overall survival; T300+D: tremelimumab 300 mg + 1 dose + durvalumab 1500 mg Q4W.

Presented by: Ghassan K. Abou-Alfa, MD, MBA

LEAP-002 Study Design (NCT03713593) : HCC



Stratification Factors
- Geographic region (Asia vs Japan and rest of world)
- Macroscopic portal vein invasion/extrahepatic spread (yes vs no)
- AFP level (≤400 vs >400 ng/mL)
- ECOG PS (0 vs 1)

Dual primary endpoints:
- OS
- PFS[b] per RECIST v1.1 by BICR

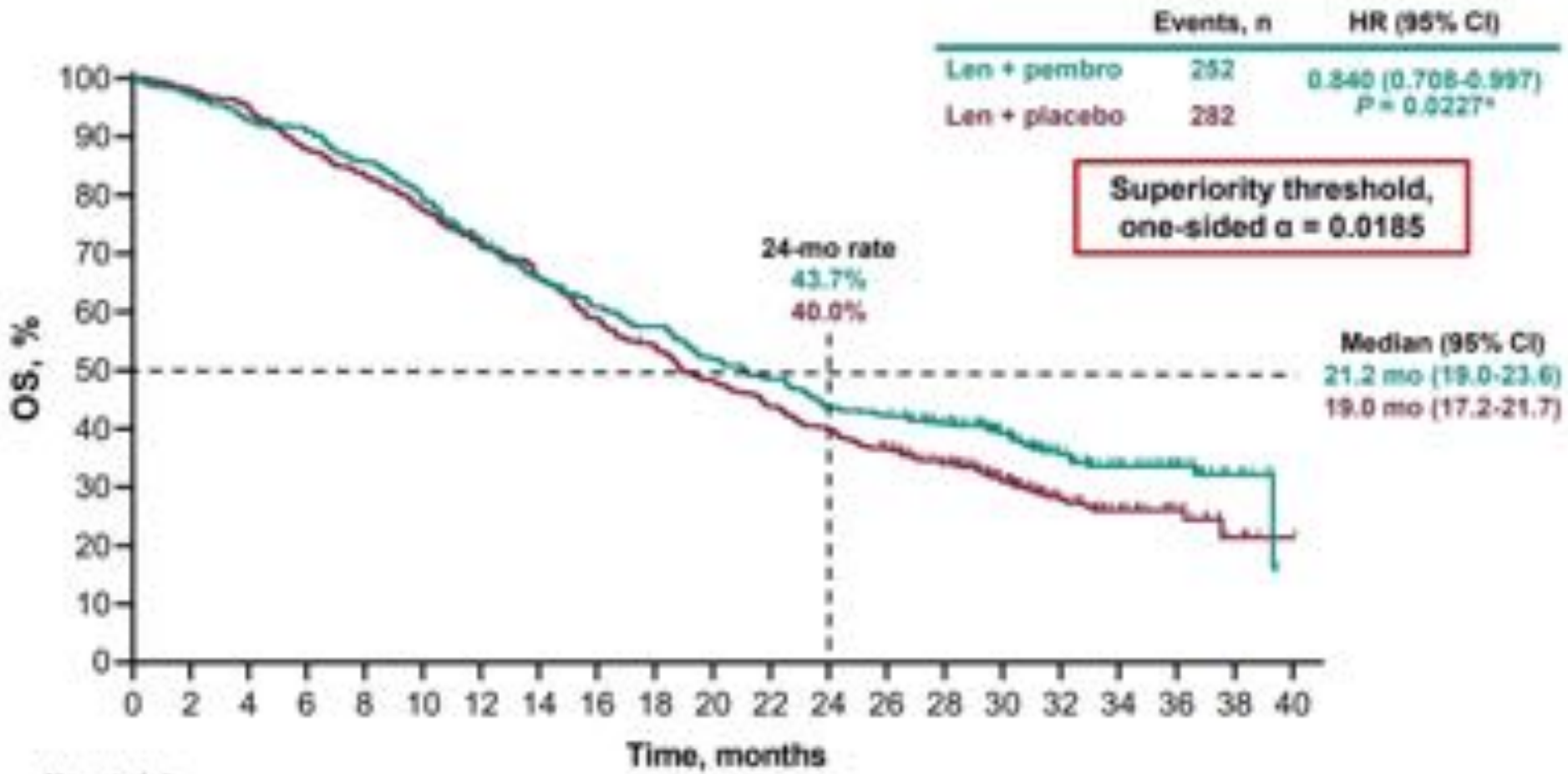
Secondary endpoints included:
- ORR and DOR per RECIST v1.1 and mRECIST by BICR
- Safety/tolerability

Post-treatment follow-up to assess
- Safety
- Disease status
- Survival status

Finn et al: ESMO 2022

[a]Diagnosis to be confirmed by radiology, histology, or cytology (fibrolamellar and mixed hepatocellular/cholangiocarcinoma subtypes are not eligible). Radiologic confirmation of diagnosis is provided by the study site. Clinically confirmed diagnosis of HCC (with liver mass >1 cm and arterial hypervascularity with washout in the venous phase seen with either triphasic CT or MRI) per American Association for the Study of Liver Diseases criteria. [b]Radiological imaging assessment performed Q9W.

Overall Survival, ITT, FA



*Did not reach superiority threshold; one-sided α=0.0185.
Data cutoff date for FA: 21 June 2022; median follow-up: 32.1 months.

2022 ASCO® ANNUAL MEETING

Nimotuzumab Combined with Gemcitabine versus Placebo plus Gemcitabine in K-Ras Wild-type locally Advanced or Metastatic Pancreatic Cancer:

A Prospective, Randomized-controlled, Double-blinded, Multicenter and Phase III Clinical Trial (Notable Study)

Shukui Qin, MD[1]; Jin Li, MD[2]; Yuxian Bai, MD[3]; Zishu Wang, MD[4]; Zhendong Chen, MD[5]; Ruihua Xu, MD[6]; Jianming Xu, MD[7]; Hongmei Zhang, MD[8]; Jia Chen, MD[9]; Ying Yuan, MD[10]; Tianshu Liu, MD[11]; Lin Yang, MD[12]; Haijun Zhong, MD[13]; Donghui Chen, MD[14]; Lin Shen, MD[15]; Chunyi Hao, MD[16]; Deliang Fu, MD[17]; Ying Cheng, MD[18]; Jianwei Yang, MD[19]; Qiong Wang, MD[20]; Baoli Qin, MD[21]; Qingshan Zheng, MD[22] ;Xian hong Bai, MD[23]

[1]Jinling Hospital, Nanjing University of Chinese Medicine, China; [2]Shanghai East Hospital, China; [3]Harbin Medical University Cancer Hospital, China; [4]The First Affiliated Hospital of Bengbu Medical College, China; [5]The Second Affiliated Hospital of Anhui Medical University, China; [6] Sun Yat-sen University Cancer Center, China; [7] Oncology, The Fifth Medical Center, General Hospital of PLA, China; [8]Xijing Hospital, Air Force Medical University of PLA, China; [9]Jiangsu Cancer Hospital, China; [10], The Second Affiliated Hospital Zhejiang University School of Medicine, China; [11] Zhongshan Hospital, Fudan University, China; [12]Cancer Hospital, Chinese Academy of Medical Sciences and Peking Union Medical College, China; [13] Zhejiang Cancer Hospital, China; [14] First People's Hospital, School of Medicine, Shanghai Jiao Tong University, China; [15] Peking University Cancer Hospital & Institute, China; [16]Beijing Cancer Hospital, China; [17] Huashan Hospital, Fudan University, China; [18]Jilin Cancer Hospital, China; [19] Fujian Cancer Hospital, Fuzhou, China; [20]Jiangyin People‘s Hospital, China; [21]Liaoning Cancer Hospital & Institute, China; [22]Shanghai University of traditional Chinese medicine, China; [23]Biotech Pharmaceutical Ltd., Corp, China.

Notable Study design (NCT01074021)

- **A Prospective, Randomized-controlled, Double-blinded, Multicenter Phase III Clinical trial, the Registered & Pivotal Study**

Key eligibility criteria:

- **Aged 18-75 years;**
- **Histologically confirmed locally advanced or metastatic pancreatic cancer;**
- **At least one measurable lesion evaluated by RECIST version 1.1;**
- **K-Ras wild-type;**
- **Karnofsky Performance Status ≥60.**

R 1:1

Nimotuzumab (400mg, weekly) + Gemcitabine (1000mg/m², on days 1, 8, and 15, every four weeks), until disease progression or intolerable toxicity

- **Stratification factors**:
  - Head vs. body or tail
  - Previous surgery (yes *vs* no).
  - Previous treatment of biliary obstruction (yes *vs* no).
  - Previous adjuvant chemotherapy (yes *vs* no).

Placebo (400mg,QW) + Gemcitabine (1000mg/m², on days 1, 8, and 15, every four weeks), until disease progression or intolerable toxicity

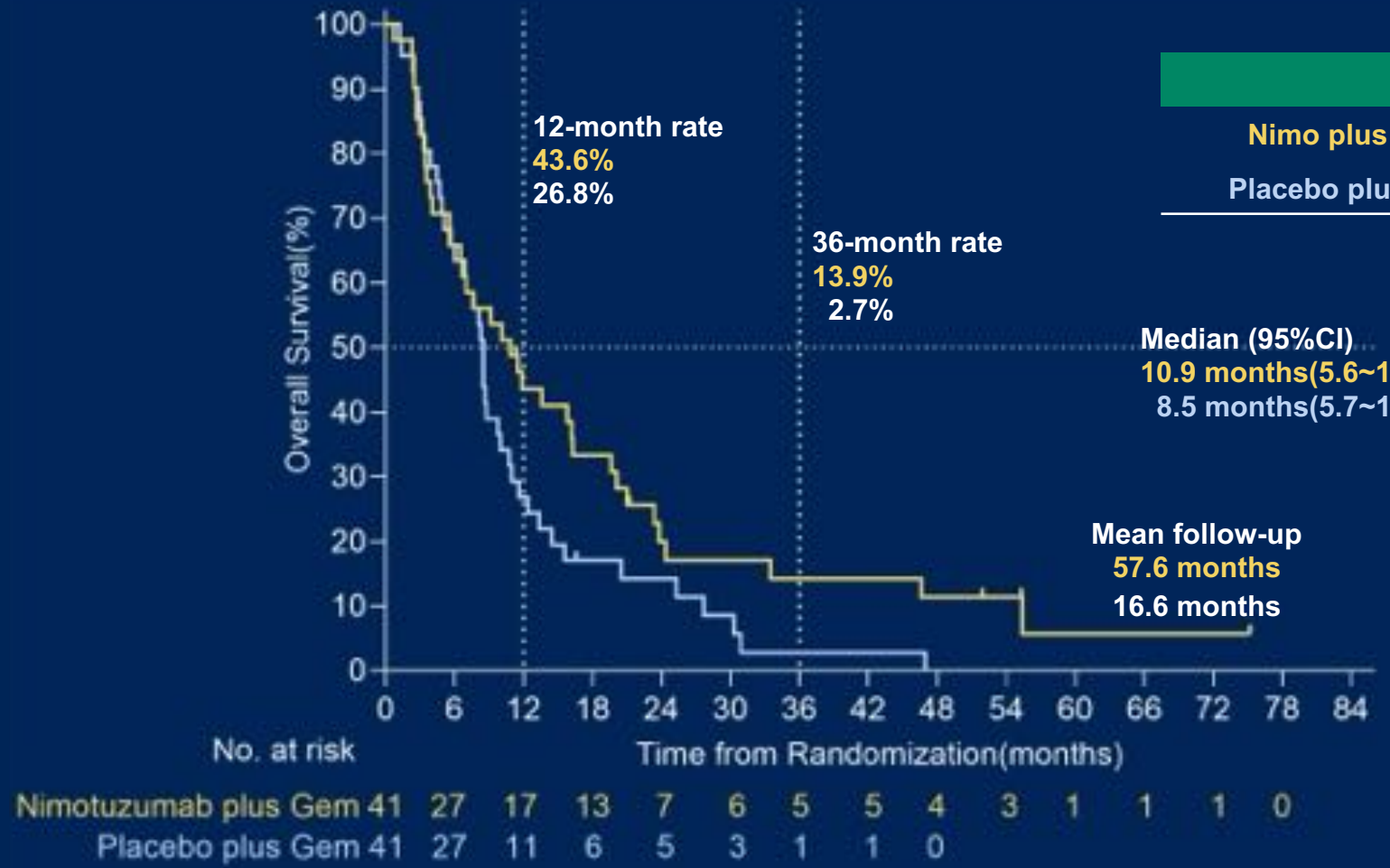
Follow up

A sample size of 79 patients, the study would have 80% power to detect a 5.95 months difference of mOS with Nimo (11.62 months) vs. Placebo (5.65 months) at a two-sided alpha level of 0.05. Finally it will be a sample size of 92 patients at 20% drop out.

- **Primary endpoint:** OS
- **Secondary endpoints:** PFS, TTP, ORR,DCR.CBR & Safety

* OS, overall survival; PFS, progression-free survival; TTP, time to disease progression; ORR, objective response rate; DCR, disease control rate, CBR, clinical benefit response

Overall Survival (Full Analysis Set)



	mOS	HR(95%CI)	*P*
Nimo plus Gem	10.9 months	0.50	RMST-Log
Placebo plus Gem	8.5 months	（0.06-0.94)	*P=0.024*

- **Nimo plus Gem regime improved mOS compared with Placebo plus Gem, with a decrease of 50% mortality risk.**

* There was a violation of the proportional hazards (PH) because the two survival curves cross. Restricted Mean Survival Time (RMST) method (RMSTREG procedure, log-linear models) was used to estimate hazard risk. The adjusted HR with 95% CI was used as primary estimate of the difference between the arms, stratified by tumor location, previous surgery history, previous treatment of bile obstruction, previous adjuvant chemotherapy history at baseline. Data cut-off, Nov.23,2021.

DYNAMIC Adjuvant Chemotherapy Guided by Circulating Tumor DNA Analysis in Stage II Colon Cancer

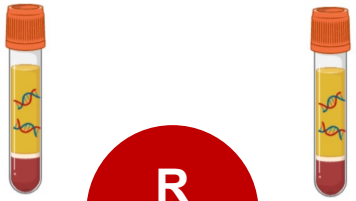
ACTRN12615000381583

Stage II Colon Cancer

- R0 resection
- ECOG 0 – 2
- Staging CT within 8 weeks
- Provision of adequate tumor tissue within 4 weeks post-op
- No synchronous colorectal cancer

Plasma Collections

Week 4 + 7 post-op



R
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ctDNA-Guided Management

- **ctDNA-Positive → Adjuvant Chemo** (oxaliplatin-based or single agent FP)
- **ctDNA-Negative → Observation**

ctDNA-Positive = Positive result at week 4 and/or 7

Standard Management

Adjuvant treatment decisions based on conventional clinico-pathologic criteria

Endpoints

Primary
- RFS rate at 2 years

Key Secondary
- Proportion receiving adjuvant chemo

Secondary
- RFS by ctDNA status for ctDNA-guided arm
- TTR
- OS

Stratification Factors
- T stage (T3 vs T4)
- Type of participating center (metropolitan vs regional)

Surveillance:
- CEA → 3-monthly for 24M, then 6-monthly for 36M
- CT C/A/P → 6-monthly for 24M, then at 36M

PRESENTED BY:
Jeanne Tie

ctDNA Analysis: Tumor-Informed Personalized Approach

Resected tumor tissue

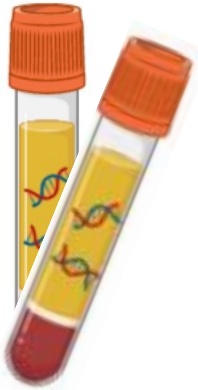
FFPE tissue from primary tumor

Targeted sequencing identifies mutation(s) unique to that cancer

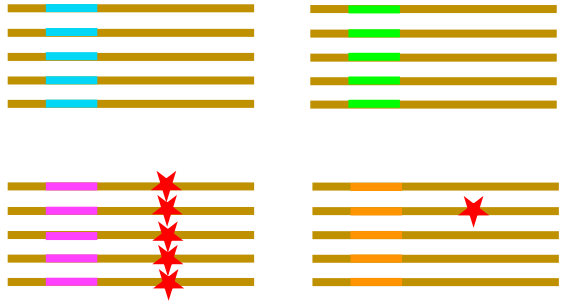
15 recurrently mutated genes in colorectal cancer

(APC, TP53, KRAS, PIK3CA, FBXW7, BRAF, SMAD4, RNF43, POLE, CTNNB1, ERBB3, NRAS, PPP2R1A, AKT1, HRAS)

Week 4 + 7 plasma



At least one patient-specific mutation assessed in plasma



ctDNA detection by Safe-Sequencing System*

(error reduction technology designed to detect low frequency mutations using unique molecular identifier)

*Kinde *et al*. Proc Natl Acad Sci U S A. 2011;108(23):9530-5

Baseline Characteristics

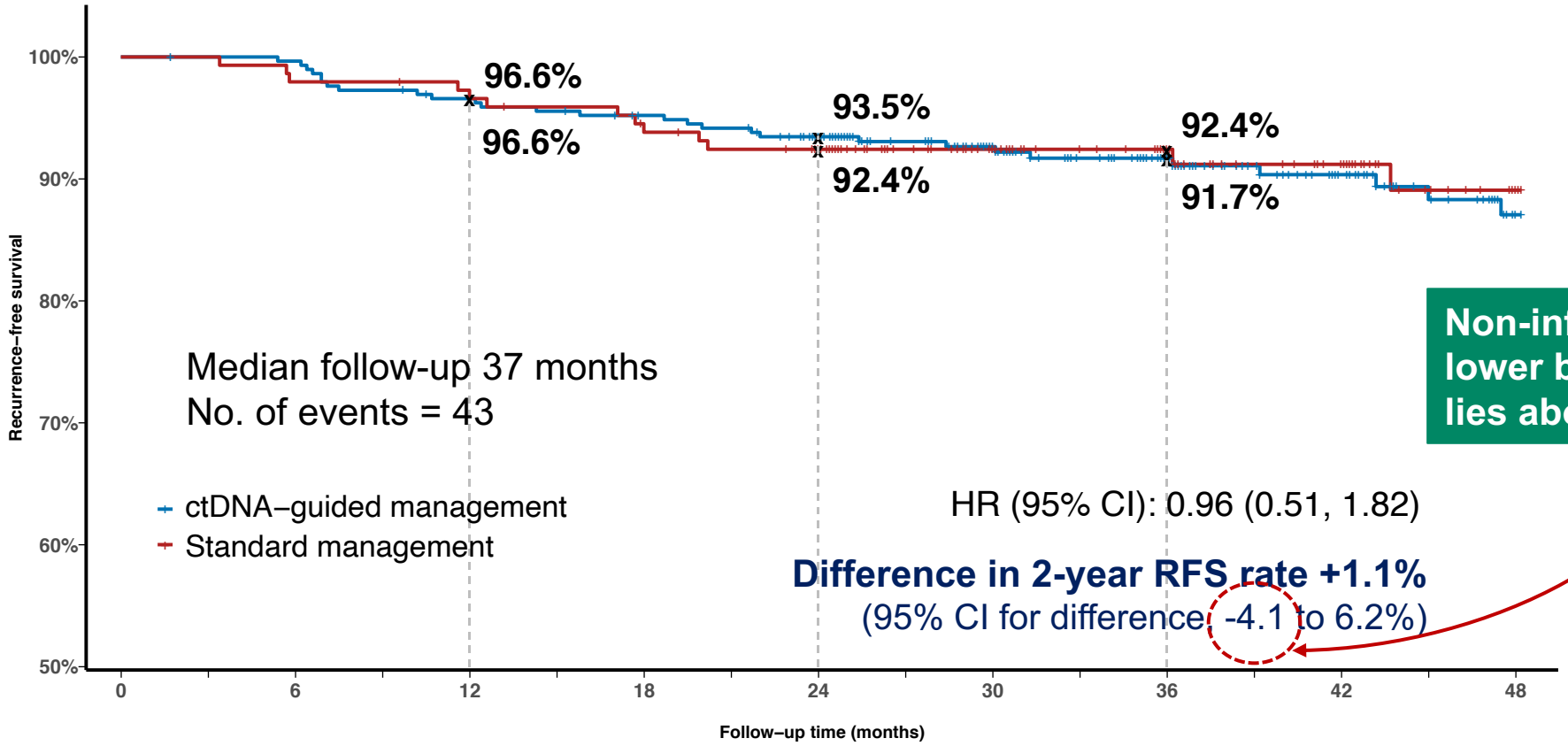
Characteristics	ctDNA-Guided Management N = 294, N (%)	Standard Management N = 147, N (%)
Age, median (range), years	65 (30 , 94)	62 (28 , 84)
Sex, Male	154 (52)	81 (55)
ECOG, 0	226 (77)	124 (84)
Center type, metropolitan	240 (82)	121 (82)
Primary tumor site, left-sided	126 (43)	78 (53)
Tumor stage, T3	250 (85)	127 (86)
Tumor differentiation, poor	43 (15)	17 (12)
Lymph node yield, < 12	13 (4)	7 (5)
Lymphovascular invasion, present	82 (28)	38 (26)
MMR, deficient	59 (20)	27 (18)
Clinical risk group, high*	116 (40)	60 (41)

*High clinical risk = proficient MMR + ≥1 high-risk feature (T4, poor tumor differentiation, <12 lymph node yield, LVI, tumor perforation and/or bowel obstruction)

Adjuvant Treatment Delivery

Treatment Information	ctDNA-Guided N = 294	Standard Management N = 147	P-value
Adjuvant Chemotherapy received, n	45 **(15%)**	41 **(28%)**	0.0017
Chemotherapy regimen received, n			
Oxaliplatin-based doublet	28/45 **(62%)**	4/41 **(10%)**	
Single agent fluoropyrimidine	17/45 **(38%)**	37/41 **(90%)**	<.0001
Time from surgery to commencing chemotherapy, median (IQR), days	83 (76, 89)	53 (49, 61)	<.0001
Treatment duration, median (IQR), weeks	24 (19, 24)	24 (21, 24)	0.9318
Completed planned treatment, n	38 (85%)	32 (78%)	0.7036
Percentage of full dose delivered, median (IQR)	78 (56, 100)	84 (64, 100)	0.6194

Recurrence-Free Survival (RFS)



Non-inferiority confirmed: lower bound of 95% CI lies above -8.5%

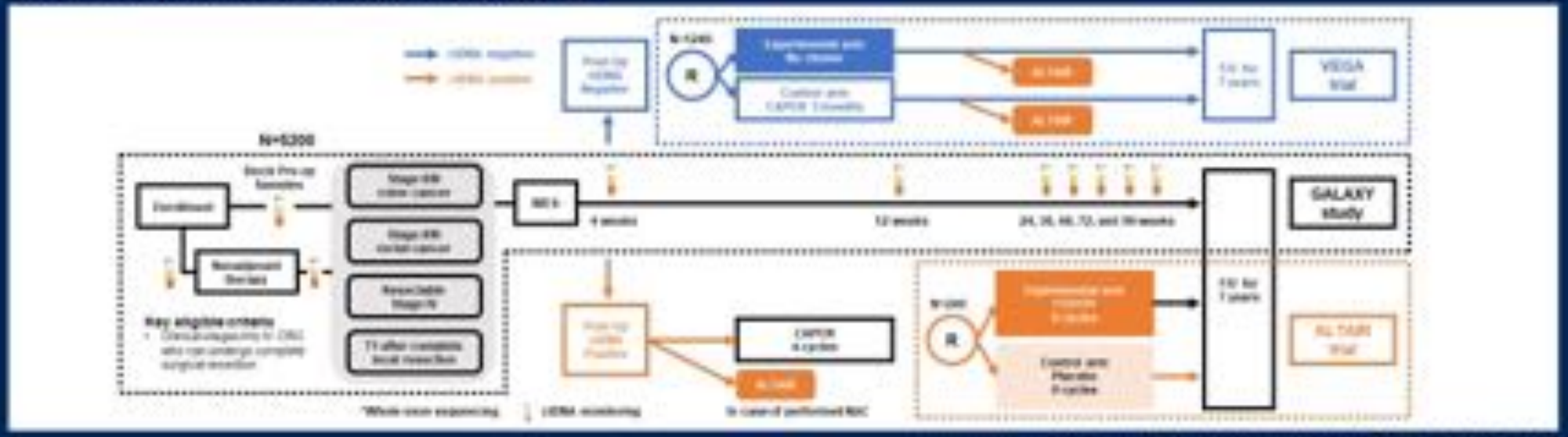
Numbers at risk

ctDNA-guided	294	292	281	273	259	207	155	109	64
Standard	147	144	142	136	128	97	78	57	33

Background

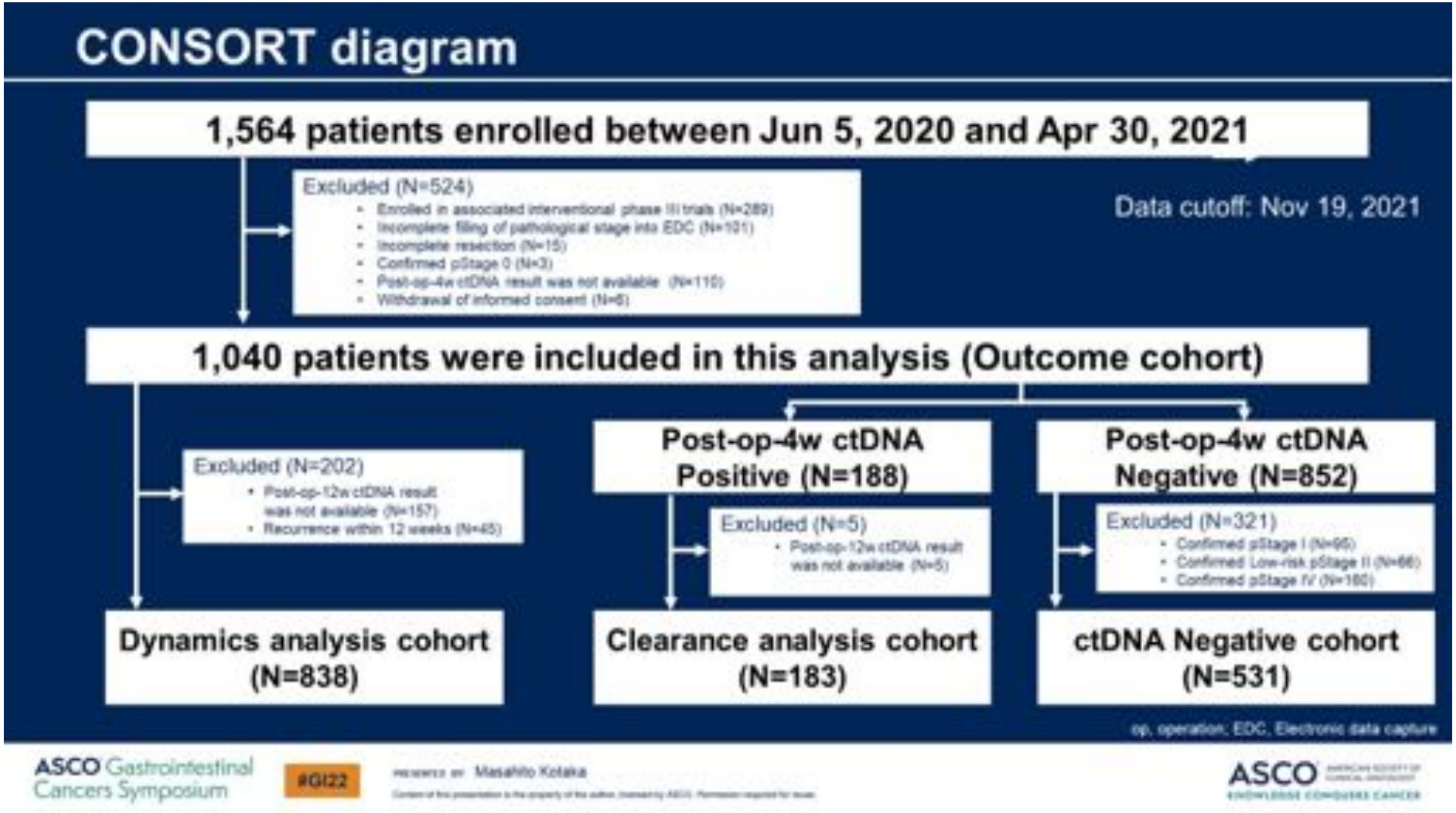
- Circulating tumor DNA (ctDNA)-based molecular residual disease (MRD) has the potential to select patients who may benefit more from standard-of-care (SOC) adjuvant chemotherapy (ACT) by accurately assessing recurrence-risk post-surgery and by evaluating ACT efficacy.
- CIRCULATE-Japan project is a large platform enrolling patients with clinical stage II–IV resectable colorectal cancer (CRC) to evaluate the clinical utility of ctDNA MRD analysis. The study comprises of one observational (GALAXY study) and two randomized phase III trials (VEGA and ALTAIR trials)[1,2].

Schema of CIRCULATE-Japan project



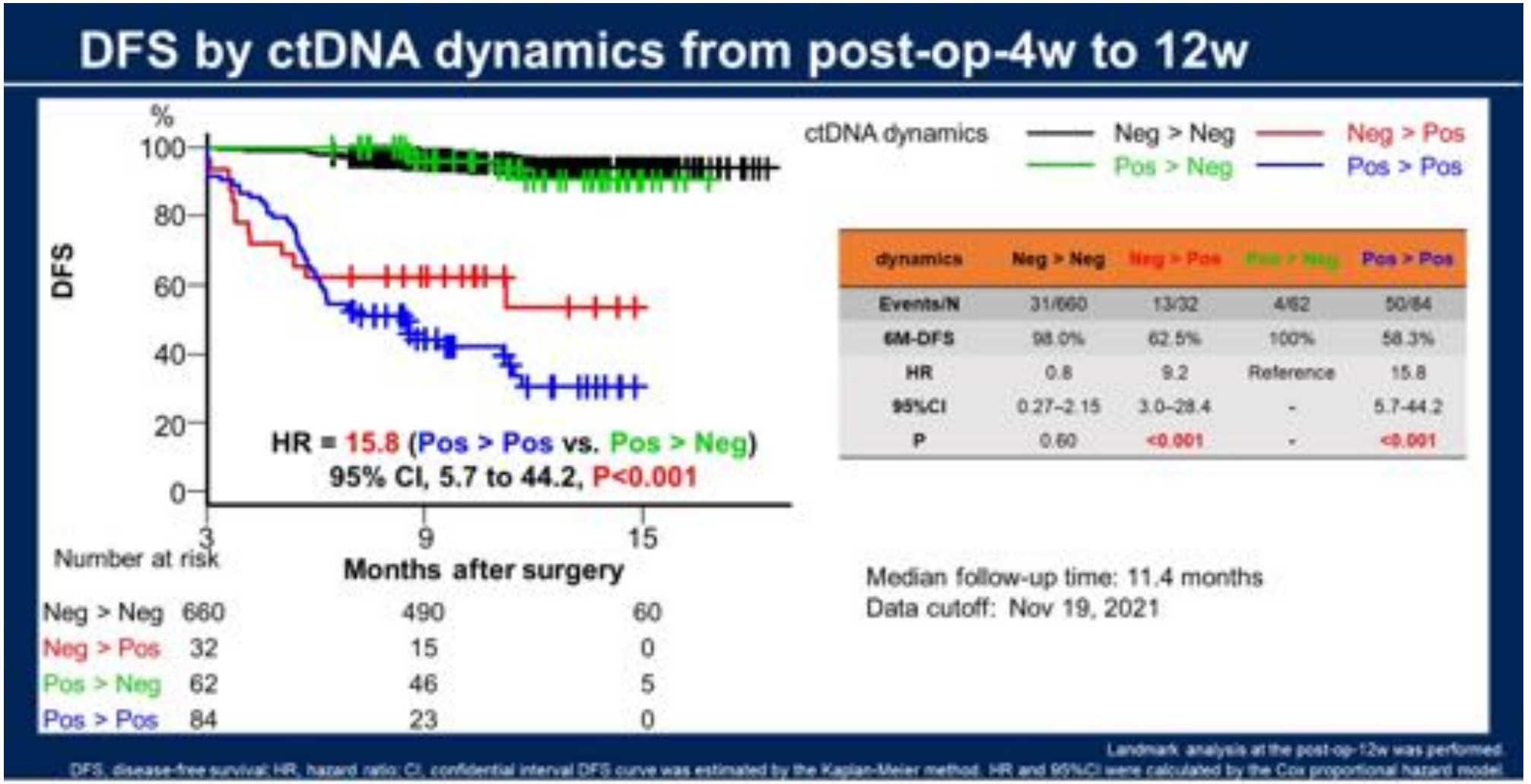
1. Taniguchi H, et al. Cancer Sci 2021, 2. Miyo M, et al. Cancer Sci 2021.

CIRCULATE-JAPAN (GALAXY Study) Results



JCO.2022.40.4_suppl.009

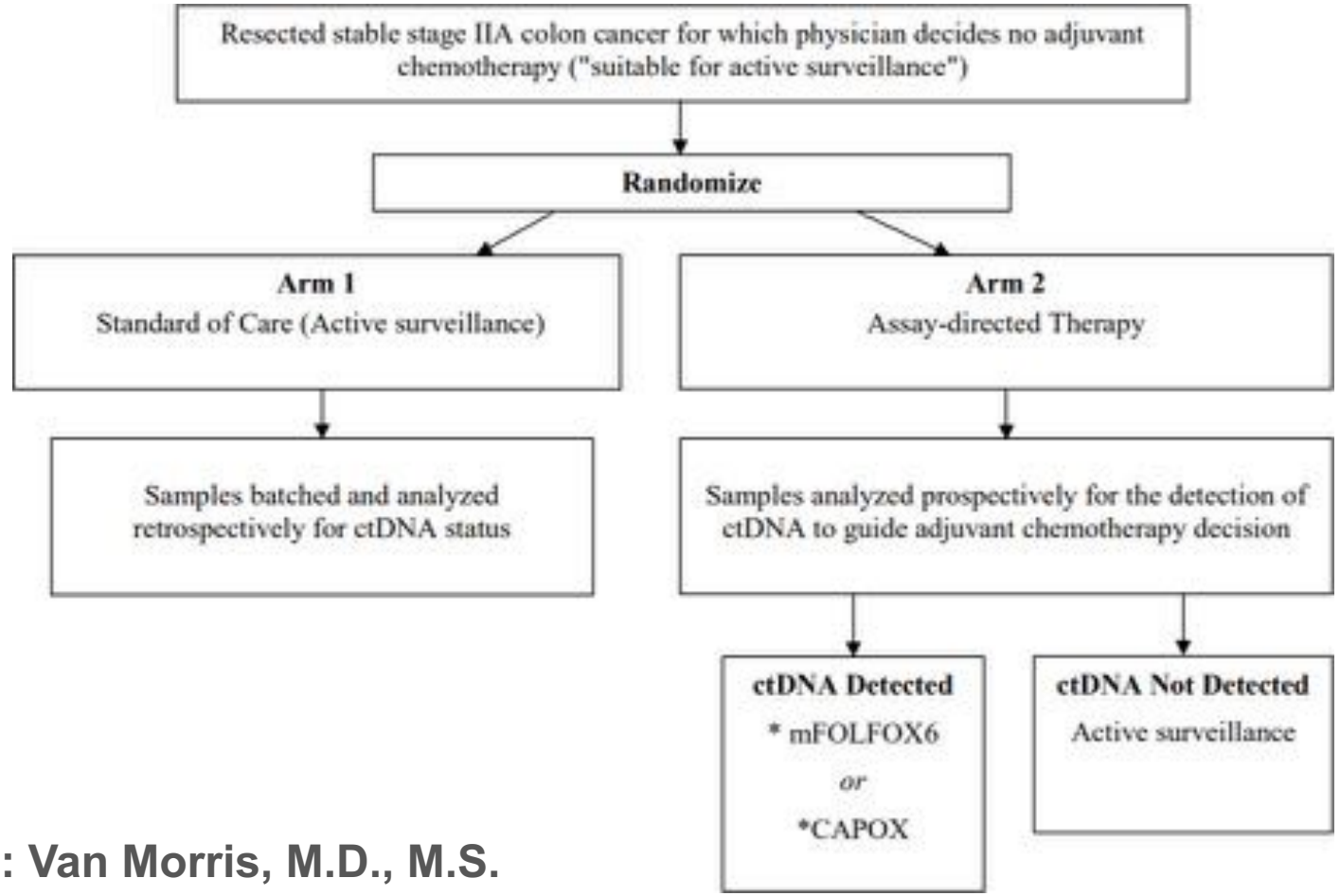
ctDNA May Guide Adjuvant Treatment for CRC



JCO.2022.40.4_suppl.009

NRG GI-005 (COBRA)

- **Phase II - To compare the rate of ctDNA clearance in "ctDNA detected" patients treated with or without adjuvant chemotherapy following resection of stage IIA colon cancer.**
- **Phase III - To compare recurrence-free survival (RFS) in "ctDNA detected" patients treated with or without adjuvant chemotherapy following resection of state IIA colon cancer**
- **Platform: Guardant**

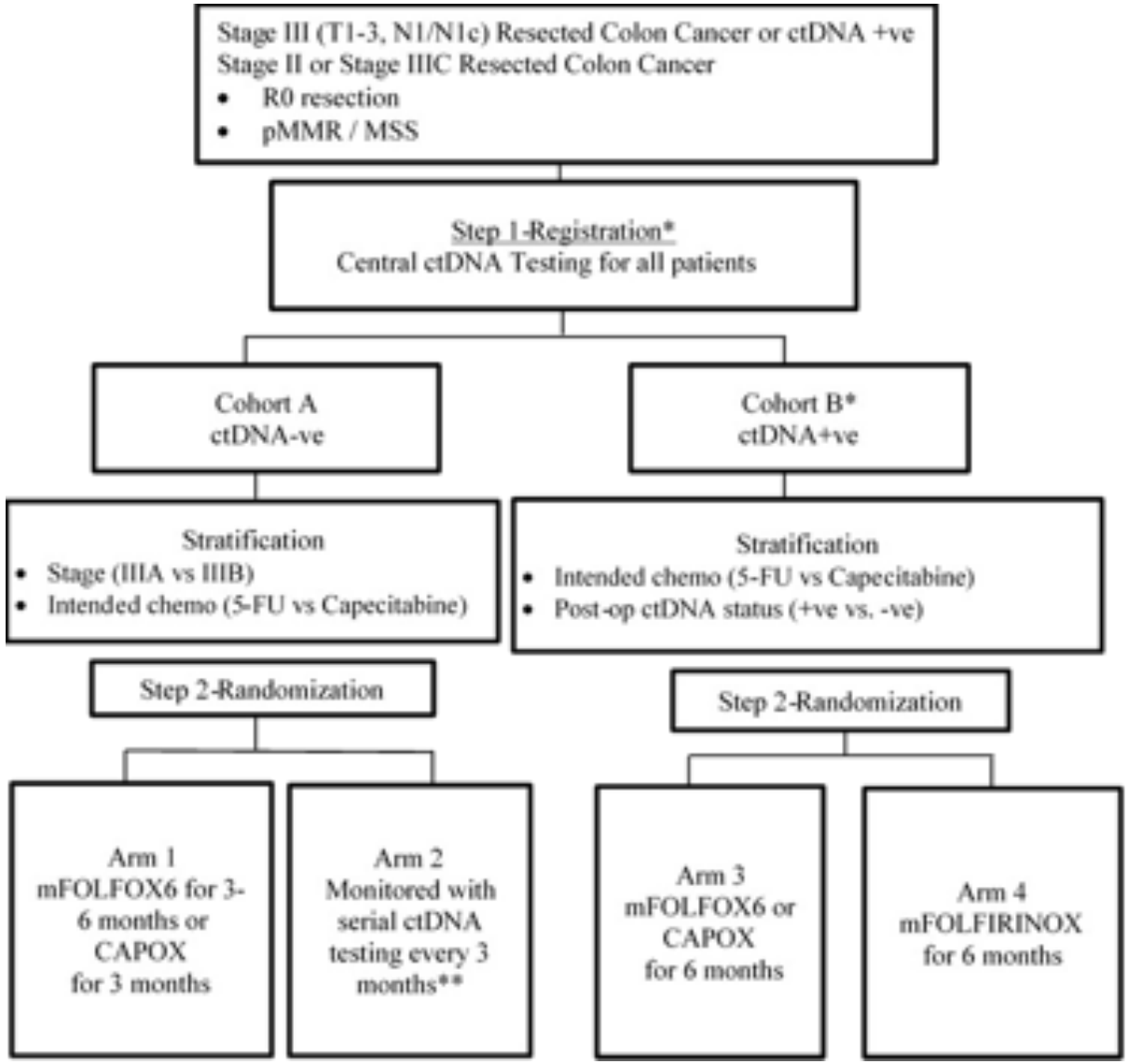


PI's: Van Morris, M.D., M.S.
Greg Yothers, Ph.D.,
Scott Kopetz, M.D., Ph.D,
Thom George, M.D.

NRG ONCOLOGY™

NCT04068103

Study Schema



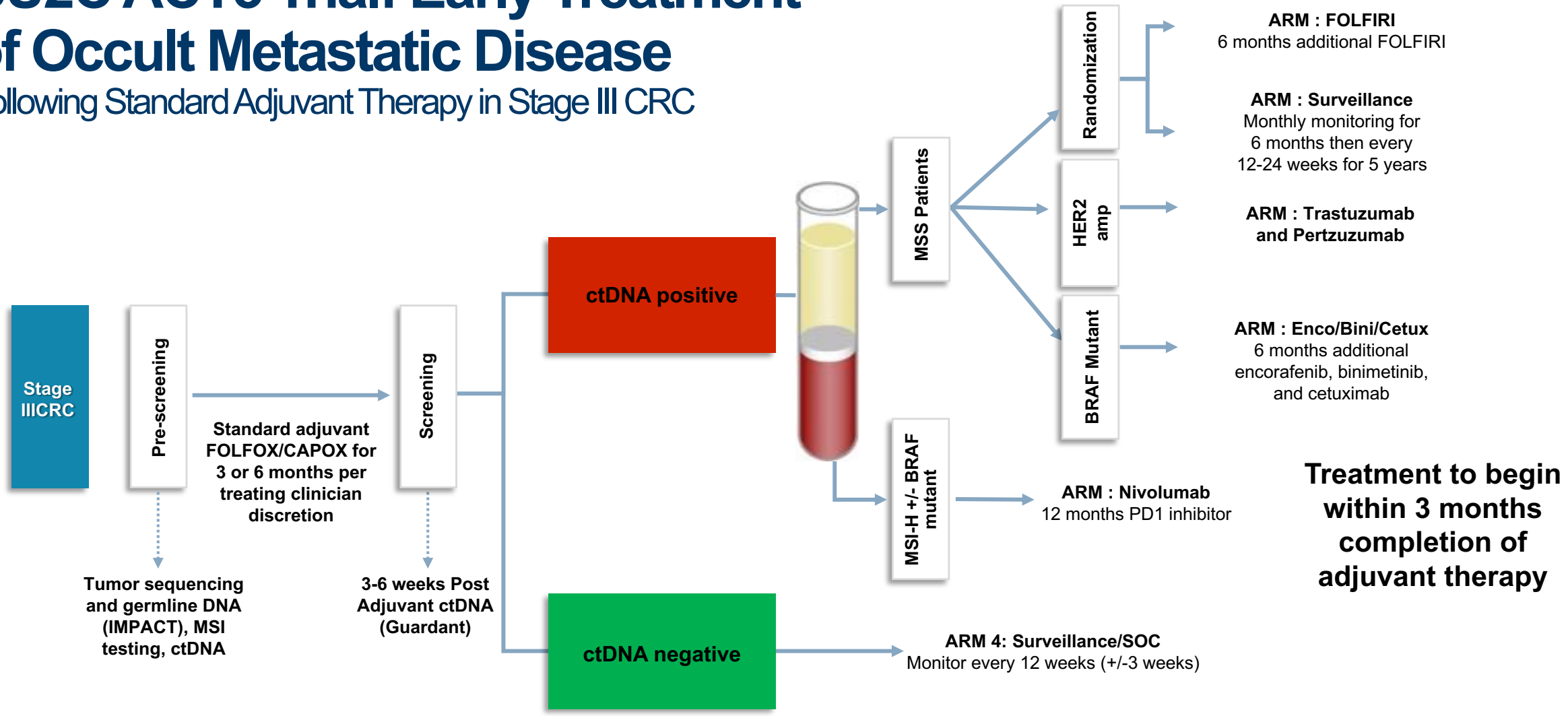
*Patients with completely resected stages II or IIIC colon cancer who are ctDNA +ve as determined by a Signatera ctDNA test performed outside of the trial through routine clinical care and who otherwise meet all eligibility criteria for Step 1-Registration are eligible for enrollment into Cohort B.

**Patients in Cohort A (Arm 2) who develop a ctDNA +ve assay during serial monitoring may transition to the ctDNA+ve cohort (Cohort B) and undergo a second randomization.

NCT04089631

SU2C ACT3 Trial: Early Treatment of Occult Metastatic Disease

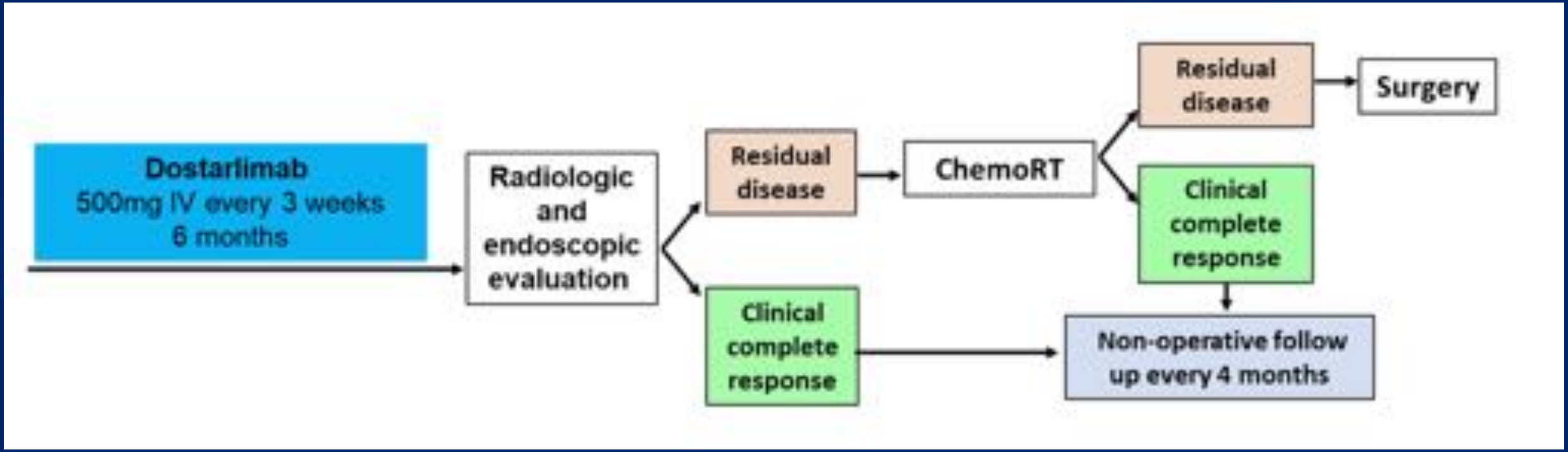
Following Standard Adjuvant Therapy in Stage III CRC



Treatment to begin within 3 months completion of adjuvant therapy

Parikh, A. NCT03803553 [clinicaltrials.gov]. Accessed August 8, 2022. https://www.clinicaltrials.gov/ct2/show/NCT03803553.

PD-1 Blockade in Locally Advanced MSI-H Rectal Cancer



Patient population: Stage II and III mismatch repair deficient rectal cancer

Target Enrollment: 30 subjects

Study Design: Simon's two stage minimax design

Cercek et al: NEJM, 2022

NCT04165772

Demographic and disease characteristics of the patients at baseline

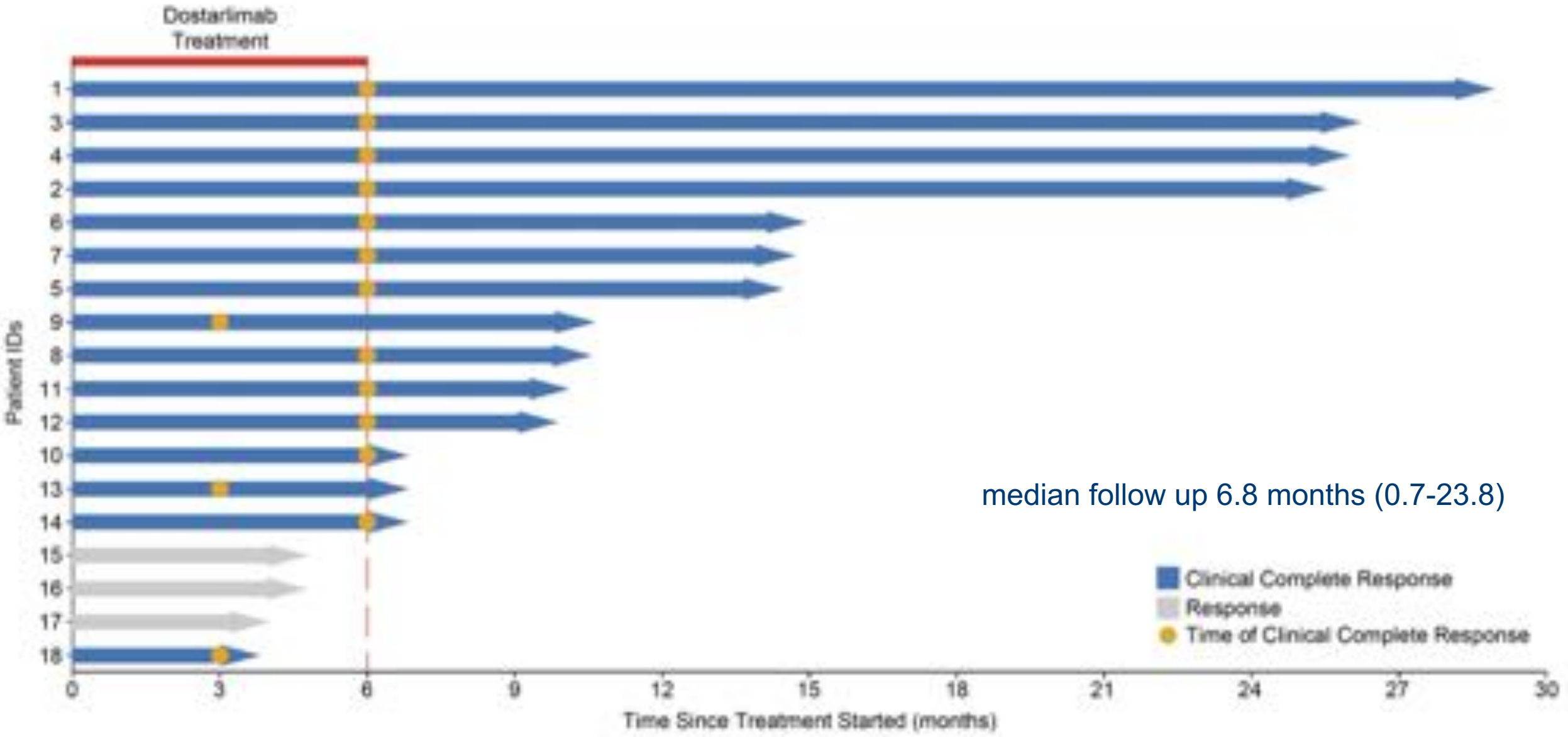
	Value (%)
Sex	
Male	6 (33)
Female	12 (67)
Age, median (range)	54 (26-78)
Race/Ethnicity	
White non-Hispanic	11 (61)
Hispanic	1 (6)
Black or African American	3 (17)
Asian-Far East/Indian Subcontinent	3 (17)
Tumor Staging	
T1/2	4 (22)
T3, T4	**14 (78)**
Nodal Staging	
Node-positive	**17 (94)**
Node-negative	1 (6)
Germline Mutation Status n=17	
MSH2, MLH1, MSH6, or PMS2	**10 (59)**
Negative	7 (41)
BRAF V600E wild type	18 (100)
Tumor Mutational Burden (mut/Mb), mean (range)	67 (36 -106)

Individual responses to PD-1 blockade with dostarlimab

Patients who completed 6-months of dostarlimab

ID	Age	Stage T	Stage N	FU (months)	Digital rectal exam response	Endoscopic best response	Rectal MRI best response	Overall response 100%
1	38	T4	N+	23.8	CR	CR	CR	**cCR**
2	30	T3	N+	20.5	CR	CR	CR	**cCR**
3	61	T1/2	N+	20.6	CR	CR	CR	**cCR**
4	28	T4	N+	20.5	CR	CR	CR	**cCR**
5	53	T1/2	N+	9.1	CR	CR	CR	**cCR**
6	77	T1/2	N+	11.0	CR	CR	CR	**cCR**
7	77	T1/2	N+	8.7	CR	CR	CR	**cCR**
8	55	T3	N+	5.0	CR	CR	CR	**cCR**
9	68	T3	N+	4.9	CR	CR	CR	**cCR**
10	78	T3	N-	1.7	CR	CR	CR	**cCR**
11	55	T3	N+	4.7	CR	CR	CR	**cCR**
12	27	T3	N+	4.4	CR	CR	CR	**cCR**
13	26	T3	N+	0.8	CR	CR	CR	**cCR**
14	43	T3	N+	0.7	CR	CR	CR	**cCR**

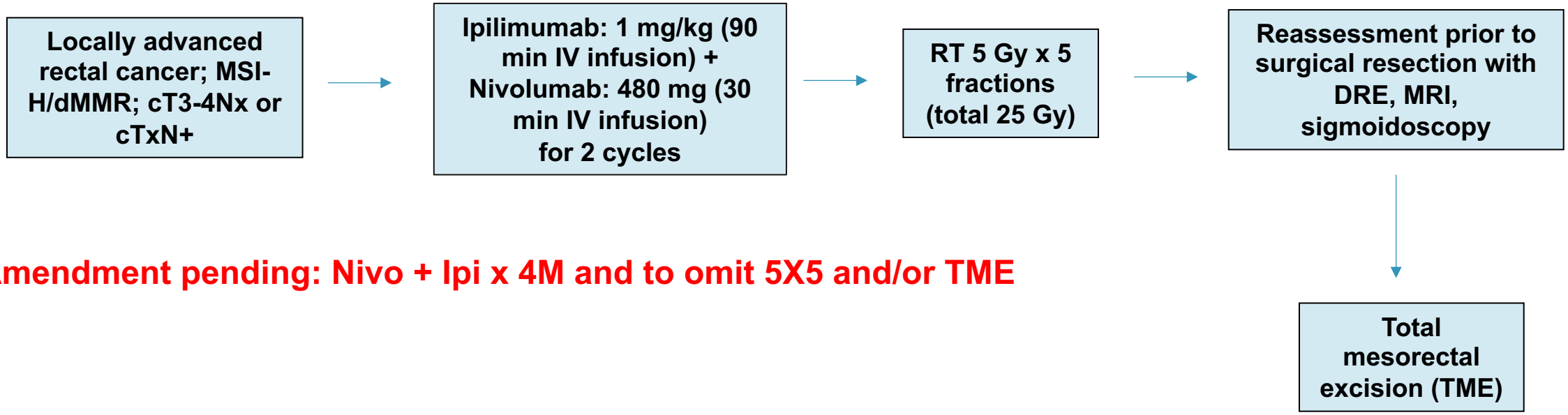
Duration of response



median follow up 6.8 months (0.7-23.8)

EA2201: Phase II Study of Neoadjuvant Nivolumab plus Ipilimumab +/- Short Course Radiation in MSI-H Rectal Tumors

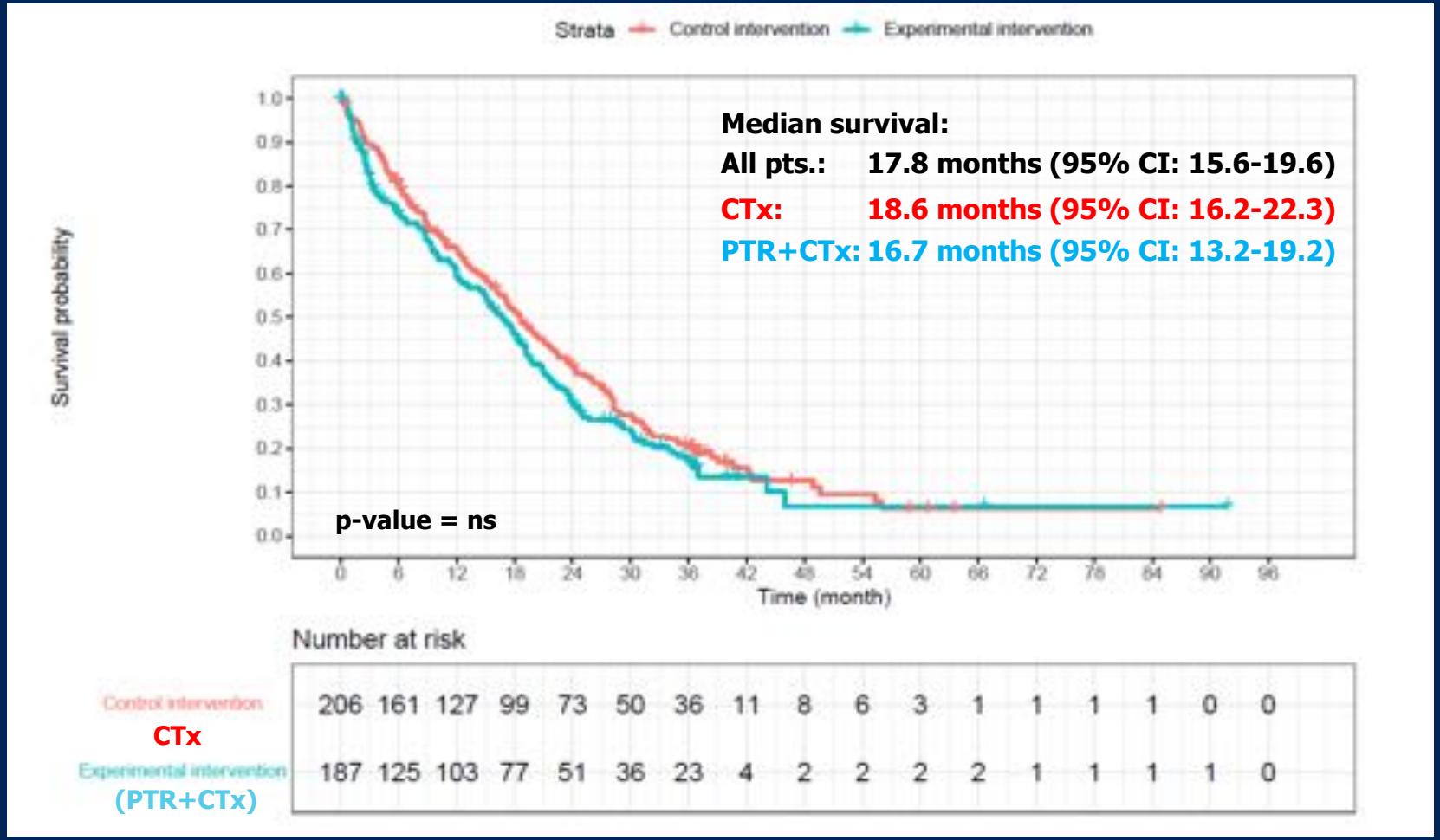
- Rectal adenocarcinoma
- T3-4Nx or TxN+ disease based on imaging
- MSI-H/dMMR based on IHC or PCR
- Integral biomarker
- ECOG PS 0-2



Amendment pending: Nivo + Ipi x 4M and to omit 5X5 and/or TME

NCT04751370: PI: Kristen Ciombor and co-PI: Cathy Eng

Primary Endpoint: Overall Survival (ITT)



PRESENTED BY:
Jürgen Weitz, MD
Department of Visceral-, Thoracic and Vascular Surgery
Universitätsklinikum Carl Gustav Carus

2022 ASCO® ANNUAL MEETING

Panitumumab plus mFOLFOX6 versus Bevacizumab plus mFOLFOX6 as first-line treatment in patients with *RAS* wild-type metastatic colorectal cancer: results from the phase 3 PARADIGM trial

Takayuki Yoshino[1], Jun Watanabe[2], Kohei Shitara[1], Kentaro Yamazaki[3], Hisatsugu Ohori[4], Manabu Shiozawa[5], Hirofumi Yasui[4], Eiji Oki[6], Takeo Sato[7], Takeshi Naitoh[8], Yoshito Komatsu[9], Takeshi Kato[10], Masamitsu Hihara[11], Junpei Soeda[11], Kouji Yamamoto[12], Kiwamu Akagi[13], Atsushi Ochiai[14], Hiroyuki Uetake[15], Katsuya Tsuchihara[16], Kei Muro[17]

[1]Department of Gastroenterology and Gastrointestinal Oncology, National Cancer Center Hospital East, Kashiwa, Japan; [2]Gastroenterological Center, Yokohama City University Medical Center, Yokohama, Japan; [3]Division of Gastrointestinal Oncology, Shizuoka Cancer Center, Shizuoka, Japan; [4]Division of Medical Oncology, Japanese Red Cross Ishinomaki Hospital, Miyagi, Japan; [5]Division of Gastrointestinal Surgery, Kanagawa Cancer Center, Kanagawa, Japan; [6]Department of Surgery and Science, Graduate School of Medical Sciences, Kyushu University, Fukuoka, Japan; [7]Research and Development Center for Medical Education, Department of Clinical Skills Education, Kitasato University School of Medicine, Sagamihara, Japan; [8]Department of Lower Gastrointestinal Surgery, Kitasato University School of Medicine, Sagamihara, Japan; [9]Division of Cancer Chemotherapy, Hokkaido University Hospital Cancer Center, Sapporo, Japan; [10]Department of Surgery, National Hospital Organization Osaka National Hospital, Osaka, Japan; [11]Japan Medical Affairs, Japan Oncology Business Unit, Takeda Pharmaceutical Company Ltd., Tokyo, Japan; [12]Department of Biostatistics, Yokohama City University School of Medicine, Yokohama, Japan; [13]Division of Molecular Diagnosis and Cancer Prevention, Saitama Cancer Center, Saitama, Japan; [14]Pathology Division, Exploratory Oncology Research & Clinical Trial Center, National Cancer Center, Chiba, Japan; [15]National Hospital Organization, Disaster Medical Center, Tokyo, Japan; [16]Division of Translational Informatics, Exploratory Oncology Research & Clinical Trial Center, National Cancer Center, Chiba, Japan; [17]Department of Clinical Oncology, Aichi Cancer Center Hospital, Nagoya, Japan

PARADIGM Trial Design

Phase 3, randomized, open-label, multicenter study (NCT02394795)

Patients with *RAS* WT mCRC

- Unresectable disease
- No previous chemotherapy[a]
- Age: 20–79 years
- ECOG performance status 0–1
- At least 1 evaluable lesion
- Adequate organ function
- Life expectancy ≥ 3 months

N=823

R 1:1

Panitumumab +mFOLFOX6[b]

Bevacizumab +mFOLFOX6[b]

Primary endpoint

- OS: left-sided[c] population; if significant, analyzed in overall population

Secondary endpoints

- PFS, RR, DOR, R0 resection: left-sided[c] and overall populations
- Safety: all treated patients

Exploratory endpoints

- ETS, depth of response, DCR: left-sided[c] and overall populations

Stratification factors

- Institution
- Age: 20–64 vs 65–79 years
- Liver metastases: present vs absent

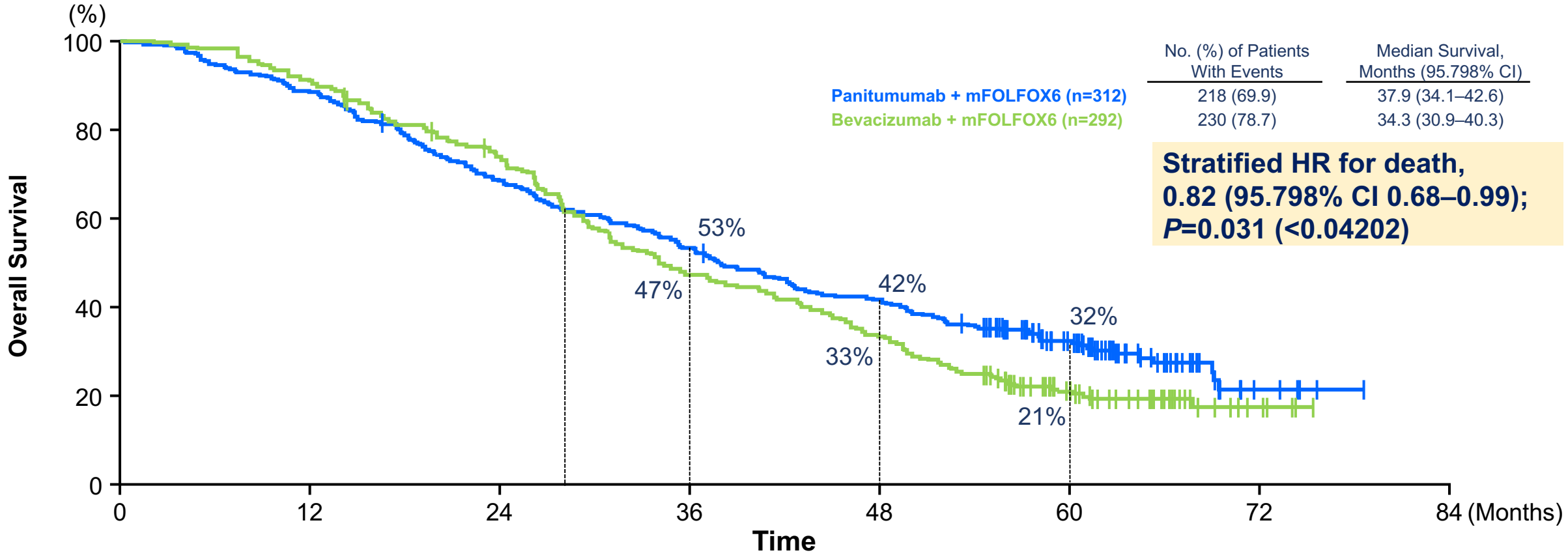
DCR, disease control rate; DOR; duration of response; ECOG, Eastern Cooperative Oncology Group; ETS, early tumor shrinkage; mCRC, metastatic colorectal cancer; OS, overall survival; PFS, progression free survival; RR, response rate; R0, curative resection; WT, wild type.
[a]Adjuvant fluoropyrimidine monotherapy allowed if completed > 6 months before enrollment. [b]Until disease progression, unacceptable toxicity, withdrawal of consent or investigator's judgement or curative intent resection.
[c]Primary tumor in descending colon, sigmoid colon, rectosigmoid, and rectum.

Baseline Patient Characteristics

Characteristic	Left-sided Population		Overall Population	
	Panitumumab + mFOLFOX6 (n=312)	Bevacizumab + mFOLFOX6 (n=292)	Panitumumab + mFOLFOX6 (n=400)	Bevacizumab + mFOLFOX6 (n=402)
Age category, n (%)				
20–64 years	138 (44.2)	127 (43.5)	164 (41.0)	168 (41.8)
65–79 years	174 (55.8)	165 (56.5)	236 (59.0)	234 (58.2)
Sex, female, n (%)	104 (33.3)	91 (31.2)	148 (37.0)	134 (33.3)
ECOG performance status, n (%)				
0	261 (83.7)	231 (79.1)	328 (82.0)	319 (79.4)
1	51 (16.3)	61 (20.9)	71 (17.8)	83 (20.6)
Primary tumor location, n (%)[a]				
Left-sided	312 (100.0)	292 (100.0)	312 (78.0)	292 (72.6)
Right-sided	0	0	84 (21.0)	103 (25.6)
Number of metastatic organs, n (%)				
1	155 (49.7)	147 (50.3)	196 (49.0)	194 (48.3)
≥2	157 (50.3)	145 (49.7)	204 (51.0)	208 (51.7)
Metastatic site, n (%)				
Liver	225 (72.1)	206 (70.5)	275 (68.8)	278 (69.2)
Liver as only site of metastasis	90 (28.8)	89 (30.5)	105 (26.3)	113 (28.1)
Prior treatment, n (%)				
Primary tumor resection	185 (**59.3**)	193 (**66.1**)	239 (59.8)	272 (67.7)
Radiotherapy	2 (0.6)	2 (0.7)	2 (0.5)	3 (0.7)
Adjuvant chemotherapy[b]	17 (5.4)	16 (5.5)	22 (5.5)	20 (5.0)

[a] 4 patients receiving panitumumab and 7 patients receiving bevacizumab had multiple primary lesions in both the left-sided and right-sided. [b] Adjuvant fluoropyrimidine monotherapy allowed if completed > 6 months before enrollment.

Primary Endpoint-1; Overall Survival in Left-sided Population



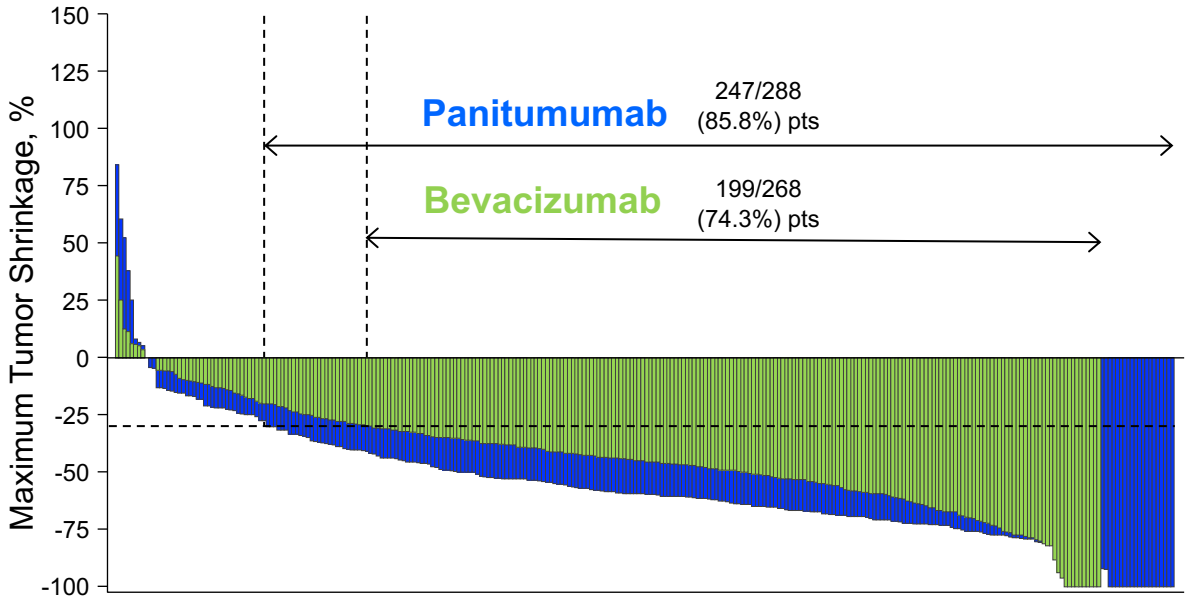
	No. (%) of Patients With Events	Median Survival, Months (95.798% CI)
Panitumumab + mFOLFOX6 (n=312)	218 (69.9)	37.9 (34.1–42.6)
Bevacizumab + mFOLFOX6 (n=292)	230 (78.7)	34.3 (30.9–40.3)

Stratified HR for death, 0.82 (95.798% CI 0.68–0.99); *P*=0.031 (<0.04202)

No. at risk								
Panitumumab	312	276	213	166	129	68	5	0
Bevacizumab	292	266	212	136	96	40	5	0

Other Efficacy Outcome: Depth of Response and RR

Left-Sided Population



Horizontal dotted line at 30% indicates response per RECIST v1.1.

Parameter	Left-sided Population	
	Panitumumab + mFOLFOX6 (n=308)	Bevacizumab + mFOLFOX6 (n=287)
Response rate, % (95% CI)	80.2 (75.3–84.5)	68.6 (62.9–74.0)
Difference, % (95% CI)	11.2 (4.4–17.9)	
DCR, % (95% CI)	97.4 (94.9–98.9)	96.5 (93.7–98.3)
Median DOR,[a] months (95% CI)	13.1 (11.1–14.8)	11.2 (9.6–13.1)
R0 rate,[b] % (95% CI)	18.3 (14.1–23.0)	11.6 (8.2–15.9]

	Left-sided Population	
	Panitumumab + mFOLFOX6 (n=288)	Bevacizumab + mFOLFOX6 (n=268)
Median, %	-59.4	-43.6

Depth of response was assessed in patients with measurable lesions at baseline.

2022 ASCO Annual Meeting

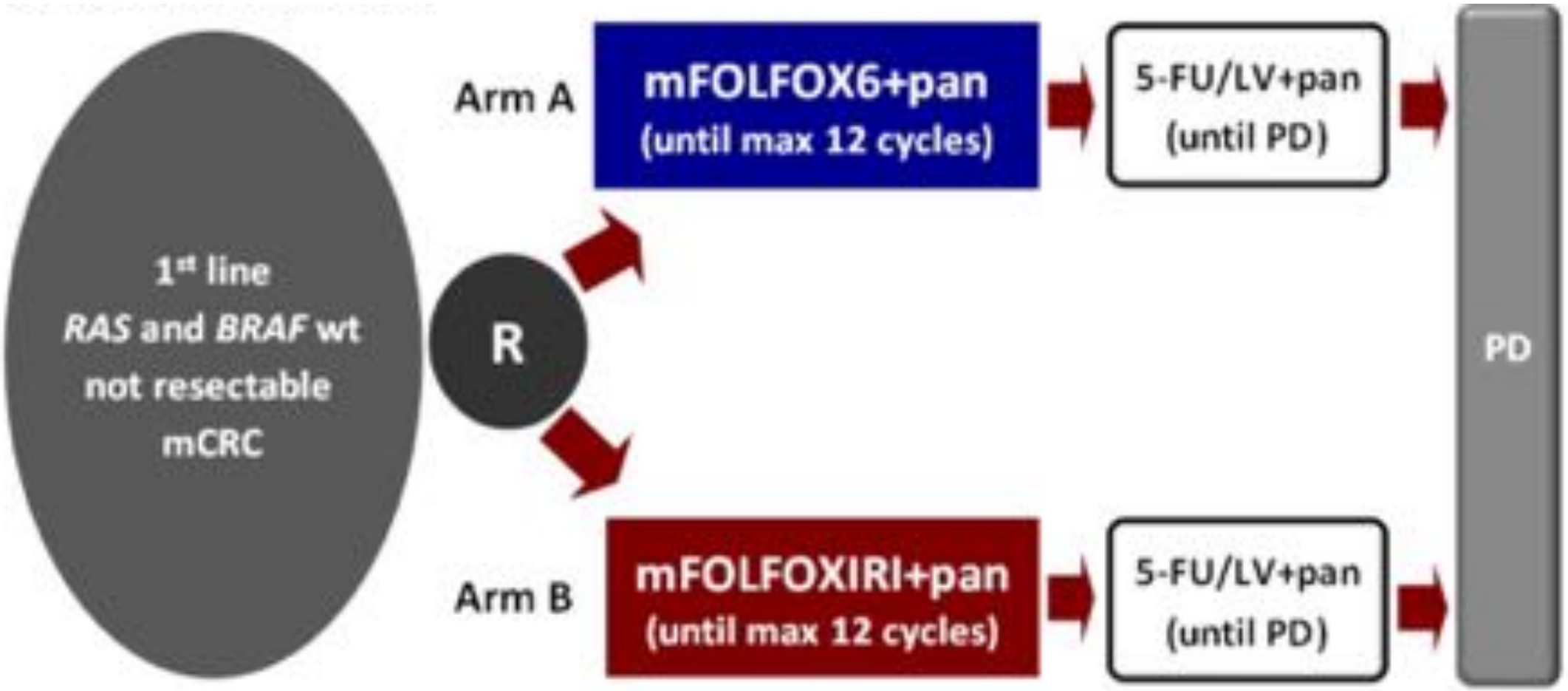
Chicago, 6th June 2022

Modified FOLFOXIRI plus panitumumab (mFOLFOXIRI/PAN) versus mFOLFOX6/PAN as initial treatment of patients with unresectable *RAS* and *BRAF* wild-type metastatic colorectal cancer (mCRC): Results of the phase III randomized TRIPLETE study by GONO.

Cremolini C, Rossini D, Lonardi S, Antoniotti C, Pietrantonio F, Marmorino F, Antonuzzo L, Boccaccino A, Randon G, Giommoni E, Pozzo C, Moretto R, De Grandis MC, Viola MG, Passardi A, Buonadonna A, Formica V, Aprile G, Boni L, Masi G

on behalf of the GONO Investigators

TRIPLETE trial



Stratification factors:

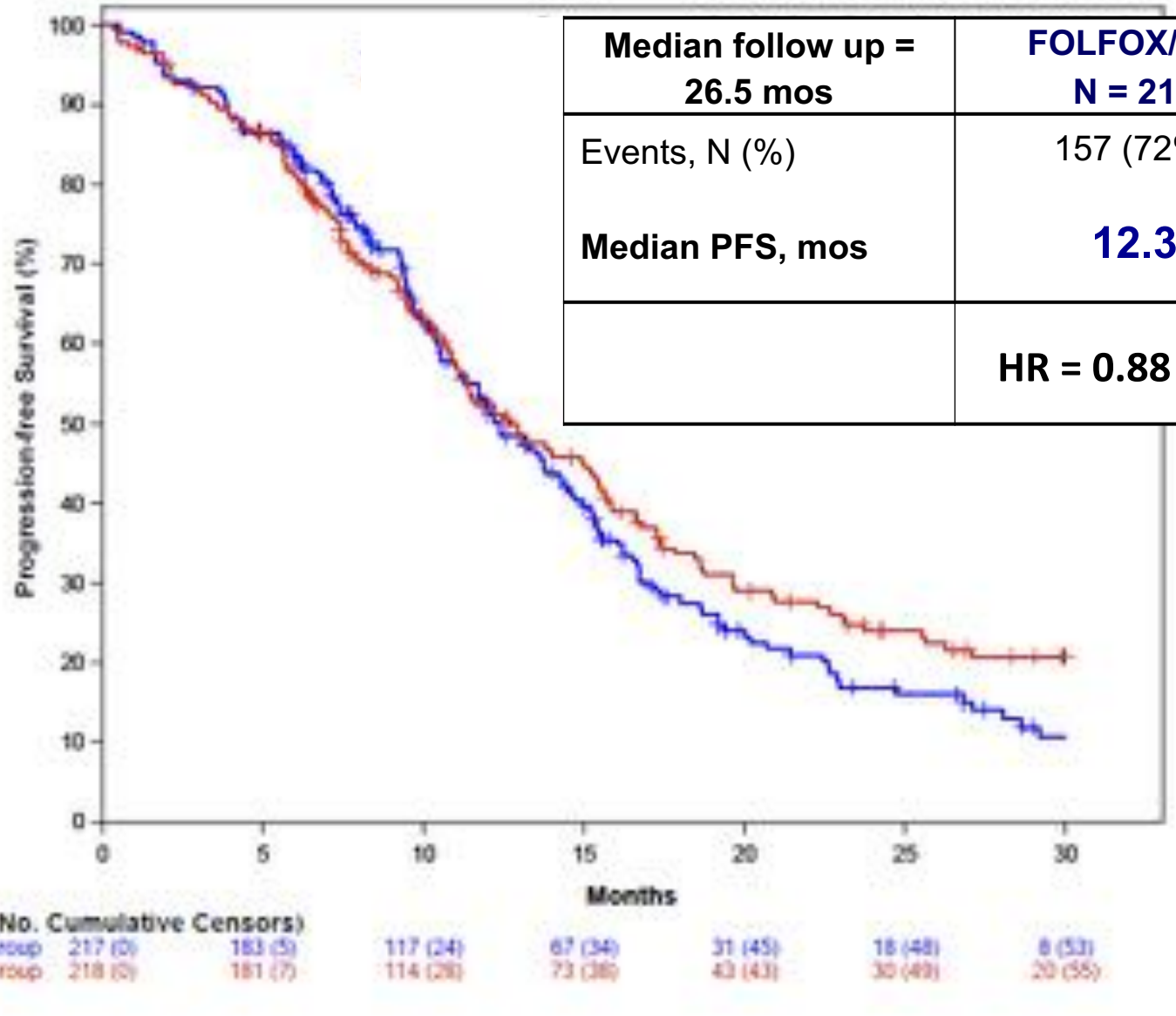
- ECOG Performance Status (0-1 vs 2)
- Primary tumor location (right vs left)
- Metastatic spread (liver-only vs not liver-only)

57 participating centers
From September 2017 to September 2021

Response and Resection Rate

	FOLFOX/Pan N = 213	mFOLFOXIRI/Pan N = 218	OR [95%CI], p
Complete Response	7%	7%	
Partial Response	69%	66%	
Response Rate	**76%**	**73%**	**0.87 [0.56-1.34], p=0.526**
Stable disease	17%	18%	
Progressive Disease	5%	5%	
Not Assessed	2%	4%	
R0 Resection Rate	**29%**	**25%**	**0.81 [0.53-1.23], p=0.317**

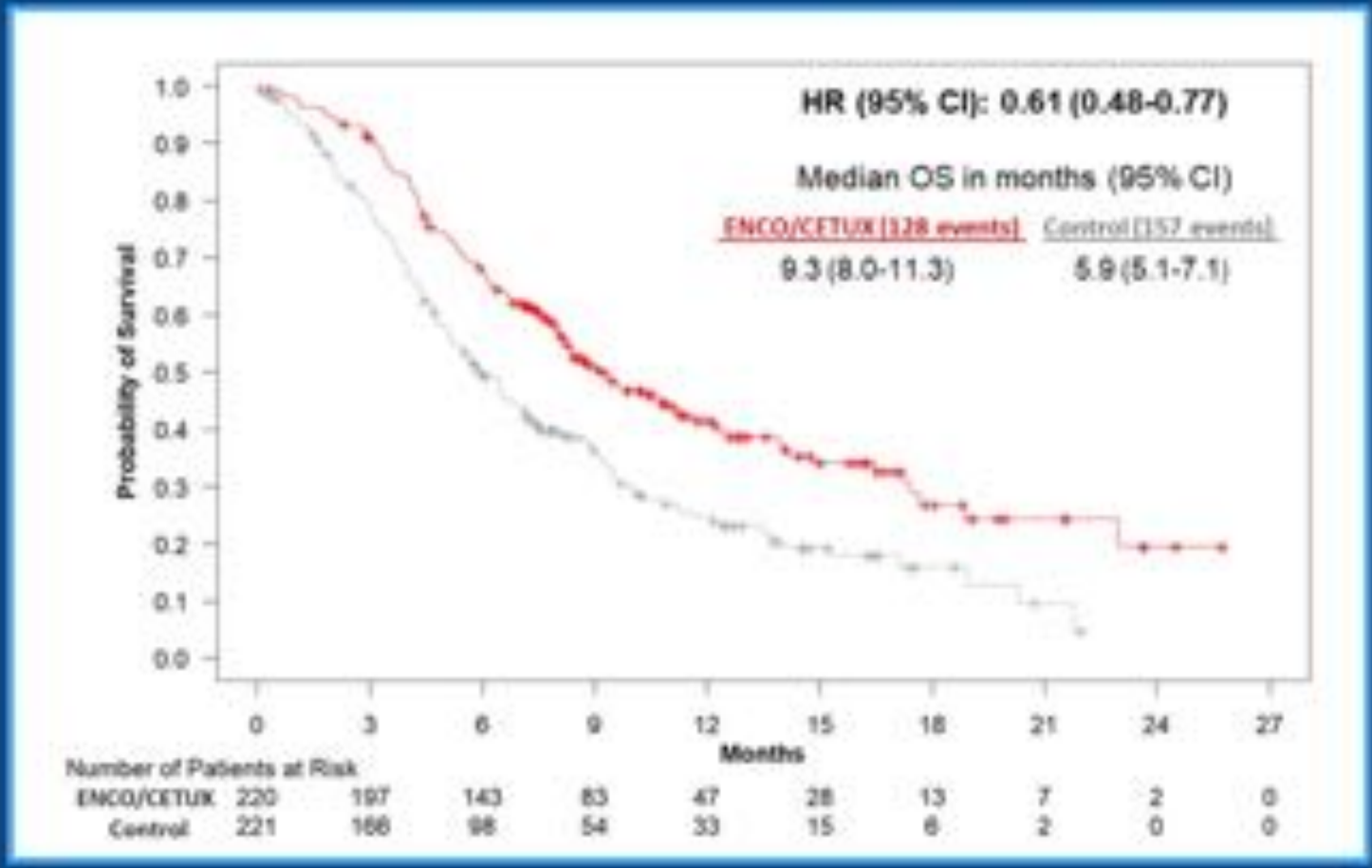
Progression Free Survival



Median follow up = 26.5 mos	FOLFOX/Pan N = 217	mFOLFOXIRI/Pan N = 218
Events, N (%)	157 (72%)	148 (68%)
Median PFS, mos	**12.3**	**12.7**
	HR = 0.88 [95% CI: 0.70-1.11] p=0.277	

MSI-S Colorectal Cancer: BRAF MT

Updated Overall Survival: ENCO/CETUX vs Control



J Tabenero et al: JCO 2021

ASCO Gastrointestinal Cancers Symposium

Phase I/II trial of encorafenib, cetuximab, and nivolumab in patients with microsatellite stable, *BRAF*^{V600E} metastatic colorectal cancer

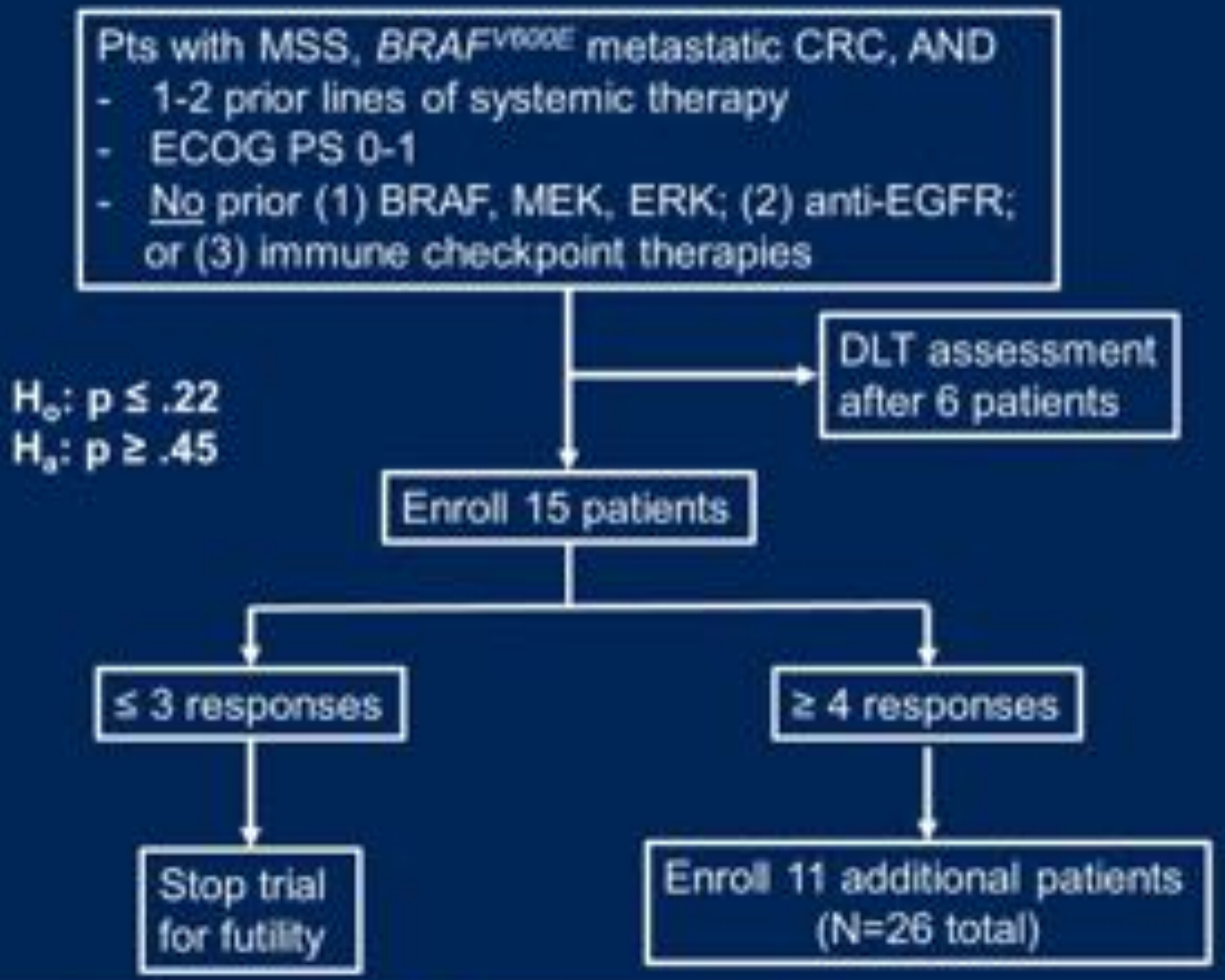
Abstract #351993

Van K. Morris[1], Christine M. Parseghian[1], Michelle Escano[1], Benny Johnson[1], Kanwal Pratap Singh Raghav[1], Arvind Dasari[1], Ryan Huey[1], Michael J. Overman[1], Jason Willis[1], Michael S. Lee[1], Robert A. Wolff[1], Bryan K. Kee[1], John Paul Y.C. Shen[1], M. Pia Morelli[1], Alda Tam[2], Wai Chin Foo[3], Lianchun Xiao[4], Scott Kopetz[1]

Departments of [1]Gastrointestinal Medical Oncology, [2]Interventional Radiology, [3]Pathology, & [4]Biostatistics

University of Texas – MD Anderson Cancer Center, Houston TX

Study Design



Study Treatment:

Encorafenib 300 mg PO daily

Cetuximab 500 mg/m^2 IV every 14 days

Nivolumab 480 mg IV every 28 days

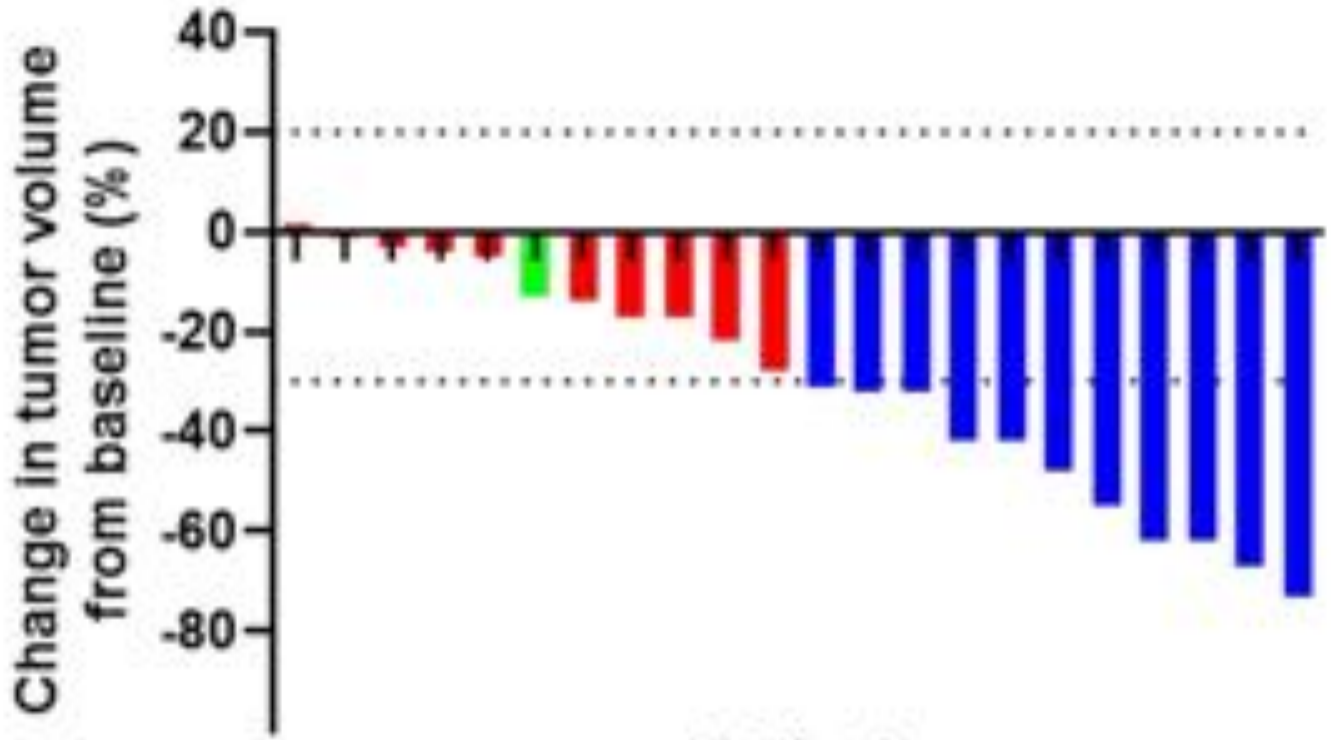
Primary endpoints:

- Radiographic response (RECIST 1.1)
- Safety/tolerability (CTCAE v5)

Secondary endpoints:

- Progression-free survival
- Overall survival
- Duration of response
- Disease control rate
- Time to response

Overall response: encorafenib + cetuximab + nivolumab



Partial Response
Stable Disease
Progressive Disease

22 evaluable patients:

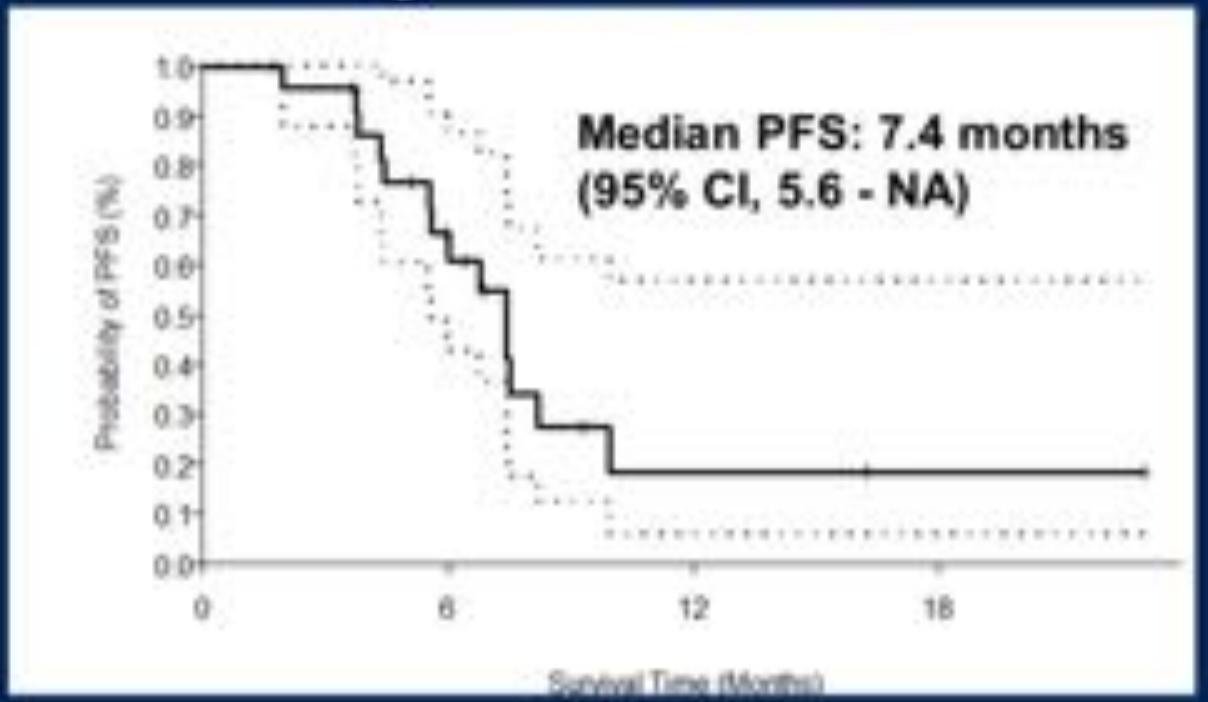
ORR 50%(95%CI, 28-72)
DCR 96% (95% CI, 77-100)

Encorafenib + cetuximab: ORR 20% (95% CI, 13-29)[1]

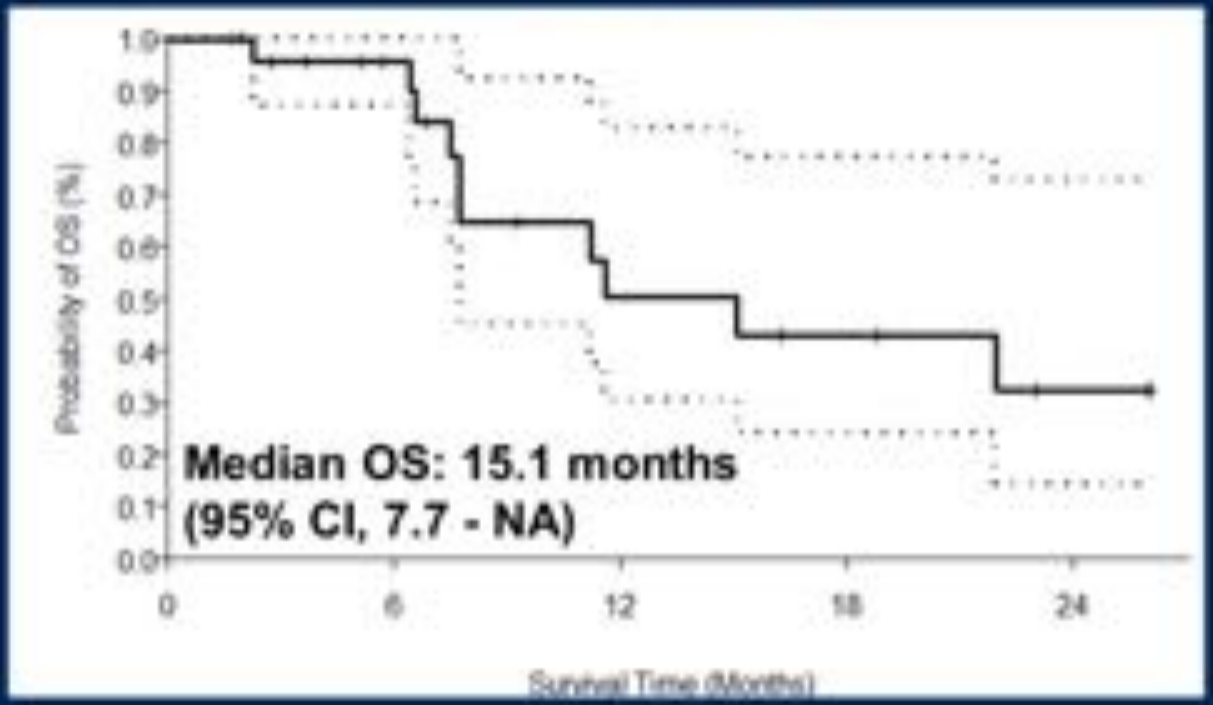
[1]Kopetz S et al. NEJM 2019

Survival outcomes: encorafenib + cetuximab + nivolumab

Progression-free survival



Overall survival



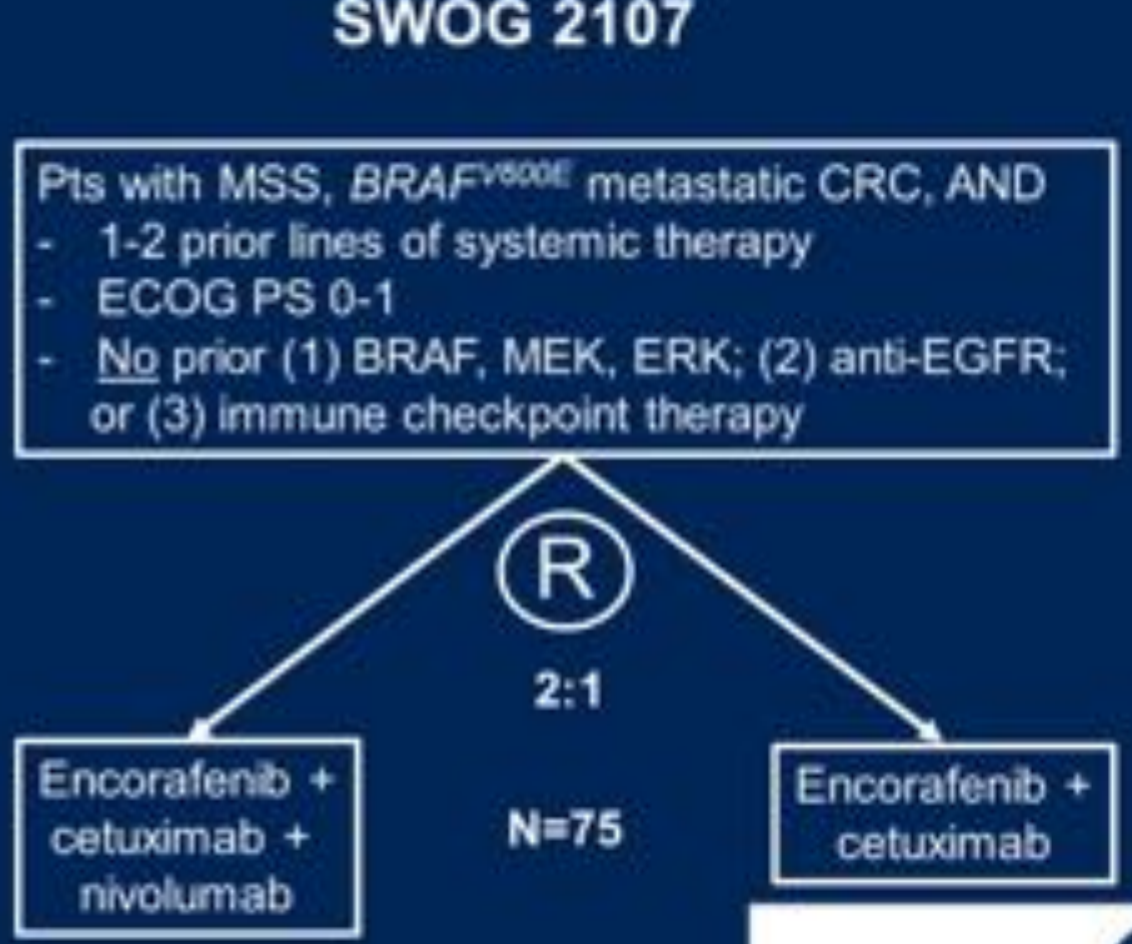
Median follow-up time: 16.3 months (95% CI, 6.9 –NA)
Median duration of response: 7.7 months (95% CI, 3.8 – NA)

Encorafenib + cetuximab: median PFS 4.2 months (95% CI, 3.7-5.4), median OS 8.4 months (95% CI, 7.5-11.0) [1]

[1]Kopetz S et al. NEJM 2019

Conclusions

- Encorafenib + cetuximab + nivolumab is safe and well tolerated for participants with MSS, *BRAF*^{V600E} metastatic CRC.
- The predefined efficacy endpoint for encorafenib + cetuximab + nivolumab has been met for participants with MSS, *BRAF*^{V600E} metastatic CRC: ORR is 50%, and median PFS is 7.4 months.
- These results compare favorably relative to encorafenib + cetuximab (without immunotherapy) as reported in the BEACON study.
- SWOG 2107 is a randomized phase II study that will activate across the United States in 2022 to evaluate encorafenib + cetuximab with or without nivolumab in this population.

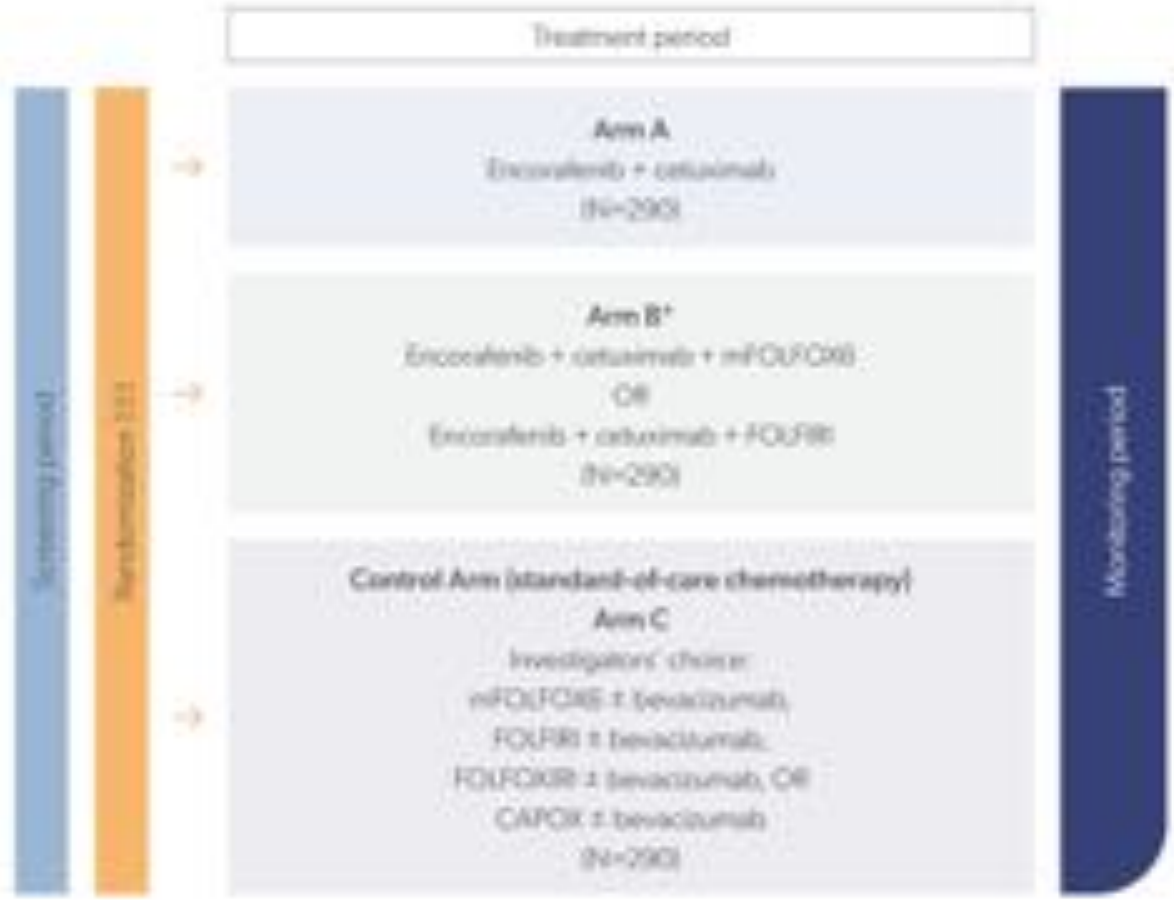


SWOG
Leading cancer research. Together.

The BREAKWATER study design

The BREAKWATER study involves a pre-screening period, a screening period, a randomized treatment period, and a monitoring period. Participants who qualify and choose to take part will attend study visits once every two or three weeks until their participation ends.

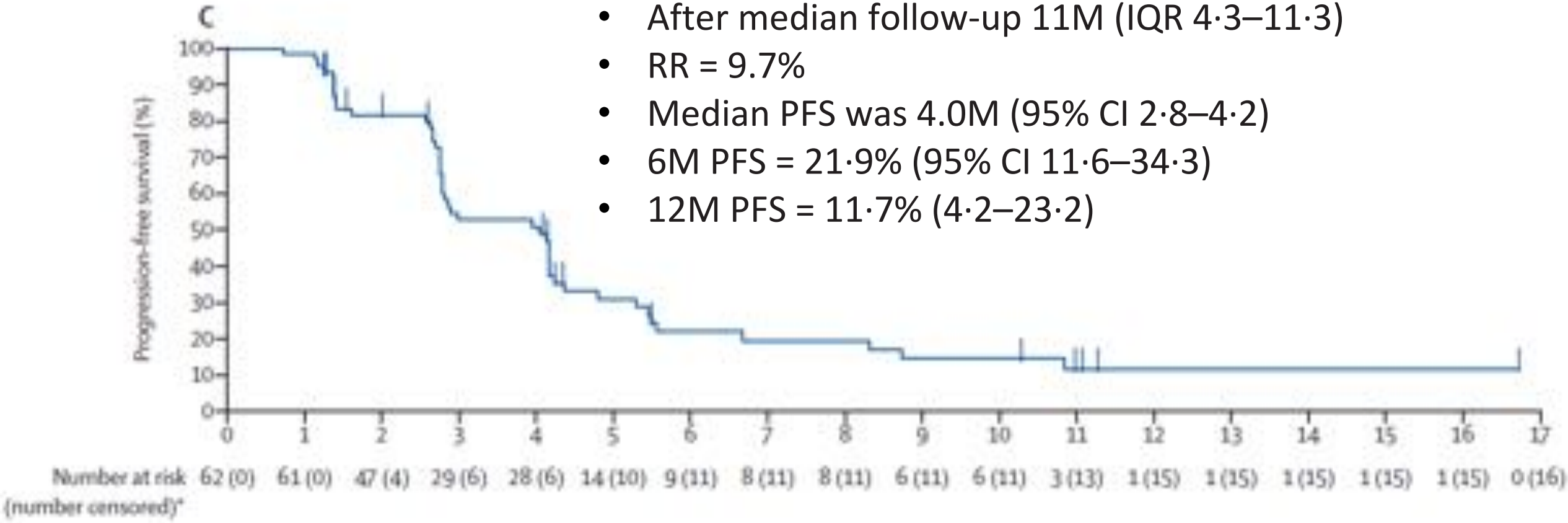
Participants can remain in the treatment period until side effects become intolerable, unacceptable toxicity, disease progression, or withdrawal of consent.



*Whether mFOLFOX6 or FOLFIRI is used in Arm B will depend on the results of a safety lead-in study evaluating the safety, tolerability and pharmacokinetics of encorafenib and cetuximab in combination with these treatments. If neither regimen is selected, this study will proceed without Arm B.

KRAS G12C Mutation Inhibitors

Sot0rasib: KRAS G12C Previously Treated mCRC



- After median follow-up 11M (IQR 4·3–11·3)
- RR = 9.7%
- Median PFS was 4.0M (95% CI 2·8–4·2)
- 6M PFS = 21·9% (95% CI 11·6–34·3)
- 12M PFS = 11·7% (4·2–23·2)

Fakih et al, Lanc Onc 2021

CodeBreaK 101 Subprotocol H Study Design

Phase 1b, multicentre study*:
Sotorasib + panitumumab in chemorefractory *KRAS G12C*-mutated mCRC

Screening/enrolment

Key eligibility criteria (Part 2 Cohort A)
- *KRAS G12C*-mutated mCRC, identified through molecular testing
- $KRAS^{G12C}$ inhibitor-naive
- ≥1 prior treatment for advanced disease†
- Progressed on or after fluoropyrimidine, oxaliplatin, irinotecan, and an anti-angiogenic agent

Part 1: Cohort A dose exploration‡

Sotorasib PO daily
+
Panitumumab 6 mg/kg IV Q2W

Part 2: Cohort A dose expansion (N=40)

Sotorasib: 960 mg PO daily
+
Panitumumab: 6 mg/kg IV Q2W

Treatment until disease progression, withdrawal of consent, or end of study

Primary endpoint: Safety/tolerability
Secondary endpoints: Anti-tumour efficacy (ORR, DCR, DOR, TTR, PFS per RECIST v1.1, and OS) **and PK**

*NCT04185883; EudraCT 2020-004721-23.
†For patients with tumours known to be microsatellite instability high, prior checkpoint inhibitor therapy is required if clinically appropriate and locally available for that indication.
‡Dose exploration is completed.
DCR, disease control rate; DOR, duration of response; IV, intravenous; KRAS, Kirsten rat sarcoma; mCRC, metastatic colorectal cancer; ORR, objective response rate; OS, overall survival; Q2W, every 2 weeks; PFS, progression-free survival; PK, pharmacokinetics; PO, orally; RECIST, Response Evaluation Criteria in Solid Tumors; TTR, time to response.

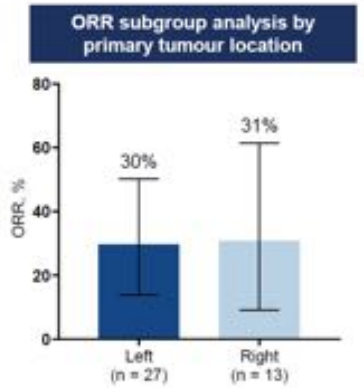
Yasutoshi Kuboki

Codebreak 101: Sotorasib in combination with panitumumab in refractory *KRAS G12C*-mutated colorectal cancer:

Efficacy

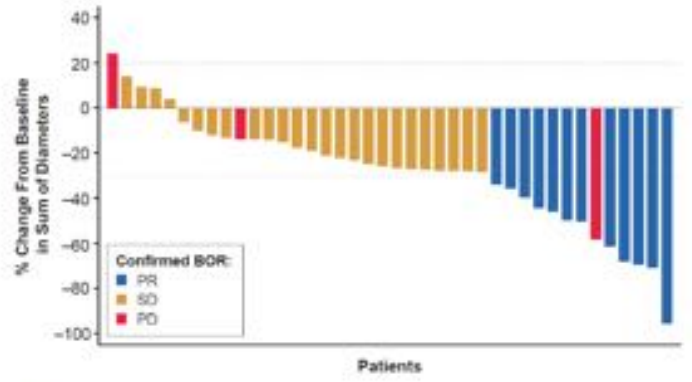
Response by investigator assessment	N = 40 n (%)
ORR confirmed (95% CI)	**12 (30)** (16.6, 46.5)
Complete response	0
Partial response	12 (30)
Stable disease*	25 (63)
Progressive disease	3 (8)
DCR (95% CI)	**37 (93)** (79.6, 98.4)

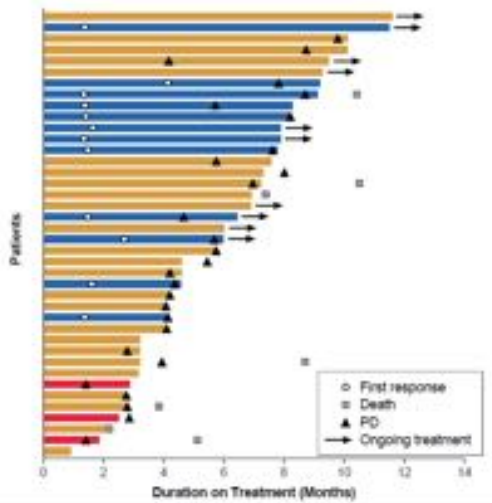
Data cutoff: June 24, 2022
*Minimum requirement for stable disease was 5 weeks.
DCR, disease control rate; mCRC, metastatic colorectal cancer; ORR, objective response rate



- 30% confirmed response rate for sotorasib + panitumumab in patients with chemorefractory mCRC, with disease control rate of 93%
- No obvious differences in response based on tumour location

Tumour Response



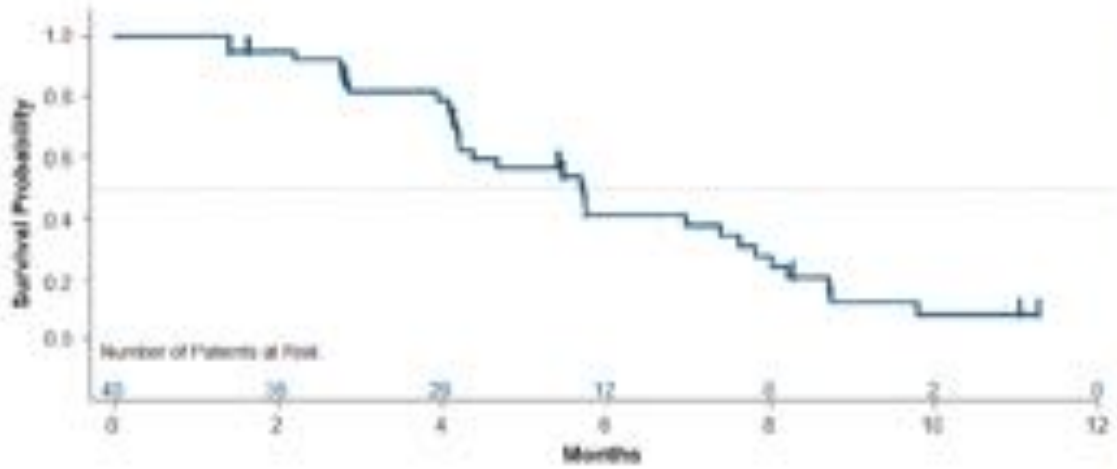


- Reduction in RECIST target lesions observed in 88% of patients
- Median (range) duration of treatment was 5.9 (0.5, 11.3) months, with 25% of patients remaining on treatment

Data cutoff: June 24, 2022
BOR, best overall response; PD, progressive disease; PR, partial response; RECIST, Response Evaluation Criteria in Solid Tumors; SD, stable disease

Kuboki et al: ESMO 2022

Progression-Free Survival (PFS)



Kaplan-Meier estimate of PFS	N = 40
Median PFS, months (95% CI)	5.7 (4.2, 7.6)
Left primary tumour	5.8 (4.2, 7.8)
Right primary tumour	5.5 (3.9, 8.2)
PFS rate, % (95% CI)	
At 3 months	81.7 (65.4, 90.9)
At 6 months	41.1 (24.7, 56.7)
At 9 months	12.3 (3.4, 27.2)

With median follow-up of 11.0 months, median PFS was 5.7 months

Data cutoff: June 24, 2022

KRYSTAL-1 (849-001) Phase 1b/2 CRC Cohorts Study Design

Key Eligibility Criteria

- CRC with a KRAS^{G12C} mutation[a]
- Unresectable or metastatic disease
- Prior systemic treatment for metastatic disease
- No available treatment with curative intent or available standard of care

Phase 1b
CRC Combination

Adagrasib 600 mg BID[b] + cetuximab[c] (n=32)

Phase 2
CRC Monotherapy

Adagrasib 600 mg BID[b] (n=44)

Study Objectives

Phase 1b

- Primary endpoints: safety, RP2D, PK
- Secondary endpoints: ORR (RECIST 1.1), DOR, PFS, OS

Phase 2

- Primary endpoint: ORR (RECIST 1.1)[d]
- Secondary endpoints: safety, DOR, PFS, OS

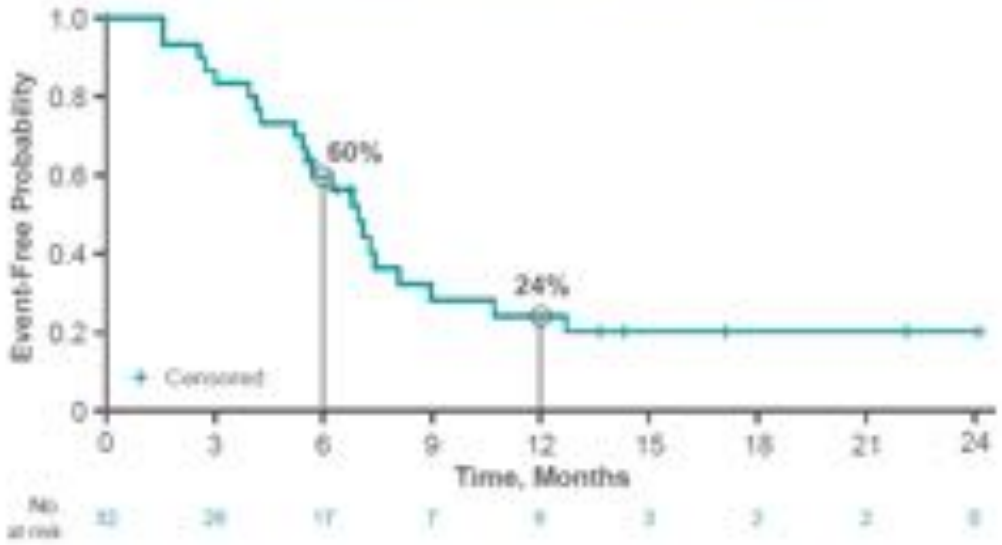
- Previously reported data demonstrated clinical activity of adagrasib monotherapy and adagrasib + cetuximab in patients with previously treated KRAS^{G12C}-mutated CRC[10,e]
- Here we report updated data for adagrasib 600 mg BID as monotherapy (Phase 2; median follow-up: 20.1 months) and in combination with cetuximab (Phase 1b; median follow-up: 17.5 months) in patients with previously treated KRAS^{G12C}-mutated CRC

[a]KRAS^{G12C} mutation detected in tumor tissue and/or ctDNA per protocol. [b]Capsule, fasted. [c]Cetuximab dosing: 400 mg/m^2 followed by 250 mg/m^2 QW, or 500 mg/m^2 Q2W. [d]Response was analyzed in the clinically evaluable population with local radiology review. [e]Previous data were reported for 46 patients (n=2 in Phase 1 lb and n=44 in Phase 2) receiving adagrasib monotherapy (median follow-up: 8.9 months) and 32 patients receiving adagrasib + cetuximab (median follow-up: 7 months)[10]

ClinicalTrials.gov: NCT03785249

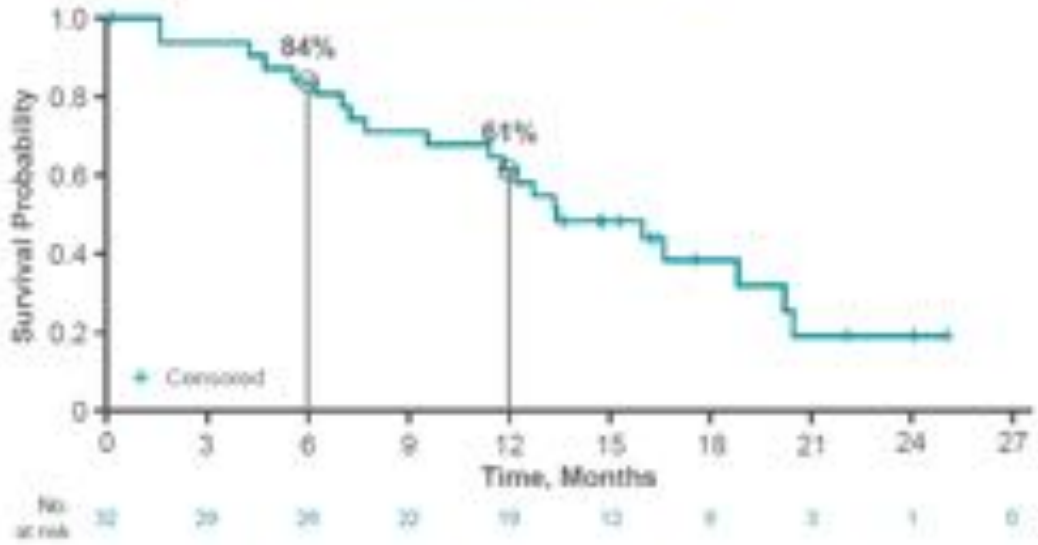
Adagrasib + Cetuximab in Previously Treated Patients with KRAS^{G12C}-Mutated CRC: Progression-Free Survival and Overall Survival

Progression-Free Survival



Median PFS was 6.9 months (95% CI, 5.4–8.1)

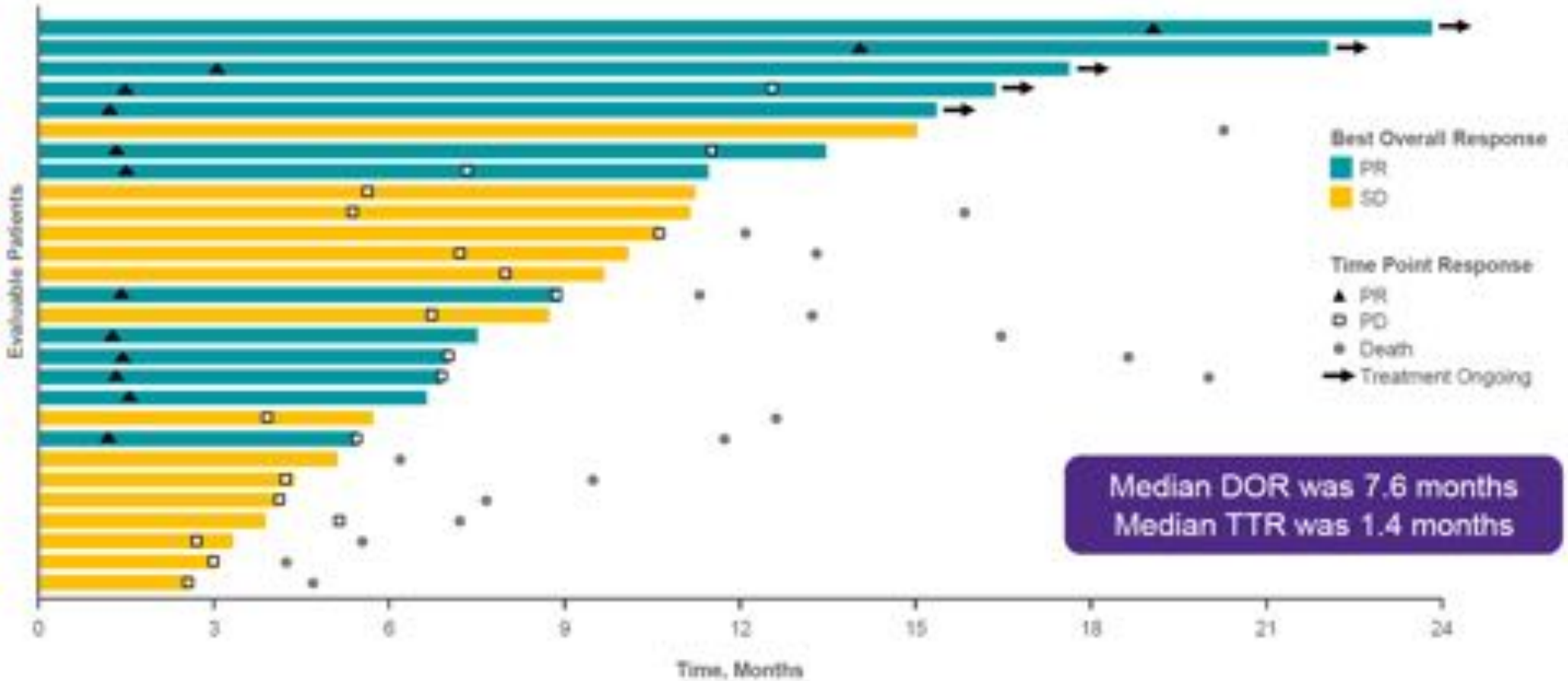
Overall Survival



Median OS was 13.4 months (95% CI, 9.5–20.1)

PFS per investigator assessment (n=32)
Data as of June 16, 2022 (median follow-up, 17.5 months)

Adagrasib + Cetuximab in Previously Treated Patients with KRAS^{G12C}-Mutated CRC: Duration of Treatment



Median DOR was 7.6 months
Median TTR was 1.4 months

Response outcomes per investigator assessment (n=28; four patients are not included due to no post-baseline assessment of target lesions)
Data as of June 16, 2022 (median follow-up, 17.5 months)

Ongoing Phase I and III Trials: KRAS G12C

Phase 3: Sotorasib + Panitumumab

Patients
- > 1 prior line of treatment for mCRC
- KRAS G12C MT
- ECOG PS 0-2
- N=193
- *Not yet recruiting

NCT05198934

Arms A: Sotorasib 960 mg + Panitumumab or
Arm B: Sotorasib (240 mg) + PMab

1:1 Randomization

Physician's Choice: Regorafenib or TAS-102

Primary Endpoint: PFS

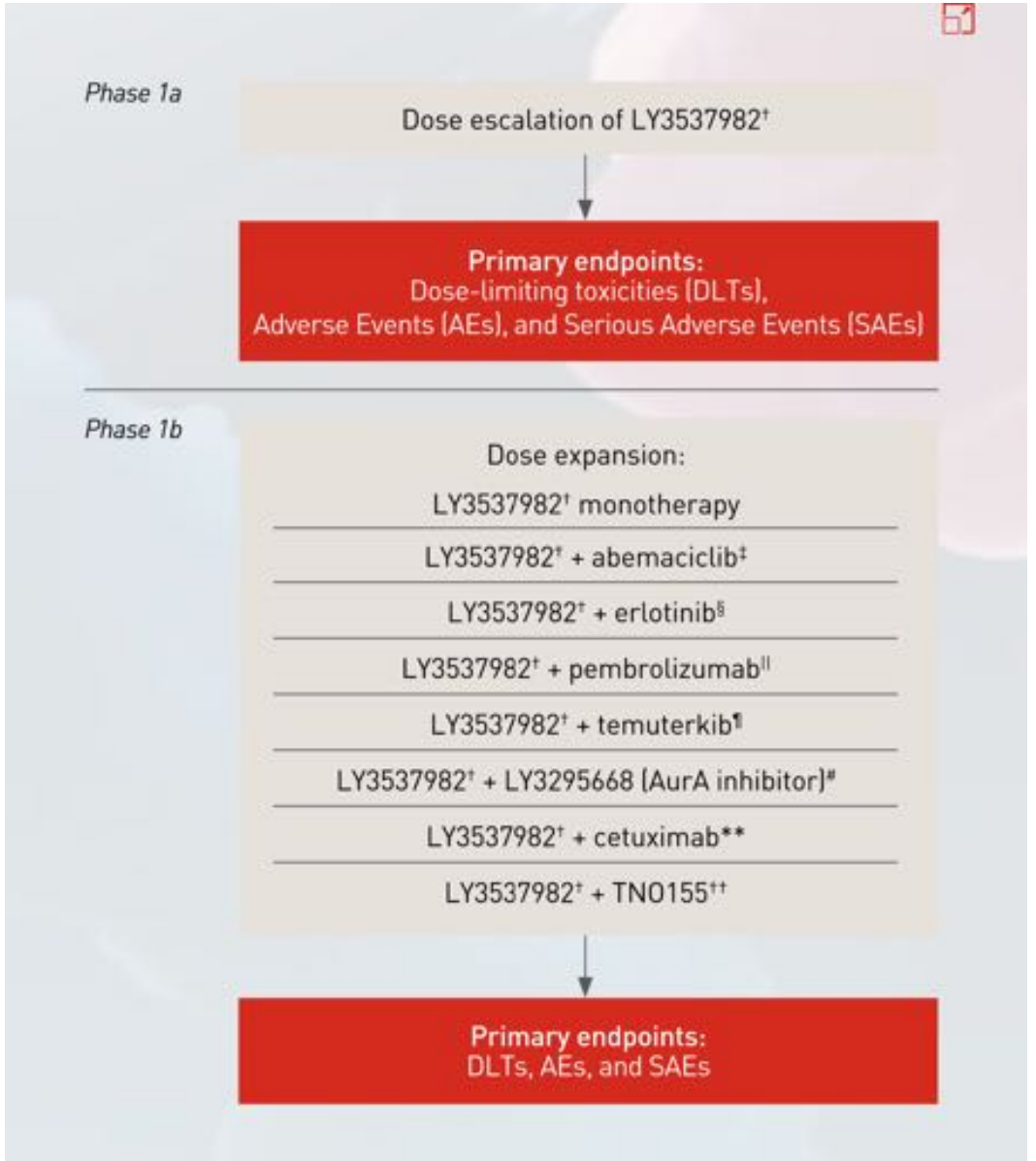
- **Metastatic CRC**
- ***KRAS* G12C in tumor**
  - Local test acceptable for enrollment; central confirmation req'd w/in 30d
- **PD on 1L fluoropyrimidine + oxaliplatin or irinotecan**
- **No prior anti-EGFR or direct KRAS G12Ci**

1:1
N~420

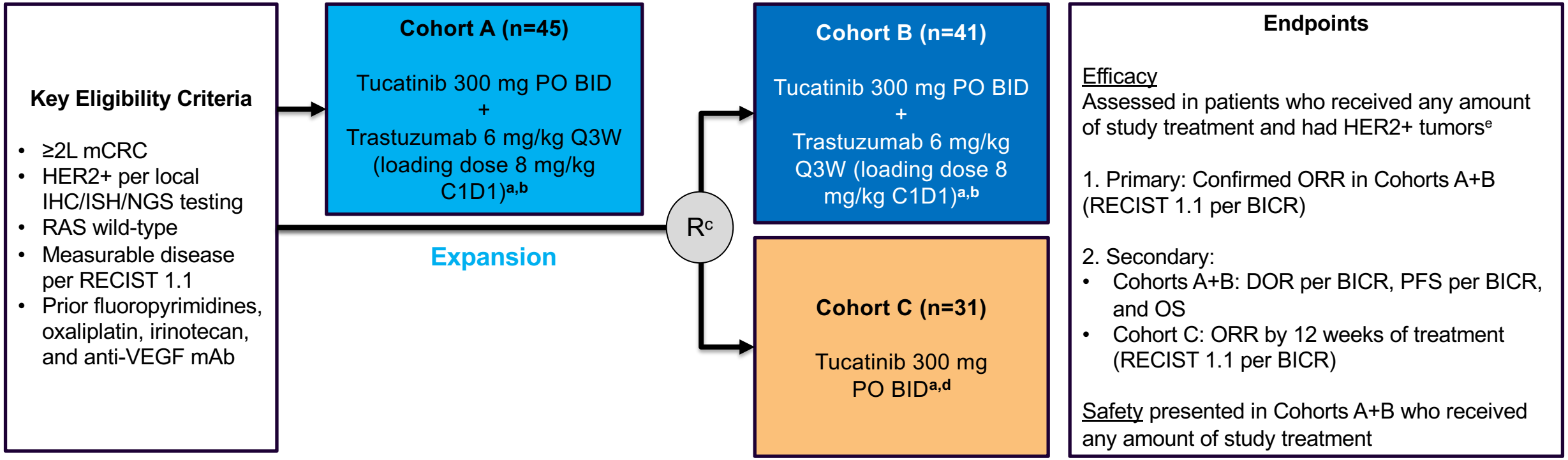
Adagrasib 600 mg BID + Cetuximab 500 mg/m² Q2W

FOLFIRI or mFOLFOX6§

§Anti-VEGF/VEGFR allowed per Investigator discretion



MOUNTAINEER: Global, Open-Label, Phase 2 Trial



MOUNTAINEER began as a US Investigator-Sponsored Trial and initially consisted of a single cohort (Cohort A) and was expanded globally to include patients randomised to receive tucatinib + trastuzumab (Cohort B) or tucatinib monotherapy (Cohort C)

Data cut-off for current analysis, March 28, 2022

a Each treatment cycle is 21 days; b Patients remained on therapy until evidence of radiographic or clinical progression, unacceptable toxicity, withdrawal of consent, or study closure; c Stratification: Left sided tumor primary vs other; d Patients were allowed to cross over and receive tucatinib and trastuzumab if they experienced radiographic progression at any time point or if they had not achieved a PR or CR by week 12; e Patients had HER2+ tumors as defined by one or more protocol required local tests: IHC 3+ (n=46), amplification by ISH (n=36), or amplification by NGS (n=69)

2L+, second line and later; BICR, blinded independent central review; BID, twice a day; C1D1, cycle 1 day 1; CR, complete response; DOR, duration of response; HER2, human epidermal growth receptor 2; IHC, immunohistochemistry; ISH, in situ hybridization; mAb, monoclonal antibody; mCRC, metastatic colorectal cancer; NGS, next-generation sequencing; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; PO, orally; Q3W, every 3 weeks; PR, partial response; R, randomisation; RAS, rat sarcoma virus; RECIST, Response Evaluation Criteria in Solid Tumors; US, United States; VEGF, vascular endothelial growth factor.

https://clinicaltrials.gov/ct2/show/NCT03043313

Key Baseline Patient Characteristics

Characteristics, n (%)		Tucatinib + Trastuzumab Cohorts A+B n=84[a]	Tucatinib Monotherapy Cohort C n=30[b]
Median age, years (range)		55.0 (24, 77)	59.5 (29, 75)
Sex	Male	51 (60.7)	15 (50.0)
	Female	33 (39.3)	15 (50.0)
ECOG Performance Status	0	50 (59.5)	17 (56.7)
	1	31 (36.9)	13 (43.3)
	2	3 (3.6)	0
Primary tumor site	Left colon and rectum	71 (84.5)	27 (90.0)
	All other primaries	13 (15.5)	3 (10.0)
	Transverse colon	7 (8.3)	0
	Right colon	5 (6.0)	3 (10.0)
	Multiple/overlapping sites	1 (1.2)	0
Stage IV at initial diagnosis		50 (59.5)	19 (63.3)
Patients with liver metastases at study entry		54 (64.3)	15 (50.0)
Patients with lung metastases at study entry		59 (70.2)	20 (66.7)

a Two patients did not have HER2+ disease as specified per protocol and were excluded; b One patient discontinued before receiving treatment

ECOG, Eastern Cooperative Oncology Group.

Tucatinib + Trastuzumab: Efficacy Outcomes

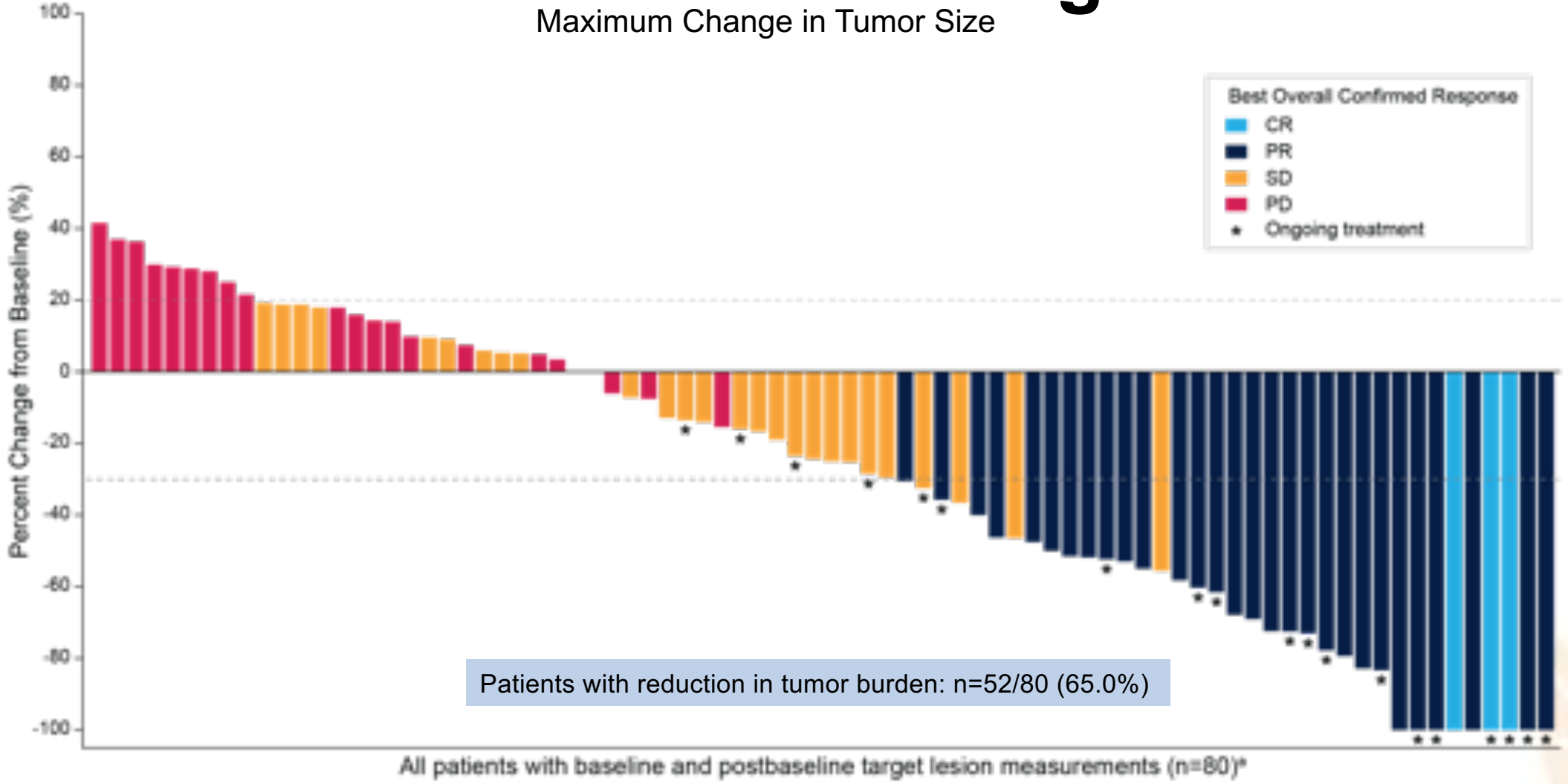
Responses	Tucatinib + Trastuzumab Cohorts A+B n=84
Best overall response per BICR[a], n (%)	
CR	3 (3.6)
PR	29 (34.5)
SD[b]	28 (33.3)
PD	22 (26.2)
Not available[c]	2 (2.4)
cORR per BICR, % (95% CI)[d]	**38.1 (27.7, 49.3)**
cORR per Investigator, % (95% CI)[d]	42.9 (32.1, 54.1)
Median time to objective response per BICR[e], months (range)	2.1 (1.2, 9.8)
DCR[f] per BICR, n (%)	60 (71.4)
Median DOR per BICR, months (95% CI)	**12.4 (8.5, 20.5)**

a Confirmed best overall response assessed per RECIST 1.1; b Includes SD and non-CR/non-PD; c Includes patients with no post-baseline response assessment and patients whose disease assessments are not evaluable; d Two-sided 95% exact confidence interval, computed using the Clopper-Pearson method (1934); e Time from the start of study treatment (Cohort A) or date of randomisation (Cohort B) to the first documentation of objective response (CR or PR that is subsequently confirmed); f Defined as sum of CR, PR, and SD

BICR, blinded independent central review; cORR, confirmed objective response rate; CR, complete response; DCR, disease control rate; PD, progressive disease; PR, partial response; RECIST, Response Evaluation Criteria in Solid Tumors; SD, stable disease.

Data cutoff: 28 Mar 2022

Tucatinib + Trastuzumab: Change in Tumor Size



a Four patients who did not have baseline and/or post-baseline target lesion measurements are excluded

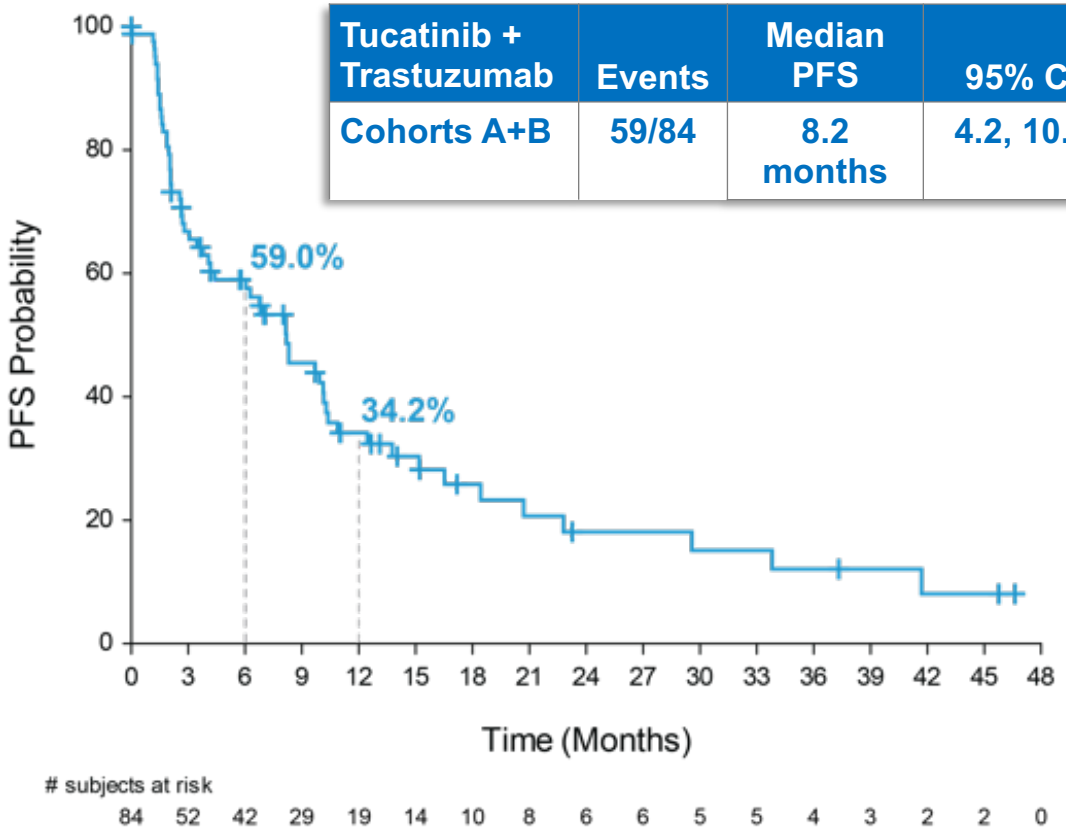
CR, complete response; PD, progressive disease; PR, partial response; SD, stable disease.

Data cutoff: 28 Mar 2022

Tucatinib + Trastuzumab: PFS and OS

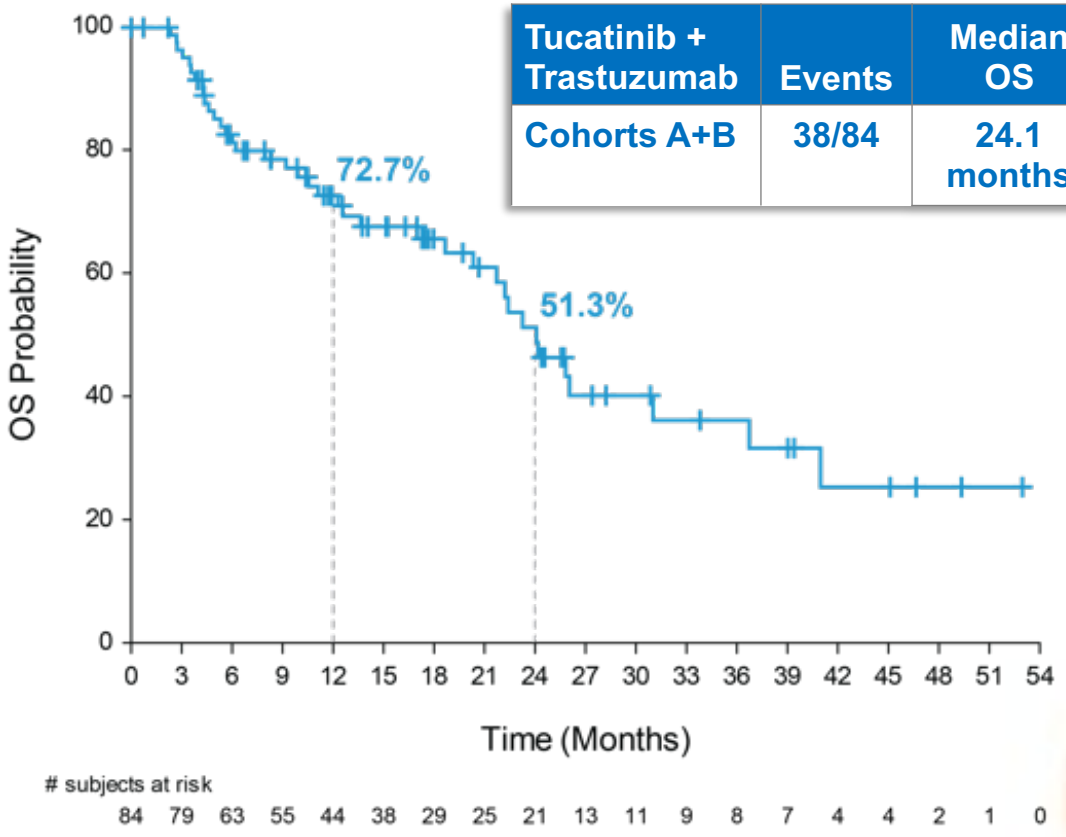
Progression-free Survival per BICR

Tucatinib + Trastuzumab	Events	Median PFS	95% CI
Cohorts A+B	59/84	8.2 months	4.2, 10.3



Overall Survival

Tucatinib + Trastuzumab	Events	Median OS	95% CI
Cohorts A+B	38/84	24.1 months	20.3, 36.7

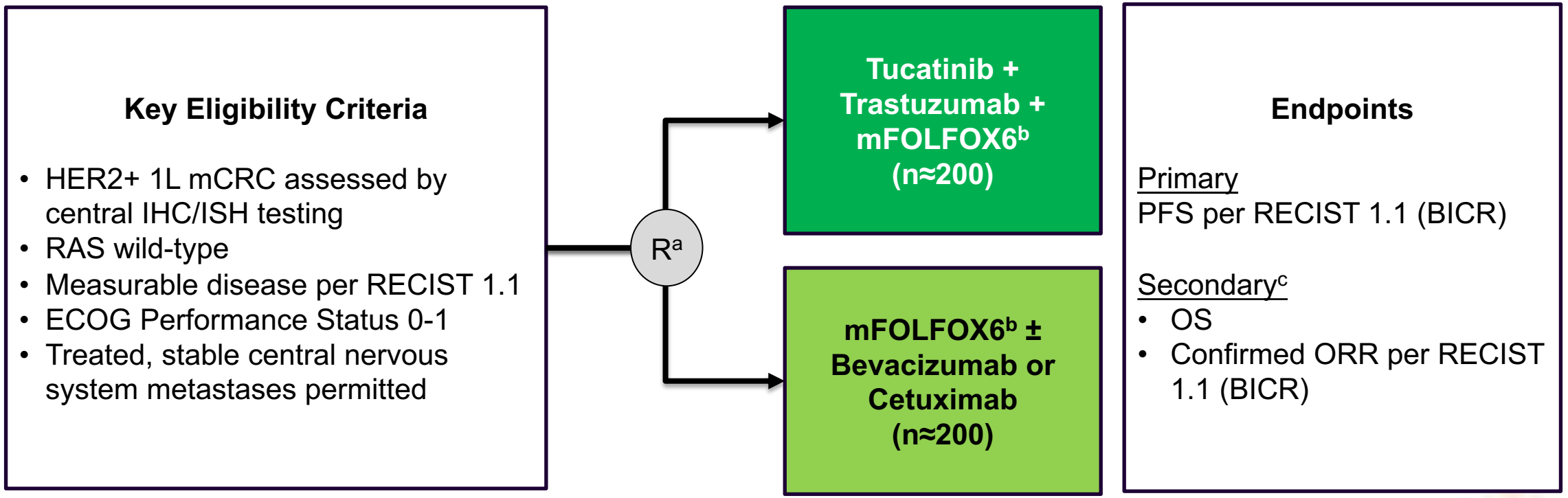


Median follow-up for Cohorts A+B was 20.7 months (IQR, 11.7, 39.0)

BICR, blinded independent central review; IQR, interquartile range; OS, overall survival; PFS, progressive-free survival.

Data cutoff: 28 Mar 2022

MOUNTAINEER-03: Global, Randomised, Open-Label, Phase 3 Trial



a Stratification: Primary tumor sidedness, liver metastases; b Levoleucovorin may be given in place of leucovorin; c Alpha-controlled

1L, first line; BICR, blinded independent central review; ECOG, Eastern Cooperative Oncology Group; HER2, human epidermal growth factor receptor 2; IHC, immunohistochemistry; ISH, in situ hybridization; mCRC, metastatic colorectal cancer; mFOLFOX6, 5-fluorouracil, leucovorin, and oxaliplatin; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; R, randomisation; RAS, rat sarcoma virus; RECIST, Response Evaluation Criteria in Solid Tumors.

https://clinicaltrials.gov/ct2/show/NCT05253651

PARIS 2022 ESMO congress

FRESCO-2: A global phase 3 multiregional clinical trial evaluating the efficacy and safety of fruquintinib in patients with refractory metastatic colorectal cancer

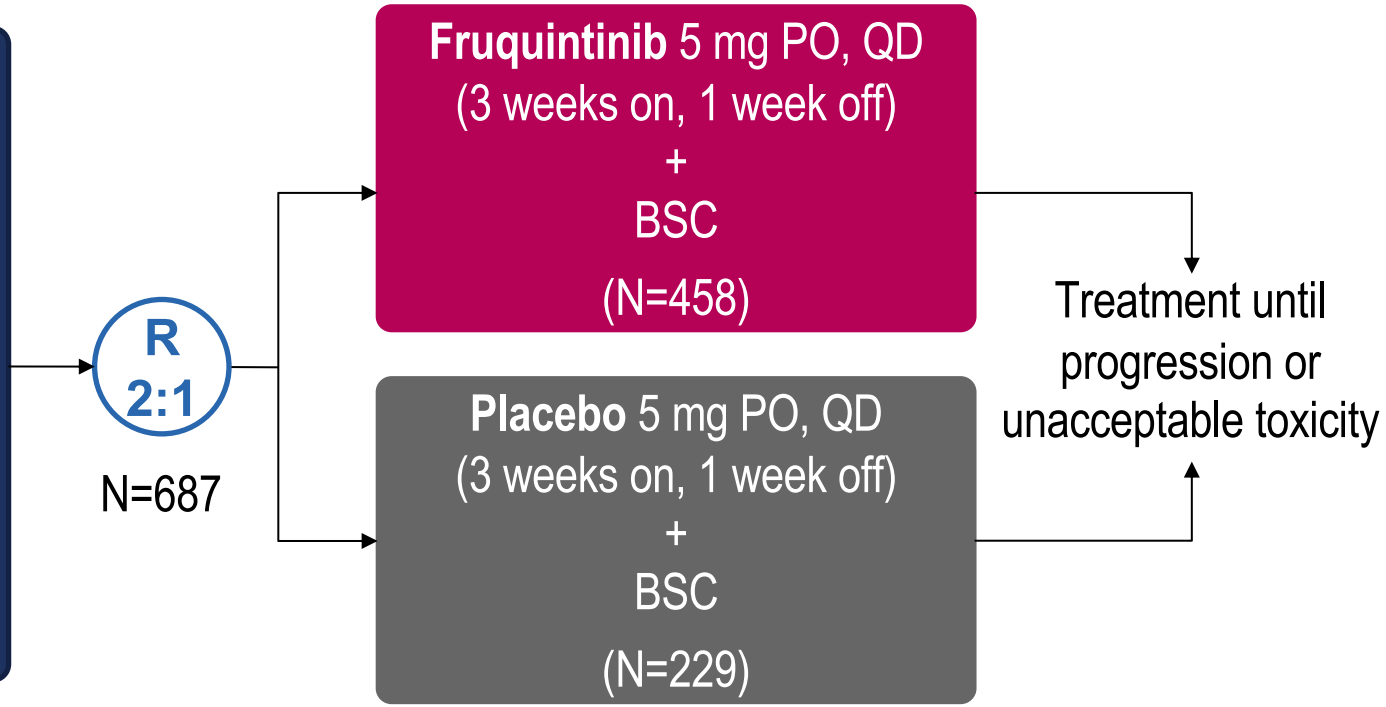
Arvind Dasari[1], Sara Lonardi[2], Rocio Garcia-Carbonero[3], Elena Elez[4], Takayuki Yoshino[5], Alberto Sobrero[6], James Yao[1], Pilar García-Alfonso[7], Judit Kocsis[8], Antonio Cubillo Gracian[9], Andrea Sartore-Bianchi[10], Taroh Satoh[11], Violaine Randrian[12], Jiri Tomasek[13], Geoff Chong[14], Zhao Yang[15]; William Schelman[15]; Marek Kania[15], Josep Tabernero[4], and Cathy Eng[16]

[1]Department of Gastrointestinal Medical Oncology, The University of Texas MD Anderson Cancer Center, Houston, TX, USA, [2]Medical Oncology Unit 1, Veneto Institute of Oncology IOV-IRCCS Padua, Padua, Italy, [3]Oncology Department, Hospital Universitario 12 de Octubre, Imas 12, UCM, Madrid, Spain, [4]Vall d'Hebron Barcelona Hospital Campus, Vall d'Hebron Institute of Oncology, Barcelona, Spain, [5]Department of Gastroenterology and Gastrointestinal Oncology, National Cancer Center Hospital East, Kashiwa, Japan, [6]Department of Medical Oncology, Azienda Ospedaliera San Martino, Genoa, Italy, [7]Medical Oncology, Hospital Universitario Gregorio Marañón, Madrid, Spain, [8]Department of Oncoradiology, Bács -Kiskun Megyei Oktatókórház, Kecskemét, Hungary, [9]Medical Oncology, Hospital Universitario Madrid Sanchinarro Centro Integral Oncológico Clara Campal, Madrid, Spain, [10]Department of Oncology and Hemato-Oncology, Università degli Studi di Milano, Milan, Italy, [11]Department of Gastroenterological Surgery, Graduate School of Medicine, Osaka University, Osaka, Japan, [12]Hepato-Gastroenterology Department, Poitiers University Hospital, Poitiers, France, [13]Department of Complex Oncology Care, Masaryk Memorial Cancer Institute, Brno, Czech Republic, [14]Olivia Newton-John Cancer & Wellness Centre, Austin Hospital, Heidelberg, VIC, Australia, [15]HUTCHMED International Corporation, Florham Park, NJ, USA, [16]Department of Medicine, Division of Hematology and Oncology, Vanderbilt-Ingram Cancer Center, Nashville, TN, USA

FRESCO-2 Study Design

Patient Eligibility

- Prior treatment with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF biological therapy, and, if *RAS* wild type, an anti-EGFR therapy
- Progression on, or intolerance to, TAS-102 and/or regorafenib
- Prior treatment with an immune checkpoint inhibitor or BRAF inhibitor if indicated



Stratification Factors

- Prior therapy (TAS-102 vs regorafenib vs TAS-102 and regorafenib)
- *RAS* mutational status (wild-type vs mutant)
- Duration of metastatic disease (≤18 months vs >18 months)

Note: To ensure the patient population is reflective of clinical practice, the number of patients treated with prior regorafenib was limited to 344 patients (50%)

BSC, best supportive care.
NCT04322539.

PARIS 2022 ESMO congress

Dasari A et al. ESMO 2022, Presentation LBA25

Patient and Disease Characteristics

ITT Population

Enrollment: Sep 2020 to Dec 2021

Data Cutoff: 24 June 2022

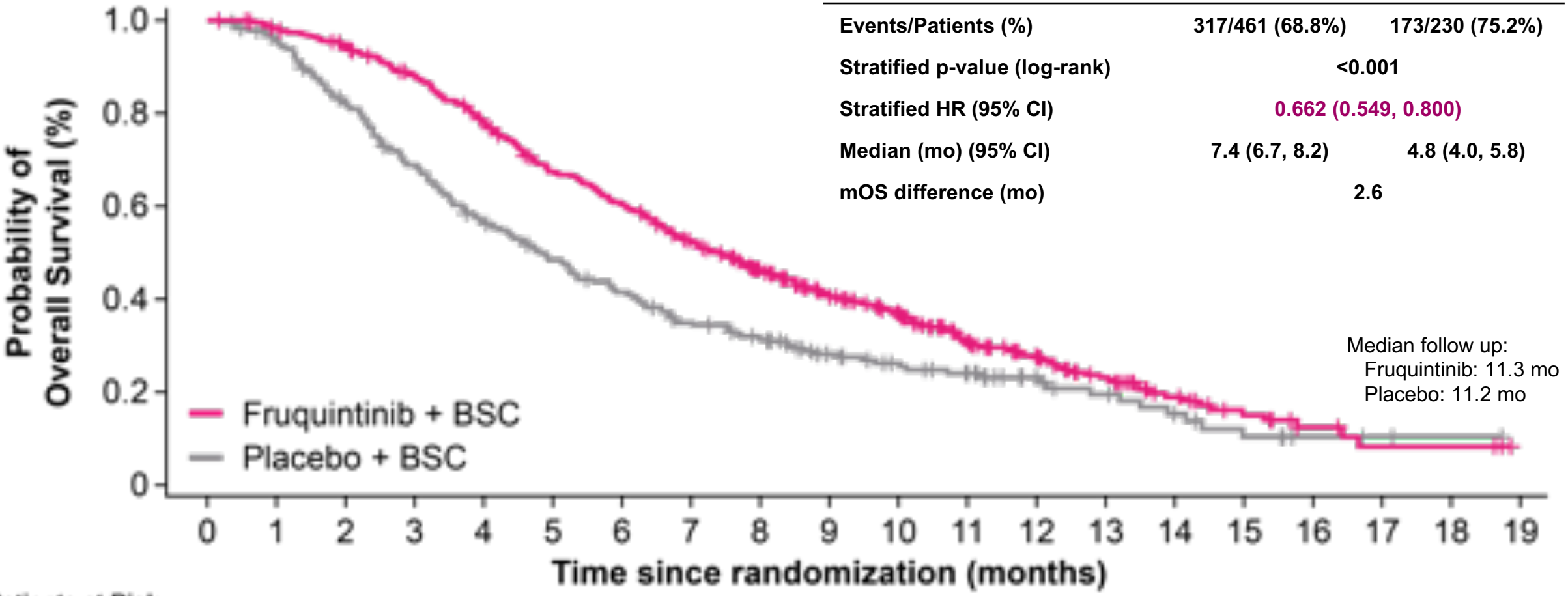
Characteristic, n (%)		Fruquintinib (N=461)	Placebo (N=230)
Age, y	Median (range)	64 (25, 82)	64 (30, 86)
	≥ 65	214 (46.4)	111 (48.3)
Sex	Female	216 (46.9)	90 (39.1)
	Male	245 (53.1)	140 (60.9)
Region	North America	82 (17.8)	42 (18.3)
	Europe	329 (71.4)	166 (72.2)
	Asia Pacific	50 (10.8)	22 (9.6)
ECOG PS	0	196 (42.5)	102 (44.3)
	1	265 (57.5)	128 (55.7)
Primary site at 1st diagnosis	Colon left	192 (41.6)	92 (40.0)
	Colon right	97 (21.0)	53 (23.0)
	Colon left and right	4 (0.9)	2 (0.9)
	Colon unknown	25 (5.4)	13 (5.7)
	Rectum only	143 (31.0)	70 (30.4)
Liver metastases	Yes	339 (73.5)	156 (67.8)

Characteristic, n (%)		Fruquintinib (N=461)	Placebo (N=230)
Duration of metastatic disease	≤ 18 mo	37 (8.0)	13 (5.7)
	> 18 mo	424 (92.0)	217 (94.3)
RAS status	WT	170 (36.9)	85 (37.0)
	Mutant	291 (63.1)	145 (63.0)
BRAF V600E mutation	No	401 (87.0)	198 (86.1)
	Yes	7 (1.5)	10 (4.3)
	Other/Unknown	5 (11.5)	22 (9.6)
Number of prior treatment lines in metastatic disease	Median (range)	5 (2, 16)	5 (2, 12)
	≤ 3	125 (27.1)	64 (27.8)
	> 3	336 (72.9)	166 (72.2)
Prior therapies	VEGF inhibitor	445 (96.5)	221 (96.1)
	EGFR inhibitor	180 (39.0)	88 (38.3)
Prior TAS-102 and/or regorafenib	TAS-102	240 (52.1)	121 (52.6)
	Regorafenib	40 (8.7)	18 (7.8)
	Both	181 (39.3)	91 (39.6)

Primary Endpoint: Overall Survival

ITT Population

	Fruquintinib	Placebo
Events/Patients (%)	317/461 (68.8%)	173/230 (75.2%)
Stratified p-value (log-rank)	<0.001	
Stratified HR (95% CI)	0.662 (0.549, 0.800)	
Median (mo) (95% CI)	7.4 (6.7, 8.2)	4.8 (4.0, 5.8)
mOS difference (mo)	2.6	



Median follow up:
Fruquintinib: 11.3 mo
Placebo: 11.2 mo

Patients at Risk

Fruquintinib	461	449	429	395	349	297	266	224	184	143	113	79	58	41	23	14	7	4	4	0
Placebo	230	216	184	153	125	105	89	73	63	45	37	31	20	15	10	6	3	2	1	0

Subsequent anti-cancer medication balanced between the two arms: **29.4% fruquintinib arm** vs. **34.3% placebo arm**

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OS Subgroup Analysis

ITT Population

Subgroup		Fruquintinib n/N	Placebo n/N	HR (95% CI)
ITT population		317/461	173/230	0.662 (0.549, 0.800)
Age	< 65	171/247	89/119	0.694 (0.534, 0.903)
	≥ 65	146/214	84/111	0.648 (0.494, 0.851)
Sex	Female	149/216	61/90	0.828 (0.609, 1.125)
	Male	168/245	112/140	0.584 (0.456, 0.749)
ECOG PS	0	121/196	67/102	0.775 (0.573, 1.050)
	1	196/265	106/128	0.571 (0.499, 0.728)
Race	Caucasian	260/367	145/192	0.696 (0.567, 0.854)
	Asian	24/43	14/18	0.377 (0.171, 0.833)
	African American	7/13	5/7	0.550 (0.135, 2.231)
	Other	26/38	9/13	1.199 (0.478, 3.006)
Region	North America	50/82	29/42	0.620 (0.387, 0.995)
	Europe	237/329	130/166	0.688 (0.554, 0.855)
	Asia Pacific	30/50	14/22	0.631 (0.321, 1.241)
Duration of metastatic disease	≤ 18 mo	30/37	8/13	0.605 (0.260, 1.406)
	> 18 mo	287/424	165/217	0.642 (0.529, 0.779)
Primary tumor site at 1st diagnosis	Colon	195/279	109/137	0.672 (0.528, 0.855)
	Rectum	99/143	49/70	0.633 (0.446, 0.900)
	Colon and Rectum	23/39	15/23	0.686 (0.339, 1.388)
RAS status	WT	119/170	62/85	0.667 (0.489, 0.909)
	Mutant	198/291	111/145	0.683 (0.539, 0.865)
# of prior treatment lines in metastatic disease	≤ 3	80/125	45/64	0.714 (0.488, 1.043)
	>3	237/336	128/166	0.645 (0.519, 0.802)
Prior VEGFi	Yes	306/445	167/221	0.683 (0.565, 0.827)
	No	11/16	6/9	0.193 (0.024, 1.557)
Prior EGFRi	Yes	127/180	64/88	0.689 (0.507, 0.936)
	No	190/281	109/142	0.666 (0.524, 0.846)
Prior TAS-102 and Regorafenib	TAS-102	165/240	88/121	0.723 (0.557, 0.938)
	Regorafenib	25/40	12/18	0.772 (0.379, 1.573)
	Both	127/181	73/91	0.600 (0.447, 0.805)
Liver metastases	Yes	255/339	132/156	0.576 (0.465, 0.713)
	No	62/122	41/74	0.771 (0.513, 1.158)

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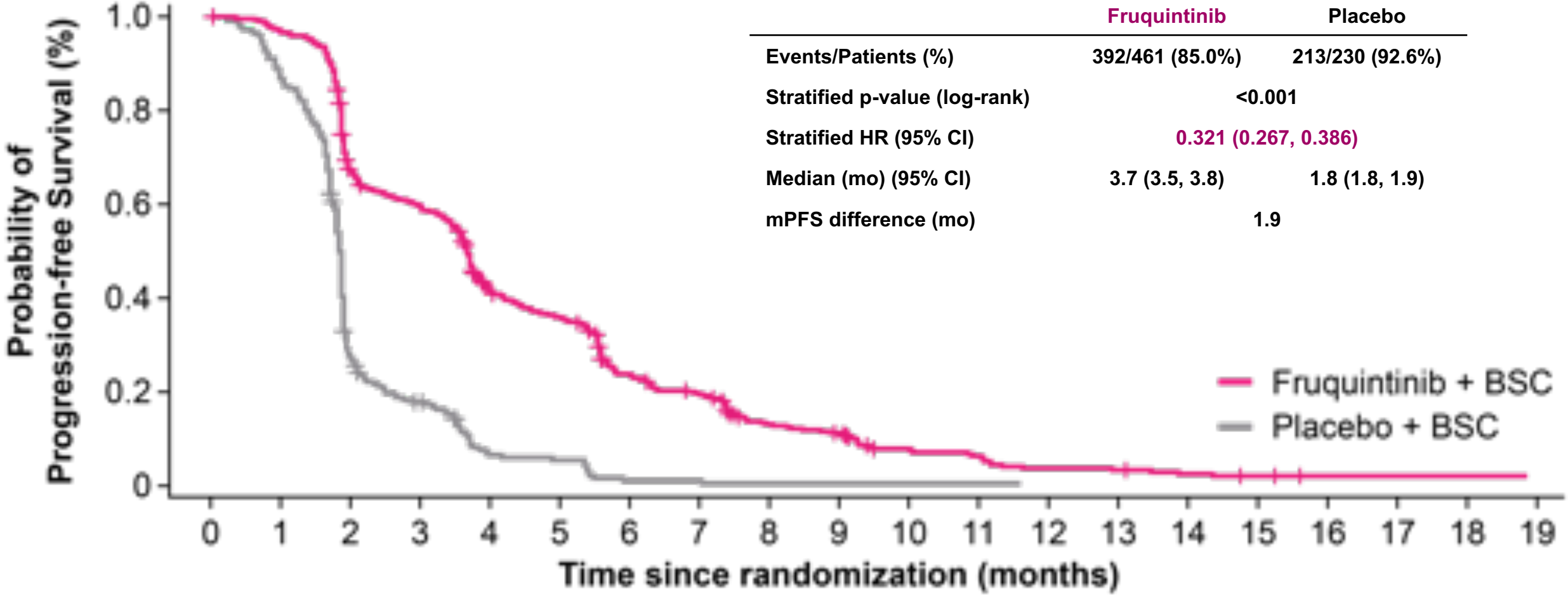
Progression-Free Survival

ITT Population

	Fruquintinib	Placebo
Events/Patients (%)	392/461 (85.0%)	213/230 (92.6%)
Stratified p-value (log-rank)	<0.001	
Stratified HR (95% CI)	0.321 (0.267, 0.386)	
Median (mo) (95% CI)	3.7 (3.5, 3.8)	1.8 (1.8, 1.9)
mPFS difference (mo)	1.9	



Patients at Risk

Fruquintinib	461	430	291	256	170	146	89	71	43	36	21	17	10	9	6	4	2	2	2
Placebo	230	194	60	36	12	10	2	2	1	1	1	1	0						

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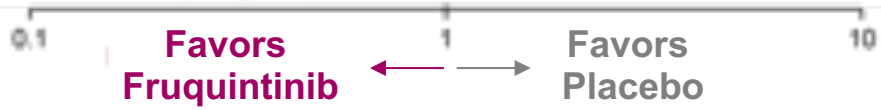
PFS Subgroup Analysis

ITT Population

Subgroup		Fruquintinib n/N	Placebo n/N	HR (95% CI)
ITT population		392/461	213/230	0.321 (0.267, 0.386)
Age	< 65	214/247	111/119	0.329 (0.255, 0.424)
	≥ 65	178/214	102/111	0.314 (0.241, 0.410)
Sex	Female	190/216	81/90	0.351 (0.263, 0.468)
	Male	202/245	132/140	0.302 (0.237, 0.385)
ECOG PS	0	169/196	90/102	0.264 (0.197, 0.354)
	1	223/265	123/128	0.351 (0.277, 0.446)
Race	Caucasian	312/367	176/192	0.313 (0.255, 0.383)
	Asian	37/43	17/18	0.286 (0.140, 0.584)
	African American	9/13	7/7	0.081 (0.014, 0.468)
	Other	34/38	13/13	0.525 (0.248, 1.110)
Region	North America	64/82	36/42	0.261 (0.163, 0.417)
	Europe	283/329	158/166	0.324 (0.261, 0.401)
	Asia Pacific	45/50	19/22	0.271 (0.144, 0.509)
Duration of metastatic disease	≤ 18 mo	35/37	11/13	0.361 (0.166, 0.787)
	> 18 mo	357/424	202/217	0.300 (0.249, 0.363)
Primary tumor site at 1st diagnosis	Colon	241/279	127/137	0.294 (0.231, 0.375)
	Rectum	118/143	64/70	0.315 (0.225, 0.441)
	Colon and Rectum	33/39	22/23	0.386 (0.202, 0.739)
RAS status	WT	145/170	76/85	0.333 (0.245, 0.454)
	Mutant	247/291	137/145	0.318 (0.254, 0.399)
# of prior treatment lines in metastatic disease	≤ 3	108/125	57/64	0.280 (0.192, 0.409)
	>3	284/336	156/166	0.334 (0.270, 0.412)
Prior VEGFi	Yes	377/445	206/221	0.335 (0.278, 0.402)
	No	15/16	7/9	0.020 (0.001, 0.385)
Prior EGFRi	Yes	154/180	79/88	0.325 (0.239, 0.440)
	No	238/281	134/142	0.310 (0.247, 0.391)
Prior TAS-102 and Regorafenib	TAS-102	210/240	111/121	0.367 (0.287, 0.470)
	Regorafenib	29/40	16/18	0.292 (0.139, 0.611)
	Both	153/181	86/91	0.285 (0.212, 0.382)
Liver metastases	Yes	297/339	149/156	0.291 (0.234, 0.362)
	No	95/122	64/74	0.334 (0.235, 0.476)



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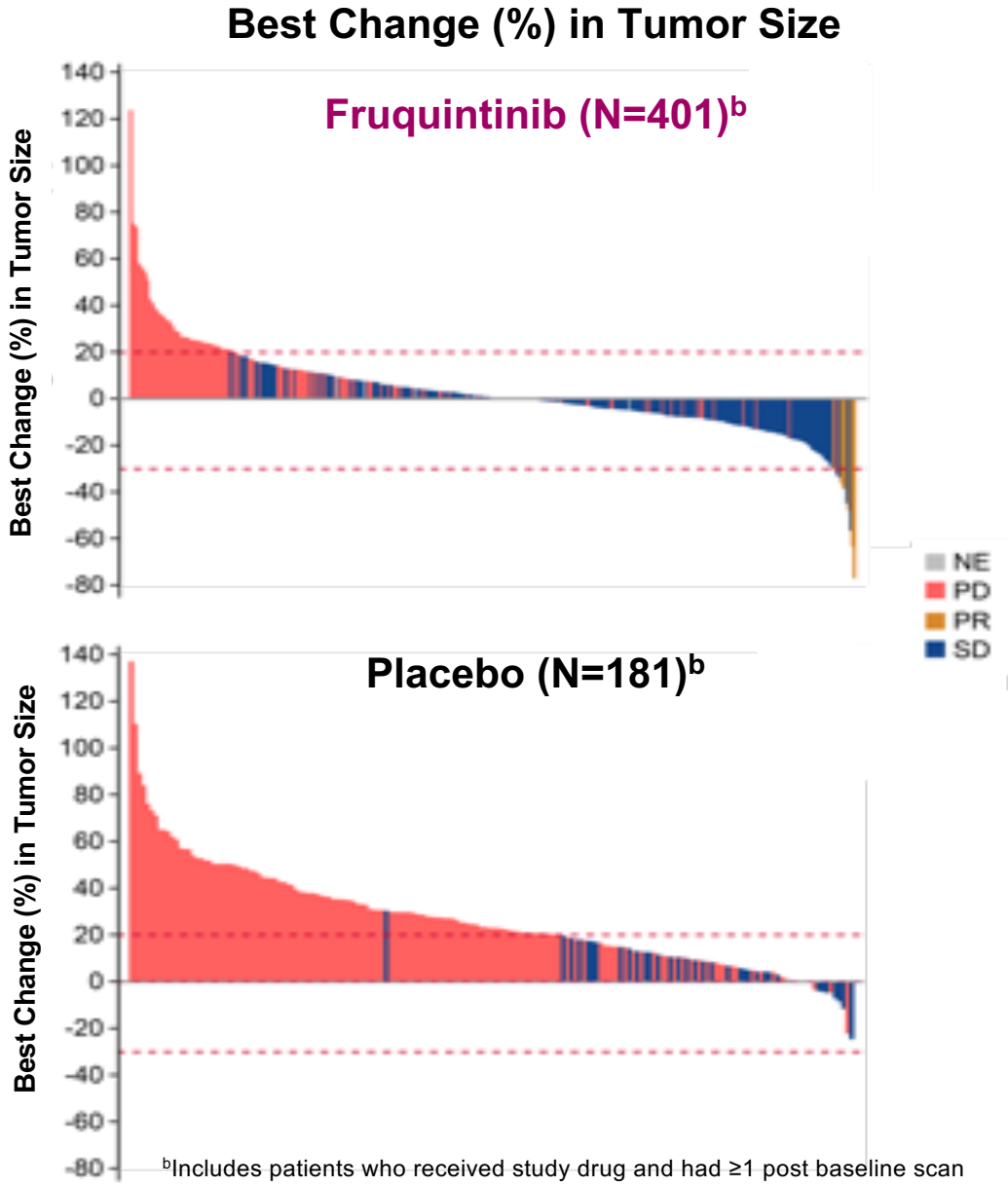
Anti-Tumor Activity

Category	Fruquintinib N=461	Placebo N=230
Confirmed ORR (CR + PR)[a]	7 (1.5)	0
Adjusted difference (95% CI)	1.5 (0.4, 2.7)	
Two-sided p-value	0.059	
Disease Control Rate (CR + PR + SD)	**256 (55.5)**	**37 (16.1)**
Adjusted difference (95% CI)	39.4 (32.8, 46.0)	
Two-sided p-value	< 0.001	

[a]No CR reported

- Tumor assessments were performed every 8 weeks until disease progression



[b]Includes patients who received study drug and had ≥1 post baseline scan

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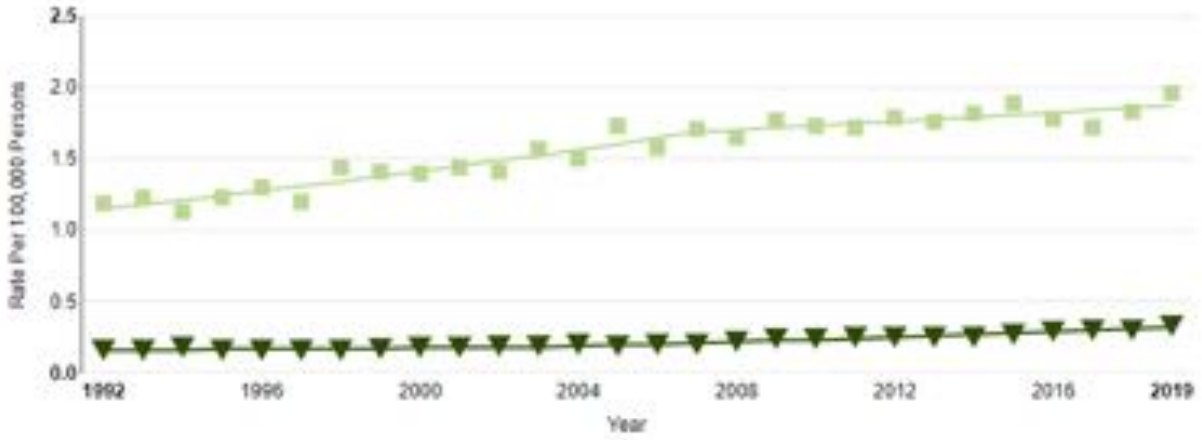
Incidence of Anal Cancer

Rising in annual incidence by 2.7%

Estimated New Cases in 2022	9,440
% of All New Cancer Cases	0.5%

Estimated Deaths in 2022	1,670
% of All Cancer Deaths	0.3%

5-Year Relative Survival
70.1%
2012-2018



https://seer.cancer.gov/statfacts/html/anus.html; Eng et al: JCO, 2022

Efficacy of Immune Checkpoint Inhibition in Previously Treated Metastatic SCCA

Drug	Phase	N	Dose	Primary endpoint	Secondary Endpoints
ETCTN NCI9673: Nivolumab (Part A)	II	34	3 mg/kg IV q2 wks	ORR: 24% (2CR's)	PFS: 4.1M OS: 11.5M
Pembrolizumab (KN-158)	I/II	112	200 mg IV q3 wks	ORR:11% (No CR's)	PFS: 2.0M OS: 11.9M
Retifanlimab (POD1UM-202)	II	94	500 mg IV q4 wks	ORR: 14% (1CR)	PFS: 2.3M OS:10.1M

Morris et al: Lanc Onc, 2017; Marabelle et al: Lancet Gastro and Hep, 2022;; Rao et al: Annals of Onc, 2020

2022 ASCO ANNUAL MEETING

GERCOR

PRODIGE
PARTENARIAT DE RECHERCHE EN ONCOLOGIE DIGESTIVE

LBA 3508: Atezolizumab plus modified DCF (docetaxel, cisplatin, and 5-fluorouracil) as first-line treatment for metastatic or locally advanced squamous cell anal carcinoma (SCCA). A SCARCE-PRODIGE 60 randomized phase II study

Stefano Kim,[1] François Ghiringhelli, Christelle de la Fouchardière, Eric François, Denis Smith, Emmanuelle Samalin, Daniel Lopez-Trabada Ataz, Aurélia Parzy, Jérôme Desramé, Nabil Baba Hamed, Bruno Buecher, David Tougeron, Oliver Bouché, Benoist Chibaudel, Farid El Hajbi, Marie-Line Garcia-Larnicol, Aurélia Meurisse, Dewi Vernerey, Simon Pernot, Christophe Borg

[1]Clinical Investigational Center CIC-1403, University Hospital of Besançon; University of Bourgogne-Franche Comté, Besançon, France

SCARCE-PRODIGE 60 Study Design

Key eligibility criteria

- Advanced SCCA
  - Metastatic
  - Non-resectable local recurrence
- **Treatment naïve**
- Age ≥ 18 years
- ECOG PS 0-1
- Evaluable disease

R (2:1)

2

Arm A

Atezolizumab 800 mg / q2w / up to 1 year

mDCF 8 cycles

1

Arm B

mDCF 8 cycles

Primary endpoint
- 1-year PFS rate by mITT

Secondary endpoints
- Median PFS
- OS
- ORR
- Safety
- HRQoL
- Biomarkers

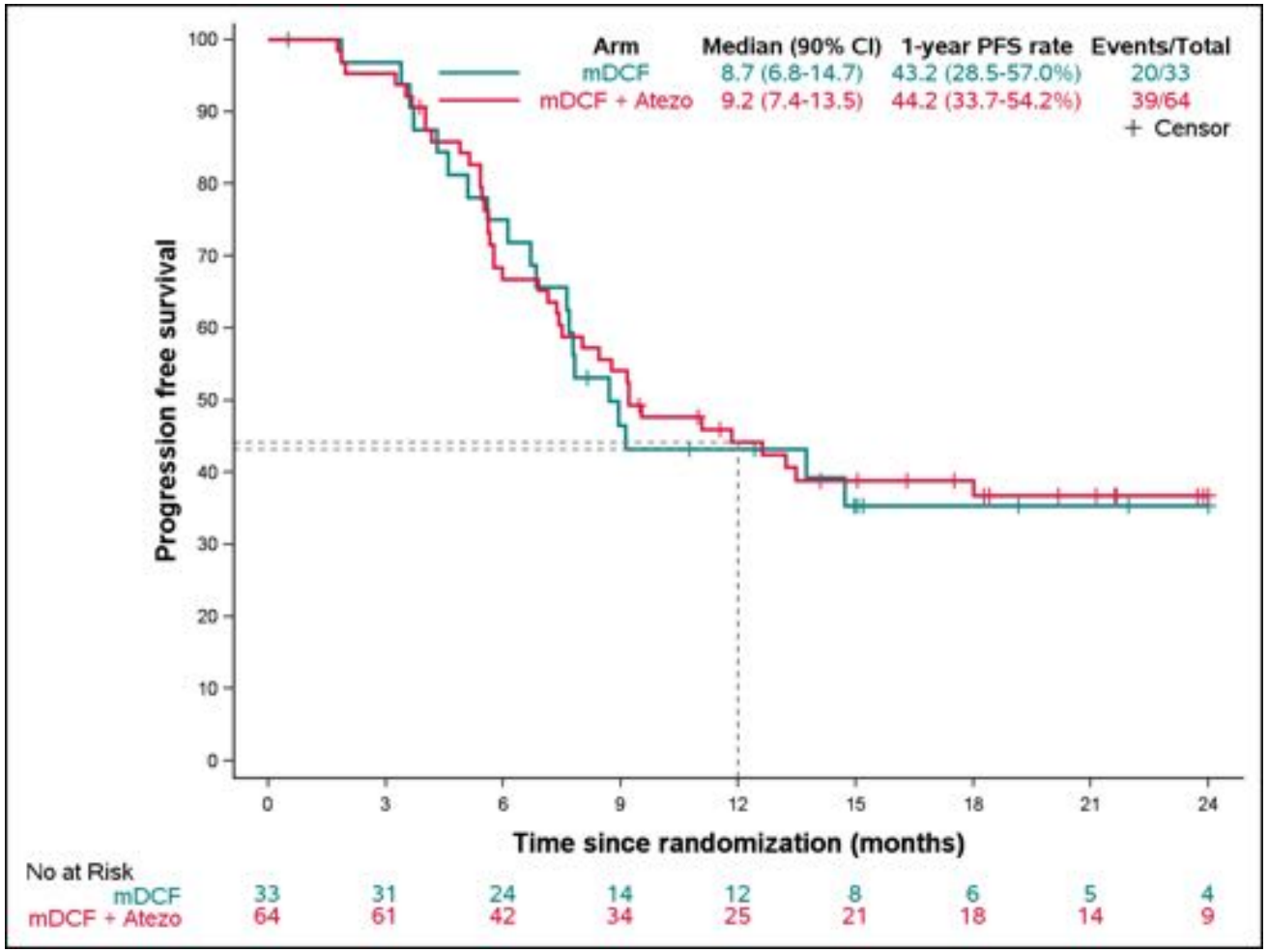
Stratification: age (<65 vs ≥65 years), stage (synchronous metastatic vs metachronous metastatic vs locally advanced unresectable disease without metastasis)

Kim et al: ASCO, 2022

Primary endpoint – 1-year PFS rate

Arm A

1-year PFS rate: 44.2%
(90% CI 31.7-56.0)



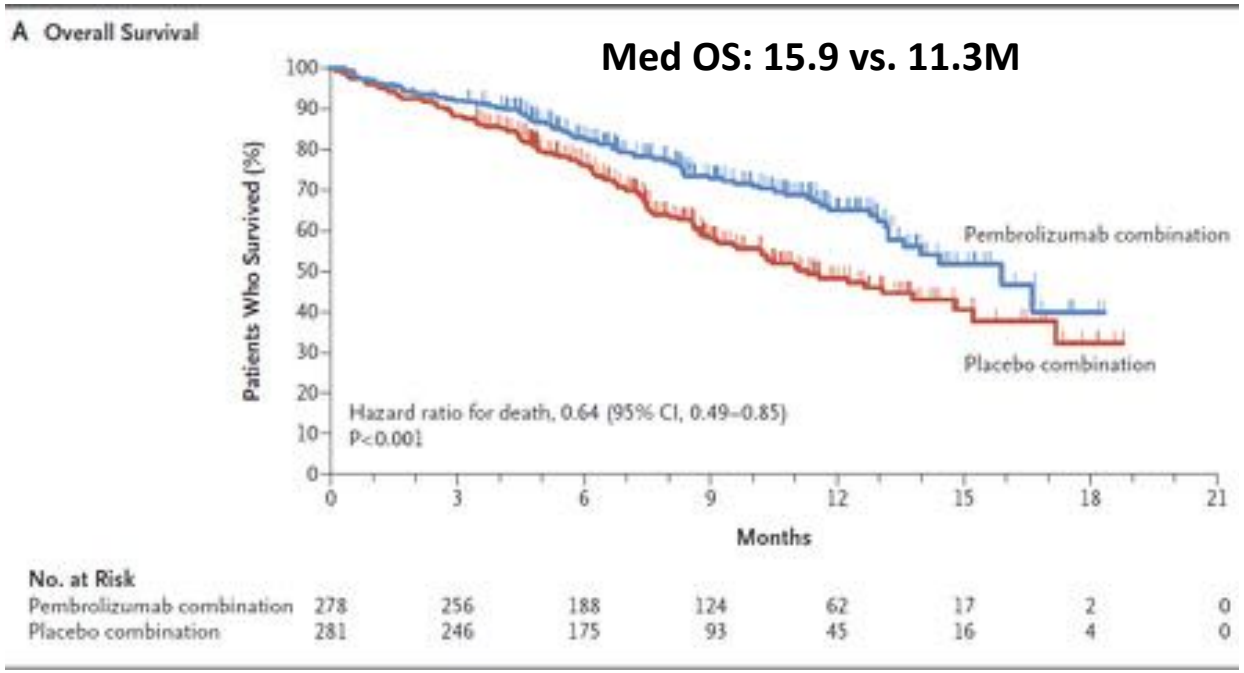
Arm B

1-year PFS rate: 43.2%
(90% CI 25.8-59.4)

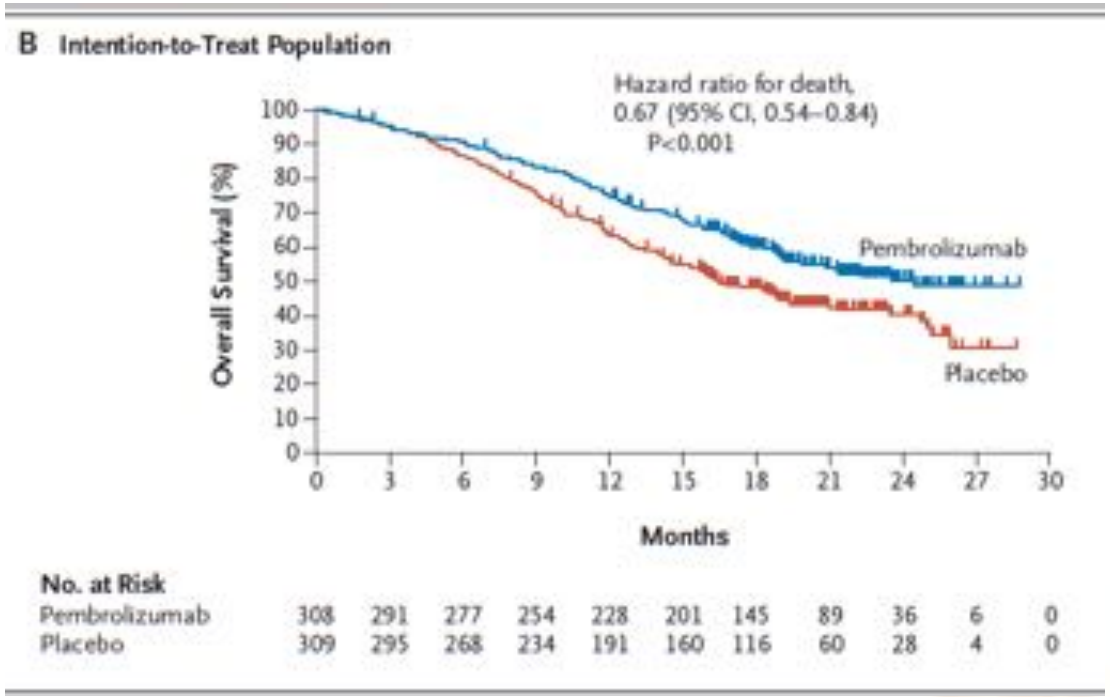
Kim et al: ASCO, 2022

Platinum +/- Immune Checkpoint Inhibitors in Other Squamous Cell Cancers

Phase III: Carboplatin + Paclitaxel (Nab) +/- Pembrolizumab in Squamous NSCLC (KN407)



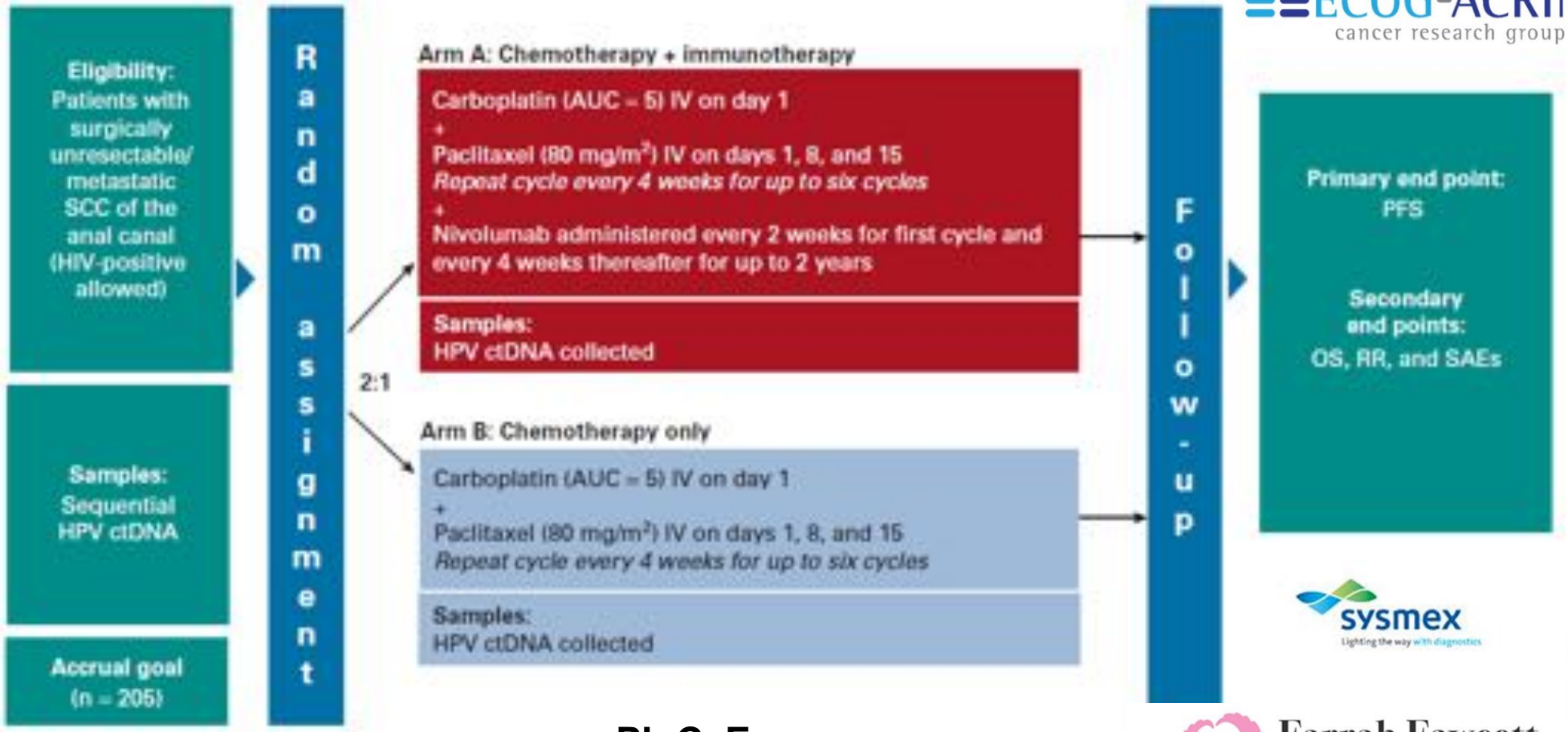
Platinum +/- Pembrolizumab in Cervical Cancer 24M OS = 50.4% and 40.4% (KN826)



Paz-Arez et al: NEJM, 2018; Colombo et al: NEJM, 2021

EA2176: Phase 3 Clinical Trial of Carboplatin and Paclitaxel +/- Nivolumab in Treatment-Naive Metastatic Anal Cancer Patients

NCT04444921



ECOG-ACRIN cancer research group

sysmex

Lighting the way with diagnostics

PI: C. Eng

Co-PI's: A. Benson, K. Ciombor

Farrah Fawcett Foundation

Eng et al, JCO 2022

FIGHT™ COLORECTAL CANCER

Colorectal Cancer Awareness

Courtesy of Anjee Davis