# Performance evaluation of a reflex blood-based methylated ctDNA multi-cancer early detection test in individuals with obesity.

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**Background:** Obesity increases risk of 13 distinct cancers, most without screening programs, and collectively representing 40% of all annual US cancer diagnoses.With recent CDC data (2023) showing that obesity rates exceed 35% in 23 U.S. states, multi-cancer early detection (MCED) testing represents a unique opportunity to address a critical screening gap in this population. In this case-control study, we examined the performance of a reflex blood-based ctDNA methylation MCED test in individuals with obesity (BMI $\geq$ 30 kg/m$^2$), evaluating cancer-specific intrinsic accuracy (sensitivity) and positive predictive value (PPV). **Methods:** We analyzed peripheral blood samples (NCT05435066) from individuals with obesity, including 424 treatment-naïve cancer patients and 458 non-cancer controls, using a reflex test by Harbinger Health. The test system consists of a primary methylome profiling test optimized for high sensitivity (rule-out), followed by a confirmatory reflex analysis utilizing an expanded methylation panel designed to achieve high PPV (rule-in) and tissue of origin (TOO) classification. Test performance metrics were derived using 10-fold cross-validation with patient-level stratification. Overall cancer incidence in the obese population was estimated at 1.6%. Prospective PPV for each TOO readout was calculated using cancer-specific intrinsic accuracy estimated from the case-control study in combination with incidence values. **Results:** In this cohort (mean age 57.1 $\pm$ 13.4 years; 63.3% female; 67.8% White; 22.4%, Black or African American), the test achieved an overall 29.7% (95CI, 25.3-34.6) correct-TOO sensitivity (66.1% false negative, 4.2% incorrect TOO) at 98.9% (95CI, 97.6-99.6) specificity and 98.9% negative predictive value (95CI, 98.85,99.0). Among a subset of cancers associated with obesity, TOO-specific PPVs were: hepatobiliary (HB: liver, biliary duct; 100%; 95CI, ND), CRC (87.5; 95CI, 61.1-96.9), upper gastrointestinal (UGI; 81.8; CI95, 48.6-95.5), uterine (66.7%; 95CI, 26.5-91.7), pancreaticobiliary (PB: pancreas, gallbladder; 17.6%; 95CI 3.1-59.0). Corresponding cancer group sensitivities (early stage, I-II) were: HB 50.0 (35.1), CRC 51.9 (28.6), UGI 40.9 (9.1), uterine 8.5 (3.8), PB 56.5 (25.0). In a modeled cohort of 100,000 tested individuals, the expected TOO readout counts (correct case-type odds) were: 23 for HB (23:0), 60 for CRC (7:1), 42 for UGI (9:2), 23 for uterine (2:1), 279 for PB (1:5). **Conclusions:** Inindividuals with obesity at increased risk for multiple cancers, especially those lacking established screening guidelines, the reflex ctDNA methylation MCED test demonstrated clinically meaningful PPV and early-stage sensitivity for each cancer type. These results warrant prospective validation to assess the test's clinical validity and utility in early-stage cancer detection in this high-risk population.
Research Sponsor: None.

# Prognostic significance of blood-based multi-cancer detection in circulating tumor DNA (ctDNA): 5-year outcomes analysis.

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**Background:** In the case-control Circulating Cell-free Genome Atlas (CCGA) study (NCT02889978), a multi-cancer early detection (MCED) test was developed that uses next-generation sequencing to detect a cancer signal shared across > 50 cancer types using ctDNA in blood. The concentration of ctDNA in blood is associated with cancer aggressiveness and prognosis. Previous analysis of participant outcomes in the second (cross-validation) CCGA substudy evaluated the prognostic value of cancer signal detection by an early version of the MCED test with 3-year follow-up. Participants with confirmed cancer and no cancer signal detected (NCSD) MCED test result had better 3-year survival than those with a cancer signal detected (CSD). In the present analysis, we evaluated the prognostic value of cancer signal detection by a refined version of the MCED test in the third (validation) CCGA substudy (CCGA3) using an updated statistical methodology with 5-year follow-up, a typical timeframe for cancer-survivor status. **Methods:** Participant blood samples collected during CCGA3 were analyzed using the MCED test. Participants with confirmed cancer were followed for up to 5 years and their overall survival stratified by cancer signal detection (CSD/NCSD). Observed survival was compared to the expected survival of a reference population calculated using Surveillance, Epidemiology, and End Results (SEER) data matched to the distribution of age, sex, cancer type, and stage in each signal detection group. A one-sample proportional hazard model was used to assess differences between observed and expected survival based on cancer signal detection status. **Results:** Follow-up data were available for 2475/2513 (99%) of participants with stageable, invasive cancer. Of these, 792 (32%) died during follow-up, 673/792 (85%) of whom had a CSD; of the 1683 (67%) participants alive at follow-up, 579/1683 (35%) had a CSD. Overall observed survival rates of both groups were higher than the expected survival rates based on SEER data matched for known clinical factors (43% vs 40% [CSD]; 88% vs 81% [NCSD]). Observed vs expected survival rates for participants with: stage I cancer were 66% vs 71% (CSD) and 90% vs 85% (NCSD); stage II cancer were 64% vs 67% (CSD) and 92% vs 83% (NCSD); stage III cancer were 48% vs 42% (CSD) and 79% vs 66% (NCSD); stage IV cancer were 22% vs 16% (CSD) and 56% vs 32% (NCSD). Overall HR for NCSD vs CSD across all stages was 0.60 (95% CI: 0.50-0.72; P = 6.18e-09). HRs for signal detection group vs SEER reference populations were < 1 at all stages with NCSD; with CSD, HRs were < 1 at stages III and IV and ≥1 at stages I and II. **Conclusions:** In CCGA3, 5-year follow-up confirmed that while CSD was associated with hazard of death, early-stage cases had long-term survival close to expected rates. These results suggest that a CSD MCED test result may inform prognosis and urgency of treatment. Clinical trial information: NCT02889978. Research Sponsor: GRAIL, Inc.

# A phase 1 study of intracerebroventricular (ICV) delivery of bivalent chimeric antigen receptor (CAR) T-cells targeting EGFR and IL13Ra2 in patients with recurrent glioblastoma (rGBM).

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**Background:** Outcomes in patients with rGBM are poor, with historical median overall survival (OS) of 6-9 months. Here we report the results from the dose exploration phase of a phase 1 trial investigating ICV-delivered, bivalent CAR T-cells targeting EGFR epitope 806 and IL13Rα2 in rGBM. **Methods:** Patients with EGFR-amplified GBM that was recurrent/progressive following front-line radiotherapy were enrolled using a 3+3 design (dose levels: $5.0 \times 10^6$, $1.0 \times 10^7$, and $2.5 \times 10^7$ cells). Patients underwent surgery for (1) maximal safe resection and confirmation of viable tumor and (2) Ommaya reservoir placement. Post-operatively, patients received a single ICV dose of CART-EGFR-IL13Rα2 cells without lymphodepleting chemotherapy. Primary endpoints included dose-limiting toxicity (DLT) and determination of the maximum tolerated dose (MTD). Secondary endpoints included objective radiographic response, progression-free survival (PFS), and OS. Serial CSF samples were analyzed for CAR T-cell pharmacokinetics and single-cell RNA sequencing (scRNAseq). **Results:** Eighteen patientsreceived CART-EGFR-IL13Rα2 cells (n=6 per dose level). Median age was 57, 15 (83%) were male, 13 (72%) had MGMT unmethylated tumors, and 7 (39%) had >1 prior relapse. One DLT (grade 3 lethargy/fatigue) was observed at the MTD ($2.5 \times 10^7$ cells). Acute neurotoxicity related to CAR T-cells occurred in all patients. Using immune effector cell-associated neurotoxicity syndrome (ICANS) grading, 10 of 18 patients (56%) experienced grade 3 neurotoxicity; none had grade 4-5 neurotoxicity. Using tumor-inflammation associated neurotoxicity (TIAN) grading, 2 of 18 patients (11%) had grade 3 and 1 patient (6%) had grade 4 neurotoxicity. Grade 1-2 fever occurred in all patients. Eleven of 13 patients (85%) with measurable disease at time of CAR T-cell infusion experienced tumor shrinkage, ranging from 1-62% reductions (median 35%, IQR 12 – 39%) in target lesions and with one confirmed partial response by modified RANO criteria. PFS and OS continue to mature and will be presented. CAR T-cell expansion in CSF was robust with a dose-response relationship observed. The CAR transgene remained detectable in CSF and blood 12 months post-CART infusion in a patient experiencing durable stable disease lasting for 17 months (ongoing at data cut-off). In patients undergoing repeat resection following treatment, CART-EGFR-IL13Rα2 cell infusion markedly increased the number of tumor-infiltrating lymphocytes. scRNAseq in post-treatment CSF revealed higher cytotoxicity and exhaustion scores in CD8+ CAR T-cells as compared to the infusion product, indicative of target cell engagement. **Conclusions:** ICV delivery of CART-EGFR-IL13Rα2 is feasible and appears safe. CART-EGFR-IL13Rα2 cells are bioactive and exhibit an encouraging early efficacy signal in rGBM. Clinical trial information: NCT05168423. Research Sponsor: Kite Pharma (a Gilead company).

# Neoadjuvant biomarker trial of pepinemab to enhance nivolumab or ipilimumab activity in resectable head and neck cancer.

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**Background:** Neoadjuvant treatment with immune checkpoint blockade (ICB) improves clinical benefit in patients with multiple types of cancers. Window of opportunity studies permit integrated assessments of safety and efficacy, including biomarker assessments of treatment effects and mechanisms of resistance in the tumor microenvironment. SEMA4D blocking antibody, pepinemab (pepi), has been reported to overcome resistance mechanisms including immune exclusion and myeloid suppression in preclinical and clinical studies. We conducted a neoadjuvant integrated biomarker study (NCT03690986) to evaluate the effect of pepi alone and in combination with ICB on the immune profile in the tumor and blood of patients with resectable head and neck squamous cell carcinoma (HNSCC). **Methods:** Patients were randomized to receive one dose of either pepi alone, pepi/ipilimumab (ipi), pepi/nivolumab (nivo), ipi, nivo (n = 6 patients/group), or no treatment (n = 4); followed by surgery within days 17-36. The primary objective is biomarker assessments; clinical endpoints include pathologic response (pMR), safety, surgical delays, RFS, and OS. Analysis of pretreatment and surgically resected tissue and blood to evaluate spatial distribution of tumor and immune populations employed high dimensional 36+ multiplex IHC and 32-color flow cytometry. Biomarker results were stratified by demographic and clinical outcome measures. **Results:** Thirty-four patients were enrolled (median age 63 (58-69); 70.6% male; 79.4% OC, 20.6% OP; 82.4% HPV/p16 Neg). All patients proceeded to surgery without delay; no additional or unexpected TRAEs were observed in pepi combinations; 9/10 patients who experienced TRAEs were Grade 1-2. Biomarker analysis was stratified by HPV status due to vast difference between highly infiltrated HPV+ compared to immunologically cold HPV- TME. Among 24 available HPV- resected tumors,an increase in the number of intratumoral tertiary lymphoid structures (TLS) was observed in pepinemab containing cohorts, whereas B cells lined the tumor edge and were generally excluded from tumor bed in cohorts lacking pepinemab. A significant increase in density of mature TLS (including CD21+ follicular DC and CD23+ germinal center B cells) was observed in patients treated with pepi+nivo compared with pepi or nivo alone and untreated patients. This finding was unexpected, as mature TLS are generally rare in poorly immunogenic HPV-negative HNSCC. Clinical assessments of pathologic response and RFS are being analyzed. **Conclusions:** Neoadjuvant treatment with pepi enhanced the density and maturity of TLS deep within the tumor which was most prominent in combination with nivo notably in HPV-negative disease. Pepi represents a novel strategy to boost tumor immunity and organization of functional TLS to overcome limitations of ICB in HPV- HNSCC. Clinical trial information: NCT03690986. Research Sponsor: Winship Cancer Institute of Emory University, Atlanta, GA.

# Efficacy and safety of IBI363 monotherapy or in combination with bevacizumab in patients with advanced colorectal cancer.

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**Background:** The prognosis of patients (pts) with microsatellite stable/proficient mismatch repair (MSS/pMMR) colorectal cancer (CRC) who failed standard chemotherapy is poor, highlighting a significant unmet need. No immune-oncology therapy has succeeded in this indication due to the "cold" tumor nature. IBI363 is a PD-1/IL-$2^{\alpha\text{-bias}}$ bispecific antibody fusion protein that blocks PD-1 and stimulates tumor-specific T cells that could potentially turn "cold" tumors into "hot" tumors. **Methods:** The analysis of efficacy and safety data were from 68 pts treated with IBI363 monotherapy and 73 pts treated with IBI363 plus bevacizumab (beva), respectively. Eligible pts were locally advanced unresectable or metastatic CRC who failed or were intolerant to the standard treatment. Data cutoff date was Dec 6, 2024. **Results:** A total of 68 pts and 73 pts (None were confirmed as microsatellite instability-high/deficient mismatch repair [MSI-H/dMMR]; MSS/pMMR: 86.8% and 90.4%; unknown microsatellite/MMR status: 13.2% and 9.6%; liver metastases: 61.8% and 54.8%; *KRAS/NRAS* mutations: 42.6% and 41.1%; previous treatment lines ≥ 3: 63.2% and 53.4%; previous immunotherapy: 27.9% and 16.4%) were treated with IBI363 monotherapy (0.1 mg/kg to 3 mg/kg every week [QW], every 2 weeks [Q2W] or every 3 weeks [Q3W]) and IBI363 plus beva (0.6 or 1 mg/kg Q2W, 1.5, 2 or 3 mg/kg Q3W, plus beva 5 mg/kg Q2W or 7.5 mg/kg Q3W), respectively. Median follow-up time was 11.8 months (range: 0.4–22.5) for monotherapy and 5.1 months (range: 1.2–14.9) for combination. In efficacy-evaluable pts (n = 63 for monotherapy and n = 68 for combination), the objective response rate (ORR) was 12.7% (95% confidence interval [CI]: 5.6–23.5) and 23.5% (95% CI: 14.1–35.4). The median duration of response was 7.5 months (95% CI: 1.2–19.6) for monotherapy and not mature for combination. The median OS was 16.1 months (95% CI: 10.1–not reached) for monotherapy and not mature for combination. Especially, in pts without liver metastasis who received the combination therapy (n = 31), the ORR was 38.7% (95% CI: 21.9–57.8), the DCR was 83.9% (95% CI: 66.3–94.6), and median PFS was 9.6 months (95% CI: 4.1–12.2). Grade ≥ 3 treatment-related adverse events were reported in 16 (23.5%) pts with monotherapy and 22 (30.1%) pts with combination. Arthralgia, rash, and thyroid disorders were commonly reported immune-related adverse events. **Conclusions:** IBI363 monotherapy demonstrated prolonged overall survival in pts with advanced CRC compared to historic data of standard of care. IBI363 plus beva showed even more encouraging efficacy with acceptable safety and warrants further development. Clinical trial information: NCT05460767. Research Sponsor: None.

# Safety and efficacy of ABBV-706, a seizure-related homolog protein 6 (SEZ6)–targeting antibody-drug conjugate, in high-grade neuroendocrine neoplasms.

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**Background:** SEZ6 is a potential neuroendocrine lineage marker that is expressed in small cell lung cancer (SCLC) and high-grade neuroendocrine neoplasms (NENs). NENs have a significant unmet need for novel effective targeted therapies. ABBV-706, a unique antibody-drug conjugate comprising a SEZ6-directed antibody conjugated to a potent topoisomerase 1 inhibitor payload, is being evaluated in a phase 1 study (NCT05599984) in patients (pts) with advanced solid tumors. Preliminary results from ABBV-706 monotherapy dose escalation showed a manageable safety profile with promising efficacy in SCLC and NENs (*J Clin Oncol* 2024;42 [suppl 16]: abs 3001). Herein, updated safety and efficacy of ABBV-706 monotherapy in NENs are presented. **Methods:** Pts (≥18 yr) with relapsed/refractory high-grade NENs (well-differentiated grade [G] 3 neuroendocrine tumors [G3 NETs] and poorly differentiated neuroendocrine carcinomas [NECs]), atypical lung carcinoid, and medullary thyroid cancer (MTC) were enrolled in dose-escalation and -expansion cohorts of a phase 1, open-label study. Pts received ABBV-706 monotherapy IV at 1.3–3.5 mg/kg once every 3 weeks. Primary study objectives are assessment of safety, PK, and efficacy. SEZ6 expression is evaluated retrospectively. **Results:** As of Aug 27, 2024, 191 pts were enrolled overall, including 64 with NENs. In the NEN cohort, median age was 63 yr (range 33–86) and pts had received a median of 3 (range 1–8) prior therapies. NEN histologies were large cell NEC (LCNEC; 22%, n=14), gastroenteropancreatic NEC (GEPNEC; 19%, n=12), MTC (9%, n=6), neuroendocrine prostate carcinoma (NEPC; 8%, n=5), G3 NETs (8%, n=5), and other NECs (34%, n=22). The safety profile for ABBV-706 was similar across NEN subtypes and aligned with the entire study population. For the overall study population, TEAEs occurred in 184 (96%) pts and G≥3 in 134 (70%). Most frequent hematologic TEAEs were anemia (58%; G≥3: 45%), neutropenia (44%; G≥3: 33%), and thrombocytopenia (35%; G≥3: 21%). Most frequent nonhematologic TEAEs were fatigue (45%; G≥3: 3%) and nausea (38%; G≥3: 2%). Unadjudicated pneumonitis/interstitial lung disease rate was 4% (G≥3 in 2 pts). For the entire NEN cohort, the objective response rate (ORR) was 31.3% (20/64) and the clinical benefit rate was 92.2% (59/64). ORR by NEN type was: LCNEC, 28.6% (4/14); GEPNEC, 16.7% (2/12); NEPC, 60.0% (3/5); G3 NET, 60% (3/5); MTC, 16.7% (1/6); other NEC, 31.8% (7/22). The median duration of response was 5.59 mo (95% CI: 4.24, not estimable) and median progression-free survival was 6.80 mo (95% CI: 5.45, 7.75). Correlation analysis of efficacy with SEZ6 expression is ongoing. **Conclusions:** ABBV-706 showed preliminary efficacy in several high-grade NENs with a high unmet need, supporting its further development in specific subtypes. Clinical trial information: NCT05599984. Research Sponsor: AbbVie Inc.; n/a

# Phase 1 study of SHR-1826, a c-MET–directed antibody-drug-conjugate (ADC), in advanced solid tumors.

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**Background:** MET alterations are key drivers of diverse oncogenic processes, including tumor invasion, growth, and metastasis, and are associated with poor prognosis. SHR-1826 is a novel ADC of a humanized c-MET-directed IgG2 monoclonal antibody attached to a topoisomerase I inhibitor payload via a tetrapeptide-based cleavable linker. We conducted a multi-center, first-in-human, phase 1 trial of SHR-1826 in advanced solid tumors, and here report preliminary results from the dose-escalation and expansion portions. **Methods:** Patients (pts) with advanced solid tumors harboring MET alterations (overexpression, amplification, or activating mutation) who had failed standard therapy or no available standard therapy, were enrolled. The study consisted of dose-escalation (i3+3 design), dose-expansion and efficacy-expansion phases, during which pts received SHR-1826 at 2.2–6.0 mg/kg, Q3W, iv. Primary objectives were to assess safety and tolerability. **Results:** As of Dec.5, 2024, 116 pts were enrolled and treated (NSCLC/CRC/GC/PC, n=72/32/10/2; median age, 59.2 yrs; ECOG PS 1, 87.9%; ≥3 lines of prior therapy, 44.0%; median c-MET H-score, 163 [range 9-300]). During dose-escalation, 1 DLT was observed at 6.0 mg/kg (grade 3 febrile neutropenia). Grade ≥3 TRAEs were reported in 56 (48.3%) pts, with the most common being decreased neutrophil count (32.8%), decreased white blood cell count (22.4%), anaemia (13.8%), and decreased platelet count (11.2%). Interstitial lung disease occurred in 3 (2.6%; grade 1-2, n=2; grade 3, n=1) pts. 2 (1.7%) pts discontinued treatment due to TRAE. There were no treatment-related deaths. Among 58 evaluable pts with NSCLC, ORR was 39.7% (95% CI 27.0–53.4) and DCR was 94.8% (95% CI 85.6–98.9; Table 1); response was observed across a range of c-MET expression levels, and in both *EGFR*-mutated and wild-type tumors. Median duration of response was not reached, with 21 of 23 responses ongoing. In all 72 NSCLC pts, median progression-free survival was 6.8 mo (95% CI 4.5–7.2). **Conclusions:** SHR-1826 demonstrated a manageable safety profile in pts with heavily pretreated advanced solid tumors. Promising anti-cancer activity was observed in MET-altered NSCLC, warranting further investigation in this population. Clinical trial information: NCT06094556. Research Sponsor: Jiangsu Hengrui Pharmaceuticals Co., Ltd.

**Efficacy in pts with NSCLC.**

| | 2.2 mg/kg (n=2) | 4 mg/kg (n=24) | 5 mg/kg (n=31) | 6 mg/kg (n=1) | All patients (n=58) |
|---|---|---|---|---|---|
| **Best overall response, n (%)** | | | | | |
| **Complete response** | 0 | 0 | 0 | 0 | 0 |
| **Partial response*** | 0 | 9 (37.5) | 13 (41.9) | 1 (100.0) | 23 (39.7) |
| **Stable disease** | 2 (100.0) | 14 (60.9) | 16 (51.6) | 0 | 32 (55.2) |
| **Progressive disease** | 0 | 0 | 2 (6.5) | 0 | 2 (3.4) |
| **Not evaluable** | 0 | 1 (4.2) | 0 | 0 | 1 (1.7) |
| **ORR*, % (95% CI)** | 0.0 (0.0–84.2) | 37.5 (18.8–59.4) | 41.9 (24.5–60.9) | 100.0 (2.5–100.0) | 39.7 (27.0–53.4) |
| **DCR, % (95% CI)** | 100.0 (15.8–100.0) | 95.8 (78.9–99.9) | 93.5 (78.6–99.2) | 100.0 (2.5–100.0) | 94.8 (85.6–98.9) |

Data are shown for pts with ≥1 post-baseline assessment.
*Including 6 unconfirmed responses across groups.

# Phase 1 trial of SHR-A2102, a nectin-4–directed antibody drug conjugate (ADC), in advanced solid tumors.

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**Background:** Nectin-4 is a cell adhesion molecule that is highly expressed in a wide variety of cancers and is associated with poor prognosis. SHR-A2102 is a novel ADC consisting of a fully humanized Nectin-4–directed monoclonal antibody, bound to topoisomerase I inhibitor payload via a cleavable linker. We conducted a multi-center, phase 1 trial to evaluate SHR-A2102 in advanced solid tumors. **Methods:** Patients (pts) with Nectin-4 positive, locally advanced unresectable or metastatic solid tumors were enrolled. The study included dose-escalation (D-ESC), dose-expansion (D-EXP) and efficacy-expansion (E-EXP) phases. SHR-A2102 was given IV at 2–10 mg/kg, Q3W during D-ESC, and at 6 mg/kg and 8 mg/kg Q3W during D-EXP and E-EXP. The primary objectives were to assess safety and tolerability. **Results:** As of Dec. 20, 2024,369 pts were enrolled and treated (median age, 59 y; ECOG PS 1, 85.6%; ≥2 lines of prior therapy, 64.0%). During D-ESC, DLT occurred in 1 pt (10 mg/kg; grade 4 decreased platelet count). Overall, grade ≥3 TRAEs occurred in 167 (45.3%) pts, with the most common (≥3%) being decreased neutrophil count (25.5%), decreased white blood cell count (16.3%), anaemia (11.7%), decreased lymphocyte count (8.7%), decreased platelet count (4.9%), asthenia (3.5%) and nausea (3.3%). 2 (0.5%) pts discontinued treatment due to TRAE. ILD occurred in 1 (0.3%; grade 3) pt. In 304 evaluable pts for response, ORR was 35.2% (95% CI 29.8-40.9) and DCR was 84.2% (95% CI 79.6-88.1). As of data cutoff, 146 (39.6%) pts had disease progression or died; median PFS was 4.7 mo (95% CI 4.3-5.6). Efficacy in selected tumor types is shown in Table. **Conclusions:** SHR-A2102 demonstrated a manageable safety profile and promising activity across a variety of pretreated advanced solid tumors. Multiple trials are ongoing to further assess SHR-A2102 both as monotherapy and in combination therapy for solid tumors. Clinical trial information: NCT05701709. Research Sponsor: Jiangsu Hengrui Pharmaceuticals.

**Efficacy in selected tumor types (efficacy evaluable set).**

| | *EGFR*-mut Nsq NSCLC (N=69) | *EGFR*-wt Nsq NSCLC (N=44) | Sq NSCLC (N=44) | HR+/HER2-BC (N=20) | TNBC (N=32) | HNSCC (N=12) | All patients† (N=304) |
|---|---|---|---|---|---|---|---|
| **Best overall response, n (%)** | | | | | | | |
| **CR*** | 0 | 1 (2.3) | 0 | 0 | 0 | 0 | 1 (0.3) |
| **PR*** | 30 (43.5) | 10 (22.7) | 11 (25.0) | 13 (65.0) | 18 (56.3) | 6 (50.0) | 106 (34.9) |
| **SD** | 28 (40.6) | 21 (47.7) | 33 (75.0) | 4 (20.0) | 9 (28.1) | 5 (41.7) | 149 (49.0) |
| **PD** | 11 (15.9) | 11 (25.0) | 0 | 3 (15.0) | 5 (15.6) | 1 (8.3) | 47 (15.5) |
| **Not evaluable** | 0 | 1 (2.3) | 0 | 0 | 0 | 0 | 1 (0.3) |
| **ORR*, % (95% CI)** | 43.5 (31.6-56.0) | 25.0 (13.2-40.3) | 25.0 (13.2-40.3) | 65.0 (40.8-84.6) | 56.3 (37.7-73.6) | 50.0 (21.1-78.9) | 35.2 (29.8-40.9) |
| **DCR, % (95% CI)** | 84.1 (73.3-91.8) | 72.7 (57.2- 85.0) | 100.0 (92.0-100.0) | 85.0 (62.1-96.8) | 84.4 (67.2-94.7) | 91.7 (61.5-99.8) | 84.2 (79.6-88.1) |
| **PFS‡, mo (95% CI)** | 5.7 (5.1-NR) | 4.3 (2.0-7.3) | 4.5 (4.1-6.8) | 5.6 (4.3-NR) | 5.6 (4.3-7.1) | 6.8 (2.4-6.8) | 4.7 (4.3-5.6) |

*Include responses to be confirmed.
†Other tumor types include ESCC, PAAD, CRC, CC and UC.
‡Evaluated in full analysis set (n=369).