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GECP lung cancer research

BRAF Mutations: Small Changes, Big Impact

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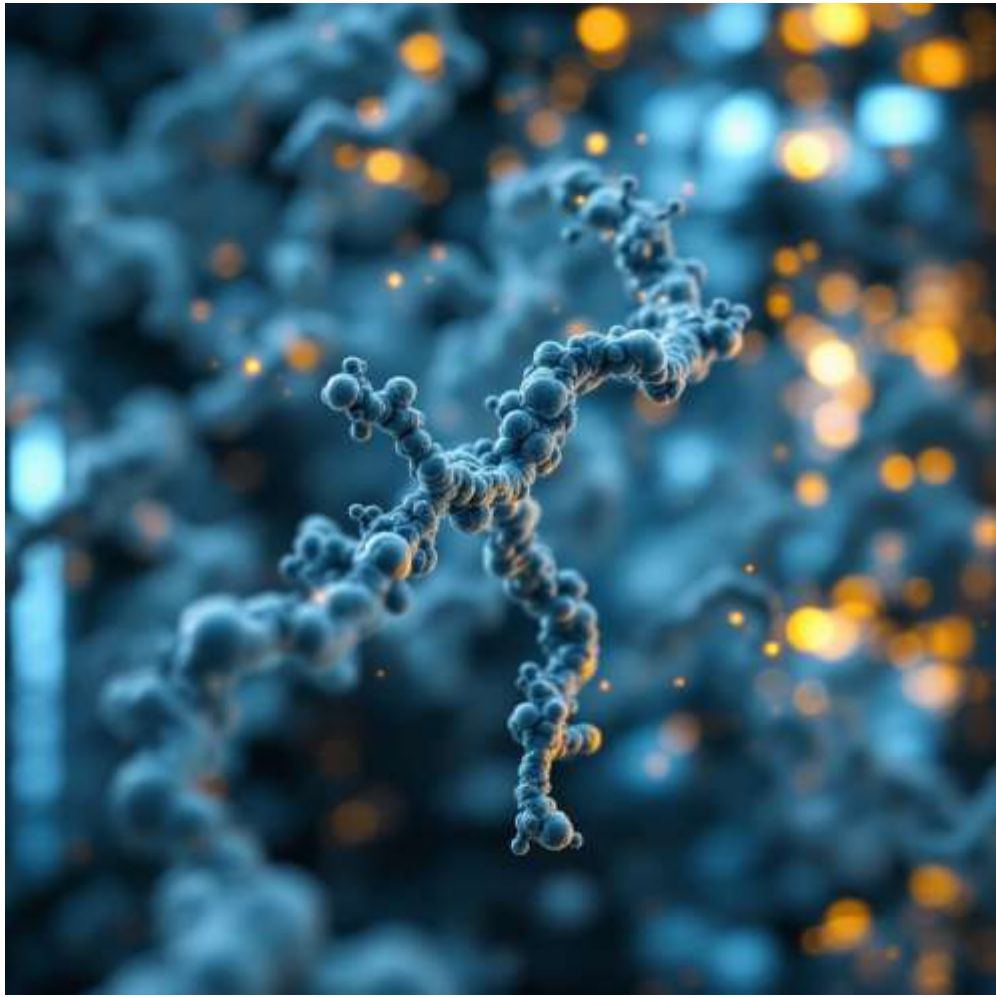
CONFLICTO DE INTERESES

- Advisory Boards: Roche, MSD, Pierre Fabre, Astrazeneca, Janssen
- Sesiones formativas: Takeda, Pfizer, Astrazeneca, BMS, Roche, Merck, Regeneron, Sanofi, Amgen, MSD
- Viajes – Congresos: Roche, MSD, Astrazeneca

Outline

- Biology and spectrum of BRAF mutations
- Clinical phenotype and thromboembolic risk
- Treatment:
    - Targeted therapies
    - Immunotherapy
    - Sequencing



BRAF in the MAPK Pathway

- BRAF is a **serine/threonine kinase** of the RAF family
- Key component of the RAS–RAF–MEK–ERK **(MAPK)** cascade.
- Transduces signals from activated receptor tyrosine kinases
- Regulates **proliferation, differentiation and cell survival**

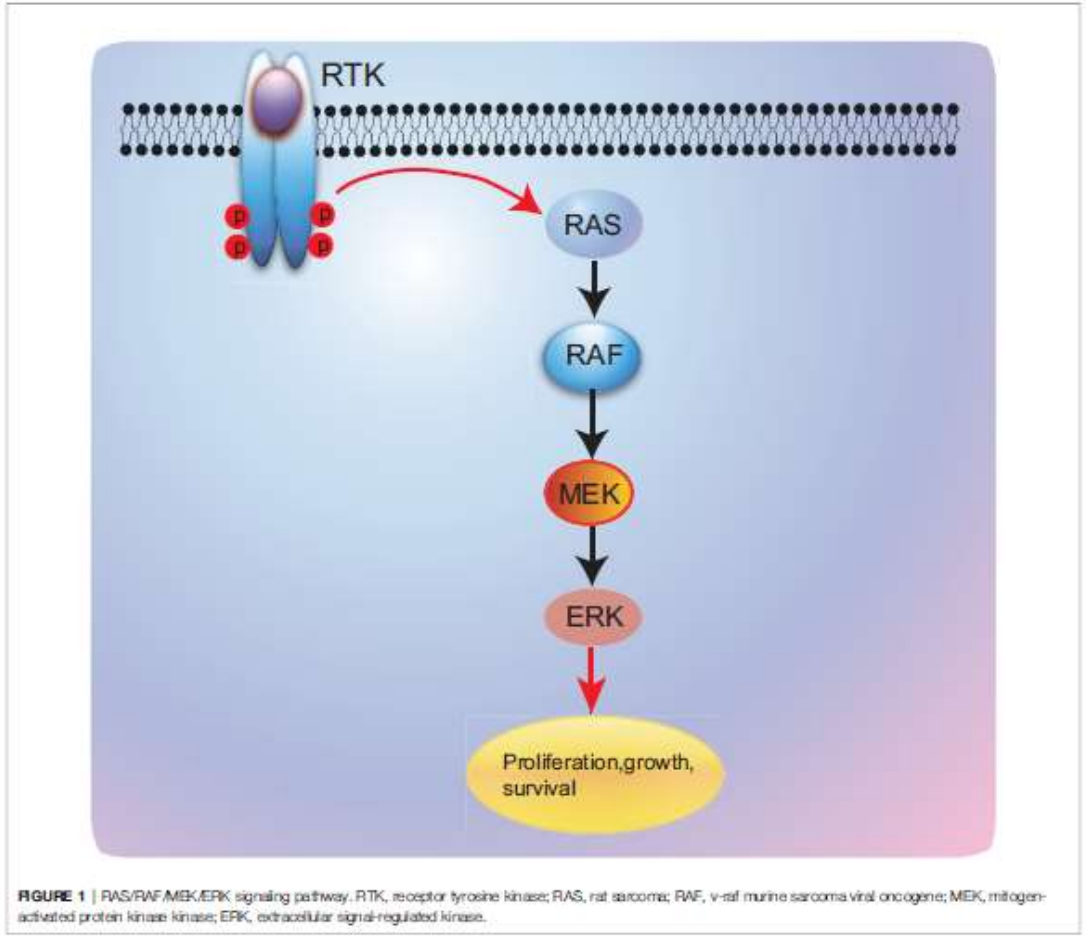


FIGURE 1 | RAS/RAF/MEK/ERK signaling pathway. RTK, receptor tyrosine kinase; RAS, rat sarcoma; RAF, v-raf murine sarcoma viral oncogene; MEK, mitogen-activated protein kinase kinase; ERK, extracellular signal-regulated kinase.

1. Yan N, et al. Front Oncol. 2022;12:863043; 2. Dagogo-Jack I, et al. Clin Cancer Res. 2019;25(1):158-165; 3. Riudavets M, et al. Lung Cancer. 2022;169:102-114; 4. Šutić M, et al. J Pers Med. 2021;11(11):1102.

Classes of BRAF Mutations

- *BRAF* mutations can be classified as Class I, II or III based on the point mutation(s) and effects on the MAPK pathway[1,2]
- Class I mutations include V600E/K/D/R/M/G[3]
- Class II and III encompass non-V600 *BRAF* mutations[1]
- Approximately 50% of *BRAF* mutations involve the V600 point mutation[1,4]

BRAF Mutation Class	Class I	Class II	Class III
Incidence, %[1]	**~50%**	**~50%**	
***BRAF* mutations[3]**	**V600 (including V600E)**	• G496 • G464 • R462I • I463 • E586 • L485 • L597 • A598 • T599 • K601 • A727 • P367	• G466 • S467 • G469 • K483 • N581 • D287 • V459 • F595 • D594 • G596
Effect on the MAPK pathway[1,4]	Promotes constitutive activity of the MAPK pathway, which causes strong activation of the *BRAF* kinase gene	Signals as RAS-independent dimers	Amplifies ERK signalling in the presence of activated upstream RTKs or coalterations that increase the RAS activity
	Micropapilar, mujeres no fumadoras	Mucinoso, hombres fumadores	
	mejor pronóstico (menos Mtx SNC)		

Different classes → different biology and drug sensitivity

BRAF V600E, the only targetable mutation with approved therapies

1. Yan N, et al. Front Oncol. 2022;12:863043; 2. Dagogo-Jack I, et al. Clin Cancer Res. 2019;25(1):158-165; 3. Riudavets M, et al. Lung Cancer. 2022;169:102-114; 4. Šutić M, et al. J Pers Med. 2021;11(11):1102.

Incidence of BRAF mutations in cancer

- **BRAF mutations are present in several tumor types**

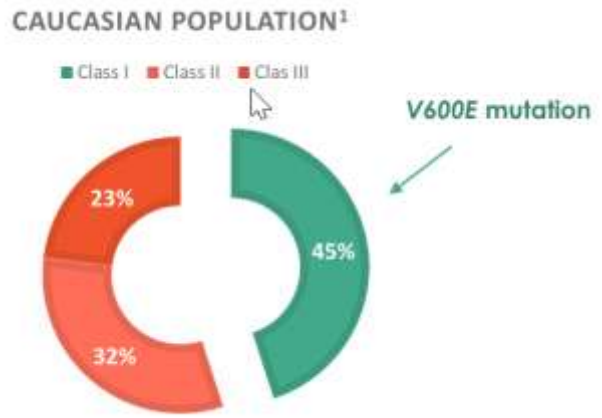
Tumor type	%	Class 1	Class 2	Class 3
Melanoma	39,6%	30,8%	5%	3,1%
NSCLC	**4,1%**	**1,3%**	**1,4%**	**1,3%**
Thyroid Carcinoma	33,3%	32,4%	0,9%	0%
Colorectal Cancer	8,7%	6,9%	0,5%	1,2%

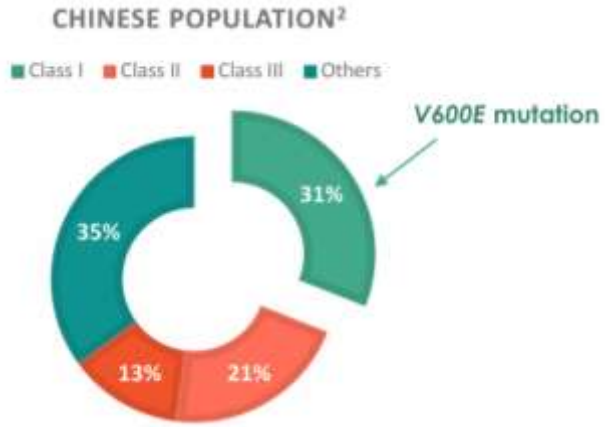
- **Common in melanoma (up to ~40 %)**
- **Relevant subset in colorectal, thyroid and others**
- **Less frequent in NSCLC (~1–5 % of cases)**
- **Despite low prevalence, major therapeutic implications**

Adapted from: Owsley J et al., Prevalence of class I-III BRAF mutations among 114,662 cancer patients in a large genomic database. Exp Biol Med (Maywood). 2021 Jan;246(1):31-39.

Clinical Characteristics of BRAF-Mutant NSCLC

- **BRAF mutations in NSCLC**





BRAF V600 NSCLC

Clinical Features
Never smokers
Females

Pathological Features
IV
Late-stage diagnoses
Micropapillary
Adenocarcinoma

Genetic Features
~4 mutations/Mb
Lower median tumor mutational burden
SETD2
TP53
Frequent co-occurring mutations

Frequency
~1-2% of all NSCLCs

BRAF non-V600 NSCLC

Clinical Features
Previous/current smokers
Males

Pathological Features
I → III
Diagnosed at early stages
Adenocarcinoma

Frequency
~2-3% of all NSCLCs

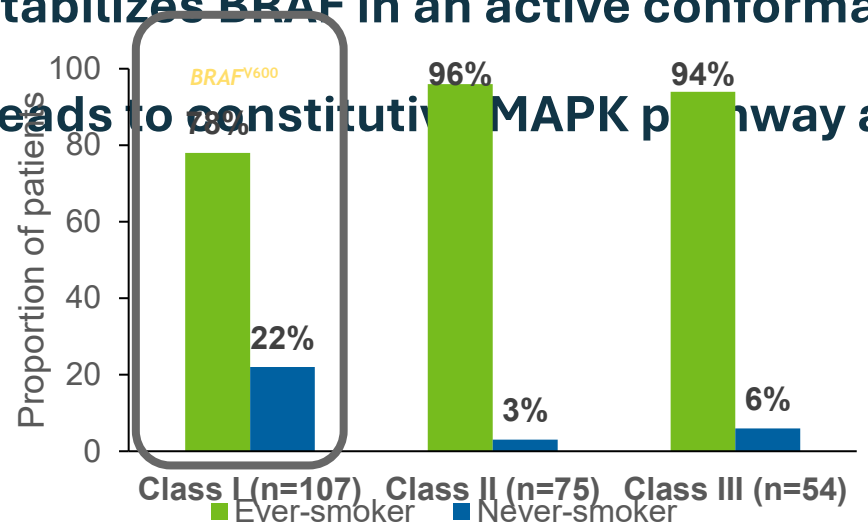
Genetic Features
~9 mutations/Mb
Higher median tumor mutational burden
STK11
KRAS
KEAP1
Frequent co-occurring mutations

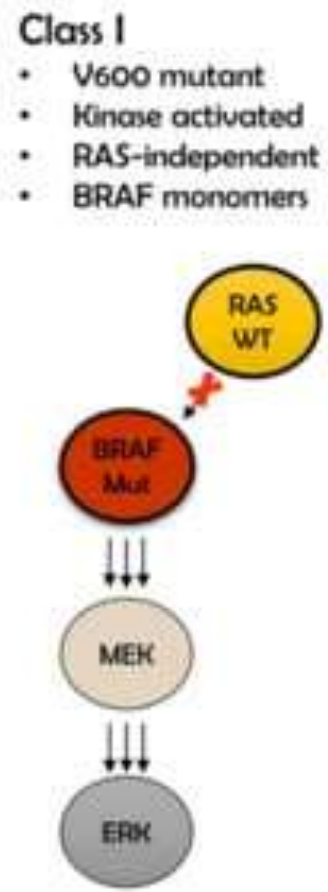
All BRAF mutant
Poor prognostic impact compared to BRAF WT NSCLC

1. Ibiayi D et al. Clin Cancer Res; 25(1) January 1, 2019. 2. Lin Q et al. J transl Med 2019;30;17(1):298. 3Dankner M, Maxwell J, Rose AAN. The evolving treatment landscape for BRAF-mutated non-small cell lung cancer. Transl Lung Cancer Res. 2024;13(4):930-935. doi:10.21037/tlcr-24-117.

V600E: A “Small Change” With Big Consequences

- Valine → glutamic acid substitution at codon 600
- Mimics phosphorylation of the activation segment
- Stabilizes BRAF in an active conformation
- Leads to constitutive MAPK pathway activation





1. Yan N, et al. Front Oncol. 2022;12:863043; 2. Dagogo-Jack I, et al. Clin Cancer Res. 2019;25(1):158-165; 3. Riudavets M, et al. Lung Cancer. 2022;169:102-114; 4. Šutić M, et al. J Pers Med. 2021;11(11):1102. 5. Dagogo-Jack I, et al. Clin Cancer Res. 2019;25(1):158-165

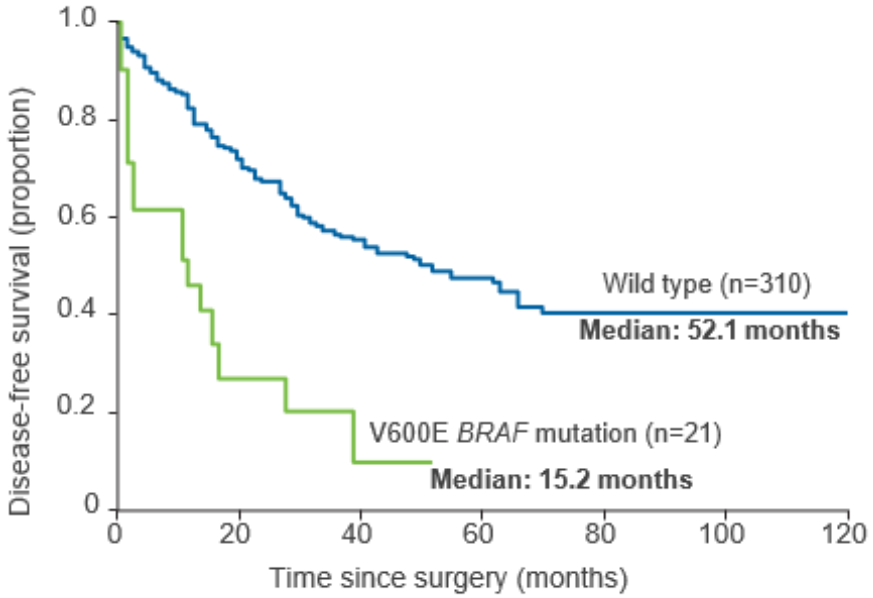
Clinical Impact of BRAF V600E in NSCLC

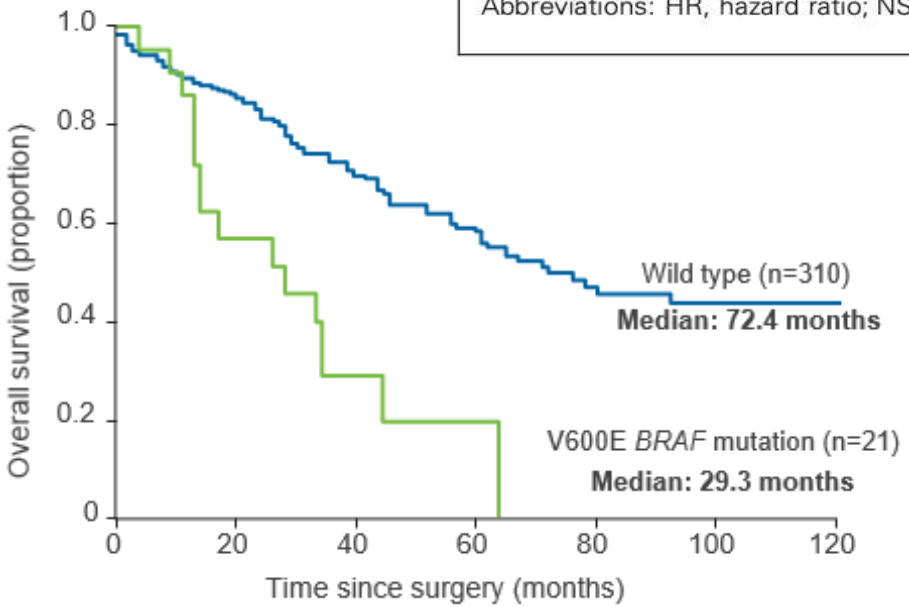
- n=331 adenocarcinoma patients
- Bad prognostic, more common in women and never smokers, and Advanced stages

Table 4. Association Between V600E *BRAF* Mutations and Independent Covariates Computed by Multivariate Logistic Regression Analysis

		Logistic Regression Analysis		
Variable	Category	HR	95% CI	*P*
Sex	Female/male	11.29	3.65 to 34.87	< .001
Smoking	Never smoker/smoker	1.19	0.45 to 3.21	.7; NS
Stage	III + IV/I + II	2.25	0.92 to 5.51	.08; NS

Abbreviations: HR, hazard ratio; NS, not significant.





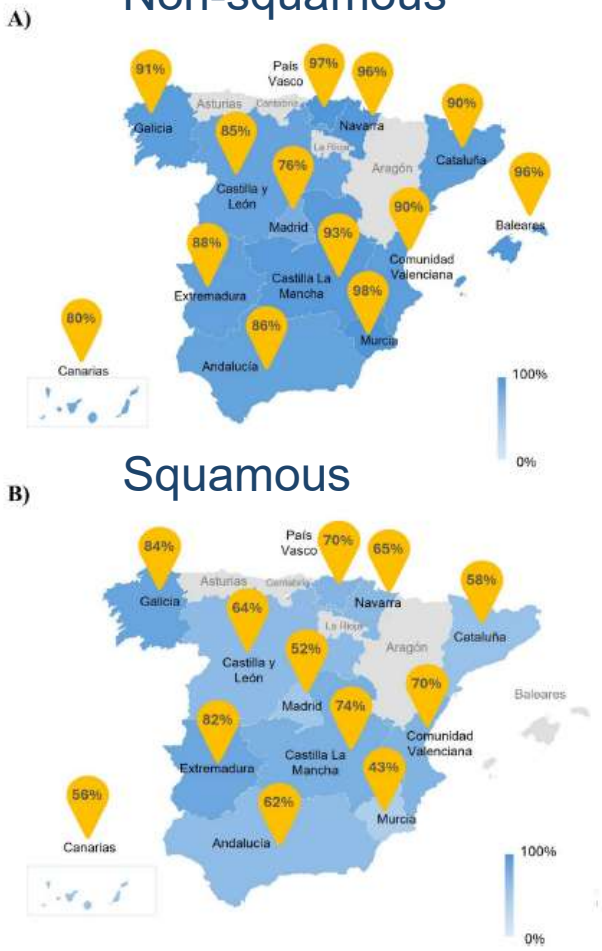
1. Marchetti A, et al. J Clin Oncol. 2011;29(26):3574-3579.

Diagnostic of BRAF in Spain

- **Information from RRTT of GECP: n= 13,583 patients with stage IV NSCLC**
  - BRAF was tested in 2,726 of 13,583 patients (20.1%)
  - Non-squamous NSCLC: BRAF was tested in 23.0% of patients

    Squamous NSCLC: BRAF was tested in only 8.2% of patients.
  - 4.5% of tested patients had a detectable BRAF alteration
    - (Non-squamous: 4.9% / Squamous: 0.5%)
  - BRAF tested according to institution

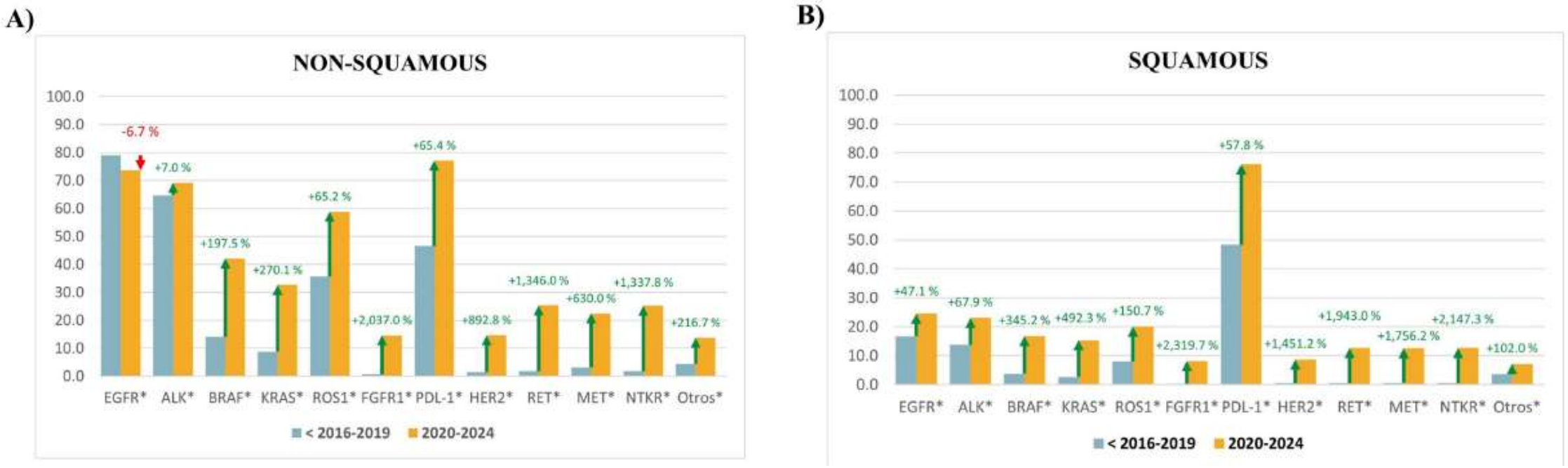
>600 beds	600-300 beds	<300 beds
24.5%	13.7%	15%



1. Provencio M, et al. Biomarker landscape in advanced NSCLC: insights from a national prospective registry. Lung Cancer. 2025 Sep;207:108680. doi: 10.1016/j.lungcan.2025.108680.

Diagnostic of BRAF in Spain

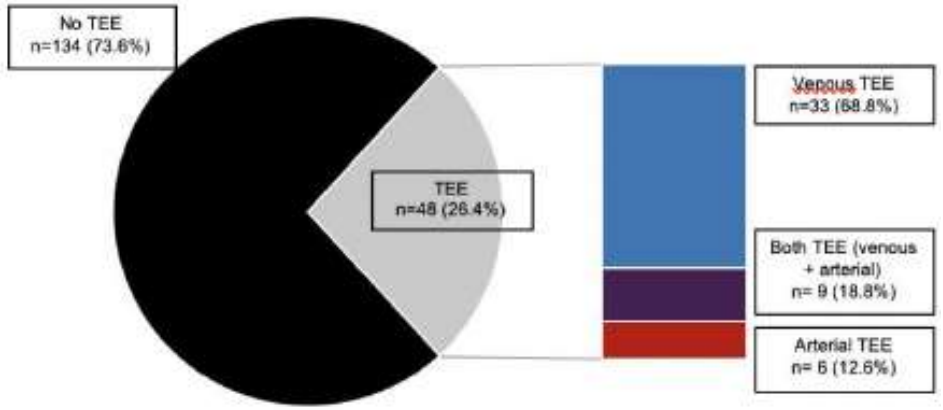
- **Information from RRTT of GECP: n= 13,583 patients with stage IV NSCLC**
  - Increase in time: currently around 40% in Non-squamous and 15% in squamous histology

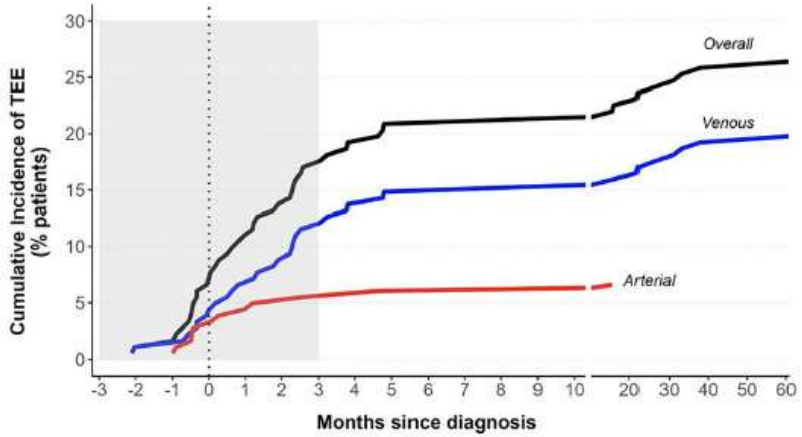


1. Provencio M, et al. Biomarker landscape in advanced NSCLC: insights from a national prospective registry. Lung Cancer. 2025 Sep;207:108680. doi: 10.1016/j.lungcan.2025.108680.

Study of Thromboembolic Risk in BRAF mutated patients

- **Multicenter retrospective study in Spain (2008-2021)**
- **N=182 patients with BRAF mutations (70 with V600E)**
- **Objective: characterize incidence, timing and impact of Tl**
- **Incidence 26.4 % (95 % CI 19.9–32.9)**
- **Venous TEE (82%), Arterial TEE (18%)**
- **Median time to TEE: 2 months (range −0.2–4.8) -> 69 % of TEE occurred in the peridiagnostic window (±90 days of diagnosi**
- **Classical risk factors and Khorana score did not identify hig risk patients**





Thrombosis appears as a distinct clinical hallmark of BRAF-mutant NSCLC

1. Aparicio I, Iranzo P, Reyes R, Bote H, Saigi M, Bringas M, Bosch-Barrera J, …., Calles A. Brief report: High incidence of peridiagnosis thromboembolic events in patients with BRAF-mutant lung cancer. Thromb Res. 2023 Dec;232:133-137.

Timeline of treatment of NSCLC BRAF V600E

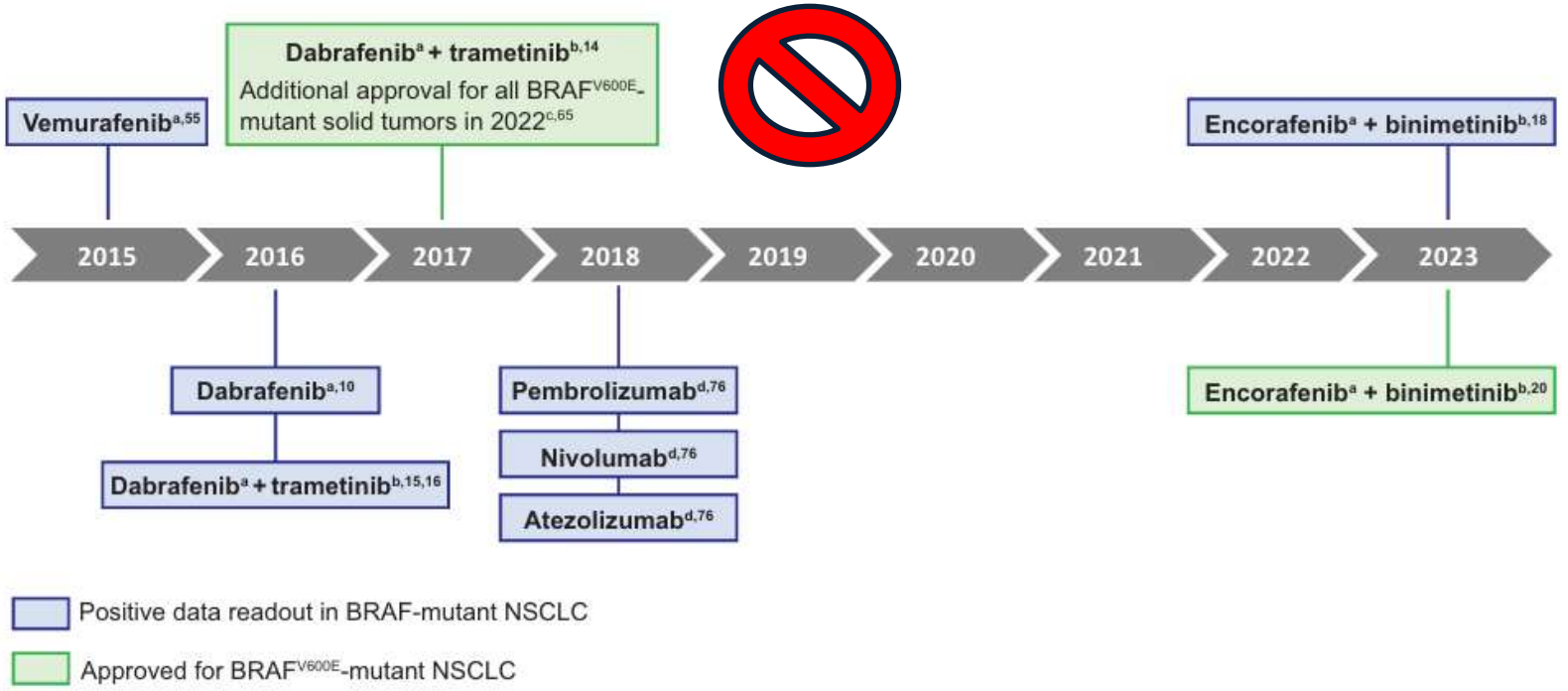


Fig. 2 | Timeline of key advancements in the treatment of BRAF^{V600E}-mutant NSCLC. Positive data readouts for BRAF-mutant NSCLC (blue) and approved treatments for BRAF^{V600E}-mutant NSCLC (green) are shown. [a]BRAF inhibitors. [b]MEK inhibitors. [c]In 2022, dabrafenib plus trametinib was approved for patients with unresectable metastatic BRAF^{V600E}-mutant solid tumors who progressed on previous treatments and have no acceptable alternative option. [d]Immunotherapy that targets PD-1. [e]Immunotherapy that targets PD-L1.

Approved in Spain Aug/2025

1 Planchard D. et al. NPJ Precision Oncology| (2024) 8:90

Treatment with IO of BRAF V600E NSCLC

- **No data from pivotal trials of IO / IO-CT for BRAF mutated patients (if included):**

  A) IO-CT non selected molecular patients:

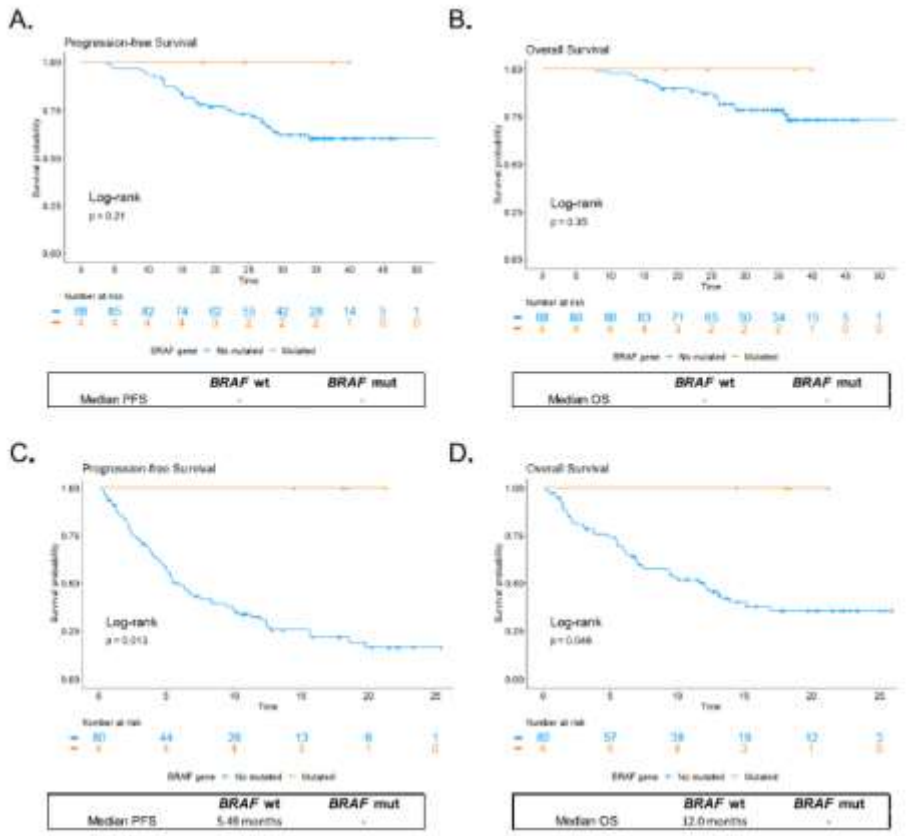
  PFS: 7-8.8 months / OS: 15.6-22.2 months

  B) IO (PD-L1 high):

  PFS: 8.1-10.3 months / OS: 20.2-30 months

- **Are BRAF mutated patients more sensitive to IO?**

Results from NADIM trials (neoadjuvant CT-IO, n=4 (3.5%)) and retrospective analysis (n=4 (4.76%)) shows better results but small number of BRAFm patients



1. Provencio M, Robado de Lope L, Serna-Blasco R, Nadal E, et al. BRAF mutational status is associated with survival outcomes in locally advanced resectable and metastatic NSCLC. Lung Cancer. 2024 Aug;194:107865.

Treatment of BRAF V600E NSCLC

Objective: OCTOPUS (NCT05546905) is an ongoing study which aims to address knowledge gaps in the real-world management of *BRAF*^{V600E}-mutant metastatic NSCLC (mNSCLC) in Europe by analysing clinical characteristics, treatment patterns, and outcomes

Study design: OCTOPUS is a multicentre, observational, descriptive, ambispective study in patients aged ≥18 years with *BRAF*^{V600E}-mutant mNSCLC

Study site locations: France, Germany, Italy, Spain, and the United Kingdom

PLANNED SAMPLE SIZE*

180 patients: 30 prospective and 150 retrospective

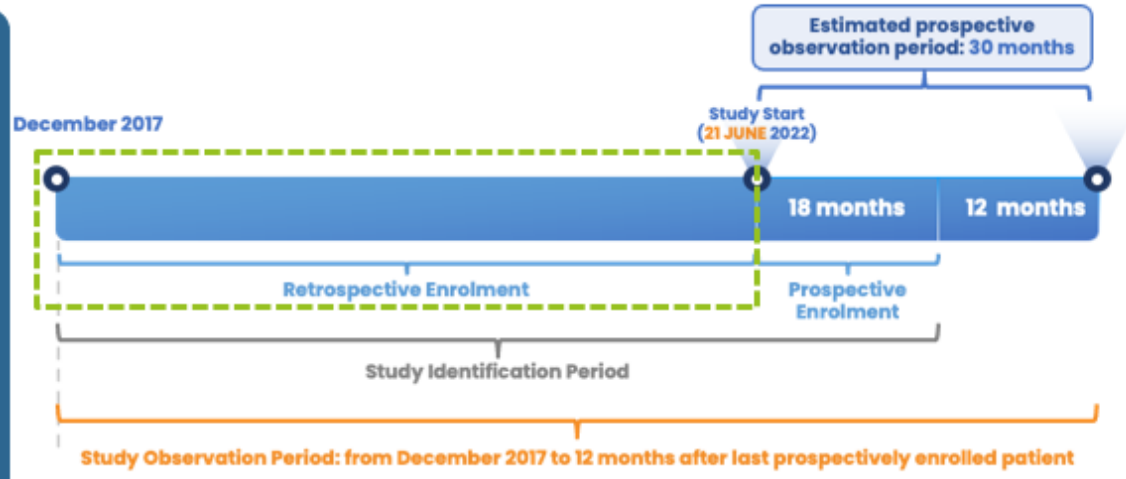
Inclusion criteria:

- Confirmed stage IV mNSCLC and *BRAF*^{V600E}-mutant (via tumour/liquid biopsy or metastasectomy before study inclusion)
- 1st systemic LoT initiated after 1 December 2017, and either before (retrospective cohort) or after (prospective cohort) study entry

Exclusion criteria:

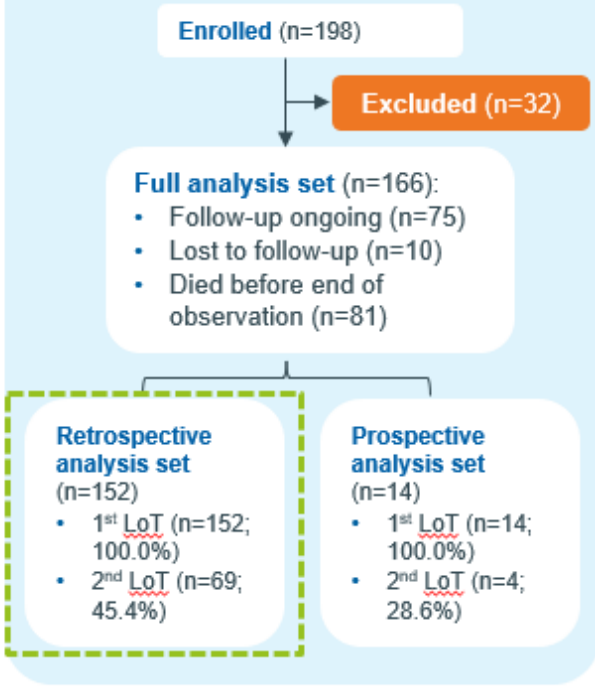
- Concurrent/previous malignancy within 2 years†
- Previous, ongoing, or planned clinical trial participation for mNSCLC interventional drug

OCTOPUS STUDY DESIGN



This interim analysis (data cut-off 4 April 2024) describes data for the retrospective cohort only

PATIENT DISPOSITION



*The sample size was determined based on the precision with which the 95% CI of the primary outcome could be estimated (<6%). †Except for curatively treated basal or squamous cell skin cancer, prostate intraepithelial neoplasm, cervical carcinoma *in situ*, Bowen's disease or Gleason ≤6 prostate cancer.

BRAF, B-Raf proto-oncogene serine/threonine-protein kinase; CI, confidence interval; LoT, line of therapy; mNSCLC, metastatic non-small cell lung cancer.

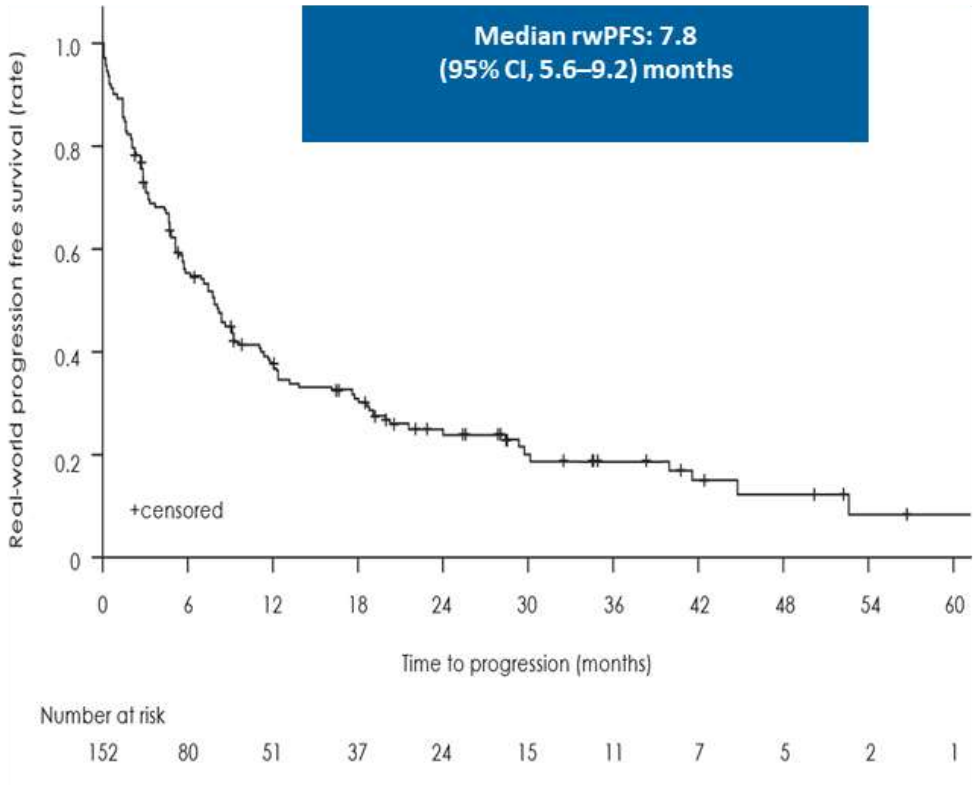
1. Planchard D, et al. Presented at ELCC; 2025. Poster [86P].

Treatment of BRAF V600E NSCLC

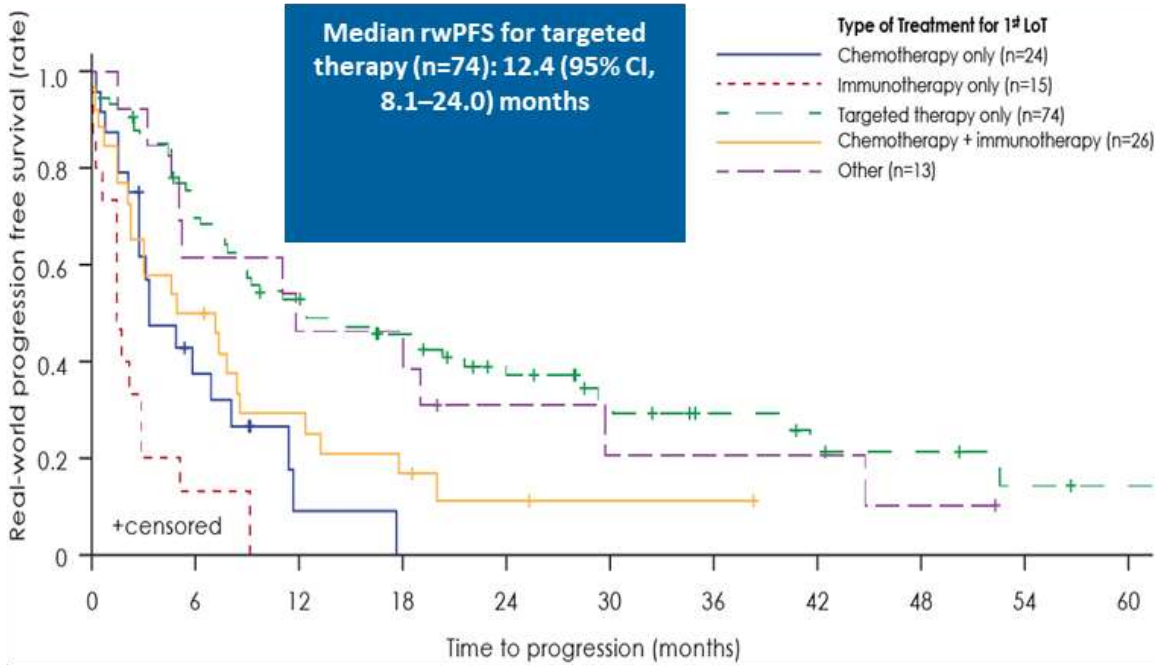
OCTOPUS: outcomes 1st line (interim analysis, data cut-off 4 April 2024)

First line Targeted therapy seems better, than CT, CT-IO or IO (n=152 patients)

rwPFS* in 1st LoT (n=152)



rwPFS* in 1st LoT by treatment type (n=152)

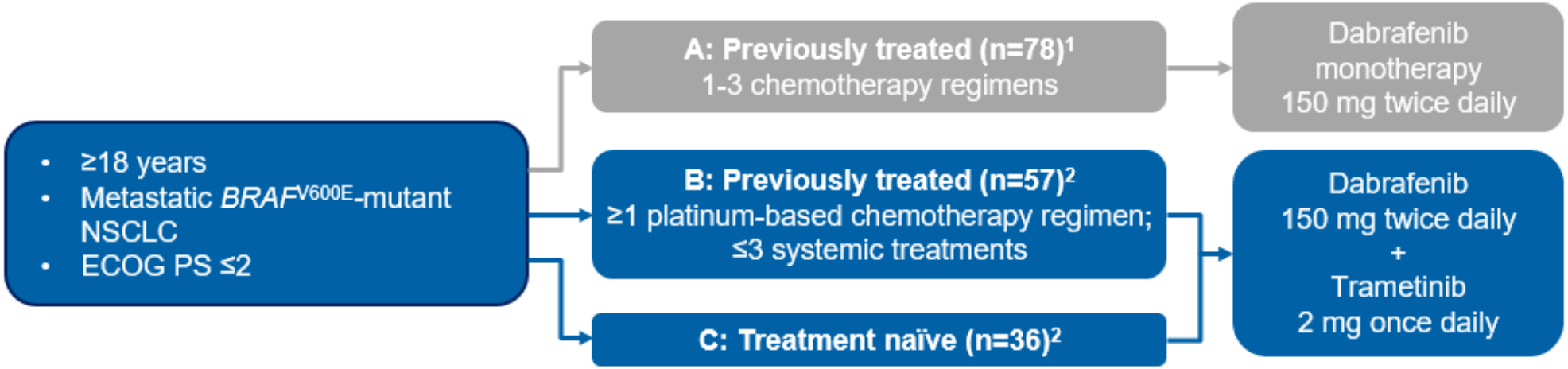


1. Planchard D, et al. Presented at ELCC; 2025. Poster [86P].

Targeted therapy for NSCLC BRAF V600E

BRF113928: Dabrafenib + Trametinib

- **Phase 2 multicentric trial. 3 arms: Monotherapy, combo previously treated, combo naive.**
- **Small number of patients**



Endpoints

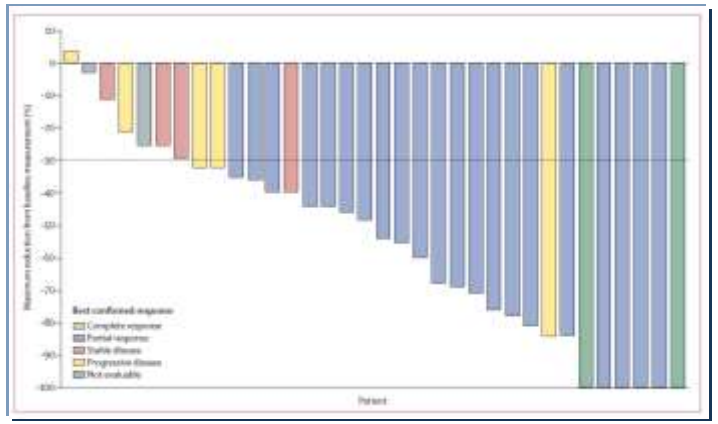
- Primary: ORR (investigator assessed)
- Secondary: PFS and DOR (investigator assessed), OS, safety, tolerability and pharmacokinetics

1. Planchard D, et al. *Lancet Oncol*. 2016;17(5):642-650; 2. Planchard D, et al. *J Thorac Oncol.* 2022;17(1):103-115.

Targeted therapy for NSCLC BRAF V600E

BRF113928: Dabrafenib + Trametinib

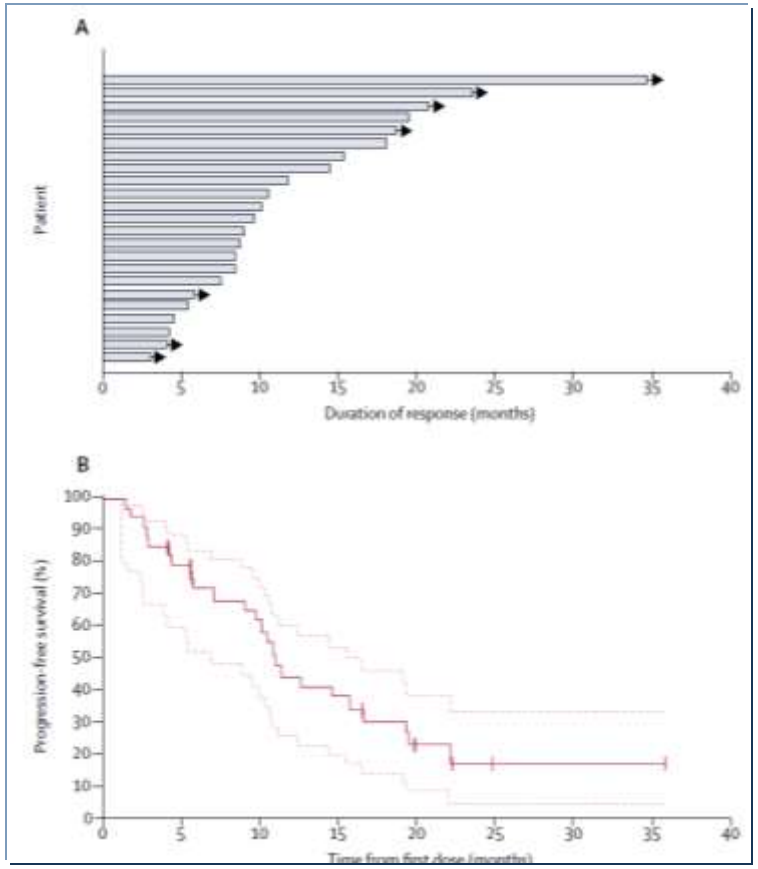
Investigator-assessed best response	Previously treated (n=57)	Treatment naïve (n=36)
ORR (CR + PR), % (95% CI)	**68.4** (54.8-80.1)	**63.9** (46.2-79.2)
CR, n (%)	**3** (5)	**2** (6)
DCR (CR + PR + SD), % (95% CI)	**80.7** (68.1-90.0)	**75.0** (57.8-87.9)
Median PFS, months (95% CI)	**10.2** (6.9-16.7)	**10.8** (7.0-14.5)
Median OS, months (95% CI)	**18.2** (14.3-28.6)	**17.3** (12.3-40.2)
Median DOR, months (95% CI)	**9.8** (6.9-18.3)	**10.2** (8.3-15.2)



June/2017

Aug/2017

Oct/2018



1. Planchard D, et al. *Lancet Oncol*. 2016;17(5):642-650; 2. Planchard D, et al. *J Thorac Oncol*. 2022;17(1):103-115.

Targeted therapy for NSCLC BRAF V600E

PHAROS: Encorafinib-binimetinib

- **Phase 2 multicentric trial. 2 arms: previously treated or naive.**

Objective: To determine the safety, tolerability and efficacy of encorafenib given in combination with binimetinib in patients with *BRAF*^{V600E}-mutant metastatic NSCLC who are either treatment naïve or who have been previously treated with platinum-based chemotherapy and/or anti-PD-1/PD-L1 inhibitor therapy*

Key eligibility criteria

- Metastatic *BRAF*^{V600E}-mutant NSCLC
- ECOG performance status 0 or 1
- No *EGFR* mutation, *ALK* fusion or *ROS1* rearrangement
- No more than 1 prior line of treatment in the advanced setting
- No prior treatment with BRAF or MEK inhibitor
- No symptomatic brain metastases

***BRAF* mutation testing**

- Determined locally by PCR- or NGS-based assay; sent to central laboratory†
- Pleural fluid, fresh and archived tissue, and fine needle aspiration were acceptable[2]

Patients enrolled

- Treatment naïve n=59
- Previously treated n=39

Encorafenib: 450 mg QD
Binimetinib: 45 mg BID
28-day cycles
Treat until progression or unacceptable toxicity

Primary endpoint

- ORR‡ by IRR

Secondary endpoints

- ORR by investigator
- DOR, DCR, PFS and TTR (all by IRR and investigator)
- OS
- Safety

Exploratory endpoints

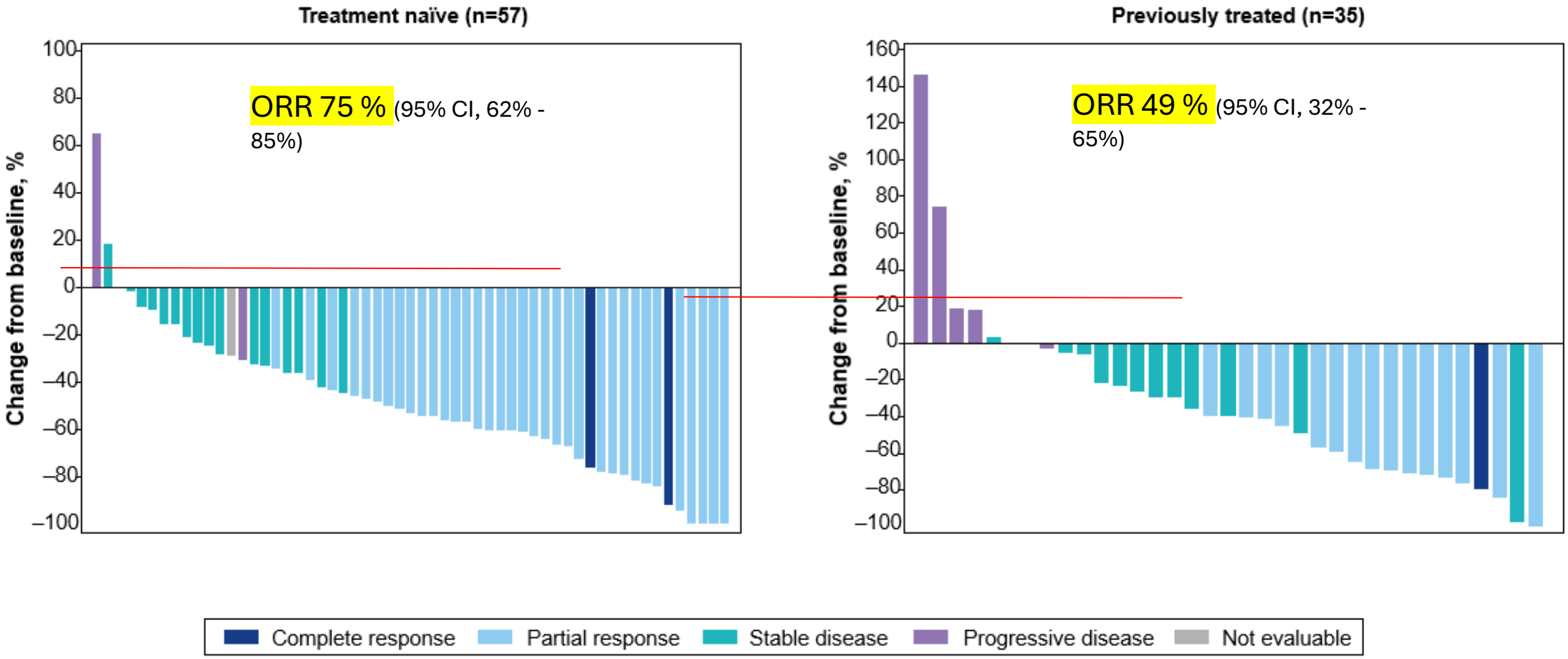
- Biomarker and pharmacokinetic analyses

*PHAROS also allowed for the enrollment of patients with less common BRAFV600 mutations other than V600E in a third arm, but no patients were recruited into this arm so are not shown above. †*BRAF*^{V600} mutations were retrospectively confirmed by FoundationOne CDx (Foundation Medicine, Cambridge, MA). ‡According to RECIST 1.1.

1 1. Riely GJ, et al. *J Clin Oncol*. 2023;41(21):3700-3711; 2. Riely GJ, et al. *J Clin Oncol*. 2023;41(21, Suppl. Study Protocol):S1-S121

Targeted therapy for NSCLC BRAF V600E

PHAROS: Encorafinib-binimetinib



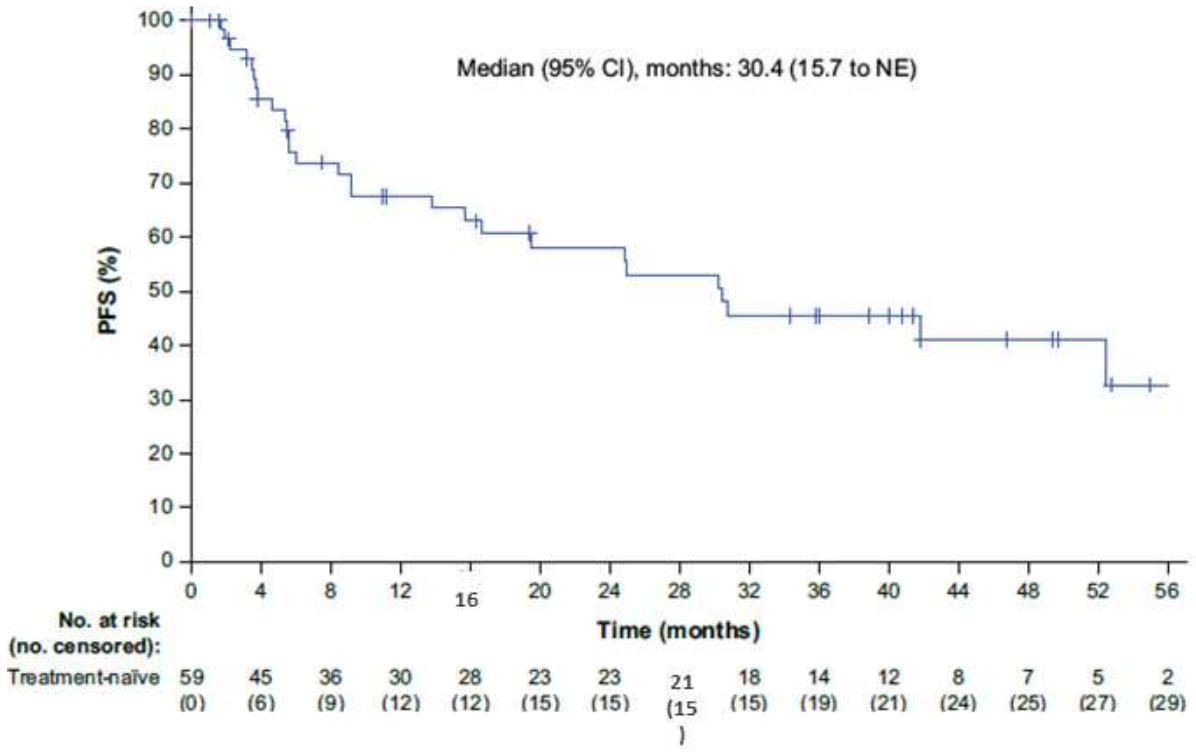
1 1. Riely GJ, et al. *J Clin Oncol*. 2023;41(21):3700-3711; 2. Riely GJ, et al. *J Clin Oncol*. 2023;41(21, Suppl. Study Protocol):S1-S121

Targeted therapy for NSCLC BRAF V600E

PHAROS: Encorafinib-binimetinib

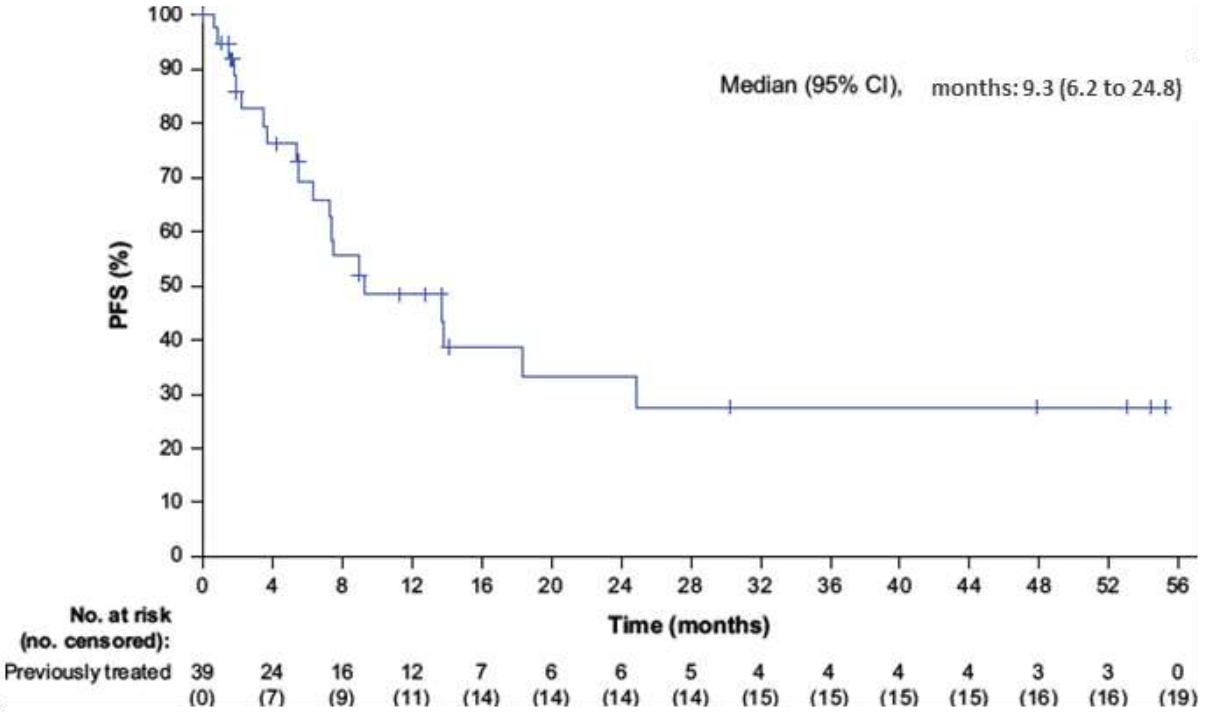
Treatment Naïve

PFS= 30.4 m



Previously treated

PFS= 9.3 m



1 Johnson ML et al. J Clin Oncol. 2025. DOI:10.1200/JCO-25-02023

Targeted therapy for NSCLC BRAF V600E

PHAROS: Encorafinib-binimetinib

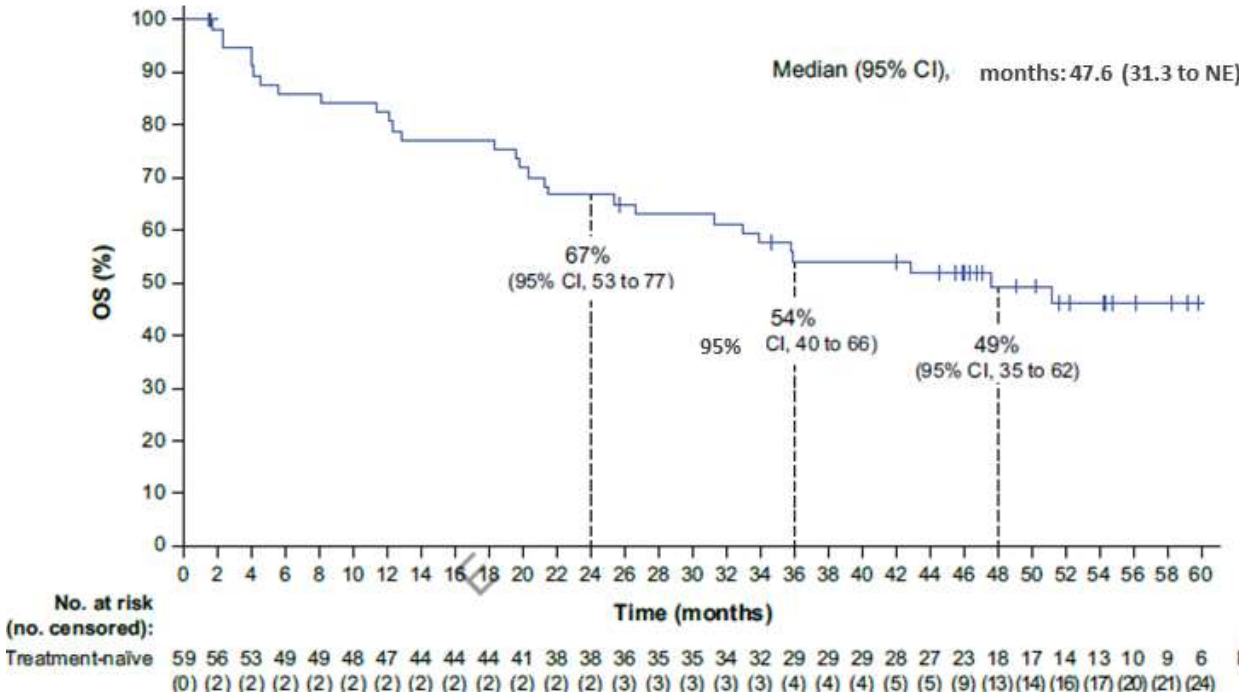
Oct/2023

Aug/2024

Jul/2025

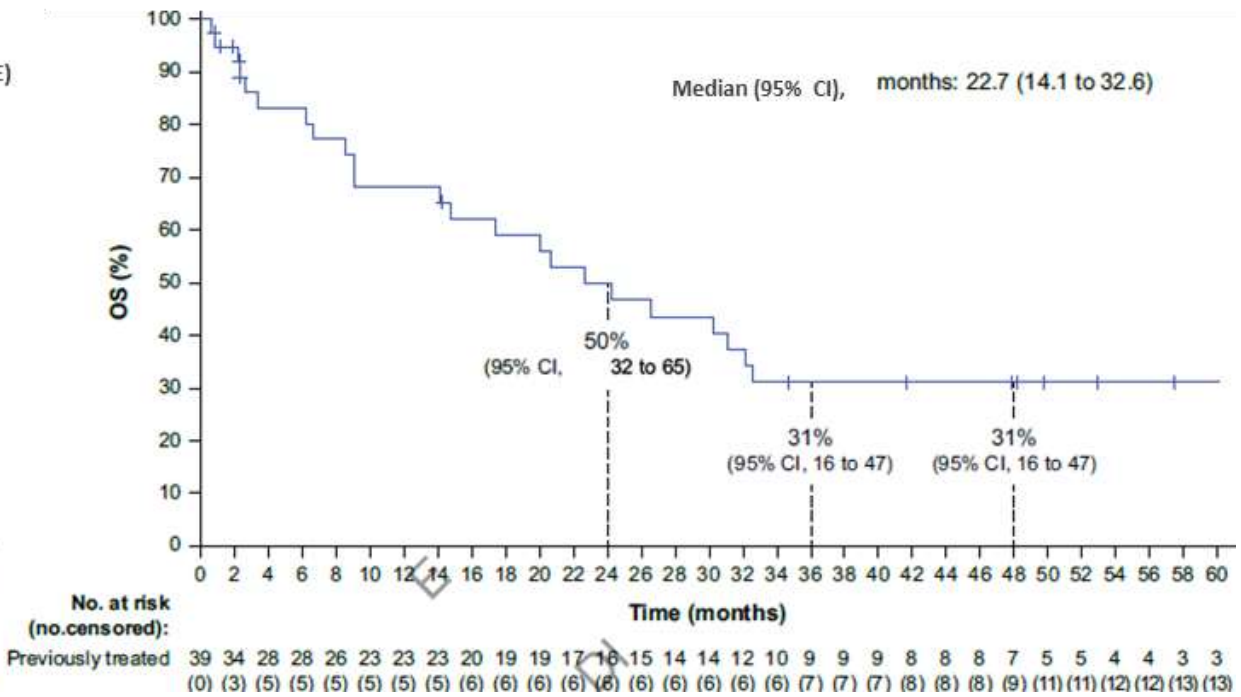
OS= 47.6 m

Treatment Naïve



OS= 22.7 m

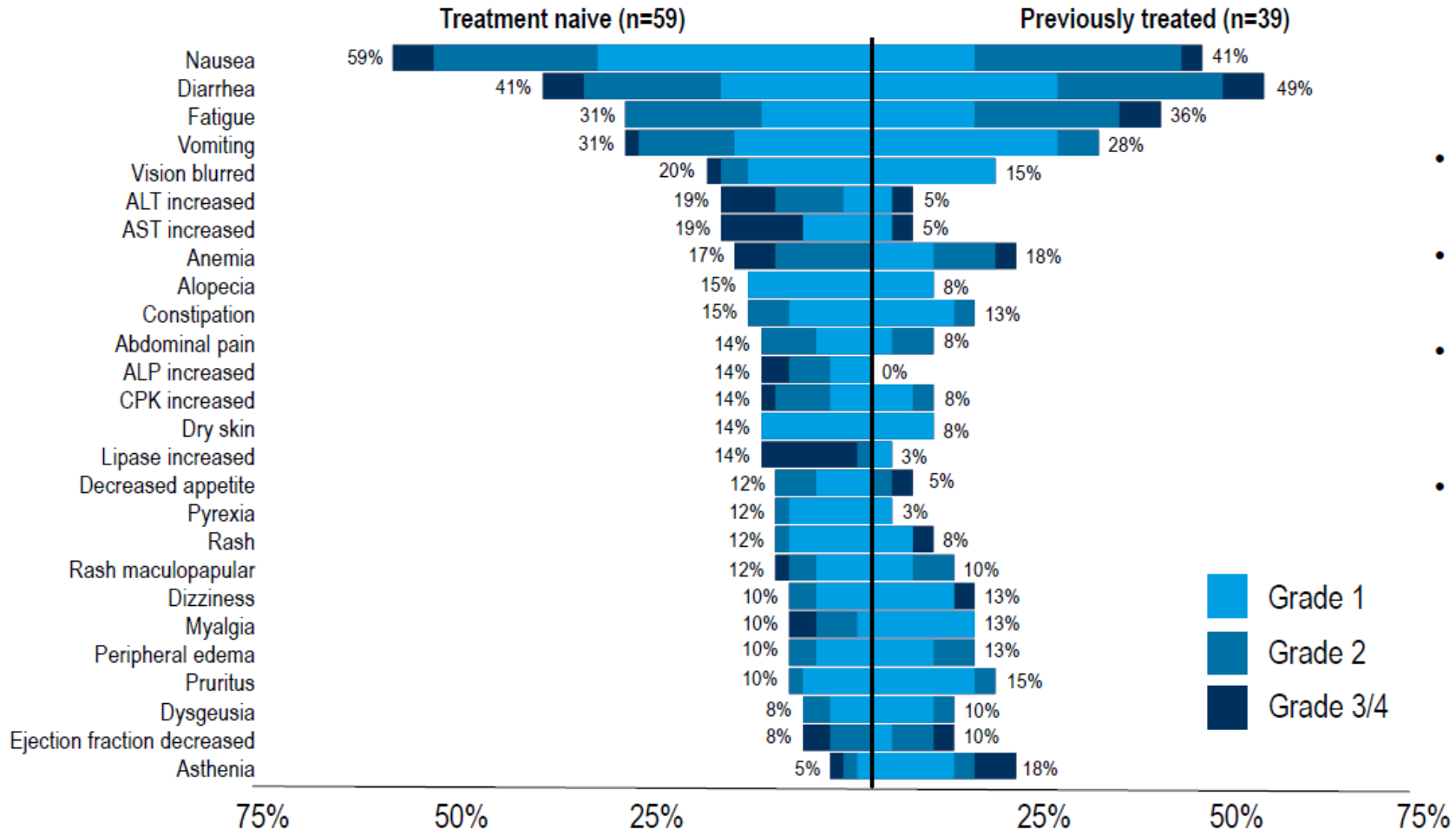
Previously treated



1 Johnson ML et al. J Clin Oncol. 2025. DOI:10.1200/JCO-25-02023

Targeted therapy for NSCLC BRAF V600E

PHAROS: Encorafinib-binimetinib



AE, adverse event; ALP, alkaline phosphatase; ALT, alanine aminotransferase; AST, aspartate aminotransferase; CPK, creatine phosphokinase.
1. Riely GJ, et al. *J Clin Oncol*. 2023;41(21):3700-3711. 2. Riely GJ, et al. *J Thorac Oncol*. Published online June 4, 2025.

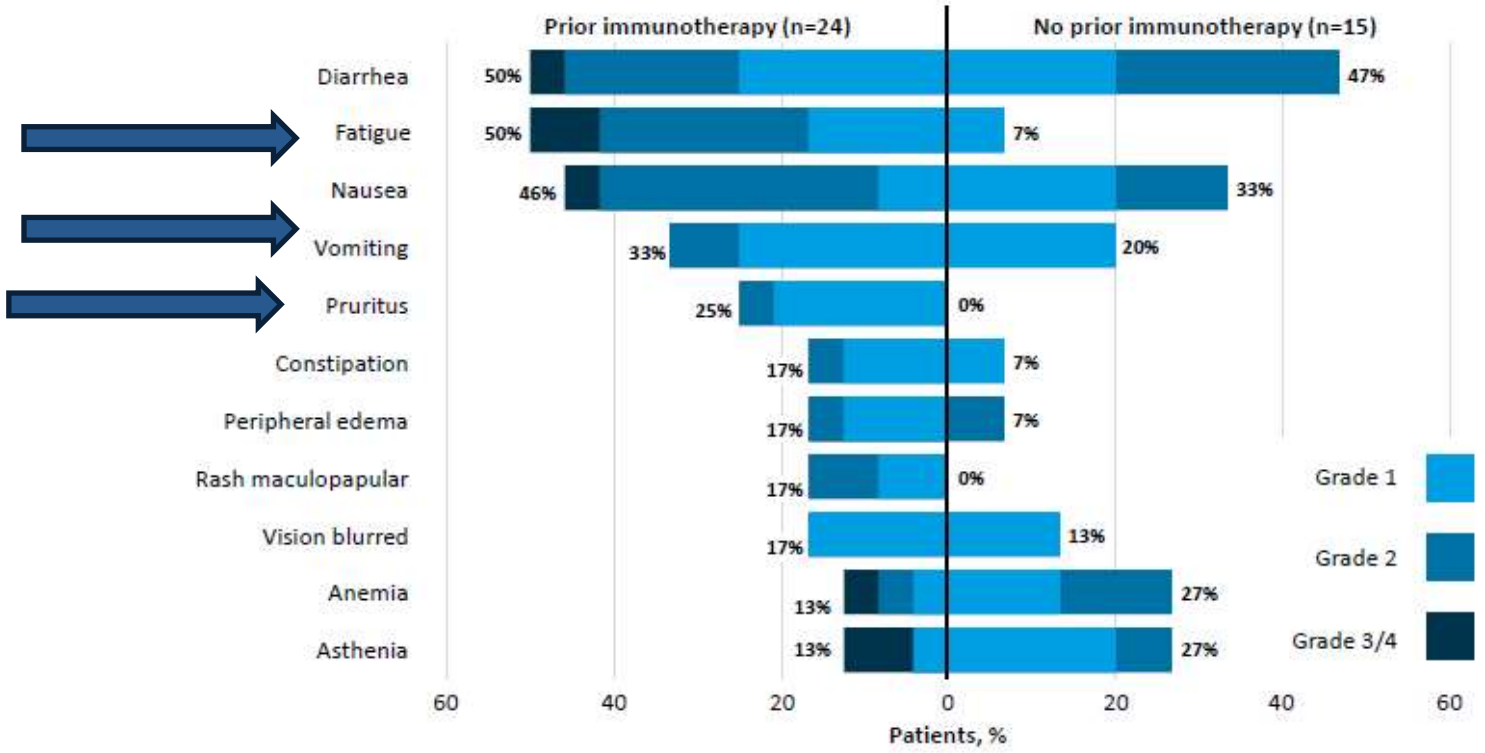
- Safety profile was consistent with prior analyses[1,2]
- No new safety signals were observed with longer follow-up
- Treatment-related AE profiles were comparable across both treatment lines
- Similar to the prior analysis,[2] any-grade treatment-related pyrexia occurred in 8% of patients; all were grade 1/2 in severity

1 Johnson ML et al. J Clin Oncol. 2025. DOI:10.1200/JCO-25-02023

Targeted therapy for NSCLC BRAF V600E

PHAROS: Encorafinib-binimetinib

TRAEs (≥15%) in previously treated patients with or without prior immunotherapy: current analysis



TRAE, treatment-related adverse event.

Targeted therapy for NSCLC BRAF V600E

Encorafinib-binimetinib: IFCT 1904 ENCO-BRAF

ENCO-BRAF Study Design

single-arm, open-label, multicenter phase II trial

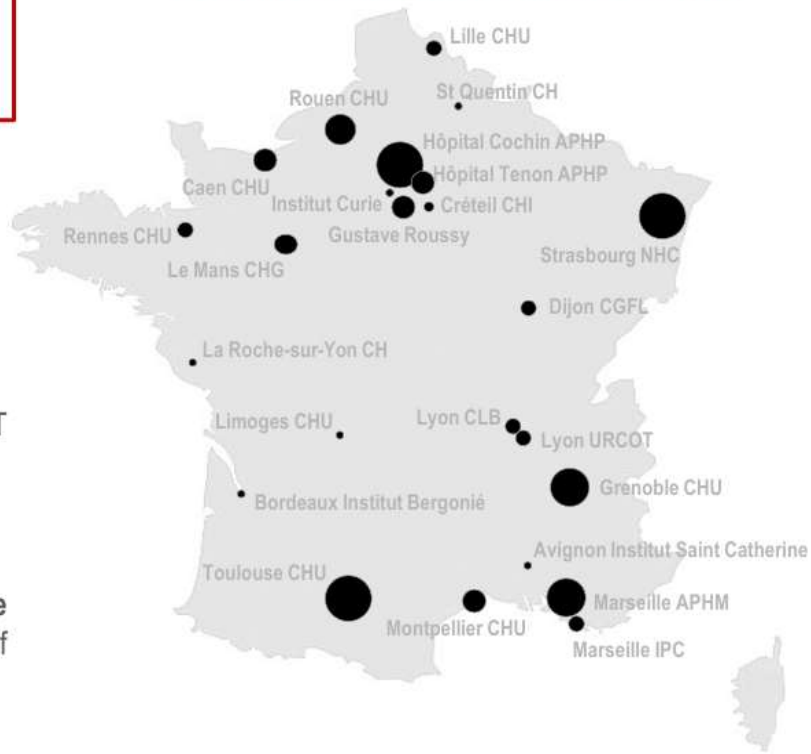
Patients with BRAF-V600E-mutant metastatic NSCLC

Key inclusion criteria
- ≥ 18 years
- WHO performance status 0-1
- BRAF V600E mutation (enrolment by local assay)
- No prior anti-BRAF cancer therapy
- Stable CNS metastases allowed
- 1st or 2nd line

COHORT A 1st line → **Binimetinib: 45mg bid Encorafenib: 450 mg QD** 28-Day cycles
N = 60

COHORT B 2nd line → **Binimetinib: 45mg bid Encorafenib: 450 mg QD** 28-Day cycles
N = 59

24 French sites
(enrolment : March 2021 to September 2023)



Cohort A: 1st line Encorafenib plus Binimetinib

The primary endpoint: confirmed ORR according to the investigator evaluation RECIST (v1.1) every 8 weeks (for 12months then every 12 weeks)

Secondary endpoints include PFS, DOR, DCR, OS and safety.

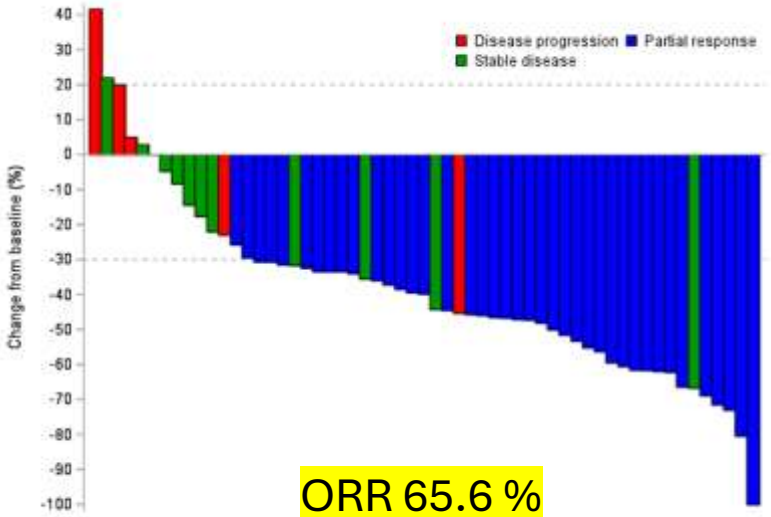
Study was designed to test the null hypothesis (H0) of **≤40% ORR in treatment-naïve patients** and an alternative target rate of at least **60% (H1)** with a one-sided α error of 0.05. 60 patients to be included

Data cut-off: MARCH 28, 2024 and Cohort B is still being recruited.

Annals of Oncology (2024) 35 (suppl_2): S802-S877. 10.1016/annonc/annonc1602

Targeted therapy for NSCLC BRAF V600E

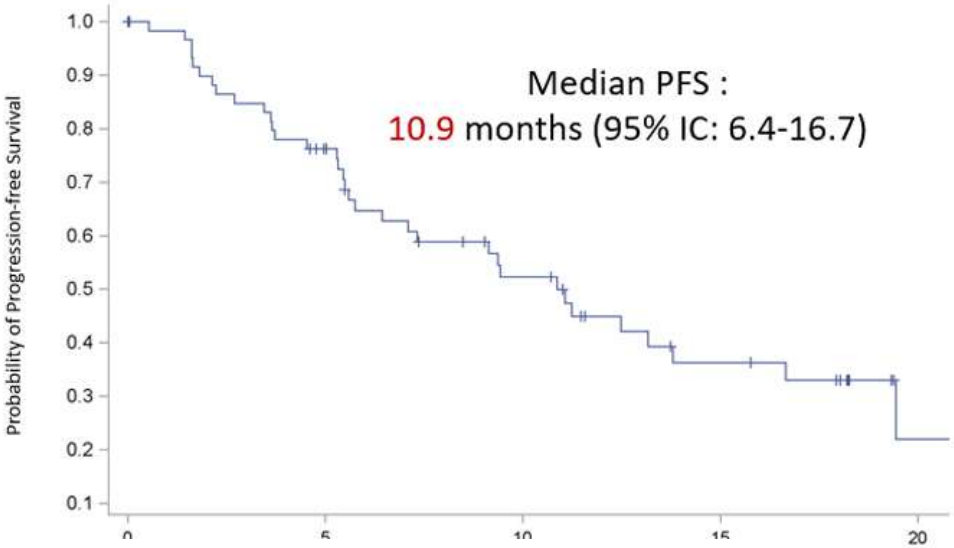
Encorafinib-binimetinib: IFCT 1904 ENCO-BRAF

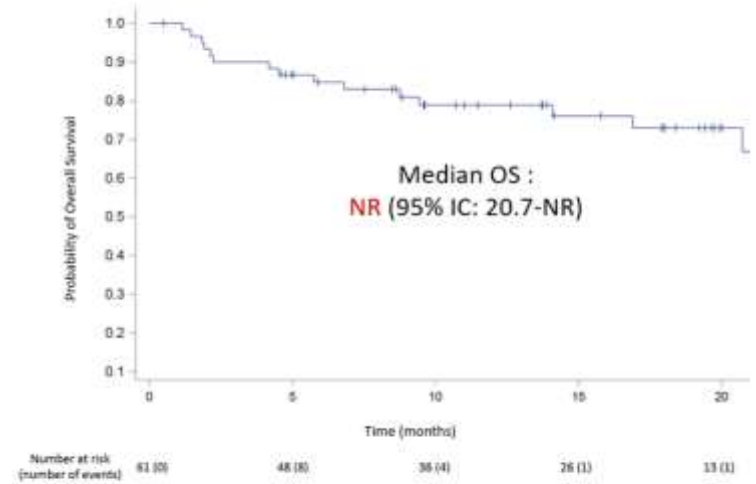


ORR 65.6 %

	Cohorte A (n=61)
Overall response confirmed, n (%) [95% CI]	**40 (65.6%) [53.7% - 77.5%]**
Partial response, n (%)	40 (65.6%)
Stable disease, n (%)	12 (19.7%)
Progressive disease, n (%)	5 (8.2%)
Not evaluable*, n (%)	4 (6.6%)
DOR, median [95% CI], months	**13 months [9.1-NR]**
DCR , % [95% CI]	**85.2% [76.3% - 94.1%]**

*4 patients were not evaluable



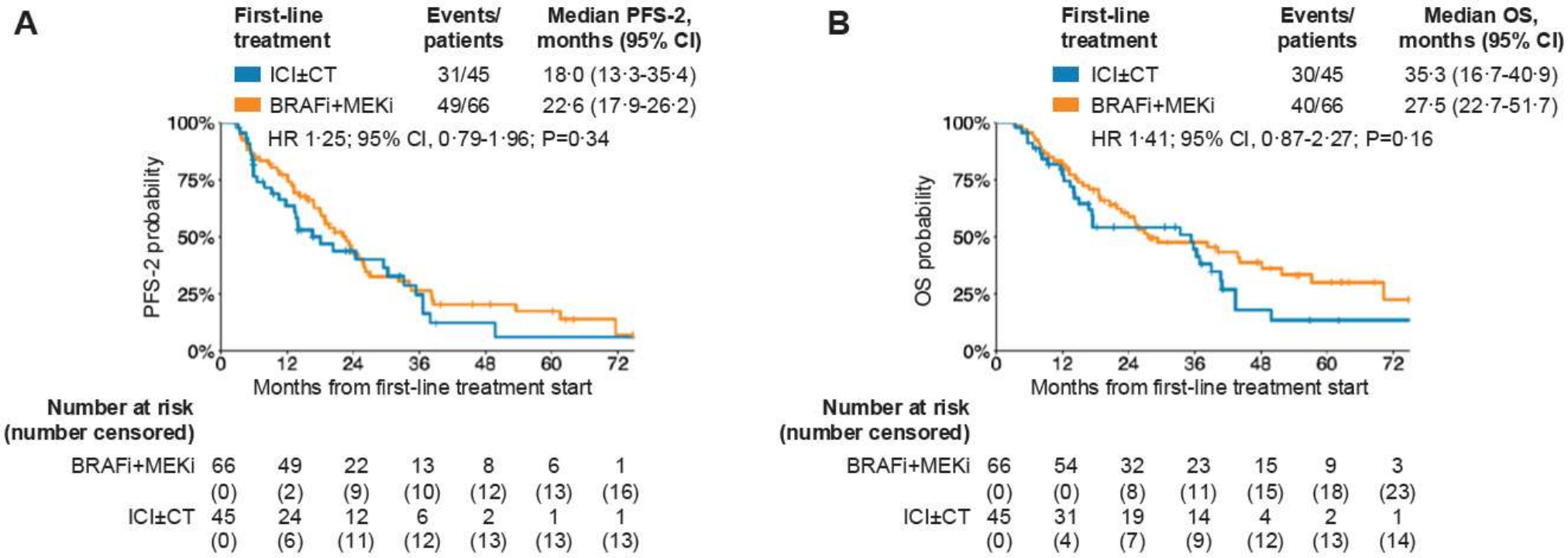


Median follow-up OS of 18 months (95% IC: 12.6 – 19.4)

Annals of Oncology (2024) 35 (suppl_2): S802-S877. 10.1016/annonc/annonc1602

Sequence of IO – TKI for NSCLC BRAF V600E

FRONT-BRAF (retrospective): Results – IO / TT sequentially

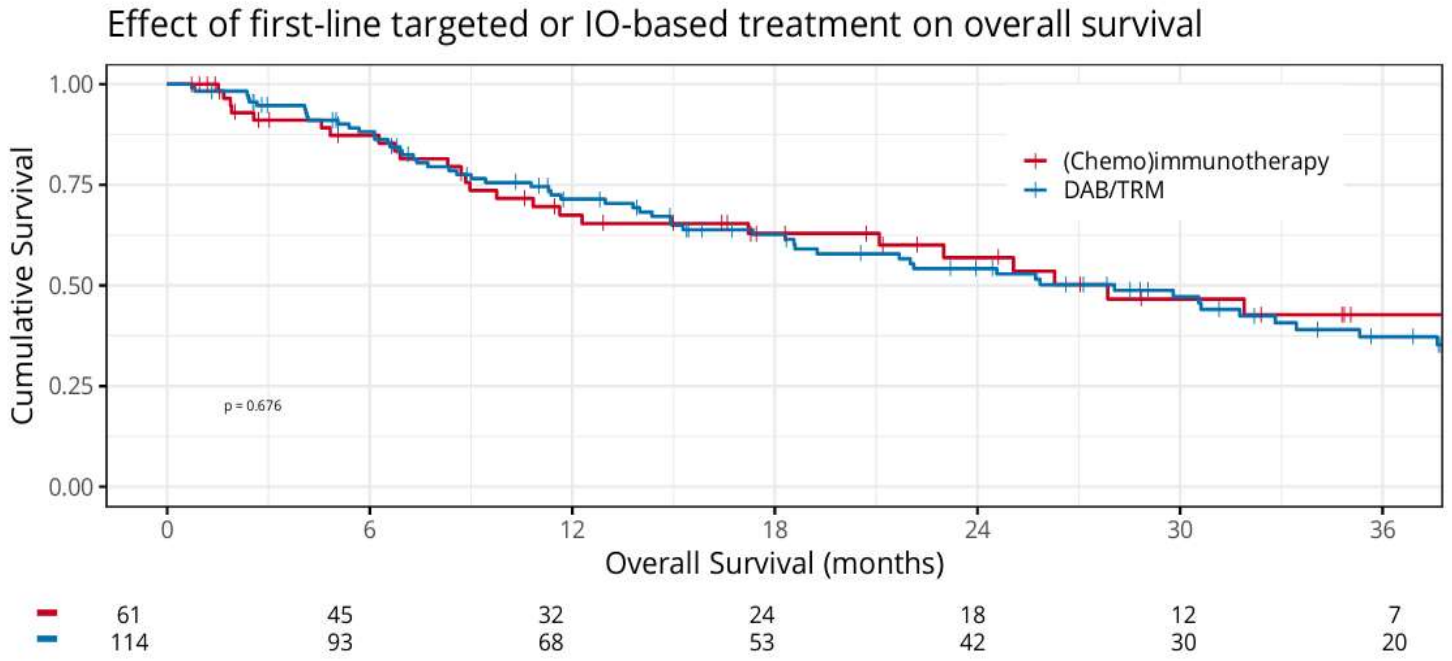


Di Federico A, et al. First-line immunotherapy with or without chemotherapy versus BRAF plus MEK inhibitors in BRAFV600E-mutated metastatic non-small-cell lung cancer (FRONT-BRAF): a multicentre, retrospective cohort study. Lancet Oncol. 2025;26(10):1357–1369.

Sequence of IO – TKI for NSCLC BRAF V600E

Treatment sequences in BRAF-V600-mutated non-small cell lung cancer: First-line targeted therapy versus first-line (chemo-) immunotherapy

Table 1: Patient Characteristics (n=205)			
Sex	Female	90	43.9%
	Male	115	56.1%
Age at Diagnosis	Median (Min – Max)	67.7 years (40.0 – 82.8)	
Smoking History	Smoker	144	70.2%
	Never Smoker	49	23.9%
	Undocumented	12	5.9%
ECOG PS	ECOG 0	71	34.6%
	ECOG 1	66	32.2%
	ECOG ≥ 2	41	20.0%
	Undocumented	27	13.2%
Tumor Histology	Adenocarcinoma	199	97.1%
	Squamous	2	1.0%
	Sarcomatoid	2	1.0%
	LCNEC	1	0.5%
	Undocumented	1	0.5%
V600 Mutation Subtype	p.V600E	202	98.5%
	p.V600L	1	0.5%
	p.Val600_Lys601delinsGlu	1	0.5%
	p.V600x	1	0.5%
PD-L1 TPS	PD-L1 TPS < 1%	42	20.5%
	PD-L1 TPS 1 – 49%	73	35.6%
	PD-L1 TPS ≥ 50%	83	40.5%
	Undocumented	7	3.4%
Stage at diagnosis	Initial stage I-III, later recurrence	56	27.3%
	Initially stage IV	149	72.7%
First-line regimen	DAB/TRM	114	55.6%
	Immunotherapy	34	16.6%
	Chemoimmunotherapy	27	13.2%
	Platinum doublet	17	8.3%
	Undocumented	13	6.3%



Wiesweg M, et al. 1300P Treatment sequences in BRAF-V600-mutant non-small cell lung cancer: First-line targeted therapy versus first-line (chemo-) immunotherapy. Ann Oncol. 2024;35(Suppl 1):S827-S828.

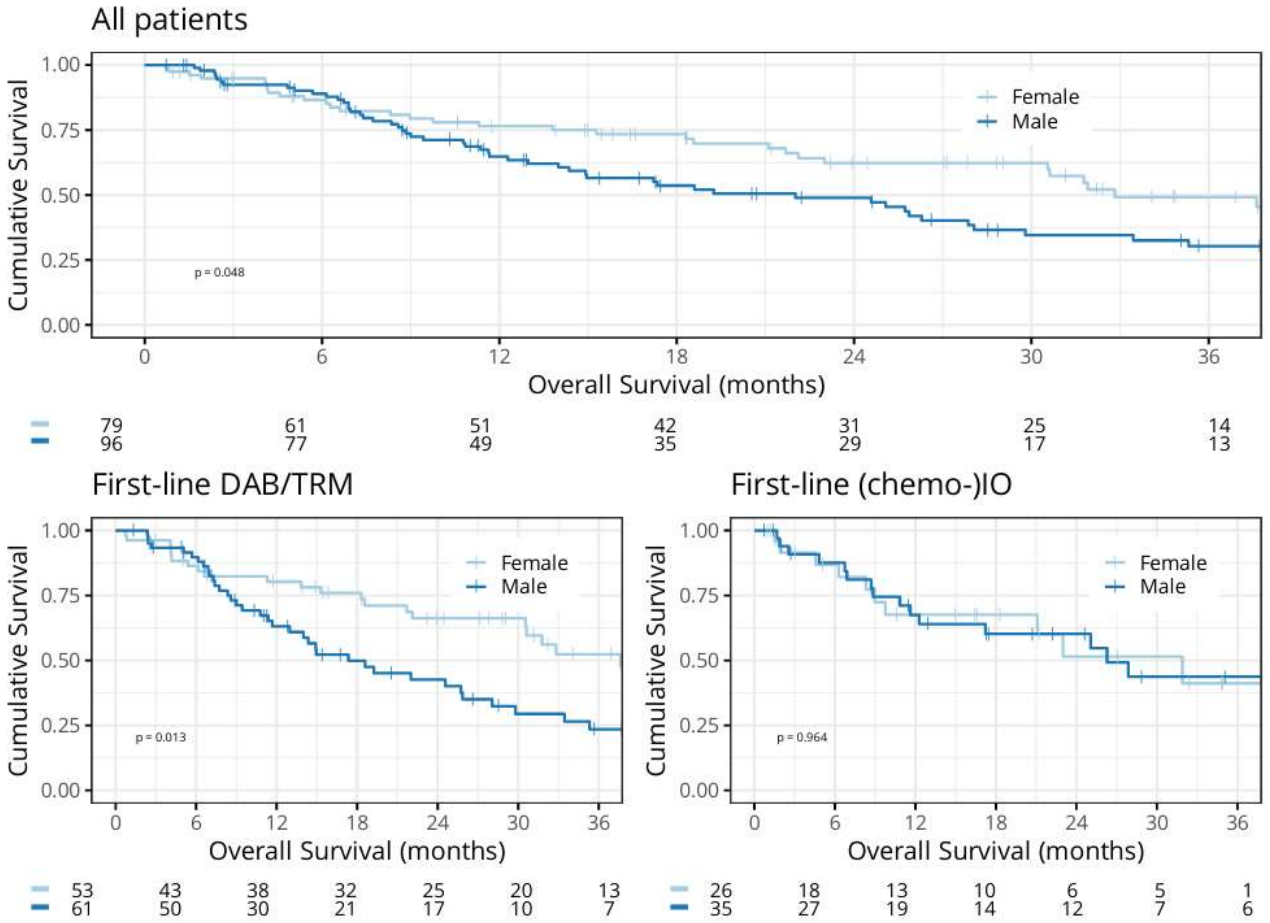
Sequence of IO – TKI for NSCLC BRAF V600E

nNGM | Nationales Netzwerk Genomische Medizin Lungenkrebs

Treatment sequences in BRAF-V600-mutated non-small cell lung cancer: First-line targeted therapy versus first-line (chemo-) immunotherapy

Universitätsmedizin Essen
Universitätsklinikum
Innere Klinik – Tumorforschung

Better results of targeted therapy in female



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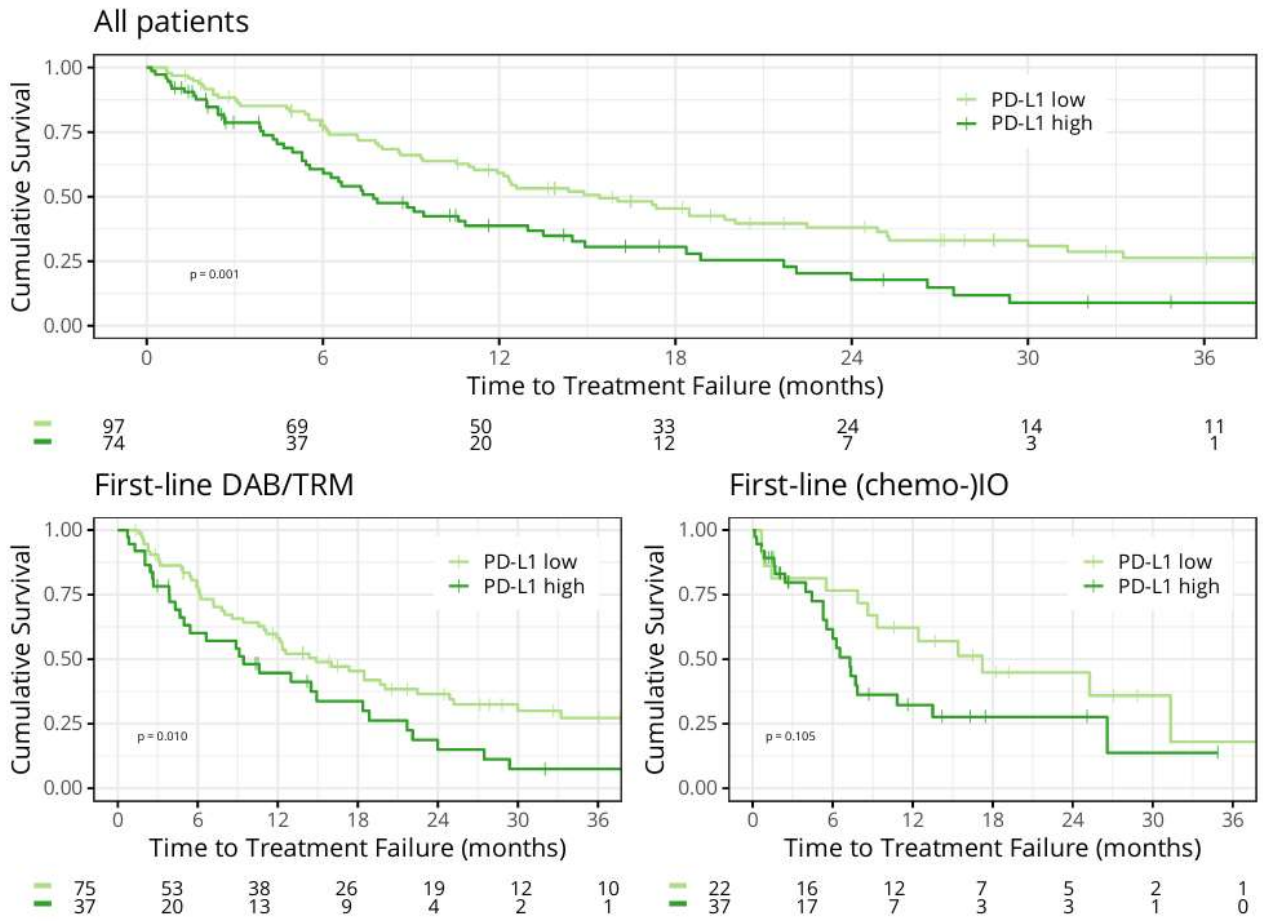

Worst prognostic in PD-L1 high

Wiesweg M, et al. 1300P Treatment sequences in BRAF-V600-mutant non-small cell lung cancer: First-line targeted therapy versus first-line (chemo-) immunotherapy. Ann Oncol. 2024;35(Suppl 1):S827-S828.

Conclusions

- BRAF mutations are rare (1-4%) but impactful in NSCLC: we have to find them (NGS)
- Thrombosis is emerging as a clinical hallmark, with high incidence (26%)
- Immunotherapy in BRAF-mutant patients is active (add IO at some point of the treatment strategy)
- BRAF V600E is a clearly targetable driver; non-V600 remains a therapeutic challenge
- Targeted therapies are active (higher ORR and PFS in 1st line): encora-bini is the only approved in Spain (since first targeted therapy approved 8 years ago)
- Best sequence still unclear

16th CONGRESS Lung ON CANCER

BARCELONA 27 / 28 NOVEMBER 2025

THANK YOU

GECP lung cancer research