16th CONGRESS Lung ON CANCER

BARCELONA 27 / 28 NOVEMBER 2025

GECP lung cancer research

Multidisciplinary approach for patients with early and locally advanced non-small cell lung cancer (NSCLC): 2nd SLCG consensus

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Conficts of interest

- I have no conflicts of interest related to this presentation

Background

- Locally advanced NSCLC presents a **heterogeneous profile** → **individualized management**.
- The **2023** SLCG **consensus** provided **standardized protocols** for the initial diagnosis and treatment of **stage III NSCLC including Neo-IO and controversial issues**.

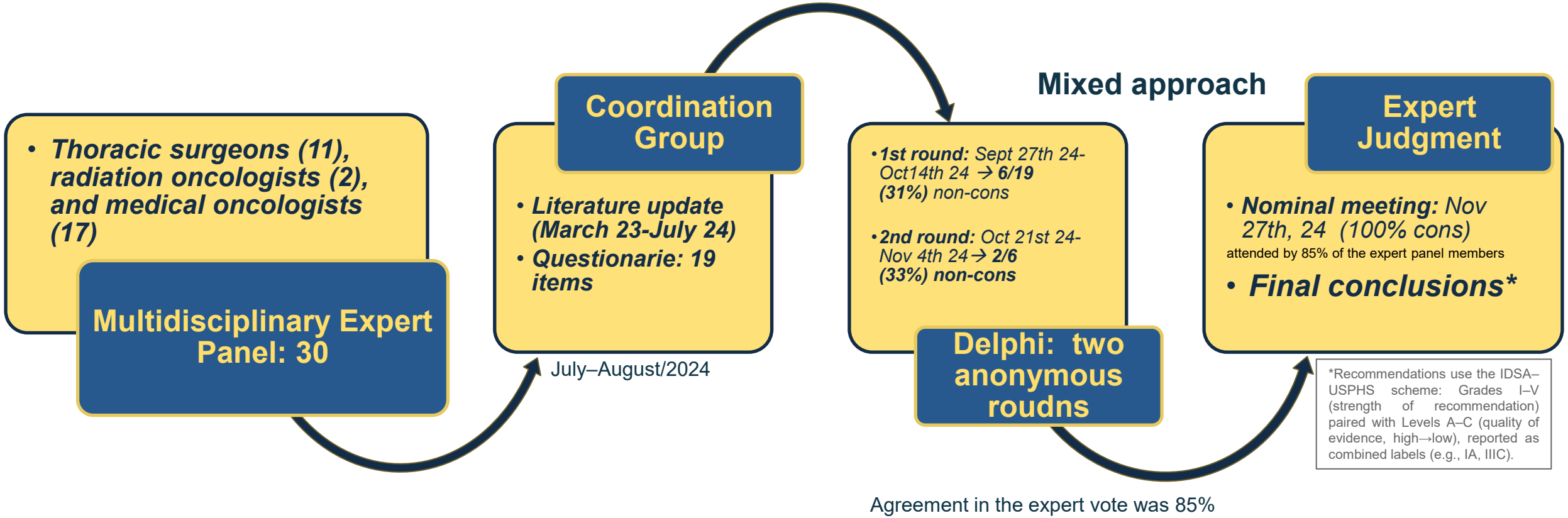
Objectives 2025:

- The SLCG **updated** its consensus to incorporate the **latest advances** in the **early and locally advanced** treatment of NSCLC, **highlighting** the role of a **multidisciplinary approach**.

"valuable tool for standardizing and supporting clinical practice"

Ospina-Serrano et al, Transl Lung Cancer Res 2025;14(9):3299-3322

Methods: (From July to November 2024)



Agreement in the expert vote was 85%

Ospina-Serrano et al, Transl Lung Cancer Res 2025;14(9):3299-3322

Overall results

1. **Main updates** included 2025 consensous:
    1. Advances in **molecular diagnosis and biomarkers**
    2. Role of the **multidisciplinary thoracic committee (MTC)**
    3. **Criteria** for **neoadjuvant** and **perioperative** treatment
    4. **Neoadjuvant CRT**
    5. **Adjuvant treatment** recommendations
    6. **Approaches** to **inoperable** or **unresectable** disease

2. Unchanged sections: proposals that did not require updates were not re-voted and remain from the original version.
    1. Radiological diagnoses
    2. Mediastinal staging and surgical decisions
    3. Follow-up

Ospina-Serrano et al, Transl Lung Cancer Res 2025;14(9):3299-3322

1. Advances in molecular diagnosis and biomarkers

2023 Consensus

- Mandatory PD-L1 and EGFR testing
- Optional ALK, KRAS, ROS1 if available

2025 Update

- Systematic **PD-L1**, **EGFR**, and **ALK** testing at diagnosis
- Optional **KRAS** and **ROS1** if available Clinical Trial
- NGS only if available at the diagnostic center (not mandatory)

Perform **molecular profiling**, including **EGFR, ALK**, and **PD-L1** (± KRAS/ROS1), at diagnosis to **select the optimal treatment** for each patient

Ospina-Serrano et al, Transl Lung Cancer Res 2025;14(9):3299-3322

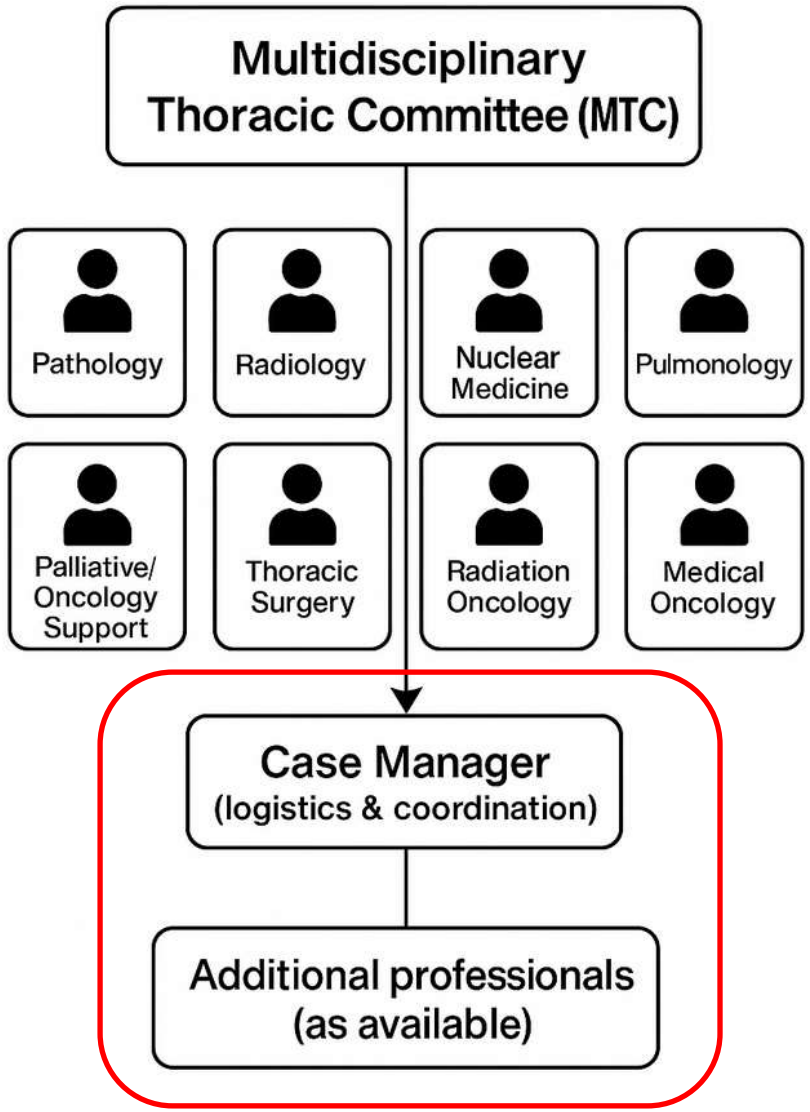
2. Role of the multidisciplinary thoracic committee (MTC)

2023 Consensus

- Composition defined (pathology, radiology, nuclear med, pulm., surgery, oncology, palliative care)
- Stage III
- Case manager optional

2025 Update

- **Expanded MTC scope**:
  - Stages Ib-II, EGFR, ALK Complex cases
  - Best mediastinal techniques
  - Mandatory review before/after neoadjuvant therapy/after surgery
- Standardized **case manager** role
- **Other professionals** can also participate



Emphasizes **structured** decision-making **improves OS !!**

Ospina-Serrano et al, Transl Lung Cancer Res 2025;14(9):3299-3322

Image ChatGPT5

3. Criteria for neoadjuvant and perioperative treatment

Neoadjuvant IO

Study	Population	Exp vs Contr	Primary endpoints	Key results (selected)
CheckMate-816	Resectable IB-IIIA	Nivolumab + platinum-chemo (3 cycles) vs chemo	pCR; DFS	pCR ↑ (~24% vs 2.2%); EFS HR≈0.63; ↑R0; surgery feasible
NADIM II	Resectable IIIA-IIIB	Nivolumab + chemo vs chemo	pCR; EFS	Higher pCR and EFS with IO
LCMC3 / LCC3	Resectable NSCLC	Atezolizumab (mono) surgical program	MPR; pCR	MPR ~20%; defines feasibility & pathology metrics
NEOSTAR	Resectable NSCLC	Nivovs Nivo+Ipi	MPR	Higher MPR/pCR with dual ICI

Forde PM, et al. CheckMate 816. N Engl J Med. 2022;386(21):1973-1985; Provencio M, et al. (NADIM II). N Engl J Med. 2023;389(6):504-513; Chaft JE, et al. (LCMC3). Nat Med. 2022;28:2155-2161; Cascone T, et al. (NEOSTAR). J Thorac Cardiovasc Surg. 2021;162(5):1379-1392.e3.

TNM 7[a]/8[a]

Perioperative IO

Study	Population	Exp vs Contr	Primary endpoints	Key results (selected)
KEYNOTE-671	Resectable IB-IIIA	Pembrolizumab + chemo → surgery → pembrolizumab vs placebo regimen	EFS; pCR (key sec)	↑EFS and ↑pCR; consistent across stage/PD-L1 OS (ns)
AEGEAN	Resectable II-IIIB (N2)	Durvalumab + chemo → surgery → durvalumab vs placebo regimen	EFS; pCR	EFS HR≈0.68; pCR ↑; surgery not compromised
CheckMate 77T	Resectable IIA-IIIB; PD-L1 all-comers; EGFR/ALK excluded	Nivolumab + chemo → surgery → nivolumab vs placebo regimen	EFS; pCR (key sec); MPR	EFS HR≈0.58 (18-mo 70.2% vs 50.0%); pCR 25.3% vs 4.7%; MPR 35.4% vs 12.1%
NEOTORCH	Mainly stage III resectable	Toripalimab + chemo → surgery → toripalimab vs chemo	EFS; MPR	EFS HR≈0.40; MPR 48.5% vs 8.4%; pCR 24.8% vs 1%
RATIONALE-315	Resectable stage II-IIIA (multicentre, China)	**Tislelizumab + chemo (neo)** → surgery → **tislelizumab (adj)** vs matched placebo regimen	**EFS; MPR (co-primary)**	**EFS HR≈0.56; MPR 56% vs 15%;** surgery feasible; safety manageable

Spicer J, et al. (KEYNOTE-671). N Engl J Med. 2023;389(6):491-503; Heymach JV, et al. (AEGEAN). N Engl J Med. 2023;389; Forde PM, et al. (CheckMate 77T) N Engl J Med. 2024;390:1756-1769; Wang Z, et al. (NEOTORCH). JAMA. 2024;331(3):201-211; Yue D, et al. (RATIONALE-315). *Lancet Respir Med.* 2025;13(2):119-129

TNM 8[a]

- **Benefit in N2 disease**
- **Periop ↑EFS? → No-head to head comparisons**
- **EGFR/ALK under-represented**

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3. Criteria for neoadjuvant and perioperative treatment

2023 recommendations

- Platinum doublet + immunotherapy (nivolumab) for resectable stage IIIA–IIIB
- 3 cycles recommended
- No consensus on neoadjuvant IT for EGFR/ALK-mutant tumors

2025 recommendations

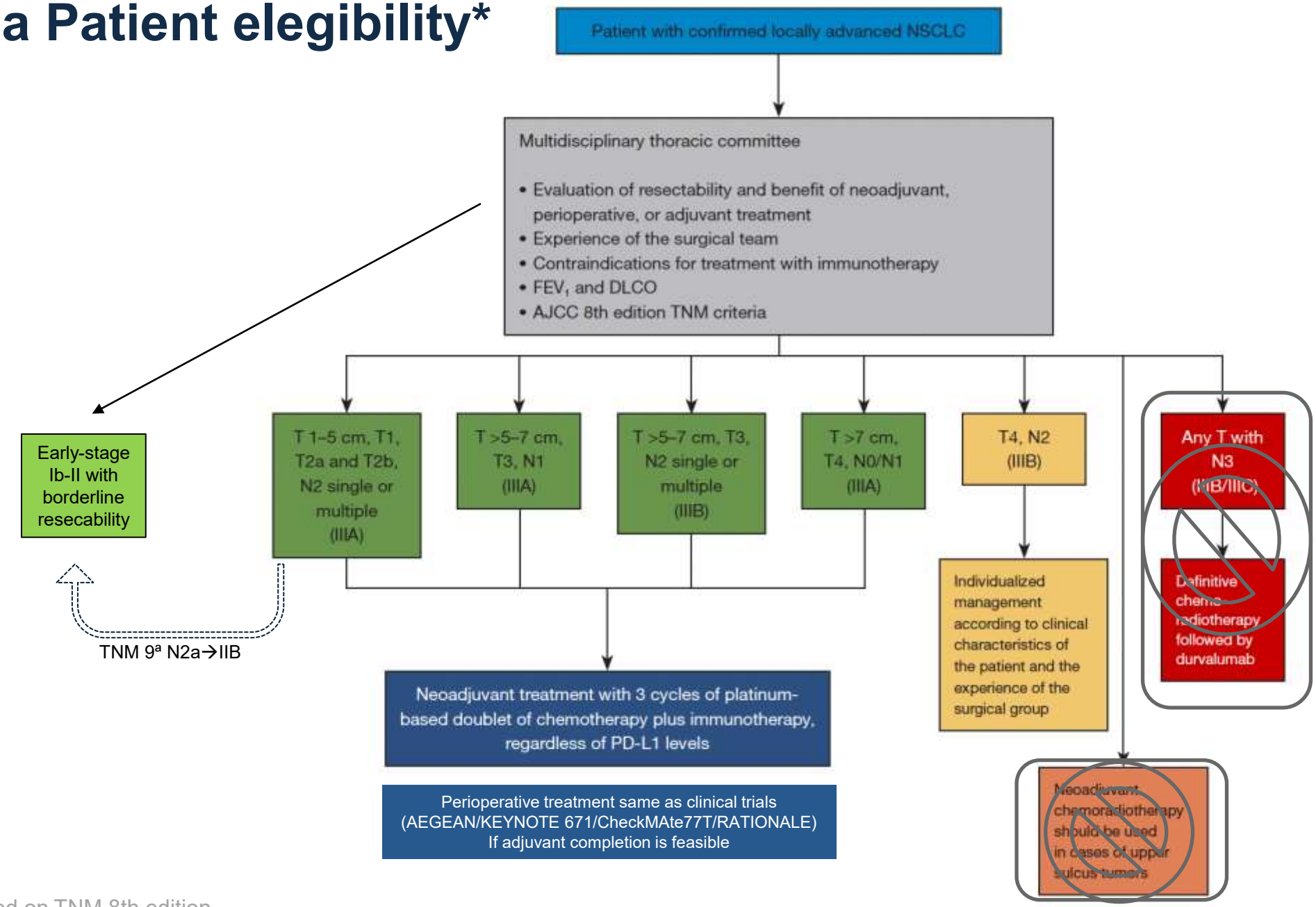
- Evaluate **at diagnosis** at MTC
- Include **early-stage (IB–II):** Borderline
- **N2 disease**: Individualize IIIB (T4N2)
- **Adds perioperative Ch-IO** (nivo, pem, durva) (AEGEAN/KEYNOTE-671/CheckMate77T)*
- Neo/Periop IT **not recommended** for **EGFR/ALK**
- **Re-evaluate** with **MTC** after neoadyuvant for “resecability”

Expands eligibility for pre/perioperative treatment regardless of PD-L1 levels, excludes patients with driver mutations, and emphasizes the role of the MTC

*criteria based on TNM 8th edition

Ospina-Serrano et al, Transl Lung Cancer Res 2025;14(9):3299-3322

3.a Patient elegibility*



*criteria based on TNM 8th edition

Adapted from Ospina-Serrano et al, Transl Lung Cancer Res 2025;14(9):3299-3322

3.b Mediastinal re-staging and response criteria

	2025 recommendation	GoR/LoE
When to re-stage	• After neoadjuvant therapy **if imaging response is unclear** to guide surgery.	IIIC
Techniques after induction	• (EBUS-TBNA/EUS-FNA) has variable NPV (≈20–78%); repeat mediastinoscopy reduced sensitivity (adhesions/fibrosis) → **discuss in MTC**	Expert opinion
If nodes look worse on imaging	• **Biopsy to confirm** progression **if technically feasible**.	Expert opinion
N2 after neo-IO—surgical candidacy	• **CR/PR and technically resectable → surgery** • **SD→ discuss in MTC** (feasibility, patient factors).	Expert opinion
Unresectable/inoper after induction	• **Definitive CRT → consolidation IO** if no progression during RT. • **Systemic treatment** if distant PD	Expert opinion

MTC: defines **need** for re-staging and **best technique** and **reviews stable/complex cases**

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Ospina-Serrano et al, Transl Lung Cancer Res 2025;14(9):3299-3322

3.c IASLC Patology Report:

	Recommendations
Terminology	• Define **tumor bed** (pre-treatment tumor area)
Sampling	• **≤3 cm**: sample entirely • **>3 cm**: map and photograph; include a **~0.5 cm** cross-section through the largest dimension + **≥1 cm** adjacent lung.
Rad-path correlation	• Use pre/post-therapy **CT (± FDG-PET)** to localize the tumor bed
Quantification	• Record % **viable/necrosis/stroma**
Response	• **MPR: ≤10%** viable tumor • **pCR/CPR: 0%** viable tumor in lung **and** sampled nodes (**ypT0N0**)
Lymph nodes	• **Sample thoroughly** when feasible • Report % components as for the primary. **Nodal pCR** = scar/necrosis **without** viable tumor.
Post-therapy staging	• If no discrete mass: **viable invasive size ≈ tumor-bed size × % viable invasive tumor**; apply special rules for lepidic; **ypT0N+** if lung 0% but nodes positive.

Tables ChatGPT5

Travis WD, et al. J Thorac Oncol. 2020;15(5):709-740

3.c IASLC Patology Report:

2023 recommendations

- Mentions pathological response but format is variable across centers
- pCR/MPR referenced but not uniformly enforced.
- Pathology informs decisions, linkage less explicit.

2025 recommendations

- **Surgeon must detail** preoperative therapy, specimen labels, tumor count, and any involvement of nearby structures.
  - Pneumonectomy not absolute contraindication
- The **pathology report** should measure treatment effects, including **percentages of viable tumor, necrosis, stroma, and inflammation level** (IASLC)

The patology-report **supports decision-making for MTC** and provides **quality control**

Ospina-Serrano et al, Transl Lung Cancer Res 2025;14(9):3299-3322
Travis WD, et al. J Thorac Oncol. 2020;15(5):709-740

4. Neoadjuvant Chemorradiation + Surgery

Study (year)	Design / Population	Induction Strategy (vs comparator)	Main finding
Intergroup 0139 (Albain 2009)	Phase III, stage IIIA-N2	**cCRT → surgery** vs **definitive cCRT**	**No OS benefit** with surgery after cCRT (trial pre-IO era).
SAKK 16/00 (Pless 2015)	Phase III, stage IIIA-N2	**cCRT → surgery** vs **chemo → surgery**	Randomized data **did not show OS advantage** for induction CRT.
WJTOG9903 (Katakami 2012)	Phase III, pathologic N2 (IIIA)	**Concurrent CRT → surgery** vs **chemo → surgery**	**No superiority** of CRT over chemotherapy induction.
SWOG 9416 / Intergroup 0160 (Rusch 2007)	Phase II/trimodality, **superior sulcus (Pancoast)**	**Induction CRT → surgery** (single-arm)	Durable outcomes in Pancoast tumors with trimodality.
De Leyn 2009 (trimodality series)	Observational, **superior sulcus**/central T4	**CRT → surgery**	Long-term survival achievable in selected anatomy.
Exploratory (SAKK 16/18; INCREASE, 2023-24)	Phase II, CRT + IO (cT1-4N0-2M0)	**Neo-IO ± CRT** (single-arm/phase II)	Hypothesis-generating; no definitive OS data.

NO survival impact

Trimodality: PANCOAST

Insufficient to recommend

Albain KS, et al. (Intergroup 0139). Lancet. 2009;374(9687):379-386; Pless M, et al. (SAKK 16/00). Lancet. 2015;386(9998):1049-1057; Katakami N, et al. (WJTOG9903). Ann Oncol. 2012;23(11):2807-2812; Rusch VW, et al. (SWOG 9416/INT 0160). J Clin Oncol. 2007;25(3):313-318; De Leyn P, et al. J Thorac Oncol. 2009;4(1):62–68; Mauti LA, et al. SAKK 16/18. J Clin Oncol 2023;41:8547; Bahce I, et al. INCREASE. J Immunother Cancer 2024;12:e009799

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4. Neoadjuvant Chemorradiation

2023 recommendations

- Induction CRT could **be considered** in selected **IIIA-N2** cases (trimodality)
- **Superior sulcus tumors (Pancoast)**

2025 recommendations

- The SLCG 2025 panel **does not recommend** routine **pre-operative CRT**
- Reserved for **superior sulcus (Pancoast) tumors**

The **SLCG 2025 consensus** limits **preoperative CRT** to Pancoast tumors and identifies **ChIO** (**neoadjuvant** or **perioperative**) as the **standard induction therapy**

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5. Adjuvant treatment recommendations

Ajuvant IO

Study	Population	Exp vs contr	Primary endpoints	Key results
IMpower010	Resected IB(≥4 cm)-IIIA post-cisplatin	Atezolizumab (16cy) vs BSC	DFS	DFS ↑; strongest in II-IIIA PD-L1 ≥1% (max ≥50%)
KEYNOTE-091 (PEARLS)	Resected IB-IIIA (± prior chemo)	Pembrolizumab (18cy) vs placebo	DFS (overall; PD-L1 ≥50%)	Overall DFS HR≈0.76; PD-L1 ≥50% not clearly superior

Felip E, et al. (IMpower010). Lancet. 2021;398(10308):1344-1357; O'Brien M, et al. (PEARLS/KEYNOTE-091). Lancet Oncol. 2022;23(10):1274-1286.

Adjuvant Target

Study	Population	Exp vs contr	Primary endpoints	Key results
ADAURA	Resected IB-IIIA **EGFR-mut**	Osimertinib (3y) vs placebo (± prior chemo)	DFS; CNS-DFS	Large DFS benefit (HR≈0.23-0.27); CNS protection
ALINA	Resected IB(≥4 cm)-IIIA **ALK+**	Alectinib (1y) vs platinum chemo	DFS	DFS HR≈0.24; strong CNS control

Wu Y-L, et al. (ADAURA). N Engl J Med. 2020;383(18):1711-1723; Tsuboi M, et al. (ADAURA OS). N Engl J Med. 2023;389(2):137-147; Wu Y-L, et al. (ALINA). N Engl J Med. 2024;390(14):1265-1276

5. Adjuvant treatment recommendations

2023 recommendations

- Pathology per IASLC
- Adjuvant osimertinib for EGFR-m
- Adjuvant RT only for R1/N2 (selected)

2025 recommendations

- **Formal** IASLC-based **pathology report** required
- **Re-evaluate with MTC** after "surgery"→ only Adj in periop
- Adds **pembrolizumab**, **atezolizumab** as adjuvant options in primary resected
- Adjuvant **osimertinib (EGFR)** and **alectinib (ALK)**

Improves identification of patients needing **postoperative treatment** using **standardized IASLC pathology reports** and **molecular testing (MTC role)**

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6. Approaches to inoperable or unresectable disease

Study	Setting	Population	Exp vs Contr	Primary endpoints	Key results
PACIFIC (+5y)	Unresectable	Stage III unresectable, no progression after cCRT	**Consolidation Durvalumab vs placebo (1y)**	OS; PFS	Sustained OS/PFS benefit at 5 years
LAURA	Unresectable	Stage III unresectable **EGFR-mut** (Del19/L858R), no progression after cCRT	**Consolidation Osimertinib** vs placebo (until PD)	**PFS** (BICR); OS (secondary)	**Median PFS ~39.1 vs 5.6 months; HR ~0.16**; OS immature with favorable trend

Antonia SJ, et al. (PACIFIC—primary). N Engl J Med. 2017;377:1919-1929; Spigel DR, et al. PACIFIC 5y. J Clin Oncol. 2022;40(12):1301-1311; Lu S, et al. (LAURA). N Engl J Med. 2024;391(7):585-597.

6. Approaches to inoperable or unresectable disease

2023 recommendations

- Ch-RDT: Only for unresectable stage IIIB or superior sulcus tumors

2025 recommendations

- Unresect/inoper: **Ch-RT + durvalumab** consolidation (PACIFIC) as standard
- Neo-IO failure: **PACIFIC** (case by case) **MTC**
- In EGFRm (Del19, L858R) Osimertinib after Ch-RT: **(LAURA)**

No specific trial for "neo-IO failure"; the application of PACIFIC in this context is based on extrapolation and **expert judgment**

*criteria based on TNM 8th edition

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Take home messeges

What defines the 2025 SLCG Consensus?

- The **2025 SLCG consensus** establishes our group's position within both national and **international frameworks** for managing **early-stage and locally advanced** NSCLC
  - Dynamically incorporating the **latest advances** in neo/perioperative/adjuvant treatments
  - Emphasizing coordinated multidisciplinary efforts through **MTC**
  - Addressing and responding to **current challenges** through **expert opinion**

To provide **precise, patient-centered care!!**

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THANK YOU

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