P3.12.46

Enhanced vs standard dermatologic management with amivantamab-lazertinib in *EGFR*m advanced NSCLC: the COCOON global RCT

Byoung Chul Cho[1], Weimin Li[2], Alexander I Spira[3], Maxwell Sauder[4], Jill Feldman[5], Farastuk Bozorgmehr[6], Milena Mak[7], Janellen Smith[8], Pei Jye Voon[9], Panwen Tian[2], Jiunn-Liang Tan[10], Cheng-Ta Yang[11], Jin-Yuan Shih[12], Nuri Karadurmus[13], Juan Esteban Cundom[14], Glaucio Bertollo[15], Irfan Cicin[16], Jorge Nieva[17], Ana Laura Ortega-Granados[18], Pascale Tomasini[19], Danny Nguyen[20], Enriqueta Felip[21], Julia Schuchard[22], Sean P Murphy[23], Bailey G Anderson[23], Tonatiuh Romero[23], Yichuan Xia[24], Shubin Sheng[23], Joshua M Bauml[24], Parthiv J Mahadevia[23], Julian Kam[23], Mehregan Nematian-Samani[23], Jairo Simoes[23], Mark Wildgust[23], Nicolas Girard[25]

[1]Division of Medical Oncology, Yonsei Cancer Center, Yonsei University College of Medicine, Seoul, Republic of Korea; [2]Department of Pulmonary Care and Critical Care Medicine, West China Hospital of Sichuan University, Chengdu, Sichuan, China; [3]Virginia Cancer Specialists, Fairfax, VA, USA; [4]University of Toronto and Princess Margaret Cancer Centre Toronto, Toronto, ON, Canada; [5]EGFR Resisters, Deerfield, IL, USA; [6]Thoraxklinik Heidelberg gGmbH, University Hospital Heidelberg, Heidelberg, Germany; [7]Instituto do Câncer do Estado de São Paulo – Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo, São Paulo, Brazil; [8]University of California-Irvine, Irvine, CA, USA; [9]Department of Radiotherapy and Oncology, Sarawak General Hospital, Kuching, Sarawak, Malaysia; [10]Department of Medicine, University of Malaya, Kuala Lumpur, Malaysia; [11]Department of Internal Medicine, Division of Thoracic Medicine, Linkou Chang Gung Memorial Hospital and College of Medicine, Chang Gung University, Taoyuan, Taiwan; [12]Department of Internal Medicine, National Taiwan University Hospital, Taipei City, Taiwan; [13]SBU Gulhane Training and Research Hospital, Ankara, Turkey; [14]Instituto Argentino de Diagnóstico y Tratamiento, Buenos Aires, Argentina; [15]AFECC/Hospital Santa Rita de Cássia, Vitória-ES, Brazil; [16]İstinye Üniversitesi Medical Oncology and İ.A.Ü. VM Medical Park Florya Hospital, Istanbul, Turkey; [17]University of Southern California, Norris Comprehensive Cancer Center, Los Angeles, CA, USA; [18]Hospital Universitario de Jaén, Jaén, Spain; [19]Aix Marseille University - CNRS, INSERM, CRCM; CEPCM - AP-HM Hôpital de La Timone, Marseille, France; [20]City of Hope National Medical Center, Duarte, CA, USA; [21]Medical Oncology Service, Vall d'Hebron Institute of Oncology (VHIO), Vall d'Hebron Barcelona Hospital Campus, Universitat Autònoma de Barcelona, Barcelona, Spain; [22]Johnson & Johnson, Horsham, PA, USA; [23]Johnson & Johnson, Raritan, NJ, USA; [24]Johnson & Johnson, Spring House, PA, USA; [25]Institut du Thorax Curie-Montsouris, Paris, France and Paris Saclay University, UVSQ, Versailles, France

Key Takeaway

Participants who received COCOON DM had a significantly lower incidence of grade ≥2 dermatologic AEs and a reduced impact of skin conditions on quality of life versus SoC DM

Conclusions

- COCOON DM is an uncomplicated, widely available, prophylactic regimen that significantly reduced the incidence of grade ≥2 DAEIs on the scalp, face, and other body locations
- Participants who received COCOON DM reported a lower impact of anticancer treatment on dermatologic symptoms and quality of life compared with SoC DM
- Discontinuations and dose modifications of the COCOON DM components were rare, which demonstrates the feasibility of using the regimen
- A modified prophylactic approach with longer oral antibiotic use, noncomedogenic skin moisturizer, and oral zinc in combination with early intervention is being investigated
- As first-line amivantamab plus lazertinib has demonstrated a clinically meaningful and statistically significant OS improvement versus osimertinib, and the COCOON DM regimen further enhances the benefit-risk profile for this regimen, amivantamab plus lazertinib represents a new standard of care

COCOON data have been published simultaneously in the Journal of Thoracic Oncology.

Please scan QR code

Poster

Narrated poster video

https://www.congresshub.com/Oncology/WCLC2025/Amivantamab/Cho

The QR code is intended to provide scientific information for individual reference, and the information should not be altered or reproduced in any way.

Acknowledgments

The authors would like to thank the individuals who participated in this study and their families and caregivers, the physicians and nurses who cared for the participants, the staff members who supported this clinical trial, and the staff members at the study sites and involved in data collection/analyses. This study was funded by Janssen Research & Development, LLC, a Johnson & Johnson company. Medical writing assistance was provided by Lumanity Communications Inc. and was funded by Johnson & Johnson.

Disclosures

BCC served in a consulting or advisory role for AstraZeneca, Boehringer Ingelheim, Roche, Bristol Myers Squibb, Pfizer, Yuhan Corporation, Janssen, Takeda, Merck Sharp & Dohme, Ono Pharmaceutical, Eli Lilly, MedPacto, Blueprint Medicines, Cyrus Therapeutics, Guardant Health, Novartis, CJ Bioscience, Abion, BeiGene, CureLogen, Onegene Biotechnology, GI Cell, HK inno.N, Imnewrun Biosciences, Hanmi, RAND Bioscience, Kanaph Therapeutics, BridgeBio, and Oscotec; served in a leadership role for Interpark Bio and J INTS BIO; holds patents, royalties, or other intellectual property for Champions Oncology, Crown Bioscience, and Imagen; has other relationships with DAAN Biotherapeutics; owns stock or other ownership interests with Theravance, Gencurix, BridgeBio, Kanaph Therapeutics, Cyrus Therapeutics, Interpark Bio, and J INTS BIO; and received research funding from Novartis, Bayer, AstraZeneca, MOGAM Institute for Biomedical Research, Dong-A ST, Champions Oncology, Janssen, Yuhan Corporation, Ono Pharmaceutical, Dizal Pharma, Merck Sharp & Dohme, AbbVie, GI Innovation, Eli Lilly, Blueprint Medicines, Interpark Bio, LG Chem, Oscotec, GI Cell, Abion, Boehringer Ingelheim, CJ Bioscience, CJ Blossom Park, Cyrus Therapeutics, Genexine, Nuvalent, Oncternal Therapeutics, Regeneron, BridgeBio, ImmuneOncia, Illumina, Kanaph Therapeutics, Therapex, J INTS BIO, Hanmi, and CHA Bundang Medical Center. **AIS** served in a consulting or advisory role for Array BioPharma, MedImmune, Incyte, Amgen, Novartis, AstraZeneca, Mirati Therapeutics, Gritstone bio, Jazz Pharmaceuticals, Merck, Bristol Myers Squibb, Takeda, Janssen, Mersana, Blueprint Medicines, Daiichi Sankyo, Regeneron, Eli Lilly, Black Diamond Therapeutics, and Sanofi; served in a leadership role for NEXT Oncology; owns stock or other ownership interests with Eli Lilly; received honoraria from CytomX Therapeutics, MedImmune, AstraZeneca, Merck, Takeda, Amgen, Janssen, Novartis, Bristol Myers Squibb, and Bayer; and received research funding from Roche, AstraZeneca, Boehringer Ingelheim, Astellas, MedImmune, Novartis, Incyte, AbbVie, Ignyta, Takeda, MacroGenics, CytomX Therapeutics, LAM Therapeutics, Astex Pharmaceuticals, Bristol Myers Squibb, Loxo Oncology, Arch Therapeutics, Gritstone bio, Plexxikon, Amgen, Daiichi Sankyo, ADC Therapeutics, Janssen, Mirati Therapeutics, Rubius Therapeutics, Synthekine, Mersana, Blueprint Medicines, Regeneron, Alkermes, Revolution Medicines, Medikine, Black Diamond Therapeutics, BluPrint Oncology, NALO Therapeutics, Scorpion Therapeutics, and ArriVent BioPharma. **MS** served in a consulting role and/or as investigator for Alumis, Amgen, AbbVie, Arcutis, Bausch Health, Eli Lilly Canada, Galderma, Incyte, Janssen, LEO Pharma, Merck, Novartis, Pfizer, Regeneron, Sanofi, Sun Pharmaceuticals, and UCB Canada. **JF** received consulting fees from Johnson & Johnson, 23andMe, and EQRx; received payment or honoraria from CME Events, Blueprint Medicines, and Takeda; received support for attending meetings and/or travel from IASLC, AACR, ASCO, ASTRO, NLCRT, ESMO, NY Lung Cancer Foundation, and Johnson & Johnson; and served in a leadership role for IASLC, EGFR Resisters, NLCRT, and ECOG-ACRIN. **FB** received grants or contracts from Bristol Myers Squibb, Roche, and AstraZeneca; received payment or honoraria from Novocure, Daiichi Sankyo, GSK, and AstraZeneca; received support for attending meetings and/or travel from Janssen and Roche; and participated on a data safety monitoring board or advisory board for Regeneron, GSK, Amgen, AstraZeneca, Daiichi Sankyo, and Janssen. **MM** received payment or honoraria from Bayer, Pfizer, Merck Serono, Takeda, Amgen, Eli Lilly, AstraZeneca, and Johnson & Johnson. **J Smith** received support for attending meetings and/or travel from UC Irvine; served as a consultant for Janssen Pharmaceutical; participated on a data safety monitoring board or advisory board for the American Academy of Dermatology; and served in a leadership role for the executive board of the Pacific Dermatology Association. **PJV** received grants or contracts from AstraZeneca, Novartis, Boehringer Ingelheim, Janssen-Cilag, Johnson & Johnson, Viracta Therapeutics, Inc., Roche, Merck KGaA, Merck Sharp & Dohme, BeiGene, Amgen, and Revolution Medicines; received consulting fees from AstraZeneca, Novartis, Merck Sharp & Dohme, Pfizer, BeiGene, Amgen, Merck KGaA, Janssen-Cilag, and Johnson & Johnson; and received payment or honoraria from AstraZeneca, Novartis, Merck Sharp & Dohme, Pfizer, Amgen, Merck KGaA, Janssen-Cilag, and Johnson & Johnson. **J-LT** received payment or honoraria from Merck Sharp & Dohme, Boehringer Ingelheim, Johnson & Johnson, Novartis, GSK, and Pfizer; received support for attending meetings and/or travel from Merck Sharp & Dohme, Takeda, and Pfizer; and received consulting fees from Merck KGaA, GSK, and Bristol Myers Squibb. **J-YS** received grants or contracts from Roche, Genconn Biotech, and Taipei City Thoracic Disease Academic Research and Education Foundation; received payment or honoraria from ACT Genomics, Amgen, Genconn Biotech, AstraZeneca, Roche, Bayer, Boehringer Ingelheim, Eli Lilly, Pfizer, Novartis, Merck Sharp & Dohme, Chugai, Takeda, CStone Pharmaceuticals, Janssen, TTY Biopharm, Orient EuroPharma, Mundipharma, GSK, Lotus Pharmaceutical, Ono Pharmaceutical, and Bristol Myers Squibb; received support for attending meetings and/or travel from AstraZeneca, Roche, and Chugai; and participated on a data safety monitoring board or advisory board for Takeda. **JEC** received consulting fees from Merck Sharp & Dohme; and received payment or honoraria from Merck Sharp & Dohme Argentina, AstraZeneca, Pfizer, and Amgen. **GB** received support for attending meetings and/or travel from AstraZeneca and Daichii Sankyo; and received payment or honoraria from AstraZeneca. **IC** served in a consulting or advisory role for AstraZeneca, Boehringer Ingelheim, Eli Lilly, Merck, Novartis, Pfizer, Roche, and Quintiles; and received research funding from Astellas, AstraZeneca, Bristol Myers Squibb, Boehringer Ingelheim, Eli Lilly, Merck, Merck KGaA, Parexel, Pfizer, Quintiles, and Taiho. **JN** received grants or contracts from Merck and Genentech; received royalties or licenses from Cansera; received consulting fees from Aadi Bioscience, ANP Technologies, BioAtla, Genentech, MindMed, Sanofi, Affylmmune Therapeutics, AstraZeneca, G1 Therapeutics, KaliVir Immunotherapeutics, Naveris, and Catalym; received support for attending meetings and/or travel from AstraZeneca; has patents with Human Performance Monitoring; participated on a data safety monitoring board or advisory board for ICON; and has stock or stock options with Amgen, Novartis, Intragel, Indie Bio, Johnson & Johnson, Cansera, and Affylmmune Therapeutics. **P Tomasini** received payment or honoraria from AstraZeneca, Takeda, Bristol Myers Squibb, Roche, Janssen, and Amgen; and received support for attending meetings and/or travel from Takeda, AstraZeneca, and Bristol Myers Squibb. **DN** received payment or honoraria from Janssen; and served in a leadership or fiduciary role for Gryt Health. **EF** served in a consulting or advisory role for Amgen, AstraZeneca, Bayer, Bristol Myers Squibb, Eli Lilly, GSK, Janssen, Merck Serono, Novartis, Pfizer, Sanofi, Takeda, Peptomyc, Daiichi Sankyo Europe GmbH, Roche, Merck Sharp & Dohme, BerGenBio, and Turning Point Therapeutics; participated in speaker bureaus for AstraZeneca, Bristol Myers Squibb, Eli Lilly, Medscape, Merck Sharp & Dohme, PeerVoice, Pfizer, Takeda, Amgen, Roche, Janssen, Medical Trends, Merck Serono, Sanofi, and touchONCOLOGY; has other relationships with Grifols; and received research funding from Merck and Merck KGaA. **J Schuchard**, **SPM**, **BGA**, **TR**, **YX**, **SS**, **JMB**, **PJM**, **JK**, **MN-S**, **J Simoes**, and **MW** are employees of and may hold stock in Johnson & Johnson. **NG** received consulting fees from AbbVie, Amgen, AstraZeneca, BeiGene, Boehringer Ingelheim, Bristol Myers Squibb, Daiichi Sankyo, Gilead, Roche, Janssen, LEO Pharma, Eli Lilly, Merck Sharp & Dohme, Novartis, Sivan, Mirati Therapeutics, Pfizer, Sanofi, and Takeda; received payment or honoraria from AbbVie, Amgen, AstraZeneca, BeiGene, Boehringer Ingelheim, Bristol Myers Squibb, Daiichi Sankyo, Gilead, Roche, Janssen, LEO Pharma, Eli Lilly, Merck Sharp & Dohme, Novartis, Sivan, Mirati Therapeutics, Pfizer, Sanofi, and Takeda; received support for attending meetings and/or travel from Janssen, Amgen, and Bristol Myers Squibb; and participated on a data safety monitoring board or advisory board for Roche. **WL**, **P Tian**, **C-TY**, **NK**, and **ALO-G** report no conflicts of interest.

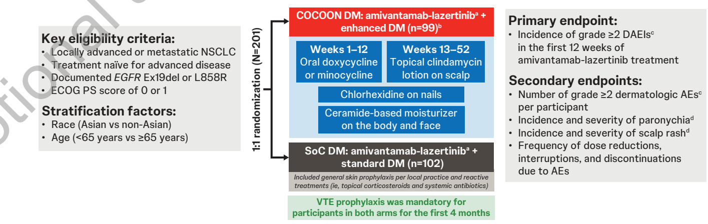
Background

- Amivantamab plus lazertinib significantly improved progression-free survival and prolonged overall survival (OS) versus osimertinib among participants with epidermal growth factor receptor (*EGFR*)–mutant non-small cell lung cancer (NSCLC) in the MARIPOSA trial, with a projected >1-year median OS benefit[1,2]
- Consistent with EGFR-targeted therapies, amivantamab plus lazertinib is associated with dermatologic adverse events (AEs), including rash, dermatitis acneiform, pruritus, and paronychia[1,2]
  - Dermatologic AEs are mostly grade 1 or 2 and generally occur in the first 4 months of treatment[1,3]
- Mitigation strategies for dermatologic AEs were not evaluated in MARIPOSA; therefore, the COCOON study investigated the effect of enhanced dermatologic management (DM) versus standard of care (SoC) DM on the incidence of dermatologic AEs among participants with *EGFR*-mutant NSCLC who were treated with first-line amivantamab plus lazertinib
  - At the preplanned interim analysis of COCOON (n=138), enhanced DM significantly reduced the incidence of grade ≥2 dermatologic AEs versus SoC DM in the first 12 weeks[4]
- Here, we present results from the fully enrolled (N=201) COCOON study

Methods

- COCOON enrolled adult participants with histologically or cytologically confirmed locally advanced or metastatic NSCLC with *EGFR* exon 19 deletion or exon 21 L858R substitution mutations who were treatment naïve and had an Eastern Cooperative Oncology Group performance status score of 0 or 1 (**Figure 1**)
- Participants were randomized 1:1 to enhanced COCOON DM or SoC DM
- Venous thromboembolism (VTE) prophylaxis was mandatory for all participants for the first 4 months
- Efficacy endpoints presented here include the incidence of grade ≥2 dermatologic AEs of interest (DAEIs) in the first 12 weeks (primary endpoint) and the change from baseline in patient-reported outcomes

Figure 1: COCOON study design



COCOON (ClinicalTrials.gov Identifier: NCT06120140).
[a]Amivantamab IV was administered at 1050 mg (1400 mg if ≥80 kg) once weekly for 4 weeks and every 2 weeks thereafter; lazertinib was orally administered daily at 240 mg. [b]Prophylactic antibiotics: oral doxycycline or minocycline 100 mg BID and topical clindamycin lotion 1% on the scalp QD before bedtime. Paronychia prophylaxis: chlorhexidine 4% on the fingernails and toenails QD. Skin moisturization: La Roche Posay Lipikar AP+M moisturizer on the body and face at least QD. [c]DAEIs include rash, dermatitis acneiform, pruritus, skin fissures, acne, folliculitis, erythema, eczema, maculopapular rash, skin exfoliation, skin lesion, skin irritation, dermatitis, rash erythematous, rash macular, rash papular, rash pruritic, rash pustular, dermatitis contact, dermatitis exfoliative generalized, drug eruption, dyshidrotic eczema, eczema asteatotic, and paronychia. [d]AE severity per NCI CTCAE v5.0.
AE, adverse event; BID, twice daily; DAEI, dermatologic adverse event of interest; DM, dermatologic management; ECOG PS, Eastern Cooperative Oncology Group performance status; EGFR, epidermal growth factor receptor; Ex19del, exon 19 deletion; IV, intravenous; L858R, exon 21 L858R substitution; NCI CTCAE, National Cancer Institute Common Terminology Criteria for Adverse Events; NSCLC, non-small cell lung cancer; QD, once daily; SoC, standard of care; VTE, venous thromboembolism.

Results

Baseline demographic and clinical characteristics

- A total of 199 participants were treated with amivantamab plus lazertinib (safety population)
  - 99 received COCOON DM
  - 100 received SoC DM
- As of the clinical cutoff (November 13, 2024), median follow-up was 7.1 months, with 74% ongoing treatment
- Baseline demographic and clinical characteristics were balanced between arms (**Table 1**)

Table 1: Baseline demographic and clinical characteristics[a]

Characteristic	COCOON DM (n=99)	SoC DM (n=100)
Median (range) age, years	63.0 (34–80)	62.5 (28–83)
Female, n (%)	61 (62)	57 (57)
Race, n (%)		
Asian	66 (67)	65 (65)
White	32 (32)	32 (32)
Other[b]	1 (1)	3 (3)
Median (range) body weight, kg	63.0 (29–97)	64.2 (39–106)
ECOG PS score of 1, n (%)	59 (60)	55 (55)
History of brain metastases, n (%)	32 (32)	43 (43)

[a]Safety population. Two participants randomized to SoC DM did not meet the inclusion criteria at C1D1 and discontinued the study prior to receiving amivantamab plus lazertinib. [b]Includes American Indian or Alaska Native, Black or African American, and multiple.
C, Cycle; D, Day; DM, dermatologic management; ECOG PS, Eastern Cooperative Oncology Group performance status; SoC, standard of care.

Primary endpoint

- In the first 12 weeks (primary endpoint), the incidence of grade ≥2 DAEIs was significantly lower with COCOON DM versus SoC DM (42% vs 75%, respectively; odds ratio, 0.24 [95% confidence interval (CI), 0.13–0.45]; *P*<0.0001; **Figure 2A**)
  - A significant reduction in the incidence of grade ≥2 skin DAEIs (excluding paronychia) was consistent across anatomic locations (**Figure 2B**)
  - The incidence of paronychia was comparable between arms in the first 12 weeks of treatment

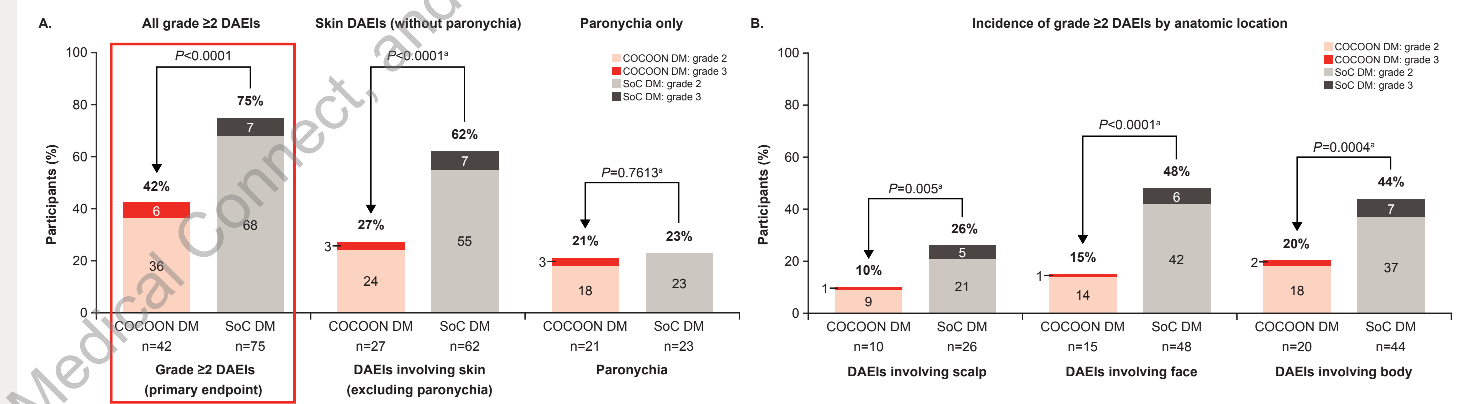
Antitumor efficacy

- The investigator-assessed objective response rate was 82% (95% CI, 73–89) in the COCOON DM arm and 75% (95% CI, 65–83) in the SoC DM arm among unconfirmed responders (**Figure 3**)

Prophylactic dermatologic intervention and reactive management

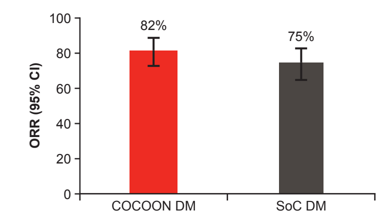
- In the SoC DM arm, 28% (28/100) of participants received some component of prophylactic dermatologic intervention (mostly sunscreen or moisturizing creams)
- Few participants received prophylactic antibiotics or antiseptics, including systemic tetracyclines (3%), topical doxycycline (1%), and chlorhexidine (3%)
  - 2% of participants received systemic doxycycline and 1% received systemic minocycline
- Participants in the SoC DM arm received the following reactive management for DAEIs: corticosteroids (83%), topical anti-infectives (67%), systemic antibacterials (61%; mostly tetracyclines [54%]), and emollients and antiseptics (38% each)
- In the COCOON DM arm, reactive management included: corticosteroids (57%), topical anti-infectives (53%), systemic antibacterials (35%; mostly tetracyclines [25%]), antiseptics (28%), and emollients (14%)

Figure 2: Incidence of grade ≥2 DAEIs in the first 12 weeks after initiation of amivantamab + lazertinib



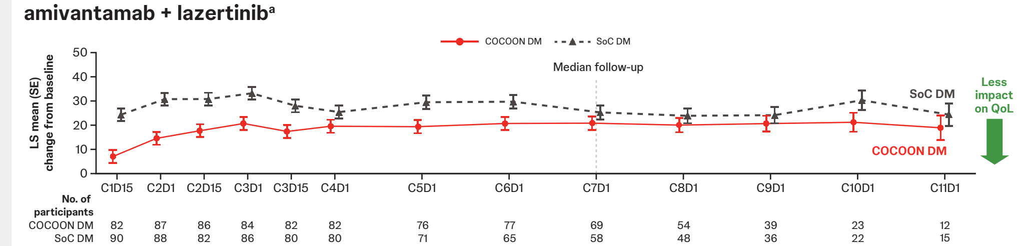
[a]Nominal *P* value.
DAEI, dermatologic adverse event of interest; DM, dermatologic management; SoC, standard of care.

Figure 3: ORR[a]



[a]Median follow-up was 7.1 months.
CI, confidence interval; DM, dermatologic management; ORR, objective response rate; SoC, standard of care.

Figure 4: Change from baseline in Skindex-16 total score in the first 12 months after initiation of amivantamab + lazertinib[a]



[a]Baseline in the graph corresponds to C1D1, with values of 0 for COCOON DM and SoC DM.
C, Cycle; D, Day; DM, dermatologic management; LS, least squares; QoL, quality of life; SE, standard error; SoC, standard of care.

Patient-reported outcomes

- Mean (standard error) Skindex-16 total scores at baseline were comparable in the COCOON DM and SoC DM arms (4.05 [1.01] vs 4.05 [1.02], respectively)
  - Skindex-16 measures the impact of skin conditions on quality of life, including 3 subscales: functioning, emotional, and symptoms
- Early separation in the least squares mean change from baseline in the Skindex-16 total score favored COCOON DM versus SoC DM (**Figure 4**)
  - Separation was maintained up to the median follow-up, even after prophylactic antibiotics were stopped (per protocol) in the COCOON DM arm

Safety

- The safety profile of amivantamab + lazertinib was consistent with previous studies, and no new safety signals were observed
  - Except for significantly fewer grade ≥2 DAEIs with COCOON DM, the safety profile was comparable between arms, including a similar incidence of infections and liver function alterations
    - Other than paronychia, infections were uncommon in both the COCOON DM and SoC DM arms; conjunctivitis (7% vs 10%, respectively) and upper respiratory tract infection (both 7%) were the most frequent infections
    - The incidence of grade ≥3 increased alanine aminotransferase (8% vs 5%) and aspartate aminotransferase (2% vs 1%) was similar in the COCOON DM and SoC DM arms, respectively
- VTE was reported in 13% of participants in both arms, with the majority being grade 1 or 2
  - The incidence of AEs related to per-protocol VTE prophylaxis was low (grade ≥3 bleeding was 1% during the first 4 months of treatment)
- Discontinuations and dose modifications of the COCOON DM components due to related AEs were rare, with interruptions, reductions, and discontinuations occurring in 8%, 3%, and 1% of participants, respectively
  - Interruptions of COCOON DM components due to related AEs were reported by 7 (7%) participants for doxycycline and/or minocycline and by 1 (1%) participant for clindamycin
- Interruption of amivantamab or lazertinib due to DAEIs was less frequent with COCOON DM versus SoC DM in the first 12 weeks (10% vs 23%, respectively) and throughout the study duration (22% vs 33%; up to the clinical cutoff date)

References

1. Cho BC, et al. *N Engl J Med*. 2024;391(16):1486–1498. 2. Yang JC-H, et al. Presented at: European Lung Cancer Congress (ELCC); March 26–29, 2025; Paris, France. 3. Li Y, et al. *Front Oncol*. 2022;12:804212.
4. Girard N, et al. Presented at: European Lung Cancer Congress (ELCC); March 26–29, 2025; Paris, France.

Lung Cancer

Presented by BC Cho at the World Conference on Lung Cancer (WCLC); September 6–9, 2025; Barcelona, Spain.