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COMMENTARY

Current and Future Perspectives of Health-Related Quality of Life in Resectable EGFR-Mutated Non-Small Cell Lung Cancer: A Podcast

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Transcript

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MM: Margarita Majem (medical oncologist)
DL: Diane Legg (patient advocate)

TJ: Hello. Welcome to this podcast on health-related quality of life in resectable EGFR-mutant non-small cell lung cancer current and future perspectives. My name is Thomas John, I'm a medical oncologist and researcher at the Department of Medical Oncology, Peter MacCallum Cancer Centre in Melbourne, Australia. I'm joined today by Dr. Margarita Majem who's a faculty member in the Department of Medical Oncology, Hospital de la Santa Creu in Barcelona, Spain, by Dr. Jonathan Goldman who's a researcher at the David Geffen School of Medicine, at the University of California in Los Angeles, USA, and also by Diane Legg who's an advocate for patients living with lung cancer and founder of LUNGSTRONG, which is based in Massachusetts, USA. So thank you for joining me to discuss health-related quality of life. I'm going to begin by asking Jonathan, what are the current treatment approaches for patients with early-stage, resectable non-small cell lung cancer?

JG: Thanks very much Tom, it's a pleasure to be part of this. For about a third of our patients with early-stage disease, which we define as stages I–IIIA, their optimal therapy is surgery [1] and we have found that giving additional therapy either before or after surgery can improve our ability to prevent the cancer from coming back. Most patients will proceed to surgery first and then get after surgery post-operative or sometimes called 'adjuvant' chemotherapy, usually with two drugs called a platinum-based chemotherapy for stages II and up to IIIA [2]. There are increasingly the utilization of pre-operative or neoadjuvant chemotherapy, especially chemotherapy with immunotherapy, for some patients [2–4]. However, for many, the standard remains surgery followed by chemotherapy [2]. Despite some significant advances, the outcomes remain poor [3–5] and there is significant and important research underway to try to improve the outcomes for our patients.

TJ: Thanks Jonathan. Margarita, what are the key challenges that are associated with these treatment approaches and what are the unmet needs in this setting?

MM: Well, the risk of lung cancer recurrence increases with increasing disease stage [5] and up to half of all patients with non-small cell lung cancer will see their cancer spread to other parts of their body, such as the liver, brain, or bone, which can have a negative impact on their health-related quality of life [6]. Researchers are therefore trying to find ways to reduce the chance of the cancer recurring and extend the 'disease-free' period after surgery, while maintaining their quality of life [7]. In addition to adjuvant chemotherapy, immunotherapy or targeted therapy is sometimes used to improve patient outcomes [2]. Targeted therapy involves identifying a genetic mutation in the tumor that caused the cancer, and then selecting a medication based on this mutation. EGFR mutations are the most common of these mutations in non-small cell lung cancer, observed in approximately 50% of Asian patients, and around 15 or 20% of non-Asian patients [8–10]. A trial called CTONG1104 investigated a first-generation EGFR-TKI called gefitinib that found that adjuvant gefitinib improved disease-free survival compared with chemotherapy, but not overall survival, when used for 2 years [11, 12]. There have since been other studies investigating newer EGFR-TKIs in this setting, [the] ADAURA trial is one of [the] key trials.

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TJ: Thanks Margarita and thank you setting the scene in terms of the ADAURA trial. This is a new trial and I might ask you Jonathan if you can take us through how this trial will influence the treatment landscape?

JG: The ADAURA trial is a phase III trial. We refer to it by its NCT number as NCT02511106 and it is an important trial looking at the efficacy and safety of an EGFR oral medication, an EGFR-TKI called osimertinib, and this trial looked at its use in the adjuvant setting [13]. Osimertinib was a significant step forward in our EGFR pills. It's the third generation of these drugs and it improved both the efficacy and the safety and tolerability compared to previous examples [14]. EGFR mutations are primarily one of two. An exon 19 deletion or a specific point mutation called L858R and together these are the vast majority, about 90% of EGFR mutations that we see in patients [15]. On ADAURA, patients had to have one of these two mutations [13]. Osimertinib was used in this setting because of its good ability to slow down or stop cancer growth [16]. It's ability to go throughout the body quite effectively, including into the brain, and its good tolerability [14, 17–20]. Some previous trials only used 1 to 2 years of EGFR therapy, but because osimertinib is so well tolerated for most patients [14, 17, 18], 3 years of treatment was feasible for many.

The trial looked at patients that had stage IB to IIIA lung cancer, and these patients had surgery completely removing their cancer. The patients could but [were] not required to receive chemotherapy; that decision was made by the treating doctor and the patient. Then, they were randomly assigned to either get osimertinib or a placebo. The patients were to take this for up to 3 years after surgery and were followed for cancer recurrence. Many of the patients on the ADAURA trial received chemotherapy, but it was not required and, therefore, the trial doesn't really address the specific efficacy of getting the chemotherapy and really, instead, addresses the question of receiving osimertinib or not, after surgery [13].

TJ: Thanks Jonathan. I totally agree with you. It certainly wasn't the assessment it was more a pragmatic design, and that is certainly a conversation that we have with patients that can often be difficult, and a lot of patients do decline chemotherapy based on a very small absolute benefit in overall survival. So I think that in some ways [this] probably explains why adjuvant chemotherapy wasn't mandated in the study. What about the actual efficacy findings from ADAURA? Can you take us through that?

JG: Sure, so the results were published about 2 years ago in October of 2020 in the [journal] *New England Journal of Medicine* and really it was … it was a … I'd say an overwhelmingly positive trial regarding this reduction in … in cancer recurrence [13]. For the primary set of patients [of] stage II and III, there was about an 80% reduction in cancer recurrence and one of the most exciting subsets was the identification that cancer recurrence to the brain was … was reduced quite significantly [13, 20]. About 10% of the patients that got placebo had recurrence to the brain, whereas only 1% of the patients on osimertinib did. Of course, this is a really important outcome for our patients and with brain recurrence patients often get surgery or radiation and being able to delay or avoid that I think is a really important outcome that we saw [13, 20]. So it was considered a positive trial across the board of patients studied.

TJ: Thanks Jonathan. Just on the brain metastases data, were there scans that were mandated as part of assessing brain metastases?

JG: That is a very important question. We wanted to make sure that the differences seen in the two arms of the trial were due to the treatment effect and not due to other differences, such as one group getting more scans than the other, for example. Brain imaging was required for all patients at the time of surgery, and then while they were on treatment it was body imaging of the chest and abdomen [that was] required on a specified schedule. Brain imaging was not required during that time, but if a patient had a new symptom, [for example] a headache or something similar, they could be ordered a scan by the treating physician. Also, if a patient was identified as having cancer recurrence, then at that time a brain scan was required. When we looked back and compared the two arms of the trial, we saw that brain imaging was similar on the two arms [13] and, therefore, we believe that the difference in the outcome between these arms was due to the treatment effect of the osimertinib, and not to another factor.

TJ: Thanks for clarifying that Jonathan. Margarita, what were the safety findings from the ADAURA primary analysis?

MM: In the ADAURA trial, the most common side effects (of any severity) experienced by patients who received osimertinib were diarrhea (46% vs 20%, with placebo), nail effects (25 vs 1%), dry skin (23 vs 6%), and itching skin (19 vs 9%). Side effects considered medically important, requiring hospitalization or significant treatment, were reported in 20% of patients who were treated with osimertinib and 13% of patients who were treated with placebo. The number of patients who stopped treatment due to side effects was low; 11% of patients who took osimertinib and 3% of patients who took placebo. Additionally, the side effects observed were consistent with what we already know about osimertinib in patients with advanced disease [13, 20].

TJ: Thanks Margarita. So I think it's important to summarize what both Jonathan and Margarita have taken us through so far. The ADAURA trial primary analysis has shown a very significant disease-free survival benefit and that was initially presented in 2020. We have more recently been updated with the disease-free survival analysis which was presented at the *European Society of Medical Oncology*

[congress] in Paris recently and this continues to show a significant benefit with the use of osimertinib compared to placebo and this is now with 2 further years of additional follow-up [21].

Of course, one of the questions many people are asking is how does this translate into overall survival? And we are anticipating further results to be presented, most likely in 2023. So there are several other studies that are ongoing and the treatment landscape is certainly expanding in the settings. For example, there are other trials investigating other EGFR-TKIs in the adjuvant setting. This includes the APEX trial, which is looking at aumolertinib (NCT04762459), and the ALCHEMIST trial, which was initially looking at erlotinib (NCT02193282), and the FORWARD trial, which is investigating furmonertinib (NCT04853342; Table 1 of the Electronic Supplementary Material [ESM]). Apart from erlotinib, these other agents are very similar to osimertinib. So it would certainly be interesting to see how they perform. Jonathan, can you take us through some of the previous studies that have looked at previous published data looking at other EGFR-TKIs?

JG: Absolutely, there have been a variety of trials over the years; some of them single arm looking only at patients receiving erlotinib or gefitinib and including trials even comparing gefitinib to chemotherapy. In general, they have shown an improvement in disease-free survival but not an improvement in overall survival. These include the EVAN trial (NCT01683175), the RADIANT trial (NCT00373425), and the CTONG1104 trial (NCT01405079), as well as IMPACT (UMIN000006252) and EVIDENCE (NCT02448797) [11, 12, 22–25].

TJ: Thank you. There's also some further information that is available in the actual paper in a supplementary table for those that are interested in looking through some of those studies (Table 1 of the ESM). What about using TKIs earlier, Margarita? Perhaps I can ask you whether you're aware of other studies that are looking at TKIs or even other agents in the earlier phase setting?

MM: Sure, Tom. There are some trials that are investigating the use of EGFR-TKIs in [the] neoadjuvant setting such as NeoADAURA (NCT04351555). That is a trial that is investigating the efficacy and safety of neoadjuvant osimertinib, with or without chemotherapy, given to patients whose tumor[s] are resectable and harbor an EGFR mutation. [The treatment] is given before surgery, which is called neoadjuvant treatment [26]. Also, neoadjuvant chemo and immunotherapy are being evaluated following the CheckMate 816 trial. In this study, it was shown that it could be an option for patients with non-small cell lung cancer, but probably this is not the best option for patients with EGFR mutation [27].

TJ: Thank you. So yes, there's certainly a lot of the studies that are being conducted in both neoadjuvant [and] also in the adjuvant setting as we've described. It's great to be able to discuss a little bit more about quality of life. Jonathan, why is it important to assess quality of life outcomes in patients with early-stage resectable lung cancer?

JG: So the perioperative setting is really a very interesting and exciting one and as we've just reviewed, really, perhaps the most active area in lung cancer research. I do think there's in some ways a double-edged sword, if you will, [in] that you know some of these patients are already cured. So we really don't want to cause significant side effects or impact on quality of life and we're seeing that some of these therapies need to be continued for months or years. So we want patients to be able to live their lives—that's what this is all about. At the same time, as a medical oncologist, being able to be [a] part of a potential cure for patients or significant delay in their cancer recurrence is really some of the most powerful ways that we can treat our patients. So, we want to draw that line or find that balance between an effective therapy and one that is well tolerated and doesn't degrade the quality of life [7].

TJ: Thank you. It's fantastic to be able to talk through this with Margarita who's the first author on the quality of life data from the ADAURA trial [28] and good to get some insights from you, Margarita, about the testing that was used and, in particular, there have been several questions that have been asked about why the particular questionnaire that was used in the ADAURA trial was chosen. Can you talk us through that?

MM: Thanks Tom. I think that this is a very important question regarding quality of life in ADAURA. It's important to underline that changes in quality of life can be caused by any reason other than cancer relapse or treatment side effects. The short form 36 item questionnaire (it's known as SF-36) is a generic non-cancer specific tool for assessing quality of life. This questionnaire uses 36 questions that combine into eight different domains that cover different aspects of both physical and mental functioning. The answers that patients give to the 36 questions are summarized into two overall scores, the physical and mental component summary scores. All eight domains contribute to both scores. The physical and mental component summary scores summarize the different ways that patients' diseases limit their everyday physical and social activities and well-being from a physical and mental health perspective [29]. It was anticipated that the data collected with this tool would provide a useful insight into the impact of adjuvant osimertinib treatment on social and emotional functioning [28].

Some peers questioned the use of a non-cancer specific questionnaire; however, as patients in ADAURA were disease-free after surgery, a generic tool such as SF-36 was deemed appropriate, as opposed to using a tool designed and validated for patients currently living with lung cancer [28]. Patients' survey responses were collected at the start of the

trial, at week 12 at week 24, and then every 24 weeks until the patient experienced recurrent disease, completed treatment, or met a discontinuation criterion [28].

TJ: Thanks Margarita. We'll go through the results of that shortly, but one of the questions I guess, and I'll ask you this Jonathan, was why didn't quality of life continue after the adjuvant treatment had ended? Why did it stop with disease recurrence?

JG: Yes, I do understand that. That's a frequent question. The design of the trial was to analyze the effect of quality of life from the adjuvant therapy, from the osimertinib [28]. So, when that therapy was stopped as planned at 3 years, or if an earlier event occurred [13], then there wouldn't be a value in understanding osimertinib with continued quality of life assessment. It's also very possible that at that point, several years after surgery and off of treatment, that there would be many other effects on quality of life that would be hard to evaluate and interpret [28].

TJ: Yes, thank you. So, I guess that what we are sort of saying here is this is a tool that was designed to assess general quality of life, not lung cancer specific quality of life.

Let's go through those results. What were the findings, Margarita?

MM: Yes, Tom. In summary, the SF-36 survey results showed that quality of life was maintained with osimertinib. The baseline physical and mental component summary scores were comparable between osimertinib and placebo and only slightly lower than those in the general population. This indicates that patients included in the ADAURA trial were highly functioning with only a small degree of quality of life impairment compared with the general population before starting treatment. Changes from baseline were calculated until week 96 to ensure a balanced comparison between both arms [28].

Physical and mental component summary scores were maintained to week 96. For the physical component summary score, mean change from the baseline at week 96 was 1.13 for osimertinib and 2.31 for placebo, resulting in a mean change of −1.18 for osimertinib. For the mental component summary score, mean changes from baseline at week 96 were 1.34 for osimertinib and 2.68 for placebo, resulting in a mean change of −1.34 for osimertinib. Both scores were less than what is considered a significant difference in patients' quality of life that is between 3–6 for [the] physical component summary score and 5–8 for [the] mental component summary score [29]. There were also no differences between treatment arms in time to deterioration of the physical and mental component summary scores due to any cause [28].

TJ: Thank you Margarita. So, it's good to have the actual data and it's good to reflect on it. And I think, as Jonathan mentioned earlier, you know we're treating patients for 3 years with an adjuvant treatment, whereas [there are] some of these patients who may not necessarily need this treatment; and so it is really important that quality of life is maintained in patients who are treated with osimertinib. We knew already from the stage IV context that this is a relatively well-tolerated treatment, but it is good to see now in the adjuvant context that this … but, well, by looking at quality of life domains in the SF-36 that quality of life is indeed maintained [28]. So, now we have not only good efficacy from ADAURA in terms of preventing relapse [13], and, hopefully, will see this translating into [a] more longer term survival advantage, but we are also quite confident in saying that quality of life is maintained [28].

Only a few other studies have really reported the effect of adjuvant treatment and different sorts of questionnaires have been used [30–32]. In the JBR.10 study, which looked at adjuvant cisplatin and vinorelbine, this actually resulted in a modest and temporary worsening of EORTC or [the] European Organisation of Research and Treatment of Cancer Quality of Life questionnaire, and this is the QLQ-C30 [30]. Now, we know that chemotherapy is certainly not as well tolerated as osimertinib is and so that dip in quality of life was certainly not unexpected, but it was felt that despite that given that there was a survival advantage to using adjuvant chemotherapy that this favored using chemotherapy despite the quality of life dip. Other chemotherapy regimens, such as gemcitabine with cisplatin and docetaxel with cisplatin, do not appear to have significantly negatively impacted on that same questionnaire (the QLQ-C30) in patients with stage IB to stage III lung cancer [31].

In the ADJUVANT or the CTONG1104 study, which we mentioned previously, [it] compared gefitinib, a first-generation EGFR-TKI, with chemotherapy, which was cisplatin plus vinorelbine. This actually showed improved scores across three quality of life instruments: so, functional assessment of cancer therapy, a lung cancer symptom scale, and a trial outcome index. And it was associated with a longer time to deterioration in quality of life [32]. Again, this is probably not that unexpected given that the comparator is chemo[therapy] and we know that using a targeted therapy is better tolerated than using chemotherapy. Jonathan, we did touch briefly about some of the studies that are ongoing, but specifically EGFR-mutant lung cancer. What are the ongoing studies that we're looking out for?

JG: The success, the positive results from the ADAURA trial have led to a few other trials. One of them is called ADAURA2. It's a follow-on study looking at smaller tumors. ADAURA2 is looking at the smaller tumors called stage IA, and there are IA2 and IA3, meaning they're between 1 and 3 cm in size and, again, patients will go through surgery and then be randomized to osimertinib or placebo for 3 years (NCT05120349).

There's also some exciting developments in the before surgery realm, the neoadjuvant therapies, and one of those

trials is called the NeoADAURA trial (NCT04351555) and this is looking at stage II–IIIB EGFR-mutated non-small cell lung cancer and, prior to surgery, they will get osimertinib, or chemotherapy, or both [26]. Lastly, there is a trial looking at the stage III patients that are not eligible for surgery. These patients currently get chemotherapy at the same time as radiation and the LAURA trial is looking at osimertinib after chemo[therapy] and radiation (NCT03521154). It will be very exciting to look for the results from those three trials.

TJ: Thank you Jonathan. So, we've taken you through the clinical aspects of the ADAURA trial, the efficacy and the quality of life, but what is perhaps even more important is being able to get the feedback and input from a patient advocate, and I'm very pleased to be able to discuss the results of ADAURA and the quality of life [data] from the ADAURA trial with Diane Legg, who I introduced previously. Perhaps, Diane, if you're able to begin by sharing your background and journey living with lung cancer?

DL: Thank you, I would like to [and] I'm really happy to be part of this project. In 2004, I was a senior account manager for General Electrics Plastics Division. I was married and the mother of three young boys aged 8, 6, and 1. At the time, lung cancer was not on my radar. I figured it was a disease that would never affect me or my family, but in the spring of 2004 a close family friend, who was also in her young 40s, also [a] mother of three, was diagnosed with advanced-stage lung cancer. And I thought it was a fluke, just bad luck. While she was in the fight of her life that August, I pulled a back muscle picking up my then almost 1-year-old and it literally floored me. I went to see a family practitioner who was not my primary care, my primary care was off that day, and she wanted to rule out a pulmonary embolism so she ordered a CAT scan. I had a CAT scan done. The doctor then on call asked me why I had a CAT scan and then also asked me if I had pneumonia recently or if I was a smoker. Both of which questions I answered no to. He said he didn't think it was like that big of a deal, but that I should follow up with a pulmonologist after the long weekend, it was a holiday weekend that particular day.

So, I did see a pulmonologist and that pulmonologist said that it did not look like a metastasis. I had no risk factors for this disease. Sent me home to take a heavy-duty antibiotic and told me to come back in a month or so to repeat the CAT scan. With everything that was going on with our friend, I went and got a second opinion. This pulmonologist told me that I was more likely to be struck by lightning than to get lung cancer. So, I was feeling pretty happy about those particular appointments. I did go back to the first pulmonologist about 4 weeks later and at that appointment he told me that it wasn't smaller; therefore, that they were going to do a biopsy. Four days later we got a call that we never were expecting and that I too had lung cancer. Because of the fact that we caught it incidentally and caught it early, the prognosis was very good and I was scheduled for surgery. I ended up having a lobectomy. They removed the upper lobe of my left lung and after surgery my surgeon told me that I was cured, that he cured me, and that I did not need to do any further therapy. My primary oncologist agreed with that decision, but we went to get a second opinion and that particular thoracic oncologist said that because I was borderline stage IA–IB, he highly recommended that we move forward with an adjuvant chemotherapy. Because I was only 42 years old and [had] three young boys I … my husband and I and my family we wanted to address this very aggressively and so I agreed to go ahead and do adjuvant therapy.

Unfortunately, my lung cancer re-occurred 2 years later, in both of my lungs, but, had I not done the adjuvant chemo[therapy], I would have thought that because I hadn't done that, that's why it came back. So at least when my lung cancer did come back, I felt like we had done everything that we had in our toolbox at the time to try to treat this lung cancer. Over the past 18 years, I have based my treatment decisions really on quality of life and also the effectiveness of treatments and also what was going on with my family at the time as well.

I am a chemist by education. My husband is a biologist so we're very into science also and always we're very interested in the research and helping [to] improve research, specifically for lung cancer. Since my surgery and adjuvant chemo[therapy], I then went on two separate clinical trials over the last 18 years. Although the two trials that I was on ultimately ended for me due to very poor and medically concerning side effects or progression, I feel that the trials really helped me get to where I am today. I will have had lung cancer for 18 years this next month, most of which have been stage IV. I also feel that the two trials that I was on helped with the research of lung cancer and moving forward. Today I'm on a standard-of-care treatment, a third-generation EGFR-targeted therapy.

TJ: Thank you Diane for sharing your story and how things have evolved. Having your perspective in … in this is … is incredibly relevant given that you've actually undertaken a lot of the therapies that we're discussing here with this trial. So given that, so you've heard the data that we've discussed so far with Jonathan and Margarita, what are your perspectives on the study? I mean you … you have had surgery, you've had chemotherapy, you've had these targeted therapies. Do you think the ADAURA trial assesses quality of life appropriately for you? Do you think it alters how you would think about using these therapies?

DL: I think as a lung cancer patient and also a patient advocate I think this trial is very exciting. I, you know, particularly for newly diagnosed patients that have an operable lung cancer that they have an opportunity to be able to go on a therapy that, although there are some side effects and some people may have more side effects, ultimately, it's a

very tolerable drug. And the fact that the study has shown an 80% reduction in lung cancer recurrence [13] is really amazing because anybody that is living with lung cancer, whether you were diagnosed at surgery and are now cancer free, the thought and idea of it returning and reoccurring is always in the back of these patients' minds. So, I think that it's a great study. I think it's really promising, and I think that, like I said, I just think I'm really pleased to see where this research is going and how this particular trial, I think, will ultimately change lives.

TJ: Thank you. I guess this is a bit more of a clinical question asking you to take a step back from your own personal journey. Because one of the criticisms of the study so far is that we have reported disease-free survival and we do not have overall survival and certainly a criticism has been, what does disease-free survival mean? We've sort of touched on it previously but what are your thoughts on this as an endpoint? People I guess are saying well what's the difference between using this now to prevent the cancer recurring versus using it once the cancer has come back. There are obviously … it's a different context and it's a different cost to the treatment ultimately. Do you have any thoughts on that?

DL: I think it's a very interesting question and I could see why there might be some controversy or, you know, why … why this is even a question. I understand that, however, the findings of the trial with having this 60–80% reduction depending on which stage you are in reoccurrence is significant versus the placebo [13]. So, I do think it's very beneficial for lung cancer patients, I think, when doctors sit down and explain this particular trial to patients, you know, this discussion is a really good one for them to have with their doctor to understand if this is beneficial for them. I mean I think there's a lot of different reasons why maybe one patient or another may not want to go on a trial, but, I think in this case, I think that the numbers really speak for themselves. If the percent reduction was a lot lower than 60–80% then I could understand that question, but I think that these numbers really are very significant in my mind.

TJ: Thank you. Also, again an unfair question about the questionnaire. So that, I'm asking you this because there was again criticism that we didn't use a lung cancer-specific questionnaire in this study. So, this is a very general assessment, you know, the thought was that these patients do not have lung cancer so you can't really use the lung cancer-specific symptom scale. Do you think the quality of life tool that we've used is okay for you? Do you think it's reasonable to use it, given this quality of life data?

DL: I think that this particular quality of life survey seems very appropriate, and I am not a quality of life survey expert so I can't really say that but what … but for my mind where I'm coming from is that these patients [in ADAURA] that are taking osimertinib is they do not have lung cancer today, they are cancer free. And you're comparing quality of life for someone who does not have cancer to someone who does not have cancer but is taking a[n] adjuvant therapy. So, in my mind I think that, that particular quality of life survey makes sense to me.

TJ: Thank you. I might summarize now what we've discussed so far. So, I think it's really wonderful to actually to be able to talk to you Diane and get your … your personal input into what this data means. I think these data are … are telling us as clinicians that there is certainly a significant disease-free survival benefit [13]. But, importantly, the quality of life data is telling us that these patients want to live as normal a life as possible even while they're on a therapy to reduce the risk of disease recurrence and the quality of life data from ADAURA do support this. Quality of life was maintained with adjuvant osimertinib for stage IB to stage IIIA EGFR-mutant lung cancer [in patients who] were disease-free after complete resection, with or without adjuvant chemotherapy, and it supports this as a new treatment in this setting [28].

Alongside these improved treatments, such as osimertinib, I think it's important that we continue to have ongoing dialogue and communications. Certainly not everyone tolerates osimertinib well and there are some patients who needed to reduce the dose or to actually even come off [the treatment]. This was actually a minority and I think overall with the disease-free survival data [13] and the quality of life data [28] they strongly support using osimertinib in this context.

So, with that I'd like to thank you all for listening to this podcast. Specifically, I'd like to thank Dr. Goldman and Dr. Majem for joining me and [I am] really very grateful to have insights from Diane who's shared her personal journey with us. Thank you very much for doing that. I hope you've gained some insights into the [ADAURA] study, [and] into the quality of life aspects of the study.

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