ASCO Update 2026

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Disclosure

- No Conflicts

Objectives

At the end of this presentation participants will be able to:

1. Identify recently presented efficacy data that may impact the standard of care
2. Describe patient populations that should be considered for these new treatments
3. Recognize the potential toxicity associated with these new treatments

Pre Q1. Which of the following is true about treatment of Pancreatic Cancer Patients?

a. Immunotherapy is replacing cytotoxic chemotherapy
b. A novel TKI is replacing cytotoxic chemotherapy
c. Sequencing therapy makes this a chronic disease
d. Cytotoxic chemotherapy is highly effective

Pre Q2. Which of the following is true about adjuvant NSCLC treatment?

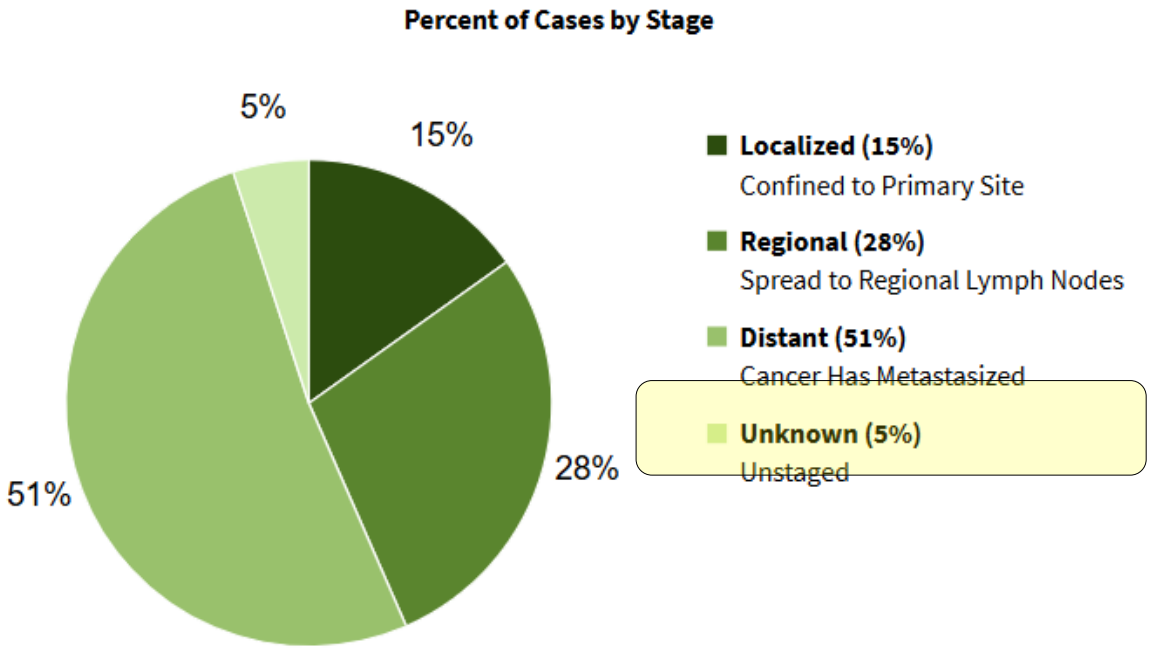
a. Adjuvant therapy of any type provides minimal to no OS benefit
b. Antibody directed cytotoxic therapy has expanded into adjuvant NSCLC therapy
c. An adjuvant RET inhibitor appears to be a significant improvement
d. Adjuvant TKI therapy beyond EGFR and ALK inhibitors has failed to show promise

Another step in Personalized Treatment

Outline and trials discussed

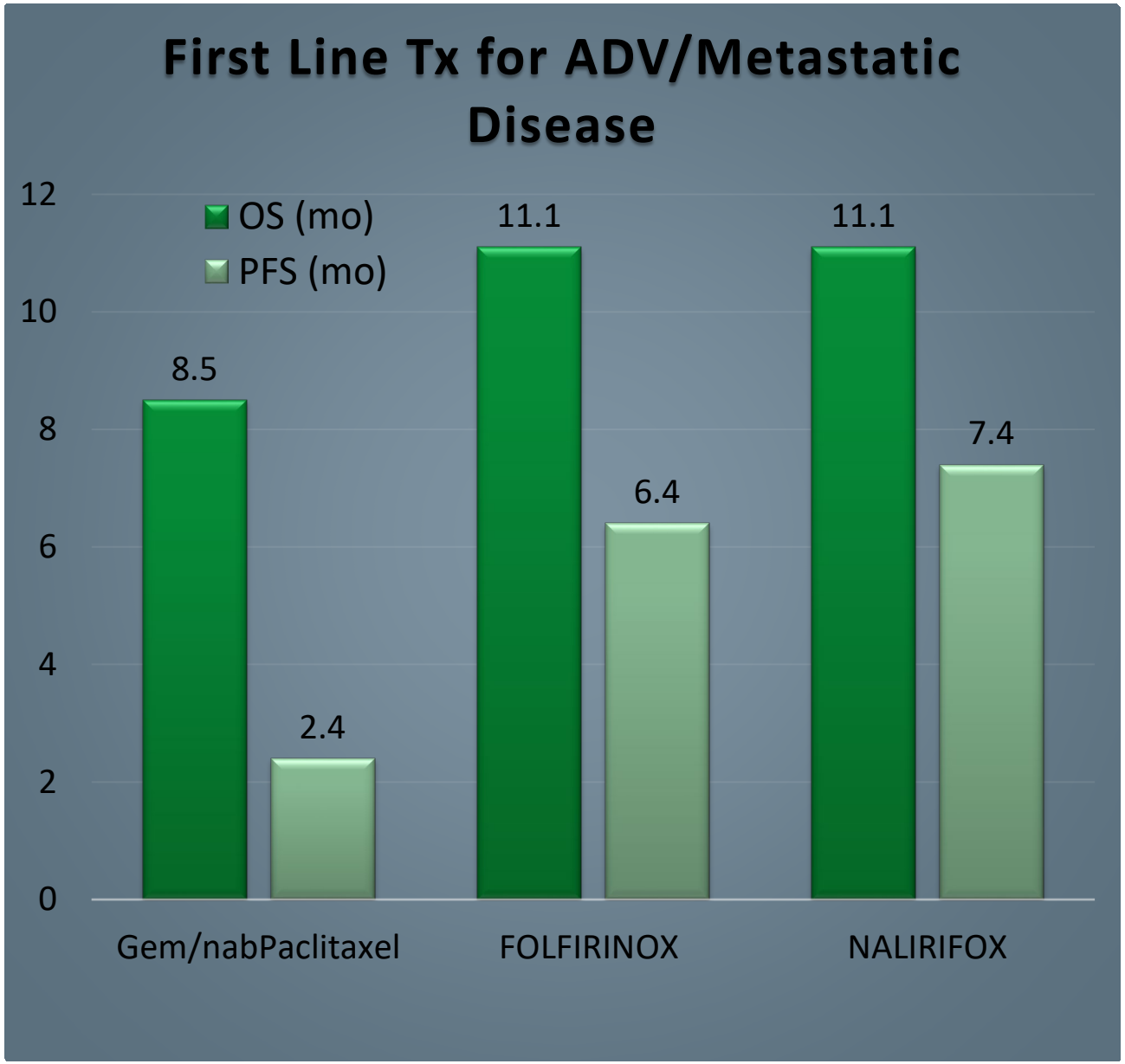
- Pancreatic Cancer: Daraxonrasib (RASolute 302 trial)
- Lung Cancer: Adjuvant Selpercatinib for RET+ NSCLC (Libretto-432), Ivonescimab plus chemotherapy (HARMONi-6)
- Breast Cancer: Adjuvant Girecestrant (LidERA)
- Colorectal Cancer: Encorafenib + cetuximab + FOLFIRI (Breakwater)
- Treatment De-escalation: Chemotherapy avoidance for N+ high risk breast cancer patients (OPTIMA), 3 months of adjuvant CRC therapy instead of 6 months based on ctDNA (GALAXY ctDNA Insight)

Pancreatic Cancer



Median OS from 2nd line treatment is ~ 4 months

Preferred 2nd line therapy is clinical trial



https://seer.cancer.gov/statfacts/html/pancreas.html, N Engl J Med 2013;369:1691-1703, N Engl J Med 2011;364:1817-1825, Lancet 2023;402(10409):1272-81

Pancreatic Cancer – RASolute 302

2nd Line pancreatic ductal carcinoma

Previously treated mPDAC

Stratified by:

- Performance status (0 or 1)
- Presence of Mets at original Dx
- Liver metastases
- Ras mutational status (G12, G13, or Q61, or none identified)

Daraxonrasib 300 mg po daily

N=248

Investigator's Choice of:

Gem/nab-Paclitaxel Or

5FU based regimen

N=252

Primary objective: RAS G12-mut - PFS and OS

Secondary objectives: PFS, OS, ORR

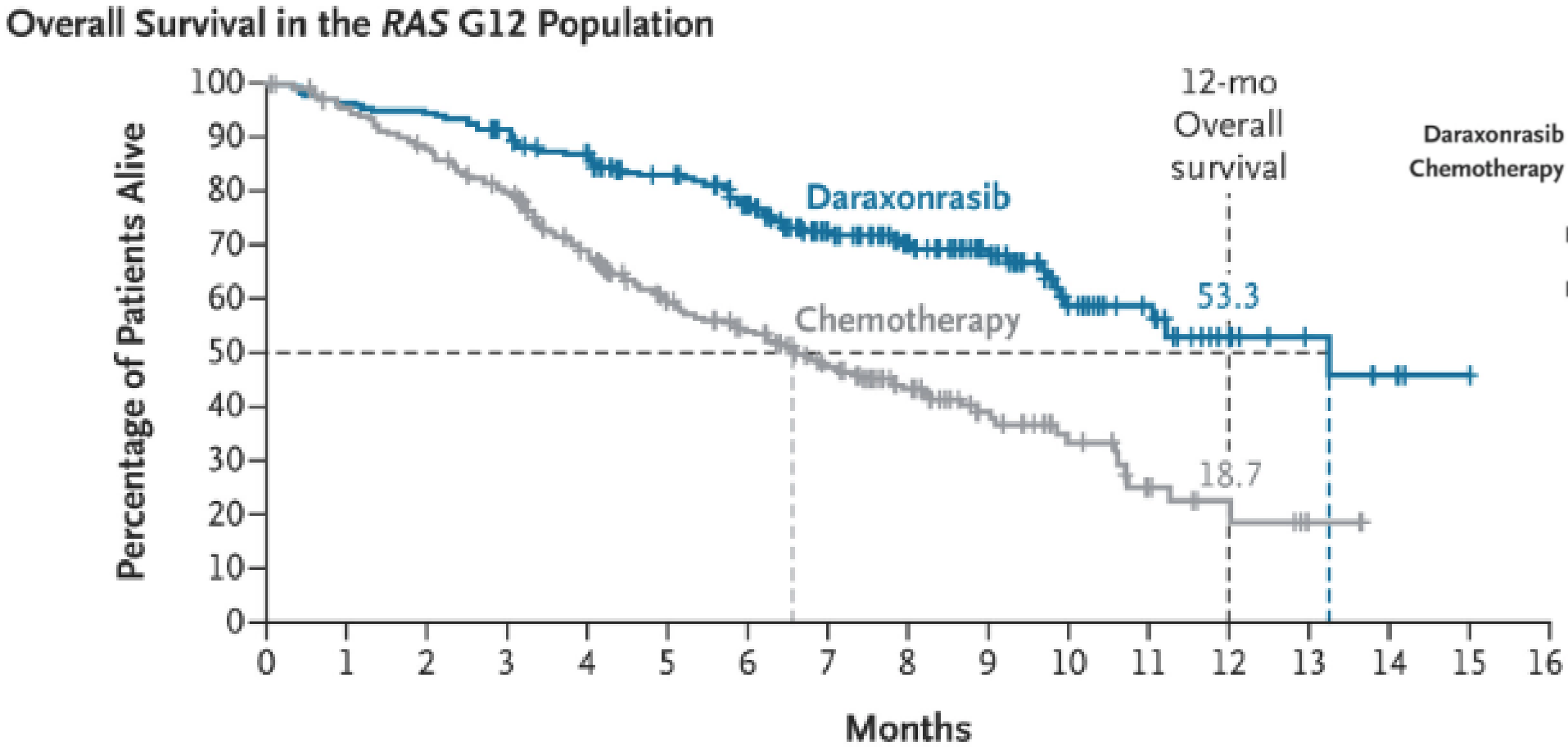
N Engl J Med 2026 (online) DOI: 10.1056/NEJMoa2605555

Demographics – RASolute 302

Characteristic		Daraxonrasib (n = 248)	Chemotherapy (n = 252)
Mean age, yr		**66 (30-88)**	**65 (36-86)**
Women		47%	43%
Race:	White	69%	66%
	Asian	12%	11%
	Black	3%	6%
ECOG PS	0	52%	47%
	1	48%	53%
Prior Regimen:	FOLFIRINOX	40%	42%
	Gem/nabPaclitaxel	38%	37%
	NALIRIFOX	2%	1%
Prior Whipple Procedure		23%	22%
Liver Metastases		70%	70%
RAS Mutation:	G12D or G12V	79%	78%
	other G12 mut	13%	14%
	G13 or Q61 or None	8%	8%

N Engl J Med 2026 (online) DOI: 10.1056/NEJMoa2605555

Overall Survival – RASolute 302 (primary endpoint)



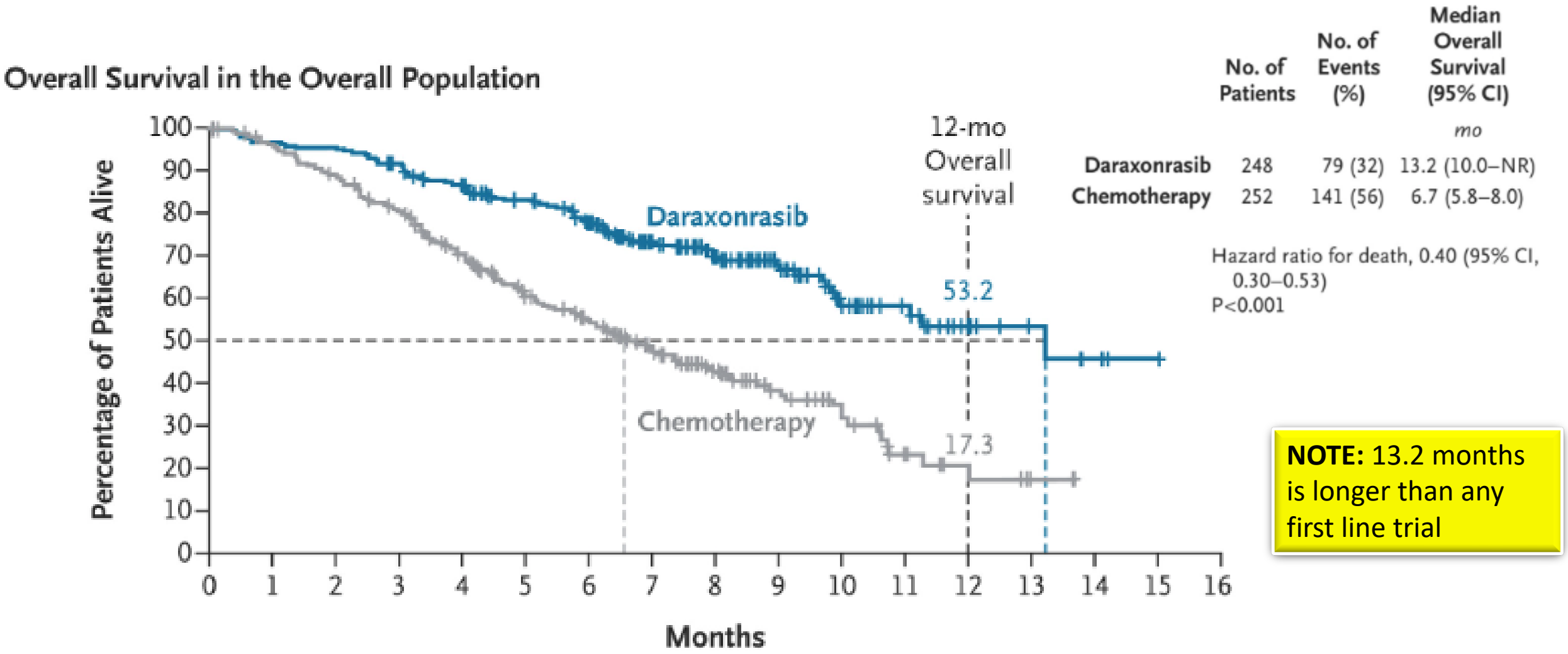
	No. of Patients	No. of Events (%)	Median Overall Survival (95% CI)
			mo
Daraxonrasib	228	72 (32)	13.2 (10.0–NR)
Chemotherapy	231	127 (55)	6.6 (5.4–8.2)

Hazard ratio for death, 0.40 (95% CI, 0.30–0.54)
P<0.001

NOTE: 13.2 months is longer than any first line trial

N Engl J Med 2026 (online) DOI: 10.1056/NEJMoa2605555

Overall Survival – RASolute 302 (ALL pts)



NOTE: 13.2 months is longer than any first line trial

N Engl J Med 2026 (online) DOI: 10.1056/NEJMoa2605555

Toxicity (select common) – RASolute 302

Event	Daraxonrasib (n = 241)	Chemotherapy (n = 214)
Any (grade 3/4/5)	**10% (62%)**	**98% (70%)**
AE leading to discontinuation	1%	11%
Rash all grades (grade 3+)	86% (14%)	6% (0%)
Diarrhea all grades (grade 3+)	58% (5%)	40% (7%)
Stomatitis all grades (grade 3+)	53% (12%)	17% (3%)
Nausea all grades (grade 3+)	47% (2%)	40% (2%)
Fatigue all grades (grade 3+)	23% (4%)	44% (6%)
Anemia all grades (grade 3+)	18% (4%)	40% (16%)
Neutropenia all grades (grade 3+)	8% (2%)	38% (28%)
ALT all grades (grade 3+)	10% (2%)	10% (1%)

N Engl J Med 2026 (online) DOI: 10.1056/NEJMoa2605555

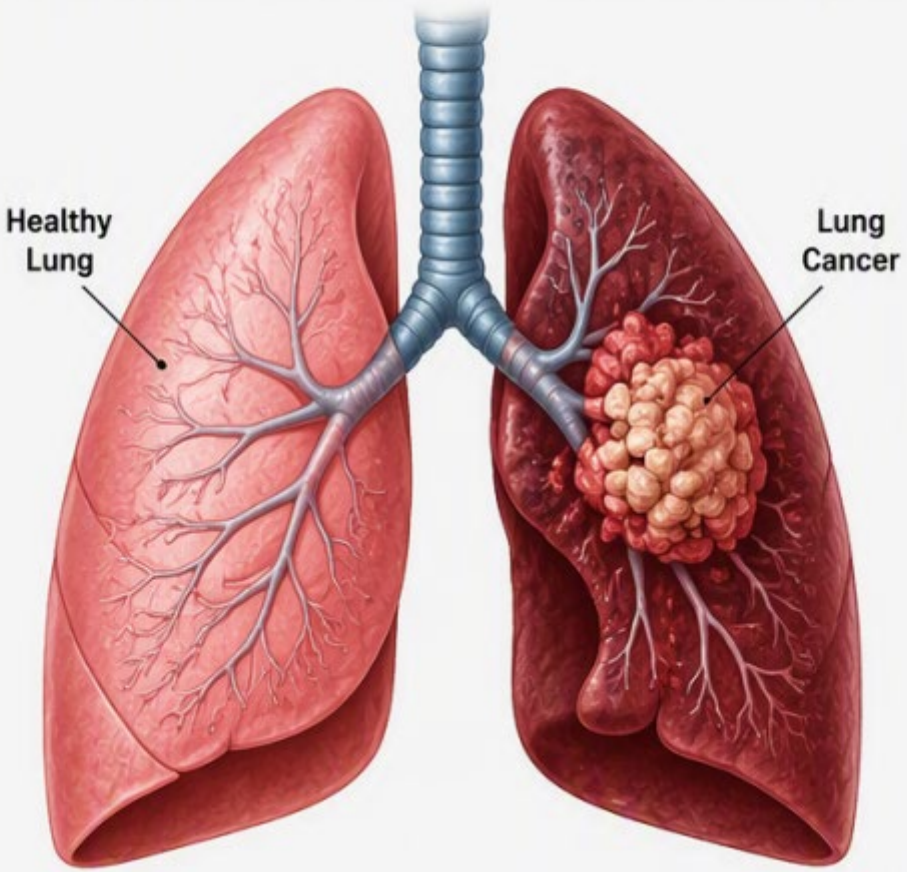
Daraxonrasib is being reviewed by the FDA

Stay Tuned for Limitations: line of therapy or genetically restricted?

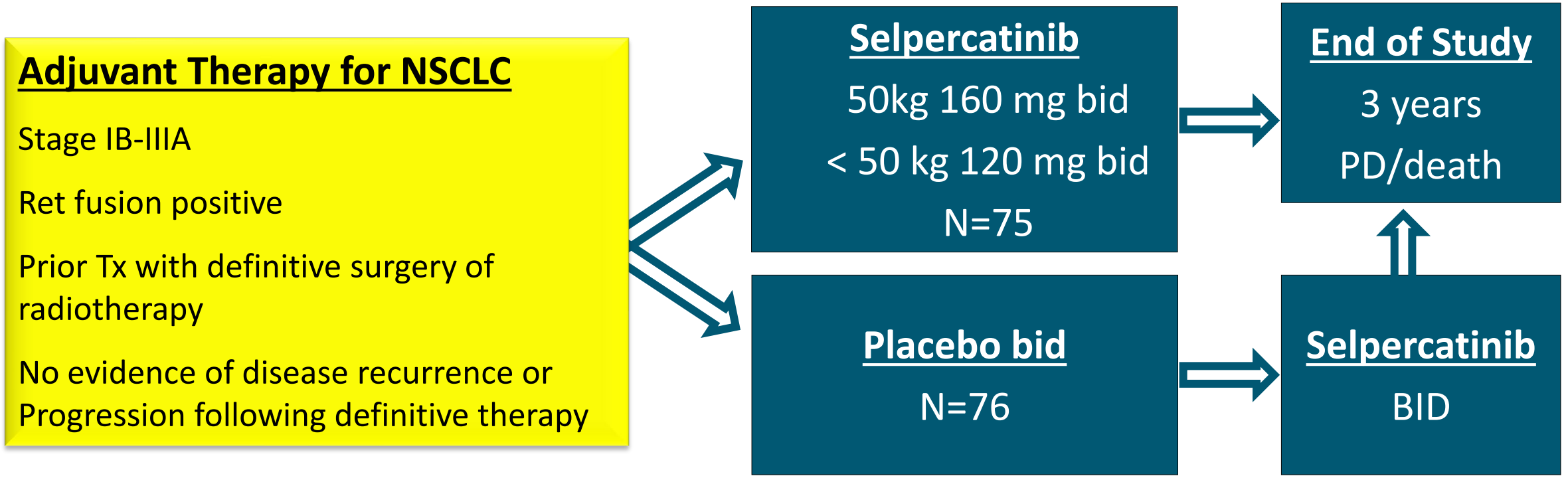
RASolute 302

LUNG CANCER

KNOW IT. DETECT IT. TAKE ACTION.



RET mutated NSCLC – LIBRETTO-432 Trial

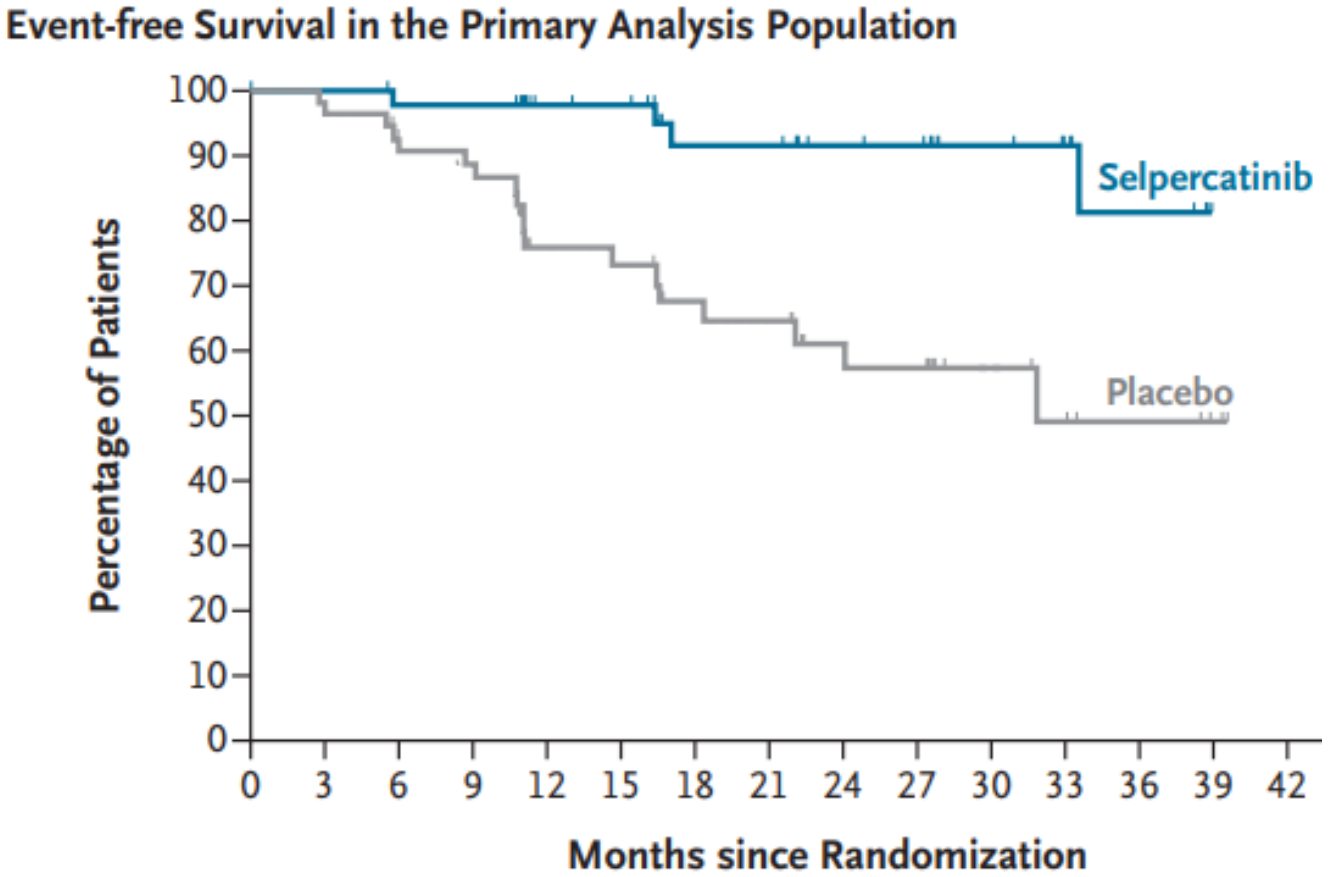


Primary objective: EFS in stage II-IIIa RET fusion + patients

Secondary objectives: EFS in all patients, Safety and Tolerability

NEJM 2026; Online DOI: 10.1056/NEJMoa2602628 – Schema from protocol in the appendix

RET mutated NSCLC – LIBRETTO-432 Trial



Investigator-assessed EFS (stage II–IIIA)

	Selpercatinib (n=54)	Placebo (n=55)
Events, n	4	19
24-month EFS, rate (95%CI)	**92% (75.4, 97.2)**	**61% (44.2, 74.3)**
HR (95%CI); p-value	**0.17** (0.058, 0.509); 0.0003	

Investigator-assessed EFS (stage IB–IIIA)

	Selpercatinib (n=75)	Placebo (n=76)
Events, n	4	20
24-month EFS, rate (95%CI)	**94% (81.5, 98.0)**	**70% (55.5, 80.1)**
HR (95%CI); p-value	**0.16** (0.056, 0.485); 0.0002	

NEJM 2026; Online DOI: 10.1056/NEJMoa2602628

RET mutated NSCLC – LIBRETTO-432 Trial

- **Key results (cont.)**

TEAEs, n (%)	Selpercatinib (n=75)	Placebo (n=76)
Any	75 (100)	74 (97.4)
Grade ≥3	50 (66.7)	18 (23.7)
Led to study treatment discontinuation[a]	13 (17.3)	1 (1.3)
Led to dose modifications	66 (88.0)	35 (46.1)
Dose interruptions	58 (77.3)	20 (26.3)
Dose reductions	41 (54.7)	6 (7.9)
Serious in ≥1	17 (22.7)	10 (13.2)
Serious led to discontinuation	2 (2.7)	1 (1.3)

	Selpercatinib (n=75)		Placebo (n=76)	
TEAEs, n (%)	Any Grade	Grade ≥3	Any Grade	Grade ≥3
Patients with ≥1 (≥20%)	75 (100)	50 (66.7)	74 (97.4)	18 (23.7)
ALT increased	47 (62.7)	13 (17.3)	14 (18.4)	1 (1.3)
AST increased	45 (60.0)	14 (18.7)	12 (15.8)	2 (2.6)
Diarrhea	29 (38.7)	3 (4.0)	13 (17.1)	0
Dry mouth	30 (40.0)	0	12 (15.8)	0
Cough	20 (26.7)	0	18 (23.7)	0
Bilirubin increased	20 (26.7)	1 (1.3)	11 (14.5)	0
Hypertension	23 (30.7)	8 (10.7)	8 (10.5)	2 (2.6)
Constipation	17 (22.7)	0	10 (13.2)	0
Hyperuricemia	15 (20.0)	0	8 (10.5)	0

- **Conclusions**
  - In patients with stage IB–IIIA RET fusion-positive NSCLC, adjuvant selpercatinib significantly prolonged EFS versus placebo with a safety profile consistent with prior findings

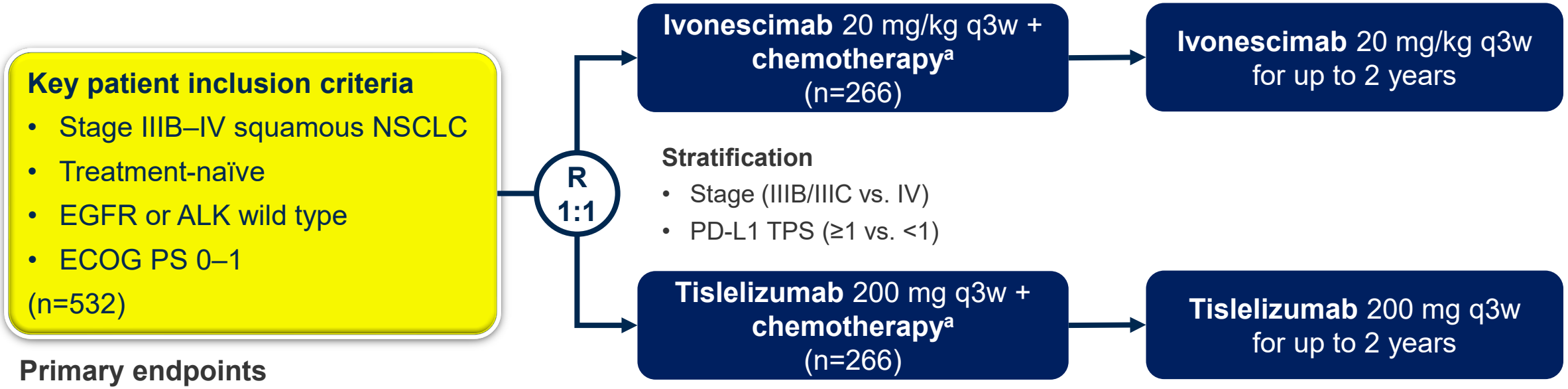
[a]Most common reason for selpercatinib discontinuation: ALT increased (n=4); AST increased (n=2); interstitial lung disease (n=2).

Goldman JW, et al. J Clin Oncol 2026;44(suppl):Abstr LBA3

Adjuvant Selpercatinib is arguably a new SOC for early stage resected RET+ NSCLC

Adv/Met Squam NSCLC - HARMONi-6 trial

- **Study objective**
  - To evaluate OS at a pre-specified interim analysis with 1L ivonescimab + chemotherapy vs tislelizumab + chemotherapy in patients with advanced squamous NSCLC



Primary endpoints

- PFS (IRRC, RECIST v1.1)

Secondary endpoints

- OS, PFS (investigator-assessed), ORR, DCR, DoR, TTR, safety

Ivonescimab: A bispecific mab that binds VEGF and PD1

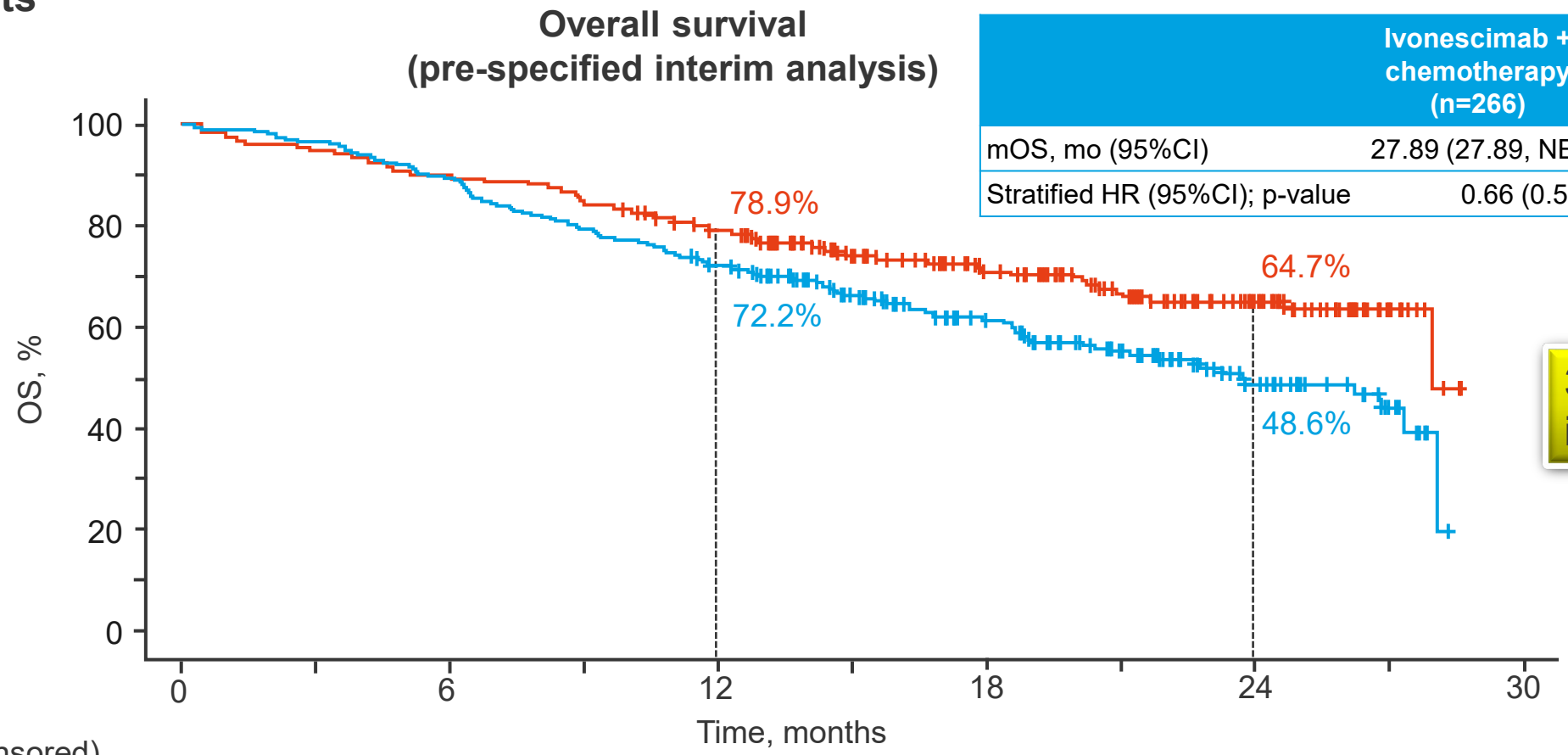
Tislelizumab: An anti-PD1 mab

[a]Carboplatin AUC5 q3w + paclitaxel 175 mg/m^2 q3w (up to 4 cycles).

Lu, S, et al Lancet 2026; 407: 2620–29

Adv/Met Squam NSCLC - HARMONi-6 trial

- **Key results**



	Ivonescimab + chemotherapy (n=266)	Tislelizumab + chemotherapy (n=266)
mOS, mo (95%CI)	27.89 (27.89, NE)	23.69 (20.11, NE)
Stratified HR (95%CI); p-value	0.66 (0.50, 0.87); 0.0017	

3 mo OS improvement

Median follow-up: 21.36 months.

Lu, S, et al Lancet 2026; 407: 2620–29

Adv/Met Squam NSCLC - HARMONi-6 trial

- **Key results (cont.)**

AEs, n (%)	Ivonescimab + chemotherapy (n=266)	Tislelizumab + chemotherapy (n=265)
TRAE	264 (99.2)	263 (99.2)
Grade ≥3	184 (69.2)	156 (58.9)
Serious	**110 (41.4)**	**91 (34.3)**
Led to treatment discontinuation	14 (5.3)	12 (4.5)
Led to death	10 (3.8)	11 (4.2)
Grade ≥3 irAE	34 (14)	36 (14)

TRAEs occurring in ≥15% of patient, %	Ivonescimab + chemo		Tislelizumab + chemo	
	All grade	Grade ≥3	All grade	Grade ≥3
Alopecia	66.2	-	61.5	-
Anemia	57.1	7.1	60.8	4.9
Neutrophil count decreased	47.0	32.3	44.5	26.0
White blood cell count decreased	38.0	10.9	37.0	9.4
Proteinuria	34.2	4.5	18.7	-
Platelet count decreased	32.3	3.0	28.3	3.0
Hypoesthesia	28.2	-	26.0	-
Appetite decreased	25.6	2.3	25.7	0.8
ALT increased	22.6	0.8	23.0	0.4
AST increased	21.1	1.1	19.6	1.9
Pain in extremity	19.9	1.1	14.0	0.4
Hypertriglyceridemia	19.5	1.9	14.7	2.3
Hypoalbuminemia	19.5	-	11.7	-
Hypothyroidism	18.8	0.4	14.3	-
Hyperuricemia	16.9	0.4	18.7	-
Nausea	16.2	0.8	20.0	-

- **Conclusions**

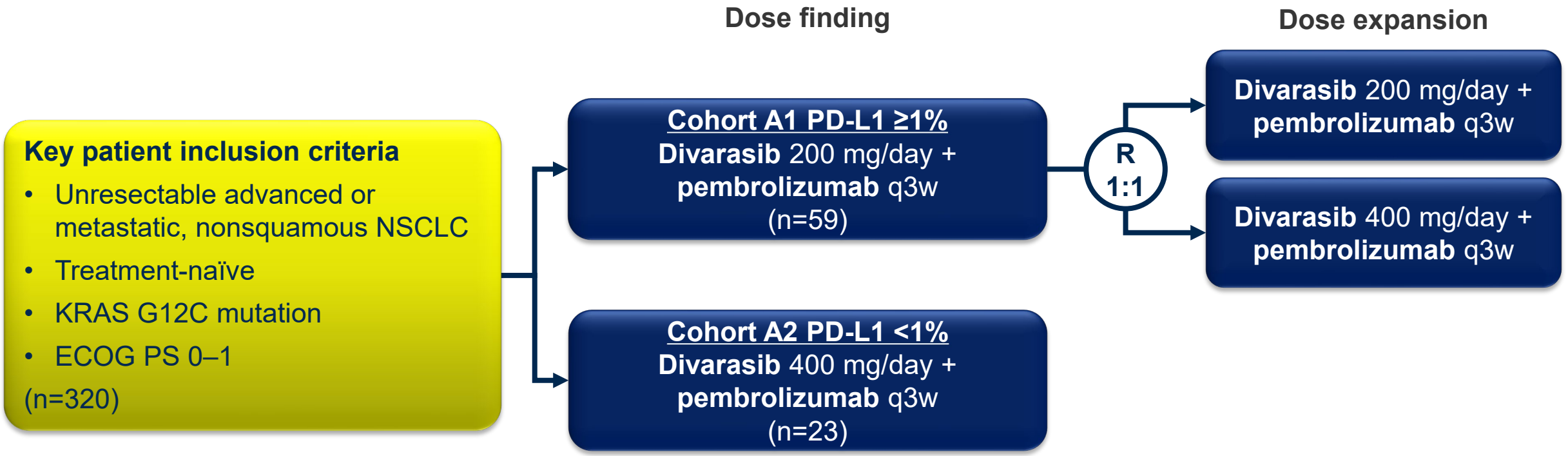
This bispecific antibody appears safe and effective in Squamous histology NSCLC, albeit with increased toxicity

Lu, S, et al Lancet 2026; 407: 2620–29

Bispecific PD1/VEGF combined with chemotherapy for Squam NSCLC is Coming

RAS G12C mut NSCLC - Krascendo-170 Trial

- **Related Background**
  - 1st line Sotorasib + chemo – ORR 65% PFS 11mo.



Primary endpoint

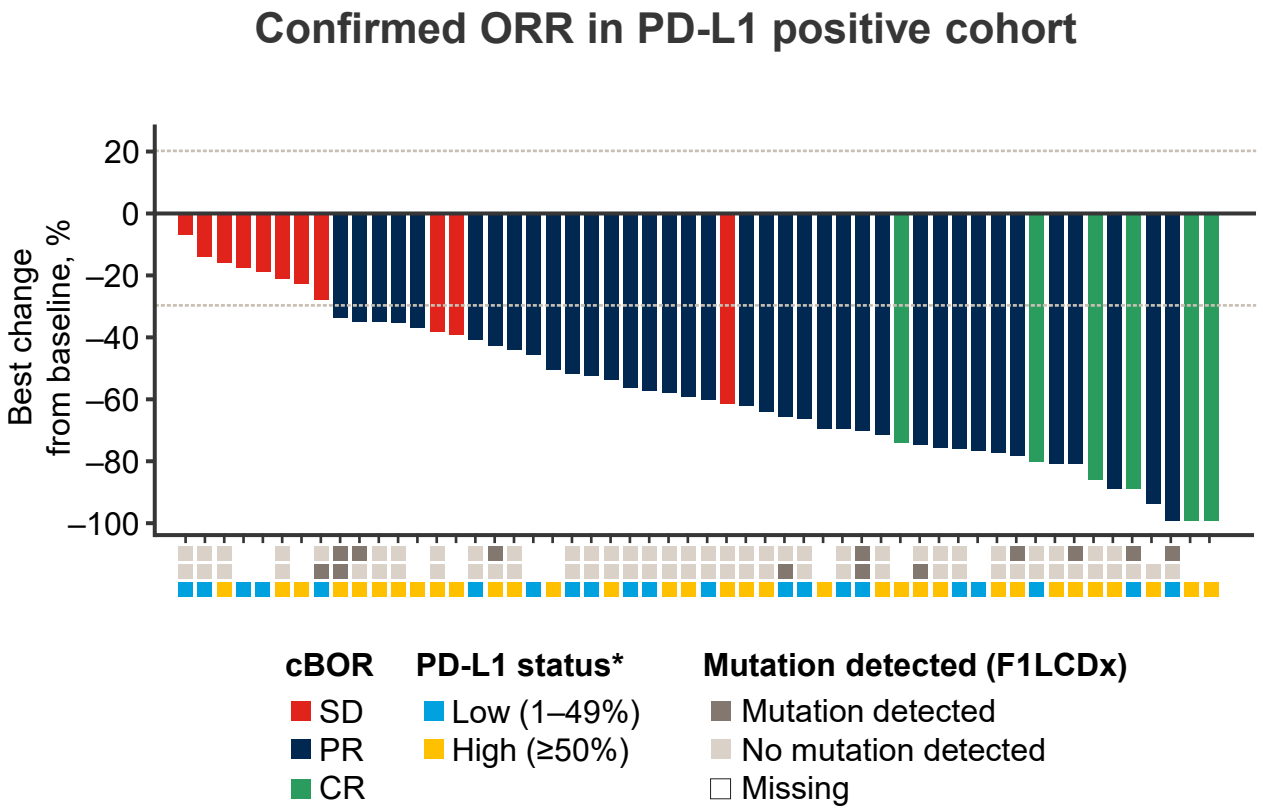
- Safety

Secondary endpoints

- ORR, PFS, DoR, PK, PRO

RAS G12C mut NSCLC - Krascendo-170 Trial

- **Key results**



PD-L1 positive cohort	Divarasib + pembrolizumab (n=59)
Confirmed **ORR**, n (%) [95%CI]	43 (**72.9**) [59.7, 83.6]
BOR, n (%)	
CR	6 (10.2)
PR	37 (62.7)
SD	11 (18.6)
NE	5 (8.5)
Median time to first response, days (range)	43 (36–164)
Median DoR, mo (95%CI)	NE (14.5, NE)
mPFS, mo (95%CI)	19.3 (12.4, NE)
6-mo PFS rate, % (95%CI)	83.5 (73.6, 93.3)

Skoulidis F, et al. J Clin Oncol 2026;44(suppl):Abstr 8510

RAS G12C mut NSCLC - Krascendo-170 Trial

- **Key results (cont.)**

PD-L1 negative cohort	Divarasib + pembrolizumab (n=23)
Unconfirmed **ORR**, n (%) [95%CI]	16 (**69.6**) [47.1, 86.8]
BOR, n (%)	
PR	16 (69.6)
SD	4 817.4)
PD	1 (4.3)
NE	2 (8.7)
Median time to first response, days (range)	40.5 (36–120)

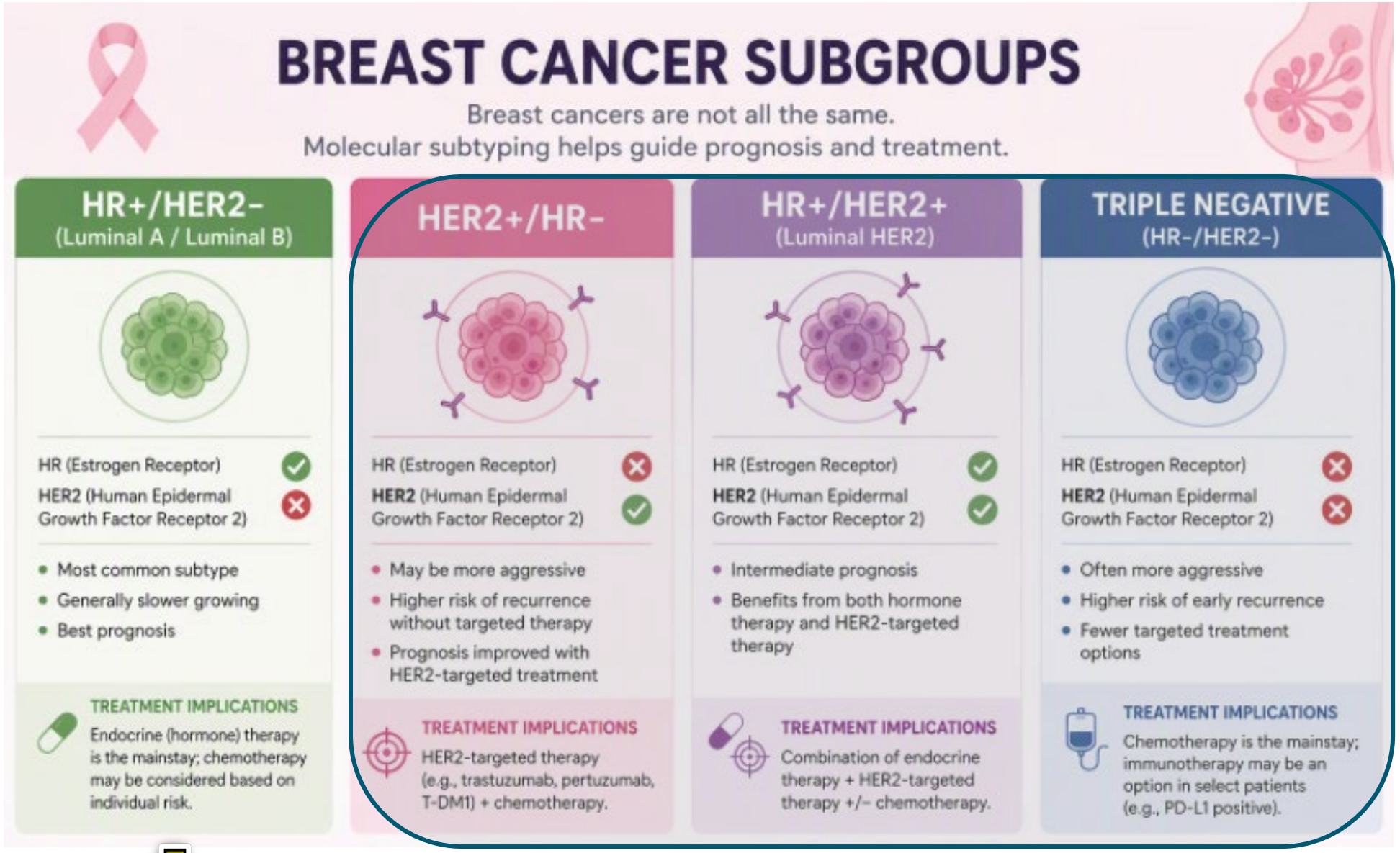
Safety in Cohorts A1 and A2, n (%)	Divarasib + pembrolizumab (n=78)[a]
Any grade AE	78 (100)
Grade ≥3	60 (76.9)[a]
Serious	39 (50.0)
Any grade TRAE	77 (98.7)
Grade 3–4	51 (65.4)
Serious	22 (28.2)
Led to divarasib dose reduction	41 (52.6)
Led to dose interruption	54 (69.2)
Led to study treatment discontinuation	10 (12.8)

TRAEs occurring in ≥20% in Cohorts A1 and A2, n (%)	Divarasib + pembrolizumab (n=78)	
	Any grade	Grade 3–4
Diarrhea	58 (74.4)	14 (17.9)
Nausea	50 (64.1)	1 (1.3)
Vomiting	36 (46.2)	1 (1.3)
ALT increased	41 (52.6)	18 (23.1)
AST increased	38 (48.7)	14 (17.9)
Lipase increased	23 (29.5)	7 (9.0)
Appetite decreased	24 (30.8)	0
Amylase increased	16 (20.5)	3 (3.8)

- **Conclusions**
  - In patients with advanced KRAS G12C-mutant NSCLC, 1L divarasib + pembrolizumab demonstrated encouraging antitumor activity across PD-L1 subgroups with a manageable safety profile

[a]Four patients had grade 5 AEs.

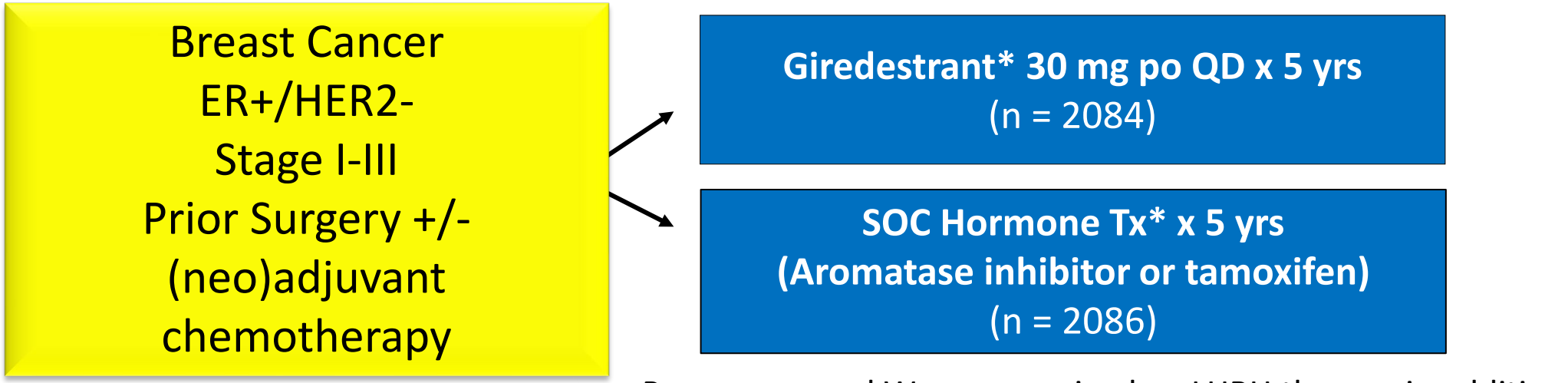
Second Generation KRAS G12C inhibitors combined with ICI for NSCLC is Coming



Improvement on Aromatase Inhibitors or Tamoxifen?

Adjuvant Hormone Therapy – LidERA

- Multicenter, open-label, randomized global phase III study



Premenopausal Women received an LHRH therapy in addition

- **Primary endpoint:** Invasive Disease-Free Survival (IDFS)
- **Key secondary endpoints:** Distant Recurrence-Free Interval (DRFI), safety and tolerability

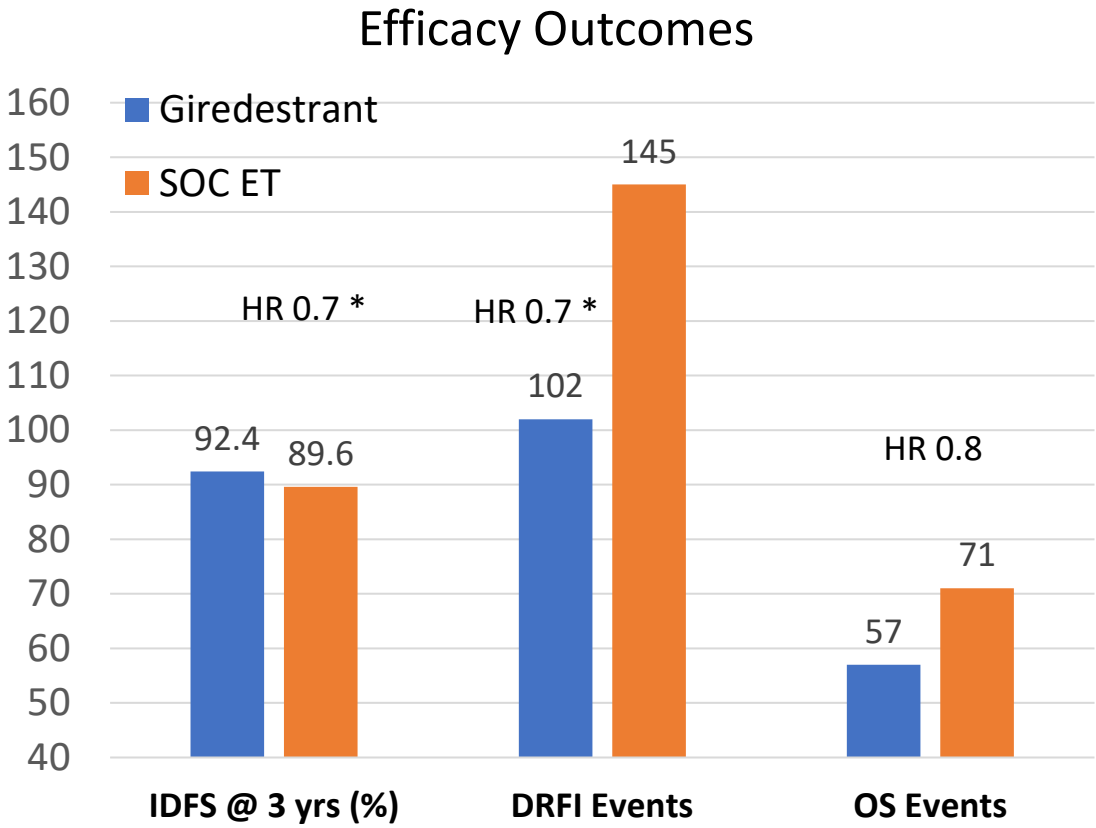
NCT04961996. Schmid. ASCO 2026. Abstr 502. DOI: 10.1200/JCO.2026.44.16_suppl.502

Adjuvant Hormone Therapy – LidERA Interim Analysis

After a median F/U of 32.3 months.

- Median Age 54 yrs; 59% postmenopausal
- Stage: I = 13%, II = 47%, III = 40%
- Most common AEs

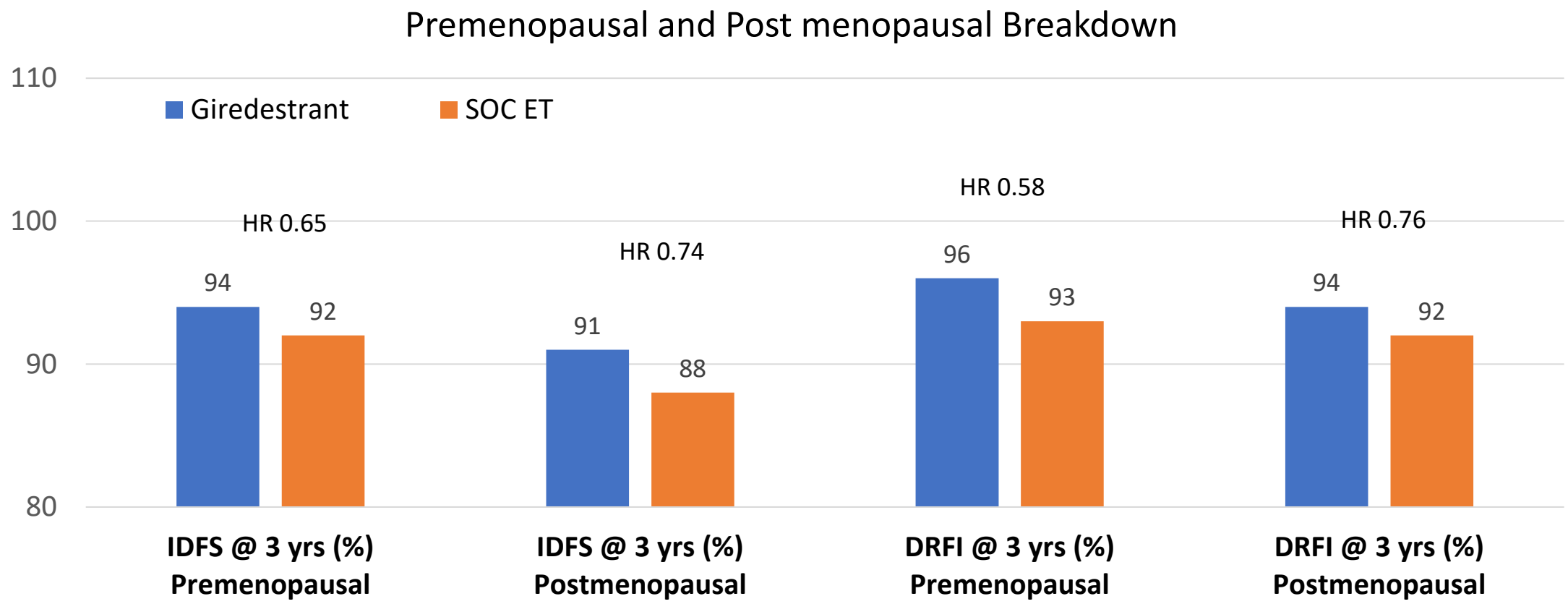
Event	Giredestrant	SOC ET
Arthralgia	48%	47%
Headache	15%	13%
Hot flush	27%	29%
Hypertension (g3/4)	3%	2%
Discontinue due to AE	5%	8%



IDFS = Invasive Disease Free Survival
DRFI = Distant Recurrence Free Interval
OS = Overall Survial
* Statistically significant

SABCS Abst GS1-10 San Antonio, TX 12/2025

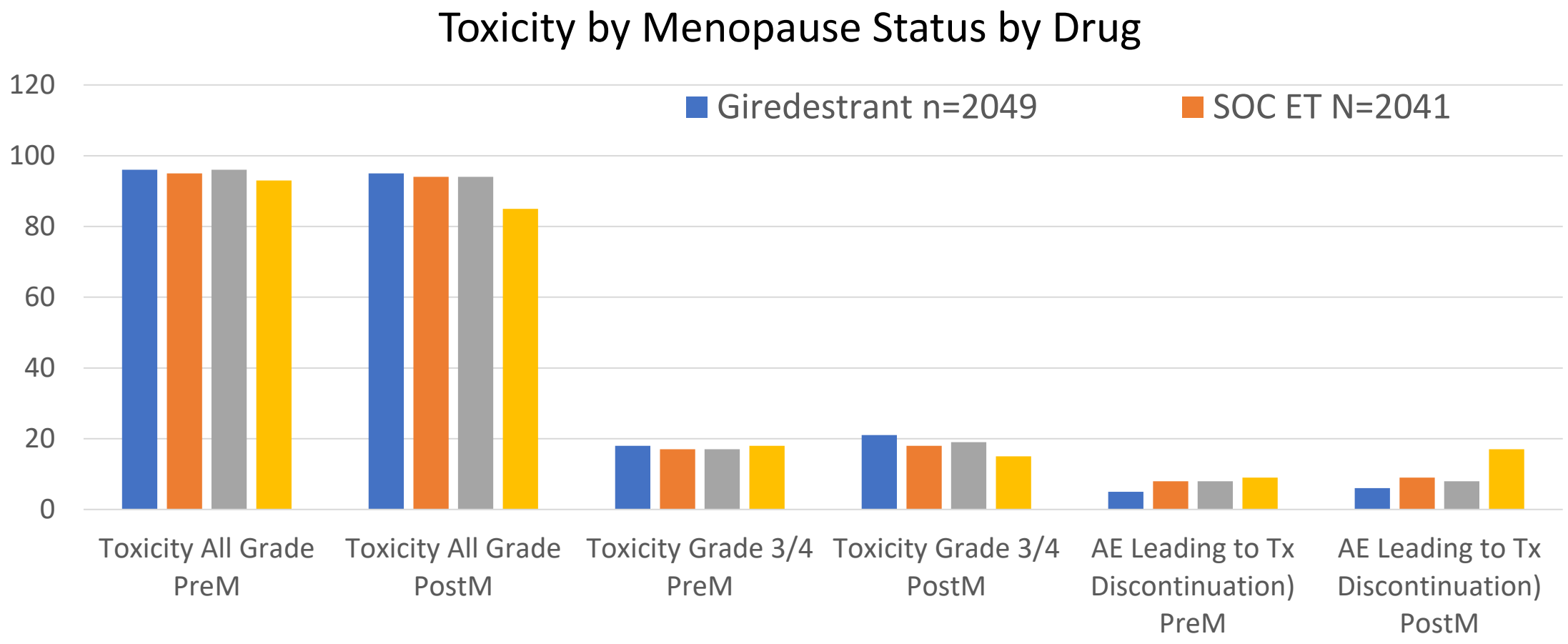
Adjuvant Hormone Therapy – LidERA Interim Analysis



IDFS = Invasive Disease Free Survival
DRFI = Distant Recurrence Free Interval

J clin Oncol 44;abst502(2026) - DOI: 10.1200/JCO.2026.44.16_suppl.502

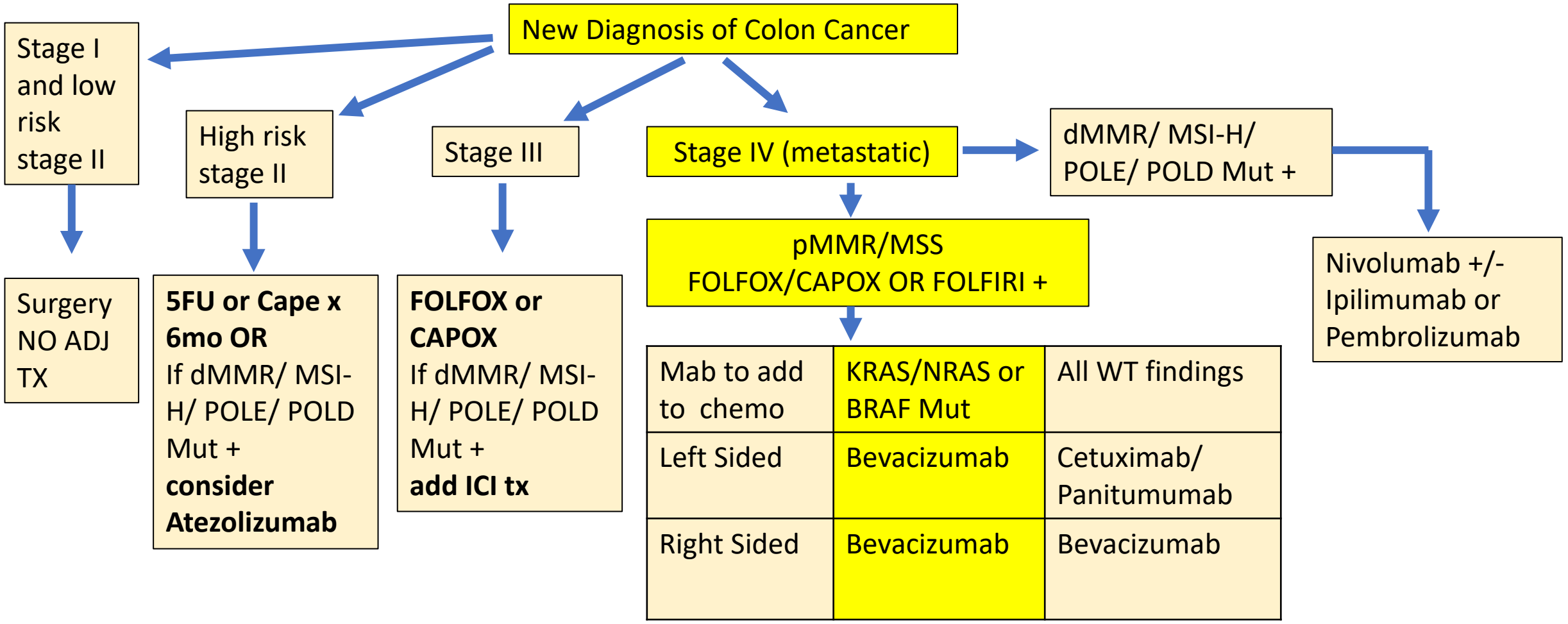
Adjuvant Hormone Therapy – LidERA Interim Analysis



J Clin Oncol 44;abst502(2026) - DOI: 10.1200/JCO.2026.44.16_suppl.502

GIREDESTRANT LOOKS LIKE IT COULD BECOME THE NEW HORMONE THERAPY FOR eBC

Colorectal Cancer Subgroups (First Line Tx)



BRAF, NRAS, KRAS mutations

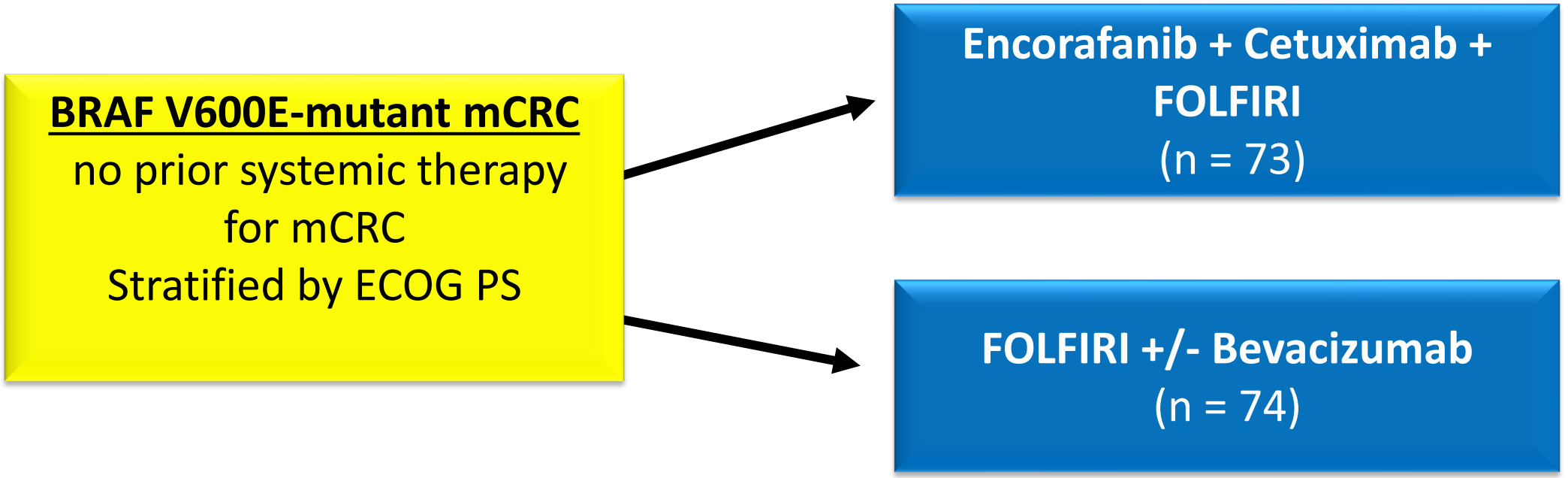
Group – Variable	FOLFOX-Panitumumab	FOLFOX
No RAS or BRAF mut – OS	28.3 mo (n=228)	20.9 mo (n=218)
BRAF only mut – OS	**10.5 mo (n=24)**	**9.2 mo (n=29)**
KRAS mut in exon 2 – OS	15.5 mo (n=221)	19.2 mo (n=219)
BRAF or RAS mut – OS Includes NRAS mut	15.3 mo (n=296)	18.0 mo (n=305)

PFS results reflect same trend of no benefit/delitarious when mutations present and panitumumab used

Douillard J et al. N Engl J Med 2013;369:1023-1034.

Breakwater Cohort 3: Study Schema

- Multicenter, randomized, open-label phase III trial



This is a comparison between Arms D and E of a larger study (Arm A: Encorafenib + cetuximab discontinued and arm D and E added with amendment 5)

- **Primary endpoint:** ORR ITT (BICR)
- **Key secondary endpoints:** PFS (BICR), OS, and safety

Kopetz. ASCO 2026. Abstr LBA3503. DOI: 10.1200/JCO.2026.44.17_suppl.LBA3503.

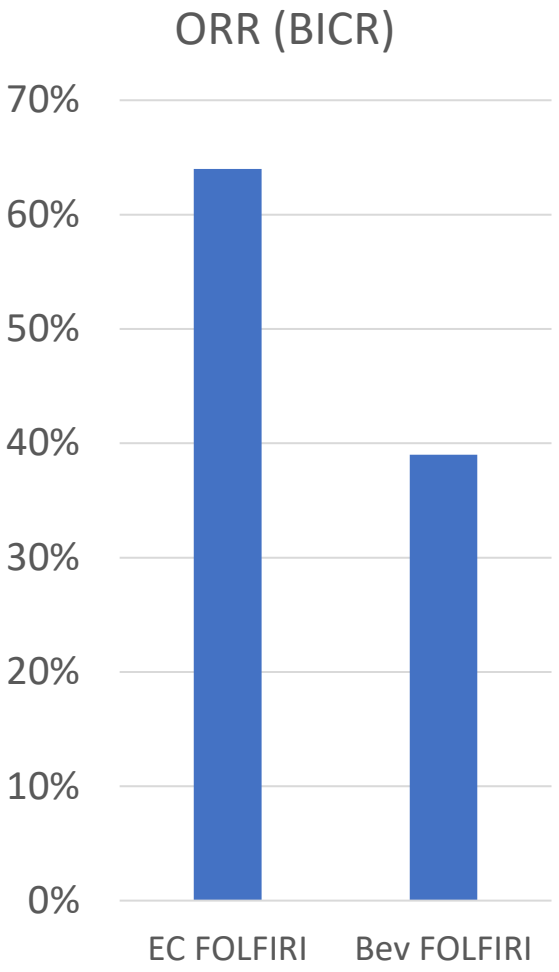
Breakwater Cohort 3- Demographics

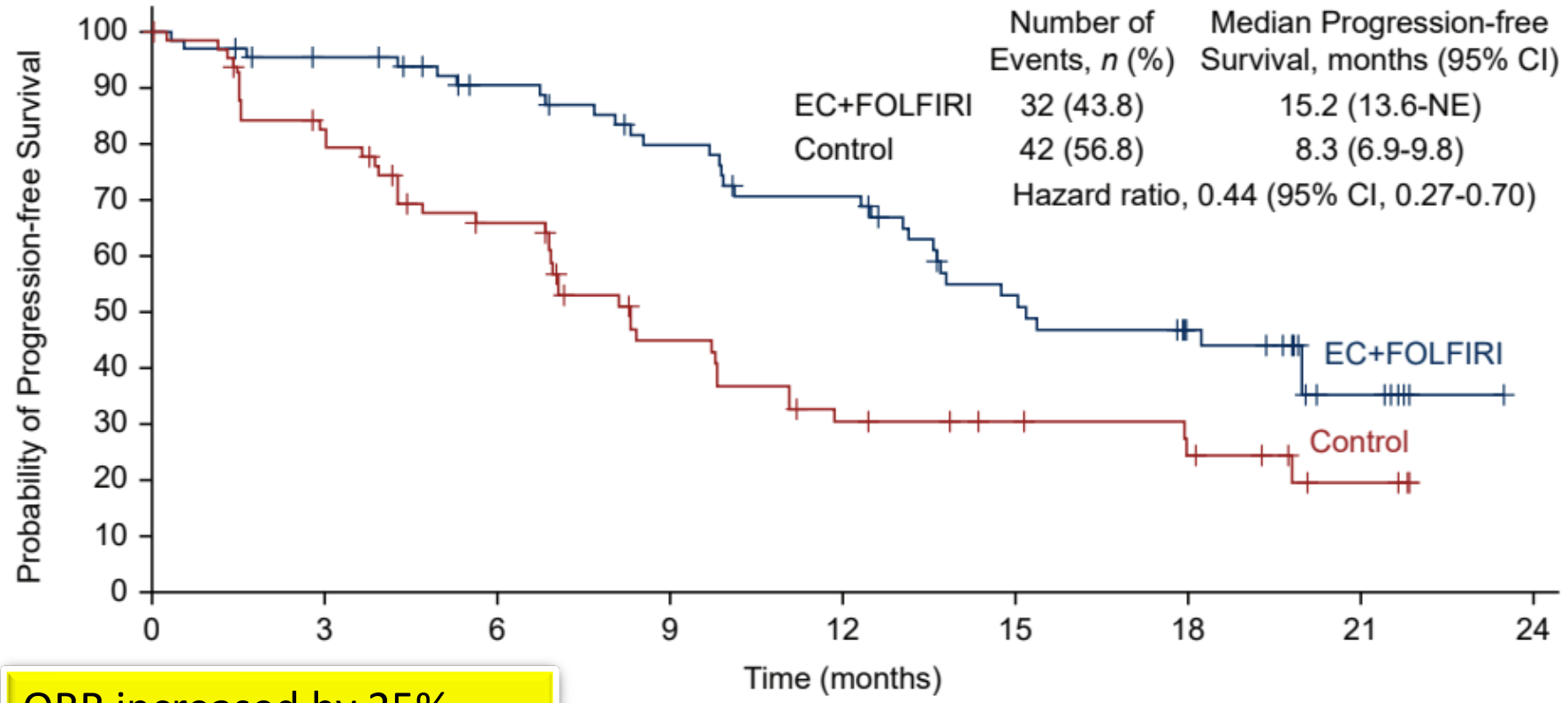
Characteristic	EC FOLFIRI (n = 73)	FOLFIRI Bev (n = 74)
Median age, yr (range)	62 (28-81)	61 (29-84)
Female, n (%)	40 (55)	39 (53)
Race, n (%) ▪ White ▪ Asian	 41 (56) 29 (40)	 49 (66) 20 (27)
ECOG PS, n (%) ▪ 0 ▪ 1	 47 (64) 24 (33)	 41 (55) 27 (37)
Side of Tumor, n (%) ▪ Left ▪ Right	 31 (43) 41 (56)	 36 (49) 38 (51)

Characteristic, n (%)	EC FOLFIRI (n = 73)	FOLFIRI Bev (n = 74)
Stage IV at initial diagnosis, n (%)	54 (74)	47 (64)
No. of organs involved ▪ < 3 ▪ 3+	 38 (52) 35 (48)	 34 (46) 40 (54)
Liver Metastasis ▪ Yes	 43 (59)	 46 (62)
MSI-H/dMMR-positive	0 (0)	0 (0)

Ann of Oncol Online May 2026. doi.org/10.1016/j.annonc.2026.04.017

Breakwater Cohort 3- Efficacy

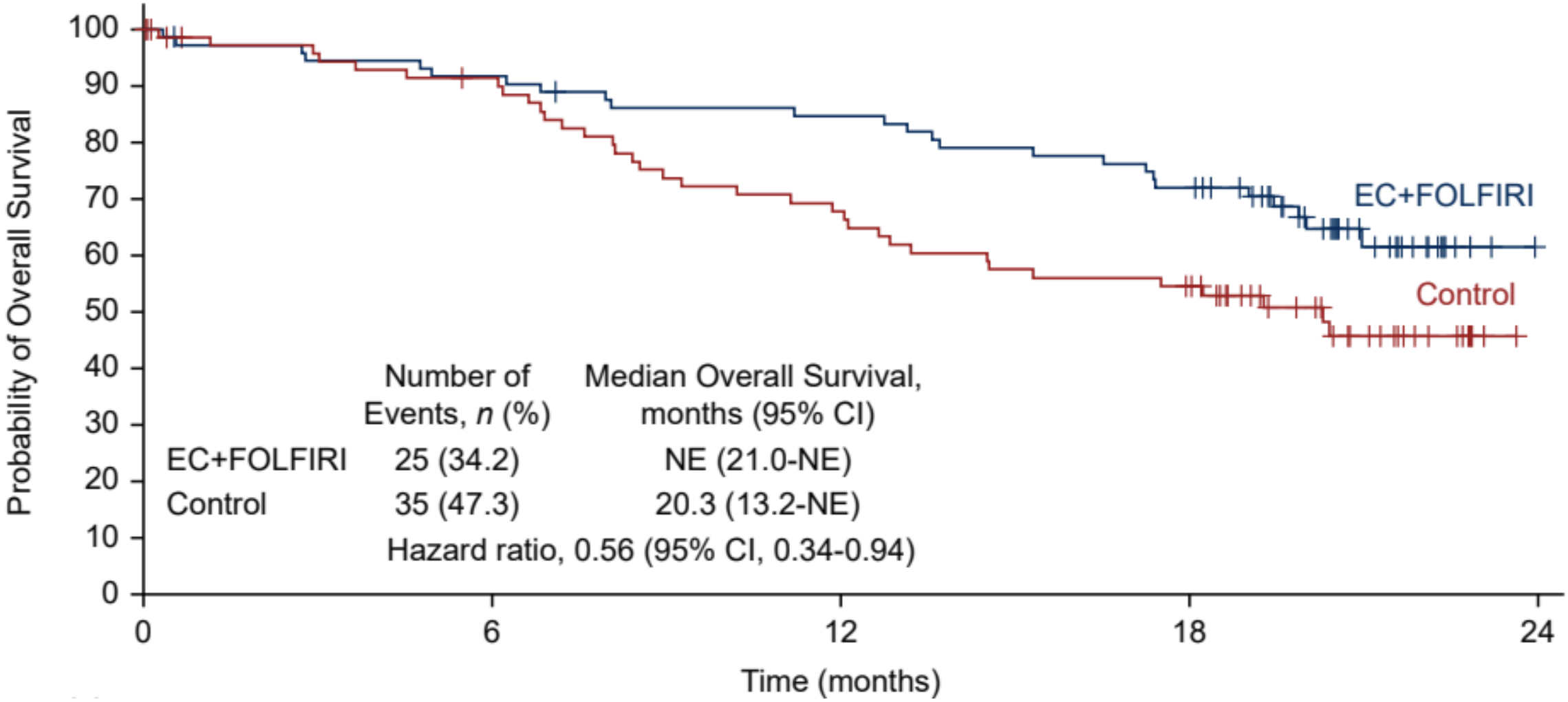




ORR increased by 25%
PFS increased by 7 months

Ann of Oncol Online May 2026. doi.org/10.1016/j.annonc.2026.04.017

Breakwater Cohort 3- Efficacy



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Toxicity (Select) – Breakwater Cohort-3

Event	EC FOLFIRI (n = 71)	FOLFIRI Bev (n = 68)
Treatment-emergent AE (G3-5)	**100% (70%)**	**99% (81%)**
AE leading to discontinuation (any Rx)	16%	10%
Treatment Related AE leading to DEATH	1 (1%)	1 (1%)
Adverse Event	**All grades (G3+)**	**All grades (G3+)**
Nausea	**65% (3%)**	59% (2%)
Vomiting	**51% (3%)**	32% (0%)
Inc Lipase	**20% (11%)**	6% (6%)
Diarrhea	**59% (13%)**	50% (9%)
Neutropenia	35% (18%)	29% (21%)
Fatigue	35% (3%)	40% (3%)
Anemia	**45% (14%)**	27% (2%)
Constipation	32% (1%)	29% (2%)

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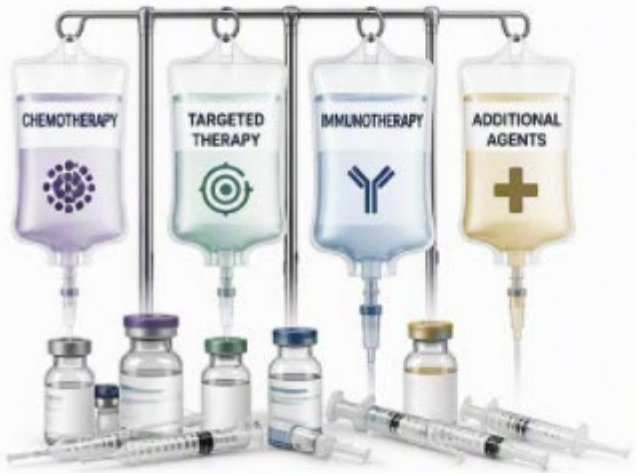
Met BRAF V600E + CRC 1st line therapy may include Encorafenib + Cetuximab + FOLFIRI

SAME OUTCOMES. LESS TOXICITY.

De-escalate treatment without compromising effectiveness

MORE TREATMENT



HIGHER TOXICITY RISK

Fatigue · Neuropathy · Diarrhea · Rash · Hospitalization

- More treatment
- Higher treatment burden
- More toxicity

SAME TUMOR CONTROL

PROGRESSION-FREE SURVIVAL ▬ = ▬

OVERALL SURVIVAL ▬ = ▬

RESPONSE RATE ▬ = ▬

LESS TREATMENT

LOWER TOXICITY RISK

More Energy · Better Quality of Life · Fewer Side Effects

- Less treatment
- Lower toxicity
- Better quality of life

Adjuvant Chemotherapy or Not - OPTIMA

- **Multicenter, open-label, randomized global phase III study, non-inferiority design**

Breast Cancer
- ER+/HER2-
- 40+ years old
- 0-9 nodes
- Recommended to receive chemotherapy (N0 & T>30mm, or N+)

Chemo + Hormone Tx x 5 yrs
(n = 2214)

PAM50
(n = 2215)

68% Endocrine Therapy Alone

32% Chemo + Endocrine Therapy

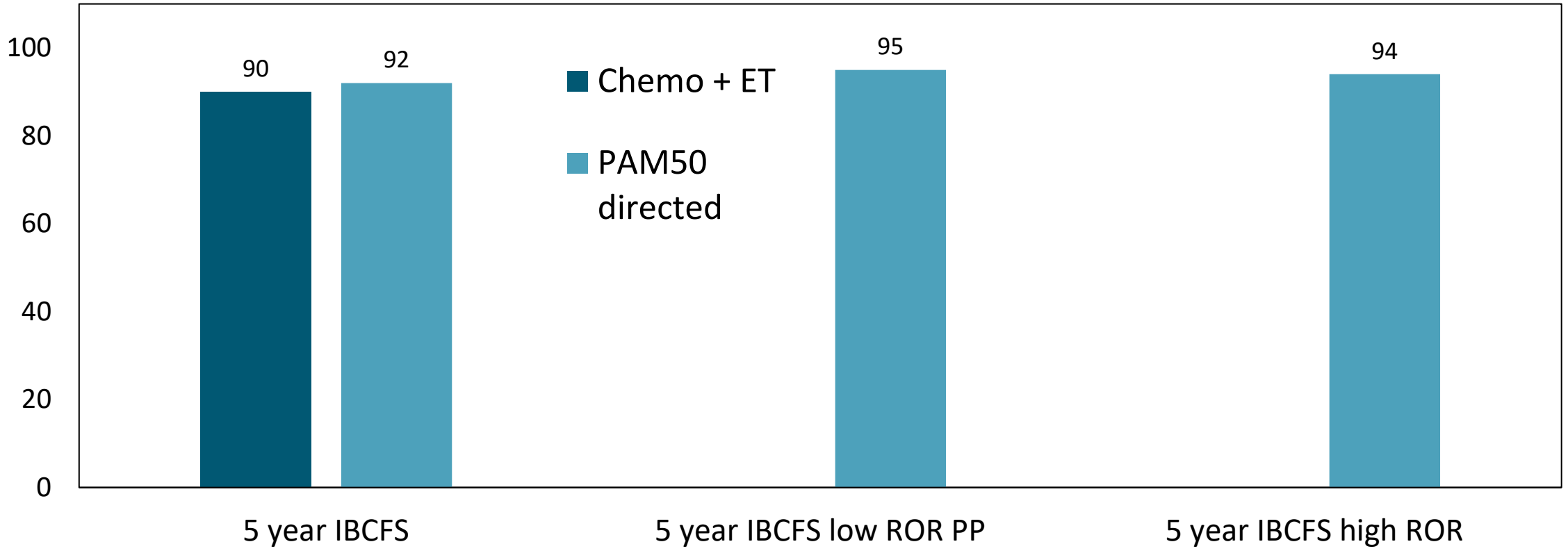
Well Balance groups:
- Postmenopausal 62%
- pN1 73%
- pN0/pN1mi 8%
- pN2 19%

Pam50 – Prosigna 50 gene test. ROR score 60+ get chemo, those with an ROR score < 60 receive endocrine therapy alone (adjuvant abemaciclib permitted, ovarian suppression given to pre-menopausal women)

- **Primary endpoint: 5-year** Invasive Breast Cancer Free Survival (IBCFS)
- **Key secondary endpoints:** Distant Recurrence-Free Interval (DRFI), safety and tolerability

NCT04961996. Schmid. ASCO 2026. Abstr 502. DOI: 10.1200/JCO.2026.44.16_suppl.502

Chemo + Endocrine Tx vs PAM50 directed - OPTIMA

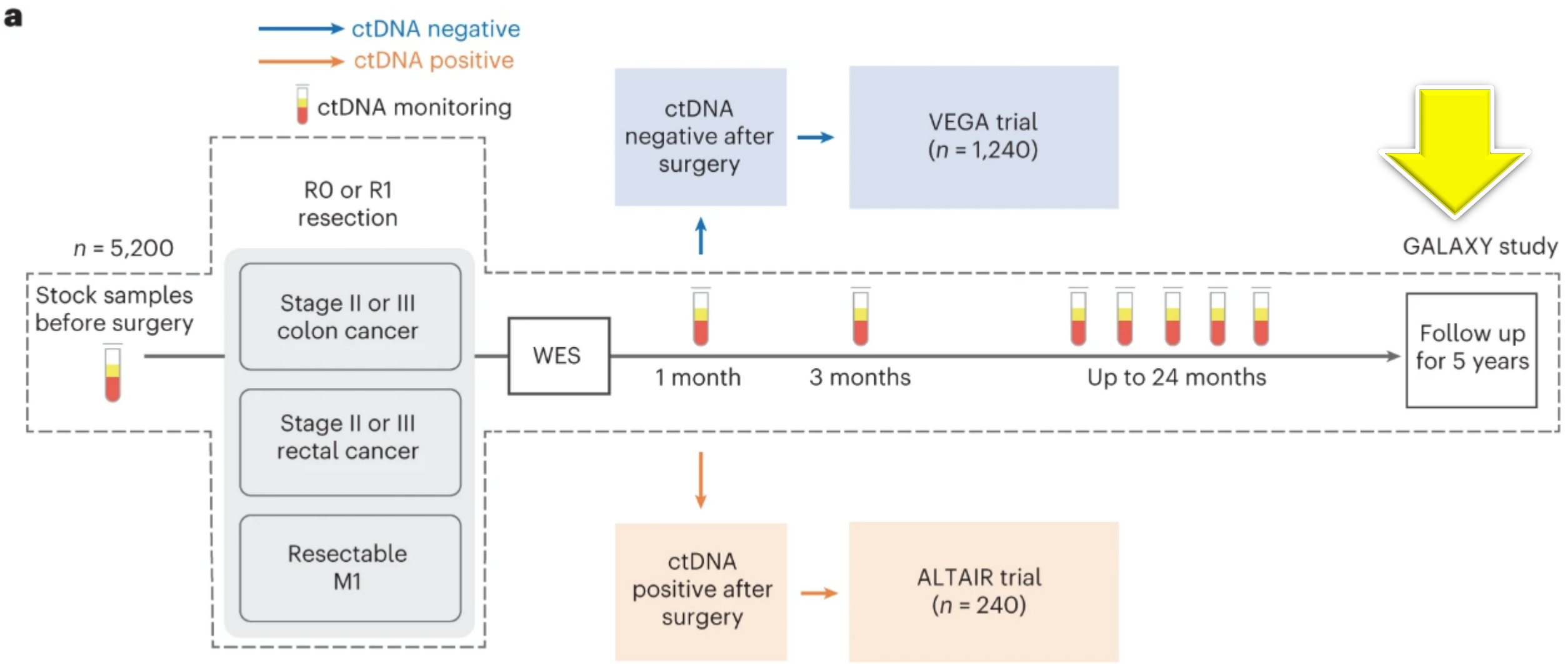


Median of 3.9 years of follow-up

Non-Inferiority met HR=0.99 [90% CI 0.81- 1.20], NI p = 0.013

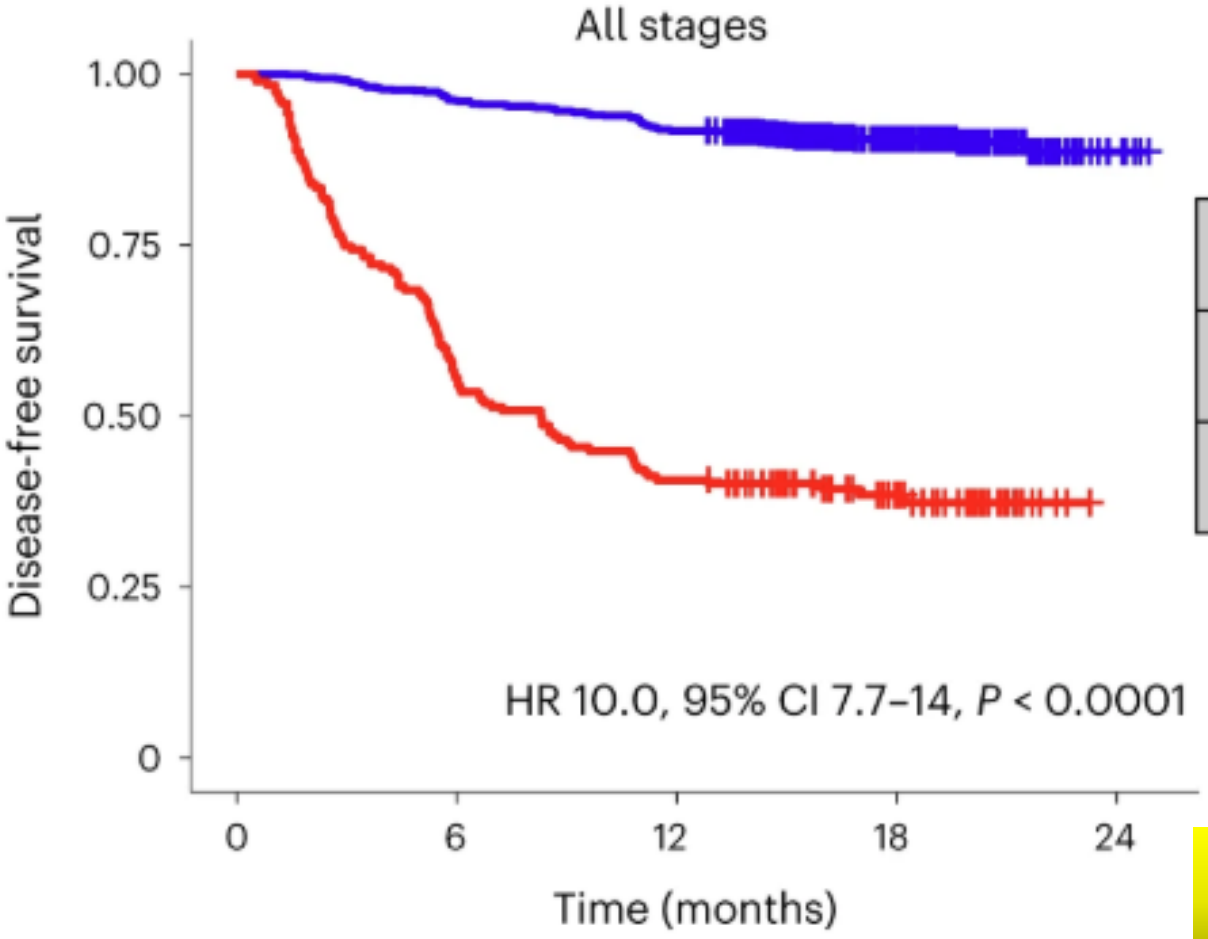
Stein *J Clin Oncol* **44**, 500(2026). DOI:10.1200/JCO.2026.44.16_suppl.500

Adjuvant Chemotherapy or Not - GALAXY



*Nature Medicine 2023;***29:**127–34

Benefit of Adjuvant Chemo in Resected stage I-IV CRC



ctDNA at 4 weeks post-op

ctDNA	Number of events	6M-DFS (95% CI)	12M-DFS (95% CI)	18M-DFS (95% CI)
ctDNA negative	81 out of 852	96.1% (94.6–97.2)	91.7% (89.6–93.3)	90.5% (88.3–92.3)
ctDNA positive	115 out of 187	55.6% (48.2–62.64)	40.6% (33.6–47.6)	38.4% (31.4–45.5)

ctDNA negative at 4 weeks, patients have minimal benefit from Adjuvant Chemotherapy – BUT some still have recurrence.

KEY QUESTION: Does the 12-week ctDNA test capture patients who would benefit from Adj Chemotherapy

*Nature Medicine 2023;***29:**127–34

Adjuvant Chemotherapy or Not - Galaxy

Colorectal Cancer
- Surgical Resection
- ctDNA negative

at 4 weeks post-op
(n = 1034)

ctDNA at 12 Weeks Negative
(n=998)

→ **2-year DFS**
Obs = 84.1%
ACT = 87.1%
HR 0.8 p=0.1744

ctDNA at 12 Weeks Positive
Observation or
Adjuvant Chemotherapy
(n=36)

→ **2-year DFS**
Obs = 2.5%
ACT = 45.5%
HR 0.3 p=0.0165

Demographics: 48% Female, Colon CA 74%
Stage Distribution:
11% Stage I / Low Risk Stage II,
72% High Risk Stage II/Stage III,
17% stage IV
Median age 69 (25-93)
Median time to ACT 6.7 weeks (3-12)

Conclusion:
Clear role for obtaining a 12 ctDNA
Patients who convert from ctDNA neg to positive at 12 weeks benefit from Adjuvant Chemotherapy

Yokota ASCO 2026. Abstr 102. DOI: 10.1200/JCO.2026.44.16_suppl.102

ASCO 2026 Summary

- Pancreatic Cancer
  - 2nd line therapy with **Daraxonrasib** is BETTER than chemotherapy (coming soon)
- Lung Cancer
  - RET+ early-stage Lung cancer adjuvant therapy should consist of **Selpercatinib**
  - Squamous Histology metastatic NSCLC has improved outcomes when **Ivonescimab** (bispecific PD1/VEGF mab) is added to chemotherapy
  - KRAS G12C+ metastatic NSCLC 1st line treatment **Divarasib** + Pembrolizumab
- Breast Cancer
  - HR+/HER2- early-stage Breast Cancer found **Giredestrant** (a new SERD) is better than AI or Tam in both pre and post menopausal women.
- CRC
  - BRAF V600E mut CRC – 1st line **Encorafenib + Cetuximab** + FOLFIRI is better
- De-escalation
  - Genetic testing can identify high risk Breast Cancer Patients who can **avoid chemo**
  - ctDNA at 4 and 12-weeks can identify adjuvant CRC patients who can **avoid or should receive adjuvant chemo**