



eP-1595: Real-World Superiority of Immunotherapy Consolidation After Chemoradiotherapy in Unresectable Stage III NSCLC: A Retrospective Cohort Study

Yanjun Xu¹, Kaibo Ding², Xinyue Li¹, Ruiqi Song¹

¹Department of Thoracic Medical Oncology, Zhejiang Cancer Hospital, Hangzhou, China.

²Department of Respiratory Medicine, Changxing County People's Hospital, Huzhou, 313100, China.

Correspondence : junxy88@163.com(YJ. Xu).



IASLC 2026 World
Conference on Lung Cancer

SEPTEMBER 12 – 15, 2026
SEOUL, REPUBLIC OF KOREA

INTRODUCTION

The PACIFIC trial established durvalumab consolidation after definitive chemoradiotherapy (CRT) as standard of care for unresectable stage III NSCLC (5-year OS 42.9%). However, optimal sequencing remains unsettled — PACIFIC-2 failed to show benefit with concurrent durvalumab, and upfront immunotherapy (IO-CRT) or chemotherapy-based strategies (Chemo±IO) lack comparative real-world evidence. We compared four treatment strategies in a large Chinese cohort and identified independent prognostic factors.

METHODS

Design: Retrospective, two-center (Zhejiang Cancer Hospital; Changxing County People's Hospital), Jan 2015 – Dec 2023; 1,152 unresectable stage III NSCLC patients (AJCC 8th ed.); IRB-2023-318.

Groups: CRT alone (n=492); CRT → consolidation immunotherapy (CRT-IO, n=187); immunotherapy → CRT (IO-CRT, n=160); chemotherapy ± immunotherapy without radiotherapy (Chemo±IO, n=313).

Endpoints: PFS, OS (primary); ORR, DCR per RECIST v1.1, pneumonitis ≥grade 2 (secondary).

Statistics: Kaplan–Meier + log-rank (Bonferroni); multivariable Cox; R v4.1.

DISCUSSION AND CONCLUSION

Actionable Take Away Message

- Consolidation immunotherapy after CRT is the preferred standard; apply to all eligible patients.
- Radiotherapy is indispensable — do not substitute with chemotherapy ± immunotherapy alone.
- Upfront immunotherapy requires optimization; expect progression risk with delayed CRT.
- Pneumonitis is manageable and does not compromise survival with proper care.

Future Direction for Research

- Biomarker-driven selection (PD-L1, TMB) to identify who benefits from IO-CRT vs CRT-IO.
- Optimized sequencing to shorten the CRT delay inherent to upfront immunotherapy.
- Prospective evaluation of novel combinations (TIGIT inhibitors, dual immunotherapy).

REFERENCES & ACKNOWLEDGEMENTS

Key references:

- 1Antonia SJ, N Engl J Med 2017 (PACIFIC);
- 2Spigel DR, J Clin Oncol 2022 (5-yr PACIFIC);
- 3Bradley JD, J Clin Oncol 2020 (RTOG 0617);
- 4Lu S, N Engl J Med 2024 (LAURA).

Acknowledgments

This study was supported by the Natural Scientific Foundation of Zhejiang Province, China (Grant No. LTGY23H160007)

Registry of the study

This study was conducted in accordance with the Declaration of Helsinki and was approved by the ethics committee of Zhejiang Cancer Hospital. Written informed consent was obtained from each patient.

RESULTS

Survival (Fig. 1): CRT-IO achieved the best outcomes — mPFS 23.7 mo vs 20.8 (IO-CRT), 16.5 (CRT), 11.3 (Chemo±IO; p<0.001); mOS 47.9 mo vs 38.2, 40.3, 33.9 mo (p<0.001).

Response: ORR 70.1% (CRT-IO) vs 72.5% (IO-CRT), 67.1% (CRT), 56.2% (Chemo±IO); DCR 100% vs 98.8%, 97.8%, 91.7% (both p<0.001).

Prognostic factors (Fig. 2–3): CRT-IO conferred the strongest survival benefit (OS HR 0.41, 95% CI 0.30–0.56; p<0.001); radiotherapy omission increased mortality (HR 1.40; p=0.012); adenocarcinoma favored OS (HR 0.70; p<0.001); ECOG PS 1 and age ≥65 were adverse (HR 1.24 and 1.25).

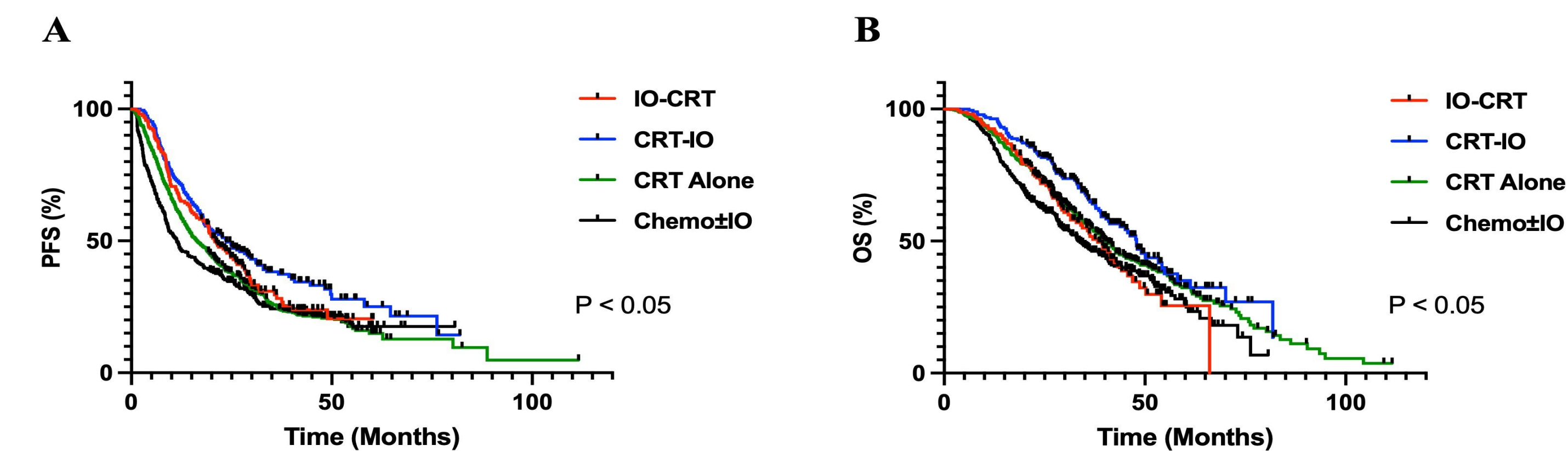


Figure 1. Progression-Free Survival (PFS) and Overall Survival (OS) outcomes by treatment regimens.

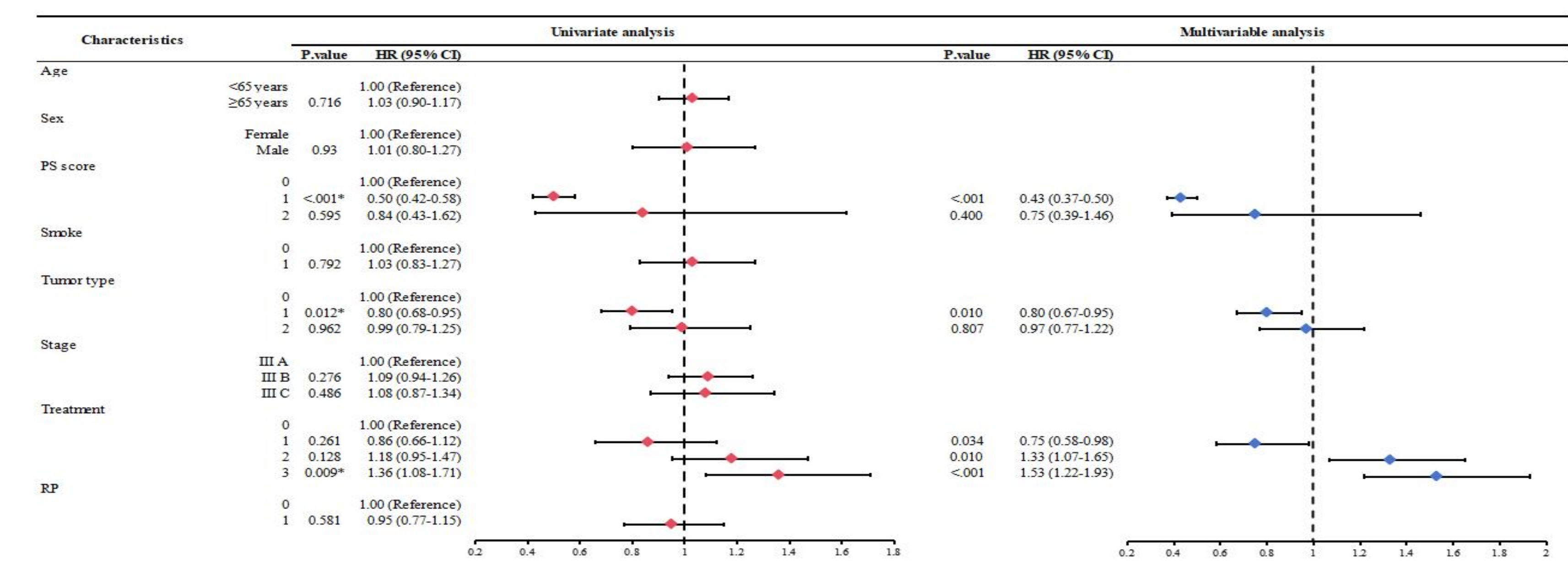


Figure 2. Forest plot showing univariate and multivariate analysis Progression-Free Survival (PFS)

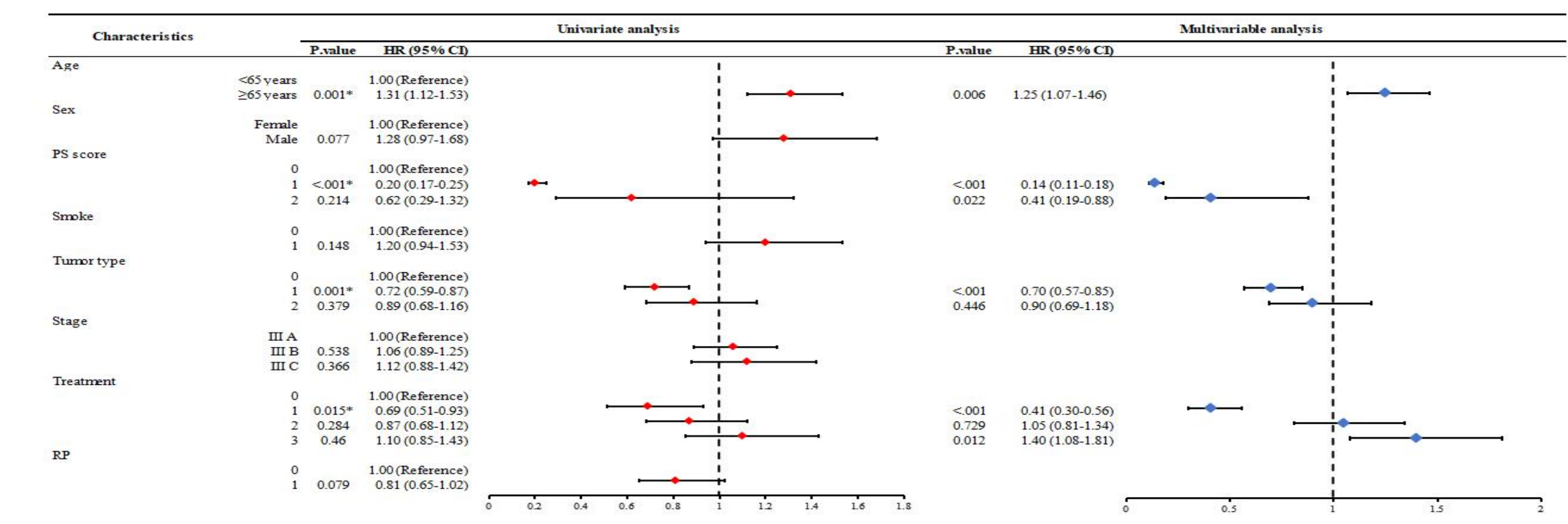


Figure 3. Forest plot showing univariate and multivariate analysis of Overall Survival (OS)