



EP13.12: A Study on Efficacy and Safety of Neoadjuvant Chemotherapy Versus Immunochemotherapy in Limited-Stage Small Cell Lung Cancer

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INTRODUCTION

Neoadjuvant immunotherapy has dramatically changed the treatment landscape of thoracic malignancies, but real-world surgical evidence focusing on limited-stage small-cell lung cancer (LS-SCLC) remains limited¹⁻⁴. This study aimed to evaluate the efficacy and safety of neoadjuvant chemotherapy (NC) versus neoadjuvant immunochemotherapy (NIC; PD-(L)1 inhibitors combined with chemotherapy) followed by radical surgery in patients with selected LS-SCLC.

METHODS

In this retrospective study, electronic medical records from Xuanwu Hospital, Capital Medical University, between January 2017 and September 2025 were reviewed. Patients with pathologically confirmed SCLC who received either neoadjuvant chemotherapy or neoadjuvant immunochemotherapy followed by curative-intent surgery were included. Baseline clinical characteristics, pathological responses, survival outcomes, and safety profiles were systematically collected and analyzed. Follow-up ended on March 1, 2026, or at the time of death or disease recurrence.

DISCUSSION AND CONCLUSION

Compared with neoadjuvant chemotherapy alone, neoadjuvant immunochemotherapy is associated with greater pathological response and improved event-free survival in selected patients with LS-SCLC, without increasing perioperative risks.

These findings suggest that neoadjuvant immunochemotherapy may represent a safe and effective treatment option for carefully selected patients with limited-stage small-cell lung cancer.

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- All authors declare no other conflicts of interest.

Questions:

If you have any questions about this poster, please email Professor Yi Zhang, zhangyixwhosp@xwh.ccmu.edu.cn.

RESULTS

A total of 46 patients were included: 27 in the NC group and 19 in the NIC group. Among patients receiving immunochemotherapy, 14 were treated with atezolizumab, 4 with serplulimab, and 1 with tislelizumab. No patient experienced progressive disease after neoadjuvant therapy. All patients achieved R0 resection. Forty patients underwent video-assisted thoracoscopic surgery, while six underwent open thoracotomy. Two patients received pneumonectomy, and 44 underwent lobectomy with mediastinal lymph node dissection. There were no significant differences in surgical parameters—including operative duration, intraoperative blood loss, time to chest tube removal, postoperative hospital stay, or postoperative complication rates between the two groups. No patient in the NC group achieved pathological complete remission (pCR) or major pathological response (MPR). In contrast, the pCR and MPR rates in the NIC group were 26.3% (5/19) and 31.6% (6/19), respectively. The median follow-up duration was 19.6 months (95% confidence interval [CI], 10.2–29.0 months). Patients in the NIC group showed significantly improved event-free survival compared with those in the NC group (median EFS in NC: 13.4 months [95% CI: 11.5–15.3]; median EFS in NIC: not reached; $P = 0.000$) (Figure 1). Median overall survival (OS) was not reached in either group. The most common grade ≥ 3 treatment-related adverse event was neutropenia, occurring in 39.1% (18/46) of patients. Additionally, five patients (26.3%) experienced grade 1 immune-related adverse events.

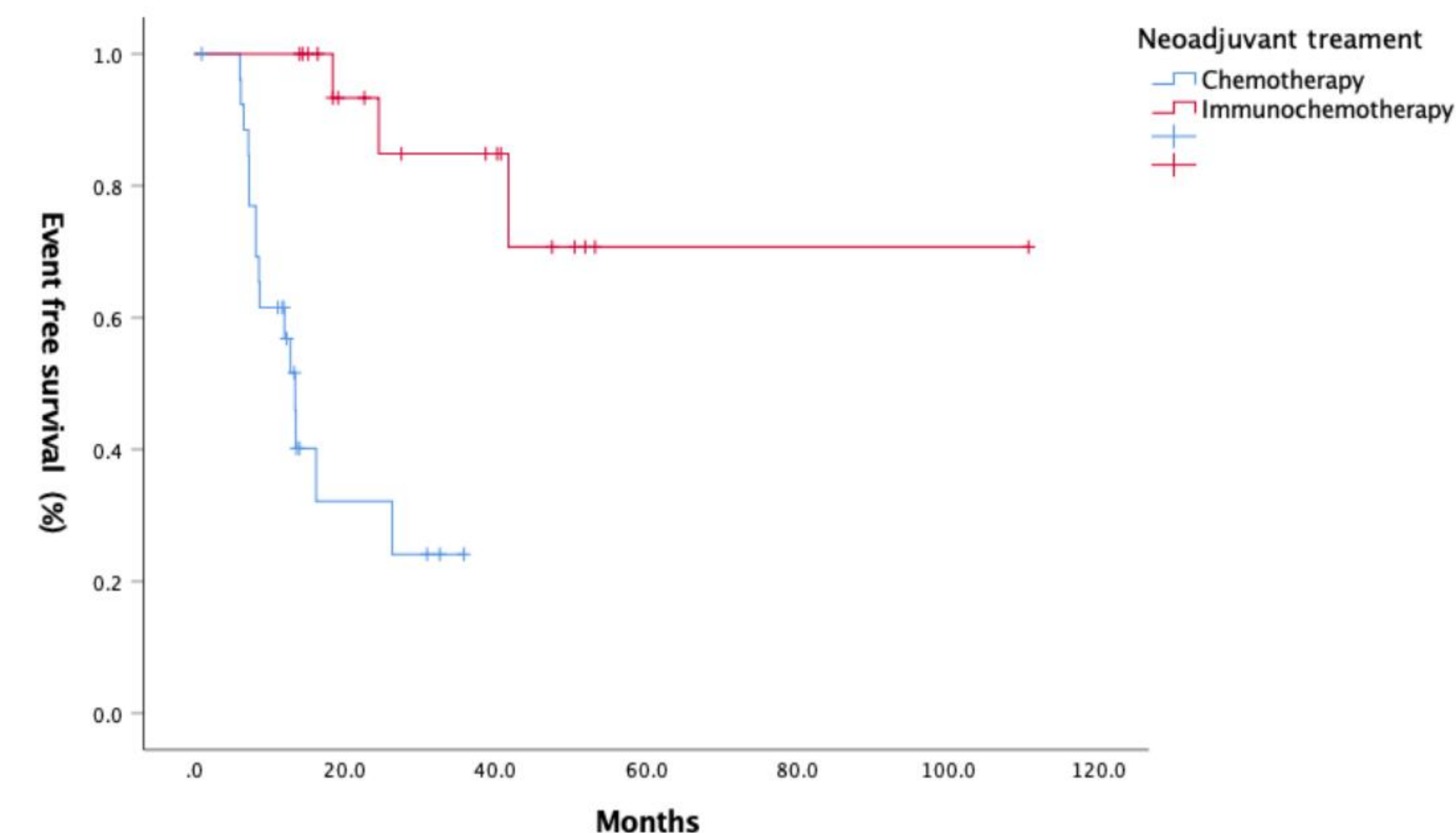


Figure1. Kaplan–Meier estimates of event-free survival in patients receiving neoadjuvant chemotherapy versus neoadjuvant immunochemotherapy ($P = 0.000$).