

INTRODUCTION

ES-SCLC is highly malignant with a poor prognosis. Immune checkpoint inhibitors(ICIs) have greatly improved the therapeutic effect of ES-SCLC. However, in real-world practice, a subset of patients(pts) did not receive ICIs during first-line treatment. With limited evidence regarding survival discrepancies between upfront first-line immunotherapy and deferred second-line/later immunotherapy, this real-world study was performed to explore the clinical value of varied immunotherapy initiation timings.

METHODS

This is a single-center retrospective observational study.

A total of 115 ES-SCLC patients receiving ICI treatment were enrolled from the Fourth Hospital of Hebei Medical University.

Patients were divided into two groups: first-line immunotherapy group (1L-IT) and second-line and higher-order immunotherapy group (2L+IT).

Multiple landmark time points were applied to eliminate starting time bias.

The primary endpoint was overall survival (OS).

DISCUSSION AND CONCLUSION

Second-line and later ICIs are clinically applicable

- There is no significant difference in overall survival between ES-SCLC patients in the 1L-IT group and the 2L+IT group.
- For patients who fail to receive first-line immunotherapy, ICI administration in subsequent lines still has reliable clinical application value.
- Prospective validation is warranted.

REFERENCES & ACKNOWLEDGEMENTS

REFERENCES

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2. Ren R, et al. Ther Adv Med Oncol, 2025, 17: 17588359251387570.

ACKNOWLEDGEMENTS

We thank all patients and their families for their participation. We are grateful to the doctors and nursing staff at the Fourth Hospital of Hebei Medical University.

RESULTS

1. No significant difference in median OS was observed between the 1L-IT group and the 2L+IT group (16.2 months vs. 16.7 months, HR=0.943, 95%CI: 0.602–1.476, $P=0.797$).
2. Multivariate Cox regression analysis showed that immunotherapy initiation timing was not an independent prognostic factor for OS (HR=1.057, 95%CI: 0.652–1.716, $P=0.821$).
3. Landmark analysis at 6 months showed consistent OS results (10.5 months vs. 10.7 months, $P=0.881$).
4. Sensitivity analyses with 5-month and 7.7-month landmark points further verified that immunotherapy timing was not associated with OS, confirming the robustness of the study conclusions.

Figure 1.Kaplan-Meier estimates of OS

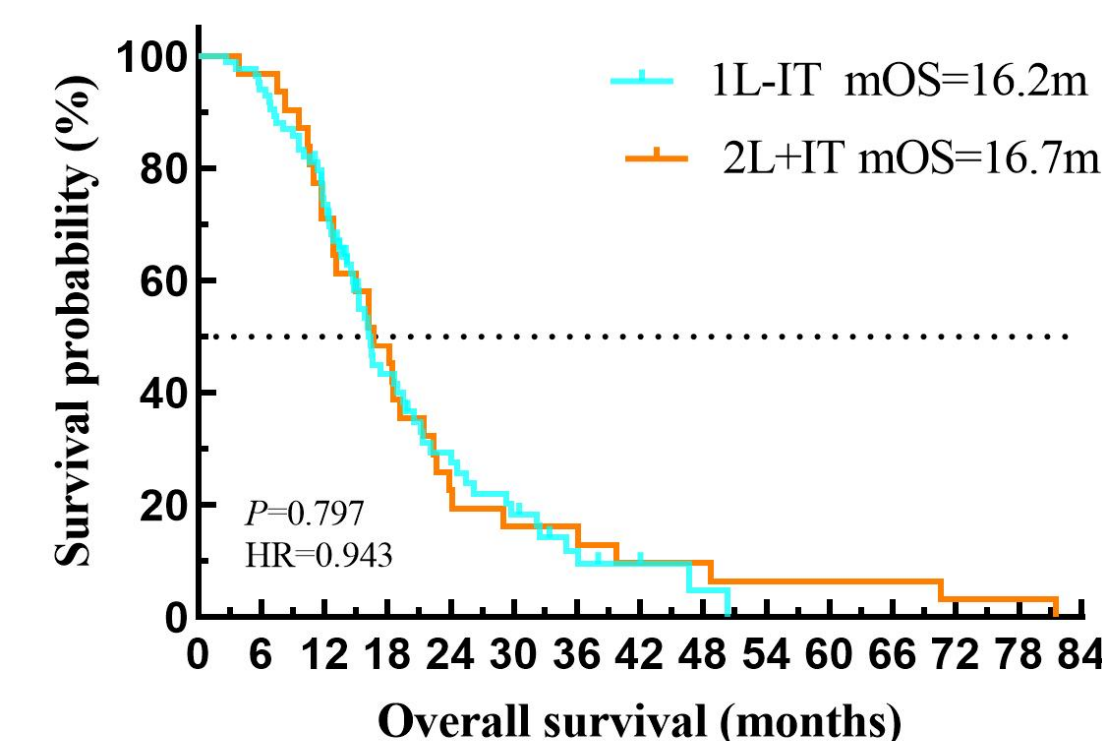


Figure 2. Multivariate Cox regression analysis for OS

	P	HR	95%CI
Gender(male, female)	0.943	0.969	0.412-2.279
Smoking history(no, yes)	0.393	1.319	0.699-2.489
PS score(0, 1/2)	0.076	1.798	0.940-3.440
Bone metastases(no, yes)	0.141	1.406	0.893-2.214
Liver metastases(no, yes)	0.086	1.505	0.944-2.399
Adrenal metastases(no, yes)	0.121	0.642	0.366-1.125
Thoracic radiotherapy(no, yes)	0.009	0.510	0.308-0.845
PCI(no, yes)	0.296	0.578	0.206-1.617
Immunotherapy initiation timing(1L, 2L+)	0.821	1.057	0.652-1.716

Figure 3. Kaplan-Meier estimates of OS (Landmark point: 6m)

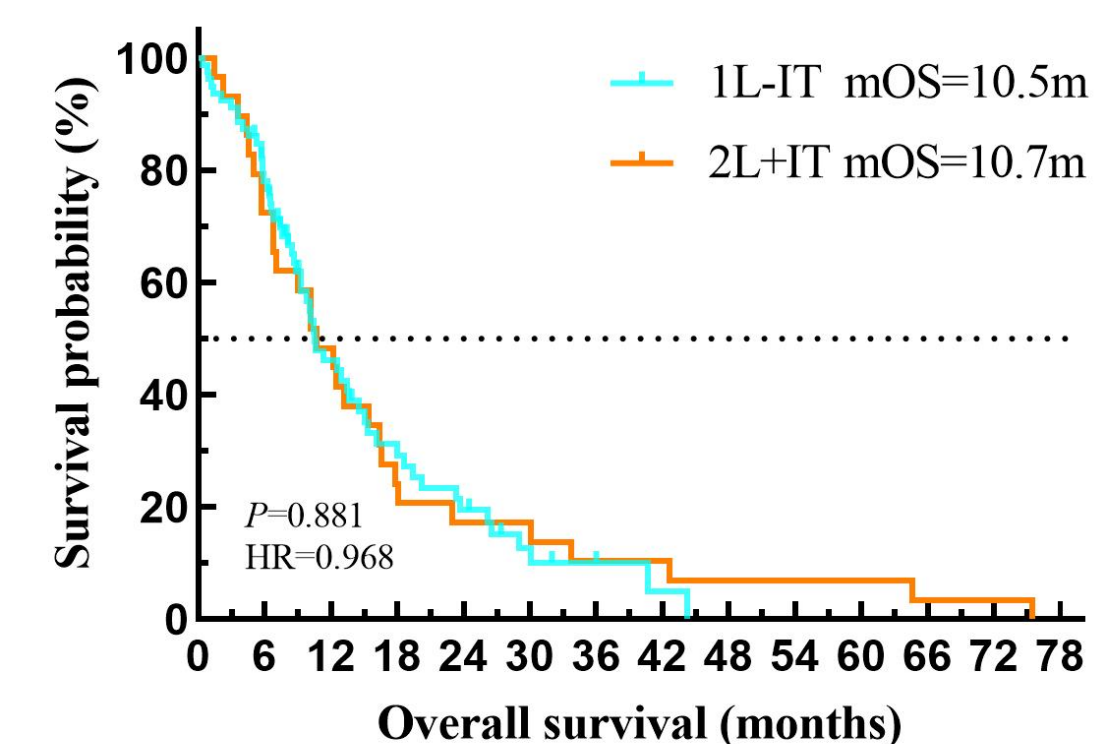


Table 1. Results of multivariate Cox regression under different Landmark points

Landmark point (m)	Number of enrolled cases	1L-IT group	2L+IT group	HR	95% CI	P value
5	111	82	29	1.009	0.616~1.652	0.972
6 (main)	108	79	29	1.052	0.634~1.744	0.845
7.7	102	74	28	1.080	0.651~1.792	0.765