



Efficacy and Safety of Delayed First-Line PD-L1 Inhibitor Immunotherapy in Extensive-Stage Small Cell Lung Cancer : A Prospective Phase II Study

B. Qin¹, Y. Li^{1,2}, J. Zhai¹, X. Ge^{1,2}, Y. Gao^{1,2}, Y. Mao^{1,2}, Y. Jia^{1,2}, I. Lin^{1,2}, M. Li³, H. Zhou³, X. Zhang³, S. Li³, D. Yin^{1,2}, J. Wang^{1*}

¹Senior Department of Oncology, Fifth Medical Center of Chinese PLA General Hospital, Beijing, China; ²Medical School of Chinese PLA, Beijing, China; ³School of Medicine, Nankai University, Tianjin, China

Correspondence: wangjinliang301@163.com



IASLC 2026 World
Conference on Lung Cancer

SEPTEMBER 12 - 15, 2026
SEOUL, REPUBLIC OF KOREA

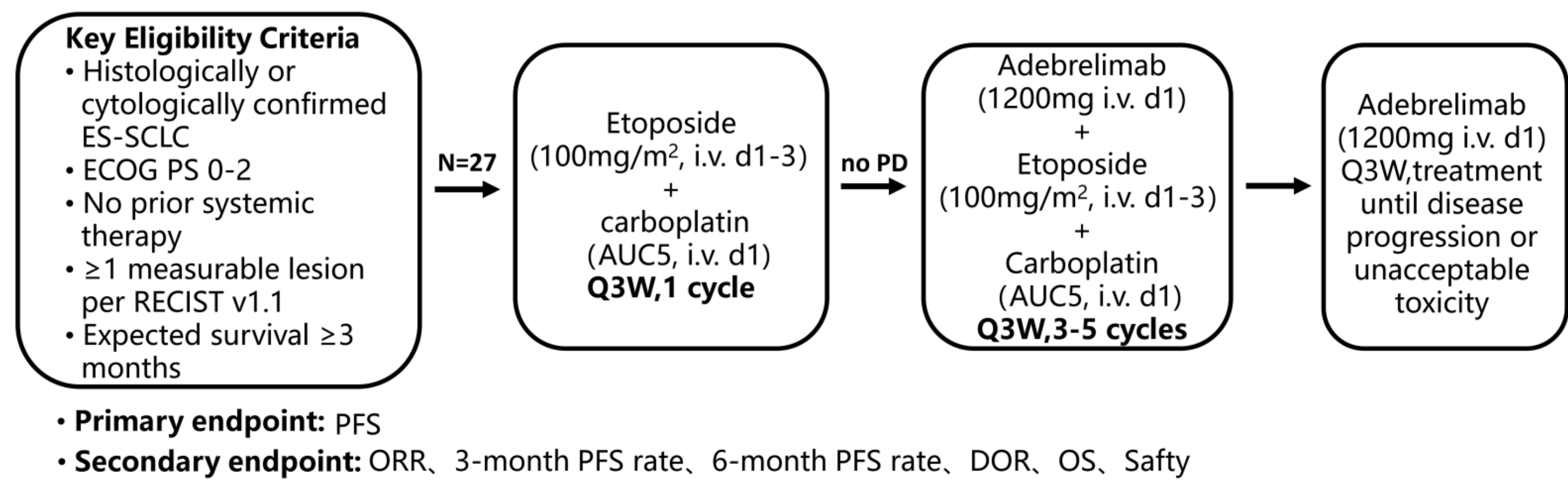
INTRODUCTION

Although immunotherapy combined with chemotherapy is the standard first-line treatment for extensive-stage small cell lung cancer (ES-SCLC), the optimal timing for initiating immunotherapy remains unclear. This study evaluates a strategy of delayed administration of adebrelimab, starting from the second cycle following response to initial chemotherapy, with the aim of identifying patients who may benefit, reducing toxicity, and informing the optimal timing of immunotherapy in ES-SCLC treatment.

METHODS

This prospective, single-arm phase II clinical study enrolled treatment-naïve ES-SCLC patients (aged ≥ 18 years, ECOG performance status 0-2). Patients received etoposide (100 mg/m², intravenous infusion, D1-3) plus carboplatin (5 AUC, intravenous infusion, D1) in Cycle 1. Adebrelimab (1200 mg, intravenous infusion, D1) was added from cycle 2 in patients achieving stable disease (SD) or partial response (PR) after cycle 1. After 4-6 cycles, adebrelimab maintenance continued until disease progression (PD) or unacceptable toxicity.

Figure1. Study Design



DISCUSSION AND CONCLUSION

- This prospective study provides preliminary evidence that the delayed adebrelimab administration strategy (introduced from cycle 2) in first-line ES-SCLC treatment demonstrates promising clinical benefit and improves patient safety, particularly with regard to grade 3 or higher treatment-related adverse events (TRAEs).
- This strategy may offer a novel option for enhancing the efficacy of immunotherapy in ES-SCLC and warrants further validation in larger studies.

RESULTS

As of March 6, 2026, 27 patients were enrolled. Baseline characteristics: median age 62.6 years; 88.9% (24/27) male; 59.3% (16/27) had a smoking history; all patients had ECOG PS 1; 25.9% (7/27) had liver metastases; 11.1% (3/27) had brain metastases.

Table1. Baseline characteristics

Features	Patients (N=27)
Age (year) , (mean (SD))	62.6 (6.5)
< 65, n(%)	16 (59.3)
≥ 65 , n(%)	11 (40.7)
Sex, n(%)	
Male	24 (88.9)
Female	3 (11.1)
ECOG performance ststus, n(%)	
1	27 (100.0)
Smoking status, n (%)	
Yes, n (%)	16 (59.3)
No, n (%)	11 (40.7)
Liver metastasis, n (%)	7 (25.9)
Brain metastasis, n (%)	3 (11.1)

At data cutoff (median follow-up of 17.7 months), 59.2% (16/27) of patients had discontinued treatment due to PD or death, 3.7% (1/27) had withdrawn informed consent, and 37.0% (10/27) remained on treatment.

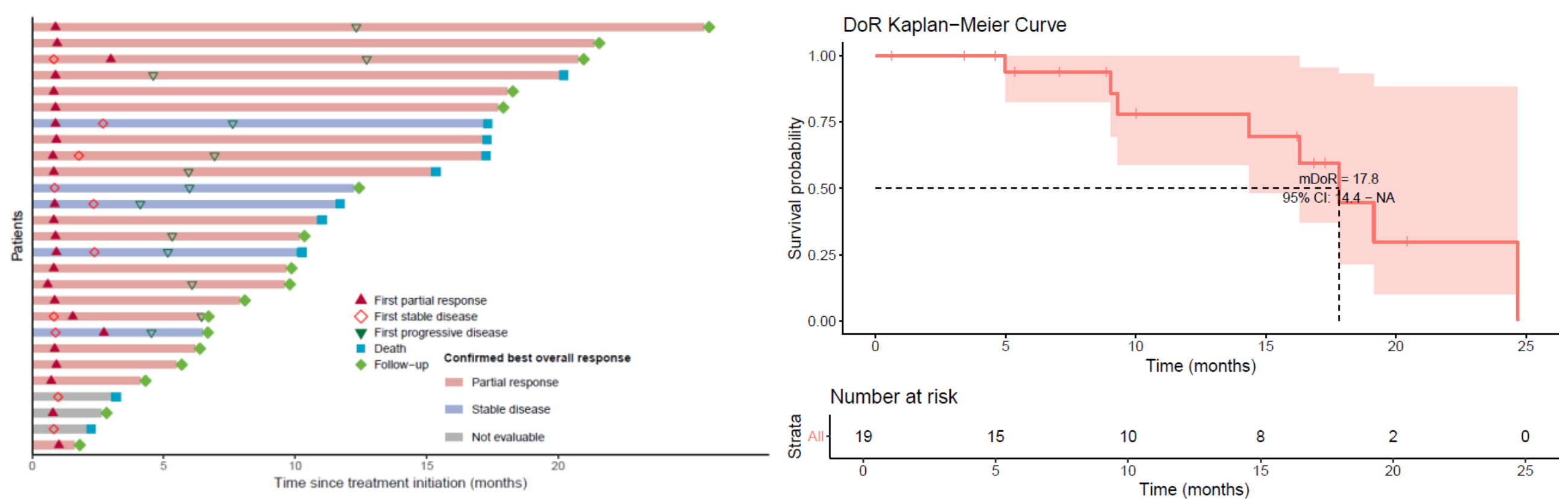


Figure2. Time to response and duration of response

Efficacy analysis showed that the ORR was 74.1% (20/27, 95% CI: 53.72%-88.89%) and the DCR was 88.9% (24/27, 95% CI: 70.8%-97.6%).

Table2. Tumor response

Variables	All Patients (N=27)
Best overall response,n(%)	
Complete response	0
Partial response	20 (74.1)
Stable disease	4 (14.8)
Progressive disease	0
NE	3 (11.1)
Objective response rate,n(%), [95%CI]	20 (74.1) [53.72-88.89]
Disease control rate,n(%) (%), [95%CI]	24 (88.9) [70.8-97.6]

Median PFS was 7.6 months (95% CI: 6.9 to NR). The 3-month PFS rate was 100% and the 6-month PFS rate was

RESULTS

67.8% (95% CI: 51.0% to 91.0%). The median OS was 17.1 months (95 % CI: 15.1-NA), the 6-month OS rate was 92.1 % (95 % CI: 82%-100%), and the 12-month OS rate was 72.8 % (95 % CI: 54%-97%).

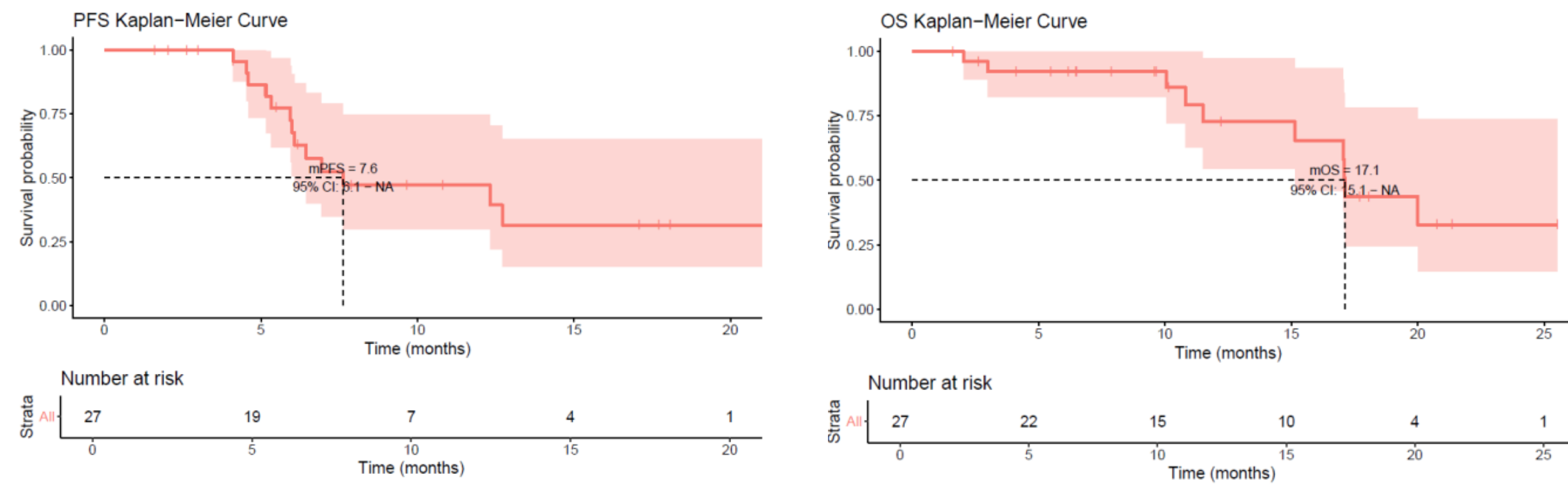


Figure 3. Kaplan-Meier Plot for Progression-Free Survival (PFS) and Overall survival (OS)

Safety assessment revealed that 100% (27/27) of patients experienced treatment-related adverse events (TRAEs). The most common TRAEs were hematologic toxicities: anemia (81.5%, 22/27), neutropenia (37%, 10/27), decreased white blood cell count (18.5%, 5/27), decreased lymphocyte count (22.2%, 6/27). Non-hematologic toxicities included: nausea (14.8%, 4/27), increased aspartate aminotransferase (7.4%, 2/27), hypoalbuminemia (18.5%, 5/27). The incidence of grade ≥ 3 TRAEs was only 25.9% (7/27), with a neutropenia incidence of 14.8% (4/27). No treatment-related deaths were reported.

Table 3. Summary of treatment-related AEs

Treatment-related adverse events	Any grade, n (%)	Grade ≥ 3 , n (%)
Hematologic toxicity		
Anemia	22 (81.5)	0
Neutropenia	10 (37.0)	4 (14.8)
Decreased white blood cell count	5 (18.5)	0
Decreased lymphocyte count	6 (22.2)	1 (3.7)
Decreased platelet	2 (7.4)	0
Non-hematologic toxicity		
Nausea	4 (14.8)	0
Hypoproteinemia	5 (18.5)	0
Increased aspartate aminotransferase	2 (7.4)	1 (3.7)
Increased Alanine Aminotransferase	2 (9.5)	1 (3.7)
Rash	1 (3.7)	0
Increased activated partial thromboplastin	1 (3.7)	0

ACKNOWLEDGEMENTS

This study was supported by grants from the DCMST.NHC Clinical Research Project (WKZX2023CXO20005).