Conclusion: Concurrent STK11 loss and c-MYC amplification in NSCLC is uncommon, but had no impact on survival in a limited patient set. This study underscores the importance of large-scale, clinically annotated genomic data sharing initiatives in systematically exploring the clinical relevance of rare genomic alterations.

B09
The CANOPY Program: Three Phase 3 Studies Evaluating Canakinumab in Patients with Non-Small Cell Lung Cancer (NSCLC)

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Background: Canakinumab (CAN) is a selective IL-1β inhibitor that aims to target tumor-promoting inflammation to reduce immune suppression. In the CANTOS study, CANA treatment was associated with reduced lung cancer incidence and mortality in patients (pts) with stable post-myocardial infarction who had elevated high-sensitivity C-reactive protein levels, thus providing a rationale to investigate its possible therapeutic role in lung cancer. Methods: CANOPY-A, CANOPY-1, and CANOPY-2 are phase III, multicenter, randomized, double-blind, placebo-controlled studies. In CANOPY-A, pts (~1,500) with stages IIA–IIIA and IIIB (T>5 cm N2), any histology, completely resected (R0) NSCLC, who received cisplatin-based chemotherapy (CTx), will be enrolled and randomized 1:1 to receive either CANA (200 mg Q3W SC) or placebo (Q3W SC) for 18 cycles. As of Oct 8, 2019, there are 278 study locations per clinicaltrials.gov. The primary endpoint will be disease-free survival. Key secondary endpoint will be overall survival (OS). CANOPY-1 and CANOPY-2 will each consist of part 1 (open-label, safety run-in) and part 2 (randomized, placebo-controlled; efficacy and safety evaluation). Eligible pts should have ECOG PS ≤1 and no prior EGFR sensitizing mutations and/or ALK rearrangements. In CANOPY-1, pts with previously untreated stage IIIA–IIIB NSCLC and known PD-L1 status (part 2 only) will be enrolled. Part 1 will consist of 3 cohorts of ~9 pts each (based on different platinum-CTx) to confirm the recommended phase 3 regimen (RP3R) for CANA. Pts will be treated with full doses of CTx plus pembrolizumab plus CANA. Enrollment and safety observation period for part 1 is complete. In part 2, pts (~600) will be randomized (1:1:1:1) to receive CANA (200 mg Q3W SC) or placebo + pembrolizumab + platinum-doublet CTx for 4 cycles, followed by maintenance until progressive disease. As of Oct 15, there are 129 study locations per clinicaltrials.gov. In CANOPY-2, pts with stage IIIB–IV NSCLC, who received prior PD-(L)1 inhibitor therapy and platinum-based CTx, and no PD-(L)1 selection, will be enrolled. Part 1 will enroll ~9 pts to confirm the RP3R of CANA. Pts will be treated with full doses of CANA 200 mg SC + docetaxel 75 mg/m² i.v. on day 1 of each 21-day cycle. Enrollment to part 1 of the study is complete. In part 2, pts (~226) will be enrolled and randomized 1:1 to receive CANA (200 mg Q3W SC) or placebo + docetaxel. As of Oct 23, there are 85 study locations per clinicaltrials.gov. In part 1 (both studies), the primary endpoint is the incidence of dose limiting toxicities in the first 42 days of treatment. In part 2, the primary endpoints are progression-free survival (PFS) and OS in CANOPY-1, and OS in CANOPY-2. Common secondary endpoints (both studies) include overall response rate, disease control rate, time to response, duration of response, PFS (CANOPY-2), pharmacokinetics, safety, patient-reported outcomes, and immunogenicity. All three studies (CANOPY-A, CANOPY-1, and CANOPY-2) are currently recruiting.

B10
Prevalence of EGFR Mutation Among Vietnamese Non-Small Cell Lung Cancer: A Preliminary Study

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Aims: To investigate the distribution of epidermal growth factor receptor (EGFR) mutations, and explore any relationships with characteristics of non-small cell lung cancer (NSCLC) patients. Materials and Methods: EGFR mutations were assessed by Scorpions and ARMS technologies (therascreen® EGFR RQ PCR Kit - Qiagen) in randomized sample block of 200 NSCLC patients from Vietnam National Cancer Hospital. Relationships between EGFR mutation and patient characteristics were analyzed by R statistical software. Results: The EGFR mutation rate was 41% (83/200); 19-del and L858R mutations occurred predominantly, accounting for 55.4% and 27.2%, respectively, in mutated cases. Moreover, 3.5% patients were found to carry double mutations. EGFR mutations occurred more frequently in women (75%) than in men (27.1%) (P<0.001). Mean ages of patient with mutation and without mutation were 56.51 (±8.86) and 58.83 years (±9.05), respectively (P=0.073). Gender distribution was significantly different between the 2 groups of mutation and no mutation (p<0.001). In EGFR mutation group, 98.3% of them possessed the Vietnamese health insurance and 9.6% of them which their first diagnosis had no relation with lung carcinoma. Conclusions: The EGFR mutation rate was 41% in NSCLCs in Vietnam, so that about 40% of patients might benefit from targeted therapies. Further studies are required to have a comprehensive understanding about the other clinical characteristics and EGFR mutation in Vietnamese patients.

B11
Accurate Detection of METex14 Mutations in Non-Small Cell Lung Cancer (NSCLC) with Comprehensive Genomic Sequencing: Results from the GEOMETRY Mono-1 Study

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Background: MET exon 14 skipping mutations (METex14) occur in 3–4% of patients (pts) with NSCLC. Accurate detection of the genomic variants that result in METex14 in MET-driven tumors could facilitate timely intervention with selective MET inhibitors (METi) and improve