Alberta patients with a diagnosed 2018-2020 with unresectable Stage III NSCLC, having received consolidation durvalumab following ≥2 cycles of platinum-doublet chemotherapy and concurrent definitive radiotherapy, without progression and suitable for immunotherapy treatment, were identified. Demographic, clinical, treatment and outcome details were extracted from the Glans-Look Lung Cancer Research Database. Patients were grouped according to response to durvalumab: 'Early-failure' were those with progressive disease as best treatment response, or those with non-evaluable disease due to durvalumab discontinuation prior to treatment response assessment. 'Responders' were defined as those achieving a best response of stable disease or higher. Univariate and multivariate methods compared the Early-Failure and Responder groups and identified factors predictive of early durvalumab failure while controlling for confounders. **Results:** 94 patients were identified: 53% female, 89% ever-smokers, 91% ECOG<2, 69% overweight/obese, 48% recorded as experiencing an immune-related adverse event (irAE), 54% PD-L1 positive, 31% age > 70 years at diagnosis, 6% with detected oncodriver (83% EGFR-mutant, 17% ROS1-rearranged), 23% receiving additional post-durvalumab systemic therapy, and median overall survival of 36.7 months. 75% of the cohort were Responders, and the remaining 25% meeting the criteria to be categorized as Early-failure: 78% by virtue of progressive disease present at first response evaluation, and the remainder discontinuing durvalumab due to toxicity (13%) or patient decline/death (9%). Early-failure and Responders were similar in relation to demographic and clinical characteristics with the exception that when compared to Responders, Early-failures reported a significantly lower rate of mild irAE characterized primarily as skin rash or endocrine-related (0% vs. 38%, p<0.001), a higher rate of post-durvalumab systemic therapy (52% vs. 14%, p<0.001) and a significantly shorter survival time (13.1 month vs. not reached, log-rank p<0.001). Additional systemic therapy in the Early-failure cohort failed to salvage outcome, with no significant difference in survival between those with and without additional post-durvalumab systemic therapy (18.1 vs. 11.6 months, log-rank p=0.61). Multivariate analysis revealed a history of smoking decreased the odds of experiencing Early-failure on durvalumab [OR: 0.09, p=0.02] **Conclusions:** This study found 25% of patients in a real-world clinical setting failed to achieve clinical disease control on durvalumab, mostly by virtue of primary durvalumab resistance. Demographic and clinical features fail to distinguish those at risk of early failure on durvalumab, suggesting other underlying and not routinely assessed features of the tumour microenvironment may be placing patients at risk of early failure and poor outcome. Future investigation to identify other factors associated with response to durvalumab appears crucial, particularly in the finding of this study that additional post-durvalumab systemic therapy appears to be limited in meaningfully impacting patient prognosis. **Keywords:** durvalumab, locally advanced NSCLC, treatment failure

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Who Benefits More of Durvalumab after Chemoradiotherapy (CRT) in Real-World Patients with Locally Advanced Non-Small-Cell Lung Cancer (NSCLC)?

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Introduction: Durvalumab received EMA approval as consolidation therapy (CT) for unresectable stage III NSCLC with PD-L1 ≥1% and who did not have progression after CRT. Our objective was to analyze in real clinical practice the effectiveness of durvalumab and explore the clinical factors that may be associated with the benefit from CT. **Methods:** Retrospective study was made at Hospital of Leon (Spain), including 37 patients with locally advanced NSCLC treated with durvalumab after CRT treatment between March 2018 and october 2021 (40.5% patients were included in the durvalumab early access program). The neutrophil-to-lymphocyte ratio (NLR) could identified after CRT as a factor that may be benefit from durvalumab. **Results:** Median age was 67 years (range 46-82 years). 40.5% of patients were ≥70 years old. 78.4% were male and 51.4% smokers. 54% had non-squamous histology. PD-L1 expression was <1% in 5% and not available in 8% patients. 2.7% ROS1 rearrangements, 5.4% KRAS mutations and not available in 43.2% patients. Stage IIIA, IIIB, IIIC disease were 24.3%, 54.1% and 21.6%, respectively. Median time from end of CRT to onset durvalumab was 44 days (range 13-120 days). Overall median CT duration was 214.8 days (range 69-399 days) with a median of 14 infusions (range 6-27 infusions). With a median follow up of 19.7 months (range 1.4-34.9 months); 67.6% had stopped CT: 37.8% due to completing treatment, 16.2% disease progression, 10.8% adverse event and 2.7% due to COVID19 infection. Median real-world progression-free survival (rwPFS) was 17 months (95% CI, 11-23). Median real-world overall survival (rwOS) was 29.9 months (95% CI, 23.3-36.6). % rwOS at 6, 18 and 24 months were 100%, 86.9% and 74.5%, respectively. For patients with post-CRT NLR not exceeding the cohort median value of 6, receipt of durvalumab was associated with an improvement in rwOS (median not reached vs 25.7 months; p=0.025). 56.8% patients had any grade of radiation pneumonitis (median time from CRT start: 119 days [range 36-241 days]). Of these, 19% patients developed worsening of radiation pneumonitis with durvalumab. 54,1% developed immune-mediated toxicity, mostly G1-2 (85.1%). **Conclusions:** Our results demonstrate the effectiveness of durvalumab consolidation in this patients population in a real-life setting. We identified low NLR after CRT as a potentially predictive factor for the benefit of CT in locally advanced NSCLC. **Keywords:** DURVALUMAB, PACIFIC, REAL WORLD DATA

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Durvalumab after Chemoradiotherapy (CRT) in Unresectable Stage III NSCLC. Comparative Study of Two Cohorts in the Real-World Setting

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Introduction: Durvalumab is the new standard of care for unresectable locally advanced NSCLC, with PD-L1 ≥1% and who did not have progression after CRT treatment in the European Union. Our study compares the effectiveness and the frequency of radiation pneumonitis in patients treated with concurrent CRT with or without durvalumab consolidation during the same period in real clinical practice. **Methods:** A single-center retrospective study. 71 treated patients with unresectable stage III NSCLC were included between March 2018 and December 2021, 37 with CRT followed by durvalumab and 34 with CRT alone. Real-world progression-free survival (rwPFS) and real-world overall survival (rwOS) were calculated since the date of the end CRT. Propensity score matching (PSM) 1:1 was used to account for differences in baseline characteristics. **Results:** Median age was 67 years (range 46-82). 25.4% of the patients were ≥75 years old. 78.9% were men and 53.5% former smokers. 54.9% had squamous histology and 28%, 51% and 21% stage IIIA, IIIB and