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Osimertinib Plus Chemotherapy for EGFR-mutated Advanced Non-Small-Cell Lung Cancer

Date: January 1,2026

EGFR-mutated advanced non-small-cell lung cancer (NSCLC) has traditionally been treated with EGFR tyrosine kinase inhibition, but disease progression and central nervous system involvement remain major clinical challenges that limit long-term disease control.

The FLAURA2 study was an international, phase 3, randomized trial that enrolled 557 patients with untreated, EGFR exon 19 deletion or L858R-mutated locally advanced or metastatic NSCLC. Participants were assigned to osimertinib plus platinum-pemetrexed chemotherapy or osimertinib alone, with the final analysis showing a median overall survival of 47.5 months versus 37.6 months, respectively. This corresponded to a hazard ratio for death of 0.77 (95% confidence interval [CI] 0.61–0.96; P=0.02).

Apart from the survival benefit, the study observed improved disease control, including prolonged progression-free survival, and the benefit was observed across clinically relevant subgroups, including patients with and without baseline brain metastases. However, this combined regimen also increased treatment burden, with grade 3 or higher adverse events reported in 70% of patients receiving osimertinib plus chemotherapy (leading to 12% of discontinuation) versus 34% with osimertinib alone (7% of discontinuation).

In conclusion, the study reinforced osimertinib as a backbone EGFR-targeted agent while establishing platinum-pemetrexed as an effective intensification strategy in selected first-line patients.

Source: www.nejm.org

A Placebo-Controlled Trial of the Oral PCSK9 Inhibitor Enlicitide

Date: February 4, 2026

A recent phase 3 trial evaluated whether enlicitide, an oral PCSK9 inhibitor, could provide potent LDL cholesterol lowering in adults at elevated cardiovascular risk. The study was designed to test a convenient oral alternative to injectable PCSK9-targeted therapy in patients who still had residual LDL-C burden despite receiving standard lipid-lowering treatment.

The CORALreef Lipids trial enrolled 2,909 adults, with a mean age of 63 years and 39.3% women. Participants were randomized 2:1 to enlicitide 20 mg once daily or placebo for 52 weeks, with the primary endpoint defined as the percent change in LDL-C from baseline to week 24.

Enlicitide produced a mean LDL-C reduction of 57.1% at 24 weeks, compared with a 3.0% increase in the placebo group, corresponding to an adjusted between-group difference of -55.8 percentage points (95% confidence interval [CI] -60.9 to -50.7; P<0.001). The LDL-lowering effect was sustained through week 52, and key secondary lipid outcomes also favoured enlicitide compared to placebo, including reductions in non-HDL cholesterol, apolipoprotein B, and lipoprotein(a). A large proportion of treated patients achieved clinically meaningful LDL-C goals, with 70.3% reaching both at least a 50% LDL-C reduction and an LDL-C level below 70 mg/dL. Safety outcomes were broadly similar between groups, and no major new tolerability signal was reported.

These results suggest that oral PCSK9 inhibition with enlicitide may become a valuable option for intensive lipid lowering, especially for patients with atherosclerotic cardiovascular disease or high residual cardiovascular risk who would benefit from a non-injectable therapy for better adherence.

Source: www.nejm.org

Ileocaecal Resection Versus Infliximab for Ileal Crohn's Disease: Retrospective 10-year Follow-Up of the LIR!C Trial

Date: February 18, 2026

As a chronic inflammatory bowel disease, Crohn's disease can be difficult to control when it is localized to the ileocaecal region and does not respond to conventional treatment. In this setting, long-term comparative data from the LIR!C trial suggest that ileocaecal resection (ICR) may offer a durable alternative to infliximab (IFX), particularly when the goal is sustained remission without ongoing therapy.

In this study, a retrospective 10-year follow-up of the LIR!C trial evaluated ileocaecal resection versus infliximab in adults with non-structuring, immunomodulator-refractory ileocaecal Crohn's disease. The analysis included 129 of 143 original participants, with follow-up data available for 66 patients in the resection group and 63 in the infliximab group; the median age at randomisation was 28 years and the median follow-up was 11 years.

The primary long-term endpoint was 10-year therapy-free remission, defined as clinical remission without Crohn's disease-related therapy after resection or discontinuation of infliximab. Therapy-free remission was significantly higher with ICR than with IFX, at 35.8% versus 13.2%, respectively, with an absolute difference of 22.6 percentage points (95% confidence interval [CI] 7.8–36.8; p=0.0038–0.004). For overall 10-year clinical remission, the two strategies were broadly comparable: 36.5% in the ICR group versus 28.4% in the IFX group. The hazard ratio for clinical remission was 0.79 (95% confidence interval [CI] 0.52–1.20; p=0.27), indicating no statistically significant difference in the overall time-to-remission analysis.

Moreover, an exploratory age-stratified analysis suggested that younger patients exhibited greater benefit from surgery. The estimated 10-year clinical remission rate in a 20-year-old was 54% with ileocaecal resection versus 24% with infliximab, while for a 30-year-old it was 38% versus 28%, respectively.

Overall, the study supports ileocaecal resection as an effective early treatment option for selected patients with ileal Crohn's disease, particularly when the goal is remission without ongoing Crohn's disease therapy.

Source: www.thelancet.com

Finerenone Demonstrates Clinical Benefits in Albuminuria for Patients with Type 1 Diabetes and Chronic Kidney Disease

Date: March 5, 2026

Despite advancement in diabetes care over the past years, renin-angiotensin system inhibitors remains as the mainstay treatment approach for patients with chronic kidney disease (CKD) derived from type 1 diabetes. Finerenone, a nonsteroidal mineralocorticoid receptor antagonist, was previously proven to delay CKD progression in patients with type 2 diabetes and CKD. Yet, its clinical efficacy and safety amongst patient groups with type 1 diabetes and CKD remain unknown.

The FINE-ONE trial was a phase 3, international, prospective, double-blind and randomized study which compared the use of finerenone with placebo in adults with type 1 diabetes and CKD. A total of 242 eligible participants were randomly assigned in 1:1 ratio to receive oral daily finerenone (n=120) or matching placebo (n=122) for 6 months. The initial dosing of finerenone in the treatment group was done based on participant's eGFR at screening: (1) 20 mg per day if eGFR ≥ 60 ml/min/1.73m2 or (2) 10 mg per day if eGFR is between 25 to less than 60 ml/min/1.73m2. Participants receiving 10 mg per day as initial dose may further titrate dose to 20 mg per day from month 1 onwards, depending on subsequent serum potassium and eGFR levels. The primary efficacy outcome was the relative change in urinary albumin-to-creatinine ratio from baseline over 6 months.

At month 6, the geometric mean percentage change in urinary albumin-to-creatinine ratio was -34% (least-squares geometric mean ratio to baseline=0.66, 95% confidence interval [CI], 0.60-0.73) in the finerenone group and -12% (least-squares geometric mean ratio to baseline=0.88, 95% confidence interval [CI], 0.79-0.98) in the placebo group respectively. The urinary albumin-to-creatinine ratio using finerenone had decreased by 25% more than matching placebo (least-squares geometric mean ratio=0.75, 95% confidence interval [CI], 0.65-0.87, P<0.001). Safety outcomes were similar in both groups with comparable incidence of adverse events.

In conclusion, finerenone demonstrates statistically meaningful decrease in urinary albumin-to-creatinine ratio than placebo over 6 months in adult patients with type 1 diabetes and CKD.

Source: www.nejm.org

Apixaban Demonstrates Lower Bleeding Risk than Rivaroxaban among Patients with Acute Venous Thromboembolism

Date: March 12, 2026

Patients with acute venous thromboembolism (VTE) usually requires anticoagulation therapy for a minimum of 3 months in order to prevent recurrent thrombotic events. Given the ease of drug administration and reduced need of monitoring, apixaban and rivaroxaban are the most commonly prescribed direct oral anticoagulants for patients suffering from VTE. However, uncertainty remains regarding the difference in bleeding risk between the two anticoagulants.

The prospective, international, randomized, open-label, blinded end-point COBRRA trial randomized 2700 patients with acute venous thromboembolism in 1:1 ratio to receive either (1) apixaban 10 mg twice daily for 7 days followed by 5 mg twice daily (n=1345) or (2) rivaroxaban 15 mg twice daily for 21 days then 20 mg daily (n=1355) for 3 months. The primary outcome was the incidence of clinically relevant bleeding, a composite of major bleeding or clinically relevant non-major bleeding as defined by the International Society on Thrombosis and Haemostatsis during the 3-month treatment period.

Clinically relevant bleeding occurred in 3.3% of patients in the apixaban group and 7.1% of patients in the rivaroxaban group (relative risk=0.46, 95% confidence interval [CI], 0.33-0.65, P<0.001) during the 3-month trial period based on intention-to-treat analysis. Recurrence of symptomatic VTE was documented in 1.1% and 1.0% of patients in the apixaban and rivaroxaban group respectively (relative risk=1.08, 95% confidence interval [CI], 0.52-2.23). No deaths attributed to recurrent venous thromboembolism was noted in both treatment groups.

To summarize, the risk of clinically relevant bleeding was significantly lower when patients with acute VTE were given apixaban as compared with rivaroxaban as primary treatment.

Source: www.nejm.org

Atezolizumab-FOLFOX Therapy Prolongs Disease-free Survival in Patients with Stage III Mismatch Repair Deficient Colon Cancer

Date: March 26, 2026

Colorectal cancer is the third commonest cancer in Hong Kong and local data reveals approximately 15% of localized colon cancers demonstrates mismatch repair deficiency (dMMR), which poses intrinsic resistance against standard fluoropyrimidine therapy. Thus, immunotherapy targeting dMMR colorectal cancer is rapidly developing to improve survival outcomes. Atezolizumab, an anti-programmed death ligand 1 antibody, prevents the downregulation of anti-tumour T cells and hence enhancing the immune system to work against the malignant tumour.

In this phase 3, international ATOMIC trial, a total of 712 eligible patients with resected stage III dMMR colon cancer were randomly assigned in 1:1 ratio to receive either (1) atezolizumab (IV 840 mg every 2 weeks) plus modified FOLFOX6 (mFOLFOX6) for 12 cycles followed by atezolizumab monotherapy for 13 cycles (n=355) or (2) modified FOLFOX6 therapy for 12 cycles per standard of care (n=357). The mFOLFOX6 regimen in both groups consisted of fluorouracil, oxaliplatin and leucovorin with the same dose per square meter. The key primary end point was disease-free survival, defined as the time from randomization to disease recurrence or death from any cause.

As of the data-cutoff date (February 4, 2025), the 3-year disease-free survival was 86.3% (95% confidence interval [CI], 81.8-89.8) in the atezolizumab-mFOLFOX6 group and 76.2% (95% confidence interval [CI], 70.9-80.6) in the mFOLFOX6 group, with a stratified hazard ratio for disease recurrence or death of 0.50 (95% confidence interval [CI], 0.35-0.73, P<0.001). Yet, the 5-year overall survival between the two groups did not show statistically significant difference (89.7% in atezolizumab-mFOLFOX6 group vs 87.9% in mFOLFOX6 group, stratified hazard ratio=0.90, 95% confidence interval [CI], 0.55-1.47). Incidence of grade 3 or above adverse events was also more prevalent in atezolizumab-mFOLFOX6 group (84.1%) than mFOLFOX6 group (71.9%).

To conclude, the addition of atezolizumab to mFOLFOX6 regimen as immunotherapy significantly improved disease-free survival among patients with stage III dMMR colon cancer.

Source: www.nejm.org