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HCP CONVERSATIONS ON FERMA · CONFIDENTIAL

ESMO 2026: what oncologists took home

20 AI-moderated oncologist interviews in the two weeks after the congress.



EXECUTIVE SUMMARY

One study changed practice in every market; access, not conviction, sets the clock

01 DeLLphi-305 is the undisputed practice-changer

02 SAFFRON makes MET testing at progression the default

03 ADCs move into new tumours and earlier lines

04 Immunotherapy frontiers split the room

05 Time to practice is set by national access

TOP OF MIND

What they would tell a colleague

DeLLphi-305.



7 of 20 named the tarlatamab plus durvalumab maintenance data. Next came INTerpath-001, named by four.

UNPROMPTED

The study they raised without being asked

Krascendo 1.

7 of 20 raised the KRAS G12C data unprompted, though it was not on our list.
Divarasib against sotorasib or adagrasib: PFS 9.8 vs 5.7 months.

RESPONDENT PROFILE

Who we spoke to

20

interviews completed

18 EU and UK against a quota of 16, plus 2 US

6

countries

Italy 5 · Germany 4
Spain 3 · UK 3
France 3 · US 2

12 / 6

academic / community

2 unspecified (UK NHS consultant, Spain tertiary)

93

pre-screener completes

85 medical oncology,
8 haemato-oncology;
70 academic,
23 community

APPROACH

The method

Format	AI-moderated voice interview, 10 to 15 minutes, in the two weeks after the congress
Structure	Unaided reactions, top-3 impact ranking, then up to three scripted deep dives chosen from a priority list by familiarity and attendance
Close	1 to 7 familiarity rating on 12 sessions; four ADC-sequencing agreement statements

CAVEATS

Read with care

01 US 02 answers were often cut off mid-sentence, and Germany 04 switched language mid-interview; both are counted.

02 Two HCPs were deep-dived on sessions they had not reviewed (Italy 02 on INTerpath-001; Spain 03 on INTerpath-001 and TroFuse-005).

03 France 01 lost the moderator repeatedly over 45 minutes; UK 03 answers are thin. Numbers quoted by HCPs are their recall, not the abstracts.

COVERAGE

Deep-dive coverage and familiarity

Session	Deep dives	Familiarity (1-7)	Rated 6+
SAFFRON	11	5.4	11 of 20
DeLLphi-305	11	5.5	11 of 20
INTerpath-001	7	4.8	10 of 20
DESTINY-Lung04	5	5.8	13 of 20
VOLGA	5	4.8	9 of 20
OptiTROP-Lung04	5	5.2	10 of 20
TroFuse-005	4	4.5	4 of 20
CLARITY-Gastric01	4	4.8	8 of 20
KEYNOTE-C93	3	5.1	10 of 20
SANOVO	2	5.5	11 of 20
HARMONi-GI1	2	4.5	5 of 20
KEYNOTE-866	1	4.8	10 of 20

TAKEAWAY 01

DeLLphi-305

Tarlatamab plus durvalumab maintenance is the new standard in ES-SCLC, in every market

11 deep dives, 11 positive; median OS 21 vs 12.7 months; replaces IMforte for 8 of 9



TAKEAWAY 01 · DELLPHI-305

All eleven deep dives call it practice-changing

HCPs quote median OS 21 vs 12.7 months, HR about 0.42, PFS 7.4 vs 1.9 months, ORR 26% vs 4%. The one hesitation (Italy 05) is that first-line combinations may overtake it.

> Median overall survival is already 21 months, exceeding 20 months, a result we would never have expected in this serious cancer.
>
> Medical oncologist, community hospital, France (FR-01)

> Previously, we thought we had reached a plateau potentially.
>
> Medical oncologist, teaching hospital, UK (UK-02)

TAKEAWAY 01 · DELLPHI-305

It replaces IMforte rather than adding to it

Eight of the nine who compared them would displace atezolizumab plus lurbinectedin: better OS, less haematologic toxicity, a novel mechanism. US 01 would once monitoring is solved; US 02 sees an extra option.



TAKEAWAY 01 · DELLPHI-305

The share of patients on maintenance does not grow

Eight of eleven say the proportion stays the same because it is set by response to induction; Italy 02 and 03 and US 02 would treat more patients.



TAKEAWAY 01 · DELLPHI-305

CRS monitoring is the operational cost

US 01, Italy 05, UK 02 and France 03 raise inpatient or day-hospital starts, monitoring pathways and scale-up; Spain 02 wants a predictive biomarker; no head-to-head with IMforte exists.

> “I think it is definitely practice-changing to use tarlatamab with durvalumab in the maintenance setting. However, tarlatamab is a difficult drug to administer, so we’ll have to see how it works in real-world practice.
>
> Haematologist-oncologist, community hospital, US (US-01)

TAKEAWAY 02

SAFFRON

SAFFRON turns MET testing after osimertinib into the default, but testing is the bottleneck

11 deep dives; 8 of 10 asked would test every patient; oral, chemo-free; gated by testing infrastructure



TAKEAWAY 02 · SAFFRON

Joint most-discussed study: 11 of 20 deep-dived it

HCPs cite PFS 7.5 vs 5.4 months (HR 0.55), a 30 to 32% lower risk of death and median OS 17.8 months.

10 of 11



Reactions are positive in ten; UK 03 is the outlier.

TAKEAWAY 02 · SAFFRON

An oral, chemo-free option beats amivantamab on burden

France 01 and 03, Germany 02 and US 01 see it as at least as effective as MARIPOSA-2 and far simpler to give; Italy 05 and Spain 02 call the populations non-comparable.

> It is an oral treatment and much simpler than amivantamab, which is difficult to administer, not well tolerated, and involves three injectable treatments when chemotherapy is included.
>
> Medical oncologist, community hospital, France (FR-01)

TAKEAWAY 02 · SAFFRON

Most would test every patient for MET

Eight of ten asked would test every patient for MET at progression, often by re-biopsy. Spain 03 says half and UK 03 “quite likely”; Spain 02 warns it is not yet routine.

> The results of SAFFRON are good news for patients, but they are a challenge for clinicians, who will need to be more insistent about re-biopsying patients at progression.
>
> Thoracic oncologist, academic hospital, France (FR-03)

TAKEAWAY 02 · SAFFRON

Timeline depends on the lab, not the label

Months in France, Germany and the US; a year to 18 months in Italy to get upfront testing in place; UK 03 sees no change for five years.

> At least a year to a year and a half, because appropriate upfront testing must be ensured for all patients.
>
> Thoracic medical oncologist, academic, Italy (IT-05)

TAKEAWAY 03

Antibody-drug conjugates

ADCs are moving into endometrial, gastric and first-line HER2 lung; a second ADC is accepted

TroFuse-005, CLARITY-Gastric01, DESTINY-Lung04, OptiTROP-Lung04; 16 to 18 of 20 accept a second ADC, 13 want another treatment first



TAKEAWAY 03 · ANTIBODY-DRUG CONJUGATES

TroFuse-005: a new post-IO line in endometrial cancer

OS 19 vs 12 months, PFS 7.2 vs 3.9. France 01 makes it the second-line standard after immunochemotherapy; UK 01 parks it in third line behind biomarker-targeted options.

> I would probably leave it to third line and use other biomarker-targeted therapy in second line.
>
> Consultant oncologist, NHS, UK (UK-01), on TroFuse-005

TAKEAWAY 03 · ANTIBODY-DRUG CONJUGATES

CLARITY-Gastric01 broadens the CLDN18.2 pool

OS 10 vs 5 months in third line plus; expression in over 25% of cells qualifies, wider than zolbetuximab. Germany 01 and 04 would use it second line, US 02 third line; Italy 03 would test every patient.

> It was also notable that CLDN18.2 expression in more than 25% of tumor cells was sufficient, which means the eligible population may be broader than with established CLDN18.2-targeted treatments such as zolbetuximab.

Oncologist and haemato-oncologist, cancer centre, Germany (DE-01)

TAKEAWAY 03 · ANTIBODY-DRUG CONJUGATES

DESTINY-Lung04 brings T-DXd to first-line HER2-mutant NSCLC

HCPs cite PFS 14.3 vs 8.3 months (HR 0.63), first shown at WCLC; ESMO added patient-reported outcomes. Called practice-changing in Germany, Italy and Spain; ILD monitoring and immature OS are the caveats.

> It could allow me to use a drug that is currently indicated only in later lines as early as first line, with a considerable response benefit without increasing toxicity for the patient.
>
> Medical oncologist, public hospital, Italy (IT-04), on DESTINY-Lung04

TAKEAWAY 03 · ANTIBODY-DRUG CONJUGATES

A second ADC works, but most want something in between

18 of 20 agree a second ADC can work with a different payload, 16 with a different antigen, 17 that ideally both differ. Yet 13 of 20 want a different treatment, such as chemotherapy, first; 5 disagree.



TAKEAWAY 04

Immunotherapy frontiers

The neoantigen vaccine and perioperative bladder data impress Germany and divide the UK

INTerpath-001 and VOLGA praised in Germany, questioned in the UK; KEYNOTE-C93 chemo-sparing; KEYNOTE-866 dismissed



> The risk of recurrence or death fell by 52% compared with pembrolizumab alone.

Haemato-oncologist, university hospital, Germany (DE-03), on INTerpath-001

TAKEAWAY 04 · IMMUNOTHERAPY FRONTIERS

INTerpath-001: feasible, positive, not yet superior

Germany 02 and 03 call the 52% lower recurrence risk practice-changing. The UK melanoma specialist says it was not shown better than neoadjuvant therapy, OS is missing and scale-up takes one to two years. Two of seven assigned had not reviewed it.

> One thing which it didn't show is that it is any better than what I think is the current standard of care, which is neoadjuvant.
>
> Medical oncologist, melanoma, teaching hospital, UK (UK-02), on INTerpath-001

TAKEAWAY 04 · IMMUNOTHERAPY FRONTIERS

VOLGA: a standard for the cisplatin-ineligible, with asterisks

EFS risk down 49%, OS down 42%. Germany 03, France 01, Spain 01 and the US adopt it; Spain 01 notes the comparator was surgery alone; UK 02 doubts a cisplatin-unfit patient tolerates the added toxicity.

> The comparator arm received no treatment, neither neoadjuvant nor adjuvant, and was compared with surgery. But these are also patients for whom there is no current standard treatment.
>
> Medical oncologist, university hospital, Spain (ES-01), on VOLGA

TAKEAWAY 04 · IMMUNOTHERAPY FRONTIERS

KEYNOTE-C93 spares chemotherapy in dMMR endometrial

PFS 30 to 38 vs 8 months with pembrolizumab alone; positive in all three deep dives, used first for frail patients. Italy 02 flags an underpowered comparator.

3 of 3

TAKEAWAY 04 · IMMUNOTHERAPY FRONTIERS

KEYNOTE-866 is written off; HARMONi-GI1 is a quiet win

KEYNOTE-866

Germany 02: primary endpoint not met, grade 3 to 5 toxicity, unlikely to be approved.

HARMONi-GI1

Italy 04 sees ivonescimab plus chemo replacing durvalumab plus chemo in biliary tract cancer; US 02 calls the gains dramatic.

TAKEAWAY 05

Time to practice

Conviction is uniform; the calendar is national

France
immediate where drugs exist

Germany and US
months

Spain
6 to 12 months

Italy and UK
1 to 2 years

TAKEAWAY 05 · TIME TO PRACTICE

France: immediate where the drug already has a label

Tarlatamab and enfortumab vedotin are already in use in later lines, so DeLLphi-305 and VOLGA need only reimbursement; new molecules wait a year or two for early access.

> Immediately, since both treatments are already available. We just need official authorization for reimbursement in the first line.
>
> Medical oncologist, community hospital, France (FR-01), on DeLLphi-305

TAKEAWAY 05 · TIME TO PRACTICE

Germany and the US: a few months after approval

The gating item is operational: MET testing, ILD surveillance, CRS monitoring. US 02 expects three months; US 01's gap is access plus tarlatamab monitoring.

- **France** · immediate where drugs exist
- **Germany and US** · months
- **Spain** · 6 to 12 months
- **Italy and UK** · 1 to 2 years

TAKEAWAY 05 · TIME TO PRACTICE

Spain: six to twelve months

Drugs already marketed move faster; SAFFRON and SANOVO wait for the indication and for MET testing to enter routine practice.

- **France** · immediate where drugs exist
- **Germany and US** · months
- **Spain** · 6 to 12 months
- **Italy and UK** · 1 to 2 years

TAKEAWAY 05 · TIME TO PRACTICE

Italy and the UK: one to two years, and uneven

Italy cites a slow agency and compassionate use as the only early route; the UK cites funding and pathway redesign. Italy 05 sees the gap between high-volume and peripheral centres widening.

> Unfortunately, in my country, Italy, I do not think this could be implemented in practice very quickly. The regulatory agency takes quite a long time, so we will not be able to benefit from these data quickly.
>
> Medical oncologist, public hospital, Italy (IT-04)

> 1 to 2 years. Again, we need to wait for funding and understand that this is something which we can scale up and give to more patients, particularly how to manage CRS and what the pathways are that would change in what we do currently.

Medical oncologist, teaching hospital, UK (UK-02), on DeLLphi-305

RECOGNITION

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