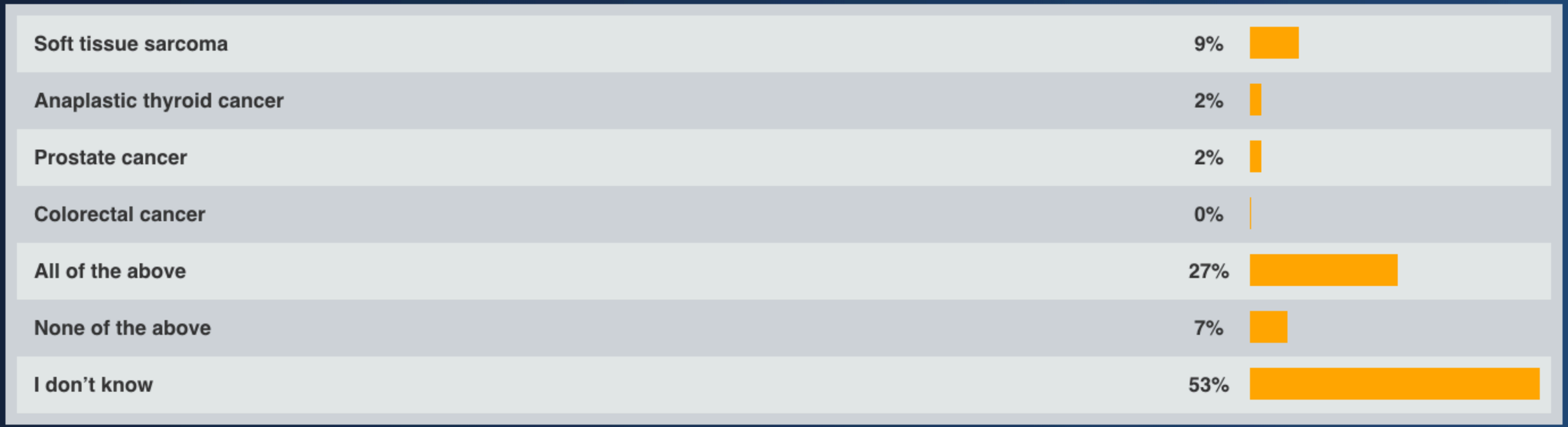
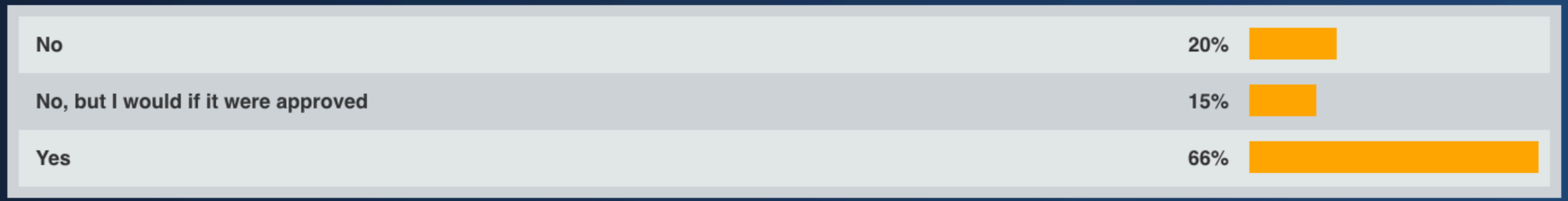
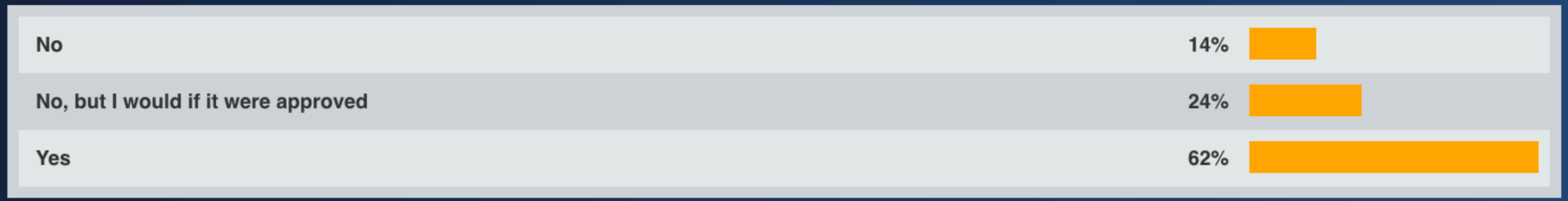
The CD274 gene amplification seen in Hodgkin lymphoma that is thought to relate to its sensitivity to PD-1/PD-L1 blockade has also been found in:



For an asymptomatic patient with unresectable, nonbulky Stage IIIB adenocarcinoma who has received and responded to your recommended chemoradiation therapy regimen, would you administer durvalumab as consolidation therapy?



For a mildly symptomatic patient with unresectable, bulky Stage IIIB adenocarcinoma who has received and responded to your recommended chemoradiation therapy regimen, would you administer durvalumab as consolidation therapy?



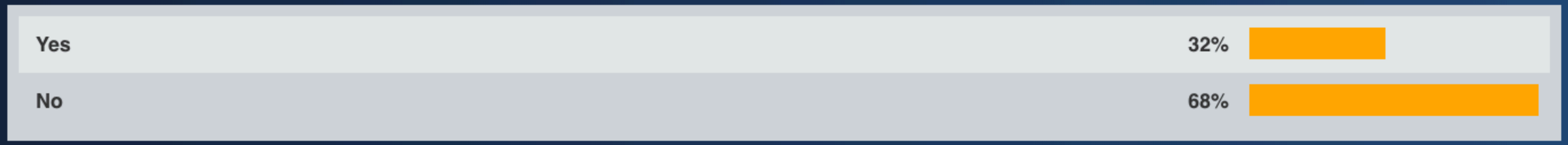
For a mildly symptomatic patient with unresectable, bulky Stage IIIB EGFR-mutated adenocarcinoma who has received and responded to your recommended chemoradiation therapy regimen, would you administer durvalumab as consolidation therapy?

For a mildly symptomatic patient with unresectable, bulky Stage IIIB adenocarcinoma, would you administer durvalumab as consolidation therapy if the patient achieved a partial response to chemoradiation therapy but was experiencing asymptomatic imaging changes suggestive of pneumonitis?

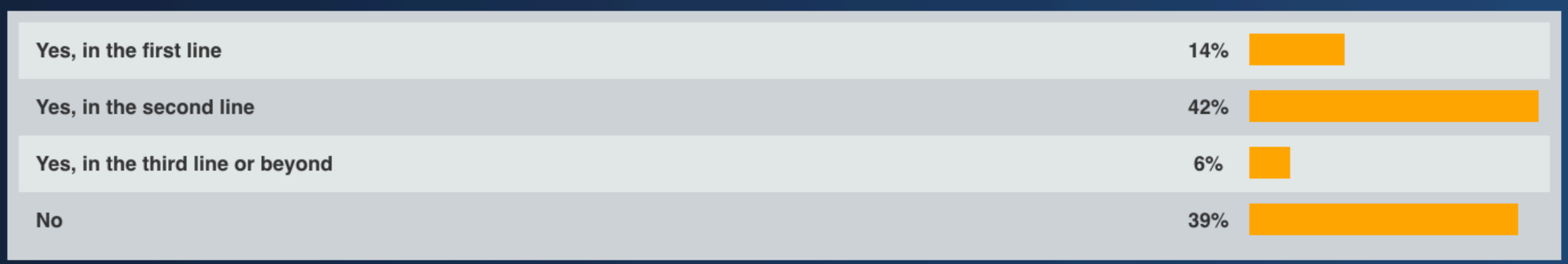
For a mildly symptomatic patient with unresectable, bulky Stage IIIB adenocarcinoma, would you administer durvalumab as consolidation therapy if the patient achieved a partial response to chemoradiation therapy but was experiencing mildly symptomatic pneumonitis?

For a mildly symptomatic patient with unresectable, bulky Stage IIIB adenocarcinoma, would you administer durvalumab as consolidation therapy if the patient achieved a partial response to chemoradiation therapy but was experiencing mildly symptomatic esophagitis?

Outside of a protocol setting, would you generally offer durvalumab as consolidation therapy after chemoradiation treatment to a patient with locally advanced NSCLC and Crohn's disease that is well controlled on infliximab?



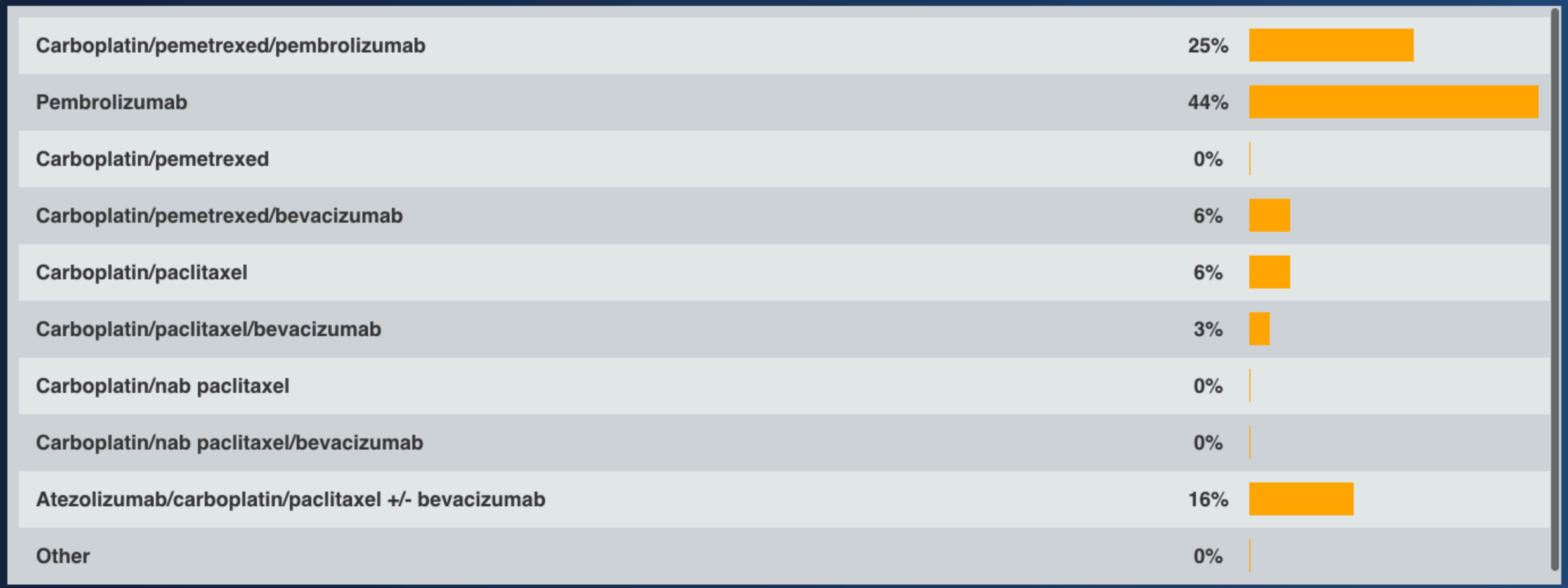
Outside of a protocol setting, would you generally offer an anti-PD-1/anti-PD-L1 antibody to a patient with metastatic NSCLC with no targetable tumor mutation and Crohn's disease that is well controlled on infliximab?



Reimbursement and regulatory issues aside, which first-line treatment regimen would you most likely recommend for an asymptomatic patient with metastatic nonsquamous lung cancer and no identified targetable mutations with a PD-L1 tumor proportion score (TPS) of 10%?

Carboplatin/pemetrexed/pembrolizumab	21%
Carboplatin/pemetrexed	21%
Carboplatin/pemetrexed/bevacizumab	24%
Carboplatin/paclitaxel	6%
Carboplatin/paclitaxel/bevacizumab	3%
Carboplatin/nab paclitaxel	3%
Carboplatin/nab paclitaxel/bevacizumab	6%
Atezolizumab/carboplatin/paclitaxel	3%
Atezolizumab/carboplatin/paclitaxel/bevacizumab	9%
Other	3%

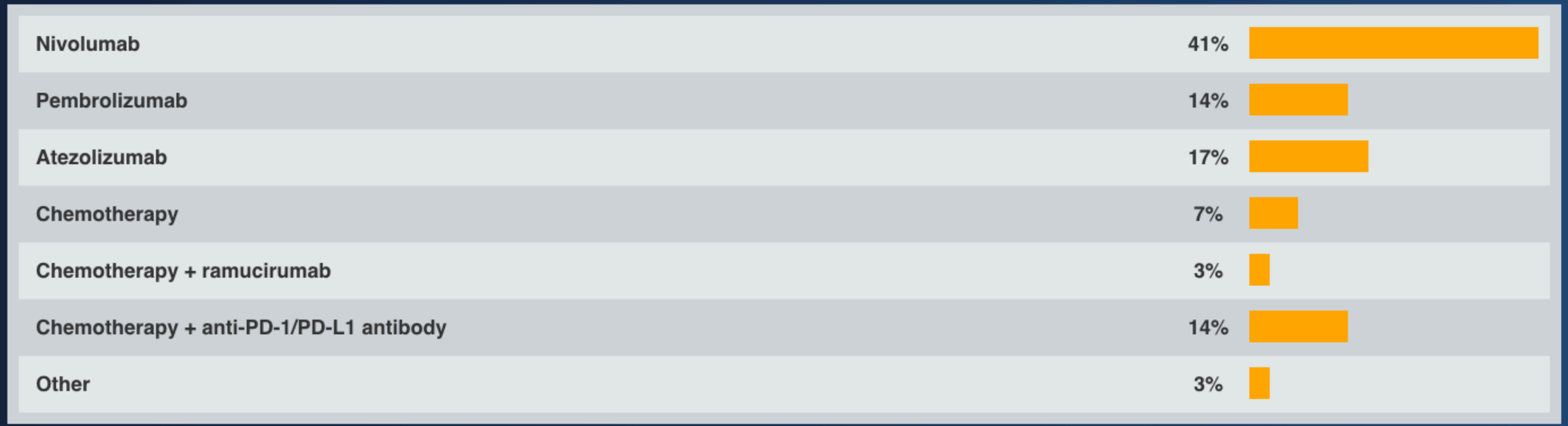
A 65-year-old patient presents with significant respiratory distress and highly symptomatic metastatic nonsquamous lung cancer with no identified targetable mutations and a PD-L1 TPS of 60%. Reimbursement and regulatory issues aside, what would be your most likely treatment recommendation?



A 65-year-old patient presents with significant respiratory distress and highly symptomatic metastatic squamous cell cancer of the lung and a PD-L1 TPS of 60%. What would be your most likely treatment recommendation?

Pembrolizumab	42%
Carboplatin/gemcitabine	6%
Carboplatin/paclitaxel	6%
Carboplatin/nab paclitaxel	6%
Cisplatin/gemcitabine	6%
Cisplatin/gemcitabine/necitumumab	10%
Carboplatin/gemcitabine/necitumumab	0%
Chemotherapy + anti-PD-1/PD-L1 antibody	13%
Other	10%

A patient with metastatic nonsquamous lung cancer with no identified targetable mutations and a PD-L1 TPS of <1% responds to first-line carboplatin/paclitaxel/bevacizumab but then experiences asymptomatic disease progression. What would you most likely recommend for this patient?



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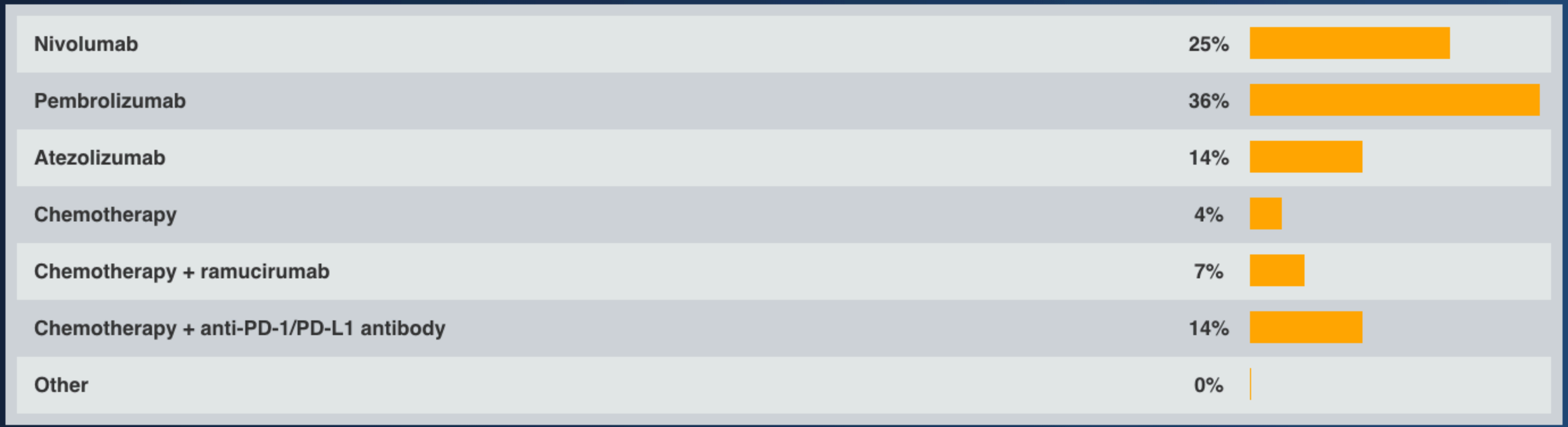
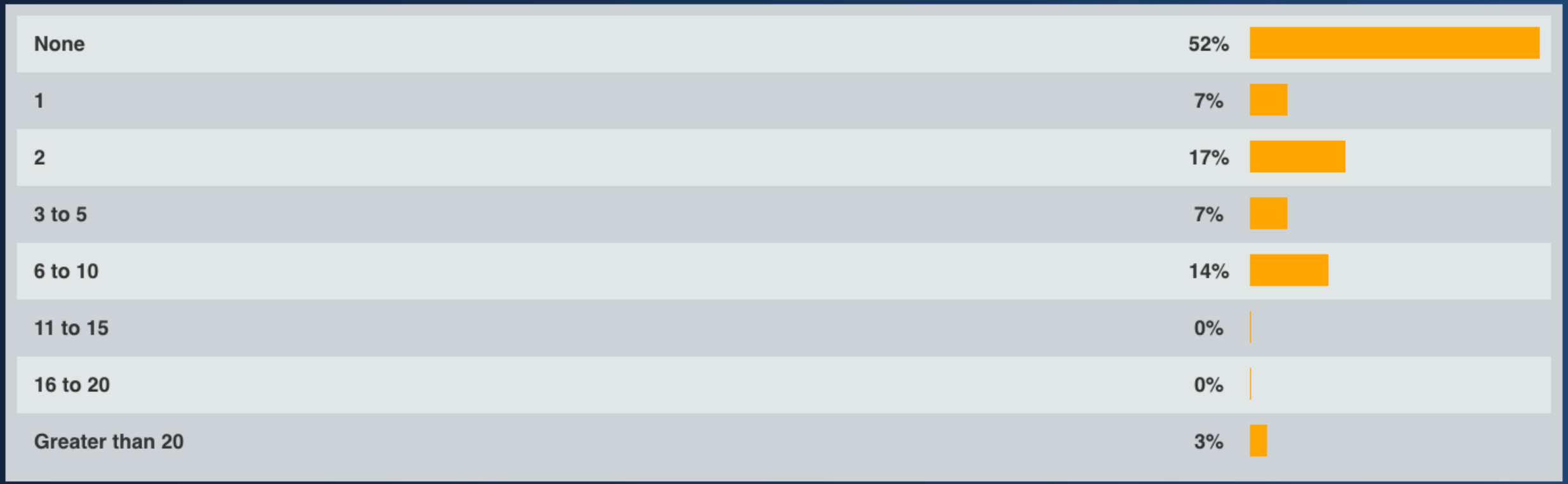
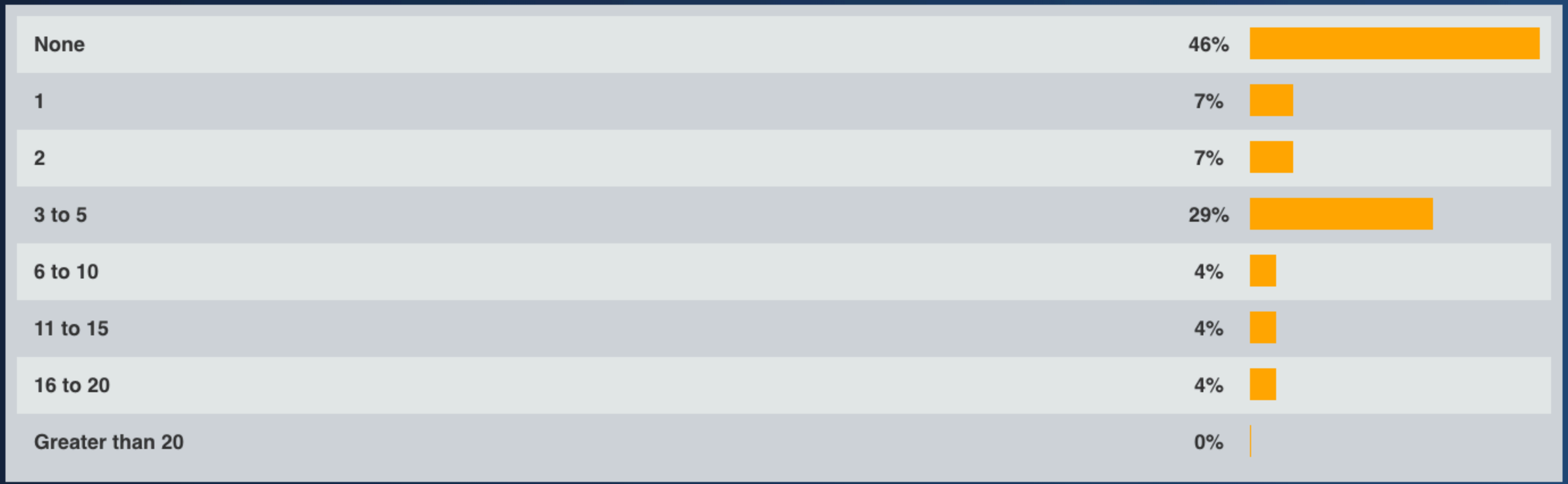


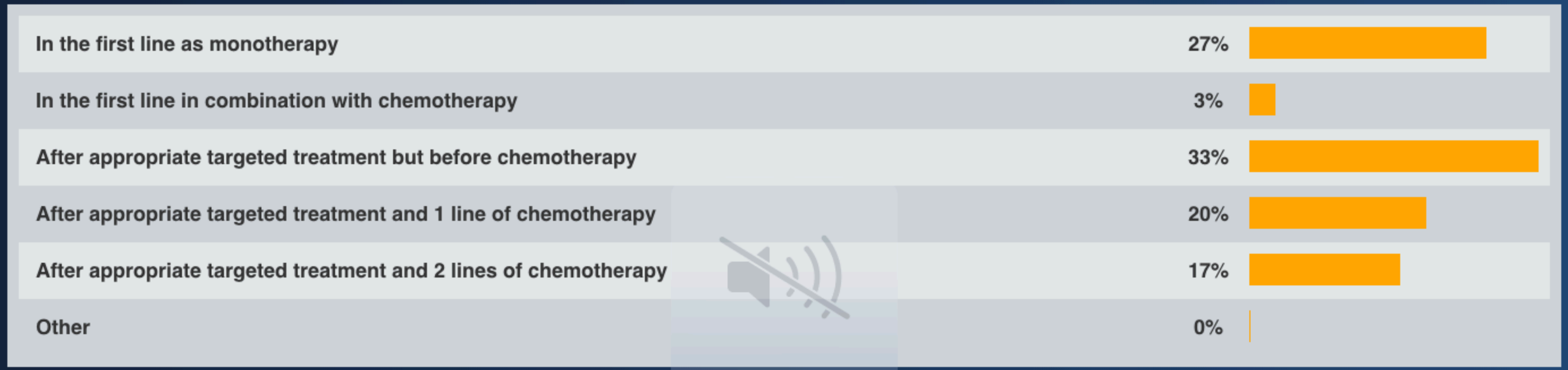
How many patients, if any, have you had in your practice who you would define as having experienced hyperprogression upon receipt of an anti-PD-1/anti-PD-L1 antibody?



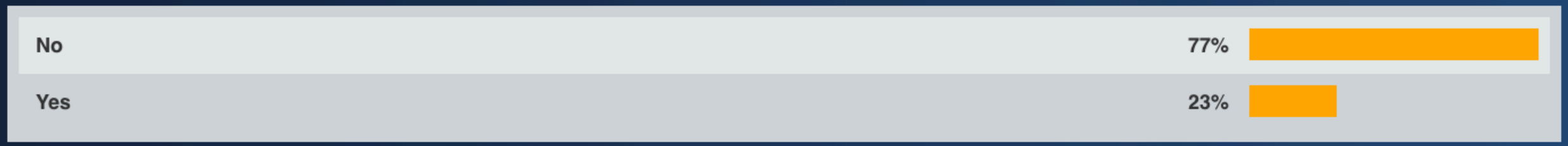
How many patients, if any, have you had in your practice who experienced objective disease progression while receiving an anti-PD-1/anti-PD-L1 antibody who then went on to have an objective response to continued treatment with that agent?



In general, when do you believe checkpoint inhibitors should be introduced into the treatment algorithm for a patient who is presenting with metastatic EGFR-mutated NSCLC and a PD-L1 TPS of 60%?



Are there any situations in which you would use the combination of an anti-PD-1/PD-L1 antibody and an anti-CTLA-4 antibody for metastatic NSCLC outside of a trial setting?



A 60-year-old patient with metastatic small cell lung cancer experiences a response to first-line carboplatin/etoposide but then experiences disease progression after 3 months. What would you recommend?