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ABSTRACT #818

EARLY TREATMENT DISCONTINUATION IN NSCLC: EVIDENCE FROM ASIAN REAL-WORLD SETTINGS

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BACKGROUND & OBJECTIVE

Background — NSCLC remains a leading cause of cancer mortality; trial benefits from targeted therapies and immunotherapy are not always sustained in practice.

ETD drivers — progression, deterioration, toxicity, financial toxicity, access barriers, and limited reimbursement.

Objective — assess ETD signals across India, Thailand, and Bangladesh.

Importance — improve outcomes, resource use, and equitable access.

METHODS

Literature review — publicly available real-world evidence studies.

Publication period — 2015–2025.

Countries — India, Thailand, and Bangladesh.

ETD assessment — direct reporting was limited; proxy indicators were evaluated.

Proxies — completion, duration, next-line transition, discontinuation reasons, and reimbursement impact.

Synthesis — descriptive by country; heterogeneous measures were not pooled.

STUDY AT A GLANCE

3 Asian countries reviewed

5 Real-world studies informing findings

10 y Evidence window: 2015–2025

0 Registry-based ETD studies identified for Bangladesh

ETD ASSESSMENT FRAMEWORK

✓ **Treatment completion rates** — persistence through the intended course.

✓ **Duration of treatment** — persistence when ETD was not directly reported.

✓ **Transition to subsequent lines** — continuity after first-line care or progression.

✓ **Reasons for discontinuation** — progression, deterioration, toxicity, or other causes.

✓ **Healthcare reimbursement impact** — relationship of coverage to persistence and outcomes.

Access context — financial toxicity and barriers after treatment eligibility were also assessed.

INTERPRETIVE CAUTION

Measures are heterogeneous.
The included studies represent different populations, disease stages, treatments, and points in the care pathway.

Complementary gaps were calculated only for interpretation.
For example, 57% completion corresponds to 43% noncompletion.

No pooled ETD estimate was produced.
Percentages should be read as directional signals within their original study contexts.

The synthesis therefore emphasizes recurring patterns—not direct country ranking.

EVIDENCE SCOPE

INDIA • THAILAND • BANGLADESH

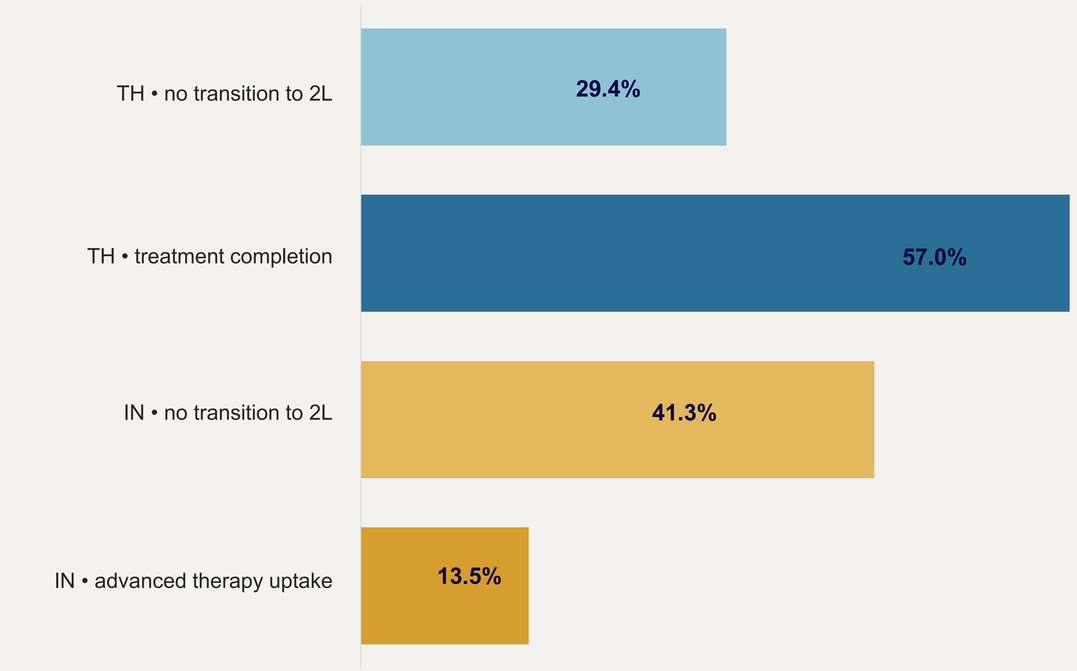
2015 — 2025

Noncommercial evidence synthesis using generic drug names and publicly available studies.

RESULTS

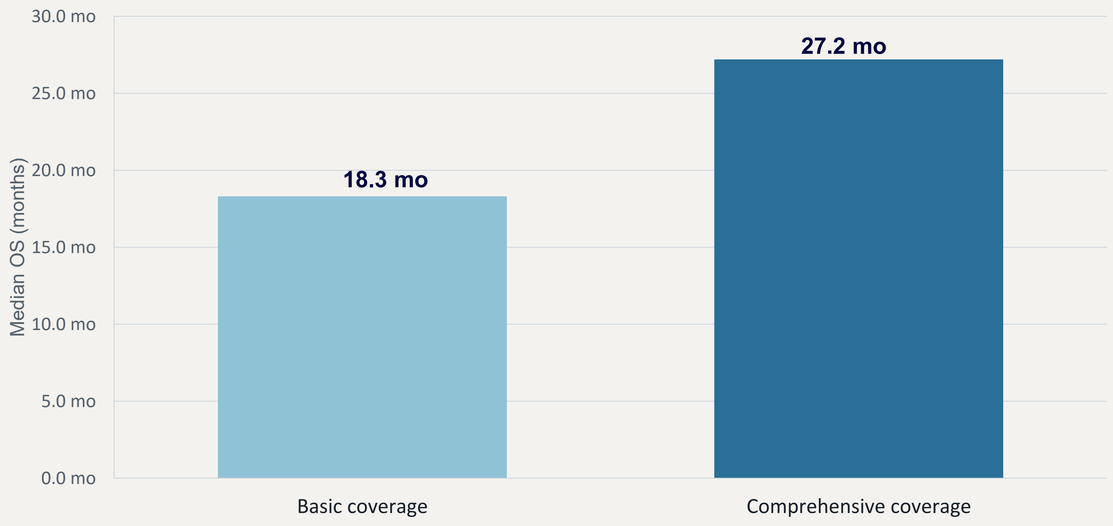
Across Asian real-world settings, attrition occurs early and repeatedly—from access and planned completion through progression and transition to subsequent therapy.

GRAPH 1: PERCENTAGE METRICS — THAILAND VS INDIA



Percentages show complementary care-pathway gaps derived from distinct study measures and populations. They describe where attrition may occur, but are not directly comparable or suitable for pooling.

GRAPH 2: OVERALL SURVIVAL BY HEALTHCARE COVERAGE — THAILAND[1]



Basic = not reimbursed • Comprehensive = reimbursed • Observed median OS difference: +8.9 months

TABLE 1: THAILAND AND INDIA FINDINGS SUMMARY

METRIC	THAILAND	INDIA	INTERPRETATION
No transition to 2L therapy	29.4%	41.3%	Greater transition gap in India
Treatment completion reported	57.0%	Limited	Direct completion evidence is limited for India
Access constraints	Moderate	High	Access limitations remain significant in India
Advanced therapy uptake	Not reported	13.5%	Uptake reported only for India
Reimbursement impact documented	Yes	Emerging	Evidence is more established in Thailand

COUNTRY FINDINGS

THAILAND

- **Transition after first line:** 29.4% did not receive second-line therapy[1]—nearly 3 in 10 patients.
- **Planned durvalumab:** 57% completed treatment; the complementary noncompletion gap was 43%.[2]
- **Tolerability:** 7.3% discontinued durvalumab because of adverse events.[2]
- **Coverage-associated outcome:** median OS was 18.3 months with basic coverage versus 27.2 months with comprehensive coverage[1]—a difference of 8.9 months

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Interpretation: clinical attrition and reimbursement-related access may operate together.

INDIA

- **Access after eligibility:** 13.5% received osimertinib[3]; the complementary access gap was 86.5%.
- **Transition after progression:** 58.7% proceeded to second-line therapy[4]; 41.3% did not.
- **Reported clinical drivers:** progression or clinical deterioration frequently preceded discontinuation.[5]

Interpretation: losses are visible both before treatment initiation and between lines of therapy.

BANGLADESH

- **Evidence: no registry-based ETD study identified.**
- Consequence: frequency, timing, and reasons for stopping remain unquantified.
- Priority: build longitudinal data across treatment transitions.

DISCUSSION

PERSISTENCE	Attrition occurs early and frequently throughout treatment pathways, spanning initiation, planned completion, progression, and transition to later lines.
ACCESS & POLICY	Reimbursement appears to support persistence and improved outcomes. Access limitations remain significant in India; ETD is a clinical and health-system challenge requiring policy intervention.
EVIDENCE GAPS	Direct ETD measurement remains uncommon. Data infrastructure is underdeveloped in several countries—particularly Bangladesh—limiting longitudinal evidence.

LIMITATIONS

- **Heterogeneity:** populations, disease stages, treatments, and follow-up periods differed.
- **Proxy outcomes:** most studies did not define ETD directly.
- **Comparability:** reported percentages should not be interpreted as country-level rankings.
- **Evidence gaps:** reasons for stopping and longitudinal registry data were inconsistently available.

CONCLUSIONS

1. Attrition recurs across access, completion, progression, and later-line transitions.

2. Reimbursement can support persistence and outcomes; access gaps remain in India.

3. Pair clinical action with affordability, access, and standardized longitudinal data—especially in Bangladesh.

KEY TAKEAWAY

"Patients may stop treatment not only because it stops working—but because the system does."

Implication: persistence strategies must address clinical management and structural access together.

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Abbreviations
NSCLC, non-small cell lung cancer; ETD, early treatment discontinuation; RWE, real-world evidence; OS, overall survival; 2L, second-line therapy; EGFR, epidermal growth factor receptor; AE, adverse event.

Disclosures & Disclaimer
No financial disclosures reported. This poster synthesizes previously published, publicly available real-world studies; no new patient-level data were collected.