Intended for UK healthcare professionals only.
This promotional flyer is created and funded by AstraZeneca. The adverse event reporting information, references and UK Prescribing Information for IMFINZI® (durvalumab) can be found on the back side of this flyer.

NICE RECOMMENDED[1]

FOR ELIGIBLE ADULTS WITH RESECTABLE GC/GOJC

[ID6374]

IMFINZI® durvalumab
50 mg/mL concentrate for solution for infusion

Extending the boundaries of curative-intent treatment – with evidence of longer survival vs. standard perioperative chemotherapy*[1–5]

Indication: IMFINZI in combination with FLOT chemotherapy as neoadjuvant and adjuvant treatment, followed by adjuvant IMFINZI monotherapy, for eligible adults with resectable gastric and gastro-oesophageal junction adenocarcinoma (GC/GOJC)[2]

IMFINZI + FLOT (n=474) achieved a statistically significant and clinically meaningful improvement in event-free survival (EFS) and overall survival (OS) vs. FLOT alone (n=474)*[3–5]

EFS at 2 years (primary endpoint)

67.4% vs. 58.5% (HR, 0.71 [95% CI 0.58–0.86]; p<0.001)†‡§[3,4]

OS at 3 years (secondary endpoint)

68.6% vs. 61.9% (HR, 0.78 [95% CI 0.63–0.96]; p=0.021)§¶‖[5]

The addition of IMFINZI to FLOT saw double the pathological complete response rates with no impact to surgical completion vs. FLOT alone[3]

pathological complete response (key secondary endpoint§#):

19.2% vs. 7.2%

(relative risk, 2.69; 95% CI 1.86–3.90)[3]

R0 resection (secondary endpoint):

~92% of patients

who completed surgery in both treatment arms[3]

The safety profile for the combination of IMFINZI + FLOT was consistent with the known profiles of each agent and **no new safety signals were observed**[**3,4]

The **most common AEs (≥20%)** reported in the IMFINZI + FLOT arm were diarrhoea (62.3%), nausea (50.7%), neutropenia (32.2%), alopecia (30.5%), decreased appetite (30.5%), fatigue (28.8%), vomiting (26.1%), anaemia (25.1%), neutrophil count decreased (25.1%), peripheral sensory neuropathy (20.2%), asthenia (20.0%) and pyrexia (20.0%)[3]

Please refer to the SmPC for more information on the management of adverse events and special warnings[2]

*The MATTERHORN trial was a double-blind Phase III trial, whereby eligible patients with resectable GC/GOJC were assigned in a 1:1 ratio to receive IMFINZI 1500 mg (n=474) or placebo Q4W on Day 1 of each cycle, plus FLOT chemotherapy, Q2W on Day 1 and Day 15 of each cycle for 4 cycles (n=474; 2 cycles of each neoadjuvant and adjuvant therapy), followed by IMFINZI 1500 mg or placebo Q4W for 10 cycles.[3]
†EFS was defined as the time from randomisation until the following, according to RECIST v1.1 per BICR assessment and/or locally by pathology testing: progression that precludes surgery or requires non-protocol therapy, local or distant recurrence or progression of disease, or death due to any cause.[3]
‡Median duration of follow-up was 31.5 months across both treatment arms (IQR 26.7–36.6 months). Median EFS was not reached (95% CI 40.74–NR) with IMFINZI + FLOT vs. 32.8 months (95% CI 27.86–NR) with FLOT alone.[3,4]
§ITT analysis set (all randomised patients, regardless of treatment received).[3,5]
¶OS was defined as the time from randomisation until the date of death from any cause.[5]
‖Median duration of follow-up in censored patients was 43.0 months (range 3.4–57.0 months) with IMFINZI + FLOT vs. 42.9 months (range 0.0–56.5 months) with FLOT alone. Median OS was not reached (95% CI NR–NR) with IMFINZI + FLOT vs. not reached (95% CI NR–NR) with FLOT alone (prespecified significance threshold: p<0.0499).[5]
#Pathological complete response was defined by no presence of residual viable tumour cells in the primary tumour and resected lymph nodes at surgery, corresponding to 100% pathological regression as assessed by BICR in accordance with modified Ryan criteria.[3]
**Safety analysis set (participants who received at least one dose of study treatment). IMFINZI + FLOT (n=475); FLOT alone (n=469).[3]

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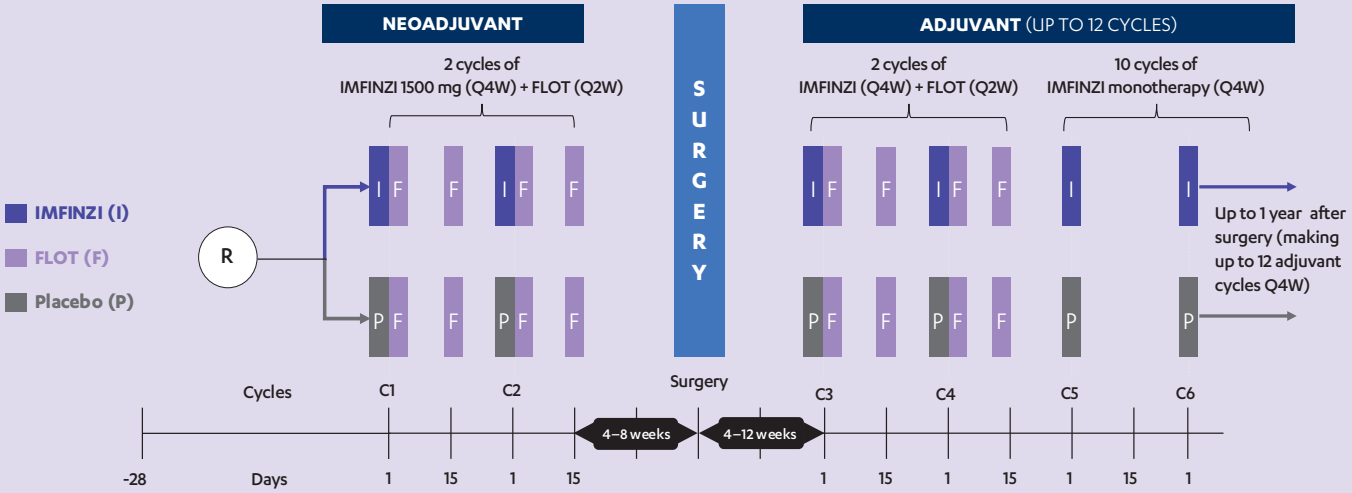
Improvements in EFS and OS with IMFINZI + FLOT were generally consistent across most patient subgroups[3–5]

(exploratory analysis; not formally tested for statistical significance)[3–5]

The MATTERHORN regimen (for patients with a body weight of >30 kg): perioperative IMFINZI + FLOT, followed by adjuvant IMFINZI monotherapy[2,3]



Neoadjuvant phase

IMFINZI 1500 mg Q4W in combination with FLOT chemotherapy Q2W for up to 2 cycles or until disease progression that precludes definitive surgery or unacceptable toxicity[2,3]

Adjuvant phase

IMFINZI 1500 mg Q4W with FLOT chemotherapy Q2W for up to 2 cycles, then IMFINZI (1500 mg) monotherapy Q4W for up to 10 cycles, or until disease progression, recurrence, unacceptable toxicity or a maximum of 12 cycles after surgery[2,3]

Patients with a body weight of ≤30 kg must receive weight-based dosing of IMFINZI at 20 mg/kg[2]

FLOT was administered as fluorouracil 2600 mg/m², leucovorin 200 mg/m², oxaliplatin 85 mg/m² and docetaxel 50 mg/m² in the MATTERHORN trial[3]

Please refer to the SmPC for further information on management of adverse reactions, dilution and adminstration instructions[2]

Abbreviations:
AE, adverse event; BICR, Blinded Independent Central Review; CI, confidence interval; DCO, data cut-off; EFS, event-free survival; FLOT, fluorouracil, leucovorin, oxaliplatin and docetaxel; GC, gastric cancer; GOJC, gastro-oesophageal junction cancer; HR, hazard ratio; imAE, immune-mediated adverse event; ITT, intent-to-treat; MHRA, Medicines and Healthcare products Regulatory Agency; NICE, National Institute for Health and Care Excellence; NR, not reached; OS, overall survival; Q2/4W, every two/four weeks; RECIST, Response Evaluation Criteria in Solid Tumours; R0, complete tumour resection; SmPC, Summary of Product Characteristics.

Scan or click the QR code to access the IMFINZI® (durvalumab) UK Prescribing Information

References:
1. NICE. TA11440; 2. IMFINZI. Summary of Product Characteristics. United Kingdom; 3. Janjigian YY, et al. *N Engl J Med.* 2025;393(3):217–230; 4. Janjigian YY, et al. Presented at ASCO 2025; 30 May–2 June; Chicago, IL. Abstract #LBA5; 5. Tabernero J, et al. Presented at ESMO 2025; 17–21 October; Berlin, Germany. Abstract #LBA81.

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