



American Society of Clinical Oncology

Errata

The Editor of the *2014 ASCO Annual Meeting Proceedings* has authorized correction of the following errors:

Abstracts LBA4, 517, 633, 2517, 2519, 2605, 2533, TPS2629, 3518, 6601, 11012

Notice of Correction: Conflict of interest information for José Baselga, MD, PhD, has been updated to reflect previously undisclosed relationships. The corrected disclosures of potential conflicts of interest provided by the author are available with the online abstracts on JCO.org and ASCO.org.

Abstract 1132

After publication of the abstract, the author discovered that grant information was not included in the abstract. The correct grant information is as follows: IGA NT14599-32013 and Biomedreg CZ.1.05/2.1.00/01.0030.

Abstract 2544

After publication of the abstract, the authors noted an error in the progression-free survival analyses for the 5 mg/kg dose group. With updated programming, that includes a patient previously censored early, the correct value is 5.3 months, not 6.3 months.

Abstract 3609

After publication of the abstract, the author noted an error in the results, which stated that, “*VEGF-A* rs25648 was an independent prognostic biomarker for PFS and OS in pts with mCRC, with allele C conferring improved prognosis, but was not predictive of B efficacy. This finding is biologically plausible as rs25648 is in the *VEGF-A* 5’UTR/promoter region, and in previous studies the CC genotype has been associated with lower *VEGF-A* levels/expression.” The phrase “promoter region” should not appear, and the correct statement should read, “*VEGF-A* rs25648 was an independent prognostic biomarker for PFS and OS in pts with mCRC, with allele C conferring improved prognosis, but was not predictive of B efficacy. This finding is biologically plausible as rs25648 is in the *VEGF-A* 5’UTR, and in previous studies the CC genotype has been associated with lower *VEGF-A* levels/expression.”

Abstract 5509

After publication of the abstract, the authors discovered an error in matching clinical data to molecular subgroups. The changes are as follows:

1. The proliferative and mesenchymal molecular subgroups have the largest improvement of PFS when treated with bevacizumab. The mesenchymal and differentiated groups showed the largest improvements in the original abstract.
2. Patients in the proliferative group who received bevacizumab had a 10-month improvement in PFS, which is statistically significant. This difference was not statistically significant in the original abstract.
3. Analysis of overall survival was added and shows the greatest advantage in the proliferative and mesenchymal groups, similar to PFS results. OS was not included in original abstract.

4. Non-ovarian cancer cases have been removed based on centralized pathology review. All cases were included in original analysis.

Abstract 8019

After publication of the abstract, the authors discovered that a drug name was spelled incorrectly in the title as afatanib. The correct drug name is afatinib.

Abstract 8043

After publication of the Proceedings Part I, it was discovered that abstract 8043 was not included in the body of the printed edition. The abstract appears below:

E7080 (lenvatinib) in addition to best supportive care (BSC) versus BSC alone in third-line or greater nonsquamous, non-small cell lung cancer (NSCLC). Presenting author: Libor Havel, 3rd Medical Faculty, Charles University, Hospital Bulovka, Czech Republic

Background: Lenvatinib (E7080; LEN) is an oral, tyrosine kinase inhibitor targeting VEGFR1-3, FGFR1-4, RET, KIT, and PDGFR with evidence of antitumor activity in a broad range of solid tumors. Currently there is an unmet medical need for treatments in third-line or greater NSCLC patients (pts). **Methods:** This study was a double-blind, placebo-controlled, multicenter, randomized Phase II study of LEN 24 mg PO once daily + BSC vs. placebo (PBO) + BSC (2:1 randomization). Pts with nonsquamous NSCLC who had failed ≥ 2 two systemic anticancer regimens were enrolled. Prior erlotinib or gefitinib was required for pts with known EGFR-activating mutations. The primary endpoint was overall survival (OS). Progression free survival (PFS), overall response rate (ORR), and disease control rate (DCR) were based on investigator assessment. Efficacy endpoints were estimated via Kaplan-Meier. **Results:** 135 pts enrolled in the study. Per protocol, the study was unblinded and analyzed after 90 deaths. 76% received ≥ 3 prior anti-cancer regimens and 85% received prior erlotinib or gefitinib (similar rates in each arm). A summary of efficacy and safety is presented by study arm (Table). In a post hoc analysis, a similar treatment effect was observed among subjects with wild-type EGFR. **Conclusions:** LEN in addition to BSC demonstrated a clinically meaningful improvement in both OS and PFS (~ 3 months) in heavily pretreated patients with NSCLC, including those who received prior EGFR inhibitors. LEN was generally well-tolerated, with an AE profile consistent with observed LEN monotherapy studies. These data warrant additional evaluation of LEN in this population.

Median value or percentage	LEN + BSC (n = 89)	PBO + BSC (n = 46)	P value
OS, wks (95% CI)	38.4 (26.57, 47.86) N= 58 events	24.1 (15.29, 36.43) N = 37 events	p = 0.065
PFS, weeks (95% CI)	20.9 (15.86, 23.86) N =73 events	7.9 (7.43, 8.14) N= 45 events	p < 0.001
ORR	10.1%	2.2%	0.1635
DCR	42.7%	19.6%	0.0079
Treatment duration (days)	113	58	Not compared (NC)
Serious adverse events (AEs)	52%	46%	NC
Grade 3/grade 4 AEs:	69%	50%	NC
Hypertension	17%	0%	
Dyspnea	9%	13%	
Pneumonia	9%	6.5%	
Study discontinuation due to AE	24.7%	17.4%	NC

Abstract 8134

This abstract appears in the eTote of the Proceedings but was withdrawn.

Abstract 8524

After publication of this abstract, an error in the table values was discovered. The total value for column CR (n) is 3, not 4, and the total value for column PR (n) is 9, not 8.

All errors have been corrected in the online versions of the abstracts on JCO.org and ASCO.org. This notice is updated on a rolling basis, as needed.