ASCO 2026

Practice changing data from the Annual American Society of Clinical Oncology Meeting
June 2026

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ASCO 2026 edition

The American Society of Clinical Oncology (ASCO) Annual Meeting was held in Chicago, Illinois, from May 29 to June 2, 2026, with more than 3,000 abstracts presented across five days. A subset of these results meet the threshold of practice-changing evidence: findings substantial enough to alter standards of care, drive near-term regulatory submissions, and require formulary and health system response. Among these, RASolute 302 represents the first phase III trial to demonstrate a survival benefit in RAS-mutated metastatic pancreatic adenocarcinoma, and the NHS-Galleri trial provides the first randomized controlled trial evidence for a multi-cancer early detection blood test.

Cancer science is moving faster than policy. The drugs being approved today were unimaginable a decade ago — and Canadian patients deserve access to them without delay. What was presented at ASCO 2026 will reshape the standard of care globally. The question for policymakers is how quickly will Canada respond?

This notebook summarizes the most practice changing findings from ASCO 2026 in plain language, organized by cancer type. It is designed to prepare Canadian policymakers, patient advocates, and health system leaders for the wave of new evidence that will drive regulatory submissions, formulary reviews, and calls for system investment in the months ahead.

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Pancreatic Cancer

RASolute 302: Daraxonrasib vs. Chemotherapy in Previously Treated Metastatic Pancreatic Cancer (Abstract LBA5)

Daraxonrasib nearly doubled median overall survival compared to standard chemotherapy in previously treated metastatic pancreatic cancer. This is the first phase III trial to demonstrate a survival benefit in this disease in over a decade.

Pancreatic cancer is among the deadliest cancers. For patients whose disease has progressed after initial chemotherapy, median survival has historically been six to seven months, and second-line treatment options have offered only modest benefit. Nearly all pancreatic tumours carry mutations in the RAS gene family, long considered undruggable. The RASolute 302 trial tested whether that assumption still held.

The phase III RASolute 302 trial enrolled 500 patients with metastatic pancreatic ductal adenocarcinoma (mPDAC) who had received one prior line of chemotherapy. Patients were randomized 1:1 to receive either daraxonrasib, a first-in-class oral pan-RAS(ON) inhibitor taken once daily, or the investigator's choice of standard second-line chemotherapy. The trial ran across 59 sites in six countries, and results were published simultaneously in the New England Journal of Medicine.

In the overall study population, patients receiving daraxonrasib had a median overall survival of 13.2 months compared to 6.7 months with chemotherapy, representing a 60% reduction in the risk of death. Median progression-free survival was 7.2 months versus 3.6 months, and objective response rates were nearly three times higher: 31.6% with daraxonrasib versus 11.2% with chemotherapy. The benefit held regardless of specific RAS mutation type, meaning virtually all pancreatic cancer patients with a RAS mutation are potentially eligible. Patients also experienced better quality of life on daraxonrasib. Time to deterioration in pain was 9.0 months versus 3.7 months, and quality-of-life scores declined more slowly. The drug was better tolerated than chemotherapy across the measures that matter most to patients, with fewer grade 3 or higher adverse events (43.6% versus 57.5%), less neutropenia, less peripheral neuropathy, and a substantially lower discontinuation rate (1.2% versus 11.2%). Patients remained on daraxonrasib for a median of 6.2 months, compared to 1.5 to 3.2 months on chemotherapy.

Conclusions. Daraxonrasib demonstrated a statistically significant and clinically meaningful improvement in overall survival and progression-free survival compared to second-line chemotherapy in patients with previously treated metastatic pancreatic cancer, regardless of RAS mutation status. The drug was well tolerated, with a manageable safety profile and no unexpected safety signals. These results support daraxonrasib as a new standard of care for second-line treatment of mPDAC.

What this means. Pancreatic cancer has been one of the most resistant cancers to new treatment for decades, and this trial changes that. Doubling survival while also improving tolerability compared to chemotherapy is an exceptional result. For Canadian patients with this diagnosis, timely access to daraxonrasib will materially affect outcomes. The FDA has already granted expanded access. Because the drug requires molecular profiling to identify RAS status, this result also reinforces the need for comprehensive tumour testing infrastructure across Canada.

DARAXONRASIB REDUCED THE RISK OF DEATH BY 60% AND DOUBLED SURVIVAL IN METASTATIC PANCREATIC DUCTAL ADENOCARCINOMA. THIS IS THE FIRST PHASE III TRIAL TO DEMONSTRATE A SURVIVAL ADVANTAGE IN RAS-MUTATED MPDAC, AND IT IS EXPECTED TO BECOME A NEW GLOBAL STANDARD OF CARE. CANADIAN PATIENTS AND ADVOCATES WILL BE WATCHING CLOSELY HOW DECISION-MAKERS AND REIMBURSERS RESPOND TO THIS FILE.

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Lung Cancer

LIBRETTO-432: Adjuvant Selpercatinib in Early-Stage RET Fusion-Positive Non-Small Cell Lung Cancer (Abstract LBA3)

Adjuvant selpercatinib reduced the risk of recurrence or death by approximately 83% in patients with early-stage RET fusion-positive lung cancer following surgery.

Non-small cell lung cancer (NSCLC) is the leading cause of cancer death worldwide. For patients with tumours carrying RET fusions, a specific gene rearrangement, targeted therapy with selpercatinib (Retevmo) is already standard in advanced disease. Until now, however, no targeted adjuvant therapy had been approved for early-stage RET-positive NSCLC after surgery, leaving this group with the same recurrence risk as patients without an approved targeted option. The LIBRETTO-432 trial addressed this gap.

The global phase III LIBRETTO-432 trial enrolled 151 patients with stage IB to IIIA RET fusion-positive NSCLC who had undergone surgery, with or without chemotherapy. Patients were randomized to receive either adjuvant selpercatinib or placebo, with event-free survival as the primary endpoint.

The trial met its primary endpoint with substantial results. In the stage II to IIIA population, 4 event-free survival events occurred in the selpercatinib arm compared to 19 in the placebo arm (hazard ratio 0.17, p=0.0003). At two years, 91.5% of patients receiving selpercatinib remained event free, compared to 61.1% in the placebo group, a 30 percentage point improvement. Across the full study population, including stage IB, two-year event-free survival was 94% versus 71%. Overall, selpercatinib reduced the risk of recurrence or death by approximately 83%. The safety profile was consistent with selpercatinib's established profile.

Conclusions. Adjuvant selpercatinib demonstrated a statistically significant and clinically meaningful improvement in event-free survival in patients with early-stage RET fusion-positive NSCLC. The benefit was consistent across subgroups and confirmed by independent central review. These results establish a new standard of care for this patient population following surgery, and reinforce the importance of comprehensive biomarker testing, including RET fusion testing, at the time of surgical resection rather than only at diagnosis of advanced disease.

What this means. This trial has two significant implications for Canada. First, patients with early-stage RET-positive lung cancer now have a highly effective adjuvant treatment option that can reduce the risk of recurrence after surgery. Second, if RET fusion testing is not performed routinely at the time of surgery, eligible patients will be missed. Canada must ensure comprehensive molecular profiling is available and

funded at all stages of lung cancer diagnosis, not only in advanced disease. This follows the precedent set by adjuvant osimertinib for EGFR-mutated NSCLC (ADAURA) and adjuvant alectinib for ALK-positive NSCLC (ALINA).

SELPERCATINIB REDUCED THE RISK OF DISEASE RECURRENCE OR DEATH BY 83% AFTER SURGERY IN PATIENTS WITH RET FUSION-POSITIVE EARLY-STAGE LUNG CANCER. THIS RESULT IS IMMEDIATELY PRACTICE-CHANGING. CANADA MUST ENSURE RET FUSION TESTING IS ROUTINELY AVAILABLE AT THE TIME OF SURGERY, SINCE PATIENTS WHO ARE NOT TESTED CANNOT BENEFIT.

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HARMONi-6: Ivonescimab Plus Chemotherapy vs. Standard Chemoimmunotherapy in Squamous NSCLC (Abstract LBA4)

Ivonescimab, a bispecific antibody, improved survival over existing immunotherapy in the most common subtype of advanced lung cancer, and was the first China-originated drug selected for an ASCO plenary session in the Society's 61-year history.

Squamous NSCLC accounts for roughly 25% to 30% of all lung cancers and has historically been difficult to treat. Standard first-line treatment combines a checkpoint inhibitor with chemotherapy. Ivonescimab is a first-in-class bispecific antibody that simultaneously blocks two targets: PD-1, the same target as existing checkpoint inhibitors such as pembrolizumab, and VEGF. The HARMONi-6 trial tested whether this dual blockade could outperform existing immunotherapy plus chemotherapy.

HARMONi-6 enrolled patients with treatment-naive, metastatic squamous NSCLC in China. Patients were randomized to receive ivonescimab plus chemotherapy or tislelizumab, a PD-1 inhibitor, plus chemotherapy, a head-to-head comparison against a current standard of care.

Ivonescimab plus chemotherapy demonstrated a statistically significant overall survival benefit, with a median of 27.9 months versus 23.7 months (hazard ratio 0.66, statistically significant), a four-month improvement over an already active control arm. Notably, the benefit was observed regardless of PD-L1 expression level, a biomarker that typically predicts which patients benefit most from immunotherapy. In patients

with high PD-L1 expression, median overall survival had not yet been reached in the ivonescimab arm, suggesting durable responses.

Conclusions. Ivonescimab plus chemotherapy demonstrated superior overall survival compared to a PD-1 inhibitor plus chemotherapy in first-line squamous NSCLC, with benefit observed regardless of PD-L1 expression. This is the first regimen to demonstrate superiority over another PD-1-based regimen in this frontline setting.

What this means. This result matters for Canadian patients with squamous lung cancer in two respects. First, it suggests a more effective treatment option may be available that works across all patients regardless of PD-L1 status, which currently guides treatment decisions. Second, demonstrating superiority over an active comparator is a high evidentiary bar, which makes this result particularly compelling. Canadian policymakers should anticipate a regulatory submission for ivonescimab and monitor for confirmatory data from global trials, since this trial was conducted exclusively in China.

IVONESCIMAB OUTPERFORMED THE CURRENT STANDARD IMMUNOTHERAPY IN SQUAMOUS LUNG CANCER ON OVERALL SURVIVAL, REGARDLESS OF PD-L1 STATUS. THIS IS THE FIRST DRUG TO OUTPERFORM PD-1 INHIBITORS HEAD TO HEAD IN FIRST-LINE ADVANCED LUNG CANCER. IF CONFIRMED IN GLOBAL TRIALS, IT WILL MEANINGFULLY CHANGE HOW SQUAMOUS NSCLC IS TREATED.

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Prostate Cancer

PROTEUS: Perioperative Apalutamide Plus ADT With Radical Prostatectomy in High-Risk Localized or Locally Advanced Prostate Cancer (Abstract LBA1)

Adding apalutamide to androgen deprivation therapy before and after radical prostatectomy increased the odds of a complete pathologic response ten-fold and reduced the risk of metastasis or death by 20% in patients with high-risk localized or locally advanced prostate cancer.

Radical prostatectomy is potentially curative for patients with high-risk localized or locally advanced prostate cancer, yet approximately half of these patients ultimately relapse. PROTEUS tested whether adding apalutamide, a more potent androgen receptor inhibitor, to androgen deprivation therapy (ADT) before and after surgery could improve pathologic response and long-term outcomes.

This randomized, double-blind, phase III trial enrolled 2,109 patients with newly diagnosed high-risk localized or locally advanced disease across 18 countries, making it the largest therapeutic trial ever conducted in localized prostate cancer. Patients were randomized 1:1 to apalutamide (1,057 patients) or placebo (1,052 patients), each combined with ADT, for six months before radical prostatectomy and six months after. Median baseline PSA was 14.8 ng/mL, and 95.8% of patients had a Gleason score of 8 or higher, reflecting a very high-risk population. The trial had dual primary endpoints, assessed by blinded independent central review: pathologic complete response or minimal residual disease, and metastasis-free survival based on conventional imaging or PSMA PET imaging.

At a median follow-up of 61.7 months, both primary endpoints were met. The rate of pathologic complete response or minimal residual disease was 8.9% with apalutamide versus 1.0% with placebo, a ten-fold higher odds (odds ratio 10.17; $p<0.0001$). Metastasis-free survival was significantly improved, with a 20% reduction in risk of metastasis or death (hazard ratio 0.80; $p=0.0169$) and a five-year metastasis-free survival rate of 78.2% versus 73.5%. Several secondary endpoints also favoured apalutamide: event-free survival improved by 29% (hazard ratio 0.71; $p<0.0001$; median 57.1 versus 38.4 months), time to first subsequent therapy was extended by nearly three years (hazard ratio 0.65; $p<0.0001$; median 74.2 versus 41.5 months), and time to distant metastasis improved by 32% (hazard ratio 0.68; $p=0.0002$). Grade 3 or higher treatment-emergent adverse events occurred more frequently with apalutamide (39.6% versus 31.0%), with a higher rate of treatment discontinuation due to adverse events (7.4% versus 2.7%).

Conclusions. Apalutamide plus ADT significantly increased the curative success of radical prostatectomy in high-risk localized or locally advanced prostate cancer, with a

ten fold higher odds of pathologic complete response and a clinically meaningful 20% reduction in risk of distant metastasis or death. These results support combined apalutamide and ADT with radical prostatectomy as a new standard of care for this population.

What this means. This trial shifts the paradigm for high-risk prostate cancer surgery toward treatment intensification before and after the procedure, rather than reserving systemic therapy for recurrence. The efficacy benefit comes with a real increase in toxicity and treatment discontinuation that should be weighed in clinical and formulary decision-making. The trial's use of PSMA PET imaging as part of its metastasis-free survival endpoint also points to a parallel access consideration: this imaging modality remains inconsistently funded and available across Canadian provinces, and its availability may affect how completely Canadian patients can be monitored and benefit from this treatment approach.

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Breast Cancer

SERENA-6: Camizestrant vs. Aromatase Inhibitor Upon Detection of ESR1 Mutation in Advanced ER+ Breast Cancer (Abstract LBA1007)

Switching treatment as soon as a resistance mutation is detected in a blood test, before the cancer is visible on a scan, extended progression free survival by 7.6 months.

Estrogen receptor positive (ER+), HER2-negative breast cancer is the most common subtype of breast cancer. Patients are typically treated with hormone blocking therapy combined with a CDK4/6 inhibitor. Over time, many tumours develop a mutation in the ESR1 gene that allows the cancer to grow despite hormone therapy. This mutation can now be detected in circulating tumour DNA (ctDNA) in the blood before the cancer shows up on a scan. SERENA-6 asked whether treatment should be switched as soon as this mutation is detected, or whether clinicians should wait until the cancer visibly progresses.

The phase III SERENA-6 trial enrolled patients with ER+/HER2- advanced breast cancer who were receiving a first-line aromatase inhibitor plus CDK4/6 inhibitor and who developed a detectable ESR1 mutation in their blood. Patients were randomized to either switch to camizestrant plus CDK4/6 inhibitor, or continue their current aromatase inhibitor. The trial used liquid biopsy to trigger treatment switching, a novel trial design.

At the primary analysis, with a median follow-up of 23.5 months, switching to camizestrant reduced the risk of progression or death by 55% (hazard ratio 0.45, $p<0.00001$). Median progression-free survival was 16.8 months with camizestrant versus 9.2 months with continued aromatase inhibitor, an improvement of 7.6 months. At 24 months, 34.9% of camizestrant patients remained progression free versus 14.2% in the control arm. Time to second progression was also significantly improved (hazard ratio 0.63, $p=0.0037$), confirming that the benefit was not simply borrowed from future lines of therapy. The combination was well tolerated with no new safety signals.

Conclusions. Proactively switching to camizestrant upon ESR1 mutation detection in ctDNA, ahead of radiographic progression, significantly improved progression-free survival and time to second progression in patients with ER+/HER2- advanced breast cancer. All primary, secondary, and exploratory endpoints supported the benefit of the early switch. The European Medicines Agency has already recommended camizestrant for approval in the EU based on these data. The trial establishes a new paradigm of biomarker-guided, pre-emptive treatment switching.

What this means. This study fundamentally changes how clinicians think about managing ER+ metastatic breast cancer. Rather than waiting for progression, clinicians can now use a blood test to detect resistance early and switch treatment before the patient gets sicker. For Canadian women with this cancer type, this will require access to ctDNA testing and liquid biopsy to detect ESR1 mutations, which is not yet standard across Canada, as well as timely access to camizestrant. Policymakers will need to ensure liquid biopsy infrastructure is in place for Canadians to benefit.

SERENA-6 ESTABLISHES A NEW APPROACH TO PERSONALIZED CANCER MANAGEMENT: TREATING EARLY, GUIDED BY A BLOOD TEST, BEFORE THE CANCER PROGRESSES. SWITCHING TO CAMIZESTRANT CUT THE RISK OF PROGRESSION BY 55% AND EXTENDED TIME BEFORE NEXT TREATMENT BY MORE THAN SIX MONTHS. LIQUID BIOPSY ACCESS WILL BE NECESSARY TO ENSURE APPROPRIATE ACCESS TO THIS BENEFIT.

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SENOMAC: Omission of Axillary Lymph Node Dissection in Breast Cancer With Limited Sentinel Node Involvement (Abstract LBA503)

Skipping additional armpit surgery in women with limited lymph node spread did not compromise survival and significantly reduced arm complications.

When breast cancer spreads to nearby lymph nodes in the armpit, or axilla, surgeons have traditionally removed all of those nodes through axillary lymph node dissection (ALND). This procedure causes significant side effects, including arm swelling (lymphedema), pain, reduced arm function, and lasting impairment to arm-specific quality of life. The SENOMAC trial enrolled patients with one or two sentinel lymph node macrometastases and asked whether it was safe to skip the full ALND.

The phase III SENOMAC trial randomized patients to either omission of full ALND (sentinel node biopsy only) or completion ALND after cancer was found in one or two sentinel nodes. With a median follow-up of 60.1 months, five years, both survival and cancer control outcomes were compared. Omitting ALND did not compromise survival. Five-year overall survival was 94.4% in the omission group versus 93.4% in the ALND group, meeting the threshold for non-inferiority. Cancer-specific outcomes were equivalent. Patients who skipped the full ALND had significantly fewer arm complications and significantly better arm-specific function and symptom scores; global health-related quality of life did not differ significantly between the two arms at

three or five years. This de-escalation approach allows patients to avoid a surgery that does not improve outcomes and causes real arm-related harm.

Conclusions. Omission of completion axillary lymph node dissection is oncologically safe for patients with breast cancer and limited sentinel lymph node involvement. Survival outcomes are maintained while arm morbidity is significantly reduced. The SENOMAC trial supports omission of completion ALND as the new standard of care for eligible patients with limited sentinel node involvement.

What this means. This is a significant de-escalation result for Canadian women with breast cancer. Many patients currently undergo surgery that causes lasting arm-related harm, including arm swelling, nerve damage, and restricted movement, without any corresponding survival benefit. SENOMAC confirms that skipping this procedure is safe. For Canadian breast cancer programs, this means updating surgical guidelines and ensuring patients are counselled on the option to forgo additional node surgery. It is also a powerful example of patient-centred oncology: doing less, when less is just as effective, in order to protect arm function.

SENOMAC SHOWS THAT SKIPPING ADDITIONAL ARMPIT SURGERY IN WOMEN WITH LIMITED SENTINEL NODE INVOLVEMENT DOES NOT AFFECT SURVIVAL BUT DOES PROTECT ARM-SPECIFIC FUNCTION. THIS IS A CLEAR WIN FOR PATIENTS AND FOR SMARTER RESOURCE USE. CANADIAN BREAST CANCER PROGRAMS SHOULD IMPLEMENT THESE FINDINGS INTO SURGICAL PRACTICE WITHOUT DELAY.

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Liposarcoma (Sarcoma)

SARC041: Abemaciclib vs. Placebo in Advanced Dedifferentiated Liposarcoma ([Abstract LBA2])

SARC041 is the first positive phase III trial in dedifferentiated liposarcoma, a rare and aggressive cancer with almost no effective treatment options.

Dedifferentiated liposarcoma (DDLPS) is a rare cancer of fatty tissue that is highly resistant to treatment. Until now, no systemic therapy had shown meaningful benefit in a phase III trial for this disease. Patients with advanced DDLPS have had no treatment options once surgery is no longer possible. Abemaciclib, a CDK4/6 inhibitor, targets a molecular pathway known to be highly amplified in DDLPS. The SARC041 trial tested whether this drug could make a difference.

SARC041 enrolled patients with advanced, recurrent DDLPS who had received prior treatment. They were randomized to abemaciclib or placebo, with progression-free survival as the primary endpoint. Abemaciclib improved median progression-free survival from 1.5 months with placebo to 9.7 months, a six-fold improvement (hazard ratio 0.39), with a trend toward improved overall survival (hazard ratio 0.55). Response rates were also higher, at 9% with abemaciclib versus 0% with placebo. Despite 85% of placebo patients crossing over to receive abemaciclib after progression, there was still a trend toward improved overall survival favouring the abemaciclib arm. A pre-planned exploratory analysis found that patients who received abemaciclib with no prior systemic therapy had a median progression-free survival of 16.4 months, compared to 5.3 months in patients who had received one or more prior lines of therapy, suggesting earlier use of the drug may improve outcomes further.

Conclusions. Abemaciclib significantly improved progression-free survival compared to placebo in patients with advanced, recurrent DDLPS, the first positive phase III trial in this disease. The results establish abemaciclib as a new treatment option for patients with DDLPS and support earlier use of the drug for optimal benefit.

What this means. For patients with dedifferentiated liposarcoma, a disease where there has historically been little to offer, this is a landmark result. It validates years of research suggesting that CDK4/6 inhibition could work in this setting, and opens a real treatment option for a rare cancer with few alternatives. For Canadian patients with DDLPS, the next steps are drug access and coverage. Because abemaciclib is already approved in Canada for breast cancer, this is a case where an existing, approved drug is being considered for a new indication. Regulatory and formulary bodies should move quickly to expand access for DDLPS patients.

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SARC041 IS THE FIRST POSITIVE CLINICAL TRIAL IN DEDIFFERENTIATED LIPOSARCOMA, A DISEASE THAT HAS HAD ALMOST NO TREATMENT OPTIONS FOR DECADES. ABEMACICLIB MULTIPLIED PROGRESSION-FREE SURVIVAL SIX-FOLD. THIS IS PRACTICE-CHANGING FOR A RARE CANCER COMMUNITY THAT HAS BEEN WAITING FOR A BREAKTHROUGH. IN CANADA, ABEMACICLIB IS ALREADY APPROVED FOR BREAST CANCER, SO EXPANDING ACCESS FOR DDLPS PATIENTS SHOULD BE A PRIORITY.

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Lymphoma

frontMIND: Tafasitamab Plus Lenalidomide Added to R-CHOP in High-Risk Diffuse Large B-Cell Lymphoma (Abstract LBA7000)

Adding two targeted drugs to standard chemotherapy reduced the risk of disease progression or death by 25% in patients with the most aggressive type of lymphoma.

Diffuse large B-cell lymphoma (DLBCL) is the most common type of aggressive blood cancer, and the current frontline treatment, R-CHOP chemotherapy, cures many patients. However, those with intermediate or high-risk disease still face significant recurrence rates. The frontMIND trial tested whether adding tafasitamab, a CD19-targeting antibody, and lenalidomide, an immune-modulating drug, to R-CHOP could improve outcomes in high-risk patients.

frontMIND enrolled 899 patients with newly diagnosed intermediate or high-risk DLBCL or high-grade B-cell lymphoma. Patients were randomized to receive R-CHOP alone or R-CHOP plus tafasitamab plus lenalidomide, with progression-free survival as the primary endpoint. With a median follow-up of 35.2 months, the triple combination reduced the risk of progression or death by 25% compared to R-CHOP alone (hazard ratio 0.75, p=0.019). Three-year progression-free survival was 67.3% versus 60.7%. Among the 773 patients with centrally confirmed diagnoses, the risk reduction was even greater, at 32%. Overall survival data were immature but trending favourably (81.7% versus 78.9% alive at time of analysis). The combination was associated with more frequent toxicity than R-CHOP alone: grade 3 or higher treatment-emergent adverse events occurred in 86.7% of patients receiving the combination versus 76.1% with R-CHOP alone, treatment discontinuation due to adverse events occurred in 25.7% versus 17.9%, and deaths attributed to treatment-emergent adverse events occurred in 5.9% versus 3.8%, though overall mortality was lower in the combination arm.

Conclusions. Tafasitamab plus lenalidomide added to R-CHOP significantly improved progression-free survival in patients with newly diagnosed intermediate or high-risk DLBCL and high-grade B-cell lymphoma. The investigators concluded that this combination represents a potential new standard of care for frontline therapy in this patient population, with adverse events that were more frequent than with R-CHOP alone but manageable and consistent with the expected safety profile of the combination.

What this means. DLBCL is diagnosed in approximately 3,000 Canadians each year. The standard R-CHOP regimen has been unchanged for over two decades. frontMIND delivers the first evidence that intensifying frontline treatment in high-risk patients, using drugs that are already approved for other settings, can meaningfully reduce

recurrence, though this benefit comes with a real increase in treatment toxicity that should be weighed in clinical decision-making and formulary evaluation. Canadian policymakers should anticipate a regulatory submission for this new indication. Access to tafasitamab plus lenalidomide in the frontline setting will require funding decisions at both the federal and provincial levels, and should be evaluated through the CDA-AMC/INESSS review process with urgency appropriate to the strength of the data.

frontMIND DELIVERS THE FIRST MEANINGFUL IMPROVEMENT TO FRONTLINE LYMPHOMA THERAPY IN OVER 20 YEARS. ADDING TWO TARGETED DRUGS TO STANDARD CHEMOTHERAPY REDUCED THE RISK OF PROGRESSION BY 25% TO 32% IN HIGH-RISK PATIENTS. APPROXIMATELY 3,000 CANADIANS ARE DIAGNOSED WITH DLBCL EACH YEAR, SO THIS RESULT MATTERS AT A POPULATION LEVEL.

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Multi Cancer Early Detection

NHS-Galleri Trial: Multi-Cancer Early Detection Blood Test in a Randomized Controlled Trial (Abstract 100)

The first randomized controlled trial of a multi-cancer blood test found 14% fewer stage IV cancer diagnoses and four times as many cancers caught by screening, with major implications for how Canada approaches early detection.

The Galleri test is a multi-cancer early detection (MCED) blood test developed by GRAIL that detects fragments of tumour DNA circulating in the blood and can signal the presence of more than 50 types of cancer before symptoms appear. The NHS-Galleri trial, conducted by the UK National Health Service, is the largest randomized controlled trial conducted for an early detection technology, enrolling over 140,000 participants in the UK. This was the first randomized controlled trial to evaluate a multi-cancer blood test, with prior evidence coming only from observational studies.

Participants were randomized to receive either the Galleri test, in addition to standard NHS screening, or standard screening alone, for three years. The pre-specified primary endpoint was a reduction in the number of cancers diagnosed at stage III or IV in 12 pre-specified cancer types. Secondary endpoints included stage shift, screening-detected cancers, and emergency presentations.

The trial did not meet its pre-specified primary endpoint of a statistically significant reduction in late-stage cancers in the 12 designated cancer types. However, the results showed meaningful real-world signals: 14% fewer stage IV diagnoses across all cancers over the three-year period, 19% more stage I to III diagnoses, and four times as many cancers detected by screening (1,173 versus 290). There were also 21% fewer clinically detected cancers, meaning cancers presenting with symptoms, and 21% fewer emergency cancer presentations, meaning cases discovered in crisis. Importantly, the reduction in stage IV diagnoses improved with each successive year of screening: 9% in year 1, 22% in year 2, and 26% in year 3, suggesting increasing benefit over time.

Conclusions. While the NHS-Galleri trial did not meet its pre-specified primary endpoint of a statistically significant reduction in late-stage cancers across 12 pre-specified types, the findings demonstrate meaningful downstaging across all cancer types over three years of annual screening. The data show substantial increases in screening-detected cancers, reductions in emergency cancer presentations, and a progressive trend toward earlier-stage diagnosis. The evidence suggests particular value for cancers with no existing early detection screening, such as ovarian and pancreatic cancer.

What this means. This trial result is nuanced and will generate significant debate, but its policy implications for Canada are immediate. The Galleri test detected four times as many cancers through screening as standard care, and reduced emergency cancer presentations by 21%. Even without meeting the formal statistical bar for the primary endpoint, these signals suggest a national multi-cancer screening program could meaningfully change the trajectory of cancer care in Canada. The Pan-Canadian Cancer Early Detection Initiative and Health Canada should prioritize evaluating MCED technologies for potential inclusion in a national screening framework. The data from this trial also reinforce the importance of population-level screening infrastructure: catching more cancers earlier means treating more people successfully and reducing overall healthcare resource use.

THE NHS-GALLERI TRIAL IS THE FIRST RANDOMIZED PROOF THAT A MULTI-CANCER BLOOD TEST CAN DETECT FAR MORE CANCERS EARLIER THAN STANDARD CARE. THERE WERE 14% FEWER LATE-STAGE DIAGNOSES AND 21% FEWER EMERGENCY CANCER PRESENTATIONS, AND FOUR TIMES AS MANY CANCERS WERE CAUGHT BY SCREENING. CANADA SHOULD DEVELOP A NATIONAL STRATEGY FOR MULTI-CANCER EARLY DETECTION, SINCE THE UNDERLYING SCIENCE IS NOW IN PLACE.

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Additional Promising Findings

The following studies presented at ASCO 2026 did not reach the same level of immediate practice change as the featured results above, but represent important signals that will shape future trials, regulatory submissions, and treatment standards.

OPTIMA (Abstract 500): Prosigna Gene Expression Test to Guide Chemotherapy Decisions in Node-Positive Breast Cancer. A molecular test identified two-thirds of high-risk breast cancer patients who could safely skip chemotherapy, including patients previously considered too high risk for de-escalation. In the phase III OPTIMA trial, a Prosigna (PAM50) based genomic test identified patients with ER+/HER2- node-positive breast cancer who were at low risk of recurrence. Sixty-eight percent of clinically high-risk patients were classified as low risk by the test and safely avoided chemotherapy while maintaining a 5-year invasive breast cancer free survival of 90.4% versus 91.5% with standard chemotherapy plus endocrine therapy, meeting the threshold for non-inferiority. This included patients with up to nine positive lymph nodes and premenopausal women on ovarian suppression, groups traditionally considered too risky to de-escalate. For Canadian patients, this means less chemotherapy-related toxicity without compromising outcomes, provided genomic testing is available. Consistent access to PAM50/Prosigna testing across Canada is needed to realize this benefit.

OPTIMA CONFIRMS THAT GENOMIC TESTING CAN SAFELY SPARE TWO THIRDS OF NODE POSITIVE BREAST CANCER PATIENTS FROM CHEMOTHERAPY. CANADA MUST ENSURE THIS TESTING IS FUNDED AND ACCESSIBLE NATIONALLY.

CROWN Trial, 7-Year Update (Abstract 8502): Lorlatinib in ALK-Positive Metastatic NSCLC. Seven years in, more than half of patients on lorlatinib remained alive without progression, a result that would have seemed almost unimaginable a decade ago in advanced lung cancer. The 7-year follow-up from the phase III CROWN trial showed that 55% of patients with ALK-positive metastatic NSCLC receiving lorlatinib (Lorbrena) remained alive without disease progression, compared to only 3% in the comparator arm. Investigator-assessed median progression-free survival had still not been reached at 7 years. The drug also demonstrated a 94% reduction in risk of intracranial progression, meaning it protects the brain, a site of frequent metastasis in this cancer type. This is one of the most remarkable long-term datasets in oncology. For Canadian patients with ALK-positive lung cancer, lorlatinib should be considered frontline standard of care, and ensuring timely access through provincial formularies is essential.

SEVEN YEARS WITHOUT PROGRESSION IN MORE THAN HALF OF ALK POSITIVE LUNG CANCER PATIENTS IS AN EXTRAORDINARY RESULT. LORLATINIB CONTINUES TO EXPAND

WHAT IS POSSIBLE IN THIS DISEASE, AND ELIGIBLE CANADIAN PATIENTS WILL NEED ACCESS.

ROADS (Abstract LBA2000): Implanted Tile-Based Radiation in Patients Undergoing Resection of Large Brain Metastases. A novel radiation technique implanted during brain surgery reduced the risk of local tumour recurrence by 94%. The phase III ROADS trial evaluated a tile-based radiation device (GammaTile) implanted at the time of surgical resection of a large brain metastasis. Compared to standard post-operative stereotactic radiotherapy, the implanted radiation device reduced surgical bed recurrence by 94% and was associated with lower risk of death. GammaTile delivers targeted radiation directly to the surgical cavity from the moment of implantation, without the delay required for post-surgical external radiation. For Canadian patients undergoing brain metastasis surgery, this technology could become a significant advance, pending regulatory approval in Canada and availability in neurosurgical centres.

A RADIATION IMPLANT PLACED DURING BRAIN SURGERY REDUCED LOCAL RECURRENCE BY 94%. ROADS REPRESENTS A POTENTIALLY MAJOR ADVANCE FOR PATIENTS WITH BRAIN METASTASES.

EV-302 Updated Follow-Up (Abstract 4507): Enfortumab Vedotin Plus Pembrolizumab in Urothelial (Bladder) Cancer. Long-term follow-up data confirm enfortumab vedotin plus pembrolizumab as a durable standard of care for advanced bladder cancer. Updated results from EV-302, with 42.8 months of median follow-up, confirmed the durability of the enfortumab vedotin (Padcev) plus pembrolizumab regimen in previously untreated urothelial carcinoma, with a 42-month overall survival rate of 44.0% versus 24.6% for chemotherapy (hazard ratio 0.53). Among the subset of patients who achieved a complete response, the 42-month overall survival rate was considerably higher, at 83.6%. Two-thirds of these complete responders had initially achieved only a partial response before converting to a complete response over time, suggesting continued deepening of response and the potential for long-term disease control in some patients. This regimen is already approved in Canada, and these updated data support its continued use as the frontline standard for eligible patients.

EV-302 LONG-TERM DATA REINFORCE THAT THE ENFORTUMAB VEDOTIN PLUS PEMBROLIZUMAB COMBINATION DELIVERS DURABLE SURVIVAL IN BLADDER CANCER, WITH MORE THAN 4 IN 10 PATIENTS ALIVE AT 3.5 YEARS OVERALL, AND OVER 80% ALIVE AMONG THOSE WHO ACHIEVED A COMPLETE RESPONSE. THIS IS THE CURRENT STANDARD AND MUST REMAIN ACCESSIBLE TO ALL ELIGIBLE CANADIANS WITH ADVANCED BLADDER CANCER.

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What ASCO 2026 Means for Canada

Molecular testing is no longer optional. Three of the five plenary results at ASCO 2026 required a specific molecular or genetic test to identify eligible patients: RET fusions (LIBRETTO-432), ESR1 mutations via liquid biopsy (SERENA-6), and RAS mutation status (RASolute 302). Patients who are not tested cannot benefit. Canada must invest in comprehensive genomic profiling as a standard of care across cancer types and stages, not only at advanced disease.

The pipeline is full, and moving fast. Daraxonrasib is already in FDA expanded access. Camizestrant has a positive recommendation from the EMA. Selpercatinib in adjuvant lung cancer is immediately practice-changing. Formulary review timelines in Canada must accelerate accordingly. CDA-AMC, INESSS, and provincial drug formularies need adequate resourcing to keep pace with the speed of oncology innovation.

Multi-cancer early detection is not a future question. It is a present one. The NHS-Galleri trial is the first randomized evidence that a blood test can detect cancers earlier at scale. Whether or not the primary endpoint was met, the signal is strong enough for Canada to develop a national strategy for MCED, similar to the approach the UK NHS is taking. A pan-Canadian feasibility pilot should be considered now.

Rare cancers deserve attention. SARC041 demonstrated that rare cancers can and do have practice-changing trials. Canada's drug access framework must include pathways for rare cancer indications, including expanded use of already approved drugs like abemaciclib in new settings.

De-escalation is smart medicine. SENOMAC and OPTIMA both demonstrate that doing less, when the science supports it, protects patients and conserves health system resources. Canadian cancer programs should actively integrate de-escalation evidence into clinical guidelines and patient conversations.

Cancer science is moving faster than ever. The data presented at ASCO 2026 will reshape how cancer is diagnosed and treated globally, and Canada must be ready. Policy must keep pace with science, because patients cannot afford to wait.

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