TPS4221 Poster Session

EMERALD-Y90: A phase 2 study to evaluate transarterial radioembolization (TARE) followed by durvalumab (D) and bevacizumab (B) for the treatment of participants (pts) with unresectable hepatocellular carcinoma (uHCC) eligible for embolization.

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Background: Locoregional therapy, such as transarterial chemoembolization (TACE) or TARE, is commonly used to treat uHCC eligible for embolization. Despite advances in TACE and TARE delivery, median progression-free survival (PFS) following treatment is <1 year, highlighting a need for new treatment options. EMERALD-1 (NCT03778957), a global phase 3 study, demonstrated a statistically significant improvement in PFS with TACE + D + B versus TACE + placebos in pts with uHCC eligible for embolization (hazard ratio, 0.77 [95% confidence interval, 0.61–0.98]; two-sided p-value = 0.032). With the increased use of TARE for patients with uHCC eligible for embolization in the US, a need exists for evidence to support additional treatment options in settings where TARE is preferred. The EMERALD-Y90 study will evaluate the efficacy and safety of TARE with D monotherapy, followed by D + B in pts with uHCC eligible for embolization. **Methods:** EMERALD-Y90 (NCT06040099) is a phase 2, single-arm study that will enroll ~100 pts aged ≥18 years with uHCC amenable to embolization who are ineligible for or have declined treatment with resection and/or ablation or liver transplant (transplant candidates are those listed for transplant or eligible to be listed and within Milan criteria). Eligible pts also must have Child-Pugh class A liver function and an Eastern Cooperative Oncology Group performance status of 0–1. Pts are allowed to receive a single TACE or TARE ≥6 months before the study or >1 TACE or TARE ≥12 months before the study. Prior TACE or TARE must have been administered for a different primary intrahepatic lesion unrelated to the current lesion, and pts should have a functional liver remnant $>30\%$. Exclusion criteria include prior systemic therapy, evidence of extrahepatic spread, or major portal vein invasion. Pts will receive partition-based dosing of TARE using Y-90 glass microspheres. Following TARE, pts will receive D 1500 mg (one dose) followed by D 1120 mg + B 15 mg/kg every 3 weeks until study completion or discontinuation criteria are met. The primary endpoint is PFS (time from start of TARE until date of disease progression [investigator (INV)-assessed per modified Response Evaluation Criteria in Solid Tumors (mRECIST)] or death due to any cause). Secondary endpoints include safety and tolerability, 6-, 12-, and 24-month PFS, objective response rate (percentage of pts with confirmed complete or partial response [INV-assessed per mRECIST]), overall survival (time from start of TARE until death due to any cause), and duration of response (time from date of first documented response until date of progression or death due to any cause). An early safety review is planned when approximately 15 pts have completed their first cycle of D + B dosing. Study enrollment is ongoing at 22 US sites. Clinical trial information: NCT06040099. Research Sponsor: AstraZeneca.