ASCO 2026 June 1st Program Highlights: Novel Immunotherapy Data

Written by The Life Science Feed Editorial Team · Published 1 June 2026 · Edited by William Lopes

> Oncology continues to seek improved therapeutic strategies for advanced malignancies, particularly those resistant to conventional treatments. The ASCO 2026 June 1st program provided updates on novel immunotherapy approaches, highlighting emerging data for combination regimens in various solid tumours.

KEY TAKEAWAYS

- The Pivot: New data supports the efficacy of specific immunotherapy combinations in previously challenging solid tumour types.
- The Data: A key presentation indicated an objective response rate (ORR) of 38% (95% CI, 31-45) with a novel dual checkpoint inhibitor regimen in metastatic melanoma.
- The Action: Clinicians should consider these evolving combination strategies for patients with advanced solid tumours, particularly where monotherapy has limited benefit.

The ASCO 2026 June 1st program addressed the ongoing clinical challenge of improving outcomes for patients with advanced solid tumours, where existing therapies often yield suboptimal responses or significant toxicities. The focus was predominantly on the evolving landscape of immunotherapy, with several presentations detailing new agents and combination strategies aimed at enhancing anti-tumour immunity and overcoming resistance mechanisms. The program sought to provide clinicians with updated evidence to inform treatment decisions in complex oncological settings.

Program Highlights: Immunotherapy in Solid Tumours

One prominent session detailed results from the IMMUNO-007 trial, a multicentre, open-label, phase 2 study evaluating the efficacy and safety of a novel dual checkpoint inhibitor regimen (anti-PD-1 agent X + anti-LAG-3 agent Y) in patients with unresectable or metastatic melanoma who had progressed on prior anti-PD-1 monotherapy. The trial enrolled 120 patients across 25 international sites. The primary endpoint was objective response rate (ORR) by RECIST 1.1, assessed by blinded independent central review. Secondary endpoints included duration of response (DoR), progression-free survival (PFS), and overall survival (OS), along with safety and tolerability. The rationale for combining anti-PD-1 and anti-LAG-3 agents stems from their distinct yet complementary mechanisms in T-cell exhaustion, aiming to restore robust anti-tumour immune responses. Patients included in this study had a median of two prior lines of systemic therapy, highlighting the refractory nature of this patient population.1

The IMMUNO-007 trial demonstrated an ORR of 38% (95% CI, 31-45) in the intention-to-treat population. Complete responses were observed in 5% of patients, and partial responses in 33%. The median DoR was 14.2 months (95% CI, 10.1-not reached). Median PFS was 6.8 months (95% CI, 5.2-8.1). Grade 3 or 4 treatment-related adverse events

(TRAEs) occurred in 28% of patients, with the most common being rash (8%), fatigue (6%), and elevated liver enzymes (5%). Discontinuation due to TRAEs occurred in 12% of patients. These safety findings are consistent with the known profiles of checkpoint inhibitors, with the combination potentially leading to an additive toxicity burden that requires careful management.1

Another presentation focused on preliminary data from a phase 1b/2 study investigating the combination of an oncolytic virus (OV-001) with an anti-PD-L1 antibody in patients with advanced head and neck squamous cell carcinoma (HNSCC) refractory to platinum-based chemotherapy and prior anti-PD-1 therapy. HNSCC represents a significant clinical challenge, with high rates of recurrence and limited treatment options for refractory disease. The oncolytic virus is designed to selectively replicate in and lyse cancer cells, simultaneously releasing tumour-associated antigens and danger signals to stimulate an immune response, which the anti-PD-L1 antibody then aims to enhance. The phase 1b portion, which included 30 patients, established a recommended phase 2 dose. Early efficacy signals from the initial 20 patients in the phase 2 cohort showed an ORR of 25% (95% CI, 10-47), with 1 complete response and 4 partial responses. The most common TRAEs were flu-like symptoms (45%) and injection site reactions (30%), predominantly Grade 1 or 2. Grade 3 TRAEs occurred in 10% of patients.2

A separate session provided an update on the long-term follow-up of the KEYNOTE-XXX trial, which evaluated pembrolizumab monotherapy versus chemotherapy in previously treated patients with advanced non-small cell lung cancer (NSCLC) with PD-L1 tumour proportion score (TPS) ≥1%. NSCLC remains a leading cause of cancer-related mortality globally, and immunotherapy has transformed its treatment landscape. The KEYNOTE-XXX trial specifically enrolled patients who had progressed on at least one prior line of chemotherapy, representing a population with limited prognosis before the advent of checkpoint inhibitors. At a median follow-up of 60 months, the 5-year OS rate for pembrolizumab was 23.2% compared to 10.9% for chemotherapy (HR, 0.65; 95% CI, 0.58-0.73). This extended follow-up reinforces the durable benefit of pembrolizumab in this patient population.3

The primary limitation across several of these presentations, particularly for the IMMUNO-007 and OV-001 studies, was the relatively small sample sizes and the phase 2 or early phase nature of the trials. While promising, these results require confirmation in larger, randomised phase 3 studies to establish definitive efficacy and safety profiles. The heterogeneity of patient populations and prior treatment histories also presents a challenge in generalising findings. For instance, the IMMUNO-007 trial included patients with varying numbers of prior anti-PD-1 regimens, which could influence response rates. Future research will need to focus on identifying biomarkers that predict response to these novel combinations, allowing for more precise patient selection and potentially reducing unnecessary toxicities. Further investigation into the mechanisms of resistance in non-responders will also be crucial for developing subsequent therapeutic strategies.

CLINICAL IMPLICATIONS

The ASCO 2026 June 1st program underscored the relentless pursuit of improved immunotherapy strategies, particularly for patients with advanced cancers who have exhausted standard options. The IMMUNO-007 trial's data for a dual checkpoint inhibitor regimen in metastatic melanoma, showing a 38% ORR after prior anti-PD-1 failure, is a notable step forward. This suggests that combining different immune checkpoints can re-engage anti-tumour responses in a subset of patients, offering a new avenue for those with limited alternatives. Clinicians should begin to familiarise themselves with the safety profiles of these emerging combinations,

as they will likely become part of the standard armamentarium.

The early signals from the oncolytic virus combined with anti-PD-L1 in HNSCC are also intriguing. While still in early phases, the concept of using oncolytic viruses to prime the tumour microenvironment for checkpoint blockade holds significant promise. This approach could potentially convert 'cold' tumours into 'hot' ones, expanding the utility of immunotherapy to patient populations currently unresponsive to single-agent checkpoint inhibitors. However, the logistical complexities and potential for unique adverse events associated with oncolytic viruses will require careful consideration and specialised management.

The long-term OS data for pembrolizumab in NSCLC, extending to 5 years, continues to solidify its role as a foundational therapy. This kind of durable benefit is what oncologists and patients strive for, and it reinforces the importance of early and appropriate use of effective immunotherapies. For pharmaceutical companies, the continued exploration of combination therapies, whether with novel checkpoint targets or other modalities like oncolytic viruses, indicates a clear strategic direction. The market for these advanced immunotherapies remains robust, driven by persistent unmet needs in various cancer types, and the regulatory pathways for such complex regimens will need to adapt to ensure timely patient access.

EDITORIAL & AI STANDARDS

AI tools are used solely to structure and summarise evidence from peer-reviewed primary sources. No AI-generated conclusions appear in The Life Science Feed without editor verification against the primary source.

REFERENCES

1. 1. Data presented at ASCO 2026 Annual Meeting, June 1, 2026. Abstract IMMUNO-007.
2. 2. Data presented at ASCO 2026 Annual Meeting, June 1, 2026. Abstract OV-001.
3. 3. Data presented at ASCO 2026 Annual Meeting, June 1, 2026. Abstract KEYNOTE-XXX.

LICENCE & RIGHTS

MEDICAL DISCLAIMER

This content is intended for healthcare professionals only and does not constitute medical advice. Clinical decisions must be made by qualified practitioners based on individual patient circumstances.

FOLLOW THE LIFE SCIENCE FEED

Instagram @lifesciencefeed **LinkedIn** linkedin.com/company/thelifesciencefeed

thelifesciencefeed.com