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Extended survival with lurbinectedin in a heavily pretreated SCLC-patient: a case report and review of the literature

Arnold Pilz

arnold.pilz@gesundheitsverbund.at

Department of Pneumology, Clinic Penzing, Vienna Healthcare Group, Vienna, Austria
https://orcid.org/0000-0003-0084-2841

Case Report

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Abstract

Introduction

Small-cell lung cancer (SCLC) is an aggressive malignant neuroendocrine tumor with a very poor prognosis. Most patients are diagnosed with extended-stage (ES) disease, for which 3-year survival is lower than 20%. The case of a patient with SCLC who responded to lurbinectedin therapy after progression from three previous lines is presented.

Case Presentation

A 62-year-old male patient was diagnosed with limited-stage SCLC in March 2020 and received cisplatin etoposide and irradiation as first-line therapy, achieving initial partial remission (PR). Four months after the end of the therapy, the patient progressed to ES-SCLC. PRs were achieved with second- and third-line therapies consisting of chemo-immunotherapy (carboplatin-etoposide-atezolizumab followed by atezolizumab maintenance) alternating with courses of irradiation, to which the patient responded well for almost 3.5 years. When no further remission could be achieved, lurbinectedin was initiated as the fourth line, corresponding to the third ES-SCLC treatment line, enabling further PR. Lurbinectedin treatment was effective and well tolerated over 13 cycles, which is substantially longer than the commonly reported progression-free survival for lurbinectedin in clinical practice. Upon relapse, the patient received topotecan as the fifth-line treatment. Overall, the patient has survived for more than 5.5 years after the initial diagnosis.

Conclusion

This patient case describes the treatment challenges at the end-stage of heavily pre-treated patients. When standard treatments are exhausted and the cumulative toxicity of cytotoxic chemotherapies becomes a challenge, the selection of subsequent treatments becomes highly individualized. The presented case suggests that lurbinectedin can be effective in this difficult setting.

Introduction

Small-cell lung cancer (SCLC) is a malignant neuroendocrine tumor mainly associated with tobacco use (past and present) and accounts for approximately 10% to 15% of all lung cancer diagnoses.[1] SCLC is initially highly responsive to chemotherapy but has a tendency to relapse quickly within 6 to 12 months with frequent secondary chemoresistance.[2,3]

Due to its aggressive nature, most patients present with extensive-stage (ES)-SCLC at diagnosis, which has long had a very poor prognosis and treatment intent is palliative in most cases.[4] In patients receiving immuno- or chemoimmunotherapy, the 3-year survival rate is 56.5% for limited-stage (LS)-SCLC and 17.6% for ES-SCLC.[1]

The mainstay of treatment for SCLC has long consisted of surgery, irradiation, and platinum-based chemotherapy in combination with etoposide or topotecan.[4] Platinum-based therapies are still the standard-of-care for first-line SCLC treatment.[1–6] However, over the past 10 years, checkpoint inhibitors (CPI), lurbinectedin, and tarlatamab have been approved.[2,4] These innovations have added checkpoint inhibitor consolidation immunotherapy to the first-line treatment of LS-SCLC.[1] For ES-SCLC, the standard first-line therapy now consists of platinum-etoposide in combination with a CPI.[3,5,6] In second and later lines, treatment depends on platinum sensitivity and the duration of the chemotherapy-free interval. The ESMO and NCCN guidelines recommend a platinum rechallenge, topotecan, irinotecan, other chemotherapies, clinical trials, and compounds with orphan drug designation.[5,6] Lurbinectedin received orphan designation from the European Commission in 2019[7] and is recommended by the ESMO guidelines as a third- or higher-line option after platinum-resistant relapse.[5]

Lurbinectedin is an analog of the marine compound ET-736 isolated from the sea squirt *Ecteinascidia turbinata*. It selectively inhibits oncogenic transcription by breaking down ribonucleic acid (RNA) polymerase II, which eventually leads to tumor cell apoptosis.[8,9] The US FDA has approved lurbinectedin in 2020 for use in SCLC after disease progression on or after platinum-based chemotherapy.[10] After FDA, lurbinectedin was approved in 17 additional countries including Switzerland. In March 2026, a positive opinion was granted by the European Medicines Agency's (EMA) Committee for Medicinal Products for Human Use (CHMP) for lurbinectedin in combination with atezolizumab for the maintenance treatment of adult patients with ES-SCLC, whose disease had not progressed after first-line induction therapy with atezolizumab, carboplatin, and etoposide.[11]

Here, we present the case of a male patient with SCLC who responded to lurbinectedin therapy after progression from three previous lines. This case report addresses the treatment dilemma at the late stages of SCLC treatment. In heavily pre-treated patients with accumulating toxicity and decreasing responsiveness, the challenge of choosing an effective treatment remains significant.

Case Presentation

The patient, who was 62 years old at the time of initial diagnosis, was referred to the pulmonary outpatient clinic in March 2020 by a general practitioner with a mass in the right upper lobe and right hilar lymphadenopathy. The mass was originally detected on imaging (Fig. 1A) as part of an investigation to clarify the right thoracic pain that had been present for one month.

The patient's medical history included chronic tobacco use for 40 years (approximately 30 pack-years). Additionally, the patient had a history of treatment for arterial hypertension and hyperlipidemia. Two years earlier, thyroidectomy was performed for a multinodular goiter and thyroxine substitution was administered. The patient presented with a good general and nutritional status and no performance limitations.

To clarify the pulmonary mass, staging examinations were scheduled and bronchoscopy was performed. Histology using endobronchial ultrasound (EBUS) confirmed SCLC (Fig. 1B). In subsequent staging examinations (MRI of the brain, ultrasound of the lymph nodes/abdomen, and bone scintigraphy), no further foci were found, resulting in clinical TNM staging of T4N2M0 in the sense of limited disease. Fig. 2 shows the patient's treatment history and outcomes.

The tumor board then decided on concomitant radiochemotherapy with cisplatin-etoposide (four cycles) and irradiation starting in the second therapy cycle (total radiation dose of 60 Gy). The patient tolerated the therapy well with granulocyte colony-stimulating factor (G-CSF) support. Restaging CT showed a good response to therapy, with only residual mediastinal soft tissue involvement. The possibility of prophylactic whole-brain irradiation was discussed with the patient, who decided against irradiation and opted for regular magnetic resonance imaging (MRI) checks.

In the next restaging check-up, just over four months after irradiation, there was an increase in the primary tumor at the upper right hilum and nodular enlargement of both adrenal glands (Fig. 3A).

With clear progressive disease and transition to extensive disease, re-induction with carboplatin and etoposide plus immune-checkpoint inhibitor (ICI) therapy with atezolizumab was started in November 2020. At the start of therapy, hyponatremia also occurred in a paraneoplastic syndrome with inappropriate antidiuretic hormone (SIADH) secretion, which was treated with tolvaptan.

After the first cycle of chemotherapy, bicytopenia occurred, and the carboplatin dose had to be reduced from AUC (area under the free carboplatin plasma concentration versus time curve) 5 (mg/ml/min) to AUC 4. The subsequent cycles were well tolerated by the patient. With a good response to therapy after four cycles and a significant reduction in the size of all lesions, maintenance therapy with atezolizumab was initiated in January 2021, and tolvaptan was discontinued in February 2021.

Immunotherapy was continued without interruption for almost two years until October 2022 because of a sustained response to therapy (Fig. 3B), when a computed tomography (CT) revealed a new round lesion in the right upper lobe (14 mm in diameter; Fig. 3C). After discussion in the tumor board, the decision was made to perform local irradiation of the lesion, which was carried out until the beginning of December 2022.

After irradiation of the lesion, immunotherapy was reinstated and continued until September 2023. At that time, multifocal progression became apparent, with a bilateral increase in the size of the adrenal mass and right supraclavicular lymph node (Fig. 4A).

Due to pain, local irradiation of the lymph node was performed, and after an almost 3-year chemotherapy-free interval, a new re-induction with carboplatin and etoposide in reduced dosage (AUC 3.5) in combination with atezolizumab was attempted in the sense of treatment-beyond-progression. The therapy was well-tolerated; however, the response to the therapy was mixed. Pulmonary and cervical

findings were stable, while the mass in the left adrenal gland continued to grow in size, but not in the right adrenal gland (Fig. 4B).

The patient case was again presented to the tumor board for consideration of the local irradiation of the left adrenal gland. At the same time, in view of the atypical course of the disease with SCLC, liquid biopsy next-generation sequencing (NGS) was performed, which revealed an untreatable TP53 mutation. Local irradiation of the left adrenal gland was performed in February 2024 and ICI therapy with atezolizumab was continued.

By April 2024, multifocal progression occurred once again (Fig. 4C); therefore, therapy with atezolizumab ultimately had to be discontinued after 59 cycles over a period of 3.5 years and a change in systemic therapy became necessary.

Due to the multiple previous platinum chemotherapies and the expected more favorable side effect profile, a therapy decision was made in favor of lurbinectedin over topotecan as the third-line when counted from ES-SCLC and fourth-line when counted from SCLC diagnosis.

The first dose of lurbinectedin (dose 3.2 mg/m²) was administered at the end of April 2024. No significant side effects were observed during treatment. During the post-therapeutic checkup after several doses, moderate thrombocytopenia (>100 G/L) resolved without any intervention. Gamma knife treatment was also performed as part of therapy for a newly occurring solitary cerebral metastasis. With good tolerability and response to lurbinectedin after 4 cycles, the therapy was continued. Starting with the 7^{th} cycle of lurbinectedin, fatigue increased, and the patient wanted to take a break from the therapy after eight cycles. After a 3-month break in therapy, the patient felt increasing pressure on his right flank, and a CT scan showed a significant size increase in the right and left adrenal metastases. There was no further deterioration of the pulmonary and cerebral findings. In January 2025, lurbinectedin was reinstated at the same dose (Fig. 5).

In April 2025, four cycles after reinstatement of lurbinectedin therapy, a CT scan was performed, which showed increasing tumor infiltration of the left kidney. The patient also reported increased pain in his left flank. The patient presented again to the tumor board for reirradiation of the left adrenal gland and kidney. Palliative radiation therapy was then administered. However, after further imaging in May 2025, the metastasis of the right adrenal glands also progressed in size; therefore, therapy with lurbinectedin was discontinued after 13 cycles, and systemic therapy was switched to weekly administration of topotecan. The patient’s ECOG, which was 0 up until April 2025, had deteriorated to ECOG 1 by May 2025.

Unfortunately, after the change in therapy, the patient's condition deteriorated owing to more severe hematotoxic side effects (neutropenia and thrombocytopenia) and recurrence of SIADH, requiring the patient to be admitted to the hospital. During this hospital stay, MRI was performed because of increasing pain in the lumbar spine region. This revealed new intraspinal metastasis. Subsequently, palliative radiotherapy was being performed in the spinal canal in an inpatient setting; therapy with

topotecan could not be continued because of deterioration in the patient's general condition and therapy-associated side effects. The patient has meanwhile deceased.

Discussion

The patient was diagnosed with LS-SCLC in March 2020, which quickly progressed to ES-SCLC, an often-observed course of the disease. The first-line treatment for ES-SCLC in our patient was platinum-based chemo-immunotherapy, followed by immunotherapy maintenance, a rechallenge of platinum-based chemo-immunotherapy upon relapse, and another course of immunotherapy maintenance, all with intermittent irradiation at each relapse, a strategy that stabilized the disease for approximately 3.5 years. After relapse, lurbinectedin was chosen because its mode of action is different from that of previous therapies and its expected side effect profile is more favorable than that of topotecan.[12,13]

Two interventional trials investigated lurbinectedin as a monotherapy: the completed Phase II basket trial, which included a subset of patients with SCLC and was the basis for EMA orphan drug designation and FDA accelerated approval, and the ongoing Phase III LAGOON trial, which also has a monotherapy arm.[7,10,14,15]

The Phase II basket trial enrolled 105 patients with SCLC who received lurbinectedin (3.2 mg/m^2 once every 3 weeks [Q3W]) as a second-line treatment after platinum-based chemotherapy.[14] Most patients (70%) had ES-SCLC and ECOG status 0 (36%) or 1 (56%); CNS involvement was present in 4%. Patients received a median of 4 (interquartile range [IQR] 2–8) cycles per patient and were followed for a median of 17.1 months (IQR 6.5-25.3). Investigator-assessed overall response (complete and partial response) was observed in 37 patients (35.2%; 95% confidence interval [CI] 26.2-45.2). The median duration of response was 5.3 months (95% CI 4.1-6.4), median progression-free survival (PFS) was 3.5 months (95% CI 2.6-4.3), and median overall survival (OS), an exploratory endpoint, was 9.3 months (95% CI 6.3-11.8). Patients with chemotherapy-sensitive disease who had a chemotherapy-free interval of 90 days or longer (n=60), the overall response rate was 45.0% (95% CI 32.1–58.4) had an overall response, with a median duration of response of 6.2 months (95% CI 3.5–7.3). Patients who had chemotherapy-resistant disease with a chemotherapy-free interval of less than 90 days (n=45), the overall response rate was 22.2% (95% CI 11.2–37.1, with a median duration of response of 4.7 months (95% CI 2.6–5.6). The lurbinectedin treatment regimen had an acceptable and manageable safety profile with reversible myelosuppression as the main toxicity. Serious treatment-related adverse events (TRAEs) occurred in 11 (10%) of patients. Two (2%) patients discontinued lurbinectedin therapy owing to TRAEs.

The ongoing Phase III LAGOON trial is evaluating two experimental arms (lurbinectedin 3.2 mg/m^2 Q3W alone and lurbinectedin 2 mg/m^2 plus irinotecan Q3W) versus the investigator's choice of topotecan or irinotecan.[15] Recruitment was completed, but the results have not yet been published.[16]

Further data on lurbinectedin monotherapy in SCLC are obtained from real-world studies and compassionate use programs.[17-27]

The Jazz EMERGE 402 study (NCT04894591) is ongoing and plans to enroll 300 patients with ES-SCLC patients in USA and Canada including diverse subgroups, such as older patients, those with platinum-resistant disease, or CNS involvement (25%).[22-24] The results of 265 patients have recently been published. Lurbinectedin was used as second-line therapy in 63% (n = 168) and in third line 29% (n = 77) of patients. The overall response rate was 27% (95% CI 20-33) with similar responses in the second- and third-line settings, at 29% (95% CI 21-38) and 23% (95% CI 13-36), respectively. The disease control rate was 45% (95% CI 38-53). The median duration of response was 4.0 months (95% CI 3.0-4.9), the median progression-free survival was 3.3 months (95% CI 2.6-4.1). Patients with chemotherapy-resistant disease (n = 64) had an objective response rate of 22% (95% CI 13-34) versus 29% (95% CI 20-39) in patients with chemotherapy-sensitive disease. Adverse events occurred in 60% of patients, serious adverse events occurred in 37%; 11% had serious TRAEs and 7% had AEs leading to discontinuation.[24]

A real-world study from Korea evaluated 34 patients with metastatic SCLC (20% LS-SCLC, 80% ES-SCLC) and brain involvement in 53%. Patients received lurbinectedin at 3.2 mg/m² as second (35%) or higher (65%) line of therapy. The overall objective response rate was 20% and the disease control rate was 47%. The median progression-free survival (PFS) was 2.8 months, and the median overall survival (OS) was 3.3 months. Overall, 24% of patients experienced grade ≥3 adverse events, with the most common being anemia (9%) and neutropenia (9%).[25]

A real-world study from Israel evaluated 59 patients receiving lurbinectedin as second line (66.1%) or third- or higher-line treatment (33.9%). Prior immune checkpoint inhibitor exposure during any therapy line was 71.9%. CNS involvement was present at baseline in 48.4%. The median lurbinectedin treatment duration was 4.3 months. The overall response rate was 37.3%, with 38.5% in patients receiving lurbinectedin as second-line treatment and 35.0% in those receiving the drug as third-line or higher line. The median overall survival was 7.7 months. Patients with prior immune checkpoint inhibitor exposure had a non-significantly longer median treatment duration (4.6 vs. 2.3 months; log-rank p =0.14), a trend toward lower hazard of treatment discontinuation (hazard ratio [HR] 0.58; p = 0.20) and a lower hazard of death (HR 0.46; p = 0.07). The presence of baseline brain metastases (47%) did not preclude clinical benefit.[26]

The IFCT-2105 LURBICLIN study, a nationwide, non-interventional, retrospective chart review study based on the cohort of consecutive patients enrolled in the named patient use (NPU) for lurbinectedin in France, included 312 patients receiving at least one dose of lurbinectedin 3.2 mg/m^2 Q3W in second or later line of therapy.[17] LURBICLIN enrolled a broader and more severe population of patients with SCLC than the basket clinical trial with 28% of patients with ECOG performance status ≥2, 47% of patients with CNS involvement, and 56% of patients who received third or higher line therapy.[14] The objective response rate (complete and partial remission) was 22% (95% CI 17-27), median PFS was 1.9 months (95% 1.8-2.0), and median OS was 4.7 months (95% CI 4.0-5.4). Grade 3 TRAEs were observed in 28 (9%) and grade 4 TRAEs in 15 (4.8%) patients.[17]

A retrospective analysis of data from the Mayo Clinic Health System included 90 patients, of whom 64 had ES-SCLC. Of these, 50 (78%) received lurbinectedin in second and 14 (22%) third or higher lines of therapy after they had all received platinum-based chemotherapy and immunotherapy, 38 (59%) had CNS involvement. This study assessed the PFS, OS, and safety of this treatment regimen. Patients receiving lurbinectedin as second-line therapy had a median PFS of 2.1 months and median OS of 5.1 months. Patients receiving lurbinectedin as a third- or higher-line treatment had a median PFS of 3.4 months and a median OS of 5.6 months. No overall TRAE rate was reported; the occurring adverse events were described as manageable.[27]

In a small French cohort of 13 patients with ES-SCLC, lurbinectedin 3.2 mg/m^2 was administered as a second-line treatment after first-line platinum-based chemotherapy. CNS involvement was observed in 2 patients (15%). The chemotherapy-free interval was £90 days 11 patients (85%) and >90 days in two patients (15%). After a mean follow-up of 4.1 months, the objective response rate was 31%, the disease control rate was 17%. The investigator-assessed median progression-free survival was 1.9 months (IQR 0.9-1.5) and overall survival was 4.1 months (IQR 0.9–8.8) months.[19]

Data collected as part of the lurbinectedin early access program in Australia included 46 patients who received lurbinectedin in second (83%) or higher line (17%); all patients had received first-line platinum-based therapy. The overall response (complete and partial response) rate was 33%, median PFS was 2.5 months (95% CI 1.8-2.9), and median OS was 4.5 months (95% CI 3.5-7.2). No overall TRAE rate was reported; grade 3 or higher adverse events occurred in 28% of patients.[20]

Data from the Netherlands and Italy, collected within the framework of a compassionate use program, included 238 patients receiving lurbinectedin in second (33.8% in Netherlands, 52.9% in Italy), third (47.1% and 32.4%), or higher (19.1% and 14.7%) line of therapy. Most patients had ES-SCLC (72.5% and 61.8%), and CNS involvement was present in 19.1% and 41.2% of patients, respectively, at the start of lurbinectedin treatment. All patients had received prior chemotherapy, and prior chemoimmunotherapy had been administered to 12.3% of patients in the Dutch cohort and in 64.7% of the Italian cohort. The initial dose of lurbinectedin was reduced in 2.0% and 64.7%, respectively. The objective response (complete and partial response) rate was 24.5% and 14.7%, the median PFS was 1.8 months (95% CI 1.0–2.7) and 2.3 months (95% CI 2.0–2.7), and the median OS was 5.6 months (95% CI 4.7–6.4) and 3.6 months (95% CI 1.8–5.3) in the Dutch and Italian cohort, respectively. Adverse events occurred in 92% of patients, grade 3-4 adverse events in 29%.[21]

The presented patient received 13 cycles of lurbinectedin (including the initial 8 cycles and subsequent reinstatement of 5 cycles after a 3-months treatment interruption) achieving a duration of clinical benefit of approximately 9 months, which is substantially longer than the 1.9 to 3.5 months of median PFS observed in the real-world studies discussed above. Apart from fatigue leading to treatment interruption and mild thrombocytopenia, the patient did not experience any notable adverse events during therapy. This allowed the patient to experience a long period of time with low toxicity between the previous sequences of platinum-based therapy and the subsequent topotecan treatment. In this case, the patient

responded well to previous chemoimmunotherapy for a long period. As shown above, sensitivity to previous platin-chemotherapy favored the lurbinectedin response in the basket trial, and prior exposure to immunotherapy showed a tendency to improve the response.[14,26]

All treatments described in this case were given in routine clinical practice outside a formal trial. Treatment decisions were guided by clinical follow-up, routine imaging assessments, performance status in outpatient care, and the patient's symptoms and preferences. Formal trial-based evaluations such as RECIST, CTCAE toxicity grading, or extended molecular analyses were not performed. This mirrors the real-world setting in which late-line treatment decisions for SCLC are often taken.

Patient case reports have an inherent bias towards to selection of exceptional cases. Patient cases serve as both an interesting finding and a call for further research. Although lurbinectedin provides an effective treatment window, the challenges of subsequent treatment remain significant, emphasizing the importance of optimizing the treatment sequence. The educational value of this case does not lie in demonstrating the efficacy of lurbinectedin in isolation, but rather in illustrating how treatment sequencing, tolerability considerations, and preservation of functional status can meaningfully influence outcomes in patients with heavily pretreated SCLC.

In conclusion, even in heavily pretreated patients beyond the third line of therapy, lurbinectedin can show a therapeutic response. In heavily pretreated patient populations, the cumulative toxicity of cytostatic chemotherapy is an increasing problem. Owing to its favorable side effect profile, lurbinectedin represents a possible therapeutic alternative. Further data on the efficacy of lurbinectedin in neuroendocrine carcinomas, including as an addition to first-line atezolizumab maintenance therapy, have recently been presented.[28-30] Nevertheless, many unanswered questions remain. Although it has been shown that chemotherapy-sensitive relapse patients respond better to lurbinectedin than patients with prior response to ICI, further studies are needed to identify a clear profile for potential lurbinectedin candidates and biomarkers should be identified. The LAGOON Phase III trial was planned to include 70% of patients with previous ICI therapy and may provide answers in this regard.

Statements

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Statement of Ethics

Written informed consent was obtained from the patient for publication of this case report and accompanying images. Institutional approval to publish the case was not required.

Conflict of Interest Statement

The author has no conflicts of interest to declare.

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Author Contributions

The author made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; has agreed on the journal to which the article has been submitted; and agrees to be accountable for all aspects of the work.

Data Availability Statement

This is a report of a patient treated in routine clinical practice, and data not included in this article are protected by physician-patient privilege and subject to the patient's consent to make it available. Further inquiries can be directed to the corresponding author.

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Figures

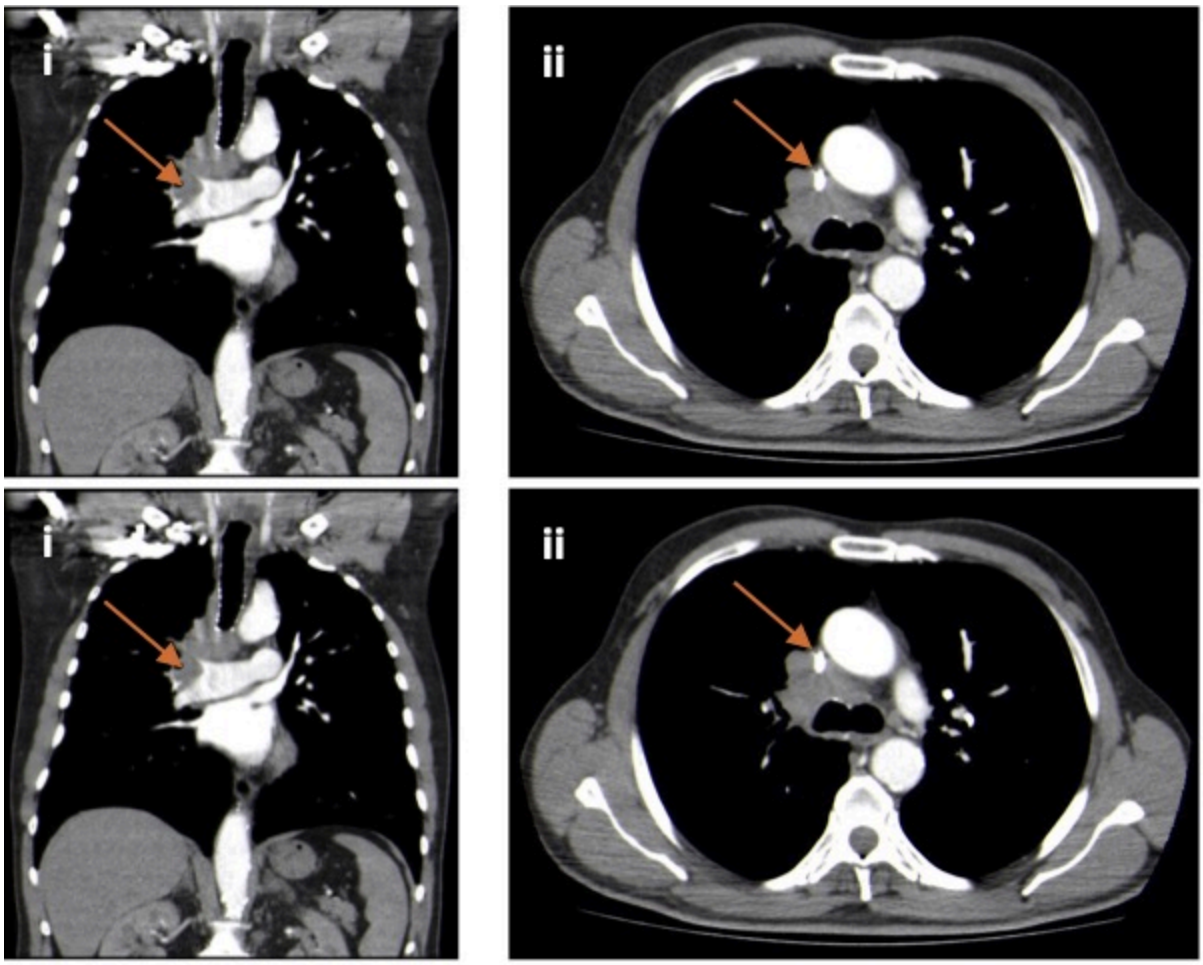


Figure 1

Status at diagnosis, 03/2020

Fig. 1A. Central mass (red arrow) in the right upper lobe with compression of the right pulmonary artery (i); mediastinal lymphadenopathy with narrowing (red arrow) of the superior vena cava (ii).

Fig. 1B. Bronchoscopy showing extraluminal compression of the upper lobes of the right carina (i) and pathological lymph nodes in EBUS over lymph node region 4R (ii).

EBUS, endobronchial ultrasound; lymph node region 4R, right lower paratracheal region

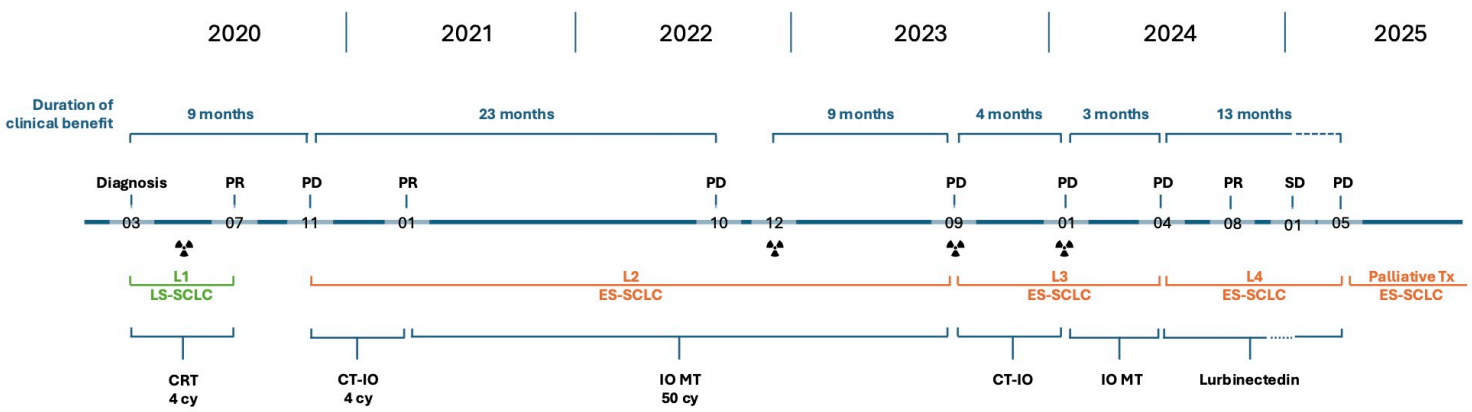


Figure 2

Overview of treatment course and outcomes

Green font indicates LS-SCLC stage, orange font indicates ES-SCLC stage

Chemo-IO: Carboplatin-etoposide-atezolizumab; CRT: Cisplatin-etoposide 4 cycles and irradiation (60 Gy); ES-SCLC, extended-stage small-cell lung cancer; IO MT: Atezolizumab maintenance; L, line; LS-SCLC, limited-stage small-cell lung cancer; Lurbinectedin: Lurbinectedin 13 cycles w/ break after 8 cycles; palliative Tx: 1 cycle of topotecan 1 cycle, followed by palliative treatment; PD, progressive disease; PR, partial remission; w/, with

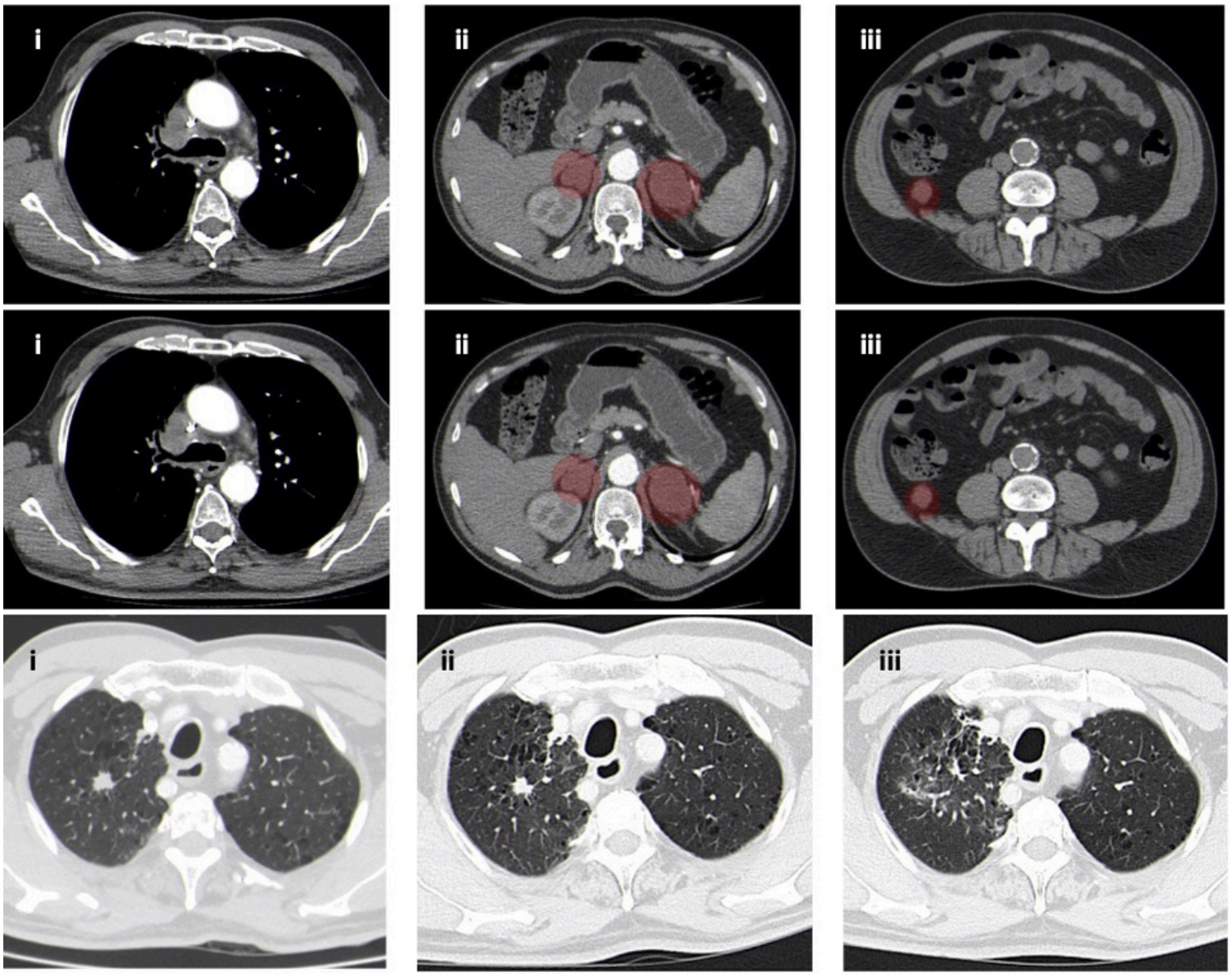


Figure 3

Course during chemo-immunotherapy and irradiation (2L)

Fig. 3A. Progression of primary tumor (i), adrenal glands on both sides (brown highlighted region) (ii), and infrarenal lesion on the right (brown highlighted region) (iii), 11/2020.

Fig. 3B. Sustained response to therapy with atezolizumab, primary tumor 06/2022.

Fig. 3C. Progressive round lesion in the right upper lobe 10/2022 (i), post-irradiation 02/2023 (ii), and 05/2023 with post-actinic changes (iii).

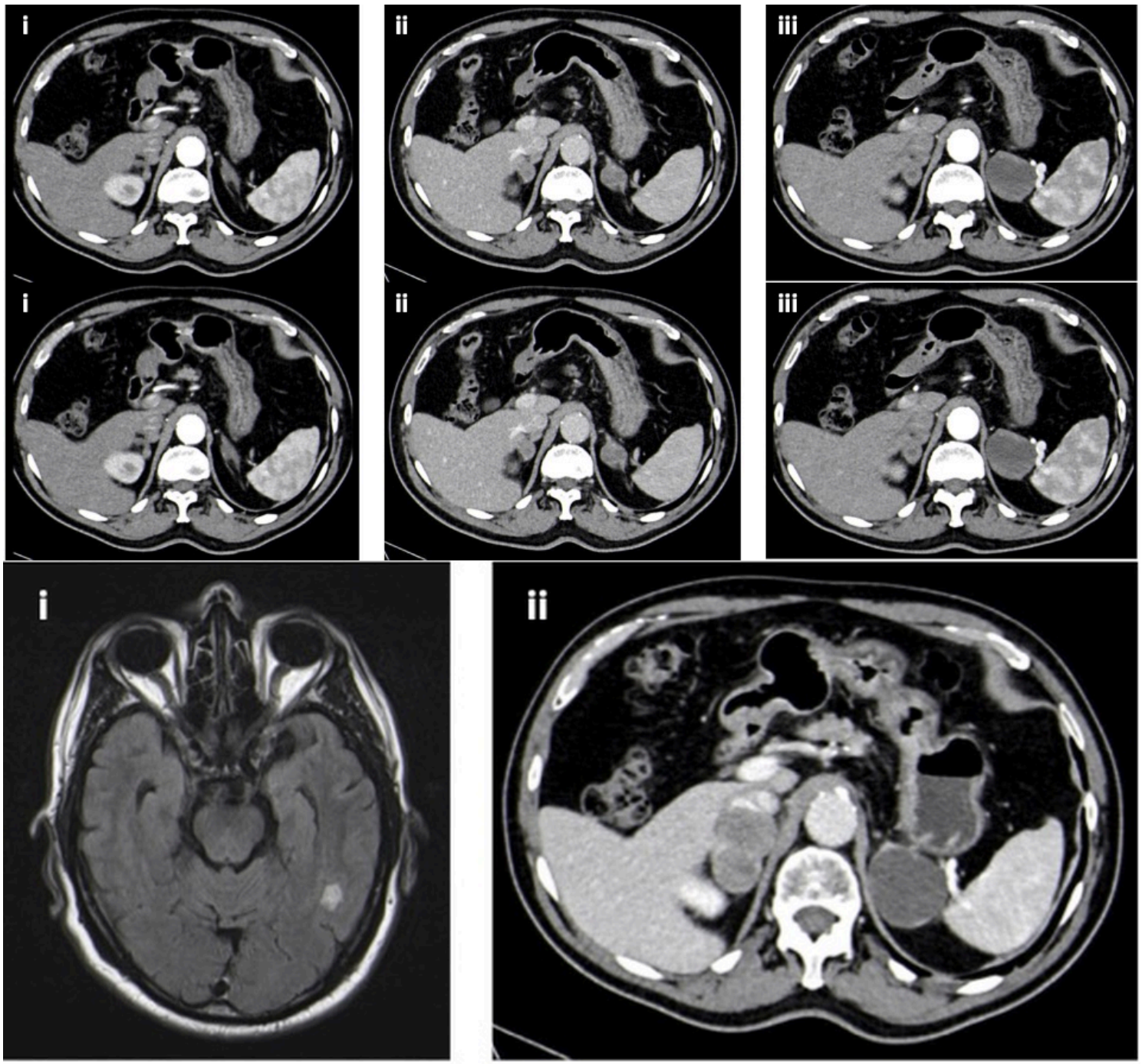


Figure 4

Course during chemo-immunotherapy and irradiation (3L)

Fig. 4A. Pathological right supraclavicular lymph node, 09/2023.

Fig. 4B. Progression of adrenal metastases on both sides 06/2023 (i), 09/2023 (ii), 01/2024 (iii).

Fig. 4C. Cerebral metastasis temporal left (i) and again significant progression of adrenal metastases (ii), 04/2024.

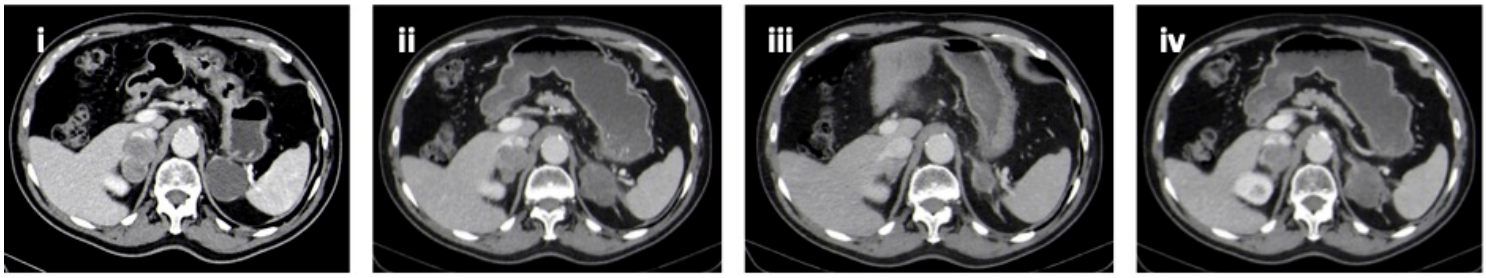


Figure 5

Course under lurbinectedin (4L)

04/2024 (i), 07/2024 (ii), 10/2024 (iii), and after therapy break 01/2025 (iv).