Outcomes are significantly compromised in pts harboring OD mutation but who are treated initially with C, ICI or both, even in pts quickly switched to TKI.

**Table 1. General demographics and clinical characteristics in treated patient subgroups**

<table>
<thead>
<tr>
<th>Group</th>
<th>Treated with TKI</th>
<th>Switched to No TKI</th>
<th>Switched to ICI</th>
<th>Switched to C</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>n=144</td>
<td>n=379</td>
<td>n=47</td>
<td>n=86</td>
</tr>
<tr>
<td>B</td>
<td>n=235</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>n=79</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Discussion**

- While subject to the limitations inherent to a retrospective, observational RWD study, these results strongly suggest outcomes are significantly compromised in patients, subsequently proven to harbor an OD mutation, treated prior to this report by chemotherapy, ICI, or both.
- The 35-day window for switching therapy in Group B prevented the capture of early deaths in this group and may have contributed to the OS not reaching statistical significance for the comparison of Group A versus Group B. Further analysis will provide insight into the extent of the effect on outcomes.
- Ultra-fast NGS or liquid biopsy for oncogenic driver testing to minimize turnaround time should be employed to avoid treatment after mutation report. Results in Group C emphasize the need for near-real-time, near-patient testing with time to genotyping decreased to 4 days.
- These negative outcomes indicate the need to evaluate use of immuno-oncogenic pri TKI to determine if results are worse than when chemotherapy alone is utilized, and thus validating current NCCN guidelines.
- This encourages update of guidelines, as this will never be tested in a prospective, randomized trial.

**References**


**Contact/Declaration of Interest**

Dr. Choksi has no conflicts of interest to declare.