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LBA48

Liver function trajectory and post-progression outcomes in the phase 3 EMERALD-3 study of tremelimumab (T) + durvalumab (D) ± lenvatinib (L) + transarterial chemoembolisation (TACE) in participants (pts) with embolisation-eligible hepatocellular carcinoma (eeHCC)

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Background

EMERALD-3 met its primary endpoint. Favourable OS trends were seen for STRIDE ± L + TACE vs TACE. Preserved liver function allows pts to receive subsequent (sub) Tx post progression. We report post-hoc exploratory analyses of liver function trajectory and outcomes by baseline (BL) liver function.

Methods

Pts (≥18 yr) with eeHCC were randomised 1:1:1 to STRIDE (T 300 mg + D 1500 mg on Day 1; D 1500 mg Q4W) + L (8 or 12 mg QD) + TACE; STRIDE + TACE; or TACE until reaching 175 pts/arm, then 1:1 until STRIDE + L + TACE and TACE reached ⊠275 pts/arm. Pts were stratified by region, prior palliative embolisation and BL tumour burden. Primary endpoint was PFS for STRIDE + L + TACE vs TACE. Key secondary endpoints were OS for STRIDE + L + TACE vs TACE; PFS and OS for STRIDE + TACE vs TACE. PFS2 was a secondary endpoint.

Results

As of 23 Feb 2026, in the SAS, mean ALBI and Child-Pugh scores were stable over Tx period across BL gr. In the FAS, median OS was 44.6 mo (95% CI 39.5–NC) for STRIDE + L + TACE vs 39.2 mo (34.7–NC) for TACE in ALBI gr 1 (HR 0.86 [95% CI 0.60–1.22]); 28.5 mo (20.7–34.3) vs 22.1 mo (17.4–33.3), respectively, in gr 2/3 (HR 0.88 [0.60–1.28]). Median OS was NC (37.8–NC) for STRIDE + TACE vs 39.2 mo (28.0–NC) for TACE in ALBI gr 1 (HR 0.57 [95% CI 0.36–0.90]); 27.9 mo (17.8–NC) vs 20.4 mo (16.6–30.1), respectively, in gr 2/3 (HR 0.81 [0.52–1.26]). STRIDE ± L + TACE numerically improved PFS2 and TTNT vs TACE across BL gr (Table). Sub Tx use was 43% (of FAS; ALBI gr 1) and 46% (gr 2/3) for STRIDE + L + TACE; 50% and 53% for STRIDE + TACE; 72% and 68% for TACE. Max gr 3/4 TRAE rates were similar across BL gr.Table: LBA48

	ALBI gr 1				ALBI gr 2/3			
	STRIDE+L+ TACE	TACE	STRIDE+ TACE	TACE*	STRIDE+L+ TACE	TACE	STRIDE+ TACE	TACE*
FAS, n	188	183	105	111	105	109	70	64
PFS2 (95% CI)								
HR	0.70 (0.51–0.95)		0.53 (0.36–0.79)		0.74 (0.52–1.05)		0.69 (0.46–1.05)	
Median, mo	39.5 (34.0–NC)	25.8 (21.6–NC)	NC (37.8–NC)	23.9 (17.4–38.4)	24.5 (18.8–34.1)	17.4 (14.6–25.2)	24.7 (15.8–32.5)	17.1 (13.3–22.1)
TTNT (95% CI)								
HR	0.56 (0.43–0.72)		0.46 (0.33–0.64)		0.57 (0.41–0.77)		0.55 (0.38–0.80)	
Median, mo	21.1 (18.5–27.3)	10.6 (8.7–12.8)	20.3 (15.6–33.7)	9.2 (7.2–11.3)	14.0 (10.8–20.4)	7.3 (5.5–9.2)	13.4 (8.4–17.6)	6.0 (4.6–8.9)
SAS, n	185	181	105	109	102	109	70	64
Max gr 3/4 TRAEs, n (%)	115 (62)	32 (18)	49 (47)	22 (20)	65 (64)	22 (20)	36 (51)	17 (27)

*Of first 175.

Conclusions

STRIDE ± L + TACE showed clinically relevant improvements in post-progression and survival outcomes vs TACE, with stable liver function over Tx period and comparable safety regardless of BL gr, supporting a STRIDE-based regimen + TACE as a potential new Tx option for eeHCC.

Clinical trial identification

NCT05301842.

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Legal entity responsible for the study

AstraZeneca.

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