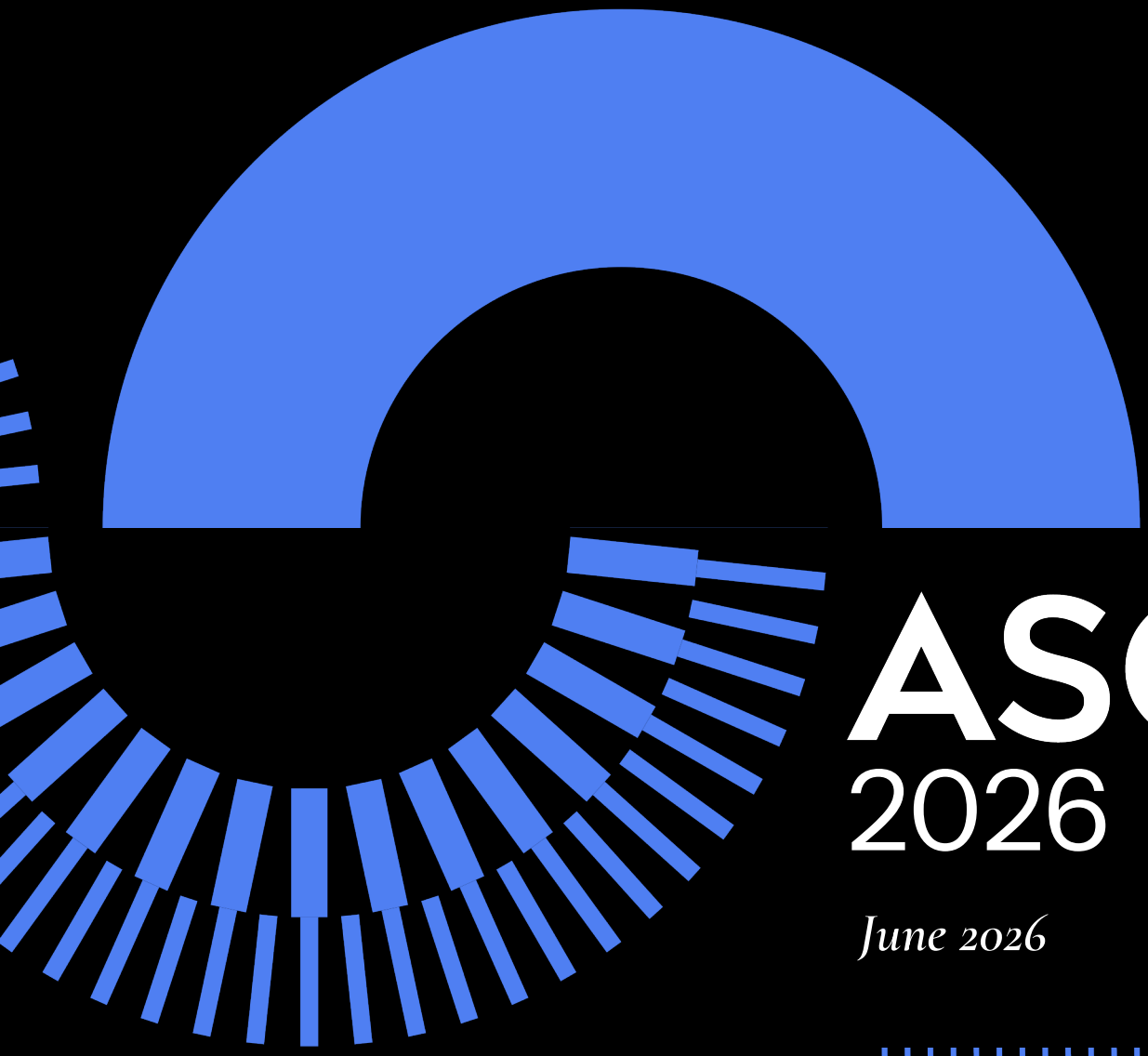

ASCO® 2026

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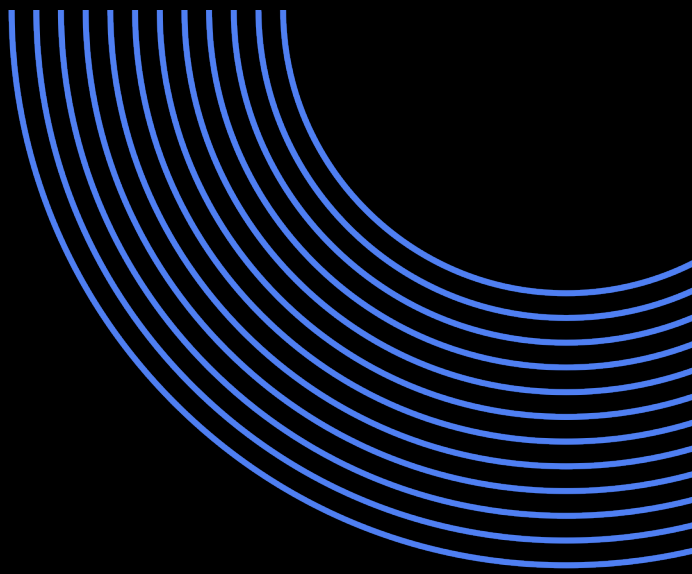

OMNICOM HEALTH

Oncology is more complex.

The opportunity is to make it usable.

ASCO 2026 reinforced a clear thesis: oncology is earlier, more precise, more combinatorial, more platform-driven, and more operationally demanding.

The marketing winners will be the teams that help clinicians translate data into decisions.

ASCO 2026: More powerful science, more complex decisions

ASCO 2026 made one thing clear: oncology innovation is advancing faster than the system's ability to absorb it.

Across pancreatic cancer, prostate cancer, lung cancer, breast cancer, and the growing AI conversation, the science became more powerful, but the decisions around it became harder. New data did not simply add options, it raised sharper questions about which patients to identify, which tests to run, which combinations to trust, which trade-offs to explain, and how to make increasingly sophisticated advances work in routine care.

Across tumor types, the most important story was not the arrival of more options alone, it was the rising complexity around how those options are selected, sequenced, explained, and put to work in real-world care. Oncology is earlier, more precise, more combinatorial, more platform-driven, and more operationally demanding.

The opportunity is not only to amplify positive results. It is to build the evidence narratives, education, tools, and brand stories that help clinicians understand which patients are most appropriate, when to act, how to weigh trade-offs, and what must happen across the care pathway for innovation to reach the people it is intended to help.

The data felt more specific **because the decisions are more specific**

One of the defining features of ASCO 2026 was how much of the conversation sat at the intersection of scientific progress and decision complexity.

The headline pancreatic cancer discussion around daraxonrasib in the RASolute 302 trial carried both scientific and emotional weight. Without making the story brand-centered, it was a reminder that progress in historically difficult tumors and previously "undruggable" targets may require new treatment philosophies, not just better versions of existing classes. For healthcare marketers, that kind of moment needs more than a data headline. It needs a story about what it means when a category long defined by limited options begins to behave differently.

At the same time, earlier and more selective treatment strategies continued to sharpen across tumor types. The PROTEUS and TALAPRO-3 trials raised different questions in prostate cancer: one about clinical-risk intensification in curative-intent care, the other about genomic-risk intensification in HRR-altered metastatic hormone-sensitive disease. The CROWN long-term follow-up trial in ALK-positive non-small cell lung cancer showed how durable targeted therapy data can shape confidence over time. Emerging HER2 bispecific approaches pointed to continued innovation in breast cancer, while also raising practical questions about regimen fit, safety, and where new options belong.

The pattern matters. Earlier treatment is not a simpler commercial story; it is a more exacting one. Clinicians and patients are asking who truly needs escalation, how mature the evidence is, what benefit is meaningful enough to justify added treatment, what toxicity burden is acceptable, and how today's decisions may affect tomorrow's options.

The strongest strategies will not simply say "earlier." They will explain "earlier for whom, why, compared with what, and with what trade-off."

Platforms are replacing single products

ASCO 2026 made clear that the innovation story is becoming less about one product in a single line of therapy and more about modality platforms that can reshape multiple decisions over time.

ADCs; RAS and KRAS inhibitors; bispecific antibodies; PARP and other targeted combinations; IO combinations, including IO-plus-ADC regimens; and next-generation immuno-oncology approaches are not just new assets, they are platform stories. They create questions about sequencing, combination strategy, resistance, toxicity management, diagnostic readiness, and how clinicians should understand differences within an increasingly crowded class.

That is why RAS in pancreatic cancer mattered beyond a single data moment. It suggested that a historically difficult target and tumor type may be entering a new strategic chapter. The same is true for the attention around ivonescimab and immuno-oncology combination data, which points to a broader move from single-axis immuno-oncology stories toward more integrated mechanisms and more complex competitive comparisons.

For healthcare marketers, platform-driven innovation changes the communications job. **A platform needs more than a launch message. It needs a learning agenda: what the modality means, where it may fit, how to compare it with familiar standards, how to prepare for future indications, and how to help clinicians make sense of a field that is evolving faster than linear brand narratives can handle.**

Patient selection is becoming a workflow challenge

Precision oncology has always depended on identifying the right patient. What is changing is how many operational steps now sit between clinical possibility and clinical use.

Biomarker testing, multiplex panels, ctDNA, MCED, pathology, imaging, trial eligibility, prior authorization, community oncology workflows, data interpretation, and care-team coordination all shape whether an eligible patient is found in time to act. A therapy that depends on HRR or BRCA status, for example, can only reach eligible patients if testing happens early enough, results are trusted, and clinicians know how to use those results in treatment planning.

The marketing question is no longer simply whether the diagnostic journey matters. Most marketers know that it does. The sharper questions point to where adoption breaks: Which patients are not being tested? Which results arrive too late? Which clinicians are uncertain how to interpret them? Which sites lack the infrastructure to act? Which patients face access barriers before the treatment conversation can even begin?

This makes precision oncology an infrastructure story as much as a drug story. The brands that help teams map those friction points and solve for them will be better positioned than brands that treat testing as a separate educational module.

AI has to earn its place in the workflow

The AI conversation at ASCO 2026 was not just about novelty, it was about whether AI can reduce the complexity that precision oncology is creating.

As biomarker testing, imaging, pathology, genomics, treatment sequencing, and longitudinal monitoring become harder to manage, AI will be judged by whether it improves the quality, speed, equity, and explainability of decisions. Companies such as Tempus, and the broader move toward multiplex testing and AI-enabled interpretation, point to a future in which clinical decision support becomes more deeply embedded in oncology care.

But AI will not earn trust by being another layer of work. It must help clinicians act on better information, faster, and with more confidence. That means being clear about where AI fits in the workflow, what decisions it supports, how it handles bias and uncertainty, how outputs can be explained, what governance is needed as tools evolve, and what role the clinician retains.

For healthcare marketers, this is an adoption challenge as much as a technology challenge. The credible AI story is not “AI is coming.” It is “AI can help reduce the burden of precision oncology when it is accountable, explainable, and useful at the point of care.”

Patient-centered evidence is becoming central evidence

As therapies move earlier and patients live longer, patient-centered evidence is no longer a supporting message. It is becoming part of the core value story.

Survivorship, quality of life, access, lifestyle, function, cognition, fatigue, toxicity management, supportive care, and patient-reported outcomes all matter more when treatment decisions affect a longer arc of life. In earlier disease settings, the question is not only whether an intervention can delay recurrence or progression. It is what that intervention asks of the patient, what burden it creates, what it preserves, and how it changes the lived experience of care.

This is especially important as combination regimens and platform therapies become more common. More sophisticated science can also mean more complex toxicity, more visits, more monitoring, more financial pressure, and more decisions that patients and caregivers must absorb. If the value story does not account for those realities, it can feel incomplete.

For healthcare marketers, patient-centered evidence should not be treated as a softer add-on to efficacy. **It should help define what meaningful benefit looks like: not just longer time before an event, but better function, fewer downstream interventions, more confidence in the care plan, and a treatment experience patients can realistically navigate.**

Evidence communication has to become decision support

As treatment decisions happen earlier and become more combinatorial and more nuanced, clinicians are asking more sophisticated questions of the evidence.

A positive endpoint may start a conversation, but it rarely ends one. Clinicians want to understand absolute benefit, not only relative risk reduction. They want to know whether survival data are mature, whether subgroups are clinically meaningful, whether biomarker-defined populations overlap, how toxicity is managed, and whether quality-of-life measures capture what patients actually experience.

That changes the role of the brand story. In a complex oncology category, a brand can differentiate by clarifying who to test, who to treat, when to escalate, how to sequence, how to discuss trade-offs, what to monitor, and how to coordinate across the care team. That is more durable than a feature claim because it becomes part of clinical problem-solving.

This is where thought leadership, medical education, field strategy, and creative work increasingly converge. **The most valuable communications will not simply make data memorable, they will make decisions easier to navigate.**

From data amplification **to adoption design**

ASCO 2026 showed an oncology landscape that is earlier, more precise, more combinatorial, more platform-driven, and more operationally demanding. That is why the post-congress opportunity has changed. Success depends not only on having compelling evidence, but on building the conditions that allow evidence to change clinical practice appropriately.

For healthcare marketers, the mandate is to move from data amplification to adoption design. That means developing clearer patient-selection frameworks, investing in diagnostic and biomarker education, preparing transparent evidence narratives, equipping field teams for nuanced conversations, building platform-level education, and creating tools that help clinicians act on evidence with confidence.

The next era of oncology brand building will not be defined only by who has the most promising science. It will be defined by who tells the most useful story: one that makes complex science understandable, makes evidence actionable, and helps the right patient reach the right option at the right moment in the real world.

Want to learn more or

keep the conversation going?

If you're exploring how to help clinicians navigate this evolving landscape and turn innovation into meaningful patient impact, we would love to connect.

Reach out to our team:
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