

ESMO 2026

November 2026

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The Next Frontier of *Personalized Cancer Care*

Knowing when to treat, switch, or stop

Personalized cancer care often starts with a question about the tumor. What does its biology tell us about which treatment might work? Once a patient has received that treatment, the questions change. Is there a reason to add another therapy? What should guide a switch? Could a treatment that's working be given less often? When might it make sense to defer an intervention and monitor closely? At the 2026 European Society for Medical Oncology (ESMO) Congress in Madrid, our colleagues saw how those questions are shaping the next frontier of personalized cancer care: knowing when to treat, switch or stop.

In this piece, 5 Omnicom Health colleagues who attended the congress shared what stood out to them and why. Danielle Frechette looks at what the SANO trial tells us about deferring surgery after a clinical complete response in esophageal cancer. Nicole Habib and Michael Kowalski look at what the MOIO trial tells us about the evidence needed to give immunotherapy less often. Chris Miller explores what a melanoma trial suggests about adding a therapy individualized to each patient's tumor, and what remains unanswered about sequencing antibody–drug conjugates. And Alexandre Sakihara shares what he heard in rare tumor discussions about the benefits patients want to see in their daily lives, from less pain to greater independence.

Together, their perspectives point to a practical question for oncology brand teams — how can we help patients and clinicians understand what the evidence supports, what remains uncertain, and what each option would mean for the person weighing it?

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When a response opens the door to surveillance

Danielle Frechette, Biolumina

The SANO trial stood out to me because it asked what to do after initial treatment had already achieved a clinical complete response. For patients with locally advanced esophageal cancer who had no detectable disease on clinical assessment after chemotherapy and radiation, could close monitoring offer a way to defer removal of the esophagus? Surgery can help control the disease, but it also carries the risk of complications and a substantial recovery.

The phase 3 trial compared standard surgery with a structured surveillance strategy, which, if effective, would reserve surgery for patients with evidence of disease. The original analysis found surveillance was noninferior for 2-year overall survival. In the longer follow-up presented in Madrid, 5-year overall survival was 50% with surveillance and 54% with standard surgery. The difference was not statistically significantly different, and distant metastases were more frequent in the surveillance group.

For me, the unresolved question is how to identify the patients most likely to do well with surveillance. A patient weighing these options needs to understand what they could gain by avoiding or deferring a major operation, what repeated assessments involve and what findings could trigger surgery later. Those details belong in the shared decision from the start.

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Can a treatment that's working be given less often?

Nicole Habib and Michael Kowalski, NEON

One study that stood out to us at ESMO was MOIO. It asked a practical question—if a patient with an advanced or metastatic solid tumor has responded to immunotherapy, can they receive it less often without losing the benefit?

The phase 3 trial compared giving immune checkpoint inhibitors every 12 weeks with the standard schedule. The interim results did not establish that the longer interval preserved progression-free survival, and a signal in overall survival led the independent monitoring committee to recommend ending the trial early. The findings do not support using the 12-week schedule in this population.

What stayed with us was the decision the trial put under the microscope. For patients who are doing well and may stay on therapy for an extended period, time in the clinic, side effects and the demands of ongoing treatment can become increasingly important. MOIO leaves open which patients, if any, could safely receive treatment less often, when that change could happen and what evidence clinicians would need to make that decision with confidence.

For oncology brand teams, this is a reminder to look at the decisions patients and clinicians face once treatment is underway. Medical education can help clinicians interpret emerging evidence about when a plan might change. Patient support can help people talk with their care team about how treatment is fitting into their lives and what has changed since they started.

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When to add a therapy
and what to consider before switching

Chris Miller, Wildtype

Two developments at ESMO made me think differently about how we match patients to treatment. With antibody–drug conjugates, or ADCs, one question is how much a biomarker cutoff can tell us about who might respond. The next questions come comes after a patient has already received an ADC — would the next treatment be better directed at the same target or a different one? Should it carry the same drug payload or a different one? Those questions need to be answered for specific drugs and patient populations.

As ADCs are studied earlier in disease progression, the time patients spend on treatment also matters. If options eventually offer similar benefit in the same setting, differences in side effects and tolerability could carry more weight in the decision. Understanding what treatment, a patient has already received, and how they tolerated it, will be part of making sense of the next choice.

INTerpath-001 showed a different kind of personalization. The phase 3 trial studied an investigational therapy— intismeran autogene— designed around mutations in each patient's tumor. Among patients with completely resected stage IIB–IV melanoma, 82.2% of those who received the individualized therapy plus pembrolizumab were alive without recurrence at 2 years, compared with 70.0% of those who received pembrolizumab plus placebo.

I'm interested in where that approach could go next, including other cancers, stages and combinations. There's also a practical question about delivery. If individualized therapies are to reach patients reliably, care teams will need to coordinate tumor sampling, manufacturing, and treatment schedules.

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What patients want
treatment to give them back

Alexandre Sakihara, OLIXIR UK

What stayed with me from the rare tumor discussions was how people talked about success. The word “benign” can obscure the day-to-day impact of some tumors. Chronic pain, limited mobility, and the uncertainty of recurrence can make it hard to work, plan ahead, or take part in family life. From the patient’s perspective, a meaningful improvement might be getting back to a hobby or being able to keep up with their children.

I heard this across scientific presentations and conversations with patient advocacy groups. Tumor response is an important measure. Patient-reported outcomes can also tell us whether people are experiencing symptom relief, moving more easily or regaining independence. Those changes help explain what a clinical result can mean in someone’s life.

That matters when patients are weighing another intervention. What do they hope to be able to do again? What demands would treatment, recovery, or follow-up place on them? Bringing those questions into the discussion can help patients and their care teams decide what kind of benefit would make the next step worthwhile.

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Helping patients make sense of the next step

The perspectives from Madrid show why the next step in cancer care can look different for each patient. The evidence helps clarify which options are possible, and what patients hope to preserve or get back in daily life helps them weigh those options.

For oncology brand teams, a practical place to start is with a patient discussion guide or an HCP education resource. Review it against three questions:

- **Who does the evidence apply to?** Make clear who was studied, what the findings support and where questions remain
- **What might change the plan?** For surveillance, explain what follow-up involves and what findings might lead the care team to revisit surgery. When discussing a possible switch, explain how prior treatment and side effects may factor into the options. When a different treatment schedule is being studied, explain what the evidence would need to show before it could inform care
- **What would each option ask of the patient?** Make the practical trade-offs visible, from monitoring visits and recovery time to how treatment could affect daily routines

As personalized cancer care advances, the next frontier is bringing the same precision we use to select a therapy to the decisions that follow. Knowing when to treat, switch, or stop will depend on how well we understand what each option can offer and what it asks of the person living with cancer. That's the promise of more personalized care: helping more patients and their care teams choose a next step that makes sense for the life they want to live.

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Want to talk about what these shifts mean for your oncology brand?

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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