

Candel Therapeutics: Should It Commit to the Next Glioblastoma Trial?

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The case

A decision amid several milestones

On October 2, 2026, Candel Therapeutics was preparing for a possible prostate-cancer biologics license application (BLA), starting a global pivotal lung-cancer trial, and advancing a separate viral immunotherapy for recurrent glioblastoma. Each program carried scientific promise and uncertainty. The most recent disclosures had added new prostate biomarker results and a peer-reviewed phase 2a lung-cancer publication. Candel had also reported that its current repeat-dose glioblastoma cohort was supported by a foundation, while describing a potential randomized phase 2 as still in the enabling-work stage.

Your assignment is to prepare a capital and operating-capacity recommendation for a **hypothetical Candel leadership discussion**. Public sources do not disclose a board decision about funding or deferring the next glioblastoma study. Recommend whether to authorize a defined, gated linoserpaturev randomized phase 2 dose-regimen-finding study now, stage it behind specified milestones, or preserve resources for prostate BLA/commercial readiness and the pivotal AURORA NSCLC trial. The ongoing phase 1b glioblastoma study is not the choice: its repeat-dose Arm C had completed enrollment and was supported by Break Through Cancer Foundation. These alternatives are constructed for teaching, not reported company proposals.

Do not assume the company's current runway covers incremental work. Candel did not disclose program-level budgets, costs to complete, or resource commitments by indication. Do not invent a board discussion, clinical results, spending plan, probabilities of success, product pricing, or expected returns. Label any hypothetical inputs and show how they affect your recommendation.

Company and financial position

Candel is a clinical-stage biotechnology company developing two virus-based immunotherapy platforms. Its most advanced candidate, aglatimagene besadenovec, uses an adenoviral vector and is being studied in localized prostate cancer and NSCLC. Linoserpaturev is an HSV-based candidate in phase 1b for recurrent high-grade glioma. The candidates have different indications, trial stages, delivery, and evidence; a common "viral platform" label does not make their economics comparable. [P01, P05-P07]

At June 30, 2026, Candel reported **\$201.6 million** of cash and cash equivalents and **\$47.8 million** of debt. It used **\$35.2 million** of cash in operating activities during the first half of

2026. Management said the existing current operating plan should be funded into **Q1 2028**, based on its current plans and assumptions, including increased clinical and commercialization-readiness investment. In the same filing, Candel said additional capital would be needed to commercialize aglatimagene, conduct the NSCLC phase 3 trial, and advance linoserpaturev beyond its current trials. The runway estimate is not a commitment to fund an additional phase 2 study. [P01, HTML lines 1586-93, 1634-63]

The second quarter reported a **\$38.9 million** net loss. That included a **\$12.3 million** adverse noncash change in the fair value of warrant liabilities. Q2 R&D expense was **\$19.8 million**, including **\$13.1 million** in clinical development; G&A was **\$6.9 million**, including **\$2.4 million** in commercial readiness. These are consolidated company expenses, not program budgets. [P01, HTML lines 995-1021]

The company had drawn the first **\$50 million** of a Trinity term-loan facility. A further \$20 million and \$30 million tranches depended on milestones, and a final \$30 million was at the lender's discretion. The loan was secured by a first-priority lien on substantially all company assets; the June 30 weighted-average effective rate was 13.91%, and minimum-cash covenants applied under specified conditions. Candel also had a **\$100 million** agreement with RTW payable only after FDA approval for localized intermediate- or high-risk prostate cancer, in exchange for tiered royalties on future U.S. sales. Neither contingent debt tranches nor the approval-dependent RTW payment should be counted as cash available now. [P01, HTML lines 656-76, 927-37]

Three programs, different evidence and commitments

Program	Status by the cutoff	What the evidence does and does not show
Aglatimagene - localized prostate cancer	Candel planned to submit a BLA in Q4 2026 and described a possible 2027 launch. Both were management expectations, not completed milestones.	In the completed randomized phase 3 study, the company reported a 635-patient intermediate-risk subgroup with median 58-month follow-up and a hazard ratio of 0.59 for recurrence or prostate-cancer-specific death versus placebo plus external-beam radiation. Other endpoints were exploratory. A separate phase 2 biomarker comparison had 13 treated patients and 6 standard-care controls; formal comparison was ongoing. Aglatimagene was not FDA-approved. [P05]
Aglatimagene - advanced NSCLC	The phase 3 AURORA study had activated its first site and opened enrollment in June. Candel reported it was enrolling globally by October 1.	AURORA compares aglatimagene plus valacyclovir and continued pembrolizumab with docetaxel in metastatic stage IV non-squamous NSCLC progressing after pembrolizumab and platinum chemotherapy; the 10-Q described about 500 participants across approximately 150 sites. AURORA is randomized. [P01, HTML lines 1164-73; P08, lines 50-51]
Linoserpaturev - recurrent glioblastoma	Phase 1b Arm C repeat-dose enrollment was complete. The company reported 9 patients in the cohort, 4 alive and 5 deceased at a median follow-up of 8.9 months. The cohort was supported by Break Through Cancer. The FDA had cleared an IND for enabling work toward a potential randomized phase 2 dose-regimen-finding study.	These are small, uncontrolled phase 1b observations, not proof of efficacy. Foundation support was for Arm C; funding for a future phase 2 was not disclosed. Candel expected further Arm C information at a future November meeting, outside the cutoff. [P01, HTML lines 1213-23; P03, slide 72]

The October 1 peer-reviewed phase 2a NSCLC paper reported an open-label, single-arm study: 76 patients enrolled, 73 in the safety population, and 46 evaluable per protocol. Median overall survival was 24.5 months among evaluable patients and 14.3 months among treated patients. Historical comparisons to docetaxel were descriptive; the authors said randomized confirmation was needed. This is a different population and study design from AURORA. It informs the rationale to test the candidate, but does not predict AURORA results. [P07-P08]

On October 2 at 09:00 ET, Candel announced two future SITC posters: an NSCLC multi-omics analysis and phase 1b linoserpaturev findings. The actual poster results would be presented in November and were not known at the cutoff. [P09]

The capital choice

The company's public filings describe the existing operating plan and financing, but do not say how much a randomized phase 2 would cost, how many patients or sites it would require, or which staff and manufacturing resources it would use. The Q1 2028 runway estimate includes management's current plan; it cannot be treated as proof that this incremental trial fits within the plan. Conversely, the disclosures do not say that the company must stop current glioblastoma work or draw the contingent debt tranches.

Consider three constructed approaches:

1. **Authorize a capped, gated phase 2.** Define an initial commitment only after a costed protocol, protected BLA/AURORA capacity, and objective continuation criteria are approved. This could preserve trial momentum and generate patient evidence while limiting exposure before later gates.
2. **Stage enrollment behind lead-program milestones.** Fund protocol design, regulatory preparation, and other bounded enabling work; release the next commitment after specified prostate BLA-readiness and AURORA execution milestones, or after the November phase 1b information arrives. This buys time for information but could delay the trial.
3. **Preserve capacity for the current plan.** Defer additional corporate phase 2 commitments until the BLA and AURORA demands are clearer, while maintaining existing funded phase 1b work and studying partner or non-dilutive support. This protects near-term flexibility but risks losing time and delaying evidence in glioblastoma.

You may recommend a coherent hybrid. State what work is funded now, what is deferred, who owns each gate, and what evidence or financing releases the next commitment. Separate scientific, regulatory, operational, and financial gates. Explain the strongest objection to your choice and identify one fact that would change your recommendation.

Source notes

- **P01:** Candel Q2 2026 Form 10-Q, SEC accession 0001193125-26-347980; [SEC filing](#). Locators are listed in the research source register.
- **P02:** Candel Q2 2026 results release, Aug. 13, 2026; [issuer release](#).
- **P03:** Candel Sep. 9, 2026 SEC-filed presentation, Exhibit 99.1; [SEC filing index](#).
- **P05-P06:** Candel Sep. 30 prostate clinical and biomarker issuer releases; **P07:** Aggarwal et al., *Journal for ImmunoTherapy of Cancer*, DOI [10.1136/jitc-2026-015821](#); **P08:** Candel Oct. 1 publication notice; **P09:** Oct. 2 09:00 ET SITC notice. Full locators and limitations are in the source register.