20as Jornadas HITOS ONCOLÓGICOS: LO MEJOR DE 2025
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20 ANIVERSARIO

Avances terapéuticos en cáncer de ovario (Balance 2025)

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Clínica Universidad de Navarra | Cancer Center

GEICO Grupo Español de Investigación en Cáncer ginecológico

ENGOT European Network of Gynaecological Oncological Trial groups

Avances terapéuticos en cáncer de ovario

- Cirugía
- Primera línea
- Recaída
- Futuro

Avances terapéuticos en cáncer de ovario

- **Cirugía**
- Primera línea
- Recaída
- Futuro

Never-ending questions regarding surgery in newly diagnosed advanced ovarian cancer:

- Primary (PCS) vs Interval Cytoreductive Surgery (ICS)

Evidence before 2025 regarding surgery in front-line:

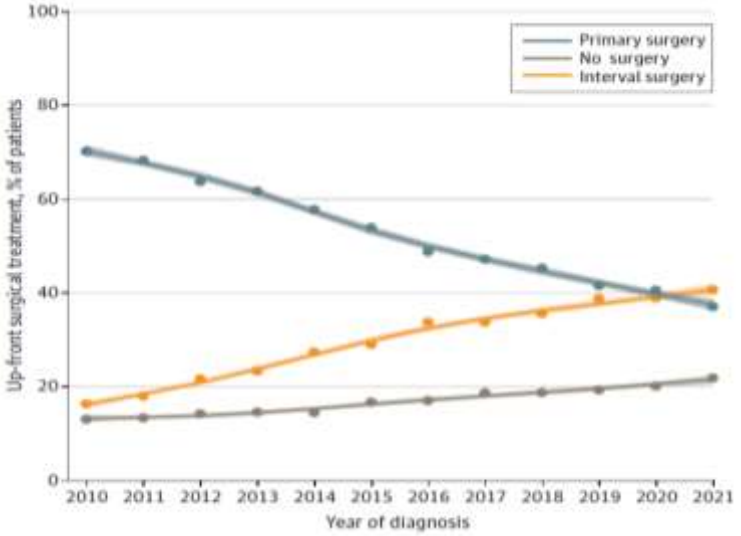
- Patients with complete cytoreduction live longer
- 4 Randomized Clinical Trials have demonstrated NACT-ICS is not inferior but not superior to PCS*


JAMA Network | Open

Research Letter | Obstetrics and Gynecology

Utilization of Primary Cytoreductive Surgery for Advanced-Stage Ovarian Cancer

Alexandra Bercow, MD; Taylor Stewart, MD; Amy J. Brega, MD; Allison Godley, MD; Varvara Mazina, MD; J. Alejandro Rauh-Hain, MD, MPH; Alexander Melamed, MD, MPH



*

EORTC 55971 (Vergote et al. NEJM 2011)
CHORUS (Kehoe et al. Lancet 2015)
SCORPION (Fagotti et al. Int J Gynecol Cancer 2016)
JCOG0602 (Onda et al. Eur J Cancer 2016)

Evidence before 2025 regarding surgery in front-line:

- Patients with complete cytoreduction live longer
- 4 Randomized Clinical Trials have demonstrated NACT-ICS is not inferior but not superior to PCS*

But…

- Rate of complete cytoreduction was low in the arm of PCS
- Most of the patients in RCT included had non-resectable disease or were operated in non-specialized centers

*
EORTC 55971 (Vergote et al. NEJM 2011)
CHORUS (Kehoe et al. Lancet 2015)
SCORPION (Fagotti et al. Int J Gynecol Cancer 2016)
JCOG0602 (Onda et al. Eur J Cancer 2016)

TRUST Rationale

TRUST was designed to evaluate the optimal timing of maximal effort cytoreductive surgery in patients with advanced ovarian cancer

- considered resectable
- fit enough to tolerate radical surgery
- treated in gynecologic cancer centers with defined surgical quality assurance criteria.
  - complete resection rates (≥50% in upfront surgery for FIGO IIIB-IVB pts)
  - surgical volume (≥36 cytoreductive surgeries/year).

Adapted from Sven Manher presentation at ASCO

PRESENTED BY: Sven Mahner, MD Sven.Mahner@med.uni-muenchen.de

TRUST Study Design

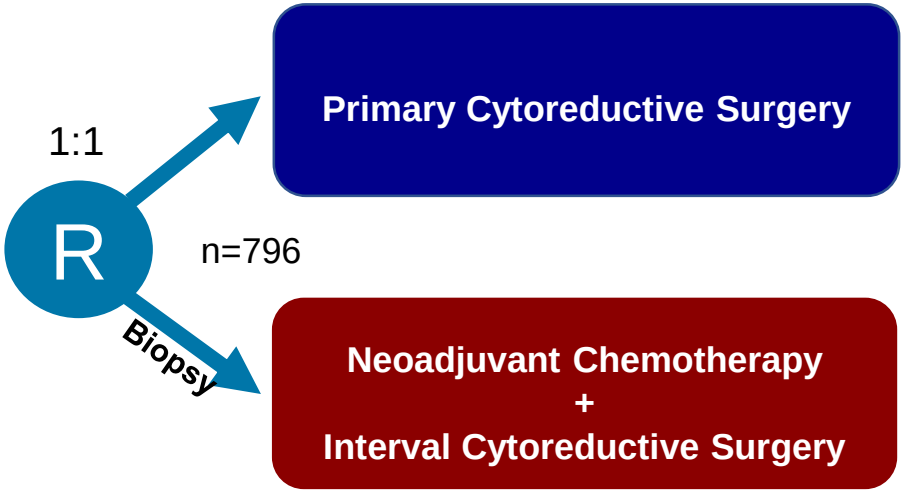
Main Inclusion Criteria

- Epithelial ovarian, fallopian tube or peritoneal cancer
  - FIGO stage IIIB/C, IVA/B
  - Considered resectable
- Fit enough to tolerate radical surgery

Stratification factors

- Center
- Age-ECOG-combination ECOG0 and age ≤65y vs. ECOG>0 or age >65y

Qualification process for participating centers to ensure surgical quality



Recommended systemic treatment:

- Carboplatin AUC5, Paclitaxel 175mg/m^2 q3w
- Bevacizumab 15mg/kg q3w as indicated
- PARPi as indicated
- Study participation or any other treatment as long as applicable for both study arms

Primary endpoint

- Overall survival

Key secondary endpoints

- Progression-free survival
- Complete resection rate
- Surgical procedures
- Surgical morbidity
- Quality of life

Predefined exploratory and translational endpoints

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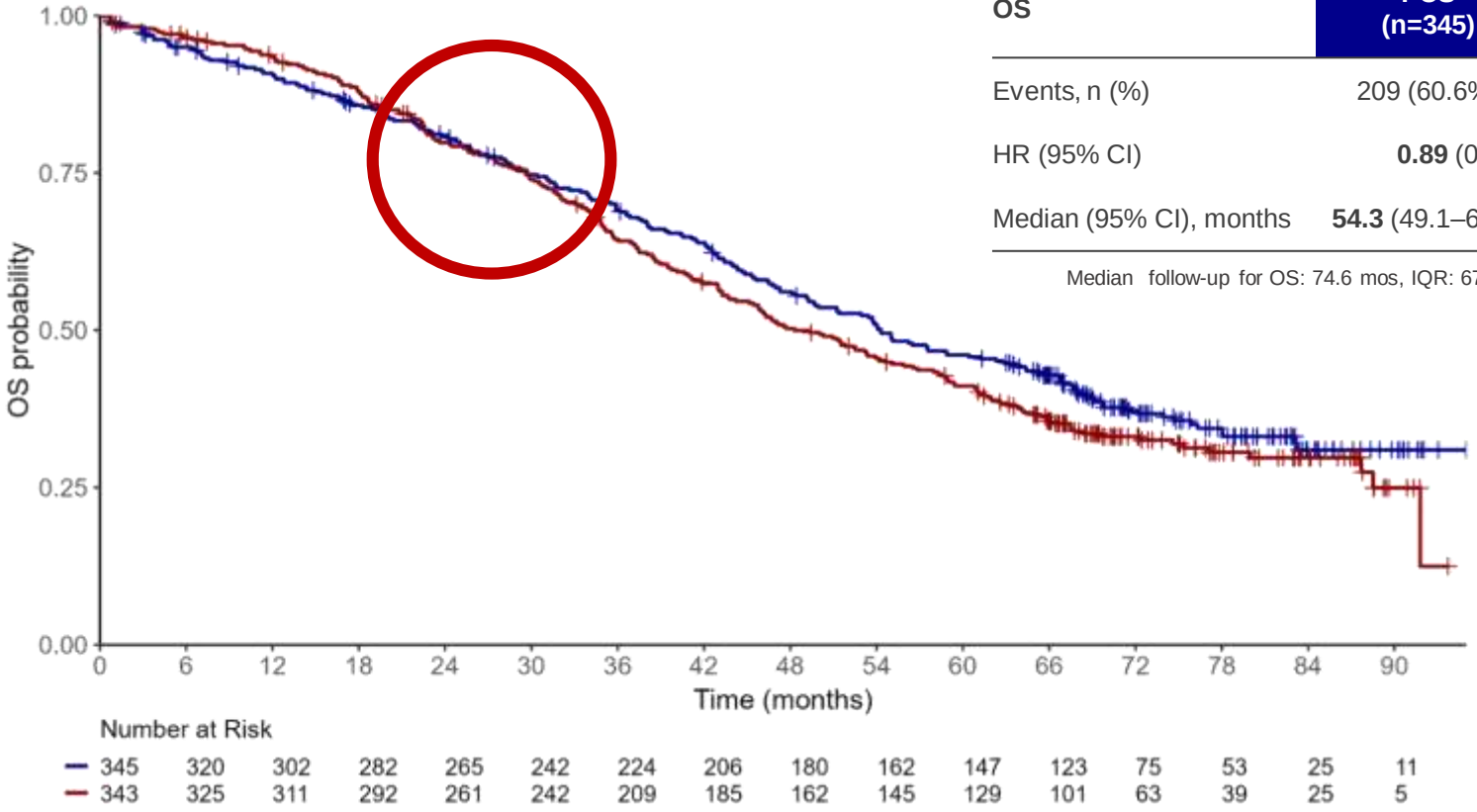
TRUST Results: Overall Survival (ITT)



OS	PCS (n=345)	NACT-ICS (n=343)
Events, n (%)	209 (60.6%)	223 (65.0%)
HR (95% CI)	**0.89** (0.74–1.08); *p=0.24*	
Median (95% CI), months	**54.3** (49.1–63.3)	**48.3** (43.6–55.9)

Median follow-up for OS: 74.6 mos, IQR: 67.1-83.6 mos (63% maturity)

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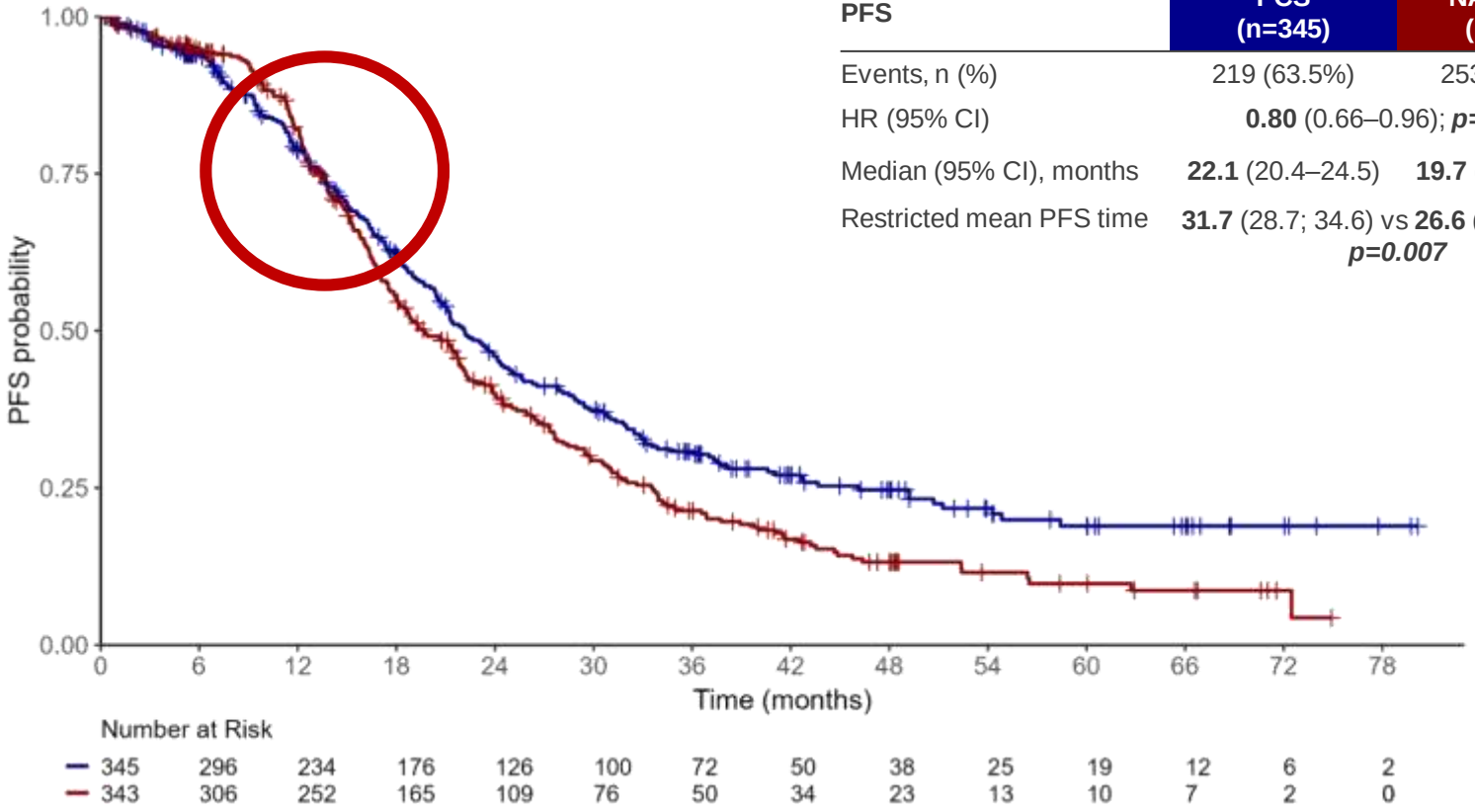
TRUST Results: Progression-free Survival (ITT)



PFS	PCS (n=345)	NACT-ICS (n=343)
Events, n (%)	219 (63.5%)	253 (73.8%)
HR (95% CI)	**0.80** (0.66–0.96); ***p=0.018***	
Median (95% CI), months	**22.1** (20.4–24.5)	**19.7** (17.9–21.9)
Restricted mean PFS time	**31.7** (28.7; 34.6) vs **26.6** (24.3; 28.9); ***p=0.007***	

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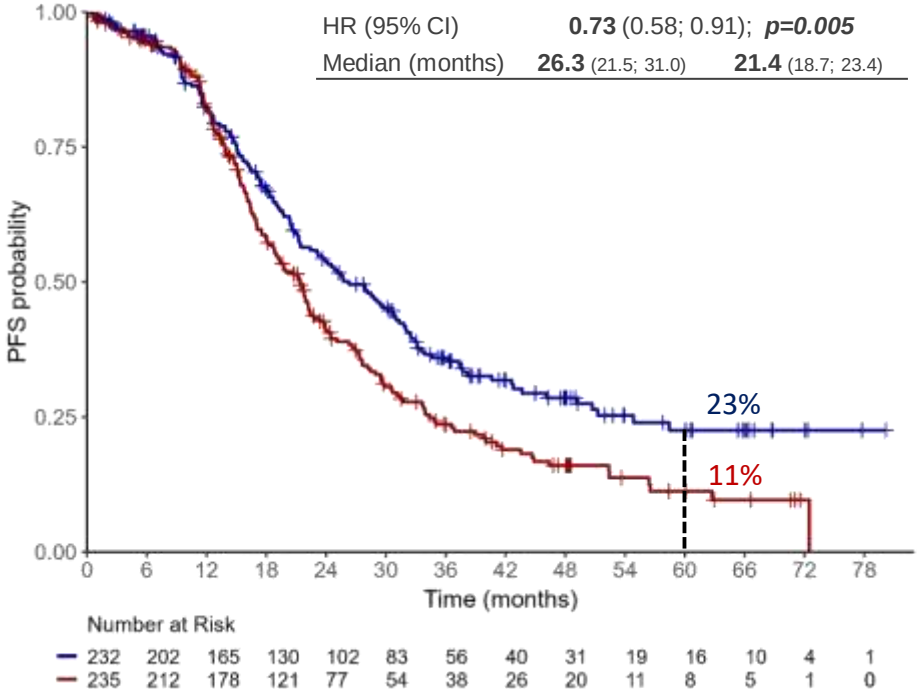
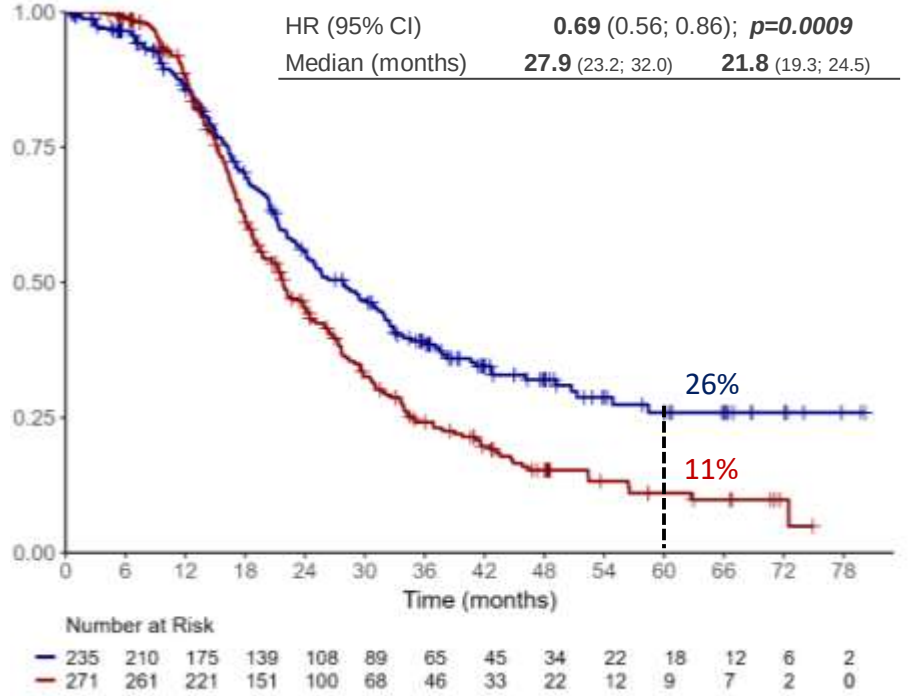
TRUST Results: Prespecified Exploratory Subgroup Analyses

PFS FIGO III	PCS (n=232)	NACT-ICS (n=235)
Events, n (%)	140 (60.3%)	172 (73.2%)
HR (95% CI)	**0.73** (0.58; 0.91); ***p=0.005***	
Median (months)	**26.3** (21.5; 31.0)	**21.4** (18.7; 23.4)



PFS macro R_0	PCS (n=235)	NACT-ICS (n=271)
Events, n (%)	137 (58.3%)	199 (73.4%)
HR (95% CI)	**0.69** (0.56; 0.86); ***p=0.0009***	
Median (months)	**27.9** (23.2; 32.0)	**21.8** (19.3; 24.5)



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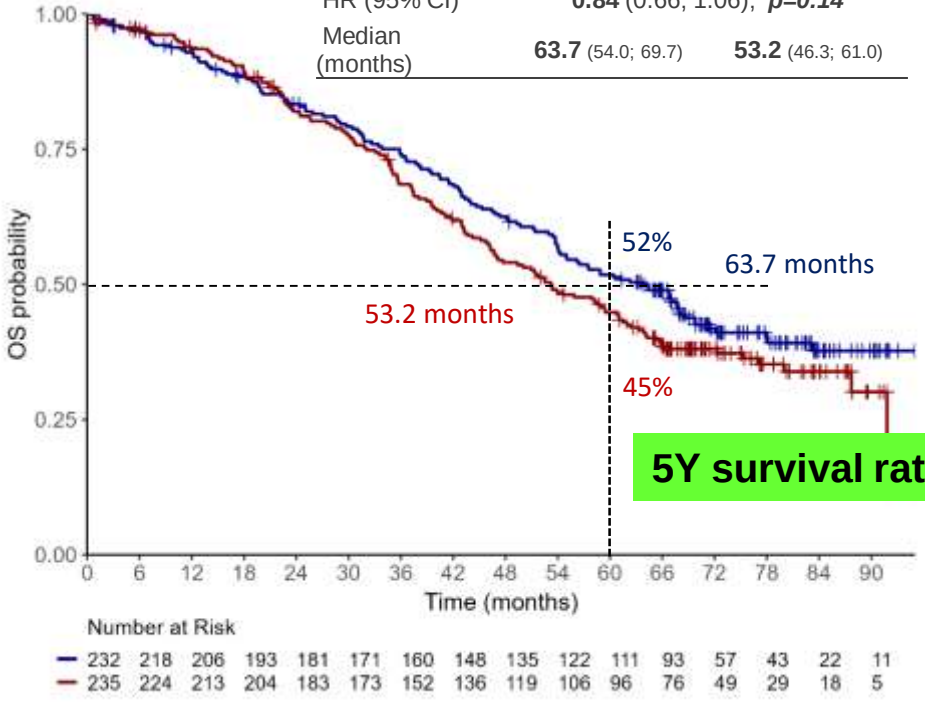
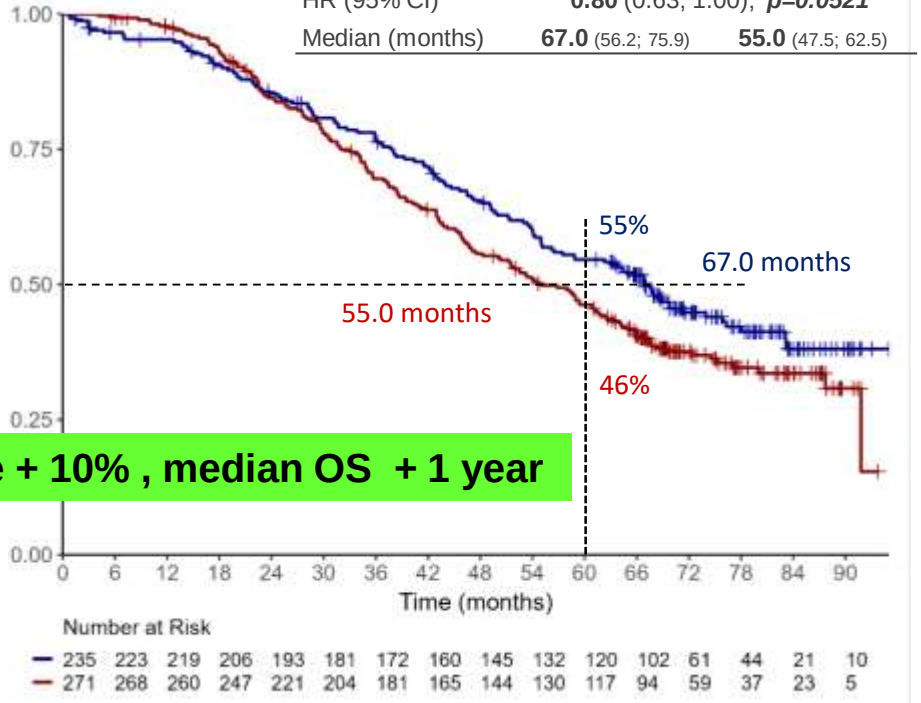
TRUST Results: Prespecified Exploratory Subgroup Analyses

OS FIGO III	PCS (n=232)	NACT-ICS (n=235)
Events, n (%)	127 (54.7%)	143 (60.9%)
HR (95% CI)	**0.84** (0.66; 1.06); ***p=0.14***	
Median (months)	**63.7** (54.0; 69.7)	**53.2** (46.3; 61.0)



OS macro R_0	PCS (n=236)	NACT-ICS (n=271)
Events, n (%)	126 (53.6%)	167 (61.6%)
HR (95% CI)	**0.80** (0.63; 1.00); ***p=0.0521***	
Median (months)	**67.0** (56.2; 75.9)	**55.0** (47.5; 62.5)



5Y survival rate + 10% , median OS + 1 year

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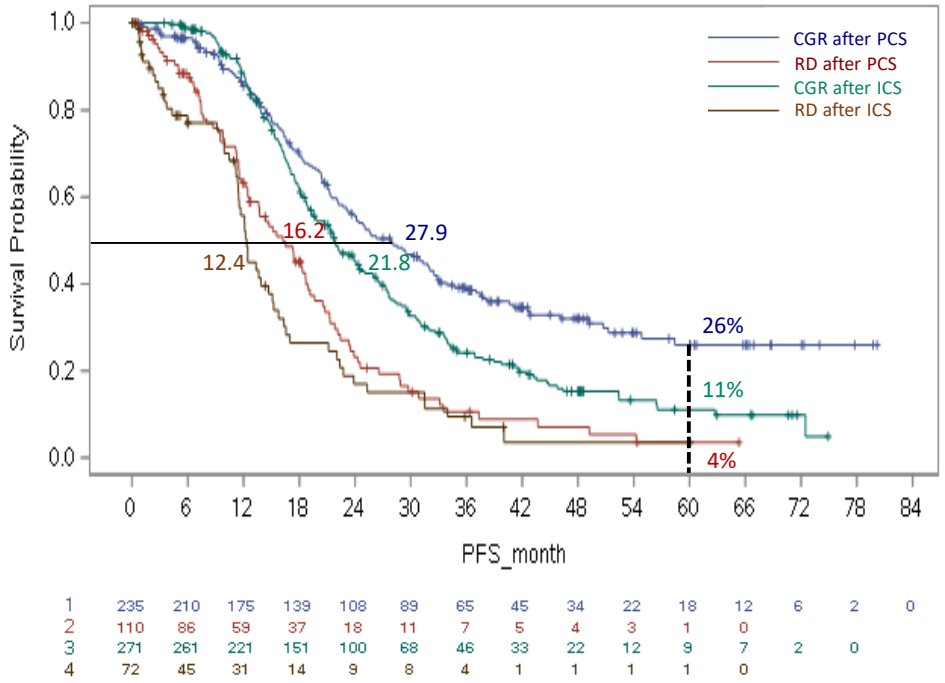
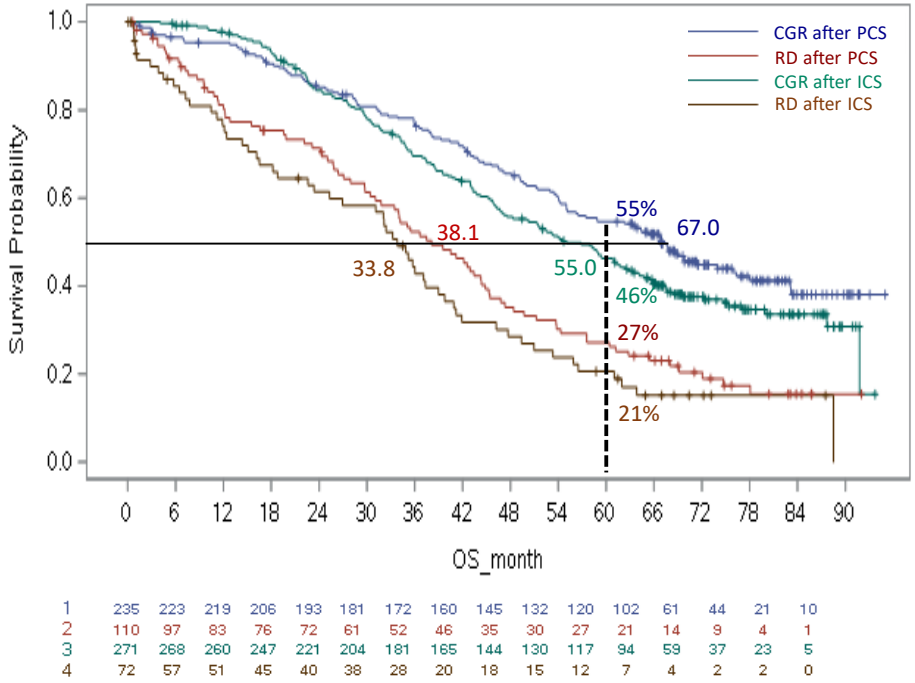
TRUST Results: Prespecified Exploratory Subgroup Analysis by Residual Disease

PFS



1	235	210	175	139	108	89	65	45	34	22	18	12	6	2	0
2	110	86	59	37	18	11	7	5	4	3	1	0			
3	271	261	221	151	100	68	46	33	22	12	9	7	2	0	
4	72	45	31	14	9	8	4	1	1	1	1	0			

OS



1	235	223	219	206	193	181	172	160	145	132	120	102	61	44	21	10
2	110	97	83	76	72	61	52	46	35	30	27	21	14	9	4	1
3	271	268	260	247	221	204	181	165	144	130	117	94	59	37	23	5
4	72	57	51	45	40	38	28	20	18	15	12	7	4	2	2	0

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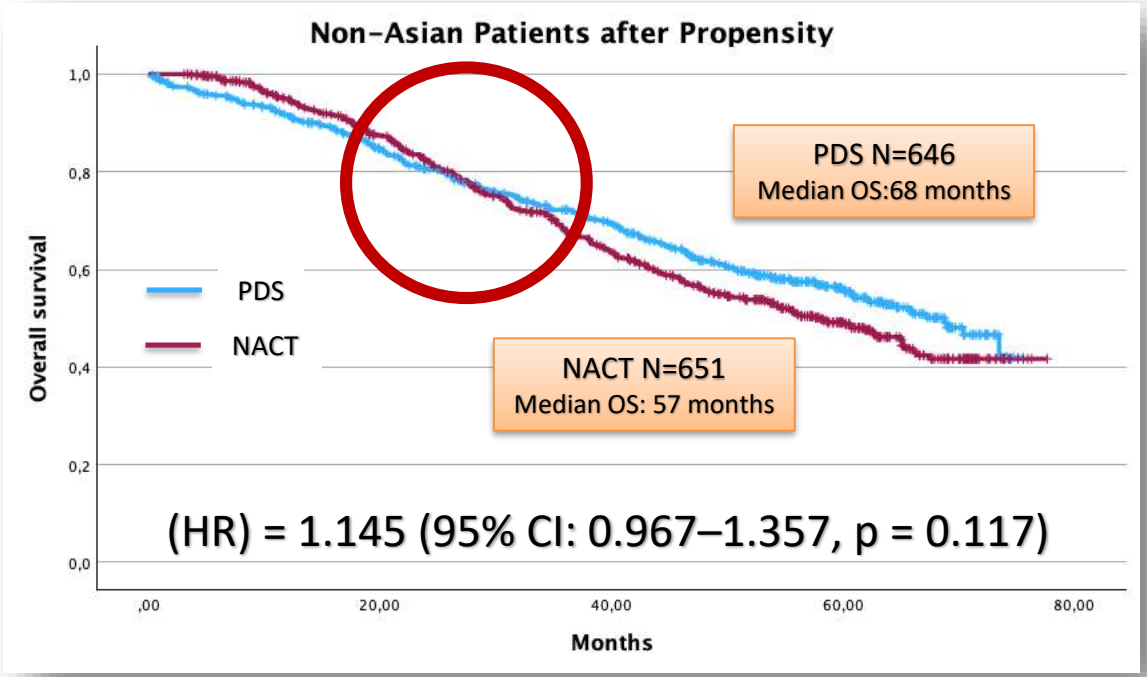
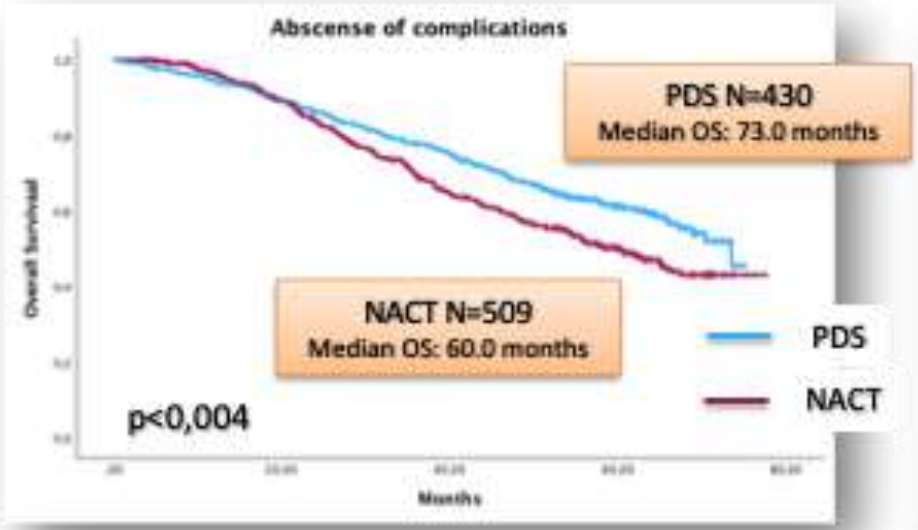
SUROVA study

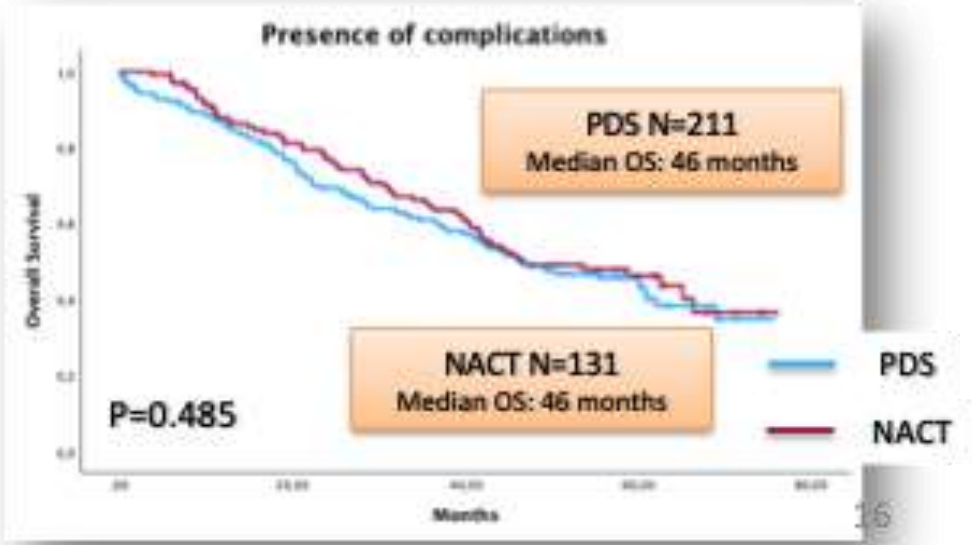
- Final Accrual 3,531 patients
- After Exclusions 3,286 patients
- Propensity Matching Score 1,524 patients



Chiva et al. ESGO 2025 and Int J Gyn Oncol 2025 (in press)

SUROVA study: Impact of complications





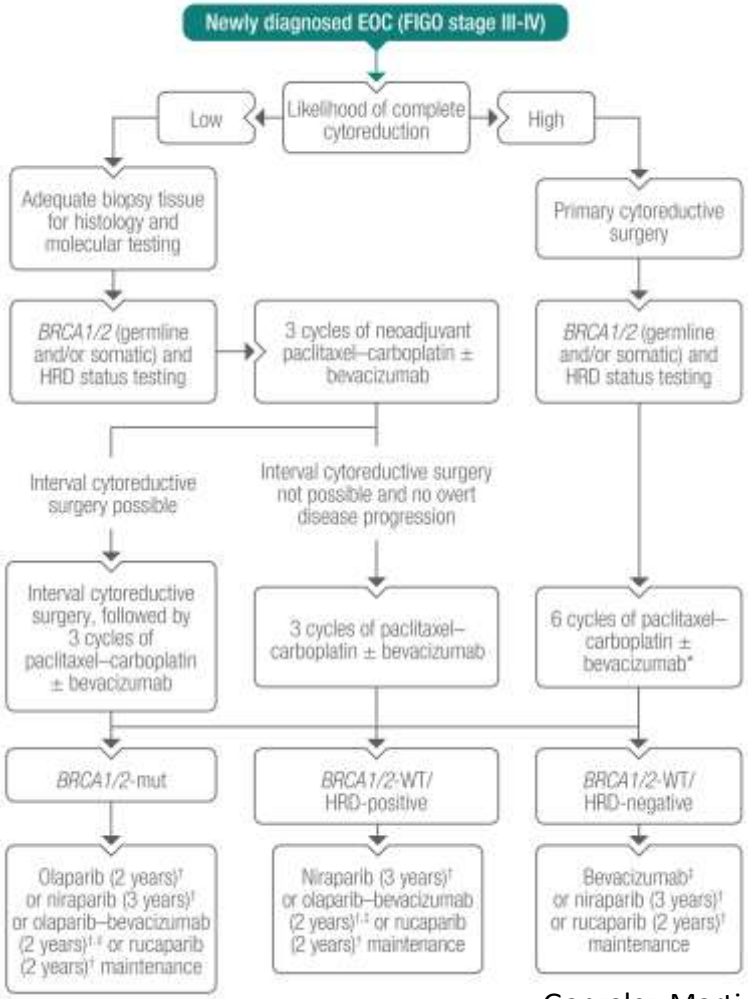
Chiva et al. ESGO 2025 and Int J Gyn Oncol 2025 (in press)

Take home regarding Primary (PCS) vs Interval Cytoreductive Surgery (ICS)

- PCS is preferred if achieving NGR (No Gross Residual) seems feasible and patient is fit enough (or grade $\geq$ 3 complications are not anticipated)
- Patient selection is key
- Quality of Surgery is also key (specialized centre)

Avances terapéuticos en cáncer de ovario

- Cirugía
- **Primera línea**
- Recaída
- Futuro



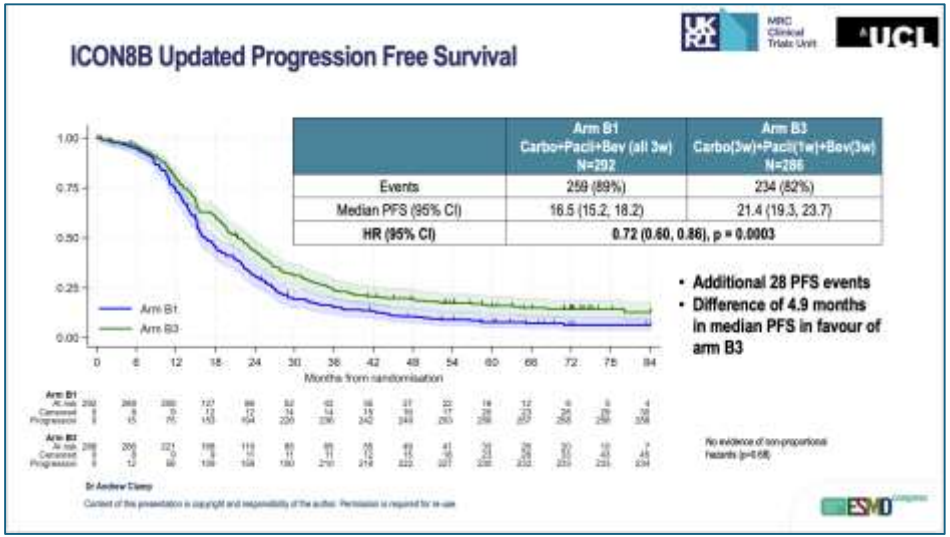
- Is dose dense still alive?
- Could outcomes be improved by adding CPI to first-line treatment?

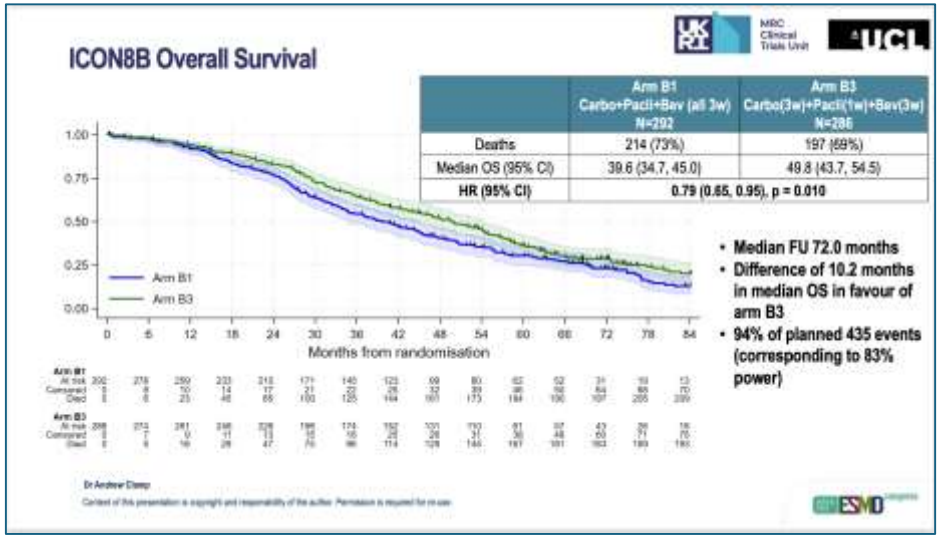
Gonzalez-Martin et al. ESMO Pocket Guideline

Bevacizumab & Dose dense

ICON-8B

Experimental
Paclitaxel 80 mg/m2 d1,8,15
Carboplatin AUC 5 d1
Bevacizumab 7.5 mg/kg





Only 14% received PCS

A. Clamp et al. ESMO2025

Check-point inhibitor clinical trials in OC

	Chemo ± CPI	Chemo + Bev ± CPI	Chemo ± Bev ± CPI	Chem + PARPi ± CPI	Chemo + Bev ± PARPi ± CPI	Chemo + PARPi ± Bev ± CPI	Chemo ± Bev ± PARPi ± CPI
1L	JAVELIN[1] 100	IMAGYN050[3] ENGOT-Ov39		ATHENA[7] ENGOT-Ov45	DUO-O[9] ENGOT-Ov46	FIRST[10] ENGOT-Ov44	KEYLINK-01[11] ENGOT-Ov43
PSOC		ATALANTE[4] ENGOT-Ov29		ANITA[8] ENGOT-Ov41			
PROC	JAVELIN[2] 200	OVAR 2.29[5] ENGOT-Ov34	K-96[6] ENGOT-Ov65				
N	1564	2480	643	1280	1130	1331	1367

9804 patients included in phase 3 clinical trials!

Positive

Negative

1L: First line; PSOC: Platinum-sensitive ovarian cancer; PROC: Platinum-resistant ovarian cancer

1. Monk et al. Lancet Oncol. 2021 Sep;22(9)9. 2. Pujade et al. Lancet Oncol. 2021 Jul;22(7):1034-1046
3. Moore et al. J Clin Oncol. 2021 Jun 10;39(17):1842-1855; 4. Kurtz et al. J Clin Oncol 2023. 5. Marmé et al. Presented at ASCO 2024.
6. N. Colombo et al . Presented at ESMO 2025. 7. Monk et al. Presented at ESMO 2024. 8. Gonzalez-Martin et al. J Clin Oncol 2024:
9. Harter et al. Presented at SGO 2024; 10. Hardy-Bessard AC, et al. Presented at ASCO 2025; 11. Powel et al. Presented at SGO

Check Point Inhibitors

Combinations + Bev + Ola

Chemo + Pembro

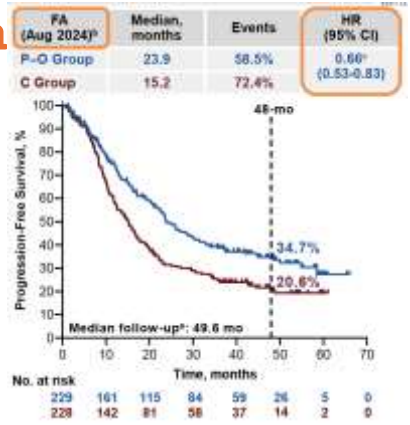
1L KEYLINK 001
ENGOT-Ov43
Non-tBRCAm

Positive trial for Pembro-Ola ± Bev

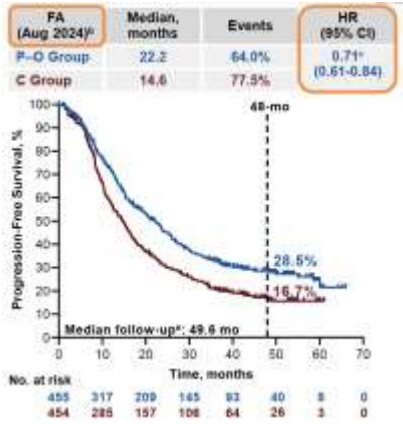
Inappropriate control arm for HRD-positive

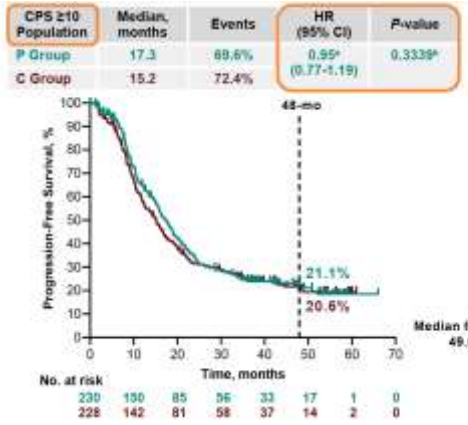
Pembro ± Bev is like Observation ± Bev

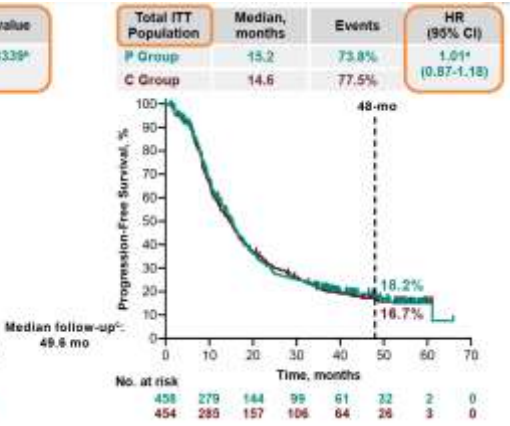
CPS ≥ 10



ITT







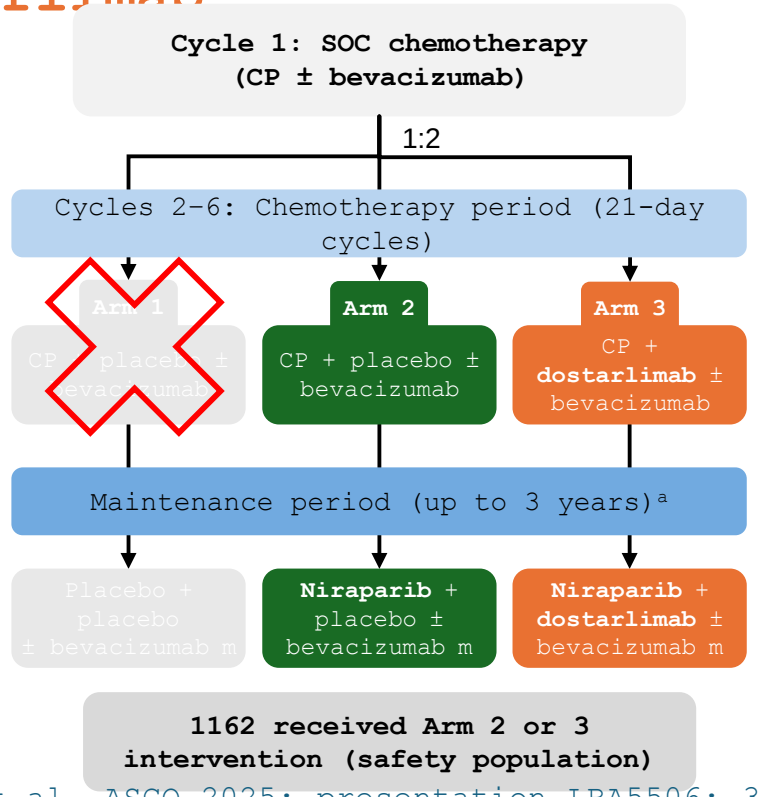
Powell e al. In press

Check Point Inhibitors

Combinations Chemo ± Bev + Nira ± Dostarlimab

1L FIRST
ENGOT-Ov44
tBRCAm and
Non-tBRCAm

- Given ongoing PARPi maintenance clinical trials during the design of FIRST, it was an *a priori* intention to amend the protocol to redefine the control arm if emerging evidence supported the incorporation of PARPis during the maintenance period
- Following approvals of olaparib and niraparib as 1LM therapy,[1,2] enrollment into Arm 1 was terminated



Hardy-Bessard AC, et al. ASCO 2025; presentation LBA5506; 30 May–3 June, Chicago, IL.

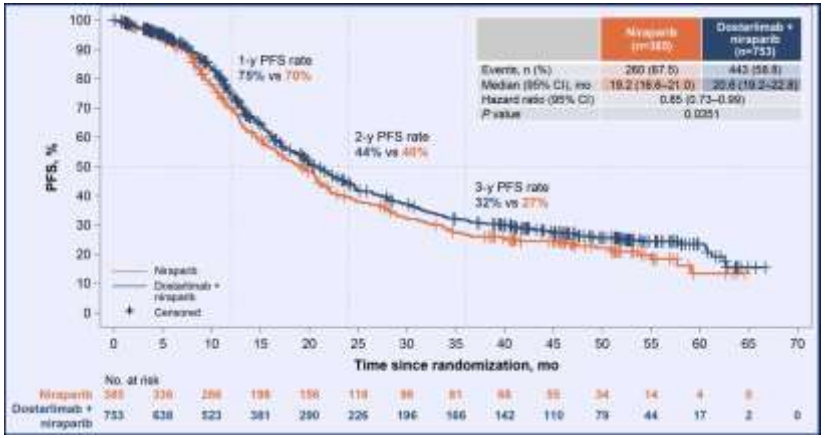
Check Point Inhibitors Combinations

Chemo + Bev + Nira + Dostarlimab

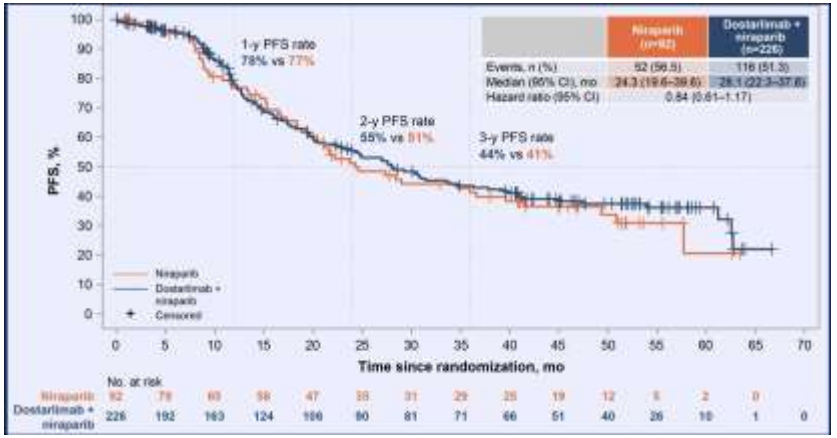
1L FIRST / ENGOT-Ov44
tBRCAm and Non-tBRCAm

Median duration of follow-up was 53.1 months (IQR, 47.5–59.7)

PFS in the ITT population



PFS in the PD-L1+ population



Hardy-Bessard AC, et al. ASCO 2025; presentation LBA5506; 30 May–3 June, Chicago, IL.

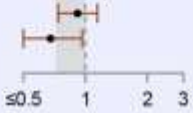
Check Point Inhibitors Combinations

Chemo + Bev + Nira + Dostarlimab

1L FIRST
ENGOT-Ov44
tBRCAm and
Non-tBRCAm

PFS Subgroup Analyses: Treatment and Biomarker Subgroups

Subgroup	Niraparib n / N (%)	Dostarlimab + niraparib n / N (%)	Hazard ratio (95% CI)
All patients	260/385 (68)	443/753 (59)	0.85 (0.73–0.99)
Concurrent bevacizumab use, as per exposure			
Yes	137/199 (69)	244/398 (61)	0.84 (0.68–1.03)
No	123/186 (66)	199/355 (56)	0.86 (0.69–1.08)
PD-L1 status			
TAP ≥5% (positive)	52/92 (57)	116/226 (51)	0.84 (0.61–1.17)
TAP <5% (negative)	166/230 (72)	248/403 (62)	0.87 (0.71–1.06)
Myriad MyChoice status			
*BRCA*m	37/81 (46)	63/151 (42)	0.98 (0.65–1.48)
*BRCA*wt	184/253 (73)	336/513 (65)	0.87 (0.73–1.04)
*BRCA*wt HRd	43/65 (66)	86/147 (59)	0.83 (0.58–1.20)
HRd	80/146 (55)	149/298 (50)	0.95 (0.72–1.24)
HRp	126/164 (77)	219/312 (70)	0.92 (0.74–1.14)
HRD unknown	54/75 (72)	75/143 (52)	0.68 (0.48–0.96)



Hardy-Bessard AC, et al. ASCO 2025; presentation LBA5506; 30 May–3 June, Chicago, IL.

Take home regarding systemic therapy with CPI in front-line

- Clinical trials with checkpoint inhibitors (CPIs) added to front-line systemic therapy in advanced ovarian cancer have not demonstrated a convincing improvement in outcomes to change current practice.
- No reliable biomarkers have been identified.
- A better understanding of the tumor microenvironment and immune escape mechanisms is needed for the design of new immunotherapy strategies.

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- Primera línea
- **Recaída**
- Futuro

Check-point inhibitor clinical trials in OC

	Chemo ± CPI	Chemo + Bev ± CPI	Chemo ± Bev ± CPI	Chem + PARPi ± CPI	Chemo + Bev ± PARPi ± CPI	Chemo + PARPi ± Bev ± CPI	Chemo ± Bev ± PARPi ± CPI
1L	JAVELIN[1] 100	IMAGYN050[3] ENGOT-Ov39		ATHENA[7] ENGOT-Ov45	DUO-O[9] ENGOT-Ov46	FIRST[10] ENGOT-Ov44	KEYLINK-01[11] ENGOT-Ov43
PSOC		ATALANTE[4] ENGOT-Ov29		ANITA[8] ENGOT-Ov41			
PROC	JAVELIN[2] 200	OVAR 2.29[5] ENGOT-Ov34	K-96[6] ENGOT-Ov65				
N	1564	2480	643	1280	1130	1331	1367

9804 patients included in phase 3 clinical trials!

Positive

Negative

1L: First line; PSOC: Platinum-sensitive ovarian cancer; PROC: Platinum-resistant ovarian cancer

1. Monk et al. Lancet Oncol. 2021 Sep;22(9)9. 2. Pujade et al. Lancet Oncol. 2021 Jul;22(7):1034-1046
3. Moore et al. J Clin Oncol. 2021 Jun 10;39(17):1842-1855; 4. Kurtz et al. J Clin Oncol 2023. 5. Marmé et al. Presented at ASCO 2024.
6. N. Colombo et al . Presented at ESMO 2025. 7. Monk et al. Presented at ESMO 2024. 8. Gonzalez-Martin et al. J Clin Oncol 2024:
9. Harter et al. Presented at SGO 2024; 10. Hardy-Bessard AC, et al. Presented at ASCO 2025; 11. Powel et al. Presented at SGO

Check Point Inhibitors

Combinations

Chemo + Pembrolizumab + Bev

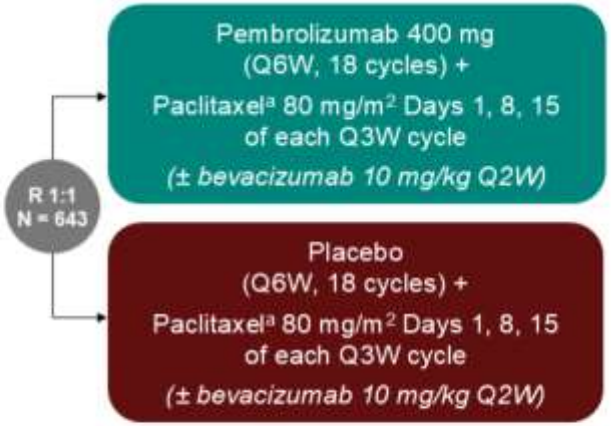
PROC KN-B96
ENGOT-Ov65

Key Eligibility Criteria

- Histologically confirmed epithelial ovarian, fallopian tube, or primary peritoneal carcinoma
- 1 or 2 prior lines of therapy; at least 1 platinum-based chemotherapy
  - Prior anti-PD-1 or anti-PD-L1, PARPi and bevacizumab permitted
- Radiographic progression within 6 months after the last dose of platinum-based chemotherapy
- ECOG PS 0 or 1

Stratification Factors

- Planned bevacizumab use (yes vs no)
- Region (US vs EU vs ROW)
- PD-L1 CPS (<1 vs 1 to <10 vs ≥10)[b]



Primary Endpoint: PFS per RECIST v1.1 by investigator

Key Secondary: OS

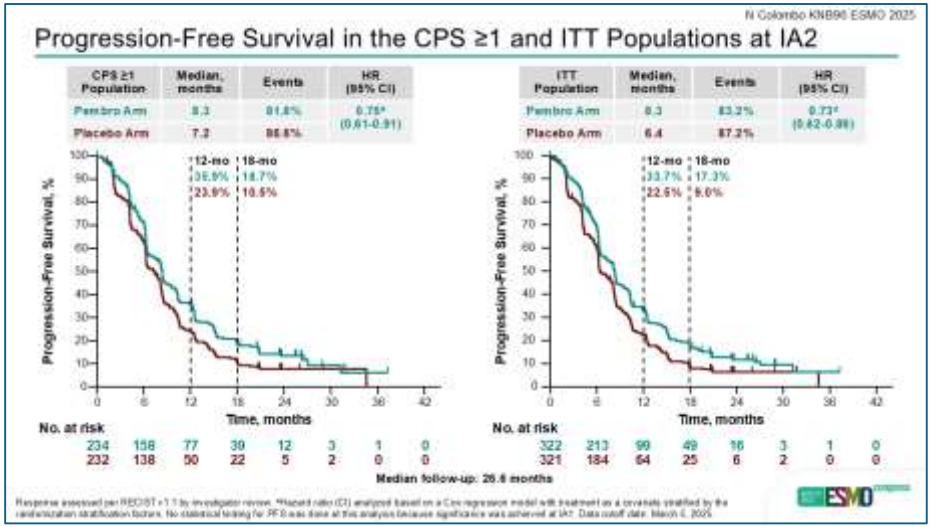
N. Colombo presented at ESMO 2025.

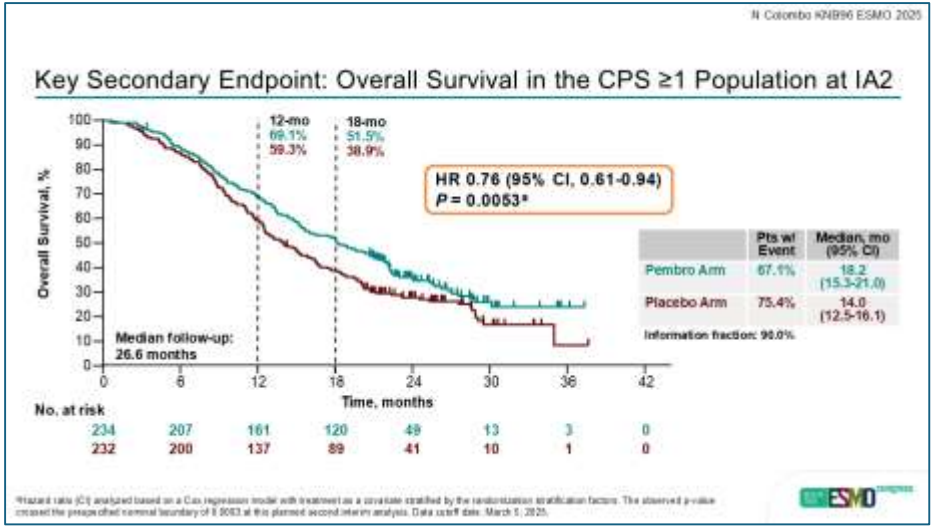
Check Point Inhibitors

Combinations

Chemo + Pembrolizumab + Bev

PROC KN-B96 / ENGOT-Ov65





Antonio González-Martín MD, PhD

N. Colombo presented at ESMO 2025.

AGO-OVAR 2.29/ENGOT-ov34: Trial Design

Main Inclusion Criteria:

- Epithelial ovarian, fallopian tube or peritoneal cancer
  - 1st or 2nd relapse; TFIp < 6 months
  - OR 3rd relapse
- Recent & archival biopsy mandatory
- ECOG PS ≤ 1
- life expectancy > 3 months
- Prior Bevacizumab allowed

Stratification factors:

- Number of prior lines (1-2 vs 3)
- Planned chemotherapy (PLD vs paclitaxel)
- Prior bevacizumab (yes vs no)
- PD-L1 status (SP142 IC 1/2/3 vs 0 vs non informative)*

* PD-L1 status was prospectively tested, but introduced as a stratification factor as part of an amendment.

\- Tumors with non-informative test results were to be capped at 10%

1:1

R

n=550

PLD or Paclitaxel + Bevacizumab + Placebo

PLD or Paclitaxel + Bevacizumab + Atezolizumab

Treatment until disease progression, intolerable toxicity or a maximum duration of 24 months, whatever occured first

PLD: 40 mg/m² d1, q28d;
Paclitaxel: 80 mg/m² d1, 8, 15, 22, q28d;
Bevacizumab: 15 mg/kg d1, q14d;
Atezolizumab OR Placebo: 840 mg d1, q14d

PLD, pegylated liposomal doxorubicin; PS, performance status; TFIp, treatment free interval for platinum

Primary endpoints:

- Overall survival
- Progression-free survival

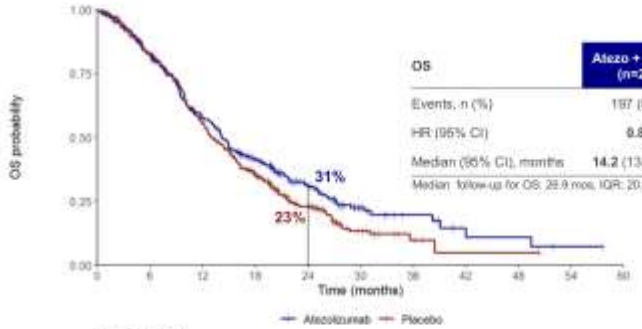
Secondary endpoints:

- ORR & DOR
- Safety & tolerability
- *OS, PFS, ORR & DOR by PD-L1 status*
- HrQoL/PROs

Exploratory & translational endpoints

2024 ASCO ANNUAL MEETING #ASCO24 Presenter: Frederik Marmé ASCO

Primary Endpoint: Overall Survival (ITT)



OS	Atezo + CT/Bev (n=285)	Placebo + CT/Bev (n=289)
Events, n (%)	197 (69.1)	221 (76.5)
HR (95% CI)	0.83 (0.68–1.01); p=0.06	
Median (95% CI), months	14.2 (13.0–16.1)	13.0 (11.9–15.1)

Median follow-up for OS: 28.9 mos, IQR: 20.5-31.4 mos (73% maturity)

2024 ASCO ANNUAL MEETING #ASCO24 Presenter: Frederik Marmé ASCO

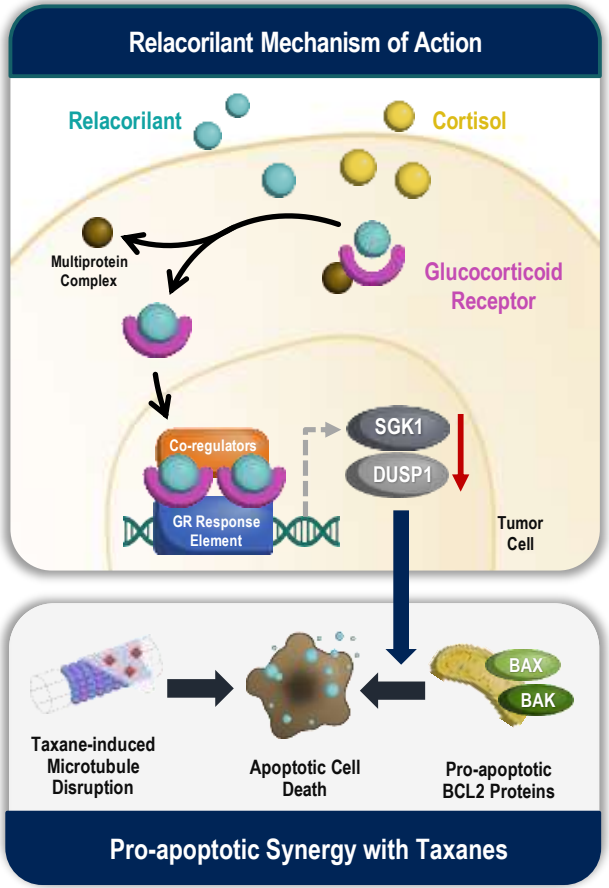
Antonio González-Martín MD, PhD

Treatment Effects on OS according to Subgroups

Subgroup	Atezo N/E	Placebo N/E	Hazard Ratio	95% CI	
Overall	285/197	289/221	0.83	(0.68; 1.01)	
PD-L1 at rando					
PD-L1 pos	63/40	68/49	0.76	(0.49; 1.17)	
PD-L1 neg	153/106	153/124	0.73	(0.57; 0.95)	$p_{interact}$=0.18
PD-L1 non-informative/missing	69/51	68/48	1.18	(0.79; 1.76)	
Previous Beva					
No	75/56	83/60	1.18	(0.81; 1.71)	$p_{interact}$=0.065
Yes	210/141	206/161	0.74	(0.59; 0.93)	
Planned Chemo					
PLD	129/93	135/102	0.91	(0.69; 1.21)	$p_{interact}$= 0.32
Paclitaxel	156/104	154/119	0.75	(0.57; 0.98)	
No of prior lines					
1 or 2	183/129	182/141	0.83	(0.65; 1.06)	$p_{interact}$= 0.87
3	102/68	107/80	0.85	(0.61; 1.19)	
Previous PARPi					
No	171/120	169/130	0.86	(0.67; 1.11)	$p_{interact}$= 0.77
Yes	114/77	120/91	0.78	(0.58; 1.07)	
Latest previous line containing Pt					
No	119/85	139/107	0.81	(0.61; 1.09)	$p_{interact}$= 0.99
Yes	166/112	149/113	0.87	(0.66; 1.13)	

RELACORILANT

- Relacorilant is a novel, selective glucocorticoid receptor antagonist (SGRA) that restores the sensitivity of cancers to cytotoxic chemotherapy[2,3,4]
- Phase 2: The addition of relacorilant to nab-paclitaxel extended PFS (HR 0.66, P=0.038) and showed a trend to improved OS (HR 0.67, P=0.066) in patients with platinum-resistant ovarian cancer (PROC)[5]
- Phase 3 **(ROSELLA):** Relacorilant + nab-paclitaxel showed improvements in the dual primary endpoints of PFS (HR 0.70, P=0.0076) and OS (HR 0.69, P=0.0121) in patients with PROC[6]



HR, hazard ratio; OS, overall survival; PARP, poly(ADP-ribose) polymerase; PFS, progression-free survival; TTSST, time to second subsequent therapy.

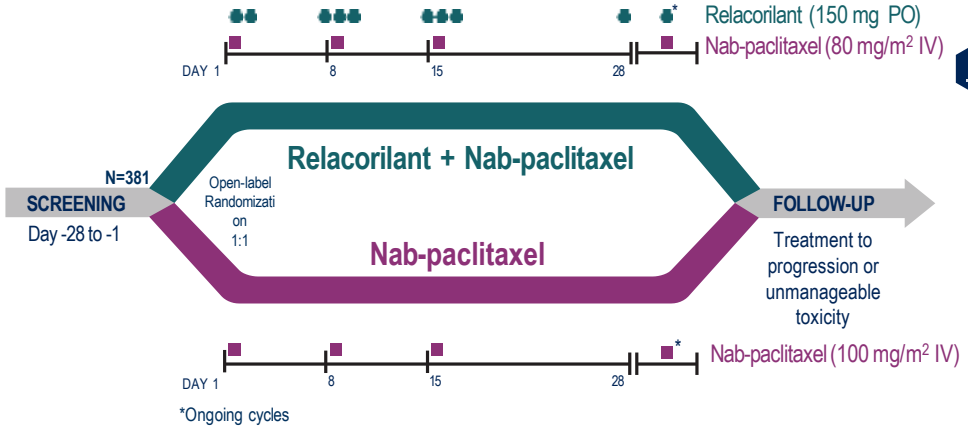
1. Harter, et al. *Ann Oncol*. 2025;36(2):185-96. 2. Greenstein, et al. *Oncotarget*. 2021;12(13):1243-55. 3. Stringer-Reasor, et al. *Gynecol Oncol*. 2015;138(3):656-62. 4. Munster, et al. *Clin Cancer Res*. 2022;28(15):3214-24. 5. Colombo, et al. *J Clin Oncol*. 2023;41(30):4779-89. 6. Olawaiye, et al. *Lancet*. 2025; 405(10496):2205-2216.

Adapted from Prof. Domenica Lorusso

ROSELLA | PHASE 3 TRIAL IN PLATINUM-RESISTANT OVARIAN CANCER

Population

- Epithelial ovarian, primary peritoneal or fallopian tube cancer
- ECOG performance status 0 or 1
- Progression >1 to <6 months after the last dose of platinum therapy†
- 1–3 prior lines of therapy
- Prior bevacizumab required



Stratification Factors

- Prior lines of therapy (1 vs >1)
- Region (North America vs Europe vs Korea, Australia, & Latin America)

Dual Primary Endpoints

- PFS by RECIST v1.1 assessed by BICR
- OS

Secondary Endpoints

- PFS by RECIST v1.1 assessed by Investigator
- Safety

NCT05257408

Data cutoff: Feb 24, 2025

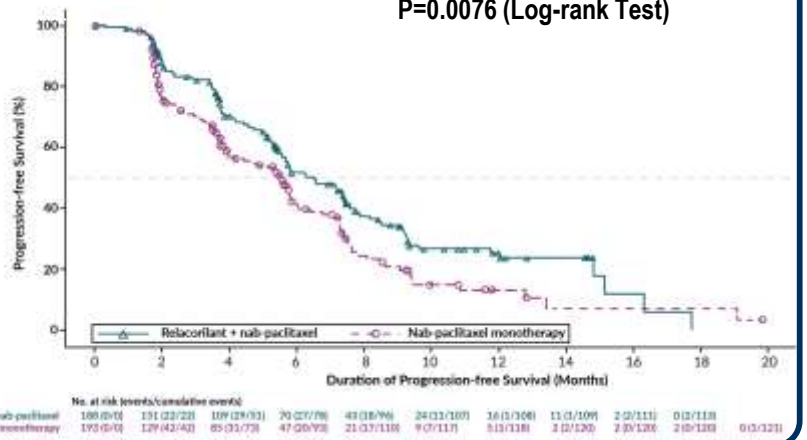
†Excluding disease with no response or progression ≤1 month after last dose of platinum therapy in first-line treatment.
ECOG, Eastern Cooperative Oncology Group; IV, intravenous; OS, overall survival; PFS, progression-free survival; PO, by mouth; RECIST, Response Evaluation Criteria in Solid Tumors.

Prof. Domenica Lorusso

ROSELLA | Relacorilant Improved PFS Assessed by BICR in the ITT Population[1]

	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	113 (60.1)	121 (62.7)
Median PFS, m (95% CI)	**6.54** (5.55–7.43)	**5.52** (3.94–5.88)
HR (95% CI)	**0.70** (0.54–0.91)	

P=0.0076 (Log-rank Test)

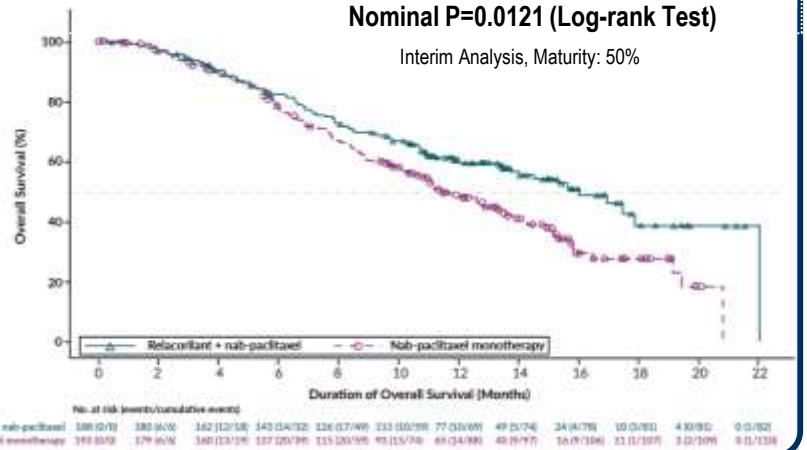


ROSELLA | Relacorilant Improved OS at an Interim Analysis in the ITT Population[1]

	Relacorilant + Nab-paclitaxel N=188	Nab-paclitaxel N=193
Events, n (%)	82 (43.6)	110 (57.0)
Median OS, m (95% CI)	**15.97** (13.47–NR)	**11.50** (10.02–13.57)
HR (95% CI)	**0.69** (0.52–0.92)	

Nominal P=0.0121 (Log-rank Test)

Interim Analysis, Maturity: 50%



The Kaplan–Meier method was used to estimate the curves, median estimates and the 95% confidence intervals (CI) for progression-free survival in each treatment arm. The HR and the associated 95% CI were estimated using a Cox regression model with treatment group as the main effect and stratification factors at randomization as covariates.

BICR, blinded-independent central review; CI, confidence interval; HR, hazard ratio; ITT, intent-to-treat; m, months; OS, overall survival; PFS, progression-free survival.

1. Olawaiye, et al. *Lancet*. 2025; 405(10496):2205-2216.

Data cutoff: Feb 24, 2025

Prof. Domenica Lorusso

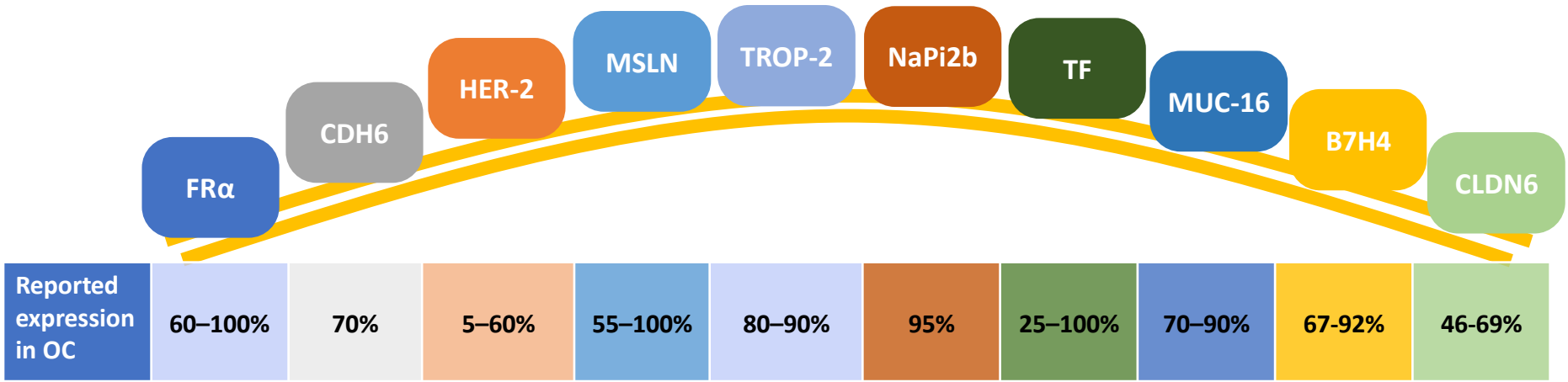
Take home regarding systemic therapy in recurrent disease

- New options for patients non-eligible for platinum with improvement in OS
  - Mirvetuximab Soravtansine if FR-alfa high (≥ 75%) (EMA approved)
  - Relacorilant – nab-paclitaxel (Pending approval)
  - Weekly pac + Pembrolizumab ± Bevacizumab (Pending approval)
- Weekly paclitaxel is the strongest control arm in PROC studies

Avances terapéuticos en cáncer de ovario

- Cirugía
- Primera línea
- Recaída
- **Futuro**

Targets for ADC directed therapy in EOC

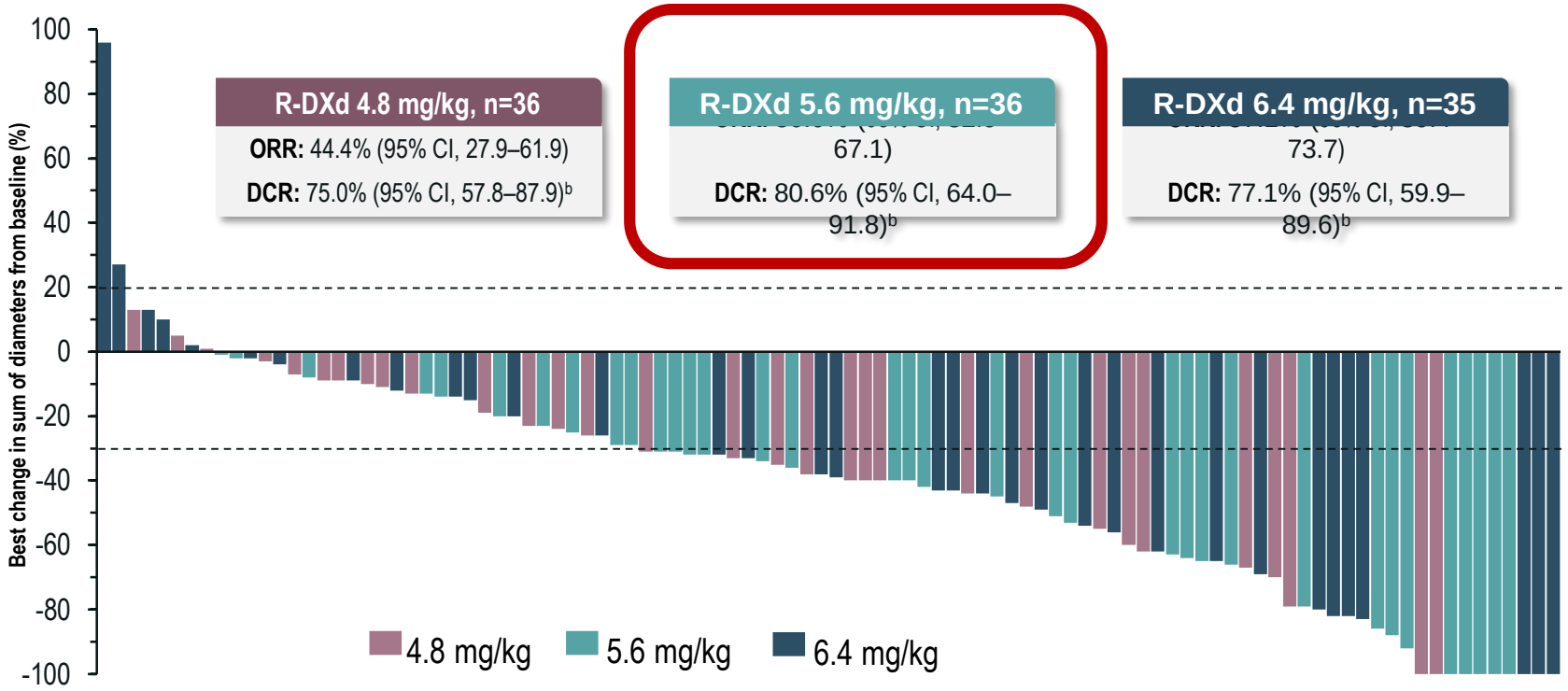


Adapted from Toon Van Gorp's presentation and updated with B7H4 and CLDN6 data
Based on:
Chelariu-Raicu A, et al. Int J Gynecol Cancer 2023;33:420–429
Zhou L, et al. Front. Immunol. 2024; 15:1426050.
Yuceer RO et al. Medicine 2025 Jun 27;104(26):e43110
Wang et al. Diagnostic Pathology 2013, 8:190

Antonio González-Martín MD, PhD

REJOYCE Phase 2

Clinically meaningful tumor responses were seen irrespective of dose[a]



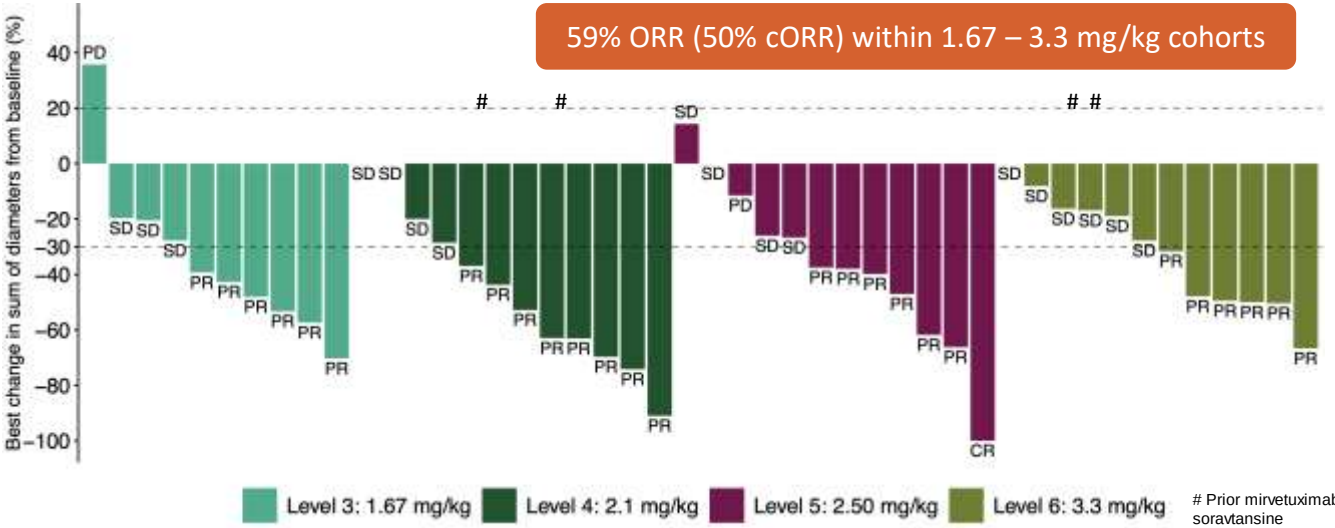
Data cutoff: February 26, 2025. The median follow-up for 4.8-mg/kg, 5.6-mg/kg, and 6.4-mg/kg cohorts was 5.6 months (95% CI, 4.7–6.3), 5.6 months (95% CI, 4.6–5.8), and 5.2 months (95% CI, 4.9–5.8), respectively.

[a]Antitumor response assessed by BICR per RECIST 1.1. Only patients with measurable disease at baseline and ≥1 post-baseline tumor scan, both by BICR, were included in the waterfall plot (n=100). Six patients (R-DXd 4.8 mg/kg [n=5]; 6.4 mg/kg [n=1]) did not have measurable disease at baseline and one patient (R-DXd 5.6 mg/kg) had no adequate post-baseline tumor assessment. [b]DCR was defined as percentage of patients with BOR of CR, PR, or SD (per RECIST 1.1).

BICR, blinded independent central review; CI, confidence interval; DCR, disease control rate; ORR, objective response rate; RECIST 1.1, Response Evaluation Criteria in Solid Tumours, version 1.1.

Anti-Napi2b
TUB-040 Efficacy across a wide therapeutic range with complete responses

59% ORR (50% cORR) within 1.67 – 3.3 mg/kg cohorts



Prior mirvetuximab soravtansine

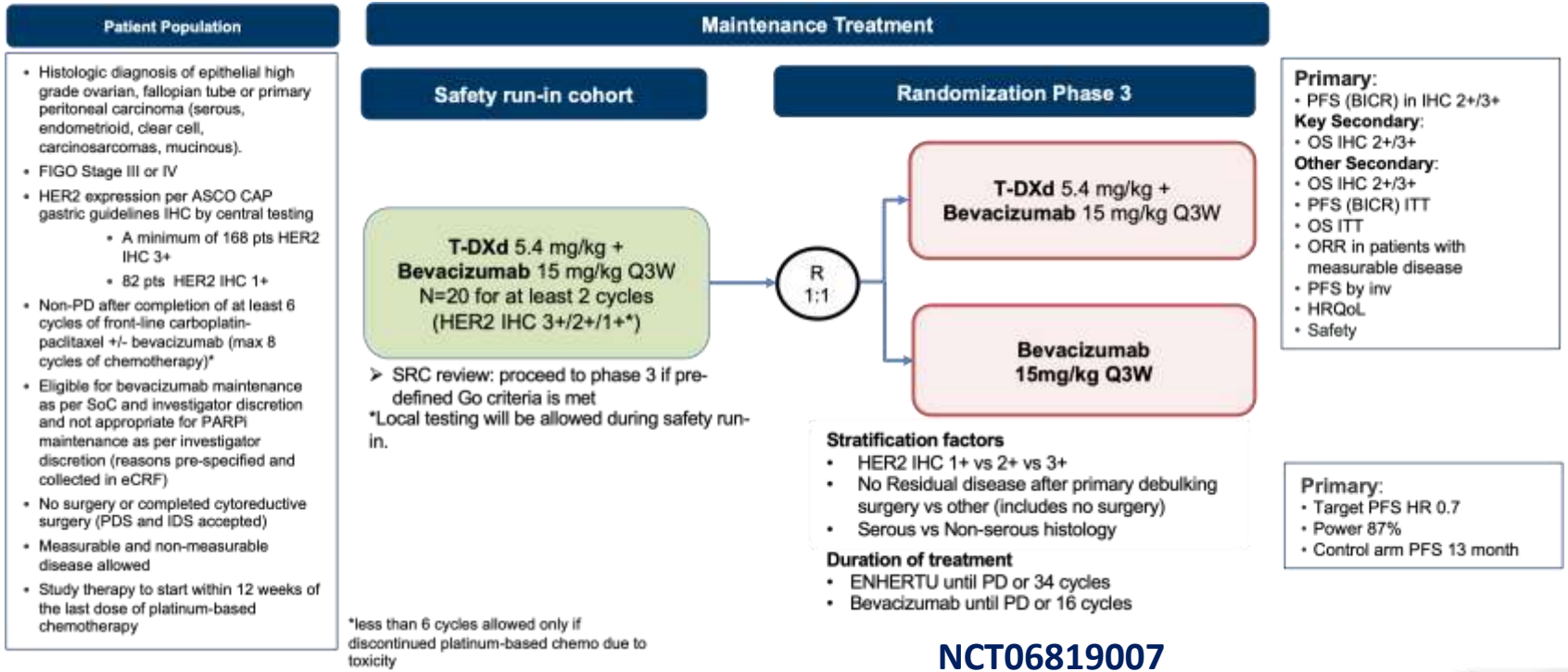
Across 1.67 – 3.3 mg/kg:

- Onset of activity at low doses
- Complete response observed
- CA125 response rate[4] 81%
- 93% (25/27) of responding patients are ongoing
- 80% (37/46) of patients remain on treatment, indicating durable benefit

Efficacy	Dose Levels				All evaluable patients
	1.67 mg/kg (n=10)	2.1 mg/kg (n=12)	2.5 mg/kg (n=12)	3.3 mg/kg (n=12)	1.67-3.3 mg/kg (n=46)	0.5 – 5.3 mg/kg (n=66)[1]
ORR[2] n (%)	6 (60)	8 (67)	7 (58)	6 (50)[3]	27 (59)	36 (55)
Confirmed ORR, n (%)	4 (40)	7 (58)	7 (58)	5 (42)	23 (50)	26 (39)
DCR n (%)	9 (90)	12 (100)	11 (92)	12 (100)	44 (96)	64 (97)
Confirmed DCR, n (%)	9 (90)	12 (100)	11 (92)	12 (100)	44 (96)	60 (91)
Confirmed CR, n (%)	0	0	1 (8)	0	1 (2)	1 (2)

1. N=66 evaluable patients who had at least 1 RECIST response assessment across doses from 0.5 – 5.3 mg/kg. There were no responses observed at doses below 1.67 mg/kg. 2. Responses of PR/CR per RECIST at a minimum of 1 post-baseline assessment. 3. Efficacy data in patients treated at 3.3 mg/kg continue to mature. 4. CA125 responses determined per GCIG; 34 responders in 42 CA125 evaluable subjects. CR, complete response; DCR, disease control rate; PR, partial response; SD, stable disease. Data Cut off: 01 September 2025.

An open-label, randomized, multicenter, phase 3 study of T-DXd with BEV vs BEV monotherapy as first-line maintenance therapy in HER2-expressing ovarian cancer: DESTINY-Ovarian01 (DO-01) ENGOT-OV89/GEICO 144-O/GOG-3112/APGOT-0V13



NCT06819007

Antonio González-Martín MD, PhD


Live longer,
Live better...

Muchas gracias

Antonio González-Martín

Cancer Center Clínica Universidad de Navarra

Clínica Universidad de Navarra | Cancer Center

GEICO Grupo Español de Investigación en Cáncer ginecológico

ENGOT European Network of Gynaecological Oncological Trial groups