VII SIMPOSIO NACIONAL
de ONCOLOGÍA de PRECISIÓN
Vigo, 20 y 21 de febrero de 2025

LO MEJOR DE 2024 EN 20 DIAPOSITIVAS

Cáncer ginecológico

Luis Manso MD PhD

Head of Gynecologic Cancer Unit.

Medical Oncology Division
12 de Octubre University Hospital.

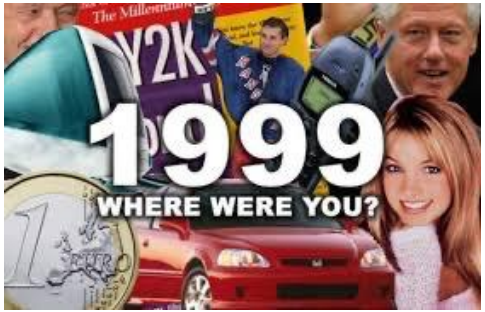
DISCLOSURE SLIDE

- Employment: Hospital Universitario 12 de Octubre
- Consultant or Advisory Roles: Lilly, GSK, Clovis, AstraZeneca, Roche, Novartis, Pfizer.
- Research Assistance: Tesaro-GSK
- Speaking Engagements: Lilly, Roche, AstraZeneca, Novartis, Pfizer, GSK, Clovis

DISCLOSURE SLIDE

Cervical cancer

MAJOR EVENTS 1999



"Californication"

Dreamcast Console

Baby one more time

ENGOT-cx11/ GOG-3047/KEYNOTE-A18

Key Eligibility Criteria

- FIGO 2014 stage IB2-IIB (node-positive disease) or FIGO 2014 stage III-IVA (either node-positive or node-negative disease)
- RECIST 1.1 measurable or non-measurable disease
- Treatment naïve

R
1:1
N = 1060

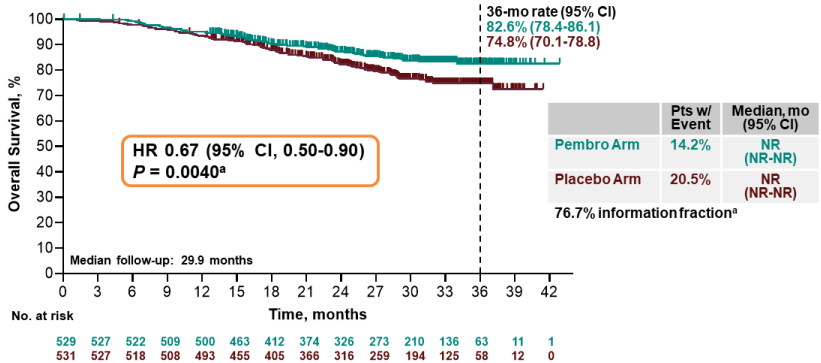
Cisplatin 40 mg/m² QW for 5 cycles[a] + EBRT followed by brachytherapy + Pembrolizumab 200 mg Q3W for 5 cycles	Pembrolizumab 400 mg Q6W for 15 cycles
Cisplatin 40 mg/m² QW for 5 cycles[a] + EBRT followed by brachytherapy + Placebo Q3W for 5 cycles	Placebo Q6W for 15 cycles

Stratification Factors

- Planned EBRT type (IMRT or VMAT vs non-IMRT or non-VMAT)
- Stage at screening (stage IB2-IIB N+ vs III-IVA)
- Planned total radiotherapy dose (<70 Gy vs ≥70 Gy [EQD2])

End Points:
- Primary: PFS (per RECIST v1.1) by investigator or histopathologic confirmation and OS.
- Secondary: 24-month PFS, 36-month OS, ORR, patient-reported HRQoL, and safety

Primary Endpoint: Overall Survival at IA2



[a]With 184 of the 240 deaths expected at the final analysis (76.7% information fraction), the observed *P* = 0.0040 (1-sided) crossed the prespecified nominal boundary of 0·01026 (1-sided) at this planned second interim analysis. At this time, 66 patients had received immunotherapy as post-progression treatment, including 15/138 patients (10.9%) in the pembro arm and 51/193 patients (26.4%) in the placebo arm; of those, 10 (7.2%) and 41 (21.2%), respectively, had received pembro. Data cutoff date: January 8, 2024.

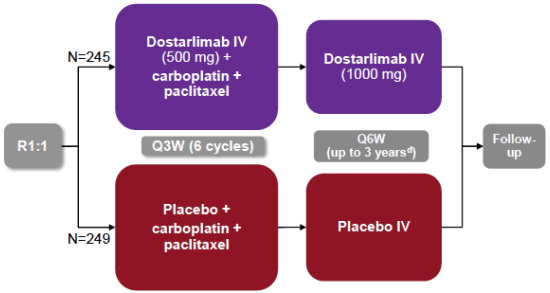
Loruso D, Lancet, 2024

Endometrial cancer

ENGOT-EN6-NSGO/GOG-3031/RUBY (NCT03981796) Part 1

Eligible patients
- Stage III/IV disease or first recurrent EC[a]
  - All histologies except sarcomas[b]
- Naive to systemic anticancer therapy or had a recurrence or PD ≥6 months after completing systemic anticancer therapy

Stratification
- MMR/MSI status[c]
- Prior external pelvic radiotherapy
- Disease status



Primary endpoint
- PFS by INV[e] (IA1)
- OS (IA1 & IA2)

Secondary endpoints
- PFS by BICR (IA1)
- PFS2 (IA1 & IA2)
- ORR (IA1)
- DOR (IA1)
- DCR (IA1)
- HRQOL/PRO (IA1)
- Safety (IA1 & IA2)

On-study imaging assessments were performed Q6W (±7 days) from the randomization date until week 25 (cycle 8), followed by Q9W (±7 days) until week 52. Subsequent tumor imaging was performed every 12 weeks (±7 days) until radiographic PD was documented by investigator assessment per RECIST v1.1 followed by one additional imaging 4–6 weeks later, or subsequent anticancer therapy was started, whichever occured first. Thereafter, scans may have been performed per standard of care. [a]Histologically/cytologically proven advanced or recurrent EC, stage III/IV disease or first recurrent EC with low potential for cure by radiation therapy or surgery alone or in combination. [b]Carcinosarcoma, clear cell, serous, or mixed histology permitted (mixe histology containing at least 10% carcinosarcoma, clear cell, or serous histology). [c]Patients were randomized based on either local or central MMR/MSI testing results. Central testing was used with local results were not available. For local determination of MMR/MSI status, IHC, next-generation sequencing, and polymerase chain reaction assays were accepted. For central determination of MMR/MSI status, IHC per Ventana MMR RxDx panel was used. [d]Treatment ends after 3 years, PD, toxicity, withdrawal consent, investigator's decision, or death, whichever occurs first. Continued treatment with dostarlimab or placebo beyond 3 years may be considered following discussion between the sponsor and the investigator. [e]The threshold for the primary endpoint of was crossed at IA1. Therefore, IA1 was considered the final analysis for PFS.
BICR, blinded independent central review; DCR, disease control rate; DOR, duration of response; EC, endometrial cancer; HRQOL, health-related quality of life; IA, interim assessment; IHC, immunohistochemistry; INV, investigator assessment; MMR, mism repair; MSI, microsatellite instability; ORR, objective response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; PRO, patient-reported outcome; Q3W, every 3 weeks; Q6W, every 6 weeks; Q9W, every 9 weeks; R, randomization; RECIST v1.1, Response Evaluation Criteria in Solid Tumors version 1.1.

NRG-GY018/KEYNOTE-868 (NCT03914612): Randomized, Placebo-Controlled, Phase 3

Key Eligibility Criteria
- Measurable stage III/IVA or measurable/nonmeasurable stage IVB or recurrent endometrial cancer
- Pathology report showing results of institutional MMR IHC testing
- ECOG PS 0, 1, or 2
- No prior chemo except prior adjuvant chemo if completed ≥12 mo before study

N = 810 (588 pMMR, 222 dMMR)

R 1:1

Arm 1
Placebo IV Q3W + Paclitaxel 175 mg/m² IV Q3W + Carboplatin AUC 5 IV Q3W
for 6 cycles

Arm 1
Placebo IV Q6W
for up to 14 additional cycles

Arm 2
Pembrolizumab 200 mg IV Q3W + Paclitaxel 175 mg/m² IV Q3W + Carboplatin AUC 5 IV Q3W
for 6 cycles

Arm 2
Pembrolizumab 400 mg IV Q6W
for up to 14 additional cycles

Stratification Factors
- dMMR vs pMMR
- ECOG PS (0 or 1 vs 2)
- Prior adjuvant chemo (yes vs no)

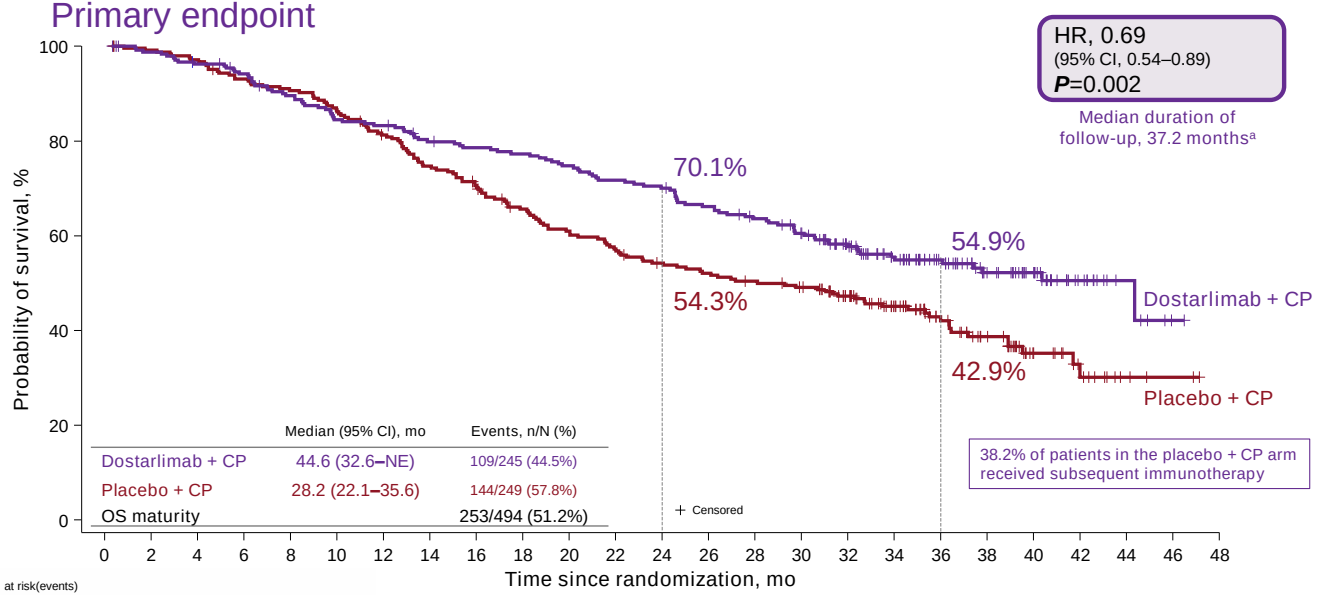
Endpoints
- **Primary:** PFS per RECIST v1.1 by investigator in pMMR and dMMR populations
- **Select secondary & exploratory*:**
  - OS in pMMR and dMMR populations
  - PD-L1 status (positive vs negative) in pMMR and dMMR populations
  - PFS per RECIST v1.1 by investigator by PD-L1 status in pMMR and dMMR populations
  - BICR vs investigator assessed outcomes by MMR status

*MMR status as randomized

ENGOT-EN6/GOG-3031/RUBY trial

Statistically Significant OS Benefit in Overall Population

Primary endpoint



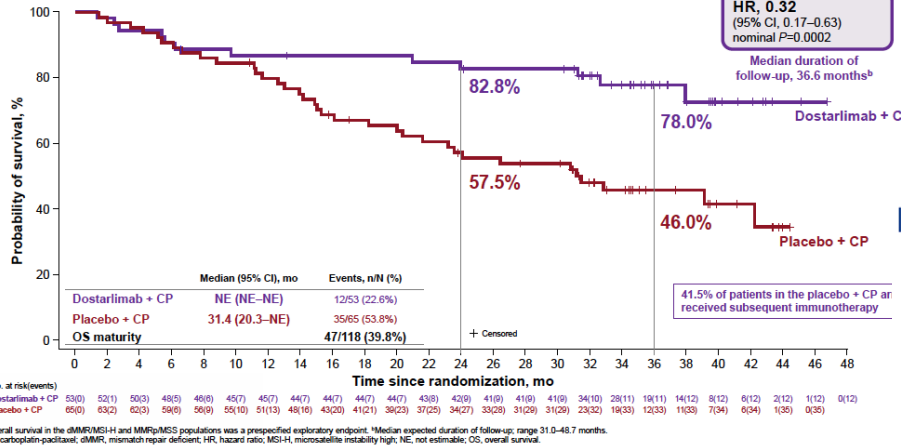
[a]Median expected duration of follow-up; range 31.0–49.5 months.
CP, carboplatin-paclitaxel; HR, hazard ratio; NE, not estimable; OS, overall survival.

Scan for slides

ENGOT-EN6/GOG-3031/RUBY trial

ENGOT NSGO-CTU GOG FOUNDATION

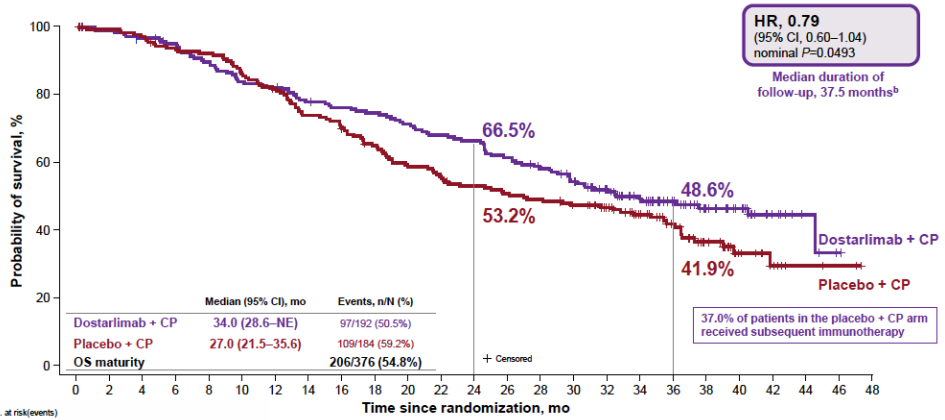
Substantial OS Benefit in dMMR/MSI-H Population[a]



[a]Overall survival in the dMMR/MSI-H and MMRp/MSS populations was a prespecified exploratory endpoint. [b]Median expected duration of follow-up; range 31.0–48.7 months.
CP, carboplatin-paclitaxel; dMMR, mismatch repair deficient; HR, hazard ratio; MSI-H, microsatellite instability high; NE, not estimable; OS, overall survival.

ENGOT NSGO-CTU GOG FOUNDATION

Clinically Meaningful OS Difference in MMRp/MSS Population[a]

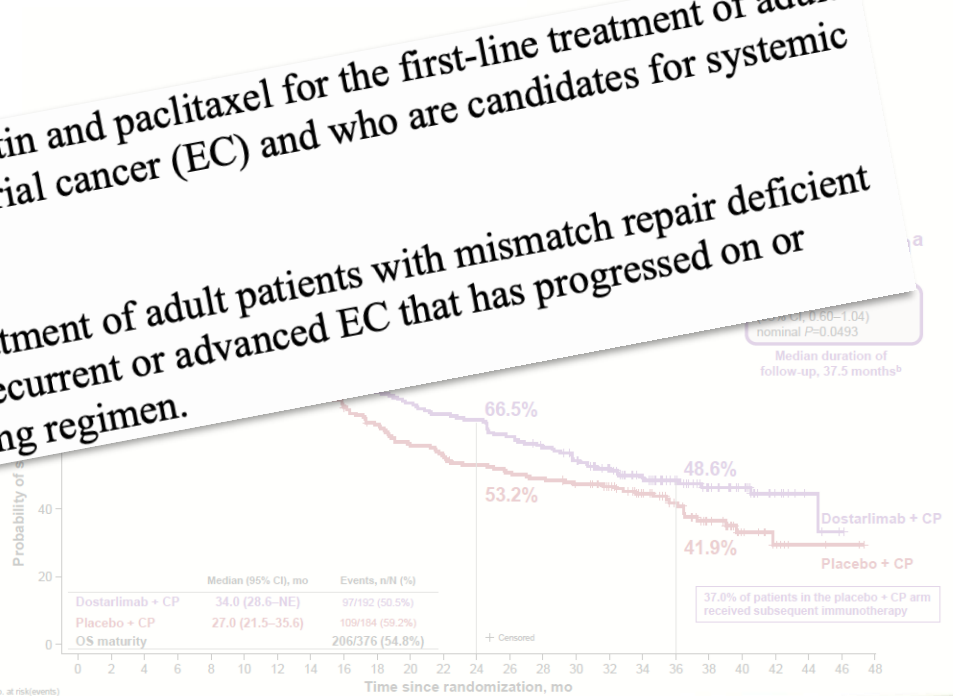


[a]Overall survival in the dMMR/MSI-H and MMRp/MSS populations was a prespecified exploratory endpoint. [b]Median expected duration of follow-up; range 31.2–49.5 months.
CP, carboplatin-paclitaxel; HR, hazard ratio; MMRp, mismatch repair proficient; MSS, microsatellite stable; NE, not estimable; OS, overall survival.

Date: 23 Jan 2025
EMA Extension of Indications for Dostarlimab

JEMPERLI is indicated in combination with carboplatin and paclitaxel for the first-line treatment of adult patients with primary advanced or recurrent endometrial cancer (EC) and who are candidates for systemic therapy.

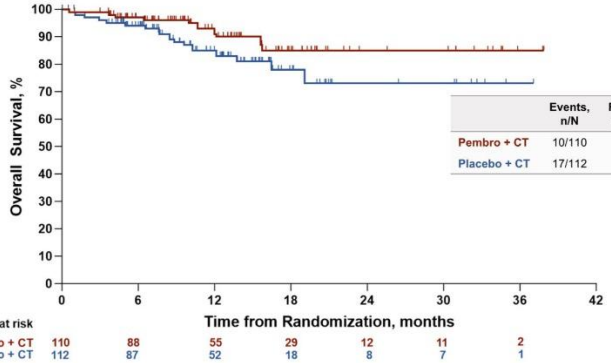
JEMPERLI is indicated as monotherapy for the treatment of adult patients with mismatch repair deficient (dMMR)/ microsatellite instability-high (MSI-H) recurrent or advanced EC that has progressed on or following prior treatment with a platinum-containing regimen.



NRG-GY018/KEYNOTE-868

Favorable Trend in OS With Pembro + CT for dMMR EC

OS Data Immature at IA (18.0% information fraction)



	Events, n/N	Follow-up Duration[a], median (range), mo	Median OS (95% CI), mo	HR (95% CI)[b], *P*-value[c]
Pembro + CT	10/110	13.3 (0.6–39.4)	NR (NR–NR)	0.55 (0.25–1.19)
Placebo + CT	17/112	13.7 (1.0–38.0)	NR (NR–NR)	*P* = 0.0617

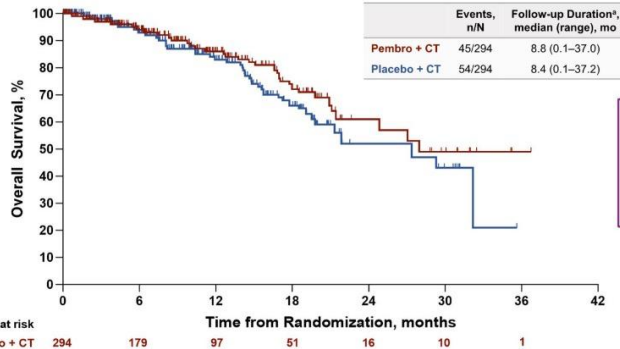
Among those who discontinued treatment, more patients in the placebo +CT group vs the pembro + CT group received subsequent PD-1/PD-L1 inhibitors (54.5% vs 19.1%)

THE POWER OF SHARED PURPOSE: Transforming Gynecologic Cancer Care

[a]Follow-up duration is defined as the time from randomization to the date of death or the database cutoff date if the participant is still alive.
[b]Based on Cox regression model with Efron's method of tie handling with treatment as a covariate stratified by prior chemotherapy.
[c]One-sided *P*-value based on log-rank test stratified by prior chemotherapy.
Database cutoff: Dec 16, 2022.

Favorable Trend in OS With Pembro + CT for pMMR EC

OS Data Immature at IA (27.2% information fraction)



	Events, n/N	Follow-up Duration[a], median (range), mo	Median OS (95% CI), mo	HR (95% CI)[b], *P*-value[c]
Pembro + CT	45/294	8.8 (0.1–37.0)	27.96 (21.42–NR)	0.79 (0.53–1.17)
Placebo + CT	54/294	8.4 (0.1–37.2)	27.37 (19.52–NR)	*P* = 0.1157

Among those who discontinued treatment, more patients in the placebo +CT group vs the pembro + CT group received subsequent PD-1/PD-L1 inhibitors (45.0% vs 19.3%)

THE POWER OF SHARED PURPOSE: Transforming Gynecologic Cancer Care

[a]Follow-up duration is defined as the time from randomization to the date of death or the database cutoff date if the participant is still alive.
[b]Based on Cox regression model with Efron's method of tie handling with treatment as a covariate stratified by prior chemotherapy.
[c]One-sided *P*-value based on log-rank test stratified by prior chemotherapy.
Database cutoff: Dec 6, 2022.

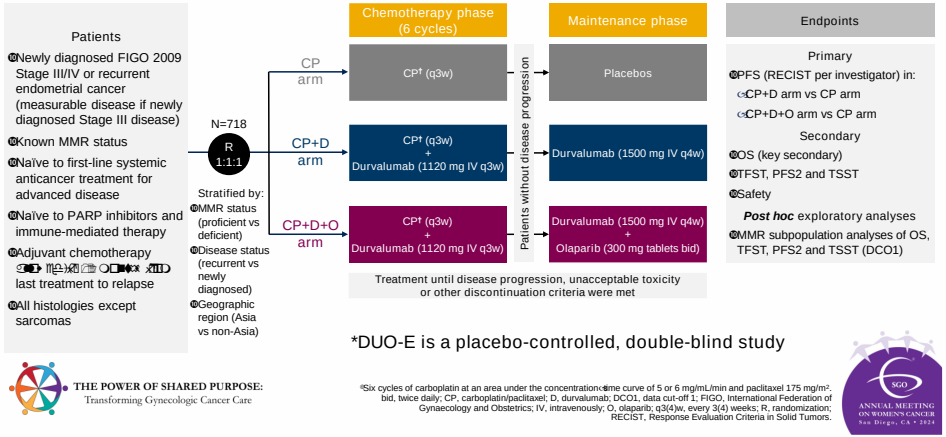
Date: 07 Oct 2024

EMA Extension of Indications for Pembrolizumab

KEYTRUDA, in combination with carboplatin and paclitaxel, is indicated for the first-line treatment of primary advanced or recurrent endometrial carcinoma in adults who are candidates for systemic therapy.

KEYTRUDA, in combination with lenvatinib, is indicated for the treatment of advanced or recurrent endometrial carcinoma in adults who have disease progression on or following prior treatment with a platinum-containing therapy in any setting and who are not candidates for curative surgery or radiation.

DUO-E study



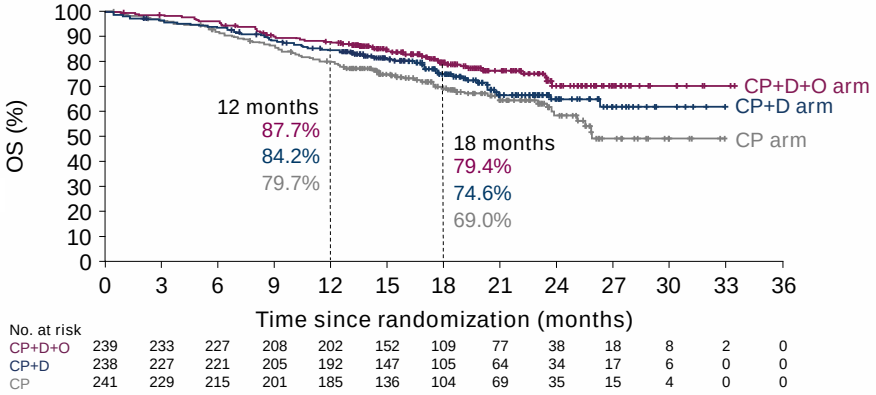
*DUO-E is a placebo-controlled, double-blind study

†Six cycles of carboplatin at an area under the concentration-time curve of 5 or 6 mg/mL/min and paclitaxel 175 mg/m², bid, twice daily; CP, carboplatin/paclitaxel; D, durvalumab; DCO1, data cut-off 1; FIGO, International Federation of Gynaecology and Obstetrics; IV, intravenously; O, olaparib; q3(4)w, every 3(4) weeks; R, randomization; RECIST, Response Evaluation Criteria in Solid Tumors.

THE POWER OF SHARED PURPOSE: Transforming Gynecologic Cancer Care

SGO ANNUAL MEETING ON WOMEN'S CANCER San Diego, CA • 2024

OS: Secondary endpoint; prespecified interim analysis



No. at risk

CP+D+O	239	233	227	208	202	152	109	77	38	18	8	2	0
CP+D	238	227	221	205	192	147	105	64	34	17	6	0	0
CP	241	229	215	201	185	136	104	69	35	15	4	0	0

	CP arm (N=241)	CP+D arm (N=238)	CP+D+O arm (N=239)
Events, n (%)	82 (34.0)	65 (27.3)	52 (21.8)
Median OS (95% CI), months	25.9 (23.9–NR)	NR (NR–NR)	NR (NR–NR)
HR (95% CI) vs CP arm†		0.77 (0.56–1.07); ***P***=0.120	0.59 (0.42–0.83); ***P***=0.003
HR (95% CI) vs CP+D arm†			0.77 (0.53–1.10)

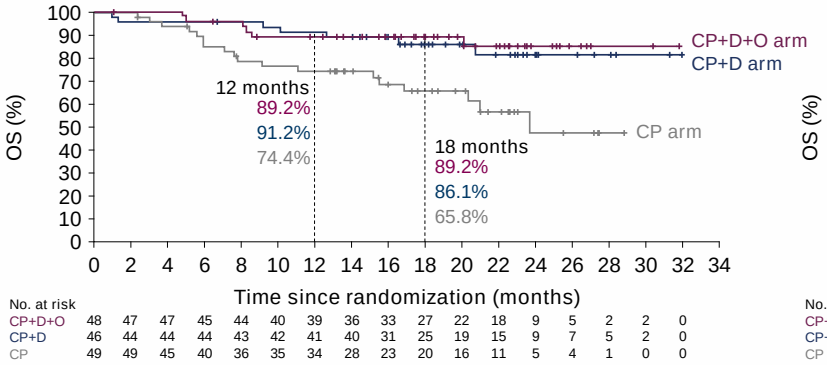
Overall data maturity: 27.7%

DU

MMR subpopulations: OS

Post hoc exploratory analyses

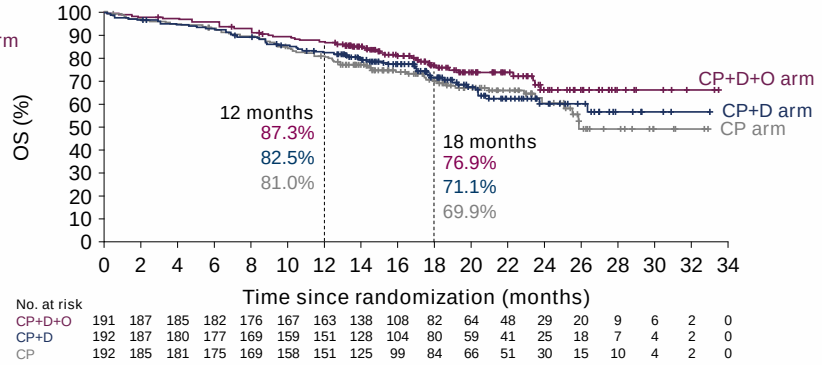
dMMR (20% of ITT population)



	CP arm (n=49)	CP+D arm (n=46)	CP+D+O arm (n=48)
Events, n (%)	18 (36.7)	7 (15.2)	6 (12.5)
Median OS (95% CI), months	23.7 (16.9–NR)	NR (NR–NR)	NR (NR–NR)
HR (95% CI) vs CP arm*		0.34 (0.13–0.79)	0.28 (0.10–0.68)
HR (95% CI) vs CP+D arm*			0.84 (0.27–2.52)

Overall data maturity: 21.7%

pMMR (80% of ITT population)



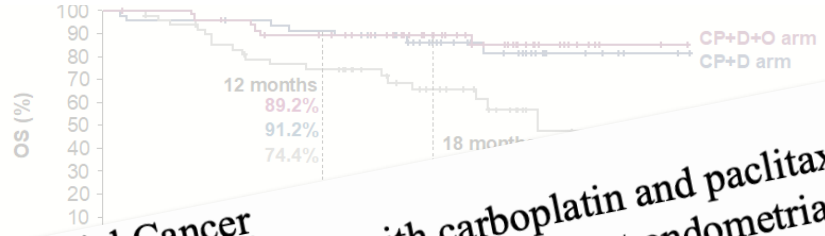
	CP arm (n=192)	CP+D arm (n=192)	CP+D+O arm (n=191)
Events, n (%)	64 (33.3)	58 (30.2)	46 (24.1)
Median OS (95% CI), months	25.9 (25.1–NR)	NR (NR–NR)	NR (NR–NR)
HR (95% CI) vs CP arm*		0.91 (0.64–1.30)	0.69 (0.47–1.00)
HR (95% CI) vs CP+D arm*			0.75 (0.51–1.11)

Overall data maturity: 29.2%

DCO: April 12, 2023. For the dMMR subpopulation, median duration of follow-up for OS was 18.4 (CP), 19.1 (CP+D) and 19.9 months (CP+D+O) in censored patients; for the pMMR subpopulation, median duration of follow-up was 18.6 (CP), 18.2 (CP+D) and 18.4 months (CP+D+O) in censored patients. MMR status was evaluated using the Ventana MMR immunohistochemistry panel. OS rates were estimated by the Kaplan–Meier method. *HRs and CIs were estimated from an unstratified Cox proportional hazards model.

Date: 02 Aug 2024

EMA Extension of Indications for Durvalumab



Endometrial Cancer

IMFINZI in combination with carboplatin and paclitaxel is indicated for the first-line treatment of adults with primary advanced or recurrent endometrial cancer who are candidates for systemic therapy, followed by maintenance treatment with:

- IMFINZI as monotherapy in endometrial cancer that is mismatch repair deficient (dMMR) proficient (pMMR).
- IMFINZI in combination with olaparib in endometrial cancer that is mismatch repair

	CP+D arm (n=192)	CP+D+O arm (n=191)
	64 (33.3)	58 (30.2)	46 (24.1)
Median OS (95% CI), months	25.9 (25.1–NR)	NR (NR–NR)	NR (NR–NR)
HR (95% CI) vs CP arm*		0.91 (0.64–1.30)	0.69 (0.47–1.00)
HR (95% CI) vs CP+D arm*			0.75 (0.51–1.11)

0.28 (0.10–0.68)
0.84 (0.27–2.52)

Overall data maturity: 21.7%

Overall data maturity: 29.2%

DCO: April 12, 2023. For the dMMR subpopulation, median duration of follow-up for OS was 18.4 (CP), 19.1 (CP+D) and 19.9 months (CP+D+O) in censored patients; for the pMMR subpopulation, median duration of follow-up was 18.6 (CP), 18.2 (CP+D) and 18.4 months (CP+D+O) in censored patients. MMR status was evaluated using the Ventana MMR immunohistochemistry panel. OS rates were estimated by the Kaplan–Meier method. *HRs and CIs were estimated from an unstratified Cox proportional hazards model.

ENGOT-en11/GOG-3053/KEYNOTE-B21 Study Design

Key Eligibility Criteria

- Newly diagnosed EC or carcinosarcoma
- Curative surgery with no residual disease
- At high risk for recurrence:
  - FIGO (2009) surgical stage I/II, non-endometrioid with myometrial invasion
  - FIGO (2009) surgical stage I/II with myometrial invasion of any histology with known aberrant p53 expression or TP53 mutation
  - FIGO (2009) surgical stage III/IVA of any histology
- No prior radiation or systemic therapy (including neoadjuvant) for EC

Stratification Factors

- **MMR status (pMMR vs dMMR)**, and within pMMR stratum:
  - Planned radiation (chemo-EBRT vs EBRT vs no EBRT)
  - Histology (endometrioid vs non-endometrioid)
  - FIGO (2009) surgical stage (I/II vs III/IVA)

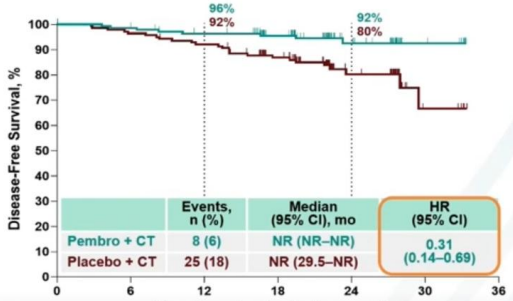
R 1:1
N=1095

	Stage 1	Stage 2
Carboplatin (AUC 5 or 6) + paclitaxel 175 mg/m² (Q3W, 4 or 6 cycles)	± radiotherapy ± cisplatin
Pembrolizumab 200 mg Q3W (6 cycles)	Pembrolizumab 400 mg Q6W (6 cycles)
Carboplatin (AUC 5 or 6) + paclitaxel 175 mg/m² (Q3W, 4 or 6 cycles)	± radiotherapy ± cisplatin
Placebo Q3W (6 cycles)	Placebo Q6W (6 cycles)

Dual Primary Endpoints

- DFS as assessed radiographically by the investigator or by histopathologic confirmation
- OS (not mature at this interim analysis)

Pembrolizumab Plus Chemotherapy Improved DFS[a] per Investigator in dMMR Subgroup



[a]DFS was defined as the time from randomization to local or distant recurrence of EC (assessed radiographically by the investigator or by histopathologic confirmation) or death from any cause. Data cutoff date: March 4, 2024.

Ovarian cancer

PRIMA/ENGOT-OV26/GOG-3012 trial of niraparib 1L maintenance

Phase 3 PRIMA trial enrolled patients with newly diagnosed aOC at a high risk for disease recurrence

Eligible patients
- Newly diagnosed HGS/HGE aOC
- CR or PR to 1L PBCT[a]
- Tumor sample for HRD testing

Stratification factors
- Neoadjuvant chemotherapy: yes or no
- Best response to 1L PBCT: CR or PR
- Tumor HRD status: HRd or HRp/HRnd

R 2:1

- Niraparib
- Placebo

Patients treated once daily[b] for 36 months or until disease progression

Endpoints

Primary endpoint:
- PFS by BICR[c]

Key secondary endpoint
- OS

Secondary endpoints:
- PFS2, TFST, PRO, safety

OS testing
- Conducted at ~60% maturity in overall population (≈440 deaths)
- Hierarchical testing: overall then HRd
- 80% power to detect a statistically significant difference if the true hazard ratio was ≤0.75 in overall population

Key risk characteristics of PRIMA population[1,2]

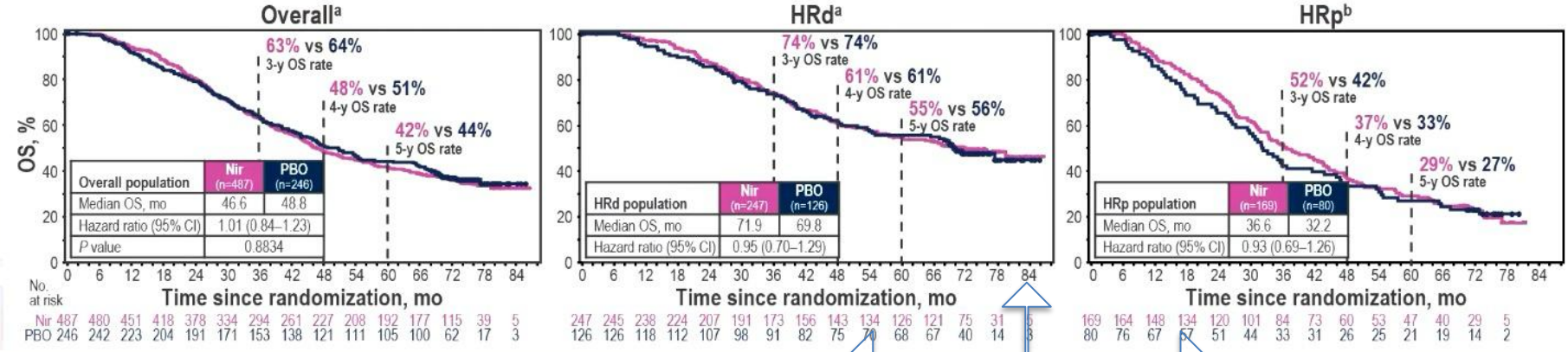
Disease stage		Residual disease		Tumor HRD/*BRCA* status	
35.1%	stage IV disease at diagnosis	**>99%**	stage III disease at diagnosis with residual disease after primary debulking surgery	**50.9%**	HRd
Initial treatment				**30.4%**	HRd/*BRCA*m
66.7%	received neoadjuvant chemotherapy	**47.5%**	postoperative visible residual disease or no debulking surgery	**34.0%**	HRp
30.6%	achieved partial response to 1L PBCT				

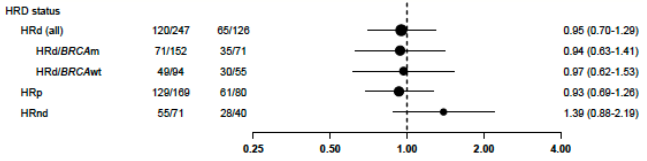
PRIMA/ENGOT-OV26/GOG-3012 trial (NCT02655016). [a]Patients must have either had CA-125 in the normal range or a ≥90% decrease in CA-125 during 1L treatment that was stable for at least 7 days. At baseline, 7.1% of the overall population had CA-125 above the upper limit of normal. [b]At study start, all patients received a fixed starting dose of 300 mg once daily. Subsequently, the protocol was updated to use an individualized starting dose adjusted according to baseline body weight/platelet count. [c]Primary endpoint of PFS by BICR assessed by hierarchical testing, first in patients with HRd tumors and then in the overall population. 1L, first-line; aOC, advanced ovarian cancer; BICR, blinded independent central review; *BRCA*m, *BRCA*-mutated; CA-125, cancer antigen 125; CR, complete response; HGE, high-grade endometrioid; HGS, high-grade serous; HRD, homologous recombination deficiency; HRd, homologous recombination deficient; HRnd, homologous recombination status not determined; HRp, homologous recombination proficient; OS, overall survival; PBCT, platinum-based chemotherapy; PFS, progression-free survival; PFS2, progression-free survival 2; PR, partial response; PRO, patient-reported outcomes; TFST, time to first subsequent therapy.

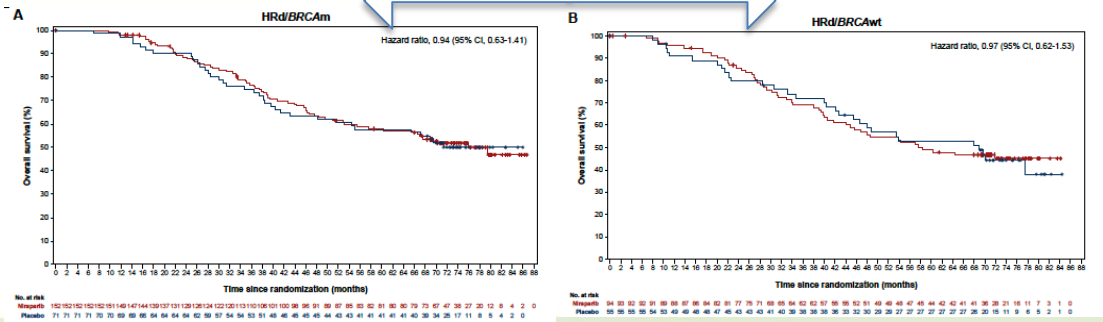
1. González-Martín A, et al. *N Engl J Med*. 2019;381(25):2391–2402. 2. O'Cearbhaill RE, et al. *Gynecol Oncol*. 2022;166(1):36–43.

Final OS (62.5% maturity in overall population)

No difference in OS between niraparib and placebo arms in the overall, HRd, and HRp populations

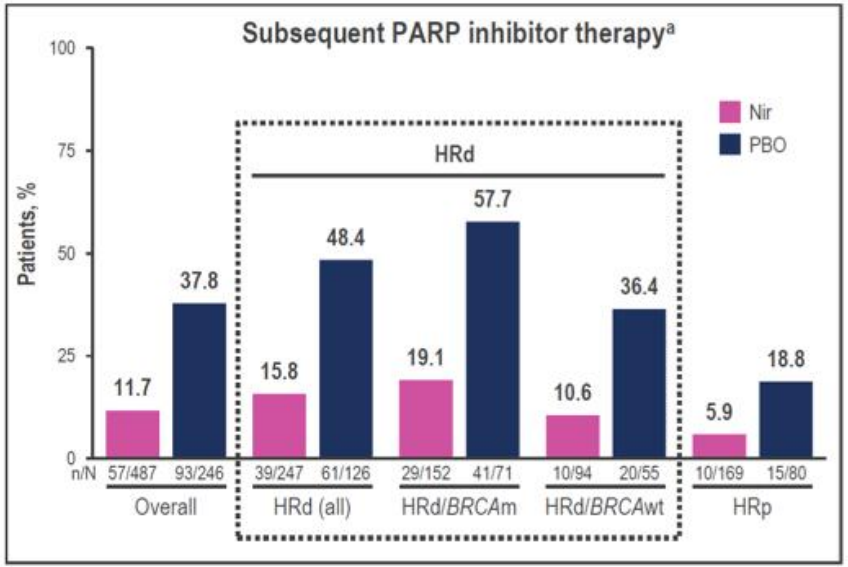






Subsequent PARP inhibitor therapy

3-fold higher subsequent PARP inhibitor use in placebo arm than niraparib arm across populations



Subsequent PARP inhibitor use

- Most predominant in HRd population, with highest use in HRd/*BRCA*m population
- Most patients initiated in the 2L setting

Any subsequent PARP inhibitor by treatment line, %[a]	Overall		HRd	
	Nir (n=487)	PBO (n=246)	Nir (n=247)	PBO (n=126)
Any treatment line	11.7	37.8	15.8	48.4
2L	8.2	30.5	13.0	37.3
3L+	3.5	7.3	2.8	11.1

[a]Percentages calculated out of the total number of patients in each population, not the number of patients who experienced disease progression. 2L, second-line; 3L+, third-line and beyond; *BRCA*m, *BRCA*-mutated; *BRCA*wt, *BRCA* wild-type; HRd, homologous recombination deficient; HRp, homologous recombination proficient; Nir, niraparib; PARP, poly(ADP-ribose) polymerase; PBO, placebo.

Mirvetuximab soravtansine (MIRV)

MIRASOL (NCT04209855) – Study Design[1,2]

An open-label, phase 3 randomized trial of MIRV vs investigator's choice chemotherapy in patients with FRα-high platinum-resistant ovarian cancer

Patient Population
(N=453)

Enrollment and Key Eligibility
Platinum-resistant disease (PFI ≤6 mo)
FRα detected by IHC with PS2+ intensity among ≥75% of viable tumor cells
High-grade serous histology
1º platinum-refractory disease excluded (primary PFI <3 mo)
1-3 prior lines of therapy
Prior BEV and PARPi allowed
Patients with BRCA mutations allowed

1:1 Randomization

Treatment Regimen-Experimental
MIRV
(6 mg/kg AIBW Q3W)

Treatment Regimen-Control
Investigator's Choice Chemotherapy
(Paclitaxel, PLD, or Topotecan)

Stratification Factors
IC chemo: paclitaxel, PLD, or topotecan
Prior lines of therapy: 1 vs 2 vs 3

Primary Endpoint
PFS by INV
(BICR sensitivity analysis)

Key Secondary Endpoints
1) ORR by INV
2) OS
3) PROs[a]

Secondary Endpoints
Safety and tolerability
DOR
CA-125 response[b]
PFS2

Enrolled patients: 62% prior Bevacizumab, 55% prior PARPi

Moore et al. NEJM 2023; Konecny GE SGO 2024

Mirvetuximab soravtansine (MIRV)

Date: 14 nov 2024

EMA Recommends Granting a Marketing Authorisation for Mirvetuximab Soravtansine

ELAHERE as monotherapy is indicated for the treatment of adult patients with folate receptor-alpha (FRα) positive, platinum-resistant high grade serous epithelial ovarian, fallopian tube, or primary peritoneal cancer who have received one to three prior systemic treatment regimens (see section 4.2).

Enrolled patients: 62% prior Bevacizumab, 55% prior PARPi

Moore et al. NEJM 2023; Konecny GE SGO 2024

Pantumor Gyn

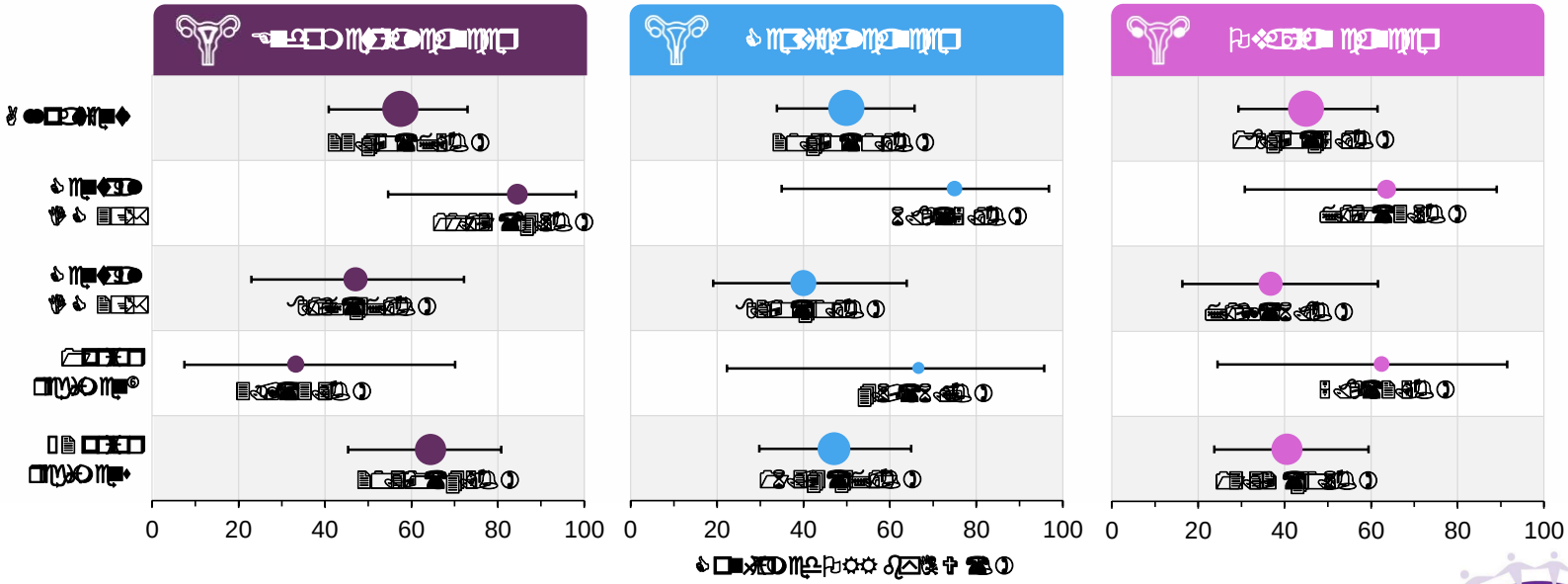
DESTINY-PanTumor02

Efficacy and safety of trastuzumab deruxtecan in patients with HER2-expressing solid tumors: biomarker and subgroup analyses from the cervical, endometrial, and ovarian cancer cohorts of the DESTINY-PanTumor02 study

Vicky Makker,[1,2] Ana Oaknin, Luis Manso, Antonio González-Martín, Iwona Ługowska, Funda Meric-Bernstam, Domenica Lorusso, Susana Banerjee, John B Liao, Salvatore Siena, Chien-Hsing Lu, Naiyarat Prasongsook, Bohuslav Melichar, Anitra Fielding, Lindsey Jung, Soham Puvvada, Flavia Michelini, Jung-Yun Lee

[1]Gynecologic Medical Oncology Service, Memorial Sloan Kettering Cancer Center, New York, NY, US
[2]Department of Medicine, Weill Cornell Medical College, New York, NY, US

2024 SGO Annual Meeting on Women's Cancer | 16 March 2024, 08:30–09:45 PST



Error bars represent 95% confidence intervals
*In patients with IHC 1+/0/unknown by central testing, responses were observed in 4/10 patients with endometrial cancer, 6/12 patients with cervical cancer, and 4/10 patients with ovarian cancer; †one patient with endometrial cancer was reported to have received no prior regimens
IHC, immunohistochemistry; INV, investigator; ORR, objective response rate

CONCLUSIONS

- **Pembrolizumab** in addition to **chemoradiotherapy** as a **new standard of care** for LACC.

- **Immune checkpoint inhibitors** should be incorporated to first line Chemo in patients with advanced/recurrent endometrial cancer.

- No difference in OS between **niraparib** and placebo arms in overall population and by HRD status.

- **T-DXd** demonstrated clinically meaningful ORRs in heavily pre-treated patients with HER2-expressing endometrial, cervical, and ovarian tumors.