IGCS 2022 Abstracts: Late-Breaking Oral Abstract Presentations

Late-breaking oral abstract presenters will present their abstracts in the below session.

The session will be live-streamed in real time onto the Meeting Portal and recorded for on-demand viewing from 24 hours after the session ends until December 28, 2022.

Plenary 01: Opening Ceremony and Oral Abstract Presentations

- **Thursday, September 29, 2022**
- **08:00 AM - 10:30 AM EDT**
- **Hall 501**

LB001 / #1731

Plenary Session
PLENARY 01: OPENING CEREMONY AND ORAL ABSTRACT PRESENTATIONS
29-09-2022 8:00 AM - 10:30 AM

LATE-BREAKING ABSTRACT PRESENTATION: OVERALL SURVIVAL BY NUMBER OF PRIOR LINES OF CHEMOTHERAPY IN PATIENTS WITH BRCA-MUTATED PLATINUM-SENSITIVE RELAPSED OVARIAN CANCER RECEIVING OLAPARIB TREATMENT OR NON-PLATINUM CHEMOTHERAPY IN SOLO3

Charles Leath Iii[1], Giovanni Scambia[2], Ricardo Villalobos[3], Nicoletta Colombo[4], David Cibula[5], Mariusz Bidziński[6], Jae-Weon Kim[7], Joo-Hyun Nam[8], Radosław Mądry[9], Carlos Hernandez[10], Paulo Mora[11], Sang Young Ryu[12], Mei-Lin Ah-See[13], Elizabeth S Lowe[14], Natalia Lukashchuk[15], Dave Carter[16], R.T Penson[17]
[1]O'Neal Comprehensive Cancer Center, The University of Alabama at Birmingham, Division Of Gynecologic Oncology, Birmingham, United States of America, [2]Fondazione Policlinico Universitario A. Gemelli, IRCCS, UOC Ginecologia Oncologica, and MITO, Dipartimento Per La Salute Della Donna E Del Bambino E Della Salute Pubblica, Rome, Italy, [3]Centro Medico Dalinde, Department Of Medical Oncology, Mexico City, Mexico, [4]University of Milan-Bicocca, European Institute of Oncology IRCCS, Gynecologic Oncology Department, Milan, Italy, [5]First Faculty of Medicine, Charles University and General University Hospital, Department Of Obstetrics And Gynecology, Prague, Czech Republic, [6]Maria Skłodowska-Curie Memorial Cancer Center and Institute of Oncology, Oncological Gynaecology Clinic, Warsaw, Poland, [7]Seoul National University Hospital, Obstetrics And Gynecology, Seoul, Korea, Republic of, [8]Asan Medical Center, Obstetrics And Gynecology, Seoul, Korea, Republic of, [9]Medical University K. Marcinkowski and the Clinical Hospital of the Transfiguration, Department Of Oncological Gynecology, Poznań, Poland, [10]Oaxaca Site Management Organization, Research, Oaxaca de Juarez, Mexico, [11]Instituto COI de Educação e Pesquisa, Research, Rio de Janeiro, Brazil, [12]Korea Institute of Radiological & Medical Science, Gynecologic Oncology, Seoul, Korea, Republic of, [13]AstraZeneca, Oncology R&d, Late-stage Development, Cambridge, United Kingdom, [14]Oncology, AstraZeneca, Global Medicines Development, Gaithersburg, United States of America, [15]AstraZeneca, Translational Medicine, Oncology R&d, Cambridge, United Kingdom, [16]AstraZeneca, Biostatistics, Oncology Biometrics, Oncology R&d, Cambridge, United Kingdom, [17]Harvard Medical School, Massachusetts General Hospital, Division Of Hematology And Oncology, Boston, United States of America

Objectives: In the open-label Phase III SOLO3 trial (NCT02282020), olaparib treatment improved objective response rate (primary endpoint) and progression-free survival, versus single-agent non-platinum chemotherapy treatment of physician's choice (TPC), in patients with germline BRCA1 and/or BRCA2-mutated (gBRCAm) platinum-sensitive relapsed ovarian cancer (PSROC) with ≥2 prior lines of platinum-based chemotherapy (Penson et al. JCO 2020). In the full analysis set, median overall survival (OS) was 34.9 months with olaparib versus 32.9 months with TPC (HR 1.07; 95% CI 0.76–1.49) (Penson et al. SGO 2022). We investigated OS by number of prior lines of chemotherapy.

Methods: Patients were randomized (2:1) to olaparib (300 mg bid) or TPC (paclitaxel [P], topotecan [T], gemcitabine [G], or pegylated liposomal doxorubicin [PLD]). The prespecified final analysis of OS (secondary endpoint) was performed at approximately 60% data maturity. This post hoc subgroup analysis evaluated OS in patients with 2 or ≥3 prior lines of chemotherapy.

Results: 266 patients were randomized (olaparib, n=178; TPC, n=88 [PLD, n=47; P, n=20; G, n=13; T, n=8]). At final DCO (April 16, 2021), the HRs for OS were 0.83 (95% CI 0.51– 1.38) and 1.33 (95% CI 0.84–2.18) in patients with 2 and ≥3 prior lines of chemotherapy, respectively (Table). Adverse events were consistent with olaparib's known safety profile and previous SOLO3 analyses, with no new safety

signals.

Table. Subgroup analysis of OS by number of prior lines of chemotherapy

	Olaparib		TPC
2 prior lines of chemotherapy	**n=88**		**n=46**
Events, n (%)	53 (60)		23 (50)
Median OS, months	37.9		28.8
HR (95% CI)		0.83 (0.51–1.38)	
≥3 prior lines of chemotherapy	**n=90**		**n=42**
Events, n (%)	63 (70)		23 (55)
Median OS, months	29.9		39.4
HR (95% CI)		1.33 (0.84–2.18)	

Study treatment continued until objective radiological disease progression, unacceptable toxicity, or other discontinuation criteria were met. Overall, at final DCO (April 16, 2021), 11% of olaparib patients versus no TPC patients were still receiving study treatment; 11% of patients in the olaparib group versus 25% of patients in the TPC group left the study prior to death. At final DCO in the full analysis set, 6% and 4% of olaparib patients versus 37% and 38% of TPC patients received subsequent PARP inhibitor therapy, in patients who had received 2 and ≥3 prior lines of chemotherapy, respectively.

CI, confidence interval; DCO, data cutoff; HR, hazard ratio; PARP, poly(ADP-ribose) polymerase.

Conclusions: This post hoc subgroup analysis suggests a survival benefit for olaparib treatment versus TPC in patients with gBRCAm PSROC with 2 prior lines of chemotherapy and a potential detrimental effect in patients with ≥3 prior lines of chemotherapy.

Funding source: This study was funded by AstraZeneca and is part of an alliance between AstraZeneca and Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA

LB002 / #1545

Plenary Session
PLENARY 01: OPENING CEREMONY AND ORAL ABSTRACT PRESENTATIONS
29-09-2022 8:00 AM - 10:30 AM

LATE-BREAKING ABSTRACT PRESENTATION: COMPARATIVE EFFECTIVENESS OF HIPEC FOLLOWING INTERVAL CYTOREDUCTIVE SURGERY IN PATIENTS WITH ADVANCED-STAGE OVARIAN CANCER UNDERGOING NEOADJUVANT CHEMOTHERAPY: MULTICENTER, PROSPECTIVE, COHORT STUDY (KGOG 3042)

Yong Jae Lee[1], Joo-Hyuk Son[2], Min Chul Choi[3], Dong Hoon Suh[4], Dae Gy Hong[5], Mi-Kyung Kim[6], Jae-Hoon Kim[7], Jung-Yun Lee[8], Suk-Joon Chang[2]
[1]Institute of women's Life Medical Science, Yonsei University College of Medicine, Department Of Obstetrics And Gynecology, Seoul, Korea, Republic of, [2]Ajou University School of Medicine, Department Of Obstetrics And Gynecology, Suwon, Korea, Republic of, [3]CHA Bundang Medical Center, CHA University,, Comprehensive Gynecologic Cancer Center,, Seongnam-si, Korea, Republic of, [4]Seoul National University Bundang Hospital, Obstetrics And Gynecology, Seongnam, Korea, Republic of, [5]Kyungpook National University Chilgok Hospital, Department Of Obstetrics And Gynecology, Daegu, Korea, Republic of, [6]Ewha Womans University College of Medicine, Department Of Obstetrics And Gynecology, Seoul, Korea, Republic of, [7]Gangnam Severance Hospital, Yonsei University, Department Of Obstetrics And Gynecology, Gangnam-gu, Seoul, Korea, Republic of, [8]Institute of Women's Medical Life Science, Yonsei University College of Medicine, Department Of Obstetrics And Gynecology, Seoul, Korea, Republic of

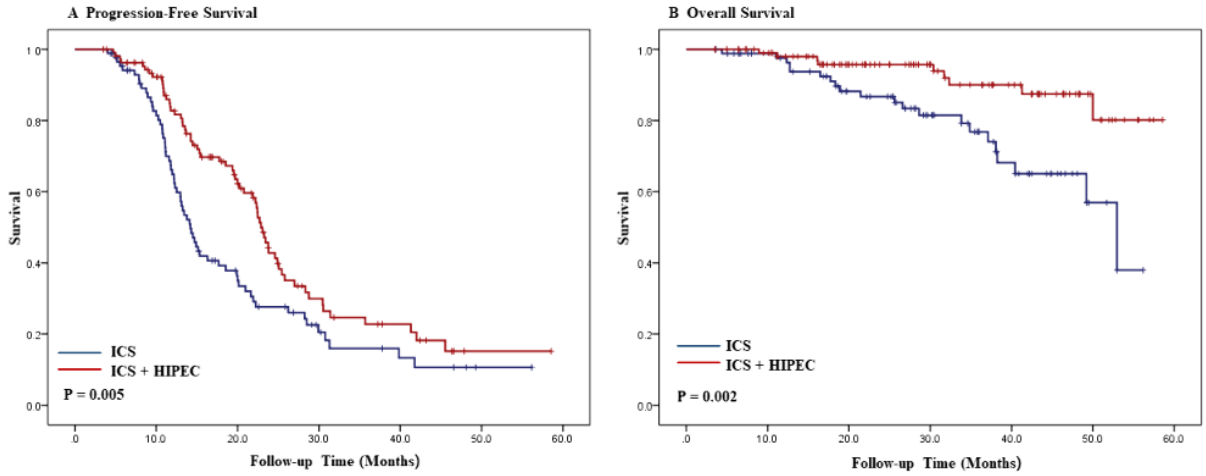
Objectives: The aim of this study was to determine the effectiveness and safety of hyperthermic intraperitoneal chemotherapy (HIPEC) to interval cytoreductive surgery (ICS) in clinical practice

Methods: This is a prospective, multicenter, cohort study, a total of 205 patients were enrolled. 9 patients were excluded, because they did not meet the inclusion criteria. We enrolled stage III/IV ovarian cancer who had at least three cycles of neoadjuvant chemotherapy followed by ICS either with or without HIPEC at seven Korean Gynecologic Oncology Group institutions between 2017 and 2021. The primary end point was progression-free survival (PFS). Overall survival (OS) and safety profile were key secondary endpoint.

Results: 196 patients were included in this trial. 87 patients receive ICS without HIPEC and 109 patients receive ICS with HIPEC. The median duration of follow up was 28.2 months. 128 (65.3%) patients had disease recurrence and 30 (15.3%) patients had died. ICS with HIPEC was associated with significantly improved PFS (22.9 vs. 14.2 months; p = 0.005) and OS (not reached vs. 53.0; p = 0.002), compared with IDS without HIPEC. Grade III/IV postoperative complications were similar in the two groups (p = 1.000). Peritoneal recurrences were more common in ICS without HPEC compared to the ICS with HIPEC (41/64 [64.1%] vs 21/64 [32.8%], p =

0.001].

Figure. Kaplan-Meier curves of progression-free survival and overall survival according to HIPEC (A,B). ICS, interval cytoreductive surgery



Conclusions: The incorporation of HIPEC to IDS resulted in longer PFS and OS than IDS alone without higher rates of side effects in advanced-stage ovarian cancer. Lower rate of peritoneal recurrence after HIPEC might have a prominent impact on OS.