IGCS 2024 Annual Global Meeting DUBLIN
OCTOBER16-18, 2024

IGCS 2024 Abstracts: Late-Breaking Oral Presentations

Late-breaking abstracts selected for oral and short oral presentations are included in the below sessions. The sessions will be recorded for on-demand viewing via the IGCS 360 Educational Portal. The order in this publication is based on the abstract topic. For the exact presentation times, please visit the interactive program from 7:00 am on the day of embargo release.

PLENARY 01: ORAL ABSTRACT PRESENTATIONS
Wednesday, October 16, 9:00 – 10:30 AM | Auditorium

IGCS POSTER TALKS 01
Wednesday, October 16, 2:00 – 3:15 PM | The Liffey B

PLENARY 03: ORAL ABSTRACT PRESENTATIONS
Thursday, October 17, 4:00 – 5:00 PM | Auditorium

PLENARY 04: ORAL ABSTRACT PRESENTATIONS
Friday, October 18, 4:00 – 5:30 PM | Auditorium

LB003 / #1607

PLENARY 03: ORAL ABSTRACT PRESENTATIONS

Topic: *AS03. Cervical Cancer*

ENGOT-CX11/GOG-3047/KEYNOTE-A18: PEMBROLIZUMAB OR PLACEBO WITH CHEMORADIOTHERAPY FOR NEWLY DIAGNOSED, HIGH-RISK, LOCALLY ADVANCED CERVICAL CANCER (LACC): RESULTS FROM INTERIM ANALYSIS 2 FOR PATIENTS ENROLLED IN ASIA

Yang Xiang[1], Kosei Hasegawa[2], Hong Zhu[3], Qi Zhou[4], Xiang Zhang[5], Jung-Yun Lee[6], Tomoka Usami[7], Ekkasit Tharavichitkul[8], Shiro Suzuki[9], Ting-Chang Chang[10], Guonan Zhang[11], Chih-Long Chang[12], Arb-Aroon Lertkhachonsuk[13], Byoung-Gie Kim[14], Kan Li[15], Karin Yamada[15], Sarper Toker[15], Domenica Lorusso[16]
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Introduction: The phase 3 ENGOT-cx11/GOG-3047/KEYNOTE-A18 study (NCT04221945) evaluated pembrolizumab+concurrent chemoradiotherapy (CCRT) followed by pembrolizumab versus placebo+CCRT followed by placebo in patients with high-risk LACC. At interim analysis 1 (IA1), addition of pembrolizumab significantly

improved PFS (HR, 0.70 [95% CI, 0.55–0.89]; *P*=0.0020) with a favorable trend for improved OS (HR, 0.73 [95% CI, 0.49–1.07]) in the intention-to-treat population. We present updated PFS and safety data from IA2 for patients enrolled in Asia.

Methods: Patients had newly diagnosed, high-risk LACC (FIGO 2014 stage IB2-IIB with node-positive disease or stage III-IVA regardless of lymph node status). Patients were randomized (1:1) to receive 5 cycles of pembrolizumab 200mg or placebo Q3W plus CCRT, then 15 cycles of pembrolizumab 400mg or placebo Q6W. CCRT included 5 cycles (optional 6th dose) of cisplatin 40mg/m^2 QW+EBRT, then brachytherapy. Primary endpoints were PFS per RECISTv1.1 by investigator assessment or histopathologic confirmation and OS.

Results: 299 patients were enrolled in Asia (pembrolizumab+CCRT, n=153; placebo+CCRT, n=146). Median follow-up at database cutoff (January 8, 2024) was 31.2 (range, 12.8–43.0) months. Median PFS was not reached in either group; HR favored pembrolizumab+CCRT (0.61 [95% CI, 0.40–0.93]). 24-month PFS rate was 78.3% and 64.2% with pembrolizumab+CCRT and placebo+CCRT, respectively. No grade 5 treatment-related AEs occurred. Grade 3/4 treatment-related AE incidence was 78.9% and 78.1%, respectively. Immune-mediated AE incidence was 46.7% and 15.1% (grade 1/2, 42.1% and 13.7%).

Conclusion/Implications: At IA2, pembrolizumab+CCRT continued to demonstrate PFS benefit versus placebo+CCRT, with manageable safety in patients with high-risk LACC enrolled in Asia.

LB014 / # 1671

PLENARY 01: ORAL ABSTRACT PRESENTATIONS

Topic: *AS03. Cervical Cancer*

CADONILIMAB PLUS CHEMOTHERAPY ± BEVACIZUMAB AS 1L TREATMENT FOR PERSISTENT, RECURRENT, OR METASTATIC CERVICAL CANCER (R/M CC): A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED PHASE 3 STUDY (COMPASSION-16)

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Introduction: Cadonilimab has been approved by China's NMPA for advanced CC as ≥2L treatment in 2022. Here we report the benefit of adding cadonilimab to chemotherapy ± bevacizumab in 1L R/M CC.

Methods: In this randomized, double-blind, placebo-controlled phase 3 trial, 1L R/M CC pts were randomized 1:1 to receive cadonilimab (10mg/kg) or placebo Q3W plus platinum-based chemotherapy ± bevacizumab (15mg/kg) per investigator discretion. Randomization were stratified by the use of bevacizumab (yes/no) and prior CCRT (yes/no). The dual primary endpoints were PFS per RECIST v1.1 assessed by BICR and OS in the ITT population.

Results: 445 pts were randomized to cadonilimab group (n=222) or placebo (n=223) group. The demographic and baseline characteristics were well balanced. 59.6% of pts used bevacizumab and 48.3% received previous CCRT. 116 pts (26.1%) had a PD-L1 CPS<1. As of DCO for the PFS interim analysis (IA) (Sep 4, 2023), the median follow-up time was 17.87 mo. Median PFS was significantly improved by cadonilimab (12.7 vs 8.1 mo, HR 0.62, p<0.0001). As of the DCO for the OS IA (Apr 30, 2024), with median follow-up time of 25.63 mo, median OS was significantly prolonged by cadonilimab (NE vs 22.8 mo, HR 0.64, p=0.0011). The Benefits with cadonilimab were consistent across all predefined subgroups. Grade ≥ 3 TEAEs occurred in 85.4% of pts in cadonilimab group and 80.4% in placebo group.

Conclusion/Implications: Cadonilimab significantly improved PFS and OS with manageable safety profile in patients with 1L R/M CC, which may be a new treatment option for this population.

LB012 / #1602

PLENARY 01: ORAL ABSTRACT PRESENTATIONS

Topic: *AS04. Endometrial/Uterine Corpus Cancers*

ENGOT-EN11/GOG-3053/KEYNOTE-B21: PHASE 3 STUDY OF PEMBROLIZUMAB OR PLACEBO IN COMBINATION WITH ADJUVANT CHEMOTHERAPY WITH OR WITHOUT RADIOTHERAPY IN PATIENTS WITH NEWLY DIAGNOSED, HIGH-RISK ENDOMETRIAL CANCER

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Introduction: The phase 3 ENGOT-en11/GOG-3053/KEYNOTE-B21 study (NCT04634877) evaluated pembrolizumab (versus placebo)+adjuvant chemotherapy (±radiotherapy) in patients with newly-diagnosed, high-risk endometrial cancer (EC) after surgery.

Methods: Patients had histologically-confirmed high-risk (FIGO stage I/II of non-endometrioid histology or endometrioid histology with p53/*TP53* abnormality, or stage III/IVA of any histology) EC with no evidence of disease postoperatively. Patients were randomized to pembrolizumab 200mg or placebo Q3W for 6 cycles plus carboplatin-paclitaxel followed by pembrolizumab 400mg or placebo Q6W for 6 cycles, respectively. At investigator discretion, radiotherapy was administered. Randomization was stratified by MMR status and, within pMMR, by planned radiotherapy, histology, and FIGO (2009) surgical stage. Primary endpoints were investigator-assessed DFS and OS in the intention-to-treat (ITT) population. Analyses of the dMMR subgroup were descriptive without hypothesis testing.

Results: 1095 patients were randomized (pembrolizumab, n=545; placebo, n=550); 281 had dMMR tumors (n=141; n=140). At interim analysis (data cutoff, Mar 4, 2024), HR for DFS was 1.02 (95% CI, 0.79–1.32; *P*=0.570) in the ITT population. In the dMMR subgroup, there were 8 (6%) DFS events (3 recurrences: 1 loco-regional/2 distant) in the pembrolizumab group and 25 (18%) DFS events (23 recurrences: 12 loco-regional/11 distant) in the placebo group (HR, 0.31 [95% CI, 0.14–0.69]); 2-year DFS rates were 92% and 80%, respectively. Grade ≥3 AEs occurred in 79% and 66% of patients in the dMMR subgroup, respectively; no treatment-related grade 5 AEs occurred.

Conclusion/Implications: Adjuvant pembrolizumab+chemotherapy led to clinically meaningful improvement in DFS in patients with dMMR EC with no new safety signals and manageable safety.

LB001 / #1593

PLENARY 01: ORAL ABSTRACT PRESENTATIONS

Topic: *AS04. Endometrial/Uterine Corpus Cancers*

DURVALUMAB PLUS CARBOPLATIN/PACLITAXEL FOLLOWED BY DURVALUMAB WITH/WITHOUT OLAPARIB FOR ENDOMETRIAL CANCER: MISMATCH REPAIR DEFICIENT AND/OR MICROSATELLITE INSTABILITY-HIGH SUBPOPULATION EFFICACY ANALYSES FROM THE DUO-E TRIAL

Els Van Nieuwenhuysen[1], Kathleen Moore[2], Todd Tillmanns[3], Christen Haygood[4], Setsuko K. Chambers[5], Anna Priebe[6], Young Kim[7], Brian Slomovitz[8], Goda Jonuškienė[9], Maria Pilar Barretina-Ginesta[10], Tibor Csőszi[11], Flora Zagouri[12], Jae-Weon Kim[13], Qinglei Gao[14], Fernando Contreras Mejia[15], Andreia Cristina De Melo[16], Tadaaki Nishikawa[17], Matthew Kowgier[18], Ying Wang[19], Shannon N. Westin[20]
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Introduction: The placebo-controlled DUO-E study (NCT04269200) showed statistically significant and clinically meaningful progression-free survival (PFS) benefit with carboplatin/paclitaxel (CP) plus durvalumab followed by durvalumab with/without olaparib versus CP in endometrial cancer (intent-to-treat population; primary endpoints), with the greatest benefit for CP plus durvalumab followed by durvalumab in the mismatch repair deficient (dMMR) subpopulation (prespecified exploratory analysis). Exploratory *post hoc* analyses of PFS in the microsatellite instability (MSI)-high (MSI-H) subpopulation, and combined dMMR and/or MSI-H subpopulation are presented.

Methods: Patients with newly diagnosed stage III/IV or recurrent endometrial cancer were randomized 1:1:1 to CP (CP alone), CP+D (CP plus durvalumab followed by durvalumab), or CP+D+O (CP plus durvalumab followed by durvalumab plus olaparib). MSI status and tumour mutational burden (TMB) were assessed by next-generation sequencing.

Results: There was a 94.5% (95% confidence interval [CI] 91.9–96.2) overall percentage agreement between dMMR and MSI-H status. **Table 1** shows a breakdown of patients by MMR and MSI status. A high frequency of TMB (≥10 mutations/megabase) was observed in dMMR and/or MSI-H tumours. At the primary data cutoff (12 April 2023), PFS benefit with CP+D versus CP was consistent across the dMMR, MSI-H, and combined dMMR and/or MSI-H subpopulations (**Table 2**).

Table 1. The MMR and MSI status of patients from DUO-E at baseline

Characteristics		Intent-to-treat population			
		CP (n=241)	**CP+D** (n=238)	**CP+D+O** (n=239)	**Total** (n=718)
MMR status, %	Proficient	79.7	80.7	79.9	80.1
	Deficient	**20.3**	**19.3**	**20.1**	**19.9**
MSI status (per tissue),* %	**High**	**13.7**	**15.5**	**18.0**	**15.7**
	Equivocal	2.5	3.4	2.9	2.9
	Stable	44.0	42.0	46.4	44.2
	Unknown	39.8	39.1	32.6	37.2

*Overall status is defined as 'High' if ≥0.0124, 'Equivocal' if >0.0041 and <0.0124, and 'Stable' if ≤0.0041.

Table 2. Analyses of PFS in the dMMR and MSI-H subpopulations, and the combined dMMR and/or MSI-H subpopulation

Population	**dMMR** (n=143)			**MSI-H** (n=113)			**dMMR and/or MSI-H** (n=161)		
	CP (n=49)	**CP+D** (n=46)	**CP+D+O** (n=48)	**CP** (n=33)	**CP+D** (n=37)	**CP+D+O** (n=43)	**CP** (n=52)	**CP+D** (n=55)	**CP+D+O** (n=54)
Events, n (%)	25 (51.0)	15 (32.6)	18 (37.5)	21 (63.6)	13 (35.1)	17 (39.5)	28 (53.8)	17 (30.9)	20 (37.0)
Median PFS, months (95% CI)	7.0 (6.7–14.8)	NR (NR–NR)	31.8 (12.4–NR)	6.9 (5.5–13.1)	26.0 (9.7–NR)	31.8 (12.3–NR)	7.0 (6.3–13.5)	NR (NR–NR)	31.8 (13.9–NR)
HR (95% CI) vs CP		**0.42 (0.22–0.80)**	**0.41 (0.21–0.75)**		**0.35 (0.17–0.70)**	**0.31 (0.16–0.60)**		**0.37 (0.20–0.67)**	**0.37 (0.20–0.67)**

At the primary data cutoff (12 April 2023). Medians were estimated by the Kaplan–Meier method; CIs for median PFS were derived via the Brookmeyer Crowley method.

HR, hazard ratio; NR, not reached.

Conclusion/Implications: There was strong concordance between DUO-E dMMR and MSI-H subpopulations. High TMB prevalence observed in dMMR and/or MSI-H tumours supports the hypothesis that they are primed to respond to checkpoint inhibition. *Post hoc* analyses demonstrate consistent clinically meaningful PFS improvement with addition of durvalumab to CP in patients with dMMR and/or MSI-H endometrial cancer.

LB002 / #1594

PLENARY 01: ORAL ABSTRACT PRESENTATIONS

Topic: *AS04. Endometrial/Uterine Corpus Cancers*

DURVALUMAB PLUS CARBOPLATIN/PACLITAXEL FOLLOWED BY DURVALUMAB WITH/WITHOUT OLAPARIB IN ENDOMETRIAL CANCER: EXPLORATORY ANALYSES OF BIOMARKER/HISTOLOGICAL HETEROGENEITY AND EFFICACY IN THE DUO-E MISMATCH REPAIR PROFICIENT SUBPOPULATION

Shannon N. Westin[1], Kathleen Moore[2], Hye Sook Chon[3], Jessica Thomes Pepin[4], Erin Salinas[5], David Starks[6], Paul A. Disilvestro[7], Brian Slomovitz[8], Elen Vettus[9], Fernando Gálvez Montosa[10], Kofi Agyemang-Prempeh[11], Flora Zagouri[12], Jae-Weon Kim[13], Qinglei Gao[14], Fernando Contreras Mejia[15], Andreia Cristina De Melo[16], Tadaaki Nishikawa[17], Matthew Kowgier[18], Sonia Iyer[19], Els Van Nieuwenhuysen[20]
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Introduction: DUO-E (NCT04269200) showed statistically significant progression-free survival (PFS) benefit with carboplatin/paclitaxel (CP) plus durvalumab followed by durvalumab with/without olaparib versus CP alone in endometrial cancer (intent-to-treat population; primary endpoints); addition of olaparib enhanced benefit in the mismatch repair proficient (pMMR) subpopulation. Therefore, we conducted exploratory analyses of biomarkers and histological heterogeneity in the pMMR subpopulation.

Methods: Patients with newly diagnosed stage III/IV or recurrent endometrial cancer were randomized 1:1:1 to CP (CP alone), CP+D (CP plus durvalumab followed by durvalumab), or CP+D+O (CP plus durvalumab followed by durvalumab plus olaparib). In the pMMR subpopulation, prevalence and overlap of biomarker-defined subgroups, and *post hoc* exploratory PFS analyses, were conducted. Subgroups included: PD-L1 status; HRR, *BRCA1/2, POLE* and *TP53* mutation status; and histological subtype.

Results: The pMMR subpopulation included 575 patients (**Table 1**); 486/575 patients had evaluable samples for all biomarkers. The biomarker-known pMMR subpopulation (n=486) was heterogeneous with large overlap of biomarkers; 84% of patients were positive for at least one marker (PD-L1 positive, BRCAm, HRRm, *POLE*m, *TP53*m, serous histology). PD-L1 positive and *TP53*m were the most prevalent biomarker subgroups. PFS benefit was observed across a range of subgroups for the CP+D arm versus CP alone. Addition of olaparib in the CP+D+O arm further enhanced benefit across multiple subgroups (**Table 2**).

Conclusion/Implications: The DUO-E pMMR subpopulation was highly heterogeneous. Exploratory analyses suggest PFS benefit across a range of molecular/histological subgroups for CP plus durvalumab versus CP alone. Addition of olaparib further enhanced this benefit in multiple subgroups including PD-L1 positive, *TP53*m and serous histology.

Table 1. Baseline biomarker and histological characteristics in the pMMR subpopulation*

Characteristic, n (%)		CP (n=192)	CP+D (n=192)	CP+D+O (n=191)	Total (n=575)
PD-L1 status†	Positive, TAP score ≥1%	124 (65)	133 (69)	112 (59)	369 (64)
	Negative, TAP score <1%	67 (35)	53 (28)	73 (38)	193 (34)
	Unknown	1 (1)	6 (3)	6 (3)	13 (2)
HRRm status‡§	HRRm	27 (14)	35 (18)	40 (21)	102 (18)
	Non-HRRm	135 (70)	131 (68)	126 (66)	392 (68)
	Unknown	30 (16)	26 (14)	25 (13)	81 (14)
BRCAm status‡	BRCAm	13 (7)	10 (5)	14 (7)	37 (6)
	Non-BRCAm	149 (78)	156 (81)	152 (80)	457 (79)
	Unknown	30 (16)	26 (14)	25 (13)	81 (14)
*POLE*m and *TP53*m status‡‖	*POLE*m	1 (1)	5 (3)	5 (3)	11 (2)
	*TP53*m	90 (47)	101 (53)	89 (47)	280 (49)
	TP53 wild-type	71 (37)	60 (31)	72 (38)	203 (35)
	Unknown	30 (16)	26 (14)	25 (13)	81 (14)
Histology type at diagnosis	Endometrioid	98 (51)	108 (56)	107 (56)	313 (54)
	Serous	52 (27)	56 (29)	42 (22)	150 (26)
	Other	42 (22)	28 (15)	42 (22)	112 (19)

Percentages may not total 100% due to rounding. *MMR status evaluated using the Ventana® MMR RxDx panel (Roche Diagnostics, Rotkreuz, Switzerland); †PD-L1 expression evaluated using Ventana SP263. PD-L1 positive defined as TAP ≥1%, PD-L1 negative defined as TAP <1%; ‡Status determined retrospectively in two ways: from tissue samples (FoundationOne®CDx assay; Foundation Medicine, Inc.), and by molecular profiling of ctDNA (FoundationOne®Liquid CDx; Foundation Medicine, Inc.) from blood samples; §Positive HRRm status defined as a sample with a deleterious or suspected deleterious mutation in any of the following prespecified genes: *ATM, BRCA1, BRCA2, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, RAD51B, RAD51C, RAD51D*, and *RAD54L*; negative HRRm status (non-HRRm) defined as a sample with no deleterious or suspected deleterious mutations in any of the prespecified genes; and unknown HRRm status included patients recruited in China, where HRR testing was not performed, and who withdrew consent or due to sample unavailability; ‖*TP53*m status defined as a sample with a deleterious or suspected deleterious mutation in *TP53* excluding samples with a deleterious or suspected deleterious mutation in *POLE*; *TP53* wild-type status defined as a sample with no deleterious or suspected deleterious mutation in *TP53* excluding samples with a deleterious or suspected deleterious mutation in *POLE*; and unknown *TP53*m status included patients recruited in China, where *TP53* and/or *POLE* testing was not performed, and who withdrew consent or due to sample unavailability.

BRCAm, *BRCA1* and/or *BRCA2* mutation; ctDNA, circulating tumour DNA; HRRm, homologous recombination repair mutation; NGS, next-generation sequencing; PD-L1, programmed death-ligand 1; *POLE*m, DNA polymerase epsilon, catalytic subunit mutation; TAP, tumour area positivity; *TP53*m, tumour protein 53 mutation.

Table 2. PFS events and HRs in the pMMR subpopulation*

		CP (n=192)	CP+D (n=192)		CP+D+O (n=191)	
		Events n/N (%)	Events n/N (%)	HR (95% CI) vs CP	Events n/N (%)	HR (95% CI) vs CP
All pMMR patients		148/192 (77)	124/192 (65)	0.77 (0.60–0.97)	108/191 (57)	0.57 (0.44–0.73)
PD-L1 status†	Positive, TAP score ≥1%	94/124 (76)	85/133 (64)	0.71 (0.53–0.95)	54/112 (48)	0.44 (0.31–0.61)
	Negative, TAP score <1%	53/67 (79)	35/53 (66)	0.95 (0.61–1.45)	52/73 (71)	0.87 (0.59–1.28)
	Unknown	1/1 (100)	4/6 (67)	NC (NC–NC)	2/6 (33)	NC (NC–NC)
HRRm status‡§	HRRm	22/27 (81)	16/35 (46)	0.45 (0.23–0.87)	22/40 (55)	0.47 (0.26–0.86)
	Non-HRRm	105/135 (78)	89/131 (68)	0.82 (0.61–1.08)	72/126 (57)	0.58 (0.43–0.78)
	Unknown	21/30 (70)	19/26 (73)	1.05 (0.56–1.96)	14/25 (56)	0.74 (0.37–1.45)
BRCAm status‡	BRCAm	11/13 (85)	4/10 (40)	NC (NC–NC)	7/14 (50)	NC (NC–NC)
	Non-BRCAm	116/149 (78)	101/156 (65)	0.77 (0.59–1.00)	87/152 (57)	0.57 (0.43–0.75)
	Unknown	21/30 (70)	19/26 (73)	1.05 (0.56–1.96)	14/25 (56)	0.74 (0.37–1.45)
*POLE*m and *TP53*m status‡‖	*POLE*m	0/1 (0)	0/5 (0)	NC (NC–NC)	1/5 (20)	NC (NC–NC)
	*TP53*m	73/90 (81)	69/101 (68)	0.80 (0.57–1.11)	52/89 (58)	0.47 (0.32–0.67)
	TP53 wild-type	54/71 (76)	36/60 (60)	0.69 (0.44–1.04)	41/72 (57)	0.71 (0.47–1.07)
	Unknown	21/30 (70)	19/26 (73)	1.05 (0.56–1.96)	14/25 (56)	0.74 (0.37–1.45)
Histology type at diagnosis	Endometrioid	71/98 (72)	61/108 (56)	0.74 (0.52–1.04)	56/107 (52)	0.60 (0.42–0.85)
	Serous	43/52 (83)	40/56 (71)	0.76 (0.49–1.18)	24/42 (57)	0.46 (0.27–0.76)
	Other	34/42 (81)	23/28 (82)	0.93 (0.54–1.58)	28/42 (67)	0.64 (0.38–1.06)

The HR and CI are estimated from an unstratified Cox proportional hazards model.

*MMR status evaluated using the Ventana® MMR RxDx panel (Roche Diagnostics, Rotkreuz, Switzerland); †PD-L1 expression evaluated using Ventana SP263. PD-L1 positive defined as TAP ≥1%, PD-L1 negative defined as TAP <1%; ‡Status determined retrospectively in two ways: from tissue samples (FoundationOne®CDx assay; Foundation Medicine, Inc.), and by molecular profiling of ctDNA (FoundationOne®Liquid CDx; Foundation Medicine, Inc.) from blood samples; §Positive HRRm status defined as a sample with a deleterious or suspected deleterious mutation in any of the following prespecified genes: *ATM, BRCA1, BRCA2, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, RAD51B, RAD51C, RAD51D*, and *RAD54L*; negative HRRm status (non-HRRm) defined as a sample with no deleterious or suspected deleterious mutations in any of the prespecified genes; and unknown HRRm status included patients recruited in China, where HRR testing was not performed, and who withdrew consent or due to sample unavailability; ‖*TP53*m status defined as a sample with a deleterious or suspected deleterious mutation in *TP53* excluding samples with a deleterious or suspected deleterious mutation in *POLE*; *TP53* wild-type status defined as a sample with no deleterious or suspected deleterious mutation in *TP53* excluding samples with a deleterious or suspected deleterious mutation in *POLE*; and unknown *TP53*m status included patients recruited in China, where *TP53* and/or *POLE* testing was not performed, and who withdrew consent or due to sample unavailability.

CI, confidence interval; HR, hazard ratio; NC, not calculated (due to low event numbers).

LB011 / #1557

Topic: *AS04. Endometrial/Uterine Corpus Cancers*

PLENARY 01: ORAL ABSTRACT PRESENTATIONS

BENMELSTOBART (TQB2450) ALONE OR COMBINED WITH ANLOTINIB IN PREVIOUSLY TREATED ADVANCED ENDOMETRIAL CANCER: UPDATED RESULTS FROM A MULTICOHORT, OPEN-LABEL, MULTICENTER PHASE II CLINICAL TRIAL TQB2450-II-08

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Introduction: The TQB2450-II-08 (NCT04574284) study aims to evaluate the efficacy and safety of benmelstobart alone or combined with anlotinib in patients with advanced Endometrial Cancer (EC). Here, we reported the updated safety and efficacy data for stage 2 of cohort 1.

Methods: Patients with pathologically confirmed advanced, recurrent or metastatic EC failed at 1 or 2 prior lines of platinum-based chemotherapy were enrolled. In cohort 1, non-MSI-H/dMMR patients received benmelstobart (1200 mg IV D1/Q3W) + anlotinib (12 mg PO QD D1-14/Q3W) until disease progression or intolerable toxicity. Cohort 1 was carried out in 2 stages. The study would progress to stage 2 if 8 or more of the 22 patients achieved CR/PR in stage 1. Additional 85 patients would be enrolled in stage 2. The primary endpoint was ORR by IRC. The secondary endpoints included ORR by investigator, DCR, DoR, PFS, OS and safety.

Results: At data cutoff (May 9, 2024), 85 patients were enrolled in stage 2 of cohort 1 (22 patients in stage 1 with 8 achieved PR), the median age was 60.0 years, 80.0% were endometrioid carcinoma. The confirmed ORR by IRC was 34.12%. The mPFS and mOS was 8.80 months (95%CI 5.75, 15.18) and 21.78 months (95%CI 19.48, 29.14). The safety analysis includes all patients of cohort 1 (n=107). The most common any-grade TEAEs were hypertension, hypothyroidism and weight loss. The incidence of grade ≥3 TEAEs were 77.57%.

Conclusion/Implications: Benmelstobart plus anlotinib showed promising antitumor activity with a manageable safety profile in the treatment of recurrent or metastatic EC.

LB010 / #1590

IGCS POSTER TALKS 01

Topic: *AS10. Ovarian Cancer*

A PHASE 2 RANDOMIZED DOSE OPTIMIZATION TRIAL OF GOTISTOBART, A PH-SENSITIVE ANTI-CTLA-4, IN COMBINATION WITH PEMBROLIZUMAB IN PLATINUM-RESISTANT OVARIAN CANCER (PROC, PRESERVE-004/GOG-3081; NCT05446298)

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Introduction: Gotistobart (ONC-392/BNT316) is a humanized anti-CTLA-4 mAb that preserves CTLA-4 immune checkpoint activity by avoiding lysosomal degradation. The safety and clinical activity of gotistobart monotherapy in ovarian cancer was previously reported. We report safety and efficacy results of gotistobart+pembrolizumab in an ongoing randomized, open-label, multicenter phase 2 trial in patients with PROC.

Methods: Patients with platinum-resistant high-grade serous OC, tubal or peritoneal cancer who previously received 1 line of platinum-based therapy and progressed between 3-6 months, or received ≥1 line and progressed within 6 months of last dose, were randomized 1:1 to receive different doses of gotistobart+pembrolizumab 200 mg, Q3W. Primary endpoints are ORR (RECIST 1.1) and safety. Secondary endpoints include PFS and OS.

Results: As of May 24, 2024, 83 patients had received ≥1 dose of gotistobart+pembrolizumab with 33 and 29 patients in 1 mg/kg and 2 mg/kg gotistobart+pembrolizumab groups, respectively. At the safety and efficacy cutoff date of May 10, 2024, with a median follow-up of 2.1 months (range 0.1-9.2), grade≥3 treatment-related adverse events (TRAEs) were observed in 35.7% and 31.0% patients

in 1 mg/kg or 2 mg/kg groups, respectively (Table 1). No grade 5 TRAEs were observed. Common grade 3 TRAEs from combined groups were ALT increased (7.0%), AST increased (7.0%) and diarrhea (5.3%). Unconfirmed ORR was 31.8% (7/22; 95% CI 13.9-54.9) and 36.4% (8/22; 95% CI 17.2-59.3) in 1 mg/kg and 2 mg/kg groups, respectively (Table 1).

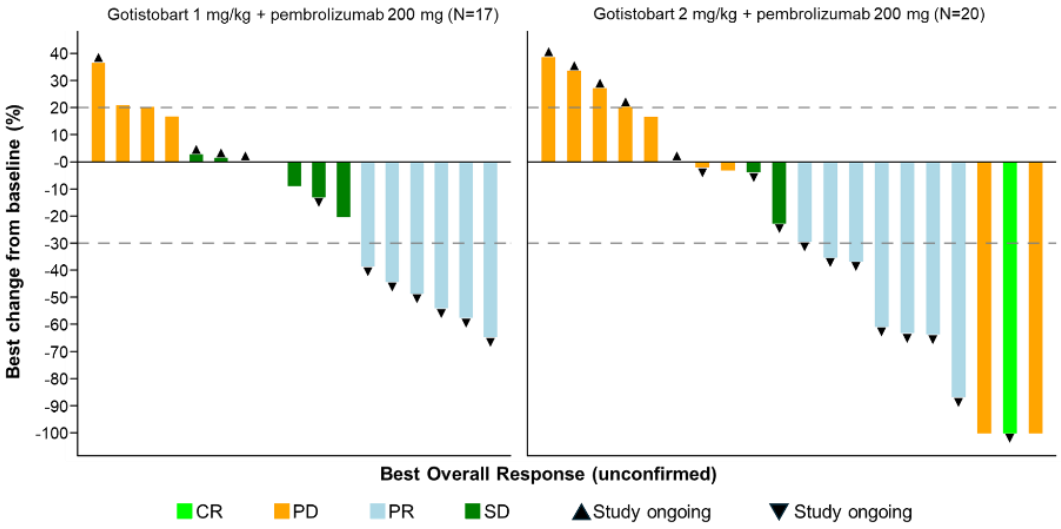
Conclusion/Implications: Early results show encouraging safety and clinical activity in PROC patients receiving gotistobart+pembrolizumab.

Table 1. Patient characteristics, safety profile and efficacy summary

Dose Level Gotistobart + 200 mg Pembrolizumab Q3W	**1 mg/kg**	**2 mg/kg**
Demographics and baseline characteristics		
Number of patients treated	28	29
Median age (Range)	64.5 (44-87)	65.0 (45-78)
Race (White/Black/Asian/Other)	22/1/2/3	25/2/1/1
ECOG score, N (%)		
ECOG = 0	17 (60.7)	15 (51.7)
ECOG = 1	11 (39.3)	14 (48.3)
With metastatic lesions	20 (71.4)	24 (82.8)
Safety Data (cutoff date: 10MAY2024)		
Treatment cycles, Mean (Range)	3.6 (1-9)	3.4 (1-9)
Treatment duration in months, Mean (Range)	2.71 (0.1-7.6)	2.55 (0.3-7.1)
Any TEAEs, N (%)	25 (89.3)	26 (89.7)
TRAEs: All grades, N (%)	21 (75.0)	20 (69.0)
TRAEs: Grade ≥ 3, N (%)	10 (35.7)	9 (31.0)
irAE All grades, N (%)	11 (39.3)	13 (44.8)
irAE: Grade ≥ 3, N (%)	5 (17.9)	8 (27.6)
TRAE leading to study drug discontinuation	4 (14.3)	3 (10.3)
Preferred Term (>3% in combined groups)	**Gr ≥ 3 TRAE N (%)**	**Gr ≥ 3 TRAE N (%)**
Diarrhea	3 (10.7)	0
Colitis	0	2 (6.9)
Increased AST	3 (10.7)	1 (3.4)
Increased ALT	3 (10.7)	1 (3.4)
Adrenal Insufficiency	1 (3.6)	1 (3.4)
Efficacy Data (cutoff date: 10MAY2024)		
Efficacy-evaluable population	22	22
Unconfirmed ORR, N (%)	7 (31.8)	8 (36.4)
CR	1 (4.5)	1 (4.5)
PR	6 (27.3)	7 (31.8)
SD	6 (27.3)	2 (9.0)
PD*	9 (40.9)	12 (54.5)

*PD included those without post baseline disease assessment

Figure 1. Waterfall plot of best change in tumor burden and best overall response*



*Includes patients with baseline and at least one evaluable post baseline tumor measurement

LB008 / #180

IGCS POSTER TALKS 01

Topic: *AS10. Ovarian Cancer*

KGOG3056/NIRVANA-R TRIAL: EFFICACY OF MAINTENANCE NIRAPARIB RECHALLENGE PLUS BEV ACCORDING TO MINIMAL RESIDUAL DISEASE (MRD) ASSESSMENT IN PATIENTS WITH PLATINUM-SENSITIVE, RECURRENT OVARIAN CANCER PREVIOUSLY TREATED WITH A PARP INHIBITOR

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Introduction: Given the expanding clinical use of PARP inhibitor, there is a significant need for optimal strategies with which to treat patients whose cancer progresses while using a PARPi.

Methods: This is a multi-center, single-arm, phase 2 study (NCT04734665) evaluating niraparib and bevacizumab maintenance in patients with platinum-sensitive recurrent ovarian cancer (PSROC) who received at least 2 prior platinum-containing therapy and had been treated with a PARPi. Patients who had responded to the last platinum regimen were eligible to participate in this study. The primary endpoint is a 6-month progression-free survival (PFS) rate. A total of forty-four patients were recruited. Minimal residual disease (MRD) status from baseline circulating tumor DNA (ctDNA) were assessed by whole-exome sequencing.

Results: Most of the patients (93.2%) had high-grade serous carcinoma. After interim analysis of the first stage, the efficacy boundary to proceed to the second stage was met (6-month PFS rate 66.5%). We will report efficacy outcomes from the primary analysis (date cutoff June 2024), including 6-month PFS rate, PFS, and OS, in the overall population. A table will provide detail of results according to MRD status, BRCA status, platinum-free interval, and response of latest chemotherapy. Adverse events (AEs), dose modifications, and discontinuations will be reported. Genomic mechanisms of PARPi resistance will be reported.

Conclusion/Implications: This is the first report of niraparib and bevacizumab as a maintenance therapy in PSROC patients previously treated with a PARPi. This study is expected to demonstrate that doublet maintenance is a potential new treatment option for patients previously treated with a PARPi.

LB006 / #1568

PLENARY 04: ORAL ABSTRACT PRESENTATIONS

Topic: *AS10. Ovarian Cancer*

NEOADJUVANT NIRAPARIB MONOTHERAPY IN HOMOLOGOUS RECOMBINATION DEFICIENCY-POSITIVE ADVANCED OVARIAN CANCER: A PROSPECTIVE, MULTICENTER, SINGLE-ARM, PHASE II STUDY (NANT)

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Introduction: PARP inhibitors have been widely used as maintenance therapy in ovarian cancer management. However, their potential as neoadjuvant therapy remains unclear. Here, we report the activity and safety of neoadjuvant niraparib (NANT) monotherapy in homologous recombination deficiency (HRD)-positive high-grade serous ovarian cancer (HGSOC), and investigate cell clusters that associate with response to niraparib.

Methods: Key eligibility: patients with newly diagnosed FIGO III/IV HRD-positive HGSOC and low likelihood of optimal cytoreduction or poor surgical candidates. Enrolled patients received daily oral niraparib (200 or 300 mg) for two 28-day cycles. The co-primary endpoints were objective response rate (ORR) and R0 resection rate. Cell clusters were profiled by scRNA-seq and mIHC.

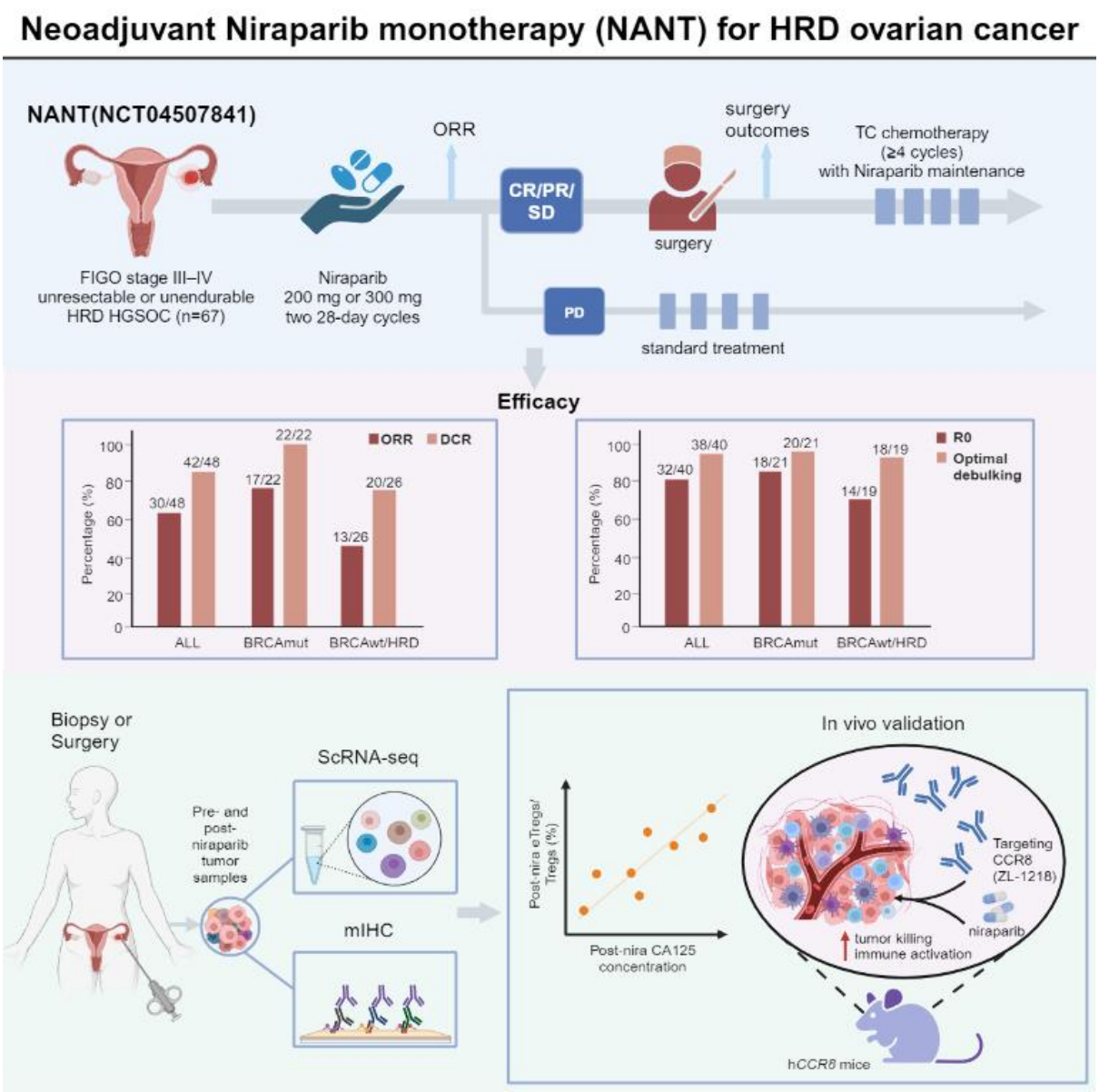
Results: Between January 18, 2021 and July 18, 2023, 67 patients received NANT monotherapy, 48 patients completed response evaluations, and 40 patients underwent interval debulking surgery. The ORR was 62.5% (30 PRs; Table). The R0 resection rate was 80.0% (*n*=32). The GCIG CA125 response rate was 79.2% (*n*=38). The prevalence of CRS 3, 2, and 1 was 17.9%, 51.3%, and 30.8%, respectively. No new safety signal was observed. Grade ≥3 treatment-related adverse events occurred in 61.2% (*n*=41) of patients. Post-treatment eTreg cell proportion was positively correlated with CA125

concentrations and targeting eTreg cells using anti-CCR8 antibody (ZL-1218) potentiated niraparib in preclinical models (Figure).

Table. Summary of response, surgical, and pathological assessments

	All (*n*=48)	*BRCA*$_{mut}$ (*n*=22)	*BRCA*$_{wt}$/HRD-positive (*n*=26)
RECIST v1.1 response			
Partial response	30 (62.5%)	17 (77.3%)	13 (50.0%)
Stable disease	12 (25.0%)	5 (22.7%)	7 (26.9%)
Progressive disease	6 (12.5%)	0 (0.0%)	6 (23.1%)
Objective response rate (95% CI)	62.5% (47.4%–76.0%)	77.3% (54.6%–92.2%)	50.0% (29.9%–70.1%)
	All (*n*=40)	*BRCA*$_{mut}$ (*n*=21)	*BRCA*$_{wt}$/HRD-positive (*n*=19)
Residual disease			
R0	32 (80.0%)	18 (85.7%)	14 (73.7%)
R1	6 (15.0%)	2 (9.5%)	4 (21.1%)
R2	2 (5.0%)	1 (4.8%)	1 (5.3%)
R0 resection rate (95% CI)	80.0% (64.4%–90.9%)	85.7% (63.7%–97.0%)	73.7% (48.8%–90.9%)
	All (*n*=48)	*BRCA*$_{mut}$ (*n*=22)	*BRCA*$_{wt}$/HRD-positive (*n*=26)
GCIG CA125 response			
Response	38 (79.2%)	19 (86.4%)	19 (73.1%)
Non-response	10 (20.8%)	3 (13.6%)	7 (26.9%)
CA125 response rate (95% CI)	79.2% (65.0%–89.5%)	86.4% (65.1%–97.1%)	73.1% (52.2%–88.4%)
Chemotherapy response score	3	2	1
number (%, 95% CI)	7 (17.9%, 7.5%–33.5%)	20 (51.3%, 34.8%–67.6%)	12 (30.8%, 17.0%–47.6%)

The percentages were rounded and the sum might not add up to 100.0%. Abbreviations: *BRCA*$_{mut}$, *BRCA1/2* mutations. *BRCA*$_{wt}$, wild-type *BRCA1/2*. HRD, homologous recombination deficiency. RECIST v1.1, Response Evaluation Criteria in Solid Tumors (version 1.1). 95% CI, 95% confidence interval. GCIG, Gynecological Cancer Intergroup. CRS, chemotherapy response score.



Conclusion/Implications: NANT monotherapy achieved encouraging clinical activity and tolerable toxicities in HRD-positive HGSOC, offering an alternative option for patients unwilling to receive or unable to tolerate neoadjuvant chemotherapy (NANT study/NCT04507841). Niraparib plus anti-CCR8 antibodies is a promising combination strategy for HRD-positive HGSOC.

LB005 / #1605

PLENARY 04: ORAL ABSTRACT PRESENTATIONS

Topic: *AS10. Ovarian Cancer*

RANDOMIZED, PHASE II/III STUDY OF PEGYLATED LIPOSOMAL DOXORUBICIN, BEVACIZUMAB, AND ATEZOLIZUMAB IN PLATINUM-RESISTANT OVARIAN CANCER (NRG-GY009): CLINICAL OUTCOMES BY PD-L1 AND T CELL INFILTRATION STATUS

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Introduction: NRG-GY009 was a randomized clinical trial of pegylated liposomal doxorubicin (PLD), bevacizumab (BEV), and atezolizumab (ATEZO) and PLD/ATEZO compared to PLD/BEV in patients with platinum-resistant ovarian cancer (PROC) (n=444). Addition of ATEZO to PLD/BEV did not result in a statistically significant

prolongation of progression-free survival or overall survival (OS). Here, we present interaction/subgroup analyses by baseline tumor PD-L1 expression and tumor infiltrating lymphocyte (TIL) status.

Methods: Archival tumor samples were analyzed for immune cell PD-L1 and CD8 infiltration using Ventana SP142 and CD8 IHC assays, respectively. Outcomes were examined by PD-L1 status using 5% or 1% as cutoffs, CD8 status using quartiles, and TIL status using tertiles. Log-rank and Cox models were used to assess the relationships between the individual biomarkers and PFS/OS.

Results: Baseline tissue was analyzed from PLD/BEV/ATEZO (n=131), PLD/ATEZO (n=105), and PLD/BEV (n=134) patients, yielding PD-L1≥5% and PD-L1≥1% in 45 and 169 patients, respectively. Patients in the PD-L1<1% group who received PLD/BEV/ATEZO exhibited prolonged PFS (HR 0.55, 95% CI 0.391-0.784) and OS (HR 0.66, 95% CI 0.458-0.940) when compared to PLD/BEV. No significant differences were noted between the treatment arms in the PD-L1≥1% group. When examining CD8+ T cell TIL status, no significant associations were observed between the presence of immune cells and clinical outcomes.

Conclusion/Implications: In this exploratory analysis, patients with PD-L1<1% tumors demonstrated improved PFS/OS when treated with PLD/BEV/ATEZO when compared to PLD/BEV, highlighting the unreliability of PD-L1 as a biomarker in PROC. Identification of immune biomarkers relevant to PROC remains an unmet need.

LB013 / #1571

PLENARY 03: ORAL ABSTRACT PRESENTATIONS

Topic: *AS14. Pre-Invasive Disease*

ADJUVANT VACCINATION AGAINST HPV IN SURGICAL TREATMENT OF CIN LESIONS: RESULTS OF THE VACCIN-STUDY, A RANDOMISED PLACEBO-CONTROLLED TRIAL

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Introduction: Loop Electrosurgical Excision Procedure (LEEP) is considered the gold standard for treating high-grade cervical dysplasia (CIN II-III), but the risk of recurrence persists. HPV vaccines are highly effective for primary prevention of HPV-naive women. Evidence from retrospective studies exploring adjuvant HPV vaccination to reduce recurrent CIN lesions is limited and primarily not designed for this question. No prospective trial has explored this question so far. Adjuvant vaccination may enhance immune response, protect against new HPV infections and reduce the risk of recurrent CIN lesions and treatment.

Methods: Women treated with LEEP for primary CIN II or III were randomised to receive three injections with nonavalent HPV vaccine or physiological salt solution (placebo), double-blind placebo-controlled. The primary outcome was CIN II or CIN III recurrence rate 24 months after treatment. Secondary outcomes included recurrence rates at different time points, HPV presence, Pap-smear results, cost-effectiveness and quality-of-life. To reduce recurrence from 8% to 3%, power calculation required 750 women. (Trial-Registration-NL7938)

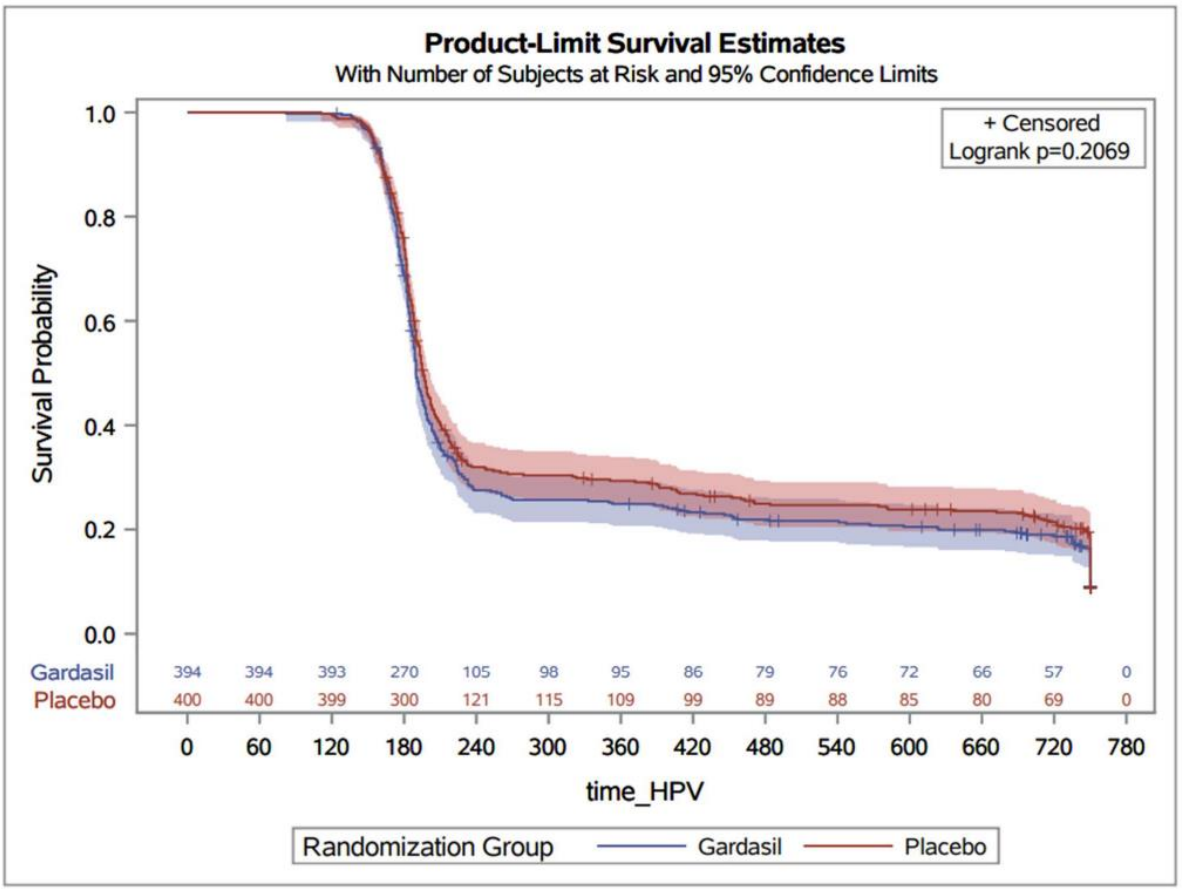
Results: From December 2019 to February 2022, 840 patients were recruited. Thirty-one were excluded, leaving 809 patients vaccinated. Four hundred-two received an HPV-vaccine, and 407 received a placebo-vaccine. In the follow-up period after 24 months, recurrences of CIN II and III were respectively 23 (5.7%) versus 34 (8.3%), RR 0.67, 0.40-1.11) p=0.11. (table 1). HPV positivity during follow-up was 127 patients (31.6%) in the HPV-vaccination group versus 148 patients (36.4%) in the placebo group (p=0.12).

Conclusion/Implications: Routinely administering additional HPV vaccination in women treating for CIN II of CIN III is not effective and should not be recommended.

Outcomes during 24 months follow-up	Placebo N=407 (%)	Nonavalent HPV vaccine N=402 (%)	Rel. risk (95% CI%)	p-value
CIN grade II or III (prim. outcome)	35 (8.6%)	23 (5.8%)	0.67 (0.40 – 1.11)	0.11
Pathology, highest grade diagnosed				
No CIN	283 (69.5)	282 (69.9)	1.00 (ref.)	-
CIN 1 (LSIL)	15 (3.7)	15 (3.7)	1.00 (0.50 – 2.02)	0.99
CIN 2 (HSIL)	16 (3.9)	10 (2.5)	0.64 (0.30 – 1.39)	0.25
CIN 3 (HSIL)	19 (4.7)	13 (3.2)	0.70 (0.35 – 1.39)	0.31
AIS / carcinoma	1 (0.3)	2 (0.5)	2.00 (0.18 - 54.4)	1.00*
Histology not obtained at 24 months	42 (10.3)	53 (13.2)	1.27 (0.87 – 1.85)	0.22
PAP 1 HPV unknown	14	24		
PAP 1 HPV positive	19	18		
PAP 2 HPV positive/unknown	3	3		
PAP 2 HPV negative	4	4		
PAP 3a1 HPV negative	0	1		
PAP 3a1 HPV positive	1	3		
PAP 3a2 HPV negative	1	0		
Loss follow-up	26 (6.4)	20 (5.0)	0.77 (0.42 - 1.41)	0.40
Loss FU: PAP 1, HPV neg at 6-<24 m	15	18		
Loss FU: PAP 1, HPV pos/unknown at 6-< 24m	7	0		
Loss FU: no other data	4	2		
Not done of AIS/carcinoma at start	4	3		
Hysterectomy other reason CIN	1	4		
HPV-status during 24 months follow-up				
Negative	281 (69.0)	274 (68.1)	1.00 (ref.)	-
Positive	148 (36.4)	127 (31.6)	0.87 (0.72 – 1.05)	0.15
Missing	6 (1.5)	6 (1.5)	n/c	-
Highest cytology during follow-up:				
PAP1 (NILM)	298 (73.2)	311 (77.4)	1.00 (ref.)	-
PAP2 (ASC-US)	45 (11.1)	37 (9.2)	0.81 (0.54 – 1.22)	0.31
PAP 3A1 (LSIL)	18 (4.4)	17 (4.2)	0.91 (0.48 – 1.73)	0.77
PAP 3A2 (HSIL)	25 (6.1)	22 (5.5)	0.85 (0.49 – 1.48)	0.57
PAP 3B (HSIL)	15 (3.7)	10 (2.5)	0.65 (0.30 – 1.43)	0.28
≥ PAP 4 (>AIS/HSIL)	0 (0.0)	0 (0.0)	n/c	-
Missing	6 (1.5)	5 (1.2)	n/c	-
Additional treatment during follow-up for CIN				
Hysterectomy/portio amputation (1)	6 (1.5)	3 (0.5)	0.51 (0.10 – 2.13)	0.51*
Second LEEP**	35 (8.5)	30 (7.5)	0.87 (0.56 – 1.39)	0.57
Topical imiquimod	1 (0.2)	0 (0.0)	n/c	-
Additional colposcopy during follow-up (not at 24m)	54 (13.3)	41 (10.2)	0.79 (0.54 - 1.15)	0.22
Vaccination scheme				
complete	392 (96.3)	389 (96.8)		
two vaccinations	5 (1.2)	4 (1.0)		
one vaccination	10 (2.5)	9 (2.2)		

* Fisher's exact test

Time to HPV negative test



LB009 / #1562

IGCS POSTER TALKS 01

Topic: *AS16. Rare Tumors*

A PHASE II TRIAL OF PEMBROLIZUMAB AND LENVATINIB IN RECURRENT OR PERSISTENT CLEAR CELL OVARIAN CARCINOMA (NCT05296512): STAGE 1 RESULTS

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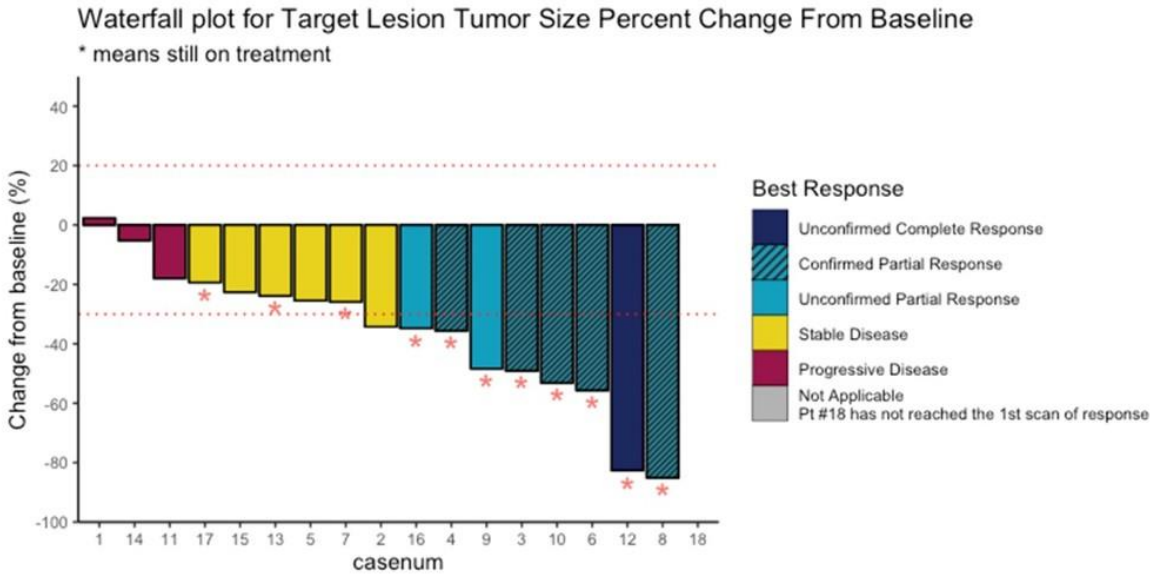
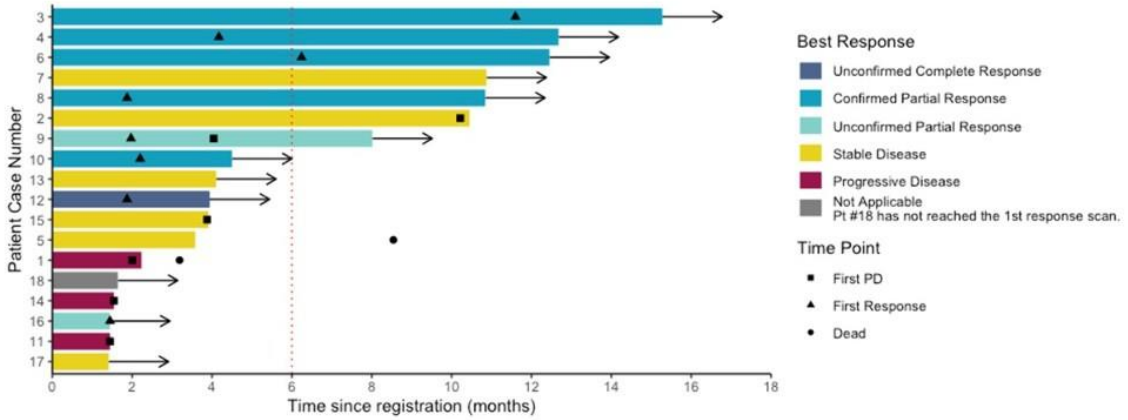
Introduction: Clear cell ovarian carcinoma (CCOC) is a chemoresistant subtype of ovarian cancer. Given clinical evidence of immune checkpoint inhibitor activity in CCOC and molecular alterations suggesting a role for anti-angiogenic agents, we conducted a single-arm two-stage phase 2 investigator-initiated trial of pembrolizumab/lenvatinib in patients (pts) with CCOC (NCT05296512). Here we present the results of stage 1.

Methods: Pts with CCOC and measurable disease received pembrolizumab 200mg IV every 3 weeks and lenvatinib 20mg daily. Co-primary endpoints were objective response rate and rate of PFS at 6 months (mo) per RECIST 1.1. Two objective responses or 3 pts progression-free and alive at 6 mo was needed to proceed from stage 1 (n=18) to stage 2 (n=13). Data cut-off occurred 16-April-2024.

Results: Of 18 pts in stage 1, 88.9% were Caucasian and 5.6% were Asian, with a median age of 54.2 years. 44% (8/18) of pts achieved a response (1 CR, 7 PR); 11.1% (2/18) achieved SD≥6 mo. Median PFS was not reached. Estimated PFS at 6 mo was 65.52% (95% CI 35.29%-84.23%). The criteria to proceed to stage 2 were met. The most common treatment-related AEs were hypertension (73%), hypothyroidism (67%), and fatigue (56%).





Conclusion/Implications: Pembrolizumab/lenvatinib demonstrated encouraging preliminary evidence of clinical activity in CCOC, with 8 of 18 pts enrolled in stage 1 of this trial experiencing a response, meeting criteria to proceed to stage 2 of enrollment. There were no new safety signals. Enrollment to stage 2 is ongoing.

LB007 / #1548

PLENARY 03: ORAL ABSTRACT PRESENTATIONS

Topic: *AS16. Rare Tumors*

EFFICACY AND SAFETY OF AVUTOMETINIB ± DEFACTINIB IN RECURRENT LOW GRADE SEROUS OVARIAN CANCER: PRIMARY ANALYSIS OF ENGOT-OV60/GOG-3052/RAMP 201

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Introduction: Low grade serous ovarian cancer (LGSOC) is a rare, clinically distinct cancer commonly driven by RAS/MAPK pathway alterations. Avutometinib ([A] oral

RAF/MEK clamp) + defactinib ([D] oral FAK inhibitor) is being investigated in recurrent LGSOC. We report the primary analysis of A±D from RAMP 201.

Methods: Patients with recurrent, measurable LGSOC after at least one line of platinum chemotherapy were enrolled. Patients were randomized to A (4.0mg BIW) monotherapy or A (3.2mg BIW) + D (200mg BID). A+D was selected for expansion. Subsequently a 1.6mg dose of A +D was evaluated. The primary endpoint is ORR per RECISTv1.1 by BICR.

Results: At the 30June2024 visit cutoff, 115 patients were enrolled to A (3.2mg BIW) + D (200mg BID). Median age was 54 (range, 21-87) and patients had a median of 3 (range, 1-9) prior lines of therapy. Prior therapies included endocrine (86%), bevacizumab (51%), and MEK inhibitor (22%). Confirmed ORR of 31% was observed (44% *KRAS* mt; 17% *KRAS* wt); median DOR, 31.1mo and median PFS, 12.9mo. The most common non-laboratory treatment-related AEs (all grades, grade ≥3) were nausea (67.0%, 2.6%) and diarrhea (58.3%, 7.8%). The most common laboratory abnormality was increased blood creatinine phosphokinase (60.0%, 24.3%). Discontinuations due to AEs were infrequent (10%). Results from all cohorts will be presented.

Conclusion/Implications: A+D was well tolerated allowing prolonged exposure to therapy. ORR and durable responses observed are clinically meaningful in this heavily pretreated population and support the potential of A+D as a new standard of care for recurrent LGSOC.

Efficacy in RAMP 201 for Avutometinib + Defactinib by BICR*

Endpoint	Total N=109	KRAS mt N=57	KRAS wt N=52
Confirmed ORR, (95% CI)	31% (23, 41)	44% (31, 58)	17% (8, 30)
DOR, median (95% CI)	31.1 mo (14.8, 31.1)	31.1 mo (14.8, 31.1)	9.2 mo (5.5, NE)
PFS, median (95% CI)	12.9 mo (10.9, 20.2)	22 mo (11.1, 36.6)	12.8 (7.4, 18.4)
DCR ≥6 months	61%	70%	50%

Minimum 9.5 mo follow-up for 115 enrolled; ≥12 mo for 113 patients.

*Evaluable patients defined as all treated patients with measurable disease. Data summarized for patients receiving A (3.2 mg BIW) + D (200mg BID), 3 weeks on / 1 week off (includes patients in Parts A, B, and C).