IGCS 2024 Annual Global Meeting DUBLIN
OCTOBER16-18, 2024

IGCS 2024 Abstracts:

Seminal Abstract Presentations (Plenary Sessions)

Seminal abstract presentations are included in the below sessions. The sessions will be recorded for on-demand viewing via the IGCS 360 Educational Portal.

PLENARY 02: ORAL ABSTRACT PRESENTATIONS
Thursday, October 17, 9:00 – 9:30 AM | Auditorium

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

SA001 / #1611

SEMINAL ABSTRACT: FINAL OVERALL SURVIVAL (OS) IN PATIENTS (PTS) WITH NEWLY DIAGNOSED ADVANCED OVARIAN CANCER (AOC) TREATED WITH NIRAPARIB (NIR) FIRST-LINE (1L) MAINTENANCE: RESULTS FROM PRIMA/ENGOT-OV26/GOG-3012

PLENARY 02: ORAL ABSTRACT PRESENTATIONS

Antonio Gonzalez-Martín[1], Bhavana Pothuri[2], Maria Pilar Barretina-Ginesta[3], Whitney Graybill[4], Ignace Vergote[5], Colleen Mccormick[6], Mansoor Mirza[7], Richard Moore[8], Domenica Lorusso[9], Roisin O'cearbhaill[10], Gilles Freyer[11], David O'malley[12], Florian Heitz[13], Mark Shahin[14], Ilan Bruchim[15], William Bradley[16], Natalie Compton[17], Izabela Malinowska[18], Andrés Redondo[19], Bradley Monk[20]
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Introduction: The phase 3 PRIMA trial met its primary endpoint: niraparib first-line maintenance significantly extended PFS in patients with advanced OC (aOC) that responded to first-line platinum-based chemotherapy in the homologous recombination-deficient (HRd) and overall populations. Final planned OS results are reported.

Methods: Patients (N=733) were randomized 2:1 to niraparib or placebo. Hierarchical OS testing occurred after 60% maturity was reached in the overall population. Other secondary efficacy outcomes and long-term safety were assessed; an updated, ad hoc analysis of investigator-assessed PFS was also conducted (data cutoff, 08Apr2024).

Results: Median follow-up was 73.9 months; see Table for OS/TFST/PFS2. OS hazard ratios (95% CI) for niraparib versus placebo were 1.01 (0.84–1.23), 0.95 (0.70–1.29), and 0.93 (0.69–1.26) in the overall, HRd, and homologous recombination-proficient populations, respectively. In the overall population, 11.7% of niraparib and 37.8% of placebo patients received subsequent PARP inhibitor therapy (HRd population: niraparib, 15.8%; placebo, 48.4%). 5-year PFS in the overall population was 22% for niraparib versus 12% for placebo (HRd population: 35% versus 16%). MDS/AML incidence was <2.5% (niraparib, 2.3%; placebo, 1.6%); no new safety signals were observed.

Conclusion/Implications: In patients with newly diagnosed aOC at high risk for recurrence, no difference in OS was observed between treatment arms. Subsequent PARP inhibitor use was higher in the placebo arm. In the HRd population, patients alive at 5 years were twice as likely to be progression free with niraparib treatment than placebo. Long-term safety data remained consistent with the known niraparib safety profile. Previously presented at the European Society for Medical Oncology (ESMO) Congress 2024; September 13–17, 2024; Barcelona, Spain. Final Publication Number: LBA29. Antonio González-Martín et al. Reused with permission.

Table/Chart/Figure:

	Overall population		HRd population	
	Niraparib (n=487)	**Placebo (n=246)**	**Niraparib (n=247)**	**Placebo (n=126)**
TFST				
Median, mo	17.0	12.0	26.9	13.9
Hazard ratio (95% CI)	0.74 (0.62–0.89)		0.55 (0.43–0.71)	
PFS2				
Median, mo	30.1	27.6	43.4	39.3
Hazard ratio (95% CI)	0.96 (0.79–1.17)		0.87 (0.66–1.17)	
OS				
Median, mo	46.6	48.8	71.9	69.8
Hazard ratio (95% CI)	1.01 (0.84–1.23)		0.95 (0.70–1.29)	
P value (2-sided)	0.8834		NA[a]	

[a]*P* value was not generated because testing stopped at the overall population. HRd, homologous recombination-deficient; NA, not applicable; OS, overall survival; PFS2, progression-free survival 2; TFST, time to first subsequent therapy.

SA002 / #1449

SEMINAL ABSTRACT: PEMBROLIZUMAB PLUS CHEMORADIOTHERAPY FOR HIGH-RISK LOCALLY ADVANCED CERVICAL CANCER: OVERALL SURVIVAL RESULTS FROM THE RANDOMIZED, DOUBLE-BLIND, PHASE 3 ENGOT-CX11/GOG-3047/KEYNOTE-A18 STUDY

PLENARY 03: ORAL ABSTRACT PRESENTATIONS

Domenica Lorusso[1], Yang Xiang[2], Kosei Hasegawa[3], Giovanni Scambia[4], Manuel Leiva[5], Pier Ramos-Elias[6], Alejandro Acevedo[7], Marketa Bednarikova[8], Andrea De Santana Gomes[9], Fernando Contreras Mejia[10], Ari Reiss[11], Flora Zagouri[12], Jung-Yun Lee[13], Valeriya Saevets[14], Peng Liu[15], Karin Yamada[15], Martina Puglisi[15], Sandro Pignata[16], Linda Duska[17]

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Introduction: At the first interim analysis of the phase 3 ENGOT-cx11/GOG-3047/KEYNOTE-A18 study (NCT04221945), pembrolizumab plus concurrent chemoradiotherapy (CCRT) showed a statistically significant and clinically meaningful improvement in PFS vs placebo plus CCRT in patients with high-risk locally advanced cervical cancer (LACC). Based on this study, the US FDA has approved pembrolizumab plus CCRT for patients with International Federation of Gynecology and Obstetrics (FIGO) 2014 Stage III-IVA cervical cancer. We present the OS results from the second interim analysis.

Methods: Eligible patients with newly diagnosed, previously untreated, high-risk LACC (FIGO 2014 stage IB2-IIB with node-positive disease or stage III-IVA regardless of lymph node status) were randomized 1:1 to 5 cycles of pembrolizumab 200 mg or placebo Q3W plus CCRT, then 15 cycles of pembrolizumab 400 mg or placebo Q6W. CCRT included 5 cycles (optional 6th dose) of cisplatin 40 mg/m^2 Q1W plus EBRT then brachytherapy. Patients were stratified by planned EBRT type (intensity-modulated radiotherapy [IMRT] or volumetric-modulated arc therapy [VMAT] vs non-IMRT or non-VMAT), stage at screening (IB2-IIB vs III-IVA), and planned total radiotherapy dose (<70 Gy vs ≥70 Gy [EQD2]). Primary endpoints are PFS per RECIST version 1.1 by investigator and OS.

Results: 1060 patients were randomized to pembrolizumab plus CCRT (n=529) or placebo plus CCRT (n=531). At this analysis (January 8, 2024, data cutoff), median follow-up was 29.9 (range, 12.8-43.0) months. Pembrolizumab plus CCRT showed a statistically significant improvement in OS compared with placebo plus CCRT. The 36-month OS rate was 82.6% with pembrolizumab plus CCRT vs 74.8% with placebo plus CCRT; median OS was not reached in either group (hazard ratio [HR]=0.67 [95% CI, 0.50-0.90]; *P*=0.0040). The benefit of pembrolizumab plus CCRT was generally consistent in all prespecified subgroups, including FIGO stages IB2-IIB (HR=0.89 [95% CI, 0.55-1.44]) and III-IVA (HR=0.57 [95% CI, 0.39-0.83]). Grade ≥3 treatment-related AE incidence was 69.1% in the pembrolizumab plus CCRT group and 61.3% in the placebo plus CCRT group.

Conclusion/Implications: Pembrolizumab plus CCRT showed a statistically significant and clinically meaningful improvement in OS vs placebo plus CCRT in patients with high-risk LACC and had a manageable safety profile. These data provide further support for pembrolizumab plus CCRT as a new standard of care for this population.

SA003 / #1659

SEMINAL ABSTRACT: DATOPOTAMAB DERUXTECAN (DATO-DXD) IN PATIENTS WITH ENDOMETRIAL (EC) OR OVARIAN CANCER (OC): RESULTS FROM THE PHASE 2 TROPION-PANTUMOR03 STUDY

PLENARY 03: ORAL ABSTRACT PRESENTATIONS

Ana Oaknin[1], Joo Ern Ang[2], Sun Young Rha[3], Kan Yonemori[4], Rebecca Kristeleit[5], Chia-Chi Lin[6], Taroh Satoh[7], Purificación Estévez-García[8], Mehmet Ali Nahit Şendur[9], Laura Medina Rodriguez[10], Antoine Italiano[11], Iwona Lugowska[12], Isabelle Ray-Coquard[13], Amit Oza[14], Jimmy Zhao[15], Srikanth Gajavelli[15], Justyna Filant[16], Shamin Gharagoozloo[17], Yelena Janjigian[18], Funda Meric-Bernstam[19]
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Background: The Phase 2, multicentre, open-label TROPION-PanTumor03 study (NCT05489211) comprises independent cohorts evaluating the TROP2-directed antibody-drug conjugate Dato-DXd as monotherapy and in combination in several tumour types. We present results from patients (pts) who received Dato-DXd monotherapy in the EC and OC cohorts.

Methods: The EC cohort enrolled pts with histologically documented recurrent unresectable advanced/metastatic endometrial carcinoma, whose disease had progressed on ≥1 line of platinum-based chemotherapy (CT). The OC cohort enrolled pts with histologically documented recurrent unresectable advanced/metastatic high-grade ovarian, fallopian tube, or primary peritoneal carcinoma whose disease had progressed after ≥1 line of platinum-based CT. Patients with platinum-sensitive and platinum-resistant OC were included. Both cohorts had ECOG PS of 0 or 1 and were unselected for TROP2 expression. The Dato-DXd monotherapy regimen is 6 mg/kg IV Q3W for both cohorts. Primary endpoints are objective response rate (ORR) and safety/tolerability.

Results: At data cut-off (March 1, 2024), 40 pts with EC and 35 pts with OC had received Dato-DXd. In the EC cohort, (median of 1 prior line of therapy; range 1–2) confirmed ORR was 27.5% (1 complete response [CR], 10 partial responses [PR]) and disease control rate (DCR) was 85.0%. Duration of response (DoR) was not yet reached. Median progression-free survival (PFS) was 6.3 months (95% CI 2.8–not yet reached). In the OC cohort (median of 2 prior lines of therapy; range 1–4), confirmed ORR was 42.9% (1 CR, 14 PR). DCR was 91.4%, DoR was 5.6 months and median PFS was 5.8 months (95% CI 4.1–7.1). Efficacy by subgroups will be presented. Safety is summarised in the Table.

Conclusions: Dato-DXd monotherapy demonstrated encouraging efficacy and a manageable safety profile in pts with recurrent endometrial or ovarian cancer.

Table

Incidence of adverse events (AEs), n (%)	**Endometrial cohort N=40**	**Ovarian cohort N=35**
Treatment-related AEs (TRAEs)	37 (92.5)	35 (100.0)
Grade ≥3 TRAEs	17 (42.5)	16 (45.7)
Any TRAE leading to:		
Dose reduction	10 (25.0)	11 (31.4)
Dose interruption	11 (27.5)	11 (31.4)
Discontinuation	2 (5.0)	2 (5.7)
Death	0	0
Most common TRAEs:		
Stomatitis, all grades	21 (52.5)	22 (62.9)
Grade ≥3	1 (2.5)	3 (8.6)
Nausea, all grades	15 (37.5)	17 (48.6)
Grade ≥3	2 (5.0)	1 (2.9)
Alopecia, all grades	10 (25.0)	17 (48.6)
Adjudicated drug-related interstitial lung disease, n	1 (Grade 3)	1 (Grade 3)

SA004 / #1663

SEMINAL ABSTRACT: EFFICACY AND SAFETY OF SACITUZUMAB TIRUMOTECAN (SAC-TMT) PLUS PEMBROLIZUMAB IN PATIENTS WITH RECURRENT OR METASTATIC CERVICAL CANCER

PLENARY 04: ORAL ABSTRACT PRESENTATION

Jing Wang[1], Ruifang An[2], Yi Huang[3], Jieqing Zhang[4], Jeffrey C. Goh[5], Kui Jiang[6], Guohua Yu[7], Liang Chen[8], Diane Provencher[9], Ying Tang[10], Guiling Li[11], Hui Qiu[12], Omobolaji·o. Akala[13], Elliot Chartash[13], Yiting Zhou[14], Xiaoping Jin[14], Junyou Ge[14], Xiaohua Wu[15]
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Background Anti-PD-1 antibody is the standard therapy for recurrent or metastatic (R/M) cervical cancer (CC) patients (pts) after platinum-based chemotherapy. It was shown that ADC combined with PD-1/L1 antibody has a potential additive effect. Sac-TMT (also known as MK-2870/ SKB264) is a TROP2 ADC developed with novel linker to conjugate a belotecan-derivative topoisomerase I inhibitor. Here, we report the efficacy and safety results from the CC cohort in an ongoing Phase 2 basket study (SKB264-Ⅱ-06, NCT05642780).

Methods Pts with R/M CC who had progressed on or after platinum-doublet chemotherapy and received no more than 2 systemic therapies for R/M disease were enrolled. Sac-TMT 3 or 5 mg/kg Q2W+ pembrolizumab 400 mg Q6W were assessed in safety run-in period and the doses deemed well tolerated were being explored in expansion period. Tumor assessments per RECIST 1.1 were performed once every 8 weeks for the first 12 mo, and every 12 weeks thereafter.

Results As of March 25, 2024, 38 pts were treated and followed up for at least 17 weeks or 2 tumor assessments (3 received sac-TMT 3 mg/kg, 35 received sac-TMT 5 mg/kg). The median follow-up was 6.2 mo. The median age was 52 years. 76.3% had squamous histology. 47.4% had received two prior lines of therapy, 52.6% had received

bevacizumab, and 42.1% had received anti-PD-1 based therapy. The ORR was 57.9% (22/38, 3 unconfirmed), with 3 complete responses. Median DoR was not reached and 6-mo DoR rate was 82.1%. Responses were also observed in pts were pre-treated with anti-PD-1 based therapy (ORR 68.8%, 11/16). Median PFS was not reached and 6-mo PFS rate was 65.7%. Grade ≥ 3 treatment-related AEs (TRAEs) occurred in 47.4% of pts. The most common Grade ≥ 3 TRAEs were neutrophil count decreased (23.7%), anemia (21.1%) and WBC decreased (15.8%). TRAEs led to dose reduction of sac-TMT in 44.7% of pts. TRAE led to discontinuation of sac-TMT in 1 pt (2.6%). No TRAEs led to discontinuation of both drugs.

Conclusions Sac-TMT plus pembrolizumab demonstrated promising and durable antitumor activity with manageable safety profile. No new safety signal was observed. Considering the activity of this combination among pts who were pre-treated with anti-PD-1 based therapy, further investigation is warranted.

SA005 / #1666

SEMINAL ABSTRACT: ATHENA-COMBO, A PHASE 3, RANDOMIZED TRIAL COMPARING RUCAPARIB (RUCA) + NIVOLUMAB (NIVO) COMBINATION THERAPY VS RUCA MONOTHERAPY AS MAINTENANCE TREATMENT IN PATIENTS (PTS) WITH NEWLY DIAGNOSED OVARIAN CANCER (OC)

PLENARY 04: ORAL ABSTRACT PRESENTATION

Iain Mcneish[1], David O'malley[2], Michelle Wilson[3], Ana Oaknin[4], Shannon Westin[5], Amit Oza[6], Domenica Lorusso[7], Thomas Herzog[8], Olga Mikheeva[9], Flora Zagouri[10], Robert Coleman[11], Myong Cheol Lim[12], Christine Parkinson[13], Ramez Eskander[14], Anita Chudecka-Głaz[15], Sharad Ghamande[16], Ilan Bruchim[17], Emily Prendergast[18], Darrin Despain[19], Keiichi Fujiwara[20], Rebecca Kristeleit[21], Bradley Monk[22]
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Introduction: ATHENA (NCT03522246) comprises MONO and COMBO studies. In MONO, rucaparib monotherapy provided sustained investigator-assessed median

progression-free survival (mPFS) versus placebo (20.2 vs 9.2 months; data cutoff: 23 March 2022) in newly diagnosed, advanced, high-grade ovarian cancer (HGOC) after first-line treatment. COMBO evaluated whether adding nivolumab to rucaparib further delayed time to progression. COMBO primary efficacy and safety are reported and compared with MONO, with 2 additional years of follow-up (data cutoff: 17 May 2024).

Methods: Patients with FIGO stages III–IV HGOC responding to first-line platinum-based chemotherapy were randomised 1:1 to rucaparib 600-mg PO BID + nivolumab 480-mg IV Q4W (COMBO) or rucaparib + placebo (MONO). Primary endpoint was intent-to-treat mPFS. mPFS in homologous recombination deficiency (HRD) and programmed death-ligand 1 (PD-L1) subgroups was exploratory.

Results: As of 26 October 2020, 863 patients were randomised. Median follow-up was 48 months. mPFS was numerically shorter for COMBO versus MONO in the intent-to-treat (15.0 vs 20.2 months; HR, 1.3; 95% CI, 1.1–1.5), HRD, and PD-L1 ≥1% and ≥5% subgroups (Table). MONO's mPFS benefit (20.2 months) was maintained with the 2-year follow-up. COMBO had shorter median treatment exposure than MONO (PO: 8.4 vs 14.7 months; IV: 4.6 vs 11.1 months). Common grade ≥3 treatment-related adverse events (COMBO vs MONO) were anemia/hemoglobin decreased (27.1% vs 28.6%), neutropenia/neutrophil count decreased (25.4% vs 15.4%), and ALT/AST increased (21.2% vs 10.0%).

Conclusions/Implications: Addition of nivolumab did not increase the PFS benefit of rucaparib. COMBO safety was consistent with previous reports and known individual safety profiles.

Table.

	COMBO vs MONO (data cutoff: 17 May 2024)			
	Rucaparib + nivolumab (COMBO), n	Rucaparib + placebo (MONO), n	mPFS, months	Hazard ratio (95% CI)
Intent-to-treat	436	427	15.0 vs 20.2	1.3 (1.1–1.5)
HRD	193	185	28.9 vs 31.4	1.1 (0.9–1.5)
BRCA mutation	94	91	48.0 vs NR	1.1 (0.7–1.7)
BRCA wt/LOH^{high}	99	94	17.3 vs 22.3	1.1 (0.7–1.5)
BRCA wt/LOH^{low}	188	189	11.0 vs 12.1	1.3 (1.0–1.7)
BRCA wt/LOH^{indeterminate}	55	53	9.2 vs 17.5	1.6 (1.0–2.5)
PD-L1 ≥ 5%	69	72	22.8 vs 52.2	1.5 (0.9–2.4)
PD-L1 ≥ 1%	199	197	18.3 vs 25.8	1.3 (1.0–1.7)

HRD, homologous recombination deficient; LOH, loss of heterozygosity; mPFS, median investigator-assessed progression-free survival; NR, not reached; PD-L1, programmed death-ligand 1; wt, wild-type.

SA006 / #1669

SEMINAL ABSTRACT: MIRVETUXIMAB SORAVTANSINE (MIRV) IN RECURRENT PLATINUM-SENSITIVE OVARIAN CANCER (PSOC) WITH HIGH FOLATE RECEPTOR-ALPHA (FRα) EXPRESSION: RESULTS FROM THE PICCOLO TRIAL

PLENARY 04: ORAL ABSTRACT PRESENTATION

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Background: There is an urgent patient-driven unmet need to identify novel effective and tolerable therapies for those with PSOC, especially for those treated with prior PARPi, where diminished response to subsequent platinum-based chemotherapy has been reported. MIRV is an antibody-drug conjugate comprising an FRα-binding antibody, cleavable linker, and maytansinoid DM4 payload, a potent tubulin-targeting agent and is FDA approved in patients with platinum-resistant ovarian cancer who received 1-3 prior treatment regimens. PICCOLO is a single-arm Phase 2 study evaluating the efficacy and safety of MIRV in patients with PSOC, primary peritoneal, or fallopian tube cancer.

Methods: PICCOLO enrolled PSOC patients with high (≥ 75% of cells with PS2+ staining intensity) FRα expression by immunohistochemistry (VENTANA FOLR1 [FOLR1-2.1] RxDx Assay) with at least 2 prior lines of platinum-containing therapy or documented platinum allergy. Patients received MIRV at 6 mg/kg, adjusted ideal body weight, on Day 1 of a 21-day cycle until disease progression or unacceptable toxicity. The primary

endpoint was confirmed objective response rate (ORR) per RECIST v1.1 by the investigator; key secondary endpoint was duration of response (DOR); additional secondary endpoints included safety, progression-free survival (PFS), and overall survival (OS).

Results: With a data cutoff of 17 Jan 2024, 79 patients were enrolled. 97.5% had prior taxanes, 81% prior poly (ADP-ribose) polymerase inhibitors (PARPi) [74.7% of whom progressed while on PARPi], 64.6% prior bevacizumab, 98.8% had 2+ prior lines of therapy, and BRCA status was 27.8% positive, 72.2% negative. ORR was 51.9% (95% CI 40.4, 63.3), including 6 complete and 35 partial responses, DOR was 8.3 months (95% CI 5.6, 10.8), mPFS was 6.9 months (95% CI 5.9-9.6). The ORR was 45.8% in 59 patients with progressive disease while on PARPi; OS was not mature at data cutoff. The most common treatment-emergent adverse events (TEAEs) (all grade and grade ≥ 3) were blurred vision (63% and 10%), dry eye (37% and 3%), nausea (37% and 1%), keratopathy (33% and 4%), and diarrhea (30% and 3%). TEAEs led to dose delays, reductions, and discontinuations in 61%, 42%, and 16% of patients, respectively.

Conclusion: MIRV demonstrated notable efficacy in this heavily pretreated PSOC population, including among those who may have PARPi resistance. MIRV continues to demonstrate a differentiated safety profile consisting primarily of low-grade neurosensory, GI, and resolvable ocular AEs. These data position MIRV to become a novel treatment option for patients in ≥3L PSOC with FRα positive expression. Clinical Trial: NCT05041257