



ENNA

1 Marzo 2019  
Hotel Federico II  
2 Marzo 2019  
Aula Magna Ospedale Umberto I



INNOVAZIONE,  
ACCESSIBILITÀ,  
SOSTENIBILITÀ,  
INFORMAZIONE  
IN ONCOLOGIA

# Le novità della Consensus Conference di Tokyo: Quando il platino è una buona opzione di terapia?

**Dott.ssa Rossella Sollami**

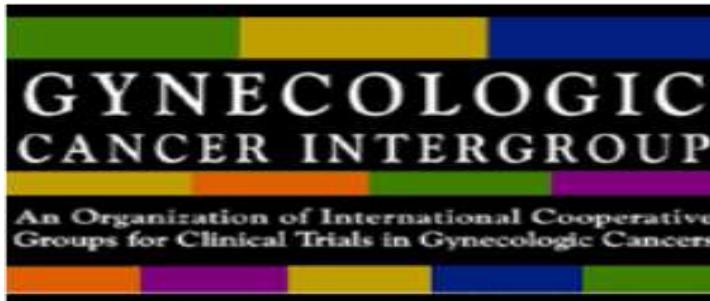
U.O.C .Oncologia

**Direttore Dott. Stefano Vitello**

P.O. Sant'Elia di Caltanissetta



# 5th Ovarian Cancer Consensus Conference of the Gynecologic Cancer InterGroup: Recurrent Disease



Tokyo, Japan  
November 7-9, 2015

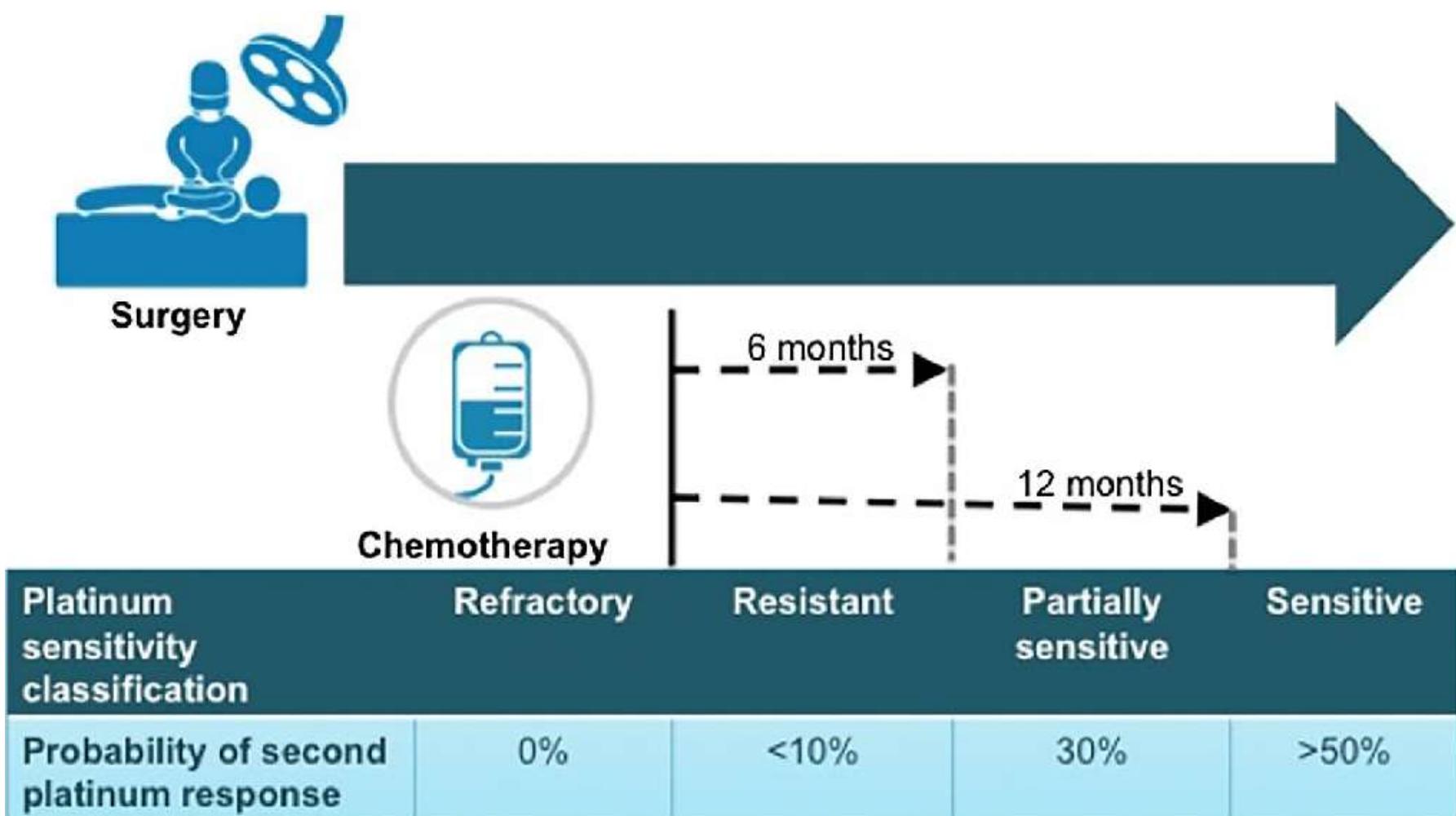
## Three Questions

- 1. What are the subgroups for clinical trials in ROC (recurrent ovarian cancer)?**
- 2. What are the control arms for clinical trials in ROC ?**
- 3. What are the endpoints for clinical trials in ROC?**

## 5° OCCC Of The GCIG: Factors for Defining Recurrnt Population

- Treatment-free interval (TFI)
  - TFI<sub>p</sub> (platinum)
  - TFI<sub>np</sub> (nonplatinum), TFI<sub>b</sub> (biological agent to be specified)
- Histological type
- *BRCA* status (*gBRCA* and *sBRCA*)
- Type of prior therapy (anti-angiogenic agents, PARP inhibitors [PARPi], chemotherapy, and others)
- Number of prior lines of chemotherapy
- Presence or absence of symptoms and type (eg, ascites, abdominal symptoms, pain, performance status)
- Other factors to be considered: Tumor volume and previous surgical outcome

# 4th Ovarian Cancer Consensus Conference of the Gynecologic Cancer InterGroup (Vancouver, 2010)





## Definizione di PFI

**The historical classification of recurrent ovarian cancer according to FIGO has recently been criticized for various reasons...**

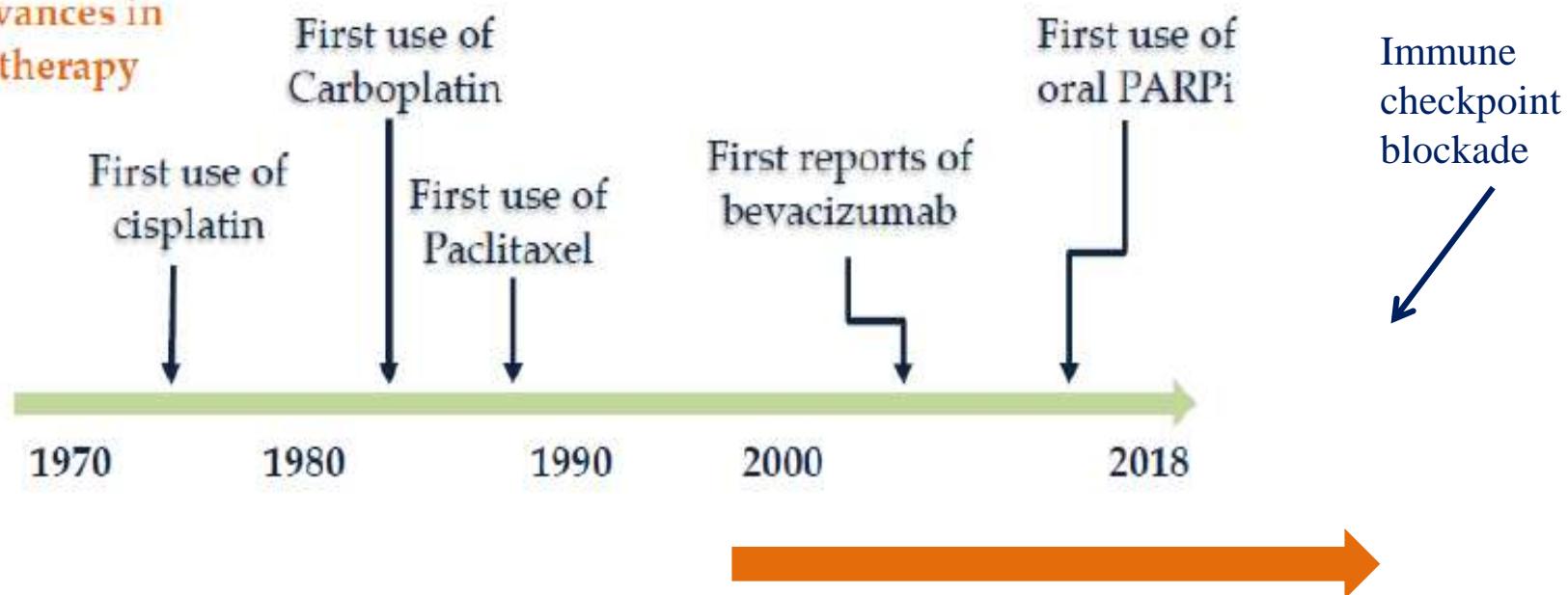
- ✓ Platinum sensitivity definition has been defined arbitrarily, based on observational studies, and a probabilistic partition with the likelihood of response being a continuous variable.
  - ✓ It can be heavily influenced by the timing of follow-up visits, and the use of CA125 as a trigger leading to further imaging examinations, modalities which have significantly changed over the time.
  - ✓ Furthermore, improvements in surgical cytoreduction technique and the introduction of biological agents as maintenance therapy could have modified the natural course of disease.
  - ✓ Finally, the platinum sensitivity definition only applies to chemotherapy, since no similar relationship has been demonstrated for other agents currently used in the clinical practice.

# PROGRESS IN THE MANAGEMENT OF OVARIAN CANCER

Five-year survival

15% → 30% → 40% → ? 50% ?

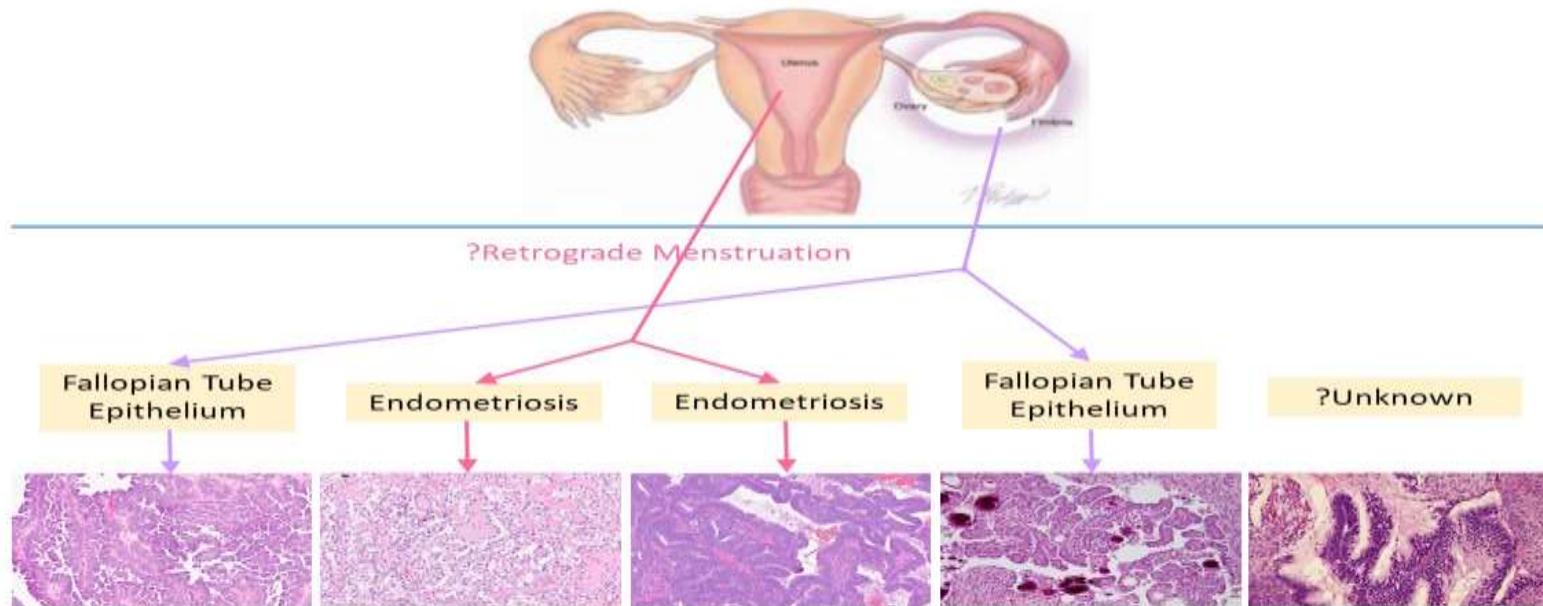
Key advances in chemo-therapy



## 5° OCCC Of The GCIG: Factors for Defining Recurrnt Population

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# Histological type

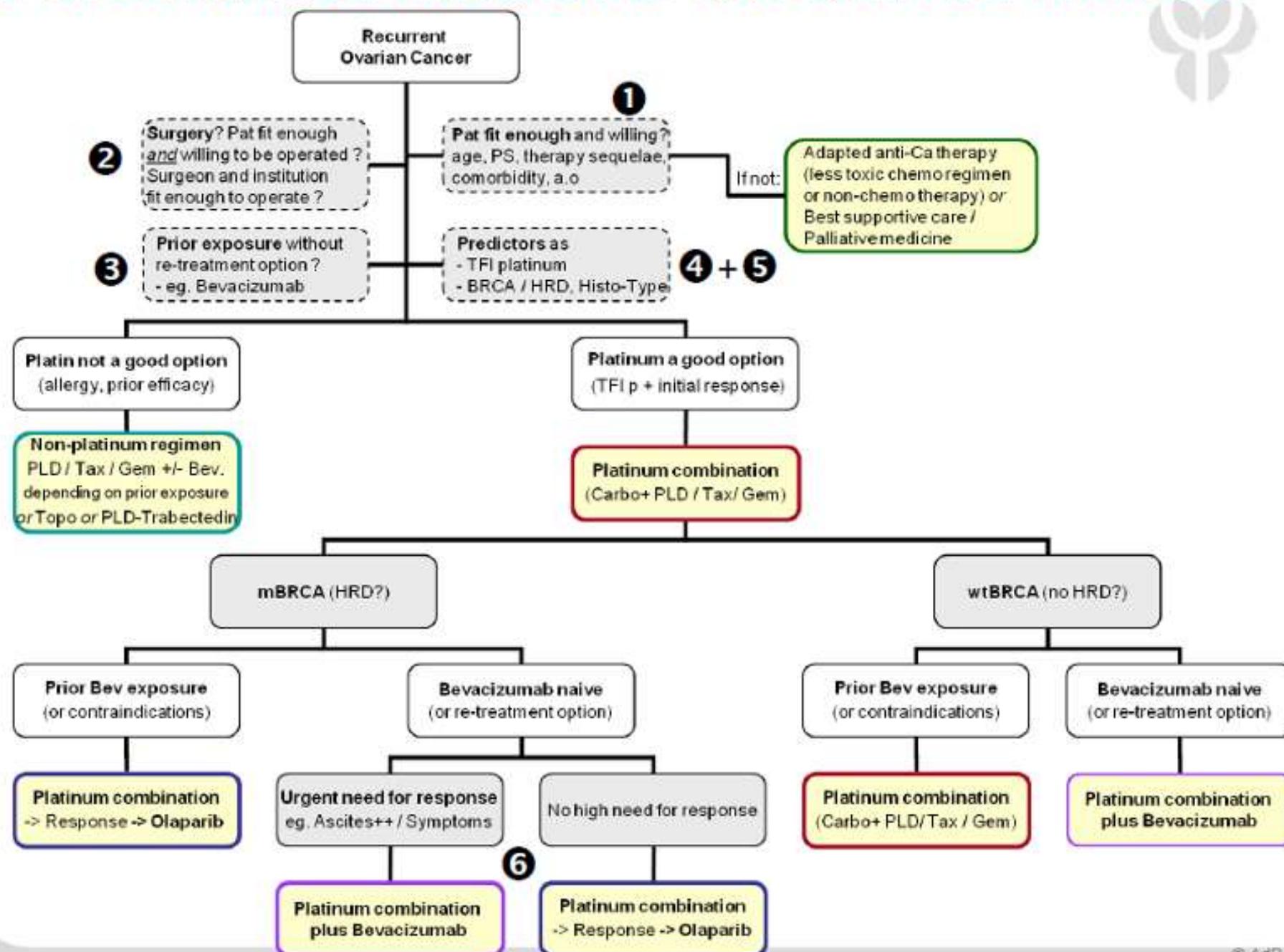


	High-Grade Serous Carcinoma	Clear Cell Carcinoma	Endometrioid Carcinoma	Low-Grade Serous Carcinoma	Mucinous Carcinoma
% of all Ovarian Carcinomas	~70%	~10%	~10%	<5%	<5%
Precursor Lesions	Serous tubal intraepithelial carcinoma (STIC)	Clear Cell Borderline Tumor	Endometrioid Borderline Tumor	Serous Borderline Tumor	Mucinous Borderline Tumor
Inherited Syndromes	BRCA1/2, Hereditary Breast and Ovarian Cancer (HBOC)	Lynch Syndrome	Lynch Syndrome	?	?
Common Mutations and Molecular Aberrations	TP53 BRCA1/2 and HRD Chromosomal instability Aneuploidy (100%)	ARID1A PIK3CA CTNNB1 PPP2R1A MSI	PTEN CTNNB1 ARID1A PPR2R1A MSI	KRAS BRAF	KRAS HER2 amplification
Potential Molecular Targeted Therapies	PARP inhibitors, immune checkpoint inhibitors	Tyrosine kinase inhibitors	mTOR inhibitors	MEK1/2 inhibitors	Trastuzumab

# 5° OCCC Of The GCIG: Factors for Defining Recurrnt Population

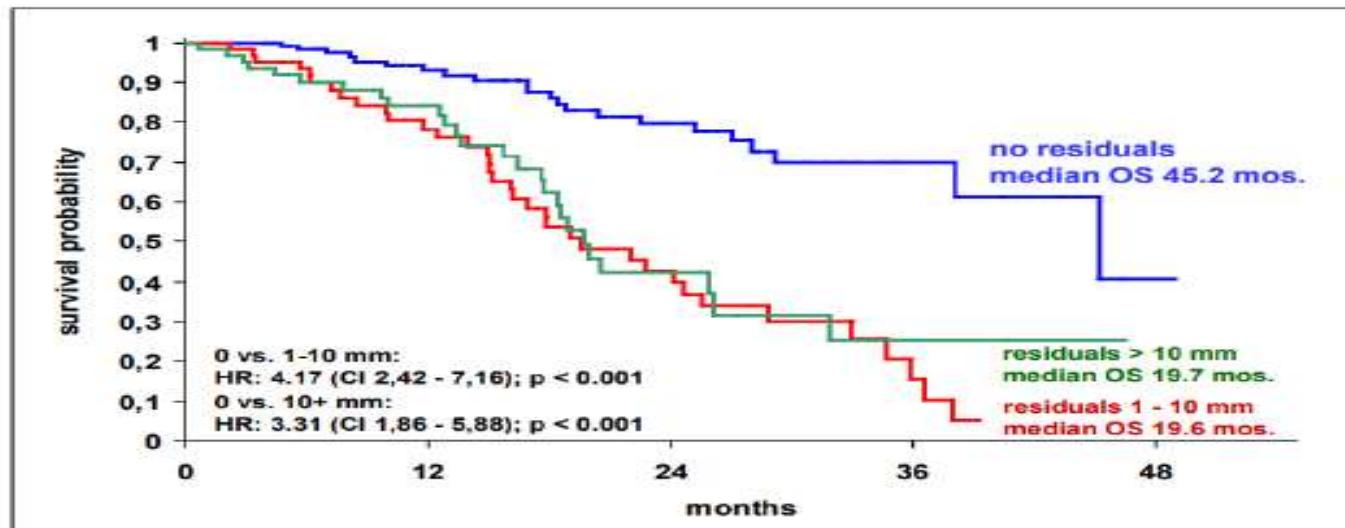
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- Other factors to be considered: Tumor volume and previous surgical outcome

## Personalized medicine has arrived in ROC



# Is There a Role for Surgery in the Recurrent Disease Setting?

## AGO DESKTOP I

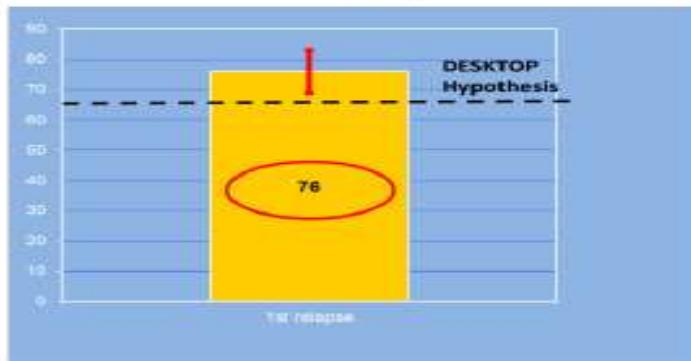


A combination of PS, early FIGO stage initially or no residual tumor after first surgery, and absence of ascites could predict complete resection in 79% of patients.

Harte P et al Ann Surg Oncol, 2006

## AGO DESKTOP OVAR II

Frequency of complete resection by applying the AGO score within a prospective validation trial in 524 patients



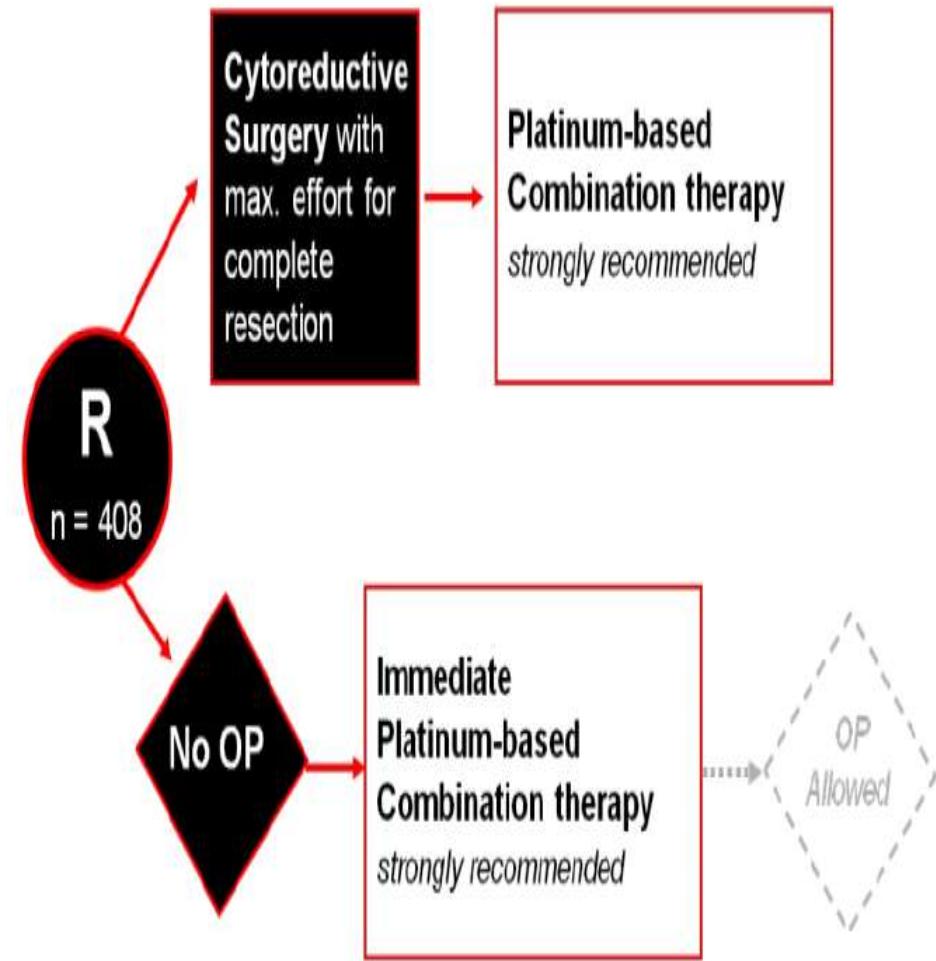
complete resection in 76%  
of the study cohort  
=

AGO score could predict  
with 95% probability  
A complete resection in  
at least 2 out of 3 patients

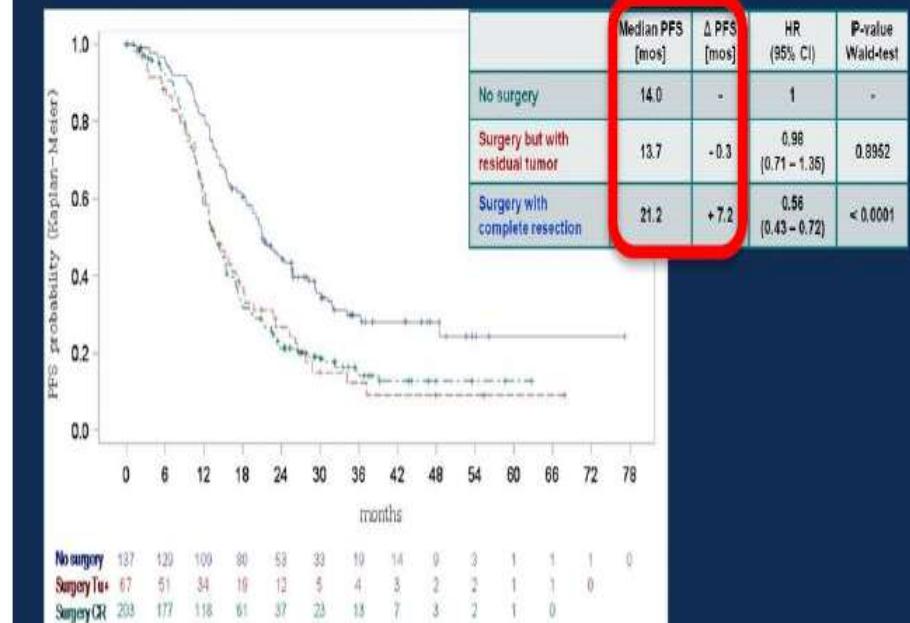
-> first prospective trial with successful validation of a predictive score

Harte P. DESKTOPII. Int J Gynecol Cacer 2011

# Is There a Role for Surgery in the Recurrent Disease Setting? AGO-OVAR DESKTOP III

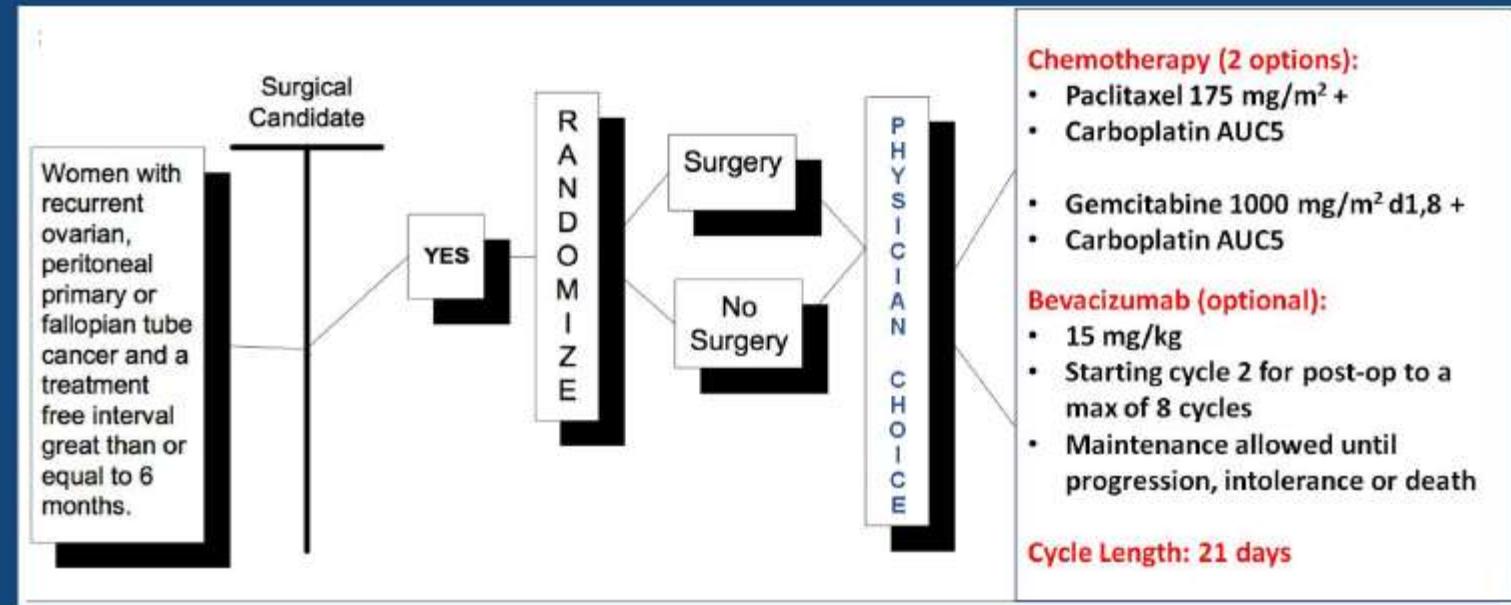


AGO DESKTOP III: Outcome 3 (PFS by surgical outcome)  
(AGO-OVAR OP.4; ENGOT-ov20; NCT01166737)



# GOG 213

## GOG 213: Schema Modification 8/29/2011



PRESENTED AT:  
2018 ASCO<sup>®</sup>  
ANNUAL MEETING

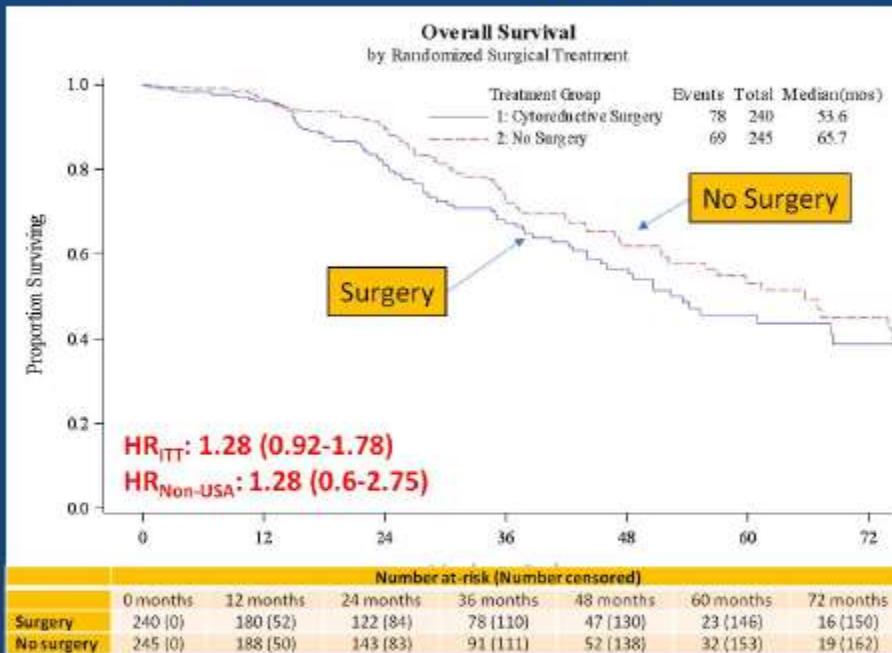
#ASCO18  
Data are the property of the author. Reproduction required for reuse.

PRESENTED BY:

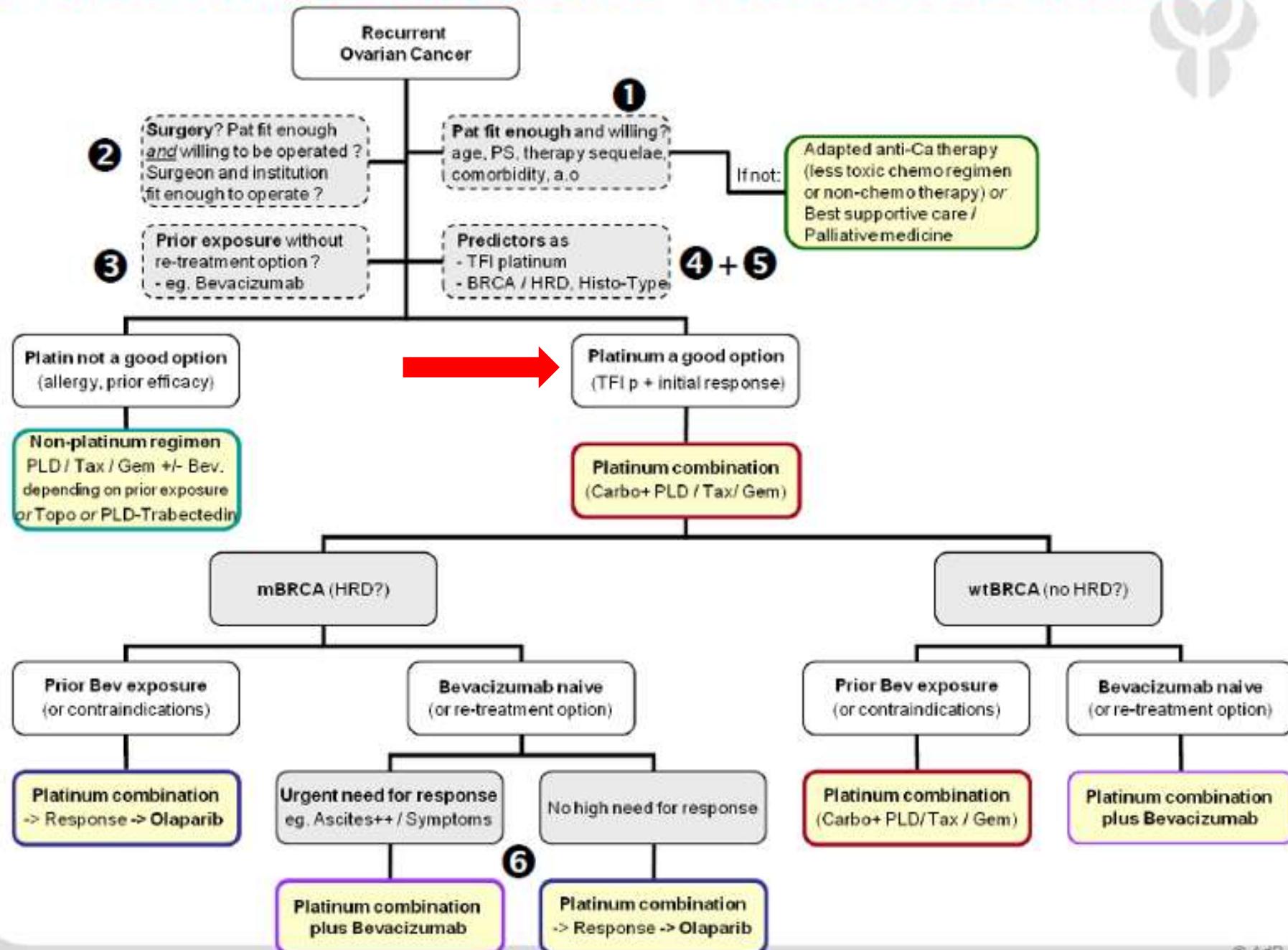
Presented By Robert Coleman at 2018 ASCO Annual Meeting

Domenica Lorusso - Grandangolo 2018. Un anno di oncologia. 20<sup>a</sup> edizione - Genova, 13-15 dicembre 2018

## Primary Endpoint OS: Surgery vs. No Surgery



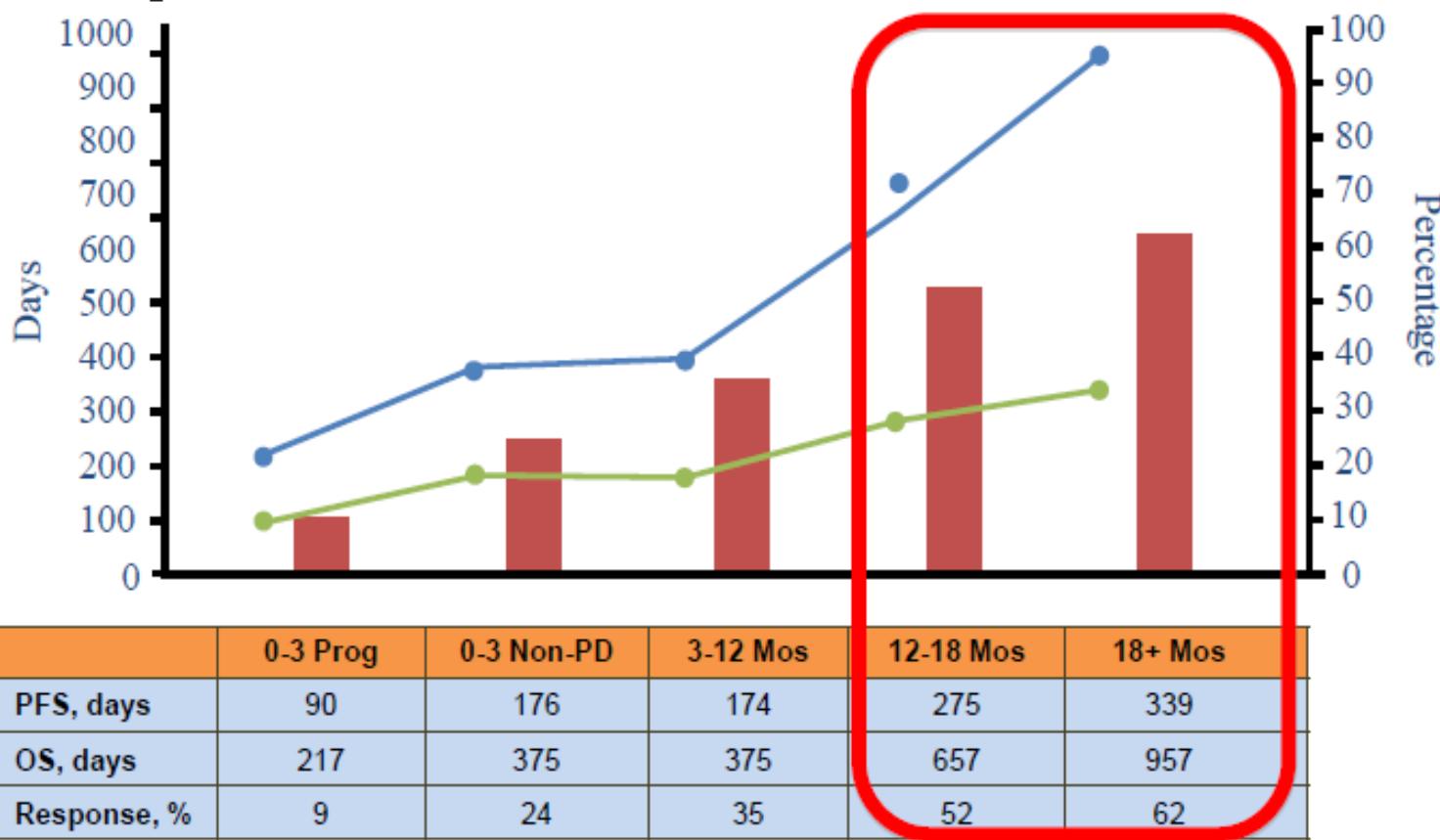
# Personalized medicine has arrived in ROC



## 5° OCCC Of The GCIG: Platinum Seems to be an option

- Platinum should remain a key component of treatment options at relapse
- Selection of therapy according to the possibility of receiving platinum
- Platinum is still an option when the patient has...
  - NOT progressed during platinum-based chemotherapy
  - NOT a short TFlp (minimum of 6 months) based on symptoms or RECIST
  - NOT a significant platinum allergy or comorbidity

# Malattia platino sensibile



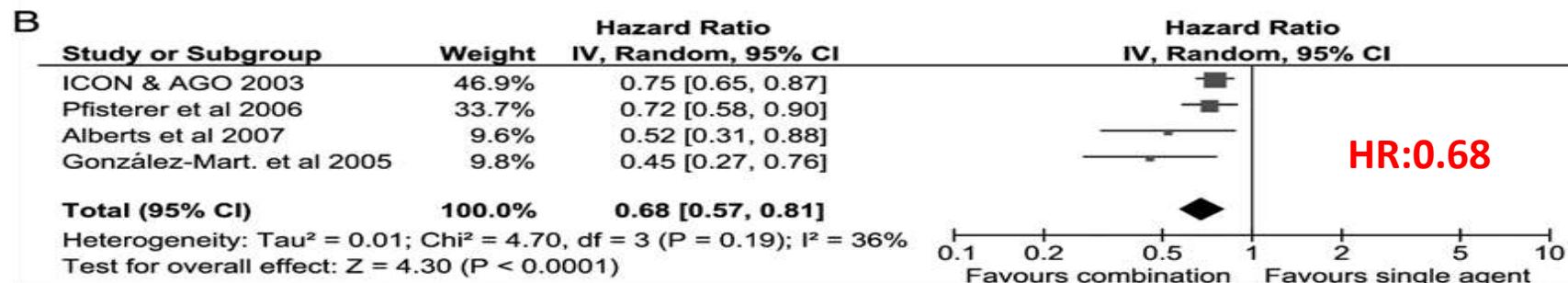
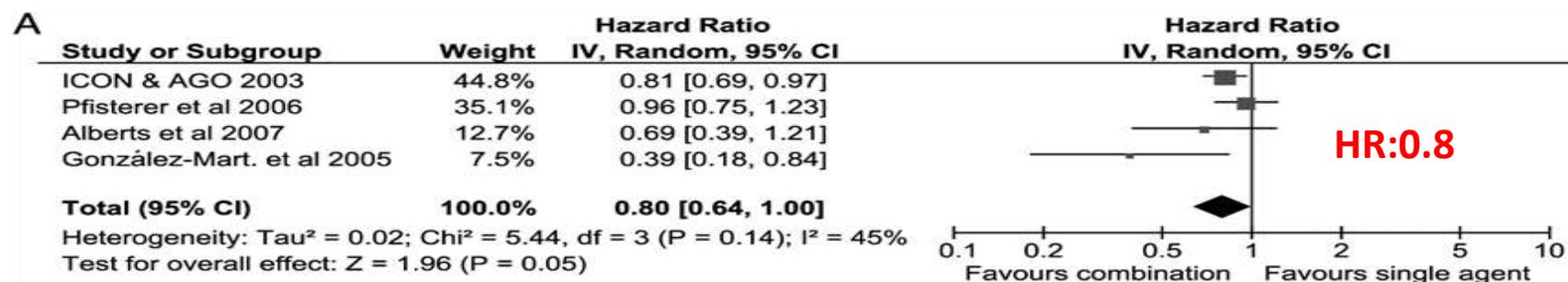
Pujade-Lauraine E, et al. ASCO 2002

# Treatment Options for the Patients

- **Carboplatin doublet**
- **Carboplatin doublet with bevacizumab followed by maintenance with bevacizumab**
- **Carboplatin doublet followed by PARPi in case of response, but only if sBRCA is mutated**
- **Carboplatin doublet followed by PARPi in case of response, independently of sBRCA status**

# Platinum-Doublet is Superior to Platinum Single Agent in Overall Survival and Progression-Free Survival

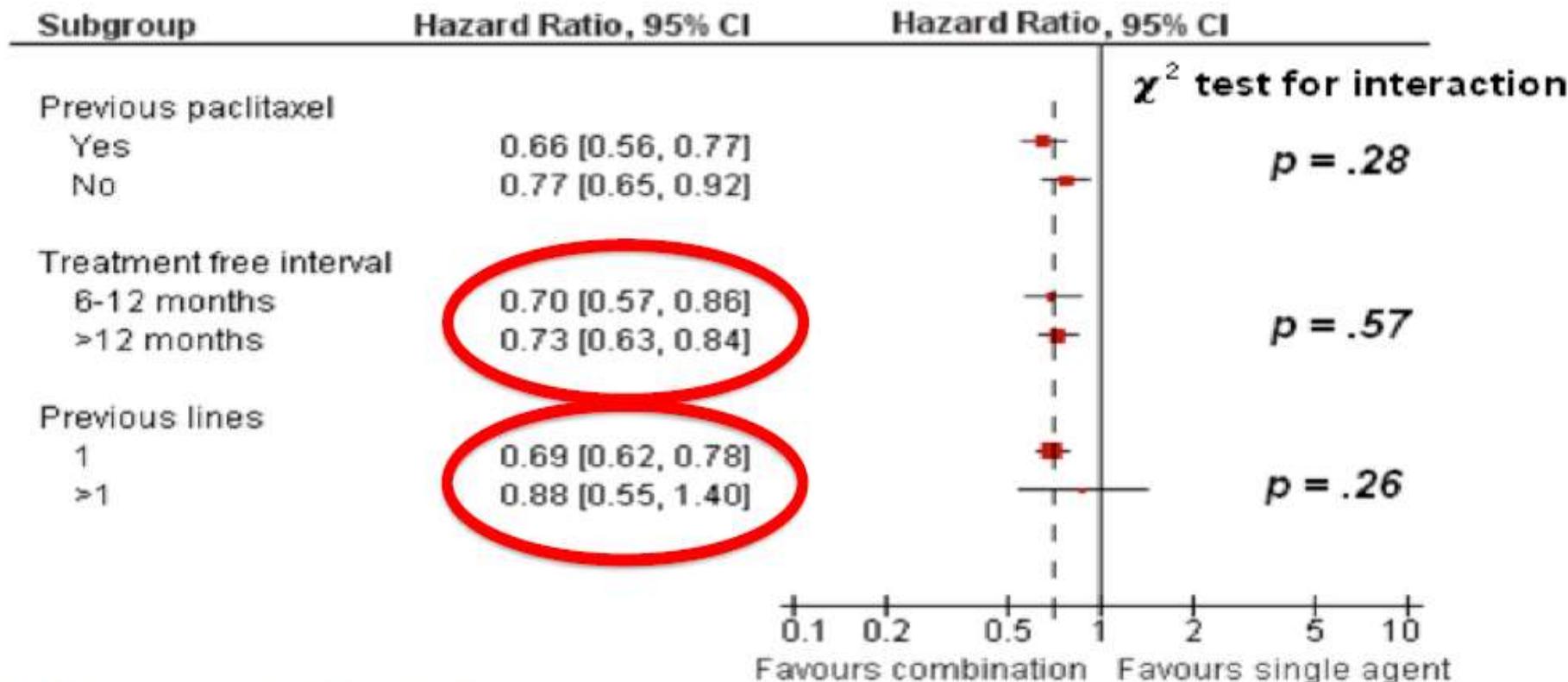
Trial	ICON & AGO	Pfisterer et al.	Alberts et al.	González-Martin et al.	Bolis et al.
Accrual period (years)	1996–2002	1999–2002	2002–2004	2000–2002	1991–1998
Location	Europe*	Europe and Canada	USA	Spain	Italy
Patients randomized	802	356	61	81	190
FIGO stage	Not available	I–IV	III–IV	I–IV	II–IV
Median follow-up (months)	42.5	27.1	59.3	13.7	Not available
Planned carboplatin dose	AUC 5 Cisplatin: 50 mg/m <sup>2</sup> (75 mg/m <sup>2</sup> in controls)	AUC 4 (AUC 5 in controls)	AUC 5	AUC 5	300 mg/m <sup>2</sup>
Planned combination dose	Paclitaxel: 175 mg/m <sup>2</sup> ICON 185 mg/m <sup>2</sup> AGO	Gemcitabine 1000 mg/m <sup>2</sup> d1,d8 q3 weeks.	PLD <sup>b</sup> 30 mg/m <sup>2</sup>	Paclitaxel 175 mg/m <sup>2</sup>	Epidoxorubicin 120 mg/m <sup>2</sup>
Planned treatment duration	MRC CTU: ≥6 cycles Italy: 3–6 cycles AGO: 6–8 cycles every 3 weeks	6–10 cycles every 3 weeks	Every 4 weeks	6–9 cycles every 3 weeks	5 cycles every 4 weeks



Forest plot showing the effect of platinum-combination chemotherapy on (A) overall survival (OS) and (B) progression-free survival (PFS)

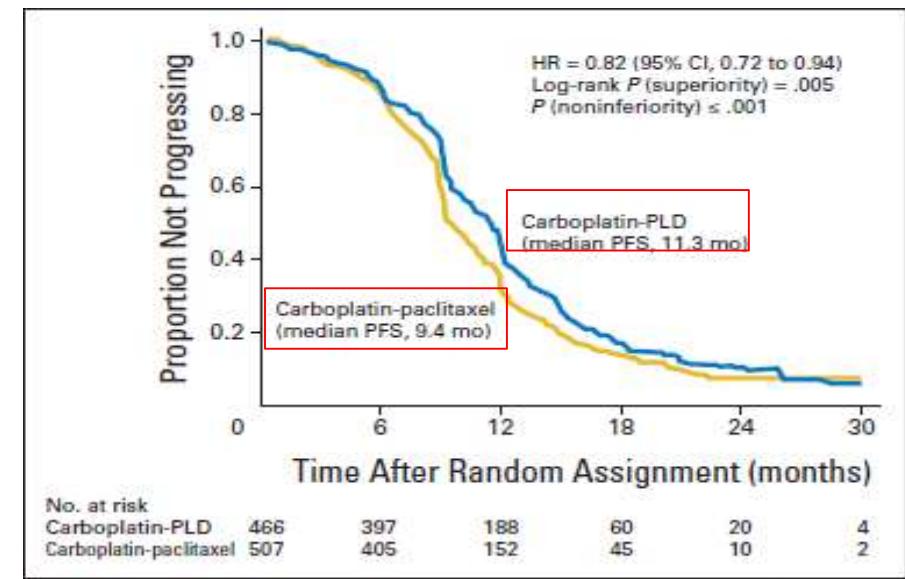
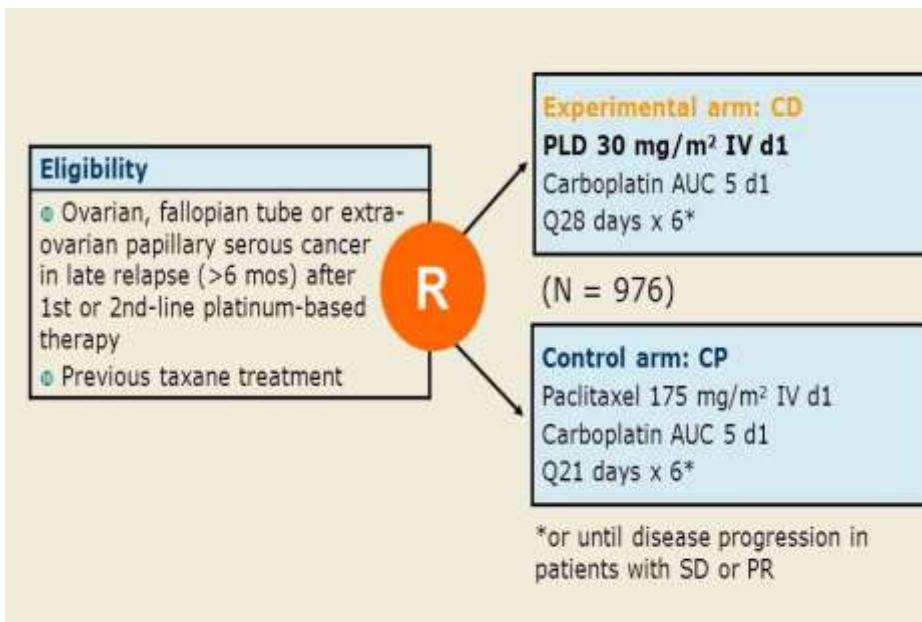
# Platinum – Doublet is superior to Platinum Single Agent Independently of TFlp and Previous Lines

Forest plot showing the effect of combination platinum chemotherapy on PFS, by pre-specified patient subgroups



# CALYPSO TRIAL

## Pegylated Liposomal Doxorubicin and Carboplatin Compared With Paclitaxel and Carboplatin for Patients With Platinum-Sensitive Ovarian Cancer in Late Relapse



**Fig 2.** Progression-free survival (PFS). HR, hazard ratio; PLD, pegylated liposomal doxorubicin.

Toxicity (G3/4); %	CD (n=466)	CP (n=501)	P Value
<b>Neutropenia</b>	35	46	<0.01
<b>Thrombocytopenia</b>	16	6	<0.001
<b>Severe HTOX</b> - Leading to TRT disc	28	39	<0.01
<b>Alopecia (≥ G2; %)</b>	7	84	<0.001
<b>HSR</b>	6	19	<0.001
<b>Sensory neuropathie</b>	5	27	<0.001
<b>HSF (G2-3)</b>	12	2	<0.001
<b>Nausea</b>	35	24	<0.001
<b>Mucositis</b>	14	7	<0.001

# Treatment Options for the Patients

- Carboplatin doublet
- **Carboplatin doublet with bevacizumab followed by maintenance with bevacizumab**
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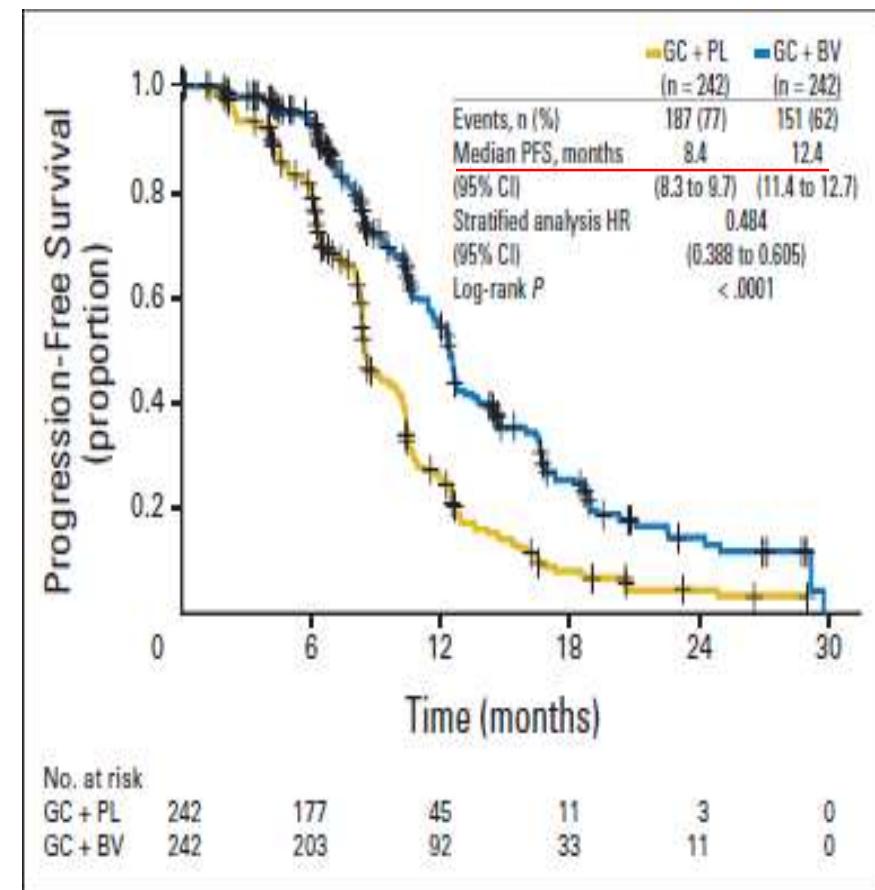
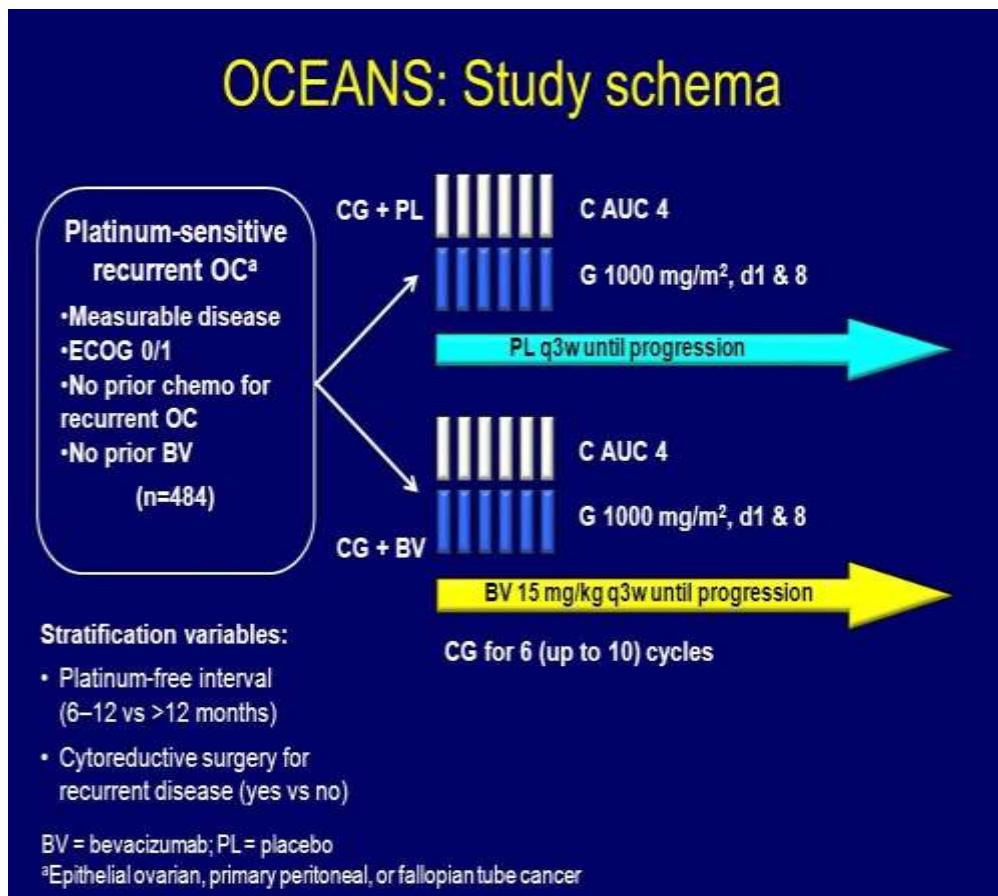
# OCEANS and GOG-213 Explored the Addition of Bevacizumab to Carboplatin Doublet in First Relapse

	OCEANS	GOG-213
Carbo-doublet	Gemcitabine	Paclitaxel
Placebo	Yes	No
Prior Bev	No	Yes (10%)
Endpoint	PFS	OS

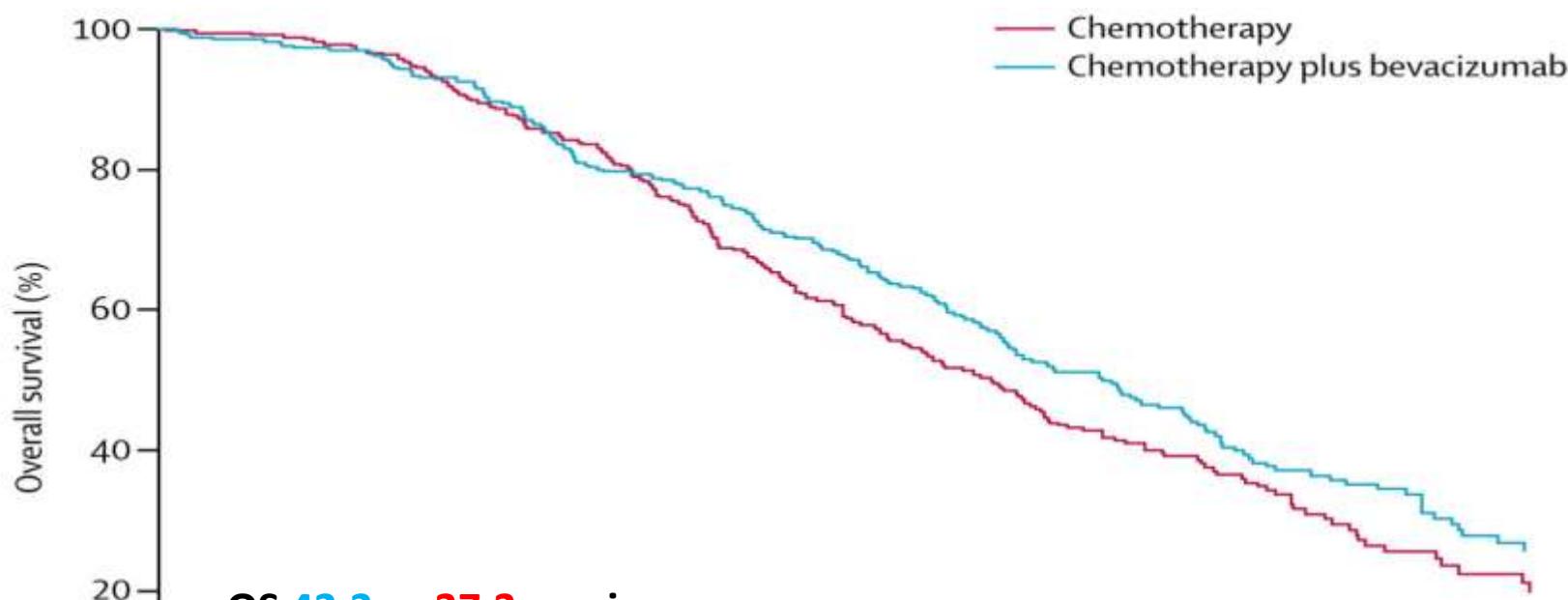
1. Aghajanian C, et al. *J Clin Oncol.* 2012;30(17):2039-2045. 2. Coleman RL, et al. *Lancet Oncol.* 2017;18(6):779-791.

# OCEANS TRIAL

## A Randomized, Double-Blind, Placebo-Controlled Phase III Trial of Chemotherapy With or Without Bevacizumab in Patients With Platinum-Sensitive Recurrent Epithelial Ovarian, Primary Peritoneal, or Fallopian Tube Cancer



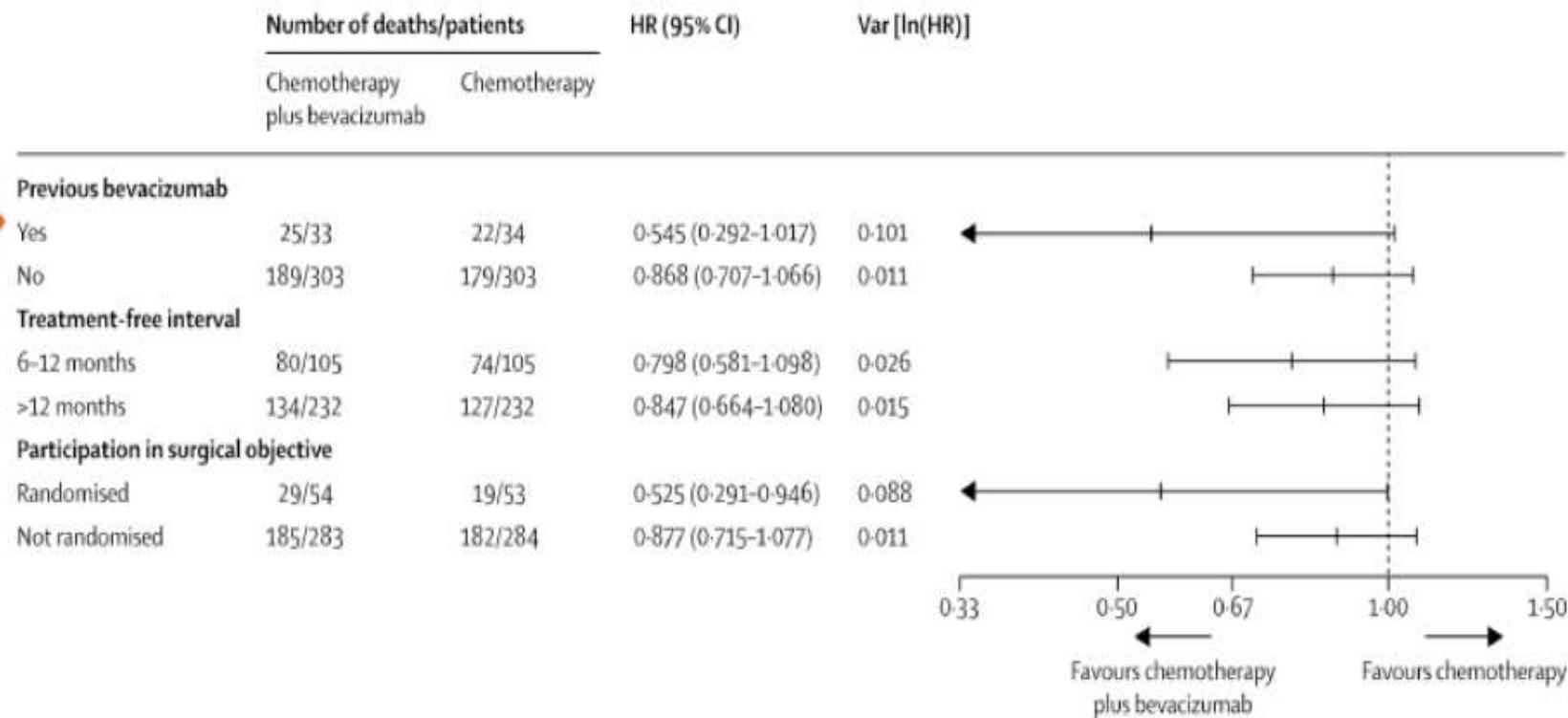
**Bevacizumab and paclitaxel–carboplatin chemotherapy and secondary cytoreduction in recurrent, platinum-sensitive ovarian cancer (NRG Oncology/Gynecologic Oncology Group study GOG-0213): a multicentre, open-label, randomised, phase 3 trial**



**Number at risk  
(number censored)**

	0	12	24	36	48	60
Chemotherapy	337 (0)	303 (15)	234 (17)	152 (30)	69 (77)	18 (109)
Chemotherapy plus bevacizumab	337 (0)	306 (8)	253 (9)	183 (20)	75 (82)	28 (110)

# Are the GOG-213 Results Enough For Rechallenge With Bevacizumab in First Relapse and Platinum as Option?



# EN GOT-OV17 MITO-16B MANGO OV2B

## Study Design



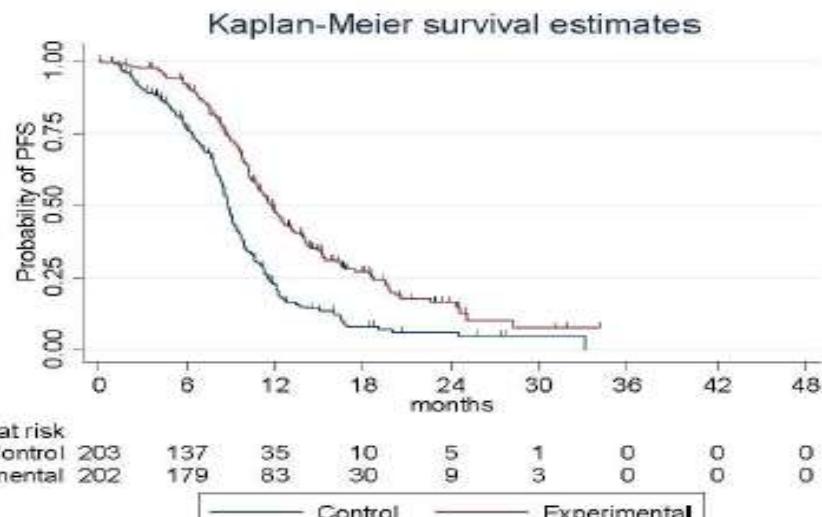
### Platinum-based Chemotherapy:

- Carboplatin + Paclitaxel +/- Beva 15mg/kg q 21
- Carboplatin + Gemcitabine +/- Beva 15mg/kg q 21
- Carboplatin + PLD q 28 +/- Beva 10mg/kg q 14

### Stratification:

- center
- relapse during or after 1° line Beva
- performance status
- chemo backbone

## PFS Investigator assessed (primary end-point)



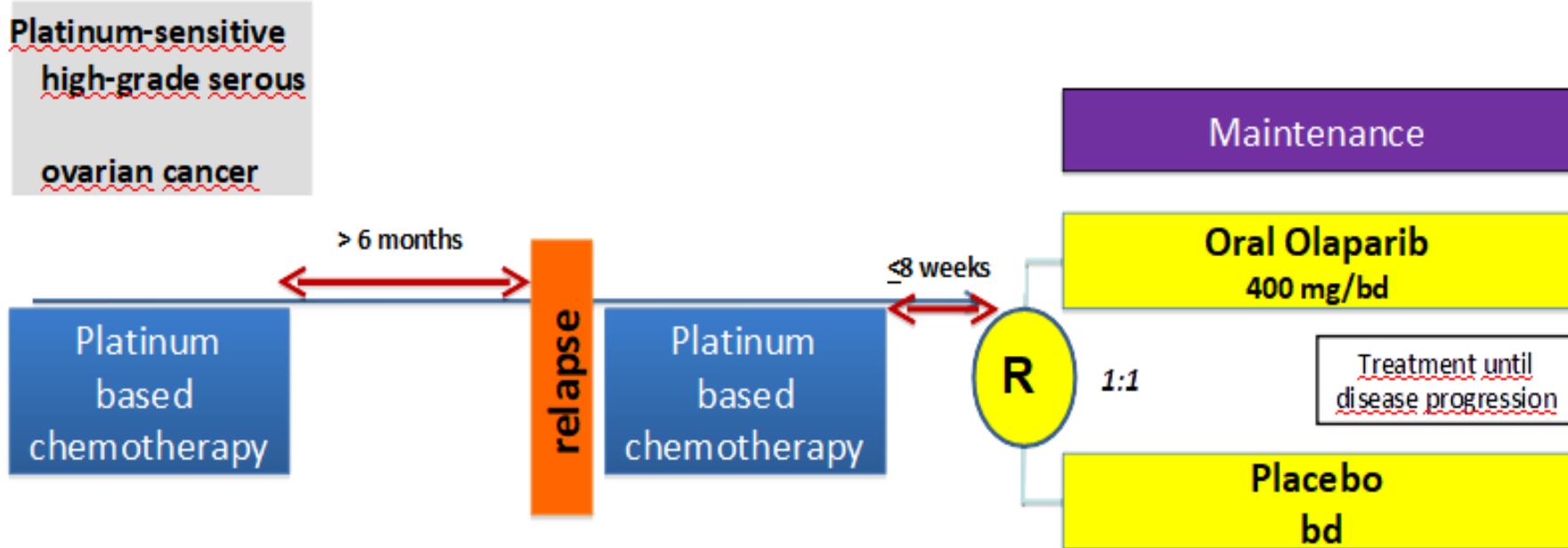
	Standard	Experimental	Log Rank P
events	161	143	
Median PFS	8.8 mos	11.8 mos	<0.001
HR	0.51 (0.41-0.65)		

# Treatment Options for the Patients

- Carboplatin doublet
- Carboplatin doublet with bevacizumab followed by maintenance with bevacizumab
- **Carboplatin doublet followed by PARPi in case of response, but only if sBRCA is mutated**
- Carboplatin doublet followed by PARPi in case of response, independently of sBRCA status

# Study 19: Aim and design

- Randomised, double-blind, placebo-controlled Phase II study



## Stratification

- Time to disease progression on penultimate platinum therapy
- Objective response to last platinum therapy
- Ethnic descent

## Primary endpoint:

Progression-free survival (PFS) by RECIST\*

## Secondary endpoints:

Time to progression by CA-125 (GCIG criteria) or RECIST

Overall survival

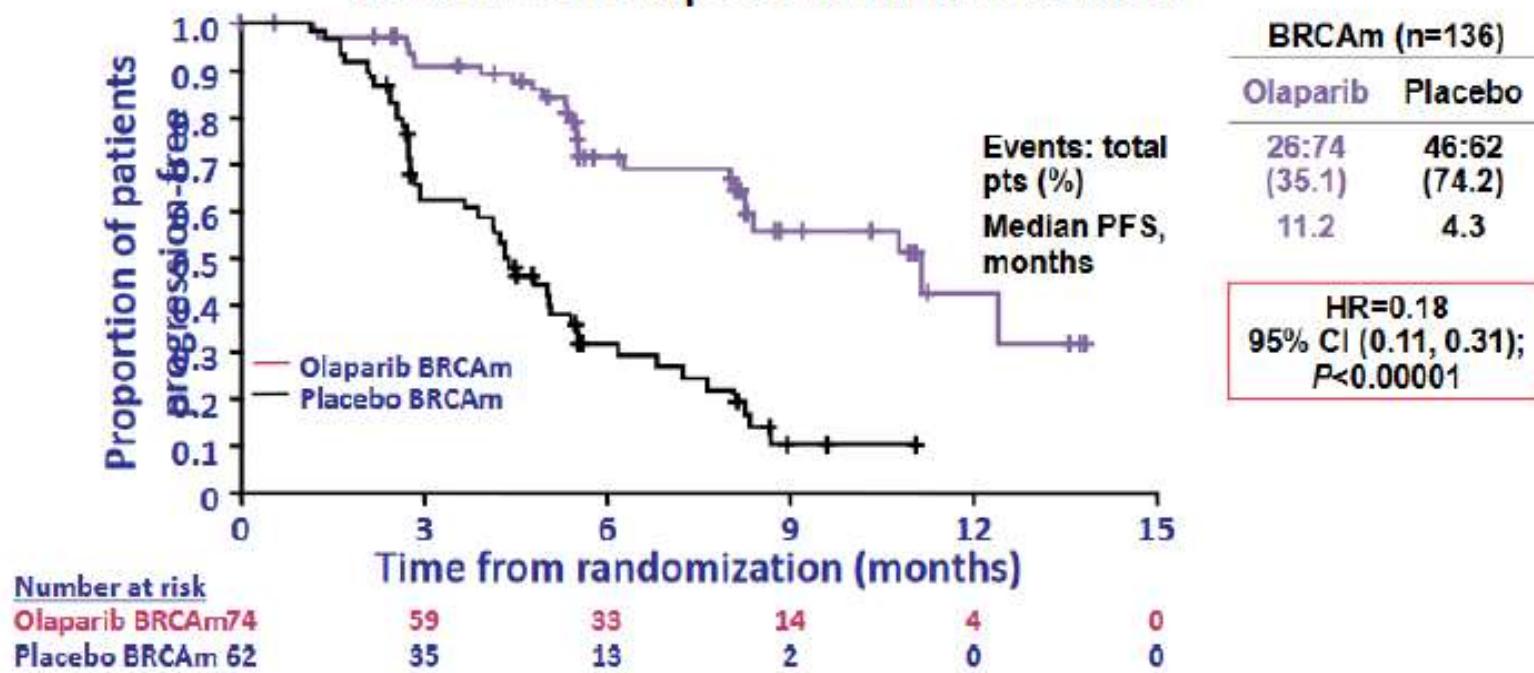
Objective response rate by RECIST

Safety and tolerability

Health-related quality of life and symptoms

Ledermann J et al. N Engl J Med 2012;366:1382-92

## Study 19: Olaparib maintenance therapy in platinum-sensitive relapsed ovarian cancer

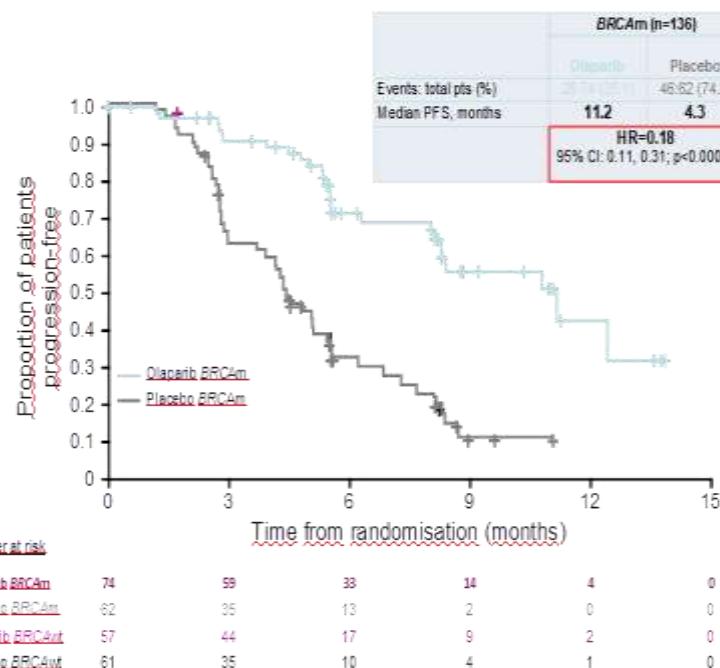


- 82% reduction in risk of disease progression or death with olaparib

# Study 19

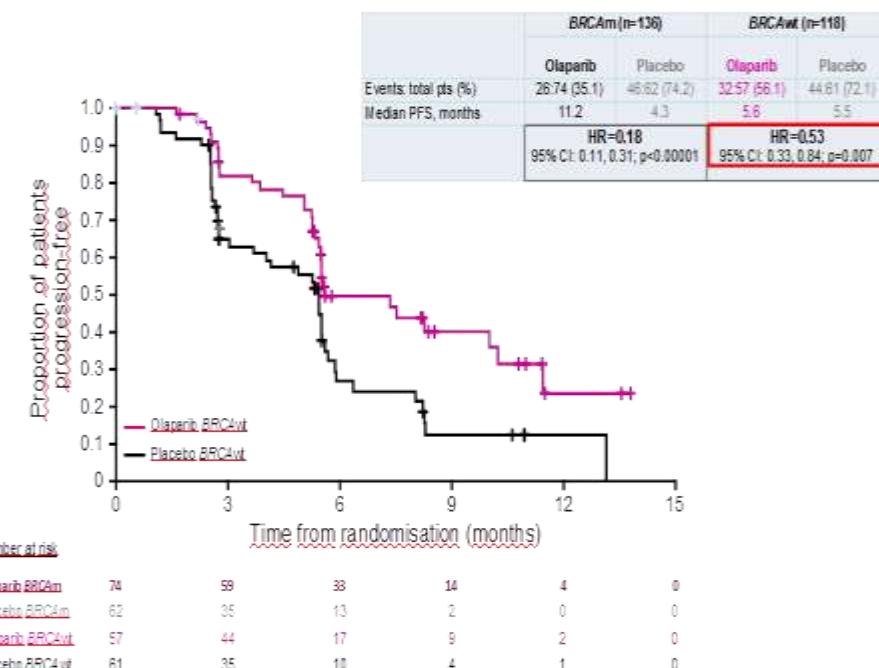
	Olaparib 400 mg bid (n=136)	Placebo (n=129)
BRCA- germline-mutation status, (%)		
BRCA1 or BRCA2 mutation	23	22
Known negative	13	16
Unknown	64	63

Study 19: PFS in BRCA mutated pts



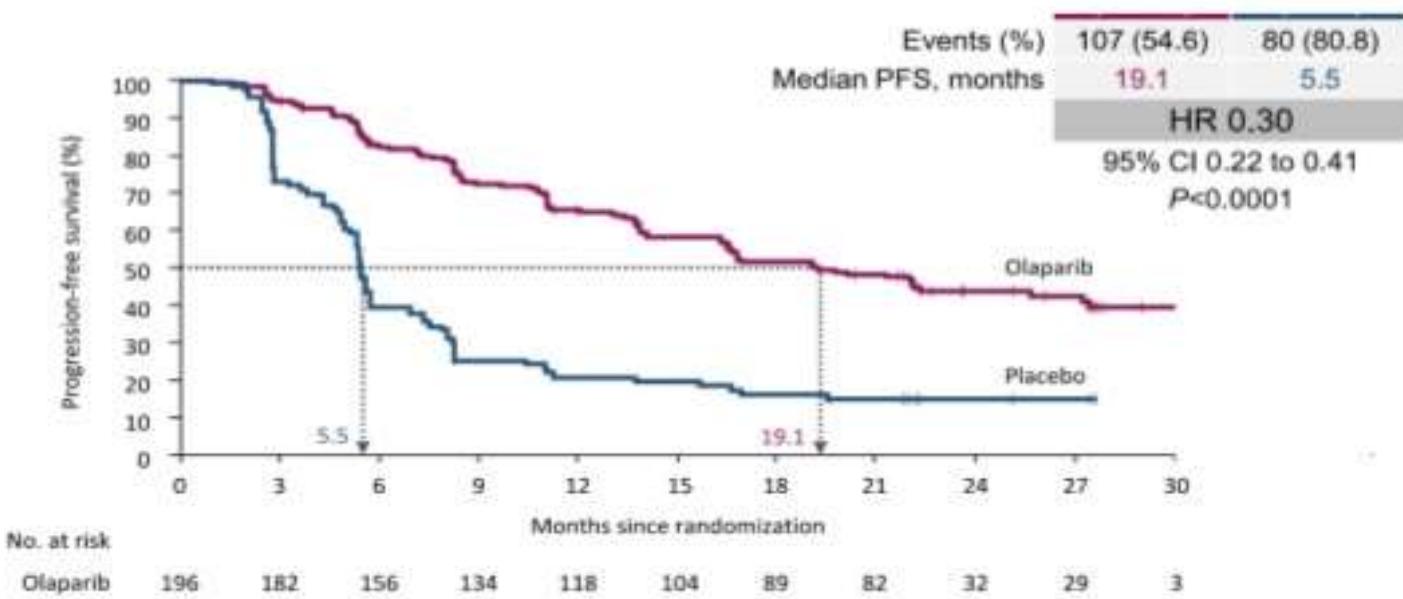
\* 82% reduction in risk of disease progression or death with olaparib

Study 19: PFS in BRCA wild type pts



\* 82% reduction in risk of disease progression or death with olaparib

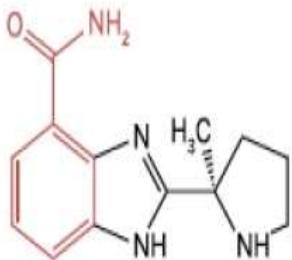
# SOLO2: Olaparib Maintenance



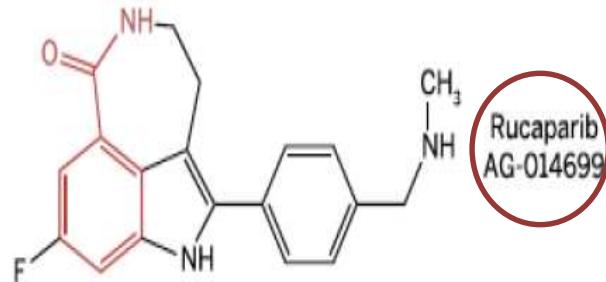
Median follow-up was 22.1 months in the olaparib group and 22.2 months for placebo

Pujade-Lauraine et al SGO 2017

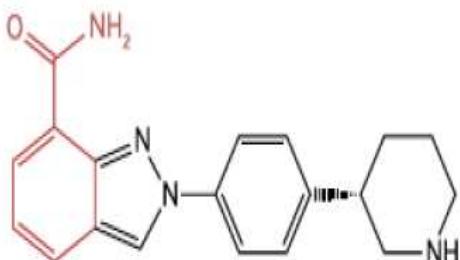
# PARP Inhibitors



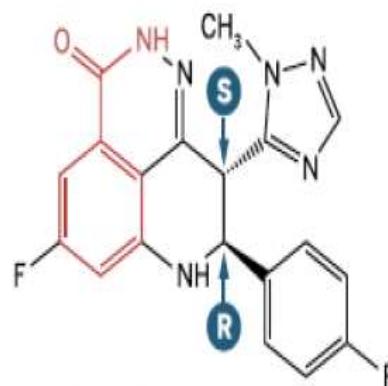
Veliparib  
ABT-888



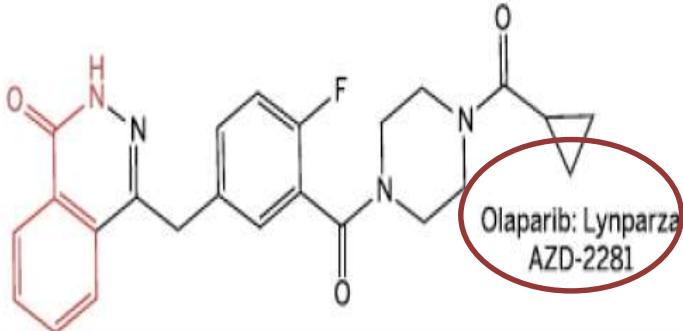
Rucaparib  
AG-014699



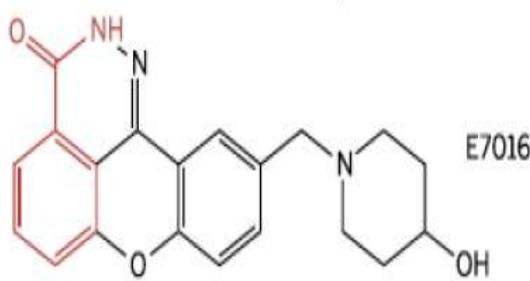
Niraparib  
MK-4827



Talazoparib  
BMN-673



Olaparib: Lynparza  
AZD-2281

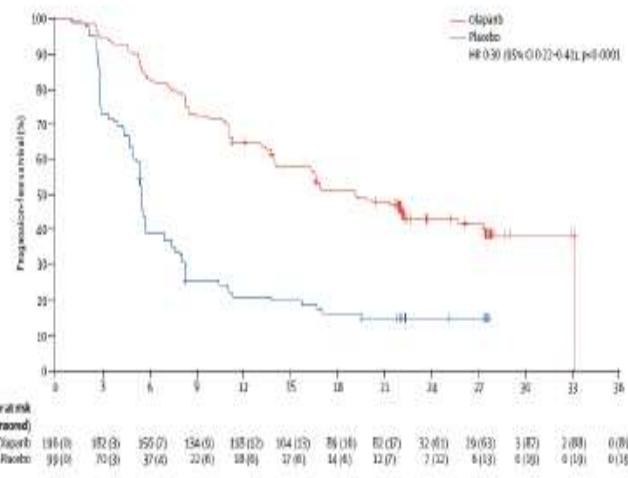


E7016

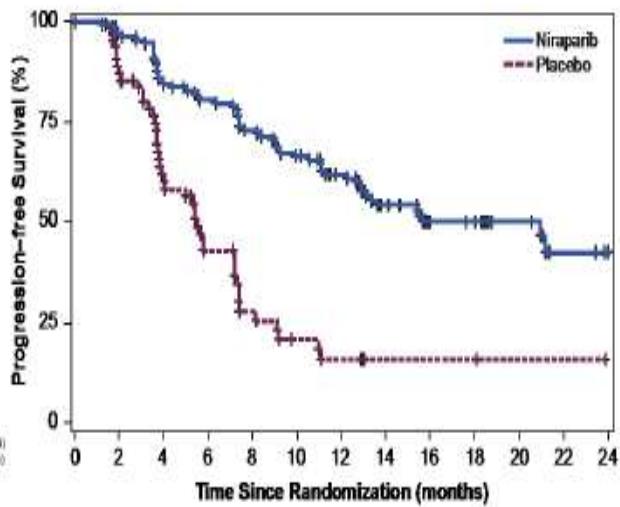
# Efficacy of PARPi in Patients with BRCA-Mutant Disease

## Primary Endpoint: PFS

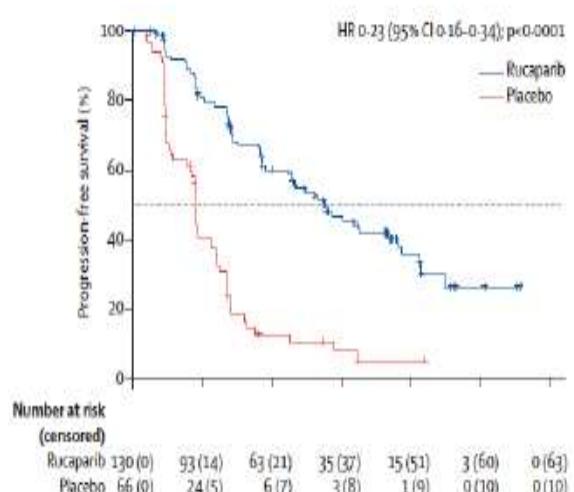
**1 SOLO-2**



**2 NOVA**



**3 ARIEL-3**



**19.1 vs 5.5 months**

**HR 0.3 (95% CI: 0.22-0.41)**

**21.0 vs 5.5 months**

**HR 0.27 (95% CI: 0.17-0.41)**

**16.6 vs 5.4 months**

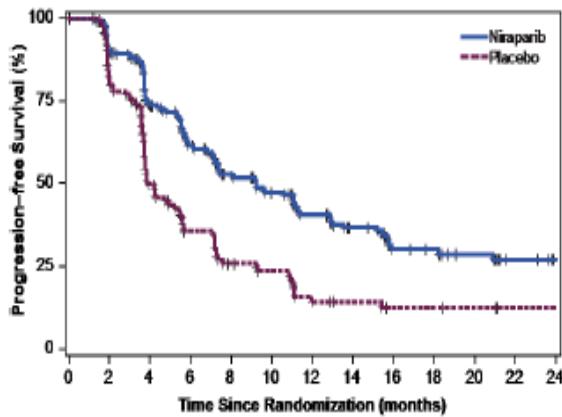
**HR 0.23 (95% CI: 0.16-0.34)**

# Treatment Options for the Patients

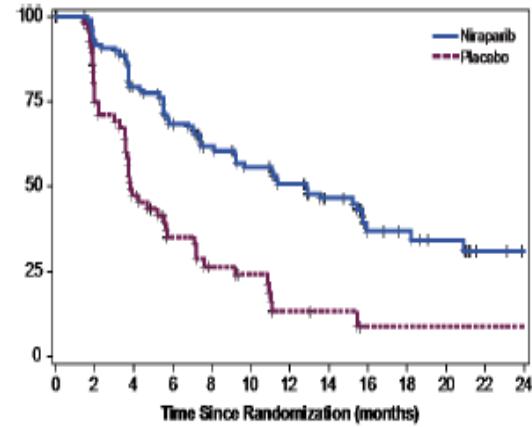
- Carboplatin doublet
- Carboplatin doublet with bevacizumab followed by maintenance with bevacizumab
- Carboplatin doublet followed by PARPi in case of response, but only if sBRCA is mutated
- **Carboplatin doublet followed by PARPi in case of response, independently of sBRCA status**

# Efficacy of PARPi in Patients with Non-gBRCA-Mutant Disease ENGOT-ov16/NOVA

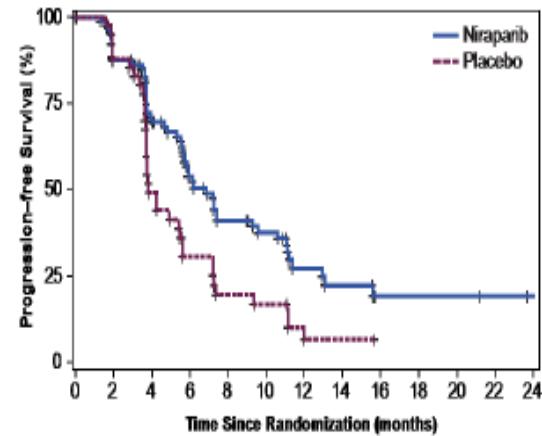
## PFS: Non-gBRCAmut



## PFS: HRD Positive



## PFS: HRD Negative



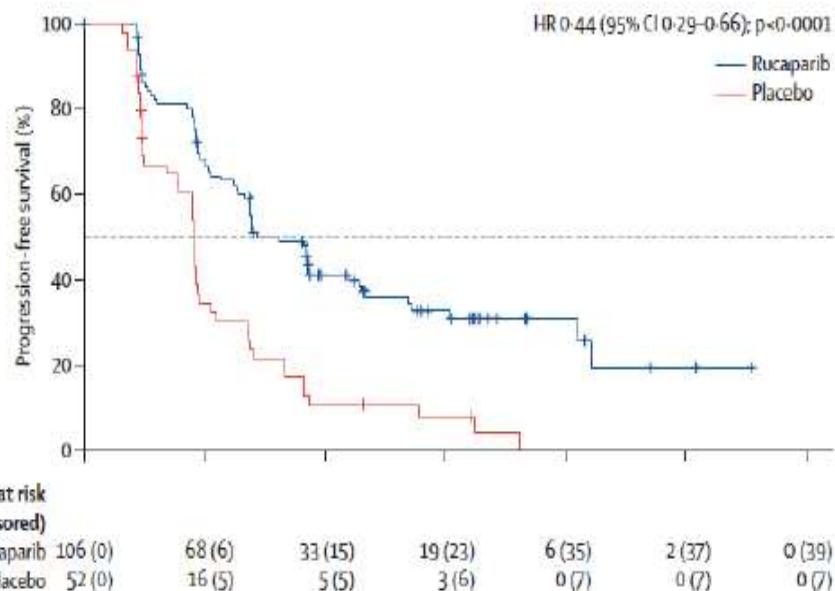
Treatment	PFS Median (95% CI) (Months)	Hazard Ratio (95% CI) p-value
Niraparib (N=234)	<b>9.3</b> (7.2, 11.2)	<b>0.45</b> (0.338, 0.607) p<0.0001
Placebo (N=116)	<b>3.9</b> (3.7, 5.5)	

Treatment	PFS Median (95% CI) (months)	Hazard Ratio (95% CI) P value
Niraparib (N=106)	<b>12.9</b> (8.1, 15.9)	<b>0.38</b> (0.243, 0.586) P<0.0001
Placebo (N=56)	<b>3.8</b> (3.5, 5.7)	

Treatment	PFS Median (95% CI) (Months)	Hazard Ratio (95% CI) p-value
Niraparib (N=92)	<b>6.9</b> (5.6, 9.6)	<b>0.58</b> (0.361, 0.922)
Placebo (N=42)	<b>3.8</b> (3.7, 5.6)	p=0.0226

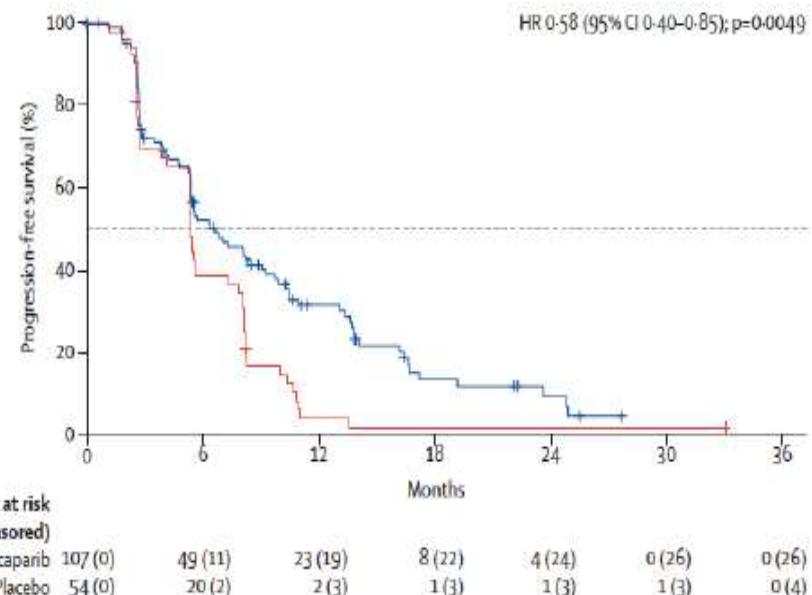
# Efficacy of PARPi in Patients with BRCAwt Disease ARIEL-3

## PFS: BRCAwt LOH High



9.7 months vs 5.4 months  
HR 0.44 (0.29–0.66);  $P < .0001$

## PFS: BRCAwt LOH Low



6.7 months vs 5.4 months  
HR 0.58 (0.40–0.85);  $P = .0049$

# PARPi Maintenance Therapy is Changing Clinical practice in Ovarian Cancer

In clinical studies, PARP inhibitors have demonstrated improved progression-free survival compared with placebo<sup>1-3</sup>

Current approval status of PARP inhibitors as maintenance therapy for recurrent ovarian cancer:

Niraparib  
NOVA trial, 2016<sup>1</sup>

Olaparib  
Study 19, 2014<sup>2</sup>

Rucaparib  
ARIEL3 study, 2017<sup>3</sup>

Europe



Indicated as maintenance therapy<sup>4</sup>

Indicated as maintenance therapy for patients with BRCAmut disease<sup>5</sup>

Not indicated as maintenance therapy, indicated as single agent<sup>7</sup>

USA



Indicated as maintenance therapy<sup>4</sup>

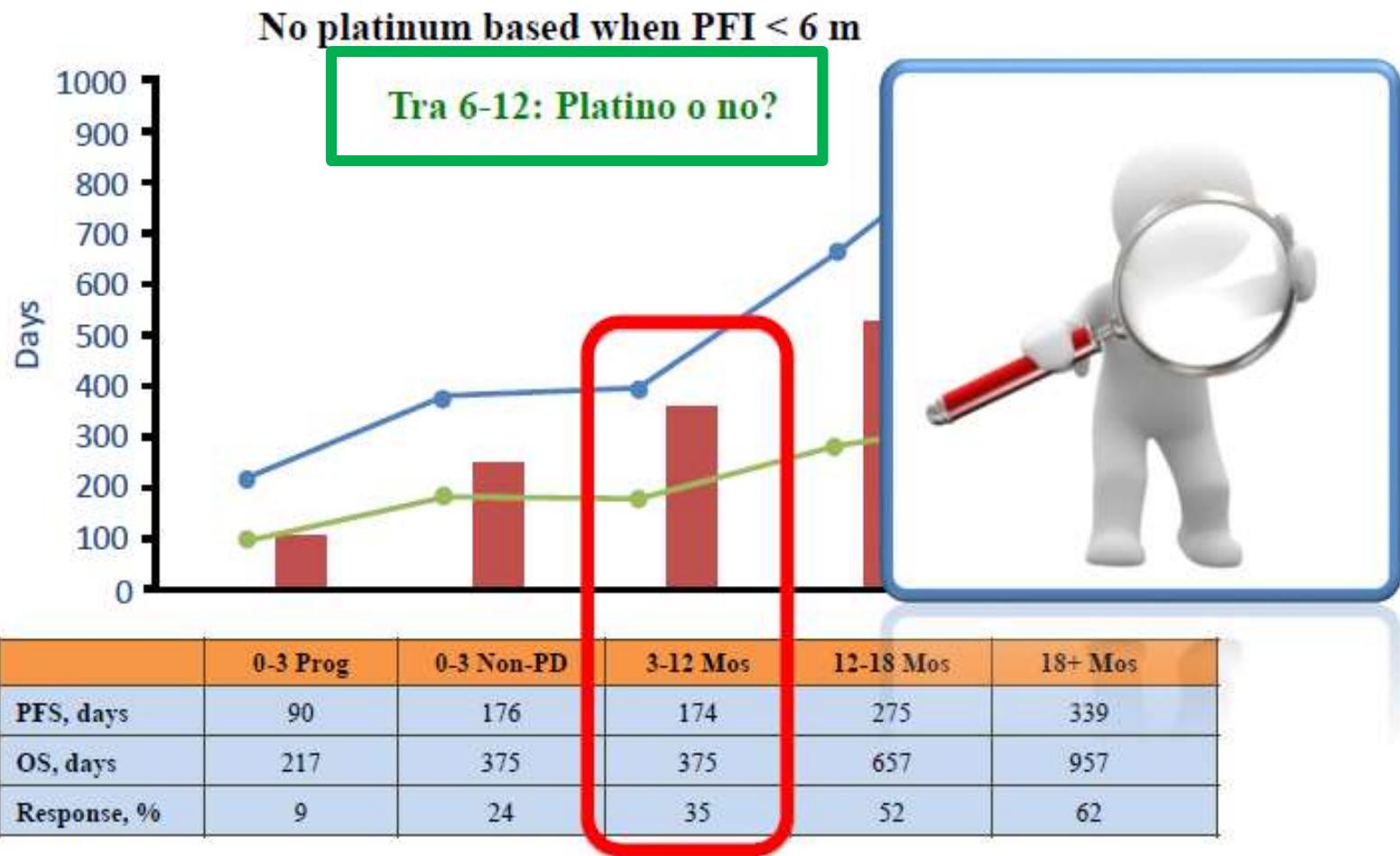
Indicated as maintenance therapy and as single agent<sup>6</sup>

Indicated as maintenance therapy and as single agent<sup>8</sup>

BRCA, breast cancer susceptibility gene; BRCAmut, BRCA1 mutation; PARP, poly(ADP) ribose polymerase.

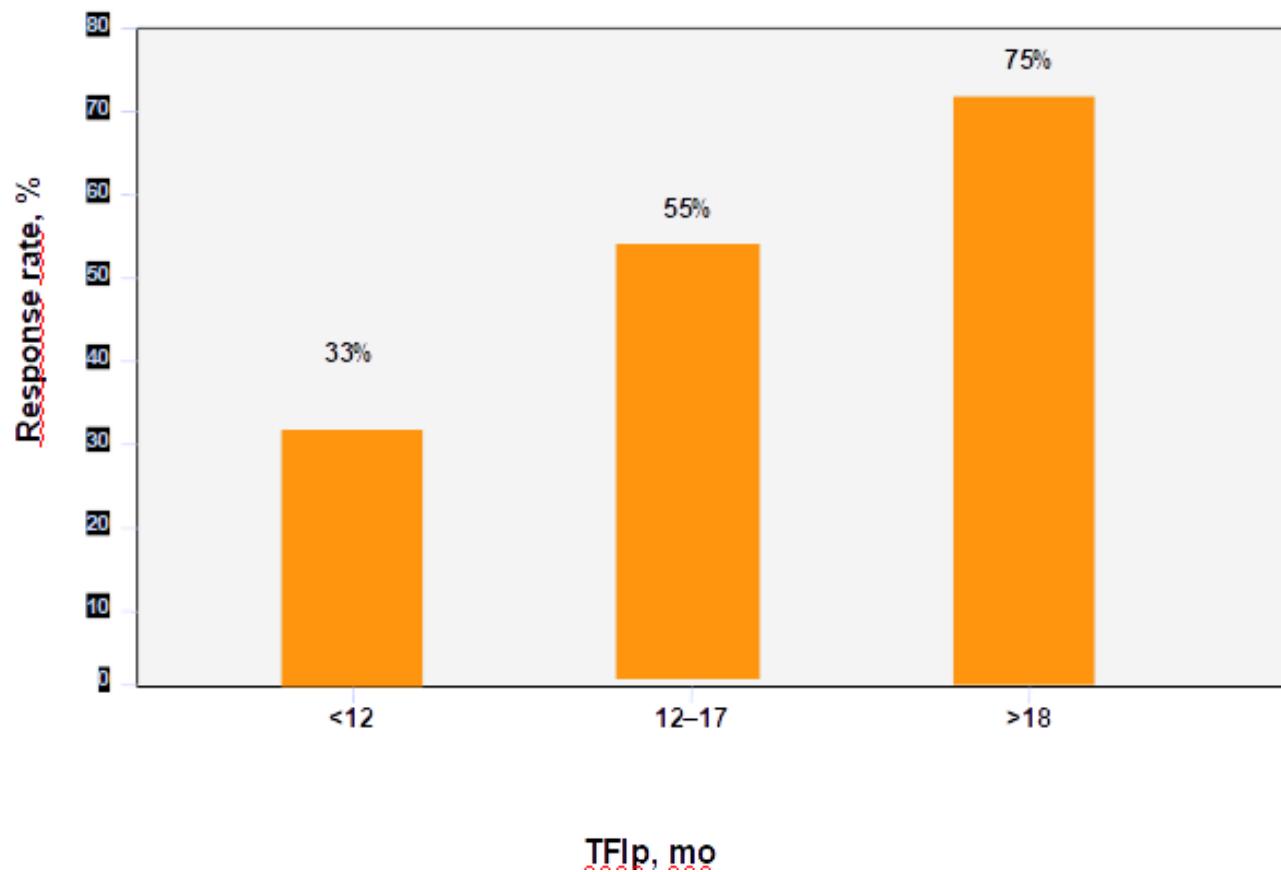
1. Mirza MR et al. *N Engl J Med* 2016; 375 (22): 2154–2164. 2. Ledermann J et al. *Lancet Oncol* 2014; 15 (8): 852–861. 3. Coleman RL et al. *Lancet* 2017; 390 (10106): 1949–1961. 4. Tesaro, Inc. ZEJULA™ – package insert; 2017. 5. AstraZeneca Pharmaceuticals LP. Lynparza™ – package insert; AstraZeneca Pharmaceuticals LP, Wilmington, USA, 2017. 6. AstraZeneca UK Ltd. Lynparza™ – product information; AstraZeneca UK Ltd, Waltham, MA: TESARO, Inc; 2017. 7. Clovis Oncology UK Ltd. Rubraca® 200 mg / 250 mg / 300 mg film coated tablets – summary of product characteristics. Clovis Oncology UK Ltd., Cambridge, May 2018. 8. Clovis Oncology, Inc. Rubraca® – prescribing information; April 2018.

# Malattia parzialmente platino sensibile

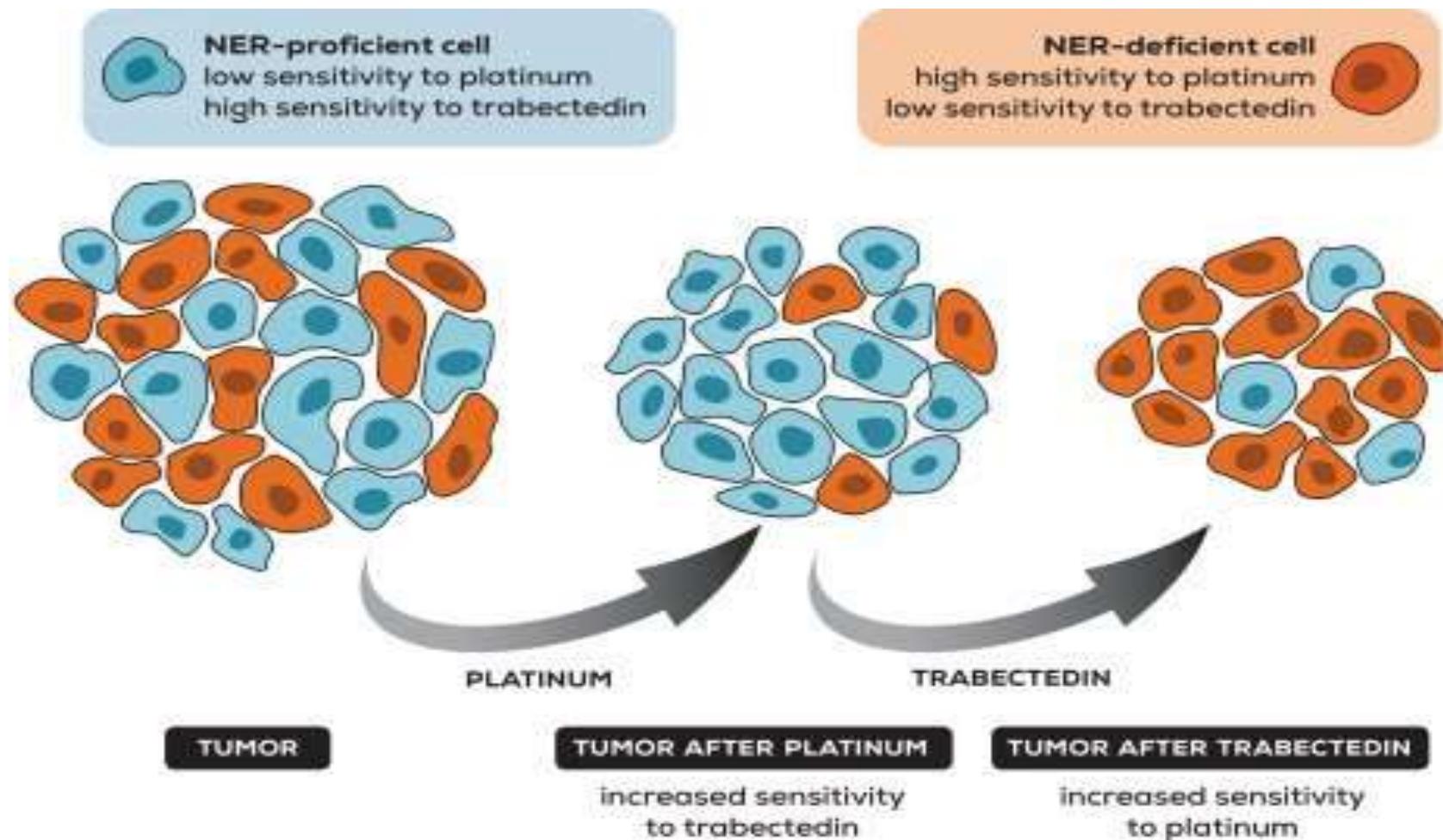


Pujade-Lauraine E, et al. ASCO 2002

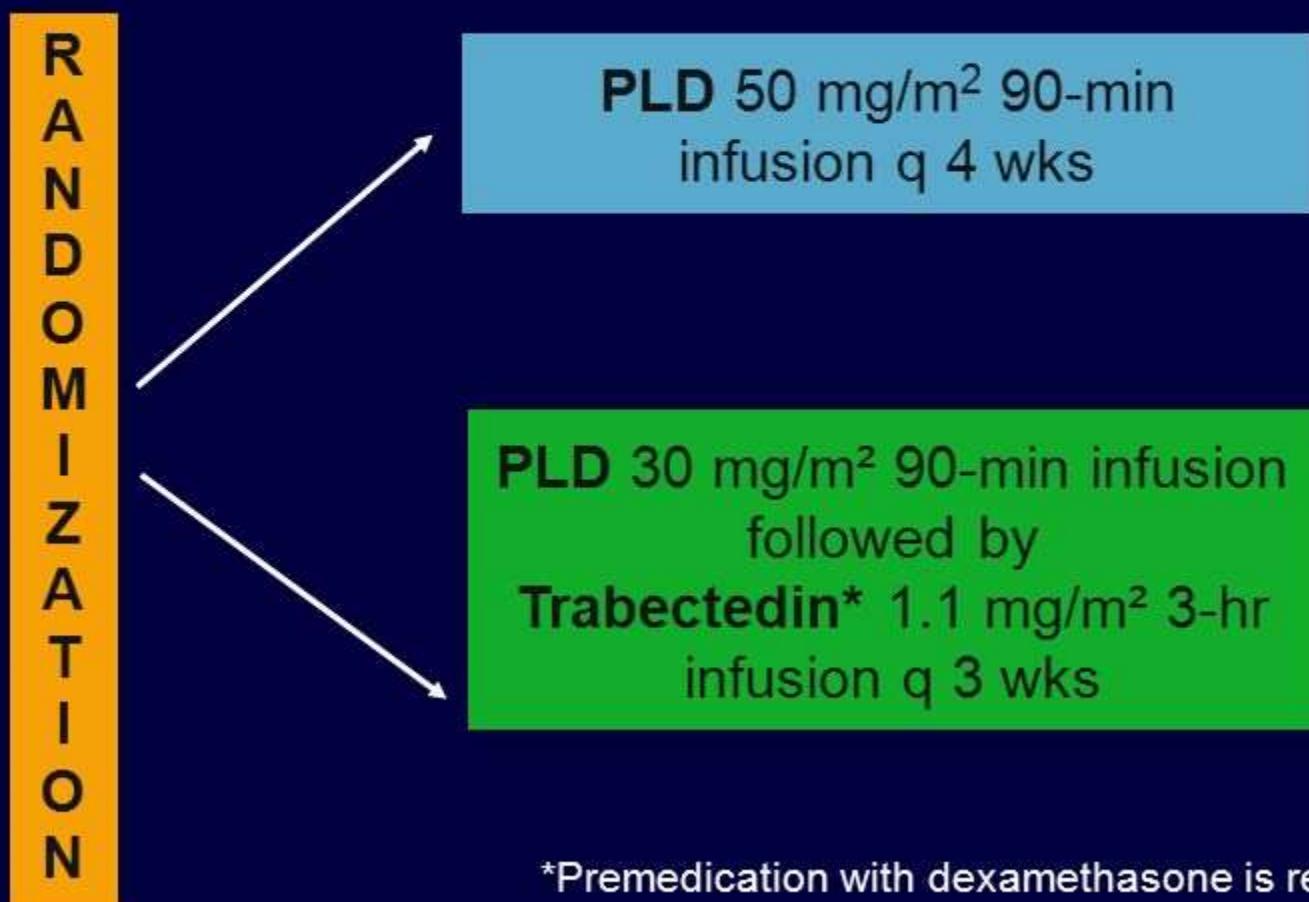
# Effect of platinum-free interval on platinum rechallenge



# The Sequence Effect

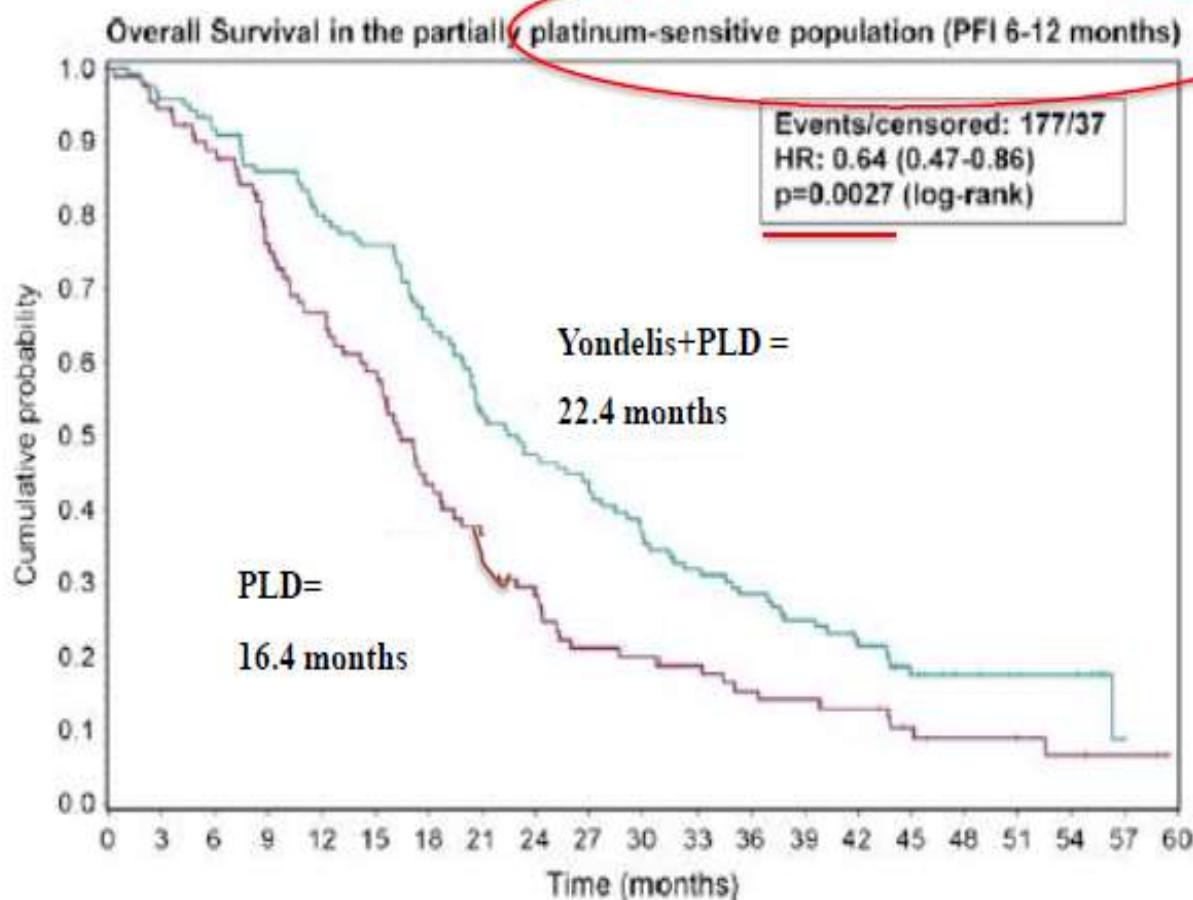


# OVA-301: Methods—Study Design Phase III Trial



\*Premedication with dexamethasone is required.

# Trabectedin: OVA-301 Study Design



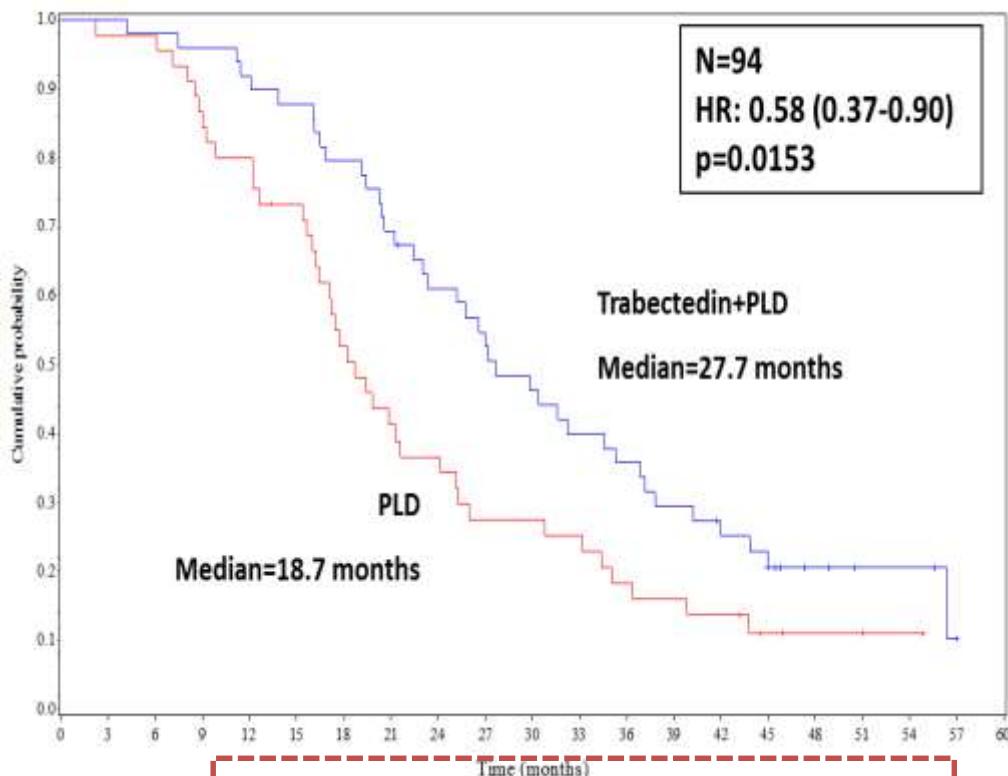
Furthermore:

- ✓ Longer time to new treatment (*Kaye S et al., 2011*)
- ✓ longer OS in patients treated successively with platinum based strategy (*Colombo N et al., 2011*)

# Pazienti PPS: effetto di trabectedina nelle linee successive

- Nelle pazienti PPS (n=94) che fanno platino come successiva terza linea di trattamento il braccio trabectedina + PLD riporta una riduzione del rischio relativo di morte del 42% verso PLD (HR 0.58, p=0.0153)
- Dalla randomizzazione... si riporta una sopravvivenza mediana nel gruppo trabectedina + PLD di 27,7 mesi verso 18,7, con un aumento significativo di 9 MESI

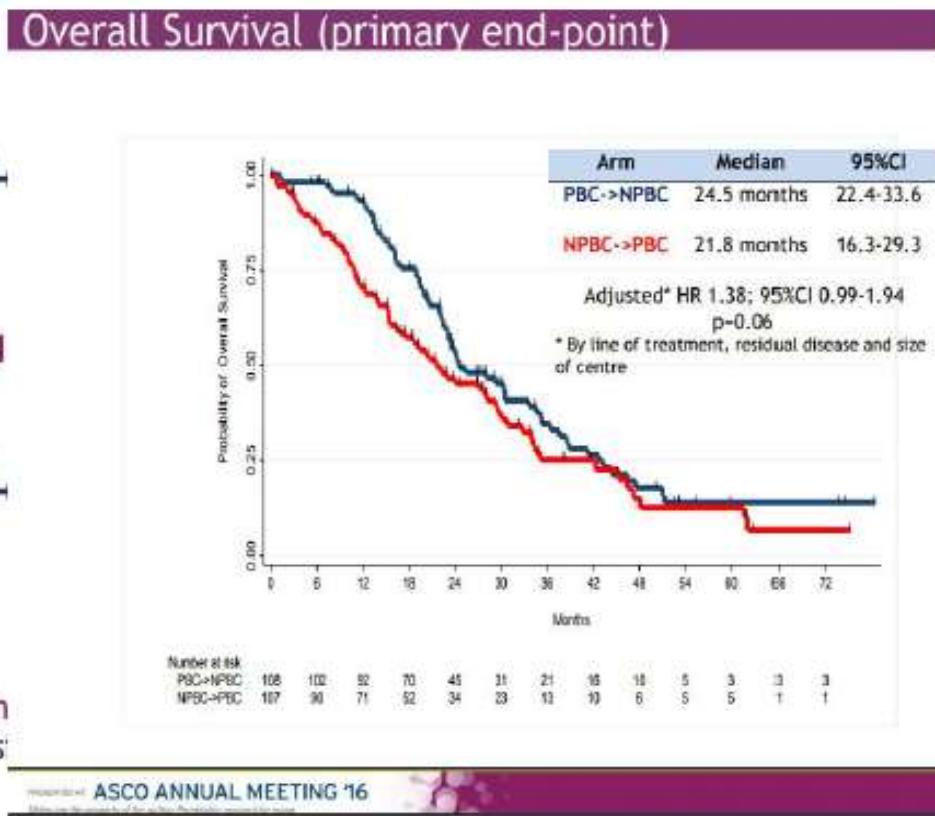
Overall survival in PPS patients with platinum as subsequent treatment



Concludiamo che trabectedina, oltre al suo effetto primario, aumenta l'efficacia della linea successiva a base di platino

# Extension of Platinum Free Interval: Myth o Reality?

## MITO 8



\*Pt-based Chemotherapy:  
• Carboplatin + Paclitaxel or  
• Carboplatin + Gemcitabine  
(in case of neurotoxicity at baseline)

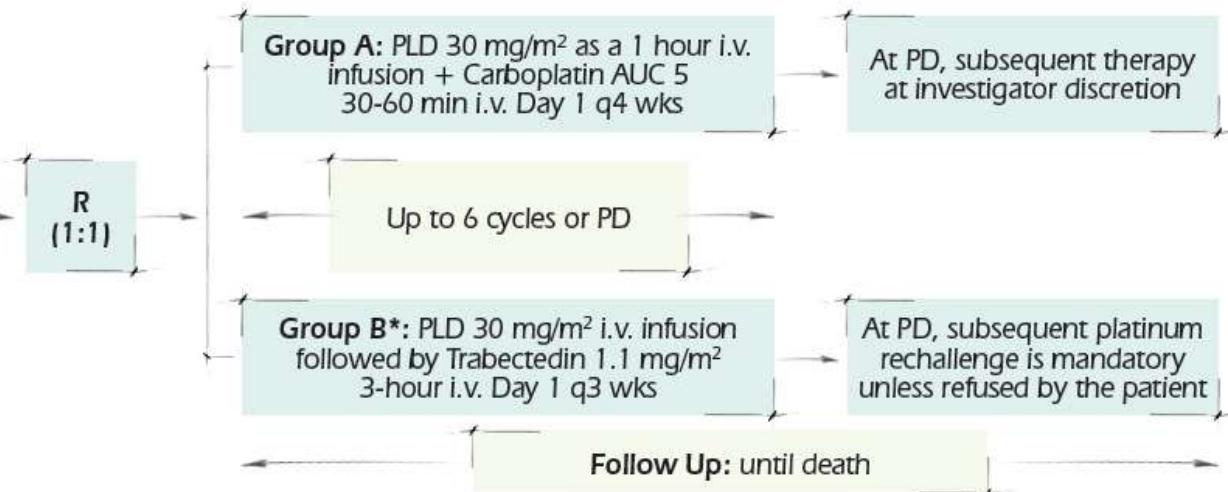
\*\*Non-Pt-Based Chemoth  
• PLD or other approved s

# Inovatyon Study

## Patients with Ovarian Cancer



Relapsed ovarian cancer with progression free interval of 6-12 months after end of last platinum-taxane therapy



\*Dexamethasone premedication

### Primary Endpoint

- To evaluate overall survival (OS) in patients with relapsed ovarian cancer progressing within 6-12 months after end of last platinum

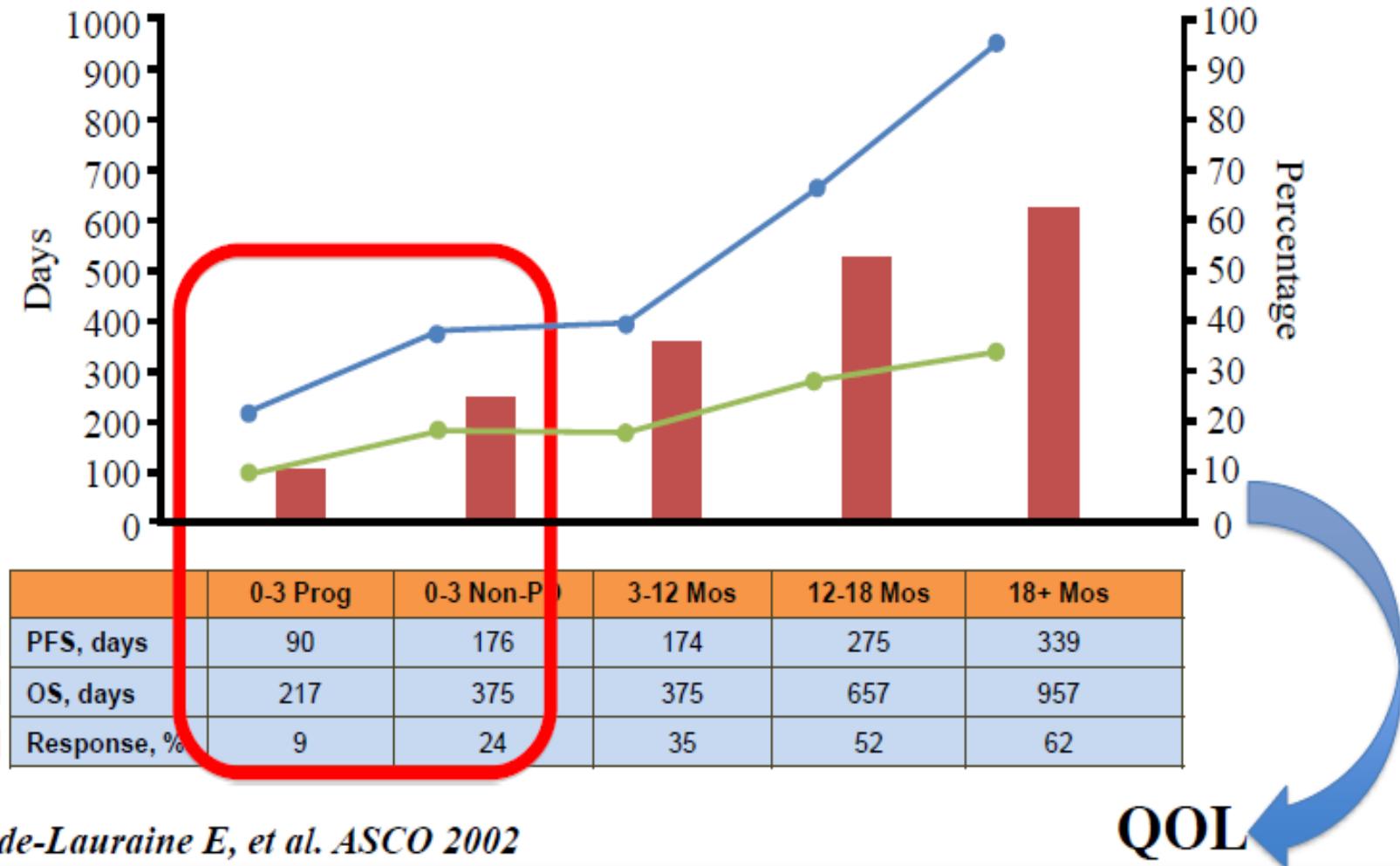
### Sponsor

- MaNGO group (Mario Negri Gynecologic Oncology)

### Secondary Endpoints

- To evaluate the time from randomization to subsequent chemotherapy and the OS counted from the administration of subsequent chemotherapy
- To evaluate serological response of CA-125
- Quality of life
- Safety profile, progression free survival, objective response rate

# Malattia Platino Refrattaria/Resistente



# Recurrent Platinum Resistant Ovarian Cancer

## Studi di fase III

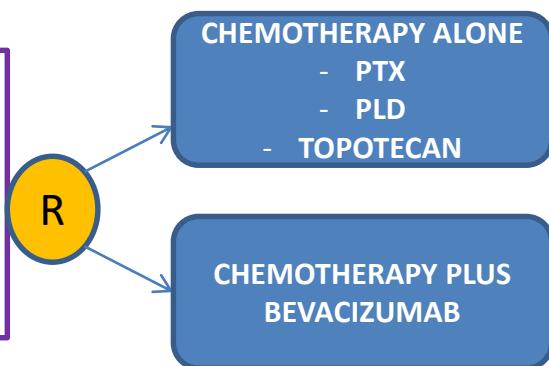
O' Byrne 2002	PLD vs. paclitaxel	No difference
Ten Bokkel Huinik 2003	Topotecan vs. paclitaxel	No difference
Gordon 2004	PLD vs. topotecan ence	No difference
Mutch, Ferrandina 2006	PLD vs. gemcitabine	No difference

## Studi di fase III sull'uso di combinazioni vs singoli agenti nella malattia refrattaria/resistente

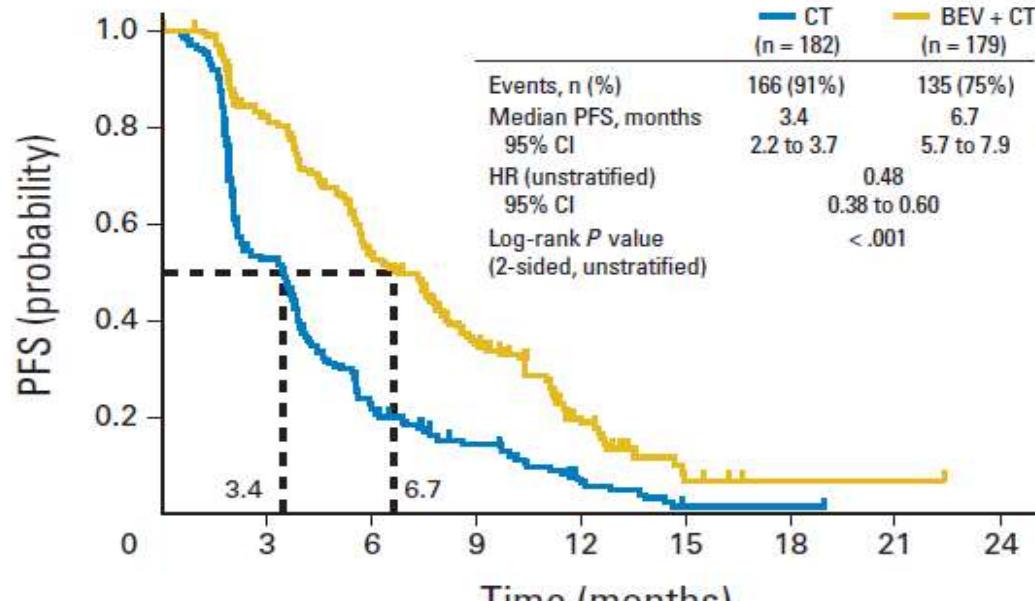
Author	N pts	Drugs	RR (%)	PFS (median)	OS (median)	Note
Buda 2004	212	PTX vs PTX+EPI	46.9 37.4	6.0 m 6.0 m	14.0 m 12.0 m	Increased toxicity in the combination arm
Bolis 1999	81	PTX vs PTX+EPI	17.1 34.2	NR NR	18 10 (2-year OS)	Increased toxicity in the combination arm
Sehouli 2008	502	TPT vs TPT+ VP 16 vs TPT +GEM	27.8 36.1 31.6	7.0 m 7.8 m 5.3 m	17.2 m 17.8 m 15.2 m	Increased toxicity in the combination arm
Vergote 2010	125	PLD vs CAN+PLD	12.3 8.3	3.7 m 5.6 m	NR NR	Increased toxicity in the combination arm
Monk 2010	242	PLD vs PLD + ET743	12.2 13.4	4.0 m 3.7 m	12.4 m 14.2 m	Increased toxicity in the combination arm
Lortholary 2012	165	PTX w vs CBDA + PTX w vs TPT w	35 37 39	3.7 m 4.8 m 5.4 m	19.9 m 15.2 m 18.6 m	Increased toxicity in the combination arm

# AURELIA

Recurrent/  
resistant  
ovarian  
cancer  
Endpoints  
PFS, QoL  
N=300

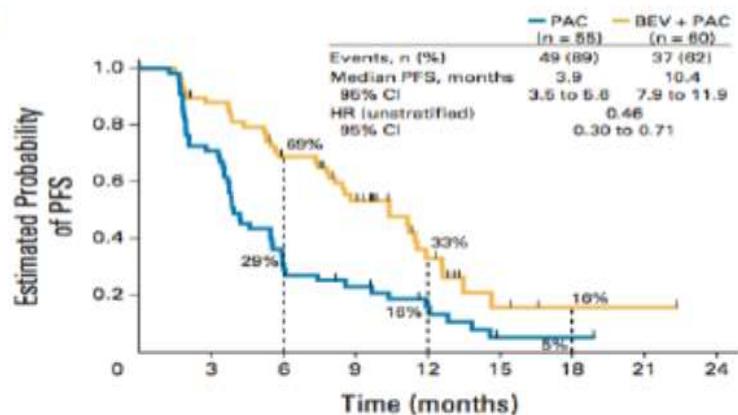


Pujade-Lauriane E et al, JCO 2014

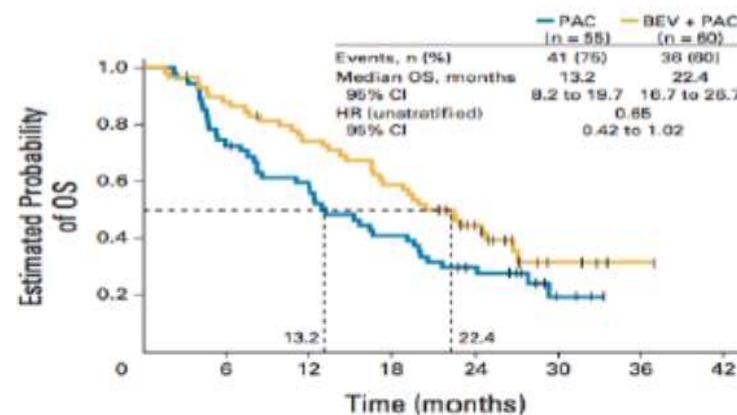


## Paclitaxel cohort

**A**



**B**



No. at risk  
PAC  
BEV + PAC

No. at risk  
PAC  
BEV + PAC

# Immune Checkpoint inhibitors in Ovarian Cancer: still room for improvement

	Nivolumab <sup>1</sup>	Pembrolizumab <sup>2</sup>	Avelumab <sup>3</sup>	Atezolizumab <sup>4</sup>	Durvalumab <sup>5</sup>
No	20	26	124	12	20*
PD-L1+ prevalence	80% (IC 2/3)	100% ( $\geq 1\%$ TC)	77% ( $\geq 1\%$ TC)	83% (IC 2/3)	73% ( $> 5\%$ TC)
Prior therapies	$\geq 4$ in 55% of cases	$\geq 5$ in 38.5%	$\geq 3$ In 65.3%	$\geq 6$ In 58%	4* Median:
ORR	15%	11.5%	9.7%	25%	Not reported

1. Hamanishi, et al. J Clin Oncol 2015;33:4015-4022. Abstract 5510;

2. Varga, et al. Presented at ASCO 2015;

3. Disis, et al. Presented at ASCO 2016. Abstract 5533;

4. Infante, et al. Presented at ESMO 2016. Abstract 871;

5. Lee, et al. Presented at ASCO 2016. Abstract 3015

PD-L1: programmed death-ligand 1

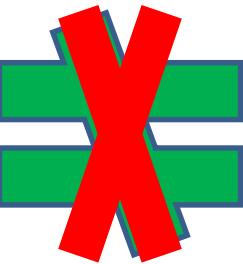
# Conclusioni (1)

- La chemioterapia a base di platino rimane una certezza
- Il Bevacizumab incrementa la PFS nelle varie linee di trattamento
- La determinazione del BRCA 1-2 diventa una necessità, oltre che per la prevenzione familiare, anche per la terapia con PARP inhibitors e i suoi risultati.
- I trials randomizzati ongoing in tutti i setting di malattia risponderanno al quesito sul ruolo dell'immunoterapia nel trattamento del carcinoma ovarico
- Ancora molto c'è da fare

INNOVAZIONE

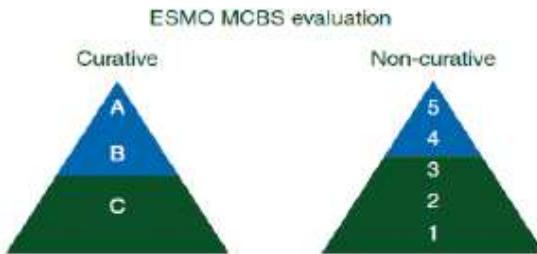


ACCESSIBILITA'



SOSTENIBILITA'

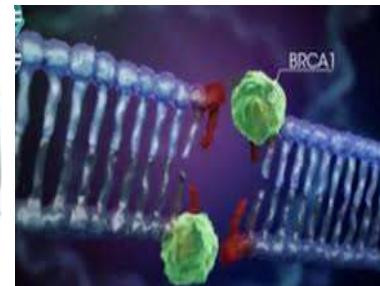
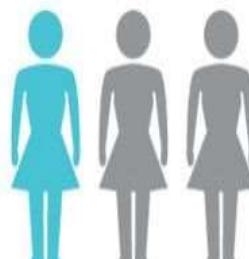
Bilancio  
Benefici/Rischi



Curative-Evaluation form 1: for new approaches to adjuvant therapy or new potentially curative therapies

Non-curative-Evaluation forms 2a, b or c: for therapies that are not likely to be curative

INFORMAZIONE



*Grazie per l'attenzione*