IGCS 2025 CAPE TOWN

Annual Global Meeting, November 5–7, 2025

IGCS 2025 Abstracts: Seminal Presentations

Seminal abstract presentations are included in the sessions listed below. Sessions with oral/mini oral presentations will be recorded for on-demand viewing via the IGCS 360 Educational Portal as indicated.

ORAL PRESENTATIONS:

Plenary: High-Impact Oral Abstract Presentations
Wednesday, November 5, 08:30 - 09:30 | Hall A&B | in-person & on-demand

Plenary: Endometrial Cancer Oral Abstract Presentations
Wednesday, November 5, 09:35 - 10:35 | Hall A&B | in-person & on-demand

Plenary: Ovarian Cancer Oral Abstract Presentations
Thursday, November 6, 08:00 - 09:25 | Hall A&B | in-person & on-demand

MINI ORAL PRESENTATIONS:

Mini Oral Abstract Presentations 01
Friday, November 7, 09:15 - 10:45 | Hall C | in-person & on-demand

Mini Oral Abstract Presentations 02
Friday, November 7, 11:25 - 12:25 | Hall C | in-person & on-demand

SE001 / #1325

TRUST: TRIAL OF RADICAL UPFRONT SURGICAL THERAPY IN ADVANCED OVARIAN CANCER (ENGOT OV33/AGO-OVAR OP7)

PLENARY: HIGH-IMPACT ORAL ABSTRACT PRESENTATIONS

Giovanni Aletti[1], Florian Heitz[1,2], Sahar Salehi[3], Alexander Reuss[4], Frederic Guyon[5], Andreas Du Bois[6], Philipp Harter[6], Christina Fotopoulou[7], Denis Querleu[8], Berit Mosgaard[9], Bernhard Krämer[10], Francesco Raspagliesi[11], Björn Lampe[12], Alexander Burges[13], Barbara Schmalfeldt[14], Pauline Wimberger[15], Holger Bronger[16], Dennis Chi[17], Jalid Sehouli[18], Sven Mahner[19]
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Background: Optimal timing of cytoreduction in non-frail patients (pts) with seemingly resectable stage IIIB-IVB ovarian, tubal, and peritoneal carcinoma (OC) remains controversial.

Methods: TRUST is an international randomized multicenter phase III trial in pts with stage IIIB-IVB OC and good performance status (ECOG 0/1) comparing primary cytoreductive surgery (PCS) followed by 6 cycles of intravenous (iv) chemotherapy to 3 cycles of neoadjuvant iv chemotherapy (NACT) followed by interval cytoreductive surgery (ICS) and 3 further iv cycles. Maintenance treatment with bevacizumab and/or

PARP inhibitors was allowed if selection criteria was similar for both arms. Pts were eligible for the study if preoperative clinical and radiologic assessment identified them as potential candidates for PCS. To ensure surgical quality, participating centers complied with an onsite surgery quality assurance audit, had adequate infrastructure, surgical proficiency (complete resection rates ≥50% in PCS) and sufficient volume (≥36 PCS/year). The intent to treat analysis population included all eligible pts with confirmed stage IIIB-IVB disease. The primary endpoint was overall survival (OS). Superiority was tested using a two-sided stratified log-rank test with significance level 0.05. Secondary endpoints were progression-free survival (PFS) and surgical complications.

Results: A total of 688 eligible pts (median age: 63y; range: 32-83) underwent randomization: 345 were assigned to PCS and 343 to NACT/ICS. 92% had high-grade serous histology. Complete resection was achieved in 68%/70% of all randomized/all operated pts in the PCS group and 79%/85% in the ICS group. Median PFS was 22.1 months in the PCS group, and 19.7 months in the ICS group (HR 0.80 95%CI: 0.66-0.96; p=0.02). Median OS was 54.3 months in the PCS group and 48.3 months in the ICS group (HR 0.89 95%CI: 0.74-1.08; p=0.24). Pts with complete cytoreduction after PCS had the most favorable outcome, with a median PFS and OS of 27.9 and 67.0 months, respectively. A long-term benefit from PCS was seen in all analyzed subgroups. The benefit of PCS was most prominent in stage III pts (n=468): median PFS for PCS vs ICS, 26.3 vs 21.4 mos; median OS for PCS vs ICS, 63.7 vs 53.2 months. Major postoperative complication rates were acceptable, with a 30-day postoperative mortality rate of < 1% in both groups.

Conclusions: In expert centers with proven surgical quality, PCS followed by iv chemotherapy resulted in a significantly longer median PFS and a numerically longer OS compared to NACT/ICS in non-frail OC pts. Although statistical significance in the primary endpoint was not reached, this is the first randomized trial to show a benefit of PCS over ICS. This benefit is likely to be associated with the high complete resection rate, reinforcing PCS as a standard of care in non-frail pts with seemingly resectable advanced OC.

SE002 / #1326

ULTRASENSITIVE DETECTION AND TRACKING OF CIRCULATING TUMOR DNA (CTDNA) AND ASSOCIATION WITH RELAPSE AND SURVIVAL IN LOCALLY ADVANCED CERVICAL CANCER (LACC): PHASE 3 CALLA TRIAL ANALYSES

PLENARY: HIGH-IMPACT ORAL ABSTRACT PRESENTATIONS

Jyoti Mayadev[1], Juan Carlos Vázquez Limón[2], Francisco Javier Ramírez Godinez[3], Manuel Leiva[4], Lucely Del Carmen Cetina-Pérez[5], Szilvia Varga[6], Alejandro Molina Alavez[7], Ashley Efrain Alarcon-Rozas[8], Natalia Valdiviezo[9], Xiaohua Wu[10], Masaki Mandai[11], Ronnie Shapira-Frommer[12], Maria Del Pilar Estevez-Diz[13], Sewanti Atul Limaye[14], Wenjing Xin[15], Hannah Dry[16], Maria Broggi[17], Daniel Y. Yuan[17], Ross Stewart[18], Bradley J. Monk[19]
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Background In LACC, there is an unmet need for prognostic biomarkers as about 1/3 of patients (pts) relapse after chemoradiotherapy (CRT). The global randomized CALLA trial (NCT03830866) of durvalumab (D) in combination with CRT followed by D (D+CRT arm) vs CRT (CRT arm) did not significantly improve progression-free survival (PFS) in a biomarker unselected intent-to-treat (ITT) population. We analyzed the association of ultrasensitive ctDNA detection with relapse and survival in the largest ctDNA data set in LACC to date.

Methods Adult women with Stage IB2-IIB node positive (N+) or IIIA-IVA any N LACC (ITT) were randomized 1:1 to D+CRT or CRT alone. NeXT Personal™ (Personalis, Fremont,

CA), an ultrasensitive tumor-informed MRD assay with up to 1,800 patient-specific variants from WGS, was used for ctDNA analysis from Cycle 1 Day 1 (C1D1; baseline [BL]), C3D1, and 6 mo post treatment initiation. Correlations were analyzed between ctDNA detection and outcomes (PFS, overall survival [OS]).

Results Of 770 pts randomized, the biomarker-evaluable population (BEP) comprised 185, 186, and 130 pts at BL, C3D1, and 6 mo, respectively. BL pt characteristics, PD-L1, PFS, and OS between BEP and ITT populations were generally similar. ctDNA was detected in 99% of pts at BL and decreased after treatment, reaching 23% in the D+CRT and 36% in the CRT arm at 6 mo. The lower detection rate in the D+CRT arm was associated with the PD-L1 tumor area positivity (TAP) ≥20% subpopulation. At BL, pts with low (<BL median [5268.2 ppm]) ctDNA levels had a reduced risk of progression vs pts with high (≥median) ctDNA levels (PFS hazard ratio [HR] D+CRT 0.57 [95% CI, 0.26-1.26]; CRT 0.62 [0.31-1.23]). Pts with detectable ctDNA at C3D1 or 6 mo had a higher risk of progression independent of treatment arm (Table). No differences in risk of progression between the D+CRT vs CRT arms were observed based on ctDNA detection. Correlations between ctDNA and OS will be presented.

	D+CRT		CRT	
	Not detected	Detected	Not detected	Detected
C3D1	n=60	n=33	n=56	n=37
Median PFS (95% CI), mo	NC (NC-NC)	14.03 (7.49-NC)	NC (NC-NC)	10.68 (7.39-NC)
HR (95% CI)	0.23 (0.11-0.50)		0.15 (0.07-0.33)	
6 mo	n=49	n=15	n=42	n=24
Median PFS (95% CI), mo	NC (NC-NC)	10.35 (7.49-NC)	NC (NC-NC)	12.98 (10.38-NC)
HR (95% CI)	0.04 (0.01-0.16)		0.04 (0.01-0.17)	

NC, not computed / not reached

Conclusions

This pre-planned analysis of a large, global LACC population from CALLA demonstrates the high sensitivity of a personalized ctDNA assay. High ctDNA levels at BL were

associated with higher risk of progression or death. Lower ctDNA detection rates after treatment with D+CRT and CRT correlated with improved survival and highlight increased tumor control by D, especially in the PD-L1 TAP ≥20% subpopulation. This analysis supports the potential utility of ultrasensitive ctDNA analysis to guide treatment decisions in LACC.

SE003 / #1327

RALUDOTATUG DERUXTECAN (R-DXD) IN PATIENTS WITH PLATINUM-RESISTANT OVARIAN CANCER (PROC): PRIMARY ANALYSIS OF THE PHASE 2, DOSE-OPTIMIZATION PART OF THE REJOICE-OVARIAN01 STUDY

PLENARY: HIGH-IMPACT ORAL ABSTRACT PRESENTATIONS

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Background: R-DXd, an antibody–drug conjugate, comprises a humanized cadherin 6 (CDH6) IgG1 mAb attached to a topoisomerase I inhibitor payload via a tumor-selective cleavable linker. CDH6 is aberrantly expressed in 65–85% of ovarian cancer (OC) tumors.

Methods: Patients with platinum-resistant OC (PROC), primary peritoneal, or fallopian tube cancer who received 1–3 prior lines of systemic therapy (LOT), including bevacizumab and/or PARPi if eligible, were enrolled in the Phase 2, dose-optimization part of REJOICE-Ovarian01 (NCT06161025), irrespective of tumor CDH6 expression. Patients were randomized to R-DXd 4.8, 5.6, or 6.4 mg/kg IV Q3W until disease progression or unacceptable toxicity, stratified by LOT and CDH6 expression. Patients

had completed ≥18 weeks of follow-up or discontinued treatment. The primary endpoint was ORR by BICR per RECIST 1.1.

Results: At data cutoff (Feb 26, 2025), 107 patients with PROC were included in the dose-optimization analysis. Median number of prior LOT was 3; 83.2% received prior bevacizumab and 70.1% prior PARPi. Median treatment duration was 23.9 weeks (range, 3.0–42.1). Across doses, ORR by BICR was 50.5%, including 3 CRs (Table 1). Clinically meaningful responses were observed across a range of tumor CDH6 expression levels. Most frequent TEAEs were nausea (69.2%), anemia (57.0%), and asthenia (46.7%) (Table 2). TRAEs led to R-DXd delay, reduction, or discontinuation in 23.4%, 18.7%, and 5.6% of patients, respectively.

Conclusions: R-DXd 5.6 mg/kg was identified as the optimal dose for further evaluation in the Phase 3 study. R-DXd demonstrated promising efficacy and a manageable safety profile in patients with PROC.

Table 1

Efficacy	**4.8 mg/kg n=36**	**5.6 mg/kg n=36**	**6.4 mg/kg n=35**	**Total N=107**
ORR by BICR, % (95% CI)	44.4 (27.9–61.9)	50.0 (32.9–67.1)	57.1 (39.4–73.7)	50.5 (40.6–60.3)
Best overall response, n (%) CR PR	1 (2.8) 15 (41.7)	2 (5.6) 16 (44.4)	0 20 (57.1)	3 (2.8) 51 (47.7)
Disease control rate, % (95% CI)	75.0 (57.8–87.9)	80.6 (64.0–91.8)	77.1 (59.9–89.6)	77.6 (68.5–85.1)
Median time to response, weeks (range)	7.1 (5.4–18.7)	6.6 (5.1–18.3)	7.2 (5.3–19.1)	7.1 (5.1–19.1)

Table 2

Safety	**4.8 mg/kg n=36**	**5.6 mg/kg n=36**	**6.4 mg/kg n=35**	**Total N=107**
TEAEs, n (%) Any-grade Grade ≥3	35 (97.2) 16 (44.4)	36 (100) 20 (55.6)	35 (100) 20 (57.1)	106 (99.1) 56 (52.3)
Interstitial lung disease adjudicated as treatment-related, n (%) Any-grade Grade ≥3	1 (2.8) 1 (2.8) (*Gr 3*)	1 (2.8) 0	2 (5.7) 0	4 (3.7) 1 (0.9)

SE004 / #1324

PHASE 2 OPEN-LABEL MULTICENTER TRIAL OF NAB-SIROLIMUS + LETROZOLE IN ADVANCED/RECURRENT ENDOMETRIOID ENDOMETRIAL CANCER

PLENARY: ENDOMETRIAL CANCER ORAL ABSTRACT PRESENTATIONS

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Background: The PI3K/AKT/mTOR pathway is dysregulated in >90% of endometrioid endometrial cancer (EEC) and mTOR–estrogen pathway crosstalk is associated with endocrine therapy resistance. In GOG-3007, the greatest benefit of mTOR inhibition + hormonal therapy in advanced endometrial cancer was in chemotherapy naïve patients (pts) and those with endometrioid histology. Here, we report initial data from an ongoing phase 2 study of letrozole + *nab*-sirolimus—a nanoparticle albumin-bound form of sirolimus with better intratumoral accumulation, mTOR inhibition, and antitumor activity vs conventional mTOR inhibitors preclinically—in advanced/recurrent EEC (NCT05997017).

Methods: Eligible pts have advanced/recurrent EEC with ≤1 prior chemotherapy regimen for advanced/metastatic EEC (resulting in at least partial response). Treatment is IV *nab*-sirolimus (100 mg/m^2 day 1 and 8) + oral letrozole (2.5 mg daily) in 21-day cycles. Primary endpoint is overall response rate (ORR) by RECIST v1.1. Secondary endpoints are disease control rate (DCR), time to response (TTR), PFS, OS, and safety.

Results: For 24 pts enrolled by April 1, 2025 (8 still on treatment), EEC was mostly FIGO grade 1-2 (87%); 50% of pts had prior chemotherapy (any setting) and 21% had prior hormonal therapy. All EECs were estrogen receptor-positive, 20/23 progesterone receptor-positive, 18/19 TP53 wild type, and 16/20 mismatch repair proficient. For 22 efficacy evaluable pts, confirmed ORR was 36% (1 complete response) and DCR was 68%; responses were seen in chemotherapy naïve and exposed pts. Median TTR was 3.4 months (95% CI, 1.2–5.5); time-to-event endpoints are not mature. Any grade treatment-related adverse events (TRAEs; ≥30% of pts) were dysgeusia, fatigue,

stomatitis, hypokalemia, decreased appetite, diarrhea, and peripheral edema; most common grade 3–4 TRAEs were anemia (13%) and hypertriglyceridemia (13%).

Conclusions: Dual inhibition of mTOR and estrogen pathways with *nab*-sirolimus + letrozole has encouraging activity in chemotherapy naïve and exposed pts with advanced/recurrent low-grade EEC. Safety findings are consistent with each agent's known profile. Further exploration of this non-chemotherapy approach is warranted.

Funding source: Aadi Bioscience (a subsidiary of Kaken Pharmaceutical Co., Ltd). ***Previously presented at ESMO 2025, FPN: 1122P, Lauren E. Dockery, et al. - Reused with permission****

SE005 / #1323

ICON8B: GCIG PHASE III RANDOMISED TRIAL COMPARING FIRST-LINE WEEKLY DOSE-DENSE CHEMOTHERAPY + BEVACIZUMAB TO THREE-WEEKLY CHEMOTHERAPY + BEVACIZUMAB IN HIGH-RISK STAGE III-IV EPITHELIAL OVARIAN CANCER (EOC): FINAL OVERALL SURVIVAL (OS) ANALYSIS

PLENARY: OVARIAN CANCER ORAL ABSTRACT PRESENTATIONS

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Background: In ICON8B the use of dose-dense weekly paclitaxel (ddWT) with 3-weekly (q3w) carboplatin (C) and bevacizumab (BEV) as first-line treatment improved median progression-free survival (PFS) by 5.5 months (m) compared to standard q3w paclitaxel (T) dosing with C+BEV (22.2m vs 16.7m; Hazard Ratio (HR) 0.75, 95% CI 0.62-0.90 p=0.002). We now report the final OS analysis conducted at trial closure.

Methods: Eligible participants (pts) with high-risk stage III (residual disease >1cm diameter after immediate primary surgery (IPS) or requirement for primary chemotherapy) or stage IV EOC were randomised 1:1:1 to Arm B1 (standard- q3w C AUC5/6+q3w T 175mg/m^2+ q3w BEV 7.5mg/kg); Arm B2- (q3w C AUC5/6+ddwT 80mg/m^2); Arm B3- (q3w C AUC5/6+ddwT 80mg/m^2+ q3w BEV 7.5mg/kg). Up to six cycles chemotherapy and 18 BEV cycles were administered. Arm B2 recruitment discontinued after ICON8 saw no evidence of PFS improvement with q3wCddwT vs q3wCT. OS was a key secondary outcome and pts were followed for survival endpoints until trial closure on 18th Dec 2024 at end of academic funding.

Results: From 07/2015 to 03/2020 579 pts were randomised to arms B1 + B3. Median age was 64 years; 91% had High Grade Serous Carcinoma; 93% Stage IIIc/IV; 84% primary chemotherapy with planned delayed primary surgery ,14% IPS, 2% inoperable; 50.2% cases sequenced for germline BRCA1/2 mutations. After a median follow-up of 72.0m, 411 deaths were reported (197 in B3; 214 in B1). Median OS was 49.8m (95% CI 43·7-54.5m) in B3 and 39.6m (95% CI 34·7-45·0m) in B1 (HR 0·79, 95% CI 0·65-0·95, p=0·010). In pts receiving primary chemotherapy, median OS was 47.3m (95% CI 42.0-52.6m) in B3 and 37.1m (95% CI 32.3-42.1m) in B1.

Conclusions: In pts with high-risk stage III-IV EOC, the use of ddwT in combination with q3w C + BEV as first-line systemic therapy improves median OS by 10.2m compared to q3w T dosing. ddwT with q3wC+BEV should now be considered a standard-of-care first-line treatment option in this group. Further research is required to determine whether efficacy of this regimen is impacted by tumour homologous recombination deficiency and intrinsic chemosensitivity.

SE006 / #184

HS-20089 IN PATIENTS WITH PLATINUM-RESISTANT OVARIAN CANCER: AN OPEN-LABEL, MULTI-CENTER, PHASE 2 STUDY

MINI ORAL ABSTRACT PRESENTATIONS 01

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HS-20089 (GSK5733584), a novel antibody-drug conjugate targeting B7-H4, has shown preliminary anti-tumor activity and a manageable safety profile in phase 1 study (NCT05263479). Here we report results of cohort 1 from a phase 2 study (NCT06014190).This open label, multi-center, phase 2 study consisted of 4 cohorts. Cohort 1 enrolled patients aged ≥18 years with platinum-resistant ovarian cancer, fallopian tube cancer, or primary peritoneal cancer (PROC). Patients intravenously received HS-20089 at dose of 4.8 mg/kg, every 3 weeks. The primary endpoint was investigator-assessed objective response rate (ORR).As of 2025-03-20, 33 Asian PROC patients with a mean age of 56.3 (rang: 42.0, 70.0) years were enrolled and received at least one dose. All patients had high-grade serous cancer and were heavily treated. The median follow-up time was 10.7 (rang: 2.6 to 14.1) months. Among 33 patients, the confirmed ORR was 48.5% (95% CI: 30.8, 66.5) and the disease control rate was 75.8% (95%CI: 57.7, 88.9). Of the 16 patients who achieved a response, the median duration of response was 5.7 (95% CI: 4.4, 9.7) months. The median progression free survival was 6.4 (95% CI: 3.6, 10.3) months and median overall survival was not reached. No new safety signal was observed. The most common TEAEs of grade ≥3 (occurring in ≥20% of patients) were neutrophil count decreased, anaemia, white blood cell count decreased

and platelet count decreased.HS-20089 as monotherapy demonstrated promising clinical activity in PROC patients and showed consistent safety profile with the phase 1 study.

SE007 / #1329

BLOOD CTDNA VS TUMOR TISSUE SCREENING FOR THE DETECTION OF KRAS MUTATIONS IN LOW-GRADE SEROUS OVARIAN CANCER: RESULTS FROM ENGOT-OV60/GOG-3052/RAMP 201

MINI ORAL ABSTRACT PRESENTATIONS 02

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Background: For determination of KRAS status in patients with low-grade serous ovarian cancer (LGSOC), tumor tissue-based biopsy procedures are most commonly employed. However, blood-based liquid biopsies could offer less invasive testing if circulating tumor DNA (ctDNA) can reliably detect KRAS mutations in these patients.

Methods: Samples from a phase 2 study evaluating the combination of avutometinib (RAF/MEK clamp) + defactinib (FAK inhibitor) versus avutometinib monotherapy in patients with LGSOC (RAMP 201) were analyzed to determine ctDNA fraction and presence of mutations in 105 cancer-related genes including KRAS using the Tempus xF panel.

Results: Only 32% (21/65) showed ctDNA tumor fraction above the limit of detection of 0.25% (range 0.4% to 19%). Among the patients for which KRAS mutations were detectable in tumor tissue, 44% (22/50) showed KRAS mutation by blood-based ctDNA testing, whereas more than half of patients (56%; 28/50) showed a false negative result by blood-based KRAS testing. No correlation between high KRAS VAF in tumor tissue samples and detection rate of KRAS mutation in blood samples was observed. Among the 22 patients with a KRAS mutation detected using both blood and tumor tissue samples, the same KRAS mutation variants were detected in blood and tumor. In patients for which KRAS mutations were not detectable in tumor tissue, none tested positive for a KRAS mutation in ctDNA.

Conclusions/Implications: These findings suggest that LGSOC is a low shedding cancer and that blood-based KRAS ctDNA testing is not a sufficiently robust method for detecting KRAS mutations in patients with LGSOC.

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SECOND PROGRESSION-FREE SURVIVAL (PFS2) AND SUBSEQUENT TREATMENT IN PATIENTS (PTS) WITH FOLATE RECEPTOR ALPHA (FRA)-POSITIVE PLATINUM-RESISTANT OVARIAN CANCER (PROC) TREATED WITH MIRVETUXIMAB SORAVTANSINE (MIRV) VS. INVESTIGATOR'S CHOICE CHEMOTHERAPY (ICC): PHASE 3 MIRASOL TRIAL

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Background: In MIRASOL, MIRV showed superior progression-free survival (PFS) and overall survival (OS) vs ICC in pts with FRα-positive PROC. Here, we describe PFS2 and treatment sequencing in the intent-to-treat (ITT) population.

Methods: Adults with FRα-positive (≥75% of cells with ≥2+ membrane staining), high-grade serous PROC and 1–3 prior lines were randomized 1:1 to MIRV (6 mg/kg adjusted ideal body weight every 3 weeks) or single-agent ICC. Primary endpoint was PFS by investigator. PFS2 was assessed as a secondary endpoint.

Results: At MIRASOL final analysis, with 30.5 mo median follow-up (ITT, N=453: MIRV, n=227; ICC, n=226), median PFS (mPFS) of MIRV vs ICC was 5.6 mo (95% CI, 4.3–5.9) vs 4.0 (95% CI, 2.9–4.5), with a hazard ratio (HR) of 0.63 (95% CI, 0.51-0.79). The mPFS2 of MIRV vs ICC was 11.0 mo (95% CI, 9.3–12.0) vs 7.59 mo (6.6–8.84), with HR of 0.59 (95% CI, 0.48–0.73). In pts with prior PARPi maintenance (MIRV, n=124; ICC, n=128), mPFS2 of MIRV vs ICC was 11.5 mo (95% CI, 10.5–12.8) vs 7.2 mo (95% CI, 6.4–8.6), with HR of 0.49 (95% CI, 0.37-0.65). In pts with prior bevacizumab exposure (MIRV, n=138; ICC, n=143), mPFS2 of MIRV vs ICC was 9.3 mo (95% CI, 7.6–11.5) vs 6.9 mo (95% CI, 5.8–8.2), with HR of 0.61 (95% CI, 0.47–0.78). In the ITT, 152/227 (67%) MIRV pts vs 147/226 (65%) ICC pts went on to receive a new anticancer therapy, including, most commonly, taxanes (35% vs 26%), gemcitabine (24% vs 26%), platinum-based compounds (19% each), bevacizumab (19% vs 16%), and anthracyclines (25% vs 9%); 2 (<1%) vs 16 (7%) pts received MIRV. Reasons for treatment discontinuation in the MIRV arm were progressive disease (n=138 [91%]), adverse event (n=11 [7%]), investigator discretion (n=2 [1%]), and withdrawal of consent (n=1 [<1%]). Analyses of subsequent anticancer therapies per line of MIRV or ICC at study entry will be presented.

Conclusions: MIRV demonstrated favorable PFS2 vs ICC irrespective of prior PARPi or bevacizumab exposure. These results further strengthen MIRV as the standard of care with durable clinical benefit continuing beyond progression. Previously presented at the European Society for Medical Oncology 2025 Congress, FPN (Final Publication Number): 1068P, Kathleen Moore et al. – Reused with permission.