IGCS 2025 CAPE TOWN

Annual Global Meeting, November 5–7, 2025

IGCS 2025 Abstracts:
Regular Submission Mini Oral Presentations

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

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

MO001 / #483

Topic: *AS06. Tumor Types / AS06c. Endometrial & Uterine Corpus Cancers*

LENVATINIB PLUS PEMBROLIZUMAB IN PARTICIPANTS WITH ADVANCED OR RECURRENT ENDOMETRIAL CANCER: STUDY 309/KEYNOTE-775 AND ENGOT-EN9/LEAP-001 POST-(NEO)ADJUVANT THERAPY OUTCOMES

MINI ORAL ABSTRACT PRESENTATIONS 01

Christian Marth[1], Domenica Lorusso[2], Mariusz Bidziński[3], Vanda Salutari[4], Huseyin Akilli[5], Ana Oaknin[6], Diego Lucas Kaen[7], Angelica Nogueira-Rodrigues[8], David Miller[9], Kosei Hasegawa[10], Helen MacKay[11], Richard G. Moore[12], Alessandro D. Santin[13], Mayu Yunokawa[14], Jiabu Ye[15], Brian Slomovitz[16], Jodi McKenzie[17], Robin Meng[18], Vicky Makker[19]
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Introduction: In Study 309 (EU CT, 2017-004387-35; N=827), lenvatinib+pembrolizumab (L+P) improved PFS, OS, and ORR vs doxorubicin or paclitaxel in advanced EC (aEC). In LEAP-001 (2018-003009-24; N=842), first-line L+P showed antitumor activity in aEC but did not meet prespecified statistical criteria for PFS or OS vs paclitaxel+carboplatin. We report exploratory outcomes in the subgroup of participants who received prior (neo)adjuvant chemotherapy only in these phase 3 trials.

Methods: Study 309 enrolled participants with advanced, recurrent, or metastatic EC (measurable per RECISTv1.1) with PD after 1 line of platinum-based chemotherapy (an additional line permitted if given as [neo]adjuvant therapy), and without prior anti–PD-(L)1 therapy. LEAP-001 enrolled participants with stage III–IV or recurrent, radiographically apparent EC and no prior chemotherapy or PD ≥6 months after (neo)adjuvant platinum-based chemotherapy. Participants were randomized 1:1 to L 20mg QD + P 200mg Q3W or chemotherapy (doxorubicin or paclitaxel in study 309; paclitaxel+carboplatin in LEAP-001). Primary endpoints were OS and PFS in both trials; ORR and safety were secondary endpoints.

Results: Median (range) follow-up in participants with prior (neo)adjuvant chemotherapy only was 68.8 (61.0–79.1) months in Study 309 (data cutoff: February 26, 2025) and 50.7 (46.6–63.7) months in LEAP-001 (data cutoff: February 5, 2025). Results are in **Tables 1–2**. Additional results will be included in the presentation (efficacy by MMR status, histology, PFI etc).

Conclusion/Implications: Efficacy outcomes were improved with L+P vs chemotherapy. L+P had a manageable safety profile. L+P can be considered an effective option in patients with aEC who received prior (neo)adjuvant chemotherapy only.

Table 1. Efficacy Results in Participants Who Received Prior (Neo)Adjuvant Chemotherapy Only (All-Comers)

	Study 309/KEYNOTE-775		ENGOT-en9/LEAP-001	
	L + P (n = 143)	TPC (n = 157)	L + P (n = 63)	PC (n = 58)
OS				
Median (95% CI),[a] mo	17.4 (14.0–22.8)	13.3 (10.9–15.5)	35.4 (26.6–NR)	22.1 (16.4–34.8)
HR (95% CI)[b]	0.67 (0.52–0.87)		0.66 (0.42–1.03)	
HR (95% CI)[b] for OS by platinum-free interval				
<6 mo	0.66 (0.46–0.94) (n = 152)		–	
6–12 mo	0.70 (0.43–1.15) (n = 79)		–	
>12 mo	0.63 (0.35–1.13) (n = 67)		–	
<12 mo	–		0.83 (0.35–1.96) (n = 37)	
12–18 mo	–		0.63 (0.25–1.57) (n = 28)	
>18 mo	–		0.55 (0.28–1.06) (n = 54)	
PFS[c]				
Median (95% CI),[a] mo	7.2 (5.6–8.0)	3.9 (3.6–5.4)	15.0 (8.3–21.0)	8.3 (6.2–10.2)
HR (95% CI)[b]	0.52 (0.40–0.68)		0.52 (0.33–0.81)	
HR (95% CI)[b] for PFS[c] by platinum-free interval				
<6 mo	0.51 (0.36–0.74) (n = 152)		–	
6–12 mo	0.46 (0.26–0.80) (n = 79)		–	
>12 mo	0.55 (0.32–0.97) (n = 67)		–	
<12 mo	–		0.80 (0.35–1.81) (n = 37)	
12–18 mo	–		0.77 (0.32–1.86) (n = 28)	
>18 mo	–		0.31 (0.15–0.65) (n = 54)	
PFS2[c] (next-line therapy)				
Median (95% CI),[a] mo	14.9 (12.4–17.7)	10.6 (9.1–12.2)	27.6 (18.9–35.5)	20.2 (13.1–24.9)
HR (95% CI)[b]	0.66 (0.51–0.86)		0.65 (0.42–1.01)	
BOR (95% CI),[c,d] %				
ORR	34.3 (26.5–42.7)	16.6 (11.1–23.3)	63.5 (50.4–75.3)	43.1 (30.2–56.8)
CR	11.2 (6.5–17.5)	5.1 (2.2–9.8)	27.0 (16.6–39.7)	13.8 (6.1–25.4)
PR	23.1 (16.4–30.9)	11.5 (6.9–17.5)	36.5 (24.7–49.6)	29.3 (18.1–42.7)
SD	44.8 (36.4–53.3)	38.2 (30.6–46.3)	30.2 (19.2–43.0)	41.4 (28.6–55.1)
PD	14.0 (8.8–20.8)	29.3 (22.3–37.1)	3.2 (0.4–11.0)	3.4 (0.4–11.9)
Not evaluable[e]	0.7 (0.0–3.8)	3.2 (1.0–7.3)	1.6 (0.0–8.5)	0 (0.0–6.2)
No assessment[f]	6.3 (2.9–11.6)	12.7 (8.0–19.0)	1.6 (0.0–8.5)	12.1 (5.0–23.3)
DCR[c,g] (95% CI),[d] %	71.3 (63.2–78.6)	47.8 (39.7–55.9)	93.7 (84.5–98.2)	84.5 (72.6–92.7)
DOR, median (95% CI),[a] mo	15.7 (9.2–34.0)	5.6 (3.9–9.5)	19.9 (16.1–27.1)	8.3 (6.0–10.9)

NR, not reached; PC, paclitaxel+carboplatin; TPC, treatment of physician's choice (doxorubicin or paclitaxel).
[a]Kaplan-Meier method for censored data.
[b]Based on unstratified Cox regression model with the Efron method of tie handling and treatment as a covariate.
[c]Per RECIST version 1.1 by BICR (for PFS, BOR, DCR, and DOR) or per investigator (for PFS2).
[d]Based on binomial exact CI method.
[e]Postbaseline assessment available but not evaluable.
[f]No postbaseline assessment available for response evaluation.
[g]CR + PR + (SD ≥7 wk).

Table 2. Exposure and Safety Results in Participants Who Received Prior (Neo)Adjuvant Chemotherapy Only

	Study 309/KEYNOTE-775		ENGOT-en9/LEAP-001	
	L+P (n = 141)	TPC (n = 149)	L+P (n = 63)	PC (n = 54)
Duration on therapy, median (range), d	229.0 (2.0–2212.0)	106.0 (1.0–846.0)	294.0 (10.0–1624.0)	113.0 (1.0–198.0)
Both L+P	176.0 (1.0–967.0)	–	215.0 (1.0–804.0)	–
L	211.0 (2.0–2212.0)	–	273.0 (1.0–1624.0)	–
P	196.0 (1.0–967.0)	–	274.0 (1.0–804.0)	–
L dose reduction, n (%)	101 (71.6)	–	47 (74.6)	–
0	40 (28.4)	–	16 (25.4)	–
1	34 (24.1)	–	17 (27.0)	–
2	44 (31.2)	–	12 (19.0)	–
3	12 (8.5)	–	10 (15.9)	–
4	11 (7.8)	–	8 (12.7)	–
Time to first L dose reduction, median (range), mo	2.1 (0.1–15.2)	–	1.7 (0.2–26.0)	–
AEs leading to L, TPC, or PC dose reduction, n (%)	96 (68.1)	22 (14.8)	39 (61.9)	12 (22.2)
AEs leading to interruption of any treatment, n (%)	100 (70.9)	36 (24.2)	47 (74.6)	24 (44.4)
L	86 (61.0)	–	40 (63.5)	–
P	71 (50.4)	–	40 (63.5)	–
Both L+P	37 (26.2)	–	25 (39.7)	–
AEs leading to discontinuation of any treatment, n (%)	60 (42.6)	7 (4.7)	29 (46.0)	12 (22.2)
L	54 (38.3)	–	26 (41.3)	–
P	37 (26.2)	–	15 (23.8)	–
Both L+P	25 (17.7)	–	8 (12.7)	–
Treatment-related AEs, n (%)	136 (96.5)	140 (94.0)	62 (98.4)	53 (98.1)
Grade 3–5	109 (77.3)	88 (59.1)	47 (74.6)	34 (63.0)
Led to any treatment discontinuation	49 (34.8)	5 (3.4)	27 (42.9)	11 (20.4)
Serious	58 (41.1)	24 (16.1)	24 (38.1)	3 (5.6)
Led to death	2 (1.4)	4 (2.7)	0 (0.0)	0 (0.0)

MO002 / #664

Topic: *AS06. Tumor Types / AS06c. Endometrial & Uterine Corpus Cancers*

SAME STAGE, SAME OUTCOME: CHALLENGING THE AGGRESSIVE HISTOLOGY PARADIGM IN FIGO 2023 STAGE IIC

MINI ORAL ABSTRACT PRESENTATIONS 01

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Introduction: FIGO 2023 staging for endometrial cancer (EC) aimed to improve risk-stratification but remains debated. A key controversy concerns stage IIC, which groups “aggressive” histologies regardless of uterine factors, potentially oversimplifying distinct oncologic behaviors. While recent studies support FIGO 2023’s prognostic value, specific validation within stage IIC remains limited.

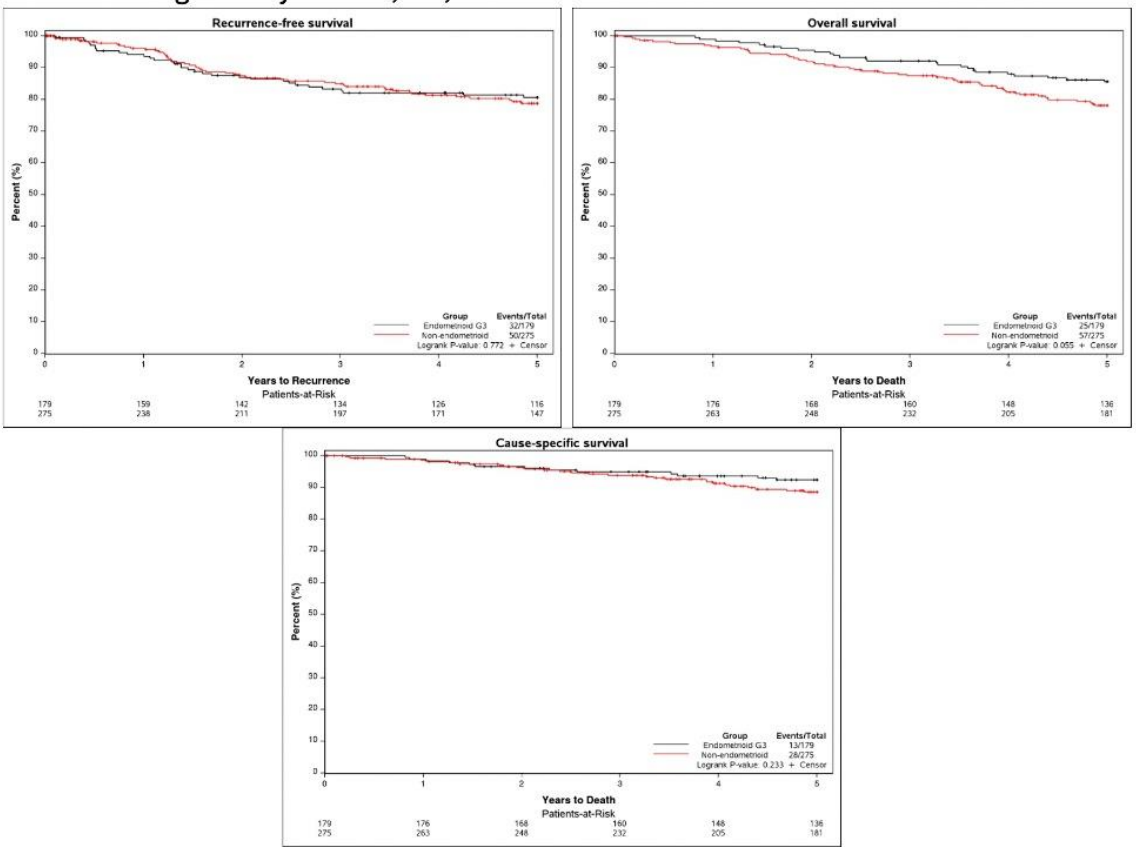
Methods: We retrospectively identified patients surgically treated for EC at Mayo Clinic Rochester (1999–2021) meeting FIGO 2023 stage IIC criteria. Immunohistochemical assessment of p53 and mismatch repair status was available in a subset. Comparisons were performed for grade 3 endometrioid versus non-endometrioid groups for recurrence-free survival (RFS), overall survival (OS), and cause-specific survival (CSS), using Kaplan-Meier. We also report univariate Cox proportional hazard models.

Results: We included 454 patients: 179 endometrioid G3, 275 non-endometrioid. Within 5 years, no statistically significant differences in RFS, OS, or CSS were observed between the two histology groups (Figure). Similarly, no differences were observed in the subset with known p53 status or when stratified by p53 status. On univariate analysis, cervical stromal invasion, myometrial invasion and histology were not predictive of recurrence, while LVSI (HR: 1.863, 95% CI: 1.195–2.905) and p53 abnormality (HR: 3.471, 95% CI: 1.528–7.885) significantly predicted recurrence (Table).

Table. Univariate analysis of characteristics evaluated for an association with recurrence within 5 years following surgery (n=454 unless specified otherwise)

Characteristics	Number of recurrences	Adjusted HR (95% CI)	P
Myometrial invasion (reference <50%)	<50%=57/316 ≥50%= 25/138	1.150 (0.719-1.841)	0.560
Cervical stromal invasion (reference=No)	No=75/430 Yes=7/24	2.06 (0.950-4.478)	0.067
Lymphovascular space invasion (reference=No)	No=50/330 Yes=32/124	1.863 (1.195-2.905)	**0.006**
Histology (reference Non-endometrioid)	Endometrioid=32/179 Non-endometrioid=50/275	0.937 (0.601-1.460)	0.773
P53 status (reference Wild type) n=188	Wild type=7/78 Abnormal=31/110	3.471(1.528-7.885)	**0.003**
MMR status (reference MMRp) N=210	MMRp=36/153 MMRd=7/57	0.465 (0.207-1.045)	0.064

Figure: 5- year RFS, OS, and CSS for endometrioid G3 vs non-endometrioid



Conclusion/Implications: Our findings suggest that FIGO 2023 stage IIC includes patients with similar oncologic outcomes, demonstrating comparable prognoses across “aggressive” histologies, independent of other histopathological features except LVSI. The prognostic impact of p53 abnormalities underscores the importance of integrating molecular profiling in staging and risk stratification. Larger studies are needed to validate these findings.

MO003 / #361

Topic: *AS06. Tumor Types / AS06e. Trophoblastic Disease & Rare Tumors*

PRIMARY ANALYSIS: PHASE II STUDY OF AVUTOMETINIB AND DEFACTINIB IN WOMEN WITH ADVANCED OR RECURRENT GYNECOLOGIC MESONEPHRIC CANCER

MINI ORAL ABSTRACT PRESENTATIONS 01

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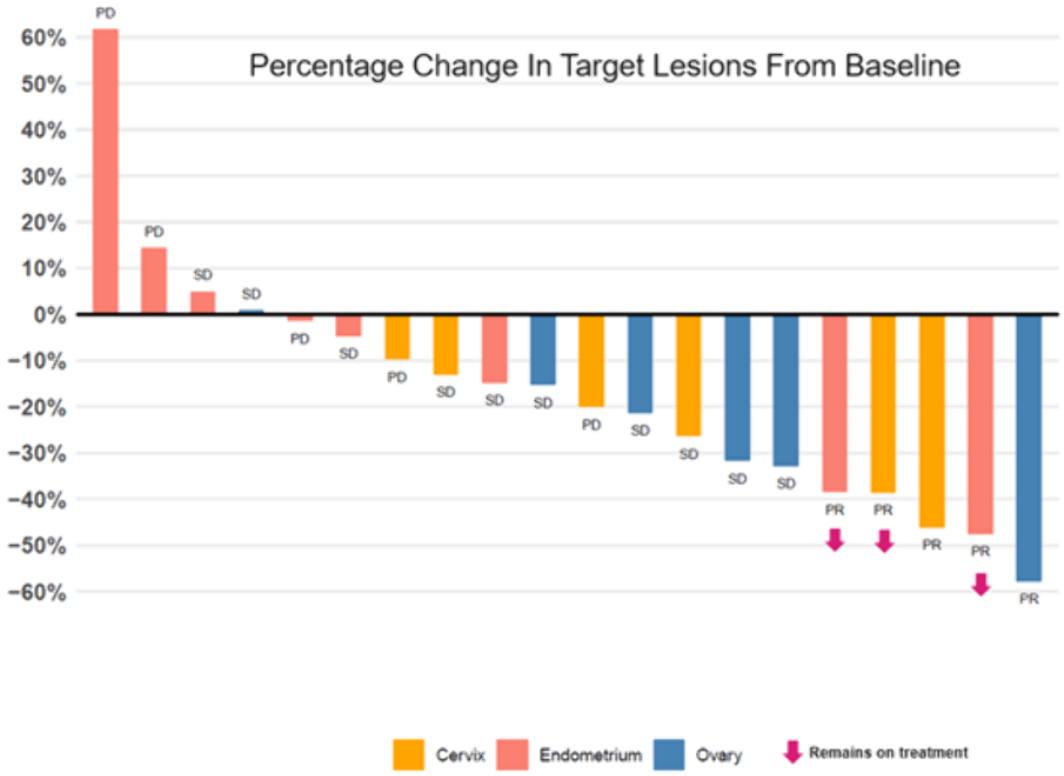
Introduction: Mesonephric carcinoma arises from cervix, while mesonephric-like carcinoma originates from the endometrium, vagina or ovary. These cancers are jointly referred to as gynecologic mesonephric cancer (GMC) and unified by histologic appearance, propensity for lung metastases, and nearly ubiquitous association with RAS/MAPK alterations, most commonly *KRAS*.

Methods: This is a Phase II, single-institution study of avutometinib 3.2mg (RAF/MEK clamp; taken PO twice weekly) in combination with defactinib 200mg (FAK inhibitor; taken PO twice daily), both 3 weeks on/ 1 week off, for women with RECIST 1.1 measurable GMC (NCT05787561). Simon 2-stage design was utilized. Based on historical results ≥ 3/20 confirmed responses was considered a positive study. Molecular results via CLIA approved NGS sequencing platform were collected.

Results: From 3/2023-12/2024 the study enrolled 20 patients with GMC (Cervical=6, Endometrial=8, Ovarian=6) with a median of 2 prior therapies (0-7). Based on 4/2025 data cut-off the confirmed response rate was 25%, with confirmed responses seen in women with cervical (2/6), endometrial (2/8) and ovarian (1/6) GMC. Sixty percent of patients remained progression free at 6 months of treatment and 3/5 of the responders remain on treatment. Most common related adverse events were asymptomatic elevated CPK (80%), diarrhea (65%), limb-edema (65%), and fatigue (65%); no patients

discontinued treatment due to toxicity. 85% (17/20) of patients harbored somatic *KRAS* mutation.

Conclusion/Implications: The combination of avutometinib with defactinib demonstrated a promising clinical activity and was well tolerated in patients with GMC. Based on these positive results the study will enroll an additional 20 patient expansion cohort as planned.



MO004 / #641

Topic: *AS06. Tumor Types / AS06d. Ovarian Cancer*

TARGETING HER2 IN OVARIAN CANCER: SUBTYPE-DRIVEN OPPORTUNITIES AND PROGNOSTIC IMPACT

MINI ORAL ABSTRACT PRESENTATIONS 01

Junsik Park[1], Dahye Lee[2], Soyeon Kim[3], Yoo-Na Kim[3], Yong Jae Lee[3], Sunghoon Kim[3], Jung-Yun Lee[3]
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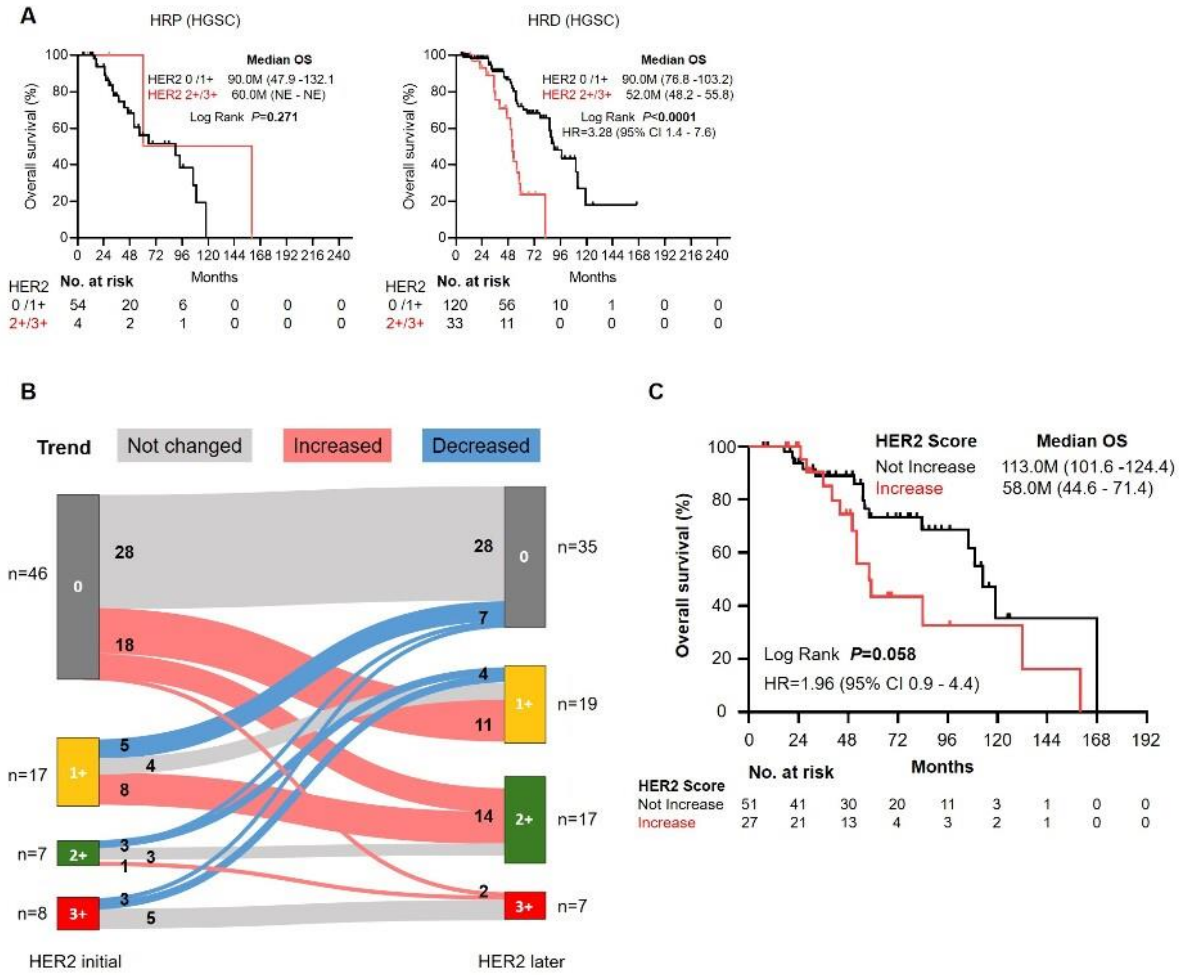
Introduction: This study evaluated HER2 expression by histological subtype and key biomarkers, including homologous recombination deficiency (HRD) status, and accessed its overlap with folate receptor alpha (FRα) overexpression in ovarian cancer.

Methods: Patients with primary or recurrent ovarian cancer who underwent HER2 immunohistochemistry (IHC) testing between 2015 and 2024 at Yonsei Cancer Center were retrospectively identified (n = 441). Data on histological subtypes, HER2 IHC scores, *BRCA1/2* mutation/HRD status, and FRα expression (PS2+ score) were collected, and correlations with overall survival (OS) were analyzed.

Results: Among 441 patients, 259 (58.7%) had a HER2 score of 0, and 31 (7.0%) had a HER2 3+ score. HER2 3+ expression was more frequent in mucinous (25.0%) and clear cell carcinoma (14.6%) subtypes. In 211 high-grade serous carcinoma patients with available HRD status, HER2 2+ tumors were more common in the HRD group (18.3%) than in the HRP group (3.4%). Overall, the patients with HER2 2+/3+ tumors had significantly poorer OS than those with HER2 0/1+ tumors. Among HRD patients, HER2 2+/3+ status was significantly associated with poorer OS, whereas no significant difference was observed in HRP patients. Of 78 patients with sequential HER2 data, 27 (34.6%) showed increased score during progression, correlating with a trend toward poorer OS. Concurrent HER2 2+/3+ and high FRα expression was observed in only 9 of 110 patients (8.2%).



Conclusion/Implications: HER2 overexpression is relatively common in ovarian mucinous or clear cell carcinomas, as well as in *BRCA1/2* mutated/HRD ovarian cancer, highlighting the promising therapeutic potential of HER2-targeted ADCs for these subgroups.

MO005 / #644

Topic: *AS06. Tumor Types / AS06d. Ovarian Cancer*

SAFETY OF HYPERTHERMIC VERSUS NORMOTHERMIC INTRAPERITONEAL CHEMOTHERAPY FOLLOWING INTERVAL CYTOREDUCTIVE SURGERY FOR STAGE III EPITHELIAL OVARIAN CANCER

MINI ORAL ABSTRACT PRESENTATIONS 01

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Introduction: Hyperthermic Intraperitoneal Chemotherapy (HIPEC) during interval cytoreductive surgery (ICRS) for advanced ovarian cancer (OC) improves survival, but the effects of hyperthermia are unclear and adverse events (AEs) may be under-reported. We aimed to evaluate the safety of HIPEC versus Normothermic Intraperitoneal Chemotherapy (NIPEC).

Methods: This randomised phase 2 trial (ANZGOG1901/2020/CTC0302) enrolled participants (pts) from 3 Australian centres with stage III OC, stable disease or better after 3-4 chemotherapy cycles and ≤2.5mm residual disease at ICRS. Pts were randomised 1:1 to cisplatin 100mg/m^2 as HIPEC (42°C) or NIPEC (37°C). Primary outcome was severe ≥grade 3 (≥G3) Clavien-Dindo AEs <30 days. Secondary outcomes included early (<30days) and late (30-90days) ≥G3 AEs of special interest (AESI) CTCAEv5, and progression-free survival (PFS).

Results: We randomised 40 pts with a median follow-up of 15 months (IQR, 10-21). Median age was 60 years (IQR, 53-67); 33% (13/40) had a germline or somatic *BRCA1/2* pathogenic variant. Surgical characteristics and morbidity rates were similar between groups (Table1). Chemotherapy resumed at median 4.7 weeks (IQR, 3.9-5.4) after ICRS. Clavien-Dindo ≥G3AEs occurred <30 days in 25% (5/20) assigned HIPEC vs 20% (4/20) NIPEC. Early CTCAE AESIs occurred in 80% (16/20) assigned HIPEC vs 65% (13/20) NIPEC. Late AESIs occurred in 3/20 per group (Table2). Across both arms, 6-month PFS was 89% (95%CI 74%-96%).

Table 1. *Surgical characteristics and morbidity by randomised treatment*

	HIPEC N = 20[1]	NIPEC N = 20[1]	Overall N = 40[1]
Baseline characteristics			
Age at study entry (years); median (Q1-Q3)	58.0 (48.0, 63.0)	63.0 (57.5, 68.0)	60.0 (52.5, 67.0)
FIGO Stage			
FIGO stage IIIA	0 (0%)	3 (15%)	3 (8%)
FIGO stage IIIB	0 (0%)	1 (5.0%)	1 (3%)
FIGO Stage IIIC	20 (100%)	16 (80%)	36 (90%)
Histology			
High grade non-serous (excluding mucinous)	1 (5%)	4 (20%)	5 (13%)
High grade serous	19 (95%)	16 (80%)	35 (88%)
Surgical characteristics			
Peritoneal Cancer Index (PCI) score at surgery; median (Q1-Q3)	15 (9, 18)	13 (7, 19)	14 (9, 19)
Residual disease prior to randomized treatment			
CC0 (no macroscopic residual)	18 (90%)	18 (90%)	36 (90%)
CC1 ≤2.5mm	2 (10%)	2 (10%)	4 (10%)
Surgical morbidity			
Bowel resection			
Bowel resection without stoma	6 (30%)	7 (35%)	13 (33%)
Bowel resection with stoma	2 (10%)	4 (20%)	6 (15%)
Days in hospital; mean (SD)	11 (7)	11 (6)	11 (6)
Days in ICU; mean (SD)	4.5 (4.9)	3.9 (2.6)	4.2 (3.8)
Returned to theatre	2 (10%)	0 (0%)	2 (5%)
Days of TPN; median (Q1-Q3)	8.0 (5.5, 12.5)	10.0 (3.0, 12.0)	10.0 (5.5, 12.0)
Days to first bowel motion; mean (SD)	7.4 (4.0)	7.9 (4.2)	7.7 (4.1)

Data are presented as N (%), mean (SD), or median (Q1 – Q3).

Table 2. *Adverse events and Adverse Events of Special Interest ≥ Grade 3 by randomised treatment*

	HIPEC N = 20	NIPEC N = 20	Overall N=40
Adverse Events grade ≥3 within 30 days by Clavien-Dindo	**5 (25%)**	**4 (20%)**	**9 (22.5%)**
Adverse Events of Special Interest (AESI) grade ≥3 by CTCAE v5			
Any early AESIs (within 30 days)*	16 (80%)	13 (65%)	29 (73%)
Anaemia	10 (50%)	9 (45%)	19 (47.5%)
Gastro-intestinal	4 (20%)	3 (15%)	7 (17.5%)
Infection	3 (15%)	1 (5.0%)	4 (10%)
Renal	1 (5.0%)	2 (10%)	3 (7.5%)
Cardiac	_	2 (10%)	2 (5.0%)
Thromboembolic Event	1 (5.0%)	2 (10.0%)	3 (7.5%)
Any late AESIs (30-90 days)	3 (15%)†	3 (15%)†	6 (15%)

*Participants may experience more than one event of each organ class, and more than one AE term within each organ class.
† These includes small intestinal obstruction, fall, hematoma and thromboembolic events in 3 patients the NIPEC group, and ileus, small intestinal obstruction, and fatigue in the HIPEC group

Conclusion/Implications: HIPEC and NIPEC showed comparable rates of ≥G3 adverse events. The frequency of AEs was higher compared to prior studies, highlighting the importance of optimal perioperative care and accurate reporting of well-defined AEs in future trials involving multimodality treatment.

MO006 / #609

Topic: *AS03. Patient-Centered Care / AS03b. Palliative, Symptomatic & Supportive Care*

VARIATIONS IN EMOTIONAL SUPPORT NEEDS AND PROVISION OF CARE FOR WOMEN WITH OVARIAN CANCER IN THE EVERY WOMAN STUDY LOW- AND MIDDLE-INCOME COHORT

MINI ORAL ABSTRACT PRESENTATIONS 01

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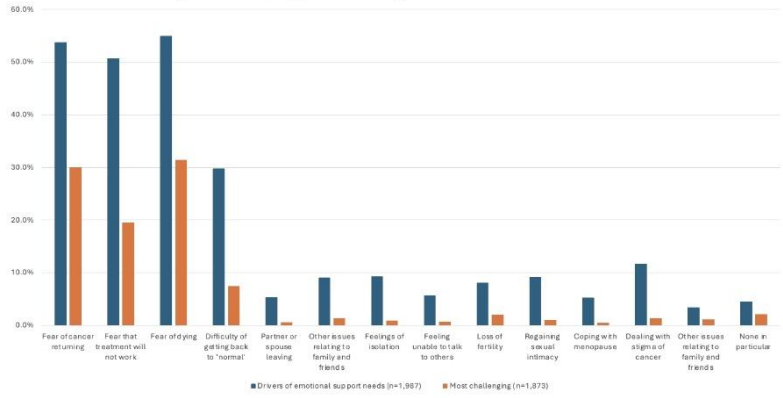
Introduction: Emotional wellbeing is often significantly impacted by the diagnosis of ovarian cancer; however, limited information is available about women's support needs in low- and middle-income countries (LMICs) and how and if they are being met.

Methods: Data on emotional support needs was collected from 2446 women, through 82 hospitals in 22 LMICs across Africa, Asia and Latin America using a standardised questionnaire translated to local languages, online, on paper, or in interview.

Results: Over eight in 10 women reported emotional support needs (82.9%) but varied widely by country (52.6% - 100%). Most commonly this was at the point of diagnosis (61.4%), and during treatment (55.6%). Regardless of location, fear of recurrence and unsuccessful treatment is by the biggest driver of need (~50%, Figure 1). Issues such as stigma, and abandonment were also reported ranging 0%-33% and 0%-16.7% by location. Half had their needs met fully (54.7%), but in African countries this was 35.8% compared to 66.8% in Latin America. Just 16% of women had received professional psychological support, highest in Latin America (40.1%) and lowest in Africa (7.2%). In some countries, doctors managed emotional support for women (3.3% - 82.4%), in others family and friends are relied on (12.5% - 61.8%).

Conclusion/Implications: There is an urgent need to improve psychological support for women with ovarian cancer in LMIC particularly in the African region. Women's needs are strongly driven by fear and targeted interventions by professionals could improve the rates of support needs being met and reduce the burden on clinical teams and families.

Figure 1: Emotional support needs among women with ovarian cancer in 22 LMICs



MO007 / #926

Topic: *AS04. Prevention & Downstaging / AS04c. Screening & Early Detection*

EVALUATING USER EXPERIENCES WITH INDIGENOUS HPV SELF-SAMPLING DEVICES IN A LOW-RESOURCE SETTING

MINI ORAL ABSTRACT PRESENTATIONS 01

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Introduction: Cervical cancer remains a major public health issue in India, where limited awareness and access to screening often lead to late-stage diagnoses. Self-sampling for HPV testing offers a potentially acceptable and scalable alternative to clinician-collected methods, especially in low-resource settings. Understanding women's experiences and concerns related to self-sampling is essential for successful implementation and uptake.

Methods: This qualitative sub-analysis was conducted as part of a larger study involving 632 women who participated in a comparative cervical cancer screening program. The study evaluated the acceptability and usability of self-sampling using an indigenous collection device and testing platform, compared with physician-collected samples. Participants' experiences, difficulties, and perceptions were gathered using structured feedback tools. Data on knowledge, attitudes, and beliefs regarding cervical cancer, HPV, screening, and vaccination were collected through standardized questionnaires.

Results: The median age of participants was 40 years (22–69). High-risk groups included 41.3% HIV-positive women and 25.2% referred for colposcopy. Reported issues included difficulties with insertion (4.4%), rotation (0.6%), removal (0.5%), breaking (1.4%), device retention (2.4%), discomfort (1.9%), and lack of confidence (0.6%). Awareness was low: 75.8% were unaware of warning signs, and over 70% did not recognize common risk factors. Only 20.6% knew screening could detect precancerous lesions, and 17.9% were aware of the HPV vaccine. Despite this, most were willing to be screened (96.2%) and sought more education (90.9%).

Conclusion/Implications: Self-sampling is broadly acceptable, though technical difficulties and knowledge gaps may limit its use. User-friendly instructions and community education are vital to improve uptake and effectiveness.

MO008 / #928

Topic: *AS04. Prevention & Downstaging / AS04b. Prevention & Vaccination*

HPV PREVALENCE AND VACCINE EFFECTIVENESS IN PARTIALLY VS FULLY VACCINATED YOUNG SOUTH AFRICAN WOMEN

MINI ORAL ABSTRACT PRESENTATIONS 01

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Introduction: During our previous successful implementation project in South Africa (2010-2014), girls were vaccinated with either bi- or quadrivalent HPV vaccines. Here were report HPV prevalence and vaccine effectiveness (VE) in partial and fully vaccinated vaccine recipients compared to a historical control group of unvaccinated young women.

Methods: Vaccinated young women from our implementation project were included. Extended HPV genotyping was performed on self-collected vulvo-vaginal specimens (Evalyn brushes); vaccine data were collated from vaccination registers. Full vaccination(FV) was defined as 3-dose series (0, 1-2, 6 months) or, 2-dose series (0, at least 22 weeks) if vaccination initiated at ages 9-14 years. Partial vaccination(PV) was defined as 1 dose, or 2 doses less than 22 weeks apart, or only 2 doses if vaccination initiated after age 15 years. Historical control group comprised 137 young women, zero-dose vaccinated(ZV), with matching age-group and demographics. Vaccine effectiveness was calculated as 100*(1-Odds Ratio).

Results: One-hundred-and-two vaccinated participants were enrolled, 73.5% FV, 26.8% PV; age range:16-22 years (mean 19.5). Mean time since vaccination: 8.6 years. Mean vaccination age: 11.0 years. HPV16;18;45 prevalence in FV|PV|ZV were 0%;0%;0%|0%;0%;3.7%|15.3%;4.4%;5.1%. Measured against control group (ZV), VE against HPV16/18 in FV|PV was 91.1%|96.8% and against HPV31/33/45 66.9%|-21.3%.

Table 1. HPV prevalence per vaccination status

	Full vaccination, FV n=75	Partial vaccination, PV n=27	Zero vaccination, ZV n=137
	n (%)	n (%)	n (%)
HPV16	0	0	21 (15.3)
HPV18	0	0	6 (4.4)
HPV31	1 (1.3)	0	5 (3.6)
HPV33	0	1 (3.7)	5 (3.6)
HPV35	2 (2.7)	2 (7.4)	5 (3.6)
HPV45	0	1 (3.7)	7 (5.1)
HPV52	5 (6.7)	5 (18.5)	11 (8.0)
HPV58	2 (2.7)	1 (3.7)	6 (4.4)

Table 2. Vaccine effectiveness per vaccination status measured against the control group (ZV)

Vaccination status	OR (95% CI)	Vaccine effectiveness (VE) % (95% CI)	p-value
1. HPV 16/18			
Full vaccination, FV	0.0323 (0.002-0.539)	96.8 (46.1-99.8)	0.0169
Partial vaccination, PV	0.0886 (0.005-1.504)	91.1 (-50.4- 99.5)	0.0934
2. HPV 16/18/31/33/35/45/52/58 (top-8 high-risk HPVs found in invasive cervical cancer)			
Full vaccination	0.331 (0.150-0.727)	66.9 (27.3-85.0)	0.006
Partial vaccination	1.213 (0.503-2.926)	-21.3 (-192.6-49.7)	0.668

Conclusion/Implications: After a mean of 8.6 years, no cases of HPV infection by vaccine types were identified in a cohort with high HPV prevalence. Significant cross-protection against HPV31/33/45 was seen in fully vaccinated participants, but not in partially vaccinated women.

MO009 / #1132

Topic: *AS04. Prevention & Downstaging / AS04b. Prevention & Vaccination*

COST-EFFECTIVENESS OF DIFFERENT HPV VACCINATION STRATEGIES FOR CERVICAL CANCER PREVENTION IN SOUTH AFRICA

MINI ORAL ABSTRACT PRESENTATIONS 01

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Introduction: Most cervical cancers can be prevented by population-wide vaccination of pre-adolescent girls with highly efficacious HPV vaccines. In South Africa, first-dose coverage of bivalent HPV vaccination among girls (aged 10) is ~80%. We assessed the long-term impact and cost-effectiveness of bivalent and nonavalent HPV vaccination strategies among the general population and women living with HIV (WLHIV).

Methods: We used an individual-based, population-level model for HPV and HIV transmission in South Africa to estimate the epidemiological impact of HPV vaccination. The costs of interventions in the cervical cancer care cascade are estimated in 2024 USD based on resource use and prices obtained from research studies. Outcomes were evaluated in USD per disability-adjusted life years (DALYs) averted and compared to an opportunity cost threshold of USD 3,005.

Results: Current interventions are projected to reduce age-standardised cervical cancer incidence from 54 to 12 per 100,000 women by 2120. Increasing girl-only bivalent coverage to 90% would prevent an additional 5% of cases and be cost-saving. Gender-neutral vaccination at 80% coverage would yield similar impact, with a USD/DALY averted of USD 2,782. Vaccinating WLHIV up to age 45 could prevent 10% of cervical cancer cases in this group and remains cost-effective. The nonavalent vaccine would be cost-effective if priced below USD 40 per dose.

Conclusion/Implications: Enhanced HPV vaccination strategies—including higher coverage, gender-neutral programs, and targeted vaccination of WLHIV—are cost-effective in South Africa. However, achieving WHO elimination thresholds will require integrated approaches combining vaccination with cervical screening and treatment.

MO010 / #63

Topic: *AS06. Tumor Types / AS06b. Cervical Cancer*

BODY COMPOSITION AND SYSTEMIC INFLAMMATION AS PREDICTORS OF SURVIVAL IN LOCALLY ADVANCED CERVICAL CANCER PATIENTS UNDERGOING PRIMARY RADIO-CHEMOTHERAPY: A SUBGROUP ANALYSIS OF A PROSPECTIVE RANDOMIZED TRIAL

MINI ORAL ABSTRACT PRESENTATIONS 01

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Introduction: Obesity, sarcopenia and chronic inflammation impact on clinical outcomes in several cancer entities. However, in cervical carcinoma their roles are currently not well defined. Here, we analyzed baseline body composition and serum inflammation parameters in patients with locally advanced cervical cancer undergoing concurrent chemoradiotherapy.

Methods: Anthropometric data and CT scan-derived body composition measured at lumbar vertebra L4 as well as serum inflammation parameters were derived from FIGO stage IIB-IVA locally advanced cervical cancer patients included in the randomized controlled multicenter Uterus-11 trial (NCT01049100). Overall and progression-free survival were analyzed by Kaplan-Meier and Cox proportional hazards models.

Results: From 255 patients, 83 were eligible for analysis with a median follow-up of 50 months. While the body-mass-index was not significantly associated with survival, univariate analyses revealed that measures of visceral obesity such as a high waist circumference (≥968 mm), increased waist-to-hip-ratio (≥0.96) and relative fat mass (>42.2 %), but not local, intrapelvic fat content were associated with significantly shorter survival. In addition, a psoas muscle index lower than 3.011 and increased systemic inflammation indicated by leukocytosis (>10 x 10^3/µl) and stage 1 modified Glasgow-prognostic-score were also negative prognostic factors. In multivariate analysis, psoas muscle index and leukocytosis remained independent negative prognostic factors besides stage IVA disease.

Conclusion/Implications: Analyses of this randomized controlled trial suggest that body composition and inflammation parameters represent prognostic markers in cervical cancer patients undergoing chemoradiotherapy. Sarcopenia and systemic inflammation were independent negative prognostic factors. If proven in future studies, pre-therapeutic body composition and inflammation parameters might stratify clinical decision makings.