IGCS 2025 CAPE TOWN

Annual Global Meeting, November 5–7, 2025

IGCS 2025 Abstracts: Late-Breaking Presentations

Late-breaking abstract presentations are included in the sessions listed below. Some sessions with oral/mini oral presentations will be recorded for on-demand viewing via the IGCS 360 Educational Portal as indicated. Featured printed posters (Poster Rounds) will be presented during morning and afternoon coffee breaks, and E-Posters will be available for on-demand viewing to registered attendees via the IGCS 2025 mobile application, IGCS 360 Educational Portal, and the onsite E-Poster stations.

ORAL PRESENTATIONS:

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

Survivorship Care Workshop
Wednesday, November 5, 14:45 - 15:45 | Meeting Room 11 | in-person only

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

FEATURED POSTER PRESENTATIONS:

Poster Rounds 3: Fertility & Outcomes in Endometrial Cancer
Wednesday, November 5, 10:40 - 11:10 | Poster Area | in-person only

Poster Rounds 6: Innovations in Gynecologic Cancer Care
Wednesday, November 5, 15:45-16:30 | Poster Area | in-person only

E-POSTERS:
No designated presentation slot – available for on-demand viewing to registered attendees.

LB001 / #570

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

PHASE 3 ROSELLA (GOG-3073, ENGOT-OV72) TRIAL OF RELACORILANT + NAB-PACLITAXEL VS NAB-PACLITAXEL IN PLATINUM-RESISTANT OVARIAN CANCER: PRIMARY RESULTS AND OUTCOMES IN OLDER PATIENTS

PLENARY: HIGH-IMPACT ORAL ABSTRACT PRESENTATIONS

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Introduction: Relacorilant, a first-in-class, selective glucocorticoid receptor antagonist, increases tumor sensitivity to chemotherapy-induced apoptosis. The phase 3 ROSELLA study assessed the safety and efficacy of relacorilant+nab-paclitaxel in patients with platinum-resistant ovarian cancer (PROC).

Methods: In ROSELLA, patients were randomized 1:1 to relacorilant (150mg PO: day before, of, and after nab-paclitaxel)+nab-paclitaxel (80mg/m^2: days 1, 8, and 15 of each 28-day cycle) or nab-paclitaxel alone (100mg/m^2 on the same schedule).
Progression-free survival (PFS) by blinded independent central review (BICR) and overall survival (OS) are dual primary endpoints. A pre-planned exploratory efficacy and safety analysis in older patients (≥65 years) was also conducted.

Results: The addition of relacorilant to nab-paclitaxel showed a statistically significant improvement in PFS by BICR and a clinically meaningful benefit in OS at the interim analysis **(Table)**. Patients aged ≥65 were heavily pretreated, had advanced disease, and were similarly distributed between treatment arms (38.3% vs 41.5%). The addition of relacorilant was associated with a 39% reduction in the risk of progression in this subgroup (PFS by BICR: HR 0.61 [95% CI 0.40-0.94] P=0.0247). The safety profile of the combination arm in this subgroup was comparable to the combination arm in the ITT population, with similar rates of grade ≥3 (81.9% vs 74.5%) and serious (34.7% vs 35.1%) treatment-emergent adverse events.

Table. Efficacy outcomes in the ITT population and the ≥65 years subgroup

		ITT		≥65 years	
		Relacorilant + Nab-paclitaxel N=188	**Nab-paclitaxel N=193**	**Relacorilant + Nab-paclitaxel n=72**	**Nab-paclitaxel n=80**
PFS (BICR)	**PFS Events**, n	113	121	40	54
	Median PFS, m (95% CI)	6.54 (5.55-7.43)	5.52 (3.94-5.88)	7.39 (5.82-11.76)	5.85 (4.17-7.29)
	HR (95% CI)	0.70 (0.54-0.91)		0.61 (0.40-0.94)	
	P-value (Log-rank)	P=0.0076		Nominal P=0.0247	
OS (Interim)	**OS Events**, n	82	110	26	47
	Median OS, m (95% CI)	15.97 (13.47-NR)	11.50 (10.02-13.57)	16.92 (15.28-NR)	11.07 (9.72-14.82)
	HR (95% CI)	0.69 (0.52-0.92)		0.55 (0.34-0.89)	
	P-value (Log-rank)	P=0.0121		Nominal P=0.0143	

Data cutoff: Feb 24, 2025

BICR, blinded independent central review; CI, confidence interval; HR, hazard ratio; ITT, intent-to-treat; m, months; NR, not reached; OS, overall survival; PFS, progression-free survival

Conclusion/Implications: Relacorilant+nab-paclitaxel demonstrated clinically meaningful improvements in PFS and OS in the ITT population and in the subgroup of older patients with PROC without significantly adding to the safety burden, positioning it as a new standard for all age groups.

LB002 / #1301

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

PEMBROLIZUMAB VS PLACEBO PLUS PACLITAXEL ± BEVACIZUMAB FOR PLATINUM-RESISTANT RECURRENT OVARIAN CANCER: RESULTS FROM THE PHASE 3 ENGOT-OV65/KEYNOTE-B96 STUDY

PLENARY: HIGH-IMPACT ORAL ABSTRACT PRESENTATIONS

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Introduction: Pembrolizumab plus weekly paclitaxel demonstrated antitumor activity and manageable safety in a phase 2 study of participants with platinum-resistant recurrent ovarian cancer. The phase 3 ENGOT-ov65/KEYNOTE-B96 study (NCT05116189) evaluated pembrolizumab (vs placebo) plus weekly paclitaxel ± bevacizumab in this setting.

Methods: Eligible participants had histologically confirmed epithelial ovarian, fallopian tube, or primary peritoneal carcinoma; received 1–2 prior systemic regimens (≥1 prior platinum-based therapy with ≥4 cycles in first line); and platinum-resistant disease (PD ≤6 months after last platinum dose). Participants were randomized 1:1 to pembrolizumab 400 mg IV or placebo Q6W, each combined with weekly paclitaxel (80 mg/m^2 on days 1, 8, and 15 of each 3-week cycle) ± bevacizumab (10 mg/kg Q2W) until PD or unacceptable toxicity. Primary endpoint was investigator-assessed PFS per RECIST v1.1 in participants with PD-L1 CPS ≥1 and in all participants. OS was the key secondary endpoint in both populations. Progression after next line of treatment (PFS2) was an exploratory endpoint. Subsequent anticancer therapies by type were summarized.

Results: Efficacy results favored the pembrolizumab arm (**Table 1**). Subsequent anticancer therapies were used by 52.2% and 60.4% in the pembrolizumab and placebo arms, respectively (**Table 2)**. Grade ≥3 treatment-related adverse events occurred in 67.5% vs 55.3%, respectively.

Conclusion/Implications: Pembrolizumab (vs placebo) plus weekly paclitaxel ± bevacizumab significantly improved PFS, regardless of PD-L1 CPS, and OS in participants with PD-L1 CPS ≥1. PFS2 was improved in the pembrolizumab arm. Subsequent anticancer therapies were more common in the placebo arm. The safety profile of the pembrolizumab regimen was manageable.

Table 1. Efficacy Results

Endpoint	PD-L1 CPS ≥1		All Participants	
	Pembrolizumab n = 234	Placebo n = 232	Pembrolizumab N = 322	Placebo N = 321
PFS (primary)[a]				
Median, mo	8.3	7.2	8.3	6.4
HR (95% CI)	0.72 (0.58–0.89); $P = 0.0014$		0.70 (0.58–0.84); $P < 0.0001$	
OS (secondary)[b]				
Median, mo	18.2	14.0	17.7	14.0
HR (95% CI)	0.76 (0.61–0.94); $P = 0.0053$		0.81 (0.68–0.97); $P = 0.0114$	
PFS2 (exploratory)[b]				
Median, mo	14.3	11.4	13.5	11.5
HR (95% CI)	0.70 (0.57–0.86)		0.75 (0.62–0.89)	

[a]Data cutoff date: April 3, 2024 (median follow-up, 15.6 months).

[b]Data cutoff date: March 5, 2025 (median follow-up, 26.6 months).

Table 2. Subsequent Anticancer Therapies in All Participants

	Pembrolizumab N = 322	Placebo N = 321
≥1 subsequent anticancer therapy[a]	168 (52.2)	194 (60.4)
Type of subsequent anticancer therapy		
Targeted therapy	7 (2.2)	9 (2.8)
Anti–PD-1/PD-L1	5 (1.6)	14 (4.4)
Chemotherapy	149 (46.3)	175 (54.5)
Bevacizumab	27 (8.4)	28 (8.7)
Other VEGF inhibitors	1 (0.3)	1 (0.3)
Antibody–drug conjugates	12 (3.7)	16 (5.0)
Immunotherapy	1 (0.3)	0
PARPi	3 (0.9)	1 (0.3)
Hormonal therapy	12 (3.7)	6 (1.9)
Other antineoplastic agents or investigational drugs	7 (2.2)	9 (2.8)
All other therapeutic products	7 (2.2)	17 (5.3)

Data are n (%) of participants. PARPi, poly (ADP-ribose) polymerase inhibitor; VEGF, vascular endothelial growth factor.

[a]Data cutoff date: March 5, 2025.

LB003 / #868

Topic: *AS02. Clinical Disciplines / AS02d. Radiation Oncology*

TOXICITY, HEALTH-RELATED-QUALITY-OF-LIFE AND SEXUAL-HEALTH FOLLOWING MOLECULAR-BASED ADJUVANT TREATMENT IN THE INTERNATIONAL RANDOMISED PORTEC-4A TRIAL

SURVIVORSHIP CARE WORKSHOP

Anne Sophie van den Heerik[1], Cathalijne Post[2], Marie Haverkort[2], Nienke Kuijsters[3], Stefan Kommoss[4], Friederike Koppe[5], Marlies Nowee[6], Henrike Westerveld[7,8], Marianne de Jong[9], Filip Frühauf[10], Jeltsje Cnossen[11], Jan Willem Mens[8], Jannet Beukema[12], Cyrus Chargari[13], Charles Gillham[14], Ina Jurgenliemk-Schulz[15], Katrien Vandecasteele[16], Moritz Hamann[17], Mandy Kiderlen[18], Stefan Polterauer[19], Hans Nijman[20], Elefteria Asteinidou[1], Bastiaan Wortman[1,11], Stephanie de Boer[1], Karen Verhoeven-Adema[21], Remi Nout[1,8], Hein Putter[22], Tjalling Bosse[23], Carien Creutzberg[1], Nanda Horeweg[1]
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Introduction: PORTEC-4a is first to incorporate a molecular-integrated-risk-profile in adjuvant-treatment for early-stage endometrial-cancer patients with high-intermediate-risk-features (HIR-EC). Primary and secondary endpoints were recently presented.[1] The current analyses investigated health-related-quality-of-life (HRQOL), sexual-health and adverse-events (AE).

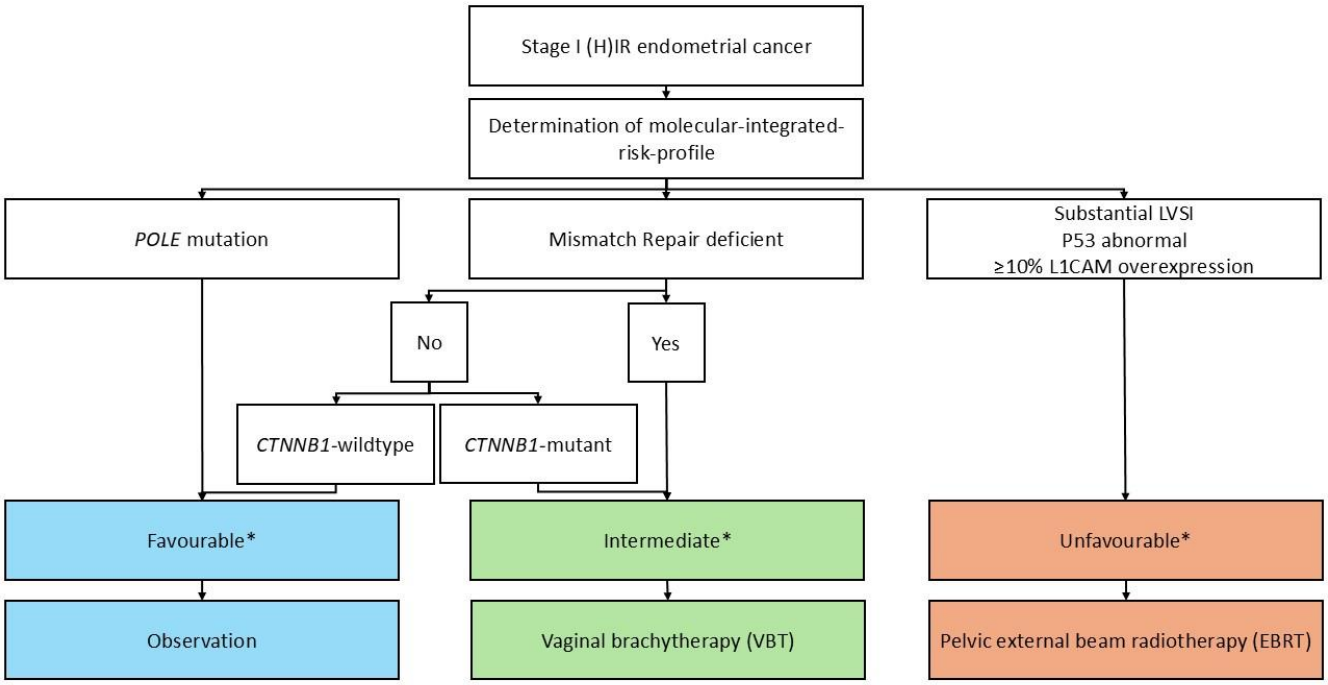
Methods: HIR-EC-patients were randomised (2:1) to molecular-based adjuvant-treatment or vaginal-brachytherapy (VBT), figure-1. Analyses were conducted on per-protocol-population. HRQOL and sexuality were assessed with EORTC-QLQ-C30-EN24-modules at baseline, after treatment, and 6-monthly up to 3-years and compared with age-matched-normative-data. AEs were graded using CTCAE-v4.0 and evaluated by odds-ratio (OR). HRQOL-analysis were done according EORTC-guidelines, with 2-sided $p<0.01$ statistically significant.

Results: 564 patients were included, 367 molecular-profile-arm and 197 standard-arm, with median age 69. Similar physical and role functioning, as well as quality-of-life was observed between arms, with no clinical significance differences, figure-2A/B/C. Subgroup analyses demonstrated slightly higher scores in patients without adjuvant-treatment, while patients receiving external-beam-radiotherapy reported slightly lower scores, with little to moderate clinical significance, figure-2D/E/F. At baseline ≥65% of patients reported not being sexually interested and/or active. At 3-years, 36% reported no sexual-interest, and 42% not being sexually-active. Most frequent reasons for no sexual interest/activity, were having no partner and/or sex not important. Own illness was reported at baseline and during treatment by 20% of patients, and by 6% at 3-years. Toxicity was mostly grade 1-2, without significant differences between arms at baseline (OR 0.88, 95%CI 0.62-1.27), after treatment (OR 0.96(0.64-1.44)) and during 3-year follow-up period (OR 0.71(0.79-1.61)).

Conclusion/Implications: Molecular-based adjuvant-treatment for HIR-EC is safe, with all patients reporting high quality-of-life and similar HRQOL.

[1]Van den Heerik et al – PORTEC-4a; an international randomised trial of molecular profile-based adjuvant treatment for women with high-intermediate risk endometrial cancer – ESTRO 2025 Vienna

Figure 1: PORTEC-4a study design



*Patients in the standard-arm were all treated with VBT

Figure 2 Patient reported quality of life and functioning compared to age-matched-normative-data

A Physical functioning scores over time between two treatment arms

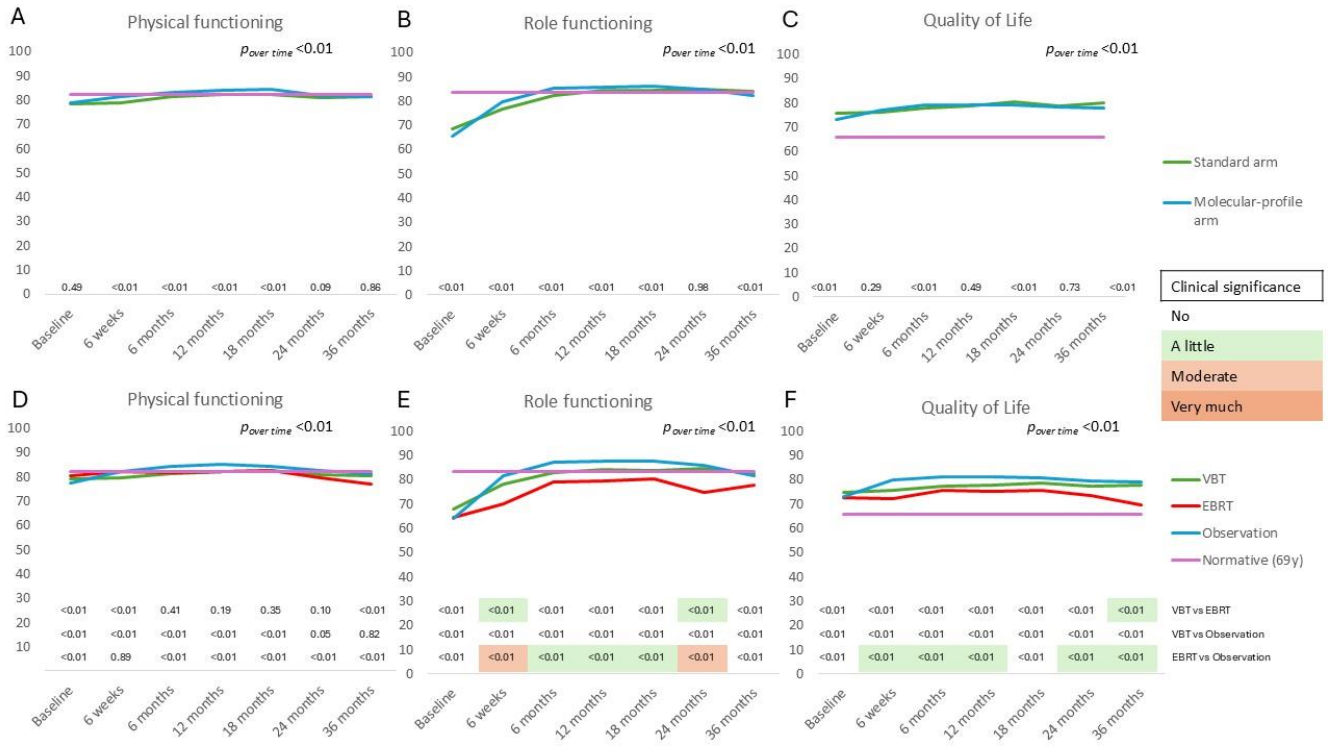
B Role functioning scores over time between two treatment arms

C Quality of life over time between two treatment arms

D Physical functioning scores over time between observation vs vaginal brachytherapy vs pelvic external beam radiotherapy

E Role functioning scores over time between observation vs vaginal brachytherapy vs pelvic external beam radiotherapy

F Quality of life over time between observation vs vaginal brachytherapy vs pelvic external beam radiotherapy



LB004 / #455

Topic: *AS02. Clinical Disciplines / AS02a. Diagnostics & Imaging*

TRANSFORMING OVARIAN CANCER DIAGNOSTIC PATHWAYS (SONATA): ROMA VERSUS CA125 IN COMMUNITY SETTING FOR DIAGNOSIS OF OVARIAN CANCER. A REAL-WORLD PROSPECTIVE DIAGNOSTIC TEST ACCURACY STUDY – PRELIMINARY RESULTS

PLENARY: OVARIAN CANCER ORAL ABSTRACT PRESENTATIONS

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Introduction: Ovarian cancer survival is stage dependent. Evidence suggests that the Risk of Malignancy Algorithm (ROMA) is superior to the currently used CA125 in the diagnosis of ovarian cancer (OC), especially in early stage, in the hospital setting.[1,2] ROMA combines CA125 and HE4 in an algorithm with menopausal status adjusted thresholds. We investigated ROMA's diagnostic accuracy and cost-efficiency in community settings using novel linkage and real-world data.

Methods: Prospective diagnostic test accuracy cohort study. Routinely collected serum samples from symptomatic women in community settings undergoing testing for CA125 were additionally tested for HE4/ROMA. Laboratory results were linked with NHS hospital cancer centre patient outcomes and analysed in a Secure Data Environment. Powered to detect a 30-percentage point difference in sensitivity between ROMA and CA125. Ethical approvals for sample testing and data linkage without patient consent in place (23/CAG/0086, Research 23/WS/0107, NCT06129968). Primary Outcome: accuracy of ROMA vs CA125 for diagnosis of OC.

Results: After record linkage, 34457 patients had 37346 tests (minimum 94 days follow-up) with 62 invasive and 9 borderline OCs (Figure-1). Sensitivity of CA125 75.0% (95% CI 62.1, 85.3) and

ROMA 73.2% (95%CI 59.7, 84.2) (p=1.000) were comparable. Specificity of CA125 92.6% (95% CI 92.4, 92.9) was higher than ROMA 86.5% (95%CI 86.1, 86.8) (p<0.0001) (Table-1).

Figure 1 Diagnostic test analysis flowchart

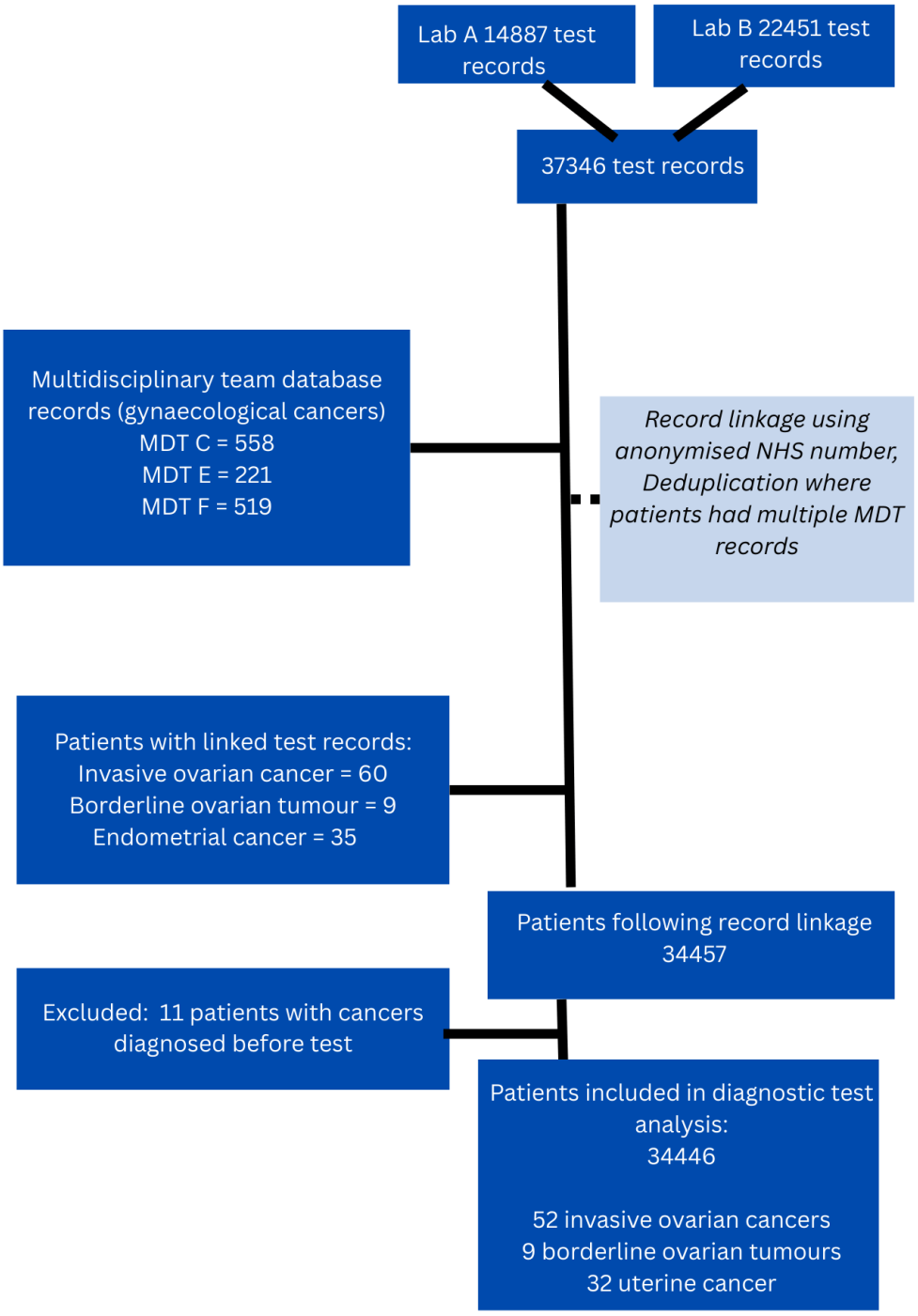

Table 1 CA125 and ROMA for diagnosis of invasive and borderline ovarian cancer in the primary care setting

Index test combination	Threshold	Diagnosis based on reference standard, n=34,446		Number of Participants, n (%)	Sensitivity (%) (95% CI)	Specificity (%) (95% CI)	Positive predictive value (PPV) (%) (95% CI)	Negative predictive value (NPV) (%) (95% CI)
		Ovarian cancer n=61	No ovarian cancer n=34,385					
CA125, n (%)	Missing	1 (1.6)	137 (0.4)					
	≥35 U/ml	45 (73.8)	2,523 (7.3)	34,308 (99.6)	75.0 (62.1, 85.3)	92.6 (92.4, 92.9)	1.8 (1.3, 2.3)	100.0 (99.9, 100.0)
	<35 U/ml	15 (24.6)	31,725 (92.3)					
ROMA, n (%)	Missing	5 (8.2)	1,738 (5.1)					
	Elevated	41 (67.2)	4,421 (12.9)	32,703 (94.9)	73.2 (59.7, 84.2)	86.5 (86.1, 86.8)	0.9 (0.7, 1.2)	99.9 (99.9, 100.0)
	Normal	15 (24.6)	28,226 (82.1)					
Absolute difference in sensitivity (95% CI): 0.0 (-8.8, 8.8), n = 56, p = 1.0000 Absolute difference in specificity (95% CI): 6.2 (5.8, 6.6), n = 32,647, p =< 0.0001								

Conclusion/Implications: In community settings ROMA showed comparable sensitivity and less specificity than CA125 with 3 months minimum follow-up. Longer follow-up results are expected in 2026. Our innovative use of real-world data linkage has enabled the first large scale diagnostic accuracy study in community settings.

References:

1. Davenport CF, Rai N, Sharma P et al. Diagnostic Models Combining Clinical Information, Ultrasound and Biochemical Markers for Ovarian Cancer: Cochrane Systematic Review and Meta-Analysis. Cancers. 2022 Jan;14(15):3621.
2. Dayyani F, Uhlig S, Colson B et al. Diagnostic Performance of Risk of Ovarian Malignancy Algorithm Against CA125 and HE4 in Connection With Ovarian Cancer: A Meta-analysis. Int J Gynecol Cancer Off J Int Gynecol Cancer Soc. 2016 Nov;26(9):1586–93.

LB005 / #1259

Topic: *AS03. Patient-Centered Care / AS03c. Patient Advocacy & Survivorship*

EXERCISE THERAPY ADDED TO FIRST-LINE CHEMOTHERAPY FOR OVARIAN CANCER: EFFECTS ON PROGRESSION-FREE SURVIVAL AND PHYSICAL WELLBEING IN THE RANDOMISED, PHASE 3 ECHO TRIAL (ANZGOG1304/CTC121)

PLENARY: OVARIAN CANCER ORAL ABSTRACT PRESENTATIONS

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Introduction: ECHO is a randomised, controlled, phase 3 trial evaluating whether addition of exercise therapy to first-line chemotherapy improves progression-free survival (PFS) and physical wellbeing in newly diagnosed ovarian, primary peritoneal or fallopian tube cancer.

Methods: Participants were randomised to exercise plus standard of care chemotherapy (exercise) versus standard of care chemotherapy alone (control). The exercise intervention targeted 150 minutes per week of mixed-mode, moderate-intensity exercise. The primary endpoints were PFS and physical wellbeing (FACT-O subscale), assessed at baseline (before starting 2nd chemotherapy cycle), then 6 and 12 months follow up. Analyses were by intention-to-treat, used Kaplan-Meier and Cox regression for times to events, and Generalised Estimating Equations (GEE) for physical wellbeing.

Results: 489 eligible participants were randomised to either the exercise (243) or control (246) group. Average age was 61 years; 74% had stage III or IV disease. The exercise program was safe (no participants had exercise-related adverse events of grade 3 or greater) and feasible (median minutes/week of exercise completed: 135). After median follow-up of 4.5 years, a PFS event had occurred in 159 (65%) assigned exercise versus 148 (60%) assigned control (median PFS: 24 vs 23 months, respectively; HR: 1.09, 95% CI 0.87 to 1.36; p=0.45). Physical wellbeing at 6- and 12-months was similar among those assigned exercise versus control (difference (95% CI) from GEE: 0.11 (-0.66 to +0.87), p=0.78)).

Conclusion/Implications: Exercise therapy added to first-line chemotherapy did not improve PFS or physical wellbeing in ovarian cancer.

LB015 / #1363

FINAL OVERALL SURVIVAL RESULTS FROM THE GOG281/LOGS STUDY EVALUATING TRAMETINIB VERSUS PHYSICIAN'S CHOICE STANDARD-OF-CARE THERAPY FOR RECURRENT LOW-GRADE SEROUS OVARIAN CANCER (LGSOC)

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

PLENARY: OVARIAN CANCER ORAL ABSTRACT PRESENTATIONS

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Introduction: The GOG281/LOGS study (ClinicalTrials.gov identifier: NCT02101788) demonstrated that the MEK1/2 inhibitor trametinib significantly increased progression-free survival (PFS) compared to physician's choice standard of care (SoC) in patients with recurrent

LGSOC [hazard ratio (HR) 0·48 (95% CI 0·36-0·64); p<0·0001]. At the time of the primary analysis (16th July 2019) 43% of patients had died. Here we present the prespecified final overall survival (OS) analysis and long-term toxicity data after >7 years of follow-up.

Methods: This international phase 2/3 trial randomly assigned (1:1) patients with recurrent LGSOC to receive either oral trametinib 2 mg once daily (n=130) or one of five SoC treatment options (n=130): intravenous paclitaxel 80 mg/m^2 by body surface area on days 1, 8, and 15 of every 28-day cycle; intravenous pegylated liposomal doxorubicin 40–50 mg/m^2 once every 4 weeks; intravenous topotecan 4 mg/m^2 on days 1, 8, and 15 of every 28-day cycle; oral letrozole 2·5 mg once daily; or oral tamoxifen 20 mg twice daily. Patients in the SoC group were allowed to crossover to trametinib on progression. A prespecified analysis of OS and toxicity, both secondary endpoints, was conducted after 85.8 months of median follow-up.

Results: At the time of the final analysis, 29 (22.3%) patients in the trametinib arm and 15 (11.5%) patients in the SoC arm remained alive. The median OS was 36.4 months in the trametinib arm versus 29.8 months in the SoC arm (HR 0.68; 95% CI 0.49-0.94; p=0.018, 1-sided), despite the fact that 72% of patients in the SoC arm crossed over to trametinib following progression. In the 93 SoC patients who crossed over to trametinib the median PFS following cross-over was 9.5 months compared to 6.5 months with the preceding SoC therapy (HR 0.66; 95% CI 0.49-0.89). The most common trametinib toxicities were skin rash (13%), anaemia (13%), diarrhoea (10%) and nausea (9%) with no new long term toxicity signal. There were no treatment-related deaths.

Conclusion/Implications: Trametinib is the first agent to demonstrate an overall survival advantage in recurrent LGSOC.

LB006 / #1331

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

GLOBAL PHASE II STUDY OF RISOVALISIB, A SELECTIVE PI3Kα INHIBITOR, AS MONOTHERAPY IN PATIENTS WITH RECURRENT/PERSISTENT OVARIAN CLEAR CELL CARCINOMA HARBORING PIK3CA HOTSPOT MUTATIONS

MINI ORAL ABSTRACT PRESENTATIONS 02

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Introduction: Recurrent or persistent ovarian clear cell carcinoma (OCCC) is rare and chemo-resistant (ORR <8%). *PIK3CA* hotspot mutations, found in 20-30% of OCCC, drive tumorigenesis and are correlated with poor prognosis, making them a promising target for therapeutic interventions.

Methods: This single-arm phase II study (NCT05043922) evaluates the efficacy and safety of risovalisib 40 mg orally once daily (QD) in patients with recurrent or persistent OCCC harboring *PIK3CA* hotspot mutations. The primary endpoint was the ORR assessed by a blinded independent review committee. Secondary endpoints included investigator-assessed ORR and other efficacy, safety and PK parameters.

Results: As of July 31, 2024, a total of 93 female patients (China 44.1%, Japan 55.9%) were enrolled; median age 49.0 years. All patients had prior systemic platinum-based chemotherapy; 67.7% received ≥2 lines of systemic therapy. Bevacizumab was used by 69.9% of patients.
Among the 84 efficacy-evaluable patients (China 45.2%; Japan 54.8%), the investigator-assessed ORR was 32.1% (95%CI: 22.36, 43.22), and disease control rate was 75.0% (95%CI: 64.36, 83.81). The median duration of response was 6.28 months (95%CI: 3.515, 11.269).
Among all 93 patients, the most common treatment-related adverse events (TRAEs) were hyperglycemia and rash, which were also the most frequent Grade ≥3 TRAEs. Most cases were manageable. No TRAEs led to death.

Conclusion/Implications: Risovalisib 40 mg QD showed manageable safety and encouraging efficacy in prior systemically-treated recurrent or persistent OCCC harboring *PIK3CA* hotspot mutations.

*Japanese Gynecologic Oncology Group (JGOG) majorly contributed to the enrollment in Japan. Also, Next Generation Sequencer (NGS) contributed to the identification of Japanese patients.

LB007 / #826

Topic: *AS03. Patient-Centered Care / AS03a. Fertility & Pregnancy*

LIFE AFTER FERTILITY-SPARING SURGERY: A QUALITATIVE INTERVIEW STUDY ON FERTILITY AND PREGNANCY CONCERNS, AND FERTILITY-RELATED NEEDS IN YOUNG WOMEN WITH CERVICAL CANCER AND THEIR PARTNERS

MINI ORAL ABSTRACT PRESENTATIONS 02

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Introduction: Many adolescents and young adults (AYAs) treated for gynecological cancer experience long-term concerns about fertility, pregnancy and psychological distress. There is limited knowledge on patients' perspectives regarding subsequent pregnancy attempts, fertility- and pregnancy-related concerns, and patients' needs in onco-fertility care. This study aims to provide in-depth insight into these perspectives of AYAs treated with fertility sparing surgery (FSS) and their partners.

Methods: AYAs were selected from our questionnaire study for interviews through purposive sampling based on self-reported reproductive concerns and pregnancy attempts.

Results: Consensus on data saturation was reached after 32 interviews, 24 with AYAs and eight with their partners. The analysis revealed several new insights on factors and concerns influencing the decision to pursue pregnancy. AYAs mentioned treatment-related physical complaints, expected complicated pregnancies, and expressed a changed perspective towards having children after cancer treatment. Nonetheless, only three women refrained from pursuing pregnancy. Additionally, the findings underscore the post-treatment challenges these AYAs encounter, including a sense of time pressure, and a common need for assisted reproductive techniques. Nearly all AYAs expressed their need for fertility counseling, although the preferred timing for this support appeared to vary. Partners viewed their primary role as providing emotional

support in the treatment decision-making and emotional support throughout the process of conception.

Conclusion/Implications: This qualitative study addresses important issues faced by gynecological cancer patients following FSS, emphasizing post-treatment challenges and personal considerations in the pursuit of pregnancy. These findings contribute to future development of personalized onco-fertility care tailored to the unique needs of AYAs and their partners.

LB008 / #534

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

METFORMIN COMBINED WITH CHEMORADIOTHERAPY IN PATIENTS WITH LOCALLY ADVANCED CERVICAL CANCER: A PHASE II, RANDOMIZED CLINICAL TRIAL.

MINI ORAL ABSTRACT PRESENTATIONS 02

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Introduction: Tumor hypoxia is a prognostic factor, associated with poor radiotherapy response representing a valid, interventional target. This clinical trial investigated if the antidiabetic drug metformin, could decrease hypoxia according to established biomarkers. Adding metformin to chemoradiotherapy has previously been found to be tolerable and safe[1].

Methods: Cervical cancer patients were included in a 1:1 randomized, open-label design, comparing standard chemoradiotherapy +/- metformin. Metformin 850 mg twice daily was administered one week before and during chemoradiotherapy. Tumor-biopsies and MR-images were collected at baseline, after one week and at the first fraction of brachytherapy. Efficacy was evaluated by changes in the expression of hypoxia- associated genes and MRI parameters.

Results: Eighteen and 23 patients were allocated to the intervention and control arm, respectively. Changes in gene- and MRI-based hypoxia measures did not reach statistical significance between study arms (P> 0.05). However, relative tumor-volume regression after one week differed significantly (P = 0.0063). After one week, there was a small increase (median + 7.9%, P= 0.023) in tumor-volume in the control arm, while tumor-volume decreased slightly (median -10.1%, P= 0.098) in the metformin arm. This difference persisted at brachytherapy (−95.4% vs −86.5%, P= 0.041).

Conclusion/Implications: There were no statistically significant differences in our hypoxia biomarkers after one week of metformin. However, a difference in tumor-volume regression, favoring patients treated with metformin, could indicate reduced tumor growth and increased cell kill following metformin treatment.

[1]Tolerability, safety and feasibility of metformin combined with chemoradiotherapy in patients with locally advanced cervical cancer: A phase II, randomized study. Acta Oncol. 2025 Mar 19;64:439-447.

LB009 / #959

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

CIRCULATING TUMOR DNA (CTDNA) AS A PROGNOSTIC MARKER IN PATIENTS WITH HIGH-RISK ENDOMETRIAL CANCER (HREC)

MINI ORAL ABSTRACT PRESENTATIONS 02

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Introduction: Despite adjuvant therapy, HREC patients remain at substantial risk of recurrence. The role of current clinicopathologic factors in predicting outcomes is limited. Precise biomarkers are needed to guide treatment and surveillance. This study investigates the prognostic value of ctDNA in HREC patients.

Methods: In an ongoing prospective study of patients with early-stage HREC, serial plasma samples were prospectively collected at: pre-/post-operative (pre-op/post-op), and post-definitive treatment (EOT). ctDNA analysis was performed using a clinically validated, tumor-informed mPCR-NGS assay (Signatera™, Natera, Inc.) and correlated with recurrence-free survival (RFS).

Results: Personalized ctDNA assays were successfully designed for 90/97 patients, with a median age of 66 years (range: 30-85), and follow-up of 26 months (range: 1-67). Positive ctDNA detection rates were 60% (51/85) pre-op, 19% (14/74) post-op, and 14% (6/44) EOT. Patients with ctDNA positivity post-op (N=11) had significantly higher risk for recurrence (HR 6.5; 95% CI: 2.1-19.9; p=0.002) compared to those with ctDNA negativity (N=46). ctDNA positivity at the end of systemic treatment was also significantly associated with inferior RFS (HR 9; 95% CI: 2.1-42.2; p<0.001).

Conclusion/Implications: ctDNA positivity post-op or at EOT in patients with HREC is associated with the highest risk of relapse and death. These results support ctDNA as a promising biomarker for clinical decision-making in this population.

LB010 / #822

Topic: *AS03. Patient-Centered Care / AS03a. Fertility & Pregnancy*

LONG-TERM REPRODUCTIVE CONCERNS AND ASSOCIATED FACTORS IN ADOLESCENTS AND YOUNG ADULTS TREATED WITH FERTILITY SPARING SURGERY FOR GYNECOLOGICAL CANCER: A DUTCH NATIONWIDE COHORT STUDY

POSTER ROUNDS WITH THE PROFESSORS

Yaël Stroeken[1], Madeleine van den Berg[2], Petra Zusterzeel[3], Ronald Zweemer[4], Refika Yigit[5], Constantijne Mom[2], Eva Maria Roes[6], Ruud Bekkers[7,8], Brigitte Slangen[9], Teska Schuurman[2], Christianne Lok[2], Nienke van Trommel[2], Jogchum Beltman[1], Moniek ter Kuile[1]
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Introduction: Fertility-sparing surgery (FSS) is increasingly performed in adolescents and young adults (AYAs) with early-stage gynecological cancer who wish to preserve fertility. However, many continue to face long-term reproductive concerns despite undergoing FSS, and research on these concerns remains limited. This nationwide study explored the prevalence and associated factors of reproductive concerns among gynecological cancer survivors treated with FSS.

Methods: Women aged 18-39 at diagnosis, treated with FSS for cervical or ovarian cancer between 2000-2020 in Dutch gyneco-oncology centres, were invited to complete an online questionnaire. Factors identified in literature, with possible correlations to reproductive concerns (Reproductive Concerns After Cancer scale (RCAC)), were analysed using univariate and multivariable linear models.

Results: A total of 269 (32.4%) women completed the questionnaire (median time since diagnosis 10 years). Among these participants, nearly half (45.4%) experienced a high level of reproductive concerns. Factors significantly associated with higher levels of reproductive concerns included nulliparity at diagnosis, current pregnancy wish, having no partner, no attempts to conceive, higher levels of cancer worries and psychological distress. In multivariable models, psychological distress consistently emerged as a strong correlate of reproductive concerns across the subscales. Additionally, current pregnancy wish, nulliparity, not having a partner, and cancer worries were associated with specific subdomains of fertility-related concerns, independent of other variables.

Conclusion/Implications: This nationwide study underscores that long-term reproductive concerns are prevalent among gynecological cancer survivors following FSS, and are associated with ongoing psychological distress. It is essential that addressing individual fertility-related questions and concerns becomes a standard component of onco-fertility care during follow-up.

LB011 / #838

Topic: *AS05. Social Responsibility: Global Health, Economic Challenges & Inequity*

Q-GOAL STUDY: QUALITY IN GYNECOLOGIC ONCOLOGY ADVANCEMENT FOR LEARNING – A GLOBAL PERSPECTIVE

POSTER ROUNDS WITH THE PROFESSORS

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Introduction: Gynaecologic oncology training is highly variable worldwide, with differences in its availability, structure and content. The Q-GOAL (Quality in Gynaecologic Oncology Advancement for Learning) study aimed to evaluate the global training pathways, adequacy, and unmet needs.

Methods: A cross-sectional, web-based survey (SurveyMonkey®) was distributed globally to trainees and consultants in obstetrics and gynaecology, general surgery, gynaecologic oncology, and surgical oncology, from 20th July to 20th Sept 2025. Descriptive statistics and thematic analysis were applied.

Results: 1,205 respondents participated, with a 54% completion rate. Respondents represented 45 countries, highlighting the global reach of the survey. Core training backgrounds included obstetrics and gynaecology (77%) and general surgery (23%). Among consultants, 84% reported formal gynecologic oncology subspecialty training. Subspecialty trainees represented 237 respondents, of whom 65% were <40 years old and 59% female. For surgical oncology trainees (n=43), 68% were male and 70% under 40 years. Access to rotations was inconsistent: 75% of core trainees reported at least one dedicated gynaecologic oncology rotation, while 25% reported none (20% have a mandatory rotation in their training and 5% do not have a mandatory rotation). International mobility was frequent: 18% of respondents reported travelling abroad for training. Satisfaction levels were mixed: 61% trainees considered their programs comprehensive, common gaps included advanced cytoreductive surgery exposure, mentorship (19%), and structured research opportunities (38%).

Conclusion/Implications: Q-GOAL reveals marked disparities in gynaecologic oncology training, with many regions lacking standardized curricula and sufficient surgical exposure. These findings highlight the need for international collaboration, harmonized curricula, and expanded fellowship opportunities to strengthen the global workforce and improve cancer outcomes.

LB013 / #1330

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

VIBOSTOLIMAB AND PEMBROLIZUMAB COFORMULATION COMBINED WITH LENVATINIB FOR MISMATCH REPAIR-PROFICIENT ADVANCED ENDOMETRIAL CANCER: RESULTS FROM COHORT B2 OF THE PHASE 2 KEYVIBE-005 STUDY

E-POSTER

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Introduction: Lenvatinib+pembrolizumab demonstrated antitumor activity in advanced endometrial cancer (aEC) in the phase 1b/2 Study 111/KEYNOTE-146 trial and is a standard-of-care for previously treated aEC (all-comers in Europe, pMMR in USA) based on the phase 3 Study 309/KEYNOTE-775 trial. While anti-TIGIT therapy plus immunotherapy demonstrated promise in phase 1/2 studies in other cancers (eg, lung), benefit was not observed in phase 3. Cohort B2 of the phase 2 KEYVIBE-005 study (NCT05007106) evaluated coformulated vibostolimab (anti-TIGIT) and pembrolizumab (vibostolimab/pembrolizumab) plus lenvatinib in previously treated pMMR aEC.

Methods: Participants were aged ≥18 years with unresectable or metastatic EC, centrally confirmed pMMR tumors, PD after 1 prior platinum-chemotherapy regimen (2 prior lines if 1 was neoadjuvant/adjuvant), and no prior anti–PD-(L)1 therapy. Participants received vibostolimab 200

mg/pembrolizumab 200 mg Q3W for ≤35 cycles and lenvatinib 20 mg QD. Primary endpoint was ORR (RECISTv1.1 per investigator). Secondary endpoints included DOR and PFS (RECISTv1.1 per investigator), OS, and safety.

Results: 40 participants received ≥1 dose of treatment (80% received only 1-line prior therapy, any setting [68% prior (neo)adjuvant therapy]). Median follow-up was 41.5 (range, 40.0-45.6) months at data cutoff (August 5, 2025). ORR per investigator was 43% (95% CI, 27%-59%) (**Table 1**). Treatment-related AEs occurred in all participants (SAEs, 38%; **Table 2**).

Conclusion/Implications: Vibostolimab/pembrolizumab plus lenvatinib demonstrated benefit with manageable safety; however, adding vibostolimab provided no further benefit, with additional toxicity compared with lenvatinib+pembrolizumab in aEC (ORRs by BICR 38% [non-MSI-H/pMMR population] and 32% [pMMR population] and treatment-related SAEs 32% and 35% for Study 111/KEYNOTE-146 and Study 309/KEYNOTE-775, respectively).

Table 1. Efficacy Results

	Vibostolimab/Pembrolizumab + Lenvatinib (N=40)
ORR (95% CI),[a] %	43 (27–59)
Best overall response, n (%)	
CR	4 (10)
PR	13 (33)
SD	16 (40)
PD	6 (15)
No assessment	1 (3)
DCR (CR + PR + SD) (95% CI),[a] %	83 (67–93)
DOR, median (range),[b] mo	8.3 (4.1–32.0+)
PFS, median (95% CI),[b] mo	6.4 (4.8–8.3)
OS, median (95% CI),[b] mo	22.9 (11.6–32.2)

+, no progressive disease by the time of last disease assessment before data cutoff.

[a]Based on the exact method for binomial data.

[b]Based on the Kaplan-Meier method for censored data.

Table 2. Safety Results

Treatment-Related AEs, n (%)	Vibostolimab/Pembrolizumab + Lenvatinib (N=40)	
Any	40 (100)	
Grade 3–5	31 (78)	
SAEs	15 (38)	
Led to discontinuation of any study treatment	14 (35)	
Vibostolimab/pembrolizumab	8 (20)	
Lenvatinib	13 (33)	
Led to death	0	
Occurring in ≥20% of participants	**Any Grade**	**Grade 3–5**
Hypertension	22 (55)	13 (33)
Asthenia	18 (45)	3 (8)
Decreased appetite	18 (45)	1 (3)
Hypothyroidism	18 (45)	0
Diarrhea	14 (35)	2 (5)
Alanine aminotransferase increased	13 (33)	2 (5)
Pruritus	13 (33)	0
Aspartate aminotransferase increased	12 (30)	2 (5)
Proteinuria	12 (30)	1 (3)
Nausea	11 (28)	0
Palmar-plantar erythrodysesthesia syndrome	11 (28)	1 (3)
Fatigue	10 (25)	4 (10)
Weight decreased	10 (25)	4 (10)
Rash	8 (20)	3 (8)

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

SACITUZUMAB TIRUMOTECAN MONOTHERAPY IN ADVANCED/METASTATIC ENDOMETRIAL CARCINOMA: RESULTS FROM A PHASE 1/2 STUDY (2870-001/KL264-01)

E-POSTER

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Introduction: Sacituzumab tirumotecan (sac-TMT; SKB264/MK-2870) is an antibody-drug conjugate comprising a humanized anti-TROP2 monoclonal antibody, a unique, bifunctional linker, and the cytotoxic payload KL610023. We report efficacy and safety results from the phase 2 endometrial carcinoma (EC) cohort of the phase 1/2 study of sac-TMT monotherapy (NCT04152499).

Methods: Eligible participants had locally advanced unresectable/metastatic EC and had progressed after ≥1 prior line of platinum-based chemotherapy. Participants with MSI-H/dMMR status must have received prior anti–PD-(L)1 therapy. Participants received sac-TMT 4 or 5 mg/kg Q2W (nonrandomized) until PD or unacceptable toxicity. The primary objective was ORR per

RECIST v1.1 by investigator assessment. Subgroup analyses of ORR were completed as post hoc exploratory objectives.

Results: As of May 21, 2025, median (range) follow-up was 11.7 (7.9–15.9) months and 21.8 (19.1–28.1) months in the 4- and 5-mg/kg groups, respectively. 102 participants (64.6%) had received ≥2 prior lines of therapy. Treatment was ongoing for 31 participants (27.2%) and 2 participants (4.5%) in the 4- and 5-mg/kg groups, respectively, with PD the most common reason for treatment discontinuation. Confirmed ORR was 30.7% and 34.1% in the 4- and 5-mg/kg groups, respectively (**Table 1**). Grade ≥3 treatment-related AEs occurred in 59 participants (51.8%) and 34 participants (77.3%) in the 4- and 5-mg/kg groups, respectively (**Table 2**).

Conclusion/Implications: Sac-TMT monotherapy demonstrated promising antitumor activity as ≥2-line therapy for participants with advanced/metastatic EC, and manageable safety. These data led to initiation of the phase 3 TroFuse-005 study (NCT06132958) of sac-TMT 4 mg/kg Q2W in advanced EC.

Table 1. Efficacy

	Sac-TMT 4 mg/kg (n = 114)	Sac-TMT 5 mg/kg (n = 44)	Total population (N = 158)
Confirmed ORR,[a] % (95% CI)	30.7 (22.4–40.0)	34.1 (20.5–49.9)	31.6 (24.5–39.5)
Subgroups, responders/n, % (95% CI)			
Histology			
Endometrioid	23/80	8/26	31/106
	28.8 (19.2–40.0)	30.8 (14.3–51.8)	29.2 (20.8–38.9)
Nonendometrioid	12/27	6/15	18/42
	44.4 (25.5–64.7)	40.0 (16.3–67.7)	42.9 (27.7–59.0)
Carcinosarcoma	0/7	1/3	1/10
	0 (0.0–41.0)	33.3 (0.8–90.6)	10.0 (0.3–44.5)
pMMR carcinoma[b]	22/54	7/17	29/71
	40.7 (27.6–55.0)	41.2 (18.4–67.1)	40.8 (29.3–53.2)
Confirmed + unconfirmed ORR, % (95% CI)	35.1 (26.4–44.6)	36.4 (22.4–52.2)	35.4 (28.0–43.4)
pMMR carcinoma[b]	46.3 (32.6–60.4)	47.1 (23.0–72.2)	46.5 (34.5–28.7)
DOR, median, mo (range)	9.3 (2.1+ to 12.0+)	8.7 (3.8 to 17.7)	9.3 (2.1+ to 17.7)
PFS, median, mo (95% CI)	6.0 (5.5–7.4)	7.3 (3.8–9.4)	6.4 (5.6–7.4)
OS, median, mo (95% CI)	14.4 (11.8-NE)	18.1 (10.7–NE)	17.6 (12.6-NE)

"+" indicates a censored observation.
[a]All responses were PR.
[b]pMMR carcinoma includes participants with endometrioid, nonendometrioid, and other tumors and with ≥1 imaging assessment completed.

Table 2. Safety

	Sac-TMT 4 mg/kg (n = 114)	Sac-TMT 5 mg/kg (n = 44)	Total population (N = 158)
Treatment-related AEs, n (%)			
Any grade	113 (99.1)	44 (100)	157 (99.4)
Grade ≥3	59 (51.8)	34 (77.3)	93 (58.9)
Led to any treatment discontinuation	2 (1.8)	1 (2.3)	3 (1.9)
Led to any dose reduction	28 (24.6)	19 (43.2)	47 (29.7)
Led to death[a]	1 (0.9)	0	1 (0.6)
Most common (>10%) grade ≥3 treatment-related AEs, n (%)			
Decreased neutrophil count	32 (28.1)	19 (43.2)	51 (32.3)
Decreased white blood cell count	17 (14.9)	19 (43.2)	36 (22.8)
Anemia	22 (19.3)	13 (29.5)	35 (22.2)
Stomatitis	3 (2.6)	8 (18.2)	11 (7.0)

[a]1 participant in the sac-TMT 4 mg/kg group died due to cardiac failure.