Thank you for joining us.
The program will commence momentarily.

RTP
RESEARCH
TO PRACTICE

Clinical Investigator Perspectives on the Current and Future Role of PARP Inhibition in the Management of Ovarian Cancer

A Meet The Professor Series

Don S Dizon, MD
Professor of Medicine, Brown University
Director, Women's Cancers and Hematology-Oncology Outpatient Clinics
Lifespan Cancer Institute
Director, Medical Oncology and the Oncology Sexual Health Program
Rhode Island Hospital
Providence, Rhode Island

Commercial Support

These activities are supported by an educational grant from GlaxoSmithKline.

RTP
RESEARCH
TO PRACTICE

Dr Love — Disclosures

Dr Love is president and CEO of Research To Practice. Research To Practice receives funds in the form of educational grants to develop CME activities from the following commercial interests: AbbVie Inc, Acerta Pharma — A member of the AstraZeneca Group, Adaptive Biotechnologies Corporation, Agendia Inc, Agios Pharmaceuticals Inc, Amgen Inc, Array BioPharma Inc, a subsidiary of Pfizer Inc, Astellas, AstraZeneca Pharmaceuticals LP, Bayer HealthCare Pharmaceuticals, Biodesix Inc, bioTheranostics Inc, Blueprint Medicines, Boehringer Ingelheim Pharmaceuticals Inc, Boston Biomedical Inc, Bristol-Myers Squibb Company, Celgene Corporation, Clovis Oncology, Daiichi Sankyo Inc, Dendreon Pharmaceuticals Inc, Eisai Inc, EMD Serono Inc, Exelixis Inc, Foundation Medicine, Genentech, a member of the Roche Group, Genmab, Genomic Health Inc, Gilead Sciences Inc, GlaxoSmithKline, Grail Inc, Guardant Health, Halozyme Inc, Helsinn Healthcare SA, ImmunoGen Inc, Incyte Corporation, Infinity Pharmaceuticals Inc, Ipsen Biopharmaceuticals Inc, Janssen Biotech Inc, administered by Janssen Scientific Affairs LLC, Jazz Pharmaceuticals Inc, Kite, A Gilead Company, Lexicon Pharmaceuticals Inc, Lilly, Loxo Oncology Inc, a wholly owned subsidiary of Eli Lilly & Company, Merck, Merrimack Pharmaceuticals Inc, Myriad Genetic Laboratories Inc, Natera Inc, Novartis, Oncopeptides, Pfizer Inc, Pharmacyclics LLC, an AbbVie Company, Prometheus Laboratories Inc, Puma Biotechnology Inc, Regeneron Pharmaceuticals Inc, Sandoz Inc, a Novartis Division, Sanofi Genzyme, Seattle Genetics, Sirtex Medical Ltd, Spectrum Pharmaceuticals Inc, Taiho Oncology Inc, Takeda Oncology, Tesaro, A GSK Company, Teva Oncology, Tokai Pharmaceuticals Inc, Tolero Pharmaceuticals and Verastem Inc.

RTP
RESEARCH
TO PRACTICE

Research To Practice CME Planning Committee Members, Staff and Reviewers

Planners, scientific staff and independent reviewers for Research To Practice have no relevant conflicts of interest to disclose.

Dr Dizon — Disclosures

Consulting Agreements	AstraZeneca Pharmaceuticals LP, Clovis Oncology, GlaxoSmithKline, Regeneron Pharmaceuticals Inc
Contracted Research	Bristol-Myers Squibb Company, GlaxoSmithKline, Kazia Therapeutics Limited
Data and Safety Monitoring Board/Committee	AstraZeneca Pharmaceuticals LP, Clovis Oncology, Regeneron Pharmaceuticals Inc

RTP
RESEARCH
TO PRACTICE

Upcoming Live Webinars

Friday, August 21, 2020
12:00 PM – 1:00 PM ET

Optimizing the Selection and Sequencing of Therapy for Patients with Chronic Lymphocytic Leukemia

Faculty
Brad S Kahl, MD

Moderator
Neil Love, MD

Tuesday, August 25, 2020
5:00 PM – 6:00 PM ET

Optimizing the Selection and Sequencing of Therapy for Patients with Chronic Lymphocytic Leukemia

Faculty
Anthony R Mato, MD, MSCE

Moderator
Neil Love, MD

Upcoming Live Webinars

Wednesday, August 26, 2020
12:00 PM – 1:00 PM ET

Current Questions and Controversies in the Management of Lung Cancer

Faculty
Lecia V Sequist, MD, MPH

Moderator
Neil Love, MD

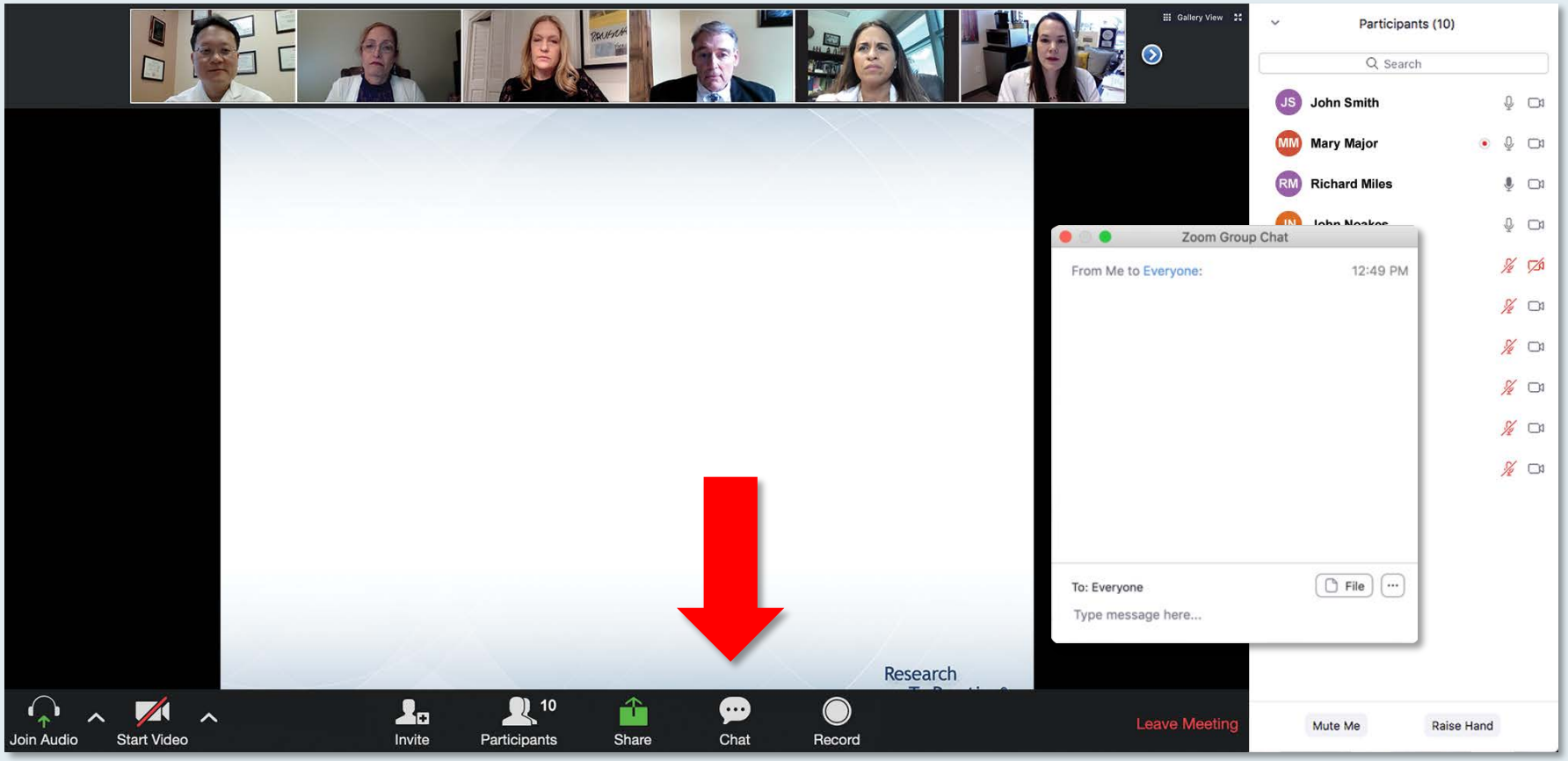
Friday, August 28, 2020
12:00 PM – 1:00 PM ET

Exploring the Role of Immune Checkpoint Inhibitor Therapy and Other Novel Strategies in Gynecologic Cancers

Faculty
Michael J Birrer, MD, PhD

Moderator
Neil Love, MD

We Encourage Clinicians in Practice to Submit Questions

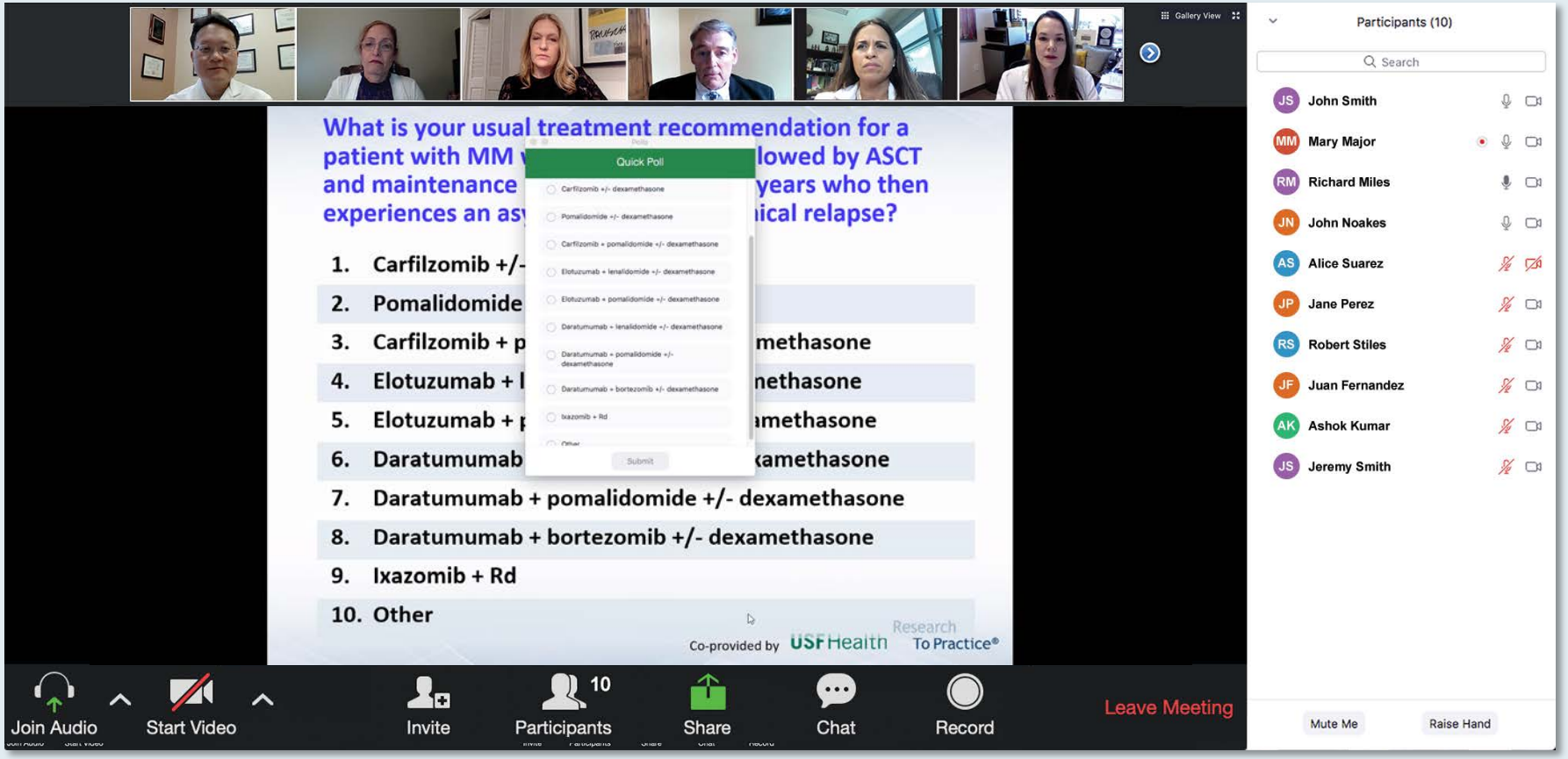


Feel free to submit questions now before the program commences and throughout the program.

RTP RESEARCH TO PRACTICE

Familiarizing yourself with the Zoom interface

How to answer poll questions



When a poll question pops up, click your answer choice from the available options. Results will be shown after everyone has answered.

RTP RESEARCH TO PRACTICE

Thank you for joining us!

CME and MOC credit information will be emailed to each participant within 5 days.

RTP
RESEARCH
TO PRACTICE

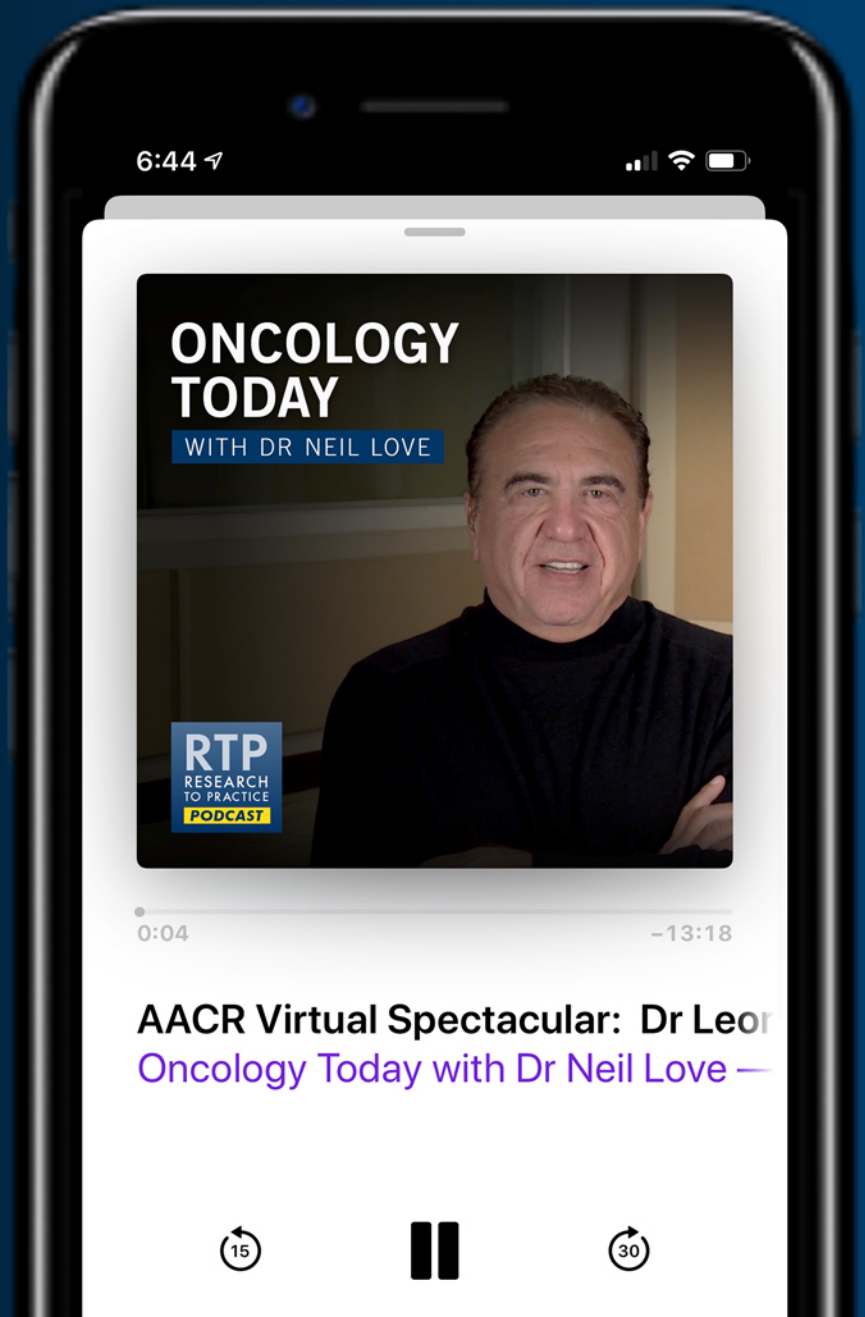
ONCOLOGY TODAY

WITH DR NEIL LOVE

Listen on Apple Podcasts

Spotify

Listen on Google Podcasts



Clinical Investigator Perspectives on the Current and Future Role of PARP Inhibition in the Management of Ovarian Cancer

A Meet The Professor Series

Don S Dizon, MD
Professor of Medicine, Brown University
Director, Women's Cancers and Hematology-Oncology Outpatient Clinics
Lifespan Cancer Institute
Director, Medical Oncology and the Oncology Sexual Health Program
Rhode Island Hospital
Providence, Rhode Island

Meet The Professor Program Participating Faculty

Deborah K Armstrong, MD
Professor of Oncology
Professor of Gynecology and Obstetrics
Skip Viragh Outpatient Cancer Building
Johns Hopkins Sidney Kimmel
Comprehensive Cancer Center
Baltimore, Maryland

Professor Jonathan A Ledermann
Professor of Medical Oncology
Clinical Director
University College London Cancer
Institute
Director, Cancer Research UK and UCL
Cancer Trials Centre
London, United Kingdom

Don S Dizon, MD
Professor of Medicine, Brown University
Director, Women's Cancers and Hematology-
Oncology Outpatient Clinics
Lifespan Cancer Institute
Director, Medical Oncology and the Oncology
Sexual Health Program
Rhode Island Hospital
Providence, Rhode Island

Ursula Matulonis, MD
Chief, Division of Gynecologic Oncology
Brock-Wilson Family Chair
Dana-Farber Cancer Institute
Professor of Medicine
Harvard Medical School
Boston, Massachusetts

RTP
RESEARCH
TO PRACTICE

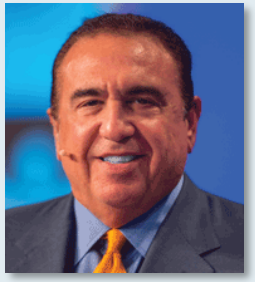
Meet The Professor Program Participating Faculty

Mansoor Raza Mirza, MD
Medical Director, Nordic Society of Gynaecological Oncology
Vice-Chairman, Danish Society of Gynaecologic Oncology
Executive Director, Gynecologic Cancer InterGroup
Chief Oncologist, Department of Oncology
Rigshospitalet, Copenhagen University Hospital
Copenhagen, Denmark

Kathleen Moore, MD
The Virginia Kerley Cade Endowed Chair
in Cancer Development
Associate Director, Clinical Research
Director, Oklahoma TSET Phase I Program
Stephenson Cancer Center
Associate Professor, Section of Gynecologic Oncology
Director, Gynecologic Oncology Fellowship
Department of Obstetrics and Gynecology
University of Oklahoma Health Sciences Center
Oklahoma City, Oklahoma

Professor Ignace Vergote
Chairman, Department of Obstetrics and Gynaecology
Gynaecological Oncologist
Leuven Cancer Institute
University Hospital Leuven
Leuven, Belgium

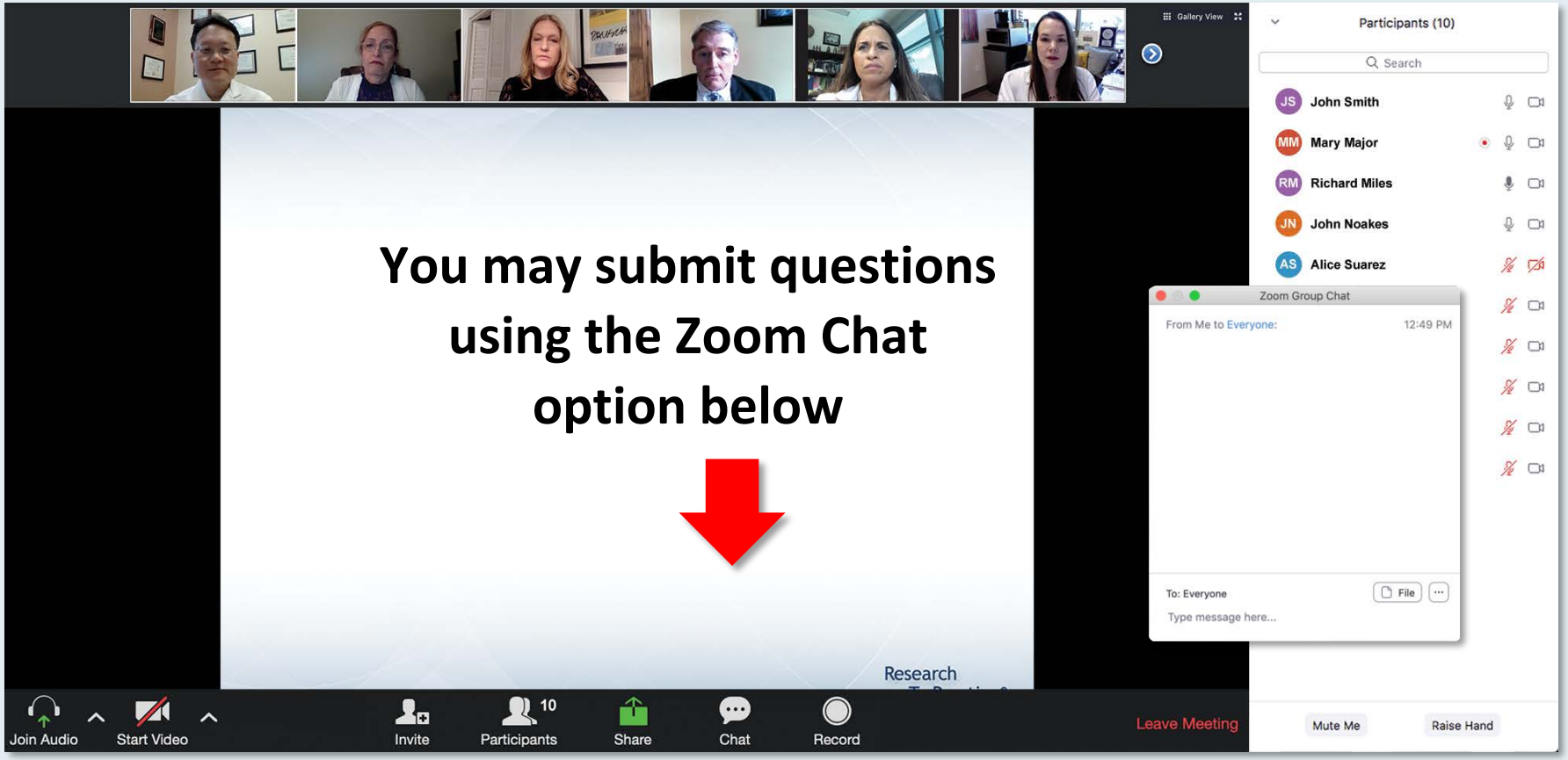
Shannon N Westin, MD, MPH
Associate Professor
Director, Early Drug Development
Department of Gynecologic Oncology and Reproductive Medicine
The University of Texas
MD Anderson Cancer Center
Houston, Texas



Project Chair
Neil Love, MD
Research To Practice
Miami, Florida

RTP
RESEARCH TO PRACTICE

We Encourage Clinicians in Practice to Submit Questions

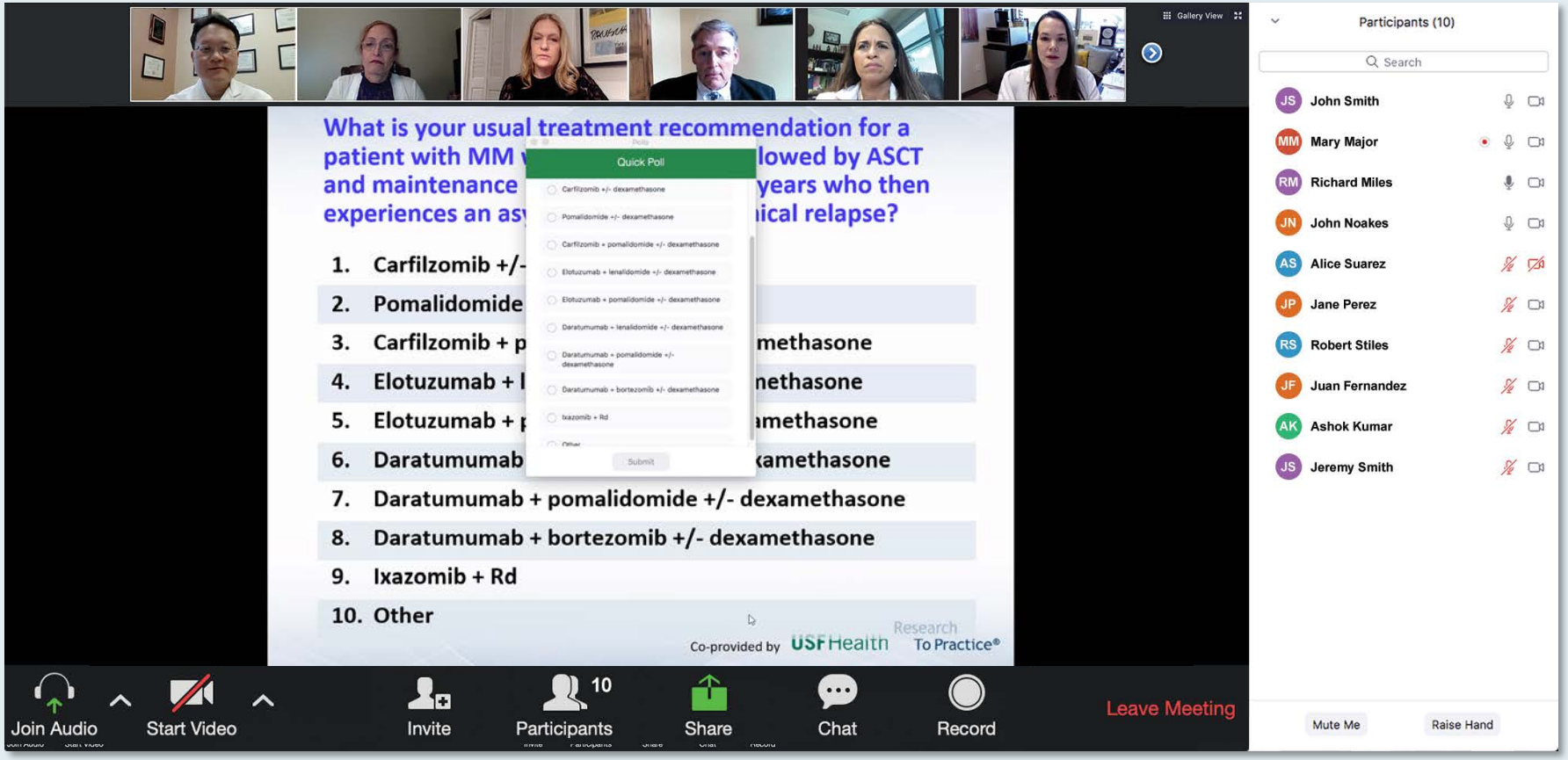


Feel free to submit questions now before the program commences and throughout the program.

RTP RESEARCH TO PRACTICE

Familiarizing Yourself with the Zoom Interface

How to answer poll questions



When a poll question pops up, click your answer choice from the available options. Results will be shown after everyone has answered.

RTP RESEARCH TO PRACTICE

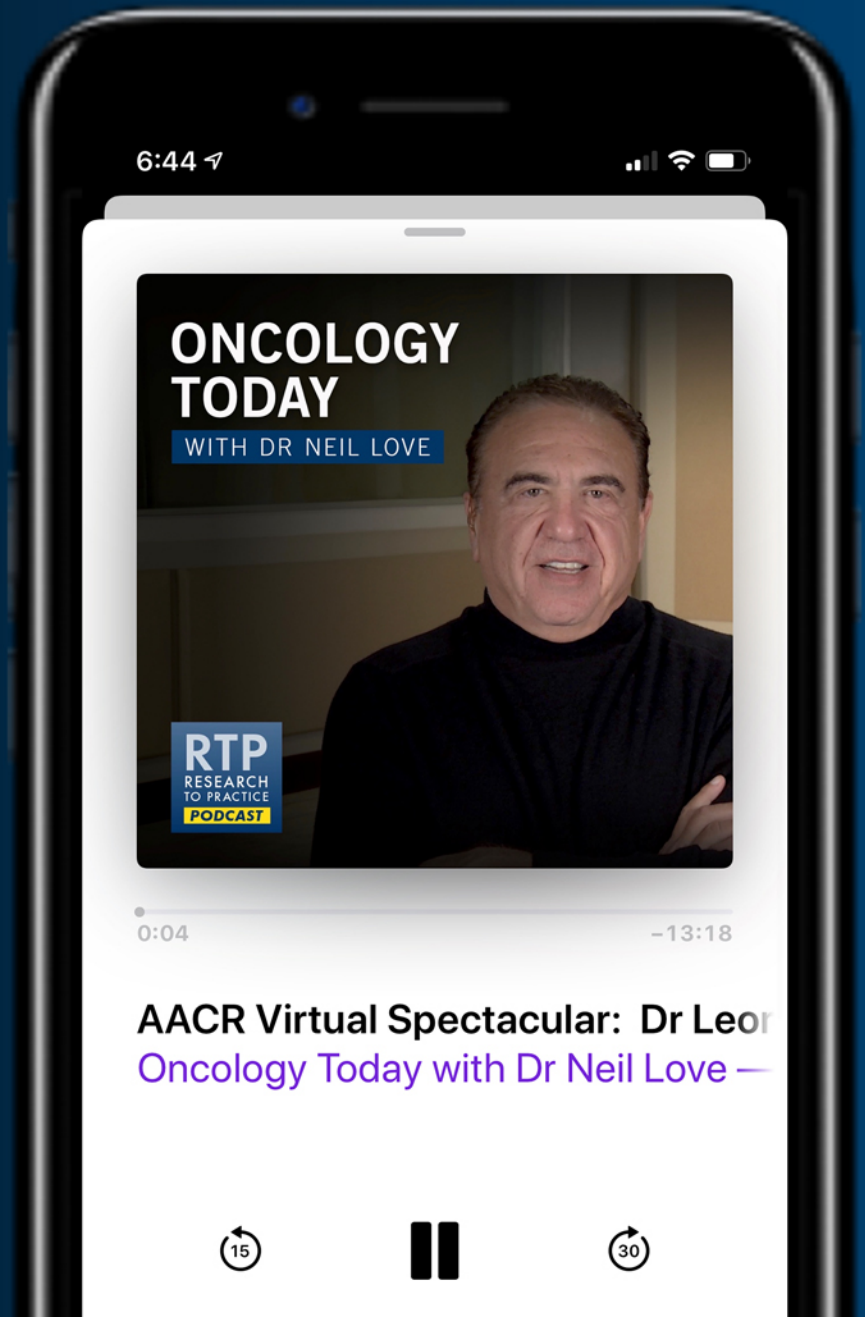
ONCOLOGY TODAY

WITH DR NEIL LOVE

Listen on Apple Podcasts

Spotify

Listen on Google Podcasts



Optimizing the Selection and Sequencing of Therapy for Patients with Chronic Lymphocytic Leukemia

A Meet The Professor Series

Friday, August 21, 2020
12:00 PM – 1:00 PM ET

Faculty
Brad S Kahl, MD

Moderator
Neil Love, MD

RTP RESEARCH TO PRACTICE

Optimizing the Selection and Sequencing of Therapy for Patients with Chronic Lymphocytic Leukemia

A Meet The Professor Series

Tuesday, August 25, 2020
5:00 PM – 6:00 PM ET

Faculty
Anthony R Mato, MD, MSCE

Moderator
Neil Love, MD

RTP RESEARCH TO PRACTICE

Current Questions and Controversies in the Management of Lung Cancer

A Meet The Professor Series

Wednesday, August 26, 2020
12:00 PM – 1:00 PM ET

Faculty
Lecia V Sequist, MD, MPH

Moderator
Neil Love, MD

RTP RESEARCH TO PRACTICE

Exploring the Role of Immune Checkpoint Inhibitor Therapy and Other Novel Strategies in Gynecologic Cancers

A Meet The Professor Series

Friday, August 28, 2020
12:00 PM – 1:00 PM ET

Faculty
Michael J Birrer, MD, PhD

Moderator
Neil Love, MD

RTP
RESEARCH
TO PRACTICE

Clinical Investigator Perspectives on the Current and Future Role of PARP Inhibition in the Management of Ovarian Cancer

A Meet The Professor Series

Don S Dizon, MD
Professor of Medicine, Brown University
Director, Women's Cancers and Hematology-Oncology Outpatient Clinics
Lifespan Cancer Institute
Director, Medical Oncology and the Oncology Sexual Health Program
Rhode Island Hospital
Providence, Rhode Island

Contributing Oncologists

Brian M Slomovitz, MD
Professor, Department of Obstetrics and Gynecology
Florida International University
Miami, Florida

Professor Ignace Vergote
Chairman, Department of Obstetrics and Gynaecology
Gynaecological Oncologist
Leuven Cancer Institute
University Hospital Leuven
Leuven, Belgium

Meet The Professor with Dr Dizon

MODULE 1: Management of Newly Diagnosed Ovarian Cancer

- Case presentations
- Key clinical trials
  - SOLO-1, PRIMA, PAOLA

MODULE 2: PARP Inhibitors in the Management of Relapsed Disease

- Case presentations
- Class and agent-specific toxicities; management strategies
- Key clinical trials
  - TOPACIO, MEDIOLA

Meet The Professor with Dr Dizon

MODULE 1: Management of Newly Diagnosed Ovarian Cancer

- Case presentations
- Key clinical trials
  - SOLO-1, PRIMA, PAOLA

MODULE 2: PARP Inhibitors in the Management of Relapsed Disease

- Case presentations
- Class and agent-specific toxicities; management strategies
- Key clinical trials
  - TOPACIO, MEDIOLA

Are you currently administering more neoadjuvant treatment for patients with Stage III ovarian cancer at your institution than you were in 2019?

1. Yes
2. No

RTP RESEARCH TO PRACTICE

Challenging Comments and Questions

Brian M Slomovitz, MD

What is the age of the oldest patient with Stage IIIC ovarian cancer for whom you have performed or ordered debulking surgery?

1. 65-70
2. 71-75
3. 76-80
4. 81-85
5. 86-90
6. 91-95
7. 96-100
8. Older than 100

RTP
RESEARCH
TO PRACTICE

An 87-year-old woman with Stage IIIC ovarian cancer (BRCA wild type, HRD-positive) is s/p optimal debulking surgery. Regulatory and reimbursement issues aside, what would you recommend as postoperative systemic therapy?

1. Carboplatin/paclitaxel
2. Carboplatin/paclitaxel → olaparib
3. Carboplatin/paclitaxel → niraparib
4. Carboplatin/paclitaxel + bev → olaparib
5. Carboplatin/paclitaxel + bev → niraparib
6. Carboplatin/paclitaxel + bev → bev/olaparib
7. Carboplatin/paclitaxel + bev → bev/niraparib
8. Other

Bev = bevacizumab

RTP RESEARCH TO PRACTICE

Case Presentation – Prof Vergote: An 87-year-old woman with Stage IIIC ovarian cancer

Professor Ignace Vergote

- PMH: Hypertension, coronary artery stent
- High-grade Stage IIIC serous ovarian cancer, but not extensive disease
- Primary debulking surgery, with all tumor removed
- Paclitaxel/carboplatin 3-weekly x 6
- Somatic and germline BRCA-negative

Questions

- What about patients who are HRD-negative, BRCA wild type? Would you also give bevacizumab? Would you also give a PARP inhibitor?
- Have you tried a PARP inhibitor after a PARP inhibitor, where there is not a lot of data? Have you seen responses with a PARP inhibitor – the same PARP inhibitor or another PARP inhibitor – after a former PARP inhibitor?

Case Presentation – Dr Slomovitz: A 55-year-old woman

Brian M Slomovitz, MD

- Bilateral adnexal masses (8-cm, 7-cm), omental caking, large ascites, mesenteric implants
- CA-125: 2100
- CT guided biopsy: confirmed high grade serous carcinoma consistent with GYN primary
- Neoadjuvant chemotherapy: Carboplatin, paclitaxel x 3 cycles
- IDS: optimal cytoreduction with disease in omentum, b/l ovaries
- Genetic testing: no BRCA mutation, no mutations identified
- Somatic NGS: p53 pathogenic mutation
- HRD testing: +HRD
- Completed cycle 4-6 of carboplatin and paclitaxel and bevacizumab → NED

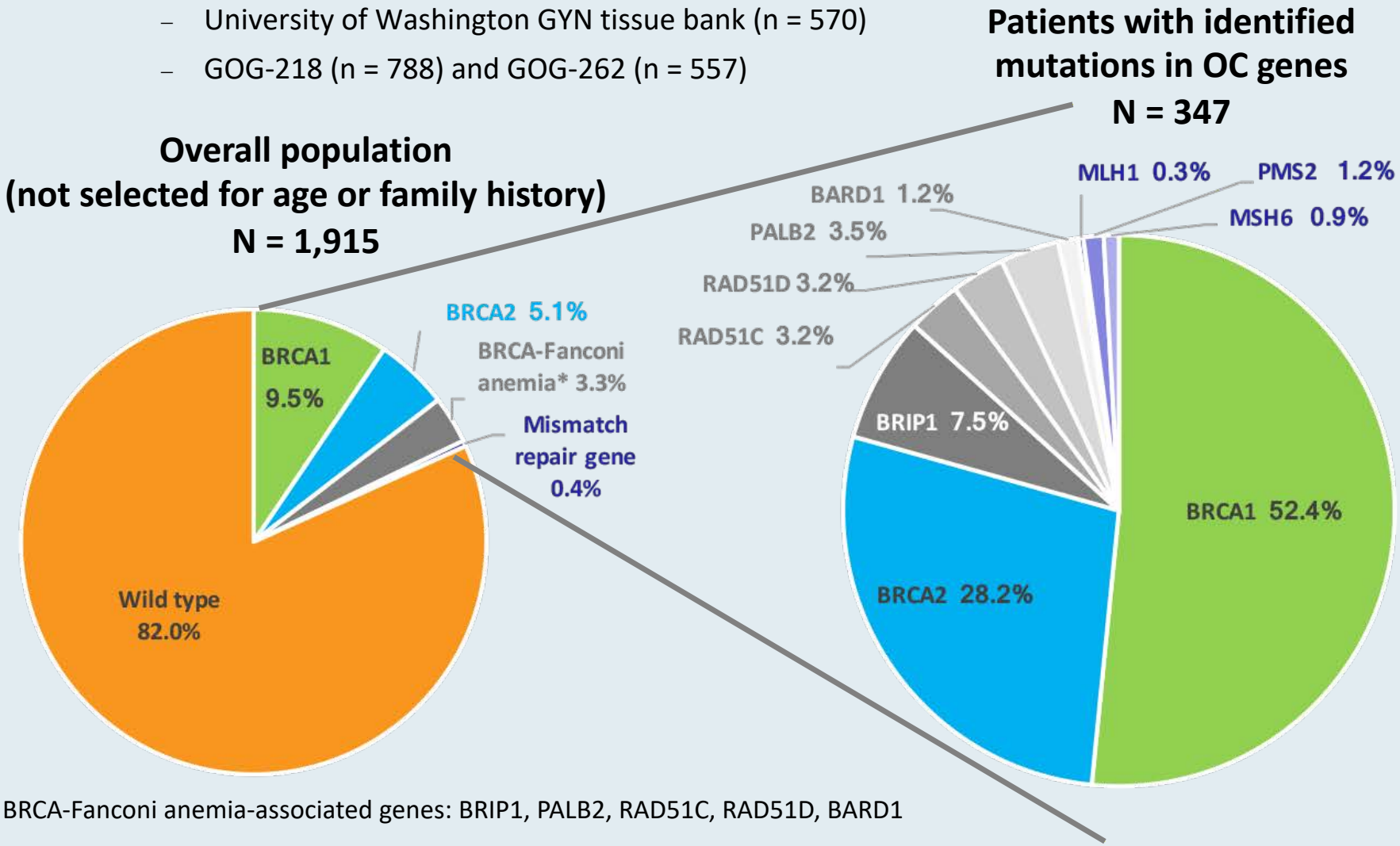
Questions

- When should you stick with bevacizumab alone and not add a PARP inhibitor?
- When is it best to give combination therapy?
- When do you discontinue bevacizumab and just go to the PARP inhibitor?
- When do you discontinue therapy?
- How do you choose between olaparib, niraparib and rucaparib?

Recent Relevant Data Sets

Summary of Germline DNA Mutations in OC

- Germline DNA sequenced from women with OC (N = 1,915) using a targeted capture and multiplex sequencing assay
  - University of Washington GYN tissue bank (n = 570)
  - GOG-218 (n = 788) and GOG-262 (n = 557)



* BRCA-Fanconi anemia-associated genes: BRIP1, PALB2, RAD51C, RAD51D, BARD1

Norquist BM et al. *JAMA Oncol* 2016;2(4):482-90.

RTP RESEARCH TO PRACTICE

BRCA1/2 Mutations in Ovarian Cancer: Who Should Be Tested?

NCCN[1]

Genetic counseling and testing should be considered for women with a history of ovarian carcinoma, fallopian tube or primary peritoneal cancer

SGO[2]

Women diagnosed with epithelial ovarian, tubal and peritoneal cancers should receive genetic counseling and be offered genetic testing even in the absence of family history

ASCO[3]

Genetic counseling and testing should be considered for women with epithelial ovarian, fallopian tube or primary peritoneal cancer even in the absence of family history

NCCN = National Comprehensive Cancer Network; SGO = Society of Gynecologic Oncology;
ASCO = American Society of Clinical Oncology

1. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Genetic/Familial High-Risk Assessment: Breast and Ovarian V2.2019.

2. Lancaster JM et al. *Gynecol Oncol* 2015;136(1):3-7.

3. Lu KH et al. *J Clin Oncol* 2014;32(8):833-40.

Multigene Panel Testing

Advantages

- More “diagnoses”
- More cost effective
- More time efficient
- Higher mutational detection rate
- Efficient use of single specimen
- Decrease in testing fatigue for patients and providers

Disadvantages

- Cancer risk and management options often not well defined for low- and moderate-penetrance genes
- High uncertain variant rate
- Longer turnaround time
- Panels may include genes that patients don’t want to test for
- Unexpected findings such as “off-phenotypic-target” gene mutation
- Increased prevalence of VUS

Lynce F, Isaacs C. *ASCO Educational Book* 2016:72-8.

Current FDA-Approved and Investigational PARP Inhibitors: Differences

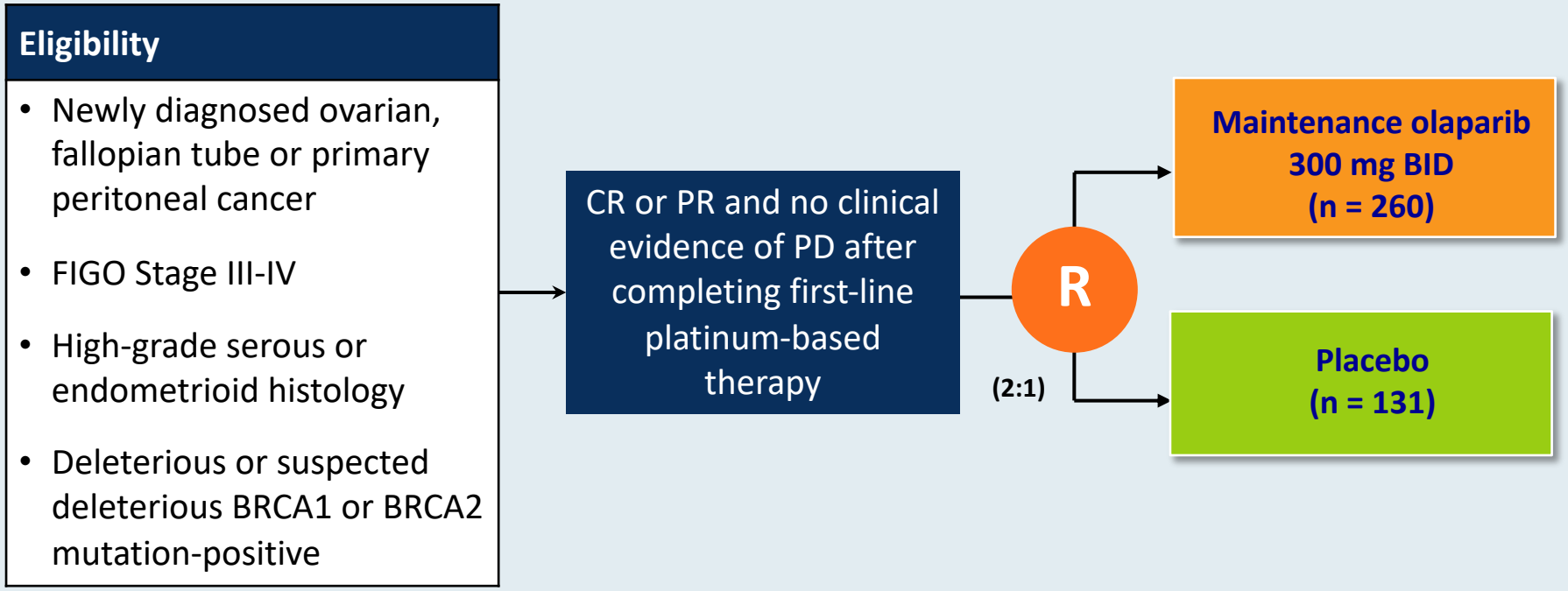
PARP inhibitor	IC_{50}	PARP trapping potency	PARPi target selectivity (strength of binding)	Half life	Dose
Olaparib	6 nM	1	Potent PARP1 inhibitor, less selective	11.9 hours	400 mg BID
Rucaparib	21 nM	1	Potent PARP1 inhibitor, less selective	18 hours	600 mg BID
Niraparib	60 nM	~2	Selective inhibitor of PARP1 and 2	36 hours	300 mg qd
Veliparib	30 nM	<0.2	Potent PARP1 inhibitor, less selective	5 hours	400 mg BID
Talazoparib	4 nM	~100	Potent PARP1 inhibitor, less selective	50 hours	1 mg qd

Lim JSJ, Tan DSP. *Cancers* 2017;9(8):pii:E109.

RTP RESEARCH TO PRACTICE

SOLO-1: A Phase III Trial of Maintenance Olaparib in OC with BRCA Mutation

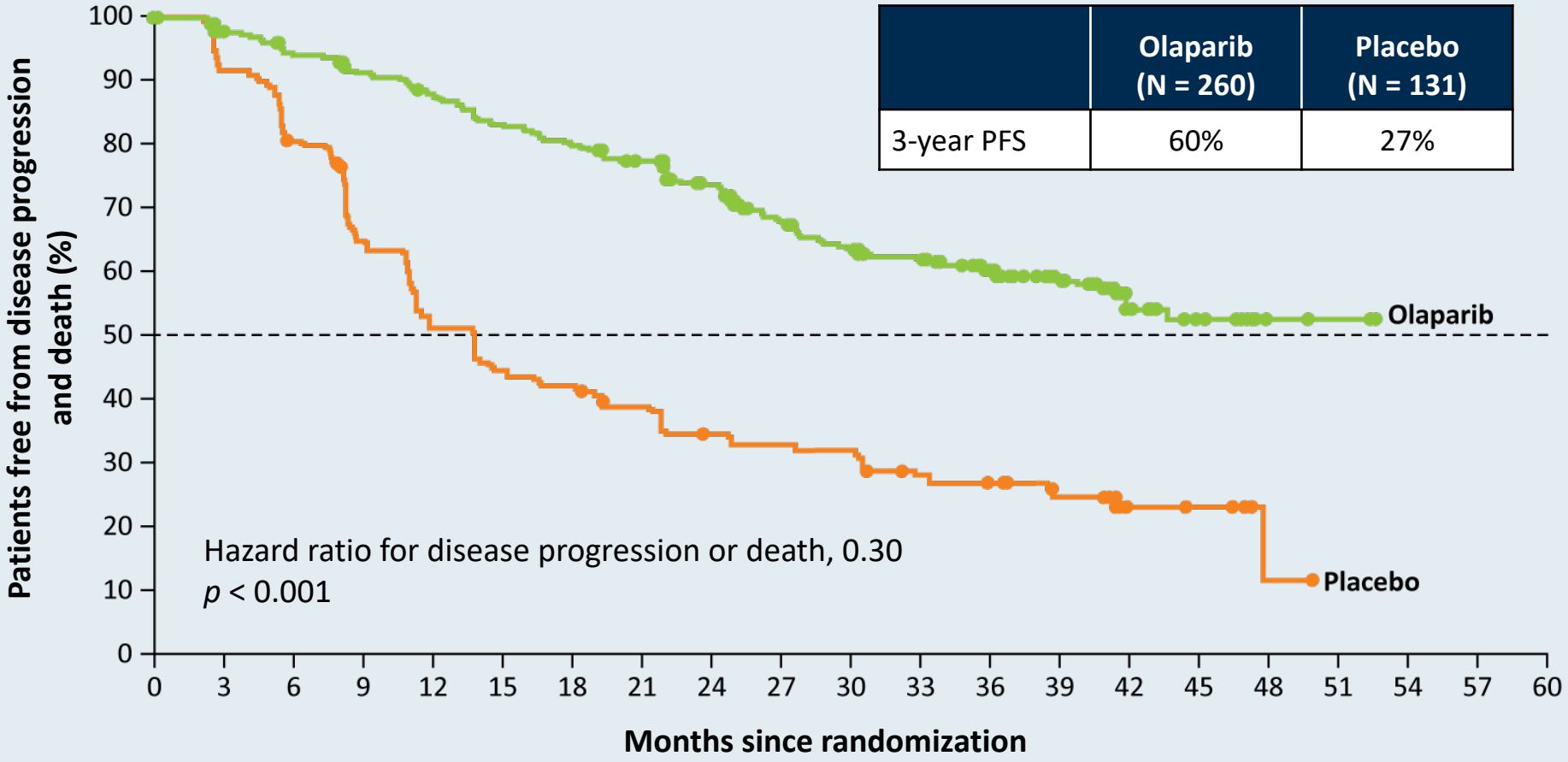
NCT01844986



Primary endpoint: Investigator-assessed progression-free survival

www.clinicaltrials.gov; Moore KN et al. ASCO 2014;Abstract TPS5616; Moore K et al. *N Engl J Med* 2018;[Online ahead of print].

SOLO-1: Primary Endpoint Progression-Free Survival (Investigator Assessed)

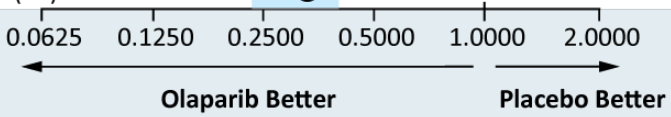


	Olaparib (N = 260)	Placebo (N = 131)
3-year PFS	60%	27%

Moore K et al. *N Engl J Med* 2018;[Online ahead of print].

SOLO-1: PFS Subgroup Analyses

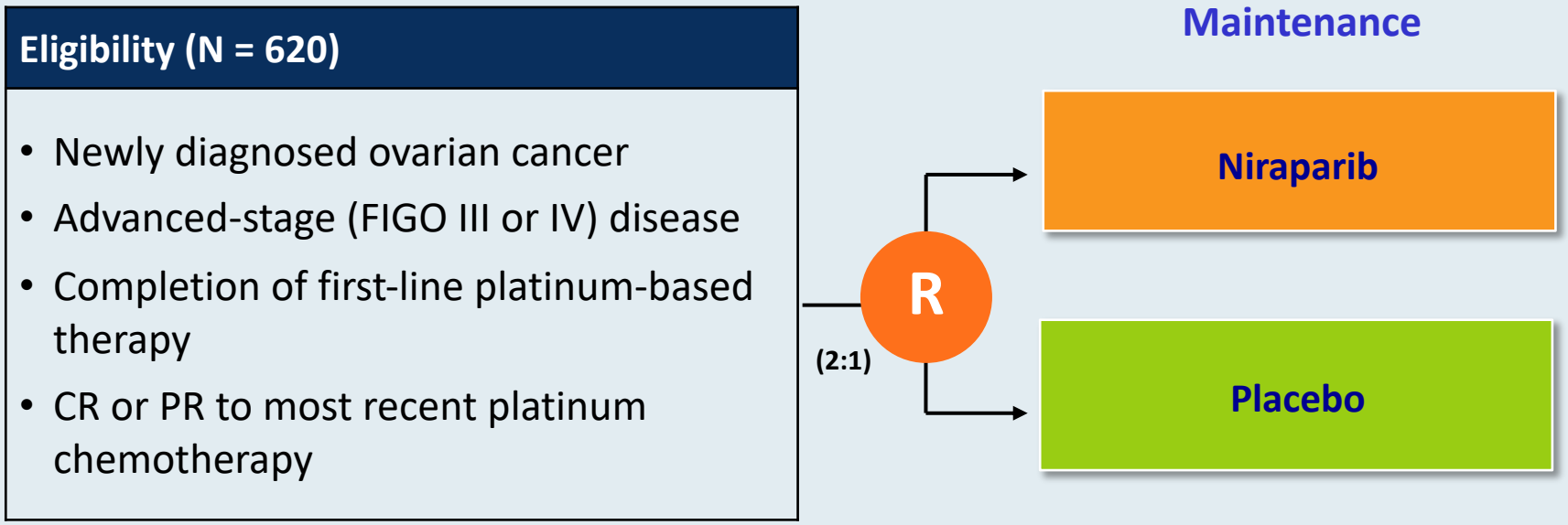
Subgroup	Olaparib	Placebo	Hazard Ratio for Disease Progression or Death
	no. of patients with disease progression or death/total no. (%)		
All patients	102/260 (39)	96/131 (73)	0.30
Clinical response after chemotherapy			
Complete response	73/213 (34)	73/107 (68)	0.35
Partial response	29/47 (62)	23/24 (96)	0.19
ECOG performance status at baseline			
Normal activity	75/200 (38)	76/105 (72)	0.33
Restricted activity	27/60 (45)	20/25 (80)	0.38
CA-125 level at baseline			
≤ULN	92/247 (37)	89/123 (72)	0.34
>ULN	10/13 (77)	7/7 (100)	NC
Germline BRCA mutation according to testing at Myriad			
BRCA1	84/188 (45)	69/91 (76)	0.40
BRCA2	15/62 (24)	26/39 (67)	0.20
BRCA1 and BRCA2	0/3	0/0	NC
None	3/7 (43)	1/1 (100)	NC
Age at baseline			
<65 yr	85/225 (38)	82/112 (73)	0.33
≥65 yr	17/35 (49)	14/19 (74)	0.45
International FIGO stage at initial diagnosis			
Stage III	83/220 (38)	79/105 (75)	0.32
Stage IV	19/40 (48)	17/26 (65)	0.49
Presence of residual macroscopic disease after debulking surgery performed before trial entry			
Yes	29/55 (53)	23/29 (79)	0.44
No	70/200 (35)	69/98 (70)	0.33



Moore K et al. *N Engl J Med* 2018;[Online ahead of print].

RTP RESEARCH TO PRACTICE

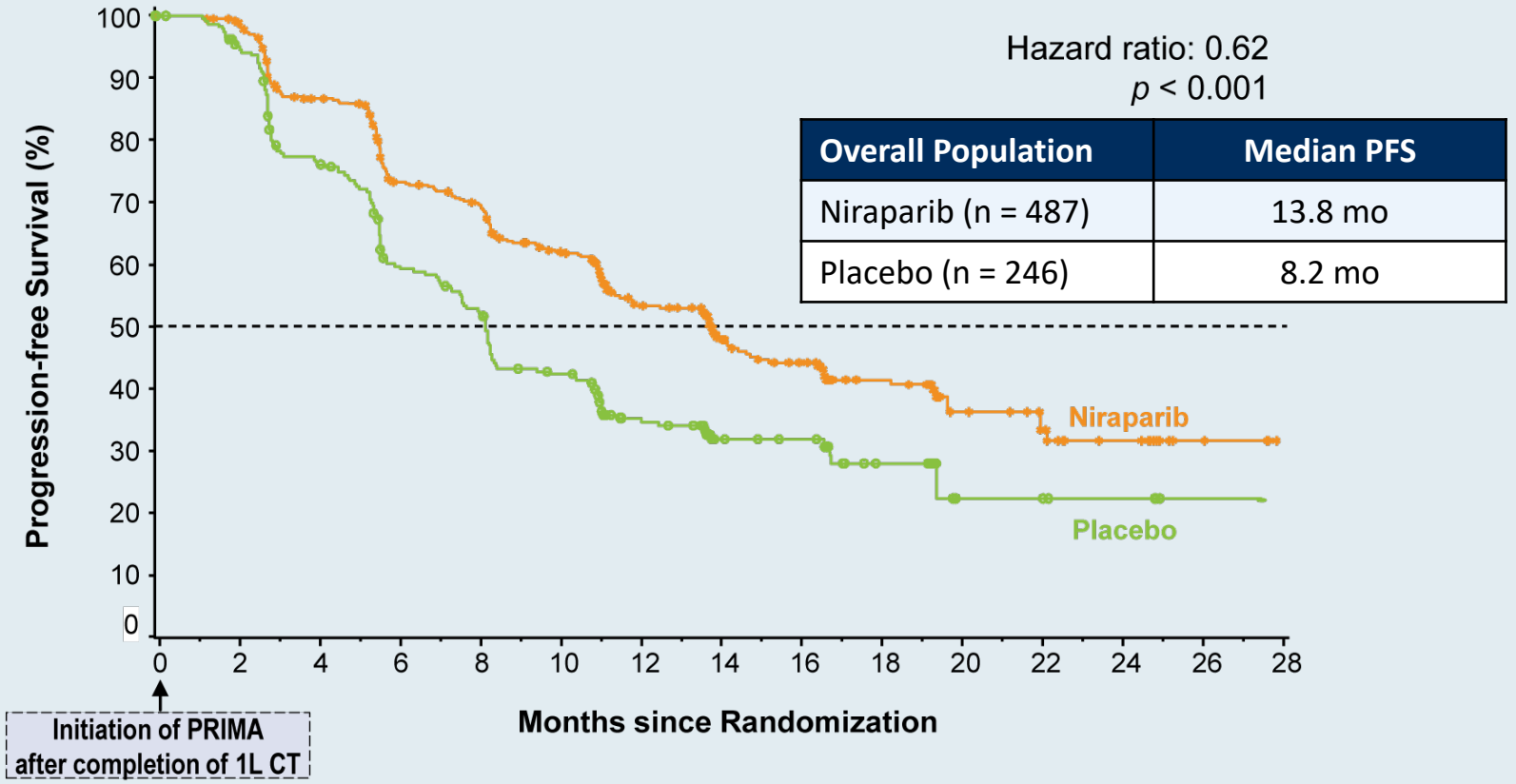
PRIMA Trial: Maintenance Niraparib for Advanced Ovarian Cancer After Response to Front-Line Platinum-Based Chemotherapy



Primary endpoint: Progression-free survival

Gonzalez-Martin A et al. ESMO 2018;Abstract 941PD.

PRIMA Primary Endpoint: Progression-Free Survival



- Median PFS in the HR-deficient population was 21.9 mo for niraparib and 10.4 mo for placebo (HR 0.43, $p < 0.001$).
- No new safety signals were identified for niraparib.

Gonzalez-Martin A et al. ESMO 2019;Abstract LBA1.

PRIMA: Progression-Free Survival Subgroup Analysis

	Hazard ratio for PFS (95% CI)
Overall	0.62 (0.50–0.76)
Age group	
<65 years	0.61 (0.47–0.81)
≥65 years	0.53 (0.38–0.74)
Stage of disease at initial diagnosis	
III	0.54 (0.42–0.70)
IV	0.79 (0.55–1.12)
Neoadjuvant chemotherapy	
Yes	0.59 (0.46–0.76)
No	0.66 (0.46–0.94)
Best response to platinum therapy	
CR	0.60 (0.46–0.77)
PR	0.60 (0.43–0.85)
Homologous recombination status	
HRd–*BRCA*mut	0.40 (0.27–0.62)
HRd–*BRCA*wt	0.50 (0.31–0.83)
HRp	0.68 (0.49–0.94)
HRnd	0.85 (0.51–1.43)

Gonzalez-Martin A et al. ESMO 2019;Abstract LBA1.

Efficacy of niraparib therapy in patients with newly diagnosed advanced ovarian cancer by *BRCA* and homologous recombination status: PRIMA/ENGOT-OV26/GOG-3012 study

Monk BJ et al.

SGO 2020; Abstract 31.

Time to first subsequent therapy (TFST) and progression-free survival 2 (PFS2) from the phase 3 randomized, double-blind PRIMA/ENGOT-OV26/GOG-3012 study in patients with newly diagnosed ovarian cancer

Han SN et al.

SGO 2020; Abstract 32.

Patient-reported outcomes (PRO) in patients receiving niraparib in the PRIMA/ENGOT-OV26/GOG-3012 trial

Pothuri B et al.

SGO 2020; Abstract 83.

FDA approves olaparib plus bevacizumab as maintenance treatment for ovarian, fallopian tube, or primary peritoneal cancers

Press Release – May 28, 2020

"The Food and Drug Administration expanded the indication of olaparib to include its combination with bevacizumab for first-line maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to first-line platinum-based chemotherapy and whose cancer is associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious *BRCA* mutation, and/or genomic instability.

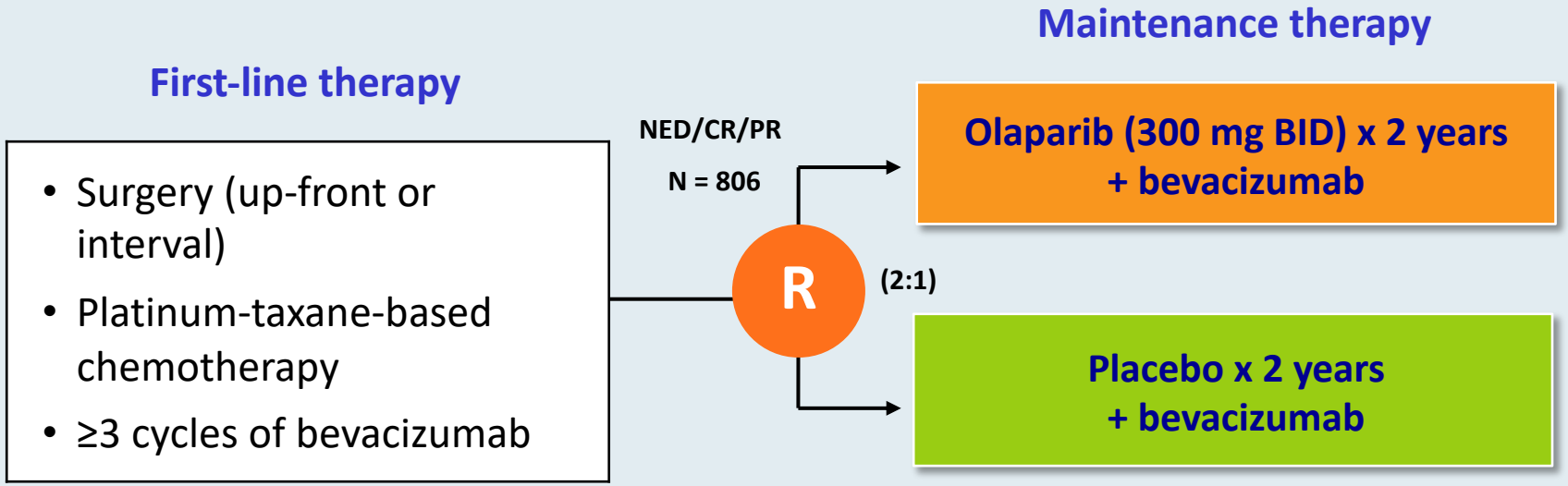
FDA also approved the Myriad myChoice® CDx (Myriad Genetic Laboratories, Inc.) as a companion diagnostic for olaparib.

Efficacy of this new indication was investigated in PAOLA-1 (NCT03737643), a randomized, double-blind, placebo-controlled, multi-center trial comparing olaparib with bevacizumab versus placebo plus bevacizumab in patients with advanced high-grade epithelial ovarian cancer, fallopian tube, or primary peritoneal cancer following first-line platinum-based chemotherapy and bevacizumab."

https://www.fda.gov/drugs/drug-approvals-and-databases/fda-approves-olaparib-plus-bevacizumab-maintenance-treatment-ovarian-fallopian-tube-or-primary

PAOLA-1 Trial: Maintenance Olaparib with Bevacizumab for Advanced Ovarian Cancer After Response to Front-Line Platinum-Based Chemotherapy and Bevacizumab

Newly diagnosed FIGO Stage III or IV high-grade serous/endometrioid ovarian, fallopian tube or primary peritoneal cancer

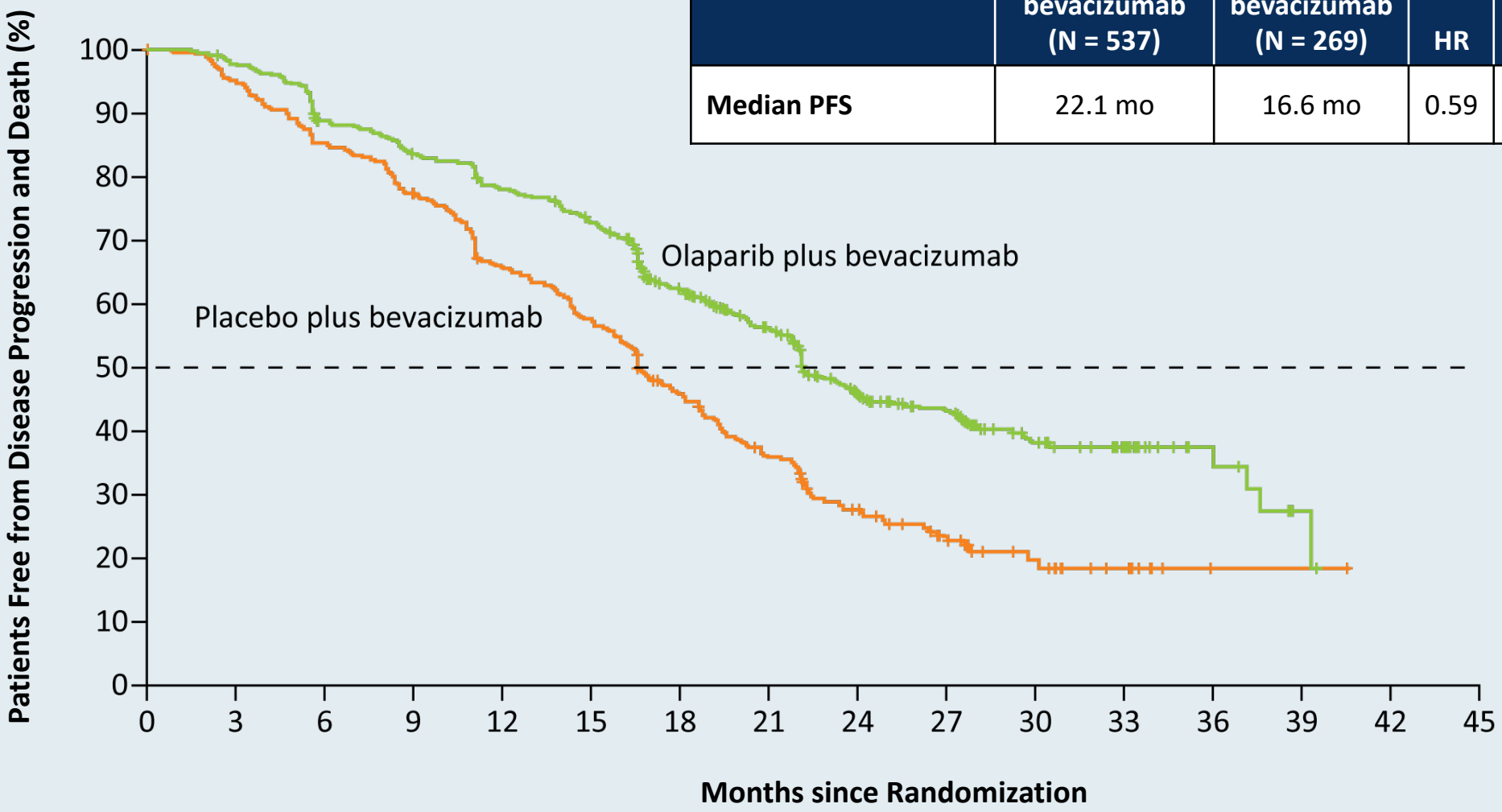


Ray-Coquard I et al. ESMO 2019;Abstract LBA2.

RTP RESEARCH TO PRACTICE

PAOLA-1: Investigator-Assessed PFS (Primary Endpoint)

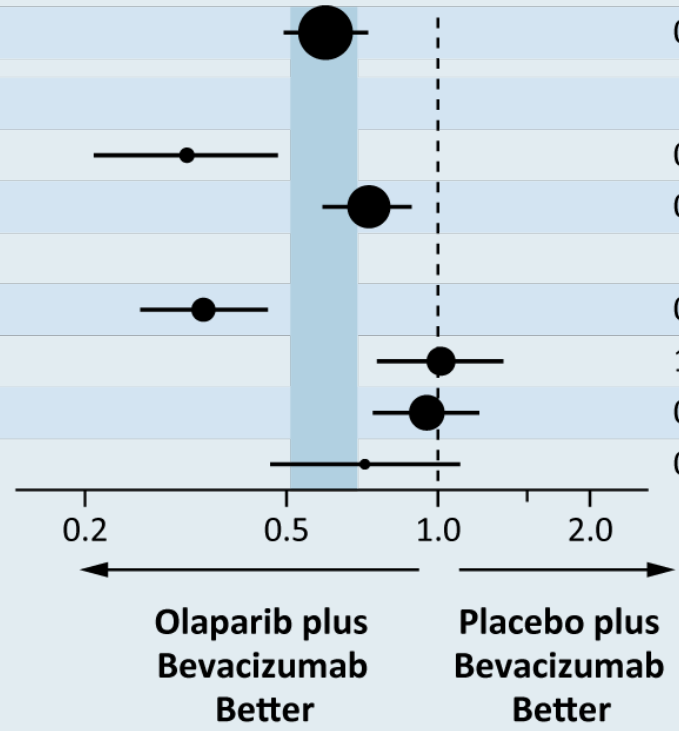
	Olaparib + bevacizumab (N = 537)	Placebo + bevacizumab (N = 269)	HR	*p*-value
Median PFS	22.1 mo	16.6 mo	0.59	<0.001



Ray-Coquard I et al. *NEJM* 2019;381:2416-28.

PAOLA-1: Select Subgroup Analysis of PFS

Subgroup	Olaparib plus Bevacizumab	Placebo plus Bevacizumab	Hazard Ratio for Disease Progression or Death (95% CI)
	no. of patients with disease progression or death/total no. (%)		
All patients	280/537 (52)	194/269 (72)	0.59 (0.49–0.72)
Tumor BRCA mutation status			
BRCA mutation	41/157 (26)	49/80 (61)	0.31 (0.20–0.47)
No BRCA mutation or unknown	239/380 (63)	145/189 (77)	0.71 (0.58–0.88)
Tumor HRD status			
Positive	87/255 (34)	92/132 (70)	0.33 (0.25–0.45)
Negative	145/192 (76)	66/85 (78)	1.00 (0.75–1.35)
Negative or unknown	193/282 (68)	102/137 (74)	0.92 (0.72–1.17)
Unknown	48/90 (53)	36/52 (69)	0.71 (0.46–1.10)



Ray-Coquard I et al. *NEJM* 2019;381:2416-28.

Ongoing Phase III Clinical Trials of PARP Inhibitors as Maintenance After First-Line Therapy

Trial name (trial identifier)	N	Eligibility	First-line treatment	Maintenance treatment arms
FIRST (NCT03602859)	960	• BRCA mut or wt • Stage III or IV • Surgery or inoperable	• Platinum-based chemo • Platinum-based chemo + TSR-042	• Niraparib + TSR-042 • Niraparib + placebo • Placebo + placebo
ATHENA (NCT03522246)	1,012	• BRCA mut or wt • Stage III or IV • Prior surgery	• Platinum-based chemo	• Rucaparib + nivolumab • Rucaparib + placebo • Placebo + nivolumab • Placebo + placebo

www.clinicaltrials.gov. Accessed December 2018.

RTP RESEARCH TO PRACTICE

In general, what is the optimal approach to mutation testing for possible use of a PARP inhibitor for a patient with newly diagnosed ovarian cancer? Do you routinely assess homologous recombination deficiency (HRD) status in your patients with advanced ovarian cancer?

	Optimal approach to mutation testing	Routinely assess HRD status?
 DON S DIZON, MD	Germline BRCA; if negative, multigene somatic (eg, NGS)	Yes
 PROFESSOR JONATHAN A LEDERMANN	Multigene germline and somatic/NGS	No
 KATHLEEN MOORE, MD	Multigene germline and somatic/NGS	Yes
 PROFESSOR IGNACE VERGOTE	Germline BRCA; if negative, multigene somatic (eg, NGS)	No
 SHANNON N WESTIN, MD, MPH	Germline BRCA; if negative, multigene somatic (eg, NGS)	Yes

NGS = next-generation sequencing

A 60-year-old woman with Stage IIIC ovarian cancer and a germline BRCA mutation is status post (s/p) optimal debulking surgery with a normal CA-125 level. Regulatory and reimbursement issues aside, what would you recommend as postoperative systemic therapy?

 DON S DIZON, MD	Carboplatin/paclitaxel → olaparib
 PROFESSOR JONATHAN A LEDERMANN	Carboplatin/paclitaxel → olaparib
 KATHLEEN MOORE, MD	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib
 PROFESSOR IGNACE VERGOTE	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib
 SHANNON N WESTIN, MD, MPH	Carboplatin/paclitaxel → olaparib or niraparib

A 60-year-old woman with Stage IIIC ovarian cancer (BRCA wild type, HRD-negative) is s/p optimal debulking surgery with a normal CA-125 level. Regulatory and reimbursement issues aside, what would you recommend as postoperative systemic therapy?

 DON S DIZON, MD	Carboplatin/paclitaxel → niraparib
 PROFESSOR JONATHAN A LEDERMANN	Carboplatin/paclitaxel
 KATHLEEN MOORE, MD	Carboplatin/paclitaxel + bevacizumab → bevacizumab
 PROFESSOR IGNACE VERGOTE	Carboplatin/paclitaxel + bevacizumab → bevacizumab
 SHANNON N WESTIN, MD, MPH	Carboplatin/paclitaxel *OR* carboplatin/paclitaxel → niraparib

A 60-year-old woman with Stage IIIC ovarian cancer and a germline BRCA mutation is s/p suboptimal debulking surgery with an elevated CA-125 level. Regulatory and reimbursement issues aside, what would you recommend as postoperative systemic therapy?

 DON S DIZON, MD	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib
 PROFESSOR JONATHAN A LEDERMANN	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib
 KATHLEEN MOORE, MD	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib
 PROFESSOR IGNACE VERGOTE	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib
 SHANNON N WESTIN, MD, MPH	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib

A 60-year-old woman with Stage IIIC ovarian cancer and a somatic BRCA mutation is s/p suboptimal debulking surgery with an elevated CA-125 level. Regulatory and reimbursement issues aside, what would you recommend as postoperative systemic therapy?

 DON S DIZON, MD	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib
 PROFESSOR JONATHAN A LEDERMANN	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib
 KATHLEEN MOORE, MD	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib
 PROFESSOR IGNACE VERGOTE	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib
 SHANNON N WESTIN, MD, MPH	Carboplatin/paclitaxel + bevacizumab → bevacizumab + olaparib

A 60-year-old woman with Stage IIIC ovarian cancer (BRCA wild type) is s/p suboptimal debulking surgery with an elevated CA-125 level. Regulatory and reimbursement issues aside, what would you recommend as postoperative systemic therapy if her disease was…

	HRD-positive	HRD-negative
 DON S DIZON, MD	Carbo/pac + bev → bev + olaparib	Carbo/pac + bev → niraparib
 PROFESSOR JONATHAN A LEDERMANN	Carbo/pac + bev → bev + olaparib	Carbo/pac + bev → bev
 KATHLEEN MOORE, MD	Carbo/pac + bev → bev + olaparib	Carbo/pac + bev → bev
 PROFESSOR IGNACE VERGOTE	Carbo/pac + bev → bev + olaparib	Carbo/pac + bev → bev
 SHANNON N WESTIN, MD, MPH	Carbo/pac + bev → bev + olaparib	Carbo/pac + bev → bev

Carbo/pac = carboplatin/paclitaxel; bev = bevacizumab

A 60-year-old woman with Stage IIIC ovarian cancer and a germline BRCA mutation undergoes suboptimal debulking surgery and receives carboplatin/paclitaxel followed by olaparib. For how long would you typically continue the olaparib if the patient is tolerating it well?

 DON S DIZON, MD	Indefinitely
 PROFESSOR JONATHAN A LEDERMANN	2 years
 KATHLEEN MOORE, MD	2 years
 PROFESSOR IGNACE VERGOTE	2 years
 SHANNON N WESTIN, MD, MPH	2 years

A 60-year-old woman with Stage IIIC ovarian cancer (BRCA wild type, HRD-positive) undergoes suboptimal debulking surgery and receives carboplatin/paclitaxel followed by niraparib. For how long would you typically continue the niraparib if the patient is tolerating it well?

 DON S DIZON, MD	Indefinitely
 PROFESSOR JONATHAN A LEDERMANN	3 years
 KATHLEEN MOORE, MD	3 years
 PROFESSOR IGNACE VERGOTE	3 years
 SHANNON N WESTIN, MD, MPH	3 years

Regulatory and reimbursement issues aside, which starting dose of niraparib would you use for a 125-lb patient with advanced ovarian cancer and a platelet count of 200,000 after a response to front-line platinum-based chemotherapy?

1. 300 mg daily
2. 200 mg daily
3. 100 mg daily
4. Other

RTP
RESEARCH
TO PRACTICE

What starting dose of niraparib would you use for a 125-lb patient with advanced ovarian cancer after response to front-line platinum-based chemotherapy with a platelet count of 200,000 for whom you are about to initiate maintenance niraparib?

 DON S DIZON, MD	300 mg daily
 PROFESSOR JONATHAN A LEDERMANN	200 mg daily
 KATHLEEN MOORE, MD	200 mg daily
 PROFESSOR IGNACE VERGOTE	200 mg daily
 SHANNON N WESTIN, MD, MPH	200 mg daily

Meet The Professor with Dr Dizon

MODULE 1: Management of Newly Diagnosed Ovarian Cancer

- Case presentations
- Key clinical trials
  - SOLO-1, PRIMA, PAOLA

MODULE 2: PARP Inhibitors in the Management of Relapsed Disease

- Case presentations
- Class and agent-specific toxicities; management strategies
- Key clinical trials
  - TOPACIO, MEDIOLA

RTP RESEARCH TO PRACTICE

Case Presentation – Prof Vergote: A woman with Stage IV ovarian cancer

Professor Ignace Vergote

- Stage IV ovarian cancer, with deep infiltration of the liver and pleural metastases
- Neoadjuvant chemo x 3, with good response
- Plans for interval debulking surgery

Questions

- If an R0 resection is achieved, should we continue the chemotherapy? Should we administer bevacizumab? A PARP inhibitor?
- If the patient had a BRCA mutation, would you give the PARP inhibitor alone, or would you give bevacizumab and the PARP inhibitor? The same questions apply if the patient was BRCA wild type but had HRD
- What if the patient was BRCA wild type and without HRD — would you give bevacizumab, a PARP inhibitor, or the combination?

A 58-year-old woman with a BRCA1 germline mutation is started on olaparib, and after 7 cycles she develops Grade 3 anemia. What would be your most likely response?

1. Continue olaparib
2. Lower the olaparib dose
3. Hold olaparib until hemoglobin increases and restart at the same dose
4. Hold olaparib until hemoglobin increases and restart at a lower dose
5. Switch to another therapy
6. Other

Case Presentation – Prof Vergote: A 58-year-old woman with Stage IVA ovarian cancer

Professor Ignace Vergote

- Two paternal aunts with breast cancer at age 60; BRCA status uncertain
- Surgical resection of adnexal mass
- MRI whole body diffusion: Stage IVA (supraclavicular node), extensive abdominal disease
- Neoadjuvant paclitaxel/carboplatin weekly + bevacizumab x 15 → interval debulking surgery, with no residual disease
- BRCA1 mutation
- Continued bevacizumab 3-weekly, initiated olaparib 300 mg BID
  - After 7 cycles of olaparib, developed Grade III anemia
  - Dose reduced olaparib to 250 mg BID and anemia resolved to Grade I
  - After 18 cycles of olaparib, she is in complete remission

Question

- For how long would you treat her?

Adverse Events: Class Effects and Specific Drug Differences

	Notes	Olaparib	Niraparib	Rucaparib	Talazoparib	Veliparib
Fatigue	50%-70%, mainly Gr1-2	✓	✓	✓	✓	✓
Hematologic AEs						
Anemia	40%-60%	✓	✓	✓	✓	✓ --
Thrombocytopenia	Niraparib dose adjustment, based on platelet counts	✓	✓ ++	✓	✓	✓
Neutropenia	~20%	✓	✓	✓	✓	✓
Gastrointestinal AEs						
Nausea/vomiting	Moderately emetic >30%	✓	✓	✓	✓	✓
Diarrhea	~33%	✓	✓	✓	✓	✓
Laboratory abnormalities						
ALT/AST elevation	5%-10% olaparib, niraparib; 34% rucaparib	✓ --	✓ --	✓ ++	✓ ++	?
Creatinine elevation	10%-12%	✓	✓	✓	NR	NR

NR = not reported

Olaparib PI, rev 5/2020; Niraparib PI, rev 4/2020; Rucaparib PI, rev 5/2020; Talazoparib PI, rev 3/2020;
Madariaga A et al. *Int J Gyn Cancer* 2020 April 9;[Online ahead of print]; Litton JK et al. *NEJM* 2018;379:753-63.

Adverse Events: Class Effects and Specific Drug Differences

	Notes	Olaparib	Niraparib	Rucaparib	Talazoparib	Veliparib
Respiratory disorders						
Dyspnea +/- cough	10%-20%, usually Gr 1-2	✓	✓	✓	✓	NR
Nasopharyngitis	~10%	✓	✓	✓	✓	NR
Nervous system and psychiatric disorders						
Insomnia/headache	10%-25%, usually Gr 1-2	✓	✓	✓	✓	✓
Dermatologic toxicity						
Rash, photosensitivity		<1%	✓	✓++	NR	NR
Cardiovascular toxicity						
Hypertension, tachycardia, palpitation		1%	✓++	NR	NR	NR
Rare AEs						
MDS/AML	~1% of pts	✓	✓	✓	✓	✓

NR = not reported

Olaparib PI, rev 5/2020; Niraparib PI, rev 4/2020; Rucaparib PI, rev 5/2020; Talazoparib PI, rev 3/2020; Madariaga A et al. *Int J Gyn Cancer* 2020 April 9;[Online ahead of print]; Litton JK et al. *NEJM* 2018;379:753-63.

Dose Adjustments for Adverse Events

Olaparib dose reductions	Dose (tablet)
Starting dose	• 300 mg BID
First dose reduction	• 250 mg BID
Second dose reduction	• 200 mg BID

Niraparib dose reductions	Dose
Starting dose	• 300 mg daily
First dose reduction	• 200 mg daily
Second dose reduction	• 100 mg daily

Rucaparib dose reductions	Dose
Starting dose	• 600 mg twice daily
First dose reduction	• 500 mg twice daily
Second dose reduction	• 400 mg twice daily
Third dose reduction	• 300 mg twice daily

Courtesy, Shannon N Westin, MD, MPH

FDA Prescribing Information.

Recent Relevant Data Sets

Determinants of Platinum Sensitivity and Resistance

- Distribution of platinum in the tumor cell
- Cellular metabolism of platinum agents
- Expression levels of epithelial-mesenchymal transition (EMT)-related transcription factors
- PARP1 expression level
- BRCA1/2 mutational status
- Hyperexpression or polymorphism of ERCC1
- Mutational status of homologous recombination (HR) pathway genes

Colombo PE et al. *Crit Rev Oncol Hematol* 2014;89(2):207-16.

FDA-Approved PARP Inhibitors as Maintenance Therapy for Recurrent, Platinum-Sensitive Disease

Niraparib

Indications:
- Maintenance following response to platinum-based therapy
- Irrespective of BRCA status

Pivotal study: ENGOT-OV16/NOVA

Approved: 3/2017

Rucaparib

Indications:
- Maintenance following response to platinum-based therapy
- Irrespective of BRCA status

Pivotal study: ARIEL3

Approved: 4/2018

Olaparib

Indications:
- Maintenance following response to platinum-based therapy
- Irrespective of BRCA status

Pivotal studies: SOLO-2, Study 19

Approved: 8/2017

Niraparib FDA insert, revised 3/2017; Rucaparib FDA insert, revised 4/2018; Olaparib FDA insert, revised 1/2018; Pujade-Lauraine E et al. *Lancet* 2017;18(9):1274-84; Mirza MR et al. *N Engl J Med* 2016;375(22):2154-64; Coleman RL et al. *Lancet* 2017;390(10106):1949-61; Ledermann J et al. *N Engl J Med* 2012;366:1382-92.

Eligibility and Dosing in Pivotal Studies of PARP Inhibitors for Recurrent, Platinum-Sensitive OC

	NOVA[1] (Niraparib)	SOLO-2[2] (Olaparib)	ARIEL3[3] (Rucaparib)
BRCA status	With or without gBRCA mutation	gBRCA mutation (Study 19: +/- gBRCA mutation)	With or without gBRCA mutation
HRD testing	Yes	No	Yes
Tumor assessment schedule	Every 8 wk to C14 → every 12 wk	Every 12 wk until wk 72 → every 24 wk	Every 8 wk to C14 → every 12 wk
Dosing/formulation	300 mg qd	300 mg BID	600 mg BID
No. of prior lines of chemo	2 or more	2 or more	2 or more

[1] Mirza MR et al. *N Engl J Med* 2016;375(22):2154-64; [2] Pujade-Lauraine E et al. *Lancet* 2017;18(9):1274-84; [3] Coleman RL et al. *Lancet* 2017;390(10106):1949-61.

RTP RESEARCH TO PRACTICE

Efficacy Summary of PARP Inhibitors for Recurrent, Platinum-Sensitive OC

	PARPi	Control	HR
NOVA[1] — Niraparib			
gBRCA mutation	21.0 mo	5.5 mo	0.27
No gBRCA mutation, HRD+	12.9 mo	3.8 mo	0.38
No gBRCA mutation	9.3 mo	3.9 mo	0.45
SOLO-2[2] — Olaparib			
gBRCA mutation	19.1 mo	5.5 mo	0.30
ARIEL3[3-4] — Rucaparib			
ITT (All comers)	10.8 mo	5.4 mo	0.36
g or sBRCA mutation	16.6 mo	5.4 mo	0.23
HRD+	13.6 mo	5.4 mo	0.32
$BRCA^{WT}$/High LOH	13.6 mo	5.4 mo	0.32
$BRCA^{WT}$/Low LOH	6.7 mo	5.4 mo	0.58

[1] Mirza MR et al. *N Engl J Med* 2016;375(22):2154-64; [2] Pujade-Lauraine E et al. *Lancet* 2017;18(9):1274-84; [3] Coleman RL et al. *Lancet* 2017;390(10106):1949-61; [4] Ledermann JA et al. *Lancet Oncol* 2020;21(5):710-722.

FDA-Approved PARP Inhibitors as Monotherapy for Multiply Relapsed Disease

Olaparib	Rucaparib	Niraparib
Indications: • 4th-line therapy and beyond • Germline BRCA mutation **Dosing:** • 300 mg BID **Approved: 12/2014**	**Indications:** • 3rd-line therapy and beyond • Germline and/or somatic BRCA mutation **Dosing:** • 600 mg BID **Approved: 12/2016**	**Indications:** • 4th-line therapy and beyond • HRD-positive **Dosing:** • Weight- and platelet count-dependent: 200 or 300 mg QD **Approved: 102/2019**

Olaparib prescribing information, revised 12/2018; Rucaparib prescribing information, revised 4/2018; Niraparib prescribing information, revised 04/2020

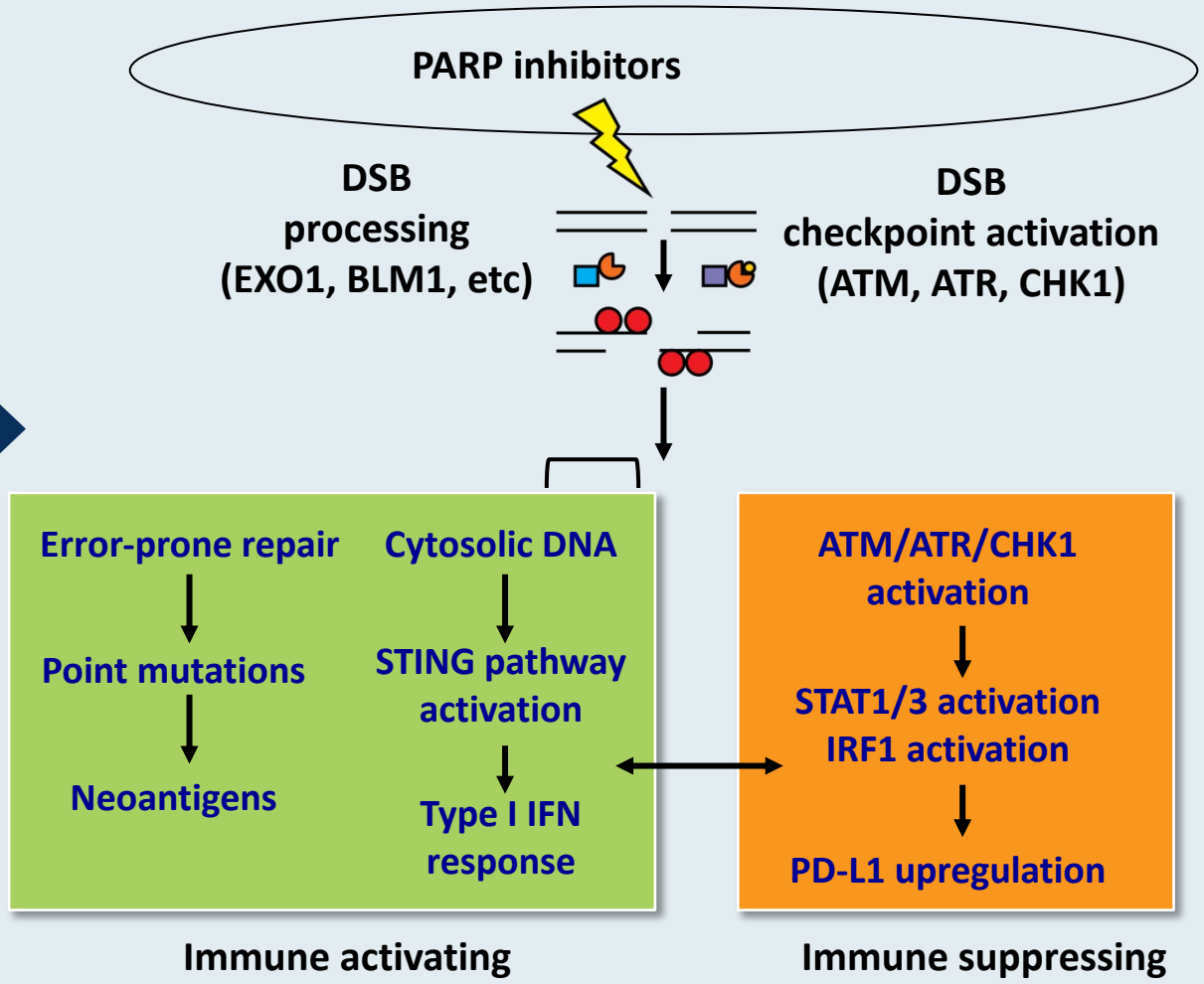
Efficacy Summary of PARP Inhibitors for Multiply Relapsed OC

	Objective Response Rate
QUADRA[1] — Niraparib	
HRD-positive	29/189 (15%)
HRD-negative/unknown	8/230 (3%)
BRCA-mutated	18/63 (29%)
SOLO-3[2] — Olaparib	
gBRCA-mutation	109/151 (72%)
ARIEL2[3-4] — Rucaparib	
g or sBRCA mutation	57/106 (54%)

[1] Moore KN et al. *Lancet Oncol* 2019;20(5):636-648; [2] Penson RT et al. ASCO 2019;Abstract 5506;
[3] Oza AM et al. *Gynecol Oncol* 2017;147:267-75.

Biologic Rationale for the Combination of a PARP Inhibitor with an Immune Checkpoint Inhibitor

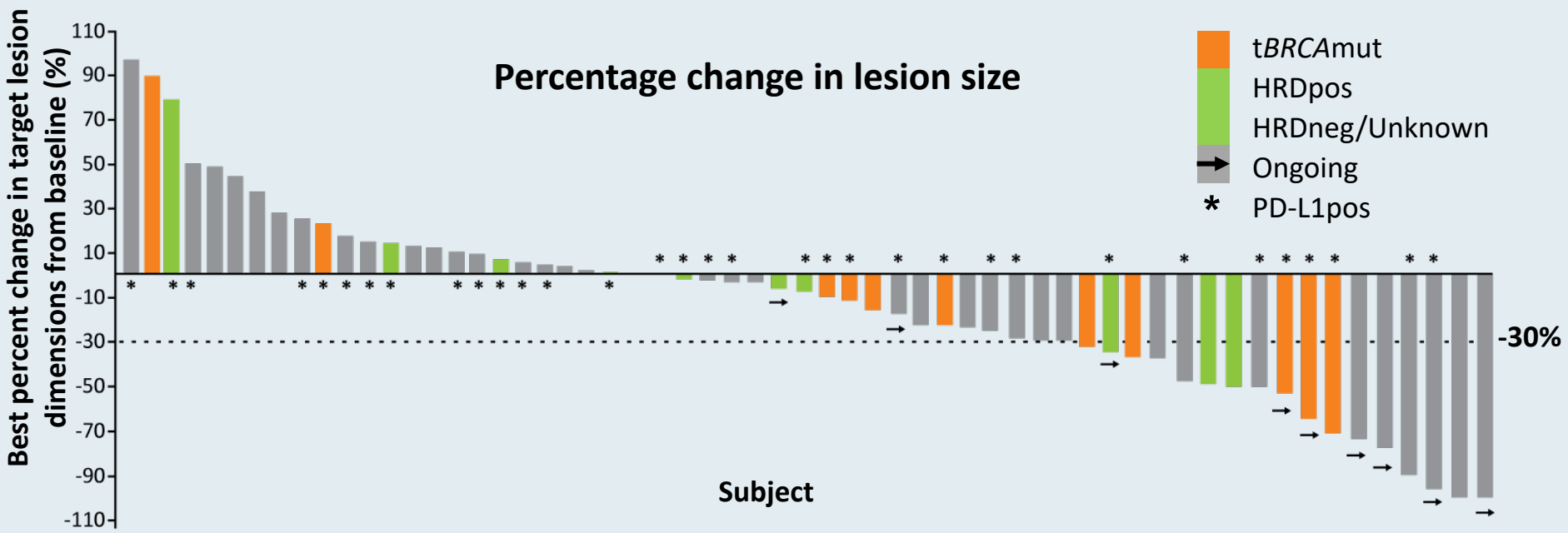
Preclinical models indicate synergy between PARPi + anti-PD-1 agents regardless of *BRCA* mutation status or PD-L1 status



Preclinical data demonstrate synergy with PARPi and anti-PD-1 combinations.

Konstantinopoulos P et al. ASCO 2018;Abstract 106.

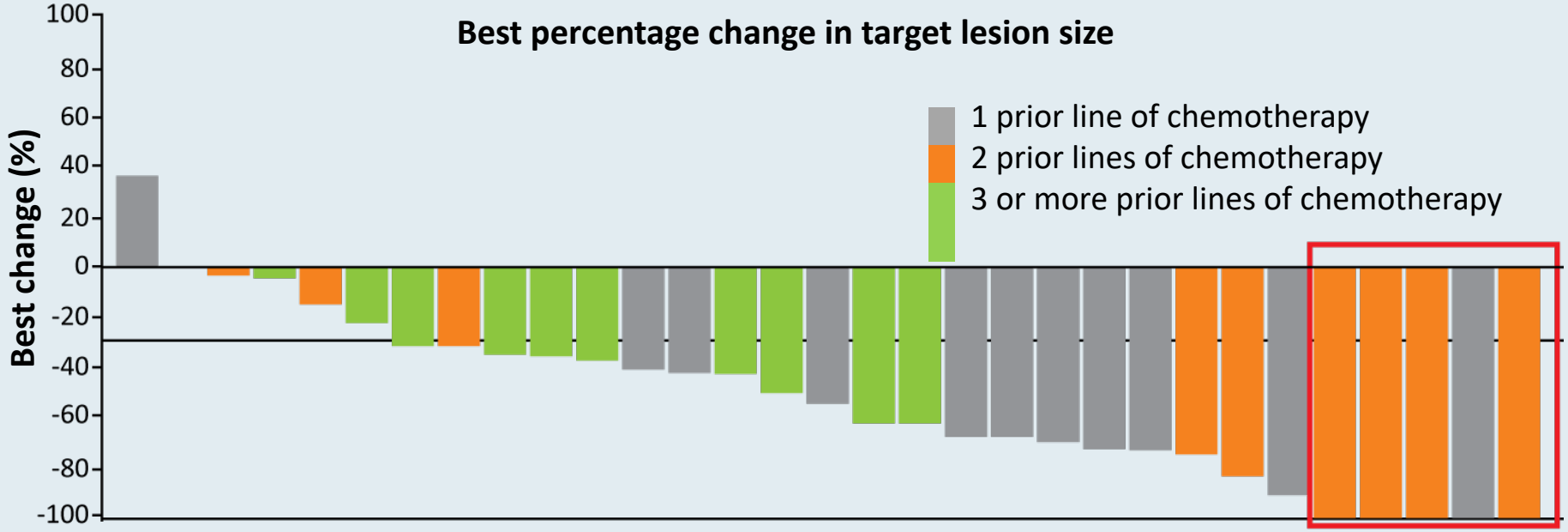
TOPACIO (KEYNOTE-162): A Phase I/II Study of Niraparib with Pembrolizumab in Recurrent, Platinum-Resistant OC



Response	All patients	tBRCAmut	HRD-pos	tBRCAwt	HRD-neg
ORR	11/47 (23%)	2/8 (25%)	4/16 (25%)	9/37 (24%)	7/26 (27%)
DCR	30/47 (64%)	5/8 (63%)	11/16 (69%)	24/37 (65%)	15/26 (58%)

Konstantinopoulos P et al. ASCO 2018;Abstract 106.

MEDIOLA: A Phase I/II Study of Olaparib and Durvalumab in Recurrent, Platinum-Sensitive OC with gBRCA Mutation

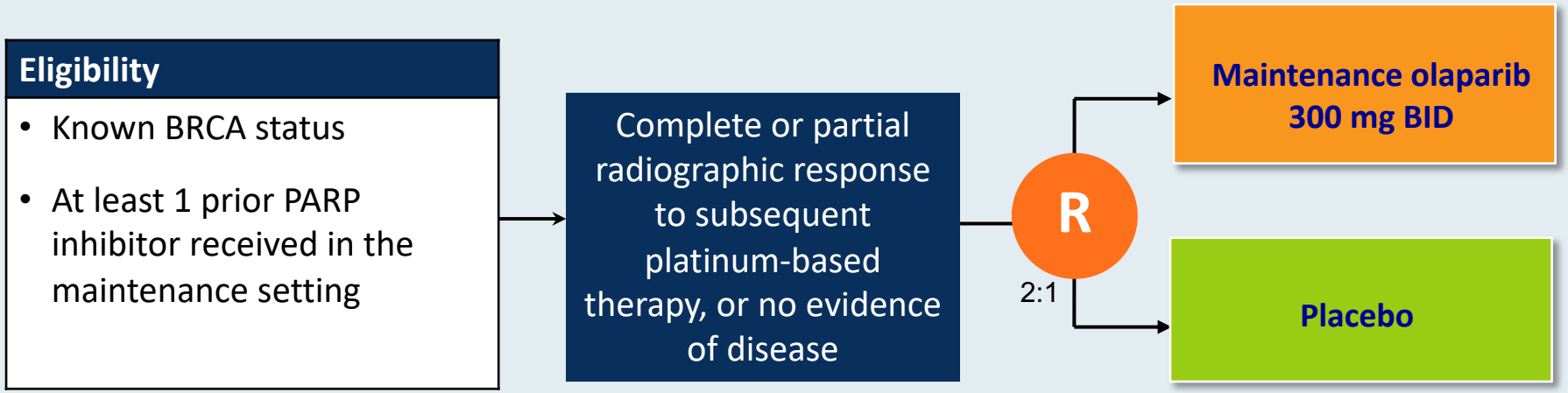


	Second line	Third line	Fourth line	All lines
ORR	10/13 (77%)	6/9 (67%)	7/10 (70%)	23/32 (72%)

Drew Y et al. SGO 2018;Abstract LBA4.

OReO/ENGOT Ov-38: A Phase IIIb Trial of Olaparib Maintenance Retreatment in Patients with EOC Previously Treated with a PARP Inhibitor and Responding to Repeat Platinum Chemotherapy

NCT03106987



Primary endpoint: Investigator-assessed progression-free survival

www.clinicaltrials.gov; Accessed August 2020.

Select Ongoing or Planned Phase III Trials of PARP Inhibitors in Combination Therapy

Trial name (Trial identifier)	N	Setting	Treatment arms
ATHENA (NCT03522246)	1,012	Maintenance therapy after 1L platinum-based chemo	• **Rucaparib** + Nivolumab • **Rucaparib** + Placebo • Nivolumab + Placebo • Placebo
DUO-O (NCT03737643)	1,056	Maintenance therapy after 1L platinum-based chemo/Bev ± Durvalumab	• Bev • Bev + Durvalumab • Bev + Durvalumab + **Olaparib**
NRG-GY004 (NCT02446600)	549	Recurrent, platinum-sensitive	• Platinum-based chemo • **Olaparib** • **Olaparib** + Cediranib
ANITA (NCT03598270)	414	Recurrent, platinum-sensitive	• Placebo + Platinum-based chemo → **Niraparib** • ATEZO + Platinum-based chemo → **Niraparib** + ATEZO

Bev = bevacizumab; ATEZO = atezolizumab

www.clinicaltrials.gov. Accessed December 2018.

A woman in her mid-60s with recurrent high-grade serous ovarian cancer begins rucaparib monotherapy (600 mg BID). Within a few weeks her serum creatinine increases from 0.86 mg/dL to 1.6 mg/dL. What would be the optimal management approach?

 DON S DIZON, MD	Hold rucaparib until creatinine returns to normal, then restart at reduced dose
 PROFESSOR JONATHAN A LEDERMANN	Hold rucaparib until creatinine returns to normal, then restart at the same dose
 KATHLEEN MOORE, MD	Continue rucaparib at the same dose
 PROFESSOR IGNACE VERGOTE	Hold rucaparib until creatinine returns to normal, then restart at the same dose
 SHANNON N WESTIN, MD, MPH	Continue rucaparib at the same dose

In general, what is your approach to antiemetic therapy for a patient with ovarian cancer who is starting treatment on a PARP inhibitor? Does your approach to antiemetic therapy differ according to which PARP inhibitor is administered?

	Antiemetic approach	Differ by PARPi?
 DON S DIZON, MD	Prophylactic antiemetic prior to PARPi	No
 PROFESSOR JONATHAN A LEDERMANN	Recommend antiemetic if pt has nausea	No
 KATHLEEN MOORE, MD	Prophylactic antiemetic prior to PARPi for the first 2 months	No
 PROFESSOR IGNACE VERGOTE	Recommend antiemetic if pt has nausea	No
 SHANNON N WESTIN, MD, MPH	Recommend antiemetic if pt has nausea	No

For a patient with Stage IIIC ovarian cancer and a germline BRCA mutation who has undergone optimal debulking surgery followed by chemotherapy and 2 years of PARP inhibitor maintenance therapy, do you believe the risk of developing MDS (myelodysplastic syndromes) or AML (acute myeloid leukemia) is increased by the PARP inhibitor?

 DON S DIZON, MD	Yes (Incidence in SOLO-1 was 1%, in SOLO-2 was 16%)
 PROFESSOR JONATHAN A LEDERMANN	Yes, by 1%
 KATHLEEN MOORE, MD	Yes, by 2%
 PROFESSOR IGNACE VERGOTE	Yes, by 1%
 SHANNON N WESTIN, MD, MPH	Yes, by 1%

According to your clinical experience, do PARP inhibitors cause insomnia?

 DON S DIZON, MD	No
 PROFESSOR JONATHAN A LEDERMANN	Yes
 KATHLEEN MOORE, MD	Yes
 PROFESSOR IGNACE VERGOTE	No
 SHANNON N WESTIN, MD, MPH	Yes

A 70-year-old woman with advanced ovarian cancer and a germline BRCA mutation undergoes debulking surgery followed by chemotherapy with carboplatin/paclitaxel and experiences disease relapse 1 year later. Which treatment would you likely recommend?

 DON S DIZON, MD	Carbo/pac → maintenance olaparib
 PROFESSOR JONATHAN A LEDERMANN	Carbo/PLD → maintenance olaparib
 KATHLEEN MOORE, MD	Platinum doublet → maintenance olaparib
 PROFESSOR IGNACE VERGOTE	Platinum doublet → maintenance olaparib
 SHANNON N WESTIN, MD, MPH	Carbo/pac + bevacizumab → maintenance olaparib

PLD = pegylated liposomal doxorubicin

A 70-year-old woman with advanced ovarian cancer (BRCA wild type, HRD-negative) undergoes debulking surgery followed by chemotherapy with carboplatin/paclitaxel and experiences disease relapse 1 year later. Which treatment would you likely recommend?

 DON S DIZON, MD	Carboplatin/paclitaxel → maintenance niraparib
 PROFESSOR JONATHAN A LEDERMANN	Carboplatin/PLD → maintenance rucaparib
 KATHLEEN MOORE, MD	Platinum doublet + bevacizumab → maintenance bevacizumab
 PROFESSOR IGNACE VERGOTE	Platinum doublet + bevacizumab → maintenance bevacizumab
 SHANNON N WESTIN, MD, MPH	Carbo/PLD + bevacizumab → maintenance bevacizumab

A 70-year-old woman with advanced ovarian cancer and a germline BRCA mutation undergoes debulking surgery, then receives carboplatin/paclitaxel/bevacizumab followed by maintenance therapy with a PARP inhibitor for 2 years and experiences disease relapse 1 year later. Which treatment would you likely recommend?

 DON S DIZON, MD	Carboplatin/paclitaxel → maintenance w/ alternate PARPi than received
 PROFESSOR JONATHAN A LEDERMANN	Carboplatin/PLD
 KATHLEEN MOORE, MD	Platinum doublet → maintenance niraparib
 PROFESSOR IGNACE VERGOTE	Platinum doublet + bev → maintenance bev + PARPi
 SHANNON N WESTIN, MD, MPH	Carboplatin/PLD → maintenance olaparib

PARPi = PARP inhibitor

A 70-year-old woman with advanced ovarian cancer (BRCA wild type, HRD-negative) undergoes debulking surgery, then receives carboplatin/paclitaxel/ bevacizumab followed by maintenance therapy with a PARP inhibitor for 2 years and experiences disease relapse 1 year later. Which treatment would you likely recommend?

 DON S DIZON, MD	Carboplatin/paclitaxel
 PROFESSOR JONATHAN A LEDERMANN	Carboplatin/PLD + bevacizumab → maintenance bevacizumab
 KATHLEEN MOORE, MD	Platinum doublet + bevacizumab → maintenance bevacizumab
 PROFESSOR IGNACE VERGOTE	Platinum doublet
 SHANNON N WESTIN, MD, MPH	Carboplatin/PLD + bevacizumab → maintenance bevacizumab

A 70-year-old woman with advanced ovarian cancer (BRCA wild type, HRD-positive) undergoes debulking surgery, then receives carboplatin/paclitaxel/bevacizumab followed by maintenance therapy with a PARP inhibitor for 2 years and experiences disease relapse 1 year later. Which treatment would you likely recommend?

 DON S DIZON, MD	Carboplatin/paclitaxel → maintenance w/ alternate PARPi than received
 PROFESSOR JONATHAN A LEDERMANN	Carboplatin/PLD
 KATHLEEN MOORE, MD	Platinum doublet → maintenance olaparib
 PROFESSOR IGNACE VERGOTE	Platinum doublet → maintenance olaparib
 SHANNON N WESTIN, MD, MPH	Carbo/pac → maintenance niraparib *OR* Carbo/PLD → maintenance niraparib

Outside of a clinical trial, have you used or would you use a second PARP inhibitor or continue the same PARP inhibitor for a patient with ovarian cancer who experienced disease progression on a PARP inhibitor?

 DON S DIZON, MD	I have
 PROFESSOR JONATHAN A LEDERMANN	I have
 KATHLEEN MOORE, MD	I have
 PROFESSOR IGNACE VERGOTE	I have
 SHANNON N WESTIN, MD, MPH	I have

RTP RESEARCH TO PRACTICE

Optimizing the Selection and Sequencing of Therapy for Patients with Chronic Lymphocytic Leukemia

A Meet The Professor Series

Friday, August 21, 2020
12:00 PM – 1:00 PM ET

Faculty
Brad S Kahl, MD

Moderator
Neil Love, MD

RTP RESEARCH TO PRACTICE

Thank you for joining us!

CME and MOC credit information will be emailed to each participant within 5 days.