Highlights from the2017 Annual Meeting on Women's Cancer

Society of Gynecologic Oncology (SGO)

by

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SGO ATTENDANCE

As a new patient advocate member of NCI's Gynecologic Cancer Steering Committee, I came to my sixth SGO annual meeting with an additional goal to broaden my perspective beyond ovarian cancer to all gynecologic cancers. While my reports for OCRFA will continue focus on ovarian cancer, I may include information on other gynecologic cancers from time to time because it is important to recognize that we are part of an even larger community with similar needs and barriers to research and care.

I also reflected on how different this experience was from my very first SGO. In 2008, I was newly in third remission, understood very little and was so desperate to find answers. This year, I participated in a scientific advisory committee meeting for an advocacy organization and had my work with professional colleagues presented during the Featured Poster Session (more details below). I marveled at the progress that advances in technology and research have brought and changes to clinical practice since I was diagnosed in 2004. However, more research is urgently needed because overall mortality remains virtually the same. There is still so much that is unknown--and the women and men of the Society of Gynecologic Oncology are hard at work to make new discoveries, analyze data and improve the lives of women living with gynecologic cancers.

THE CRISIS IN GYNECOLOGIC CANCER CLINICAL TRIAL ACCESS

Since 2011, there has been a 90% decline in enrolment of phase III clinical trial for women with gynecologic cancers. For various reasons, fewer clinical trials are available. For a summary about this crisis, please see this flyer from the SGO:

https://www.sgo.org/wp-content/uploads/2012/09/SGO-Clinical-Trial-Crisis-FINAL.pdf

Everyone can join OCRFA's efforts to maintain funding for ovarian cancer! If you have not done so already, please follow this link to sign up for Action Alerts and encourage your friends and family members to do the same:

https://ocrfa.org/advocacy/how-you-can-help/

HPV VACCINATION

Did you know that the HPV vaccine can potentially prevent over 90 percent of cervical cancers and a very high number of other HPV-associated cancers of the vulva, vagina, anus, penis, and some head and neck cancers? The SGO strongly supports vaccination of both girls and boys against HPV to prevent HPV-related cancers. Read more here: https://www.sgo.org/hpv/

I include this important information so that women with ovarian cancer can encourage members of their families to learn more and take appropriate action to protect the next generation from cancers that can be prevented.

TREATMENT

Several PARP inhibitors studies were presented confirming clinical benefit in recurrent ovarian cancer for people who are BRCA mutation carriers (germline mutations) and people who have tumors that have mutations in homologous recombination deficiency (HRD) pathways (somatic mutations). Platinum sensitivity continues to appear to be an indicator of response to PARP inhibitors. More research is ongoing to determine optimal strategies (maintenance, single agent or combination), timing, understanding and overcoming resistance, as well as efficacy for those who are not mutation carriers or have mutations in HRD.

- **ARIEL2: rucaparib**

  Dr. Gottfried Konecny, University of California, Los Angeles, presented an integrated summary of the phase II ARIEL2 study of single-agent rucaparib in recurrent ovarian cancer. Platinum-sensitive mutation carriers had the best response. ARIEL3 in the maintenance setting and ARIEL4 in the treatment setting are ongoing to confirm these findings.

  Dr. Liz Swisher of the University of Washington Medical Center in Seattle presented additional data from ARIEL2 and suggested that routine sequencing of high grade ovarian cancer prior to first-line chemotherapy would help identify responders to PARP inhibition.

- **GOG 3003: motolimod**

  Dr. Bradley Monk of the University of Arizona College of Medicine presented results of GOG 3003, a phase II randomized of an immunotherapy agent motolimod combined with pegylated liposomal doxorubicin (PLD) in recurrent ovarian cancer. Although the combination appeared to be well tolerated, motolimod added to PLD did not improve overall survival or progression free survival.

MAINTENANCE THERAPY

The results of several maintenance therapy trials were presented. Maintenance is when a someone newly in remission continues on the same treatment or uses a different treatment as a strategy to prevent or delay a recurrence (such as trastuzumab for HER2-positive breast cancer), or to maintain stable disease or a partial response to treatment.

- **GOG 212: taxane maintenance**

  Dr. Larry Copeland, Ohio State University, presented the results of GOG 212, a phase III randomized trial comparing maintenance after the completion of first-line treatment with a taxane (either paclitaxel or paclitaxel conjugate CT-2103) to the standard of care, which is

surveillance. There was no improvement in overall survival (OS) with taxane maintenance which was also associated with increased side effects.

- **SOLO2: olaparib maintenance**

Dr. Eric Pujade-Lauraine from the Hopital Hotel Dieu in Paris, France presented the findings of SOLO2, a phase III randomized trial of maintenance with single-agent olaparib in BRCA mutation carriers with platinum-sensitive relapsed ovarian cancer. There was a statistically significant improvement in progression free survival (PFS). It was interesting to note that the rate of myelodysplastic syndrome (MDS) was 2% with olaparib and 4% with placebo.

- **ENGOT-OV16/NOVA: niraparib maintenance**

Dr. Sven Mahner of the University Medical Center Hamburg-Eppendorf in Hamburg, Germany presented results of ENGOT-OV16/NOVA, a phase III randomized study of maintenance with single-agent niraparib in platinum-sensitive recurrent ovarian cancer. Progression free survival (PFS) and other secondary endpoints were prolonged, regardless of BRCA mutation or HRD status. Patient reported outcomes (PROs) were similar in both the niraparib and placebo arms.

BIOMARKERS

Dr. Kunle Odunsi of Roswell Park Cancer Institute presented a distillation on biomarkers and the need to integrate developing information. To change clinical practice, biomarkers need to be reliable, identify clinically relevant subgroups and improve clinical outcomes.

Dr. Megan McDonald of University of Iowa Hospitals and Clinics presented an analysis of molecular data involving non-response to chemotherapy. Prospective studies and validation of pre-treated tumors are needed to develop diagnostic tools for response to chemotherapy. Identifying those unlikely to respond to standard treatment would avoid unnecessary toxicities and allow patients to seek clinical trials based on molecular differences in the cancer.

PERSONALIZING HEALTH CARE DECISIONS

An entire plenary session was devoted to collection of patient preferences to personalize decisions. This is a simple list of the presenters since much of the work is ongoing:

- Dr. Heidi Donovan, RN of the University of Pittsburgh presented findings of GOG 259, which defined priority symptoms in recurrent ovarian cancer and development of the WRITE system for symptom management.
- Dr. Nicole Nevadunsky of Albert Einstein College of Medicine in the Bronx, NY presented retrospective findings that showed early palliative care is feasible in ethnically and racially diverse populations and that universal screening was associated with increased access to care compared to consultation.
- Dr. David Cohn of the University of California, Irvine presented important work on the Patient Centered Outcome Aid (PCOA) to aid patients deciding between front-line interperitoneal and intravenous therapy, concluding that understanding patient preferences regarding toxicities is critical to enhancing shared decision making.

- Dr. Megan Buechel of the University of Oklahoma Health Sciences Center in Oklahoma City presented findings of a retrospective study of elderly patients (70 and over) who participated in Phase I clinical trials at that institution. There appeared to be no difference in survival or toxicities experience in elderly patients compared to younger patients, concluding that well selected elderly patients can be safely considered for enrollment in phase I trials. This is important because elderly patients are generally underrepresented in clinical trials.

FEATURED POSTER SESSION GROUP II: Putting the Patient First

I did not have the opportunity to visit as may scientific posters as I would have liked because I participated in a fascinating moderated Featured Poster Session titled Putting the Patient First. Some of the posters in that session include:

- Decision-making surrounding genetic testing amount women with ovarian carcinoma (L.L. Holman et al, University of Oklahoma and FORCE)
- Prospective patient-elicited value assessments of options in the primary treatment of ovarian cancer (J.R. Foote et al, Duke, Ohio State, MSKCC, Cedars-Sinai)
- Bald and beautiful? Quality of life and chemotherapy-induced alopecia (M.L. Clements et al, Moffitt Cancer Center)
- Automated patient-reported symptom data capture, tracking and intervention during recovery from ambulatory gynecologic cancer surgery (O. Zivanovic et al, Memorial Sloan Kettering)
- Patient and physician expectations and communication regarding ovarian cancer prognosis (S.P. Huepenbecker et al, Washington University School of Medicine, University of Pennsylvania)

Here is a picture of the poster that my colleagues, Dr. Stephanie Blank from Icahn School of Medicine at Mount Sinai, Dr. Melissa Frey from New York Presbyterian Hospital—Weill Cornell Medicine, Savannah Shyne from SHARE, and I presented.

DEDICATED EXPERIENCED SUPPORT
SHARE
for women facing breast and ovarian cancers

Bridging the gap: A priorities assessment tool to support shared decision-making, maximize limited appointment time and increase patient satisfaction

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BACKGROUND

- Women with ovarian cancer, even those who present at advanced stage, often achieve long overall survival and receive multiple treatment regimens.
- Physicians and patients must carefully consider and balance treatment toxicities and quality of life when selecting treatments in this population.
- Previous qualitative and quantitative work demonstrates that patient-physician communication is an essential element in determining treatment course and a discussion about goals and values should precede all treatment decisions.

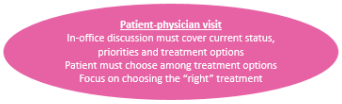
Objective: To develop a patient-centered priorities assessment tool (PAT) that could be completed quickly and easily in the waiting room immediately prior to appointments to streamline communication, enhance treatment discussions and increase patient satisfaction.

METHODS

- We designed a one page PAT utilizing the validated ovarian cancer symptom index (NCCN-FACT FOSI-18) combined with an index to assess daily quality of life priorities that may be impacted by treatment side effects (Figure 2).
- The PAT was distributed to women with ovarian cancer in small focus group settings and online, followed by a post-activity feedback form.

Figure 1. Patient-physician communication: Traditional model vs. PAT

1a. Traditional model of patient-physician communication



1b. Proposed model of patient-physician communication using PAT

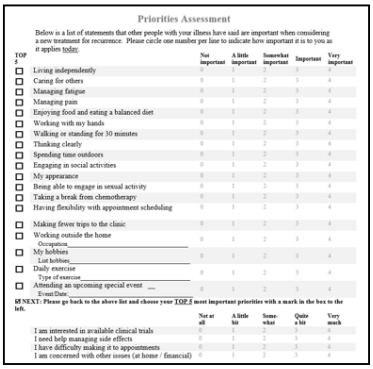
IDEAL FEATURES OF PAT

- PAT appears to be most helpful to recurrent patients requiring treatment changes.

For patients, PAT should:
- help assess current physical status
- facilitate identification of what is most important to them (priorities)
- be easy to complete in waiting room prior to appointments (10-15 mins)
- increase satisfaction with shared decision-making

For physicians, PAT should:
- optimize use of limited appointment time
- be easy to review prior to meeting patient
- enhance physician-patient communication
- create natural segue to discussion about potential risks and benefits

Figure 2. Priorities Assessment Tool (PAT)


Priorities Assessment

Below is a list of statements that other people with your illness have said are important when considering a new treatment for recurrence. Please circle one number per line to indicate how important it is to you as it applies today.

TOP 5		Not important	A little important	Somewhat important	Important	Very important
☐	Living independently	0	1	2	3	4
☐	Caring for others	0	1	2	3	4
☐	Managing fatigue	0	1	2	3	4
☐	Managing pain	0	1	2	3	4
☐	Enjoying food and eating a balanced diet	0	1	2	3	4
☐	Working with my hands	0	1	2	3	4
☐	Walking or standing for 30 minutes	0	1	2	3	4
☐	Thinking clearly	0	1	2	3	4
☐	Spending time outdoors	0	1	2	3	4
☐	Engaging in social activities	0	1	2	3	4
☐	My appearance	0	1	2	3	4
☐	Being able to engage in sexual activity	0	1	2	3	4
☐	Taking a break from chemotherapy	0	1	2	3	4
☐	Having flexibility with appointment scheduling	0	1	2	3	4
☐	Making fewer trips to the clinic	0	1	2	3	4
☐	Working outside the home Occupation:	0	1	2	3	4
☐	My hobbies List hobbies:	0	1	2	3	4
☐	Daily exercise Type of exercise:	0	1	2	3	4
☐	Attending an upcoming special event Event Date:	0	1	2	3	4

NEXT: Please go back to the above list and choose your TOP 5 most important priorities with a mark in the box to the left.

		Not at all	A little bit	Some-what	Quite a bit	Very much
	I am interested in available clinical trials	0	1	2	3	4
	I need help managing side effects	0	1	2	3	4
	I have difficulty making it to appointments	0	1	2	3	4
	I am concerned with other issues (at home / financial)	0	1	2	3	4

RESULTS

- Thirty-six women completed the PAT and thirty-five completed the post-activity feedback form between September 2015 and May 2016.
- All participants reported that the PAT was easy to understand and comprehensive in scope.
- Thirty-four (94%) participants completed the PAT in under 15 minutes, with most (n=29/81%) completing it in 5-10 minutes.
- Most participants (n=31/86%) were able to stratify their priorities and identify five top treatment-related priorities.
- Participants who indicated their goals and priorities had changed since diagnosis (n=26/72%) reported that the PAT helped them to identify current goals and priorities (n=22/26 or 85%) and that the PAT would help them feel more comfortable participating in shared decision-making with their medical team (n=21/26 or 81%).
- Two participants asked to take the PAT with them to their next clinic appointment
- **Feedback patient comments:**

"Just thinking over the experiences of the last 2 years was enlightening."
"Helps identify what is important."
"Makes you assess your priorities."
"The most helpful part is listing the top 5 priorities."

CONCLUSIONS

- A PAT that combines current symptom index with daily quality of life priorities was easy to complete and viewed as comprehensive and useful in a pilot cohort of women with ovarian cancer.
- Use of a PAT has the potential to enhance communication, promote shared decision-making and improve patient satisfaction while maximizing efficiency of limited appointment time.
- A pilot of this PAT in gynecologic oncologists' offices is ongoing.

References
1. Frey MK, Philips SR, Jeffries J, Herzberg AJ, Harding-Peets GL, Gordon JK, et al. A qualitative study of ovarian cancer survivors' perceptions of endpoints and goals of care. Gynecol Oncol. 2014.
2. Minion LE, Coleman RL, Alvarez RD, Herzog TJ. Endpoints in clinical trials: What do patients consider important? A survey of the Ovarian Cancer National Alliance. Gynecol Oncol. 2016.
3. Herzog TJ, Armstrong DK, Brady MF, Coleman RL, Einstein MH, Monk BJ, et al. Ovarian cancer clinical trial endpoints: Society of Gynecologic Oncology white paper. Gynecol Oncol. 2014

FOR MORE SGO MEETING COVERAGE:

Onclive.com: http://www.onclive.com/conference-coverage/sgo-2017

Cure: http://www.curetoday.com/tumor/ovarian

ASCO Post: http://www.ascopost.com/News/52430

Oncology Practice: http://www.mdedge.com/oncologypractice/conferences/society-gynecologic-oncology-sgo-2017-annual-meeting-womens-cancer

Oncology Nurse Advisor: http://www.oncologynurseadvisor.com/sgo-2017-annual-meeting/section/7435/

International Gynecologic Cancer Society: https://igcs.org/gynecologic-oncology-news-updates/