difficult disease to treat, this phase II study was conducted to determine if the addition of pertuzumab to gemcitabine would improve clinical activity.
Methods: Patients with platinum-resistant EOC (including ovarian, fallopian tube, or primary peritoneal cancer) who had received up to one prior treatment for platinum-resistant disease were randomized to gemcitabine 800 mg/m^2 on Days 1 and 8 of a 21-day cycle plus pertuzumab or placebo. Pertuzumab was given as an 840 mg initial dose followed by 420 mg IV every 3 weeks. Tumor response was assessed by RECIST every 6 weeks. The primary endpoint was progression-free survival (PFS).
Results: One hundred thirty patients (65 patients per treatment cohort) were treated. Clinical characteristics were balanced between the treatment groups. The adjusted hazard ratio for PFS was 0.67 (95% CI: 0.43–1.02), p = 0.06 in favor of pertuzumab + gemcitabine. The median PFS was 3.0 months (range: 0−8.7 months) vs. 2.6 months (range: 0−9+), and the PFS rate at 4 months was 49% vs. 34% in the pertuzumab + gemcitabine and placebo + gemcitabine arms, respectively. The most common AEs increased in the pertuzumab-treated patients were fatigue, nausea, diarrhea, back pain, Grade 3−4 neutropenia, rash, headache, stomatitis, epistaxis, and rhinorrhea. CHF was reported in one patient in the pertuzumab + gemcitabine cohort. The left ventricular ejection fraction results were similar between treatment arms. One patient who received pertuzumab + gemcitabine experienced a fatal adverse event (hemolytic-uremic syndrome).
Conclusions: These data suggest that pertuzumab may add activity to gemcitabine as reflected by improvements in PFS in patients with platinum-resistant ovarian, primary peritoneal, or fallopian tube cancer. Clinical outcomes by biomarker analysis and overall survival data will be presented.

5003 ORAL

A randomised phase II study of carboplatin plus liposomal doxorubicin (CLD) vs carboplatin plus paclitaxel (CP) in potentially platinum sensitive ovarian cancer patients. A Hellenic Cooperative Oncology Group study

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Background: Platinum-based combinations are standard 2nd-line treatment for platinum-sensitive ovarian cancer. Liposomal doxorubicin is effective as monotherapy and combined with carboplatin in recent phase II studies. We evaluated CLD vs CP in platinum-sensitive ovarian cancer patients.
Materials and Methods: Patients with recurrent ovarian cancer, at least 6 months after platinum-based therapy, with measurable disease or elevated CA-125, entered this randomized phase II study. Patients received 6 cycles of CP (carboplatin AUC5 + paclitaxel 175 mg/m^2, d1q21) or CLD (carboplatin AUC5 + liposomal doxorubicin 45 mg/m^2, d1q28).
Results: From 11/1999 to 01/2006, 204 patients were randomized; 189 eligible patients are included in the analysis (CP 96, CLD 93). Median age was 63 years (37−89) and median PS 0. Platinum-free interval (PFI) was >12 months in 65% of patients (median 16.5 months). A median of 6 cycles per patient was delivered. The number of patients completing treatment did not differ between groups, however, the discontinuation rate due to toxicity was higher in CP (13.5% vs 3%, p = 0.016). Paclitaxel median RDI was 0.96, LD 0.92 and carboplatin cumulative dose was similar in both groups. Overall response rate was not statistically different between groups: CP 58% vs CLD 51% p = 0.309 (CR 34% for CP vs 23% for CLD, PR 24% for CP vs 28% for CLD). At median follow-up of 43.6 months there was no statistical difference in TTP or overall survival: median TTP was 10.8 months (95% CI 9.3−12.3) for CP vs 11.7 (95% CI 10.9−12.6) for CLD, while overall survival was 30.4 months (95% CI 23.4−37.4) for CP vs 24.4 (95% CI 21.1−27.6) for CLD. No toxic deaths were recorded in either arm. Neutropenia was the commonest grade 3−4 toxicity (CP 30% vs CLD 35%). Severe thrombocytopenia was more frequent in CLD (CP 2% vs CLD 12% p = 0.016); severe neurotoxicity and alopecia were significantly higher in CP (CP 7% vs CLD 0%, p = 0.029 and CP 83% vs CLD 11% p = 0.003, respectively). Supportive care parameters did not differ significantly between groups, except of RBC transfusion rate being higher in CLD (CP 3% vs CLD 14% p = 0.015). Cox regression analysis revealed PS and PFI as important individual prognostic factors for TTP and OS.
Conclusions: Carboplatin plus LD is highly effective with acceptable toxicity profile, similar to carboplatin plus paclitaxel in 2nd line treatment of platinum-sensitive ovarian cancer patients and should be considered as a treatment option for this patient population.

5004 ORAL

Survival risks and benefits with adjuvant therapy for endometrial cancer: systematic review and meta-analysis

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Background: The contribution of adjuvant post-operative pelvic external beam radiotherapy (EBRT) to disease free survival (DFS) in early endometrial cancer is well established but no convincing overall survival (OS) benefit has been shown.
Materials and Methods: meta-analysis of randomised controlled trials (RCT).
Results: 2431 patients' data were accessed from RCTs. Patients were stratified into three risk groups for recurrence: low (1524 patients), intermediate (557 patients), and high (350 patients). Pelvic EBRT affected survival odds ratios (OR) differently in the three groups: low OR 0.71 (95% CI 0.52−0.96); intermediate OR 0.97 (95% CI 0.69−1.35); high OR 1.76 (95% CI 1.07−2.89). Not all patients died from cancer progression. For high risk cancers EBRT reduces the chance of death by cancer OR 0.59 (95% CI 0.30−1.17). Pelvic EBRT reduced pelvic recurrence in all groups; OR 0.27 (95% CI 0.08−2.51).
Conclusions: Pelvic EBRT is very effective in reducing pelvic relapse of early endometrial cancer but is either harmful or ineffective in improving overall survival in women with low or intermediate risk cancers. In contrast, for high risk cancers EBRT reduces the absolute chance of death by cancer by approximately 10%.

5005 ORAL

Randomized, multicenter, 2-dose-level, open-label, phase IIa study with the intraperitoneally infused trifunctional bispecific antibody catumaxomab (anti-EpCAM x anti-CD3) to select the better dose level in platinum refractory epithelial ovarian cancer patients

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Background: The trifunctional antibody catumaxomab specifically binds EpCAM+ tumor cells, CD3+ T lymphocytes and accessory cells via the Fcγ RI/III thereby inducing a tumor specific cell mediated cytotoxicity in vitro and in vivo. This study was conducted to evaluate efficacy and safety of two different regimens of catumaxomab.
Methods: Women with platinum-refractory (progressing during or <6 mos. after the last platinum containing regimen) epithelial ovarian cancer and measurable recurrent disease were randomized to receive either 10–10–10–10 μg or 10–20–50–100 μg of catumaxomab over 6 h i.p on days 0, 3, 7 and 10.
Results: 45 pts. were entered (22 high dose [HD]-arm, 23 low dose [LD]-arm). Both groups were well balanced concerning ECOG-performance score, with a median age of 65.6 y. in the HD- and 57.6 y. in the LD-arm and with a median diameter of measurable lesions of 90 mm in the HD- and 104 mm in the LD-arm. Based on the AEs, changes in laboratory parameters and other safety variables observed in the safety population in the course of this study, the accumulated safety experience is consistent with the key features of the mode of action of catumaxomab. Their intensity on median level was mostly mild to moderate. A clinical benefit was detectable in 27.3% of pts. for the HD- (1PR/5SD) and 8.7% of pts. for the LD-arm (2SD). After a median follow-up of 4.96 months, the median overall survival time was 182 d for the HD- and 114 d for the LD-arm.
Conclusion: The results demonstrate that catumaxomab is safe with acceptable toxicity when administered as a sequence of 4 IP infusions at 10, 20, 50 and 100 μg. A modest dose effect is observed for the higher doses of catumaxomab.