in the EVE group vs. with PBO. Adverse events, mostly grade 1−2, were consistent with the known safety profile of everolimus; there were no on-study deaths or discontinuations due to an adverse event.
Conclusion: Everolimus is an effective, well-tolerated treatment option for TSC patients with SEGA. Everolimus was also associated with clear improvement in other TSC-associated manifestations.

Presidential Session II
Sunday 25 September 2011, 12:20−14:40
5LBA LATE BREAKING ABSTRACT

Efficacy in Patient Subgroups in OCEANS, a Randomized, Double-blinded, Placebo-controlled, Phase 3 Trial of Chemotherapy ± Bevacizumab in Patients with Platinum-sensitive Recurrent Epithelial Ovarian (OC), Primary Peritoneal (PPC), or Fallopian Tube Cancer (FTC)

C. Aghajanian[1], S.V. Blank[2], B. Goff[3], P.L. Judson[4], S. Makhija[5], S.K. Sharma[6], L.R. Nycum[7], J. Yi[8], A. Husain[9]. *[1]Memorial Sloan Kettering Cancer Center, New York, USA; [2]Memorial Sloan Kettering Cancer Center, Department of Obstetrics and Gynecology, New York, USA; [3]University of Washington School of Medicine, Department of Obstetrics and Gynecology, Seattle, USA; [4]H. Lee Moffitt Cancer Center & Research Institute, Center for Women's Oncology, Tampa, USA; [5]University of Louisville School of Medicine, Department of Obstetrics Gynecology and Women's Health, Louisville, USA; [6]Adventist Hinsdale Hospital, Obstetrics/Gynecology, Hinsdale, USA; [7]Forsyth Regional Cancer Center, Gynecologic Oncology, Winston-Salem, USA; [8]Genentech Inc., Biostatistics, South San Francisco, USA; [9]Genentech Inc., BioOncology Development, South San Francisco, USA*

Background: OCEANS, a placebo (PL)-controlled trial of carboplatin (C) and gemcitabine (G) with bevacizumab (BV) followed by BV to disease progression (PD) showed a statistically significant and clinically meaningful improvement in progression-free survival (PFS) with the addition of BV in women with platinum-sensitive (Plat-S) recurrent OC. Further subset analyses were conducted and are presented.
Material and Methods: Subjects had first recurrence of Plat-S OC, PPC, or FTC, no prior BV, ECOG PS of 0 or 1, and measurable disease. They were randomized to arm A: CG (C [AUC 4, day 1] and G [1000 mg/m^2 days 1 and 8], q21d for 6−10 cycles) + concurrent PL (q21d), followed by PL until PD or unacceptable toxicity; or arm B: CG + concurrent BV (15 mg/kg q21d), followed by BV until PD or unacceptable toxicity.
Stratification factors included platinum free-interval (PFI) and secondary cytoreductive surgery. The primary end point was investigator-assessed PFS (RECIST). Secondary end points included objective response, overall survival, and safety. NCT00434642 (status: ongoing; sponsor: Genentech, Inc)

Table: PFS results by subgroups

	n	CG + PL n = 242 (mo)	CG + BV n = 242 (mo)	HR (95% CI)
Initial PFI (mo)				
<12	171	7.4	12.5	0.36 (0.25–0.53)
12–24	209	8.6	12.3	0.52 (0.37–0.72)
>24	104	11.6	16.6	0.62 (0.38–1.01)
Cytoreductive surgery for recurrent disease				
Yes	54	7.5	16.7	0.50 (0.24–1.01)
No	430	8.4	12.3	0.49 (0.39–0.62)
Age (yr)				
<65	306	8.5	12.5	0.47 (0.36–0.62)
⩾65	178	8.4	12.3	0.50 (0.34–0.72)
ECOG PS				
0	367	8.6	12.5	0.47 (0.36–0.60)
1	116	8.3	10.6	0.61 (0.39–0.95)
Tumor measurements				
SLD ⩽59 mm	244	8.5	12.6	0.49 (0.36–0.66)
SLD >59 mm	240	8.4	11.4	0.48 (0.35–0.66)

Results: 484 women (242/arm) were enrolled with a median follow-up of 24 mos. The addition of BV to CG followed by single-agent BV to PD significantly increased PFS compared with CG alone, with a hazard ratio (HR) of 0.484 (95% CI: 0.388–0.605; $P < 0.0001$) and a median PFS of 8.4 vs 12.4 mos. In all clinically relevant subgroups, including initial PFI, age, ECOG PS, and tumor size defined by the sum of the longest diameter (SLD), HRs favored the BV arm.
Conclusions: The addition of BV to CG in Plat-S recurrent OC resulted in a 52% reduction in the risk of PFS events in the overall population. This treatment effect was consistent across the majority of clinically relevant subgroups, including prespecified partially Plat-S (PFI, 6−12 mos) OC. Additional subgroups were analyzed and will be presented. These data demonstrate the benefit BV provides to women with differing clinical characteristics.

Presidential Session II
Sunday 25 September 2011, 12:20−14:40
6LBA LATE BREAKING ABSTRACT

Results From VELOUR, a Phase 3 Study of Aflibercept (A) Versus Placebo (pbo) in Combination with FOLFIRI for the Treatment of Patients (pt) with Previously Treated Metastatic Colorectal Cancer (MCRC)

J. Tabernero[1], E. Van Cutsem[2], R. Lakomy[3], J. Prausova[4], P. Ruff[5], G. Van Hazel[6], V. Moiseyenko[7], D. Ferry[8], J. McKendrick[9], K. Soussan-Lazard[10], E. Boelle[11], C. Allegra[12]. *[1]Vall D'Hebron University Hospital, Medical Oncology Department, Barcelona, Spain; [2]University Hospital Gathuisberg, Medical Oncology Department, Leuven, Belgium; [3]Masaryk Memorial Cancer Institute, Medical Oncology Department, Brno, Czech Republic; [4]Fakultni nemocnice v Motole, Medical Oncology Department, Praha, Czech Republic; [5]University of Witwatersrand Faculty of Health Sciences, Medical Oncology Department, Johannesburg, South Africa; [6]Sir Charles Gairdner Hospital, Medical Oncology Department, Western Australia, Australia; [7]Oncology Reseach Institute Na. N.N. Petrov, Medical Oncology Department, St-Petersburg, Russian Federation; [8]Russells Hall Hospital, Medical Oncology Department, West Midlands, United Kingdom; [9]Monash University, Medical Oncology Department, Victoria, Australia; [10]Sanofi Aventis R&D, SCP Clinical Sciences & Operations, Chilly-Mazarin, France; [11]Sanofi Aventis, R&D, Biostatics Department, Vitry-sur-Seine; [12]University of Florida, Medical Oncology Department, Gainesville, USA*

Background: A is a new anti VEGF/PlGF fusion protein. Primary efficacy results were presented at ESMO/WCGC meeting 2011 (Abstract O-0024) showing significant improvement in overall survival (OS) (13.5 *vs* 12.06 mos, HR: 0.817, p = 0.0032) and progression free survival (PFS) (6.90 *vs* 4.67 mos, HR: 0.758, p = 0.00007) in favor of A, with a consistent treatment effect across stratification factors (SF).
Methods: Pt were randomized 1:1 to either 1-hour IV A (4 mg/kg) or Pbo, plus FOLFIRI stratified by ECOG PS (0/1/2) and prior bevacizumab (bev) exposure. Prespecified subgroup analyses (SF, demographics, disease characteristics) were planned to assess robustness of results by testing interaction between treatment and pt subgroups on efficacy outcome at the 2-sided 10% level. In this abstract we report the results of prespecified subgroups analyses.
Results: From Nov 2007 to Mar 2010, 1226 pt were randomized to FOLFIRI and A (n = 612) or Pbo (n = 614). Subgroup analyses were conducted for SF, age (<65/⩾65), gender, race, prior hypertension (Y/N), number of organs involved (⩽1/>1), liver metastases only (Y/N) and primary cancer location (colon/sigmoid/rectum). Supported by the absence of evidence of interaction among subgroups (p value >0.1) the positive effect of A on OS was consistent across all subgroups but one. A significant interaction (p = 0.0899) was observed between treatment arm and liver metastases only (Y/N), indicating a greater treatment effect in pt with only liver metastases (A: 146 vs pbo: 153 pt) (HR: 0.649, 95.34% CI: 0.492 to 0.855) than in pt with disease not confined to liver (HR: 0.868, 95.34% CI: 0.742 to 1.015). Similar results were observed for PFS.
In A arm, 186 pt had prior treatment with bev and 426 had not. There was no significant interaction between treatment and prior bev exposure on efficacy outcomes (OS: p = 0.7231; PFS: p = 0.6954). For prior bev pt, HR for OS was 0.862 (95.34% CI: 0.673 to 1.104) and for PFS 0.661 (99.99% CI: 0.399 to 1.095). Incidences (grade 3−4) of anti-VEGF class events such as hypertension (16.6% *vs* 20.5%), hemorrhage (3.2% *vs* 2.8%), venous and arterial thromboembolic events (8.0% *vs* 7.8% and 2.1% *vs* 1.7%) were similar in pt with and without prior bev.
Conclusion: Pre-specified subgroup analyses confirmed robustness of efficacy results, demonstrating that addition of A to FOLFIRI does improve OS and PFS in MCRC pt previously treated with oxaliplatin. Consistency of effect was seen among pt who had and had not received prior bev.