# Sistematización de los resultados terapéuticos actuales en el cáncer de ovario: supervivencia global y libre de enfermedad


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Oncología médica
Complejo Universitario Cartagena
Cartagena, 04 de abril de 2014

# Mortalidad regional por causas en el año 2012.

Fuente: Boletín epidemiológico de la Región de Murcia
(vol 34, nº 773; Feb 2014).

Tasa bruta de mortalidad en la región: 724.3 x 100.000 (10680).
Femenina: 691.4.

Segunda causa de muerta: neoplasias (24.9%). 2ª causa en mujeres (18.9%).

**Las neoplasias son el factor más importante en años de vida perdidos.**

# Introducción

4ª causa de cáncer en mujeres

Menos del 40% de las mujeres con cáncer de ovario se curan.

Mediana de edad al diagnóstico: 63 años

Incidencia: 14 casos/100000 hab/año: 14x4= 56

Mortalidad: 7 casos/100000 hab/año: 7x4= 28

60-70% estadios avanzados (III-IV): 33-40

Pronóstico: estadio y cirugía

| Estadio | I | II | III | IV |
|---|---|---|---|---|
| Descripción | Limitado a los ovarios | Limitado a pelvis | Limitado abdomen/ ganglios linfáticos | Metástasis a distancia |
| Incidencia | 20% | 5% | 58% | 17% |
| Recaída | 20-25% | | 75-90% | >90% |
| Supervivencia | 73% | 45% | 21% | < 5% |

# *Screening*

*Ultrasound Obstet Gynecol* 2012; 40: 338–344
Published online in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/uog.12270

## Risk of epithelial ovarian cancer in asymptomatic women with ultrasound-detected ovarian masses: a prospective cohort study within the UK collaborative trial of ovarian cancer screening (UKCTOCS)

A. SHARMA[1], S. APOSTOLIDOU[1], M. BURNELL[1], S. CAMPBELL[2], M. HABIB[1], A. GENTRY-MAHARAJ[1], N. AMSO[3], M. W. SEIF[4], G. FLETCHER[1], N. SINGH[5], E. BENJAMIN[6], C. BRUNELL[6], G. TURNER[7], R. RANGAR[8], K. GODFREY[8], D. ORAM[5], J. HEROD[9], K. WILLIAMSON[10], H. JENKINS[7], T. MOULD[11], R. WOOLAS[12], J. MURDOCH[13], S. DOBBS[14], S. LEESON[15], D. CRUICKSHANK[16], E.-O. FOURKALA[1], A. RYAN[1], M. PARMAR[17], I. JACOBS[1,18] and U. MENON[1]

# *Screening*

*Ultrasound Obstet Gynecol* 2012; 40: 338–344
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## Risk of epithelial ovarian cancer in asymptomatic women with ultrasound-detected ovarian masses: a prospective cohort study within the UK collaborative trial of ovarian cancer screening (UKCTOCS)

ECO y Ca 125

*vs*

ECO

*vs*

No screening

# *Screening*

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## Risk of epithelial ovarian cancer in asymptomatic women with ultrasound-detected ovarian masses: a prospective cohort study within the UK collaborative trial of ovarian cancer screening (UKCTOCS)

ECO y Ca 125

*vs*

ECO

*vs*

No screening

## Sensitivity and specificity of multimodal and ultrasound screening for ovarian cancer, and stage distribution of detected cancers: results of the prevalence screen of the UK Collaborative Trial of Ovarian Cancer Screening (UKCTOCS)

*Usha Menon, Aleksandra Gentry-Maharaj, Rachel Hallett, Andy Ryan, Matthew Burnell, Aarti Sharma, Sara Lewis, Susan Davies, Susan Philpott, Alberto Lopes, Keith Godfrey, David Oram, Jonathan Herod, Karin Williamson, Mourad W Seif, Ian Scott, Tim Mould, Robert Woolas, John Murdoch, Stephen Dobbs, Nazar N Amso, Simon Leeson, Derek Cruickshank, Alistair Mcguire, Stuart Campbell, Lesley Fallowfield, Naveena Singh, Anne Dawnay, Steven J Skates, Mahesh Parmar, Ian Jacobs*

# *Screening*

ORIGINAL CONTRIBUTION

ONLINE FIRST

## Effect of Screening on Ovarian Cancer Mortality

### The Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Randomized Controlled Trial

Saundra S. Buys, MD
Edward Partridge, MD
Amanda Black, PhD, MPH

**Context** Screening for ovarian cancer with cancer antigen 125 (CA-125) and transvaginal ultrasound has an unknown effect on mortality.

# *Screening*

ORIGINAL CONTRIBUTION

ONLINE FIRST

## Effect of Screening on Ovarian Cancer Mortality

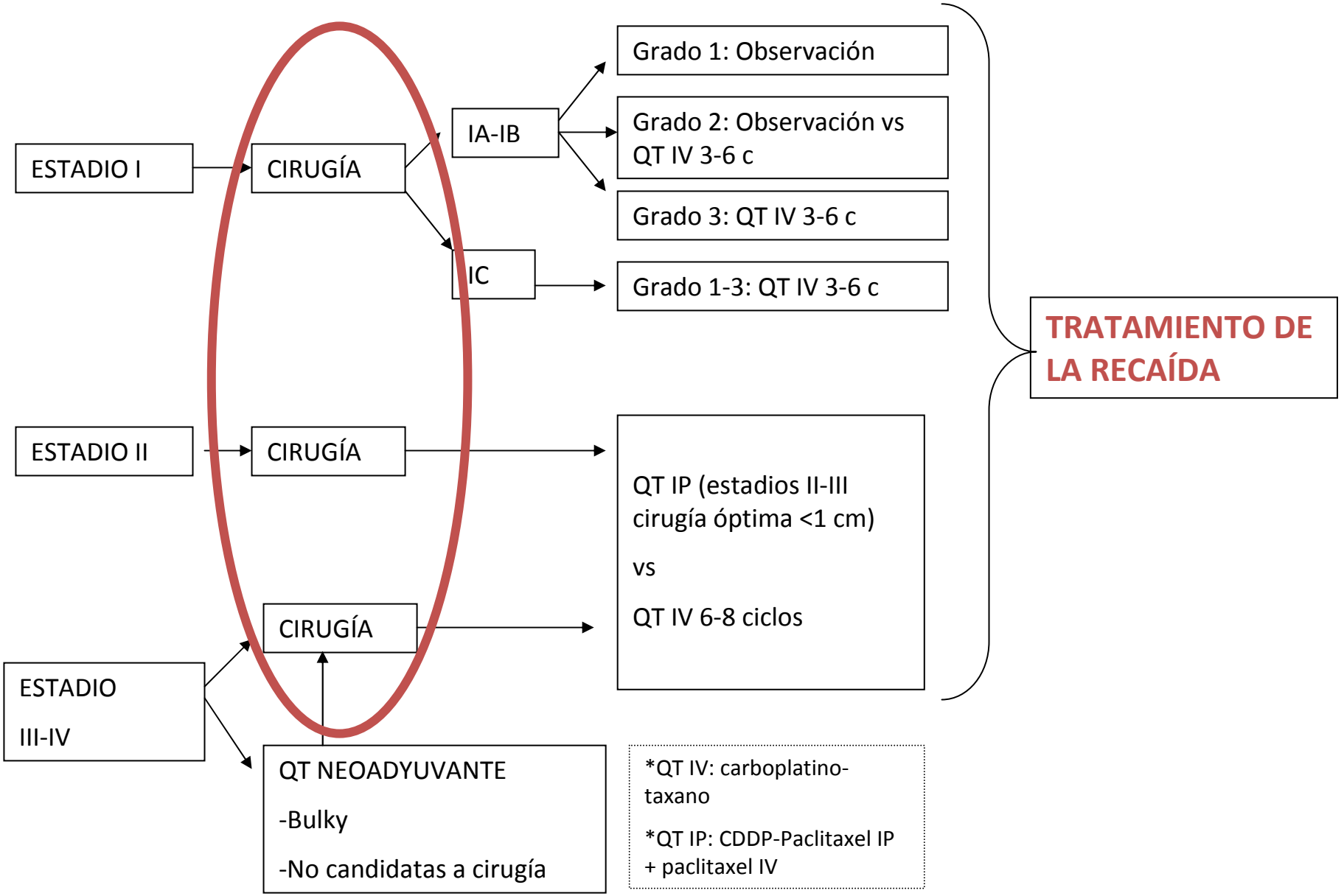
### The Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Randomized Controlled Trial

**Conclusions** Among women in the general US population, simultaneous screening with CA-125 and transvaginal ultrasound compared with usual care did not reduce ovarian cancer mortality. Diagnostic evaluation following a false-positive screening test result was associated with complications.

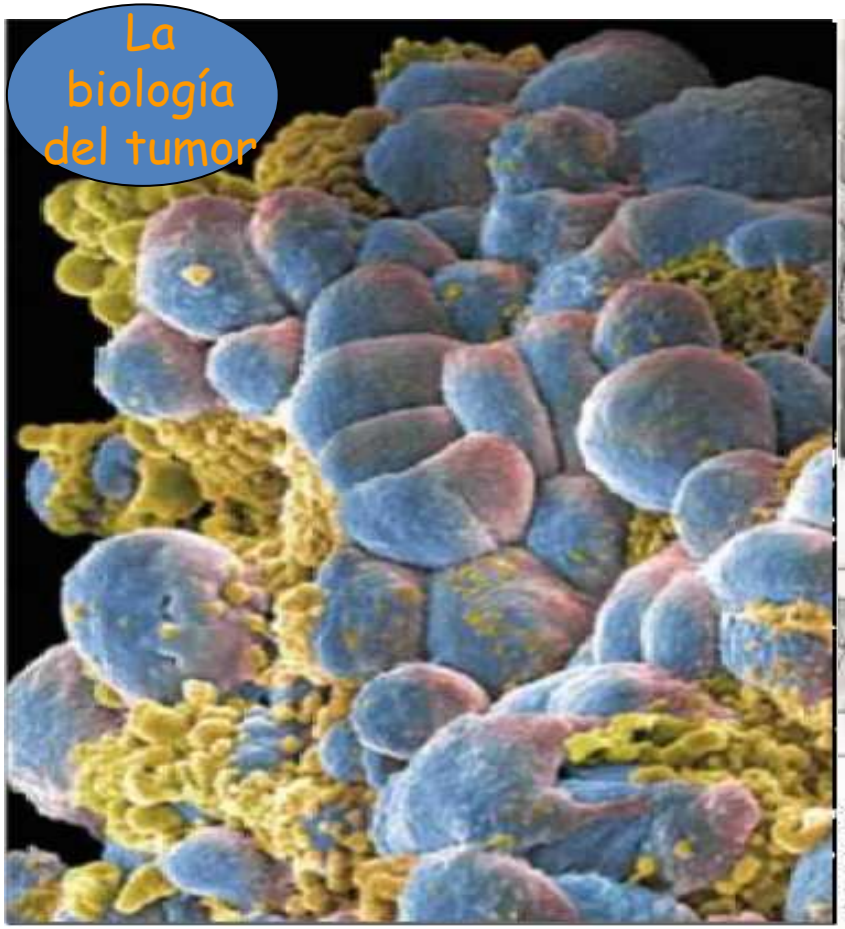
**Trial Registration** clinicaltrials.gov Identifier: NCT00002540

*JAMA. 2011;305(22):2295-2303*
Published online June 4, 2011. doi:10.1001/jama.2011.766 www.jama.com

# ALGORITMO TERAPÉUTICO CARCINOMA DE OVARIO



# Variables que influyen en la cirugía citorreductora de inicio.




# Variables que influyen en la cirugía citorreductora de inicio

## EVIDENCIAS QUE RELACIONAN CAPACIDAD QUIRÚRGICA/RESECABILIDAD



1.- Kehoe S et al. The influence of the operating surgeons specialization on patient survival in ovarian carcinoma. *Br J Cancer* 1994; 70: 1014-7.

2.- Heintz APM et al. Cytorreductive surgery in ovarian carcinoma-feasibility and morbidity. *Obstet Gynecol* 1986; 67: 783-8.

3.- Hacker NF et al. Primary cytoreductive surgery for epithelial ovarian cancer. *Obstet Gynecol* 1983; 61:413-20.

# Cirugía

- El tratamiento inicial de un probable cáncer de ovario es una adecuada cirugía de estadificación y citorreducción, seguido en la mayoría de las pacientes, pero no en todas, de QT.
- La cirugía citorreductora es el tratamiento inicial para las pacientes en estadio II, III y IV.

# Cirugía


GCIG Prague 2010
On behalf of the Gynecologic Cancer Intergroup (GCIG)
4th Ovarian Cancer Consensus Conference
Co-Chairs
Gavin CE Stuart & Henry C Kitchener,
GYNECOLOGIC CANCER INTERGROUP
An Organization of International Cooperative Groups for Clinical Trials in Gynecologic Cancers

# Cirugía

Debe realizarse estadificación quirúrgica y debe hacerlo un cirujano experimentado

El objetivo final es la citorreducción de la enfermedad microscópica. Hay evidencia de que la reducción de la enfermedad macroscópica a <de 1 cms se asocia a beneficio.

El término “citorreducción óptima” debe reservarse para cuando no existe enfermedad residual macroscópica

La neoadyuvancia en estadio IIIC y IV es una opción.

# Cirugía

¿Hay que definir la extensión y el tipo de cirugía en estas pacientes en los ensayos de 1ª línea?

-Debe obtenerse tejido que confirme la presencia de carcinoma de ovario

-Debe estadificarse según FIGO, lo que incluye al menos una muestra ganglionar y la estadificación peritoneal en la enfermedad precoz (FIGO I-IIA)

-Debe realizarse el mayor esfuerzo posible en la citorreducción con el objetivo de no dejar enfermedad residual

-Si no es posible la cirugía citorreductora inicialmente, ésta debería considerarse en pacientes que tras 3-6 ciclos de QT no hayan progresado.

-Las pacientes con cáncer de ovario deben ser intervenidas por un cirujano con experiencia en cáncer de ovario.

Gynecologic Oncology 114 (2009) 26–31

Contents lists available at ScienceDirect

Gynecologic Oncology

journal homepage: www.elsevier.com/locate/ygyno

# Improved progression-free and overall survival in advanced ovarian cancer as a result of a change in surgical paradigm ☆

Dennis S. Chi [a,*], Eric L. Eisenhauer [a], Oliver Zivanovic [a], Yukio Sonoda [a], Nadeem R. Abu-Rustum [a], Douglas A. Levine [a], Matthew W. Guile [b], Robert E. Bristow [b], Carol Aghajanian [c], Richard R. Barakat [a]

[a] *Gynecology Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center, New York, NY 10065, USA*
[b] *Department of Obstetrics and Gynecology, Johns Hopkins Medical Center, Baltimore, MD 21287, USA*
[c] *Solid Tumor Service, Department of Medicine, Memorial Sloan-Kettering Cancer Center, New York, NY 10065, USA*

Gynecologic Oncology 114 (2009) 26–31

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Improved progr
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Dennis S. Chi [a,*], Eri
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Rustum [a],
R. Barakat [a]

[a] Gynecology Service, Department
[b] Department of Obstetrics and G
[c] Solid Tumor Service, Departmen

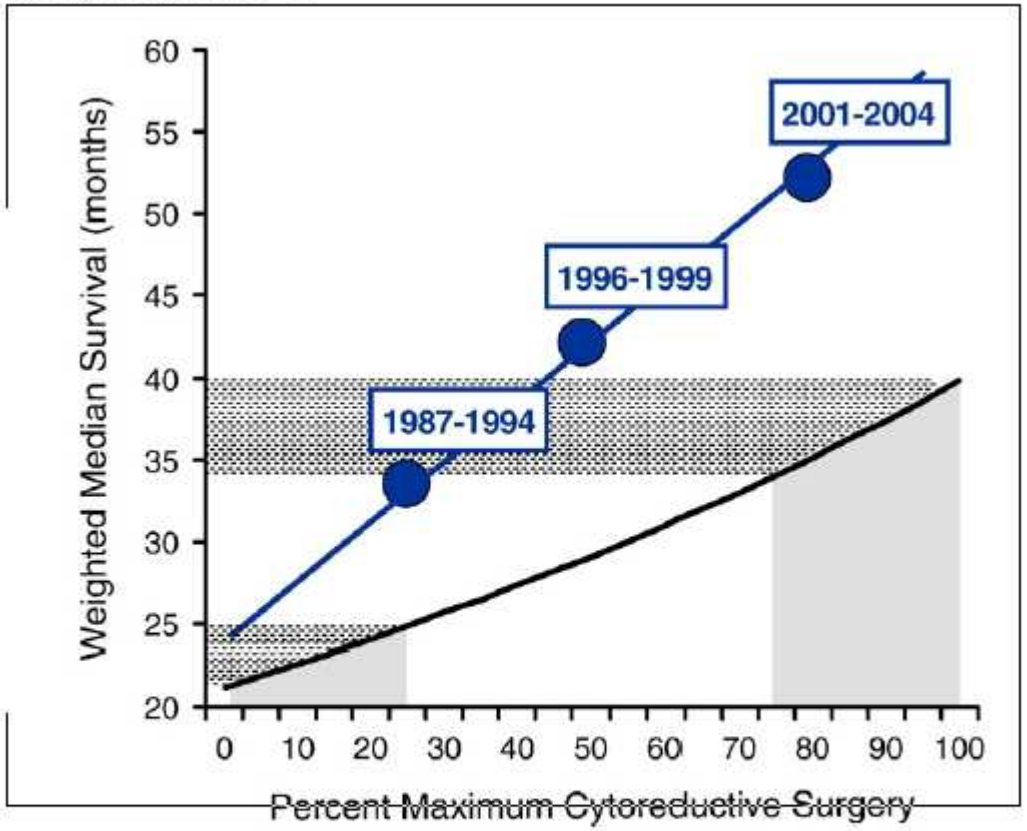


**Fig. 2.** Median overall survival as a function of percent maximum or optimal cytoreductive surgery. MSKCC survival 1987–2004 superimposed on model by Bristow et al. (Modified with permission Bristow RE, Tomacruz RS, Armstrong DK, et al: Survival effect of maximal cytoreductive surgery for advanced ovarian carcinoma during the platinum era: a meta-analysis. J Clin Oncol 20:1248–1259, 2002).

Gynecologic Oncology 114 (2009) 26–31

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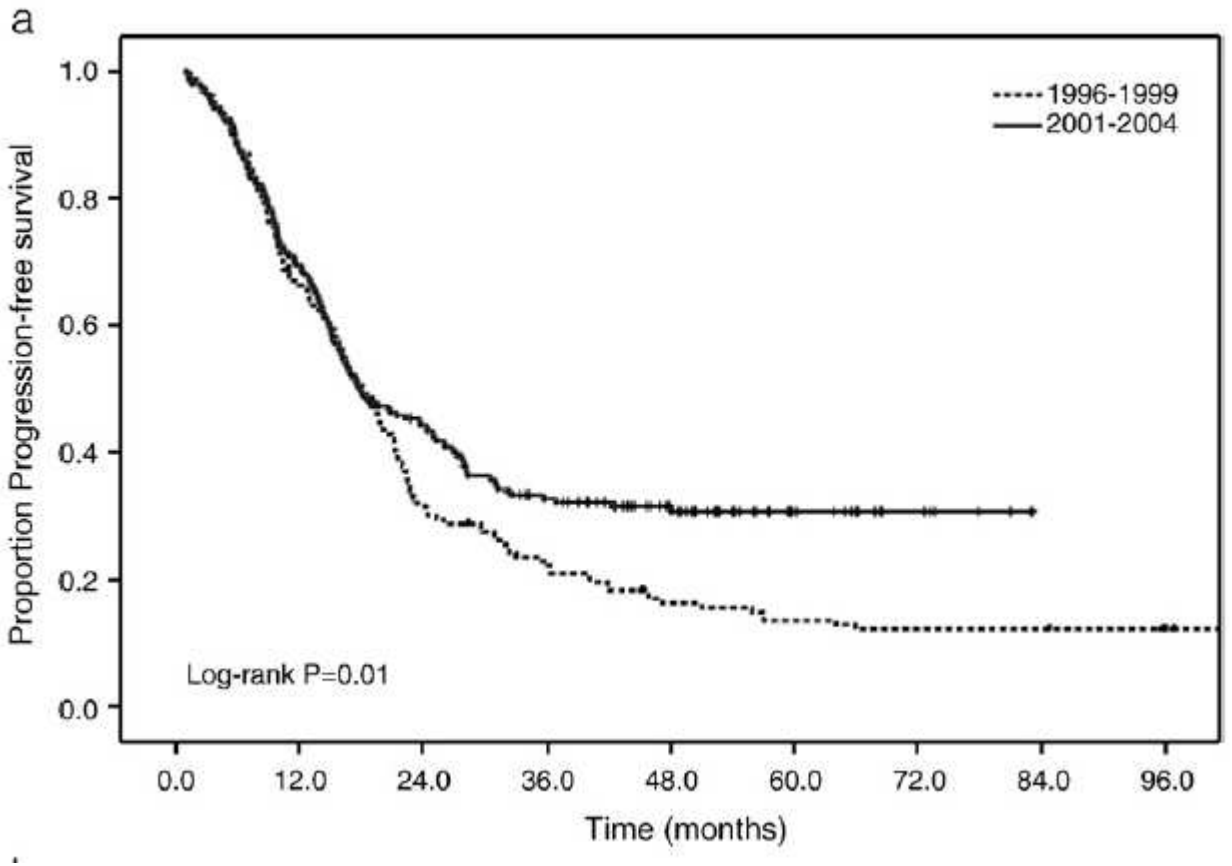


SVLP a 5 años: 31 *vs* 14%. HR: 0.75

Gynecologic Oncology 114 (2009) 26–31

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[b] Department of
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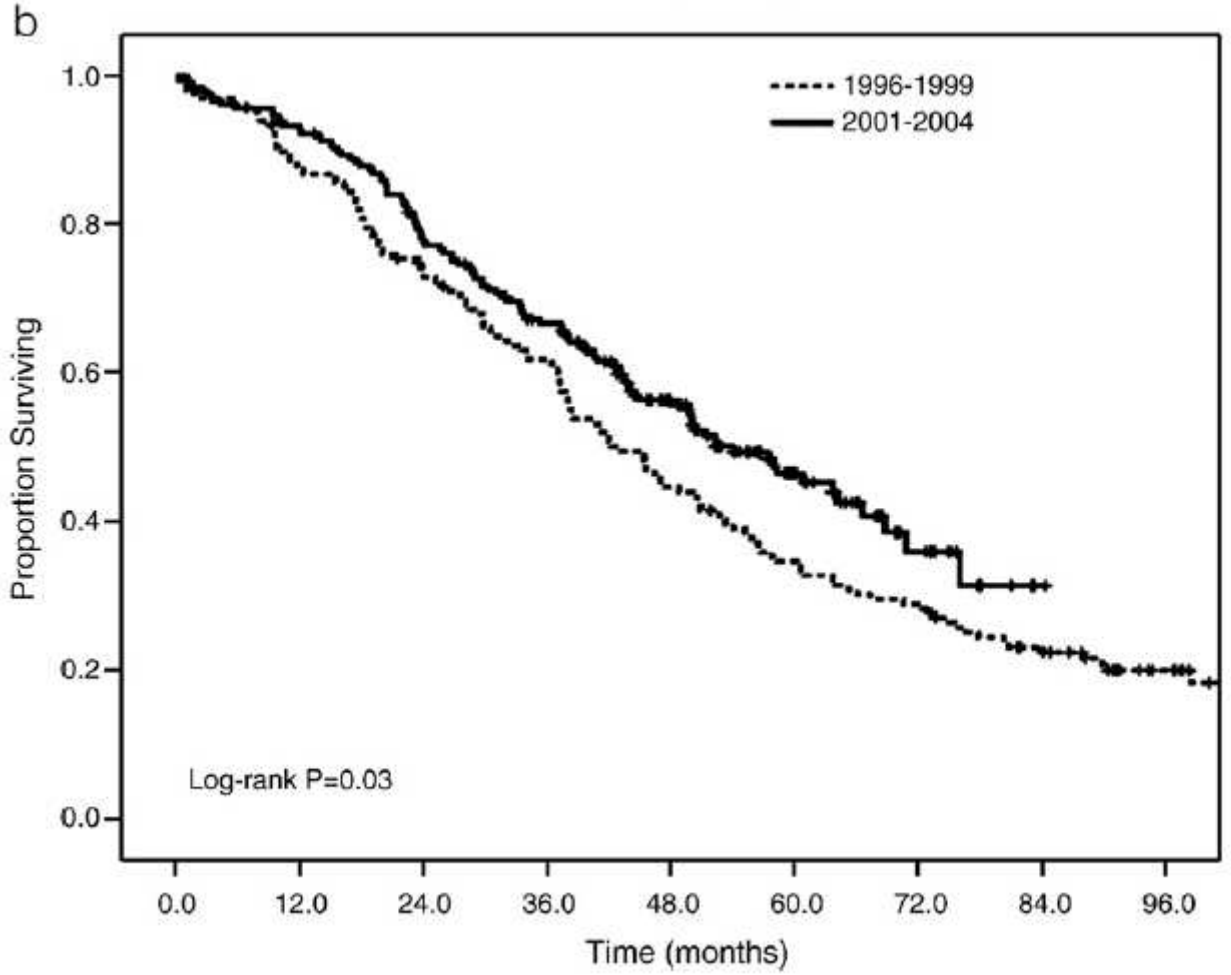
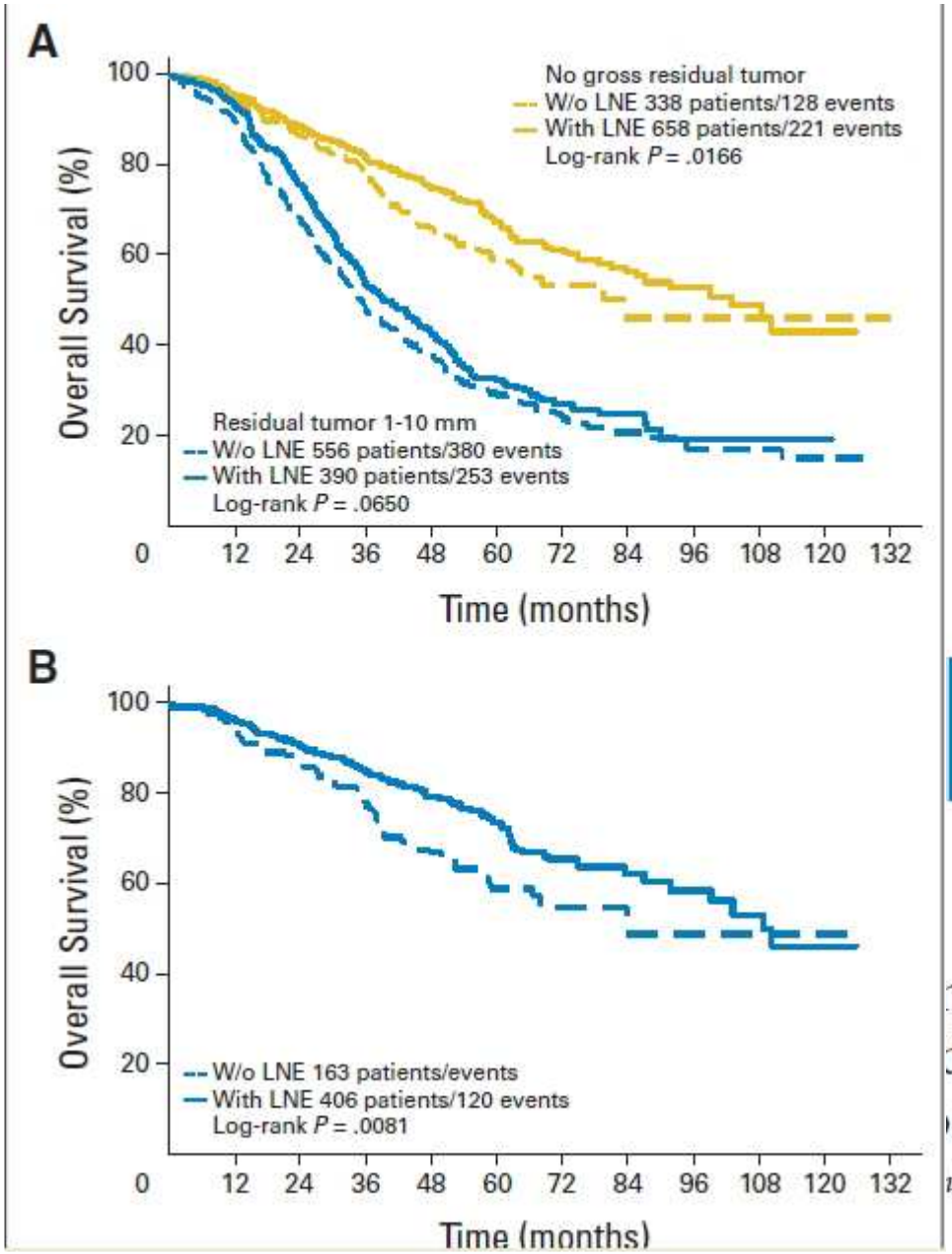



SG a 5 años: 47 *vs* 35%. HR: 0.76

# Cirugía

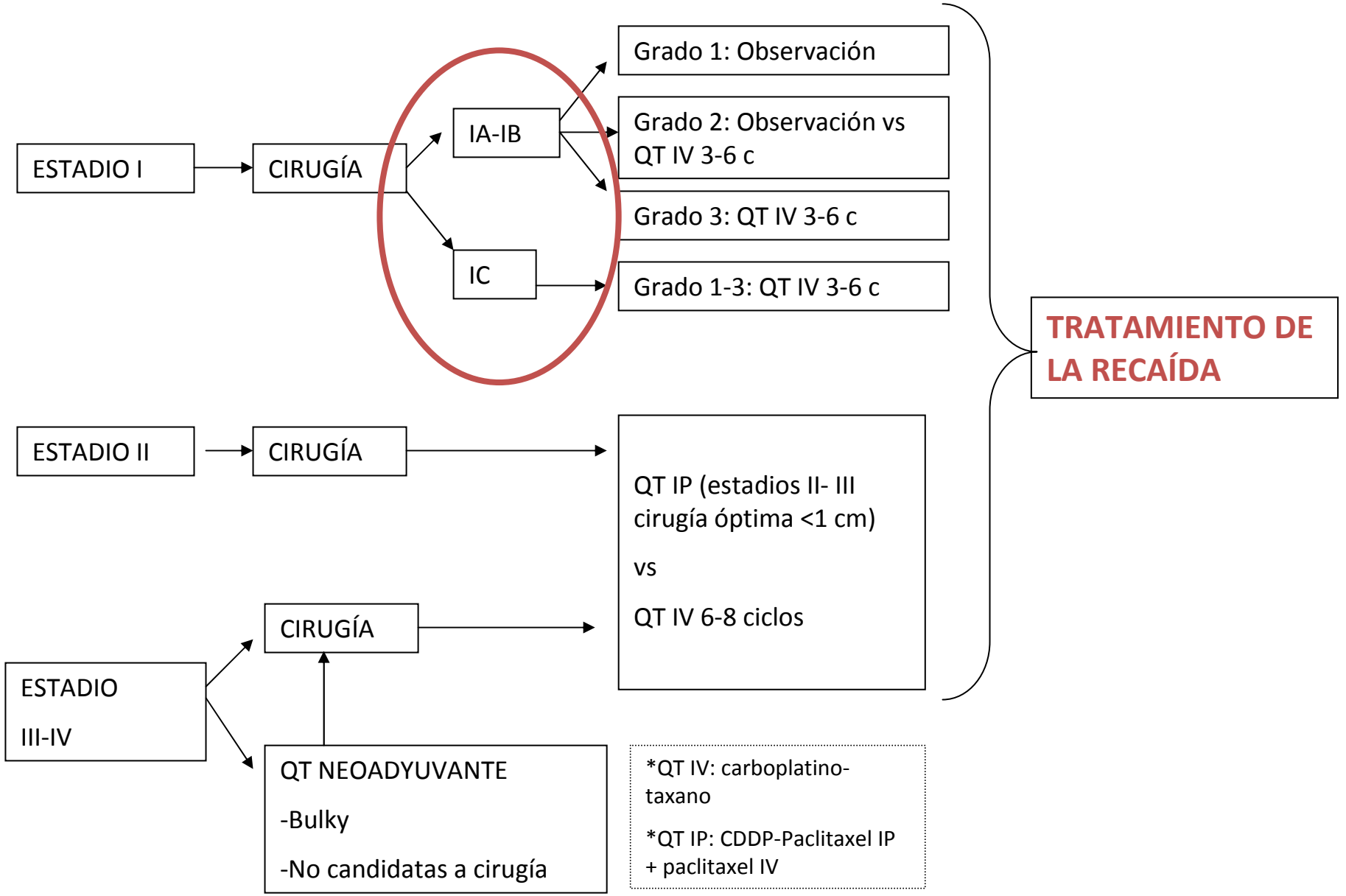



ORIGINAL REPORT

mphadenectomy in Advanced Ovarian
d Exploratory Analysis of Three
mized Phase III Multicenter Trials

*ilipp Harter, Eric Pujade-Lauraine, Isabelle Ray-Coquard,*

# ALGORITMO TERAPÉUTICO CARCINOMA DE OVARIO



# Adyuvancia Estadio I

The New England
Journal of Medicine



Volume 322 APRIL 12, 1990 Number 15

## ADJUVANT THERAPY IN STAGE I AND STAGE II EPITHELIAL OVARIAN CANCER

### Results of Two Prospective Randomized Trials

ROBERT C. YOUNG, M.D., LESLIE A. WALTON, M.D., SUSAN S. ELLENBERG, PH.D., HOWARD D. HOMESLEY, M.D., GEORGE D. WILBANKS, M.D., DAVID G. DECKER, M.D., ALEXANDER MILLER, M.D., ROBERT PARK, M.D., AND FRANCIS MAJOR, JR., M.D.

# Adyuvancia Estadio I

**Adjuvant (post-surgery) chemotherapy for early stage epithelial ovarian cancer (Review)**

Winter-Roach BA, Kitchener HC, Dickinson HO

THE COCHRANE COLLABORATION®

# Adyuvancia Estadio I

Las mujeres que reciben QT adyuvante basada en platino tiene mejor SG y SVLP que las que no lo hacen: HR respectivos de 0.71 y de 0.67

Subgrupos:

Cirugía óptima no parece haber beneficio; sí lo hay si cirugía subóptima (HR para SG de 1.22 y de 0.63 respectivamente)

Bajo riesgo no parece haber beneficio; sí lo hay si alto riesgo (HR para SG de 0.95 y de 0.48 respectivamente)

**CONCLUSIÓN**: Parece seguro no ofrecer QT adyuvante a las mujeres con cirugía adecuada y tumores bien diferenciados.

# Adyuvancia Estadio I

Acta Oncol. 2001;40(2-3):340-60.

**A systematic overview of chemotherapy effects in ovarian cancer.**

Högberg T[1], Glimelius B, Nygren P; SBU-group. Swedish Council of Technology Assessment in Health Care.

**Author information**

**Abstract**

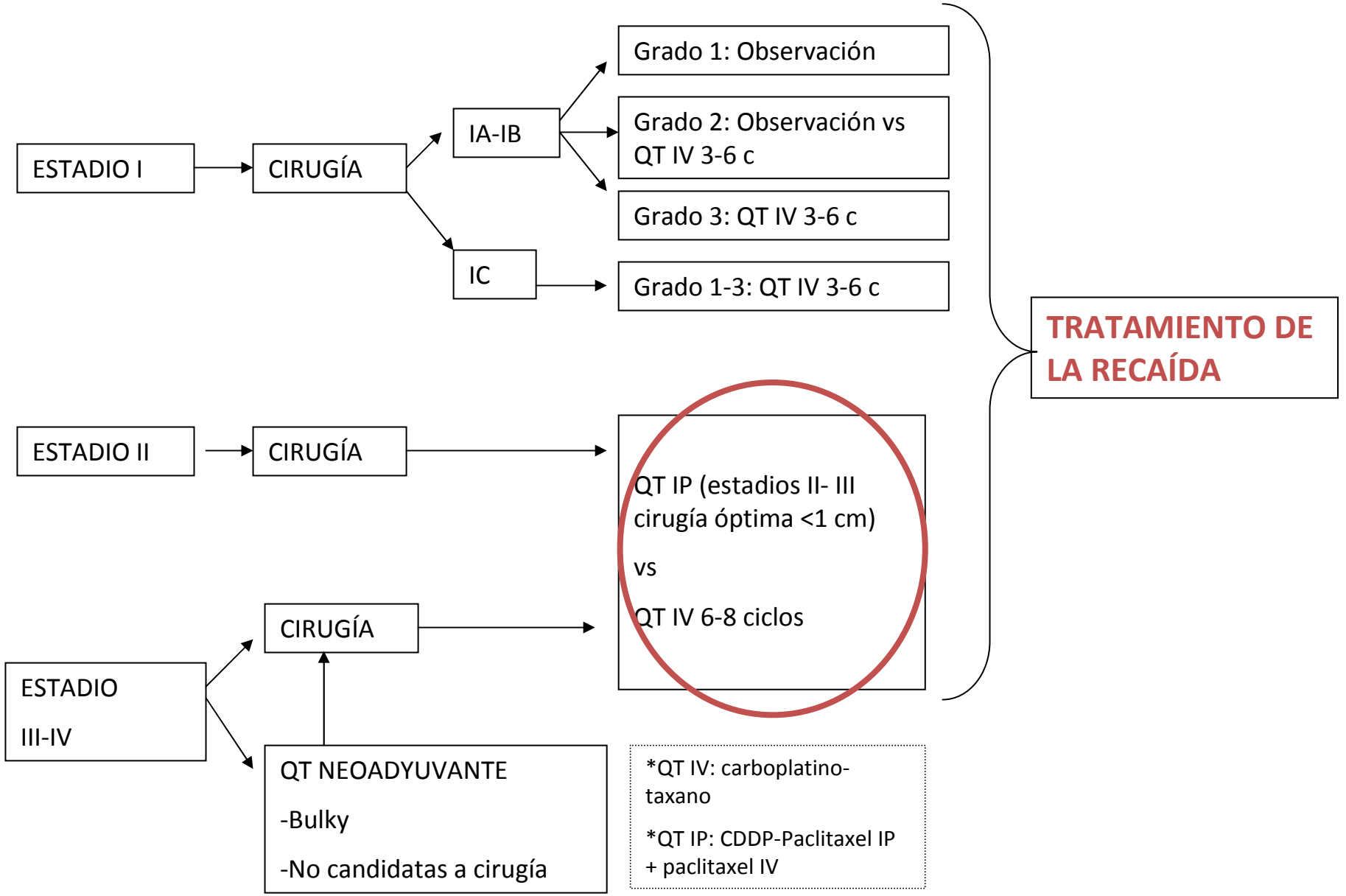
A systematic review of chemotherapy trials in several tumour types was performed by The Swedish Council of Technology Assessment in Health

Más de 33000 pacientes

Pacientes de bajo riesgo con cirugía radical: estadios IA o IB no células claras, bien diferenciados): no adyuvancia

Pacientes de alto riesgo con cirugía radical: células claras, estadios IA o IB moderadamente o mal diferenciados y IC: Planteable la adyuvancia

# ALGORITMO TERAPÉUTICO CARCINOMA DE OVARIO



# Adyuvancia Estadios II y III

Estadios II: se acepta ofrecer QT IP, aunque no hay ensayos que demuestren impacto en SV.

Estadios III: QT IP e IV vs QT iv.

# Adyuvancia

Si se consigue enfermedad mínima residual tras cirugía citorreductora, las pacientes pueden ser candidatas a QT intraperitoneal

The NEW ENGLAND JOURNAL of MEDICINE

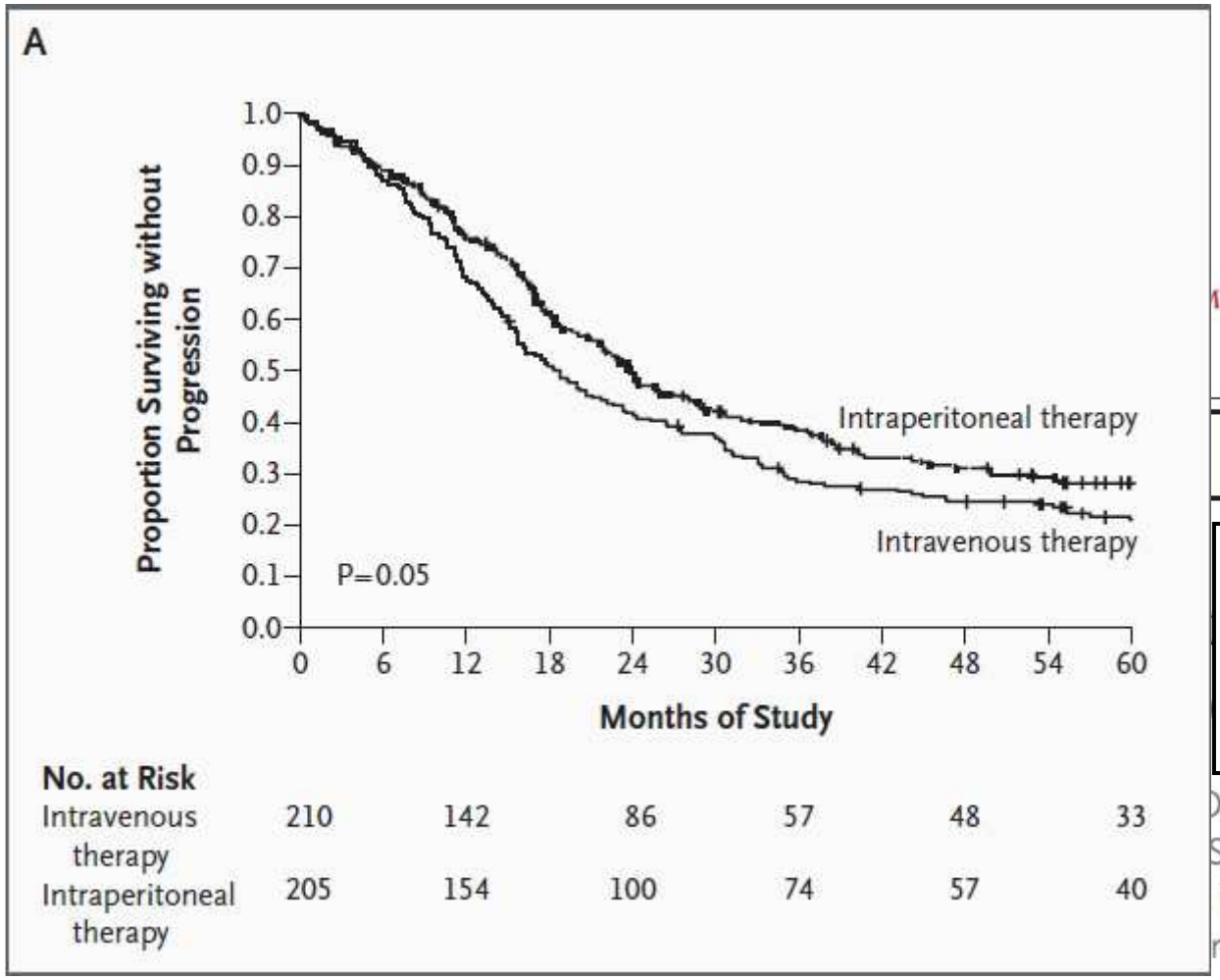
ORIGINAL ARTICLE

## Intraperitoneal Cisplatin and Paclitaxel in Ovarian Cancer

Deborah K. Armstrong, M.D., Brian Bundy, Ph.D., Lari Wenzel, Ph.D., Helen Q. Huang, M.S., Rebecca Baergen, M.D., Shashikant Lele, M.D., Larry J. Copeland, M.D., Joan L. Walker, M.D., and Robert A. Burger, M.D., for the Gynecologic Oncology Group*

ABSTRACT

# Adyuvancia




MEDICINE

Mediana de SVLP:

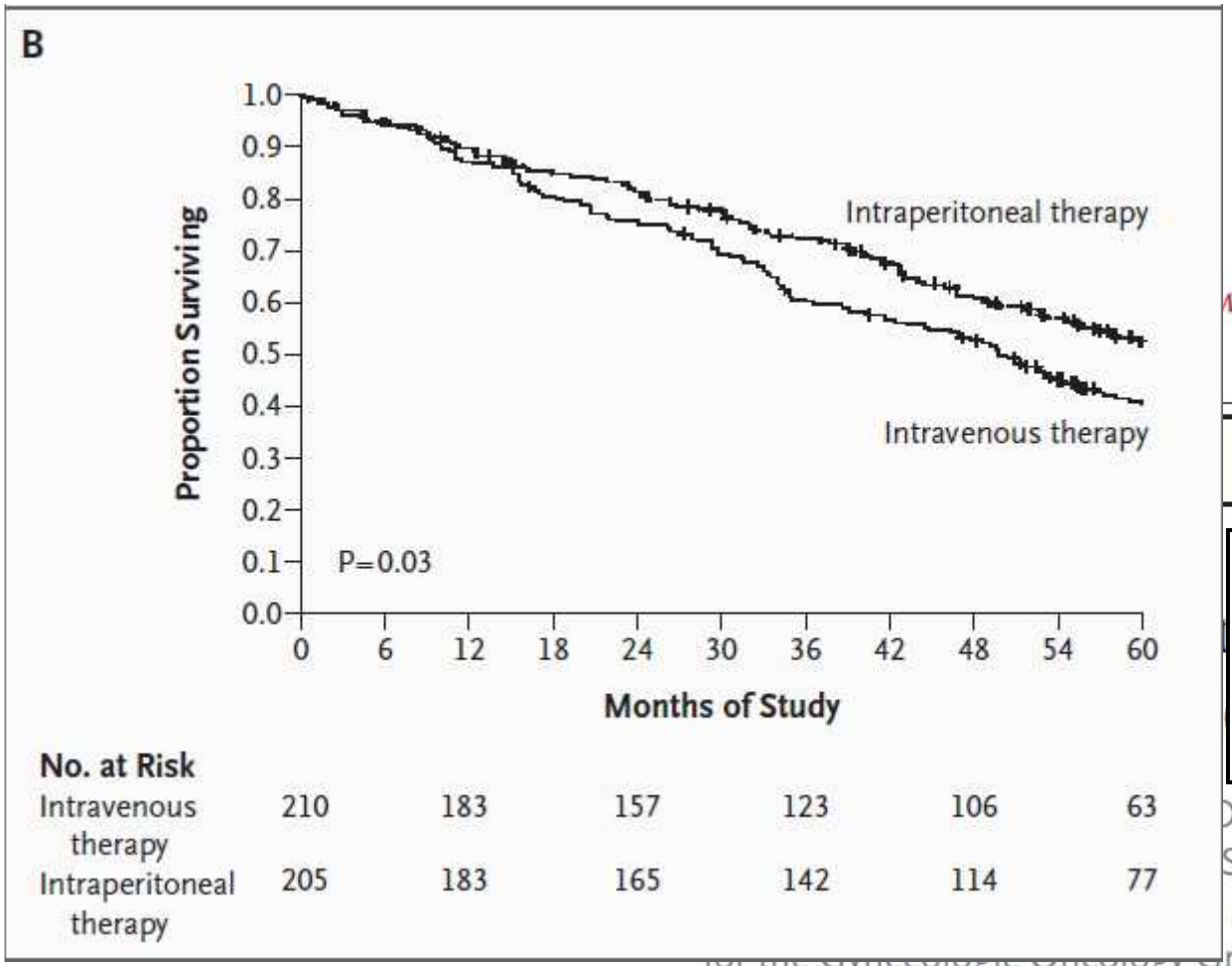
18.3 *vs* 23.8 meses

p=0.005

D., Lari Wenzel, Ph.D.,
Shashikant Lele, M.D.,
Robert A. Burger, M.D.,
roup*

ABSTRACT

# Adyuvancia




MEDICINE

Mediana de SG:

49.7 *vs* 65.6 meses

p=0.03

D., Lari Wenzel, Ph.D.,
Shashikant Lele, M.D.,
Robert A. Burger, M.D.,
for the Gynecologic Oncology Group*

ABSTRACT

# Adyuvancia

Mediana de SVLP:

18.3 *vs* 23.8 meses

p=0.005

Mediana de SG:

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p=0.03

The NEW ENGLAND JOURNAL of MEDICINE

**Empeora calidad de vida. Sólo el 42% completa la QT programada**

## Intraperitoneal Cisplatin and Paclitaxel in Ovarian Cancer

Deborah K. Armstrong, M.D., Brian Bundy, Ph.D., Lari Wenzel, Ph.D., Helen Q. Huang, M.S., Rebecca Baergen, M.D., Shashikant Lele, M.D., Larry J. Copeland, M.D., Joan L. Walker, M.D., and Robert A. Burger, M.D., for the Gynecologic Oncology Group*

ABSTRACT

# Adyuvancia

## Phase III Trial of Carboplatin and Paclitaxel Compared With Cisplatin and Paclitaxel in Patients With Optimally Resected Stage III Ovarian Cancer: A Gynecologic Oncology Group Study

By Robert F. Ozols, Brian N. Bundy, Benjamin E. Greer, Jeffrey M. Fowler, Daniel Clarke-Pearson, Robert A. Burger, Robert S. Mannel, Koen DeGeest, Ellen M. Hartenbach, and Rebecca Baergen

*Purpose:* In randomized trials the combination of cisplatin and paclitaxel was superior to cisplatin and cyclophosphamide in advanced-stage epithelial ovarian cancer. Although in nonrandomized trials, carboplatin and paclitaxel was a less toxic and highly active combination regimen, there remained concern regarding its efficacy in patients with small-volume, resected, stage III disease. Thus, we conducted a noninferiority trial of cisplatin and paclitaxel versus carboplatin and paclitaxel in this population.

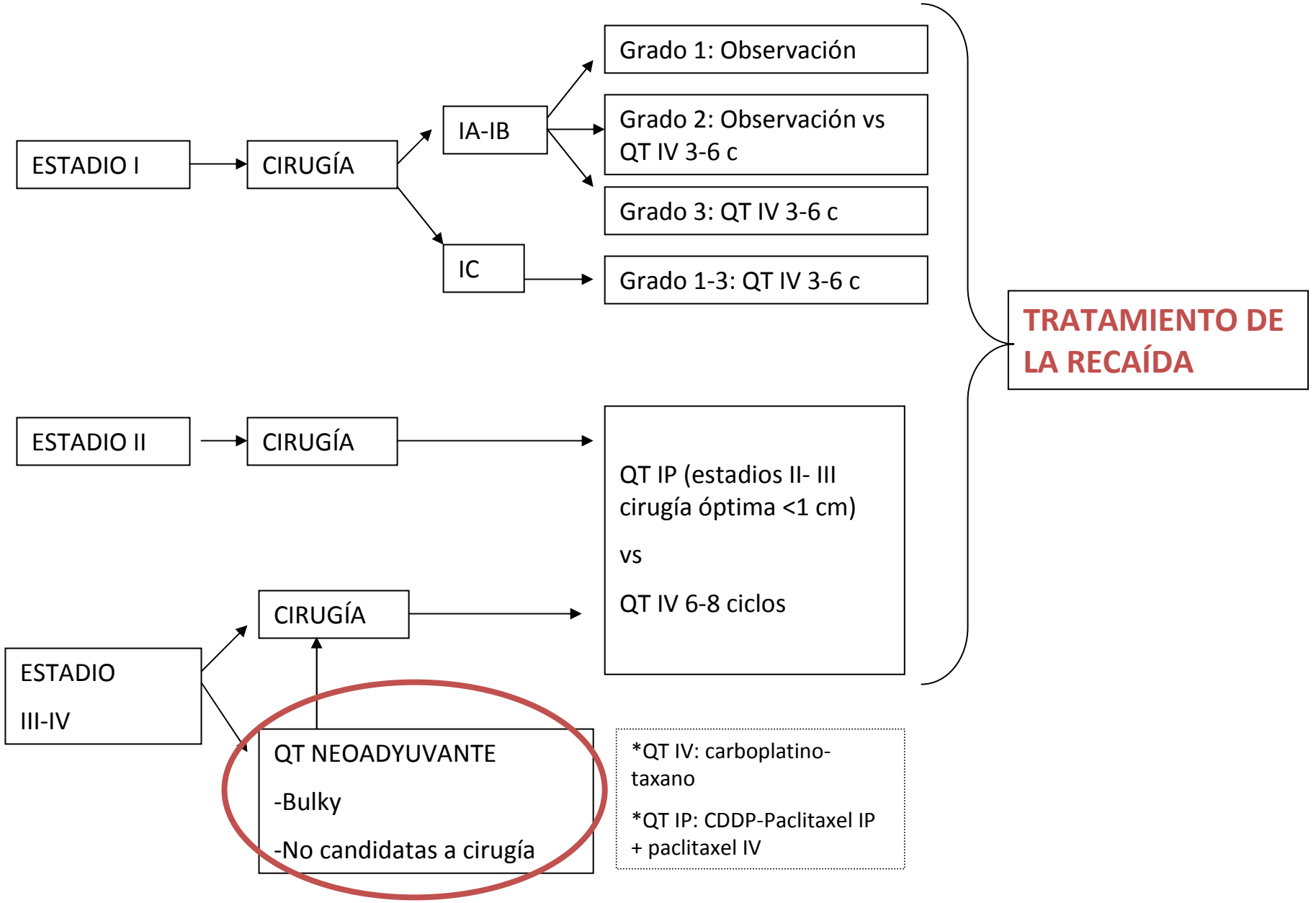
*Patients and Methods:* Patients with advanced ovarian cancer and no residual mass greater than 1.0 cm after surgery were randomly assigned to receive cisplatin 75 mg/m$^2$ plus a 24-hour infusion of paclitaxel 135 mg/m$^2$ (arm I), or carboplatin area under the curve 7.5 intravenously plus paclitaxel 175 mg/m$^2$ over 3 hours (arm II).

*Results:* Seven hundred ninety-two eligible patients were enrolled onto the study. Prognostic factors were similar in the two treatment groups. Gastrointestinal, renal, and metabolic toxicity, as well as grade 4 leukopenia, were significantly more frequent in arm I. Grade 2 or greater thrombocytopenia was more common in arm II. Neurologic toxicity was similar in both regimens. Median progression-free survival and overall survival were 19.4 and 48.7 months, respectively, for arm I compared with 20.7 and 57.4 months, respectively, for arm II. The relative risk (RR) of progression for the carboplatin plus paclitaxel group was 0.88 (95% confidence interval [CI], 0.75 to 1.03) and the RR of death was 0.84 (95% CI, 0.70 to 1.02).

*Conclusion:* In patients with advanced ovarian cancer, a chemotherapy regimen consisting of carboplatin plus paclitaxel results in less toxicity, is easier to administer, and is not inferior, when compared with cisplatin plus paclitaxel.

*J Clin Oncol 21:3194-3200.* 

# ALGORITMO TERAPÉUTICO CARCINOMA DE OVARIO



# Neoadyuvancia

Sigue siendo controvertida. Planteable en estadios III-IV bulky.

The NEW ENGLAND JOURNAL of MEDICINE

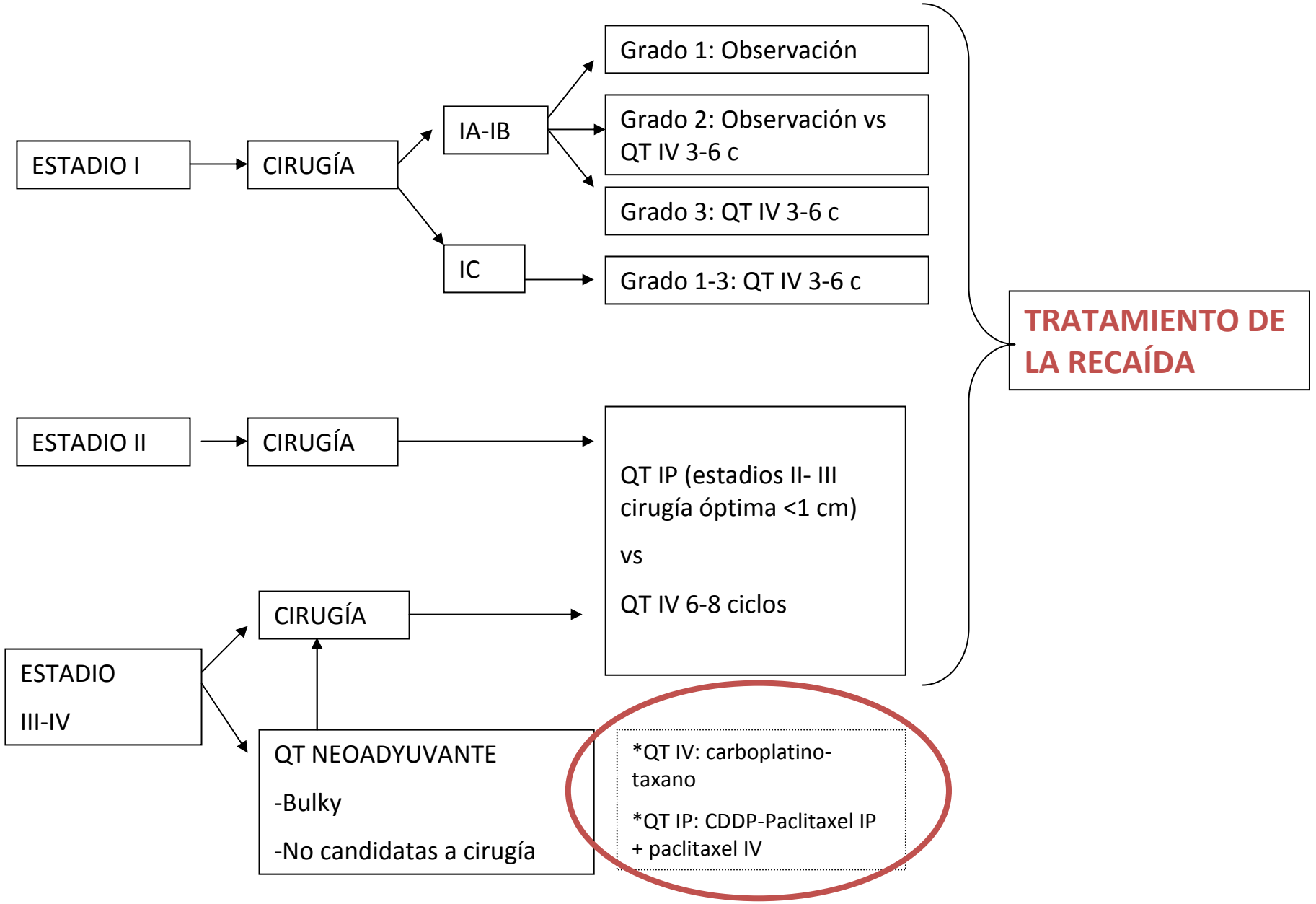
ORIGINAL ARTICLE

1.15). Complete resection of all macroscopic disease (at primary or interval surgery) was the strongest independent variable in predicting overall survival.

**CONCLUSIONS**

Neoadjuvant chemotherapy followed by interval debulking surgery was not inferior to primary debulking surgery followed by chemotherapy as a treatment option for patients with bulky stage IIIC or IV ovarian carcinoma in this study. Complete resection of all macroscopic disease, whether performed as primary treatment or after neoadjuvant chemotherapy, remains the objective whenever cytoreductive surgery is performed. (Funded by the National Cancer Institute; ClinicalTrials.gov number, NCT00003636.)

# ALGORITMO TERAPÉUTICO CARCINOMA DE OVARIO



# Cáncer de ovario avanzado

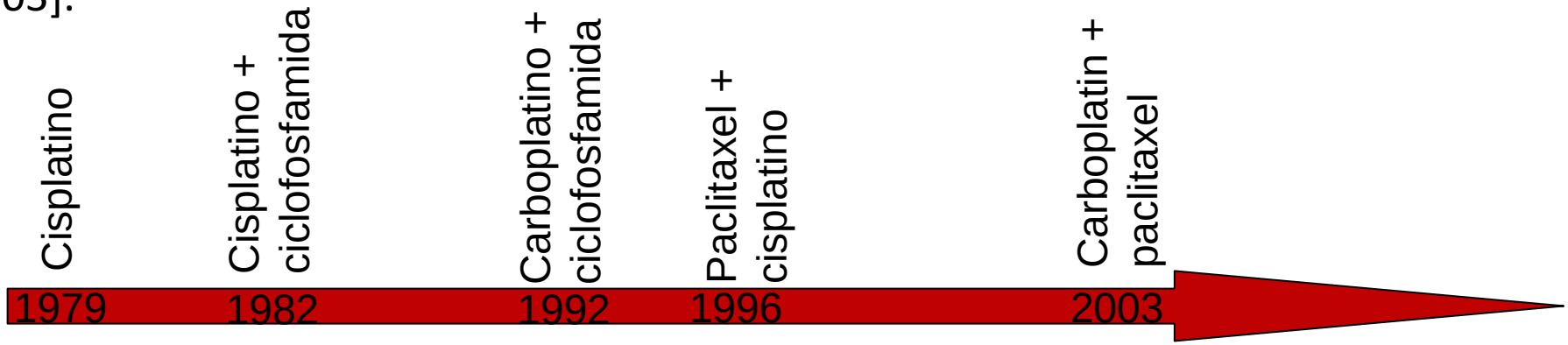
Cisplatino como QT activo en cáncer de ovario avanzado o recurrente. Respuestas del 13-30% [Rossof et al. 1979; Thigpen et al.1979].

Cisplatino + ciclofosfamida [Decker et al. 1982].

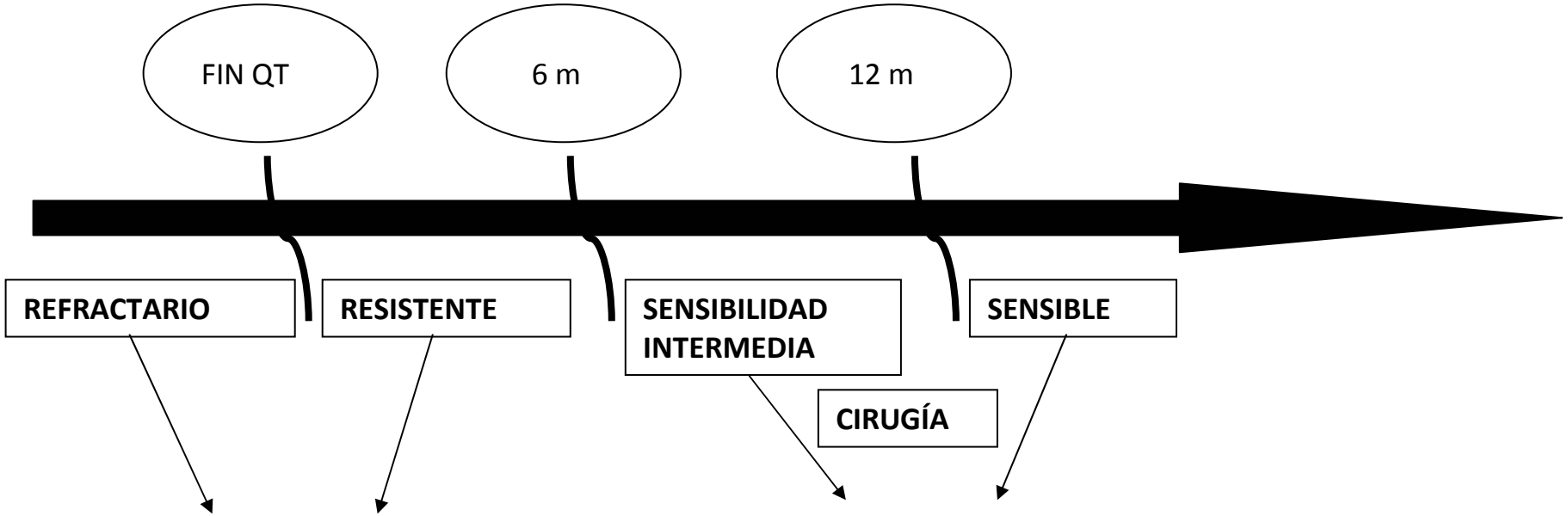
Cisplatino + ciclofosfamida *vs* carboplatino + ciclofosfamida [Alberts et al. 1992].

Paclitaxel + cisplatino vs cisplatino + ciclofosfamida [Piccart et al. 2000; McGuire et al. 1996].

Cisplatino + paclitaxel *vs* carboplatin + paclitaxel [Ozols et al. 2003; du Bois et al. 2003].



# TRATAMIENTO DE LA RECAÍDA




**MONOTERAPIA**

-Gemcitabina

-Topotecan

-DLP

-Trabectedina

-Bevacizumab

-Nuevas moléculas

**COMBINACIÓN FÁRMACOS**

-Carboplatino-paclitaxel

-Carboplatino-gemcitabina

-Carboplatino-DLP

-DLP-trabectedina

# TRATAMIENTO DE LA RECAÍDA

- Cirugía con intención citorreductora

# TRATAMIENTO DE LA RECAÍDA

- Cirugía con intención citorreductora

ELSEVIER

Gynecologic Oncology 112 (2009) 265–274

www.elsevier.com/locate/ygyno

Review

## Cytoreductive surgery for recurrent ovarian cancer: A meta-analysis

Robert E. Bristow [a,*], Isha Puri [a], Dennis S. Chi [b]

[a] *The Kelly Gynecologic Oncology Service, Departments of Gynecology and Obstetrics and Oncology, The Sidney Kimmel Comprehensive Cancer Center, The Johns Hopkins Medical Institutions, 600 North Wolfe Street, Phipps #281, Baltimore, Maryland 21287, USA*

[b] *Gynecology Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center, New York, New York, USA*

Received 29 July 2008

Available online 19 October 2008

- Con impacto en SG tras recaída

# TRATAMIENTO DE LA RECAÍDA

- Cirugía con intención citorreductora + HIPEC

Gynecologic Oncology 127 (2012) 502–505

Contents lists available at SciVerse ScienceDirect

Gynecologic Oncology

journal homepage: www.elsevier.com/locate/ygyno

Cytoreductive surgery plus HIPEC in platinum-sensitive recurrent ovarian cancer patients: A case–control study on survival in patients with two year follow-up

Anna Fagotti [a,*], Barbara Costantini [a], Marco Petrillo [a], Giuseppe Vizzielli [a], Francesco Fanfani [a], Pasquale Alessandro Margariti [a], Luigi Carlo Turco [a], Elisa Piovano [a,b], Giovanni Scambia [a]

- Con impacto en SG tras recaída

# TRATAMIENTO DE LA RECAÍDA

- Cirugía con intención citorreductora + HIPEC

Ann Surg Oncol
DOI 10.1245/s10434-014-3599-4

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ORIGINAL ARTICLE – GYNECOLOGIC ONCOLOGY

**Treatment of Microscopic Disease with Hyperthermic Intraoperative Intraperitoneal Chemotherapy After Complete Cytoreduction Improves Disease-Free Survival in Patients with Stage IIIC/IV Ovarian Cancer**

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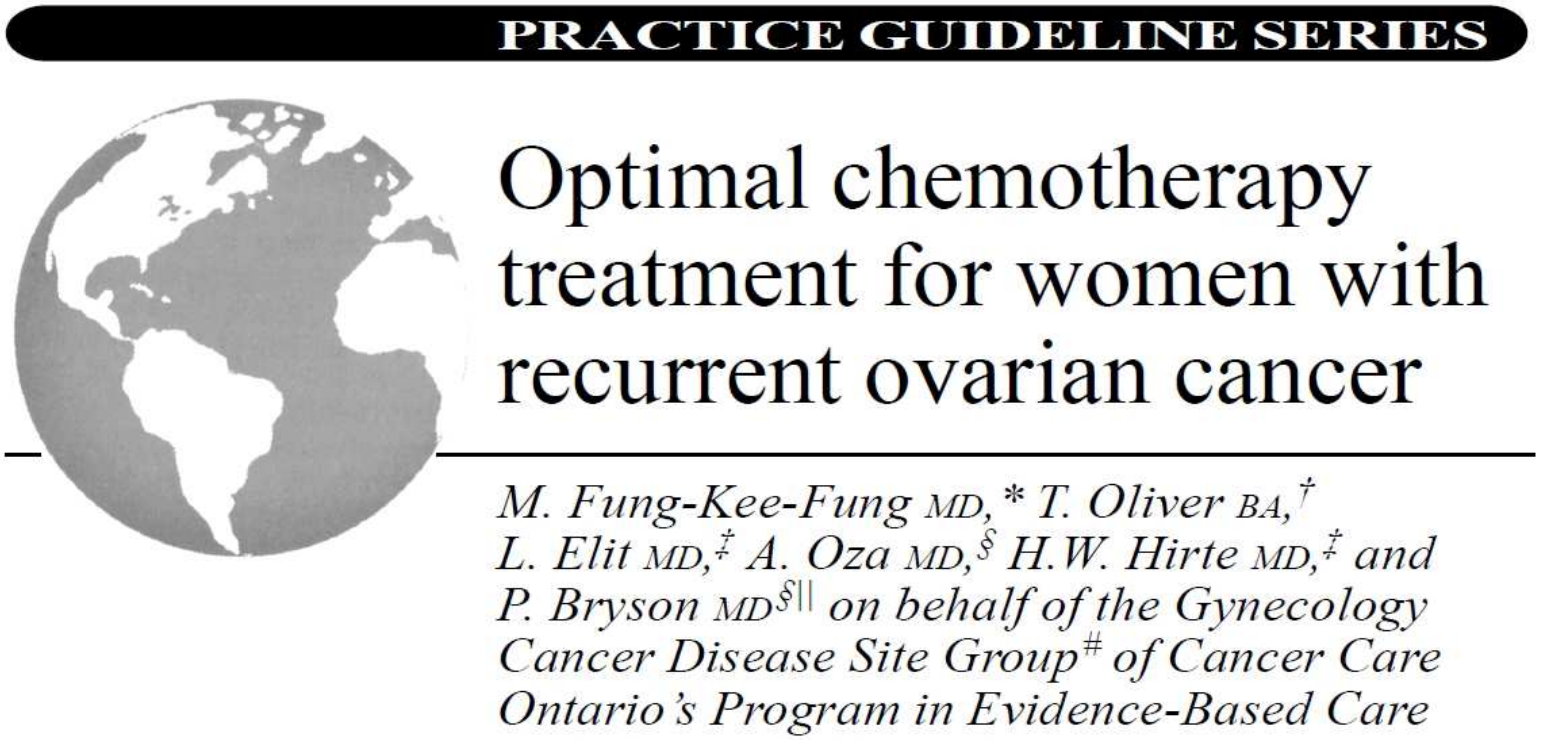
- Con impacto en SG tras recaída

# TRATAMIENTO DE LA RECAÍDA

- QT



### ACCEPTABLE RECURRENCE THERAPIES (1 OF 2)†

| Agents | Cytotoxic Therapy | Hormonal Therapy | Targeted Therapy | Radiation Therapy |
|---|---|---|---|---|
| Preferred Agents | <u>Combination if platinum sensitive</u> ‡ ¶<br>Carboplatin/paclitaxel (category 1)[1]<br>Carboplatin/weekly paclitaxel[2]<br>Carboplatin/docetaxel[3,4]<br>Carboplatin/gemcitabine[5]<br>Carboplatin/gemcitabine/bevacizumab* (category 2B)[6]<br>Carboplatin/liposomal doxorubicin[7]<br>Cisplatin/gemcitabine[8]<br><u>Single-agent if platinum sensitive</u><br>Carboplatin[5]<br>Cisplatin[1]<br><u>Single-agent non-platinum-based if platinum resistant</u><br>Docetaxel[9]<br>Etoposide, oral[10]<br>Gemcitabine[11,12]<br>Liposomal doxorubicin[11,12]<br>Paclitaxel, weekly[13]<br>Topotecan[14,15] | | Bevacizumab[16,17] | |
| Other Potentially Active Agents | <u>Single agents</u>[18]<br>Altretamine<br>Capecitabine<br>Cyclophosphamide<br>Doxorubicin<br>Ifosfamide<br>Irinotecan<br>Melphalan<br>Oxaliplatin<br>Paclitaxel<br>Paclitaxel, albumin bound (nab-paclitaxel)<br>Pemetrexed<br>Vinorelbine | Anastrozole<br>Letrozole<br>Leuprolide acetate<br>Megestrol acetate<br>Tamoxifen | | Palliative localized radiation therapy |

†Patients who progress on two consecutive therapy regimens without evidence of clinical benefits have diminished likelihood of benefitting from additional therapy. (Griffiths RW, et al. Outcomes after multiple lines of chemotherapy for platinum-resistant epithelial cancers of the ovary, peritoneum, and Fallopian tube. Int J Gyn Ca 2011;21:58-65.) Decisions to offer clinical trials, supportive care, or additional therapy should be made on a highly individual basis.

‡In general, the Panel would recommend combination regimens based on randomized trial data, especially in first relapses.
*In patients who have not previously received bevacizumab.
¶Platinum-based combination therapy should be considered for platinum-sensitive recurrences.

See References (OV-D 2 of 2)

**Note: All recommendations are category 2A unless otherwise indicated.**
**Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.**

# Tratamiento tras la recaída

# Tratamiento tras la recaída

¿Cuál es el impacto del tratamiento de la recurrencia sobre los objetivos en la primera línea de tratamiento?

-Hay un impacto del tratamiento de la recaída en la SG

¿Debemos normalizar el tratamiento de la recaída, o si no, cómo podemos determinar su impacto en la SV?

-No es posible normalizar el tratamiento de la recaída actualmente

**Aunque la SG es un objetivo importante, la SVLP puede preferirse debido al impacto de tratamientos posteriores en la SG.**

# Objetivos

## Cuáles debieran ser los objetivos de los ensayos:

Fase II que buscan actividad: respuestas

Fase III:

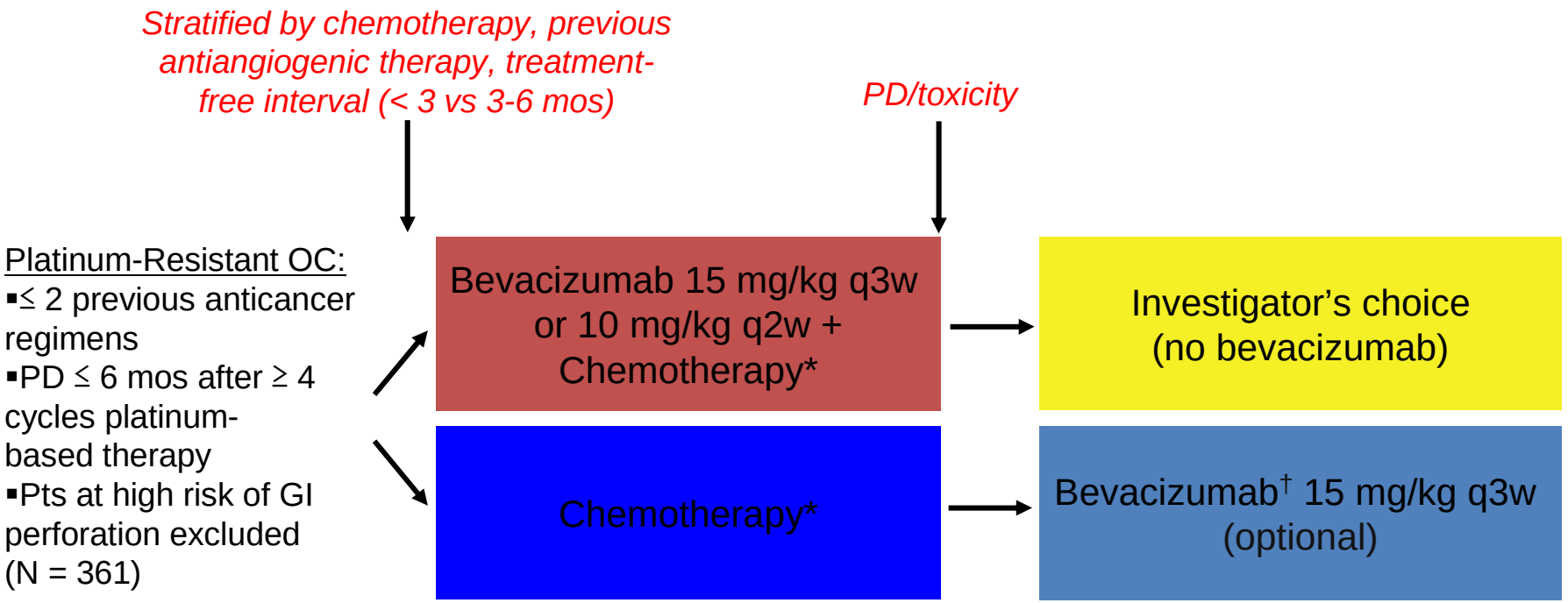
- Cáncer de ovario inicial: SVLP
- Cáncer de ovario avanzado 1ª y 2ª Línea: SG y SVLP
- Mantenimiento tras 1ª línea: SG

Ensayos postrecurrencia/progresión:

- Control de síntomas, calidad de vida, SG, SVLP

# AURELIA: Bevacizumab + QT en cáncer de ovario recurrente, platino resistente

- Ensayo randomizado Fase III




*Investigator's choice: paclitaxel 80 mg/m$^2$ Days 1, 8, 15, and 22 q4w; topotecan 4 mg/m$^2$ Days 1, 8, and 15 q4w (or 1.25 mg/m$^2$ Days 1-5 q3w); PLD 40 mg/m$^2$ Day 1 q4w.
†Permitted on clear evidence of PD.

Pujade-Lauraine E, et al. ASCO 2012. Abstract LBA5002.

# AURELIA: Características iniciales

| Characteristic | Bevacizumab + CT (n = 179) | CT (n = 182) |
|---|---|---|
| Median age, yrs (range) | 62 (25-80) | 61 (25-84) |
| ECOG PS 0, % | 60 | 54 |
| Primary ovarian cancer, % | 93 | 86 |
| Serous/adenocarcinoma at diagnosis, % | 87 | 84 |
| Grade 2/3 histology at diagnosis, % | 82 | 84 |
| Previous antiangiogenic therapy, | 7 | 8 |
| PFI < 3 mos, % | 28 | 25 |
| Measurable disease, % | 80 | 79 |
| Ascites, % | 34 | 30 |

Pujade-Lauraine E, et al. ASCO 2012. Abstract LBA5002. Reproduced with permission.

# AURELIA: Eficacia y seguridad

| Outcome | Bevacizumab + CT (n = 179) | CT (n = 182) | HR (95% CI) | *P* Value |
|---|---|---|---|---|
| Median PFS, mos* | 6.7 | 3.4 | 0.48 (0.38-0.60) | < .001 |
| ORR, % | 30.9 | 12.6 | - | < .001 |

*Primary endpoint.

- PFS (301 events) consistent across subgroups: age, PFI, measurable disease, ascites, CT
- OS data expected in 2013
- Bevacizumab safety profile consistent with previous reports
  - Grade ≥ 3 AEs of special interest in bevacizumab + CT arm: hypertension (7.3%), proteinuria (1.7%), GI perforation (1.7%), fistula/abscess (1.1%), bleeding (1.1%), thromboembolic event (5.0%), wound-healing complication (0%), RPLS (0.6%), CHF (0.6%), cardiac disorders (excluding CHF [0%])

Pujade-Lauraine E, et al. ASCO 2012. Abstract LBA5002.

# AURELIA: Implicaciones clínicas

- Cuarto estudio que demuestra que bevacizumab, junto con QT prolonga las SVLP en cáncer de ovario
- Es el primer fase III en pacientes con cáncer de ovario platino resistente que logra el objetivo primario
- Bevacizumab tiene aún que demostrar un beneficio en la SG en cáncer de ovario
- ¿Es mejor usar bevacizumab en 1ª línea, en recurrencia o en ambos?
- Cómo tratamos a los pacientes que ya han usado bevacizumab?

Pujade-Lauraine E, et al. ASCO 2012. Abstract LBA5002.

# Conclusiones

# El caso de Ana

45 años masa abdominal.

Cirugía no adecuada

Se reinterviene Resección con lesión macroscópica

Taxol-Carbo x4- Cirugía Taxol-Carbo x4-

Recaída mayor de 6 meses: adenopatías retroperitoneales: Nueva cirugía con HIPEC

Taxol-Carbo x 6

Recaída mayor de 6 meses: adenopatías retroperitoneales: RT

Recaída mayor de 6 meses: Taxol Carbo x 6, en RC tras 5

# Conclusiones