Navigating the Complicated World of Advanced Breast and Ovarian Cancer

Tuesday, May 23, 2017

To listen to the presentation by phone,
Dial: 888-632-3384
Code: SHARSHERET
WELCOME

Shera Dubitsky, MEd, MA
Director of Navigation and Support Services
Sharsheret

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WHO WE ARE

Sharsheret supports young Jewish women and families facing breast and ovarian cancer at every stage. We help you connect to our community whatever your personal background, stage of life, genetic risk, diagnosis, or treatment.

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Women with advanced breast cancer are surviving longer, study says
EMBRACE PROGRAM

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Navigating Advanced Cancer

Advanced or Metastatic Breast Cancer

Adam Brufsky, MD, PhD, FACP
Associate Chief, Hematology/Oncology
Director, Breast Cancer Program
University of Pittsburgh

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The Latest in Breast Cancer Therapy

Adam Brufsky, MD, PhD
Associate Chief, Hematology/Oncology
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Breast Cancer: Background

• Leading cause of cancer for women
  – 2017: estimated new cases of invasive breast cancer is about 250,000

• Second leading cause of cancer death in women
  – Estimated 40,000 deaths in 2017

• Biology is main driver of treatment

• Goal is to provide a more tailored individualized approach by targeting dysregulated pathways

Metastatic Breast Cancer: What’s new?

- Bones and metastatic breast cancer
- BRCA associated breast cancer
- New agents: palbociclib
- New agents: immunotherapy

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# Metastatic Bone Disease Is Prevalent

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>5-y World Prevalence, Thousands</th>
<th>Proportion Developing Metastases</th>
<th>Incidence of Bone Metastases in Advanced Cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal</td>
<td>586</td>
<td>60%</td>
<td>20–25</td>
</tr>
<tr>
<td>Melanoma</td>
<td>643</td>
<td>20%</td>
<td>14–45</td>
</tr>
<tr>
<td>Bladder</td>
<td>1,100</td>
<td>40%</td>
<td>40</td>
</tr>
<tr>
<td>Thyroid</td>
<td>475</td>
<td>10%</td>
<td>60</td>
</tr>
<tr>
<td>Lung</td>
<td>1,362</td>
<td>90%</td>
<td>30–40</td>
</tr>
<tr>
<td>Breast</td>
<td>4,406</td>
<td>40%</td>
<td>65–75</td>
</tr>
<tr>
<td>Prostate</td>
<td>2,369</td>
<td>35%</td>
<td>65–75</td>
</tr>
</tbody>
</table>

Bone Metastases in Breast Cancer

Skeletal Related Events (SREs)
- Fracture
- Need for radiation to bone
- Need for surgery to bone
- Spinal Cord Compression
- Hypercalcemia of malignancy

Bone metastases also effect:
- Pain
- Mobility
- Quality of life
- Anemia secondary to compromised marrow

Oncologic Emergency
Skeletal Event Rates Are High in Breast Cancer Patients With Bone Metastases

Placebo arms of large randomized studies

SREs = Skeletal-related events.

Prevention of SREs in Metastatic Breast Cancer
Breaking the Vicious Cycle

Anti-cancer therapy

Adjunctive Bone directed therapy

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Meta-analysis of SRE Risk Reduction in Breast Cancer

Cochrane database comparing placebo-controlled trials in breast cancer setting.

ZOL = zoledronic acid; PAM = pamidronate.
Bone Microenvironment
Tumor Cell Interactions and Bone Destruction

Pre-B cell expansion

Osteoprotegerin (denosumab is humanized form)

RANKL

Stromal cell activation

IL-6

Osteoclast precursor

Phosphorylation

↑ PGE₂

↑ IL-1, TNF-α

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Skeletal Morbidity Rate (SMR)

\[ P = 0.004 \]

22% Relative Reduction

Mean SMR per subject per year:

- Zoledronic Acid: 0.58 (N = 1020)
- Denosumab: 0.45 (N = 1026)

*SMR = number of SREs for each subject (allowing 1 per 3-week assessment), divided by the subject’s time at risk.

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How Often Should We Be Giving Bisphosphonates (or Denosumab) for Metastatic Bone Disease?
Final OPTIMIZE-2 study design

**Patients:**
- Patients with breast cancer and bone metastases
- Prior therapy with ≥ 9 doses of IV BP
- N = 412 patients

**Randomization 1:1**
- Zoledronic acid q4wk (n=206)
- Zoledronic acid q12wk (n=206) (placebo for interim infusions)

**Protocol revisions during the course of the clinical trial**
- The placebo arm was dropped early in the study secondary to poor accrual
- The sample size was reduced from n=705 to n=412, based on new data that became available (ZOOM trial)
- The statistical assumption of 10% non-inferiority margin remained unchanged.
Time-to-First SRE

Times to first on-study SRE were similar in the two arms

HR=1.06; 95% CI, 0.70 to 1.60

P = 0.792
Metastatic Breast Cancer: What’s New?

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CDK4/6 is a Rational Therapeutic Target

- CDK, cyclin-dependent kinase
- Vidula N, Rugo SH. Clin Breast Cancer 2016;16:8–17

CDK4/6 inhibition restores cell cycle control

\[ \text{G0} \rightarrow \text{G1} \rightarrow \text{S} \rightarrow \text{G2} \rightarrow \text{M} \]

- Cell cycle arrest at G1
- Active tumour suppressor
- Inactive

- Selective CDK4/6 inhibition

E2F

- RB

CDK4/6

Cyclin D

Gene transcription

CDK, cyclin-dependent kinase
# Landscape: CDK Inhibitors

<table>
<thead>
<tr>
<th>Agent</th>
<th>Targets</th>
<th>Phase of Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alvocidib (flavopiridol)</td>
<td>CDK 1/2/4/6/7/9</td>
<td>Phase I/II</td>
</tr>
<tr>
<td>Seliciclib (R-roscovitine)</td>
<td>CDK 2/7/9</td>
<td>Phase I</td>
</tr>
<tr>
<td>Dinaciclib (SCH 727965)</td>
<td>CDK 1/2/5/9</td>
<td>Phase III</td>
</tr>
<tr>
<td>BAY 1000394</td>
<td>CDK 1/2/4/9</td>
<td>Phase I</td>
</tr>
<tr>
<td>Palbociclib (PD 0332991)</td>
<td>CDK 4/6</td>
<td>Phase III- FDA Approved</td>
</tr>
<tr>
<td>Abemaciclib(LY2835219)</td>
<td>CDK 4/6</td>
<td>Phase III</td>
</tr>
<tr>
<td>LEE 011</td>
<td>CDK 4/6</td>
<td>Phase III</td>
</tr>
</tbody>
</table>
PALOMA-2: Study Design (1008)

N=666

- Postmenopausal
- ER+, HER2– advanced breast cancer
- No prior treatment for advanced disease
- AI-resistant patients excluded

Randomization

2:1

- Palbociclib (125 mg QD, 3/1 schedule) + letrozole (2.5 mg QD)
- Placebo (3/1 schedule) + letrozole (2.5 mg QD)

Primary endpoint
Investigator-assessed PFS

Secondary endpoints
Response, OS, safety, biomarkers, patient-reported outcomes

Stratification factors
- Disease site (visceral, non-visceral)
- Disease-free interval (de novo metastatic; ≤12 mo, >12 mo)
- Prior (neo)adjuvant hormonal therapy (yes, no)

Statistical analysis designed to detect an increase in PFS with a true HR of 0.69 (representing a 31% improvement) with 347 events - 90% power with 1-sided α=0.025

Assumptions: Median PFS of placebo plus letrozole = 9 mos vs. palbociclib plus letrozole = 13 mos

Blinded independent central review of efficacy endpoints performed as supportive analysis

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aActual. Al=aromatase inhibitor; HER2=human epidermal growth factor receptor 2; OS=overall survival; PFS=progression-free survival; QD=once daily

Presented By Richard Finn at 2016 ASCO Annual Meeting
PFS: Blinded Independent Central Review
Confirms PFS Advantage Observed Using Investigator Assessment

Presented By Richard Finn at 2016 ASCO Annual Meeting

Number of events n (%) Median (95% CI) PFS HR (95% CI); 1-sided P-value
PAL + LET (n=444) PCB + LET (n=222)
152 (34.2) 96 (43.2)
30.5 (27.4, NR) 19.3 (16.4, 30.6)
0.65 (0.51, 0.84); P=0.0005

Survival Distribution Function

Progression-Free Survival, months

Number of patients at risk:
PAL + LET 444 431 428 394 381 378 344 342 338 319 318 306 281 280 259 252 251 232 228 226 155 149 134 70 68 42 31 31 11 9 9 2 2 2 0
PCB + LET 222 214 209 167 165 161 144 144 143 131 130 122 111 110 98 94 94 79 76 75 50 49 45 22 22 15 12 12 4 3 3 2 2 0

ITT=intent-to-treat; LET=letrozole; NR=not reached; PAL=palbociclib; PCB=placebo; PFS=progression-free survival.
### Hematologic AEs — All Causality

<table>
<thead>
<tr>
<th></th>
<th>Palbociclib + Letrozole (N=444)</th>
<th>Placebo + Letrozole (N=222)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any Grade</td>
<td>Grade 3</td>
</tr>
<tr>
<td>Any AE, %</td>
<td>99</td>
<td>62</td>
</tr>
<tr>
<td>Neutropenia&lt;sup&gt;a&lt;/sup&gt;</td>
<td>80</td>
<td>56</td>
</tr>
<tr>
<td>Leukopenia&lt;sup&gt;a&lt;/sup&gt;</td>
<td>39</td>
<td>24</td>
</tr>
<tr>
<td>Anemia&lt;sup&gt;a&lt;/sup&gt;</td>
<td>24</td>
<td>5</td>
</tr>
<tr>
<td>Thrombocytopenia&lt;sup&gt;a&lt;/sup&gt;</td>
<td>16</td>
<td>1</td>
</tr>
</tbody>
</table>

Febrile neutropenia 2.5%

AE=adverse event. <sup>a</sup>Includes clustered Medical Dictionary for Regulatory Activity (MedDRA) preferred terms.

Presented By Richard Finn at 2016 ASCO Annual Meeting
**PALOMA-3: Phase III Study Design**

- **Primary endpoint:** investigator-assessed PFS
- **Secondary endpoints:** ORR, CBR (CR, PR, or SD for ≥ 24 wks), OS, pt-reported outcomes, safety

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Primary Endpoint: PFS (ITT Population)

- Median PFS, months (95% CI):
  - Palbociclib + Fulvestrant: 9.2 (7.5, NE)
  - Placebo + Fulvestrant: 3.8 (3.5, 5.5)
- HR (95% CI):
  - Palbociclib + Fulvestrant: 0.422 (0.318, 0.560)
  - Placebo + Fulvestrant: NE
- 2-sided P value: <0.000001

Number of patients at risk:
- PAL+FUL: 347 279 132 59 16 6
- PCB+FUL: 174 109 42 16 6 1

CI=confidence interval; HR=hazard ratio; ITT=intent-to-treat; NE=not estimable; PFS=progression-free survival.

Presented By Nicholas Turner at 2015 ASCO Annual Meeting
## PALOMA-3: Grade 3/4 AEs

- Febrile neutropenia incidence was similar with palbociclib + fulvestrant and placebo + fulvestrant (0.9% vs 0.6%, respectively)
- Discontinuations due to AEs were similar with palbociclib + fulvestrant and placebo + fulvestrant (4% vs 2%, respectively)

<table>
<thead>
<tr>
<th>Nonhematologic AE, n</th>
<th>Palbociclib + Fulvestrant (n = 345)</th>
<th>Placebo + Fulvestrant (n = 172)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Fatigue</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Headache</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Decreased appetite</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Rash</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Back pain</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Stomatitis</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Dizziness</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Insomnia</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hematologic Event, n (%)</th>
<th>Palbociclib + Fulvestrant (n = 345)</th>
<th>Placebo + Fulvestrant (n = 172)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neutropenia</td>
<td>223 (65)</td>
<td>1 (&lt; 1)</td>
</tr>
<tr>
<td>Anemia</td>
<td>10 (3)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>93 (27)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>6 (2)</td>
<td>0</td>
</tr>
</tbody>
</table>
Her2 Mutations in Endocrine Resistant MBC

Acquired HER2 Mutations in ER+ MBC

Nayar et al. – Poster P3-04-08

ERBB2 mutations in 7%
83% of ERBB2 mutations (5/6) in metastatic samples with matched primaries were acquired.
Neratinib + Fulvestrant Response

Best change in tumor burden: neratinib + fulvestrant (n=17)

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Triple Negative Breast Cancer

- Only identified subtype for which we have NO targeted therapy
- Relatively poor prognosis
- Molecular subtypes of biologic interest

Defined as negative for ER, PR, and HER2 on clinical assays

- 25% HER2+
- 20% ER+ Low Grade
- 15% ER+ High Grade
- 40% Triple Negative

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HR deficiency in triple-negative breast cancer.

- 40% HR-deficient/BRCAness phenotype
- 15% Germline BRCA mutations
- 45% HR-proficient

Priyanka Sharma The Oncologist 2016;21:1050-1062
PARP inhibitors

- Olaparib
- Niraparib
- Rucaparib
- Talazoparib
- Veliparib
- CEP-9722
- E7016

**FDA approved PARP inhibitors in Ovarian Cancer: olaparib and niraparib**
- olaparib: germline BRCA mutation-associated advanced refractory ovarian cancers
- rucaparib: previously treated BRCA-mutant ovarian cancer
- niraparib: recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to platinum-based chemotherapy
PARPi Trials in BRCA+ MBC

• EMBRACA: phase III trial of talazoparib (BMN673) vs. physician’s choice

• OlympiAD: phase III trial of olaparib to chemotherapy (capecitabine, eribulin, or vinorelbine)

• BRAVO: phase III trial of niraparib to physician’s choice

• NCT01506609: Phase II/III trial of carboplatin and paclitaxel with or without veliparib (ABT-888)

• Planned SWOG 1416: combination of PARPi and cisplatin to test for PARPi activity in both BRCA-associated and BRCAness phenotype metastatic TNBC

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Molecular interactions between immune cells modulate the immune response to cancer
PD-1 Pathway and Immune Surveillance

- PD-1 is expressed primarily on activated T cells\(^1\)
- Binding of PD-1 to its ligands PD-L1 and PD-L2 impairs T-cell function\(^1\)
- PD-L1 is expressed on tumor cells and macrophages\(^2\)
- Tumors can co-opt the PD-1 pathway to evade immune surveillance\(^2\)

Pembrolizumab (MK-3475) Is a Humanized IgG4, High-Affinity, Anti-PD-1 Antibody

- High affinity for the PD-1 receptor (KD ≈ 29 pM)
- Dual ligand blockade of PD-L1 and PD-L2
- No cytotoxic (ADCC/CDC) activity
- PK supports dosing every 2 weeks (Q2W) or every 3 weeks (Q3W)
- Demonstrated clinical activity in multiple tumor types\textsuperscript{1-6}
- Recently approved in the United States for the treatment of patients with unresectable or metastatic melanoma and disease progression following ipilimumab and, if BRAF V600 mutation positive, a BRAF inhibitor

Maximum Percentage Change From Baseline in Target Lesions (RECIST v1.1, Central Review)\textsuperscript{a,b}

\textsuperscript{a}5 patients were excluded from the analysis because they did not have measurable disease at baseline per RECIST v1.1 by central review.

\textsuperscript{b}Only patients with evaluable tumor measurements by central review at baseline and ≥1 post-baseline assessment are included.

Analysis cut-off date: November 10, 2014.
Impassion 130 Study Schema: nab-paclitaxel +/- Atezo for met TNBC

Patients with metastatic or unresectable locally advanced TNBC

Stratification:
• Presence of liver metastases
• Prior taxane treatment
• Tumor PD-L1 status (IC0 vs. IC1/2/3)

Atezolizumab 840mg (q2w) + nab-paclitaxel 100mg/m²
(3 wk on/1 wk off) x ≥ 6 cycles

Placebo (q2w) + nab-paclitaxel 100mg/m²
(3 wk on/1 wk off) x ≥ 6 cycles

Disease Progression (RECIST v1.1)

ECOG: Eastern Cooperative Oncology Group; IC: tumor-infiltrating immune cells; q2w: every 2 weeks; R: randomization.
Summary

- Bone targeted agents given every three months can reduce skeletal events from bone metastases
- CDK 4/6 inhibitors with hormonal therapy are the new standards in HR positive MBC
- Her2 mutations may be a frequent cause of resistance in HR positive MBC
- PARP inhibitors and immunotherapy are new directions in metastatic TNBC

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Mira Hellmann, MD, FACOG
Gynecologic Oncologist,
Hackensack University Medical Center

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Recurrent Ovarian Cancer

How to navigate these choppy waters…..

Mira Hellmann MD, FACOG
Division of Gynecologic Oncology
John Theurer Cancer Center
Regional Cancer Care Associates

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Recurrent Ovarian Cancer

Patients diagnosed in **stage I** have a 10 percent chance of recurrence.

Patients diagnosed in **stage II** have a 30 percent chance of recurrence.

Patients diagnosed in **stage III** have a 70 to 90 percent chance of recurrence.

Patients diagnosed in **stage IV** have a 90 to 95 percent chance of recurrence.
What Is Recurrence?

A. Refractory:

B. Primary Resistance:

C. Platinum-Sensitive Recurrence

D. and

E. Subsequent Acquired Resistance:

- Primary resistant cancer cells
- Putative cancer stem cells/dormant cells
- Acquired resistant cancer cells
- Sensitive cancer cells

ECM
Recurrent Ovarian Cancer- Definition

Recurrent Ovarian Cancer: Definition of Disease Sensitivity

- Refractory
- Resistant
- Sensitive
- Highly Sensitive

Time to Recurrence (mos)

0  3  6  12  18  24

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Recurrent Ovarian Cancer Symptoms

BLOATING

CONSTIPATION

PAIN

NAUSEA

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Recurrent Ovarian Cancer - Diagnosis

Physical exam - palpable mass, recurrent ascites, pleural effusions

CA125 - rise in CA125 - double baseline, asymptomatic rise, biochemical recurrence

CT scan - recurrence identified on imaging

PET/CT - help determine extent of recurrence

Is biopsy necessary?

When to start treatment?

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Recurrent Ovarian Cancer - Imaging

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Recurrent Ovarian Cancer - goals of treatment

Prolong survival

Control disease related symptoms

Delay time to progression

Minimize treatment related symptoms

Improve or maintain quality of life

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Recurrent Ovarian Cancer

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Recurrent Ovarian Cancer

Platinum Sensitive
- Surgery
- Chemotherapy
- Targeted therapy
- Clinical trial

Platinum Resistant
- Chemotherapy
- Targeted therapy
- Clinical trial
- Palliative care

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Recurrent Ovarian Cancer - Platinum Sensitive

SURGERY-secondary debulking

Retrospective Data

GOG 213, data still not resulted

Limited to oligometastases

HIPEC

Significant morbidity

Only on protocol

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Recurrent Ovarian Cancer - Secondary Debulking
Recurrent Ovarian Cancer - Surgery

HIPEC (HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY)
Recurrent Ovarian Cancer- Platinum Sensitive

Platinum based treatment

ICON 4 - doublet therapy improves progression free survival (PFS) and overall survival (OS)

CALYPSO - carboplatin and liposomal doxorubicin non-inferior to carboplatinum and paclitaxel.

OCEANS- carboplatin and gemcitabine with or without bevacizumab

NOVA- niraparib FDA approved as maintenance for platinum sensitive recurrence (2017)
ANGIOGENESIS INHIBITORS

Blood Vessel Overgrowth on Cell

1. Tumor secretes VEGF
2. VEGF increases blood vessel expression and movement to tumor
3. Tumor has increased blood supply

TUMOR CELLS

- Trastuzumab
- Bevacizumab
- VEGF
- bFGF
- TGF-α
- Cetuximab
- Panitumumab
- Erlotinib (TKI)

ENDOTHELIAL CELLS

- Sunitinib
- Sorafenib
- Rapamycin (targets mTOR)
- MMPs

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Recurrent Ovarian Cancer - Platinum Sensitive
ANGIOGENESIS/ANGIOKINASE INHIBITORS

BEVACIZUMAB
GOG 213
ICON7
OCEANS
AURELIA

CEDIRANIB
Improved PFS in combination with Olaparib
ICON 6
Recurrent Ovarian Cancer-PARP inhibitors

PARP Inhibitors: Mechanism

- PARP and BRCA1/2 normally function to repair daily DNA damage
- Allows cells to grow in a healthy way
- Too much DNA damage -> cell death

- If BRCA1/2 is damaged or not working, the cell is dependent on PARP for all DNA repair
- PARP inhibitors prevent DNA repair in cancer cells
  - May increase cancer cell death
  - May help chemo and radiation work better

Ellisen, Cancer Cell 2011; Tutt et al, Lancet 2010
Recurrent Ovarian Cancer - PARP inhibitors

Olaparib - Study 19

Approved for platinum sensitive recurrent disease after three prior chemotherapies in BRCA mutation carriers (12/19/2014)

Need BRCAAnyalsis CDX testing

Niraparib - NOVA

Maintenance in platinum sensitive recurrence for both gBRCA and non BRCA mutation carriers

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Recurrent Ovarian Cancer - PARP inhibitors

Rucaparib - ARIEL 2

Approved for use after two prior chemotherapies (12/19/2016)

BRCA mutation carriers, or loss of heterozygosity (LOH)

Mutation testing using FoundationFocus CDx_{BRCA}
Recurrent Ovarian Cancer- Platinum Resistant

Limited effective treatment options

Focus should be on limiting toxicity

Focus on single agent therapy (exclusion cisplatin/gemcitabine)

AURELIA - addition of bevacizumab increases progression free survival

Integration of palliative care

Limited role for surgical intervention

Consideration for molecular profiling

Enrollment in clinical trials is of utmost importance
Recurrent Ovarian Cancer

NCCN guidelines - exhaustive list of approved therapies in platinum sensitive and platinum resistant categories

WHAT IS MISSING???

List of approved targeted therapies for ovarian cancer - NCCN website:

1. Bevacizumab
2. Olaparib
3. Rucaparib
4. THAT’S IT!

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Recurrent Ovarian Cancer - Targeted therapy

WHY IS IT IMPORTANT???
Recurrent Ovarian Cancer- Targeted Therapy

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Recurrent Ovarian Cancer - Targeted Therapy

Angiogenesis inhibitors - VEGF receptor inhibitors (bevacizumab)

Angiokinase inhibitors - inhibit PDGFR (Pazopanib, cediranib, nintedanib)

PARP inhibitors - inhibits DNA repair (olaparib, rucaparib, niraparib - all have FDA approval, veliparib still being investigate)

Folate receptor alpha antagonist - Morphotek

Her 2- ERBB2 inhibitor (herceptin)

Hormone receptor inhibitors - tamoxifen, fluvestrant, anastrozole, letrazole, exemstane (aromatase inhibitors)

Immunotherapy - checkpoint inhibitors PD-1, PDL-1 (nivolumab)
Recurrent Ovarian Cancer - Targeted Therapy

Human Genome Project - allows to sequence tissue to analyze for inherited as well as non inherited mutations

Precision Medicine - personalized medicine, finding a treatment that fits your specific cancer based on specific molecular profiling.
Precision Medicine

Assessing BRCAness

FoundationFocus CDx_{BRCA}

Foundation testing

Foundation one

Foundation Heme

FoundationACT (assessing tumor cells in the blood stream)

Not FDA approved, has not demonstrated improved survival

Next Generation sequencing

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SEEK THE BEST CARE FOR YOU!

Seek a physician that will personalize your care to you

ACS advises to obtain second opinions, especially in recurrence where treatment recommendations may vary

Ensure appropriate genetic testing has been performed to help both you and your family

Don’t be afraid of palliative care, it will significantly enhance quality of life, without detracting quantity

Strongly consider enrollment in clinical trials (NCCN recommendations)
Recommended Websites

Cancer.gov
ACS.org
OCRFA.org
NCCN.org
SGO.org
Dikla shares her personal story about navigating metastatic breast cancer.

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To ask a question, please dial *1 or enter your question into the chat box.

Questions will be addressed in the order received.

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EVALUATION

Your feedback is important to us.

Please complete the online evaluation that will be sent to you.

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You will be able to access the transcript, slides, and audio of the webinar at:

https://sharsheret.org/resource/teleconferences-webinars/

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THANK YOU

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