OVARIAN CANCER TREATMENT IS INCREASINGLY INDIVIDUALISED

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Up to 70% of patients with advanced Stage III–IV high-grade OC will **relapse**,[1] and **>80%** of patients with late-stage OC will become **platinum resistant**.[2]

IN THE PAST

Patient

A deeper understanding of OC tumour biology has gradually led to subclassifications and the identification of some molecular markers.[2]

In the past, patient characterisation and treatment decisions were based on disease staging, treatment response, and adverse event profiles.[3]

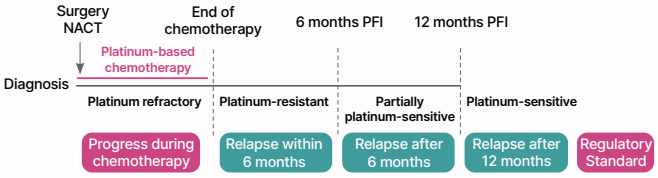
Treatment

Prior to the development of targeted therapies, treatment options in OC were restricted to surgical intervention and PbC.[4]

A 'regulatory standard' was developed to define PbC eligibility (Figure 1), and PROC was defined as a disease that relapses within 6 months of PbC.[5]

- However, this definition may not be sufficient to predict potential benefit from subsequent PbC or non-platinum-based therapy.[6]

Figure 1[5]



IN THE PRESENT

Patient

Due to the identification and validation of **clinically actionable biomarkers, individualised treatment** paths for patients are now possible.[7]

Currently, patient characterisation and treatment decisions should also consider tumour characteristics, survival outcomes, tumour burden, adverse event management, quality of life, treatment-free interval, histology, and mutation/biomarker status.[1,7]

Treatment

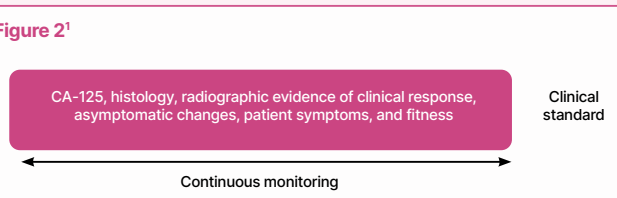
Therapeutic advancements in OC, such as bevacizumab or PARP inhibitors, provide more opportunities to treat when PbC is not the best option.[1]

- Despite all of these advancements, treating patients with PROC remains a clinical challenge.[8]

Today, a '**clinical standard' has emerged** whereby suitability for PbC is determined through the assessment of many patient factors (Figure 2).[1]

- For some patients with recurrent OC, **PbC rechallenge may not be clinically appropriate.**[1]
- The concept of a '**platinum-ineligible**' status allows for more **individualisation** of therapy.[1]

Figure 2[1]



IN THE FUTURE

Patient

An **increasing understanding** of tumour biology in OC is informing novel therapeutic development.[4]

In the future, patient characterisation and treatment decisions may also consider tumour cell **subtype burden**, cumulative **adverse event burden**, patient **choice, sequencing**, and **evolving biomarker/mutation** status. (Moore, personal communication)

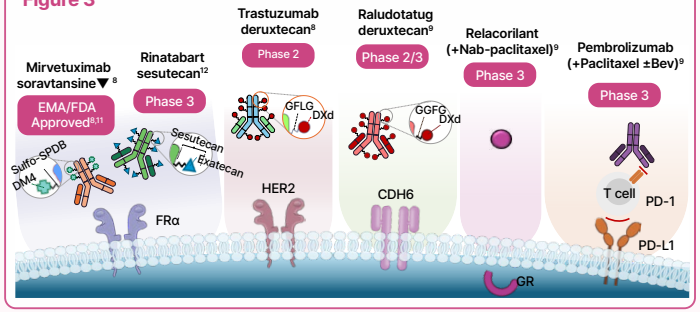
Treatment

Advancements in **targeted therapies** and **health technologies** may usher in a future of **personalised** care.[7-9]

With perspectives on platinum sensitivity changing, novel approaches to treatment are needed to fill the gap.[2,4]

Several **antibody–drug conjugates** and **targeted therapies** are in late-stage development, which may expand therapeutic options in PROC (Figure 3).[7,10]

Figure 3



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Prescribing information and indication for UK HCPs can be found here.

Abbreviations:
Bev: bevacizumab; CDH6, cadherin 6; FRα: folate receptor alpha; GR: glucocorticoid receptor; HER2: human epidermal growth factor receptor 2; Nab: nanoparticle albumin-bound; NACT: neoadjuvant chemotherapy; OC: ovarian cancer; PARP: poly-ADP ribose polymerase; PbC: platinum-based chemotherapy; PD-1: programmed cell death protein 1; PD-L1: programmed death-ligand 1; PFI: platinum-free interval; PROC: platinum-resistant cancer; SPDB: N-Succinimidyl 4-(2-pyridyldithio)butyrate.

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CONCLUSION

- Evolving understanding of patient and tumour biology is leading to a **changing tide in PROC diagnosis and treatment.**[1,7]
- The **emerging 'clinical standard'** determines suitability for PbC through the assessment of many patient factors.[1]
- The future of **tailored therapy** will **harmonise** considerations for **tumour biology** and what is right for the **patient.**[2,8,9]