

ESMO Clinical Practice Guidelines

Ovarian Cancer Clinical Case Presentation

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Disclosures

Jonathan Ledermann has attended Advisory Boards and given invited lectures for AstraZeneca with remuneration to his institution.

Advisory Boards: Clovis Oncology, Bayer, Oxigene, Merck/MSD,

He is the Chief Investigator of Study 19 with olaparib but has not received any financial compensation.

Speaking honoraria: Roche

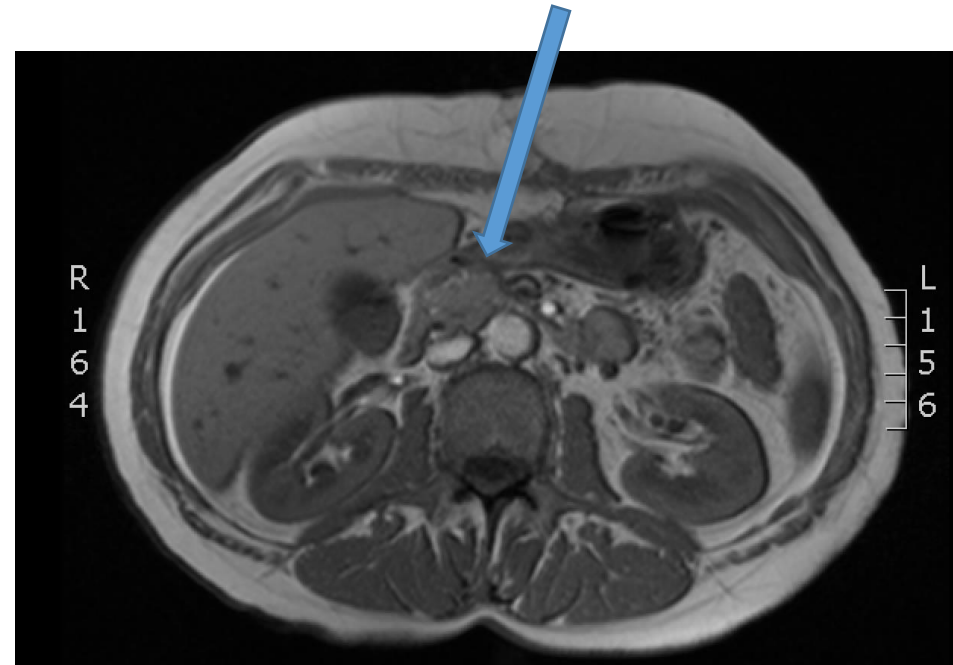
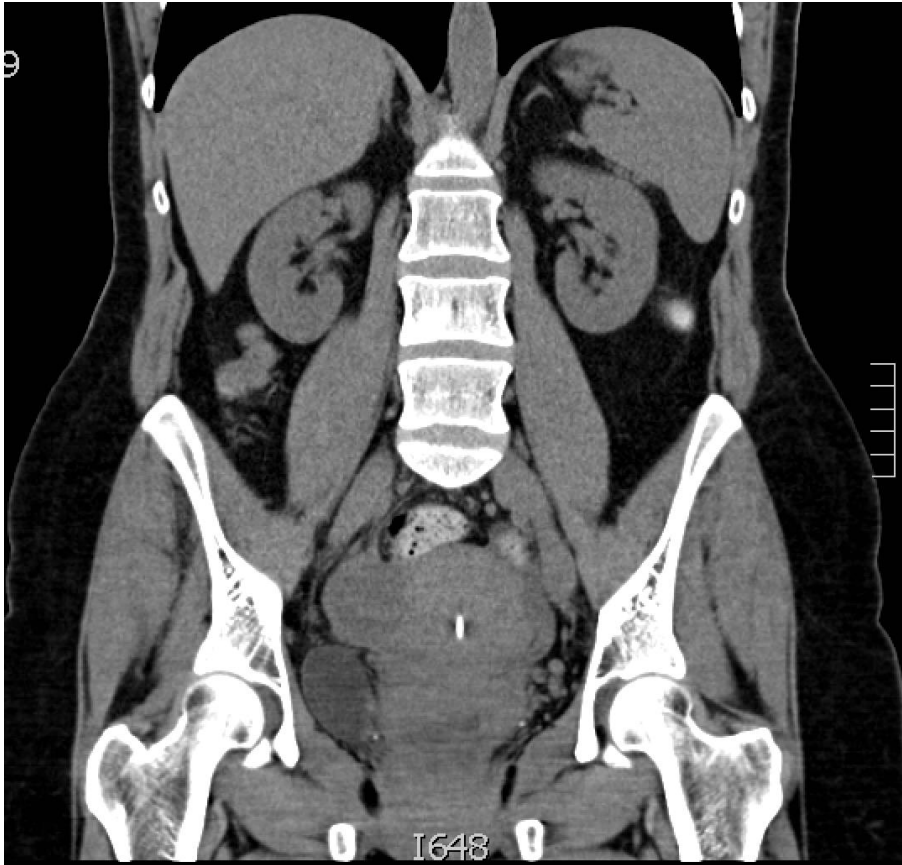
Introduction

- Most patients with advanced ovarian cancer have a disease recurrence
- A multidisciplinary approach is needed to make appropriate choices for treatment at each stage of recurrence. Decisions can be complex, and are based around location of disease, size and symptoms
- The role of surgery for recurrent disease is uncertain
- Some patients respond to multiple lines of treatment and over the last 5 years there has been an increase in the treatment options available

Clinical Case

- *Nov 2008*: 45 year old woman presents with pain and a Rt ovarian mass. Laparoscopic biopsy reported poorly differentiated serous tumour.
- Total abdominal hysterectomy and bilateral salpingo oophorectomy and omentectomy.
- Bilateral ovarian tumours; nodular omentum and 1.5 cm paracecal mass removed. 5 x 3 cm aorto-caval mass partially resected (residual 1.9 cm disease) remained between aorta and IVC.
- CA125= 78
- Histology: Grade 3 serous carcinoma of ovary with disease in omentum, peritoneum and lymphnodes. Washings: positive

Presentation with Rt Ovarian Mass 2009. Residual Para-aortic LN



Treatment plan

- Treatment plan: **Carboplatin and paclitaxel x 6 cycles**
- Allergic reaction to paclitaxel after 2nd cycle, so continued with single agent carboplatin completing in Jan 2009
- MRI- Mass about 1 cm ? Fibrotic. Normal CA125

Recurrent ovarian cancer

November 2010

- CT: 2.3 cm mass at porta hepatis and 1.3 cm aorto-caval nodes. Normal CA125
- **Biopsy:** high grade carcinoma
- Family history of breast and other cancers of unknown types.
- Found to have a deleterious BRCA1 germ line mutation



Q1: What to do for relapse?

1. Retreat with carboplatin + Pegylated Liposomal doxorubicin
2. Carboplatin alone
3. Carboplatin and gemcitabine
4. Surgery
5. Surgery followed by chemotherapy
6. Continued observation

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Second line chemotherapy

- **Carboplatin 3 weekly AUC 5 and abraxane 100 mg/m² weekly** continuously
- 6 cycles completed June 2011
- MRI : Porta hepatis node 1 cm; aorto-caval nodes 0.7 cm.

February 2012

- nodal mass increasing. No new disease. Normal CA125
- Laparotomy with removal of nodes. Only nodes around porta contained tumour. No residual disease



Q2: Management of recurrent ovarian cancer post surgery

1. Further course of chemotherapy ?
2. Observation?

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Follow up

- Between February 2012 and Jan 2013 she remained well. Aug 2012: CT/PET no evidence of disease

January 2013

- CA125 started to rise, reaching 930 iu/l in March 2013:
- CT/PET: nodal disease; perihepatic and perisplenic deposits and nodule at Rt pleural base

March 2013

- Third line chemotherapy **Carboplatin AUC4;**
Gemcitabine 800 mg/m² ; Bevacizumab 15 mg/kg.
6 cycles followed by maintenance bevacizumab

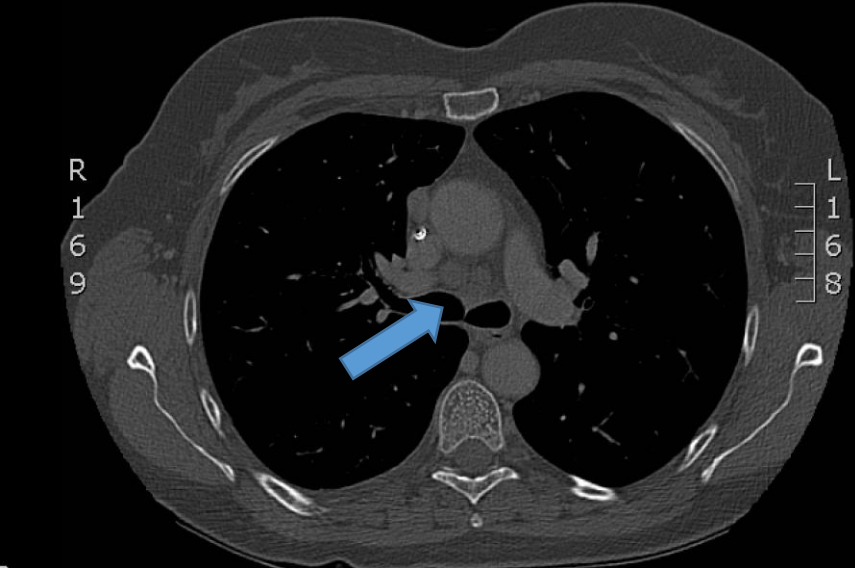
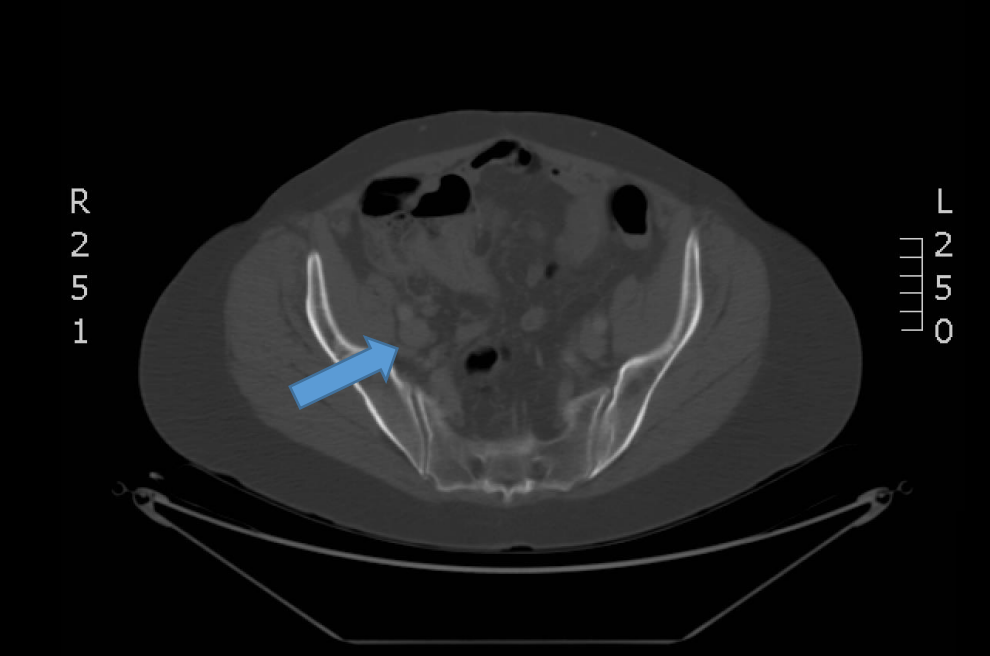
Maintenance bevacizumab

- Maintenance bevacizumab continued from June 2013.

October 2014

- CT shows new peritoneal, mediastinal and abdomino-pelvic nodal disease, and serosal disease on small intestine. Disease dimensions range from 1 to 2.5 cm diameter.
- CA125 = 68
- Clinically well - no symptoms

Recurrent disease- 2014



Q3: Three previous lines of chemotherapy - What are the next steps?

1. Pegylated liposomal doxorubicin (PLD)?
2. Olaparib?
3. Single agent carboplatin?
4. Carboplatin and PLD?
5. Carboplatin/PLD followed by maintenance olaparib?
6. Continue observation?

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Fourth-line chemotherapy

November 2014

- **Carboplatin AUC 5 and PLD 30 mg/m²**
- CA125 normalised after 1 cycle (24 iu/l)
- 6 cycles completed March 2015
- March 2015: CT: Excellent response. All remaining lesions < 1 cm

April 2015

- **Olaparib 400mg (capsules) BD**
- October 2015: Well. Normal CA125. Continues on treatment without toxicity

