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ESMO SUMMIT AFRICA

Report on the Ovarian Consensus Conference

C. Sessa

IOSI, Bellinzona, CH

Cape Town 15-17 February 2019

CONFLICT OF INTEREST DISCLOSURE

None

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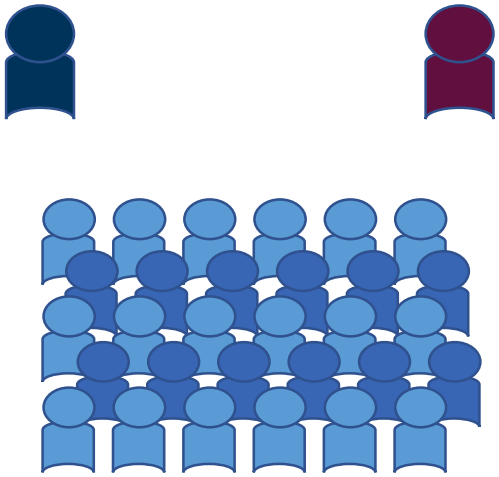
ESGO European Society of Gynaecological Oncology

1st ESGO-ESMO Consensus Conference on Ovarian Cancer

STRUCTURE OF CONSENSUS CONFERENCE GROUP

CC chair / ESMO Nicoletta Colombo



CC Chair / ESGO Denis Querleu

40 members

- Pan-European and global representation
- Acknowledged multidisciplinary experts and authorities in field
- Declaration of interest obtained from all participants

CC, Consensus Conference

ESGO-ESMO Consensus Conference on ovarian cancer

Methodology (1)

- 5 relevant questions for each area/WG
- Review of relevant literature and current guidelines in each WG
- Draft of preliminary recommendation before the meeting in each WG
- Discussion of draft during the meeting and preparation of recommendations by each WG in parallel sessions
- Presentation and voting of recommendation in the plenary session

Methodology (2)

Consensus Chairs to manage conference proceedings

- Nicoletta Colombo
- Denis Querleu

Four working groups / each group led by two Working Group Chairs

- **WG1: Pathology and Molecular Biology**
  - Chairs: Glenn McCluggage and Iain McNeish
- **WG2: Early stage and borderline**
  - Chairs: Philippe Morice and Isabelle Ray-Coquard
- **WG3: Advanced stage**
  - Chairs: Sandro Pignata and Ignace Vergote
- **WG4: Recurrent disease**
  - Chairs: Andreas du Bois and Jonathan Ledermann

Levels of evidence

Level	Evidence
I	≥1 large RCT of good methodological quality (low potential for bias) or meta-analyses of well-conducted randomised trials without heterogeneity
II	Small randomised trials or large randomised trials with a suspicion of bias (lower methodological quality) or meta-analyses of such trials or of trials with demonstrated heterogeneity
III	Prospective cohort studies
IV	Retrospective cohort studies or case–control studies
V	Studies without control group, case reports, experts opinions

RCT, randomised controlled trial

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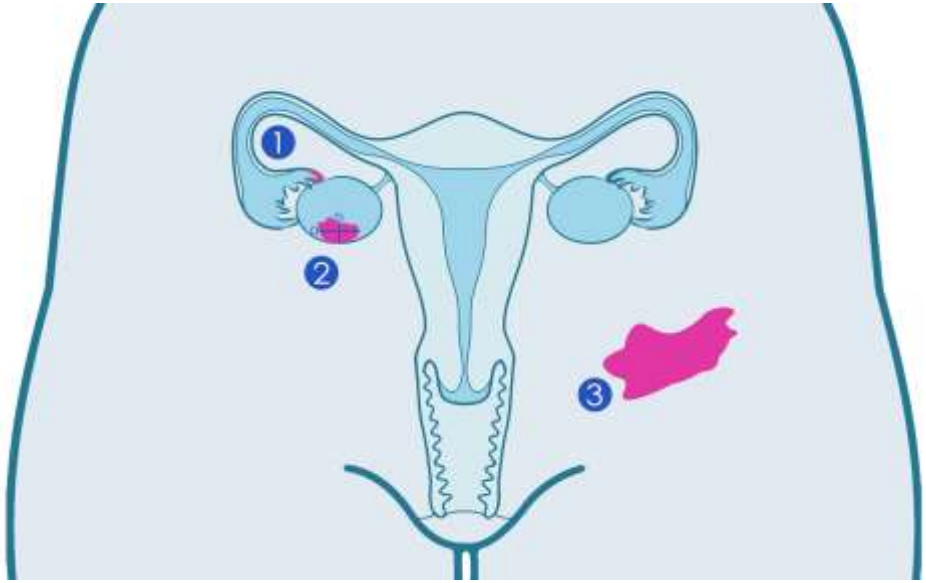
PATHOLOGY AND MOLECULAR BIOLOGY

1)How to determine the site of origin of extra-uterine high grade serous carcinoma (HGSC)? *(continued)*

Summary of recommendations	LoE	GoR	Consensus
Correct and uniform use of site assignment criteria is particularly important for accurate staging of early tumours	III	A	Yes: 100% *(40 voters)*
STIC should count as a disease site for staging purposes; for example, a case with a STIC and HGSC confined to the ovary should staged as stage IIA fallopian tube cancer	IV	A	Yes: 95% *(38 voters)* Abstain: 5% *(2 voters)*
True primary peritoneal HGSC is extremely rare	IV	A	Yes: 100% *(40 voters)*
Multifocal origin of extrauterine HGSC is exceptionally rare and thus tumours currently staged as IB should be considered as stage IIA	IV	A	Yes: 95% *(38 voters)* No: 5% *(2 voters)*



STIC + small volume ovarian HGSC + large volume peritoneal HGSC

Ovarian?
Peritoneal?
Tubal?
Undesignated?

Summary of Site Assignment Proposals

Criteria	Primary site	Comment
STIC present	Fallopian tube	Regardless of presence and size of ovarian and peritoneal disease
Invasive mucosal carcinoma in tube, with or without STIC	Fallopian tube	Regardless of presence and size of ovarian and peritoneal disease
Distal end or entire tube incorporated into ovarian mass	Fallopian tube	Regardless of presence and size of ovarian and peritoneal disease
No STIC or invasive mucosal carcinoma in either tube in presence of ovarian mass	Ovary	Regardless of presence and size of peritoneal disease
Both tubes and both ovaries grossly and microscopically normal or involved by benign process in presence of peritoneal HGSC	Primary peritoneal HGSC	As recommended in WHO blue book 2014[57]

PATHOLOGY AND MOLECULAR BIOLOGY

2)How to identify tumours that will respond to targeted therapies, including poly-(ADP-ribose) polymerase (PARP) inhibitors and immune checkpoint inhibitors?

Summary of recommendations	LoE	GoR	Consensus
There are no validated predictive molecular biomarkers of bevacizumab benefit	IV	A	Yes: 100% *(40 voters)*
PARP inhibitors have greatest activity in patients with *BRCA1/2* mutations	I	A	Yes: 100% *(40 voters)*
Testing for *BRCA1/2* mutations is recommended for all patients with non-mucinous ovarian cancer	I	A	Yes: 95% *(38 voters)* Abstain: 5% *(2 voters)*
Testing for mutations in other HR genes, in particular *RAD51C/D, BRIP1* and *PALB2* should be considered	III	A	Yes: 100% *(40 voters)*
Current assays of homologous recombination function cannot be used to exclude patients from PARP inhibitor therapy	I	A	Yes: 100% *(40 voters)*
Moderate-strong ER staining may be a predictor of response to hormone therapy	III	B	Yes: 100% *(40 voters)*
There are currently no prospectively validated predictive biomarkers of response to immune checkpoint inhibitors that are specific to ovarian cancer	V	A	Yes: 100% *(40 voters)*

PATHOLOGY AND MOLECULAR BIOLOGY

4) Can we develop accurate and sensitive circulating and tissue biomarkers both of response and relapse?

Summary of recommendations	LoE	GoR	Consensus
The CA125 criteria for response and progression as agreed by GCIG have utility in routine practice but should be used in combination with radiological and clinical assessment	III	A	Yes: 97.5% *(39 voters)* Abstain: 2.5% *(1 voter)*
The role of CA125 as a marker of response and progression in non-HGSC is less clear	V	A	Yes: 100% *(40 voters)*
The use of CA125 in assessing response and progression to targeted therapies is not yet proven and thus radiological and clinical assessment should be used	V	A	Yes: 100% *(40 voters)*
HE4 should not be used routinely to assess response and progression due to conflicting results	IV	A	Yes: 97.5% *(39 voters)* Abstain: 2.5% *(1 voter)*
Quantification of circulating cell-free DNA has not been established as a tool to assess response and relapse	IV	A	Yes: 97.5% *(39 voters)* Abstain: 2.5% *(1 voter)*
Pathological chemotherapy response score after neoadjuvant chemotherapy may provide an objective and reproducible prognostic measure of outcome in HGSC	IV	A	Yes: 82.5% *(33 voters)* No: 12.5% *(5 voters)* Abstain: 5% *(2 voters)*

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EARLY STAGE AND BORDERLINE

1) Are there exceptions to the standard surgical management for early stage ovarian carcinoma?

Summary of recommendations	LoE	GoR	Consensus
Laparotomy is the standard surgical approach to treat and stage patients with apparent early stage ovarian carcinoma	V	A	Yes: 100% *(40 voters)*
Minimally invasive surgery can be performed for restaging	IV	B	Yes: 75% *(30 voters)* No: 12.5% *(5 voters)* Abstain: 12.5% *(5 voters)*
Whatever the approach used, rupture of an intact tumour with spillage of cancer cells at the time of surgery must be avoided	IV	A	Yes: 100% *(40 voters)*

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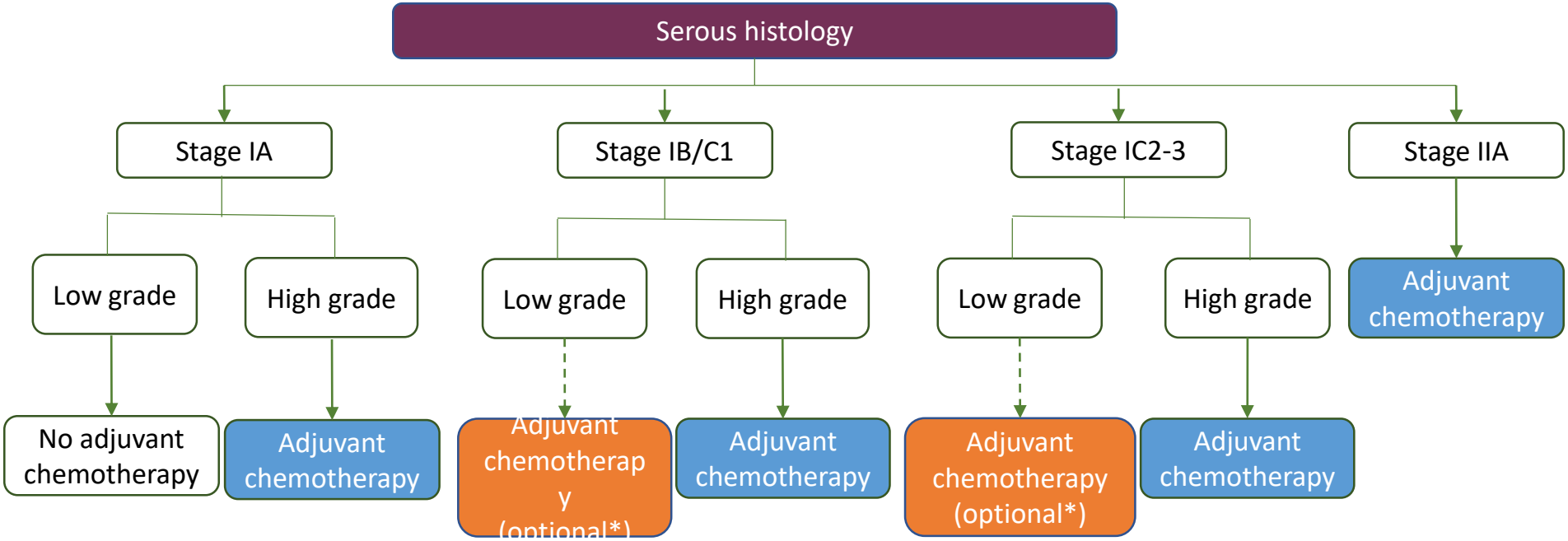
EARLY STAGE AND BORDERLINE

2) Are there exceptions to the standard surgical management for early stage ovarian carcinoma?

Summary of recommendations	LoE	GoR	Consensus
Peritoneal restaging should be considered in cases of incidentally detected apparently isolated STIC lesions	IV	B	Yes: 100% *(40 voters)*
The standard surgical staging of apparent early epithelial ovarian cancer includes systematic lymph node dissection of the pelvic and the para aortic regions up to the left renal vessel origin	IV	A	Yes: 77.5% *(31 voters)* No: 22.5% *(9 voters)*
Lymph node dissection for restaging purposes may be avoided if the nodal status does not alter the patient management	V	B	Yes: 95% *(38 voters)* Abstain: 5% *(2 voters)*



*Considered no adjuvant chemotherapy only for patients with complete surgical staging

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EARLY STAGE AND BORDERLINE

3) Should all stage I carcinoma receive adjuvant chemotherapy and if not which ones? *(continued)*

Summary of recommendations	Lo E	Go R	Consensus
For patients with early stage disease requiring adjuvant chemotherapy, acceptable treatment regimens are: • carboplatin alone or • carboplatin /paclitaxel	 I II	 A A	 Yes: 100% *(40 voters)* Yes: 100% *(40 voters)*
For patients receiving single agent adjuvant carboplatin, 6 cycles are recommended	I	A	Yes: 100% *(40 voters)*
For patients receiving carboplatin and paclitaxel, a minimum of 3 cycles is recommended except for the serous subgroup or stage IC (any histological type) in whom 6 cycles are recommended	II	B	Yes: 77.5% *(31 voters)* Abstain: 22.5% *(9 voters)*

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EARLY STAGE AND BORDERLINE

5) How should ovarian serous borderline tumour with extra ovarian implants be managed?

Summary of recommendations	LoE	GoR	Consensus
Peritoneal staging surgery is recommended for ovarian serous borderline tumour	III	B	Yes: 100% *(40 voters)*
The benefit of restaging is not clear but should be considered in patients with: • Serous borderline tumour with micropapillary pattern • Serous borderline tumour with incomplete visual exploration of the peritoneal cavity	 IV III	 B B	 Yes: 100% *(40 voters)* Yes: 100% *(40 voters)*
There is no role for appendectomy in ovarian borderline tumour	V	A	Yes: 85% *(34 voters)* Abstain: 15% *(6 voters)*
All the peritoneal implants must be removed	IV	A	Yes: 100% *(40 voters)*
There is no proven benefit of systematic lymph node dissection in stage II/III serous borderline tumours	IV	B	Yes: 97.5% *(39 voters)* Abstain: 2.5% *(1 voter)*
Fertility sparing surgery could be considered in selected patients with stage II or III ovarian serous borderline tumours	V	B	Yes: 100% *(40 voters)*
Adjuvant systemic treatment is not recommended for primary treatment of ovarian serous borderline tumour with extraovarian invasive/non invasive implants	III	B	Yes: 92.5% *(37 voters)* Abstain: 7.5% *(3 voters)*

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ADVANCED STAGE

What is the current role of bevacizumab in first-line treatment?

Summary of recommendations	LoE	GoR	Consensus
Bevacizumab (15mg/kg or 7.5 mg/kg every 3 weeks for maximum of 15 months) improves progression-free survival in patients with stage III-IV ovarian cancer and should be considered in addition to carboplatin and paclitaxel	I	A	Yes: 97.5% *(39 voters)* Abstain: 2.5% *(1 voter)*
Bevacizumab in the neoadjuvant setting can be considered although the additional improvement in efficacy is not proven with level I evidence	II	B	Yes: 97.5% *(39 voters)* No: 2.5% *(1 voter)*
Bevacizumab can be safely administered in the neo-adjuvant setting before and after IDS providing the interval between surgery and administration is at least 4-6 weeks	II	B	Yes: 100% *(40 voters)*

ADVANCED STAGE

Should we use weekly regimens in first-line?

Summary of recommendations	LoE	GoR	Consensus
Incorporation of weekly chemotherapy into first-line treatment for women with epithelial ovarian cancer does not improve progression-free survival or overall survival in population of western countries	I	A	Yes: 100% *(40 voters)*
The schedule of weekly chemotherapy with Carboplatin (AUC2) and Paclitaxel (60 mg/m^2) shows better quality of life and reduced toxicity (e.g. alopecia, neuropathy) compared to standard 3-weekly schedule and can be considered	I	B	Yes: 95% *(38 voters)* Abstain: 5% *(2 voters)*
Weekly chemotherapy cannot be regarded as a substitution for Bevacizumab	V	B	Yes: 100% *(40 voters)*
3-weekly carboplatin-paclitaxel remains the standard-of-care chemotherapy of first-line ovarian cancer treatment	I	A	Yes: 100% *(40 voters)*

ADVANCED STAGE

Is there a place for intraperitoneal chemotherapy and hyperthermic intraperitoneal chemotherapy?

Summary of recommendations	LoE	GoR	Consensus
Intraperitoneal chemotherapy is not a standard of care as first-line treatment	I	A	Yes: 95% *(38 voters)* Abstain: 5% *(2 voters)*
Hyperthermic intraperitoneal chemotherapy is not a standard of care as first-line treatment	II	A	Yes: 95% *(38 voters)* Abstain: 5% *(2 voters)*

Is there a place for intraperitoneal chemotherapy and hyperthermic intraperitoneal chemotherapy?

IP Study	Design	N	Progression-free survival (months, p value)	Overall survival (months, p value)	Toxicity

GOG172 (Armstrong et al. NEJM 2006)	• EOC FIGO III
	• 2 arms
	  • Cisplatin-Paclitaxel (CiP) IV
	  • Paclitaxel IV + CiP IP
		415
		R 1:1
			CiP IV: 18.3 m
			Pacl+ CiP IP : 23.8 m
			p= 0.05
				CiP IV: 49.7 m
				Pacli + CiP IP : 65.6 m
				p= 0.03
					Pacl + CIP IP showed lower QOL and lower completion of CT

GOG252* **Unpublised data**	• EOC FIGO II-IV
	• 3 arms receiving bevacizumab:
	  • Carboplatin q3w + paclitaxel q1w IV (CP) IV
	  • carboplatin IP + paclitaxel q1w IV
	  • Paclitaxel q3w IV + CiP IP
		1560
		R
		1:1:1
			CP IV
			FIGO II/III <1cm: 26.8 m / **FIGO III no residual disease:** 31.3 m
			Carboplatin IP + Paclitaxel q1w IV
			FIGO II/III <1cm: 28.7 m / **FIGO III no residual disease:** 31.8 m
			Paclitaxel q3w IV + CiP IP
			FIGO II/III <1cm: 27.8 m / **FIGO III no residual disease:** 33.8 m
				Not yet reached	IV chemotherapy was better tolerated than IP chemotherapy

HIPEC Study	Design	N	Progression-free survival	Overall survival	Toxicity

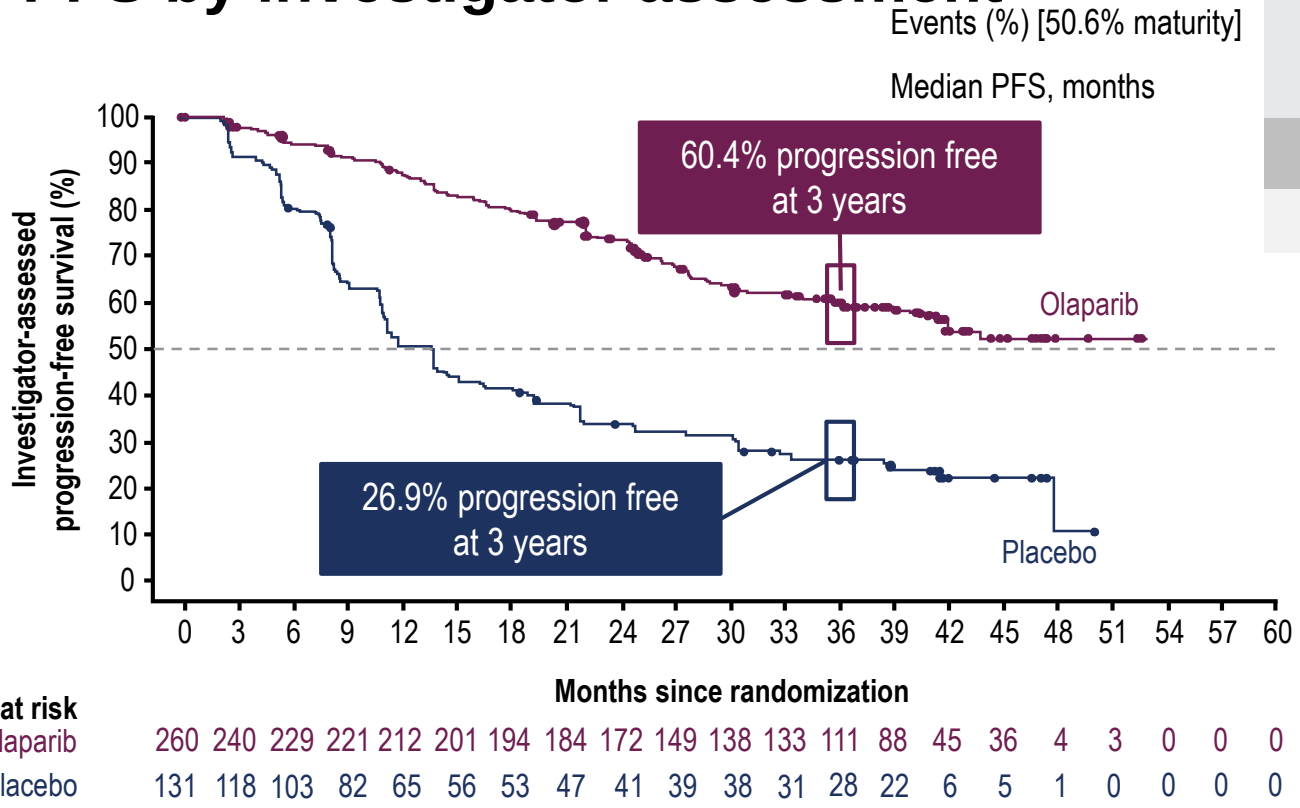
Lim trial (Lim et al. JCO 2017)
Korea
	• EOC FIGO III and IV
	• Inclusion criteria
	  • UDS or IDS with residual tumor <1 cm
	• 2 arms:
	  • HIPEC (Cisplatinum 75 mg/mq)
	  • NO HIPEC
		184
		R 1:1
			5-Years PFS HIPEC: 20.9 %
			5-Years PFS NO HIPEC: 16.0%
			p= 0.569
				5-Years OS HIPEC: 51.0 %
				5-Years OS NO HIPEC: 49.4 %
				p= 0.574
					HIPEC group:
					• More surgical time (p<0.001)
					• More anaemia (p=0.025)
					• More ↑ creatinine (p=0.026)

OVHIPEC (Van Driel et al. NEJM 2018)
The Netherlands
	• EOC FIGO III
	• Inclusion criteria:
	  • abdominal disease too extensive for UDS or after UDS with residual disease >1cm
	  • response after 3 cycles of NACT
	• 2 arms: IDS with
	  • HIPEC (Cisplatin 100 mg/mq)
	  • NO HIPEC
		245
		R 1:1
			Mean PFS HIPEC: 14.2 months
			Mean PFS NO HIPEC: 10.7 months
			p= 0.003
				Mean OS HIPEC: 45.7 months
				Mean OS NO HIPEC: 33.9 months
				p=0.02
					No significant difference in toxicity profiles in both groups.

SOLO 1

Maintenance olaparib in newly diagnosed OvCa patients

PFS by investigator assessment



Olaparib (N=260)	Placebo (N=131)
102 (39.2)	96 (73.3)
NR	13.8
HR 0.30	
95% CI 0.23, 0.41; *P*<0.0001	

CI, confidence interval; NR, not reached

MUNICH 2018 ESMO congress

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ADVANCED STAGE

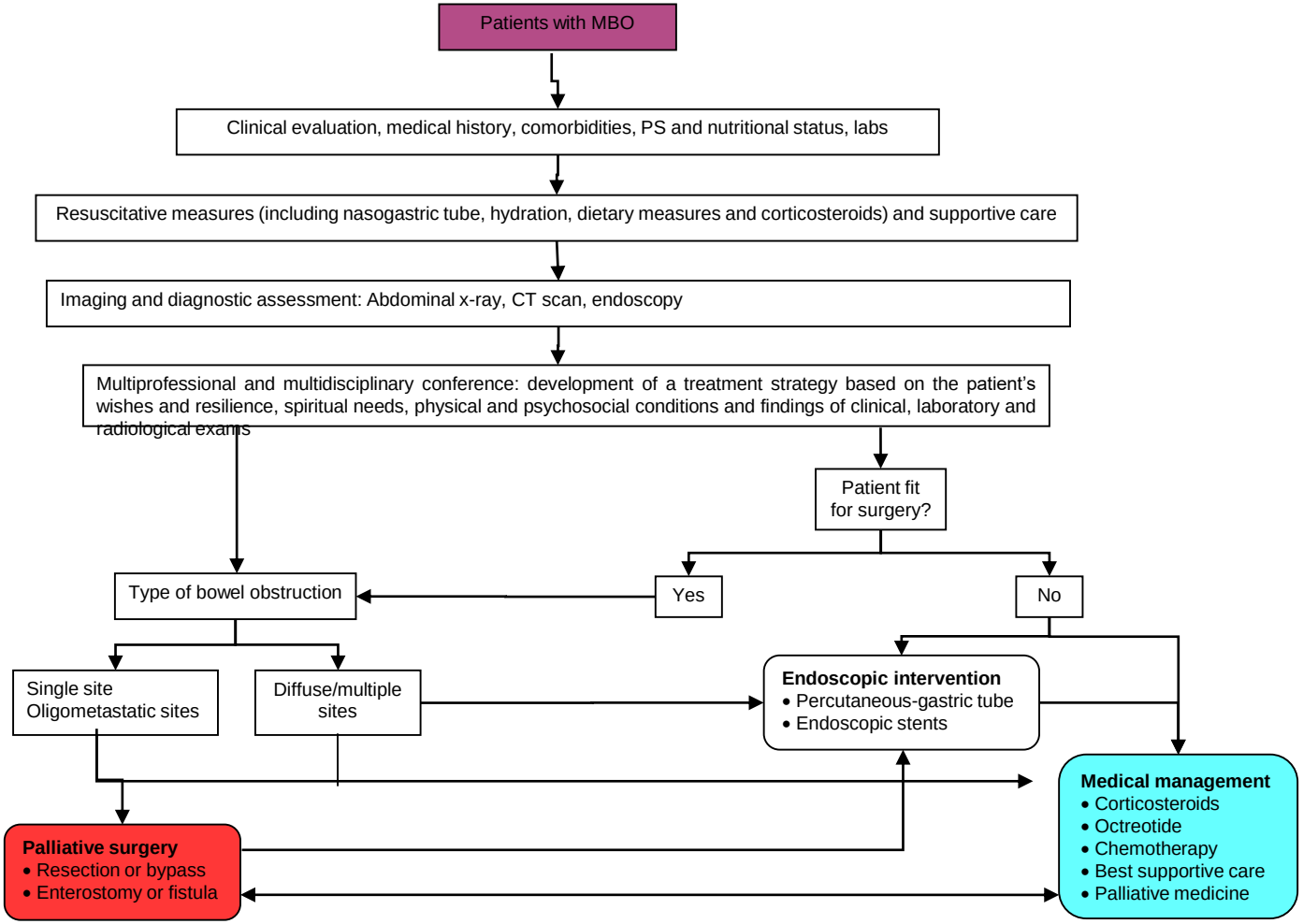
Is the standard management of non high grade serous epithelial ovarian carcinoma different?

Summary of recommendations	LoE	GoR	Consensus
Advanced (FIGO III and IV) non-high grade serous ovarian cancer in first-line			
• Primary debulking surgery with no macroscopic residual disease is of pivotal importance due the low chemosensitivity in low grade serous, mucinous and clear cell ovarian carcinoma	IV	A	Yes: 95% *(38 voters)* Missing: 5% *(2 voters)*
• Even debulking with residual disease <1cm in low grade serous ovarian carcinoma may improve survival when complete cytoreduction is not feasible	IV	C	Yes: 95% *(38 voters)* Missing: 5% *(2 voters)*
• Carboplatin in combination with Paclitaxel is the standard chemotherapy. Addition of Bevacizumab should be considered	I	B	Yes: 92.5% *(37 voters)* Abstain: 2.5% *(1 voter)* Missing: 5% *(2 voters)*
• Maintenance anti oestrogen therapy after chemotherapy can be considered in low grade serous ovarian carcinoma	IV	C	Yes: 87.5% *(35 voters)* Abstain: 7.5% *(3 voters)* Missing: 5% *(2 voters)*

RECURRENT DISEASE

What is the place of surgery for recurrent disease?

Summary of recommendations	LoE	GoR	Consensus
Complete cytoreductive surgery followed by systemic treatment improves progression-free survival and extends benefit up to the next line of treatment in selected patients with first recurrence of ovarian cancer ; Overall survival data are not yet mature. Patients eligible for cytoreductive surgery should be informed about this option	I	A	Yes : 95% *(38 voters)* Missing : 5% *(2 voters)*
Complete cytoreductive surgery in second or later recurrence may provide benefit in selected patients and specialized centres	V	A	Yes : 92.5% *(37 voters)* Missing :7.5% *(3 voters)*
In recurrent ovarian cancer hyperthermic intraperitoneal chemotherapy added to cytoreductive surgery has not been proven to be beneficial in appropriately designed prospective studies	IV	A	Yes : 95% *(38 voters)* Missing : 5% *(2 voters)*
Malignant bowel obstruction should be managed on an individual basis. There is a lack of evidence for optimal management and a need for clinical trials to evaluate medical, endoscopic and surgical approaches	V	A	Yes : 92.5% *(37 voters)* Missing :7.5% *(3 voters)*


Patients with MBO
Clinical evaluation, medical history, comorbidities, PS and nutritional status, labs
Resuscitative measures (including nasogastric tube, hydration, dietary measures and corticosteroids) and supportive care
Imaging and diagnostic assessment: Abdominal x-ray, CT scan, endoscopy
Multiprofessional and multidisciplinary conference: development of a treatment strategy based on the patient's wishes and resilience, spiritual needs, physical and psychosocial conditions and findings of clinical, laboratory and radiological exams
Patient fit for surgery?
Yes
No
Type of bowel obstruction
Single site Oligometastatic sites
Diffuse/multiple sites
Endoscopic intervention
• Percutaneous-gastric tube
• Endoscopic stents
Palliative surgery
• Resection or bypass
• Enterostomy or fistula
Medical management
• Corticosteroids
• Octreotide
• Chemotherapy
• Best supportive care
• Palliative medicine

RECURRENT DISEASE

How should molecularly targeted therapy be integrated into the management of recurrent ovarian cancer?

Summary of recommendations	LoE	GoR	Consensus
Bevacizumab in combination with platinum-based 2nd-line chemotherapy (gemcitabine or paclitaxel) followed by bevacizumab maintenance has proven benefit with respect to tumour response rate and progression-free survival, and could be recommended	I	A	Yes : 95% *(38 voters)* Missing : 5% *(2 voters)*
Bevacizumab in combination with 2nd or 3rd line non-platinum chemotherapy (weekly paclitaxel, pegylated liposomal doxorubicin, topotecan) has proven benefit with respect to tumour response rate and progression-free survival, and has been associated with improvement in Quality of Life, and could be recommended	I	A	Yes : 95% *(38 voters)* Missing : 5% *(2 voters)*
PARP inhibitors (olaparib, niraparib and rucaparib) when given as maintenance therapy following a response to platinum-based 2nd- or higher line of treatment have proven benefit with respect to progression-free survival, and could be recommended. The benefit is greatest in but not limited to patients with a BRCA^{mut}	I	A	*Yee: 87.5% (35 voters)* *Missing:12.5% (5 voters)*
PARP inhibitors (rucaparib*, olaparib) are active as monotherapy in patients with a BRCA mutation and could be considered (* 5/2018 only rucaparib currently licensed by EMA).	III	B	Yes : 95% *(38 voters)* Missing : 5% *(2 voters)*

Bevacizumab therapy and maintenance

	OCEANS	GOG-213	AURELIA
N (pts)	484	674	361
Inclusion	1st relapse with TFI-p >6months	1st relapse with TFI-p > 6 months	1st or 2nd relapse with TFI-p ≤ 6 months
Exclusion	• prior bevacizumab; • history of abdominal fistula or perforation, or intra-abdominal abscess • signs or symptoms of GI obstruction and/or requirement for parenteral hydration or nutrition • significant cardiovascular disease • major surgery within 28 days	• Prior/ concurrent immuno-therapy or radiotherapy • clinically significant cardiovascular disease • active bleeding or conditions associated with a high risk of bleeding	• Prior bevacizumab • history of bowel obstruction, abdominal fistula or perforation, or abscess • Rectosigmoid/large bowel involvement on CT scan • Prior pelvic/abdominal radiotherapy • thrombotic or haemorrhagic disorders within 6 months, uncontrolled hypertension or active significant cardiovascular disease
Regimen	• Carboplatin AUC 4, d1 q21 • Gemcitabine 1000 mg/m2, d 1+ 8 • +/- Bevacizumab (15 mg/kg) d1 -> Bev. Monotherapy until PD or toxicity	• Carboplatin AUC 5, d1 q21 • Paclitaxel 175 mg/m2, d 1 q21 • +/- Bevacizumab (15 mg/kg) d1 -> Bev. Monotherapy until PD or toxicity	• PLD or weekly paclitaxel, or topotecan • +/- Bevacizumab (10 mg/kg every 2 weeks or 15 mg/kg every 3 weeks) until progression or toxicity
PFS	• 12.3 vs 8.6 months • HR 0.48 (0.39-0.61), p<0.0001	• 13.8 vs 10.4 months • HR 0.63 (0.53–0.74), p<0.0001	• 6.7 vs 3.4 months • HR 0.48 (0.38-0.60), p< 0.001
OS	• 32.9 vs 33.6 months • HR 0.95 (0.77–1.18) – ns	• 42.4 vs 37.3 months • HR 0.83 (0.68-1.01), p=0.056	• 16.6 vs 13.3 months • HR 0.85 (0.66-1.08) p< 0.174
Reference	Aghajanian C et al. J Clin Oncol 2012	Coleman, RL et al. Lancet Oncol 2017	Pujade-Lauraine, E et al. J Clin Oncol 2014

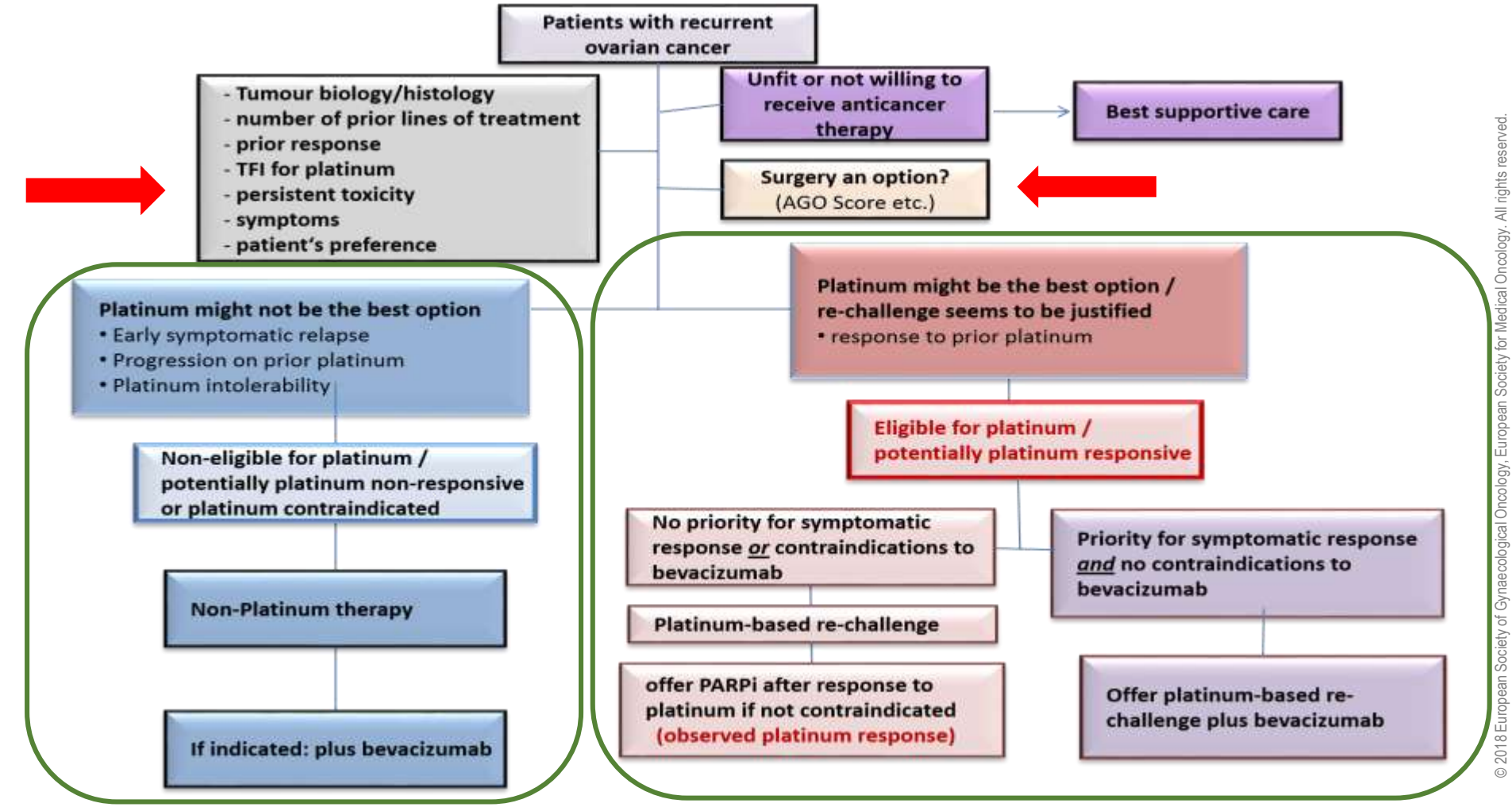
PARP inhibitors maintenance post platinum-based chemotherapy

	Study 19 Olaparib	SOLO2 Olaparib	NOVA Niraparib	ARIEL 3* Rucaparib
N (pts)	265	295	533	564
Inclusion	• HGSOC	• BRCA1/2 mutated • HGSOC or high-grade endometrioid ovarian cancer	• HGSOC	• HGSOC or high-grade endometrioid ovarian cancer
Median PFS months	**All HGSOC** ▪ 4.8 v 8.4 mo ➢ HR 0.35 **BRCA mutation** ▪ 11.2 v 4.3 mo ➢ HR 0.18 **BRCA-wt** ▪ 7.4 v 5.5 mo ➢ HR 0.54	**BRCA mutation** ▪ 19.1 vs 5.5 mo ➢ HR 0.30	**gBRCA mutation** ▪ 21.0 vs 5.5 mo ➢ HR 0.27 **non gBRCA** ▪ 9.3 vs 3.9 mo ➢ HR 0.45	**tBRCA mutation** ▪ 16.6 vs 5.4 mo ➢ HR 0.23 **ITT (with or w/o BRCA mutation)** ▪ 10.8 vs 5.4 mo ➢ HR 0.36
Median OS	▪ 27.8 vs 29.8 months • HR 0.73	▪ 45 vs 27 months • HR 0.80 (immature)	• immature	• immature
Reference	Ledermann et al NEJM 2012; Lancet Oncol 2014	Pujade-Lauraine, E et al Lancet Oncol 2017	Mirza, M et al., NEJM 2016	Coleman, RL et al, Lancet 2017 **FDA licence. EMA Pending*

RECURRENT DISEASE

What defines platinum resistance and how does that influence subsequent treatment?

Summary of recommendations	LoE	GoR	Consensus
There are currently no molecular biomarkers to predict platinum-response. Resistance to platinum in recurrent ovarian cancer is a therapeutic-oriented definition : 1. Proven platinum resistance: progression during platinum therapy 2. Assumed /expected platinum resistance: early symptomatic relapse with low probability of response to platinum. These patients should be treated with sequential non-platinum therapy adding bevacizumab if indicated. Sensitivity to platinum in recurrent ovarian cancer is a therapeutic-oriented definition : 1. Proven platinum sensitivity: response to platinum; these patients can receive maintenance PARP inhibitors 2. Assumed /expected platinum sensitivity: previous response to platinum without early symptomatic relapse; these patients should be treated with platinum-based therapy adding bevacizumab or followed by maintenance PARP Inhibitor therapy, if indicated. This group includes those who did not receive prior platinum or those who received adjuvant platinum post-surgery without any evaluable residual disease to assess chemotherapy response.	I-IV	A	Yes: 75% *(30 voters)* No: 10% *(4 voters)* Abstain: 2.5% *(1 voter)* Missing: 12.5% *(5 voters)*



Post Consensus Conference

- Final document should be approved by all participants
- All Consensus Conference participants will be listed as authors

THANK YOU FOR YOUR ATTENTION!