peritoneal cancer and lung cancer each recorded 1 (1.5%) case. In most cases bilateral disease was present (43 cases, 67.2%), while surface involvement was recorded in 55 patients (86%). Survival data existed only for a subset of 15 patients with median overall survival of 23.7 months (95% CI 11.2-34.8).

**Conclusion** Metastatic ovarian cancer is more usually seen from primary gastric, breast and colon cancer. Hematogenous spread appears a more common route in these cases, rather than transserosal pathway. Despite survival data were limited in a subset of patients, data indicate the presence of long-term survivors. Analysis of larger datasets is warranted to optimize surgical and medical treatment in patients with metastatic disease to the ovary.

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**CORRELATIVE ANALYSES OF PHASE 1B STUDY OF NAVICIXIZUMAB PLUS PACLITAXEL IN PATIENTS WITH PLATINUM RESISTANT OVARIAN CANCER USING XERNA™ TME PANEL**

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**Introduction/Background** No biomarkers have been established yet to predict response to anti-angiogenic treatment. To test whether the Xerna™ TME Panel, a novel biomarker, is predictive of anti-angiogenic treatment outcome, an exploratory, retrospective analysis of the Phase 1b study of navicixizumab in combination with paclitaxel in platinum resistant ovarian cancer was performed. Navicixizumab is a bispecific anti-angiogenic antibody to vascular endothelial growth factor (VEGF) and delta-like ligand 4. The Xerna™ TME Panel, a novel biomarker, is hypothesized to predict response to anti-angiogenic treatment outcome, an exploratory, retrospective analysis of the Phase 1b study of navicixizumab in combination with paclitaxel in platinum resistant ovarian cancer was performed. Navicixizumab is a bispecific anti-angiogenic antibody to vascular endothelial growth factor (VEGF) and delta-like ligand 4. The Xerna™ TME Panel evaluates RNA gene expression data of ~100 genes defining the immune and angiogenic biologies that dominate the tumor microenvironment (TME). This novel diagnostic employs a machine learning model to classify a patient’s TME along immune and angiogenic axes, resulting in classification into one of four TME subtypes—Angiogenic (A), Immune Suppressed (IS), Immune Active (IA) and Immune Desert (ID). We hypothesized that patient TME subtypes classified with angiogenic dominant biology (A/IS) are more likely to benefit from treatment with navicixizumab relative to those in the biomarker negative subgroup (IA/ID).

**Methodology** The Phase 1b study of navicixizumab (3 mg/kg or 4 mg/kg, IV, q2w) in combination with paclitaxel (80 mg/m2 IV on D0, D7, and D14 of 28-day cycle) was an open-label, non-randomized study that included 44 patients with platinum-resistant, grade 2/3 ovarian cancer. Patients received a median of 4 prior treatments (63% prior bevacizumab, 45% prior PARP). Pre-treatment tumor tissue was analyzed retrospectively using the Xerna™ TME Panel.

**Results** The objective response rate per RECIST 1.1 was 43.2% in the overall patient population (n=44). Responses were durable (median 6 months [95% CI, 5.4 months, not estimable]). Pre-treatment tumor tissue was available for 33 patients. In the B-positive subgroup (A/IS, n=13), 62% of patients had an objective response, compared to 25%, in the B-negative subgroup (IA/ID, n=20). PFS was 9.2 months in the B-positive subgroup vs. 3.9 months in the B-negative subgroup, HR = 0.43 [95% CI 0.188 to 0.999].

**Conclusion** Navicixizumab plus paclitaxel demonstrated promising clinical activity in this heavily pretreated patient population. The Xerna™ TME Panel may identify patients more likely to benefit from treatment with navicixizumab and should be prospectively evaluated in a future study.