TRENDS IN PHASE 3 CLINICAL TRIALS IN OVARIAN CANCER FROM 2001–2021

Katherine Cotangco, Anja Aliabadi, Caitlin Johnson, Amanda Mann, Ritu Salani, Joshua Cohen, Daniel Kapp, John K Chan. University of California Los Angeles, Obstetrics and Gynecology, Los Angeles, USA; UCLA, David Geffen School of Medicine, Los Angeles, USA; California Pacific Medical Center Research Institute, Gynecologic Oncology, San Francisco, USA; Palo Alto Medical Foundation Research Institute, Gynecologic Oncology, Palo Alto, USA; Stanford University School of Medicine, Radiation Oncology, Palo Alto, USA

Objectives To determine the trends and progress of clinical trials on ovarian cancer over the last 20 years.

Methods From 2001 to 2021, all phase 3 clinical trials were identified from clinicaltrials.gov. Demographics and characteristics were analyzed for comparison and trends using chi square analysis.

Results Of 43,641 ovarian cancer patients enrolled in 58 clinical trials, 19 were based in the US and 39 were based internationally. There were 35 (60%) government sponsored trials vs. 23 (40%) industry trials. 18 (31%) trials studied chemotherapy vs. 40 (69%) targeted therapies; 17 (30%) trials incorporated biomarkers. The median number of patients per trial was 581 (range 50–1952), and those using PFS vs. OS was 35 (60%) vs. 14 (24%). To evaluate trends, we studied two time periods, 2001–2010 and 2011–2021. There was an increase in industry sponsored trials (5% (2001–2010) vs. 9% (2011–2021); p-value<.05), targeted therapy trials (10% to 43%; p-value <.05), biomarker use (BRCA, HRD, PDL1) (67% to 89%; p-value<.05), and incorporation of PFS endpoint (57% to 70%; p-value=0.3). There was a decrease in the median number of patients enrolled per trial (n= 820 to 426) and in the proportion of patients with comorbidities (ECOG>2) (17% to 7%; p-value=.02).

Conclusions Over the past 20 years, targeted therapy trials incorporating biomarker use has increased, but the number of patients enrolled and those with comorbidities has decreased. These trends in trial design and enrollment are important in understanding the applicability of their results to our patients.

PATTERNS OF PALLIATIVE CARE UTILIZATION BY WOMEN WITH GYNECOLOGIC MALIGNANCIES IN ONTARIO, CANADA: A 13-YEAR POPULATION-BASED RETROSPECTIVE ANALYSIS

Sarah J Mah*, Lia Eriksson, Daniel Carter Ramirez, Kara Schnarr, Hsien Seow. McMaster University and Juravinski Cancer Centre, Gynecologic Oncology, Hamilton, Canada; Juravinski Hospital and Cancer Centre, Division of Gynecologic Oncology, Hamilton, Canada; McMaster University and Juravinski Cancer Centre, Palliative Care (family Practice), Hamilton, Canada; McMaster University and Juravinski Cancer Centre, Oncology, Hamilton, Canada

Objectives Early palliative care (PC) (≥6–12mo from death) has been associated with improved patient quality-of-life, less aggressive end-of-life care, and prolonged survival, and is understudied in gynecology. We characterized patterns of PC utilization and predictive factors in gynecologic cancer patients.

Methods We conducted a population-based, retrospective cohort study of gynecologic cancer decedents in Ontario from 2006–2018 using ICES-linked administrative healthcare data. Multivariable logistic regression was used to determine factors associated with PC utilization.

Results In this cohort of 16,237 women, 93.4% of decedents accessed palliative care, initially in the outpatient setting for 68.8% and institutional for 31.2%. Palliative care was initiated a median 127 days before death (IQR 38–361d), and PC users accessed a median 8 institutional days (IQR 0–21d) and 41 community days (IQR 3–174d). While use of community PC gradually increased toward the end of life, use of institutional palliative care exponentially increased from 12 weeks until death. On multivariable analyses, factors significantly associated with an increased likelihood of receiving palliative care were longer cancer-related survival and Deyo-Charlson comorbidity score ≥1. Factors significantly associated with decreased likelihood of palliative care were age ≥80 years, diagnosis of uterine or vulvar-vaginal cancers, initial diagnosis of stage I–III malignancy (vs. stage IV), living rurally or in the third income quintile, or death after 2007.

Conclusions While >90% of gynecologic cancer decedents accessed palliative care, median initiation was within the last 4 months of life (late PC), which may result in suboptimal quality of life and end-of-life care. Access to PC may be inequitable.