Future Perspectives on Personalized Medicine for Endometrial Cancer

Ritu Salani, MD, MBA
University of California Los Angeles
Professor, Obstetrics & Gynecology
Division Director, Gynecologic Oncology
rsalani@mednet.ucla.edu

Monday, November 6, 2023
Disclosures

Advisory Board/Consultant

• Merck
• Eisai
• Seagen
• Karyopharm
• GSK
Endometrial Cancer Recurrence Risk

- Median PFS is ~8 months
- 80% will recur within first two years.

<table>
<thead>
<tr>
<th>Study (control arm)</th>
<th>Median PFS (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GY-018</td>
<td>8.7m</td>
</tr>
<tr>
<td>RUBY</td>
<td>7.9m</td>
</tr>
<tr>
<td>GOG 209 (TC arm)</td>
<td>13m</td>
</tr>
<tr>
<td>MITO END-2</td>
<td>10.5m</td>
</tr>
<tr>
<td>FANDANDO</td>
<td>7.2m</td>
</tr>
</tbody>
</table>
Overall survival in MMRp advanced/recurrent EC is ~30 months
Clinical Trial Overview
Endometrial cancer MMRp, P53wt
# Clinical trials in dMMR EC - Can we eliminate chemotherapy?

<table>
<thead>
<tr>
<th><strong>Pembrolizumab</strong></th>
<th><strong>Dostarlimab</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KEYNOTE-C93</strong></td>
<td><strong>DOMENICA</strong></td>
</tr>
<tr>
<td><strong>Study treatment</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Pembrolizumab 400 mg IV q6w for 18 cycles (2 years)</td>
<td>▪ Dostarlimab 500 mg q3w (cycles 1-4) then dostarlimab 1000 mg q6w (for up to 2 years)</td>
</tr>
<tr>
<td>▪ Carboplatin AUC 5 or 6 mg/mL/min IV q3w + paclitaxel 175 mg/m² IV q3w for 6 cycles (with option for &gt;6 cycles)</td>
<td>▪ Carboplatin AUC 5-6 + paclitaxel 175 mg/m² q3w (for 6 cycles)</td>
</tr>
<tr>
<td><strong>Key eligibility criteria</strong></td>
<td></td>
</tr>
<tr>
<td>▪ dMMR status</td>
<td>▪ dMMR/MSI-H status</td>
</tr>
<tr>
<td>▪ Stage III/IV or recurrent EC including carcinosarcoma Radiographically evaluable disease (measurable or nonmeasurable per RECIST v1.1)</td>
<td>▪ Endometrial adenocarcinoma with primary advanced stage IIIC2 or stage IV disease or first recurrence</td>
</tr>
<tr>
<td>▪ No prior systemic therapy</td>
<td>▪ Prior neo/adjuvant chemotherapy allowed if ≥6 months from last treatment to relapse</td>
</tr>
<tr>
<td>▪ ECOG PS 0-1</td>
<td>▪ All histologic subtypes of endometrial adenocarcinoma included if dMMR/MSI-H</td>
</tr>
<tr>
<td>▪ ECOG PS 0-1</td>
<td>▪ ECOG PS 0-1</td>
</tr>
</tbody>
</table>

MK-3475-B21/ENGOT-en11/GOG-3053: KEYNOTE-B21

A Phase 3, Randomized, Double-Blind Study of Pembrolizumab versus Placebo in Combination With Adjuvant Chemotherapy With or Without Radiotherapy for the Treatment of Newly Diagnosed High-Risk Endometrial Cancer After Surgery With Curative Intent

Key eligibility criteria:
- Newly diagnosed endometrial carcinoma or carcinosarcoma
- High Risk*
- No prior therapy including XRT or neo-adjuvant
- Curative intent TH/BSO +/- LN sampling/dissection
- No residual disease

Dual Primary Endpoints:
- Disease Free Survival (DFS)
  - Investigator
  - Overall Survival (OS)

Secondary Endpoints:
- DFS by blinded independent central review
- DFS/OS by TMB, PD-L1 status
- Safety
- QoL

Stratification factors:
- MMR status (if pMMR, then further stratification by:
  - Stage (I/II vs III/IVA)
  - Planned radiation (EBRT vs Chemo-EBRT vs no EBRT)
  - Histology (non-endometroid vs endometroid)

* High Risk:
  - FIGO (2009) Surgical Stage I or II with myometrial invasion of non-endometroid histology or any histology with known aberrant p53 expression or p53 mutation
  - FIGO (2009) Surgical Stage III or IVA of any histology

NCT04634877
ENGOT-en9/LEAP-001
A Phase 3 Randomized, Open-Label, Study of Pembrolizumab (MK-3475) Plus Lenvatinib (E7080/MK-7902) Versus Chemotherapy for First-line Treatment of Advanced or Recurrent EC

**Screening period**
- Patients (N=875)
  - Stage III, stage IV, or recurrent endometrial cancer with measurable or radiographically apparent disease
  - May have received 1 prior line of adjuvant/neoadjuvant chemotherapy (chemotherapy and/or chemoradiation), if recurrence occurred ≥6 months after last dose of chemotherapy.
  - ECOG PS of 0 or 1

**Treatment period**
- Pembrolizumab 200 mg IV Q3W + lenvatinib 20 mg orally QD<sup>a</sup>
- N-306 (pMMR) plus ~132 dMMR patients<sup>b</sup>
- Paclitaxel 175 mg/m<sup>2</sup> IV Q3W + carboplatin AUC 6 IV Q3W<sup>c,d</sup>
- N-306 (pMMR) plus ~132 dMMR patients<sup>b</sup>

**Posttreatment follow-up**
- Follow-up:
  - Safety
  - Disease status
  - Survival status

**Stratification factors**
- pMMR vs dMMR
  - If pMMR
    - ECOG (0 vs 1)
    - Measurable disease (yes vs no)
    - Prior chemotherapy and/or chemoradiation (yes vs no)

© IGCS and ESGO 2022. Re-use permitted under CC BY. Published by BMJ.
Marth C. Int J Gynecol Cancer 2022.
A Phase 2/3 Study of Navtemadlin as Maintenance Therapy in Subjects with TP53WT Advanced or Recurrent Endometrial Cancer Who Responded to Chemotherapy

Figure 1: Study Schema

**ENROLLMENT**

Subjects with *TP53WT*
Advanced or Recurrent Endometrial Cancer Who Have a CR/PR after Chemotherapy

**PART 1 (PHASE 2)**

*ARM 1*

Navtemadlin 180 mg
7D on / 21D off
(n=21)

*ARM 2*

Navtemadlin 240 mg
7D on / 21D off
(n=21)

*ARM 3*

Observational Control
28-day Cycle
(n=21)

1 Cycle = 28 days

**PART 2 (PHASE 3)**

Randomized 2:1

*ARM A/B*

Navtemadlin Phase 3 dose
7D on / 21D off
(n=130)

*ARM C/D*

Placebo (Matching Navtemadlin Phase 3 dose)
7D on / 21D off
(n=65)

NCT05797831
KRT-232-11: Navtemadlin

Phase 2/3 Study of Navtemadlin as Maintenance Therapy in Subjects with TP53WT Advanced or Recurrent Endometrial Cancer Who Responded to Chemotherapy 8/GOG-3089

- Oral MDM2 inhibitor
- Restores p53 activity to drive apoptosis of wild type TP53 cells
  - Expression of pro-apoptotic Bcl-2 family proteins
Randomized, Double-blinded, Phase 3 Trial of Maintenance with Selinexor/Placebo After Combination Chemotherapy for Participants with Advanced or Recurrent EC

**ARM A**
Selinexor, 80 mg, oral, once weekly. Start 5 to 8 weeks after completion of chemo

**ARM B**
Placebo, 80 mg, oral, once weekly. Start 5 to 8 weeks after completion of chemo

**PFS as assessed by the investigator per RECIST 1.1**

**PFS as assessed by the BIRC per RECIST 1.1, DSS, OS, TFST, PFS2, TSST, & DCR**

**KEY INCLUSION CRITERIA:**

- Histological confirmed endometrial cancer of the endometrioid, serous, or undifferentiated type. Carcinosarcoma of the uterus is also allowed.
- Completed a single line of at least 12 weeks of taxane-platinum combination therapy (not including adjuvant or neoadjuvant therapy), and achieved partial or complete remission (PR or CR) according to RECIST version 1.1 for:
  - Primary Stage IV disease, OR
  - At first relapse (i.e., relapse after primary therapy including surgery and/or chemotherapy therapy for Stage I-IV disease).
- Must be able to initiate study drug 5 to 8 weeks after completion of their final dose of chemotherapy.

**KEY EXCLUSION CRITERIA:**

- Previous treatment with an exportin 1 (XPO1) inhibitor or with anti-PD1 or anti-PD-L1 immunotherapy (e.g., pembrolizumab).
Selinexor

- XPO1 exports the major tumor suppressor proteins away from the nucleus

- Cancer cells
  - Overexpress XPO1
  - Inactivate cytoplasmic p53 through protein degradation

- Selinexor inhibits XPO1 nuclear export
  - Leads to retention and reactivation of TSPs in the nucleus and stabilization of p53
  - Results in selective killing of cancer cells
## Patient Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Selinexor (n = 174)</th>
<th>Placebo (n = 89)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years, median (range)</td>
<td>65.5 (40-81)</td>
<td>64.0 (33-81)</td>
</tr>
<tr>
<td>&lt;70</td>
<td>116 (66.7)</td>
<td>61 (68.5)</td>
</tr>
<tr>
<td>≥70</td>
<td>58 (33.3)</td>
<td>28 (31.5)</td>
</tr>
<tr>
<td>Race, No. (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>4 (2.3)</td>
<td>4 (4.5)</td>
</tr>
<tr>
<td>Black or African American</td>
<td>7 (4.0)</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>Native Hawaiian or other Pacific Islander</td>
<td>1 (0.6)</td>
<td>0</td>
</tr>
<tr>
<td>White</td>
<td>158 (90.8)</td>
<td>81 (91.0)</td>
</tr>
<tr>
<td>Others</td>
<td>4 (2.3)</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>Ethnicity, No. (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>9 (5.2)</td>
<td>5 (5.6)</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>160 (92.0)</td>
<td>83 (93.3)</td>
</tr>
<tr>
<td>Not reported</td>
<td>1 (0.6)</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>4 (2.3)</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>ECOG performance status, No. (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>99 (56.9)</td>
<td>54 (60.7)</td>
</tr>
<tr>
<td>1</td>
<td>71 (40.8)</td>
<td>35 (39.3)</td>
</tr>
<tr>
<td>2</td>
<td>1 (0.6)</td>
<td>0</td>
</tr>
<tr>
<td>Histology, No. (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endometrioid</td>
<td>96 (55.2)</td>
<td>48 (53.9)</td>
</tr>
<tr>
<td>Serous</td>
<td>49 (28.2)</td>
<td>28 (31.5)</td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>4 (2.3)</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Carcinosarcoma</td>
<td>10 (5.7)</td>
<td>6 (6.7)</td>
</tr>
<tr>
<td>Endometrial adenocarcinoma (^{a})</td>
<td>15 (8.6)</td>
<td>6 (6.7)</td>
</tr>
</tbody>
</table>

### Molecular characterization of TP53 mutation status, No. (%)

- Wild type 67 (38.5) 36 (40.4)
- Mutant/aberrant 74 (42.5) 40 (44.9)
- Unknown 33 (19) 13 (14.6)

### Molecular characterization of microsatellite instability status, No. (%)

- MSS/pMMR 113 (64.9) 59 (66.3)
- MSI-H/dMMR 22 (12.6) 13 (14.6)
- Unknown 39 (22.4) 17 (19.1)

### Disease at the time of taxane-platinum combination therapy, No. (%)

#### Unaudited stratification factors

- Primary stage IV disease 82 (47.1) 41 (46.1)
- Recurrent disease 83 (47.7) 41 (46.1)
- Missing \(^{1}\) 9 (5.2) 7 (7.9)

#### Audited stratification factors

- Primary stage IV disease 78 (44.8) 43 (48.3)
- Recurrent disease 96 (55.2) 46 (51.7)

### Disease status after the most recent chemotherapy, No. (%)

#### Unaudited stratification factors

- Complete response 72 (41.4) 37 (41.6)
- Partial response 102 (58.6) 52 (58.4)

#### Audited stratification factors

- Complete response 70 (40.2) 40 (44.9)
- Partial response 104 (59.8) 49 (55.1)
**KCP-330-024/BGOG-EN5/ENGOT-EN5/SIENDO/GOG-3055**

**PFS: ITT population**

**PFS: TP53 status**

## SIENDO TEAEs

<table>
<thead>
<tr>
<th>Event</th>
<th>Selinexor n = 171 (per patient), No. (%)</th>
<th>Placebo n = 88 (per patient), No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any Grade</td>
<td>Grade 3 or 4</td>
</tr>
<tr>
<td><strong>Hematologic AEs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>61 (35.7)</td>
<td>12 (7.0)</td>
</tr>
<tr>
<td>Anemia</td>
<td>42 (24.6)</td>
<td>4 (2.3)</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>41 (24.0)</td>
<td>15 (8.8)</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>15 (8.8)</td>
<td>2 (1.2)</td>
</tr>
<tr>
<td><strong>Nonhematologic AEs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>137 (80.1)</td>
<td>16 (9.4)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>86 (50.3)</td>
<td>2 (1.2)</td>
</tr>
<tr>
<td>Constipation</td>
<td>32 (18.7)</td>
<td>0</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>46 (26.9)</td>
<td>1 (0.6)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>53 (31.0)</td>
<td>10 (5.8)</td>
</tr>
<tr>
<td>Asthenia</td>
<td>48 (28.1)</td>
<td>10 (5.8)</td>
</tr>
<tr>
<td>Decreased appetite</td>
<td>52 (30.4)</td>
<td>2 (1.2)</td>
</tr>
<tr>
<td>Dysgeusia</td>
<td>28 (16.4)</td>
<td>0</td>
</tr>
<tr>
<td>Dizziness</td>
<td>20 (11.7)</td>
<td>2 (1.2)</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>15 (8.8)</td>
<td>2 (1.2)</td>
</tr>
<tr>
<td>Decreased weight</td>
<td>15 (8.8)</td>
<td>0</td>
</tr>
<tr>
<td>Headache</td>
<td>11 (6.4)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Dose reduction</strong></td>
<td>84 (49.1)</td>
<td></td>
</tr>
<tr>
<td><strong>Dose interruption</strong></td>
<td>78 (45.6)</td>
<td></td>
</tr>
<tr>
<td><strong>Discontinuation because of AE</strong></td>
<td>17 (9.9)</td>
<td><strong>15.8%</strong></td>
</tr>
</tbody>
</table>
GOG 3055/SIENDO: Long-term PFS follow up, TP53

**TP53wt**
- Selinexor (n=77): 27.4 mo (95% CI 13.1-NR)
- Placebo (n=36): 5.2 mo (95% CI 2.0-13.1)
- HR: 0.42 (95% CI 0.25-0.70)
- One-sided nominal P-value = 0.0003

**TP53mut/abn**
- Selinexor (n=79): 4.2 mo (95% CI 3.6-5.6)
- Placebo (n=47): 5.4 mo (95% CI 3.7-7.2)
- HR: 1.34 (95% CI 0.89-2.02)
- One-sided nominal P-value = 0.9202

Median follow-up: 25.3 months for TP53wt, 22.9 months for TP53mut/abn.

Pre-specified subgroups
GOG 3055/SIENDO: Long-term PFS follow up, $TP53$, $MMR$

**TP53wt / MSS(pMMR)**

- **Selinexor (N=47):** NR (95% CI 20.8-NR)
- **Placebo (N=23):** 4.9 mo (95% CI 2.0-NR)
- HR: 0.32 (95% CI 0.16-0.66)
- One-sided nominal P-value = 0.0006

**TP53wt / MSI-H(dMMR)**

- **Selinexor (N= 20):** 13.1 mo (95% CI 3.6-NR)
- **Placebo (N=9):** 3.7 mo (95% CI 1.9-NR)
- HR: 0.45 (95% CI 0.16-1.27)
- One-sided nominal P-value = 0.0643
ENGOT-EN20/GOG 3083/XPORT-EC-042

ENGOT-EN20/GOG-3083/XPORT-EC-042 (NCT05611931)
Selinexor in Maintenance Therapy After Systemic Therapy for Participants With p53 Wild-Type, Advanced or Recurrent Endometrial Carcinoma

Study is ongoing and actively enrolling.

Planned enrollment (N = 220)
Patients ≥ 18 years with
• Known TP53 wt EC by central NGS
• Primary stage IV disease or first recurrent EC
• Received ≥ 12 weeks of platinum-based chemotherapy ± immunotherapy

PR/CR per RECIST v1.1
R 1:1
Selinexor 60 mg P.O. QW
Placebo P.O. QW

Stratification
• Primary stage IV vs recurrent
• PR vs CR

Primary endpoint
• PFS assessed by investigator

Key secondary endpoint
• OS

Other secondary endpoints
• Safety
• TFST
• TSST
• PFS2
• PFS assessed by BICR
• QoL (EQ-5D-5L)

Exploratory endpoints
• PFS per histology subtypes and per other molecular features
• CR rate
• Duration of CR
• Tumor biomarkers
• PK exposure parameters and efficacy/safety endpoints
Impact on future treatment algorithm: How to approach frontline and subsequent therapies for advanced endometrial cancer
Advanced disease: carboplatin and paclitaxel

- **MMR IHC or MSI testing**
  - Aberrant
    - **dMMR or MSI-H**
      - + Checkpoint inhibitor \(\rightarrow\) maintenance
    - NSMP
      - xport-EC-042
      - + Checkpoint inhibitor(?) or + Trastuzumab (HER2)
  - Normal
    - **p53 immunohistochemistry**
      - Normal/Wild-type pattern
      - Aberrant/Mutant pattern

- **POLE sequencing**

- **POLE**

- Rechallenge carboplatin and paclitaxel
## What is on the Horizon?

<table>
<thead>
<tr>
<th>Targeting HER2</th>
<th>Kickstarting apoptosis</th>
<th>Revisiting endocrine therapy</th>
<th>FR-α inhibition</th>
<th>Inhibiting TROP-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trastuzumab deruxtecan: DESTINY (phase 2)¹</td>
<td>Selinexor: SIENDO (phase 3)³; xport-EC-042 (phase 3)⁴</td>
<td>Letrozole + palbociclib: PALEO (phase 2)⁶</td>
<td>Mirvetuximab soravtansine + gemcitabine: NCT02996825 (phase 1)⁸</td>
<td>Farletuzumab ecteribulin: NCT03386942 (phase 2)⁹</td>
</tr>
<tr>
<td>Trastuzumab ± C/P: NCT01367002 (phase 2)²</td>
<td>Navtemadlin: EURUS (phase 2/3)⁵</td>
<td>Letrozole + abemaciclib: GOG-3039 (phase 2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FR-α = folate receptor alpha; HER2 = human epidermal growth factor 2; TROP-2 = Trophoblast cell surface antigen 2.

Endocrine therapy

Progestin therapy
- Response rates in recurrent disease: 11-24%
- 1st line, positive ER/PR status, lower grade, and younger age
- Often reserved for fertility preservation or palliative therapy

Everolimus and Letrozole
- Response rate 24% (53% if no prior chemotherapy)
- Clinical benefit rate 78%

Aromatase and CDK 4/6 inhibitors
- PALEO (palbociclib + letrozole v letrozole)
- DCR 63.6% vs 37.8%; PFS 8.3 vs 3.0 months
- Abemaciclib + letrozole
- ORR 30%; PFS 9.1 m (no response in TP53m)

Targeting HER2

- HER2 is a negative prognostic marker
- Prevalence in uterine cancer ~20%
  - No standard testing
- Phase II trial of trastuzumab + chemotherapy
  - Improved PFS in UPSC with HER2 overexpression
Trastuzumab ADCs in Endometrial Cancer

- Ado-trastuzumab emtansine (T-DM1)
  - HER2 Amplified Tumors (Basket Trial)

  Endometrial Cancer

  ![Response (%) graph showing different responses to treatment]

  - ORR: 21.0% (95% CI 9%-41%)
  - One patient not RECIST evaluable has SD by non-target lesions
  - NED for 36+ M post treatment discontinuation

- Trastuzumab Deruxtecan (T-Dxd): DESTINY PanTumor 02
  - HER2 expression (2-3+)
  - 2L population
  - 40 patients/cohorted

- Trastuzumab Deruxtecan (T-Dxd): STATICE
  - HER2 Expressing Uterine Carcinosarcoma

  - HER2 high
  - HER2 low

  ![Graph showing maximum change in sum of diameters of target lesion from baseline, %]

  - Confirmed ORR
  - ORR in IHC 3+: 47.1%
  - ORR in IHC 2+: 57.5%

  - Maximum Tumor Shrinkage (%)
  - 5.4 mg/kg
  - 6.4 mg/kg

  ![Breakthrough designation graph]

Inhibiting TROP2

- **TROP 2**
  - Implicated in intracellular signaling pathways
  - May be a modulator of EpCAM-induced cell signaling
  - Fosters cell migration

- **Overexpression in endometrial cancer is common**
  - Present in 90+% of samples
    - 62% with expression in at least 50% of tumor cells

**TARGET: TROP2**

Sacituzumab Govitecan

---

TROP2 Inhibition in Endometrial Cancer

- 2+ TROP 2 IHC staining
  - Median 3 prior lines

<table>
<thead>
<tr>
<th>Table 2. Overall response rate and durable disease control</th>
<th>SG (n = 21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Best overall response</td>
<td>n (%)</td>
</tr>
<tr>
<td>Confirmed complete response (CR)</td>
<td>1 (4.8)</td>
</tr>
<tr>
<td>Confirmed partial response (PR)</td>
<td>6 (28.5)</td>
</tr>
<tr>
<td>Stable disease</td>
<td>11 (47.6)</td>
</tr>
<tr>
<td>Progressive disease</td>
<td>3 (14.3)</td>
</tr>
<tr>
<td>Objective response rate (confirmed CR + PR)</td>
<td>7 (33.3)</td>
</tr>
<tr>
<td>Durable disease control (confirmed CR + PR + SD ≥ 6 months)</td>
<td>7 (35.0)*</td>
</tr>
</tbody>
</table>

*Out of 20 patients evaluable for durable disease control

- Median PFS 5.7 months; OS 22.5 months

- TROPiCS-03: Endometrial Cancer Cohort
  - Prior anti PD(L)1 therapy in 61%
  - 20 patients

- 25% ORR; clinical benefit rate 35%
- Median PFS 5.6 months
FR-α Inhibition: ADCs

- FRα overexpression in ~64% of endometrial tumors

- Ongoing trials:
  - Mirvetuximab soravtansine in MSS EC (NCT03835819)
  - STRO-002 in recurrent EC (NCT03748186)

TARGET: Folate Receptor α

Assaraf et al. Drug Resistance Updates (2014); Moore et al. Cancer 2017
Take-Aways

• Molecular profiling is critical in EC treatment selection
• Maintenance strategies being utilized for high risk patients
• Emerging therapies with novel targets being explored

Thank you!

“It’s always Sit, Stay, Heel - never Think, Innovate, Be yourself.”