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An Industry Supported Symposium during the IGCS 2025 Global Annual Meeting

Global Perspective in Advance, Recurrent Cervical Cancer: Resources, Opportunities and Access to Care

This session is not included in the main event CME/CPD credit.

Cape Town, South Africa

Thursday, November 6, 2025

18:15 - 19:15 GMT+2

Welcome and Introductions

Leslie Randall, MD

Inova Health

Fairfax, Virginia, USA

MODERATOR

Leslie Randall, MD, MAS

Inova Health
Fairfax, Virginia, USA

FACULTY

Kosei Hasegawa, MD, PhD

Saitama Medical University
Kawagoe, Japan

Ritu Salani, MD, MBA

UCLA Health
Los Angeles, California, USA

Disclosures

Faculty	
Leslie Randall, MD, MAS	Consultant (AstraZeneca; Genmab; Pfizer; GSK, Eisai; Merck; Abbvie; GOG Foundation, Corcept, Regeneron) Research Funding (Merck; AbbVie; GOG Foundation, Regeneron, Genmab, Seagen/Pfizer)
Ritu Salani, MD, MBA	Advisory board: Genmab, Pfizer, Abbvie, Daiichi, Merck, Eisai, Karyopharm Royalties: Up to Date.
Kosei Hasegawa, MD, PhD	

Learning Objectives

Upon completion of this activity, learners will:

- Review the current landscape for the treatment of recurrent cervix cancer based on pivotal clinical trial data and current insights.
- Understand the role of ADC in cervix cancer, and how to educate patients on this novel treatment option.
- Review and understand prevalence of disease, prevention and available resources.

Agenda

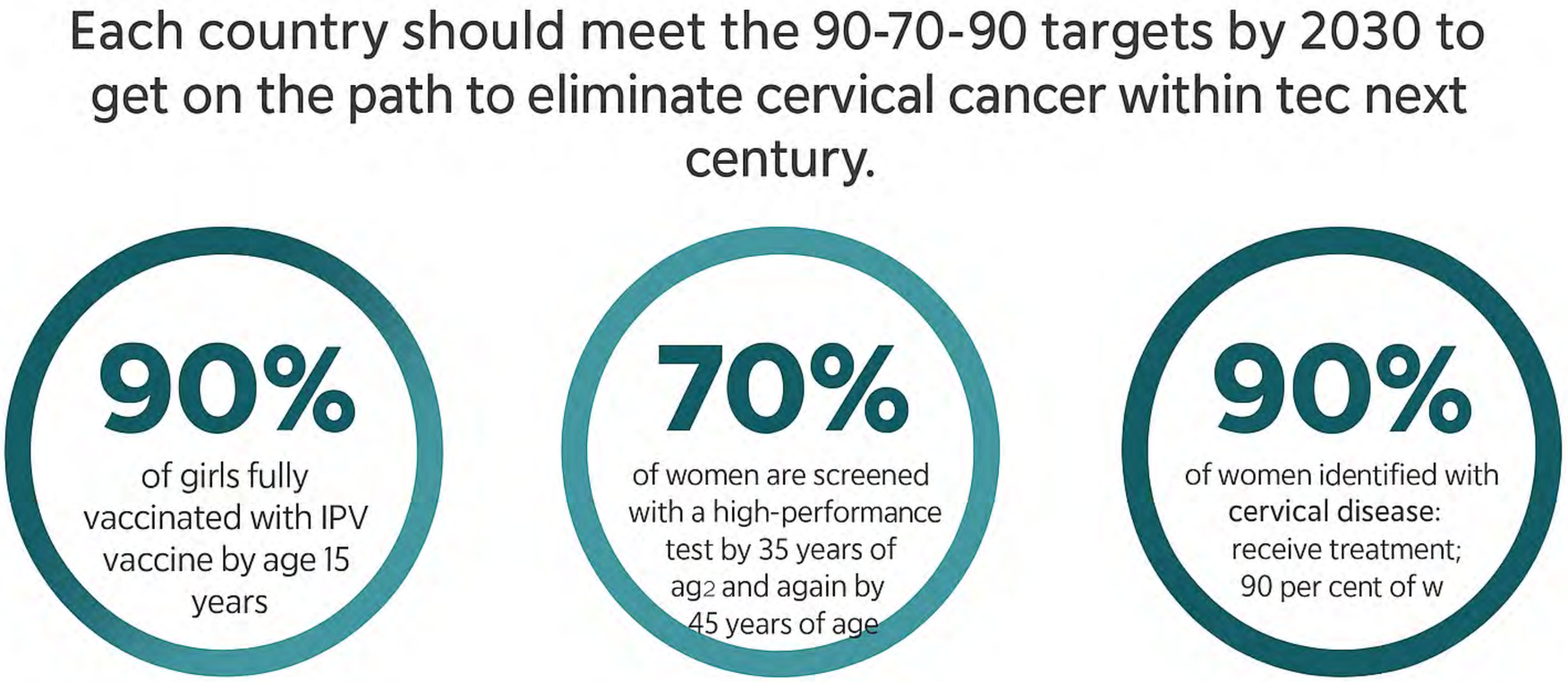
Topic	Presenter
Welcome and Introduction	Dr. Leslie Randall Inova Health, Washington, DC, USA
Current Landscape of Recurrent Cervical Cancer	Dr. Kosei Hasegawa Saitama Medical University, Saitama, Japan
Antibody Drug Conjugates (ADCs) in Cervical Cancer	Dr. Ritu Salani UCLA Health, Los Angeles, CA, USA
Global Epidemiology & Prevention Strategies	Dr. Leslie Randall Inova Health, Washington, DC, USA
Panel Discussion, Q&A and Closing Comments	All Faculty

Current Landscape of Recurrent Cervical Cancer

Kosei Hasegawa, MD, PhD

Saitama Medical University International Medical Center
Saitama, Japan

- Cervical cancer: ~600,000 new cases, ~340,000 deaths annually (GLOBOCAN 2024).
- 9 of 10 deaths occur in low- and middle-income countries.
- But for the first time, *elimination* is possible.



Cervical Cancer in Japan and US

Cancer types	Number of Diagnosis (2018)	Number of Death (2019)	5 year relative survival rate (2009-11)
Japan	10,978	2,921	76.5 %
US	12,967	4,152	-

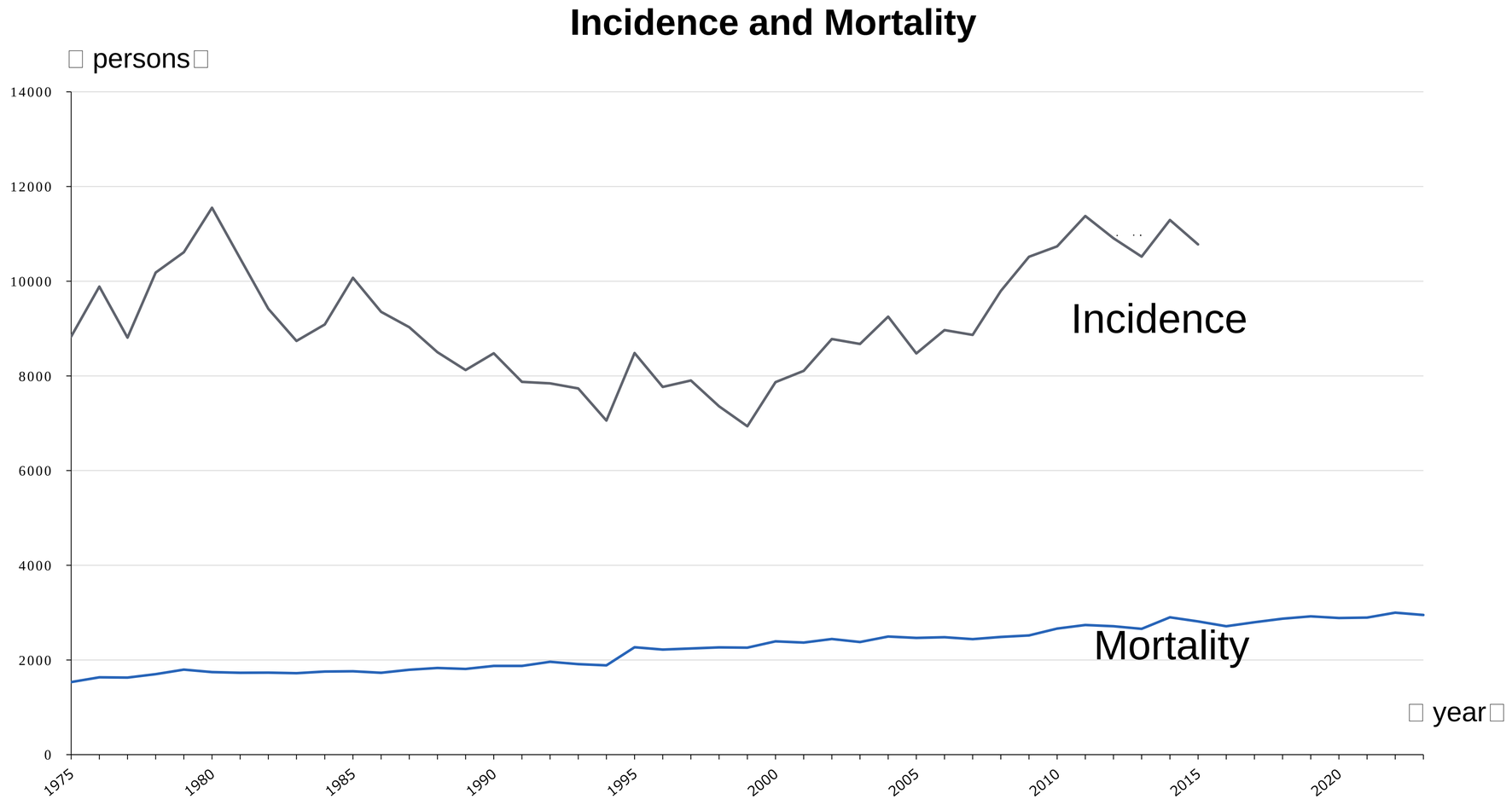
- HPV vaccination coverage by age15, females: Japan 6%, US 44% in 2015
- Cervical cancer screening: Japan 43.7%, US 72.6% in 2019

https://gis.cdc.gov/Cancer/USCS/#/Trends/

ganjoho.jp

Trends in Cervical Cancer Incidence and Mortality in Japan

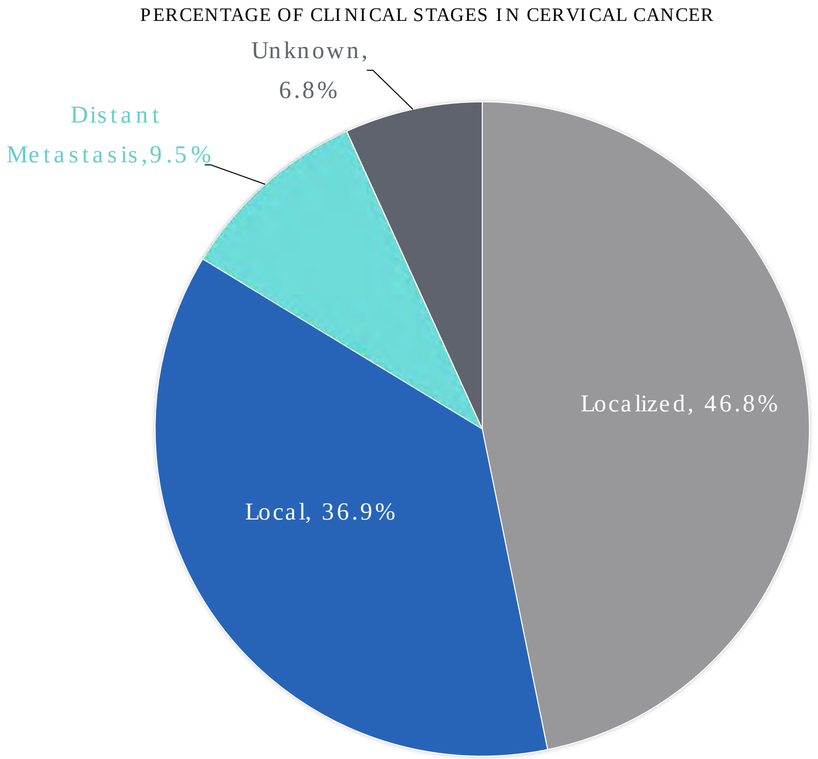
The number of cervical cancer cases in Japan exceeds 10,000 annually, with approximately 3,000 deaths from the disease in 2023. The trends in cervical cancer incidence and mortality are shown in the figure below, with mortality continuing to rise.

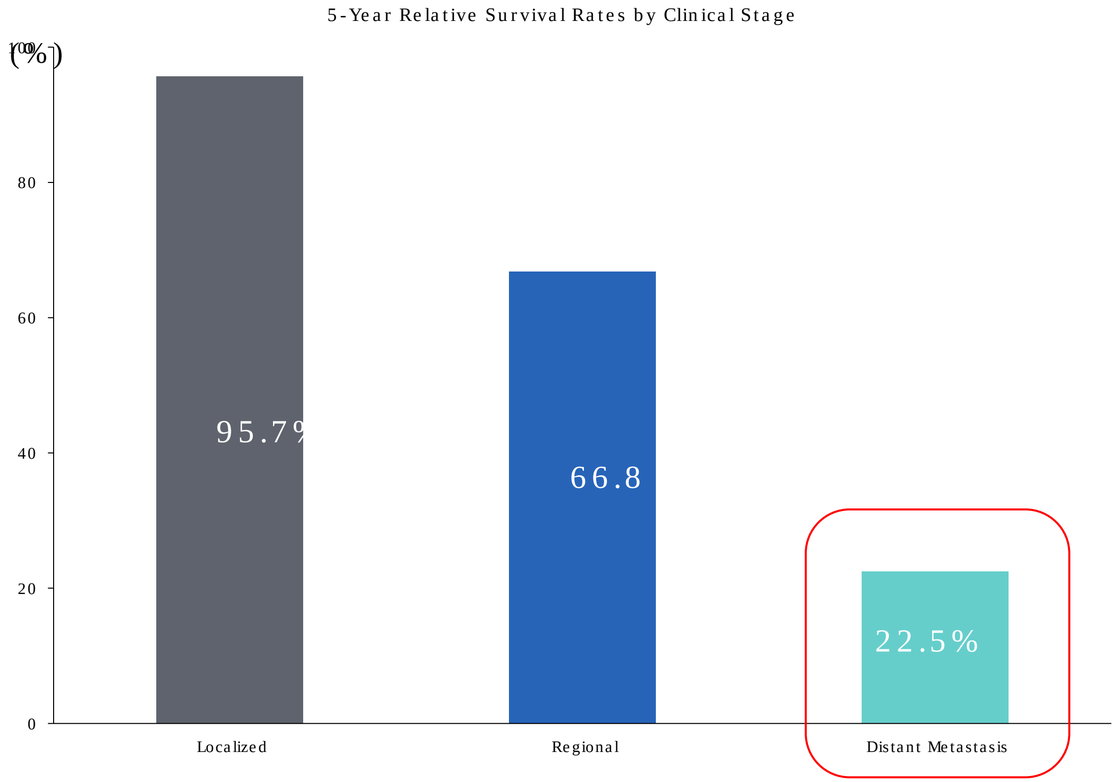


https://ganjoho.jp/reg_stat/statistics/stat/cancer/17_cervix_uteri.html 2025 2 5

Epidemiology of Advanced or Recurrent Cervical Cancer

In Japan, 9.5% of cervical cancer patients are diagnosed with distant metastasis, and the 5-year relative survival rate for patients with distant metastasis is 22.5%, indicating this is a group with a poor prognosis.





Localized: Confined to the primary organ

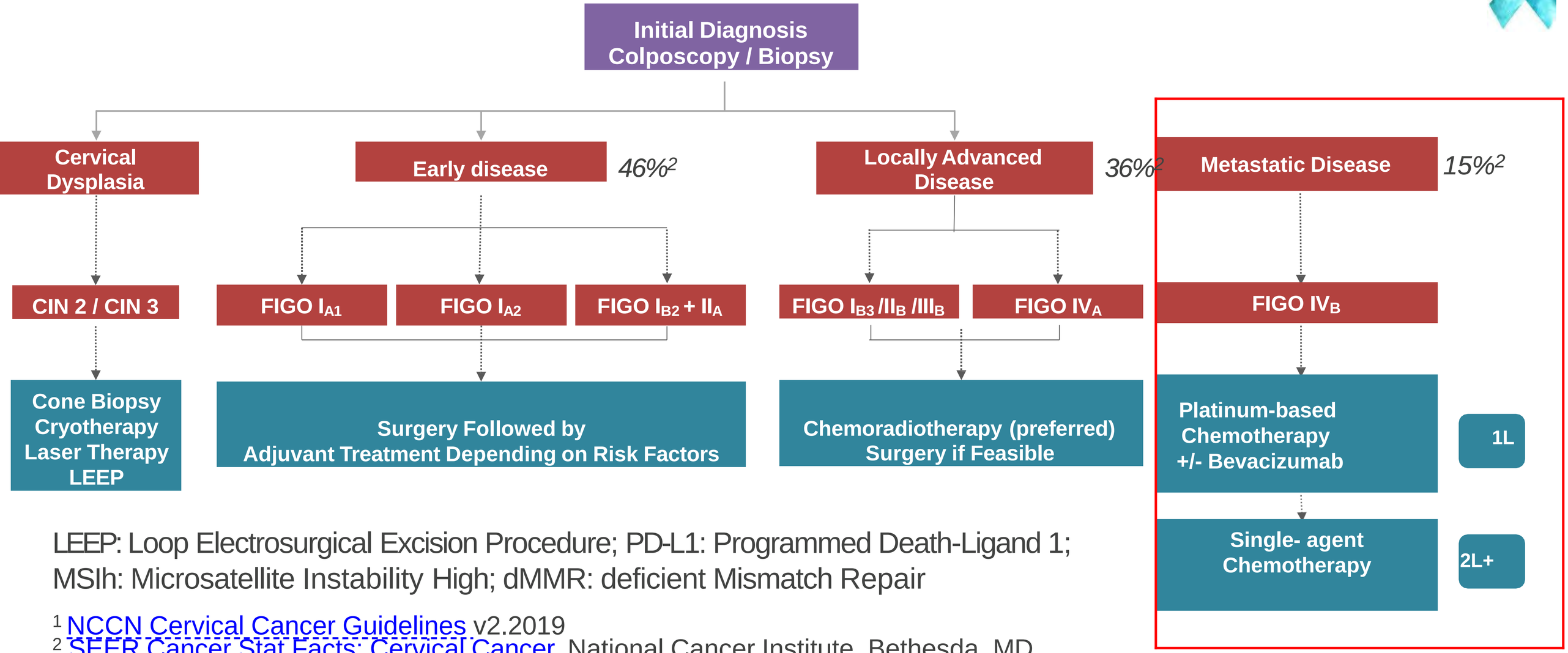
Regional: Regional lymph node metastasis (involvement of regional lymph nodes draining the primary organ, but no invasion of adjacent organs) or invasion of adjacent organs (direct invasion of adjacent organs, but no distant metastasis)

Distant metastasis: Metastasis or invasion to distant organs, distant lymph nodes, etc.

National Cancer Incidence Monitoring Summary: 2009-2011 Survival Rate Report (National Cancer Center Cancer Control Information Center, 2020)
National Cancer Center Research and Development Fund "Research on Improving the Accuracy and Utilization of Regional Cancer Registries" FY2010 Report

National Cancer Center Cancer Information Service: Cancer Survival Rate Data from Regional Cancer Registries (Cases Diagnosed 1993-2011) (5-Year Survival Rate)
https://ganjoho.jp/reg_stat/statistics/data/dl/index.html#a32[Accessed February 5, 2025]

Cervical Cancer: Summary of Treatment



LEEP: Loop Electrosurgical Excision Procedure; PD-L1: Programmed Death-Ligand 1; MSIh: Microsatellite Instability High; dMMR: deficient Mismatch Repair

[1] NCCN Cervical Cancer Guidelines v2.2019
[2] SEER Cancer Stat Facts: Cervical Cancer. National Cancer Institute. Bethesda, MD

2/3 Line+ Recurrent

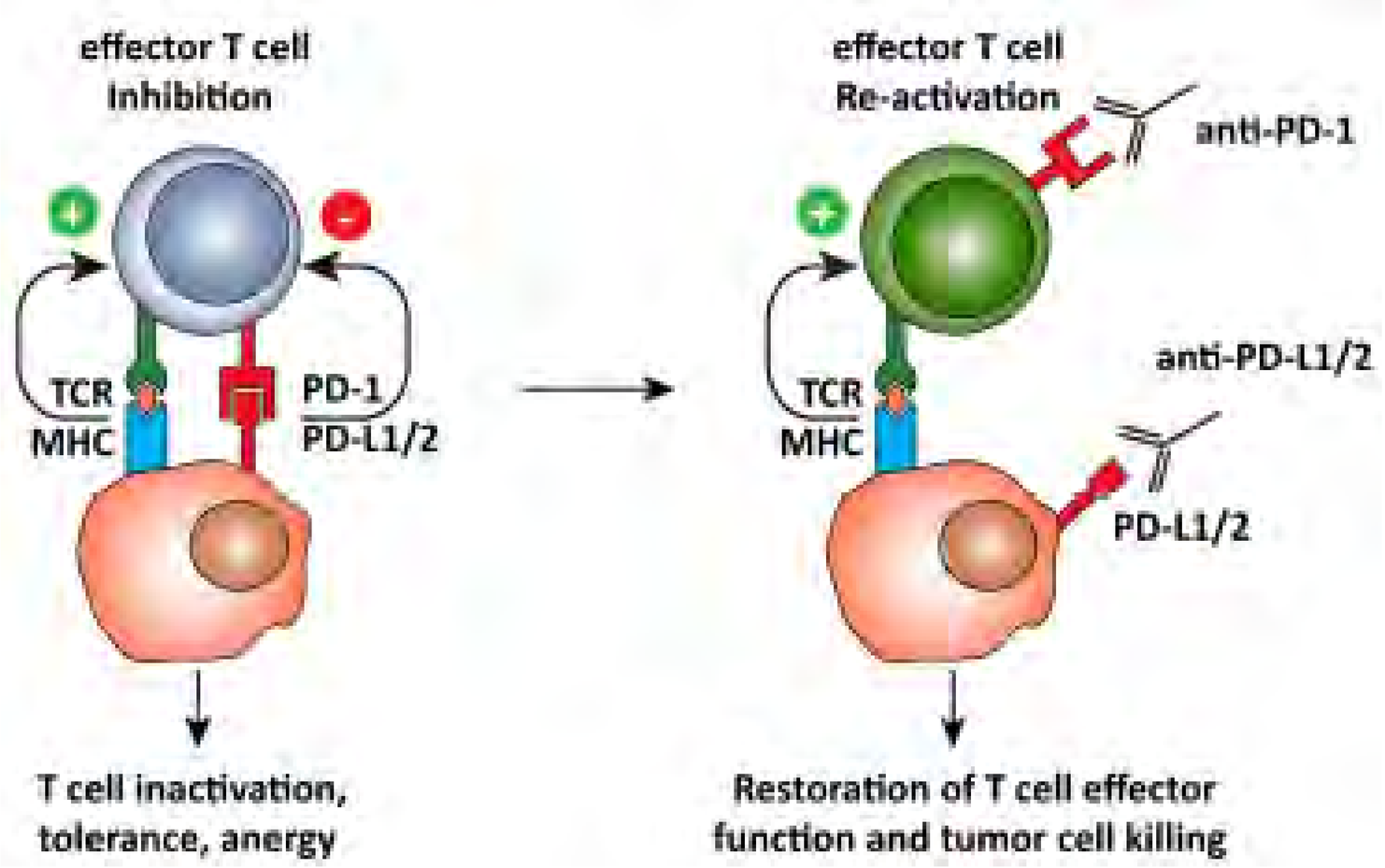
Regimen for 2L+ Metastatic Cervical Cancer

Design	N	ORR (%)	PFS (months)	OS (months)
Topotecan	45	12.5	2.1	6.6
Vinorelbine	44	13.7	NS	NS
Pemetrexed	**29**	**15**	**3.1**	**7.4**
Pemetrexed	**43**	**13.9**	**2.3**	**8.05**
Docetaxel	**27**	**8.7**	**3.8**	**7.0**
Gemcitabine	22	4.5	2.1	6.5
Bevacizumab	46	10.9	3.4	7.29

Non-platinum PFS: 2-3 M OS: 6-7 M

[1] *Yu et al., Am J Hematol Oncol 2015;11:27-31*

Reactivation of anti-tumor immunity through PD-1/L1 pathway blockade



PD-1/L1 pathway inhibition is effective against highly immunogenic tumors

KEYNOTE-158 (NCT02628067)
Cohort K – MSI-H Solid Tumors

Key Eligibility Criteria
- Any advanced solid tumor that is MSI-H[a], excluding colorectal cancer
- Progression on or intolerance to ≥1 line of standard therapy for unresectable and/or metastatic disease
- Measurable disease per RECIST v1.1
- ECOG PS 0 or 1
- Provision of a tumor sample for biomarker assessments

N = 351[b] → Pembrolizumab 200 mg IV Q3W Up to 35 cycles[c]

Primary Endpoint
- ORR per RECIST v1.1 by BICR

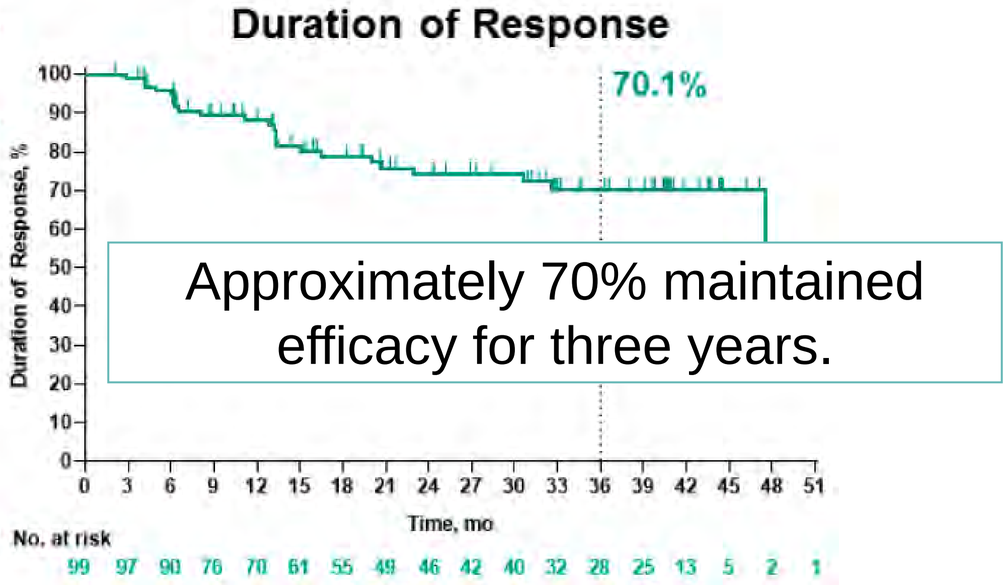
Secondary Endpoint
- DOR and PFS per RECIST v1.1 by BICR
- OS
- Safety

Statistical Analysis Details
- Efficacy assessed in all patients who received ≥1 dose of treatment with ≥6 mo follow-up
- Safety assessed in all treated patients

Efficacy Analysis Population	N = 321
ORR, % (95% CI)	30.8 (25.8–36.2)
CR	27 (8.4)
PR	72 (22.4)
SD	61 (19.0)
PD	131 (40.8)
Nonevaluable	3 (0.9)
No assessment[a]	27 (8.4)

The effect lasts for a long time

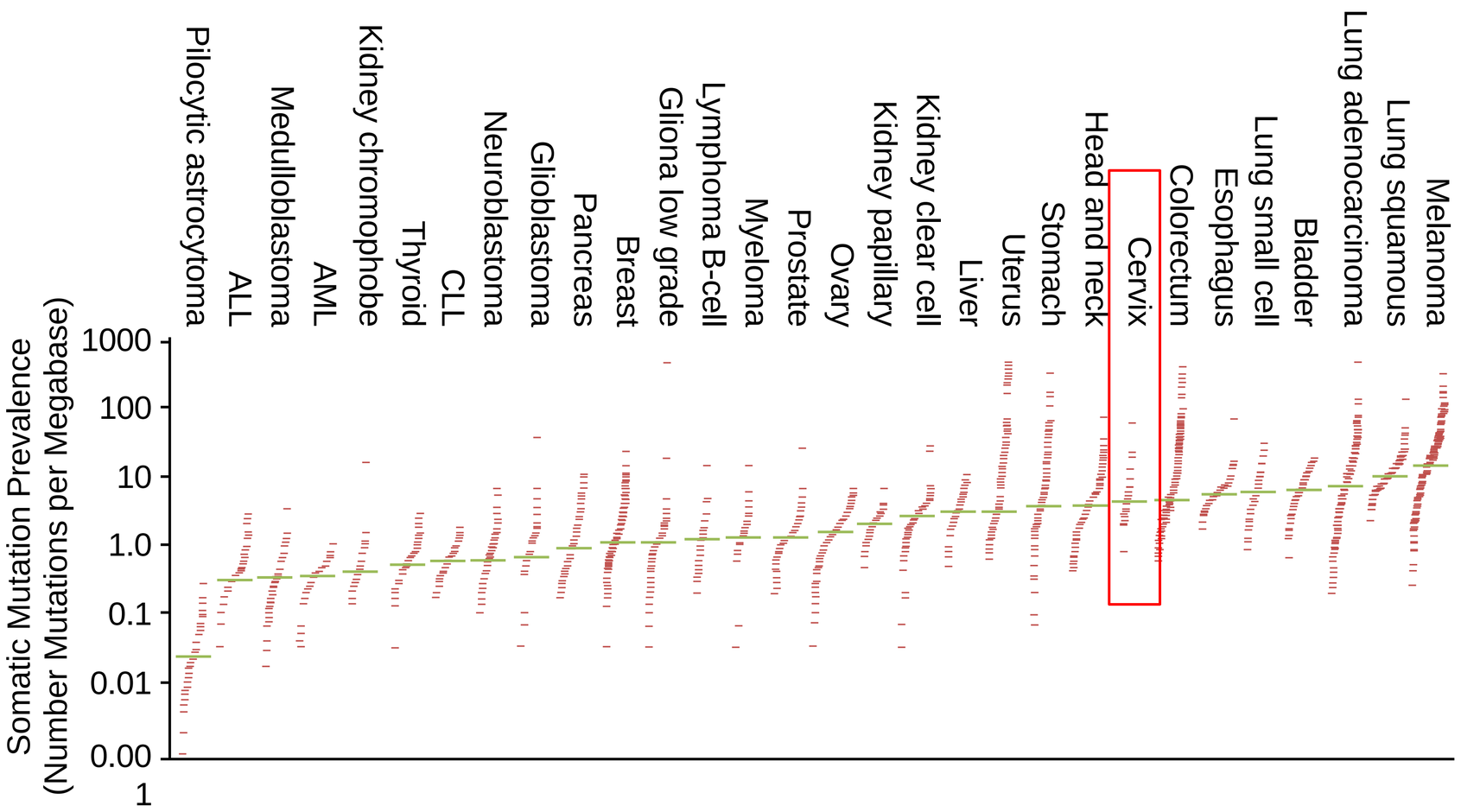
DOR is long



Approximately 70% maintained efficacy for three years.

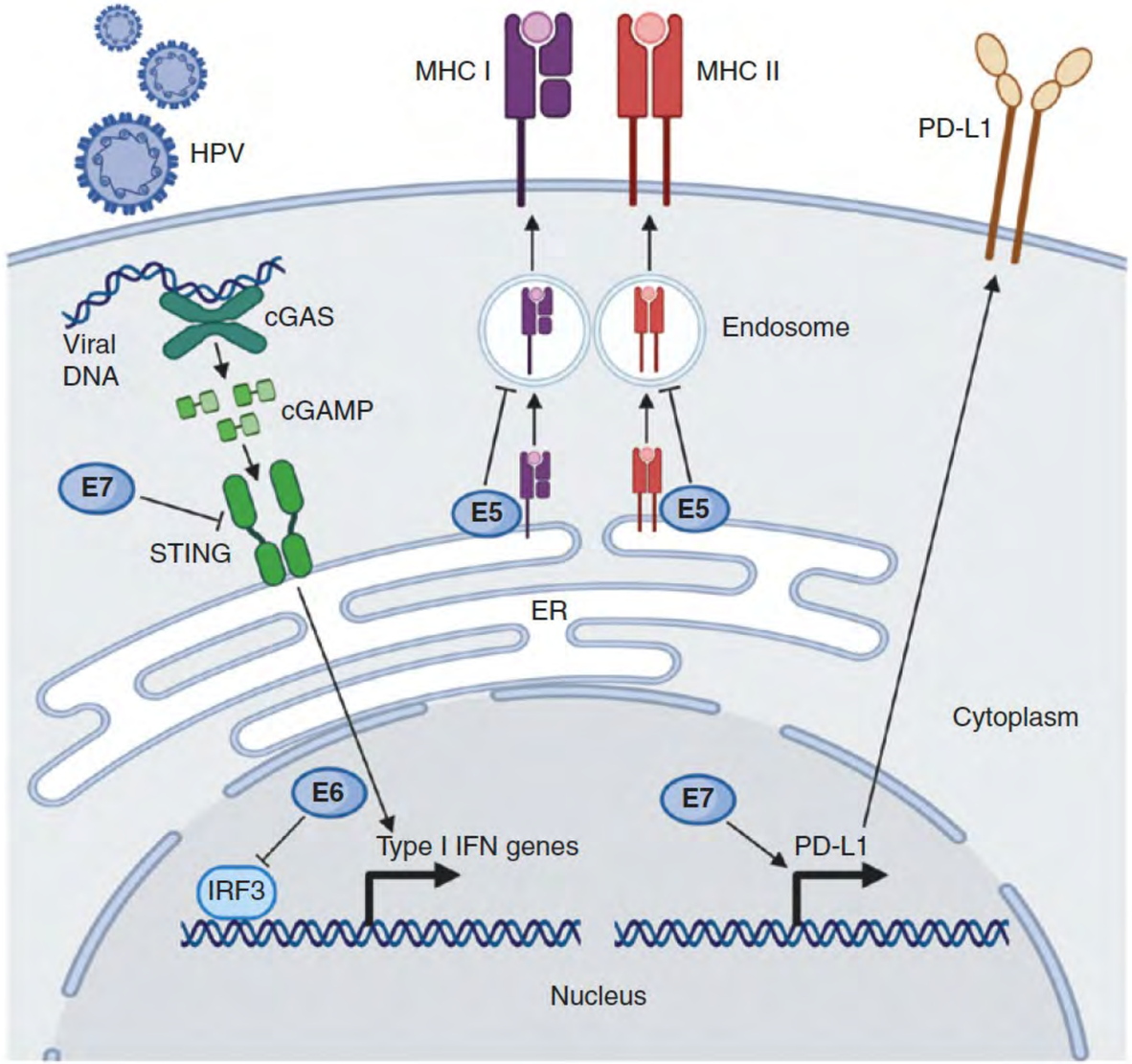
M Maio. ASCO 2021.

Mutational Burden Compared With Other Tumors



Alexandrov LB, et al. *Nature*. 2013;500(7463):415-421.

Cervical cancer is a target for immunotherapy



Virus-related (HPV)

- Viral antigens also targeted
- PD-L1 Expression
- Activation of innate immune pathways

Achraf A. Shamseddine et al. AUGUST 2021 CANCER DISCOVERY

Early Development of PD-1/L1 Pathway Inhibition for Cervical Cancer

Target	Drug（Study）	Ph	N. of pts	CR	PR	SD	ORR (%)	DCR (%)
PD-1	Pembrolizumab（KEYNOTE-028）	Ib	24	0	4	3	17	-
PD-1	Pembrolizumab（KEYNOTE-158）	Ⅱ	98	3	9	18	12.2	-
PD-1	Nivolumab（CheckMate358）	Ⅱ	19	1	4	8	26.3	68.4
PD-1	Nivolumab (ONO-4538-39)	Ⅱ	20	0	5	10	25	75
PD-1	Nivolumab (NRG-GY002)	Ⅱ	25	0	1	9	4	36
PD-1	Cemiplimab (R2810-1423)	Ib	10	0	1	3	10	40

- KETNOTE-158 showed an ORR of 14.6% in PD-L1 positive cases, 0% in negative cases
- ONO-4538-39 showed an ORR of 33% in PD-L1 positive cases, 0% in negative cases

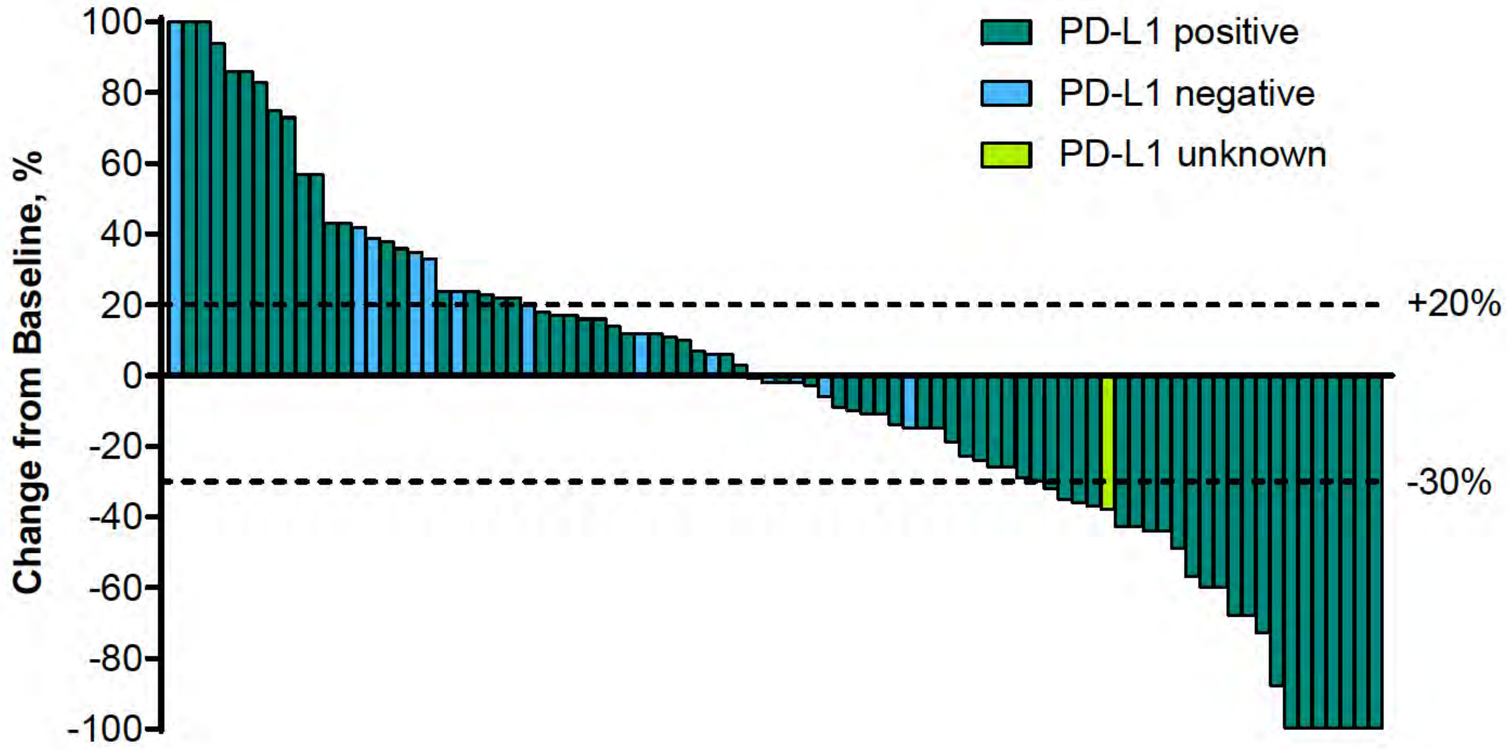
J Clin Oncol. 2017 Dec 20;35(36):4035-4041
J Clin Oncol 37:1470-1478.2019

J Clin Oncol 35, 2017 (suppl; abstr 5504)
J Clin Oncol 36, 2018 (suppl; abstr 5594)

Gynecol Oncol .2020 Apr;157(1):161-166
Gynecol Oncol. 2020; 159(2): 322–328

Early Development of PD-1/L1 Pathway Inhibition for Cervical Cancer

KEYNOTE-158

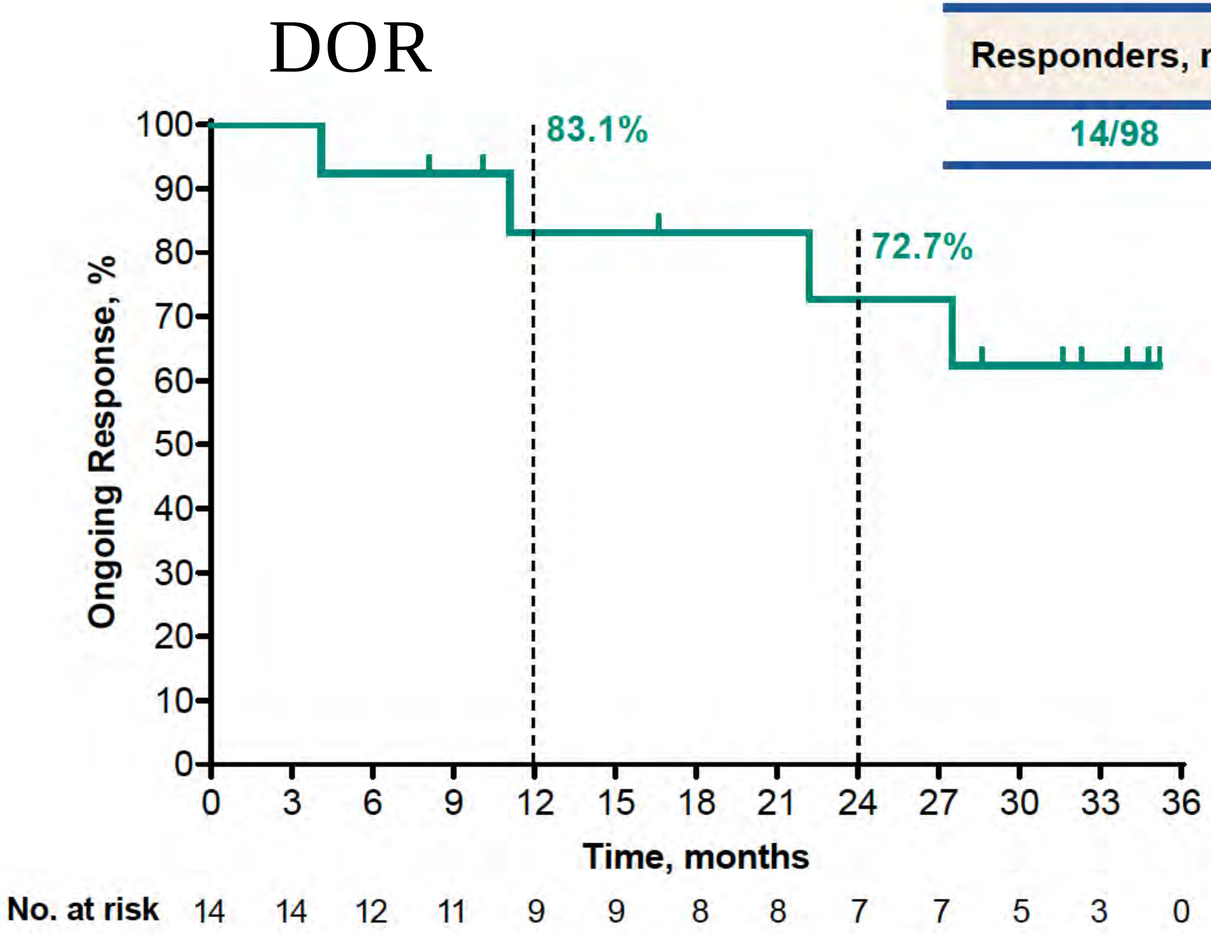


- ORR:14.3%
- PD-L1 +：17.1%
- PD-L1 -：0%
- TMB-h：31.1%
- non-TMB-h:11.9%

Includes patients with ≥1 evaluable post-baseline tumor assessment (n = 86). Data cutoff date: June 27, 2019.

Chung HC SGO2021

KEYNOTE-158



Responders, n/N	Median, months (95% CI)
14/98	NR (3.7+ to 35.2+)

- Over 70% of cases showing efficacy maintained that response for more than two years.

Includes patients with best overall response of complete or partial response (n = 14). NR = Not Reached. "+" indicates there is no progressive disease by the time of last disease assessment. Data cutoff date: June 27, 2019.

Chung HC SGO2021

EMPOWER-CERVICAL 1

EMPOWER-CERVICAL 1/GOG-3016/ENGOT-CX9 STUDY DESIGN* (NCT03257267)

Recurrent and metastatic cervical cancer resistant to platinum-based chemotherapy ≥2nd line
ECOG PS ≤1

N=608: 477 SCC, 131 AC
Randomised 1:1
Stratified by:
- Histology (SCC/AC)
- Geographic region
- Prior bevacizumab (Y/N)
- ECOG PS (0 vs 1)

Patients were enrolled regardless of PD-L1 expression

Cemiplimab 350 mg Q3W IV

IC chemotherapy

Options:
- Pemetrexed 500 mg/m² Q3W IV
- Gemcitabine 1,000 mg/m² IV on Days 1 and 8 and every 21 days
- Topotecan 1 mg/m² daily IV for 5 days, every 21 days
- Irinotecan 100 mg/m² IV weekly x 4, followed by 10–14 days rest
- Vinorelbine 30 mg/m² IV on Days 1 and 8 and every 21 days

Treat up to 96 weeks with option for re-treatment

Tumour imaging conducted on Day 42 (±7 days) of cycles† 1–4, 6, 8, 10, 12, 14, and 16

Primary endpoint: OS

Secondary endpoints: PFS, ORR, DOR, safety, QoL

Exploratory endpoints: PK, immunogenicity, biomarkers, PD

- Two interim analyses were prespecified per protocol
- At first interim analysis, IDMC recommended trial to continue
- At second interim analysis (85% of total OS events), IDMC recommended trial be stopped early for efficacy; presented here

*Performed according to ENGOT Model C.[1] †To account for differences in drug administration schedules, one cycle is defined as 6 weeks.
AC, adenocarcinoma or adenosquamous carcinoma; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; IC, investigator's choice; IDMC, Independent Data Monitoring Committee; IV, intravenously; ORR, objective response rate; OS, overall survival; PD, pharmacodynamics; PD-L1, programmed cell death ligand 1; PFS, progression-free survival; PK, pharmacokinetics; Q3W, every 3 weeks; QoL, quality of life; SCC, squamous cell carcinoma.

1. Vergote I et al. *Int J Gynecol Cancer*. 2019;0:1–4.

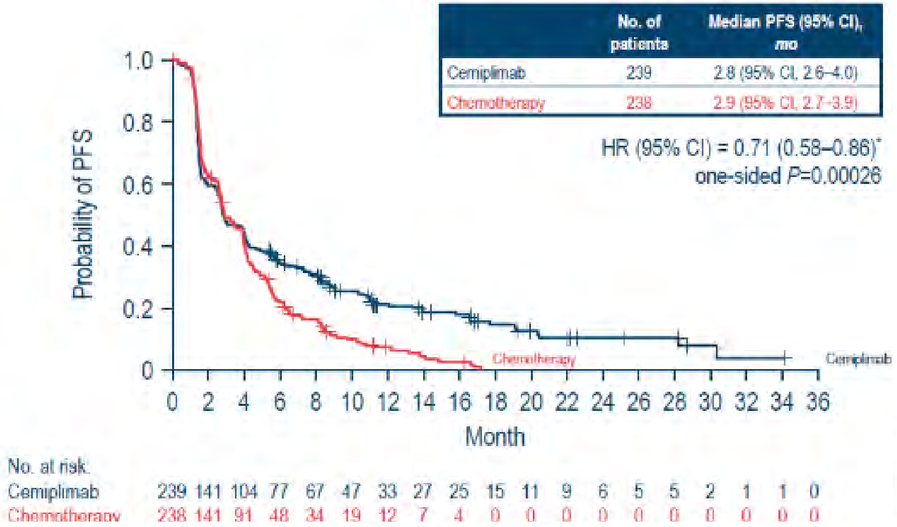
本邦において未承認情報を含みます

国内で承認された効能又は効果・用法及び用量につきましては、当該製品の添付文書をご参照ください

EMPOWER-CERVICAL 1

PROGRESSION-FREE SURVIVAL

SCC Population

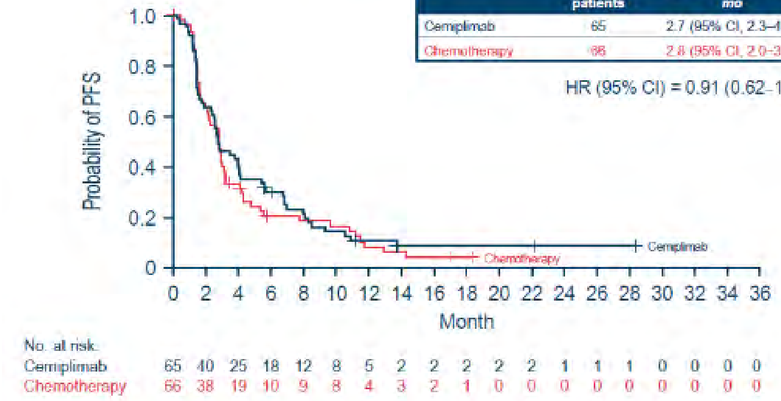


	No. of patients	Median PFS (95% CI), *mo*
Cemiplimab	239	2.8 (95% CI, 2.6–4.0)
Chemotherapy	238	2.9 (95% CI, 2.7–3.9)

HR (95% CI) = 0.71 (0.58–0.86)*
one-sided *P*=0.00026

No. at risk:																			
Cemiplimab	239	141	104	77	67	47	33	27	25	15	11	9	6	5	5	2	1	1	0
Chemotherapy	238	141	91	48	34	19	12	7	4	0	0	0	0	0	0	0	0	0	0

AC Population



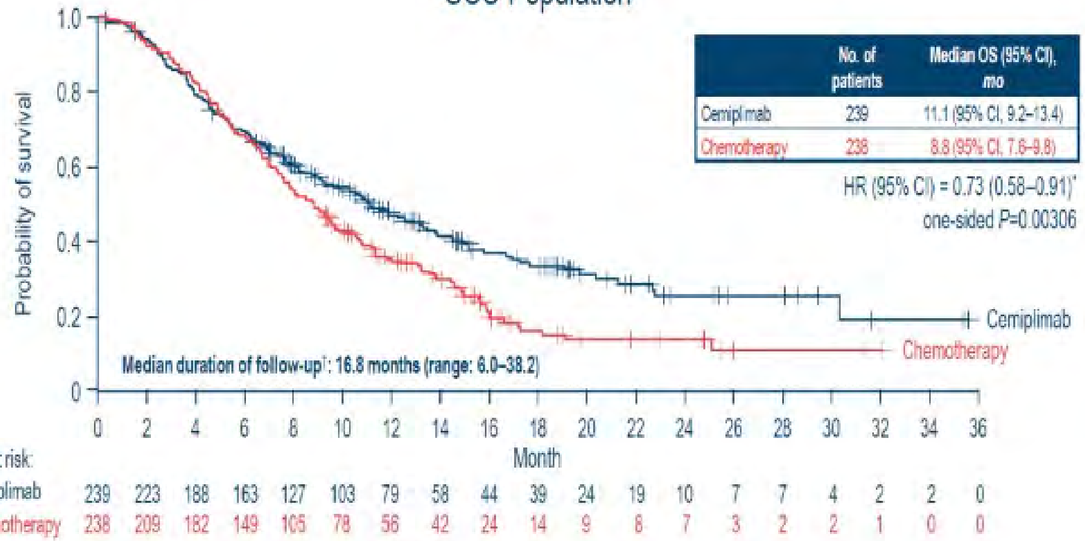
	No. of patients	Median PFS (95% CI), *mo*
Cemiplimab	65	2.7 (95% CI, 2.3–4.0)
Chemotherapy	66	2.8 (95% CI, 2.0–3.2)

HR (95% CI) = 0.91 (0.62–1.34)†

No. at risk:																			
Cemiplimab	65	40	25	18	12	8	5	2	2	2	2	2	1	1	1	0	0	0	0
Chemotherapy	66	38	19	10	9	8	4	3	2	1	0	0	0	0	0	0	0	0	0

OVERALL SURVIVAL

SCC Population

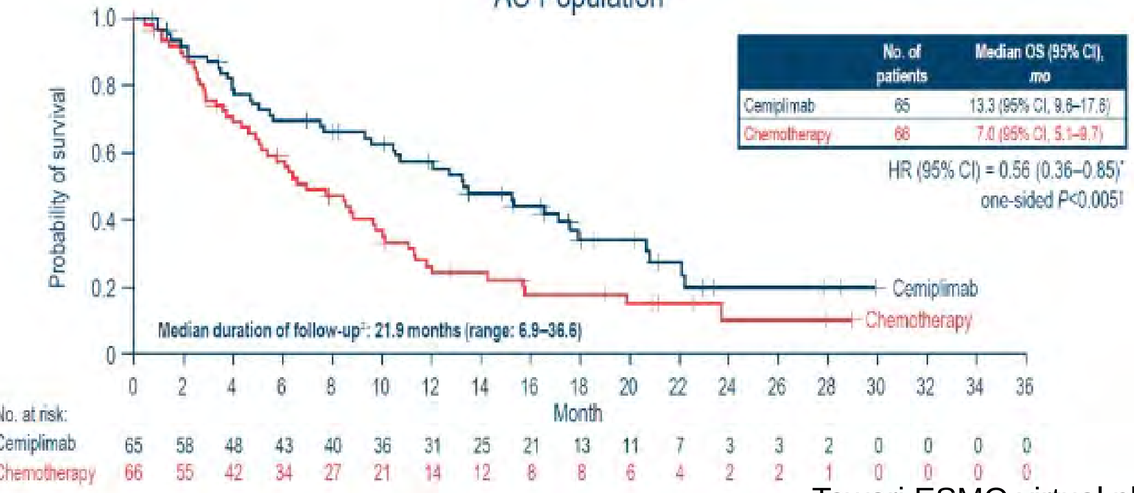


	No. of patients	Median OS (95% CI), *mo*
Cemiplimab	239	11.1 (95% CI, 9.2–13.4)
Chemotherapy	238	8.8 (95% CI, 7.6–9.8)

HR (95% CI) = 0.73 (0.58–0.91)*
one-sided *P*=0.00306

No. at risk:																			
Cemiplimab	239	223	188	163	127	103	79	58	44	39	24	19	10	7	7	4	2	2	0
Chemotherapy	238	209	182	149	105	78	56	42	24	14	9	8	7	3	2	2	1	0	0

AC Population



	No. of patients	Median OS (95% CI), *mo*
Cemiplimab	65	13.3 (95% CI, 9.8–17.6)
Chemotherapy	66	7.0 (95% CI, 5.1–9.7)

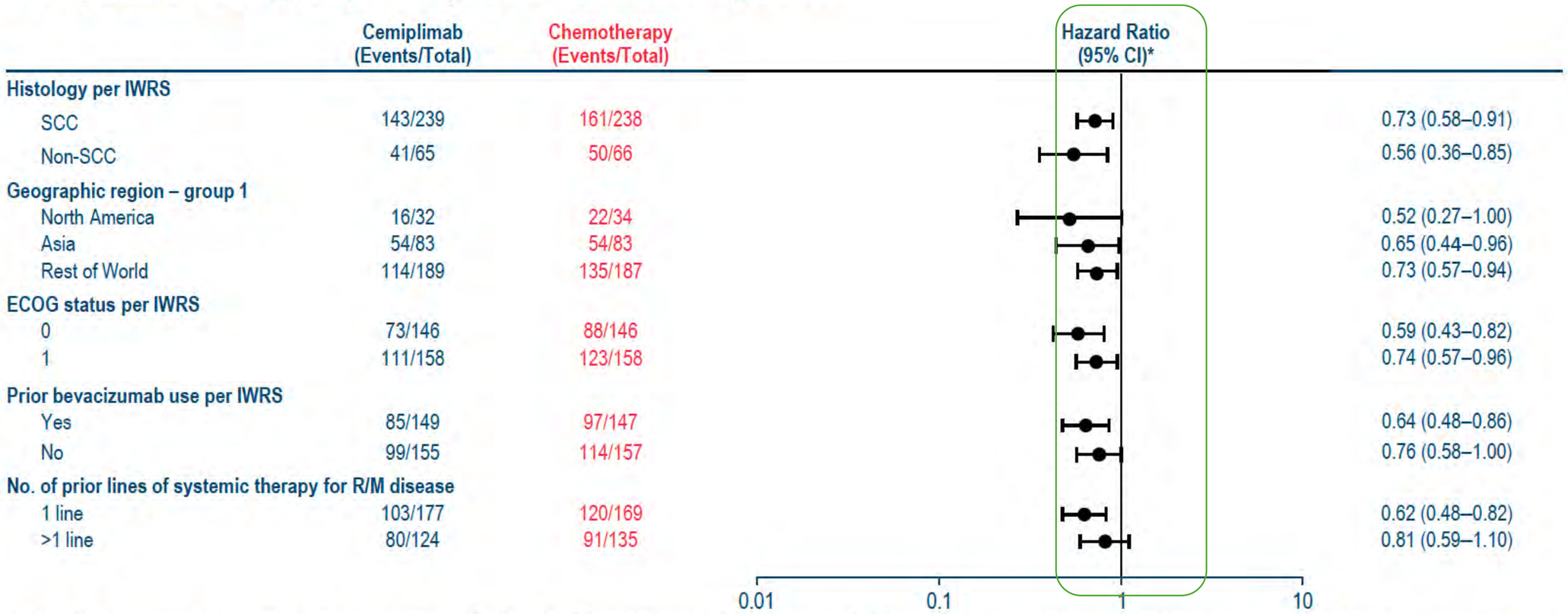
HR (95% CI) = 0.56 (0.36–0.85)*
one-sided *P*<0.005‡

No. at risk:																			
Cemiplimab	65	58	48	43	40	36	31	25	21	13	11	7	3	3	2	0	0	0	0
Chemotherapy	66	55	42	34	27	21	14	12	8	8	6	4	2	2	1	0	0	0	0

EMPOWER-CERVICAL 1

OVERALL SURVIVAL

Prespecified Subgroup Analyses in Overall Population



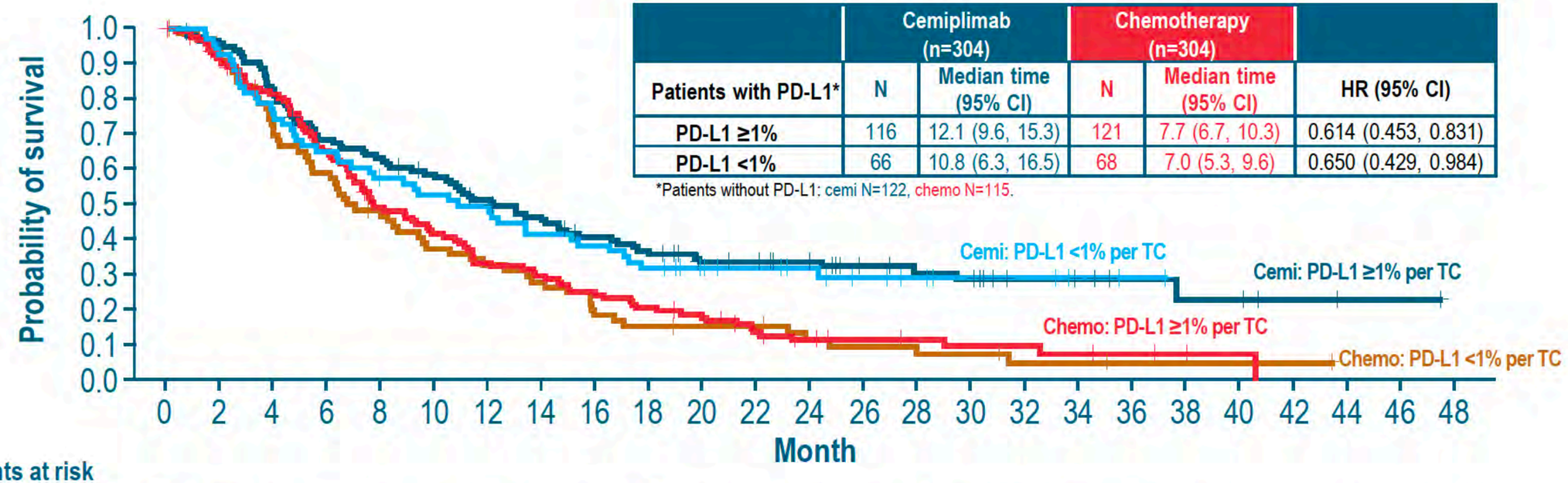
*Stratified by geographic region (North America vs Asia vs ROW per IWRS) and histology (SCC vs AC per IWRS) except for geographic region, histology subgroups (cemiplimab vs chemotherapy). Geographic region is stratified by histology (SCC vs AC per IWRS). Histology is stratified by geographic region (North America vs Asia vs ROW per IWRS) (cemiplimab vs chemotherapy).
AC, adenocarcinoma or adenosquamous carcinoma; CI, confidence interval; ECOG, Eastern Cooperative Oncology Group; IWRS, interactive web response system; ROW, rest of world; R/M, recurrent or metastatic; SCC, squamous cell carcinoma.

EMPOWER-CERVICAL 1

Cemiplimab monotherapy significantly improved OS vs chemotherapy regardless of PD-L1 status

	Cemiplimab (n=304)		Chemotherapy (n=304)		
Patients with PD-L1*	N	Median time (95% CI)	N	Median time (95% CI)	HR (95% CI)
PD-L1 ≥1%	116	12.1 (9.6, 15.3)	121	7.7 (6.7, 10.3)	0.614 (0.453, 0.831)
PD-L1 <1%	66	10.8 (6.3, 16.5)	68	7.0 (5.3, 9.6)	0.650 (0.429, 0.984)

*Patients without PD-L1: cemi N=122, chemo N=115.



Patients at risk

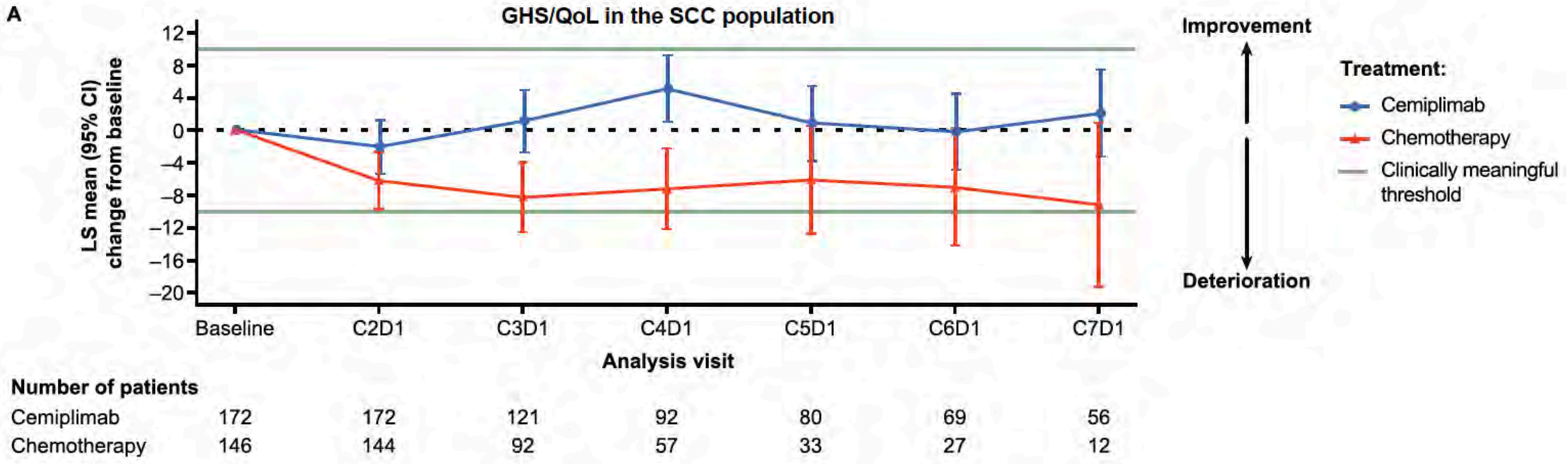
Cemi: PD-L1 ≥1% per TC	116	110	93	77	71	63	55	48	41	36	30	29	25	20	17	16	10	9	5	4	4	2	1	1	0
Cemi: PD-L1 <1% per TC	66	61	49	43	36	33	30	26	24	20	16	14	12	9	7	5	5	3	1	0	0	0	0	0	0
Chemo: PD-L1 ≥1% per TC	121	107	92	73	54	46	37	33	27	23	19	13	9	7	6	5	5	4	3	2	1	0	0	0	0
Chemo: PD-L1 <1% per TC	68	60	46	39	30	24	21	18	12	10	9	9	6	5	4	4	2	2	1	1	1	1	0	0	0

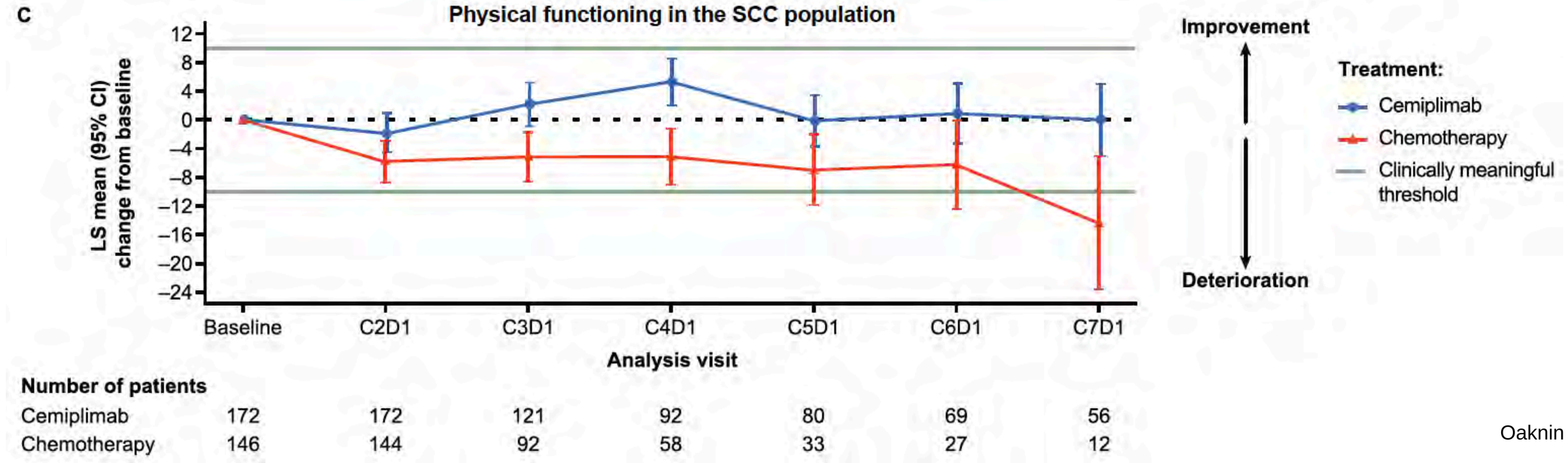
Kaplan–Meier curves of overall survival in the full analysis set. **Data cutoff date: 4 Jan 2022**

Cemi, cemiplimab; Chemo, chemotherapy; CI, confidence interval; HR, hazard ratio; OS, overall survival; PD-L1, programmed cell death-ligand 1; TC, tumour cell; PD-L1 expression was detected with the SP263 monoclonal antibody (Ventana; Tewari et al., NEJM, 2022)

Oaknin A, ESMO2022

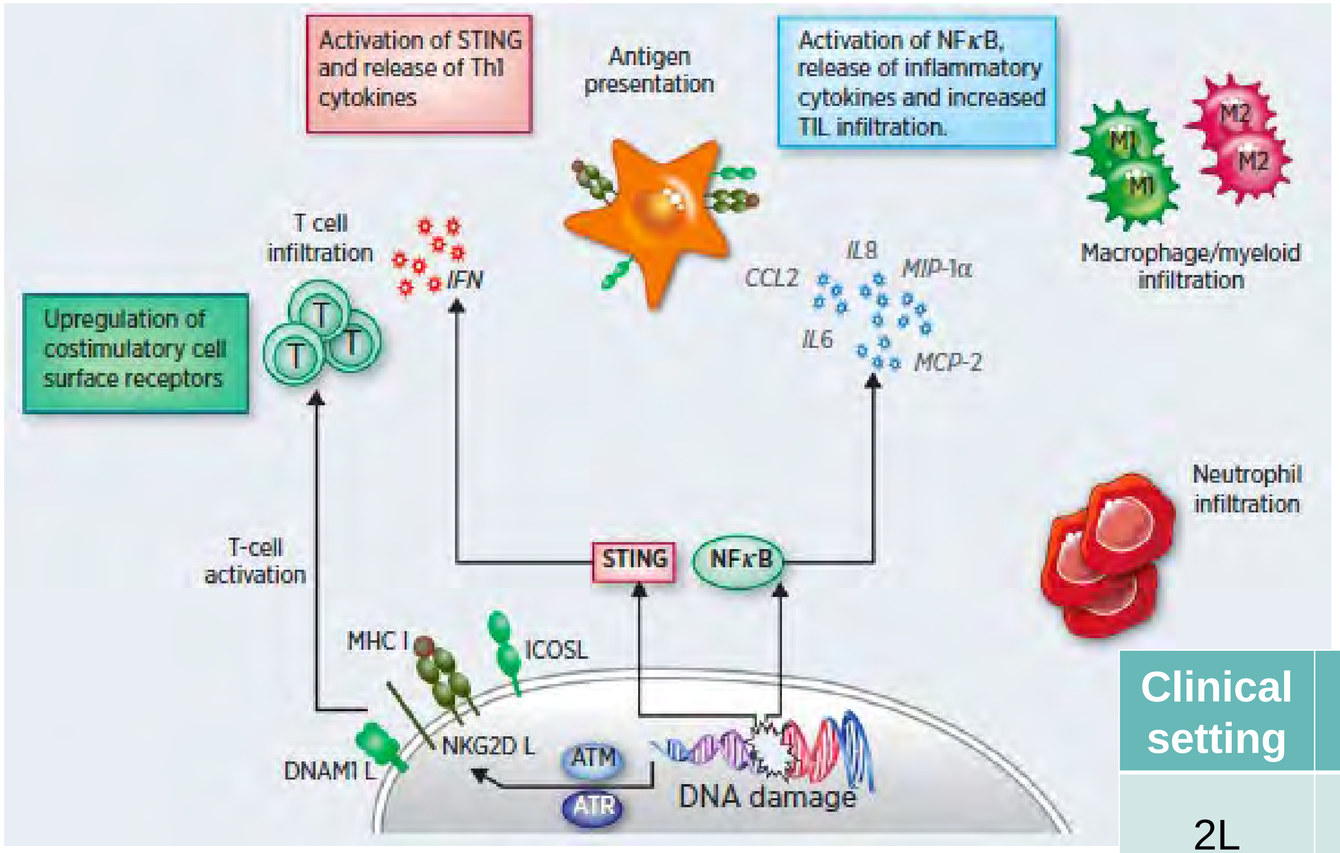
Patient-reported QOL





Oaknin A, EJC2022

PD-1/L1 pathway inhibitor + PARPi combination



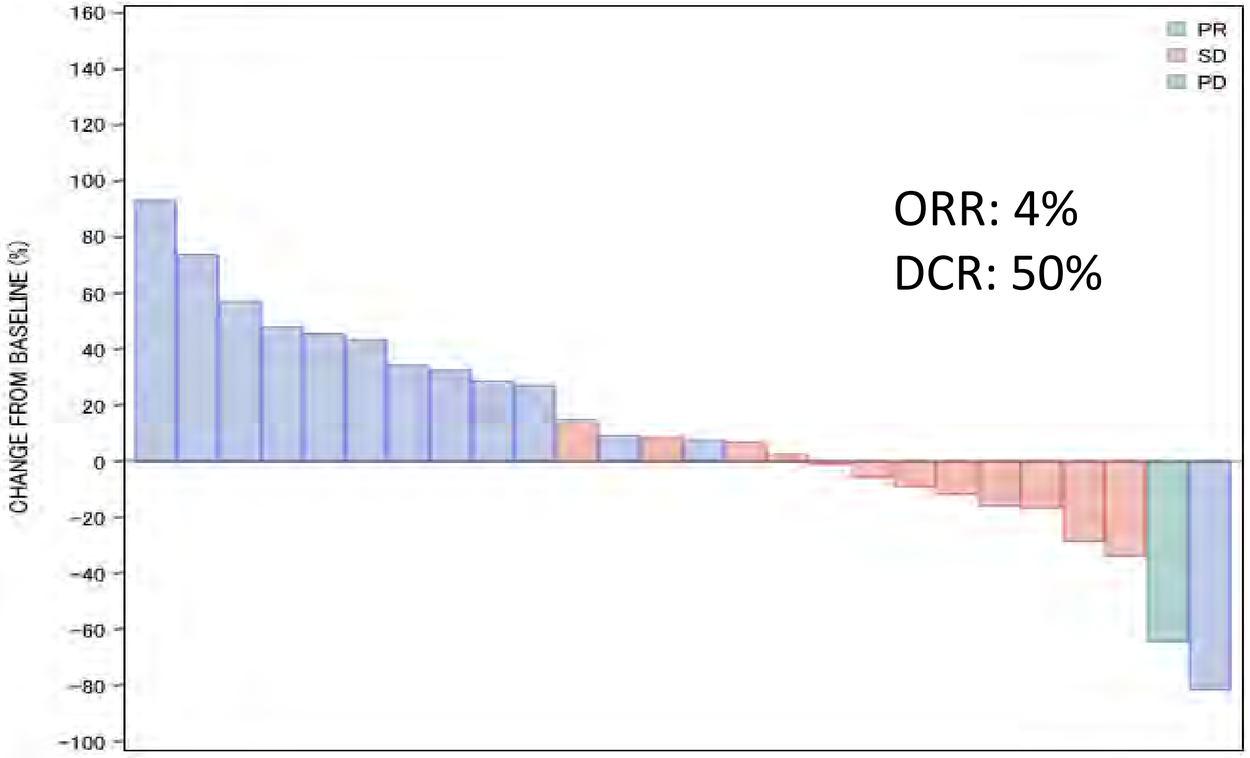
Jianfeng Shen Cancer Res; 79(2) January 15, 2019
Ross A Stewart Cancer Res; 78(24) December 15, 2018

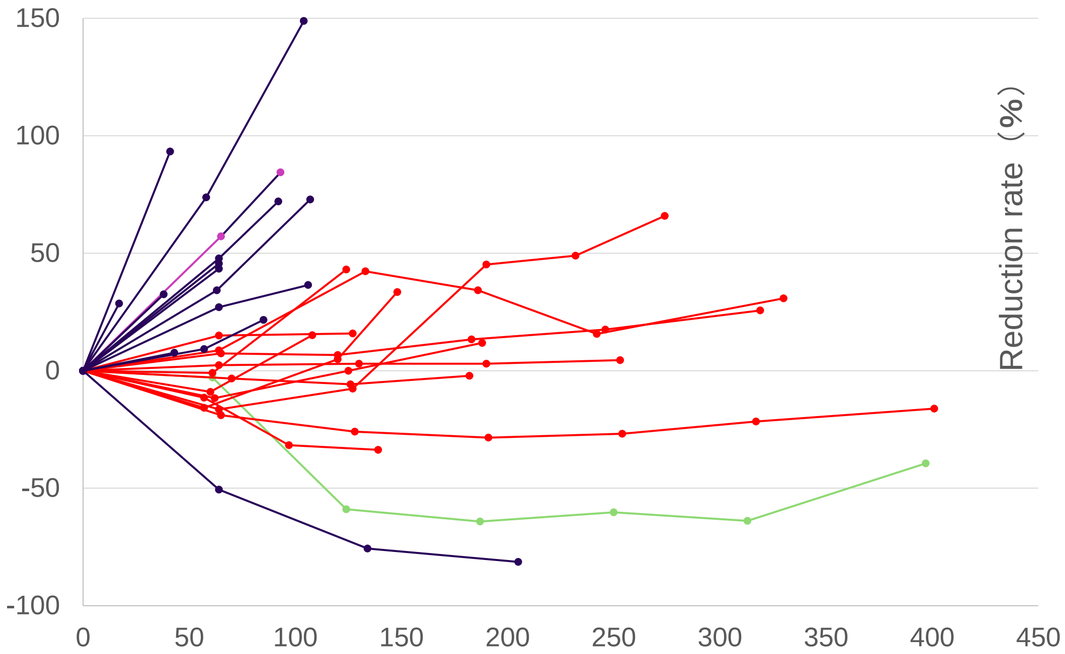
- PARPi induces immunemodulation
- cGAS/STING activation releases Th1 cytokines

Clinical setting	Study ID (Name)	Combination	N of pts	Endpoints
2L	NCT04068753	Dostal + Niraparib	66	•ORR •DOR
2L	NCT04483544	Pembro + Olaparib	48	•ORR •PFS
2L	NCT04641728 (GOTIC-025)	Pembro + Olaparib	28	•ORR •PFS

Pembrolizumab+Olaparib for 2ndline CxCa

GOTIC-025





Median PFS: 3.4M, median OS: 11.9M

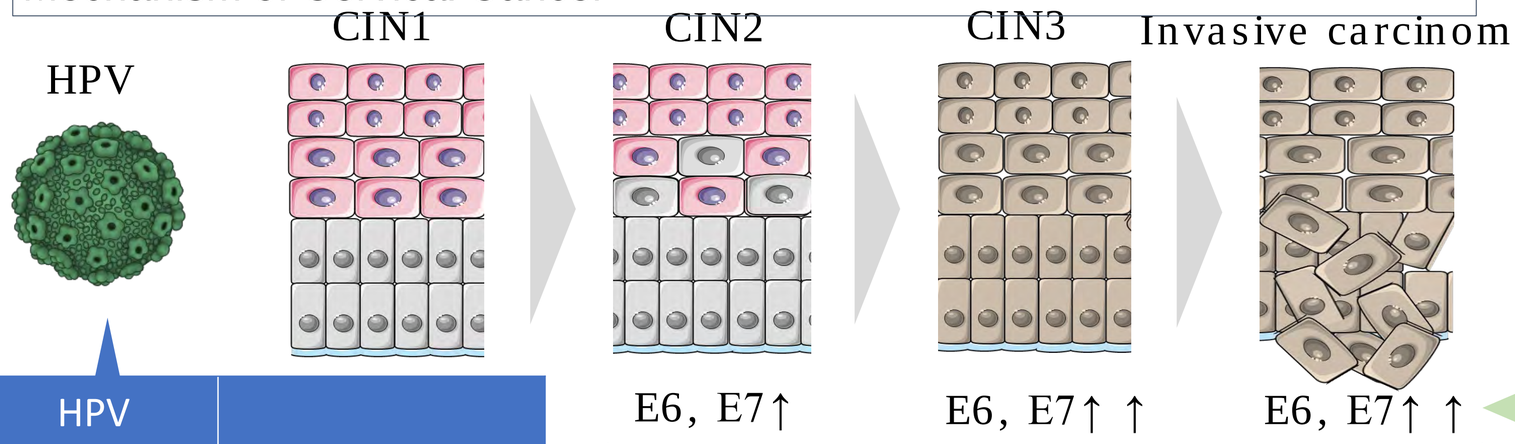
Shitani and Hasegawa, ESMO 2024

Primary metastatic (4B), recurrent, persistent

Angiogenesis in Cervical Cancer

● In cervical cancer, the positivity rate for VEGF (Vascular Endothelial Growth Factor), which is involved in angiogenesis, is high at 72-94%. and it has been reported that high VEGF expression in resected cervical cancer tissue is a poor prognostic factor.

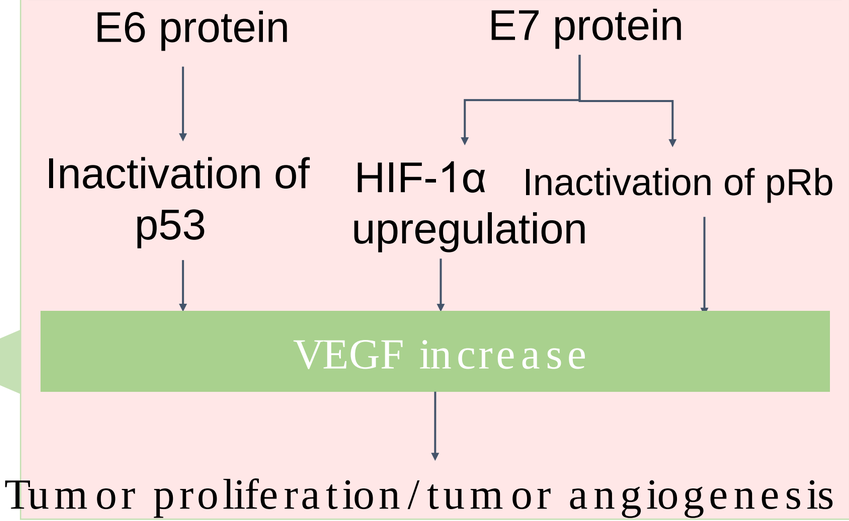
Viral Genes and Molecular Biological Changes in the Carcinogenesis Mechanism of Cervical Cancer



HPV Gene Product	Function
E6, E7	Oncoprotein
E1, E2	Replication
L1, L2	Capsid synthesis

- Cell immortalization
- Loss of cell cycle control
- Promotion of epithelial-mesenchymal transition
- Apoptosis inhibition
- Immune response suppression
- Inhibition of cell differentiation
- Accumulation of genetic mutations

HPV Persistent Infection and Promoted VEGF Expression

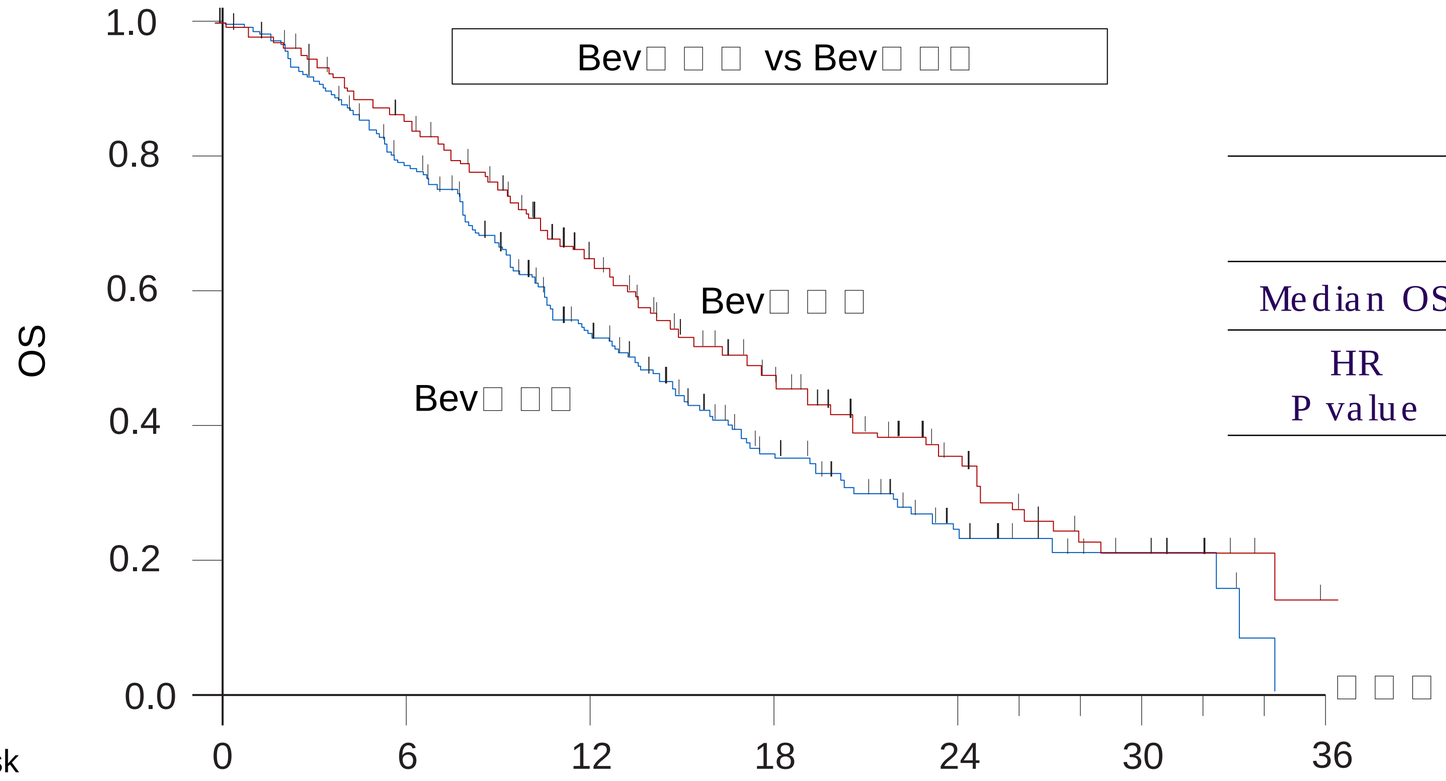


□Bevacizumab□
By specifically binding to VEGF, it inhibits VEGF and the binding of VEGF to its receptors on vascular endothelial cells

HPV: human papillomavirus; CIN: cervical intraepithelial neoplasia
VEGF: vascular endothelial growth factor HIF-1α: hypoxia-inducible factor-1α

Edited by Aiko Okamoto: Update on Gynecologic Oncology Treatment, Chuobu Medical Publishing, pp. 151-152
Kei Kawana: Clinical Series Selection in Obstetrics and Gynecology: Malignant Tumors, Nakayama Shoten, pp. 5-6
Ishiguro, T. et al.: Nihon Rinsho Special Issue Gynecologic Cancer 2nd Edition, Nihon Rinsho Sha, p. 204
Avastin Package Insert Revised September 2020 (3rd Edition)

GOG240: OS



	Bev□ □ □ □ n=227□	Bev□ □□ □ n=225□
Median OS	17.0□□	13.3□□
HR	0.71 (0.54-0.95)	
P value	P= 0.004	

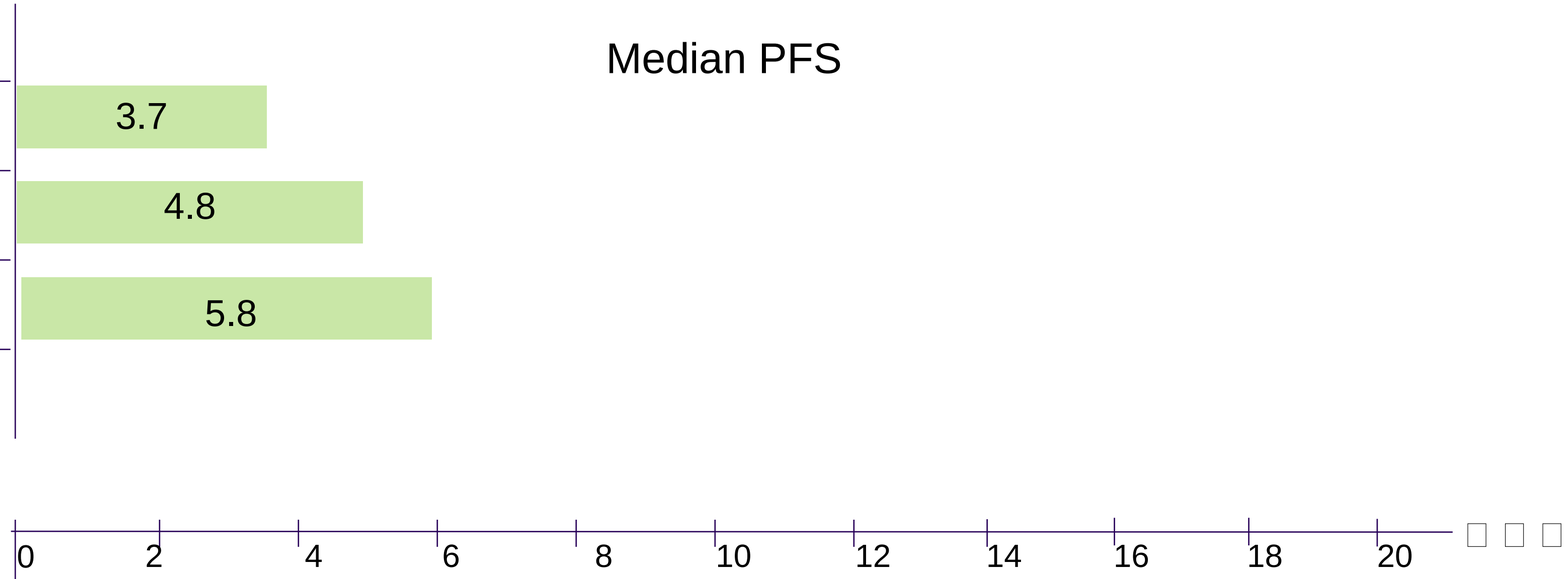
No at risk

Bev□ □ □ □	227	184	121	69	30	10
Bev□ □□ □	225	167	94	45	17	8

Tewari KS et al. N Engl J Med 2014□ 370□ 734-743.

Evolution of treatment for R/M cervical Cancer

Year	Study	Regimen
1985	GOG43	CDDP50mg/m^2
2004	GOG169	TP
2009	GOG204	TP



Year	Study	Regimen
1985	GOG43	CDDP50mg/m^2
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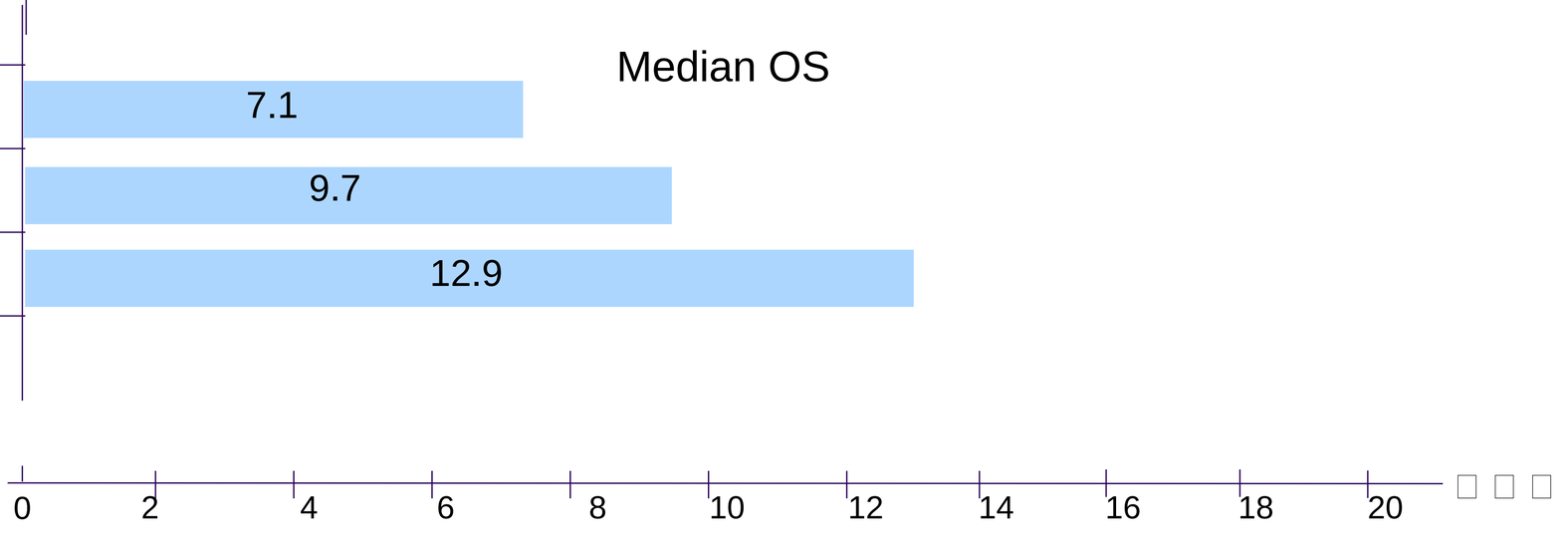
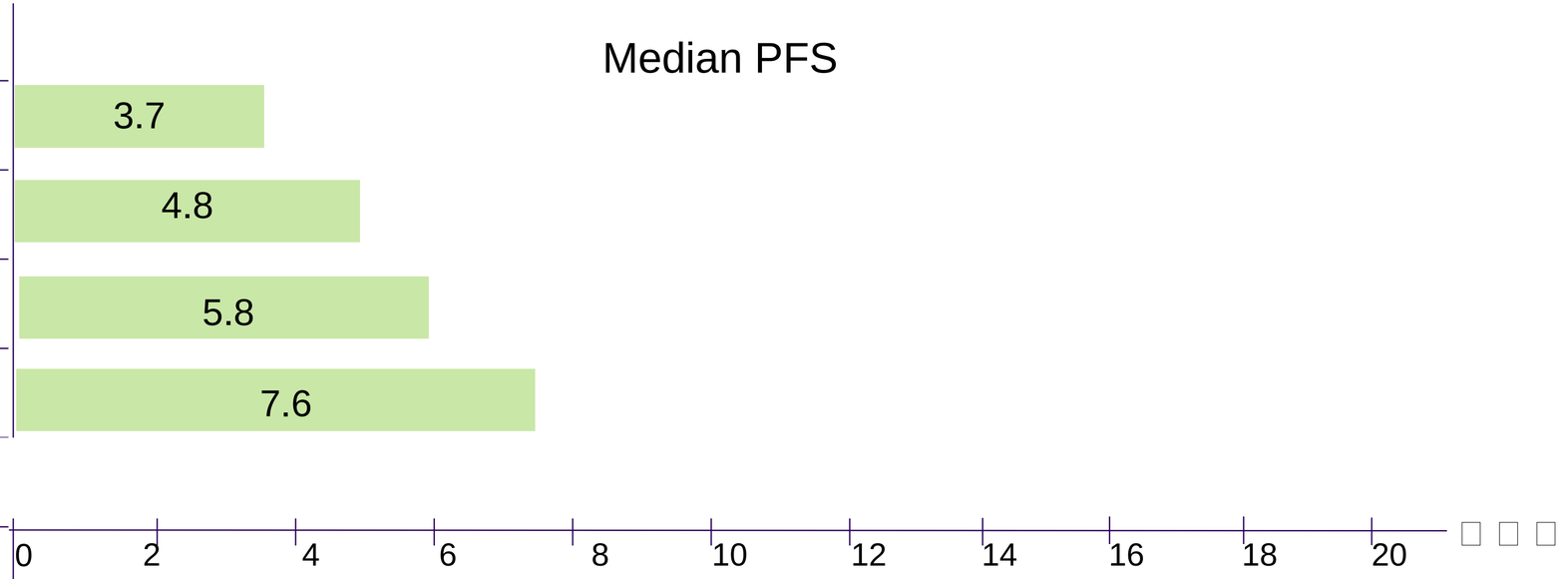
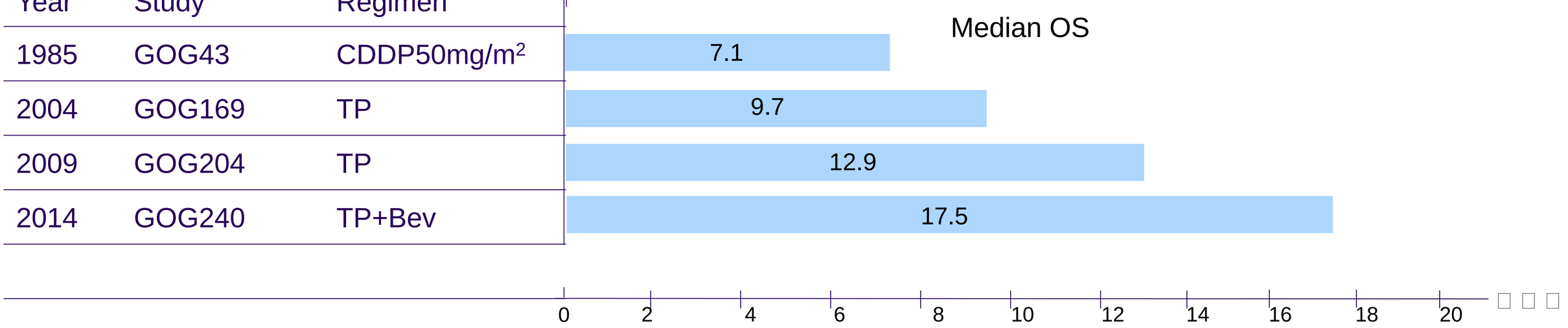


Evolution of treatment for R/M cervical Cancer

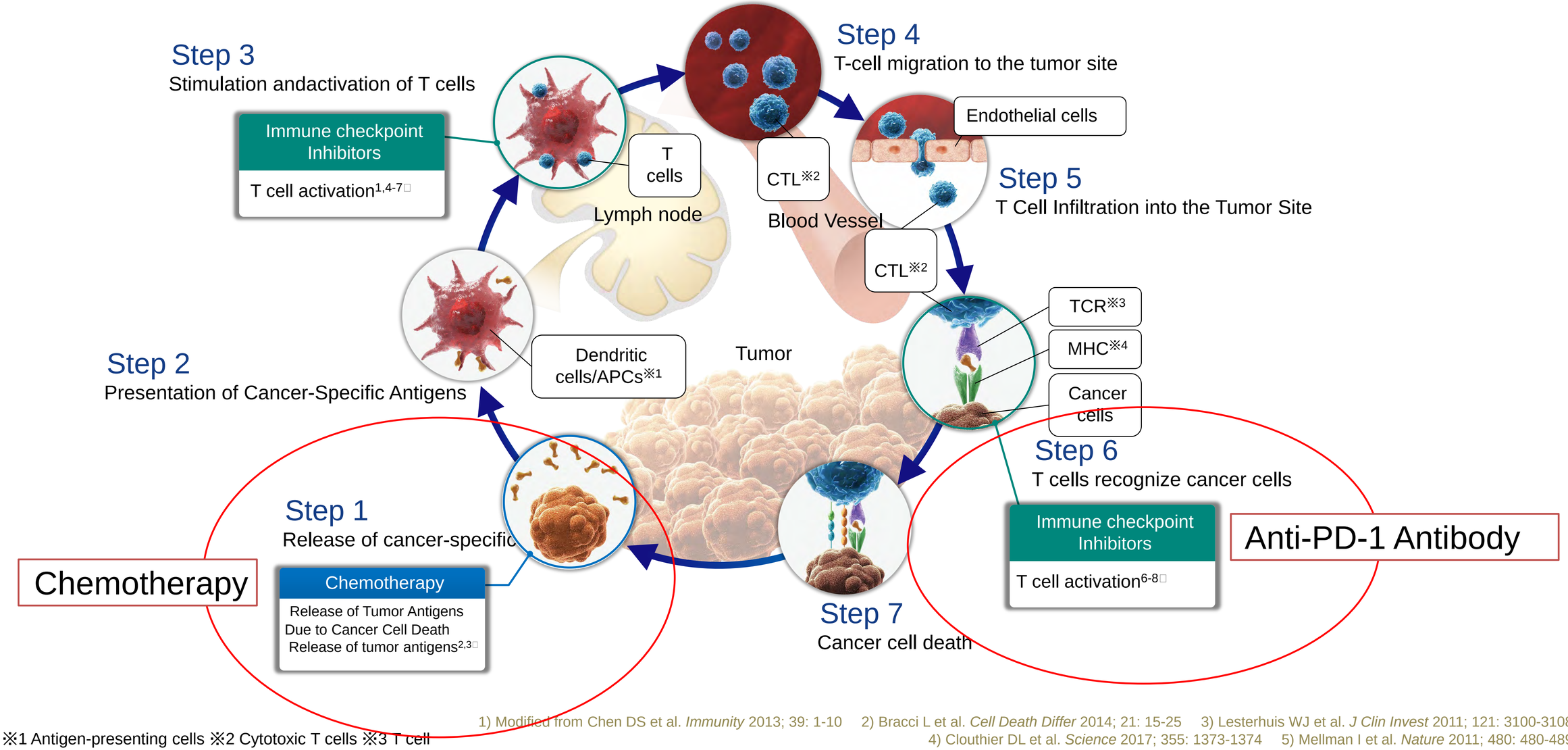
Year	Study	Regimen
1985	GOG43	CDDP50mg/m^2
2004	GOG169	TP
2009	GOG204	TP
2014	GOG240	TP+Bev



Year	Study	Regimen
1985	GOG43	CDDP50mg/m^2
2004	GOG169	TP
2009	GOG204	TP
2014	GOG240	TP+Bev



Mechanisms of Action: Immune Checkpoint Inhibitors and Chemotherapy



※1 Antigen-presenting cells ※2 Cytotoxic T cells ※3 T cell receptor ※4 Major histocompatibility complex

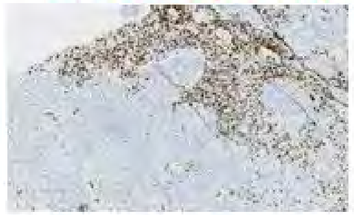
1) Modified from Chen DS et al. *Immunity* 2013; 39: 1-10 2) Bracci L et al. *Cell Death Differ* 2014; 21: 15-25 3) Lesterhuis WJ et al. *J Clin Invest* 2011; 121: 3100-3108
4) Clouthier DL et al. *Science* 2017; 355: 1373-1374 5) Mellman I et al. *Nature* 2011; 480: 480-489
6) Postow MA et al. *J Clin Oncol* 2015; 33: 1974-1982. Some authors received honoraria from MSD.
7) Pardoll DM. *Nat Rev Cancer* 2012; 12: 252-264 8) Topalian SL et al. *Curr Opin Immunol* 2012; 24: 207-212

Chemotherapy may enhance local immunity

Immune Phenotypes in IMagyn050

Desert (17%)

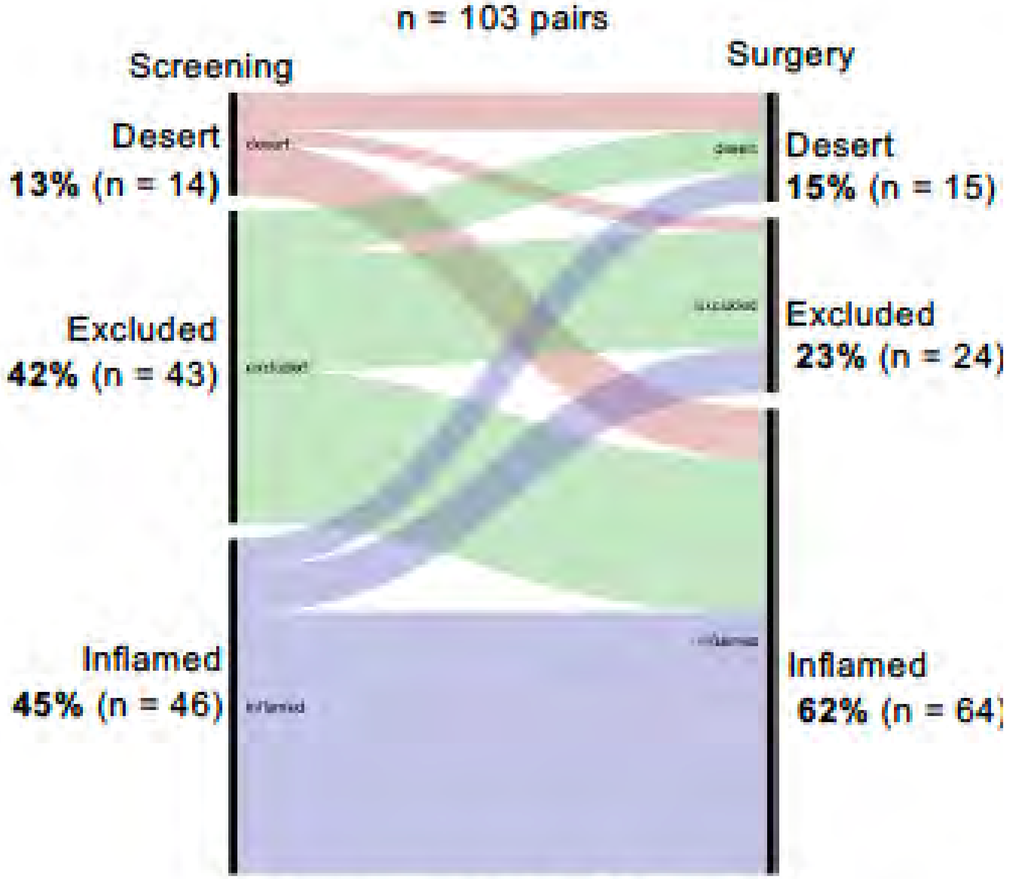
Excluded (36.5%)



Inflamed (46.5%)

CD8/PanCK
IHC (n = 860)

Chemo+Bev



Consistency: 55.34%; **Kappa**: 0.262
McNemar test p-value=0.0109

CD8/Pan-CK (IHC)

KEYNOTE-826: Randomized, Double-Blind, Phase 3 Study

Key Eligibility Criteria

- Persistent, recurrent, or metastatic cervical cancer not amenable to curative treatment
- No prior systemic chemotherapy (prior radiotherapy and chemoradiotherapy permitted)
- ECOG PS 0 or 1

Stratification Factors

- Metastatic disease at diagnosis (yes vs no)
- PD-L1 CPS (<1 vs 1 to <10 vs ≥10)
- Planned bevacizumab use (yes vs no)

R 1:1

Pembrolizumab 200 mg IV Q3W
for up to 35 cycles
+
Paclitaxel + Cisplatin or Carboplatin IV Q3W
for up to 6 cycles[a]
±
Bevacizumab 15 mg/kg IV Q3W

Placebo IV Q3W
for up to 35 cycles
+
Paclitaxel + Cisplatin or Carboplatin IV Q3W
for up to 6 cycles[a]
±
Bevacizumab 15 mg/kg IV Q3W

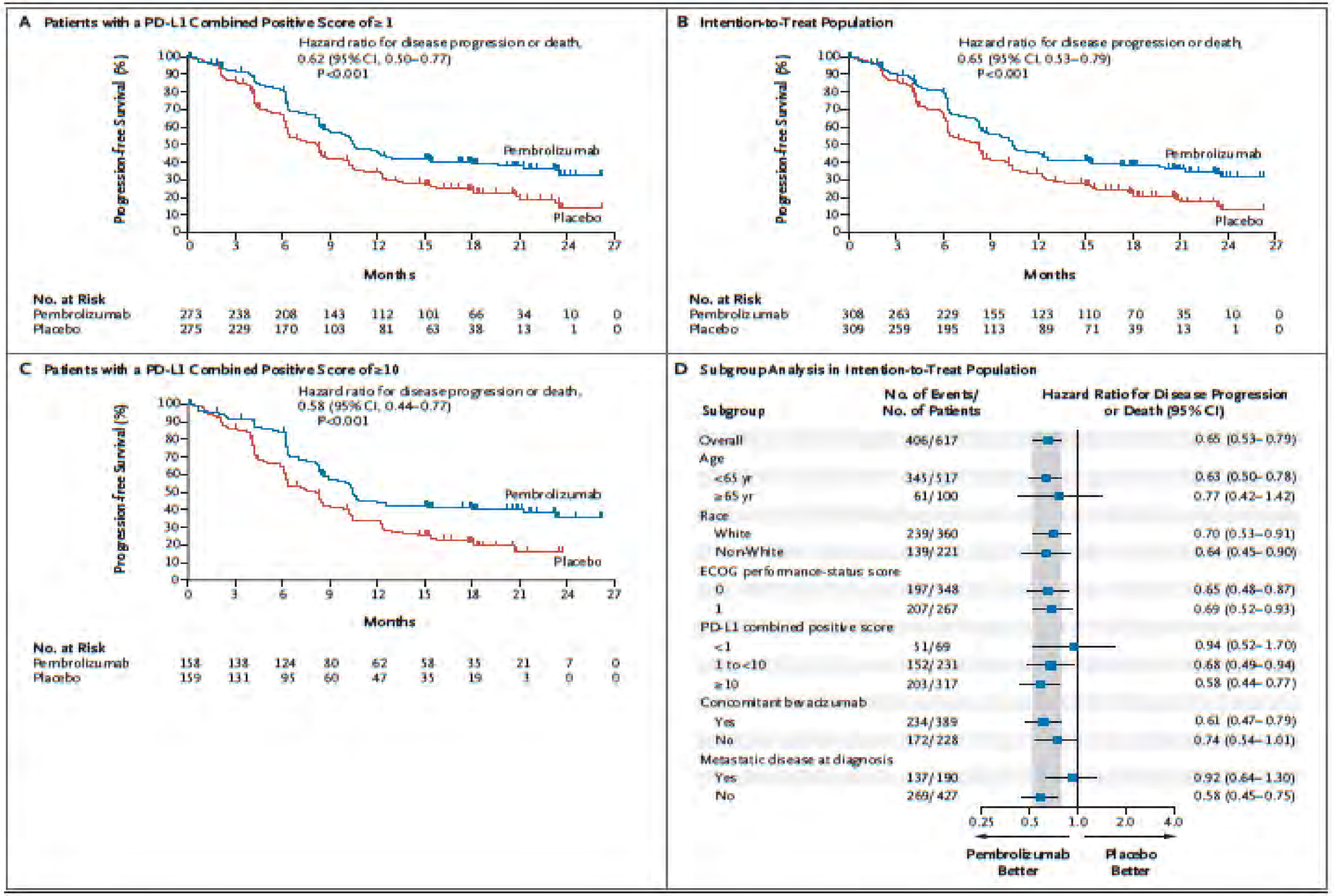
End Points

- **Dual primary:** OS and PFS per RECIST v1.1 by investigator
- **Secondary:** ORR, DOR, 12-mo PFS, and safety
- **Exploratory:** PROs assessed per EuroQol EQ-5D-5L VAS

[a]Paclitaxel: 175 mg/m^2. Cisplatin: cisplatin 50 mg/m^2. Carboplatin: AUC 5 mg/mL/min. The 6-cycle limit was introduced with protocol amendment 2, although participants with ongoing clinical benefit who were tolerating chemotherapy could continue beyond 6 cycles after sponsor consultation.
CPS, combined positive score (number of PD-L1–staining cells [tumor cells, lymphocytes, macrophages] divided by the total number of viable tumor cells, multiplied by 100); PROs, patient-reported outcomes; VAS, visual analog scale. KEYNOTE-826 ClinicalTrials.gov identifier, NCT03635567.

Keynote 826
PFS by PD-L1

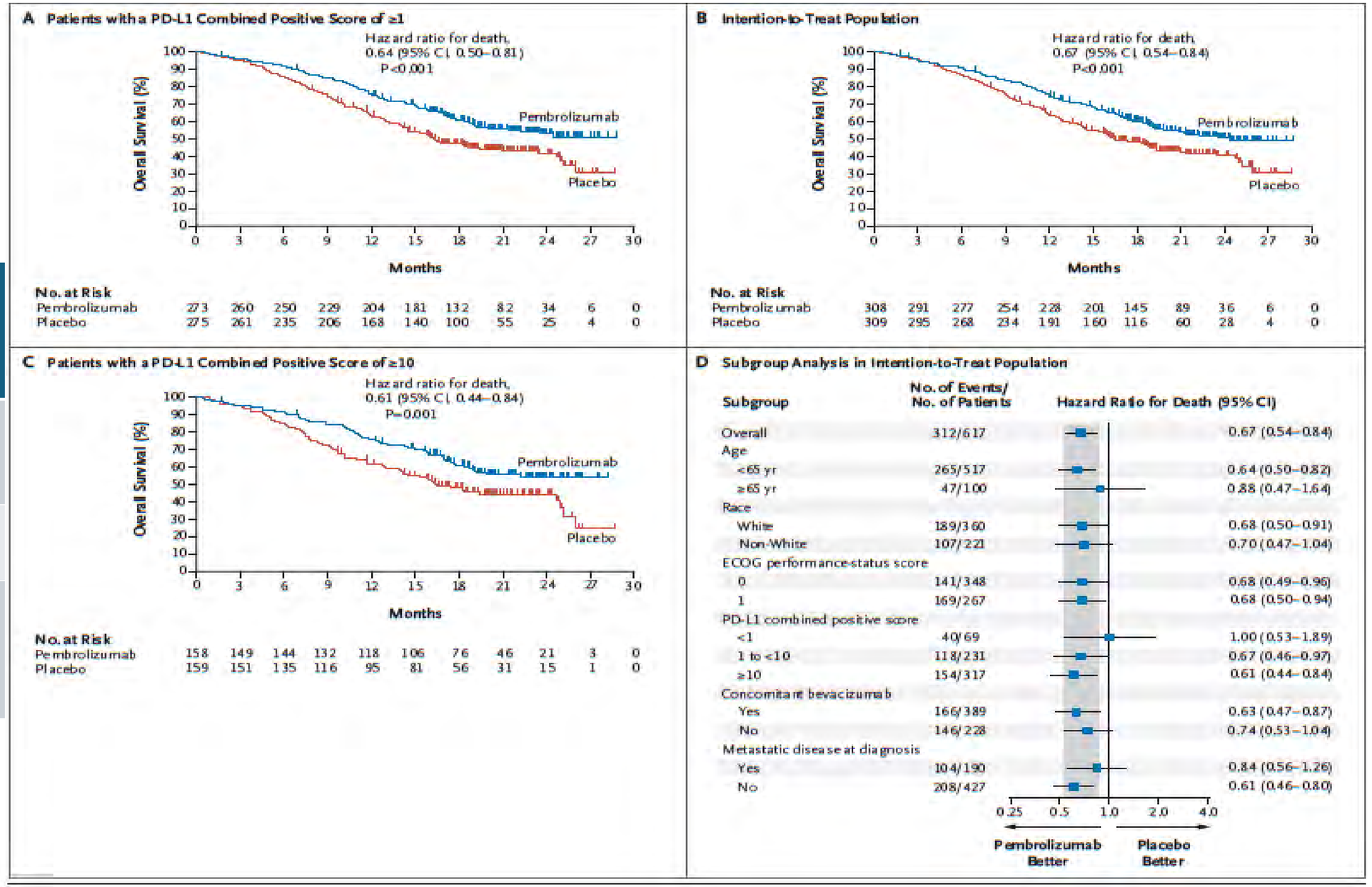
	PFS HR
CPS ≥ 1	0.62
ITT	0.65
CPS ≥ 10	0.58



Colombo et al NEJM 2021

Keynote 826 OS by PD-L1

	OS HR
CPS ≥ 1	0.64
ITT	0.67
CPS ≥ 10	0.61

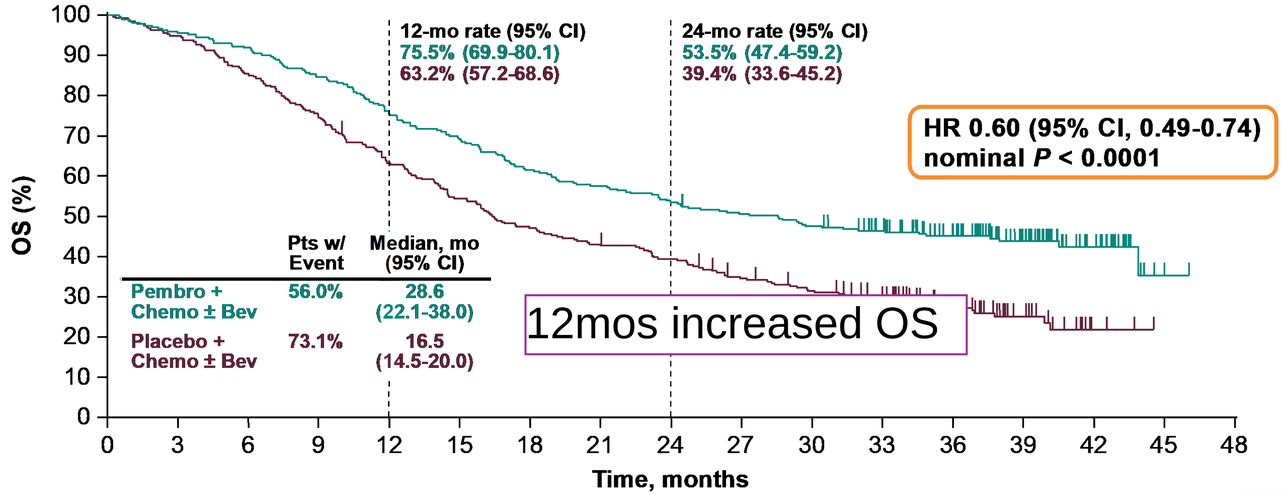


Colombo et al NEJM 2021

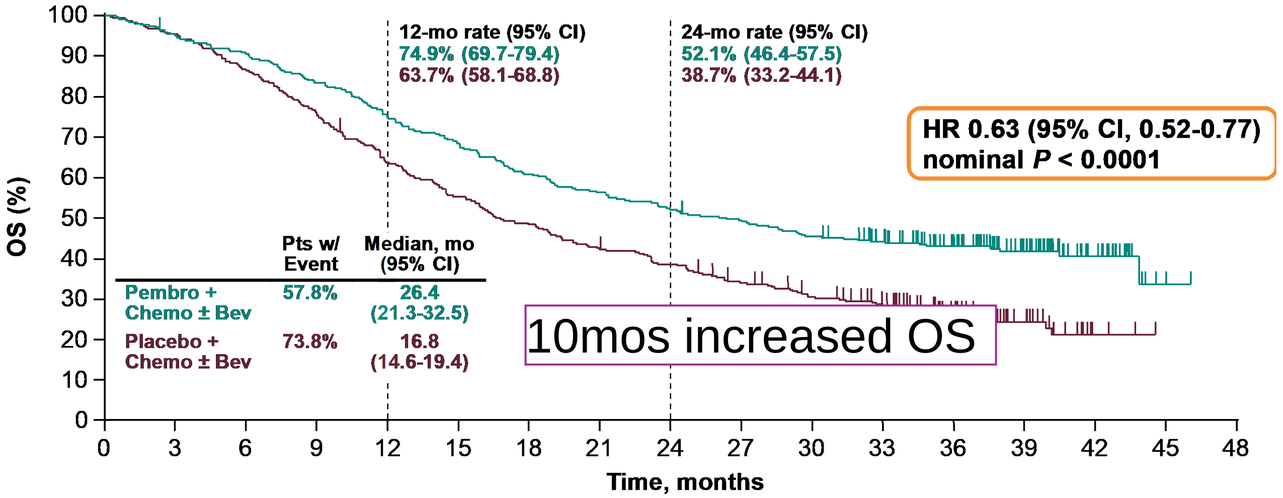
KEYNOTE-826 Final OS

Median follow-up, 39.1 months

Protocol-Specified Final OS: PD-L1 CPS ≥1 Population



Protocol-Specified Final OS: All-Comer Population



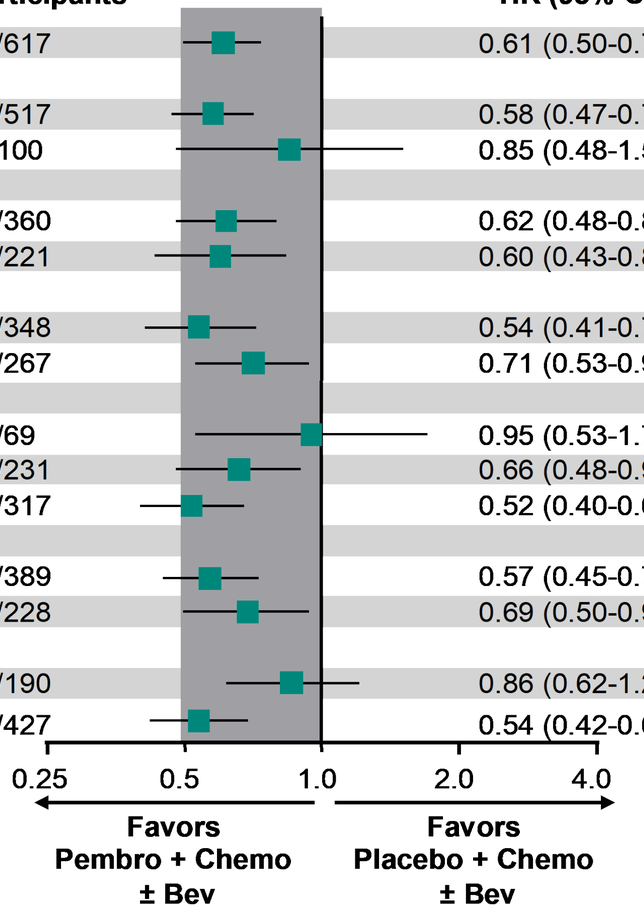
Monk JCO 2023

KEYNOTE-826 Final analysis

Protocol-specified final analysis in subgroups

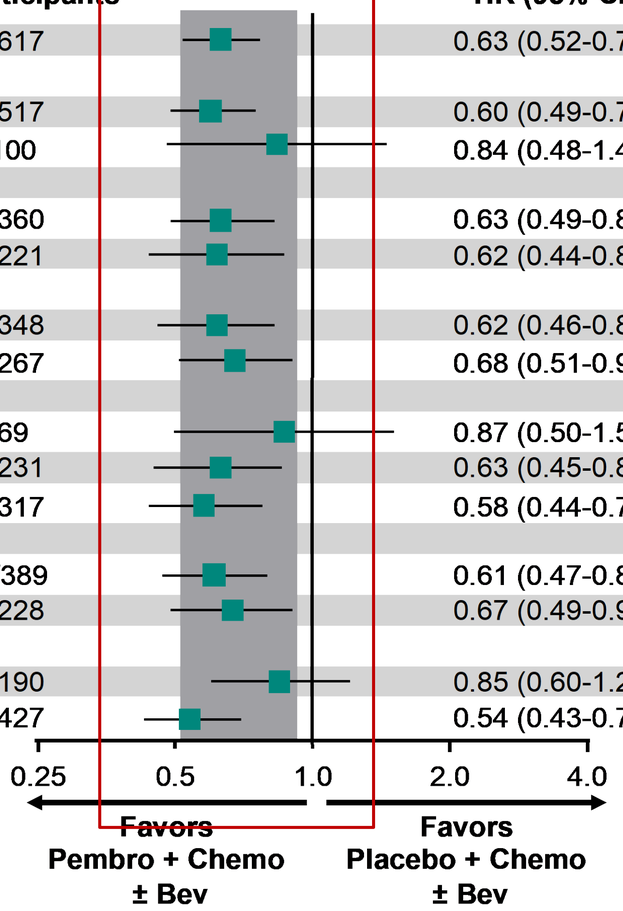
PFS

	No. of Events/ No. of Participants	HR (95% CI)
Overall	443/617	0.61 (0.50-0.74)
Age		
<65 years	376/517	0.58 (0.47-0.71)
≥65 years	67/100	0.85 (0.48-1.51)
Race		
White	261/360	0.62 (0.48-0.80)
All others	154/221	0.60 (0.43-0.84)
ECOG performance-status score		
0	224/348	0.54 (0.41-0.72)
1	217/267	0.71 (0.53-0.94)
PD-L1 combined positive score		
<1	52/69	0.95 (0.53-1.71)
1 to <10	167/231	0.66 (0.48-0.90)
≥10	224/317	0.52 (0.40-0.68)
Concomitant bevacizumab		
Yes	264/389	0.57 (0.45-0.73)
No	179/228	0.69 (0.50-0.94)
Metastatic disease at diagnosis		
Yes	149/190	0.86 (0.62-1.21)
No	294/427	0.54 (0.42-0.69)



OS

	No. of Events/ No. of Participants	HR (95% CI)
Overall	406/617	0.63 (0.52-0.77)
Age		
<65 years	345/517	0.60 (0.49-0.75)
≥65 years	61/100	0.84 (0.48-1.46)
Race		
White	238/360	0.63 (0.49-0.83)
All others	144/221	0.62 (0.44-0.87)
ECOG performance-status score		
0	192/348	0.62 (0.46-0.83)
1	212/267	0.68 (0.51-0.91)
PD-L1 combined positive score		
<1	52/69	0.87 (0.50-1.52)
1 to <10	155/231	0.63 (0.45-0.86)
≥10	199/317	0.58 (0.44-0.78)
Concomitant bevacizumab		
Yes	229/389	0.61 (0.47-0.80)
No	177/228	0.67 (0.49-0.91)
Metastatic disease at diagnosis		
Yes	135/190	0.85 (0.60-1.21)
No	271/427	0.54 (0.43-0.70)



Monk ASCO 2023

KEYNOTE-826 5-year follow-up

Plenary: Cervical Cancer Oral Abstract Presentations

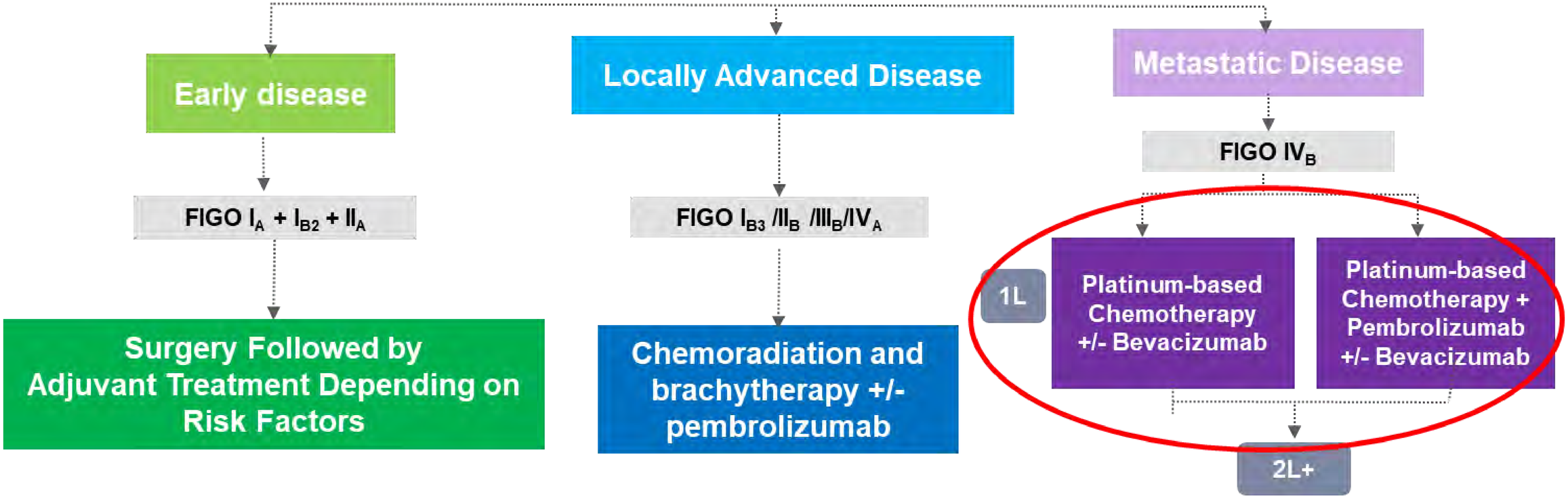
Session Type Plenary Session
Date Fri, 07.11.2025
Session Time 14:20 - 16:05
Room Hall A&B
Chair(s) Hennie Botha (South Africa), Krishnansu S. S. Tewari (United States of America)
Session Icon

OP023 - PEMBROLIZUMAB PLUS CHEMOTHERAPY WITH OR WITHOUT BEVACIZUMAB IN PARTICIPANTS WITH PERSISTENT, RECURRENT, OR METASTATIC CERVICAL CANCER: 5-YEAR FOLLOW-UP RESULTS FROM KEYNOTE-826 (ID 426)

Presenter Kosei Hasegawa (Japan)
Lecture Time 15:19 - 15:27

1L Immunotherapy for CxCa

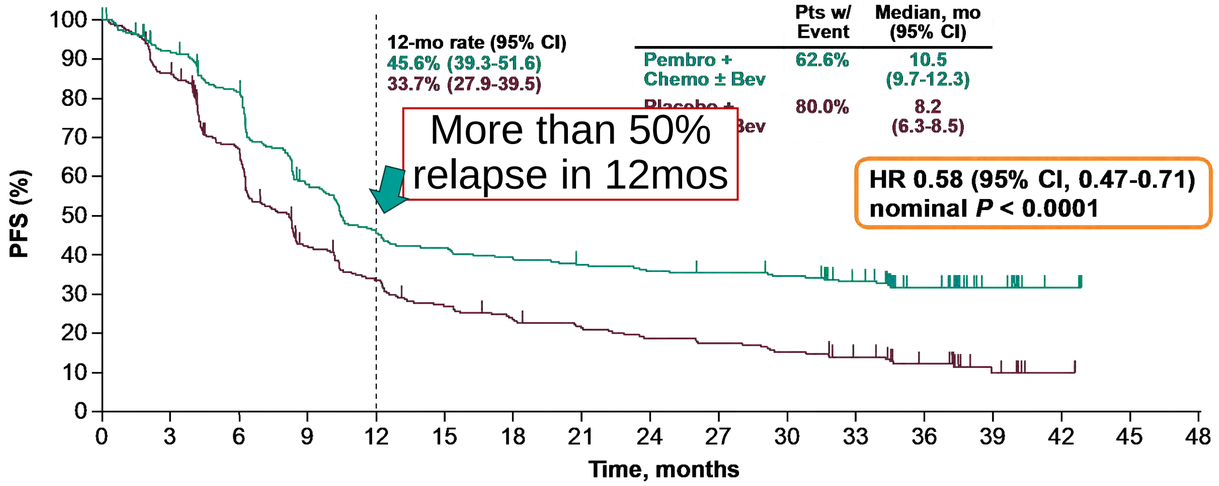
Trial (Immunotherapy)	N (Immuno/ Control)	Primary Endpoint(s)	PFS (months, HR)	OS (months, HR)	Key Factors/Population
KEYNOTE-826 (Pembrolizumab)	308/309	PFS, OS (dual primary)	Median PFS: 10.4 vs 8.2; HR 0.65	Median OS: 24.4 vs 16.5; HR 0.67	Chemo ± bevacizumab; PD-L1+ and all-comers
BEATcc (Atezolizumab)	205/205	OS (primary), PFS	Median PFS: 13.0 vs 10.4; HR 0.73	Median OS: 32.1 vs 22.8; HR 0.68	Chemo + bevacizumab; all-comers
COMPASSION-16 (Cadonilimab)	222/223	PFS, OS (dual primary)	Median PFS: 10.7 vs 8.5; HR 0.67	Median OS: 23.9 vs 17.9; HR 0.67	Chemo ± bevacizumab; PD-L1-agnostic, China


Early disease
FIGO I_A + I_{B2} + II_A
Surgery Followed by Adjuvant Treatment Depending on Risk Factors
Locally Advanced Disease
FIGO I_{B3} /II_B /III_B/IV_A
Chemoradiation and brachytherapy +/- pembrolizumab
Metastatic Disease
FIGO IV_B
1L
Platinum-based Chemotherapy +/- Bevacizumab
Platinum-based Chemotherapy + Pembrolizumab +/- Bevacizumab
2L+

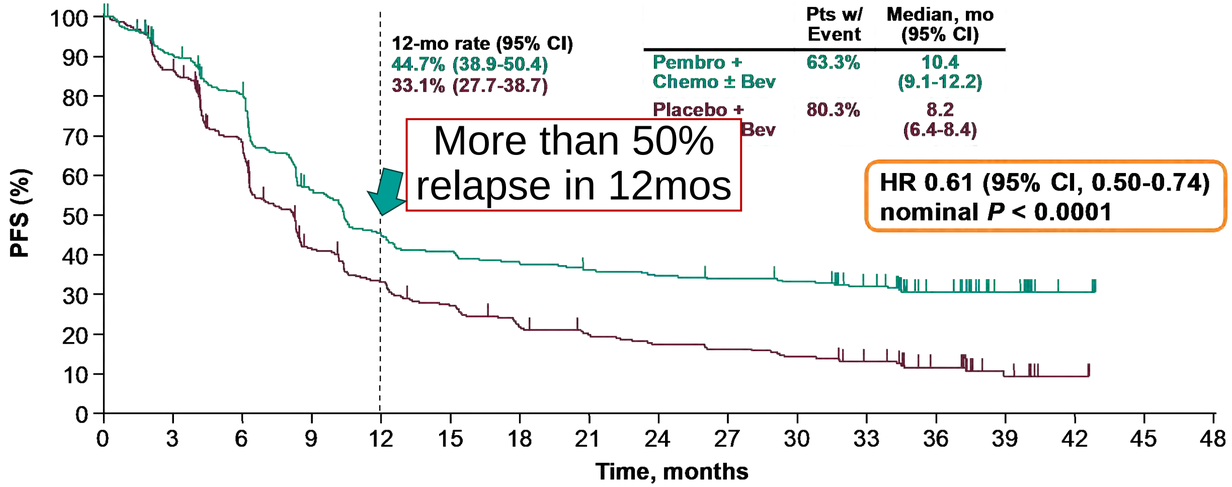
KEYNOTE-826 Final PFS

Median follow-up, 39.1 months

Protocol-Specified Final PFS: PD-L1 CPS ≥1 Population

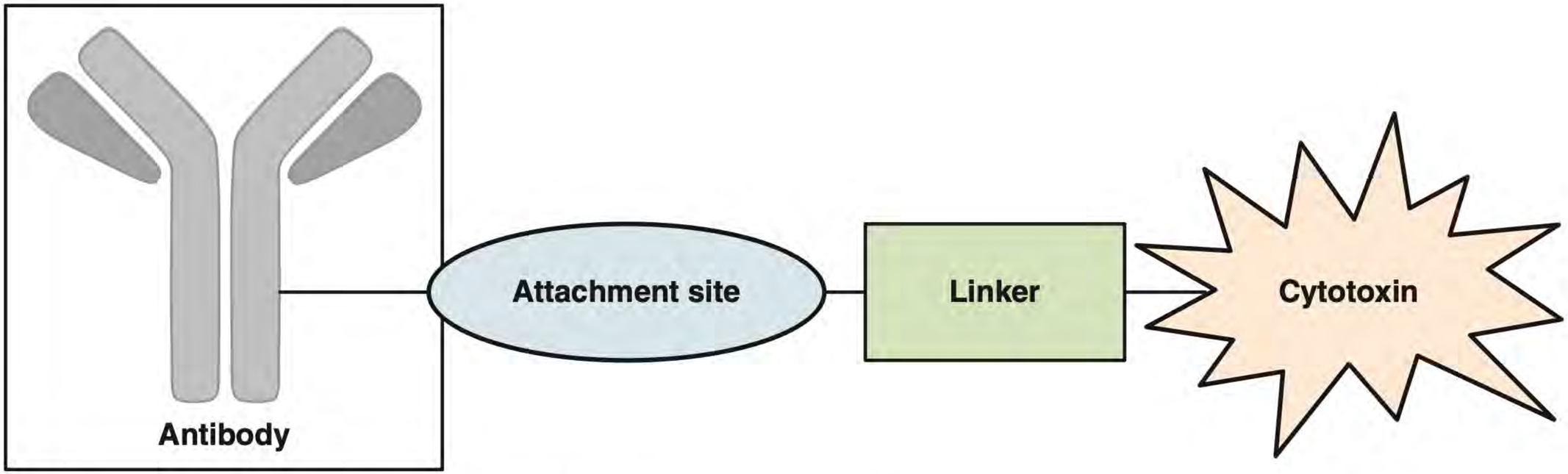


Protocol-Specified Final PFS: All-Comer Population



Monk JCO 2023

Antibody Drug Conjugate（ ADC）



- Targets a well-characterized antigen with high tumor expression and limited normal tissue expression
- Maintains binding, stability, internalization, PK, etc. when conjugated to a cytotoxin
- Minimal nonspecific binding

- Typically through nonspecific modification of cysteine or lysine residues on the antibody
- Mixture of conjugates with variable drug:antibody ratios
- Site-selective conjugation technologies can produce more homogeneous ADCs

- Cleavable or noncleavable
- Stable in circulation
- Selective intracellular release of drug (e.g. via enzymatic cleavage or antibody degradation)

- Highly potent
- Non-immunogenic
- Amenable to modifications for linker attachment
- Defined mechanism of action

Perez et al., Drug Discovery Today, 2014.

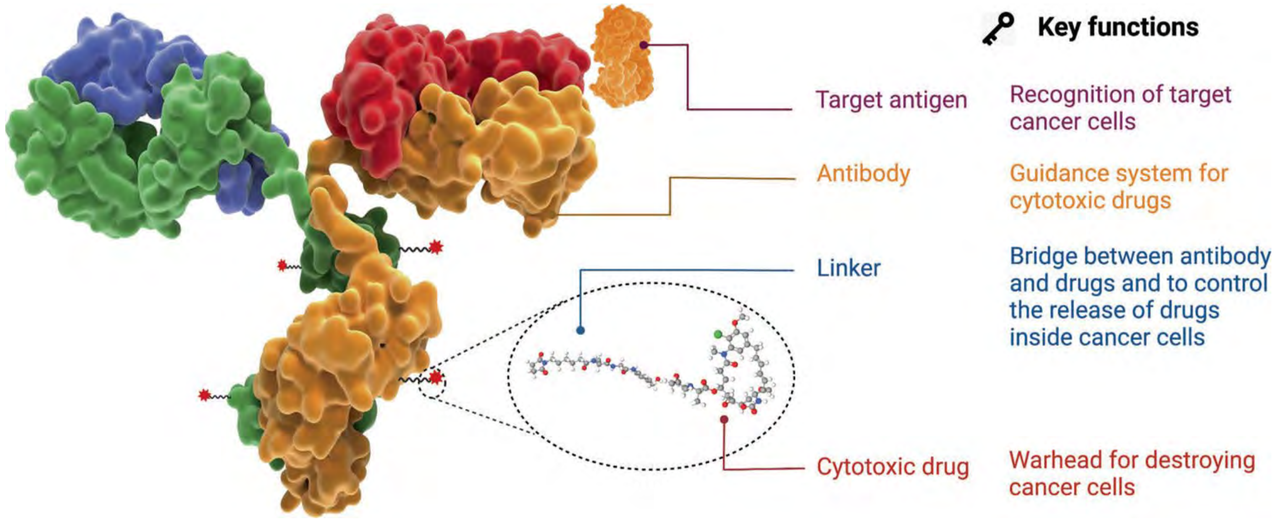
The Role of Antibody Drug Conjugates (ADCs) in Cervical Cancer

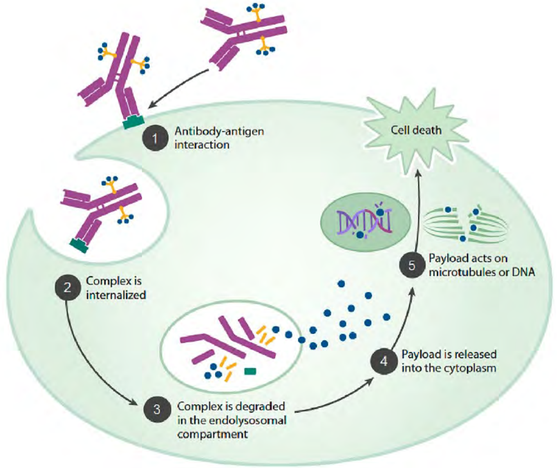
Ritu Salani, MD, MBA

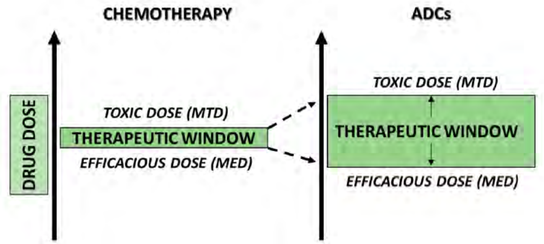
UCLA Health

Los Angeles, California, USA

Antibody Drug Conjugate





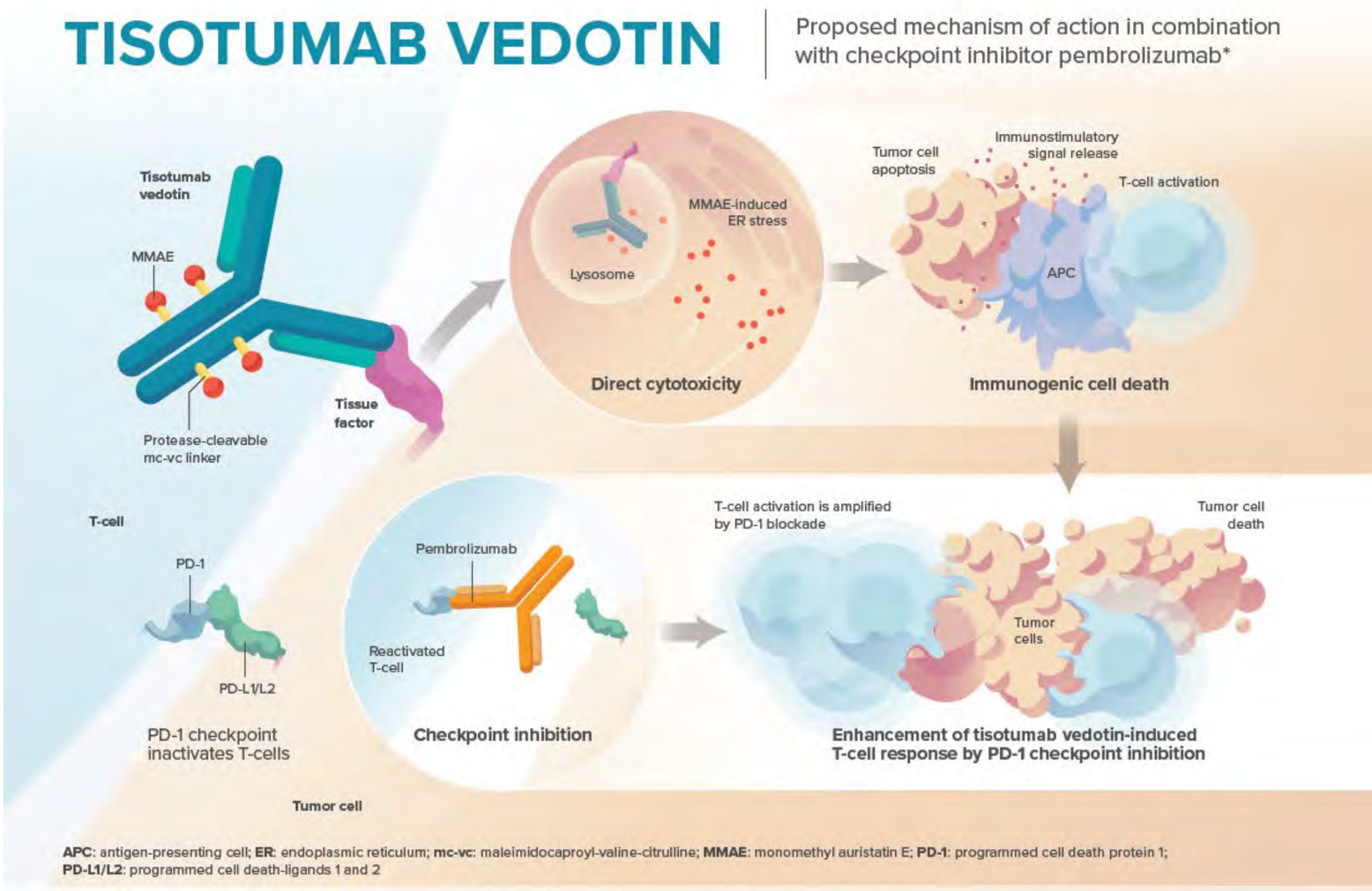


Fu Z et al Signal Transduction and Targeted Therapy 2022

Tisotumab Vedotin (TV)

Tissue factor (TF) ADC

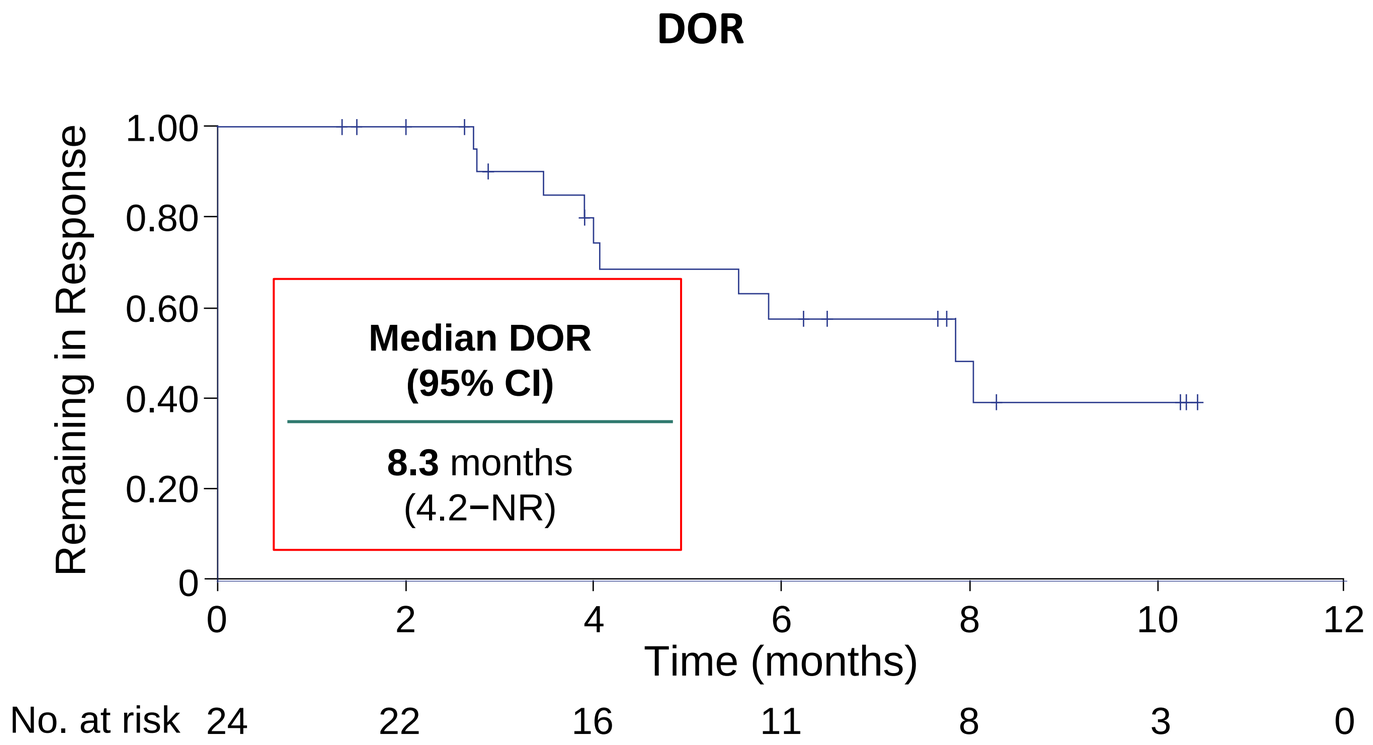
- Microtubule-disrupting agent MMAE
- Highly expressed in cervix cancer
- Involved in progression and metastases



Cocco E. BMC Cancer 2011. Coleman R. Lancet Oncol 2021.

Phase 2: innovaTV 204

	N = 101
Confirmed ORR (95% CI),[a] %	**24 (15.9−33.3)**
CR, n (%)	7 (7)
PR, n (%)	17 (17)
SD, n (%)	49 (49)
PD, n (%)	24 (24)
Not evaluable, n (%)	4 (4)



Clinically meaningful and durable responses were observed
Accelerated approval

Coleman RL et al. ESMO 2020. Abstract LBA32.
Coleman RL et al. *Lancet Oncol.* 2021:22:609.

InnovaTV 301/ENGOT-cx12/GOG-3057

Key eligibility criteria

- Recurrent or metastatic cervical cancer
- Disease progression on or after chemotherapy doublet ± Bev and an anti-PD-(L)1 agent, if eligible and available
- ≤2 prior therapies for recurrent/metastatic disease
- ECOG PS 0-1

N=502

R
1:1

Tisotumab vedotin (n=253)
2.0 mg/kg IV q3w

Chemotherapy (n=249)
Topotecan, vinorelbine, gemcitabine, irinotecan, or pemetrexed (investigator's choice)

Primary endpoint: OS

Key secondary endpoints: PFS, ORR, safety

Stratification:
- ECOG PS
- Prior Bev
- Prior anti-PD(L)1 therapy
- Region

	TV (N=253)	Chemo (N=249)
Age, years, median (range)	51 (26-80)	50 (27-78)
Baseline ECOG 0	137 (54.2)	136 (54.6)
Histology, n (%)		
Squamous cell carcinoma	160 (63.2)	157 (63.1)
Adenocarcinoma	85 (33.6)	75 (30.1)
Adenosquamous	8 (3.2)	17 (6.8)
Prior regimens, n (%)		
1	159 (62.8)	149 (59.8)
2	93 (36.8)	100 (40.2)
Prior bevacizumab, n (%)	164 (64.8)	157 (63.1)
Prior anti-PD-(L)1 therapy, n (%)	71 (28.1)	67 (26.9)
Prior radiation therapy for cervical cancer, n (%)	205 (81.0)	203 (81.5)

Vergote I. ESMO 2023.

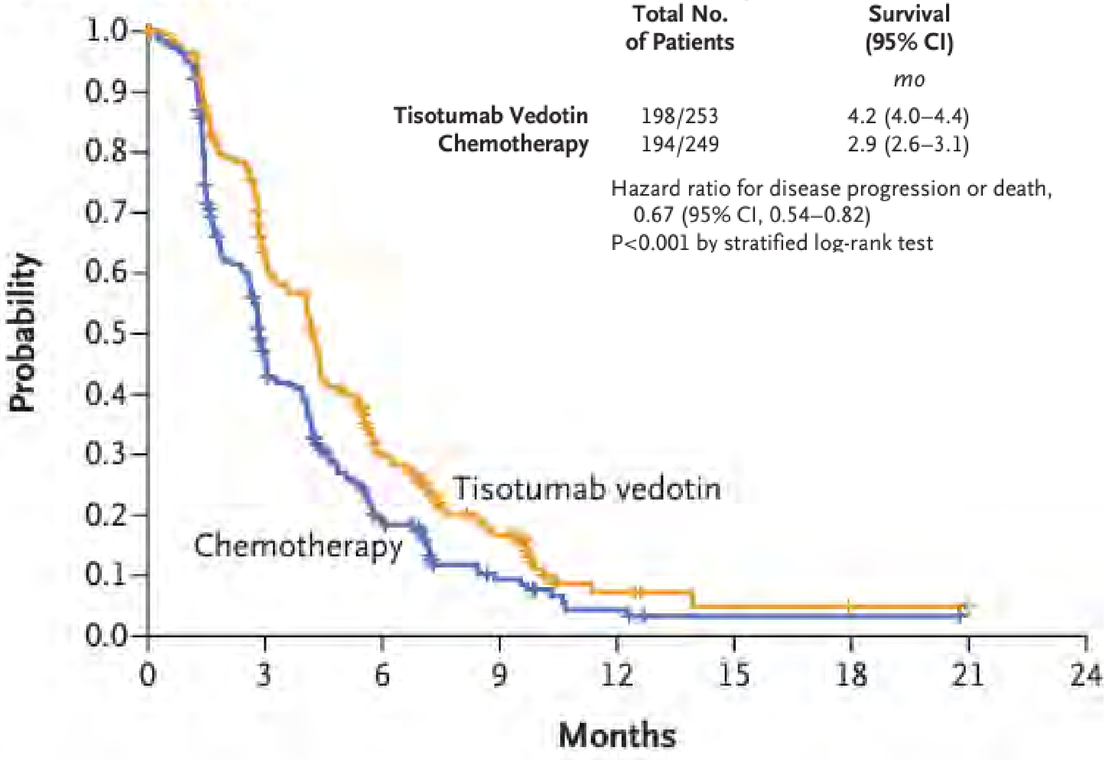
InnovaTV 301: Survival Outcomes

Tisotumab Vedotin as Second- or Third-Line Therap...
www.nejm.org

A Progression-free Survival

	No. of Events/ Total No. of Patients	Median Progression-free Survival (95% CI)
		mo
Tisotumab Vedotin	198/253	4.2 (4.0–4.4)
Chemotherapy	194/249	2.9 (2.6–3.1)

Hazard ratio for disease progression or death, 0.67 (95% CI, 0.54–0.82)
P<0.001 by stratified log-rank test



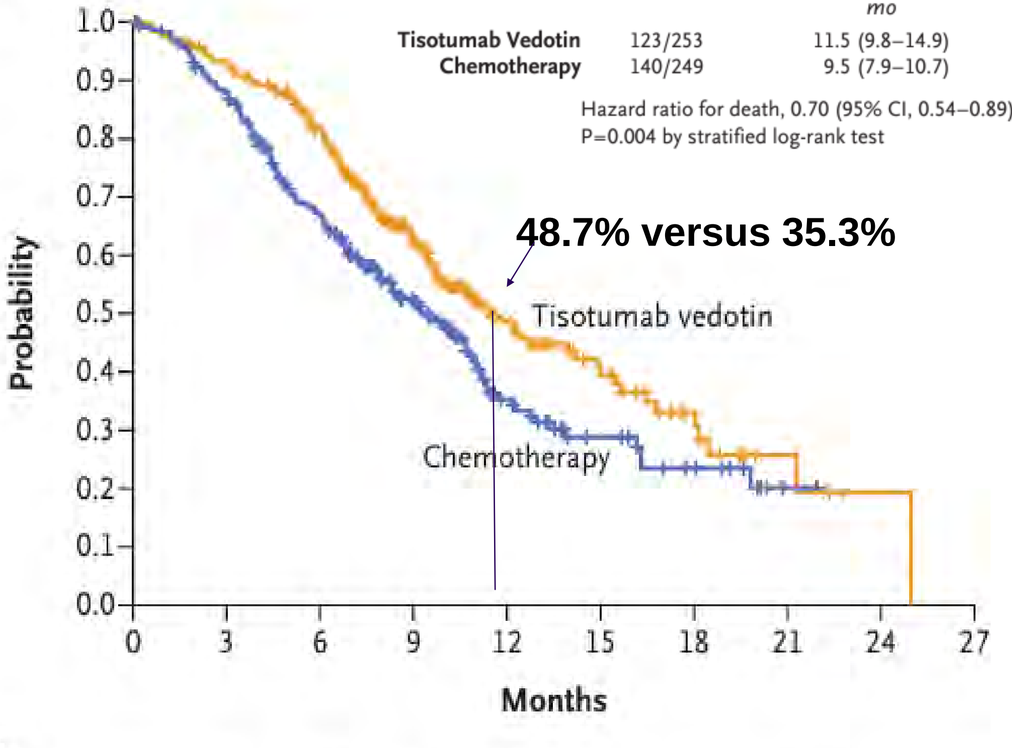
No. at Risk

Tisotumab vedotin	253	148	62	25	5	2	1	0	0
Chemotherapy	249	96	34	11	4	1	1	0	0

A Overall Survival

	No. of Events/ Total No. of Patients	Median Overall Survival (95% CI)
		mo
Tisotumab Vedotin	123/253	11.5 (9.8–14.9)
Chemotherapy	140/249	9.5 (7.9–10.7)

Hazard ratio for death, 0.70 (95% CI, 0.54–0.89)
P=0.004 by stratified log-rank test



No. at Risk

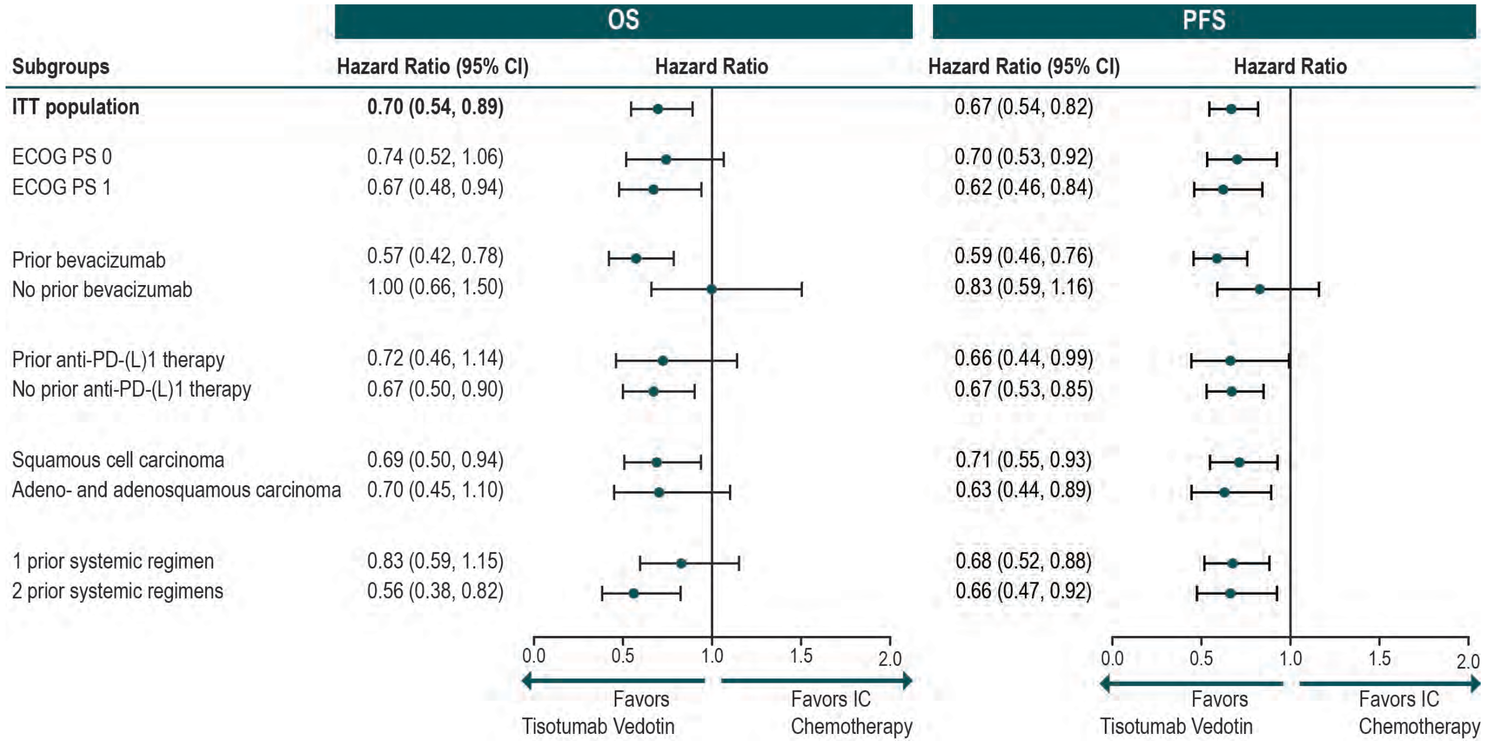
Tisotumab vedotin	253	234	191	109	52	29	14	4	1	0
Chemotherapy	249	212	150	87	37	19	11	1	0	0

Vergote I. NEJM 2024.

InnovaTV 301: Outcomes

	TV (N=253)	Chemo (N=249)
ORR, % (95% CI)	**17.8 (13.3-23.1)**	**5.2 (2.8-8.8)**
Odds ratio (95% CI) P value	4.0 (2.1-7.6) p<0.0001	
Best Overall Response, n (%)		
CR	6 (2.4)	0
PR	39 (15.4)	13 (5.2)
SD	147 (58.1)	132 (53.0)
PD	46 (18.2)	74 (29.7)
Not evaluable/Not available	15 (5.9)	30 (12.0)
DCR, % (95% CI)	**75.9 (70.1-81.0)**	**58.2 (51.8-64.4)**
Median DOR (95% CI)	5.3 (4.2-8.3)	5.7 (2.8-NR)

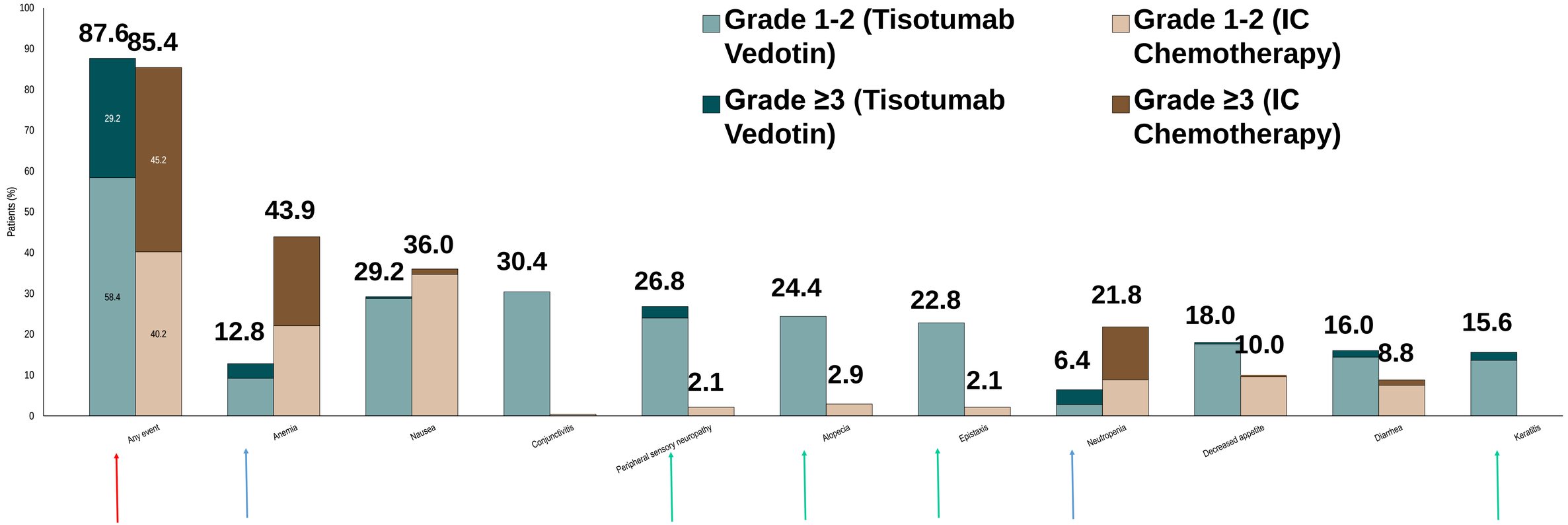
Subgroup Analysis



OS and PFS benefit was generally consistent across key subgroups

Vergote I. NEJM 2024.

Most Common Treatment-Related Adverse Events[a]

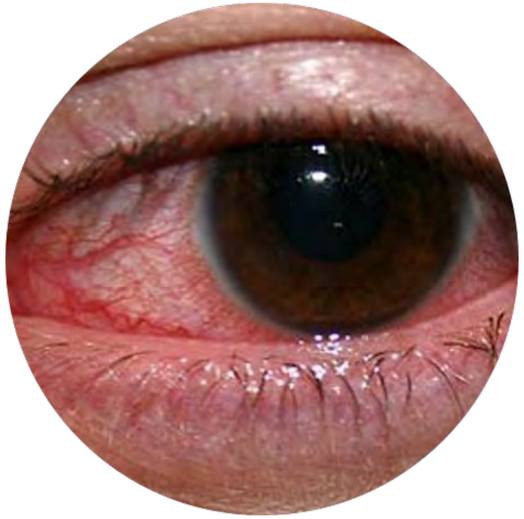


- Grade 5 TRAEs occurred in 2 (0.8%) and 1 (0.4%) patients in the tisotumab vedotin and IC chemotherapy arms, respectively[b]
- Median relative dose intensity was 96.1% and 90.0% in the tisotumab vedotin and IC chemotherapy arms, respectively

[a]TRAEs listed are those occurring in ≥15% of patients on either arm; [b]Grade 5 TRAEs included acute kidney injury (n=1) and Stevens-Johnson syndrome (n=1) in the tisotumab vedotin arm and pancytopenia (n=1) in the IC chemotherapy arm.

Ocular Toxicity

- Causes changes in corneal epithelium and conjunctiva
- May result
  - Vision changes/loss
  - Keratitis
  - Conjunctivitis
  - Corneal ulceration



- Conduct ophthalmic examination at baseline, prior to each dose, and as clinically indicated
- Eye care plan including
  - Vasoconstrictor drops
  - Steroid eye drops
  - Lubricating drops
  - Ice packs
- Withhold until improvement and resume, reduce the dose, or permanently discontinue, based on severity

GOG-3116/C5721005

PI: Scott Jordan, MD

Single-arm, prospective, low-interventional study of tisotumab vedotin in adult participants in the US with r/mCC who have received prior systemic therapy for recurrent or metastatic disease

Patient Population

r/m CC with disease progression on or after chemotherapy, following prior systemic therapy

No active ocular disease at baseline

No prior TV treatment

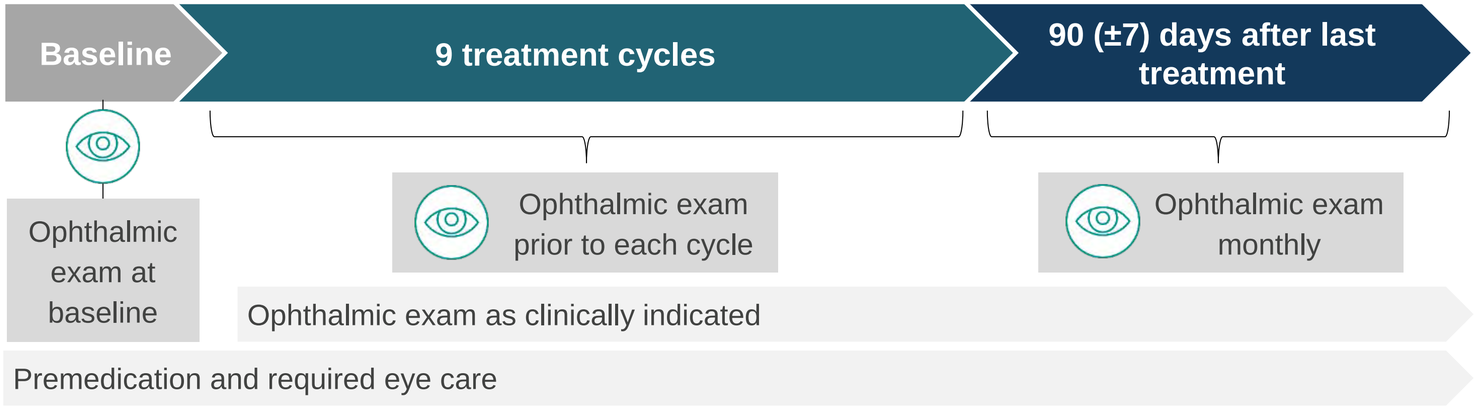
Tisotumab vedotin
2.0 mg/kg IV on Day 1 of a 21-day cycle (Q3W)

N=100

Intervention

Scheduled ocular assessments conducted by eye care providers

- Slit lamp exam of the anterior segment of the eye
- Visual acuity
- Assessment of normal eye movement
- Elicitation of visual symptoms



Endpoints

Primary endpoint

- Type, incidence and severity of ocular AEs

Secondary endpoints

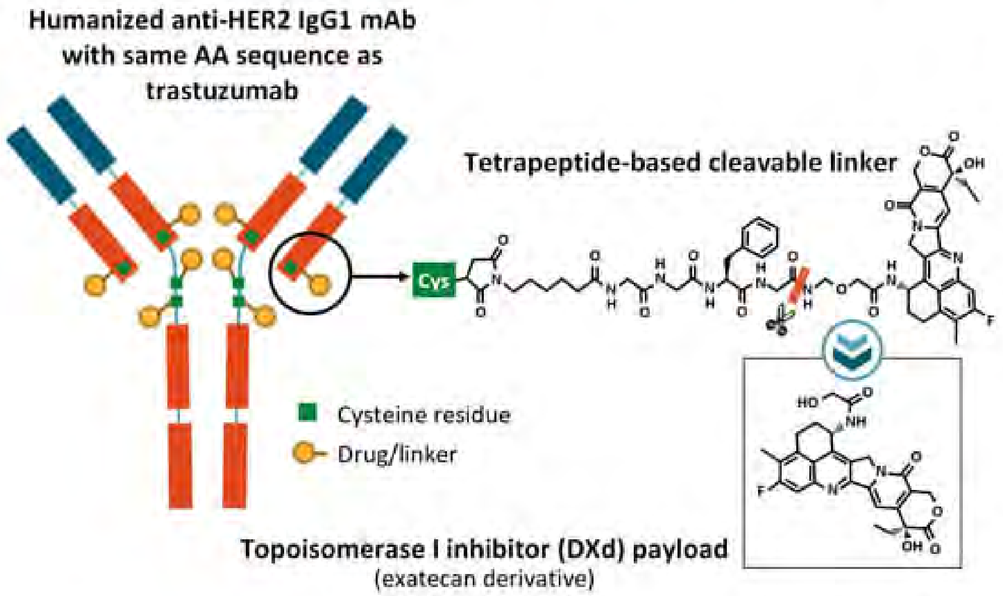
- Time to onset, time to resolution, and outcome of ocular AEs
- Incidence of serious AEs
- AEs leading to dose modifications including treatment discontinuation

Objective: to further characterize the incidence and severity of tisotumab vedotin-related ocular events with prospectively pre-specified, scheduled ocular assessments in patients receiving tisotumab vedotin for r/mCC

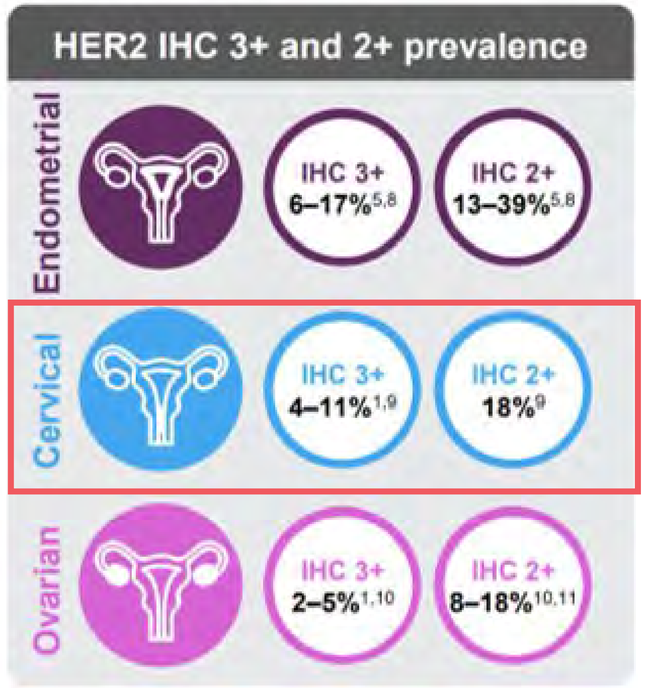
NCT06952660

Emerging ADC Options

HER2-Targeted ADC: Trastuzumab Deruxtecan



- High drug:antibody ratio: ~8
- Stable linker-payload
- Tumor-selectable cleavable linker
- High potency, membrane-permeable payload with short systemic half-life
- Bystander killing effect



Nakada. Chem Pharm Bull (Tokyo). 2019;67:173. Trail. Pharmacol Ther. 2018;181:126. Ogitani. Cancer Sci. 2016;107:1039.

DESTINY-PanTumor02: Study Design

A phase 2, multicenter, open-label study to evaluate the efficacy and safety of trastuzumab deruxtecan for the treatment of selected HER2 expressing tumors[1,2]

Key Eligibility Criteria

- Advanced solid tumors not eligible for curative therapy
- 2L+ patient population
- HER2 expression (IHC 3+ or 2+)
- Local test or central test by HercepTest if local test not feasible (ASCO/CAP gastric cancer scoring
- Prior HER-targeting therapy allowed
- ECOG/WHO PS ≤1

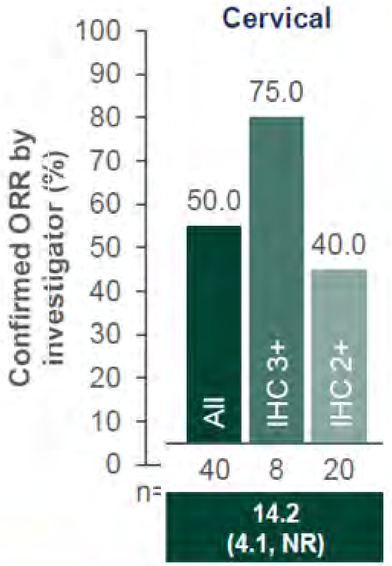
T-DXd
5.4 mg/kg Q3W

40 per cohort[b]

Frequency of HER2 mutations across tumor types

Endometrial cancer	~7%[3]
Cervical cancer	~5%[4]
Ovarian cancer	1–2%[5]
Bladder cancer	9–13%[6]
Other tumors[c]	
Biliary tract cancer	~10%
Pancreatic cancer	~1%[3]

ORR by HER2 status in Cervical Cancer

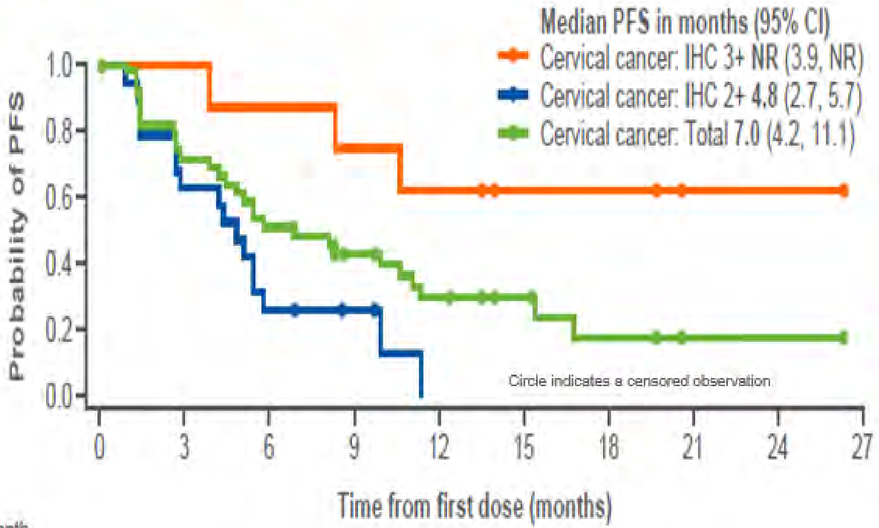


All patients were HER2-positive per local determination

Clinicaltrials.gov.NCT04482309. Accessed October 03, 2023. 2. Funda Meric-Burnstam. Presented at ESMO 2023. Presented orally LBA34. 3. Wang et al. *Front Immunol*. 2022; 13: 799988.4. Oaknin et al. *Gynecol Oncol*. 2020t;159(1):150-156; 5. Li et al. *EBioMedicine*. 2020; 62: 103074; 6. Harding JJ et al. *Nat Commun*. 2023;14(1):630. doi: 10.1038/s41467-023-36399-y.

DESTINY-PanTumor02:

PFS by HER2 status in Cervical Cancer



TEAEs	All patients (N=267); n (%)
Any drug-related TEAEs	226 (84.6)
Drug-related TEAEs Grade ≥3	109 (40.8)
Serious drug-related TEAEs	36 (13.5)
Drug-related TEAEs associated with dose discontinuations	23 (8.6)
Drug-related TEAEs associated with dose interruptions	54 (20.2)
Drug-related TEAEs associated with dose reductions	54 (20.2)
Drug-related TEAEs associated with deaths	4 (1.5)[a]

Most common TEAEs	Any Grade	Grade ≥3
Nausea	55.1	3.7
Fatigue	40.1	7.1
Neutropenia	32.6	19.1
Anemia	27.7	10.9
Diarrhea	25.8	3.7
Vomiting	24.7	1.5
Decreased appetite	17.6	1.5
Thrombocytopenia	17.2	5.6
Alopecia	16.9	
Increased transaminases	10.1	0.4
Leukopenia	10.1	2.6

ILD/pneumonitis adjudicated as T-DXd related, n (%)	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Any grade
All patients (N=267)	7 (2.6)	17 (6.4)	1 (0.4)	0	3 (1.1)	28 (10.5)

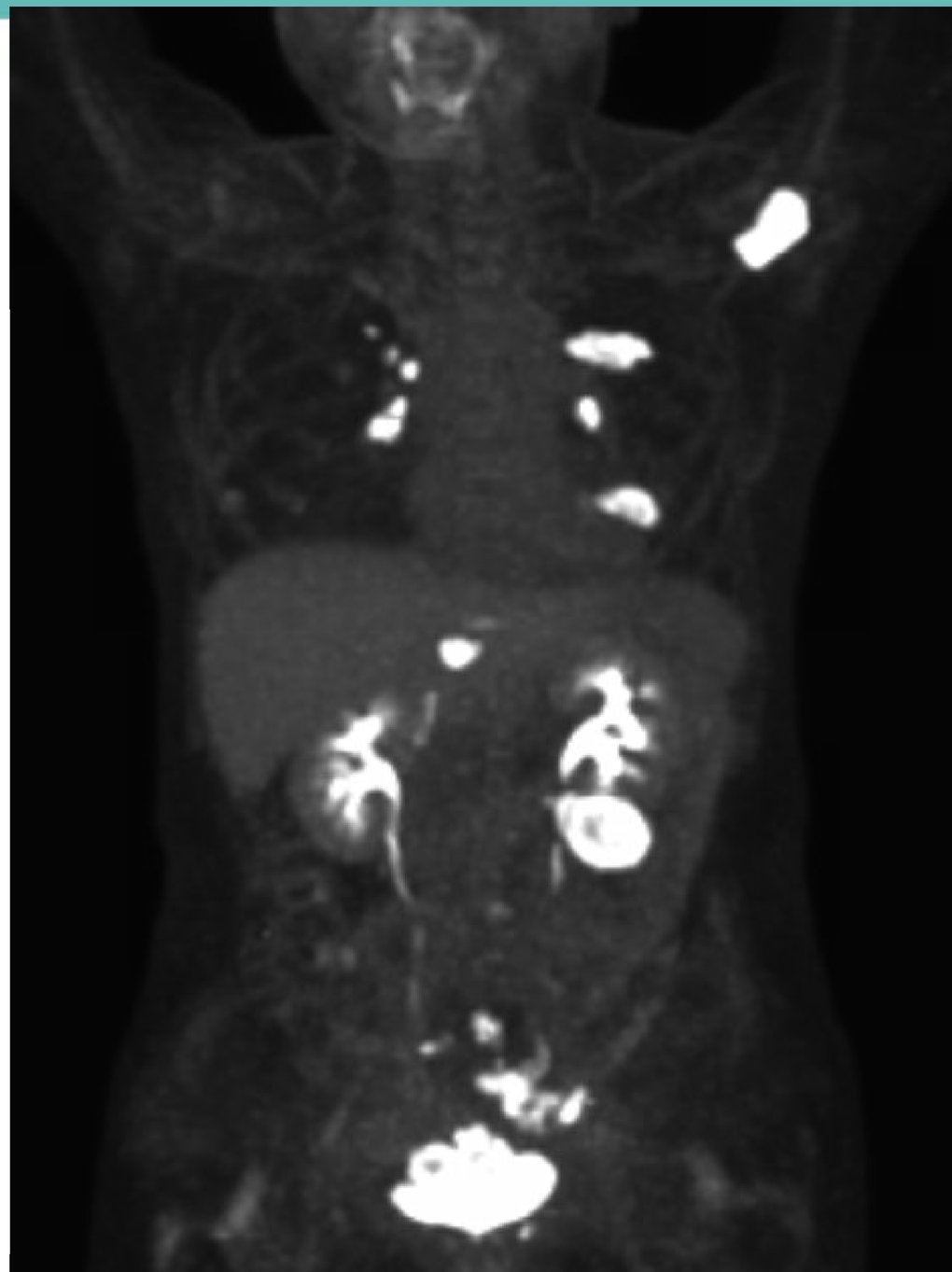
FDA accelerated approval: patients with unresectable or metastatic **HER2+ (IHC 3+) solid tumors who have received prior systemic treatment** and have no satisfactory alternative treatment options

1. Clinicaltrials.gov.NCT04482309. Accessed October 03, 2023. 2. Funda Meric-Burnstam. Presented at **ESMO** 2023. **Presented orally LBA34. 3. Wang et al. *Front Immunol*. 2022; 13: 799988.4. Oaknin et al. *Gynecol Oncol*. 2020t;159(1):150-156; 5. Li et al. *EBioMedicine*. 2020; 62: 103074; 6. Harding JJ et al. *Nat Commun*. 2023;14(1):630. doi: 10.1038/s41467-023-36399-y.**

Clinical Case

Clinical History

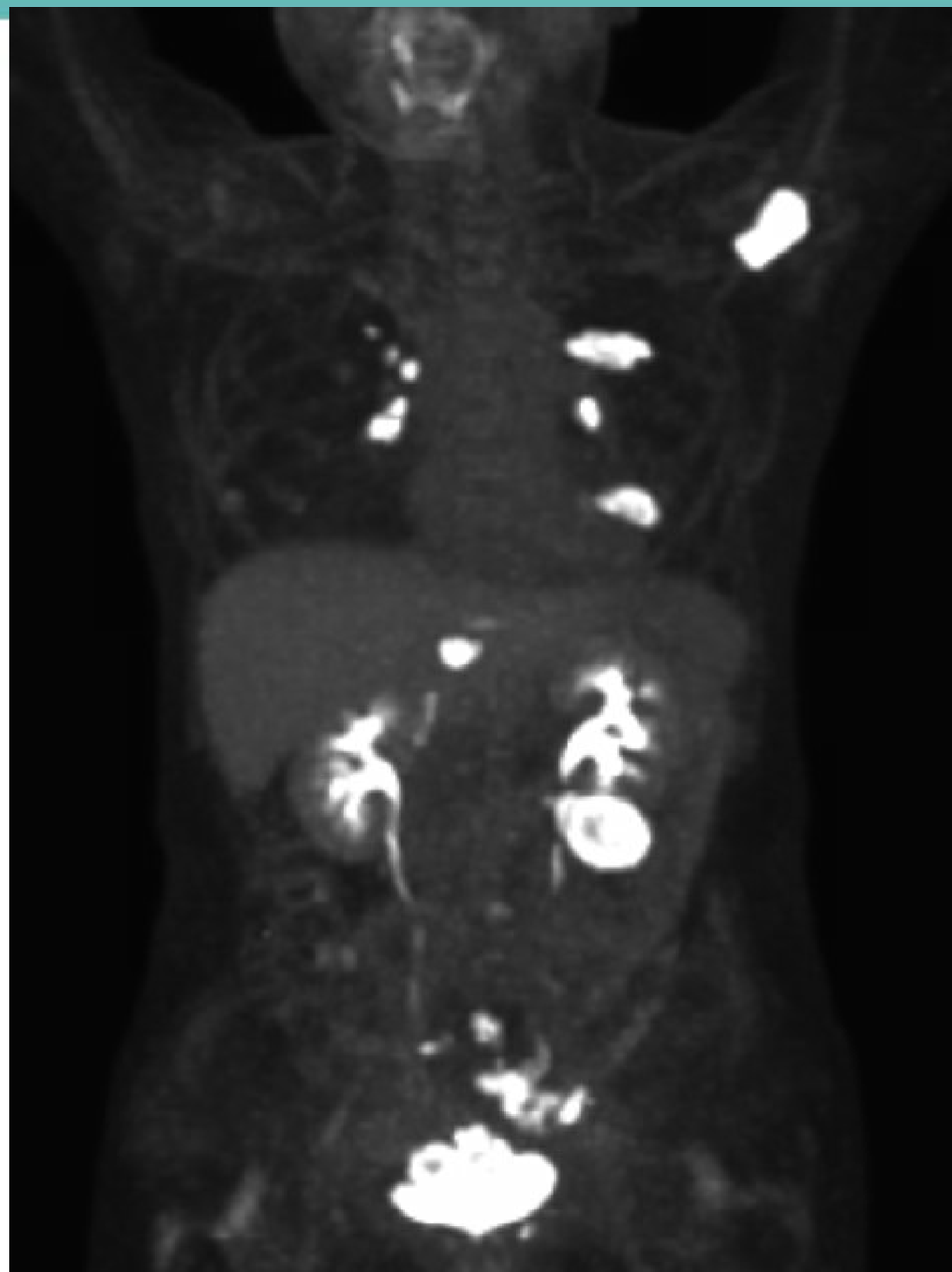
- 36 year from China who presented with advanced cervical cancer (non-vaccinated)
- **Symptom:** pelvic pain /vaginal bleeding
- **Pelvic MRI with Contrast:** 3.1 x 1.5 cm mass with ill-defined border to left bladder wall/enlarged lymph nodes adjacent to bilateral iliac vessels, largest one about 1.8 x 1.3 cm in size.
- **Cystoscopy** with space-occupying lesion in bladder
- **Biopsy:** Squamous cell carcinoma, poorly differentiated, non-keratinizing type, involving colonic submucosa. PD-L1 positive , Her 2 neu negative (0)
- **PET Scan:** FDG avid cancer involving lower segment of uterus and bladder, multiple lymph node metastases, abdominal, and pelvic metastases



Clinical Case

Treated Locally

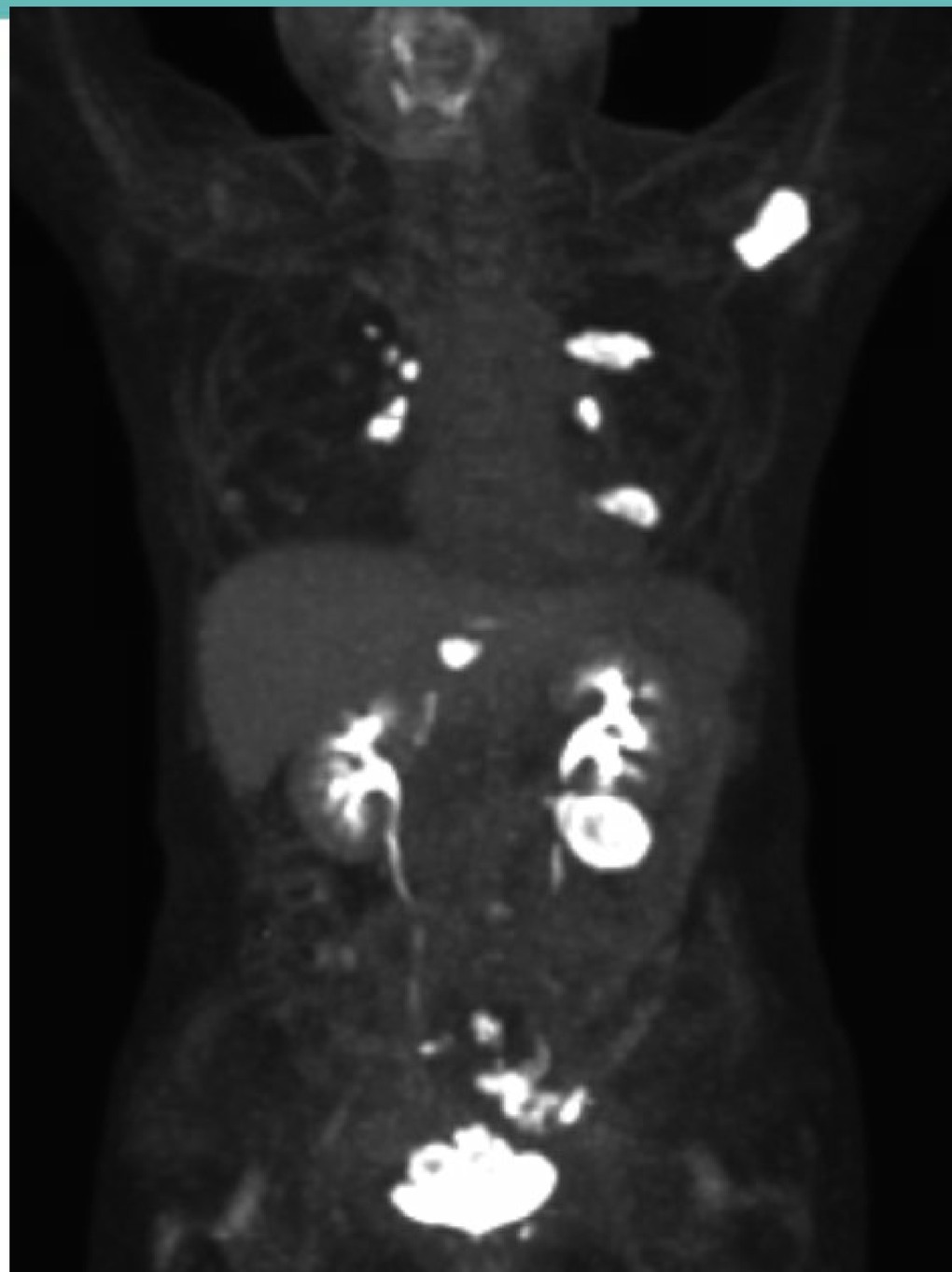
- **Carboplatin and paclitaxel**
- **Radiation Therapy** to the cervical lesion and pelvic lymph nodes
- **Post Therapy Imaging:** Cervical mass involving left bladder wall and lymph nodes significantly regressed compared with previous scan. Multiple heterogeneous masses in peritoneum of left upper abdomen.
- Treatment: Paclitaxel + Carboplatin + Pembrolizumab x 6 cycles
  - After completion of therapy, PET CT done
  - Multifocal areas of FDG avid metastatic disease involving bilateral hilar and right internal mammary lymph nodes, multifocal soft tissue implants in the abdomen and pelvis, and multiple osseous metastases.



Clinical Case

Q: Outside of clinical trials, which treatment would you consider next for this patient?

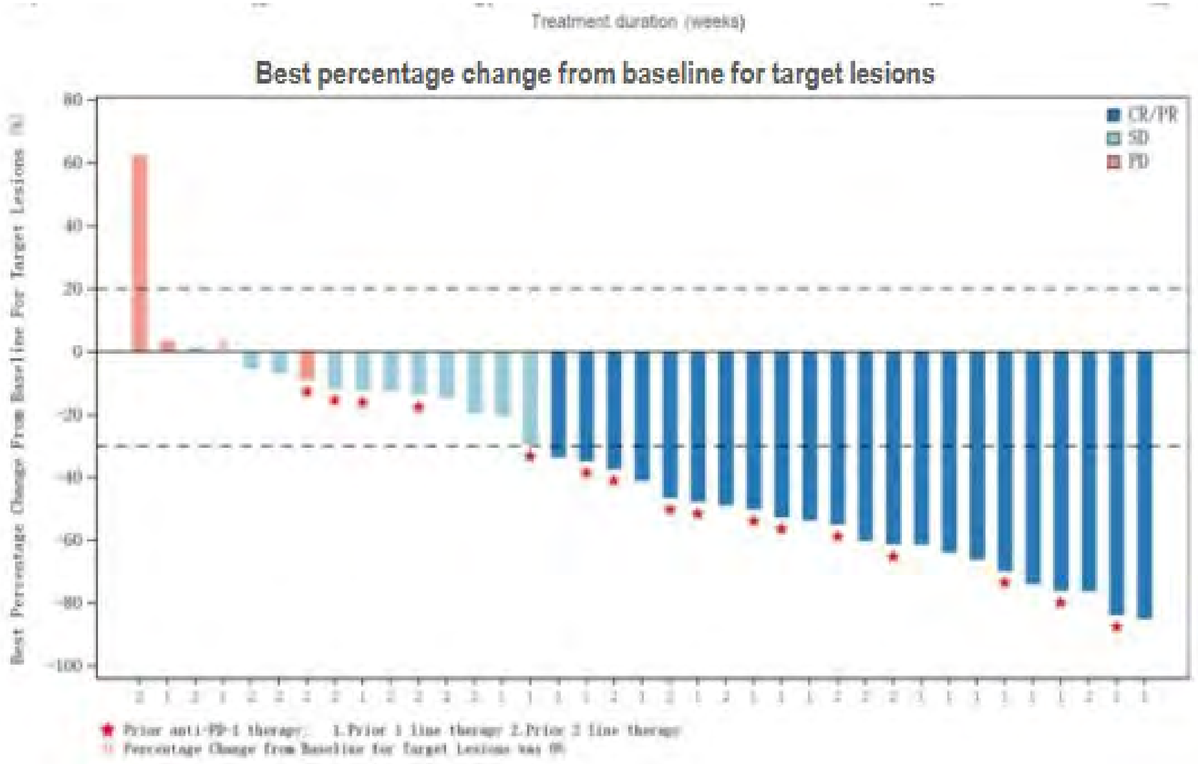
1. Tisotumab vedotin
2. Cemiplimab
3. Trastuzumab Deruxtecan
4. Nivolumab
5. Chemotherapy
6. Other



TROP 2 ADC: Sacituzumab Tirumotecan

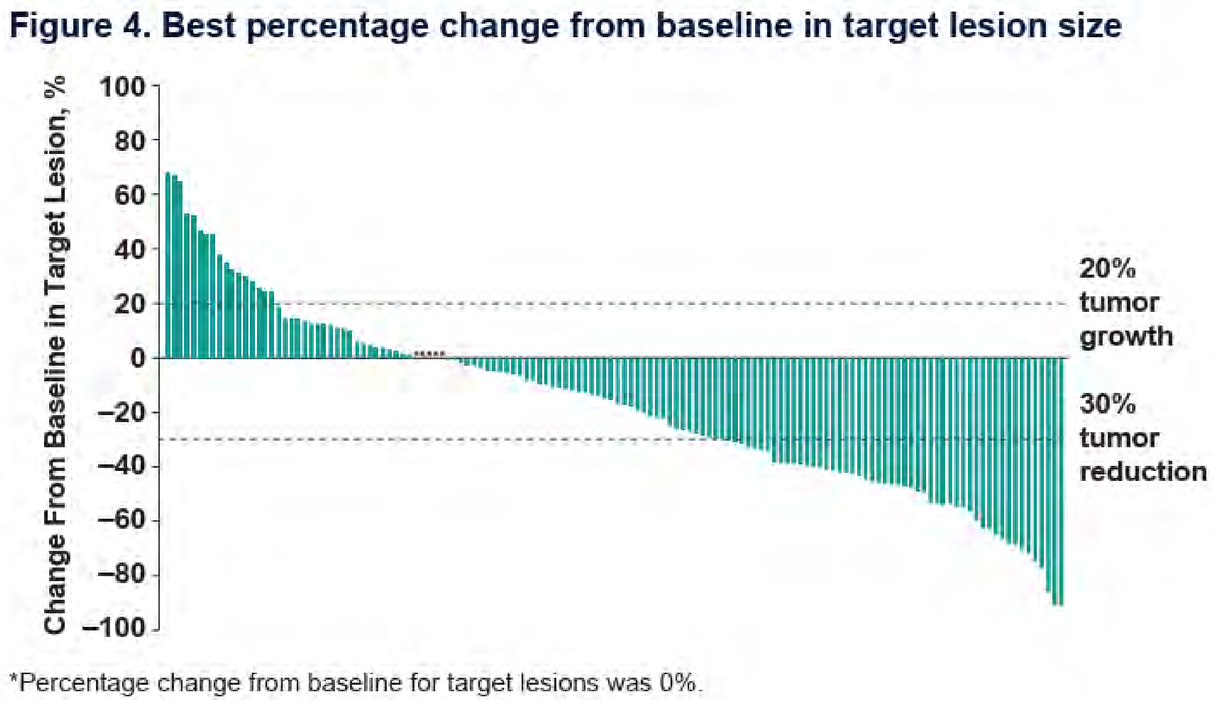
SacTMT + Pembrolizumab

ORR 57.9%



Sac TMT

ORR 24.2%
DCR 71.9%
DOR 7.5 m



Wu X. ESMO 2024; Wang ESMO 2025

GOG-3101/TroFuse-020/ENGOT-cx20

A Phase 3 Randomized, Active-controlled, Open-label, Multicenter Study to Compare the Efficacy and Safety of MK-2870 Monotherapy Versus Treatment of Physician's Choice as Second-line Treatment for Participants with Recurrent or Metastatic Cervical Cancer

PI: Ritu Salani, MD

Eligibility

- Squamous, adenosquamous, adenocarcinoma cervical cancer
- Recurrent or metastatic:
  - Progressed on or after treatment with 1 prior line of systemic platinum doublet chemotherapy (with or without bevacizumab) NOTE: may have also received prior chemoradiotherapy in the LACC setting

  AND
  - Received anti-PD-1/anti-PD-L1 therapy as part of prior cervical cancer regimens
- Measurable disease per RECIST 1.1
- ECOG PS 0-1
- <Grade 2 PN

Safety run-in

Sac-TMT 4 mg/kg IV q2 wk

ORR
Safety/Tolerability

R 1:1

Sac-TMT 4 mg/kg IV q2 wk

Physician's choice chemo
Tisotumab vedotin, pemetrexed, topotecan, vinorelbine, gemcitabine, or irinotecan

Primary Endpoint

- OS

Secondary Endpoints

- PFS
- ORR
- DOR
- Safety/Tolerability
- PROs
  - Time to first deterioration EORTC-QLQ-C30
  - Change baseline C30
    - Health status
    - QOL
    - Physical functioning
    - Role functioning

NCT06459180

ADCs in Development

	n	Target	Payload	DAR	ORR	mDOR
Disitimab vedotin	17	Her2	MMAE	4	43.8%	5.52 mo
SacTMT +pembrolizumab	38	Trop2	Belinotecan derivative	7.4	57.9%	NR
SacTMT	153	"	"	"	24.2%	7.5
Sacituzumab govitecan	18	Trop2	SN-38	7.6	50%	9.2
9MW2821	53	Nectin4	MMAE	4	35.8%	Not rep.

Wu et al. March 2024. International Journal of Gynecological Cancer 34(Suppl 1):A6.1-A6. Wu et al. Annals of Oncology (2024) 35 (suppl_2): S544-S595. 2. 10.1016/annonc/annonc1592. NCT05119907 Huijuan Y et al SGO 2024.

Key Points

- ADCs are emerging as a key strategy in the management of recurrent cervical cancer
  - Tisotumab vedotin has shown an overall survival advantage
  - Trastuzumab deruxtecan has shown impressive responses in HER2 2-3+

- Toxicity management is key
  - Ocular toxicities
  - Interstitial Lung disease

- Clinical trials are ongoing
  - TROP2 targets
  - NECTIN4
  - Combinations

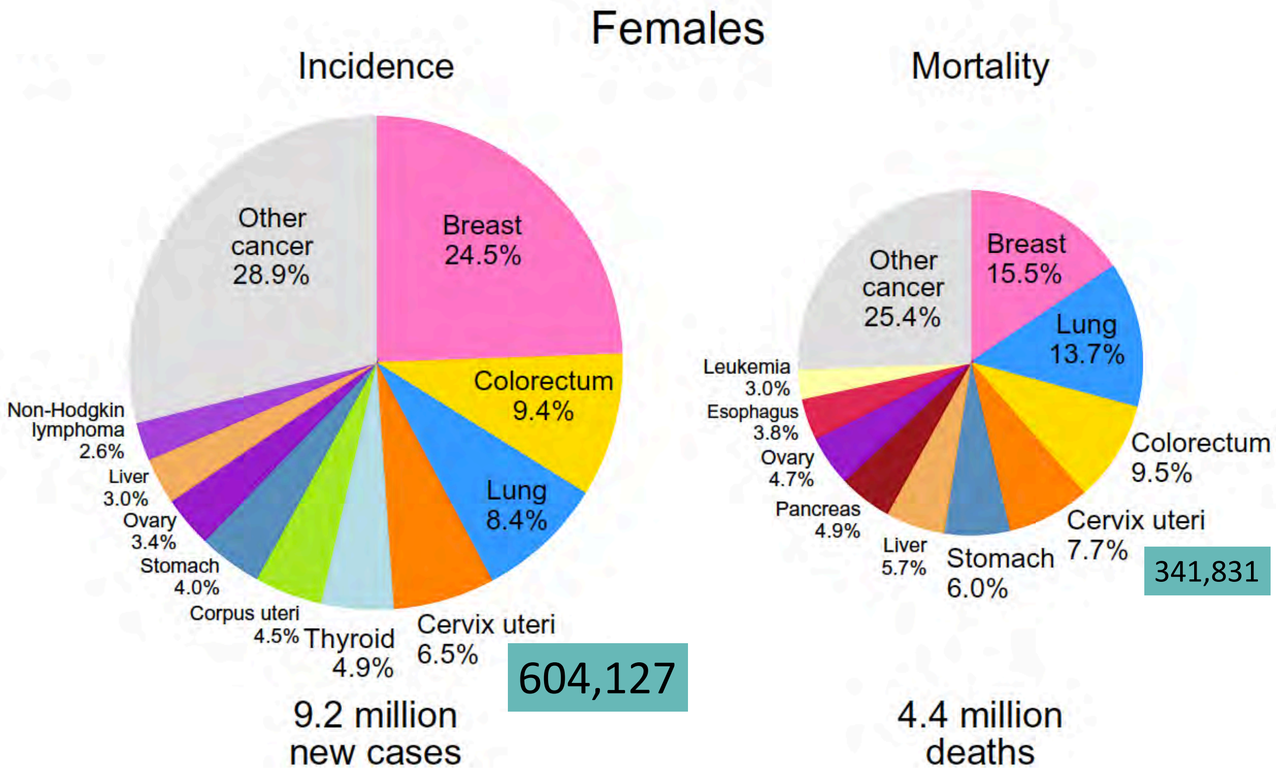
ENROLL YOUR PATIENTS!

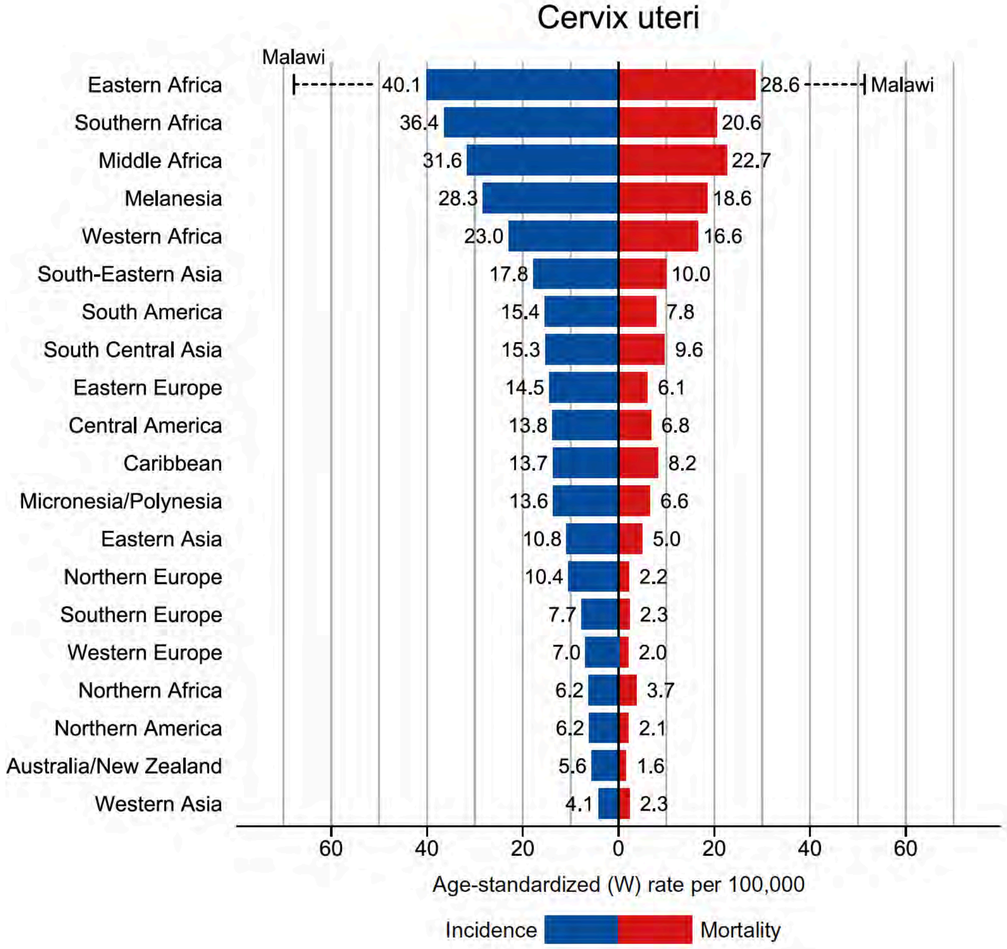
Global Epidemiology & Prevention Strategies

Leslie Randall, MD, MAS

Inova Health System
Washington, DC, USA

Region-Specific Incidence and Mortality Rates for Cervical Cancer in 2020

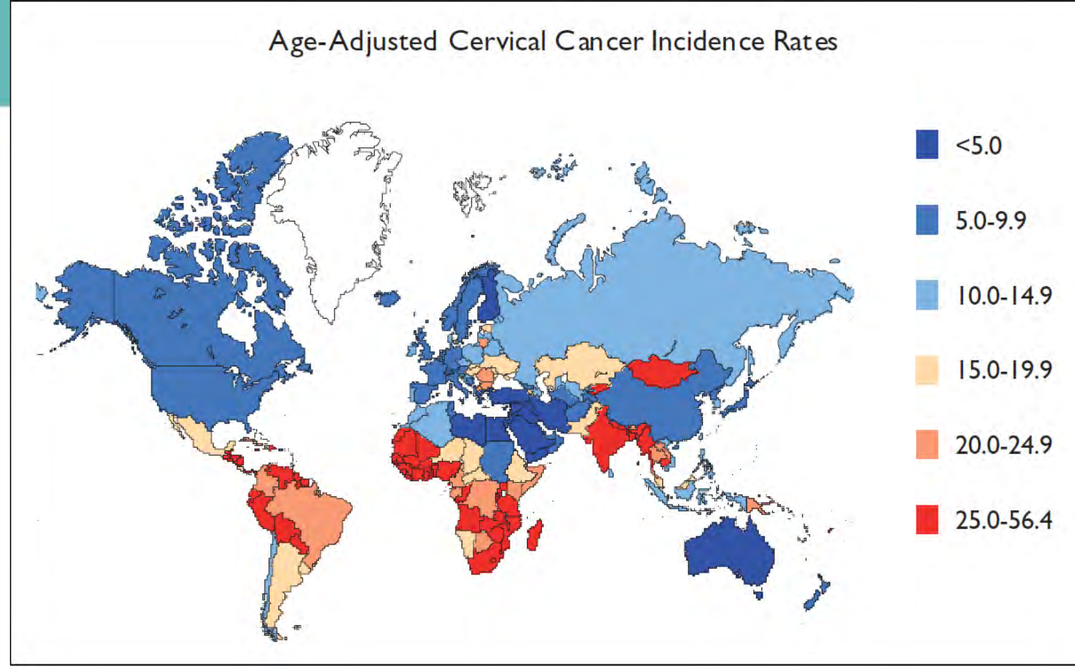


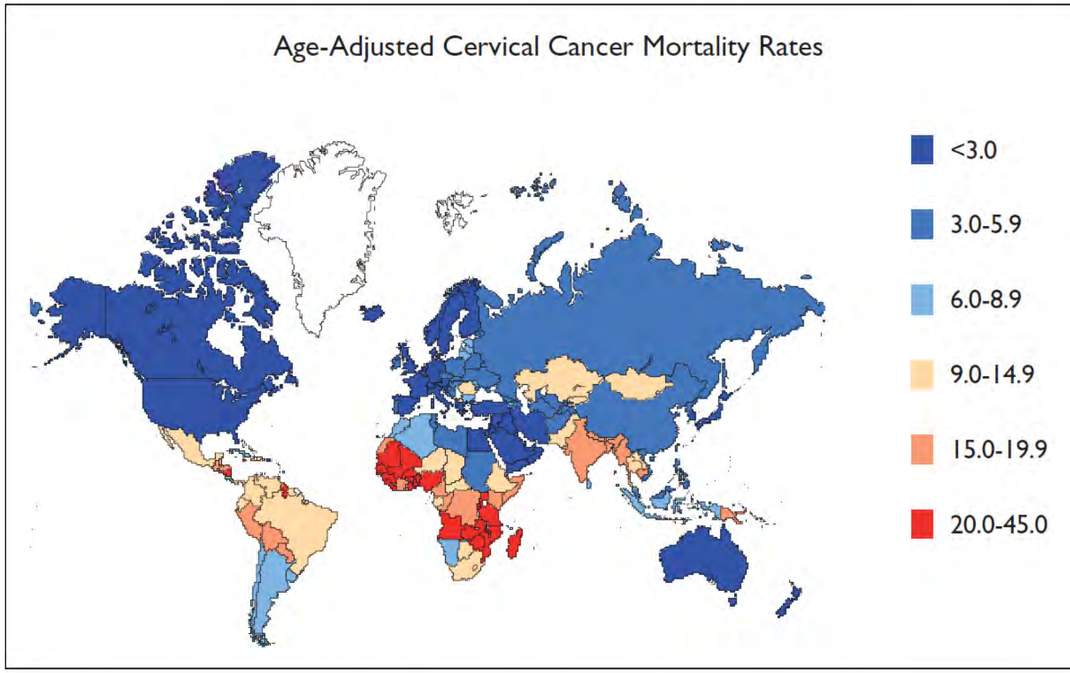


H Sung et al Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries. CA Cancer J Clin. 2021 May;71(3):209-249.

Global disparities in cervical cancer treatment access are significant, with nearly 94% of deaths occurring in low- and middle-income countries due to limited access to screening, vaccination, and advanced treatment like surgery and radiotherapy. These disparities are driven by systemic issues including poverty, inadequate healthcare infrastructure, shortages of specialists and equipment, and lack of health insurance. Addressing this requires global efforts to expand prevention, improve diagnostic and treatment capabilities, and strengthen healthcare systems in affected regions.

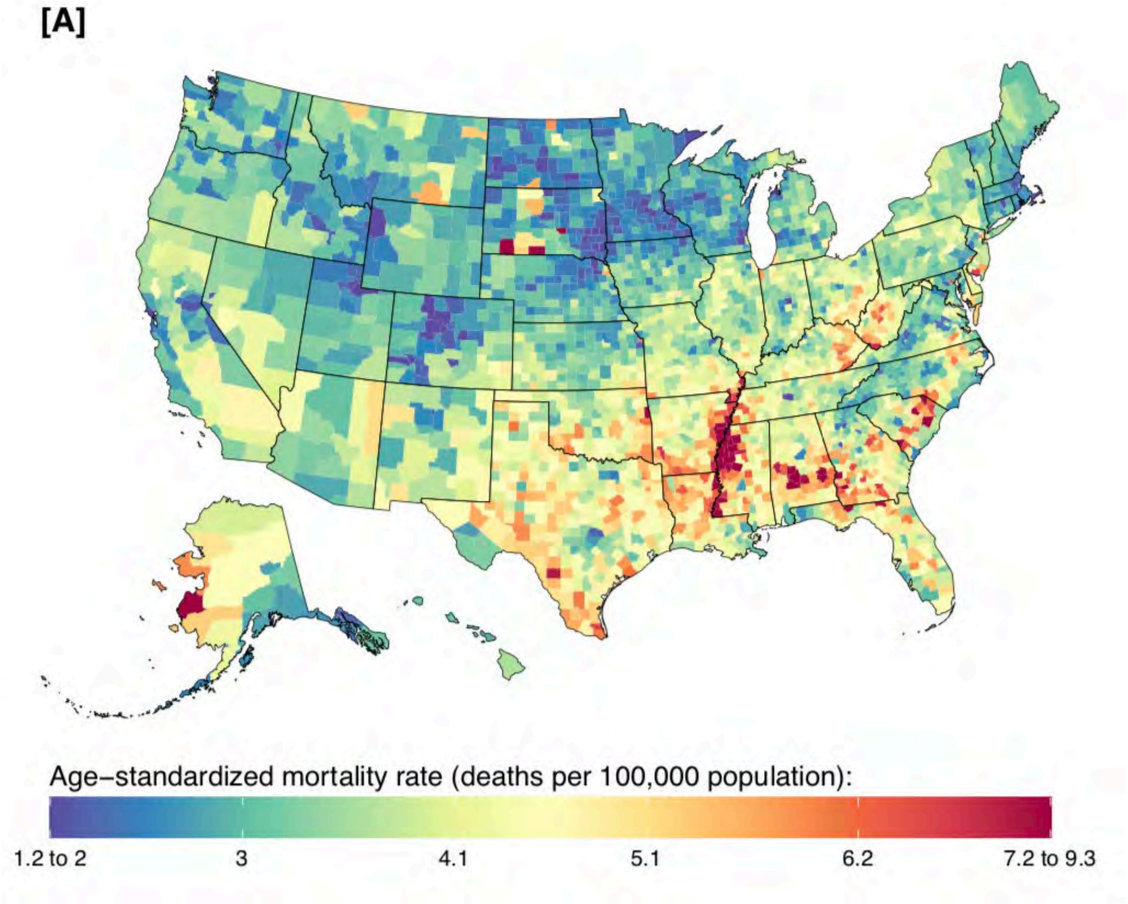
https://www.who.int/news-room/fact-sheets/detail/cervical-cancer#:~:text=Globally%2C%20cervical%20cancer%20is%20the,to%20cervical%20cancer%20(2).





Source: WHO, International Agency for Research on Cancer, GLOBOCAN, 2008.

Cervical cancer is relevant in the United States



In 2017, there were an estimated 291,704 women living with cervical cancer in the United States.

Mokdad AH et al. *JAMA.* 2017;317(4):388–406.

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Launch of the Global Strategy to Accelerate the Elimination of Cervical Cancer

17 November 2020 14:30 – 17:45 CET

العربية | 中文 | Français | Русский | Español

Related

VIA in Mumbai, India

- A cluster-randomized controlled trial
- Visual inspection with acetic acid (VIA)
- Primary health workers
- 75360 women screening group
- 76178 women control group.
- In the screening group, we achieved 89% participation for screening and 79.4% compliance for diagnosis confirmation.
- The incidence of invasive cervical cancer was 26.74 per 100000 (95% confidence interval [CI] = 23.41 to 30.74) in the screening group and 27.49 per 100000 (95% CI = 23.66 to 32.09) in the control group.
- Compliance to treatment for invasive cancer was 86.3% in the screening group and 72.3% in the control group.
- The screening group showed a statistically significant 31% reduction in cervical cancer mortality (RR = 0.69; 95% CI = 0.54 to 0.88; *P* = .003).

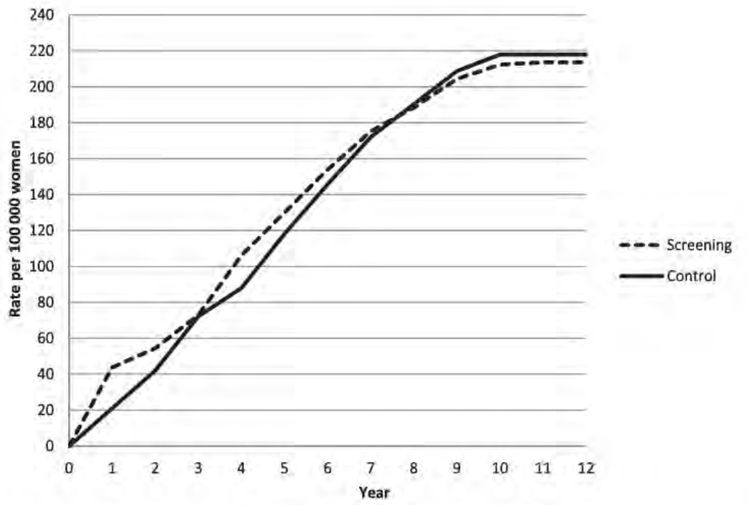


Figure 2. Cumulative incidence curve for cervix cancer. Cumulative incidence of cervical cancer in the screening and control groups after 12 years of follow-up. The screening group recruited 75 360 women aged 35 to 64 years and had an annual attrition of 2.2%, whereas the control group recruited 76 178 women also aged 35 to 64 years and had an annual attrition of 2.3%.

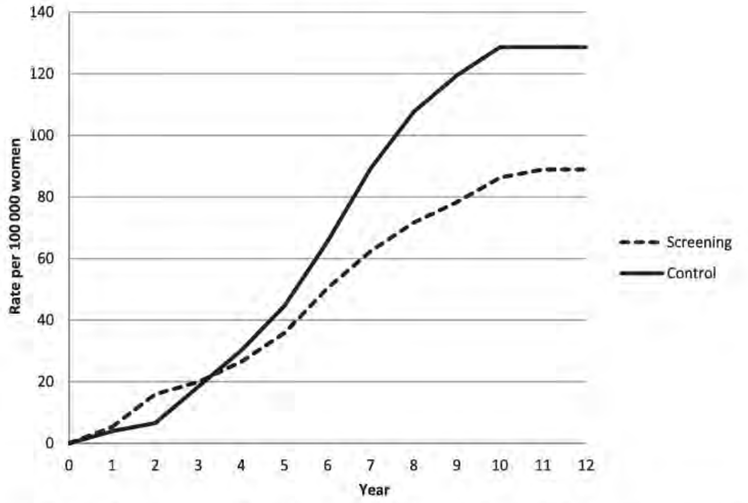


Figure 3. Cumulative mortality curve for cervix cancer. Cumulative mortality from cervical cancer in the screening and control groups after 12 years of follow-up. The screening group recruited 75 360 women aged 35 to 64 years and had an annual attrition of 2.2%, whereas the control group recruited 76 178 women also aged 35 to 64 years and had an annual attrition of 2.3%.

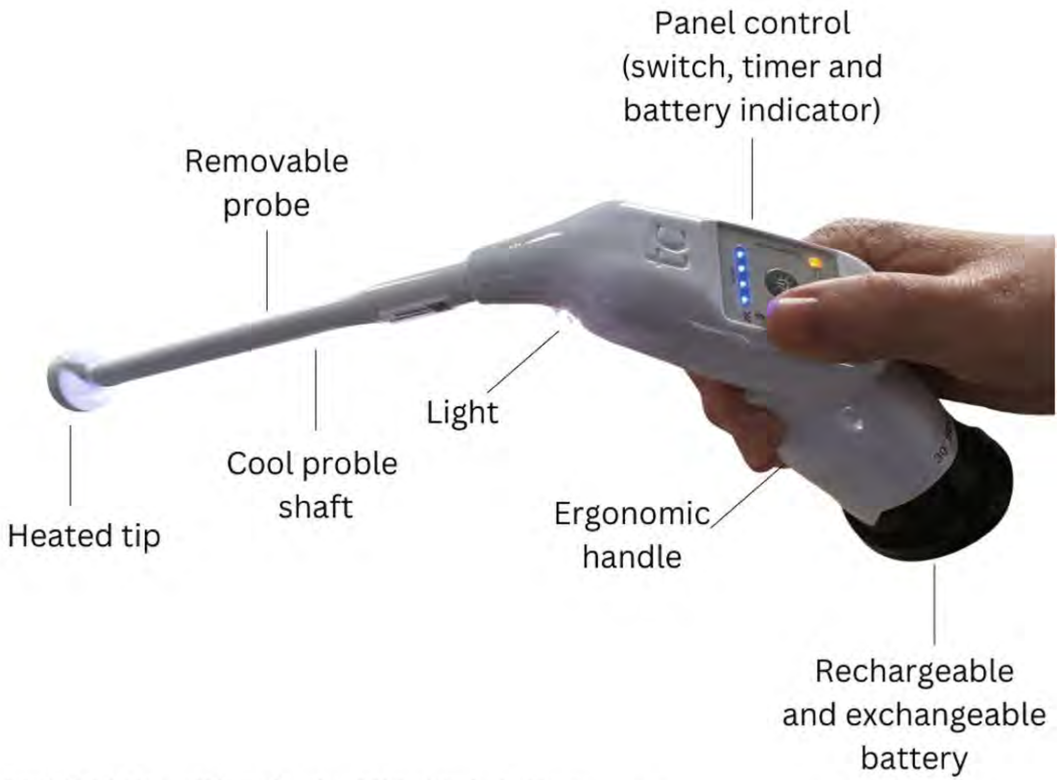
Shastri SS et al. J Natl Cancer Inst. 2014 Mar;106(3):dju009.

nature medicine

Article

https://doi.org/10.1038/s41591-024-03080-w

A portable thermal ablation device for cervical cancer prevention in a screen-and-treat setting: a randomized, noninferiority trial



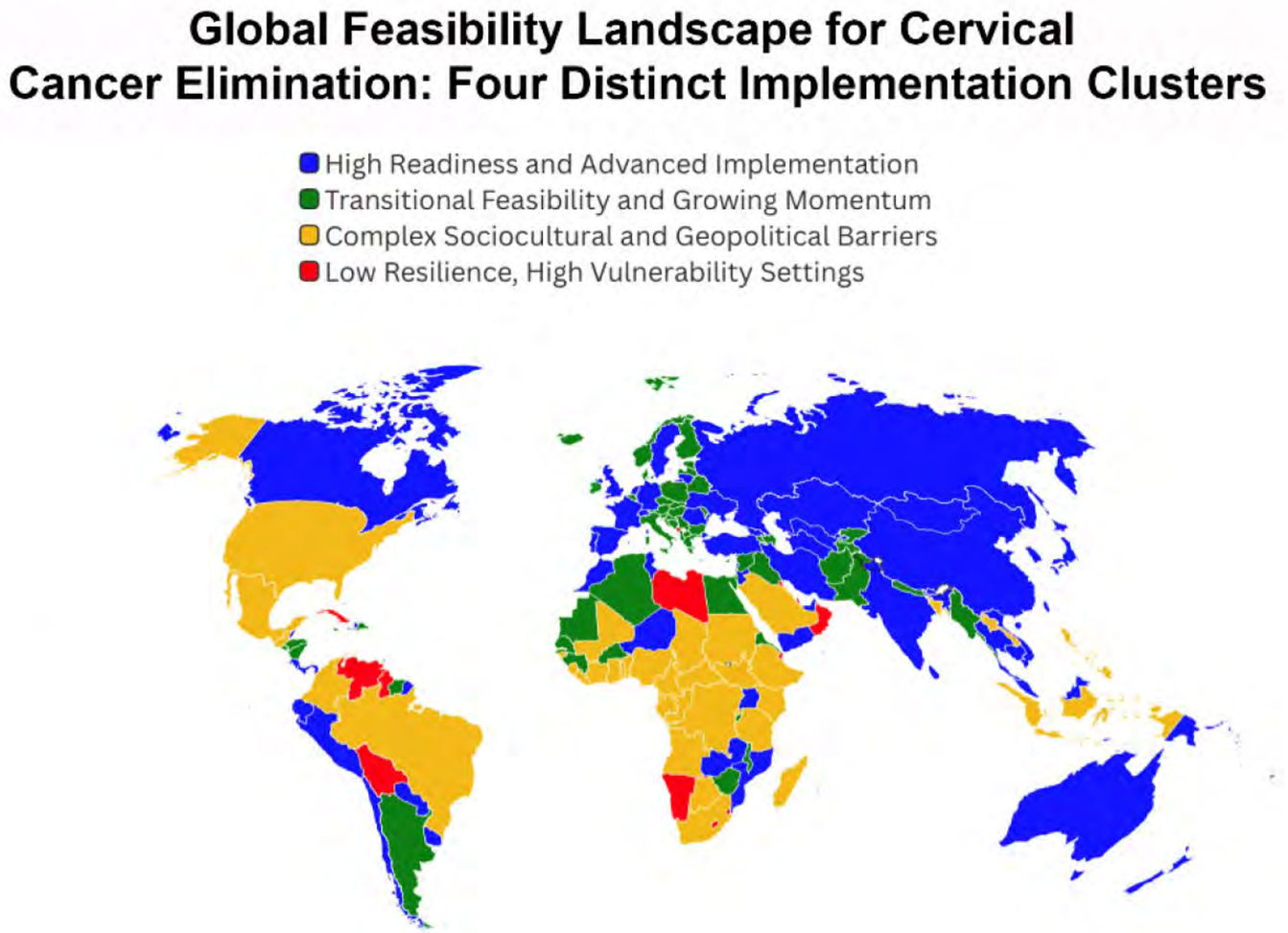
Extended Data Fig. 1 | A portable battery-driven thermal ablation device showing different components.

- Randomized controlled noninferiority trial in Zambia
- Portable, battery-driven thermal ablation (TA) device compared to cryotherapy and electrosurgical excision (large loop excision of transformation zone (LLETZ)
- 3,124 women VIA +
- HPV clearance or a negative VIA
- After a median follow-up of 12 months, treatment success rates were 74.0%, 71.1% and 71.4% for the TA, cryotherapy and LLETZ arms, respectively, thus demonstrating noninferiority (P = 0.83).
- Only 3.6% of those randomized to TA reported moderate-to-severe pain, compared to 6.5% and 1.9% for the cryotherapy and LLETZ arms, respectively.

Risk ratio for TA versus cryotherapy (95% CI)[b]	1.01 (0.96–1.07)
Risk ratio for TA versus LLETZ (95% CI)[b]	1.02 (0.95–1.08)

Basu P, Mwanahamuntu M, Pinder LF, Muwonge R, Lucas E, Nyambe N, Chisele S, Shibemba AL, Sauvaget C, Sankaranarayanan R, Prendiville W, Parham GP. A portable thermal ablation device for cervical cancer prevention in a screen-and-treat setting: a randomized, noninferiority trial. Nat Med. 2024 Sep;30(9):2596-2604.

Elimination can be geographically complex



Cuello M.A., Gomez-Valenzuela F., Wichmann I., Olawaiye A.B. **OP001 IGCS 2025**

Introducing

IGCS ACCESS Series

Accelerating Cervical Cancer Elimination Strategies Symposia

A bold 5-year plan

IGCS WORLD OF HOPE

Supported by the IGCS World of Hope Development Fund

TOGETHER, WE CAN
ELIMINATE CERVICAL CANCER

Inaugural Symposium Friday, Nov. 7th here in Cape Town to focus on Africa's elimination strategy

Region-focused symposium to be held at each IGCS Annual Global Meeting through 2030

Development of an online resource hub and navigational tool to centralize knowledge and guidance

IGCS Vision and Purpose Statement

VISION:

“All high burden regions will have a national cervical cancer elimination strategy that is being implemented - shaping locally adapted programme scale-up snd unlocking domestic and innovative funding mechanisms”

PURPOSE:

IGCS commits to 5-year focus on building a *Cervical Cancer Elimination Resource Hub and Navigational Tool* and leveraging these resources for regional and national deployment and impact in LMICs with a focus on high burden countries

Phase I: Announce the *IGCS ACCESS series*, set up hub and conduct regional deep dives

Phase II: Nuture and implement IGCS and other partner responses to gaps and needs; advocate for and feed into Global CCE Forum dialogues

Phase III: IGCS regional and 5-year summary reports to drive national action and shape CCEI targets and actions post-2030

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Dr. Diep Nguyen

Dr. Ai Ling Tan

Dr. Kate Simms

Building more than a resource hub

PHASE I: Resource hub and navigation tool

Nov 25 Hub set-up and collate CCE-plans

ACCESS annually supplement content

ACCESS regional targeted gap-filling

PHASE II: IGCS and partner responses

Showcase current IGCS offers and best practice technical assistance (Echo; workshops; fellowships)

Develop partnerships and expand IGCS offers – surgical training hubs

Multi-partner commitments and activities in all regions

PHASE III: Advocacy

Readiness for an Africa-hosted Global CCE Forum

Position at World Cancer Leader's Summit; Regional development banks

Inform consultation on post- 2030 targets

ACCESS: Africa

Accelerating **C**ervical **C**ancer
Elimination **S**trategies **S**ymposia

TOGETHER, WE CAN
ELIMINATE
CERVICAL
CANCER

CAPE TOWN
IGCS 2025
Annual Global Meeting

Cape Town, South Africa
Nov. 7-8

IGCS
INTERNATIONAL
GYNECOLOGIC
CANCER SOCIETY

Supported by the IGCS World of Hope Development Fund

IGCS WORLD OF HOPE

Pillar 1
HPV Vaccination & Public Awareness

Pillar 2
Screening & Treatment of Precancerous Lesions

Pillar 3
Treatment & Palliative Care of Invasive Cancers

ACCESS Series Pillar Leads

Dr. Suzanne Garland

Prof. Karen Canfell

Dr. Kathleen Schmeler

ACCESS: Africa Pillar Leads 2025

Dr. Nelly Mugo

Dr. Laura Muzingwani

Dr. Surbi Grover

Dr. Anisa Mburu

Dr. Deborah Watson-Jones

Dr. Rakiya Saidu

Dr. Eve Namisango

Make your commitment

Visit the IGCS Booth in the exhibit hall

- **Sign the pledge board to display your commitment**
- **Take a photo and post online with #IGCSAccessAfrica & #IGCS2025**

IGCS ACCESS Africa

Accelerating **C**ervical **C**ancer
Elimination **S**trategies **S**ymposia

Please join us
ACCESS Africa Reception

- **Urban Umami Restaurant Century City Hotel Urban Square**
- **Friday, November 7, 2025**
- **4:30 – 6:00 PM**
- **Immediately after the Closing Ceremony**

IGCS ACCESS Africa
Accelerating **C**ervical **C**ancer
Elimination **S**trategies **S**ymposia

Panel Discussion and Q&A, and Closing Comments

All Faculty

Thank You

View this symposium as part of the IGCS on-demand program following the meeting