Demographics and Survival Outcomes in Patients With Advanced or Recurrent Endometrial Cancer Following Platinum-Based Doublet in the English Real-World Setting

Poster No. 812P

Background

Endometrial cancer (EC) is the sixth most commonly diagnosed cancer among women globally, and the fourth most common in the United Kingdom (UK).1

Approximately 15%-20% of patients are diagnosed with advanced-stage disease, 10%-15% of women with any stage of disease at diagnosis will have a recurrence, and prognosis is poor for these patients.2,3

Surgery and/or radiotherapy are recommended as upfront treatments for patients with advanced-stage disease.4-6

• Treatment with a platinum-based doublet regimen is a standard-care treatment option for patients with advanced-stage EC (1L).4

• Platinum-based chemotherapy is typically the most common 2L treatment in real-world settings; however, chemotherapy regimens in this setting have a limited duration of response.7

• The use of immune-checkpoint inhibitors (ICIs) has recently shown promising anti-tumor response and duration in response in the 2L treatment of EC,8-10 suggesting ICIs may be beneficial for this patient population.

• There is limited real-world data on the current treatment landscape for advanced or recurrent EC in the eligible setting in many countries, including in England, as well as a lack of clear guidelines highlighting an unmet need in this patient population and for the clinicians who treat them.

Objective

The objectives of these analyses were to describe the treatment patterns, baseline demographics, disease characteristics, and clinical outcomes (overall survival [OS] and time to treatment failure [TTNT]) for patients with advanced or recurrent EC who progressed to 2L treatment (ICI-eligible 2L cohort) in a real-world setting in England.

Study Design

This was a non-interventional, retrospective, descriptive, cohort study.

Routine patient-level data available through Public Health England’s National Cancer Registration and Analysis Service (NCRAS) in England was used to identify patients with a primary diagnosis of EC between 1 January, 2013, and 31 December, 2018 (the “index period”), with an index date 0-180 days after diagnosis.

OS and TTNT is a proxy for progression-free survival due to a lack of data on progression in the NCRR and who received a platinum-based regimen after the index date 3 months after diagnosis of advanced or recurrent EC (Figure 1).

Data Analysis

Baseline demographics, disease characteristics, and treatments received were descriptively summarized, which included stratification by line of therapy.

OS and TTNT is a proxy for progression-free survival due to a lack of data on progression in the NCRR and who received a platinum-based regimen after the index date.

OS and TTNT are 2L were calculated from the initiation of 2L therapy to the earliest of all-cause death or censoring.

Results

Patient population

The patient populations are shown in Figure 3; there were 999 patients in the ICI-eligible 2L cohort.

Baseline demographics and disease characteristics

Table 2 summarizes treatments for the ICI-eligible 2L cohort.

Treatments

1L, in the ICI-eligible 2L cohort, 98.6% of patients received a platinum-doublet regimen as their 1L treatment, with the majority of patients (95.3%) receiving carboplatin + paclitaxel.2L The most prevalent type of drug-drug combination was platinum-based (68.2%), followed by anthracycline-based (26.0%), and taxanes (8.1%), and aromatase inhibitors (9.4%).

Systemic treatment regimens received by the ICI-eligible 2L cohort are described in Table 2.

Conclusions

While the majority of ICIs-eligible patients received 1L standard-of-care carboplatin + paclitaxel (42.4%), a range of drug classes and treatment regimens were received in the 2L setting.

OS and TTNT are 2L were poor for the ICI-eligible population.

This study highlights the need for both a defined standard of care and treatments that are more effective than current chemotherapy options in the 2L, treatment-naive advanced setting.

Durable and clinically meaningful responses have been observed with anti-PD-1 inhibitors (pembrolizumab and nivolumab) in the advanced or recurrent EC cohort in the Phase I IMpassion130NCT121 and Phase II KEYNOTE-1587 trials, respectively, suggesting that ICIs may improve survival outcomes in ICI-eligible 2L populations.

Disclosures

KH, PSK, and VS are employees of GSK. MSc is a former employee of GlaxoSmithKline (GSK). OK has no conflicts of interest to declare.

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References

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Clinical outcomes

Median OS for the ICI-eligible 2L cohort was 10.3 months (95% confidence interval [CI]: 9.2, 11.1) (Figure 4), with an OS estimate at 24 months of 21.0% (95% CI: 18.5, 24.4).

Median TTNT for the ICI-eligible 2L cohort was 7.7 months (95% CI: 7.1, 11.2) (Figure 4).

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Figure 1. Study design

Figure 2. Baseline patient demographics and disease characteristics in 1L

Figure 3. Baseline patient demographics and disease characteristics in 2L

Figure 4. Kaplan-Meier estimate of OS in 2L and TTNT for ICI-eligible 2L cohort

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