Ovarian cancer

www.sgo.or.kr

유지근
(대전성모병원)

DECLARATION OF INTERESTS

Nothing to declare

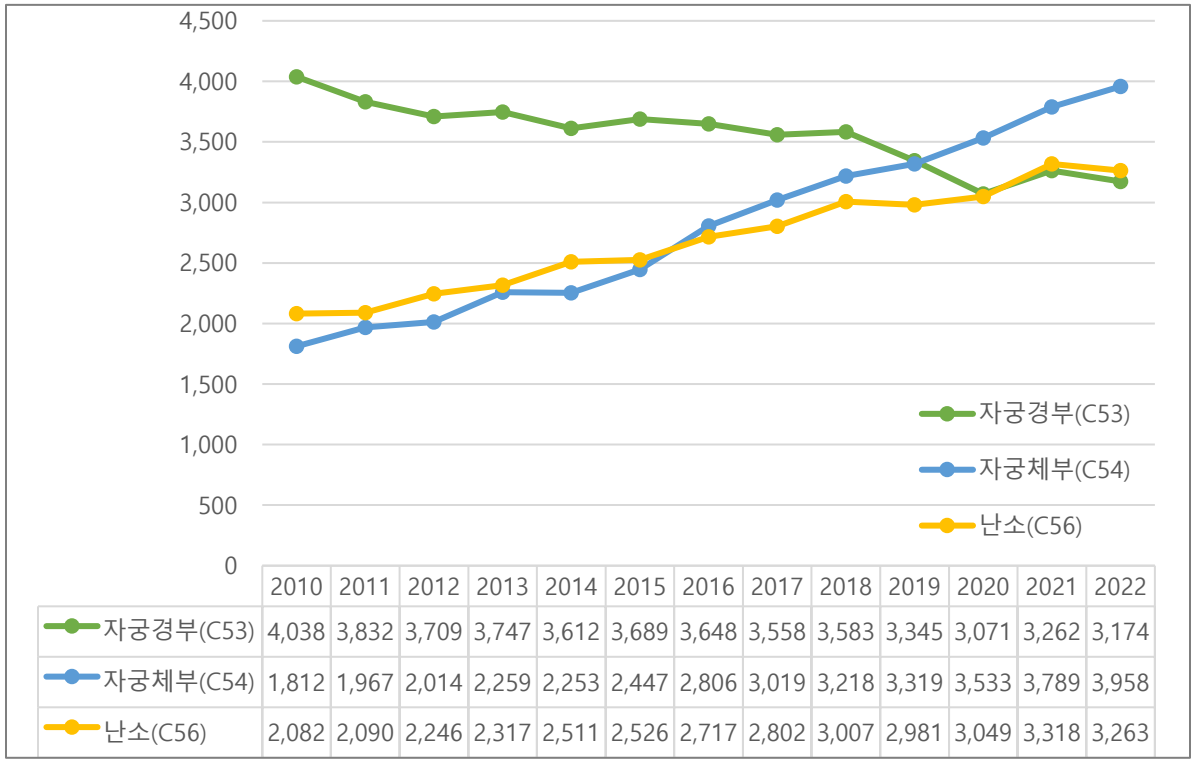
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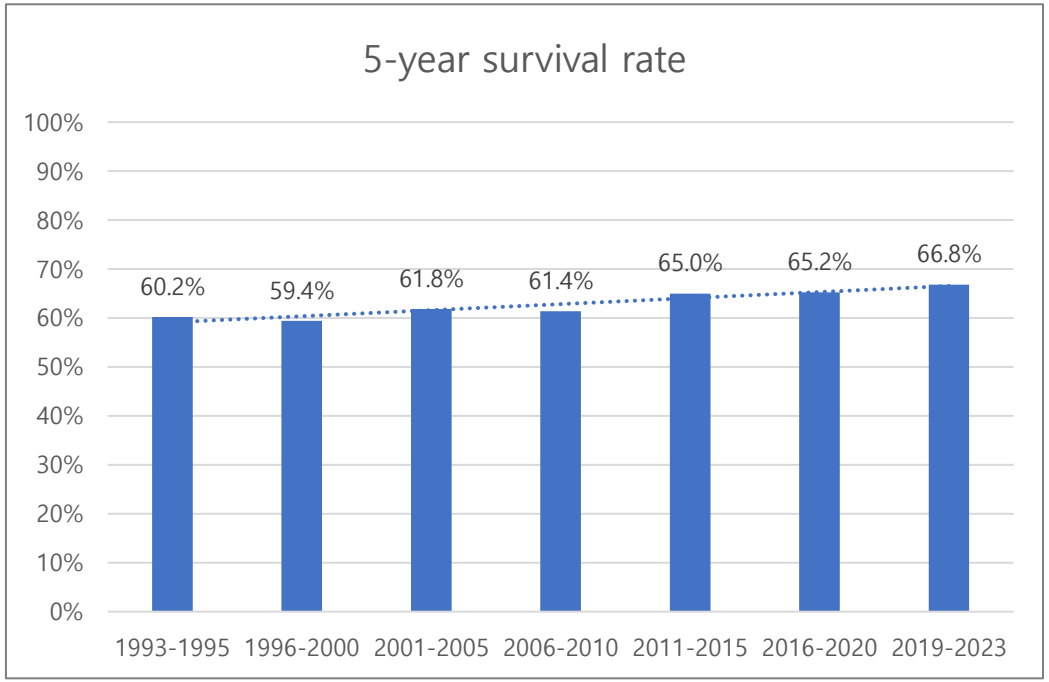
1. Epidemiology of ovarian cancer

Epidemiology of ovarian cancer

- South Korea
  - 3,299 new cases and 1,379 deaths in 2023
  - Incidence, APC 1.7; 5-year survival, APC 6.6

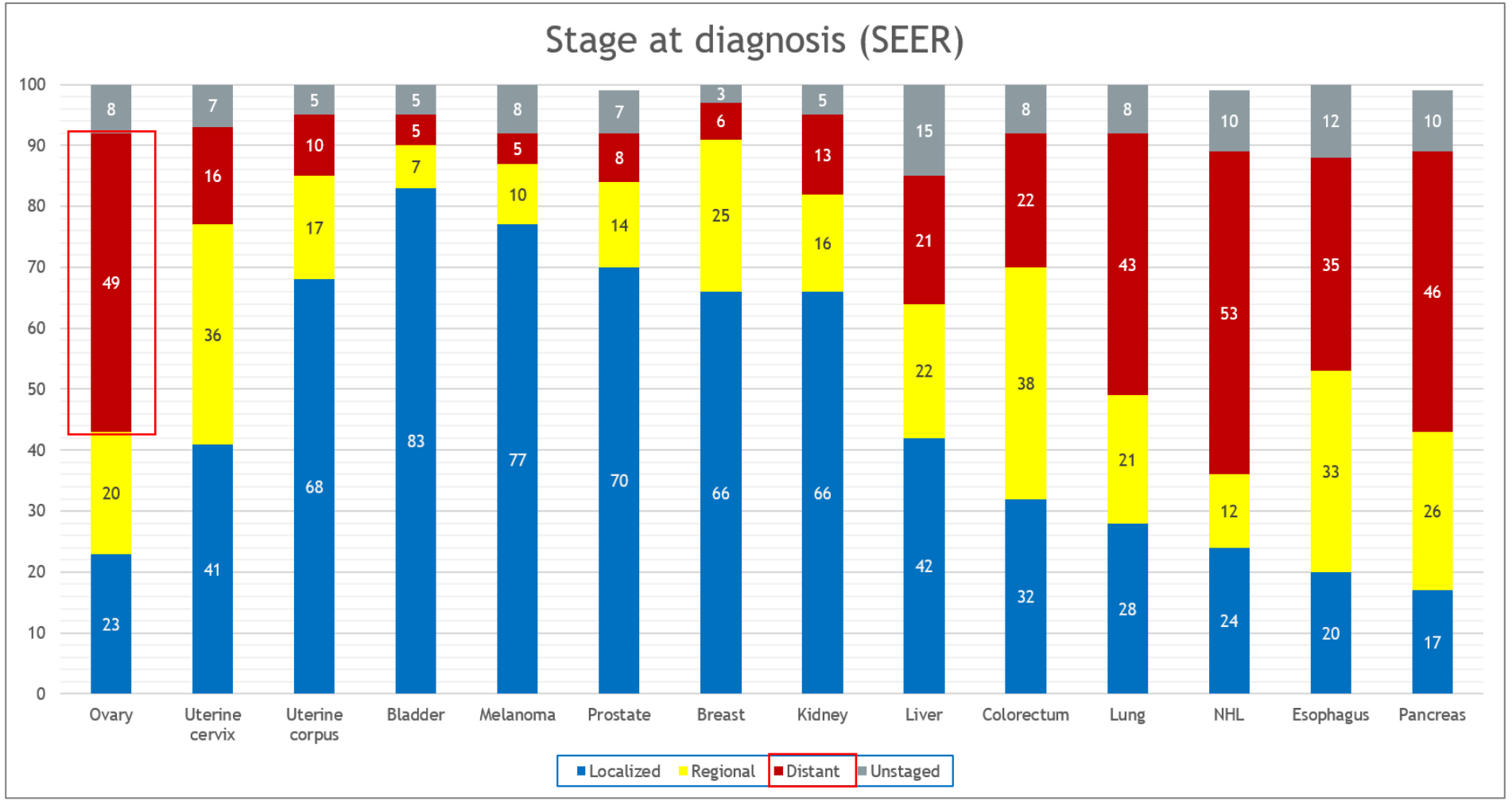


	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
자궁경부(C53)	4,038	3,832	3,709	3,747	3,612	3,689	3,648	3,558	3,583	3,345	3,071	3,262	3,174
자궁체부(C54)	1,812	1,967	2,014	2,259	2,253	2,447	2,806	3,019	3,218	3,319	3,533	3,789	3,958
난소(C56)	2,082	2,090	2,246	2,317	2,511	2,526	2,717	2,802	3,007	2,981	3,049	3,318	3,263



국립암센터. 국가암등록통계(2026.01)

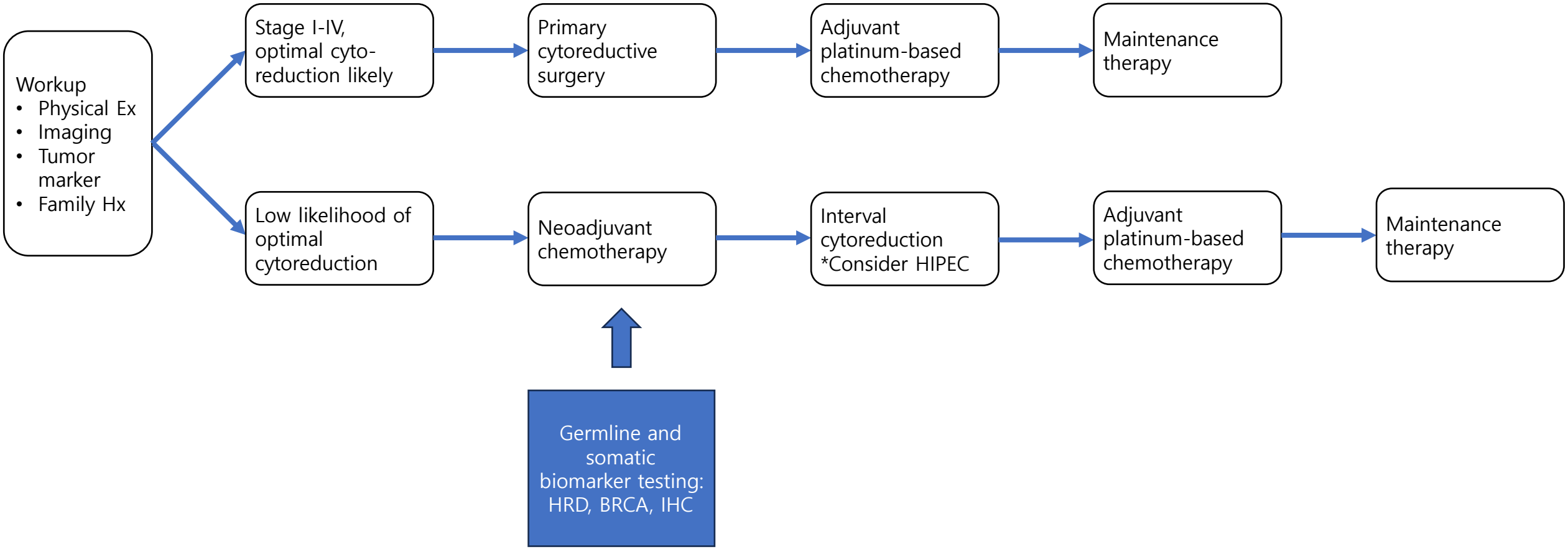
Epidemiology of ovarian cancer

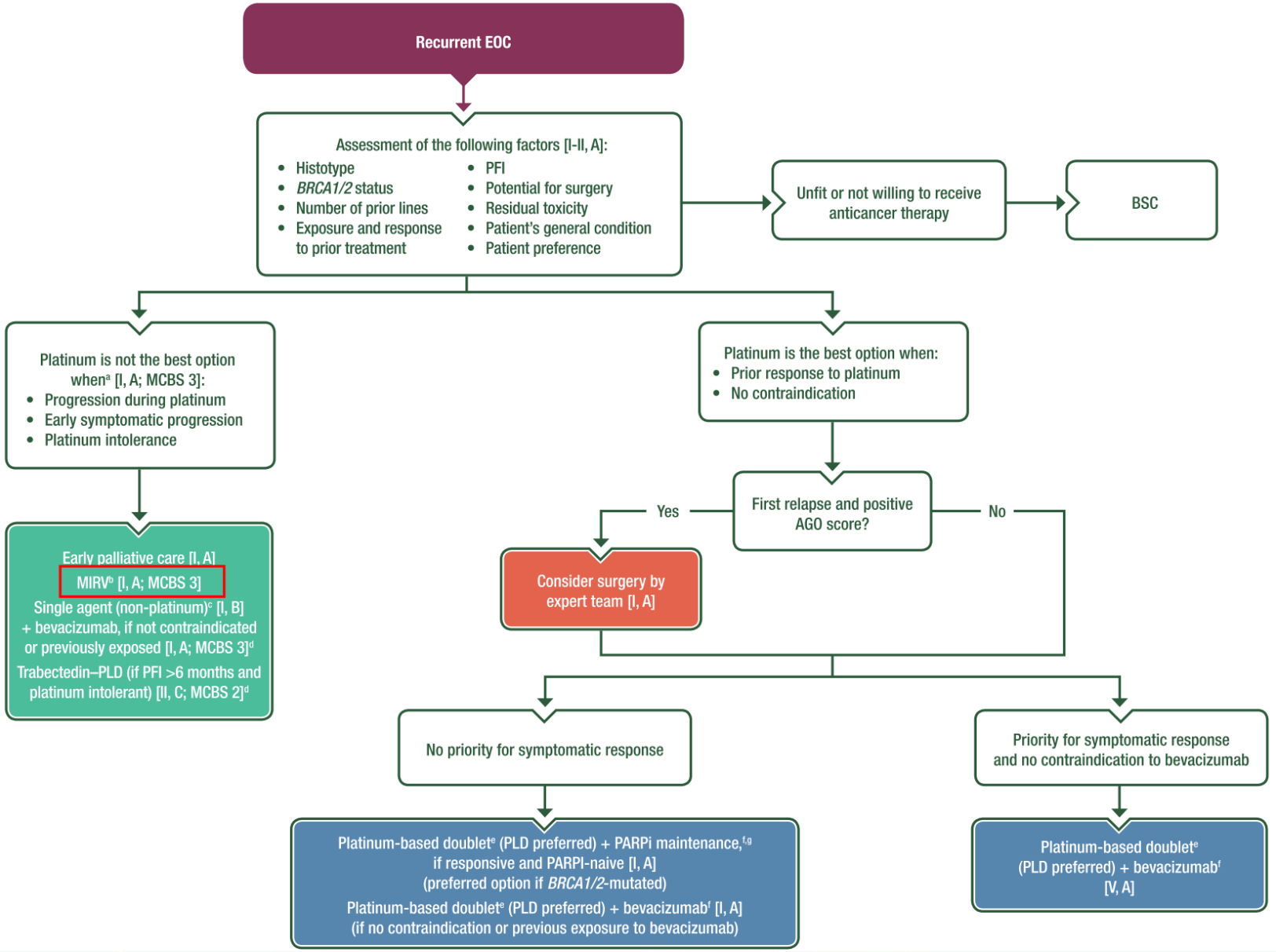


Siegel RL, et al. Cancer statistics, 2026. CA Cancer J Clin. 2026 Jan-Feb; 76(1): e70043.

2. Recent updates in ovarian cancer treatment guidelines

General principle: primary treatment




Recurrent EOC
Assessment of the following factors [I-II, A]:
Histotype
BRCA1/2 status
Number of prior lines
Exposure and response to prior treatment
PFI
Potential for surgery
Residual toxicity
Patient's general condition
Patient preference
Unfit or not willing to receive anticancer therapy
BSC
Platinum is not the best option when[a] [I, A; MCBS 3]:
Progression during platinum
Early symptomatic progression
Platinum intolerance
Early palliative care [I, A]
MIRV[b] [I, A; MCBS 3]
Single agent (non-platinum)[c] [I, B] + bevacizumab, if not contraindicated or previously exposed [I, A; MCBS 3][d]
Trabectedin–PLD (if PFI >6 months and platinum intolerant) [II, C; MCBS 2][d]
Platinum is the best option when:
Prior response to platinum
No contraindication
First relapse and positive AGO score?
Yes
No
Consider surgery by expert team [I, A]
No priority for symptomatic response
Priority for symptomatic response and no contraindication to bevacizumab
Platinum-based doublet[e] (PLD preferred) + PARPi maintenance,[f,g] if responsive and PARPI-naive [I, A] (preferred option if BRCA1/2-mutated)
Platinum-based doublet[e] (PLD preferred) + bevacizumab[f] [I, A] (if no contraindication or previous exposure to bevacizumab)
Platinum-based doublet[e] (PLD preferred) + bevacizumab[f] [V, A]

FIGO 2025 updates

SUPPLEMENT ARTICLE

INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS FIGO WILEY

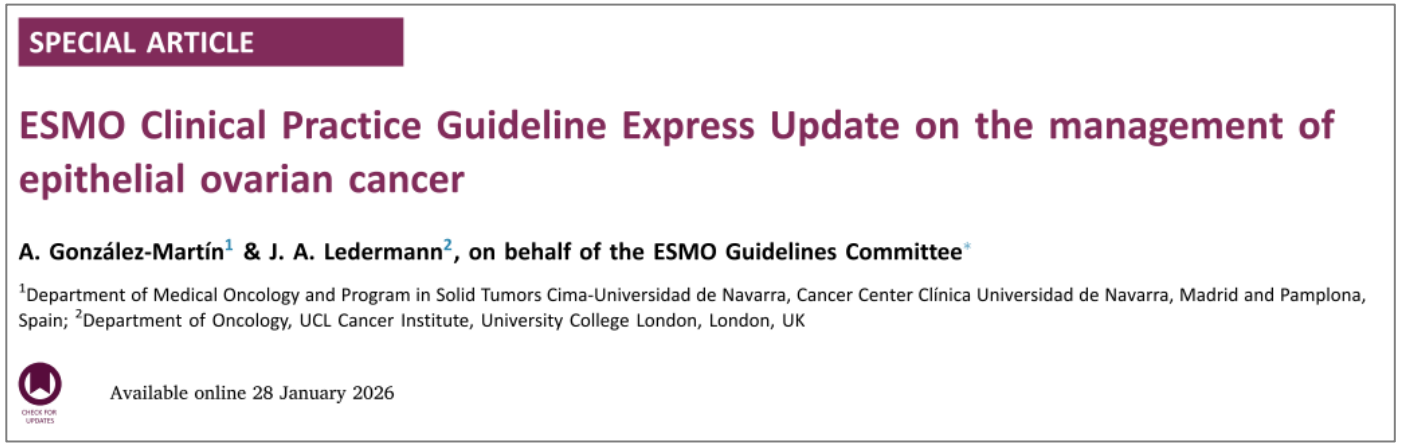
Cancer of the ovary, fallopian tube, and peritoneum: 2025 update

Malte Renz[1] | Michael Friedlander[2,3] | Jonathan S. Berek[4]

Compared with the 2021 guidelines:

- FIGO staging follows the 2014 FIGO staging system
- Extensive updates have been made across all aspects of diagnosis and treatment.

ESMO guidelines



SPECIAL ARTICLE

ESMO Clinical Practice Guideline Express Update on the management of epithelial ovarian cancer

A. González-Martín[1] & J. A. Ledermann[2], on behalf of the ESMO Guidelines Committee*

[1]Department of Medical Oncology and Program in Solid Tumors Cima-Universidad de Navarra, Cancer Center Clínica Universidad de Navarra, Madrid and Pamplona, Spain; [2]Department of Oncology, UCL Cancer Institute, University College London, London, UK

Available online 28 January 2026

Compared with the 2023 guidelines:

- Rucaparib for PARPi maintenance treatment (ATHENA-MONO)
- Mirvetuximab soravtansine (MIRV) for platinum-resistant ovarian cancer

NCCN guidelines

- ROSELLA, KN-B96 regimen added
- Pembrolizumab and berahyaluronidase alfa-pmph SC (KEYTRUDA QLEX) added
- Less common ovarian cancers (LCOC)
  - Clear-cell carcinoma: Ipilimumab (anti-CTLA4) + Nivolumab (anti-PD-1) (BrUOG 354)
  - Algorithm added for small cell carcinoma of the ovary (hypercalcemic type) (SCCOHT)
  - Borderline epithelial tumors: *According to WHO, invasive implants are synonymous with low-grade serous carcinoma and require adjuvant therapy. Noninvasive implants appear to confer at least a 15% to 20% increased risk of subsequent low grade serous carcinoma. While these patients do not require adjuvant therapy, they do require extended clinical follow-up as recurrences may occur 5 years or more after diagnosis.*

ROSELLA (2025)
: Chemo + GR

AURELIA (2014)
: Chemo + Bev

MIRASOL (2024)
: ADC mono

KN-B96 (2025)
: Chemo + IO

BRUOG-354 (2025)
: IO combination

PRINCIPLES OF SYSTEMIC THERAPY

Acceptable Recurrence Therapies for Epithelial Ovarian (including LCOC)[p]/Fallopian Tube/Primary Peritoneal Cancer

Recurrence Therapy for Platinum-Resistant Disease (alphabetical order)

Preferred

Cytotoxic Therapy
- Albumin-bound Paclitaxel/ Relacorilant[x,y,44]
- Docetaxel[45]
- Gemcitabine[46,47]
- Liposomal Doxorubicin[46,47]
- Liposomal Doxorubicin + Bevacizumab[r,48]
- Paclitaxel (Weekly)[h,49]
- Paclitaxel (Weekly) + Bevacizumab[h,r,48]
- Oral Cyclophosphamide + Bevacizumab[r,50]
- Topotecan[51,52]
- Topotecan + Bevacizumab[r,48]

Targeted Therapy (single agents)
- Mirvetuximab soravtansine-gynx (for FRα-expressing tumors [≥75% positive tumor cells])(category 1)[v,53,54]

Other Recommended

Cytotoxic Therapy[t]
- Albumin-bound Paclitaxel
- Capecitabine
- Carboplatin[z]
- Carboplatin/Docetaxel[z]
- Carboplatin/Paclitaxel (Weekly)[h,z]
- Carboplatin/Gemcitabine[15] ± Bevacizumab[r,s,z,16]
- Carboplatin/Liposomal Doxorubicin[17] ± Bevacizumab[r,z,18]
- Carboplatin/Paclitaxel[h,19] ± Bevacizumab[r,s,z,20]
- Cisplatin/Gemcitabine[z,21]
- Cyclophosphamide
- Doxorubicin
- Gemcitabine + Bevacizumab[r,55]
- Ifosfamide/Mesna
- Irinotecan
- Ixabepilone + Bevacizumab (category 2B)[r,aa,56]
- Oral Cyclophosphamide + Pembrolizumab + Bevacizumab[r,57,58]
- Oral Etoposide[59]
- Oxaliplatin
- Paclitaxel
- Pemetrexed
- Sorafenib/Topotecan[60]
- Vinorelbine

Targeted Therapy (single agents)
- Bevacizumab[r,25,26]
- Pazopanib (category 2B)[28]

Hormone Therapy
- Aromatase inhibitors (Anastrozole, Exemestane, Letrozole)
- Goserelin acetate
- Leuprolide acetate
- Megestrol acetate
- Tamoxifen[k]

Useful in Certain Circumstances

- Albumin-bound Paclitaxel/Carboplatin (for confirmed taxane hypersensitivity)[z]
- Carboplatin/Paclitaxel (for age >70)[h,u,z]

Immunotherapy[v]
- Dostarlimab-gxly (for dMMR/MSI-H recurrent or advanced tumors)[42]
- Paclitaxel + Pembrolizumab ± Bevacizumab (for PD-L1-positive tumors [CPS≥1])[h,r,s,bb,61]
- Pembrolizumab (for patients with MSI-H or dMMR solid tumors, or TMB-H tumors ≥10 mutations/megabase)[43]
- For clear-cell carcinoma
  - Ipilimumab + Nivolumab[62,63]

Hormone Therapy
- Fulvestrant (for low-grade serous carcinoma)

Targeted Therapy[v]
- Dabrafenib/Trametinib (for *BRAF* V600E positive tumors)[30]
- Entrectinib[31] or Larotrectinib[32] or Repotrectinib[33] (for *NTRK1/2/3* gene fusion-positive tumors)
- Fam-trastuzumab deruxtecan-nxki (for HER2-positive tumors [IHC 3+ or 2+])[34]
- Mirvetuximab soravtansine-gynx + Bevacizumab (for FRα-expressing tumors [≥25% positive tumor cells])[r,36,64,65]
- Selpercatinib (for *RET* gene fusion-positive tumors)[37]
- For low-grade serous carcinoma:
  - Avutometinib/Defactinib (for *KRAS*-mutated tumors)[38]
  - Trametinib[39]
  - Binimetinib (category 2B)[40,41]
- For mucinous carcinoma:
  - FOLFIRI ± Bevacizumab[r] (category 2B)[66-69]

Phase 3 clinical trials in PROC

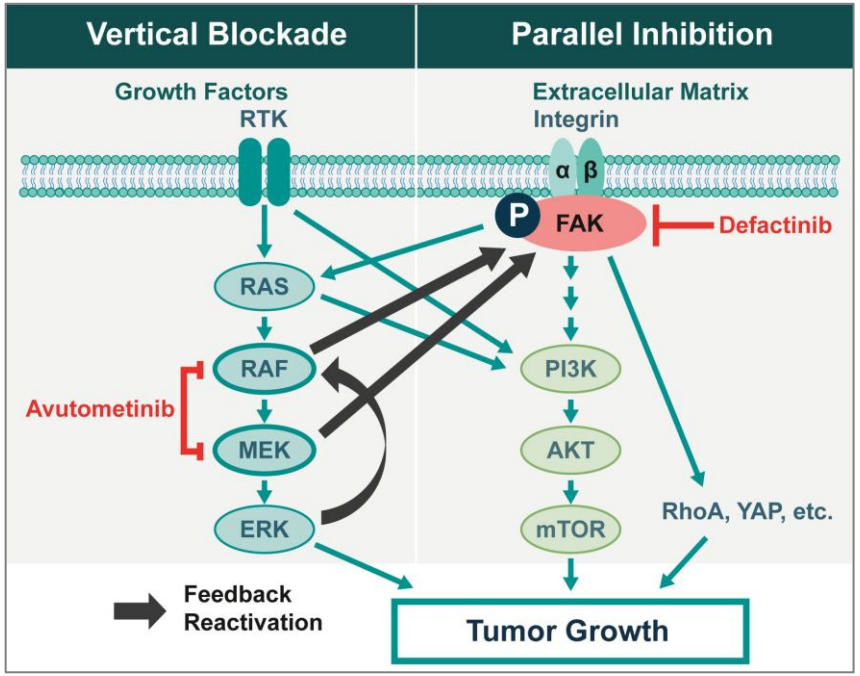
Trial	Biomarker	Experimental vs Control	Median PFS	Median OS	국내 사용 승인
MIRASOL (2024)	FRα-high	**Mirvetuximab soravtansine** vs chemotherapy	**5.6 vs 4.0 mo** (+1.6 mo) HR 0.63 (0.51-0.79), p<0.0001	**16.9 vs 13.3 mo** (+3.6 mo) HR 0.68 (0.54-0.84), p=0.0004	승인
ROSELLA (2025)	None	**Relacorilant + nab-paclitaxel** vs nab-paclitaxel	**6.5 vs 5.5 mo** (+1.0 mo) HR 0.70 (0.54-0.91), p=0.0076	**16.0 vs 11.9 mo** (+4.1 mo) HR 0.65 (0.51-0.83), p=0.0004	Relacorilant 국내 도입 안됨
KEYNOTE-B96 (2025)	PD-L1 CPS ≥1	**Pembro + paclitaxel ± bev** vs paclitaxel ± bev	**8.3 vs 7.2 mo** (+1.1 mo) HR 0.72 (0.58-0.89), p=0.0014	**18.2 vs 14.0 mo** (+4.2 mo) HR 0.76 (0.61-0.94), p=0.0053	승인

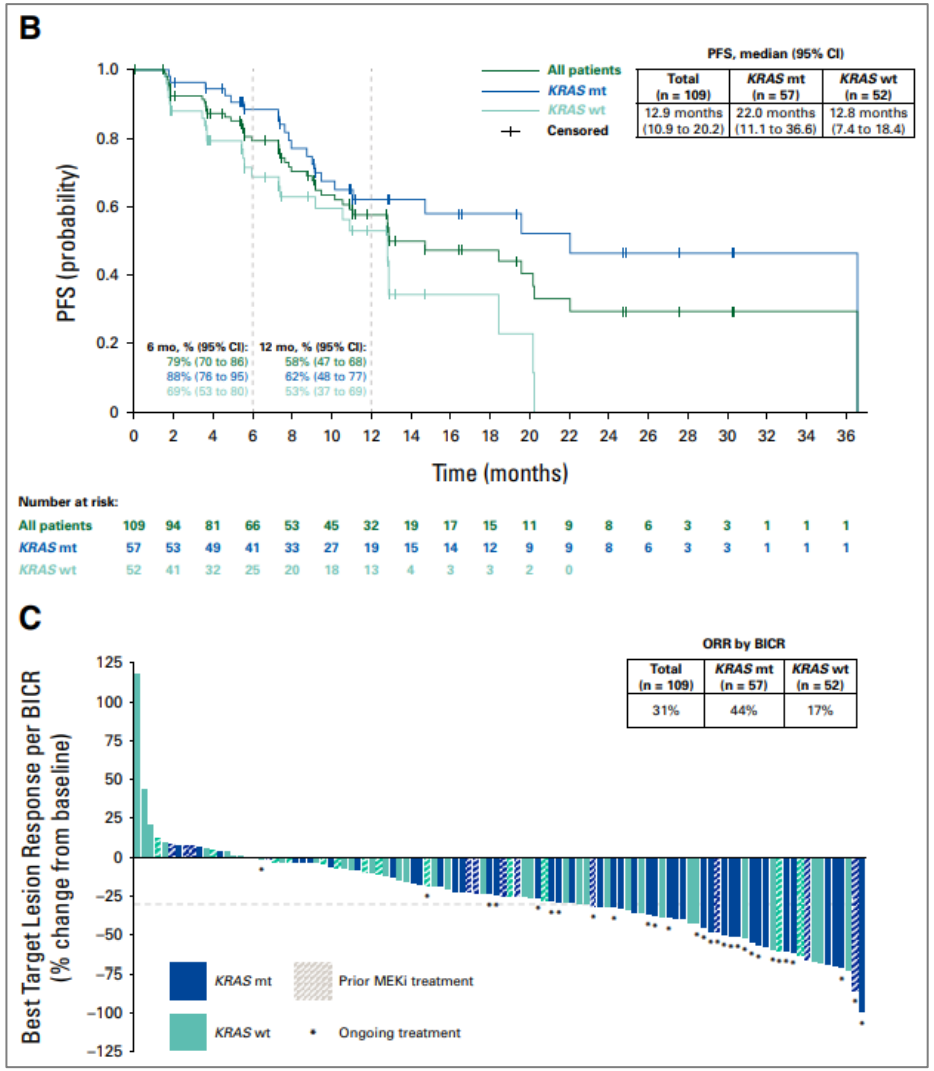
Recent advances in ovarian cancer treatment: Targeted therapy

Efficacy and Safety of Avutometinib ± Defactinib in Recurrent Low-Grade Serous Ovarian Cancer: Primary Analysis of ENGOT-OV60/GOG-3052/RAMP 201

Susana N. Banerjee, PhD, MBBS, MA, FRCP[1]; Els Van Nieuwenhuysen, MD[2]; Carol Aghajanian, MD[3,4]; Véronique D'Hondt, MD, PhD[5]; Bradley J. Monk, MD, FACS, FACOG[6]; Andrew Clamp, PhD, MSc, BMBCh, MRCP[7]; Emily Prendergast, MD[8]; Ana Oaknin, MD, PhD[9]; Kari Ring, MD[10]; Nicoletta Colombo, MD, PhD[11,12]; Robert W. Holloway, MD[13]; Manuel Rodrigues, MD[14,15]; Hye Sook Chon, MD[16]; Charlie Gourley, PhD, FRCP[17]; Alessandro D. Santin, MD[18]; Premal H. Thaker, MD[19]; Christine Gennigens, MD, PhD[20]; Gregg Newman, MD[21]; Erin Salinas, MD[22]; Hagop Youssoufian, MD[23]; Kathleen N. Moore, MD, MS, FASCO[24]; Stephanie Lustgarten, PhD[23]; David M. O'Malley, MD[25]; Toon Van Gorp, MD, PhD[2]; and Rachel N. Grisham, MD[3,4]

DOI https://doi.org/10.1200/JCO-25-00112





Banerjee SN et al. J Clin Oncol 43, 2782-2792(2025).

Recent advances in ovarian cancer treatment: Targeted therapy

Phase II Trial of Ribociclib Plus Letrozole in Women With Recurrent Low-Grade Serous Carcinoma of the Ovary, Fallopian Tube, or Peritoneum: A GOG Partners Trial (GOG 3026)

Brian M. Slomovitz, MD[1]; S. John Weroha, MD[2]; Wei Deng, MD[3]; Hye Sook Chon, MD[4]; Vivek Podder, MD[1]; Mary Tilley Jenkins Vogel, MD[5]; Floor Backes, MD[6]; Eric D. Thomas, MD[7]; Lee-May Chen, MD[8]; Meaghan Elizabeth Tenney, MD[9]; Shannon N. Westin, MD[10]; Merry Jennifer Markham, MD[11]; David S. Miller, MD[12]; Mitchell I. Edelson, MD[13]; Carolyn Y. Muller, MD[14]; Michael J. Callahan, MD[15]; Laura L. Holman, MD[16]; J. Rebecca Liu, MD[17]; Eleonora Teplinsky, MD[18]; Aparna Kamat, MD[19]; Michael Guy, MD[20]; Jing-Yi Chern, MD[4]; Jayanthi Lea, MD[12]; Martina Murphy, MD[11]; Grace M. Choong, MD[2]; Elena D. Moore, MD[5]; Edwin A. Alvarez, MD[8]; William H. Rodgers, MD, PhD[21]; David M. O'Malley, MD[22]; Larry J. Copeland, MD[6]; Thomas J. Herzog, MD[23]; Robert L. Coleman, MD[24]; and David M. Gershenson, MD[10]

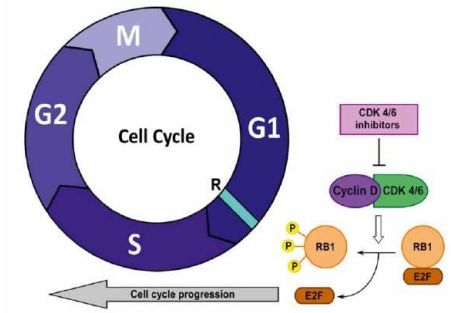


TABLE 2. Study Clinical Outcomes

Clinical End Point	Ribociclib + Letrozole (n = 49), No. (%)
Response (per RECIST 1.1)	
CR	1 (2.0)
PR	14 (28.6)
SD	26 (53.1)
PD	4 (8.2)
Nonevaluable[a]	4 (8.2)
CBR	
Yes (CR + PR + SD)	41 (83.7)
No (PD or nonevaluable)	8 (16.3)
Response within 1 from initiation of protocol therapy (per RECIST 1.1)	
PR	10 (20.4)
SD	31 (63.3)
PD	4 (8.2)
Nonevaluable[a]	4 (8.2)

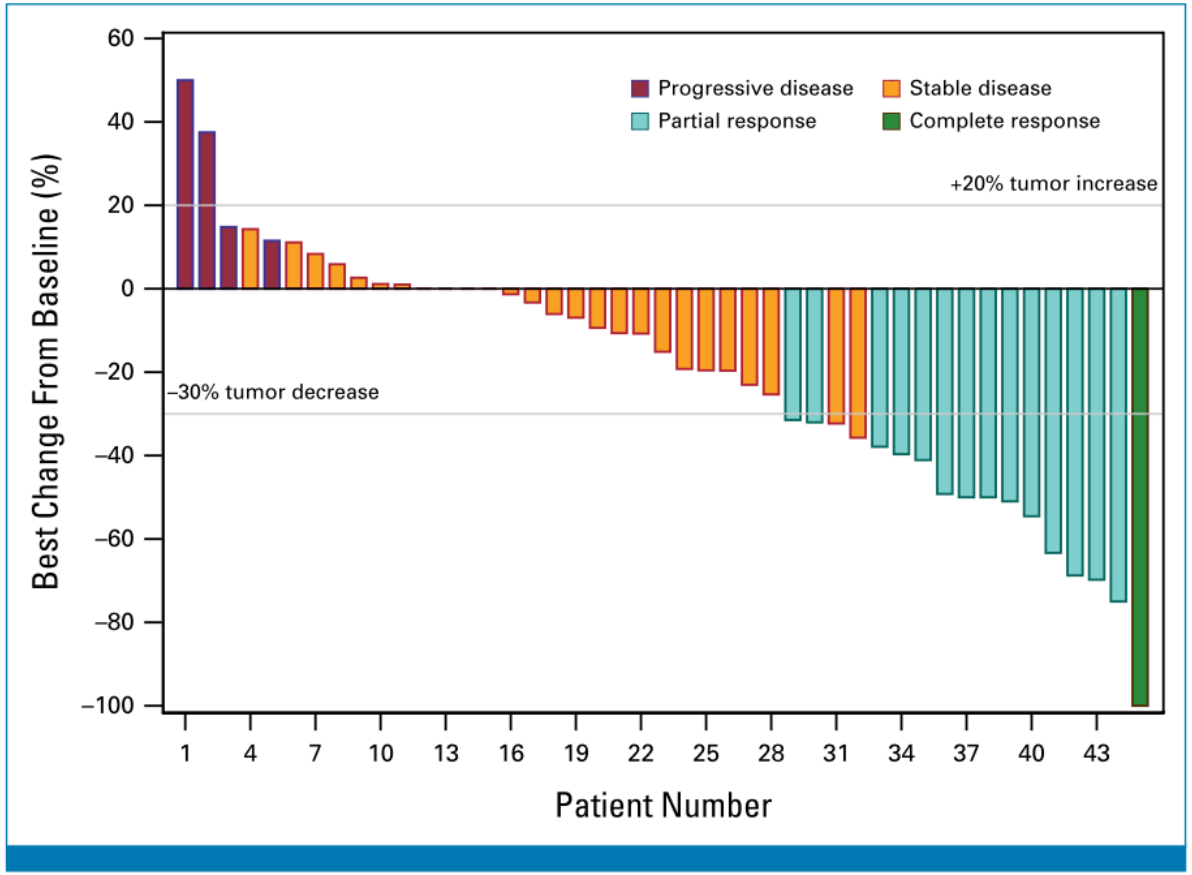
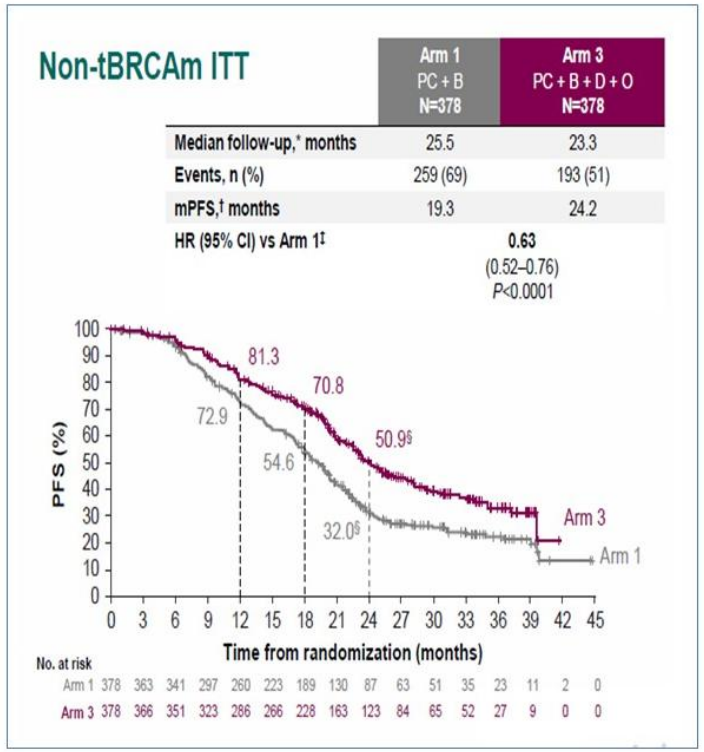


FIG 1. Best percentage change from baseline in the sum of target tumor size (n = 45). The waterfall plot illustrates the variability in tumor response, highlighting complete, partial, and stable responses and progressive disease thresholds based on RECIST 1.1 criteria.

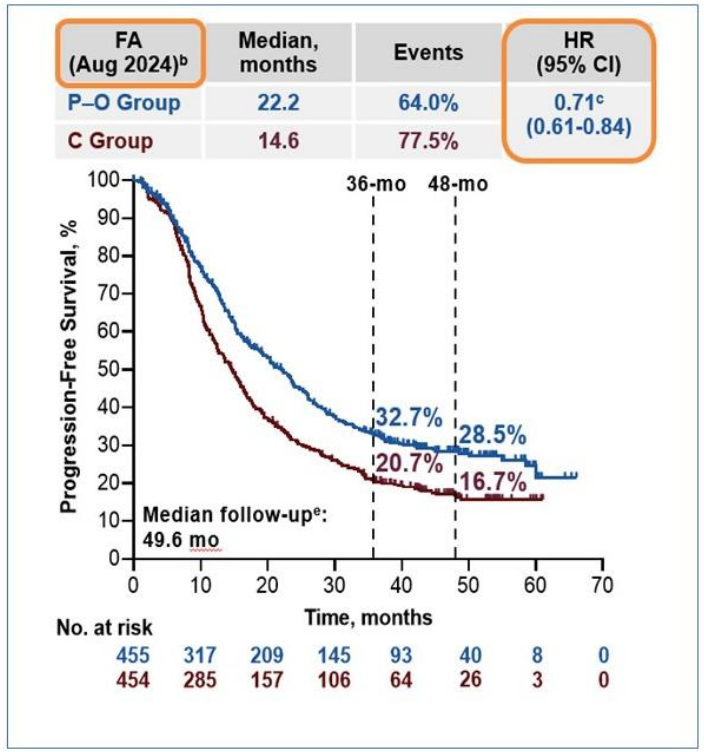
J Clin Oncol. 2026 Jan 20;44(3):153-163.

Recent advances in ovarian cancer treatment: Immunotherapy

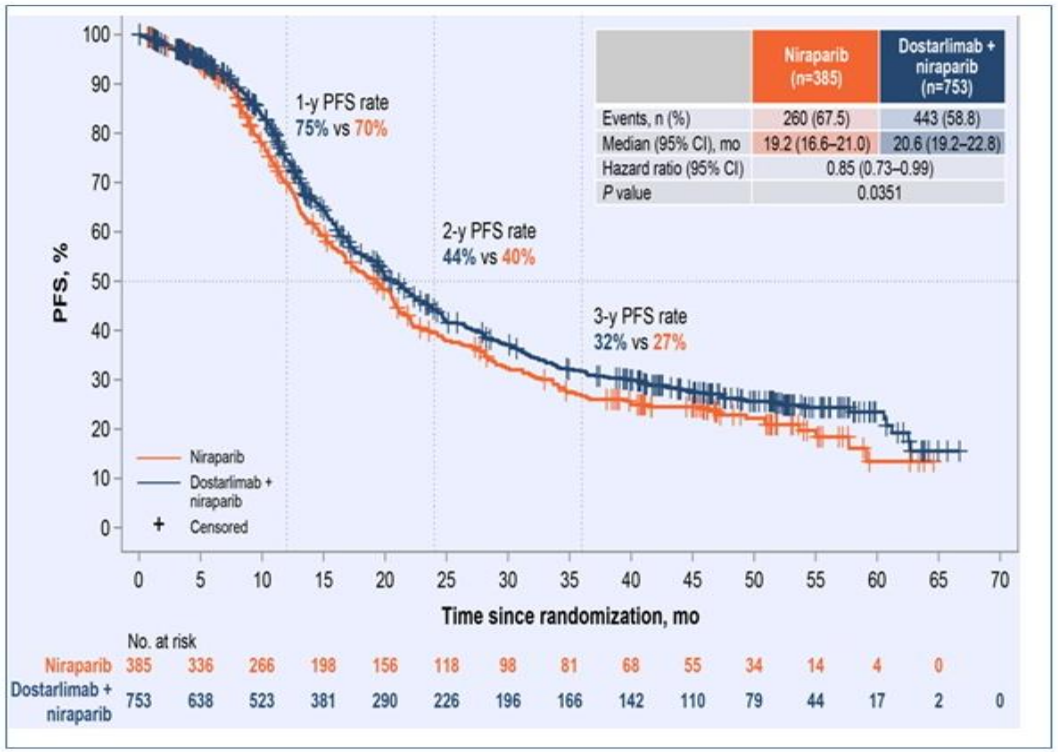
DUO-O: Control arm is bevacizumab maintenance



KEYLINK: Control is +/- bevacizumab maintenance



FIRST: Control is niraparib +/- bevacizumab maintenance



Richardson DL. ASCO 2025

Recent advances in ovarian cancer treatment: Immunotherapy

JAMA Oncology | Original Investigation

Nivolumab and Ipilimumab Combination Treatment in Advanced Ovarian and Endometrial Clear Cell Cancers
A Nonrandomized Clinical Trial

Bo Gao, PhD; Matteo S. Carlino, PhD; Michael Michael, MD; Craig Underhill, MD; Henry Marshall, MD; Ashray Gunjur, MD; Jane So, MD; Damien Kee, MD; Yoland Antill, MD; Wei-Sen Lam, MD; Howard Chan, MD; Rosemary Harrup, MD; Anne Hamilton, MD; John Grady, PhD; Mandy Ballinger, PhD; Elnaz Tavancheh, PhD; Won-Hee Yoon, MD; Jodie Palmer, PhD; David Thomas, PhD; Kylie Wilkie, PhD; Jonathan Cebon, PhD; Oliver Klein, MD

Figure 3. Tumor Genomic Analysis

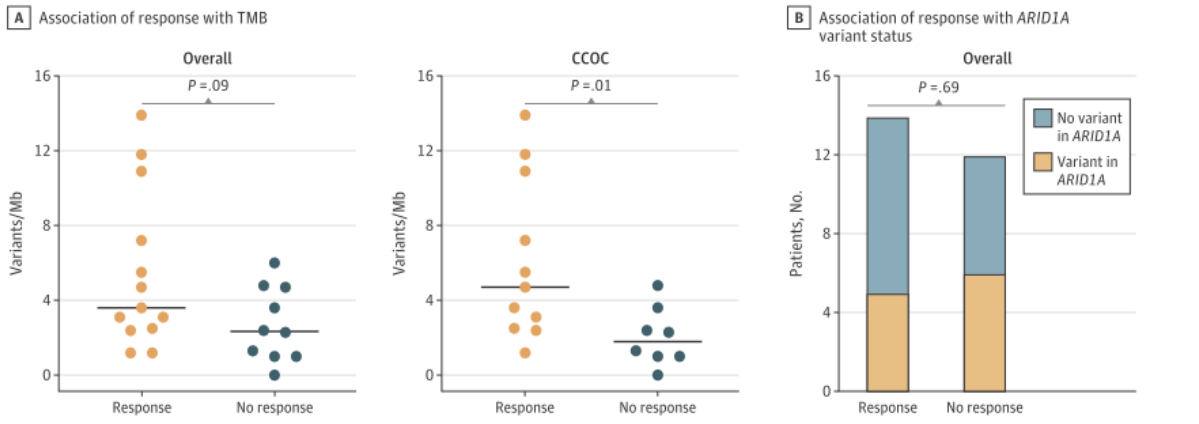
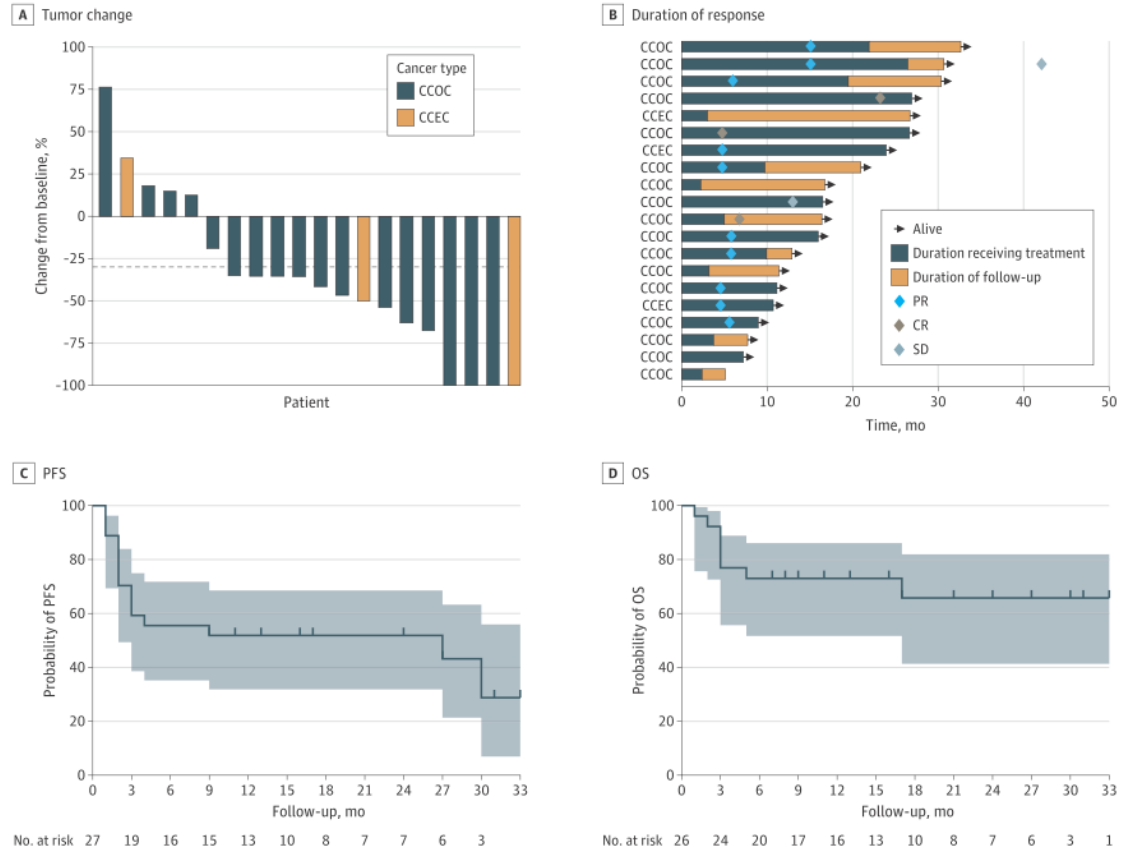


Figure 2. Efficacy Outcomes



A, Waterfall plot of best percentage tumor change to baseline depicting all patients who have undergone at least 1 radiological reassessment (n = 20). The dashed line indicates objective response per Response Evaluation Criteria In Solid Tumour (RECIST) version 1.1 criteria. B, Swimmer plot demonstrating corresponding duration of response (n = 20). C, Kaplan-Meier graphical representation of progression-free survival (PFS) (n = 26). D, Kaplan-Meier graphical representation of overall survival (OS) (n = 27). The shaded area indicates 95% CIs. CCEC indicates clear cell endometrial cancer; CCOC, clear cell ovarian cancer; CR, complete response; PR, partial response; SD, stable disease.

JAMA Oncol. 2025 Sep 1;11(9):982-989.

Recent advances in ovarian cancer treatment: Immunotherapy

Pembrolizumab plus lenvatinib in recurrent gynaecological clear cell carcinoma (LARA): a multicentre, single-arm, phase 2 trial

	Stage 1 (n=15)	Stage 2 (n=25)
Outcomes per RECIST (version 1.1)		
Confirmed partial response	4 (27%)	11 (44%)
Unconfirmed partial response	0	1* (4%)
Stable disease	7 (47%)	9 (36%)
Progressive disease	4 (27%)	4 (16%)
Objective response rate (95% CI)	27% (8–55)	44% (24–65)
Outcomes per immune RECIST (version 1.1)		
Confirmed immune partial response	5 (33%)	12 (48%)
Unconfirmed immune partial response	0	1* (4%)
Immune stable disease	6 (40%)	8 (32%)
Immune progressive disease	4 (27%)	4 (16%)
Objective response rate (95% CI)	33% (12–62)	48% (28–69)
Best response at 24 weeks†		
Objective response rate (95% CI)‡	27% (8–55)	40% (21–61)
Partial response	4 (27%)	10 (40%)
Unconfirmed partial response	0	1* (4%)
Stable disease	7 (47%)	10 (40%)
Progressive disease	4 (27%)	4 (16%)
Clinical benefit rate (95% CI)§	73% (45–92)	84% (64–96)

Data are n (%) unless specified. Stages 1 and 2 reflect Simon's two-stage minimax design, which was used to calculate the sample size. Outcomes per RECIST (version 1.1) occurring before and after 24 weeks are described post-hoc. RECIST=Response Evaluation Criteria in Solid Tumours. *One patient had a 30% reduction in target lesion size at the first tumour assessment, but showed progressive disease at the next tumour assessment. †Best response at 24 weeks was the same when assessed by RECIST or immune RECIST. ‡Objective response rate at 24 weeks was defined as partial or complete response occurring within the first 24 weeks of treatment. §Clinical benefit rate at 24 weeks was defined as partial response, complete response, or stable disease occurring within the first 24 weeks of treatment.

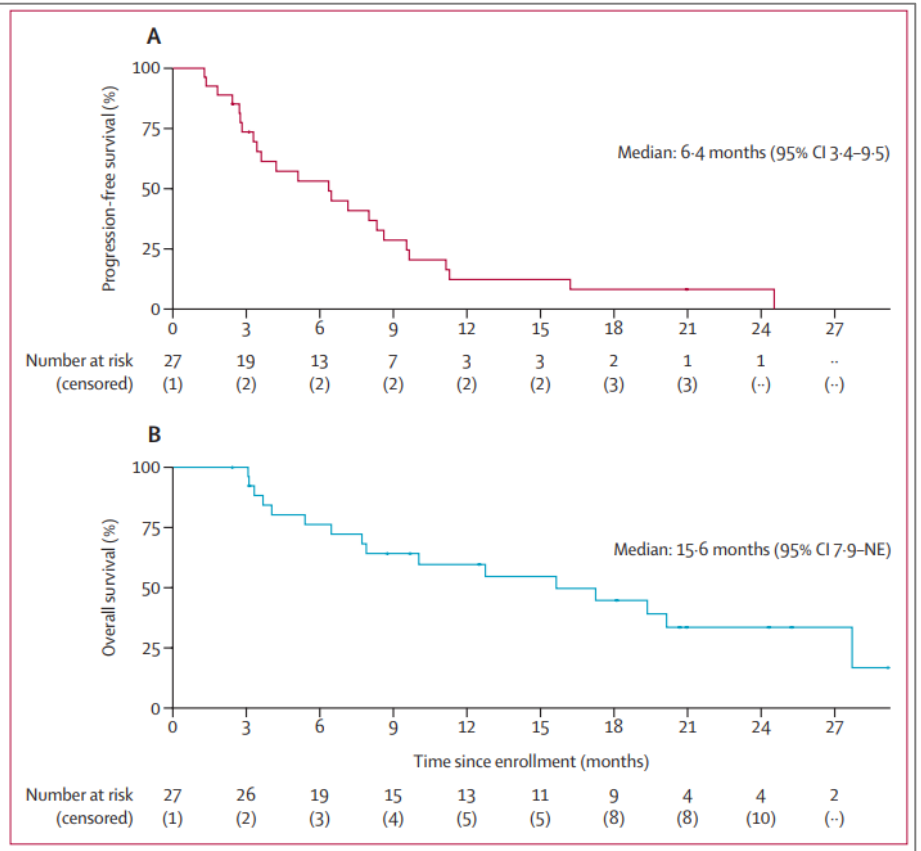


Figure 3: **Progression-free survival and overall survival**
Kaplan–Meier survival curves of progression-free survival (A) and overall survival (B) among all patients who received at least one dose of study treatment.

Ngoi NYL et al. Lancet Oncol. 2026 Feb;27(2):201-211.

Recent advances in ovarian cancer treatment: Immunotherapy

DOVE | APGOT-OV7 | ENGOT-ov80

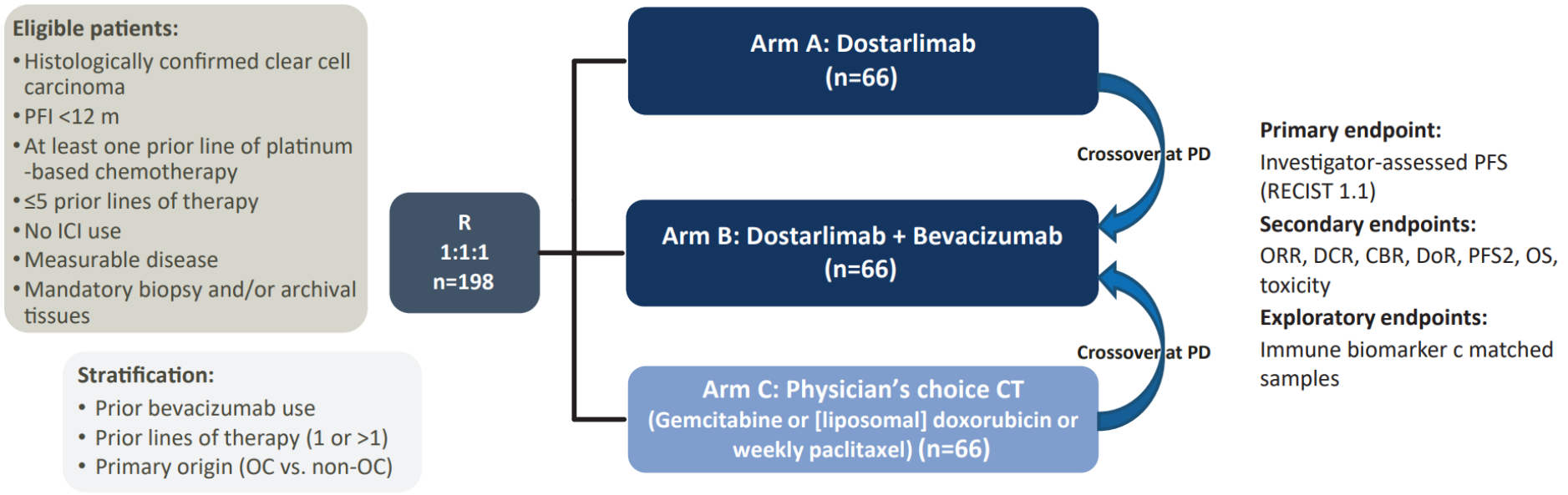


Fig. 1. Trial design.
CBR, clinical benefit rate; DCR, disease control rate; DoR, duration of response; ICI, immune checkpoint inhibitor; OC, ovarian cancer; ORR, objective response rate; OS, overall survival; PFI, platinum-free interval; PFS, progression-free survival.

Lee JY et al. J Gynecol Oncol. 2024 Dec 16;36(1):e51

Recent advances in ovarian cancer treatment: Immunotherapy

ORIGINAL ARTICLE

Subcutaneous versus intravenous pembrolizumab, in combination with chemotherapy, for treatment of metastatic non-small-cell lung cancer: the phase III 3475A-D77 trial

E. Felip[1*], C. I. Rojas[2], M. Schenker[3], D. M. Kowalski[4], I. A. Casarini[5], T. Csöszi[6], M. A. N. Şendur[7], J. Martins[8], A. Calles Blanco[9], C.-C. Wang[10], M. Wang[11], R. A. L. Ramirez Fallas[12], H. Yoshioka[13], S. Nair[14], X. Song[15], X. Deng[16], M. Lala[16], R. Eiras[16] & T. Takahashi[17]

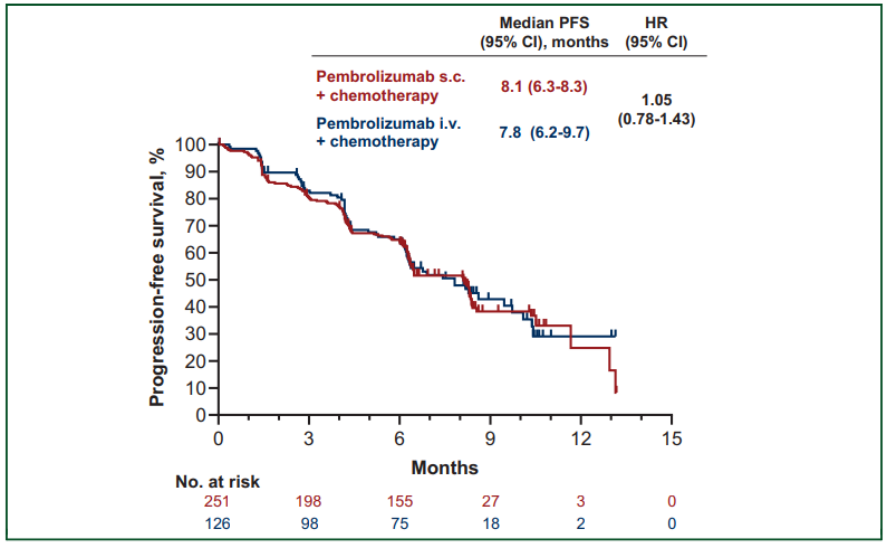


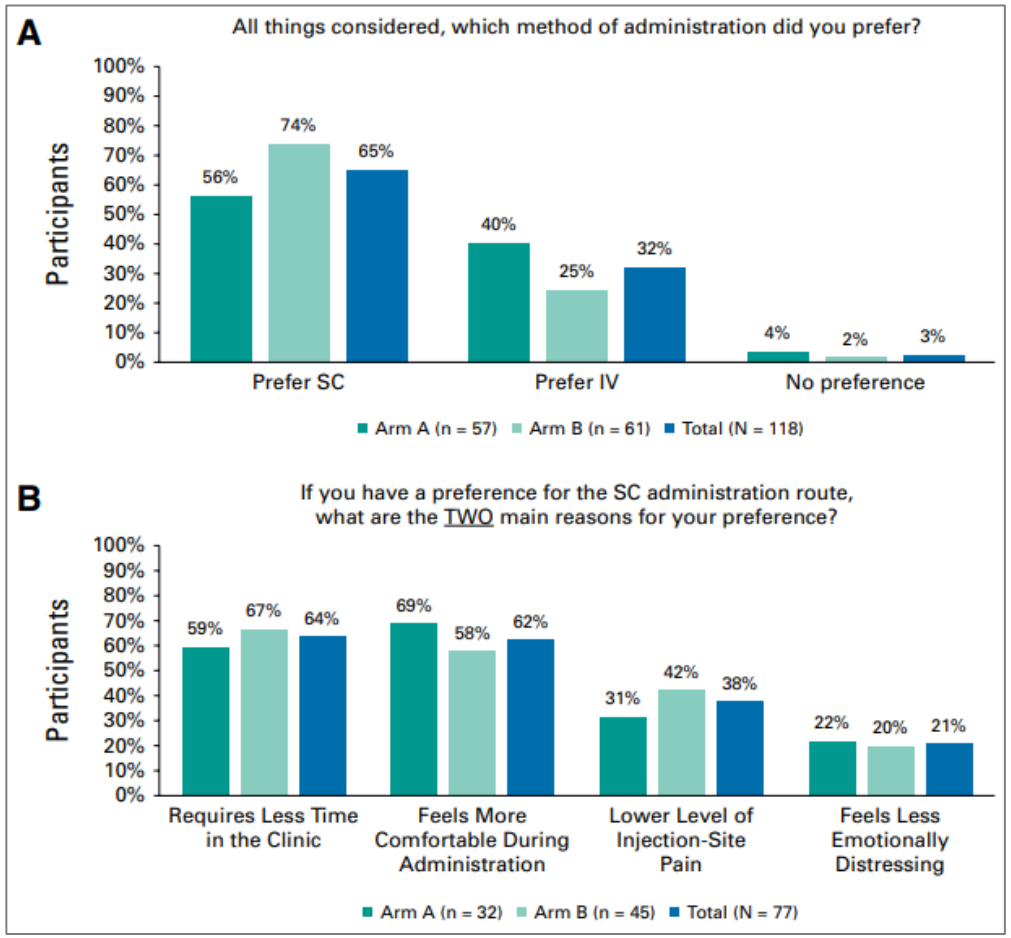
Figure 3. **Kaplan–Meier estimates of PFS in the overall study population.** PFS was based on blinded independent central review as per RECIST v1.1. CI, confidence interval; HR, hazard ratio; i.v., intravenous; PFS, progression-free survival; s.c., subcutaneous.

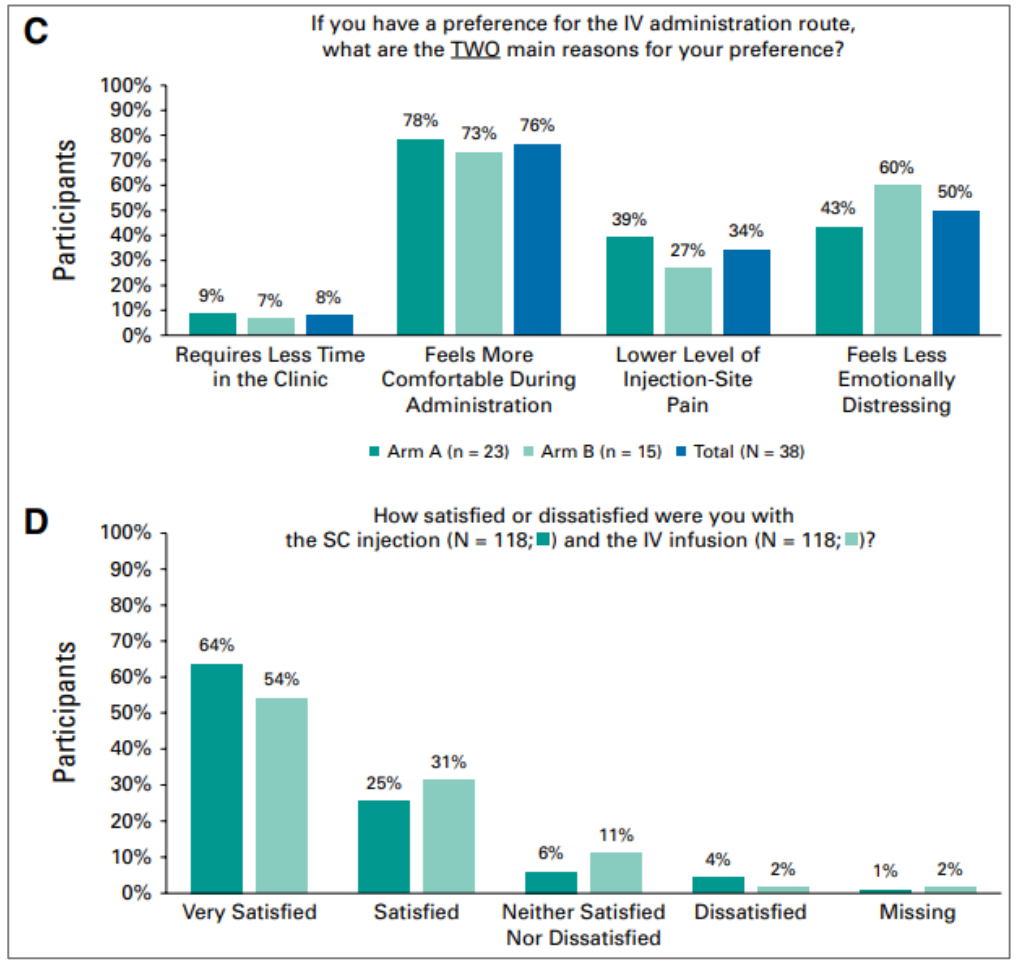
Table 3. Summary of treatment-related adverse events

Participants[a], *n* (%)	Pembrolizumab s.c. + chemotherapy (*N* = 251)	Pembrolizumab i.v. + chemotherapy (*N* = 126)
With one or more adverse events	249 (99.2)	123 (97.6)
With treatment-related[b] adverse events	226 (90.0)	121 (96.0)
With grade 3-5 treatment-related[b] adverse events	118 (47.0)	60 (47.6)
With serious treatment-related[b] adverse events	53 (21.1)	25 (19.8)
Who discontinued any treatment due to a treatment-related[b] adverse event	44 (17.5)	19 (15.1)
Who discontinued pembrolizumab s.c. or i.v.	21 (8.4)	11 (8.7)
Who discontinued chemotherapy	38 (15.1)	15 (11.9)
Who died due to a treatment-related[b] adverse event	9 (3.6)[c]	3 (2.4)[d]

Ann Oncol. 2025 Jul;36(7):775-785.

Recent advances in ovarian cancer treatment: Immunotherapy





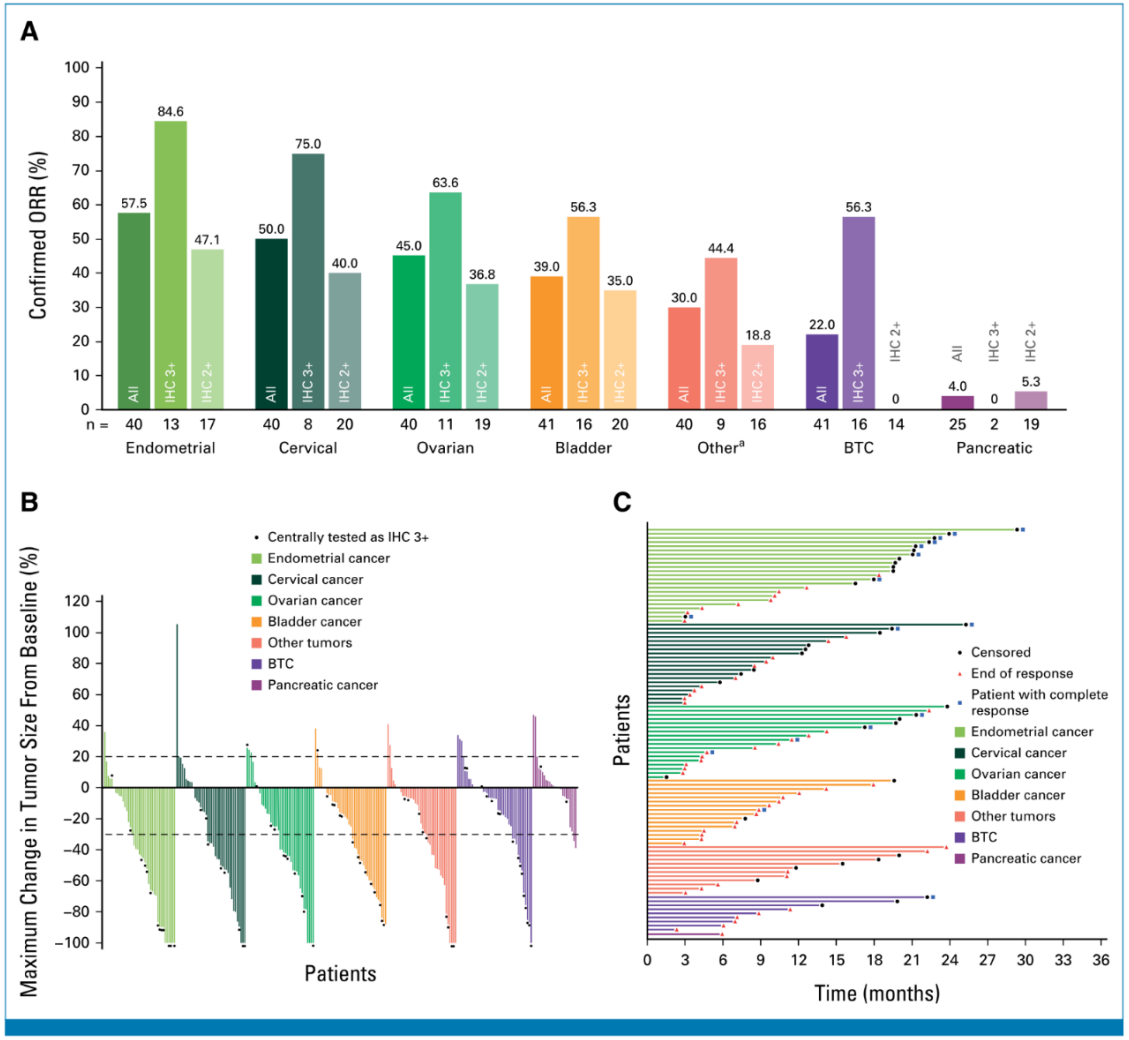
JCO Oncol Pract. 2026 Jun 3:OP2501248.

Recent advances in ovarian cancer treatment: ADCs

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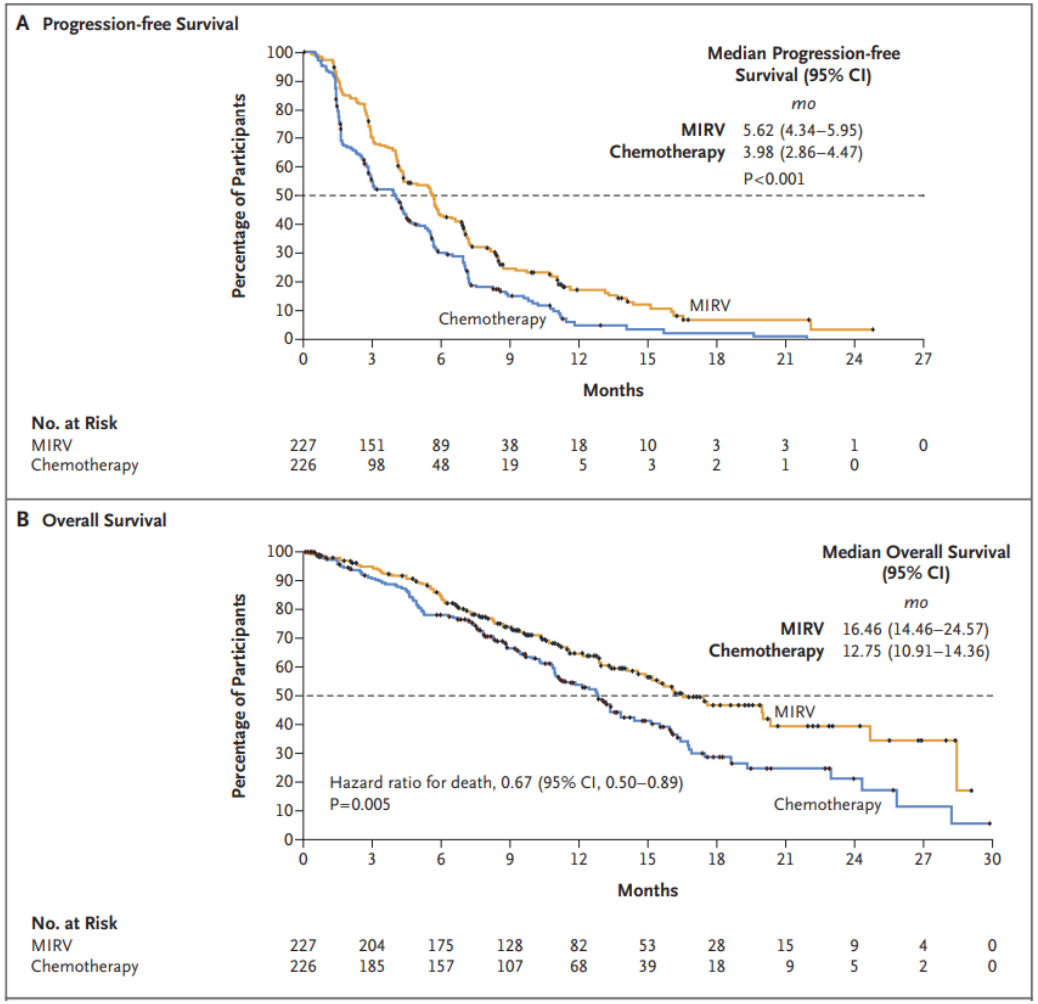
Recent advances in ovarian cancer treatment: ADCs

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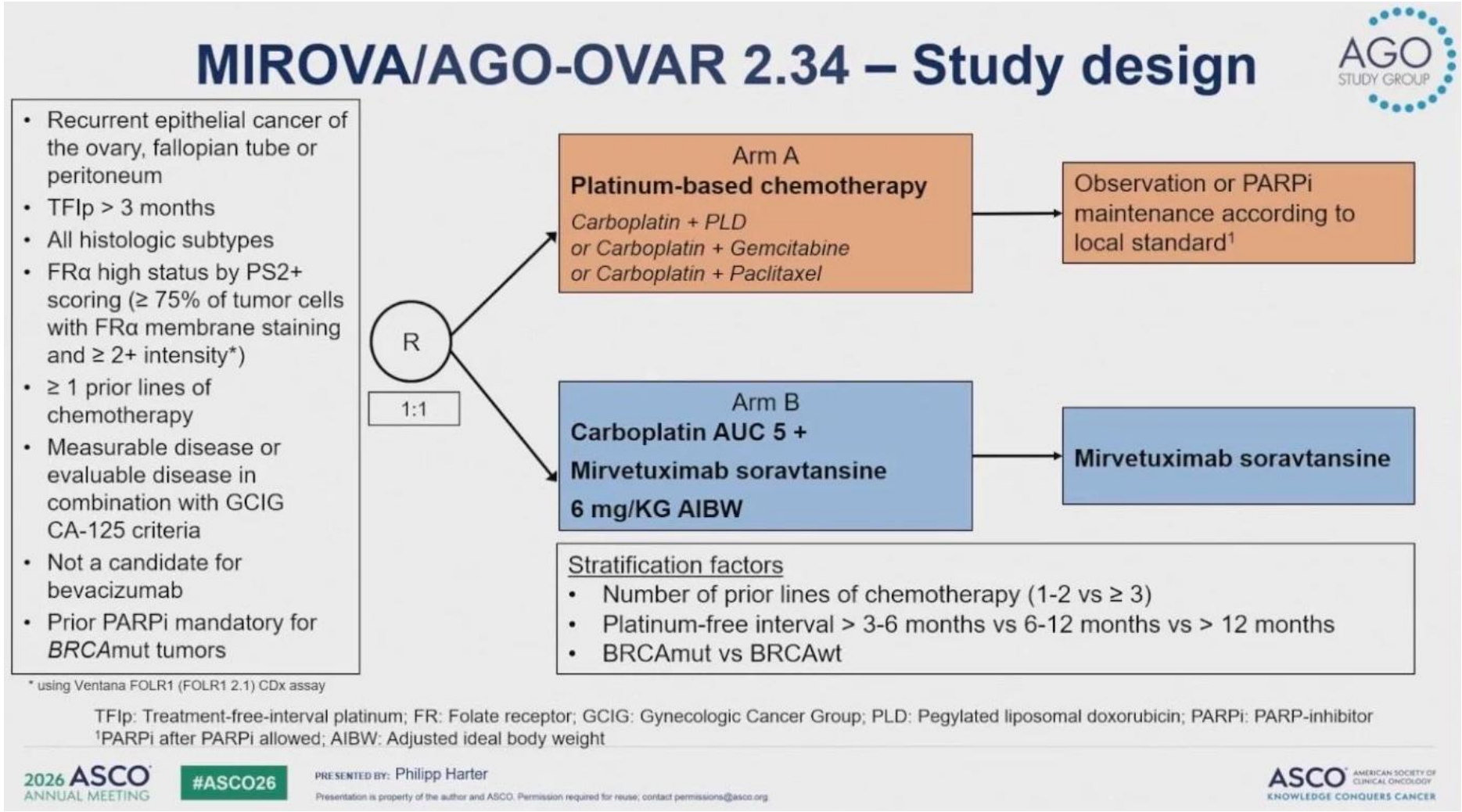
Mirvetuximab Soravtansine in FRα-Positive, Platinum-Resistant Ovarian Cancer

K.N. Moore, A. Angelergues, G.E. Konecny, Y. García, S. Banerjee, D. Lorusso, J.-Y. Lee, J.W. Moroney, N. Colombo, A. Roszak, J. Tromp, T. Myers, J.-W. Lee, M. Beiner, C.M. Cosgrove, D. Cibula, L.P. Martin, R. Sabatier, J. Buscema, P. Estévez-García, L. Coffman, S. Nicum, L.R. Duska, S. Pignata, F. Gálvez, Y. Wang, M. Method, A. Berkenblit, D. Bello Roufai, and T. Van Gorp, for Gynecologic Oncology Group Partners and the European Network of Gynaecological Oncological Trial Groups*

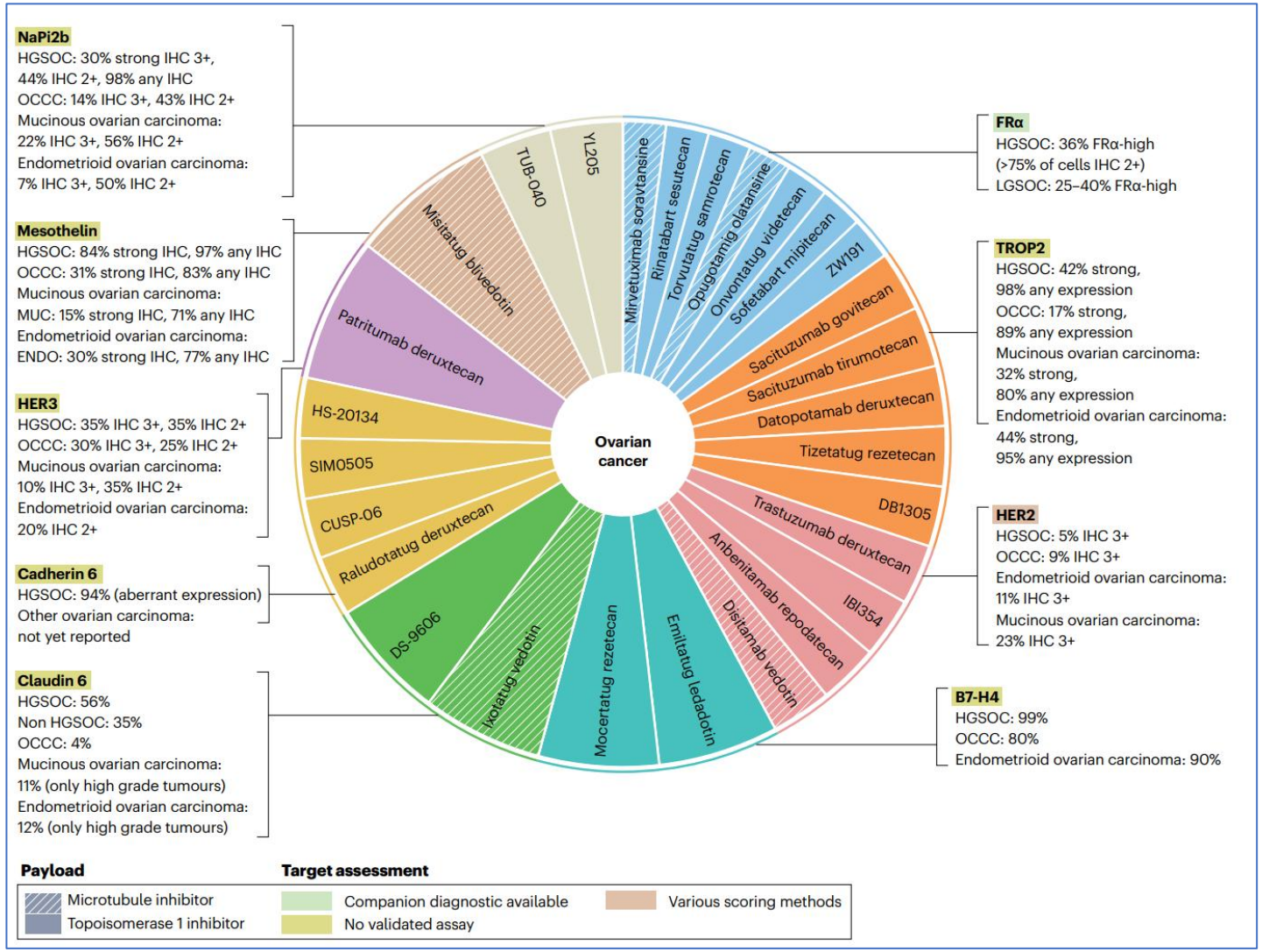


N Engl J Med 2023;389:2162-2174

Recent advances in ovarian cancer treatment: ADCs



Recent advances in ovarian cancer treatment: ADCs



Kathleen N Moore. Nat Rev Clin Oncol. 2026 Sep;23(9):672-693.

Recent advances in ovarian cancer treatment: ADCs

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Histology-specific ADC target landscapes in ovarian cancer and therapy-associated antigen downshift after ADC exposure

Yong Jae Lee [a], Junsik Park [b], Yoo-Na Kim [b], Soyeon Kim [a], Mi Jang [c], Sunghoon Kim [a], Eun Kyung Kim [d,**], Jung-Yun Lee [a,*]

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[b] Department of Obstetrics and Gynecology, Soonchunhyang University Bucheon Hospital, Soonchunhyang University College of Medicine, Bucheon, South Korea
[c] Department of Pathology, Yongin Severance Hospital, Yonsei University College of Medicine, Yongin-si, Republic of Korea
[d] Department of Pathology, National Health Insurance Service Ilsan Hospital, Goyang-si, Republic of Korea

Table 2
Expression profiles antibody-drug conjugate targets in high grade serous carcinoma ($n = 120$)[a].

	Diagnosis ($n = 59$)	IDS ($n = 33$)	Relapse ($n = 73$)
HER2			
0	40 (67.8%)	23 (69.7%)	54 (74.0%)
1+	7 (11.9%)	7 (21.2%)	14 (19.1%)
2+	10 (16.9%)	3 (9.1%)	4 (5.5%)
3+	2 (3.4%)	0 (0%)	1 (1.4%)
TROP2			
0	0 (0%)	0 (0%)	3 (4.1%)
1+	0 (0%)	0 (0%)	2 (2.7%)
2+	25 (42.4%)	13 (39.4%)	15 (20.5%)
3+	34 (57.6%)	20 (60.6%)	53 (72.7%)
CLDN6			
0	11 (18.6%)	8 (24.2%)	27 (36.9%)
1+	10 (16.9%)	8 (24.2%)	6 (8.2%)
2+	29 (49.2%)	15 (45.5%)	25 (34.4%)
3+	9 (15.3%)	2 (6.1%)	15 (20.5%)
FOLR1[b]			
Low	8 (13.6%)	7 (21.2%)	20 (27.4%)
High	51 (86.4%)	26 (78.8%)	53 (72.6%)
B7H4			
0	6 (10.2%)	7 (21.2%)	12 (16.4%)
1+	17 (28.7%)	5 (15.2%)	13 (17.8%)
2+	28 (47.5%)	15 (45.5%)	39 (53.4%)
3+	8 (13.6%)	6 (18.2%)	9 (12.3%)
B7H3			
0	24 (40.7%)	18 (54.5%)	27 (36.9%)
1+	18 (30.5%)	10 (30.3%)	21 (28.8%)
2+	16 (27.1%)	5 (15.2%)	21 (28.8%)
3+	1 (1.7%)	0 (0%)	4 (5.5%)
CDH6			
0	32 (39.5%)	10 (27.8%)	16 (21.9%)
1+	26 (32.1%)	13 (36.1%)	22 (30.1%)
2+	23 (28.4%)	13 (36.1%)	30 (41.2%)
3+	0 (0%)	0 (0%)	5 (6.8%)

Table 3
Expression profiles antibody-drug conjugate targets in non-high grade serous carcinoma ($n = 38$)[a].

	Endometrioid ($n = 11$)	Clear cell ($n = 20$)	Mucinous ($n = 10$)	Others[b] ($n = 10$)
HER2				
0	6 (54.5%)	7 (35.0%)	1 (10.0%)	9 (90.0%)
1+	2 (18.2%)	8 (40.0%)	2 (20.0%)	1 (10.0%)
2+	3 (27.3%)	5 (25.0%)	1 (10.0%)	0 (0%)
3+	0 (0%)	0 (0%)	6 (60.0%)	0 (0%)
TROP2				
0	0 (0%)	0 (0%)	4 (40.0%)	1 (10.0%)
1+	0 (0%)	0 (0%)	0 (0%)	0 (0%)
2+	0 (0%)	8 (40.0%)	2 (20.0%)	5 (50.0%)
3+	11 (100%)	12 (60.0%)	4 (40.0%)	4 (40.0%)
CLDN6				
0	9 (82.0%)	15 (75.0%)	7 (70.0%)	6 (60.0%)
1+	0 (0%)	1 (5.0%)	1 (10.0%)	1 (10.0%)
2+	1 (9.0%)	3 (15.0%)	0 (0.0%)	2 (20.0%)
3+	1 (9.0%)	1 (5.0%)	2 (20.0%)	1 (10.0%)
FOLR1[c]				
Low	6 (54.5%)	16 (80.0%)	10 (100%)	4 (40.0%)
High	5 (45.5%)	4 (20.0%)	0 (0%)	6 (60.0%)
B7H4				
0	1 (9.0%)	4 (20.0%)	7 (70.0%)	4 (40.0%)
1+	5 (45.5%)	4 (20.0%)	3 (30.0%)	2 (20.0%)
2+	5 (45.5%)	9 (45.0%)	0 (0%)	4 (40.0%)
3+	0 (0%)	3 (15.0%)	0 (0%)	0 (0%)
B7H3				
0	0 (0%)	6 (30.0%)	8 (80.0%)	5 (50.0%)
1+	4 (36.5%)	7 (35.0%)	1 (10.0%)	1 (10.0%)
2+	6 (54.5%)	7 (35.0%)	0 (0%)	3 (30.0%)
3+	1 (9.0%)	0 (0%)	1 (10.0%)	1 (10.0%)
CDH6				
0	8 (72.8%)	11 (55.0%)	8 (80.0%)	6 (60.0%)
1+	1 (9.0%)	5 (25.0%)	1 (10.0%)	1 (10.0%)
2+	2 (18.2%)	4 (20.0%)	1 (10.0%)	3 (30.0%)
3+	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Gynecologic Oncology. Volume 210, July 2026, Pages 131-139

ASCO 2026_Ovarian cancer

- Overall survival subgroup analyses for prior taxane use in the phase 3 ROSELLA trial of relacorilant plus nab-paclitaxel versus nab-paclitaxel monotherapy in patients with platinum-resistant ovarian cancer

- A phase III CHIPRO study of chiauranib plus weekly paclitaxel for platinum-resistant or refractory ovarian cancer.

- CHRONO: A randomized phase II trial of the chronology of surgery after neoadjuvant chemotherapy for ovarian cancer.

- A randomized phase II trial of mirvetuximab soravtansine in folate receptor alpha (FRα)–high recurrent ovarian cancer eligible for platinum-based chemotherapy (MIROVA/AGO-OVAR 2.34).

ESMO 2026_Ovarian cancer

- Randomized dose optimization of ZW191 in heavily pretreated patients with platinum-resistant ovarian cancer

- Raludotatug Deruxtecan (R-DXd) + Bevacizumab (Bev) in Participants (Pts) With Platinum-Resistant Recurrent Ovarian Cancer (PROC): Results for Cohort B-1 of the Phase 1b/2 REJOICE-Ovarian02 Study

Conclusion

- New treatment options are emerging for platinum-resistant ovarian cancer.
- Novel targeted therapies for low-grade serous ovarian cancer are rapidly advancing.
- Several ADCs are currently being evaluated in phase II and III trials, and their results are eagerly anticipated.



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