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TEXT

During the 23rd Congress on Gynaecological Oncology held in Berlin in October 2022, eight interviews on relevant and up-to-date topics in gynecologic oncology with leading speakers were conducted by current and former Editorial Fellows of the IJGC endorsed by the ENYGO.

New ESGO-ESTRO-SIOPe Guidelines on Vaginal Cancer: Surgical Aspects

Interviewee: Professor Christina Fotopoulou from West London Gynecological Cancer Centre; Hammersmith Hospital, Imperial College, London, UK.
Interviewer: Dr. Martina A. Angeles, IJGC Editorial Fellow.

Primary vaginal cancer is a rare malignancy, less common than cervical cancer [1]. It may be associated with human papillomavirus (HPV) infection and the most common histologic type is squamous cell carcinoma [2,3]. Given the low incidence and complexity of care of vaginal cancer, ESGO in collaboration with ESTRO and SIOPe developed the new guidelines to ensure a standardization of management of these patients.

During the interview with Prof. Fotopoulou, we discussed important surgical aspects of the recent guidelines on vaginal cancer. Regarding the role of sentinel lymph node (SLN), she stated that *"there is currently no data assessing the oncologic safety of the use of this procedure alone in vaginal cancer and it is not part of the standard oncologic treatment"*, but of course clinical trials and the use of the SLN concept in conjunction with standard lymphadenectomy is encouraged to enrich experience and evidence in this rare disease. According to the embryologic development of the vagina, the lymphatic drainage of tumors located at the upper two thirds is equivalent to the cervix and therefore pelvic lymphadenectomy should be performed in these cases. An inguinofemoral lymphadenectomy is recommended for tumors located at the lower

third of the vagina. However, it is not advocated to routinely perform both pelvic and inguinofemoral lymph node dissection in tumors located at the junction in order to avoid unnecessary morbidity. In these cases, the treating expert clinician should decide at physical examination which is the most likely lymphatic pathway, and it could be helpful to perform SLN procedure, in addition to the lymphadenectomy, to define the lymphatic drainage of the tumor. We also discussed the role of surgery in upper-third vaginal tumors below 2 cm. *"Uterine preservation can be considered in patients wishing a fertility-sparing treatment if free margins can be obtained",* Prof. Fotopoulou explained. However, she highlighted that *"it is mandatory to reconstruct the vaginal defect in a way to avoid stenosis or obstruction which could lead to recurring hematometra through impaired uterine drainage".* Also access to the cervix should always be ensured to enable cervical screening. Regarding the surgical approach in upper-third tumors, it would be possible to combine a minimal invasive with a vaginal approach, to dissect the uterus abdominally and then remove the tumor vaginally, as long as the oncologic principles of avoiding tumor exposure in the peritoneal cavity are followed.

Concerning the follow-up, Prof. Fotopoulou mentioned that: *"There is no data regarding the oncologic safety of patient-initiated follow-up alone without clinical examination, and these patients should be seen and followed-up with standard principles of face-to-face attendance",* she stated. She also emphasized the importance of cervical cancer screening in patients with uterine preservation, especially in HPV-related vaginal cancers. *"In patients treated by surgery alone, both cervical cytology and HPV testing are recommended. However, in patients treated with radiotherapy, the cytology is not reliable because it has a high rate of false-positive results. HPV testing is recommended in these patients as its results are not influenced by radiotherapy".* At the end of the interview, she highlighted the importance of specialized and multidisciplinary care for this rare disease and participation to clinical trials and large databases when possible to enrich evidence.

Surgery of the Vulva and Plastic Reconstruction

Interviewee: Professor Sven Mahner from Ludwig Maximilian University of Munich, Munich, Germany.

Interviewer: Dr. Felix Boria, IJGC Editorial Fellow.

Vulvar cancer is a rare disease with an annual incidence of two to three per 100,000 women [4]. Last years, treatment for early-stage disease has undergone major advances [4–7]. In patients with unifocal tumors, less than 4 cm and non-suspicious groin nodes, SLN biopsy has become the standard of care over systematic inguinofemoral lymphadenectomy [4,5].

The GROINSS-V I study showed that omission of inguinofemoral lymphadenectomy is safe in patients with a negative SLN with an isolated groin recurrence rate after SLN biopsy of 2.3% [95% CI 0.6% - 5.0%] [6]. Later, the GROINSS-V II study showed that inguinofemoral radiotherapy for vulvar cancer patients with SLN micrometastasis is a safe alternative for inguinofemoral lymphadenectomy. The toxicity of radiotherapy is acceptable, and treatment-related morbidity is less frequent compared with inguinofemoral lymphadenectomy. However, for patients with SLN macrometastasis, radiotherapy with a total dose of 50 Gy showed more isolated groin recurrences than inguinofemoral lymphadenectomy, therefore surgery is recommended in these cases [7].

Our discussion with Prof. Mahner started emphasizing the importance of centralization of surgery in this type of cancer. *"Vulvar cancer is a rare disease that should be treated only in specialized centers with high volume whenever possible",* he stated. Regarding the SLN mapping in vulvar cancer, Prof. Mahner usually employs technetium as standard radiotracer and combines it occasionally with indocyanine green or blue dye. We discussed the benefits of sending the lymph nodes for frozen section vs. performing a delayed histological analysis. At this point, Prof. Mahner explained the need of individualizing each case. *"If a macrometastasis is found in*

a lymph node, an inguinofemoral lymphadenectomy is mandatory. Therefore, frozen section will avoid a second surgery", he explained. However, as ultrastaging has a better sensitivity to detect lymph node metastasis, Prof. Mahner recommends doing a two-step procedure for almost all cases, unless the patient has comorbidities and will benefit from only one surgery, assuming the higher risk of false-negative results with frozen section. Moreover, based on GROINSS-V II data, full groin lymph node resection can be omitted in some patients with only micrometastasis.

As many vulvar cancer patients present with comorbidities that can compromise the surgery, he advocates to adjust the anesthetic procedure to the patient. Surgical morbidity related to anesthesia can be decreased with a regional anesthesia or even with local anesthesia in selected cases. When talking about the reconstruction of the vulva, Prof. Mahner considers that there is no “one fit for all” in vulvar cancer, and *"we have to tailor our reconstruction technique to the tumor and patient characteristics"*. He suggested to perform a flap in almost all cases and try to avoid primary closure, as this latter has poorer aesthetic and functional results. Regarding clitoris preservation, he recommended to always try to preserve this organ, as quality of life will be dramatically decreased in those patients in whom it has been resected.

Finally, we discussed the need of working within a multidisciplinary team with plastic surgeons for vulvar reconstruction. In Prof. Mahner's opinion, they are required in selected cases and most of the routine vulvar reconstructive procedures can be safely performed by skilled gynecological oncologists.

HPV Vaccines: Current State of the Art and Future Prospects

Interviewee: Professor Murat Gültekin from Hacettepe University Faculty of Medicine, Ankara, Turkey. ESGO Prevention Committee Chair,

Interviewer: Dr. Alexander Shushkevich, IJGC Editorial Fellow.

Cervical cancer is the fourth most common female malignancy worldwide, with 604,127 new cases in 2020 [8]. It is well known that the cause of invasive cervical cancer is HPV infection [9] and 13 types of HPV have been classified as carcinogenic for humans [10]. The most common genotypes of HPV associated with invasive cervical cancer are HPV 16 and 18, and genotypes 16, 18, 31, 33, 45, 52, and 58 cause approximately 90% of HPV-positive squamous cell carcinoma of the cervix [11].

During 2022 ESGO Congress, we interviewed Prof. Gültekin and discussed topics of HPV prevention. We started by focusing on the human body's natural immunity. Prof. Gültekin stated that, nowadays, HPV infection appears to be the most common sexually transmitted infection in the world. *"The risk of HPV infection is around 80% throughout life",* he mentioned. In 95% of cases, natural immunity clears out the virus infection. However, the risk of reinfection and reactivation of the viruses in the unvaccinated population is high. *"Unfortunately, in many cases, we do not see proper antibody response after HPV infection",* Prof. Gültekin concluded. Vaccination is the way to resolve cervical cancer issue worldwide.

The first vaccine against HPV infection came out in 2006. Long-term clinical data, as well as long-term real-life data, are available today. *"If we look within all clinical trials, HPV vaccination is extremely safe and effective. After the vaccination, women have nearly ten times higher antibodies level compared to natural immunity",* Prof. Gültekin explained. More than 160 trials have shown that HPV vaccines have an encouraging safety profile [12]. At the end of our discussion, we focused on dose variations. WHO suggested a 2-dose schedule (0, 6 months) for all females below 15 years at the time of the first dose. For women aged 15 years or older, a 3-dose schedule (0, 2, 6 months) is recommended. However, recent data from several randomized controlled trials showed that a single dose of HPV vaccine has a similar protection rate in infection persistence [13,14]. *"However, we do not have enough data about the single-dose schedule, which means that we cannot immediately implement this schedule, but it could be an option for low-income countries",* stated Prof. Gültekin.

2022 Update of the ESGO-ESTRO-ESP Cervical Cancer Guidelines

Interviewee: Professor David Cibula from the Gynecologic Oncology Center, Department of Obstetrics and Gynecology, First Faculty of Medicine, Charles University and General University Hospital, Prague, Czech Republic.
Interviewer: Dr. Nicolò Bizzarri, IJGC Editorial Fellow.

One of the most attended sessions at ESGO 2022 Congress was the update of the ESGO-ESTRO-ESP Cervical Cancer Guidelines presented by Prof. David Cibula. The first edition was published in 2018 [15] and represented a landmark work originating from the collaboration of international key opinion leaders gynecologic oncologists, radiation oncologists and pathologists. The interview started with a discussion of the main updates of the 2022 version. There are new components which include: surgical management of FIGO 2018 stage IB3 and IIA2 N0, quality of life and palliative care, and rare tumors. In addition, the most recent evidence in cervical cancer literature led to the need of updating topics such as SLN biopsy, surgical approach, fertility-sparing treatment, systemic treatment, and recurrent disease. Moreover, some previous recommendations were improved, and several algorithms were restructured.

Since the last edition, the publication of the Laparoscopic Approach to Cervical Cancer (LACC) Trial in 2018 [16] led to the change of recommendation on surgical approach to radical hysterectomy, with laparotomy as standard of care. In the current updated guidelines, minimally invasive surgery is proposed as an acceptable approach for lymph node staging, meaning that the first step could be performed by minimal access, perform the frozen section of the (sentinel) lymph node and if negative then convert to open surgery to complete the radical hysterectomy. Guidelines committee also opened the window to minimally invasive surgery in the group of "low-risk" tumors (defined as tumors with diameter <2 cm after cone biopsy with free margins)

if operated in high-volume centers experienced in performing radical hysterectomy with minimally invasive surgery, which meet the ESGO quality criteria for surgery, using protective maneuvers and if patient agrees after comprehensive counseling on current evidence.

The discussion then moved to the potential future indication for radical hysterectomy in early-stage disease, as the gynecologic oncology community is gradually moving toward a less radical approach (SLN only and non-radical hysterectomy). Prof. Cibula strongly believes in the SLN concept in view of the step-by-step lymphatic spread of cervical cancer, also recently demonstrated by the results of the SENTIX study [17]. Regarding radical hysterectomy, *"the new challenge is represented by the role of radical surgery alone in the "intermediate-risk" disease and the ongoing CERVANTES trial [18] is aiming to assess the role of adjuvant (chemo)radiotherapy in this setting",* he stated. *"We are also awaiting the results of the SHAPE trial to understand the role of radical surgery in low risk disease",* he added.

Lastly the interview briefly touched on the fields that deserve further research in cervical cancer. In early stage, there are different developments aiming to de-escalate the treatments in a trend toward less radical management. *"However, one has to be cautious with the final survival outcomes",* he underlined. LACC trial showed us that we are currently reaching very high survival rates (laparotomy arm of the trial) and we could not aim for more, but we could risk worsening them, so it will be important to focus on improving quality of life maintaining such high oncological outcomes. *"Of course, improvement in survival rates and quality of life of locally advanced and metastatic disease is one of the priorities for future research",* Prof. Cibula concluded at the end of the interview.

Fertility-sparing Treatment in Endometrial Cancer

Interviewee: Professor Alexandros Rodolakis, from the 1st Department of Obstetrics and Gynaecology, Alexandra Hospital, National and Kapodistrian University of Athens, Greece.

Interviewer: Dr. Charalampos Theofanakis, IJGC Editorial Fellow.

Fertility-sparing treatment for young patients with endometrial cancer is a contemporary clinical problem. Since delayed childbearing is increasingly more common among women, diagnosing an endometrial cancer in nulliparous young patients is becoming more frequent [19].

At the beginning of the interview, we asked Prof. Rodolakis about the selection of patients diagnosed with endometrial cancer eligible for fertility-sparing treatment. He explained that it is crucial to evaluate if the patient fulfills the selection criteria. *"Well differentiated tumors without myometrial invasion is mandatory to offer fertility-sparing treatment",* he stated [20]. However, prior to performing a conservative approach, we must evaluate the reproductive potential of each patient, to be sure there is no previous history of infertility. As well, it is recommended that an experienced pathologist reviews the pathology report to confirm grade 1 endometrioid subtype. Thereafter, the patient is offered progesterone treatment with oral progestin, an intrauterine device, or a combination of both.

We also discussed the role of hysteroscopy in patients referred with a histologically confirmed endometrial cancer. *"There is strong evidence showing that blind techniques alone - such as curettage or Pipelle endometrial biopsy- should be avoided and supporting to perform an additional hysteroscopy"*. It is necessary to resect focal lesions and to assess the extent of the disease in the endometrial cavity [21].

Once the conservative treatment is considered successful, patients should be referred to female reproductive health specialists in order to conceive as soon as possible. Regarding delayed childbearing, we asked Prof. Rodolakis about the management of young patients willing to delay childbearing after a successful conservative treatment and he mentioned that this is a major issue. A maintenance treatment is required to prolong the complete remission of the disease, which is usually succeeded with a levonorgestrel-intrauterine device. However, it is

crucial to counsel these patients regarding the high rate of recurrence, which is close to 40%. Therefore, pregnancy should be planned as soon as possible [22].

At the end of the interview, Prof. Rololakis gave us the following take-home message: *"A young patient with grade 1 endometrioid stage IA endometrial cancer without myometrial invasion with a strong desire for childbearing is the definitive indication for fertility-sparing treatment. However, we need to individualize each case to offer our patients the best possible management".*

Molecular Analysis in Endometrial Cancer

Interviewee: Professor Domenica Lorusso from the Department of Obstetrics and Gynecology at the Catholic University of Rome and responsible for clinical research at Fondazione Policlinico Gemelli Rome, Italy.

Interviewer: Dr. Gabriella Schivardi, IJGC Editorial Fellow.

Historically adjuvant treatment of endometrial cancer was based exclusively on clinicopathological parameters. In the last decade, starting from the publication in 2013 of the "Integrated genomic characterization of endometrial carcinoma" by The Cancer Genome Atlas (TCGA), a new prognostic classification has been proposed that integrates molecular and clinicopathological factors [23–25]. Indeed, the last ESGO/ESTRO/ESP guidelines, published in 2020 have combined the molecular categories with the histological features for endometrial cancer risk classification and adjuvant treatment recommendations [21]. Since then, different progress on the role of the molecular classes in adjuvant treatment has been made and various trials are ongoing.

During the ESGO 2022 Congress, we discussed with Prof. Lorusso some of the most relevant aspects of the molecular evaluation. We started by discussing the need of performing a

complete molecular analysis in all endometrial cancer patients. Prof. Lorusso stated that ideally, all endometrial cancer patients should undergo a complete molecular analysis, including POLE, however in a low-resource setting the POLE test could be limited to high-intermediate and high-risk patients where this information could change the choice of adjuvant treatment. Considering that the primary issue of the cost is related to POLE, we asked if there is any way to assess POLE mutation besides next-generation sequencing. Prof. Lorusso underlined the option to limit the analysis to the exons that contain the 11 hotspot mutations or even to limit the test to the 5 most frequent mutations, which represents the minimal requirement for the POLE mutation diagnosis. Our discussion continued on the POLE category, asking Prof. Lorusso how she would manage adjuvant treatment in POLE mutated tumors stage III, she explained that *"to date there is no sufficient data to omit adjuvant treatment in these tumors. However, the RAINBO umbrella program currently ongoing will be able to answer this issue"*. Later, Prof. Lorusso summarized the design of the RAINBO program: *"p53abn tumors will receive chemotherapy and then will be randomized to receive PARP inhibitor or placebo for two years, MMRd tumors will receive radiation therapy or chemoradiation therapy and then will be randomized to receive one year of immunotherapy or placebo, no specific molecular profile (NSMP) tumors will receive radiotherapy and then will be randomized to receive hormonal treatment or placebo for two years, and finally POLE tumors will not receive any adjuvant treatment regardless of the stage"*.

Prof. Lorusso also talked about the role of immunotherapy in first-line treatment of endometrial cancer patients among MMRd category. Besides the RAINBO trial, there are several ongoing trials evaluating immunotherapy in first-line treatment for MMRd tumors in combination with chemotherapy but also as an alternative to chemotherapy. Prof. Lorusso believes that in the next two to three years the results of those trials will provide us with the knowledge to define the role of immunotherapy in this setting. Finally, we asked her if she believes that molecular analysis performed on the preoperative biopsy will be able to tailor the surgical management in the near future. She mentioned that either medical or surgical treatment

is moving forward with more tailored treatment, and she seemed convinced that *"what we are discovering on the prognostic role of molecular classification will impact the radicality of surgery"*.

Major Achievements in the Management of Ovarian Cancer (SOLO1, PAOLA1, PRIMA, ATHENAmono, Atalante)

Interviewee: Professor Mansoor Raza Mirza from the Department of Oncology of the Finsen Centre, Rigshospitalet - Copenhagen University Hospital, Denmark.

Interviewer: Dr. Joanna Kacperczyk-Bartnik, IJGC Editorial Fellow.

Introduction of PARP inhibitors (PARPi) in ovarian cancer management protocols has significantly improved patients' prognosis and outcome during the last decade. Numerous clinical trials have been performed since the publication of the first phase 2 trial evaluating PARPi in maintenance therapy in platinum-sensitive relapsed ovarian cancer in 2012 (NCT00753545) and the announcement of the phase 3 NOVA trial results in 2016 (NCT02655016) [26,27]. Positive results of SOLO-1 (NCT01844986) and PAOLA-1 (NCT02477644) trials published in 2018 and 2019 showed that PARPi can be used not only as the maintenance therapy in patients with relapsed ovarian cancer, but also after first-line treatment of newly diagnosed disease [28,29]. Similarly, favorable results were confirmed in the PRIMA trial (NCT02655016) and data from recently presented phase 3 ATHENA MONO trial (NCT03522246) and phase 3 PRIME trial (NCT03709316). Based on the aforementioned studies, we know that PARPi significantly prolong median progression-free survival in patients with ovarian cancer as half of the patients with maintenance therapy after first-line treatment have no progression after 5 years compared to 20% 5-year survival before PARPi era.

During the ESGO meeting, we interviewed Prof. Mirza in this interesting topic. The molecular mechanism of how PARPi work in the biomarker positive population is well known. However, we still need to understand why PARPi can also be effective in the biomarker negative population. High efficacy was confirmed in BRCA mutated cases and in patients with mutations detected in homologous recombination–deficiency (HRD) tests. However, based on the cut-off in HRD tests, it is not possible to predict which patients will respond to PARPi treatment. Therefore, Prof. Mirza would recommend using PARPi maintenance therapy after first-line treatment in most patients with ovarian cancer until a more sensitive test is available.

Prof. Mirza also discussed the role of immunotherapy in ovarian cancer. Currently, data available from four phase 3 randomized clinical trials examining immunotherapy in first line, in platinum-sensitive relapse and in platinum-resistant relapse showed negative results (NCT02718417, NCT02580058, NCT03038100, NCT02891824). *"In order to change this, we need to find a specific biomarker for ovarian cancer, other than PD-L1",* he stated. Prof. Mirza continued explaining that *"another point to examine is the regimens of immune checkpoint inhibitors administration as they were found ineffective in single agent therapy".* Two trials exploring the combination of immunotherapy with bevacizumab were also negative (NCT03038100, NCT02891824). Both treatment mechanisms and selection of patients need to be further investigated before introducing immunotherapy in routine clinical practice. Data from trials examining the combination of checkpoint inhibitors, PARPi and bevacizumab will be soon available and will help us learn more about the role of immunotherapy in ovarian cancer.

Regarding the future of ovarian cancer research, *"it should focus on treatment protocols for relapsed patients with previous PARPi maintenance therapy",* he mentioned. Another area to explore is therapy options for HRD proficient patients with moderate response to PARPi. *"More strictly selected populations with already predicted positive response based on patients' molecular characteristics should be a priority when planning future trials",* he added.

Prof. Mirza explained that both patients and centers can enroll into ENGOT clinical trials by contacting national clinical trials groups. There are currently 21 ENGOT groups active in 32 European countries. During the initiation process of every new trial, all groups associated with ENGOT are invited to participate.

ESMO-ESGO-ESP Guidelines on Ovarian Cancer: Surgical and Medical Implications

Interviewee: Professor Anna Fagotti from the Fondazione Policlinico A. Gemelli, Catholic University of the Sacred Heart, Rome, Italy; and Professor Jonathan A. Ledermann from the Department of Oncology, UCL Cancer Institute and UCL Hospitals, London, UK.

Interviewer: Dr. Aleksandra Strojna, IJGC Editorial Fellow.

The first ESMO–ESGO consensus conference manuscript on ovarian cancer was published in 2019, since then the evidence on the standards of care for ovarian cancer patients has evolved. During the interview, Prof. Fagotti and Prof. Ledermann focused on the main medical and surgical highlights of the 2022 ESMO-ESGO-ESP guidelines.

We started the interview discussing some important medical aspects with Prof. Ledermann. He highlighted that *"the introduction of front-line use of PARP inhibitors (PARPi) is a new milestone in treatment of ovarian cancer"*. Both olaparib and niraparib have led to significant improvements in progression-free survival [27,30]. Patients with a BRCA mutation have the greatest benefit from PARPi maintenance therapy. *"Standard treatment for BRCA-mutated patients should include either olaparib, olaparib plus bevacizumab or niraparib"* [27,29,30], he explained. *"Similarly, patients with HRD-positive tumors may benefit from the combination of olaparib and bevacizumab, or from niraparib monotherapy, so for these patients, maintenance therapy with a PARPi should be given"*, he added. In HRD-negative patients, the evidence supporting the use of niraparib as maintenance therapy is not as strong and it is not

clear how great is the clinical benefit. At diagnosis, it is important to perform BRCA and HRD testing to optimize the use of maintenance therapy in an individual patient.

Regarding the use of bevacizumab in ovarian cancer, we discussed the reintroduction of bevacizumab in recurrent disease, he said *"a randomized phase 3 trial (NCT01802749) showed that re-introducing or continuing bevacizumab beyond progression after first-line treatment with the same drug improved progression-free survival compared to standard chemotherapy alone"* [31]. Whilst bevacizumab is continued to progression for recurrent ovarian cancer, recent data have demonstrated that prolonging therapy in the first line setting does not improve outcome. He mentioned that *"'The BOOST' trial (NCT01462890) showed that there was no difference in progression-free survival in patients receiving 15 or 30 months of bevacizumab, so the standard length of treatment remains as 15 months"*.

Regarding low-grade ovarian cancer, Prof. Ledermann explained that it is a disease with a different biology, in which we need to improve treatment options. There is an ongoing clinical trial, NRG-019 (NCT04095364), to see whether letrozole alone is non-inferior to adding letrozole to chemotherapy in stage II-IV low grade serous ovarian cancer. Another important study (NCT02101788) in recurrent low-grade disease has shown that trametinib (MEK inhibitor) improves progression-free survival compared with physician choice, and although it is not licensed for use in ovarian cancer, it has become an option of the treatment of this rare cancer [32].

We also discussed with Prof. Fagotti the surgical aspects of the guidelines. She explained that *"the treatment of serous tubal intraepithelial carcinoma (STIC) has been updated"*. Patients with BRCA mutation diagnosed with STIC after undergoing a prophylactic bilateral salpingo-oophorectomy have a 30%-risk of developing peritoneal carcinomatosis over 10 years. Therefore, it is recommended to perform peritoneal biopsies by minimally invasive surgery. There is no supporting evidence to perform a staging lymphadenectomy but performing a

hysterectomy in BRCA-mutated patients should be considered due to the increased risk of uterine serous carcinoma.

Regarding the role of secondary cytoreductive surgery for recurrent ovarian cancer, Prof. Fagotti highlighted that *"DESKTOP III and SOC-1 trials have shown that complete gross resection at the time of recurrent disease followed by adjuvant chemotherapy offers an improved survival compared to chemotherapy alone"* [33,34]. "*The main issue is to define the patients that should undergo this surgery, and in this purpose, we should use prospectively validated algorithms",* she added. It is currently recommended to evaluate the possibility of performing a secondary cytoreductive surgery in all patients presenting with a platinum-sensitive recurrence.

At the end of the interview, we focused on the management of oligometastatic recurrences which occur more often since the introduction of PARPi maintenance therapy. This is probably due to the appearance of PARPi-resistant clones. Prof. Fagotti concluded that, regardless of BRCA status, these patients should be treated with surgery or chemotherapy to clear the PARPi-resistant clones and reintroduce a maintenance therapy with PARPi.

Conclusion:

In this meeting summary we include eight interviews that were conducted during the 23rd Congress on Gynaecological Oncology, which was held in Berlin in October 2022. These interviews were recorded, and the videos are available online in the following link https://tinyurl.com/9dv289s8.

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