Neoadjuvant chemotherapy versus debulking surgery in advanced tubo-ovarian cancers: pooled analysis of individual patient data from the EORTC 55971 and CHORUS trials.

DOI: 10.1016/S1470-2045(18)30566-7

Citation for published version (APA):

Published in:
Lancet Oncology

Citing this paper
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Neoadjuvant chemotherapy versus upfront debulking surgery in advanced tubo-ovarian cancers: meta-analysis of individual patient data from the EORTC and CHORUS trials

Ignace Vergote, Connee Coens, Matthew Nankivell, Gunnar B Kristensen, Mahesh K B Parmar, Tom Ehlen, Gordon C Jayson, Nick John, Ann Marie Swart, René Verheijen, W Glenn McCluggage, Tim Perren, Pierluigi Benedetti Panici, Gemma Kenter, Antonio Casado MD, Cesar Mendiola, Gavin Stuart, Nick S Reed, Sean Kehoe, and the EORTC and MRC CHORUS study investigators

Summary
Background Individual patient data from two randomised trials comparing neoadjuvant chemotherapy with upfront debulking surgery in adenocarcinoma in advanced tubo-ovarian cancer were analysed to examine long-term outcomes for patients and to identify any preferable therapeutic approaches for subgroup populations.

Methods We did a preplanned meta-analysis of individual patient data from the European Organisation for Research and Treatment of Cancer (EORTC) 55971 trial (NCT0003636) and the Medical Research Council Chemotherapy Or Upfront Surgery (CHORUS) trial (ISRCTN74802813). In the EORTC trial, eligible women had biopsy-proven International Federation of Gynecology and Obstetrics (FIGO) stage IIIC or IV invasive epithelial tubo-ovarian carcinoma. In the CHORUS trial, inclusion criteria were similar to those of the EORTC trial, and women with apparent FIGO stage IIIA and IIIB disease were also eligible. The main aim of the meta-analysis was to show non-inferiority in overall survival with neoadjuvant chemotherapy compared with upfront debulking surgery, using the reverse Kaplan-Meier method. Tests for heterogeneity were based on Cochran’s Q heterogeneity statistic.

Findings Data for 1220 women were included in the meta-analysis, 670 from the EORTC trial and 550 from the CHORUS trial. 612 women were randomly allocated to receive upfront debulking surgery and 608 to receive neoadjuvant chemotherapy. Median follow-up was 7.6 years (IQR 6.0–9.6; EORTC, 9.2 years [IQR 7.3–10.4]; CHORUS, 5.9 years [IQR 4.3–7.4]). Median age was 63 years (IQR 56–71, range 25–88) and median size of the largest metastatic tumour at diagnosis was 8 cm (IQR 4.8–13.0, range 0–50). 55 (5%) women had FIGO stage II–IIIB disease, 831 (68%) had stage IIIC disease, and 23 (19%) had stage IV disease, with staging data missing for 104 (9%) women. [A: please check numbers of women] In the entire population, no difference in median overall survival was noted between patients who underwent neoadjuvant chemotherapy and upfront debulking surgery (27.6 months [IQR 14.1–51.3] and 26.9 months [12.7–50.1], respectively; hazard ratio [HR] 0.97, 95% CI 0.86–1.10; p = 0.586). [A: data in Results were different (I think you had added those for PFS), I’ve amended to match Results; please check carefully] Median overall survival for EORTC and CHORUS patients was significantly different at 30.2 months (IQR 15.7–53.7) and 23.6 months (10.5–46.8), respectively (HR 1.20, 95% CI 1.06–1.36; p = 0.004), but was not heterogeneous (Cochran’s Q, p = 0.17). [Variables were noted in some cohorts.]

Interpretation Long-term follow-up data substantiate previous results showing [A: OK change for “confirm”] that neoadjuvant chemotherapy and upfront debulking surgery result in similar overall survival in advanced tubo-ovarian cancer, without preferential outcomes [A: can you be specific?] in some [A: which?] patients. This meta-analysis, with long-term follow-up, shows that neoadjuvant chemotherapy is a valuable treatment option for patients with stage IIIIC–IV tubo-ovarian cancer, particularly in patients with a high tumour burden at presentation or poor performance status.

Funding National Cancer Institute, Vlaamse Liga tegen kanker (Flemish League against Cancer), Cancer Research UK, Royal College of Obstetricians and Gynaecologists, Medical Research Council (MRC) Clinical Trials Unit, and MRC. [A: please check]

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Surgery, primary surgery has been an essential, or even mandatory, therapeutic strategy in clinical practice.1 [A: please check reference numbering, you had referenced Griffiths as number 2 but it was originally 3 in the list] However, to date, no randomised controlled trials have shown that primary debulking surgery improves the prognosis of patients with advanced tubo-ovarian cancer.

An alternative approach to primary debulking surgery is neoadjuvant chemotherapy, administered before attempting cytoreductive surgery. In 2010, the European Organisation for Research and Treatment of Cancer (EORTC) published the first findings from a trial comparing neoadjuvant chemotherapy followed by interval debulking surgery versus upfront debulking surgery followed by chemotherapy. This study showed both treatment strategies had similar overall survival and progression-free survival in women with International Federation of Gynecology and Obstetrics (FIGO) stage IIIC or IV tubo-ovarian cancer, and operative and postoperative morbidity was lower with neoadjuvant chemotherapy. These results were later substantiated in the randomised Medical Research Council (MRC) Chemotherapy Or Upfront Surgery (CHORUS) trial,2 leading to the acceptance of neoadjuvant chemotherapy followed by interval debulking surgery as an alternative to upfront debulking surgery in women with stage IIIC and IV tubo-ovarian cancer. However, the selection of women with advanced ovarian cancer for neoadjuvant chemotherapy or upfront debulking surgery remains controversial.

In 2003, while accrual for the EORTC study was ongoing but before the start of the CHORUS trial, the EORTC and MRC planned the current analysis with the aim of analysing long-term follow-up of both trials and identifying any subgroups of women that might benefit from neoadjuvant chemotherapy compared with upfront debulking surgery. Herein, we report the results of this analysis.
Methods

Study design and data collection

We did a preplanned meta-analysis of individual patient data from the EORTC 55971 trial and the MRC CHORUS trial, according to PRISMA guidelines. The appendix includes the protocols of the EORTC (pp 11–69) and CHORUS (pp 70–116) trials. A list of recruiting sites and investigators is also in the appendix (pp 121–123).

Briefly, in the EORTC trial, women were eligible if they had had biopsy-proven FIGO stage IIIIC or IV invasive epithelial ovarian, primary peritoneal, or fallopian tube carcinoma. If a biopsy specimen was not available, fine-needle aspiration showing an adenocarcinoma was acceptable under the following conditions: presence of a pelvic adnexal mass, presence of extrapelvic metastases of 2 cm or larger (measured during diagnostic laparoscopy or laparotomy, or if laparoscopy or laparotomy was not done, on the basis on CT findings), and a ratio of cancer antigen 125 (CA125) to carcinoembryonic antigen (CEA) greater than 25; biopsy findings were mandatory for inclusion in the trial if any of these three criteria was not present. If the CA125:CEA ratio was less than 25, investigations to exclude a gastrointestinal carcinoma were necessary before entry. In the CHORUS trial, inclusion criteria were similar to those in the EORTC trial, and women with apparent FIGO stage IIIA and IIIB were also eligible. The size of the largest metastasis was estimated on the basis of CT imaging only in the CHORUS trial.

In both trials, participants were randomly allocated to receive either upfront debulking surgery followed by at least six courses of platinum-based chemotherapy, or three courses of neoadjuvant platinum-based chemotherapy followed by interval debulking surgery followed by at least three additional courses of platinum-based chemotherapy. In women allocated to receive upfront debulking surgery whose surgery was completed without optimum cytoreduction, interval debulking surgery was permitted, and these patients were included for analyses in the upfront debulking surgery group in the EORTC trial. randomisation used a minimisation technique and was stratified by the following factors: institution, method of biopsy (image-guided, laparoscopy, laparotomy, or fine-needle aspiration), FIGO stage IIIC or IV, disease, and largest tumour size (excluding ovaries) before surgery (<5 cm, ≥5 to <10 cm, ≥10 to <20 cm, or ≥20 cm). In the CHORUS trial, randomisation used a minimisation method with a random element, which stratified patients according to randomising centre, largest radiological tumour size, clinical FIGO stage, and prespecified chemotherapy regimen [A: this sentence seems like repetition, unless the first sentence is about the EORTC trial and this sentence is about CHORUS (as I have edited, by assumption). Can you please double-check the wording?]. For details on size of residual tumour, residual tumour per country, type of surgery, number of cycles and type of chemotherapy, and time to (re)initiation of chemotherapy, we refer to the original reports.

Procedures

Our analysis was designed in 2003 by the chief investigators of the EORTC and CHORUS trials (IV and SK) and members of the EORTC and MRC trial managing committees. Trial databases were set up to ensure appropriate comparable information was gathered in both trials to allow the planned individual patient data meta-analysis. Women were followed up until database lock. Data from CHORUS were transferred to EORTC headquarters and

Figure 1: PRISMA flow diagram

CHORUS=Medical Research Council Chemotherapy Or Upfront Surgery trial. EORTC=European Organisation for Research and Treatment of Cancer 55971 trial. Figure 1; appendix

Table 1: Baseline characteristics, by study

<table>
<thead>
<tr>
<th></th>
<th>EORTC (n=670)</th>
<th>CHORUS (n=550)</th>
<th>Total (n=1220)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>62 (54–69)</td>
<td>65 (58–72)</td>
<td>63 (56–71)</td>
</tr>
<tr>
<td>Range</td>
<td>25–86</td>
<td>26–88</td>
<td>25–88</td>
</tr>
<tr>
<td>Largest metastatic tumour size (mm)</td>
<td>80 (42–140)</td>
<td>80 (50–120)</td>
<td>80 (48–130)</td>
</tr>
<tr>
<td>Range</td>
<td>25–86</td>
<td>26–88</td>
<td>25–88</td>
</tr>
<tr>
<td>CA125 at entry (kU/L)</td>
<td>1016 (431–2599)</td>
<td>1089 (311–2599)</td>
<td>1089 (431–2599)</td>
</tr>
<tr>
<td>Range</td>
<td>15–41 456</td>
<td>30–39 323</td>
<td>15–41 456</td>
</tr>
</tbody>
</table>

Data are median (IQR), unless otherwise indicated. CA125=cancer antigen 125; CHORUS=Medical Research Council Chemotherapy Or Upfront Surgery trial; EORTC=European Organisation for Research and Treatment of Cancer 55971 trial; [A: please provide IQRs with the median]
Table 2: Baseline characteristics, by allocated treatment

<table>
<thead>
<tr>
<th></th>
<th>Upfront debulking surgery (n=612)</th>
<th>Neoadjuvant chemotherapy (n=608)</th>
<th>Total (n=1220)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>63 (55–71)</td>
<td>64 (57–70)</td>
<td>63 (56–71)</td>
</tr>
<tr>
<td>Range</td>
<td>25–87</td>
<td>33–88</td>
<td>25–88</td>
</tr>
<tr>
<td>Largest metastatic tumour size (mm)</td>
<td>80 (49–130)</td>
<td>80 (47–125)</td>
<td>80 (48–130)</td>
</tr>
<tr>
<td>Range</td>
<td>0–430</td>
<td>0–500</td>
<td>0–500</td>
</tr>
<tr>
<td>CA125 at entry (kU/L)</td>
<td>1039 (409–2548)</td>
<td>1137 (446–2606)</td>
<td>1089 (431–2599)</td>
</tr>
<tr>
<td>Range</td>
<td>16–39</td>
<td>15–41</td>
<td>15–41</td>
</tr>
</tbody>
</table>

Data are median (IQR), unless otherwise indicated. CA125=cancer antigen 125.

Figure 2: Overall survival and progression-free survival, by treatment

A Overall survival

- Upfront debulking surgery
- Neoadjuvant chemotherapy

Hazard ratio 0·97, 95% CI 0·86–1·09
Overall score test stratified for study p=0·586

B Progression free survival

- Upfront debulking surgery
- Neoadjuvant chemotherapy

Hazard ratio 0·99, 95% CI 0·89–1·09
Overall score test stratified for study p=0·688

Statistical analysis

At the planning stage, we estimated that the pooled dataset would contain between 800 and 900 events (deaths). Assuming a median overall survival of 3 years, this number of events allowed assessment of non-inferiority, with a one-sided type I error of 0·05 and a power of 80%, with inferiority regarded as an increase of more than 18–19% in hazard. Similarly, to ensure the estimated number of events would allow 90% power in excluding a hazard increase of 22–23%, a two-sided test of superiority at 5%, the dataset would allow detection of an 18% increase in hazard with 80% power.

The principal analysis was done on an intention-to-treat basis. Median overall survival and progression-free survival were estimated by the Kaplan-Meier method and compared via the log-rank test. Hazard ratio (HR) estimates and their 95% CIs were obtained from a Cox proportional hazards model. In those subgroups for which the proportional hazards assumption was violated, restricted mean survival times were calculated to provide a more useful general measure to report the average survival times between the two treatment arms. All baseline characteristics and results were checked for homogeneity between the two studies and stratified per trial when possible. Tests for heterogeneity in progression-free survival or overall survival were based on Cochran’s Q statistic. All analyses were done with SAS, version 9.4.

Role of funding source

The funders of the studies had no role in study design, data collection, data analysis, data interpretation, or writing of the report. CC, MN, and MKBP had full access to MRC CHORUS raw data. CC had full access to EORTC 55971 raw data. The corresponding author had full access to all data in the study and had final responsibility for the decision to submit for publication.

Kaplan-Meier method and calculates time-to-events for all patients; in the original CHORUS paper, however, only the median duration of follow-up for surviving patients was calculated. [A: Ok as edited?]

The primary outcome of our meta-analysis was overall survival, and the prespecified secondary endpoint was progression-free survival. Prespecified subgroup analyses were done on the basis of stratification factors that were common to both trials: randomising centre, largest tumour size (excluding ovaries) before surgery (<5 cm, ≥5 to ≤10 cm, >10 to ≤20 cm, or >20 cm), and clinical FIGO stage. Definitions for overall survival and progression-free survival have been published elsewhere.

Articles

analysed by us [A: who?] in cooperation with the EORTC statistician (CC). We derived median follow-up with the EORTC standard method, which uses the reverse
Results

Patients’ data from both trials were updated and merged into one database (database lock for EORTC was on June 6, 2015; for CHORUS, June 3, 2014), which contained 1220 patients with tubo-ovarian cancer who had been randomly allocated to receive either upfront debulking surgery (n=612) or neoadjuvant chemotherapy (n=608). Total combined recruitment lasted almost 12 years (in EORTC, 670 patients from Oct 12, 1998 to Nov 29, 2006; in CHORUS, 550 patients from March 5, 2004, to Aug 26, 2010). Median follow-up was 7·6 years (IQR 6·0–9·6 years; EORTC, 9·2 years [IQR 7·3–10·4]; CHORUS, 5·9 years [IQR 4·3–7·4]). Characteristics of patients by study and study group are summarised in tables 1 and 2, respectively. Pretreatment characteristics were well balanced between both treatment groups. Median age was 63 years (IQR 56–71, range 25–88) and median size of the largest metastatic tumour at diagnosis was 8 cm (IQR 4·8–13·0, range 0–50). 55 (5%) women had FIGO stage II–IIIB disease, 831 (68%) had stage IIIC disease, and 230 (19%) had stage IV disease, with staging data missing for 64 (9%) women. [A: I’ve added these data from the Summary, to ensure the Results contain all data in the Summary]

Overall survival and progression-free survival for the entire population were similar with neoadjuvant chemotherapy and upfront debulking surgery, with median overall survival of 27·6 months (IQR 14·1–51·3) and 26·9 months (12·7–50·1), respectively (HR 0·97, 95% CI 0·86–1·09; p=0·568). [A: you’ve written in the next sentence (now deleted) 0·87; please check] and progression-free survival of 11·6 months (IQR 7·9–17·7) and 11·1 months (6·4–17·5), respectively (HR 0·95, 95% CI 0·89–1·00; p=0·688; figure 1). [A: please add HR and 95% CI] The lower one-sided 95% CIs for overall survival and progression-free survival excluded the 18% non-inferiority margin.

Overall survival was significantly better in the EORTC trial as compared with the CHORUS trial (median 30·2 months [IQR 15·7–53·7] vs 23·6 months [10·5–46·9]; HR 1·20, 95% CI 1·06–1·36; p=0·004; figure 1), but progression-free survival was similar in the two trials (median 11·5 months [IQR 8·0–17·0] vs 10·9 months [6·1–18·1]; HR 0·96, 95% CI 0·86–1·08; p=0·531; appendix p 1). [A: I’ve deleted last page of your appendix because we add a title page later; please check p values in appendix, log-rank is p=0·530] Overall survival and progression-free survival according to trial and treatment groups are presented in the appendix (pp 2, 3). [A: please check p values in appendix, log-rank p differs in plot and table below plot] Cochran’s Q for heterogeneity was not significant for either overall survival (p=0·17) or progression-free survival (p=0·32).

Median overall survival was significantly different for women with FIGO stage IV disease compared with those with stage III and II cancer (median 23·3 months [IQR 12·4–40·8] vs 30·0 months [15·6–55·7] and

![Figure 3: Overall survival, by study](image-url)

EORTC=European Organisation for Research and Treatment of Cancer 55012; CHORUS=Medical Research Council Chemotherapy Or Upfront Surgery trial. [A: please provide HR and 95% CI; numbers at risk at 10 years are missing, please add]

![Figure 4: Overall survival in patients with FIGO stage IV disease, by treatment](image-url)

Upfront debulking surgery Hazard ratio 0·76, 95% CI 0·58–1·00 Overall score stratified for study, p=0·048

54
danger for stage IV vs stage II, HR 2·75, 95% CI 1·49–5·08; for stage III vs stage II, 1·92, 95% CI 1·05–3·49; p<0·0001 for trend [A: OK? Is the p value across all groups?]; please check p values in red are correct; data match appendix, but original text was the other way around] Overall survival was similar with neoadjuvant chemotherapy and upfront debulking surgery in patients with stage IIIC disease (respectively, median 30·8 months [IQR 16·5–51·3] and
Discussion

This preplanned analysis of updated data from the EORTC and CHORUS trials assessing neoadjuvant chemotherapy versus upfront debulking surgery in advanced tubo-ovarian cancer (stage IIC and IV) shows that, with long-term follow-up, neoadjuvant chemotherapy was associated with significantly better overall survival and progression-free survival as compared with upfront debulking surgery. The planned non-inferiority margin—with an increase in HR of more than 18–19%—was well outside the lower bounds of the 95% CIs (figure 4A). Forest plots according to FIGO stage are in the appendix (figure 4B). Because of deviation from the proportional hazards assumption in this subgroup, restricted mean survival times are presented in table 3. Age and performance status were not predictive for treatment effect on survival (appendix p 10).

Overall survival did not differ between upfront debulking surgery and neoadjuvant chemotherapy (median 33.0 months [IQR 13.5–78.7] vs 30.2 months [16.5–51.3] months; HR 0.87; 95% CI 0.59–1.29; p=0.48) for patients with stage IV tubo-ovarian cancer, neoadjuvant chemotherapy was associated with significantly better overall survival than was upfront debulking surgery (median 26.3 months [IQR 14.1–47.6] vs 21.2 months [10.0–36.4]; HR 0.73; 95% CI 0.58–1.00; p=0.048; figure 5A). Forest plots according to largest metastatic tumour size are in the appendix (p 9). Overall survival did not differ between upfront debulking surgery and neoadjuvant chemotherapy (median 24.0 months [IQR 12.2–35.3] vs 21.7 months [8.3–16.4]; HR 0.86; 95% CI 0.66–1.12; p=0.017; figure 5A). Forest plots according to largest metastatic tumour size are in the appendix (p 9). Overall survival did not differ between upfront debulking surgery and neoadjuvant chemotherapy (median 33.0 months [IQR 13.5–78.7] vs 30.2 months [16.5–51.3] months; HR 0.87; 95% CI 0.59–1.29; p=0.48) for patients with stage IV tubo-ovarian cancer, neoadjuvant chemotherapy was associated with significantly better overall survival than was upfront debulking surgery (median 26.3 months [IQR 14.1–47.6] vs 21.2 months [10.0–36.4]; HR 0.73; 95% CI 0.58–1.00; p=0.048; figure 5A). Forest plots according to FIGO stage are in the appendix (figure 4B). Because of deviation from the proportional hazards assumption in this subgroup, restricted mean survival times are presented in table 3. Age and performance status were not predictive for treatment effect on survival (appendix p 10).

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Table 3: Estimates of restricted mean survival time in patients with FIGO stage IIC disease and largest metastatic tumour size less than 5 cm at study entry

<table>
<thead>
<tr>
<th></th>
<th>Overall survival</th>
<th>Progression free survival</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Restricted mean survival time (months)</td>
<td>95% CI</td>
</tr>
<tr>
<td>Overall survival</td>
<td>Upfront debulking surgery</td>
<td>47.3</td>
</tr>
<tr>
<td></td>
<td>Neoadjuvant chemotherapy</td>
<td>39.3</td>
</tr>
<tr>
<td>Progression free survival</td>
<td>Upfront debulking surgery</td>
<td>27.5</td>
</tr>
<tr>
<td></td>
<td>Neoadjuvant chemotherapy</td>
<td>17.0</td>
</tr>
</tbody>
</table>

Figure 5: Progression-free survival and overall survival in patients with FIGO stage IIC disease and a largest metastatic tumour size less than 5 cm at entry, by treatment

FIGO=International Federation of Gynecology and Obstetrics. [A: numbers at risk at 10 years are missing, please add]
Both the EORTC and CHORUS trials investigated the timing of surgery in advanced tubo-ovarian cancer, these trials have been criticised for inclusion of low proportions of patients with no macroscopic disease (R0) and for survival [A: OK as edited, since Lancet style is to avoid use of “rates” where there is no time component?]. However, at the time the patients in these trials were enrolled [A: OK change for “randomised”?], neoadjuvant chemotherapy was not accepted as an alternative to upfront debulking surgery, and furthermore most patients recruited to these trials had extensive FIGO stage IIIC or IV disease that was visible on CT. Moreover, the SCORPION15 and JCOG060216 randomised trials [A: what was the date of these trials? What interventions were they testing, in what population?] concluded that interval debulking after neoadjuvant chemotherapy was associated with improved perioperative morbidity as compared with primary debulking surgery. A randomised trial of neoadjuvant chemotherapy versus primary debulking surgery in advanced tubo-ovarian cancer (the TRUST trial; NCTxxx/ISRCTNxxx) [A: can you reference or provide an NCT id or other registry id?] has recruited up to 50% of patients with maximal cytoreduction (R0) [A: OK change for “patients from selected centres have been recruited with R0 of 50% or more?”]. The results of this trial are awaited.

One limitation of our meta-analysis is that only patients with FIGO stage IIIC and IV disease were included in the EORTC trial, whereas in the CHORUS trial only a few patients with stage IIIA and B were included. Furthermore, the number of patients with stage IIIC–IV disease without residual tumour after upfront debulking surgery was lower in the CHORUS trial than in the EORTC trial.

Application of the findings of this analysis to the care of women with FIGO stage IIIC or IV tubo-ovarian cancer should be assessed in the context of each patient’s clinical picture. Women in the EORTC and CHORUS studies that contributed data to this analysis had metastatic disease with a high tumour burden at presentation, and many had a poor performance status.18 This clinical scenario is not uncommon, and improving outcomes for this population is as important—if not more so—than for patients with better prognostic factors. The results of this analysis are derived from one of the largest cohorts of women with FIGO stage IV disease in phase 3 studies.19 Although some patients with stage IV disease have a better prognosis and present with less spread and more easily resectable disease20 than other patients with stage IV disease [A: this seems rather obvious; can you explain what you mean by inclusion of this sentence?], our data suggest that neoadjuvant chemotherapy should be the standard of care for most patients with FIGO stage IV tubo-ovarian cancer, and primary surgery should only be undertaken in exceptional circumstances in women selected on an individual basis.
Contributors
All authors contributed to study design and study implementation. IV and SK wrote the draft of the report, and all authors were involved in writing and approval of the report. All authors have seen and approved the final version and, after consultation with the collaborators, agreed to submit for publication.

Declaration of interests
MN reports grants from the Medical Research Council Clinical Trials Unit and Cancer Research UK, during the conduct of the study. NJ reports that the Royal United Hospital (his employing institution) received support (EORTC) for a clinical trials nurse, who obtained and reported data from some participants in one of the trials reported here. CM reports personal fees from Roche Farmo España, outside the submitted work; and other [A: please say what “other” was] from Pharmamar, outside the submitted work. TP reports personal fees and non-financial support from AstraZeneca, outside the submitted work; and non-financial support from Roche and IGEA Medical, outside the submitted work; and is co-chief investigator for the ICON7 trial of bevacizumab in first-line treatment of patients with advanced ovarian cancer. IV, CC, GBK, MKBP, TE, GCJ, AMS, RV, WGMcC, PBP, GK, AC, GS, NSR, and SK declare no competing interests.

Acknowledgments
This study was supported by grants (2U10 CA1488-28 through 2U10 CA01488-36) from the National Cancer Institute; and by a donation from the Vlaamse Liga tegen kanker (Flemish League against Cancer) to the EORTC Charitable Trust. Funding was also provided by Cancer Research UK. Funding for a pilot phase of the trial was provided by the EORTC Charitable Trust. Funding was also provided by Cancer Research UK. CA011488-36) from the National Cancer Institute; and by a donation from the Vlaamse Liga tegen kanker (Flemish League against Cancer) to the EORTC Charitable Trust. Funding was also provided by Cancer Research UK. Funding was also provided by Cancer Research UK. Funding was also provided by Cancer Research UK. Funding was also provided by Cancer Research UK. Funding was also provided by Cancer Research UK. Funding was also provided by Cancer Research UK. Funding was also provided by Cancer Research UK. Funding was also provided by Cancer Research UK. Acknowledgments

References