commercially available AKT and DNAPK inhibitors with cisplatin, and elucidate their mechanism of action within the PI3K/AKT/mTOR pathway.

Methodology Platinum resistant immortalised HGSOC cell lines (PEO4, PEA2, OVCAR8, Kuramochi) were treated with cisplatin plus/minus AKT or DNA-PK inhibitors and Isobologram assays performed to establish synergy/antagonism between drug treatments. Cells were treated with inhibitors plus/minus cisplatin at different time points, protein lysates collected, and Reverse Phase Protein Array (RPPA) proteomics performed and analysed to establish mechanisms of action of inhibitors on the PI3K/AKT/mTOR pathway.

Result(s)* Following treatment with cisplatin in combination with AKT or DNA-PK inhibitors, different levels of synergy were observed in platinum resistant HGSOC cell lines; strong synergy was noted for AKT inhibitors Afurosertib, Uprosertib, and Triciribine. Proteomic analysis revealed a response signature for AKT or DNAPK inhibition showing activation of AKT at S473 and decrease of downstream targets pS6_235/236 and 240/44, and p70S6K_T389.

Conclusion* In the platinum resistant immortalised HGSOC cell lines tested, AKT inhibitors showed a synergistic effect when used in combination with cisplatin. Proteomic analysis confirmed targeting of the PI3K/AKT/mTOR pathway. With the aim of resensitising a resistant patient to their platinum-based chemotherapy a synergistic effect between the resensitising compound and chemotherapy agent is essential; this data suggests targeting of the PI3K/AKT/mTOR pathway in platinum-resistant HGSOC patients with AKT or DNAPK inhibition is a potentially useful therapeutic strategy.

400 IMPLEMENTATION AND FEASIBILITY OF PROPHYLACTIC BILATERAL SALPINGECTOMY AT BENIGN, MINIMALLY INVASIVE HYSTERECTOMY IN STYRIA (AUSTRIA)

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Introduction/Background* Numerous societies, including the Austrian Society of Obstetrics & Gynecology (OEGGG) in 2015, have recommended prophylactic bilateral salpingectomy (PBS) at the time of benign gynecologic surgery with the intent of ovarian cancer risk reduction. We evaluated implementation and feasibility of PBS at benign, minimally invasive hysterectomy in public hospitals in the Austrian province of Styria in 2014 vs. 2018 (before and after the official recommendation in 2015).

Methodology We reviewed surgical consent forms and operative notes of patients undergoing vaginal or laparoscopic hysterectomy for benign indications in Styria in 2014 and 2018. Ethics approval was obtained.

Result(s)* 1,256 benign, minimally invasive hysterectomies were identified (580 in 2014, 676 in 2018). 68% of patients were consented for PBS in 2014 and 94% in 2018 ($P < 0.05$). The PBS rate in consented patients was 88% in 2014 and 83% in 2018 (n.s.). In 2018 PBS was completed more often at laparoscopic than at vaginal hysterectomy (95% vs. 74%, $P < 0.05$). Age and parity were the major influencing factors for success of PBS.

Conclusion* PBS at minimally invasive hysterectomy was widely performed in Styria even before the official recommendation in 2015, and increased thereafter to 83% overall in 2018. PBS was accomplished somewhat more often at laparoscopic than at vaginal hysterectomy.

403 ANALYSIS OF THE CLINICAL EXPERIENCE WITHIN RUCAPARIB'S EARLY ACCESS PROGRAM IN SPAIN – A GEICO STUDY

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Introduction/Background* Rucaparib is a PARP-1/2/3 inhibitor approved for the treatment of high-grade ovarian cancer (HGOC). In ARIEL3, rucaparib improved PFS as maintenance therapy for platinum (Pt)-sensitive recurrent OC. Study 10, ARIEL2, and ARIEL4 showed rucaparib's benefit as treatment. An observational study was performed in HGOC pts treated within the rucaparib access program (RAP) in Spain. The aim was to better understand rucaparib's management in real-life setting, to optimize future use, considering Pt-sensitive and Pt-resistant BRCAmut treatment and maintenance patients.

Methodology A retrospective study was performed at 22 GEICO hospitals in Spain that treated pts within RAP (600 mg BID) since September 2018. Adult women with high-grade epithelian ovarian, fallopian tube, or primary peritoneal cancer, with medical record available, were included. Patient characteristics, medical history, safety, efficacy, and dosing data were collected.

Result(s)* Between July 2020 and February 2021, 51 pts were recruited with median age 63 years (36-86). At diagnosis, 45.1% of patients harbored gBRCA mutations, 19.6% sBRCA mutations, and 31.4% were BRCAwt. Before rucaparib, pts had ECOG PS 0, 1, or 2 (37.3%, 49.0%, and 5.9%) and 72.5% had measurable disease. The median number of previous lines was 4 (1-9), 51.0% of pts received prior bevacizumab, and notably 25.5% of pts had received a prior PARPi. Rucaparib was given as maintenance, Pt-resistant, and Pt-sensitive treatment in 35.3%, 51.0%, and 13.7% of pts respectively (median dose 557.7 mg [300-600]). 82.4% of pts received rucaparib for ≤12 mo and 17.6% >12 mo. 50.0%

had at least one dose reduction and 60.0% at least one dose interruption. 9.8% discontinued due to rucaparib toxicity and 5 pts remained on treatment upon analysis. Median PFS was 6.0 mo (95% CI 2.5-7.8). For treatment group (19 radiologically-evaluable pts), the disease control rate was 42.0% (21.0% PR and 21.0% SD). Overall, 86.3% of pts had rucaparib-related toxicities, while most common G3-4 hematological events were anemia (13.7%), neutropenia (5.9%), and thrombocytopenia (5.9%).

Conclusion* Rucaparib's safety profile in real-life setting is manageable and efficacy results, even considering heavily pretreated pts, are comparable to those of previous trials. The RAP in Spain showed a consolidated management of rucaparib and, consequently, an improved safety profile.

Abstract 403 Table 1 Patient characteristic and treatment information

	Total (n=51)	Maintenance (n=18)	Treatment (n=33)
Age			
Median	63.0	65.5	63.0
Min	36	44	36
Max	86	86	86
70 y or older	10 (19.6%)	4 (22.2%)	6 (18.2%)
ECOG			
0	19 (37.3%)	7 (38.9%)	12 (36.4%)
1	25 (49.0%)	10 (55.6%)	15 (45.5%)
2	3 (5.9%)	0 (0.0%)	3 (9.1%)
Unknown	4 (7.8%)	1 (5.6%)	3 (9.1%)
Measurable disease	37 (72.5%)	9 (50.0%)	28 (84.8%)
Relevant comorbidities	17 (33.3%)	10 (55.6%)	7 (21.2%)
Rucaparib exposure (months)			
Median	4.5	7.9	2.7
Min	<1	1	<1
Max	30	30	18
Rucaparib dose (mg)			
Median	557.7	553.9	600.0
Min	300	316	300
Max	600	600	600
Dose reductions	n=50	n=18	n=32
0	25 (50.0%)	7 (38.9%)	18 (56.3%)
1	16 (32.0%)	5 (27.8%)	11 (34.4%)
2	8 (16.0%)	5 (27.8%)	3 (9.4%)
3	1 (2.0%)	1 (5.6%)	0 (0.0%)
Dose interruptions	n=50	n=18	n=32
0	20 (40.0%)	8 (44.4%)	12 (37.5%)
1	20 (40.0%)	7 (38.9%)	13 (40.6%)
2	8 (16.0%)	1 (5.6%)	7 (21.9%)
≥3	2 (4.0%)	2 (11.2%)	0 (0.0%)
EoT reason			
PD	36 (70.6%)	13 (72.2%)	23 (69.7%)
Toxicity	5 (9.8%)	1 (5.6%)	4 (12.1%)
Other	5 (9.8%)	1 (5.6%)	4 (12.1%)
Ongoing	5 (9.8%)	3 (16.7%)	2 (6.1%)

Abstract 403 Table 2 Rucaparib-related most common toxicity (per patient)

	Total (n=51) n (%)		Maintenance (n=18) n (%)		Treatment (n=33) n (%)	
AE term (CTCAE 5.0)	All grades	G3-4	All grades	G3-4	All grades	G3-4
Anemia	23 (45.1)	7 (13.7)	5 (27.8)	2 (11.1)	18 (54.5)	5 (15.2)
Thrombocytopenia	13 (25.5)	3 (5.9)	1 (5.6)	0 (0.0)	12 (36.4)	3 (9.1)
Neutropenia	7 (13.7)	3 (5.9)	3 (16.7)	0 (0.0)	4 (12.1)	3 (9.1)
ALT increased	13 (25.5)	1 (2.0)	6 (33.3)	1 (5.6)	7 (21.2)	0 (0.0)
Fatigue	13 (25.5)	2 (3.9)	6 (33.3)	0 (0.0)	7 (21.2)	2 (6.1)
Nausea	13 (25.5)	1 (2.0)	8 (44.4)	1 (5.6)	5 (15.2)	0 (0.0)
AST increased	12 (23.5)	0 (0.0)	7 (38.9)	0 (0.0)	5 (15.2)	0 (0.0)
Creatinine increased	7 (13.7)	0 (0.0)	6 (33.3)	0 (0.0)	1 (3.0)	0 (0.0)
Hyponatremia	7 (13.7)	2 (3.9)	0 (0.0)	0 (0.0)	7 (21.2)	2 (3.9)
ALP increased	6 (11.8)	2 (3.9)	2 (11.1)	1 (5.6)	4 (12.1)	1 (3.0)
Diarrhea	6 (11.8)	0 (0.0)	5 (27.8)	0 (0.0)	1 (3.0)	0 (0.0)
Abdominal pain	5 (9.8)	1 (2.0)	3 (16.7)	0 (0.0)	2 (6.1)	1 (3.0)
Vomiting	5 (9.8)	2 (3.9)	2 (11.1)	0 (0.0)	3 (9.1)	2 (3.9)
Asthenia	4 (7.8)	0 (0.0)	1 (5.6)	0 (0.0)	3 (9.1)	0 (0.0)
Dysgeusia	4 (7.8)	0 (0.0)	3 (16.7)	0 (0.0)	1 (3.0)	0 (0.0)
Pruritus	4 (7.8)	0 (0.0)	3 (16.7)	0 (0.0)	1 (3.0)	0 (0.0)
Constipation	3 (5.9)	0 (0.0)	1 (5.6)	0 (0.0)	2 (6.1)	0 (0.0)
Colonic obstruction	1 (2.0)	1 (2.0)	0 (0.0)	0 (0.0)	1 (3.0)	1 (3.0)
GGT increased	1 (2.0)	1 (2.0)	1 (5.6)	1 (5.6)	0 (0.0)	0 (0.0)
Intestinal obstruction	1 (2.0)	1 (2.0)	0 (0.0)	0 (0.0)	1 (3.0)	1 (3.0)
Pleural effusion	1 (2.0)	1 (2.0)	0 (0.0)	0 (0.0)	1 (3.0)	1 (3.0)
Myelodysplastic syndrome	1 (2.0)	1 (2.0)	0 (0.0)	0 (0.0)	1 (3.0)	1 (3.0)

411 OVARIAN CANCER METASTASES IN THE LIVER AREA: PROPOSAL OF A STANDARDIZED ANATOMO-SURGICAL CLASSIFICATION

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Introduction/Background* The combination of emerging target therapies and continuous technological advancement in surgical procedures support a trend toward a prolonged survival in advanced ovarian cancer (AOC) patients. Upper abdominal carcinomatosis hides challenging locations for complete gross resection in the hands of expert gynecologic oncologists. We developed an anatomo-surgical classification for ovarian cancer metastases in the liver area from a gynecological point of view, aiming to provide an anatomo-topographical tool to address each surgical task and to standardize the nomenclature in the radiological and surgical report.

Methodology After the identification of four conceptually distinct anatomical areas, we used both the three-dimensional anatomical model and the surgical video report to represent them individually.

Result(s)* Our anatomo-surgical classification is divided into 4 distinct categories:

TYPE1 GLISSON'S CAPSULE: superficial metastases involving only the Glisson's sheat with no parenchymal infiltration (either focal or extensive).

TYPE2 LIGAMENTOUS: this is a heterogeneous group defining cancer deposits along the lines of reflection between the liver and surrounding organs. We can further divide it into 'falciform ligament', 'round ligament', 'Arantii and hepato-gastric ligament', 'coronary and triangular ligament' localizations.

TYPE3 HEPATIC HILUM: the porta hepatis is considered as a single entity due to its potentially dual neoplastic involvement both peritoneal or 'external' as hepato-duodenal ligament and lymphatic or 'internal' while involving lymph-nodes along the portal triad.

TYPE4 PARENCHYMAL: we identified, based on surgical management, the 'superficial' intra-parenchymal localization, infiltrating the less than 1 cm in depth, and the fully intra-parenchymal.

Conclusion* Our classification represents a useful guide while planning the surgical strategy to AOC metastases in the liver area.

Identification of each category, specific underlining anatomical pitfalls and its surgical-related management, guarantees a didactic and effective tool in supporting the daily intraoperative decision-making algorithm, and in assigning the specific procedure within a multidisciplinary team, based on surgical competence.