

intolerable toxicity (maximum 35 pembrolizumab cycles; nemvaleukin can be continued). Primary endpoint: investigator-assessed progression-free survival (RECIST v1.1) in the nemvaleukin+pembrolizumab versus chemotherapy arms. Secondary/exploratory endpoints include overall survival, other anti-tumour measures, safety, health-related quality of life, and pharmacokinetic/pharmacodynamic effects.

Results not applicable

Conclusion not applicable

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SURVIVAL OUTCOMES OF ADVANCED OVARIAN CANCER PATIENTS UNDERGOING MAXIMAL EFFORT CYTOREDUCTION

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Introduction/Background Surgery remains one of the main treatment modalities for the treatment of ovarian cancer. Patients with advanced stage disease will likely undergo neoadjuvant chemotherapy as the majority of surgeons is not familiarized with maximal effort cytoreduction. The purpose of the present study is to evaluate morbidity and mortality outcomes of ovarian cancer patients undergoing procedures with and intermediate and high complexity score.

Methodology We performed a retrospective chart review of patients undergoing intermediate and high complexity procedures (according to the Mayo Clinic classification system) between 2008 and 2020. We assessed morbidity and survival outcomes in order to evaluate which subgroups benefited the most from maximal effort cytoreduction.

Results Overall 107 patients were included with a median duration of follow-up of 45 months (24–156). The median surgical complexity score was 7 (4–15). The progression free and overall survival rates of the entire cohort were 28 (22 – 34) and 47 (37–57) months respectively. Sixteen patients experienced a grade IIIB Clavien-Dindo complication. Median high dependency unit stay was 3 days (1–15). Five patients required hospitalization in the intensive care unit. Patients undergoing primary debulking had a clear overall survival benefit compared to patients that had interval debulking surgery (54 months (40–67) vs 35 months (24–46)). Kaplan Meier curves revealed that the difference became evident among patients that survived for at least 50 months. Recurrence free survival was not influenced by this parameter. A progressive decrease in overall survival rates was observed with advancing stage. Complexity of the procedure (intermediate vs high) did not affect survival rates of patients.

Conclusion Maximal effort cytoreduction is feasible and is accompanied by acceptable morbidity and mortality rates. Primary debulking should be considered in appropriately selected patients as this considerably increases overall survival rates of patients.

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PRIMARY AND INTERVAL DEBULKING SURGERY IN ADVANCED OVARIAN CANCER: REAL-WORLD CLINICAL OUTCOMES OF PATIENTS IN 1ST LINE SETTING, ANALYSIS FROM THE FRENCH NATIONAL ESME-UNICANCER DATABASE

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Introduction/Background Primary cytoreductive surgery is the standard of care for advanced ovarian cancer. This work would like to explore the prognostic according the surgical management in advanced ovarian cancer of a real-world multicentre cohort.

Methodology A non-interventional, retrospective study in patients selected from the Epidemio-Strategy and Medical Economics (ESME) Ovarian Cancer (OC) Data Platform of Unicancer, a multicentre real-life database using a supervised, retrospective data collection process was conducted.

Patients treated with surgery for advanced ovarian cancer between January 01, 2011 and December 31, 2017 in 18 French Comprehensive Cancer Centers (FCCC) were included. The database was locked on January 01, 2020. Propensity scores were performed in population analyses.

Results 1831 female patients with FIGO stage III or IV ovarian cancer at diagnosis underwent surgery, including 879 (48%) primary debulking surgery (PDS) and 952 (52%) interval debulking surgery (IDS).

The median follow-up was 59.2 months CI 95% [57.1–61.7]. The median overall survival (OS) was 90.4 months for PDS, CI95% [79.4–95.3] and 47.8 months for IDS, CI95% [43.3–54.1], HR = 0.48 CI 95% [0.41–0.56], p<0.0001. The median progression-free survival (PFS) was 23.6 months for PDS, CI95% [20.9–26.1] and 14.3 months for IDS, CI95% [13.0–16.0], HR = 0.66 CI95% [0.59–0.75], p<0.0001.

In the multivariate Cox analysis, the covariates treatment strategy (PDS versus IDS) HR = 0.57 CI 95% [0.44–0.74], $p < 0.0001$, and residual tumor after surgery HR = 1.78 CI 95% [1.25–2.53], $p < 0.0001$ remain significant as a PFS prognostic factors. The OS prognostic factors was the covariates treatment strategy (PDS versus IDS) ($p < 0.002$), residual tumor after surgery ($p < 0.0001$), age at diagnosis ($p < 0.02$) and BRCA mutation ($p < 0.02$).

Conclusion Our data of real-world are in line with those reported in clinical trial for patient with advanced ovarian cancer in 1st line setting with surgical treatment.

2022-RA-704-ESGO TREATMENT PATTERNS AND TIME TO NEXT TREATMENT AMONG PATIENTS WITH OC IN A REAL-LIFE SETTING IN FINLAND: THE OCRWE-FINLAND STUDY

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Introduction/Background Ovarian cancer (OC) is a disease characterized by a dynamic treatment landscape in the real-life setting. The OCRWE-Finland study aims at describing the real-life burden of patients with OC, including treatment patterns, time to next treatment, disease characteristics and progression, survival, and healthcare resource utilization. This abstract reports on the observed treatment patterns.

Methodology OCRWE-Finland is a multicentre, retrospective, noninterventional study collecting hospital medical records from university hospitals in Helsinki, Turku, and Tampere. Patients with ovarian, fallopian tube, or primary peritoneal cancer who were newly diagnosed as part of routine clinical care and received all OC treatments in these hospitals from 2014–2019 were included. Registry data were collected and combined by Findata (authorization holder), operating under the performance guidance of the Finnish Ministry of Social Affairs and Health.

Abstract 2022-RA-704-ESGO Table 1 Baseline characteristic and first-line treatment patterns among patients with HGSOc

| | Patients with HGSOc N=621 |
|---|---------------------------|
| FIGO stage at diagnosis | |
| Stage IV | 20% |
| Stage III | 55% |
| Stage II | 5% |
| Stage I | 9% |
| No data | 11% |
| First-line treatment | |
| Primary debulking surgery | 59% |
| Neoadjuvant chemotherapy and interval debulking surgery | 21% |
| Chemotherapy only | 12% |
| Residual tumour status after primary debulking surgery | |
| Optimal debulking | 37% |
| Suboptimal debulking | 44% |
| Residual <1cm | 27% |
| Residual ≥1cm | 17% |
| Unknown residual tumour status | 19% |

FIGO, International Federation of Gynaecology and Obstetrics; HGSOc, high-grade serous ovarian cancer.

Results In total, 1711 patients with OC (mean age=65.9 y, StDev=13.4 y) and 621 patients with high-grade serous OC

(HGSOc) (mean age=68.0 y, StDev=10.1 y) were identified. Disease origin was ovaries in 75% of patients and peritoneum in 19%. Baseline characteristics and first-line treatment (TL1) patterns among patients with HGSOc can be found in table 1. During the observation period, 57% of patients received TL2, with 48% of these moving to TL3. The probability of undergoing TL2 was higher among stage III/IV patients and those with residual disease. In TL2, the most common treatment was platinum-based chemotherapy (32%); 26% received 'other chemotherapy', 33% of patients did not receive TL2 during this period but were still alive, and 9% died before initiating TL2.

Conclusion This study documents real-life treatment patterns across lines of treatment among patients with OC and HGSOc during the first years of disease from the 3 biggest university hospitals in Finland. These results can provide useful baseline information about the rapidly evolving treatment landscape in OC in recent years.

2022-RA-706-ESGO PROGNOSTIC IMPACT OF VAGUS NERVE ACTIVITY AT INITIAL MANAGEMENT OF OVARIAN CANCER

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Introduction/Background Finding new modifiable prognostic markers is important in ovarian cancer (OC). The autonomic nervous system plays an important role in cancer initiation and progression. Low parasympathetic nervous system activity is associated with inflammation, oxidative stress and sympathetic activation. Low vagal nerve activity, measured by low heart rate variability (HRV) predicts poor cancer prognosis. Our study examined the prognostic value of HRV in OC.

Methodology We conducted a bicentric retrospective study. We analyzed patients diagnosed with serous OC stage FIGO ≥ IIB, between January 2015 to August 2019, with an electrocardiogram (ECG) available around diagnosis. We used the time domain HRV parameter of the standard deviation of all normal-to-normal beat interval (SDNN) in 10 seconds ECG. Optimal SDNN cut-off was found using the Youden index criteria of time-dependent ROC curve. We carried out multivariable analysis including HRV and well-known OC prognostic factors.

Results We included 202 patients with a median age of 65 years, 93% had stage FIGO IIIC/IV, 56% had complete surgical resection. Median overall survival (OS) was 38.6 months [95%CI:34.4–47.4]. The median SDNN was 11.1 ms (min=1.93; max=74.5), with an optimal cut off of 10 ms to predict OS. Median OS was significantly shorter for patients with low HRV compared to high HRV (26.4 vs 45.1 months; $p < 0.001$). In a multivariable analysis, HRV remained a strong independent prognostic factor with a two-fold higher risk of death among patients with low SDNN compared to those with high SDNN (HR=2.09 [1.40–3.124], $p < 0.001$); other associated factors with higher risk of death were ECOG > 0, high CA125 level and incomplete resection.