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320 STARTING A HIPEC PROGRAMME IN A LOW RESOURCE SETTING

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Objectives Hyperthermic IntraPeritoneal Chemotherapy (HIPEC) after maximal cytoreduction is a promising modality of treating women with ovarian cancer. In order to determine the feasibility of setting up a HIPEC programme in India, we document our initial experience.

Methods Ethics Committee clearance was obtained to start the programme. The electronic medical records of all patients who underwent HIPEC in our department was reviewed.

Results A total of 14 patients underwent HIPEC in the first 2 years: one primary, 6 interval and 7 recurrent cytoreductions.

The women had a mean age of 46.9 years (36 to 62), median performance score of 1 (0 to 2) and a median peritoneal carcinomatosis index (PCI) of 10 (2 to 25).

The histology was serous in 9, mucinous in 4 and endometrioid in one.

Four patients had bowel resection of whom 2 had an end ileostomy and one had an end colostomy. The median duration of surgery was 9 hours (5 to 10) and the median completeness of cytoreduction score was 1 (0 to 2). The drugs used in HIPEC were Cisplatin and Oxaliplatin. The median duration of hospital stay was 9 days (6 to 21).

Two patients were readmitted to hospital and 3 patients had re-laparotomy. The main complications were venous thromboembolism in one, bleeding in one and wound dehiscence in one.

Conclusions Cytoreductive surgery with HIPEC is feasible in a low resource setting with acceptable morbidity where the main limitations are non-availability of operating time and patient's ability to pay for treatment.

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321 MAINTENANCE OLAPARIB FOR BRCA-MUTATED OVARIAN CANCER (OC) PATIENTS IN 1ST LINE AND PLATINUM-SENSITIVE RELAPSED (PSR) SETTINGS: MAXIMIZING TREATMENT OPPORTUNITIES

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Objectives In Phase III randomized trials, maintenance therapy with the PARP inhibitor olaparib demonstrated a significant benefit versus placebo in BRCA-mutated advanced OC patients who had a complete/partial response to platinum-based chemotherapy (PBC) in newly diagnosed (SOLO1; NCT01844986) and PSR (SOLO2/ENGOT-Ov21; NCT01874353) settings. We investigate missed opportunities for maintenance olaparib in relapsed settings.

Abstract 321 Table 1

Patient setting	Cohort, n	Calculation	Population eligible for olaparib, n (%)
Newly diagnosed BRCAm	1000	1000 × 0.75 (first-line response rate) × 1.12 (BRCA response rate factor)	844 (84)
PSR OC BRCAm	1000	1000 × 0.75 (first-line response rate) × 1.12 (BRCA response rate factor) × 0.806 (platinum sensitivity) × 0.646 (second-line response rate)	439 (44)

Methods Published response rates to PBC in newly diagnosed BRCA-mutated advanced OC are scarce. These are estimated by applying a BRCA response rate factor determined from a population-based study (Alsop et al) to expected PBC response rates in newly diagnosed high grade serous OC (75%). For BRCA-mutated PSR OC, response to second-line PBC was 64.6% (Alsop et al). Platinum sensitivity for second-line PBC eligibility was determined from placebo patients in SOLO1 remaining progression free after 6 months (80.6%).

Results In newly diagnosed and PSR settings, predicted proportions of eligible patients for olaparib are 84% and 44%, respectively (table 1). Missed treatment opportunities in PSR settings are likely due to platinum resistance and non-response to second-line PBC. Approximately 48% of patients could miss the opportunity to benefit from PARP inhibitor maintenance if untreated in the first line.

Conclusions Earlier olaparib therapy provides the chance of long-term remission and prevents patients missing opportunities for second-line PARP inhibitor maintenance due to platinum resistance or non-response to PBC. Disease burden associated with multiple chemotherapy lines in advanced settings is also reduced or delayed.

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322 THE USE OF CURETTAGE IN THE MANAGEMENT OF DIAPHRAGMATIC INVOLVEMENT IN PATIENTS WITH PRIMARY ADVANCED-STAGE OVARIAN OR PERITONEAL CANCER

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Objectives To know the usefulness of diaphragm curettage to remove all metastasis in patients with primary advanced-stage ovarian or peritoneal cancer, with diaphragmatic involvement.

Methods In 16 consecutive patients with advanced primary epithelial ovarian or peritoneal cancer with diaphragmatic involvement we performed diaphragm curettage with a big sharp curette (Aesculap N 16) as a part of cytoreductive surgery, after liver mobilization. We used narrow curettes in areas with difficult access. The procedure had limited bleeding controlled by coagulation and hot compress.

Results In all 16 patients, the curettage removed completely the tumor implants, in one or both diaphragms, without residual disease. In the postoperative time, 3 patients had basal pleural effusion, reabsorbed spontaneously.

Conclusions Diaphragmatic curettage is a safe and effective procedure to treat the diaphragm involvement in cytoreductive