For the HRs (olaparib tablets 300 mg bid for up to 24 months plus bevacizumab 15 mg/kg q3w for up to 15 months in total vs placebo plus bevacizumab), the size of the circle is proportional to the number of events, the gray band represents the 95% CI for the overall population and the dashed line indicates the point of no effect. PFS assessed using modified RECIST v1.1

*For higher-risk patients, median PFS was 20.3 months in the olaparib plus bevacizumab group vs 14.7 months in the placebo plus bevacizumab group, 36.0 vs 16.0 months, respectively, in the HRD-positive subgroup, 16.6 vs 13.9 months, respectively, in the HRD-negative/unknown subgroup, and 36.0 vs 19.4 months, respectively, in the subgroup with a tumour BRCAm

†For lower-risk patients, median PFS was 39.3 months in the olaparib plus bevacizumab group vs 22.9 months in the placebo plus bevacizumab group, NR vs 22.1 months, respectively, in the HRD-positive subgroup, 23.8 vs 22.9 months, respectively, in the HRD-negative/unknown subgroup, and NR vs 22.2 months, respectively, in the subgroup with a tumour BRCAm

bid, twice daily; BRCAm, BRCA mutation; CI, confidence interval; HR, hazard ratio; HRD, homologous recombination deficiency; NR, not reached; PFS, progression-free survival; q3w, every 3 weeks

Abstract 18 Figure 2 Analysis of investigator-assessed PFS in higher-risk* and lower-risk† patients, including in biomarker subgroups

Introduction In the Phase III PAOLA-1/ENGOT-ov25 trial (NCT02477644), adding maintenance olaparib to bevacizumab improved progression-free survival (PFS) in patients with advanced ovarian cancer in response after first-line platinum-based chemotherapy plus bevacizumab (HR 0.59; 95% CI 0.49–0.72) (Ray-Coquard et al. NEJM 2019). Outcomes in patients classified by clinical risk according to biomarker status are unknown.

Methods Patients were classified as higher-risk (stage III patients with upfront surgery and residual disease or who received neoadjuvant chemotherapy, or stage IV patients) or lower-risk (stage III patients with upfront surgery and no residual disease). This exploratory analysis evaluated PFS in higher-risk and lower-risk patients, including by biomarker status: homologous recombination deficiency (HRD)-positive, HRD-negative/unknown and tumour BRCA mutation (BRCAm)-positive.

Results Of 806 randomized patients, 74% were higher risk and 26% were lower risk, with median follow-up of 22.4 and 23.8 months, respectively. PFS significantly favoured olaparib plus bevacizumab versus placebo plus bevacizumab in higher-risk and lower-risk patients. In both higher- and lower-risk patients, the greatest PFS benefit was seen with olaparib plus bevacizumab versus bevacizumab alone in the HRD-positive subgroup (figures 1 and 2) and the subgroup with a tumour BRCAm (figure 2). Outcomes in the higher- and lower-risk HRD-negative/unknown subgroups are shown in figure 2.

Conclusions In PAOLA-1, maintenance olaparib plus bevacizumab provided a substantial PFS benefit over bevacizumab alone in higher-risk and lower-risk patients, especially in the HRD-positive and BRCAm populations.

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IGCS20_1248

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OVERALL SURVIVAL AFTER SURGICAL STAGING BY LYMPH NODE DISSECTION VERSUS SENTINEL LYMPH NODE BIOPSY IN ENDOMETRIAL CANCER: A NATIONAL CANCER DATABASE STUDY

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Objectives To investigate the association between the type of lymph node (LN) assessment and overall survival (OS) in endometrial cancer (EC).

Methods Patients with stage I-III EC who underwent a hysterectomy and LN assessment from 2012 to 2015 were identified from the National Cancer Database. Multivariable Cox proportional hazards regression analysis was performed to assess factors associated with OS.

Results Of 68,614 patients identified, 64,796 underwent lymphadenectomy (LND) only, 1,777 sentinel lymph node biopsy only (SLN-B), and 2,041 both procedures (SLN-B/LND). On multivariable analysis, SLN-B and SLN-B/LND were not associated with different OS compared to LND (hazard ratio [HR]: 0.92; 95%CI: 0.73–1.17 - HR: 0.91; 95%CI: 0.77–1.07,

respectively). Similarly, when stratified by LN status, SLN-B and SLN-B/LND reported similar OS compared to LND, both in negative (HR: 1.03; 95%CI: 0.85–1.26 – HR :0.95; 95% CI: 0.73–1.23, respectively) and positive (HR: 0.92; 95%CI: 0.55–1.54 – HR: 0.76; 95%CI: 0.57–1.03, respectively) LNs. Including only LND with ≥ 10 pelvic and ≥ 1 para-aortic LNs removed, no difference in OS was observed between LND and SLN-B or SLN-B/LND in the entire cohort, and in negative or positive LNs. In all analyses, older age, Charlson-Deyo Score ≥ 2 , black race, higher American Joint Committee on Cancer (AJCC) pathologic T stage, grade 3, presence of lymphovascular infiltration, type-2 histology, and absence of chemotherapy or radiation therapy were independently associated with worse OS.

Conclusions When compared to SLN-B or SLN-B/LND, LND does not appear to improve OS in EC, even in the presence of LN metastases.

IGCS20_1082

20 LONG-TERM SURVIVAL OUTCOMES OF INTRAVENOUS VS INTRAPERITONEAL CHEMOTHERAPY IN THE TREATMENT OF ADVANCED OVARIAN CANCER

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Objectives The role of intraperitoneal (IP) chemotherapy in the management of advanced ovarian cancer has been controversial. We aimed to compare survival outcomes associated with IP vs intravenous (IV) chemotherapy.

Methods We reviewed the long-term survival records of 271 women with stage IIIC or IV high-grade serous ovarian cancer treated with primary cytoreductive surgery (PCS) followed by IP or intravenous (IV) chemotherapy between 2001–2015 with a minimum follow-up of 4 years. 5-year progression free (PFS) and overall survival (OS) rates were compared using Kaplan-Meier survival analysis and covariates were evaluated using Cox regression analysis.

Results Women who received IP chemotherapy after PCS (n=91) were more likely to have undergone aggressive surgery (p<0.001), longer surgery (p<0.001), and had no residual disease (p<0.001) compared to the IV arm (n=180). Median follow-up was 51.6 months. Five-year PFS was 19% vs. 18% (p=0.63) and OS was 73% vs. 44% (p=0.00016) in the IP vs. IV arms, respectively. After controlling for covariates in a multivariable model, the use of IP was no longer a significant predictor of OS in the entire cohort (p=0.12). In patients with 0 mm residual disease, PFS was 28% vs. 26% (p=0.67) and OS was 81% vs. 60% (p=0.059) in IP (n=61) vs. IV (n=69), respectively. In patients with residual of 1–9 mm, PFS was 30% vs. 48% (p=0.076) and OS was 60% vs. 43% (p=0.74) in IP (n=29) vs. IV (n=31), respectively.

Conclusions IP chemotherapy showed a trend towards improved survival over conventional IV chemotherapy, especially in patients with no residual disease.

IGCS20_1170

21 CAN CONISATION SPECIMENS PREDICT SENTINEL LYMPH NODE STATUS IN EARLY-STAGE CERVICAL CANCER? A SENTICOL GROUP STUDY

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Objectives The goal of this study was to determine pathologic risk-factors on conisation specimen predicting the sentinel lymph node (SLN) in early-stage cervical cancer.

Methods An ancillary analysis of 2 prospective multicentric database on SLN biopsy for cervical cancer (SENTICOL I and II) were carried out. Patients with IA to IB1 FIGO stage, who underwent SLN biopsy and conisation were included.

Results and Discussion Between January 2005 and July 2012, 161 patients from 25 French centers fulfilled the inclusion criteria. The majority of patients had IB1 clinical FIGO stage (81.4%) and squamous cell carcinoma (76.3%). Macrometastases, micrometastases and isolated tumor cells (ITCs) were found in 4 (2.5%), 6 (3.7%) and 5 (3.1%) patients respectively. Compared to negative SLN patients, patients with micrometastases or macrometastases were more likely to have lymphovascular space invasion (LVSI) (60% vs 29.5%, p = 0.04) and deep stromal invasion (DSI) ≥ 10 mm (50% vs 17.8%, p = 0.046). By multivariate analysis, DSI ≥ 10 mm on conisation specimens was an independent factor of micrometastases and macrometastases (OR = 3.91, 95%CI = [1.03 – 14.9], p = 0.046). Among the 94 patients with DSI < 10 mm and absence of LVSI on conisation specimens, 4 patients (4.2%) had ITCs and only one (1.1%) had micrometastases.

Conclusions Patients with DSI ≥ 10 mm and LVSI had higher risk of micrometastatic and macrometastatic SLN. In this subpopulation, SLN mapping should be performed meticulously to avoid missing metastatic nodes.

IGCS20_1222

22 COVID-19: A REVIEW OF THE IMPACT OF THE PANDEMIC ON OVARIAN CANCER PATIENT ADVOCACY ORGANIZATIONS FROM AROUND THE WORLD

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Introduction The World Ovarian Cancer Coalition is a not-for-profit organization that works with patient organizations in 47 countries around the world to ensure that every woman diagnosed with ovarian cancer has the best chance of survival and best quality of life where ever she may live.

Methods Concerned about the impact of COVID-19 on all aspects of their members' work, a survey was conducted as part of a joint effort with four other global cancer coalitions.