Methods we reviewed retrospectively all the data of 184 patients receiving complete cytoreductive surgery, whether as primary or interval debulking between January 2005 and October 2019 at Hôtel-Dieu de France University Hospital.

Results Median age at surgery was 56 years. 41.8% benefited from a primary cytoreductive surgery while 42.9% of patients received their surgery after a neoadjuvant chemotherapy. 74% of patients were in stage III. High-grade serous epithelial ovarian cancer was the most encountered histology (69%). Bowel resection and upper abdominal surgery was needed in 46% and 39.1% of cases, respectively. Survival rate was 66% (122 out of 184 patients). No recurrence was noted in 53.8% of cases and 74.7% of recurrences occurred after 12 months. According to cox regression test, better survival was significantly correlated to younger age (< 50 years), negative lymph node status, lymph node ratio (<0.18), early stage, primary surgery, no bowel resection, no more than one positive lymph node (p=0.006, p=0.000, p=0.000, p=0.001, p=0.000, p=0.000, respectively). Early recurrence was correlated to advanced stage (p=0.000), positive lymph node status (p=0.002), bowel resection (p=0.046), interval surgery (p=0.025). In the multivariate analysis, survival was only correlated to lymph node status, lymph node ratio, stage, absence of bowel resection and number of positive lymph nodes.

Conclusion Negative lymph node status, LNR <0.18, early stage, absence of bowel resection and the presence of only one positive LN predict a better survival.

IGCS20_1428

Impact of a Laparoscopic Triage Program for Advanced Ovarian Cancer on Surgical Outcomes, Disease-Free Survival, and Overall Survival

Introduction This study evaluates whether implementing a laparoscopic triage algorithm (LSC) to grade initial disease burden impacts surgical outcomes, disease-free survival (DFS), and overall survival (OS) in advanced ovarian cancer (OC).

Methods In 2013, LSC was implemented for advanced high-grade serous OC. LSC scores volume and distribution of intra-abdominal disease in order to disposition patients to either primary cytoreductive surgery (PDS) or neoadjuvant chemotherapy (NACT) followed by interval cytoreduction. Outcomes for patients offered management with LSC (post-LSC) were compared to a cohort from 2010–2012 who would have qualified for laparoscopy (pre-LSC). Summary statistics were used to describe surgical outcomes, and DFS and OS were estimated using the Kaplan-Meier method.

Results Between 2013–2016, 201 OC patients were offered LSC; 182 underwent laparoscopy. We identified 161 pre-LSC control patients for comparison. There were no differences in clinico-demographic features between both cohorts. Prior to implementing LSC, 64 (40%) patients underwent PDS compared to 88 (44%) post-LSC (p=0.42). Complete cytoreduction (R0) was achieved more frequently in the post-LSC cohort (81 vs 51%, p<0.001). There were no differences in median DFS or OS between pre- and post-LSC cohorts (DFS 17 vs 16 months, p=0.76; OS 45 vs 48 months, p=0.38). However, within the PDS group, a significantly greater median OS was observed in post-LSC compared to pre-LSC cohort (not reached vs 51 months, p<0.013).

Conclusion Our data suggest that LSC allows for a greater R0 resection rate and, for patients triaged to PDS, is associated with improved median OS.
(NO-LND). We compared surgical outcomes (operative time, blood loss, need for blood transfusions) and complications within 30 days from surgery (stratified as follows: intra-operative, in-hospital, post-discharge, non-surgical).

**Results** Overall 109 patients were included: 71 (65.45%) and 38 (34.56%) in LND and NO-LND groups, respectively. No differences were found in terms of baseline characteristics between the groups. Surgical approach was laparoscopic in 95 patients (87.16%) and open surgery in 14 (12.84%). Median operative time was 325 min (240–390) for LND and 135 (170–200.5) for NO-LND (p<0.001). No significant differences between the groups were found in terms of blood loss, transfusion rates and complications.

**Conclusions** The execution of systematic lymphadenectomy for aEOC was associated with prolonged operative time. However, in a referral center for minimally invasive surgery, the retroperitoneal staging did not influence the overall surgical morbidity.

**IGCS20_1430**

**REAL WORLD OUTCOMES OF OLAPARIB MAINTENANCE THERAPY IN PATIENTS WITH BRCA1/2-MUTATED PLATINUM-SENSITIVE EPITHELIAL OVARIAN CANCER**

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**Introduction** Maintenance Olaparib is approved for use after response to platinum-based chemotherapy in both first line and relapsed BRCA-mutated ovarian cancer. Here we present real world outcomes for women treated in a single institution.

**Methods** Between January 2017 and November 2019, data was collected retrospectively from patients with a germ-line or somatic BRCA mutation who received at least one cycle of Olaparib after > 4 cycles of platinum-based chemotherapy.

**Results** 53 patients were included in analysis (median age 60 years; 40 relapsed, 13 first line). In relapse, 14 (35%) continued on olaparib and 20 (50%) patients had died (median follow-up 21 months, range 8–42 months). Median progression free survival (PFS) was 13 months (95%CI 8.4–17.6 months). 5 patients had a PFS of over 2 years. Median overall survival (OS) was 24 months (95%CI 21.3–26.7 months). In first line, (median follow-up 12 months, range 8–16 months), 5 patients (38%) had progressed and 2 (15%) had died.

Overall, 27 patients (53%) required dose interruption (DI), and 36 (68%) required a dose reduction (DR). The most common reasons for DR were fatigue and anaemia (both 8 patients, 22%). One patient had grade 3 pneumonitis, one had a grade 4 allergic reaction, and one developed a secondary cancer (SCC of tongue) whilst on treatment.

**Conclusions** DR were more common in all patients and PFS and OS in the recurrent population was shorter in a real world population than in published trial data, but longer than in the placebo arm. Long term responders are seen.