

previous to dChR may reduce the tumour burden and improve symptoms. We evaluated the overall survival [OS] (primary outcome), the complete radiological response rate [CRRR] and the disease-free survival [DFS] (secondary outcomes) of the patients [pts] treated with iChT+dChR at our institution.

Methodology This is a Portuguese, single-centre, retrospective cohort study, including all LACC pts treated with QRTD between 2012 and 2019. The control group received dChR and the experimental group iChT+dChR. Standard uni/multivariate analyses were performed, with logistic regression models assessing the impact of iChT on CRRR, and Cox regression models for OS/DFS.

Results 57 pts (median age 53yo, 90% squamous cell carcinoma) were included; 1 with FIGO IB2 stage, 3 IB3, 1 IIA2, 28 IIB, 5 IIIB, 11 IIIC and 8 IVA; 45 were treated with dChR and 12 with iChT+dChR (carboplatin/paclitaxel, median 3 cycles). FIGO staging was higher in the iChT+dChR group ($p<0.001$). One patient progressed during iChT, and all others were treated with dChR (1 with carboplatin, 55 with cisplatin, median 6 cycles/66.6Gy); 39% were treated with brachytherapy boost [BT]. The response rate was evaluable in 51 pts (5 died before radiological evaluation and 1 was waiting for it at the time of inclusion). The CRRR was lower in the iChT+dChR group (42% vs 76%, $p=0.03$), but not after adjusting for age, FIGO stage and BT use ($p=0.06$). With a median follow-up of 49 months, 23 pts died (33% of the dChR group and 67% of the iChT+dChR group): 13 due to progression, 3 due to treatment complications (radiation enterocolitis, pelvic fistulization/abscess), and 7 due to other causes. In univariate analysis, both DFS (median 11.3 vs 80.2 months, HR 5.8, $p<0.001$) and OS (median 22.2 months vs NR, HR 3.4, $p=0.006$) were lower in the iChT+dChR group. In multivariate analysis, adjusting for age and FIGO stage, the difference remained significant on DFS ($p=0.01$) but not on OS ($p=0.10$).

Conclusion Pts treated with iChT had worse CRRR, DFS and OS compared with dChR alone, possibly due to selection bias caused by inclusion of pts with worse prognosis in the iChT group. Although our data does not support the addition of iChT to dChR in LACC pts, it may be considered in symptomatic pts, with urgent need for treatment.

Disclosures Pedro Simões (presenting author) has no potential conflicts of interest to declare.

João Godinho – Scientific Advisory Board: Grunenthal

Luísa Leal-Costa has no potential conflicts of interest to declare.

Mafalda Casa-Nova – Scientific Advisory Board: Roche, Pfizer, Merck; Honoraria received: AstraZeneca, Tesaro, Novartis

Fernando Igreja has no potential conflicts of interest to declare.

Gustavo Mendinhos has no potential conflicts of interest to declare.

Rosa Madureira has no potential conflicts of interest to declare.

Vanessa Monteiro has no potential conflicts of interest to declare.

Vera Mendonça has no potential conflicts of interest to declare.

José Luís Passos-Coelho – Advisory/consultancy: Roche, Novartis, AstraZeneca, Lilly; research Grant/Funding (self): Roche, Novartis

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IMPACT OF TREATMENT MODALITY ON SURVIVAL OF FIGO STAGE IIB CERVICAL CANCER: A PROPENSITY-SCORE MATCHING ANALYSIS BASED ON IMPACT OF TREATMENT MODALITY ON SURVIVAL OF FIGO STAGE IIB CERVICAL CANCER: A PROPENSITY-SCORE MATCHING ANALYSIS BASED ON SURVEILLANCE, EPIDEMIOLOGY, AND END RESULTS DATABASE

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10.1136/ijgc-2020-ESGO.28

Introduction/Background Concurrent chemoradiotherapy is the standard of care for FIGO stage IIB cervical cancer. However, there remains a role of surgical treatment in these patients. The aim of this study was to investigate the impact of treatment modality on survival of patients with stage IIB cervical cancer.

Methodology Patients with stage IIB cervical cancer registered in the Surveillance, Epidemiology, and End Results database between 1988 and 2015 were identified and grouped according to their treatment modalities. For patients identified as surgical group, only those receiving both hysterectomy and chemotherapy were included. For patients identified as non-surgical group, only those receiving both beam radiation and chemotherapy were included. A 1:1 propensity score matching (PSM) were performed to adjust the baseline characteristics.

Results A total of 4718 eligible patients were identified, of whom 902 were in the surgical and 3816 in the non-surgical group. Patients undergoing surgery were younger and were more likely to be married, non-Black race, non-squamous cell carcinoma, N1 stage, and have medical insurance, small tumor compared to those receiving non-surgical treatment ($P=0.037$ for insurance; $P<0.001$ for all of others). Before PSM, the surgical group showed significantly improved overall survival (OS) compared with the non-surgical group ($P=0.005$), while the difference in cancer-specific survival (CSS) only approached significance ($P=0.084$). After PSM, both the differences in OS and CSS between the two groups reached significance ($P<0.001$, both). In multivariate analysis, the treatment modality was found to be an independent factor for both CSS (hazard ratio [HR] =1.276, 95% confidence interval [CI] 1.084–1.502, $P=0.003$) and OS (HR=1.312, 95%CI 1.129–1.524, $P<0.001$). Other independent factors for both OS and CSS included histological type, tumor size and N-stage. Age was an independent factor for OS but not CSS. Subgroup analysis revealed that patients receiving radiotherapy prior to surgery had significantly improved CSS compared with those treated by other modalities ($P<0.001$), and that the omission of brachytherapy in non-surgical treatment was associated with significantly decreased CSS ($P<0.001$). Furthermore, for patients with squamous-cell histology, surgical and non-surgical treatments provided similar CSS ($P=0.123$). However, for patients with non-squamous-cell histology, surgical treatments provided significantly improved CSS compared with non-surgical ($P=0.002$).

Conclusion The treatment modality has significant impact on survival of patients with stage IIB cervical cancer. Surgical treatment should be preferentially considered in patients with non-squamous-cell histology. Chemoradiotherapy with completion surgery may be the most effective treatment. However,

when non-surgical treatment was selected, the omission of brachytherapy should be avoided.

Disclosures The authors declare that they have no competing interests.

361 REAL-WORLD HEALTHCARE COSTS BY LINE OF THERAPY AMONG NEWLY DIAGNOSED CERVICAL CANCER PATIENTS AND CERVICAL CANCER PATIENTS NEWLY INITIATING SYSTEMIC THERAPIES

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10.1136/ijgc-2020-ESGO.29

Introduction/Background There are little data describing the economic burden among newly diagnosed and advanced cervical cancer patients, by line of therapy (L). NCCN recommends the use of systemic treatment for advanced cervical cancer patients. Therefore, this study aimed to assess healthcare costs among newly diagnosed cervical cancer patients and those newly initiating systemic treatments.

Methodology This was a retrospective observational study conducted using the Optum Clinformatics DataMart database. The first cohort consisted of cervical cancer patients newly diagnosed between January 2015 – June 2018, and continuous enrollment for 12 months prior and 6 months post diagnosis. The start of 1L was the date of the first treatment. Treatments initiated within 90 days of a surgery or the end of radiotherapy, and systemic treatment started within 28 days of any previous treatment were part of the same treatment line.

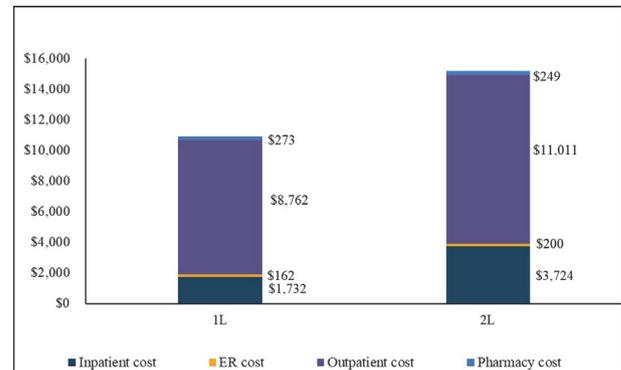
The second cohort consisted of cervical cancer patients with ≥2 claims for systemic therapy (i.e., chemo- or immunotherapy) within a 4-week period between June 2014 – October 2018, and continuously enrolled for 6 months prior and 3 months post therapy initiation. All claims for the same systemic therapy without a >90-day gap, or initiation of a new systemic therapy within 28 days of a previous treatment were attributed to the same treatment line. Claims for adjuvant systemic therapy (i.e., within ±90-days of a cervical cancer-related surgery) were excluded.

The per patient per month (PPPM) components of healthcare costs attributable to 1L and 2L were summarized for both cohorts (figures 1 and 2). Analyses for the second cohort were stratified by the presence of comorbid non-cervical cancers prior to systemic therapy initiation.

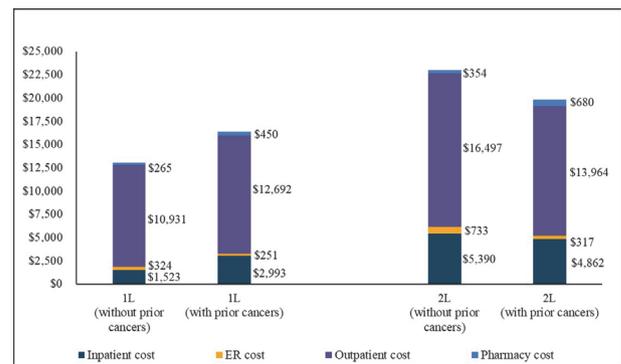
Results The first cohort included 655 patients who received at least 1L of which 162 received 2L. The mean PPPM healthcare cost from diagnosis to end of follow-up was \$10,121. The mean PPPM healthcare costs (figure 1) attributable to 2L (\$15,183) exceeded that of 1L (\$10,929).

The second cohort included 1,229 patients who newly initiated 1L of which 357 received 2L. The mean PPPM healthcare cost from initiation of systemic therapy to end of follow-up was \$15,463. The PPPM healthcare costs (figure 2) was higher during 2L versus 1L (without prior cancers: \$22,973 vs \$13,044; with prior cancers: \$19,822 vs \$16,387). Outpatient costs accounted for >70% of total PPPM healthcare costs attributable to 1L and 2L for both cohorts.

Conclusion Moving from 1L to 2L was associated with an increase in healthcare costs which may be indicative of disease progression/recurrence.



Abstract 361 Figure 1 Mean per patient per month healthcare costs by line of therapy among newly diagnosed cervical cancer patients



Abstract 361 Figure 2 Mean per patient per month healthcare costs by line of therapy among cervical cancer patients newly initiating systemic therapy

Disclosures This study was funded by Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., Kenilworth, NJ, USA. Chizoba Nwankwo is an employee of Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., Kenilworth, NJ, USA. Anuj Shah, Ruchit Shah, Shelby Corman, and Nehemiah Kebede are employees of Pharmerit International, which received consulting fees related to this study.

363 STUDY OF NEOADJUVANT CHEMOTHERAPY WITH A CARBOPLATIN AND TAXOL FOLLOWED BY CHEMORADIATION VERSUS CHEMORADIATION FOR LOCALLY ADVANCED CERVICAL CANCER

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10.1136/ijgc-2020-ESGO.30

Introduction/Background The incidence of locally advanced cancer cervix (LACC) in developing countries is still high due to the absence of regular screening programs and vaccination. Besides, the survival in LACC patients remains low. So we conducted this study to evaluate the use of neoadjuvant chemotherapy (NAC) induction before the definitive concomitant chemoradiation (CCR) for downstaging of the tumor.

Methodology A 68 patients with LACC (International Federation of Gynecology and Obstetrics FIGO stage IB2 to IVA) randomly assigned to group A (received three cycles of NAC with Carboplatin AUC5 + Taxol 175 mg/m2 followed by the