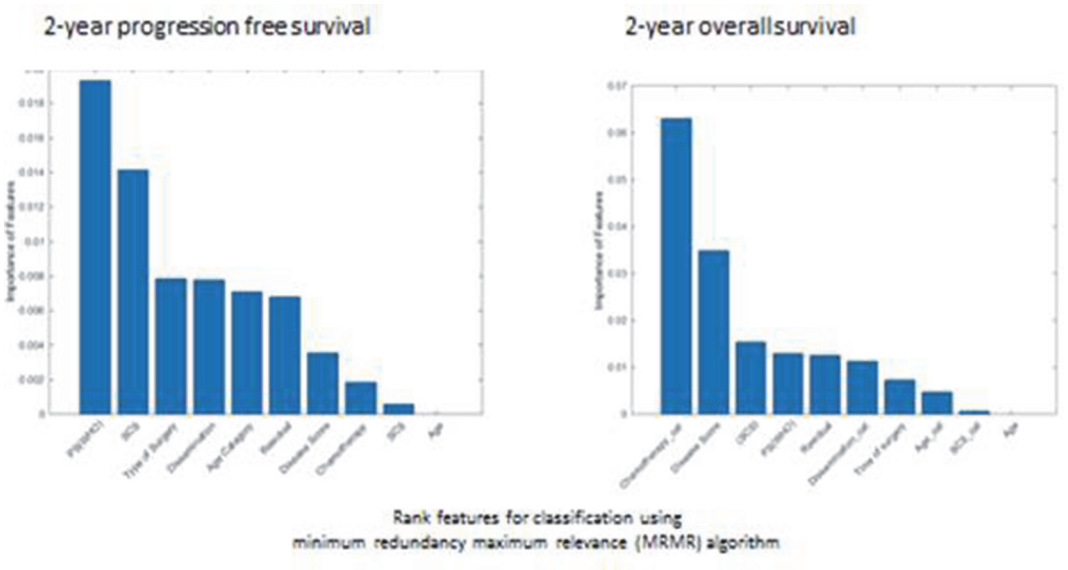
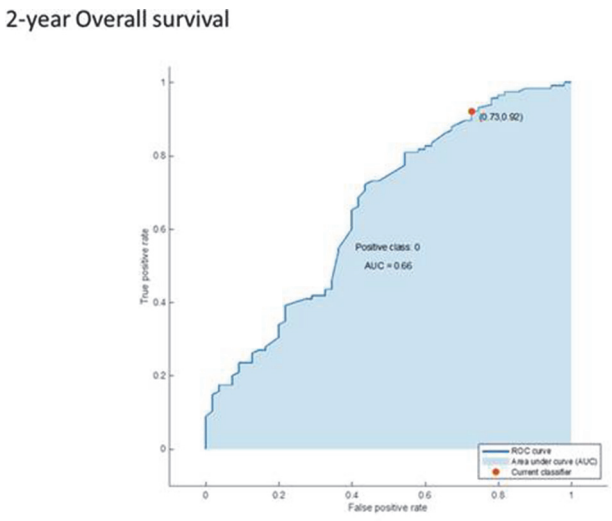


Abstract 332 Figure 1



Abstract 332 Figure 2

were considered in the negative class. The study was restricted to the most common prognostic variables and focused on predictive model comparisons. Dataset was split into training and test cohorts with repeated random sampling until there was no significant difference (p=0.20) between the two cohorts with respect to all variables.

Results 172 out of 209 patients with fully curated data were eligible for 2-year prognosis prediction analysis. 104/172 (60%) and 55/172 (32%) patients had disease recurrence or died of disease within two years, respectively. The variable importance for the 2-year progression free survival (PFS) and overall survival (OS) is shown in figure 1. A combination of good performance status, upfront cytoreduction and increased surgical complexity score best predicted 2-year PFS with an accuracy of 63% and 62.1% for the SVM and K-NN classifiers, respectively. SVM best predicted 2-year OS by a combination of Carboplatin/Taxol chemotherapy, low disease score, no residual disease, increased surgical complexity score, and upfront cytoreduction with an accuracy of 71.6% (AU-ROC: 0.66) (figure 2).

Conclusion ML appears to be promising for accurate estimation of HGSOC prognosis. We provide evidence as to what combination of prognosticators leads to the largest impact on the HGSOC two-year prognosis. The cohort is currently expanding to further examine the short term vs long term contribution of the clinical variables from the comparative models

Disclosures No disclosures.

336 THE EFFECT OF ENDOMETRIOSIS ON THE PROGNOSIS OF OVARIAN CLEAR CELL CARCINOMA: THE JURY IS STILL OUT

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Introduction/Background Women with endometriosis carry an increased risk for ovarian clear cell ovarian carcinoma (OCCC), also referred to as 'endometriosis-associated ovarian carcinoma'. Considered as the precursor lesion of a subset of OCCC, the prognostic role of endometriosis amongst women with OCCC remains a field of contention. Few studies have evaluated the prognostic significance of the concurrent endometriosis with conflicting results. The aim of this study was to ascertain the effect of endometriosis on the prognosis of OCCC.

Methodology This was a retrospective cohort study, from 2000 to 2019. Population-based prospectively collected data on OCCC with or without concurrent endometriosis were retrieved via the Pan-Birmingham Gynaecological Oncology database. Ninety-four women with a primary diagnosis of OCCC have been divided into groups based upon the detection of cancer arising from ovarian endometriosis (n=48,

51.1%) or not (n= 46, 48.9%) according to Samson and Scott criteria. Chi-squared test, t-test, and univariate/multivariate Cox regression were used. Survival curves were plotted via the Kaplan-Meier method, whilst survival differences were examined via the log-rank test for categorical variables or Cox regression for continuous variables. All reported p-values were two-tailed. Statistical significance was set at p-value <0.05. The statistical analysis was performed using Stata version 16.1 (Stata Corporation, TX, USA).

Results Women with OCCC arising from endometriosis had significantly lower levels of pre-operative CA-125 (434.63 ± 1135.57 Vs 867.30 ± 1609.67, p-value=0.02) and significantly lower incidence of post-operative residual disease (RD) (p-value=0.02). Age, post-menopausal status, FIGO stage and incidence of capsule rupture were not statistically significant. The mean overall survival (OS) and overall progression free survival (PFS) were 86.35 (95% CI 69.47 – 103.22) and 115.97 (95% CI 98.77 – 133.17) months, respectively. The presence of endometriosis did not affect neither the OS (87.99 Vs 75.30, p-value=0.25) nor the PFS (111.13 Vs 117.42, p-value=0.48). In univariate analysis, the FIGO stage II-IV and RD were correlated with poorer OS, whilst capsule rupture (CR) with poorer PFS. In multivariate analysis, FIGO stage [HR=2.86 (95% CI 1.47 – 5.55), p-value=0.002] and RD [HR=2.52 (95% CI 1.28 – 4.94, p-value=0.007) were found independent predictors for OS, whilst CR [HR=0.3 (95% CI 0.11 – 0.82), p-value=0.02] for PFS, respectively. No factors affected OS after stratification by stage.

Conclusion In this cohort concurrent endometriosis was not a predictive factor for the survival of OCCC women. Further studies are warranted to ascertain whether OCCC with or without coexisting endometriosis develop via distinct pathogenic pathways.

Disclosures Nil to disclose.

347 EFFICACY AND SAFETY OF NIRAPARIB IN OLDER PATIENTS (PTS) WITH ADVANCED OVARIAN CANCER (OC): RESULTS FROM THE PRIMA/ENGOT-OV26/GOG-3012 TRIAL

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Introduction/Background The PRIMA/ENGOT-OV26/GOG-3012 (PRIMA) trial showed that niraparib significantly improves progression-free survival (PFS) in pts with newly diagnosed advanced OC that responded to first-line platinum-based chemotherapy (CT) (hazard ratio [HR] 0.62; 95% CI 0.50–0.76). Here we discuss the impact of age on efficacy and safety of niraparib.

Methodology This double-blind, placebo (PBO)-controlled phase 3 trial evaluated niraparib in pts with newly diagnosed, advanced, high-grade serous or endometrioid ovarian, primary peritoneal, or fallopian tube cancer with a complete or partial response to first-line platinum-based CT. Pts were randomised 2:1 to receive either a fixed starting dose (FSD) of 300 mg niraparib or PBO QD. A protocol amendment introduced an individualised starting dose (ISD): 200 mg QD in pts with bodyweight <77 kg or platelet count <150,000/µL or 300 mg QD for all others. Pts were dichotomized by age group <65 vs ≥65 years old (yo) to analyse efficacy and

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	Niraparib		Placebo	
Safety population	**<65 yo n=294**	**≥65 yo n=190**	**<65 yo n=145**	**≥65 yo n=99**
Any-grade TEAE, n (%)				
Thrombocytopenia event[a]	187 (64)	134 (71)	8 (6)	4 (4)
Anemia event[b]	185 (63)	126 (66)	21 (14)	22 (22)
Neutropenia event[c]	126 (43)	79 (42)	13 (9)	6 (6)
Grade ≥3 TEAE, n (%)				
Thrombocytopenia event[a]	101 (34)	87 (46)	0	1 (1)
Anemia event[b]	98 (33)	52 (27)	1 (1)	3 (3)
Neutropenia event[c]	60 (20)	40 (21)	2 (1)	1 (1)

[a]Includes thrombocytopenia and platelet count decreased.

[b]Includes anemia, hemoglobin decreased, and anemia macrocytic.

[c]Includes neutropenia, neutrophil count decreased, and febrile neutropenia.

TEAE=treatment-emergent adverse event; yo=years old.