cohort had significantly longer PFS (hazard ratio [HR]=0.43, 95% CI 0.32–0.58, $P<0.0001$) and significantly longer OS (HR=0.43, 95% CI 0.32–0.60, $P<0.0001$). Furthermore, the simulated-broader cohort demonstrated a survival curve above the simulated-PRIMA curve. Within the 2010–2015 diagnosis (contemporary) stage III cohort ($n=169$), 57.4% had IDS and 42.6% had PDS, of whom 23.1% had PDS VRD, 17.2% had PDS NVRD, and 2.4% were PDS not evaluable for residual disease.

Conclusion The simulated-broader cohort showed longer duration of OS and PFS outcomes as the survival curves lie above the simulated-PRIMA cohort. This difference is driven by the better prognosis for patients with stage III NVRD after PDS population; this population accounted for approximately 17% of the contemporary patient cohort at this UK centre.

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Clinical Trial Registration: N/A

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SYSTEMATIC LITERATURE REVIEW OF EFFICACY AND SAFETY OF FIRST-LINE MAINTENANCE THERAPY TRIALS IN ADVANCED OVARIAN CANCER

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Introduction/Background Maintenance therapies have changed the treatment landscape in ovarian cancer (OC) in recent years. Here we sought to review safety and efficacy outcomes in clinical trials of first-line maintenance therapies.

Methodology A systematic literature review (SLR) was performed on 27 February 2020 to identify clinical outcomes associated with first-line maintenance therapies and maintenance therapies initiated alongside first-line chemotherapy followed by a maintenance phase for advanced OC. Randomised controlled trials (RCTs), non-RCTs and observational studies were eligible. Selection criteria following the PICOS (population, interventions, comparators, outcomes and study type) principle were specified. Outcomes of interest were progression-free survival (PFS), overall survival (OS), and treatment emergent adverse events (TEAEs). Selected studies were then extracted by one reviewer and assessed for quality by a second reviewer. Disagreements were resolved by a third reviewer when required.

CENTRAL, Cochrane Central Register of Controlled Trials; EED, Economic Evaluation Database; HTA, Health Technology Assessment; NHS, National Health Service; SchARRHUD, School of Health and Related Research Health Utilities Database.

Abstract 373 Figure 1 PRISMA diagram

Results This SLR retrieved 8,631 unique references of which a total of 50 references were accepted and extracted in this SLR (figure 1).

The 50 references identified covered 18 clinical trials that evaluated maintenance therapies in OC patients following one prior line of chemotherapy. Of these 18 trials, 12 were RCTs and the remaining 6 were observational, dose escalation and retrospective review studies.

Of the 18 trials, only 2 did not assess PFS as an efficacy endpoint (NCT00058435 and MIMOSA). PARP inhibitors across the board reported a better PFS hazard ratio (HR) than other OC maintenance therapies (table 1). No pattern was identified in relation to PFS amongst patients who were treated with a maintenance therapy following first-line platinum-based chemotherapy versus those who received a

maintenance drug concurrently with first-line platinum-based chemotherapy and then continued with the maintenance treatment.

OS was reported as a secondary endpoint in 12 trials (MIMOSA, AGO-OVAR16, SOLO-1, ICON-7, GOG-0218, AGO-OVAR12, VELIA/GOG-3005, TRINOVA-3, ESME, CHIVA/GINESCO, PRIMA and PAOLA-1). Only PARP inhibitor-containing therapies reported significant OS HRs below 1 across all trial populations.

TEAEs were reported for 11 of the 18 trials. Discontinuation due to AEs was reported in 10 of the 18 trials.

Conclusion Therapies that included PARP inhibitors reported better PFS HR than other OC maintenance therapies. In study populations including both BRCA mutation positive and wild type, clinical benefit is conferred by both olaparib plus bevacizumab and niraparib as indicated by PFS. OS data remain immature.

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Dr Guy and Walder report institutional reimbursements from GlaxoSmithKline.

Drs. Travers, Hawkes, Malinowska, and Gupta are employees of GlaxoSmithKline.

Abstract 373 Table 1 PFS and OS studies included in the analysis

Trial	Drug(s)	PFS, HR (95% CI)	OS, HR (95% CI)
NCT00058435 Sabbatini 2006	Abagovomab	NA	NA
MIMOSA (NCT00418574) Sabbatini 2013	Arm 1: Abagovomab Arm 2: Placebo	1.099 (0.919-1.315)*	1.15 (0.872-1.1518)
ICON-7 (NCT00483782) Oza 2015	Arm 1: Chemotherapy + surveillance Arm 2: Chemotherapy + Bevacizumab	0.93 (0.83-1.05)	0.99 (0.85-1.14)
AGO-OVAR16 (NCT00866697) Du Bois 2014	Arm 1: Pazopanib Arm 2: Placebo	0.766 (0.643-0.911)	0.96 (0.805-1.145)*
SOLO-1 (NCT01844986) Moore 2018	Arm 1: Olaparib Arm 2: Placebo	0.30 (0.23-0.41)	0.95 (0.60-1.53)
Knipprath-Meszáros 2017	Arm 1: Letrozole Arm 2: "Do Nothing"	NR	NA
Goel 2017	Arm 1: Tamoxifen Arm 2: Treatment Surveillance	NR	NA
AGO-OVAR16 (NCT00866697); NCT01227928 (East Asian sub study) Kim 2018	Arm 1: Pazopanib Arm 2: Placebo	1.114 (0.818-1.518)	NR
NCT01227928 Zang 2013	Arm 1: Pazopanib Arm 2: Placebo	0.98 (0.593-1.620)	NA
JGOG3022 (NCT00951496) Komiya 2019	Arm 1: Chemotherapy + Bevacizumab	NR	NA
OSCAR (NCT01863693) Hall 2018	Arm 1: Chemotherapy + Bevacizumab + Bevacizumab maintenance	NR	NA
PAOLA-1 (NCT02477644) Ray-Coquard 2019	Arm 1: Olaparib + Bevacizumab Arm 2: Placebo + Bevacizumab	0.59 (0.49-0.72)	NR
PRIMA (NCT02655015) Gonzalez-Martin 2019	Arm 1: Niraparib Arm 2: Placebo	0.62 (0.5-0.76)	0.7 (0.44-1.11)
CHIVA/GINECO (NCT01583322) Feron 2019	Arm 1: NACT + Nintendanib + Nintendanib maintenance Arm 2: NACT + Placebo + Placebo maintenance	1.5	1.54
ESME (NCT03275298) Romeo 2019	Arm 1: Platinum-based Chemotherapy + maintenance	NR	NR
TRINOVA-3 (NCT01493505) Vergote 2019	Arm 1: Chemotherapy + Trebananib + maintenance Arm 2: Chemotherapy + Placebo + Placebo maintenance	0.93 (0.79-1.09)	0.99 (0.79-1.25)
VELIA/GOG-3005 (NCT02470585) Coleman 2020	Arm 1: Chemotherapy + Veliparib + Veliparib maintenance Arm 2: Chemotherapy + Placebo + Placebo maintenance	0.68 (0.56-0.83)	NR
AGO-OVAR12 (NCT01015118) Ray-Coquard 2017	Arm 1: Chemotherapy + Nintendanib + Nintendanib maintenance Arm 2: Chemotherapy + Placebo + Placebo maintenance	NR	0.99 (0.83-1.17)
GOG-0218 (NCT00262847) Burger 2011	Arm 1: Chemotherapy + Bevacizumab + maintenance Arm 2: Chemotherapy + Placebo + Placebo maintenance	0.77 (0.681-0.870)	0.915*

*Reported HR is for recurrence-free survival; OS HR is from Vergote 2018; *Results from the GOG-0218 trial indicated that the OS HR of 0.915 was not significant. HR, hazard ratio; NA, not assessed; NACT, neoadjuvant chemotherapy; NR, not reported; OS, overall survival; PFS, progression-free survival.

374 REAL WORLD PROGNOSTIC RELEVANCE OF RESIDUAL DISEASE AND OTHER CLINICAL FACTORS ON THE PROGRESSION OF DISEASE AND DEATH IN PATIENTS WITH ADVANCED OVARIAN CANCER IN THE US

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Introduction/Background Although most patients with ovarian cancer (OC) respond to first line (1L) treatment, 70% of women experience disease progression (PD) within 3 years. Identifying prognostic factors that impact survival is crucial to identify patients who may benefit from new treatment regimens such as maintenance therapies. The objective of this study was to assess the association between visible residual disease (VRD) following interval (IDS) or primary debulking surgery (PDS) and other clinical factors, and the risk of PD or death in patients with advanced OC in a real-world setting.

Methodology This retrospective cohort study included patients diagnosed with invasive ovarian cancer between January 1, 2011 and February 29, 2020, from the Flatiron Health electronic health record-derived de-identified US database (most OC patients (87%) originate from community oncology practices). Inclusion/exclusion criteria are shown in table 1. The index date (ID) was defined as the last date of 1L treatment. Multivariate Cox regression models were used to identify demographic and clinical factors associated with time to next

Abstract 374 Table 1 Inclusion/Exclusion criteria

Inclusion criteria	Exclusion criteria
Patients were ≥18 years old	Missing an IDS or PDS date
Stage III or IV disease	Had IDS or PDS and unknown VRD status
Received any 1L treatment	
Had ≥12 weeks of follow-up after completing 1L treatment	