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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Clinical Trial Registration: N/A

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-Meszaro 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 + 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	

Abstract 374 Table 2 TTNT and OS results (unadjusted)

	Patients with VRD (N=1109)	Patients with no VRD (N=811)	Overall (N=1920)
Median TTNT (95% CI), months	6.4 (5.7–7.1)	11.9 (10.7–12.9)	8.0 (7.5–8.5)
Hazard ratio (90% CI)	1.7 (1.5–1.8)		
Median OS (95% CI), months	28.6 (26.0–31.2)	54.5 (48.5–65.3)	36.6 (34.5–38.9)
Hazard ratio (90% CI)	2.1 (1.9–2.4)		

TTNT=time to next treatment; OS=overall survival; VRD=visible residual disease.

treatment (TTNT, a proxy for PD), defined as time from ID to start date of second line treatment, death, or last confirmed structured activity. Overall survival (OS) was defined as time from ID to death or last confirmed structured activity. Kaplan Meier analysis was used to assess median TTNT and OS.

Results A total of 1,920 advanced OC patients with a median (25th, 75th percentile) age of 67.0 (58.0, 75.0) years were included. Most patients were white (74%) and originated from a community oncology practice (88%). While 67% of patients had evidence of a BRCA biomarker test, only 5% had evidence of a homologous recombination deficient (HRD) test.

Results are shown in table 2. Statistically significant predictors of OS were VRD, age, BRCA status, Eastern Cooperative Oncology Group (ECOG) score, extent of debulking, histology, stage of disease, and therapy modality. Statistically significant predictors of TTNT included: VRD, BRCA status, extent of debulking, histology, practice type, race, stage of disease, and therapy modality.

Conclusion VRD was a key predictor of TTNT and mortality in patients with advanced OC. Among biomarkers, BRCA status was a key predictor of OC outcomes; HRD could not be assessed due to lack of data. A key strength of this study is that it presents outcomes from community practices primarily, whereas most retrospective studies contain a higher proportion of academic practices.

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Drs. Kalilani, Perhanidis, Sansbury, Woodward and Gupta are employees of GlaxoSmithKline.

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REAL WORLD RETROSPECTIVE STUDY OF PATIENTS WITH EPITHELIAL OVARIAN CANCER: AN INTERNATIONAL COMPARISON

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Introduction/Background Clinical trials in Epithelial Ovarian Cancer (EOC) frequently examine treatment at a particular phase of the patient's disease trajectory. Few major studies have examined the management of patients from diagnosis to death. This international network was developed to compare

Abstract 379 Table 1 Characteristics of ovarian cancer patients treated at 6 participating centres between 2012 and 2018

		Treatment centre											
		Institute of Oncology Ion Chiricut, Cluj (Romania)		Universitätsklinikum Frankfurt (Germany)		ICO (France)		Institut Curie (France)		Leeds Teaching Hospitals (UK)		Yonsei Severance (South Korea)	
Total site cohort size		427		160		409		460		522		911	
Characteristic	Group/Result	n	%	n	%	n	%	n	%	n	%	n	%
Age	Median	55		61		64		61		67		53	
	IQR	46-63		51-68		56-72		52-69		58-75		46-61	
Morphology	Low grade serous	40	9.4	8	5%	23	5.6%	5	1%	26	4.9%	17	1.87%
	High grade serous	276	65%	96	60%	286	69.9%	240	52%	356	68.2%	532	58.40%
	Serous, grade unknown	-	-	11	6.9%	-	-	-	-	<6		29	3.18%
	Endometrioid	32	7.5%	8	5%	22	5.4%	20	4%	20	3.8%	55	6.04%
	Clear cell	9	2.1%	4	2.5%	12	3.2%	17	4%	43	8.2%	99	10.87%
	Mucinous	26	6.1%	8	5%	11	2.7%	5	1%	9	1.7%	87	9.55%
	Carcinosarcoma	2	0.5%	-	-	9	2.2%	4	1%	15	2.9%	3	0.33%
	Mixed	23	5.4%	-	-	16	3.9%	1	0.2%	8	1.5%	5	0.55%
	Other	5	1.2%	25	15.6%	22	5.4%	110	24%	36	6.9%	49	5.38%
	Undifferentiated	1	0.2%	-	-	-	-	-	-	<6		-	-
	Missing	9	2.1%	-	-	-	-	58	13%	-	-	-	-
	Unknown/ Could not be assessed	4	0.9%	-	-	7	1.7%	-	-	-	-	35	3.84%
FIGO Stage	I	95	22%	24	15%	51	12.5%	70	15%	57	10.9%	248	27%
	II	36	8.4%	8	5%	29	7.1%	33	7%	26	4.9%	80	9%
	III	249	58%	86	53.8%	226	55.3%	302	66%	297	56.9%	281	31%
	IV	47	11%	38	23.8%	103	25.2%	55	12%	141	27.0%	177	19%
	Not staged/ unknown	-	-	1	0.6%	-	-	-	-	<6		17	2%
	Missing	-	-	3	1.9%	-	-	-	-	-	-	108	12%