441 CHEMOTHERAPY RESPONSE SCORE: CORRELATION WITH PREOPERATIVE SEROLOGICAL AND RADIOLOGICAL ASSESSMENT OF RESPONSE AND CLINICAL IMPLICATIONS IN OVARIAN CANCER PATIENTS

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10.1136/ijgc-2020-ESGO.140

Introduction/Background The 3-Tier Chemotherapy Response Score (CRS) was developed to quantify the response after neoadjuvant chemotherapy (NACT) in high-grade serous ovarian cancer patients undergoing interval debulking surgery. CRS3 (optimal response) identifies patients with a longer progression-free (PFS) and overall survival (OS) compared to patients with a CRS1/2 (no or minimal response/partial response). We critically evaluated the clinical value of CRS and compared its predictive power to standard serological (CA125) and radiological response in patients with advanced epithelial ovarian cancer.

Methodology A retrospective analysis of 277 patients, who received primary chemotherapy for advanced epithelial ovarian cancer was performed. CRS, serological, and radiological findings, and pathological complete remission (pCR) were correlated to PFS and OS.

Results Only 62.1% (172/277) patients treated with NACT could be assessed by CRS, as the CRS score can only be determined in patients that undergo interval debulking surgery, have a representative biopsy of the omentum, and have tumours with a high-grade serous histology. In patients with CRS3 (n=50) a longer median PFS and OS was observed compared to patients with CRS1/2 (n=122) (31.2 vs. 18.9, P<0.001; 55.0 vs. 36.1 months, P=0.050). Patients with serological and radiological complete response showed longer PFS (23.0 vs. 14.4, P=0.011; 21.4 vs. 9.6 months, P<0.001) and OS (49.5 vs 29.0, P=0.003; 45.0 vs. 12.9 months, P<0.001). Patients with a pCR had the best median PFS (52.8 months), even compared to non-pCR CRS3 (27.8 months).

In the total study cohort, serological and radiological complete response was better at predicting PFS (hazard ratio 2.23 and 2.77). Radiological complete response was better at predicting OS (hazard ratio 2.34).

Conclusion In this study, evaluation of response to chemotherapy by CRS was not superior to conventional methods (CA125 or radiology). Independent of the used evaluation method, response to NACT was predictive of PFS and OS. Conventional methods should even be considered more clinically relevant, as these can be applied to all ovarian cancer patients receiving upfront chemotherapy, while only 62% of patients in our cohort could be assessed by CRS. Conventional response assessment, based on radiology and/or CA125, is used to evaluate whether a patient should be offered IDS and can, similar to CRS, be used to predict PFS and OS. As CRS has no influence on the treatment of patients undergoing NACT for ovarian cancer, the added value of response assessment using CRS is negligible.

Disclosures JPR has no conflict of interest to declare.

TB has been an advisor for Tesaro and received research grant from Amgen, non-financial support from Amgen, MSD, Roche, and Tesaro, outside the submitted work.

MLM, AT, KUW, SH have no conflict of interest to declare.

PH reports grants and personal fees from Astra Zeneca and Roche, personal fees from Sotio, grants and personal fees from Tesaro and GSK, personal fees from Stryker, Zai Lab, and MSD, grants from Public funding (DKH, DFG, EU), personal fees from Clovis, and Immunogen, grants from Boehringer Ingelheim, Medac, and Genmab, outside the submitted work.

AdB reports personal fees from Roche, Astra Zeneca, Tesaro, Clovis, Pfizer, Genmab, Pharmar, and Biocad, outside the submitted work.

462 SAFETY OF BEVACIZUMAB THERAPY IN ELDERLY PATIENTS WITH OVARIAN CANCER: AN EXPERIENCE FROM THE DEPARTMENT OF GYNAECOLOGIC ONCOLOGY IN THE UNIVERSITY HOSPITAL CENTRE ZAGREB

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10.1136/ijgc-2020-ESGO.141

Introduction Bevacizumab is a recombinant humanized monoclonal antibody to vascular endothelial growth factor. It is an effective treatment for epithelial ovarian cancer, both in primary and recurrent disease. The incidence of ovarian cancer increases with advancing age. Despite the high prevalence of the ovarian cancer in elderly, the management of these patients is often less aggressive than that in younger patients. Our aim was to investigate the safety of bevacizumab administration in patients older than 65 years.

Methodology Retrospectively, we have analysed the medical data of 65 patients with epithelial ovarian, fallopian tube, or primary peritoneal cancer who started treatment with bevacizumab in primary advanced and in first relapse of the disease at the Department of Gynaecologic Oncology in the University Hospital Centre Zagreb in the period from April 2017 to December 2018. Patients are divided in two categories according to age: group 1 (>65 years) and group 2 (≤65 years).

Results Our analysis included 65 patients:18 (27,7%) patients in group 1 compared with 47 (72.3%) in group 2. Bevacizumab have been administered to 38 (58.5%) patients as first-line treatment and to 27 (41.5%) patients as second-line treatment. The median age was 70 (range 66–76) years in group 1 and 55 (range 35–65) in group 2. ECOG performance status 0 had 44.7% of patients in group 2 compared with only 33.3% in group 1. At the time of diagnosis, elderly patients had presented with at least one comorbidity in 66.6% of the cases, compared with 40.4% in group 2. The median number of cycles of bevacizumab was 9 in elderly patients and 17 cycles in group 2. Among those patients receiving bevacizumab in the first-line setting, median progression free interval (PFI) was 12 months in younger patients versus 7 months in elderly patients. Similarly, among those receiving bevacizumab in the second-line setting PFI was 9 months in younger patients versus 1 months in elderly patients. The occurrence of adverse events did not increase in elderly patients; 51.1% of patients