Abstract 1 Table 1

Baseline characteristics	Rucaparib		
	Exceptional benefit n=79	Short-term subgroup n=64	Odds ratio (95% CI)
No measurable disease	58 (73%)	26 (41%)	4.0 (2.0–8.0) ^a
Complete response to latest platinum	31 (39%)	13 (20%)	2.5 (1.2–5.3) ^a
Penultimate platinum-free interval >12 mo	55 (70%)	30 (47%)	2.6 (1.3–5.2) ^a
BRCA mutation	46 (58%)	12 (19%)	6.0 (2.8–13.3) ^a
BRCAwt/LOH-high	18 (23%)	19 (30%)	0.7 (0.3–1.5)
BRCAwt/LOH-low	8 (10%)	28 (44%)	0.14 (0.1–0.4) ^a
BRCAwt + RAD51C/D mutation ^b	6 (8%)	0	NA
BRCAwt + high BRCA1 promoter methylation ^c	6/25 (24%)	7/47 (15%)	1.8 (0.5–6.0)

BRCAwt, BRCA wild type; LOH, loss of heterozygosity; NA, not applicable

^aSignificant result; ^bP=0.033 (Fisher's exact test); ^cIn samples with known methylation status.

and BRCA1 promoter methylation) and baseline clinical characteristics were compared between patients who derived exceptional benefit (PFS ≥ 2 years), and those with disease progression on first scan (≈ 12 weeks; the short-term subgroup) within each treatment arm.

Result(s)* Of 564 patients, a greater percentage of rucaparib vs placebo patients showed exceptional benefit: 79/375 (21%) in the rucaparib arm and 4/189 (2%) in the placebo arm (including 26/375 [7%] patients in the rucaparib arm and 1/189 [0.5%] patient in the placebo arm with PFS >4 years as of the data cutoff date). Within the rucaparib arm, exceptional benefit patients had more favourable clinical prognostic factors at baseline versus the short-term subgroup (table 1). Although BRCA (BRCA1 or BRCA2) mutations were enriched in the rucaparib exceptional benefit subgroup, 33/79 (42%) of these patients were BRCA wild type. Patterns of enrichment varied among other biomarkers. Overall trends were similar in the placebo arm.

Conclusion* Exceptional benefit in ARIEL3 was more common in, but not exclusive to, patients with favourable clinical characteristics and known mechanisms of sensitivity to a PARP inhibitor. Our results suggest rucaparib can deliver exceptional benefit to a diverse set of patients with HGOC.

14 ABSTRACT WITHDRAWN

25 ROLE OF ULTRASOUND IN STAGING OF OVARIAN CANCER

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10.1136/ijgc-2021-ESGO.332

Introduction/Background* Ovarian cancer is usually staged surgically. Radiologic staging using CT scan along ca125 is used before surgery. Ultrasound can be used in staging before surgery related to the advances in technology and machines. Ultrasonography has some advantages over CT and MRI being a dynamic procedure during which the assessment of sliding and vascular patterns are evaluated. Vascularity can assess the nature of the lesion and the borders. We are trying here to spot the lights over this staging along with a pictorial illustration of different stages.

Methodology With advances in machines, sonography has become an accurate staging method for early and advanced gynecological tumors. Other techniques, such as computed

tomography and magnetic resonance imaging, can be used as an adjunct to ultrasound in specific cases. There are still limitations in some cases. In such cases, a complementary imaging method or diagnostic laparoscopy can be used. Staging of ovarian cancer is as follows. Stage 1 with ovarian involvement, stage 2 with pelvic affection, stage 3 with abdominal and nodal affection and stage 4 with extra abdominopelvic metastasis.

Result(s)* Ultrasound is main imaging method for the differential diagnosis of benign and malignant ovarian tumors based on IOTA classification. Ultrasound can be used to detect early and locally advanced cancers along with detection of extrapelvic tumor in the abdominal cavity in the form of parietal or visceral carcinomatosis, omental and/or mesenteric infiltration. we can proceed with pattern recognition by expert, deal as malignant or apply IOTA adnex model. Secondly, we proceed with Staging of ovarian cancers.

Conclusion* Ultrasound can be used in staging ovarian cancer iota malignant cases and after pattern recognition with some limitation.

29 DOSE MODIFICATION FOR CHINESE PATIENTS ON NIRAPARIB MAINTENANCE TREATMENT FOR PLATINUM-SENSITIVE RECURRENT OVARIAN CANCER: A POST HOC ANALYSIS

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10.1136/ijgc-2021-ESGO.333

Introduction/Background* In the NOVA trial of niraparib maintenance treatment (MT) in platinum-sensitive recurrent ovarian cancer (PSROC), dose reduction due to treatment-emergent adverse events (TEAEs) occurred in 66.5% of patients initiating niraparib at 300 mg. Based on NOVA RADAR analysis, subsequent individualised starting dose (ISD)

recommends patients with baseline bodyweight <77 kg or baseline platelet count <150×10³/μl to initiate niraparib at 200 mg and all other patients, at 300 mg. ISD was adopted in NORA (NCT03705156), the published pivotal study in Chinese patients, who generally have lower body weights than Western patients. While niraparib demonstrated acceptable safety in NORA, dose reduction remained essential and occurred in 59.9% of patients. This post hoc analysis aims to characterise the major TEAEs necessitating dose modification in NORA, to inform TEAE management in Chinese patients receiving niraparib.

Methodology In NORA, adults with PSROC and complete/partial response to most recent platinum-containing chemotherapy were randomised 2:1 to niraparib or placebo MT of 28-day cycles. Primary endpoint was progression-free survival (PFS). First 16 patients started treatment at 300 mg, before ISD was implemented. Dose interruption ≤28 days and dose reduction were permitted. Niraparib-treated patients with stabilised dosing at Cycle 4 were analysed, with descriptive statistics summarising TEAEs and descriptive PFS analysis by dose levels at the beginning of Cycle 4.

Result(s)* During Month 1/2, platelet count decrease caused dose interruption and reduction in 32.8%/36.2% and 22.0%/23.6% of patients, respectively; neutrophil count decrease caused dose interruption and reduction in 9.0%/12.1% and 8.5%/9.2% of patients, respectively. These percentages decreased from Month 3 and remained low through Months 4–6 (figure 1). Anaemia-related dose interruption/reduction occurred in ≤10% of patients. Most patients' stabilised doses at Cycle 4 were 100 mg (n=74) or 200 mg (n=78). These two groups had comparable baseline characteristics and showed similar PFS (figure 2) from Cycle 4 onward through 12 months, regardless of germline *BRCA* mutation status.

Abstract 29 Figure 1 Hematologic TEAEs Leading to niraparib dose interruption and reduction by month (Safety set)

Abstract 29 Figure 2 Kaplan-meier curves for progression free survival by niraparib dose level at the beginning of cycle 4 (Intention-to-treat Set)

Conclusion* Platelet count decrease and neutrophil count decrease were the major TEAEs necessitating niraparib dose modification. Early dose modification helped maintain safety and tolerability in Chinese patients receiving niraparib MT without compromising efficacy.

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SURVIVAL TRENDS AND FEASIBILITY OF SURGERY IN OVARIAN CANCER PATIENTS WITH RARE METASTATIC SITES

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10.1136/ijgc-2021-ESGO.334

Introduction/Background* Ovarian cancer is the commonest gynaecologic malignancy in Egypt after breast cancer. Although metastasis from ovarian cancer is common, there is still sites with rarely reported deposits as non-regional nodes, bone, and brain.

Methodology We herein study retrospectively a group of patients over 7 years period recruited from data system of tertiary cancer centre. All the recruited patients suffered a rare