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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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

Abstract 33 Figure 1

Abstract 33 Figure 2

distant metastasis from ovarian cancer (metastasis to sites other than peritoneum, liver, and lung). Demographic data, pathology, surgical treatment, and survival of these patients were analysed. **Result(s)*** Out of 1135 ovarian cancer patients, 48 patients with FIGO stage IV rare metastatic sites were enrolled. The most common site of rare metastasis was the non-regional lymph nodes (56.3%), while the most common pathology was high grade serous carcinoma (87.5%). Nearly half of the cases presented with the metastasis, while the rest developed during disease course. Interestingly, debulking was feasible in nearly a half of the patients with acceptable overall and progression free survival. Patients with non-regional nodal metastases tend to have better overall survival (39 vs 13 months $p=0.003$) (figure 1) and progression free survival (29 vs 13 months $p=0.034$) than visceral or skeletal metastasis.

Conclusion* Ovarian cancer can metastasize to rare sites. Non-regional nodes were the commonest and had better survival trends than other rare sites of metastasis. Although surgical treatment was feasible in nearly half the cases with an accepted overall and progression free survival, we could not detect survival benefit of surgical resection in these patients (figure 2).

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SURVIVAL OUTCOMES IN OLDER PATIENTS WITH OVARIAN CANCER DEBULKING SURGERY. IS THERE ANY DIFFERENCE BEYOND 65 YEARS OLD?

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Introduction/Background* The surgical management of advanced epithelial ovarian cancer (AEOC) is controversial in fragile subjects like elderly patients. The aim of this study was to report the global survival of primary and interval debulking surgery (PDS/IDS) over 65 years and to compare the outcomes with younger patients.

Methodology Between 2005 and 2016, 145 patients with ovarian cancer in FIGO stages IIIC or IV and PDS or IDS were included. We compared patient characteristics, type of surgery, major postoperative complications, hospital length of stay, disease free survival (DFS) and overall survival (OS) for patients under and over 65 years.

Result(s)* 93 patients were up to 65 years and 60 patients were over. There were no difference between the two groups for performance status, CA 125, tumors histotypes and FIGO

Abstract 49 Table 1 Characteristics and outcomes of advanced ovarian cancer patients undergone to debulking surgery by age groups

		Overall N=153	≤65years N=93	>65 N=60	P- value
ECOG-PS					
N 147	0-1	113	72	41	.553
	2	30	15	15	
	≥3	4	2	2	
Charlson					
N 151	0-2	95	82	13	.000
	≥3	56	10	46)	
CA 125 (IU/mL), mean		1328,4	1624.9	1524.8	.805
Hystotypes					
N 153	Serous - High grade	133	82	51	.437
	Seroso - low grade	1	1	0	
	Clear cells	8	5	3	
	Endometrioid	6	2	4	
	Mucinous	2	2	0	
	Myscelaneous	3	2	1	
Grade					
N 101	G1	9	9	0	.047
	G2	29	16	13	
	G3	63)	39	29	
FIGO Stage (2014)					
N 146	IIIC	124	77	47	.803
	IVA	2	1	1	
	IVB	22	7	7	
Type of debulking surgery					
N 153	PDS	100	66	34	.070
	IDS	53	27	26	
Residual tumor					
N 152	R0	85	52	33	.218
	R0-10mm	43	29	14	
	R>10mm	24	13	24	
Surgical Complexity Score					
N 152	Low	11	8	3	.676
	Mild	43	25	18	
	High	97	59	38	
Postop. complications.	Clavien-Dindo	14	8	6	.640
N 122	III	8	5	3	
	IV	5	2	3	
	Exitus (<30d)	1	1	0	
Length of stay (days)		13.4	7.98	10.8	.094
Relapse		119	76	43	.144
N 153					
DFS(months)		22.6	24.6	19.14	.092
N 153					
OS (months)		51.2	52.8	48.7	.517
N 153					