Abstract 124 Figure 1 Change in NACT regimen and impact on overall survival

six cycles. 39% (24/61) of patients inoperable after 3 cycles changed chemotherapy regimens; 42% (10/24) of the latter switched to weekly paclitaxel, 21% (5/24) to bevacizumab-based regimen, and 13% (3/24) to carboplatin + liposomal doxorubicin (Caelyx®). 25% (6/24) had palliative aromatase inhibitors or stopped chemo entirely. Of those who had their chemotherapy changed, only 1 patient in bevacizumab group (4%) achieved optimal debulking. Median overall survival (OS) in those who switched regimen was 17.47 vs 37.40 months in those who did not, $p=0.79$.

Conclusion* Switching chemotherapy regimen in previously inoperable patients did not lead to improved OS. This may reflect the poor prognosis conferred by inadequate response to platinum-based therapy, and needs further evaluation. Though the numbers in each group were small, a change to bevacizumab-based regimen did not appear to improve outcomes. The ICON 8b study will provide further information regarding bevacizumab's role in the neoadjuvant setting.

131 EXTRAPERITONEAL LEFT PELVIC LYMPHADENECTOMY

A Rychlik*, J Rzepka, M Bidzinski. *Maria Skłodowska-Curie National Research Institut of Oncology, Gynecologic Oncology, Warsaw, Poland*

10.1136/ijgc-2021-ESGO.344

Introduction/Background* Retroperitoneal lymphadenectomy of the pelvis is rarely performed due to its apparently high degree of difficulty. More and more clinical situations, especially in young people or those with medical problems, require breaking the treatment down into several steps.

Methodology The featured video describes the pelvic right retroperitoneal lymphadenectomy procedure.

Result(s)* As a result we present step by step procedure.

Conclusion* Retroperitoneal lymphadenectomy of the pelvis is a skill that should be mastered by everyone involved in endoscopic surgery in gynecological oncology.

144 A COMPLICATED CASE OF PARAAORTIC NODAL DISSECTION IN A WOMAN WITH FALLOPIAN TUBE CANCER

CR Iavazzo*, A Fotiou, K Kokkali, S Lekka, D Giannouloupoulos, P Giannakas, G Vorgias. *Metaxa Cancer Hospital of Piraeus, Gynecologic Oncology Department, Piraeus, Greece*

10.1136/ijgc-2021-ESGO.345

Introduction/Background* Paraaortic lymph node dissection is a challenging surgical procedure. Recent data mentioned that bulky nodal disease in ovarian/fallopian tube cancer patients stage IIB and above should be dissected in fallopian tube cancer patients that optimal primary cytoreduction has been achieved.

Methodology A challenging paraaortic lymph node dissection of a nodal block arising from fallopian tube cancer in a 76 years old patient is presented in this surgical video. Patient has been diagnosed with ovarian/fallopian tube cancer. Her CA 125 was 2161 IU/ml and her preoperative imaging has revealed a mass of right adnexa 7 x 3 cm, a metastatic abdominal mass involving the transverse colon and paraaortic lymph node 6 cm in dimension.

Result(s)* Abdominal hysterectomy, omentectomy, resection of the transverse colon, peritonectomies and dissection of the paraaortic nodal mass took place. No macroscopic residual disease was observed at the end of the procedure.

Conclusion* Removal of bulky nodal disease is indicated for patients with advanced ovarian/fallopian tube cancer. As applies in any paraaortic/retroperitoneal lymph node dissection resection of bulky lymph nodes can lead in intra or postoperative complications. Therefore, awareness of anatomical landmarks and anatomic variation are of paramount importance.

167 SAFETY AND QUALITY OF LIFE OF FIRST-LINE MAINTENANCE OLAPARIB PLUS BEVACIZUMAB IN OLDER PATIENTS WITH ADVANCED OVARIAN CANCER IN THE PAOLA-1 TRIAL

¹C Montégut*, ²C Falandry, ³S Cinieri, ⁴L Montane, ¹F Rousseau, ⁵F Joly, ⁶J Frindte, ⁷AM Mosconi, ⁸E Guerra-Allia, ⁹C Schauer, ¹⁰H Fujiwara, ¹¹IB Vergote, ¹²G Parma, ¹³G Lindahl, ¹⁴A Anota, ¹⁵U Canzler, ¹⁶F Marmé, ¹⁶E Pujade-Lauraine, ^{4,17}I Ray-Coquard, ¹R Sabatier. ¹Institut Paoli-Calmette, and GINECO, Marseille, France; ²CHU Lyon, and GINECO, Lyon, France; ³U.O.C. Oncologia Medica – Ospedale Senatore Antonio Perrino, and MITO, Puglia, Italy; ⁴Centre Léon Bérard, Lyon, France; ⁵Centre François Baclesse, and GINECO, Caen, France; ⁶Kliniken Essen-Mitte, Department of Gynecology and Gynecologic Oncology, and AGO, Essen, Germany; ⁷S.C. di Oncologia Medica Ospedaliera S. Maria della Misericordia – AO di Perugia, and MITO, Perugia, Italy; ⁸Hospital Ramon y Cajal, and GEICO, Madrid, Spain; ⁹Hospital Barmherzige Brüder Graz, and AGO, Graz, Austria; ¹⁰Jichi Medical University, and GOTIC, Tochigi, Japan; ¹¹University Hospital Leuven, Leuven Cancer Institute, and BGOG, Leuven, Belgium; ¹²European Institute of Oncology IRCCS, and MANGO, Milan, Italy; ¹³Linköping University Hospital, and NSGO, Linköping, Sweden; ¹⁴Universitätsklinikum Carl Gustav Carus, Technische Universität Dresden, and AGO, Dresden, Germany; ¹⁵Universitätsklinikum Heidelberg, and AGO, Heidelberg, Germany; ¹⁶ARCAGY Research, and GINECO, Paris, France; ¹⁷University Claude Bernard Lyon I, and GINECO, Lyon, France

10.1136/ijgc-2021-ESGO.346

Introduction/Background* The Phase III PAOLA-1/ENGOT-ov25 study (NCT02477644) demonstrated that the addition of olaparib to bevacizumab maintenance following standard platinum-based therapy plus bevacizumab improved progression-free survival (PFS) in patients with newly diagnosed advanced ovarian cancer (Ray-Coquard *et al.* NEJM 2019). We aimed to describe safety, quality of life (QoL), and efficacy with olaparib plus bevacizumab in patients ≥ 70 years old.

Methodology Safety (adverse events [AEs] graded according to CTCAE v5.0) and QoL (measured using EORTC QLQ-C30 global health status [GHS]) data were collected. We compared safety by age (older ≥ 70 years] and younger patients [< 70 years]) in the olaparib arm. Geriatric features, including Geriatric Vulnerability Score (GVS; Falandry *et al.* Ann Oncol 2013) items, and QoL by treatment arm were assessed in older patients.

Abstracts

Abstract 167 Table 1 Baseline geriatric characteristics in older patients (≥ 70 years)

Characteristic	Olaparib arm (n=104)	Placebo arm (n=38)
Median age, years (range)	73 (70–87)	73 (70–85)
ECOG PS		
0	65 (62.5)	22 (57.9)
1	36 (34.6)	16 (42.1)
BMI		
<21 kg/m ²	30 (28.8)	14 (36.8)
21–33 kg/m ²	72 (69.2)	22 (57.9)
>33 kg/m ²	1 (1.0)	2 (5.3)
Albumin <35 g/L	5 (4.8)	1 (2.6)
ADL scores		
ADL <6	15 (14.4)	8 (21.1)
IADL <25	23 (22.1)	12 (31.6)
Age-adjusted CCI ≥ 5	4 (3.8)	3 (7.9)
HADS ≥ 14	16 (15.4)	7 (18.4)
Haemoglobin <10 g/dL	0	0
Lymphocyte count <1 G/L	14 (13.5)	2 (5.3)
Neutrophil count <1.5 G/L	1 (1.0)	0
Platelet count <150 G/L	9 (8.7)	8 (21.1)
Renal function		
Normal	32 (30.8)	13 (34.2)
Mild and moderate insufficiency	71 (68.3)	25 (65.8)

Abstract 167 Table 2 Safety of olaparib plus bevacizumab in older (≥ 70 years) and younger (<70 years) patients

	Older (≥ 70 years) (n=104)	Younger (<70 years) (n=431)
Grade ≥ 3 TRAEs	42 (40.4)	138 (32.0)
Dose reductions due to TRAEs	43 (41.3)	159 (36.9)
Dose interruptions due to TRAEs	51 (49.0)	181 (42.0)
Discontinuations due to TRAEs	25 (24.0)	70 (16.2)
Treatment-related deaths	0	1
Median duration of treatment, months (range)	14.9 (0.0–33.0)	17.9 (0.0–32.1)
Median duration of follow-up, months (IQR)	25.9 (20.0–30.9)	26.0 (22.4–31.3)

Result(s)* Of 806 patients enrolled, 142 (17.6%) were ≥ 70 years old; 104 of these were in the olaparib arm. There was no notable difference in baseline characteristics between olaparib and placebo arms (table 1). In evaluation of safety, moderately increased rates of grade ≥ 3 treatment-related AEs (TRAEs), dose reductions and interruptions, and treatment discontinuation due to TRAEs were reported in older than younger patients (table 2). Grade 3–4 any-cause anaemia (21.2% vs 16.5%) and neutropenia (9.7% vs 5.1%) were more frequent in older patients. The most common grade 3–4 non-haematological AE was hypertension (26.9% vs 16.7%). No acute myeloid leukaemia, myelodysplastic syndrome, or treatment-related death was reported among older patients. Interestingly, GHS during the first 2 years of maintenance was similar between arms. Median PFS was 21.1 months with

olaparib vs 14.3 months with placebo. Analyses by GVS and homologous recombination deficiency subgroups are ongoing and will be presented.

Conclusion* Among older patients in PAOLA-1, olaparib plus bevacizumab maintenance had a manageable safety profile and had no adverse impact on GHS. Median PFS in older patients was similar to the overall population. Analyses stratified by GVS will provide further insight into the safety profile of maintenance olaparib plus bevacizumab in older patients.

172

EFFICACY AND SAFETY OF MAINTENANCE OLAPARIB BY PATIENT AGE IN NON-GERMLINE BRCA-MUTATED PLATINUM-SENSITIVE RELAPSED OVARIAN CANCER IN OPINION

¹E Skof*, ²M Bjurberg, ³MJ Rubio Pérez, ⁴D Davidson, ⁴C Blakeley, ⁴J Bennett, ⁵A Poveda. ¹Institute of Oncology Ljubljana, Ljubljana, Slovenia; ²Skånes University Hospital, Lund, Sweden; ³Hospital Universitario Reina Sofía, Córdoba, Spain; ⁴AstraZeneca, Cambridge, UK; ⁵Initia Oncology, Valencia, Spain

10.1136/ijgc-2021-ESGO.347

Introduction/Background* The Phase IIb single-arm OPINION study was the first study to prospectively evaluate maintenance olaparib in patients with non-germline *BRCA1* and/or *BRCA2*-mutated (non-gBRCAm) platinum-sensitive relapsed ovarian cancer (PSR OC). Median progression-free survival (PFS) in OPINION was 9.2 months (95% confidence interval [CI] 7.6–10.9) (Poveda *et al.* ASCO 2021), showing clinical benefit vs historical controls. Limited data are available focussing on older patients with OC receiving olaparib. We evaluated the efficacy and safety of maintenance olaparib in OPINION patients aged <70 and ≥ 70 years.

Methodology Patients with high-grade serous or endometrioid non-gBRCAm OC who had received ≥ 2 prior lines of platinum-based chemotherapy and were in response to their most recent platinum regimen received olaparib tablets (300 mg bid) until disease progression or unacceptable toxicity. This *post hoc* subgroup analysis evaluated investigator-assessed PFS (modified RECIST v1.1; primary endpoint), time to first subsequent therapy or death (TFST) and safety in patients aged <70 and ≥ 70 years.

Result(s)* At enrolment, median patient age was 65.0 years (range 40–85); 192 patients were aged <70 years (median 60.0 years; range 40–69) and 87 were aged ≥ 70 years

Abstract 172 Figure 1