0.74-1.12, $p=0.37$), respectively. In contrast, “ever-users” of sBB had a significantly elevated risk for recurrence and death in multivariate analysis (PFS HR 1.22 95%-CI 1.05-1.41, $p=0.009$; OS HR 1.25 95%-CI 1.06-1.47, $p=0.009$).

Conclusion* In this large pooled analysis neither a co-medication with metformin nor with statins had a significant impact on survival in patients with primary ovarian cancer. In contrast, co-medication with a beta-blocker was associated with worse survival. Further studies are warranted to confirm this observation.

242

PARP-INHIBITORS BEYOND PROGRESSION: A NEW WAY TO MANAGE OLIGOMETASTATIC OVARIAN CANCER RECURRENCE

¹C Marchetti*, ¹E Palluzzi, ¹S Cappuccio, ¹G Avesani, ¹A Nardangeli, ^{1,2}G Scambia, ^{1,2}A Fagotti. ¹Fondazione Policlinico Agostino Gemelli-IRCCS, Dipartimento di Scienze della Salute della Donna, del Bambino e di Sanità Pubblica, Rome, Italy; ²Università Cattolica del Sacro Cuore, Rome, Italy

10.1136/ijgc-2021-ESGO.367

Introduction/Background* The benefit of surgery and maintenance treatment with parp inhibitors (PARPi) has been recently shown in ovarian cancer (OC) recurrence. Also, the efficacy and safety of stereotactic body radiotherapy (SBRT) is demonstrated in patients with metastatic, persistent, and recurrent OC. The management of oligometastatic progression (OMP) during PARPi maintenance is unclear and continuing the treatment beyond progression could be an option.

Methodology This is an observational, retrospective, single arm study. Patients affected by OC recurrence treated with PARPi

Abstract 242 Figure 1

in maintenance setting received surgery or SBRT, if OMP occurred. OMP was assessed by either CT scan or PET/CT scan, in case of isolated disease progression (one nodule) or discrete diffusion (up to three nodules in different locations) or progression in “sanctuary” site. Maintenance treatment was continued until extensive progression of disease. Primary objectives were: Progression Free Survival 1 (PFS1), defined as the time elapsed from the start of PARPi and OMP; post-progression-PFS (ppPFS), defined as the time elapsed from OMP and the last follow up (FU). Beyond-progression PFS (bpPFS), defined as the time elapsed from the start of PARPi and the definitive progression of disease or last FU (PFS1+ppPFS), and efficacy of surgery versus SBRT at OMP were secondary objectives.

Result(s)* From June 2017 to December 2020 186 OC patients were treated with PARPi maintenance at recurrence. Of these 24 (13%) developed OMP (58% lymphnodes, 17% peritoneal, 25% visceral disease). Median age was 51 years. Olaparib and Niraparib maintenance were administered to 9 (38%) and 15 (62%) patients, respectively. Median PFS1 was 23 months [Confidence Interval (CI) 95% 11 – 34]. When OMP occurred 9 (38%) and 15 (62%) pts were subjected to surgery and SBRT, respectively. Median ppPFS was 6 months (CI 95% 5 – 7). At the time of this publication 62.5% patients are still on treatment with PARPi beyond progression. **Conclusion*** OC patients, who have an OMP during PARPi maintenance at recurrence, may continue to benefit from PARPi treatment if combined with local treatment. Molecular assessment at oligometastatic and extensive progression could provide further information to define PARPi resistance mechanisms according to the type of disease progression.

Abstract 242 Table 1

	PARPi maintenance
	Nr. (%)
All patients	24
Median age (years) (range)	51 (35-67)
Histology	
Serous	24 (100)
PARPi	
Olaparib	9 (38)
Niraparib	15 (62)
BRCA status	
BRCA MT	10 (42)
BRCA WT	14 (58)
Therapy at oligometastatic progression	
Surgery	9 (38)
SBRT	15 (62)
Site of oligometastatic progression	
Lymphnode	14 (58)
Peritoneal	4 (17)
Parenchymal disease	6 (25)
PFS	
	Months
	(CI)
Median PFS1	23 months
	(CI 95% 11 – 34)
Median ppPFS	6 months
	(CI 95% 5 – 7)
Median bpPFS	29 months
	(CI 95% 17 – 40)

253

PFS OF ELDERLY OVARIAN CANCER PATIENTS MIGHT BE PREDICTED BY G-8 GERIATRIC SCREENING TOOL – RESULTS OF A RETROSPECTIVE COHORT STUDY

¹K Anic*, ¹S Birkert, ¹R Schwab, ¹MW Schmidt, ¹V Linz, ¹S Krajnak, ¹A-S Heimes, ¹M Schmidt, ²C Westphalen, ³EK Hartmann, ¹A Hasenburger, ¹M Battista. ¹University Medical Centre of the Johannes Gutenberg University Mainz, Department of Gynaecology and Obstetrics, Mainz, GERMANY; ²University Medical Centre of the Johannes Gutenberg University Mainz, Department of Geriatric Medicine, Mainz, GERMANY; ³University Medical Centre of the Johannes Gutenberg University Mainz, Department of Anesthesiology, Mainz, GERMANY

10.1136/ijgc-2021-ESGO.368

Introduction/Background* The aim of this study was to evaluate the impact of the preoperative global health status on the prognosis of patients with ovarian cancer (OC) older than 60 years, who received cytoreductive surgery.

Methodology G-8 geriatric screening tool (G-8 score), Lee Schonberg prognostic index, Eastern Cooperative Oncology Group (ECOG) performance status and Charlson Comorbidity Index (CCI) were determined retrospectively in a consecutive

Abstract 253 Table 1 G-8 geriatric screening tool

Category	Items	Possible responses (score)
{1}	<u>Nutritional status</u>	Has food intake declined over the past three months due to loss of appetite, digestive problems, chewing, or swallowing difficulties?
		□0: severe decrease in food intake □1: moderate decrease in food intake □2: no decrease in food intake
{2}	Body-Mass-Index (BMI) [kg/m ²]	□0: BMI <19 □1: BMI between 19-21 □2: BMI between 21-23 □3: BMI ≥ 23
{3}	Weight loss during the last three months?	□0: weight loss >3 kg □1: unknown □2: weight loss between 1 and 3 kg □3: no weight loss
{4}	<u>Functional status</u>	Mobility?
		□0: bed or chair bound □1: able to get out of bed/chair but does not go out □2: goes out
{5}	<u>Cognitive status</u>	Neuropsychological problems?
		□0: severe dementia/depression □1: mild dementia/depression □2: no psychological problems
{6}	<u>Comorbidities</u>	Takes more than three prescription drugs per day?
		□0: yes □1: no
{7}		In comparison with other people of the same age, how does the patient consider his/her health status
		□0: not as good □0,5: does not know □1: as good □2: better
{8}		Age?
		□0: >85 years □1: 80 - ≤85 years □2: <80 years

cohort of elderly patients with OC. Univariate and multivariate Cox regression analyses and Kaplan-Meier method were performed to analyze the impact of the preoperative global health status on survival.

Result(s)* 116 patients entered the study. In multivariate analysis adjusted for clinical-pathological factors, only the G-8 score retained significance as a prognostic parameter of PFS (HR: 2.009; 95%-CI [1.091-3.699]. 56 patients were classified as G-8 non-frail with an increased PFS compared to 50 G-8 frail patients (53.4% vs. 16.7%; $p=0.010$). A higher CCI was associated with decreased PFS (45.1% vs. 22.2%; $p=0.012$) but it did not influence the risk of recurrences or death ($p=0.360$; $p=0.111$, respectively). The Lee Schonberg prognostic index, the ECOG and mean age were not associated with survival.

Conclusion* The G-8 score independently predicted PFS in elderly OC patients regardless of maximal surgical effort.

Thus, it could be useful to assess surgical treatment based on frailty rather than age alone.

260

IMPACT OF BRCA & PD-L1 IN EOC PATIENTS RECEIVING STANDARD 1ST LINE THERAPY +/- PEMBROLIZUMAB: EXPLORATORY ANALYSES FROM THE NEOPEMBROV STUDY (GINECO)

¹O Le Saux, ²AM Savoye, ³MA Mouret-Reynier, ⁴C Schiffler, ⁵O Derbel, ⁶T Isabelle, ⁷E Kalbacher, ⁸S Gouverant, ⁹A Martinez, ¹⁰C Cornila, ¹¹M Martinez, ¹²L Bengrine Lefevre, ¹³F Priou, ¹⁴N Cloarec, ¹⁵L Venat-Bouvet, ¹⁶A Angelergues, ¹⁷D Berton, ¹⁸O Collard, ¹⁹E Coquan, ²⁰I Ray-Coquard*. ¹Centre Léon Bérard, Centre de Recherche en Cancérologie de Lyon, Lyon, France; ²Institut Jean Godinot, Reims, France; ³Centre Jean Perrin, Department of Medical Oncology, Clermont-Ferrand, France; ⁴Centre Léon Bérard, Direction de la Recherche clinique et de l'Innovation, Lyon, France; ⁵Institut de Cancérologie, Hôpital Privé Jean Mermoz, Lyon, France; ⁶Centre Léon Bérard, Lyon, France; ⁷CHRU Jean Minjoz, Besançon, France; ⁸Centre Henri-Becquerel, Department of Medical Oncology, Rouen, France; ⁹Institut Claudius Régaud IUCT-O, Toulouse, France; ¹⁰Centre Hospitalier Régional d'Orléans, Orléans, France; ¹¹Clinique Pasteur, Toulouse, France; ¹²Centre Georges-François Leclerc, Dijon, France; ¹³CHD Vendée – Hôpital Les Oudairies, La Roche-Sur-Yon, France; ¹⁴Centre Hospitalier Henri Duffaut, Avignon, France; ¹⁵Centre Hospitalier Universitaire Dupuytren, Limoges, France; ¹⁶Groupe Hospitalier Diaconesses Croix Saint-Simon, Department of Medical Oncology, Paris, France; ¹⁷ICO – Centre René Gauducheau, Saint-Herblain, France; ¹⁸Institut de Cancérologie de la Loire – Lucien Neuwirth, Department of Medical Oncology, Saint-Priest-en-Jarez, France; ¹⁹Centre François Badlesse, Department of Medical Oncology, Caen, France

10.1136/ijgc-2021-ESGO.369

Introduction/Background* In the randomized phase II Neo-PembroV study (NCT03275506), Pembrolizumab in combination with neoadjuvant chemotherapy (NACT) met its primary endpoint of complete debulking rate (CRR) for the treatment of patients with advanced up-front non-resectable high-grade serous ovarian cancer (HGSOC). However, the CRR in the control group was similar. Identification of potential predictive biomarkers is fundamental to better understand the place of Pembrolizumab in this setting.

Methodology 91 Patients (pts) with HGSOC unable to received complete upfront debulking surgery were included and received Carboplatin (AUC5) Q3W + Paclitaxel (175mg/m²) Q3W +/- Pembrolizumab 200 mg Q3W IV before and after surgery. Pembrolizumab was given until 24 months maximum. After interval debulking surgery, optional bevacizumab was proposed. BRCA1/2 mutation status (BRCA) was assessed using standard algorithms. Immunohistochemical PD-L1 expression was evaluated on both tumour and immune cells (IC) using the Ventana SP263 assay. Associations of progression-free survival (PFS) with BRCA, and PD-L1 expression were evaluated.

Result(s)* BRCA status was available for 81 pts (89%). 3 out of 30 pts (10%) in the control arm harboured a BRCA mutation (mBRCA) versus 13/61 in the experimental arm (21.3%). Median PFS (mPFS) in both arms in the BRCA wild-type (wtBRCA) subgroup were not different (mPFS 20.8 months [95% IC, 15.0-25.7] vs 18.2 months [95%IC, 16.8.0-21.4] in control and experimental arms respectively). mPFS in the mBRCA subgroup were not reached in both arms. PD-L1 expression was available for 85/91 patients (93.4%). PD-L1 IC ≥5% was positive in 29/85 patients (34.1%) and correlated to mPFS in the whole population (18.2m in PDL1 IC <5% vs 23.4m PD-L1 IC ≥5% respectively, $p=0.02$). mPFS was