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 (bppPFS), 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

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

Abstract 242 Figure 1

Abstract 253

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

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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

<table>
<thead>
<tr>
<th>Category</th>
<th>Items</th>
<th>Possible responses (score)</th>
</tr>
</thead>
</table>
| (1) Nutritional status | 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/m²]? |                                                                      | 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) Functional status | Mobility?                                                             | 0: bed or chair bound  
1: able to get out of bed/chair but does not go out  
2: goes out |
| (5) Cognitive status | Neuropsychological problems?                                         | 0: severe dementia/ depression  
1: mild dementia/ depression  
2: no psychological problems |
| (6) Comorbidities | 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: <75 years  
1: 70-<85 years  
2: >85 years |

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)

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9Centre Henri-Becquerel, Department of Medical Oncology, Rouen, France  
10Institut Claudius Régaud IUCT-O, Toulouse, France  
11Centre Hospitalier Régional d’Orléans, Orléans, France  
12Clinique Pasteur, Toulouse, France  
13Centre Georges-François Leclerc, Dijon, France  
14CHD Vendée – Hôpital Les Oudairies, La Roche-Sur-Yon, France  
15Centre Hospitalier Henri Dufait, Avignon, France  
16Centre Hospitalier Universitaire Dupuytren, Limoges, France  
17Groupe Hospitalier Diagonoses Croix Saint-Simon, Department of Medical Oncology, Paris, France  
18ICO – Centre René Gauduchaud, Saint-Herblain, France  
19Centre de Cancérologie de la Loire – Lucien Neuwirth, Department of Medical Oncology, Saint-Priest-en-Jarez, France  
20Centre François Baclesse, Department of Medical Oncology, Caen, France

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 (HGSOCC). 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 HGSOCC 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% CI, 15.0-25.7] vs 18.2 months [95% CI, 16.8-20.5] 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