cases (N: 14). Mean time of hospitalization was 7.84 days (4.16 SD; max:15, min:1). Few patients had complications: surgical urologic complications: 12.0% N:3; postsurgery complications: urological (N:2), abdominal wall infection (N:2), eventration (N:1), vascular (N:1).

Conclusion* Ovarian cancer in premenopausal women is a threatening condition, diagnosed in most cases in advanced stages, that needs a combination of quemotherapy and surgery. Surgical approach must be aggressive in order to achieve a complete resection of the tumor.

491 THE IMPACT OF ERAS IN CYTOREDUCTION FOR ADVANCED OVARIAN CANCER

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Introduction/Background* Complete cytoreduction is the cornerstone of the treatment for advanced ovarian cancer (AOC). To achieve this goal multiple organ resection is required, with an important impact on the patient's overall health. These patients may benefit from the implementation of enhanced recovery after surgery (ERAS). The aim of this study is to evaluate the possible benefit in the patient's postoperative morbidity.

Methodology Retrospective analysis of women with AOC from the 1st Department of Obstetrics & Gynecology AUTh at "Papageorgiou" Hospital (ESGO Certified Center for AOC), 2014 – 2019. From 2014 to 2016 conventional management (CM) was applied, while from 2017 to 2019 patients where managed with ERAS protocol. Patient & tumor characteristics, treatment options and follow-up information were collected. Primary outcomes where ICU admittance, post-operative complications (Clavien – Dindo classification) and hospitalization.

Result(s)* 142 patients met the inclusion criteria. Patients underwent either primary debulking surgery (PDS) or interval debulking surgery (IDS). 84 patients were treated with conventional management and 58 with ERAS protocol. The mean age for the ERAS group was 60 ± 13 vs. 61 ± 13 years old for the CM group (p=0.8315). Furthermore, there was no difference between the type of surgery operation duration between the 2 groups. (CM group: 210min vs. ERAS group: 240min, p=0.1497/CM group: 50% PDS – 50% IDS vs. ERAS group: 38% PDS – 62% IDS, p=0.1554). However, the occurrence of ICU admittance (32% vs. 14%, p=0.01263), overall postoperative complications (32 vs. 22.6, p=0.004) and hospitalization (9 vs. 7 days, p<0.001) were significantly reduced by the implementation of the ERAS protocol. Last but not least, concerning 30day mortality: 3 patients died during conventional management, while only 1 died during ERAS protocol.

Conclusion* The implementation of the ERAS program in the management of AOC improves patient's postoperative morbidity, reducing the interval time between surgery and systematic therapy. Less need for the ICU and fewer days in the hospital can decrease healthcare costs in high-volume gynecological – oncological centers.

494 MAINTENANCE OLAPARIB IN PLATINUM-SENSITIVE RECURRENT OVARIAN CANCER: A COMPREHENSIVE CANCER CENTRE'S EXPERIENCE

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Introduction/Background* The majority of newly diagnosed patients with ovarian cancer respond to platinum-based chemotherapy (ChT). However, most patients eventually relapse and will need subsequent treatment. Olaparib is a poly ADP–ribose polymerase inhibitor that has shown efficacy as maintenance treatment in patients with platinum-sensitive relapsed ovarian cancer.

Methodology We retrospectively evaluated patients with platinum-sensitive relapsed ovarian cancer treated with maintenance olaparib (400mg bid, capsules or 300mg bid, tablets), who previously received ≥2 platinum-based ChT regimens and had a partial or complete response to last platinum-based regimen. All patients were BRCA 1/2 mutated (germline and/or somatic). Study endpoints were progression-free survival (PFS), overall survival (OS), overall response rate and adverse events.

Result(s)* Between May 2016 and December 2020, 21 patients were treated with olaparib. Median age was 55 years (range 44-69), and all had ECOG ≤1. The majority had an ovary primary tumour location (81.0%) and serous histology (85.7%). Thirteen patients (61.9%) had partial response to most recent platinum-based ChT, and eight (38.1%) had complete response. Median follow-up time was 18.3 months (1.8-60.3), with 13 patients alive. Median PFS was 8.3 months (CI95% 6.0-10.6). Median OS was not reached. Overall response rate was 19.0% (4 complete responses) and 16 patients had stable disease; hence, 95.2% benefited from treatment with olaparib. There were no differences in PFS by number of prior platinum regimens, response to last platinum-based ChT, time-to-progression after penultimate platinum-based ChT (>6-12 vs >12 months) or BRCA mutation type (germline vs somatic). Most adverse events reported were grade 1 or 2 and were mainly nausea and haemathologic toxicity. Grade 3 and 4 adverse events occurred in six (28.6%) patients and were: anaemia, neutropaenia and nausea. Thirteen (61.9%) patients suspended olaparib, 12 (57.1%) due to disease progression and one due to her own will. There were no patients that suspended treatment due to toxicity.

Conclusion* Our results confirm the effectiveness and safety of maintenance olaparib in real-world setting. This treatment is feasible in the clinic and well tolerated, with manageable toxicity.

498 METASTATIC HIGH GRADE SEROUS OVARIAN CANCER HAS AN IMMUNE EXCLUDED TUMOR MICROENVIRONMENT – EXPLAINING FAILURE OF IMMUNOTHERAPY TO DATE

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