pathogenic variant carriers, respectively. The origin of PC is yet unknown. However, as the origin of ovarian cancer probably lies in the Fallopian tube, the Serous Tubal Intraepithelial Carcinoma (STIC) may be the origin of PC as well. In this Individual Patient Data Meta-Analysis (IPD-MA), we determine the risk of PC for BRCA1/2 pathogenic variant carriers with and without STIC at RRSO.

**Methodology**
We performed a systematic search of MEDLINE, EMBASE and Cochrane on studies providing follow-up in BRCA-mutation carriers after RRSO. Individual patient data was extracted and the authors of eligible studies were contacted to complete this data. Additionally, we retrospectively collected data from the Radboudumc (Nijmegen, the Netherlands), Kaiser Permanente (San Francisco, USA) and MD Anderson (Houston, USA) of BRCA1/2 pathogenic variant carriers undergoing RRSO.

**Result(s)**
After screening, 15 out of 2,151 studies were included. Including the retrospective case series, individual patient data was available for 3,121 women without STIC and 115 women with STIC at RRSO. The median age (range) was 46 (24-80) of women without and 52 (36-77) for women with STIC. The hazard ratio to develop PC after RRSO was 29.3 for women with STIC compared to women without STIC at RRSO (P<0.001) (figure 1). The five-year risk to develop PC was 0.4% (0.2%-0.7%) for women without STIC and 12.6% (5.2%-19.3%) for women with STIC. The respective ten-year risks are 0.9% (0.3-1.4) and 23.5% (10.6-34.5%). Additional sensitivity analyses did not alter the results.

**Conclusion**
From this IPD-MA we conclude that BRCA pathogenic variant carriers with a STIC at RRSO are at increased risk to develop PC during follow-up. These results are important for clinical awareness and future research. The question arises whether a STIC should be considered as precursor or early stage ovarian cancer. Larger prospective-multicenter studies are needed to investigate the additional value of staging surgery and/or chemotherapy in case of STIC.
Methodology  Retrospective observational cohort study. We reviewed medical records of diagnosed EOC patients (pts) who were eligible for SACT, between 2012 and 2018. Primary endpoint was overall survival (OS). Secondary endpoints were description of platinum sensibility patterns and lines of treatment (LOT). Descriptive analysis of main demographic, clinical and treatment variables were performed. Kaplan-Meier method was used for OS. Uni and multivariable analysis were done using Cox proportional hazard analysis.

Result(s)* We identified 268 EOC pts with median age of 66 (24-94). Debulking surgery was performed in 119 pts (44.4%). Most were stage III-IV FIGO (200, 74.6%) and had high-grade serous morphology (103, 38.6%). BRCA mutations (germline and/or somatic) were detected in 7.6% of 131 tested pts. A third of pts never relapsed (86, 32.1%). Platinum-based CT was the 1st LOT in 173 pts (64.6%). After relapse or progression, primary platinum resistance (PPR) was present in 34 (19.7%), partial platinum sensibility in 29 (16.8%) and full platinum sensibility in 24 (13.9%). Of the 180 pts who progressed, 41 (22.8%) were submitted to 2nd SACT and 20 (11.1%) to 3rd SACT. Median number of LOT was 2 (1-8). Bevacitumab concomitant with CT was used in 45 pts (16.8%) at some point. PARPi was used in 23 (8.6%) pts as maintenance treatment after ≥2 platinum-based CT complete or partial response. Median OS was 25.5 months [IC95% 19.55-35.42], which was significantly worse for more advanced disease [HR 8.46 IC95% 4.13-17.31] and PPR [HR 2.72 IC95% 1.63-4.54].

Conclusion* Our results confirm that EOC outcomes are modest and in line with other published cohorts. Multicentric real-world studies are needed to evaluate how innovative targeted therapies, recently introduced in the daily clinical practice, will change the course of this disease.

Abstracts

THE ROLE OF CA-125 AND HE-4 IN EPITHELIAL OVARIAN CANCER FOLLOW-UP
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Methodology All patients were diagnosed of any stage of EOC from January 2014 to June 2020. They were retrospectively selected for the assessment of HE-4 and Ca-125 levels.

All patients selected had to undergo surgical treatment with optimal cytoreduction and chemotherapy if indicated, and they had to show radiological complete response after surgery. Out of 105 patients diagnosed during this period, 79 subjects met the inclusion criteria. 7 of them were lost during the follow-up, so 72 patients were included in the analysis.

Result(s)* 47 out of 72 patients relapsed during the follow-up (65,3%). Out of all relapses, 32 patients had available data and reached normal levels of HE-4 after the surgery. 15/32 presented positive levels of HE-4 when the relapse was diagnosed (46,9%). Moreover, in 6/32 cases the levels of HE-4 tend to increase in the moment of the relapse, even though the value did not become positive (18,8%).

Out of all relapses, 43 patients had available data and reached normal levels of Ca-125 after the surgery. 20 out of 43 presented positive levels of Ca-125 when the relapse was diagnosed (46,5%). In addition, in 15/43 cases the levels of Ca-125 tend to increase in the moment of the relapse, even though the value did not become positive (34,9%).

30 patients had available data and reached normal levels of HE-4 and Ca-125 after the surgery. 9/30 cases presented positive levels of both HE-4 and Ca-125 in the moment of relapse (30%).

Conclusion* Most patients showed an increase of biomarkers in agreement with radiologic relapse; in half of the cases the markers level became positive, but in some patients the values tend to increase despite being in the negative range. Both markers used together seem to be useful for the follow-up.