achieved in 19 patients (60%), while 5 (16%) had postoperative residual disease (n=8 missing data). Sixteen patients (50%) commenced systemic treatment within 90 days from surgery, as documented. Thirty- and 90-day surgical mortality rates were 1 (3%) and 2 (6%), respectively. Within a postoperative median follow-up time of 43.8 months, 12 (38%) deaths were reported. Median overall survival after surgery (OS) was 54.0 months. One- and 2-year OS rates were 91% and 84%, respectively.

Conclusion Cytoreductive surgery for subsequent ovarian cancer relapse appears feasible and with low mortality in selected patients who received non-surgical treatment at 1st relapse despite a positive AGO -score. Surgery could be considered as an option in carefully selected patients also later in their journey within a specialized gynecological cancer setting.

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REAL WORLD DATA OF TREATMENT AND OUTCOME OF PATIENTS WITH EARLY OVARIAN CANCER (FIGO I) IN GERMANY (FIGO OVAR OF THE AGO STUDY GROUP)
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Introduction/Background Recent data regarding treatment quality and outcome of patients with early Ovarian Cancer (FIGO I) in Germany.

Methodology All German hospitals treating patients with ovarian cancer were asked to document all patients with first diagnosis in the third quarter of the years 2004, 2008, 2012 and 2016. Surgery quality was categorized as ‘optimal’ (OP+; maximum 1 parameter missing), vs ‘suboptimal’ (OP-). Chemotherapy was defined as optimal according to national guidelines. The overall treatment quality was classified in 3 categories: (1) surgery and chemotherapy optimal (OP+/CT+) versus (2) optimal/suboptimal combined (OP+/CT- or OP-/CT+) versus (3) both suboptimal (OP-/CT-).

Results 19.9% (n=700) of all OC patients were diagnosed FIGO I, of which 47.1% were FIGO IA, 47.9% FIGO IC. Median follow-up period was 51.0 months. Median age was 60 years and 37.1% showed high-grade serous ovarian cancer. The OP+ collective increased from 42.2% to 70.9%. Most common not performed surgical steps were peritoneal biopsies, paraaortic and pelvic lymphadenectomy. Progression-free survival (PFS) and overall survival (OS) were improved with OP+ (84% and 91% at 48-months compared with 71% and 76% with non-optimal surgery: both p<0.001). Optimal chemotherapy standard (CT+) was administered increasingly frequent (71.4% to 80.8%). PFS and OS were prolonged with CT+: 48-months PFS 84% vs. 63% (p<0.001) and 48-months OS 90% vs. 68% (p<0.001). The overall treatment quality cohort 1 increased from 37.9% to 54.1%. 48-months PFS was 86% vs. 76% vs. 62% in group 1 vs. 2 vs. 3, respectively (p<0.001), 48-months OS rates were 93% vs. 81% vs. 68% in group 1 vs. 2 vs. 3, respectively (p<0.001).

Conclusion The Q Ovar shows that the quality of therapy has steadily improved over the years in Germany. Best prognosis could be achieved if surgery and chemotherapy is done according to treatment guidelines.

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RUCAPARIB IN CLINICAL PRACTICE – WHAT ARE THE ELEMENTS OF PATIENT ADHERENCE?

Introduction/Background Patients with advanced ovarian cancer experience relapse and chemotherapy failure which severely reduces quality of life. Despite a positive AGO-score, surgery could be considered as an option in carefully selected patients also later in their journey within a specialized gynecological cancer setting.

Methodology This study will recruit 150 patients with historically diagnosed platinum-sensitive relapsed high grade ovarian cancer, fallopian tube cancer, or primary peritoneal cancer, that are eligible for rucaparib maintenance therapy according to Summary of Product Characteristics (SmPC). Throughout the study, individual patient data will be collected at baseline and every three months until disease progression or patient’s death whichever occurs first. To capture adherence to rucaparib therapy an adaptation (according to the rucaparib therapy) of the ‘Essener Compliance Score’ (ECS) is used. As of June 2022, 13 patients have been included in this study.

Results / Conclusion /