Conclusion The MTD of the triple combination was established and the study met its secondary endpoint of initial efficacy; however, significant cytopenias were noted with this regimen, which may limit further development.

2022-RA-466-ESGO LONG-TERM RESPONDERS (LTR) TO RUCAPARIB IN RECURRENT OVARIAN CANCER: A SUB-GROUP ANALYSIS FROM THE RUCAPARIB ACCESS (RAP) PROGRAM IN SPAIN BY GEICO

[1]Alfonso Yubero, [2]Aranzazu Barquín, [3]Lydia Gaba, [4]Bella Pajares, [5]Piedad Reche, [6]Carmen Salvador, [7]Jesús Alarcón, [8]Luis Manso, [9]Raúl Marquez, [10]Jose Fuentes, [11]Julia Madani, [12]Manuel Costenla, [13]Maria Gutierrez-Toribio, [14]Purificacion Estevez-García, [15]Ana Santaballa, [16]Luisa Sanchez-Lorenzo, [17]Julia Calzas, [18]Ana Herrero, [19]Alvaro Taus, [16]Antonio Gonzalez-Martin. *[1]Hospital Universitario Lozano Blesa, Zaragoza, Spain; [2]Centro integral oncológico Clara Campal, Madrid, Spain; [3]Hospital Clinic de Barcelona, Barcelona, Spain; [4]Hospital Universitario Virgen de la Victoria, Malaga, Spain; [5]Hospital de Torrecárdenas, Almería, Spain; [6]Hospital Lluis Alcanyis, Xativa, Spain; [7]Hospital Son Espases, Palma de Mallorca, Spain; [8]Hospital Universitario 12 de Octubre, Madrid, Spain; [9]MD Anderson, Madrid, Spain; [10]Hospital Universitario Virgen del Valme, Sevilla, Spain; [11]Hospital San Jorge, Huesca, Spain; [12]Complejo Hospitalario Universitario de Pontevedra, Pontevedra, Spain; [13]Hospital Araba-Txagorritxu, Vitoria, Spain; [14]Hospital Universitario Virgen del Rocío, Sevilla, Spain; [15]Hospital Universitari i Politecnic La Fe, Valencia, Spain; [16]Clinica Universidad de Navarra, Madrid, Spain; [17]Hospital Universitario de Fuenlabrada, Fuenlabrada, Spain; [18]Hospital Universitario Miguel Servet, Zaragoza, Spain; [19]Hospital del Mar, Barcelona, Spain*

10.1136/ijgc-2022-ESGO.513

Introduction/Background Rucaparib is a PARPi approved as maintenance (MTN) for platinum (Pt)-sensitive recurrent HGOC, and as treatment (Tx) for *BRCA*-mutated recurrent HGOC patients. Real-world data about LTR patients from the RAP is analyzed here.

Methodology A retrospective GEICO study was performed at 22 hospitals that treated patients within the RAP. Women with HGOC received rucaparib (600 mg BID) in the MTN, Tx Pt-sensitive or Tx Pt-resistant setting. In this subanalysis, long-term response was defined as progression-free survival (PFS) $\geq$12 months for the MTN group and $\geq$6 months for the Tx group.

Results In the study 51 patients were recruited: 18 received rucaparib as MTN and 33 as Tx.In the MTN group, 6 patients (33.3%) were LTR. Of them, 2 patients (33.2%) harbored *BRCA* or *RAD51C*mutations. The median number of prior lines was 3 (2–6), being $\geq$5 in 33.2%, 66.6% had measurable disease and 50.0% achieved PR to prior Pt-based chemotherapy. In the Tx group, 10 patients (30.3%) were LTR. All of them harbored *BRCA* and/or *RAD51C* mutations. The median number of prior lines was 6 (2–9), with 60.0% receiving $\geq$5 prior lines, 60.0% were Pt-resistant and 60.0% had measurable disease. The median PFS of LTR was not achieved in the MTN group and was 10.9 months (95% CI: 7.0–16.7) in the Tx group. Adverse events (AE) of any grade were reported in 66.6% of LTR within the MTN group and in 100.0% within the Tx group, while AE of grade $\geq$3 occurred in 16.6% and 50.0%, respectively. No new safety signals were detected. At present, 3 and 1 patients are still receiving rucaparib as MTN and Tx, respectively.

Conclusion A durable response was achieved in a notable proportion of patients, despite their unfavorable conditions at treatment initiation. The safety profile of rucaparib in this real-world setting is consistent with that previously reported.

2022-RA-567-ESGO THE GENEVA HRD TEST: CLINICAL VALIDATION ON 469 SAMPLES FROM THE PAOLA-1 TRIAL

[1]Yann Christinat, [1]Liza Ho, [2]Sophie Clément, [3]Catherine Genestie, [4]Jalid Sehouli, [5]Antonio Gonzalez Martin, [6]Ursula Denison, [7]Keiichi Fujiwara, [8]Ignace Vergote, [9]Germana Tognon, [10]Sakari Hietanen, [11]Eric Pujade-Lauraine, [12]Isabelle Ray-Coquard, [1]Thomas A McKee. *[1]Clinical Pathology Division, Geneva University Hospitals, Genève, Switzerland; [2]Université de Genève, Geneva, Switzerland; [3]Gustave Roussy, Paris, France; [4]Charité – Universitätsmedizin Berlin (CVK), Berlin, Germany; [5]MD Anderson Cancer Center Madrid, Madrid, Spain; [6]Klinik Hietzing, Institute for gynaecological oncology und senology, Vienna, Austria; [7]Saitama Medical University International Medical Center, Saitama, Japan; [8]University hospitals leuven and Leuven Cancer Institute, Leuven, Belgium; [9]Spedali Civili di Brescia, Brescia, Italy; [10]Turku University Hospital, Department of Obstetrics and Gynecology, Turku, Finland; [11]ARCAGY-GINECO, Paris, France; [12]Centre Leon Bérard, Lyon, France*

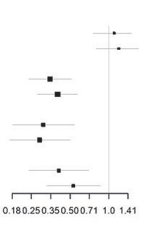
10.1136/ijgc-2022-ESGO.514

Introduction/Background The efficacy of the Myriad myChoice® Homologous Recombination Deficiency (HRD) test to guide use of PARP inhibitors has been demonstrated in several phase III trials. However, its high failure rate and limited accessibility establish a need for a clinically validated laboratory developed test.

Methodology As part of the ENGOT HRD European Initiative, a subset of the PAOLA-1/ENGOT-ov25 phase 3 trial was analyzed in the Geneva University Hospitals with the OncoScan™ CNV Assay and an in-house algorithm developed using TCGA data. Results were compared to Myriad myChoice Genomic Instability Score (GIS) with respect to the progression-free survival in the Olaparib+Bev and placebo+Bev arms.

Results The analysis of the TCGA cohort revealed that a normalization of the number of LST (large-scale state transitions) by the number of whole-genome doubling events allows a better separation and classification of HRD samples than the Myriad GIS. On the 469 PAOLA-1 samples, the Geneva test yielded a lower failure rate than Myriad (10/469 vs 59/469 inconclusive results) and positive and negative agreement values of 96% (204/213) and, respectively, 81% (159/197). In Geneva HRD-positive samples, the hazard ratio (HR) was 0.40 (95% CI: 0.28–0.57; figure 1). For Myriad, the HR was 0.35. In BRCA wild-type and Geneva HRD-positive samples, the HR was 0.53 (Myriad: 0.41). Of note, in this subpopulation the Geneva test and the Myriad test yielded a similar 1-year PFS (87% and 88%) but a different 2-year PFS (52% vs 60%).

Subgroup	Olaparib arm	Placebo arm	Hazard ratio (95% CI)
HRD negative - All			
Myriad (GIS<42)	136/195 (70%)	59/195 (30%)	1.1 (0.76-1.5)
Geneva (nLST<15)	113/165 (68%)	52/165 (32%)	1.2 (0.8-1.7)
HRD positive - All			
Myriad (GIS>=42)	144/210 (69%)	66/210 (31%)	0.35 (0.24-0.51)
Geneva (nLST>=15)	167/240 (70%)	73/240 (30%)	0.4 (0.28-0.57)
HRD positive - BRCAmut			
Myriad (GIS>=42)	84/119 (71%)	35/119 (29%)	0.31 (0.18-0.54)
Geneva (nLST>=15)	89/127 (70%)	38/127 (30%)	0.29 (0.17-0.5)
HRD positive - BRCAwt			
Myriad (GIS>=42)	60/91 (66%)	31/91 (34%)	0.41 (0.24-0.7)
Geneva (nLST>=15)	78/113 (69%)	35/113 (31%)	0.53 (0.33-0.86)



Abstract 2022-RA-567-ESGO Figure 1

Conclusion The proposed test is a viable alternative to the Myriad myChoice HRD test and can easily be implemented in a clinical laboratory for routine practice. The performance of the tests is similar in terms of hazard ratio but the lower failure rate of the Geneva HRD test allows a 10% increase in the number of patients receiving a conclusive laboratory result.

2022-VA-572-ESGO HUDSON POSTERIOR EXENTERATION, WITH THE USE OF ICG FLUORESCENCE TO ASSESS RECTAL ANASTOMOSIS AND URETERAL INTEGRITY

Dong Bach Nguyen, Beatriz Navarro Santana, Guillaume Babin, Sara Forte, Mathilde Mairé, Frédéric Guyon. *Gynécologie Oncologie, Institut Bergonié, Bordeaux, France*

10.1136/ijgc-2022-ESGO.515

Introduction/Background The surgical approach to hysterectomy for ovarian cancer has remained largely unchanged since Hudson described the en-bloc resection of fixed ovarian tumors using a retrograde technique in 1968. When a colorectal resection is required for optimal debulking, anastomotic leak remains a significant concern. While the traditional techniques used to evaluate for anastomotic perfusion lack accuracy, data from a recent systematic review and meta-analysis favours the use of ICG intra-op to reduce the incidence of anastomotic leak and associated need for re-intervention.

Methodology With the use of surgical footage, this video aims to present the surgical steps to a Hudson procedure with colorectal resection, ending with the use of ICG fluorescence to assess the perfusion of the colorectal anastomosis and ureters.

Results The surgical approach can be summarized in the following ten steps: (1) retroperitoneal dissection of the vascular pedicles and ureters, and transection of the IP ligament; (2) dissection of the paravesical and pararectal spaces; (3) lateral and pre-vesical peritonectomy; (4) ureterolysis and transection of the uterine vessels; (5) transection of the vesciouterine and uterosacral ligaments; (6) colpotomy; (7) mesorectal dissection and distal rectal transection; (8) proximal rectosigmoid transection; (9) vaginal vault closure and colorectal anastomosis; (10) assessment of colorectal anastomosis and ureteral vascularization by ICG fluorescence.

Conclusion This video presented 10 reproducible steps to perform a Hudson procedure with colorectal resection for ovarian cancer. The use of ICG as an adjunct to assess the vascularization of the colorectal anastomosis appears to reduce the risk of anastomotic leak in colorectal surgery, and may be of interest in gynecologic-oncologic surgery.

2022-RA-576-ESGO EXPRESSION VIII – FIRST STUDY OF INDIVIDUAL PERCEPTION AND LEVEL OF INFORMATION OF PATIENTS WITH LOW GRADE OVARIAN CANCER AND BORDERLINE TUMOR OF THE OVARY IN 321 PATIENTS

[1]Laura Naomi Beckmann, [1]Sara Alavi, [2]Maren Keller, [3]Clemens Liebrich, [4]Karol Kubiak, [5]Pauline Wimberger, [6]Vera Czolk, [7]Anette Ligl-Löhner, [8]Hans-Martin Enzinger, [9]Aline Burdack, [10]Dorothea Fischer, [11]Jürgen Terhaag, [12]Cornelia Müller, [13]Volker Hanf, [14]Mateja Condic, [15]Georg Kunz, [16]Tilmann Lantzsch, [17]Ute Schilling, [1]Gülten Oskay-Özcelik, [1]Jalid Sehouli. *[1]Department of Gynecology with Center for Oncological Surgery, European Compe-tence Center for Ovarian Cancer, Charité – Campus Virchow-Klinikum, University Medicine of Berlin, Berlin, Germany; [2]North-Eastern German Society of Gynecological Oncology (NOGGO), Berlin, Germany; [3]Gynäkologisches Krebszentrum, Klinikum Wolfsburg, Wolfsburg, Germany; [4]St. Franziskus-Hospital GmbH, Münster, Germany; [5]Department of Gynecology and Obstetrics, TU Dresden Medizinische Fakultat Carl Gustav Carus, Dresden, Germany; [6]Diako Mannheim, Mannheim, Germany; [7]Diakonissen-Stiftung-Krankenhaus Speyer, Speyer, Germany; [8]Sozialstiftung Bamberg, Bamberg, Germany; [9]Sana Klinikum Lichtenberg, Berlin, Germany; [10]Klinikum Ernst von Bergmann gemeinnützige GmbH, Potsdam, Germany; [11]Rottal-Inn Kliniken KU Eggenfelden, Eggenfelden, Germany; [12]Universitätklinikum Brandenburg an der Havel, Brandenburg an der Havel, Germany; [13]Klinikum Fürth, Fürth, Germany; [14]Universitätsklinikum Bonn, Bonn, Germany; [15]St.-Johannes-Hospital Dortmund, Dortmund, Germany; [16]Krankenhaus St. Elisabeth und St. Barbara Halle (Saale) GmbH, Halle (Saale), Germany; [17]Park-Klinik Weißensee, Berlin, Germany*

10.1136/ijgc-2022-ESGO.516

Introduction/Background Low-grade serous carcinomas (LGSC) are associated with better prognoses compared to their high-grade serous (HGSC) counterparts. Nevertheless, we are confronted with a challenging treatment, since the median age upon diagnosis is younger, standard platinum-based chemotherapy is less effective and, most importantly, it has still not been as well studied as HGSC. The purpose of this ongoing study was to examine patients' perception and assessment regarding their disease and therapy as well as the level of information among women with LGSC and borderline ovarian tumors (BOT).

Methodology A questionnaire was developed based on the experiences of previous EXPRESSION-trials and provided to patients with LGSC and BOT. The hardcopy-version was converted into an online database and statistically analyzed via SPSS-Software.

Results From March 2019, 321 patients with LGSC and BOT from eighteen German clinics and gynecological practices participated in the survey, 90 (28%) with LGSC and 231 (72%) with BOT. While nearly all patients (97.8% LGSC; 94.3% BOT) had primary surgery, 58% of LGSC patients received adjuvant chemotherapy. Patients indicated the attending physician as the main source of information (81% LGSC; 85% BOT). The majority were pleased with the explanation about their illness and therapy. Significantly more BOT-patients were not aware of their tumor stage during initial diagnosis