

were factors related to CDC grade  $\geq$ IIIa. Of 300 patients, 25 patients did not receive chemotherapy after surgery and were excluded from TTC analysis. In 26% (72/275) TTC was  $>$  42 days: median (IQR) 39 days (29–50) in patients with CDC grade  $\geq$ IIIa versus 33 days (25–41) in patients without CDC grade  $\geq$ IIIa,  $p=0.008$ . Patients with the following factors: WHO performance grade  $\geq 2$  ( $p=0.045$ ), intra-operative bowel injury ( $p=0.043$ ), other visceral injury ( $p=0.008$ ) and post-operative CDC grade  $\geq$ IIIa ( $p=0.032$ ) had a significantly higher adjusted odds of developing TTC  $>$ 42 days.

**Conclusion** Patients with advanced age, cardiovascular comorbidity, and those who required diaphragmatic surgery had a greater adjusted odds of develop CDC grade  $\geq$ IIIa. CDC grade  $\geq$ IIIa was independently associated with TTC  $>$ 42 days. A proper pre-operative risk assessment and prevention of intra-operative morbidity are essential in order to prevent severe post-operative complications and the delayed time to chemotherapy.

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#### THE ROLE OF SYSTEMATIC PELVIC AND PARA-AORTIC LYMPHADENECTOMY IN THE MANAGEMENT OF PATIENTS WITH ADVANCED EPITHELIAL OVARIAN, TUBAL, AND PERITONEAL CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

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**Introduction/Background** The objective of the current study is to investigate whether systematic pelvic and para-aortic lymphadenectomy offers superior survival rates and fewer peri-operative complications in patients with advanced epithelial ovarian cancer (EOC), tubal, or peritoneal cancer.

**Methodology** We searched the electronic databases PubMed, Cochrane Central Register of Controlled trials, and Scopus from inception to September 2021. We considered randomised controlled trials (RCTs) comparing systematic pelvic and para-aortic lymphadenectomy with no lymphadenectomy in patients with advanced EOC. Primary outcomes were overall survival and progression-free survival. Secondary outcomes were peri-operative morbidity and operative mortality. The revised Cochrane tool for randomised trials (RoB 2 tool) was utilised for the risk of bias assessment in the included studies. We performed time-to-event and standard pairwise meta-analyses, as appropriate.

**Results** Two RCTs with a total of 1074 patients were included in our review. Meta-analysis demonstrated similar overall survival (HR = 1.03, 95% CI [0.85 – 1.24]; low certainty) and progression-free survival (HR = 0.92, 95% CI [0.63 – 1.35]; very low certainty). Regarding peri-operative morbidity, systematic lymphadenectomy was associated with higher rates of lymphoedema and lymphocysts formation (RR = 7.31, 95% CI [1.89 – 28.20]; moderate certainty) and need for blood transfusion (RR = 1.17, 95% CI [1.06 – 1.29]; moderate certainty). No statistically significant differences were observed in

regard to other peri-operative adverse events between the two arms.

**Conclusion** Systematic pelvic and para-aortic lymphadenectomy is likely associated with similar overall survival and progression-free survival compared to no lymphadenectomy in optimally debulked patients with advanced EOC. Systematic lymphadenectomy is also associated with an increased risk for certain peri-operative adverse events. Further research needs to be conducted on whether we should abandon systematic lymphadenectomy in completely debulked patients during primary debulking surgery.

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#### WHO RECEIVES MAINTENANCE THERAPY AFTER FIRST-LINE CHEMOTHERAPY? A REAL-WORLD ASSESSMENT OF PATIENTS WITH OVARIAN CANCER WHO RECEIVED NIRAPARIB FIRST-LINE MAINTENANCE THERAPY IN THE UNITED STATES

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**Introduction/Background** Niraparib, a poly(ADP-ribose) polymerase inhibitor (PARPi), was approved 29Apr2020 in the US for first-line maintenance (1LM) treatment of advanced epithelial ovarian cancer (EOC). To better understand how niraparib 1LM approval impacted who received niraparib in clinical practice, this study characterised real-world patients with EOC prescribed niraparib for 1LM before and after FDA approval using real-world data.

**Methodology** This retrospective cohort study used the nationwide Flatiron Health electronic health record-derived de-identified database and included patients diagnosed with EOC between 01Jan2011 and 30Nov2021, who were  $\geq 18$  years old at initial diagnosis and received first-line platinum-based treatment. The index date was defined as the initiation date of 1LM niraparib monotherapy, on or after 01Jan2017. Demographic and clinical characteristics of the study cohort were assessed from initial EOC diagnosis to index date. Patients were stratified by index date: before 29Apr2020 (niraparib preapproval cohort) or after 29Apr2020 (niraparib postapproval cohort).

**Results** A total of 374 patients initiated 1LM niraparib monotherapy. Most patients had stage III (50%) or IV (35%) disease and had BRCAwt (84%); 40% of patients had no visible residual disease (table 1). Demographic and clinical characteristics were mostly similar across the cohorts. However, the niraparib postapproval cohort (n=284) had fewer patients with stage IV disease (30% vs 49%) and more with BRCAwt (90% vs 63%) than the preapproval cohort (n=90). Furthermore, fewer patients in the niraparib postapproval cohort had unknown BRCA status (3% vs 16%), unknown HRD status (63% vs 84%), and no debulking surgery (13% vs 27%).