need to offer maximum effort surgery (MES) with the aim of complete cytoreduction (R0 resection), to improve survival. The objective of this study is to analyse the implementation of a paradigm shift in the surgical management of women with AOC at the University Hospitals of Leicester NHS Trust (UHL) in 2015, until 2020, compared to 2011–2014.

Methodology Retrospective cohort study of women with AOC who underwent cytoreductive surgery (CRS). The two groups were: 153 women from January 2011 to December 2014 (group 1), 136 women from January 2015 to January 2020 (group 2).

Results In group 1, the 1 year, 3 years and 5 years overall survival rates (OS) were 90.4%, 33.7% and 19.3%, compared to 90.2%, 55.4% and 29.7%, respectively, in group 2 \( (p=0.012) \). Significantly more women had CRS in group 2: 45 – Primary debulking surgery (PDS) and 57 – interval debulking surgery (IDS) vs. 17 – PDS & 67 – IDS in group 1 \( (P<0.001) \). Surgical complexity score (modified Aletti score) was higher in group 2 compared to group 1 \( (p=0.001) \). No significant difference was noted in the postoperative complications, in group 2, in women who underwent PDS vs. IDS, yet PDS was associated with higher OS.

Conclusion The transition from standard surgery to maximal effort surgery in AOC patients (a paradigm shift in surgical approach) had a positive impact on OS and PFS rates in our institution. Our data highlights the importance of a dedicated team to implement this change in cancer centres treating AOC. In women who had maximum effort cytoreductive surgery from 2015 onwards, PDS was associated with higher survival rates and comparable post-operative complications than IDS although the surgical complexity was higher in the PDS group.

Introduction/Background ARTISTRY-7 will evaluate the novel engineered cytokine nemvaleukin alfa (nemvaleukin, ALKS 4230) in patients with gynaecological cancers. Epithelial ovarian cancer (EOC) is the 7th most common cause of cancer mortality in women, and many patients become resistant/refractory to frontline platinum-based chemotherapy. Nemvaleukin was designed to selectively bind to the intermediate-affinity interleukin-2 receptor, preferentially activating antitumour CD8+ T and NK cells with minimal regulatory T cell expansion. This selectivity may provide enhanced tumour killing and improved safety/tolerability versus high-dose interleukin-2. In ARTISTRY-1, responses were observed with nemvaleukin+pembrolizumab in 4 patients with platinum-resistant ovarian cancer: 2 complete responses (1 in a patient with 5 prior lines of therapy), and 2 partial responses.

Methodology ARTISTRY-7 (NCT05092360) is an ongoing, currently enrolling phase 3, multicentre, randomised study of nemvaleukin and/or pembrolizumab versus chemotherapy. Eligible patients are women \((\geq 18\) years) with histologically confirmed EOC (high-grade serous, endometrioid, clear cell), fallopian tube cancer, or primary peritoneal cancer. Patients must have had \( \geq 1 \) prior line of systemic therapy (platinum-sensitive setting), \( \leq 3 \) prior lines (platinum-resistant setting), and prior bevacizumab, with radiographic progression on most recent therapy. Patients with primary platinum-refractory disease (progression on first-line platinum therapy) or primary platinum resistance (progression \(<3 \) months after first-line platinum therapy completion) are excluded. Approximately 376 patients are being randomised \((3:1:1:3) \) to receive nemvaleukin 6 \( \mu \)g/kg intravenously \((\text{days 1–5}) \) + pembrolizumab 200 mg intravenously \((\text{day 1}) \) of each 21-day cycle, pembrolizumab or nemvaleukin mono-therapy, or chemotherapy, and stratified by PD-L1 status, histologic subtype, and chemotherapy (paclitaxel vs others). Patients will continue treatment until disease progression or
intolerable toxicity (maximum 35 pembrolizumab cycles; nemvaleukin can be continued). Primary endpoint: investigator-assessed progression-free survival (RECIST v1.1) in the nemvaleukin+pembrolizumab versus chemotherapy arms. Secondary/exploratory endpoints include overall survival, other anti-tumour measures, safety, health-related quality of life, and pharmacokinetic/pharmacodynamic effects.

**Results** not applicable

**Conclusion** not applicable

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**2022-RA-688-ESGO**  
**SURVIVAL OUTCOMES OF ADVANCED OVARIAN CANCER PATIENTS UNDERGOING MAXIMAL EFFORT CYTOREDUCTION**

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10.1136/ijgc-2022-ESGO.547

**Introduction/Background**  
Surgery remains one of the main treatment modalities for the treatment of ovarian cancer. Patients with advanced stage disease will likely undergo neo-adjuvant chemotherapy as the majority of surgeons is not familiarized with maximal effort cytoreduction. The purpose of the present study is to evaluate morbidity and mortality outcomes of ovarian cancer patients undergoing procedures with and intermediate and high complexity score.

**Methodology**  
We performed a retrospective chart review of patients undergoing intermediate and high complexity procedures (according to the Mayo Clinic classification system) between 2008 and 2020. We assessed morbidity and survival outcomes in order to evaluate which subgroups benefited the most from maximal effort cytoreduction.

**Results**  
Overall 107 patients were included with a median duration of follow-up of 45 months (24–156). The median surgical complexity score was 7 (4–15). The progression free and overall survival rates of the entire cohort were 28 (22 – 34) and 47 (37–57) months respectively. Sixteen patients experienced a grade IIB Clavien-Dindo complication. Median high dependency unit stay was 3 days (1–15). Five patients required hospitalization in the intensive care unit. Patients undergoing primary debulking had a clear overall survival benefit compared to patients that had interval debulking surgery (54 months (40–67) vs 35 months (24–46)). Kaplan Meier curves revealed that the difference became evident among patients that survived for at least 50 months. Recurrence free survival was not influenced by this parameter. A progressive decrease in overall survival rates was observed with advancing stage. Complexity of the procedure (intermediate vs high) did not affect survival rates of patients.

**Conclusion**  
Maximal effort cytoreduction is feasible and is accompanied by acceptable morbidity and mortality rates. Primary debulking should be considered in appropriately selected patients as this considerably increases overall survival rates of patients.