Introduction/Background Standard of care chemotherapy in patients (pts) with advanced ovarian cancer (AOC) is the combination of carboplatin and paclitaxel (C/P). Data from the PRIMA trial has shown a significant benefit in pts by the addition of a maintenance treatment (MT) with niraparib irrespective of BRCA or HRD-status in high-grade AOC. The PAOLA-1 trial evaluated MT in pts with AOC with the combination of olaparib and bevacizumab and has also shown a significant benefit compared to bevacizumab monotherapy. However, the role/benefit of bevacizumab in addition to PARP-inhibitor (PARPi) in MT is unclear. Therefore, we investigate, if the treatment strategy of carboplatin/paclitaxel/bevacizumab/PARPi is superior to the treatment of carboplatin/paclitaxel/PARPi in a population regardless of biomarker status.

Methodology AGO-OVAR 28/ENGOT-ov57 (NCT05009082; EudraCT-Number: 2021-001271-16) is a multicenter, randomized, prospective phase III trial. The trial population is composed of adult pts with newly diagnosed, high-grade epithelial AOC, primary peritoneal cancer or fallopian tube cancer FIGO III/IV (except FIGO IIIA2 without nodal involvement). All pts should have completed cycle1 of chemotherapy (C/P) as part of Study-Run-In-Period. Prior to day1 of cycle2, pts with a valid central tumour BRCA (tBRCA) test will be randomized 1:1 into either Arm1 and will receive 5 additional cycles of C/P q21d followed by niraparib for up to 3 years; or into Arm2 where pts will receive 5 additional cycles of C/P plus bevacizumab q21d followed by bevacizumab q21d (for up to 1 year) and niraparib for up to 3 years. Patients who are scheduled for neoadjuvant chemotherapy and interval debulking surgery can also be enrolled. The primary objective is progression-free-survival (PFS). Secondary objectives include but are not limited to: PFS according to tBRCA-status, overall survival, PFS2, safety/tolerability, and quality of life. First-Patient-First-Visit is expected in August 2022. Target recruitment is 970 patients.

Results Trial-In-Progress.

Conclusion Trial-In-Progress.
difference in PFS was observed between treatment arm in patients without HRD positive tumors (HR, 0.92; 95% CI, 0.59–1.43; P=0.69). The effect of the interaction between olaparib and HRD status on PFS, in the interim study, was similar for the two stratification methods (P=0.20).

Conclusion The interim results of SOPHiA DDM Dx HRD Solution evaluation study support the value of lpWGS data for patient stratification, making it suitable for HRD testing in the clinical setting.

2022-RA-919-ESGO A PILOT STUDY OF INTERVAL CYTOREDUCTIVE SURGERY AND HIPEC FOR ADVANCED EPITHELIAL OVARIAN CANCER IN THE UK

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Introduction/Background The Christie is one of the first cancer referral centres to offer hyperthermic intraperitoneal chemotherapy (HIPEC) to patients with advanced epithelial ovarian cancer (AEOC) in the UK. Despite the OVIHIPEC1-trial showing longer recurrence free and overall survival for patients undergoing interval cisplatin cytoreductive surgery (CRS) with the addition of HIPEC compared to CRS alone, HIPEC is not yet offered as NHS-funded treatment for AEOC. We report early follow-up data on safety and feasibility of CRS+HIPEC in ovarian cancer patient at the Christie, including costs, adding to the evidence that HIPEC is a cost-efficient addition to current treatment for patients with AEOC.

Methodology Patients with high grade AEOC who achieved a partial response to 3 or 4 cycles of neoadjuvant carboplatin and paclitaxel chemotherapy were selected for interval CRS+HIPEC. The procedure was performed by Gynaecological Surgical Oncologists in collaboration with Peritoneal Surgeons with extensive experience in performing HIPEC procedures. Closed HIPEC delivery technique was used. Cisplatin was perfused at a dose of 100 mg/m2.

Results 9 patients have undergone CRS+HIPEC for AEOC at The Christie since October 2021. By the LBA submission deadline, this will be 10. We will report on median time to surgery from chemotherapy, pre- and postsurgical PCI score, mean length of stay and CCU stay, intra- and postoperative complications and 30 and 90 day mortality. Overall costs of the postoperative care of CRS+HIPEC will be compared to CRS alone in our setting.

Conclusion Interval CRS+HIPEC is feasible and safe for AEOC in a tertiary cancer centre setting. There does not seem to be a significant difference in postoperative complication rate and associated costs compared to the current standard treatment of interval CRS alone.