Results There were 354 (76%) and 114 (24%) women in the pre-Covid and Covid cohorts, respectively. Demographics did not differ between cohorts (table 1). At multidisciplinary team evaluations there were no differences in allocation to primary surgery (PDS), interval surgery (IDS) or chemotherapy only (CT) between cohorts. Surgical complexity scores at PDS and IDS were similar in both cohorts. At PDS significantly more women in the covid cohort had residual disease <10 mm. Type and amount of chemotherapy did not differ between cohorts. Significantly more women in the Covid cohort received PARPi maintenance therapy. A significantly higher cumulative incidence of recurrence was found for the covid cohort (p<0.0003), figure 1a. For women undergoing exploratory laparotomy or IDS the risk of recurrence was higher in the Covid cohort than the pre-Covid cohort during initial 18 months after diagnosis, for IDS HR=2.75 [95% CI, 1.45–5.2], figure 1b.

Conclusion Despite equal surgical capacity and favorable prognostic characteristics, women with advanced stage HGSC diagnosed during the Covid pandemic had a significantly higher risk of recurrence when compared to pre-covid cohort, particularly for women undergoing IDS.

Abstract 2022-RA-1309-ESGO

Conclusion In our series, higher MLR at diagnosis predicted worse outcomes in FIGO III – IV patients.

Introduction/Background Parallel panel-germline and somatic testing in all women with ovarian-cancer (OC) identifies more pathogenic-variants (PV) benefitting from poly-ADP-ribose (PARP) inhibitor (PARP-i) therapy, and unaffected PV-relatives

Univariate Cox PFS analysis: MLR at diagnosis >0.32 predicted worse PFS, 19.2 vs 31.7 months, p<0.001, HR 3.49. PLR at diagnosis >289.1 predicted worse PFS, 19.2 vs 24.8 months, p=0.01, HR 2. On multivariate PFS analysis none of the variables retained its significance.

Int J Gynecol Cancer 2022;32(Suppl 2):A1–A504

A321

Int J Gynecol Cancer: first published as 10.1136/ijgc-2022-ESGO.685 on 20 October 2022. Downloaded from

http://ijgc.bmj.com/ on September 14, 2023 by guest. Protected by copyright.
for precision prevention. This study aims to estimate cost-effectiveness and population impact of parallel panel-germline and somatic BRCA-testing all OC-patients incorporating PARP-i therapy, compared with family-history (FH)/clinical-criteria based germline BRCA-testing in UK and USA health-systems.

Methodology Microsimulation cost-effectiveness modelling using data from 2,391 unselected population-based OC-patients recruited to UK (n=1,483) and USA (n=908) research studies. The lifetime costs-&-effects of BRCA1/BRCAR2/ RAD51C/RAD51D/BRIP1 germline-testing and somatic BRCA1/ BRCA2-testing in all OC-cases (BRCA-mutated patients undergo PARP-i therapy) (Strategy-A), was compared with FH/clinical-criteria based germline BRCA-testing (Strategy-B). Unaffected relatives with germline BRCA1/BRCAR2/RAD51C/RAD51D/BRIP1 PVs identified through cascade-testing undergo relevant OC and breast-cancer (BC) risk-reduction interventions (risk-reducing salpingo-oophorectomy, MRI/mammography, chemoprevention or risk-reducing-mastectomy). We also evaluated cost-effectiveness of germline-panel testing alone (without PARP-i therapy). A lifetime horizon with payer/societal perspectives, along-with probabilistic and one-way sensitivity-analyses are presented. Incremental-cost-effectiveness-ratio (ICER): incremental-cost per quality-adjusted-life-year (QALY) gained, was compared to £30,000/QALY(UK) and $100,000/QALY(USA) thresholds. OC-incidence, BC-incidence and prevented deaths were estimated.

Results Compared with clinical-criteria/FH-based BRCA-testing, BRCA1/BRCAR2/RAD51C/RAD51D/BRIP1 germline-testing and BRCA1/BRCAR2 somatic-testing all OC patients incorporating PARP-i therapy demonstrates UK-ICERs (payer-perspective=£42,433/QALY; societal-perspective=£41,622/ QALY) and USA-ICERs (payer-perspective=£145,071/QALY; societal-perspective=£144,564/QALY) are higher than UK/ NICE and USA cost-effectiveness thresholds. Strategy-A becomes cost-effective if PARP-i costs fall by 32% (UK) or 33% (USA), or overall-survival (OS) with PARP-i reaches HR=0.28. Unselected panel-germline testing (without PARP-i therapy) is extremely cost-effective from payer-perspective (UK-ICER=£11,291/QALY; USA-ICER=£65,786/QALY). One year’s unselected testing could prevent 199 BC/OC-cases and 236 deaths in UK-women; and 523 BC/ OC-cases and 581 deaths in USA-women.

Conclusion Unselected panel-germline and somatic BRCA-testing is currently not cost-effective but becomes cost-effective if PARP-i costs fall by 32%-33% or OS reaches HR=0.28. Regarding germline-testing, unselected panel-germline testing is highly cost-effective and should replace BRCA-testing alone.

**Int J Gynecol Cancer: first published as 10.1136/ijgc-2022-ESGO.685 on 20 October 2022. Downloaded from http://ijgc.bmj.com/ on September 14, 2023 by guest. Protected by copyright.**