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.

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.

Abstract 2022-RA-1309-ESGO Figure 1

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

Analytical Value of Systemic Inflammation Markers Obtained from the Complete Blood Count in Patients Treated for Advanced Ovarian Carcinoma at the CUN in the Period 2000–2015

Introduction/Background Markers of systemic inflammation have been described as prognostic factors in epithelial ovarian cancer (EOC). We aimed to retrospectively explore these new markers in our patient population and define its relationship with prognosis.

Methodology Medical records of patients with newly diagnosed FIGO stage III – IV EOC between 2000 and 2015 were reviewed. We examined the red cell distribution width (RDW), mean platelet volume (MPV), neutrophil to lymphocyte (NLR), monocyte to lymphocyte (MLR), and platelet to lymphocyte (PLR) ratios at diagnosis.

Results 77 patients were analyzed. Mean age 58.3 years. FIGO IIIC 56%, serous 87% (80% high grade). 69% had primary surgery, 47% optimal cytoreduction. Relevant values at diagnosis: median RDW 13.7 (IQR 12.8 – 14.8), median MPV 8.6 fl (IQR 8.1 – 9.5), median NLR 3.4 (IQR 2.3 – 4–5), median MLR 0.3 (IQR 0.25 – 0.45), median PLR 217.5 (IQR 151.5 – 309.6). Survival analysis: Median PFS 21.8 months, CI95% 18.8 – 27.5. Median OS 74.4 months (CI95% 51.6 – 123.6). Multivariate Cox OS analysis: MLR≥0.245 was a risk factor for OS, HR 7.04, p=0.059

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.
Abstracts

Impact of Obesity on the Feasibility of Carboplatin Monotherapy Versus Carboplatin-Paclitaxel in Frail Elderly Epithelial Ovarian Cancer Patients

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Introduction/Background Frail elderly patients with ovarian cancer (OC) are often treated with 3-weekly carboplatin (3wC) rather than carboplatin-paclitaxel (CP). Elderly Women with OC (EWOC)-1 trial demonstrated that 3-weekly carboplatin-paclitaxel (3wCP) achieved better survival outcomes and was more feasible (defined as the ability to complete 6 chemotherapy cycles without disease progression, death, or premature discontinuation due to toxicity) than 3wC in patients ≥70 years old (≥70 yo) with FIGO stage III/IV OC. We compared the feasibility of treatment with 3wC or 3wCP in frail elderly OC patients.

Methodology Data from two cancer centres was retrospectively analysed for newly-diagnosed stage III/IV OC patients ≥70 yo treated with 3wC or 3wCP. Frailty was scored using the Charlson-Comorbidity Index (CCI) and ECOG performance status. Toxicity was graded using CTCAE v5.0.

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/BRCA2/RAD51C/RAD51D/BRIP1 germline 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/BRCA2/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/BRCA2/RAD51C/RAD51D/BRIP1 germline and somatic testing all OC patients incorporating PARP-i therapy demonstrates UK-ICERs (payer-perspective=$42,843/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. Unaffected panel-germline testing (without PARP-i therapy) is extremely cost-effective from payer-perspective (UK-ICER=$11,291/QALY; USA-ICER=$68,808/QALY) and societal-perspectives (UK-ICER=$6,923/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.

References

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Introduction/Background While obesity is associated with a higher risk of mortality in several cancers, this relationship is equivocal in ovarian cancer. Some studies show a significant effect of this comorbidity on both incidence and survival. However, other studies do not show a significant difference in survival and recurrence-free survival. The primary objective of our study is to investigate the impact of obesity in the management of patients with FIGO III or IV high-grade serous epithelial ovarian cancer. Secondary objectives include evaluation of postoperative complications, number of patients treated according to the referral, and analysis of survival data.

Methodology Retrospective multicenter cohort study of epithelial ovarian cancer from the FRANCOGYN database. The inclusion criterion is surgical management of high-grade invasive epithelial ovarian cancer, FIGO stage III or IV, regardless of treatment strategy. All patient characteristics will be analyzed as risk factors for the development of postoperative complications and adjuvant treatments. Patients were stratified by body mass index (BMI) according to World Health Organization definitions into 3 groups (<25 kg/m², between 25 and 29.9 kg/m², and >30 kg/m²). Surgical procedures and intraoperative complications were studied. Comparison of group characteristics will be performed using Chi-2 Test and ANOVA, and survival analysis will be performed using Kaplan-Meier method and Log-Rank test.

Results A total of 2288 patients were included in the study. Regarding disease-free survival, there was no significant difference between the 3 groups (p=0.3). However, there was a lower overall survival in the obese group compared to overweight patients with a normal BMI (p=0.02). There was no significant difference regarding the operative time nor regarding the per- and postoperative complications.

Conclusion There is an impact of obesity on overall survival in patients with epithelial ovarian cancer, and the initial treatment strategy remains unchanged in these patients with a high BMI.