Introduction/Background The use of HIPEC is still controversial since there is no consensus about its benefits and implementation in the current literature. We present a descriptive analysis of the results in a single reference center gynecologic oncology unit.

Methodology We did a retrospective observational study from 2015 to 2019. We included every woman who underwent CRS + HIPEC procedure during the study period. Demographic data, pre and post operative data, OS and PFS and current status were registered.

Results 35 patients were included. Preanesthetic risk was low in 87% of cases (ASA I-II), 62.9% (n=22) of patients were treated initially with CRS vs 37.1% (n=13) who received neoadjuvant chemotherapy. In our sample, the most frequent timing of HIPEC was after relapse (45.7%). Laparotomic approach was the most frequent representing 68.6% (n=24). The most commonly used chemotherapeutic agent was Paclitaxel. In our sample, median time to recurrence was 29.6 months. 51.4% (n=18) suffered a recurrence and 25.7% (n=9) progressed after intervention. Regarding current status, 45.7% (n=16) live without disease, 28.6% (n=10) live with disease and 25.7% (n=9) died because of the disease. Complete cito-reduction (R0) was achieved in 45.7% (n=16), being 31.4% (n=11) R1, and 20% (n=7) R2. 23 complications (65.7% of the sample) were recorded. All of them were classified by systems and gravity (major and minor). Regarding major complications, 13.04% (n=4) were due to intestinal injury during surgery, 8.7% (n=2) were bladder injury, 4.35% (n=1) ureteral injury and 21.74% (n=5) of them were due to blood loss (>1L), which required blood transfusion. It is noteworthy that kidney failure rate is 0% in our sample. In relation to minor complications, 13.04% correspond to fever without a focus, 8.7% to infection of the surgical wound (seromas). We only found 4 complications Clavien-Dindo IIIa, IIIB, and IV. In the sample, the average ICU stay is 1.3 days. The average hospital stay was 7.6 days.

Conclusion Despite the radicality of the surgical procedures performed, toxicity was mild and major complications were rare and successfully resolved. In our study there have been no complications resulting in death.

2022-RA-1638-ESGO RANDOMIZED PHASE III TRIAL ON NIRAPARIB-TSR-042 (DOSTARLIMAB) VERSUS PHYSICIAN’S CHOICE IN RECURRENT OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER PATIENTS NOT CANDIDATE FOR PLATINUM RETREATMENT: NITCHE TRIAL (MITO 33)


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Introduction/Background Platinum resistant ovarian cancer patients have a poor prognosis, and few treatment options are available. Preclinical and clinical data demonstrated that the combination of poly-ADP ribose polymerase inhibitors (PARPi) with immune checkpoint inhibitors (ICIs) could have a synergistic antitumor activity in this setting of patients. MITO 33 trial will assess the hypothesis that the combination niraparib/dostarlimab therapy is effective in increasing overall survival, progression free survival and time to first subsequent therapy with respect to chemotherapy alone.

Methodology Patients will be randomized 1:1 to receive: Arm A (physician’s choice chemotherapy): pegylated liposomal doxorubicin 40 mg/m² d1 q28, weekly paclitaxel 80 mg/m² d1,8,15q28, gemcitabine 1000 mg/m² d1,8,15q28 or topotecan 1.25 mg/m² d1–5q21; Arm B (dostarlimab + niraparib): dostarlimab 500 mg every 3 weeks for 4 cycles, then 1000 mg every 6 weeks + niraparib 300 mg or 200 mg daily. Patients will be stratified according to homologous recombination deficiency status (positive vs negative), PD-L1 status, previous immunotherapy, previous PARPi treatment and Bevacizumab therapy. Homologous Recombination Deficiency status will be evaluated with Foundation One CDx test and tumor PD-L1 expression will be evaluated on archival pretherapy lesion.

Results Inclusion Criteria - Recurrent platinum resistant epithelial ovarian, fallopian tube or primary peritoneal cancer (no more than 2 previous chemotherapy lines). Previous treatment with PARPi and/or ICIs are allowed (if at least 6 months from last treatment have intercurred).

Conclusion Primary Endpoint Overall Survival Secondary Endpoints: Progression Free Survival; Time to First Subsequent Therapy and Objective Response Rate; Safety and Tolerability of Dostarlimab plus Niraparib