Methods ERAS protocol for CRS± HIPEC was implemented in 80 patients from January 2021 to March 2022. We documented compliance rate and analysed the reason for non-compliance, effect of compliance on length of hospital stay, postoperative complications and readmission rate and compared the same with the 95 patients who had CRS HIPEC before adopting ERAS protocol from January 2019 to December 2020.

Results Of 175 patients in the study, 95 were in pre eras group and 80 in ERAS group. Demography, pre-operative and operative parameters were comparable between the groups. The average compliance rate achieved for entire cohort was 78.5%. Lowest compliance rates were seen for post-operative elements especially, early feeding and early mobilization. After implementation of ERAS, median length of hospital stay reduced from 12 to 9 days, length of ICU stay reduced from 4 to 2 days and postoperative complications were reduced from 14.7% to 7%, respiratory complications 15.7% to 7%, surgical complications 10.5% to 2.9%, resurgery from 6.3% to 1.4% and in hospital mortality reduced from 5.3% to 1.4%. The ERAS group didn’t receive any long acting opioids, less usage of intraoperative crystalloids (\( \text{mL/kg/hr} \) vs \( \text{mL/kg/hr} \), \( p = 0.0001 \)), early extubation and less readmission rates.

Conclusions The implementation of ERAS protocol is safe and feasible for CRS and HIPEC patients. Implementation of ERAS program has significantly reduced the length of hospital stay, length of ICU stay and postoperative morbidity.

Poster rounds with the professors: Group C2

28/#262 DOSE-DENSE, WEEKLY PACLITAXEL AND CARBOPLATIN WITH OR WITHOUT BEVACIZUMAB, IN METASTATIC OR RECURRENT CERVICAL CARCINOMA (FINAL ANALYSIS OF JCOG13111)

Objective To assess the efficacy of dose-dense weekly paclitaxel plus carboplatin (dTC) with or without bevacizumab in metastatic or recurrent cervical carcinoma, we conducted a phase II/III randomized controlled study comparing with conventional TC (cTC) with or without bevacizumab (JCOG13111, jRCTs0311800007). We previously reported that this study had not met the primary endpoint of phase II in ASCO2020.

Methods Patients were randomly assigned to either cTC or dTC arm. The cTC was paclitaxel 175 mg/m^2 and carboplatin (AUC 5) on day 1. The dTC was paclitaxel 80 mg/m^2 on day 1, 8, 15 and carboplatin (AUC 5) on day 1. Patients on both arms received bevacizumab 15 mg/m^2 if not contraindicated. The primary endpoint of phase II was response rate (RR), and that of phase III was overall survival (OS).

Results A total of 122 patients was enrolled. The RR in dTC arm was 60.7% and not higher than cTC arm (67.9%). The study was terminated early before starting phase III part. After a further two years of follow-up, the final analysis was conducted. Median OS and progression-free survival (PFS) in cTC arm was 17.7 months and 7.9 months, and in dTC arm 18.5 months and 7.2 months, respectively. The median follow-up of surviving patients was 2.9 years. There were no significant differences between the arms either for OS or PFS. Adverse events related to bevacizumab in 82 patients included fistula in 5 patients and gastrointestinal perforation in 3 patients.

Conclusions Dose-dense paclitaxel plus carboplatin was not promising for metastatic or recurrent cervical carcinoma.

29/#956 COST-EFFECTIVENESS OF PEMBROLIZUMAB FOR FIRST-LINE TREATMENT IN PATIENTS WITH PERSISTENT, RECURRENT, OR METASTATIC CERVICAL CANCER IN THE UNITED STATES

Objectives The FDA recently approved pembrolizumab in combination with chemotherapy, with or without bevacizumab, to treat patients with persistent, recurrent, or metastatic cervical cancer (PRMCC) whose tumors express PD-L1 (Combined Positive Score (CPS) ≥ 1). This study assesses the cost-effectiveness of pembrolizumab plus previous standard of care (SoC) vs previous SoC alone in this population from a US payer perspective.

Methods Distinct from other evaluations, we modeled health outcomes and costs using a state transition model comprising the health states 'pre-progression', 'post-progression', and 'death' informed by patient-level data from the Phase 3 KEYNOTE826 (KN-826) trial. Time to progression, progression-free survival, post-progression survival, and time on treatment were extrapolated using parametric models to encompass all effects and costs, both discounted at 3% per annum. Costs included drug acquisition/administration, resource use, adverse events, and end-of-life. Real-world data informed the proportion of patients receiving subsequent treatment, weighted to the distribution in KN826, to reflect US clinical practice. Several subsequent treatment scenarios were explored. Parameter and model uncertainty were explored via deterministic/probabilistic sensitivity analyses.

Results Pembrolizumab + SoC offers substantial incremental health benefits compared to SoC. At an additional cost of $203,700 each patient gains 1.90 life years (LYs) and 1.42 quality-adjusted life years (QALYs). The estimated incremental cost-effectiveness ratio over a lifetime (50 years) was $107,328/LY and $142,996/QALY. Based on probabilistic analysis, pembrolizumab has a 58.5% chance of being cost-effective at a willingness-to-pay threshold of $150,000/QALY.

Conclusions Modeling suggests pembrolizumab + SoC is cost-effective for first-line treatment of CPS ≥ 1 patients with PRMCC in the US.