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 sepsis 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(7 ml/kg/hr vs 13 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 JCOG1311)

1Mitsuya Ishikawa*, 2Taro Shibata, 3Tomoko Katoaka, 4Munetaka Takekuma, 5Hiromi Kobayashi, 6Nobuo Yasagishi, 7Yojiro Sato. 1National Cancer Center Hospital, Japan, Department of Gynecology, Tokyo, Japan; 2National Cancer Center Hospital, Tokyo, Japan; 3Japan Clinical Oncology Group Data Center, Operations Office, Tokyo, Japan; 4Shizuoka Cancer Center, Division of Gynecology, Shizuoka, Japan; 5Faculty of Medicine, Kagoshima University, Department of Obstetrics and Gynecology, Kagoshima, Japan; 6Tohoku University Graduate School of Medicine, Department of Obstetrics and Gynecology, Miyagi, Japan; 7University of Tsukuba, Department of Obstetrics and Gynecology, Tsukuba, Japan

Objectives 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 (JCOG1311, 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/m² and carboplatin (AUC 5) on day 1. The dTC was paclitaxel 80 mg/m² on day 1, 8, 15 and carboplatin (AUC 5) on day 1. Patients on both arms received bevacizumab 15 mg/m² 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

1Bradley Monk*, 2Jennifer Boer, 3Frank Van Hees, 4Sophie Van Mens, 5Shipa Swami, 6Dominic Muston, 7Cumhur Tekin, 8Steve Keefe, 9Matthew Monberg. 1HonorHealth Research Institute, University of Arizona, Creighton University School of Medicine, Division of Gynecologic Oncology, Phoenix, USA; 2Luminary, Health Economics Analysis Team, Utrecht, Netherlands; 3MSD (UK) Limited, Biostatistics and Research Decision Sciences, London, UK; 4Merck and Co., Inc., Rahway, USA

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.
Objectives One of the major changes in the revised 2018 FIGO-staging system is the addition of stage IIIIC, which includes patients with pelvic and/or para-aortic lymph node metastases. Therefore, we evaluated the prognostic value of positive pelvic and/or para-aortic lymph nodes in patients with cervical cancer.

Methods A nationwide retrospective cohort study was performed by identifying all patients diagnosed with stage IB-IVA between 2005–2018 from the Netherlands Cancer Registry. Data was converted to the FIGO 2018 stage based on the TNM-classification. 5-year and overall survival rates (OS) were estimated with the Kaplan-Meier method.

Results Of the included 6,082 patients, 1,740 patients, had pelvic and/or para-aortic lymph node metastases. For patients with FIGO 2009 stage IB-IB1-IIA-IIA1 with pelvic and/or para-aortic lymph node metastases 5-year survival is 77% and OS is 70%, without lymph node metastases survival rates are 92% and 87% (p<0.001). For FIGO 2009 stage IB2-IIA2-IIIB, with pelvic and/or para-aortic lymph node metastases 5-year survival is 67% and OS is 62%, without lymph node metastases survival rates are 74% and 65% (p=0.009). FIGO 2009 stage IIIA-IIIB and IVA survival rates are not significantly influenced by pelvic and/or para-aortic lymph node metastases (p=0.640, p=0.939). Patients with FIGO 2018 stage IIIIC have a 5-year survival of 65% and OS of 59%.

Conclusions Patients with FIGO 2009 stage IB1-IIA1-IIA2-IB2-IIIA2-IIIB cervical cancer with positive pelvic and/or para-aortic lymph node metastases have a significantly impaired survival compared to patients without metastases. Survival rates of patients with FIGO 2009 stage IIIA-IIIB-IVA are not significantly affected by lymph node metastases.

Objectives More recent data suggests that patients with BRCA1 are at an increased risk of developing uterine serous cancers. This raises the question of whether a hysterectomy should be done at time of rrBSO. We developed a decision model to compare the cost-effectiveness of rrBSO with or without hysterectomy for patients with BRCA1 mutations.

Methods A Markov model was created to simulate the clinical trajectory of a hypothetical cohort of 10,000 women aged 40 years of age with BRCA1 mutations undergoing rrBSO. The initial decision point in the model was whether a hysterectomy was performed at the time of rrBSO. A time horizon of 60 years was used. Postoperative morbidity and mortality were included in the model as well as risk for subsequent hysterectomy and prolapse after hysterectomy. Model probabilities, cost and utility values were derived with assumptions drawn from published literature. The effectiveness was calculated in terms of average quality adjusted life years (QALYs). The primary outcome was incremental cost-effectiveness ratios (ICERs), expressed in 2018 US dollars/QALYs. One way sensitivity analyses were performed to vary the assumptions across a range of plausible values.

Results RrBSO with hysterectomy was the least costly strategy at $13,628, followed by rrBSO alone ($14,630). Hysterectomy at time of rrBSO was cost-effective compared with rrBSO. rrBSO alone was subjected to absolute dominance because it was both more costly and less effective. Multiple one-way sensitivity analyses did not substantially impact the cost-effectiveness.

Conclusions Hysterectomy at time of rrBSO for BRCA1 patients constitutes a cost-effective management strategy.