#195 UNDERSTANDING CURRENT PRACTICES FOR THE MANAGEMENT OF ADVANCED EPITHELIAL HIGH-GRADE OVARIAN CANCER IN THE UK: INTERIM ANALYSIS FROM THE OC-NOW SURVEY (2023)

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Introduction/Background Advanced high-grade ovarian cancer (OC) treatment has recently evolved to include novel targeted agents such as PARP-inhibitors (PARPi). ESMO/ESGO guidelines recommend biomarker testing to guide treatment decision-making. Our survey explores current management of advanced OC in the UK.

Methodology This interim descriptive analysis used data collected between March-April 2023 from ongoing structured interviews with UK-based healthcare professionals (HCPs) involved in the secondary care management of advanced OC (OC-NOW).

Results The analysis included survey responses from 50 HCPs who treat patients with OC. Respondents were mainly based in England (84%; 42/50). HRD (100%; 41/41) and BRCA1/2 (98%; 40/41) were routinely tested before planning maintenance treatment. BRCA1/2 (90%; 37/41) were frequently ranked as the most important biomarkers for treatment decision-making. Most respondents (90%; 36/40) reported a turnaround time of 6 weeks for HRD test results. The median proportion (interquartile range [IQR]) of patients with a BRCA mutation (BRCAmut) was 20.0% (15.0–20.0%), while 25.0% (18.8–30.0%) were HRD (test positive) and BRCA wild type (HRD/BRCAwt), 49.0% (35.0–60.0%) were HRp (test negative) and 10.0% (5.0–11.2%) were HRnd (HR test failure/not determined/inconclusive). Inadequate tissue sampling (73%; 30/41) was the main reason for HRnd. Platinum-sensitive patients typically received PARPi maintenance therapy, regardless of HRD status (table 1). At first relapse, most HCPs (68%; 19/28) used the DESKTOP-III criteria to identify optimal candidates for secondary cytoreduction, with up to 30% of platinum-sensitive patients considered as eligible in 85% (23/27) of centres.

Abstract #195 Table 1 Percentage of patients with advanced high-grade ovarian cancer reported to be receiving treatment following complete response or partial response to first-line platinum-based chemotherapy, according to genetic status

% patients, n (% n=40)*	Active surveillance	Anti-angiogenic/VEGF monotherapy maintenance	PARPi monotherapy maintenance	PARPi in combination with anti-angiogenic/VEGF maintenance	Other treatment
Patients with BRCAmut (%)					
Mean (SD)	3.1 (5.4)	3.0 (6.5)	62.0 (28.1)	32.4 (27.2)	0.0 (0.2)
Median (IQR)	0.5 (0.0–5.0)	0.0 (0.0–4.2)	65.0 (47.5–85.8)	26.0 (10.0–50.0)	0.0 (0.0–0.0)
Patients with HRD/BRCAwt (%)					
Mean (SD)	7.7 (14.3)	7.3 (15.9)	39.9 (21.1)	46.4 (24.2)	0.3 (1.6)
Median (IQR)	5.0 (0.0–10.0)	0.0 (0.0–10.0)	40.0 (27.5–52.5)	47.5 (29.0–65.0)	0.0 (0.0–0.0)
Patients with HRp (HR test negative) or HRnd (inconclusive) (%)					
Mean (SD)	17.5 (21.4)	29.5 (21.1)	51.5 (26.2)	N/A	1.0 (4.1)
Median (IQR)	10.0 (5.0–20.0)	27.5 (13.8–41.2)	50.0 (30.0–75.0)	N/A	0.0 (0.0–0.0)

*N refers to the number of HCPs who provided an estimate for each type of treatment patients received following complete response or partial response to first-line platinum-based chemotherapy. It should be noted that, as HCPs were asked to estimate the percentage of patients receiving each treatment, the average percentage for each treatment type was reported and the results may not necessarily add up to 100%.

BRCAmut, BReast CAncer gene mutation; BRCAwt, BReast CAncer gene wild-type; HRD, homologous recombination deficiency; HRnd, homologous recombination test failure, not determined or inconclusive; HRp, homologous recombination proficiency; IQR, interquartile range; N/A, not applicable; PARPi, poly-adenosine-diphosphate-ribose polymerase inhibitors; SD, standard deviation; VEGF, vascular endothelial growth factor

Conclusion These results provide an update on the evolving UK biomarker-driven practice in advanced OC. HRD and BRCA1/2 are now routinely assessed with adequate turnaround times to allow appropriate decision-making for the maintenance regimens of advanced OC. Platinum-sensitive patients typically received PARPi maintenance therapy, irrespective of HRD status. Most HCPs used DESKTOP-III criteria to determine secondary debulking candidates at first relapse.

Disclosures Christina Fotopoulou has received honoraria and expenses from AstraZeneca, MSD, GSK, Tesaro, Roche, Ethicon, and Clovis. Rebecca Bowen has received consultancy and advisory board fees from GSK, AstraZeneca, and Clovis. Ranjit Manchanda has received grants/research support from Barts Charity, Yorkshire Cancer Research, GSK, and Rosetrees Trust, and has also received honoraria and consultancy fees from GSK and EGL. Agnieszka Michael has received consultancy and advisory board fees from EUSA Pharma, GSK, and Ipsen and has received research funding and expenses from Merck. Stephen McCormack, Allan Ullmann, and Anthony Wesselbaum are employees of GSK. Joe Eva is an employee of OPEN Health. Rowan Miller has received grants/research support from MSD and GSK and honoraria/consultancy fees from MSD, GSK, AstraZeneca, Ellipses, Shionogi, Clovis Oncology, and GI Innovation, and has participated in company sponsored speaker's bureau for GSK, AstraZeneca, Clovis, and Roche.

#199 TREATMENT OF OVARIAN CANCER AND THE LACK OF SPECIALTY GYNAECOLOGIC ONCOLOGY IN OUR COUNTRY – WHAT DOES IT REQUIRE AND WITH WHAT FREQUENCY?

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Introduction/Background For radical surgical treatment of advanced ovarian cancer in our country, a multidisciplinary surgical team of gynecologists and abdominal surgeons is formed, and when necessary with vascular and thoracic surgeons, urologists and etc, but only in hospitals where this is possible, because of lack of subspecialty gynecologic oncology. The aim of this study is to show the frequency of participation of a multidisciplinary surgical team in the treatment of advanced ovarian carcinoma in a single gynecological center and hence the need for acceptance of the specialty gynaecologic oncology by official government health authorities.

Methodology This single-center, retrospective, survey conducted at the Department of Gynecology of the Military Medical Academy, Sofia, (2019–2022 years), included 72 (100%) patients aged 28–82 years, divided into two groups: Group I (n-42/58.3%) patients with clinical and imaging preoperative results showing the possibility of surgical cytoreduction of advanced ovarian cancer (FIGO III-IV); and Group II (control) – (n-30/41.7%) patients with early stages ovarian carcinoma (FIGO I-II), selected at random from all patients coming for surgical treatment in that period extracted from the electronic database. For all patients, the pre-post-operative and pathological results are presented at a Clinical Multidisciplinary Committee for cancer patients. All statistical analyses were performed with SPSS 10.1 for windows (SPSS Inc., Chicago IL).

Abstract #199 Table 1 Statistical results for the two groups and need of a multidisciplinary surgical treatment

Groups	Involvement of multidisciplinary surgical team - n	Without the participation of other specialists - n	Total - n	P
Group I	31 (19.83) [6.29]	11 (22.17) [5.63]	42	P < 0.00001
Group II	3 (14.17) [8.80]	27 (15.83) [7.88]	30	
Total - n	36	38	72	
Pearson (chi-square) result - 28.5898. P < 0.00001. The result is significant at P < 0.05				

Results Our results show that surgical treatment of advanced ovarian carcinoma, a multidisciplinary surgical team is statistically more often required (n-31/43.1%) than in early stages (n-3/4.2%).
Conclusion Surgical treatment of advanced ovarian carcinoma more often requires interventions in the upper and lower abdomen affecting other abdominally located systems. In the absence of a oncological gynecologist trained in these interventions it is necessary to form a multidisciplinary surgical team for the treatment of advanced ovarian carcinoma
Disclosures Authors declare no conflict of interest

#201 REAL WORLD EVIDENCE (RWE) ON THE EFFICACY OF CHEMOTHERAPY AFTER PROGRESSION DURING OR FOLLOWING PARPI EXPOSURE IN OVARIAN CANCER. A MULTICENTRE, INTERNATIONAL STUDY

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Introduction/Background A significant proportion of OC patients eventually progress during or following PARPi exposure. Progression under PARPi may undermine sensitivity to chemotherapy.
Methodology We retrospectively identified patients treated with a PARPi as maintenance in the 4 participating centers and who received subsequent CT. We evaluated progression-free survival (PFS) calculated from the start of the subsequent CT to the next progression/death.
Results 291 patients were identified (2003–2021). PARPi exposure was as maintenance in adjuvant (n=41) or relapsed setting (n=250) with a median number of previous lines of chemotherapy of 1 (range: 1.0–7.0). Progression under PARPi exposure was predominant (n=253/291; 87%). BRCA mutation was identified in 129 pts and negative/unknown in 162 pts. Median duration of PARPi exposure was 6.5 months (range: 0.2–54.3). Subsequent treatment included platinum-based CT (PBC) for 182 (62.5%) pts and non-platinum-based CT (nPBC) for 109 (37.5%) pts. With a median follow-up of 25.3 months (95% CI [23.0; 31.7]), median PFS was 6.7 m (95% CI [5.7; 7.6]) and 3.5 m (95% CI [2.8; 4.6]) with PBC and nPBC respectively. In BRCA mutated pts, median PFS was 6.7 [5.2; 8.3] and 2.7 [2.4; 4.3] with subsequent PBC (n=99) and nPBC (n=30) based CT respectively. Platinum free interval (PFI) under PARPi was associated with numerically longer PFS with subsequent CT: PFI ≤ 6m (PFS =3.0m [2.7;4.1]) ; PFI]6 ;12] (PFS=6.5m [4.7 ;7.6]) and PFI> 12 m (PFS= 6.9m [5.9 ;8.0]). Subsequent treatment for adjuvant PARPi exposure included PBC for 35 (85.4%) pts. With a median follow-up of 16.8m (95% CI [9.3;-]), median PFS was 6.8m (95% CI [5.1;10.3]) with PBC for these patients.
Conclusion This is the largest series of RWE on the efficacy of chemotherapy after progression under PARPi maintenance. Outcomes appear poor when pts progress under the pressure of PARPi whether received in 1st or subsequent lines.
Disclosures See online

#213 G8-FRAIL WOMEN WITH OVARIAN CANCER RELATE WORSE PERIOPERATIVE OUTCOMES: FRAIL-B: A PROSPECTIVE INTERDISCIPLINARY TRAIL

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Introduction/Background Frailty is an underdiagnosed multidimensional age-related syndrome. Frail patients need to be identified preoperatively to reduce their risk of adverse surgical outcomes. We present first results of our systematic, preoperative two-step frailty screening algorithm of elderly ovarian cancer (OC) patients regarding their perioperative outcomes.
Methodology All women with the diagnosis of OC regardless of the previous treatments or the histological type were screened preoperatively by the G8 geriatric screening tool (G8-Score). If a patient was considered to be G8-frail (cut-off:≤14points), various geriatric assessment tools followed. The main outcome measures were the relationship between perioperative laboratory results, intraoperative surgical parameters and the incidence of immediate postoperative in-hospital complications with the preoperatively evaluated frailty status.
Results Till now, 37 consecutive patients with OC standardly treated with laparotomy for tumor debulking/extirpation at the University Medical Center Mainz between May 2020 and April 2023 were included. Mean age in the study cohort was 69.0 (±7.5) years. Most of the patients (72.9%) had advanced stage ovarian cancer ≥FIGOIIB. 35.1% of the patients were preoperatively identified as G8-frail (n=13). The G8-frail cohort had a significant longer hospital stay (p=0.005) and displayed a higher prevalence of polypharmacy than the G8-non-frail cohort (p=0.067). The G8-frail cohort showed a numerically but not statistically significant higher Clavien-Dindo-Score than the G8-non-frail cohort (grade≤2: 53.9% vs. 79.1%; grade≥3: 46.2% vs. 20.8%; p=0.402). Furthermore, the G8-frail cohort had significant more surgical revisions and readmitted more often to the hospital than the G8-non-frail cohort (revisions: 30.8% vs. 4%, p=0.042; readmission: 23.1% vs. 4%, p=0.115). One patient in each cohort died during the hospital stay.
Conclusion The first interim-analysis shows that preoperative frailty assessment with the G8-Score can prospectively identify elderly women with OC associated with polypharmacy, a