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 wild type (HRD/BRCAwt) were used to define HRd status. Most (73%; 30/41) were routinely tested before planning 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.

#195
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 gynecologic 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 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).
**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 an 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.

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**Abstracts**

**#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.

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**#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/extration 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 ≥FIGOIIIB. 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 (grades2: 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