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.

Abstract #199 Table 1

<table>
<thead>
<tr>
<th>Groups</th>
<th>Involvement of multidisciplinary surgical team - n</th>
<th>Without the participation of other specialists - n</th>
<th>Total - n</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group I</td>
<td>31 (9.83%) [6.29]</td>
<td>11 (22.17%) [5.63]</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Group II</td>
<td>3 (14.17%) [8.80]</td>
<td>27 (55.83%) [7.88]</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Total - n</td>
<td>36</td>
<td>38</td>
<td>72</td>
<td></td>
</tr>
</tbody>
</table>

Pearson (chi-square) result: 28.3598, P < 0.00001. The result is significant at P < 0.05

### #201

REAL WORLD EVIDENCE (RWE) ON THE EFICACY OF CHEMOTHERAPY AFTER PROGRESSION DURING OR FOLLOWING PARPi EXPOSURE IN OVARIAN CANCER: A MULTICENTRE, INTERNATIONAL STUDY

1Jean-Sebastien Frenel*, 2Catherine Guerin-Charbonnel, 3Alexandre Xu-Vuillard, 4Sur Chesseman, 5Paul Kubelac, 6Morgan Zenati, 7Geoffrey Hall, 8Patricia Patriucu, 9Brunhilde Harvic, 10Hayley Fenton, 11Ana-Maria-Lacrima Sturz-Lazar, 12Paula Augereau, 13Isabelle Ray-Coqaud, 14Alexandra Leary, 15Francois Boquet, 16Institut de Canecrologie of L’Ouest, Nantes, France; 17Institut Gustave Roussy, Villejuif, France; 18Leeds hospital, Leeds, UK; 19Kul, Klij, Romania; 20Institut de Canecrologie de L’Ouest, Saint-Herblain, France; 21Leeds, Leeds, UK; 22Centre Leon Berard, Lyon, France; 23KU Leuven, Leuven, Belgium; 24University, Oxford, UK; 25City Hospital, Timisoara, Romania; 26Institut de Canecrologie de L’Ouest, Angers, France; 27Centre Leon Berard, Lyon, France; 28Gustave Roussy, Villejuif, France

10.1136/ijgc-2023-ESGO.534

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 ≥ 6m (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

Katherina Aric*, Slavomir Krajnak, Marcus Schmidt, Michael Mohr, Michael Schuster, Annette Hasenburg, Marco Johannes Battista. University Medical Centre Mainz, Mainz, Germany

10.1136/ijgc-2023-ESGO.535

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:s14points), 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 (FIGOIB. 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 (grade2: 53.9% vs. 79.1%; grade3: 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