However, not all patients are candidates to complete primary resection and will be offered platinum chemotherapy with expected low response rates (<5%). Whether adding bevacizumab may improve response to platinum chemotherapy in LGSOC is poorly described.

Methodology We identified patients with advanced or metastatic LGSOC treated at Gustave Roussy Institute between 2013 and 2023 who received neoadjuvant or first line platinum-based chemotherapy with or without bevacizumab for LGSOC. We assessed overall response rate (ORR) by imaging, biological CA125 response (RUSTIN criteria) and progression free survival (PFS).

Results We identified 29 patients who received neoadjuvant platinum and 9 who received platinum at 1st relapse. Among all evaluable patients (neoadjuvant and 1st relapse setting), the addition of bevacizumab resulted in a statistically significant improvement in ORR (ORR=62% (13/21) for bevacizumab versus 24% (4/17) without bevacizumab; p-value: 0.0247). In the neoadjuvant setting, ORR was 67% in patients with bevacizumab and 27% of patients without bevacizumab. In the relapsed cohort, response rate was 60% with bevacizumab and 25% without bevacizumab. Among 24 patients evaluable according to RUSTIN criteria, the biological ORR to neoadjuvant chemotherapy with bevacizumab was 80% and 50% without bevacizumab. In the relapsed cohort, biological ORR was 100% with or without bevacizumab. Regarding survival, in the neoadjuvant setting, median PFS was 36 months (95% CI 27-NR) with bevacizumab, and 31 months (95% CI 20-NR) with chemotherapy alone. At relapse, median PFS was 16 months (95% CI 11-NR) with bevacizumab and 11 months (95% CI 5.5-NR) with chemotherapy alone.

Conclusion Bevacizumab increases response rate to first line platinum-based chemotherapy both in neoadjuvant and 1st line metastatic/recurrent LGSOC. Our data support the addition of bevacizumab to neoadjuvant platinum in an effort to improve tumor shrinkage and achievement of complete interval cytoreduction.

Disclosures No disclosures.

#288 PROGNOSTIC FACTORS FOLLOWING CYTOREDUCTIVE SURGERY FOR ADVANCED EPITHELIAL OVARIAN CANCER

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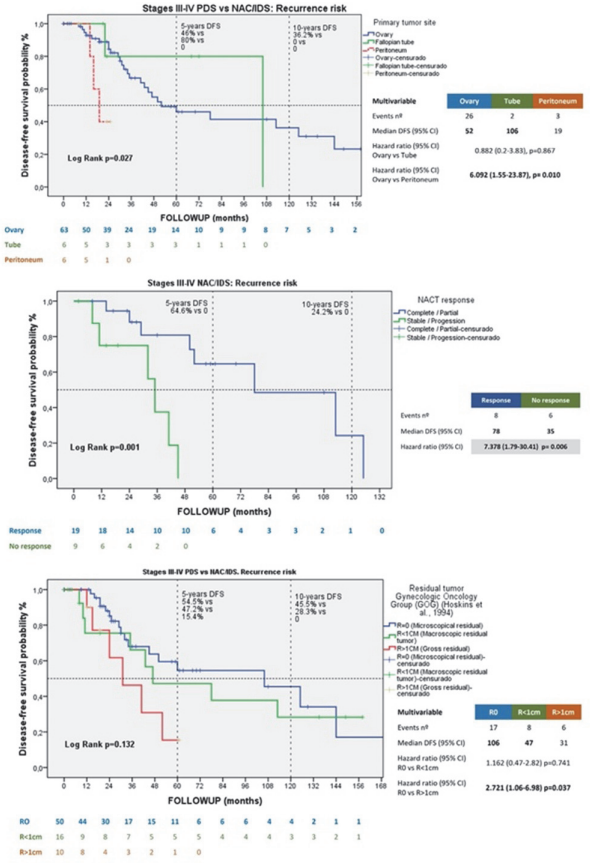
Introduction/Background To examine the association between clinicopathological factors and survival in advanced epithelial ovarian, tubal, and primary peritoneal cancers patients (stages III-IV FIGO 2017) who had primary cytoreductive surgery (PDS) and those that received neoadjuvant platinum-based chemotherapy (NAC) followed by interval debulking surgery (IDS).

Results of univariable and multivariable analysis (Cox proportional hazard model): Risk of tumor recurrence.

Tumor recurrence	*Univariable*		*Multivariable*	
Variable	Hazard ratio (95% CI)	*P*-value	Hazard ratio (95% CI)	*P*-value
Age*				
<= 57	1 (Ref.)		1 (Ref.)	
>57	1.44 (0.68-3.05)	0.336	1.233 (0.51-2.94)	0.638
ASA				
ASA I - II	1 (Ref.)		1 (Ref.)	
ASA III	1.405 (0.67-2.91)	0.36	1.341 (0-6.04)	0.985
Primary tumor site				
Ovarian cancer	1 (Ref.)		1 (Ref.)	
Fallopian tube carcinoma	0.755 (0.17-3.21)	0.704	0.882 (0.2-3.83)	0.867
Primary peritoneal cancer	5.014 (1.30-19.32)	0.019	6.092 (1.55-23.87)	0.010
Germinal line mutations				
No mutations	1 (Ref.)		1 (Ref.)	
Germline mutations	1.074 (0.2-5.62)	0,933	1.295 (0,23-7.04)	0.765
Stage FIGO 2017				
IIIA-IIIB	1 (Ref.)		1 (Ref.)	
IIIC-IV	1.399(0.66-2.92)	0.372	1.205 (0,02-56.41)	0.924
Ca 125 level (U/mL)*				
<= 446	1 (Ref.)		1 (Ref.)	
>446	1.054 (0.43-2.57)	0.907	1.649 (0-98.8)	0.941
Ascities				
Absence	1 (Ref.)		1 (Ref.)	
Presence	1.013 (0.48-2.09)	0.973	1.689 (0.26-10.8)	0.580
Carcinomatosis				
Absence	1 (Ref.)		1 (Ref.)	
Presence	1.790 (0.72-4.40)	0.205	2.356 (0.74-7.44)	0.144
Pretreatment tumor size (cm)*				
<= 12	1 (Ref.)		1 (Ref.)	
>12	2.389 (0.76-7.44)	0.133	2.486 (0.8-7.7)	0.115
Tumor involvement of lymph nodes				
No	1 (Ref.)		1 (Ref.)	
Yes	1.227 (0.59-2.53)	0.58	1.376 (0.65-2.89)	0.399
Lymphadenectomy vs no lymphadenectomy				
Yes	1 (Ref.)		1 (Ref.)	
No	1.02 (0.41-2.49)	0.966	1.338 (0.99-17.99)	0.826
Surgical status				
No residual tumor R=0	1 (Ref.)		1 (Ref.)	
Residual tumor R<1 cm	1.079 (0.46-2.48)	0.858	1.162 (0.47-2.82)	0.741
Residual tumor R>1 cm	2.523 (1.002-6.351)	0.049	2.721 (1.06-6.98)	0.037
Number of adyuvant chemo-cycles				
3 (<6)	1 (Ref.)		1 (Ref.)	
6	2.685 (0.81-8.83)	0.104	3.348 (0.77-14.51)	0.106
Chemotherapy response				
Complete / Partial response	1 (Ref.)		1 (Ref.)	
Stable / progression	7.378 (1.79-30.41)	0.006	8.855 (1.76-44.45)	0.008

*The cut-off value of age, body mass index (BMI), CA125 and tumor size were based on the ROC curve by the method proposed by Liu (Liu X, 2012. Classification accuracy and cut point selection. *Stat Med*, 31, 2676-86.



Abstract #288 Figure 1

Methodology 75 women were recruited in this study who had PDS or IDS between January 2008-March 2023. Association between clinical characteristics, pretreatment imaging, serum markers, surgical and pathological factors, and disease recurrence and overall survival was examined in univariable and multivariable analysis (Kaplan-Meier and Cox proportional hazard model).

Results 47 women (PDS) and 28 (IDS) women were included. No residual tumor (R0) was in 72.3% of patients after PDS and in 57.2% of patients after IDS. Postoperative rates of adverse effects and mortality were higher after PDS than after IDS (p=0.793). Median overall survival was not reached for the PDS group and 78 months for the IDS group (p=0.292). Median progression-free survival was 60 months in the PDS group and 52 months in the IDS group (p=0.04). Factors in multivariable analysis associated with increased risk of recurrence included primary peritoneal carcinoma (hazard ratio HR: 6.09, 95% CI 1.55–23.87, p= 0.01), residual tumor >1cm (HR: 2.72, 95% CI 1.06–6.98, p= 0.037) and stable/progression in response to chemotherapy (HR 8.85, 95% CI 1.76–44.45, p= 0.008).

Conclusion PDS before chemotherapy is the standard of care for patients with advanced ovarian cancer. NAC appeared to be a good option when the PDS is not likely as a first choice. The worse survival outcome was associated with primary peritoneal carcinoma, residual tumor in surgical status and a bad response to chemotherapy.

Disclosures Factors independently associated with increased risk of death included residual tumor>1 cm (HR: 4.52, 95% CI 1.86–11.02, p= 0.001) and stable disease/progression at chemotherapy (HR: 13.42, 95% CI 2.7–66.57, p= 0.001)

#293 THE ROLE OF BOWEL RESECTION TO ACHIEVE COMPLETE CYTOREDUCTION FOR RECURRENT EPITHELIAL OVARIAN CANCER: AN OBSERVATIONAL STUDY

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Introduction/Background Complete cytoreduction in recurrent epithelial ovarian cancer has been shown to improve progression-free survival and overall survival in recurrent ovarian cancer patients, with minimal impact on quality of life. Discussions revolving around bowel resection and stoma formation are most distressing for patients during pre-operative counselling. We aimed to quantify these risks in patients undergoing Secondary Cytoreduction Surgery (SCS) at a tertiary cancer centre.

Methodology We included all patients who underwent SCS between 2014–2022. Data were retrospectively collected on demographics, stage and histology at presentation, and resection status at previous cytoreduction. Recurrent disease pattern, bowel resection rates, enterostomy rates and final resection status were evaluated. Descriptive statistics were performed on Microsoft Excel.

Results 64 patients underwent SCS during the study period. High-grade serous ovarian cancer was the most common histological subtype (60.9%) followed by low-grade serous (15.6%). 60.9% had advanced disease (III-IVB) at presentation. Resection status at primary surgery was R0 in 90.6%. Median disease-free interval was 52.6months (IQR 33.8–70.5). 40.6% of patients underwent surgery for single-site recurrence, while 59.4% had multisite disease. The most common recurrence sites at SCS were pelvic peritoneum (34.4%), rectosigmoid serosa (31.3%), small bowel mesentery (25.0%) and small bowel serosa (20.3%). R0 at SCS was achieved in 89.1% and bowel resection was required in 29.7%. Rectosigmoid resection was the most common type of bowel resection (15.6%). 18.8% of patients underwent enterostomy (25.7% of patients with a transcoelomic recurrence pattern, 21.4% of patients with a mixed pattern, and none of the patients with nodal recurrence). End colostomy was the most common stoma type (12.5%).

Conclusion The proportion of women having bowel resection during SCS for recurrent epithelial ovarian cancer is 29.7% and that requiring stoma is 18.8%. Appropriate preoperative counselling is recommended especially in the context of non-nodal recurrent disease pattern.

Disclosures Nothing to disclose

#297 PROGNOSTIC FACTORS AMONG YOUNG WOMEN WITH EPITHELIAL OVARIAN CANCER: THE YOC-CARE STUDY (YOUNG OVARIAN CANCER – CARE)

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Introduction/Background Ovarian cancer is the most lethal of all gynaecological neoplasms in young women, affecting up to 10–15% of premenopausal women, however, there is very limited data on which are the most important prognostic factors

Methodology A multicentre and retrospective study was performed including women treated for epithelial ovarian cancer who were younger than 45 years old collected between January-2010 and December-2019. Borderline and non-epithelial ovarian cancers were excluded from the study

Results A total of 998 young patients with epithelial ovarian cancer from 55 different institutions in Spain were collected. The mean (standard deviation) age in the study population was 38.9 (5.8) years, and 853 (85.5%) presented an ECOG performance status grade 0 at diagnosis. The grouped FIGO stage distribution was 508 (50.9%) patients in initial stages (stages I and II) and 490 (49.1%) in advanced ones (stages III and IV). Three hundred thirty-four (33.4%) patients presented with recurrent disease after a mean follow up of 43.94 (SD 34.4) months. The type of staging surgery (incomplete vs. complete), the type of initial treatment modality (primary