(p=0.576), and 95.7%/76.2% (p=0.025), respectively. In Group C, the RDI of capecitabine/oxaliplatine and fluorouracil/oxaliplatin was 87.1%/65.8%, and 87.3%/81.6%, respectively. The 3y-DFS and 5y-OS rates for CAPOX/FOLFOX were 0%/50% (p=0.774), and 50%/100% (p=0.090), respectively. In patients with low-risk tumors, the 3y-DFS rates of CAPOX/FOLFOX in Group A and Group B was 100%/100%, and 73.3%/80% (p=0.821), respectively. In patients with high-risk tumors, the 3y-DFS rates of CAPOX/FOLFOX in Group A and Group B was 58.3%/100% (p=0.025), and 57.1%/40% (p=0.675), respectively.

Conclusion: CAPOX was poorer than FOLFOX regarding DFS and OS in patients with poor renal function. However, CAPOX tended to be better than FOLFOX in patients with Ccr of 50-80 ml/min. In patients with Ccr $\geq$ 80 ml/min, FOLFOX was significantly associated with better DFS than CAPOX, especially in high-risk tumors. This may indicate that the prescribed dose of capecitabine was not sufficient for the patients with good renal function.

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P-208 Is there a role for adjuvant chemotherapy in ypN0 disease rectal cancer patients?

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Background: Several studies attempted to identify prognostic factors to predict long-term outcomes and support adjuvant chemotherapy (ACh) after neoadjuvant chemoradiation (NACRT) in rectal cancer. Currently, there is no definitive evidence that ACh is able to improve disease-free survival (DFS). We aimed to evaluate the impact of ACh in DFS in pathological node-negative (ypN0) rectal cancer patients.

Methods: We conducted a retrospective single-center analysis of stage II and III rectal cancer patients treated with NACRT followed by surgery from 2016 to 2018 who achieved ypN0. We defined DFS as the time from surgery until disease recurrence/distant metastases. Analysis at 3 years (y) was performed.

Results: In total, 119 ypN0 patients were analyzed. Median age was 66y [interval 35-83], 59% were male, 66% had an ECOG PS of 0 and 34% 1. The tumor was localized to the upper-third of the rectum in 37%, medium in 42% and lower-third in 21%. Adenocarcinoma histology was well differentiated in 80%, moderately in 17% and poorly in 3%. Stage III disease was observed in 84% and stage II in 16%. All patients underwent NACRT (84% 5-fluorouracil infusion and 16% capecitabine for 5 weeks (w)). Long-course radiotherapy was administered in all patients. Pre-treatment CEA was elevated in 24%. Median time between NA treatment completion and surgery was 12w [5-19]. In 68% of patients, $\geq$12 lymph nodes were surgically resected. Pathologic complete response (pCR) was achieved in 45%, a tumor regression score was 1 in 8%, 2 in 45% and 3 in 2%. In total, 63% underwent ACh (87% 5-fluorouracil infusion and 13% capecitabine). Median follow-up was 32 months. Disease recurrence was detected in 13%. Those who underwent ACh were younger (median 64y vs median 70y, p=0.005), surgically removed more lymph nodes ($\geq$12 47% vs 27%, p=0.02), had more ECOG PS 0 (76% vs 50%, p=0.004), more moderately/poorly-differentiated histology (24% vs 14%, p=0.03) and less pCR (33% vs 64%, p=0.001). Patients who underwent ACh had a DFS at 3y of 85% vs 74% in the surveillance group (p=0.501). In univariate analysis, ACh did not impact on DFS at 3y along with ECOG PS, gender, histology, NACRT regimen, MRI restaging, time between NACRT completion and surgery, removed lymph nodes, pathologic T status, and pCR. Patients >65y (p=0.04), elevated pre-treatment CEA (p< 0.001), and pathologic regression score of 3 (p=0.008) negatively impacted on DFS at 3y. In multivariate analysis, only elevated pre-treatment CEA (HR 12.9 [CI 95% 4.0-41.8], p< 0.001) and pathologic regression score 3 (HR 8.8 [CI 95% 1.6-48.7], p=0.013) had a negative impact in DFS at 3y.

Conclusion: In our cohort of ypN0 patients, there was no impact from ACh in DFS at 3y, regardless of ypT status. Although pCR is a parameter for treatment success, our study suggests no impact on relapse. In this cohort, elevated pre-treatment CEA and pathological NACRT non-response increased the risk of recurrence, perhaps identifying a high-risk group of patients.

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P-209 Multicenter real life experience of biological agents in patients with metastatic colorectal cancer

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Background: To investigate therapeutic approaches and the effect of waiting time for molecular test results in clinical daily practice on the treatment decision in patients with metastatic colorectal cancer (mCRC).

Methods: As of January 2018, the first 25 patients admitted to each institution participating in the study and with at least 3 months follow-up were included in the study. Data of 282 patients from 11 centers were analyzed retrospectively.

Results: Fifty-eight percent (n = 164) of the patients included in the study were male and 42% (n = 118) were female. The median age of patients at the time of metastasis was 60 (16-90 years). Seventy-five percent of the patients were metastatic at diagnosis, and 25.0% developed metastases afterwards. Localization was specified in 269 patients; 73.2%, 23.0% and 3.7% in the left colon, right colon and transverse colon, respectively. While the frequency of RAS wild-type in patients was 49.3%, the frequency of BRAF mutation was 3.5% and MSI-High in 3.5% of the patients. Regardless of treatment regimen, 53.5% of the patients received chemotherapy + anti-VEGF, 35.3% received chemotherapy + anti-EGFR therapy and 11.2% received chemotherapy alone. Of the patients with right colon tumors; 78.5% received chemotherapy + anti-VEGF, 14.3% chemotherapy + anti-EGFR, and 7.2% chemotherapy alone. The frequency in patients with left colon tumor was 45.9%, 42.6% and 11.5%, respectively. In RAS wild-type patients with left tumors, median PFS was 10.8, 13.8 and 6.9 months in patients treated with chemotherapy + anti-VEGF, chemotherapy + anti-EGFR, and chemotherapy alone, respectively (P = 0.119). While 80.2% of patients with RAS wild-type and left colon tumor received chemotherapy + anti-EGFR, 14.3% received chemotherapy + anti-VEGF, and 5.5% chemotherapy alone. In patients with RAS wild-type and right colon tumor, the frequency of chemotherapy + anti-EGFR was 33.3% and chemotherapy + anti-VEGF was 66.7%. The median time to the start of biological therapy was 14 days.

In 15.2 % of patients, the time to start biological treatment was longer than 30 days, and 15.6% of the patients had not received any biological treatment.

Conclusion: Biological therapy was started in the first 30 days in 69.1% of the patients. Since biological treatment was added to chemotherapy at the second cycle of treatment in the vast majority of patients, we did not observe PFS differences between groups according to the timing of biological treatment.

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P-210 The outcomes and toxicity of FOLFIRINOX treatment in a cohort of patients with incurable pancreatic cancer treated in a single centre in Northern Ireland

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Background: The ACCORD 11 trial demonstrated the superiority of FOLFIRINOX over Gemcitabine monotherapy in patients with metastatic pancreatic cancer, with minimal co-morbidities and an ECOG performance status of 0 or 1. This regimen also has increased toxicity, particularly neutropenia and diarrhoea. We report the outcomes and toxicity of FOLFIRINOX treatment in a 'real world' cohort of sequential patients with incurable pancreatic cancer treated in a single centre.

Methods: Patients who received FOLFIRINOX (Irinotecan 180mg/m^2, Oxaliplatin 80mg/m^2, Folinic acid 200mg/m^2 and 5FU infusion 2400mg/m^2 over 46 hours) for advanced pancreatic cancer between 2010 and 2019 in the Northern Ireland Cancer Centre, were identified from the oncology information system. GCSF prophylaxis was not routinely used. Data was extracted from standard electronic patient records and the ARIA prescribing system. Information on the patient's treatment toxicity profile, dose interruptions, cycles of FOLFIRINOX received, response to treatment and admissions to hospital were collected during this period. Survival was calculated using the Kaplan Meier method using Statplus software.

Results: Seventy-seven patients who had received FOLFIRINOX chemotherapy between January 2010 and December 2019 for pancreatic cancer were reviewed. Forty of these patients had locally-advanced pancreatic cancer and thirty-seven patients had metastatic disease. There were 45 males and 32 females, and the median age was 61. 53/77 (69%) were ECOG performance status 0 and 24/77 (31%) were ECOG PS 1. 57 patients (74%) experienced at least one grade three/four toxicity with 37% of