of treatment between both groups (9.8% vs 15.8% p= 0.231). No patient died as a result of an adverse event to the treatment.

Table: 42P

Characteristics	<65 years (41)	>65 years (19)	
Comorbidities:	7.3%	26.3%	
Hypertension	2.4%	10.5%	
Diabetes	14.6%	21.0%	
Hypercholesterolemia	2.4%	0%	
Ischemic event	0%	5.26%	
Heart failure			
Smoking habit	14.6%	1%	
Current	29.3%	36.8%	
Former			
Stage at diagnosis	I-II: 14.6% III-IV: 86.4%	I-II: 15.8 III-IV: 84.4%	
Toxicity (any)	43.9%	63.2%	p=0.165
Grade >G3	14.6%	5.3%	P=0.293
Toxicity	33%	50%	
Gastrointestinal	22.2%	25%	
Cardiological	33.4%	21%	
Hematological	5.5%	4%	
Others:			
Median treatment duration (months)	11.5	7	
Discontinuation:	9.8%	21.0%	P= 0.231
Delays:	9.8%	15.8%	P=0.498
Subsequent treatment	68.2%	71.4%	P=0.333

Conclusions: Patients >65 years treated with iPARPs did not experience higher rates of adverse events or treatment interruptions/discontinuations. iPARPs should be a valid treatment option for ovarian cancer in this increasingly frequent subgroup of patients.

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43P Malignant bowel obstruction in advanced ovarian cancer: A retrospective analysis of patients supported with parenteral nutrition

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Background: Malignant bowel obstruction (MBO) is common in advanced ovarian cancer (AOC). Treatment options are limited as majority of cases present with widespread, multilevel peritoneal dissemination and platinum-resistant disease. The benefit of Parenteral Nutrition (PN) in MBO is debated, given the limited overall survival (OS) of this patient group. Aim: to identify which clinical features correlate with improved survival in AOC and MBO, to support clinical decision-making.

Methods: Retrospective review of patients admitted with MBO between April 2019 and October 2021 to a single tertiary cancer centre. Those with AOC established on PN with the aim to discharge home on PN were included. Univariate analysis for survival after commencing PN was performed using log-rank test.

Results: 103 patients with MBO were identified with 33 patients excluded (PN not initiated, 15; PN withdrawn: covid service constraint, 5, acute medical event, 13). 70 patients were successfully established on PN and 49 discharged on PN; 16 patients clinically deteriorated; 5 returned to enteral diet. Median OS of patients that did not receive PN was 19 days, PN stopped due to general deterioration 39 days and 100 days (range 18-807) for those established on PN ($p<0.0001$). Clinical features associated with improved OS: no prior systemic therapy ($p=0.0067$), platinum sensitivity ($p=0.043$), ECOG performance status (PS) 1 vs 2-3 ($p=0.004$), falling modified Glasgow Prognostic Score (mGPS) during admission ($p=0.0027$). In the treatment naïve group, chemotherapy resolved MBO in 6/9 cases. In the pre-treated group, 60% of patients received subsequent chemotherapy (median duration 8 weeks), with early cessation due to toxicity and no clinical benefit. Only 1 patient achieved resolution of MBO on chemotherapy.

Conclusions: PN may improve survival of patients with AOC in MBO. ECOG PS, platinum sensitivity and mGPS trend may be useful to select patients for PN. In those presenting with MBO at AOC diagnosis, PN can enable safe delivery of chemotherapy, which usually will resolve MBO. In pre-treated patients, PN is a life-long commitment and chemotherapy is largely ineffective in resolving MBO. Further research should focus on quality of life in patients receiving PN.

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44TiP ENGOT-ov65/KEYNOTE-B96: Phase III, randomized, double-blind study of pembrolizumab vs placebo + paclitaxel with optional bevacizumab for platinum-resistant recurrent ovarian cancer

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Background: There is an urgent need for new treatments for platinum-resistant recurrent ovarian cancer (PROC). Addition of bevacizumab (bev) to non-platinum-based chemotherapy (chemo) significantly improved PFS in patients (pts) with PROC but did not show a clear OS benefit. Thus far, the combination of paclitaxel + bev has shown the most promise in PROC, although the proportion of pts eligible for bev is limited by treatment-related toxicities. Combination of the anti-PD-1 antibody pembrolizumab (pembro) with weekly paclitaxel showed antitumor activity and manageable toxicity in pts with PROC in a single-arm, phase II study. ENGOT-ov65/KEYNOTE-B96 (NCT05116189) compares the efficacy and safety of pembro + standard of care chemo (weekly paclitaxel) ± bev vs placebo (pbo) + weekly paclitaxel ± bev in pts with PROC.

Trial design: In this randomized, pbo-controlled, double-blind, phase III study, eligible pts are aged ≥18 y with histologically confirmed epithelial ovarian, fallopian tube, or primary peritoneal carcinoma with 1-2 prior lines of systemic therapy, including ≥1 prior platinum-based therapy with ≥4 cycles in first line. Pts must have platinum-resistant disease (radiographic evidence of PD ≤6 mo after last platinum-based therapy dose), be eligible for paclitaxel (± bev per investigator discretion), have ECOG PS ≤1, radiographically evaluable disease per RECIST v1.1, and have a tumor sample for central evaluation of PD-L1 status. ~616 pts will be randomized 1:1 to pembro 400 mg IV or pbo Q6W for up to 18 cycles (~2 y) + paclitaxel 80 mg/m^2 on days 1, 8, and 15 of each Q3W cycle (± bev 10 mg/kg Q2W per investigator discretion) until PD or unacceptable toxicity. Randomization is stratified by planned bev use (yes vs no), region (US vs Europe vs rest of world), and PD-L1 status (combined positive score [CPS] <1 vs CPS 1-<10 vs CPS ≥10). Primary endpoint is PFS per RECIST v1.1 by investigator review in pts with tumor PD-L1 CPS ≥1 and in all pts. Secondary endpoints are OS in pts with tumor PD-L1 CPS ≥1 and in all pts, PFS per RECIST v1.1 by blinded independent central review in pts with tumor PD-L1 CPS ≥1 and in all pts, safety, and pt-reported outcomes. Enrollment is ongoing.

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45TiP A randomized, molecular driven phase II trial of carboplatin-paclitaxel-bev vs carboplatin-paclitaxel-bev-rucaparib vs carboplatin-paclitaxel-rucaparib, selected according to HRD status, in patients with advanced ovarian cancer

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Background: Poly (ADP-ribose) polymerase (PARP) inhibitors alone and in combination with Bevacizumab have shown significant clinical benefit as maintenance therapy in women with newly diagnosed ovarian cancer (OC) regardless BRCA mutational status and in homologous-recombination deficiency (HRD)-positive patients, respectively. However, despite the remarkable improvements in the therapeutic algorithm of ovarian cancer disease over the years, several open questions remain: a) what is the best treatment in HRD-positive patients? b) what is the added value of bevacizumab in HRD positive tumors with respect to PARPi alone? c) what is the preferred treatment in HRD-negative tumors: PARPi or bevacizumab? MITO 25.1 aims to evaluate the best first line treatment regimen in the different molecular subgroups, HRD-positive and HRD-negative OC, evaluated with Foundation Medicine LOH test.

Trial design: MITO 25.1 is a multicenter, randomized open-label, phase II study in which patients with high-grade serous or endometrioid advanced OC will be randomized in a 1:1 ratio according to a molecular driven treatment to receive: HRD-negative patients · ARM A: Carboplatin AUC 5 + Paclitaxel 175 mg/m2 q 21 + Bev 15 mg/kg for 5 cycles (starting from cycle 2) followed by Bev 15 mg/kg q 21 for 16 cycles · ARM B: Carboplatin AUC 5 + Paclitaxel 175 mg/m2 q 21 for 6 cycles followed by Rucaparib 600 mg BID q 28 for 24 cycles as maintenance HRD-positive patients · ARM B: Carboplatin AUC 5 + Paclitaxel 175 mg/m2 q 21 for 6 cycles followed by Rucaparib 600 mg BID q 28 for 24 cycles as maintenance · ARM C: Carboplatin AUC 5+ Paclitaxel 175 mg/m2 q 21 + Bev 15 mg/kg for 5 cycles (starting from cycle 2) followed by Bev 15 mg/kg q 21 days for 16 cycles + Rucaparib 500 mg part BID q 28 for 24 cycles as maintenance The primary endpoint will be PFS. The secondary endpoints will be overall survival (OS), PFS2, adverse events according to CTCAE 5.0 and patient-reported outcome. Patients recruiting started in March 2021. To date, 136 of the 290 patients planned have been enrolled.

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