had at least one dose reduction and 60.0% at least one dose interruption. 9.8% discontinued due to rucaparib toxicity and 5 pts remained on treatment upon analysis. Median PFS was 6.0 mo (95% CI 2.5-7.8). For treatment group (19 radiologically-evaluable pts), the disease control rate was 42.0% (21.0% PR and 21.0% SD). Overall, 86.3% of pts had rucaparib-related toxicities, while most common G3-4 hematological events were anemia (13.7%), neutropenia (5.9%), and thrombocytopenia (5.9%).

Conclusion* Rucaparib's safety profile in real-life setting is manageable and efficacy results, even considering heavily pretreated pts, are comparable to those of previous trials. The RAP in Spain showed a consolidated management of rucaparib and, consequently, an improved safety profile.

Abstract 403 Table 1 Patient characteristic and treatment information

	Total (n=51)	Maintenance (n=18)	Treatment (n=33)
Age			
Median	63.0	65.5	63.0
Min	36	44	36
Max	86	86	86
70 y or older	10 (19.6%)	4 (22.2%)	6 (18.2%)
ECOG			
0	19 (37.3%)	7 (38.9%)	12 (36.4%)
1	25 (49.0%)	10 (55.6%)	15 (45.5%)
2	3 (5.9%)	0 (0.0%)	3 (9.1%)
Unknown	4 (7.8%)	1 (5.6%)	3 (9.1%)
Measurable disease	37 (72.5%)	9 (50.0%)	28 (84.8%)
Relevant comorbidities	17 (33.3%)	10 (55.6%)	7 (21.2%)
Rucaparib exposure (months)			
Median	4.5	7.9	2.7
Min	<1	1	<1
Max	30	30	18
Rucaparib dose (mg)			
Median	557.7	553.9	600.0
Min	300	316	300
Max	600	600	600
Dose reductions	n=50	n=18	n=32
0	25 (50.0%)	7 (38.9%)	18 (56.3%)
1	16 (32.0%)	5 (27.8%)	11 (34.4%)
2	8 (16.0%)	5 (27.8%)	3 (9.4%)
3	1 (2.0%)	1 (5.6%)	0 (0.0%)
Dose interruptions	n=50	n=18	n=32
0	20 (40.0%)	8 (44.4%)	12 (37.5%)
1	20 (40.0%)	7 (38.9%)	13 (40.6%)
2	8 (16.0%)	1 (5.6%)	7 (21.9%)
≥3	2 (4.0%)	2 (11.2%)	0 (0.0%)
EoT reason			
PD	36 (70.6%)	13 (72.2%)	23 (69.7%)
Toxicity	5 (9.8%)	1 (5.6%)	4 (12.1%)
Other	5 (9.8%)	1 (5.6%)	4 (12.1%)
Ongoing	5 (9.8%)	3 (16.7%)	2 (6.1%)

Abstract 403 Table 2 Rucaparib-related most common toxicity (per patient)

	Total (n=51) n (%)		Maintenance (n=18) n (%)		Treatment (n=33) n (%)	
AE term (CTCAE 5.0)	All grades	G3-4	All grades	G3-4	All grades	G3-4
Anemia	23 (45.1)	7 (13.7)	5 (27.8)	2 (11.1)	18 (54.5)	5 (15.2)
Thrombocytopenia	13 (25.5)	3 (5.9)	1 (5.6)	0 (0.0)	12 (36.4)	3 (9.1)
Neutropenia	7 (13.7)	3 (5.9)	3 (16.7)	0 (0.0)	4 (12.1)	3 (9.1)
ALT increased	13 (25.5)	1 (2.0)	6 (33.3)	1 (5.6)	7 (21.2)	0 (0.0)
Fatigue	13 (25.5)	2 (3.9)	6 (33.3)	0 (0.0)	7 (21.2)	2 (6.1)
Nausea	13 (25.5)	1 (2.0)	8 (44.4)	1 (5.6)	5 (15.2)	0 (0.0)
AST increased	12 (23.5)	0 (0.0)	7 (38.9)	0 (0.0)	5 (15.2)	0 (0.0)
Creatinine increased	7 (13.7)	0 (0.0)	6 (33.3)	0 (0.0)	1 (3.0)	0 (0.0)
Hyponatremia	7 (13.7)	2 (3.9)	0 (0.0)	0 (0.0)	7 (21.2)	2 (3.9)
ALP increased	6 (11.8)	2 (3.9)	2 (11.1)	1 (5.6)	4 (12.1)	1 (3.0)
Diarrhea	6 (11.8)	0 (0.0)	5 (27.8)	0 (0.0)	1 (3.0)	0 (0.0)
Abdominal pain	5 (9.8)	1 (2.0)	3 (16.7)	0 (0.0)	2 (6.1)	1 (3.0)
Vomiting	5 (9.8)	2 (3.9)	2 (11.1)	0 (0.0)	3 (9.1)	2 (3.9)
Asthenia	4 (7.8)	0 (0.0)	1 (5.6)	0 (0.0)	3 (9.1)	0 (0.0)
Dysgeusia	4 (7.8)	0 (0.0)	3 (16.7)	0 (0.0)	1 (3.0)	0 (0.0)
Pruritus	4 (7.8)	0 (0.0)	3 (16.7)	0 (0.0)	1 (3.0)	0 (0.0)
Constipation	3 (5.9)	0 (0.0)	1 (5.6)	0 (0.0)	2 (6.1)	0 (0.0)
Colonic obstruction	1 (2.0)	1 (2.0)	0 (0.0)	0 (0.0)	1 (3.0)	1 (3.0)
GGT increased	1 (2.0)	1 (2.0)	1 (5.6)	1 (5.6)	0 (0.0)	0 (0.0)
Intestinal obstruction	1 (2.0)	1 (2.0)	0 (0.0)	0 (0.0)	1 (3.0)	1 (3.0)
Pleural effusion	1 (2.0)	1 (2.0)	0 (0.0)	0 (0.0)	1 (3.0)	1 (3.0)
Myelodysplastic syndrome	1 (2.0)	1 (2.0)	0 (0.0)	0 (0.0)	1 (3.0)	1 (3.0)

411 OVARIAN CANCER METASTASES IN THE LIVER AREA: PROPOSAL OF A STANDARDIZED ANATOMO-SURGICAL CLASSIFICATION

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Introduction/Background* The combination of emerging target therapies and continuous technological advancement in surgical procedures support a trend toward a prolonged survival in advanced ovarian cancer (AOC) patients. Upper abdominal carcinomatosis hides challenging locations for complete gross resection in the hands of expert gynecologic oncologists. We developed an anatomo-surgical classification for ovarian cancer metastases in the liver area from a gynecological point of view, aiming to provide an anatomo-topographical tool to address each surgical task and to standardize the nomenclature in the radiological and surgical report.

Methodology After the identification of four conceptually distinct anatomical areas, we used both the three-dimensional anatomical model and the surgical video report to represent them individually.

Result(s)* Our anatomo-surgical classification is divided into 4 distinct categories:

TYPE1 GLISSON'S CAPSULE: superficial metastases involving only the Glisson's sheat with no parenchymal infiltration (either focal or extensive).

TYPE2 LIGAMENTOUS: this is a heterogeneous group defining cancer deposits along the lines of reflection between the liver and surrounding organs. We can further divide it into 'falciform ligament', 'round ligament', 'Arantii and hepato-gastric ligament', 'coronary and triangular ligament' localizations.

TYPE3 HEPATIC HILUM: the porta hepatis is considered as a single entity due to its potentially dual neoplastic involvement both peritoneal or 'external' as hepato-duodenal ligament and lymphatic or 'internal' while involving lymph-nodes along the portal triad.

TYPE4 PARENCHYMAL: we identified, based on surgical management, the 'superficial' intra-parenchymal localization, infiltrating the less than 1 cm in depth, and the fully intra-parenchymal.

Conclusion* Our classification represents a useful guide while planning the surgical strategy to AOC metastases in the liver area.

Identification of each category, specific underlining anatomical pitfalls and its surgical-related management, guarantees a didactic and effective tool in supporting the daily intraoperative decision-making algorithm, and in assigning the specific procedure within a multidisciplinary team, based on surgical competence.

Furthermore, the standardization of nomenclature allows an easy exchange of surgical information for scientific purposes, that are otherwise difficult to interpret and compare.

414 SURGERY FOR MALIGNANT OVARIAN GERM CELL TUMOURS: A MULTICENTRE RETROSPECTIVE COHORT STUDY

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Introduction/Background* Malignant ovarian germ cell tumours (MOGCTs) are rare with a yearly-adjusted incidence of 3.7 per million [1] and account for 1-2% of all ovarian malignancies in Europe. There is a clinical imperative to clarify the optimal surgical approach and establish surgical radicality since this is a predominantly young population and minimising treatment morbidity and optimising future fertility is of real importance. Here we aim to describe the current surgical management of ovarian germ cell tumours and relate this to clinical outcome. Specifically, we aimed to compare outcomes of open versus laparoscopic surgery, the use of fertility-sparing approaches, surgical staging, and the potential utility of cystectomy alone in the management of patients with stage 1 immature teratoma.

Methodology A retrospective cohort study of all consecutive patients with primary ovarian germ cell tumours treated in four major UK gynaecology oncology centres over 12 years.

Abstract 414 Table 1

	All pathologies	Dysgerminoma	Yolk sac tumour	Mixed germ cell tumour	Immature teratoma	Primitive neuroectodermal tumour
Total, N (%)	137 (100.0)	37 (27.0)	23 (16.8)	29 (21.1)	44 (32.1)	4 (2.9)
FIGO 2014 stage						
Stage 1	86 (62.3)	24 (64.9)	13 (56.5)	10 (34.5)	39 (88.6)	0 (0.0)
Stage 2	11 (8.0)	2 (5.4)	2 (8.7)	6 (20.7)	0 (0.0)	1 (25.0)
Stage 3	23 (16.7)	6 (16.2)	7 (30.4)	7 (24.1)	1 (2.3)	2 (50.0)
Stage 4	15 (10.9)	4 (10.8)	1 (4.3)	6 (20.7)	3 (6.8)	1 (25.0)
Age						
Median (IQR)	23 (14)	21 (10)	27 (13)	23 (14)	26 (15.5)	23 (11.75)
< 18, N (%)	31 (22.6)	10 (27.0)	3 (13.0)	3 (10.3)	14 (31.8)	1 (25.0)
> 18, N (%)	106 (77.3)	27 (73.0)	20 (87.0)	26 (89.7)	30 (68.2)	3 (75.0)
Surgical route						
Laparotomy	109 (80.0)	23 (62.1)	21 (91.3)	25 (86.2)	36 (81.8)	4 (100.0)
Laparoscopy	22 (16.0)	11 (8.0)	2 (8.7)	2 (6.9)	7 (5.1)	0 (0.0)
Surgery type						
Fertility sparing	120 (87.6)	31 (83.8)	22 (95.7)	24 (82.8)	40 (90.9)	3 (75.0)
Non-fertility sparing	16 (11.7)	6 (16.2)	1 (8.7)	4 (13.8)	4 (9.1)	1 (25.0)
Primary debulking	10	1	1	4	1	1
Interval debulking	5	2	0	0	3	0
Prophylactic surgery	3	3	0	0	0	0
Chemotherapy						
None	61 (44.5)	15 (40.5)	4 (17.4)	9 (31.0)	33 (75.0)	0 (0.0)
Neoadjuvant	16 (11.7)	7 (18.9)	2 (8.7)	2 (6.9)	4 (9.1)	1 (25.0)
Adjuvant	60 (43.8)	15 (40.5)	17 (73.9)	18 (62.1)	7 (15.9)	3 (75.0)
Residual disease						
none	112 (81.8)	35 (94.6)	14 (60.9)	21 (72.4)	39 (88.6)	3 (75.0)
<1cm	4 (2.9)	0 (0.0)	2 (8.7)	1 (3.4)	1 (2.3)	0 (0.0)
>1cm	20 (14.6)	2 (5.4)	7 (30.4)	6 (20.7)	4 (9.1)	1 (25.0)
Completion surgery						
performed	11 (8.0)	1 (2.7)	4 (17.4)	2 (6.9)	4 (9.1)	0 (0.0)
not performed	124 (90.5)	36 (97.3)	19 (82.6)	26 (89.7)	39 (88.6)	4 (100.0)
Recurrence	39 (28.5)	3 (8.1)	8 (34.8)	15 (51.7)	9 (20.5)	4 (100.0)
Time to recurrence (days)						
median (IQR)	211 (249)	363 (1398.5)	153 (296.25)	174 (126.5)	212 (208)	367.5 (368.75)
Censor outcome						
Dead	10 (7.3)	0 (0.0)	3 (13.0)	5 (17.2)	0 (0.0)	2 (50.0)
Alive with disease	3 (2.2)	0 (0.0)	1 (0.0)	0 (0.0)	1 (2.2)	1 (25.0)
Alive and disease free	127 (17.5)	37 (100.0)	20 (87.0)	24 (82.8)	43 (97.7)	1 (25.0)
Time to censor outcome (years)						
median (IQR)	4.6 (4.6)	6.0 (3.2)	4.9 (4.6)	4.9 (5.2)	3.2 (3.4)	1.3 (1.6)