were performed for different tumour lengths. All analyses were performed with SPSS v25.0. KM analyses were performed with the Kaplan-Meier. KM curve comparisons were performed with the log-rank test; a probability level of 5% was used as the cut-off for statistical significance in all analyses.

Results: Among the 84 patients included in the study, 31 (36.9%) patients were alive at the time of database closure. Median age at diagnosis was 78.4 ± 9 years. The majority of the patients were male (65.5%) with a performance status of 1 (73.8%). The majority had stage III (40.5%) and stage IVa (25%) disease. Adenocarcinoma was the predominant histology (65.2%). 61.9% had a GTV of < 0.002 and Heart DVHs-V30 (Correlation Coefficient 0.394, p < 0.001). Overall survival (OS) and progression-free survival (PFS) for the whole cohort was 22.5 months (95% CI 13.9, 31.2) and 10.7 months (95% CI 6.8, 14.5). Comparison of both OS and PFS for different tumour length category did not demonstrate a statistically significant outcome (p = 0.247 for OS and p = 0.233 for PFS).

Conclusion: The data demonstrates that it is feasible to treat longer tumours without increasing clinically significant toxicities and it is also feasible to achieve good local control for patients with longer tumours who would otherwise not have any radical treatment options. In future trials, it will be feasible to include patients with longer tumours, especially if modern RT techniques like VMAT are adopted and mandated.

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P-274 RELEVANT study: Patient and physician perspectives on clinically-meaningful outcomes in advanced pancreatic ductal adenocarcinoma

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Background: No previous studies have investigated patient and physician views on treatment decision-making, goals and clinically-meaningful outcomes in advanced pancreatic ductal adenocarcinoma (PDAC).

Methods: This prospective observational study recruited consecutive patients with newly-diagnosed advanced PDAC who were due to start palliative chemotherapy and their physicians. Patients completed 2 Quality-of-Life questionnaires (EORTC QLQ-C30 and PAN26) and a study survey at 3 time points: (T1) before starting chemotherapy, (T2) before, and (T3) after 1st on-treatment CT scan. Paired surveys were completed by physicians at each time point.

Results: Seventy-one patients consented, median age 65years, 52% male, 93% stage IV. 60% of patients received chemotherapy (mean, SD/C212 (22), 38% doublet and 23% monotherapy. Baseline EORTC QLQ-C30 scores (out of 100) were: QoL 57 points (mean, SD/C212 ±21), physical functioning 73 points (±22), fatigue 46 points (±6.2) and pain 45 points (±33) (lower scores indicated worse symptoms). Both physical functioning (p < 0.003) and pain (p = 0.002) worsened over time. 61% of patients died during the study. Surveillance compliance at timepoints: T1: 65/71, T2: 39/61, T3: 36/45; reasons for non-compliance were patient deterioration or death. Chemotherapy adverse event acceptability was similar between patients and physicians, but rash and alopecia were more acceptable (both p < 0.004) and diarrhoea was less acceptable to patients (p < 0.001) than physicians thought. Tiredness became less acceptable for patients between timepoints (p = 0.005). For 45% of patients, the most important aspect when selecting between chemotherapy options was overall survival (OS); most physicians (58%) favoured OS/side-effect balance (p < 0.001). Over 80% of patients indicated that they had a personal goal that they wanted to reach with the help of treatment, whilst only 12% of physicians were aware of this. The importance of some priorities also varied; being able to travel (mean 3.7 compared to 5.1, for clinicians and patients, respectively; p < 0.001), spending time with family (1.4 to 2.4, p < 0.001) and special events (3.2 to 4.7, p < 0.001) were all rated as more important by patients than clinicians. Significant differences regarding the length of time chemotherapy was expected to extend patients’ lives were identified (p < 0.001); 81% of physicians and 12% of patients and 0% of physicians and 58% of patients thought that this would be within 1-6 months or 1-5 years, respectively. Differences were also identified regarding the minimal survival gain considered to be important: 76% of physicians and 17% of patients and 0% of physicians and 43% of patients thought that it would be 1-6 months and 1-5 years of minimal survival gain, respectively (p < 0.001). Differences were also observed in treatment-related toxicities: 81% of physicians and 12% of patients thought that toxicities of interest; no disclosure provided for the first author.

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P-275 Quality of life and symptoms in patients undergoing CRS-HIPEC with or without perioperative systemic treatment for colorectal peritoneal metastases: Results from the randomised CAIRO6 trial

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Background: To investigate the effect of perioperative systemic therapy in addition to cytoreductive surgery and hyperthermic intraperitoneal chemotherapy (CRS-HIPEC) on quality of life (QoL) and symptoms during and after treatment for colorectal peritoneal metastases.

Methods: During this phase II, randomized, controlled trial, all consecutive patients were randomized 1:1 for a) CRS-HIPEC (control group) and b) CRS-HIPEC with perioperative systemic treatment (experimental group). Analyses were performed on the per-protocol study population. QoL and symptoms were measured at baseline, after neoadjuvant treatment (experimental group only), and at 3 and 6 months after surgery. The EORTC QLQ-C30, QLQ-CR29, and EQ-S5-L questionnaires were used.

Results: Eighty patients were included: 43 in the control group and 37 in the experimental group. Response rates were 100%, 94.9%, 83.5%, and 74.9% at baseline, after neoadjuvant treatment, at 3 and 6 months after surgery, respectively. The C30 summary score, EQ-VAS score, and index score were similar between the groups at baseline, at 3 and at 6 months after CRS-HIPEC. Also, all EORTC QLQ-C30 and CR29 functional and symptom scores were not significantly different between the groups at any point. In the experimental group, higher index scores were observed in patients who received adjuvant systemic treatment compared with patients who did not at 6 months after surgery.

Conclusion: Perioperative systemic therapy in patients undergoing CRS-HIPEC for colorectal peritoneal metastases did not significantly deteriorate QoL or worsen symptoms. Furthermore, in both groups, all QoL and symptom scores returned to baseline values at 3 or 6 months after surgery.

Legal entity responsible for the study: The authors.

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P-276 Neutrophil/lymphocyte ratio (NLR) predicts survival after curative treatments for rectal cancer patients

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Background: Inflammation presents a connection with tumorigenesis. Simultaneously, ionizing radiation causes tumour cell death and an immune response takes place. Patients’ baseline immune response can be a predictor of tumour response to rectal cancer treatments. Our aim was to evaluate the role of neutrophil/lymphocyte ratio (NLR) patient survival in rectal cancer.

Methods: Patients, treatment, and survival data were retrospectively collected, concerning radiotherapy treatments administered with curative intent, from 2013 to 2017. Survival data were evaluated through Cox-analysis, log-rank and survival tables. For the 5-y overall (OS) and disease-specific survival (DSS), the discriminative cut-off NLR was estimated applying Area Under Curve (AUC), receiver operating characteristic (ROC), DeLong method. All analyses were performed using an IBM-SPSS v25 and, for all, a level of significance α = 0.05 was noted.

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