1324P Real world patterns of first-line maintenance therapy in BRCA wild-type, HRD-positive advanced epithelial ovarian cancer across five European countries (EU5)

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Background

First-line (1L) maintenance therapy is a key component in managing advanced epithelial ovarian cancer (AEOC), particularly in Homologous recombination deficiency (HRD)-positive disease where multiple options exist. Nevertheless, real-world evidence on routine treatment patterns in Europe remains limited. Treatment choices may differ across countries due to clinical practice, regulatory approvals, and reimbursement policies. This study explored 1L maintenance patterns in routine European practice, highlighting variations in therapy allocation across five major healthcare systems (United Kingdom [UK], France [FR], Germany [DE], Italy [IT], Spain [ES]; collectively EU5).

Methods

This retrospective, real-world study was conducted among physicians across the EU5 (UK, FR, DE, IT, ES). Between November 2024 and February 2026, respondents extracted anonymised data from consecutive eligible patients (pts) medical records. Inclusion criteria were women with histologically confirmed AEOC (International Federation of Gynaecology and Obstetrics [FIGO] stage III–IV) who had completed 1L platinum-based chemotherapy without evidence of disease progression, and were BRCA wild-type, HRD-positive. Pts participating in clinical trials were excluded. Physicians reported demographic and clinical characteristics, including age, Eastern Cooperative Oncology Group (ECOG) performance status (PS), and treatment history. Maintenance strategies were classified as surveillance (Surv), bevacizumab (Beva), niraparib (Nira), rucaparib (Ruca), Olaparib plus Bevacizumab (Ola/Bev) or other. Inter-country differences in therapy allocation were analysed using chi-square tests with Pearson residuals, with additional exploratory pairwise comparisons between selected countries.

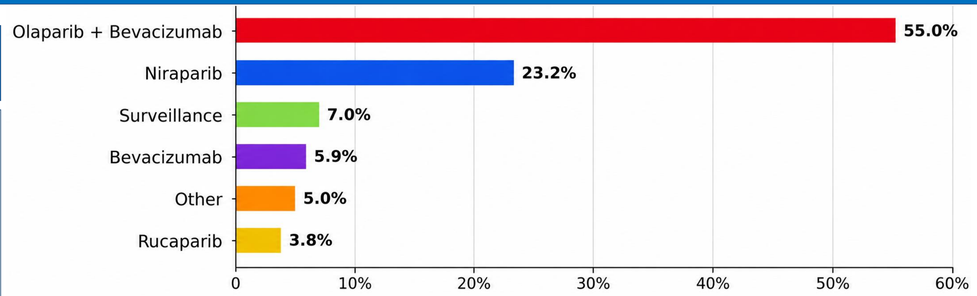

Figure 1. Proportion of 1L maintenance therapies in BRCA wild-type, HRD-positive AEOC across the EU5.

Therapy	Country with higher use	n (%)	Country with lower use	n (%)	p-value
Ola/Bev	FR	198 (67.1)	ES	130 (40.6)	<0.0001
Niraparib	ES	152 (47.5)	DE	22 (11.5)	<0.0001
Surveillance	IT	46 (16.5)	ES	7 (2.2)	<0.0001
Bevacizumab	DE	18 (9.4)	IT	5 (1.8)	0.0002

Table 1. Pairwise comparisons of 1L maintenance therapy allocation across the EU5. Data shown as n (%); p-values from χ^2 tests.

Therapy	FR	DE	IT	ES	UK
Olaparib + Bevacizumab	4.7	1.8	1.9	-5.9	-2.1
Niraparib	-5.0	-4.1	-3.9	11.8	0.2
Surveillance	-2.8	-0.8	7.0	-3.9	0.6
Bevacizumab	2.7	2.2	-3.3	-1.9	0.6
Other	2.2	3.0	-3.1	-3.0	1.4
Rucaparib	-3.2	-0.6	1.9	0.2	1.7

Table 2. Variation in 1L maintenance therapy allocation across the EU5. Data shown as Pearson residuals from the χ^2 tests; red indicates over-representation, blue indicates under-representation.

Results

In total, 1,352 pts were included. Most were aged ≥60 years (yrs) (n=926, 68.5%), including 626 (46.3%) aged 60–69 yrs and 300 (22.2%) aged ≥70 yrs. Twenty one pts (1.6%) were <40 yrs, and 405 (30.0%) were aged 40–59 yrs. ECOG PS was 0 in 400 pts (29.6%), 1 in 848 (62.7%), and ≥2 in 104 (7.7%). Reported 1L maintenance therapies were Ola/Bev (n=744, 55.0%), Nira (n=313, 23.2%), Surv (n=95, 7.0%), Bev (n=80, 5.9%) Ruca (n=52, 3.8%), and other therapies (n=68, 5.0%), (Fig. 1). Maintenance choice differed significantly across the EU5 (χ^2=252.93, df=20, p<0.0001). Surv was more frequent in IT (17.2%) and uncommon in ES (2.2%). Nira was the leading option in ES (47.5%), whereas use was lowest in the DE (10.8%). Ola/Bev predominated in four countries, whereas it was prescribed relatively less often in ES (40.6%). (Table 1). Patterns of deviation from expected allocation are illustrated in the heatmap (Table 2). ECOG PS was associated with treatment choice. Patients with ECOG PS ≥2 were over-represented in the surveillance group compared with those receiving active maintenance (18/95, 18.9% vs 86/1,257, 6.8%; χ^2=18.23, p<0.0001).

Conclusions

This study documents substantial variation in the use of 1L maintenance therapies for BRCA wild-type, HRD-positive AEOC across major European countries. Such differences likely reflect a combination of national guidelines, reimbursement criteria, and established clinical practice patterns. Further investigations of this kind are warranted to characterise real-world treatment decisions more comprehensively. Generating such evidence may help inform future discussions aimed at achieving more consistent practice across European healthcare systems.