

observation, surgical resection of nodules, administration of progesterone, selective estrogen receptor modulators, aromatase inhibitor and gonadotropin releasing hormone agonists. In postmenopausal women, BML could be mistaken for metastatic cancer.

Ovarian cancer

2022-RA-127-ESGO MESENTERIC RETRACTION IN OVARIAN CANCER ON ULTRASOUND

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Introduction/Background Ovarian cancer is common in gynecologic oncology clinics. usually follow up of patients is done by CT after the chemotherapy. CT scan is very irritating for women especially if done every 6 months and using dye injection.

Methodology Therefore, we aimed here to present some of our work regarding using ultrasound in assessing the response of chemotherapy. the chemotherapy response score (CRS) is assessed by histopathology, but CT and ultrasound can be used. CRS 1 indicates no response to chemotherapy, CRS 2 indicates partial one and CRS 3 indicates complete response. we are reporting response in relation to the primary tumor and the metastasis. After surgery, score 3 should be confirmed by histopathology as there could be microscopic deposits. regarding ultrasound scoring, it can be done using some criteria including initial size, doppler signal, shape of the primary and the metastasis comparing them with response after chemotherapy 6–12 weeks and later on follow up. Further points are normalization of the ovarian size, regularity, adhesions of the ovary to the surrounding indicating previous infiltration and malignant adhesions, scoring of doppler signal, symmetry between both ovaries, necrosis and change in echogenicity and echotexture.

Results complete interval surgical debulking is common in CRS 3. Tumor marker measurement in addition is a useful marker for detecting disease progression after chemotherapy. The chemotherapy response is assessed on the primary tumor and the metastasis. The Doppler findings can be graded as 1–4.

Conclusion We aimed here to propose a way for assessing response for chemotherapy using ultrasound using the histopathological chemotherapy response score in a way to reach an agreement.

2022-RA-130-ESGO ULTRASOUND CHEMOTHERAPY RESPONSE ASSESSMENT IN OVARIAN CANCER

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Introduction/Background Detection of ovarian malignancies is by transvaginal ultrasound. Currently, the first-line imaging #for staging and assessing disease response in ovarian cancer is computed tomography (CT) of the abdomen and pelvis. However, CT has limitations in mesenteric and small-bowel implants. Ultrasonography by an expert can

evaluate the intra-abdominal spread of disease Because of the low cost and high availability. (1) we are describing 2 cases showing common signs on ultrasound to suspect retraction

Methodology Small bowel mesentery root involvement is of great clinical importance because achieving complete cytoreduction is unfeasible. laparoscopic evaluation is undertaken before surgery using the Fagotti score for the small bowel mesentery root. ultrasound can detect that lesion easily based on limited mobility of the intestine, cauliflower mass of the intestine, failure to identify the mesentery individually.

Results US was done revealed multiple implant over ileum & jejunum with mesenteric affection o the small intestine that was detected as limited mobility of the loops of the intestine in the ascites, cawliflower shaped closely packed intestinal loops and limited mobility of the cauliflower mass. Case 2: Ultrasound revealed limited mobility of the intestine on the right side (ileum) than on left side in relation to each other with cauliflower mass appearance with packed closely intestinal loops.

Conclusion Ultrasonography performed by an expert may be a strategy for evaluating the intra-abdominal spread which allows the accurate qualification of patients for PDS or IDS

2022-RA-173-ESGO ENDOMETRIOID BORDERLINE OVARIAN TUMOR: CLINICAL CHARACTERISTICS, PROGNOSIS AND MANAGEMENT

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Introduction/Background Endometrioid Borderline Ovarian Tumor (EBOT) is a rare subtype of borderline ovarian malignancies. This study aimed to determine the prognosis of a series of EBOT.

Methodology A retrospective review of patients with EBOT treated in or referred to our institutions. A centralized histological review by a reference pathologist; data on the clinical characteristics, management (surgical and medical) and oncologic outcomes of patients were required for inclusion.

Results

Forty-eight patients were identified Median age was 52 years (range 14–89). Fourteen patients underwent a conservative surgery and 32 a bilateral salpingo-oophorectomy (unknown in 2 cases). Two patients had bilateral tumors. Forty-three patients had stage-I disease and 5 patients had a stage-II disease (10%). Stromal microinvasion and intraepithelial carcinoma was observed in 6 (12%) and in 13 (27%) patients respectively. Endometriosis was histologically associated in 12 patients (25%). Synchronous endometrial disease was found in 7 (24%) of 29 patients with endometrial histological evaluation. The median follow-up was 72 months (range 6–146 months). Two patients developed a recurrence after cystectomy in form of borderline disease (5%). No death related to EBOT occurred.

Conclusion Peritoneal restaging surgery should be performed if not realized initially, since 5% of EBOTS are diagnosed at stage II-III. Fertility-sparing surgery seems a safe option in selected patients. Because synchronous endometrial diseases including endometrial carcinoma are frequent, systematic hysterectomy (or endometrial sampling in case of fertility-sparing