Progression Free Survival (PFS) & Overall Response Rate was calculated.Quality of life (QOL)was calculated monthly.
Results The median PFS was 4 months (3 mon–5 mon).The median ORR was 15% (13%-17%).Commonest toxicity was grade 2 anaemia. No grade 3 toxicity.There were 10 deaths all secondary to disease progression.Among QOL pain & vomiting improved most.
Conclusion OMCT is quite effective least toxic therapy in heavily treated progressive ovarian cancer. However randomized trial required comparing it with single agent oral etoposide & best supportive care.

2022-RA-608-ESGO MANAGEMENT OF BORDERLINE OVARIAN TUMORS; A TERTIARY REFERRAL CENTER EXPERIENCE IN EGYPT

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Introduction/Background
Background In this retrospective study we discuss our experience as a large tertiary referral center in Egypt in the management and follow up of borderline tumors
Methodology This is a retrospective cohort study where all patients who were diagnosed with a borderline ovarian tumor at the Oncology Center Mansoura University from November 2014 to June 2020 were included.
Results We included 27 patients with borderline ovarian tumors. The mean age of the study patients was (47.67 ±16.39 years). The median CA 125 was 33 (6–304 U/ml). Frozen section examination was utilized in 13 patients (48.14%) where a diagnosis of borderline ovarian tumors was revealed in 8 patients. Recurrence was reported in one patient with serous type after approximately 26 months. The most common pathological type in our cohort was the mucinous borderline type which was reported in 14 patients (51.9%) followed by the serous type was reported in 11 patients (40.7%) and the seromucinous type in 1 patient only. Patients with mucinous borderline type were significantly younger (40.083±18.47 vs 53.73±11.91 years, p=0.028). Interestingly, Cancer Antigen 125 levels were significantly higher in mucinous than serous and seromucinous types (67(16–304) vs 20(6–294.6) U/ml, P=0.027). On the other hand, the radiological tumor size of serous and seromucinous type was larger than that of the mucinous type (23 (19–31) cm vs 8(5–20) cm, P=0.001). Over a median follow up period of 58.66 (54.16–63.16) months, only one postoperative mortality was reported while only one recurrence was reported.
Conclusion Borderline ovarian tumors still represent a dilemma either in diagnosis or management. Frozen section examination could help to reach a preliminary diagnosis. Total abdominal hysterectomy and bilateral salpingo-oophorectomy is the cornerstone of surgical management, however, fertility-sparing surgery could be a valid option for women desiring fertility.

2022-RA-609-ESGO FACTORS RELATED TO GRADE IIIA CLAVIEN-DINDO COMPLICATIONS AND DELAYED TIME TO CHEMOTHERATPY AFTER CYTOREDUCTIVE SURGERY FOR ADVANCED STAGE OVARIAN CANCER: A PROSPECTIVE COHORT STUDY

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Introduction/Background Early post-operative chemotherapy improves the survival of advanced-stage epithelial ovarian cancer (AEOC) patients by increasing the benefit of systemic therapy. As a result, recovery time after surgery and time to chemotherapy (TTC) are crucial endpoints for ovarian cancer treatment. The present study aimed to evaluate predictors for 30-day severe post-operative complications classified by Clavien-Dindo classification (CDC) grade ≥IIIa and TTC after cytoreductive surgery for primary AEOC.
Methodology Patients undergoing cytoreductive surgery for primary AEOC were enrolled from February 2018 to September 2020. Post-operative complications were graded according to CDC. Logistic regression analysis was performed to evaluate factors predicting CDC grade ≥IIIa and TTC>42 days.

Abstract 2022-RA-609-ESGO Table 1 Clavien-Dindo classification

Clavien-Dindo grades	Definition
Grade I	Any deviation from the normal postoperative course without the need for pharmacological treatment or surgical, endoscopic and radiological interventions Allowed therapeutic regimens are: drugs as antiemetics, antipyretics, analgesics, diuretics and electrolytes and physiotherapy. This grade also includes wound infections opened at the bedside.
Grade II	Requiring pharmacological treatment with drugs other than such allowed for grade I complications. Blood transfusions and total parenteral nutrition are also included.
Grade III	Requiring surgical, endoscopic or radiological intervention
Grade IIIa	Intervention not under general anesthesia
Grade IIIb	Intervention under general anesthesia
Grade IV	Life-threatening complication (including CNS complications) * requiring IC/ICU-management
Grade IVa	single organ dysfunction (including dialysis)
Grade IVb	Multiorgan dysfunction
Grade V	Death of a patient

*Brain hemorrhage, ischemic stroke, subarachnoid bleeding, but excluding transient ischemic attack, IC: intermediate care, ICU: intensive care unit
Reference: Dindo D, Demartines N, Clavien P-A. Classification of surgical complications: a new proposal with evaluation in a cohort of 6336 patients and results of a survey. *Ann Surg*. 2004;240(2):205-213

Results CDC grade ≥IIIa occurred in 51(17%) patients. In multivariable analysis, age (p=0.037), cardiovascular comorbidity (p<0.001), diaphragmatic surgery (p<0.001), intraoperative urinary tract injury (p=0.017), and other visceral injury (e.g., pancreas, stomach, liver or spleen) (p=0.013)

were factors related to CDC grade ≥IIIa. Of 300 patients, 25 patients did not receive chemotherapy after surgery and were excluded from TTC analysis. In 26% (72/275) TTC was > 42 days: median (IQR) 39 days (29–50) in patients with CDC grade ≥IIIa versus 33 days (25–41) in patients without CDC grade ≥IIIa, $p=0.008$. Patients with the following factors: WHO performance grade ≥2 ($p=0.045$), intra-operative bowel injury (p=0.043), other visceral injury ($p=0.008$) and post-operative CDC grade ≥IIIa ($p=0.032$) had a significantly higher adjusted odds of developing TTC >42 days.

Conclusion Patients with advanced age, cardiovascular comorbidity, and those who required diaphragmatic surgery had a greater adjusted odds of develop CDC grade ≥IIIa. CDC grade ≥IIIa was independently associated with TTC >42 days. A proper pre-operative risk assessment and prevention of intra-operative morbidity are essential in order to prevent severe post-operative complications and the delayed time to chemotherapy.

2022-RA-617-ESGO THE ROLE OF SYSTEMATIC PELVIC AND PARA-AORTIC LYMPHADENECTOMY IN THE MANAGEMENT OF PATIENTS WITH ADVANCED EPITHELIAL OVARIAN, TUBAL, AND PERITONEAL CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction/Background The objective of the current study is to investigate whether systematic pelvic and para-aortic lymphadenectomy offers superior survival rates and fewer peri-operative complications in patients with advanced epithelial ovarian cancer (EOC), tubal, or peritoneal cancer.

Methodology We searched the electronic databases PubMed, Cochrane Central Register of Controlled trials, and Scopus from inception to September 2021. We considered randomised controlled trials (RCTs) comparing systematic pelvic and para-aortic lymphadenectomy with no lymphadenectomy in patients with advanced EOC. Primary outcomes were overall survival and progression-free survival. Secondary outcomes were peri-operative morbidity and operative mortality. The revised Cochrane tool for randomised trials (RoB 2 tool) was utilised for the risk of bias assessment in the included studies. We performed time-to-event and standard pairwise meta-analyses, as appropriate.

Results Two RCTs with a total of 1074 patients were included in our review. Meta-analysis demonstrated similar overall survival (HR = 1.03, 95% CI [0.85 – 1.24]; low certainty) and progression-free survival (HR = 0.92, 95% CI [0.63 – 1.35]; very low certainty). Regarding peri-operative morbidity, systematic lymphadenectomy was associated with higher rates of lymphoedema and lymphocysts formation (RR = 7.31, 95% CI [1.89 – 28.20]; moderate certainty) and need for blood transfusion (RR = 1.17, 95% CI [1.06 – 1.29]; moderate certainty). No statistically significant differences were observed in regard to other peri-operative adverse events between the two arms.

Conclusion Systematic pelvic and para-aortic lymphadenectomy is likely associated with similar overall survival and progression-free survival compared to no lymphadenectomy in optimally debulked patients with advanced EOC. Systematic lymphadenectomy is also associated with an increased risk for certain peri-operative adverse events. Further research needs to be conducted on whether we should abandon systematic lymphadenectomy in completely debulked patients during primary debulking surgery.

2022-RA-618-ESGO WHO RECEIVES MAINTENANCE THERAPY AFTER FIRST-LINE CHEMOTHERAPY? A REAL-WORLD ASSESSMENT OF PATIENTS WITH OVARIAN CANCER WHO RECEIVED NIRAPARIB FIRST-LINE MAINTENANCE THERAPY IN THE UNITED STATES

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Introduction/Background Niraparib, a poly(ADP-ribose) polymerase inhibitor (PARPi), was approved 29Apr2020 in the US for first-line maintenance (1LM) treatment of advanced epithelial ovarian cancer (EOC). To better understand how niraparib 1LM approval impacted who received niraparib in clinical practice, this study characterised real-world patients with EOC prescribed niraparib for 1LM before and after FDA approval using real-world data.

Methodology This retrospective cohort study used the nationwide Flatiron Health electronic health record-derived de-identified database and included patients diagnosed with EOC between 01Jan2011 and 30Nov2021, who were ≥18 years old at initial diagnosis and received first-line platinum-based treatment. The index date was defined as the initiation date of 1LM niraparib monotherapy, on or after 01Jan2017. Demographic and clinical characteristics of the study cohort were assessed from initial EOC diagnosis to index date. Patients were stratified by index date: before 29Apr2020 (niraparib preapproval cohort) or after 29Apr2020 (niraparib postapproval cohort).

Results A total of 374 patients initiated 1LM niraparib monotherapy. Most patients had stage III (50%) or IV (35%) disease and had *BRCA*wt (84%); 40% of patients had no visible residual disease (table 1). Demographic and clinical characteristics were mostly similar across the cohorts. However, the niraparib postapproval cohort (n=284) had fewer patients with stage IV disease (30% vs 49%) and more with *BRCA*wt (90% vs 63%) than the preapproval cohort (n=90). Furthermore, fewer patients in the niraparib postapproval cohort had unknown *BRCA* status (3% vs 16%), unknown HRD status (63% vs 84%), and no debulking surgery (13% vs 27%).