cells. A previous phase 1 study in Japan of MORAb-202 (NCT03386942) demonstrated antitumour activity across multiple tumour types and identified interstitial lung disease (ILD) as an adverse event of interest (Shimizu 2021). An expansion cohort (doses: 0.9, 1.2 mg/kg) in patients with platinum-resistant ovarian cancer (OC) found meaningful efficacy across all FRα-expression levels and ILD/pneumonitis (mainly low grade) was the most common adverse event (Nishio ASCO 2022).

Methodology This multicentre phase 1/2 study (NCT04300556) consists of Dose-Escalation and Dose-Confirmation cohorts. In the Dose-Escalation phase, the primary objectives were to evaluate safety/tolerability and determine the recommended phase 2 dose of MORAb-202 in patients with OC, endometrial cancer (EC), non-small cell lung cancer (NSCLC), or triple-negative breast cancer (TNBC). In the ongoing Dose-Confirmation phase, the primary objectives are (1) to further evaluate safety/tolerability and (2) to evaluate preliminary efficacy (ORR) in patients with OC or EC. Based on a population pharmacokinetics model (Hayato ASCO 2022), body-surface-area-based dosing is utilised. The initial cohort will enrol 6 patients at a MORAb-202 25 mg/m^2 IV Q3W dose and additional patients will be enrolled at 25 mg/m^2 and 33 mg/m^2 following ILD safety evaluation. Tumour assessments will be conducted by investigators using RECIST v1.1 at screening, every 6 weeks for 24 weeks, then every 12 weeks or as needed. Potential ILD assessments of CT scans will be conducted by a central ILD expert review board.

Results Trial in Progress

Conclusion TIP

2022-RA-1243-ESGO ANXIETY AND POST-TRAUMATIC STRESS DISORDER IN WOMEN REFERRED AFTER SYMPTOM TRIGGERED TESTING FOR OVARIAN CANCER – ANALYSIS FROM THE LARGE MULTICENTRE NATIONAL UK ROCKETS STUDY

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Introduction/Background International guidelines recommend symptom-triggered testing to detect ovarian cancer (OC). In the UK, symptomatic women are referred if they have an abnormal CA125 and/or ultrasound. Some women will experience adverse psychological responses to testing and be less motivated to attend further investigations. We analysed data from the ROCkeTS prospective test accuracy study to investigate psychological morbidity in diagnostic testing and identify women most at risk.

Methodology Participants completed a questionnaire at enrolment and, if not diagnosed with OC at 12 months. Anxiety and post-traumatic stress disorder (PTSD) were measured using the State-Trait Anxiety Inventory (STAI) and Revised Impact of Event Scale (IES-r). Their association with variables was explored using Wilcoxon Rank-Sum and Kruskal-Wallis tests. The effect on scores at 12 months was explored using the Wilcoxon signed-rank test.

Results Responses from 2574 women were analysed. Women experienced 'moderate' anxiety and 'severe' PTSD' at enrolment with median (IQR) STAI and IES scores of 43 (40–50) and 41 (29–62) respectively. Age, employment status, educational level, smoking history, route of presentation and a change in menstruation were associated with PTSD (table 1). None of the variables were associated with anxiety (table 1). Anxiety levels in those without an OC diagnosis increased to 'high' at 12 months (n=487), 47 (40–50) but this change was not statistically significant (p=0.197). IES-r scores decreased to 36 (27–55) at 12 months (n=492), which was statistically (p=0.033) and clinically significant resulting in a lowering of IES-r severity categorisation.

Abstract 2022-RA-1243-ESGO Table 1 Associations between patinet characteristics and STAI and IES-r scores at enrolement

Table 1. Associations between patient characteristics and STAI and IES-r scores at enrolment

	Number of responses	STAI score Median (interquartile range)	IES-r score Median (interquartile range)
Age			
- Under 50	932	43 (40-50)	44 (30-63)
- Over 50	1386	43 (40-50), p=0.823	40 (28-60), p=0.000
Marital status			
- Living alone	796	43 (40-50)	42 (29-60)
- Living together	1527	43 (40-50)	41 (29-63)
- Other	2	48 (43-53), p=0.710	39 (28-49), p=0.690
Employment status			
- Employed fulltime or part-time	1143	43 (40-50)	44 (30-63)
- Self employed	147	43 (40-50)	41 (28-59)
- Retired	697	43 (40-50)	36 (27-55)
- Unemployed	162	47 (40-50)	43 (29-72)
- Student	175	47 (40-50), p=0.079	42 (28-64), p=0.000
Educational level			
- No qualifications	467	47 (40-50)	38 (27-59)
- At least secondary level	1098	43 (40-50)	42 (29-63)
- At least tertiary level	564	43 (40-50)	44 (31-62)
- Other	189	43 (40-50), p=0.211	38 (26-59), p=0.001
Ethnicity			
- Non-White	185	47 (40-50)	42 (29-70)
- White	2139	43 (40-50), p=0.196	41 (29-61), p=0.266
Ever smoked			
- No	1289	43 (40-50)	41 (28-60)
- Yes	1033	43 (40-50), p=0.854	42 (30-63), p=0.027
Route of presentation			
- Accident and emergency	142	47 (40-50)	45 (30-65)
- Two week wait referrals	1575	43 (40-50)	43 (30-63)
- Cancer unit or other specialties	401	43 (40-50)	39 (27-59)
- Routine GP referral	211	43 (40-50), p=0.614	33 (26-53), p=0.000
Performance status			
- 0	2004	43 (40-50)	42 (29-62)
- 1	218	47 (40-50)	40 (29-60)
- 2	55	43 (40-50)	39 (29-62)
- 3	30	43 (40-50)	35 (28-48)
- 4	2	45 (40-50), p=0.636	42 (38-46), p=0.606
History of subfertility			
- No	830	43 (40-50)	45 (31-63)
- Yes	156	43 (40-50), p=0.553	47 (30-60), p=0.884
History of ovarian stimulation for subfertility			
- No	918	43 (40-50)	45 (31-63)
- Yes	65	47 (40-50), p=0.099	48 (32-62), p=0.841
Change in nature of periods			
- No	434	43 (40-50)	44 (29-61)
- Yes	551	43 (40-50), p=0.249	47 (32-64), p=0.015
Use of contraception			
- No	660	43 (40-50)	46 (31-64)
- Yes	321	43 (40-50), p=0.959	44 (30-61), p=0.301
Any postmenopausal bleeding			
- No	622	47 (40-50)	38 (28-60)
- Yes	187	43 (40-50), p=0.498	38 (28-60), p=0.885
Current of previous use of HRT			
- No	932	47 (40-50)	38 (28-59)
- Yes	380	43 (40-50), p=0.080	40 (29-61), p=0.167
Number of pregnancies			
- 0	97	43 (40-50)	43 (32-65)
- 1 to 4	1645	43 (40-50)	41 (29-61)
- 5 or more	61	47 (40-50), p=0.780	34 (24-66), p=0.147

Validated classification for STAI and IES-r:
STAI: 'no or low anxiety' (20-37), 'moderate anxiety' (38-44), and 'high anxiety' (45-80)
IES-r: 'PTSD is a clinical concern' (24 -32), 'probable PTSD' (33 - 36) and 'severe enough to suppress the immune system and effects may persist even 10 years following the event' (37 or more).

Conclusion To our knowledge, this is the first study investigating psychological morbidity after diagnostic testing for OC. Women experience significant anxiety and distress with certain

groups more predisposed to PTSD. Distress was highest in emergency admissions, reinforcing the need for earlier diagnosis through improved diagnostic pathways. Psychological support may improve patient experience, especially for younger, less educated unemployed women.

2022-RA-1255-ESGO CLINICOPATOLOGICAL FEATURES AND TREATMENT OUTCOMES OF OVARIAN CLEAR CELL CARCINOMA: THE PAN-BIRMINGHAM GYNAECOLOGICAL CANCER CENTRE EXPERIENCE

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Introduction/Background To evaluate clinico-pathological factors and oncological outcomes in ovarian clear cell carcinoma (OCCC)

Methodology Retrospective cohort study, spanning the period 2000–2022. One-hundred women with OCCC were enrolled. Clinico-pathological, and treatment data were analysed to identify plausible predictors. Survival analysis was performed via the Kaplan-Meier method, log-rank test and Cox-regression. The census day was 1st April 2022.

Results The median age at diagnosis was 59.6 years. The majority of women were diagnosed with stage I 55/100 (55%). Of these, 28/55 (50.9%) were stage IA, 16/55 (20.1%) stage IC on the basis of rupture-only, and 11/55 (20%) stage IC on the basis of surface involvement and/or positive cytology. 45/100 (45%) of women were stage III-IV. 51/100 (51%) of women had concomitant diagnosis of endometriosis. The median PFS and OS in women with stage I was 58.00 (95% CI 29.00 – 68.00) and 189.00 (95% CI 60.00 – 189.00) months, respectively. There was statistical difference in PFS/OS in women with stage IA and IC. In the subgroup analyses, women with stage IC on the basis of surface involvement and/or positive cytology demonstrated a statistically significant decrement in both PFS (HR=3.79, 95% CI 1.12 – 22.6) and OS (HR=5.32, 95% CI 1.25–26.2). The median PFS and OS in women with stage III-IV was 24.00 (95% CI 14.00 – 47.00) and 44.00 (95% CI 19.00 – 65.00) months, respectively. The presence of residual disease was found to be a prognosticator for survival, whilst adjuvant chemotherapy or presence of endometriosis were not significantly associated with poorer outcomes.

Conclusion OCCC usually presents in young women and at early-stage. Stage IA has an excellent prognosis compared to stage IC and III/IV. Surface involvement and/or positive cytology are seemingly independent prognosticators vis-à-vis endometriosis or adjuvant chemotherapy. Owing to high chemoresistance novel treatment paradigms are warranted.

2022-RA-1256-ESGO FIRST EXPERIENCES OF IMPLEMENTING 'ENHANCED RECOVERY AFTER SURGERY' (ERAS) AT TWO GERMAN ESGO CENTERS OF EXCELLENCE – KORE-INNOVATION: THE FIRST PROSPECTIVE CLINICAL TRIAL TO ASSESS A PERIOPERATIVE PATHWAY TO REDUCE POSTOPERATIVE COMPLICATIONS IN OVARIAN CANCER PATIENTS

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Introduction/Background The perioperative ERAS pathway has been established in many surgical fields and has shown to improved health care quality and costs. We report our first experiences implementing the ERAS pathway as part of the KORE INNOVATION trial in patients with ovarian cancer.

Methodology KORE INNOVATION is an ongoing clinical trial to assess the effects of an innovative perioperative care pathway to reduce complications for patients undergoing surgery for ovarian cancer by implementing a prehabilitation strategy combined with an ERAS pathway. The trial is conducted at two study sites in Germany, both ESGO centers of excellence for ovarian cancer surgery: Charité Universitätsmedizin Berlin and Evangelische Kliniken Essen Mitte. ERAS guidelines were adapted for the clinical settings, and multiple training sessions for all staff were conducted. An interdisciplinary 'KORE-team' consisting of physicians, nurses, nutritionists, and physiotherapists was established to aid implementation, monitor staff adherence, follow the patients throughout the entire care process, and function as interface managers. We report our first experiences with the staff's adherence to ERAS items at both study sites.

Results The following ERAS items showed good adherence: omission of bowel preparation, carboloading, disinfection using chlorhexidine, use of opioid-sparing anesthesia and epidurals, early postoperative mobilization, and feeding. In contrast, the following items showed decreased adherence: omission of preoperative sedatives, omission of drains, goal-oriented fluid management during the postoperative phase, and the omission of postoperative antibiotic treatment. Adherence increased through monitoring through daily rounds and active staff engagement administered by the KORE team.

Conclusion Continuous training and adherence monitoring are by multi professional and interdisciplinary KORE team are key factors for the successful implementation of the ERAS pathway.