

(5.9%), unilateral adnexectomy in 14 (41.1%) and unilateral adnexectomy with contralateral cystectomy in 3 (8.9%). Mean tumour size and CA125 at diagnosis was 8.72 cm and 21, respectively. Twelve patients (35.2%) relapsed with a mean follow-up time of 95 months, being earlier in case of unilateral cystectomy (median 30 months, IQR 29) and bilateral cystectomy (18 months, IQR 0), compared to unilateral adnexectomy (median 78 months, IQR 64). Up to 41% relapses occurred after 45 months. Surgical factors related to laparoscopy and risk of recurrence were studied without finding significant differences.

Abstract 2022-RA-1715-ESGO Table 1 Univariate analysis of the risk of recurrence after the first surgery

Factor	Category	Odds Ratio (IC 95%)	P value
Histology	Serous	4 (0.6744003 23.72478)	0.10
	Mucinous		
FIGO Stage 2014	IA-IB	0.54 (.1192275 2.311757)	0.394
	IC-III		
Laterality	Bilateral	1.21 (.1751372 8.389066)	0.845
	Unilateral		
Type of surgery	Cystectomy	1.51 (.3865568 5.950685)	0.550
	Adnexectomy		
Capsular rupture	Yes	1.1 (.2602337 4.649666)	0.897
	No		
Endobag use	Yes	1.06 (.2736021 4.1802)	0.923
	No		

Conclusion Laparoscopic FSS for BOTs is a safe treatment in patients with reproductive desire without impacting on overall survival. A long-term follow-up is essential to detect late recurrences.

2022-RA-1725-ESGO

PAZOPANIB WITH TOPOTECAN WEEKLY FOR PATIENTS WITH PLATINUM-RESISTANT OR INTERMEDIATE-SENSITIVE RECURRENT OVARIAN CANCER- RESULTS OF A MULTICENTRE NOGGO PHASE I AND II STUDY (TOPAZ)

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Introduction/Background Patients with recurrent ovarian cancer (ROC) have a particularly poor prognosis. So far recurrent treatment are mostly restricted by previous toxicity and of limited activity. The role of adding modern multi-targeted tyrosine kinase inhibitors (TKIs) for targeting angiogenesis

could be a promising therapeutic strategy. The investigator-initiated multicentre TOPAZ trial aimed to evaluate the safety and efficacy of the combination of Topotecan with Pazopanib.

Methodology Patients with platinum-resistant ROC with no more than two prior lines of chemotherapy were enrolled. The chemotherapy backbone was based on weekly Topotecan (4 mg/m², d1,8,15 q28d). In phase I, pazopanib was added orally 400 mg/d in a dose-escalating regime to determine the maximum tolerated dose (MTD). The aim of phase II was to evaluate the safety and efficacy of pazopanib in the optimal MTD together with weekly Topotecan based on progression-free survival.

Results From June 2012 to February 2017, 11 patients were enrolled in phase I and 50 patients in phase II. The MTD of pazopanib was set at 400 mg/d. In phase I, the most common adverse event was haematological toxicity. In phase II, the median progression-free survival was 3,5 months (95% CI:2.0–5.0 months), with haematological toxicity being the most common reason for dose change and treatment delays. The combination of Topotecan and Pazopanib is shown to be feasible in terms of safety profile. It offers no clinical advantage in progression-free or overall survival compared to Topotecan monotherapy.

Conclusion Adding pazopanib to topotecan is safe and feasible, but does not seem to have any clinical benefit. We will not pursue this combination. Further studies are needed that pursue the approach of novel combination therapies with chemotherapy and anti-angiogenesis inhibitors. In addition, the promising therapeutic options with PARP and immune checkpoint inhibitors should also be considered.

Palliative care

2022-RA-747-ESGO

QUALITY OF END-OF-LIFE CARE AND PATTERNS OF PALLIATIVE CARE USE BY WOMEN WITH GYNAECOLOGIC MALIGNANCIES IN ONTARIO, CANADA: A 13-YEAR POPULATION-BASED RETROSPECTIVE ANALYSIS

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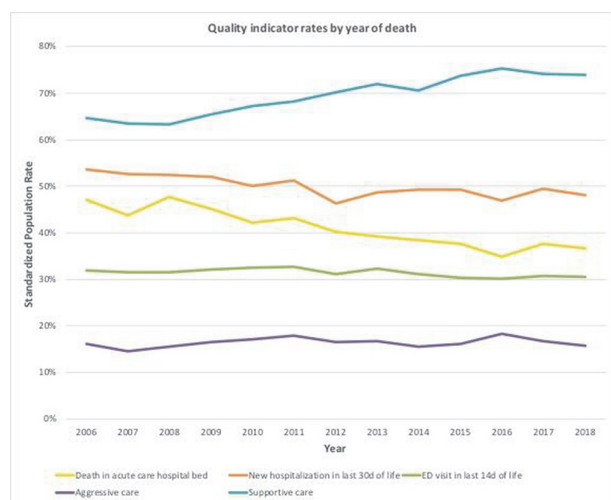
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Introduction/Background A large body of research has validated several quality indicators of end-of-life (EOL) cancer care, but few have examined these in gynecologic cancer. Early palliative care (PC) is associated with improved patient quality of life, less aggressive EOL care, and prolonged survival. We examined provincial palliative and EOL care patterns.

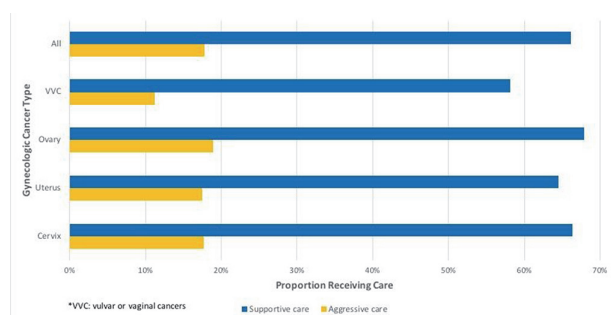
Methodology This population-based, retrospective cohort study of gynecologic cancer decedents in Ontario from 2006–2018 used linked administrative health care databases. Quality indices included: emergency department (ED) use, hospital or

intensive care unit (ICU) admissions, chemotherapy ≤ 14 d of death, PC home visits, and death in hospital. Multivariable logistic regression examined factors associated with aggressive and supportive care.

Results There were 16,237 included decedents. Hospital death rates decreased from 47% to 37%, supportive care use rose from 65% to 74%, and aggressive care remained stable (16%). Within 30d of death, 50% were hospitalized, 5% admitted to ICU, and 67% accessed palliative homecare. Within 14d of death, 31% visited the ED and 4% received chemotherapy. Vulvovaginal cancer patients accessed the least resources. Factors associated with aggressive EOL care included younger age, shorter survival, lower income, and rurality. Palliative care was accessed by 93.4% of decedents a median 127d before death, with first contact as outpatients for 68.8% and institutionally for 31.2%. Those accessing PC used median 8 institutional days and 41 community days. While use of community PC gradually increased toward end-of-life, use of institutional PC exponentially increased from 12 weeks until death.



Abstract 2022-RA-747-ESGO Figure 1 Rates of supportive and aggressive end-of-life care received by patients with gynaecologic cancers in Ontario Canada from 2005–2018



Abstract 2022-RA-747-ESGO Figure 2

Conclusion Over time, fewer women dying with gynecologic cancers in Ontario experienced death in hospital, and more

accessed supportive care. However, most were hospitalized and a significant proportion received aggressive care. While >90% of gynecologic cancer decedents accessed PC, median initiation was within the last 4 months of life (late PC), which may result in suboptimal care quality.

2022-RA-854-ESGO

GIVING PROGNOSTIC INFORMATION BY USING SCENARIOS – ATTITUDES OF WOMEN WITH GYNECOLOGICAL CANCER

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Introduction/Background Providing prognostic information is considered challenging, and as a consequence, such information is often not discussed. Communication of 3 scenarios to explain survival times has been shown to provide an accurate view of prognosis that leaves room for realistic hope. However, little is known about the preferences for prognostic information among women with gynecological cancer.

Methodology This cross-sectional survey recruited women with gynecological cancers at 5 sites in Norway. The survey described 2 formats for explaining life expectancy to a hypothetical patient with advanced cancer—providing either 3 scenarios for survival (best case, worst case, and typical scenario) or just the median survival time.

Results A total of 252 women were recruited. 122 (48%) were on current anti-cancer treatment. Participants had primary cancer of the ovaries 110 (44%), corpus 61 (24%), and cervix 52 (21%). Only 35% of responders recalled to have received prognostic information, and out of those that did not, 51% would have liked to receive such information. More participants agreed that explaining 3 scenarios (vs. median survival) would make sense (81% vs. 74%), help to plan for the future (71% vs. 65%), and convey hope (58% vs. 38%), while fewer respondents agreed that explaining 3 scenarios (vs. median survival) would upset people (29% vs. 39%). Even if the presentation of the worst-case scenario was upsetting (51%), the vast majority felt that it improved their understanding of survival times (72%). 41% would prefer both the median and 3 scenarios to be discussed when prognostic information is given.

Conclusion Only a third of women recalled to have received prognostic information. We recommend the 3 scenarios to be included when giving prognostic information, but it seems important to make sure the patient wishes to receive such information.