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394 CA125 NORMALIZATION FOLLOWING NEOADJUVANT CHEMOTHERAPY COMPLEMENTING THE CHEMOTHERAPY RESPONSE SYSTEM IN THE PROGNOSTICATION OF PATIENTS WITH HIGH-GRADE SEROUS OVARIAN CARCINOMA

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Objective To investigate whether CA125 normalization following neoadjuvant chemotherapy (NACT) can complement the chemotherapy response system (CRS) in the prognostication of patients with tubo-ovarian high-grade serous carcinoma (HGSC).

Methods In total, 106 HGSC patients who received NACT followed by interval debulking surgery (IDS) for FIGO stage IIIC-IV disease were included, and their clinical data were retrospectively reviewed. The primary endpoint was progression-free survival (PFS). Cox regression analysis was performed to identify predictors of PFS.

Results Following NACT, CRS3 was noted in 24 patients (22.6%), and CA125 normalization (≤ 35 U/ml) was noted in 54 patients (50.9%). Both CRS3 and CA125 normalization were identified as independent prognosticators of PFS. Combining these two factors, we stratified the 106 patients into three groups with different risks of recurrence: low-risk group (CRS3 + post-NACT CA125 ≤ 35 U/ml; $n = 17$, 16.0%), intermediate-risk group (CRS3 + post-NACT CA125 > 35 U/ml; $n = 7$, 6.6%) and high-risk group (CRS1-2; $n = 82$, 77.4%). The differences in PFS between the three groups were significant (log-rank test, $P < 0.0001$). In Cox regression analyses, the new stratification method was found to have an independent prognostic effect.

Conclusion Both the CRS system and the normalization of CA125 following NACT could reliably predict the risk of recurrence following primary treatment. The combination of the two factors refined the prognostic stratification of HGSC patients who were treated with NACT and IDS.

IGCS20_1425

395 POST-CONE RESIDUAL DISEASE IN MICROINVASIVE CERVICAL CANCER: IMPORTANCE OF SURGICAL MARGIN

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Introduction Microinvasive diseases of the cervix are conventionally treated with radical hysterectomy after confirmation of invasion depth and lymphovascular invasion in excisional biopsy. In some cases conization could be the definitive treatment in patients who wish to preserve fertility, it is essential to know the state of the section margins. The objective of this presentation is to demonstrate the risk of residual disease with cone positive margins.

Methods Retrospective review of patients with microinvasive cervical cancer between December 2014 and February 2020.

The contact of the lesion directly with the edge of the cone was taken as positive margin, we compared results of cone biopsies and hysterectomies.

Results The study included 47 patients (median age 42.9). Diagnoses of microinvasive cervical cancer: insitu adenocarcinoma, (FIGO IA1 and IA2), histological: adenocarcinoma and squamous. 42 patients met the inclusion criteria (cone biopsy and hysterectomy). 30 (71%) with squamous cancer and 12 (29%) with adenocarcinoma.

In 30 patients with squamous types, 14 cones had a positive margins, from which 10 (71%) surgical specimens resulted with residual disease, and 16 cones with negative margins, from which 1 (6.25%) specimen resulted with residual disease. In 12 patients with adenocarcinoma, there were 8 cones with positive margins, 6 (75%) surgical pieces were found with residual disease; 4 cones with negative margins, 3 (75%) surgical pieces were found with residual disease.

Conclusions Patients with positive margins regardless of histologic type are at increased risk for residual disease and is clearly more risky in adenocarcinomas due to multifocality.

IGCS20_1426

396 PREDICTIVE FACTORS OF SURVIVAL AND RECURRENCE IN PATIENTS WITH EPITHELIAL OVARIAN CANCER AFTER COMPLETE CYTOREDUCTIVE SURGERY: SERIES OF 185 PATIENTS

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Objectives to determine predictive factors of better survival and delayed recurrence in patients operated on for epithelial ovarian cancer.

Abstract 396 Table 1

	Survival rate (%)	P value
Age		
< 50 years	77.6%	p = 0.006
> 50 years	61.1%	
Lymph node status		
negative	80.3%	p = 0.000
positive	56.7%	
Lymph node ratio		
< 0.18	78.2%	p = 0.000
> 0.18	55.6%	
Stage of the disease		
Early (I-II)	90%	p = 0.000
Advanced (III-IV)	57%	
Type of surgery		
Primary surgery	79%	p = 0.001
Interval surgery	52%	
Bowel resection		
yes	57.6%	p = 0.000
no	73.7%	
Number of positive Lymph nodes		
1 positive lymph node	75.8%	p = 0.000
> 1 positive lymph node	55.1%	

Methods we reviewed retrospectively all the data of 184 patients receiving complete cytoreductive surgery, whether as primary or interval debulking between January 2005 and October 2019 at Hôtel-Dieu de France University Hospital.

Results Median age at surgery was 56 years. 41,8% benefited from a primary cytoreductive surgery while 42,9% of patients received their surgery after a neoadjuvant chemotherapy. 74% of patients were in stage III. High-grade serous epithelial ovarian cancer was the most encountered histology (69%). Bowel resection and upper abdominal surgery was needed in 46% and 39,1% of cases, respectively. Survival rate was 66% (122 out of 184 patients). No recurrence was noted in 53,8% of cases and 74,7% of recurrences occurred after 12 months. According to cox regression test, better survival was significantly correlated to younger age (< 50 years), negative lymph node status, lymph node ratio (< 0,18), early stage, primary surgery, no bowel resection, no more than one positive lymph node ($p=0.006$, $p=0.000$, $p=0.000$, $p=0.000$, $p=0.001$, $p=0.000$, $p=0.000$, respectively). Early recurrence was correlated to advanced stage ($p=0.000$), positive lymph node status ($p=0.002$), bowel resection ($p=0.046$), interval surgery ($p=0.025$). In the multivariate analysis, survival was only correlated to lymph node status, lymph node ratio, stage, absence of bowel resection and number of positive lymph nodes.

Conclusion Negative lymph node status, LNR <0.18, early stage, absence of bowel resection and the presence of only one positive LN predict a better survival.

IGCS20_1428

398 IMPACT OF A LAPAROSCOPIC TRIAGE PROGRAM FOR ADVANCED OVARIAN CANCER ON SURGICAL OUTCOMES, DISEASE-FREE SURVIVAL, AND OVERALL SURVIVAL

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Introduction This study evaluates whether implementing a laparoscopic triage algorithm (LSC) to grade initial disease burden impacts surgical outcomes, disease-free survival (DFS), and overall survival (OS) in advanced ovarian cancer (OC).

Methods In 2013, LSC was implemented for advanced high-grade serous OC. LSC scores volume and distribution of intra-abdominal disease in order to disposition patients to either primary cytoreductive surgery (PDS) or neoadjuvant chemotherapy (NACT) followed by interval cytoreduction. Outcomes for patients offered management with LSC (post-LSC) were compared to a cohort from 2010–2012 who would have qualified for laparoscopy (pre-LSC). Summary statistics were used to describe surgical outcomes, and DFS and OS were estimated using the Kaplan-Meier method.

Results Between 2013–2016, 201 OC patients were offered LSC; 182 underwent laparoscopy. We identified 161 pre-LSC control patients for comparison. There were no differences in clinicodemographic features between both cohorts.

Prior to implementing LSC, 64 (40%) patients underwent PDS compared to 88 (44%) post-LSC ($p=0.42$). Complete cytoreduction (R0) was achieved more frequently in the post-LSC cohort (81 vs 51%, $p<0.001$). There were no differences in median DFS or OS between pre- and post-LSC cohorts (DFS 17 vs 16 months, $p=0.76$; OS 45 vs 48 months, $p=0.38$). However, within the PDS group, a significantly greater median OS was observed in post-LSC compared to pre-LSC cohort (not reached vs 51 months, $p<0.013$).

Conclusion Our data suggest that LSC allows for a greater R0 resection rate and, for patients triaged to PDS, is associated with improved median OS.

IGCS20_1429

399 SURGICAL MORBIDITY OF THE RETROPERITONEAL STAGING IN PATIENTS UNDERGOING SURGERY FOR EARLY STAGE EPITHELIAL OVARIAN CANCER

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Introduction Surgery is the cornerstone of the apparent early stage ovarian cancer (aEOC) treatment. For the purpose of this study we evaluated perioperative outcomes and 30-days surgical morbidity of the retroperitoneal staging in patients undergoing surgery for aEOC.

Methods This is a retrospective single-center observational study conducted at Del Ponte Hospital of Varese (Italy) between January 2000 and December 2019. We included consecutive patients who underwent surgery for aEOC over the study period. Women who had a fertility-sparing approach were excluded. The cases were stratified into two groups: lymph node dissection performed (LND) and not-performed

Abstract 399 Table 1

Baseline population characteristics			
	RETROPERITONEAL STAGING n=71 (65.45%)	NO RETROPERITONEAL STAGING n=38 (34.86%)	p-value
Age	54.9 (49 - 63)	55.5 (45 - 68)	0.81
Menopause	48 (67.6%)	22 (57.9%)	0.31
Parity	1 (0 - 3)	2 (0 - 5)	0.22
Previous open surgery	23 (32.4%)	16 (42.1%)	0.31
Previous laparoscopy	25 (35.2%)	5 (13.2%)	0.01
Surgical outcomes			
	RETROPERITONEAL STAGING n=71 (65.45%)	NO RETROPERITONEAL STAGING n=38 (34.86%)	p-value
Operative time (min)	325 (240 - 390)	135 (70 - 200.5)	< 0.001
Blood loss (ml)	300 (137.5 - 500)	100 (50 - 325)	0.72
Intra-operative transfusion	7 (9.9%)	1 (2.6%)	0.18
In-hospital transfusion	5 (7.7%)*	1 (2.9%)*	0.33
Intra-operative complications	4 (5.6%)	1 (2.6%)	0.48
In-hospital complications	6 (8.8%)*	3 (7.9%)	0.90
Post-discharge complications	12 (16.9%)	3 (7.9%)	0.19
Non-surgical complications	3 (4.2%)	4 (10.5%)	0.20

*missing data: 6 patients **missing data: 3 patients