cisplatin-resistant phenotype of A2780 cell line (BCARE A2780 3.3% versus 39% in A2780-cisplatin-resistant cells). The assay currently tests ex vivo patient derived cultures using a retrospective cohort of ovarian cancer patients. Correlations between BCARE scores and patient response to treatment will be investigated.

Conclusions Our BCARE-Score is capable of identifying dynamic alterations in HR-pathways as indicated by the differences observed in A2780 and cisplatin-resistant subline, which is not assessed by the current clinically applied HR assays. BCARE shows clear potential to be an effective tool in the prediction of primary drug response and more importantly in the detection of developed drug resistance.

EPV198/#424 LAPAROSCOPIC RESTAGING SURGERY FOR GYNAECOLOGICAL MALIGNANCIES

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Objectives To evaluate the feasibility and safety of laparoscopically staging patients with previous incomplete staged gynaecological cancers

Methods Patients without presurgical evidence of metastatic disease were laparoscopically reassessed. The procedure involved para-aortic and pelvic lymph node dissection and omentectomy for ovarian, fallopian tube and endometrial carcinoma; exclusive pelvic lymph node dissection for cervical carcinoma, oophorectomy and omentectomy for borderline tumors. Medical records were reviewed.

Results We performed 51 laparoscopic restaging surgeries: 14 ovarian cancer, 15 endometrial cancer, 17 borderline ovarian tumors, 4 cervical cancers and one fallopian tube carcinoma. Mean age was 48 years (16–70). In 39 patients the first surgery was performed by laparotomy. The mean body mass index was 28 (20–40). Operative room time was 203 min (70–390) and mean postoperative hospital stay was 2 days. We performed 32 pelvic lymphadenectomies (average 15 lymph nodes), 30 para-aortic lymphadenectomies (8 lymph nodes), 27 omentectomies and 17 hysterectomies. Average estimated blood lost was 85 cc. There was one laparo-conversion for adhesions, one bowel injury, one cardiorespiratory arrest at recovery room and 2 lymphatics cystics. Lymph nodes and omentum were negative for metastasis. There were no patients up staged, in 9 endometrial and 9 ovarian cancers the complete negative restaging allowed us to decide that adjuvant therapy was not necessary. Five patients received adjuvant radiotherapy and 5 chemotherapy

Conclusions Laparoscopy is a feasibility technical option to perform restaging of gynaecological malignancies. Decreasing hospital stay, postoperative pain, few blood lost and low morbidity. Laparotomy for adhesions and risk of visceral injury may be anticipated.

EPV199/#430 CLINICAL AND SURVIVAL OUTCOMES OF MALIGNANT NON-DYSGERMINOMATOUS GERM CELL TUMOR OF OVARY: A SINGLE INSTITUTIONAL EXPERIENCE OF 64 PATIENTS

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Objectives To evaluate clinicopathological features and survival outcomes of malignant non-dysgerminomatous germ cell tumor (MNDGCT) of the ovary.

Methods We retrospectively recorded clinicopathological and therapeutic data of 64 patients with MNDGCT of ovary treated at the Salah Azaiez Institute of Tunisia between 1970 and 2012.

Results The median age was 26 years (range7–75 years).The most frequent subtype was immature teratoma (n=27, 42.18%) followed by yolk-sac tumor (n=15, 23.43%) and mixed germ cell tumor (n=11, 17.18%).Most of the patients had stage I and II disease (41 cases, 64.1%) while 17 (26.6%) and 6 (9.3%) were staged III and IV disease, respectively. Radical surgery was performed in 23 patients (35.8%) and conservative surgery in 41 patients(64.2%) associated with lymph node dissection in 19 cases. Complete macroscopic resection was obtained in 48 patients (78.68%) and lymph node metastasis was observed in 41.5% of cases. Adjuvant chemotherapy was indicated in cases in 54.68% of cases. After a mean time follow-up of 74 months (7–182 months), complete remission was observed in 47 patients. The 5-year progression-free survival (PFS) was 73.5%.The 5 year overall survival (OS) was 82.23% and was significantly decreased in young patients ≤15 years (49.5% vs 89.4%;p=0.003), advanced stage (94.6% in stage I-II vs 59.8% in stage III-IV; p=0.01) and macroscopic residual disease (88.9% vs 52.9%; p=0.02).No difference in OS was noted following stratification by tumor size ≤or>20cm (84.7% vs 74.6;p=0.44) and conservative or radical surgery (89.8% vs 70%;p=0.34)

Conclusions Macroscopic residual disease as well as advanced FIGO stage and age are the main prognostic factors in MNDGCT.

EPV200/#432 CLINICAL AND SURVIVAL OUTCOMES OF PURE DYSGERMINOMA OF OVARY: A SINGLE INSTITUTIONAL EXPERIENCE OF 31 PATIENTS

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