Introduction/Background Ovarian cancer (OC) represents the most lethal gynaecological malignancy, with approximately 80% of advanced OC patients experiencing a recurrence after primary treatment. The role of radiotherapy in recurrent OC has been recently explored. The aim of this study was to assess the efficacy of advanced radiotherapy at the time of the 1st platinum-sensitive oligometastatic recurrence.

Methodology Patients with epithelial OC undergoing primary treatment at the European Institute of Oncology, Milan, from January 2010 to April 2019 were retrospectively identified. Among those, patients treated with stereotactic or intensity-modulated radiotherapy (IMRT) alone at the time of 1st platinum-sensitive oligometastatic recurrence were included. Patients with encephalic or vertebral recurrence were excluded. Response rate (based on RECIST 1.1 criteria), predictor of treatment response, and survival outcome were evaluated with appropriate statistical analysis.

Abstract 2022-RA-1028-ESGO Table 1

Table.

	Total N=31	Complete or partial response N=25 (80.6%)	Progression disease N=6 (19.4%)	p-value
Age, median, years, median (range)	56 (34-75)	56 (34-75)	51.5 (42-67)	0.32
ECOG score				1.0
0	24 (77.4%)	20 (80%)	5 (83.3%)	
1	7 (22.6%)	5 (20%)	1 (16.7%)	
Histology, n (%)				1.0
High grade serous	28 (90.3%)	22 (88%)	6 (100%)	
High grade endometrioid	3 (9.7%)	3 (12%)	/	
FIGO stage at diagnosis, n (%)				0.56
I	1 (3.2%)	1 (4%)	/	
II	4 (12.9%)	3 (12%)	1 (16.7%)	
III	21 (67.7%)	17 (68%)	4 (66.6%)	
IV	5 (16.2%)	4 (16%)	1 (16.7%)	
BRCA status, n (%)				1.0
BRCA wild-type	12 (38.7%)	10 (40%)	2 (33.3%)	
BRCA 1/2 mutated	10 (32.3%)	9 (36%)	1 (16.7%)	
BRCA test not performed	9 (29%)	6 (24%)	3 (50%)	
Vital status, n (%)				0.44
Alive with disease	13 (41.9%)	10 (40%)	3 (50%)	
Died of other causes	1 (3.2%)	1 (4%)	/	
Died of disease	5 (16.2%)	3 (12%)	2 (33.3%)	
Alive with no evidence of disease	12(38.7%)	11 (44%)	1 (16.6%)	
Type of primary treatment, n (%)				0.29
Primary debulking surgery	23 (74.2%)	17 (68%)	6 (100%)	
Interval debulking surgery	8 (25.8%)	8 (32%)	/	
Residual tumour after 1st surgery, n (%)				0.31
No	25 (80.6%)	19 (76%)	6 (100%)	
Yes	6 (19.4%)	6 (24%)	/	
>1 cm	2 (6.4%)	2 (8%)	/	
1-5 mm	4 (12.9%)	4 (16%)	/	
Platinum-based CT, n (%)				
Yes	31 (100%)	/	/	
No	0 (0%)	/	/	
Maintenance with Bevacizumab, n (%)				
Yes	10 (32.3%)	7 (28%)	3 (50%)	0.36
No	21 (67.7%)	18 (72%)	3 (50%)	
Maintenance with PARP inhibitors, n (%)				
Yes	0 (0%)	/	/	
No	31 (100%)	/	/	
Platinum-free interval before RT, months, median (range)	21 (6-37)	23 (8-37)	11 (6-28)	0.06
CA125 at 1st recurrence, (KU/L), median (range)	26 (5.9-500)	23 (5.9-500)	35 (5.9-55.2)	0.5
ECOG score at recurrence, n (%)				1.0
0	30 (97.8%)	24 (96%)	6 (100%)	
1	1 (3.2%)	1 (4%)	/	
AGO score, n (%)				0.29
Negative	7 (22.6%)	7 (28%)	/	
Positive	24 (77.4%)	18 (72%)	6 (100%)	
Site of recurrence, n (%)				1.0
Abdominal lymph nodes	22	18	4	
Abdominal peritoneum	5	5	/	
Extra-abdominal lymph nodes	10	7	3	
Type of RT, n (%)				1.0
Stereotactic body radiation therapy (SBRT)	29 (93.5%)	23 (92%)	6 (100%)	
Intensity-modulated radiation therapy (IMRT)	2 (6.5%)	2 (8%)	/	
N. of lesions treated with RT, n (%)				0.67
1	15 (55.6)	12 (52.2)	3 (75)	
2	11 (40.7)	10 (43.5)	1 (25)	
3	1 (3.7)	1 (4.3)	0 (0)	
Missing	4	2	2	
Interval between RT and recurrence requiring CT, months, median (range)	16 (4-126)	18 (4-126)	4.5 (4-8)	0.0007
Interval between RT and recurrence requiring CT (binary), n (%)				
≥ 6 months	24 (77.4)	/	/	
<6 months	7 (22.6)	/	/	
Interval between RT and recurrence requiring CT (binary), n (%)				
≥ 12 months	18 (58.1)	/	/	
<12 months	13 (41.9)	/	/	

Abbreviations: ECOG, Eastern Cooperative Oncology Group; FIGO, International Federation of Gynecology and Obstetrics; n, number; CT, chemotherapy; PARP, Poly ADP Ribose Polymerase; RT, radiotherapy.
AGO score, Arbeitsgemeinschaft Gynäkologische Onkologie. A positive AGO score assumes surgical resectability with the presence of 3 factors: good performance status (ECOG 0), complete resection at 1st surgery and ascites ≤500 mL.

Results In total, 31 patients meeting inclusion criteria were included. Of them, 18(58,1%) had a complete response, 7 (22,6%) a partial response, and 6 (19.3%) a progressive disease [1(3.2%) both in-field and out-of-field, 5(16.1%) out-of-field]. Among them, 30(96.8%) had a subsequent relapse, of which 22(73.3%) were treated with chemotherapy while the remaining 8(26.7%) underwent further radiotherapy or thermoablation. The median interval between radiotherapy and the subsequent recurrence requiring chemotherapy was 16 months (range 4–126), with 18(58.1%) patients having a subsequent recurrence requiring chemotherapy after 12 months or more. Upon univariate analysis, median platinum-free interval before radiotherapy in patients with complete/partial response was longer than in patients with progressive disease (23 vs. 11 months, p=0.06), although the association did not meet the conventional level of statistical significance.

Conclusion In our experience, radiotherapy alone represents a valuable option in the treatment of 1st oligometastatic platinum-sensitive recurrent epithelial OC, providing a good response rate and allowing to extend the platinum-free interval. Further studies are required to confirm our results and identify predictors of treatment response.

2022-RA-1029-ESGO COMPARISON OF O-RADS AND IOTA ADNEX MODEL CRITERIA WITH PATHOLOGY RESULTS IN ADNEXIAL MASSES

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Introduction/Background International Ovarian Tumor Analysis-Adnex Model (IOTA Adnex Model) and Ovarian-Adnexal Reporting and Data System (O-RADS) have been developed for the diagnostic accuracy of adnexal masses in the preoperative period. This study aimed to evaluate O-RADS and IOTA Adnex Model scores of patients who had surgery for an adnexal mass and and interpret the roles of scores in management.

Methodology The study consists patients who had surgery for an adnexal mass in Ankara City Hospital Gynecology and Obstetrics Hospital between 2019–2021 and met the inclusion criterias. Demographic characteristics, ages, parities, menopause statuses, ultrasonographic morphologies of the patients were recorded. IOTA Adnex Model and O-RADS scores calculated based on these data.

Results This study consisted of 413 patients whom 295 benign and 118 malign patients. Mean of CA 125 of the benign patients were 15,2 (2- 3096) unit/ml and mean of CA 125 of the malign patients were 72,5 (5 – 9820) unit/ml. According to the ROC analysis for CA 125 in postmenopausel patients; AUC:0,847 (%95 CI, 0,79–0,9), cut-off: 34,8 unit/ml, sensitivity:%70,8 and specificity:%83,8. In the premenopausal group; AUC: 0,727 (%95 CI, 0,65–0,80), cut-off:180,5 unit/ml, sensitivity:%32,1 and specificity:%92,7 (p<0,001). Sensitivity and specificity of the IOTA Adnex Model and O-RADS were found%78,8-%48,3 and%97,9–93,5 respectively for the distinction of the malignancy (p<0,001). There is moderate agreement between IOTA Adnex Model and O-RADS(κ = 0,53).

Conclusion IOTA Adnex Model shows similar specificity but better sensitivity than O-RADS for the distinction of the malignancy. In case of increasing sensitivity without decreasing specificity and clarifing the ultrasonographic features for the physicians who will apply the model, IOTA Adnex Model can be used widely as a ultrasonography-based risk stratification model in adnexal masses.