



Abstract 69 Figure 1 Overall survival Curve

of optimal cytoreduction (<1 cm largest residual disease) were comparable between groups (79.6% vs 84.1%,  $p=0.48$ ). The median OS for the whole cohort was 5.9 years. Using Time-varying Cox model, the use of bevacizumab did not improve OS (HR 0.46, 95% CI 0.17–1.25,  $p=0.13$ ).

**Conclusions** In our center, the addition of bevacizumab to standard chemotherapy in patients with advanced stage ovarian carcinoma had no impact on OS.

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### IMPACT OF TIMING OF CYTOREDUCTIVE SURGERY(CRS) ON EPITHELIAL OVARIAN CANCER(EOC), PRIMARY PERITONEAL CARCINOMATOSIS(PPC), AND FALLOPIAN TUBE CANCER(FTC) AT AMERICAN UNIVERSITY OF BEIRUT MEDICAL CENTER(AUBMC)

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**Objectives** To study the impact of timing of CRS whether done at diagnosis or following neoadjuvant chemotherapy (NACT) on progression free(PFS) and overall survival(OS) of patients with advanced EOC between 1997–2017 at AUBMC. Patients underwent either primary debulking (PDS) or received NACT followed by interval debulking surgery (IDS) in cases with extensive disease, multiple comorbidities, or poor performance status.

**Methods** A retrospective review of the impact of PDS versus NACT followed by IDS on PFS and OS.

**Results** Of 273 patients with EOC, PPC and FTC, 220 were found to have advanced epithelial cancer (stage IIIB, IIIC and IV). 63% had interval debulking surgery (IDS) while 37% had primary debulking (PDS). Results are shown in table 1. In stage IIIC, the PFS of patients who underwent PDS was significantly higher than patients undergoing IDS (table 1,  $Pvalue=0.003$ ). In Stage IV, the PFS was not significantly affected by the timing of surgery (table 1,  $Pvalue=0.274$ ). The OS was not affected by the timing of CRS in all stages.

**Conclusions** Timing of the CRS (PDS vs. IDS) significantly impacts PFS but not OS in stage IIIC but not IV EOC. This

Abstract 70 Table 1 Effect of timing on the PFS and OS in stages IIIC and IV

Stage	Timing	N	Median PFS (months)	P-value	N	Median OS (months)	P-value
IIIC	Primary	57	24.0	0.003	57	46.0	0.838
	Interval	100	20.0		100	48.0	
	overall	157	22.0		157	47.0	
IV	Primary	33	14.0	0.274	33	28.0	0.052
	Interval	14	17.0		14	22.0	
	overall	47	15		47	26.0	

difference in survival is explained by the higher tumor burden, higher morbidity, and worse performance status of patients who underwent IDS.

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### THE ONCOLOGICAL SAFETY OF HYSTEROSCOPY IN THE DIAGNOSIS OF EARLY-STAGE ENDOMETRIAL CANCER: AN ISRAEL GYNECOLOGIC ONCOLOGY GROUP STUDY

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**Objectives** To compare survival measures of women with early-stage endometrial cancer who underwent either hysteroscopy or a non-hysteroscopic procedure as a diagnostic procedure.

**Methods** An Israel Gynecologic Oncology Group multicenter study of 1324 patients with stage I endometrial cancer who underwent surgery between 2002 and 2014. Patients were divided into two groups: hysteroscopy and non-hysteroscopy (curettag or office endometrial biopsy). Clinical, pathological, and survival measures were compared between the groups.

**Results** There were 355 patients in the hysteroscopy group and 969 patients in the non-hysteroscopy group. The median follow-up was 52 months (range 12–120 months). There were no differences between the groups in the 5-year recurrence-free survival (90.2% vs. 88.2%;  $p=0.53$ ), disease-specific survival (93.4% vs. 91.7%;  $p=0.5$ ), and overall survival (86.2% vs. 80.6%;  $p=0.22$ ).