

mass and prognosis of elderly epithelial ovarian cancer patients has not been clarified. This study aimed to evaluate association between iliopsoas muscle mass and prognosis of elderly ovarian cancer patients in the Japanese population.

**Method** Medical charts of 110 epithelial ovarian cancers aged 60 years and older at our hospitals between 2013 and 2014 were retrospectively reviewed. Muscle areas of bilateral psoas major muscles at the third lumbar vertebra were measured using images obtained by computed tomography tested before treatment. Psoas muscle index (PMI) was calculated as the psoas muscle area divided by the height squared. Cox-regression Hazard Models were applied.

**Results** Median follow-up period was 40 months, average age was 67.8 years, and median PMI was 313 mm<sup>2</sup>/m<sup>2</sup> (range 137–572). 44 patients (40.0%) with less than 300 mm<sup>2</sup>/m<sup>2</sup> PMI were found to be statistically significant poor prognosis in multivariate analysis (Hazard Ratio: 2.896, 95% Confidence Interval: 1.1510–7.287, P value: 0.024).

**Conclusions** Low PMI was a statistically significant poor prognostic factor in Japanese elderly patients with epithelial ovarian cancer. It suggests that low PMI can be a biomarker that predicts poor prognosis in elderly patients with epithelial ovarian cancer.

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### DOUBLE ARM STUDY OF PERFORMING BOWEL ANASTOMOSIS AFTER OR BEFORE HIPEC IN PATIENTS UNDERGOING CRS+ HIPEC FOR ADVANCED EPITHELIAL OVARIAN CANCER

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**Introduction** Bowel anastomosis before or after HIPEC has been an unresolved debate. We report our experience of impact of HIPEC on anastomosis performed before or after.

**Methods** Patients diagnosed with advanced epithelial ovarian cancer undergoing CRS+ HIPEC who had bowel resection & anastomoses performed were included in the study. Our institution has two teams, of which one performs anastomosis before and one after HIPEC. Uni-variate and multivariate analysis performed to find factors predicting bowel complications.

**Results** 135 of 220 patients had bowel resection & restoration as a part of CRS+ HIPEC for advanced epithelial ovarian cancer. Of 135 patients, 66 had anastomosis before HIPEC and 69 after HIPEC. Mean PCI 13.4±4.5, blood loss 850 ±302.9 ml, duration of surgery 9.5±2.4 hr. Overall 57.05% had bowel resections, of which large bowel was 75.8% & small bowel 24.2% & stoma rate was 6.4%. Both the group had same number of total (55.4%vs58.6%), small (15.3% vs16.5%) & large bowel resections (44.3%vs 49.5%). We had 4 (2.9%) leak overall, of which 2 were in either groups. Prior surgical score, recurrent ovarian cancers, number of anastomosis >2, duration of surgery >8.5 hrs were significant on univariate analysis. On multivariate analysis prior surgical score >1 was significant.

**Conclusions** We conclude that leak rates & complications related to small or large bowel anastomosis is same when anastomosis is done either before or after HIPEC. However,

since this is not a randomized study a well-designed multi-institutional randomized study needs to be planned for stronger evidence of the same.

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### A RETROSPECTIVE COHORT STUDY FOR FEASIBILITY OF LAPAROSCOPIC HYSTERECTOMY IN PATIENTS WITH STAGE IA1 CERVICAL CANCER

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**Objective** The objective of this study was to verify the feasibility of laparoscopic hysterectomy in patients with stage IA1 cervical cancer.

**Methods** This retrospective study was carried out using data for 103 patients with stage IA1 cervical cancer at Hokkaido Cancer Center from January 2000 to December 2016. Study outcomes including operation time, estimated blood loss, blood transfusion, recurrence, and survival were compared between conization group (n=36) and hysterectomy group (n=67). Among patients in the hysterectomy group, those outcomes were compared between non-laparoscopic hysterectomy group (n=31) and laparoscopic hysterectomy group (n=36).

**Results** In the present study, there was only one patient with cancer recurrence who underwent cervical conization. The rate of cases of cancer recurrence in the conization group tended to be higher than in the hysterectomy group (2.8% vs. 0%, P=0.18). Estimated blood loss in the laparoscopic hysterectomy group was significantly less than in the non-laparoscopic group (213 g vs. 46.5 g, P=0.0017). The rate of patients who received blood transfusion in the laparoscopic hysterectomy group tended to be higher than in the non-laparoscopic group (9.7% vs. 0%, P=0.056).

**Conclusion** It is highly possible that laparoscopic hysterectomy is a safe operative procedure in stage IA1 cervical cancer when performed by experienced surgeons in tertiary centers.

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### MANAGEMENT OF BENIGN METASTASIZING LEIOMYOMA: A REPORT OF THREE CASES

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Benign metastasizing leiomyoma (BML) is a rare disease associated with a history of uterine surgery leiomyomas. BML is often seen in the lungs. Symptomatic patients with BML are usually treated with surgical resection or medical castration. Here, we report three patients diagnosed with BML. A 58-year-old patient presented with back pain. Magnetic resonance imaging (MRI) and positron emission tomography – computed tomography (PET/CT) showed a tumor of 3 cm in diameter in the L2/L3 vertebrae with Fluorine-18 deoxyglucose (FDG) accumulation. Histopathology of CT-guided biopsy was

smooth muscle tumor, which was compatible with the specimen obtained by hysterectomy for leiomyoma five years before. After administration of letrozole for one month, her back pain improved. Letrozole was used for 5 years, and the size of the tumor remained stable. A 38-year-old patient presented with abdominal distension. CT demonstrated multiple abdominal and subcutaneous tumors and uterine leiomyomas. She had myomectomy and complete surgical resection of the multiple tumor, and was diagnosed with BML. Six years later, she presented with slight cough, and CT showed multiple small nodules in the lungs. Because her symptom diminished spontaneously, she was followed without treatment. Her lung tumors gradually increased without symptoms. A 45-year-old patient with a past history of myomectomy twice presented with Raynaud symptom. CT showed multiple small nodules in the lung which showed no accumulation of 18-FDG. Histopathology of CT-guided biopsy was well-differentiated smooth muscle tumors, and she was diagnosed with BML. Because she had no symptoms, she was followed conservatively without treatment.

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### PROSPECTIVE FEASIBILITY STUDY OF NEOADJUVANT DOSE-DENSE PACLITAXEL PLUS CARBOPLATIN WITH BEVACIZUMAB THERAPY FOR ADVANCED OVARIAN, FALLOPIAN TUBE AND PRIMARY PERITONEAL CANCER PATIENTS

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**Objectives** This study aimed to investigate the clinical benefit of dose-dense paclitaxel plus carboplatin (ddTC) with bevacizumab (Bev) therapy in neoadjuvant setting for advanced ovarian, fallopian tube and primary peritoneal cancer patients (UMIN-CTR: 000016176).

**Methods** Ovarian, fallopian tube or primary peritoneal cancer patients with estimated stage III-IV were included. They received paclitaxel (80 mg/m<sup>2</sup>) on day1, 8, 15, carboplatin (AUC 6.0 mg/mL x minute) on day 1, and Bev (15 mg/kg) on day 1 every 3 weeks as neoadjuvant chemotherapy. Interval debulking surgery (IDS) was performed after 3 cycles of ddTC +Bev therapy. The primary endpoint was rate of complete surgery. Secondary endpoints were response rate and adverse events.

**Results** Twenty-four patients were included in this study. The median age was 55.5 years (37–80 years), and high-grade serous carcinoma accounted for 18 patients. IDS was performed in all patients and the rate of complete surgery was 75%. The response rate in NAC was 79%, and CA125 declined below the cut-off in 58% of patients. Grade 4 hematological toxicities and grade 3/4 non-hematological toxicities were observed in 29% and 17% of patients during NAC respectively. Grade 3/4 perioperative complications were found in 29% of patients, but there was no gastrointestinal perforation or treatment-related death.

**Conclusions** Neoadjuvant ddTC+Bev therapy was well tolerated, and the sufficient rate of complete surgery in IDS was obtained.

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### GENOMIC PROFILE OF CLEAR CELL OVARIAN CANCERS AND EVOLUTION WITH DISEASE PROGRESSION

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**Introduction** In clear cell ovarian cancers (CCOC) limited data is available on genomic evolution with disease progression.

**Methods** 23 FFPE tumours collected from 12 patients with advanced CCOC, and 1 mixed clear cell endometrioid OC, treated at Auckland Hospital from 2003–2017, underwent whole exome sequencing (MacroGen), with matched normal tissue.

**Results** 8 patients had diagnostic samples, 5 had diagnostic and first relapse samples, of these 2 had samples from a second relapse.

10/13 patients had 10 distinct ARID1A mutations, most were indels. In 3 patients ARID1A mutations were present at diagnosis and relapse, in 1 patient ARID1A mutation was present at first and second relapse but absent at diagnosis. Other driver mutations were identified in PIK3CA 2/13, AKT1 2/13, PTEN 1/13, NOTCH1 1/13, SMARCA4 1/13, PPP2R1A 1/13, TP53 1/13 and ARID5B 1/13. Putative driver mutations in ACVR1B and IGF2R were seen in relapse and not diagnostic samples.

Three patients had euploid tumours, the remainder had a range of aneuploidy, predominantly in chromosomes 8, 9, 16 and 19. Ploidy remained stable with relapse, except in one chemotherapy-naïve patient, who was euploid at diagnosis, and developed loss of heterozygosity (LOH) in several chromosomes at relapse. Tumour mutational burden (TMB) ranged from <1 to >10 mutations per MB, with no clear trend with disease progression. In one patient TMB was higher in the primary compared with 2 metachronous metastatic sites.

**Conclusion** There was little change in genomic characteristics with disease progression. One chemotherapy naïve patient developed LOH and increased TMB at relapse.

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### EFFECT OF WAITING TIME FROM PATHOLOGICAL DIAGNOSIS TO DEFINITIVE CONCURRENT CHEMORADIATION (CCRT) FOR CERVICAL CANCER ON OVERALL SURVIVAL

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**Objective** This study aimed to evaluate the effect of waiting time, from diagnosis to initiation of definitive concurrent chemoradiation (CCRT), on overall survival in cervical cancer patients.

**Methods** Patients with cervical cancer who were diagnosed with definitive CCRT between 2000 and 2017 were retrospectively reviewed. Time from pathological diagnosis to definitive