debulking surgery followed by adjuvant chemotherapy were randomised to either receive (study group) or not to receive (control group) the non-chemotherapeutic maintenance therapy (oral Metformin, Anastrazole, Aspirin, Atorvastatin, Vitamin-D, Injection.Zoledronic acid). Both groups were followed up and trends of RFS and CSS were analysed.

Results 100 patients were analysed. Median RFS was 18 months (95% CI: 13–24) in study group versus 16 (95% CI: 14–20) in the control group (P-value = 0.57). Median CSS in the study group was lesser than that in the control group [47 months (95% CI: 31–68) versus 51 (95% CI: 32–66), P-value= 0.76]. 5-year CSS was not significantly different between the groups (47% study vs 40% control, P-value = 0.51).

Conclusion The use of combination of non-chemotherapeutic drugs as maintenance therapy was found to have no significant impact on the survival or reduction of recurrences in patients with advanced epithelial ovarian cancer.

IGCS20_1494

453 CLINICAL AUDIT ON QUALITY OF CANCER CARE WITHIN THE ONCOLOGICAL NETWORK OF PIEDMONT AND VALLE D'AOSTA: OVARIAN CANCER TREATMENT, INTERIM ANALYSIS 2017-2018

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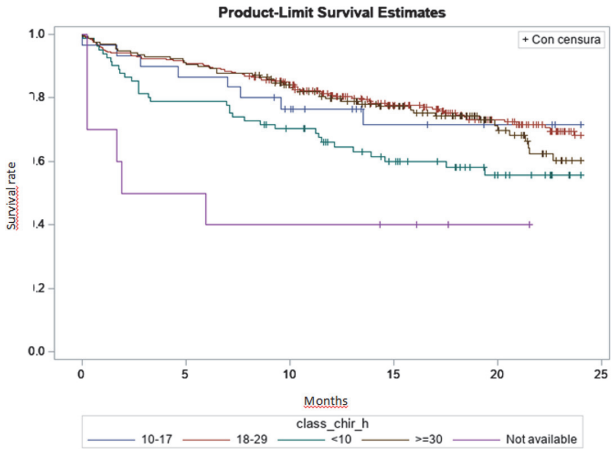
Objectives The aim of this study is to assess the management of patients affected by ovarian cancer at first diagnosis in the Oncological Network of Piedmont and Valle d'Aosta.

Specific objectives of this audit are description of first line treatment, evaluation of adherence to international guidelines, description of overall survival and assessment of clinical and organizational factors that could influence the outcome.

Methods We carried out an audit of newly diagnosed cases of ovarian cancer treated within the oncological network of Piedmont and Valle d'Aosta between May 2017 and December 2018. Using an algorithm we have identified 531 patients, whose data has been stratified by the surgical activity of the different centres of the network: group A with ≥ 30, group B 18–29, group C ≤ 17.

Results A preliminary analysis shows a statistically significant difference in quality of diagnostic and treatment pathways between centres with high volume activity and those with a low volume as shown in figure 1.

Conclusions These preliminary data suggest how diagnostic pathway, treatment efficacy and consequently survival could depend on amount of the surgical procedures of the hospital. If results will be confirmed at the end of the Audit (December 2020), it could be possible exporting this system also outside the Oncological Network in order to set improvement strategies.



Abstract 453 Figure 1

IGCS20_1495

454 STUDY IN PROGRESS: INTERNATIONAL RETROSPECTIVE STUDY ON LYMPHADENECTOMY IN ENDOMETRIOID OVARIAN CARCINOMA PATIENTS WITH EARLY STAGE DISEASE (LEOPARD)

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Introduction The benefit of systematic lymphadenectomy (LNE) in low-stage, low-grade ovarian carcinoma is unknown. However, most guidelines still recommend LNE in these patients. Prior studies examining the benefit of this invasive procedure have been hampered small numbers, and large-scale studies that consider modern classification are needed.

Methods A cohort of 666 pathology-reviewed and immunohistochemistry-validated endometrioid ovarian carcinomas has recently been evaluated using endometrial carcinoma-inspired molecular subtyping. This molecularly characterized series is now being used to assess the value of LNE. Contributing centers are performing detailed chart reviews, so that surgical procedures and lymph node status can be correlated with molecular subtype and outcomes.

Results 349 stage I, 181 stage II, 85 stage III, and 22 stage IV cases with a median OS follow-up of 6.11 years (RevKM) were collected from 17 centres across Canada and Europe.

Analysis of the first 70/666 cases revealed positive nodes in only a single presumed low stage patient after systematic pelvic and paraaortic LNE (n=1/44). LNE was not performed in 3/44 and restricted to pelvic nodes in 6/44 low-stage cases, all of which were pN0. Tumor spread beyond the Uterus and/or Adnexa was associated with positive nodes in 33%.

Conclusion Preliminary results indicate that abandonment of LNE in low-stage, low-grade endometrioid ovarian carcinoma may reduce morbidity without worsening prognosis for these patients. Completion and expansion of our international team initiative stands to provide a powerful statement on the value of LNE, and influence of molecular subtype on disease spread, possibly improving precision care for ovarian carcinoma patients.

IGCS20_1496

455 EPIDEMIOLOGY OF ENDOMETRIUM CANCER IN BELARUS

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Introduction According to GLOBOCAN STATISTICS 2018, Endometrial Carcinoma (EC) is the 6th most common cancer among female population in the world, and the 2nd among all tumors of the female reproductive system. Belarus takes the first place in the world by incidence rate of EC 24.9 per 100,000.

Objective The aim of this study was to estimate incidence rate, mortality and survival rate of newly diagnosed EC in Belarus from 2009 to 2018.

Method We analyzed the data from the Belarusian Cancer Registry.

Results In Belarus, from 2009 to 2018 were diagnosed 19 388 new cases of EC. The standardized incidence rate of EC has increased from 18.7 per 100,000 in 2009 to 24.1 per 100,000 in 2018 (p<0,01).

Comparison of two five year periods (2009–2013 and 2014–2018) showed that the rate of stage I EC increased from 72.6% to 76.6%, respectively. Meanwhile rates of advanced EC (stage III-IV) hasn't been significantly changed 7,43% and 7,36%, respectively.

Standardized mortality rate in the studied period was 2,98 and 3,3, respectively. Adjustive relative survival rate for stage I EC was 93,1±0,5% and 92,1±0,5%, stage II 75,5±1,9% and 75,6±2%, for stage III 44,1±2,2% and 49,5±2%, for stage IV 15,9±3,3% and 17,3±2,3%, respectively.

Conclusions We did not find significant changes in the survival rate between the studied periods. The level of survival and mortality rate complies with international standards.

IGCS20_1497

456 COMPARISONS OF CLINICAL OUTCOMES IN WOMEN WITH ADVANCED OVARIAN CANCER TREATED WITH FRONTLINE INTRAPERITONEAL VERSUS DOSE-DENSE PLATINUM/PACLITAXEL CHEMOTHERAPY WITHOUT BEVACIZUMAB

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Background We aimed to compare the clinical outcomes between intraperitoneal chemotherapy and dose-dense chemotherapy for the frontline treatment of advanced ovarian, fallopian tube and primary peritoneal cancer in women not receiving bevacizumab.

Methods All consecutive women with stage II~IV cancer treated with either frontline intraperitoneal or dose-dense platinum/paclitaxel chemotherapy and not receiving bevacizumab between March 2006 and June 2019 were reviewed.

Results A total of 50 women (intraperitoneal group, n=22; dose-dense group, n=28) were reviewed. Median progression-free survival (32.6 months versus 14.2 months; adjusted hazard ratio=0.38; 95% CI=0.16 to 0.90, p=0.03, figure 1a) and overall survival (not reached versus 30.7 months; adjusted hazard ratio=0.23, 95% CI=0.07 to 0.79, p=0.02, figure 1b) were significantly higher in the intraperitoneal group than in the dose-dense group. A multivariable Cox proportional-hazards model also indicated that the number of frontline chemotherapy cycles (adjusted hazard ratio=0.66, 95% CI 0.47 to 0.94, p=0.02, table 1) was a predictor of better overall survival. Nausea/vomiting and nephrotoxicity occurred more frequently in the intraperitoneal group (p=0.02 and <0.0001, respectively).

Conclusion Intraperitoneal chemotherapy seems to be superior in progression free survival and overall survival to dose-dense

Abstract 456 Table 1 Cox proportional-hazards model to predict overall survival (n=50)

	Univariate			Multivariable		
Variable	Hazard ratio	95% CI	†p	Hazard ratio	95% CI	‡p
Regimen (IP=1 vs. dose-dense=0)	0.35	0.13 to 0.93	0.04	0.23	0.07 to 0.79	0.02
Age (years)	1.04	0.99 to 1.10	0.10	1.04	0.99 to 1.10	0.13
FIGO stage	1.34	0.70 to 2.55	0.37	0.57	0.22 to 1.49	0.26
ECOG score	1.55	0.76 to 3.14	0.23	1.33	0.49 to 3.57	0.57
Suboptimal debulking	1.96	0.85 to 4.53	0.12	1.53	0.57 to 4.14	0.40
Number of IP or dose-dense chemotherapy cycles	0.84	0.66 to 1.09	0.19	0.66	0.47 to 0.94	0.02

CA-125=cancer antigen 125, CI=confidence interval, ECOG=Eastern Cooperative Oncology Group, FIGO=The International Federation of Gynecology and Obstetrics, IP=intraperitoneal. †Univariate Cox proportional-hazards model. ‡Multivariable Cox proportional-hazards model.