IGCS20_1063

39 DEVELOPMENT OF A NOMOGRAM TO PREDICT INTERVAL DEBULKING SURGERY FEASIBILITY WHEN PRIMARY CYTOREDUCTION IS NOT AN OPTION

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Introduction Neoadjuvant chemotherapy (NACT) and subsequent interval debulking surgery (IDS) has been proposed as an alternative to primary debulking surgery in advanced epithelial ovarian carcinoma. However, no biomarkers of NACT efficacy are reliable in predicting chemo response. This study aimed to identify pre-operative factors of IDS success probability.

Methods Single institution, retrospective study. Preoperative variables were used to predict the likelihood of IDS using multivariable models. A nomogram was developed and internal validation was performed.

Results 359 women were submitted to NACT between January 2016 and June 2019.

A complete cytoreductive surgery was achieved in 255 (85%) patients, while an optimal/suboptimal cytoreduction was reached in the remaining 46 (15%) and 58 (16%) did not undergo surgery after NACT. Women with BRCA 1/2 mutation (OR 4.84, CI 95% 1.75–13.34; $p = 0.002$) and lower tumour load (OR 8.15, CI 95% 1.06–62.32; $p = 0.043$) were more likely to undergo IDS. Among patients who did not undergo IDS, only 5 (13%) presented with BRCA 1/2 mutation, compared with 34 (87%) wild type BRCA ($p < 0.001$). According to the predictive model, we constructed a nomogram to report the probability of IDS using five variables: age, Charlson-comorbidity category, histology, LPS-PIV and BRCA-status (figure 1). The calibration plot demonstrated

Abstract 39 Figure 2 Calibration plot of the nomogram

good agreement between predicted and actual probability of surgical treatment (figure 2).

Conclusions This is the first nomogram developed in this setting and it might help physicians with their decision-making algorithm.

IGCS20_1007

40 INTEGRATED MODEL OF PATIENT FACTORS, RESECTABILITY SCORE AND SURGICAL COMPLEXITY INDEX TO PREDICT SURGICAL OUTCOME IN DEBULKING SURGERY FOR ADVANCED OVARIAN CANCER

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Objectives To assess integrated prediction model (IPM) including patient factors, radiological and surgical complexity scores, as a tool to predict optimal debulking (OD) in patients with newly diagnosed advanced ovarian cancer (AOC).

Methods Starting October-1-2018, all patients with newly diagnosed AOC were presented in designated ovarian cancer

Abstract 39 Figure 1 Nomogram predicting surgery probability in patients with ovarian cancer

Abstract 40 Figure 1

rounds. Decision for primary debulking (PDS) or neoadjuvant chemotherapy was made based on radiologic and clinical factors. For the IPM we used: 1. Patient factors score (Age, ECOG, albumin) 2. Resectability score: designated radiologists scored specific radiologic criteria (previously identified as associated with suboptimal debulking). 3. Surgical complexity index: surgeons scoring of anticipated procedures required to achieve OD.

Surgical outcome, complications and time to chemotherapy were recorded.

Results Ninety-five patients met inclusion criteria (October-2018 to August-2019). Forty-four (47%) underwent PDS: 39 (89%) had optimal debulking: 12 to < 1 cm and 27 to no visible residual disease. 5/44(11%) had 'open-and-close' procedure due to non-resectable disease at the time of surgery.

Median Length of stay was 6 days, (1–14d), time from surgery to chemo was 25 days, (7–42d), and grade 3 complications were recorded in 9 patients (20%).

Patients triaged to PDS were significantly younger (median 57 vs. 67, $p < 0.0001$), had lower patient factors scores (median 0.5 vs 2 $p < 0.0001$), lower resectability score (median 2 vs. 4, $p < 0.0001$) and lower surgical complexity index (median 5 vs. 9 $p < 0.0001$).

Conclusion IPM is an effective clinical tool in managing patients with newly diagnosed AOC, and can be utilized to select patients who will benefit from PDS.

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41

INCREASE IN UTERINE SEROUS CARCINOMA: WILL IT SURPASS UTERINE ENDOMETRIOID CANCER? A POPULATION ANALYSIS OF 720,984 UTERINE CANCER PATIENTS

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Objective To evaluate the trends of uterine serous carcinoma compared to endometrioid uterine cancer.

Methods From 2001–2016, incidence rates were estimated from United States Cancer Statistics after correcting for

Abstract 41 Figure 1