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157 LAPAROSCOPIC APPROACH TO COMPREHENSIVE SURGICAL STAGING FOR CLINICAL STAGE I ENDOMETRIAL CANCER: AN INSTITUTIONAL REVIEW OF OPERATIVE OUTCOMES, COSTS AND ITS CLINICAL IMPLICATIONS

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Objectives The absence of local oncologic results utilizing laparoscopic surgery for early stage endometrial cancer prevents its adoption as procedure of choice in the Philippines. The purpose of this study was to determine the clinical profile, operative outcomes and costs of undergoing laparoscopic surgery for clinical stage I endometrial cancer.

Methodology Data from 28 patients who underwent TLHBSO, PFC, LND for presumed stage I endometrial cancer were collected retrospectively from May 2017 to May 2019 in a tertiary institution.

Results Mean age of the patients was 46.7 (range, 25 to 71). Risk factors included obesity (53.5%), nulliparity (46.4%), diabetes mellitus (14.3%), primary infertility (14.3%), PCOS, (7.1%) and dyslipidemia (3.6%). None of the cases were converted to laparotomy, one necessitated mini-laparotomy to deliver the uterine specimen. Median length of operations was 236 minutes and 281 minutes depending on whether para-aortic lymphadenectomy was included. Complications include blood transfusion (3), vaginal vault dehiscence (1) and lymphocyst formation (1). Mean hospital stay was 7 days. Blood loss was minimal (217.3 ± 171.4 mL). Two out of the 28 cases have stage III disease intra-operatively. Median follow up was 13.5 months. Sixteen subjects (57%) had no evidence of disease on follow up while 2 (7%) already died of disease. The presence of LVSI and tumor size ≥ 2 cm were factors identified for progression. Average hospital cost was \$1,137.15 (range, \$336.47 to \$2,386.98).

Conclusion Laparoscopic surgery is a safe and viable surgical option for carefully selected clinical stage 1 endometrial cancer patients.

IGCS20_1143

158 NON-EPITHELIAL OVARIAN TUMORS: A SINGLE INSTITUTE RETROSPECTIVE STUDY

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Introduction Non-epithelial ovarian tumors (NEOT) account for 10% of ovarian cancers. They occur in all age groups and include diverse tumors of germ cell origin, sex cord-stromal cell origin, as well as extremely rare types of ovarian cancer. The etiology and molecular origins of each sub-group remain poorly understood. Our aim is to determine the clinical, epidemiologic and histological features of the NEOT.

Methods A retrospective coorte study involving 33 patients diagnosed with NEOT and treated at IPO-Coimbra between

2011–2015. Patients 'data were obtained from hospital records.

Results The average age was 56 years. 42.4% of the patients were pre menopausal. We diagnosed 11 germ cell tumors (9 mature cystic teratomas, 1 mature teratoma and 1 immature teratoma), 21 sex cord-stromal tumors (16 ovarian fibromas/thecomas, 3 adult granulosa cell tumors, 1 juvenile granulosa cell tumor and 1 Sertoli-Leydig cell tumor) and 1 small cell carcinoma hypercalcaemic type tumor. All patients had surgery as a primary treatment; in 18.2% of the cases was performed a conservative surgery. Only 9.1% of patients were diagnosed in a stage $> IA$ (FIGO). 2 patients were subjected to adjuvant chemotherapy (Sertoli-Leydig cell tumor and immature teratoma). After a mean follow up of 2.2 years, we reported 3 cases of relapse. 3 patients died between 2011–2015, but only one due the disease. The overall survival at 5 years was 97%.

Conclusions Our study reveals that the overall prognosis of NEOT is good. Relapse cases were mainly related to FIGO stage and more rare histologic type of tumor.

IGCS20_1144

159 TARGET THERAPY IN HEAVILY PRETREATED WOMEN AFFECTED BY DIFFERENT CANCERS: A PRELIMINARY SINGLE CENTER EXPERIENCE AFTER THE INTRODUCTION OF COMPREHENSIVE GENOMIC PROFILING IN CLINICAL PRACTICE

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Introduction Cancer treatment is evolving towards precision medicine. When traditional chemotherapy is not effective anymore in heavily pretreated patients, tumour profiling can be an helpful tool able to match genomic data to available target therapies.

Methods Patients treated at our Gynaecologic Oncology Unit from 09/2018 to 06/2020 with no other available standard options were proposed for the FOUNDATIONONE®CDx genomic profiling. Clinical data were collected. In case of targetable alterations, patients were treated with the suggested molecular-driven treatments, when possible. Follow-up is still ongoing.

Results We collected specimens and clinical data of 67 patients. The majority were ovarian tumors (44/67; 65.7%); 18/67 patients (26.8%) had no mutation detected, one (1.5%) had not enough cancer cells in the specimen and 10/67 (14.9%) tests are ongoing. Of the 38 patients with a viable targeted therapy, 16 (28.9%) were treated with a FOUNDATIONONE®CDx-guided targeted therapy, 5 of those with PARP-inhibitors within approved indications; one (2.6%) is waiting to start. The remaining (21/38; 55.3%) died before starting or decided for no therapy for poor performance status (tables 1–2).

Conclusions In the era of precision medicine, integration of molecular biology and targeted therapy is an effective option especially for patients with heavily treated cancers. Large randomized trials are needed to draw relevant conclusions about the patient clinical outcomes improvement and correct

Abstract 159 Table 1 Main results

All patients	
N	67 (100%)
Cancer types	
Ovarian	44 (65.7%)
Uterine	15 (22.4%)
Other	8 (11.9%)
Profiling test results	
No alteration detected	18 (26.9%)
Not enough specimen	1 (1.5%)
Alteration detected	38 (56.7%)
Ongoing	10 (14.9%)
Treatments	
Targeted therapy (off label)	11/38 (28.9%) +1/38 (2.6%)
Targeted therapy in patients with BRCA mutations within approved guidelines	5/38 (13.2%)
No therapy for progressive disease/DOD before starting	21/38 (55.3%)

Abstract 159 Table 2 Patients who actually started a FoundationONE® CDx off-label guided therapy.

Patient	Cancer type	Alteration detected	Treatment started (off-label)	Clinical outcome
#1	High grade serous ovarian cancer	CCND1 - E275*	Ribociclib	Stability of disease; Treatment ongoing (5 months)
#2	Endometrioid endometrial cancer	PIK3CA E545K	Everolimus Exemestane	Stability of disease; Treatment ongoing (6 months)
#3	Mixed endometrial cancer	KRAS - D33E	Trametinib	1 month treatment then clinical progression of disease
#4	Endometrioid ovarian cancer	PIK3CA - H1047L	Everolimus-Exemestane	Stability of disease; Treatment ongoing (5 months)
#5	Endometrioid endometrial cancer	CCND1 - amplification - equivocal	Palbociclib	1 month treatment then clinical progression of disease
#6	High grade serous ovarian cancer	BRCA1 - A1708E	Niraparib	3 months of stability of disease
#7	High grade serous ovarian cancer	BRCA1 - rearrangement intron 12	Talazoparib	4 months of stability of disease
#8	Cervical adenocarcinoma	ERBB2 - amplification	Trastuzumab	4 months of stability of disease
#9	High grade serous ovarian cancer	KRAS- Q22K NF1- W2317	Trametinib	9 months of stability of disease
#10	Endometrioid endometrial cancer	PIK3CA - E545K	Everolimus	Stability of disease; treatment ongoing (>12 months)
#11	High grade serous ovarian cancer	BRCA1 - splice site 787+1G>T	Niraparib	1 month treatment then clinical progression of disease

timing of the molecular test-guided therapies. Nevertheless, with the increasing use of target-based therapy, accessibility should be granted for all patients.

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160 THE IMPACT OF HYSTEROSCOPY ON THE DISEASE COURSE OF HIGH GRADE ENDOMETRIAL CARCINOMA

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Background With hysteroscopy, concerns have surfaced regarding intraperitoneal spread of endometrial cancer (EC); no studies have evaluated the effect of hysteroscopy on the disease course of a large series of patients with exclusively high risk histology.

Methods Patients who underwent hysterectomy for grade 3 EC at Mayo Clinic in Rochester, MN between January 2009-June 2016 were included, noting hysteroscopy within 6 months. Follow-up was restricted to five years. Cox proportional hazards models were fit to evaluate associations between hysteroscopy exposure and progression.

Results Among 831 patients, 133 underwent hysteroscopy. Patients with versus without hysteroscopy did not differ in mean age (67.7 vs. 67.8 years), BMI (31.6 vs. 31.3 kg/m²), ASA ≥ 3 (35.3% vs. 38.3%), or serous histology (47.4% vs. 48.7%). Advanced disease (III/IV) was less common among hysteroscopy patients (30.1% vs 43.8%, $p=0.003$). No difference was observed between those with hysteroscopy versus without (all $p>0.05$) in positive cytology (22.0% [26/118] vs. 29.7% [191/643]), stage IV disease (16.5% [22/133] vs. 21.9% [153/698]), any positive cytology OR adnexal invasion OR stage IV (28.6% [38/133] vs. 36.1% [252/698]), the aforementioned OR peritoneal recurrence within 2 years (30.8% [41/133] vs. 39.3% [274/698]). After stratifying by stage, hysteroscopy did not increase risk of progression (HR 1.06, 95% CI 0.59–1.92 for stage I/II; HR 0.96, 95% CI 0.62–1.48 for stage III/IV).

Conclusion In this retrospective study of high grade EC, we did not observe any significant association between pre-operative hysteroscopy EC and incidence of positive cytology, peritoneal disease, or progression.

IGCS20_1147

161 PREDICTION OF OVARIAN CANCER USING A MULTIVARIATE ASSAY: A RANDOMIZED CONTROLLED TRIAL TO IMPROVE DIAGNOSTIC STRATEGIES IN FILIPINO WOMEN (PRELIMINARY RESULTS OF THE OVERA STUDY)

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Introduction In our setting, conventional utilization of clinico-diagnostic, sonographic and single biochemical marker characteristics predominates the pre-operative evaluation of ovarian masses, while the value of multivariate assays has yet to be elucidated. In this study, a multivariate assay (OVERA®) was compared to singular and combined models for malignancy risk calculation.

Methods This is an ongoing randomized controlled trial using OVERA among Filipino women with ovarian masses in the