underestimated and S-LPS helped to avoid SDS in 89% because of noting a diffuse bowel mesentery involvement.

**Conclusion** A combination of MRI/CT scans and staging laparoscopy in PCI evaluating is an effective treatment modality which can improve the cytoreductive outcomes in patients with advanced ovarian cancer.

**Disclosures** No conflict of interest exits in the submission of this study. We confirm that no funding source were used in this study.

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**Prevention of gynaecologic cancer**

**577 EARLY SALPINGECTOMY (TUBECTOMY) WITH DELAYED OOPHORECTOMY AS AN ALTERNATIVE FOR RISK-REDUCING SALPINGO-OOPHORECTOMY TO IMPROVE QUALITY OF LIFE IN WOMEN WITH A BRCA1/2 PATHOGENIC VARIANT (TUBA STUDY): A PROSPECTIVE MULTICENTER PREFERENCE TRIAL**

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**Introduction/Background** Currently, risk-reducing salpingo-oophorectomy (RRSO) around the age of 40 is recommended to women with a BRCA1/2 pathogenic variant (PV). To prevent premature menopause, risk-reducing salpingectomy (RRS) is considered, because recent data indicate the Fallopian tube instead of the ovary as origin of high grade serous ovarian carcinoma (HGSC). Based on this hypothesis, the TUBA study (NCT02321228) compares quality of life (QoL) between the novel RRS with delayed oophorectomy (RRO) and standard RRSO.

**Methodology** Within this national multicenter preference trial, BRCA1/2-PV carriers chose between the novel strategy (RRS) after completion of childbearing and RRSO at age 40–45 (BRCA1) or 45–50 (BRCA2) and the standard strategy (RRSO at age 35–40 (BRCA1) or 40–45 (BRCA2)). The primary outcome is menopause-related QoL, measured by the Greene climacteric scale (GCS). A higher sum of the GCS represents more menopausal complaints.

**Results** A total of 577 women were included, 51.5% carried a BRCA1-PV, and 72% chose the novel RRS with delayed RRO. Until now, 394 women underwent RRS and 154 RRSO of which 30% did not start hormone replacement therapy (HRT). Without HRT, the adjusted mean increase from baseline on the GCS was 0.6 points (95% confidence interval (CI) 0.0;1.1) one year after RRS and 7.7 points (95% CI 6.2;9.9) one year after RRSO. Thus, the adjusted mean difference between the treatment groups was 7.2 (95% CI 5.4;9.0, P<0.001). In women with HRT after RRSO, a difference of 3.4 points (95% CI 2.2;4.6, P<0.001) was found compared to RRS. For sexual functioning, women without HRT had an increase of 0.4 points (95% CI -0.3;1.1) one year after RRS and a decrease of 5.7 points (95% CI -8.7;-3.7) one year after RRSO. A decrease of 1.6 points (95% CI -3.2;0.0) was found one year after RRSO with HRT. A decrease represents a worsening of sexual functioning. No differences in cancer worry, decisional conflict or decisional regret were found between groups. No HGSC has occurred during follow-up.

**Conclusion** Menopause-related QoL is better after novel RRS when compared to RRSO in women with a BRCA1/2-PV, regardless of HRT use. Moreover, sexual functioning is better at one year after RRS. No cancers have occurred since RRS, but follow-up is too short to draw conclusions on safety. An international follow-up study is currently recruiting to evaluate the oncological safety of RRS with delayed RRO (TUBA-WISP II, NCT04294927).

**Disclosures** Nothing to disclose.