Abstract 94 Table 2 Oncologic and reproductive outcomes

Case#	1st relapse (mo)	Treatment of 1st relapse	2nd relapse (mo)	Treatment of 2nd relapse	Attempting to conceive	Pregnancy	Follow-up (mo)	Current status
1	-	-	-	-	-	-	136	NED
2	14	Non conservative	-	-	-	-	33	NED
3	43	Still conservative	-	-	-	-	174	NED
4	17	Still conservative	-	-	yes	2 NFTD	158	NED
5	17	Still conservative	9	Still conservative	yes	-	144	NED
6	24	Still conservative	23	Still conservative	yes	1 NFTD	113	NED
7	16	Still conservative	35	Still conservative	yes	-	134	NED
8	190	Non conservative	-	-	-	-	217	NED
9	8	Non conservative	-	-	yes	1 SFTM	23	AWD
10	142	Still conservative	-	-	-	-	146	NED
11	-	-	-	-	-	-	96	NED
12	4	Still conservative	-	-	-	-	145	NED
13	69	Non conservative	32	Non conservative	-	-	207	NED

AWD, alive with disease; NED, no evidence of disease; NFTD, normal full-term delivery; SFTM, spontaneous first-trimester miscarriage.

with the aim of systematically collecting data from consecutive BOT patients. The present analysis reports the oncologic and reproductive outcomes of women with SBOT and invasive implants registered into the MITO14 database and conservatively treated between January 1995 and December 2019.

Methodology Thirteen patients (FIGO₂₀₁₄ stage II-III SBOT with invasive implants) were recruited (table 1). Primary and secondary endpoints were, respectively, recurrence, pregnancy and live birth rates. Only patients undergoing fertility-sparing surgery (FSS) were included, while patients were excluded in case of: age >45 years; presence of second tumor(s) requiring therapy interfering with the treatment of BOT.

Result(s)* Median follow-up from primary cytoreduction was 144 months (range 23–217). Eleven patients (84.6%) experienced at least one recurrence (median time to first relapse 17 months, range 4–190), all of these undergoing secondary surgery (FSS in 7). Five patients attempted to conceive (at least one pregnancy in 3; at least one healthy child in 2). At the end of the observation period, 12 patients (92.3%) showed no evidence of disease and 1 (7.7%) was alive with disease (table 2).

Conclusion* Despite the recurrence high rate, survival and pregnancy outcomes indicate that FSS could be considered in SBOT with invasive implants.

197 ABSTRACT WITHDRAWN

265 LOSS OF OVARIAN FUNCTION IN YOUNG PATIENTS WITH CANCER: PROGNOSTIC MODEL

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Introduction/Background* Chemotherapy negatively affects ovarian function and fertility. At present, clinical assessment does not allow an accurate prediction of ongoing ovarian function after cancer or future ability to conceive. This study aims to develop a predictive model for premature ovarian failure (POF) after chemotherapy analyzing the outcomes of a cohort of young women with different

types of cancer in terms of menstrual function recovery and fertility.

Methodology Retrospective, monocentric cohort study including 348 patients referring to Oncofertility Unit of San Raffaele Hospital (Milan, Italy) from August 2011 to January 2020. POF was defined as absence of menstrual cycles for at least 12 months before the time of study. Infertility was defined as failure to achieve a spontaneous pregnancy after regular unprotected intercourse for at least 12 months. Prognostic factors associated with POF were identified using ANOVA, χ -square test and univariate binary logistic regression. A multivariate logistic regression analysis using forward conditional mode was performed to create a predictive model by selecting the best combination of prognostic factors. A ROC curve was constructed, with measurement of area under the curve (AUC) and corresponding 95% confidence intervals.

Result(s)* At follow-up, a total of 227 patients were alive without disease. Data about menstrual function resumption was available for 184 patients. Forty-five patients (25%) experienced POF after cancer treatment. A total of 60 patients (33%) were infertile. Factors and chemotherapy schemes associated with a higher prevalence of POF are reported in table 1 and table 2, respectively. The best predictive model for POF could be identified by the combination of the following factors: age; number of chemotherapy lines; vincristine, adriamycin and ifosfamide/adriamycin and ifosfamide (VAI/AI), capecitabine and adriamycin, bleomycine, vinblastine and doxorubicin (ABVD) (AUC=0.906, CI 95% 0.858 – 0.954, $p=0.0001$).

Conclusion* The model we constructed predicts with good accuracy the individual probability of loss of ovarian function

Abstract 265 Table 1 Factors associated with a higher prevalence of premature ovarian failure (POF). AMH: anti-mullerian hormone; AFC: antral follicle count; FSH: follicle-stimulating hormone. Data are expressed as mean $\pm$ standard deviation

	POF	No POF	p-value
Age	31.0 $\pm$ 6.0	30.1 $\pm$ 6.5	ns
BMI	21.0 $\pm$ 2.3	21.4 $\pm$ 3.1	ns
AMH	1.2 $\pm$ 1.1	2.2 $\pm$ 1.8	0.03
AFC	10.3 $\pm$ 6.4	12.2 $\pm$ 6.7	ns
FSH	10.2 $\pm$ 7.1	7.4 $\pm$ 3.0	0.01

Abstract 265 Table 2 Results of chi-square tests comparing premature ovarian failure (POF) prevalence with different chemotherapy schedules. OR: odds ratio; CI: confidence intervals; TaxAC-CMF: Anthracycline and taxane – cyclophosphamide, methotrexate, and fluorouracil; VAI/AI: vincristine, adriamycin and ifosfamide/adriamycin and ifosfamide; EPI-IFO: epirubicin and ifosfamide; ABVD: adriamycin, bleomycine, vinblastine and doxorubicin; CHOP: cyclophosphamide, doxorubicin, vincristine and prednisone; FEC: fluorouracil, epirubicine and cyclophosphamide; BEACOPP: bleomycin, etoposide, adriamycin, cyclophosphamide, vincristine, procarbazine and prednisone

Schedule	POF prevalence	OR (95% CI)	p-value
Platinum-based	8/24 (33%)	1.6 (0.6 – 4)	ns
TaxAC-CMF	7/18 (39%)	2.0 (0.7 – 5.7)	ns
VAI/AI	2/8 (25%)	1 (0.1 – 5.1)	ns
EPI-IFO	9/19 (47%)	3.1 (1.1 – 8.2)	0.02
Capecitabine	3/4 (75%)	9.5 (0.9 – 94.4)	0.04
ABVD	2/41 (4.9%)	0.1 (0.02 – 0.4)	0.0001
CHOP	8/13 (62%)	5.6 (1.7 – 18.2)	0.004
FEC + weekly paclitaxel	3/16 (19%)	0.6 (0.1 – 2.4)	ns
Oncocarbide	0/4 (0%)	0.7 (0.6 – 0.8)	ns
Fludarabine	1/3 (33%)	1.5 (0.1 – 17.0)	ns
BEACOPP	3/5 (60%)	4.7 (0.7 – 29.3)	0.09
Temozolomide	2/7 (29%)	1.2 (0.2 – 6.4)	ns
Monoclonal antibody	8/24 (33%)	1.6 (0.6 – 4)	ns
Trabectedin	1/5 (20%)	0.7 (0.08 – 6.8)	ns
High-dose	22/24 (94%)	63.6 (14 – 289)	0.0001

at cancer diagnosis and with every change of treatment. This has a very important implication: the necessity to implement fertility preservation strategies when the risk increases.

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THE IMPACT OF A NATIONAL MULTIDISCIPLINARY TUMOR BOARD FOR CANCER DURING PREGNANCY

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Introduction/Background* Physicians encounter pregnant women with cancer only incidentally, leading to lack of expertise or confidence to inform and treat these patients according to up to date guidelines and expert opinions. In the Netherlands, a national multidisciplinary tumor board (MDT) for cancer and pregnancy was founded in 2012, and consists of 33 physicians from all over the country. Requests to discuss patients in the MDT were received by e-mail and a recommendation letter was generated based on available literature and expert opinion of the board members.

Methodology All requests and recommendations were gathered in a database and analyzed for tumor type, stage, gestational age and recommendation given. A survey was sent out to 93 physicians who requested recommendations of the MDT, containing questions regarding their experiences with the MDT and the impact on treatment decisions.

Result(s)* From December 2012 to May 2021, 209 recommendations were formulated, mostly regarding pregnant

Abstract 290 Figure 1