three patients who gross extrauterine disease and in the aforementioned patient who had not surgery. Eleven (48%) patients had adjuvant treatments, consisting in anthracycline-based chemotherapy (n=4), gemcitabine-based chemotherapy (n=2), mTOR inhibitors (n=4) and hormonal treatment (n=1). Median (range) follow-up as 23 (2, 99) months. Eleven (48%) recurrences occurred with a mean (SD) progression free-survival of 14 (11) months. After a median (range) follow-up of 23 (2, 99) months, nine (39%) patients died of disease. Residual tumor at surgery was the only factor correlating with the risk of developing recurrent disease (p=0.023) and worse overall survival (p=0.014). In our small series, stage of disease and adjuvant therapy administration had no impact on survival outcomes.

Conclusion* Uterine PEComa represents a rare and aggressive entity. Molecular/genomic profiling of the disease is necessary to predict response to treatment. Further collaborative investigations are warranted to assess the role of various prognostic factors and evaluate the most effective surgical and medical treatment modalities.

142

LOW PREOPERATIVE SKELETAL MUSCLE DENSITY PREDICTS POSTOPERATIVE COMPLICATIONS AND FUNCTIONAL DECLINE IN OLDER WOMEN WITH OVARIAN CANCER

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Introduction/Background* Insights in how to select older patients who can benefit from standard care and patients that need adjusted treatment are necessary. This study aims to determine the predictive value of lumbar skeletal muscle mass and density, measured on a computed tomography (CT) scan, for postoperative outcomes in older women with advanced stage ovarian cancer.

Methodology A multicentre, retrospective cohort study was performed in women ≥ 70 years old with advanced stage ovarian cancer who underwent surgery. Skeletal muscle mass and density were assessed in axial CT slices on level L3. Low skeletal muscle mass was defined as skeletal muscle index $< 38.50 \text{ cm}^2/\text{m}^2$. Low skeletal muscle density was defined as one standard deviation below the mean (muscle attenuation < 22.55 Hounsfield Units). The primary outcome was any postoperative complication ≤ 30 days after surgery. Secondary outcomes included severe complications, infections, delirium, prolonged hospital stay, discharge destination, discontinuation of adjuvant chemotherapy and mortality.

To investigate whether skeletal muscle density was of added value as a predictor for postoperative complications, we first

Abstract 142 Table 1 Results from univariable and multivariable analysis of predictors used to build the multivariable predictable model for postoperative complications within 30 Days after surgery

Potential Predictors	Odds ratio	95% confidence interval	p-value	Odds ratio	95% confidence interval	p-value
Univariable analysis			Multivariable analysis (n=178)			
Low skeletal muscle density*	2.83	1.41-5.67	0.003	2.57	1.21-5.45	0.01
KATZ-ADL ≥ 2 (n=178)	3.11	1.05-9.20	0.04	2.67	0.88-8.12	0.08
Candidate predictors associated with postoperative complications (p < 0.20), but not improving the model						
Bowel surgery (n=210)	1.92	0.90-4.12	0.09			
FIGO stage IV	1.61	0.87-2.99	0.13			
Charlson Comorbidity Index ≥ 2	0.61	0.32-1.18	0.14			
Polypharmacy†	1.55	0.85-2.82	0.15			
Candidate predictors not associated with postoperative complications (p ≥ 0.20)						
Living at home with help (n=210)	1.62	0.72-3.65	0.24			
Undifferentiated tumor (n=195)	4.67	0.30-73.38	0.27			
Use of walking aid (n=178)	1.52	0.66-3.49	0.32			
Risk for malnutrition (n=117)	1.42	0.65-3.08	0.38			
ASA score ≥ 3 † (n=211)	1.50	0.58-3.87	0.40			
Body Mass Index	1.03	0.96-1.09	0.46			
History of confusion during illness (n=181)	1.43	0.31-6.58	0.65			
Fall risk (n=173)	1.21	0.51-2.87	0.66			
Age	0.99	0.92-1.06	0.72			
Pre-existing memory problems (n=181)	0.79	0.20-3.18	0.74			

ASA = American Society of Anesthesiologists; FIGO = International Federation of Gynecology and Obstetrics; KATZ-ADL = Six-item Katz index on independence in Activities in Daily Living.

Boldface data are statistically significant. If a variable has missing values, the number presented behind a variable represents the number of patients included in this analysis.

* Low skeletal muscle density is defined as a mean muscle attenuation (MA) $< 22.55 \text{ HU}$.

† Polypharmacy was defined as the daily use of ≥ 5 different medicines.

‡ The ASA classification (measured before surgery) ranges from 1 to 6, with higher scores indicating a worse physiological status and a higher operative risk.

built a model with pre-existing relevant preoperative predictors only. After this model was built, we added skeletal muscle density to assess if it improved the model. A statistically significant step Chi-square statistic demonstrated that the new model performed better than the model with existing predictors.

Result(s)* 213 Patients were included. Preoperative low skeletal muscle density was associated with postoperative complications ≤ 30 days after surgery (Odds Ratio (OR) 2.83; 95% Confidence Interval (CI) 1.41-5.67), severe complications (OR 3.01; 95%CI 1.09-8.33), infectious complications (OR 2.79; 95%CI 1.30-5.99) and discharge to a care facility (OR 3.04; 95%CI 1.16-7.93). Preoperative low skeletal muscle mass was only associated with infectious complications (OR 2.32; 95% CI 1.09-4.92). In a multivariable model (table 1), low skeletal muscle density was of added predictive value for postoperative complications to the strongest existing predictor functional impairment (KATZ-ADL ≥ 2) (OR 2.57; 95%CI 1.21-5.45; step Chi-Square statistic p=0.01).

Conclusion* Low skeletal muscle density, as a proxy of muscle quality, is associated with worse postoperative outcomes in older patients with advanced stage ovarian cancer. These findings can contribute to preoperative risk assessment and clinical decision making.

147

USEFULNESS OF HYSTEROSCOPY IN THE MANAGEMENT OF BREAST CANCER PATIENTS WITH TAMOXIFEN AS AN ADJUVANT TREATMENT

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