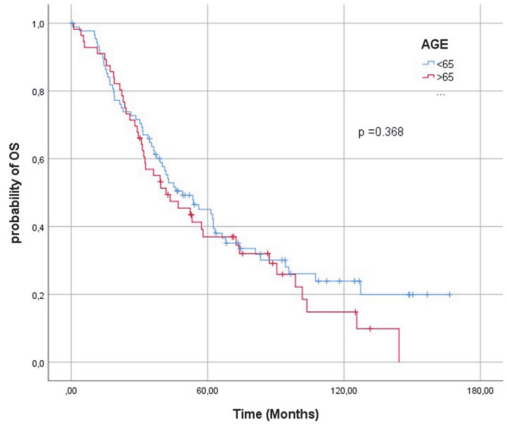

Kaplan Meier Curves. Overall Survival in advanced ovarian cáncer after debulking surgery

Abstract 49 Figure 1 Kaplan Meier curves. Overall survival in advance ovarian cancer after bebulking surgery

stage. Charlson comorbidity index and tumor grade were higher among aged patients. The proportion of PDS and the surgical complexity score did not show statiscally signficative differences, as well as the rate of major postoperative complications or length of stay.

Patients over 65 years had optimal cytorreduction in 78.3%, the progression free survival was 19.1months and overall survival was the 48.7 months compared with patients up to 65 years, which had 87.1% of optimal debulking surgery, 24.6 months of DFS and 52.7 months. None of these outcomes revealed any statistical significant difference between groups.

Conclusion* The survival outcomes in elderly ovarian cancer patients are the same as younger patients. The age should not be the main factor to decide the upfront treatment of AEOC.

70 PATIENT REPORTED OUTCOME IN PLATINUM-RESISTANT RECURRENT OVARIAN CANCER AND METASTATIC BREAST CANCER TREATED WITH METRONOMIC CHEMOTHERAPY

S Krajnak*, M Battista, K Almstedt, K Anic, AS Heimes, V Linz, R Schwab, A Hasenburg, M Schmidt. *University Medical Centre of the Johannes Gutenberg University Mainz, Department of Gynaecology and Obstetrics, Mainz, Germany*

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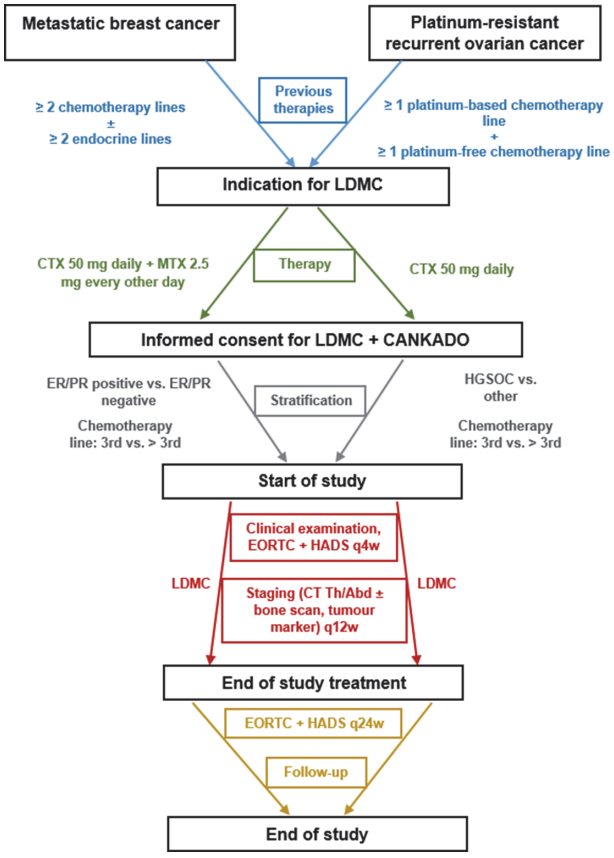
Introduction/Background* In the treatment of both platinum-resistant recurrent ovarian cancer (ROC) and metastatic breast cancer (MBC), symptom control and maintenance of quality of life (QoL) play a crucial role. In the advanced stage of disease, metronomic chemotherapy (MCT) may be a favourable treatment option. The aim of this study is to assess the QoL of heavily pretreated patients with ROC and MBC treated with MCT.

Methodology PROmetronomic, FoR.UM 19-02193, is a monocentric, open-label, single-arm observational study to assess health-related patient-reported outcome data in ROC and MBC patients treated with MCT (cyclophosphamide 50 mg p.o. daily ± methotrexate 2.5 mg p.o. every other day). QoL data are evaluated using European Organisation for Research and Treatment of Cancer (EORTC) QLQ-C30 version 3.0, EORTC QLQ-OV28 version 1.0 (ROC)/EORTC QLQ-BR23



Abstract 70 Figure 1

version 1.0 (MBC), and Hospital anxiety and depression scale (HADS-D) questionnaires via an internet-based therapy support system CANKADO. Patients previously treated with at least 1 line of platinum-based and 1 platinum-free chemotherapy (ROC)/at least 2 lines of endocrine therapy (for hormone receptor-positive cancer) and at least 2 lines of chemotherapy (MBC) are included. Secondary endpoints are disease control rate at 12 and 24 weeks, duration of response, progression-free survival and overall survival. Assessment of safety and tolerability is conducted according to the National Cancer Institute Common Terminology Criteria for Adverse Events (NCI CTCAE) version 5.0. As part of the translational research approach, potentially relevant anti-angiogenic and immunomodulatory biomarkers are being investigated.

Result(s)* Until 2021-05-01, 4 ROC and 3 MBC patients have been enrolled. It is planned to include a total of 65 patients until 08/2023.

Conclusion* Potentially toxic chemotherapy is often required to achieve disease control in patients with metastatic cancer. However, well-being and personal preferences must not be neglected. MCT could provide an efficacious treatment option with limited toxicities and positive impact on QoL.

81 CYTOLOGICAL SAMPLES FOR DETECTION OF BRCA 1/2 MUTATIONS IN PATIENTS WITH HIGH GRADE SEROUS OVARIAN CANCER

E Skof*, S Novaković, V Stegel, S Miceska, M Krajc, S Bebar, V Kloboves-Prevodnik, V Setrajcic Dragos, A Blatnik. *Institute of Oncology Ljubljana, Slovenia*

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Introduction/Background* Since approval of PARP inhibitor olaparib, testing for germline BRCA 1/2 (gBRCA) gene mutations from blood and testing from formalin-fixed-paraffin-embedded (FFPE) tumor tissue for detection of somatic BRCA 1/2 (sBRCA) gene mutation has become standard procedure for patients with high-grade serous ovarian cancer (HGSOC). Since the DNA extracted from FFPE is of poor quality, the new alternative materials are being investigated. Cytological samples (CS) from malignant ascites or other metastatic sites provide intact DNA material for BRCA 1/2 gene testing. The aim of study was to determine if CS can be used for BRCA 1/2 gene testing in patients with HGSOC.

Methodology For patients with HGSOC to be eligible three samples were obtained: blood sample, FFPE (tumor block) and CS from malignant ascites or other metastatic sites. From FFPE and CS status of gBRCA 1/2 or sBRCA 1/2 gene mutations status was obtained, from blood samples status of gBRCA 1/2 gene mutations was obtained. Comparison of reliability in BRCA 1/2 gene testing between all three samples was performed. BRCA 1/2 gene testing was performed by next generation sequencing.

Result(s)* Overall 122 patients were included in the period from 2015-2020, 63 (52%) of them were eligible for analysis. BRCA 1/2 gene mutation had 21/63 (33%) of patients: 18 (28%) gBRCA 1/2 and 3 (5%) sBRCA 1/2 gene mutation. There was 98% correlation (62/63) between CS and FFPE in determination of BRCA 1/2 gene mutational status. One patient had sBRCA 2 gene mutation present in FFPE but not in CS (ascites).

Conclusion* In experienced oncology centers cytological samples can be used for BRCA 1/2 gene mutation testing in patients with HGSOC.

93 EVALUATION OF PERIOPERATIVE MANAGEMENT OF ADVANCED OVARIAN (TUBAL/PERITONEAL) CANCER PATIENTS. A SURVEY FROM MITO-MANGO GROUPS

[1]S Greggi*, [2]F Bifulco, [3]A Ferrero, [4]P Zola, [5]E Busato, [6]N Biglia, [7]M Stefanetti, [8]S Danese, [9]G Valabrega, [1]F Falcone. *[1]Istituto Nazionale Tumori, IRCSS, "Fondazione G. Pascale", Department of Gynecologic Oncology, Italy; [2]Istituto Nazionale Tumori, IRCSS, "Fondazione G. Pascale", Division of Anesthesia and Pain Medicine, Italy; [3]Mauriziano Hospital, Academic Department Gynaecology and Obstetrics, Italy; [4]University of Turin, Department of Surgical Sciences, Italy; [5]Treviso Regional Hospital, Department of Obstetrics and Gynecology, Italy; [6]Umberto I Hospital, Division of Gynecology and Obstetrics, Italy; [7]Infermi Hospital, Obstetrics and Gynecology, Italy; [8]University of Turin, Città della Salute e della Scienza, Gynecology and Obstetrics, Italy; [9]Candiolo Cancer Institute, FPO-IRCCS, Candiolo, Department of Oncology, Italy*

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Introduction/Background* Enhanced Recovery After Surgery (ERAS) is currently considered as a global surgical quality improvement initiative. There is a paucity of data, however, concerning its application in advanced ovarian cancer (AOC) patients. The present analysis shows the results of a survey aimed at gathering detailed information on current perioperative management of AOC patients within MITO-ManGO Groups.

Abstract 93 Table 1 Survey outcomes compared with the recommendations from the ERAS society

Recommendations from ERAS Society*	Recommendation strenght	Centres responding in accordance with the recommendation, n (%)
Preoperative phase		
Preadmission information, education and counselling (including alcohol/smoking cessation and physical exercise/prehabilitation programs)	strong positive	17 (56.7)
Preoperative anemia (Hb <12 g/dl): need for screening and treatment	strong positive	3 (10)
Nutritional screening (supplementation if needed)	strong positive	5 (16.6)
Preoperative anaesthetic assessment Assessment of cardiac risk and function, screening for obstructive sleep apnea, complete labs, frailty screening	strong positive	11 (36.6)
Pharmacological thromboprophylaxis started 12 hours prior to surgery	strong positive	23 (76.6)
Preoperative bowel preparation low risk for intestinal surgery: mechanical bowel preparation high risk for intestinal surgery: mechanical bowel preparation ± oral antibiotic	 weak negative weak positive	 18 (60) 15 (50)
Preoperative fasting Light meal until 6 hours, clear fluids including oral carbohydrate drinks until 2 hours	strong positive	5 (16.6)
Pre-anaesthetic medication Preoperative multimodal analgesia Sedative/anxiolytics	 weak positive weak negative	 25 (83.3) 18 (60)
Intraoperative phase		
Prophylactic antibiotics	strong positive	30 (100)
Skin preparation by chlorhexidine	strong positive	19 (63.3)
Anaesthetic protocol Epidural analgesia (for >72 hours after surgery) Multimodal analgesia Protective ventilation Cardiac output monitoring Deep neuromuscular block and reversal by specific antagonists Prevention of intraoperative hypothermia Intraoperative glycaemic control Advanced monitoring to guide fluid therapy	 strong positive weak positive strong positive strong positive weak positive strong positive strong positive strong positive	 21 (70) 25 (83.3) 25 (83.3) 28 (93.3) 20 (66.6) 28 (93.3) 24 (80) 19 (63.3)
Prophylactic abdominal drains	weak positive	27 (90)
Prophylactic thoracostomy after diaphragmatic peritonectomy ± full thickness muscle resection	weak positive	1 (3.3)
Postoperative phase		
Prophylactic nasogastric drainage	weak negative	16 (53.3)
Avoidance of antibiotic prophylaxis	weak positive	21 (70)
Early removal of urinary catheter (within the morning of postoperative day 3)	strong positive	30 (100)
Early oral intake resumption clear liquids on the day of surgery solid food from postoperative day 1	 strong positive strong positive	 14 (46.6) 22 (73.3)
Mobilisation as early as the day of surgery (out of bed)	strong positive	0 (0)
Post-operative nausea and vomiting Use of antiemetic drugs Total intravenous anaesthesia	 strong positive weak positive	 30 (100) 6 (20)
Pharmacological thromboprophylaxis until 4 weeks after surgery	strong positive	25 (83.3)