

the patients were discussed at an MDT when they experienced subsequent relapses indicating reduced access to a multidisciplinary care. *BRCA* mutation status was considered the most important biomarker. Whilst HRD status was also considered important, at the time of the survey this was not routinely assessed, highlighting issues with test availability. The use of active surveillance was expected to decrease in favour of targeted therapies such as PARPi as the treatment pathway evolves.

121 EFFECT OF SURGICAL PARADIGM CHANGE ON OVERALL SURVIVAL IN PATIENTS WITH ADVANCED EPITHELIAL OVARIAN CANCER

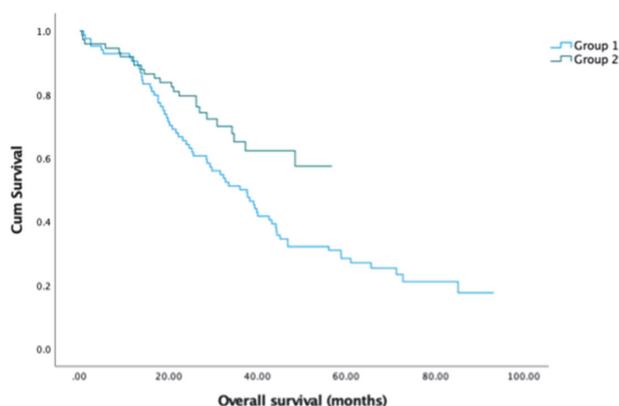
N Norppa*, S Saarelainen, S Staff, A Auranen. *Tampere University Hospital, Department of Obstetrics and Gynecology, Tampere, Finland*

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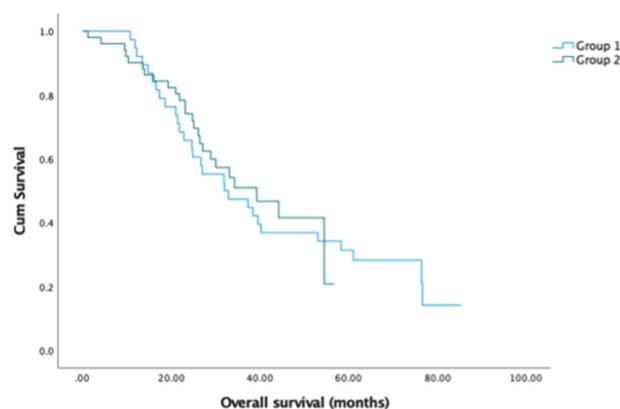
Introduction/Background* Ultra-radical procedures have been introduced into surgical treatment of advanced epithelial ovarian cancer to better reach the goal of resection of all visible tumor from the abdominal cavity. This has enabled surgical treatment for patients with advanced and more widespread disease. The aim of this study was to evaluate the effect of this change in surgical paradigm on overall survival.

Methodology We collected retrospectively 247 patients with FIGO Stage IIIB-IVB ovarian, tubal and primary peritoneal carcinoma operated between 2013 and 2019 either by primary or interval cytoreduction in Tampere University Hospital. Patients were categorized into two groups and compared based on the date of the operation. Group 1 was operated between January 2013 and February 2016. Group 2 was operated between March 2016 and March 2019, during which time the change in surgical approach occurred. Groups were similar in age, ASA classification, tumor histology and primary vs interval debulking surgery rate. Patients were followed up to November 2020.

Result(s)* Complete cytoreduction (R0) increased from 14% to 54% in Stage III patients and from 23% to 49% in Stage IV patients after the change in surgical approach towards ultra-radical surgery. The proportion rate of Stage IV patients increased slightly from 31% in Group 1 to 40% in Group 2 ($p=0.145$). The median follow-up was 28.7 months (0.5–92.7). In all stages combined, the median OS increased from 33.5 months in Group 1 to 54.5 months in Group 2 ($p=0.028$). The median OS for stage III patients in Group 1



Abstract 121 Figure 1



Abstract 121 Figure 2

was 36.1 months (27.4 – 44.8) but could not be reached in Group 2 ($p=0.009$). In Stage IV patients, OS was 32.0 months (16.4 – 47.7) and 39.3 months (24.8 – 53.8) in Group 1 and 2, respectively ($p=0.691$).

Conclusion* The change of surgical approach towards ultra-radical techniques improves overall survival of patients with advanced epithelial ovarian cancer, but the survival benefit is only seen in stage III patients.

122 PREOPERATIVE IMAGING ASSESSMENT OF PERITONEAL CANCER INDEX (PCI): CONCORDANCE WITH SURGICAL FINDINGS IN ADVANCED OVARIAN CANCER. A PROSPECTIVE STUDY

¹S Greggi*, ²O Catalano, ²SV Setola, ¹G Casella, ¹G Laurelli, ¹F Scala, ³V Simeone, ²C Granata, ²A Petrillo, ¹C Scaffa. ¹Istituto Nazionale Tumori IRCCS "Fondazione G. Pascale", Department of Gynecologic Oncology, Naples, Italy; ²Istituto Nazionale Tumori IRCCS "Fondazione G. Pascale", Department of Radiology, Naples, Italy; ³Università degli Studi della Campania "Luigi Vanvitelli", Department of Medical Statistics, Naples, Italy

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Introduction/Background* The extent of peritoneal spread in advanced ovarian cancer (AOC) heavily impacts on the chance of a complete surgical cytoreduction. The decision-making process on the feasibility of cytoreductive surgery should include a dedicated imaging evaluation. The aim of this study was to prospectively compare a radiologic Peritoneal Cancer Index (rPCI) with the surgical PCI (sPCI).

Methodology 128 consecutive AOC patients planned for cytoreductive surgery underwent preoperative contrast-enhanced Computed Tomography (CT) scan to calculate the rPCI, then the sPCI was determined intraoperatively. CT scans were performed by two dedicated radiologists, and re-evaluated by a third. The rPCI correlation with sPCI was calculated by Lin's Concordance Correlation Coefficient (CCC), and represented by Bland-Altman agreement plot and Passing-Bablok regression line.

Result(s)* Primary debulking surgery (PDS), and interval debulking surgery (IDS) were performed in 88 and 40 patients, respectively (complete cytoreduction in 56.8% PDS and 67.5% IDS). Overall, mean±SD rPCI was 16.2±6.4 (95%CI:15.1-17.3) and sPCI 14.7±6.9 (95%CI:13.5-15.9), showing a moderate correlation between preoperative CT scan and surgical findings (figures 1-2, CCC=0.64). The best concordance was reported for PDS vs. IDS (CCC=0.64 vs. 0.60) and in middle-high abdominal vs. low quadrants (CCC=0.57 vs. 0.40), while rPCI overestimated ileo-jejunal spread (CCC=0.21).