Abstract 266 Figure 1 Patient recruitment. Patients were recruited from the Department of Gynecology at Freiburg University Hospital between July 2013 and July 2015. Data and samples of 43 of the patients were analyzed with an age range of 19 to 81 years

Conclusion* The calculated formula with the combination of CA125, HE4, OPN, leptin and prolactin plasma levels surpasses each single marker in its diagnostic value to discriminate between benign and malignant ovarian tumors. The formula, applied to our patient population was highly accurate but should be validated in a larger cohort.

267 OUTCOME QUALITY STANDARDS IN ADVANCED OVARIAN CANCER SURGERY

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Introduction/Background* Advanced ovarian cancer surgery (AOCS) frequently results in serious postoperative complications. Because managing AOCS is difficult, some standards need to be established that allow surgeons to assess the

quality of treatment provided and consider what aspects should improve. This study aimed to identify quality indicators (QIs) of clinical relevance and to establish their acceptable quality limits (i.e., standard) in AOCS.

Methodology We performed a systematic search on clinical practice guidelines, consensus conferences, and reviews on the outcome and quality of AOCS to identify which QIs have clinical relevance in AOCS. We then searched the literature (from January 2006 to December 2018) for each QI in combination with the keywords of advanced ovarian cancer, surgery, outcome, and oncology. Standards for each QI were determined by statistical process control techniques. The acceptable quality limits for each QI were defined as being within the limits of the 99.8% interval, which indicated a favorable outcome.

Result(s)* A total of 38 studies were included. The QIs selected for AOCS were complete removal of the tumor upon visual inspection (complete cytoreductive surgery), a residual tumor of < 1 cm (optimal cytoreductive surgery), a residual tumor of > 1 cm (suboptimal cytoreductive surgery), major morbidity, and 5-year survival. The rates of complete cytoreductive surgery, optimal cytoreductive surgery, suboptimal cytoreductive surgery, morbidity, and 5-year survival had quality limits of < 27%, < 23%, > 39%, > 33%, and < 27%, respectively.

Conclusion* Our results provide a general view of clinical indicators for AOCS. Acceptable quality limits that can be considered as standards were established.

268 VALIDATION OF THREE PREDICTIVE MODELS FOR SUBOPTIMAL CYTOREDUCTIVE SURGERY IN ADVANCED OVARIAN CANCER

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Introduction/Background* The standard treatment for advanced ovarian cancer (AOC) is cytoreduction surgery and adjuvant chemotherapy. Tumor volume after surgery is a major

Complete cytoreductive surgery (CCS) rate (P-chart).

Abstract 267 Figure 1 Complete cytoreductive surgery (CCS) rate (P-chart). Each dot represents an included study. The gray area (standard zone) is within the 95% confidence interval, the blue area (alert zone) is between the 95% and 99.8% confidence intervals, and the white area (alarm zone) is outside the 99.8% limit

Abstract 268 Figure 1

Abstract 268 Figure 2 Comparative graph of the ROC curves for the different models

prognostic factor for these patients. The ability to perform complete cytoreduction depends on the extent of disease and the skills of the surgical team. Several predictive models have been proposed to evaluate the possibility of performing complete cytoreductive surgery (CCS).

Methodology External validation of the prognostic value of three predictive models (Fagotti index and the R3 and R4 models) for predicting suboptimal cytoreductive surgery (SCS) in AOC was performed in this study. The scores of the 3 models were evaluated in one hundred and three consecutive patients diagnosed with AOC treated in a tertiary hospital were evaluated. Clinicopathological features were collected prospectively and analyzed retrospectively. The performance of the three models was evaluated, and calibration and discrimination were analyzed.

Result(s)* The calibration of the Fagotti, R3 and R4 models showed odds ratios of obtaining SCSs of 1.5, 2.4 and 2.4, respectively, indicating good calibration. The discrimination of the Fagotti, R3 and R4 models showed an area under the ROC curve of 83%, 70% and 81%, respectively. The negative

predictive values of the three models were higher than the positive predictive values for SCS.

Conclusion* The three models were able to predict suboptimal cytoreductive surgery for advanced ovarian cancer, but they were more reliable for predicting CCS. The R4 model discriminated better because it includes the laparotomic evaluation of the peritoneal carcinomatosis index.

270 POSTOPERATIVE INTESTINAL FISTULA IN PRIMARY ADVANCED OVARIAN CANCER SURGERY

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Introduction/Background* Advanced ovarian cancer (AOC) requires an aggressive surgery with large visceral resections in order to achieve an optimal or complete cytoreduction and increase the patient's survival. However, the surgical aggressiveness in the treatment of AOC is not exempt from major complications, such as the gastrointestinal fistula (GIF), which stands out among others due to its high morbidity and mortality.

Abstract 270 Figure 1 Disease-free survival according to the existence or absence of GIF