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MANAGEMENT OF PATIENTS WITH ADVANCED STAGE EPITHELIAL OVARIAN CANCER: RESULTS OF A NATIONAL FRENCH SURVEY ON CURRENT PRACTICES IN 2021

¹L Drouin*, ^{2,3}B Guani, ²V Balaya, ⁴H Azais, ⁵S Betrian, ⁶PA Bolze, ⁷Y Dabi, ⁸Y Kerbage, ⁹C Sanson, ⁹F Zaccarini, ^{2,3}P Mathevet, ¹⁰F Lécure, ¹¹F Guyon, ¹²C Akladios, ¹³S Bendifallah, ¹⁴E Deluche. ¹CHU de Limoges, Department of Gynecology, Limoges, France; ²CHUV, Gynecology, Lausanne, Switzerland; ³UNIL, Faculty of Biology and Medicine, Lausanne, Switzerland; ⁴Georges Pompidou European Hospital, Gynecologic and Breast Oncologic Surgery Department, Paris, France; ⁵IUCT Oncopole, Department of Medical Oncology, Toulouse, France; ⁶CHU Lyon Sud, Department of Gynecology, Lyon, France; ⁷Tenon Hospital, AP-HP, Département of Gynecology, Paris, France; ⁸Jean de Flandre Hospital, Département of Gynecology, Lille, France; ⁹Gustave Roussy Institute, Surgical Oncology Department, Villejuif, France; ¹⁰Curie Institute, Breast, Gynecology and reconstructive surgery unit, Paris, France; ¹¹Bergonié Institute, Surgical oncology Department, Bordeaux, France; ¹²University Hospital of Strasbourg, Department of Obstetrics and Gynecology, Strasbourg, France; ¹³Tenon Hospital AP-HP, Department of Gynecology, Paris, France; ¹⁴CHU de Limoges, Department of Medical Oncology, Limoges, France

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Introduction/Background* The management of ovarian cancer has rapidly become more complex in recent years due to surgical and medical advances. The aim of this study was to assess French current practice in management of patients with advanced epithelial ovarian cancer.

Methodology An anonymous survey was sent to the SFOG, GINECO-ARCAGY and FRANCOGYN members. The survey consisted of 58 items divided in five sections dealing with diagnostic staging, pathological and genetic data, surgical practice patterns, adjuvant/neoadjuvant treatment, and follow-up strategies.

Result(s)* Overall, 107 answers were available. Most of participants were obstetrician-gynecologists (37.4%), surgical oncologists (34.6%), and medical oncologists (17.8%). Most of participants came from University Hospitals (40.2%) and Comprehensive Cancer Center (37.4%).

For 76.8% of respondents, less than 50% of patients are eligible for primary debulking surgery. In case of neoadjuvant chemotherapy, surgical resectability is assessed after 3 cycles for 92.7% of respondents. LION study's criteria were always applied during primary surgery for 69.5% of respondents. Hyperthermic Intraperitoneal Chemotherapy (HIPEC) is used as a first-line treatment for 41.4% of respondents (26.8%

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within clinical trial and 14.6% outside) and during interval surgery for 37.8% of respondents.

According to the completeness of cytoreduction surgery and the BRCA mutation status, association of Paclitaxel-Carboplatin (every 3 weeks) is the most used combination as adjuvant chemotherapy for 69.7 to 84.8% of respondents and bevacizumab 15mg/kg is used in case of no residual disease for 52.9 to 61.7% of respondents.

In case of BRCA1-2 mutations, Olaparib is given by 75.8% to 84.8% of respondents. The delay to obtain BRCA germline mutation results is less than 1 month for 26.5% of respondents and less than 3 months for 76.5% of respondents. An Homologous Recombination Repair Deficiency is searched for 73.5% of respondents and mainly by Myriad test (91.3%).

Conclusion* In our study, the rate of HIPEC was high because 2 clinical trials are currently ongoing in France on HIPEC as 1st line treatment.

Our results provide an interesting picture of current management in France in relation to International Guidelines. They provide a basis for further research and raise the question of updating guidelines for ovarian cancer management.

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RELATIONSHIP AMONG SURGICAL COMPLEXITY, EARLY AND LATE MORBIDITIES, AND SURGICAL TIMING IN ADVANCED OVARIAN CANCER

¹D Ferraioli*, ²L Fuso, ³F Beurrier, ¹P Meeus, ⁴H Lorraine, ¹I Ray-Coquard, ¹N Chopin. ¹Léon Bérard Center, Lyon, France; ²Mauriziano Umberto Hospital, Torino, Italy; ³Caluire-et-Cuire, Surgical Oncology, Caluire-et-Cuire, France; ⁴Institute Cancer De Lorraine – Alexis Vautrin, Vandœuvre-lès-Nancy, France

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Introduction/Background* Epithelial ovarian cancer (EOC) requires an aggressive surgical approach. The type and the number of procedures performed during primary (PDS) or interval (IDS) debulking surgery in order to achieve no residual disease are associated with considerable morbidities.

The objective is to describe a relationship among surgical complexity, early and late morbidities, and surgical timing in advanced EOC.

Methodology A retrospective study was performed at Leon Berard Cancer Center between 2006 and 2018. Surgical complexity was classified into three groups (standard, radical and ultra-radical surgery) based on the type and the number of procedures performed during PDS or IDS for advanced EOC. During the 30- and 90-day period after the surgery, the post-operative complications were registered according to the Clavien-Dindo classification.

Diagnostic initial workup and staging

Abstract 301 Figure 1

Abstracts

Result(s)* 311 patients with advanced EOC were included. 84 patients underwent PDS (27%) and 227 IDS (73%), respectively.

No residual disease was achieved in 258 out of 311 patients (83%). Standard surgery was performed in 80 patients (25.7%), radical surgery in 45 patients (14.5%) and ultra-radical surgery in 186 patients (59.8%). No residual disease was reached in 72 out of 80 standard surgery (90%), 37 out of 45 radical surgery (82.2%) and 149 out of 186 (80.1%) ultra-radical surgery.

Early and late severe (G3-4) complications were present in 32/311 patients (10.3%) and 23/311 patients (7.4%), respectively. Increased postoperative morbidity was directly related to the following perioperative factors: HIPEC [OR 4.4 (1.0-20)], addition of each single surgical procedures to the standard surgery [OR 1.3 (1.1-1.5)], number of surgical procedures added to modified pelvic posterior exenteration [OR 1.4 (1.1-2.0)], surgical complexity [SR vs S or R; OR 2.4 (1.1-5.7)].

In multivariate analysis, OS is not correlated with surgical complexity [OR 1.0(0.5-2.1)] and with the burden of early [OR 0.7(0.3-1.5)] or late [OR 0.7(0.3-1.7)] severe complications.

Conclusion* Despite surgical timing, ultra-radical-surgery is needed to reach no residual disease in >80% of our patients. The risk of early and late severe morbidities is increased for complex surgeries but they don't affect OS. Risk stratification should be used to plan perioperative care and best treatment.

315 ERAS LEADS TO FEWER HOSPITAL COSTS IN ADVANCED OVARIAN CANCER SURGERY: A SECONDARY OUTCOME OF THE PROFAST TRIAL

¹V Bebia Conesa*, ¹S Rodríguez Conde, ¹PB Asuncion, ²Y Cossio Gil, ¹A Gil-Moreno, ²JL Sánchez Iglesias. ¹Hospital Universitari Vall d'Hebron, Gynecologic Oncology Unit, Barcelona, Spain; ²Hospital Universitari Vall d'Hebron, Information Systems, Barcelona, Spain

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Introduction/Background* Enhanced recovery after surgery (ERAS) programs in advanced ovarian cancer (AOC) surgery

have been developed in the last few years. The PROFAST randomized controlled trial showed that ERAS was associated with a decrease on length of stay and readmission. Here, we present the results of a secondary outcome, cost analysis, of the PROFAST trial.

Methodology The PROFAST trial was a prospective, interventional randomized clinical trial that enrolled women undergoing surgery for either suspected or diagnosed advanced ovarian cancer, at a reference hospital in gynecologic oncology in Barcelona (Spain). Patients were treated following either an ERAS protocol or conventional management (CM) protocol. The primary outcome was to evaluate reduction in length of stay (LOS). One of the secondary outcomes was to perform cost analysis between both groups.

Cost estimations were performed by two strategies: gross counting (cost of inpatient care, intensive care unit and surgery care), and microcosting (costs associated to image testing and laboratory). In both cases, costs were based on 2014 cost data. A sensitivity analysis of cost savings in different scenarios was performed. This trial was registered at ClinicalTrials.gov (NCT02172638).

Result(s)* From June 2014 to March 2018, 110 women were recruited, of which eleven were excluded. The ERAS group comprised 50 patients, and the CM group, 49 patients. LOS. Although mean overall cost per patient was higher in ERAS vs CM (14347 € vs 12597€), ERAS cost distribution was skewed by two patients that accounted for 48% of total intensive care unit costs. Comparing median costs, ERAS costs were significantly lower than CM costs (7642€/patient vs 8594€/patient, P=.0275). Decrease in hospital readmission rates led to higher readmission costs in the CM group (Total costs 6126€ v 125725€, P=.028). Sensitivity analysis

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	ERAS group	Conventional group	Difference
Worst scenario	9 median days 3,507 €	12 median days 4,654.01 €	3 median days -1,146.63 €
Best scenario	5 median days 1,949 €	7 median days 2,714.84 €	2 median days -766.30 €

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Resources	ERAS (n: 50 patients)				Conventional group (n: 49 patients)				p-value*
	Total	Mean	Median	IQR	Total	Mean	Median	IQR	
Cost in wards									
First hospitalization in ward	180.888 €	3.618 €	2.848 €	2.085 €	204.255 €	4.169 €	3.280 €	2.193 €	0,0588
Readmission day in ward	5.894 €	118 €	0 €	0 €	59.303 €	1.210 €	0 €	0 €	0,0287
Total cost	186.783 €	3.736 €	2.849 €	2.098 €	263.558 €	5.379 €	3.430 €	3.021 €	0,0143
Surgical costs									
Primary surgical program	195.669 €	3.913 €	3.638 €	1.012 €	184.997 €	3.775 €	3.697 €	1.022 €	0,3253
Reinterventions	0 €	0 €	0 €	0 €	10.750 €	219 €	0 €	0 €	0,0771
Total cost	195.669 €	3.913 €	3.638 €	1.012 €	195.747 €	3.995 €	3.697 €	1.070 €	0,2312
Image test and lab									
Image test and lab at first hospitalization	31.789 €	662 €	231 €	499 €	19.650 €	401 €	238 €	468 €	0,5421
Image test and lab at readmissions	322 €	6 €	0 €	0 €	4.607 €	94 €	0 €	0 €	0,0455
Total cost	32.111 €	642 €	205 €	474 €	24.257 €	495 €	265 €	490 €	0,1673
ICU cost									
Total ICU cost at first hospitalization	302.761 €	6.582 €	925 €	350 €	82.633 €	1.836 €	964 €	233 €	0,7209
Total ICU cost at readmissions	0 €	0 €	0 €	0 €	51.065 €	1.042 €	0 €	0 €	0,151
Total cost	302.761 €	6.055 €	900 €	337 €	133.698 €	2.729 €	964 €	296 €	0,6093
Total cost of inpatient resources									
Total cost first hospitalization	711.108 €	14.222 €	7.642 €	3.062 €	491.535 €	10.031 €	8.236 €	4.015 €	0,089
Total cost readmissions	6.216 €	124 €	0 €	0 €	125.725 €	2.569 €	0 €	0 €	0,0287
Total cost	717.324 €	14.347 €	7.642 €	3.062 €	617.260 €	12.597 €	8.594 €	4.693 €	0,0275