value of 90.2% for intra-operative detection of diaphragmatic disease

Conclusion* Whilst it is accepted that CT is a poor predictor of diaphragmatic disease, we suggest our figures may be

Abstract 543 Figure 1

Abstract 543 Figure 2

additionally compounded by a local radiological focus on identification of surgical stopping-points in the context of a unit with a well-established ultra-radical service and experience of diaphragmatic surgery. Gynaecological-oncologists should, however, remain mindful of the limitations of CT and hence approach all relevant cases with the anticipation of encountering diaphragmatic disease.

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DIAGNOSTIC AND THERAPEUTIC APPROACHES FOR PATIENTS WITH A STIC LESION – RESULTS OF THE AGO OVAR QUESTIONNAIRE BASED SURVEY IN GERMANY

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Introduction/Background* Despite growing understanding of the carcinogenesis of high-grade serous ovarian cancer and its precursor lesion serous tubal intraepithelial carcinoma (STIC), there is a lack of evidence based recommendations for the clinical management of patients with a STIC lesion.

Methodology We created 23 questions to explore the experience with STIC patients and the diagnostic, surgical and histopathological approaches and used SoSci Survey to host the questionnaire. We invited all German directors of gynecological departments to participate.

Result(s)* 550 colleagues were invited. 131 questionnaires (response rate 24.3%) were returned and included in this survey. 45.8% of the respondents treated one to three STIC patients. 76.0% of the participants performed opportunistic bilateral salpingectomies during other gynecological interventions. Most of the participants requested the SEE-FIM protocol from their pathologists since 2017. It was used by 54.2% for prophylactic salpingectomies, by 28.1% for both prophylactic and opportunistic salpingectomies and by 17.7% for neither of both. In a case of a STIC lesion 58.8%, 2.4%, 37.6% of participants used the laparoscopic, transvers- or longitudinal laparotomic approach, respectively. The respondents performed a hysterectomy, bilateral ovariectomy or affected side ovariectomy in pre- and postmenopausal patients in 25.6% (54.6%), 24.42 (88.4%) and 50.0% (4.6%), respectively (all p-values >0.001). Omentectomy, pelvic and para-aortic lymphadenectomy were performed in pre- and postmenopausal women in 60.5% (63.9%), 9.30% (11.6%) and 9.3% (11.6%) (all p-values <0.05).

Conclusion* This survey highlights significant inconsistency in the management of patients with a STIC lesion. Further studies are urgently warranted to elucidate the clinical impact and the necessary therapeutic approach of STIC lesions.

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UTERINE SEROUS CARCINOMA MIMICKING ADVANCED OVARIAN CANCER. ARE THERE CLUES TO PRE-OPERATIVE DIAGNOSTIC DIFFERENTIATION? A MINI CASE SERIES

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Introduction/Background* The clinical presentation of advanced USC may overlap significantly with that of serous carcinoma of tubo-ovarian origin. Differentiation facilitates patient counselling; guides choice of imaging; accurately stages; and fully informs MDT discussion – bearing in mind primary surgery as the treatment of choice for the less chemo-sensitive USC.

Methodology Cases of serous carcinoma initially presumed of tubo-ovarian origin, but confirmed on final histopathology as USC, were identified and patient care records reviewed retrospectively.

Result(s)*

Three cases were identified Mean age 75.7years. All presented with pain, distension but no post-menopausal bleeding. Each had an elevated CA125. Initial CT reported disseminated disease. Image-guided biopsy reported serous carcinoma. All three specimens were positive for p16, p53 and CA125; but only two WT1 positive (with focal/weak pattern) and one WT1 negative. After MDT discussion, all patients underwent neoadjuvant chemotherapy for presumed stage IIIc/IV tubo-ovarian serous carcinoma. Delayed primary surgery achieved R0 in all cases. Whilst final histopathology confirmed serous carcinoma, the diagnosis was amended to USC in each – arising from an endometrial polyp (mean size 16mm) in all three women.

Conclusion* Whilst several immunohistochemical markers are universal between the tumour types, the literature suggests

Abstract 552 Figure 1 Diffuse strong WT1 staining of tubo-ovarian HGSC v focal weak WT1 staining of USC

that the majority (94.7%) of serous carcinomas of tubo-ovarian origin exhibit positive WT1; compared to only 10-20% of USC. Further distinction arises in the pattern of WT1 positivity – strong/diffuse in tubo-ovarian versus focal/weak in the cross-over USC group. This correlates with our case series. We suggest that in disseminated serous carcinoma with negative WT1 or focal/weak positivity pre-operative hysteroscopy/biopsy is considered. Whilst this may not always alter management, for patients on the border of suitability for primary surgery a preparedness to exert maximal surgical effort may be favoured on identifying USC.

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WHY PREFER DIFFUSION MRI OVER CT IN DIAGNOSTICS, STAGING AND DETECTION OF RECURRENCE IN OVARIAN CANCER PATIENTS? INTERESTING ILLUSTRATIVE CASES

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Introduction/Background* Correct pre-operative staging and operability assessment is crucial for ovarian cancer (OC) patients' treatment decision. Diffusion weighted MRI (DW-MRI) is a functional imaging technique, which is sensitive e.g. in detecting peritoneal, diaphragmatic, liver capsular and bowel serosal carcinomatosis and has potential in the future to guide therapy assessments in personalized direction. Yet, DW-MRI is seldom used in daily clinical routine in OC.

Methodology We informed the gynecologist oncologist colleagues in our ESGO certified university hospital tumor center about the 3-Tesla whole-body DW-MRI modality, possible for OC. Until now, 25 patients are referred and included to the study. Acquisition time from the neck to symphysis requires 30 minutes and the protocol does not include contrast medium. Six women were referred because of suspicion on chemical or symptomatic recurrence (REC), 10 for the follow-up staging (F-up) after cancer therapy and six for primary

Abstract 552 Figure 2 Suggested pre-operative algorithm to distinguish USC v HGSC of tubo-ovarian origin