done, the trocar is reinserted into the peritoneal space, always through the same incision, to perform the endoscopic lymphadenectomy and bilateral pelvic lymphadenectomy, along with the hysterectomy. The procedure was undertaken for a 66 years old patient, with a supposed FIGO IC2 ovarian tumour previously diagnosed after a trans-umbilical single-port endoscopic bilateral adnexectomy.

Result(s)* The intervention has been successful in this patient with FIGO stage IC2 ovarian cancer with a duration of 5 hours. Recent history of bilateral adnexectomy did not cause gas leakage from the retroperitoneal space. 48 lymph nodes were retrieved, all free from disease. No complications occurred.

Conclusion* We describe here a promising technique that combines all the advantages of the two previously described retroperitoneal accesses without their disadvantages. It can also be extended to any other type of retroperitoneal surgery.

759 EFFECTIVENESS OF BEVACIZUMAB IN PLATINUM-RESISTANT RECURRENT EPITHELIAL OVARIAN CANCER

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Introduction/Background* bevacizumab is an anti-VEGF monoclonal antibody that has shown efficacy in platinum-resistant recurrent epithelial ovarian cancer (EOC) in clinical trials. Our aim was to evaluate real-world effectiveness of bevacizumab in northern Portugal in this setting.

Methodology retrospective observational series of cases in a single comprehensive cancer center between 2015 and 2020. We reviewed consecutive medical records of platinum-resistant recurrent EOC patients, who underwent bevacizumab with chemotherapy (CT). Primary endpoint was overall survival (OS). Secondary endpoints were overall response rate (ORR), progression free survival (PFS) and safety according to CTCAE v4.0. Descriptive analysis of main demographic, clinical and treatment variables were performed. Kaplan-Meier method was used for OS and PFS.

Result(s)* 21 EOC patients with median age of 61 years (47-72 years). Majority were FIGO stage III (10, 47.6%) or IV (8, 38.1%) and had high-serous morphology (11, 52.5%). Most patients had been previously submitted to up-front (42,9%) or interval (42,9%) debulking surgery. All underwent platinum-based CT as 1st line of treatment (LOT). At baseline, more than half of the patients (57.4%) had previously undergone 2 or more LOT. Median number of cycles of bevacizumab was 9 (2-62), concomitant with pegylated liposomal doxorubicin in 10 (47.6%), paclitaxel in 8 (38,1%) and topotecan in 3 (14.3%) patients. Median follow-up time was 19.3 months (4.9-40.8 months). ORR was 42.9%: 2 (9,5%) complete response and 7 (33.3%) partial response. Nine patients (42.9%) had stable disease. Median OS was 25.8 months [IC95% 11.3-40.3] and PFS 10.8 months [IC95% 7.0-14.7]. Grade ≥ 3 hypertension incidence was 14.3% and grade ≥ 3 proteinuria 4.8%. There was one death due to gastrointestinal fistula (4.8%).

Conclusion* bevacizumab had the predictable safety profile, with better effectiveness than the published in clinical trials, reflecting the small number of patients included in our real-

world unicentric series. Nevertheless, new molecular biomarkers and clinical trials urge to improve outcomes in platinum-resistant recurrent ovarian cancer patients in clinical practice.

766 IS LAPAROSCOPIC INTERVAL DEBULKING SURGERY ACHIEVABLE FOR ADVANCED OVARIAN CANCER AFTER NEOADJUVANT CHEMOTHERAPY?

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Introduction/Background* Standard treatment of advanced ovarian cancer is complete cytoreductive surgery, historically done by laparotomy, and survival is directly linked to the residual tumor at the end of surgery. When optimal upfront surgery is not achievable, neoadjuvant chemotherapy (NACT) followed by interval debulking surgery (IDS) is an alternative. Laparoscopy as IDS for advanced ovarian cancer is controversial. We wanted to evaluate the feasibility of laparoscopic IDS compared to laparotomy by analyzing overall survival (OS) and progression free survival (PFS), as well as per and post-operative morbidity.

Methodology We conducted a retrospective cohort study and included patients with IDS avec neoadjuvant chemotherapy for advanced ovarian cancer. We included patients with stage III or IV FIGO (International Federation of Gynecology and Obstetrics) serous ovarian cancer who had no residual disease after IDS. We applied a propensity score to match patients on confounding factors.

Result(s)* We included 37 patients in the laparoscopy group and 40 in the laparotomy group, from the 1st of January 2009 to the 1st of June 2019. Median overall survival was 23.1 months (95% CI 15.7-29.7) and 26.3 months (95% CI 21.7-31.7) for women who underwent laparoscopy and laparotomy, respectively (p=0.17). Median PFS was 14.8 months (95% CI 10.6-21.5) for the laparoscopy group and 12 months (95% CI 11-15.1) for the laparotomy group (p=0.057). After applying the propensity score, we included 25 patients in each group with similar baseline characteristics. OS was modified with a HR of 0.45 (CI 95% 0.19-0.95) p = 0.04 in favor of laparoscopy. Laparotomy group had more early post-operative complications (17 versus 6 in the laparoscopy group, P=0.01) and a longer hospitalization time (7.5 days compared to 12.1 days, p<0.001).

Conclusion* Oncological outcome was better in patients with similar pre-operative characteristics who underwent laparoscopic IDS. Laparoscopic IDS is a safe alternative for laparotomy in selected patients and is associated with less post-operative morbidity.

770 IMPACT OF SPLENECTOMY DURING INITIAL CYTOREDUCTIVE SURGERY IN ADVANCED STAGE EPITHELIAL OVARIAN CANCER; A NATIONWIDE POPULATION-BASED STUDY

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Introduction/Background* Epithelial ovarian cancer (EOC) patients undergoing splenectomy during cytoreductive surgery represent a small subgroup of patients. Splenic metastases or technical reasons due to extensive upper abdominal disease may require a splenectomy. However, there is limited knowledge on the impact of splenectomy on the long-term outcome of patients. Particularly, it has been hypothesized that as the antitumor immunologic functions of the spleen may inhibit cancer growth, splenectomy may promote the growth of residual disease during the postoperative period as observed in murine models of other cancer types [3-6]. The aim of this study was to assess the effect of a splenectomy during cytoreductive surgery on perioperative outcomes and survival of advanced stage EOC patients.

Methodology In this nationwide population-based study, all consecutive patients diagnosed with FIGO stage IIIC and IV EOC between 01-01-2008 and 31-12-2015 were identified from the Netherlands Cancer Registry. Patients who underwent cytoreductive surgery combined with platinum-based chemotherapy as primary treatment were selected. Differences in clinicopathological characteristics between splenectomy and non-splenectomy patients were assessed. Progression-free survival (PFS) and overall survival (OS) were analyzed using Kaplan-Meier survival curves and log-rank tests. Cox proportional hazards models were used to adjust for covariates that influence survival.

Result(s)* A total of 3,911 patients were identified, including 99 splenectomy and 3,812 non-splenectomy patients. Splenectomy patients were more likely to undergo extensive surgery or surgical reintervention, to receive intraperitoneal chemotherapy, intraoperative and postoperative blood transfusion, to experience postoperative infections, and to be admitted to Intensive Care Unit (all $p < 0.002$). No significant differences in PFS and OS were observed between splenectomy versus non-splenectomy patients after adjusting for covariates.

*An additional 163 patients were excluded from the survival analysis with reference to figure 1, since these patients had unknown follow-up or survival data.

*An additional 10 patients were excluded from the survival analysis with reference to figure 1, since these patients had unknown follow-up or survival data.

Conclusion* While advanced stage EOC patients who undergo splenectomy during cytoreductive surgery have more extensive

Abstract 770 Figure 1 Kaplan-Meier estimates of the progression-free survival (PFS) of non-splenectomy patients (N = 3,654, dash line) and splenectomy patients (N = 94, solid line). The median PFS in months were 16 and 18 months for the non-splenectomy and splenectomy patients, respectively. No significant difference in PFS was observed with the log-rank test ($p = 0.477$).

Abstract 770 Figure 2 Kaplan-Meier estimates of the overall survival (OS) of non-splenectomy patients (N = 3,803, dash line) and splenectomy patients (N = 98, solid line). The median OS in months was 36 months for both the non-splenectomy and splenectomy patients. No significant difference in OS was observed with the log-rank test ($p = 0.306$).

disease and undergo intensive treatment, no adverse effect of splenectomy on the survival was observed. Splenectomy during cytoreductive surgery is justified to achieve complete cytoreduction in advanced stage EOC patients.

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CHANGES IN THEATRE UTILISATION FOLLOWING IMPLEMENTATION AND ESTABLISHMENT OF MAXIMAL EFFORT SURGICAL PHILOSOPHY FOR ADVANCED EPITHELIAL OVARIAN CANCER

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Introduction/Background* The most significant prognostic factors in AOC are platinum sensitivity and residual disease following cytoreductive surgery. In order to achieve complete (R0) cytoreduction advanced surgical procedures may be required, so called ultraradical (UR) surgery. Such a change from traditional pelvic centred surgery to abdominal and thoracic wide surgery increases operative time. We aimed to evaluate the change in operative time (OT) following the establishment of a maximum effort treatment paradigm.

Methodology We performed a retrospective study looking at all stage 3/4 epithelial ovarian, tubal and peritoneal cancers operated on between 2014 and 2020 inclusive in one Cancer Centre in the UK. 198 patients were looked at with two patients excluded for missing variables. Surgical complexity was classified by the surgical complexity score as advocated by Aletti. OT was measured in minutes. Continuous variables were expressed as mean and standard deviation. Categorical variables were analysed using chi-squared testing. Groups were compared using one-way ANOVA.

Result(s)* A total of 196 were included. Results identified increasing year-on-year OT (2014; 192 ± 88 vs. 2020; 426 ± 121 , $p < 0.0001$). In latter years, OT plateaued (2018; 366 ± 131 vs. 2020; 426 ± 121 , $p > 0.05$). During this time period the R0 rate increased from 61% to 96%, $p = 0.001$, achieved by more UR procedures, which increased from 13% to 71%, $p < 0.0001$ and intermediate/high complexity surgery from 34% to 86%, $p = 0.0003$. In 2014, when more standard procedures were being performed, mean OT was approximately 3 hours, excluding anaesthetic time (2014; mean OT