192 $\pm$ 88). As UR Surgeries increased to >50% of overall number of surgeries for advanced disease, the mean OT was a full operating day (2018; 367 $\pm$ 132, 2019; 375 $\pm$ 153 and 2020; 426 $\pm$ 122). Further increases in UR rates had less impact on OT (F(3,62)=1.11, $p>0.05$).

Conclusion* Effectively treating AOC patients requires appropriate theatre resources. We recommend that the standard of care for cytoreductive surgeries operated with maximal effort should be that only case is performed on that day. Funding and resource allocation for ovarian cancer surgery in the United Kingdom needs to reflect the greater theatre utilisation needed for these patients.

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ROLE OF OPTIMAL CYTOREDUCTION IN ADVANCED STAGE MALIGNANT OVARIAN GERM CELL TUMORS, DATA FROM THE MITO-9 TRIAL

¹A Bergamini*, ²C Cassani, ³F Raspagliesi, ³G Bogani, ¹L Bocciolone, ¹E Rabaiotti, ¹R Cioffi, ¹G Sabetta, ⁴G Scarfone, ⁵A Savarese, ⁶MG Ferrandina, ⁶F Mascilini, ⁷G Cormio, ^{8,9}G Giorda, ¹⁰S Pignata, ¹G Taccagni, ¹G Mangili. ¹IRCCS San Raffaele Hospital, Obstetrics and Gynecology, Milan; ²Fondazione I.R.C.C.S. Policlinico San Matteo, Pavia, Italy; ³Istituto Nazionale dei Tumori | Fondazione IRCCS, Milano, Italy; ⁴Mangiagalli Clinic IRCCS Cà Granda Foundation Ospedale Maggiore Policlinico, Milano, Italy; ⁵Ospedale Regina Elena, Roma, Italy; ⁶Agostino Gemelli University Policlinic, Roma, Italy; ⁷Ospedale Oncologico Giovanni Paolo II, Bari, Italy; ⁸Aviano, Italy; ⁹Oncology Referral Center, Aviano, Italy; ¹⁰IRCCS Istituto Nazionale Tumori "Fondazione G. Pascale"

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Introduction/Background* the role of optimal cytoreduction in advanced stage MOGCTs is still a debated issue, considering the high chemosensitivity of these tumors and young patients' age. The aim of the present study was to analyze the role of residual tumor at primary surgery in advanced stage MOGCTs.

Methodology clinicopathological data from patients with stage III-IV MOGCTs were retrospectively collected among MITO centers (Multicenter Italian Trials in Ovarian cancer

and gynecologic malignancies) and analyzed. All patients underwent primary surgery. Optimal cytoreduction was defined as macroscopic residual tumor=0. All patients received adjuvant platinum-based chemotherapy. Clinicopathological features were evaluated for association with relapse.

Result(s)* 42 patients were included. 18 (42.8%) were affected by dysgerminomas, 24 (57.2%) by non-dysgerminomatous MOGCTs. 24 patients (57.2%) achieved optimal cytoreduction at primary surgery (residual tumor=0). No statistical difference was detected in stage distribution, age, rate of optimal cytoreduction between the dysgerminomas and non dysgerminomatous groups. Median 5year- disease free survival (DFS) rates were 87.8% and 50.0% for dysgerminomas and non-dysgerminomas, respectively. In the whole cohort, there was no difference in terms of 5 years-DFS according to residual tumor at primary surgery (74.6% vs 56.0%, $p=0.25$). Residual tumor at primary surgery was a prognostic factor for DFS only for non-dysgerminomatous MOGCTs (64% vs 30% for optimal vs suboptimal cytoreduction, respectively, $p=0.05$).

Conclusion* in the present study, optimal cytoreduction at primary surgery was a prognostic factor affecting disease-free survival only for non-dysgerminomatous MOGCTs.

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IS THE SEROUS TUBAL INTRAEPITHELIAL CARCINOMA TO BLAME FOR PERITONEAL CARCINOMATOSIS AFTER RISK-REDUCING SALPINGO-OOPHORECTOMY?

¹MP Steenbeek*, ²J Bulten, ¹S Study Group, ³RPMG Hermens, ³J Inthout, ¹JA De Hullu. ¹Radboud university medical center, Obstetrics and Gynaecology, Nijmegen, Netherlands; ²Radboud university medical center, Pathology, Nijmegen, Netherlands; ³Radboud university medical center, Scientific Institute for Quality of Healthcare, Nijmegen, Netherlands

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Introduction/Background* After risk-reducing salpingo-oophorectomy (RRSO), there is an approximate 3.9% and 1.9% risk of developing peritoneal carcinomatosis (PC) for BRCA1/2

Abstract 781 Figure 1 The incidence of PC in women with and without STIC at RRSO.

pathogenic variant carriers, respectively. The origin of PC is yet unknown. However, as the origin of ovarian cancer probably lies in the Fallopian tube, the Serous Tubal Intraepithelial Carcinoma (STIC) may be the origin of PC as well. In this Individual Patient Data Meta-Analysis (IPDMA), we determine the risk of PC for *BRCA1/2* pathogenic variant carriers with and without STIC at RRSO.

Methodology We performed a systematic search of MEDLINE, EMBASE and Cochrane on studies providing follow-up in *BRCA*-mutation carriers after RRSO. Individual patient data was extracted and the authors of eligible studies were contacted to complete this data. Additionally, we retrospectively collected data from the Radboudumc (Nijmegen, the Netherlands), Kaiser Permanente (San Francisco, USA) and MD Anderson (Houston, USA) of *BRCA1/2* pathogenic variant carriers undergoing RRSO.

Result(s)* After screening, 15 out of 2.151 studies were included. Including the retrospective case series, individual patient data was available for 3.121 women without STIC and 115 women with STIC at RRSO. The median age (range) was 46 (24-80) of women without and 52 (36-77) for women with STIC. The hazard ratio to develop PC after RRSO was 29.3 for women with STIC compared to women without STIC at RRSO ($P < 0.001$) (figure 1). The five-year risk to develop PC was 0.4% (0.2%-0.7%) for women without STIC and 12.6% (5.2%-19.3%) for women with STIC. The respective ten-year risks are 0.9% (0.3-1.4) and 23.5% (10.6-34.5%). Additional sensitivity analyses did not alter the results.

Conclusion* From this IPDMA we conclude that *BRCA* pathogenic variant carriers with a STIC at RRSO are at increased risk to develop PC during follow-up. These results are important for clinical awareness and future research. The question arises whether a STIC should be considered as precursor or early stage ovarian cancer. Larger prospective-multicenter studies are needed to investigate the additional value of staging surgery and/or chemotherapy in case of STIC.

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SURVIVAL IN ADVANCED-STAGE OVARIAN CARCINOMA WITH HIGH VEGF-A EXPRESSION AFTER ADDITION OF BEVACIZUMAB. RESULTS FROM THE GERMAN ICON7 PATIENT COHORT

^{1,2,3}S Komoss*, ^{2,3}F Heitz, ⁴L Serna-Higuera, ^{2,5}TW Park-Simon, ^{2,6,7}A Belau, ^{2,8}L Hanker, ^{2,9}KR Kimmig, ^{2,10}N De Gregorio, ^{2,11}B Schmalfeldt, ^{2,12}K Baumann, ^{2,13}W Schroeder, ^{2,14}U Canzler, ^{2,15}J Sehouli, ^{2,16}A Burges, ^{2,17}F Hilpert, ⁴P Martus, ¹⁸A Reuß, ^{2,16}S Mahner, ^{2,3}P Harter, ^{2,19}J Pfisterer. ¹Tübingen University Hospital, Department of Women's Health, Tübingen, Germany; ²AGO Study Group, Wiesbaden, Germany; ³Kliniken Essen-Mitte, Department of Gynecology and Gynecologic Oncology, Essen, Germany; ⁴Tuebingen University Hospital, Institut für Klinische Epidemiologie und angewandte Biometrie; ⁵Hannover Medical School, Hannover, Germany; ⁶Frauenarztpraxis Dr. Belau, Greifswald, Germany; ⁷University Hospital Greifswald, Greifswald, Germany; ⁸University Hospital Schleswig-Holstein, Campus Lübeck, Lübeck, Germany; ⁹University Hospital Essen, Essen, Germany; ¹⁰SLK-Kliniken Heilbronn, Klinikum am Gesundbrunnen, Gynecology and Obstetrics, Heilbronn, Germany; ¹¹University Medical Center Hamburg-Eppendorf, Hamburg, Germany; ¹²Hospital Ludwigshafen, Gynecology and Obstetrics, Ludwigshafen, Germany; ¹³Gynaekologikum Bremen, Bremen, Germany; ¹⁴University Hospital Carl Gustav Carus, Technische Universität Dresden, Dresden, Germany; ¹⁵Charité – Universitätsmedizin Berlin, Campus Virchow, Berlin, Germany; ¹⁶University Hospital, LMU Munich, Department of Obstetrics and Gynecology, Munich, Germany; ¹⁷Krankenhaus Jerusalem Hamburg, Hamburg, Germany; ¹⁸Philipps-University Marburg, Coordinating Center for Clinical Trials, Marburg, Germany; ¹⁹Gynecologic Oncology Center, Kiel, Germany

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Introduction/Background* It has previously been demonstrated that bevacizumab may differentially improve ovarian cancer survival. TCGA classification as well as molecular targets of anti-VEGF therapy were shown to be associated with different levels of bevacizumab efficacy. Translation into individualized treatment options or improved disease outcome was yet hindered by inconsistent results across trials and tissue types. It was the aim of this project to validate retrospective analyses of GOG-0218 derived predictive value of microvessel density (CD31) and tumor VEGF-A.

Methodology CD31 and VEGF-A immunohistochemistry was performed on whole section FFPE tissue samples from the AGO-OVAR11 (ICON7) trial. Patients were stratified into high and low biomarker-expressing subgroups using median cutoffs. The association between biomarker expression and bevacizumab therapy efficacy was evaluated using a proportional Cox regression model. Efficacy endpoints were progression free survival (PFS) and overall survival (OS).

Result(s)* Complete CD31 and VEGF-A immunohistochemical data were available from 387 patients of the German ICON7 trial cohort. Among all biomarker subgroups, only patients with high VEGF-A expression levels had a statistically significant benefit from the addition of bevacizumab to standard chemotherapy. Median PFS and OS of VEGF-A high patients was 23.1 months (95% CI 15.9-30.2) and 64.9 months (median not reached) respectively if bevacizumab was added to standard chemotherapy but only 14.3 (95% CI 11.2-17) and 47.3 months (95% CI 5.6-36.3) in the control arm. In multivariable analysis, adjusted for age, FIGO and postoperative residual tumor, the anti-angiogenic therapy showed improved PFS (HR: 0.62 [95%CI 0.43-0.89], $p = 0.011$) and OS (HR 0.59 [95%CI 0.39-0.91], $p = 0.02$) among VEGF-A high patients. Patients with low VEGF-A expression levels showed no statistically significant improvement of PFS (HR 0.96 95% CI 0.67-1.38, $p = 0.83$) or OS (HR 1.06 95% CI 0.69-1.62, $p = 0.80$) after addition of bevacizumab. CD31 immunohistochemistry was not predictive for bevacizumab treatment effects in our cohort.

Conclusion* A potential predictive value of VEGF-A expression levels was observed in advanced stage ovarian carcinoma patients from the German ICON7 patient cohort, partly confirming GOG-0218 derived findings. Our results may help to develop biomarker stratified anti-VEGF therapy and hold potential to promote personalized treatment strategies in ovarian carcinoma patients.

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REAL-WORLD OF OVARIAN CANCER TREATMENT OUTCOMES IN NORTHERN PORTUGAL

J Savva-Bordalo*, M Magalhães, R Calisto, P Redondo, M Borges, A Petiz, MJ Bento, D Pereira. Porto, Medical Oncology, Porto, Portugal

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Introduction/Background* Epithelial ovarian cancer (EOC) is the fifth most lethal cancer in women in Portugal. Despite advances in surgical and anti-cancer systemic treatment (SACT), EOC overall prognosis remains poor. The objective of this study is to describe SACT outcomes patterns, including target therapies (bevacizumab and PARPi) using real-world data from a comprehensive cancer center, which serves Northern Portugal population.