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OVARIAN CANCER IN KAZAKHSTAN FOR 15 YEARS (2005–2020)

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Introduction/Background* According to Globocan 2020, ovarian cancer (OC) is the 11th most common cancer among women worldwide. It is more than 320,000 new cases of OC were registered each year and more than 200,000 deaths worldwide in 2020. To date, there are no recommended methods for screening of OC. More than 70 per cent of OC is detected in the late stages. In Kazakhstan (KZ), OC is the 3rd most common gynaecological cancer with the one of highest mortality rate in women. The proportion of OC among all cancers was 2.9% in 2020. The purpose of this study was to analyse OC incidence, mortality and survival for 15 years (2005-2020) in KZ.

Methodology Incidence data, mortality statistics were sourced from the cancer registry database. All incidence and mortality rates were directly age-standardised to the World Standard Population. Data on survival were obtained from specific reports. We used Kaplan-Meier method to estimate cumulative observed survival. The statistical processing was carried out with SPSS 23.0 for Windows

Result(s)* In KZ 14.125 new cases of OC have been diagnosed from 2005 to 2020. In the analysis of Standardized Incidence of OC, there is a stable rate for 10 years: 9.8 per 100,000 female population in 2005 and 10.0 per 100,000 female population in 2020. OC is found in all age groups and a noticeable increase in a group of 65-69 years. In the analysis of OC by stages is marked a decrease in the detection rate of the disease at the 4th stage for the period from 2005 to 2020, from 20 to 8.8%. Despite this, mortality from OC for ten years remains stable high and it is 4.6 per 100,000 female population in 2020. It is 7.458 women with OC who died from 2005 to 2020. Five-year relative survival for all stages of OC estimates of 20.3% (95%CI: 18.7-21.1).

Conclusion* Analysis of OC Incidence in KZ showed a stable rate. Despite the reduction in the detection of ovarian cancer at stage 4, mortality from this disease remains high. According to these results, Kazakhstan is among the counties with low five-year OC survival.

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RADIOTHERAPY IS AN EFFECTIVE TREATMENT OPTION FOR RECURRENT OVARIAN ADULT GRANULOSA CELL TUMOURS

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Introduction/Background* The management of recurrent adult granulosa cell tumour (AGCT) of the ovary is a challenging therapeutic scenario. When surgery and hormonal therapies are no longer feasible, further treatment options are limited since there are low response rates to chemotherapy. Traditionally radiotherapy has not been widely used, but with recent advances in radiotherapy techniques this may provide a further option for either localised disease or palliative treatment.

Aim To evaluate the response to radiotherapy in recurrent AGCT.

Methodology A retrospective analysis was undertaken of patients who received radiotherapy for recurrent AGCT. Descriptive statistics were used to describe baseline characteristics, treatment and outcomes.

Result(s)* A total of 11 patients with AGCT were treated between 2012-2020. The mean age at diagnosis was 49 (28-57). 7(64%) patients had multi-site disease. 8 (50%) had pelvic disease, 6 (33) upper abdominal and 4 (17%) nodal disease. Most patient had large volume tumours with range 37.8-5942.7cm³. In total, 21 sites were treated with radiotherapy with 5(45%) patients receiving multiple courses of radiotherapy, including one who had re-irradiation of 3 sites. One patient had post-operative RT and one died soon after pelvic radiotherapy due to progressive upper abdominal disease. Nine patients with 16 sites were evaluable for response assessment at first irradiation. Technique: Stereotactic radiotherapy for 2 sites, IMRT/conformal 10 sites, large volume palliative fields to 4 sites. Radiation dose ranged from 20 to 45Gy in 5-20 fractions. There was a response in 100% sites with median reduction in tumour volume by 80% (range 18-100%) after 3 months and by 88% (range 24-100%) at 12 months demonstrating continued regression. Two patients had a complete radiological response, and two had <1% residual disease. One patient had progression within the irradiated field after 47 months and overall local control was 89% with median follow up 32.4 months. One patient had grade 2 acute bowel toxicity and two patients had grade 1 bowel toxicity.

Conclusion* Radiotherapy is a very effective treatment for recurrent AGCT, achieving maintained local control. This demonstrates that chemo-refractory tumours can still be very sensitive to radiation treatment, which should be considered for selected patients.

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TUMOR MARKERS IN PATIENTS WITH RECURRENT BORDERLINE OVARIAN TUMORS

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Introduction/Background* Borderline tumors have good prognosis and mostly low recurrence rate. Still, predicting their recurrence is especially important for patients who wish to maintain reproductive function. The study aim was to investigate the prognostic value of tumor markers for recurrence of borderline ovarian tumors.

Methodology Study included all patients operated due to borderline ovarian tumors during the past ten years. One year after operation, during regular check-up, serum levels of tumor markers Ca 125, HE4 and CEA were measured. Follow-up continued and all tumor recurrences were noted.

Result(s)* Study included 91 patients who in average had 33.36 +/- 8.77 years of age. Recurrence occurred in 13.2% of patients mostly after 2.83 +/- 2.89 years. Patients with recurrent tumors had elevated serum levels of Ca 125 in 16.7%, HE4 in 22.2% and CEA in 12.5% of cases. However, there were no significant differences in mean serum levels of tumor markers between patients with and without

tumor recurrence (Ca 125 $p=0.993$; HE4 $p=0.311$; CEA $p=0.417$). On ROC analysis only elevated Ca 125 serum levels were found to significantly indicate tumor recurrence ($p=0.031$; sensitivity=80%; specificity=94.1%), while serum levels of CEA ($p=0.196$) and HE4 ($p=0.754$) were not significant predictors. Nevertheless, serum levels of investigated tumors markers were not correlated with time of tumor recurrence (Ca 125 $p=0.954$; HE4 $p=0.952$; CEA $p=0.702$).

Conclusion* Elevated serum levels of Ca 125 in the follow-up period of patients operated due to borderline ovarian tumors could be used as marker of tumor recurrence.

821 DIFFERENT SURGICAL APPROACHES FOR EARLY-STAGE OVARIAN CANCER STAGING: A LARGE MONOCENTRIC EXPERIENCE

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Introduction/Background* Ovarian cancer is the third most frequent gynecological cancer. In early stage ovarian cancer (ESOC) comprehensive surgical staging is recommended.

Surgical staging is traditionally approached by laparotomy, although minimally invasive surgery can be a valid alternative in selected patients. This study aims to analyze the surgical and oncological outcomes of these three different approaches in a large series of patients.

Methodology We retrospectively included all histologically proven ESOC cases treated between January 2014 and December 2017. ESOC was defined as stage IA to IIB according to the 2018 FIGO staging system. Subjects were divided into groups 1, 2, and 3, based on the surgical approach (open abdominal, laparoscopic, or robotic, respectively).

Result(s)* Within patients enrolled during the study period, 455 met the inclusion criteria.

No difference in intraoperative complications was recorded in the three groups

($p=0.709$). Conversely, a significant difference occurred in postoperative complications

(16.2% vs. 3.8% vs. 11.1%, in groups 1, 2, and 3 respectively, $p=0.004$). No difference was found in overall survival (OS) (32 vs. 31 vs. 25 months, $p=0.481$) and disease-free survival (DFS) (26 vs. 29 vs. 24 months, $p=0.178$) in groups 1, 2, and 3, respectively.

Abstract 821 Table 1

General Population	TOTAL	Open Abdominal	Laparoscopy	Robot	p value
G1-G2*	41	28	8	5	$p=0.008$
G3-G4**	4	4	0	0	$p=0.112$
Fertility sparing					
G1-G2	6	2	2	2	$p=0.318$
G3-G4**	1	2	0	0	$p=0.139$
Radical surgical staging					
G1-G2	35	26	6	3	$p=0.076$
G3-G4**	3	2	0	0	$p=0.156$

*Vascular lesions, ureteral lesions, pulmonary embolism, pneumonia, sepsis, anemia, urinary tract infection, ileus, lymphocele, fistula, surgical site infection.

** Intestinal lesions requiring reintervention.

Abstract 821 Table 2

	TOTAL	Open Abdominal	Laparoscopy	Robot	p value
Median (range)	455;100%	Median (range)197;43.3%	Median (range)213; 46.8%	Median (range)45; 9.9%	
General Population					
DFS (months)	28 (10-44)	26 (8-43.5)	29 (10.8-48)	24 (12-31-5)	0.178
OS (months)	30 (12-47)	32 (11.5-52.5)	31 (13-48)	25 (12-33)	0.481
Relapse (n.%)	60; 13.2	39; 19.8	19; 8.9	2; 4.4	0.072

At univariate analysis FIGO stage I ($p=0.004$) showed a lower recurrence rate compared to FIGO stage II.

Conclusion* No significant difference was found in OS and DFS among the three groups (open, laparoscopic, and robotic). The minimally invasive approach showed lower rate of complications than the laparotomic one, thus it should be preferred in selected patients.

823 COMPARATIVE STUDY OF LAPAROSCOPY SCORING AND LAPARATOMY STAGING IN ADVANCE OVARIAN CANCER

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Introduction/Background* comparative study between laparoscopic scoring and laparotomy scoring in patient with advanced ovarian cancer

Methodology This prospective study conducted between march2020 and march2021. Participant in the study were 27 patients with advanced ovarian cancer who underwent laparoscopy and laparotomy scoring at hospitals affiliated to Isfahan University of Medical Science. Predictive index value (PIV) score (range: 0–14) was calculated for all patients. Patients with PIV scores <8 were offered primary cytoreductive surgery and those with score ≥ 8 received NACT (neoadjuvant chemotherapy). Patients who underwent primary cytoreductive surgery received a second PIV score at the time of their laparotomy and concordance between two PIV scores were calculated. All patients had primary surgery at the same day as laparoscopy. Residual disease following primary cytoreductive surgery was documented for each patient. PPV was used to determine the ability of the PIV score at laparoscopy to predict R0 at primary cytoreductive surgery.

Result(s)* 27 patients underwent laparoscopic scoring, 25 patient (92/5%) had a PIV score <8 and 2 (7/5%) had a PIV score ≥ 8 . There was overall 92% concordance between PIV scores at laparoscopy and laparotomy. Concordance scores by location were: bowel infiltration 76%, mesenteric disease 92%, liver surface involvement 96%, omental disease 92%, diaphragm disease 96%, stomach infiltration 100%, peritoneal carcinomatosis 96%. A laparoscopic PIV score of <8 had a PPV of 92% at predicting R0 at primary cytoreductive surgery.

Conclusion* Laparoscopic scoring allowed for a more personalized approach to the management of patients with advanced-stage ovarian cancer at our institution. It resulted in an objective triage of patients to primary cytoreduction or NACT, and