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)	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, 25patient (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 disease92%, 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

improved R0 resection rates at primary cytoreductive surgery. This study has described select the patients that would achieve the most benefit from primary surgery.

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 improved R0 resection rates at primary cytoreductive surgery. The present study has designed to assess the patients that would experience the maximum benefits from primary surgery.

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HOW TO DO RETROPERITONEAL EN BLOC POSTERIOR PELVIC EXENTERATION IN ADVANCED OVARIAN CANCER: HUDSON-DELLEPIANE PROCEDURE IN 10 STEPS

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Introduction/Background* The aim of cytoreduction in advanced ovarian cancer is complete removal of gross disease. Retroperitoneal approach is crucial in radical surgery for advanced ovarian cancer. Hudson-Delle Piane is a radical procedure which allows en-bloc removal of uterus, ovaries, pouch of Douglas peritoneum, recto-sigmoid with a retrograde approach in cases where recto-sigmoid sparing is not an option.

Methodology We present an educational video on how to perform retroperitoneal en bloc posterior pelvic exenteration in advanced ovarian cancer with a step-by-step procedure. The patient was a 52-year-old woman, with body mass index of 21.1 who presented with abdominal pain and distension; the CT-scan showed peritoneal carcinomatosis. The different phases of the Fagotti's score performed at diagnostic laparoscopy to triage for the operability, are demonstrated. The Vizzielli's score was used to determine the risk of post-operative complications in case of primary debulking surgery is also presented.

Result(s)* Immediately after the diagnostic laparoscopy a conversion to laparotomy with a cytoreductive surgery was performed. The Hudson-Delle Piane technique is demonstrated in 10 steps. The surgery lasted 360 minutes and the estimated blood loss was 400 ml. No peri-operative complication was recorded. The histology revealed a FIGO stage IIIC high-grade serous ovarian cancer.

Conclusion* The present video demonstrates that retroperitoneal approach to advanced ovarian cancer with high volume pelvic disease, allows en bloc tumor debulking with safe handling of important structures.

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THE ROLE OF CYTOREDUCTIVE MULTIVISCERAL SURGERY IN OVARIAN GROWING TERATOMA SYNDROME – CASE SERIES

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Introduction/Background* Immature teratomas are rare germ cell ovarian tumours occurring in about 1% of ovarian cancers. Growing Teratoma Syndrome (GTS) is a rare clinical situation where seemingly successful chemotherapy is followed by a rapid tumor progression, while tumour markers normalize. Despite radiological progression, the phenomenon is characterised by the maturation of the teratoma, and in most cases there is hardly any immature component left. In these rare cases radical surgical treatment is usually effective and can lead to complete recovery.

Methodology case report

Result(s)* A joint working group of the Department of Gynecology and Department of Genitourinary, Medical Oncology and Clinical Pharmacology of the National Institute of Oncology, Hungary diagnosed three immature ovarian teratoma cases with extended pelvic/abdominal tumor mass which showed progressive growth during and following chemotherapy. In all three cases, we had to perform multivisceral cytoreductive surgery with peritonectomy leading to complete cytoreduction. All patients are currently tumor-free. Postoperative histological findings showed 80-100% maturation, one of them operated 19 years after the primary treatment.

Conclusion* By presenting these 3 patients, our goal is to raise awareness of the possibility of GTS and to emphasize the importance of adequate treatment.

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STUDY OF THE LYMPHATIC MAP AND DETECTION OF THE SENTINEL LYMPH NODE IN OVARIAN MASSES WITH SUSPECTED MALIGNANCY

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Introduction/Background* Systematic pelvic and paraortic lymphadenectomy is part of the initial epithelial ovarian cancer (EOC) staging surgery but this procedure is associated with potential severe morbidity. Moreover, there is no evidence suggesting a possible therapeutic value. The detection of the sentinel lymph node (SLN) in the early stage of EOC is in the experimental phase and there is little literature about it. This study evaluates the lymphatic mapping with radiotracer and indocyanine green (ICG) and the detection of ovarian SLN.

Methodology Prospective cohort study in ovarian masses suspected of malignancy or re-staging surgery after confirmed malignancy. Albumin [^{99m}Tc] Tc-nanocolloid was injected into the utero-ovarian and infundibulo-pelvic ligaments. After 15 minutes, intraoperative images were acquired with a portable gammacamera. Subsequently, the adnexectomy and intraoperative pathological analysis were performed. In the cases in which malignancy was confirmed, ICG was injected proximally to the sectioned area of the ligaments and the lymphatic chains were traced with the fluorescence camera prior to the pelvic and paraortic lymphadenectomy. Ultrastaging of the SLN was done. The follow-up for possible adverse events lasted 30 days after surgery.

Result(s)* 20 patients were included between September-2020 and May-2021. Ovarian carcinoma was confirmed in 8 (40%) cases. In all cases gamma probe was used, in 60% the gamma camera and 40% the fluorescence camera. Some SLN was