with complete cytoreduction. In this study, we evaluated the survival impact of cardiophrenic lymph node enlargement in women with advanced stage epithelial ovarian cancer who have undergone cytoreductive surgery.

Methodology The Embase, Medline, Web of science, Cochrane Library and Google scholar databases were searched for articles from the database inception to November 2020. Meta-analysis was conducted to determine the prognostic impact of surgical outcome, postoperative complication and survival using random-effects models.

Result(s)* Fifteen relevant studies, involving 727 patients with CPLN adenopathy and 981 patients without CPLN adenopathy, were included in the review. The prevalence of ascites, and intra and extra abdominal metastases were highest in the CPLN adenopathy group. The mean size of pre-operative CPLN was 9.1 ± 3.75 mm. Eighty-two percent of the patients with CPLN resection, the resected CPLN were histological confirmed pathologic nodes. Surgical outcomes and perioperative complications did not differ between both groups. The pooled median overall survival (OS) was 42.7 months (95% CI 10.8-74.6) versus 47.3 months (95% CI 23.2-71.2) in patients with and without CPLN adenopathy. The pooled median progression free survival (PFS) was 14.6 months (95% CI 4.9-24.4) versus 27.8 months (95% CI 3.2-52.5) respectively. Patients with CPLN adenopathy had a significantly increased risk of disease recurrence (OR 4.56, 95% CI 1.98-10.51, $P < 0.001$) and of dying from disease (OR 2.96, 95% CI 2.08-4.22, $p < 0.001$) compared to those without CPLN adenopathy.

Conclusion* Patients with CPLN adenopathy had a higher tumor burden in both intra and extra-abdominal sites, and lower survival compared to patients without CPLN adenopathy. The available data was not sufficient to definitively confirm a therapeutic role of CPLN resection. A randomized controlled trial is needed to demonstrate the benefit of CPLN resection in cytoreductive surgery.

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IMPACT OF DISEASE PROGRESSION ON HEALTH-RELATED QUALITY OF LIFE OF ADVANCED OVARIAN CANCER (AOC) PATIENTS – POOLED ANALYSIS FROM THE PRIMA TRIAL

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Introduction/Background* Clinical trials consistently demonstrate the detrimental impact of progressive disease (PD) on patients' health-related quality of life (HRQoL). Progression-free survival (PFS) is an established regulatory endpoint. However, PFS is often excluded as an efficacy endpoint on the basis that — PFS is not patient relevant — in early benefit assessment by select EU health technology agencies. The PRIMA/ENGOT-OV26/GOG-3012 (NCT02655016) Phase 3 trial showed niraparib significantly prolongs median PFS vs placebo in patients with AOC responsive to 1L platinum (Pt)-based chemotherapy, (CT), regardless of biomarker status. This post-hoc analysis of PRIMA is the first study to examine the relationship between HRQoL and PD in a broad frontline AOC maintenance treatment setting.

Methodology In PRIMA, patients with AOC responsive to 1L Pt CT were randomised 2:1 to once-daily, maintenance niraparib or placebo. Impact of PD on patient HRQoL, irrespective of treatment, was evaluated within the pooled ITT population by comparing HRQoL at the last on-treatment (pre-progression) visit with HRQoL at end of treatment (EOT), +4 weeks, +8w, +12w, and +24w. Assessments included FOSI, EORTC QLQ-C30, EQ-5D-VAS, and EORTC QLQ-OV28 abdominal/GI symptom scale. ANCOVA was applied with treatment as a fixed effect and HRQoL at last on-treatment visit as a continuous covariate. Mixed models for repeated measurements (MMRM) evaluated cumulative HRQoL changes.

Result(s)* Significant reductions in HRQoL from pre- to post-progression were observed across all measures. Compared with pre-progression, FOSI scores (Least-squares mean [95% CI]) were lower at EOT+4w (-2.2 [-2.8, -1.6]) and EOT+24w (-1.7 [-2.3, -1.1]); each $p < 0.0001$. Similarly, at these timepoints EORTC-QLQ-C30 scores were lower by -10.2 (-12.4, -8.0) and -10.7 (13.2, -8.2) points, respectively, and EQ-5D-VAS by -8.2 (-10.4, -6.0) and -6.2 (-8.2, -4.2) points, respectively; each $p < 0.0001$. EORTC QLQ-OV28 scores were significantly worse at EOT+4w (6.6 [4.3, 8.9]) and EOT+24w (5.0 [2.8, 7.2]); each $p < 0.0001$. Similar changes were seen on MMRM analysis.

Conclusion* These findings demonstrate HRQoL is negatively impacted by PD in AOC. Preservation of HRQoL, an important therapy goal in the maintenance setting particularly for asymptomatic patients, can be achieved with PFS prolongation. PFS is of significant relevance and clinically important for AOC patients.

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CLEAR CELL BORDERLINE OVARIAN TUMOR: CLINICAL CHARACTERISTICS, PROGNOSIS AND MANAGEMENT

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Introduction/Background* Most frequent borderline ovarian tumors are serous and mucinous subtypes. Clear Cell Borderline Ovarian Tumor (CCBOT) is one of the rarest subtypes of borderline ovarian malignancies. Very few are known about this subtype and most of reports concerns very short series or case reports. The aim of this study was to determine the prognosis of a series of CCBOT and to analyze data published in the literature about this rare disease.

Methodology A retrospective review of patients with CCBOT treated or referred to our institutions. A centralized histological review by a reference pathologist and data on the clinical characteristics, management and outcomes of patients were required for inclusion.

Result(s)*

Nineteen patients were identified Median age was 62 (range 36-83) years. Four patients underwent a conservative surgery and a bilateral salpingo oophorectomy +/- hysterectomy (unknown in 1 case). One patient had bilateral tumor and all cases were a stage-I disease. All CCBOTs showed an adenofibromatous pattern. Stromal microinvasion was observed in 7 cases and intra-epithelial carcinoma in 2 cases. Endometriosis was histologically associated in one case. The median follow-up was 76 months (range 6 – 231 months). No recurrence occurred. Two patients died of intercurrent disease.

Conclusion* Peritoneal restaging surgery is not required, since all patients reported had stage-I disease. Fertility sparing surgery appears to be a safe alternative in young patients. Synchronous endometrial disorders with atypia are infrequent. Prognosis is generally excellent and long-term risk of recurrence is low. The 2 recurrences described in literature occurred in stage-IC diseases, highlighting the importance of avoiding perioperative rupture.

Abstract 964 Figure 1 Histological aspect of clear cell borderline ovarian tumor with adenofibromatous architecture (hematoxylin-eosin staining, x5)

Abstract 964 Table 1 Charecteristics of case series treated for clear cell borderline ovarian tumor

Patient	Age, y	Stage	Surgery	ED	Histology	Recurrence	Status (months)
1	62	IA	TH, BSO, PL, PAL	Normal	- CCBOT Af - CC cervical cancer	No	DID > 6
2	63	IA	TH, BSO, PC	Normal	CCBOT Af with SMI	No	NED 98
3	81	IA	TH, BSO, PC, App, Om	Normal	CCBOT Af with SMI	No	NED 64
4	41	IA	USO, PC, PB, App, Om, EB	Normal	CCBOT Af with SMI	No	NED 12
5	60	IA	TH, BSO, PC	Normal	CCBOT Af	-	LFU
6	57	IA	TH, BSO, PC	-	CCBOT Af with SMI	-	LFU
7	64	IA	BSO, PC	-	CCBOT Af with SMI	No	NED 13
8	54	IA	BSO	-	CCBOT Af	No	NED 21
9	36	IC1	1° Cy, 2° PB	Normal	CCBOT Af with typical endometriosis	No	NED 87
10	39	IA	USO, EB	Normal	CCBOT Af	No	NED 231
11	62	IB	TH, BSO, PC	Polyps	CCBOT Af with endometrioid BOT	No	DID > 6
12	68	IA	-	-	CCBOT Af with endometrioid BOT	No	NED 145
13	78	IA	TH, BSO, PC, PB	Hyperplasia with atypia	CCBOT Af	-	LFU
14	78	IA	TH, BSO, PC	Normal	CCBOT Af with SMI	No	NED 48
15	75	IA	TH, BSO, PC	Normal	CCBOT Af with SMI and IEC	No	NED 53
16	36	IA	USO, PC, PB, Om, App	Normal	CCBOT Af and endometrioid BOT with SMI	No	NED 14
17	71	IA	TH, BSO, Om	Normal	CCBOT Af	No	NED 157
18	61	IA	BSO	Normal	CCBOT Af	No	NED 147
19	83	IA	TH, BSO, PC	Hyperplasia	CCBOT Af with IEC	No	DID 108

Af: Adenofibroma; App: appendectomy; CCBOT: Clear Cell Borderline Ovarian Tumor; BSO: bilateral salpingo-oophorectomy; Cy: Cystectomy; DID: died of intercurrent disease; EB: endometrial biopsy; ED: endometrial disease; IEC: Intraepithelial carcinoma; PAL: Para-aortic lymphadenectomy; NED: no evidence of disease; Om: infracolic omentectomy or omental biopsies; PB: peritoneal biopsies; PC: peritoneal cytology; PL: pelvic lymphadenectomy; SMI: stromal microinvasion; TH: total hysterectomy; USO: unilateral salpingo-oophorectomy.