

**Abstract 997 Table 1** Kaplan-Meier survival curve for overall survival with groups

Groups	Mean	Median	% 1 year	% 3 year	% 5 year	Log rank	
						$\chi^2$	p
GP	47.47	-	85.8	64.2	53.4	0.004	0.948
ED	48.76	-	81.1	67.3	57.8		

overall survival rates between the two groups did not show statistical difference (p=0.948).

When comparing the overall survival rates in each stage of ovarian cancer, there was no statistical significant difference between the 1- year, 3-year and 5-year overall survival in ovarian cancer patients referred from GP and ED with ovarian cancer in stage 1 (p=0.262), stage 2 (p=0.350), stage 3 (p=0.906) and stage 4 (p=0.224).

**Conclusion\*** The mode of referral of ovarian cancer patients does not affect the overall survival for any FIGO stage (p=0.948). Women with ovarian cancer, at presentation, irrespective of the mode of referral should be assessed by the gynaecological oncology team to offer timely treatment with initial surgery or neo-adjuvant chemotherapy.

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**EXPLORING THE REASONS BEHIND OPTING FOR PALLIATIVE CHEMOTHERAPY OR NO TREATMENT IN ADVANCED OVARIAN CANCER PATIENTS**

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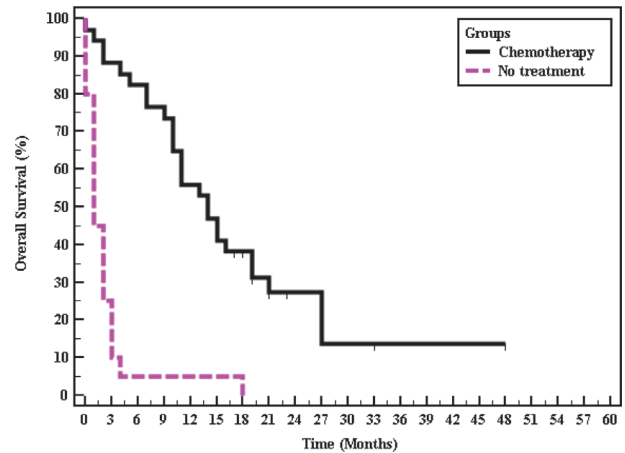
**Introduction/Background\*** The role of palliative chemotherapy in treating advanced ovarian cancer remains unclear. Some evidence suggests that chemotherapy has a role in relieving symptoms in advanced ovarian cancer. This study aims to explore the reasons why patients were managed by palliative chemotherapy or no treatment. Moreover, to evaluate the effectiveness of palliative chemotherapy in advanced ovarian cancer.

**Methodology** A retrospective study was conducted in the University Hospitals of Leicester from January 2015 to January 2020 involving 54 patients with advanced ovarian cancer: 34 patients received palliative chemotherapy and 20 patients had no treatment. Data was statistically analysed, and the overall survivals were calculated from Kaplan Meier Curves.

**Result(s)\*** In patients undergoing palliative chemotherapy, 27 (79.4%) were not suitable for debulking surgery, 4 (11.8%) died before surgery, 3 (8.8%) patients declined surgery. Twenty patients had no treatment: 13 (65%) died before chemotherapy and 5 (25%) were not fit for any treatment, 1 (5%) patient died before surgery and 1 (5%) patient declined surgery.

The 12- and 18-months overall survival in patient who had chemotherapy were 55.9% and 38.2% respectively, while it was 5% and 0% in those not having any treatment. The overall survival rates were significantly higher in the patients receiving palliative chemotherapy (p<0.001).

**Conclusion\*** Palliative chemotherapy increases the overall survival in advanced ovarian cancer patients, but the cost of



**Abstract 998 Figure 1** Kaplan-Meier survival curve for overall survival with groups

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Groups	Mean	Median	% 12 month	% 18 month	Log rank	
					$\chi^2$	p
Chemotherapy	17.91	14.0	55.9	38.2	35.466*	<0.001*
No treatment	2.30	1.0	5.0	0.0		

treatment and the effect on quality of life should be balanced to meet the patients' expectations.

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**ROBOT ASSISTED LAPAROSCOPIC STAGING SURGERY FOR EARLY STAGE BORDERLINE OVARIAN TUMOUR**

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**Introduction/Background\*** Till recently primary surgery for ovarian cancer and borderline ovarian tumours was done by laparotomy irrespective of the stage of the disease. Slowly the role of minimally invasive surgery in selected cases of borderline ovarian tumours and early stage ovarian cancers is becoming well known.<sup>1</sup>

**Methodology** A 42 year old P2L2, previous 1 LSCS with history of Heavy Menstrual Bleeding and Abdominal pain not responding to medical management was evaluated outside. A pelvic ultrasound showed multiple intramural uterine fibroids, largest measuring 3cm and a 6 x 4 x 4cm mass in left adnexa away from the left ovary, with both ovaries appearing normal and visualised separately. Her Ca 125 was 121 IU/L. Magnetic Resonance Imaging of the pelvis was reported as multiple intramural fibroids and propable broad ligament mass. She was referred to our hospital for management. Patient underwent Robot assisted laparoscopic Staging with hysterectomy, B/L Salpingo-oophorectomy, Frozen section of the left adnexal mass, Bilateral Pelvic lymph node dissection, Omental biopsy, pelvic peritoneal biopsy.

**Result(s)\*** Time taken for performing the surgery was 102 minutes. Frozen section of the left adnexal mass was reported as serous Borderline Ovarian tumour. Cytology of the peritoneal washing collected was reported to be negative for malignant cells. Pathological examination of the specimen showed Atypical proliferative serous tumour/serous borderline ovarian tumour of left ovary with surface involvement- FIGO stage I C2. Uterus had multiple leiomyoma. The pelvic nodes, omental tissue and the peritoneal tissues were negative for implants or malignancy. The post-operative period was uneventful, and the patient was discharged on postoperative day 2.

**Conclusion\*** Robot Assisted Laparoscopic staging surgery can be performed safely in selected cases by well-trained surgeons without compromising the oncological outcomes.

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### RESOLUTION AND PERSISTENCE OF OVARIAN CYSTS USING CYST DIAMETER IN ORDER TO RELATE FINDINGS TO THE PRACTICING PHYSICIAN

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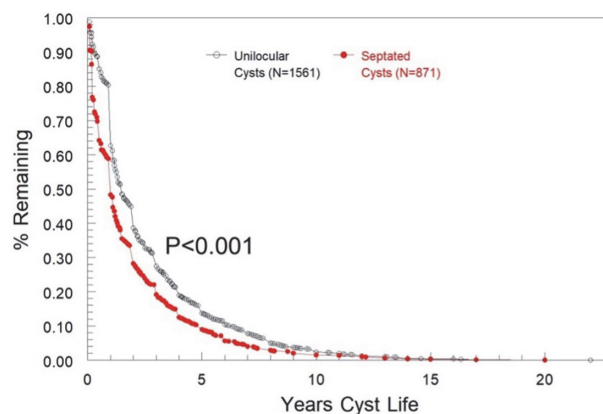
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**Introduction/Background\*** Ovarian cysts frequently resolve on their own, but little information on resolution is available for use in clinical practice. The objective of this study was to characterize the resolution of incident ovarian cysts in relation to cyst diameter, structure, age, body habitus, and menopausal status. These categorizations are important for decisions on whether to continue monitoring the cyst or intervene surgically.

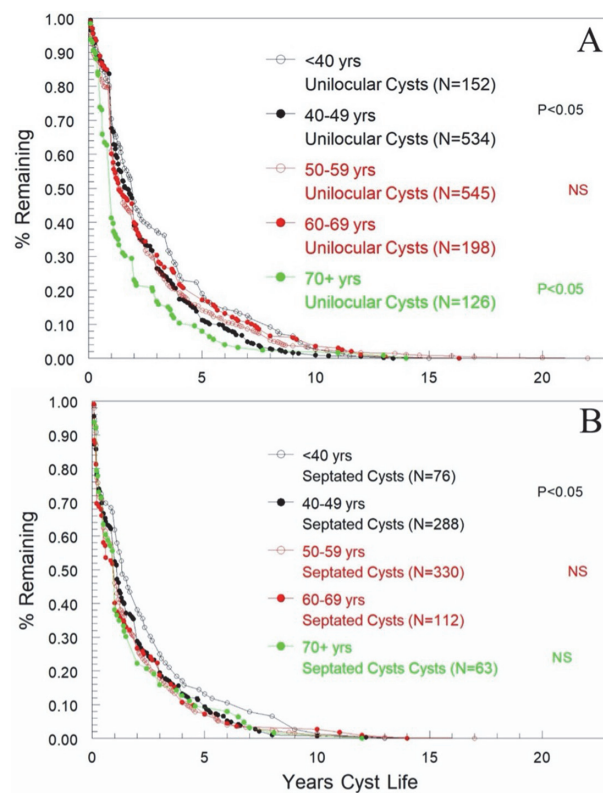
**Methodology** A total of 2,638 women with incident cysts were selected who had undergone 51,356 transvaginal ultrasound examinations in the University of Kentucky Ovarian Cancer Screening Program and were negative for ovarian malignancy. Prevalent cysts were excluded as they would be examined with an undefined course of first appearance when defining resolution time. Other exclusions included women with concurrent ovarian malignancies, cysts with solid components, and cases where surgery interrupted the natural history of measured cysts. The descriptor reported here is cyst diameter used to relate findings to physicians discovering these structures by bimanual examination. The variables collected in this study were: age, BMI, cyst diameter, cyst structure (loculation/septation), family history of ovarian cancer, and use of hormone replacement therapy. All images were reviewed by a physician. Methods of analysis include t-tests, chi-square, and Cox regression analysis of cyst resolution times.

**Result(s)\*** Women with a history of 1 or more cysts were included so that 2,465 unilocular and 1,420 septated cysts were available for analysis. Septated cysts (mean  $\pm$  SEM, 3.8  $\pm$  0.03) had a larger diameter than unilocular cysts (3.4  $\pm$  0.03),  $P < 0.05$ . The resolution of incident septated cysts was faster than unilocular cysts. Unilocular cysts, but not septated cysts, resolved the quickest in women 70+ years of age, and resolution was the most prolonged in women <40 years. No difference in resolution was observed between pre- and post-menopausal status nor BMI in the resolution of unilocular or septated cysts.

**Conclusion\*** While septated cysts tended to have a larger diameter than unilocular cysts, they were observed to resolve more rapidly. Menopausal status and body mass index were



Abstract 1013 Figure 1



Abstract 1013 Figure 2

not seen to have an influence on the time to resolution of unilocular and septated cysts. For the clinician, this study establishes expectations for cyst resolution based on a primary estimation of cyst diameter in a population where no malignancy was observed.

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### LINEAR RELATIONSHIP OF PERITONEAL CANCER INDEX AND SURVIVAL IN PATIENTS WITH EPITHELIAL OVARIAN CANCER IN CARCINOMATOSIS

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