reinforce the interest of an initial peritoneal staging in order not to ignore an advanced tumor stage.

1152 EN-BLOCK CYTOREDUCTION FOR ADVANCED OVARIAN CANCER

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10.1136/ijgc-2021-ESGO.520

Introduction/Background* Surgical procedures in primary debulking operations are challenging. Teaching these procedures in young Gynae/Oncologist also poses significant difficulties. En-block systematic excision of specimens could possibly lead to better understanding of peritoneal anatomy and facilitate training.

Methodology Primary debulking for advanced ovarian cancer in a 64 year old patient with stage 3C high grade serous ovarian cancer. The operation was performed in a systematic way allowing for excision of the spleen, omentum, right diaphragmatic peritoneum, Morrison's pouch peritoneum, lateral abdominal peritoneum, uterus, ovaries, tubes, recto-sigmoid colectomy and pelvic peritoneum in one single specimen.

Result(s)* Complete cytoreduction was achieved with minimal blood loss. The patient went home on post op day 7

Conclusion* En-block excision of specimens in advanced ovarian cancer might be a good method of training young Gynae/Oncologist in performing primary debulking operations for advanced ovarian cancer

1171 DEBULKING SURGERY FOR TREATMENT ADVANCED-STAGE OVARIAN CANCER WITH HIPEC COMPARED WITH DEBULKING SURGERY WITHOUT HIPEC, SHORT-TERM OUTCOMES

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10.1136/ijgc-2021-ESGO.521

Introduction/Background* The gold standard of advanced-stage ovarian cancer treatment is debulking surgery and systematic chemotherapy. However, alternative ways of drug delivery are exist and Hyperthermic Intraperitoneal Chemotherapy (HIPEC) is one of such methods.

Since June 2020 we have started to perform these procedures in Republican Oncology Clinic, Ufa, Russian Federation for the purpose of upgrade the medical care for women with advanced-stage ovarian cancer.

Methodology

Result(s)* Eighteen cytoreduction procedures were made from June 2020 through May 2021 and HIPEC was considered at the time of debulking surgery in six cases. There were four patients with stage 3B and fourteen with 3C. The mean time of procedure was 570 minutes in debulking surgery plus HIPEC group and 387 minutes in the group of debulking surgery only. The median postoperative hospital stay was 25 days in the group with HIPEC and 11 days in the group without HIPEC. It was performed 12 optimal debulking procedures with the completeness of cytoreduction score (CC) – 1, and 6 complete debulking procedures CC – 0. The average score of

Abstract 1171 Figure 1

Abstract 1171 Figure 2

peritoneal carcinomatosis index was 15,6. The percentage of patients who had adverse events of grade 3 or 4 in surgery with HIPEC group was 33%, and in surgery group – 22%. Out of 100% adverse events of grade 3 or 4, 60% complications were in the surgery with HIPEC group.

Conclusion* Overall, our data shows that addition HIPEC to the debulking procedure extends mean time of procedure, postoperative hospital stay and increases risk of adverse events grade 3 or 4.

Palliative care

1022 DOCUMENTING THE JOURNEY FROM DNACPR TO SURGICAL R ZERO – RADICAL EXTENT IN A YOUNG PATIENT WITH METASTATIC UNDIFFERENTIATED LEIOMYOSARCOMA RELAPSE

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10.1136/ijgc-2021-ESGO.522

Introduction/Background* Palliative surgery for advanced cancer involves complex decision-making - to identify ethical dilemmas in consideration of attitudes and factors influencing

case selection. In general, this includes preservation of patient choice and informed consent regarding realistic outcomes balanced with surgical risk and morbidity. Further patient individualised factors include age and performance status, comorbidities, tumour grade and extent and symptom severity. **Methodology** We present a 44-year-old otherwise fit and well female whom previously underwent complete resection of leiomyosarcoma. Subsequent imaging identified lung metastases, pelvic nodal disease and further avid pelvic mass managed with chemotherapy. Despite complete distant disease resolution, pelvic progression led to bilateral ureteric stenting and nephrostomy insertion, with enactment of Do Not Attempt Cardiopulmonary Resuscitation directive (DNACPR), palliative care and hospice input.

Abstract 1022 Figure 1

Abstract 1022 Figure 2

Result(s)* Multidisciplinary team recommendation was for palliative debulking surgery due to significant symptom profile and pain in view of potential resectability despite visceral involvement. The patient underwent midline laparotomy, modified posterior en-bloc exenteration, right ureteric resection and reimplantation with psoas hitch and stent replacement, bladder repair, primary ileo-ascending colon anastomosis, Hartmann's procedure and end sigmoid colostomy. The patient made an uneventful recovery with a normal postoperative retrograde cystogram and whilst histopathology reported involvement of bowel mucosa and serosa, clear margins were achieved.

Conclusion* Palliation aims to relieve suffering and support quality of life for seriously ill patients and their families, alongside life-prolonging and curative surgical treatments. We report on this case to highlight the value of radical and multiple resections of sarcoma in younger patients as well as the value of the surgical multidisciplinary team in achieving clear resection margins. We recognise a shift from cancer elimination to symptom elimination. Palliative care need not be synchronous with end of life care; an illustration of which is that the DNACPR was withdrawn in our patient's case. Whilst impact on survival may be limited, we emphasise the value in continuing to explore all treatment options and further delineate the balance between provision of false hope versus not giving up hope.

Pathology

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PATHOLOGICAL ASSESSMENT OF LYMPH NODE STATUS IN CERVICAL CANCER: COMPLETE EMBEDDING DOES NOT DOES NOT YIELD MORE NODE METASTASES

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10.1136/ijgc-2021-ESGO.523

Introduction/Background* Assessment of lymph node status is essential in patients with cervical cancer, particularly to determine prognosis and further therapy. The current pathological protocol states that only tissue with visible or palpable lymph nodes is investigated, the residual fatty tissue is stored.

We determined in a retrospective cohort study the value of embedding and examining all removed tissue, compared to the current pathological protocol.

Methodology Patients surgically treated (radical hysterectomy and pelvic lymph node dissection) for early stage cervical cancer at the Erasmus MC between 2017 and 2019 were included. In a multivariate analysis the extra lymph node count is compared to BMI and initial lymph node count.

Result(s)* Ninety-eight patients were included, the residual fatty tissue was assessed in 50 (51%). The median number of lymph nodes found by conventional pathological assessment was 26 (range 9-58) and 9 (range 0-28) in the residual fatty tissue. Ten patients (10.2%) had positive lymph nodes, all were found during conventional pathological assessment. In patients with a BMI above 30 kg/m², more lymph nodes are detected in the residual fatty tissue, compared to patients with a BMI under 30 kg/m² (R²=0.265). The calculated extra costs of assessment of the rest fatty tissue is € 240.