Objectives To evaluate clinicopathological features and survival outcomes of pure dysgerminoma of the ovary

Methods We retrospectively recorded clinicopathological and therapeutic data of 31 patients with pure dysgerminoma of ovary treated at the Salah Azaiez Institute of Tunisia between 1970 and 2012.

Results The median age was 22 years (12–60 years). The distribution of patients according FIGO stage was as follow:stage I:16 (51.6%),stage II:3 (9.7%),stage III: 11(35.5%) and stage IV:1 case.Radical surgery was performed in 11 patients and conservative surgery in 20 patients (64.5%) associated with node picking lymphadenectomy in 7 cases and complete lymphadenectomy in 7 cases. Complete macroscopic resection was obtained in 22 cases (70.96%) and lymph node metastasis was observed in 51.1% of cases. Adjuvant chemotherapy was indicated in 15 cases and adjuvant radiotherapy in 10 cases. After a mean time follow-up of 74 months (7–182 months), complete remission was observed in 26 patients. The 5-year progression-free survival (PFS) was 85.2%. The 5-year overall survival (OS) was 89.5% and was significantly decreased in the advanced stage (100% in stage I-II vs 75% in stage III-IV; p=0.02). There was a significant difference in OS and PFS between complete resection and residual disease groups (100% vs 67.5%;p=0.03 and 88.9 vs 75%;p=0.03, respectively).No difference in OS and PFS was noted following stratification by age ≤or>15 years (p=0.36 and p= 0.1), tumor size ≤or>20cm (p=0.27 and p=0.68) and conservative or radical surgery (p=0.87 and p=0.17).

Conclusions Macroscopic residual disease, as well as advanced FIGO stage, were the main prognostic factors in pure dysgerminoma of the ovary.

EPV201/#44 REAL-WORLD DATA ANALYSIS OF SECOND-LINE POLY (ADP-RIBOSE) POLYMERASE INHIBITOR MAINTENANCE THERAPY IN PATIENTS WITH ADVANCED OVARIAN CANCER

[1]R Reid*, [2]Y Xie, [2]J Shi, [3]K Wallace. *[1]US Oncology, Virginia Cancer Specialists, Medical Oncology, Fairfax, USA; [2]Ontada, Real World Research, The Woodlands, USA; [3]Clovis Oncology, Inc., Health Economics and Outcomes Research, Boulder, USA*

10.1136/ijgc-2021-IGCS.272

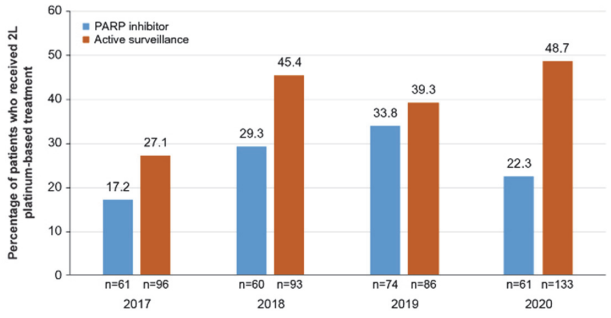
Objectives Poly(ADP-ribose) polymerase inhibitors (PARPis) have been recommended since 2017 as second-line (2L) maintenance treatment by the NCCN for ovarian cancer (OC) patients with or without BRCA1 or BRCA2 (BRCA) alterations. Here, we assessed PARPi use from real-world data.

Methods From the iKnowMed electronic health record database of the US Oncology Network (>470 sites), adult females were included if they were diagnosed with advanced OC, received a 2L platinum-containing regimen for advanced OC, and had ≥2 visits between 1 January 2016 and 1 July 2020. Patients were followed until 31 October 2020, last patient record, or death, whichever occurred earliest. A 24-month landmark survival analysis was performed.

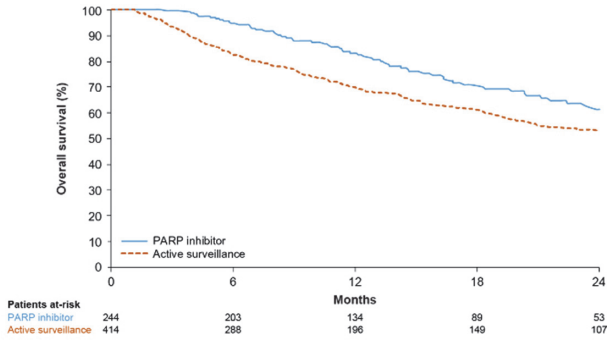
Results Out of 11,494 patients diagnosed with advanced OC, 1051 met the inclusion criteria; 513/1051 (49%) subsequently received any maintenance therapy (table 1). The proportion of patients receiving 2L PARPi maintenance increased from 17% in 2018 to 34% in 2019 but decreased to 22% in 2020 (figure 1). Among BRCA^{+}patients, 33% (46/140) received 2L PARPi maintenance, while documented BRCA^{-}patients received PARPi maintenance at a significantly lower rate (23%; 155/622; P=0.0192). Survival at 24 months was significantly higher with PARPi maintenance vs active surveillance: 61.2% (95% CI, 52.4%–68.8%) vs 53.0% (95% CI, 47.1%–58.7%; log-rank P=0.0045) (figure 2).

Abstract EPV201/#44 Table 1

n (%)	Patients receiving 2L platinum-based chemotherapy (N=1051)
Received 2L maintenance therapy	513 (49)
PARP inhibitor	271 (26)
Bevacizumab	294 (28)
Nonplatinum chemotherapy	32 (3)
Did not receive 2L maintenance therapy (active surveillance)	538 (51)



Abstract EPV201/#44 Figure 1 Propotion of patients receiving 2L PARPi maintenance (active surveillance)



Abstract EPV201/#44 Figure 2 Overall survival

Conclusions Our data suggest a significant proportion of eligible patients are not receiving 2L maintenance therapy despite treatment guideline recommendations and apparent survival benefits associated with its use.

EPV202/#446 SENTINEL LYMPH NODE IDENTIFICATION IN EARLY STAGE OVARIAN CANCER: IS IT STILL POSSIBLE AFTER PRIOR TUMOR RESECTION?

[1]P Laven*, [2]R Kruitwagen, [2]S Lambrechts, [3]T Van Gorp, [4]B Slangen, [5]P Zusterzeel, [6]J Van Der Pol. *[1]Maastricht Universitair Medisch Centrum, Gynaecology, Maastricht, Netherlands; [2]Maastricht University Medical Centre, Gynecology, Maastricht, Netherlands; [3]University Hospital Leuven, Gynaecological Oncology, Leuven, Belgium; [4]Maastricht University Medical Center, Gynaecology and Obstetrics, Maastricht, Netherlands; [5]Radboud Univeristy Hospital, Gynaecological Oncology, Nijmegen, Netherlands; [6]Maastricht Universitair Medisch Centrum, Nuclear Medicine, Maastricht, Netherlands*

10.1136/ijgc-2021-IGCS.273

Objectives Sentinel lymph node (SLN) detection in ovarian cancer is feasible when tracers are injected before the pathological ovary is resected. This study aims to investigate

whether the SLN identification is also feasible in patients whose ovarian tumor has already been resected with injection of the tracer into the ovarian ligaments stumps, i.e. in the event that a frozen section confirms malignancy.
Methods Patients who underwent laparotomy with frozen section confirming an ovarian malignancy, and those who underwent a second staging laparotomy after prior resection of a malignant ovarian mass, were included. Blue dye and a radioactive isotope were injected in the stumps of the ligamentum ovarium proprium and the ligamentum infundibulo-pelvicum. After an interval of at least 15-minutes, the sentinel node(s) were identified using either the gamma-probe and/or blue dye.
Results A total of 11 patients were included in the study, the sentinel node (SLN) procedure was completed in all 11 patients. At least one SLN was identified in 3 patients, resulting in a rather low detection rate of 27,3%.
Conclusions In this study we showed that SLN procedure after (previous) resection of the tumor seems inferior to detect sentinel nodes when compared to injection of the tracer in the ovarian ligaments before tumor resection.

EPV203/#449 'QUICK' LAPAROSCOPY FOR SUSPECTED ADVANCED OVARIAN CANCER

N Taumberger*, R Laky, A-M Schütz, T Bracic, E Petru, A Bader, T Aigmüller, G Trutnovsky, K Tamussino. *Medical University of Graz, Obstetrics and Gynecology, Graz, Austria*

10.1136/ijgc-2021-IGCS.274

Objectives Primary therapy planning, meaning primary surgery vs. neoadjuvant chemotherapy (NACT), in suspected advanced ovarian cancer is a professional and logistical challenge. Prompt diagnostic laparoscopy in such patients should confirm the diagnosis by frozen section, assess operability and thus, avoid unnecessary laparotomies.
Methods Retrospective evaluation of 130 patients who presented in 2016–2020 with suspected advanced ovarian cancer (peritoneal carcinomatosis, ascites on average 1,5L).
Results In 2016–20, 82/130 patients (63%) underwent diagnostic laparoscopy; the others received either primary laparotomy, NACT, palliative chemotherapy, or best supportive care. 47% percent of the 82 patients were triaged to NACT, and 53% to primary surgery. The median time between initial presentation and laparoscopy was almost 8 days, the time from laparoscopy to 1st cycle of NACT was 14 days, and the time from laparoscopy to laparotomy was 15d. The rate of R0 resections in patients with primary surgery after laparoscopy was 84%.
Conclusions Diagnostic laparoscopy seems to be an efficient measure in the workup and treatment planning of patients with suspected advanced ovarian cancer. The times between first presentation and laparoscopy as well as between laparoscopy and NACT or primary laparotomy need improvement.

EPV204/#454 INGUINAL METASTASES AS PRESENTING SIGN OF OVARIAN CANCER

[1]V Cataldo*, [1]C Putino, [1]F Arezzo, [2]L Resta, [2]G Serio, [2]G Cazzato, [3]V Loizzi, [1]G Cormio, [1]M Mongelli. *[1]University of Bari 'Aldo Moro', Department of Biomedical Science and Human Oncology, Obstetrics and Gynecology Unit, Bari, Italy; [2]University of Bari 'Aldo Moro', Emergency and Organ Transplantation, Pathology Section, Bari, Italy; [3]University of Bari 'Aldo Moro', Interdisciplinar Department of Medicine, Obstetrics and Gynecology Unit, Bari, Italy*

10.1136/ijgc-2021-IGCS.275

Objectives Inguinal lymph nodes involvement as first manifestation of ovarian cancer is a rare event and its prognostic value is not well known.
Methods A retrospective chart review was conducted on ovarian cancer patients treated at the University of Bari, between 2008 and 2020. Pertinent clinical information (age, size, histology, BRCA status, laterality at diagnosis, other distant sites of disease), response to first-line treatment, site of relapse and overall survival were collected for 7 patients.
Results Median age at diagnosis was 64 years (range 40–81), 3 patients had other sites of distant disease at the time of ovarian cancer diagnosis (spleen, liver, bone, lung). Median size of inguinal lymph node was 24 mm (range 14–36 mm), 4 had right inguinal involvement, 2 left and one bilateral nodes. The patients had primary surgery including groin dissection, whereas 5 patients had neoadjuvant chemotherapy with paclitaxel and carboplatin following biopsy or removal of groin nodes and complete inguinal dissection was performed at interval debulking surgery. Six patients had high grade serous ovarian carcinoma and one had high grade ovarian endometrioid histotype. BRCA status was known for five patients, and only one patient was a BRCA2 mutation carrier. 4 patients experienced a relapse at a median of 15 months (range 6–25) and in no case relapse was at the level of the groins. 3 patients died and 4 are alive without evidence of disease. Median survival was 64 months (range 16–151).
Conclusions Groin involvement is rare presenting sign of ovarian cancer and this location carries a good prognosis.

EPV205/#458 THE FOLLOW UP MANAGEMENT OF BORDERLINE OVARIAN TUMOURS: A 10-YEAR EXPERIENCE

C Wood*, R Dwivedi. *University Hospitals Dorset NHS Foundation Trust, Obstetrics and Gynaecology, Bournemouth, UK*

10.1136/ijgc-2021-IGCS.276

Objectives Borderline ovarian tumours (BOT) are a unique category of ovarian tumours. National guidance states regular sonographic follow up is essential after fertility sparing surgery (FSS), whereas, follow up in patients with early disease after BSO is uncertain. Our aim was to audit current practice and determine local recurrence rate.
Methods A retrospective single centre study over a 10-year period to compare current standard of care to the BGCS and Local Network Guidelines.
Results 78 patients were diagnosed with BOT during the 10-year period. 9 patients had FSS, the majority were mucinous BOT (77.8%) and stage 1 disease (88.9%). 44.4% have had or plan to have completion surgery and remaining 55.6% had variable sonographic/clinical follow up to a maximum 5 years. 69 patients had non-fertility sparing surgery, the majority were serous BOT (55.1%). 78.2% had stage 1 disease, 44.4% were discharged, 40.7% enrolled in the Borderline Ovarian Trial (annual review and CA125) and the remaining 14.8% had variable follow up. 14.5% had stage 2 or 3 disease, 60% received standardised follow up for 5 years, 30% enrolled in the Trial and 10% discharged. 2 patients (2.6%) experienced a malignant recurrence, 1 serous and 1 mucinous BOT. Both had initial pelvic clearance surgery with full staging.
Conclusions In line with guidance, all patients who had FSS underwent follow up, and the majority of patients with early stage disease after BSO were appropriately discharged. Overall,