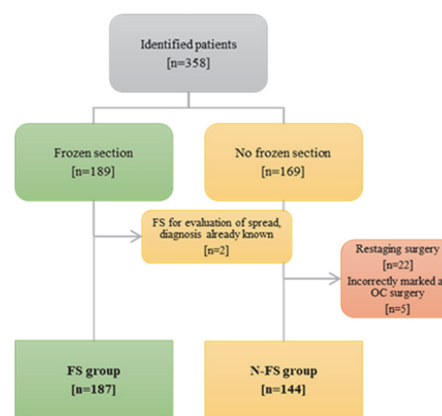


Results S-PCI correlated with both OS (1.067, (1.018–1.119); $p < 0.007$) and PFS. Patients exhibiting S-PCI of 18.5 or higher, adjusted to age, performance status and RD, had a two-fold risk of dying (HR 2.070, 95%CI 1.061–4.038; $p = 0.033$). CT-PCI correlated significantly with OS in crude data (1.037, (1.005–1.071); $p = 0.025$), but this was not sustained in multivariate analyses. Patients with RD at any size had more than two times higher risk of dying compared to those without RD (2.177, (1.235–3.838); $p = 0.007$).

Conclusion The tumor extent at the beginning of surgery seemed to affect OS in patients with AOC, regardless RD at the end of the surgery. PCI above 18.5 doubled the risk of dying of the disease. No difference in major complications were noted in the two groups of patients. CT-PCI seemed to play a prognostic role for PFS, however as a prognostic factor for OS, it is still to be investigated.



Abstract 2022-RA-245-ESGO Figure 1

2022-RA-245-ESGO OVARIAN TUMOR FROZEN SECTION, A MULTIDISCIPLINARY AFFAIR

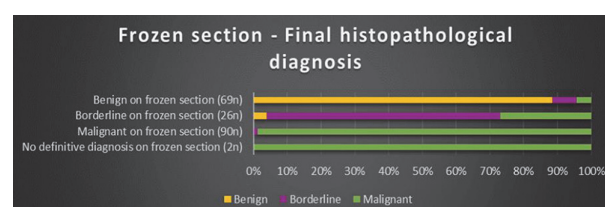
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Introduction/Background Ovarian Cancer (OC) constitute the eighth most common cancers among women worldwide. Surgery remains the cornerstone in the management of OC. Intraoperative frozen section (FS) diagnosis is widely used to decide the surgery course. We aimed to assess the reliability of intraoperative FS diagnosis for treatment planning of patients with suspected OC from a multidisciplinary perspective. The clinical consequences of reclassification and the multidisciplinary management of the therapy plan, is the secondary aim of this study. To our knowledge, this information is sparsely investigated.

Methodology A single-center, retrospective population-based study of patients who underwent surgery for suspected OC between 2018–2020. Histopathological outcomes were classified as benign, borderline, or malignant. The FS diagnosis was the diagnostic test, and the final histopathology report was the gold standard. Diagnostic capability for treatment planning was assessed, and modifications made possible by overall clinical knowledge were discussed.

Results A total of 358 patients were identified, of whom 187 were included in the FS group. Overall accuracy was 89.8%, and 19 patients were reclassified; the malignancy grade of 15 tumors was underestimated. Prevalence, sensitivity, specificity, positive predictive value, and negative predictive value for invasive malignancies on FS were 54.0% (CI 46.6–61.3%), 88.1% (CI 80.2–93.7%), 98.8% (CI 93.7–99.9%), 98.9% (CI 92.7–99.8%), and 87.6% (CI 80.6–92.4%), respectively. Tumors incorrectly graded by FS tended to be of borderline-related.



Abstract 2022-RA-245-ESGO Figure 2

Abstract 2022-RA-245-ESGO Table 1 Concordance of frozen section diagnosis with final histopathological diagnosis

Frozen section	Final histopathological diagnosis		
Benign	61	5	3
Borderline	1	18	7
Malignant		1	89
No definitive diagnosis			2

Abstract 2022-RA-245-ESGO Table 2 Frozen section as a diagnostic test with final histopathological diagnosis as the gold standard. St

N = 187	Benign	Borderline	Malignant
Prevalence	33.2% (26.5–40.4%)	12.8% (8.4–18.5%)	54.0% (46.6–61.3%)
Sensitivity	98.4% (91.3–99.9%)	75.0% (53.2–90.2%)	88.1% (80.2–93.7%)
Specificity	93.6% (87.7–97.2%)	95.1% (90.6–97.9%)	98.8% (93.7–99.9%)
PPV	88.4% (79.6–93.2%)	69.2% (52.4–82.1%)	98.9% (92.7–99.8%)
NPV	99.2% (94.4–99.8%)	96.3% (92.8–98.1%)	87.6% (80.6–92.4%)

Conclusion The reliability of the FS methodology was an accurate test to help perform appropriate surgery and plan swift oncological treatment. FS is a reliable method to diagnose invasive malignancies and benign pathology. The communication between the pathologist, surgeon, and medical oncologist is highly important for both intraoperative decision-making and postoperative patient care.

2022-RA-249-ESGO

OVERALL SURVIVAL RESULTS FROM ARIEL3: A PHASE 3 RANDOMISED, DOUBLE-BLIND STUDY OF RUCAPARIB VS PLACEBO FOLLOWING RESPONSE TO PLATINUM-BASED CHEMOTHERAPY FOR RECURRENT OVARIAN CARCINOMA

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Introduction/Background In ARIEL3 (NCT01968213), progression-free survival (PFS) improved significantly with rucaparib maintenance treatment versus placebo. We present updated PFS2 and preplanned final overall survival (OS) analyses.

Methodology ARIEL3 enrolled patients with platinum-sensitive, high-grade ovarian carcinoma who had received ≥ 2 previous platinum-based chemotherapy regimens and had responded to their last platinum-based regimen. Patients were randomised 2:1 to receive rucaparib 600 mg twice daily or placebo, with 3 protocol-defined nested cohorts: BRCA-mutant, homologous recombination deficient (HRD) and intent-to-treat (ITT). Efficacy outcomes for the nested cohorts included the secondary endpoint of OS (with analysis planned after 70% of events) and the exploratory endpoint of PFS2 (defined as time from randomisation to second event of investigator-assessed disease progression or death due to any cause). Patients were followed for the incidence of myelodysplastic syndrome (MDS) and acute myeloid leukaemia (AML). Data cutoff dates were 31 December 2019

(safety), 4 April 2022 (efficacy) and 12 April 2022 (monitoring of MDS/AML).

Results After a median follow-up of 77.0 months in the ITT population, 410/564 (72.7%) of OS events had occurred. OS and PFS2 are presented in table 1. A PARP inhibitor was administered as subsequent treatment to $\approx 45\%$ of patients who received placebo. Safety data were consistent with those of prior reports. MDS/AML was reported in 14 (3.8%) and 6 (3.2%) patients in the rucaparib and placebo arms, respectively ($P=0.72$). Among these, 8 patients in the rucaparib arm and 6 in the placebo arm developed MDS/AML after completion of study drug treatment.

Abstract 2022-RA-249-ESGO Table 1

	PFS2 events, n (%)	Median PFS2, months (95% CI)	PFS2 HR (95% CI), P value	OS events, n (%)	Median OS, months (95% CI)	OS HR (95% CI), P value
BRCA						
Rucaparib (n=130)	98 (75.4)	26.1 (22.8–32.8)	0.672 (0.460–0.941)	82 (63.1)	45.9 (37.7–59.6)	0.832 (0.551–1.192)
Placebo (n=66)	54 (81.8)	18.4 (15.7–24.4)	$P=0.02$	48 (72.7)	47.8 (43.2–55.8)	$P=0.32$
HRD						
Rucaparib (n=236)	183 (77.5)	24.7 (21.9–26.8)	0.718 (0.558–0.923)	159 (67.4)	40.5 (36.6–48.4)	1.005 (0.766–1.320)
Placebo (n=118)	99 (83.3)	18.4 (15.8–22.1)	$P<0.01$	85 (72.0)	47.8 (42.7–53.0)	$P=0.97$
ITT						
Rucaparib (n=375)	302 (80.5)	20.6 (18.7–22.5)	0.703 (0.579–0.854)	270 (72.0)	36.0 (32.9–39.4)	0.995 (0.809–1.223)
Placebo (n=189)	162 (85.7)	16.3 (14.6–17.9)	$P<0.01$	140 (74.1)	43.2 (38.1–46.9)	$P=0.96$

HRs and associated P values were calculated by using a stratified log-rank test and stratified Cox-proportional model.

P values are nominal with no adjustment for multiplicity.

BRCA, BRCA1 and BRCA2 genes; CI, confidence interval; HR, hazard ratio; HRD, homologous recombination deficient; ITT, intent-to-treat; OS, overall survival; PFS, progression-free survival.

HRs and associated P values were calculated by using a stratified log-rank test and stratified Cox-proportional model

P values are nominal with no adjustment for multiplicity

BRCA, BRCA1 and BRCA2 genes; CI, confidence interval; HR, hazard ratio; HRD, homologous recombination deficient; ITT, intent-to-treat; OS, overall survival; PFS, progression-free survival

Conclusion These data support the use of rucaparib as a maintenance treatment for recurrent ovarian carcinoma. Although no OS benefit was observed, the PFS benefit for rucaparib was maintained through the next subsequent line of therapy.

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'DOUBLE O' TECHNIQUE OF BOWEL ANASTOMOSIS

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Introduction/Background Bowel resection and anastomosis is an integral part of subspecialty training in gynecological Oncology. The principles of bowel surgery are not only to remove cancer to achieve optimal debulking but also to reduce leak rate and postoperative morbidity. Reduction in leak rate is achieved by good technique and adequate training. In hand held anastomosis, proper suturing of the corners of the bowel is considered crucial to reduce leak rate. We hereby present a surgical video demonstrating a novel technique of hand sewn ileo-ileal anastomosis in a lady undergoing debulking surgery for ovarian cancer.

Methodology A 53-year-old lady with stage IIIc high grade serous ovarian carcinoma underwent total hysterectomy, bilateral adnexectomy, peritonectomy, omentectomy and resection anastomosis of the involved ileal bowel segment. The novel technique used is a double layered closure of the enterotomy in continuous circular fashion, thus eliminating the perception