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

[1,2]Robert L Coleman, [3]Amit M Oza, [4]Domenica Lorusso, [5]Carol Aghajanian, [6]Ana Oaknin, [7]Andrew Dean, [8]Nicoletta Colombo, [9]Johanne I Weberpals, [10]Andrew R Clamp, [11]Giovanni Scambia, [12]Alexandra Leary, [13]Robert W Holloway, [14]Margarita Amenedo Gancedo, [15]Peter C Fong, [16]Jeffrey C Goh, [17]David M O'Malley, [18]Sandra Goble, [19]Lara Maloney, [20]Jonathan A Ledermann. *[1]Department of Gynecologic Oncology and Reproductive Medicine, The University of Texas MD Anderson Cancer Center, Houston, TX; [2]*current location: US Oncology Research, The Woodlands, TX; [3]Division of Medical Oncology and Hematology, Princess Margaret Cancer Centre, University Health Network, Toronto, ON, Canada; [4]MITO and Gynecologic Oncology Unit, Fondazione IRCCS Istituto Nazionale dei Tumori, Milan, Italy; [5]Gynecologic Medical Oncology, Memorial Sloan Kettering Cancer Center, New York, NY; [6]Gynaecologic Cancer Programme, Vall d'Hebron Institute of Oncology (VHIO), Hospital Universitari Vall d'Hebron, Vall d'Hebron Barcelona Hospital Campus, Barcelona, Spain; [7]Department of Oncology, St John of God Subiaco Hospital, Subiaco, WA, Australia; [8]Gynecologic Cancer Program, European Institute of Oncology and University of Milan-Bicocca, Milan, Italy; [9]Division of Gynecologic Oncology, Ottawa Hospital Research Institute, Ottawa, ON, Canada; [10]Department of Medical Oncology, The Christie NHS Foundation Trust and University of Manchester, Manchester, UK; [11]Fondazione Policlinico Universitario A. Gemelli IRCCS and Scientific Directorate, Rome, Italy; [12]Gynecological Unit, Gustave Roussy Cancer Center, INSERM U981, and Groupe d'Investigateurs Nationaux pour l'Etude des Cancers Ovariens (GINECO), Villejuif, France; [13]Department of Gynecologic Oncology, Florida Hospital Cancer Institute, Orlando, FL; [14]Medical Oncology Department, Oncology Center of Galicia, La Coruña, Spain; [15]Medical Oncology Department, Auckland City Hospital, Grafton, Auckland, New Zealand; [16]Department of Oncology, Cancer Care Services, Royal Brisbane and Women's Hospital, Herston, QLD, Australia, and University of Queensland, St Lucia, QLD, Australia; [17]Clinical Research Gynecologic Oncology, The Ohio State University, James Cancer Center, Columbus, OH; [18]Biostatistics, Clovis Oncology, Inc., Boulder, CO; [19]Clinical Development, Clovis Oncology, Inc., Boulder, CO; [20]Department of Oncology, UCL Cancer Institute, University College London and UCL Hospitals, London, UK*

10.1136/ijgc-2022-ESGO.488

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 ≈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 (0.480–0.941) *P*=0.02	82 (63.1)	45.9 (37.7–59.6)	0.832 (0.581–1.192) *P*=0.32
Placebo (n=66)	54 (81.8)	18.4 (15.7–24.4)		48 (72.7)	47.8 (43.2–55.8)	
HRD						
Rucaparib (n=236)	183 (77.5)	24.7 (21.9–26.8)	0.718 (0.558–0.923) *P*=0.01	159 (67.4)	40.5 (36.6–48.4)	1.005 (0.766–1.320) *P*=0.97
Placebo (n=118)	99 (83.9)	18.4 (15.8–22.1)		85 (72.0)	47.8 (42.7–53.0)	
ITT						
Rucaparib (n=375)	302 (80.5)	20.6 (18.7–23.5)	0.703 (0.579–0.854) *P*<0.01	270 (72.0)	36.0 (32.8–39.4)	0.995 (0.809–1.223) *P*=0.96
Placebo (n=189)	162 (85.7)	16.3 (14.6–17.9)		140 (74.1)	43.2 (38.1–46.9)	

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.

2022-RA-272-ESGO 'DOUBLE O' TECHNIQUE OF BOWEL ANASTOMOSIS

[1]TS Shylasree, [2]Pabashi Poddar, [2]Manish Bhandare. *[1]Gynecological Oncology, Aberdeen Royal Infirmary, Aberdeen, UK; [2]Tata Memorial Hospital, Mumbai, India*

10.1136/ijgc-2022-ESGO.489

Introduction/Background Bowel resection and anastomosis is an integral part of subspeciality 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

of corner while suturing. Two delayed absorbable sutures with double ended needle are used for the technique.
Results Patient had optimal debulking surgery and the postoperative course was uneventful. She received adjuvant chemotherapy and is disease free for 24 months.
Conclusion Surgical skill development is crucial for reducing postoperative morbidity and to achieve optimal debulking. Due to increased use of staplers for bowel anastomosis in recent decades, hand sewn bowel anastomosis is not practiced regularly. However, hand sewn anastomosis is cost effective and is especially useful in resource limited or emergency setting. 'Double O' technique is simpler to use and eliminates many technical nuances described in traditional hand-sewn anastomosis. The technique helps the gynecological oncology surgical trainee to learn and retain the steps due to its simplicity and also helps to overcome the fear of suturing corners in bowel anastomosis during the learning curve.

2022-RA-275-ESGO COMPARISON OF PATIENTS WITH TRUCUT BIOPSY, ACID CYTOLOGY WITH FINAL PATHOLOGY RESULTS FROM PATIENTS OPERATED WITH PREDIAGNOSE OF OVARIAN CANCER

Fatma Basak Tanoglu, Caglar Cetin, Gurkan Kiran. *Bezmialem Vakif University, Istanbul, Turkey*

10.1136/ijgc-2022-ESGO.490

Introduction/Background Ovarian cancer ranks 4th among the deadliest cancers in women and has the highest mortality rate among all gynecological malignancies. In women who are believed to have ovarian cancer but have poor performance status or have advanced disease believed to be beyond the scope of primary cytoreductive surgery and whose pathology cannot be obtained before staging surgery, NACT can be given to patients with acid cytology and/or tru-cut biopsy referral. Our aim is to determine the accuracy, adequacy, safety and reliability of these minimally invasive interventional procedures.
Methodology This is a retrospective analysis of 63 patients with a prediagnosis of ovarian cancer in our hospital between 2014 and 2021, who underwent ultrasound-guided acid cytology and tru-cut biopsy, and also had postoperative final pathology results.
Results When the pathology results of the patients who received acid cytology, tru-cut biopsy, acid cytology and tru-cut biopsy at the same time were compared with the postoperative final pathology results, it was seen that the PPV was 100% in all groups. It was revealed that the sensitivity of acid cytology was 64%, the specificity was 100%, the NPV was 12%, and the accuracy of the test was 65%. The sensitivity of the Tru-cut biopsy was 91%, the specificity was 100%, the NPV was 42%, and the accuracy of the test was 92%. In the case of both procedures, the sensitivity was calculated as 93% and the accuracy of the test was calculated as 93%. There were no false positive cytology and biopsy results that could lead to unnecessary NACT therapy in the study. 97 minimally invasive procedures were performed under ultrasound guidance.

Abstract 2022-RA-275-ESGO Table 1

	Sensitivity	*Specificity*	*PPV*	*NPV*	*Accuracy*
Acid cytology	%64	%100	%100	%12	%65
Tru-cut biopsy	%91	%100	%100	%42	%92
Acid cytology + tru-cut biopsy	%93	YOK	%100	YOK	%93

Conclusion Minimally invasive procedures can be safely applied to patients with low complication and high accuracy rates, since they provide NACT in patients who are thought to be candidates for interval surgery.

2022-RA-276-ESGO VALUE OF SURGICAL CYTOREDUCTION FOR SUBSEQUENT OVARIAN CANCER RELAPSE IN PATIENTS PREVIOUSLY TREATED WITH CHEMOTHERAPY ALONE AT 1ST-RELAPSE: A SUBANALYSIS OF THE DESKTOP III/ ENGOT-OV20 TRIAL

[1]Christina Fotopoulou, [2]Jalid Sehouli, [3]Ignace Vergote, [4]Alexander Reuss, [5]Marianne Leheurteur, [6]Felix Hilpert, [7]Aude-Marie Savoye, [8]Stefano Greggi, [9]Johanna Vernersson, [10]Benoît Resch, [11]Michel Gatineau, [12]Jean Levêque, [13]Rongyu Zang, [14]Pernille T Jensen, [15]Jae W Kim, [16]Domingo Santiago, [17]Francesco Raspagliesi, [18]Ulla Peen, [19]Andreas du Bois, [19]Philipp Harter. *[1]AGO and Imperial College, London, UK; [2]AGO and Campus Virchow, Charité, Berlin, Germany; [3]BGOG and University Hospitals Leuven, Leuven, Belgium; [4]Coordinating Center for Clinical Trials, AGO and Philipps-University Marburg, Marburg, Germany; [5]GINECO and Centre Henri Becquerel, Rouen, France; [6]AGO and Onkologisches Therapiezentrum Krankenhaus Jerusalem, Hamburg, and UKSH Kiel, Hamburg, Germany; [7]GINECO and Institut Jean Godinot, Reims, France; [8]MITO and Istituto Nazionale per lo Studio e la Cura dei Tumori di Napoli, Milano, Italy; [9]NSGO-CTU and Karolinska University Hospital, Clinical Trials Unit Solna, Solna, Sweden; [10]GINECO and CHU de Rouen, Rouen, France; [11]GINECO and Hôpital St Joseph, Paris, France; [12]GINECO and CHU Rennes, Rennes, France; [13]SGOG and Fudan University Zhongshan Hospital, Shanghai, China; [14]NSGO-CTU and Odense University Hospital, Gynecology and Obstetrics, and Department of Clinical Medicine, Faculty of Health, Aarhus University, Aarhus, Denmark; [15]KGOG and Seoul National University, Seoul, Korea, Republic of; [16]GEICO and Hospital Universitari i Politecnic La Fe, Valencia, Spain; [17]MITO and Fondazione IRCCS Istituto Nazionale dei Tumori Milan, Milan, Italy; [18]NSGO-CTU and Herlev University Hospital, Herlev, Denmark; [19]AGO and Ev. Kliniken Essen-Mitte, Essen, Germany*

10.1136/ijgc-2022-ESGO.491

Introduction/Background The DESKTOP III trial has demonstrated a significant survival benefit in AGO-score positive patients who underwent complete cytoreduction at 1st relapse compared to those treated with chemotherapy alone. The question whether eligible patients who missed the opportunity of potentially life prolonging surgery at 1st relapse would benefit from surgery at the time of their second relapse, remains open.
Methodology We evaluated separately the patients who were randomized in the standard, non-surgical arm of the DESKTOP III trial who then subsequently underwent cytoreductive surgery at a subsequent relapse at investigator's discretion.
Results The median progression-free survival (PFS) counted from randomization of 201 patients in the control arm of DESKTOP III was 14.0 months. 171 (85%) had progressive or relapsing disease and 32 of 171 (19%) underwent cytoreductive surgery. Patients' median age at this subsequent surgery was 63 years (range: 46 – 78). Complete tumor resection was