neuroendocrine pulmonary tumor with local invasion and poor response to radiochemotherapy; however during therapy she was diagnosed with bilateral ovarian tumors and ascites which significantly impeded the respiratory function. In order to exclude the presence of a synchronous ovarian cancer and to improve the respiratory function, a total hysterectomy with bilateral adnexectomy was performed; meanwhile 5.5 l of ascites were removed. The histopathological studies demonstrated the metastatic origin of the lesion and enabled the oncologist to administer a second line cytotoxic therapy. However, the patient died of disease after the first cycle of chemotherapy.

Conclusion Although very rare conditions, Krukenberg tumors from ovarian cancer should be suspected whenever an association of confirmed pulmonary malignancy and incidental suspect ovarian tumors are found.

**Abstract 2022-RA-455-ESGO TYPICAL RECURRENCES OF OVARIAN GRANULOSA CELL TUMOR RECURRENT**

Nicolae Bacalbasa, Irina Baleascu. Carol Davila University, Bucuresti, Romania

10.1136/ijgc-2022-ESGO.509

Introduction/Background Ovarian granulosa cell tumors represent a particular subset of ovarian tumors characterized through a low rate of multiplication of the tumoral cells and a low risk of developing distant metastases. However, in isolated cases recurrences might develop.

Methodology The current paper presents the cases of two patients diagnosed with mesosigmoidian metastases from ovarian granulosa cell tumors.

Results The first case was investigated for diffuse abdominal pain after an incidental abdominal trauma while the second case was investigated for subocclusive syndrome. In the first case the preoperative suspicion of diagnostic was of a retroperitoneal hematoma while in the other case the preoperative suspicion of diagnostic was of peritoneal carcinomatosis. Intraoperatively in the first case a large ruptured recurrence with perilesional hematoma was found while in the second case a recurrent tumor at the level of the mesosigmoidian area, in close contact with the sigmoidian lumen was found. In both cases a rectosigmoidian resection was performed, the histopathological studies demonstrating the metastatic origin of the lesion and enabled the oncologist to administer a second line cytotoxic therapy. However, the patient died of disease after the first cycle of chemotherapy.

Conclusion Although very rare conditions, Krukenberg tumors from ovarian cancer should be suspected whenever an association of confirmed pulmonary malignancy and incidental suspect ovarian tumors are found.

**Abstract 2022-RA-456-ESGO GYNAE-ONCOLOGY SURGEONS’ PREPAREDNESS TO UNDERTAKE COLORECTAL PROCEDURES DURING CYTOREDUCTIVE SURGERY FOR OVARIAN CANCER: A CROSS SECTIONAL SURVEY**

1-3Daniel Huddart, 1Savithri Rajkumar, 1Gautam Mehra, 1Rahul Nath, 1Ahmad Sayasneh, 1Women’s Health, Guy’s and St Thomas’ NHS Foundation Trust, London, UK; 2King’s College London, London, UK

10.1136/ijgc-2022-ESGO.510

Introduction/Background Cytoreductive surgery for advanced ovarian cancer commonly involves bowel resection. Although gynaecological oncologists in the UK are trained in bowel surgery, there exists national variations in the degree to which these specialists perform bowel surgery independently. A recent joint policy statement from the British Gynaecological Cancer Society (BGCS) emphasises the need for formalised colorectal support for cytoreductive surgery.

Methodology An anonymous, online survey was emailed to members of the BGCS to assess the current status of multidisciplinary working between gynaecological oncology and colorectal/general surgical teams in the UK. The survey explored access to colorectal surgeons in the pre and peri operative periods and the role of colorectal/general surgical support in common bowel procedures performed during cytoreductive surgery, alongside their input with surgical complications and post-operative management.

Results 46 members responded (8.2% response rate). There was a large variety in the involvement of colorectal and general surgical teams in pre-operative planning. Despite nearly all respondents working in tertiary care centres, 13% of respondents had no formalised agreement for intraoperative support. 72.1% of respondents independently performed rectal peritoneal stripping and 60.5% of respondents independently performed small bowel resection. This reduced to only 27.9% for right hemicolectomy with primary anastomosis and 16.3% for left hemicolecetomy with primary anastomosis. Respondents often involved colorectal support for post-operative complications.

Conclusion Overall, the degree to which gynaecological oncologists independently perform bowel procedures varies within the UK. The majority involve colorectal or general surgical teams in such procedures. Surgical team involvement is more common for large bowel procedures compared to small bowel