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 administrate 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.

2022-RA-455-ESGO TYPICAL RECURRENCES OF OVARIAN GRANULOSA CELL TUMOR RECURRENCE

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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 presence of mesosigmoidian recurrences.

Conclusion Although ovarian granulosa cell tumors usually exhibit a good prognostic and a low rate of recurrence, relapsed tumors with atypical locations might be found. In such cases different visceral resections might be needed in order to control the disease

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

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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 hemicolectomy with primary anastomosis. Respondents often involved colorectal support for post-operative complications.

Abstract 2022-RA-456-ESGO Table 1 How do you perform bowel procedures with regard to colorectal/general surgical

	Independently with remote emergency colorectal/general surgical support if required	Independently with remote pre planned colorectal/general surgical support if required	Colorectal/general surgical attend theatre for the purpose of direct supervision	Colorectal/general surgical would undertake the procedure
Procedure				
Small bowel resection with ileostomy	60.5%	13.4%	4.7%	20.9%
Small bowel resection with primary anastomosis	60.5%	16.3%	7.0%	16.3%
Right hemicolectomy with no anastomosis (bowel stoma)	32.6%	16.3%	11.6%	39.5%
Right hemicolectomy with primary anastomosis	27.9%	11.6%	11.6%	48.8%
Transverse colectomy with colostomy	37.2%	11.6%	4.7%	46.5%
Transverse colectomy with primary anastomosis	25.6%	11.6%	14.0%	48.9%
Left hemicolectomy with colostomy	39.5%	14.0%	11.6%	34.9%
Left hemicolectomy including recto-sigmoid resection with primary anastomosis	16.3%	9.3%	20.9%	53.5%
Sigmoid colectomy with primary anastomosis and de-functioning ileostomy	23.3%	9.3%	18.6%	48.8%
Hartmann's procedure	46.5%	14.0%	7.0%	32.6%
Peritoneal stripping of the rectum	72.1%	16.3%	4.7%	7.0%
Resection of bowel mesenteric or serosal disease	74.4%	18.6%	4.7%	2.3%

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

and for left colon compared to right colon procedures. Nevertheless, 16.3% of respondents were able to independently perform all bowel procedures surveyed. Future research should examine factors such as training and experience within these groups to address this disparity.

2022-RA-459-ESGO UPLIFT (ENGOT-OV67/GOG-3048) A REGISTRATIONAL TRIAL OF UPIFITAMAB RILSODOTIN (XMT-1536; UPRI), A NAPI2B-DIRECTED ANTIBODY DRUG CONJUGATE (ADC) IN PLATINUM-RESISTANT OVARIAN CANCER

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Introduction/Background UpRi is a first-in-class NaPi2b-targeting ADC with a novel scaffold-linker-payload that enables high drug-to-antibody ratio and controlled bystander effect. NaPi2b is a sodium-dependent phosphate transporter protein broadly expressed in high-grade serous epithelial ovarian, fallopian tube and primary peritoneal cancers (HGSOC), with limited expression in healthy tissues. Preliminary antitumor activity from the Phase 1b expansion cohort of heavily pretreated patients with recurrent HGSOC has been reported (Richardson et al., SGO 2022). These data suggested clinically meaningful activity in patients, notably in those with NaPi2b-high tumors (TPS≥75). Effective and well-tolerated treatments for platinum-resistant ovarian cancer (PROC) remain a substantial unmet medical need. The standard of care, single agent chemotherapy, has limited efficacy, significant toxicities, and short duration of response. UPLIFT was designed as a single-arm Ph2 registrational trial for UpRi monotherapy in PROC.
Methodology UPLIFT is enrolling patients with platinum-resistant HGSOC with up to 4 prior lines of therapy (LoT). Prior bevacizumab is required for patients with 1–2 prior LoT only; it is not required for patients with 3–4 prior LoT. Patients may enroll regardless of NaPi2b expression; ≤ Grade 2 peripheral neuropathy is permitted. Primary platinum refractory patients are excluded. UPLIFT will enroll ~180 patients globally, including approximately 100 patients with NaPi2b-high expression. UpRi will be dosed intravenously at 36 mg/m^2 up to ~80 mg dose maximum every 4 weeks. Baseline tumor samples (fresh or archived) will be collected for central analysis of NaPi2b expression. Based on data from the Ph1b expansion cohort, the cut-off for high NaPi2b expression is Tumor Proportion Score (TPS) ≥75. The primary endpoint is ORR in NaPi2b-high expressing patients. Secondary endpoints include ORR in the overall population, duration of response, and safety. UPLIFT is being conducted in collaboration with ENGOT (ENGOT-ov67) and GOG (GOG-3048). NCT03319628
Results N/A trial in progress
Conclusion N/A trial in progress

2022-RA-464-ESGO A PHASE I DOSE ESCALATION AND EXPANSION COHORT TRIAL OF CARBOPLATIN AND GEMCITABINE WITH THE ATR INHIBITOR BERZOSERTIB IN FIRST OR SECOND RECURRENCE PLATINUM SENSITIVE EPITHELIAL OVARIAN, PERITONEAL, AND FALLOPIAN TUBE CANCER

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Introduction/Background The combination of carboplatin and gemcitabine is a commonly used regimen for platinum-sensitive recurrent ovarian cancer. Preclinical studies showed that ATR knockdown in ovarian cancer cell lines sensitized to a wide variety of genotoxic stresses, including gemcitabine and cisplatin. A phase II study evaluating the addition of berzosertib to gemcitabine in platinum resistant ovarian cancer revealed an improvement in progression-free survival (PFS). We sought to assess the safety and preliminary efficacy signal of the triple combination therapy in high grade ovarian cancer (NCT02627443).
Methodology Eligible participants included women with histologically confirmed high grade serous or endometrioid epithelial ovarian, fallopian tube or peritoneal cancer in first or second platinum sensitive recurrence. Using a standard 3+3 design, participants were treated with carboplatin on day 1, gemcitabine on days 1 and 8, and escalating doses of berzosertib on days 2 and 9 of a 21 day cycle. An additional 22 participants enrolled at maximum tolerated dose (MTD). Tumor biopsies were obtained at 3 different timepoints in the expansion cohort.
Results Thirty-three eligible participants were enrolled across 7 institutions in the US, with 28 eligible patients treated at the MTD (6 during dose escalation, 22 during dose expansion). The MTD was deemed to be carboplatin AUC 4, gemcitabine 640 mg/m^2 and berzosertib 90 mg/m^2/day with grade 4 thrombocytopenia as the only DLT. A confirmed response was observed in 14/28 (50%) participants. Median progression free survival was estimated to be 15.1 months (95% CI, 9.8-NE). The most common adverse events were cytopenias (96% grade 3–4 hematologic adverse event). Translational correlates from the expansion cohort are underway.