Progression Free Survival (PFS) & Overall Response Rate was calculated. Quality of life (QOL) was calculated monthly.

Results The median PFS was 4 months (3 mon–5 mon). The median ORR was 15% (13%–17%). Commonest toxicity was grade 2 anemia. No grade 3 toxicity. There were 10 deaths all secondary to disease progression. Among QOL pain & vomiting improved most.

Conclusion OMCRT is quite effective least toxic therapy in heavily treated progressive ovarian cancer. However randomized trial required comparing it with single agent oral etoposide & best supportive care.

Management of Borderline Ovarian Tumors; A Tertiary Referral Center Experience in Egypt

Introduction Background In this retrospective study we discuss our experience as a large tertiary referral center in Egypt in the management and follow up of borderline tumors

Methodology This is a retrospective cohort study where all patients who were diagnosed with a borderline ovarian tumor at the Oncology Center Mansoura University from November 2014 to June 2020 were included.

Results We included 27 patients with borderline ovarian tumors. The mean age of the study patients was (47.67 ± 16.39 years). The median CA 125 was 33 (6–304 U/ml). Frozen section examination was utilized in 13 patients (48.14%) where a diagnosis of borderline ovarian tumors was revealed in 8 patients. Recurrence was reported in one patient with serous type after approximately 26 months. The most common pathological type in our cohort was the mucinous borderline type which was reported in 14 patients (51.9%) followed by the serous type in 11 patients (40.7%) and the seromucinous type in 1 patient (0.36%).

Fertility-sparing surgery could be a valid option for women who are diagnosed with a borderline ovarian tumor during their reproductive age.

Factors Related to Grade IIIa Clavien-Dindo Complications and Delayed Time to Chemotherapy After Cytoreductive Surgery for Advanced Stage Ovarian Cancer: A Prospective Cohort Study

Introduction Background Early post-operative chemotherapy improves the survival of advanced-stage epithelial ovarian cancer (EOC) patients by increasing the benefit of systemic therapy. As a result, recovery time after surgery and time to chemotherapy (TTC) are crucial endpoints for ovarian cancer treatment. The present study aimed to evaluate predictors for 30-day severe post-operative complications classified by Clavien-Dindo classification (CDC) grade ≥IIa and TTC after cytoreductive surgery for primary AEOC.

Methodology Patients undergoing cytoreductive surgery for primary AEOC were enrolled from February 2018 to September 2020. Post-operative complications were graded according to CDC. Logistic regression analysis was performed to evaluate factors predicting CDC grade ≥IIa and TTC > 42 days.

Abstract 2022-RA-609-ESGO Table 1 Clavien-Dindo classification

<table>
<thead>
<tr>
<th>Clavien-Dindo grade</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Grade I</td>
<td>Any deviation from the normal postoperative course without the need for surgical or radiological interventions</td>
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<tr>
<td>Grade II</td>
<td>Requiring surgical, endoscopic or radiological intervention</td>
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<tr>
<td>Grade III</td>
<td>Intervention not under general anesthesia</td>
</tr>
<tr>
<td>Grade IV</td>
<td>Life-threatening complication (including organ dysfunction)</td>
</tr>
<tr>
<td>Grade V</td>
<td>Death of a patient</td>
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</table>

Results CDC grade ≥IIa occurred in 51 (17%) patients. In multivariable analysis, age (p = 0.037), cardiovascular comorbidity (p < 0.001), diaphragmatic surgery (p < 0.001), intraoperative urinary tract injury (p = 0.017), and other visceral injury (e.g., pancreas, stomach, liver or spleen) (p = 0.013)
were factors related to CDC grade ≥IIIa. Of 300 patients, 25 patients did not receive chemotherapy after surgery and were excluded from TTC analysis. In 26% (72/275) TTC was > 42 days: median (IQR) 39 days (29–25) in patients with CDC grade ≥IIIa versus 33 days (25–41) in patients without CDC grade ≥IIIa, p = 0.008. Patients with the following factors: WHO performance grade ≥2 (p = 0.045), intra-operative bowel injury (p = 0.043), other visceral injury (p = 0.008) and post-operative CDC grade ≥IIIa (p = 0.032) had a significantly higher adjusted odds of developing TTC >42 days.

Conclusion Patients with advanced age, cardiovascular comorbidity, and those who required diaphragmatic surgery had a greater adjusted odds of developing CDC grade ≥IIIa. CDC grade ≥IIIa was independently associated with TTC >42 days. A proper pre-operative risk assessment and prevention of intra-operative morbidity is essential in order to prevent severe post-operative complications and the delayed time to chemotherapy.

THE ROLE OF SYSTEMATIC PELVIC AND PARA-AORTIC LYMPHADENECTOMY IN THE MANAGEMENT OF PATIENTS WITH ADVANCED EPITHELIAL OVARIAN, TUBAL, AND PERITONEAL CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

Introduction/Background The objective of the current study is to investigate whether systematic pelvic and para-aortic lymphadenectomy offers superior survival rates and fewer peri-operative complications in patients with advanced epithelial ovarian cancer (EOC), tubal, or peritoneal cancer.

Methodology We searched the electronic databases PubMed, Cochrane Central Register of Controlled trials, and Scopus from inception to September 2021. We considered randomised controlled trials (RCTs) comparing systematic pelvic and para-aortic lymphadenectomy with no lymphadenectomy in patients with advanced EOC. Primary outcomes were overall survival and progression-free survival. Secondary outcomes were peri-operative morbidity and operative mortality. The revised Cochrane tool for randomised trials (RoB 2 tool) was utilised for the risk of bias assessment in the included studies. We performed time-to-event and standard pairwise meta-analyses, as appropriate.

Results Two RCTs with a total of 1074 patients were included in our review. Meta-analysis demonstrated similar overall survival (HR = 1.03, 95% CI [0.85 – 1.24]; low certainty) and progression-free survival (HR = 0.92, 95% CI [0.63 – 1.35]; very low certainty). Regarding peri-operative morbidity, systematic lymphadenectomy was associated with higher rates of lymphoedema and lymphocysts formation (RR = 7.31, 95% CI [1.89 – 28.20]; moderate certainty) and need for blood transfusion (RR = 1.17, 95% CI [1.06 – 1.29]; moderate certainty). No statistically significant differences were observed in regard to other peri-operative adverse events between the two arms.

Conclusion Systematic pelvic and para-aortic lymphadenectomy is likely associated with similar overall survival and progression-free survival compared to no lymphadenectomy in optically debulked patients with advanced EOC. Systematic lymphadenectomy is also associated with an increased risk for certain peri-operative adverse events. Further research needs to be conducted on whether we should abandon systematic lymphadenectomy in completely debulked patients during primary debulking surgery.