were factors related to CDC grade IIa. 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 (29–50) in patients with CDC grade IIa versus 33 days (25–41) in patients without CDC grade IIa, 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 IIa (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 develop CDC grade IIa. CDC grade IIa 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.

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**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**

1Alexander A Tzanis, 2Stavros A Antoniou, 3Konstantinos Ntapoloulou, 4Hara Tsouvali, 5Dimosthenis Zacharoulis, 6Alexandros Daponte, 1University of Thessaly, Larissa, Greece; 2European University Cyprus, Nicosia, Cyprus; 3University Hospital of Ioannina, Ioannina, Greece

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**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 optimally 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.