institution preoperatively due to suspected malignancy. Group 2 comprises patients with incidental findings of OVCA or BOT operated at a non-tertiary center that were referred to our institution postoperatively for completion of surgical staging and adjuvant treatment.

Results

Out of 390 patients, 224 were diagnosed with BOT or OVCA. Clinicopathological data are provided in Table 1, mean follow-up was 63 months. Compared to patients in group 1, patients in group 2 underwent a higher number of surgical interventions (2.1 vs. 1.3, P < .001), showed a longer time from diagnosis until start of chemotherapy (45 vs. 33 days, P = .006), and from diagnosis until completion of staging surgery (73 vs. 32 days, P < .001). Incidental diagnosis was not associated with increased risk of recurrence in patients with BOT (HR 4.6, 95% CI 0.4–52.3, P = .216), early stage (HR 0.6, 95% CI 0.2–1.7, P = .348) or advanced stage (HR 0.9, 95% CI 0.5–1.5, P = .631) OVCA.

Conclusion

Although patients with incidental findings of OVCA or BOT have a longer time until completion of surgical staging and start of chemotherapy our results showed no compromise in oncological outcome. Our findings further highlight the importance of an untimely referral of these patients to a tertiary centre.

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**SURGICAL OUTCOME AFTER UPPER ABDOMINAL SURGERY PROCEDURES FOR OVARIAN CANCER**

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**Introduction/Background**

Surgery has a central role in treatment of advanced ovarian cancer. Various incidence of the surgical procedures in the upper abdominal cavity is reported. This study aims to elucidate surgical outcome after advanced upper abdominal surgery.

**Methodology**

375 patients eligible for surgery for stage IIB-IV ovarian/tubar/peritoneal cancer at the Academic Uppsala University hospital, Sweden, between 2014 and 2022 were included in this study. Inclusion criteria were primary or interval debulking, complete or near to complete (max 2,5 mm residual disease) cytoreduction. T-test and Chi-square-test were used.

**Results**

Complete cytoreduction was achieved in 334/375 (89.1%) cases and near to complete cytoreduction in 41/375 (10.9%) cases. Incidence of complete cytoreduction was higher at stages IIB-III (91.9%) compared to stage IV (82.3%), Chi-square=4.42, p=0.04. High-grade 30-days postoperative complications occurred in 63/375 (16.8%) cases. Incidence of splenectomy was 183/375 (48.8%). Incidence of high-grade postoperative 30-days complications after splenectomy was 46/183 (25.1%) compared to 17/192 (8.8%) when splenectomy was not performed (Chi-square=17.8, p<0.01). Peritoneal cancer index (PCI) was 3-fold higher for patients who underwent splenectomy compared to those who did not need the procedure, 25 and 8, correspondently. Incidence of extirpation of non-regional bulky nodes (cardiofrenic, hepatic hilum and celiac) was 84/375 (22.4%). Incidence of high-grade 30-days postoperative complications after extirpation of non-regional bulky nodes (17/84 – 20.2%) and when procedure was not performed – 43/287 (15%) was similar (Chi-square=1.32, p=0.3). An average PCI for patients who underwent extirpation of non-regional bulky nodes was 25.

**Conclusion**

Significantly more high-grade 30-days postoperative complications occurred after splenectomy, but not after extirpation of the non-regional bulky nodes compared to
when procedure was not necessary. However, incidence of splenectomy and of the extirpation of non-regional bulky nodes is associated with increased PCI, a previously identified by us strong predictor of high-grade postoperative complications.

RARE CANCERS IN GYNECOLOGIC ONCOLOGY, ENGOT INITIATIVE FOR A EUROPEAN REGISTRY

Introduction/Background Management of rare cancers is challenging due to limited data, experience, low referral rates to oncological centers, and the fact that most treatments can only be based on experts’ opinions. Many gynecologic malignancies are considered rare diseases due to their low incidence. The European Commission has highlighted the need for treatment standardization in rare cancers, suggesting the creation of international networks and registries. Our purpose is to create an international European registry for the collection of data on rare gynecologic cancers.

Methodology This is a multi-center, international, retrospective, and prospective observational study collecting data of patients with rare gynecological cancers in centers among the European Network of Gynecological Oncological Trial Group (ENGOT). In its initial development, the study includes patients with malignant germ cell tumors, sex-cord stromal tumors, and low-grade serous tumors of the ovary, and can be expanded to other rare gynecological cancers. The aim is to collect complete clinical, surgical, and pathologic data. The follow-up of patients will continue for up to 20 years. REDCap (Research Electronic Data Capture) web application will be used for data collection. A survey was conducted in order to assess interests and issues among the representatives of each ENGOT collaborative group. Periodical meetings were set up in order to update the ENGOT rare tumor working group on database development and share critical points.

Results The survey showed an interest in adopting the database in 94.4% of responders. The database has been developed, revised by a reviewers committee, and shared for data entry.

Conclusion National collaborative groups will participate independently in setting up a REDCap-based database with the same database structure. A central ENGOT coordination will ensure the appropriate data entry and registry management for future data analysis. This project will allow improving the knowledge of these rare cancers in Europe.

WHOLE-BODY DIFFUSION-WEIGHTED MRI (WB-DWI/MRI) FOR THE PREDICTION OF RESECTABLE DISEASE AT THE TIME OF SECONDARY CYTOREDUCTIVE SURGERY FOR RELAPSED EPITHELIAL OVARIAN CANCER

Introduction/Background Current ESGO guidelines recommend secondary cytoreductive surgery (SCS) followed by chemotherapy in case of first recurrent epithelial ovarian cancer and a platinum-free interval (TFIp) of >6 months as it is the best strategy to prolong progression free survival (PFS) and overall survival (OS). Two prediction models have been developed to improve patient selection for complete resection: AGO and iMODEL. Whole-body diffusion-weighted MRI (WB-DWI/MRI) is a powerful tool to predict resectable disease, however, it has not yet been integrated in the two prediction models. Our aim was to identify the best tool for prediction of resectable disease.

Methodology A retrospective cohort study was performed in the University Hospitals Leuven, a tertiary referral centre, using a database search identifying patients between January 2012 and December 2021. Inclusion criteria were: (a) first relapse after 6+ months TFIp, and (b) WB-DWI/MRI. AGO and iMODEL scores were calculated when MRI demonstrated resectable disease.

Results In total, 246 patients were included. Based on the WB-DWI/MRI, 124 (50.4%) underwent SCS. The performance of WB-DWI/MRI, AGO, and iMODEL score are summarized in Table 1. WB-DWI/MRI (without the use of any model) had the highest accuracy (89%) compared with the addition of AGO and iMODEL scores: 44.6% (p<0.001) and 80.2% (p=0.54), respectively. Adding the AGO or iMODEL score had a negative effect on both the sensitivity and specificity in predicting resectable disease.

Furthermore, when WB-DWI/MRI revealed resectable disease, these patients had a significant longer median PFS: 42.9 months vs. 10.0 months (HR: 0.36; 95%CI 0.25–0.48) and median OS: 64.9 months vs. 31.4 months (HR: 0.36; 95%CI 0.25–0.53) for resectable versus non-resectable disease, respectively.