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.
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.

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

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**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.

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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

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**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 (Hazard Ratio [HR]: 0.35; 95%CI 0.26–0.48) 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.