Abstracts

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A COMPARISON OF END-TO-END AND END-TO-SIDE ANASTOMOSIS FOLLOWING RECTOSIGMOID RESECTION IN OVARIAN CANCER CYTOREDUCTIVE SURGERY
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Introduction/Background Rectosigmoid resections are performed commonly during cytoreductive surgery for ovarian cancer. The two most common approaches to reconstruction are end-to-end (EE) and end-to-side (ES) anastomosis. Data from colorectal studies, including a meta-analysis of randomised controlled trials, suggest a significantly lower anastomotic leak rate following end-to-side compared to end-to-end anastomosis. Here we present the experience from a single gynaecological oncology centre.

Methodology Retrospective data regarding surgery was collected from electronic records for all patients who underwent primary cytoreductive surgery for stage III/IV ovarian cancer during the study period.

Results Over a period of 51 months (01/01/2018–01/04/2022), 243 cytoreductive surgeries were undertaken. A recto-sigmoid resection was performed in 80 (32.9%) patients. Fifteen (18.8%) patients had an end colostomy and five (6.3%) an end ileostomy following total colectomy. A reconstruction with an end-to-end anastomosis was undertaken in 34 (42.5%) patients, and an end-to-side anastomosis in 26 (32.5%). The rate of defunctioning ileostomy was 4 (15.4%) in the ES group and 12 (35.3%) in the EE group and was not significantly different between the two groups. There were two cases (5.9%) of anastomotic leak in the EE group, and no leaks in the ES group. Both leaks were small, and successfully conservatively managed. There was no statistically significant difference in leak rate found between the two groups.

Conclusion This study reports successful implementation of the end-to-side anastomosis technique in ovarian cancer cytoreductive surgery. Additional prospective randomised trials, specifically focussed in this group, are warranted.

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EIGHT YEARS SURVIVORS OF ADVANCED OVARIAN CANCER
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Introduction/Background For patients with epithelial ovarian cancer (EOC), relative 5-year survival rate over all stages is 40%. Long-term survival in advanced disease is observed only in a small proportion of patients with little improvements over the past years. We aimed to identify tumor and patient characteristics of FIGO stage III or IV patients in our cohort, who survived at least 8 years.

Methodology Monocentric retrospective study at a tertiary care university hospital center. Between 2006 and 2012, maximum effort primary debulking surgery at the Department of Gynecology of Jena University Hospital was conducted in 156 advanced stage ovarian carcinoma patients. Follow up data were screened to identify patients, who were still alive 8 years after diagnosis.

Results 16 patients with stage III or IV disease and complete medical records were still alive 8 years after diagnosis. Of these, 15 had tumors with serous histology (high grade: 9, low grade: 4, unknown grade: 3) and one had adenocarcinoma of unknown origin. FIGO stage IIIC was found in 10 patients, stage IV in 4 patients and two patients presented with stage IIIB. Complete cytoreduction (CC0) was achieved at primary debulking surgery in 12 patients, while in 4 patients there was macroscopic residual tumor (CC3). Of these, 3 had high grade carcinoma. At primary surgery, tumor was detected in lymph nodes of 10 long survivors (missing information in 4 patients). Recurrence (at 2.4, 2.9 and 5.0 years after diagnosis, resp.) occurred in three patients (19%).