Abstract 2022-RA-1148-ESGO Table 1

<table>
<thead>
<tr>
<th></th>
<th>Sig3+</th>
<th>Sig3-</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>56</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Primary therapy outcome</td>
<td></td>
<td></td>
<td>0.025</td>
</tr>
<tr>
<td>Complete response</td>
<td>38</td>
<td>69.1</td>
<td>28</td>
</tr>
<tr>
<td>Partial response</td>
<td>15</td>
<td>27.3</td>
<td>19</td>
</tr>
<tr>
<td>Stable disease</td>
<td>3</td>
<td>5.1</td>
<td></td>
</tr>
<tr>
<td>Progressive disease</td>
<td>2</td>
<td>3.6</td>
<td>9</td>
</tr>
<tr>
<td>No data</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Platinum-free interval <0.001
<br>&lt;6 months | 11 | 20.4 | 30 | 50.8 |<br>6–12 months | 9 | 16.7 | 17 | 28.8 |<br>&gt;12 months | 34 | 16.7 | 17 | 28.8 |

Conclusion
Mutational signature 3 test can identify reliable cancers with HRD. Sig3 status predicts treatment outcome and overall survival. Further studies are needed to evaluate clinical validity of Sig3-based assay for predicting PARPi benefit.

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OXALIPLATIN-BASED TREATMENTS ARE CURRENTLY A VALID THERAPEUTIC OPTION IN HEAVILY PRETREATED OVARIAN CANCER PATIENTS WITH HYPERSENSITIVITY REACTIONS (HRs) TO CARBOPLATIN IN THE ANTIANGIOGENICS AND PARPi ERA

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Introduction/Background
Oxaliplatin, in the era prior to anti-angiogenics and PARPi therapies, demonstrated activity in patients (pts) with ovarian cancer (OC) in phase I, II and III studies. Oxaliplatin may play a role in pts with hypersensitivity reactions (HRs) to carboplatin.

Methodology
Single-institution retrospective experience (2004–2022) in terms of efficacy and safety with oxaliplatin in recurrent OC, especially in pts with HRs to carboplatin.SPSS version 22.0 was used for statistical analyses

Results
68 pts were treated with oxaliplatin (monotherapy, 25%, in combination 75%, mostly with gemcitabine (56.4%) or paclitaxel (15.1%). Pts and disease characteristics are shown in Table 1. Median progression free survival (mPFS) and overall survival (mOS) were 3 and 13 months (m), respectively. There was no difference between platinum-resistant and platinum-sensitive in terms of PFS, but there was a benefit in mOS in platinum-sensitive disease (13 vs 6 m). Pts who attained controlled disease with oxaliplatin showed a mPFS of 6 months and mOS of 15 months. 45.9% of patients had experienced prior HRs to carboplatin; 67% of them did not require desensitization to oxaliplatin. However, 17.8% of the patients suffered HRs to oxaliplatin. PARPi before oxaliplatin was used in 5 pts. Of them, two stable diseases were achieved with no objective responses. Pts with clinical benefit to oxaliplatin and who had received prior bevacizumab had a 64% lower risk of progression (HR 0.36 IC 95% 0.169–0.800, p 0.012), and patients with no benefit from oxaliplatin had a better outcome with the previous use of bevacizumab (HR 0.20, IC 95% 0.064 – 0.679, p=0.009). Grade 3/4 toxicity was observed in 36.8%, mainly hematological and gastrointestinal toxicity.

Conclusion
Oxaliplatin improves PFS and OS in pts with OC recurrent setting, in particular in those pts not candidates to receive carboplatin-based regimens mainly due to HRs. Oxaliplatin is currently a valid treatment.

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VALIDATION OF PERITONEAL CANCER INDEX (PCI) SCORE AS A NON-INVASIVE TOOL FOR SURGICAL RESECTABILITY IN ADVANCED OVARIAN CANCER PATIENTS IN A TERTIARY CARE CENTER OF PAKISTAN

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10.1136/ijgc-2022-ESGO.653
Introduction/Background Ovarian cancers (OC) are amongst the worst of all gynecological cancers in terms of their morbidity, recurrence, and survival outcome. Optimal debulking with no macroscopic evidence of residual disease is associated with better progression-free and overall survival. Sugarbaker in 1998 developed a peritoneal cancer index (PCI) score (ranging from 0–39) to assess peritoneal disease spread in gastrointestinal cancers. The application of this score in ovarian cancers will validate it and help in the individualization of the treatment and in predicting operability and residual disease.

Methodology This prospective cross-sectional study was conducted in the department of Obstetrics & Gynaecology, Aga Khan Hospital Karachi after obtaining institutional ethical approval, from September 2021 to May 2022. All consecutive patients with a diagnosis of advanced ovarian cancer were included. The extent of ovarian cancer was calculated by using the Sugarbaker PCI score based on contrast-enhanced computed tomography (CT) pre-operatively. This score was then compared with the surgical PCI score ascertained intra-operatively. The association of both scores with residual disease status was also calculated.

Results A total of 26 patients were included in this study. The mean age of patients was 50.17±11.04. Twenty percent of patients underwent upfront surgery and 80% interval debulking surgery after neoadjuvant chemotherapy. The interclass correlation between CT and surgical PCI was 0.52 (95% CI:0.17–0.75). The agreement between the PCI scores is presented in the Bland and Altman graph (bias=1.115 ±1.96×4.61). Ninety percent of the patients with PCI score <10 had no residual disease and surgical assessment. The mean duration of surgery and estimated blood loss was significantly low in PCI <10 as compared to score >10.

Conclusion PCI is an effective tool to predict the operability and residual disease in a noninvasive manner prior to surgery. This can be of tremendous help in the decision regarding the timing of surgery.

Abstract 2022-RA-1157-ESGO Figure 1

Abstract 2022-VA-1166-ESGO

2022-VA-1166-ESGO SUSPICIOUS LYMPH NODES IN ADVANCED OVARIAN CANCER: DEBULKING SURGERY

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10.1136/ijgc-2022-ESGO.655

Introduction/Background Lymph node staging in ovarian cancer is surgical and is performed by pelvic and para-aortic lymphadenectomy. However, it has not been observed that systematic pelvic and para-aortic lymphadenectomy in advanced ovarian cancer without clinically suspicious lymph nodes is associated with an improvement in patient survival. Nevertheless, to improve the prognosis of patients with advanced ovarian cancer is important to eradicate cancer cells completely and there is sufficient evidence to perform lymph node debulking when there are clinically suspicious nodes.