**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 of <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.

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**Abstract 2022-RA-1157-ESGO**

**IS STILL POSSIBLE TO TREAT OVARIAN CANCER IN A DISTRICT GENERAL HOSPITAL? CONSIDERATIONS FROM OUR EXPERIENCE**

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10.1136/ijgc-2022-ESGO.654

**Introduction/Background** Epithelial ovarian cancer continues to be the leading cause of death from gynecological malignancies. Most patients present at advanced stage, which contributes to the high mortality rates. We all know that patients treated by gynecologic oncologists at cancer centers have better survival outcomes. The purpose of this study is to show our experience in a district general hospital.

**Methodology** Retrospective audit study

**Results** Between January 2011 and June 2020 we treated 170 patients with ovarian cancer; 127pts (74%) showed an advanced stage. Mean age was 61.7 years. Patients were treated by TAH and BSO or USO with multisite resections. Neoadjuvant chemotherapy (NACT) was performed in 46 pts (26.9%); interval surgery (IS) in 43 cases and primary surgery (PS) in 124 patients (73.1%). Residual disease was 0 (68%), < 1 cm (16%), > 1 cm (16%). All the operation were done by single surgeon (GG) with the help of abdominal surgeon (AV) when needed. Total overall survival (OS) was 39.7 months. OS for patients undergone to PS was 41.7 months, and 32.8 months in the group of IS. Recurrence disease was observed in 29.7% of patients.

**Conclusion** We wanted to review all our ovarian cancer cases in order to see if our clinical outcome were similar at other gynecological cancer unit. We have clear in mind that the most important prognostic factor associated with improved survival is a complete resection of the all visible disease. We strong believe that if there are all the facilities inside the hospital to upfront this illness and there are the oncological culture together with the surgical skills is still possible to treat ovarian cancer patients in a district general hospital with comparable clinical outcome.

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**Abstract 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.