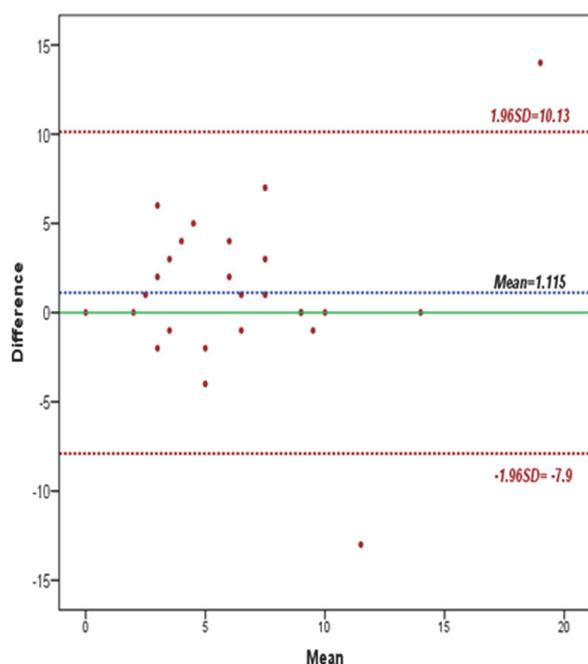


**Introduction/Background** Ovarian cancers (OC) are amongst the worst of all gynecological cancers in terms of their morbidity, recurrence, and survival outcome. Optimal debulking with no macroscopic evidence of residual disease is associated with better progression-free and overall survival. Sugarbaker 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  $50.17 \pm 11.04$ . 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 =  $1.115 \pm 1.96 \times 4.61$ ). 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.



Abstract 2022-RA-1156-ESGO Figure 1

**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.

2022-RA-1157-ESGO

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

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**Introduction/Background** Epithelial ovarian cancer continues to be the leading cause of death from gynaecological malignancies. Most patients present at advanced stage, which contributes to the high mortality rates. We all know that patients treated by gynaecologic 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 multivisceral 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 (GC) 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 gynaecological 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.

2022-VA-1166-ESGO

### SUSPICIOUS LYMPH NODES IN ADVANCED OVARIAN CANCER: DEBULKING SURGERY

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**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.

The objective of this video is to highlight the importance of to perform a complete radical ovarian surgery that includes lymph node debulking of suspicious nodes.

**Methodology** We present the interval surgery of a 61-year-old woman, who was found to have an advanced serous papillary ovarian cancer, described as FIGO IIIC.

**Results** During the exploratory laparoscopy an important adenopathic lump was observed above inferior mesenteric, fixed to the vena cava, with a mass effect, unresectable from the outset. The surface of the spleen suggested the presence of metastatic implants; small subdiaphragmatic and peritoneal implants were observed, so treatment with neoadjuvant chemotherapy was decided. After neoadjuvant treatment the PET-CT shows an interaortocaval retroperitoneal hypermetabolic adenopathy, suggestive of tumour infiltration. No more morphometabolic lesions were observed, so interval surgery was decided. Interval surgery was uneventful, and lymph node debulking of the inter-aortocaval adenopathy was also performed. For this, a careful dissection of the adventitia of the aorta was performed until accessing the interaortocaval plane and locating the adenopathy (located between the exit of the inferior mesenteric artery and the crossing of the left renal vein). A complete exeresis of the adenopathy was achieved without incident

**Conclusion** This video proves that the surgical procedure of debulking surgery of suspicious lymph nodes is feasible without major complications if performed by experienced gynaecologists.

#### 2022-RA-1172-ESGO

#### CLINICAL OUTCOMES OF OVARIAN CANCER MANAGEMENT: A SINGLE TERTIARY REFERRAL CENTRE EXPERIENCE

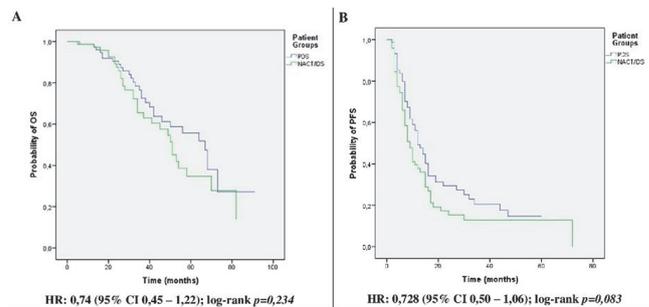
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**Introduction/Background** High grade serous carcinomas are the most common subtype of ovarian cancer. Mostly the patients diagnosed with advanced stage disease. The main approach for management consists of primary debulking surgery (PDS). However, some patients cannot be good candidates for primary surgery, and neoadjuvant chemotherapy (NACT) followed by interval debulking surgery (IDS) emerges as an alternative strategy. In our study, it was aimed to show that both strategies applied in our clinic are similar in terms of effectiveness.

**Methodology** Our study retrospectively included 151 patients who were treated between January 2014 and May 2021 in Hacettepe University, Gynaecological Oncology Clinic with a diagnosis of advanced stage high-grade serous carcinoma. These patients were divided into two groups by their strategies as 77 patients for PDS and 74 patients for NACT/IDS groups in terms of 1:1 ratio. Two groups were comparatively investigated for patient characteristics, staging, recurrence and survival rates, and follow up outcomes.  $p < 0,05$  was considered to be statistically significant.

**Results** The importance of performance status ( $p=0,003$ ) and the clinical stage of patients ( $p=0,001$ ) were shown regarding to patient selection for the appropriate strategy. Direct effect of 'no residual tumour after surgery' on overall survival rates was determined by multivariate analysis (HR: 0,57 [95% CI 0,34 – 0,96];  $p=0,034$ ). In terms of overall survival (HR: 0,74 [95% CI 0,45 – 1,22];  $\log$  rank  $p=0,234$ ) and progression-free survival (HR: 0,728 [95% CI 0,50 – 1,06];  $\log$  rank  $p=0,083$ ), it was shown that both of strategies were similar for effectiveness. There was no impact of pandemic on strategy selection ( $p=0,073$ ).



**Abstract 2022-RA-1172-ESGO Figure 1** Kaplan meier plots for overall survival (OS): A and progression-free survival (PFS): B 3-years OS: 73% for PDS and 3-years OS: 63% for NACT/IDS groups

**Conclusion** NACT/IDS and PDS strategy have the same effectiveness, in terms of surgical complications, recurrence and survival rates. However, if it is envisaged that no residual disease after surgery with appropriate patient selection for strategy, PDS strategy can be considered as leading option.

#### 2022-RA-1176-ESGO

#### BORDERLINE OVARIEN TUMOR MANAGEMENT IN A TUNISIAN HOSPITAL

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**Introduction/Background** The aim of this study was to determine the epidemiology and clinicopathological characteristics of the borderline ovarian tumors (BOTs). Additionally we sought to characterize the outcomes of the borderline ovarian management and identify variables affecting survival.

**Methodology** A retrospective study of 49 patients with BOTs all stages taken together treated or referred to our institutions was conducted over a period from June 2016 to July 2021. Data was analyzed by using SPSS Statistics for Windows, Version 23.0.

**Results** The median age was 43.3 (range=21–61) years. The majority of BOTs was serous tumors (61.2%) followed by mucinous tumors (36.7%) and less common histotypes as Endometrioid borderline tumours (2.1%). In the case of 34 patients (66.7%) a frozen section was taken intraoperatively