levels were positive in their second-look. 70% of patients with residual tumors having the greatest diameter less than or equal to 2 cm had normal CA125 with a mean value of 21 u/ml. 42% of patients with tumors having the greatest diameter greater than 2 cm had normal CA125, while all the 8 patients with no macroscopic tumor during surgery had normal CA125 level. These results show that the residual tumor size found in the second-look was related to the serum CA125 level.

Conclusion As CA125 levels within normal limits gave more false negatives, the necessity of second-look surgery can not be judged by serum CA125 assay though elevated CA125 levels do predict the presence of tumor.

**2022-VA-1284-ESGO**

**INDOCYANINE GREEN AS A LEARNING TOOL FOR PARA-AORTIC LAPAROSCOPIC LYMPHADENECTOMY AFTER SENTINEL LYMPH NODE DETECTION IN OVARIAN CANCER**

Ana Conde Adán, Sorsoles Alonso, María F Cherequini, Carmen Yelo, Virginia Corraliza, Rafael Navarro, Marisa Argente, Francisco Javier De Santiago García. Gynecology, MD Anderson Cancer Center, Madrid, Spain

10.1136/ijgc-2022-ESGO.676

Introduction/Background Indocyanine green is being widely used in gynecology oncology; specially in sentinel node detection in endometrial cancer. New applications are being studied, as sentinel node detection in ovarian cancer.

Methodology We are performing indocyanine green laparoscopic sentinel node detection in a woman affected by ovarian cancer. She had been diagnosed after an anexectomy for a suspicious ovarian mass in another center. We inject indocyanine green in the infundibulopelvic and the ovaric ligament stumps through the abdominal wall.

Results After the detection of the sentinel nodes we perform the lymphadenectomy with the fluorescent camera on. We perceive the anatomical marks more clearly, the difference between the vessels and the lymphatic tissue became more individualized. Avoiding vessel injury is one of the challenges in the learning curve for para-aortic lymphadenectomy. Anatomical variations in the para-aortic region occurred in one third of the women.

Conclusion Indocyanine green is a useful tracer for sentinel node detection. We propose that it could be a learning tool for beginners in the lymphadenectomy technique and in cases of special difficulty, for example in anatomical variations.

**2022-RA-1288-ESGO**

**UNKNOWN OVARIAN NEOPLASM WITH RETROPERITONEAL INVOLVEMENT – METASTASIS OR TWO PRIMARY TUMORS? – CASE REPORT**

1Archil Sharashenidze, 2Mariam Jashi, 1Gvantsa Kociashvili, 1Ana Khoperia, 1Beqa Aslanishvili, 1Leoko Lagnava, 2Solomon Kerashvili, 3Irine Khubua. Gynecologic Oncology, Caucasus Medical Center, Tbilisi, Georgia; 2David Tvlidiani Medical University, Tbilisi, Georgia; 3General Surgery, Caucasus Medical Center, Tbilisi, Georgia; 4Clinical Oncology, Caucasus Medical Center, Tbilisi, Georgia

1,2Archil Sharashenidze, 1Mariam Jashi, 1Gvantsa Kociashvili, 1Ana Khoperia, 1Beqa Aslanishvili, 1Leoko Lagnava, 2Solomon Kerashvili, 3Irine Khubua. Gynecologic Oncology, Caucasus Medical Center, Tbilisi, Georgia

10.1136/ijgc-2022-ESGO.678

Introduction/Background Proper diagnosis of abnormal ovarian masses determines the extent of surgical procedure and adjuvant chemo/radiation treatment. Occasionally, invasive, radiologic and laboratory tests are inconclusive and planning of upcoming steps in management requires individual approach. Detailed description of such cases in scientific literature could be beneficial for the management of similar occurrences.

Methodology 54 year old patient admitted to the onco-gynecology department with pain and unpleasant sensation in right hypogastric area. Contrast-enhanced CT scan revealed non-contrast-enhancing, nonhomogeneous cystic mass, 10.6 cm in diameter in place of right ovary. 2.7 cm and 2.3 cm masses were visualized in pararectal and presacral areas, embedded in retroperitoneal fat. Ovarian markers were within normal inhibitors as part of treatment for relapsed ovarian cancer. The 71-year-old was diagnosed with high-grade serous ovarian carcinoma (HGSOC), FIGO stage IIIIB, BRCA-1 positive, in 2013 and underwent extensive treatment for almost ten years. First-line therapy included six cycles of carboplatin-paclitaxel plus bevacizumab between January and May, 2013 followed by maintenance therapy with bevacizumab until March, 2014. After relapsing in June, 2017 the patient underwent salvage surgery with complete resection and platinum rechallenge therapy with six cycles of carboplatin-celox plus bevacizumab. As maintenance therapy all three PARP-inhibitors were used consecutively from May, 2018 two of which had to be discontinued due to side effects. First niraparib following recurrent thrombocytopenia, then olaparib for abdominal pain. To enable treatment with a PARP-inhibitor, she receivedrucaparib from October, 2018 until her second relapse in June, 2020. After another salvage surgery with complete resection she was given three cycles of carboplatin and one cycle of cisplatin from September, 2020 to January, 2021. She has received maintenance therapy with rucaparib since March, 2021 with manageable side effects.

Methodology Patient’s file, Excel, patient interview

Results Rucaparib caused a slower and smaller decrease in platelet count. Transaminases only increased slightly without reaching adverse effect level according to CTCAE, making it an asymptomatic laboratory finding.

Conclusion This report gives an example of how to manage potential side effects during PARP-inhibitor therapy in routine clinical practice. Even after intolerance of two PARP-inhibitors, another was tolerated, showing that switching PARP-inhibitors during therapy is possible. Patients react differently to side effects of PARP-inhibitors, further studies should focus on predictive clinical and pharmacodynamic parameters to identify individual toxicity for optimization of the efficacy of PARP-inhibitors.

**2022-RA-1287-ESGO**

**CASE REPORT OF A PATIENT WITH RELAPSED OVARIAN CANCER AND THERAPY WITH ALL THREE APPROVED PARP-INHIBITORS**

1Katharina Franziska Keller, 1Elena Ioana Braicu, 1Jacek P Grabowski, 1Klaus Pietzner, 2Jalid Sehouli. 1Department of Gynecology including center of oncological surgery (CVK), Charité Campus Virchow-Klinikum, Berlin, Germany; 2Medical Department of the Department of Gynecology including center of oncological surgery (CVK), Charité Campus Virchow-Klinikum, Berlin, Germany

10.1136/ijgc-2022-ESGO.677

Introduction/Background We report on the first patient to our knowledge, to receive all three approved PARP-