2022-RA-1294-ESGO CHEMOSENSITIVITY IN VULNERABLE OLDER PATIENTS IS UNFAVORABLE AND HIGHLY DEPENDENT ON THE TREATMENT REGIMEN: CA125 ELIMINATION RATE CONSTANT K (KELIM) ANALYSIS OF THE GINECO-ENGOT EWOC-1 TRIAL

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Introduction/Background Older patients (pts) with ovarian cancer have a poorer survival, classically related to suboptimal treatment or excessive toxicities; however histological aggressivity and chemoresistance may contribute to this worse outcome. CA-125 elimination rate constant K (KELIM) was shown to be a robust marker of intrinsic chemosensitivity either in adjuvant or neoadjuvant settings. EWOC-1 trial (NCT02001272) was designed to evaluate the feasibility of three treatment regimens in vulnerable pts aged ≥70 years in first line; pts treated with carboplatin monotherapy (C) had a 2.79-fold higher risk of death compared to carboplatin-paclitaxel (CP). An ancillary analysis of EWOC-1 was designed to evaluate the differential chemosensitivity in the 3 treatment arms using KELIM.

Methodology KELIM calculation was performed according to You et al. (www.biomarker-kinetics.org™/CA125-neo) on EWOC-1 trial database of 120 pts (40 in each arm: standard CP (arm A); C (arm B); 3w/4 weekly CP (arm C)).

Results KELIM was evaluable for 58 pts (A: 18; B: 22; C: 18), its median [IQR] was 0.76 (0.59; 0.90) in the total population, significantly associated with treatment arms: A: 0.99 [0.71; 1.11]; B: 0.56 [0.32; 0.77]; C: 0.77 [0.50; 0.90], p=0.008; pairwise comparison arm A vs B, p=0.001. Only 15 pts (25.9%) had a favorable (≥1) KELIM, associated with a significant increase in overall survival (HR: 0.240; 95%CI: 0.089–0.645; p=0.002).

Conclusion KELIM values were globally unfavorable in this older population. Chemosensitivity was highly dependent on the treatment regimen, with a median KELIM comparable in the standard carboplatin-paclitaxel arm (A) to previously published data on younger patients. These data strengthen the need to avoid under-treatment in the older population. KELIM™ may be considered in older pts as both a marker of intrinsic- (tumor-related) and extrinsic-(treatment-related) chemosensitivity.

2022-RA-1295-ESGO THE ROLE OF INTRAOPERATIVE INDOCYANINE GREEN FLUORESCENCE ANGIOGRAPHY IN PREVENTING ANASTOMOTIC LEAKAGE AFTER COLORECTAL RESECTION FOR ADVANCED OVARIAN CANCER

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Introduction/Background The use of intraoperative indocyanine green fluorescence angiography (ICG-FA) in the assessment of anastomotic perfusion after bowel resection has been widely increased in the last years. However, few data are available on its use for ovarian cancer surgery. This study aimed to assess the impact of ICG-FA in reducing anastomotic leakage after colorectal resection during primary cytoreductive surgery for advanced ovarian cancer (AOC).

Methodology Patients with AOC who underwent a primary cytoreductive surgery with colorectal resection at the European Institute of Oncology, Milan from 1/2009 to 12/2021 were retrospectively identified. The use of ICG-FA to assess the anastomotic perfusion was introduced at our institution on 1/2020. The rate of anastomotic leak after colorectal resection was compared between the group using ICG-FA and the group not using ICG-FA. The association between the use of ICG-FA and the occurrence of anastomotic leakage was evaluated with univariate and multivariate statistical analysis.

Abstract 2022-RA-1295-ESGO Table 1

				Predictors of rectosigmoid anastomotic leak		
				Univariate analysis	*Multivariate analysis*	
	N of patients	Rectosigmoid leakage No (N=412)	Rectosigmoid leakage Yes (N=27)	p-value	Adjusted OR[1] (95% CI)	p-value
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Age *(Median- IQR)*	60 (50.5 – 67)	62 (52.0-70.0)	60 (50.0-67.0)	0.20		
Albumin *(Median- IQR)*	4.1 (3.8 - 4.3)	4.1 (3.8 - 4.3)	4.1 (3.8 - 4.4)	0.86		
Preoperative hemoglobin *(Median- IQR)*	12.4 (11.4 - 13.2)	12.4 (11.4 - 13.1)	12.6 (11.3- 13.8)	0.54		
Preoperative platelets *(Median- IQR)*	320.5 (249.7 - 420.5)	320.5 (248.7- 418.5)	312.5 (264.6-460.2)	0.63		
Ca125 *(Median- IQR)*	874 (346.3 - 2547.8)	850.9 (334.2-2605.9)	947.5 (605.7- 2123)	0.46		
Additional small bowel resection (%) *No* *yes*	365 (79.7) 74 (20.3)	344 (80.2) 68 (19.8)	21 (71.4) 6 (28.6)	0.44		
Additional large bowel resection (%) *No* *Yes*	355 (76.3) 84 (23.7)	336 (77.4) 76 (22.6)	19 (57.9) 8 (42.1)	0.15		
Residual Tumor (%) *No* *Yes* *Unknown*	280 (63.8) 157 (35.8) 2 (0.4)	269 (65.3) 141 (34.2) 2 (0.5)	11 (40.7) 16 (59.3) 0 (0)	0.03	Ref 2.32 (0.99-5.41)	0.12
Surgical time (min) *(Median- IQR)*	315 (268 – 353)	310 (263 – 345)	338.5 (284.7- 394.2)	0.005	1 (1.00-1.01)	0.02
Use of ICG-FA (%) *Yes* *No*	118 (36.8) 321 (63.2)	116 (28.2) 296 (71.8)	2 (8) 25 (92)	0.02	Ref 4.66 (1.07- 20.32)	0.01

[1]OR were adjusted for residual tumor, surgical time, and use of ICG-FA.

Results In total, 439 patients meeting inclusion criteria were included. Among them, in 118 (36.8%) the ICG-FA was used, while in 321 (63.2%) the ICG-FA was not used. Overall, 27/439 (6.1%) patients had an anastomotic leak, including 2/118 (1.69%) in the group using ICG-FA and 25/321 (7.8%) in the