Results 107 patients received 3wC (n=31) or 3wCP (n=76, 2 receiving 3wC with weekly paclitaxel). Patients treated with 3wC rather than 3wCP were older ((median age 83 vs. 75 (p<0.001)) with more comorbidities (median CCI 4 vs. 3 (p<0.001)). Treatment was discontinued for 4 of the 31 (13%) 3wC patients and 6 of the 76 (8%) patients who received 3wCP, with death and disease progression the most common reasons for discontinuation respectively, although the difference in discontinuation rate was not significant (p>0.05). Dose reductions occurred in 16% (5/31) of patients who received 3wC and 57% (43/76) of patients treated with 3wCP, most commonly due to haematological toxicity and peripheral neuropathy respectively.

Conclusion In spite of the limitations of our retrospective analysis, 3wCP appears as feasible as 3wC monotherapy for frail ≥70 yo FIGO stage III/IV OC patients, in keeping with the EWOC-1 data, and should be considered in this cohort given that it has been shown to achieve better survival outcomes. Toxicity profiles differ and dose reductions may be required in each treatment arm.

Introduction/Background Ovarian cancer is a common malignancy associated with poor outcomes. The tumour microenvironment (TME) has been shown to be important in tumorigenesis and prognosis. Tumour associated macrophages (TAM) are the most abundant type of immune cells in TME. Dependent on stimuli, TAM may become anti-tumorigenic or pro-tumorigenic.

Methodology The study group consisted of 86 patients diagnosed for epithelial ovarian cancer at Çukurova University Faculty of Medicine which were operated between June 2009 and November 14, 2018. Of these 86 patients; 46 of them are high grade serous ovarian cancer, 7 of them are low grade serous ovarian cancer, 14 of them are mucinous carcinoma, 19 of them were in the histopathological type of clear cell carcinoma. MUC1, HER2neu, Estrogen, Progesterone antibodies were applied immunohistochemically to pathological samples of the patients and the expression status of these markers, relationship between clinical-pathological features and prognosis were analyzed by statistical methods.

Results In all patients in the low grade serous ovarian cancer and clear cell carcinoma groups MUC1 stained strongly positive. The frequency of MUC1 positive staining was lower in mucinous carcinoma; but it was observed that in high grade serous ovarian cancer it was higher (p<0.01). Half of the mucinous carcinoma group HER2neu stained strongly positive. In the high grade serous ovarian cancer pathology group who were resistant to platinum therapy estrogen receptor was found to be positive in all 16 patients.

Conclusion High positive staining of MUC1 was determined in low grade serous ovarian cancer and clear cell carcinoma group patients. The higher estrogen-progesterone receptor expressions in platinum resistant patients in high grade serous ovarian cancer group, the detection of HER2neu positivity in half of the population in the mucinous carcinoma group is an important result of this study. For targeted therapy results should be taken into account in these epithelial ovarian cancers which are difficult to manage.
CD68 and CD163 were highly significantly expressed in cancers compared with BOT (p<0.001 and 0.004 respectively). Similarly, stromal CD163 mean count and percentage were more abundant in malignant tumours (p=0.03 and 0.02). Mean stromal CD68 count and percentage correlated positively with mean CD163 stromal count and percentage (p=0.02). Risk of malignancy index was a significant predictor of ovarian cancer diagnosis (p=0.04). 15 cancer patients died of the disease. There was no significant association between TAM expression and patient survival.

Conclusion TAM subtypes analysis in ovarian neoplasia of young women confirms higher expression in malignant compared with borderline ovarian tumours. This might have implications on their pathogenesis and management.

**Introduction/Background**

The uptake of a minimally invasive approach in the management of gynaecological malignancies has increased over the years, because of advancement in skills, equipment, and the advantages of a swifter recovery, lower blood loss and reduction in the length of hospitalisation. However, this has been viewed with much hesitance in the realm of ovarian malignancies due to fear of spill and incomplete clearance of tumour, especially when the tumours are large.

**Methodology**

We describe two cases in which the large pelvic masses (both about 12 cm in size) were handled in an oncologically sound manner, allowing for accurate intra abdominal assessment of disease, and removal of the ovarian mass without surgical spill. The first is that of an ovarian immature teratoma with gliomatosis peritonei in a 6 year old girl, the second is that of a 35 year old lady with a mucinous ovarian carcinoma.

**Results**

In the case of the 6 year old, a computed tomography scan showed a 12 cm heterogenous suspicious looking ovarian mass with no evidence of distal or nodal metastases. A laparoscopic approach was undertaken to remove this mass with the steps outlined below. 1. Supraumbilical camera port placement and intra abdominal survey 2. Peritoneal washings 3. Tilting patient to expose the gonadal vessels; isolating the ureter before performing a unilateral salpingo oophorectomy (USO) 4. Putting the entire USO specimen into a 6 litre retrieval bag and removal via the suprapubic port with manual morcellation 5. Omental biopsy, examination of bowel and mesentery, digital palpation of the retroperitoneal lymph nodes performed 6. Excision of pouch of Douglas (POD) lesions performed. The second case was approached in a similar manner, excluding the final step.

**Conclusion**

In carefully selected cases of ovarian malignancy, a minimally invasive approach can be undertaken safely.