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MINIMALLY INVASIVE VS. OPEN INTERVAL DEBULKING SURGERY IN ADVANCED OVARIAN CANCER PATIENTS: PATTERN OF RECURRENCE AND ONCOLOGICAL OUTCOME IN A PROPENSITY MATCHED POPULATION

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Introduction/Background Minimally invasive interval debulking surgery (MI-IDS) is a promising approach for women with optimal response to neo-adjuvant chemotherapy (NACT). Safety is currently under investigation with a prospective randomized multicentric international phase III trial. This study aims to compare sites and spread of recurrence and overall survival (OS) after MI-IDS or laparotomic IDS (LPT-IDS).

Methodology We retrospectively identified all epithelial advanced ovarian cancer patients who underwent IDS after NACT between 2014 and 2020. Patients were divided in two groups according to the type of approach at IDS: MIS or laparotomic. The choice for one approach vs the other was surgeon dependent. A 1:1 propensity score-matched analysis was applied to balance the two surgical groups according to prognostic clinical factors such as radiological response after NACT, Ca125 serological response, number of peritoneal sites involved, and high-volume surgeon (≥ 30 cytoreductive surgeries per year). The site of recurrence was classified based on PET/CT scan, as peritoneal, lymph-nodal, or other (parenchymal and mixed). The extension of recurrence was classified as single, oligometastatic (≤ 3 nodules), multifocal/diffused (> 3 nodules or wide peritoneal spread).

Abstract 2022-RA-1375-ESGO Table 1 Preoperative and recurrence data in the propensity matched population

Variables	All patients n (%)	Group 1 MI-IDS n (%)	Group 2 LPT-IDS n (%)	p-value
All cases	184	92	92	
Technical Response after NACT (RECIST)				0.165
CR	32 (17.4)	19 (20.7)	13 (14.3)	
PR	152 (82.6)	73 (79.3)	79 (85.9)	
Ca125 response after NACT				0.148
CR	187 (102.8)	97 (105.7)	90 (97.9)	
PR	75 (41.2)	33 (35.7)	42 (45.7)	
High-volume surgeon *				0.133
No	58 (31.5)	27 (27.2)	31 (33.8)	
Yes	126 (68.5)	65 (72.8)	61 (66.1)	
Peritoneal sites involvement, n				0.590
≤ 2	173 (94.0)	87 (94.6)	86 (93.5)	
> 2	11 (6.0)	5 (5.4)	6 (6.5)	
Surgical complexity score by AMB				0.296
1	169 (91.8)	86 (93.5)	83 (90.2)	
1-2	15 (8.2)	6 (6.5)	9 (9.8)	
RT				0.383
0	172 (93.5)	87 (94.6)	85 (92.4)	
≥ 1	12 (6.5)	5 (5.4)	7 (7.6)	
Recurrence *	138 (75.0)	67 (72.8)	71 (77.3)	0.121
Site of recurrence *				0.780
Peritoneum	33 (23.2)	14 (15.0)	19 (20.2)	
Lymph-node (n)	15 (10.8)	8 (8.7)	7 (7.6)	
Other	66 (48.0)	32 (34.8)	34 (36.8)	
Number of lesions *				0.560
Single	17 (14.0)	8 (14.8)	9 (11.4)	
Oligometastatic (2-3 nodules)	30 (18.3)	16 (17.3)	14 (15.2)	
Multifocal/Diffused/Circumferential	94 (77.7)	49 (52.9)	45 (49.6)	

* ≥ 10 radical surgery for AOC per year

* Rates calculated by the total of patients with recurrence information (117 of 138 patients)

Abbreviations: MI-IDS: minimally invasive interval debulking surgery; NACT: neo-adjuvant chemotherapy; CR: complete response; PR: partial response; RT: residual tumor.

Results In the propensity-matched population, 92 patients underwent MI-IDS and 92 LPT-IDS. We documented 138 recurrences (75.8%) without statistically significant differences between the two populations (72.2% vs. 79.3%; $p=0.171$) (table 1). Information on the site of recurrence was available in 117 of 138 patients, and we reported a high rate of mixed disease in both groups (59.3% vs. 58.7%) with a low rate of lymph-nodal recurrence (14.8% vs. 11.1%) ($p=0.780$). Most

patients relapsed as a widespread disease without difference between the two approaches (74.1% vs. 80.6%; $p=0.560$). The median OS was 43 months in MI-IDS and 48 months in LPT group ($p=0.968$).

Conclusion This study shows no significant impact of the type of surgical approach at IDS (MIS vs. LPT) on the site and extension of recurrence and overall survival.

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PATIENTS WITH MINIMAL RESIDUAL DISEASE AT UPFRONT DEBULKING SURGERY HAVE SIMILAR SURVIVAL OUTCOME THAN PATIENTS WITH COMPLETE CYTOREDUCTION AFTER NEOADJUVANT CHEMOTHERAPY

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Introduction/Background Complete primary debulking surgery (PDS) is the mainstay of treatment for advanced ovarian cancer. However, three randomized trials have demonstrated non-inferiority survival outcome of neoadjuvant chemotherapy followed by interval debulking surgery (IDS). It is widely accepted that NACT is the preferred approach for patients with poor medical performance or with unresectable disease. Best treatment strategy for patients with minimal residual disease at PDS remains under debate. Aim of this study is to evaluate if patients with minimal residual disease of less than 2.5 mm (CC-1) at the time of PDS have similar oncologic outcome from patients with complete macroscopic resection at the time of IDS.

Methodology A retrospective multi-centric study was designed collecting data from patients treated of advanced ovarian cancer with IIIC-IV FIGO stage and CC-0 or CC1 residual disease from January 2008 to December 2015. Patients underwent PDS nor IDS/DDS after 3–4 cycles or 6 of neoadjuvant chemotherapy (NACT). Overall survival (OS) and disease-free survival (DFS) were assessed based in surveillance follow-up to 60 months.

Results 549 patients were included. PDS was performed in 175 patients (31.9%) while 374 (68.1%) underwent IDS. 18 of PDS patients had a CC-1 after surgery and 324 of IDS patients had a CC-0 result. Overall median DFS and OS were 19.4 months [95%CI=18.0–20.6] and 68.1 months [95%CI=62.9–73.3], respectively. Univariable analysis revealed no statistical differences in either OS nor DFS between PDS/CC-1 group and IDS/CC-0 group [OS: HR 95% CI=0.54–1.82, p -value=0.9687] [DFS: HR 95% CI=0.52–1.43, p -value=0.5608]. In multivariable analysis PCI score > 10 and surgical complexity were statistically significant for DFS, but only surgical complexity was associated with OS.