

Surgical variables, intra and postoperative complications according to Classification of ovarian cancer metastases in the liver area

| Variable | Class I N (%) | Class II N (%) | Class III N (%) | Mixed N (%) | p-value |
|------------------------------------|------------------|------------------------|------------------------|-------------------------|---------|
| All cases | 337 | 25 | 42 | 161 | |
| SCS | 1-2 3 | 15 (20.0) 60 (80.0) | 11 (26.2) 31 (73.8) | 22 (13.7) 139 (86.3) | 0.239 |
| OT, mL (median, IQR) | 380 (300-462) | 400 (310-480) | 395 (300-480) | 450 (360-560) | <0.001 |
| EBL, mL (median, IQR) | 400 (300-600) | 400 (300-700) | 375 (300-500) | 500 (400-1000) | <0.001 |
| IO complications | 33 (13.7) | 11 (43.7) | 2 (4.8) | 20 (12.7) | 0.297 |
| IO Transfusion | 60 (17.8) | 14 (58.7) | 5 (11.9) | 49 (30.4) | 0.004 |
| Diaphragmatic injury | 22 (6.5) | 3 (4.0) | 0 (0.0) | 9 (5.5) | 0.329 |
| Vascular injury | 5 (1.5) | 6 (8.0) | 0 (0.0) | 5 (3.1) | 0.009 |
| Visceral injury | 26 (7.7) | 2 (2.7) | 2 (4.8) | 12 (7.5) | 0.417 |
| IO complication, grade | | | | | 0.713 |
| CTCAE 1-2 | 50 (92.6) | 11 (100) | 3 (100) | 25 (96.2) | |
| CTCAE 3-5 | 4 (7.4) | 0 (0.0) | 0 (0.0) | 1 (3.8) | |
| PO complications | 163 (49.0) | 45 (60.0) | 21 (50.0) | 104 (66.6) | 0.007 |
| Hilary Fibrosis | 1 (0.3) | 0 (0.0) | 0 (0.0) | 0 (0.0) | 0.243 |
| Peritoneal collection | 4 (1.2) | 3 (4.0) | 4 (9.5) | 10 (6.2) | 0.003 |
| Intraoperative Hemostasis/Albion | 0 (0.0) | 0 (0.0) | 2 (4.8) | 0 (0.0) | <0.001 |
| Plotic effusion | 87 (25.8) | 25 (33.3) | 6 (14.3) | 63 (39.1) | 0.002 |
| Sepsis | 45 (13.4) | 4 (5.3) | 6 (14.3) | 36 (22.4) | 0.084 |
| Anemia | 83 (24.6) | 23 (30.7) | 8 (19.0) | 58 (36.0) | 0.030 |
| Others | 111 (32.9) | 33 (44.0) | 14 (33.3) | 71 (45.3) | 0.031 |
| Postoperative complications, grade | | | | | 0.008 |
| Dindo grade 0-1-2 | 286 (84.9) | 59 (78.7) | 40 (95.2) | 122 (75.8) | |
| Dindo grade 3-5 | 25 (7.5) | 16 (21.3) | 2 (4.8) | 39 (25.2) | |



Classification of ovarian cancer metastases in the liver area:
Green area:
Class I or Peritoneal (Ovarian capsule, Ligaments, Gallbladder)
Yellow area:
Class II or Hepaticoduodenal lymph nodes
Black line:
Class III or Liver parenchyma
Class IV or Mixed

Risk factors for Severe postoperative complications: Multivariate analysis

| Variable | Multivariate | | p-value |
|-------------------|---------------------|----------|---------|
| | OR | (95% CI) | |
| Surgical timing | | | |
| Primary Surgery | Ref | | |
| Secondary Surgery | 0.832 (0.218-3.097) | | 0.772 |
| SCS 3 vs. 1-2 | 3.922 (1.597-9.629) | | 0.003 |
| RT >= 9h | 1.748 (1.006-3.037) | | 0.048 |
| Class | | | |
| Mixed | | | |
| I | 0.582 (0.361-0.936) | | 0.026 |
| II | 0.936 (0.478-1.835) | | 0.848 |
| III | 0.188 (0.041-0.849) | | 0.030 |

Abstract 2022-RA-1387-ESGO Figure 1 Overall survival (A) and disease-free survival (B) curves in patients according surgery modality (PDS or IDS-DDS) and existence of macroscopical residual disease (CC0 or CC1)

Conclusion There are no differences between PDS/CC1 and IDS/CC0 when compared in terms of OS or DFS. PDS can be considered when complete or minimal residual disease can be obtained.

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PERIOPERATIVE NON-INVASIVE ADVANCED HEMODYNAMIC MONITORING OF PATIENTS WITH PRIMARY OVARIAN CANCER UNDERGOING MULTIVISCERAL DEBULKING SURGERY

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Introduction/Background Patients undergoing high-risk surgery show an increased haemodynamic instability and have an increased risk of morbidity and mortality. However, the available haemodynamic data concentrate only on the intraoperative period. The aim of this study is to characterize patients hemodynamically throughout the whole intra- and postoperative period non-invasively by thoracic electrical cardiometry (EC) for advanced cardiovascular assessment.

Methodology In a prospective, observational, monocentric study, EC measurements were obtained before surgery, during surgery, and repeatedly throughout the hospital stay in 30 patients with primary ovarian cancer undergoing multivisceral cytoreductive surgery. The inflammatory markers interleukine-6 (IL-6) and inter-cellular-adhesion-molecule-1 (ICAM-1) were analyzed perioperatively. Severe postoperative complications were classified according to the Clavien-Dindo classification

and used as a binary grouping criterion (≥ 3 and < 2 or no complications).

Results Throughout the perioperative course, patients showed a longitudinally reduced cardiac index (CI, $p < 0.0001$), while the stroke volume index (SVI, $p = 0.0528$) remained unchanged. Patients suffering from postoperative complications differed over the longitudinal perioperative course in the index of contractility (ICON, $p = 0.0435$) and the systolic time ratio ($p = 0.0008$), without showing differences in CI ($p = 0.3337$). Also, the groups differed during the longitudinal perioperative course in IL-6 ($p = 0.0343$) and ICAM-1 ($p = 0.0398$).

Conclusion Longitudinally over the perioperative time course CI showed a relevant decrease. Patients with postoperative complications differed from patients without complications in the markers of cardiac function, ICON and STR, as well as showing a lower SVI. These data show haemodynamic alterations during surgery in all patients and especially the association of alterations to complications during the postoperative course. Therefore, they are a first approach to improve noninvasive haemodynamic patient assessments and interdisciplinary perioperative care in the future.

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ADULT GRANULOSA CELL TUMOUR OF THE OVARY: AN UNEXPECTED DIAGNOSIS

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Introduction/Background Ovarian sex cord-stromal tumours (SCTs) are a group of benign and malignant neoplasms that develop from different types of cells, mostly specialized in the production of steroid hormones. In contrast to the more common epithelial ovarian malignant neoplasms, most patients with malignant SCTs are diagnosed with early-stage disease. Histology is generally low grade, lymph node metastases are rare and prognosis is usually good.

Methodology To present a clinical case of an unexpected diagnosis of an adult granulosa cell tumour of the ovary with review of the literature.

Results A 37-year-old woman was admitted to the emergency department with abdominal pain. The patient did not have any relevant medical history. As a contraceptive method, she used the subcutaneous implant with etonogestrel. On physical examination, she had pain and tenderness on the right iliac fossa. The transvaginal ultrasound demonstrated a 6 cm ovarian cyst on the right side (with regular walls and anechoic content) but with decreased doppler flow. The blood work revealed light leucocytosis. Faced with a possible diagnosis of adnexal torsion, the patient was then proposed for diagnostic laparoscopy. She was submitted to a diagnostic laparoscopy that had to be converted to laparotomy due to extensive pelvic adhesions – the surgery confirmed the adnexal torsion and she underwent right adnexectomy and left salpingectomy. The anatomopathological examination of the surgical specimen confirmed that it was an adult granulosa cell tumour of the ovary. As the patient didn't want any more children, she was latter submitted to total hysterectomy + contralateral oophorectomy and surgical staging.

Conclusion With the presentation of this case, the authors intend to emphasize that even in the face of ultrasound aspects of an adnexal mass suggestive of benignity, we must always bear in mind the possibility that we are facing a borderline or malignant tumor.

2022-RA-1402-ESGO **IMPLEMENTING HRD TESTING IN ROUTINE CLINICAL PRACTICE AMONG PATIENTS WITH PRIMARY HIGH-GRADE ADVANCED OVARIAN CANCER**

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Introduction/Background Chemotherapy backbone for patients with high-grade advanced epithelial ovarian cancer (HG-AOC) is carboplatin and paclitaxel, followed by a maintenance therapy either with bevacizumab, a PARP inhibitor, or a combination of both which is defined by homologous recombination deficiency (HRD) and BRCA status.

Methodology Inclusion of patients with primary diagnosis of HG-AOC treated in a tertiary gynecologic center between 12/2019–12/2021. Offering germline testing is recommended by national guidelines and was conducted by using the True-Risk-Panel[®]. HRD status was measured using the Myriad myChoice[®] Test in patients with the indication for HRD testing.

Results HRD-testing was requested in 190 patients, and in 163 patients (85.8%) a HRD test result was available. HRD test result could not be reported in 27 patients due to an insufficient tumor yield. Median time to receive the HRD test results was 37 days (range, 8–97). In total HRD was present in 44.7% (73/163) based on $GIS \geq 42$ in 42.9% and a tumor BRCA mutation in 3 cases (all with $GIS < 42$). Germline testing results were available in 148 patients, and in 18 patients (12.2%) pathological germline mutations were detected. Of the 27 patients without sufficient HRD testing, BRCA germline testing results were available in 19 patients (70.4%), and pathological germline mutations were detected in 2 patients (7.4%).

Conclusion Implementation of HRD testing is feasible and results are available for treatment decisions in a timely manner for most patients. Prerequisite for HRD testing is enough tumor tissue, which should be taken at primary diagnosis of the disease as it is rather unlikely, that enough tumor tissue will be available later after chemotherapy initiation. Co-testing of HRD and BRCA-germline testing should be aimed for to enable optimal, and timely treatment decision on maintenance therapy also for patients in whom the HRD test will not be evaluable.

2022-RA-1405-ESGO **INDOCYANINE GREEN IN NEAR-INFRARED LIGHT FOR INTRA-OPERATIVE IMAGING OF RESIDUAL OVARIAN CANCER AFTER NEOADJUVANT CHEMOTHERAPY. INITIAL EXPERIENCE**

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Introduction/Background Interval debulking surgery (IDS) has similar outcomes and less morbidity in comparison with primary debulking in advanced ovarian cancer, however, there is controversy regarding the selection of chemotherapy-resistant clones. Complete resection (CR) is an essential prerequisite and near-infrared surgery (NIS) combined with various techniques for highlighting malignant foci is striving to achieve true CR. This study investigated the role of Indocyanine Green (ICG) for identifying residual malignant foci during IDS.

Methodology Patients that agreed and underwent IDS were included between 2020–2022. A bolus of ICG was administered and suspect peritoneal samples in NIR (defined by ICG hyper-/hypointensity in comparison with background ICG using Zeiss Pentero 800) were excised.

Results Fifteen patients were included, with a median age at diagnosis of 56 years (range 38–71). Fourteen patients (93.33%) had a high-grade serous carcinoma and most cases (73%) were FIGO stage III. All patients underwent 4 to 7 cycles of neoadjuvant platinum based chemotherapy. Forty per cent of regimens associated Bevacizumab. Six patients (40%) had a BRCA mutant variant and the median interval between neoadjuvant chemotherapy and IDS was 42 days (range 20–78 days). A total number of 39 suspect additional peritoneal samples were analyzed, with 41% confirming malignant foci. Positivity for malignant foci was confirmed on 4 out of 13 (30%) ICG hyperintense areas and 12 out of 26 (46%) ICG hypointense areas (OR 1.93, 95%CI 0.47–7.88).

Conclusion The use of ICG was associated with an increase in the resection of samples with residual malignant foci. Overall, hypointense ICG areas had a higher positivity rate for malignant foci in comparison with hyperintense ICG areas (46% vs. 30%), which could be interpreted in the context of dynamic changes in the tumor microvasculature or different patterns of tumor remodeling following neoadjuvant chemotherapy, that needs to be validated in larger cohorts.

2022-RA-1406-ESGO **A REVIEW OF OVARIAN CANCER IN NORTHERN IRELAND: A RETROSPECTIVE COHORT STUDY**

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Introduction/Background In Northern Ireland (NI) an average of 211 women are diagnosed with ovarian cancer each year with a median age at diagnosis of 65. Ovarian cancer is not a single disease but is comprised of distinct subtypes with a considerable variation in outcomes. In 2018 a funded ovarian