Introduction/Background Introduction: Ovarian carcinoma (OC) has high mortality, 75 to 80% presents in locally advanced stages (1) and a large proportion of patients receive neoadjuvant chemotherapy followed by interval surgery. Despite the high response rates to primary treatment, 70% of patients will have a recurrence within 2 years. There are multiple studies that have described the patterns of recurrence in OC (2); however, the recurrence in our case was unusual.

Methodology Results Case description A 60-year-old patient diagnosed with high-grade serous OC, clinical stage IIIc, who received induction chemotherapy with Carboplatin/paclitaxel for 4 cycles, underwent interval cytoreductive surgery, remaining R0, and subsequently completed 4 cycles of chemotherapy, with complete response by tumor marker and imaging. At 18 months of follow-up, a PET-CT showed hyper-uptake in the pancreas with a SUVMAX of 7, without elevation of CA 125. EUS was performed, which showed a subepithelial lesion of 14 mm in the submucosa of the stomach. FNA reported a malignant neoplasm. Distal gastrectomy was performed. Except in the stomach, no data of disease was found. Pathology found a 1.2 cm intramural nodule in the minor curvature, well-defined, without involvement of the mucosa. The diagnosis was a mural metastasis of high-grade serous OC. Experimental chemotherapy was restarted for 6 cycles. A PET-CT study was performed with no data on tumor activity 8 months after surgery.

Conclusion Discussion The most frequent sites of recurrence are peritoneal, lymph node and as a location at the pelvic level (3,4). It is worth mentioning that in a large proportion the recurrence in our case was unusual.

Methodology Results Of 93 patients screened, 61 patients with histologically or cytologically confirmed ovarian, peritoneal, or fallopian tube cancer were eligible for randomization. No significant difference could be found between both groups for the hemodynamic parameters of heart rate, estimated stroke volume and estimated continuous cardiac output. The comparison of systolic and diastolic blood pressure profile showed no significant differences between the full drainage and limited drainage group. At baseline both groups showed similar results for creatinine: 0.7 mg/dl (IQR 0.7–0.8) in the free drainage versus 0.7 mg/dl (IQR 0.6–0.9) in the limited drainage group (p=0.81). Re-evaluation 24-h post paracentesis showed no differences in median values between both groups (0.7 mg/dl [IQR 0.6–0.8]).

Conclusion This first randomized trial to evaluate the safety of total paracentesis in patients with malignant ascites from ovarian cancer was not able to detect a negative impact of total paracentesis on hemodynamics or kidney function. Considering the limitations of this trial as a pilot study, we conclude that total paracentesis seems to be a safe procedure in this population.

2022-RA-1441-ESGO

EPITHELIAL OVARIAN CANCERS DURING PREGNANCY: THE RESULTS OF A LARGE RETROSPECTIVE STUDY FROM THE INCIP NETWORK

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Introduction/Background The malignancy rate of adnexal masses in pregnancy is 0.2–3.8/100.000 cases. Even though malignant ovarian cancer diagnoses in pregnancy are uncommon, awareness is crucial to obtain an adequate oncological treatment and a good obstetrical outcome.

Methodology Using the INCIP (International Network on Cancer, Infertility and Pregnancy) registry, we describe the safety of total paracentesis of malignant ascites in patients with ovarian cancer. Patients were randomized one-to-one into a limited-paracentesis group where only 3000 ml of ascites were drained, and a total-paracentesis group with free drainage of all intraperitoneal fluid. Extensive peri- and postinterventional hemodynamic monitoring was performed for 24-hours and the kidney function was assessed before and after paracentesis.

Results Of 93 patients screened, 61 patients with histologically or cytologically confirmed ovarian, peritoneal, or fallopian tube cancer were eligible for randomization. No significant difference could be found between both groups for the hemodynamic parameters of heart rate, estimated stroke volume and estimated continuous cardiac output. The comparison of systolic and diastolic blood pressure profile showed no significant differences between the full drainage and limited drainage group. At baseline both groups showed similar results for creatinine: 0.7 mg/dl (IQR 0.7–0.8) in the free drainage versus 0.7 mg/dl (IQR 0.6–0.9) in the limited drainage group (p=0.81). Re-evaluation 24-h post paracentesis showed no differences in median values between both groups (0.7 mg/dl [IQR 0.6–0.8]).

Conclusion This first randomized trial to evaluate the safety of total paracentesis in patients with malignant ascites from ovarian cancer was not able to detect a negative impact of total paracentesis on hemodynamics or kidney function. Considering the limitations of this trial as a pilot study, we conclude that total paracentesis seems to be a safe procedure in this population.

2022-RA-1438-ESGO SAFETY OF TOTAL PARACENTESIS IN PATIENTS WITH MALIGNANT ASCITES FROM OVARIAN CANCER: RESULTS FROM THE PROSPECTIVE, RANDOMISED ATLANTIS-TRIAL

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10.1136/ijgc-2022-ESGO.714

Introduction/Background Despite the very common occurrence, no guidelines exist on the management of malignant ascites. It remains unclear if total drainage of the intraperitoneal volume is safe. Due to concerns for paracentesis-induced circulatory dysfunction, hemodynamic shock and kidney failure, many centers limit the drained volume and do not perform total paracentesis.

Methodology The ATLANTIS-trial is a prospective, randomized pilot study, designed to address the question on the
characteristics and the outcomes of a series of patients affected by borderline ovarian tumors (BOT) and invasive epithelial ovarian cancers (EOC).

Results 129 patients were included, 69 (53%) affected by BOT and 60 (47%) by EOC. The majority of patients (74%) diagnosed in the first trimester of pregnancy were treated with surgery ± chemotherapy. During the second trimester, 22 patients received surgery and 16 surgery + chemotherapy. In the third trimester, only two patients were treated with surgery because of severe symptomatic diseases. No major surgical or chemotherapy-related adverse events were reported. The median gestational age at the delivery was 39, three patients had a preterm delivery due to oncological reasons. Birthweight was significantly lower in women treated with chemotherapy (mean 2528 grams vs 3031, p: 0.01). 20 patients with BOT relapsed and two of them died (one relapsed as low-grade serous carcinoma and one as a mucinous carcinoma). Among patients with EOC, the relapse rate was 25% and mortality was 18%. In two patients a benign disease was suspected, and they were not treated during pregnancy. Unfortunately, they relapsed and subsequently died.

Conclusion Treatment of ovarian tumors is feasible during pregnancy and obstetrical outcomes are satisfactory. Both surgery and chemotherapy appear to be safe and effective. When chemotherapy is administered during pregnancy, fetal growth should be carefully monitored. Further research is needed to enlighten the possible influence of pregnancy on the oncological outcome of ovarian cancer patients.

Introduction/Background Ovarian cancer (OC) is a heterogeneous disease with increasing incidence rate. Epidemiological studies associate androgens with OC aetiology, nonetheless, their role, and especially that of their 11-oxygenated metabolites is not clear. Here we explore whether androgen metabolism can take place locally in ovarian tumours and assess the expression of the androgen receptor (AR) in OC tissues.

Methodology The expression of key enzymes in the androgen metabolism was examined in model cell lines of high-grade serous OC (HGSOC). Next, the profile of androgen metabolites formed from precursors, dehydroepiandrosterone sulphate (DHEA-S) and 11-OH-androstenedione (11-OH-A4) was determined by liquid chromatography-tandem mass spectrometry (LC-MS/MS). The TCGA Pancancer atlas data was used to explore AR expression in OC tissues.

Results Our gene expression data indicate that in HGSOC cell lines, classical androgen precursors, such as DHEA-S can give rise to potent androgens, such as testosterone (T) and dihydrotestosterone (DHT), however, not to 11-oxyandrogens. Indeed, our metabolism studies showed that HGSOC cell lines metabolize DHEA-S mainly to DHEA and A4. Interestingly, highest T and DHT levels formed in the chemo resistant cell line COV362, which expresses highest SRD5A2 and SRD5A2 expression correlated to a better overall survival in HGSOC patients (data from the TCGA Pancancer atlas).

Conclusion In ovarian tumours, classical androgen precursors give rise to classical bioactive androgens, whereas 11-oxyandrogen precursors to equally potent 11-oxyandrogens. Higher SRD5A2 expression contribute to greater T and DHT synthesis, whereas higher HSD11B2 expression to greater 11-KT levels. AR expression correlates with a better overall survival, suggesting a prognostic potential of androgens and 11-oxyandrogens in OC. Studies of the molecular mechanism of androgen signalling in OC are ongoing.