(sensitivity=92.1%, specificity=86.2%, overall accuracy 87.4%). The main cause of non-optimal interventions (n=52) were: diffuse carcinomatosis of the small intestine and its mesentery – 73% (38/52), carcinomatosis of the hepatoduodenal zone – 9% (5/52) and a total of 16% (9/52) were other non-resectable tumors. Radiation diagnostic and intraoperative revision were comparable in 60.5% (115/190). The sensitivity of CT in detecting of the small intestine lesions was 23.7%, the specificity was 90%, while for laparoscopy – the sensitivity was 93.3%, and the specificity was 100%. In assessing of carcinomatosis of the hepatoduodenal zone, the advantage belongs to radiation diagnostic Methods the sensitivity of CT was 66.7%, the specificity was 97%, while the sensitivity of diagnostic laparoscopy was 0%.

Conclusion The threshold value for performing complete or optimal cytoreduction is PCI = 9 points. The leading reasons for suboptimal cytoreductive operations were diffuse carcinomatosis of the small intestine wall and the mesentery. Diagnostic laparoscopy reduces the frequency of suboptimal cytoreductive operations from 6.7% to 13%.

2022-VA-1485-ESGO SURGICAL ANATOMY OF THE RIGHT UPPER QUADRANT AFTER CYTOREDUCTIVE SURGERY

1Ganim Khatib, 2Mesut Mısırlıoğlu. Gynecologic Oncology, Cukurova University, Adana, Turkey; 2Cukurova University, Adana, Turkey

Introduction/Background On the basis of evidence substantial effort is exerted by gynecologic oncologists to achieve no residual macroscopic disease for obtaining best oncologic outcomes in cytoreductive surgery performed for ovarian cancer. In this regard, dealing with upper abdomen metastases and being familiar with related surgical procedures is essential. Right upper quadrant cytoreduction harbors serious potential of complications and morbidities, and therefore one of the most time-consuming and challenging procedures. Good knowledge of surgical anatomy is crucial for performance of these procedures and techniques and avoiding complications and potential morbidities.

Methodology Video presentation.

Abstract 2022-VA-1485-ESGO Figure 1

Results In this video, we demonstrate the surgical anatomy of the right upper quadrant after complete tumoral clearance in a 72 years old woman operated for advanced ovarian cancer with extensive peritoneal carcinomatosis and implants in the right upper quadrant.

Conclusion As gynecologic oncologists, dealing with upper abdomen metastases and being familiar with related surgical procedures is essential. Good knowledge of surgical anatomy is crucial for performing cytoreductive surgical procedures in upper abdomen.

2022-RA-1486-ESGO CHARACTERISTICS, TREATMENT PATTERNS AND OUTCOMES OF PATIENTS WITH NEWLY DIAGNOSED ADVANCED OVARIAN CANCER (AOC) IN ENGLAND

1Angela Whittle, 1Betina Blak, 2Amy Zalin-Miller, 1Orlaith Condon. 1Medical affairs, Oncology Business Unit, AstraZeneca UK Ltd, London, UK; 2Health Data Insight, Cambridge, UK; 3National Disease Registration Service at NHS Digital, Cambridge, UK

Introduction/Background Personalised care and targeted therapy approaches in aOC have evolved during the last decade with introduction of bevacizumab to platinum-doublet chemotherapy being one of these early advances during this period. This observational, retrospective database study builds on previously published real-world evidence describing patient characteristics and outcomes in newly diagnosed aOC patients treated with systemic therapy with/without bevacizumab.

Methodology Newly diagnosed aOC patients (stage III/IV) were selected from the National Cancer Registration Dataset 01/08/2014 through 31/12/2018. This work includes patient data collated by the National Disease Registration Service. Patients aged ≥18 years at diagnosis, with no other cancers diagnosed in the five years prior to aOC, treated with systemic anti-cancer therapy (SACT) were included. Follow-up ended 31/12/2019. An algorithm defined probable therapy line occurring after aOC diagnosis. Time to next treatment (TTNT): days from start of first-line therapy to start of second-line therapy. Characteristics, treatment patterns and outcomes were described overall and by a sub-cohort receiving bevacizumab in first-line.

Results In the 8717 patients, median age at first-line therapy start was 68.8 (Inter-Quartile-Range (IQR):59.8–75.7) years, 2968 (34%) were diagnosed at stage IV and 1717 (20%) had recorded performance status (PS) 2–3 during first-line. Total, 5505 (63%) received surgery; 2556 (29%) had surgery before first-line therapy. Median TTNT was 331 (IQR:194–488) days in patients observed receiving second-line (n=4193 (48%)). Total 1833 (21%) received bevacizumab in first-line. This sub-cohort had median age 64.8 (IQR:56.4–71.3) years; 921 (50%) were diagnosed at stage IV; 210 (11%) had recorded PS 2–3 during first-line. Median bevacizumab cycles was 11 (IQR:6–16). Surgery occurred in 1291 (70%) patients, with 420 (23%) receiving surgery before first-line. Median TTNT was 426.5 (IQR:309.5–602) days in patients observed receiving second-line (n=972 (53%)).