Result 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**

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10.1136/ijgc-2022-ESGO.728

**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 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-VA-1485-ESGO**

**SURGICAL ANATOMY OF THE RIGHT UPPER QUADRANT AFTER CYTOREDUCTIVE SURGERY**

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**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

(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 67% to 13%.

**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.

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**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 These observations add to the collective body of evidence regarding the changing treatment landscape in aOC.

HOMOLOGOUS RECOMBINATION DEFICIENCY (HRD): A NEW OVARIAN CANCER BIOMARKER — VALIDATION OF DECENTRALIZED GENOMIC PROFILING, WITH A FOCUS ON GENOMIC LARGE REARRANGEMENTS (LRS)

Introduction/Background The diagnostic evaluation of HRD is central to define targeted therapy strategies for patients with ovarian carcinoma, so advances in decentralized genomic profiling are mandatory to allow for broader testing. We show the feasibility of implementing HRD assays in academic setting laboratories, and evaluate prevalence of genomic large rearrangements (LRs) in real life cohorts of high-grade ovarian cancer patients.

Methodology We evaluated HRD in 514 ovarian carcinoma samples by a hybrid capture next-generation sequencing assay using the standardized Myriad Mychoice cdx HRD test. Each patient’s HRD status was evaluated by measuring the BRCA1/2 mutational status and the Genomic Instability Score (GIS). All samples were measured twice, in the central Myriad laboratory and in an academic molecular pathology laboratory, and the concordance was analyzed. Afterwards, the cohort was extended to 1163 ovarian cancer samples to determine real world prevalence of LRs in HRR genes.

Results Combining GIS and BRCA-mutations, a total of 200 (38.9%) of 514 tumors were HRD-positive. High-grade serous histology (p<0.000001), grade 3 tumors (p=0.001) and patient age <60 years (p=0.001) were significantly associated with a positive GIS. Concordance between both laboratories for the HRD-status was 97.1% (499/514 tumors) with a sensitivity of 94.6% and a specificity of 98.4%.

LRs were found in 88/1163 (7.5%) of ovarian cancer samples. Interestingly, RAD51B, CDK12, BRCA1, ATM and BRCA2 were found to constitute 74% of all observed LRs.

Conclusion The percentage of HRD-positive tumors found was similar to that observed in the PAOLA-1 trial, with a high concordance between central and local laboratories. These results support introduction of standardized HRD assay in academic molecular pathology laboratories, to allow for broad access to personalized oncology strategies for patients with ovarian cancer. Genomic LRs are observed in a small portion of ovarian cancer samples, with a skewed occurrence towards 5/15 genes.