and fertility-sparing surgery (p=0.001) but not with the tumor histology (p=0.215).

Conclusion The study delineated two different patient profiles related to the tumor pattern of growth. The exophytic pattern was associated with the presence of invasive and non-invasive peritoneal implants, an advanced FIGO stage, without impact on DFS. Identification of the BOT pattern during preoperative workup could be useful for better surgical planning.

Introduction/Background The discrimination of borderline ovarian tumor (BOT) is challenging. Ultrasonography (US) is the most essential imaging modality for distinguishing ovarian masses but depends on the experience of radiologists. In 2014, the IOTA group carried out the assessment of different neoplasia’s in the Adnex Model. It was used to discriminate benign, BOTs, stage I, stage II-IV invasive ovarian cancer, and secondary metastatic cancer. This study aims to evaluate the efficacy of the Adnex model in the discrimination of BOTs.

Methodology This was a retrospective study; medical records of histopathologically proven cases of BOTs were included from the year 2009 to 2021. The ultrasound and clinical findings were entered in an online Adnex calculator. These results were used to calculate the absolute risk predicting the probability of mass being as BOT.

Results A total of 22 cases of BOT were included. Efficacy in terms of sensitivity of the Adnex model for preoperative diagnosis of BOTs was 18.2% [95% CI: 7.31–38.52]. Performance of the Adnex model based on absolute risk (AR) improves with a selection of a more inclusive cut-off value, varying from 4.5% (1/22) correctly classified case of BOT with the cut-off 20%, 18.2% (4/22) with the cut-off 10% and up to 55.5% (12/22) classified cases of BOT with cut off value of 3%. Similarly, relative risk (RR) was also used to classify the BOT, but only 4 (18.2%) cases were identified correctly.

Conclusion More encompassing cut-off values allow the model to differentiate BOTs better. The calculation based on RR or AR with a cut-off value of at least 10% should be used when evaluating BOTs. The IOTA Adnex model did not perform well in predicting cases of BOTs that were histopathologically proven in terms of sensitivity.
Abstracts

women with newly diagnosed ovarian cancer (OC) regardless BRCA mutational status and in homologous-recombination deficiency (HRD) positive patients, respectively. However, despite the remarkable improvements in the therapeutic algorithm of OC disease over the years, the best first line treatment is still controversial.

Methodology MITO 25.1 is a multicenter, randomized open-label, phase II study comparing Carboplatin-Paclitaxel-Bevacizumab vs Carboplatin-Paclitaxel-Bevacizumab-Rucaparib vs Carboplatin-Paclitaxel-Rucaparib. Eligible patients, with histological confirmed high grade serous or endometrioid advanced OC, will be randomized in a 1:1 ratio according to HRD status.

Results HRD negative patients: ARM A: Carboplatin AUC 5 + Paclitaxel 175 mg/m2 q 21 + Bevacizumab 15 mg/kg for 5 cycles (starting from cycle 2) followed by Bevacizumab 15 mg/kg q 21 for 17 cycles, ARM B: Carboplatin AUC 5 + Paclitaxel 175 mg/m2 q 21 for 6 cycles followed by Rucaparib 600 mg BID q 28 for 24 cycles as maintenance HRD positive patients: ARM B: Carboplatin AUC 5 + Paclitaxel 175 mg/m2 q 21 for 6 cycles followed by Rucaparib 600 mg BID q 28 for 24 cycles as maintenance: ARM C: Carboplatin AUC 5 + Paclitaxel 175 mg/m2 q 21 + Bevacizumab 15 mg/kg for 5 cycles (starting from cycle 2) followed by Bevacizumab 15 mg/kg q 21 days for 16 cycles + Rucaparib 500 mg part BID q 28 for 24 cycles as maintenance.

Conclusion The primary endpoint will be PFS. The secondary endpoints will be overall survival (OS), PFS2, adverse events and PFS3. The results observed in randomized trials when exploring were investigated every three months for the first two years, then every six months.

Results 108 patients with AOC were selected to undergo laparoscopic PDS (40 patients), IDS (44 patients), and SC (24 patients) surgeries. Optimal cytoreduction (RT=0) was obtained in 96%, 89%, and 88% of patients after SC, IDS, and PDS, respectively. Early post-operative complications occurred in 19% of cases, with 7% requiring a reintervention. One patient died of respiratory failure in the immediate post-operative period. Late postoperative complications occurred in 15%, 7%, and 4% of cases following PDS, IDS, and SC. The recurrence rate observed was 37% after laparoscopic optimal cytoreduction with a median observation time of 25 months. The overall survival (OS) at three and five years was 84% and 67% after PDS, and 66% and 32% after IDS. Three-year disease-free survival (DFS) was 48% and 51% after PDS and IDS, respectively.

Conclusion Minimal invasive laparoscopic surgery for AOC is feasible in strictly selected patients with high rates of optimal cytoreduction, satisfactory peri-operative morbidity, and encouraging survival outcomes.