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 q 28 for 24 cycles as maintenance HRD positive patients: ARM A: Carboplatin AUC 5 + Paclitaxel 175 mg/m² q 21 for 6 cycles followed by Rucaparib 600 mg 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 according to CTCAE 5.0 and patient-reported outcome. Patients recruiting started in March 2021. To date, 159 of the 300 patients planned have been enrolled.
150); 379 had weekly CP (≥70: 132). Median follow-up was 64.9 months, median OS 61.3 months (95%CI: 58.0–63.8). In patients aged ≥70, OS was 43.8 months (95%CI: 40.5–47.0), HR[≥70]: 1.74 (95%CI: 1.59–1.90), p<.0001; C was associated with a worse outcome (reference: sCP): HR[C≥70]: 1.61 (95%CI: 1.29–2.00), HR[wCP,≥70]: 0.96 (95% CI: 0.73–1.27), p<.001. In patients treated with sCP or wCP, the impact of older age persisted at a lesser extent: HR[≥70, sCP/wCP]: 1.64 (95%CI: 1.46–1.84), p<.0001. Bev tended to improve survival in older patients (HR[Bev,≥70]: 0.80 (95% CI: 0.64–1.01), p=0.057), but not in younger patients (HR[Bev,<70]: 0.96 (95%CI: 0.84–1.10), p=0.596).

Conclusion In this real-world population, C was associated in univariate to a higher risk of death, confirming the conclusions of EWOC-1 trial. When considering sCP/wCP treatment, worse age impact persisted with a 1.64-fold risk of premature death. Bev tended to improve survival raising the possible role of chemo-resistance in the poorer outcome of older patients.

**2022-RA-1552-ESGO**

**SURVIVAL AFTER HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY IN KAZAKHSTANI WOMEN WITH OVARIAN CANCER: KAZIOR EXPERIENCE**

Dilyara Kaidarova, Raikhan Bolatbekova, Yerlan Kukubassov, Tolkyn Sadykova, Alima Satanova. Kazakh Institute of Oncology and Radiology, Almaty, Kazakhstan

Introduction/Background Ovarian cancer (OC) one of the main cause of deaths from gynecological cancer. More than 1,000 new cases and 500 deaths from ovarian cancer are detected annually in Kazakhstan (KZ). More than 80% of OCs are found in a advanced stages. The standard treatment of advanced OC includes debulking surgery followed by chemotherapy to minimize the residual tumor size. Results of Hyperthermic Intraperitoneal Chemotherapy are controversial (HIPEC). The aim of this study was to assess the clinical benefit of HIPEC after primary and interval debulking surgery in kazakhstani women with III and IV stages of OC.

Methodology 14 patients with stage III or IV of OC was included in this prospective study. Surgical treatment and HIPEC were presented in Kazakh Institute of Oncology and Radiology. The primary end point was progression-free survival. Second points was to assess adverse events. Data was analyzed using SPSS 23.0 and medians were reported.

Results The mean age of the patients was 58.6 years. In 78% cases patients were represented with serous ovarian adenocarcinoma. 92% of cases presented HIPEC+ interval debulking. Complete surgery was performed in 35% and suboptimal surgery in 50%. Bowel resection with anastomosis was performed in 1 case. HIPEC+ surgery time ranged from 120 to 240 min. The median duration of hospitalization was 11 days with including +1 day stay in the intensive care unit. After treatment 92% of patients received adjuvant chemotherapy (Paclitaxel+Carboplatinum) Recurrence in 3 years were registered in 64% cases. Disease-free survival at 3 years was 16.4%.

Conclusion HIPEC plus debulking surgery in OC can increase median disease-free survival. The research is currently ongoing. We think that in a few years we will be able to present data on the overall survival of patients with ovarian cancer treated with HIPEC.

**2022-VA-1553-ESGO**

**URETEROURETEROSTOMY: STEP BY STEP**

Seda Şahin Aker. Gynecologic Oncology, Kayseri city education and training hospital, KAYSERI, Turkey

**Introduction/Background** Metastatic involvement of the urinary tract in patients with advanced ovarian carcinoma can occur with hydrourephrosis. In treatment, ureteroureterostomy is required. In this video presentation, we present step by step ureteroureterostomy procedure.

**Methodology** 62-year-old woman with ovarian cancer admitted to gynecologic oncology unit with abdominal and flank pain. Abdominopelvic computerized tomography showed grade 2 hydrourephrosis in left kidney and 10 cm diameter left adrenal solid mass. At surgery, adnexial mass showed involvement in the left ureter.

Results Step 1: First step is the identification the ureter and mobilization the ureter to obtain adequate length for repair without revascularization Step 2: The edges of both the proximal and distal ureteral segments are resected to ensure that viable tissue is being anastomosed. Step 3: Insertion of double J catheter Step 4: Both ends of the ureter are spatulated. After placement of corner sutures, the anastomosis is done in a running fashion.

Conclusion Postoperatively, the urethral catheter and wound drainage removed after seven days.

**2022-RA-1557-ESGO**

**MESENTERIC LYMPH NODE INVOLVEMENT IN PATIENTS UNDERGOING A BOWEL RESECTION DURING DEBULKING SURGERY IN ADVANCED OVARIAN CANCER**

1Federica Galli, 1Giorgio Candotti, 1Alessandro Ruffolo, 2Maria Luisa Fais, 3Patrizia de Marzi, 3Michelle Peiretti, 1Enrico Erdas, 2Stefano Angioni, 3Giulia Sabetta, 1Luca Boccidone, 1Massimo Candiani. 1Obstetrics and Gynecology Unit, IRCCS San Raffaele Scientific Institute, Milan, Italy., Milan, Italy 2Department of Surgical Sciences, Division of Gynecology and Obstetrics, University of Cagliari, Cagliari, Italy. 3Department of Surgical Sciences, University of Cagliari, Monserrato, CA, Italy, Monserrato, Italy

Introduction/Background The aim of this retrospective study was to investigate the incidence of mesenteric lymph node (MLN) involvement in patients undergoing a bowel resection at the time of debulking surgery in advanced ovarian cancer (OC).

Methodology OC patients undergoing rectosigmoid resection during primary debulking surgery or interval debulking surgery were recorded. The characteristics of mesenteric node involvement were evaluated.

Results MLNs were detected in 29/54 patients (54%); the rate of MLN involvement was 61%. A progressive increase in the rate of metastatic MLNs was documented in association with depth of bowel infiltration (p=0.009). A statistic correlation between positive MLN and pelvic lymph nodes (PLN) (p=0.022), aortic lymph nodes (ALN) (p=0.003) was found.

Conclusion OC patients undergoing rectosigmoid resection during debulking surgery revealed metastatic MLN involvement in 61% of cases. Metastatic MLN status is related to PLN and ALN metastases.