WHAT HAS GREATEST IMPACT ON RISK OF RECURRENCE IN PRIMARY EPITHELIAL OVARIAN CANCER?

Emma Frederike Lischke, Diethelm Wallwiener, Cornelia Bachmann. Department of Women’s Health, University Hospital Tübingen, Tübingen, Germany

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Introduction/Background Ovarian cancer (OC) is the eighth most common cancer in women in Germany and the deadliest gynecologic malignancy. Many risk factors for OC are known (age/obesity/hereditary forms etc.). Overall 70–80% of OC patients suffer from recurrences. This gives reason to further improve the prediction of the risk of recurrent OC and the quantification of the impact of various factors on the occurrence of relapse.

Methodology This work includes 137 consecutive patients that were treated for primary epithelial OC (EOC) at our department from 2014 through 2016 and who were followed up through 1st of April 2020. Overall median follow-up time was 39 months. The patients were subdivided into 2 groups depending on the occurrence of relapse (recurrence-, n=105; no recurrence-group, n=32). Data were retrospectively analyzed and tested for differences in relapse behavior.

Results Overall recurrence-rate was 76.6%. In the recurrence-group median progression free survival was 14 (2–56) months and median overall survival (OS) was 31 (6–68) months. In the no recurrence-group median OS was 51.5 (39–73) months. The largest impact regarding the incidence of recurrence was observed for FIGO-stage III (OR 26.33, 95% CI 6.6–105.3, P<0.001) and IV (OR 28.89, 95% CI 5.0–165.6, P<0.001), followed by initial existence of peritoneal carcinomatosis (OR 9.96, 95% CI 4.0–25.0, P<0.001) and poor differentiation (G3) (OR 9.43, 95% CI 2.6–34.2, P<0.001). Recurrence was more likely for high-grade serous cancer (HGSC) in comparison to other histologies (OR 3.31, 95% CI 1.4–7.9, P=0.007) and in case of lymph-node metastasis (OR 2.84, 95% CI 1.2–6.7, P=0.016).

Conclusion The likelihood of EOC recurrence is primarily determined by the FIGO stage. Stage III/IV increase the probability of recurrence by 26 and 29, respectively. Furthermore, recurrence is more likely for G3- and high-grade serous carcinoma, although these factors have less impact on occurrence of relapse than FIGO-stage.

DABRAFENIB AND TRAMETINIB FOR BRAF MUTANT LOW GRADE SEROUS OVARIAN CANCER

Inbal Greenhouse, Smadar Bauer, Akram Saad, Abigail Arieli, Yulia Tsarbaev, Ronnie Shapira-Frommer. Oncology Institute, Sheba Medical Center, Ramat Gan, Israel

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Introduction/Background MAP kinase pathway alterations are prevalent in low grade serous ovarian cancer (LGSOC) in up to 60% of patients, of them, minority harbor BRAF V600E mutation. While MILO-ENGOT ov11 study showed 13% response to Binimetinib (a MEK inhibitor), irrespective of mutation status, the value of BRAF and MEK inhibition in BRAF mutant patients was not evaluated. Herein we report the results of 5 patients treated with Dabrafenib and Trametinib (D+T) for non-resectable LGSOC.

Methodology We collected data from 5 patients who received D+T combination as compassionate use for BRAF V600E mutant LGSOC. All patients signed the Israeli informed consent for the use of off-label medications. Data on disease stage, prior lines of therapy, best response per RECIST, duration of response (DOR), survival and safety were collected.

Results 5 patients were treated with the combination of D+T. The median age was 53.8 years. The stage of the disease varied from IIIC-JVB (2/3). Median prior systemic treatment lines was 2 (range 0–5). Overall 4 of 5 patients (80%) had documented response. 2 patients achieved CR, and 2 patients had PR as best response. 1 patient was not evaluated due to early clinical deterioration. PFS was 18 months for the first patient, other 3 have ongoing responses at 18, 5 and 5 months. All patients had major relief of symptoms. 1 patient had 2 inductions of treatment following subsequent chemotherapy with 6 months PFS in each re-induction. The most frequent side effects were fatigue G1 (5/5) and pyrexia (4/5). None required permanent discontinuation. 3 patients are still receiving treatment.

Conclusion Targeting BRAF V600E mutation with combined BRAF and MEK inhibition in LGSOC yields high response rate with durable and meaningful improved disease control. These cases should emphasize the importance of performing the BRAF V600E mutation test for all patients with LGSOC.
CONTRIBUTION OF ADDING ROUTINE OPTIMAL TIME INTERVAL BETWEEN ENDOSCOPY AND COLONOSCOPY SCREENING TO SURGICAL AND ONCOLOGICAL OUTCOMES

Yağış Cicek, Ganim Khatib, Umar Kucukgaz Gulec, Ahmet Baris Gzel, Mehmet Ali Vardar. Gynecologic Oncology, Cukurova University, Adana, Turkey

Introduction/Background There is no routine screening protocol in ovarian cancer. In many clinics, screening endoscopy and colonoscopy are performed for patients who are thought to have ovarian cancer and gastrointestinal system metastasis. In this study we aimed to examine the contribution of preoperative endoscopy and colonoscopy screening to surgical and oncological outcomes in patients followed up with suspected ovarian cancer.

Methodology The files of 1446 patients who were operated on with the suspicion of ovarian cancer or treated with the diagnosis of ovarian cancer in our hospital between August 17, 1992 and November 27, 2018 were retrospectively analyzed. Of these patients, 676 patients between Stage 2 and Stage 4 were included. Such following parameters were evaluated: age range, body mass index, parity status, comorbidity, tumor marker, preoperative ascites, preoperative tumor diameter, cytoreduction adequacy, adjuvant chemotherapy, peri- and postoperative complications, tumor histology, grade, and stage. These comprehensive features were compared between the bowel metastasis and bowel resection groups using appropriate statistical analysis.

Results The mean age at diagnosis of the patients was 54.7 ±12.4; The median age at diagnosis was 55 years. There was no significant difference between the presence of bowel resection according to the laboratory findings (p>0.05). While postoperative CA125 values were detected to be higher in patients with intestinal metastasis comparing to those without bowel metastasis (p<0.05) Preoperative tumor diameter value was found to be higher in patients with intestinal metastasis (p<0.05). It was determined that mean survival time of the patients who had bowel metastasis was low (p>0.05).

Conclusion Since seromuscular involvement is usually seen in intestinal metastases of ovarian cancer, the sensitivity of the endoscopy and colonoscopy in screening is low. Risk-adjusted endoscopy and colonoscopy screening may be a reasonable strategy.