CONTRIBUTION OF ADDING ROUTINE OPTIMAL TIME INTERVAL BETWEEN ENDOSCOPY AND COLONOSCOPY SCREENING TO SURGICAL AND ONCOLOGICAL OUTCOMES

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10.1136/ijgc-2022-ESGO.754

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.