SHOULD DELAYED DEBULking/D EVELOPMENT OF AN INTRA-OPERATIVE TREATMENT PATTERNS AND OUTCOMES TO ALL ADVANCED OVARIAN/FALLOPIAN TUBAL CANCER PATIENTS THAT DID NOT HAVE SURGERY?


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Introduction/Background Primary and Interval Debulking/ Cytoreductive Surgery (PDS and IDS) are standard of care for surgical management of advanced stage 3 and 4 epithelial Ovarian/Fallopian Tubal Cancer. There has been very little research regarding outcomes of Delayed Debulking Surgery (DDS); performed upon completion of adjuvant chemotherapy. Aim to evaluate survival following DDS and compare cytoreductive outcomes, post-operative morbidity, PCI scores and survival outcomes in women who underwent PDS, IDS, DDS.

Methodology Prospective data collection and retrospective review of all cases that underwent DDS in our centre from 1/7/2014 to 31/12/2020.

Results All 384 patients were divided in PDS (n=109), IDS (n=235) and DDS (n=40). Mean age of the entire cohort was 64 years old. PDS and IDS group were comparable, and DDS has significantly higher comorbidities like cardiovascular and diabetes. Overall R=0 was achieved in 70% of cases with a further 12% of residual under 0.5 cm. Ongoing mean overall survival (OS) is 56 months and the complexity of surgery did not significantly impacted morbidity (mean length of hospital stay 7 days) or survival rates. There was a significant survival benefit seen with complete cytoreduction (R0) in primary, interval and delayed debulking surgery (p<0.05) and OS was not statistically different in between the three groups (p<0.05). Age over 70 years, performance status, ASA score and residual tumour volume negatively correlated to overall survival after logistic regression. On Cox regression analysis, the hazard ratio was significantly higher for R>2 cm in all sub-groups (HR=2.7, 95% CI-1.23–6.07, p<0.05).

Conclusion Delayed debulking surgery is a safe and oncologically acceptable option for women who have missed the opportunity for clinical and/or personal reasons to undergo surgery in the primary or interval setting. We recommend that all cases that did not have surgery to be considered for surgery at completion of their chemotherapy by MDT.

DEVELOPMENT OF AN INTRA-OPERATIVE DISEASE SCORE TO PREDICT COMPLETE CYTOREDUCTION IN ADVANCED-STAGE OVARIAN CANCER BY USING ARTIFICIAL INTELLIGENCE

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Introduction/Background The Peritoneal Carcinomatosis Index (PCI) and the Intra-operative Mapping for Ovarian cancer (IMO) to a lesser extent have been universally validated in advanced-stage epithelial ovarian cancer (EOC) to describe the extent of peritoneal dissemination and proven powerful predictors of the surgical outcome with an added sensitivity of assessment at laparotomy around 70%. This leaves room for improvement because the two-dimensional anatomic model for scoring fails to reflect the patient’s real anatomy, as seen by the surgeon.

Methodology We analyzed prospectively collected data from 508 patients with FIGO stage IIIB to IVB EOC who underwent cytoreductive surgery between January 2014 and December 2019 in a UK tertiary center. We adapted the structured ESGO ovarian cancer report to provide detailed information on the patterns of tumor dissemination (cancer anatomic fingerprints). We applied the Shapley Additive Explanations (SHAP) framework to support the feature selection of the narrated cancer fingerprints. We employed the eXtreme Gradient Boost (XGBoost) to model only variables referring to the tumor disseminated patterns, to create an intra-operative score, and to judge the predictive power of the score alone for complete cytoreduction (CC0). Receiver operating characteristic (ROC) curves were then used for performance comparison between the new score, and the existing PCI and IMO tools.

Results An intra-operative disease score was created based on specific weights allocated to the cancer anatomic fingerprints (figure 1a). The score ranged from 0 to 39. The new score was not inferior to PCI and IMO for the prediction of CC0 (AUC: 0.81 vs 0.73 vs 0.67, p: NS) (figure 1b).

Conclusion The presence of cancer dissemination collectively in specific anatomical sites, including small bowel mesentery, diaphragmatic peritoneum, and large bowel may be more predictive of CC0 than the entire PCI and IMO. Early intra-operative assessment of these areas may reveal whether CC0 is achievable.
**Abstracts**

**Introduction/Background** The treatment of older women with ovarian cancer is challenging due to increased pre-existing co-morbidities and frailty, often leading to less radical treatment than the standard of care. Older women are frequently excluded from clinical trials. Recent studies such as the EWOC-1 study focused on elderly women with ovarian cancer suggest worse outcomes associated with less radical treatment approaches.

**Methodology** Women diagnosed with ovarian cancer ≥65 years old referred to oncology services at three Irish University Hospitals between 2015 and 2021 were included. We evaluated patterns regarding surgery and chemotherapy sequencing, choice of agent and completion rates, according to age group. Survival outcomes were examined by Kaplan Meier analysis. The study received ethical approval.

**Results** 190 patients were included in this study. 65.26% (124) of these women had an ECOG performance status of 0–1 at diagnosis. 129 patients (67.89%) had (FIGO) stage III or stage IV disease at diagnosis. 55% of all stage III/IV patients had optimal debulking surgery. 37% of stage III/IV patients received neoadjuvant chemotherapy followed by surgery and 27% had surgery followed by chemotherapy. Women in the ≥75 group were more likely to receive single agent carboplatin (38%), compared to women aged 65–74 years (30%). Median overall survival for all stage III/IV patients who received SA Carboplatin was 15 months versus 22 months for Carboplatin and Paclitaxel groups. BRCA testing was sub-optimal in this age group at 28% of all patients although routine BRCA testing has only been available in Ireland since 2019.

**Conclusion** Elderly ovarian cancer patients, particularly those ≥75 years, may receive less radical treatment approaches than standard of care. Our cohort suggests improved survival with carboplatin/paclitaxel, although our cohort is too small to draw significant conclusions. Rates of BRCA testing were low. Geriatric oncology assessments should be incorporated into treatment decisions.

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**VTE IN NEWLY DIAGNOSED OVARIAN CANCER PATIENTS**

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**Introduction/Background** Ovarian cancer is commonly diagnosed at advanced stages, and is frequently treated with neoadjuvant chemotherapy. Advanced cancer patients are at risk for venous thromboembolism (VTE) and benefit has been shown using anticoagulants in risk stratified populations. Although a limited number of publications describe high rates of VTE among ovarian cancer patients, predictors of risk in this population have not been well studied. Our objective was to define rates of VTE among ovarian cancer patients receiving first-line chemotherapy and to identify predictors.

**Methodology** Ovarian cancer patients receiving first-line chemotherapy in Sheba Medical Center between 2013–2021 were identified, and data retrieved from the electronic medical record (EMR), institutional pharmacy records and imaging reports using dedicated software (MDClone©, Israel). A Natural Language Processing algorithm was created to identify VTE events to augment recorded diagnoses. Descriptive statistics were used to compare patients experiencing a VTE around and up to one year after beginning chemotherapy, to patients who did not. Logistic regression analysis was used to evaluate predictors of VTE.

**Results** 697 records were identified. VTE during the first year was diagnosed in 74 (10.6%), of whom 40 were DVT and 34 were PE. The majority were diagnosed in the first 6 months (figure 1). Only 5 were diagnosed in the 30-day postoperative period. Patients with a VTE diagnosis were older (mean, 65.4 vs 62.3, p=0.03) and had lower albumin levels (mean, 3.08 vs 3.29, p=0.04). Other predictors of VTE on univariable regression analysis included poor performance status, neoadjuvant chemotherapy and a Khorana Score ≥ 2, but none were found to be independent predictors (table 1).

**Conclusion** VTE is frequent in the first year, and particularly in the 6 months around ovarian cancer diagnosis. Risk may be predicted using established risk algorithms. Prophylactic anticoagulation may be considered in at-risk patients during first line chemotherapy.

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**A DYNAMIC, RISK-BASED DETERMINATION OF FOLLOW-UP INTERVALS FOR ADVANCED EPITHELIAL OVARIAN CANCER BASED ON SERUM CA125 TESTS**

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