biopsy of an enlarged inguinal lymph node, which the patient self noticed, while tumor markers (TM), gynecological examination and imaging techniques were negative for Mullerian neoplasia. High dose corticosteroids (75 mg a day of prednisone) were needed to treat DM during hospitalization, but it only recovered when Carboplatin AUC 5 d1q21 neoadjuvant chemotherapy was started. Then DM reappeared with disease progression during chemotherapy and at recurrence after cytoreductive surgery.

Conclusion 3 to 40% of DM are paraneoplastic: ovarian, colorectal, breast and lung cancer are most frequently related, so every patient with DM must be carefully evaluated in order to identify or exclude malignancy. Every woman with DM has to be assessed by a gynecologist, and then referred to an oncological gynecologist if OC is detected in order to receive appropriate treatment; patients with family history of OC and breast cancer have to be carefully evaluated during time, since OC may be occult. During OC treatment and follow up, in a patient with paraneoplastic DM, the cutaneous and muscular symptoms have to be investigated because they represent a red flag to identify recurrence or disease progression.

Disclosures The authors have indicated they have no conflicts of interest.

#384 FIRST INTERIM ANALYSIS OF THE SCOUT-1 STUDY (NOGGO OV54, NCT04830709): A NON-INTERVENTIONAL STUDY TO EVALUATE TREATMENT PATTERNS AND LONGTERM OUTCOME IN PATIENTS WITH NEWLY DIAGNOSED ADVANCES OVARIAN CANCER


Introduction/Background The first SCOUT-1 data reflects current real-world practice and transfer from phase III trials into clinical routine. Future analysis should define the barriers to improve the quality of care.

Disclosures Sponsor: AstraZeneca and Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., Rahway, NJ, USA, in cooperation with North-Eastern German Society of Gynecological Oncology (NOGGO e.V.). Medical writing assistance was provided by Dr. Katharina Bakhass, Alcedis GmbH, Giessen.

#390 ACCURACY OF ULTRASOUND US, MRI AND INTRAOPERATIVE FROZEN SECTION IN THE DIAGNOSIS OF OVARIAN TUMOURS: DATA FROM A LONDON TERTIARY CENTRE

1Sian Mitchell*, 1Joseph Gleeson, 1Mansi Tiwari, 2Frances Bailey, 1Jonathan Gaughran, 2Mr Gautham Mehta, 1Med Mustafa Zelal Musaik, 2,4Ahmad Sayasneh, 2Guy’s and St Thomas’s NHS foundation trust, London, UK, 3Department of Gynecological Oncology, Guy’s and St Thomas’s NHS Foundation Trust, London, UK, 4Deputy Director of Department of Gynecology with Center for Oncological Surgery, Charité Medical University of Berlin, Berlin, Germany.

Introduction/Background Ovarian cancer has the worst prognosis among all gynaecological cancers. The pre-operative and intraoperative diagnosis of ovarian tumours is imperative to ensure the right operation is performed and to improve patients’ outcomes.

Methodology This was a retrospective study from January 2017 to December 2021. Cases submitted for intraoperative frozen section diagnosis for the ovary and subsequent histopathological diagnosis were analysed. Frozen section cases were categorized as benign, borderline and malignant.

In cases where a pre-operative US and MRI subjective impression of the examiner was given, the diagnosis on imaging was compared to the final histological diagnosis.

Statistical analysis was performed using Stata MP v17.0 software (USA, 2023) and the diagnostic performance of US, MRI and frozen section compared to the final histological diagnosis was recorded.