Introduction/Background Epithelial ovarian cancer is women’s fourth oncological cause of death. One of the main prognostic factors is the tumor stage. For instance, surgical staging of the disease is focal to choose the best therapeutic option for each case. Although open surgery is the prevalent approach for staging and treating ovarian cancer, the use of minimally invasive surgery (MIS) finds recent application in staging or restaging cases of early disease. Our work compares oncological outcomes after MIS staging for FIGO I epithelial ovarian cancer with the laparoscopic approach.

Methodology Following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement recommendations, we systematically searched the Pub Med and Scopus databases in February 2023. No temporal nor geographical limitation was made. We included the articles containing data about Disease-free survival (DFS) and Overall Survival (OS), Recurrence Rates (RR), and Upstaging Rates (UpR). We used comparative studies for meta-analysis.

Results After the database search and article selection, 19 works matched the inclusion criteria for the systematic review. 11 of them were comparative studies between MIS and Open Surgical Staging (OSS) approaches for ovarian cancer staging and were included in the meta-analysis. The Meta-analysis did not show a statistically significant difference between the MIS and the OSS group concerning DFS, OS, and RR. Only upstaging rate \( \geq \) FIGO Stage II was statistically significant higher in the OSS group. Likewise, MIS is confirmed to be an approach with a lower profile of surgical complications.

Conclusion Our study did not show one approach to be safer than the other. However, the lack of dedicated studies limits the evidence of our study. For instance, we recommend adequately selecting the specimen, minimizing the risk of spillage, and optimizing surgical staging.

Disclosures The authors declare no conflict of interests.

#419 Lymph Node Recurrence With Ligation of Hypogastric Vessels in Secondary Cytoreductive Surgery of Ovarian Endometrioid Carcinoma

Nadia Veiga*, Juan Carlos Muruzábal, Sara Aguirre, Sonia Lapeña, Orencio Tarrio. Hospital Universitario de Navarra, Pamplona, Spain

10.1136/ijgc-2023-ESGO.576

Introduction/Background Current randomized studies have pointed out the impact of secondary cytoreductive surgery in recurrent ovarian cancer.

In patients who relapse after a disease-free period greater than 6 months, the general state (ECOG 0), the result R0 of the first surgery and the presence of less than 500 ml ascites (AGO scoring criteria) are ideal criteria, but non-exclusive, to assess the possibility of secondary cytoreduction. If an R0 is achieved after the second cytoreduction following these criteria, disease-free and overall survival are increased.

Endometrioid ovarian cancer accounts about 10% of all epithelial tumors. In most cases, it develops in perimenopausal women and is diagnosed at early stage. In approximately 42% of the cases, endometrioid ovarian cancer is associated with ovarian and/or pelvic endometriosis.

Methodology We present a case report of a 43 years-old patient with a recurrent endometrioid ovarian cancer. Previously, she was diagnosed with endometriosis.

2019, primary cytoreductive surgery, FIGO IIIA2, endometrioid ovarian cancer. She completed six cycles of adjuvant chemotherapy with Carboplatin and Paclitaxel.

In November/2021 she presented a multiple nodal recurrence in the left iliac and para-aortic region.

She underwent secondary debulking surgery with ligation of left hypogastric vessels.

Results Secondary debulking surgery.

PCI 10. Multiple nodal recurrence (left hypogastric artery, left internal obturator).

Surgery time 10h 50 min.

Blood transfusion 5 units of red blood cells and 2 of plasma.

R0 achieved.

BRCA1, BRCA2 and CHEK2 negative.

Post-operative complication neuropathic pain in left leg.

Nowadays she is alive.

Conclusion Secondary debulking surgery can be considered a feasible and therapeutic option for the management of recurrences, although long-term follow-ups are necessary to evaluate the overall oncologic outcomes of this procedure.

Interruption of the hypogastric artery by ligation can result in ischemic complications, but it can be considered in case of an uncontrollable major bleeding or in the context of a R0 surgery.

Disclosures Some authors suggested to consider to avoid systematic lymph node dissection in patients affected by early-stage low-grade endometrioid cancer and SEO-EC without apparent lymph node involvement at pre-operative imaging.

In this case, despite the patient underwent complete surgery with systematic pelvic and para-aortic lymphadenectomy, and completed six cycles of adjuvant chemotherapy with Carboplatin and Paclitaxel, she had nodal recurrence.
Huge adnexal masses may be managed using fluoroscopy C-Arm cover bag successfully without any contamination.

Conclusion
Huge adnexal masses may be managed using fluoroscopy C-Arm cover bag successfully without any contamination.

#428  LOW-GRADE SEROUS OVARIAN CARCINOMA IN PREGNANCY – A CASE REPORT


10.1136/ijgc-2023-ESGO.579

Introduction/Background
Adnexal masses are encountered in 2.4–5.8% of all pregnancies. In 0.2–3.8 per 100 000 pregnancies, ovarian cancer is diagnosed. Low-grade serous ovarian cancer is rare, as it accounts for 2% of all epithelial ovarian cancers.

Results
A 26-year-old primigravida was referred to our gynecological oncology unit for evaluation and management of an adnexal mass during pregnancy. At a gestational age of 12 weeks, sonography revealed a heterogeneous image in the left ovary of 122x104x90 mm with vascularized inner wall. Pelvic MRI revealed a large right adnexal cystic mass of 104x118x116 mm, multiloculated with papillary projections. Blood serum demonstrated cancer antigen (CA) 125 levels of 60 U/mL, carcinoembryonic antigen (CEA) and CA 19.9 were within normal limits. The patient underwent exploratory laparotomy at 27 weeks of gestation, a right adnexal tumor of approximately 8 cm was attached to the right posteroateral wall of the uterus and to posterior cul-de-sac. Left adnexa without macroscopic changes and absence of peritoneal carcinomatosis.

Right salpingoophorectomy was performed, with intraoperative capsule rupture, and inconclusive frozen section. Final histopathology revealed a low-grade serous cystadenocarcinoma, absence of lymphovascular infiltration, ovarian surface was not compromised, right uterine tube not compromised, and peritoneal fluid cytology negative for malignancy.

Following discussion in the multidisciplinary tumor board, it was decided to perform videolaparoscopy for resecting at a second time after delivery. Patient underwent cesarean delivery at 36 weeks of gestation due to labor and anomalous fetal presentation. Videolaparoscopy was performed 46 days after the delivery, peritoneal washings were collected and multiple peritoneal biopsies were performed, intraoperative frozen section and the final histopathology revealed absence of malignancy. The patient had a well recovery, in clinical follow-up, with no evidence of the disease so far.