involved in progress of the disease. Further study is needed in order to understand the exact mechanism of action as well as prognostic value of Th9 lymphocytes in ovarian cancer.

**Disclosures** The authors hereby disclose no conflict of interests.

## #561 SURGICAL TIMING AND MEDICAL TREATMENT IN ADVANCED OVARIAN CANCER: REAL-LIFE IMPACT ON DISEASE FREE SURVIVAL AND RELAPSE PATTERN

[1,2]Margherita Giorgi*, [1,2]Roberta Massobrio, [1]Luca Fuso, [1]Daniela Attianese, [1]Pier Giorgio Spanu, [1,2]Luca Pace, [1,2]Jeremy Oscar Smith Pezua Sanjinez, [1,2]Francesca Govone, [1,2]Alessandra Testi, [1,2]Maria Pascotto, [1,2]Beatrice Campigotto, [1,2]Elisa Maisto, [1,2]Nicoletta Biglia, [1,2]Annamaria Ferrero. *[1]Academic Department of Gynecology and Obstetric, Mauriziano Umberto I Hospital, Torino, Italy; [2]University of Turin, Department of Surgical Sciences, Torino, Italy*

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**Introduction/Background** The standard of care for advanced epithelial ovarian cancer (EAOC) is primary debulking surgery (PDS) followed by platinum-based chemotherapy and maintenance treatment. If optimal cytoreduction is not achievable, 3–4 cycles of neoadjuvant chemotherapy (NACT) followed by interval debulking surgery (IDS) are recommended. The impact on outcomes of delayed IDS (IDS-D) after 6 cycles remains debated.

This study aims to assess the real-life impact of surgical timing, medical treatment and their combination on disease free survival (DFS) and relapse pattern in EAOC patients.

**Methodology** EAOC patients who underwent PDS, IDS, or IDS-D from January 2012 to December 2022 were identified from the institutional database. The Cox regression model was used to compare DFS and adjusted for confounding factors provided by inverse probability of treatment weighting propensity score (IPTW) based on age, performance status and stage, collected retrospectively. The pattern of recurrence was also evaluated according to surgical timing, chemotherapy and maintenance treatment.

**Results** Of 226 EAOC-included patients, 116 (51.6%) underwent PDS, 61 (27.1%) IDS and 48 (21.3%) IDS-D. After a median follow-up of 40 months, DFS was 24.2 months in PDS, 17.4 months in IDS (HR=1.5; CI 95% [0.9 -2.2]) and 17.5 months in IDS-D (HR=1.1; CI 95% [0.7–1.8]) from IPTW analysis. The absence of residual disease was the only prognostic factor (HR=1.8; CI 95% [1.2–2.6], p=0.001).

Sites of recurrences were identified as follows: 21 (14.4%) in lymph nodes, 14 (9.6%) isolated peritoneal with or without lymph nodes, 57 (39.0%) diffuse peritoneal without parenchymal involvement, 26 (17.8%) in liver and spleen parenchyma, 28 (19.2%) extra-abdominal. Timing of surgery and medical treatment do not affect the pattern of recurrence (lymph nodes + single peritoneal vs diffuse peritoneal + epatic + extra-abdominal p=0.27).

**Conclusion** In our series IDS or IDS-D do not impact DFS. Timing of surgery and medical treatment do not affect relapse pattern.

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## #565 THE ORIGIN AND CLINICAL CHARACTERISTICS OF HIGH-GRADE SEROUS CARCINOMA

[1]Mariam Dalaty*, [1]Ovidiu Nicodin, [1]Anca Popescu, [1]Mihnea Andrei Nicodin, [1]Nicolae Niculescu, [1]Simona Criste, [2]Diana Badiu, [3]Constantin Ghita, [2]Costin Niculescu. *[1]'Doctor Carol Davila' Central Military Emergency University Hospital, Bucharest, Romania; [2]ObstetricsandGynaecology Department, Faculty of Medicine, 'Ovidius' University from Constanta, 'Sf. Apostol Andrei' Emergency Clinic County Hospital, Constanta, Romania; [3]General Surgery Department, Faculty of Medicine, 'Ovidius' University from Constanta, 'Dr. Alexandru Gafencu' Emergency Military Hospital, Constanta, Romania*

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**Introduction/Background** High-grade serous carcinoma (HGSC) is most of the time diagnosed in later stages. New assumptions show that HGSC ovarian cancers have their origin in the fallopian tubes, as tubal malignant cells travel at the adjacent ovary. This study aimed to identify the origins and clinical characteristics of women with pelviabdominal tumor.

**Methodology** Forty-five cases of serous pelviabdominal tumor were eligible and analyzed retrospectively in our department between 2019 and 2022. Clinical characteristics including age, family history of malignancy, menopausal status, number of births, and serum levels of cancer antigen (CA)-125 were collected.

**Results** Intraoperatively, we performed total hysterectomy with bilateral salpingo-oophorectomy and pelvic lymphadenectomy, viscerolysis, adhesiolysis and partial omentectomy. After mass biopsy, the diagnosis was HGSC, FIGO stage IIIC of which 26 (57.77%) patients had ovarian HGSC, and 19 (42.22%) cases had tubal HGSC. The mean age of the patients with ovarian HGSC was 57 and the mean age of the ones with tubal HGSC was 58. From the total number of patients with ovarian HGSC only 20 (76.92%), and only 11 (57.89%) diagnosed with tubal HGSC had history of malignancy, without any statistically significance. All the patients from ovarian HGSC (n=26, 100%), and only 6 (31.57%) patients suffering from tubal HGCS were at menopause, without any statistically significance. The mean number of births was 2 and the difference between CA-125 for both HGSC was also not statistically significant.

**Conclusion** The clinical data from both ovarian and tubal HGSC were similar, without any significant difference suggesting that both types of patients could receive a similar therapeutic scheme. Finally, this study shows the importance of determining the tumor's origin in order to achieve a proper management in the shortest amount of time.

**Disclosures** The authors declare no financial disclosures or conflicts of interest.

## #576 UNDIAGNOSED GRANULOSA CELL OVARIAN TUMORS IN PATENT WHO UNDERWENT MINE LAPAROTOMIES AND MULTI ORGAN REMOVAL DUE TO RECURRENT ASCITES AND GROWING PSEUDOCYST

[1]Krzysztof Nowosielski*, [2]Slawomir Mrowiec, [3]Robert Król, [1]Michal Krawczyk. *[1]Department of Gynecological Oncology, University Clinical Center, Medical University of Silesia, Katowice, Poland; [2]Department of Digestive Tract Surgery, University Clinical Center, Medical University of Silesia, Katowice, Poland; [3]Department of General, Vascular and Transplant Surgery, Medical University of Silesia, Katowice, Poland*

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**Introduction/Background** Granulosa cell ovarian tumors (GCT) originate from sex cords and the ovarian stroma. What is characteristic of these tumors is usually low dynamics of the disease and often very late relapses. As those tumors are relatively rare, the detection and treatment might be delay by late diagnosis.
**Methodology** The aim of the paper is to present a case of a woman diagnosed finally with GCT after the history of 9 laparotomies and recurrent ascites.
**Results** A 41-years old patient was admitted to the University Clinical Center in Katowice due to recurrent ascites of unknown etiology. The patient demonstrated symptoms of severe abdominal pain. She reported history of nine laparotomies, hysterectomy with adnexectomy, partial removal of the rectum and sigmoid, the creation of the colostomy, appendectomy, transverse colon resection and multiple peritoneal drainages. Some perihepatic cyst and ascites were detected on imagining (CT, MRI).

Ca-125 was normal. During the hospitalization the patient was consulted with surgeons, anesthesiologists, internists, gastroenterologists and radiologists. The multidisciplinary board decided to perform laparotomy with pseudocyst and ascites removal. During the operation, pseudocyst containing tissue-like structure were removed. Due to the hepatic bleeding, abdominal packing was performed. Finally, after next two laparotomies, the hemostasis was obtained, and the abdominal wall was closed with sutures. The patient recovered well. The histopathological examination revealed GCT, FIGO stage IV. The patient was planned for chemotherapy. However, 8 weeks after discharge from the hospital, the patient's condition deteriorated. She finale died due to multi-organ failure.
**Conclusion** GCTs are potentially curable neoplasms of the ovary with low treatment failure rates. Proper diagnosis on the early stage may help in introducing right treatment and help patients to recover.
**Disclosures** none

## #580 TREATMENT OPTIONS FOR PATIENTS WITH BRAIN METASTASES FROM OVARIAN CANCER: RETROSPECTIVE MONOCENTRIC STUDY

[1]Hanna Trukhan*, [2]Valeria Skachkova, [2]Yuliya Luferova, [3]Sergey Mavrichev, [3]Alena Dalamanava, [3]Yulia Petrushenka, [4]Olga Morozova. *[1]Belarusian Medical Academy of Postgraduate Education, Minsk, Belarus; [2]National Molecular Genetics Laboratory of Cancer Research, Minsk, Belarus; [3]NN Alexandrov National Cancer Centre of Belarus, Minsk, Belarus; [4]Polotsk Central City Hospital, Minsk, Belarus*

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**Introduction/Background** The incidence of brain metastases (BMs) in ovarian cancer (OC) is ranging from 0.49% to 6.1%. This heterogeneity can be partially explained by diagnostic procedures and treatment improvement, influencing positively on detection and outcome rates. We aimed to analyze patients with BMs from OC in a single center experience and calculate interval between diagnosis of OC and BMs, interval between BMs and data of last contact.
**Methodology** All women with OC with BMs, who were treated in Oncogynecological Department of N.N. Alexandrov National Cancer Centre of Belarus between January 1980 and December 2022 were retrospectively identified. The main criteria were serous carcinoma, endometrioid carcinoma and clear cell carcinoma and brain metastases. All data and follow-up were taken from medical records and analyzed afterward. Interval between diagnosis of OC and BMs, interval between BMs and data of last contact were studied with the use of Kaplan-Meier curves. The statistical analyses were performed using SPSS statistical software (version 23.0). A two-sided p-value $< 0.05$ was considered statistically significant.
**Results** 106 patients with BMs met the inclusion criteria. We divided patients into 4 group: 1 -without any treatment, 2- or surgery or chemotherapy or radiology, 3- combining two methods of treatment (chemotherapy with radiology (CR), chemotherapy with surgery (CS), surgery with radiology (SR)), 4 - surgery combined with radiotherapy and chemotherapy. Median time from development of BMs to last contact date for 1st group was 0 month, for 2nd – 3 months (95% CI [1.93; 10.47]), for 3rd – 11,5 months (95% CI [11.29; 20.27]), for 4th – 28 months (95% CI [21.32; 44.68]). When comparing all medians in pairs, statistically significant differences were noted in each comparison ($p< 0.05$).
**Conclusion** The best option for patients with OC with BMs were the application of the multimodal treatment.
**Disclosures** The authors have nothing to disclose.

## #583 SURVIVAL OF PATIENTS WITH BRAIN METASTASES FROM OVARIAN CANCER: RETROSPECTIVE MONOCENTRIC STUDY

[1]Hanna Trukhan*, [2]Valeria Skachkova, [3]Volha Ramanovich, [3]Sergey Mavrichev, [3]Alena Dalamanavs, [4]Darya Brashko. *[1]Belarusian Medical Academy of Postgraduate Education, Minsk, Belarus; [2]National Molecular Genetics Laboratory of Cancer Research, Minsk, Belarus; [3]NN Alexandrov National Cancer Centre of Belarus, Minsk, Belarus; [4]Minimally Invasive Surgery Department, Minsk City Clinical Cancer Center, Minsk, Belarus*

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**Introduction/Background** The incidence of brain metastases (BMs) from ovarian cancer ranges at about 1%. - 3%. Although brain metastasis development is very rare in ovarian cancer, it should be considered in the patient group with poor prognostic features, especially at the time of high-grade diagnosis.
**Methodology** We aimed to analyze patients with brain metastasis from ovarian cancer (OC), fallopian tube carcinoma (FTC), primary peritoneal carcinoma (PPC) in a single center experience and calculate overall survival (OS), disease-free (DFS) interval between diagnosis of OC and BMs.
**Methods** All women with OC, FTC and PPC with BMs, who were treated in Oncogynecological Department of N.N. Alexandrov National Cancer Centre of Belarus between January 1980 and December 2022 were retrospectively identified. The main criteria were serous carcinoma, endometrioid carcinoma and clear cell carcinoma and brain metastasis. All data and follow-up were taken from medical records and analyzed then. DFS and OS were studied with the use of Kaplan-Meier curves. All computations were performed using SPSS Statistics (version 23.0).
**Results** 106 patients with BMs met the inclusion criteria. A total of 105 patients were analyzed: all patients with OC. The mean was 61.42 ± 9.94 (95% CI [59.52; 63.32]) years. A multimodal approach (surgery combined with radiotherapy and chemotherapy) used in 21% of patients with BMs. The overall five-year survival of patients with OC with BMs was 35.7%, while one-year DFS was 67.9%. Median time to development of brain metastases was 31 ± 2.4 (95% CI [17.35; 141.4]) months.