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

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

10.1136/ijgc-2023-ESGO.601

Introduction/Background The standard of care for advanced epithelial ovarian cancer (EOC) 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 undergone 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% [1.2–1.8]) 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.

Disclosures The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper. No specific funding was obtained for this study.

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

1Mariam Dalea*, 1Ovidiu Nicolin, 1Anca Popescu, 1Mirnea Andrei Nicolin, 1Nicolae Niculescu, 1Simona Criste, 1Diana Badiu, 1Constantin Ghita, 1Constantin Niculescu. 1Obstetric and Gynecologic Department, Faculty of Medicine, ‘Ovidius’ University from Constanta, 2General Surgery Department, Faculty of Medicine, ‘Ovidius’ University from Constanta, 3Department of Obstetric and Gynaecology, Constanta County Hospital, Constanta, Romania

10.1136/ijgc-2023-ESGO.602

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 pelvicabdominal 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 PATIENT WHO UNDERWENT MINE LAPAROTOMIES AND MULTI ORGAN REMOVAL DUE TO RECURRENT ASCITES AND GROWING PSEUDOCYST

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

10.1136/ijgc-2023-ESGO.603

Int J Gynecol Cancer 2023;33(Suppl 3):A1–A453

A289
Abstracts

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 delayed 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 presented 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 drainage. Some perihepatic cyst and ascites were detected on imaging (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 finally 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

1Hanna Trukhan*, 2Valeria Skachkova, 3Volha Ramanovich, 4Sergey Mavrichev, 3Alena Dalamanava, 4Yulia Petrushenka, 3Olga Morozova. 1Belarusian Medical Academy of Postgraduate Education, Minsk, Belarus; 3National Molecular Genetics Laboratory of Cancer Research, Minsk, Belarus; 4NN Alexandrov National Cancer Centre of Belarus, Minsk, Belarus; 2National Molecular Genetics Laboratory of Cancer Research, Minsk, Belarus

Treatmenet options for patients with brain metastases (BM) from 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 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.

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 radiotherapy, 3 - combining two methods of treatment (chemotherapy with radiotherapy (CR), chemotherapy with surgery (CS), surgery with radiotherapy (SR)), 4 - surgery combined with radiotherapy and chemotherapy.

Conclusion The best option for patients with OC with BMs was the application of the multimodal treatment.

Disclosures The authors have nothing to disclose.