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PLATINUM MAY STILL BE AN OPTION FOR EPITHELIAL OVARIAN CANCER PATIENTS RELAPSING WITHIN 6 MONTHS AFTER FIRST LINE STANDARD CHEMOTHERAPY

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Introduction/Background The prognosis of patients with platinum-resistant Epithelial Ovarian Cancer (EOC) remains poor, with few therapeutic choices available, mainly based on non-platinum compounds. This study aims at exploring whether platinum rechallenge may be an option for those patients who experience a platinum-resistant relapse after first line chemotherapy.

Methodology In this retrospective, single-institute, observational study we enrolled all BRCA1/2 wild type (wt) patients who underwent primary cytoreductive surgery for EOC, between January 2017 and July 2021 and relapsed within 6 months after completing first line platinum-based chemotherapy, regardless of maintenance treatment. Patients receiving platinum monotherapy (P) were compared with those receiving pegylated liposomal doxorubicin (PLD), the most used schedule, or non-platinum/non-PLD therapy (paclitaxel or gemcitabine or topotecan, PGT).

Figure 1.

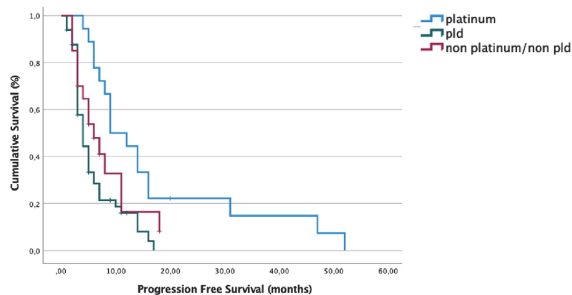
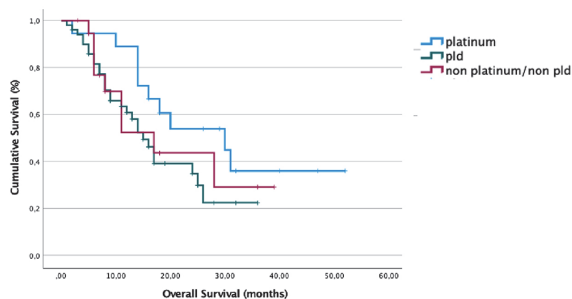


Figure 2.



Abstract #620 Figure 1 PFS, **Figure 2** OS

Results Overall, 87 patients were identified, of which 18 (21%) received P, 50 (57%) underwent PLD and 19 (22%) had PGT. Platinum-based arm had a median progression-free survival of 9 months, compared with 4 and 6 months, in PLD and PGT respectively (log rank $p = 0.002$; P vs PLD

$p < 0.001$; P vs PGT $p = 0.047$) (figure 1).

With regard of Overall Survival (OS), patients receiving P achieved a 30-month median OS, compared with 15 and 17 months of PLD and PGT, respectively (log rank $p = 0.20$; P vs PLD $p = 0.067$; P vs PGT $p = 0.26$) (figure 2).

Conclusion Platinum monotherapy is still an option in BRCAwt patients recurring within 6 months from first line treatment, with interesting survival results, compared to standard non-platinum monotherapy, commonly preferred and new targeted drugs.

Disclosures none

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OMENTAL, NODAL AND BOWEL INVASION RATE IN ADVANCED-STAGE OVARIAN CANCER PATIENTS: PROSPECTIVE OBSERVATIONAL STUDY

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Introduction/Background Debulking surgery for advanced-stage ovarian cancer often necessitates performance of demanding surgical operations. Main objective of the present cohort is to report rates of omental, nodal and bowel invasion in the context of debulking procedures.

Methodology A prospective observational cohort was performed concerning patients treated with a diagnosis of advanced-stage ovarian cancer. Epidemiological, histopathological and survival outcomes of all patients were prospectively recorded in a computerized database. The present study concerned patients treated between 2020–2022 either with primary cytoreduction or interval debulking surgery. There were studied all cases in which infragastric omentectomy, pelvic and/or para-aortic lymphadenectomy and any type of bowel resection was performed. Main outcome was to assess the overall invasion rate of relatively resected tissues.

Results There were overall 98 debulking surgeries for advanced-stage ovarian cancer performed during study period. Mean age of patients was 58.6 ± 12.1 years (range 37–80). All patients underwent infragastric omentectomy, while there were overall 19 bowel resections and 26 pelvic and 26 para-aortic lymphadenectomies performed. Specifically, 21 patients underwent both pelvic and para-aortic lymphadenectomy, while there were 5 with only pelvic and 5 with only para-aortic lymphadenectomy. Omental invasion was observed in 39.7% of cases (39/98). Pelvic nodal invasion was documented only in 5 out of 26 cases (19.2%) and para-aortic nodal invasion in 9 out of 26 cases (34.6%). In contrary, bowel invasion was reported in 89.4% of cases (17/19). No significant difference was observed regarding omental, nodal and bowel invasion rates between primary cytoreductive or neoadjuvant chemotherapy patients.

Conclusion Only 1 out of 3 patients where lymphadenectomy was performed in the context of cytoreductive surgery presented true invasion. In contrary, rate of bowel invasion was remarkably high. Lymphadenectomy should be performed only in case of high suspicion for nodal involvement based on cautious assessment of preoperative imaging and intraoperative evaluation.

Disclosures Authors have nothing to disclose