#624 CLINICAL CHARACTERISTICS, MANAGEMENT, AND OUTCOMES OF BORDERLINE OVARIAN TUMORS

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Introduction/Background Borderline ovarian tumors are diagnosed in younger patients and at earlier stages. Our aim in our study was to evaluate the preoperative conditions, treatments and post operative conditions of patients treated in our university hospital.

Methodology From the hospital databases, patient age, menopausal status, preoperative tumor markers, and preoperative ultrasound characteristics were collected. After up front surgery, the surgical technique, histological type, stage at diagnosis, tumor diameter, lymph node status, final pathological diagnosis were also collected. Additionally, adjuvant treatments, postoperative follow up periods, and possible recurrences were evaluated.

Abstract #624 Table 1 Demograghic and statistical characteristics of borderline ovarian tumors

Age	
Median (n, range in years)	42,2 (15-88)
Menopausal status (n,%)	
Premenopausal	57 (71,3%)
Postmenopausal	23 (28,8%)
Histology (n,%)	
Benign	3(3,8%)
Malign	10 (12,5%)
Borderline	67 (83,8%)
Serous	42 (52,5%)
Mucinous	25 (31,3%)
Seromucinous	7 (8,8%)
Endometrioid	3 (3,8%)
Brenner	3 (3,8%)
Tumor markers (U/mL)	
Ca125	2-5842 U/mL
Median size (range in cm)	10,58 (1-28)
Stage in diagnosis (n,%)	
1A	42 (52,5)
1B	1 (1,3)
1C	35 (43,8)
3A	1 (1,3)
3C	1 (1,3)
Surgery (n,%)	
Cyctectomy	27 (33,8%)
Bilateral cyctectomy	7 (8,8%)
Unilateral salpingo-oopherectomy (USO)	27 (33,8%)
Hysterectomy	39 (48,8%)
Omentectomy	6(7,5%)
Pelvic lymph node dissection	23 (28,8%)
Paraaortic lymph node dissection	22(27,5%)
Appendectomy	24 (30%)
Treatment after recurrence	3 (3,8%)
Cargoplatine/paclitaxel combination	
Recurrence (n,%)	3 (3,8%)

Results This study includes 80 patients who were operated between 2007–2022. Median age of our study groups was 42,2 (15–88). 57 (71,3%) of patients was premenopausal. Malignant tumor was detected in the final pathology in 10 (12,5%) patients. Six of these patients had serous tumors and 4 had mucinous tumors. Disease recurrence was detected in 3 (3,8%) patients, the mean progression free survival of these patients was 19 months. All patients with recurrence were in the early stage and 2 had micropapillary variant. And recurrence was detected in the contralateral ovary in one of the patients who relapsed after oophorectomy and the others after cystectomy. Micropapillary variant and cyctectomy had been identified as the most important risk factors for disease recurrence. Histopathological subtypes of recurrences were included serous and mucinous borderline tumors.

Conclusion In conclusion, micropapillary variant and cyctectomy is the most important risk factors for disease recurrence. Routine lymph node dissection or sampling, appendectomy or hysterectomy did not cause any difference in terms of recurrence. Our findings suggest that comprehensive surgical staging or radical surgical approaches should not be performed in borderline ovarian tumor. Cystectomy can be used to preserve fertility, but it should be noted that this increases the risk of disease recurrence.

Disclosures none

#625 THE ROLE OF SECONDARY CYTOREDUCTIVE SURGERY IN RECURRENT OVARIAN CANCER: RWD FROM THREE INSTITUTIONS

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Introduction/Background The role of secondary cytoreductive surgery (SCS) in patients (pts) with recurrent ovarian cancer (ROC) has been under debate. DESKTOP III trial demonstrated a meaningful benefit of SCS, exclusively seen in pts with a complete resection (CR). AGO score is a useful predictor for CR, validated to select pts for this strategy.

The aim of our study was to assess the efficacy of SCS in our population.

Methodology A retrospective, multicentric, observational study was conducted in pts with ROC that underwent SCS at 3 Portuguese institutions between 01/2012–12/2021.

Results A total of 22 pts was included, with a MED age of 55yo (41;76) and ECOG-PS ≤1. Nineteen pts (86%) were initially staged as FIGO III. Most were high-grade serous carcinoma. CR at initial surgery was achieved in 17 pts (77%).

All pts had received previous platinum-based chemotherapy (PBChT), 19 (86%) with platinum-free interval >12mos. Two pts (9%) received maintenance first-line treatment with Bevacizumab (BV). BRCA pathogenic variant was detected in 6 (27%) pts.

AGO-score was positive in 17 pts (77%). All pts underwent SCS, 3 (14%) combined with HIPEC, and all achieved RC. Most pts (15;68%) received postoperative PBChT, 7 (47%) continued with second-line maintenance treatment: 4 with PARP inhibitors (iPARP) and 3 with BV.

Relapse occurred in 15 pts (68%) with a MED time to relapse of 21 mos. With MED follow-up of 69mos, MED overall survival was 51mos (IC95%; 17–85). At the final analysis 10 pts (46%) are alive, 5 without recurrence.

Conclusion Our study is in line with the results of DESKTOP III trial. Although pts with negative AGO-score were included, all obtained CR. Retrospective nature and sample size are limitations. In selected pts, SCS might be an option. Due to improvement of maintenance treatment in earlier settings, further studies are warranted to evaluate the role of SCS.

Disclosures We have no conflicts of interest.

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