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### THROMBOEMBOLIC EVENTS AFTER ADVANCED OVARIAN CANCER SURGERY -A POPULATION-BASED COHORT STUDY

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**Introduction/Background** Surgeries in advanced ovarian cancer are associated with complications, including the risk of severe thromboembolic events, both due to the cancer diagnosis and the gold standard complex surgery.

**Methodology** All women diagnosed with ovarian, fallopian tube, or primary peritoneal cancer in FIGO stage III-IV treated with primary or interval debulking surgery between 2013 and 2017 were included in a population-based study. The women were identified using the Swedish Quality Registry for Gynecologic Cancer and data retrieved. Patient and tumor characteristics, surgical outcomes, including surgical complexity score and postoperative complications within 30 days graded according to the Clavien-Dindo (CD) classification system, were registered. Medical records were reviewed for completeness of all thromboembolic events.

All women were treated with thrombosis prophylaxis with low-molecular-weight heparin starting the day before surgery and continuing for four weeks. Women treated with complex surgery also had intermittent pneumatic compression devices during the surgeries and until fully mobilized. The number of thromboembolic events were calculated and analyzed.

**Results** The cohort included 384 women, where 304 (79%) were treated with primary surgery and 80 (21%) women with interval debulking surgery. Upper abdomen surgeries were performed in 121 (13.5%) women and 204 (53.1%) had intermediate or high surgical complexity scores. Complications CD I-V were registered in 112 (29%) women, whereas CD $\geq$ III in 42 (11%). There was one death within 30 days. Seven women (1.8%) were diagnosed with pulmonary embolism (CD II) and six of those also had other more severe complications. Two women (0.5%) were diagnosed with deep vein thrombosis. In total, 9 women (2.3%) had a thromboembolic event within 30 days postoperatively.

**Conclusion** Advanced ovarian cancer surgery is associated with complications but the rate of thromboembolic events can be considered low with active management with thrombosis prophylaxis.

**Disclosures** The authors declare no conflicts of interest.

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### SURVIVAL OUTCOMES OF OVARIAN CANCER PATIENTS UNDERGOING DIAPHRAGMATIC SURGERY DURING DEBULKING SURGERY

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**Introduction/Background** Rates of maximal effort cytoreduction increase gradually the last decades and surgical debulking of ovarian cancer implants in the upper abdominal cavity involve excision of multiple organs including the diaphragm.

In the present study, we sought to determine the factors that affect survival rates of these patients.

**Methodology** The study was based on a retrospective chart review of patients undergoing debulking surgery between January 2009 and December 2022. Patients were subgrouped according to the setting (primary debulking, interval debulking and secondary debulking) of the operation and site of omental metastases.

**Results** One hundred patients were included in the study of whom 22 undergone diaphragmatic excision as a part of the surgical debulking of diaphragmatic implants. Twenty eight patients had involvement of the pleural surface of the diaphragm (stage IV), whereas the remainder were assigned to stages IIIb and IIIc. Complete cytoreduction was achieved in 82 patients. Twenty-one patients developed moderate pleural effusion and 9 patients developed severe pleural effusion that required placement of a chest drainage. Within a median follow-up of 20 months (5–115) 32 patients experienced disease recurrence and 20 patients died from the disease. Diaphragmatic excision did not influence recurrence free and overall survival rates, compared to diaphragmatic stripping alone. Patients undergoing PDS had significantly longer PFS compared to patients undergoing IDS or secondary debulking (log-rank=.043). While graphical representation of the Kaplan Meier indicated differences in the overall survival of these patients differences did not reach statistical significance (log-rank=.199). Survival rates of patients with stage III disease did not differ compared to those with stage IV.

**Conclusion** Diaphragmatic surgery is an essential part of modern debulking procedures and should be ideally be performed in a PDS setting as it is accompanied by improved survival rates with acceptable rates of perioperative morbidity.

**Disclosures** The authors report no conflict of interest and no funding.

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### PREOPERATIVE ULTRASOUND ASSESSMENT TO IDENTIFY RECTOSIGMOID INFILTRATION AND NEED OF INTESTINAL RESECTION IN ADVANCED OVARIAN CANCER

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**Introduction/Background** Patients with advanced ovarian cancer (AOC) diagnosis will often undergo bowel resection when primary or interval debulking surgery is performed. Properly identifying these cases is crucial to establish an accurate operative strategy and to proportionate precise information to patients, since intestinal surgery implies higher morbidity, and surgical time and complexity.

Transvaginal Ultrasound (TVUS) is gaining interest as a tool to evaluate preoperative disease pelvic extension, especially tumour rectosigmoid infiltration.

Our objective was to assess the diagnostic accuracy of TVUS in predicting rectosigmoid infiltration and therefore the need of an intestinal resection in patients with AOC.

**Methodology** Observational prospective study in our centre between April 2021 and April 2023. Women with suspected diagnostic of ovarian cancer with a pre-treatment TVUS and

final AOC (stage IIB-IV) diagnosis confirmed histologically after primary or interval debulking surgery were included.

TVUS was performed before primary debulking surgery and after neoadjuvancy in interval surgery. Preoperative TVUS findings and prediction of rectosigmoid resection were compared to surgical procedures finally performed, and sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) were calculated.

**Results** 64 patients met inclusion criteria and were included for analysis. Preoperative TVUS identified rectosigmoid infiltration suggestive of requiring bowel resection in 24 of 64 women. In this group, the sonographic findings of 18 women were confirmed during surgery and had to undergo rectosigmoid resection. TVUS properly ruled out rectosigmoid infiltration in 33 patients with only 2 false negatives cases. Sensitivity, specificity, PPV and NPV were 90%, 85%, 75% and 94% respectively.

Sonographic rectosigmoid assessment was not valuable in 5 patients, mostly because of large adnexal tumours or abundant intestinal content.

**Abstract #971 Table 1** Contingency table. Comparison of preoperative TVUS and intraoperative findings.

		Intraoperative findings	
		Confirmed rectosigmoid infiltration (n=22)	Absence of rectosigmoid infiltration (n=42)
Preoperative TVUS findings	Rectosigmoid infiltration (n=24)	18	6
	Absence of rectosigmoid infiltration (n=35)	2	33
	Rectosigma not valuable (n = 5)	2	3

**Conclusion** Preoperative TVUS performed by a trained sonographer in AOC could be useful to identify patients with rectosigmoid infiltration and to predict the need of bowel resection, which implies better pre-surgical evaluation and planification.

**Disclosures** The authors declare no conflict of interest.

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#### DOES BIOCHEMICAL MONITORING HAVE ANY ROLE IN OVARIAN CANCER?

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**Introduction/Background** Our objective was to determine the role of HE-4 in diagnosing epithelial ovarian cancer (EOC) recurrences, in order to establish the value of adding HE-4 to Ca-125 determination in EOC surveillance.

**Methodology** All patients included in our project were diagnosed of any stage of EOC, from January 2014 to June 2020. All women had undergone surgical treatment and adjuvant chemotherapy. All patients were considered as optimal cytoreduction and showed a radiological complete response after the surgery. 43 subjects met the inclusion criteria and were included in the analysis.

Ca-125 normal levels were considered when  $<35$  U/mL. HE-4 normal levels were based on the age of the patient. The nadir value was considered the lowest biomarker level

achieved after the treatment. For CA-125, the elevation of the marker despite being negative was considered when it increased  $>5$  U/mL from the nadir value. For HE-4, it was considered when we registered an elevation by  $\geq 25\%$ .

We took the nadir value of each patient as a reference. Then, we analyzed the levels of these markers during the monitoring until the relapse.

**Results** The 59% and 48.8% of the patients had HE-4 and Ca-125 positive levels respectively at relapse diagnostic. The 26.3% of the patients had Ca-125 negative but HE-4 positive values at recurrence.

In the 30% of the patients the levels of Ca-125 increased  $>5$  UI remaining below the pathological limit. The median time between the elevation of the tumor markers and the radiologic diagnostic of relapse was 4 months for HE-4 and 3.5 months for Ca-125.

**Conclusion** It seems that adding HE-4 determination to EOC follow-up can improve the detection of recurrences. In some recurrences the levels of Ca-125 increased remaining below the pathological limit. It seems that the tendency of elevation during the follow-up can be useful to diagnose EOC recurrence, especially for Ca-125.

**Disclosures** All authors declare no conflict of interest.

#976

#### EVALUATION OF SENTINEL NODE BIOPSY IN EARLY EPITHELIAL OVARIAN CANCER USING NOVEL BLUE LED AND FLUORESCIN DYE: A PILOT PROJECT

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**Introduction/Background** Systematic pelvic and paraaortic lymphadenectomy in stage I-II EOC upstages 10–30 % patients, due to lymph node involvement. Research on role of sentinel node in ovarian cancer staging like MELISA trial, the SELLY, and SENTOV studies are ongoing. We have crafted this pilot study to evaluate novel cost-effective technique of fluorescein and blue LED or ultraviolet light torch-based SLN technique.

**Methodology** Prospective pilot study

**Clinical trial registration** CTRI/2022/07/044474

**Duration** 2 years (March 2021 to March 2023 ) at Dr B Borooah cancer Institute

**Primary objective** demonstrate feasibility and safety of novel approach

**Second exploratory objectives** sensitivity, specificity, positive and negative predictive values, detection rate and location of sentinel lymph nodes.

Recruited early ovarian cancer  $> 18$  years of age, excluded apparent III/IV disease on imaging or intraoperatively, mucinous, benign histology,

After inspection and obtaining peritoneal washings, dye was injected subperitoneally at ipsilateral infundibulopelvic and uterovarian ligament stumps .

For suspicious masses 15 minutes after dye injection. salpingo –oophorectomy was performed and specimen sent for frozen analysis

1 ml of methylene blue dye and 0.125 ml sodium fluorescein dye mixed and diluted to 5 ml with normal saline. SLN were detected as blue coloured nodes to naked eye and fluorescent nodes by blue light.