REGION-SPECIFIC RESPONSE ASSESSMENT OF BEVACIZUMAB-CONTAINING NEOADJUVANT CHEMOTHERAPY DURING INTERVAL DEBULKING SURGERY IN ADVANCED EPITHELIAL OVARIAN CANCER: A SINGLE-CENTER RETROSPECTIVE STUDY

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Introduction/Background Bevacizumab (Bev) plus neoadjuvant chemotherapy (NACT) with carboplatin and paclitaxel (CP) has shown to improve complete resection rates (CRR) in advanced epithelial ovarian cancer (AEOC) in a phase II trial, but its effect on specific metastatic sites is still unknown. We examined region-specific response rates during interval debulking surgery (IDS) to identify subpopulations that benefit most from Bev in NACT.

Methodology We retrospectively reviewed 68 patients with AEOC who received NACT with CP plus Bev (15 mg/kg) and subsequent interval debulking surgery (IDS) at Tata Medical Centre, Kolkata, India, from 2019 to 2021. Metastatic sites were assessed using contrast-enhanced CT scans pre- and post-NACT. Both surgical and histopathological analyses confirmed intra-abdominal sites of metastases. Region-specific response rates, complete resection rates (CRR), chemotherapy response scores (CRS), and progression-free survival (PFS) were analysed.

Results Among the 68 patients, 41 (60.2%) were classified as stage IV due to extra-abdominal metastasis. The pre-NACT distribution of disease within the abdominal cavity was as follows: omentum (95.5%), right diaphragm (73.5%), left diaphragm (64.7%), large bowel serosa (63.2%), retroperitoneal lymph nodes (RPLN) (45.5%), small bowel (41.1%), liver metastasis (17.6%), and portal disease (11.7%). A bowel surgery was required only in 22% of patients, showing the most common area of response to NACT, while the RPLN area exhibited the lowest response rate. The CRR was 83.6%, significantly higher than the phase II ANTHALYA trial. A CRS of two or more was achieved in 88.2% of patients. The median PFS was 18.6 months, which was significantly higher than the median PFS reported in the EORTC 55971 trial.

Conclusion The addition of bevacizumab to neoadjuvant CP has shown the highest efficacy in improving bowel serosal disease. It has resulted in improved CRR at IDS and PFS in AEOC patients. Our study urges further research on bevacizumab in NACT for AEOC.

Disclosures No conflict of interest

LYMPHADENECTOMY DURING CYTOREDUCTIVE SURGERY

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Introduction/Background Since LION trial was published, its concept was implemented in clinical work. Keeping in mind that there is no survival benefit for prophylactic lymphadenectomies, we remove only suspicious lymph nodes (not only pelvic and/or paraaortic) butinguinal, pararectal, mesenteric, gastric, pancreatic, hepatoduodenal and cardiophrenic as well. Methodology Retrospective analysis of operative reports of patients who received high complexity cytoreductive surgery from 2020 to 2023 years in department of minimally invasive surgery (Kyiv City Clinical Oncology Center). Descriptive statistics was applied.

Results It was identified 124 cases. There were 110 (89%) ovarian cancer patients. Primary debulking surgery was performed in 41 cases (33%), interval debulking surgery – in 48 (39%), redebulking after primary surgery in other center – 4 (3%), secondary cytoreductive surgery – 26 (21%), third cytoreductive surgery – 3 (2%), fourth cytoreductive surgery – 2 (2%). Lymphadenectomy was performed in 70 cases (57%). Metastatic involvement was approved in 41 patients (59%). Pelvic and/or paraaortic lymph nodes were involved in 34 cases (7 of them were combined with other localizations of lymph nodes metastases), inguinal – 1, pararectal – 2, mesenteric – 4, gastric – 1, pancreatic – 2, hepatoduodenal – 1, cardiophrenic – 4. Pelvic lymph nodes metastases were confirmed in 11 patients, paraaortic – in 9, pelvic and paraaortic – in 14. There were no cases of major intraoperative complications due to lymph nodes removal.

Conclusion Even removing suspicious lymph nodes, we have almost half of patients for whom it wouldn’t be beneficial. Further researches are needed to clarify general criteria for lymphadenectomy (for different regions it may differ) during cytoreductive surgery.

Disclosures none

LIVER PARENCHYMAL INFILTRATIVE PATTERN IN ADVANCED OVARIAN CANCER: TOPOGRAPHIC ANATOMY OF DISEASE DISTRIBUTION

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Introduction/Background The infiltration of liver parenchyma is present in up to 20% of advanced ovarian cancer. Two distinct patterns of parenchymal involvement have been described: LPI (liver peritoneal infiltration) due to the ab-extrinsic invasion of liver parenchyma from a peritoneal seeding and HHM (Hematogenous hepatic metastases) due to the hematogenous drainage of neoplastic cells through the portal venous system. The aim of this study was to describe the anatomical localization of liver parenchymal infiltration according to the infiltrative pattern (LPI vs HHM).

Methodology In this retrospective observational study we retrieved 94 patients diagnosed with advanced ovarian cancer and liver involvement, treated at Fondazione Policlinico Universitario Agostino Gemelli, from January 2015 to May 2022. All patients experienced a liver resection due to parenchymal infiltration as a part of their first cytoreductive surgery.

Results Seventy-five patients were classified in the LPI-group and 19 in the HHM-group. The median number of infiltrated segments was significantly higher in the HHM-group (1.3 vs. 1.6, p=0.036). LPI was more frequently reported in segments VI (40%) and VII (37.3%), respectively corresponding to the hepatorenal and right sub-phrenic recess, while HHM were more equally distributed to both left and right liver segments (figure1).