

#1022 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

#1023 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) but inguinal, 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%), redbulking 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 impaired 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

#1025 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).

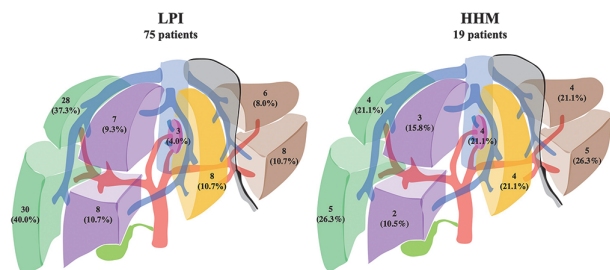
Methodology In this retrospective observational study we retrieved 94 patients diagnosed with advanced ovarian cancer and liver involvement, treated at Fondazione Policlinico Universitario Agostino Gemelli, from January 2015 to May 2022. All patients experienced a liver resection due to parenchymal infiltration 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 hepato-renal and right sub-phrenic recess, while HHM were more equally distributed to both left and right liver segments (figure1).

The median size of liver metastases was 10mm in LPI and 20mm in the HHM($p=0.02$)

Atypical resections were significantly more frequent in LPI (92%), while segmentectomy in the HHM group (78.9%, $p<0.001$).



Abstract #1025 Figure 1

Conclusion LPI was significantly associated with localizations on liver segments that are in contact with peritoneal recess or peritoneal fold where neoplastic cells can easily settle and implant, along the clockwise circulation of the peritoneal fluid.

HHM demonstrated a more heterogeneous and diffuse anatomical distribution, were significantly larger and required a higher rate of liver 'anatomical' resections.

Disclosures None

#1028 IMPACT ON SURVIVAL OF CRS SCORE IN OVARIAN CANCER TREATED WITH NEOADJUVANT CHEMOTHERAPY

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Introduction/Background Ovarian cancer remains the most common cause of mortality in pelvic gynecologic cancer. Neoadjuvant chemotherapy (NACT) followed by surgery has been shown to be an alternative treatment in patients with advanced ovarian cancer who are unlikely to achieve optimal cytoreduction with primary surgery. Successful stratification tools have been created to determine cytoreduction prognosis. The Chemotherapy Response Score (CRS) is intended to be one of them. We will evaluate the impact on OS at 3 and 5 years of patients treated with NACT followed by surgery according to the CRS

Methodology Retrospective analysis of a longitudinal cohort study. All patients diagnosed with FIGO stage IIIC ovarian cancer who received NACT followed by surgery as treatment between 2017–2022 were included. All patients received 4–6 cycles of chemotherapy, carbo-taxol schedule followed by surgery. CRS was analyzed in all of them. A CRS 1 and 2 indicated partial chemotherapy response while CRS score 3 indicated very good response to chemotherapy. Finally, 3- and 5-year survival was analyzed according to the CRS

Results A total of 57 patients met the inclusion criteria, representing 40.7% of all stage IIIC ovarian cancers in that period. Mean age was 62 years, 75.4% were menopausal and 32.6% of them had a BMI in the obese range. Regarding personal

history, 28.6% were hypertensive and 7% were diabetic. Regarding clinicopathological characteristics, the most frequent tumor type was serous carcinoma (93%). A CRS 1–2 was present in 80.7% ($n=46$). Clinicopathological characteristics were compared between the CRS 1–2 and CRS 3 groups and no statistically significant differences were found between the two groups. Survival of patients at 3 and 5 years in the CRS 3 group was 100%, while in the CRS 1–2 group it was 68.9% and 53.3% respectively, these differences being statistically significant (Log Rank of 0.04 and 0.009).

Abstract #1028 Table 1

Tabla 1 - Comparación de variables cuantitativas.		Concentración del grupo CRS		p-value	
	Tu 1	Tu 2	Mediana (IQR)	Mediana (IQR)	
Edad (años)	11,01 (3,14)	41,09 (8,54)	49,3	49,3	$p=0,008$
Edad menopausio (años)	48,83 (21,1)	11,30 (22,1)	48,83	48,83	$p=0,304$

Tabla 2 - Comparación de variables cualitativas.		Características del grupo CRS 3		p-value	
	N (%)	N (%)	N (%)		
Paridad		0	10		$p=0,172$
	Si	20	10		
	No	1	1		
Menopausia		33	10		$p=0,205$
	Si	33	10		
	No	0	0		
Tabaco		38	10		$p=0,673$
	Si	38	10		
	No	0	0		
DMC		12	3		$p=0,456$
	Si	12	3		
	No	0	0		
DM tipo 2		34	6		$p=0,004$
	Si	34	6		
	No	0	0		
HTA		31	7		$p=0,107$
	Si	31	7		
	No	22	4		
AF de cámara		24	4		$p=0,504$
	Si	24	4		
	No	0	0		

DM2= diabetes mellitus
HTA= hipertensión arterial
AF= arritmias cardíacas
QT= quimioterapia

Conclusion In our study, presenting a CRS 3 after treatment with NACT followed by surgery is a good prognostic factor with a 3 & 5-year survival of 100%.

Disclosures No disclosures

#1036 COMPARISON OF GEMCITABINE OR LIPOSOMAL DOXORUBICIN IN PATIENTS WITH HIGH GRADE SEROUS OVARIAN CANCER WITH PARTIAL PLATINUM RESPONSE

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Introduction/Background Gemcitabine or liposomal doxorubicin are well-accepted chemotherapy modalities in management of recurrent high grade serous ovarian cancer (HG-SOC) with partial platinum response. In this study we aimed to evaluate the progression free intervals after the secondline gemcitabine or liposomal doxorubicin treatments in this group.

Methodology This is a descriptive retrospective study including 67 patients with recurrent high grade serous ovarian cancer (HG-SOC) with partial platinum response. Partial response was defined as recurrence after 6 first-line therapies with platinum derives in 6–12 months. Patients who underwent gemcitabine + platinum derives ± bevacizumab was defined as Group I and liposomal doxorubicin + platinum derives ± bevacizumab as Group II.

Results The median recurrence time of the whole group was 8 months. The mean initial recurrence times were 7.4 ± 2.6 and 8.5 ± 2.3 months for group I and II, respectively. The mean progression free survival time after in Group I and II were 13.6 ± 6.1 and 13.7 ± 19.7 months, ($p=0.344$), respectively. The estimated overall survival for groups were 59.0 ± 7.2 months and 45.7 ± 3.5 months but this was not statistically significant ($p=0.135$).

Conclusion In our study, we found that progression free intervals after the secondline gemcitabine or liposomal doxorubicin