surgical gestures performed, the Surgical Complexity Score (SCS) defines three levels of complexity, low (≤3), intermediate (4–7), and high (≥8), associated with incremental postoperative morbidity.

Methodology At our institution, all patients undergo a staging laparoscopy to assess disease extension. If eligibility for CRS is established, definitive surgery is planned in 7–14 days. We analyzed the CRS complication rate according to the SCS in 239 patients, between 2017 and 2022. CRS performed was classified as low risk for 35 patients (14.6%), intermediate risk for 110 patients (46%), and high risk for 94 patients (39.3%). Within 30 days after surgery, the severe post-operative complication rate was 10%. Among patients with SCS < 8, the risk of complication was 7.6% versus 13.8% with SCS ≥ 8 (OR=1.96 [0.84- 4.57]). With a multidisciplinary team, we developed a tailored perioperative care algorithm based on presumed SCS at staging laparoscopy, and actual SCS at laparotomy.

Results Preoperative care (bowel preparation, oral supplementation) is proposed according to estimated SCS. When CRS is performed, the early postoperative period management is based on actual SCS. If CRS<8, the nasoenteric tube is removed at the end of the surgery, and no drain is placed. If SCS≥8, a nasoenteric tube is placed for enteral nutrition, and observation in an intensive care unit is proposed. For this group of patients, a short-term postoperative examination and lab tests are systematically planned 15–20 days after discharge, and then after 1 month.

Conclusion SCS resumes surgical complexity and individuates higher-risk patients. Our algorithm aims to increase adherence to evidence-based recommendations, and mostly, in the era of precision medicine, it aims to implement a patient-focused care plan.

Introduction/Background We aimed to depict the real-world surgical management of patients, with first diagnosis of FIGO stage IV primary epithelial ovarian cancer (EOC) compared to those with stage IIIC.

Methodology We conducted a retrospective analysis of all patients who underwent surgery for primary stage IIIC-IV EOC at Kliniken Essen-Mitte (KEM) from 2011–2022. Clinical parameters as time of surgery and residual tumour rates were compared between the two groups.

Results 1314 patients (median age 61; range: 21–89) underwent surgery for newly diagnosed FIGO stage IIIC or IV EOC at our centre from 2011–2022 (n=502, 38% and n=812, 62%, respectively). The tumour clearance rates at primary surgery, including procedures with no intent for complete resection, were 65% complete resection, 25% with residuals of 1–10 mm and 11% with >10 mm. The rate of interval debulking surgery (IDS) was 33% (n=163) in the IIIC cohort and 24% (n=192) in stage IV. Of note, more than 50% of IDS patients started neoadjuvant chemotherapy (NACT) prior to their referral to KEM (n=101, 62% and n=98, 51% respectively). In FIGO IIIC, complete macroscopic resection was achieved in 77% of patients who underwent NACT and in 63% of those who underwent primary surgery.
In FIGO IV, complete resection was achieved in 72% and 66% of patients, respectively (p=0.002). In FIGO IV, complete resection did not differ between the stages (p=0.34 for PS; p=0.30 for IDS). Among patients with PS for stage IV disease, pleural involvement and lung metastasis were significantly more common in patients with residual disease as compared to those with complete resection: 32% vs. 14%; p<0.001 and 2.3% vs. 0.2%; p=0.02, respectively.

Conclusion Stage IV EOC patients have similar resection rates as patients with stage IIIC disease in both NACT and PS cohorts. Our results underline, that PS is feasible in patients with FIGO stage IV.

Disclosures COI submitted where applicable.

EVALUATING THE EFFECTIVENESS OF OVARIAN TUMOUR RISK ASSESSMENT STRATEGIES IN A REAL-WORLD NATIONAL SETTING – IN COLLABORATION WITH THE DUTCH GYNAECOLOGICAL ONCOLOGY AUDIT COLLABORATOR GROUP AND THE PALGA GROUP

Introduction/Background Predicting whether an ovarian tumour (OT) is malignant remains a challenge. Risk assessment strategies are used to select which patients with an OT should be referred to oncologic centres. However, their predictive value depends on the prevalence within a population. On hospital level, this prevalence is often known, but on a national level, these data are more difficult to obtain. Significant differences in prevalence exist between individual hospitals and single-centre study results should be generalised with caution. Therefore, we aimed to evaluate the prevalence of malignancy among surgically removed OTs and the accuracy of referral to oncologic centres in the Netherlands.

Methodology Histological reports on surgically removed OTs in 2019 were retrieved from the Dutch Pathology Registry PALGA (Pathologic-Anatomic National Computerized Archive). Reports on prophylactic removed ovaries, recurrent ovarian cancer (OC) and reports of patients below 18 years were excluded. Data on stage, subtype and surgical procedure of malignant and borderline OTs from the same year were obtained from the Dutch Gynaecological Oncology Audit (DGOA).

Results A total of 17469 reports were retrieved from PALGA of which 6122 reports were eligible, including 4867 benign (79.5%), 870 malignant (14.3%) and 385 borderline OTs (BOT, 6.3%). From DGOA, 1344 reports were retrieved. Referral for cytoreductive surgery for advanced OC was 100%. Early-stage OC and BOTs were also mainly operated in oncological centres and 66 OCs were operated in non-oncological centres (figure 1).

Conclusion Correct classification of OTs is crucial for treatment planning, patients’ well-being and optimal use of health care resources. In the Netherlands, the majority of patients with early-stage OC are correctly referred. Because only 66 OCs were missed out of a total group of 6122 OTs, current risk assessment strategies generally selected the correct patients for referral. However, there is still room to improve preoperative risk assessment.