whether the SLN identification is also feasible in patients whose ovarian tumor has already been resected with injection of the tracer into the ovarian ligaments stumps, i.e. in the event that a frozen section confirms malignancy.
Methods Patients who underwent laparotomy with frozen section confirming an ovarian malignancy, and those who underwent a second staging laparotomy after prior resection of a malignant ovarian mass, were included. Blue dye and a radioactive isotope were injected in the stumps of the ligamentum ovarium proprium and the ligamentum infundibulo-pelvicum. After an interval of at least 15-minutes, the sentinel node(s) were identified using either the gamma-probe and/or blue dye.
Results A total of 11 patients were included in the study, the sentinel node (SLN) procedure was completed in all 11 patients. At least one SLN was identified in 3 patients, resulting in a rather low detection rate of 27,3%.
Conclusions In this study we showed that SLN procedure after (previous) resection of the tumor seems inferior to detect sentinel nodes when compared to injection of the tracer in the ovarian ligaments before tumor resection.

EPV203/#449 'QUICK' LAPAROSCOPY FOR SUSPECTED ADVANCED OVARIAN CANCER

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Objectives Primary therapy planning, meaning primary surgery vs. neoadjuvant chemotherapy (NACT), in suspected advanced ovarian cancer is a professional and logistical challenge. Prompt diagnostic laparoscopy in such patients should confirm the diagnosis by frozen section, assess operability and thus, avoid unnecessary laparotomies.
Methods Retrospective evaluation of 130 patients who presented in 2016–2020 with suspected advanced ovarian cancer (peritoneal carcinomatosis, ascites on average 1,5L).
Results In 2016–20, 82/130 patients (63%) underwent diagnostic laparoscopy; the others received either primary laparotomy, NACT, palliative chemotherapy, or best supportive care. 47% percent of the 82 patients were triaged to NACT, and 53% to primary surgery. The median time between initial presentation and laparoscopy was almost 8 days, the time from laparoscopy to 1st cycle of NACT was 14 days, and the time from laparoscopy to laparotomy was 15d. The rate of R0 resections in patients with primary surgery after laparoscopy was 84%.
Conclusions Diagnostic laparoscopy seems to be an efficient measure in the workup and treatment planning of patients with suspected advanced ovarian cancer. The times between first presentation and laparoscopy as well as between laparoscopy and NACT or primary laparotomy need improvement.

EPV204/#454 INGUINAL METASTASES AS PRESENTING SIGN OF OVARIAN CANCER

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Objectives Inguinal lymph nodes involvement as first manifestation of ovarian cancer is a rare event and its prognostic value is not well known.
Methods A retrospective chart review was conducted on ovarian cancer patients treated at the University of Bari, between 2008 and 2020. Pertinent clinical information (age, size, histology, BRCA status, laterality at diagnosis, other distant sites of disease), response to first-line treatment, site of relapse and overall survival were collected for 7 patients.
Results Median age at diagnosis was 64 years (range 40–81), 3 patients had other sites of distant disease at the time of ovarian cancer diagnosis (spleen, liver, bone, lung). Median size of inguinal lymph node was 24 mm (range 14–36 mm), 4 had right inguinal involvement, 2 left and one bilateral nodes. The patients had primary surgery including groin dissection, whereas 5 patients had neoadjuvant chemotherapy with paclitaxel and carboplatin following biopsy or removal of groin nodes and complete inguinal dissection was performed at interval debulking surgery. Six patients had high grade serous ovarian carcinoma and one had high grade ovarian endometrioid histotype. BRCA status was known for five patients, and only one patient was a BRCA2 mutation carrier. 4 patients experienced a relapse at a median of 15 months (range 6–25) and in no case relapse was at the level of the groins. 3 patients died and 4 are alive without evidence of disease. Median survival was 64 months (range 16–151).
Conclusions Groin involvement is rare presenting sign of ovarian cancer and this location carries a good prognosis.

EPV205/#458 THE FOLLOW UP MANAGEMENT OF BORDERLINE OVARIAN TUMOURS: A 10-YEAR EXPERIENCE

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Objectives Borderline ovarian tumours (BOT) are a unique category of ovarian tumours. National guidance states regular sonographic follow up is essential after fertility sparing surgery (FSS), whereas, follow up in patients with early disease after BSO is uncertain. Our aim was to audit current practice and determine local recurrence rate.
Methods A retrospective single centre study over a 10-year period to compare current standard of care to the BGCS and Local Network Guidelines.
Results 78 patients were diagnosed with BOT during the 10-year period. 9 patients had FSS, the majority were mucinous BOT (77.8%) and stage 1 disease (88.9%). 44.4% have had or plan to have completion surgery and remaining 55.6% had variable sonographic/clinical follow up to a maximum 5 years. 69 patients had non-fertility sparing surgery, the majority were serous BOT (55.1%). 78.2% had stage 1 disease, 44.4% were discharged, 40.7% enrolled in the Borderline Ovarian Trial (annual review and CA125) and the remaining 14.8% had variable follow up. 14.5% had stage 2 or 3 disease, 60% received standardised follow up for 5 years, 30% enrolled in the Trial and 10% discharged. 2 patients (2.6%) experienced a malignant recurrence, 1 serous and 1 mucinous BOT. Both had initial pelvic clearance surgery with full staging.
Conclusions In line with guidance, all patients who had FSS underwent follow up, and the majority of patients with early stage disease after BSO were appropriately discharged. Overall,