UK vs 5% in UK centres [Fisher's: p<0.0001]. In FIGO stage 3 aggressive debulking procedures were more likely to be performed in non-UK centres. 'TAH/BSO & Omentectomy'was performed in 62% of cases from non-UK centres vs 49% in UK centres [p=0.0002]. These differences corresponded to a greater likelihood of optimal debulking of tumour [non-UK centres 71% vs 58%: p<0.0001]. This increased surgical activity was associated with a longer operating time. [Non-UK centres, median=136 minutes; UK centres, median=95 minutes: Mann Whitney: p<0.0001].

Conclusion: This study demonstrates clear differences in surgical practice among gynaecologists referring patients for entry into this clinical trial, comparing the UK with non-UK centres. These differences in surgical practice are particularly relevant to the management of stage 3 tumours where there appears to be a greater likelihood of residual disease >2cm following UK procedures. As this is known to be a key prognostic factor, these are potentially large enough to impact significantly on treatment outcome, and might explain some of the variability in survival outcome seen in the EUROCARE studies. Survival data are awaited.

1017 ORAL

Conservative treatment of ovarian borderline tumor

P. Morice[1], S. Camatte[1], P. Pautier[2], C. Lhommé[2], C. Haie-Meder[3], P. Duvillard[4], D. Castaigne[1]. [1]*Department of Gynecologic Surgery;* [2]*Department of Oncology;* [3]*Department of Radiotherapy;* [4]*Department of Pathology, Institut Gustave Roussy, Villejuif, France*

Purpose: The aim of this study is to assess the clinical outcome and fertility of patients treated conservatively for a low malignant potential ovarian tumor (LMPOT).

Methods: Forty-four followed-up patients treated with conservative management for a stage I (n = 32) or II and III (n = 12) LMPOT were followed-up. 33 patients underwent a unilateral adnexectomy and 11 had a cystectomy (bilateral in 1 patient; with contralateral adnexectomy in 5 patients).

Results: The recurrence rates following radical surgery, adnexectomy and cystectomy were respectively: 5.7%, 15.1% and 36.3% (p < 0.01). None of the recurrences in the patients who were initially treated conservatively were under the form of ovarian carcinoma. Five patients who had recurrence underwent again a conservative management of these recurrences. All patients treated conservatively are alive and disease-free. Seventeen pregnancies (15 spontaneous) were obtained in 14 patients. Thirteen pregnancies were obtained in patients with stage I disease and 4 in patients with stage III.

Conclusion: The conservative management of LMPOT increases significantly the risk of recurrence but without affecting the overall survival. Such a management offered a chance of having spontaneous pregnancies even in patients with advanced stage of the disease (noninvasive peritoneal implants). Conservative management could be proposed in young patients wishing to preserve their fertility. But careful follow-up will be required to detect any recurrence in the ovaries.

1018 ORAL

Epirubicin/paclitaxel/carboplatin (TEC) vs paclitaxel/carboplatin in first line treatment of ovarian carcinoma figo stage II b-IV. Preliminary results. A GINECO randomized trial

B. Weber[1], W. Kuhn[2], A. Goupil[1], J. Blohmer[2], F. Guichard[1], J. Quaas[2], V. Lucas[1], W. Schröder[2], J. Plaza[1], A. du Bois[2]. [1]*GINECO, 75000, Paris, France;* [2]*AGO, Wiesbaden, Germany*

Purpose: The objective of this randomized trial was to demonstrate whether the three drug chemotherapy regimen (TEC) increases overall survival over two drug (TC).

Methods: Between 11/1997 and 02/2000, 1281 patients were randomized to receive 6 cycles of paclitaxel (175 mg/m2, 3 h iv) followed by carboplatin (AUC 5, Calvert formula) with (TEC) or without (TC) epirubicin (60 mg/m2 iv prior to Paclitaxel) on a 3 weekly schedule. Patients (pts) were stratified for stage and residual tumor (rT) (II-III + residual T ≤ 1 cm = Strate 1/IV and II-III + residual rT > 1 cm = Strate 2).

Results: Patient characteristics are well balanced between two arms (1190 pts). NCI-CTC toxicity of 3-4 grade was observed in 54% of the cycles of TEC and 30% of TC. Hematologic toxicity was grade 3-4 in 68% of the patients in TEC arm, versus 30% TC arm. Non hematologic toxicity was not significantly different between TEC and TC except for nausea and vomiting. Adjonction of epirubicin did not increase cardiac toxicity. There is no significant difference in progression free survival between TEC and TC (1190 pts). But there is a trend in favour of TEC in strate 1, 323 events/605 pts, med 18 (16/21) vs TC 333/585, med 17 (15-19). There is no difference between TEC and TC for overall survival. Follow up and analysis will be updated in autumn 2001.

Conclusion: this is the first trial evaluation of standard chemotherapy versus three drug regimen. Both regimens are feasible. TEC induces more hematologic and vomiting toxicities than TEC. Until today there is no advantage in terms of overall survival of TEC over TC.

1019 ORAL

ACTION + ICON1: two parallel randomised phase III trials comparing adjuvant chemotherapy to no adjuvant chemotherapy following surgery in women with high risk early ovarian cancer

N. Colombo, J.B. Trimbos, D. Guthrie, I. Vergote, C. Mangioni, J. Vermorken, W. Qian, G. Bolis, V. Torri, A. Anastasopoulou, M. Parmar. *On Behalf of ACTION and ICON1 Collaborators; European Institute of Oncology, Division of Gynecology, Milan, Italy*

Background: Despite a number of small randomised trials it is not clear whether adjuvant chemotherapy improves survival in women with early stage epithelial ovarian cancer.

Method: We carried out two parallel international, multicentre, randomised trials ICON1 (International Collaborative Ovarian Neoplasm studies) and ACTION (EORTC: Adjuvant Clinical Trial In Ovarian Neoplasm) to compare adjuvant platinum-based chemotherapy against chemotherapy delayed until indicated, in women with surgically resected early ovarian cancer. The primary outcome was length of survival.

Findings: 925 (477 in ICON1, 448 in ACTION) patients were randomised from 124 centres in 13 countries; 465 to adjuvant chemotherapy and 460 to no adjuvant chemotherapy. The median age was 55 years with over 90% patients being FIGO stage 1. The major histological cell types were serous (34%), mucinous (20%), endometrioid (25%) and clear cell (14%). Differentiation of disease was classified as poor in 31% of patients, intermediate in 46%, and well in 22% of patients. The patient characteristics were similar in both treatment groups. With over 3 years median follow-up for survivors, the hazard ratio for recurrence-free survival is 0.64 (95% confidence interval 0.50 to 0.83), p = 0.001, in favour of adjuvant chemotherapy. For overall survival the hazard ratio is 0.68 (95% confidence interval 0.51 to 0.92), p = 0.01, in favour of adjuvant chemotherapy. These results translate into an absolute difference of 7% in overall survival at 5-year from 75% in the no adjuvant chemotherapy to 82% in the adjuvant chemotherapy.

Preliminary Conclusion: Adjuvant chemotherapy improves both recurrence-free survival and overall survival. The clinical interpretation of these results will be discussed.

1020 ORAL

CA125 response and disease stabilisation are associated with estrogen receptor expression in a phase II trial of letrozole in ovarian cancer

J.F. Smyth[1], A. Bowman[1], H. Gabra[1], A. Lessels[2], M. Stewart[1], A. Young[1], S.P. Langdon[1]. [1]*ICRF Medical Oncology Unit, Western General Hospital, Edinburgh, United Kingdom;* [2]*Department of Pathology, Western General Hospital, Edinburgh, United Kingdom*

Purpose: We are exploring the therapeutic potential for estrogen receptor (ER) targeted approaches in ovarian cancer. In a phase II trial of the aromatase inhibitor letrozole (Femara) in relapsed ovarian cancer, we have investigated the relationship between antitumor response to letrozole and several markers relating to estrogen regulation predicted by our experimental ovarian cancer models.

Methods: 60 patients were treated with letrozole (2.5 mg daily) at CA125 relapse. To date, 45 patients are evaluable for response by CT scan and 48 by CA125 criteria. ER and progesterone receptor (PR) expression were measured in primary tumors by immunohistochemistry (IHC) using a scoring system ranging from 0 to 300 (product of % cells positive and intensity). EGF receptor and erbB2 were also measured by IHC.

Results: After 3 months treatment, using UICC criteria, letrozole produced no complete or partial responses, 8 patients had stable disease and 37 progressed. Using CA125 criteria, 5 patients had a partial response (> 50% fall), 13 had a stable value at 3 months (<50% rise) and 30 had a clearly progressing value. The UICC stable disease group had a significantly higher ER (p=0.032) and PR value (p=0.0096) than the progressive disease group and a combination of these ER > 150, PR > 70 was associated very strongly with stable disease (p < 0.0001). Using CA125 criteria, comparison of the CA125 stable/responding disease with progressive disease again indicated