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PO060 | Clinicopathological characteristics and population-level survival outcomes of mucinous adenocarcinoma across different colon segments: An analysis from SEER database

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Aim: To determine population-level survival differences for patients undergoing curative resection for mucinous adenocarcinoma (MAC) based on specific anatomical colon segment and stage over the last two decades.

Method: Study was conducted from the Surveillance Epidemiology and End Result (SEER) program. Patients who underwent curative surgery for MAC between 2004 and 2019 were identified. Demographics, clinical and histopathologic factors were grouped and compared amongst each other according to different colon segments (cecum, ascending colon, hepatic flexure, transverse colon, splenic flexure, descending and sigmoid colon) stages (I, II, III and IV) and time periods. Kaplan-Meier survival analysis was conducted for each colon subsite location and stage, and curves were compared using log-rank test.

Results: A total of 19,427 patients met the inclusion criteria. Patients with proximal colon cancers were significantly older (70.6 ± 12.6) and more likely to be female (56.5%) compared to the distally located tumors sites ($p < 0.001$). The incidence of MAC was higher in cecum (30.8%) and ascending colon (27.9%) compared to distal sites (3.4–14.6%). 3-year and 5-year overall survival rates were quite similar among the different colon sites (3-year survival rate ranging 66.7–69.9%) and 5-year overall survival rate: 54.7–58.7% for stage II–III and IV patients. Only stage-I showed significantly different outcomes among each colon site ($p = 0.018$). Multivariable cox regression analysis was performed and shown that age (HR=2.2, $p < 0.001$), stage ($p < 0.001$), degree of differentiation ($p < 0.001$) and higher tumor diameter (HR: 1.05, $p = 0.007$) were independently associated with worse survival.

Conclusion: Unlike previous literature, our study revealed long-term population-level stage-by-stage survival analysis for MAC was similar across seven different colon sites, except for stage-I patients, who showed significantly better survival in the sigmoid colon.

Disclosure of Interest: None declared.

PO061 | Factors associated with survival in incurable asymptomatic stage IV colorectal cancer patients who underwent palliative primary tumor resection and chemotherapy

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Aim: Our study aims to provide a summary of the short-term and survival outcomes of patients with stage IV colorectal cancer who

have unresectable metastasis and have undergone primary tumor resection with chemotherapy and identify the factors that predict survival outcome.

Method: A multicentre, retrospective, observational study was conducted, and all stage IV minimally symptomatic colorectal patients undergoing primary tumor resection with chemotherapy between January 2017 and March 2022 were included.

The significant factors predicting survival outcome were evaluated by using multivariate logistic regression analysis model.

Results: One hundred thirty-three patients (57% male) with a mean age of 56 ± 12 years. The most common tumors were left-sided colon cancers (62%). Seventy-nine patients (59%) had LN metastasis. The lung was the most common metastatic site (71%). Major post-operative morbidity rate was 38% (50 of 133) and the treatment-related mortality rate was 2% (3 of 133). The mean survival time was 25 ± 16 months. The median number of in-hospital days during the course of treatment was 9 (3–68) days. The results of multivariate logistic regression analysis revealed three factors that were significantly associated with poor survival: positive pathological lymph node (OR 4.24, CI 0.74–7.73, $p = 0.018$), Anastomotic leak (OR 11.61, CI 11.6–21.6, $p = 0.023$) and other complications (burst abdomen, enterocutaneous fistula, acute coronary syndrome, hospital-acquired infection) (OR 22.67, CI 7.94–37.4, $p = 0.003$).

Conclusion: In patients with incurable Stage IV colorectal cancer whose primary tumor is minimally symptomatic, a treatment strategy that includes resection of the primary tumor is associated with treatment-related morbidity and mortality, longer hospital stays, and postoperative morbidity that reduces survival.

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Disclosure of Interest: None declared.

PO062 | The prognostic ability of CT TDV staging vs CT TNM staging of right colon cancer

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Aim: To compare the prognostic ability of the CT TDV staging system to identify 'high' and 'low' risk groups in the pre-operative assessment of potentially curable right colon cancer and compare this to the current CT TNM staging, whereby those who are deemed CT node positive are deemed 'high risk'. Secondary aim to assess whether those patients deemed 'high' risk preoperatively benefit from CME surgery over standard right hemicoectomy.

Method: Retrospective study of patients who had undergone surgery with curative intent for right-sided colon cancer between January 2010 and May 2018 in 5 West London hospitals. Pre-operative CT scans re-scored by trained GI radiologists as TDV 'good' or 'poor' and compared with CT TNM stage. TDV 'poor' defined as ≥ 1 of ctT3c+, ctEMVI+ or ct tumour deposits (ctTD). 5-year DFS calculated with Kaplan Meier method and compared with Log Rank test.

Results: 365 patients included, 284 with standard portal venous CT abdo/pelvis sequences while 81 had staging performed on contrast enhanced CT colonography. CT TDV system able to prognosticate patients into high and low risk groups for 5-year DFS (81.8% CT TDV poor vs 88.7% CT TDV good, $p=0.021$). When staged as CT TNM poor vs CT TNM good, no prognostic stratification was achieved,

5-year DFS (85.5% CT TNM poor vs 84.9% CT TNM good, $p=0.569$). The greatest prognostic stratification was evident for the CT TDV staging system when utilised on CT colonography, 5-year DFS (77.3% CT TDV poor versus 96.1% CT TDV good, $p=0.002$). On Cox regression multivariate analysis for 5-year DFS, ctEMVI+ was the only significant radiological feature (HR 1.686, $p=0.041$). Significant improvement in 5-year DFS was identified in CT TDV 'poor' patients who underwent CME over standard right hemicolectomy.

Conclusion: Pre-operative CT TDV staging of right colon cancer patients can prognosticate patients into 'high' and 'low' risk groups more accurately than CT TNM staging while also identifying a group who benefit from CME surgery.

Disclosure of Interest: None declared.

PO063 | Impact of anastomotic leakage after colorectal cancer surgery on quality of life – A systematic review

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Aim: Colorectal anastomotic leakage remains one of the most frequent and dreaded post-operative complication following colorectal resection. However, limited research has been conducted on the impact of this complication on quality of life of patients undergoing colorectal cancer surgery.

The aim of this systematic review was to identify, appraise and synthesize the available evidence regarding quality of life in patients with anastomotic leakage following oncological colorectal resections in order to inform clinical decision-making.

Method: PubMed, Embase and the Cochrane library were searched for studies reporting on quality of life using validated questionnaires in patients with anastomotic leakage after oncological colorectal resections. The literature search was performed systematically and according to PRISMA guidelines. Outcomes of quality of life questionnaire scores of AL vs non-AL patients were analyzed.

Results: 13 articles reporting on 4596 individual patients were included, among which 566 patients developed AL. Quality of life was evaluated utilizing ten distinct questionnaires administered at various postoperative time points, ranging from 1 month to 14 years. Quality of life outcomes differed across studies and timepoints, but overall scores were most affected by AL up to twelve months post-operatively. There was a high heterogeneity between the included studies based on used questionnaires and time of assessment.

Conclusion: The published evidence suggests that anastomotic leakage following oncologic colorectal resection is associated with impaired quality of life, especially within the first postoperative year. The impact of anastomotic leakage on quality of life warrants further evaluation and discussion with patients.

Disclosure of Interest: None declared.