surgical training and 1/3 being trained in a Breast Unit. It is imperative to develop quality standards for breast cancer surgery training to ensure that patients get standardized and certified surgical management regardless of the country they are treated.

Conflict of interest: No conflict of interest.

24

ELECTROCHEMOTHERAPY IN MELANOMA: A EUROPEAN E-DELPHI SURVEY TO DEFINE A CONSENSUS ON INDICATIONS, TREATMENT MODALITIES AND QUALITY INDICATORS

L.G. Campana[1], P. Quaglino[2], F.G. Bechara[3], R. Marconato[4], P.A. Ascierto[5], C. Caracò[6], M. Brizio[7], J. Clover[8], M. Bourke[9], S. Valpione[10], G. Sersa[11], C. Kunte[12], M. Mühlstädt[13], G. Gerlini[14], J. Hafner[15], R. Patuzzo[16], S. Farronato[17], A. Orlando[18], K. Eisendle[19], E. Kis[20]. On behalf of InspECT (International Network for Sharing Practices of Electrochemotherapy) and members the Expert Panel[1] *Veneto Institute of Oncology IOV-IRCCS, Surgical Oncology Unit, Padova, Italy;* [2] *University of Turin, Department of Medical Sciences- Dermatologic Clinic, Turin, Italy;* [3] *Ruhr-University, Department of Dermatology- Skin Cancer Center, Bochum, Germany;* [4] *University of Padua, Department of Surgery Oncology and Gastroenterology - School of Surgery, Padua, Italy;* [5] *Istituto Nazionale Tumori Fondazione G. Pascale, Medical Oncology Unit, Naples, Italy;* [6] *Istituto Nazionale Tumori Fondazione G. Pascale, Surgical Oncology Unit, Naples, Italy;* [7] *University of Turin, Department of Medical Sciences - Dermatologic Clinic, Turin, Italy;* [8] *Cork Cancer Research Centre- Cork University, Department of Plastic- Reconstructive and Aesthetic Surgery, Cork, Ireland;* [9] *Cork Cancer Research Centre, Cork, Ireland;* [10] *The Christie NHS Foundation Trust, Medical Oncology, Manchester, United Kingdom;* [11] *Institute of Oncology Ljubljana - Ljubljana - Slovenia, Department of Experimental Oncology, Ljubljana, Slovenia;* [12] *Ludwig-Maximillian University, Department of Dermatology and Allergology, Munich, Germany;* [13] *Geneva University Hospitals, Division of Dermatology and Venereology, Geneva, Switzerland;* [14] *Tuscan Tumour Institute ITT - Santa Maria Annunziata Hospital, Plastic and Reconstructive Surgery Unit, Florence, Italy;* [15] *Zürich University, Department of Dermatology, Zürich, Switzerland;* [16] *Fondazione IRCCS Istituto Nazionale dei Tumori, Melanoma and Sarcoma Unit, Milan, Italy;* [17] *University of Padova, School of Medicine, Padova, Italy;* [18] *Southmead Hospital- North Bristol NHS Trust, Department of Plastic and Reconstructive Surgery, Bristol, United Kingdom;* [19] *Medical University Innsbruck- Central Teaching Hospital Bolzano, Department of Dermatology-Venerology, Bolzano, Italy;* [20] *University of SzegedSzeged- Hungary, Department of Dermatology and Allergology, Szeged, Hungary*

Background: Electrochemotherapy (ECT) has evolved considerably over the past decade, but its application is yet to be standardized. In fact, a lack of agreement exists on eligible patients, timing of treatment, combination strategies and outcomes. Therefore, our aim was to establish a consensus on treatment indications (TI), procedural modalities (PM), and quality indicators (QI) of ECT in melanoma.

Material and methods: We invited 156 experts from 53 European centers who fulfilled pre-specified eligibility criteria to undertake a 3-Round web-based survey, according to a modified Delphi method. The inclusion criteria were: (a) at least 20% of practice in melanoma; (b) a minimum of 5 years of post-qualification experience; (c) participation to a melanoma multidisciplinary team (MDT) meeting; (d) ability to communicate in written English; (e) working at a center where ECT is currently performed. Each center was encouraged to participate with experts from different specialties. Out of 156 invited experts, 122 (78.2%) agreed to participate and received in-depth instructions. The questionnaires were administered through an online platform powered by Scientific Network (www.scientificnetwork.org) and the participants had at least eight weeks to complete each phase of the survey (April – May 2017; August – September 2017; November 2017 – January 2018). For each item, participants were asked to rate its relevance and to express their agreement on a five-point Likert scale (from 1= completely disagree to 5=completely agree). Consensus was defined as $\geq$ 70% of subjects rating 3 or 4, and items were retained in case of stability in two successive iterations. Subject anonymity was maintained throughout the study and a controlled feedback was provided to allow participants to reassess their initial judgments.

Results: One-hundred subjects completed the first phase and thus represented the Expert Panel (Italy, n=61; UK, n=10; Germany, n=6, Ireland, n=5; Portugal, n=4, Slovenia, n=4; Poland, n=4; Switzerland, n=3; Hungary, n=3; Denmark, n=1; Spain, n=1). The composition of the Expert Panel was as follows: surgeons, n=49; dermatologists, n=29; medical oncologists, n=15; radiotherapists, n=3; nurses, n=2; clinical scientists, n=2. The completion rate of the first, second and third Round of the survey was 82% (100/122), 97% (97/100), and 93% (90/97), respectively. In the final Round, we reached a consensus on 43 items on TI and on 16 QI. For each QI, a benchmark value was individuated through a real-time Delphi method.

Conclusion: Experts suggested a set of shared, melanoma-specific TI of ECT. Moreover, they agreed on a core set of QI, which could represent critical considerations for its safe adoption and promote the standardization of the procedure. The items lacking consensus may represent useful topics for future research.

Conflict of interest: No conflict of interest.

25

INTERNATIONAL COMPARISON OF TREATMENT STRATEGY AND SURVIVAL IN METASTATIC GASTRIC CANCER: A SURVEY FROM THE EURECCA UPPER GI GROUP

Y. Claassen[1], E. Bastiaannet[1], H. Hartgrink[1], J. Dikken[1], W. De Steur[1], M. Slingerland[2], R. Verhoeven[3], E. Van Eycken[4], H. De Schutter[4], M. Lindblad[5], J. Hedberg[6], E. Johnson[7], G.O. Hjortland[8], L. Jensen[9], H. Larsson[10], T. Koessler[11], M. Chevallay[12], W. Allum[13], C. Van de Velde[1]. [1] *Leiden University Medical Center, Surgery Department, Leiden, Netherlands;* [2] *Leiden University Medical Center, Medical Oncology Department, Leiden, Netherlands;* [3] *Netherlands Comprehensive Cancer Organisation IKNL, Department of Research, Leiden, Netherlands;* [4] *Belgian Cancer Registry, Belgian Cancer Registry, Brussels, Belgium;* [5] *Karolinska University Hospital, Department of Surgical Gastroenterology, Stockholm, Sweden;* [6] *Uppsala University, Department of Surgical Science, Uppsala, Sweden;* [7] *Oslo University Hospital- University of Oslo, Department of Gastroenterological and Pediatric Surgery- Institute of Clinical Medicine, Oslo, Norway;* [8] *Oslo University Hospital, Department of Oncology, Oslo, Norway;* [9] *Aarhus University Hospital, Department of Surgery, Aarhus, Denmark;* [10] *a National Quality Improvement Programme RKKP, The Danish National Registries, Aarhus, Denmark;* [11] *Geneva University Hospital, Department of Medical Oncology, Geneva, Switzerland;* [12] *Geneva University Hospital, Department of Surgery, Geneva, Switzerland;* [13] *Royal Marsden NHS Foundation Trust, Department of Surgery, London, United Kingdom*

Background: No survival benefit was shown in the randomized Asian REGATTA trial for additional gastrectomy over chemotherapy alone in patients with advanced gastric cancer with a single non-curable factor; thereby discouraging palliative gastrectomy surgery for this group of patients. The German prospective phase II AIO-FLOT3 trial indicated a favourable survival for patients with limited metastatic disease having surgery after neoadjuvant chemotherapy, and this is further being evaluated in the ongoing randomized RENAISSANCE trial. The aim of this study was to describe treatment strategy patterns for patients with metastatic gastric cancer in daily practice in five countries in Europe. Also, relative survival according to country was determined.

Material and methods: National population-based data from Belgium, Denmark, the Netherlands, Norway, and Sweden were collected and merged. All patients diagnosed with primary metastatic gastric cancer between 2006 and 2014 were included. Resection rates and the administration of chemotherapy (irrespective of surgery) in each country were analysed. Relative survival in each country was calculated.

Results: In total, 15 057 gastric cancer patients were included. The resection rate differed from 8.1% in the Netherlands and Denmark to 18.3% in Belgium. Chemotherapy was administered in 39.2% of the patients in the Netherlands compared to 63.2% in Belgium. Six-month relative survival was 54.1 (95% CI 95%: 52.1 – 56.9) in Belgium and 49.6 (95% CI 95%: 47.3-51.9) in Denmark compared to 42.6 (95% CI 95%: 39.8-45.4) in Norway, 39.6 (95% CI 95%: 37.6-41.5) in Sweden, and 39.0 (95% CI:37.8 – 40.2) in the Netherlands.

Conclusions: In Europe, wide variation is observed in the use of a gastrectomy for patients with metastatic gastric cancer and in