oophorectomy), and ovarian cancer. Opportunistic salpingectomy at the time of tubal ligation will reduce ovarian cancer mortality by 8.15%. Opportunistic salpingectomy at the time of hysterectomy will reduce ovarian cancer mortality by 5.82%. Both strategies are highly cost effective when considering the cost of opportunistic salpingectomy alone. The excess cost of opportunistic salpingectomy at the time of tubal ligation was $280.44 with an ICER of $16,910.48 per life-yr (LY) and $14,453.43 per Quality Adjusted Life Year (QALY) when adjusting for ovarian cancer with a utility of 0.64. The ICER for opportunistic salpingectomy during hysterectomy at a cost of $112.32 was $11,278.09 per LY and $9,378.05 per QALY. However, when adding the cost of ovarian cancer, both procedures demonstrate a significant cost savings to the health care system. It is estimated that the per capita life-time savings for opportunistic salpingectomy at both tubal ligation and hysterectomy would be $225.31. This savings would increase to $491.38 with a 3% annual discount rate.

Conclusions: Universal opportunistic salpingectomy would prevent 1,967 deaths per year from ovarian cancer with a health care savings of 851 million dollars per year. Given these data, opportunistic salpingectomy should be uniformly practiced and covered by third party payers.

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Poster #28

A prospective assessment of patient preferences in ovarian cancer: What do patients value the most?

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Objectives: Discussions regarding treatment in ovarian cancer often involve the trade-off between survival benefits and complications/toxicity. However, little is known about how patients value these different aspects. The American Society of Clinical Oncology defines value in cancer care as clinical benefit in the context of morbidity and costs. Our objective was to elucidate patient preferences in ovarian cancer, and ascertain what they value the most.

Methods: From 1/2017 to 5/2017, 50 women with ovarian cancer were enrolled in this prospective study. 11 attributes related to having cancer or its treatment were assessed. Patients rated each attribute using a Likert scale from 1 (not important) to 5 (deeply important), and ranked them from the most important (1) to the least important (11). To assess preferences regarding the trade-off between survival and complications, they were asked how many additional months of overall survival a treatment approach would have to give them if it increased the complication risk from 10% to 30%, or the risk of getting a colostomy from 1% to 10%, respectively. Appropriate statistical tests were used.

Results: The median patient age was 63, the majority had Stage IIIC cancer (64%), and 70% had experienced a recurrence. Overall survival was deemed the most important attribute by patients (mean ranking 2.1, mean rating 4.8/5, with 58% of them ranking it at as the most important one). This was followed by progression-free survival, physical/mental well-being, permanent complications/sequelae (i.e. permanent colostomy), return to pre-treatment activities of daily living, time off treatment, and temporary complications/sequelae (Table). Chemotherapy schedule/type, assistance with care, cost of care, and logistical issues were the least important attributes. There were no differences in preferences between women who recurred vs those who did not. A treatment approach that increased the major complication risk from 10% to 30% would have to yield patients an additional median overall survival of 6m (range 0.25 – 54m) to be acceptable. A treatment approach that increased the colostomy risk from 1% to 10% would also have to give patients an additional median overall survival of 6m (range 0.25 – 48m).

Conclusions: Women with ovarian cancer value overall survival the most, followed by progression-free survival and physical/mental well-being. A treatment approach that increases the risk of complications or getting a colostomy would have to give patients an additional 6m of overall survival to be acceptable.

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Poster #29

Concurrent hysterectomy at the tine of risk-reducing surgery for patients with BRCA mutations

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Objectives: Risk-reducing salpingo-oophorectomy (RRSO) is standard management for women with *BRCA1/2* mutations, however the role of concurrent hysterectomy (CH) remains controversial. Shu et al. published the largest study addressing endometrial cancer among BRCA carriers in 2016, suggesting an increased risk of serous uterine cancer in women with BRCA1 mutations. Currently, there is no official recommendation for CH with RRSO however many practitioners offer this combined procedure. We sought to review our institutional experience with RRSO and CH.

Methods: Data was abstracted from the medical record for all patients at a single institution with *BRCA1/2* mutations undergoing RRSO between 2003-2018. Univariate tests were applied based on variable distribution and associations between categorical variables were evaluated by chi-square tests or Fisher's exact tests as appropriate for category size.

Results: One hundred fifty-five patients underwent RRSO (*BRCA1* 81, 53%; *BRCA2* 71, 45%; *BRCA1* and *BRCA2* 3, 2%). Thirty-six patients underwent CH at time of RRSO (23%). The median age at time of RRSO was 48 years (range 33-73). Patients undergoing CH were significantly younger than those undergoing RRSO alone (45 vs. 49.5, P=0.01). Seventy-two patients (46%) had a history of breast cancer (42% of patients with breast cancer had CH vs. 50% of patients without breast cancer had CH, P=0.45). CH was more common among women with *BRCA1* mutations vs. *BRCA2* mutations (31% vs. 14%, P=0.02). Uterine cancer risk-reduction was the most common indication for CH (n=22, 58%) (Figure 1). Following the 2016 publication, CH was significantly more common compared to prior, 43% vs. 18%, respectively (P=0.006).

Figure 1- Reason for hysterectomy