number of evaluable patients. A drop-out rate of 5% was assumed.

Result(s)* **Conclusion*** In the clinical setting of advanced and recurrent LMS and CS there are no well-evaluated therapies available. This trial is clinically highly relevant and offers opportunity for patients to receive promising therapy.

206 HIV TESTING IN CERVICAL DYSPLASIA, PRACTITIONERS' OPINION

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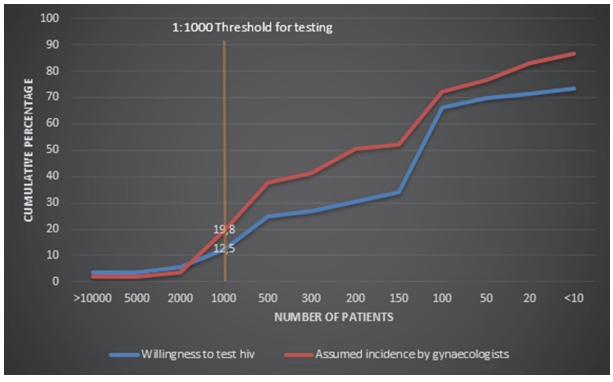
Introduction/Background* Cervical dysplasia is an HIV indicator condition and according international recommendations HIV testing is strongly advised in women with cervical dysplasia, because the risk of an undiagnosed HIV is thought to be >0.1%. Therefore an HIV test should be offered to all women with cervical dysplasia. There is no literature about the opinion of Gynaecologist on HIV screening in patients with cervical dysplasia.

Methodology We sent an online questionnaire to gynecologist in South West Netherlands to investigate 1) what they know about this issue, 2) their opinion and willingness on active HIV testing for this cervical dysplasia.

Result(s)* The questionaire was sent to 103 gynaecologists of whom fifty-six participants replied (54%). Forty-eight (86%) think patients are not offended when HIV testing is offered and 50 (89%) have no difficulty to address HIV testing. Thirty-nine (70%) gynaecologist think that the prevalence of undiagnosed HIV infection is lower than 0.1% , and only seven (12,5%) accept HIV testing in case of a prevalence of 0.1% or less. Thirthy-two (57%) are willing to test with a prevalence of 1% or higher.

Conclusion* To address and offer HIV testing seems not an issue for the gynaecologists questioned in our study. However, the willingness to routinely perform an HIV test for cervical dysplasia at the assumed 0.1% prevalence looks insufficient and differs from the recommendations of international policy makers. Discussion is needed tot change the treshold or the willingness for testing.



Abstract 206 Figure 1

222 EVALUATION OF UPA/PAI-1 AS A PROGNOSTIC MARKER IN YOUNG WOMEN WITH BREAST CANCER

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Introduction/Background* Breast cancer is uncommon in young women in developed countries. It is very heterogenous disease and studies showed, that young patients often have biologically complex and often more agressive tumours. However, little is known on markers available to improve assessment of prognosis or provide an additional therapeutic targets. One potential marker is the uPA-PAI-1 complex or each of the proteins individually. The protease uPA and its inhibitor PAI-1 have been implicated in cancer progression through facilitating tumour cell migration. The aim of this study was to evaluate the potential impact of uPA and PAI-1 as prognostic markers in young women with breast cancer.

Methodology We identified through the use of our institutional database on breast cancer 84 from 2283 (3.7%) of women diagnosed with breast cancer under the age of 45 years at the University Medical Centre Maribor, Slovenia between January 2009 – December 2019. An exam of clinical patient records was performed and clinico-pathological data were evaluated. Tumour tissue was prospectively analysed after primary surgical treatment and quantified using immunometric method ELISA sets. Values of uPA and PAI-1 were expressed in ng/mg of proteins. Correlations were evaluated using the Spearman rank test and continous data were compared using the Mann-Whitney U test. Data were evaluated using the SPSS for Mac version 23.0

Result(s)* Clinical data were available for 70 women with BC. Data on uPA/PAI-1 protein levels and the expression of the uPA-PAI-1 complex were available in 39 women (55.7%). The median age of patients in our study was 42.0 years (29-45). The complex of uPA/PAI-1 was significantly correlated with age at time of diagnosis (r_s=-.366, p<0.022). There was no significant correlation between the expression levels of uPA and levels of PAI-1 and oestrogen receptors, progesterone receptors, Ki-67 expression or tumour size. uPA/PAI-1 complex was also not significantly correlated with the hormone receptor negative (TNBC) breast cancer (p>.814).

Conclusion* Further research should evaluate the connection of age and the uPA/PAI-1 complex. uPA and PAI-1 did not show independant prognostic abilities in this pilot study.

243 INCIDENCE OF GYNAECOLOGICAL CANCER DURING THE COVID-19 PANDEMIC

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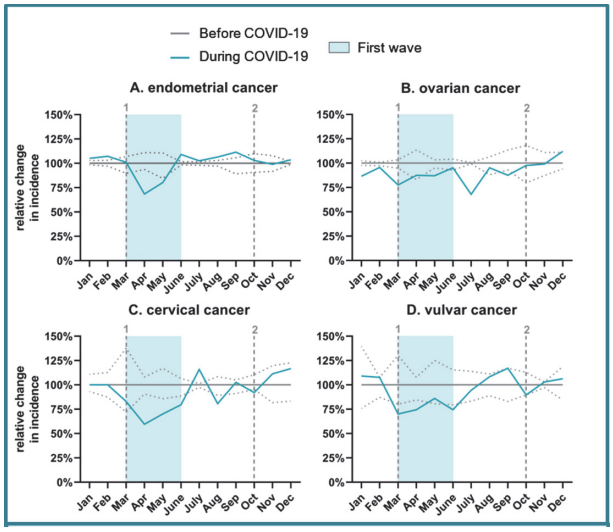
10.1136/ijgc-2021-ESGO.256



Abstract 243 Figure 1 Change in incidence over time

Introduction/Background* On the 11th of March 2020, the novel severe acute respiratory syndrome corona virus 2 (SARS-COV-2) was declared a pandemic. We studied the incidence and missed diagnoses in gynaecological oncology as a result of the impact of the COVID-19 pandemic and consequent lockdown and overcrowded hospitals in the Netherlands.

Methodology We performed a retrospective cohort study using data from the Netherlands Cancer Registry (NCR) on women of 18 years and older diagnosed with invasive endometrial, ovarian, cervical or vulvar cancer in the period 2017-2020. The incidence was calculated for the period before the COVID-19 pandemic (mean number of the period 2017-2019) and compared with the incidence during the COVID-19 pandemic (2020) for each type of gynaecological cancer. The number of missed diagnoses was calculated as the difference in incidence between the period before and during the pandemic. Analyses were stratified for age, socioeconomical status (SES) and region.

Result(s)* The incidence rate of gynaecological cancer was 57/100.000 (n = 4921) before and 53/100.000 (n = 4682) during the pandemic. Comparing the incidence of the two periods for the four types of cancer showed no significant difference (chi^2 p=0.23). During the first wave of COVID-19 (March-June 2020), a clear decrease in incidence was visible for all four types of gynaecological cancer (figure 1). Subsequently, large increases in incidence were visible. A total of 299 diagnoses were missed during the pandemic (6.2% of the incidence of the period before COVID-19). The largest number of missed diagnoses was observed in ovarian cancer (n = 157, 10.9%), followed by cervical cancer (8.3%, n = 76), vulvar cancer (7.1%, n=31) and endometrial cancer (1.7%, n = 35). No significant differences in incidence were found for different age groups, SES and between regions.

Conclusion* In the Netherlands, a clear drop in incidence was visible for all four types of gynaecological cancers during the first wave, which was caught up in the second part of 2020 hence no significant difference with the period before COVID-19. The difference in incidence was not caught up completely, for 299 women walk around with missed diagnoses, which could result in higher stage disease or even worse.

254 CONSTRUCTION OF PRE-OPERATIVE PREDICTION MODEL AND ITS USE IN GYNAECOLOGICAL ONCOLOGY USING CARDIOPULMONARY EXERCISE TESTING AND ROUTINE HEALTH DATA

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Introduction/Background* Our ever-growing population is putting greater strain upon the NHS with more complex medical problems, and strained resources. Comorbidities predispose patients to postoperative complications, impacting recovery and survival, length of stay, and mortality rates. The one size fits all attitude to treatment is no longer the best approach to tackle illness, as technology develops patient care will transform.

CPET assesses the bodies neurohumoral stress response to surgery, however not all patients complete CPET, with mobility and contraindications an issue. The ability to quantify morbidity and mortality risks enables discussions regarding appropriateness of surgical interventions, discuss likely scenarios and quality of life (QOL).

Methodology The aim is to create a pre-operative prediction model using cardiopulmonary exercise testing (CPET) and routine health data (RHD). The model can be utilised in conjunction with CPET, identifying patients in greater need of high dependency care (HDU), and at greater risk of complications.

All gynaecological oncology patients undergoing CPET from 2011 onwards are included in the retrospective analysis in one centre, which includes those over 65 years and those with multiple comorbidities. RHD, and CPET data will be collated, assessing links between the data with known clinical outcomes, producing a risk prediction tool that will then be used on a prospective cohort of patients.

Result(s)* Risk stratification tools allow shared decision making with personalised perioperative risks giving better patient experience and post-operative QOL.

RHD and CPET is currently being collated and analysed using R Studio.

Conclusion* The hope is to create a prediction model to use in conjunction with CPET to better guide care and improve patient outcome. If shown to better predict high risk patients it may be possible to improve care by prediction model alone, meaning all patients can be assessed, be cost effective, and be a more personalised approach to patient care.