

Introduction/Background Reports on outcomes and the impact of mode of delivery on the clinical course of cervical high-grade squamous intraepithelial lesions (HSIL) during pregnancy and the postpartum period are limited and inconsistent.

Methodology Data of 35 pregnant women with morphologically verified cervical HSIL who were referred to Outpatient Department at NN Alexandrov National Cancer Centre between 2006 and 2021 were retrieved. Median age was 31 (range, 23–43) years. Median weeks of gestation at first examination during pregnancy was 17 (range, 8–34). The progress and outcomes of cervical HSIL and the association with delivery mode were retrospectively analyzed.

Results Median of follow-up was 49 (range, 5.8–162) months. Among 35 women, 24 (68.5%) delivered vaginally and 11 (31.5%) underwent caesarean section. Data of postpartum biopsy or morphology of resected cervical specimen were evaluated from all patients. Postpartum regression of HSIL was noted in 9 cases (25.7%), persistence – in 26 (74.3%). There was not progression of HSIL into invasive cancer during pregnancy. Postpartum regression of HSIL was reported in 7 women who gave birth vaginally (7/24, 29.2%) and in 2 (2/11, 18.2%) women who had a caesarean section ($p = 0.685$). Among women who delivered vaginally and by caesarean section, 17 (17/24, 68.0%) and 9 (9/11, 81.8%) women, respectively, had persisted lesions after delivery ($p=0.685$).

Conclusion According to our data, postpartum regression of HSIL was noted in every fourth case (25.7%). The higher rate of regression of HSIL (29.2% vs 18.2%, $p=0.685$) and the lower rate of persistent lesions (68.0% vs 81.8%, $p=0.685$) in association with vaginal delivery compared with caesarean section were established. None of the women had progression of the invasive disease. Despite the small number of patients, postpartum results suggest that the presence of HSIL in pregnant women is not an indication for caesarean section.

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LAPAROSCOPIC RADICAL TRACHELECTOMY FOR EARLY CERVICAL CANCER – SAFE, EFFECTIVE AND FEASIBLE

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Introduction/Background Radical trachelectomy (RT) is a viable alternative in selected women who wish to preserve fertility with comparable oncological outcomes to radical hysterectomy. Laparoscopic/robotic routes are associated with better outcomes for recovery, aesthetics and blood loss. RT is undertaken for tumours <2 cm. Uterine artery conservation during LRT is associated with best fertility outcomes.

Methodology We report a case of LRT with uterine artery preservation and bilateral pelvic lymphadenectomy performed at Guy's & St Thomas' Cancer Centre in United Kingdom. This video illustrates this technique in a nulligravida woman who was 33 years old and keen to preserve fertility. She had an abnormal cervical smear followed by a large loop excision of transformation zone (LLETZ) for CIN 3. Histology of LLETZ diagnosed G3 endocervical adenocarcinoma FIGO stage IA2 completely excised (tumor

size 3.3 mm width and 3.5 mm depth with an extra focus of 1 mm). There was no lympho-vascular space invasion (LVSI). There was associated CIN-2 and high grade CGIN. Pre-operative MRI pelvis and CT chest & abdomen did not identify any metastases.

Results The histology specimen included a cervix with vaginal cuff and attached parametrial tissue and measured 55x50x25 mm. There was no residual cancer in the specimen or lymph nodes. The pelvic lymph node count was 18. The catheter was removed in 48 hrs and bladder assessed by measuring post-void residual volume. The patient was discharged on second day after surgery without complications. She continues to be under surveillance with a disease free interval of 21 months and has not yet tried to conceive.

Conclusion LRT and LND with uterine artery preservation is feasible in young women who desire future fertility. It is a safe option for early cervical cancer with <2 mm size. Advantages with minimally invasive procedures, include enhanced visualization, precise dissection, less blood loss, fewer complications, and shorter hospital stay.

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ALL-CAUSE AND CANCER-SPECIFIC MORTALITY AFTER FERTILITY-SPARING SURGERY FOR STAGE I EPITHELIAL OVARIAN CANCER

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Introduction/Background To compare all-cause and cancer-specific mortality between women who underwent fertility-sparing (FS) surgery with those who underwent standard surgery for stage I epithelial ovarian cancer.

Methodology A cohort study using data from the California Cancer Registry, identified women ages 18–45 diagnosed with stage IA and IC epithelial ovarian cancer between 2000–2015. Fertility-sparing (FS) surgery was defined as retention of at least one ovary and the uterus. Standard surgery included removal of one or both ovaries, the uterus, and possible additional structures. The primary outcome was survival based on time from diagnosis to death or study completion. Inverse probability of treatment propensity score matching was used to create cohorts balanced on covariates of interest. Survival analysis was conducted with Kaplan-Meier method and Cox proportional hazards modeling.

Results We identified 799 women ages 18–45 diagnosed with stage IA or IC epithelial ovarian cancer between 2000–2015. 265 (33.1%) received FS surgery. There was an increasing trend in FS surgery over the study period (21% in 2000 to 46% in 2015). Before matching, there were significant ($P<0.05$) differences in age at diagnosis, race/ethnicity, marital status, rurality, tumor size, grade, histology, receipt of chemotherapy and lymph node dissection. Propensity-score matching yielded a matched cohort of 176 women who did and 176 women who did not receive FS surgery, balanced on observed covariates. There were 16 overall deaths in the fertility-sparing cohort (median follow-up, 7.3 years), and 21 deaths in the control cohort (median follow-up, 8.2 years). Fertility-sparing

surgery was not associated with increased hazard of overall death (HR 0.8 95% CI 0.4–1.5) or cancer-specific death (HR 1.0 95%CI 0.5–2.4). Small number of deaths limited precision of results.

Conclusion Fertility-sparing surgery was not associated with increased risk of death compared to standard surgery among reproductive-age epithelial ovarian cancer survivors with stage IA or IC disease.

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OBSTETRIC AND NEONATAL OUTCOMES AFTER BREAST CANCER: A POPULATION-BASED STUDY

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Introduction/Background To evaluate obstetric and neonatal outcomes of the first live birth conceived following breast cancer diagnosis.

Methodology We performed a population-based study to compare live births between women with a history of breast cancer and matched controls with no cancer history. Cases and controls were identified using linked data from the California Cancer Registry and California Office of Statewide Health Planning and Development datasets. Cases were diagnosed with stage I-III breast cancer at ages 18–45 years between January 1, 2000, and December 31, 2012, and conceived ≥ 12 months after breast cancer diagnosis. Controls were covariate-matched women without a history of breast cancer who delivered during 2000–2012. The primary outcome was preterm birth < 37 weeks. Secondary outcomes were preterm birth < 32 weeks, small for gestational age, cesarean delivery, severe maternal morbidity, and neonatal morbidity. Subgroup analyses were used to assess time from initial treatment to conception and receipt of additional adjuvant therapy prior to pregnancy on outcomes of interest.

Results Of 30,021 women age 18–45 diagnosed with stage I-III breast cancer during 2000–2012, 553 met the study inclusion criteria. Those with a history of breast cancer and matched controls had similar odds of preterm birth < 37 weeks (odds ratio [OR], 1.29; 95% CI, 0.95–1.74), preterm birth < 32 weeks (OR, 0.77; 95% CI, 0.34–1.79), delivering a small for gestational age neonate (< 5 th percentile: OR, 0.60; 95% CI, 0.35–1.03; < 10 th percentile: OR, 0.94; 95% CI, 0.68–1.30), and experiencing severe maternal morbidity (OR, 1.61; 95% CI, 0.74–3.50). Patients with a history of breast cancer had higher odds of undergoing a cesarean delivery (OR, 1.25; 95% CI, 1.03–1.53), however their offspring did not have increased odds of neonatal morbidity compared to controls (OR, 1.15; 95% CI, 0.81–1.62).

Conclusion Breast cancer history was not strongly associated with obstetric and neonatal complications.

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FERTILITY OUTCOME OF PATIENTS WITH STAGE I IMMATURE TERATOMA – DO SURGICAL APPROACH AND POST-SURGICAL TREATMENT MATTER?

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Introduction/Background Immature teratomas (ITs) are a rare disease representing about one-third of all malignant ovarian germ cell tumors. They are frequently diagnosed in young women, with a peak at 15–30 years old, when the childbearing desire is not completed. Thus, fertility-sparing surgery (FSS) is the treatment of choice, followed by adjuvant chemotherapy (CT) in patients with high-risk features. We investigated the effect of CT on fertility outcome in stage I any grades ITs, also focusing on the effect of the type of ovarian surgery (unilateral salpingo-oophorectomy (USO) vs cystectomy (Cy)) on the same outcome.

Methodology Clinicopathological data were retrospectively collected and analyzed from a cohort of 74 patients with stage I ITs treated at San Gerardo Hospital (Monza, Italy). Forty-seven patients who manifested pregnancy desire and underwent a FSS were enrolled.

Results Among the 47 patients included 37 patients (78,7%) reached pregnancy. The pregnancy rate was not significantly different neither between adjuvant CT and surveillance group (62.5% and 82.0%, respectively [$p = 0.21$]), nor between USO vs Cy group (79,4% and 76,9%, respectively [$p = 0.57$]). The only statistical significant difference was found for staging (a decrease in pregnancy rate from 86.5% for stage IA to 50.0% for stage IC [$p = 0.02$]), but no factors reached a significant impact on the fertility outcome in a multivariate analysis. Interestingly, 62,5% of patients who relapsed reached a pregnancy.

Conclusion These data confirm that a fertility sparing approach is feasible in this young population, and the fertility outcome does not depend on surgical approach or post-surgical treatment. More prospective data are needed, and the role of stage of disease must be fully investigated.

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CANCER IN PREGNANCY: MESSAGE IN A BOTTLE FROM TERTIARY CENTER OF MILAN

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Introduction/Background Cancer complicates approximately 0.1% of all pregnancies. The management represent a challenge because the need of balancing the risks for mother and baby. This study reports our experience in oncological and obstetrical care in patients with cancer in pregnancy (CIP).