

Methods During our research, we examined 100 sexually active women 25–35 years old ($29,1\pm 1.25$) with precancer cervical lesions and chronic recurrent bacterial vaginosis who were separated in two groups according to cervical human papillomavirus (HPV) infection presence. We used liquid PAPP test, PCR, tissue biopsy histology, proliferation cells proteins lab tests.

Results 50 women of group I with 100% HPV highly oncogenic types showed: PAP test – ASCUS – 36 women (72%), LSIL – 7(14%), HSIL – 7(14%); HPV of 16–18 types – 39 women (78%); the histology verified HSIL – in all 50 women (100%), of which CIN II – 21(42%), CIN II-III – 22(44%), CIN III – 18 patients (36%); p16 protein was determined in specimens of 36 women (72%), Ki-67 protein - in 23 samples (46%). From group II of 50 women with HPV absence we revealed: NILM - in 10 women (20%), ASCUS - in 24(48%), LSIL - in 16 patients (32%); the histology showed parakeratosis, acanthosis – in 34 patients (68%), LSIL (CINI) – in 16 samples (32%).

Conclusions Chronic recurrent bacterial vaginosis leads to the toxic nitrosamines release, which causes the epithelial cells neogenesis generation, leads to cellular immunity decrease and favorable conditions for the HPV more advanced stage of CIN II-III development. p16 and Ki-67 proteins determine the dysplasia genesis and disease prognosis. We consider that chronic recurrent bacterial vaginosis timely treatment is obligatory in precancer cervix uterine diseases progression prevention.

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251

POST-COITAL BLEEDING AND YOUNGER AGE ARE RISK FACTORS FOR HIGH-GRADE DYSPLASIA IN WOMEN WITH BIOPSY PROVEN LOW-GRADE SQUAMOUS INTRAEPITHELIAL LESIONS

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Objectives Biopsy proven newly diagnosed Low-grade Squamous Intraepithelial lesions(LGSIL), are considered reversible lesions and as such are usually treated conservatively with follow-up or ablation. In this study we aimed to evaluate the outcome of women with LGSIL who underwent surgical conization, and assess risk factors for higher risk disease.

Methods We performed a retrospective study of all patients who underwent surgical conization for LGSIL disease, in one university affiliated medical center (2012–2017). Study group was defined as patients who had their histological classification upgraded, and control group as patients who were either downgraded or diagnosis remained. Demographics, histological outcome and indications were compared between groups.

Results Overall, 111 patients met inclusion criteria of whom 44(39%) were histologically upgraded, 1 patient was found

to have Adenocarcinoma of the cervix. Upgraded women were younger (34y vs 44y, $p<0.001$), and of lower parity (1.2 vs 2.4, $p<0.001$). There was no difference between groups as to BMI and smoking. The histologically upgraded women had higher rates of antecedent LSIL Pap smear (35% vs 15%, $p<0.001$), and higher rate of post-coital bleeding (PCB) as indication for conization (50% vs 23%, $p=0.02$). Using a logistic regression model adjusting for age, indication and possible confounders, increased age was found to be a protective factor (aOR=0.9 95% CI 0.84 – 0.97), while PCB was a predicting factor for upgrading (aOR=1.1 95% CI 1.003 – 1.195).

Conclusions Contrary to common practice, in this study, younger women with a biopsy diagnosis of LSIL, should be evaluated for high risk disease especially if they report PCB.

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252

COMPARISON OF TWO ULTRA-STAGING PROTOCOLS FOR THE DETECTION OF LYMPH NODE METASTASES IN EARLY STAGE CERVICAL AND ENDOMETRIAL CANCER

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Objectives Ultra-staging (US) of sentinel lymph nodes (SLN) increases the detection of nodal metastases. US protocols vary among gynecologic pathologists, and internationally accepted guidelines are still not available. This study compares two US protocols (US-A vs US-B) in early stage cervical (CC) and endometrial cancers (EC) (table 1).

Methods We retrospectively evaluated patients with clinical stage I endometrial cancer (EC) or stage IA-IB1 cervical cancer (CC) who underwent primary surgery with SLN biopsy from November 2010 to October 2017.

Results 229 patients were analyzed (161 ECs and 68 CCs). The rate of positive node disease was: 22% with US-A protocol and 12% with US-B protocol ($p=0.09$) for EC patients; 22% and 10% ($p=0.18$) for CC patients. Macrometastasis, micrometastases, and ITC were 31%, 61% and 8%, respectively with US-A protocol; 43%, 40% and 17%, respectively with US-B protocol ($p=0.272$). Mean size of nodal metastasis was 5.4 ± 6.3 mm for US-A and 3.2 ± 4.3 mm for US-B protocol ($p=0.09$). On multivariate analysis including grade and LVSI, the US method was not associated with the detection of nodal metastases.

Conclusions Approximately 50% of the nodal metastases detected by US of SLNs were low-volume metastases. In this study, the detection of positive node disease was not associated with the type of US protocol used. Larger multi-center prospective studies are advisable to confirm these results.