adjuvant radiotherapy with or without chemotherapy. Vaginal cuff brachytherapy (VCB) was indicated according to the radiation oncologist discretion.

Results Seventy-nine patients were selected, with a median age at diagnosis of 47.5 years (26–77). Brachytherapy was delivered in 59 (74.7%). There were no significant differences between the VCB and the no-VCB groups. A total of 13 (16.5%) patients presented one or more events, 5 (25%) and 8 (13.5%) events in the no-VCB and VCB group, respectively. Most recurrences were pelvic and/or vaginal: 7/20 (35%) in the no-VCB group and 9/59 (10.2%) in the VCB group. There were 8 systemic relapses with 8 deaths. With a median follow-up of 45 months, median overall and disease-free survival were, respectively, 85.1 and 83.8 months. No variables were correlated with overall survival. The only factor positively correlated to disease-free survival was VCB, with a mean of 86.9 and 68.4 months for patients that did and did not receive it, respectively ($p=0.043$). Vaginal recurrence was lower in the brachytherapy group, but with no significance ($p=0.065$).

Conclusions VCB was associated with a reduced recurrence rate in the post-operative setting of high-risk early stage cervical cancer patients.

IGCS19-0547

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SMALL ADENOCARCINOMA OF THE CERVIX WITH SINGLE GIANT OVARIAN METASTASIS: CASE REPORT

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Objectives To demonstrate the importance of ovarian evaluation in cases of adenocarcinoma of the cervix, since the ovaries may be the only site of metastasis.

Methods Analysis of patient medical record.

Results A 56-year-old female presented to the outpatient clinic with increased abdominal volume. Gynecological examination revealed a small exophytic lesion of 2cm in the endocervical canal, without vaginal or parametrial involvement. Biopsy of the lesion resulted in adenocarcinoma with papillary and glandular components and immunohistochemistry proving primary tumor of the uterine cervix. The patient underwent a pelvic computed tomography. Bilateral ovarian masses with solid components and ascites with no signs of carcinomatosis were observed. The patient was submitted to radical hysterectomy with bilateral salpingo-oophorectomy, pelvic lymphadenectomy, omentectomy, appendectomy and multiple peritoneal biopsies. Anatomopathological analysis resulted in usual endocervical adenocarcinoma with intestinal pattern in the cervix and cervical metastasis in both ovaries. All surgical margins were free of disease.

Conclusions This case was an unusual presentation of cervical cancer that showed the possibility of single ovarian metastasis without any other tumor involvement. The importance of adequate preoperative ovarian evaluation is highlighted, raising

the question whether there is a role for bilateral oophorectomy in all cases of adenocarcinoma of the cervix.

IGCS19-0580

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CAN AGE BE CONSIDERED AS PROGNOSTIC FACTOR OF SURVIVAL IN PATIENTS WITH UTERINE CERVICAL CANCER?

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Objectives To assess the impact of age as a determining prognostic factor in the survival of women with uterine cervical cancer (UCC).

Methods A retrospective observational study was carried out in which patients who consulted in Oncological Hospital of Buenos Aires, in the period between January 2007 and December 2011. The variables were studied: age and tumor stage. Three age groups were established: patients <35, 35 - 59, and >60. For the analysis of disease-free survival (DFS) and overall survival (OS), the Kaplan-Meier method was used and for the comparison between the different groups, the Log Rank test method using the statistical package IBM Statics Version 21. A statistically significant P value of ≤ 0.05 was considered.

Results 748 patients were included, of which 145 (19.4%) <35 years, 484 (64.7%) to the group of 35 to 59 years and 119 (15.9%) to >60 years. The median general age was 46 years. The general OS was 59.3% ($P=0.04$), 48.3%, 63.3% and 57.4% respectively in the groups. The general DFS was 55.5% ($P=0.04$), in the groups: 45.8%, 59% and 53.6% respectively. The distribution by stages was predominantly locally advanced: IIB 30.6% (229), IIIB 29.5% (221), being statistically significant for OS stages IB2, IIA2, IIB, IIIA and IVA.

Conclusions In addition to the widely known prognostic factors, age also seems to be an important factor, although probably underestimated by current treatment guidelines. There is a population of patients with UCC whose diagnosis at an early age implies an alarming prognosis.

IGCS19-0668

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LOCALLY ADVANCED CANCER OF THE CERVIX IN PREGNANCY: PECULIARITIES OF PRESENTATION AND CHALLENGES OF MANAGEMENT IN A RESOURCE-POOR SETTING

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Objectives Cancer of the cervix is the commonest female malignancy in north-western Nigeria. In resource poor settings

where cancer screening is not readily available, accessible and affordable, advanced cervical cancer can be diagnosed for the first time in pregnancy.

The objective of this report is to highlight the peculiarities of presentation and management challenges of cervical cancer in pregnancy in our setting.

Methods A retrospective review of case folders of the four patients with cervical cancer in pregnancy, diagnosed and managed in our institution, over a one-year period was carried out.

Results Seventy-seven cases of newly diagnosed cervical cancer were seen. Of these, four (5.2%) were diagnosed in pregnancy. They were unbooked grandmultiparae, never had cervical cancer screening, presented in the third trimester with antepartum haemorrhage and abnormal vaginal discharge, and all of them had locally advanced disease. Two had neoadjuvant chemotherapy and all of them were delivered via caesarean section. None of them could access radiotherapy postpartum. Two patients died from complications of renal failure within four months of diagnosis, and one has been lost to follow up. Management challenges varied from financial constraint to lack of existing protocol for management, to lack of facilities for investigation and treatment (no functional CT scan and radiotherapy), and sociocultural and religious beliefs.

Conclusions The clinical course of cancer of the cervix in pregnancy, though said to be similar to non-pregnant patients, could be more aggressive. A prospective multicenter study in our setting will be needed. The management challenges, though numerous, are surmountable.

IGCS19-0382

197 PELVIC EXENTERATION FOR GYNECOLOGIC MALIGNANCY

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Objectives The objective of this descriptive study was to determine free time to relapse after pelvic exenteration and reported surgical complication.

Methods A retrospective review of all women who underwent pelvic exenteration at Hospital Italiano de Buenos Aires between January 2008 and February 2018 was performed. Free time was defined as time from the date of exenteration to date of relapse.

Results Twenty five patients underwent pelvic exenteration for recurrent gynecologic cancers including cervical (n=18), vaginal (n=4), uterine (n=2), vulvar (n=1). Median age was 51 years (range 28–69). All patients had received prior treatment: surgery (n=14) or chemo radiotherapy (n=11). Thirteen patients underwent total pelvic exenteration (52%), eight patients anterior (32%) and one posterior pelvic exenteration. Three patients was performed radical hysterectomy.

Urinary diversions technique consisted of ileal conduits (n=20) or ureterostomy (n=1). Permanent colostomy (n=6) or ileostomy (n=7) was performed in total o posterior exenteration. According to Clavien-Dindo Classification postoperative complications were related in 50% of the cases. Median time from primary treatment to exenteration was 10 months (15–30). Median follow up time was 29 months (12–41). At the time of analysis, 9 patients had recurred (36%). Median free time from the date of exenteration to date of relapse or death was 7 months (4–27). Two-year recurrence free survival was 71%.

Conclusions Despite the high morbidity and mortality rates, pelvic exenteration could be the only curative options for patients with pelvic recurrent gynecologic cancers.

IGCS19-0456

198 U.S. SURVEY ON PROVIDER SURVEILLANCE PATTERNS IN PATIENTS WITH STAGE I CERVICAL CANCER AFTER CERVICAL CONIZATION

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Objectives To determine surveillance patterns of Stage I cervical cancer after cervical conization (CC) in the United States.

Methods A 25-question electronic survey was sent to members of the Society of Gynecologic Oncology. Provider demographics, surveillance during first year (Y1), years 1–3 (Y13) and >3 years (Y3+) after CC, use of pelvic exam, cytology, HPV testing, colposcopy and endocervical curettage (ECC) were queried. Data were analyzed.

Results 185/1381 (13%) responses were collected: all providers identified as gynecologic oncologists and characteristics shown in figure 1. Y1, 66% of providers perform pelvic exam and 35% cytology every (q) 3 months (figure 2). Y13, 60% perform pelvic exam and 46% cytology q6 months. Y3+, 54% perform pelvic exam q6 months and 67% cytology annually. HPV testing was not offered by 28% of providers at any point during 5-year follow-up. 52% recommend annual HPV testing Y3+ following CC. 86% of providers do not offer routine colposcopy and 71% do not offer ECC at any point during 5-year follow up. 75% screen patients for HPV vaccination. Surveillance results impact decisions for post-CC hysterectomy (figure 3).

Conclusions To date, there are no specific surveillance guidelines for Stage I cervical cancer treated with CC. The most common surveillance practice reported is q3 month pelvic exam with or without cytology in Y1 and q6 month thereafter. However, wide variation exists in visit frequency, cytology and HPV testing, and a clear trend away from using colposcopy and ECC. This disparate surveillance strategy provides an opportunity to define uniform surveillance guidelines.