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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10.1136/ijgc-2019-IGCS.197

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 hystercetomy. 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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10.1136/ijgc-2019-IGCS.198

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.