resection rate to 87.9% without increasing the blood loss, postoperative complications or the duration of surgery. A prospective randomized study is advised to validate these results.

IGCS20_1272

EDOXABAN ANTIACOAGULATION FOR GYNECOLOGICAL CANCER WITH VENOUS THROMBOEMBOLISM

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Objective Venous thromboembolism (VTE) is increasingly being treated with oral direct Xa inhibitors, including edoxaban. However, direct evidence supporting the use of edoxaban for thrombosis associated with gynecological cancer is limited. Thus, we compared edoxaban to warfarin with regard to their efficacy, safety and convenience in gynecological cancer patients with VTE.

Method We reviewed the medical records of 317 gynecological cancer patients who received edoxaban or warfarin treatment for VTE between January 2011 and December 2018.

Result The median follow-up period was 712 days (16–2868). Of the 317 patients, 180 and 137 were treated with edoxaban or warfarin, respectively. Details of cancer types were as follows: ovarian cancer 110 (62%), endometrial cancer 40 (22%), cervical cancer 22 (12%) and others 8 (4%) in edoxaban group and 81 (59%), 37 (27%), 16 (12%), 3 (2%) in warfarin group. There was no significant difference between two treatments groups in terms of BMI, VTE site, cancer type, histological subtype and stage. Recurrence of VTE occurred in 16 patients (8.9%) in edoxaban group and 18 (13.1%) in warfarin group (p=0.31). Adverse events that required discontinuation of anticoagulation occurred in 1 patient (0.6%) with edoxaban and 6 patients (4.4%) with warfarin (p=0.06), and no fatal events in either group. Initial heparin bridge was employed in 63 patients (37.7%) and 115 patients (92.0%) of edoxaban and warfarin group, respectively (p<0.01).

Conclusion Edoxaban is effective, safe and convenient for VTE patients with gynecological cancers.

IGCS20_1273

THE IMPACT OF HISTOLOGY AND ADJUVANT THERAPY ON SURVIVAL AND RECURRENCE PATTERNS AMONG HIGH-GRADE ENDOMETRIAL CANCER WITH RETROPERITONEAL METASTASES

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Objectives To evaluate the difference in recurrence patterns and survival among stage IIIC high-grade endometrial cancer (HGEc) treated with surgery followed by adjuvant chemotherapy, radiation (RT) or both (chemoradiation).

Methods A multicenter retrospective analysis of surgically-staged IIIC HGEc was conducted from 2000 to 2018, including grade-3 endometrioid (G3), serous, clear cell (CC) and carcinosarcoma. Differences in the frequency of recurrence sites and treatment delays were identified using Pearson’s χ2-test. PFS and OS were calculated using Kaplan-Meier estimates.
Results A total of 155 patients were evaluable; 41.9% carcinosarcoma, 36.8% serous, 17.4% G3 and 3.9% CC; 67.1% received chemoradiation, 25.8% received chemotherapy-alone and 7.1% received RT-alone. Adjuvant therapy regimens were well-balanced between different histologies (p=0.351). There was no difference in the frequency of treatment delays between regimens (p=0.571). G3 tumors recurred less frequently (66.7%) versus serous (80.7%), CC (83.3%) and carcinosarcoma (84.6%) (p=0.269). Abdominal recurrence occurred most often in CC and serous. Carcinosarcoma was most likely to recur in the lung. There was a trend towards greater retroperitoneal recurrence with chemotherapy-alone (25.9%) versus chemoradiation (8.4%) and RT-alone (7.7%) (p=0.252). G3 tumors demonstrated improved PFS and OS (26 and 42-months, respectively) versus serous (17 and 30-months, respectively), carcinosarcoma (14 and 24-months, respectively) and CC (24 and 30-months respectively) (p=0.002, p<0.001). Chemoradiation was superior to chemotherapy-alone and RT-alone in PFS (p<0.001) and OS (p<0.001).

Conclusion The majority of stage IIIC HGEC recurs. Chemoradiation was associated with improved survival and less retroperitoneal recurrence versus chemotherapy-alone. G3 tumors demonstrated improved survival compared other histologies regardless of adjuvant treatment modality.

IGCS20_1274

PRE-OPERATIVE WAIT TIMES IN HIGH RISK ENDOMETRIAL CANCER: DO SURGICAL DELAYS IMPACT PATIENT SURVIVAL?

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Objectives Practice guidelines advocating for the regionalization of endometrial cancer surgery to gynecologic oncologists (GO) practicing in designated gynecologic oncology centres were released by Cancer Care Ontario in June 2013. We sought to determine the impact this policy had on contemporary surgical wait times, and whether longer wait time to surgery is a predictor of survival in patients with high risk endometrial cancer.

Abstract 263 Table 1 Concordance of mismatch repair (MMR) immunohistochemistry (IHC) and microsatellite instability (MSI) results between ovary and endometrium for five cases with Lynch syndrome

<table>
<thead>
<tr>
<th>Case</th>
<th>Germline Mutation</th>
<th>MMR IHC in Ovary</th>
<th>MMR IHC in Endometrium</th>
<th>MSI in Ovary</th>
<th>MMR IHC Concordance between Ovary and Endometrium</th>
<th>MSI Concordance between Ovary and Endometrium</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MSH6</td>
<td>MSH6 deficient</td>
<td>MSH6 deficient</td>
<td>MSS</td>
<td>MSH-H</td>
<td>Y</td>
</tr>
<tr>
<td>2</td>
<td>MSH6</td>
<td>MSH6 deficient</td>
<td>MSH6 deficient</td>
<td>MSS</td>
<td>MSH-H</td>
<td>Y</td>
</tr>
<tr>
<td>3</td>
<td>MLH1</td>
<td>Intact</td>
<td>Intact</td>
<td>Intact</td>
<td>Intact</td>
<td>Y</td>
</tr>
<tr>
<td>4</td>
<td>MSH6</td>
<td>MSH-H</td>
<td>MSH-H</td>
<td>MSS</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>5</td>
<td>MSH6</td>
<td>MSH-H</td>
<td>MSH-H</td>
<td>MSS</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

Abbreviations: MSI-H, microsatellite instable; MSS, microsatellite stable

Study Methods This was a retrospective cohort study, which included patients diagnosed with non-endometrial high-risk endometrial cancer (serous, carcinosarcoma, clear cell, and undifferentiated) between 2003 and 2017. A cut point of January 2014 was chosen to allow 6 months for knowledge translation and define 2 regionalization periods.

Results We identified 3518 patients with high risk endometrial cancer. Patients who had surgery with a GO had a median surgical wait time from diagnosis to hysterectomy of 55 days compared to 59 days pre-regionalization (p=0.0002), and from first GO consultation to hysterectomy of 29 days compared to 32 days pre-regionalization (p=0.0006). Survival was worst for patients who had surgery within 14 days of diagnosis (HR death 1.94, 95%CI 1.48–2.54), indicating disease severity. Decreased survival occurred with surgical wait times of more than 45 days from the patient’s first GO appointment (HR death 1.19, 95%CI 1.04–1.36).

Conclusion Regionalization of surgery for high risk endometrial cancer has not had a negative impact on surgical wait times. Impact on survival is seen with patients who have surgery more than 45 days after surgical consultation.

IGCS20_1275

DISCORDANT MISMATCH REPAIR PROTEIN EXPRESSION IN SYNCHRONOUS ENDOMETRIAL AND OVARIAN CANCERS

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