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285 SURGICAL MORBIDITY DURING COVID-19 PANDEMIC – A GYNAECOLOGY ONCOLOGY PERSPECTIVE

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Introduction COVID-19 has had significant repercussions on the provision of oncological surgical services worldwide. Within any Gynaecological Oncology service, careful consideration needs to be given when weighing up peri-operative risks & potential inpatient exposure to COVID-19 versus the risk of delaying surgery. Often, for these patients, deferral of surgery may result in disease progression.

Since March 2020, we identified 118 Gynaecological Oncology patients referred to the Ireland East Gynaecological Group between the Mater Misericordiae University Hospital (MMUH) & St. Vincent's University Hospital (SVUH) for whom major oncological surgery was deemed clinically urgent. To minimise peri-operative morbidity and the risk of onward hospital transmission of COVID-19, screening questionnaires were administered before hospital admission. These screened for epidemiological risk, symptoms, recent travel & contacts. If asymptomatic, testing for SARS-CoV-2 was not performed.

Methods We analysed the clinical data of the above 118 patients to determine their baseline characteristics/risk factors for COVID-19, suspected diagnoses, surgical procedures & 7-day morbidity.

Results This cohort consisted of ovarian (n=57), endometrial (n=41), cervical (n=6) and vulvo-vaginal (n=14) cancer patients. 44% of cases were laparoscopic and 18% were major cytoreductive surgeries. All patients screened were deemed asymptomatic & low risk- therefore proceeded to surgery. 49 (41.5%) patients had a defined risk factor for COVID-19. 7-day post-operative morbidity was 13% (N=16). 3 patients met symptomatic criteria for COVID-19 testing post-operatively, however none tested positive.

Conclusion Careful patient selection based on risk factors and symptoms allows units to continue to perform safe oncological surgery during a pandemic.

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286 BARRIERS AND OPPORTUNITIES FOR OPTIMIZING PATHOLOGY MENTORING IN THE PROJECT ECHO TUMOR BOARD PROGRAM OF THE IGC: A PILOT EXAMINATION OF ADEQUACY OF PATHOLOGY CASE PRESENTATIONS

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Introduction as part of the IGCS global education curriculum since 2017, monthly tele-mentoring of gynecological oncology fellows has been implemented at 14 cancer centers in low-middle income countries (LMIC) using the Project ECHO technique of tumor board-style videoconferences (TBVC). The

effectiveness of pathologist mentors in this curriculum has not been studied and we hypothesize that it is defined, in part, by the adequacy of the pathology case presentation in pre-meeting materials and during the TBVC at each site.

Methods the cancer centers of the IGCS-sponsored TBVC are in Kenya, Ethiopia, Uganda, Mozambique, Zambia, Kazakhstan, Belarus, Nepal, Vietnam, Fiji, Guatemala, Bahamas, Jamaica and PARSGO. This study is a descriptive analysis of the experiences of the initial 3 pathologists.

Results attendance of the TBVC by a local site pathologist routinely occurs in 2/14 sites. Pre-meeting distribution of the pathologic diagnosis to the mentors occurs in 3/15 sites. The overall subjective assessment was that the pathologist mentors were routinely limited in their ability to evaluate the pathology of the case at 12/14 sites and therefore were limited in their opportunity to meaningfully contribute to the TBV.

Conclusions The role of pathology mentors in global educational programs for gynecological oncologists in LMIC is dependent on interaction with a local pathologist and on the adequacy of the pathology case presentation. We recommend that a standardized set of pathology information be presented for each case, including appropriate digital images, which may be a challenge due to resource limitations in LMIC without external funding.

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287 COMPARATIVE STUDY OF OVARIAN LOW-GRADE AND HIGH-GRADE SEROUS OVARIAN CARCINOMA

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Objectives To compare the clinical-pathological features and survival outcomes of women with low grade and high grade serous epithelial ovarian cancer.

Methods A total of 87 patients with high grade (HGSOC) (79.8%) were retrospectively compared to 22 patients with low grade (LGSOC) staged surgically in Salah Azaiez Tunisian cancer center, between 2000 and 2010.

Results We performed primary debulking surgery in 89 patients (81.7%) and 20 patients (18.3%) underwent and interval debulking surgery. Maximal cytoreduction (R0) was achieved in 38 of patients (34.9%), 32 patients had a residual disease ≤1 cm (29.4%) and 39 patients had a residual disease >1 cm (35.8%). The comparison of HGSOC to LGSOC by univariate analysis showed that HGSOC were associated to higher serum level of CA 125 >1000U/ml (52.9% vs 27.3%, p=0.032), higher quantity of ascites >1 litre (47.1% vs 13.6%, p=0.004) with more frequent carcinomatosis in the upper abdomen (54% vs 27.3%, p=0.025) and bilateral tumors (79.3% vs 54.5%, p=0.018), with more tumor necrosis (59.8% vs 18.2%, p<0.0001) and lymphovascular invasion (50.6% vs 13.6%, p=0.002) and advanced FIGO stage III-IV (94.3% vs 63.6%, p<0.0001). Among the 60 patients who underwent lymphadenectomy (55%), HGSOC were associated to more lymph metastasis (LNM) (57.8% vs 26.7%, p=0.037) with higher LN ratio (15.04±24.20 vs 5.16±10.59, p=0.034). and more frequent combined pelvic and paraaortic LNM (56.8% vs 26.7%, p=0.049). After a mean follow up of 44.73 months, HGSOC were associated to lower rates of 5-years overall