survival (31.3% vs 50%,p=0.06) and recurrence free survival (27.9% vs 50%,p=0.112).
Conclusion HGSOC are correlated to a advanced stage and extended lymph node invasion.

IGCS20_1302

288 A RARE CASE OF NASOPHARYNGEAL CARCINOMA METASTASIS TO MALE BREAST

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Introduction Nasopharyngeal carcinoma (NPC) is a rare malignancy with an incidence of 0.5–2 per 100,000 in Europe and the United States, it almost occur in young and middle-aged adults, the incidence is higher in the Chinese and Tunisian population
Case Report A 41-year-old male presented in March 2019 with a lump in the right upper neck region, which had been growing for four months. Physical examination identified multiple circular lumps, which were palpable on the right upper third of the neck on the sternocleidomastoid (facies medialis).Examination of the head and neck by computed tomography (CT) showed thickening of the soft tissues of the right wall of the nasopharynx and bilateral cervical lymphadenopathy with a maximum node size of ~9×1.5 cm, also it identified a suspect mass in the rignt breast. The patient underwent then a Breast ultrasound that showed a two aval shaped micolobulated hypoechoic mass without spiculations measuring respectively 10 mm and 12 mm located in the upper outer quadrant and behind the nipple of the right breast, associated with right axillary lymph node. Our patient underwent an ultrasound-guided biopsy, the histological examination confirmed the diagnosis of breast metastasis.

In conclusion, the present case confirmed that NPC may also metastasize to breast male. Although, there is no established guideline for the treatment, a multidisciplinary approach is always beneficial to the patient.

IGCS20_1304

290 ARE OBSTETRICS AND GYNAECOLOGY TRAINEES CONFIDENT AND COMPETENT IN THE CARE OF FRAIL GYNAECOLOGICAL ONCOLOGY PATIENTS?

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Introduction Older patients undergoing cancer surgery are at increased risk of post-operative morbidity and mortality. Frailty is particularly prevalent in this patient cohort and is a major contributor to adverse outcomes. A survey was conducted to assess the confidence and knowledge of trainees in obstetrics and gynaecology (O&G) regarding identification and management of perioperative issues encountered in frail gynaecological oncology patients.
Methods A web-based survey on the management of frail perioperative patients was disseminated to doctors-in-training (trainees) in O& G in the United Kingdom (UK) and Ireland.
Results Of the 666 trainees who participated, 67% (n=425/666) reported inadequate training in the perioperative management of frail patients. Validated frailty assessment tools were used by only 9% (n=59/638) of trainees and less than 1% (n=4/613) were able to correctly identify the diagnostic features of frailty. Common misconceptions included the use of chronological age and gender in frailty assessments. The majority trainees (>75%) correctly answered a series of questions relating to mental capacity; however, only 6% (n=36/606) were able to correctly identify all three diagnostic features of delirium. 87% (n=495/571) of trainees supported closer collaboration with geriatricians and a multi-disciplinary approach.
Conclusions O&G trainees reported inadequate training in the perioperative care of frail gynaecological oncology patients, and overwhelmingly favoured input from geriatricians. Routine use of validated frailty assessment tools may aid diagnosis of frailty in the perioperative setting. There is an unmet need for formal education in the management of frail surgical patients within the UK and Irish O&G curriculum.

IGCS20_1307

291 UNIQUE CASE SERIES OF COEXISTING ENDOMETRIAL AND HEMATOLOGIC MALIGNANCIES

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Introduction Coexistent primary neoplasms in the same individual can present as synchronous or metachronous. In the setting of endometrial cancer, most concomitant primary sites include ovarian, colon, and breast cancer.

The coexistence of endometrial and hematologic malignancies is rare and unique, with only 7 cases reported in the literature.

Over a time interval of 10 years, we have encountered this unusual condition in 7 patients of our own. This is the most extensive case series of concurrent hematologic and endometrial malignancies.
Methods Retrospective chart review from 2002–2012.
Results Our patients were referred to a gynecologic oncology office from the years 2002 and 2012 due to suspected endometrial cancer.

All of our patients underwent surgical diagnoses and staging for endometrial cancer.

The findings of significantly enlarged lymph nodes as described in the operative reports of 5 out of 7 patients.
Conclusions and Implications The presence of two primary malignancies may translate into a unique diagnostic and treatment situation where the presence of the other may impact surgical, medical, and radiation management for one cancer.

Abstract 291 Table 1

		Endometrial Cancer			Hematologic Cancer					
Case No	Age (years)	Histology	Stage	Rx	Site	Histology	Lineage	Intraoperative Findings	Rx	Follow up
1	71y/o	Endometrioid adenocarcinoma G3	IA	RATLH BSO LND	Pelvic and paraaortic nodes	Non-Hodgkin Small lymphocytic lymphoma	B cells	Enlarged lymph nodes intraop	Chemotherapy and radiotherapy	Died 2 years later from recurrent metastatic endom cancer
2	70y/o	Endometrioid adenocarcinoma G1	IA	RATLH BSO LND	Pelvic nodes	Non- Hodgkin Small lymphocytic lymphoma (B cell- CLL)	B cells	Enlarged lymph nodes intraop	Clinical trial Chemotherapy	Lost follow up
3	59y/o	Carcinosarcoma MMMT	IB	TAH BSO LND + chemothe-rapy	Paraaortic nodes	*Recurrent (treated 20 years before)* Anaplastic Large cell Lymphoma	T cells	Enlarged lymph nodes intraop	Chemotherapy	Died 7 years later
4	75y/o	Endometrioid adenocarcinoma G2	IB	TAH BSO LND	Pelvic nodes	*Diagnosed 5 years before* Non- Hodgkin Small lymphocytic lymphoma (B CELL CLL)	B cells		Chemotherapy	Died 3 years later
5	84y/o	Endometrioid adenocarcinoma G1	IA	RATLH BSO LND	Pelvic nodes	Mature B cell neoplasm with extensive plasmatic differentiation	B cells	-	No therapy indicated	Lost f/u
6	52y/o	Endometrioid adenocarcinoma G1	IA	RATLH BSO LND	Pelvic & aortic nodes	Mature B cell non Hodgkin follicular lymphoma	B cells	Extremely enlarged pelvic and paraaortic nodes densely adhered to vessels	Chemotherapy	Last follow up was 7/2019
7	54y/o	Endometrioid adenocarcinoma G2	IIIC	TAH BSO LND, OM, chemother -apy and radiothera-py	Pelvic & paraaortic nodes	B cell lymphoma	B cells	Enlarged lymph nodes	No therapy indicated	Last follow up was 8/2019

RATLH: Robotic assisted laparoscopic hysterectomy, BSO: bilateral salpingo oophorectomy, LND: lymph node dissection, OM: omentectomy

As clinicians, it is essential to be aware of the most common signs, symptoms, laboratory, imaging, and intraoperative findings of various pathologies. This knowledge could make a positive impact on patient care.

IGCS20_1309

292 CASE REPORT: RECURRENT PARAVAGINAL AGGRESSIVE ANGIOMYXOMA FIVE YEARS AFTER INITIAL EXCISION AND DIAGNOSIS

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Introduction Aggressive angiomyxoma is a rare mesenchymal tumour found mainly in the pelvis and perineum of women of reproductive age. Although benign, the tumour is deemed aggressive due to the frequency of local infiltration. The mainstay of treatment is surgical excision. Neoadjuvant use of GNRH analogues to limit tumour growth prior to surgical excision has been reported. Reports suggest a recurrence rate ranging from 30 to 72 percent.

Methods This case describes a 39 year old woman who was re-referred to the gynaecological oncology service with suspected recurrence of paravaginal angiomyxoma, five years after surgery to remove the primary tumour.

Results Preoperative magnetic resonance imaging revealed a paravaginal mass measuring 5 cm x 4.5 cm × 5.5 cm extending from the lower vagina and gradually tapering at the level of the vulva on the left side. Following six months of treatment with GNRH analogue, the mass was excised under general anaesthesia. A multilobular tumour extending from the fat of the left labium to the bladder neck and the ischiorectal fossa was excised. Excision beyond the gross margins of