IGCS20_1366

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EXTERNAL VALIDATION OF TUMOUR-FREE DISTANCE AS NOVEL PROGNOSTIC MARKER IN EARLY-STAGE CERVICAL CANCER UNDERGOING PRIMARY SURGERY

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10.1136/ijgc-2020-IGCS.295

Introduction Tumor-free distance (TFD), defined as the minimum distance of uninvolved stroma between the tumor and peri-cervical stromal ring, was recently proposed as predictive marker of recurrence in patients with early-stage cervical cancer treated by primary surgery (particularly if ≤ 3.5 mm). The aims of the present study were to assess the prognostic value of TFD and to compare TFD with other known prognostic markers in early-stage cervical cancer.

Methods Patients with pathologic FIGO 2009 stage IA1-IIB cervical cancer, treated by primary radical surgical treatment between 01/2000 and 12/2018, were retrospectively included. Adjuvant treatment was administered according to the

Abstract 343 Table 1 Univariate and multivariate cox-regression associated with pathologic high-risk factors

LYMPH NODE METASTASIS						
	UNIVARIATE ANALYSIS			MULTIVARIATE ANALYSIS		
Variable	p-value	HR	95%CI	p-value	HR	95%CI
TFD Binarized (≤ 3.5 mm vs >3.5 mm)	<0.001	7.797	4.180-14.543	0.016	2.663	1.196-5.928
Histology	0.805	1.063	0.654-1.728			
FIGO stage (binarized) (I vs II)	<0.001	0.163	0.087-0.306	0.091	0.492	0.216-1.120
Grade	<0.001	2.689	1.655-4.370	0.630	1.177	0.606-2.285
Stromal infiltration	<0.001	1.185	1.118-1.1	0.077	1.082	0.991-1.180
LVSI (neg vs pos)	<0.001	9.673	4.566-20.492	<0.001	5.353	2.274-12.600
Tumor diameter	<0.001	1.047	1.025-1.070	0.565	0.990	0.957-1.024
PARAMETRIAL INFILTRATION						
	UNIVARIATE ANALYSIS			MULTIVARIATE ANALYSIS		
Variable	p-value	HR	95%CI	p-value	HR	95%CI
TFD Binarized (≤ 3.5 mm vs >3.5 mm)	<0.001	32.129	9.588-107.657	0.001	12.823	2.797-58.794
Histology	0.695	1.125	0.623-2.034			
Grade	0.005	2.303	1.278-4.150	0.795	0.887	0.361-2.183
Stromal infiltration	<0.001	1.245	1.157-1.339	0.004	1.164	1.050-1.291
LVSI (neg vs pos)	<0.001	4.163	1.887-9.182	0.053	3.069	0.987-9.540
Tumor diameter	<0.001	1.061	1.032-1.091	0.742	1.008	0.963-1.055
POSITIVE SURGICAL MARGINS						
	UNIVARIATE ANALYSIS			MULTIVARIATE ANALYSIS		
Variable	p-value	HR	95%CI	p-value	HR	95%CI
TFD Binarized (≤ 3.5 mm vs >3.5 mm)	0.001	7.252	2.286-23.011	0.855	0.843	0.134-5.291
FIGO stage	<0.001	2.133	1.593-2.855	0.010	1.852	1.162-2.951
Histology	0.599	1.247	0.548-2.834			
Grade	0.087	2.071	0.899-4.771			
Stromal infiltration	<0.001	1.170	1.077-1.272	0.314	1.069	0.939-1.218
LVSI (neg vs pos)	0.003	9.568	2.140-42.782	0.089	6.706	0.747-60.185
Tumor diameter	0.013	1.051	1.011-1.093	0.839	0.994	0.9341.057

1A

1B

Abstract 343 Figure 1 DFS (1A) and OS (2B) in the entire cohort stratified according to TFD (cut-off 3.5 mm)

presence of previously established pathologic risk factors. TFD was measured histologically on the hysterectomy specimen.

Results 368 patients were included in the study. 115 (31.2%) patients had $TFD \leq 3.5$ mm and 253 (68.8%) had $TFD > 3.5$ mm. $TFD \leq 3.5$ mm was associated with worse 5-year disease-free survival (DFS) and overall survival (OS), compared with $TFD > 3.5$ mm ($p=0.028$ and $p=0.041$, respectively) (figure 1). DFS and OS differences were more evident in subgroups of patients who did not receive adjuvant treatment (DFS, $p=0.001$ and OS, $p=0.001$) and who underwent laparotomy approach (DFS, $p=0.017$ and OS, $p=0.034$). $TFD \leq 3.5$ mm represented the strongest predictor for lymph node metastasis and pathologic parametrial involvement at both univariate and multivariate analysis (table 1).

Conclusions $TFD \leq 3.5$ mm represents a poor prognostic factor significantly associated with lymph node metastasis and pathologic parametrial infiltration. The possibility to obtain this parameter by radiological imaging makes it the easiest measurable pre-operative marker to predict the presence of high-risk pathologic factors.

IGCS20_1367

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COMPARISON OF CLINICAL PATHOLOGICAL AND SURVIVAL OUTCOMES BETWEEN SEROUS AND NON-SEROUS OVARIAN CANCER

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10.1136/ijgc-2020-IGCS.296

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

Methods Retrospective study of 151 patients staged surgically in Salah Azaiez Tunisian cancer center, between 2000 and 2010.

Results We performed primary debulking surgery in 128 patients (84.8%) and 23 patients (15.2%) underwent interval debulking surgery. Maximal cytoreduction (R0) was achieved in 67 of patients (44.4%), 39 patients had a residual disease ≤ 1 cm (25.8%) and 45 patients had a residual disease > 1 cm (28.8%). Lymphadenectomy was performed in 57% of cases. The histological type was clearly established for all women: 109 cases of serous carcinomas (72.2%) and 71 non-serous tumors (14 endometrioid, 12 mucinous, 7 clear cell carcinomas, 2 malignant Brenner tumors, 6 undifferentiated and one case of seromucinous carcinoma). The comparison of serous (SEOC) to non-serous tumor types (NSEOC) by univariate analysis showed that SEOC were associated to higher serum level of CA 125 exceeding 1000 U/ml (47.7% vs 19%, $p=0.001$), higher quantity of ascites exceeding 1 litre (40.4% vs 21.4%, $p=0.029$) with more frequent carcinomatosis in the upper abdomen (48.6% vs 21.4%, $p=0.002$) and more residual disease R1/R2 (65.1% vs 31%, $p<0.0001$), bilateral tumors (74.1% vs 45.2%, $p=0.001$), advanced FIGO stage III-IV (88.1% vs 50%, $p<0.0001$), pelvic lymph metastasis (LNM) (11.7% vs 4.2%) as well as paraaortic LNM (16.7% vs 8.3%, $p=0.012$), higher LN ratio (12.57 ± 21.96 vs 1.77 ± 5.62 , $p=0.01$) and lymphovascular invasion (43.1% vs 9.5%, $p<0.0001$). NSEOC were associated to higher rates of 5-years overall survival (31.3% vs 54.2%, $p=0.006$) and recurrence free survival (31.8% vs 64.6%, $p=0.002$).

Conclusion The management of EOC should take into account differences between histological subtypes.

IGCS20_1368

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A CASE OF MIXED ADENOCARCINOMA OF UTERUS WITH BLADDER INVASION ORIGINATING FROM ADENOMYOSIS

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10.1136/ijgc-2020-IGCS.297

Introduction Adenocarcinomas originating from uterine adenomyosis are extremely rare. In addition, mixed adenocarcinoma of uterus with endometrial carcinoma and serous carcinoma is relatively infrequent.

Case Presentation A 52-year-old woman with a chief complaint of hematuria referred to our urology department. Tumor markers were elevated: Cancer antigen (CA) 19-9 58.6 U/ml, CA 125 101.5 U/ml. Urinary cytology, cervical cytology, and intimal cytology were all adenocarcinoma. Cystoscopy revealed protuberant lesions from posterior wall of the bladder. MRI showed a continuous tumor from anterior wall of the uterine body to the lumen of the posterior bladder, and CT showed an enlarged retroperitoneal lymph node. Transurethral resection of bladder tumor was performed to excise the tumor, which was also diagnosed as adenocarcinoma. A modified radical hysterectomy, bilateral salpingo-oophorectomy, partial cystectomy, lymph node biopsy and omentectomy were