match the final histological staging. We identified 80 cases. 13 patients had already undergone an MRI. We modelled three protocols.

Results

1. No extra cases identified that needed completion surgery and would require reporting standardisation and sonographer up–skilling.
2. Significant pressure on the radiology service.
3. Identified the best detection of cases without excessive demand from the radiology service.

Conclusion All protocols may delay service provision and lead to additional costs. Undertaking an MRI for grade 2 cancers only achieves the greatest benefit with least impact on service, increasing primary surgery but reducing the need for completion surgery/adjuvant therapy. Further investigation of ultrasound scan reporting is on-going.

IGCS20_1410

383 QUALITY OF LIFE CONCERNS DURING AND AFTER TREATMENT FOR ADVANCED BREAST OR CERVICAL CANCER IN ZAMBIA

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Introduction Improving the lives of women with breast and cervical cancer requires a multidimensional approach encompassing the entire continuum of care. Our objective was to identify key quality of life concerns among Zambian women treated for advanced breast and cervical cancer.

Methods Survivors participated in focus groups in their local languages. Common themes were analyzed.

Results Among breast cancer patients, common themes included social support, financial hardships, delayed access to care, and faith. Some family members supported treatment by traditional healers; others reported strong support for hospital-based care. Financial concerns included transportation costs, medical expenses, and children's school fees. Unavailable or missing test results and other treatment delays posed further stress. Faith wavered near the time of diagnosis but was renewed after completing treatment.

Among cervical cancer patients, common themes included delays in care, financial hardships, and community beliefs that cancer is fatal. Participants described difficulties traveling to the central treatment facility, delays in treatment initiation, and needing to ask others for financial contributions. Many experienced decreased libido and vaginal stenosis. Some had supportive husbands; others experienced marital strife and even abandonment. Among reproductive age women there was confusion over whether pregnancy is possible after treatment.

Conclusions/Implication Survivors of advanced breast and cervical cancer expressed many common concerns. Some started at the time of diagnosis and encompassed treatment choices (traditional vs conventional), finances, and sexual dysfunction. Findings from this study can inform survivorship services and underscore the need to decrease delays in diagnosis and treatment.

IGCS20_1411

384 PATIENT INITIATED FOLLOW UP: EXPERIENCES FROM A TERTIARY GYNAECOLOGICAL ONCOLOGY CENTRE

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Introduction With limited clinical evidence supporting traditional current clinical models for patient follow up post cancer treatment, there is a need to collate evidence to develop more robust protocols. There is a growing body of evidence supporting patient initiated follow up (PIFU). PIFU can lead to a more flexible, positive consultation, whilst also having a positive impact on resource utilisation. At the Northern Gynaecological Cancer Centre in Gateshead we aim to introduce a PIFU protocol based on patient experience. The aim of this project is to redesign and improve current follow up protocols.

Methods 7 focus groups of patients and their carers from the North East of England were set up. The aim was to determine the views and opinions on the acceptability of PIFU using semi-structured interviews. Outcomes measured were satisfaction with the information provided and impact on quality of life.

Results 58 participants were recruited to focus groups. Most participants thought follow up appointments were used to detect recurrences and found them reassuring. Most would have preferred to be seen at hospital because of this reason and so would not like a telephone or skype follow up.

Conclusion Most participants expressed a preference for hospital follow up this could be influenced by a lack of experience of alternatives. Our aim is to now explore PIFU experiences using information from questionnaires given to patients following treatment for endometrial cancer. If this transpires to be a positive experience and improve recurrence detection we aim to expand PIFU to ovarian cancer.

IGCS20_1412

385 SENTINEL LYMPH NODE BIOPSY FOR EARLY STAGE ENDOMETRIAL AND CERVICAL CANCER PERFORMED BY SURGEONS IN TRAINING

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Introduction The aim of this study was to evaluate the results of the sentinel lymph node (SLN) biopsy performed by doctors in training in a referral cancer center, from 2016 to 2020.

Methods 126 patients, over 18y.o., with a prior diagnosis of initial endometrial (EC) or cervical (CC) cancer underwent to SLN biopsy performed by surgical oncology residents or gynecologic oncology fellows, under direct supervision of a qualified preceptor. SLN was detected with blue dye with or without scintigraphy.

Results Patients underwent surgery by laparotomy - 22 surgeries (17.46%), by laparoscopy - 86 (81.13%) and by robotic - 18 (16.98%). SLN detection rate was 84.1% (n=106), bilateral in 53% (n=67) and mostly in younger patients (59.7% under 60y.o., p=0.022). There was a higher failure rate (non or unilateral detection) among older than 60y.o. (p=0.0075, CI:0.1656–0.7928, OR:0.3664). Among non-smokers, there was a greater bilateral detection of LNS (60.3%), and, among smokers, more cases of detection failure (59.4%). In 3 cases, the SLN was not identified, and there were positive pelvic nodes in the lymphadenectomy. There were no cases with positive nodes at lymphadenectomy with a negative SLN (false-negative). Four patients had grade 3 complications, and none died.
Conclusion We have demonstrated that residents and fellows can safely perform SLN biopsy for initial CC and EC under the direct supervision of a trained surgeon. Detection rates were aligned to the literature, and there were no false negatives. Lymph node positivity, age over 60y.o. and smoking were associated with a higher SLN non-detection rate.

IGCS20_1413

386 DIAGNOSTIC SIGNIFICANCE OF P53, P16, WT1 IN LAVAGE SAMPLES FROM UTERINE CAVITY FOR SEROUS OVARIAN CANCER DETECTION

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Purpose According to modern concepts serous ovarian cancer originate from epithelial cells of fimbria part of fallopian tube and can exfoliate cells. In this study we decided to evaluate the diagnostic significance of the expression of main cytological markers which are widely used for serous ovarian cancer detection (p53, p16, wt1) in lavage samples from uterine cavity.
Patients and Methods Lavage samples from the uterine cavity was obtained from 221 patients including patients with serous ovarian cancer (high-grade-51, low-grade-20), 50 patients with benign ovarian tumors, 50 patients with metastatic lesions of the ovaries and 50 women without oncologic pathology. Cytospin multilayer preparations were made and cytological examination and immunocytochemical analysis with monoclonal antibodies to p53, p16, wt1 ware performed on a Ventana immunohystostinner (BenchMarkULTRA).
Results The p53 marker showed the greatest diagnostic significance in the group of serous high-grade carcinomas (n=51): p53 expression was positive in 31 of 51 (61%) observations. The positive reaction of the wt1 marker was observed in 24 of 51 (47%) cases, p16 expression - in 25 of 51 (49%) cases. In the group of patients with low-grade carcinomas (n = 20), in contrast to the group of patients with high-grade tumors, a positive reaction of the p53 marker was observed in 3 of 20 cases (15%), p16 -in 2 (10%), wt1 -in 12 (60%).
Conclusion This data shows that serous ovarian cancer tumor cells are shed and can be collect in uterine cavity and this approach can be used in clinical practice.

IGCS20_1414

387 ESTROGEN-RELATED RECEPTOR ALPHA (ESRRA) COPY NUMBER VARIATION IS ASSOCIATED WITH HISTOLOGICAL GRADE IN OVARIAN CANCER

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Background Copy number variations (CNVs) are related to the genetic and phenotypic diversity among cancers. Identifying genetic alterations of ovarian cancer could benifit treatment strategies. We explored the association of estrogen-related receptor alpha (ESRRA) copy number variation (CNV) in patients with ovarian cancer using The Cancer Genome Atlas (TCGA).
Methods Gene expression data and clinical infomation were obtained from TCGA for 620 ovarian cancer patients. The association between ESRRA CNV and with clinical characteristics was evaluated by using the TCGA ovarian cancer dataset. Multivariate logistic regression analysis with odds ratio (OR) using a 95% confidence interval (CI) was performed adjusting for race, age, histological grade, and tumor size.
Results ESRRA CNV was associated with histological grade [OR 0.6235 (95% CI, 0.3593 ~ 0.8877) P<0.05] and PPARGC1A CNV [OR -0.6298 (95% CI, -0.9011 ~ -0.3585) P<0.05] in patients with ovarian cancer. On multivariate analysis, ESRRA CNV remained significantly associated with histological grade [OR 0.6492 (95% CI, 0.3549 ~ 0.9435); P<0.05] and PPARGC1A CNV [OR -0.6236 (95% CI, -0.9269 ~ 0.3203); P<0.05].
Conclusions ESRRA CNV in patients with ovarian cancer was associated with histological grade. Futher studies should be conducted to make ESRRA a potential marker for targeted molecular therapy in ovarian cancer.

IGCS20_1415

388 ABDOMINAL INCISION SITE RECURRENCE IN A PATIENT WITH ENDOMETRIAL ADENOCARCINOMA

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Endometrial cancer is frequently diagnosed at an early stage and exhibits a good prognosis. However, 10–15% of tumors recur usually within 3 years, commonly at the vaginal vault and pelvis. Only a number of case reports exist for tumor recurrence in an abdominal incision site. We present a case of a 71-year old Filipina, a diagnosed case of Endometrial Adenocarcinoma Stage IIIA s/p surgery and chemoradiation, who presents with an enlarging abdominal mass of one-year duration at the inferior aspect of the surgical scar after 8 years of no evidence of disease. Physical examination revealed a 6 × 4 cm, friable, movable, nontender suprapubic mass. Surgical resection showed that the mass was confined to the abdominal wall, with no evidence of extension into the abdominopelvic cavity. Histopathology of the mass revealed adenocarcinoma, confirming tumor recurrence in an atypical location.