1%. Primary peritoneal carcinoma remains a risk despite surgery, and although it has been suggested that this may arise from a tubal precursor lesion (STIC), in our cohort, this was not isolated in either of the patients who developed PPC.

IGCS20_1071

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NEOADJUVANT CHEMOTHERAPY WITH UTERINE ARTERY CHEMOEMBOLIZATION IN THE MANAGEMENT OF LOCALLY ADVANCED CERVICAL CANCER: BELARUS EXPERIENCE

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10.1136/ijgc-2020-IGCS.91

Objective To study the efficacy of neoadjuvant chemotherapy (NACT) with uterine artery chemoembolization (UACE) followed by radical surgery or radiotherapy in patients with locally advanced cervical cancer (LACC).

Methods Study included 55 primary LACC patients: 25 presented stage IIB (45.5%), 28 – IIIB (50.9%) and 2 – IVA (3.6%). Forty-seven patients had squamous cell carcinoma (85.5%), 7 – adenocarcinoma (12.7%) and one – undifferentiated cancer (1.8%). Patients underwent two courses of NACT: intravenous infusion of cisplatin and gemcitabine during first course and after 3 weeks transcatheter uterine artery infusion of gemcitabine, gelatin sponge particles were applied for UACE. After NACT, all patients underwent evaluation for response and operability. Those who were not amenable to surgery received radiotherapy.

Results Bilateral UACE was performed in 36 patients (65.5%) and unilateral – in 19 (34.5%). Patients who responded to NACT (42, 76.4%) underwent surgery: 40 patients had radical hysterectomy and 2 – anterior pelvic exenteration. After bilateral UACE surgery was performed in 83.3% (30/36), unilateral – in 63.1% (12/19) ($p < 0.05$). Radical surgery was performed in 38 (90.5%) of the patients. Patients who did not respond to NACT (13, 23.6%) underwent pelvic radiotherapy. The 5-

year overall survival was $76.2 \pm 6.6\%$ in patients receiving surgery and $23.1 \pm 11.7\%$ for those receiving radiotherapy ($p < 0.0011$); the 5-year disease-free survival was $82.7 \pm 6.0\%$ and $48.6 \pm 16.7\%$, respectively ($p = 0.028$).

Results In LACC patients after NACT with UACE resection rate was 76.4%, the surgery was performed radically in most of the cases (90.5%), showing better survival benefits if followed radical surgery rather than radiotherapy.

IGCS20_1072

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ARTIFICIAL INTELLIGENCE PUBLICATION TRENDS IN REPRODUCTIVE CANCERS – WHO IS BEING LEFT BEHIND?

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10.1136/ijgc-2020-IGCS.92

Introduction There is an increasing presence and utility of artificial intelligence (AI) in oncology. We proposed to determine the trends of AI publications in screening, diagnosis, surgery, and treatment of reproductive cancers over time.

Methods Using the PubMed database, we used keywords and MeSH terms to index research articles from 1990 to 2019, and the National Cancer Institute's Joinpoint Regression Program for statistical analysis.

Results We identified a significant increase in AI research on all cancer types over the last 30 years from 19 to 1,829 publications per year. 14,721 publications were related to AI and cancer, 41% of which discussed diagnosis, 30% treatment, 24% surgery, and 5% screening ($p < 0.001$). Despite having the lowest number of publications, screening had the highest average annual rate of increase at 23.6% ($p < 0.001$) (table 1A). The numbers of breast and prostate cancer publications were significantly higher than that of gynecologic cancers. Of 5,808 reproductive cancer and AI publications, prostate cancer comprised 42%, breast 40%, cervical 8%, ovarian 6%, and uterine

Abstract 103 Table 1A Average annual percent change of artificial intelligence and reproductive cancer publications

Estimated Joinpoints								
Cohort	Joinpoint	Estimate	Lower CI	Upper CI				
Breast - 1 Joinpoint	1	1996	1992	2001				
Prostate - 1 Joinpoint	1	2010	2007	2012				
GYN Cancers - 3 Joinpoints	1	1998	1995	1999				
GYN Cancers - 3 Joinpoints	2	2001	1999	2004				
GYN Cancers - 3 Joinpoints	3	2011	2007	2015				
Annual Percent Change (APC)								
Cohort	Segment	Lower Endpoint	Upper Endpoint	APC	Lower CI	Upper CI	Test Statistic (t)	Prob >
Breast - 1 Joinpoint	1	1990	1996	34.3*	15.7	56.0	4.1	0.0
Breast - 1 Joinpoint	2	1996	2019	12.3*	10.1	14.5	12.1	0.0
Prostate - 1 Joinpoint	1	1990	2010	32.8*	28.9	36.8	19.5	0.0
Prostate - 1 Joinpoint	2	2010	2019	-10.0*	-18.5	-0.6	-2.2	0.0
GYN Cancers - 3 Joinpoints	1	1990	1998	46.2*	31.2	63.0	7.3	0.0
GYN Cancers - 3 Joinpoints	2	1998	2001	-30.8	-74.4	87.3	-0.8	0.4
GYN Cancers - 3 Joinpoints	3	2001	2011	32.1*	20.6	44.6	6.4	0.0
GYN Cancers - 3 Joinpoints	4	2011	2019	-3.2	-13.1	7.9	-0.6	0.5
* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.								
Average Annual Percent Change (AAPC)								
Cohort	Range	Lower Endpoint	Upper Endpoint	AAPC	Lower CI	Upper CI	Test Statistic~	P-Value
Breast - 1 Joinpoint	Full Range	1990	2019	16.5*	12.7	20.4	9.1	0.0
Prostate - 1 Joinpoint	Full Range	1990	2019	17.7*	13.6	21.9	9.0	0.0
GYN Cancers - 3 Joinpoints	Full Range	1990	2019	16.6*	4.7	30.0	2.8	0.0
* Indicates that the AAPC is significantly different from zero at the alpha = 0.05 level.								
~ If the AAPC is within one segment, the t-distribution is used. Otherwise, the normal (z) distribution is used. See Help to Learn More								

Abstract 103 Table 1B Average annual percent change of artificial intelligence and gynecologic cancer publications

Estimated Joinpoints								
Cohort	Joinpoint	Estimate	Lower CI	Upper CI				
Uterine - 2 Joinpoints	1	2006	2000	2007				
Uterine - 2 Joinpoints	2	2010	2008	2014				
Cervical - 3 Joinpoints	1	1998	1995	2000				
Cervical - 3 Joinpoints	2	2004	2000	2007				
Cervical - 3 Joinpoints	3	2009	2006	2014				
Annual Percent Change (APC)								
Cohort	Segment	Lower Endpoint	Upper Endpoint	APC	Lower CI	Upper CI	Test Statistic (t)	Prob > t
Uterine - 2 Joinpoints	1	1990	2006	6.0*	1.4	10.9	2.7	0.0
Uterine - 2 Joinpoints	2	2006	2010	142.2*	34.4	336.4	3.1	0.0
Uterine - 2 Joinpoints	3	2010	2019	-15.7*	-24.3	-6.1	-3.3	0.0
Ovarian - 0 Joinpoints	1	1990	2019	16.1*	13.9	18.4	15.8	0.0
Cervical - 3 Joinpoints	1	1990	1998	43.7*	26.7	63.1	6.0	0.0
Cervical - 3 Joinpoints	2	1998	2004	-21.9	-39.7	1.2	-2.0	0.1
Cervical - 3 Joinpoints	3	2004	2009	70.7*	18.4	146.0	3.1	0.0
Cervical - 3 Joinpoints	4	2009	2019	-1.6	-10.1	7.7	-0.4	0.7
* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.								
Average Annual Percent Change (AAPC)								
Cohort	Range	Lower Endpoint	Upper Endpoint	AAPC	Lower CI	Upper CI	Test Statistic~	P-Value~
Uterine - 2 Joinpoints	Full Range	1990	2019	10.7*	1.5	20.7	2.3	0.0
Ovarian - 0 Joinpoints	Full Range	1990	2019	16.1*	13.9	18.4	15.8	0.0
Cervical - 3 Joinpoints	Full Range	1990	2019	14.5*	4.8	25.2	3.0	0.0
* Indicates that the AAPC is significantly different from zero at the alpha = 0.05 level.								
~ If the AAPC is within one segment, the t-distribution is used. Otherwise, the normal (z) distribution is used. See Help to Learn More								

5% of all AI research. Of gynecologic cancers, ovarian cancer publications had the highest average yearly increase at 16.1% on joinpoint analysis, whereas the average annual rates of increase in uterine and cervical cancer publications were 14.5% and 10.7% ($p < 0.001$) (table 1B).

Conclusion Compared to breast and prostate cancers, there are a disproportionately lower number and rate of publications related to gynecologic cancers and AI. Ovarian malignancies were the most widely published compared to uterine and cervical malignancies.

IGCS20_1073

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CONSERVATIVE SURGERY IN FERTILITY SPARING MANAGEMENT OF EARLY STAGE CERVICAL CANCERS – A REVIEW OF ONCOLOGIC AND REPRODUCTIVE OUTCOMES AT A TERTIARY CENTRE IN AUSTRALIA

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10.1136/ijgc-2020-IGCS.93

Introduction Less radical, fertility-preserving surgery in early stage cervical cancer has been an area of interest. We review the oncologic and reproductive outcomes of cases treated with cone biopsy or simple vaginal trachelectomy (SVT) with pelvic lymph node assessment at a tertiary institution in Australia.

Methods Patients diagnosed with stage IA1 with lymphovascular invasion (LVSI), IA2 and IB1 cervical cancer, who underwent conservative fertility-sparing surgery of cone biopsy or SVT with either sentinel lymph node biopsy (SLNB) or pelvic lymphadenectomy (PLND), from 2002 to 2018 were included. Data was reviewed retrospectively.

Results 28 patients were included; 14 underwent cone biopsy and 14 underwent SVT. All cases underwent nodal assessment by SLN ($n=10$, 35.7%) or PLND ($n=18$, 64.3%). Median age was 31.5. 82.1%(23/28) were nulliparous. By the FIGO 2009 staging criteria, stage was IA1, IA2 and IB1 in 2(7.1%), 4 (14.3%) and 22(78.6%) cases, respectively. Reclassifying by the FIGO 2018 staging criteria, stage distribution of cases was 12

(42.9%), 7(25.0%), 7(25.0%) and 2(7.1%) for IA1, IA2, IB1 and IB2, respectively. 11 had adenocarcinoma, 10 had squamous cell carcinoma, 7 were of other histologic subtypes. 6 (21.4%) had positive LVSI. 3(10.7%) were found to have nodal metastasis on histology. 4(14.3%) patients underwent adjuvant chemoradiation. Median follow-up duration was 66.5 months. Disease recurred in 1(3.6%) patient. 5-year disease-free survival was 96.4%. Of the 21 patients who were eligible and attempted to conceive post-treatment, there were 21 pregnancies and 10 livebirths.

Conclusion Conservative surgery of cone biopsy or SVT with nodal assessment is a valid fertility-preserving treatment option in carefully selected cases.

IGCS20_1074

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TIME INTERVALS FROM THE FIRST SYMPTOM TO SURGERY OF OVARIAN MALIGNANCIES IN A TERTIARY HOSPITAL

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10.1136/ijgc-2020-IGCS.94

This cross-sectional study aimed to determine the time intervals from the first symptom to surgery of 37 patients with ovarian malignancies who underwent surgery at a tertiary government hospital from June to October 2019.

Structured interviews and chart reviews identified the intervals and the reasons behind such. The data were analyzed using Stata/SE 14.1, with the time intervals presented as medians and the reasons as frequencies. Multinomial logistic regression analysis established the association of time intervals with the extent of surgery and final stage of ovarian malignancies.

The Total Time Interval from the first symptom to surgery was 214 days. The longest delay was the Total System Interval (70 days), followed by the Patient Interval (64 days) and the Initial Physician Interval (29 days). Most common reasons for the delays were the patients not acknowledging the gravity of their condition for the Patient Interval; choice to go to other