IGCS20_1151

165 APPLICABILITY OF DUKE ACTIVITY SCALE INDEX (DASI) IN PERIOPERATIVE PREDICTION OF POSTOPERATIVE COMPLICATIONS FOR GYNAEONCOLOGY PATIENTS

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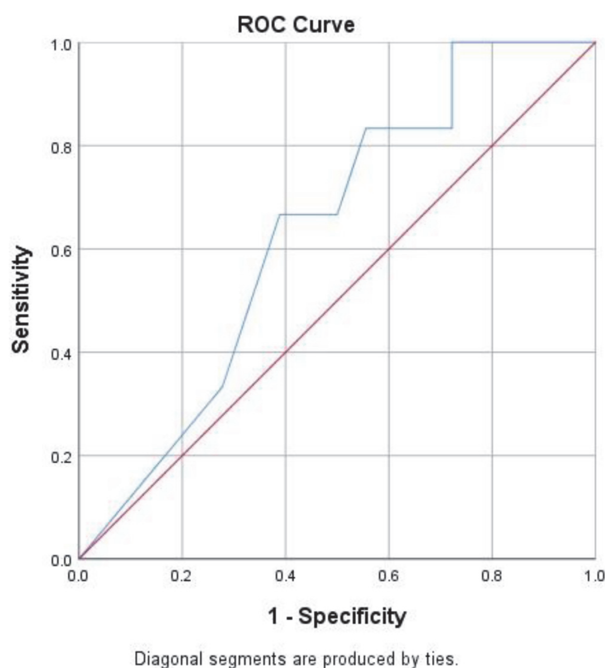
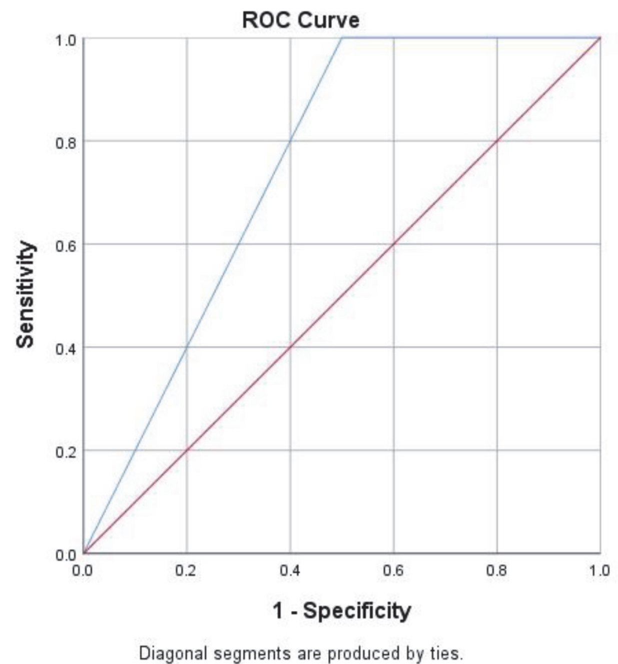
Introduction Due to increasing number of patients with multiple comorbidities requiring gynaeoncological interventions there is an unmet need for an accurate perioperative risk prediction stratification. DASI is a 12 item self-reported questionnaire based around commonly performed activities. DASI determines functional capacity through conversion to Metabolic Equivalent of Tasks (METs), which have been shown to indicate fitness for surgery. In our study we explore the accuracy of DASI in prediction of postoperative outcomes in the context of gynaeoncology.

Methods A retrospective data for 141 patients was collected using a dedicated database or patients' notes at a tertiary oncology centre. All of the patients had filled DASI questionnaire prior to surgery, which we used for the analysis. Actual postoperative complications which occurred within 30 days of the surgery were also recorded. DASI score was then compared with the occurrence of postoperative complications.

Results N=141. DASI has not found to be a statistically significant model for prediction of postoperative complications in the general population of the gynaeoncology patients (AUC-0.433). However we were able to show that a 25 point higher DASI score is predicted to deliver 1 day less in hospital. We also found that DASI score could be promising for patients with ovarian and cervical malignancy (AUC-0.634 and AUC 0.750 respectively), but there were not enough patients to validate the findings.



Abstract 165 Figure 1



Abstract 165 Figure 2

Conclusions DASI could be useful in perioperative estimation of postoperative complications for ovarian and cervical cancer patients. A study with a larger sample size and multi-centre prospective study are currently underway to validate the findings.

IGCS20_1152

166 NERVE SPARING RADICAL HYSTERECTOMY WITH A PRECISE DEFINITION OF PARAMETRIUM AND PARACOLPIUM: SHORT-TERM ONCOLOGIC, SURGICAL AND FUNCTIONAL OUTCOMES

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There is an obvious prevalence of disparity in opinions concerning the technique of nerve-sparing radical hysterectomy and its application despite agreement on the need to spare the pelvic autonomic nerve system during such radical operation. Understanding the precise three-dimensional anatomy of paracolpium and its close anatomical relationship to the components of pelvic autonomic nervous system is the key to perform the nerve-sparing radical hysterectomy. 42 consecutive patients with primary cervical cancers, who were operated in our institution between January 2017 and June 2019 were analyzed with concerning on surgical, urinary functional and short-term oncologic outcomes. Two thirds of patients had locally advanced tumor (T> 40 mm or pT≥ IIA2) with a median tumor size of 44.1 mm. The nerve-sparing radical hysterectomy combined with the complete recovery of bladder function in 90% of patients directly after surgery and in 97% of them in the first two weeks. The recurrence rate in a median follow-up time of 18 months was 9.5%. The nerve-sparing radical hysterectomy approach, which depends on the

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Abstract 166 Table 1

Characteristics		All patients n=42 (%)
Operation duration [minutes] n= 35		Median 280 (180-458)
Operative approach	Laparoscopy	24 (57.1%)
	Open surgery	18 (42.9%)
Nerve-sparing technique	bilateral	40 (95.23%)
	unilateral	2 (4.76%)
Lymph node resection	Only sentinel	2 (4.76%)
	Pelvic	25 (59.5%)
	Pelvic and paraaortal	15 (35.7%)
Median number of resected pelvic lymph nodes		44.9 (12-89)
Median number of resected paraaortic lymph nodes		16.7 (5-60)
Cases with affected pelvic lymph nodes (range) n= 40		20 (47.6%) (1-45)
Cases with affected paraaortic lymph nodes (range) n= 15		4 (9.5%) (1-16)
Parametrial infiltration		22 (52.4%)
Vaginal infiltration		11 (26.2%)
Hospital stay [days] Median (range)		10.8 (4-19)
Estimated blood loss [ml] Median (range) n= 22		97.7 (50-450) ml
Complications (Grade according to Clavien–Dindo classification	Ureter necrosis (GIII)	2 (4.76%)
	Urinary tract infections (GII)	3 (7.14%)
	Sub-ileus (GII)	1 (2.38%)
	Lymphatic oedema (GII)	3 (7.14%)
	Wound dehiscence (GIII)	1 (2.38%)
	Numbness the upper thigh (GI)	3 (7.14%)
	Nausea and vomiting (GI)	5 (11.9%)
Adjuvant therapy	Radiotherapy	Advised 2 (4.76%) Done 1 (2.38%)
	Radiochemotherapy	Advised 21 (50%) Done 17 (40.47%)
	Chemotherapy	1 (2.38%)
Bladder function	Complete healing according to protocol	38 (90.5%)
	Prolonged healing for 2 weeks	3 (7.14%)
	Persistence of impaired sensation	1 (2.38%)
Recurrences	Paraaortal relapse	1 (2.38%)
	Pelvic sidewall	2 (4.76%)
	Inguinal relapses	1 (2.38%)
	Vaginal vault	0
	All recurrences	4 (9.5%)

comprehensive understanding of the precise entire anatomy of paracolpium is feasible and applicable even in locally advanced tumors, with good functional results and convincing short-term oncologic outcomes.

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167 REFLEX METHYLATION TESTING IN ENDOMETRIAL CANCER: A SINGLE CENTRE RETROSPECTIVE STUDY

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Introduction Looking for evidence of microsatelite instablity (MSI) through immunohistochemistry (IHC) for loss of staining for mismatch repair (MMR) proteins MLH1, PMS2, MSH2 and MSH6 at the time of histopathological examination of endometrial cancers is increasingly becoming standard of care; to guide recurrent disease treatment and identify patients whose cancers may be the result of a genetic mutation eg. Lynch syndrome. Identification of IHC as a surrogate for MSI is employed in many centres. Currently patients need referral to a Familial Cancer Centre (FCC) for counselling prior to further tumour testing including methylation testing, which is more likely to be responsible for loss of staining for MLH1 and PMS2.

Aim Audit the practice of IHC for MMR proteins and identify efficiencies to the FCC referral pathway using reflex methylation testing.

Methods Patients diagnosed with endometrial cancer over a five-year period were included. Data was retrieved from the in-house clinical database, FCC database and patient histories and included: completeness of IHC for MMR, type of MMR loss of expression, proportion of referrals to FCC, number of genetic mutations identified, proportion of MLH1 and PMS2 as result of methylation.

Results Loss of staining for MMR was found in 20% of endometrial cancers. This was for MSH2/MSH6 in 1.7% and 19% for MLH1/PMS2. 95% of cases with loss of MMR proteins MLH1/PMS2 were found to be due to methylation and <5% had a germline mutation. 60% had a germline mutation in MSH2/MSH6.

Conclusion IHC for MMR at the time of endometrial cancer diagnosis is increasingly practiced. This study highlights the importance of reflex methylation testing in cases of MLH1 and PMS2 thus reducing the burden on patients and FCCs where hitherto methylation testing is not ordered before referral.

IGCS20_1154

168 ENDOMETRIAL AND COLON CANCER RISK ASSESSMENT IN WOMEN WITH LYNCH SYNDROME: PROVIDER COMFORT, KNOWLEDGE, AND CURRENT PRACTICE

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Objective Women with Lynch Syndrome (LS) experience a lifetime risk of endometrial (EC) and colon (CC) cancer of up to 57%, and the risk is approximately equal for each LS gene. Our objective was to determine knowledge of EC and CC risks, screening guidelines, and management recommendations among healthcare providers caring for women with LS.

Methods An anonymous survey was sent to providers in primary care, ob/gyn, gynecologic oncology, gastroenterology, and

Abstract 168 Table 1 Counseling by 77 respondents who report they currently care for women with LS

Survey Item	Endometrial Cancer (EC)	Colon Cancer (CC)
Counsel on increased risk of EC or CC	65 (84%)	77 (100%)
Recommend screening/early detection options for EC or CC	44 (57%)	75 (97%)
Offer screening consistent with national guidelines for EC or CC	23 (30%)	43 (56%)
Do not recommend screening for EC or CC	8 (10%)	0 (0%)
Most concerned for EC or CC to occur first	15 (20%)	48 (62%)
Recommend risk reducing hysterectomy	33 (43%)	NA

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