

Results 40 patients were included in the analysis. The mean age was 43 years (29–66). Surgical approach was extraperitoneal in 31 (77.5%) and transperitoneal in 9 (22.5%) of the cases. The mean operating time was 147.5 minutes (120.2–186.2). Surgical bleeding had a median of 30 ml (10–50). There were no intraoperative complications or death associated with the procedure. The median paraaortic lymph node count was 8.5 nodes (5.75–15). Six (15%) patients had para-aortic compromise and all received extended field radiotherapy. At follow-up, 5% of patients presented recurrent disease (n= 1 lung and n= 1 supraclavicular lymph node). The overall survival (OS) was 88.7% and the disease-free survival (DFS) was 74.3% in the population.

Conclusion Paraaortic lymphadenectomy in stage IIIC1r cervical cancer in our study detected 15% of patients with lymph node involvement, without associated morbidity. It was not possible to evaluate the oncological impact of this procedure in the study population.

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222

HIGH INCIDENCE OF VENOUS THROMBOEMBOLISM IN PATIENTS RECEIVING NEOADJUVANT CHEMOTHERAPY FOR ADVANCED STAGE OVARIAN CANCER

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Objectives There is paucity of data on venous thromboembolism (VTE) in patients receiving neoadjuvant chemotherapy (NACT) for ovarian cancer. We explored the incidence and predictors of VTE in this patient population.

Methods We performed a retrospective review of women with primary ovarian, fallopian tube or peritoneal cancer who received NACT from January 2012 to October 2018. Patients with a history of VTE prior to cancer diagnosis were excluded. The primary outcome was incidence of deep vein thrombosis (DVT) or pulmonary embolism (PE) after cancer diagnosis and before interval debulking surgery. We explored demographic and clinical variables associated with VTE.

Results VTE was diagnosed in 25 (28%) of 90 patients and 16 (64%) had PE. 67% of patients had VTE during NACT and 8 patients after their cancer diagnosis, before initiation of NACT. The majority of patients had stage III disease and serous adenocarcinoma. African Americans were 3 times more likely than other races to experience VTE (OR 3.22; CI 0.997–10.42; P = 0.051). Significantly more patients without VTE had debulking surgery (88% vs 60%, P = 0.005). The risk of DVT increased by 8.7% per year of age (OR 1.087; 95% CI 1.01–1.17). Obesity, smoking status, medical comorbidities, disease stage, histology, invasive diagnostic surgery, and length of NACT were not predictors of VTE.

Conclusions The incidence of VTE during neoadjuvant chemotherapy is high. Older age and African American race may be potential risk factors for VTE. This information will help mitigate disparities in the treatment of advanced stage ovarian cancer.

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223

A THREE PROTEIN SIGNATURE FAILS TO EXTERNALLY VALIDATE AS A BIOMARKER TO PREDICT SURGICAL OUTCOME IN HIGH GRADE SEROUS OVARIAN CANCER

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Introduction Complete cytoreduction is associated with improved survival in patients with advanced High Grade Serous Ovarian Cancer (HGSO). To aid clinical decision making, many surgical outcome prediction tools have been proposed, but none have been sufficiently validated to warrant routine clinical usage. Here we attempted to externally validate a promising three protein signature, which had shown strong association with suboptimal surgical debulking (AUC 0.89, accuracy 92.8%).

Methods 241 HGSO tumour samples were collected from patients who participated in a large multicentre trial (ICON5). Samples were collected at the time of initial surgery and before randomisation. Surgical outcome data were collated from the study records. Immunohistochemical scores were generated by two independent observers for the three proteins in the original signature (POSTN, CXCL14 and pSmad2/3). Predictive values were generated for individual and combination protein signatures and as part of a multivariable model using logistic regression.

Results When assessed individually, none of the proteins showed any predictive affinity for suboptimal surgical outcome in our cohort (AUC POSTN 0.55, pSmad 2/3 0.53, CXCL 14 0.62). The combined signature again showed poor predictive ability, AUC 0.58, as did the multivariable model, AUC 0.63.

Conclusion Despite showing original promise, when this protein signature is applied to a large external cohort, it is unable to accurately predictive surgical outcomes. This could be attributed to overfitting of the original model, or differences in surgical practice in our cohort.

IGCS20_1225

224

ADJUVANT CHEMOTHERAPY IN SURGICAL STAGE I OR II ENDOMETRIOID ENDOMETRIAL CANCER WITH MYOMETRIAL INVASION >50%: A MULTICENTER RETROSPECTIVE STUDY WITH LONG-TERM FOLLOW-UP

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Objective To evaluate the role of adjuvant chemotherapy in patients with surgical stage I-II endometrioid endometrial cancer (EC) with myometrial invasion (MI) >50%.

Methods We identified patients with stage I-II endometrioid grade 2 and 3 EC with MI >50% and negative nodes after pelvic ± para-aortic lymphadenectomy at four institutions (US and Italy). The association between adjuvant chemotherapy and cause-specific survival (CSS) or progression-free survival (PFS) was assessed with Cox proportional hazards models, adjusted for confounders using the inverse-probability of treatment weighting (IPTW).

Results From 1984 to 2012, 329 patients were identified. Median follow-up among those alive was 7.0 (interquartile

range, 3.7–11.1) years. Five-year CSS was 86.1% (95%CI: 82.0–90.4%) and 5-year PFS was 82.2% (95%CI: 77.9–86.8%). Stage II (vs stage IB) was significantly associated with poorer CSS and PFS; older age with poorer PFS. With IPTW-adjusted analysis, adjuvant chemotherapy appeared to improve CSS (hazard ratio [HR]: 0.34; 95% CI: 0.11–1.03; P=.06) and nonvaginal PFS (HR: 0.36; 95%CI: 0.12–1.08; P=.07) (figures 1 and 2). Eleven (84.6%) of 13 para-aortic recurrences were observed in 194 patients who had neither para-aortic lymphadenectomy nor adjuvant chemotherapy. Conversely, no para-aortic recurrences were observed in 64 patients who received adjuvant chemotherapy.

Conclusions Adjuvant chemotherapy for surgical stage I-II endometrioid grade 2 and 3 EC with MI >50% appeared to improve CSS and nonvaginal PFS, although not meeting the conventional level of statistical significance. Stage II patients appear to benefit most from adjuvant chemotherapy. Chemotherapy ± para-aortic lymphadenectomy may help reduce para-aortic failures.

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225

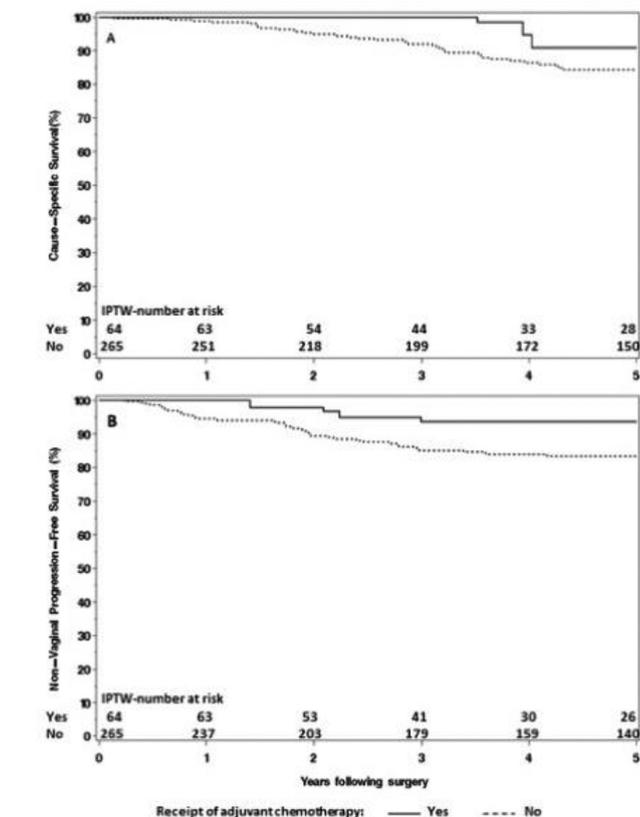
ASSOCIATION BETWEEN THE GYNECOLOGIC IMAGING REPORTING AND DATA SYSTEM IN ADNEXAL MASSES AND THE TYPE OF SPECIALIST: GYNECOLOGIST VS GYNECOLOGIC ONCOLOGIST

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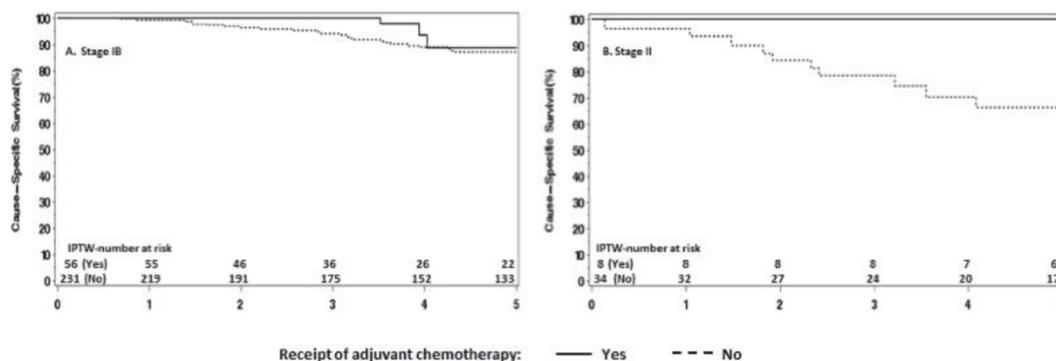
10.1136/ijgc-2020-IGCS.193

Introduction The Gynecologic Imaging Reporting and Data System (GI-RADS) is a reporting system that offers a management protocol for adnexal masses and suggests the requirement of patient remission to a gynecologic-oncologist. The aim was to determine if there is an association between GI-RADS score and the specialist that performs the surgery.

Methods Ambispective study that included 547 patients that underwent preoperative ultrasound. A total of 605 adnexal masses were evaluated by ultrasound between 2012 and 2018



Abstract 224 Figure 1 Inverse-probability of treatment-weighted cause-specific survival (A), and nonvaginal progression-free survival (B), according to receipt of adjuvant chemotherapy



Abstract 224 Figure 2 Inverse-probability of treatment-weighted cause-specific survival among patients with FIGO stage IB (A) or stage II (B), according to receipt of adjuvant chemotherapy