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 $\pm$ 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 $\pm$ para-aortic lymphadenectomy may help reduce para-aortic failures.

IGCS20_1227

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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

in one center. These masses were classified according to GI-RADS by gynecologic ultrasound experts. For the analysis, we grouped GI-RADS 1, 2 and 3 as benign masses, and GI-RADS 4 and 5 as malignant masses. We also identified the type of specialist that performed the surgery and classified them in 2 categories: gynecologist and gynecologic oncologist. A descriptive analysis of the patients and the masses found was conducted. Additionally, a Chi2 test was used in order to determine a possible association with a 95% confidence interval.

Results The median of age of the patients was 41 (range, 32–51) years, 148 (27%) were postmenopausal. Of the 605 masses, 140 (23.1%) were classified as malignant. The morphological characteristics of malignant masses included: multilocular-solid, with papillae and vascularization. A statistically significant association between GI-RADS and the specialist, and GI-RADS and the histopathology was found ($p < 0.05$).

Conclusion In our center, GI-RADS classification can be used as a tool to decide the need of remission of a patient to gynecologic oncology.

IGCS20_1229

227 ASSESSMENT OF CERVICAL CANCER SCREENING IN KAZAKHSTAN

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10.1136/ijgc-2020-IGCS.194

Introduction In Kazakhstan, cervical cancer (CC) takes 2nd place among woman cancer and 7th place in general cancer mortality. Cytological screening in country have started in 2008. Kazakhstan plans to join the program for the global elimination of cervical cancer by introducing vaccination, improving screening and treatment.

Methods The analysis was carried out using the National Cancer Register (2020). The incidence and mortality in the period before the introduction of screening (2004–2007) were studied. The screening period is conditionally divided into the first stage (2008–2014) and the second stage (2015–2018).

Results In 2004–2007, the average annual incidence was 15.1 per 100,000 women. Indicators varied from 14.5 to 15.8 with an average annual growth ratio +1.9%. The average annual mortality rate was 7.4 per 100,000 female population fluctuating within 7.0–7.6%. After the introduction of screening, an increase in the incidence was noted with the ratio of 19.9–20.1 per 100,000 of women.

The average annual incidence in the first stage of screening was 17.4% with an average annual growth rate +3.9%, whereas, the second stage showed a decrease in incidence with the average growth rate $T = -1.4\%$, and the average annual incidence at 18.9%. Mortality in the first stage had an annual growth rate of $T = +1.9\%$, in the second – $T = -5.4\%$. Screening increased stage I from 41.7% to 62.5%, and pre-cancer – from 0.06% to 0.51%.

Conclusion In the first eight years of screening, an increase of incidence and mortality was noted. Further, the growth of the initial stage and pre-cancer diseases was pointed out.

IGCS20_1230

228 PREDICTIVE FACTORS OF LYMPH NODE INVOLVEMENT AND TOPOGRAPHY OF LYMPH NODE METASTASIS IN PATIENTS WITH EPITHELIAL OVARIAN CANCER

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10.1136/ijgc-2020-IGCS.195

Objectives to determine the rate, the repartition and to predict the risk factors of lymph node metastasis in patients operated on for epithelial ovarian cancer.

Methods we reviewed retrospectively the data of 185 patients diagnosed of epithelial ovarian cancer and operated on between January 2005 and October 2019 at Hôtel-Dieu de France University Hospital.

Results 88% of patients received a pelvic and paraaortic lymphadenectomy. Node involvement was noted in 56% of cases. 85% of patients presented lymph node metastasis in the pelvic lymph nodes and 83% in the paraaortic nodes. Lymph nodes metastases in both pelvic and paraaortic levels were encountered in 70% of cases. Isolated pelvic or aortic lymph node metastases were seen in 16% and 14% of cases respectively. The median number of removed pelvic and paraaortic lymph nodes was 27 and 30 nodes respectively. In the univariate analysis, the rate of positive lymph nodes was higher in patients with serous histology (65% (serous) vs. 33% (non-serous), $p = 0.000$), high grade (68% vs. 26%, $p = 0.000$), bilateral adnexal involvement (74% vs. 27%, $p = 0.000$) and positive peritoneal cytology (79% vs. 26%, $p = 0.000$). In multivariate logistic regression analysis, the rate was significantly higher in patients with bilateral adnexal involvement, higher grade and positive peritoneal cytology.

Abstract 228 Table 1

	Lymph node involvement (%)	P value
Type of histology		0.000
serous	65%	
Non serous	33%	
Adnexal involvement		
bilateral	74%	
unilateral	27%	
Grade		
grade 3	68%	
grade 1 and 2	26%	
Peritoneal cytology		
positive	79%	
negative	26%	

Conclusion Serous histology, grade 3 tumors, positive peritoneal cytology and bilateral adnexal involvement seem to be predictive factors of lymph node involvement in patients with ovarian cancers.