in one center. This 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.

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227 | ASSESSMENT OF CERVICAL CANCER SCREENING IN KAZAKHSTAN

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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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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		
serous	65%	
Non serous	33%	
Adnexal involvement		
bilateral	74%	
unilateral	27%	0.000
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 predictive factors of lymph node involvement in patients with ovarian cancers.