



Abstract EPV051/#264 Figure 2

immunohistochemistry were consistent with SCNC. Imaging studies were done to determine the extent of the tumor. A diagnosis of small cell neuroendocrine carcinoma of the cervix, stage IIIC1r with pelvic organ prolapse, stage IVC was made. Uterine procidentia was reduced using a gellhorn pessary. The patient received external beam radiation therapy followed by brachytherapy, and chemotherapy with Cisplatin and Etoposide.

Results There was marked reduction of the cervical mass, and complete resolution of the pelvic organ prolapse, as well.

Conclusions This is the first report of small cell neuroendocrine carcinoma of the cervix complicated with uterine procidentia, locally and internationally. It required a multidisciplinary approach involving a urogynecologist, a gynecologic oncologist, and a radiation oncologist. Standard treatment guidelines for this rare tumor and case are yet to be established.

EPV052/#273

A NOVEL IMAGE-GUIDED POINT-OF-CARE ETHYL CELLULOSE ETHANOL ABLATION STRATEGY FOR RECURRENT LOCALIZED CERVICAL CANCER

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Objectives Local ablation is a promising option for recurrent localized cervical cancer in non-surgical candidates who fail platinum-based chemotherapy and radiation. We developed a low-cost polymer-assisted ethanol ablative therapy, Point-of-care Ethanol Ethyl Cellulose (PEEC), that overcomes the main shortcoming of ethanol ablation: off-target ethanol leakage. Since increased tumor coverage of ablative therapies results in reduced tumor progression and improved clinical outcomes, we hypothesized that PEEC with image-guidance would

optimize cervicovaginal tumor coverage resulting in decreased tumor progression and off-target effects.

Methods A syngeneic cervicovaginal tumor model was established in C57BL/6 mice using TC1-Luc, HPV16 E6/E7+ cells expressing luciferase. Mice were randomized into image-guided PEEC (IG-PEEC), PEEC without image guidance (PEEC only), and saline ablation groups (n=5). Tumors were monitored with bioluminescence imaging via a Perkin-Elmer in vivo imaging system (IVIS) and calipers. Ablations consisted of two intratumoral injections (50mL each) of either PEEC or saline. Image-guided ablations were performed using IVIS to both target PEEC injections at regions of highest radiance intensity (correlated to tumor mass) and to assess tumor coverage.

Results Tumors treated with IG-PEEC performed best with lower total radiance, volumes and weights, and longer survival compared to PEEC only and saline groups (p < 0.05); both PEEC groups demonstrated reduced tumor growth compared to saline (p < 0.05). off-target damage (ulceration) rates were lower for the IG-PEEC (n=0, 0%) versus the PEEC only (n=2, 40%) group.

Conclusions PEEC ablation enhanced by image-guidance significantly controls HPV16 E6/E7+ cervicovaginal tumor progression. This supports image-guidance as a critical component in optimizing PEEC ablation and eventual clinical translation.

EPV053/#282

OBSTETRICAL AND ONCOLOGIC OUTCOMES AFTER ABDOMINAL RADICAL TRACHELECTOMY

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Objectives To describe retrospectively our experience following abdominal radical trachelectomy (ART), including 5 performed during pregnancy, in terms of complications, obstetrical and oncologic outcomes.

Methods Between 2010 and 2020, all patients with early stage cervical cancer deserving to preserve their fertility were considered for ART. Out of the 19 patients who have met the inclusion criteria for ART, in 18 the trachelectomy was performed and only 1 case needed conversion to radical hysterectomy.

Results Patients' mean age was 31 years old (range 24- 38); two thirds of them were nulliparous. Six women (33.33%) were staged as IA2, 4 (22.22%) IB1, 5 (27.78%) IB2, and 4 (22.22%) stage IB3 disease. Only one intraoperative complication has occurred - both bladder and right ureteral injuries. Early postoperative complications were urinary bladder dysfunction (33.33%), symptomatic pelvic lymphocele which was drained (11.1%), peritonitis (5.5%), and wound infection (5.5%). Late postoperative complications included cervical stenosis (5.5%), amenorrhea (11.1%), and pelvic abscess (5.5%). Four out of the 18 patients were operated during pregnancy between 14 and 20 weeks; 2 of them have delivered at term, and 2 of them have aborted shortly after the surgery. One patients was operated immediately after caesarean section. Two vaginal recurrences were recorded; and both have been managed by hysterectomy, partial colpectomy and adjuvant chemoradiotherapy. At this moment, all patients are alive with no evidence of disease and 3 of them managed to conceive.

Conclusions ART is a reliable option as fertility sparing procedure. In selected cases, ART could be performed during pregnancy or after caesarean section with encouraging results.

EPV054/#283

DOES SURGICAL APPROACH INFLUENCE RECURRENCE IN EARLY STAGE CERVICAL CANCER WITH NO GROSS VISIBLE DISEASE AT PRESENTATION?

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Objectives Published results from the LACC trial reported inferior survivals after minimal invasive surgical (MIS) approach in the treatment of early cervical cancer. Spillage of gross tumours and peritoneal contamination had been proposed as possible explanations. We studied oncologic outcomes specifically in patients presenting with no clinical gross cervical cancer treated with minimal invasive versus open radical hysterectomy as this has not been reported.

Methods Retrospective chart reviews of all patients treated with radical surgery for cervical cancer from 2005 to 2018 were performed. Only patients with no gross visible tumour who were diagnosed after a LEEP/cone biopsies were included. Relevant demographics, pathologies and survival outcomes were abstracted. Descriptive and Chi Square statistics were used to summarize clinical variables. Kaplan Meier and Cox regression were used to study survival outcomes. All $p < 0.05$ were considered to be statistically significant.

Results 98 patients were included. Median age was 42. Median tumour size was 10 mm. Most was diagnosed after a cone biopsy (66%). Stage 1B1 was documented in 66% pre-operatively. MIS used in 20 patients. Uterine manipulator used in 14 cases. Median follow up was 42 months. One recurrence in MIS group (5%) vs six recurrence in laparotomy group (7.7%), $p = 0.67$. Three death in laparotomy and no death in MIS cohort. MIS is not significant in Cox model for PFS, adjusted for use of adjuvant radiation, and tumour size, $p = 0.43$.

Conclusions MIS radical hysterectomy might be safe in patients with no gross visible tumour at presentation.

EPV055/#292

THE HIGHER INCIDENCE OF CERVICAL CANCER AMONG HISPANICS IN THE US: WHAT FACTORS ARE RESPONSIBLE?

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Objectives To evaluate differences in cervical cancer incidence, screening, and HPV vaccination between Hispanics and Whites in the United States.

Methods Data were obtained from the United States Cancer Statistics (USCS) from 2001 to 2017 and the Behavioral Risk Factor Surveillance System (BRFSS). SEER*Stat and Joinpoint regression program were used for statistical analyses.

Results Based on USCS data, in 2017 the overall incidence of cervical cancer was 7.5/100,000 in Hispanic women compared to 6.2/100,000 in White women. Hispanics aged 35 to 39 years had the highest incidence at 15.9/100,000. We then used BRFSS data to identify potential deficiencies in screening and prevention, and found that 11.6% of all Hispanics were never screened compared to only 5.1% of Whites. When stratified by age, Hispanics 25 to 29 years old had the highest rate of absent screening at 11.2%, compared to 6.4% of Whites of the same age. In examining adherence to screening guidelines, we found that 11.4% of Hispanics and 26.6% of Whites were non-adherent (no screening in the last five or more years). Furthermore, of those eligible for HPV vaccination in 2006, only 37.3% of Hispanics had received the vaccine by 2017, compared to 50.0% of Whites.

Conclusions Cervical cancer incidence is 20% higher in Hispanics compared to Whites in the United States. Poor compliance with cervical cancer screening and lower vaccination rates may explain this disparity.

EPV056/#293

HIGH INCIDENCES OF CERVICAL CANCER IN US BLACK WOMEN OVER AGE 65 – SHOULD INDIVIDUALIZED SCREENING GUIDELINES BE CONSIDERED?

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Objectives In 2003 the USPSTF recommended discontinuing cervical cancer screening at age 65 in low risk adequately screened women. We aim to evaluate trends in cervical cancer incidence and screening in United States Black and White women over age 65.

Methods Data were obtained from United States Cancer Statistics (USCS) from 2001 to 2017 and from the Behavioral Risk Factor Surveillance System (BRFSS). SEER*Stat and Joinpoint regression program were used for statistical analyses.

Results Using USCS data, we evaluated differences in cervical cancer incidence by race and age. We found the highest incidence in Blacks aged 65 to 69 years at 17.6/100,000, compared to 15.0/100,000 in Whites aged 40–44 years. of note, the incidence among Blacks over age 69 remained high at 13.9–17.5/100,000 whereas the incidence in Whites decreased steadily after peaking in 40–44 year-olds. Using BRFSS data, we evaluated patterns in screening, and demonstrated that 34.7% of Blacks aged 65 and older had never been screened compared to 21.5% of Whites. of those screened, 19.8% of Blacks aged 65–69 years were non-adherent to guidelines (no Pap in five or more years) and the rate of non-compliance increased 5.2% per year over our study period ($p < 0.001$).