2022-RA-1487-ESGO CHEMO-INDUCED AMENORRHEA IN YOUNG WOMEN TREATED FOR BREAST CANCER

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Introduction/Background Chemo-induced amenorrhea represents one of the major toxicities which is a source of concern for young women suffering from breast cancer and treated with chemotherapy. It is defined by an oligo/amenorrhea for 4 months and a level of follicle stimulating hormone (FSH) > 25 IU/l twice at 4 week intervals before the age of 40 years.

Methodology We conducted a retrospective study on files, in the Medical Oncology department of the CHU Tlemcen over a period of 2 years, including young patients (≤ 35 years old) treated, during the year 2020 and 2021, by adjuvant chemotherapy for localized breast cancer to study the incidence of chemotherapy-induced amenorrhea (ICA).

Results Fourteen patients were collected. The average age is 33 years [27, 35]. Invasive ductal carcinoma was found in 11 patients (78.6%). Hormonal receptors were positive in 11 patients (78.6%) and with a luminal B molecular profile in 6 patients (42.9%). Chemo-induced amenorrhea was observed in 11 patients (78.6%), half of whom were 35 years old (45.45%). Four patients were treated with the anthracyclin based protocol (4AC 60) and 8 patients with sequential anthracylin taxane protocol (4AC/4TXT (4), 3FEC/3TXT (2), 3EC/3TXT (1), 3EC/12 Taxol w(1) and, 2 patients with sequential anthracylin – taxane -trastuzumab protocol (4AC/4TXT/12trastuzumab (1), 3EC/3TXT/12trastuzumab (1). Its was definitive amenorrhea in 9 patients. The treatment was completed by hormone therapy such as Tamoxifen in 9 patients (81.81%) and Tamoxifen + medical castration in 2 patients (14.3%).

Conclusion Young women with localized breast cancer are often candidates for adjuvant chemotherapy, which may be responsible for amenorrhea and have long-term consequences on fertility after definitive amenorrhea.

2022-RA-1512-ESGO MULTIDISCIPLINARY AND TAILORED MANAGEMENT IN YOUNG PATIENTS WITH BORDERLINE OVARIAN TUMOR RECURRENCE: A CASE SERIES

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Introduction/Background In young women with a recurrence of borderline ovarian tumor (BOT) a second conservative treatment for the preservation of reproductive potential and endocrine function should be mandatory. In our study, we reported three cases of ovarian BOT recurrences assessed to oncofertility consultation and underwent fertility sparing surgery (FSS), highlighting the importance of the tailored clinical management in the context of a multidisciplinary meeting.

Methodology From July 2020 to April 2022, we managed three cases of young women with controlateral ovarian BOT recurrence after unilateral adnexectomy. Median age at diagnosis was 26 years (I.Q.R 25–28). After multidisciplinary meeting each patient has been addressed to oncofertility consultation with the gynecologic oncologist and the reproductive physician. Two patients had strong desire to conceive furthermore they underwent a controlled ovarian hyperstimulation (COH) with concomitant letrozole and ovarian cryopreservation. In one case the ART (assisted-reproductive-technology) procedures has been performed with tumor onsite.

Results Second surgery consisted in unilateral laparoscopic cystectomy in all cases. In those patients who have undergone COH, two and five mature oocytes were cryopreserved, respectively. After 11 months of surgery one patient became pregnant spontaneously and she gave birth at 39 weeks with an excellent obstetrical outcome. In one case the oocytes cryopreservation has been rejected by the patient, but the endocrine function has been preserved.

Conclusion In young women, with BOT ovarian recurrence, a second conservative treatment should be always considered and an oncofertility consultation should be recommended. Clinical management must be tailored on a case-by-case basis by a gynecologic oncologist and reproductive physician meeting.

2022-RA-1533-ESGO ROLE OF FERTILITY SPARING SURGERY IN PATIENTS WITH BORDERLINE OVARIAN TUMORS

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Introduction/Background Borderline ovarian tumors (BOT) are considered rare tumors of the ovary and often occur in young patients, which is why fertility-sparing surgery (FSS) is of great importance.

Methodology Patients treated with a BOT between 1999 and 2022 in our gynecologic oncology center were included in this analysis. In all cases, an external pathological review was performed.

Results Among 469 patients, 365 (77.8%) were identified with FIGO stage I and 104 (22.2%) with FIGO stage ≥II. 138 patients (29.4%) received FSS. Among those patients treated with complete surgical staging, 5/331 (1.5%) relapses and 4/331 (1.2%) malignant transformations were observed, with a recurrence rate of 0/258 (0%) in FIGO I and 5/73 (6.8%) in FIGO II-IV. FSS showed 17/138 (12.3%) recurrences and 1/138 (0.7%) malignant transformation, with a recurrence rate in FIGO I of 6/107 (5.6%) and in FIGO II-IV of 11/31 (35.5%). In the multivariate analysis, FIGO stages III-IV (HR = 22.7; 95% CI: 7.4–69; p <0.001) and FSS (HR = 18.2; 95% CI: 4.8–69; p <0.001) were identified as significant risk

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factors for recurrence. 35 patients were treated with a recurrence of a BOT. FSS was repeated in 11 (36.7%) patients. After FSS, the recurrence rate was 1/11 (9%). After complete surgical staging, 3/24 (12.5%) patients experienced a recurrence.

Conclusion Patients with BOT who receive a quality assured treatment have a very low risk of a malignant transformation. After individual consideration, FSS is safe in BOT in early FIGO stages. Patients should be counseled about a higher risk of recurrence in cases of FSS, especially in higher FIGO stages. In selected cases, FSS can also be reconsidered in the recurrence situation.

2022-RA-1545-ESGO UTERINE TRANSPOSITION: IS IT AN OPTION FOR FERTILITY SPARING IN LOCALLY ADVANCED CERVICAL CANCER

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Introduction/Background In Argentina, cervical cancer is the second most frequent and 1,600 women die from this cause per year. Conventional fertility preservation surgical treatments are not viable treatment options in advanced stages. Uterine transposition was promoted by Dr. Reitán Ribeiro.

Methodology We present two cases reports of patients with cervical cancer FIGO 2018 stage IIIC1 despite this, they insisted on preserving fertility. Both nulliparous, 29 and 34 years old, the first case referred with Loop Electrosurgical Excision Procedure (LEEP): 0.7x0.5 cm with squamous no queratinizante carcinoma + HSIL in endocervix. The second case had LEEP: 1.3x1.2x0.3 cm with endocervical adenocarcinoma and compromised margins. Both had Magnetic Resonance (MR) without residual tumor; only finding: 44 mm and 8 mm obturator lymph node respectively. PET-CT: Distant hypermetabolic foci not seen. Oocyte cryopreservation in both. Subsequently, the first surgery: laparoscopic sentinel lymph nodes with intraoperative frozen-section confirming macrometastasis. The uterus and ovaries were transposed without the cervix to the upper abdomen. Ultrasound was used to guide the section on the uterus, leaving a uterine remnant of at least 1 cm suitable for cerclage. With the cervix in the pelvic position, primary treatment: concurrent chemoradiotherapy with cisplatin (6 cycles) and brachytherapy was started on postoperative day 20. Subsequently, in the second surgery, a simple trachelectomy was performed and repositioning of the uterus in the pelvis with negative margin frozen section

Results After 18 and 10 months of follow-up with physical examination, images and cytology-HPV cotesting, no signs of recurrence.

Conclusion We emphasize the importance of strict informed consent, explaining risks and benefits, especially in this controversial case that goes against scientific evidence. They were carefully selected cases with tumours less than 2 cm, without residual disease by MR post LEEP, and the best treatment tested by stage was respected without delay. Pending longer follow-up in time.

2022-RA-1599-ESGO PREGNANCY ASSOCIATED BREAST CANCER: ABOUT 10 CASES

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Introduction/Background Pregnancy-associated breast cancer (PABC) is defined as breast cancer diagnosed during pregnancy or in the first postpartum year. While it is relatively uncommon (occurring in 1 per 3000 pregnancies), it represents a challenge to both the patient and the multidisciplinary team. we ought in this study to describe, the clinical, paraclinical and management of pregnancy associated breast cancer.

Methodology we conducted a retrospective single-center cohort study of 10 patients diagnosed and treated for breast cancer during pregnancy between 2005 and 2022 in the obstetric and gynecology department of Ben Arous hospital.

Results Five patients were diagnosed during the second trimester, 3 during the first trimester and 2 in the postpartum period. A suspicious area was detected by ultrasound in 10 of 15 women. A recurrent abscess was present in 2 cases and the biopsy revealed the cancer. Five patients had positive hormone receptors and 7 sub expressed. One patient was in stage 0, 2 in stage 1, 2 in stage 3 and 5 in stage 4. Three patients decided voluntarily to legally terminate their pregnancies. Seven patients were treated with chemotherapy during pregnancy after the second trimester using anthracycline-based treatment. Three patients had gestation-related complications including preterm labor, intrauterine growth restriction dyspnea and chemotherapy related granulocytopenia.

Conclusion pregnancy associated breast cancer is a rare entity. It is associated with a high number of complications. A multidisciplinary approach is needed and patients should be an integral part of therapeutic decisions.

Miscellaneous

2022-RA-128-ESGO ULTRASOUND ASSESSMENT OF PATHOLOGICAL LYMPH NODES IN GYNECOLOGIC CANCERS

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Introduction/Background Lymph nodes can be affected in gynecologic cancers and they are uplifting the stage of cancer. They are a poor prognostic factor for cancers. They usually need radiotherpay if they are affected by metastasis. Usually they are detected by CT scan and MRI during assessing any pelvic malignancy. Ultrasound can be used for detecting suspicious nodes. We are aiming here to spot the light over this and showing a pictorial essay for nodes detected on ultrasound

Methodology Nodes are pathological on stage 3 cancer vulva (of inguinal ones and stage 4 if pelvic ones), stage 3 endometrial cancer (in pelvic ones and stage 4 if inguinal ones or scalene ones), Stage 3 cancer cervix (if pelvic and stage 4 if

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