Introduction/Background Uterine leiomyosarcoma (LMS) is a rare uterine malignancy tumor originated from smooth uterine muscle. Compared with other types of uterine cancers, LMS is an aggressive tumor associated with a high risk of recurrence and death. Most cases are diagnosis incidentally after a surgery for presumed benign uterine leiomyoma. Sometimes patients may describe symptoms as vaginal bleeding or abdominal pressure due to a rapid uterine growth. The goal of this study is to determine the clinical features in patients with LMS and the influence of type of diagnosis, comparing unexpected versus suspected LMS.

Methodology Retrospective observational study of patients diagnosed with LMS in the Gregorio Marañon Hospital (1985 – 2021). A comparison between groups of incidental and suspected diagnosis was performed.

Results Table 1 shows results. 52 patients have been diagnosed of LMS. In contrast with previous analysis, in our study less than 50% of the patients were incidentally diagnosed of LMS. In contrast with previous analysis, in our study less than 50% of the patients were incidentally diagnosed of LMS. Although global risk of recurrence and death is high, as is has been described previously, our study shows a significant higher disease-free survival rate when diagnosis are unsuspected.

Conclusion LMS are aggressive uterine tumors leading to elevated rates of recurrence and death. The events leading to the diagnosis may influence the prognosis.

Impact of COVID-19 on Waiting Times in the Gynaecological Cancer Patient Pathway, a Comparative Study

Introduction/Background We set out to quantify the effect of the COVID-19 pandemic on waiting times experienced by patients referred to a tertiary gyna-oncology service at Queen Alexandra Hospital, Portsmouth by comparing waiting times, before and during, the pandemic.

Methodology All gynaecological cancer diagnoses over two five-month periods 1/2/2019 – 30/6/2019 (the pre-Covid period), and during the initial pandemic period 1/2/2020 – 30/6/2020, (during Covid), were tracked from referral date onwards throughout the patient pathway, and waiting times (average number of days) compared. Patients receiving private care, with a diagnosis prior to formal referral or having chemo or radiotherapy prior to surgery were excluded.

Results There were 131 gynaecological cancer diagnoses in the pre-Covid period, and 87 during Covid. Waiting time from referral to see a specialist was 13.1 days pre-Covid, and 10.9 during Covid (p=0.08). Time from referral to imaging (CT/MRI) was similar between the two groups (29.0 vs 25.6 during Covid, p=0.08). Time from referral to diagnosis was significantly shorter during Covid (34.9 vs 23.7 days during Covid, p=0.0017). 74 patients (pre-Covid) and 51 (during Covid) underwent surgery as their primary treatment. Waiting time from decision to treat to operation date was similar between the two groups (29.5 vs 24.2 days during Covid, p = 0.0017). 74 patients (pre-Covid) and 51 (during Covid) underwent surgery as their primary treatment. Waiting time from initial referral to surgery was significantly shorter during the pandemic (55.5 vs 42.5 during Covid, p=0.001).

Conclusion Cancer diagnoses at this centre were a third less than the same time the previous year. Unlike benign gynaecological services, resourcing for gyna-oncology services remained consistent throughout the pandemic. The reduced patient volumes meant those in the pathway had improved care in the form of quicker diagnoses and surgery. These findings suggest that Covid-related challenges in the gyna-oncology care pathway were pre-hospital, possibly related to reduced presentations, GP access and or referrals.