disease would have been eligible for testing based on their FH.

Conclusion Family history should always be investigated and specific sets of criteria should be included in guidelines independently from a personal history of cancer.

2022-RA-1032-ESGO EVALUATION OF INTRAOPERATIVE HPV TEST AS AN EARLY MARKER OF RESIDUAL DISEASE AFTER HSIL SURGICAL TREATMENT. A PROSPECTIVE MULTICENTER STUDY. PRELIMINARY RESULTS

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Introduction/Background

Objective To evaluate if the intraoperative human papillomavirus (IOP-HPV) test has the same prognostic value as the HPV test performed 6 months after treatment of high-grade squamous intraepithelial Lesion (HSIL) to predict treatment failure.

Methodology

Design Prospective multicenter cohort studySetting: 22 Referral Hospitals in Spain.Population: 1824 women treated for cervical HSIL by Loop Electrosurgical Excision between May 2020 and December 2021

After LEEP an HPV test was performed immediately after excision using a Cobas (83%) or other genotyping test.

Subsequently, pacients were followed with citology and HPV test, 6, 12 and 24 months after treatment.

The IOP-HPV test was compared with HPV test 6 months after procedure and with surgical margins in order to detect residual disease.

Results We described results of the first 992 cases with the 6 month co-test performed. IOP HPV test was feasible (valid result 98,5%). IOP-HPV was positive in 40%, while only 25% at 6 month test. We observed association between the IOP and 6 month HPV test (ChiSquare p= 0.0001), IOP HPV positivity and abnormal citology at 6 months (p=0.063), and positive IOP HPV test and positive surgical margins. (p=0.0001)

Conclusion Preliminary results show that IOP HPV test could be a satisfactory prognostic factor of cervical HSIL treatment result.

2022-RA-1049-ESGO PATIENTS WITH TP53 MUTATION FOLLOWED UP IN A HEREDITARY GYNAECOLOGICAL CANCER UNIT

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Introduction/Background TP53 (Li Fraumeni syndrome, LFS) is located on the short arm of chromosome 17 and plays a fundamental role in the control of cell cycle and apoptosis. LFS (prevalence of 1/15,000–20,000 individuals) only represents 1% of hereditary breast cancer (BC), although it could be responsible for up to 5–8% of BC at early ages.

Methodology Retrospective observational study. Review of patients followed in the inherited cancer unit in a single tertiary centre between 1st January 2012 until 31st March 2022. The statistical analysis was carried out using SPSS 22.0.

Results During the indicated period, we followed 459 patients with confirmed genetic mutations that predispose to developing gynaecological cancer. Of the total, 1.5% (7/459) had LFS. Within this cohort of patients, 5/7 (71.4%) had family history of BC and 1/7 (14.3%) a sarcoma. 4/7 patients were diagnosed with a BC at 30, 35, 36 and 39 years old, respectively. The histology of the primary BC was invasive ductal carcinoma or invasive lobular carcinoma. Tumor stage was I in one case and IIB in three cases. Surgery treatment was: unilateral mastectomy (UM) with homolateral axillary lymphadenectomy (HAL) in 1 patient, conservative surgery with HAL in 1 patient (genetic study and confirmation was after surgery), UM with selective sentinel lymph node biopsy (SSLNB) in 1 patient and bilateral mastectomy with SSLNB and immediate breast reconstruction in 1 patient. Adjuvant treatment was needed in almost all of them: chemotherapy and hormone therapy in one case, radiation therapy in one case (it was before knowing TP53 mutation carrier status), hormone therapy in one case and unknown in one case. Characteristics of these patients are summarized in table 1.

Abstract 2022-RA-1049-ESGO Table 1

TP53 Mutation (n=7)		Frequency(%)
Family history of cancer	No cancer	1/7(14.3%)
	Cancer	6/7(85.7%)
Personal history of cancer (First tumour location)	No cancer	3/7(42.9%)
	Breast	4/7(57.1%)
Histology of the primary breast cancer	Invasive lobular carcinoma	1/4(25%)
	Invasive ductal carcinoma	3/4(75%)
	Stage I	1/4(25%)
	Stage IIB	3/4(75%)
Primary breast cancer treatment	Unilateral mastectomy with homolateral axillary lymphadenectomy	1/4(25%)
	Conservative surgery with homolateral axillary lymphadenectomy	1/4(25%)
	Unilateral mastectomy with selective sentinel lymph node biopsy	1/4(25%)
	Bilateral mastectomy with selective sentinel lymph node biopsy and immediate breast reconstruction	1/4(25%)
Adjuvant treatment	Unknown	1/4(25%)
	Chemotherapy and hormone therapy	1/4(25%)
	Radiation therapy	1/4(25%)
	Hormone therapy	1/4(25%)

Conclusion Patients carrying TP53 mutations have a high risk of developing breast cancer and should be followed in specialized hereditary cancer units, in tertiary hospitals.