**Abstract 2022-RA-463-ESGO Table 1**

Comparative table of diagnostic and test results before and after Brachytherapy

| | Cervical Cancer | | | | Endometrial cancer | | | |
|---|---|---|---|---|---|---|---|---|
| | Value | Min | Max | p | Value | Min | Max | p |
| **Age, mean(SD)** | 44±13 | 21 | 77 | | 56±7 | 45 | 66 | |
| **BMI, mean(SD)** | 28±6.7 | 14.9 | 50.39 | | 30.8±6.9 | 18.6 | 42.8 | |
| **Mean age of first sexual relationship (SD)** | 18±4 | 13 | 38 | | 20±4 | 14 | 25 | |
| **Domestic violence, n(%)** | | | | 0.149 | | | | 0.149 |
| Witness | 12(28%) | | | | 5(42%) | | | |
| Victim | 12(28%) | | | | 6(50%) | | | |
| Agressor | 7(16%) | | | | 2(18%) | | | |
| **Total score SyDSF, mean(SD)** | | | | | | | | |
| Before BT | 16.1±5 | 7 | 31 | | 16±3.5 | 9 | 22 | |
| After BT | 15.3±5.7 | 3 | 29 | | 17±4.9 | 7 | 24 | |
| **Total score CIDQ, mean(SD)** | | | | | | | | |
| Before BT | 17.4±3.8 | 13 | 28 | 0.735 | 19.75±4.8 | 14 | 32 | 0.044 |
| After BT | 17.7±4 | 14 | 31 | | 17±3.5 | 14 | 26 | |
| **Total score PHQ15, mean(SD)** | | | | | | | | |
| Before BT | 8±5.9 | 0 | 24 | 0.080 | 6.9±3.9 | 3 | 17 | 0.235 |
| After BT | 6.5±4.4 | 0 | 18 | | 5.2±2.1 | 2 | 9 | |
| **Physical symtomps, n(%)** | | | | | | | | |
| Physical symptoms presence, *before* | 30(70%) | | | 0.332 | 9(75%) | | | 1.000 |
| Physical symptoms presence, *after* | 25(58%) | | | | 8(67%) | | | |
| **FACT-G, mean(SD)** | | | | | | | | |
| Physical Well-being, *before* | 19.3±6.8 | 0 | 28 | 0.271 | 24.3±2.6 | 20 | 28 | 0.893 |
| Physical Well-being, *after* | 21.6±6.1 | 0 | 28 | | 24.1±3 | 19 | 28 | |
| Social/Family Well-being, *before* | 22.37±5.5 | 10 | 28 | 0.004 | 21.5±6.1 | 10 | 30 | 0.505 |
| Social/Family Well-being, *after* | 20.13±5 | 9 | 28 | | 20.3±5.8 | 11 | 33 | |
| Emotional Well-being, *before* | 15.4±5.6 | 3 | 24 | 0.043 | 17.5±3.8 | 12 | 24 | 0.324 |
| Emotional Well-being, *after* | 16.9±5 | 4 | 24 | | 18.6±4.7 | 10 | 24 | |
| Functional Well-being, *before* | 19.1±5.7 | 5 | 28 | 0.913 | 21.1±3.5 | 16 | 28 | 0.755 |
| Functional Well-being, *after* | 19.1±5.1 | 7 | 28 | | 20.9±3.5 | 13 | 27 | |
| Total score before Brachytherapy | 86.23±16.3 | 31 | 101 | 0.530 | 84.5±11.2 | 68 | 100 | 0.844 |
| Total score after Brachytherapy | 77.8±14.5 | 33 | 104 | | 84.1±12.9 | 62 | 105 | |
| **Total score PHQ9, mean(SD)** | | | | | | | | |
| Before BT | 7.42±6.9 | 0 | 26 | 0.105 | 5±5 | 0 | 13 | 0.413 |
| After BT | 5.6±5 | 0 | 20 | | 3.3 | 0 | 11 | |
| **Depression PHQ9, n(%)** | | | | 0.361/0.713 | | | | |
| Minimal depression, *before* | 20(47%) | | | | 7(58%) | | | |
| Minimal depression, *after* | 20(47%) | | | | 8(67%) | | | |
| Mild depression, *before* | 10(23%) | | | | 1(8%) | | | |
| Mild depression, *after* | 14(33%) | | | | 2(17%) | | | |
| Moderate depression, *before* | 7(16%) | | | | 4(33%) | | | |
| Moderate depression, *after* | 7(16%) | | | | 2(17%) | | | |
| Moderately severe depression, *before* | 2(5%) | | | | 0 | | | |
| Moderately severe depression, *after* | 1(2%) | | | | 0 | | | |
| Severe, *before* | 4(9%) | | | | 0 | | | |
| Severe, *after* | 1(2%) | | | | 0 | | | |
| **Total score HPV, mean(SD)** | 101.2±14.1 | 68 | 124 | | 103.3±12.3 | 79.000 | 120.000 | |

**Conclusion** Sexual dysfunction in gynecological neoplasms has been reported to be as high as 90% in this preliminary analysis; receiving brachytherapy did not significantly modify the prevalence before or after its application. It is important to identify the psychosocial factors in each patient's context to intervene in a timely manner and that each of the women with an oncologic pathology is evaluated in a comprehensive manner.

## 2022-RA-465-ESGO PELVIC EXENTERATION WITH NEUROVASCULAR AND BONY RESECTIONS FOR GYNAECOLOGICAL TUMOURS: A SYSTEMATIC REVIEW

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**Introduction/Background** Pelvic exenteration (PE) with neurovascular or bony resections can be curative in gynaecological oncology, but has significant impact on quality of life (QoL) and high morbidity. The primary outcome of this systematic review was the QoL and secondary outcomes included morbidity and mortality after PE with neurovascular or bony resections.

**Methodology** The protocol was registered in PROSPERO, and included specific search strategies for PubMed, EMBASE, Cochrane Library, Google Scholar, Web of Science and ClinicalTrials.gov. Studies published from 1966 onwards reporting on QoL of patients who underwent PE with neurovascular or bony resections were considered eligible. Study selection, data extraction, rating of evidence (GRADE) and risk of bias (ROBINS-I) were performed independently by two reviewers using Rayyan.

**Results** Of 341 identified records, 10 studies on 89 patients were included: 1 prospective study, 6 retrospective studies, and 3 case reports. All studies were very low quality with an overall serious risk of bias. The primary tumour was located in the cervix (n=42), uterus (n=22), vulva (n=11), vagina (n=3), ovary (n=3), Gartner duct (n=1) or synchronous tumours (n=3). For 4 patients the primary tumour was not reported. Bony resections included the pubic (n=11) and pelvic bone (n=9), hemipelvectomy (n=7), sacrectomy (n=2) and the transverse process of L5 (n=1). Margins were negative in 69 patients and were not reported for 6 patients. 14 patients had positive margins (R1: n=6; R2: n=3; 'positive': n=5). 30-day mortality was 1,1% (1/89). 3 studies reported on improved QoL after surgery, of which only one used a validated QoL questionnaire. Most frequently reported complications were infectious.

**Conclusion** Despite the sparsity of published studies, QoL seems to be improved after PE with neurovascular or bony resections in a highly selected patient group. There is a need for collecting QoL outcomes in a validated and uniform manner.

## 2022-RA-570-ESGO GYNECOLOGICAL CANCER TREATMENT AND COUPLE'S SEXUALITY

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**Introduction/Background** The aim of the study was to explore changes occurring in couples' sexuality after gynecological cancer treatment and to extract those areas that should be thoroughly investigated in study designed to propose interventions to improve couples' sexuality after cancer.

**Methodology** 69 gynecological cancer survivors were eligible for this pilot retrospective cohort study. During the control visit BETTER model was used for sexual counselling. DSM-5 criteria were used to assess female and male sexual dysfunction. Changes is Sexual Function Questionnaire (CSFQ) and Female Sexual Distress Scale (FSDS-R) was used to assess couples' sexuality after treatment.

**Results** 30 couples were finally included in the stud. Six women met the DSM-5 criteria for sexual dysfunction (20.0%). However, sexual distress (FSDS-R) was noted in 46.7%, sexual problems (CSFQ) – in 56.7%. Women survivors had worse attitudes toward sex (3.73 vs 4.48), lower sexual quality of life (63.3 vs 78.55), lower scores in arousal/excitement domain of CSFQ (7.43 vs 10.75), worse perception of their body during sex (1.36 vs 0.72) and lower sexual satisfaction both in self-concentrated and partner-concentrated domain (24.4 vs 53.5 and 28.6 vs 32.1, respectively) compared to male partners. Ten men reported Erectile Dysfunction. A decrease in importance of sex (2.7 vs 3.5), frequency of mutual masturbation (1.9 vs 3.2), and orgasm (2.9 vs 6.9) was showed. A lower satisfaction from women as a lover (3.2 vs 4.3), from sex (3.6 vs 4.1) and lower frequency of orgasm (3.8 vs 7.7) was seen in partners.

**Conclusion** Treatment of gynecological cancer does not decrease frequency of sexual activity but causes changes in its diversity. Differences in perception of sexual function, needs, satisfaction and sexual activity between woman and partner

are noted leading to possible disturbances in couples' s sex life. In cancer survivals with sexual partner both partners should be carefully consulted.

## 2022-RA-605-ESGO LONG TERM QUALITY OF LIFE AFTER CHEMOTHERAPY AMONG RARE OVARIAN CANCER SURVIVORS: THE NATIONAL GINECO CASE-CONTROL *VIVROVAIRE RARE TUMORS* STUDY

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**Introduction/Background** Treatments of non-epithelial rare germ cell tumors (GCT) and sex cord stromal tumors are associated with long survival. They mainly include conservative surgery plus chemotherapy (CT) [bleomycin, etoposide and cisplatin (BEP)] depending on stage and prognostic factors. As reported in testicular cancer survivors, BEP may induce late side effects with negative impact on quality-of-life (QOL). The French Rare Malignant Gynecological Tumors (TMRG)/GINECO case-control study assessed long term QOL among survivors treated with BEP as compared to age-matched healthy women (HW).

**Methodology** Non-epithelial ovarian cancer survivors (nEOCS), cancer-free ≥2 years after end of treatment, were identified from the INCa French Network for TMRG. HW were issued from the 'Seintinelles' research platform. QOL (FACT-G/FACT-O), chronic fatigue (MFI), anxiety/depression (HADS), insomnia (ISI), neurotoxicity (FACT/GOG-NTX), cognition (FACT-COG) and sexuality items (from FACT-O OCS) were compared between nEOCS and HW. A minimal 5% difference of scores between groups was considered as clinically relevant.

**Results** 144 nEOCS (including 112 GCT) plus 144 age-matched HW were enrolled (mean age at inclusion: 38; 60% <40). Median delay from the end of treatments to inclusion was 6 yrs. At inclusion, 42% of nEOCS were menopausal versus 17% of HW ($p<0.001$). General and ovarian QOL, fatigue, anxiety/depression and insomnia scores were similar between nEOCS and HW. Although nEOCS reported clinically significant (6%) better social functioning ($p=0.006$), nEOCS reported more perceived cognitive impairment than HW (31 vs 14%, $p<0.001$) and clinically significant (8%) neurotoxicity ($p<0.001$). They also reported less interest in sex (35% vs 55%, $p<0.001$) and more concern of childlessness (31% vs 13%, $p=0.007$) than HW, whatever the menopausal status.

**Conclusion** 6 yrs after BEP CT, most of nEOCS reported similar global QOL as HW, but they experienced more often premature menopause, some late side effects on cognition, neurotoxicity and sexuality that may impact their daily life.

## 2022-RA-723-ESGO HORMONE REPLACEMENT THERAPY IN GYNECOLOGICAL CANCER SURVIVORS AND BRCA MUTATION CARRIERS: A MITO GROUP SURVEY

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**Introduction/Background** Early menopause in gynecological cancer survivors and BRCA mutation carriers is a major health concern as it is associated with both increased long-term multiorgan morbidity and all-cause mortality. Hormone replacement therapy (HRT) is the most effective remedy but, despite reassuring data on its oncological safety (with due exceptions), it remains underutilized in clinical practice. The Multicenter Italian Trials in Ovarian cancer and gynecologic malignancies (MITO) group promoted a national survey to investigate the knowledge and attitudes of healthcare professionals on prescribing HRT.

**Methodology** The survey consisted of a self-administered multiple-choice online questionnaire, sent via email to all MITO members on January 3, 2022 and available for one month.

**Results** Overall, 61 participants completed the questionnaire. Most respondents (73.8%) were female and 52.5% were gynecologists. Over 80% of specialists usually discuss HRT with patients, especially gynecologists (91%). The percentage of respondents in favor of prescribing HRT was 65% for ovarian cancer, 82% for cervical cancer and 41% for endometrial cancer patients. Around 70% of respondents recommend HRT after prophylactic surgery in BRCA-mutated patients. The main reasons for not prescribing HRT are oncological safety concerns and the failure of women to request it. Less than a half of patients usually ask the specialist for an opinion on HRT. Over 70% of respondents prescribe systemic HRT, while 24% prefer only local HRT. The vast majority of patients generally use HRT for up to 5 years. The major reasons for interrupting HRT are concerns about both oncological and other medical risks.

**Conclusion** Real-world data suggests that many healthcare professionals, especially non-gynecologist oncologists, still do not adequately prescribe HRT for gynecological cancer survivors and healthy BRCA mutation carriers. International guidelines should be implemented to further stress the benefits and safety of HRT and support both specialists in recommending HRT and patients in accepting it.