HORMONAL REPLACEMENT THERAPY AFTER GYNECOLOGICAL MALIGNANCIES – CRITICAL LITERATURE REVIEW

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Introduction/Background Hormone Replacement therapy (HRT) after surgery for gynecological malignancy is controversial. Although the first aim is achieving the best oncological outcome, we must take into consideration quality of life and long-term health outcomes. Most gynecological malignancies are considered hormonal dependent and therefore theoretically there is a risk that HRT increases the risk for recurrence of malignant disease.

Methodology A comprehensive literature research of studies on hormone replacement therapy in gynecological cancer survivors was performed in the Pubmed Database for the literature published in the last 10 years.

Results HRT is contraindicated in survivors of breast cancer, endometrioid type of epithelial ovarian cancer, granulosa cell ovarian tumors, endometrial cancer, leiomyosarcoma and endometrial stromal sarcoma of the uterus. HRT is generally considered safe in epithelial ovarian cancer, vulvar, vaginal and cervical cancer. Caution is needed with adenocarcinoma of the cervix. Some studies seem to support that HRT does not impact negatively on outcome even in endometrial cancer survivors.

Conclusion HRT does not appear to increase the risk for gynecological malignant disease recurrence. Decision for HRT prescribing should be individualised and after patients informed consent. The gynecological-oncological society should encourage more studies and consider about consensus on HRT in cancer survivors to help gynecologist in every day practice and patients with their everyday menopausal issues.

USE OF RADIOThERAPY PLANNING CT SCANS TO PREDICT RISK OF INSUFFICIENCY FRACtURES FOLLOWING PELVIC RADIOThERAPY

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Introduction/Background Published studies quote up to 19.7% of patients treated with radical pelvic radiotherapy (RT) develop pelvic insufficiency fractures (PIF) post-treatment. We hypothesize that the risk is greatest in patients with low bone mineral density (BMD) prior to starting RT, and this could be estimated from the planning CT data.

Methodology We identified 23 patients treated with radical RT for cervical cancer who developed PIF confirmed on imaging. These patients were matched 1:2 to age-stratified controls (nonPIF) who received similar treatment. Hounsfield units (HU) were measured on radiotherapy planning scans using Eclipse treatment planning software, for L2/L4 and L5
vertebral bodies and S1 and S2 vertebrae. HU measurements of the trabecular bone were then converted to quantified CT measurements (qCT) using the equation qCT = 17.8 + (0.7xHU).

T-test for unequal variance was used to assess for statistical difference between the 2 cohorts, with 2-tailed significance testing taken as p≤0.05.

**Results** The 2 cohorts were well matched for age (median 58 years nonPIF vs 59 years PIF) and for BMI (26.5 for nonPIF vs 26 for PIF). There was a consistent trend toward lower measurements of Hounsfield units and calculated qCT values for the PIF group compared to the nonPIF group. The differences reached statistical significance for measurements of sacral bones (see table 1). In the PIF group 96% (22/23) of PIFs were in the sacrum.

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<th>Abstract 2022-RA-1308-ESGO Table 1</th>
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<td><strong>Non PIF</strong></td>
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<td>median qCT L2/L4</td>
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**Conclusion** Pelvic radiotherapy increases the risk of PIFs which can impact on quality of life. The planning CT scan can provide data to help identify patients who are at higher risk. This could allow preventive measures post RT to be considered such as lifestyle advice and bone protection agents.

**SEVERE ANAEMIA FOLLOWING FRONTLINE MAINTENANCE WITH IPARP IN A BRCA1 MUTATED HIGH-GRADE SEROUS OVARIAN CANCER: AN UNEXPECTED FOE**

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**Introduction/Background** Chronic, severe, active Crohn’s disease in a young patient creates surgical complexity with fertility considerations. The rarity of the presentation of intractable pelvic abscesses within this aetiology and their requirement for input from a multi-disciplinary team makes this a vital case in building a consensus for evidence-based management of gynaecological surgery.

**Methodology** A 29-year-old nulliparous woman was referred to our tertiary centre for consideration of surgical management of Crohn’s disease with known tubo-ovarian abscess and abdominoperineal sinuses, with subsequent renal impairment requiring stenting. Her previous surgical history included 4 midline laparotomies, bowel perforation, subtotal colectomy and proctectomy with stoma formation and reformation and a bilateral salpingectomy.

**Results** The patient first underwent egg collection to preserve fertility. This was followed by a midline laparotomy and abdominoperineal resection, which involved an anterior colotomy and a retrograde modified Hudson hysterectomy, alongside refashioning of the ileostomy. Excision and drainage of the abdominal wall abscess was performed alongside excision of the perineal sinus, with reconstruction of the perineal defect using an internal pudendal artery perforator gluteal fold flap. Involvement was sought from gynaecological oncology, colorectal, urology, plastics, stoma, fertility, microbiology, and gastroenterology teams to ensure continued patient optimisation. This multi-disciplinary collaboration resulted in successful preservation of end organ function and improvement in patient psychological well-being.