**Therapeutic Management of Cervical Cancer in Elderly Patients**

Sonia Chaibdra Tani, Soumeya Ghomari. Service d’Oncologie Médicale, CHUT, Damerdji. Laboratoire Toxicomé, Faculté de Médecine, Université de Tlemcen, Tlemcen, Algeria

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Introduction/Background Cervical cancer is the second most prevalent cancer in Algerian woman. The average age of diagnosis is between 45 and 55 years old. Beyond 65 years, mortality is high and the prognosis is poor.

Methodology A retrospective study was carried out at the Medical Oncology Department – University Hospital center Tlemcen, on the files of patients aged 65 years and over treated for cervical cancer, during the year 2020.

Results Four patients were included. The mean age of the patients was 71 years [65–74]. Two patients were diabetic and the other two were hypertensive. The reason for consultation was abdominal pain and metrorrhagia. The average diagnostic time was 3.4 months [1–5]. The histological type was squamous cell carcinoma in 100% of cases. The tumor was classified according to the FIGO classification: IIB [1], IIIA [1], IIIB [2]. After oncogeriatric evaluation, concurrent chemotherapy radiotherapy was given to the four patients. The choice of treatment depended on creatinine clearance, one patient received weekly Cisplatin and we used carboplatin (AUC 2) for others. The safety profile was good, with an average overall survival of 18 months [6–23].

Conclusion Treatment decisions in older patients are complex due to frequent comorbidities and age-related impairments but the use of geriatric evaluation seems to be useful in identifying patients suitable for treatment.

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**Cervical Cancer in Pregnancy: What are the Challenges?**

Felicia Elena Buruiana, Tejumola Olaoye, Miski Scerif, Zara Pervaiz, Kavita Singh. Gynaecological Oncology, PaBirmingham Gynaecological Cancer Centre, Birmingham City Hospital, Birmingham, UK

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Introduction/Background Cervical cancer in pregnancy is a rare event, however it is the most common malignancy diagnosed in pregnancy. The management of the cervical cancer in pregnancy is still challenging as it must take into consideration maternal health, which takes priority, and the foetal outcome. It varies according to the stage of the disease and the gestational age at diagnosis, and it follows the guidelines for the non-pregnant state, expert opinions and few case reports. The prognosis of the cervical cancer in pregnancy is not influenced by the pregnancy.

Methodology We present 3 cases of cervical cancer in pregnancy who were diagnosed and treated in our department, and their outcomes. All the 3 cases were locally advanced cervical cancer, IB1, IIB and IB2 respectively.

Results To date, all the 3 women in this case series are doing well, being under the follow up as per guidelines.

Conclusion Cervical cancer in pregnancy, regardless the gestational age at which it is diagnosed, requires an immediate multidisciplinary approach including the obstetrician, the gynaecologist oncologist, the nurse specialised in gynaecology oncology, the radiologist, histopathologist, anaesthetist, neonatologist. The counselling of the mother is paramount, since the optimal maternal treatment must be balanced versus foetal outcome. The main aim in managing pregnancies complicated by cervical carcinoma shall be balancing the benefit over the harm, as well the quality of life for mother and baby, if the clinical circumstances allow for the pregnancy to be continued. Patients with suspicious lesions of the cervix in pregnancy should be referred for a specialist review and biopsy, if required. The type of treatment and the delivery will be decided based on the histological diagnosis.

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**Impact of COVID-19 on Stage of Locally Advanced Cervical Cancer at Diagnosis in the West of Scotland, April 2020 – March 2021**

Joanna Grech, Ailsa Gemmell, Jennifer Patrick, Rufus Turner, Kathryn Graham. Beatson West of Scotland Cancer Centre, Glasgow, UK

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Introduction/Background Chemoradiotherapy (CCRT) is the gold standard treatment for locally advanced cervical cancer. The COVID-19 pandemic resulted in a UK-wide lockdown in March 2020, potentially limiting access to healthcare. We evaluated stage at presentation of women diagnosed with locally advanced cervical cancer who were referred for radical CCRT over the subsequent 12 months.

Methodology The central radiotherapy prescribing system at a single institution was interrogated to identify patients who commenced radical RT/CCRT from 1st April 2020 to 31st March 2021. Staging information (FIGO 2009 & 2018) was retrieved from corresponding electronic records and compared with a previous treatment period; 1st April 2018 to 31st March 2019.

Results Primary RT/CCRT was delivered to 80 patients in the 2020 – 2021 cohort and 88 patients in the 2018 – 2019 cohort (adjuvant/salvage therapies were excluded). Median age was 53 years (range 30 – 77) and 49 years (range 30 – 82), respectively. The proportion of squamous cell carcinoma was 75%, 2020 – 2021, and 85%, 2018 – 2019. Median tumour size was 51 mm (range 15 – 130 mm) in the 2020 – 2021 period and 44 mm (range 10 – 105 mm) in the 2018 – 2019 period. Stage distribution is illustrated in table 1. * Denotes pelvic/abdominal disease encompassed within radical field.

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**Abstract 2022-RA-1242-ESGO Table 1**

<table>
<thead>
<tr>
<th>Stage Distribution</th>
<th>FIGO 2009</th>
<th>FIGO 2009</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>IB 5%</td>
<td>IB 16%</td>
<td>IB 4%</td>
<td>IB 13%</td>
</tr>
<tr>
<td>Stage II</td>
<td>IA 5%</td>
<td>IA 3%</td>
<td>IA 5%</td>
<td>IA 2%</td>
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<tr>
<td></td>
<td>IB 56%</td>
<td>IB 62%</td>
<td>IB 21%</td>
<td>IB 50%</td>
</tr>
<tr>
<td>Stage III</td>
<td>IA 0%</td>
<td>IIA 0%</td>
<td>IIA 0%</td>
<td>IIA 0%</td>
</tr>
<tr>
<td></td>
<td>IB 11%</td>
<td>IIB 4%</td>
<td>IIB 6%</td>
<td>IIB 4%</td>
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<tr>
<td></td>
<td>IIC1 26%</td>
<td>IIC1 16%</td>
<td>IIC1 16%</td>
<td>IIC1 4%</td>
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<td></td>
<td>IIC2 15%</td>
<td>IIC2 4%</td>
<td>IIC2 4%</td>
<td>IIC2 4%</td>
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<tr>
<td>Stage IV</td>
<td>IVA 56%</td>
<td>IVA 7%</td>
<td>IVA 16%</td>
<td>IVA 7%</td>
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<td></td>
<td>IVB 7%</td>
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</table>

Denotes pelvic/abdominal disease encompassed within radical field.
Conclusion There was no significant difference in median primary tumour size, but more patients had lymph node involvement and stage IVA disease in 2020 – 2021, suggesting a delay to presentation and/or diagnosis. Inclusion of patients with more advanced disease who were directed to systemic anti-cancer therapy or best supportive care would provide a more comprehensive analysis of the effect of the pandemic on cervical cancer stage at diagnosis.

Conclusion Surgical staging in pts without PET-CT uptake in the aortic area does not impact the time to initiation of definitive chemoradiation and is not associated with prolonged total treatment compared with exclusive PET-CT staging. Other factors than surgery should be studied to implement measures to minimize prolonged total treatment times in locally advanced cervical cancer.

Introduction/Background Aortic lymph node involvement represents one of the essential prognostic factors and defines the extent of the radiation therapy. Fluorodeoxyglucose (FDG) positron emission tomography-computed tomography (PET-CT) remains the preferred and most accurate imaging technique to assess the metastatic spread of the tumor. Surgical aortic lymph node staging may be considered in case of negative paraaortic PET-CT uptake to catch up with false negatives. FIGO 2009 staging system is not associated with prolonged treatment delays compared with imaging.

Methodology From 01/2009 to 12/2019, we retrospectively reviewed all consecutive patients (pts) addressed for brachytherapy diagnosed with locally advanced cervical cancer FIGO 2009 stages IB2-Iva with negative PET-CT uptake in the aortic area. Time to initial cancer treatment (TTI), duration of overall treatment time, and total treatment beyond 50 days were analyzed in two cohorts of pts who underwent either surgical or PET-CT staging. Student and Chi 2 tests were used to compare groups.

Results Of 178 pts who underwent surgical staging, metastatic aortic lymph nodes were found in 26 cases (FN rate=14.6%). Among these 26 pts, 12 (46%) did not show pelvic PET-CT uptake, while 14 (54%) did. FIGO 2009 stages were IB2-II for 5 pts (19%), stage III for 20 pts (77%) and stage IV for 1 pt (4%). When analyzing pts with metastatic pelvic nodes, determined with preoperative PET-CT and FIGO 2009 staging system, pelvic lymph node involvement was found in 4/5 pts (80%) of stages IB2-II and 10/20 pts (50%) of stages III.

Conclusion Aortic lymph node dissection is helpful to optimize radiation therapy fields in locally advanced cervical cancer. Pts with stages III and IV and those with stage Ib2-II and positive pelvic lymph nodes seems to present the highest risk of occult aortic involvement. Aortic staging may be omitted in pts with stages Ib2-II without pelvic nodes as the risk of aortic involvement remains low.