

**Conclusion** If the HPV type is not HPV 16 or 18 and the cytology test is normal, co-test is recommended after 1 year. In this study, similar colposcopic biopsy results were found in other high-risk HPV positive cases. When colposcopy is applied widely, more preinvasive disease will be detected in HPV positive cases.

**2022-RA-1352-ESGO DOSE RECEIVED BY AXILLARY LYMPH NODES IN BREAST CANCER ADJUVANT RADIOTHERAPY**

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**Introduction/Background** The axillary region is considered problematic; a risked organ (OAR), a predictive dosimetric parameter of long-term lymphedema, and a residual-disease site in case of breast-cancer radiotherapy. Our study endeavors to determine the dose received by the axillary area in adjuvant radiotherapy for breast-cancer and to assess its clinical impact on long-term lymphedema.

**Methodology** A retrospective dosimetric study, executed in the radiotherapy department of Farhat Hached Hospital, Sousse, included 50 female patients treated with three-dimensional adjuvant radiotherapy for breast-cancer, between 2018 and 2019. The axillary-area was delineated according to the European-Organization for Research and Treatment of Cancer (EORTC) guidelines.

**Results** The average age was 52[30–80]. 64% of our patients had a mastectomy with ipsilateral axillary lymph-node dissection (IALND), while 36% had a lumpectomy with a IALND. 35 patients(70%) received regional radiotherapy and 15 patients(30%) had only local radiotherapy with 2 tangential fields. All the patients were treated with normofractionated radiotherapy dose of 50Gy. Patients with conservative surgical treatment or T4 classified tumors received an additional boost; 66Gy (21patients) and 70Gy for tumoral-surgical limits (1patient). The mean axillary volume was 77.9 cm3[9.4–181]. The mean-dose, the maximal-dose and the minimal-dose received by the axillary region were respectively 28.49Gy [3.19–53.7Gy], 54.18Gy[33.96–72.63Gy] and 9.4Gy[0.32–10.74Gy]. Late complications of lymphedema and radio induced dermatitis (GI and II according to the CTCAEV5.0-scale) were observed respectively in 6(12%) and 17(34%) patients.

**Conclusion** To conclude, the axillary-area received unintentional and significant doses during breast-irradiation; by the tangential fields or the additional supraclavicular field. Some authors consider that the axillary-lateral thoracic vessel junction (ALTJ); that's above level I Berg, as an OAR for long-term lymphedema and its dose can be minimized especially for clinically node-negative patients. Further validation of lymphedema OAR dosimetric parameters by prospective studies is justified.

**2022-RA-1354-ESGO A NEW ALGORITHM MAY HIGHLIGHT BENEFITS FROM ADDING HE4 TO CA125 IN THE PREOPERATIVE ASSESSMENT OF PREMENOPAUSAL PATIENTS WITH PELVIC MASS**

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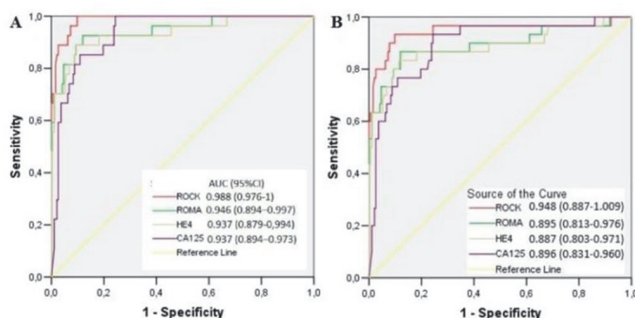
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**Introduction/Background** Recently, ESGO/ISUOG/IOTA/ESGE Consensus Statement on pre-operative diagnosis of ovarian tumors implied that neither Human epididymis protein 4 (HE4) nor Risk of Ovarian Malignancy Algorithm (ROMA) improve the discrimination between benign and malignant masses compared with CA 125 alone. This statement may be reassessed if a novel algorithm, more powerful than ROMA, will be developed. Thereby the aim of this study was to elaborate a new predictive algorithm, based on serum CA125&HE4, which performs better than ROMA

**Abstract 2022-RA-1354-ESGO Table 1 Comparison of the performance of ROCK-I and ROMA**

	Sen. % (95% CI)	Sp. % (95% CI)	Youden-J % (95% CI)	PPV % (95% CI) %	NPV % (95% CI)	Acc. % (95% CI)	LR+ % (95% CI)	DOR (95% CI)	ROC-AUC (95% CI)
<b>Training dataset (using the scenario of discrimination "benign" vs "all stages of EOC and stages Ic2-III of BOT")</b>									
ROCK-I	91.0 (76.9–98.2)	92.7* (88.8–95.7)	83.2 (68.6–89.8)	63.4* (53.0–73.7)	98.6 (96.3–99.6)	92.4* (88.9–95.4)	12.3* (8.0–20.0)	121.1 (35.4–414.1)	0.97 (0.948–0.992)
ROMA	83.9 (68.5–92.6)	83.7* (80.8–89.5)	69.6 (53.4–79.1)	45.2* (33.7–57.2)	97.4 (94.4–98.8)	85.5* (80.9–89.1)	5.9* (4.2–8.3)	31.1 (11.8–82.0)	0.941 (0.9–0.982)
<b>Validating dataset (using the scenario of discrimination "benign" vs EOC)</b>									
ROCK-I	100.0 (85.8–100.0)	92.2* (87.5–95.6)	92.2 (77.7–95.2)	61.5 (49.6–72.2)	100.0 (97.1–100)	93.1* (88.9–96.1)	12.9 (7.9–20.9)	-	0.99 (0.98–1)
ROMA	95.8 (78.9–99.9)	84.5* (78.6–89.3)	80.3 (63.2–85.9)	43.4 (33.3–51.8)	99.4 (96–99.9)	85.7* (80.3–90.1)	6.2 (4.4–8.7)	125.0 (16.3–960.7)	0.965 (0.931–0.999)
<b>Validating dataset (using the scenario of discrimination "benign" vs "all stages of EOC and stages Ic2-III of BOT")</b>									
ROCK-I	96.3 (81.0–99.9)	92.2* (87.5–95.6)	88.5 (73.2–92.8)	63.4 (51.3–73.9)	99.4 (96.3–99.9)	92.7* (88.5–95.8)	12.4 (7.6–20.3)	308.5 (39.1–2434.4)	0.988 (0.976–1)
ROMA	92.6 (75.7–99.1)	84.5* (78.6–89.3)	77.0 (60.1–84.0)	45.5 (37.1–54.1)	98.8 (95.6–99.7)	85.5* (80.1–89.8)	6.0 (4.2–8.4)	67.9 (15.3–301.9)	0.946 (0.894–0.997)
<b>Validating dataset (using the scenario of discrimination "benign" vs "all malignant diseases and stages Ic2-III of BOT")</b>									
ROCK-I	93.9 (76.5–99.1)	92.2* (87.5–95.6)	83.1 (68.9–91.1)	63.4 (51.3–74.0)	98.8 (95.9–99.7)	92.3* (88.0–95.5)	12.0 (7.3–19.6)	154.3 (33.3–713.7)	0.948 (0.887–1.009)
ROMA	89.3 (71.8–97.7)	84.5* (78.6–89.3)	73.7 (58.3–82.0)	45.5 (36.9–54.3)	98.2 (94.9–99.4)	81.1* (80.0–89.5)	5.7 (4.0–8.2)	48.3 (12.9–159.5)	0.895 (0.833–0.976)
<b>Validating dataset (using the scenario of discrimination "benign" vs "all malignant diseases and BOT")</b>									
ROCK-I	82.4 (65.2–93.2)	92.2* (87.5–95.6)	74.8 (58.0–84.3)	65.1 (52.8–75.7)	96.7 (93.3–98.4)	90.8 (86.2–94.2)	10.9 (6.4–17.7)	55.4 (19.8–154.7)	0.894 (0.815–0.974)
ROMA	79.4 (62.1–91.3)	84.5* (78.6–89.3)	63.9 (46.7–75.0)	47.4 (38.3–56.6)	95.9 (92.3–97.9)	83.7 (82.3–85.3)	5.1 (3.5–7.4)	21.0 (8.4–52.5)	0.847 (0.757–0.938)

ROCK-I – ROCK-index (Risk of Ovarian Cancer Index); ROMA – Risk of Ovarian Malignancy Algorithm; CI – confidence interval; Sen – sensitivity; Sp – specificity; Youden-J – Youden Index; PPV – positive predictive value; NPV – negative predictive value; Acc. – accuracy; LR+ – positive likelihood ratio; DOR – diagnostic odds ratio; ROC-AUC – area under receiver operating characteristic curve; EOC – epithelial ovarian cancer; BOT – borderline ovarian tumors



**Abstract 2022-RA-1354-ESGO Figure 1** ROC-curves for ROCK-index, ROMA, CA125 and HE4 in the validating dataset. A) 'benign' vs 'all stages of EOC & stages Ic2-III of BOT'; B) 'benign' vs 'all malignant diseases & stages Ic2-III of BOT'. EOC – epithelial ovarian cancer; BOT – borderline ovarian tumors