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.

Abstract 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 50 Gy. Patients with conservative surgical treatment or T4 classified tumors received an additional boost; 66 Gy (21 patients) and 70 Gy for tumoral-surgical limits (1 patient). 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 28.49 Gy [3.19-53.7 Gy], 54.18 Gy [33.96-72.63 Gy] and 9.4 Gy [0.32-10.74 Gy]. Late complications of lymphedema and radio induced dermatitis (GI and II according to the CTCAEV5.0s-calc) 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.

Abstract 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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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

Abstract 2022-RA-1354-ESGO Figure 1
Methodology A novel algorithm, based on serum HE4, CA125 and patient’s age as variables, has been developed using a training dataset. This algorithm was named Risk of Ovarian Cancer Kazan Index (ROCK-I). The validating group consisted of 227 consecutively operated premenopausal patients with pelvic mass out of which there were 193 cases of benign diseases, 27 cancers and 7 borderline ovarian tumors (BOT).

Results ROCA-I demonstrated two fold less false positive results than ROMA. Thus, in the validating dataset, there was a statistically significant superiority of ROCA-I over ROMA in the specificity (92.2% and 84.5% respectively, p=0.017).

Meanwhile, the sensitivity of ROCA-I was also numerically higher in all the scenarios of discrimination (table 1). When the scenario of discrimination ‘benign disease vs the joint group of EOC (all stages) together with BOT stage Ic2-II’ was used, ROC-AUC of ROCA-I, ROMA and CA 125 were 0.988, 0.946 and 0.937 respectively (figure 1). The difference in ROC-AUC between ROCA-I and CA125 was statistically significant (p=0.01) while the difference between ROMA and CA125 was not (p=0.79).

Conclusion ROMA provides a suboptimal prediction, at least, in premenopausal patients. If a large independent validation shows similar or even slightly lower superiority of the novel ROCA-I over ROMA, it may provide a new basis of routine-use of HE4 in the preoperative assessment of premenopausal patients with pelvic mass.