THE IGCS VIRTUAL TUMOR BOARD IN VIETNAM: AN IMPACT ASSESSMENT OF THE LAST 5 YEARS

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Objective To enhance the expertise of local gynecologic oncologists, the International Gynecologic Cancer Society (IGCS) collaborates with Da Nang Oncology Hospital (DOH) in monthly virtual tumor boards using the Project ECHO model. This study evaluates the impact of this collaboration on the diagnosis and treatment of gynecologic malignancy at DOH.

Methods A retrospective review of patients presented at tumor boards from July 2017 to April 2022 was performed. Each tumor board typically consisted of a presentation of two cases with pathology review, a discussion of management, and a short didactic lecture. We report changes in clinical and pathologic diagnoses, treatments, and outcomes. SPSS 20.0 was used for data analysis.

Results 107 cases were presented at 54 tumor boards: 43 ovarian, 23 cervical, 17 uterine, 16 vulvar and vaginal cancers, 4 gestational trophoblastic neoplasia, and 4 other gynecologic diseases. Tumor board discussion changed clinical diagnosis in 15.9%, pathologic diagnosis in 30.8%, and treatment in 74.8% of cases. 103/107 patients agreed with the treatment selected by tumor board. Complete response rate was 75.4%, partial response in 30.8%. The mean duration of treatment delay due to tumor board was 8.9 ± 7.4 days, with 97.2% being less than 4 weeks late.

Conclusions Project ECHO facilitates access by patients in low-middle income countries to best-practice care. Virtual tumor boards improve the diagnosis and treatment of gynecologic cancer patients in low-resource settings without significantly delaying treatment.

JEHOVAH’S WITNESSES PATIENTS WITH GYNECOLOGIC MALIGNANCIES IN JAPAN

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Objectives Jehovah’s Witnesses (JW) do not accept blood cell transfusions. In gynecological malignancies, such as cervical cancer and endometrial cancer patients have the risk of severe anemia with genital bleeding from the lesion. We have to select the best therapy individually for each JW patient. In Japan, institute or hospital that accept JW patients is very few. We reviewed JW patients with gynecological malignancies in our hospital.

Methods We reviewed the medical chart of JW gynecological cancer patients from 2017 to 2022. All patients signed the ‘Blood transfusion rejection’ form.

Results We had 33 JW patients (3 cervical, 15 endometrial, 12 ovarian, 1 vaginal and 1 peritoneal cancer). 8 advanced and 3 recurrent. Eleven patients died of cancer (1 cervical with stage IV, 2 ovarian with clear cell, 5 ovarian with advanced or recurrent, 1 endometrial with stage III, 5 endometrial with stage IV or recurrent disease and 1 stage IV peritoneal cancer).

Conclusions One third patients had advanced or recurrent cancer. Their prognosis was poorer than non-JW patients maybe because of their advanced disease. Most patients visited nearby hospital and were diagnosed malignant disease but they were not accepted because of JW. And then visited our hospital far from their home. Japanese Supreme Court has some precedents and some medical society of Japan have the recommendations for JW. Although, many hospitals reject JW patients to treat or operate in Japan. We have to treat cancer patients with best medical care including ‘best supportive care’ according to their social, economic, familial, and religious background.

ETHNIC DISPARITY IN CERVICAL CANCER STAGE AT DIAGNOSIS IN AN ISRAELI REFERRAL-CENTER

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Objectives We aimed to compare stage and stage-specific survivals of cervical cancer among Jewish and Arab women in a referral medical center in Israel.

Methods Consecutive patients with cervical cancer treated in a single institution between 2011–2021 were identified. A comparison between Jewish and Arab women included demographic, pathologic and clinical factors. Factors related to advanced stage (≥2B) were determined by regression analysis. Stage-specific survival was compared using the Kaplan-Meier method.

Results Included were 288 Jewish and 66 Arab women. Histology was Squamous-cell carcinoma in 2/3 of the cases in both groups. The groups did not differ in mean BMI, age at diagnosis and menopausal status. Arab women had higher parity. Arab ethnicity was related to a higher risk of advanced stage at diagnosis (54.5% vs. 70.3%, HR 1.97, 95% CI 1.10–3.54, p = 0.021). In multivariate regression analysis, older age (OR 1.02, 95% CI 1.007–1.047, p = 0.008), and Arab descent (OR 2.27, 95% CI 1.05–4.89, p = 0.036) were found to be associated with an advanced stage. Adenocarcinoma histology was independently negatively associated with advanced disease (OR 0.32, 95% CI 0.15–0.70, p = 0.004). During median follow-up period of 25 months (interquartile range 9–97 months), 88 patients died and 35 progressed. Stage-specific survival was similar among the ethnic groups.
Conclusions Advanced stage at diagnosis was more prevalent in Arabs compared to Jewish women with cervical cancer, whereas stage-specific survival was similar. Possible attributing factors to the observed disparity, such as: health-care access, socioeconomic status, education, culture, molecular and genetic mechanisms, should be further investigated.

Objectives To evaluate racial differences in long-term survival of stage III ovarian cancer patients treated on clinical trials.

Methods Data on patients with optimally cytoreduced stage III ovarian cancer from three Gynecologic Oncology Group prospective clinical trials (GOG 114, 158, 172) were utilized. Chi-squared and multivariate Cox models were employed for analyses.

Results Of 1,432 patients, 94.1% were White (n=1,347) and 5.9% Black (n=85). Compared to Whites, Blacks were younger, (64.7% less than age 57 vs 47.7%, p=0.002) and had more mucinous (7.1% vs 1.9%) and endometrioid (12.9% vs 10.2%) histologies (p=0.011). There was no difference in extended long-term survival (>15 year) for Blacks vs. Whites with regard to progression free survival (PFS, 10.6% vs. 15.1%, p=0.352) or overall survival (OS, 20.0% vs. 23.8%, p=0.245). On multivariate analysis, younger age (HR 0.82; 95% CI [0.73,0.93]; p=0.002), endometrioid histology (HR 0.69; 95% CI [0.56,0.86]; p<0.001), and grade I tumors (HR 0.64; 95% CI [0.51,0.80]; p<0.0001) were independent predictors of improved survival. However, race was not predictive of PFS (HR 1.11; 95% CI [0.87,1.40]; p=0.40) or OS (HR 1.17; 95% CI [0.91,1.50]; p=0.22) after adjusting for clinical factors.

Conclusions Black and White patients with optimally cytoreduced stage III ovarian cancer treated in clinical trials had comparable long-term survival. Younger age, endometrioid histology, and lower grade predicted improved survival outcomes.

E-poster viewing: Surgical techniques and perioperative management

A case control study to compare effect of perioperative wound infiltration system vs postoperative opioid installation along with GA in elective gynecologic oncology surgery

Objectives Black patients with uterine cancer are less likely than White patients to be diagnosed with localized tumors. To inform reasons for such disparity, we compared the quality of diagnostic evaluation received by Black versus White patients with uterine cancer.

Methods Using 2008–2019 MarketScan Multi-State Medicaid Database, we identified 858 Black and 1,749 White patients with uterine cancer presenting with abnormal uterine bleeding (AUB). Quality of diagnostic evaluation was measured by delayed diagnosis (time between AUB reporting and uterine cancer diagnosis >1 year), not receiving guideline-recommended diagnostic procedures, and delayed time to first diagnostic procedure (time between AUB reporting and first diagnostic procedure >2 months). The association between race and the quality indicators was examined by logistic regressions adjusting for patient age, concurrent gynecologic conditions, comorbidities, and other characteristics.

Results Black patients were more likely than White patients to experience delayed diagnosis (11.3% versus 8.3%, p=0.01; adjusted OR, 1.71, 95% CI, 1.27–2.29) or to not receive guideline-recommended diagnostic procedures (10.1% versus 5.0%, p<0.001; adjusted OR, 1.94, 95% CI, 1.40–2.68). Even when they did receive recommended diagnostic procedures, Black patients were more likely than White patients to experience delay in time to first diagnostic procedure (10.9% versus 9.1%, p=0.16; adjusted OR, 1.46, 95% CI, 1.09–1.97). A lower proportion of Black than White patients underwent hysterectomy (32.4% versus 39.6%, p<0.001) and transvaginal/pelvic ultrasound (61.8% vs. 73.3%, p<0.001).

Conclusions Black and White patients with uterine cancer differed in the quality of diagnostic evaluation received, which may be one plausible reason for their disparity in stage at diagnosis.

Racial disparities in diagnostic evaluation of uterine cancer among Medicaid beneficiaries

Objectives Black patients with uterine cancer are less likely than White patients to be diagnosed with localized tumors. To inform reasons for such disparity, we compared the quality of diagnostic evaluation received by Black versus White patients with uterine cancer.

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