trimester. The most common presenting complaint was vaginal bleeding (37.4%) and the commonest complication was hyperthyroidism (16.6%). Twenty-six (11.2%) patients required blood transfusion. Seventeen patients (7.2%) required a second evacuation due to ongoing bleeding with 4 patients (1.7%) requiring a hysterectomy due to excessive haemorrhage. Patients with GTD normalized their HCG at a median time of 12 weeks post evacuation. There were 40 cases of persistent trophoblastic disease (PTD), all of whom had HCG levels above 6000 mIU/mL and 4000 mIU/mL at 4 weeks and 8 weeks respectively. Almost 45% of patients never completed follow-up.

Conclusions The incidence of GTD within our centre is declining but remains an important cause of morbidity as it mainly affects the reproductive age. We strongly recommend a revised follow up protocol to accommodate patients with complex socio-economic backgrounds as the current protocol seems to be associated with an increase rate of loss to follow up.

Abstracts

TREATMENT OUTCOME OF GESTATIONAL TROPHOBLASTIC NEOPLASIA PATIENTS IN BANGLADESH: AN EXPERIENCE IN A TERTIARY REFERRAL HOSPITAL

Objectives Gestational trophoblastic disease (GTD) is a group of disorders that arises from placenta, including the premalignant complete and partial hydatidiform moles and malignant invasive mole, chorio carcinoma, PSTT and ETT. The current staging system for GTN combines both anatomic staging and a prognostic scoring system using a variety of clinical factors. So, objective of study were to see the response of treatment of GTN patients, to see the disease free survival (DFS) and overall survival (OS) of patients and prognostic factors affecting the response of treatments.

Methods Observational study

Results A total 86 patients were included. Median age 29,50 years. Persistent GTN is the most common 23.3% than chorionicarcinoma (23.3%). FIGO stage I and lung metastasis were the most common. According to GTN types, median DFS time overall was 48 months and OS time was 65 months but there were not significant. Significant association with GTN types with antecedent pregnancy and β HCG level but insignificant with tumor size. WHO prognostic score significantly associated with diagnosis to treatment interval (p=0.003), largest tumor size (p=0.005), number of metastasis (p=0.000), previously failed chemotherapy (0.000) but age, antecedent pregnancy and β HCG level were insignificant. A total of 10 patients died during course of their treatment mainly due to advanced metastatic disease and treatment complications. In low risk patients, overall treatment response was 92.85% and in high risk overall treatment response was 80%. Overall complete remission was achieved in 86.4% of patients.

Conclusions GTN is a significant source of maternal morbidity with increased risk of mortality.

THE EFFICACY OF SECOND CURETTAGE IN THE TREATMENT OF LOW-RISK GESTATIONAL TROPHOBLASTIC NEOPLASIA: A SYSTEMATIC REVIEW AND META-ANALYSIS

Objectives Patients with low-risk gestational trophoblastic neo- plasia (GTN) are almost universally cured with chemotherapy, but second uterine curettage has been explored as an alternative to avoid chemotherapy-related toxicities. We systematically reviewed intervention studies to determine whether second curettage in patients with low-risk GTN affects: 1) the proportion of patients requiring chemotherapy; 2) the number of chemotherapy cycles; and 3) the need for multi-agent chemotherapy.

Methods A literature search was performed including the Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, and Web of Science. Two authors screened titles, abstracts, and full texts and abstracted data. Risk of bias was assessed for each outcome. Data were pooled using a random-effects model and assessed for heterogeneity. Quality of evidence was assigned using GRADE.

Results Six studies met inclusion criteria; 2 randomized studies (RCT) and 4 non-randomized studies (NRS). Mean difference in number of chemotherapy cycles was 2.04 fewer in patients who underwent second curettage (95% CI -5.00 to 0.91) based on two pooled RCTs (N=138). Those who underwent second curettage had RR=0.60 (95% CI 0.31 to 1.18) for requiring chemotherapy based on 4 pooled NRS (N=1105), and RR=1.17 (95% CI 0.76 to 1.80) for multi-agent chemotherapy based on two pooled NRS (N=900). The certainty of evidence is very low due to risk of bias for potential confounding, selection bias, missing data, and inconsistency of the results.

Conclusions Second curettage may reduce the need for chemotherapy in patients with low-risk gestational trophoblastic neoplasia but the evidence is very uncertain.

PSYCHO-EMOTIONAL REHABILITATION OF PATIENTS OF FERTILE AGE WITH GESTATIONAL TROPHOBLASTIC DISEASE

Objectives To study clinicopathological, psycho-emotional features of different forms of gestational trophoblastic disease in Uzbekistan.

Methods A total of 150 patients with GTD were studied. Of these, 43 (76.8%) had complete hydatidiform mole (HM), 13 (23.2%) had partial HM, 26 (17.3%) had placental trophoblastic tumor, 56 (37.3%) had invasive HM, and 18 (12%)...
patients had choriocarcinoma. An informed consent questionnaire was analysed. The questionnaire included patient data, demographic data, socioeconomic information, and information on the patient's current condition, information on the reasons for treatment delay, medical history, and patient health awareness.

**Results** The most common reasons for delaying treatment were: after the curettage they didn't explain what to do next, which specialist to contact – 64%, the patient's opinion that it was just a miscarriage – 49%, lack of money – 34%, there were no available places in hospital – 39%, did not want the family to know about the recommended chemotherapy – 38%, family problems – 47%. History and psychological aspects: in 63% of cases women did not share their problem with others; fear of infertility after chemotherapy was the reason for delaying chemotherapy in 58% of cases.

**Conclusions** Psycho-emotional factors are of considerable importance in the full diagnosis and adequate treatment of HM. Monitoring principles for women after evacuation of a HM should be standardized. Further research on the epidemiology of HTD in Uzbekistan is needed. There are no unified surveillance centers for this disease.

**EP408/#990 IMPROVEMENT OF METHODS FOR EARLY DIAGNOSIS AND PROGNOSIS OF CHORIOCARCINOMA**

1Malika Mamatova*, 2Nargiza Zaitova, 3Zarifa Islamova. 1Andijan State Medical Institute, Gynecology, Andijan, Uzbekistan; 2Republican Specialized Scientific-Practical Medical Center of Oncology and Radiology, Tumors of The Women's Reproductive System, Tashkent, Uzbekistan; 3Republican Specialized Scientific-Practical Medical Center of Oncology and Radiology, Gynecological, Tashkent, Uzbekistan

10.1136/ijgc-2022-igcs.497

**Objectives** Purpose: to identify a prognostic biomarker indicating a possible malignant transformation of hydatidiform mole. Material: 71 patients with gestational trophoblastic disease (GTD) were divided into 3 groups: 27 samples of hydatidiform mole (HM), 23 – of invasive hydatidiform mole (IHM), and 21 - of choriocarcinoma (CC). 25 women with an uncompleted pregnancy (UP) – control group.

**Methods** Immunohistochemistry (IHC) of CLIC1 protein

**Results** The IHC study of CLIC1 antigen in 1 group showed: 13 (48.1%) – negative, 8 (29.6%) – weak staining, 4 (14.8%) – moderate staining and 2 (7.4%) – strong staining. It was concluded that 7.4% patients had a high risk of malignant transformation. In group 2, 23 patients with IHM: 1 case (4.3%) – no reactivity, 3 cases (13%) – weak staining, 8 cases (34.7%) – moderate staining and 11 cases (47.8%) – strong staining of cells. The results showed that high expression of CLIC1 protein in the nuclei of cytrophoblasts was observed in almost 48% of cases. Group 3 results: 1 case (4.7%) – weak staining, 2 cases (9.5%) – moderate staining, and 18 samples (85.7%) – strong staining, no negative result was observed in any case. IHC study of control group: 18 (72%) – no expression, 7 (28%) – weak staining. No moderate or strong staining of cells was observed.

**Conclusions** The level of CLIC1 activity is increased in malignant-transformed cells and is expressed in the nucleus and cytoplasm of trophoblastic cells. Thus, CLIC1 can serve as a prognostic marker for early detection of malignant transformation of HM.

**EP409/#892 GESTATIONAL TROPHOBLASTIC NEOPLASIA: A TUNISIAN RETROSPECTIVE STUDY**

Ines Lajnaf, Aila Latrous, Yosra Benazaqa, Haifa Rachid*, Nouria Daoud, Nesrine Mejri, Hamouda Boussen. Abderrahmen Mami Hospital, Medical Oncology, Ariana, Tunisia

10.1136/ijgc-2022-igcs.498

**Objectives** Gestational Trophoblastic neoplasia (GTN) are rare with good prognosis malignancies. We aimed in our study to evaluate clinicopathological and therapeutic characteristics and outcomes of GTN in the Tunisian context.

**Methods** We conducted a retrospective monocentric study including 29 Tunisian patients with GTN between January 2013 and May 2022. Clinicopathological Data, treatment and outcomes were collected from medical records.

**Results** Patients were under 40 years old in 55% of cases. One patient (4%) presented hemorrhagic shock which was controlled by hysterectomy. Previous pregnancies were hydatiform mole, abortion and full term pregnancy in respectively 14%, 21% and 65%. Metastatic disease was reported in 38% of patients. Metastases occurred in lung in 34% of cases and brain in 4%. Choriocarcinoma was diagnosed in 24% of cases. Interval between index pregnancy and chemotherapy was under 4 months in 71.4% of cases. High risk disease (FIGO score ≥7) was reported in 39% of cases who received EMA-CO (etoposide, methotrexate, actinomycin D, cyclophosphamide, vincristine) regimen. All patients with low risk disease received methotrexate (MTX) regimen. Median number of cycles until normalization of HCG level was 5 cycles [2–12]. Consolidation courses were received in 55% of cases. Reascension of HCG level was reported in 3 cases, 2 of them after MTX regimen. Salvage regimen were EMA-CO and BEP (bleomycin, etoposide, and cisplatin). After a median follow up of 72 months [12–120], all patients were alive.

**Conclusions** Epidemiological and clinical characteristics and therapeutic outcomes of our study population are concordant with literature.

**EP410/#198 STRATIFIED WHO RISK SCORE AND CHEMOTHERAPY RESPONSE IN GESTATIONAL TROPHOBLASTIC NEOPLASIA**

1Shalini Rajaram*, 2Ayush Heda, 3Amit Sehrawat, 4Deepak Sondhi, 5Jaya Chaturvedi, 6Anupama Bahadur, 7Amrita Gaurav, 8Rajlaxmi Mundhra, 9Kavita Khokwal, 10Latika Chawla, 11Parmod Kumar. 1All India Institute of Medical Sciences, Rishikesh, Obstetrics & Gynecology (gynecologic Oncology), Rishikesh, India; 2All India Institute of Medical Sciences, Rishikesh, Medical Oncology, Rishikesh, India; 3All India Institute of Medical Sciences, Rishikesh, Obstetrics & Gynecology, Rishikesh, India

10.1136/ijgc-2022-igcs.499

**Objectives** Grey zones exist in the management of gestational trophoblastic neoplasia(GTN). An analysis stratified into four risk groups is presented.

**Methods** Retrospective descriptive study of WHO risk groups; low risk(s0); low(0–4) and intermediate(5–6), high risk(≥7); high(7–12) and ultra-high risk(≥13). Chemotherapy regimens, cycles for remission, side effects and cumulative delay were assessed.

**Results** Of 22 cases of GTN, 13.6%(n=3) were low risk, 36.4%(n=8) intermediate risk, 40.9%(n=9) were high risk and 9.1%(n=2) ultra-high risk. Presentations included vaginal bleeding 90.9%(n=18), lung metastasis 50.0%(n=11) and...