

22.9%), BRCA 2 in 36 (8.7%), and variants of unknown significance in 77 (18.6%) patients. PARP inhibitors were used sparingly initially due to non availability and later due to high cost.

Conclusion The mainstreaming of counselling accelerated the testing in patients, but its effective use in treatment can only be possible through affordable pricing of the drug.

Disclosures NO conflict of interest

#640 EXPERIENCE OF DEVELOPING A NATIONAL TRAINING CURRICULUM IN GYNAECOLOGICAL ONCOLOGY IN INDIA

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Introduction/Background Formal training in Gynaecological Oncology (GO) in India started in 2011 with only one candidate for the degree of MCh at Tata Memorial Hospital, Mumbai. A few other University affiliated hospitals also started MCh program in the following years. The number of trainees were grossly inadequate compared to the large demand for service. The training curriculums at the different institutions were also diverse. It was strongly felt that a national curriculum for this super-speciality training was necessary. This article explores how the national curriculum was developed and implemented for training in GO in India.

Methodology The author, a key member of the team of experts assigned to develop the national curriculum, while developing a GO service at a newly built cancer institute also developed a training program to meet the demand for a rapidly increasing service and initiate the creation of the next generation of gynaecological oncologists in India.

Results The department of GO at Tata Medical Center, Kolkata (TMCK) started with one consultant in May 2021. Two trainees were recruited through a formal selection process. The structured training program, including theoretical knowledge and practical skills training, was for three years and it was planned to recruit two trainees every year. The training program was remodelled periodically according to the service need at TMCK. The Indian National Board accepted the TMCK curriculum for 3-years post-doctoral course in GO in October 2018. The appraisal system of the TMCK curriculum was changed to an exit examination. The first batch of 6 trainees were recruited in 2019 for four accredited institutions. Currently there are 11 recognised institutes recruiting 18 candidates each year to undergo this training.

Conclusion The model adopted in India can be replicated in countries where there is no structured national curriculum in GO.

Disclosures None

#677 REGIONAL IMPLEMENTATION OF MISMATCH REPAIR DEFICIENCY (MMR) SCREENING MODEL FOR LYNCH SYNDROME IN ENDOMETRIAL CANCER PATIENTS

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Introduction/Background Mismatch Repair (MMR) testing for endometrial cancer (EC) patients was recommended by the National Institute for Health and Care Excellence (NICE) October 2020 guidance as a screening tool for Lynch syndrome (LS). The North-East of England regional cancer care alliance implemented this guidance in aims to identify EC patients with suspected LS. This project evaluated the efficacy of MMR screening model via immunohistochemistry (IHC) testing for the MMR markers: MLH1, PMS2, MSH2, and MSH6 by reviewing our experience of implementing this MMR testing for LS screening in EC care.

Methodology Retrospective analysis of all newly diagnosed EC patients referred for Multi-Disciplinary Team review from six NHS trusts in the North-East of England and North Cumbria was performed, and we assessed the status and outcome of MMR testing in this cohort.

Results The status and outcome of MMR testing were collected and analysed in 202 patients, and it was shown that 97% (195) of the examined population had their MMR status reported. Approximately 73% of eligible patients for MMR testing were shown to be MMR-proficient and therefore did not require further testing. Using this screening model, at least 5% of the eligible EC patients were identified to be at risk for LS and needed referral to specialist clinical genetics service for germline testing.

Conclusion In the North-East of England region, MMR screening rate in EC remains over 95%, consistent with our pilot data from the screening project's initial implementation period in 2021. The implementation of this screening model in the region has proven to be effective in identifying EC patients with suspected LS, supporting the importance of this screening model in EC care.

Disclosures -

#689 GYNAECOLOGICAL ONCOLOGY SERVICES IN INDIA: WHERE DO WE STAND AS HEALTH CARE PROFESSIONALS?

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Introduction/Background Providing optimal care for patients with Gynaecological malignancies including screening requires insight into the preferences of the women specially in relation to their health care providers. The aim of this study was to understand the health care preferences of the women in a lower middle income country setting in relation to gynaecological cancers.

Methodology Qualitative study with semi-structured interviews was conducted among 30 women attending the Obstetrics and Gynaecology Out Patient Department (OPD) of a tertiary care centre in India. In-depth interviews were conducted until data saturation was achieved. Interviews were transcribed verbatim, coded and analysed thematically. Framework approach was used to summarize the data.

Results The age of the study participants ranged between 24 and 63 years. Pivotal themes which emerged from the interviews were physician and nursing staff attitudes, open communication, affordable and easily accessible services and also gender of the treating gynae oncologist. As most of the participants were not aware of the spectrum of gynaecological cancers, a major facilitator was open communication by a