EP377/#1514 FIRST IMPLEMENTATION OF HPV SELF-SAMPLING IN VIETNAM: AN ASSESSMENT OF ACCURACY AND FEASIBILITY

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Introduction WHO recommends HPV self-sampling as a safe and highly accepted additional strategy in cervical cancer screening for women aged 30–60 years [1]. Currently, no research on HPV self-sampling has been conducted in Vietnam. This study aims to evaluate the accuracy, acceptability, and women's experience of HPV self-sampling compared to healthcare provider collection at Da Nang Oncology Hospital.

Methods A cross-sectional study was conducted at Da Nang Oncology Hospital from April to June 2023 for women aged 30–65 years. HPV self-sampling was performed using Copan Self Vaginal FLOQSwabs prior to physician-collected HPV on the same day. Samples were preserved in Thinprep PreservCyt and analysed by Roche Cobas 4800.

Results The study included 108 cases, for which the sample-inadequacy rate was 4.6% (5/108 cases). Patient's mean age was 44.0 ± 8.1 with 75.0% aged 30–49 years. Among 103 qualified cases, positive rates for HPV16, HPV18 and 12 other high-risk HPV types were 0.97%, 0% and 2.91% respectively in self-collected versus 0.97%, 0.97% and 2.91% in physician-collected samples. The accuracy of HPV self-sampling was 99.0% when using physician-sampling as a reference (102/103 cases). 50.0% of women preferred self-collection, 44.4% preferred physician-collection, and 5.6% had no preference. 77.8% believed healthcare provider-sampling was more accurate than self-sampling. Only 8.3% reported painful experience and 9.3% encounted difficulty with self-sampling. The majority (91.7%) would choose HPV self-sampling at home for next screening and 96.3% would recommend it to other women.

Conclusion/Implications HPV self-sampling is an accurate and highly acceptable approach for Vietnamese women to improve the cervical cancer screening rate.

EP378/#519 CERVICAL CANCER PREVENTION PROGRAM IN NEPAL: A COMPREHENSIVE 'TRAIN THE TRAINER' APPROACH

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Introduction Cervical cancer is a leading cancer in Nepal. Lack of access to screening and trained health professionals to manage preinvasive and invasive cervical disease contributes to high cancer incidence and mortality.

Methods Cancer Care Nepal (CCN) and MD Anderson Cancer Center (MD Anderson) partnered to implement a 'train the trainer' (TOT) program to teach cervical cancer screening and management. TOT courses were held for specialists from five institutions throughout Nepal to learn how to deliver these trainings. Each participating institution then held local courses for nurses and doctors. The training was complemented with monthly Project ECHO® (Extension for Community Healthcare Outcomes) telementoring videoconferences.

Results Two TOT and five local training courses were held for providers from 20 centers from November 2021 to October 2022. During COVID-19 pandemic travel restrictions, the MD Anderson faculty joined the courses and provided didactics virtually. In-person, hands-on training using simulation models to teach VIA, colposcopy, ablation and LEEP were led by the Nepalese faculty. The 173 participants included 28 gynecologists, 4 gynecologic oncologists, 1 medical oncologist, 22 general practitioners, and 118 nurses. 126 (73%) completed the pre- and post-course surveys with 86% of respondents expressing their desire to make changes in their practice as a result of the courses. In 2022, CCN became a Project ECHO hub and has held 12 sessions with approximately 20 participants from 11 centers per session.

Conclusion/Implications Our TOT and local training courses have increased the reach of training, with the goal of decreasing the burden of cervical cancer in Nepal.

EP379/#991 PILOT IMPLEMENTATION OF HPV SELF-COLLECTION FOR CERVICAL CANCER SCREENING IN COLOMBIA: CHALLENGES OF NON-ORGANIZED PROGRAMS

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Introduction Objective: to assess acceptability and adherence to cervical cancer screening algorithms based on self-collected HPV testing among hard-to-reach women in Colombia

Methods a randomized trial with three arms included: 1) HPV and pap-smear samples collected by clinicians in one visit and followed by colposcopy/biopsy and treatment; 2) HPV self-collection followed by colposcopy/biopsy and treatment; and 3) HPV self-collected followed by ablative treatment. Women 30 to 65 years without history of cervical cancer screening in the previous 3-years were invited to participate. Invitation and sample collection were planned by home visits and by mail. Acceptability was defined as percentage of women tested among invited, and adherence as percentage of women compliant with the diagnostic and treatment workup among HPV-positive women

Results No women could be recruited as planned given the low efficacy for home visits and mail/post. Alternative strategies were implemented including invitation by phone call, in-person invitation in health centers, and screening campaigns. Two hundred and fifteen women were included. The patients recruited in arms 1, 2 and 3 were 68, 72, and 75,

respectively. 4.7% of women of the target population were reached by call, and 21.1% of women attending the screening campaigns were eligible. Acceptability was 74.4%, 94.7%, and 92.8% with the phone calls, in-person invitation, and screening campaigns respectively. the compliance with the diagnostic work-up was 100.0% and 53.3% in arms 1 and 2. Treatment compliance was not assessable

Conclusion/Implications HPV self-collection is highly acceptable; however, coverage of hard-to-reach populations is challenging for scenarios without organized programs

EP380/#723 IS IT NECESSARY TO EXPAND THE SCREENING AGE MARGIN FOR DIAGNOSIS OF CERVICAL CANCER AT A REGIONAL LEVEL? THIRD REGION, CHILE

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Introduction Current WHO recommendation remarks screening with high-performance tests of women with ages between 35–45 years to accelerate the elimination of cervical cancer. Our local cervical cancer screening program recommends PAP screening for women between 25 and 64 years of age.

Methods Retrospective review with statistical database analysis using clinical records, protocols, and biopsies of the gynecology oncology committee of diagnosed patients with cervical cancer between November 2020-April 2023. A bleeding, friable, exophytic lesion in the cervix was considered clinical suspicion.

Results Total of 95 patients with diagnosis of cervical cancer; 19 patients (20%) outside the recommended screening range for age: 17 patients >64 years and 2 patients <25 years. 2 patients referred with atypical pap smear results (unknown reason why PAP was done) and 17 due to clinical suspicion. On the physical examination 95% (18) had an obvious lesion. 3 patients were in stage Figo I (IA2, IB2 and IB3), 6 in stage II (2 IIA2, 4 IIB), 5 in stage III (1 III B, 4 IIIc1) and 4 in stage IV B, 1 in non-specific stage (lymphoma). Histological type: 74% (14) squamous, 21% (4) adenocarcinomas and 5% (1) lymphoma.

Conclusion/Implications We believe this to be an important finding to promote change on the prevention strategy at the regional level regarding the age of screening, since 20% of the population in approximately 3 years demonstrated to have a fatal pathology that is clearly preventable as the studies say due to timely and adequate screening.

EP382/#190 LIMITATIONS OF CERVICAL CYTOLOGY AS A SCREENING TEST IN THE DIAGNOSIS OF CERVICAL CANCER

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Introduction In Japan's Cervical Cancer Screening Guidelines (2020), the cervical cytology alone method is recommended to be performed every 2 years as a cervical cancer screening. On the other hand, its sensitivity and specificity are varied, respectively, and approximately 6% of the results are false-negative. In this study, we investigated the status of cervical cancer screening in the 2 years prior to diagnosis in our cervical cancer cases, and examined risk factor(s) for underestimation by screening.

Methods Cervical cancer patients who underwent initial treatment at our hospital between January 2012 and February 2022 were included in the study. Patient backgrounds (age at diagnosis, previous history, history of vaginal delivery, menstrual history, etc.) and cervical cancer screening status and results in the two years prior to diagnosis were extracted from medical records, and statistical analyses were conducted for patients whose cytological diagnosis was underestimated.

Results There were 323 cervical cancer cases during the study period. Of these, 22 patients (6.9%) were in the underestimated group who had undergone cervical cytology screening in the 2 years prior to diagnosis and had been diagnosed as normal. A history of cervical conization was found in 3 patients (13.6%) of the underestimated group and in 10 patients (3.3%) of the control group (n=301), which was statistically significant (p=0.0175).

Conclusion/Implications It is well known that cervical cancer screening is necessary even after conization for CIN3. Moreover, we hypothesize that results of cervical cytology screening alone may be underestimated in patients with a history of previous cervical conization.

EP383/#755 THE SIGNIFICANCE OF HPV TEST FOR CERVICAL CANCER SCREENING IN LOW-GRADE ABNORMAL CYTOLOGY GROUP USING SOUTH KOREAN DATA

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Introduction This study aimed to evaluate the significance of HPV testing as a screening test for cervical cancer.

Methods Between April 2010 and September 2021, women initially diagnosed with ASCUS or LSIL and having HPV infection were included. They underwent cytology and HPV testing every 6 months until disease progression. Cytology results were categorized as ASCUS/LSIL positive or HSIL positive. HPV infection patterns were divided into high-risk 1 (16, 18, 31, 33, 45, 52, 58), high-risk 2 (35, 39, 51, 56, 59, 66, 68), low-risk 3, and regression 4 (HPV regression within 6 months). Sensitivity for cytology and HPV testing at 1, 2, and 3-year intervals was evaluated, along with Cox analysis for disease progression.

Results Total 1,273 participants were included, and 98 women (7.7%) experienced disease progression. The best AUC for cytology was 0.85 with a sensitivity of 0.735 over 3 years in the HSIL positive group. For HPV testing, the best AUC was 0.778 and sensitivity was 0.765 over 3 years in the high-risk 1 group. Disease progression significantly differed among the HPV groups, with a hazard of 11.4 (p=0.001) in the high-risk 1 group. HPV regression showed no disease progression.