Conclusion/Implications The 2023 FIGO endometrial cancer staging schema is a major revision from the 2009 FIGO schema. Almost doubled enriched sub-stages based on detailed anatomical metastatic site and incorporation of histological information enable more robust prognostication.

Early Career Workshop

**W001/#1412**

**MOLECULAR MARKERS PERFORMED ON ENDOMETRIAL BIOPSY IN CA ENDOMETRIUM (EC) PROVIDES PROGNOSTIC AND PREDICTIVE INFORMATION**

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10.1136/ijgc-2023-IGCS.38

**Introduction** This shift towards a molecular driven Endometrial Cancer classification is an important step to the future precision medicine. These biomarkers could be used in clinical practice for a more individualized management in EC and promoting a personalized therapeutic strategy to avoid over- or under-treatment.

**Aim** To evaluate the role of IHC markers Preoperatively in endometrial biopsies (EB) (ER, PR, HER2, p53, L1CAM, MSI) in determining prognostication in patients with EC

**Methods** Observational study N= 80 patients diagnosed with endometrial cancers between September 2019–September 2021 Site-Tertiary cancer centre India IHC marker expressions in preoperative EB were correlated with post operative histopathological specimen parameters

**Results** Correlation of IHC marker was done with various post surgery pathology parameters and it showed correlation with variable p values suggesting that certain IHC markers correlated with advanced disease and aids in prognostication. ER and PR expression showed correlation with early disease, HER2 score of >10% showed correlation with pelvic lymph nodal involvement and advanced disease, MMR deficient- showed correlation with >50% myometrial invasion and no distant metastases.

**Conclusions** At present to our knowledge this is the first ever study evaluating the role of incorporating IHC in preoperative endometrial biopsies and correlating it with final staging.

**Abstract W002/#1410 Table 1**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>ASHA Workers (n=47)</th>
<th>Clients (n=465)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (in years)</td>
<td>39.47±6.45</td>
<td>37.26±6.38</td>
</tr>
<tr>
<td>Education Illiterate Primary Secondary Graduate Postgraduate</td>
<td>0 (0.0%) 16 (34.0%) 25 (53.2%) 3 (6.4%) 3 (6.4%)</td>
<td>85 (18.28%) 189 (40.65%) 105 (22.59%) 66 (14.19%) 20 (4.3%)</td>
</tr>
<tr>
<td>Occupation Unskilled Semi-skilled Skilled</td>
<td>0 (47/100) 0 378 (81.3%) 77 (16.56%) 10 (2.15%)</td>
<td>36 (7.7%)</td>
</tr>
<tr>
<td>History of cervical cancer screening in past</td>
<td>1 (2.1%)</td>
<td>NA</td>
</tr>
<tr>
<td>Average time taken to counsel (in minutes) Number of repeat training sessions required</td>
<td>26.51±4.18</td>
<td>NA</td>
</tr>
<tr>
<td>Acceptability of self-sampling by clients counselled by different ASHA workers (Clients willing to get HPV sample/Total number of clients counselled by each ASHA)</td>
<td>NA</td>
<td>58.25%</td>
</tr>
<tr>
<td>No of ASHA workers who could counsel following percentage of women &lt;50% 50-90% &gt;90%</td>
<td>10 17 20</td>
<td>NA</td>
</tr>
<tr>
<td>Feasibility (percentage of clients who find it easy/those who did self-sampling)</td>
<td>46 (97.9%)</td>
<td>461 (99.14%)</td>
</tr>
<tr>
<td>Reason of refusal of self-sampling Uncomfortable to self-sample Do not rely on test Feel embarrassed to do the test Just don’t want to do</td>
<td>NA</td>
<td>48.9% 2.1% 4.2% 36.2% 8.6%</td>
</tr>
<tr>
<td>Wants to know result of HPV test by ASHA Physician</td>
<td>NA</td>
<td>443 (95.26%) 22 (4.73%)</td>
</tr>
<tr>
<td>Positive HPV test</td>
<td>5 (10.6%)</td>
<td>51 (11%)</td>
</tr>
<tr>
<td>Visited centre for further management</td>
<td>5/5 (100%)</td>
<td>35/51 (68.6%)</td>
</tr>
</tbody>
</table>

**W002/#1410**

**NOVEL STRATEGY OF TRAINING THE ACCREDITED SOCIAL HEALTH ACTIVISTS (ASHAS) VIA TELEMEDICINE FOR CERVICAL CANCER SCREENING BY HPV SELF-SAMPLING – THE TRACK TRIAL**

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**Introduction** This is a novel, pilot study aimed to analyse training of ASHAs by telemedicine for counselling women for cervical cancer screening by HPV Self-Sampling.

**Methods** This study is a pilot, community-based, prospective, single-arm study. Physicians trained the ASHA workers over telephone using videos, e-pamphlets and video conferencing regarding self-sampling HPV testing, who in turn trained the clients in community. Self-sampling HPV kits were transported via courier.

**Results** 465 women of age group 30–65 years were tested by 47 tele-trained ASHA workers. The mean age of ASHA worker and clients was 39.47±6.45 and 37.26±8.38 years, respectively. Almost half (53%) of the ASHA worker were educated till intermediate standard. The time taken to train ASHA workers via telephone was 26.51±4.18 minutes. 91.7% of the ASHA worker were satisfied with the information provided during tele-counselling. Each ASHA recruited ten clients on average. 95.8% of the ASHAs felt it as easy to explain the clients. The acceptability of this strategy among clients was 56%. The feasibility of this strategy (percentage of clients who find it easy/those who did self-sampling) was 99%. Half of the women (48.9%) cited ‘feeling uncomfortable’ as the reason for not wanting to get screened. Among those
screened, 11% were hrHPV positive and 68% were willing for follow-up. Table 1: Characteristics of ASHAs and Patients

Conclusions

Conclusion: The current study highlights a novel strategy incorporating the role of telemedicine in training ASHA worker for the self-sampling of HPV for cervical cancer screening, with promising results. The study is funded by American Society of Clinical Oncology.

RESOURCE STRATIFIED SECONDARY CERVICAL CANCER PREVENTION: PRAGMATIC APPROACH FOR BASIC LEVEL OF SERVICE

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Introduction

The American Society of Clinical Oncology (ASCO) produced a guideline for Resource Stratified Secondary Cervical cancer prevention that recommended the use of Visual Inspection with Acetic Acid (VIA) only with the goal of developing the basic settings if HPV testing is not available. We hereby present ongoing attempts at instituting organized cervical cancer prevention programs in basic settings.

Methods

We leveraged the pre-implementation activities of the pilot HPV screening of 5,000 women in Kebbi State to train the staff of 3 non-state-owned health facilities: Police Cottage Hospital, Kebbi Command, Haske Dominican Hospital, Dabai and Medical Reception Station, Dukku Barracks. The progress made was assessed against resource stratified secondary cervical cancer prevention in the basic settings.

Results

The cervical cancer screening programs at the three facilities effectively kick started after training within an organized screening program. Although none currently use HPV-based screening due to cost, staff are trained to perform HPV testing and are ready to upgrade if resources permit. All three facilities currently refer screen-positive cases to a tertiary health facility for treatment in a hub-spoke model.

Conclusions

The resource-stratified model offers an opportunity for low-resource settings to establish sustainable cervical cancer prevention services within their economic constraints and prepare facilities for future introduction of HPV screening Program. We proposed a flexible model that allows upgrading to HPV in response to available resources.

SUPPORT FOR STANDARDIZATION: ULTRASOUND RISK STRATIFICATION MODELS ACCURATELY DISCRIMINATE BENIGN FROM MALIGNANT ADNEXAL LESIONS IN THE HANDS OF NOVICE OPERATOR

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Introduction

It is unclear whether ultrasound risk stratification models for adnexal lesions perform well when used by novice providers. We aim to compare the performance of four abstracts with figures and tables.