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.

W003/#1413 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.

W004/#1411 SUPPORT FOR STANDARDIZATION: ULTRASOUND RISK STRATIFICATION MODELS ACCURATELY DISCRIMINATE BENIGN FROM MALIGNANT ADNEXAL LESIONS IN THE HANDS OF NOVICE OPERATOR

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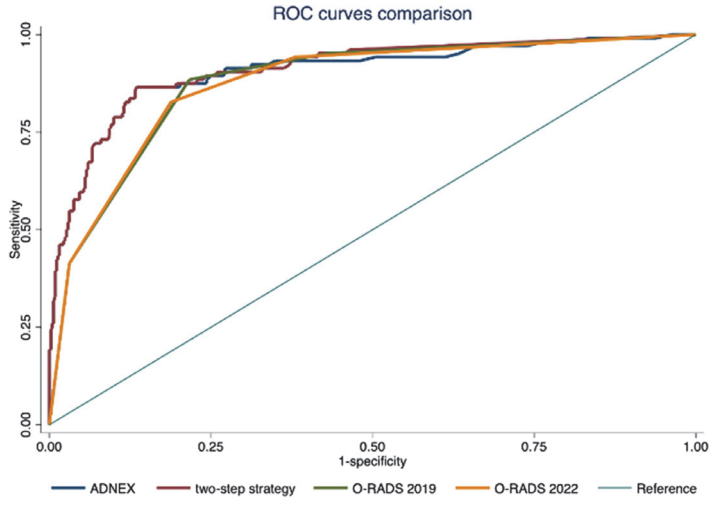
Introduction It is unclear whether ultrasound risk stratification models for adnexal lesions perform well when used by novice providers. We aim to compare the performance of four



	ADNEX	Two-step strategy	O-RADS 2019	O-RADS 2022
AUC	0.9046 [0.8676-0.9415]	0.9106 [0.8773-0.9440]	0.8790 [0.8450-0.9131]	0.8757 [0.8405-0.9110]
Sensitivity	86.54% [83.70-89.38]	86.54% [83.70-89.38]	88.46% [85.81-91.12]	82.69% [79.55-85.84]
Specificity	84.73% [81.75-87.72]	84.96% [81.98-87.93]	78.32% [74.89-81.74]	81.19% [77.95-84.44]
Accuracy	85.07% [81.83-87.93]	85.25% [82.03-88.10]	80.22% [76.66-83.45]	81.47% [77.99-84.62]
PPV	56.60% [52.48-60.72]	56.96% [52.85-61.08]	48.42% [44.27-52.58]	50.29% [46.14-54.45]
NPV	96.47% [94.94-98.01]	96.48% [94.95-98.01]	96.72% [95.24-98.20]	95.32% [93.57-97.08]

Abstract W004/#1411 Figure 1 Diagnostic performance of ADNEX, two-step strategy, O-RADS 2019 and 2022. Above, ROC curves for the four models. Below, AUC, sensitivity, specificity, accuracy, positive and negative predictive values with 95% confidence intervals. Abbreviations: AUC, area under the curve; ROC, receiver operating curve; PPV, positive predictive value; NPV, negative predictive value.

Abstract W004/#1411 Table 1 The calibration (i.e., the observed malignancy rate compared to the expected rate) is shown in Table 1A. Data are reported as number of malignant cases per cell/total number of patients in the cell (cell%). Table 1B describes the clinical and radiological characteristics of malignant cases misclassified as endometrial cancer, GI, gastro-intestinal; na, not available; N, number; US, ultrasound

Table 1A

Expected rate of malignancy	Observed rate of malignancy: ADNEX	Two-step strategy	O-RADS 2019	O-RADS 2022
<1%/score 2	1/46 (2.17)	5/261 (1.92)	5/262 (1.91)	6/286 (2.10)
1-<10%/score 3	13/351 (3.70)	9/137 (6.57)	7/104 (6.73)	12/99 (12.12)
10-<50%/score 4	36/92 (39.13)	36/91 (39.56)	49/133 (36.84)	43/114 (37.72)
≥50%/score5	54/67 (80.60)	54/67 (80.60)	43/57 (75.44)	43/57 (75.44)

Table 1B

ID	1	2	3	4	5	6	7
Risk of malignancy							
ADNEX	0.4%	1.8%	3.8%	4.9%	6.0%	4.2%	1.5%
Two-step strategy	0.4%	BD	BD	BD	BD	4.2%	1.5%
O-RADS 2019	3	2	2	2	2	2	3
O-RADS 2022	3	2	2	2	2	2	2
US characteristics							
Max dimension (mm)	24.2	13.8	54.9	35.3	26.6	51.2	14.0
N Locules	1	1	1	1	1	1	2
Internal wall	irregular	smooth	smooth	smooth	smooth	irregular	smooth
N Papillations	0	0	0	0	0	0	0
Content	anechoic	anechoic	anechoic	anechoic	anechoic	anechoic	anechoic
Shadowing	yes	no	no	no	no	no	no
Color score	1	1	1	1	2	1	1
Age	62	75	52	55	51	62	62
Menopausal status	post	post	pre	post	pre	post	post
CA125 (KU/L)	36	13	na	109	276	na	na
Histology	Borderline clear cell adenofibroma	Serous borderline	Metastatic Lymphoma	Seromucinous borderline	Metastatic GI tumour	Metastatic EC	Serous borderline
Stage	IA	IB	na	IIB	na	na	IA

commonly used models to detect ovarian cancer, when the operator has only basic experience.

Methods Women with adnexal masses treated in 2019 were identified retrospectively. Patients were included if they underwent surgery within 3 months of diagnosis or had at least 12 ±2 months of follow-up. A non-expert operator (European Federation of Societies for Ultrasound in Medicine and Biology level I) classified each lesion using ADNEX, two-step strategy (benign descriptors followed by ADNEX), O-RADS 2019, and O-RADS 2022. The primary outcome measure was AUC [95% confidence interval], compared across the four models.

Results A total of 556 women were included in the analyses: 452 benign and 104 malignant. The AUCs of ADNEX, the two-step strategy, O-RADS 2019, and O-RADS 2022 were 0.90[0.87–0.94], 0.91[0.88–0.94], 0.88[0.85–0.91], and 0.88 [0.84–0.91], respectively (figure 1). The two-step strategy performed significantly better than the O-RADS algorithms (both p=0.01). With all the algorithms, the observed malignancy rate was 1.91–2.17% among lesions categorized as 'almost certainly benign', two-fold higher than the expected <1% (table 1).

Out of the four methods, lesions wrongly classified as 'almost certainly benign' were borderline tumors (n=4) and metastases (n=3).

Conclusions In the hands of a novice provider, all algorithms performed well, and were able to distinguish benign from malignant lesions. ADNEX misclassified only one malignant patient as 'almost certainly benign', compared to 5–6 patients by the other models.

W005/#1415 PROGNOSTIC FACTORS AND SURVIVAL IN ENDOMETRIOID AND CLEAR CELL OVARIAN CARCINOMAS – A RETROSPECTIVE ANALYSIS

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Introduction Endometrioid carcinoma of ovary (ENCO) and clear cell carcinoma of ovary (CCCO) are rare, accounting for < 20% of all ovarian malignancies with a small subset arising in the background of endometrioses. The aim of this study was to analyze the clinico-pathological factors, survival outcomes and prognostic factors for survival in patients treated with ENCO and CCCO.

Methods All consecutive patients diagnosed with ENCO and CCCO between January 2014 to December 2020 were included for this single institution retrospective study. Data was retrieved from the electronic medical records. Time to event data were analyzed using the Kaplan-Meier method. Log rank test and cox regression analysis were used to analyze the effect of different variables on survival.

Results Total 295 patients were included out of which 49.5% (n=146) had CCCO and 50.5% (n=149) had ENCO. Forty-