

Conclusion/Implications We confirmed that the CSGSA discriminated early-stage EOC with high sensitivity and specificity. It is expected to identify early-stage EOC in asymptomatic women before EOC develops to advanced stage.

PR085/#158

PREDICTORS OF LIFETIME CERVICAL CANCER SCREENING AND ASSOCIATION WITH SOCIAL DETERMINANTS OF HEALTH: CROSS-SECTIONAL EVIDENCE FROM THE CANADIAN LONGITUDINAL STUDY ON AGING

¹Melissa Lavecchia*, ²Maura Marcucci, ³Amanda Selk, ⁴Parminder Raina, ⁵Waldo Jimenez, ⁶Andra Nica, ⁷Julie Nguyen. ¹McMaster University, Division of Gynecologic Oncology, Hamilton, Canada; ²McMaster University, General Internal Medicine, Hamilton, Canada; ³University of Toronto, Obgyn, Toronto, Canada; ⁴McMaster University, Health Research Methods, Evidence, and Impact, Hamilton, Canada; ⁵Juravinski Cancer Centre, McMaster University, Hamilton, Gynecologic Oncology, Hamilton, Canada

10.1136/ijgc-2023-IGCS.121

Introduction Cervical cancer screening has resulted in a decrease in the occurrence of and death from cervical cancer. The Canadian Longitudinal Study on Aging (CLSA) prospectively collected health outcomes on >50,000 individuals. We sought to identify the prevalence of Canadian female participants having never undergone cervical cancer screening and the association with social determinants of health.

Methods We performed a cross-sectional analysis from CLSA data. The main outcome was self-report of ever having undergone a pap test. Regression analyses, controlling for the complexity of the design and covariates, evaluated the association between self-reported lifetime cervical cancer screening and social determinants of health.

Results The population-based sample comprised 22,910 participants aged 45–85, of whom 99.8% had available information on cervical cancer screening (n=22,720). The prevalence of never having undergone a pap was 14.1%; weighted prevalence, 11.8% (95%CI 11.0–12.6). Older age_(10-year) (OR 1.5, 95%CI 1.4–1.6), lower education_(low vs. high) (OR 1.5, 95%CI 1.2–1.9) and low household income_(low vs. high) (OR 1.7, 95%CI 1.3–2.3) were associated with absence of lifetime screening. Having a religious affiliation (OR 1.3, 95%CI 1.1–1.5) and never being married/lived in common-law (OR 1.5, 95%CI 1.2–1.9) were also associated with never having undergone screening. Notably, not having a family physician was an important contributing factor (OR 2.3, 95%CI 1.6–3.3). However, of participants who never underwent a pap test, 97% reported having a family physician.

Conclusion/Implications Our analysis highlights inequities in access to cervical cancer screening in the Canadian context. This data can help inform targeted education and empowerment strategies to increase cancer screening uptake.

PR086/#488

CAN HPV SELF SAMPLING BE USED FOR CERVICAL CANCER SCREENING IN INDIA?

Gauravi Mishra*, Sharmila Pimple, Kavita Anand, Vasundhara Kulkarni, Sanjay Biswas, Anil Patil. Tata Memorial Hospital, Preventive Oncology, Mumbai, India

10.1136/ijgc-2023-IGCS.122

Introduction Evidence from high income countries supports HPV-self sampling (HPV-SS) for improving cervical cancer screening coverage. Success of HPV-Self sampling (HPV-SS) in

resource constrained countries like India with diverse population, will depend on developing impactful health education material, generating awareness towards cervical cancer and HPV-SS and on precision in performing test by beneficiaries. The current study was undertaken with objectives to determine knowledge, attitudes and practices (KAP), acceptability, barriers, agreement rates and prevalence of HPV in different population subgroups using varied methods of communication.

Methods The current study enrolled 1600 women in age group of 30–55 yrs, from urban slums (500), urban non-slums (500) and rural (600) settings in Maharashtra, India. Information regarding cervical cancer and steps for collecting self sample was explained by two modalities; health education by trained health personnel in health education arm and through printed pictorial depiction in the pamphlet arm. One sample for HPV testing was collected by health personnel for each participant in both arms.

Results Overall prevalence of HPV was 7.8% with no significant differences across the settings. Overall acceptance of HPV-SS was 98.4%. Awareness regarding cervical cancer and HPV-SS was similar across settings and modalities of education. The overall concordance rates between HPV-SS and health personnel collected sample was 94.8% ($k=0.508$, $CI=0.458-0.559$, $p<0.001$) and was similar across settings. Compliance for clinical assessment of screen positive women and for treatment was 76.8% and 80% respectively.

Conclusion/Implications The study demonstrated that HPV-SS is acceptable, feasible and implementable in India and will assist in improving cervical cancer screening coverage.

PR087/#201

PREVALENCE OF HIGH-RISK HPV DNA IN A SEMI-URBAN POPULATION OF UTTARAKHAND, INDIA USING A POINT-OF-CARE TEST

¹Shalini Rajaram*, ²Shilpa Panta, ³Ayush Heda, ⁴Ajeet Singh Bhadoria, ⁵Latika Chawla, ⁶Himani Bhan, ⁷Varsha Kamath, ⁸Nevetha Ravichandran, ⁹Jaya Chaturvedi. ¹All India Institute of Medical Sciences, Rishikesh, Gynecologic Oncology (Obstetrics and Gynecology), Rishikesh, India; ²AllIMS Rishikesh, Obgyn, Rishikesh, India; ³AllIMS Rishikesh, Community and Family Medicine, Rishikesh, India; ⁴All India Institute of Medical Sciences, Rishikesh, Obstetrics and Gynecology, Rishikesh, India

10.1136/ijgc-2023-IGCS.123

Introduction WHO recommends a framework shift from screening with cytology and visual inspection methods, to detection of HPV DNA as the primary screening test and, endorses vaginal self-sampling as method of collection. This study was planned with the objective to determine the prevalence of HR-HPV 16/31 & 18/45 in vaginal samples using a real-time micro-PCR analyzer and to study the acceptability of self-sampling.

Methods Micro-PCR test (Truenat[®]) was used on vaginal samples collected by self-sampling for detection of HR-HPV infections 16/31,18/45. A sample size of 975 women was calculated with 95% confidence, 20% relative precision and adjusting for 10% non-responder rate. Samples were collected in the community during Covid-19 pandemic. Prevalence of HR-HPV 16,18 was determined separately by RT-PCR using HPV-Q Real-time PCR kit (genes2me).

Results Of 975 eligible women screened, prevalence was 4.6% with 45 women testing positive for HR-HPV (16/31,18/45). Of these 60% were confirmed positive for HR-HPV 16 & 18 by RT-PCR. Of the 45 positive women, 22(48.9%) underwent colposcopy and treated accordingly while the rest declined

treatment. On studying acceptability of self-sampling, 943 (96.72%) participants were 'very satisfied', 918(94.15%) found it to be 'very comfortable' and 863(88.51%) stated that they will strongly recommend it to other eligible women.

Conclusion/Implications HR-HPV testing with limited genotyping showed a prevalence of 4.6%, 60% of these were HPV 16/18 positive. Point of care testing was feasible in the community and self-sampling was acceptable. Roughly 50% declined treatment, and reasons need to be looked into.

PR088/#198

EZH2/EZH1 INHIBITOR TULMIMETOSTAT (CPI-0209): PRELIMINARY PHASE II RESULTS AND FIRST BIOMARKER FINDINGS IN PATIENTS WITH ARID1A-MUTANT OVARIAN CLEAR CELL OR ENDOMETRIAL CARCINOMAS (OCCC/EC)

¹Charles Drescher, ²Harriet Walter, ³Elvire Pons-Tostivint, ⁴Nehal Lakhani, ⁵Vincent Ribrag, ⁶Martin Gutierrez, ⁷Ryan Sullivan, ⁸Donald Harvey, ⁹Kalyan Banda, ¹⁰Michal Kwiatek, ¹¹Alejandro Garcia-Sancho, ¹²Linda Duska, ¹³Pier Luigi Zinzani, ¹⁴Anjali Thakur*, ¹⁴Lennart Kann, ¹⁴Rainer Boxhammer, ¹⁴Nicola Faulhaber, ¹⁴Julia Jauch-Lembach, ¹⁵Hedy Kindler. ¹Swedish Cancer Institute, -, Seattle, USA; ²University of Leicester and University Hospitals of Leicester NHS Trust, -, Leicester, UK; ³Medical Oncology, University Hospital Nantes, Nantes, France; ⁴START Midwest, -, Grand Rapids, USA; ⁵Centre de Lutte Contre le Cancer (CLCC), Gustave Roussy (institut De Cancerologie Gustave-roussey), Villejuif, France; ⁶Hackensack University Medical Center, -, Hackensack, USA; ⁷Massachusetts General Hospital, -, Boston, USA; ⁸Emory University School of Medicine and Winship Cancer Institute, -, Atlanta, USA; ⁹Fred Hutchinson Cancer Center, -, Seattle, USA; ¹⁰Centrum Medyczne Pratia Poznań, -, Skorzewo, Poland; ¹¹Hospital Universitario de Salamanca, Ibsal, Salamanca, Spain; ¹²University of Virginia, -, Charlottesville, USA; ¹³RCCS Azienda Ospedaliero-Universitaria di Bologna Istituto di Ematologia 'Seràgnoli' and Dipartimento di Medicina Specialistica, Diagnostica e Sperimentale Università di Bologna, -, Bologna, Italy; ¹⁴MorphoSys AG, -, Planegg, Germany; ¹⁵University of Chicago, -, Chicago, USA

10.1136/ijgc-2023-IGCS.124

Introduction ARID1A mutation (ARID1Amut) has a high incidence in OCCC (up to 60%) and EC (up to 40%), with evidence as a negative prognostic marker for treatment resistance and outcomes. EZH2 inhibition in ARID1Amut solid tumors results in tumor growth inhibition (Bitler et al. Nat Med 2015;21:231–238). Preliminary Phase II (NCT04104776) efficacy, safety, and biomarker findings from OCCC and EC cohorts receiving tulmimetostat are reported.

Methods The Phase II study is evaluating tulmimetostat 350 mg once daily in 6 disease-based cohorts, including ARID1A-mut OCCC/EC. Per Simon 2-stage design, expansion of enrolment (plus n=19 patients per cohort in Stage 2) requires objective response rate (ORR) $\geq 1/10$ in Stage 1. Primary endpoint is ORR; secondary endpoints include safety. Evaluation of two additional dose levels was implemented for both cohorts, per FDA recommendation of Project Optimus, to inform on optimal tulmimetostat dose.

Results 24 patients were enrolled (OCCC, n=14; EC, n=10); 50% of each cohort have received ≥ 3 prior treatment lines. Both cohorts are eligible for Stage 2 expansion, with 1 and 2 confirmed partial responses in patients with OCCC and EC, respectively (table 1). The manageable safety profile across all 6 tumor cohorts (n=81) was consistent with known class effects; Grade ≥ 3 related adverse events ($\geq 10\%$ of patients) included thrombocytopenia, anemia, neutropenia, and diarrhea. Next generation sequencing did not reveal a specific hotspot for ARID1Amut locations impacting clinical outcome in patients with OCCC/EC.

Conclusion/Implications These preliminary findings in heavily pre-treated patients with ARID1Amut OCCC/EC support continued investigation of tulmimetostat monotherapy.

PR089/#862

ARTIFICIAL INTELLIGENCE-BASED DIAGNOSTIC SYSTEM FOR THE DETECTION OF ABNORMAL COLPOSCOPIC FINDINGS

¹Akihiko Ueda*, ¹Ken Yamaguchi, ¹Sachiko Kitamura, ¹Mana Taki, ¹Koji Yamanoi, ¹Ryusuke Murakami, ¹Junzo Hamanishi, ²Masatsugu Ueda, ¹Masaki Mandai. ¹Kyoto University Graduated School of Medicine, Gynecology and Obstetrics, Kyoto, Japan; ²Kio University, Faculty of Health Sciences and Cytology Training Center, Nara, Japan

10.1136/ijgc-2023-IGCS.125

Introduction Colposcopic examination requires sufficient training to detect cervical intraepithelial neoplasia (CIN) with (1) high diagnostic accuracy and (2) minimizing time and reducing tissue biopsies. This study aimed to develop an artificial intelligence (AI) based system which replicates expert colposcopic examination techniques, independent of examiner skill.

Abstract PR088/#198 Table 1 Best responses*

		OCCC	EC
Efficacy evaluable, N		14	8
Best confirmed response, † n	CR	0	0
	PR	1	2
	SD	7	2
Best confirmed or unconfirmed response, † n	CR	0	0
	PR	4	3
	SD	4	1
No response, n	Progressive disease	6	2
	Not evaluable	0	1†
	Discontinued without response assessment	0	1

CR, complete response; EC, endometrial carcinoma; OCCC, ovarian clear cell carcinoma; PR, partial response; SD, stable disease.

*data cut-off 14 February 2023; †Per RECIST 1.1; †Patient had a radiological assessment (stable disease) prior to the required protocol-specified window (at least 28 days).