EP001 / #672

Topic: *AS01. Basic & Translational Science / AS01a. Pathology & Cytology*

TEMPORAL DECLINE OF PD-L1 EXPRESSION IN STORED CERVICAL CANCER FFPE TISSUE: IMPLICATIONS FOR IMMUNOTHERAPY ELIGIBILITY

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Introduction: Programmed cell death ligand 1 (PD-L1) is a key biomarker guiding immune checkpoint inhibitor therapy in cervical cancer. In routine practice, PD-L1 testing is often performed retrospectively on archived tissue rather than at diagnosis. We evaluated temporal changes in PD-L1 expression in stored cervical cancer specimens.

Methods: Thirty-three FFPE samples from PD-L1–positive cervical cancer patients diagnosed at the Jewish General Hospital (Montreal, Canada) between 2022 and 2025 were analyzed. Archival slides and newly cut sections from the same blocks were stained with PD-L1 22C3 pharmDx. CPS≥1 defined positivity. A blinded pathologist reviewed slides. Wilcoxon and Spearman tests were used to compare CPS values and correlations.

Results: Of 33 paired specimens, 31 were evaluable and 2 were excluded because of insufficient tumor material. Median age was 46 years. Median time to initial PD-L1 testing was 16 days, and median interval to repeat testing was 27.6 months. Median CPS declined significantly from 15 [IQR 5–46] to 5 [2–15] on repeat staining ($p<0.001$), representing a median relative decline of 54.2% [35.3–82.6]. Four of 31 cases (12.9%) converted from PD-L1 positive to negative. Longer storage interval was associated with greater relative CPS decline ($p=0.038$). Samples stored >36 months showed greater decline than those stored ≤36 months ($p=0.09$).

Conclusion/Implications: PD-L1 expression in cervical cancer decreases over time in stored FFPE tissue, potentially due to antigen degradation. Reliance on archived tissue may

yield false-negative results and inappropriate treatment exclusion. PD-L1 assessment should ideally be performed at diagnosis or on newly obtained tissue.

EP002 / #433

Topic: *AS01. Basic & Translational Science / AS01a. Pathology & Cytology*

FOLATE RECEPTOR ALPHA TARGET-EXPRESSION CHANGES IN BOTH DIRECTIONS ACROSS THE TREATMENT COURSE IN WOMEN WITH HIGH-GRADE SEROUS OVARIAN CANCER

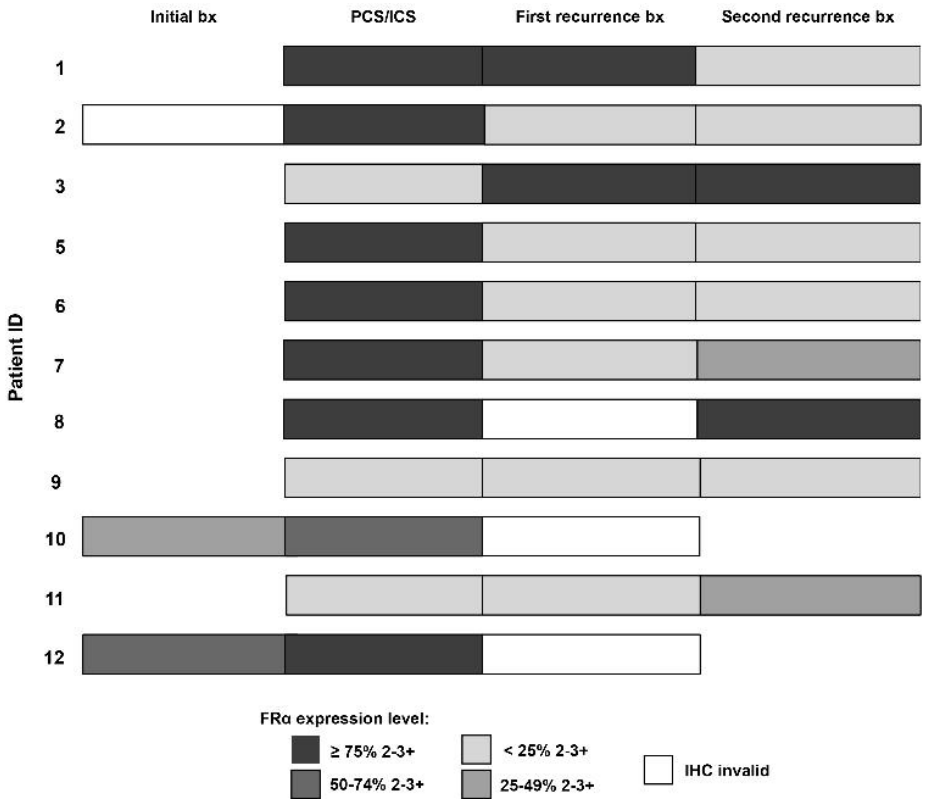
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Introduction: With multiple ADCs for FR*α,* and other antigens, FDA-approved or in clinical development, optimizing tumor testing is a clinical priority to accurately assess patient candidacy. Here we define FR*α* expression across serial tumor samples in patients with HGSOC to determine if there are changes between primary tumors and recurrences, particularly with exposure to different lines of therapy.

Methods: From an institutional database of HGSOC patients, we identified 11 cases with ≥3 serial pathology specimens available. Specimens were collected from a combination of initial, primary cytoreductive surgery, interval cytoreductive surgery and/or recurrence biopsies. FR*α* IHC was performed and scored as % cells with FR*α* 2-3+ expression. Specimens were compared using ≥75% as a cut-off for positivity and across score quartiles.

Results:



34 samples were collected from 11 patients. There was a median of 12.3 months and range of 1-8 lines of therapy between samples. Overall, 32% (11/34) of samples were FR*α*-positive. Of the 4/9 pretreatment samples that were positive, 1 maintained FR*α*-*positive* status throughout the treatment course. Importantly, FR*α* expression changed across score quartiles in 82% (9/11) of patients. FR*α* expression increased in 36% (4/11) and decreased in 46% (5/11) of patients during their treatment course. None of the 4 samples after anti-FR*α* ADC treatment (MIRV) were FR*α*-positive.

Conclusion/Implications: FR*α* expression varies greatly across serial pathology samples during the treatment course of women with HGSOC, both in the positive and negative direction. Our findings underscore the importance of repeat tumor testing to define candidacy for targeted therapies in this population with limited options.

EP003 / #922

Topic: *AS01. Basic & Translational Science / AS01a. Pathology & Cytology*

POSTPARTUM ENDOMETRIAL HISTOPATHOLOGY FOLLOWING FERTILITY-SPARING MANAGEMENT OF ENDOMETRIAL CANCER

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Introduction: Fertility-sparing management is an established option for select patients with early-stage endometrial cancer. While reproductive outcomes have been increasingly reported, there is limited data describing postpartum endometrial histopathology in this population and its clinical implications.

Methods: We conducted a retrospective review of patients with endometrial cancer who underwent fertility-sparing management and subsequently achieved pregnancy, including live birth and miscarriage. Postpartum endometrial biopsy results were reviewed, including indications for sampling and histopathological findings.

Results: A total of 15 patients were included. Postpartum histological findings were heterogeneous but predominantly benign. Specific observed findings included retained products of conception (RPOC) (n=6), placental site nodules (PSN) (n=4), endometrial hyperplasia (n=3), benign or non-specific endometrial changes (n=4). In several cases, mixed or evolving pathology was observed across serial biopsies (e.g., RPOC with concurrent PSN; progression from benign findings to atypical features; recurrent PSN or RPOC). Overall, no consistent pattern of malignant recurrence was identified in the immediate postpartum histological samples. However, the frequency of incidental trophoblastic-related findings was notable.

Conclusion/Implications: Among these endometrial cancer patients who became pregnant, postpartum endometrial histology following fertility-sparing treatment was largely benign but commonly demonstrated trophoblastic-related findings such as PSN and RPOC. Acknowledging a potentially higher incidence for these histology findings in this patient population is relevant as they may mimic other concerning lesions, although comparison with baseline postpartum populations is limited. Furthermore, these findings raise important considerations regarding the impact of endometrial cancer management

on pathophysiology, including how routine surveillance via dilation and curettage or hormonal effects may contribute.

EP004 / #1074

Topic: *AS01. Basic & Translational Science / AS01a. Pathology & Cytology*

REAL-WORLD IMPLEMENTATION OF FOLR1 IMMUNOHISTOCHEMISTRY IN OVARIAN CANCER: A MULTI-INSTITUTIONAL BRAZILIAN PATHOLOGY EXPERIENCE

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Introduction: Folate receptor alpha (FOLR1) is a clinically relevant biomarker in ovarian cancer, guiding eligibility for targeted therapies. However, access to testing remains variable, particularly in non-reflex settings where testing depends on physician request. Real-world data outside specialized oncology centers are limited. This study describes the initial experience with FOLR1 testing in a large private pathology network in Brazil.

Methods: We conducted a retrospective study of ovarian cancer cases undergoing FOLR1 immunohistochemistry between July 2025 and April 2026 in a nationwide private pathology service in Brazil, including multiple geographic regions. Testing was non-reflex and physician-dependent. Variables included age, geographic origin, specimen type (primary vs metastatic), FOLR1 expression, percentage scoring, and complementary biomarkers (PD-L1 and HER2).

Results: A total of 34 cases were included. FOLR1 expression was positive in 41% of cases and more frequent in primary tumors (54.5%) than metastatic cases (34.8%). FOLR1 testing was performed in non–high-grade serous tumors, reflecting real-world utilization beyond classical indications. PD-L1 testing was performed in 29% of cases, with 25% positivity among tested cases. HER2 testing was performed in 74% of cases, with 27% showing expression ≥1+. No clear association was observed between FOLR1 expression and PD-L1 or HER2 status.

Conclusion/Implications: This study provides early real-world data on FOLR1 testing in ovarian cancer within a large private network in a geographically diverse country. The non-reflex nature of testing highlights variability in utilization and potential barriers to access. These findings support the need for more standardized biomarker testing strategies and reinforce FOLR1 as a distinct therapeutic target.

EP005 / #1064

Topic: *AS01. Basic & Translational Science / AS01a. Pathology & Cytology*

RESTRICTION OF IMMUNE CELL INFILTRATION IN METASTATIC HIGH GRADE SEROUS OVARIAN CANCER

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Introduction: Background The nature of the immune infiltrate within the ovarian tumour microenvironment (TME) has an important impact on clinical outcomes, with high levels of tumour-infiltrating lymphocytes resulting in a favourable prognosis. However, the precise location of specific immune cells within the TME and interaction with tumour cells remains unclear. **Objectives** 1. Directly visualise the anatomical distribution of immune cell subpopulations within metastatic HGSOC to determine immune cell interaction and tumour infiltration. 2. Interrogate the spatial proximity of immune cells in chemotherapy-exposed HGSOC and evaluate TME modifications in chemotherapy resistance.

Methods: Methods Metastatic omental tissue from six advanced HGSOC cases were subjected to Multiplex Immunofluorescent staining and QuPath analysis. A bespoke panel of tumour and immunological antibodies was utilised to identify tumour ligand and immune cell marker expression.

Results: Results A total of 42 individual chemotherapy-naïve tumour cell clusters were compared to 68 chemotherapy-exposed clusters. Large populations of CD3 T cells were present in the stroma surrounding metastatic HGSOC. The proportion of CD3 T cells significantly reduced when in close proximity to tumour cell clusters ($P<0.01$) and there was minimal direct contact with the tumour cluster peripheral margins ($P<0.001$). Immune cell infiltration across the cluster border and into the tumour mass was decreased in post-chemotherapy tissue compared to those tumours managed with primary surgery ($P<0.01$).

Conclusion/Implications: T cells are restricted from contacting the metastatic tumour peripheral margin and prevented from penetrating the tumour core. Further analysis is required to understand the inhibitory mechanisms of the TME and immune cell elimination in HGSOC

EP006 / #997

Topic: *AS01. Basic & Translational Science / AS01a. Pathology & Cytology*

DETERMINANTS OF PATHOLOGICAL COMPLETE RESPONSE IN TRIPLE-NEGATIVE BREAST CANCER: A REAL-WORLD EXPERIENCE FROM TUNISIA

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Introduction: Triple-negative breast cancer(TNBC) is an aggressive subtype associated with high recurrence rates and limited therapeutic options.Pathological complete response(pCR) following neoadjuvant chemotherapy(NACT) is a major prognostic factor associated with improved survival outcomes. While immunotherapy has recently improved pCR rates in TNBC,access remains limited in many low- and middle-income countries(LMICs),where conventional chemotherapy continues to represent the main therapeutic strategy.This study aimed to identify predictive factors of pCR in TNBC patients treated with NACT.

Methods: We conducted a retrospective observational study including 60 patients diagnosed with TNBC between 2024 and 2026 and treated with NACT at Abderrahmen Mami Hospital.Clinical and pathological characteristics were analyzed,including age,menopausal status,tumor size(T stage),nodal status(N stage),Scarff–Bloom–Richardson(SBR) grade,histological subtype,Ki-67 index,chemotherapy regimen,HER2-low status and the time between diagnosis and Chemotherapy initiation.Most patients received anthracycline- and taxane-based chemotherapy,with some receiving carboplatin-containing regimens.

Results: The median age was 50.5 years[28–72].The overall pCR rate was 51.8%.Most tumors were invasive ductal carcinomas and high-grade lesions.Anthracycline–taxane regimens were the most frequently administered NACT regimens.Higher Ki67 expression showed a trend toward improved pCR rates,without statistical significance(p=0.065).No significant association was observed between pCR and age,menopausal status,clinical stage,histological grade,histological subtype,or HER2-low status.Time to chemotherapy initiation was not predictive of pCR(p=0.35);although a longer delay was associated with a slight,non-significant decrease in pCR probability,the mean delay was 62.6 days in the pCR group versus 71.9 days in the non-pCR group.

Conclusion/Implications: In TNBC patients treated in a resource-limited setting without access to immunotherapy, NACT achieved encouraging pCR rates comparable to

international data. Ki-67 emerged as a key predictive marker, warranting larger prospective studies.

EP007 / #319

Topic: *AS01. Basic & Translational Science / AS01a. Pathology & Cytology*

FYN EXPRESSION AS A POTENTIAL PREDICTOR OF RECURRENCE IN CERVICAL CANCER PATIENTS TREATED WITH ADJUVANT TP THERAPY FOLLOWING RADICAL HYSTERECTOMY

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Introduction: This study investigates the association between Fyn expression and recurrence in patients with stage IB–IIB (FIGO 2008) cervical squamous cell carcinoma treated with postoperative adjuvant TP therapy (paclitaxel and cisplatin).

Methods: This retrospective study included 88 patients with stage IB–IIB (FIGO 2008) cervical squamous cell carcinoma who received postoperative adjuvant TP therapy at our institution between 2014 and 2021. Patients were divided into a 5-year recurrence-free group (Group A, n = 70) and a recurrence group (Group B, n = 18). Fyn expression was assessed immunohistochemically using a weighted score. The study was approved by the institutional ethics committee.

Results: Lymph node metastasis was significantly more frequent in Group B than in Group A ($P < 0.01$), whereas no significant differences were observed in parametrial invasion, stage, or pretreatment serum SCC level. Median Fyn expression was significantly higher in Group B than in Group A (6 vs. 4, $P < 0.01$). Using a weighted score cutoff of 9, patients were classified into low- and high-expression groups. The recurrence rate was significantly higher in the high-expression group than in the low-expression group (53.8% vs. 17.5%, $P < 0.01$), and disease-free survival was significantly longer in the low-expression group ($P < 0.01$). Multivariate analysis identified Fyn expression as an independent factor associated with recurrence ($P = 0.02$).

Conclusion/Implications: Fyn expression may be associated with recurrence after postoperative adjuvant chemotherapy in cervical cancer patients at risk of recurrence.

EP008 / #299

Topic: *AS01. Basic & Translational Science / AS01a. Pathology & Cytology*

CHARACTERIZATION OF HER2 DISCORDANCE IN RECURRENT CERVICAL CANCER: DEFINING HIGH-RISK SUBGROUPS FOR RE-EVALUATION

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Introduction: Following the clinical success of HER2-targeted antibody-drug conjugates in various solid tumors, establishing HER2 status has become a significant requirement in cervical cancer. However, HER2 changes during disease progression remains poorly defined. This study evaluated the dynamics of HER2 expression in recurrent cervical cancer and analyzed factors associated with biomarker shifts.

Methods: We retrospectively analyzed 118 patients with recurrent cervical cancer between 2013 and 2024 who had available tissue samples at relapse. For 72 patients, matched primary tumor tissues were analyzed to evaluate status shifts. HER2 expression was independently assessed by two pathologists following 2017 CAP/ASCP/ASCO gastric cancer guidelines. IHC 2+ and 3+ were classified as positive, and fluorescence in situ hybridization was not performed for IHC 2+ cases.

Results: The HER2 positivity rate in recurrent tissues was 14.4%, with adenocarcinoma (AC) accounting for 64.7% of positive cases. Multivariate analysis showed that the AC subtype (OR 8.20; 95% CI, 2.45–31.38) and recurrence outside the previous radiotherapy field (OR 28.82; 95% CI, 3.09–850.71) were independent predictors of HER2 positivity at relapse. The overall discordance rate was 9.7%, with a 6.6% gain and a 27.3% loss. AC was a primary driver for biomarker discordance, showing a significantly higher shift rate compared to squamous cell carcinoma (OR 14.53; 95% CI, 2.28–284.32).

Conclusion/Implications: HER2 status in cervical cancer is a dynamic biomarker influenced by initial histology and treatment history. These findings suggest that re-biopsy and HER2 re-evaluation at recurrence are essential for accurate clinical assessment and targeted therapy selection.

EP009 / #474

Topic: *AS01. Basic & Translational Science / AS01a. Pathology & Cytology*

PERFORMANCE OF GENOMIC SCAR BASED HRD SIGNATURE (HRDSIG) AS PREDICTIVE BIOMARKER FOR OVARIAN CANCER PATIENTS TREATED WITH NIRAPARIB

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Introduction: Homologous recombination deficiency (HRD) is key to predicting response to PARP inhibitors. HRD testing relies on detection of somatic copy number alterations, with Myriad's Genomic Instability Score (GIS) being prospectively validated for olaparib and niraparib. The AVENIO Tumor Tissue CGP Kit outputs two HRD biomarkers—gLOH and the newer genomic scar-based HRDsig, neither validated for response to niraparib.

Methods: Formalin-fixed paraffin-embedded tumour samples were sequenced using the AVENIO kit on NextSeq 550, targeting 335 genes. HRD status was assessed by gLOH and HRDsig using FoundationOne Analysis Platform (FOAP) v1.2 and v1.3.

Results: Fifteen ovarian cancer patients with known HRD status were tested. GIS values ranged 16-84; no pathogenic/likely pathogenic *BRCA1/2* variants were identified, though variants of uncertain significance in HR pathway genes were found in 6/15 cases. HRDsig concordance with GIS-based HRD status was 93.3% (14/15), significantly higher than gLOH (80%; 12/15). The single HRDsig-discordant case tested consistently negative on repeat AVENIO testing. All five patients who received niraparib had no evidence of recurrent disease at 22–36 months follow-up, including the HRDsig-discordant case. Comparing algorithm versions, v1.3 produced more HRDsig QC failures than v1.2 (1/15 vs. 0/15 in ovarian; 9/26 vs. 4/26 in non-ovarian cases), attributed to a higher requirement for copy number quality.

Conclusion/Implications: In a predominantly BRCA-negative ovarian cancer cohort, HRDsig demonstrates high concordance with GIS-based HRD status, outperforming gLOH. Rare discordance appears to reflect true negatives rather than assay error. The updated v1.3 algorithm is associated with increased QC failure rates, which may limit employment in lower quality pathology specimens.

EP010 / #831

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

LSR DRIVES GYNECOLOGIC CANCER PROLIFERATION BY SUPPRESSING FERROPTOSIS THROUGH ALPHA-TOCOPHEROL UPTAKE

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Introduction: Lipolysis-stimulated lipoprotein receptor (LSR), a receptor involved in lipid metabolism, is highly expressed in gynecologic cancers and associated with poor prognosis. Although enhanced lipid metabolism is thought to promote cancer cell proliferation, the mechanism downstream of LSR remains unclear. We hypothesized that LSR promotes proliferation by suppressing ferroptosis, and that uptake of α-tocopherol, a form of vitamin E, mediates this anti-ferroptotic effect.

Methods: LSR was knocked down in LSR-high gynecologic cancer cell lines, and (1) cell proliferation was evaluated, with rescue assessed by ferrostatin-1, a ferroptosis inhibitor; (2) glutathione peroxidase 4 (GPX4) expression, a key ferroptosis-suppressing enzyme, was analyzed by Western blotting; and (3) reactive oxygen species and lipid peroxidation, markers of ferroptosis, were measured by flow cytometry. (4) Under H_2O_2-induced ferroptotic stress, the rescue effect of α-tocopherol on cell viability and GPX4 expression was compared between LSR-high and LSR-low cells.

Results: LSR knockdown attenuated cell proliferation in LSR-high gynecologic cancer cells, and this effect was rescued by ferrostatin-1. LSR knockdown also decreased GPX4 expression and elevated both reactive oxygen species and lipid peroxidation. Furthermore, under H_2O_2-induced ferroptotic stress, α-tocopherol restored cell viability and GPX4 expression in LSR-high cells, but not in LSR-low cells.

Conclusion/Implications: These findings suggest that LSR suppresses ferroptosis via α-tocopherol uptake, and promotes cell proliferation. Inhibition of LSR and its downstream ferroptosis pathway may be a novel therapeutic strategy for LSR-high gynecologic cancers.

EP011 / #1071

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

BIOMARKER DISCOVERY TO PREDICT ANTI-ESTROGEN THERAPY EFFICACY IN LOW-GRADE SEROUS OVARIAN CARCINOMA

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Introduction: Low-grade serous carcinoma (LGSC) of the ovary/peritoneum is characterized by the expression of estrogen (ER, ~90%), and progesterone receptors (PR, ~40%). Anti-estrogens (AE) are commonly used to treat LGSC, though 20-30% of patients experience significant side effects. Functional studies are needed to better understand ER signaling and identify predictive biomarkers of AE efficacy in LGSC.

Methods: LGSC patient tumours were implanted under the renal capsules of female immunocompromised mice. The mice were subjected to conditions of either estrogen ablation (ovariectomy) or stimulation (estradiol pellet implant). The tissues were harvested and differentially expressed transcripts were identified to create a 200-transcript ER-response panel for the Nanostring® platform. RNA was then extracted from 48 LGSC tumours in patients treated with AE after surgery. Using Cox regression, we identified RNA transcripts significantly ($p < 0.05$) associated with progression-free survival (PFS) after adjusting for residual disease burden after surgery.

Results: We identified nine ER-response transcripts that were significantly associated with a shorter PFS with higher expression (ECT2, UBE2C, SLAIN1, NRIP1, GPM6B, KLK11,BIRC5, TAGLN2, HMGA1), and three transcripts also associated with a shorter PFS when their expression was lower (FHL2, TUBB4B, and RBBP8). From this discovery cohort will develop and present several prediction models for anti-estrogen resistance in LGSC.

Conclusion/Implications: Using our unique LGSC model system, we identified novel ER-response genes predictive of AE efficacy in a small LGSC patient cohort. These results

provide a sound basis for additional validation studies and will foster future mechanistic studies to elucidate predictive biomarkers for AE efficacy in LGSC.

EP012 / #566

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

GLP-1 AGONISM BY SEMAGLUTIDE DISRUPTS AKT SIGNALLING AND ENHANCES PROGESTERONE-INDUCED FOXO1 ACTIVATION IN ENDOMETRIAL CANCER

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Introduction: Obesity not only increases Endometrial cancer (EC) risk, including in young women of reproductive age, but also complicates its clinical management. Although progesterone is the cornerstone of fertility-sparing therapy, its pro-adipogenic effects and associated progesterone-resistance may compromise therapeutic efficacy. This study evaluates semaglutide, a GLP-1 receptor agonist with established anti-obesity properties, as a strategy to enhance progesterone sensitivity and overcome its therapeutic limitations in EC.

Methods: A diet-induced obesity–associated xenograft model was used to evaluate the *in vivo* efficacy of semaglutide and progesterone combination. RNA sequencing of tumor tissue was performed to identify underlying molecular mechanisms, and pharmacological inhibitors were used to confirm pathway dependence. Co-culture of Ishikawa cells with 3T3-L1 adipocytes was used to model an obesity-associated microenvironment *in vitro*. Progesterone-resistant Ishikawa and ECC1 cell lines were developed to assess the combined effect of semaglutide and progesterone using cell viability, clonogenic assays, and immunoblotting.

Results: Semaglutide-progesterone combination significantly reduced tumor growth compared to monotherapy, association with decreased CyclinD1, increased p21 and GLP-1R expression in tumor tissue. Transcriptomic analysis revealed activation of Foxo1 signaling. Co-cultured Ishikawa cells exhibited enhanced proliferation, reduced progesterone sensitivity, and suppressed Foxo1 expression, supporting an obesity-driven pro-tumorigenic microenvironment. In progesterone resistant cells, semaglutide-progesterone combination restored progesterone sensitivity, reduced clonogenicity, and induced apoptosis. Mechanistically, the combination decreased p-AKT/AKT and p-Foxo1/Foxo1 ratios and promoted Foxo1 nuclear accumulation. Foxo1 inhibition abrogated therapeutic effects, confirming pathway dependence.

Conclusion/Implications: Semaglutide enhances progesterone efficacy by targeting the AKT/Foxo-1 signaling, supporting a translational combination strategy for EC, particularly in obese, young and progesterone resistant patients.

EP013 / #562

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

THE IMPACT OF HYPERTHERMIA ON CISPLATIN CYTOTOXICITY IN OVARIAN CANCER CELLS

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Introduction: Hyperthermic intraperitoneal chemotherapy (HIPEC) is used in ovarian cancer (OC) treatment, with hyperthermia presumed to augment chemotherapeutic activity; however, its precise biological role remains incompletely defined. We evaluated the combined effects of hyperthermia and cisplatin on OC cell viability and associated cellular responses.

Methods: Four high-grade serous OC cell lines (OVCAR-3, OAW-28, COV362, COV644) were exposed to cisplatin *in vitro* under normothermic (37°C) or hyperthermic conditions (42°C) for 90, 135, and 180 minutes. Cell viability and IC50 were determined by viability assays and dose–response curves, respectively. Transcriptomic and proteomic changes were assessed by RNA sequencing and western blotting under normothermia and hyperthermia (90 and 180 minutes).

Results: Hyperthermia reduced cell viability and decreased cisplatin IC50 in a time-dependent manner across OC cell lines, with a strong inverse correlation between duration and IC50 **(Spearman $\rho=-0.88$, $p<0.0001$**). Median cisplatin IC50s decreased from 16.4 µg/mL under normothermia to 12.4, 6.9, and 2.1 µg/mL after 90, 135, and 180 minutes, respectively, corresponding to an approximately 8-fold reduction at 180 minutes. Dose–response curves showed parallel shifts, consistent with an additive interaction. Transcriptomic analysis revealed a heat shock response, including HSP70 family upregulation, and clustering of OC samples by temperature. At the protein level, hyperthermia induced HSP70 expression, whereas cisplatin did not consistently increase HSP70 or HSP90.

Conclusion/Implications: Hyperthermia appears to enhance cisplatin cytotoxicity in OC cells *in vitro*; however, this likely reflects additive cellular stress rather than true synergistic enhancement. Hyperthermia drives the primary transcriptional response and shapes the cellular state, while cisplatin provides additional cytotoxicity.

EP014 / #570

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

NRF2 ACTIVITY IS ASSOCIATED WITH EARLY TOLERANCE TO PARP INHIBITION IN OVARIAN CANCER

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Introduction: PARP inhibitors (PARPi) are a cornerstone of therapy in ovarian cancer, yet responses remain heterogeneous and resistance is common. NRF2 regulates oxidative stress responses and is frequently hyperactivated in cancer, promoting survival and therapeutic resistance. Although KEAP1 alterations and NRF2 pathway activation are associated with poor outcomes in ovarian cancer, the role of NRF2 in early tolerance to PARPi remains poorly defined.

Methods: RNA sequencing data from The Cancer Genome Atlas (TCGA) high-grade serous ovarian cancer (HGSOC) tumors (n=434) were stratified into NRF2-high and NRF2-low groups using a curated NRF2 target gene signature. Differential expression and gene set enrichment analysis were performed to identify pathways associated with NRF2 status. NRF2 activation was induced in BRCA1-silent OVCAR8 and BRCA2-mutant PEO1 cells using siRNA-mediated KEAP1 knockdown. Cells were treated with olaparib and monitored longitudinally using IncuCyte imaging.

Results: NRF2-high tumors (n=286) and NRF2-low tumors (n=148) showed distinct transcriptomic states, with 5,500 differentially expressed genes (FDR $q<0.05$, $|\log2FC|\geq0.5$). Several DNA repair genes were upregulated in NRF2-high tumors. WNT signaling, a pathway involved in PARPi resistance, was among the top enriched pathways in NRF2-high tumors (NES=1.96, FDR q=0.005), whereas oxidative phosphorylation was enriched in NRF2-low tumors (NES=-2.38, FDR q=0.005). Functionally, NRF2 activation increased HGSOC cell proliferation and reduced sensitivity to olaparib, with a rightward shift in the dose-response curve.

Conclusion/Implications: NRF2 activity defines biologically distinct ovarian tumors and promotes early tolerance to PARP inhibition, supported by increased proliferation and reduced olaparib sensitivity following NRF2 activation. Targeting NRF2 may enhance PARPi efficacy and delay resistance.

EP015 / #892

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

DIAGNOSTIC PERFORMANCE AND GENOMIC CONCORDANCE OF CELL-FREE DNA IN HIGH-GRADE SEROUS OVARIAN CANCER

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Introduction: Cell-free DNA(cfDNA) is a non-invasive biomarker for diagnosis, monitoring, and genomic profiling in epithelial ovarian cancer. We evaluated its diagnostic performance, longitudinal dynamics, and concordance with tumor sequencing in high-grade serous ovarian carcinoma(HGSOC).

Methods: In this prospective cohort study, cfDNA was isolated from 86 HGSOC, 48 benign, and 22 healthy individuals. Tumor fraction (ctDNA) was analysed in 67 samples. Serial cfDNA was measured across treatment stages. Targeted NGS was performed on matched tumor tissue and cfDNA samples (n=10).

Results: Median cfDNA levels were significantly higher in HGSOC than benign and healthy controls (42.4[4.4–528] ng/mL vs 17.2[4.1–100.2] ng/mL vs 19.6[4.8–57.2] ng/mL;p=0.001). A threshold of 27.9 ng/mL showed AUC of 0.755 (sensitivity 69.1%, specificity 72.9%). cfDNA declined with treatment (baseline:42.4 ng/mL; post-NACT:11.7 ng/mL; post-ACT:10.2 ng/mL;p<0.001) and increased at relapse (n=4). Responders showed marked reduction in cfDNA (median 50 to 9.4 ng/mL), whereas non-responders remained elevated (149.6 to 48 ng/mL). cfDNA correlated moderately with ctDNA fraction (r=0.468,p=0.001) but not with CA-125 (ρ=0.151,p=0.17).
cfDNA sensitivity for tissue mutations was 70.6% (12/17; 95% CI46.9–86.7%) with 75.0% concordance. Variant allele frequencies were lower in cfDNA than tissue (0.098 vs 0.470; p<0.001), with moderate correlation (ρ=0.65, p=0.022). TP53 was most frequent, followed by BRCA1/2, NF1, PTEN, TSC1, and MSH6. cfDNA detected additional low-frequency subclonal variants, while copy number changes were mainly tissue-derived.

Conclusion/Implications: cfDNA demonstrates moderate diagnostic accuracy, robust treatment-response tracking, and high concordance with tissue. Its ability to capture tumor

heterogeneity and detect relapse supports its integration into precision oncology for ovarian cancer

EP016 / #876

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

MINI-LAPAROTOMY ESTABLISHMENT OF AN IMMUNOCOMPETENT RABBIT PERITONEAL CARCINOMATOSIS MODEL USING FRESH VX2 TUMOR FRAGMENTS

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Introduction: Peritoneal dissemination remains a major challenge in advanced gynecologic malignancies, requiring reproducible large-animal models for locoregional therapeutics, intraperitoneal drug delivery, and image-guided strategies. We aimed to establish a technically simple immunocompetent rabbit model of diffuse peritoneal carcinomatosis using direct intraperitoneal implantation of fresh tumor fragments.

Methods: VX2 tumors were propagated in the thigh of donor New Zealand White rabbits and harvested after 3 weeks. Viable non-necrotic tissue was minced into small fragments using sterile scissors without cell culture, enzymatic digestion, or single-cell suspension. Recipient rabbits (n=8) underwent a subcentimeter mini-laparotomy, through which approximately 1 g of fresh VX2 tumor fragments was distributed across peritoneal surfaces. Animals were evaluated at 4 weeks. At terminal laparotomy, tumor take, implant distribution, procedure-related morbidity, and modified Peritoneal Cancer Index (PCI) were recorded. Representative nodules underwent histologic analysis.

Results: Implantation was completed in 8/8 rabbits, with no perioperative deaths or procedure-related complications. Diffuse peritoneal carcinomatosis developed in all rabbits (100%), with a median modified PCI of 14.5 (range, 10–22). The central abdomen, epigastrium, right flank, and large bowel were involved in all animals. Histology confirmed viable carcinoma in all sampled implants. CD31 demonstrated tumor-associated vasculature, whereas Ki-67 showed low proliferative activity, suggesting hypoxia- and necrosis-limited growth in advanced lesions. Masson’s trichrome showed moderate-to-

prominent stromal collagen deposition.



Conclusion/Implications: Direct intraperitoneal implantation of fresh VX2 tumor fragments via mini-laparotomy generated a rapid, feasible, and quantifiable

immunocompetent rabbit model of diffuse peritoneal carcinomatosis, supporting preclinical studies of intraperitoneal therapeutics and locoregional imaging or drug-delivery platforms.

EP017 / #705

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

PROTEOME-WIDE MENDELIAN RANDOMIZATION IDENTIFIES CANDIDATE DRUG TARGETS FOR OVARIAN CANCER: EVIDENCE FROM OVARIAN CANCER ASSOCIATION CONSORTIUM (OCAC) AND BIOBANK JAPAN (BBJ)

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Introduction: Ovarian cancer remains a leading cause of gynecologic cancer mortality, highlighting the need for novel therapeutic targets. Mendelian randomization (MR) using protein quantitative trait loci (pQTLs) offers a promising approach to identify causal proteins. The aim of current study was to discover candidate proteins as novel therapeutic targets of ovarian cancer.

Methods: We conducted a proteome-wide two-sample MR analysis using publicly available pQTL data (~2,000 proteins) as exposures and ovarian cancer GWAS summary statistics from the Ovarian Cancer Association Consortium (OCAC; ncase=25,509, ncontrol=40,941). Independent validation was performed using Biobank Japan (BBJ). Multiple testing was controlled using Benjamini–Hochberg false discovery rate (FDR). Colocalization analysis was conducted to assess shared causal variants.

Results: Among 2,099 proteins tested, 11 proteins showed significant associations with ovarian cancer after FDR correction. Several proteins involved in tumor biology-including adhesion molecules and angiogenesis-related proteins (e.g., E-selectin) -demonstrated protective effects, while others (e.g., ABO transferase) showed risk-increasing effects. Directionally consistent associations were observed in BBJ. However, colocalization analysis did not identify strong evidence for shared causal variants (PP.H4), suggesting potential confounding due to linkage disequilibrium or limited power.

Conclusion/Implications: Our findings highlight several biologically plausible candidate proteins for ovarian cancer risk. While replication of directionality was observed across populations, the lack of colocalization evidence underscores the need for cautious interpretation and further validation. Future studies integrating fine-mapping and larger multi-ancestry datasets are warranted.

EP018 / #1062

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

MOLECULAR CHARACTERIZATION OF ADVANCED ENDOMETRIAL CANCER

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Introduction: The survival outcomes of advanced or recurrent endometrial cancer (EC) have not been improved markedly despite the expanding systemic treatment options, such as targeted agents and immuno-oncology drugs. We performed molecular characterization of EC to identify potential therapeutic targets and prognostic predictors.

Methods: Whole exome sequencing (WES) was performed on 67 endometrial cancer tissues, including 41 early-stage EC and 26 advanced/recurrent EC cases. The frequencies of common cancer driver gene mutations were assessed and compared between early and advanced/recurred EC. Copy number variation analysis was also performed.

Results: In overall, the top 10 common pathogenic variants were *PTEN, PIK3CA, KRAS, CTNNB1, TP53, FGFR2, APC, BRCA2, CTCF* and *ATM*. In early-stage IC, *PTEN* (51.2%). *PIK3CA*(46.3%), and *KRAS*(26.8%) mutations were commonly identified. Whereas, in advanced/recurrent EC cases, *PTEN*(46.2%), *KRAS*(42.3%), and *TP53*(38.5%) were frequently mutated. In advanced EC, *TP53* mutation was associated with poor survival outcomes (p=0.003). *KRAS* mutation or comutation of *KRAS* and *TP53* also showed a trend toward an association with lower survival (p=0.22 and p=0.008). Deletions were more frequently detected in advanced/recurrent EC, whereas duplications were more common in early EC.

Conclusion/Implications: The *PTEN, PIK3CA*, and *KRAS* mutations were identified in both early and advanced EC. However, *TP53* mutation was more frequently identified in advanced EC and was associated with poor prognosis. *KRAS* comutation in $TP53^{mut}$ EC showed the lowest survival. In addition, deletions were more common in advanced EC.

EP019 / #1023

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

DEVELOPMENT OF HIGH GRADE SEROUS OVARIAN CANCER (HGSOC) PATIENT DERIVED 3D ORGANOIDS TO INVESTIGATE NOVEL TREATMENT APPROACHES IN PARPI RESISTANT CANCER

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Introduction: Identification of novel combinations to overcome resistance, or to augment response, to poly (ADP- ribose) polymerase (PARP) inhibitors in patients with high grade serous ovarian cancer (HGSOC) is of great interest. Development of models which can recapitulate the patients tumor for high through put drug screening could potentially lead to new therapeutic directions.

Methods: By combining novel methods for cell aggregation and hydrogel based synthetic ECM supports we can reproducibly generate patient-specific tumor organoids models in weeks with greater than 90% success. Organoids grown 384 well format are stained with novel non-toxic dyes enabling live cell painting of chemoresponses to drugs alone and in combination with drugs targeting anti-apoptotic proteins. Tissue clearing combined with cyclic immunofluorescence labeling of cells with more than a dozen antibodies and automated image analysis enables the identification of different cell types within the organoids.

Results: Our data suggest that this approach captures the inherent heterogeneity of the disease, albeit local to the sampled site. We are using deep learning algorithms to enable automated analyses of 3D confocal image stacks of organoids to infer drug responses that can be compared to patient responses in the clinic. WE are investigating novel combinations including combinations of agents which inhibit pro apoptotic molecules such as Bcl-Xl)

Conclusion/Implications: Our data suggest that patient derived organoids are feasible and potentially can be used to investigate response within clinical trials

EP020 / #890

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

DECODING CERVICAL CANCER NON-INVASIVELY: A TF–FGB–KRT13 PROTEOMIC SIGNATURE FROM EXFOLIATED CELLS—FIRST EVIDENCE FROM SOUTH INDIA

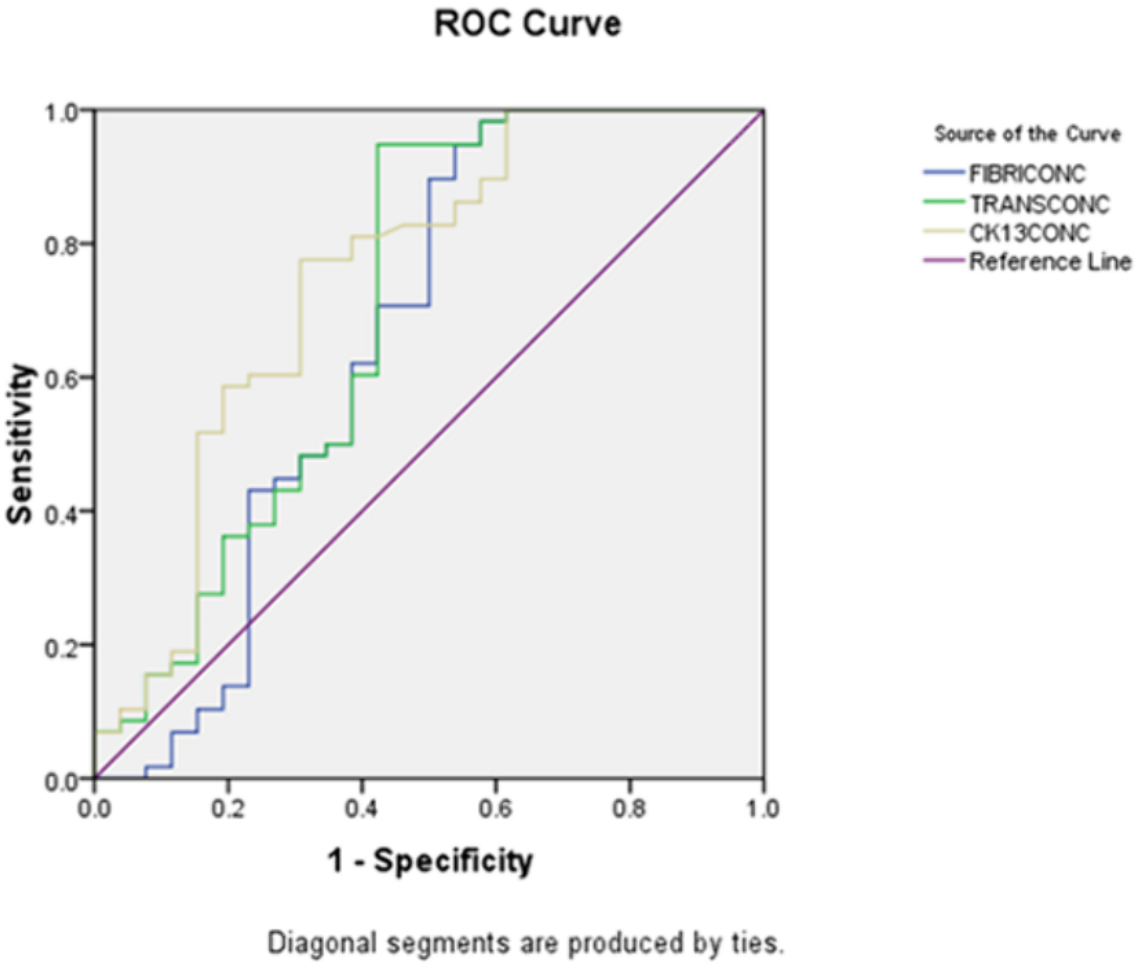
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Introduction: Persistent infection with high-risk human papillomavirus (HR-HPV) is the primary cause of cervical cancer, but HPV DNA testing alone has limited ability to predict disease progression. Host protein alterations induced during HPV-driven epithelial transformation may serve as complementary biomarkers for early detection and risk stratification.

Methods: Cervical exfoliated cell samples were collected from a community-based screening program in South India and tested for HR-HPV DNA. Forty samples were grouped into HPV16, HPV18, other high-risk HPV, and HPV-negative categories (n = 10 each) for proteomic discovery. Proteins were analyzed using two-dimensional gel electrophoresis followed by MALDI-TOF mass spectrometry. Functional and network analyses were performed. Validation was conducted using ELISA in an independent cohort of 84 samples (SCC = 58; NILM = 26).

Results: Fourteen protein spots corresponding to nine proteins were significantly overexpressed in HPV-positive samples, including transferrin(TF), fibrinogen beta chain(FGβ), and cytokeratin-13(KRT13). Functional analysis revealed clusters related to epithelial differentiation and inflammatory–metabolic pathways. In the validation cohort, 88% were HR-HPV positive. TF,FGβ, and KRT13 levels were significantly elevated in disease groups ($p<0.000001$). Individual biomarkers showed moderate diagnostic performance (AUC:0.656–0.747). A combined logistic regression model improved performance, achieving ~80% sensitivity and ~65%

specificity.



Conclusion/Implications: The synergistic interaction of CK13, transferrin, and fibrinogen β highlights the significance of systems-level biomarker integration, beyond individual analytes to mechanistically informed, minimally invasive diagnostics. Together, our results indicate that a biologically informed, multi-analyte proteomic approach to cervical cancer detection can be effective, showing that a combination of epithelial, metabolic, and hostresponse signals can improve diagnostic accuracy over single biomarkers.

EP021 / #102

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

AI-ASSISTED INTERPRETATION OF ENDOMETRIAL CANCER ORGANOIDS: COMPARISON OF CHATGPT-DERIVED PREDICTIONS WITH HISTOLOGY AND IMMUNOHISTOCHEMISTRY

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Introduction: Endometrial cancer organoids are high-fidelity biological models for studying tumour biology and for testing novel therapeutics, including applications in precision drug screening. This study aimed to evaluate the role of an untrained artificial intelligence model in pattern recognition of endometrial cancer organoids.

Methods: ChatGPT was asked to interpret endometrial cancer organoid images taken by EVOS microscope (40x), and to predict histology, growth, and main immunohistochemical features based on morphology. 22 images of 19 organoids were interpreted by ChatGPT and 2 independent researchers. Histopathology and immunohistochemistry reports of patient derived tumour tissues used for benchmarking. McNemar's and binomial tests used for statistical significance calculations.

Results: In 18 out of 22 images (81.8%) the histology defined correctly by ChatGPT ($p=0.003$). It was especially successful in differentiating low grade tumours from high grade ones. AI-generated morphological descriptions were concordant with human assessment in 77.3% of cases (17/22), significantly higher than chance (binomial test $p \approx 0.02$). The model showed 63.6% accuracy in predicting of p53 status, and 72.7% in predicting ER/PR status, however its predictive power wasn't statistically significant ($p=1$ and $p=0.07$ respectively). MMR status was predicted with 86.4% accuracy, without statistical significance ($p=0.25$).

Conclusion/Implications: AI-based interpretation of organoid morphology demonstrated the ability to predict structural tumour phenotype, particularly histological grade, but did not reliably predict molecular biomarkers including p53, ER/PR, and MMR status. Future work should focus on the development of trained image-based models in larger cohorts, integrating quantitative morphological features to improve prediction of growth behaviour, treatment response, and clonal dynamics.

EP022 / #700

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

MYC PATHWAY REMODELING DRIVES ADAPTIVE RESPONSE TO CHEMOTHERAPY IN HIGH-GRADE SEROUS OVARIAN CANCER PATIENT-DERIVED XENOGRAFTS

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Introduction: High-grade serous ovarian cancer (HGSOC) exhibits heterogeneous responses to chemotherapy, driven by adaptive transcriptional programs. We developed clinically relevant HGSOC patient-derived xenograft (PDX) models to investigate treatment response and resistance. Given MYC's central role in regulating proliferation, metabolism, and stress adaptation, we hypothesized that MYC signaling mediates chemotherapy-induced tumor adaptation.

Methods: HGSOC PDX model in NSG-SGM3 mice were treated with carboplatin and paclitaxel on a schedule mirroring the standard clinical regimen. A representative patient-derived model was selected as a proof-of-concept. Tumor growth was assessed longitudinally, and RNA profiling was performed on days 8, 16, and 30. MYC pathway activity was quantified using a curated gene signature.

Results: Chemotherapy induced robust tumor growth inhibition, consistent with preservation of patient-specific response. MYC pathway activity exhibited a phased, non-linear response rather than uniform suppression. Early after treatment, MYC activity increased in treated tumors, consistent with acute stress adaptation. At day 16, MYC activity decreased, with sustained suppression under treatment. By day 30, control tumors showed recovery of MYC activity, whereas treated tumors remained attenuated, indicating divergent transcriptional trajectories. Gene-level analysis revealed coordinated but heterogeneous regulation of MYC-associated transcriptional, metabolic, and cell-cycle programs.

Conclusion/Implications: MYC signaling functions as a dynamic regulator of chemotherapy response in HGSOC. These findings demonstrate that PDX models recapitulate treatment response and enable mechanistic dissection of adaptive pathways, supporting their use for studying resistance and developing MYC-targeted therapeutic strategies.

EP023 / #272

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

DIGOXIN ENHANCES THE ANTI-CANCER ACTIVITIES OF STANDARD-OF-CARE PLATINUM AND TAXANE-BASED CHEMOTHERAPY IN DEDIFFERENTIATED ENDOMETRIAL CARCINOMA

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Introduction: Dedifferentiated endometrial carcinoma (DDEC) is an aggressive gynecologic malignancy characterized by SWI/SNF-inactivation. Current standard-of-care platinum and taxane-based chemotherapy is insufficient in suppressing tumor progression. To gain therapeutic insights, we developed patient-derived *ex vivo* 3D spheroid models of DDEC and subjected them to high-throughput drug repurposing screen; this identified digoxin as an effective anti-cancer agent with efficacy confirmed in patient-derived xenograft tumor models (PMID: 37556934, 38970843). Herein, we evaluate for potential additive/synergistic drug combination and explore the mechanism of action of digoxin in DDEC.

Methods: Gene expression profiling, flow cytometry, mass spectrometry, western blot and PCR were performed to investigate mechanisms. A drug combination screen was conducted with low-dose digoxin (below upper serum concentration). Identified combinations were further evaluated *in vitro* and *in vivo*.

Results: Gene expression profiling and flow cytometry showed enrichment of apoptotic pathways in digoxin-treated cells (p <0.0001). Molecular profiling revealed that DDEC express lower levels of Na^+/K^+-ATPase isoforms α1 (p <0.0001), β1 (p <0.0001) and β3

(p <0.05) (targets of digoxin) versus non-DDEC. Drug combination screen identified paclitaxel and other compounds as potential candidates. Further *in vitro* evaluation confirmed the additive nature between digoxin, carboplatin and paclitaxel, while an antagonistic effect between digoxin and doxorubicin. Subsequent *in vivo* studies confirmed that digoxin, carboplatin and paclitaxel treatment resulted in significantly greater tumor growth inhibition compared to carboplatin and paclitaxel (90% versus 63%, p =0.0124 and p =0.0032).

Conclusion/Implications: Digoxin enhances the efficacy of standard-of-care chemotherapy in DDEC. Digoxin increases apoptosis and this susceptibility appears to relate to the Na^+/K^+-ATPase expression profile.

EP024 / #605

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

COMBINED THERAPEUTIC EFFICACY OF SHETA2 AND MYC INHIBITOR AGAINST CERVICAL CANCER

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Introduction: Despite advances in primary treatment, the high recurrence rate of cervical cancer represents a critical unmet clinical need, underscoring the urgency for novel therapeutic strategies. We previously established potent anticancer activity of SHetA2, an investigational new drug, against cervical cancer without associated toxicity. Notably, SHetA2 upregulated Myc expression in cervical cancer cells and xenograft tumors and demonstrated synergistic anticancer activity with Myc inhibitor (Myci975). Therefore, this study investigates the efficacy and underlying mechanism of SHetA2 combined with Myc inhibitor as an effective molecularly targeted therapeutic strategy for cervical cancer.

Methods: Effect of SHetA2 on Myc expression and cellular localization was evaluated by immunoblotting of cellular fractions and confocal imaging. Combined efficacy of SHetA2 with multiple Myc inhibitors was assessed in cervical cancer cells using cell viability assay and orthogonal matrix analysis to identify optimal combination. Synergistic effects of SHetA2 with chosen Myc inhibitor were further verified by clonogenic assays and immunoblotting. *In vivo* efficacy and toxicity of selected combinations were assessed in a cervical cancer xenograft model. RNA sequencing was performed to identify underlying mechanism of synergy.

Results: SHetA2 significantly upregulated nuclear expression of Myc. Among tested combinations, SHetA2 and Myci975 demonstrated the most potent synergistic activity and were selected for further evaluation. SHetA2 and Myci975 combination synergistically exerted antiproliferative effects, reduced clonogenic potential, enhanced apoptosis, and significantly suppressed tumor growth i*n vivo* without notable toxicity.

Conclusion/Implications: SHetA2 activates Myc signaling in cervical cancer. Myc inhibitor yields synergistic antitumor activity with SHetA2, supporting the translational potential of this combination strategy.

EP025 / #127

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

FRAGILITY OF EVIDENCE IN LANDMARK SURGICAL TRIALS IN GYNECOLOGIC ONCOLOGY: A 10-YEAR APPRAISAL

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Introduction: The extent to which statistically significant findings in randomized trials reflect robust and reproducible effects is not always quantified. The Fragility Index (FI) reflects the robustness of a trial's result: it is the smallest number of patients whose outcomes would need to change to make a statistically significant result become non-significant. A low FI indicates lower statistical robustness, and vice versa. We aim to evaluate FI across gynecologic oncology trials from the past decade.

Methods: A review of landmark gynecology oncology randomized or diagnostic trials (2015-2024) with binary primary outcomes were used for FI computation. FI was defined as the smallest number of event-status changes (in the direction of the null) that yielded $p \geq .05$. Non-inferiority trials were excluded as the FI applies only to superiority designs with dichotomous outcomes.

Results: Nine trials (n=2,737) were identified for FI calculation: five ovarian (55.5%) , three cervical (33.3%), and one vulvar (11.1%). The median sample size per trial was 245 (IQR 158–407). The overall median FI was 3 (IQR 0–7). In practical terms, this means that if the outcomes were reversed for three patients, the statistical significance would no longer hold. Among trials with statistically significant superiority results (n = 5), the median FI was 7 (IQR 3–12), indicating more robust

findings.

Fragility Index of Landmark Surgical Trials in Gynecologic Oncology

Study	Phase	Journal	Year	Cancer site	Arm A (n)	Arm B (n)	FI
GROINSS-V II	Phase II	JCO	2021	Vulvar	51	105	4
LACC	Phase III	NEJM	2018	Cervical	312	319	7
UTERUS 11	Phase III	Int J Gyn Onc	2020	Cervical	121	119	0
CONCERV	Single arm	Int J Gyn Onc	2021	Cervical	42	16	0
SCORPION	Phase III	Int J Gyn Onc	2020	Ovarian	74	84	21
OVHIPEC1	Phase III	NEJM	2018	Ovarian	123	122	2
GOG-213	Phase III	NEJM	2019	Ovarian	240	245	0
SOC-1	Phase III	Lancet Oncol	2021	Ovarian	175	182	12
DESKTOP III	Phase III	NEJM	2021	Ovarian	206	201	3

*SCORPIN – for primary outcome of complication rates**

*SOC-1 – for PFS at 2 years based on KM curves**

Conclusion/Implications: The FI was low for notable trials in gynecology oncology, indicating limited statistical robustness given that results could often be reversed by only a handful of outcome events. Reporting FI alongside conventional metrics can contextualize and guide interpretation of their results.

EP026 / #923

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

MOLECULAR LINKS BETWEEN METABOLIC RISK FACTORS AND ENDOMETRIAL CARCINOMA: A TRANSCRIPTOMIC ANALYSIS OF DIABETES AND OBESITY

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Introduction: Endometrial carcinoma (EC) is the most prevalent gynecological malignancy affecting women globally, with its incidence steadily increasing in recent years. EC is increasingly linked to metabolic comorbidities, such as *Diabetes mellitus* or obesity. Our aim was to assess transcriptomic profile of EC patients by RNA sequencing and analyze its association with risk factors of EC development – *Diabetes mellitus* and BMI (body mass index).

Methods: A total of 45 EC patients were included in pilot study and 119 EC patients into validation phase. RNA sequencing approach was used for whole transcriptome profiling of pilot set of patients. Gene expression of target genes in the validation phase (*VNN1, GFRA1, FOSB, FOSL1* and *HAVCR1*) was analyzed by qPCR.

Results: Differential gene expression analysis (DGE) regarding *Diabetes mellitus* revealed 66 significant results (e.g. *FOSB, VNN1, FOSL1, GFRA1)*. DGE comparing normal weight and overweight showed 8 significant results (e.g. *HAVCR1*), normal weight and obesity comparison revealed 41 significant results. Association of *VNN1* (p=0.021) and *GFRA1* (p=0.002) expression with *Diabetes mellitus* was validated in extended cohort. *GFRA1* correlated with BMI (p=0.003, r=0.274) and it was lower in patients without lymphovascular invasion (p=0.006). In the case of *VNN1*, higher expression associated with lower histological risk (p=0.005) in the extended validation cohort.

Conclusion/Implications: *Diabetes mellitus* diagnosis in EC patients is associated with a distinct transcriptomic signature characterized, with key alterations in *VNN1* and *GFRA1* genes. Supported by the Czech Health Research Council under project

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EP027 / #1032

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

MIRVETUXIMAB SORAVTANSINE RESISTANCE IN HIGH-GRADE SEROUS OVARIAN CARCINOMA CELL LINES

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Introduction: Mirvetuximab soravtansine (MIRV) is an antibody-drug conjugate (ADC) targeting folate receptor alpha (FRα) that delivers a microtubule-disrupting payload (DM4). MIRV demonstrates benefit in platinum-resistant recurrent epithelial ovarian carcinoma; however, evidence for inherent and acquired resistance is emerging. We sought to develop in vitro models of MIRV resistance in high-grade serous ovarian carcinoma (HGSOC) cell lines.

Methods: Baseline FRα expression, MIRV and DM4 sensitivity, and internalization were assessed in three HGSOC cell lines (OVSAHO, OVCAR4, COV362). Cell lines underwent serial cycles of MIRV treatment at cell line-specific IC80 concentrations to induce resistant phenotypes. Post-treatment FRα expression levels were assessed by immunohistochemistry (IHC). Payload-only and isotype controls were included.

Results: HGSOC cell lines showed variable FRα expression (COV362 0, OVCAR4 0, OVSAHO 2+/3+). Sensitivity to MIRV (IC50 median 54 nM, range (49–57 nM) and DM4 (IC50 median 5.9 nM, range 4–36 nM) and internalization efficiency (median 0.077 AUC, range 0.013–0.221) varied across cell lines. OVSAHO (FRα 2+/3+) displayed maximal internalization, whereas COV362 and OVCAR4 (FRα 0) showed minimal internalization; however, these associations were not consistent with IC50 MIRV sensitivity. Post-treatment FRα analysis will be presented at the conference.

Conclusion/Implications: MIRV sensitivity in HGSOC cells is independent of baseline FRα expression. Our ongoing work on preclinical HGSOC models of MIRV resistance is expected to build a foundation for identifying strategies to overcome treatment failure.

EP028 / #851

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

DIFFERENTIAL GENE EXPRESSION AND METHYLATION LANDSCAPES FOLLOWING NEOADJUVANT CHEMOTHERAPY IN OVARIAN CANCER HIGHLIGHT KEY PATHWAYS AND REGULATORY REGIONS

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Introduction: Due to delayed diagnosis and the emergence of medication resistance, epithelial ovarian carcinoma (EOC) is a serious/dismal cancer with a high death rate. One of the main challenges to effective anticancer treatment is drug resistance. Our primary goal was to examine the DNA methylation and long non-coding RNAs profiles of EOC patients treated with platinum derivatives in the neoadjuvant setting. Paired tumor samples collected before and after chemotherapy were used for identification of potential candidates responsible for drug resistance and further validation.

Methods: For the present study, we selected 25 EOC patients with paired samples of tumor tissue collected before and after neodjuvant chemotherapy. Whole transcriptome was profiled by RNA sequencing technology (N=25 pairs), whole genome DNA methylation by microarray with Infinium MethylationEPIC chip (N=20 pairs).

Results: Differential expression analysis showed in total 709 significantly deregulated genes after chemotherapeutic treatment (407 upregulated and 302 downregulated), from which 35 were from long non-coding RNA family. WikiPathways functional annotation exhibit enrichment for retinoblastoma gene in cancer (24 enriched genes), IL18 signaling pathway, orexin receptor pathway, and familial partial lipodystrophy pathways as the most interesting results. Differential methylation analysis revealed in total 27,137 significantly deregulated CpG loci after neoadjuvant chemotherapy. Analysis focused on differentially methylated regions, showed six significantly deregulated regions with overlapped genes - *GBF1, CHTF18, AC005670.3, LINC02184, SAMD13*).

Conclusion/Implications: Study identified candidates at mRNA, lncRNA levels and methylated regions with potential connection with neodjuvant chemotherapy response in

EOC patients, which should be further characterized. Supported by AZV project no. NW25J-03-00103, Cooperatio program no. 207035.

EP029 / #738

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

IDENTICAL TP53 C.371DUP VARIANTS IN BILATERAL HIGH-GRADE SEROUS OVARIAN CARCINOMA: CLONAL ORIGIN AND IMPLICATIONS FOR GERMLINE TESTING

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Introduction: TP53 mutations are the defining molecular hallmark of high-grade serous carcinoma (HGSC). In bilateral ovarian tumors, molecular profiling may provide strong evidence of clonal relatedness versus independent primary tumors. Furthermore, tumor-only sequencing may act as a catalyst for identifying potential germline predispositions. We present a case utilizing targeted next-generation sequencing (NGS) to characterize bilateral HGSC.

Methods: A 62-year-old woman presenting with pelvic pain and bilateral ovarian masses underwent surgical resection and bilateral oophorectomy. Histopathological examination confirmed HGSC in both ovaries. DNA was independently extracted from tumor tissue from the right and left ovaries. Targeted cancer gene panel NGS was performed to identify clinically relevant alterations and assess potential clonal relatedness.

Results: NGS identified an identical TP53 c.371dup variant in both ovarian tumors. This duplication causes a frameshift, leading to loss of normal p53 protein function. No additional pathogenic variants were detected. The presence of the same TP53 alteration in both distinct anatomical sites strongly supports a shared clonal origin—consistent with the typical metastatic behavior of HGSC—rather than synchronous independent primary tumors.

Conclusion/Implications: Identification of identical TP53 c.371dup variants in bilateral HGSC strongly supports a shared clonal origin. Although TP53 alterations are common somatic events in HGSC, their detection on tumor-only panels highlights the importance of reflex peripheral blood testing in selected cases. Distinguishing a somatic event from a rare germline alteration is important for evaluating possible Li-Fraumeni syndrome, informing genetic counseling, and guiding family cascade screening.

EP030 / #898

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

ENHANCING VENOUS THROMBOEMBOLISM RISK STRATIFICATION IN GYNECOLOGIC CANCERS USING THROMBOELASTOGRAPHY AND HEMATOLOGIC MARKERS

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Introduction: Venous thromboembolism (VTE) is a major cause of morbidity and mortality in gynecologic malignancies, yet current thrombosis risk models lack precision. This study evaluates whether thromboelastography (TEG), integrated with hematologic markers, can improve VTE risk stratification beyond conventional approaches.

Methods: In this prospective cohort study, 52 patients with ovarian and endometrial cancers were recruited. Following consent, blood samples were collected pre- and post-chemotherapy for TEG® 5000, platelet function, procoagulant biomarkers, and complete blood counts. Clinical risk factors were recorded, and patients were followed for six months for VTE events. Hypercoagulability was defined as ≥2 abnormal TEG parameters. Associations were assessed using correlation and multivariable regression analyses.

Results:

Table 1: Descriptive analysis of clinical characteristics, demographic and VTE risk factors in gynecologic cancer patients.

Descriptive analysis			Total N=52	Ovarian N=26		Endometrial N=26	
Demographic Data	**Age** (years) (Min-Max) (Mean+ SD)		42-84 68.4± 9.6	42-84 67.2± 11.4		54-84 69.7± 7.5	
	BMI (Kg/m^2) (Min-Max) (Mean+ SD)		18.3-52 29.6± 7.4	18.3-45.6 28± 7.2		20.4-52 31.3± 7.3	
	Blood Group (N, %)	O	21, 47.7%	12, 50%		9, 45%	
		Non-O	23, 52.3%	12, 50%		11, 55%	
Smoking (N, %)	**Current**		8, 15.4%	2, 7.7%		6, 23.1%	
	Remote		11, 21.2%	5, 19.2%		6, 23.1%	
	Never		33, 63.5%	19, 73.1%		14, 53.8%	
Co-morbidities (N, %)	**No morbidities**		24, 61.5%	16, 72.7%		8, 47.1%	
	1 DM		4, 10.3%	2, 9.1%		2, 11.8%	
	2 Hypertension		8, 20.5%	3, 13.6%		5, 29.4%	
	3 Dyslipidemia		3, 7.7%	1, 4.5%		2, 11.8%	
Cancer data (N, %)	**Cancer Stage**	I	4, 7.7%	1, 3.8%		3, 11.5%	
		II	10, 19.2%	5, 19.2%		5, 19.2%	
		III	27, 52%	12, 46%		15, 57.7%	
		IV	13, 25%	10, 38.5%		3, 11.5%	
	Histology		-	Serous	22, 85%	Squamous	2, 7.7%
			-	Mucinous	1, 3.8%	Papillary	5, 19%
			-	Clear CC	2, 7.7%	Clear CC	2, 7.7%
			-	Endometreroid	0, 0%	Endometroid	16, 62%
			-	Adenocarcinoma	1, 3.8%	Sarcoma	1, 3.8%
	Metastasis		19, 36.5%	11, 42.3%		8, 30.8%	
	Recurrence		5, 9.6%	3, 11.5%		2, 7.7%	
Cancer Therapies (N, %)	**Chemotherapy type**	Adjuvant	38, 73.1%	15, 57.7%		23, 88.5%	
		Neo-adjuvant	8, 15.4%	5, 19.2%		3, 11.5%	
		Both	6, 11.5%	6, 23.1%		0, 0%	
	Recent surgery		48, 92.3%	25, 96.2%		23, 88.5%	
	Radiation therapy		25, 48%	9, 34.6%		16, 61.5%	
	Endocrine therapy		2, 3.8%	2, 7.7%		0, 0%	
	New targeted or immune therapies		2, 3.8%	1, 3.8%		1, 3.8%	
Pro-coagulant Markers (Min-Max) (Mean+ SD)	**Platelets Aggregation** (Ohms)	Pre-chemo	0-20, 11± 4.5	2-20, 11.6± 4.2		0-18, 10.4± 4.7	
		Post-chemo	0-19.2, 7.2± 4.5	2-13.7, 7.6± 3.8		0-19.2, 6.9± 5.2	
	D-dimer (ng/mL) Pre-chemo		267-3159, 950±745	267-3159, 996± 904		294-2857, 918± 652	
	sP-selectin (ng/mL) Pre-chemo		22.6-82.7, 45.6± 19	22.8-74.7, 40.6± 16.3		22.6-82.7, 49.2± 20	
Khorana score (N, %)	1 (Intermediate risk)		19, 36.5%	9, 34.6%		10, 38.5%	
	2 (Intermediate risk)		24, 46.2%	12, 46.2%		12, 46.2%	
	3 (High risk)		6, 11.5%	3, 11.5%		3, 11.5%	
	4 (High risk)		3, 5.8%	2, 7.7%		1, 3.8%	
VTE events	**Patients developed DVT, PE or both**		3, 11.5%	2, 7.7%		5, 9.6%	

Table 2: Comparative analysis of patients' pre-chemotherapy CBC parameters based on their hypercoagulability state, assessed by TEG. Hypercoagulable state is defined as having 2 or more parameters changing towards hyper coagulability when compared to healthy control.

Pre chemotherapy CBC Parameters Mean ±SD	Hypercoagulability		*t-test* P-Value	Pearson Correlations/ Hyper-coagulability	Binary Logistic Regression analysis
	No N (%) 6 (11.5%)	Yes N (%) 46 (88.5%)		r P	P
WBCs (10^3/L)	6.9 ± 1.4	8.4 ± 3.4	0.4	-	-
RBCs (10^{12}/L)	4.2 ± 0.8	4.4 ± 0.5	0.7	-	-
Hgb. (g/L)	117.8 ± 13.8	124.4 ± 15.7	0.4	-	-
HCT (L/L)	0.36 ± 0.03	0.38 ± 0.04	0.3	-	-
MCV (fL)	87.4 ± 7.4	88.3 ± 5.3	0.7	-	-
MCH (pg)	27.3 ± 2.5	28.6 ± 2	0.2	-	-
MCHC (g/L)	319 ± 1.7	324 ± 9.3	0.3	-	-
RDW (11-14.5) %	14.7 ± 2	14.2 ± 1.8	0.6		
Platelets (10^3/L)	344 + 100	350 + 136	0.9	-	-
MPV (fL)	**6.9 + 4.0**	**10 + 1.1**	**≤0.001**	**-.483**-≤0.001**	**0.006**
Neutrophils (10^3/L)	4.3 + 1.4	5.9 + 3	0.3	-	-
Lymph. (10^3/L)	1.8 ± 0.7	1.6 ± 0.6	0.5		-
Monocyte (0.2 0.8) x10^9/L	0.5 ± 0.09	0.6 ± 0.3	0.6	-	-
Eosinophil (0-0.7) X10^9 L	0.1 ± 0.1	0.2 ± 0.2	0.4	-	-
Basophil (0 0.1) x 10^9/L	0.05 ± 0.02	0.05 ± 0.02	0.9	-	-
Immature Granulocytes (0-0.1) x10^9/L	0.08 ± 0.02	0.04 ± 0.06	0.4	-	-

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

Patients were predominantly advanced stage (77% stage III/IV), with 17.3% classified as high risk by Khorana Score (KS). TEG identified hypercoagulability in 88.5% of patients, exceeding conventional risk stratification. All VTE events (9.6%) occurred in patients with TEG-defined hypercoagulability despite only intermediate Khorana Score risk. Mean

platelet volume was significantly higher in hypercoagulable patients (10 ± 1.1 vs. 6.9 ± 4.0 fL, p≤0.001), demonstrating significant correlation (r = -0.483, p≤0.001) and independent association on regression analysis (p=0.006), and was also associated with VTE occurrence on exploratory analysis (p=0.003). Other hematologic parameters were not discriminatory.

Conclusion/Implications: TEG identifies a prevalent hypercoagulable phenotype in gynecologic cancers not captured by conventional risk models. Integration of TEG with routine hematologic markers, particularly mean platelet volume, may improve VTE risk stratification and guide thromboprophylaxis, supporting development of a multimodal predictive model in gynecologic oncology.

EP031 / #1117

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

DISCRIMINATING ENDOMETRIAL AND OVARIAN CANCERS FROM BENIGN GYNAECOLOGICAL CONDITIONS USING BLOOD-BASED RAMAN SPECTROSCOPY

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Introduction: Ovarian cancer lacks an effective population-based screening test, with over 70% of cases detected at FIGO stage III–IV. For endometrial cancer, current diagnostic pathways rely on invasive tissue sampling. Molecular screening using non-invasive liquid biopsies would provide significant clinical benefit. Raman spectroscopy (RS) provides a "molecular fingerprint" of biofluids, capturing biochemical changes associated with early malignancy. This study evaluates the diagnostic capacity of label-free RS to discriminate between early-stage gynaecological malignancies and benign conditions using both serum and plasma. Additionally, influence of pre-analytical-variables were investigated to ensure clinical translatability.

Methods: Matched patient plasma and serum samples were collected (n=80): High-Grade Serous Ovarian Carcinoma (HGSC), Endometrioid Endometrial Adenocarcinoma and benign gynaecological conditions. Liquid samples (60µL) were analysed using Horiba Jobin-Yvon LabRAM HR800 spectrometer equipped with 785nm laser and 60× water-immersion-objective. Principal-Component-Analysis (PCA) and Partial-Least-Squares-Discriminant-Analysis (PLS-DA) were employed for multivariate classification.

Results:

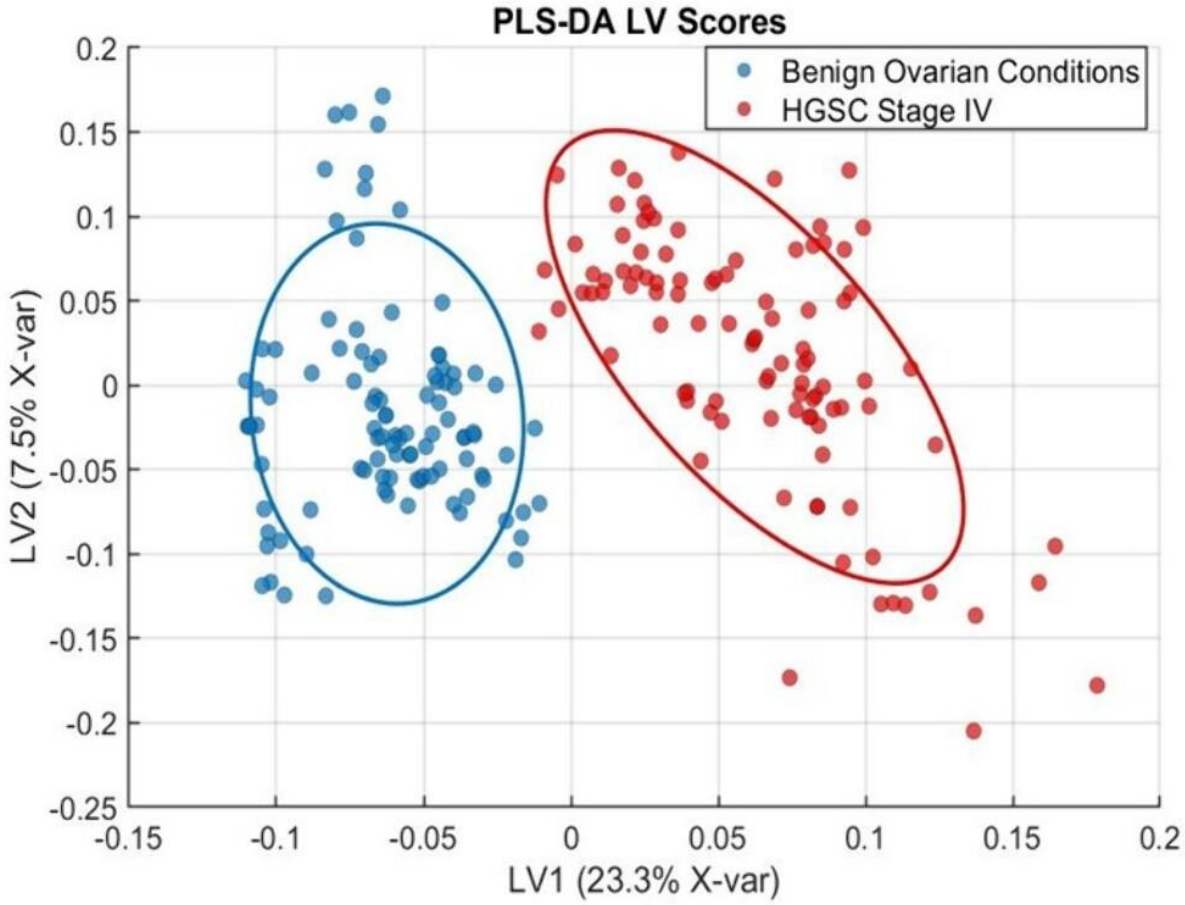


Fig 1.PLS-DA score plot Sample rapid-thawing and haemolysis induced spectral shifts indicative of protein conformational changes. For Stage IA-Endometrial-Adenocarcinoma, serum samples achieved a 95.5% F1-score. Raman-spectra exhibited enhanced glycogen and lipid/glycoprotein signatures, characteristic of early metabolic adaptation in malignancy. For Stage-IV-HGSC, 100% specificity was achieved in both biofluids, with serum yielding 93.5% F1-score. Discriminating features included elevated nucleic acid signals, consistent with increased cell turnover/ctDNA. Across all metrics, serum consistently outperformed plasma.

Conclusion/Implications: High classification accuracy for both malignancies underscores potential of Raman-spectroscopy as a rapid, non-invasive diagnostic tool for gynaecological oncology. Furthermore, this study demonstrates that rigorous control of pre-analytical variables are essential for reproducible clinical implementation of Raman-based liquid biopsies.

EP032 / #1004

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

IMPACT OF MISMATCH REPAIR STATUS ON OUTCOMES OF PATIENTS WHO RECEIVED IMMUNOTHERAPY FOR TREATMENT OF ENDOMETRIAL CANCER: A REAL-WORLD MULTI-CENTER RETROSPECTIVE STUDY

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Introduction: Recent randomized control trials have shown survival benefits of adding immunotherapy (IO) to treatment of mismatch repair deficient (dMMR) and proficient (pMMR) endometrial cancer (EC). We studied real-world, long-term outcomes of patients with late-stage or recurrent EC who received IO.

Methods: This is a multi-site retrospective cohort study of patients with EC who received IO between 10/2022–01/2026. Demographics, diagnoses, and treatment data were collected from medical records. Kaplan-Meier curves estimated progression-free survival (PFS) and overall survival (OS). Groups were compared using log-rank tests and multivariable Cox proportional hazard models. Results were reported as hazard ratios (HR) with 95% confidence intervals (CI); $p<0.05$ indicated significance.

Results: 122 EC patients received IO (48.4% dostarlimab, 51.6% pembrolizumab). Baseline characteristics are summarized in Table 1. Most had stage III/IV disease (77.8%), were pMMR (74.6%), and received IO as primary treatment (66.3%). Despite greater median PFS in dMMR patients (49.9 vs. 31.2 months), MMR status did not significantly affect PFS (pMMR vs. dMMR: HR=1.81, p=0.088) or OS (HR=1.44, p=0.512). After adjusting for age, race, FIGO stage, histology, neoadjuvant chemotherapy administration, and IO regimen, MMR status remained non-significant for both PFS (HR=0.88, p=0.772) and OS (HR=1.11, p=0.884) (see Table 2). Subgroup analysis of primary chemotherapy-IO patients showed similar trends. Adjuvant radiation did not significantly affect PFS or

Table 1. Descriptive Statistics of the Overall Sample (n=122)

Characteristic		
Age		65.4 ± 9.9
Age < 65		55 (45.1%)
Race	*White*	44 (36.1%)
	Asian	27 (22.1%)
	African American	29 (23.8%)
	Other	22 (18.0%)
FIGO 2009 Stage	*1-2*	27 (22.1%)
	3	53 (43.4%)
	4	42 (34.4%)
Histology	*Endometrioid*	48 (39.3%)
	Serous	31 (25.4%)
	Other	29 (23.8%)
	Carcinosarcoma	14 (11.5%)
MMR	*Proficient*	85 (69.7%)
	Deficient	29 (23.8%)
	Not available	8 (6.6%)
p53 Status	*Wild type*	54 (44.3%)
	Aberrant	47 (38.5%)
	Mutated	15 (12.3%)
	Not available	6 (4.9%)
Neoadjuvant Chemotherapy		37 (30.3%)
Surgery		110 (90.2%)
Adjuvant Chemotherapy		78 (63.9%)
Type of Immunotherapy	*Dostarlimab*	59 (48.4%)
	Pembrolizumab	63 (51.6%)
Adjuvant Radiation		41 (33.6%)
Recurrence		58 (47.5%)
Mortality		24 (19.7%)

OS.

Table 2. Univariate and multivariate analyses for PFS and OS

Characteristic	Progression free survival				Overall survival			
	Univariate analysis		Multivariate analysis		Univariate analysis		Multivariate analysis	
	HR (95% CI)	p-value	HR (95% CI)	p-value	HR (95% CI)	p-value	HR (95% CI)	p-value
Age *(unit=5)*	1.18 (1.03-1.36)	0.0196	1.15 (0.98, 1.35)	0.0914	1.04 (0.84, 1.30)	0.6983	0.97 (0.76, 1.24)	0.7902
Age *(≥ 65 vs. < 65)*	2.09 (1.18-3.71)	0.0104			1.10 (0.48-2.54)	0.8142		
Race		0.0610		0.0481		0.0963		0.0461
African American	1.32 (0.59-2.92)		1.34 (0.55, 3.24)		0.64 (0.15-2.73)		0.49 (0.10, 2.44)	
Asian	0.37 (0.15-0.93)		0.23 (0.07, 0.80)		2.00 (0.69-5.79)		4.39 (0.97, 19.77)	
Other	*Reference*		*Reference*		*Reference*		*Reference*	
White	0.84 (0.43-1.65)		0.97 (0.43, 2.19)		0.65 (0.18-2.26)		1.24 (0.27, 5.79)	
FIGO 2009 Stage		0.1011		0.1403		0.0057		0.0277
1-2	*Reference*		*Reference*		*Reference*		*Reference*	
3	0.53 (0.29-0.98)		1.02 (0.42, 2.48)		0.64 (0.19-2.14)		0.10 (0.02, 0.61)	
4	0.91 (0.47-1.77)		2.60 (0.79, 8.56)		2.76 (1.03-7.42)		0.37 (0.08, 1.76)	
Histology		0.1419		0.2131		0.0979		0.0959
Carcinosarcoma	1.71 (0.78-3.75)		2.53 (0.95, 6.80)		2.63 (0.69-9.98)		5.43 (0.99, 29.87)	
Endometrioid	*Reference*		*Reference*		*Reference*		*Reference*	
Other	1.98 (1.00-3.93)		2.11 (0.88, 5.07)		2.89 (0.90-9.25)		4.62 (1.03, 20.79)	
Serous	1.95 (0.92-4.15)		1.78 (0.70, 4.57)		3.84 (1.24-11.91)		6.29 (1.41, 28.00)	
MMR		0.0881		0.7716		0.5117		0.8841
Deficient	*Reference*		*Reference*		*Reference*		*Reference*	
Proficient	1.81 (0.91-3.64)		0.88 (0.38, 2.07)		1.44 (0.48-4.31)		1.11 (0.28, 4.48)	
p53 Status		0.9056				0.1276		
Aberrant	1.10 (0.59-2.08)				2.52 (0.97-6.59)			
Mutated	1.18 (0.53-2.61)				1.16 (0.28-4.75)			
Wild type	*Reference*				*Reference*			
Neoadjuvant Chemotherapy*	0.41 (0.16-1.04)	0.0520	0.41 (0.13, 1.25)	0.1174	3.90 (1.58-9.62)	0.0015	1.41 (0.41, 4.86)	0.5901
Adjuvant Chemotherapy*	1.15 (0.66-2.00)	0.6279			0.72 (0.32-1.61)	0.4149		
Type of Immunotherapy		0.9169				0.5022		
Dostarlimab	1.03 (0.59-1.81)				1.33 (0.57-3.10)			
Pembrolizumab	*Reference*				*Reference*			
Immunotherapy Regimen		0.0589		0.2294		0.0200		0.0129
Primary Treatment	0.57 (0.31-1.03)		0.51 (0.17, 1.53)		3.27 (1.17-9.15)		11.06 (1.66, 73.65)	
Recurrence	*Reference*		*Reference*		*Reference*		*Reference*	
Adjuvant Radiation*	1.17 (0.69-1.98)	0.5562			0.86 (0.37-2.00)	0.7300		

** Yes vs. No*

Conclusion/Implications: MMR status did not significantly affect PFS/OS among IO-treated EC patients, consistent with current data. Adjuvant radiation did not significantly affect prognosis in IO-treated patients, suggesting its role warrants reevaluation. These findings highlight the importance of evaluating real-world long-term IO outcomes.

EP033 / #473

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

PROFILES OF HISTONE POST-TRANSLATIONAL MODIFICATIONS THROUGH CERVICAL CARCINOGENESIS

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Introduction: The mutational landscape of squamous cell carcinoma (SCC) of the uterine cervix is limited, with *PIK3CA* (26%) and *EP300* (11%) being two of the most commonly mutated genes, of which *EP300* encodes a histone acetyltransferase (HAT). Epigenetic alterations, including histone post-translational modifications (PTMs), may therefore play a key role in cervical cancer pathogenesis.

Methods: Cases were reviewed by a gynecologic pathologist and 1.5 mm-core tissue microarrays (TMAs) constructed. Global expression of histone PTMs across all four core histones (H2A, H2B, H3, H4)—including acetylation, methylation, and ubiquitination—was assessed by multiplex immunofluorescence (mxIF) using PTM-specific antibodies on the Leica Cell DIVE platform. Intensity levels were normalized to respective total histone.

Results: Seventeen histone PTMs were examined across 44 HSIL (High-grade Squamous Intraepithelial Lesion) cores, 10 SCC cores, 24 benign cores, and 9 LSIL (Low-grade SIL) cores. Histone PTMs associated with repressive (e.g., Histone 2A lysine 119-ubiquitin, H2AK119ub) or active (e.g., Histone 3 lysine 27-acetyl, H3K27ac) transcription did not form distinct clusters with one another. Histone PTM profiles were distinct across the benign-to-SCC spectrum. Notable findings included elevated H2AK119ub and H3K27ac, with highest intensities observed in HSIL rather than SCC cores; no PTMs showed a monotonically increasing trend through carcinogenesis. Comparing HSIL cores with/without known cancer outcomes, distinct histone PTM profiles were observed.

Conclusion/Implications: Histone PTMs are significantly dysregulated in cervical dysplasia, with aberrant expression of both active and repressive marks, suggesting broadly dysregulated epigenetic landscape through the histologic spectrum. Histone PTM alterations may represent a key biological step in cervical carcinogenesis.

EP034 / #333

Topic: *AS01. Basic & Translational Science / AS01b. Translational Findings*

PLASMA CELL-FREE RNA PROFILING ENABLES GYNECOLOGIC CANCERS DISCRIMINATION AND REVEALS TUMOR-TYPE SPECIFIC IMMUNE AND TISSUE-ORIGIN SIGNATURES

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Introduction: Gynecological cancers, inculding cervical cancer(CC), endometrial cancer(EC), ovarian cancer(OC), lack non-invasive biomarkers for differential diagnosis. We evaluated plasma cell-free RNA (cfRNA) as a liquid biopsy tool for cancer-type discrimination and biological characterization.

Methods: Plasma cfRNA sequencing was performed on 40 CC, 28 EC, 36 OC patients and 27 controls . PCA separated cancer types globally. Shared and unique DEGs were identified. Immune deconvolution (CIBERSORTx) was applied to infer the relative proportions of immune cell subtypes in plasma cfRNA, and tissue-origin analysis (HPA signatures) was performed to quantify tissue-level contributions.

Results: PCA revealed healthy controls formed a compact cluster, while CC, EC, and OC samples showed broader dispersion with greater heterogeneity. Across all three cancers, common upregulated pathways were identified, including oxidative phosphorylation, neutrophil degranulation, and hemostasis. Notably, CC uniquely enriched in platelet activation and cell adhesion pathways, while OC in humoral immune response. Immune deconvolution revealed CC with elevated CD8+ T cells and neutrophils, OC with enriched M2 macrophages, and EC with higher monocytes compared to CC. Clinically, resting NK cells correlated with advanced CC stage, plasma cells with BRCA mutation in OC, monocytes with tumor differentiation in EC. Finally, only OC patients showed elevated ovary-specific cfRNA contribution with reduced bone marrow contribution, supporting plasma cfRNA for non-invasive tumor origin identification.

Conclusion/Implications: Plasma cfRNA captures both shared and tumor-type-specific transcriptomic programs. Combined with immune and tissue-origin deconvolution, it provides a non-invasive tool for differential diagnosis, immunophenotyping, and biomarker discovery in gynecologic cancers.

EP035 / #981

Topic: *AS02. Clinical Disciplines / AS02a. Artificial Intelligence Applied to Medicine*

MACHINE LEARNING SURVIVAL MODELS FOR PREDICTING RECURRENCE-FREE SURVIVAL AFTER PRIMARY RADICAL HYSTERECTOMY FOR EARLY-STAGE CERVICAL CANCER: DEVELOPMENT AND INTERNAL VALIDATION

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Introduction: Postoperative recurrence risk stratification in early-stage cervical cancer relies on categorical pathologic criteria that may not capture continuous individualized risk. Machine learning survival methods may improve prediction. We developed and internally validated multiple algorithms to predict recurrence-free survival following primary radical hysterectomy.

Methods: A single-center retrospective cohort of 1304 patients with FIGO IA1–IIA1 cervical cancer treated with primary radical hysterectomy at Chiang Mai University from 2003 to 2019. The outcome was recurrence-free survival. Sixteen pre-specified clinicopathologic and inflammatory predictors were modeled using restricted cubic splines for non-linear continuous variables. Four survival algorithms were compared: Cox proportional hazards (Cox), penalized Cox (Elastic Net), random survival forest (RSF), and componentwise gradient boosting (CoxBoost). Missing data were handled by multiple imputation. Optimism-corrected internal validation used bootstrap resampling within each imputed dataset, replaying the full modeling pipeline, including hyperparameter tuning.

Results: There were 115 recurrence events (8.8%) over a median follow-up of 72.4 months. Optimism-corrected Harrell C-indices were 0.799 for RSF, 0.731 for Cox, 0.730 for penalized Cox, and 0.728 for CoxBoost. Calibration slopes (ideal=1.0) were 1.06 for penalized Cox, 1.05 for CoxBoost, 0.77 for Cox, and 1.32 for RSF. RSF demonstrated greater optimism (ΔC=0.085) than the linear models (ΔC=0.026-0.040). The RSF integrated calibration index was 0.038 at 36 months and 0.049 at 60 months.

Conclusion/Implications: RSF offered superior discrimination but inferior calibration; penalized Cox and CoxBoost were best calibrated. Algorithm choice should match the intended clinical use, whether discrimination-focused triage or absolute risk estimation for adjuvant therapy decisions.

EP036 / #1054

Topic: *AS02. Clinical Disciplines / AS02a. Artificial Intelligence Applied to Medicine*

CONTRAST-ENHANCED CT-BASED RADIOMICS CHARACTERISATION OF OVARIAN MASSES: DIFFERENTIATING BENIGN, BORDERLINE, AND MALIGNANT LESIONS

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Introduction: Accurate preoperative differentiation of benign, borderline (BOT), and malignant ovarian tumours is essential for clinical management. CT interpretation is subjective, and biopsy is often avoided due to risk of upstaging disease. Radiomics enables quantitative imaging analysis and may improve diagnostic performance. This study evaluates a contrast-enhanced CT (CE-CT) radiomics model for adnexal mass classification.

Methods: A total of 228 histologically confirmed adnexal masses in 188 patients from a tertiary cancer centre were analysed using CE-CT. Regions of interest were manually segmented using XNAT, followed by isotropic resampling (1×1×1mm), and signal intensity normalisation (0~65535). The dataset underwent randomised stratification into training (Benign=47;BOT=40;Malignant=73) and testing (Benign=23;BOT=16;Malignant=29) sets using a 7:3 split (for model development and performance assessment, respectively), with no significant class imbalance. TexLabv3 extracted 4677 radiomic features; following variance thresholding and ANOVA -based selection, 25 features were retained for classification.

Results: In the training cohort, AUCs were 0.83 (benign), 0.86 (BOT), and 0.86 (malignant). Sensitivity was 0.47 (benign), 0.75 (BOT), and 0.80 (malignant), with specificity 0.84. PPV/NPV were 0.69/0.67 (benign), 0.71/0.79 (BOT), and 0.85/0.80 (malignant). Balanced accuracy was 0.69 (benign), 0.77 (BOT), and 0.80 (malignant). In the test cohort, AUCs were 0.63 (benign), 0.61 (BOT), and 0.73 (malignant). Sensitivity was 0.26 (benign), 0.36 (BOT), and 0.72 (malignant), with specificity 0.68. PPV/NPV were 0.40/0.55 (benign), 0.53/0.64 (BOT), and 0.70/0.72 (malignant). Balanced accuracy was 0.56 (benign), 0.60 (BOT), and 0.70 (malignant).

Conclusion/Implications: CE-CT radiomics demonstrates promising performance for ovarian tumour classification, particularly for malignant disease, supporting its potential as a decision-support tool for preoperative risk stratification.

EP037 / #620

Topic: *AS02. Clinical Disciplines / AS02a. Artificial Intelligence Applied to Medicine*

DEVELOPMENT AND VALIDATION OF LLM-BASED PATIENT DECISION AID FOR CHOOSING RISK REDUCING SURGERY IN PATIENTS WITH HEREDITARY RISK OF GYNECOLOGIC CANCER

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Introduction: Patients at genetically increased risk for gynecologic cancer face complex decisions regarding risk-reducing surgery. Decision aids can improve informed decision making, and large language models (LLMs) may enhance the accessibility and personalization of such tools when appropriately designed. We developed and validated an LLM-based patient decision aid for this population.

Methods: Expanding on prior work developing an app-based patient decision aid, we developed a retrieval augmentation generation (RAG)-based LLM on Claude Sonnet 4.5 with iterative prompt engineering to optimize accuracy, clarity, and safety. The tool was evaluated using 10 standardized clinical cases. Responses were rated for accuracy, comprehensiveness, clarity, and misinformation and scored on Likert Scale (1-5). Respondents surveyed on strengths, concerns, and asked if tool can be used by patients (Yes, No, or With Supervision). Evaluations were performed independently by both expert gynecologic oncologists and an LLM using a healthcare-focused framework (ChatGPT Healthcare).

Results: We successfully developed a RAG-based prompted LLM as a patient decision aid for patients at increased risk of gynecologic cancer due to common germline mutations (BRCA1/2, BRIP1, PALB2, RAD51C/D, ATM, and Lynch Syndrome). This tool was found to be accurate, comprehensive, clear, and minimized misinformation with mean scores >4.5/5 on Likert scales. Clinician scores were comparable to LLM-based validation. Clinical experts indicated the tool was appropriate to pilot in high-risk patient population with human supervision.

Conclusion/Implications: Development of an LLM-based patient decision aid for management of gynecologic cancer risk is feasible. Validation demonstrated strong performance across key quality domains, supporting prospective pilot testing as a supervised decision-support tool.

EP038 / #763

Topic: *AS02. Clinical Disciplines / AS02a. Artificial Intelligence Applied to Medicine*

MULTI-TASK SURVIVAL PREDICTION IN EARLY-STAGE CERVICAL SQUAMOUS CELL CARCINOMA USING AN IMMUNOHISTOCHEMISTRY-INTEGRATED PATHOLOGY MODEL

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Introduction: Early-stage cervical squamous cell carcinoma (CSCC), particularly FIGO stage I–IIA surgically resectable cases, remains difficult to stratify, as traditional Peters and Sedlis criteria fail to capture tumor heterogeneity.

Methods: We developed CIPHER (Cervical Immunohistochemistry–Pathology Enhanced Risk), a deep-learning model integrating histopathology and immunohistochemistry (IHC) representations for individualized survival prediction. CIPHER directly infers 12 IHC markers from H&E slides and jointly models overall and progression-free survival within a multi-task framework. Multi-omics analyses combining bulk RNA-seq, spatial transcriptomics, and single-cell profiling were used to characterize the biological features associated with CIPHER-defined risk.

Results: CIPHER achieved robust prognostic discrimination across four independent cohorts (C-index = 0.853 [FUSCC], 0.743 [TCGA], 0.749 [Uganda]) and significant survival separation in the Taizhou cohort (log-rank p = 0.00059). The model accurately predicted IHC marker expression (AUC range: 0.701–0.930; highest for PR). Multi-omics integration revealed that CIPHER-defined high-risk tumors exhibit epithelial–mesenchymal transition (EMT) progression and immune suppression localized at tumor–stroma interfaces. Through spatial mapping and pathology heatmaps, we identified a cluster of $MMP11^{+}$ cancer-associated fibroblasts (CAFs) enriched along these interfaces and linked to adverse prognosis.

Conclusion/Implications: CIPHER provides an interpretable and generalizable framework bridging digital pathology with tumor biology, offering quantitative precision beyond conventional clinicopathologic systems for early-stage CSCC.

EP039 / #666

Topic: *AS02. Clinical Disciplines / AS02a. Artificial Intelligence Applied to Medicine*

ENHANCING THE FEASIBILITY OF MACHINE LEARNING FOR PREDICTING CANCER-ASSOCIATED THROMBOSIS IN SMALL CLINICAL COHORTS: A PILOT STUDY

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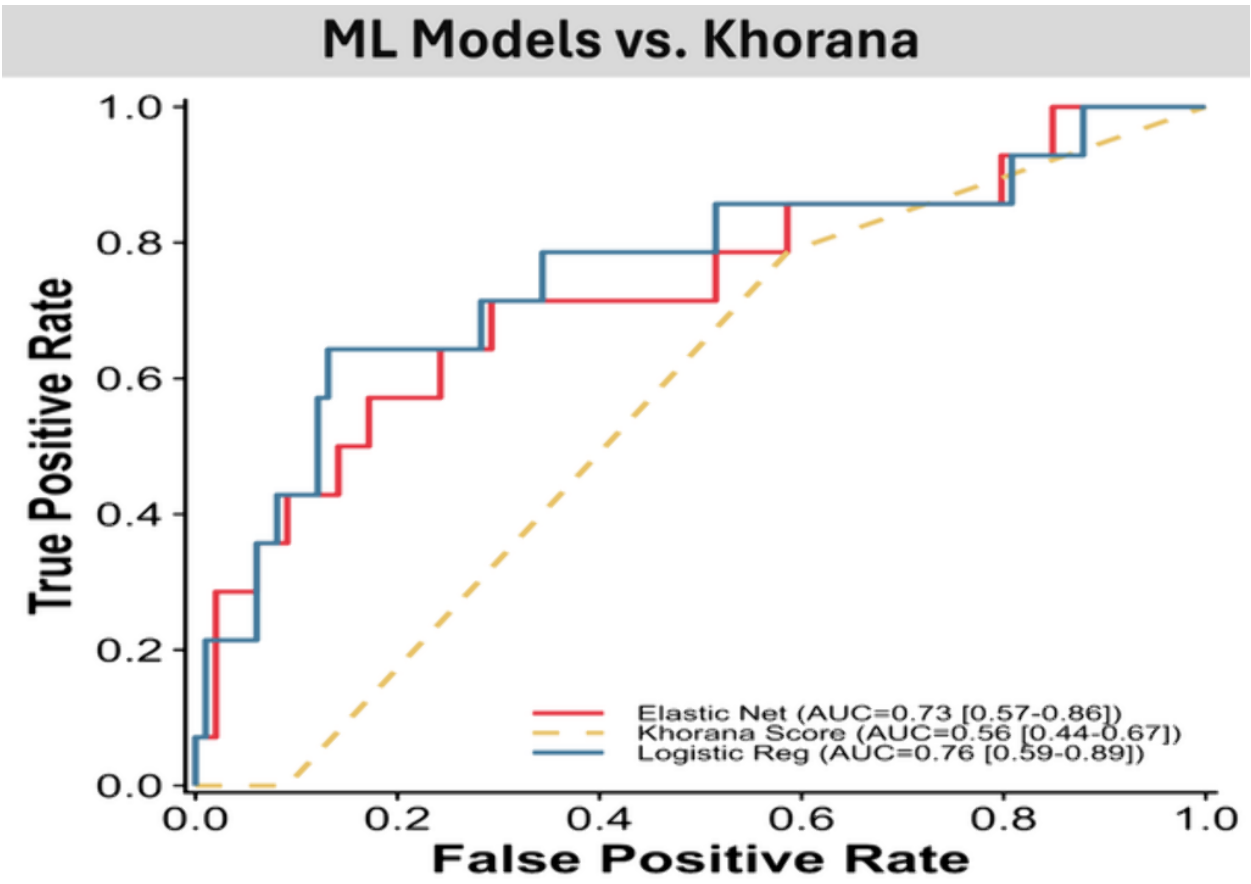
Introduction: Cancer-associated thrombosis (CAT) is the second leading cause of mortality in cancer patients. Machine learning (ML) CAT prediction is limited by CAT's multifactorial risk profile and low incidence, resulting in a low events-per-predictor (EPP) ratio. This pilot study employed Factor Analysis of Mixed Data (FAMD) dimensionality reduction to enhance ML feasibility by improving the EPP ratio.

Methods: We retrospectively studied 113 patients with breast, ovarian, or endometrial cancer receiving chemotherapy, of whom 14 (12.4%) developed venous thromboembolism within six months. 117 continuous and categorical variables were collected. FAMD compressed these variables into independent biological dimensions. Least Absolute Shrinkage and Selection Operator (LASSO) regression identified predictive dimensions, and elastic net and logistic regression models were compared to the Khorana Risk Score (KRS).

Results: FAMD compressed 117 variables into 6 dimensions, increasing the EPP from 0.12 to 2.33 (Figure 1). LASSO retained all 6 dimensions as meaningful predictors while selecting zero raw variables. Elastic net and logistic regression achieved significant discrimination [AUC=0.73 (95% CI: 0.57–0.86) and 0.76 (95% CI: 0.59–0.89)], while the KRS did not [AUC=0.56 (95% CI: 0.44–0.67)] (Figure 2). The DeLong test did not confirm statistically superior discrimination of the ML models over the KRS (p=0.108 and p=0.074). ML models achieved greater statistical power than the KRS [81.9% vs. 12.3%].

FAMD Dimensions

Dimension & Key Variables	% of Patient Differences Explained
1 **Alkylating Agent Chemotherapy & Cancer Type** Breast/Ovarian cancer · Platinum · Carboplatin · Cyclophosphamide · SII · NLR · Staging	10.9%
2 **Hematological Reserve** RBC · Hgb · Lymphocytes ([a]T1 & [b]T2)	8.5%
3 **RBC Morphology & HER2 -Targeted Therapy** MCH · MCV (T1 & T2) · Emtansine · Epirubicin · Fluorouracil	7.2%
4 **Post-Chemotherapy Immune Response** Neutrophil · SII · NLR · N/LP · WBC · SIRI (T1 & T2)	6.6%
5 **Antimetabolite Chemotherapy** Capecitabine · Gemcitabine	5.9%
6 **Baseline Hypercoagulability** Monocytes · WBC · SIRI · Platelets · Khorana intermediate risk	5.4%
Σ **Total Data Variance Captured by 6 Dimensions** Patient-to-patient data variation across all 117 variables summarized by 6 dimensions	44.5%



Conclusion/Implications: As the first application of this technique in this context, FAMD theoretically reduced the required sample size from 17,727 to 909 patients. Findings are preliminary and hypothesis-generating; prospective multicentre validation is required before clinical application.

EP040 / #1080

Topic: *AS02. Clinical Disciplines / AS02a. Artificial Intelligence Applied to Medicine*

COMPARATIVE PERFORMANCE OF LARGE LANGUAGE MODELS ON GYNECOLOGIC ONCOLOGY TUMOR BOARD QUESTIONS USING LIKERT-SCALE CONCORDANCE

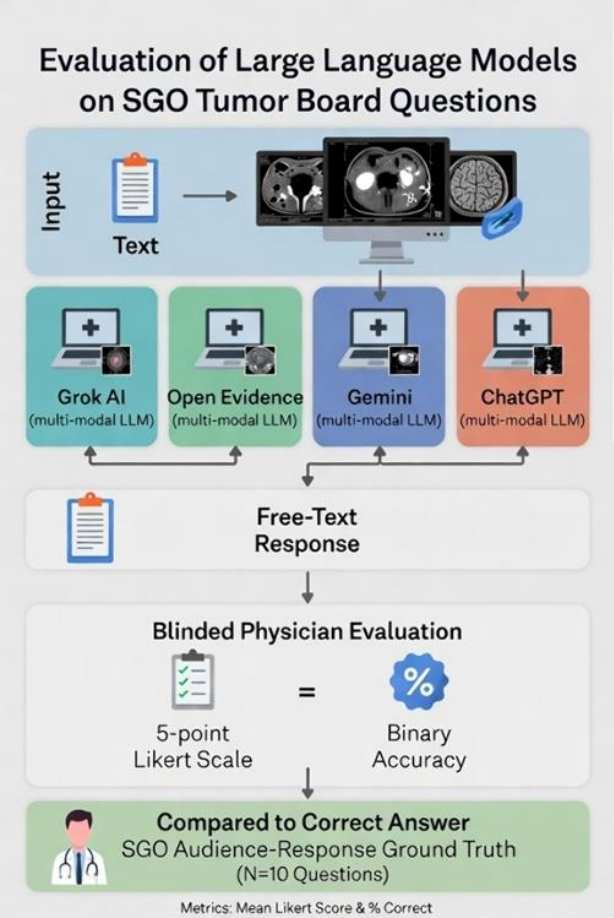
Pouya Javadian[1], Gregg Nelson[2], Leslie M. Randall[3], Jesus Bosquet[4], Christopher Tarney[5]
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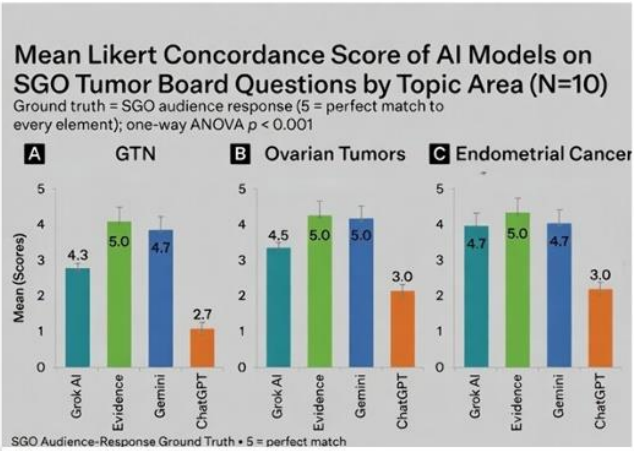
Introduction: To evaluate the performance of four large language models (Grok AI, Open Evidence, Gemini, ChatGPT) in answering real-world tumor board questions using a 5-point Likert scale for concordance with official SGO audience-response ground truth.

Methods: Ten de-identified gynecologic oncology tumor board questions from the Society of Gynecologic Oncology annual meeting (covering gestational trophoblastic neoplasia, ovarian borderline/mucinous tumors, and high-risk endometrial cancer) were presented to each model. Free-text responses were graded blindly on a 5-point Likert scale (1 = strongly disagree/major deviation; 5 = strongly agree/perfect match to every ground-truth element). Mean scores and standard deviations were calculated; overall differences were assessed by one-way ANOVA.

Results: Open Evidence achieved a perfect mean Likert score of 5.0 ± 0.0, Gemini scored 4.8 ± 0.63, Grok AI scored 4.6 ± 0.70, and ChatGPT scored 2.9 ± 1.10 (one-way ANOVA $p < 0.001$; Table 1). Binary accuracy (proportion of responses containing every ground-truth element) was 100% for Open Evidence, 90% for Gemini, 80% for Grok AI, and 40% for ChatGPT. Performance was highest on endometrial cancer questions and lowest on GTN management. Figure 1. Mean Likert concordance scores (1–5 scale) One-way ANOVA p <

0.001.





Conclusion/Implications: Select large language models demonstrate near-perfect concordance with SGO 2026 meeting's expert consensus when evaluated with a nuanced Likert scale. These findings highlight both the promise and current limitations of LLMs as decision-support tools in gynecologic oncology. Larger prospective validation on diverse datasets is warranted before clinical integration.

EP041 / #617

Topic: *AS02. Clinical Disciplines / AS02a. Artificial Intelligence Applied to Medicine*

OPTIMIZING SURVIVORSHIP CARE: A CLINICIAN-REVIEWED AI TOOL FOR ENDOMETRIAL CANCER MONITORING

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Introduction: Rising cancer survivorship is outpacing growth in the oncology workforce. The imbalance between patient needs and provider availability creates a significant need to efficiently track and monitor cancer survivors for early identification of treatment effects, recurrence, and secondary cancers. However, monitoring survivors in follow-up care can be a time-consuming process. We developed and tested an artificial intelligence (AI) approach for the identification, tracking, and management of endometrial cancer patients, with additional testing in other subspecialties.

Methods: Clinical and technical experts developed and piloted the novel AI application (VIPCare). Clinicians mapped endometrial cancer care states into a flow diagram (Figure 1). This was entered into VIPCare to automatically generate questions for retrieval and summarization of evidence from patient electronic health records. VIPCare uses the evidence to identify the current patient care state and provide justification. Model performance was evaluated via percentage agreement with clinicians using retrospective patient data.

Results: VIPCare correctly identified the care state with appropriate justifications for all ten endometrial patients (Figure 2). Similar results were observed for additional cancers (breast and prostate) with combined percentage agreement of 94% (n=16/17). The model also produced a clinical timeline with citations to underlying medical records.

Conclusion/Implications: VIPCare was successfully piloted on patients with endometrial cancer and validated on two other cancers. Our results show leveraging AI to retrieve and analyze relevant patient medical records can assist care continuity. Future work will expand the study sample, evaluate positive impacts on loss to follow-up, and extend VIPCare to include guideline-based follow-up recommendations.

EP042 / #671

Topic: *AS02. Clinical Disciplines / AS02a. Artificial Intelligence Applied to Medicine*

ASSESSING CONCORDANCE BETWEEN MULTIDISCIPLINARY TUMOR BOARD RECOMMENDATIONS AND THE AI PLATFORM OPENEVIDENCE: IMPLICATIONS FOR CLINICAL DECISION-MAKING AND EDUCATION

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Introduction: Multidisciplinary tumor boards (MDTs) are the standard of care for gynecologic oncology treatment planning, yet alignment between MDT consensus and AI clinical decision support platforms remains poorly defined. This study evaluates concordance between gynecologic oncology MDT recommendations and those generated by OpenEvidence, a guideline-anchored AI platform.

Methods: We conducted a retrospective concordance study of consecutive cases presented at a gynecologic oncology MDT conference (October 2025–March 2026). Anonymized clinical vignettes were entered into OpenEvidence and recommendations were compared across three domains: primary treatment, expanded systemic therapy, and conditional reasoning. Agreement was quantified using Cohen's kappa (κ).

Results: Forty-nine cases were analyzed. Concordance was moderate to substantial for primary treatment category ($\kappa = 0.60$, 95% CI 0.44-0.77, $p < 0.0001$), moderate for expanded systemic therapy ($\kappa = 0.42$, 95% CI 0.21–0.63, $p < 0.0001$), and minimal for conditional reasoning ($\kappa = 0.11$, 95% CI −0.11–0.33, $p = 0.33$). Overall, 40.8% of cases showed exact agreement, 34.7% partial, and 24.5% discordance.

Conclusion/Implications: OpenEvidence demonstrates meaningful concordance with MDT recommendations in structured scenarios but cannot replicate the individualized reasoning of multidisciplinary teams, particularly the integration of patient-specific context. AI tools are best positioned as structured supplements to MDT deliberation, supporting evidence-based documentation, clinical trial screening, and trainee education. In settings where formal MDT infrastructure is limited or unavailable, including lower- and middle-income countries, guideline-anchored AI platforms may bridge critical gaps in subspecialty expertise and improve equity in gynecologic oncology care. Standardization of tumor board documentation is proposed to maximize AI clinical utility across all practice settings.

EP043 / #250

Topic: *AS02. Clinical Disciplines / AS02b. Diagnostics & Imaging*

ACCURACY OF MRI COMPARED WITH CERVICAL EXCISIONAL PROCEDURES (CONIZATION, LEEP) FOR LOCAL STAGING OF CERVICAL CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

Yami Bhaskar[1], Maria Lemos[2], Camila Nakayama[3], Paweł Łajczak[4], Ayesha Ayesha[5], Joel Cardenas[6]

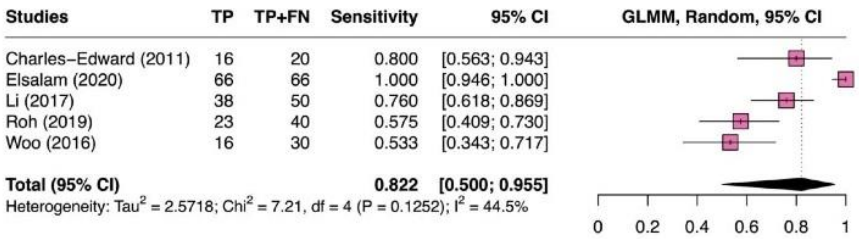
[1]Vydehi Institute of Medical Sciences and Research Centre, Bangalore, India, [2]Kurah Women's Health Institute, Macaé, Brazil, [3]University of mogi das cruzes, sao paulo, Brazil, [4]Medical University of Silesia, Katowice, Poland, [5]Shifa College of Medicine, Islamabad, Pakistan, [6]Cleveland Clinic, weston, United States of America

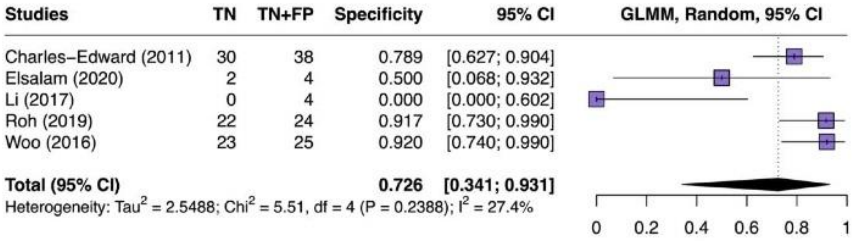
Introduction: Evaluating accurate local staging after cervical excisional procedures is essential for guiding further management in early cervical cancer. The diagnostic performance of magnetic resonance imaging (MRI) for staging and detecting residual disease in this setting remains unclear.

Methods: PubMed, EMBASE, Web of science and Cochrane Central were searched from inception to February 2026. Sensitivity and specificity were synthesized using bivariate random-effects models. Diagnostic odds ratio (DOR), accuracy, and summary receiver operating characteristic (SROC) area under the curve (AUC) were calculated.

Results: Fourteen studies comprising a total of 866 patients were included. For overall staging, pooled MRI sensitivity was 0.822 (95% CI 0.500–0.955) and specificity 0.726 (95% CI 0.341–0.931), with a DOR of 12.553 (95% CI 5.613–28.076) and accuracy of 0.804 (95% CI 0.656–0.898). The pooled SROC AUC for overall staging was 0.817, indicating good discriminatory performance. The pooled proportion of Concordance was 74.43% (95% CI 64.36–84.50), with overstaging and understaging occurring in 15.92% (95% CI 9.24–22.60) and 13.22% (95% CI 4.37–22.08) of cases, respectively. For residual disease detection, MRI demonstrated pooled sensitivity of 0.776, specificity of 0.905, DOR of 25.970, and accuracy of 0.834, with an AUC of

0.908.





Conclusion/Implications: MRI after cervical conization is a useful complementary tool for staging early cervical cancer, particularly for residual disease assessment and preoperative surgical planning. However, post-conization tissue changes may reduce its performance compared to untreated primary disease. Therefore, MRI should be interpreted as an adjunctive, rather than standalone, tool within a multimodal assessment.

EP044 / #488

Topic: *AS02. Clinical Disciplines / AS02b. Diagnostics & Imaging*

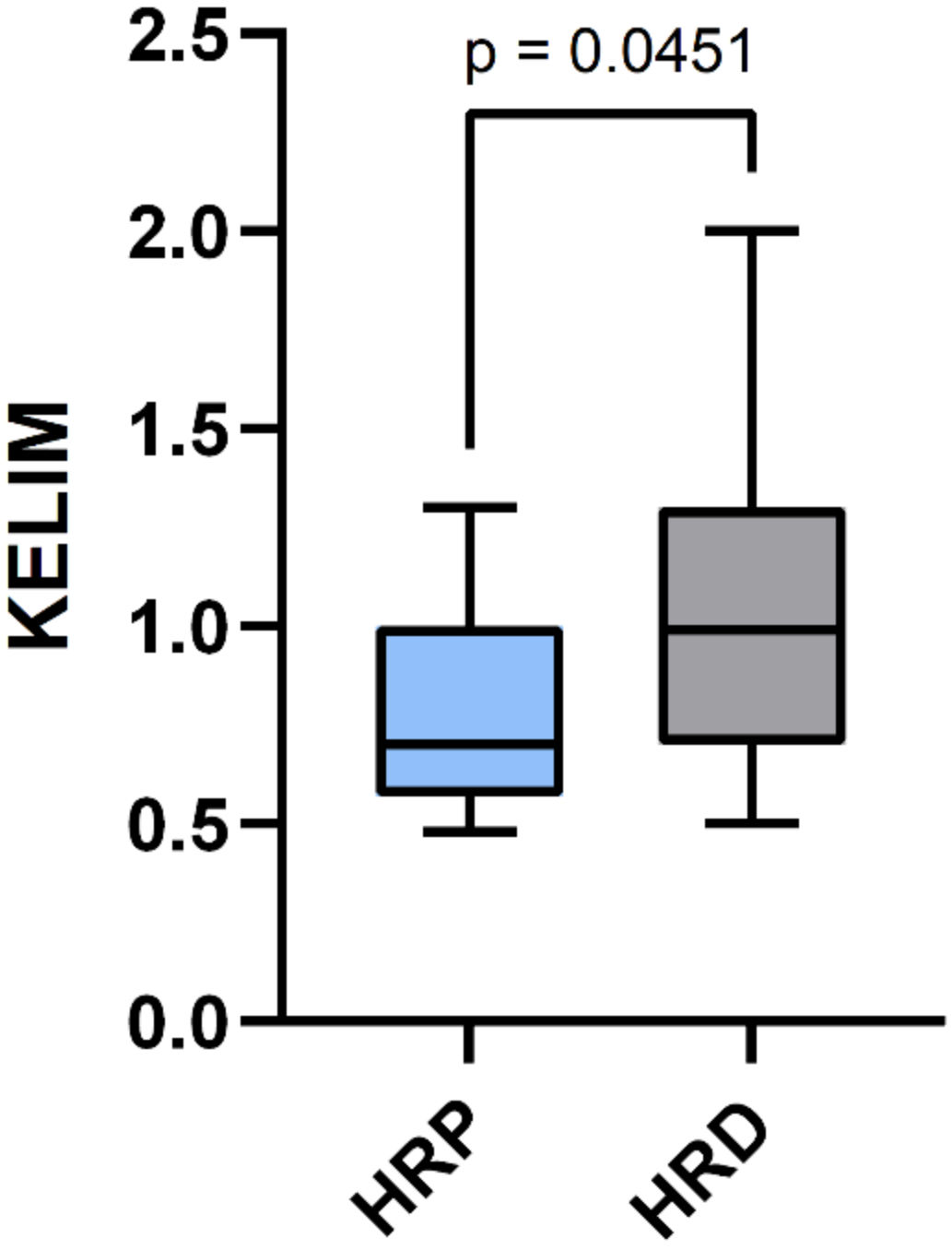
KELIM-BASED PREDICTION OF COMPLETE CYTOREDUCTION IN HIGH GRADE SEROUS OVARIAN CANCER VARIES BY HOMOLOGOUS RECOMBINATION STATUS

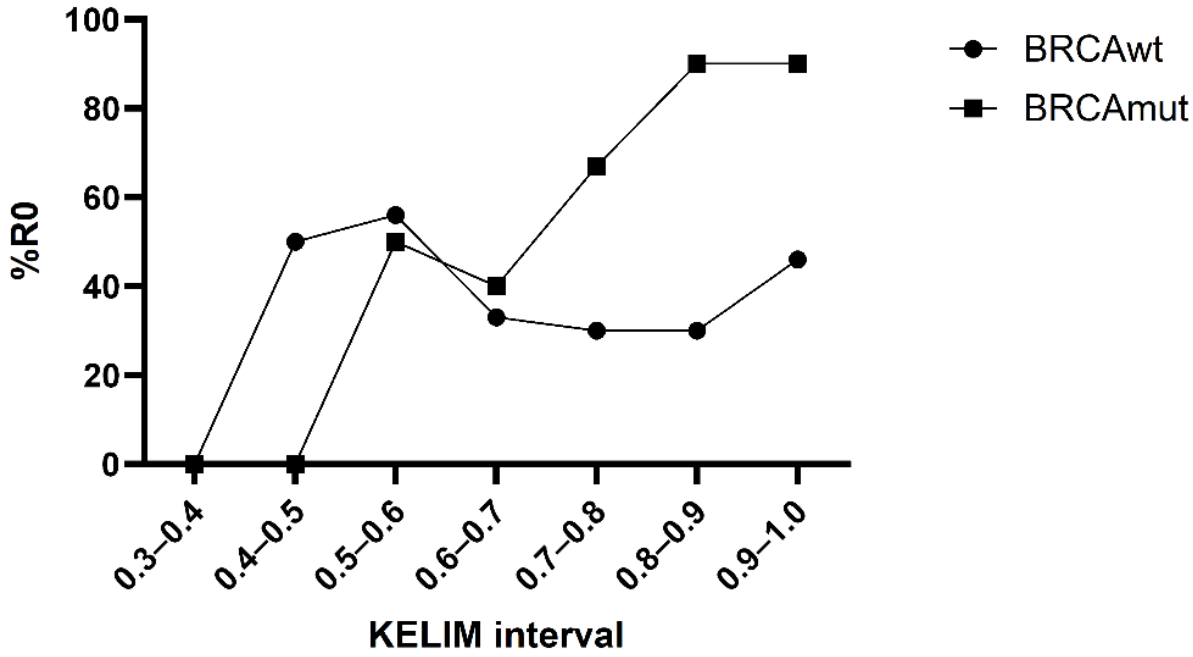
Mayerly Castrillón Sánchez[1,2], Gabriel Levin[3], Lawrie Shahbazian[3], Basile Tessier Cloutier[1,2], Laurence Bernard[3], Xing Zeng[3], Reitan Ribeiro[3], Lucy Gilbert[3], Shuk On Leung[1,2,3]
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Introduction: Currently, there is no reliable tool to predict complete cytoreduction. KELIM reflects tumor chemosensitivity. We evaluated KELIM as a predictor of complete cytoreduction in HGSOC, stratified by HRD status.

Methods: A single-center, retrospective study including HGSOC patients who underwent NACT between 2010 - 2025. KELIM values were calculated and categorized as favorable (≥1) or unfavorable (<1). ROC curve analysis was performed to determine the optimal KELIM cutoff for predicting complete cytoreduction. Associations between KELIM and degree of cytoreduction (R0, R1, R2) were evaluated. Correlations with BRCAmut/HRD status were explored.

Results: Overall, 145 patients were included, with a median age 64 years, (IQR 57–73), the median KELIM score was 0.93 (IQR 0.91–1.02). 58 (40%) patients had a favorable KELIM (≥1) and 87 (60%) had an unfavorable KELIM (<1). The rate of R0 was higher in patients with favorable KELIM 77.6% vs. 47.1% in the unfavorable KELIM group, p=0.002. KELIM values were higher in patients with R0 compared with those with incomplete cytoreduction (median 1.00, IQR 0.79–1.28 vs. 0.79, IQR 0.63–0.99; p <0 .001). HR status was available for 48 patients (33.1%), patientes who lacked HRD testing data and were excluded from analyses involving HR stratification. Subgroup ROC analyses revealed distinct KELIM cutoffs across molecular subgroups: for HRD tumors, an optimal cutoff of 0.74; for HRP tumors, cutoff 0.94; and for BRCA mutated tumors, cutoff 0.745.


p = 0.0451
KELIM
2.5
2.0
1.5
1.0
0.5
0.0
HRP
HRD



Conclusion/Implications: A single KELIM threshold may not be appropriate for all patients. Integration of KELIM with HR status may improve preoperative prediction of surgical outcomes and support individualized treatment planning.

EP045 / #888

Topic: *AS02. Clinical Disciplines / AS02b. Diagnostics & Imaging*

ASSOCIATION OF PAN-IMMUNE INFLAMMATION VALUE WITH ADVANCED CLINICAL STAGE IN OVARIAN CANCER

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Introduction: Ovarian cancer is frequently diagnosed at an advanced stage, leading to poor outcomes. The Pan-Immune Inflammation Value (PIV) has emerged as a potential biomarker reflecting systemic inflammation and tumor aggressiveness; however, its association with advanced clinical stage remains unclear. This study aimed to evaluate the relationship between PIV and advanced clinical stage.

Methods: In this cross-sectional study, 21 patients with ovarian cancer were included. Clinical stage was classified as early or advanced. PIV was calculated from pre-treatment blood counts. Group comparisons were performed, and logistic regression was used to evaluate the association between PIV and advanced clinical stage. Diagnostic performance was assessed using receiver operating characteristic (ROC) curves and the area under the curve (AUC).

Results: The mean age was 58.6 ± 10.6 years (range, 43–83). Advanced clinical stage was present in 52.4% of patients. The median PIV was 545.0 (IQR, 374.1–964.6) and was higher in patients with advanced clinical stage. PIV was associated with advanced clinical stage (OR 1.07 per 10-unit increase, 95% CI (1.01–1.13). The AUC for predicting advanced clinical stage was 0.927 (95% CI, 0.820–0.999). A PIV cutoff of 386 showed optimal diagnostic performance, with 100% sensitivity and 70% specificity.

Conclusion/Implications: PIV appears to be a promising biomarker for identifying advanced clinical stage in ovarian cancer, demonstrating high discriminative ability with clinically relevant sensitivity. These findings support its potential as a simple and accessible tool for stage stratification, particularly in resource-limited settings. However, given the small sample size and exploratory nature of this study, validation in larger cohorts is warranted.

EP046 / #771

Topic: *AS02. Clinical Disciplines / AS02b. Diagnostics & Imaging*

68GA-FAPI PET/CT IN THE STAGING OF HIGH-GRADE EPITHELIAL OVARIAN CANCERS: A PILOT STUDY

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Introduction: Accurate pre-operative mapping of disease extent is critical for surgical planning in advanced epithelial ovarian cancer (EOC). Fibroblast activation protein inhibitor (FAPI) PET/CT targets cancer-associated fibroblasts, abundant across EOC subtypes. PNT6555 is one of several dozen FAPI tracers. This pilot study assessed 68Ga-PNT6555PET/CT avidity in EOC and the correlation between site-level level ^{68}Ga-PNT6555PET/CT and intraoperative findings.

Methods: 27 treatment-naïve EOC patients were recruited and underwent 68Ga-PNT6555 PET/CT before primary cytoreductive surgery (PCS) or neoadjuvant chemotherapy (NACT); NACT patients had a second ^{68}Ga-PNT6555PET/CT pre-interval cytoreduction (ICS). ^{68}Ga-PNT6555PET/CT and surgical findings were reported independently across 25 sites. Site-level diagnostic performance was calculated; McNemar's and Wilcoxon signed-rank tests were used for paired comparisons.

Results: Median age 61; 85.2% HGS; 92.6% advanced stage. PCS in 19, NACT+ICS in 8. ^{68}Ga-PNT6555-avid disease was identified in 100% of patients across all subtypes. ^{68}Ga-PNT6555 sensitivity was 100% for adnexal and 95.0% for omental disease (PPVs 77.8%, 90.5%). Malignant ascites: sensitivity 81.2%, specificity 90.9%. Lymph nodes (LN): sensitivity 57.1%, PPV 50.0%. Other peritoneal deposits: sensitivity 96.2%, specificity 100%.Post-NACT, adnexal PPV dropped to 50.0% and 3/8 patients had unconfirmed ^{68}Ga-PNT6555PET/CT -positive LN signals (PPV
0%).

Table 1. Patient Demographics and Clinical Characteristics (n = 27)

Variable	Value (n = 27)
Age (years), mean ± SD	62.0 ± 10.2
Age (years), median [range]	61 [42–79]
Histology	
High-grade serous (HGS)	23 (85.2%)
Low-grade serous (LGS)	2 (7.4%)
Borderline (BOT)	1 (3.7%)
Borderline / LGS (BOT/LGS)	1 (3.7%)
Stage at Diagnosis	
Stage I–II	2 (7.4%)
Stage III	15 (55.6%)
Stage IV	10 (37.0%)
Stage III–IV combined	25 (92.6%)
CA-125 at diagnosis (U/mL), median (IQR)	1245 (523–2147)
Surgical Timing	
Primary cytoreductive surgery (PCS)	19 (70.4%)
Interval cytoreductive surgery after NACT (ICS)	8 (29.6%)
Surgical Outcome	
No gross residual disease (NGR)	18 (66.7%)
Optimal residual (<1 cm)	4 (14.8%)
Diagnostic laparotomy (suboptimal)	5 (18.5%)
Secondary Malignancy	
None	19 (70.4%)
History of prior malignancy	5 (18.5%)
Concurrent malignancy	3 (11.1%)

HGS, high-grade serous; LGS, low-grade serous; BOT, borderline ovarian tumour; NACT, neoadjuvant chemotherapy; ICS, interval cytoreductive surgery; IQR, interquartile range.

Table 2. Site-level Diagnostic Performance of FAPI PET vs. Intraoperative Findings (n = 27)

Site	Surg +	PET +	TP	FN	FP	TN	Sens	Spec	PPV	NPV	Accuracy	McNemar p
Adnexal mass	21/27	27/27	21	0	6	0	100%	0.0%†	77.8%	N/A‡	77.8%	0.031
Omentum	20/27	21/27	19	1	2	5	95.0%	71.4%	90.5%	83.3%	88.9%	1.000
Ascites	16/27	14/27	13	3	1	10	81.2%	90.9%	92.9%	76.9%	85.2%	0.625
Lymph nodes	7/27	8/27	4	3	4	16	57.1%	80.0%	50.0%	84.2%	74.1%	1.000
Other Peritoneal Deposits	26/27	25/27	25	1	0	1	41.7%	100.0%	100.0%	50.0%	96.3%	1.000

†Specificity = 0.0% for adnexal mass: all 6 surgery-negative patients had PET-avid adnexal uptake (TN = 0), reflecting universal FAPI uptake at this site regardless of confirmed disease. ‡NPV not calculable for adnexal mass: TN = 0 (0/0 undefined). Surg + = number with surgically confirmed disease; PET + = number with PET-avid signal at that site. TP, true positive; FN, false negative; FP, false positive; TN, true negative; Sens, sensitivity; Spec, specificity; PPV, positive predictive value; NPV, negative predictive value.

Conclusion/Implications: ^{68}Ga-PNT6555PET/CT demonstrated universal tumour avidity in EOC, with limited sensitivity for LN involvement and notably reduced diagnostic performance post-NACT. These preliminary findings indicate that ^{68}Ga-PNT6555PET/CT may be insufficiently sensitive to reliably guide pre-operative surgical planning. Larger prospective studies and protocol refinement are warranted to define its potential role as an adjunct imaging modality for EOC.

EP047 / #751

Topic: *AS02. Clinical Disciplines / AS02b. Diagnostics & Imaging*

LIVER METASTASIS AS A MARKER OF POOR SURVIVAL IN IMMUNOTHERAPY-TREATED GYNECOLOGIC CANCERS: HYPOTHESIS-GENERATING EVIDENCE FROM THE NCDB

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Introduction: Liver metastases potentially attenuate immune checkpoint inhibitor efficacy in gynecologic cancers through systemic immune tolerance.

Methods: National Cancer Database cohorts (NCDB) with lung metastatic cervical or endometrial cancers receiving immunotherapy were analyzed, comparing survival by liver involvement.

Results: For the cervical cancer cohort, 153 patients with lung metastasis at diagnosis, treated with primary immunotherapy were diagnosed, 36 (23.5%) had liver metastasis and 117 (76.5%) had no liver metastasis. The median age was 53 (interquartile range 44-60). One hundred twenty-eight patients (83.7%) were White, and 23 (15.0%) were Black. Overall, 94 (61.4%) had squamous histology, and 39 (25.5%) were adenocarcinoma histology. The median overall survival was 16.3 months (95% CI 12.0-20.5) in patients without liver metastasis, and 11.7 (10.4-12.9) in patients with liver metastasis, log rank =.002 (**Figure 1**). For the endometrial cancer cohort, there were 37 patients with lung and bone metastasis at diagnosis, treated with primary immunotherapy were diagnosed, 5 (13.5%) had liver metastasis and 32 (86.5%) had no liver metastasis. The median age was 61 (interquartile range 56-68). Thirty-two (86.5%) were White, and 4 (10.8%) were black. For histology: 19 (51.4%) were endometroid, seven (18.9%) were carcinosarcoma, and six (16.2%) were serous. The median overall survival was 19.8 months (95% CI 9.8-29.7) in patients without liver metastasis, and 2.2 (2.1-2.3) in patients with liver metastasis, log rank =.042 (**Figure 2**).

Figure 1. Cervical cancer with lung metastasis. Overall survival with and without liver metastasis.

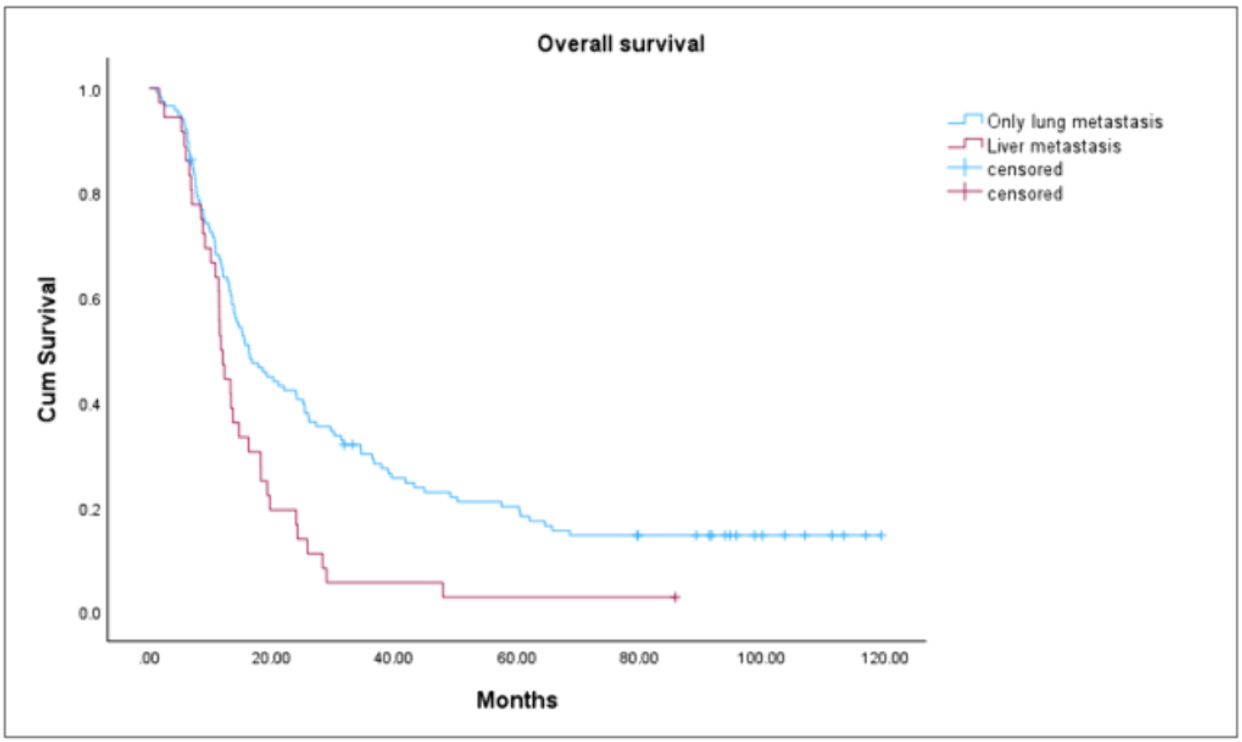
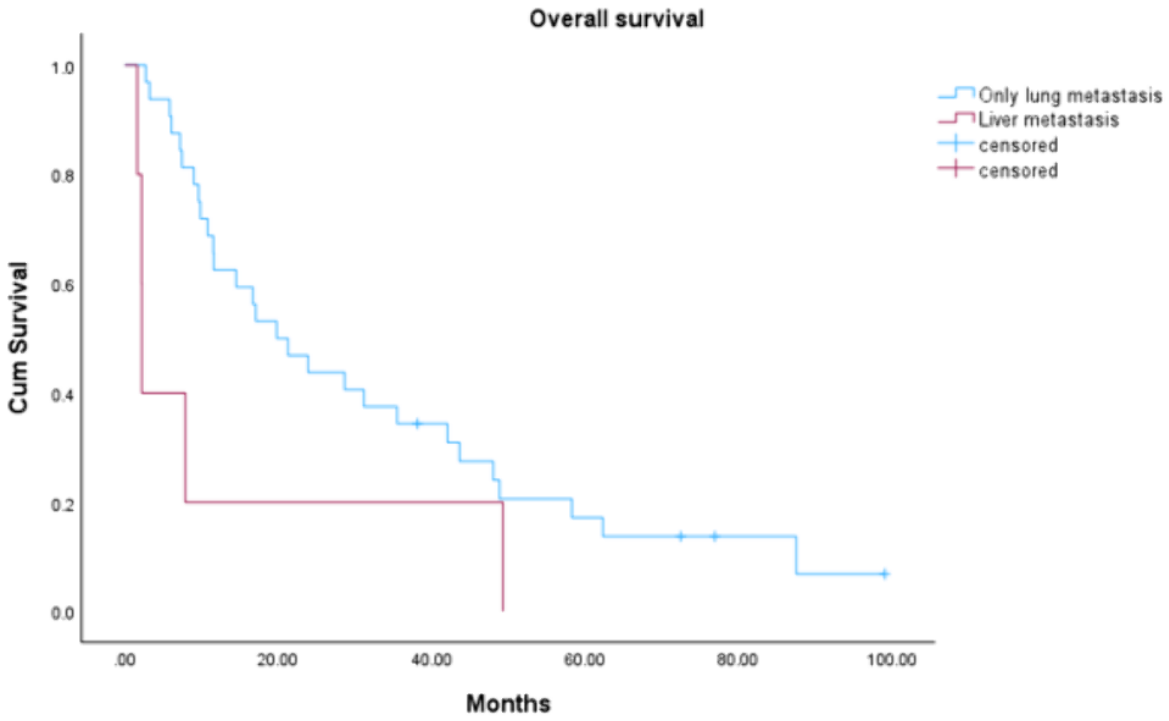


Figure 2. Endometrial cancer with lung metastasis. Overall survival with and without liver metastasis.



Conclusion/Implications: Liver metastasis significantly decreased survival, suggesting hepatic mediated resistance. Prospective research should identify strategies to overcome this immunosupressive state.

EP048 / #627

Topic: *AS02. Clinical Disciplines / AS02b. Diagnostics & Imaging*

DIAGNOSTIC ACCURACY OF ROUTINE PRE-OPERATIVE CT IN CLINICALLY EARLY-STAGE VULVAL SQUAMOUS CELL CARCINOMA

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Introduction: Preoperative imaging in Vulval Squamous Cell Carcinoma has traditionally included CT scanning of chest abdomen and pelvis to assess size of inguinal lymph nodes, which if enlarged would exclude patients from sentinel node biopsy (SLNB) and is also used to assess distant disease. More recently cross-sectional imaging has been replaced by groin ultrasound in some guidelines.

Methods: A retrospective single-institution cohort study of patients with clinical early stage VSCC between 2010 and 2025. All patients underwent pre-operative CT followed by surgical nodal staging via sentinel lymph node biopsy (SLNB), groin lymphadenectomy (GLND), or both. The primary outcome was the correlation between CT findings and histologically confirmed nodal metastasis. Diagnostic performance was calculated using sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) and accuracy.

Results: 127 patients were included. The prevalence of nodal metastasis was 24% (30/127). CT demonstrated a sensitivity of 17% and specificity of 86%. The PPV was 26%, and the NPV was 77%. Accuracy was 69%. There was no statistically significant association between CT positivity and histologically confirmed nodal metastases (Chi squared, $p = 0.8$). No distant metastatic disease was found in any patient.

Conclusion/Implications: Routine pre-operative CT demonstrated limited sensitivity and specificity for detection of nodal metastases in clinically node negative VSCC, and no distant disease was found. In appropriately selected patients, routine CT may be safely omitted, and targeted groin ultrasound is an alternative to exclude enlarged lymph nodes prior to surgical nodal staging.

EP049 / #44

Topic: *AS02. Clinical Disciplines / AS02b. Diagnostics & Imaging*

FEASIBILITY OF CTDNA FOR GYNECOLOGIC CANCER IN A COMMUNITY/TEACHING HOSPITAL

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Introduction: To determine the relationship between ctDNA and CT findings in endometrial and ovarian cancer

Methods: A chart review identified 46 patients with endometrial or ovarian cancer, ctDNA levels and recent imaging. Student's t test was used to determine the significance between ctDNA and imaging findings in endometrial cancer and between ctDNA, CA125 and imaging findings in ovarian cancer. The sensitivity, specificity, PPV and NPV were calculated.

Results: Of 46 patients, 13 had endometrial and 33 had ovarian cancer. In the 13 patients with endometrial cancer, 9 (69.2%) had findings on imaging; of these, 6 (66.67%) had elevated ctDNA levels. In patients without findings on CT scan, 0 (0%) had elevated ctDNA levels (p=0.024). Sensitivity of ctDNA was 75%, specificity was 100%, PPV 100%, NPV 57.14%. In the 33 patients with ovarian cancer, 21 (63.6%) had findings on imaging; of these, 15 (71.4%) had elevated ctDNA levels (p=0.0007) and 13 (62%) had elevated CA125 levels (p=0.009). Sensitivity of ctDNA was 77.78%, specificity was 92.31%, PPV 95.45% and NPV 66.67%. Sensitivity of CA125 was 72.41%, specificity was 85.71%, PPV 91.3% and NPV 60%.

Conclusion/Implications: ctDNA was significantly associated with findings on imaging in endometrial and ovarian cancer with a stronger relationship for ovarian cancer. CA125 was also significantly associated with findings on imaging in ovarian cancer, but the relationship was stronger for ctDNA. ctDNA had high specificity and PPV, so it may be useful when there are indeterminate findings on imaging but should not be used as a sole marker given the lower NPV.

EP050 / #213

Topic: *AS02. Clinical Disciplines / AS02c. Nursing & Allied Health Care*

INCREASING SUCCESSFUL PLATINUM HYPERSENSITIVITY REACTION RECHALLENGE RATES IN GYNECOLOGIC ONCOLOGY: A QUALITY IMPROVEMENT STUDY

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Introduction: Platinum-based chemotherapy is a cornerstone of treatment for gynecologic malignancies and is associated with well-established survival benefits. However, hypersensitivity reactions (HSRs) remain a significant barrier and often lead to treatment discontinuation or the use of less effective alternatives. Institutional data identified higher-than-expected rates of HSRs and low rechallenge success. This study evaluates whether targeted system-level interventions can improve rechallenge outcomes.

Methods: A multidisciplinary quality improvement initiative was conducted at a tertiary cancer centre. Root cause analysis identified key barriers to successful rechallenge. Interventions included (1) standardized nursing education with simulation-based training, (2) optimization of infusion capacity through dedicated rechallenge slots and additional staffing support, and (3) implementation of a standardized, evidence-based rechallenge protocol. A retrospective cohort study includes adult patients with gynecologic malignancies who experienced platinum-associated HSRs and subsequently underwent rechallenge. Data are being collected in a REDCap database using a time-series design. The primary outcome is successful completion of rechallenge. Statistical process control methods will be used to assess temporal changes following intervention implementation.

Results: A REDCap database capturing patient demographics, cancer characteristics, platinum exposure, HSR details, and rechallenge outcomes has been established. Process and balancing measures were defined to evaluate implementation fidelity and operational impact. Data collection is ongoing. Planned analyses will assess trends in successful rechallenge over time.

Conclusion/Implications: Targeted system-level interventions may improve platinum rechallenge success and support continued access to effective therapy. This initiative may inform risk stratification and individualized management of platinum hypersensitivity.

EP051 / #1048

Topic: *AS02. Clinical Disciplines / AS02c. Nursing & Allied Health Care*

IMPACT OF GESTATIONAL PATHOLOGY ON THE FORMATION AND DEVELOPMENT OF REPRODUCTIVE FUNCTION IN THE FEMALE FETUS ACROSS DIFFERENT STAGES OF EMBRYO- AND FETOGENESIS

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Introduction: Objective: To investigate the influence of gestational pathology on the genesis, structural formation, and functional activity of the fetal uterus, Fallopian tubes, and ovaries during various stages of pregnancy.

Methods: The study examined fetal internal reproductive organs (uterus, tubes, and ovaries) from two cohorts: • Control Group: Fetuses from healthy mothers. • Comparison Group: Fetuses from mothers whose pregnancies were complicated by preeclampsia and chronic lower genital tract infections. Research methodologies included macroscopic, organometric, histological, histochemical, immunohistochemical, and statistical analyses.

Results: Organometric investigation revealed a significant reduction in fetal weight and primary dimensions within the comparison group. Histological and immunohistochemical evaluations of the organs from fetuses of complicated pregnancies demonstrated: • A reduction in the ovarian follicle count. • Thinning of the uterine and Fallopian tube mucosa. • Impaired collagen maturation within the connective tissue framework of both the stroma and the vascular components of the fetal uterus, tubes, and ovaries. • An increased apoptotic index and reduced hormonal activity.

Conclusion/Implications: Women born to mothers whose pregnancies were complicated by preeclampsia and chronic lower genital tract infections exhibit a significantly higher predisposition to: 1. Dyshormonal disorders and neoplasms. 2. Primary infertility. 3. Obstetric complications during childbirth compared to those born to healthy mothers. Given current trends in obstetrics and gynecology, it is necessary to classify these individuals within a "high-risk group for infertility." Furthermore, it is recommended that these women consider oocyte cryopreservation at an earlier age than those born from uncomplicated pregnancies.

EP052 / #1052

Topic: *AS02. Clinical Disciplines / AS02c. Nursing & Allied Health Care*

IMPACT OF PREGNANCY PATHOLOGY ON THE FORMATION AND ESTABLISHMENT OF GERMINATIVE FUNCTION IN THE FEMALE FETUS DURING VARIOUS PERIODS OF EMBRYO- AND FETOGENESIS

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Introduction: Objective: This study aimed to investigate the impact of pregnancy pathology on the development, structural formation, and functional activity of the fetal uterus, fallopian tubes, and ovaries across different gestational periods.

Methods: The study utilized internal fetal organs (uterus, fallopian tubes, and ovaries) obtained from healthy mothers (control group) and female fetal reproductive organs from mothers with complicated pregnancies, specifically preeclampsia and chronic lower genital tract infections (comparison group). Research methods included macroscopic, organometric, histological, histochemical, immunohistochemical, and statistical analyses.

Results: Organometric analysis revealed a statistically significant decrease in the weight and primary dimensions of the fetuses in the comparison group. Histological and immunohistochemical evaluations of organs from the complicated pregnancy group demonstrated: • A reduced follicular count in the ovaries. • Thinning of the uterine and tubal mucosa. • Impaired collagen maturation within the connective tissue of both the stroma and the vascular components of the fetal uterus, fallopian tubes, and ovaries. • An increased apoptotic index and decreased hormonal activity.

Conclusion/Implications: Women born to mothers whose pregnancies were complicated by preeclampsia or chronic lower genital tract infections are predisposed to dyshormonal disorders, neoplasms, primary infertility, and labor complications significantly more often than those born to healthy mothers. Given current trends in obstetrics and gynecology, it is essential to categorize these women as a "high-risk group for infertility." We recommend that these individuals consider oocyte cryopreservation (egg banking) at an earlier age than women born from uncomplicated pregnancies.

EP053 / #476

Topic: *AS02. Clinical Disciplines / AS02c. Nursing & Allied Health Care*

NURSE HYSTEROSOCPY TRAINING

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Introduction: This abstract is an opinion piece on nurse hysteroscopy training at Christchurch Women's Hospital, Aotearoa New Zealand. Uterine cancer is the most prevalent gynaecological cancer in New Zealand, with an average of 627 women/people with a uterus newly diagnosed each year (from 2015 – 2020).

Methods: Hysteroscopy is usually performed by gynaecologists in New Zealand, however there is a demand for more hysterosopists as waiting lists are long. Endometrial cancer accounts for the majority of gynaecological cancers diagnosed.

Results: An on line programme was developed at a Christchurch Polytechnic, Ara and with the support of the employer, Te Whatu Ora and a clinical supervisor three nurses undertook this training in New Zealand. This poster outlines aspects of the training that occurred in Christchurch and how nurses can undertake hysteroscopy training.

Conclusion/Implications: By expanding the Registered Nurses scope of practice to train as a hysterosopist, this has provided an opportunity to assist the health system by reducing waiting times, increasing access to care and working towards improving health outcomes and reducing inequities. Nurse led hysteroscopy in the United Kingdom has demonstrated high levels of patient satisfaction and low rates of complications (Crowley et al, 2022). Research on the outcomes and patient satisfaction is an area for future research in the New Zealand setting.

EP054 / #946

Topic: *AS02. Clinical Disciplines / AS02c. Nursing & Allied Health Care*

WOMAN TO WOMAN – A PEER SUPPORT PROGRAM IN GYNECOLOGIC ONCOLOGY CARE

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Introduction: An oncologic diagnosis and initiation of treatment are often accompanied by significant anxiety and uncertainty. While medical teams provide professional care, many patients seek experiential knowledge and support from women who have undergone a similar journey. The "Woman to Woman" program was established to bridge this gap, to provide non-medical, peer-based emotional support; address practical, experience-based questions; and reduce loneliness while fostering resilience and social connection.

Methods: Using a departmental database of women treated for ovarian, endometrial, or cervical cancer, former patients who had completed treatment were invited to volunteer as peer supporters. Newly diagnosed patients were offered participation, and individualized matching was performed by a nurse coordinator based on diagnosis, treatment, age, cultural background, and language. Interactions included phone calls and in-person meetings, tailored by each pair, with ongoing support from the coordinating nurse and referral to medical staff when needed.

Results: Between January 2025 and March 2026, 42 patients were invited; 20 agreed to participate. The program fostered meaningful and sustained connections. New patients reported reduced anxiety, a sense of togetherness, and normalization of their experience. Key benefits included practical coping strategies, emotional support, hope through exposure to survivorship, and reduced isolation. Peer supporters also reported a strong sense of purpose and empowerment.

Conclusion/Implications: A structured peer-support program is feasible and valuable in gynecologic oncology care. It enhances emotional well-being, reduces isolation, and complements medical care. Integration of peer-support models may improve patient-centered outcomes and should be considered in comprehensive cancer care programs.

EP055 / #557

Topic: *AS02. Clinical Disciplines / AS02d. Radiation Oncology*

ORGAN-PRESERVING MANAGEMENT OF LOCALLY ADVANCED CERVICAL CANCER WITH A PELVIC RENAL TRANSPLANT: A MULTIDISCIPLINARY AND DOSIMETRIC APPROACH

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Introduction: Management of locally advanced cervical cancer in patients with a pelvic renal transplant who are not surgical candidates presents unique challenges, with limited guidance on integrating systemic therapy and modern radiation techniques to preserve graft function while maintaining curative intent. We describe a multidisciplinary strategy incorporating induction chemotherapy and kidney-sparing radiotherapy, supported by dosimetric evaluation.

Methods: A coordinated multidisciplinary framework involving gynecologic oncology, radiation oncology, urology, and nephrology was implemented for a patient scenario with a solitary functioning pelvic renal transplant and locally advanced cervical cancer, not amenable to surgery. Key priorities included preservation of graft function and avoidance of dialysis, with immunotherapy excluded due to autoimmune comorbidity. The treatment approach incorporated platinum-based induction chemotherapy followed by concurrent cisplatin-based chemoradiation (INTERLACE protocol). Pelvic IMRT was delivered using strict renal dose constraints, followed by MRI-guided brachytherapy. A comparative dosimetric analysis between standard pelvic radiotherapy and a kidney-sparing IMRT plan evaluated target coverage and renal dose exposure.

Results: Induction chemotherapy achieved >50% tumor reduction, facilitating radiation planning. The kidney-sparing IMRT plan reduced mean renal dose (~9.3 Gy) and high-dose exposure (<15% receiving >12 Gy) while maintaining target coverage (45 Gy/25 fractions). Treatment was completed without interruption, with minimal toxicity. MRI-guided brachytherapy provided conformal boost with negligible additional renal exposure. Renal function remained stable.

Conclusion/Implications: A multidisciplinary, patient-centered approach can preserve graft function while maintaining curative intent in complex cervical cancer. Integrating induction chemotherapy, concurrent cisplatin and radiation enables treatment in patients ineligible for surgery or immunotherapy, representing a pragmatic approach in resource-constrained settings.

EP056 / #1025

Topic: *AS02. Clinical Disciplines / AS02d. Radiation Oncology*

METASTASIS-DIRECTED RADIOTHERAPY (MDRT) IN OLIGOMETASTATIC GYNAECOLOGICAL MALIGNANCIES: A SINGLE-CENTRE EXPERIENCE.

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Introduction: MDRT using stereotactic ablative body radiotherapy (SABR) is emerging as a treatment option for patients with oligometastatic solid tumours. The primary aim of this approach is to prolong PFS and delay the initiation of systemic therapies. We report a single-institution clinical outcomes.

Methods: 87 lesions from 61 patients with relapsed oligometastatic (1 -3 lesions) gynaecological cancers (endometrium = 26 , ovary = 18, cervical = 14, vulva = 2 and Vagina = 1) were treated with SABR, delivered using both cyberknife and VMAT. Median fractions= 4 , Median dose= 45 Gy. Response was assessed with repeat imaging 8 – 12 weeks post-SABR. CTCAE version 5.0 was used to assess toxicity.

Results: Mean age was 68 years. Target lesions: pelvic node= 32, para-aortic node= 20, lung= 17, bone= 4, liver= 4, brain= 4, peritoneal mass= 2, porta-hepatis node= 2, right adnexa= 1, vaginal vault= 1. After a median follow-up of 19 months, 46% of the lesions had a partial response, 18.4% had a complete response, 20.7% were stable and 14.9% had progressive disease. Lesions greater than 30mm and disease-free interval of <6 months from primary treatment had ufavourable outcome. Median PFS was 12.4 months. Median-survival has not been reached. Three patients experienced grade 3 toxicity.

Conclusion/Implications: MDRT for patients with relapsed oligometastatic gynaecological cancers is a safe treatment with promising results in terms of local control, PFS and may impact overall survival. Distant progression remains the primary mode of failure. The combination of SABR and systemic therapies requires evaluation in randomised controlled trials.

EP057 / #945

Topic: *AS02. Clinical Disciplines / AS02d. Radiation Oncology*

HYPOFRACTIONATED ENDOMETRIAL CANCER RADIATION OUTCOMES & SAFETY (HEROS): EARLY SAFETY INTERIM ANALYSIS FROM A PROSPECTIVE PHASE I/II TRIAL

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Introduction: Interim safety analysis of the HEROS study: a prospective, non-randomized phase I/II trial assessing safety, clinical outcomes, and quality-of-life following adjuvant hypofractionated pelvic radiotherapy (WPRT).

Methods: Recruited patients with endometrial cancer for whom WPRT was indicated received 28.5 Gy in 5 fractions using VMAT. Vaginal brachytherapy boost was permitted for cervical stromal involvement. Patient-reported outcomes (EORTC QLQ-C30/EN24) were assessed at baseline, during treatment, and follow-up (6 weeks, then every 4 months). The data safety committee analyzed the first 10 patients at a predefined timepoint.

Results: Ten patients with high-risk features requiring WPRT were included: grade 3 (40%), lymphovascular invasion (50%), and deep myometrial invasion (30%). Histology included endometrioid (70%), carcinosarcoma (20%), and clear cell (10%). Molecular subgroups: ER/PR+ 80%/50%; MMRd 30%, p53m 20%, and POLEm 10%. After surgical staging, FIGO stages ranged from IA to IIIA for this cohort. Adjuvant chemotherapy was delivered in 70%. 20% received brachytherapy. Follow-up ranged from 4–12 months. Treatment was well-tolerated with low rates of acute toxicity. Gastrointestinal toxicity: 80% grade 0–1, 20% grade 2, 10% grade 3, with diarrhea (60%) as the most common. Genitourinary toxicity was minimal (grade 1 only). No unexpected toxicities or treatment interruptions occurred. One patient with carcinosarcoma died from recurrent disease at 8 months of follow up.

Conclusion/Implications: Hypofractionated 5-fraction WPRT was safe and well-tolerated. The low incidence of clinically significant toxicity in this interim safety analysis is encouraging. If sustained, this hypofractionated regimen could become a compelling alternative to conventional pelvic radiotherapy, saving precious time and healthcare resources.

EP058 / #780

Topic: *AS02. Clinical Disciplines / AS02d. Radiation Oncology*

OUTCOMES IN RADICAL CHEMORADIOTHERAPY AND BRACHYTHERAPY FOR CERVICAL CANCER TREATMENT AT A TERTIARY CANCER CENTRE

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Introduction: The *EMBRACE-I* and *II* studies established international standards for image-guided adaptive brachytherapy (IGABT) in the management of locally advanced cervical cancer. We evaluated outcomes at our centre.

Methods: A retrospective review of patients treated between January 2000 and February 2025 with radical chemoradiation followed by IGABT as per the EMBRACE-II protocol was performed. Demographic, clinical, pathological, and treatment data were collected. Brachytherapy metrics included high-risk clinical target volume (HRCTV) and cumulative CTV dose to 90% of volume (D90). Disease-free survival (DFS) and overall survival (OS) were estimated using Kaplan–Meier analysis in R.

Results: 149 patients were included (median age 51 years; 61% node negative) (*Table 1*). Median overall treatment time was 40 days. 63% completed all cycles of concurrent chemotherapy, while 10% received none. Median follow-up was 19 months. 5-year DFS and OS rates were 65% and 69% respectively (68% and 74% in EMBRACE-I). Recurrence occurred in 27%, with distant metastases being predominant (78%). Local control was 97%. Mean HRCTV volume was 51.8 cm^3 and mean D90 was 92.3Gy. The five patients with local recurrence had mean HRCTV volume of 98.5 cm^3 and mean HRCTV D90 of 89.6 Gy. Advanced stage was associated with worse DFS and OS (*Figure*

Demographics		
Age (years)	51 (41 -63)	
Histology		
Squamous cell carcinoma	116 (78%)	
Adenocarcinoma	24 (16%)	
Adenosquamous carcinoma	2 (1%)	
Carcinoma (not specified)	1 (1%)	
Neuroendocrine	2 (1%)	
Missing	4 (3%)	
Grade		
1	4 (3%)	
2	67 (45%)	
2-3	4 (3%)	
3	58 (39%)	
Missing	16 (10%)	
FIGO stage*	**2018**	**2009**
IB	17 (11%)	17 (11%)
IIA	13 (9%)	22 (15%)
IIB	48 (32%)	74 (50%)
IIIA	2 (1%)	2 (1%)
IIIB	4 (2.5%)	9 (6%)
IIIC1	37 (28%)	-
IIIC2	6 (5%)	-
IVA	21 (11%)	21 (14%)
Missing	1 (0.5%)	4 (3%)
Nodal status		
N0	91 (61%)	
N1	57 (38%)	
Missing	1 (1%)	
Treatment factors		
Total treatment time (days)	40 (38 - 43)	
Number of concomitant chemotherapy cycles (Cisplatin 40mg/m^2 weekly)		
All 5 cycles	94 (63%)	
<5 cycles	40 (27%)	
No chemotherapy	15 (10%)	
Follow up		
Median follow up (months)	19 (10 – 32)	
Brachytherapy dosimetry		
HRCTV volume (cm^3)	51.8 (41.3)	
HRCTV D90 (Gy)	92.3 (7.7)	
Cumulative D2cc rectum (Gy)	64 (10.6)	
Cumulative D2cc bladder (Gy)	74.3 (9.3)	
Cumulative D2cc bowel (Gy)	68.8 (7.3)	

Table 1: Patient, tumour and treatment characteristics, and brachytherapy dosimetry data. Patient cohort (n = 149). Dosimetry data presented as mean (SD). All other data are median (IQR) or n (%).

*FIGO = The International Federation of Gynaecology and Obstetrics. Our data was documented as per the FIGO 2018 staging. This has been converted to FIGO 2009 staging to allow for a visual comparison to EMBRACE-I dataset.

1).

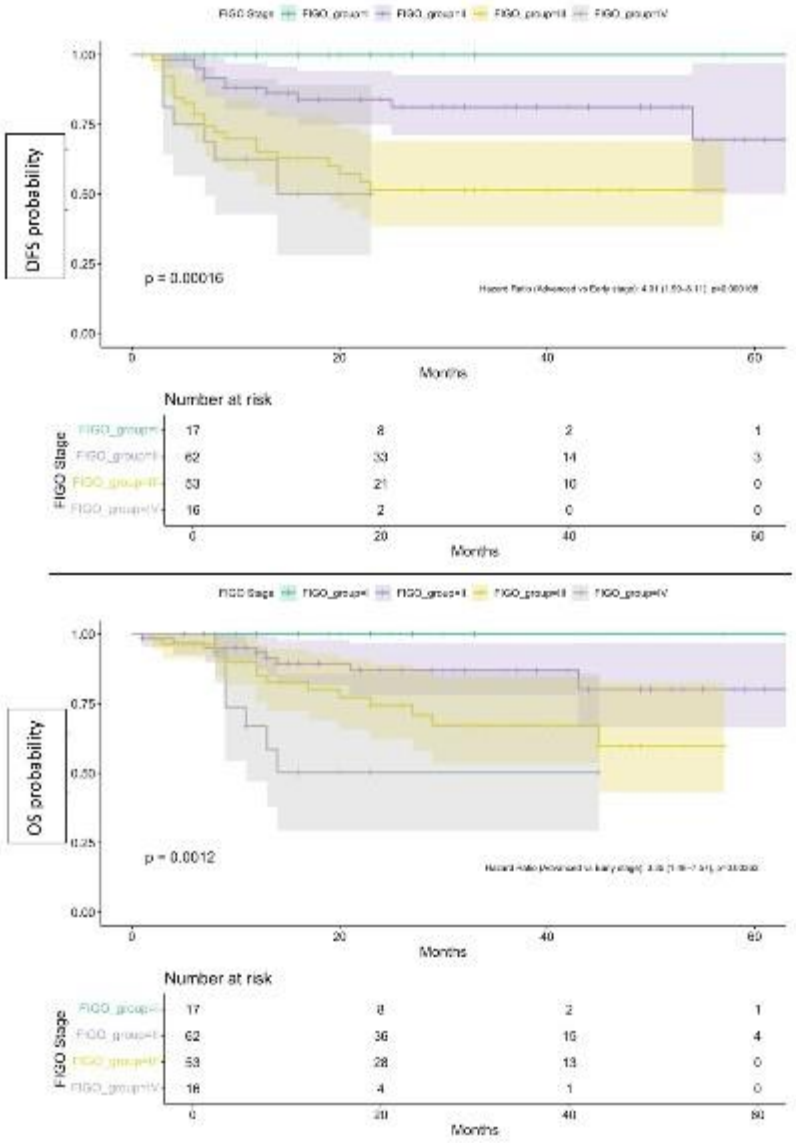


Figure 1. Disease free survival (DFS) and overall survival (OS) by FIGO 2018 stage (I–IV). Advanced-stage disease (FIGO III and IVA) was associated with significantly inferior DFS (HR = 4.01; 95% CI = 1.99-8.11; p<0.0001) and OS (HR = 3.35; 95% CI = 1.48 – 7.57; p< 0.05) compared to early-stage disease (FIGO I and II).

*FIGO – The International Federation of Gynaecology and Obstetrics.

Conclusion/Implications: Outcomes approach those reported in *EMBRACE-I*[1], with excellent local control but ongoing challenges with distant relapses. Despite larger HRCTV volumes (51.8 cm^3 vs 28 cm^3 in *EMBRACE-I*) comparable dosimetry suggests effective dose

delivery is achievable. However, larger tumour volume may still confer increased local failure risk despite adequate dosing.

EP059 / #834

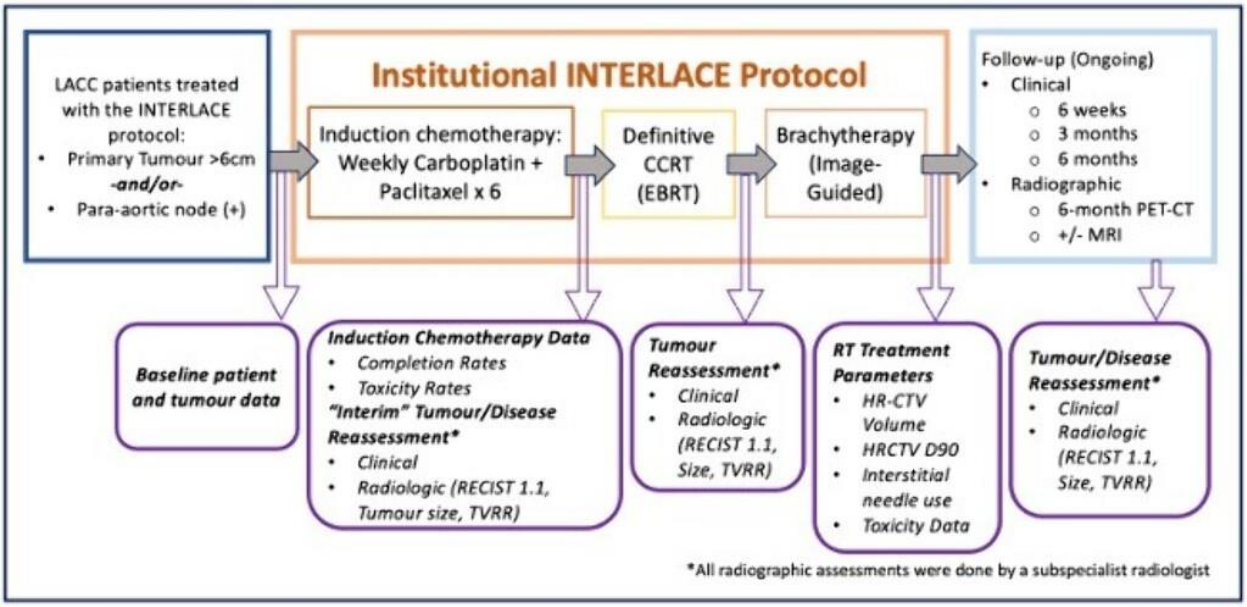
Topic: *AS02. Clinical Disciplines / AS02d. Radiation Oncology*

REAL-WORLD OUTCOMES OF THE INTERLACE PROTOCOL FOR HIGH-RISK LOCALLY ADVANCED CERVICAL CANCER: A TERTIARY CENTRE EXPERIENCE WITH MODERN STAGING AND RADIOTHERAPY TECHNIQUE

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Introduction: INTERLACE showed an overall survival benefit with induction chemotherapy (ICT) followed immediately by concurrent chemoradiotherapy (CCRT) for locally advanced cervical cancer (LACC). However, real-world outcomes for bulky, high-risk disease using contemporary staging and image-guided brachytherapy (IGBT) are uncertain.

Methods:



All patients treated with the INTERLACE protocol at a tertiary centre over the study period (Dec 2023–Sep 2025) were retrospectively reviewed. ICT was followed by CCRT, including high-dose-rate (HDR) IGBT aiming for a high-risk clinical target volume (HRCTV) D90 dose of >85Gy. Outcomes included treatment completion, tumour response, toxicity, brachytherapy optimization, and disease status at follow-up.

Results: Twelve patients were identified. The median tumour volume was 84.4cc; 91.7% were node-positive and 58.3% had para-aortic nodal involvement. After ICT, 91.7% achieved partial response (RECIST 1.1) with median tumour volume reduction rate (TVRR) of 91.6%. Mean HRCTV D90 was 85.9 ± 4Gy. Despite a 75% rate of ICT grade 3-4 toxicity (58.3% haematologic), all patients received ≥5 ICT cycles and 91.7% completed CCRT within 56 days. All tumours (100%) were ≥4cm at baseline, which decreased to 50% post-ICT and finally to just 8.4% pre-brachytherapy. Interstitial needles were used in only 27% of patients. At a median follow-up of 15.3 months, 41% had relapsed, all of which

were multi-site. Only 1 patient relapsed at the primary

Patient Staging Data		
FIGO 2018 Stage		
	▪ Stage IIIA	8.3% (1)
	▪ Stage IIIC1	41.7% (5)
	▪ Stage IIIC2	33.3% (4)
	▪ Stage IVA	16.7% (2)
Nodal involvement		
	▪ Pelvic	91.7% (11)
	▪ Para-aortic	58.3% (7)
Treatment Adherence Data		
ICT Completion Rate (All 6 cycles)		58.3% (7)
ICT Partial Completion Rate (At least 5 Cycles)		100% (12)
Chemo-RT (EBRT+Brachy) Completion Rate		91.7% (11)
Chemo-RT (EBRT+Brachy) Completed ≤ 56 Days		91.7% (11)
ICT Acute Toxicity Data		
Overall Grade 3-4 Toxicity Rate		75% (9)
Haematologic Grade 3-4 Toxicity Rate		58.3% (7)
Tumour Radiographic Data		
Pre-Treatment (Baseline) median tumour volume		84.4 cc (range 37.8-217.1)
Post ICT (Pre-EBRT) median TVRR		91.6 % (range 48.9-99.9)
Post ICT (Pre-EBRT) Partial response on RECIST 1.1		91.7% (n=11)
Post EBRT (Pre-brachytherapy) median TVRR		97.9 % (range 84.5-100)
Pre-Treatment (Baseline) Tumour Axial Diameter <4cm		0% (0)
Post ICT (Pre-EBRT) Tumor Axial Diameter <4cm		50% (6)
Post EBRT (Pre-brachytherapy) Tumor Axial Diameter <4cm		91.6% (11)
Radiotherapy Treatment Parameters		
Mean HR-CTV Volume		16.4 ± 6 cc
Mean HR-CTV D90		85.9 ± 4 Gy
Case requiring Interstitial needles		27% (3)*
Mean number of needles used per case		2.3 (range 1-3)
Patient Follow-Up Data**		
Overall Recurrence Rate (Local/Regional/Distant)		41.7% (5)
Pelvic Recurrence Rate		16.7% (2)
Primary Site Recurrence Rate		8.3% (1)

ICT: Induction chemotherapy, EBRT: External beam radiotherapy, TVRR: Tumour volume reduction rate, HR-CTV: High-risk clinical target volume

** Out of 11 that proceeded to brachytherapy*

***At a median follow up of 15.3 months*

site.

Conclusion/Implications: In this high-risk LACC cohort with bulky disease, INTERLACE achieved marked tumour regression and enabled delivery of contemporary HDR-IGBT

doses, resulting in reasonable loco-regional control. Longer follow-up is required to determine patterns of relapse, survival and late toxicity.

EP060 / #840

Topic: *AS02. Clinical Disciplines / AS02d. Radiation Oncology*

OUTCOMES OF RADIOTHERAPY AND CHEMO-RADIOTHERAPY FOR LOCALLY ADVANCED CERVICAL CANCER IN PRETORIA, SOUTH AFRICA: A RETROSPECTIVE STUDY

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Introduction: Locally advanced cervical cancer (LACC) remains the leading cause of cancer-related death for women in South Africa. In high HIV-prevalence, resource-limited settings, treatment access remains a concern, yet limited data exist on patients in a South African context. We evaluated survival outcomes for LACC patients treated with definitive radiotherapy+/-chemotherapy (RT/CRT) to provide evidence-based improvements in care.

Methods: We performed a retrospective analysis of women with LACC treated with definitive CRT+/-weekly cisplatin (30 mg/m^2) from January 2022-December 2023 at a tertiary hospital in Pretoria, ZA. Multivariable Cox proportional hazards were used to determine associations with overall survival (OS).

Results: The median age of patients (n=304) was 48.0 years (IQR 40.5-57.4). Over half of the cohort was HIV positive (n=170, 56%). Median EQD2 was 81.75 Gy (IQR 46-86). Most patients completed treatment within 56 days (n=256, 97%). Radiotherapy was completed in 96% (n=291), and brachytherapy in 60% (n=181). Concurrent chemotherapy was prescribed for 69% (n=209), with 23% of patients completing. 1- and 2-year OS was 85% and 66%, respectively. OS was evaluated against age, EQD2, chemo-cycles, tumor-stage, hemoglobin, and HIV status. Decreased hemoglobin (HR 0.88 per g/dL, p=0.037) and increased chemotherapy (HR 0.70 per cycle, p<0.001) were negatively and positively associated with OS, respectively.

Conclusion/Implications: Despite near-complete EBRT completion, brachytherapy and chemotherapy rates remained low due to infrastructure and toxicities. This research highlights the need for supportive care, including hemoglobin optimization and increased toxicity monitoring. Prospective studies evaluating treatment delivery are warranted to provide comprehensive recommendations for LACC care improvement.

EP061 / #959

Topic: *AS02. Clinical Disciplines / AS02d. Radiation Oncology*

RADIATION ONCOLOGISTS AND DIAGNOSIS DISCLOSURE IN GYNECOLOGIC ONCOLOGY: A CROSS-SECTIONAL STUDY FROM TUNISIA

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Introduction: Diagnosis disclosure is a fundamental step in gynecologic oncology, traditionally undertaken by gynecologic oncologists.In contemporary multidisciplinary care,however,radiation oncologists are increasingly engaged in this process, particularly in settings with fragmented care pathways.This study aimed to evaluate the role,practices,and perceptions of radiation oncologists in Tunisia regarding diagnosis disclosure in gynecologic cancer patients.

Methods: We conducted a cross-sectional study between March and April 2025 among 30 Tunisian radiation oncologists with at least 3 months of clinical experience.Data were collected using a structured and validated questionnaire developed by senior radiation oncologists at Salah Azaïz Institute.

Results: Participants were predominantly residents (22/30).Most respondents (26/30) reported that patients are generally informed about their treatment plan; however,25 physicians reported encountering patients who were unaware of their cancer diagnosis.In such situations,26 physicians stated that they personally performed the disclosure of the diagnosis.Nineteen respondents considered that disclosure should ideally be delivered over multiple consultations,although lack of time and the absence of structured communication settings were frequently reported barriers.The presence of a family member was considered helpful by 19 physicians,while 27 strongly supported the involvement of psychological support during disclosure.Only 19 physicians reported providing structured follow-up after disclosure.Nearly all participants (28/30) had experience in diagnosis disclosure.Self-assessed competence was rated as moderate (20/30) or low (6/30).A large majority (29/30) expressed a need for formal training in communication skills.

Conclusion/Implications: Radiation oncologists in Tunisia are involved in diagnosis disclosure in gynecologic oncology,often without structured training or optimal communication frameworks.These findings highlight the need for formal communication training and integrated psychosocial support to improve patient-centered care.

EP062 / #162

Topic: *AS02. Clinical Disciplines / AS02d. Radiation Oncology*

FERRITE NANOHEATERS FOR PRECISION MAGNETIC HYPERTHERMIA THERAPY FOR TREATMENT OF CANCER

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Introduction: Ferrite-based nanoparticles have gained considerable attention as potential heat mediators for cancer hyperthermia due to their tunable magnetic properties, chemical stability, and biocompatibility. Their ability to generate localized heat under alternating magnetic fields makes them promising candidates for targeted cancer therapy.

Methods: In this study, $CaFeO_2$, $SrFeO_2$, and $NaFeO_2$ nanoparticles were synthesized using the sol–gel technique. Structural characterization was carried out to confirm phase formation and crystallinity. Magnetic properties were analyzed through temperature-dependent measurements of saturation magnetization and coercivity to determine magnetic transitions and Curie temperatures. The heating efficiency was evaluated using calorimetric measurements of nanoparticle-based ferrofluids exposed to alternating magnetic fields of varying amplitudes and frequencies.

Results: The synthesized nanoparticles exhibited stable oxygen-deficient perovskite-related crystal structures with variations in lattice parameters and crystallite size. Magnetic analysis revealed temperature-dependent behavior, including a transition from ferromagnetic to superparamagnetic states near or below room temperature. The heating performance showed strong dependence on field strength, frequency, and nanoparticle concentration. The observed heat generation was governed by Néel and Brownian relaxation mechanisms, with optimized conditions yielding enhanced specific loss power and efficient thermal response.

Conclusion/Implications: The findings demonstrate that ferrite-based nanoparticles, particularly $CaFeO_2$, $SrFeO_2$, and $NaFeO_2$, possess favorable magnetic and thermal characteristics for magnetic hyperthermia applications. Their tunable properties and efficient heating behavior make them promising candidates for targeted cancer therapy. This work provides valuable insights into the design and optimization of ferrite nanoheaters for advanced biomedical applications, supporting their potential use in safe and effective cancer treatment strategies.

EP063 / #384

Topic: *AS02. Clinical Disciplines / AS02d. Radiation Oncology*

A RETROSPECTIVE STUDY: THE INFLUENCE OF 5 FACTORS ON PFS IN LOCALLY ADVANCED CERVICAL CANCER.

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Introduction: We have developed a predictive model to assess the prognosis of patients with locally advanced cervical cancer based on five factors. The current study aims to validate this predictive model.

Methods: Patients with locally advanced cervical who received radical radiotherapy in our hospital from 2016 to 2019 were included. Presence of para-aortic lymph node metastasis on imaging was an exclusion criterion. Patients were scored and grouped according to the five factors in the predictive model. The five factors included: tumor diameter ≥ 4.8 cm (4 points), adenocarcinoma (5 points), ≥ 2 positive sentinel lymph nodes (6 points), positive common iliac lymph nodes (10 points), and maximum para-aortic lymph node diameter ≥ 1 cm (2 points). A score of 8 was used as the cutoff value, with scores < 8 classified as the low-risk group and scores ≥ 8 as the high-risk group. Progression-free survival (PFS) and overall survival (OS) were compared between the two groups.

Results: A total of 471 patients were included, with a median follow-up of 61 months. The 5-year PFS of the low-risk group was significantly better than that of the high-risk group (84.73% vs. 66.67%, p = 0.0003), but there was no significant difference in OS between the two groups (91.76% vs. 88.16%, p = 0.366).

Conclusion/Implications: Patients with locally advanced cervical cancer who score ≥ 8 have a worse prognosis. For patients with locally advanced cervical cancer who score ≥ 8, prophylactic extended-field radiotherapy can be considered.

EP064 / #785

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

ROLE OF MULTIMODAL PREHABILITATION PROGRAM IN IMPROVING SURGICAL OUTCOMES IN GYNECOLOGIC ONCOLOGY SURGERY

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Introduction: Postoperative complications reach up to 30% following gynecological oncologic surgery, leading to prolonged hospitalization, delayed recovery, and unfavorable outcomes. Multimodal pre-habilitation has emerged as a holistic, patient-centered approach that integrates optimized nutritional support, psychological care and tailored physical exercise programs prior to surgery. This study aims to evaluate the effect of implementing this program on postoperative morbidity and mortality**,** pain intensity and length of hospital stay.

Methods: Non-randomized controlled study was carried out in the Gynecologic Oncology Unit at Women Health Hospital, Assiut University, Egypt. Trial registration: NCT07188662. A purposive sample of 140 women was equally divided into conventional and pre-habilitation groups. Data was collected using three structured tools: **Tool I** a comprehensive pre-operative evaluation including physical, nutritional and psychological evaluation. **Tool II** physical, nutritional and psychological prehabilitation of the patients **Tool III** careful postoperative care and monitoring.

Results: The pre-habilitation group demonstrated statistically significant improvement in post-operative outcomes. Notably, hospital stays were reduced, with a mean of 7 days in the pre-habilitation group compared to 22 days in control group ($p = 0.01$). Pain intensity was lower in the pre-habilitation group, with the majority reporting mild pain ($p<0.001$) compared to moderate pain in the conventional group. 6% in the conventional group needed ICU admission, while none in the pre-habilitation group. In addition, 30-day post-operative mortality was lower in the pre-habilitation group, with only one case being reported as compared to four in the conventional group.

Conclusion/Implications: Multimodal pre-habilitation improves post-operative recovery. Adoption of this protocol as a standard pre-operative care is recommended

EP065 / #150

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

THE ROLE OF REPEAT CERVICAL EXCISION IN PATIENTS WITH MICROINVASIVE CERVICAL CANCER AND MARGINS LESS THAN ONE MILLIMETRE OR POSITIVE MARGINS FOR CERVICAL DYSPLASIA ON FIRST EXCISION: A RETROSPECTIVE CASE SERIES

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Introduction: To evaluate the impact of repeat cervical excision on staging, management, and oncological outcomes in patients with microinvasive cervical cancer and margins <1 mm or positive for high-grade cervical dysplasia following initial excision.

Methods: A retrospective case series was conducted at a tertiary gynaecological oncology centre in Western Australia, including patients diagnosed with FIGO stage IA1–IA2 microinvasive cervical cancer between 2015 and 2024. Eligible patients had malignancy <1 mm from the margin or margins positive for high-grade dysplasia on initial excision. Clinicopathological characteristics, repeat excision histology, final stage, treatment, and outcomes were analysed.

Results: Sixty patients met inclusion criteria, of whom 59 (98.3%) underwent repeat excision. Residual disease was identified in 17 cases (28.8%), including residual dysplasia in 14 (22.7%) and residual invasive carcinoma in 3 (5.1%). Only one patient (1.7%) was upstaged to FIGO stage IB1. The majority (71.2%) had no residual disease. Definitive management included hysterectomy in 57.6% and fertility-sparing treatment in 40.1%. No recurrences were observed. Repeat excision did not alter final stage or management in 98.3% of cases.

Conclusion/Implications: Repeat cervical excision rarely identifies additional invasive disease or alters staging and management in patients with microinvasive cervical cancer and close or dysplastic margins. A selective approach to repeat excision may reduce unnecessary procedures without compromising oncological outcomes. Prospective studies are required to confirm these findings and inform guideline development.

EP066 / #774

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

ROBOTIC SURGERY AS A MORBIDITY-REDUCTION STRATEGY IN OBESE ENDOMETRIAL CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction: Obesity amplifies anaesthetic risk, access failure, wound morbidity and conversion during endometrial cancer staging. Robotic surgery may transform this high-risk phenotype from an indication for laparotomy into a reproducible minimally invasive pathway. We synthesised comparative evidence testing robotics as a morbidity-reduction strategy.

Methods: A PRISMA-aligned systematic review and random-effects meta-analysis searched PubMed, Embase, Scopus, Cochrane Library and registries from 2000 to June 2025 for obese women (body mass index ≥30 kg/m2) undergoing hysterectomy/staging for endometrial cancer. Risk of bias, heterogeneity and GRADE certainty were assessed.

Results: Twenty-one studies comprising 4,865 obese patients were included, supported by conversion evidence from 51 studies/10,800 patients and severe-obesity network evidence from 12 studies/1,163 patients. Compared with laparoscopy and laparotomy, robotic surgery shortened admission (1.9 versus 3.8 and 4.3 days) and reduced blood loss versus laparotomy (97 versus 337 mL), although operative time was longer (183 versus 147 and 129 minutes). Overall complications were lowest after minimally invasive surgery (robotic 14%, laparoscopic 15%, laparotomy 30%), with postoperative complications of 13%, 14% and 29%, respectively. Pooled conversion was 5.5% (95%CI 3.3-9.1) after robotic hysterectomy versus 6.5% (95%CI 4.3-9.9) after laparoscopy. In body mass index ≥40 kg/m2, conversion was 3.8% (95%CI 1.4-9.9) versus 7.0% (95%CI 3.2-14.5). Severe-obesity network analysis ranked robotics highest for intraoperative safety and complete staging.

Conclusion/Implications: Robotic surgery appears to convert obesity from a surgical liability into a controllable minimally invasive domain, reducing open-surgery morbidity while preserving staging quality. Randomised, cost-effectiveness and equity-focused implementation studies with prospective oncologic outcome surveillance are now required.

EP067 / #563

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

PATIENT-REPORTED EXPERIENCES OF GYNECOLOGIC ONCOLOGY SURGERY IN ALBERTA: A COHORT STUDY USING SURVEY AND ADMINISTRATIVE DATA

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Introduction: Despite their importance in evaluating healthcare quality, patient experience measures are poorly characterized in gynecologic oncology surgical populations. The objective of this study is to describe the patient experience measures of patients undergoing gynecologic cancer surgery in Alberta, Canada.

Methods: This is a retrospective cohort study of patients undergoing gynecologic oncology surgery in Alberta between Apr 2016-Mar 2023. Administrative data was linked with the Canadian Patient Experiences Survey–Inpatient Care (CPES-IC) instrument, a validated 52-item instrument administered by telephone to a random sample of patients after hospital discharge. Analysis included descriptive statistics of the cohort demographics and clinical characteristics. Responses to survey questions were classified according to "top box" methodology, where the percentage of patients reporting the most optimal answer choice(s) are reported.

Results: 873 eligible patients were included. The majority of patients stayed in hospital less than 3 days (64.5%). 65.5% of patients provided a "top box" overall rating of care (of 9 or 10/10). The two items with the highest "top box" ratings included receiving written discharge information (91.9% reporting "yes"), and courtesy and respect from doctors (89.4% reporting "always"). Aside from the hospital environment, the items with the lowest "top box" ratings included side effects of new medications were explained (48.5%), leaving the hospital with a better understanding of their condition (60.7%), and receiving support for anxieties/worries/fears (61.0%).

Conclusion/Implications: These results provide insight into the patient experience of undergoing inpatient gynecologic cancer surgery in Alberta and provide actionable items to improve patient-centered care delivery.

EP068 / #239

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

A DESCRIPTIVE ANALYSIS OF SURGICAL OUTCOMES IN PATIENTS WITH BMI OF 50 OR GREATER UNDERGOING ROBOTIC HYSTERECTOMY FOR ENDOMETRIAL CANCER OR HYPERPLASIA IN NOVA SCOTIA

Morgan Burgoyne[1], Estelle Mccaughan[2], Lana Saciragic[3], Stephanie Scott[3], Karla Willows[3]
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Introduction: Obesity is the leading risk factor for endometrial cancer. Minimally invasive surgery is standard, though laparoscopy is technically challenging in obesity. Robotics may improve surgical outcomes. This study examines intraoperative and early postoperative outcomes for patients with BMI ≥50 undergoing robotic hysterectomy for endometrial cancer or hyperplasia in Nova Scotia.

Methods: A descriptive retrospective cohort including patients with BMI ≥50 who underwent robotic hysterectomy for endometrial cancer or hyperplasia in Nova Scotia. Cases were identified through a prospective database at our center from March 2019 to

April 2025. Variables are listed in **Table**

Table 1. List of study variables

Variables
BMI
Estimated blood loss
Length of stay
Same day discharge
Grade
Stage
Pathology
Prior abdominal surgery
Conversion to laparotomy
Nodal staging
Intraoperative complications

1.

Results: The cohort included 51 patients (**Table 2**). Median BMI was 56 (range 50.6–78.8). Most cases were stage I (78.7%) and grade 1 (85.1%). Endometrioid histology comprised 90.2%, with serous (2.0%) and hyperplasia (7.8%) less common. Conversion to laparotomy occurred in 17.6%. Reasons for conversion include; adhesions (5.8%), bleeding (2.0%), poor visualization (3.9%), or positioning/anesthesia issues (5.8%). Median blood loss was 100 mL (50–1000). Nodal staging was completed in 48.9%, most commonly bilateral sentinel node dissection (74.2%). Intraoperative and early post-operative complications

occurred in 5.9%. Median stay was one night (0–11) with 5.9% same-day discharge

Table 2. Descriptive analysis for intraoperative and early postoperative outcomes for patients undergoing robotic surgery for endometrial cancer or hyperplasia with BMI ≥50

Continuous Variables	**Median**
BMI	56.7 (50.6-78.8)
Estimated blood loss (mL)	100 (50-1000)
Length of stay (nights in hospital)	1 (0-11)
Categorical Variables	**N (%)**
BMI	
BMI 50-59	36 (70.6)
BMI ≥60	15 (29.4)
Grade	
1	40 (85.1)
2	3 (6.4)
3	4 (8.5)
Stage (FIGO 2009)	
I	37 (78.7)
II	5 (10.6)
III	3 (6.4)
IV	0 (0)
Pathology	
Adenocarcinoma	46 (90.2)
Serous	1 (2.0)
Hyperplasia	4 (7.8)
Prior Abdominal Surgery	31 (60.8)
Intraoperative	
Rate of conversion to laparotomy	9 (17.6)
Reason for conversion	
Adhesions	3 (5.8)
Unable to tolerate anesthesia or positioning	3 (5.8)
Poor visualization	2 (3.9)
Bleeding	1 (2.0)
Rate of nodal staging	23 (48.9)
Nodal Staging Type	
Bilateral Sentinel Nodal Dissection	15 (65.2)
Sentinel (one side) + Full Nodal Dissection (other)	4 (17.4)
Bilateral Full Nodal Dissection	4 (17.4)
Rate of intraoperative complication	3 (5.9%)
Intraoperative complications	
Injury to viscera	1 (2.0)
Bleeding (≥1000 mL)	1 (2.0)
Blood transfusion	1 (2.0)
Postoperative	
Rate of same day discharge	3 (5.9%)
Length of stay (nights in hospital)	
1-2 nights	40 (83.3%)
>2 nights	8 (16.7%)

rate.

Conclusion/Implications: In patients with BMI ≥50, robotic hysterectomy showed acceptable perioperative outcomes with low blood loss and short hospital stay. Despite a notable conversion rate, complications were infrequent. Same-day discharge in this comorbid population remains a challenge. This work supports our broader project on clinical and cost effectiveness of robotic surgery compared to open and laparoscopic approaches for endometrial cancer in Nova Scotia.

EP069 / #577

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

SAME-DAY DISCHARGE AFTER MINIMALLY INVASIVE GYNECOLOGIC ONCOLOGY SURGERY: A NATIONAL SURVEY OF BARRIERS AND FACILITATORS TO IMPLEMENTATION.

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Introduction: Same-day discharge (SDD) has well-established safety and patient satisfaction data in minimally invasive (MIS) gynecologic oncology surgery; however, uptake remains variable in Canada. This study evaluated SDD practices among Canadian gynecologic oncologists and explored surgeon attitudes, facilitators, and barriers to SDD implementation.

Methods: Gynecologic oncologists were invited to complete an anonymous electronic survey distributed through the Society of Gynecologic Oncology of Canada. Survey questions assessed respondent demographics, current SDD practices, perceived facilitators and barriers, and supporting resources. Descriptive statistics were used, and free-text responses underwent thematic analysis.

Results: Fifty-three surveys were completed (response rate 52%). The largest respondent group (26.4%) were within their first 5 years of practice. Nearly all (98.1%) endorsed offering SDD, but only 45.3% reported that 76–100% of their MIS patients were discharged on POD 0. Top barriers identified included inadequate home supports for patients (67.3%), lack of anesthesiology support (57.7%), post-anesthesia care unit delays (51.9%), and patient/family worries or anxiety about SDD (50%). Most respondents rated combined ERAS-SDD protocols as very (26.4%) or extremely important (67.9%) to SDD success, and 96.2% rated pre-operative SDD teaching as very (17%) or extremely important (79.2%). Key facilitating themes included pre-operative patient education, prescription workflow, and team education.

Conclusion/Implications: These results demonstrate broad acceptance of SDD among gynecologic oncologists and identify key system- and individual-level barriers to its success. These data highlight actionable strategies, including focused pre-operative patient education and combined ERAS-SDD protocols, that can inform quality improvement initiatives to enhance SDD rates across Canada.

EP070 / #689

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

LONG-TERM ONCOLOGIC OUTCOMES FOLLOWING GYNECOLOGIC CANCER SURGERY AFTER RECOVERY FROM COVID-19 INFECTION: THE COSGO STUDY

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Introduction: During the COVID-19 pandemic, concerns were raised regarding increased perioperative risks in cancer patients recovering from prior SARS-CoV-2 infection due to persistent inflammation, thromboembolic risk, and cardiopulmonary complications. While short-term surgical outcomes have been reported, long-term oncologic outcomes remain unknown. We evaluated perioperative and long-term survival outcomes in gynecologic cancer patients undergoing surgery after recovery from COVID-19 infection.

Methods: This prospective observational cohort study included patients undergoing gynecologic cancer surgery between July 2020 and June 2025 at a tertiary cancer center. Patients with documented prior COVID-19 infection who had recovered before surgery were compared with COVID-negative controls operated during the same period. Patients undergoing surgery during active infection were excluded. Propensity score matching (1:2 nearest-neighbour matching; caliper 0.25) adjusted for baseline differences. Primary outcomes were 30/90-day mortality and major morbidity. Secondary outcomes included recurrence-free survival (RFS) and overall survival (OS).

Results: Ninety patients were analysed (30 COVID-recovered; 60 controls). Of 30 study patients, 7(23.3%) required prior hospitalization and 2(2/7) required ventilatory support. After matching for demographic, histologic, and treatment variables, 69 patients were included (24 vs 45). No significant difference was observed in 30-day mortality(0% vs 0%), 90-day mortality(4.2% vs 0%), or major complications(Grade III/IV: 4.2% vs 0%).Median follow-up was 41 months. In the matched cohort, 3-year OS (86.9% vs 79.5%) and RFS (66.0% vs 60.5%) were comparable between COVID-recovered patients and controls (both

non-
significant).

Table 1: Parameters used for Matching

Variable
Age
ASA
BMI
Pulmonary co-morbidity
Cardiovascular Comorbidity
Diabetes on Insulin
Raised Creatinine
Figo Stage (Organ wise)
Histological subtype (Organ wise)
Grade
Chemotherapy
Observation

Table 2: Sub Group analysis: **Ovarian vs Non ovarian Malignancies – There were no significant survival differences between Covid - recovered patients (study group) and controls.**

		Whole Cohort	Matched cohort
STUDY Group (N = 30)	Non-Ovarian malignancies	9	6
	Ovarian malignancies	21	18
Total		30	24
CONTROL Group (N = 60)	Non-Ovarian malignancies	18	15
	Ovarian malignancies	42	30
Total		60	45

Matched cohort

OS

variable	level	Control group event/N	Study group event/N	HR(95 % CI)	Interaction p value
	No	1/15.	0/6.	0.033(	
Ovary	Yes	8/30.	4/18.	0.999(0.299,3.338)	0.998

RFS

variable	level	Control gr event/N	Study group event/N	HR(95 % CI)	Interaction p value
	No	2/15.	0/6.	0.033(0.000,366661.78)	
Overy	Yes	16/30	9/18.	0.906(0.405,2.027)	0.957

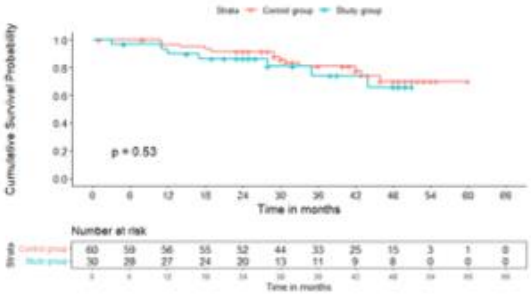
Whole cohort

variable	level	Control group event/N	Study group event/N	HR(95 % CI)	Interaction p value
	No	1/18.	0/9.	0.033(0.000,109264	
Ovary	Yes	12/42.	7/21.	1.473(0.577,3.75)	0.997

variable	level	Control gr event/N	Study group event/N	HR(95 % CI)	Interaction p value
	No	2/13.	0/9.	0.032(0.000,	
Overy	Yes	26/42.	12/21.	1.126(0.566,2.24)	0.996

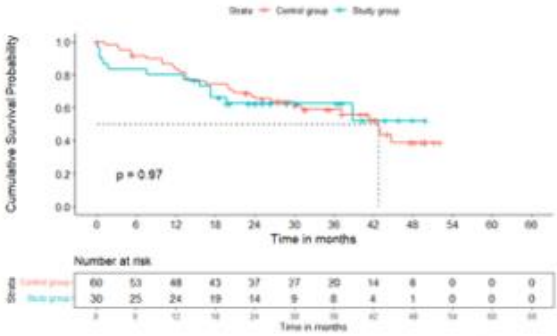
Unmatched Data (N=90)

Overall survival (OS)



	n	event	3 years OS(95% CI)
Control	60	13	0.8086(0.7073,0.9244)
Treatment	30	7	0.7405(0.5722,0.9583)

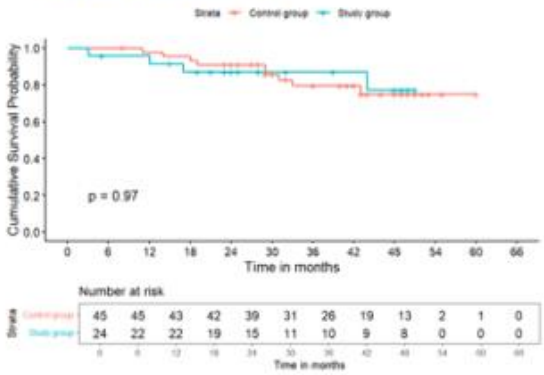
Recurrence free survival (RFS)



	n	event	3 years RFS(95% CI)
Control	60	28	0.5880(0.4700,0.7355)
Treatment	30	12	0.6253(0.4720,0.8284)

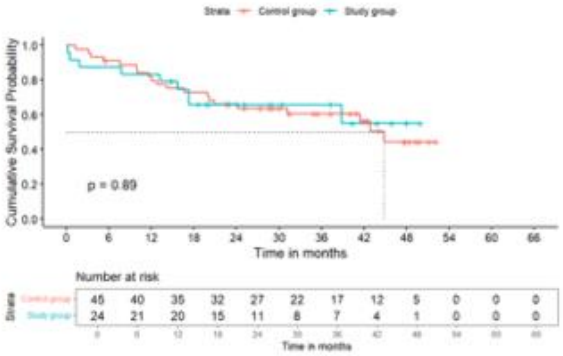
Matched data (N= 69)

Overall survival (OS)



	n	event	3 years OS(95% CI)
Control	45	9	0.7955(0.6771,0.9347)
Treatment	24	4	0.8690(0.7410,1.0000)

Recurrence free survival (RFS)



	n	event	3 years RFS(95% CI)
Control	45	20	0.6058(0.4748,0.7730)
Treatment	24	9	0.660(0.493,0.883)

Conclusion/Implications: Prior COVID-19 infection did not adversely affect perioperative or long-term oncologic outcomes, addressing an important evidence gap and informing surgical planning during future pandemics/similar health-care crisis.

EP071 / #821

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

IMPACT OF MALNUTRITION ON CYTOREDUCTIVE SURGERY AND POSTOPERATIVE MORBIDITY IN ADVANCED OVARIAN CANCER

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Introduction: Malnutrition is prevalent among advanced ovarian cancer (AOC) patients and has been associated with increased surgical risk. The optimal screening tool in AOC remains unclear. The objective is to evaluate the association between malnutrition and postoperative complications across multiple validated screening tools.

Methods: This prospective cohort study included stage III-IV AOC patients between March 2023-July 2025. Malnutrition was assessed using albumin level, Patient-Generated Subjective Global Assessment Short Form (PG-SGA; severe ≥ 9), Malnutrition Screening Tool (MST; >2) and Nutritional Risk Index (NRI; <97.5). Clinical characteristics, surgical outcomes, and postoperative complications were collected.

Results: Eighty-five patients were included with 60 (70.6%) severe malnourished by PG-SGA. Those malnourished were older, more comorbid, with similar ECOG status. Seventy (82.3%) patients underwent surgical cytoreduction including 32 (45.7%) primary (PCS), and 60 (70.6%) interval cytoreductive surgeries (ICS). Complete cytoreduction was more common among primary surgery (87.5% vs 55.3%, p=0.001), with higher surgical complexity score (SCS) (9.2 vs 3.6, p<0.001). Based on malnutrition status, there was no difference between PCS or ICS (p=0.49), surgical resection outcome (p=0.27), or surgical complexity (p=0.056). Grade ≥3 complications occurred in 11 patients (15.7%), and 51 (72.9%) had any complications. Albumin level <35g/L was not associated with surgical complication (p=0.27) on univariate analysis. Malnutrition status was not an independent predictor of postoperative complication (p=0.48) on multivariate logistic regression. Sensitivity analysis using MST and NRI screening tools remained unchanged.

Conclusion/Implications: Severe malnutrition was not associated with increased postoperative morbidity regardless of screening tool, or albumin level. Malnutrition alone should not preclude cytoreductive surgeries in AOC

patients.

Table 1: Multivariate Logistic Regression Model of 30-day Composite Postoperative Complication

	Adj. OR (95%CI)	p-value
Malnutrition		
Mild (PG-SGA SF <9)	Reference	
Severe (PG-SGA SF ≥9)	0.56 (0.10, 2.81)	0.48
BRCA mutation and HRD		
BRCA+	Reference	
HRD	0.40 (0.01, 14.59)	0.58
HRP	0.06 (0, 0.46)	**0.017**
Aletti Surgical Complexity Score (PCS and ICS)		
Low	Reference	
Intermediate	0.24 (0.02, 1.64)	0.18
High	6.26 (0.42, 229.69)	0.22
Blood transfusion		
No	Reference	
Yes	0.48 (0.05, 4.03)	0.50
Estimated blood loss (mL)	1.00 (1.00, 1.00)	0.39
Length of Stay (days)	2.01 (1.28, 3.71)	**0.009**

EP072 / #824

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

THE SENTINEL NODE SHIFT: TEMPORAL TRENDS IN NODAL SURGERY AND IMPLICATIONS FOR LYMPHADENECTOMY EXPOSURE IN GYNECOLOGIC ONCOLOGY

Ada Hsieh[1,2,3], Genevieve Bouchard-Fortier[3,4], Sakib Yasar[5], Al Covens[4,6], Danielle Vicus[2,4], Sarah Ferguson[4,7], Rachel Kupets[2,4], Lilian Gien[2,4]
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Introduction: Sentinel lymph node (SLN) is standard for staging endometrial, cervical, and vulvar cancers. We assessed temporal SLN adoption, trends in full lymphadenectomy (FLN), and postoperative morbidity.

Methods: This population-based retrospective cohort study included patients undergoing surgery for endometrial, cervical, or vulvar cancer in Ontario (2011–2024) using ICES databases. Lymph node (LN) procedures were categorized as SLN or FLN, by pelvic, para-aortic, or groin LN dissection (PLN/PALN/GLN). Temporal trends and postoperative outcomes were analyzed using Cochran–Armitage and inferential statistical tests.

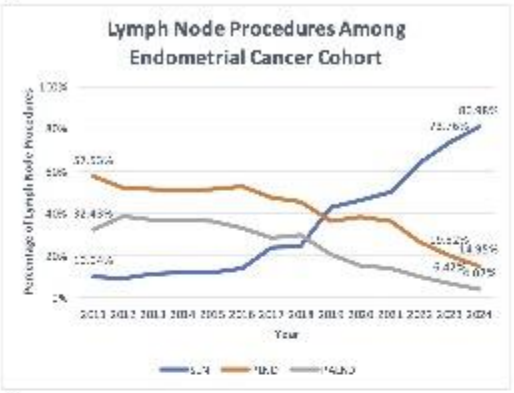
Results: A total of 14,069 surgical patients had a LN assessment (11,413 endometrial, 1279 cervical, 1377 vulvar). Among those with endometrial cancer, SLN increased from 10.0% in 2011 to 73.8% in 2023 with a decline in FLN from 89.9% to 26.2% ($p<0.001$). Cervical cancer demonstrated stable trends of SLN (62.7% to 69.8%, $p=0.17$) and FLN rates (37.3% to 30.2%, $p=0.17$). Among vulvar cancer patients, SLN use increased significantly from 51.6% to 82.2% ($p<0.001$), with reduced GLN (48.4% to 17.8%, $p<0.001$). Across all cohorts, SLN was associated with significantly lower surgical morbidity, fewer emergency department visits, with no differences in 30-day mortality or reoperation. Most LN procedures occurred in fellowship training centers including FLN procedures (69.3% endometrial, 66.4% cervical, and 65.1% vulvar). However, in 2023 only 84 PALN and 13 vulvar GLN were completed across the province, representing >50% decrease in cases.

Conclusion/Implications: SLN adoption has significantly increased among gynecologic cancers with lower morbidity. The decline in FLN and low absolute volumes especially in

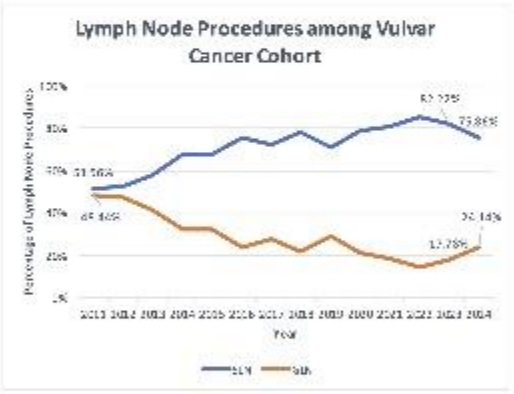
PALN and GLN, raise important considerations for surgical training and

Graph 1: Lymph Node Procedure Trends over Time
A) Endometrial Cancer Cohort; B) Vulvar Cancer Cohort; C) Cervical Cancer Cohort

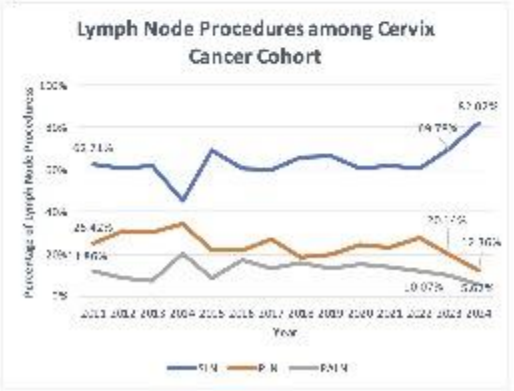
A



B



C



competency.

EP073 / #917

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

PREDICTION OF POSTOPERATIVE COMPLICATIONS FOR GYNAECOLOGICAL ONCOLOGY PATIENTS USING THE FIVE-FACTOR MODIFIED FRAILTY INDEX

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Introduction: Most patients with gynaecological malignancy are older than 65 years and are disproportionately affected by frailty - a multisystem decline in physiological reserve associated with increased postoperative morbidity, mortality, and healthcare utilisation. The 5-item modified Frailty Index (mFI-5) is a simple, comorbidity-based measure that has been validated in other surgical specialties but remains under-evaluated in gynaecologic oncology.

Methods: This retrospective cohort study included patients aged ≥70 years undergoing major elective surgery with a gynaecological oncology service at a tertiary cancer centre in Melbourne between 2020 and 2025. The primary outcome was 30-day Clavien–Dindo grade III–V complications. Secondary outcomes included length of stay, non-home discharge, unplanned readmission, and non-completion of adjuvant therapy. Logistic regression analyses were performed.

Results: A total of 245 patients were included, of whom 205 (84%) had a malignant diagnosis and 127 (52%) were planned for adjuvant therapy. Seventy-eight patients (32%) were classified as frail (mFI-5 >2). On multivariable analysis, frailty independently predicted an increased risk of grade III-V complications (OR 2.52, 95% CI 1.31-4.88, p=0.006), as well as non-home discharge (OR 8.75, 95% CI 1.90–63.2, p=0.011), and non-completion of adjuvant chemotherapy (OR 3.00, 95% CI 1.06–8.84, p=0.041).

Table 1. Multivariate analysis prediction of post-operative complications based on Modified Frailty Index – 5

Outcome	OR	95% CI	p-value
Complication: Grade* III-V	2.52	1.31 – 4.88	**0.006**
Complication: Grade* II-V	2.82	1.39 – 5.80	**0.004**
Length of stay > 7 days	2.02	0.96 – 4.26	0.063
Non-home discharge	8.75	1.90 – 63.2	**0.011**
Unplanned readmission within 30 days	1.64	0.50 – 5.08	0.40
Non-completion of planned adjuvant therapy	3.00	1.06 – 8.84	**0.041**

*Clavien-Dindo grade of complications

Conclusion/Implications: Frailty, as measured by the mFI-5, is an independent predictor of adverse postoperative outcomes in older gynaecologic oncology patients undergoing

surgery. Preoperative frailty assessment may support risk stratification and help identify patients who could benefit from targeted perioperative optimisation and multidisciplinary care, including involvement of dedicated geriatric oncology services.

EP074 / #723

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

PREDICTING LYMPH NODE METASTASIS IN ENDOMETRIAL CANCER: A RISK STRATIFICATION MODEL TO GUIDE PELVIC LYMPHADENECTOMY

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Introduction: Routine pelvic lymphadenectomy in endometrial cancer staging risks surgical morbidity and is often unnecessary for low-risk patients. This study aimed to develop a predictive model for lymph node metastasis (LNM) to guide individualized surgical management and avoid overtreatment.

Methods: We analyzed 319 patients with endometrioid endometrial cancer who underwent pelvic lymph node dissection at Siriraj Hospital (2008–2025). Logistic regression identified independent predictors to develop a clinical risk score. Model performance was assessed via AuROC and calibration plots. Optimal cut-offs were defined using established international trial thresholds (9% and 13%) to stratify patients and calculate diagnostic metrics.

Results: The model incorporated age, BMI, neutrophil lymphocyte ratio, tumor grade, tumor size, >50% myometrial invasion, and cervical involvement. It demonstrated strong discrimination (AuROC: 0.828; 95% CI: 0.779–0.876) and calibration (slope: 0.910). Patients were stratified into three risk groups: low (score <5), intermediate (score 5–7), and high (score ≥8). LNM prevalence in the low-risk group was 2.99%, yielding a 97.01% negative predictive value (NPV) and 97.98% sensitivity. Intermediate-risk LNM prevalence was 10.53% (aligning with transition trial thresholds). High-risk LNM prevalence was 43.46%, with 93.94% sensitivity and 43.46% positive predictive value.

Conclusion/Implications: This predictive model effectively stratifies patients into three LNM risk groups. The 97.01% NPV in the low-risk cohort indicates it is a reliable tool for identifying patients who can safely avoid pelvic lymphadenectomy, supporting personalized and less morbid surgical management.

EP075 / #90

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

CONTEMPORARY ANALYSIS OF POSITIVE LYMPH NODES RATE IN MINIMALLY INVASIVE STAGING OF ENDOMETRIAL CANCER

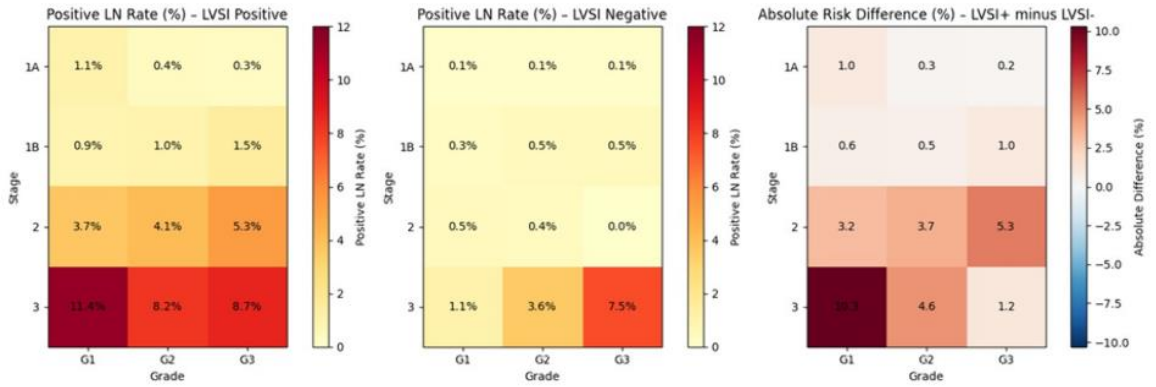
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Introduction: We aim to study the contemporary, national-scale estimates of lymph nodes (LN)+ risk, specifically among minimally invasive staged cases, stratified by lymphovascular space invasion (LVSI), histology, stage, and grade using a strict complete-case analytic approach.

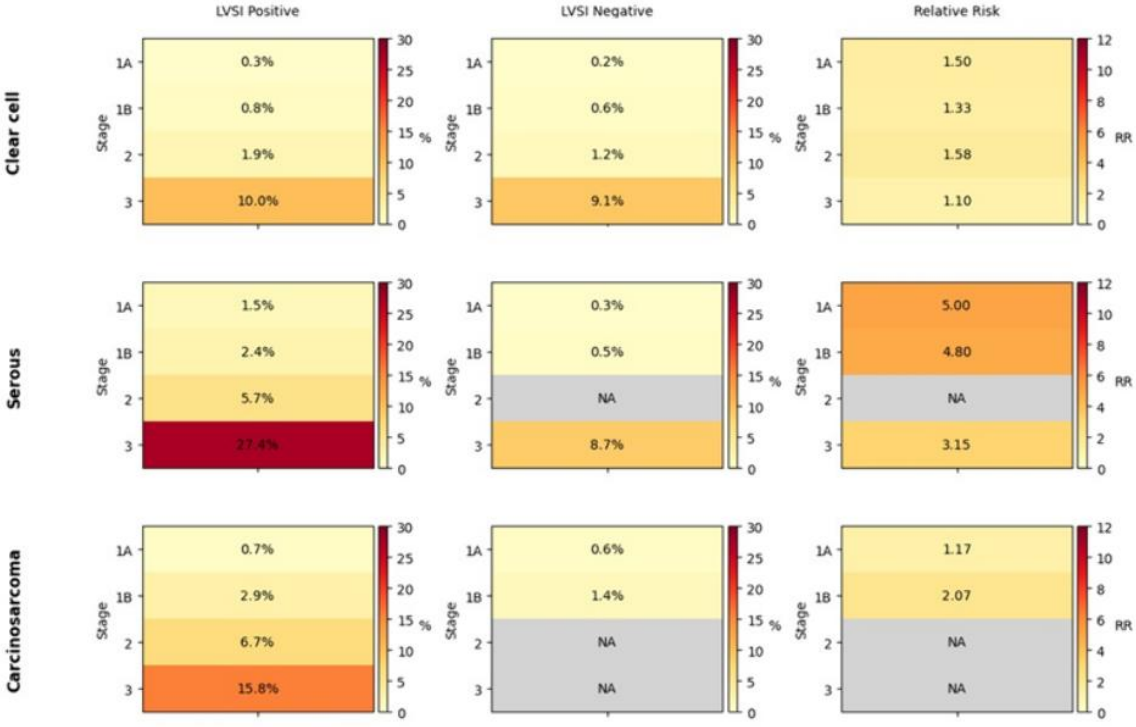
Methods: Retrospective analysis of the NCDB during 2004-2022. We included women who were operated by MIS for clinically stage I EC. We included only cases with non-missing and non-unknown values clinical stage, pathological stage, grade, LVSI, and lymph node evaluation. We stratified the analysis to the following histology: Endometroid, Clear cell, serous, and carcinosarcoma. LN+ was defined as any number of LN+. For each stratum (histology × stage × grade), LN+ rates were reported separately for LVSI+ and LVSI-.

Results: Overall, 38,430 women with a median age was 63 [IQR 57-70] were included. The most common histology was endometrioid 32,398 (84.3%), followed by clear cell 2,950 (7.7%), serous 2,074 (5.4%), and carcinosarcoma 1,008 (2.6%). Stage distribution was as follows: stage IA 28,322 (73.7%), IB 8,381 (21.8%), II 971 (2.5%), and III(A-B) 753 (2.0%). Overall LN+ rate was 0.5% (184/38,430). In endometrioid stage IA LVSI-, LN+ was 0.08% (17/22,301) across grades. The highest observed risks clustered in advanced stage and aggressive histology; Carcinosarcoma stage IB, LVSI+ 2.9% (4/140). LN+ was substantially more frequent in LVSI+ vs LVSI− tumors: 1.9% (111/5,778) vs 0.2% (73/32,652), relative risk 8.74 (95% CI 6.49–11.76).

1a



1b



Conclusion/Implications: In MIS-staged EC, LN+ was rare overall but strongly modified by LVSI, stage, and histology, providing contemporary national-scale benchmarks to support staging and adjuvant decision-making in the MIS era.

EP076 / #390

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

THE IMPLEMENTATION OF A MODIFIED ENHANCED RECOVERY AFTER SURGERY PROGRAMME PROTOCOL FOR GYNAECOLOGY AND GYNAE-ONCOLOGY PATIENTS IN A TERTIARY MEDICAL CENTER: A 4-YEAR RETROSPECTIVE AUDIT

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Introduction: Enhanced Recovery After Surgery (ERAS) is a cornerstone of perioperative care with robust evidence demonstrating improved outcomes, reduced length of stay (LOS) and enhanced patient satisfaction, without increasing readmission or complication rates. At our tertiary centre, ERAS was adopted in 2021 and has evolved to incorporate frailty screening and risk stratification to enable prehabilitation and preoptimisation for all patients regardless of age. This audit aims to evaluate the outcomes of ERAS in gynaecological and gynae-oncological surgeries at our centre.

Methods: A retrospective audit was conducted on patients who underwent gynaecology and gynae-oncology surgeries at the National University Hospital, Singapore, between December 2021 and December 2025. Data collected included patient demographics, clinical frailty scores, surgical procedures, diagnoses, LOS, postoperative complications and readmission rates.

Results: A total of 796 patients with a mean age of 55.0 years were included; 4.9% were deemed frail. Malignant pathologies accounted for 63.4%, with endometrial malignancy being the most common (29.2%). Surgical approaches included open (54.0%), laparoscopic (32.2%) and robotic (11.8%). Mean LOS was 2.9 days. Post-operative complications occurred in 9.4% (75 patients), with prolonged ileus being the most

common (24 patients). 51 patients (6.4%) were readmitted.

Variable	n=796
Age	55.0 (± 12.9)
Pathology	
Ovarian carcinoma	221 (27.8%)
Endometrial carcinoma	233 (29.2%)
Cervical carcinoma	24 (3.0%)
Vulva/Vaginal Carcinoma	8 (1.0%)
Primary peritoneal carcinoma	9 (1.1%)
Benign gynaecological conditions	291 (36.6%)
Others	10 (1.3%)
Surgical approach	
Open	430 (54.0%)
Laparoscopic	256 (32.2%)
Robotic	94 (11.8%)
Vaginal	12 (1.5%)
Others	4 (0.5%)
Outcomes	
Length of stay	2.92
Open approach	3.95
Laparoscopic approach	1.79
Robotic approach	1.54
Vaginal approach	2.17
Readmission within 30 days	51 (6.4%)
Anastomotic leak	2 (0.3%)
Urinary tract injury	5 (0.6%)
Bowel injury	3 (0.4%)
Surgical site infection	6 (0.8%)
Infected vault hematoma	4 (0.5%)
Prolonged ileus	24 (3.0%)
Bleeding	12 (1.5%)
Hospital acquired pneumonia	3 (0.4%)
Urinary tract infection	10 (1.3%)
Cardiac events	1 (0.1%)
Venous thromboembolism	4 (0.5%)
Post-operative delirium	1 (0.1%)
Death within 30 days of surgery	1 (0.1%)

Conclusion/Implications: This audit demonstrates the successful implementation of the modified ERAS protocol at a tertiary centre, with low LOS, complication and readmission

rates consistent with existing literature. Despite a heterogeneous surgical population spanning benign and malignant pathologies across various surgical approaches, outcomes remained favourable. These findings support the broader adoption of structured ERAS pathways incorporating frailty-based risk stratification in gynaecological and gynae-oncological surgery.

EP077 / #724

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

EVALUATING PATIENT OUTCOMES IN A GRADE 1 ENDOMETRIAL CANCER PROGRAM MANAGED BY GENERAL GYNECOLOGY

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Introduction: At THP, a community-based academic Canadian hospital, patients diagnosed with apparent stage 1 grade 1 endometrial cancer undergo hysterectomy without lymph node assessment by a general gynecologist. A small proportion of these patients are found to have high risk features on final pathology and return to the OR for a full pelvic lymph node dissection by a gynecologic oncologist, which is associated with risk and significant morbidity. This study aims to assess the rate of referral for lymphadenectomy and identify factors associated with returning to the OR for post-hysterectomy lymph node assessment.

Methods: This retrospective cohort study evaluates patients treated for grade 1 endometrial cancer at THP between January 1st, 2018 and December 31st, 2024. Descriptive statistics summarize baseline characteristics and outcomes.

Results: 290 patients met inclusion criteria. 8.3% (n=24) underwent pelvic lymph node dissection post-hysterectomy and positive lymph nodes were identified in 20.8% (n=5) of these cases. 75.0% (n=18) of patients who underwent lymphadenectomy received adjuvant therapy. Of these, 83.3% (n=15) had vaginal vault brachy therapy, 5.6% (n=1) external beam radiation therapy (EBRT), 5.6% (n=1) brachy therapy + EBRT, and 5.6% (n=1) EBRT + chemotherapy. One patient received unknown treatment elsewhere. There were no known recurrences among patients that underwent lymph node dissection.

Conclusion/Implications: For patients in the grade 1 endometrial cancer program with high risk features identified on hysterectomy, pelvic lymph node dissection informed tailored adjuvant treatment decisions. This data will help identify those at higher risk who are likely to benefit from sentinel lymph node dissection at time of hysterectomy.

EP078 / #1067

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

AUTOLOGOUS FAT GRAFT FOR THE TREATMENT OF CHRONIC RADIATION-INDUCED DERMATITIS AND FIBROSIS IN THE VULVA: A FEASIBILITY STUDY

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Introduction: Chronic radiation-induced dermatitis and fibrosis (CRDF) is a well-recognised complication of vulvar radiotherapy (RT) and can affect quality-of-life indices for those affected. There is evidence to support the use of autologous fat graft (AFG) in the treatment of CRDF for non-gynaecological malignancies such as breast. We present a feasibility study exploring the use of AFG in the setting of vulvar cancer.

Methods: Women were eligible if they had undergone previous vulvar RT and had symptoms of CRDF. The AFG procedure was performed under a general anaesthetic by a specialised plastic surgeon and followed a three-step process; fat harvesting, fat processing and vulvar fat reinjection (Figure 1). Participants were reviewed at 1 week, 1 month, 3 months and 6 months post-op. The primary outcomes were feasibility and safety. Secondary outcomes included fat retention as determined by interval MRI imaging and patient-related outcomes (PROs), assessed at predefined intervals using the EORTC QLQ-

C30, VPAQ and POSAS instruments.

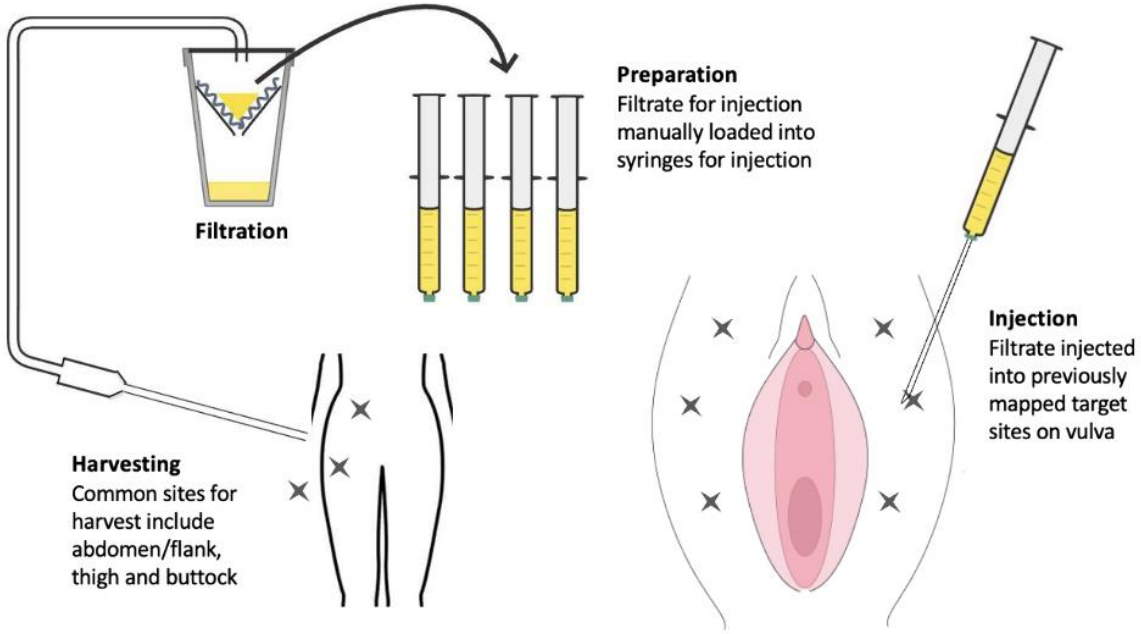


Figure 1: Procedure for AFG (from harvest to injection)

Results: Of 13 screened, 10 were eligible and 3 enrolled in the study. Mean length of operative procedure was 36.7 mins. Mean length of stay was 1 day. There was one Clavien-Dindo Grade 2 complication (simple UTI), however, no other vulva-specific or procedural complications. While there were some subjective improvements in tissue induration, there were no reported differences in mean PRO instrument scores at measured intervals on exploratory analysis.

Conclusion/Implications: AFG is feasible in the setting of vulvar CRDF, however, larger studies would be required to further evaluate acceptability, clinical outcomes and to optimise procedural protocols.

EP079 / #885

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

SURGICAL OUTCOMES OF MAXIMAL-EFFORT CYTOREDUCTIVE SURGERY IN SUSPECTED RECURRENT MALIGNANT OVARIAN GERM CELL TUMOUR: A RETROSPECTIVE STUDY.

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Introduction: Objective: To evaluate outcomes of maximal-effort cytoreduction in suspected recurrent malignant ovarian germ cell tumour (MOGCT).

Methods: Retrospective cohort study between 01/2015 and 12/2025.

Results: 31 patients underwent 35 procedures. Median age at initial diagnosis was 28 (range 15–72). 10/31 (32.3%) were Stage I–II; 16/31 (51.6%) Stage III–IV; 5/31 (16.1%) unrecorded. 27 (87.1%) had primary surgery - 24 (88.9%) laparotomies, three (11.1%) laparoscopies; others received chemotherapy before surgery. 23/31 (76.7%) underwent fertility-preserving surgery. 24/35 (68.6%) were secondary cytoreduction, tertiary 9/35 (25.7%), quaternary 2/35 (5.7%). Indications: recurrence on imaging (n=25, 71.4%); persistent disease post-chemotherapy (n=9, 25.7%); completion surgery (n=1, 2.9%). Two (5.7%) had raised biomarkers. Median disease-free interval was 9 months (1–96). Three patients had >1 procedure. Bowel stripping and reconstruction occurred in 13/35 cases (60%) and resection in 8/35 (23%) with one stoma. 20 cases involved liver mobilisation (57%), 17 diaphragmatic stripping (48.6%) and five (14%) splenectomy. Median blood loss 200 mL (range 20–3000). Fertility-sparing surgery occurred in 19 (54%). 32/35 (91.4%) had complete resection. One patient required planned ITU admission, none unplanned. Median post-operative stay was 4 days (range 2–12). No patient underwent re-laparotomy. Histology was mature teratoma/gliomatosis peritonei in 29/35 (83%), and malignant in 6/35 (17%), with 5/6 (83.3%) receiving adjuvant chemotherapy. Median follow-up is 33 months (3-106 months). Three (9.7%) patients are deceased, two (6.5%) have progressive disease. 26 (83.8%) were disease-free at last review.

Conclusion/Implications: Maximal-effort cytoreduction for suspected recurrent MOGCT achieves high complete resection with low morbidity, without precluding fertility preservation.

EP080 / #509

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

SURGICAL STOPWATCH: ANALYZING SURGICAL DURATIONS IN RISK-REDUCING GYNECOLOGIC PROCEDURES

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Introduction: With increasing emphasis on personalized and patient-centered care, individuals at elevated risk for ovarian cancer have multiple options for risk-reducing surgery. Strategies include salpingo-oophorectomy (SO), hysterectomy with salpingo-oophorectomy (H+SO), and salpingectomy (S) with delayed oophorectomy. Individuals with BRCA1/2 pathogenic variants (PV) face elevated risks of both ovarian and breast cancer, with many also pursuing breast surgery. As surgical options expand, understanding how different approaches, including combined procedures, affect operative and recovery outcomes is essential.

Methods: We conducted a retrospective review of patients with BRCA1/2 PV who underwent risk-reducing gynecologic surgery between 2003 and 2026 at a single urban academic medical center. Surgical time (ST), operating room time (OT), and recovery time (RT) were analyzed using descriptive statistics.

Results: A total of 368 patients (median age 44) underwent risk-reducing gynecologic surgery during the study period. S was associated with shorter median ST and OT compared to SO, with no difference in RT. H+SO had longer ST, OT, and RT compared to S, and longer ST and OT compared to SO, without a difference in RT between H+SO and SO. A small number of patients underwent additional procedures including hernia repair and urogynecologic sling placement. Combined breast and gynecologic procedures increased OT and ST across all groups, but RT did not differ significantly between procedures performed with and without BR within the same surgical

category.

Table 1. Surgical, operating room and recovery room duration for gynecologic risk-reducing procedures.

	Salpingectomy	Salpingectomy + Breast Reconstruction	p-value	Salpingo oophorectomy	Salpingo Oophorectomy + Breast Reconstruction	p-value	Hysterectomy + Salpingo Oophorectomy	Hysterectomy + Salpingo Oophorectomy + Breast Reconstruction	p-value	Salpingo Oophorectomy + Other	Hysterectomy + Salpingo Oophorectomy + Other
Median Operating Room Time (minutes)	85 (65-107)	238 (214-268)	< 0.001	127 (60-445)	273 (137-532)	< 0.001	167 (114-388)	302 (235-373)	< 0.001	140 (109-210)	288 (166-373)
Median Surgical Time (minutes)	37 (22-66)	147 (140-214)	< 0.001	66 (29-322)	82 (88-325)	< 0.004	110 (75-325)	235 (106-316)	< 0.001	87 (45-140)	151 (119-255)
Medican Recovery Room Time (minutes)	237 (135-417)	163 (147-339)	0.28	265 (125-676)	300 (173-384)	0.19	291 (139-566)	206 (33-437)	0.11	320 (219-418)	471 (33-1250)

Conclusion/Implications: Salpingectomy offers the shortest operative time but requires future completion surgery. Although combined procedures extend operative duration, RT is comparable, supporting their feasibility and informing patient-centered surgical decision-making.

EP081 / #568

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

"PREOPERATIVE OPTIMIZATION IN HIGH-COMPLEXITY GYNECOLOGIC SURGERIES: PERSPECTIVES AND OUTCOMES."

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Introduction: Prehabilitation has emerged as a key strategy to improve perioperative outcomes in oncologic patients. While its benefits are well established in colorectal and thoracic surgery, its implementation in gynecologic oncology remains limited. High-complexity gynecologic oncologic surgeries are associated with significant physiological stress and postoperative morbidity. Integrating multimodal prehabilitation into Enhanced Recovery After Surgery (ERAS) pathways may improve functional reserve and perioperative outcomes. However, real-world implementation—particularly the standardization of perioperative anesthetic management—remains a major challenge.

Objectives: To evaluate the implementation and clinical impact of a combined multimodal prehabilitation and ERAS-based perioperative protocol, with special emphasis on anesthetic optimization, in patients undergoing high-complexity gynecologic oncologic surgery.

Methods: Prospective, single-center, open-label, non-randomized interventional study conducted within an established ERAS program. Patients undergoing major gynecologic oncologic surgery are enrolled in a trimodal prehabilitation program initiated ≥3 weeks preoperatively. Outcomes are compared with a historical cohort and a prospective standard-care cohort. Prehabilitation includes nutritional assessment (NRS, ferritin, prealbumin, frailty stratification), home-based exercise, and psychological/psychiatric support. The study focuses on real-world implementation. Adherence to ERAS-aligned anesthetic practices is assessed via a structured post-procedure questionnaire. Evaluated components include opioid-sparing strategies, monitoring, protective ventilation, goal-directed fluid therapy, multimodal analgesia, and neuromuscular recovery (TOF ≥0.9). An adherence score is correlated with postoperative outcomes, including complications (Clavien–Dindo) and length of stay

Current Status & Future Directions: The study is in Phase 3, focusing on real-world implementation, feasibility, and adherence within ERAS. Preliminary observations identify anesthetic management as a key driver of compliance and early recovery. Future work will refine adherence strategies and evaluate oncologic and functional outcomes.

EP082 / #678

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

PREOPERATIVE ANEMIA AS A MODIFIABLE RISK FACTOR IN GYNECOLOGIC ONCOLOGY: IDENTIFYING CANDIDATES FOR SURGICAL OPTIMIZATION

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Introduction: Anemia is highly prevalent in gynecologic oncology patients yet remains inconsistently identified and treated prior to surgery. Preoperative anemia is associated with increased perioperative transfusion and prolonged recovery. This study evaluates the association between preoperative anemia and perioperative outcomes and identifies clinical subgroups with the highest risk for blood transfusion.

Methods: This retrospective matched cohort study was conducted at a large academic cancer center from 2017-2025. Patients with gynecologic malignancies undergoing open surgery were included. Anemia was defined as hemoglobin <12 g/dL. Cases were matched by ASA status, blood loss, and operative duration. The primary outcome was red blood cell transfusion within 3 days. Secondary outcomes included length of stay, 30-day readmission, and mortality.

Results: Of 1555 patients, 52% had preoperative anemia. Prevalence was highest among patients with neoadjuvant chemotherapy, stage IV disease, and ovarian cancer. Compared to matched non-anemic controls, anemia was associated with a 5-fold increase in transfusions (21.6% vs. 4.1%, p<0.001) and a longer hospital stay (3.5 vs. 3 days, p<0.001). No significant differences in readmission or mortality were observed. Subgroup analysis identified elevated transfusion risks in Black and Asian patients (RR >20), stage IV disease (RR >20), uterine cancer (RR 13.3), and neoadjuvant chemotherapy (RR 4.2). Figure 1.
Anemia
Prevalence

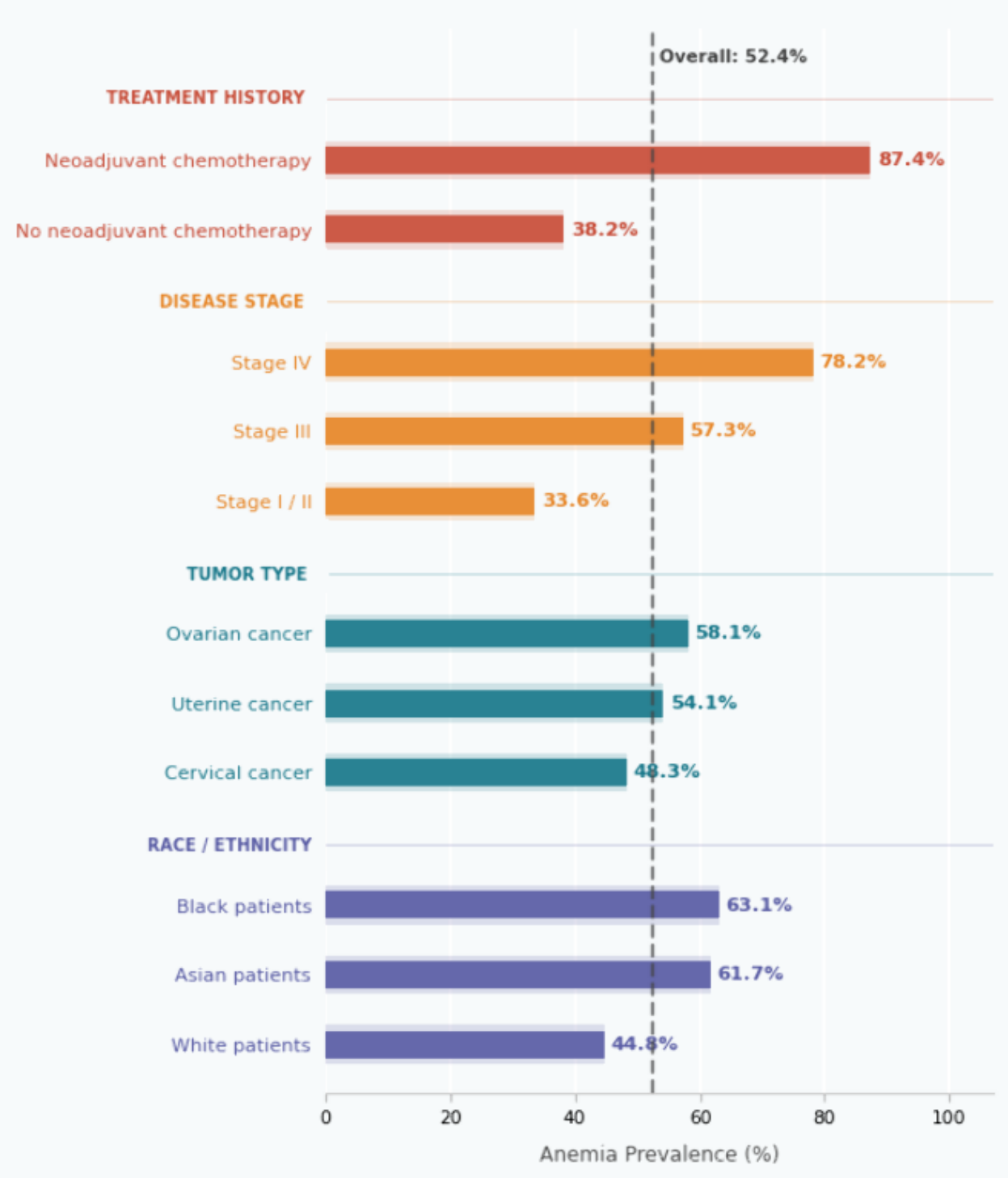
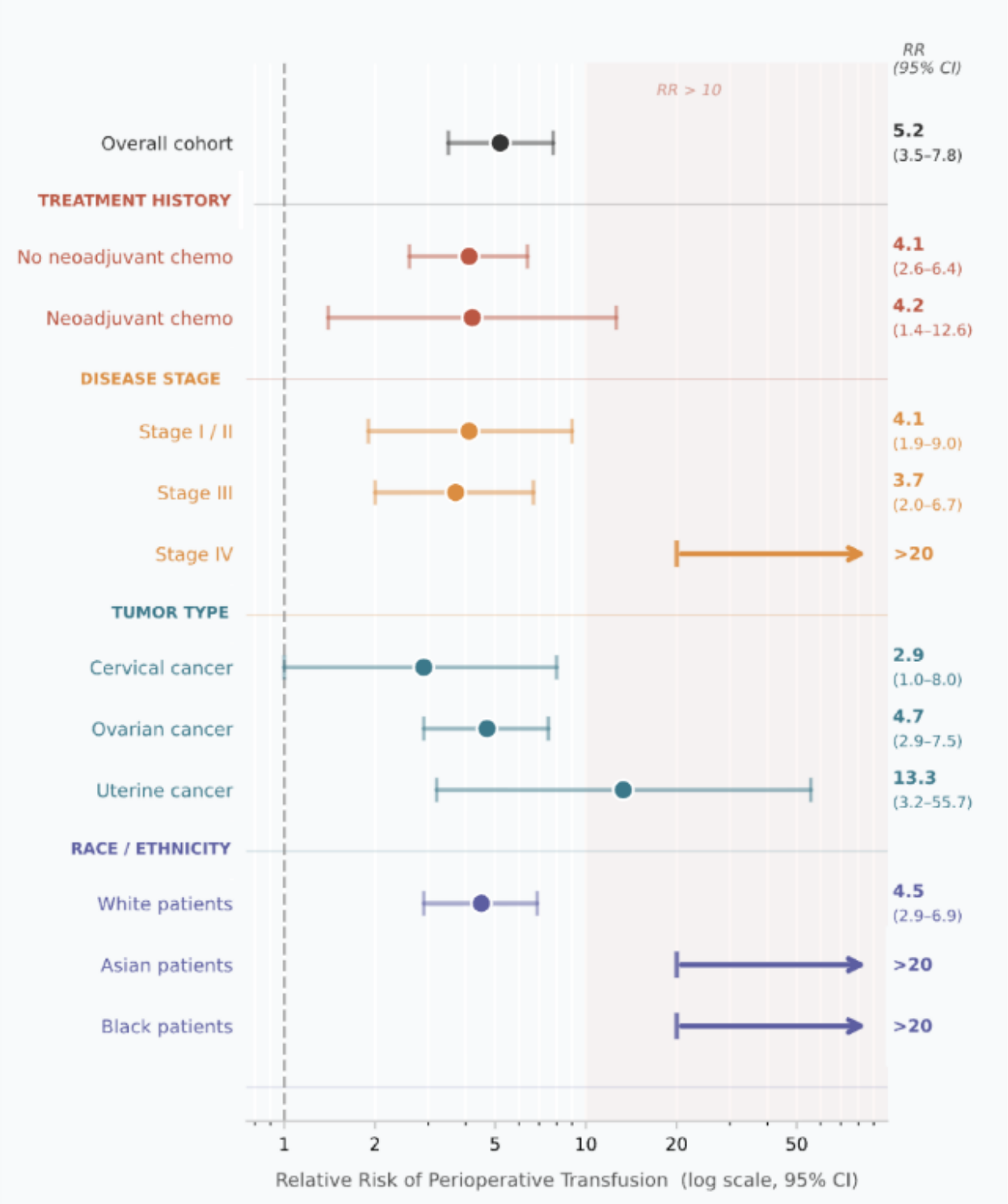


Figure 2. Blood Transfusion

Risk



Conclusion/Implications: Preoperative anemia is a prevalent, potentially modifiable risk factor in gynecologic oncology surgery. Patients with factors associated with elevated transfusion risk may benefit the most from preoperative optimization, such as iron

supplementation. These findings support anemia screening and treatment pathways in gynecologic oncology.

EP083 / #485

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

PREVALENCE AND OUTCOMES OF NEOADJUVANT CHEMOTHERAPY FOLLOWED BY RADICAL HYSTERECTOMY OR CHEMORADIATION IN STAGE IIB CERVICAL CANCER AT MOHAMMAD HOESIN CENTRAL GENERAL HOSPITAL PALEMBANG

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Introduction: Cervical cancer remains a major global health problem, with an estimated 660,000 new cases and 350,000 deaths worldwide in 2022. Asia contributes substantially to this burden, and Indonesia reported approximately 36,964 new cases and 20,708 deaths. In stage IIB disease, treatment selection may influence therapy completion and disease progression. This study aimed to describe treatment distribution and compare outcomes between neoadjuvant chemotherapy followed by radical hysterectomy and chemoradiation.

Methods: A retrospective descriptive-analytic study was conducted using medical records of patients with stage IIB cervical cancer treated from March 2025 to March 2026. Patients were categorized into two groups: neoadjuvant chemotherapy followed by radical hysterectomy and neoadjuvant chemotherapy followed by chemoradiation. Outcomes were classified as complete therapy or progressive disease.

Results: A total of 36 patients were included. Neoadjuvant chemotherapy followed by radical hysterectomy was performed in 17 patients (47.2%), while chemoradiation was performed in 19 patients (52.8%). In the radical hysterectomy group, 13 patients (76.5%) achieved complete therapy and 4 (23.5%) experienced progressive disease. In the chemoradiation group, 7 patients (36.8%) achieved complete therapy and 12 (63.2%) experienced progressive disease. A statistically significant association was found between treatment modality and outcome ($\chi^2 = 5.72$, $p = 0.017$). Patients undergoing radical hysterectomy had higher odds of achieving complete therapy (OR = 5.57; 95% CI: 1.29–23.96).

Conclusion/Implications: Chemoradiation was slightly more frequent; however, neoadjuvant chemotherapy followed by radical hysterectomy was significantly associated

with better outcomes. Further studies with larger samples are needed to confirm these findings.

EP084 / #1097

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

MULTIDISCIPLINARY MANAGEMENT OF ADVANCED HIGH-GRADE SEROUS OVARIAN CANCER: SURGICAL OUTCOMES, SURVIVAL, AND PREDICTORS OF PROGRESSION

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Introduction: We evaluated surgical outcomes, survival, and predictors of progression in advanced high-grade serous ovarian cancer (HGSOC) following multidisciplinary management involving gynecologic and surgical oncologists at a single institution.

Methods: We evaluated surgical outcomes, survival, and predictors of progression in advanced high-grade serous ovarian cancer (HGSOC) following multidisciplinary management involving gynecologic and surgical oncologists at a single institution.

Results: Sixty-one patients were included in the present study; 6 underwent primary cytoreduction and 51 underwent interval cytoreductive surgery (ICS). The complete cytoreduction rate (CC0) was 77% and 74% received PARP inhibitor maintenance. 73% (37/51) of ICS patients received hyperthermic intraperitoneal chemotherapy. Overall , the ileostomy rate was 5% and 79% experienced at least one complication, but most were grade 1-2. Median PFS was 23.6 months(95%CI 11.0-36.1) and two-year OS was 88%. On univariable analysis, PARP inhibitor use(HR=0.32, p=0.002), body mass index(BMI; HR=1.08 per kg/m2, p=0.005), stage IV(HR=2.60, p=0.012), and age(HR=1.04 per year, p=0.046) predicted PFS. On multivariable analysis, PARP inhibitor use(aHR=0.45, 95%CI 0.21-0.96, p=0.040) and BMI(aHR=1.08, 95%CI 1.02-1.15, p=0.010) independently predicted PFS after adjusting for stage. PARP benefit was confined to patients achieving complete cytoreduction (HR=0.17, p<0.001).

Conclusion/Implications: In our institution, collaboration between gynecological and surgical oncologists including decision-making in a dedicated multidisciplinary tumor board led to high complete(CC0) cytoreduction rates and favourable survival, with a low ileostomy rates and manageable complications. PARP inhibitor use and BMI independently predict PFS, with PARP-i benefit depending entirely on achieving complete cytoreduction.

EP085 / #830

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

THROMBOPROPHYLAXIS FOR ENDOMETRIAL CANCER AFTER ROBOTIC SURGERY: A RETROSPECTIVE COHORT STUDY COMPARING APIXABAN AND LOW MOLECULAR WEIGHT HEPARIN

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Introduction: Venous thrombosis events (VTE) associated with cancer are the second cause of death in cancer patients. Obesity is a risk factor for VTE. In our center, a change of practice for thromboprophylaxis occurred after recent literature demonstrated that oral anticoagulants are a safe option instead of low molecular weight heparin (LMWH). The aim of this study is to evaluate the rate of VTE events and major bleeding events following robotic hysterectomy for endometrial cancer in obese patients who received apixaban compared to LMWH. As secondary outcome, non-major bleeding events is compared between both drugs.

Methods: This is a unicenter retrospective cohort study. Once approved by the ethics committee, a retrospective analysis of the patients' files was undertaken. The study population included all patients over 18 years of age who had an endometrial cancer diagnosis histologically proven and received a hysterectomy by robotic surgery at Santa-Cabrini Hospital between November 2022 and December 2023. Statistical analysis was performed with IBM SPSS. Descriptive analysis was performed.

Results: After exclusion, 73 patients were selected. 29 patients received LMWH and 44 patients received apixaban. Both groups were similar in characteristics. No VTE events occurred in both groups. For major bleeding events, 2 events occurred in the apixaban group and none in the LMWH group (p = 0,51). For non-major bleeding events, 3 and 6 events were reported in the LMWH and apixaban group respectively.

Conclusion/Implications: Apixaban seems as effective as LMWH to prevent VTE but there seems to be a tendency towards an increased bleeding risk.

EP086 / #760

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

UTILIZATION OF M-HEALTH APPLICATION AS ADJUNCT TO ERAS PERI-OPERATIVE CARE IN GYNECOLOGIC ONCOLOGY

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Introduction: ERAS is the standard of peri-operative care in gynecologic oncology (G/O). However, patient uptake and patient reported outcomes (PROs) are not well reported. We evaluated patient compliance with select peri-operative recommendations and PROs utilizing an M-Health technology SeamlessMD in a tertiary care centre providing ERAS care for G/O patients.

Methods: Patients receiving major open, MIS or vulvo-vaginal surgery for known/suspected gynecologic malignancy were cared for as per ERAS G/O guidelines and all were offered enrollment. The application provides educational information, daily peri-operative instructions and daily health checks for 30 days post-surgery. Patients received automated prompts for symptom rating, self-education/care, contacting surgeon or presenting to emergency department based on self-reported symptoms. Patient responses from September 2023 – March 2026 (31 months) were collected.

Results: 568 patients signed up for SeamlessMD. 543 (95.5%) completed the full 30 day care plan; 385 completed 5,447 individual health checks, 158 used educational material only. 391 responses to pre-surgery readiness survey were submitted; 145 (38.5%) were given additional education. 281 patients completed the protocol-compliance survey; pre-operative compliance rates were 94% for carbohydrate loading, 99% for eating/drinking guidelines, and 48% for smoking cessation. 9 patients reported the app helping avoid emergency department or ambulatory care visit. Average PROs for anxiety, mood and wound pain was 1.7, 7 and 3.3 at POD7 and demonstrated a stability over next 21 days.

Conclusion/Implications: We describe use of M-Health technology to evaluate patient compliance with peri-operative ERAS care and PROs. Such technology is able to meaningfully impact health care resources and patient satisfaction.

EP087 / #993

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

ORTHOTOPIC RECONSTRUCTION WITH SPHINCTER PRESERVATION AFTER PELVIC EXENTERATION: FEASIBILITY AND SURGICAL OUTCOMES IN GYNECOLOGIC CANCER

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Introduction: Pelvic exenteration (PE) is one of the most radical procedures in gynecologic oncology, offering a potentially curative option for locally advanced or recurrent disease. Traditional non-continent diversions significantly impact quality of life. This study evaluated the feasibility of orthotopic reconstruction with sphincter preservation and compared postoperative outcomes with non-orthotopic techniques.

Methods: A retrospective cohort study including 94 patients undergoing PE for gynecologic cancer at Hospital Italiano de Buenos Aires (January 2008–February 2026). Feasibility was defined as completion of colorectal anastomosis and/or ileal neobladder with sphincter preservation. Postoperative complications were assessed at 0–30 and 31–90 days using the Clavien-Dindo classification and compared using Fisher's exact test.

Results: Most frequent tumors were ovarian (43.6%) and cervical cancer (37.2%). Median age was 57 years (IQR 46–67). PE type was anterior in 27.7%, posterior in 51.1%, and total in 21.3%. Median operative time was 340 minutes and hospital stay 9 days. Curative intent was achieved in 96%. Gastrointestinal orthotopic reconstruction was feasible in 85.3% (58/68); urinary orthotopic reconstruction in only 13.0% (6/46). Overall, 30-day complications occurred in 75%, including 28.2% severe (Clavien-Dindo ≥III). In orthotopic vs non-orthotopic colonic reconstruction, any complication at 0–30 days was 74.1% vs 100% (p=0.102) and severe complications 19% vs 40% (p=0.210); at 31–90 days, any complication was 17.2% vs 30.0% (p=0.389) and severe complications 10.3% vs 20.0% (p=0.334).

	Total of patients (n = 94)	Urinary orthotopic (n=6)	Non-orthotopic urinary (n=40)	Colonic orthotopic (n=58)	Non-orthotopic colonic (n=10)
Age, y, median (IQR)	57 (46–67)	39.5 (30–49)	55.5 (47–63)	59 (47–67)	68.5 (52–70)
BMI, kg/m², median (IQR)	25 (22–28)	24.5 (22 – 27)	25 (23–30)	25 (22–29)	24 (23–29)
ECOG performance status, n (%)					
0	69 (73.4%)	4 (66%)	29 (72.5%)	42 (72.4)	6 (60)
1	21 (22.3%)	2 (33%)	11 (27.5%)	12 (20,7)	4 (40)
2	4 (4.3%)	-	-	4 (6.9)	-
ASA Status, n (%)					
I	6 (6.4)	2 (33)	2 (5)	2 (3.4)	6 (60)
II	64 (68.1)	4 (66)	27 (67.5)	43 (74.1)	4 (40)
III	22 (23.4)	-	10 (25)	12 (20.7)	-
IV	2 (2.1)	-	1 (2.5)	1 (1.7)	-
Primary tumor, n (%)					
Cervix	35 (37.2)	6 (100)	25 (62.5)	14 (24.1)	3 (30)
Ovary	41 (43.6)	-	1 (2.5)	37 (63.8)	3 (30)
Endometrium	9 (9.6)	-	6 (15)	5 (8.6)	-
Vagina	8 (8.5)	-	7 (17.5)	2 (3.4)	4 (40)
Vulva	1 (1.1)	-	1 (2.5)	-	-
Surgical indication, n (%)					
Primary treatment	47 (50)	0	5 (12.5)	38 (65,5)	5 (50)
Persistence/recurrence	47 (50)	6 (100)	33 (82.5)	20 (34,5)	4 (40)
Prior pelvic radiotherapy, n (%)	49 (45.7)	6 (100)	33 (82,5)	14 (24.1)	6 (60)
Time from diagnosis to surgery, d, median (IQR)	269 (41–728)	532 (326 – 1158)	504 (260–1181)	147 (8–324)	264.5 (92–452)
Type of exenteration, n (%)					
Anterior	26 (27.7)	5 (83.3)	21 (52.5)	-	-
Posterior	48 (51,1)	-	-	44 (75.9)	4 (40)
Total	20 (21.3)	1 (16.7)	19 (47.5)	14 (24.1)	6)60)
Surgical Characteristics					
Laparotomic approach, n (%)	93 (98.9)	6 (100)	40 (100)	57 (98.3)	10 (100)
Infralevator extension, n (%)	11 (11.7)	1 (16.7)	10 (25)	6 (10.3)	5 (50)
Extrapelvic procedures, n (%)	48 (51.1)	3 (50)	6 (15)	37 (63.8)	3 (30)
Curative intent, n (%)	90 (95.7)	6 (100)	36 (90)	57 (98.3)	9 (90)
Operative time, m, median (IQR)	340 (285–445)	273 (235–330)	300 (220–405)	420 (330–540)	353 (300–400)
Intraoperative blood loss ≥500 mL, n (%)	47 (50)	NA	12 (30)	38 (65,5)	3 (30)
Length of stay, d, median (IQR)	9 (7–13)	10.5 (10–12)	12 (8–15)	9 [7–13]	12.5 (8–14)
Readmission, n (%)	27 (28.7)	3 (50)	22 (55)	14 (24,1)	6 (60)

Table 1. Baseline Demographic, Oncologic, and Surgical Characteristics

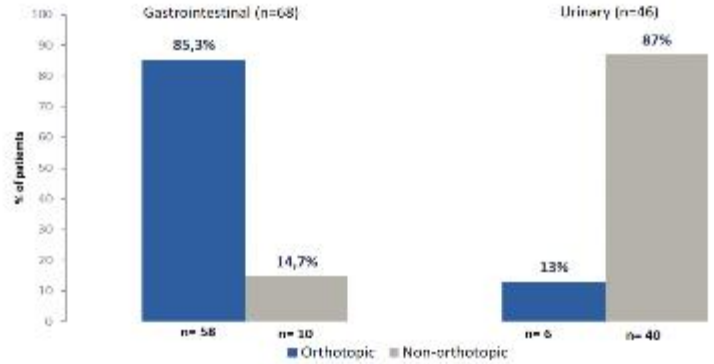


Figure 1. Feasibility of Orthotopic Reconstruction

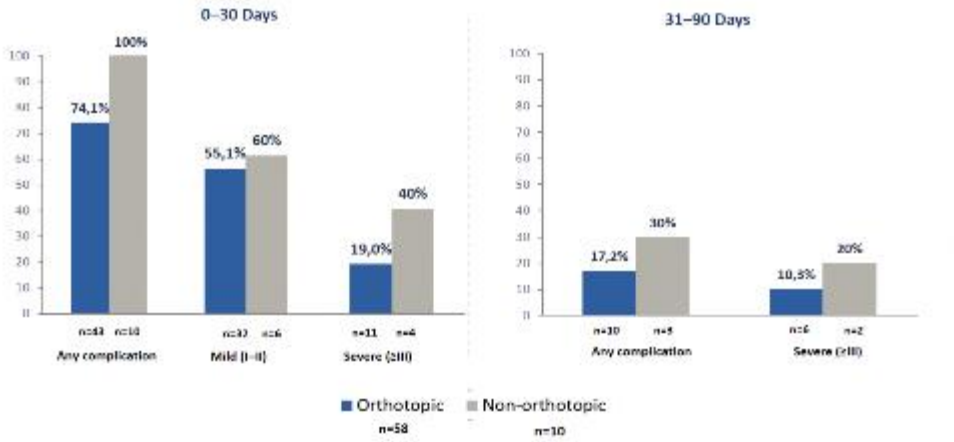


Figure 2. Postoperative Outcome Gastrointestinal Reconstruction.

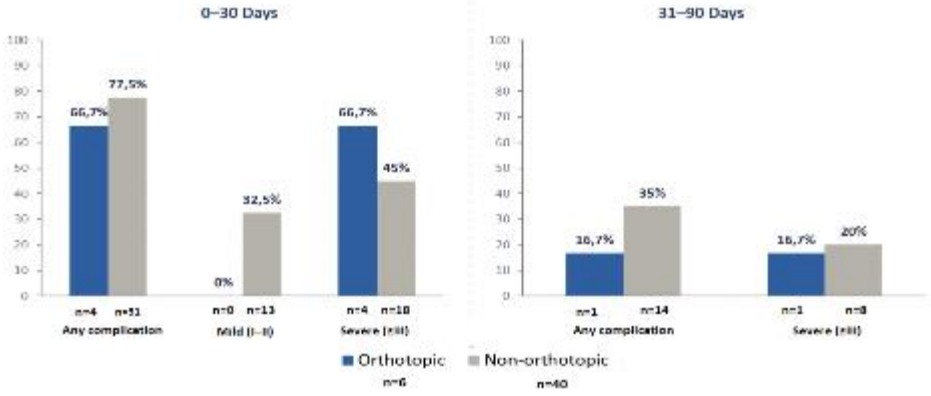


Figure 3. Postoperative Outcome Urinary Reconstruction.

Conclusion/Implications: Orthotopic gastrointestinal reconstruction is feasible in most patients and associated with a favorable complication profile. Urinary orthotopic

reconstruction remains technically challenging. These findings support sphincter-preserving approaches in carefully selected patients at experienced centers.

EP088 / #884

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

PATIENT SURVIVAL IN ADVANCED OVARIAN CANCER BASED ON THE TIMING OF DEBULKING SURGERY: A RETROSPECTIVE COHORT STUDY

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Introduction: Ovarian cancer remains a leading cause of gynecologic cancer mortality worldwide with poor overall survival. Despite advances in treatment, five-year survival remains approximately 50% globally. The optimal timing of debulking surgery in advanced ovarian cancer remains controversial, with studies comparing outcomes between primary debulking surgery (PDS) and interval debulking surgery (IDS) after neoadjuvant chemotherapy. The aim of this study was to evaluate the timing of debulking surgery on overall and disease-free survival rates of patients with advanced ovarian cancer in Kazakhstan.

Methods: This retrospective cohort study was conducted in National Research Oncology Center, a tertiary care center in Astana, Kazakhstan, during 2016-2020. 103 patients with stage III–IV ovarian cancer underwent either PDS or IDS following neoadjuvant chemotherapy. Overall survival and disease-free survival rates were analyzed using the Kaplan–Meier method.

Results: The average age of patients was 49.9±12.5 years. The overall five–year survival rate for advanced ovarian cancer was 62.2% (±5.0%) and 35.4% (±6.0%) disease-free survival for all patients. In PDS group, the median disease-free survival rate was 38.5 months, while the median overall survival was not reached due to ongoing survival at the time of analysis. In IDS group, the median overall survival was 45.5 months and the median disease–free survival was 14.0 months.

Conclusion/Implications: Primary debulking surgery was associated with improved disease-free survival outcomes compared to interval debulking surgery in patients with advanced ovarian cancer. These findings support the importance of optimal patient selection and timely surgical management to improve disease prognosis in Kazakhstan.

EP089 / #1111

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

EARLY DETECTION AND MANAGEMENT OF INFECTIOUS COMPLICATIONS FOLLOWING CYTOREDUCTION SURGERY AND HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY USING PREDEFINED C-REACTIVE PROTEIN THRESHOLD: A PROSPECTIVE MULTICENTER STUDY

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Introduction: Cytoreductive surgery (CRS) with hyperthermic intraperitoneal chemotherapy (HIPEC) is considered to be a high-risk procedure. C-reactive protein (CRP) has been demonstrated to be a reliable tool for detecting postoperative infectious complications. The objective of this study was to validate a predefined systematic CRP assay threshold for early detection of infectious complications after CRS with HIPEC.

Methods: A prospective multicentric study was conducted between January 2022 to December 2024 including all surgical oncology and gynecologic oncology patients undergoing complete CRS with HIPEC in two tertiary care centers. CRP levels were measured daily postoperatively. CRP value threshold was defined as an increase of at least 10% for two consecutive days, starting from postoperative day three. When reached, thoracoabdominal computed tomography, bloodwork, urinary analysis, and drain cultures were performed.

Results: Seventy-six patients were included. The overall incidence of infectious complications was 32.3%. Fifty-three patients reached the CRP threshold, of which 41.5% were diagnosed with infectious complications. Sensitivity of predefined CRP threshold was 88.0%, and negative predictive value was 87.0%. Mean CRP threshold was significantly higher in patients with confirmed infectious complication (143.7+/-68.4mg/L) compared to without infectious complication (90.7+/-62.4mg/L)(p=0.0045). CRP cut-off value that most accurately predicted infectious complications was 99.7mg/L. High clinical suspicion for

infection correlated with infectious complications in 90.9% of patients, whereas low suspicion correlated with infections in only 23.1% of cases.

Conclusion/Implications: Predefined CRP threshold for early detection of infectious complications following CRS with HIPEC demonstrated high sensitivity. However, it may lead to unnecessary investigation, especially in patients with low clinical suspicion.

EP090 / #37

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

IMPACT OF HIPEC (HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY) ON OUTCOME FOR GYNECOLOGIC CANCER PATIENTS IN A COMMUNITY/TEACHING HOSPITAL

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Introduction: To determine if HIPEC at interval debulking surgery for ovarian cancer affects outcomes.

Methods: A chart review identified 63 patients who had HIPEC and 20 patients who did not at the time of interval debulking surgery. Kaplan Meier survival analysis was used to determine significance of progression free survival and overall survival. Student's t test was used to determine significance of other variables.

Results: The cohort had 63 patients who received HIPEC and 20 who did not have HIPEC at the time of interval debulking surgery. Those who received HIPEC were younger on average (p=0.047) compared to controls. HIPEC patients did have a lower mean CA125 at time of surgery (0.0558), but this did not reach significance. The HIPEC patients had a longer time to recurrence (12 months vs 8.71 months, p=0.157), longer progression free survival (22.29 months vs 20.75 months, p=0.1555) and longer overall survival (33.27 months vs 29.95 months, p=0.1533), but none of these outcomes were statistically

significant.

Characteristic	No HIPEC (n=20)	HIPEC (n=63)	P-value
Age, median, y	70	63	**0.047**
Race, No. (%)			0.204
Other	3 (15)	15 (23.8)	
White	17 (85)	48 (76.2)	
BMI, mean	28.29	28.23	0.488
Stage, No. (%)			0.097
3	13 (65)	48 (79.4)	
4	7 (35)	15 (20.6)	
CA125 at surgery, mean	312.4	85.73	0.0558
Estimated blood loss, mean, mL	718.42	552.86	0.241
Blood transfusion, mean, units	1.6	1.143	0.283
ICU days, mean	2	3.78	**0.0142**
Hospital days, mean	6.6	8.43	0.061
Time to recurrence, mean, mo	8.714	12	0.157
Progression-free survival, mo	20.75	22.29	0.1555
Overall survival, mo	29.95	33.27	0.1533
Bowel resection, No. (%)			0.3159
Yes	5 (25)	25 (39.7)	0.118
No	15 (75)	38 (60.3)	
Complications, No. (%)			
Yes	7 (35)	19 (30.2)	0.344
No	13 (65)	44 (69.8)	

Conclusion/Implications: Patients receiving HIPEC had increased time to recurrence, progression free survival and overall survival, although this was not statistically significant. Patients selected for HIPEC were significantly younger. They also tended to have a lower mean CA125 at the time of surgery, which implies they had a better response to neoadjuvant chemotherapy. This identifies the question of whether it is HIPEC or if the patient selection for HIPEC that impacts these outcomes. Overall, in our community/teaching hospital, HIPEC increased progression free survival by 2 months and overall survival by 3 months.

EP091 / #27

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

CYTOREDUCTIVE SURGERY FOR HIGH-GRADE SEROUS OVARIAN CANCER IN OCTOGENARIANS: A QUEBEC TERTIARY-CARE EXPERIENCE

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Introduction: In Canada, ovarian cancer remains the fifth leading cause of cancer-related mortality among women. High-grade serous ovarian cancer (HGSOC), the most common and aggressive subtype, disproportionately affects older women. Despite increasing incidence with age, patients aged 80 years or older are underrepresented in clinical trials, and treatment is often modified due to concerns regarding frailty and comorbidities. This study aims to describe management strategies and outcomes of very elderly women with HGSOC undergoing surgical treatment.

Methods: A retrospective cohort study of women aged ≥80 years with HGSOC who underwent surgery between 2013 and 2025. Demographic, clinical, treatment, and outcome variables were abstracted from electronic medical records. Overall survival (OS) and progression-free survival (PFS) were estimated using Kaplan-Meier methods, and Cox proportional hazards regression identified factors associated with OS.

Results: Forty-two of 562 patients with HGSOC (7.5%) were aged ≥80 years. Median age was 82 years (interquartile range 81–84). Most patients had three or more comorbidities (81.0%) and advanced disease (FIGO III-IV, 71.4%). Cytoreductive surgery was performed in 66.7%, while 33.3% received neoadjuvant chemotherapy followed by interval surgery. Macroscopic cytoreduction (R0) was achieved in 64.3%. Complications occurred in 35.7%, with a median hospital stay of 5 days. Median PFS was 25 months and median OS was 37 months. Primary surgery was associated with improved OS compared with neoadjuvant chemotherapy (43 vs 24 months;
p=0.01).

Figure 1. Progression free survival by treatment strategy

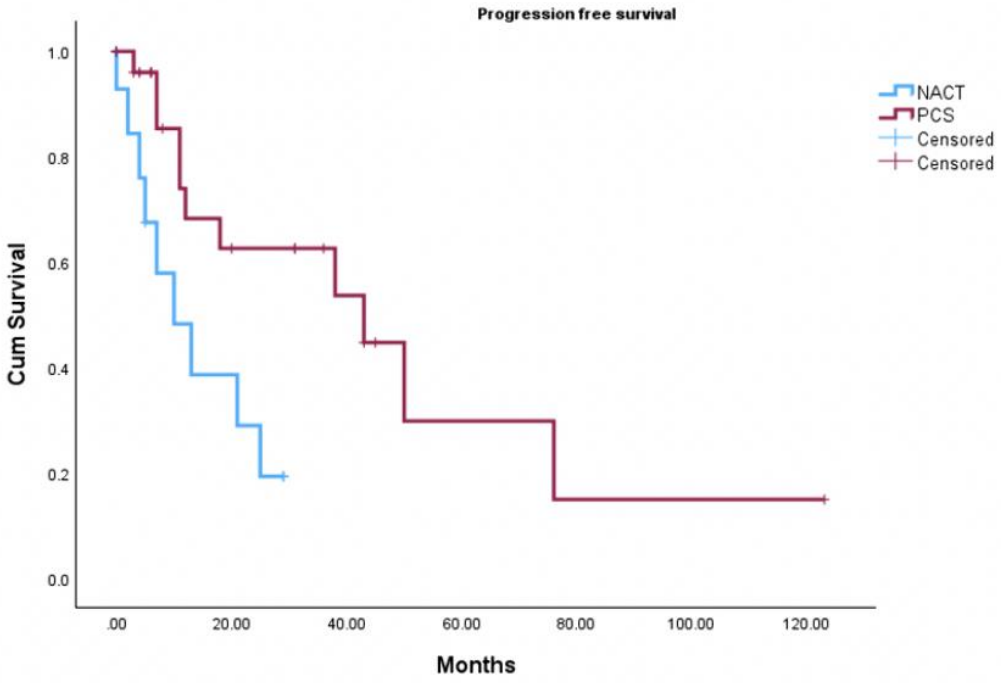
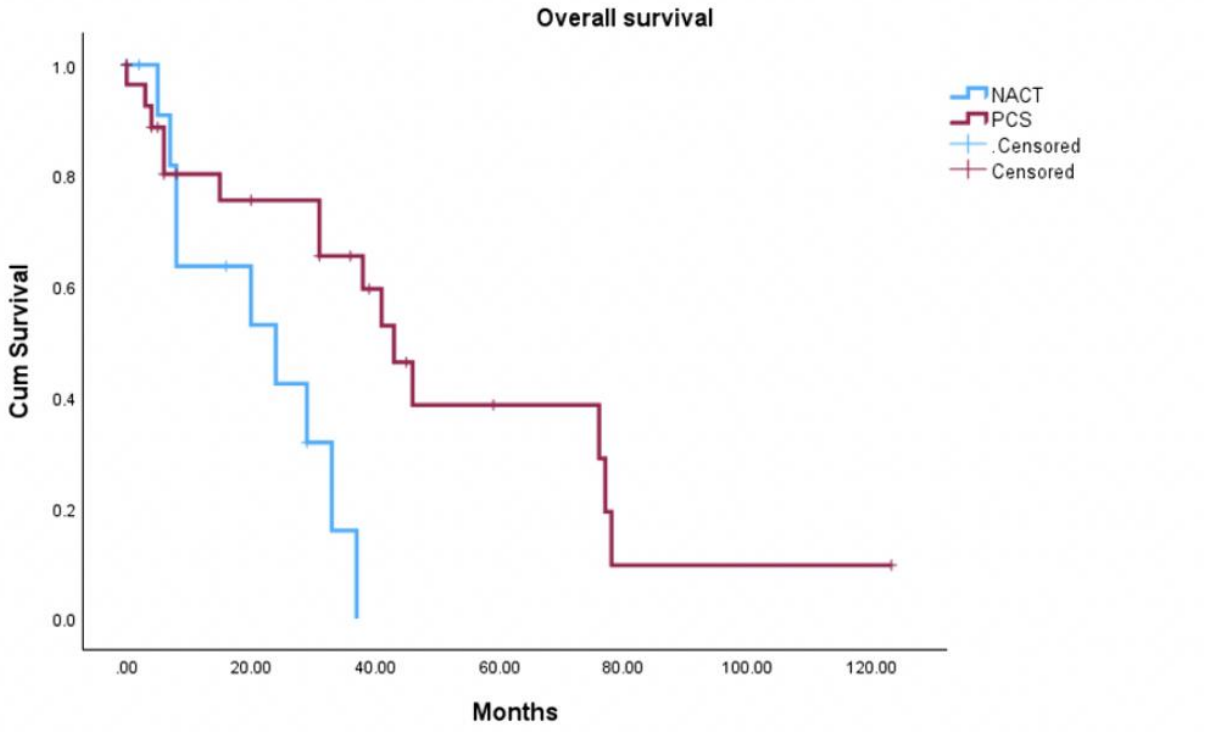


Figure 2. Overall survival by treatment strategy



Conclusion/Implications: Carefully selected octogenarians with HGSOC can achieve meaningful survival outcomes. Functional status should guide treatment decisions rather than chronological age.

EP092 / #1104

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

PATIENT EXPERIENCES OF PAIN FOLLOWING LAPAROSCOPIC HYSTERECTOMY FOR GYNECOLOGIC CANCER WITHIN AN ENHANCED RECOVERY AFTER SURGERY (ERAS) SAME-DAY DISCHARGE (SDD) PROGRAM

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Introduction: Same-day discharge is safe and effective in gynecologic oncology patients undergoing minimally invasive hysterectomy with ERAS. Multimodal analgesia reduces post-operative opioid use and opioid-associated health risks; however, uptake of low- or no-opioid prescribing is highly variable and there is limited patient-reported data of pain management post-SDD. This qualitative study characterizes patients' post-operative pain experiences within an opioid-sparing ERAS/SDD program.

Methods: Patients with gynecologic malignancy undergoing laparoscopic hysterectomy with SDD were recruited from a single Canadian tertiary care centre. Semi-structured interviews were performed 4-6 weeks post-operatively, then recorded, transcribed verbatim, and analyzed in Quirkos™ using interpretive description methodology. Concurrent data collection and analysis facilitated iterative updates to the interview guide based on emerging themes.

Results: Data saturation was achieved after 12 interviews. Most patients described a positive pain experience exceeding expectations, which was a primary theme. The vast majority were satisfied with over-the-counter analgesics without any opioid use, and none required additional visits for pain-related concerns. Exploring their expectations generated secondary themes around contributors like pre-operative education, prior medical encounters, and peer narratives. Patients dissatisfied with analgesia generally expressed a perceived deficiency in counselling affecting their pain expectations, highlighting areas for improvement in patient education. Additional emergent themes include use of non-pharmacological adjuncts, and experiences of non-pain related discomforts like sleep.

Conclusion/Implications: Most patients undergoing laparoscopic hysterectomy report positive experiences with SDD and opioid-sparing analgesia. These findings support implementation of these ERAS principles and highlight areas for improvement in patient education and surgical counselling.

EP093 / #955

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

STRENGTHENING GYNECOLOGIC ONCOLOGY SERVICES IN RWANDA THROUGH SOUTH-TO-SOUTH COLLABORATION: A MODEL FOR SUSTAINABLE CANCER CARE

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Introduction: Gynecologic malignancies pose a significant burden in Rwanda, with cervical cancer among the top three cancers. Despite available radiation and medical oncology services, access to standard surgical care has been limited. To address this gap, Rwanda adopted a South-to-South collaboration model, partnering with Ethiopia. Two Ethiopia-trained gynecologic oncologists were recruited, leading to the establishment of clinical services and the country's first gynecologic oncology fellowship at the University of Rwanda in 2022. The study was conducted to assess the impact of the gynecologic oncology fellowship training in Rwanda.

Methods: A retrospective review of surgical case logs and fellowship-related activities conducted with international partners.

Results: Between 2022 and 2025, over 636 major surgeries were performed, including 90 radical hysterectomies, 348 staging procedures for ovarian and uterine cancers, 157 fertility-sparing surgeries, and 41 vulvar cancer surgeries. National referral clinics at CHUK and RMTH now manage 25–30 patients per session, twice weekly. The model integrates South-to-South collaboration with selective global support from the International Gynecologic Cancer Society and the Czech MEDEVAC program, including mentorship, tumor boards, and advanced training exposure. The IGCS has been an integral part of the training with the provision of funding for external rotation, conducting monthly Echo tumor boards, and assignment of international mentors.

Conclusion/Implications: Rwanda's fellowship program demonstrates a sustainable, locally driven approach to strengthening gynecologic oncology care. This model offers a scalable framework for improving equitable cancer care in low- and middle-income countries.

EP094 / #355

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

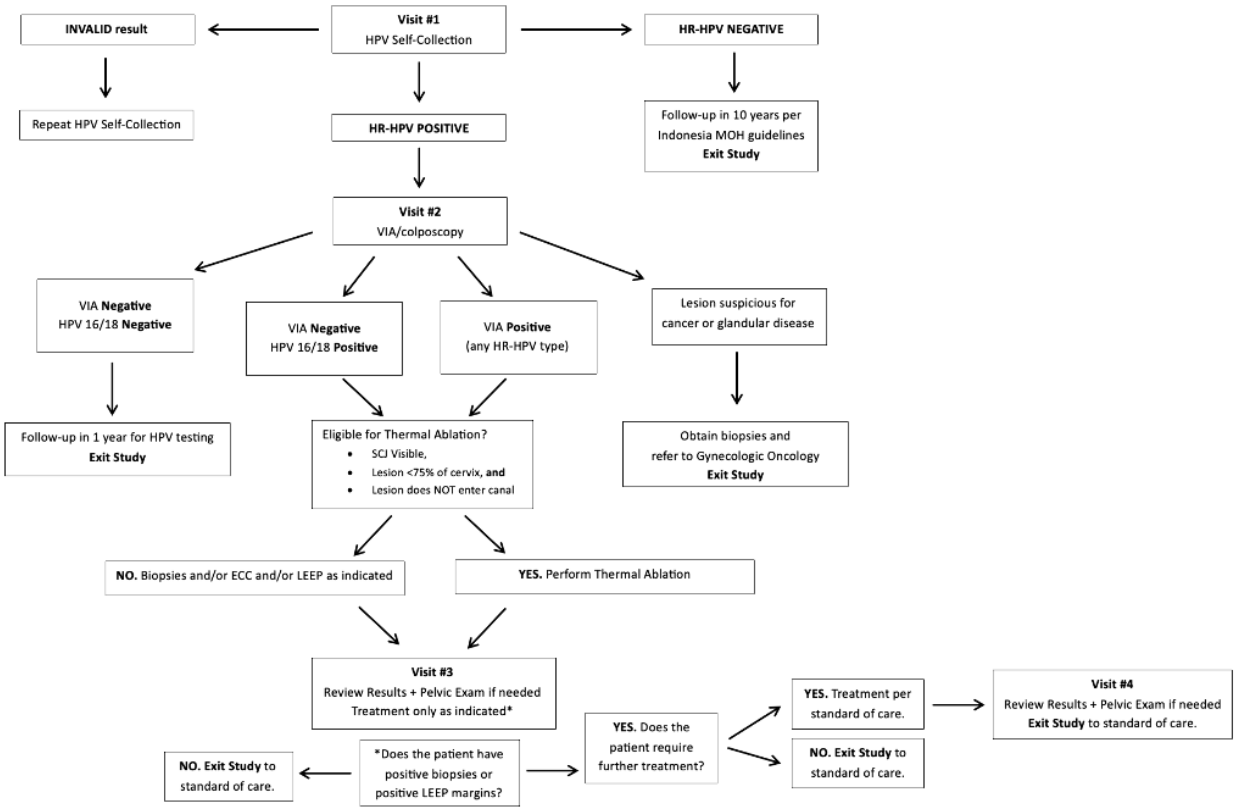
IMPLEMENTATION OF HPV SELF-COLLECTION AND FOLLOW-UP MANAGEMENT IN INDONESIA

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Introduction: Cervical cancer is the second leading cause of cancer mortality in Indonesia. In 2023, Indonesia's Ministry of Health launched a Cervical Cancer Elimination Plan prioritizing primary high-risk human papillomavirus (HR-HPV) testing. We conducted a prospective study to evaluate feasibility and acceptability of HR-HPV self-collection in Indonesia and to identify barriers to follow-up.

Methods: From August-October 2025, women aged 30-69 were recruited at community sites in West Jakarta, Depok, and Lebak. After receiving education on cervical cancer prevention, participants completed HR-HPV self-collection using the BD Onclarity™ test. Those with HR-HPV positive results underwent visual inspection with acetic acid (VIA) and were treated with thermal ablation, Loop Electrosurgical Excision Procedure (LEEP), or other procedures as indicated (Figure 1). Turn-around-times across the screening-to-treatment cascade were calculated and participants completed surveys assessing their

experiences.



Results: Of 5917 women assessed, 98 (1.7%) were ineligible, and 119 (2.0%) declined enrollment. Of 5700 enrolled participants, 100% completed HPV self-collection. The HR-HPV positive rate was 4.0% (n=226) (Table 1). Only 28 (12.4%) presented for follow-up, and 23 (10.2%) completed guideline-concordant care. Overall, 98.7% expressed willingness to self-collect again. Median time from self-collection to follow-up was 68 days (range 10-179). Barriers included limited laboratory capacity, lack of standardized result delivery, and a complex follow-up referral

system.

Initial HPV Test Results – Overall and by City

	Depok (N=2000)	Lebak (N=1900)	West Jakarta (N=1800)	Total (N=5700)
HPV Test, n (%)				
Negative	**1757 (87.9%)**	**1608 (84.6%)**	**1547 (85.9%)**	**4912 (86.2%)**
Positive	**74 (3.7%)**	**48 (2.5%)**	**104 (5.8%)**	**226 (4.0%)**
HPV 16	14 (0.7%)	5 (0.3%)	19 (1.1%)	38 (0.7%)
HPV 18	9 (0.5%)	7 (0.4%)	9 (0.5%)	25 (0.4%)
HPV 45	2 (0.1%)	0 (0.0%)	6 (0.3%)	8 (0.1%)
HPV 31	1 (0.1%)	1 (0.1%)	2 (0.1%)	4 (0.1%)
HPV 51	8 (0.4%)	3 (0.2%)	12 (0.7%)	23 (0.4%)
HPV 52	20 (1.0%)	9 (0.5%)	21 (1.2%)	50 (0.9%)
HPV 33 and/or 58	12 (0.6%)	3 (0.2%)	7 (0.4%)	22 (0.4%)
HPV 35, 39, and/or 68	11 (0.6%)	7 (0.4%)	28 (1.6%)	46 (0.8%)
HPV 56, 59, and/or 66	15 (0.8%)	18 (0.9%)	23 (1.3%)	56 (1.0%)
Invalid	**152 (7.6%)**	**232 (12.2%)**	**140 (7.8%)**	**524 (9.2%)**
Reason Invalid, n (%)				
Social	39 (25.8%)	94 (43.3%)	49 (36.0%)	182 (36.1%)
Inhibition	112 (74.2%)	123 (56.7%)	87 (64.0%)	322 (63.9%)
Missing	1	15	4	20
Run Failure, n (%)	10 (0.5%)	9 (0.5%)	4 (0.2%)	**23 (0.4%)**
Process Error, n (%)	7 (0.4%)	3 (0.2%)	5 (0.3%)	**15 (0.3%)**

Conclusion/Implications: HR-HPV self-collection is feasible and acceptable among Indonesian women. However, critical gaps in result delivery and follow-up care represent barriers to cervical cancer prevention. Sustainable scale-up requires investment in laboratory infrastructure, systemized result dissemination and patient tracking, and streamlined pathways for follow-up diagnosis and treatment.

EP095 / #583

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

"I'VE GOT ENOUGH GOING ON": A QUALITATIVE STUDY EVALUATING DISPARITIES IN CLINICAL TRIAL PARTICIPATION FOR PATIENTS WITH GYNECOLOGIC CANCER

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Introduction: Patients who identify as members of historically underrepresented racial and/or ethnic groups have had limited enrollment in clinical trials (CT). This qualitative study explored the decision-making process and influences driving CT participation among these patients with gynecologic cancer.

Methods: Semi-structured Zoom audio interviews were conducted with eligible patients with gynecologic cancer who had enrolled in a CT or declined at one urban academic institution. Interviews were transcribed verbatim. Two investigators used thematic analysis to interpret data, first by independently coding four interviews and then discussing discrepancies with a moderator. The investigators applied this codebook to all transcripts through an iterative approach.

Results: Data saturation was reached after completing interviews with 17 participants (median age 65 years, range 49-74). 28 subthemes grouped into five major themes emerged: (1) Information needs, (2) Logistics, (3) Perceptions of research, (4) Psychological and family influences, and (5) Trust. Table 1 depicts illustrative quotes corresponding to subthemes for the theme 'Perceptions of research.' Participants from historically underrepresented groups more frequently discussed limited clarity regarding trial procedures, language barriers, and social and logistical concerns. Several of these participants associated CTs with experimentation or mistrust These participants also framed decisions through the lenses of access and competing social demands, whereas white participants emphasized individual risk–benefit assessments.

Conclusion/Implications: Patients from historically underrepresented groups face complex barriers that shape the decision to enroll in a CT. Strengthening trust through transparent communication and incorporating measures to better mitigate financial toxicity are critical for facilitating equitable participation in CTs in gynecologic oncology.

EP096 / #1058

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

PHASE III RANDOMISED TRIAL OF METRONOMIC MAINTENANCE WITH ORAL METHOTREXATE AND PROPRANOLOL VERSUS OBSERVATION AFTER CHEMOTHERAPY IN RELAPSED PLATINUM SENSITIVE HIGH GRADE EPITHELIAL OVARIAN CANCER

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Introduction: The study sought to evaluate low-cost maintenance strategies in relapsed ovarian cancer The rationale for methotrexate was increased expression of folate receptors in ovarian cancer and for propranolol, its anti-angiogenic activity.

Methods: This was an open label phase III randomized study at a single tertiary care, public sector hospital. Patients with platinum sensitive relapsed high grade epithelial ovarian cancer (HGEOC) with partial response or stable disease after platinum-based doublet, not on bevacizumab or PARPi were enrolled. They were randomized 1:1 to receive either oral metronomic maintenance with tablets methotrexate (15 mg once a week) and propranolol (40 mg BD) or kept on observation. The planned sample size was 150, primary end point progression free survival (PFS) and secondary end points overall survival (OS) and toxicity.

Results: The study period was from March 2022 to December 2025. There were 405 patients of platinum sensitive relapsed HGEOC, however only 25 patients were enrolled, 11 screen-fail and 14 randomized (7 in each arm), and the study was closed for poor accrual. The median PFS in study and observational arm was 3 and 5 months, and OS at 24 months 48% and 57% respectively. No grade III/ IV toxicity. The reasons for study ineligibility were

PARPi 42(10%), bevacizumab 29 (7%), other metronomic chemotherapy 76 (19%), another trial 23(6%), secondary cytoreduction 20 (5%), unwilling for trial participation 112 (28%), others 78 (19%).

Conclusion/Implications: Though the study did not meet its primary end point, it gave an insight into the use of bevacizumab and PARPi in the real-world setting.

EP097 / #943

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

MRI-BASED PERITONEAL PROTOCOL AS A PREDICTOR OF SURGICAL TUMOR BURDEN IN INTERVAL DEBULKING SURGERY FOR ADVANCED OVARIAN CANCER IN LOW-MIDDLE INCOME COUNTRIES.

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Introduction: Complete cytoreductive surgery (R0) is a well established prognostic factor in advanced ovarian cancer, both in primary (PDS) and interval debulking (IDS) setting. Accurate preoperative assessments of disease extent is therefore essential to guide appropriate surgical selection. To improve non-invasive evaluation of peritoneal tumor burden, we implemented a dedicated MRI abdomino-pelvic with peritoneal protocol that enables estimation of the radiological Peritoneal Cancer Index (rPCI). This approach incorporates a structured reporting system based on the PAUSE framework, which standardizes the final report, :P: rPCI; A, ascites and abdominal wall involvement; U, unfavourable sites; S, small bowel and mesenteric disease; E, extra peritoneal metastases. We report our initial experience in patients undergoing IDS with this tool, the first one in the country.

Methods: Since 2022, we have analyzed (n= 27) patients (pts). Median age: 67 years, BRCA mut 14%, Stage III 55% and IV: 45%, high grade serous carcinomas 96%,median number of neoadjuvant chemotherapy (ct) cycles: 3 (R:3-6), CA 125 pre-ct: 600 U/ml (R:35-24.900) and pre-surgery was: 44 U/ml (R:10-3301)

Results: The medium rPCI for patients who underwent R0 surgery was 8/39 (p=0.002) (IQR: 6.5) Surgical outcomes: R0:59% R1: 26% and R2: 15%. A direct comparison between imaging findings and pathology reports was performed and has a 88% (IC95 0.688-0.975) of sensibility for this tool with a PPV: 91% (IC95 0.730-0.990)

Conclusion/Implications: MRI with this innovative protocol helps predict with a high sensitivity peritoneal involvement to guide the IDS decision. This could be a more accessible tool in LMIC compared to more invasive approaches.

EP098 / #745

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

PUBLICATION OUTCOMES OF ABSTRACTS PRESENTED AT THE IGCS AND SGO ANNUAL MEETINGS: A COMPARATIVE ANALYSIS OF 2018 AND 2022

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Introduction: We aim to determine the publication rate of abstracts presented at the International Gynecologic Cancer Society (IGCS) and the Society of Gynecologic Oncology (SGO) annual meetings in both 2018 and 2022, and to compare variables such as author gender, continent of origin, cancer site, intervention type, as well as study enrolment.

Methods: Google Scholar and PubMed searches were conducted to retrieve the corresponding full manuscript publications up to February 2026 inclusive. Matches were determined based on substantial similarities in study title, authorship, and study design.

Results: Overall, there were 200 abstracts. Most abstracts were presented at the SGO meeting (n=112, 56.0%), while 44.0% (n=88) were presented at the IGCS meeting. Of those, 136 (68.0%) were published. The median time to publication was 1 year (IQR 1–2). Tumor site distribution was predominantly ovarian (n=71, 35.5%), followed by combined malignancies (n=51, 25.5%), endometrial cancers (n=46, 23.0%), cervical cancers (n=20,10.0%), trophoblastic neoplasia (n=7, 3.5%) and vulvar cancer (n=5, 2.5%). The majority of studies were paramedical (n=109, 54.5%), followed by treatment-focused studies (n=62, 31.0%), while surgical studies accounted for a smaller proportion (n=29, 14.5%). The median sample size was 290 (IQR 105–1,055). The median number of authors per study was 8 (IQR 5–13). Abstract presented at IGCS were more likely to be published 70 (77.8%) vs. 66 (60.0%), p=.007. Published abstracts had higher mean number of authors (10 vs. 8, p=.046).

Conclusion/Implications: Just over two thirds of presented papers progress to publication. A higher number of authors was linked with increased publication rates.

EP099 / #259

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

ROBOTIC GYNECOLOGIC ONCOLOGY WITHIN A STRUCTURED IMPLEMENTATION PROGRAM IN A CHILEAN PUBLIC HOSPITAL: FEASIBILITY, PERIOPERATIVE OUTCOMES, AND ADAPTED MOLECULAR PROFILING

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Introduction: Robotic surgery implementation in Latin American public hospitals remains scarce and unreported. We describe feasibility and perioperative outcomes of robotic gynecologic oncology within a structured program at a Chilean public institution, focusing on a high-BMI population.

Methods: Retrospective analysis of a prospectively collected database from a robotic gynecology program (Da Vinci X with Firefly fluorescence imaging, August 2024–November 2025), Hospital Clínico San Borja Arriarán, Santiago, Chile (n=72). Oncologic cases were analyzed as a subgroup for complexity (4-tier classification), operative times, complications (Clavien-Dindo), and length of stay. CUSUM analysis assessed technical proficiency. Adapted molecular profiling (MMR immunohistochemistry and p53; POLE sequencing unavailable institutionally) was performed in all endometrial cases.

Results: Seven oncologic cases (9.7%): endometrial carcinoma (n=5), risk-reducing salpingo-oophorectomy (n=1), and abdominal cerclage after prior cervical cancer treatment (n=1). Median BMI 36.8 kg/m^2 (range 23.8–54.5); all Tier 2–3. Procedures included Surgical staging with sentinel lymph node (SLN) biopsy (n=4), pelvic lymphadenectomy (n=1), and bilateral adnexectomy (n=1); SLN mapping achieved bilaterally in all eligible cases. Median console and docking times: 97.5 min (range 37–240) and 4 min (range 1–12). No intraoperative or postoperative complications (Clavien-Dindo grade 0). Median postoperative stay 1 day (range 0–2). All endometrial cases pMMR; p53 wildtype in four (FIGO IA, surveillance), mutant in one (FIGO IIB, PORTEC-3).

Conclusion/Implications: Robotic gynecologic oncology is feasible and safe in a Chilean public hospital, including high-BMI and surgically complex patients. Adapted molecular profiling enabled risk stratification and individualized adjuvant planning. These results support broader robotic adoption in Latin American public health systems.

EP100 / #1084

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

LESSONS FROM THE FIRST LOCALLY ORGANIZED RADICAL HYSTERECTOMY TRAINING WORKSHOP IN NIGERIA.

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Introduction: The paucity of specialists with requisite skills to perform radical hysterectomy, particularly within sub-Saharan Africa, prompted the West African College of Surgeon (WACS) to organise a training workshop for trainees enrolled in the WACS post-fellowship subspecialty training in gynaecological oncology. This report highlights the challenges and lessons learnt from the workshop

Methods: We used RE-AIM framework to evaluate the implementation of the 2026 WACS Radical Hysterectomy Training Workshop at the University of Abuja Teaching Hospital Gwagwalada, Nigeria. A post-workshop survey was used to assess the perception of the participants on how the training will affect their practices

Results: The findings are presented under the RE-AIM framework as follows: **Reach**: The full cohort of five trainees in the WACS gynaecological oncology post-fellowship programme and two gynaecologists who were not in the cohort attended the workshop. **Effectiveness**: Only participants already performing some sort of radical hysterectomy before the workshop expressed confidence in ability to perform the procedure afterward, implying a need for more exposure. **Adoption**: All participants expressed satisfaction and found the workshop useful. **Implementation**: Training was conducted over two days. **Maintenance:** Patients paid for surgery since the training was integrated into the routine service-provision of the hospital.

Conclusion/Implications: Application of resource-tailored management, innovative funding strategies and pooling of patients are options that can be explored to overcome some of the challenges of organizing radical hysterectomy workshops in West Africa. More

workshops are needed for practitioners to build competence and confidence in doing the procedure.

EP101 / #750

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

HUMAN PAPILLOMAVIRUS SCREENING PROGRAM REGIONAL ANALYSIS, ASSOCIATED FACTORS, AND EPIDEMIOLOGICAL PROFILES IN 1,000 COLOMBIAN WOMEN

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Introduction: Cervical cancer remains a leading cause of cancer mortality among Latin American women, with persistent regional disparities in screening outcomes. We analyzed a Colombian HPV screening cohort to characterize regional differences, identify factors associated with abnormal cytology and high-risk HPV (HR-HPV), and detect epidemiological profiles to inform targeted interventions.

Methods: Cross-sectional analysis of 1,000 women screened across Colombia's four natural regions (Andean, Caribbean, Pacific, Amazon) using a REDCap database with 116 variables. The strategy combined bivariate analysis, multivariable logistic and modified Poisson regression, unsupervised learning (Factor Analysis of Mixed Data + K-means, k=5; bootstrap Jaccard 0.78–0.90), and supervised machine learning (LASSO, Random Forest, XGBoost) with 10-fold cross-validation and SMOTE.

Results: Mean age was 45.6 years; HR-HPV prevalence 14.1% and abnormal cytology 11.2%, with significant regional heterogeneity (Pacific: 14.2% abnormal cytology; Amazon: 16.6% HR-HPV). Smoking (adjusted OR 1.92; 95% CI 1.01–3.48), prior STI history (OR 2.21; 1.06–4.36), and educational level were independently associated with HR-HPV; smoking showed negative confounding in crude analysis. Living outside the Caribbean doubled the odds of abnormal cytology (OR 2.0–2.6). FAMD + K-means identified five profiles revealing two etiological pathways: behavioral risk (Andean urban, 15.7%) and access barriers (Amazonian, 15.1%). Supervised ML models achieved modest discrimination (best AUC: Random Forest 0.624 for cytology; XGBoost 0.601 for HR-HPV).

Conclusion/Implications: Geography structures cervical cancer risk in Colombia through two distinct etiological pathways requiring opposite interventions. Smoking was confirmed as a modifiable HR-HPV cofactor. Integrating classical epidemiology with machine learning

EP102 / #770

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

ASSESSING EQUITY IN EARLY DRUG ACCESS FOR GYNECOLOGIC CANCERS ACROSS QUEBEC'S HEALTH SYSTEM

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Introduction: Quebec, a geographically vast province of over 8 million people with the highest projected cancer incidence rate in Canada[1], provides a compelling setting to evaluate timely access to oncology therapies. Although Health Canada approval permits clinical use, public reimbursement is provincially determined and frequently delayed. During this interval, manufacturer-sponsored patient support programs (PSPs) provide access to unreimbursed therapies, though uptake is not standardized. We performed a province-wide analysis of PSP-mediated access to gynecologic oncology therapies.

Methods: We retrospectively analyzed administrative records from gynecologic oncology PSPs in Quebec. Time to first enrolment was summarized descriptively and compared across institutional and geographic factors using Wilcoxon rank-sum and χ^2 tests. Results were benchmarked against a parallel breast oncology PSP cohort. Analyses were conducted in R (v.2025.5.1).

Results: Across 4 PSPs, 48 first enrolments were captured at 22 centres across Quebec. Median time from PSP activation to first enrolment was 331.5 days (IQR 199-490; range 3-837 days). University centres demonstrated earlier uptake, with 45.5% versus 13.5% enrolling by six months ($p=0.022$). Compared with a parallel breast cohort (n=196), gynecologic access was markedly delayed: median time to enrolment was over threefold longer (331.5 vs 105 days; $p<0.0001$), with persistently lower enrolment at 3, 6, and 9 months (all $p<0.05$).

Conclusion/Implications: PSP-mediated access to gynecologic oncology therapies in Quebec reflects variability in timeliness across a universal healthcare system. These findings establish PSP uptake as a real-world marker of early access and will inform future evaluation of the clinical and health economic consequences of delayed treatment access.

EP103 / #252

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

BRIDGING THE IMPLEMENTATION GAP IN CERVICAL CANCER: TURNING PRACTICE GUIDELINES INTO LEGISLATION THROUGH ADVOCACY AND GRASSROOTS CAMPAIGNING

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Introduction: Cervical cancer is Canada's fastest-rising cancer. Despite being preventable, progress has stalled due to systemic inequities and fragmented screening delivery. This discribes an advocacy model launched following the 2025 national clinical White Paper.

Methods: The Women's Health Coalition of Canada (WHC), with the Society of Gynecologic Oncology of Canada (GOC) and eighty+ stakeholders, launched a lobby effort and "Days on the Hill" campaign to engage the Federal Government. This strategy integrated: 1. **Legislative Advocacy:** Utilizing clinical evidence to anchor **Bill S-243** (*National Framework for Women's Health in Canada Act*), mandating standardized national care and research equity. 2. **Grassroots Mobilization:** A national campaign to drive community engagement and policy support across Canada. 3. **Direct Policy Engagement:** High-level briefings with parliamentarians and the Minister of Health, using HPV testing as a model for addressing inequities that Bill S-243 could correct. 4. **Media Relations:** Partners continue raising awareness and encouraging women to self-advocate for vaccinations and screening.

Results: The campaign successfully positioned cervical cancer as a priority "test case" for Bill S-243. Advocacy emphasized that 35% of under-screened women lack primary care, making innovations like self-collection, a legislative necessity to bypass systemic barriers. Economic data highlighted that closing health gaps related to women's health could contribute **$37 billion** annually to Canada's economy.

Conclusion/Implications: By anchoring federal legislation with clinical evidence and mobilizing a diverse grassroots network, health care advocates can lead systemic reform to

meet global cervical cancer elimination targets and elevate the state of women's healthcare for all communities across Canada and finally ensure equity.

EP104 / #961

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03a. Equity-Driven Innovation*

NAVIGATING DUAL ROLES AS PARENTS AND SURGEONS: AN EXPLORATORY QUALITATIVE STUDY OF DUAL SURGEON HOUSEHOLDS.

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Introduction: The surgical workforce, including gynecologic oncology, is increasingly composed of dual-career households. However, training pathways and workplace structures remain poorly aligned with parenting and dual high-intensity careers. This study explores how dual-surgeon couples navigate career trajectories, parenthood, and equity.

Methods: We conducted qualitative dyadic interviews with dual-surgeon couples (n=10) across career stages and practice settings. Interviews were transcribed verbatim and analyzed using an iterative thematic approach, with attention to both individual and dyadic perspectives. Coding focused on career decision-making, division of labour, support systems, and institutional context.

Results: Five interrelated themes were identified. Career trajectories were co-constructed but shaped by unequal flexibility, with early job opportunities often determining whose career took precedence. Parenthood was strategically timed around training milestones but remained structurally misaligned, requiring extensive reliance on built support networks. Division of labour appeared task-based but masked persistent inequities in responsibility, particularly in the mental load and invisible labour of coordinating family life. Institutional supports varied widely by specialty and practice setting, with inconsistent access and uptake influenced by local culture. Across couples, equity was aspirational but continuously negotiated, with gendered patterns in how work, parenting, and career trade-offs were experienced and articulated.

Conclusion/Implications: Dual-surgeon households function within systems not designed for dual careers or parenting, relying on ongoing negotiation and invisible labour to sustain balance. Findings highlight the need for structural and cultural changes in surgical training and practice to better support workforce sustainability and gender equity in gynecologic oncology.

EP105 / #949

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

NATIONAL BRACHYTHERAPY CAPACITY-BUILDING SUMMITS TO IMPROVE GYNAECOLOGICAL CANCER CARE IN NIGERIA

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Introduction: This significant capacity gap in access to 3D-image-guided brachytherapy in Nigeria underscores the need for structured knowledge sharing and continuous multidisciplinary training to strengthen brachytherapy practice and improve gynecological cancer outcomes in Nigeria and similar resource-limited settings

Methods: This study is a descriptive post-program evaluation of the Brachytherapy Summit, an annual multidisciplinary capacity-building program developed to strengthen brachytherapy practice in Nigeria. The program combined onsite hands-on training in 3D brachytherapy with a hybrid summit format. Core components included keynote lectures, panel discussions, live clinical demonstrations, case-based presentations, and experience sharing. Program reach and growth were assessed using registration records, attendance logs, and faculty participation across successive annual meetings from 2023 to 2025.

Results: Table 1: Themes and Subthemes of Brachytherapy Summit

Year	Theme
2023	Innovative Approaches to Improving Brachytherapy Practices in Nigeria
2024	Enhancing Access to Brachytherapy Services in LMICs: Overcoming Barriers
2025	Advancing Gynaecological Brachytherapy in Nigeria: Bridging Gaps Through Innovation, Collaborati Enhancement

Conclusion/Implications: Brachytherapy is a critical component of curative treatment for cervical and other gynaecological cancers. Implementation of a multidisciplinary brachytherapy summit, integrated with hands-on 3D image-guided brachytherapy training, has the potential to strengthen workforce capacity, promote collaboration, and support improvements in brachytherapy delivery in Nigeria.

EP106 / #423

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

TIMELINESS OF GYNECOLOGIC ONCOLOGY CARE IN KINGSTON, ONTARIO IN 2023: A RETROSPECTIVE COHORT STUDY

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Introduction: Gynecologic cancers are a leading and rising cause of morbidity and mortality among women in Canada, with persistent disparities in access to timely care. This study evaluates wait-time patterns and adherence to provincial benchmarks (≤21 days to consultation and ≤28 days to treatment) at a regional tertiary center to identify delays and inform strategies to improve care delivery.

Methods: Single-centre retrospective study of patients referred to gynecologic oncology at Kingston Health Sciences Centre in 2023. Data were collected from a prospectively maintained referral database and patient charts. Wait times were assessed against provincial benchmarks, with targets of ≤21 days from referral to consultation and ≤28 days from consultation to treatment.

Results: Among 144 patients, the median referral-to-treatment time was 45.5 days, with most delay occurring between consultation and treatment. While 70.8% of patients met the ≤21-day referral-to-consult benchmark, only 50.0% met the ≤28-day consult-to-treatment target. Delays varied significantly by cancer type ($p < 0.025$), with the shortest in ovarian and longest in vulvar cancers. Delays in treatment were primarily attributed to patient illness and the need for additional pathology review or specialist input, while referring provider, patient rurality status, symptoms at presentation, and cancer grade were not significantly associated with increased wait times.

Conclusion/Implications: KHSC met provincial benchmarks for referral to consultation more frequently than treatment initiation benchmarks. These findings suggest that system level inefficiencies arise primarily after consultation and underscore the need for targeted interventions to improve post-consult care pathways and ensure equitable, timely access to treatment.

EP107 / #243

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

IMPACT OF THE COVID-19 PANDEMIC ON CERVICAL CANCER MORTALITY TRENDS IN MEXICO: A NATIONAL INTERRUPTED TIME-SERIES ANALYSIS

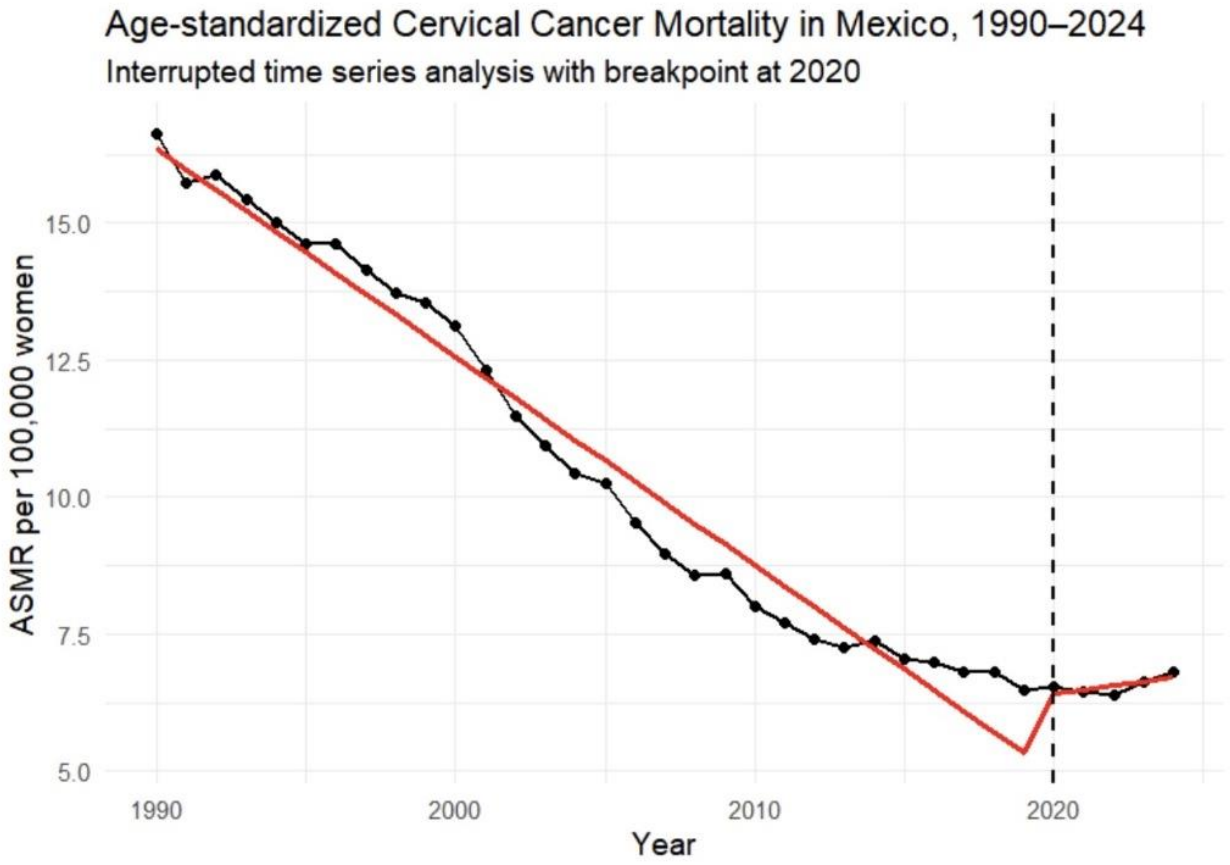
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Introduction: Cervical cancer mortality has declined in Mexico over recent decades; however, the population-level impact of COVID-19–related disruptions in cancer care remains unclear. We evaluated whether the pandemic was associated with changes in national cervical cancer mortality trends.

Methods: We conducted a population-based interrupted time-series analysis using national mortality data from Mexico (1990–2024). Cervical cancer deaths were identified using ICD-9 code 180 and ICD-10 code C53. Mortality rates per 100,000 women and age-standardized mortality rates (ASMR) were calculated using national population estimates and the WHO standard population. Segmented regression models evaluated changes in mortality level and slope after the 2020 interruption. A counterfactual scenario based on pre-pandemic trends estimated excess deaths. Uncertainty was assessed using nonparametric bootstrap resampling (2,000 iterations). Ovarian cancer mortality served as a negative control.

Results: Before 2020, cervical cancer mortality declined significantly ($\beta = -0.150$/year; $p < 0.001$). After the COVID-19 interruption, a significant slope increase was observed ($\beta = +0.267$; $p = 0.006$), indicating reversal of the previous downward trend. Similar findings were observed for ASMR ($\beta = +0.453$; $p = 0.017$). Significant slope increases occurred among women aged 45–64 years and ≥65 years. Counterfactual analysis estimated 4,087 excess deaths between 2020 and 2024 (95% CI 3,359–5,190). No slope change was observed for ovarian cancer

mortality.



Conclusion/Implications: The COVID-19 pandemic was associated with reversal of declining cervical cancer mortality trends in Mexico and substantial excess deaths, particularly among older women, suggesting that disruptions in cancer diagnosis and treatment may have contributed beyond screening reductions alone.

EP108 / #657

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

IMPACT OF HEALTH DEPRIVATION INDEX ON OUTCOMES OF LARGE LOOP EXCISION OF THE TRANSFORMATION ZONE

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Introduction: Cervical cancer disproportionally affects individuals living in socioeconomically deprived areas of the United Kingdom. Lower participation in screening programmes among disadvantaged groups is a recognised contributing factor, and disparities persist beyond screening. We reviewed the results of our large loop excision of the transformation zone (LLETZ) procedures with reference to the health deprivation and disability index (HDI).

Methods: Retrospective review of all outpatient LLETZ within a London NHS Trust between 1st December 2022 and 30th November 2024.

Results: 419 patients underwent at least one LLETZ (median age 38, range 25-68). hrHPV was present in all index smears alongside high-grade cytological abnormalities in 73.5% (n=308), low-grade abnormalities in 25.5% (n=107), and normal cytology in 1% (n=4). Final histology is demonstrated in Graph 1. HDI was known for 411 patients and divided into 5 quintiles (Table 1); with a significant difference in distribution ($p<0.0001$). There was no significant difference in index smear grade ($p=0.1534$). Although there was a greater proportion of CIN3 in the lowest quintile (Table 1), the result did not reach significance ($p=0.0648$). Test-of-cure (TOC) results were available for 374 patients. There was no difference in the proportion of normal TOC results amongst quintiles ($p=0.2553$). Despite evidence of a difference in non-attendance rates ($p=0.0008$), there was no clear trend across
quintiles.

Graph 1: Final histology results (n=419)

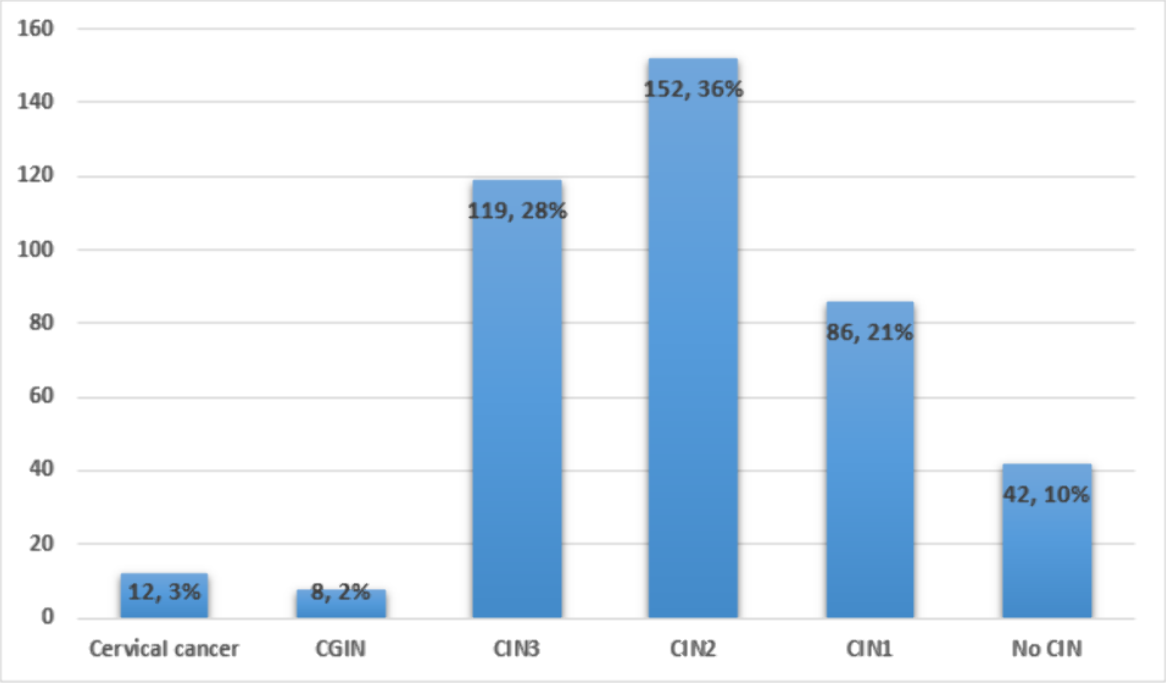


Table 1: Distribution of final histology amongst health deprivation and disability index (HDI)

Quintile	1 (lowest)	2	3	4	5 (highest)	Total
Cervical cancer	0 (0%)	0 (0%)	1 (1%)	4 (3.5%)	7 (6%)	12 (3%)
CGIN	0 (0%)	1 (2%)	1 (1%)	5 (4%)	1 (1%)	8 (2%)
CIN3	6 (60%)	12 (24%)	29 (25%)	31 (28%)	39 (32%)	117 (28.5%)
CIN2	1 (10%)	15 (31%)	45 (38%)	42 (37.5%)	45 (37%)	148 (36%)
CIN1	3 (30%)	16 (33%)	30 (25%)	19 (17%)	16 (13%)	84 (20.5%)
No CIN	0 (0%)	5 (10%)	12 (10%)	11 (10%)	14 (11%)	42 (10%)
Total	10 (2%)	49 (12%)	118 (29%)	112 (27%)	122 (30%)	411

Conclusion/Implications: There were no significant differences amongst HDI quintiles in this cohort. Although our Trust serves patients from all groups, it covers a small geographical location and is unlikely representative of the whole of the UK. Further larger studies are required.

EP109 / #660

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

CULTURE, LANGUAGE AND SILENCE: BARRIERS TO HEREDITARY CANCER CARE AMONG SOUTH ASIAN WOMEN IN BRITISH COLUMBIA, CANADA

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Introduction: In British Columbia, Canada, nearly 10 % of the 5 million population are of South Asian ancestry. Despite a public system which funds genetic counselling and testing for any eligible individual, South Asians are significantly underrepresented in Hereditary Cancer Program, representing only 3% of patients tested. The reasons for this disparity are not well understood.

Methods: Thirty-eight South Asian women participated in Punjabi/English focus groups and interviews. Participants represented diverse ages, migration histories, and language fluency. Sessions were facilitated by a bilingual, culturally matched researcher. Using qualitative data analysis, transcipts were reviewed and coded, key themes extracted.

Results: Hereditary cancer was largely unfamiliar concept: participants commonly perceived cancer as random and did not associate family history with personal risk. Key genetic concepts lacked direct linguistic equivalents in Punjabi, and participants reported difficulty naming reproductive anatomy even in English. Cultural taboos/stigma surrounding cancer and gynecologic health were prominent. Participants described concealing illness to avoid gossip, and avoidance of screening because of percieved "purity". Familial hierarchy/expectations reinforced silence and limited discussion of reproductive health. Participants reported systemic barriers: experiences of dismissal or stereotyping by healthcare providers when raising concerns about family cancer history and reliance on family members for translation which compromised privacy and accuracy of communication.

Conclusion/Implications: Intersecting linguistic, cultural, familial, and institutional barriers hinder engagement with hereditary cancer care. Despite these challenges, participants expressed motivation to gain knowledge and protect family health. Findings highlight the need for culturally and linguistically tailored education and community-based outreach to improve access and uptake of genetic services.

EP110 / #740

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

DELAYS TO CARE AMONG SCREEN-DETECTED EARLY-STAGE CERVICAL CANCER PATIENTS IN MOZAMBIQUE

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Introduction: Cervical cancer remains the leading cause of cancer-related mortality in Mozambique, where access to treatment of invasive cancer is limited. In 2017, IGCS implemented the Global Gynecologic Oncology fellowship program. The first four Gynecologic Oncologists trained in Mozambique now provide care to cervical cancer patients while training additional fellows. We describe the clinical characteristics, management, and time-to-care for cervical cancer patients diagnosed through two ongoing prospective screening studies in Mozambique.

Methods: We performed a prospective review of cervical cancer patients from two screening studies in Maputo, Mozambique. Clinical data included demographics, HIV status, pathology, stage, and treatment. Time intervals between screening, biopsy, diagnosis, imaging, and surgery were calculated.

Results: From June 2025 to April 2026, five cervical cancer patients were referred to Gynecologic Oncology. Table 1 shows clinical characteristics. Median time from screening to biopsy was 36 days (range 8–53), and from biopsy to pathologic diagnosis was 27 days

(range 10–76). Three patients underwent staging imaging, with median 65 days (range 31–73) from diagnosis. To date, two received definitive surgery, with median 146 days (range 135–157) from diagnosis. Three patients await imaging or diagnostic excisional procedures. Barriers included pathology turnaround, imaging access, operating room availability, anesthesia shortages, and patient loss to follow-
up.

Table 1. Clinical Characteristics for Cervical Cancer Patients

Clinical Characteristic	Data (n=5)
Age (years), median (range)	41 (28-48)
HIV Positive Rate	60% (n=3)
Stage (FIGO 2018)	IA1 to IB1
Histology	squamous cell carcinoma (n=4, 80%) adenocarcinoma (n=1, 20%)

Conclusion/Implications: Significant delays were identified along the cervical cancer care continuum. This highlights the need for healthcare system strengthening, including imaging and pathology services, to ensure timely access to diagnosis and treatment. Training gynecologic oncologists alone, without broader systemic support, is unlikely to meaningfully improve cervical cancer outcomes in Mozambique.

EP111 / #554

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

GLOBAL IMPLEMENTATION OF MOLECULAR CLASSIFICATION IN ENDOMETRIAL CANCER: AN INTERNATIONAL SURVEY OF PRACTICE PATTERNS AND BARRIERS

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Introduction: To assess international variation in the clinical implementation of endometrial cancer molecular classification and identify factors influencing its adoption.

Methods: A self-administered, anonymous web-based survey was emailed to members of the International Gynecologic Cancer Society and Society of Gynecologic Oncology, and to heads of European Society of Gynaecological Oncology endometrial cancer–accredited departments for onward dissemination between July 30 and September 15, 2025. Clinical

practices related to the adoption of the molecular classification and reasons for not adopting it were explored.

Results: A total of 514 physicians from 72 countries participated, with 59.7% practicing in high-income and 40.3% in non-high-income countries
Respondent implementation rates were 76.8% for MMR/MSI testing, 80.0% for p53, and 46.5% for POLE; when implemented, testing was performed in all patients in 86.3%, 82.4%, and 43.4%, respectively. Estrogen/progesterone receptor testing was implemented in 82.5% of respondents and performed in all patients in 63.5%. (**Table 1**)
Complete molecular classification (MMR/MSI, p53, and POLE) in all patients was reported by 97 (18.9%) respondents. Factors associated with complete classification included country of practice, country income level, and annual number of early-stage EC surgeries. (**Table 2**)
The primary barriers to full implementation were financial constraints (60%) and limited test availability (35.3%), whereas lack of supporting evidence was rarely cited (8.6%).

Table 1 Implementation of molecular classification

MMR (n = 395 respondents that ever perform MMR/MSI)	
In which group of patients with endometrial cancer does your institution assess MMR/MRI status?, n (%)	
In all patients with endometrial cancer	341 (86.3%)
Only in a selected subgroup of patients	36 (9.1%)
Only in few patients, on a case-by-case basis	16 (4.1%)
Not sure	2 (0.5%)
Missing	0
p53 (n=411 respondents that ever perform p53)	
In which group of patients with endometrial cancer does your institution assess p53 status?, n (%)	
In all patients with endometrial cancer	333 (82.4%)
Only in a selected subgroup of patients	53 (13.1%)
Only in few patients, on a case-by-case basis	16 (4.0%)
Not sure	2 (0.5%)
Missing	7
POLE (n=239 respondents that ever perform POLE)	
In which group of patients with endometrial cancer does your institution assess POLE status?, n (%)	
In all patients with endometrial cancer	102 (43.4%)
Only in a selected subgroup of patients	99 (42.1%)
Only in few patients, on a case-by-case basis	33 (14.0%)
Not sure	1 (0.4%)
Missing	4
ER/PR n=514	
In which group of patients with endometrial cancer does your institution assess estrogen and progesterone receptors status? n (%)	
In all patients with endometrial cancer	287 (63.5%)
Only in a selected subgroup of patients	77 (17.0%)
Only in few patients, on a case-by-case basis	60 (13.3%)
Not in any patients	16 (3.5%)
Not sure	12 (2.7%)
Missing	62

Abbreviations: MMR= Mismatch Repair, MSI= Microsatellite Instability, ER/PR= Estrogen Receptor / Progesterone Receptor

Table 2 Predictors of adoption of complete molecular assessment (MMR, p53 and POLE) in all patients

	Complete Adoption?			
	No (N=417)	Yes (N=97)	Total (N=514)	p-value*
Specialty, n (%)				0.57
Gynecologic Oncologist	258 (66.0%)	61 (62.9%)	319 (65.4%)	
Other	133 (34.0%)	36 (37.1%)	169 (34.6%)	
Missing	26	0	26	
Position, n (%)				0.22
Attending Physician/Consultant	339 (87.1%)	88 (91.7%)	427 (88.0%)	
Other	50 (12.9%)	8 (8.3%)	58 (12.0%)	
Missing	28	1	29	
Years of practice since completion of training, n (%)				0.90
Less Than 10 years/Still in Training	167 (43.6%)	43 (44.3%)	210 (43.8%)	
More Than 10 years	216 (56.4%)	54 (55.7%)	270 (56.3%)	
Missing	34	0	34	
Region of practice, n (%)				**<0.01**
Europe	81 (23.4%)	52 (60.5%)	133 (30.8%)	
US	52 (15.0%)	11 (12.8%)	63 (14.6%)	
Other	213 (61.6%)	23 (26.7%)	236 (54.6%)	
Missing	71	11	82	
Income Level country of practice**, n (%)				**<0.01**
Not High Income	157 (45.4%)	17 (19.8%)	174 (40.3%)	
High Income	189 (54.6%)	69 (80.2%)	258 (59.7%)	
Missing	71	11	82	
Type of institution, n (%)				0.54
Academic Medical Center	313 (81.7%)	81 (84.4%)	394 (82.3%)	
Other	70 (18.3%)	15 (15.6%)	85 (17.7%)	
Missing	34	1	35	
Annual number of early-stage endometrial cancers surgically treated, n (%)				**0.01**
Less Than or Equal to 50 per year	143 (40.2%)	24 (25.3%)	167 (37.0%)	
More than 50 per year	213 (59.8%)	71 (74.7%)	284 (63.0%)	
Missing	61	2	63	
Level of agreement with NCCN and ESGO/ESTRO/ESP recommendations for comprehensive molecular profiling in EC, n (%)				0.19
Neutral/Disagree	92 (26.1%)	19 (19.6%)	111 (24.7%)	
Agree	260 (73.9%)	78 (80.4%)	338 (75.3%)	
Missing	65	0	65	
Implementation of FIGO 2023 EC staging system in clinical practice, n (%)				0.25
Yes	224 (66.9%)	68 (73.1%)	292 (68.2%)	
No	111 (33.1%)	25 (26.9%)	136 (31.8%)	
Missing	82	4	86	

*Chi-Square p-value;

** according to the World Bank Income

Abbreviations: US= United States, NCCN= National Comprehensive Cancer Network , ESGO/ESTRO/ESP= European Society of Gynaecological Oncology / European Society for Radiotherapy and Oncology / European Society of Pathology, EC= Endometrial Cancer, FIGO= International Federation of Gynecology and Obstetrics

Conclusion/Implications: Molecular testing is widely implemented but remains incomplete. MMR/MSI and p53 are routinely performed, whereas POLE is less consistently adopted.

Performing comprehensive molecular profiling seems to be associated with institutional resources and case volume, with financial and structural factors representing the main barriers.

EP112 / #403

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

CERVICAL CANCER SCREENING IN CONFLICT- AND DISPLACEMENT-AFFECTED POPULATIONS: IMPLEMENTATION GAPS, EQUITY BARRIERS, AND CRISIS-ADAPTED OPPORTUNITIES

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Introduction: Women affected by conflict, forced displacement, humanitarian crises face disproportionate barriers to cervical cancer prevention. It is essential to understand whether screening is disrupted, how, for whom, and which delivery approaches appear most feasible under crisis conditions.

Methods: We conducted a systematic review and meta-analysis of 95 studies examining cervical cancer screening and related outcomes in conflict-affected, refugee, migrant, fragile health-system contexts. This focused analysis synthesized evidence on four implementation-relevant domains: target populations, recurrent barriers to screening, follow-up, screening modalities used across settings, and intervention implications.

Results: The evidence base was dominated by studies involving migrant, refugee, asylum-seeking, displaced women, particularly in high-income or middle-income host systems, with fewer studies directly assessing screening collapse in active conflict settings. Across regions, barriers were consistent and layered: low health literacy, stigma and modesty concerns, transport and cost barriers, documentation insecurity, language discordance, weak provider recommendation, fragmented follow-up. Screening models differed by system capacity: Pap and HPV testing predominated in more stable systems, while HPV self-sampling, visual inspection with acetic acid, and single-visit screen-and-treat models appeared more often in fragile and low-resource settings. The most promising intervention approaches were multicomponent and equity-oriented, combining culturally tailored education, navigation, trusted community-linked delivery, and continuity systems to reduce loss to follow-up.

Conclusion/Implications: Cervical cancer screening inequities in crisis-affected populations are driven by stacked barriers across social, structural, and health-system levels. For global oncology, these findings support a shift toward crisis-adapted, implementation-ready screening strategies that prioritize continuity, accessibility, and culturally safe care for women living through instability and displacement.

EP113 / #1121

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

COST-SAVING OR TIME-CONSUMING? EXAMINING THE IMPACT OF INSURANCE PRIOR AUTHORIZATION FOR LOCALLY ADVANCED CERVICAL CANCER

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Introduction: Insurance-required prior authorizations (PA) have been associated with delays in oncologic care. Our objective was to determine the incidence of PA for standard locally advanced cervical cancer (LACC) treatment and its impact on treatment initiation and institutional resource utilization.

Methods: We extracted electronic medical records of patients treated with chemoradiation for LACC at a single tertiary care facility (September 2018—July 2025). We collected clinical, sociodemographic, and insurance data from diagnosis through treatment completion, measured PA requests per treatment plan, and estimated PA-related staff workload by required full-time equivalents (FTEs). Data analysis included descriptive statistics and Fisher's exact test to compare PA requirements across insurance types.

Results: 37 eligible patients were included for analysis: 21 self-identified as Hispanic/Latino; 17 had Medicaid insurance. The most common stage and histology were Stage IIB (n=11) and squamous cell carcinoma (n=29). Insurance PA was required for 22 patients: 18/35 for chemotherapy, and 11/33 for radiation therapy. All PA requests were approved, and no denials occurred. Estimated administrative burden was 2.0 FTEs. Chemotherapy PA requirements differed significantly across insurance types (p=0.013), suggesting variation across payors. The median time from diagnosis to treatment initiation was 30 days (IQR-19-

Table 1: Clinical and Sociodemographic Characteristics

Race (n=37)	#	%
Caucasian	10	27.0%
Black	4	10.8%
Asian	2	5.4%
Other race	15	40.5%
Unknown	6	16.2%
Ethnicity		
Non-Hispanic/Latino	15	40.5%
Hispanic/Latino	21	56.8%
Unknown	1	2.7%
Preferred Language		
English	24	64.9%
Spanish	13	35.1%
Insurance		
WMC CharityCare	6	16.2%
Commercial/Private Insurance	10	27.0%
Medicaid	17	45.9%
Medicare	4	10.8%
LACC Stage		
IB3	7	18.9%
IIA1	1	2.7%
IIA2	2	5.4%
IIB	11	29.7%
IIIA	1	2.7%
IIIB	0	0.0%
IIIC1	9	24.3%
IIIC2	1	2.7%
IVA	4	10.8%
Other	1	2.7%
LACC Histology		
Squamous Cell Carcionoma	29	78.4%
Adenocarcinoma	5	13.5%
Adenosquamous	1	2.7%
Neuroendocrine Small Cell	1	2.7%
Other	1	2.7%
Treatment Regimen		
Weekly Cisplatin + EBRT/ICBT	29	78.4%
Weekly Cisplatin + EBRT/ICBT + Pem	4	10.8%
EBRT/ICBT	2	5.4%
Other	2	5.4%

47).

Table 2. Incidence of Prior Authorization Requests.

	# of Chemo PAs	%	# of RT PAs	%	
CharityCare	0	0%	0	0.0%	PA Required
	6	100%	7	100.0%	No PA Required
Commercial	8	80.0%	3	37.5%	PA Required
	2	20.0%	5	62.5%	No PA Required
Medicaid	8	50.0%	8	53.3%	PA Required
	8	50.0%	7	46.7%	No PA Required
Medicare	2	66.7%	1	33.3%	PA Required
	1	33.3%	2	66.7%	No PA Required
Total	35*		33*		
PA Requirement Dependency by Insurance Type					
P-value	0.013		0.11		

*Chemo PA data was only available for 35/37 patients due to patients' not receiving chemo (1) or missing documentation (1). RT PA data was only available for 33/37 patients due to patients' not receiving RT (1) or missing documentation (3).

Conclusion/Implications: Insurance PA for standard LACC treatment plans were required for over half of our cohort but universally approved. The FTEs required for PA processing are a cost burden to the institution with unclear benefit to payers. Time to chemoradiation initiation varied widely and was likely multifactorial; further analysis is ongoing to ascertain the direct impact of PAs on treatment delays.

EP114 / #753

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

DRIVERS OF UNPLANNED ACUTE CARE AFTER CHEMOTHERAPY IN GYNECOLOGIC CANCER

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Introduction: The United States Centers for Medicare & Medicaid Services uses OP-35 quality metrics to capture potentially preventable emergency department (ED) visits and hospital admissions (HA) within 30 days of outpatient chemotherapy. Diagnoses include pain, infection, hematologic, and gastrointestinal symptoms. We evaluated OP-35 outcomes for gynecologic cancers by phase of care.

Methods: A retrospective cohort study using SEER-Medicare (2017-2022) included patients ages >/= 66 years with ovarian (OC), uterine (UC), or cervical cancer (CC). Phase of care was defined using established claims-based algorithms. OP-35 events (ED visit or HA) with a qualifying primary diagnosis within 30 days of chemotherapy were analyzed.

Results: The cohort included 27,143 patients: 4,956 with OC, 19,934 with UC, and 2,253 with CC. OP-35 events clustered at the start of care (SOC) and the end of life (EOL) (Figure 1A). Pain was the most common type of event across all cancers and phases of care, with 4.2 events/100 phase-years (PY) at SOC, 0.9 events/100 PY during ongoing care, and 9.3 events/100 PY at EOL (Table 1). Patients with higher frailty scores had higher rates of pain events at SOC, whereas patients with lower frailty scores had higher rates at EOL (Figure 1B). The next most common OP-35 events included dehydration, nausea, and anemia at SOC and sepsis, nausea, and anemia at
EOL.

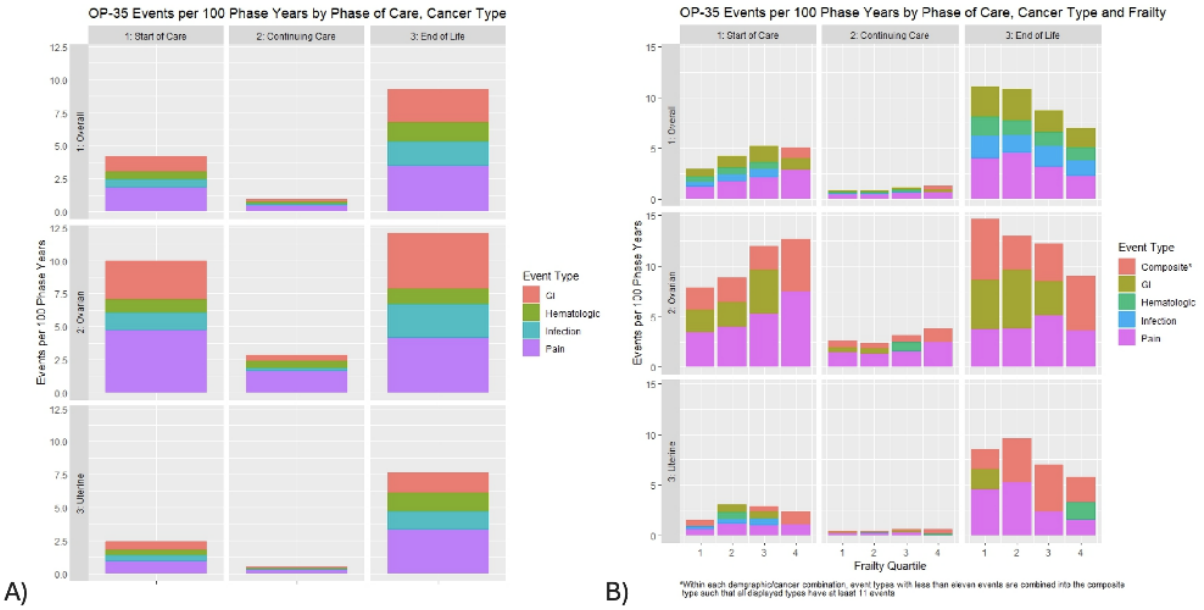


Figure 1. OP-35 events per 100 phase-years (PY) by A) Phase of Care, Cancer Type and B) Phase of Care, Cancer Type, and Frailty. PY are defined as the total years contributed to that phase by all patients; for example, if patient A had six months of SOC and patient B had six months of SOC, that's one SOC PY. Phase of care framework in accordance with Yabroff et al., JNCI (2008) with start of care (SOC) defined as the first 6 months following a cancer diagnosis, end-of-life (EOL) defined as the 6 months before death among those who died, and continuing care defined as the months between SOC and EOL.

Table 1. Events per 100 Phase Years and Most Common Event by Phase of Care and Demographic, All Cancers.

Demographic	Start of Care			Ongoing Care			End of Life		
	Phase Years	Events Per 100 Phase Years	Most Common Event	Phase Years	Events Per 100 Phase Years	Most Common Event	Phase Years	Events Per 100 Phase Years	Most Common Event
Overall	12747.4	4.2	Pain	57962.7	0.9	Pain	4458.7	9.3	Pain
Age at Diagnosis									
66-75	4593.4	4.3	Pain	22500.8	0.9	Pain	1093.6	14.7	Pain
76-85	6167	4.4	Pain	28148.1	1	Pain	2010.7	9.5	Pain
81+	1987	3	Pain	7313.7	0.7	Pain	1354.3	4.5	Pain
Race									
Black	1008.4	5.8	Pain	3636.9	1.4	Pain	509.7	10	Pain
White	11082.7	4.1	Pain	51362.1	0.9	Pain	3753.6	9.2	Pain
Other	656.3	3.8	Pain	2963.6	1.4	Pain	195.3	9.2	Pain
Ethnicity									
Non-Hispanic	901.5	5.8	Pain	3795.6	1.4	Pain	339	9.7	Pain
Hispanic	11845.8	4.1	Pain	54167.1	0.9	Pain	4119.7	9.2	Pain
Dual Eligibility									
No	10987.3	3.8	Pain	51353.4	0.9	Pain	3528.9	9.9	Pain
Yes	1760.1	6.2	Pain	6609.2	1.3	Pain	929.8	7.1	Pain
Year of Diagnosis									
2017	2699.9	4.4	Pain	18338.8	0.9	Pain	1264.4	7.8	Pain
2018	2634.5	5	Pain	15362.6	0.9	Pain	1068.9	9.8	Pain
2019	2576.1	4.1	Pain	11884.5	0.8	Pain	926.9	10.4	Pain
2020	2345.7	3.4	Pain	7751.4	1.2	Pain	726.4	10	Pain
2021	2491.2	3.9	Pain	4625.4	1.4	Pain	472.1	8.9	Pain
Rural/Urban									
Urban	10975.1	4	Pain	50042.4	0.9	Pain	3776	9.2	Pain
Rural (urban adjacent)	1104.4	5.3	Pain	4863.6	1	Pain	437.7	10.1	Pain
Rural (non-adjacent)	667.9	5.2	Pain	3056.6	0.9	Pain	244.9	9.4	Pain
Frailty Quartile									
Q1	3535.5	3.1	Pain	16999.4	0.8	Pain	850.7	11.5	Pain
Q2	3469.7	3.8	Pain	16427.3	0.8	Pain	959.8	10.8	Pain
Q3	3240.5	5	Pain	14817.4	1.1	Pain	1163.1	8.9	Pain
Q4	2501.7	5.2	Pain	9718.6	1.2	Pain	1485.1	7.3	Pain

Conclusion/Implications: These findings highlight the need for tailored, phase-specific supportive care interventions. Targeted improvements in outpatient pain and symptom management, while also considering frailty, may lead to decreased unplanned acute care usage during chemotherapy in gynecologic cancers.

EP115 / #1106

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

THE CLINICAL UTILITY OF SELECTIVE CA-125 MONITORING AT CYCLES 3 AND 6 IN OVARIAN CANCER PATIENTS RECEIVING CHEMOTHERAPY

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Introduction: CA-125 is routinely measured at every chemotherapy cycle in ovarian cancer management. Whether testing at intermediate cycles (C2, C4, C5) adds meaningful clinical value beyond C3 and C6 remains uncertain. This study assessed the risk of missing significant disease progression if intermediate cycle testing is omitted.

Methods: A retrospective study was conducted on 105 ovarian cancer patients who underwent cytoreductive surgery followed by platinum-based chemotherapy. CA-125 levels were recorded from pre-surgery through six chemotherapy cycles (C1–C6). A "missed" case was defined as a CA-125 value above 35 U/mL that was rising at an omitted cycle (C2, C4, or C5) but did not show the same upward trend at C3 or C6.

Results: Median pre-surgery CA-125 was 444.0 U/mL, falling to 220.5 U/mL after cycle 1. By C3 and C6, 57.0% and 76.5% of patients had CA-125 levels below 35 U/mL, respectively. Thirty patients (28.6%) had at least one rising CA-125 value at an omitted cycle. Of these, only 8 patients (7.6%) had a clinically relevant rise that was not detected at C3 or C6.

Conclusion/Implications: Testing CA-125 only at C3 and C6 appears safe for most patients (92.4%). A small group (7.6%) may have an early rise go undetected, but this can be addressed through routine clinical assessment and imaging during the omitted cycles, allowing for a more practical and cost-effective testing approach

EP116 / #1102

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

A 6-YEAR REVIEW OF ANATOMIC PATHOLOGY SERVICE IMPLEMENTATION IN LIBERIA: A PARTNERSHIP TO IMPROVE CANCER DIAGNOSIS FOR WOMEN.

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Introduction: Cancer incidence is increasing globally, including in LMICs. Anatomic pathology (AP), essential to providing robust cancer care, is underrepresented in many high-burden countries. In Liberia, prolonged wars demolished essential health services, including AP services with devastating outcomes in cancer management. We document the foundational work required for implementing pathology services at JFK Hospital in Monrovia using a *Structure, Process, Outcome (SPO)* framework, focusing on breast and cervical cancers

Methods: The Donabedian fMethod, based on a *Structure, Process, Outcome (SPO)* framework, was used to assess the following: *Structure*: resources including potential lab space, electrical and plumbing requirements, generators and workforce, supply-chain requirements, and both budget and time needed for implementation. *Process*: lab utility, pre-analytic factors, documentation, adherence to guidelines, quality, and reporting. *Outcomes*: Training proficiency using didactic and hands-on assessment. Clinical and operational effectiveness, documenting processing errors, lab utility, number of specimens processed, and changes in turnaround time

Results: Renovation was completed in September 2019 (Figure 1). Between November 2020 and October 2025, a total of 6,068 specimens were processed (1,027 breast cancers, 1,118 cervical cancers). Staff education and community outreach resulted in increased lab utilization, fewer errors, targeted patient referrals, and improved standards of care for women with cancer in Liberia (Figure
2).

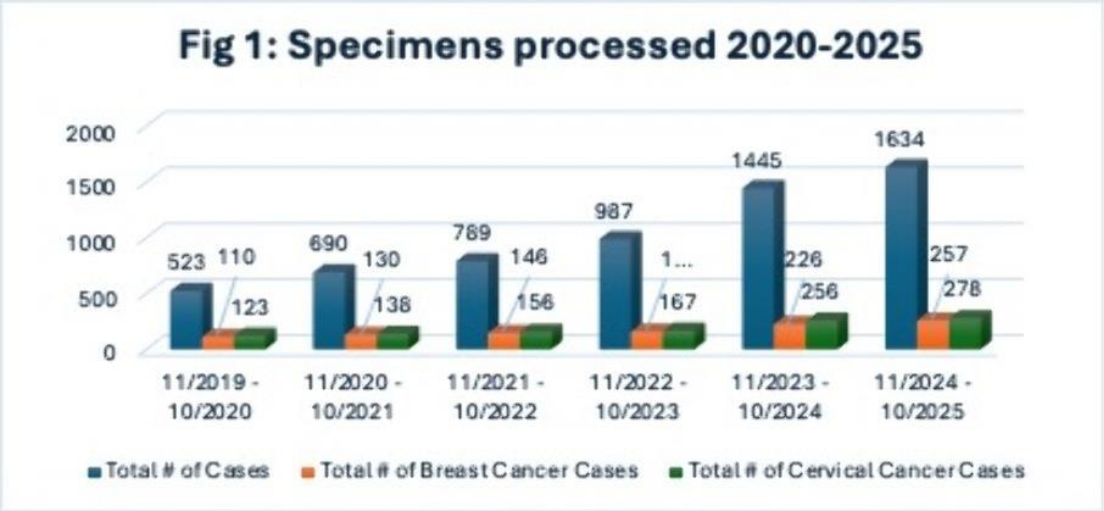
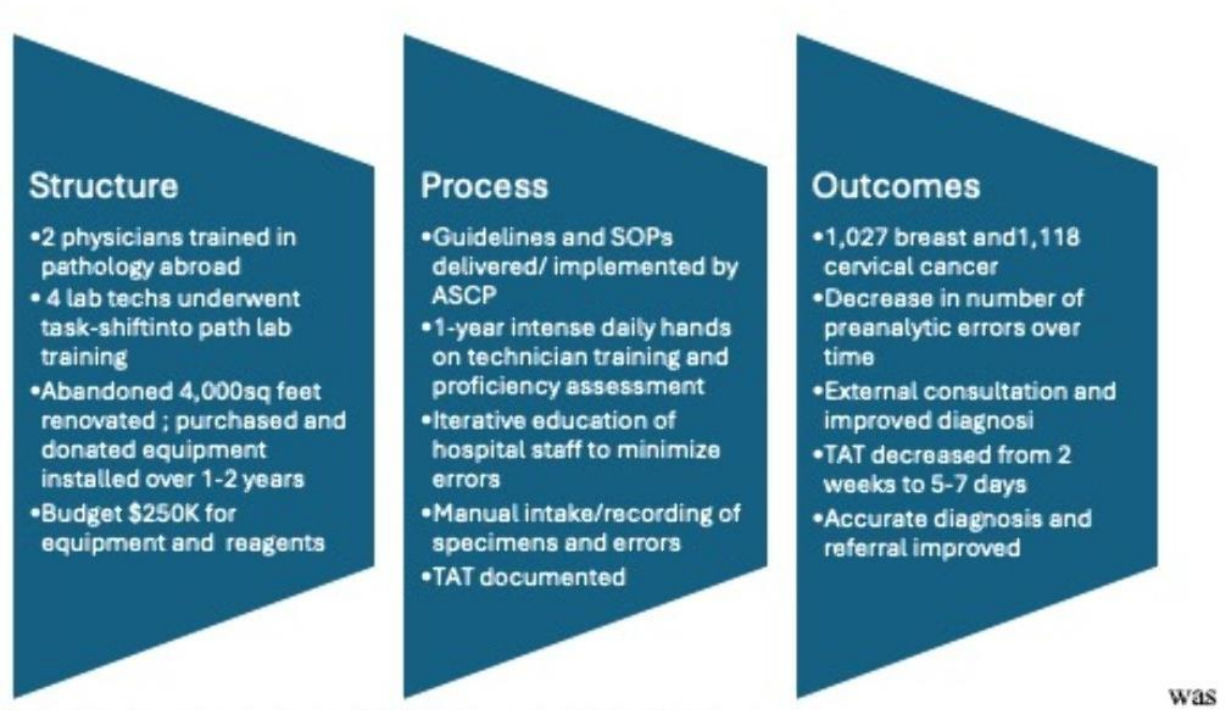


Fig 2: Pathology Lab Implementation Results



was

SOP – standard operating procedures; ASCP – American Society of Clinical Pathology.
TAT – turn-around time (from accession to report)

Conclusion/Implications: Since 2020, the pathology lab, a robust department at JFK Hospital, has been the only academic pathology lab in the country. Collaboration between JFK Administration and staff, the Women Global Cancer Initiative, the American Society of

Clinical Pathology, and Sakura Finetak has made this a successful and sustainable implementation outcome

EP117 / #924

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

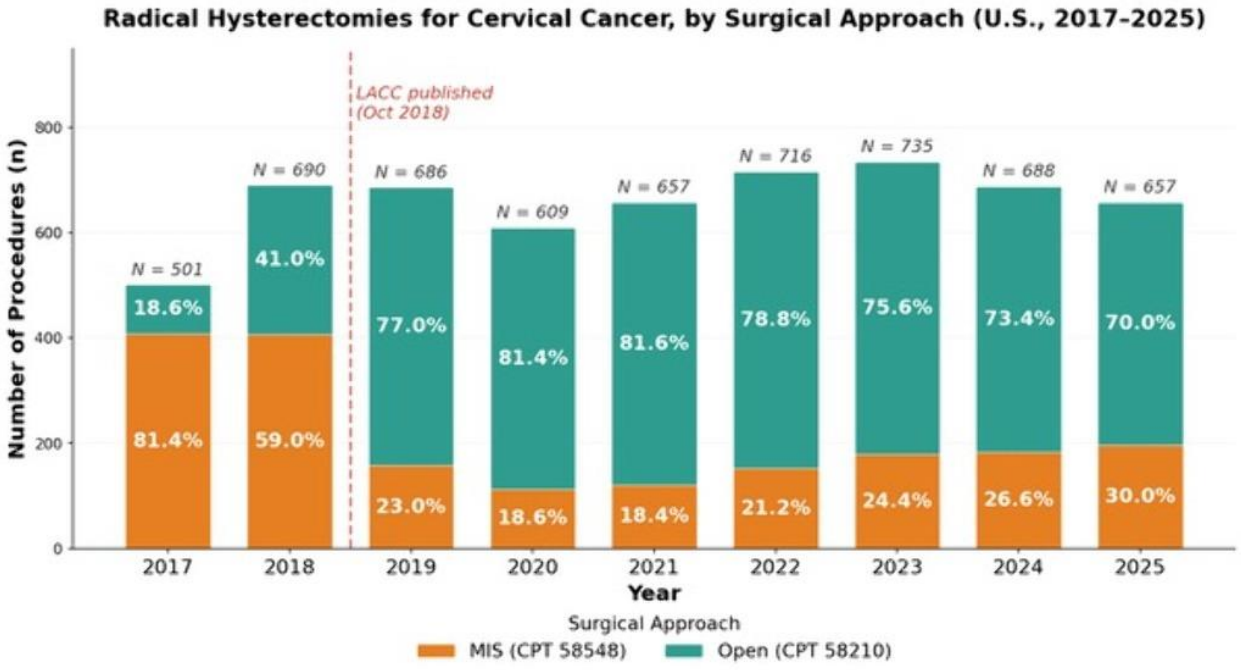
TRENDS IN MINIMALLY INVASIVE RADICAL HYSTERECTOMY: PAYER AND REGIONAL DISPARITIES IN THE UNITED STATES

Alwyn Mathew[1], Alan Pan[1], Anurag Purushothaman[1], Diletta Fumagalli[1], Daniela Flores Guerrero[1], Paula Mateo-Kubach[1], Kamilla L. David[1], Pedro Ramirez[1], Behrouz Zand[2]
[1]Houston Methodist Hospital, Department Of Obstetrics And Gynecology, Houston, United States of America, [2]Houston Methodist Hospital, Gynecology And Oncology, Houston, United States of America

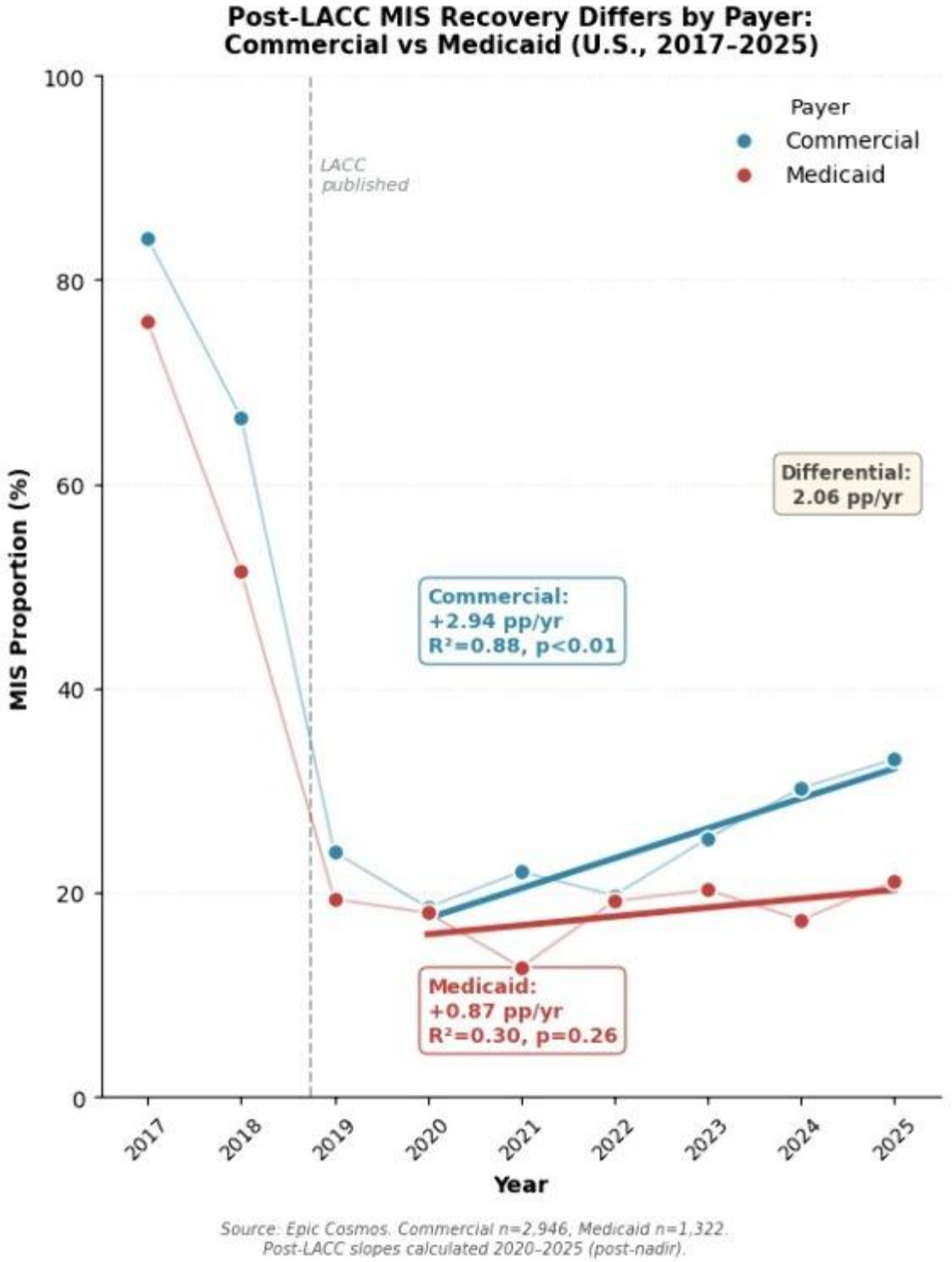
Introduction: The 2018 Laparoscopic Approach to Cervical Cancer (LACC) trial showed inferior outcomes with minimally invasive surgery (MIS) versus open radical hysterectomy. Our study evaluated U.S. trends and variation by payer and region.

Methods: Retrospective cohort study using Epic Cosmos, including adults aged 18–90 undergoing radical hysterectomy (CPT 58210 [open], 58548 [MIS]) for cervical cancer (ICD-10 C53) from 2017–2025. Annual MIS rates were modeled using segmented regression with a 2018 breakpoint. Post-nadir trends (2021–2025) were assessed overall and by payer, with payer and region evaluated across full and post-nadir cohorts. TriNetX, an academic medical center-enriched network was used for external validation.

Results: Among 5,939 patients in Cosmos (median age 46 years, IQR 38-58), MIS use declined from 81.4% (2017) to a nadir of 18.4% (2021), then increased to 30% by 2025 (+2.42 pp/year; R^2=0.96; p<0.001) (figure 1). By 2025, MIS use was ~33% in commercially insured vs ~21% in Medicaid patients (overall payer association p<0.001). The MIS rebound occurred among commercially insured patients (+2.94 pp/year; R^2=0.88; p<0.01) but not among Medicaid patients (+0.87 pp/year; R^2=0.30, p=0.26) (figure 2). Regional distribution differed (p=0.001), with higher MIS use in the South and West. TriNetX (N= 2,196) showed a similar upward trend (+1.29 pp/yr, R^2 = 0.80, p=0.02), with slower MIS re-adoption in academic centers. Chi-square analysis showed payer and region were significantly associated with surgical
approach.



Source: Epic Cosmos (n = 5,939 unique encounters). Cohort: ICD-10 C53 + CPT 58210 or 58548, age 18–90.



Conclusion/Implications: In our primary cohort, nearly 1 in 3 patients in 2025 received MIS. The payer- and region-based gap raises concern about uneven application of LACC trial evidence.

EP118 / #438

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

SYSTEM-LEVEL FAILURES IN PRIMARY CANCER CARE DELIVERY IN A MIDDLE-INCOME SETTING: IMPLICATIONS FOR EQUITY AND ACCESS.

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Introduction: Strengthening primary health care for cancer patients remains a major global challenge, particularly in middle-income countries where disparities in healthcare delivery persist. Identifying system-level gaps is essential to inform strategies that promote equitable cancer care.

Methods: We conducted a cross-sectional analytical study evaluating primary health care teams in a Brazilian municipality using the Assessment of Chronic Illness Care tool. This validated instrument assesses seven domains of care delivery for chronic conditions and was applied to oncology care. Scores range from 0 (limited capacity) to 11 (optimal capacity). Descriptive and comparative analyses were performed to evaluate variability across units.

Results: Twelve PHC units were included. The overall mean score was 5.4±2.0, indicating moderate system capacity. Substantial heterogeneity was observed between units, with scores ranging from 1.8 to 8.6. The lowest-performing domains were integration of care components (3.9±2.3) and clinical decision support (3.5±2.4), both essential for coordinated oncology care. Units with broader population coverage demonstrated lower performance, suggesting structural inequities in resource distribution and care delivery.

Conclusion/Implications: This real-world analysis identifies critical system-level failures in primary cancer care delivery, particularly in care integration and clinical support. These gaps likely drive inequities in access and quality of oncologic care in middle-income settings and represent actionable targets for health system reform.

EP119 / #546

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

IMPACT OF CYTOLOGICAL TRIAGE ON HEALTHCARE DELIVERY: EFFICIENCY OF THE REFERRAL PATHWAY FOR CERVICAL CANCER PRECURSORS IN NORTHERN CHILE.

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Introduction: Efficient referral systems between Primary Health Care (PHC) and specialized units are critical for timely cancer prevention. In the Atacama Region, geographic and socioeconomic factors necessitate a robust triage protocol. This study evaluates the diagnostic yield and operational efficiency of a specialized cervical pathology unit in managing patients referred through the national screening program.

Methods: We analyzed the clinical journey of 222 women managed at a regional reference hospital in 2025. Local referral cytologies were standardized to the Bethesda System for comparative analysis. The study measured the positive predictive value (PPV) for high-grade lesions (CIN 2+) and the system's capacity to detect occult invasive disease within "low-risk" categories.

Results: The system processed 222 complex cases. The standardized distribution was: ASC-US (37.8%), ASC-H (17.6%), and LSIL (16.7%). The global PPV for CIN 2+ was 83.3%, demonstrating high institutional efficiency. However, a critical "diagnostic gap" was identified in the ASC-US category: 57.1% of patients were upgraded to CIN 3+ and 8.3% were diagnosed with invasive carcinoma upon surgical excision. The integration of colposcopy and conization in a single specialized center provided high diagnostic resolution despite the significant regional disease burden.

Conclusion/Implications: The 83.3% PPV for high-grade disease underscores the clinical effectiveness of the specialized unit. Nevertheless, the high rate of CIN 3 and invasive cancer masked as minor atypia (ASC-US) highlights a critical failure in primary screening sensitivity. These findings advocate for "See and Treat" protocols or early excisional approaches in high-prevalence regions to ensure oncological safety ($p < 0.001$).

EP120 / #1130

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

EVALUATING THE EFFECTIVENESS OF A MULTIDISCIPLINARY CARE APPROACH FOR PATIENTS WITH HIGH-GRADE SEROUS OVARIAN CARCINOMA RECEIVING POLY (ADP-RIBOSE) POLYMERASE INHIBITOR MAINTENANCE THERAPY TREATMENT

Preety Nijjar[1], Elenna Laplante[1], Carol Ewanowhich[2,3], Martin Koebel[4,5], Sophia Pin[1], Cheng Han Lee[2,3], Christa Aubrey[1,6]
[1]Royal Alexandra Hospital, Obstetrics And Gynaecology, Edmonton, Canada, [2]University of Alberta, Laboratory Medicine And Pathology, Edmonton, Canada, [3]University of Alberta, Department Of Laboratory Medicine And Pathology, Edmonton, Canada, [4]University of Calgary, Pathology And Laboratory Medicine, Calgary, Canada, [5]University of Calgary, Department Of Pathology And Laboratory Medicine, Calgary, Canada, [6]CROSS CANCER INSTITUTE, Gynecology Oncology, EDMONTON, Canada

Introduction: As gynecologic oncology care becomes increasingly complex, structured multidisciplinary models are needed to ensure safe and efficient delivery of maintenance therapies. We describe a formalized multidisciplinary clinic (MDC) for patients receiving poly(ADP-ribose) polymerase inhibitor (PARPi) maintenance therapy and evaluate clinical outcomes and patient experience compared with a traditional follow-up model.

Methods: A mixed methods study of patients with high grade serous ovarian carcinoma who underwent PARPi maintenance therapy in two tertiary centers, one utilizing a formalized MDC. Demographic and clinical outcomes were analyzed using appropriate parametric and nonparametric tests. MDC patients were invited to a semi-structured interview exploring their care experience, with transcripts analyzed using inductive content analysis.

Results: Ninety-seven patients were included (67 MDC; 30 comparator). Baseline characteristics were similar; however, the MDC cohort demonstrated greater frailty (mFI-5, $p = 0.026$). Despite this, the MDC required fewer clinic visits (median 15 vs 23, $p = 0.001$). Treatment duration, toxicity profiles, and reasons for discontinuation did not differ significantly. Follow-up care in the MDC was distributed among gynecologic oncologists (27%), medical oncologists (24%), pharmacists (24%), and nurses (17%), compared with predominantly nurse-led follow-up (84%) at the comparator center ($p < 0.001$). Qualitative analysis identified themes of side-effect adaptation, accessibility of virtual care, and enhanced autonomy through shared decision-making.

Conclusion/Implications: A formalized PARPi multidisciplinary clinic safely managed a frailer population with fewer visits and high patient satisfaction, supporting the value of

structured, virtual multidisciplinary care in ovarian cancer maintenance therapy and offering a scalable framework for other centers.

EP121 / #729

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

QUALITY OF LIFE AND PSYCHOLOGICAL DISTRESS AMONG PATIENTS WITH GYNECOLOGIC MALIGNANCIES UNDERGOING ONCOLOGICAL TREATMENT IN A TERTIARY CARE HOSPITAL

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Cagayan Valley Medical Center, Department Of Obstetrics And Gynecology, Tuguegarao City, Philippines

Introduction: Gynecologic malignancies and their treatments significantly impact patients' quality of life (QoL) and psychological well-being. In the Philippines, there is limited evidence simultaneously examining QoL and psychological distress among women undergoing oncologic treatment. This study aimed to assess QoL and levels of psychological distress among patients with gynecologic malignancies in a tertiary care hospital and to determine the association between these variables.

Methods: A descriptive-correlational study was conducted among 94 adult patients diagnosed with gynecologic malignancies from November 2024 to November 2025. QoL was measured using the EORTC QLQ-C30, while psychological distress was assessed using the Hospital Anxiety and Depression Scale (HADS). Evaluations were performed pre-treatment, during treatment, and post-treatment. Data were analyzed using descriptive statistics, chi-square tests, and multivariate logistic regression, with statistical significance set at $p<0.05$.

Results: At baseline, most patients were neither anxious (60.64%) nor depressed (74.47%). Psychological distress improved during and after treatment. Mean global health status increased from 61.26 ± 14.8 pre-treatment to 72.16 ± 16.52 post-treatment. Emotional functioning had the lowest baseline score, while cognitive functioning was highest. Pain and appetite loss were the most prominent pre-treatment symptoms. Advanced cancer stage, comorbidities, and combined treatment modalities were associated with poorer QoL and higher psychological distress. A significant association was found between increased psychological distress and lower QoL across multiple

Relation between different dimensions of EORTC QLQ C30 and anxiety and depression of HADS

Dependent Variable	Covariates	Pre-treatment		Mid-Treatment		Post-Treatment	
		R	*p*-value	R	*p*-value	R	p-value
QoL	HADS-A	-0.7480	<0.00001	-0.7953	<0.00001	-0.8875	<0.00001
	HADS-D	-0.7100	<0.00001	-0.7757	<0.00001	-0.8661	<0.00001
	HADS-T	-0.7574	<0.00001	-0.8039	<0.00001	-0.8896	<0.00001
PF	HADS-A	-0.6990	<0.00001	-0.6368	<0.00001	-0.7327	<0.00001
	HADS-D	-0.7850	<0.00001	-0.6903	<0.00001	-0.7855	<0.00001
	HADS-T	-0.7705	<0.00001	-0.6828	<0.00001	-0.7723	<0.00001
EF	HADS-A	-0.7787	<0.00001	-0.7861	<0.00001	-0.8504	<0.00001
	HADS-D	-0.7707	<0.00001	-0.7882	<0.00001	-0.8669	<0.00001
	HADS-T	-0.8033	<0.00001	-0.8068	<0.00001	-0.8723	<0.00001
RF	HADS-A	-0.4863	<0.00001	-0.6322	<0.00001	-0.7261	<0.00001
	HADS-D	-0.6583	<0.00001	-0.6720	<0.00001	-0.7670	<0.00001
	HADS-T	-0.6519	<0.00001	-0.5399	<0.00001	-0.7592	<0.00001
CF	HADS-A	-0.6170	<0.00001	-0.5483	<0.00001	-0.7326	<0.00001
	HADS-D	-0.6170	<0.00001	-0.5095	<0.00001	-0.7326	<0.00001
	HADS-T	-0.6491	<0.00001	-0.6715	<0.00001	-0.7401	<0.00001
SF	HADS-A	-0.5357	<0.00001	-0.6284	<0.00001	-0.6758	<0.00001
	HADS-D	-0.5923	<0.00001	-0.6771	<0.00001	-0.6934	<0.00001
	HADS-T	-0.5852	<0.00001	-0.6715	<0.00001	-0.6956	<0.00001
FA	HADS-A	0.7736	<0.00001	0.6975	<0.00001	0.8013	<0.00001
	HADS-D	0.8052	<0.00001	0.7645	<0.00001	0.8268	<0.00001
	HADS-T	0.8188	<0.00001	0.7527	<0.00001	0.8274	<0.00001
NV	HADS-A	0.5310	<0.00001	0.5377	<0.00001	0.7478	<0.00001
	HADS-D	0.6050	<0.00001	0.5261	<0.00001	0.8085	<0.00001
	HADS-T	0.5894	<0.00001	0.5444	<0.00001	0.7919	<0.00001
PA	HADS-A	0.6739	<0.00001	0.4344	0.000021	0.7532	<0.00001
	HADS-D	0.6675	<0.00001	0.4527	<0.00001	0.8155	<0.00001
	HADS-T	0.6955	<0.00001	0.4555	<0.00001	0.7983	<0.00001
DY	HADS-A	0.6900	<0.00001	0.5498	<0.00001	0.6859	<0.00001
	HADS-D	0.7477	<0.00001	0.5899	<0.00001	0.7434	<0.00001
	HADS-T	0.7458	<0.00001	0.5861	<0.00001	0.7273	<0.00001
SL	HADS-A	0.7019	<0.00001	0.6330	<0.00001	0.7379	<0.00001
	HADS-D	0.6544	<0.00001	0.7080	<0.00001	0.7634	<0.00001
	HADS-T	0.7030	<0.00001	0.6912	<0.00001	0.7630	<0.00001
AP	HADS-A	0.5622	<0.00001	0.6667	<0.00001	0.7413	<0.00001
	HADS-D	0.6652	<0.00001	0.7516	<0.00001	0.7808	<0.00001
	HADS-T	0.6370	<0.00001	0.7313	<0.00001	0.7739	<0.00001
CO	HADS-A	0.7409	<0.00001	0.5080	<0.00001	0.6681	<0.00001
	HADS-D	0.7696	<0.00001	0.5211	<0.00001	0.7047	<0.00001
	HADS-T	0.7834	<0.00001	0.5280	<0.00001	0.6980	<0.00001
DI	HADS-A	0.6218	<0.00001	0.4820	<0.00001	0.5558	<0.00001
	HADS-D	0.6391	<0.00001	0.5021	<0.00001	0.6357	<0.00001
	HADS-T	0.6539	<0.00001	0.5053	<0.00001	0.6073	<0.00001
FI	HADS-A	0.5777	<0.00001	0.5359	<0.00001	0.6431	<0.00001
	HADS-D	0.5613	<0.00001	0.5177	<0.00001	0.6220	<0.00001
	HADS-T	0.5905	<0.00001	0.5389	<0.00001	0.6416	<0.00001

domains.

Regression Analysis Results of Demographic and Clinical Characteristics with Global Health dimension of EORTC QLQ C30, HADS-A and HADS-D

	Global Health		HADS-A		HADS-D	
	Coefficients	P-value	Coefficients	P-value	Coefficients	P-value
Intercept	92.5946	0.0000	-1.0071	0.6563	-2.0074	0.3765
Age	-0.0710	0.6013	0.0389	0.1448	0.0051	0.8485
Location	-1.5071	0.2541	0.1513	0.5559	0.2575	0.3179
Marital Status	-1.5459	0.5516	-0.9820	0.0550	-0.1555	0.7589
Educational Attainment	-1.3496	0.3230	-0.1872	0.4813	-0.1330	0.6171
Employment	0.4504	0.9550	4.3006	0.0069	3.6958	0.0196
Income	3.2715	0.7039	-3.5069	0.0392	-2.9694	0.0801
Financial source	-6.5017	0.3185	0.3854	0.7611	-1.4865	0.2434
Psychological Support	30.4518	0.0252	-3.4816	0.1849	0.0412	0.9874
Chronic Disease	0.5778	0.7843	0.8213	0.0487	0.7915	0.0575
Time of Diagnosis	-2.4681	0.7457	-1.8682	0.2102	-1.1177	0.4526
Primary Organ	-0.7234	0.7366	-0.3325	0.4287	-0.5236	0.2145
Cancer Stage	-10.1139	0.000003	2.1185	7.3597	2.2989	1.1389
Treatment	0.5271	0.7995	-0.0229	0.9549	-0.0392	0.9230

Conclusion/Implications: Patients experience moderate QoL impairment and psychological distress that improve over time. Integrating routine psychological assessment and supportive care into oncologic management may enhance patient outcomes and overall well-being.

EP122 / #1046

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

GYNECOLOGIC ONCOLOGY CAPACITY IN SUDAN FOLLOWING ARMED CONFLICT: A STRUCTURED NEEDS ASSESSMENT

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Introduction: The armed conflict in Sudan since April 2023 has caused catastrophic disruption to oncology services, with the flagship Khartoum Oncology Hospital rendered nonfunctional and patients redistributed to peripheral centers. [1-2] While the general impact on cancer care has been described, no study has specifically assessed gynecologic oncology capacity, which requires specialized infrastructure including brachytherapy and trained surgical oncologists. [3]

Methods: A cross-sectional electronic survey was distributed to oncology providers across Sudan via professional networks and snowball sampling. The survey assessed facility operations, workforce, diagnostic and treatment capacity, cervical cancer screening, and palliative care. Descriptive statistics were used for analysis.

Results: Fourteen providers from 10 states responded. Two facilities (14%) were permanently closed due to military strikes, and one was partially operational due to vandalization. Six respondents (43%) reported increased patient volumes from displaced populations, while four (29%) reported >50% capacity reduction. Internally displaced persons comprised 26–50% of patients at multiple facilities. Fellowship-trained gynecologic oncologists were present at only 3 facilities. Brachytherapy was unavailable across all sites. No facility had on-site radiation therapy with functional equipment; radiation wait times exceeded 5–8 weeks where referral was possible. Immunohistochemistry required external referral at most centers. Cervical cancer screening was absent at 11 of 14 facilities (79%). Oral morphine was unreliably available at most sites. The most frequently cited priorities were radiation/brachytherapy access, chemotherapy supply, and workforce training.

Conclusion/Implications: This first gynecologic oncology-specific needs assessment in conflict-affected Sudan reveals critical gaps in surgical expertise, radiation access, screening, and palliative care, necessitating urgent international support and targeted capacity-building initiatives.

EP123 / #1094

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

IMPACT OF VENOUS THROMBOEMBOLISM IN RECURRENT OVARIAN CANCER ON HEALTHCARE UTILIZATION AND TREATMENT DELAYS

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Introduction: Venous thromboembolism (VTE) is a common complication in recurrent ovarian cancer; however, its impact on healthcare utilization and treatment delays remains poorly defined.

Methods: We performed a retrospective cohort study of patients with recurrent ovarian cancer who developed VTE between 2011–2024. Clinical presentation, diagnostic and treatment patterns, and healthcare utilization were analyzed.

Results: Of 196 patients with recurrent ovarian cancer, 50 developed VTE (26%), including 25 deep vein thromboses, 18 pulmonary embolisms, and 7 with both. The sample was 90% White, with a mean age of 66 and BMI of 28.5. Most patients were platinum resistant (62%) and receiving systemic therapy at VTE diagnosis (84%), with an average 4 prior treatment lines. VTE was diagnosed across multiple settings, including the emergency department (30%), inpatient (20%), outpatient clinic (20%), and routine surveillance imaging (30%). Diagnostic evaluation was resource-intensive, with patients undergoing a mean of 1.2 imaging studies; 34% required more than one study for diagnosis. VTE was incidentally identified via CT in 40% of patients, with some requiring confirmatory studies. Across the cohort, 18 patients underwent CT pulmonary angiography and 37 underwent venous Doppler ultrasound. 40% of patients required hospital admission at diagnosis, while 24% developed VTE while hospitalized. Vascular medicine consultation was obtained in 28% of patients. VTE resulted in chemotherapy delay in 32% of patients.

Conclusion/Implications: These findings highlight a significant and potentially modifiable source of healthcare burden, which underscores the need for efficient diagnostic pathways and coordinated treatment strategies. Development of cost-conscious care models to optimize VTE prevention, detection, and treatment is needed.

EP124 / #600

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

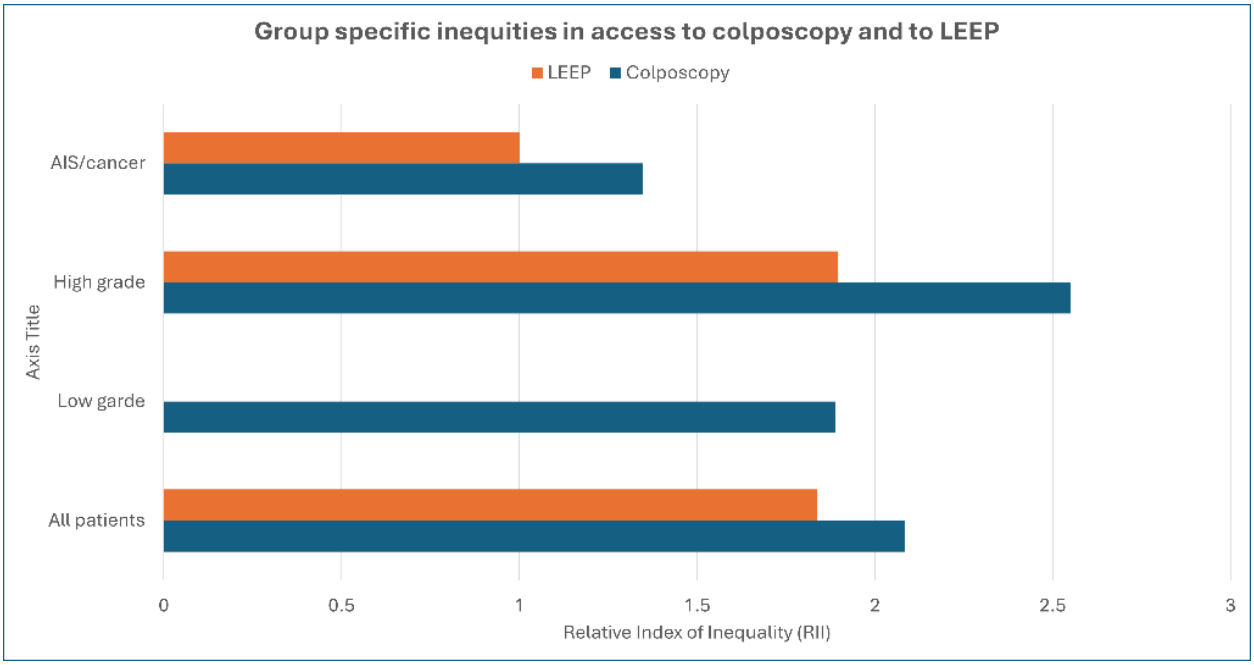
ASSESSING INEQUALITY IN COLPOSPCPY: A RETROSPECTIVE COHORT STUDY

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Introduction: Colposcopy is invaluable for assessing and treating pre-cancerous and cancerous disorders of the cervix. Our objective was to evaluate disparities in access to care in colposcopy services at our institution.

Methods: This is a retrospective cohort study between April 2022 and March 2024, with two cohorts examined: patients referred to colposcopy for a cervical diagnosis and patients who had Loop Electrosurgical Excision Procedure (LEEP). Patient's SocioEconomic Status (SES) was measured using the Ontario Marginalization Index. Disparities were examined using wait-times from referral to the colposcopy visit and wait-times from initial colposcopy to LEEP and by calculating Relative Index of Inequality (RII), a regression-based measure examining access inequity.

Results:



The colposcopy cohort included 1680 patients, median wait time from referral to colposcopy was 149 days (IQR 42-400). The LEEP cohort included 361patients, and the median wait time was 56 days (IQR 36-73). Wait time was significantly shorter for patients with more severe diagnosis for referral to colposcopy and with more severe pathology from the biopsy preceding LEEP. No association between wait times and SES was discovered for either of the cohorts. Access inequity for colposcopy and for LEEP cohorts was demonstrated with RII of 2.08 and 1.8 respectively, as well as for the different subgroups (Figure 1).

Conclusion/Implications: Wait times did not reveal SES disparity, as opposed to RII calculation that did reveal inequality in access to colposcopy and LEEP. This may indicate that patients who enter the system receive similar care, but barriers may exist before access is established.

EP125 / #980

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03b. Healthcare Delivery*

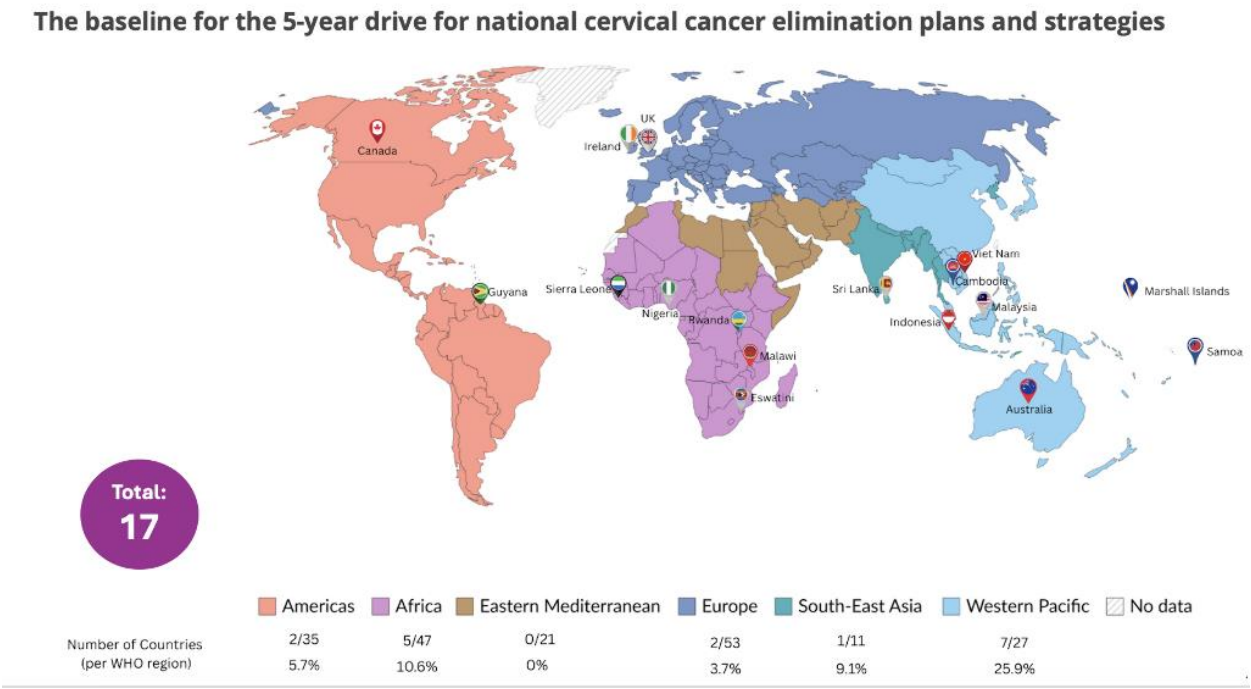
SETTING THE BASELINE OF PUBLICLY AVAILABLE NATIONAL STRATEGIES FOR ACCELERATING CERVICAL CANCER ELIMINATION: A GLOBAL MAPPING EXERCISE

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Introduction: The next 5-year period is critical for building national momentum on cervical cancer elimination and achieving the 2030 WHO elimination targets in all countries. IGCS has launched a project with the bold vision that every high-burden country will have a national cervical cancer elimination strategy actively being implemented by 2030. A global mapping exercise was initiated to establish the baseline for this call to action and track annual progress for policymakers, healthcare providers, community and advocacy organizations.

Methods: A search for national plans was conducted using advanced google search strategies. An assessment framework was applied to ensure the identified documents were current and in line with the following criteria: publicly available; an approved governmental document; national reach; outlines vision, goals and coordinated actions aligned with 90:70:90; Fixed timeframe which includes 2025.

Results:



With a search cutoff date of 31.10.2025, a total of 17 national strategies were identified. Presented by WHO region, the following distribution was found: Western Pacific 7/27 (25.9%), Africa 5/47 (10.6%), Southeast Asia 1/11 (9.1%), Americas 2/35 (5.7%), Europe 2/53 (3.7%) and Eastern Mediterranean 0/21 (0%). The identified strategies will be presented as a global map on the International Cancer Control Partnership portal for user-friendly navigation.

Conclusion/Implications: Nations with the highest burden of cervical cancer such as eSwatini, Malawi and Indonesia are leading the way in implementation of cervical cancer elimination strategies. To achieve the IGCS vision, a significant step up in advocating for national strategies and expert leadership in their development will be required.

EP126 / #875

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03c. Sustainability in Gynecologic Oncology*

CULTIVATING HOPE IN BAHIR DAR: IMPLEMENTING A SUSTAINABLE GYNECOLOGIC ONCOLOGY SUBSPECIALTY TRAINING PROGRAM TO ENHANCE LOCAL CANCER CARE IN ETHIOPIA

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Introduction: The rising burden of female cancers necessitates local specialized care. Bahir Dar University (BDU) has integrated the Helping Others through Practical Cancer Education (HOPE) initiative as a strategic partner to establish the region's first gynecologic oncology subspecialty training program as part of decentralized cancer care.

Methods: Led by BDU's College of Medicine and Health Sciences, a comprehensive needs assessment via SWOT analysis informed a rigorous, institutionally and ministerially approved curriculum aligned with local and international standards. Specialized infrastructure was established at Tibebe Ghion Specialized Hospital (TGSH), featuring a dedicated outpatient clinic, ward, and fully equipped surgical theatre supported by state-of-the-art imaging. The program fostered strategic partnerships with HOPE, Martin Luther University, and the Ethiopian Society of Obstetricians and Gynecologists (ESOG). Quality assurance was rigorously maintained through external examination and certification of the inaugural fellows by experts from the *Arbeitsgemeinschaft Gynäkologische Onkologie* (AGO)

Results: The program has achieved long-term sustainability, with two cohorts of fellows successfully graduated and a third cohort currently enrolled. Clinical impact includes over 3,000 outpatient visits, 80 radical hysterectomies with pelvic lymph node dissection (RH+PLND) for cervical cancer, and 300 additional gynecologic cancer surgeries in the first two years. Furthermore, the initiative integrated gynecologic oncology into local medical residency teaching and created robust referral linkages across the catchment area.

Conclusion/Implications: Establishing gynecologic oncology subspecialty training in regional centres is feasible and sustainable. Key success factors include engaged leadership, committed faculty, trainee pipelines, and international partnerships. This

model effectively decentralizes care, reduces late-stage presentations, and eliminates patient travel to the capital.

EP127 / #848

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03c. Sustainability in Gynecologic Oncology*

FROM INSTITUTIONAL BIOBANK TO CONSORTIUM-BASED PLATFORM: A SPECIALIZED BIOBANKING MODEL FOR GYNECOLOGIC CANCERS IN KOREA

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Introduction: Established in 2012, the Korean Gynecologic Cancer Bank (KGCB) at Yonsei University College of Medicine has served as an institutional biobank for gynecologic cancers. The KGCB integrates multi-institutional resources under standardized protocols to provide high-quality, anonymized biospecimens to researchers, reflecting its transition toward a consortium-based platform. This initiative aims to establish a researcher-oriented platform that facilitates efficient resource utilization, drives consortium-based innovation, and supports translational research.

Methods: This study was conducted to establish a biobanking platform for gynecologic cancer research. Following institutional review board approval and informed consent, biospecimens were collected and linked with clinical data. As part of a multi-institutional consortium program, a wide range of samples-including serum, plasma, buffy coat, fresh-frozen and FFPE tissues, urine, and peritoneal fluid-were processed and stored under standardized conditions for research use.

Results: The KGCB has accumulated biospecimens from a total of 3,222 patients with gynecologic cancers. Building upon this foundation, a consortium-based program expanded patient enrollment across six institutions, recruiting 404 patients under standardized protocols. Secondary resources derived from the collected biospecimens have been established, including organoid models, patient-derived xenografts (PDX), immortalized human ovarian surface epithelial (IHOSE) cell lines, and whole-genome sequencing (WGS) data, supporting integrative translational research. Furthermore, the platform is being expanded through participation in a government-supported organoid development program, reinforcing its role in supporting organoid-based research and resource utilization.

Conclusion/Implications: The KGCB provides a standardized platform for gynecologic cancer research and demonstrates a scalable, consortium-based biobanking model, supporting precision oncology and multi-institutional collaboration.

EP128 / #819

Topic: *AS03. Global Health, Economic Challenges & Inequity / AS03c. Sustainability in Gynecologic Oncology*

RESEARCH AND CLINICAL COLLABORATION IN MOZAMBIQUE: BUILDING CAPACITY TO IMPROVE CERVICAL CANCER PREVENTION AND TREATMENT

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Introduction: Cervical cancer is the leading cause of cancer and cancer-related death in Mozambique, in part due to a lack of organized screening/treatment of preinvasive disease and enough trained providers. To address these needs, a collaboration between the Mozambique Ministry of Health (MoH) and The University of Texas MD Anderson Cancer Center was established in 2014.

Methods: Educational initiatives were initiated, including hands-on cervical cancer prevention courses using simulation models, research training, and Project ECHO® (Extension for Community Healthcare Outcomes) programs for Mozambican providers. The International Gynecologic Cancer Society (IGCS) Global Gynecologic Oncology Fellowship, a two-year program, was implemented in Mozambique in 2017. Collaborative research studies have been conducted in-country.

Results: Four prospective extramurally-funded studies have been conducted (two completed and two ongoing). Educational activities included over 35 hands-on cervical cancer prevention trainings, two monthly Project ECHO programs (cervical cancer prevention and gynecologic cancer care) for providers, and research training for Mozambican investigators including two in-person courses and more than five ECHO sessions. Mozambique has become a regional training hub, hosting three international trainings for more than 25 African providers in partnership with IGCS. Four IGCS Global Fellowship graduates are currently providing care to women with cervical cancer; a third

fellowship cohort is ongoing.

Table 1. Collaborative Research Studies.

Research Studies	Timeline	Publications
The Capulana Study: A prospective evaluation of cervical cancer screening using human papillomavirus (HPV) testing in Mozambique	Completed in 2020 with 898 participants enrolled	Salcedo MP et al, *Int J Gynecol Cancer*. 2020 Oliveira CM et al, *J Glob Health Rep* 2022
The MULHER Study: Cervical cancer screening with primary HPV testing in Mozambique	Completed in 2023 with 9,014 participants enrolled	Salcedo MP et al. *Int J Gyn Cancer 2023* Batman S et al. *JCO Global Oncology 2023* Chambule et al. *Int J Gyn Cancer 2024* De Oliveira CM et al, *Infect Agents Cancer 2025*
A randomized clinical trial to assess the effectiveness of thermal ablation versus loop electrosurgical excision procedure for cervical cancer risk reduction in women living with human immunodeficiency virus in Mozambique	Started in 2024; ongoing, currently >1000 participants enrolled and > 130 randomized	Fallah PN et al, *Int J Gynecol Cancer* 2026
Low-cost mobile colposcopy and confocal imaging for global prevention of cervical cancer	Started in 2024; ongoing, currently > 110 participants enrolled	

Conclusion/Implications: Our collaboration has helped strengthen clinical and research capacity, expanding access to cervical cancer prevention and care. Empowering local clinicians and researchers and building leadership capacity are essential for sustainability, while government support and policymaker engagement are critical to ensure scalability and long-term impact.

EP129 / #987

Topic: *AS04. Patient-Centered Care / AS04a. Fertility & Pregnancy*

IMMUNE CHECKPOINT INHIBITOR EXPOSURE DURING PREGNANCY: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction: Immune checkpoint inhibitors increasingly define survival in melanoma and gynecologic malignancies, including cervical and endometrial cancer. Because programmed-death and cytotoxic T-lymphocyte pathways sustain fetomaternal tolerance, gestational exposure represents a collision between maternal oncologic rescue and fetal immune vulnerability.

Methods: A PRISMA-aligned systematic review searched PubMed, Embase, Scopus, Web of Science, Cochrane Library, pharmacovigilance databases, and registries from 2011 to April 2026 for cancer patients exposed during pregnancy to anti-programmed-death-1, anti-programmed-death-ligand-1, anti-cytotoxic T-lymphocyte-associated protein-4, or combination therapy. Random-effects proportional meta-analysis estimated fetal complications, immune-related adverse events, prematurity, fetal death, and growth restriction with 95%CIs, bias and certainty were assessed.

Results: Twenty-three studies were included: 20 case reports and three retrospective observational datasets; 2539 records yielded 1843 screened citations after duplicate removal. In case-report proportional meta-analysis, fetal complications occurred in 23.0% (95%CI 11.0-42.1), fetal immune-related adverse events in 11.5% (95%CI 4.0-29.0), preterm delivery in 54.0% (95%CI 35.5-71.2), and fetal mortality in 0% (95%CI 0.0-12.9). Observational datasets reported preterm birth in 20.9%-25.5%, fetal mortality in 2.2%-15.3%, intrauterine growth restriction in 6.5%-7.1%, and prematurity-related complications in 2.6%-5.5%. The largest pharmacovigilance cohort identified 91 exposed pregnancies without disproportionate reporting of pregnancy, fetal, or neonatal toxicity versus other anticancer drugs, although rare neonatal immune events were described.

Conclusion/Implications: Gestational checkpoint blockade is not uniformly catastrophic, but remains biologically high-risk. Intentional use should require maternal-benefit justification, multidisciplinary counselling, fetal surveillance, neonatal immune monitoring, and prospective gynecologic-oncology pregnancy registries, especially as

checkpoint indications expand across cervical and endometrial cancer worldwide and international drug-safety harmonization efforts are urgent.

EP130 / #767

Topic: *AS04. Patient-Centered Care / AS04a. Fertility & Pregnancy*

REPRODUCTIVE OUTCOMES AND FERTILITY CONSIDERATIONS WITH PROGRAMMED CELL DEATH PROTEIN 1 AND PROGRAMMED DEATH-LIGAND 1 INHIBITORS: A NARRATIVE REVIEW (2015–2026)

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Introduction: Over the past decade, programmed death ligand-1 (PD-L1) and programmed death-1 (PD-1) immune checkpoint inhibitors have become standard treatments in early-stage and curative oncology settings, increasing the number of patients of reproductive age exposed to long-term immunomodulation. The expanding use of immune checkpoint inhibitors has prompted concern about their impacts on reproductivity and fertility in these populations. The purpose of this study is to synthesize clinical and preclinical evidence published between 2015 and 2026 regarding effects of PD-1 and PD-L1 inhibitors on pregnancy, fertility, and reproductive outcomes.

Methods: A narrative review of studies published January 2015 to January 2026 was conducted using PubMed and Embase. Terms on reproductive outcomes and PD-1/PD-L1 inhibitors were applied. Sources included case reports, series, preclinical toxicology studies, and cohorts. Non-PD-1/PD-L1 inhibitors, and cytotoxic T-lymphocyte-associated protein (CTLA-4) inhibitors were excluded. Reviews were used for back referencing but were excluded.

Results: This narrative review included thirty-one studies and identified three themes: PD-1/PD-L1 signaling in maternal-fetal immune tolerance, evidence on fertility and pregnancy outcomes after exposure, and limited guidance on fertility preservation or gonadal safety. Pathway disruption was associated with fetal loss, while adverse outcomes included miscarriage, preterm delivery, fetal resorption, and growth restriction. Gonadal toxicity evidence was limited, mainly from male cohorts reporting reduced testosterone and impaired spermatogenesis.

Conclusion/Implications: The lack of longitudinal data represents a gap in patient care, potentially resulting in irreversible infertility and poor pregnancy outcomes. Prospective studies are needed to inform evidence-based counseling, standardized reproductive monitoring, and fertility/pregnancy guidance for patients of reproductive age receiving these therapies.

EP131 / #725

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

TREATMENT OUTCOMES AMONG GYNECOLOGIC ONCOLOGY PATIENTS UNDERWENT SURGERY AT HIWOT FANA SPECIALIZED UNIVERSITY HOSPITAL, EASTERN ETHIOPIA

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[1]Haramaya University, Gynecologic Oncology, HARAR, Ethiopia, [2]Saint Paul Millenium Medical College,, N/A, Ethiopia

Introduction: Gynecologic cancers have a high rate of morbidity and mortality, particularly in developing countries where there is a lack of universal screening, vaccination, diagnostic techniques, and trained personnel. This study therefore aimed to assess the treatment outcomes and factors associated with surgically treated gynecologic malignancies at Hiwot Fana Comprehensive Specialized University Hospital (HFCSUH)

Methods: A retrospective cross-sectional study was conducted at Hiwot Fana Comprehensive Specialized University Hospital from July 1, 2021 to October 30, 2023. The study included all gynecologic oncologic surgeries performed during this period using census method. Data was collected using a structured checklist from medical registration and entered into Epi-data version 4.6. Analysis was conducted using SPSS version 26. Findings were described using tables, graphs, and figures.

Results: During the study period at HFCSUH, 133 gyne-oncologic surgeries were performed, of which more than half (56.4%) were for ovarian cancer, while 21.1% were for cervical cancer. The majority of patients (60.9%) had a favorable outcome and were discharged without any complications, both during the surgery and in the post-operative period. However, 39.1% of patients developed either intraoperative or post-operative complications. Among these complications, 33.1% were related to the surgery itself, with 21.8% requiring transfusion due to hemorrhage. Additionally, 15% of patients experienced post-operative complications.

Conclusion/Implications: The majority of gynecologic oncology patients had ovarian cancer, and most were at an advanced stage. Health education on the early signs and symptoms of ovarian cancer, along with increased screening for precancerous cervical lesions and early treatment, is essential to decrease morbidity.

EP132 / #769

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

CLINICAL IMPLEMENTATION OF THE ELECTRONIC SELF ASSESSMENT AND CARE PROGRAM FOR GYNECOLOGIC ONCOLOGY PATIENTS THROUGH THE ELECTRONIC HEALTH RECORD: A TWO-YEAR EVALUATION

Donna Berry, Seth Wolpin, Priya Devgan, Holly Tomashek, Barbara Goff
University of Washington, Seattle, United States of America

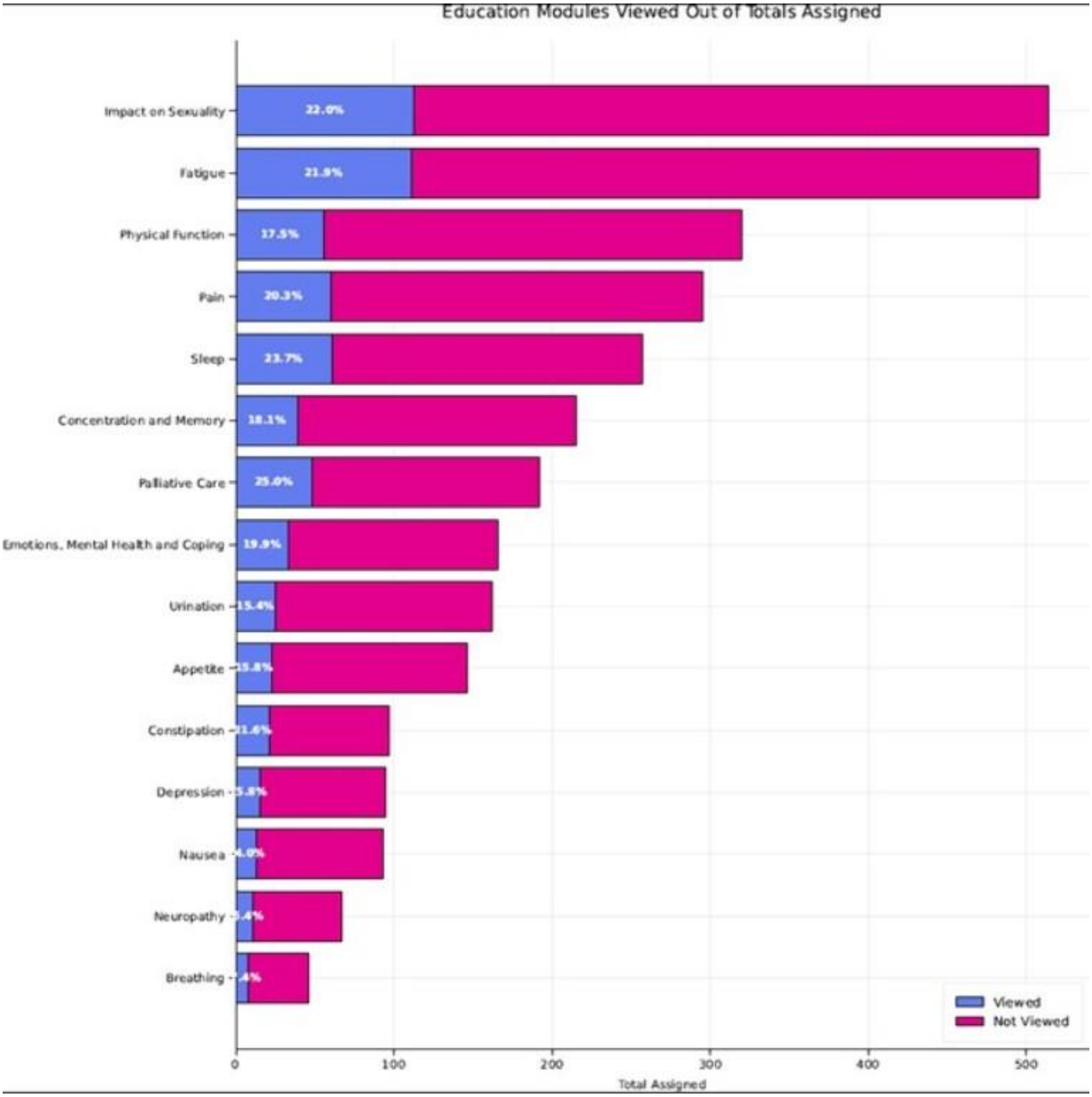
Introduction: Introduction: Patient-reported outcome measures (PROM) are recommended in oncology clinical practice. The purpose of this quality improvement project was to evaluate usage metrics for an electronic medical record-embedded PROM, the *electronic Self Assessment and Care* (eSAC).

Methods: Methods: Patients with any stage gynecologic cancer seen at a tertiary care clinic were invited through EPIC's MyChart to complete eSAC questionnaires prior to each visit and based on responses, were assigned education modules in MyChart for specific symptoms at a moderate-severe threshold. Module assignments were made separately after submission of the questionnaires. Response data were retrieved from EPIC to analyze usage.

Results: Results: 11,837 invitations were sent to 1,320 unique patients from March 2024 to March 2026. Overall, patients responded to 4,828 (40.8%) invitations; 1,013 (76.4%) of unique patients submitted at least 1 eSAC response across all encounters. Of patients with at least 4 visits per year, 638/738 (85.1%) submitted at least one response. The Table displays relevant demographic data. Over time, 238 patients were provided a total of 3,173 educational modules. The most common threshold issues were fatigue and impact on sexual activities and interest; all are listed in the Figure along with percent viewed. On average, 21% of modules were viewed, with higher rates for palliative care and sleep.

Table. Demographic characteristics of 1,320 unique patients

Age	
Range	15-92
Median	63
Employment	
Not working	702
Working	558
Unknown	60
Race	
Asian	141
Black	46
White	1007
Other/unknown	126
Ethnicity	
Hispanic	118
Non-Hispanic	1140
unknown	62



Conclusion/Implications: Conclusion/Implications: Most patients with gynecologic cancer were willing to respond to a MyChart invitation to complete eSAC, particularly those with regular clinic visits. The education modules were underutilized, likely due to the separate assignment process within MyChart, leading to misunderstanding of the assignments.

EP133 / #507

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

PATIENT AND CARE PARTNER PERSPECTIVES IN CO-DESIGNING PAINT-EC: A PERSONALIZED ARTIFICIAL INTELLIGENCE NAVIGATION TOOL FOR ENDOMETRIAL CANCER– A QUALITATIVE STUDY

Shannon James[1], Raima Lohani[2], Eliana Kagal[1], Quyhn Pham[2], Rachel Soyoun Kim[3]
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Introduction: This project seeks to understand the experiences of patients and care partners affected by endometrial cancer to inform the co-design of a Personalized Artificial Intelligence Navigation Tool for Endometrial Cancer (PAINT-EC), an AI-based tool designed to deliver personalized informational support throughout the diagnosis and active treatment touchpoints along their cancer care journey.

Methods: We used a qualitative, co-creation approach informed by mixed-methods frameworks to integrate lived experiences into the design of PAINT-EC. Patients were recruited through follow-up gynecology clinic visits, and care partners were identified through patient referral. Data collection included demographic and digital literacy surveys (3-Item Digital Health Care Literacy Measure, HLS19-DIGI) and semi-structured interviews exploring health system navigation, digital literacy, survivorship, and sociocultural perspectives. Interview data were analyzed in NVivo using a hybrid deductive-inductive approach.

Results: Participants included six patients and three care partners, who are self-identified across a range of ethnicities and racial backgrounds. To protect anonymity, specific identities and demographic combinations are not reported. Most participants reported consistent internet and phone access. Thematic analysis highlighted varied survivorship experiences among endometrial cancer patients. All participants rated their care experience at the cancer center highly; however, many described significant fear and anxiety at the time of diagnosis. Information-seeking practices varied considerably across patient and care partner groups.

Conclusion/Implications: By centring patient and care partner perspectives, this exploratory project establishes a foundation for the responsible co-design of PAINT-EC. These findings will shape future co-creation activities, guiding the development of the PAINT-EC prototype to be evaluated by patients, care partners, and clinicians.

EP134 / #510

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

CLINICIAN PERSPECTIVES ON CO-DESIGNING PAINT-EC: A PERSONALIZED ARTIFICIAL INTELLIGENCE NAVIGATION TOOL FOR ENDOMETRIAL CANCER- A QUALITATIVE STUDY

Shannon James[1], Raima Lohani[2], Eliana Kagal[1], Quyhn Pham[3], Rachel Soyoun Kim[4]
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Introduction: Successful integration of AI-based care requires the perspectives of clinicians directly involved in patient care delivery. This project explores interdisciplinary clinician experiences in endometrial cancer (EC) care to inform the co-design of the Personalized Artificial Intelligence Navigation Tool for Endometrial Cancer (PAINT-EC), an AI-based digital navigation tool for patients and care partners. Clinician insights complement parallel work examining patient and care partner perspectives and are essential to support usability, adoption, and value-based care.

Methods: Gynecologic oncologists, physician assistants, radiation oncologists, medical oncologists, and registered nurses from a large Toronto-based cancer center participated in semi-structured interviews. Interviews explored clinical workflows, barriers to patient education, and attitudes toward an AI-supported navigation tool. Interviews were conducted via Microsoft Teams, audio-recorded, transcribed, and analyzed using NVivo15. A hybrid deductive–inductive approach was used, incorporating predefined codes and emergent themes reflecting clinician priorities and experiences.

Results: Fourteen interviews identified themes related to the acceptability, anticipated adoption, feasibility, appropriateness, and perceived impact of AI-supported tools. Clinicians described challenges arising from highly individualized care pathways, limited appointment time, and a lack of standardized educational resources. Participants suggested that AI-assisted voicemail categorization and urgency flagging could improve efficiency and patient safety. While clinicians expressed interest in AI-supported education and information synthesis, concerns remained about accuracy and the need for ongoing updates as clinical guidelines evolve.

Conclusion/Implications: Ensuring AI navigation tools complement clinician–patient interactions, while maintaining accuracy, transparency, and clinician oversight, will be critical for successful integration into endometrial cancer care.

EP135 / #802

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

GENETIC TESTING AND PARP INHIBITOR USE IN EPITHELIAL OVARIAN CANCER: A RETROSPECTIVE STUDY FROM THE VERSPEETEN FAMILY CANCER CENTRE, LONDON, CANADA

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Introduction: Poly (ADP-ribose) polymerase (PARP) inhibitors have improved progression-free survival in epithelial ovarian cancer (EOC), particularly in patients with homologous recombination deficiency (HRD), including BRCA1/2 mutations. However, real-world effectiveness and access to genetic testing remain variable across centres. This study evaluates germline BRCA and HRD testing rates, characterizes PARP inhibitor use and outcomes, and examines care delivery models at a Canadian tertiary cancer centre.

Methods: We are conducting a retrospective chart review of patients diagnosed with EOC between July 2016 and December 2024 at the Verspeeten Family Cancer Centre (London, Ontario). Data extracted from electronic medical records include demographics, treatment history, genetic testing results, and outcomes. These data are being collected and stored in REDCap.

Results: A cohort of 595 patients with EOC has been identified. The mean age was 60.9 years. Among patients with available staging data (n=222), most presented with advanced disease (stage III: 62.6%; stage IV: 33.8%), with few diagnosed at stage I (2.3%) or II (1.4%). A subset of 121 patients received PARP inhibitor therapy, including 52% niraparib and 48% olaparib. Data collection is ongoing; final analyses will report BRCA and HRD testing rates, treatment outcomes, and follow-up care patterns, including the role of nurse practitioner (NP)-led clinics.

Conclusion/Implications: This study will provide real-world insights into genetic testing, treatment patterns, and care delivery in EOC. Findings may inform strategies to improve access to genetic testing, and support sustainable models of follow-up care in gynecologic oncology.

EP136 / #641

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

EVALUATION OF PALLIATIVE CARE FOR GYNAECOLOGICAL MALIGNANCIES IN RURAL MALAWI: OPPORTUNITIES FOR DIGITAL TRANSFORMATION

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Introduction: Despite advancements in prevention, screening, early detection, and treatment of cancer, more women in Malawi present with advanced-stage disease, limiting curative treatment options and increasing the need for palliative care services. Palliative care requires a holistic approach that addresses physical, psychosocial, spiritual, cultural, and end-of-life care needs through interdisciplinary care teams. However these palliative care domains remain weak especialy in rural settings. This study aims to evaluate the comprehensiveness of palliative care services and identify opportunities to leverage digital health technologies to improve symptom monitoring, care coordination, documentation, referral systems, and social support in rural low-resource setting.

Methods: This is a descritive study in which quantitative data is being collected using secondary palliative care data platforms. Final analysed results to be available by end of june 2026. The inclusion criteria is all women enrolled in the palliative care program with a confirmed histological diagnosis of a gynaecological malignancy. Data collected includes patient demographics, type and stage of malignancy, symptom assessment and management , psychosocial support, frequency of home visits and referral patterns. Continuous variables will be analysed using mean and standard deviation and proportion ratio for categorical variabtles.

Preliminary Data or Expected Results: The results will highlight gaps in comprehensive assessment, symptom management, continuity of care, and interdisciplinary coordination within the current home-based palliative care model and identify opportunities for leveraging digital health technologies.

Significance and Impact: Findings will be used to support the ministry of health in developing and integrating digital health technologies to strengthen palliative care service delivery adaptable for rural low resource settings.

EP137 / #957

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

REDUCING FEAR AND IMPROVING COMPLIANCE TO VAGINAL BRACHYTHERAPY IN ENDOMETRIAL CANCER PATIENTS: PRELIMINARY PROSPECTIVE COHORT STUDY

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Introduction: Vaginal brachytherapy poses physical and psychological challenges, including anxiety, which can compromise treatment compliance. Reducing stress and fear in patients is a vital for maintaining treatment continuity. We evaluated levels stress and fear of women undergoing brachytherapy at the Tel Aviv Medical Center and assessed the impact of care-team satisfaction on anxiety and compliance.

Methods: A prospective cohort study of 59 endometrial cancer patients (Mean Age=67.1) collected data at three points: pre-consultation (baseline), post-consultation, and post-first treatment completion. Tools included the Hospital Anxiety and Depression Scale (HADS), Distress Thermometer, a dedicated apprehension index, and an EORTC-PATSAT-C33-based satisfaction questionnaire. Anxiety changes were analyzed using Friedman and Wilcoxon signed-rank tests.

Results: The cohort demonstrated a statistically significant reduction in HADS-A score throughout the treatment trajectory ($p = 0.011$). While the initial consultation yielded a non-significant decrease in anxiety ($p = 0.384$), a significant reduction occurred between the post-consultation visit and the post-first treatment ($p = 0.036$). Overall anxiety from baseline to post-first treatment decreased significantly ($p = 0.005$). Similarly, the distress index fell from 5.6 to 3.5 ($p = 0.002$). Patient satisfaction with the care team was exceptionally high ($M = 4.72/5.00$), demonstrating consistent care delivery regardless of demographic subgroups (all $p > 0.05$).

Conclusion/Implications: This firstly done prospective study emphasize the importance of targeted multidisciplinary oncology support which effectively reduces treatment-related fear and stress in endometrial cancer patients undergoing vaginal brachytherapy. Prioritizing patient-centered care successfully alleviates fears, improves treatment compliance, and ensures protocol completion. Further studies are needed to strengthen this approach.

EP138 / #669

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

REDUCING THE RATE OF VENOUS THROMBOEMBOLISM IN PATIENTS WITH ADVANCED OVARIAN CANCER UNDERGOING NEOADJUVANT CHEMOTHERAPY: A QUALITY IMPROVEMENT INITIATIVE

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Introduction: Patients with advanced ovarian cancer receiving NACT are at increased risk of VTE which is associated with morbidity, mortality, and cost. Our purpose is to determine if universal VTE prophylaxis for patients with advanced ovarian cancer receiving NACT is feasible and effective in reducing VTE incidence, without increasing adverse effects or negatively impacting quality of life.

Methods: This quality improvement initiative is evaluating implementation of universal VTE prophylaxis. We included adult patients with advanced stage ovarian cancer who received NACT with planned IDS. A retrospective chart audit of the Jan 2024 - Jun 2025 pre-intervention cohort evaluated baseline practices and change interventions. We have completed one PDSA cycle between Jul 2025 - Jan 2026 with a second cycle currently ongoing. The primary outcome is VTE incidence pre- and post-intervention. Secondary outcomes include compliance rate to anticoagulation prescribing, rates of major and minor bleeding events, and patient-reported satisfaction.

Results: The pre-intervention cohort included 76 patients. The baseline VTE prophylaxis prescribing rate was 5/76 (6.5%) and VTE incidence was 13.1%. Initial interventions included education sessions for multidisciplinary team members and educational materials for patients. The post-intervention cohort included 26 patients; 11/26 patients received VTE prophylaxis (42%) and only one experienced a VTE (1/26 = 3.8%), RR=0.33. No patients experienced a major or minor bleeding event.

Conclusion/Implications: Our initial results demonstrate that prophylactic anticoagulation in this patient population is a safe and effective method to decrease VTE incidence. Future directions include additional PDSA cycles to increase prophylaxis prescribing rates, and incorporating patient quality of life measures.

EP139 / #1110

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

LIMITED UTILITY OF THE KHORANA SCORE IN PATIENTS WITH RECURRENT OVARIAN CANCER WHO DEVELOP VENOUS THROMBOEMBOLISM

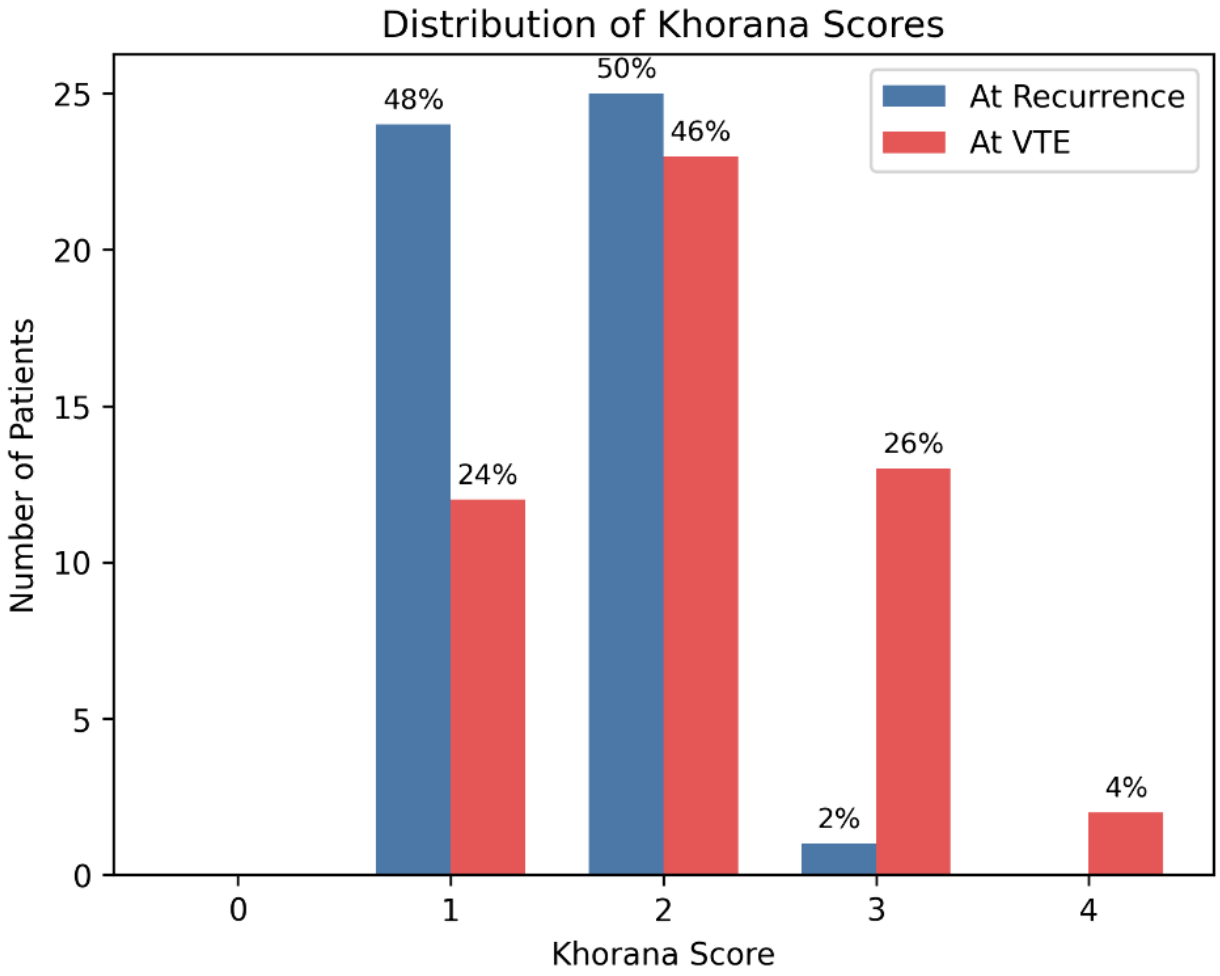
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Introduction: The Khorana score is widely used to stratify venous thromboembolism (VTE) risk in cancer patients; however, its utility in patients with recurrent ovarian cancer remains unclear, particularly in guiding prevention strategies in this high-risk population.

Methods: We conducted a retrospective cohort study of patients with recurrent ovarian cancer who developed VTE between 2011–2024. Khorana scores were calculated at the time of first disease recurrence and at VTE diagnosis using standard criteria (cancer type, platelets ≥350×10^9/L, hemoglobin <10 g/dL, leukocyte count >11×10^9/L, body mass index ≥35 kg/m^2), and categorized as low (0), intermediate (1–2), or high risk (≥3). Score distributions and component frequencies were analyzed.

Results: Fifty patients with recurrent ovarian cancer and VTE were identified. The mean Khorana score increased from 1.5 ± 0.5 at first disease recurrence to 2.1 ± 0.8 at VTE diagnosis. Despite this increase, most patients were classified as intermediate risk at time of VTE (70%), while 30% met high-risk criteria. Notably, 24% of patients had no additional Khorana score components beyond malignancy at time of VTE. At VTE diagnosis, hemoglobin <10 g/dL was the most common score component (48%), followed by thrombocytosis (38%), while elevated leukocyte count (16%) and obesity (8%) were

infrequent.



Conclusion/Implications: In patients with recurrent ovarian cancer, VTE frequently occurs in the absence of high Khorana scores, suggesting limited discriminatory utility of this tool in this population. These findings have important implications for population-level risk stratification and highlight the need for disease-specific models to guide prevention strategies and optimize resource allocation across diverse care settings.

EP140 / #454

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

USING A NOVEL MOBILE COGNITIVE TRAINING APPLICATION TO IMPROVE CANCER-RELATED COGNITIVE IMPAIRMENT IN GYNECOLOGIC ONCOLOGY PATIENTS

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Introduction: Cancer-related cognitive impairment (CRCI) is the cognitive decline experienced by patients receiving chemotherapy that significantly impacts quality of life. Cognitive training mobile applications (CTAs) are innovative tools that hold promise for counteracting CRCI; however, no interventions utilizing CTAs to improve CRCI have been reported in the gynecologic oncology literature. The objective of this study is to assess the neurocognitive changes experienced by gynecologic oncology patients receiving chemotherapy and to evaluate the efficacy of CTAs as an intervention for CRCI.

Objectives: The primary endpoints of the study are neurocognitive assessment scores compared before, during, and after treatment to assess for neurocognitive changes while receiving chemotherapy. Secondary endpoints include total time of CTA usage and the proportion of patients achieving compliance with the intervention as an assessment of feasibility.

Methods: This prospective trial will enroll 64 patients randomized 1:1 to an experimental and a control arm (Figure 1). The experimental arm will be instructed to use the CTA for 15 minutes 3-5 times a week; the control arm will be treated per standard of care. Patients newly diagnosed with gynecologic malignancy and receiving treatment with chemotherapy are

eligible.

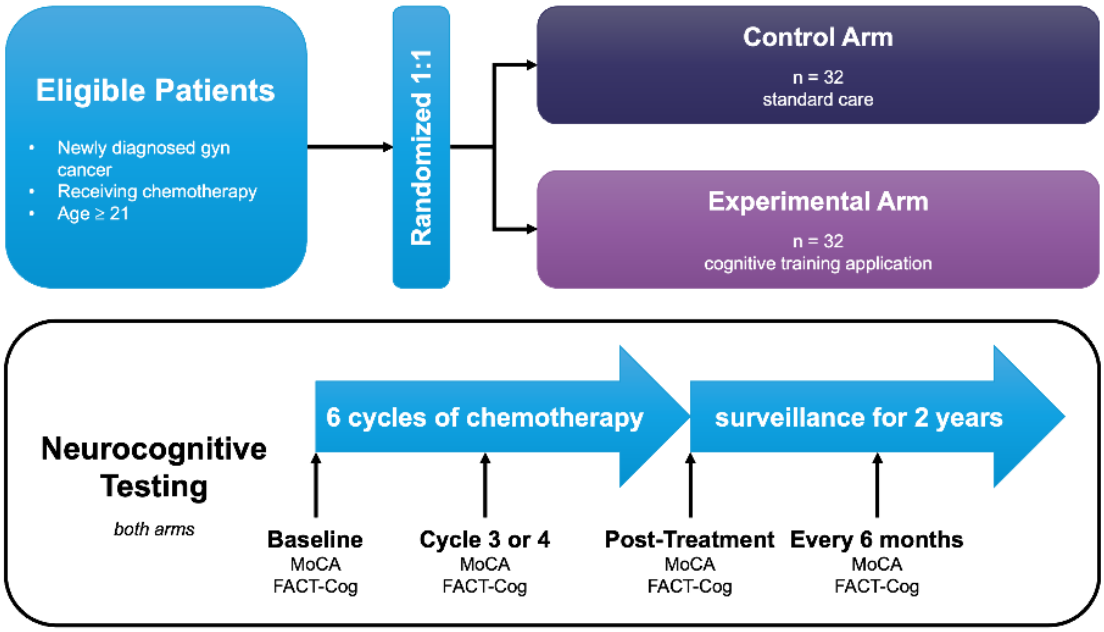


Figure 1: Study schema

Current Status & Future Directions: This ongoing clinical trial utilizes a novel approach to treat CRCI in patients receiving chemotherapy and provides a foundation for a standardized approach to assessment of CRCI in the field of gynecologic oncology. Enrollment recently finished and results are anticipated in 2027. If this CTA demonstrates efficacy, it will provide a low-cost, widely accessible, and easily implemented intervention to improve quality of life for patients experiencing CRCI.

EP141 / #591

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

A NATIONWIDE STUDY OF FIRST RECURRENCE IN EPITHELIAL OVARIAN CANCER IN THE NETHERLANDS: TREATMENT AND POST-RECURRENCE SURVIVAL

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Introduction: We investigated treatment patterns and post-recurrence survival (PRS) among patients with a first recurrence of epithelial ovarian cancer (EOC) in the Netherlands.

Methods: In this nationwide retrospective cohort study using data from the Netherlands Cancer Registry, all women diagnosed with primary EOC between 1 January 2015 and 31 December 2020 were included. Patients were followed for up to five years after primary diagnosis to identify recurrence following initial treatment.

Results: A total of 7,122 patients with EOC were included, of whom 3,635 (51%) developed recurrence within five years after primary diagnosis. Of these, 5.7% had early-stage disease (FIGO I–IIA) and 94.3% advanced-stage disease (FIGO IIB–IV) at primary diagnosis. Median time to recurrence was 14.4 months (IQR 9.9–22.2). At recurrence, chemotherapy was most frequently administered (51%), followed by targeted therapy (25.2%), hormonal therapy (6%), surgery (2.9%), radiotherapy (3.1%), other treatments (1.3%), and best supportive care (10.5%). Chemotherapy included platinum-based regimens — carboplatin/paclitaxel (10.8%), carboplatin/gemcitabine (9.7%), carboplatin monotherapy (9.6%), and carboplatin/doxorubicin (2.6%) — as well as non-platinum regimens such as doxorubicin (9.3%), gemcitabine (4.3%), and paclitaxel monotherapy (2.2%). Targeted therapies included angiogenesis inhibitor bevacizumab (15.8%) and PARP inhibitors olaparib (5.4%) and niraparib (2.7%). Median PRS was 11.1 months (IQR 4.01–22.4). Median PRS was 10.7 months (IQR 4.93–23.1) in patients with primary early-stage disease and 11.1 months (IQR 4.01–22.3) in those with advanced-stage disease.

Conclusion/Implications: Recurrence of EOC is common, treatment varies substantially, and PRS remains poor. These data provide clinicians with insights into current nationwide practice and support patient counseling regarding treatment options and prognosis.

EP142 / #581

Topic: *AS04. Patient-Centered Care / AS04b. Palliative, Symptomatic & Supportive Care*

THE USE OF MENOPAUSE HORMONE THERAPY IN BORDERLINE OVARIAN TUMOR SURVIVORS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction: Menopausal hormone therapy (MHT) is widely used to manage vasomotor and genitourinary symptoms in postmenopausal women, yet its relationship with ovarian neoplasia, especially BOTs, remains uncertain and less well defined.

Methods: Five databases were searched from inception to August 2025. Studies that met inclusion criteria were assessed for type of MHT used, duration, recurrences where reported. Included studies were assessed for risk of bias.

Results: A total of 469 studies were identified following a comprehensive literature search. Six studies reported a statistically significant association between MHT use and increased odds of BOTs. Five studies did not identify a significant association between MHT use and odds of BOTs. Combined estrogen-progestin therapy showed a stronger, more consistent positive association with increased odds of BOTs (OR 1.426, 95% CI: 1.083-1.877), whereas estrogen-only therapy showed a non-significant association. Evidence regarding post-diagnosis outcomes is extremely limited. No studies addressed the likelihood of BOTs recurrence and MHT use. Only one observational study evaluated the association between MHT use and BOTs survival; this study found no adverse association.

Conclusion/Implications: The available evidence on the association between MHT and BOTs is heterogeneous and inconsistent. While a statistical association was observed between combined MHT and increased odds of BOTs, data regarding post-surgical safety is limited. The overall certainty of evidence is very low. Indications for MHT following surgery for BOTs must be carefully considered, individualized, and discussed in multidisciplinary meetings involving both a cancer specialist and a menopause specialist to carefully balance quality of life benefits against theoretical risks that remain unquantified.

EP143 / #719

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

COMPARISON OF ONCOLOGICAL OUTCOMES BETWEEN RECTOSIGMOID WALL STRIPPING AND RECTOSIGMOID RESECTION DURING CYTOREDUCTIVE SURGERY IN ADVANCED OVARIAN CANCER

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Introduction: Rectosigmoid involvement is frequently encountered in advanced ovarian malignancies requiring rectosigmoid resection (RR) to achieve complete cytoreduction. However, full-thickness bowel infiltration is uncommon. Rectosigmoid stripping (RS) is a bowel-sparing alternative with limited oncologic data. Our study aimed to evaluate the perioperative and short term oncological outcomes between the two methods.

Methods: A retrospective cohort study of stage III–IV ovarian cancer with rectosigmoid involvement undergoing cytoreductive surgery (07/2024–10/2025) was conducted. Patients underwent either rectosigmoid wall stripping (isolated deposit excision to complete wall stripping) or rectosigmoid resection. Baseline characteristics, perioperative and oncologic outcomes were analysed using independent t-test and chi-square test.

Results: Sixty-one patients were included (RS=36; RR=25). Baseline characteristics (age, histology, serum albumin, CA-125 and PCI) were comparable. RS showed shorter operative time (4.5 vs 6.5 hr, p=0.005), lower blood loss (600 vs 1500 ml, p=<0.001), fewer transfusions (1.4±0.58 vs 2.4±0.95, p=<0.001), shorter ICU stay (p=0.001), fewer chemotherapy delays (14.81% vs 40.91%, p=0.04) and fewer postoperative complications (27.8% vs 60.0%; p=0.017). Cytoreduction rates were comparable (55.56% vs 76.3%, p=0.3). Serosal and seromuscular involvement was seen in 52.8% and 16.7% of RS group; Full-thickness involvement occurred in 8% of RR. Nil residual disease was present in 30.56% of RS and 16.0% of RR. Recurrence rates were comparable (24% vs 30%; p=0.7, with similar 12-month probability of survival (69% vs 81.3%, p=0.4)

Conclusion/Implications: In patients without full-thickness rectal involvement, RS offers similar cytoreductive rates and RFS with reduced morbidity. Larger prospective studies with long-term follow-up necessary to validate oncologic

outcomes.

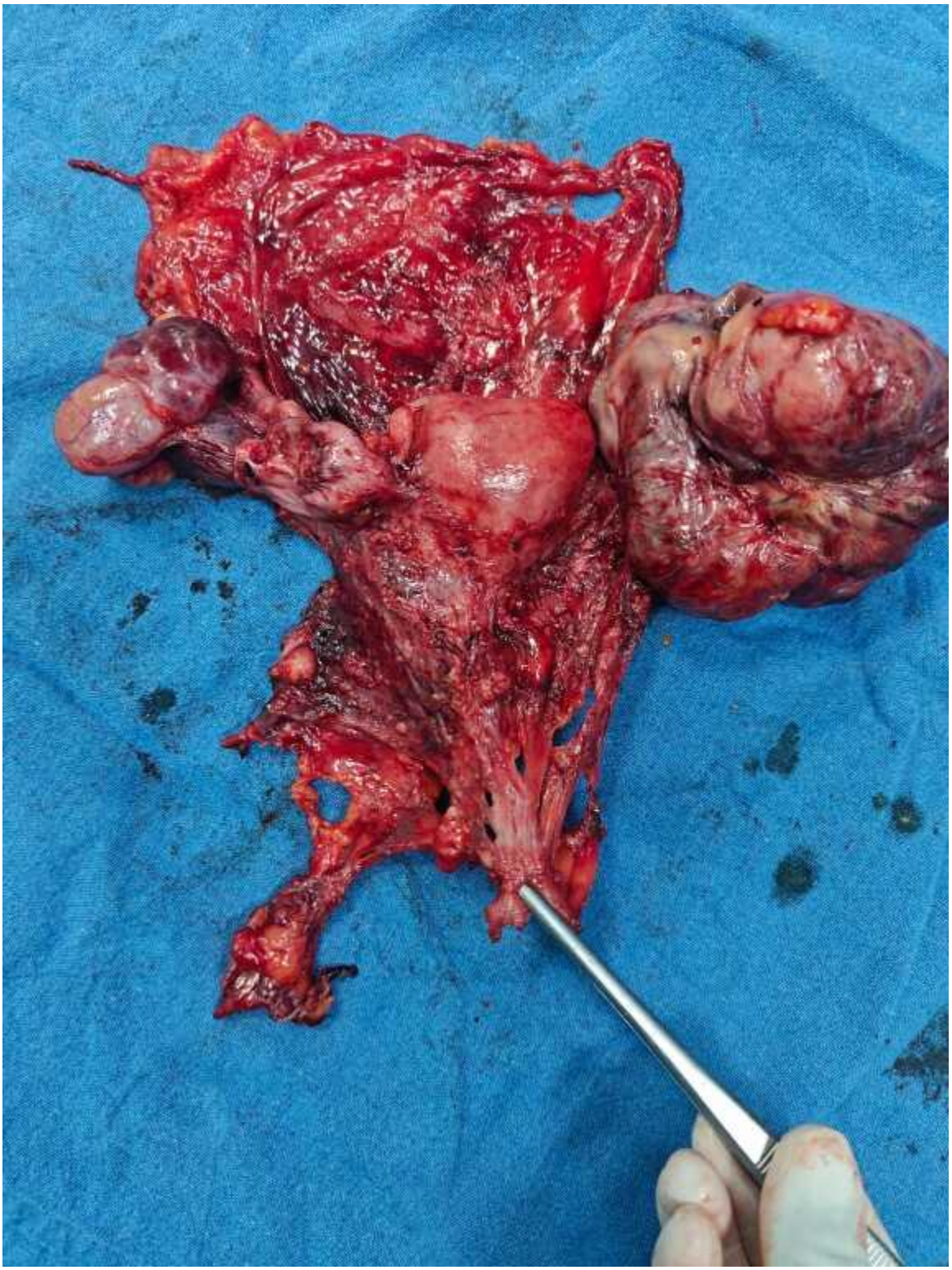




Fig: A:Surgical specimen. B: Post stripping

EP144 / #464

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

MOVING BEYOND HYPERVIGILANCE: THE PROTECTIVE ROLE OF BODY TRUST IN THE INTEROCEPTIVE EXPERIENCE OF GYNECOLOGIC AND BREAST CANCER SURVIVORS

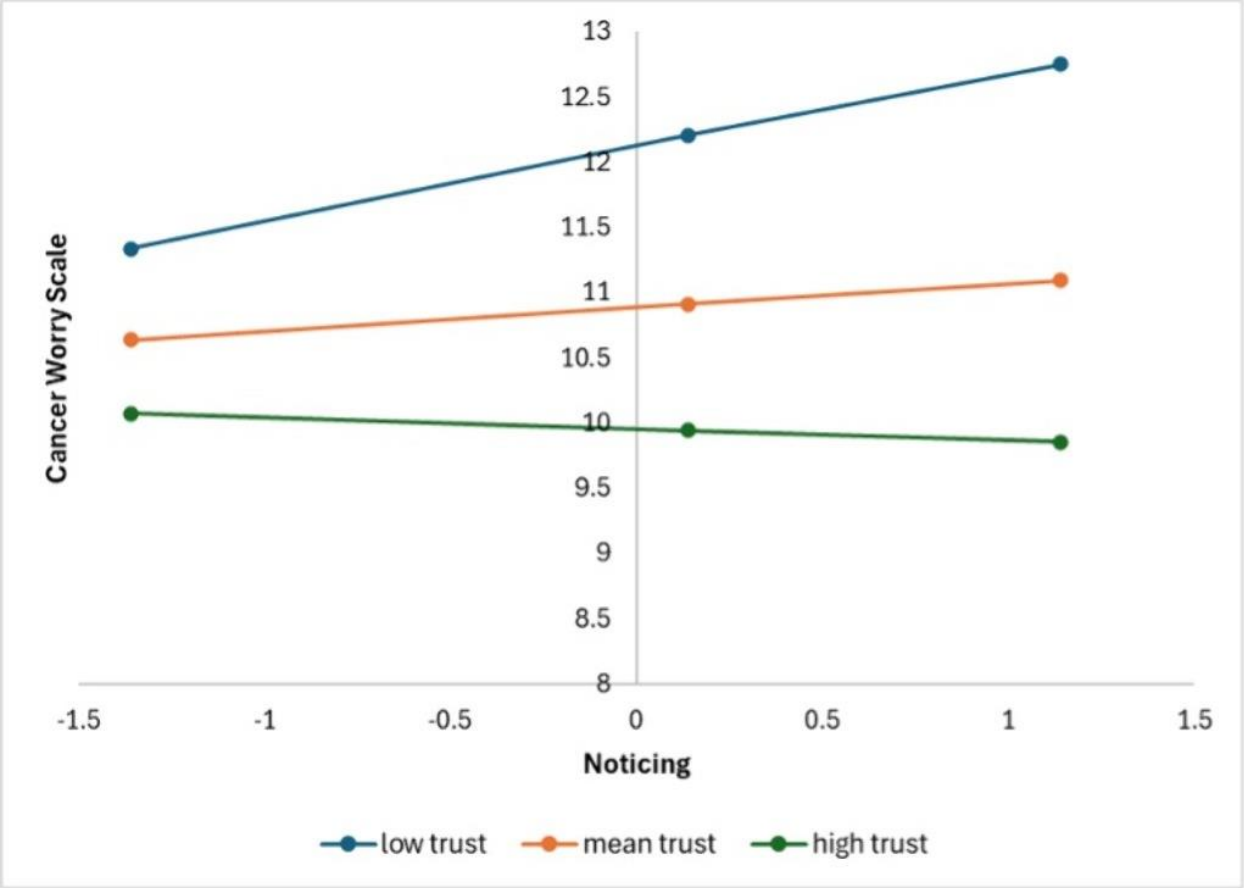
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Introduction: Fear of cancer recurrence (FCR) is a significant burden for survivors. Interoception, the perception of internal bodily signals, can manifest as either adaptive awareness or maladaptive hypervigilance. We investigated whether "body trust" moderates the relationship between interoceptive noticing and FCR in gynecologic and breast cancer survivors.

Methods: Survivors (n=215; 47% response rate) from two cohort studies at the University of Minnesota completed a one-time follow-up survey including the Multidimensional Assessment of Interoceptive Awareness (MAIA-2) and the Cancer Worry Scale. We utilized multiple linear regression to test for a moderation effect between the "noticing" (awareness of sensations) and "trusting" (viewing the body as safe) subscales on FCR. Models were adjusted for age, cancer stage, cancer type, and treatment status at time of follow-up survey.

Results: Participants had a median age of 65 (range 34-93 years) and were a median of 6 years post-diagnosis (36.7% breast, 8.4% cervical, 31.2% endometrial, 20.5% ovarian, 3.3% vaginal/vulvar). Over half (61%) were not currently receiving cancer-directed therapy. Moderation analysis revealed a significant interaction between noticing and trust (b = -0.27 [95% CI: -0.52, -0.02]). For survivors with low body trust, increased noticing of bodily sensations was strongly associated with higher FCR. Conversely, for survivors with high body trust, the relationship between noticing and FCR was attenuated, suggesting a

buffering effect (Figure 1).



Conclusion/Implications: Interoceptive noticing is not inherently maladaptive but varies depending on body trust. Rebuilding body trust may be an important treatment target in psychotherapy for reducing FCR in gynecologic and breast cancer survivors.

EP145 / #32

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

ADHERENCE TO POST-TREATMENT SURVEILLANCE AMONG GYNECOLOGIC CANCER PATIENTS IN RWANDA: A MIXED-METHODS STUDY FROM TWO TERTIARY HOSPITALS

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Introduction: Post-treatment surveillance is essential for early detection of recurrence and management of complications in gynecologic cancer survivors. Data on adherence to surveillance in low- and middle-income countries, including Rwanda, are limited.

Methods: We conducted a retrospective explanatory sequential mixed-methods study among gynecologic cancer patients treated between January 2021 and December 2023 at two tertiary hospitals in Rwanda. Surveillance adherence was assessed using electronic medical records, with optimal adherence defined as ≥80% attendance of scheduled visits. Multivariate logistic regression identified predictors, and in-depth interviews explored barriers to follow-up.

Results: A total of 122 patients met inclusion criteria. Cancer types included ovarian (38.5%), gestational trophoblastic neoplasia (23%), endometrial (18%), cervical (15.6%), and vulvar cancers (4.9%). Overall attendance to recommended surveillance visits was 61%, with only 49 patients (40.2%) achieving optimal adherence. Younger age (<30 years) was independently associated with optimal adherence (adjusted OR 3.61; 95% CI 1.18–9.65; p=0.023), as was absence of medical comorbidities (adjusted OR 2.84; 95% CI 1.06–6.83; p=0.038). Qualitative interviews revealed financial constraints, long travel distances to tertiary facilities, limited patient education on the importance of surveillance, and prolonged clinic waiting times as major barriers.

Conclusion/Implications: Adherence to post-treatment surveillance among gynecologic cancer patients in Rwanda is suboptimal, particularly among older patients and those with comorbidities. Decentralized surveillance models, enhanced patient education, and cost-mitigation strategies may improve follow-up adherence and survivorship outcomes in resource-limited settings

EP146 / #781

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

CO-DESIGNING A PATIENT-INFORMED PRAGMATIC CLINICAL TRIAL: AN OVARIAN CANCER CANADA AND SOCIETY OF GYNECOLOGIC ONCOLOGISTS OF CANADA INITIATIVE

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Introduction: The Society of Gynecologic Oncologists of Canada (GOC) convened a multistakeholder workshop to advance pragmatic clinical trials (PCTs) addressing patient and clinician priorities. We describe an Ovarian Cancer Canada's (OCC) Patient Partners in Research (PPiR) and GOC initiative to identify and prioritize patient-generated research questions, supporting the co-development of a patient-informed PCT framework.

Methods: We initially distributed a survey to OCC's patient community to identify priority research questions. Survey responses were thematically analyzed and synthesized into key concepts. These concepts were presented and refined at the GOC PCT workshop and further informed OCC's National Symposium PCT session (October 2025). Final prioritization was completed through two PPiR focus groups (March-April 2026).

Results: Through the survey (n=27 responders), six priority areas were identified including: real-world patient representation (26%), systemic toxicity (22%), communication (11%) and holistic care (11%). Patients and caregivers participated in the OCC National Symposium (n=164 participants), where additional input refined PCT concepts, including paclitaxel hypersensitivity reaction management (subsequent substitution of native paclitaxel to nab-paclitaxel following G2 reactions), paclitaxel treatment duration/de-escalation in platinum resistant ovarian cancer, menopause interventions, and neuropathy management. The OCC PPiR team (n=21 participants) reviewed and prioritized proposals, selecting paclitaxel hypersensitivity reaction and menopause symptoms for PCT pilot development. National surveys have been distributed to clinician and pharmacists to assess feasibility and clinical equipoise.

Conclusion/Implications: This co-design process generated patient-prioritized PCT concepts through an iterative engagement pathway and supports the development of a patient-informed PCT framework. A study subcommittee, including embedded patient partners, has been established to advance pilot PCT trial development.

EP147 / #366

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

ENHANCING PATIENT-CENTERED PREVENTIVE CARE: A VIRTUAL SPECIALIZED CLINIC FOR INDIVIDUALS AT INCREASED GENETIC RISK FOR OVARIAN CANCER

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Introduction: Individuals with pathogenic variants in ovarian cancer susceptibility genes (e.g., *BRCA1/2, RAD51C/D, BRIP1, PALB2*) are recommended to undergo risk-reducing salpingo-oophorectomy (RRSO) at gene-specific ages. Despite clear guidelines, uptake and timing remain inconsistent. RRSO induces surgical menopause with long-term health effects and fertility loss. Ovarian Cancer Canada conducted surveys (n=42) and interviews (n=19) in non-specialized Canadian care settings. Survey respondents reported satisfaction with healthcare provider communication regarding hormone replacement therapy (HRT) (38%), bone and cardiovascular health (33%), and fertility options (7%). Among interviewees, 42% underwent guideline-timed RRSO. The Gynecologic Cancer Prevention and Survivorship Clinic (GCPSC) is a virtual, province-wide specialized care model providing counselling, care coordination, and survivorship support for high-risk individuals. This study evaluates patient experience, satisfaction, and adherence to RRSO guidelines within the GCPSC.

Methods: This mixed-methods study included 146 GCPSC patients (2021–2025) and interviews (n=14). Adherence to age-specific RRSO guidelines was assessed, and thematic analysis explored experiences across genetic testing, counselling, surgical decision-making, and survivorship.

Results: Among 146 patients, 68 (47%) were referred early enough for guideline-timed RRSO, while 78 (53%) were referred at or beyond the recommended age but underwent surgery within one year. This indicates delays were driven by late referral to specialized care, rather than clinic processes. Interviewees (n=14) showed high satisfaction (100%) with structured, personalized virtual care and strong post-operative support for menopause and HRT management.

Conclusion/Implications: This work highlights the value of a scalable, virtual, province-wide specialized care model to improve coordinated, patient-centered prevention care for high-risk individuals and may inform development of additional specialized centres.

EP148 / #1018

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

PATIENT ATTITUDES TO GYNAECOLOGICAL RAPID ACCESS, CANCER EXCLUSION AND FOLLOW UP LOCATION (GRACEFUL STUDY)

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Introduction: Background: Gynaecological oncology care is often delivered with other women's and children's services. This can have significant impact, as nulliparity is a risk factor and many treatments cause infertility. Delivering care alongside obstetric and other gynaecological services may cause under-recognised and avoidable psychological harm to a significant proportion of patients.

Objectives: Objectives: To investigate the experience of care location on gynaecological oncology patients, to inform future design of services around patient needs.

Methods: Methods: A mixed methods study collecting data via an online UK-wide survey in >300 participants. Quantitative analysis and qualitative thematic analysis of responses.

Current Status & Future Directions: Results: 357 participants to date (median age 60 – 69 years). 257 (72%) participants had a confirmed cancer diagnosis (uterine 118; ovarian 65; cervical 17; vulval 45; vaginal 2; other 11). Only 29.5% agreed that they would be happy to be seen in an O&G setting, whilst two-thirds (67.3%) would prefer to be seen elsewhere. Futher statistical and qualitative data will be presented. **Discussion:** Our work has shown that the importance of place of care is under-recognised and many patients received care in environments that add to their distress. We are conducting semi-structured interviews with ~25 participants to explore experiences in depth using qualitative analysis. We aim to provide framework to inform immediate and medium-term changes to the design, location and/or scheduling and design of services. This work is important as we currently ignore significant and unmet needs of our patients in terms of location of care, and needlessly add to the distress of many.

EP149 / #703

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

PELVIC LATE EFFECTS AND HEALTH-RELATED QUALITY OF LIFE AMONG ENDOMETRIAL CANCER SURVIVORS

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Introduction: Endometrial cancer survivorship is often complicated by treatment-related pelvic morbidity—such as bowel and bladder dysfunction and lymphedema—that may impair quality of life. However, the extent to which these symptoms co-occur and their combined impact during early survivorship remain unclear. We investigated cross-sectional associations between pelvic symptom domains—both individually and as a composite multi-domain measure—and health-related quality of life.

Methods: Analyses included women (N=562) from the ongoing population-based Carolina Endometrial Cancer Study who completed a follow-up questionnaire at 18 months post-diagnosis. Pelvic symptoms were defined using validated measures with established or cohort-based thresholds. Using general linear models adjusted for demographic, clinical, and treatment factors, we estimated associations between individual symptom domains (bowel dysfunction, bladder dysfunction, lymphedema) and a multimorbidity measure (number of affected domains) and PROMIS Global Physical and Mental Health T-scores.

Results: Based on study-defined criteria, 35% of participants had lymphedema, 29% had bowel dysfunction, and 32% had urinary dysfunction; 30% experienced symptoms in ≥2 domains. Each domain was independently associated with lower physical and mental health scores, with the largest decrements observed for lymphedema (adjusted mean differences: −7.8 [95% CI: −9.0, −6.6], physical; −4.2 [95% CI: −5.6, −2.9], mental). There was a clear dose-response relationship with each additional domain associated with a 3.5-

point decrease in physical health and a 2.2-point decrease in mental health.

PROMIS Global Physical and Mental Health t-scores according to pelvic late effects measures among included CECS participants (N=562)

	Observed data		Imputed data	PROMIS Physical Health			PROMIS Mental Health		
	N	%	%	Mean (SD)	Unadjusted Mean Difference (95% CI)	Adjusted Mean Difference (95% CI)*	Mean (SD)	Unadjusted Mean Difference (95% CI)	Adjusted Mean Difference (95% CI)*
Lymphedema (GCLQ ≥4)									
No	303	65%	63%	52.2 (7.2)	Ref	Ref	51.2 (8.1)	Ref	Ref
Yes	165	35%	37%	42.7 (7.9)	-9.1 (-10.3, -7.8)	-7.8 (-9.0, -6.6)	46.2 (8.0)	-5.0 (-6.4, -3.7)	-4.2 (-5.6, -2.9)
Bowel dysfunction (CRADI-8 ≥75th percentile)									
No	395	71%	71%	50.6 (7.6)	Ref	Ref	50.6 (8.0)	Ref	Ref
Yes	159	29%	29%	44.7 (9.1)	-5.7 (-7.2, -4.2)	-4.2 (-5.6, -2.7)	47.1 (8.8)	-3.3 (-4.9, -1.8)	-2.3 (-3.8, -0.8)
Urinary dysfunction (UDI-6 ≥75th percentile)									
No	379	68%	68%	50.5 (8.1)	Ref	Ref	50.8 (8.3)	Ref	Ref
Yes	175	32%	32%	45.4 (8.5)	-4.7 (-6.1, -3.2)	-3.5 (-4.9, -2.1)	47.0 (8.0)	-3.7 (-5.1, -2.2)	-3.2 (-4.6, -1.7)
Number of domains affected									
0	205	44%	42%	53.4 (7.0)	Ref	Ref	51.9 (7.8)	Ref	Ref
1	129	28%	27%	47.8 (7.6)	-5.5 (-7.0, -4.0)	-4.8 (-6.2, -3.3)	48.8 (8.4)	-3.3 (-5.0, -1.7)	-2.8 (4.3, -1.2)
2	87	19%	21%	44.2 (7.3)	-8.0 (-9.6, -6.4)	-6.9 (-8.5, -5.3)	47.3 (8.1)	-4.2 (-6.0, -2.5)	-3.5 (-5.3, -1.8)
3	41	9%	9%	39.9 (9.4)	-13.3 (-15.5, -11.1)	-10.7 (-12.9, -8.5)	43.3 (7.5)	-9.1 (-11.5, -6.7)	-7.7 (-10.1, -5.3)
per additional domain					-4.3 (-4.9, -3.6)	-3.5 (-4.1, -2.9)		-2.6 (-3.3, -2.0)	-2.2 (-2.9, -1.5)

NOTE: Means (SD) are based on the observed analytic sample. Unadjusted and adjusted mean differences were estimated using general linear models fit within multiply imputed datasets to account for missing data, with estimates combined using Rubin's rules.

*Adjusted for age, race, BMI, histology, Charlson score, education, income, radiation, lymph node assessment

Conclusion/Implications: Pelvic late effects are associated with clinically meaningful reductions in quality of life, particularly when multiple domains co-occur, highlighting the need for comprehensive assessment and targeted supportive care.

EP150 / #1148

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

ASSESSING THE BURDEN OF CARE AND THE UNMET NEEDS OF PRIMARY CAREGIVERS OF WOMEN WITH GYNAECOLOGICAL CANCERS IN LAGOS, NIGERIA: A PILOT STUDY

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Introduction: The burden of care of cancer patients is largely borne by the primary caregivers and family members in Nigeria. This puts tremendous pressure on caregivers which invariably impacts their quality of life and that of the cancer patients. In the absence of data on the unmet needs experienced by primary caregivers in Nigeria, we aimed to assess these unmet needs and the severity of the burden of care they bear to provide evidence for intervention.

Methods: A cross-sectional survey conducted among primary caregivers of GC patients at the Lagos University Teaching Hospital, Lagos, Nigeria using the validate Supportive care needs survey partners & caregivers (SCNS P&C45) to assess unmet needs of caregivers. Similarly, the Zarit Scale of Caregiver Burden instrument was used to assess the burden of care of caregivers. Data was analyzed using SPSS version 25.

Results: The three priority unmet needs among primary caregivers were “Finding out about financial support and government benefits for you and/or the person with cancer” (65.5%), “Obtaining the best medical care for the person with cancer” (56.4%), and “The impact that caring for the person with cancer has had on your working life, or usual activities” (56.4%). Majority, 40.4% experienced zero to mild burden.

Conclusion/Implications: While majority of primary caregivers experienced zero to mild burden of care, their priority unmet needs included seeking financial and government support, getting the best medical care for cancer patients and impact on working life. Addressing these needs will further reduce the burden of care experience by caregivers.

EP151 / #1150

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

ASSESSING THE UNMET NEEDS OF WOMEN WITH GYNAECOLOGICAL CANCERS IN LAGOS, NIGERIA: A PILOT STUDY

Adeyemi Okunowo[1], Temitope Adekanye[2], Olufunsho Naiyeju[2], Aanuoluwa Edema[2], Robert Adieme[2], Margaret Obienu[2], Ekene Uchechukwu[3], Ayomidipupo Shobakin[2], Khadijah Jimoh[3], Esther Afiawari[3], Oluwatoyin Awosemo[3], Roseline Tunjibello[3], Babak Litkouhi[4], Lidia Schapira[5]

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Introduction: The needs of women with Gynaecological cancers (GC) are largely unknown in our environment due to the dearth of research on the subject matter. As a result, this has negatively impacted their quality of life (QoL) & health outcomes. We sought to investigate & prioritize the unmet needs that women with GC encounter with the aim of identifying and prioritizing their unmet needs for appropriate intervention.

Methods: A cross-sectional survey conducted at the Lagos University Teaching Hospital, Lagos, Nigeria among 57 women with GC using the validate supportive care needs survey – long form 59 (SCNS-LF59) to assess unmet needs of the participants. Need items were analyzed using SPSS version 25 and items with moderate & high needs were considered priority needs.

Results: Majority of the women had ovarian cancer (25, 43.9%), endometrial cancer (15, 26.3%) and cervical cancer (10, 17.5%). The most prevalent priority needs were in the health system and information need domain with “Having one member of hospital staff with whom you can talk to about all aspects of your condition, treatment and follow-up” (63.2%) and “Having access to professional counselling accounting for 63.2% and 57.9% respectively. “Concerns about your financial situation accounts for 56.1%.

Conclusion/Implications: Priority needs of GC patients are opportunity to discuss freely with oncology healthcare providers on all aspects of their care, having access to professional counselling and dealing with financial toxicity. Targeted interventions to

address these priority needs will significantly improve their quality of life and health outcomes.

EP152 / #648

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

FACTORS INFLUENCING THE DECISION TO UNDERGO CONCURRENT HYSTERECTOMY AT RISK-REDUCING SALPINGO-OOPHORECTOMY IN WOMEN WITH HEREDITARY RISK FOR GYNECOLOGIC CANCER

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Introduction: Risk-reducing salpingo-oophorectomy (RRSO) is recommended for women with hereditary breast/ovarian cancer risk, including BRCA1/2 carriers and those with a strong family history. The role of concurrent hysterectomy remains controversial and individualized. This study aimed to identify factors associated with choosing hysterectomy at the time of RRSO.

Methods: This retrospective cohort study included consecutive women with confirmed or suspected hereditary cancer risk who underwent RRSO with or without hysterectomy at a tertiary center (2021–2025). All patients received standardized preoperative counseling regarding risks and benefits. Demographic, clinical, genetic, and surgical data were collected. The primary outcome was the choice of concurrent hysterectomy. Multivariable logistic regression identified independent predictors.

Results: Among 220 women, 31 (14.1%) underwent hysterectomy and 189 (85.9%) RRSO alone. Baseline characteristics were comparable between groups. BRCA1/2 mutations were present in 83.7%, and 31.8% had a personal cancer history. Addition of hysterectomy increased operative time by 1.87-fold compared with RRSO alone. Complication rates were low and comparable between groups. On multivariable analysis, factors associated with higher likelihood of hysterectomy included BRCA1 mutation status (OR 5.44, 95% CI 1.7–17.1, $p<0.01$), personal cancer history (OR 10.36, 95% CI 1.2–85.7, $p=0.03$), abnormal uterine bleeding or abnormal Pap test (OR 6.07, 95% CI 1.2–30.1, $p=0.02$), and counseling by a gynecologic oncologist (vs. gynecologist) (OR 18.9, 95% CI 2.1–165.7, $p<0.01$). Age, parity, menopausal status, and family history were not associated with the decision.

Conclusion/Implications: Despite standardized counseling, the decision to add hysterectomy is influenced by genetic and modifiable factors, particularly the counseling provider, highlighting the importance of individualized counseling.

EP153 / #505

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

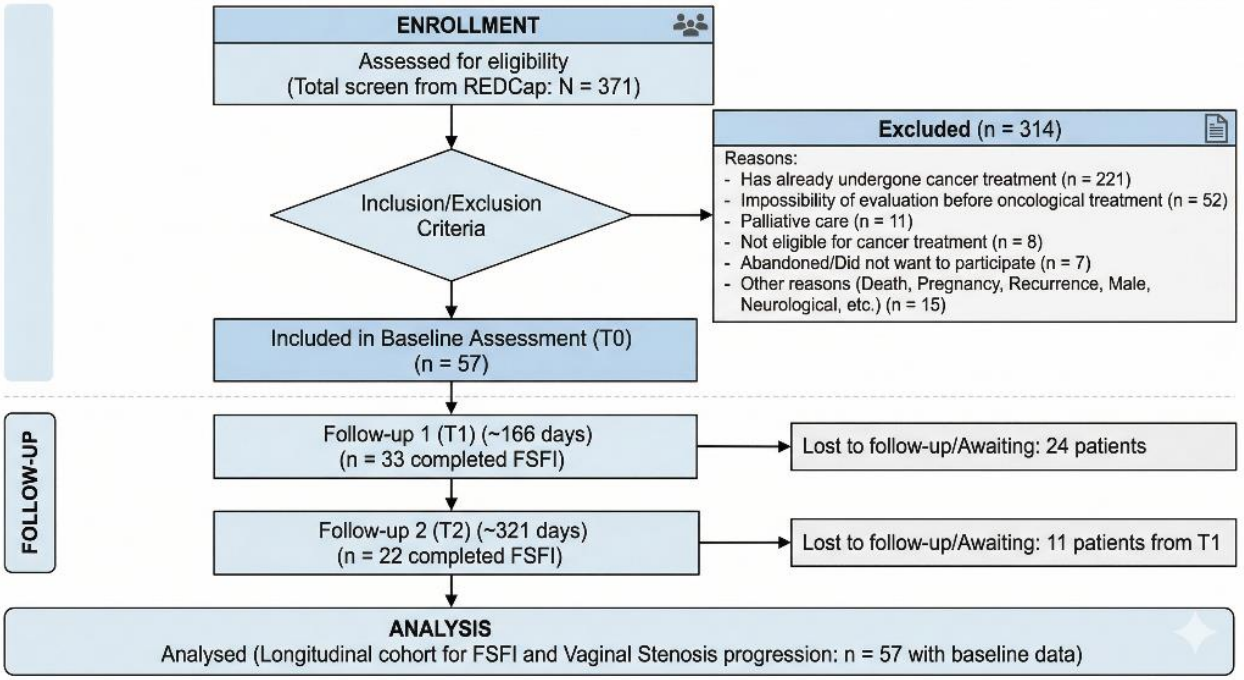
MULTIDIMENSIONAL PELVIC FLOOR DYSFUNCTION IN CERVICAL CANCER: A PROSPECTIVE LONGITUDINAL COHORT FROM PRE-TREATMENT DIAGNOSIS TO SURVIVORSHIP.

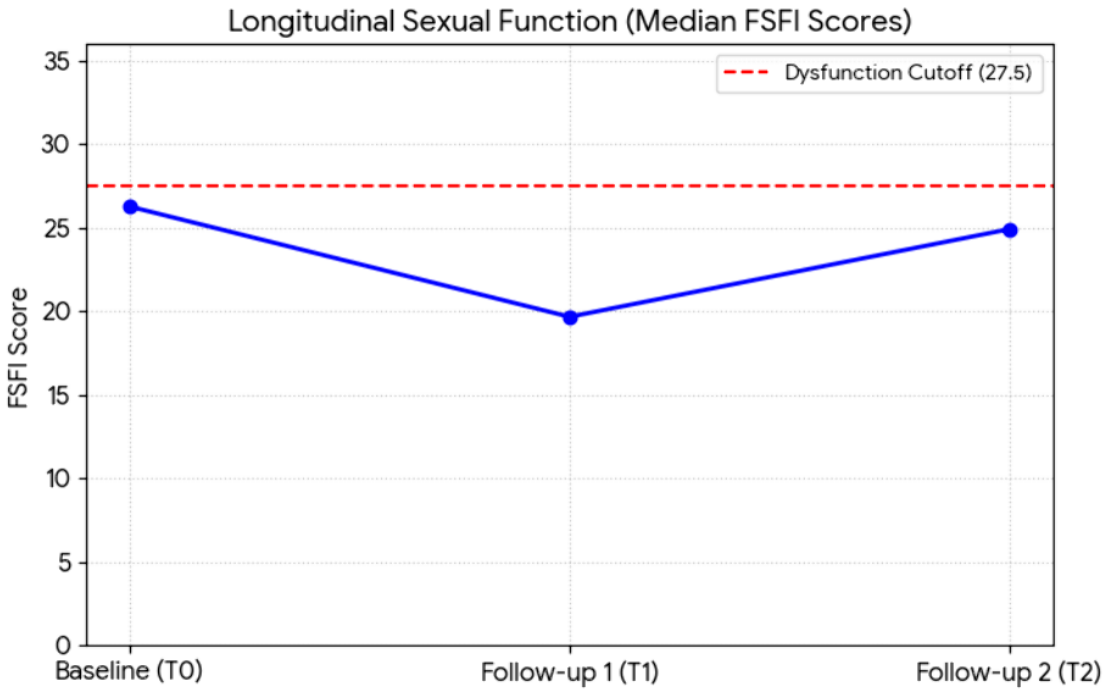
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Introduction: Pelvic floor dysfunction (PFD) is a frequent consequence of cervical cancer treatment, yet its natural history from diagnosis remains poorly characterized. This study aimed to evaluate the longitudinal progression of sexual function, vaginal patency, and pelvic floor muscle (PFM) function from diagnosis through follow-up.

Methods: A prospective cohort followed 57 women (median age 41) newly diagnosed with invasive cervical carcinoma at HCRP-USP, Brazil. Assessments occurred at diagnosis (T0), ~5 (T1), and ~10 months (T2) post-treatment. Outcomes included sexual function (FSFI), PFM strength (Modified Oxford Scale) and endurance (seconds), urinary incontinence, and vaginal stenosis (LENT-SOMA). Longitudinal changes were analyzed via Friedman and Wilcoxon tests ($p < 0.05$). Trial registration: RBR-10jjsm26.

Results: At diagnosis, 56% of patients presented with sexual dysfunction. Sexual function deteriorated post-treatment, with median FSFI scores declining from 27.3 (T0) to 10.8 (T1), with partial recovery at T2 (15.4; $p < 0.001$). Vaginal stenosis (grade 2–3) developed in 42% of patients by T2. PFM endurance decreased from 5s at baseline to 4s at T1 ($p < 0.05$), while muscle strength remained stable. Urinary incontinence was prevalent at baseline (52%) and persisted throughout follow-
up.





Conclusion/Implications: Women with cervical cancer exhibit significant pelvic floor impairment at diagnosis, which deteriorates rapidly and multidimensionally post-treatment. This high baseline prevalence identifies pelvic floor dysfunction as an overlooked pre-existing morbidity. These findings highlight a critical window for pre-

habilitation, including early counseling and physiotherapy, to mitigate treatment-related morbidity and enhance long-term survivorship outcomes.

EP154 / #758

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

CHAMPIONING THE PATIENT VOICE IN PERI-OPERATIVE CARE: A PATIENT REPORTED OUTCOMES PRIORITY SETTING WORKSHOP WITH OLDER ADULTS.

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Introduction: Older adults (65+) represent a large proportion of gynecologic oncology surgical patients. They often have chronic co-morbid conditions and experience worse side effects following a surgical procedure, including those related to anesthesia. Patient reported outcome measures (PROMs) are vital to capturing the patient's perspectives about anesthesia and surgery related side-effects, however we lack guidance in Canada on which PROMs to utilize with older adults.

Methods: To prioritize perioperative PROMs for older adults, a literature review was conducted, and questionnaires which were free, widely used, and had broad surgical applicability were identified. We then organized a workshop with relevant stakeholders (older adults with surgical experience, caregivers, surgeons, anesthesiologists, geriatric and community healthcare providers, researchers, and policy makers). Guided by a professional facilitator, the workshop prioritized surveys from three categories (Satisfaction with Anesthesia, Quality of Recovery, and Quality of Life) and discussed their optimal timing and delivery methods.

Results: 30 participants attended our 8-hour PROMs Priority Planning Workshop. The highest-rated surveys were The Bauer Survey (Satisfaction with Anesthesia) and the Quality of Recovery-15 survey. Both the EQ5D-5L and PROMIS-10 surveys were ranked highly for measuring Quality of Life. Recommended administration of PROMS varied based on survey type but often included pre-and post- surgery collection. Electronic surveys and telephone calls were the preferred delivery options.

Conclusion/Implications: We describe a process for prioritizing PROMs collection with an aim to provide better care for older adults undergoing surgery. These findings have

informed a pilot study collecting PROMs data for older adults undergoing gynecologic oncology surgery.

EP155 / #26

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

PREDICTORS OF FAILED SAME-DAY DISCHARGE AFTER MINIMALLY INVASIVE HYSTERECTOMY FOR GYNECOLOGIC MALIGNANCY: REAL-WORLD DATA FROM QUÉBEC

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Introduction: Enhanced Recovery After Surgery (ERAS) pathways and the widespread use of minimally invasive surgery (MIS) have made same-day discharge increasingly feasible in gynecologic oncology. However, translation into routine practice remains variable and data from Canadian programs are limited.

Methods: We conducted a retrospective cohort study of consecutive patients undergoing laparoscopic or robotic hysterectomy between January 2022 and October 2024 who were planned for outpatient management with attempted same-day discharge. Demographic, perioperative, and surgical factors were extracted through manual chart review. Failed same-day discharge was defined as unplanned postoperative admission. Descriptive and comparative statistics were used to identify patient and operative characteristics associated with admission or readmission.

Results: A total of 159 hysterectomies were analyzed (laparoscopic 67.3%, robotic 32.7%). Median age was 60 years (IQR 52–67) and median BMI 30.3 kg/m^2 (IQR 23.8–35.4). Endometrial cancer accounted for 60.5 % of cases. Same-day discharge was successful in 92.5%; 12 patients (7.5%) required overnight admission. Within 30 days, 5.7% presented to the emergency department and 3.8% were readmitted. Patients who failed same-day discharge had a higher BMI (36.9±8.1 vs 30.1±7.5kg/m^2, p=.003) and were more frequently ASA class 3 (50.0% vs 14.9%, p=.008). Operative complexity (lysis of adhesions) showed no significant association.

Conclusion/Implications: Same-day discharge after MIS hysterectomy for gynecologic malignancy was achieved in more than 90% of patients, with low readmission rates. Higher BMI and ASA≥ 3 independently predicted failed discharge. Incorporating these factors into

preoperative counseling and discharge planning may enhance safety and efficiency as same-day pathways expand across Canadian oncology programs.

EP156 / #801

Topic: *AS04. Patient-Centered Care / AS04c. Patient Advocacy & Survivorship*

TRANSFORMING THE COLPOSCOPY EXPERIENCE THROUGH PATIENT-CENTERED EDUCATION: A PATIENT EDUCATION QI INITIATIVE IN COLPOSCOPY THROUGH THE DEVELOPMENT OF ONLINE TOOLS TO IMPROVE PATIENT EXPERIENCE

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Introduction: Patients with abnormal cervical screening tests are anxious because of a potential cancerous lesion and limited patient-facing information. In March 2025, the change in cervical screening guidelines highlighted the need for updated patient educational material. This quality improvement (QI) initiative aims to assess the patient experience and improve it through educational resources for patients attending colposcopy appointments.

Methods: A pre-intervention survey was completed by patients prior to their appointment, aiming to assess patients' current understanding of HPV infections. An online education video series explaining relevant concepts was then developed with community partners and the Mississauga Halton Central West Regional Cancer Program (MHCW RCP) and shared. Then, a post-intervention survey was implemented to compare and assess the effectiveness of the resources in addressing anxiety and the identified knowledge gaps.

Results: Primary outcomes highlight that 16.1% of patients were unsure about HPV causing cancer and 25.4% of patients incorrectly defined colposcopy. The mean confidence scores using the Likert scale 1(strongly disagree) – 7 (strongly agree) were 4/7 (67%) for understanding colposcopy is and 2/7 (87%) for understanding what the LEEP procedure is. 74% of patients reported they received insufficient information prior to their visit (3/7) and 63.3% of patients indicated that a website would have helped inform them before their visit.

Conclusion/Implications: Preliminary data demonstrate significant gaps in patients' understanding of HPV concepts and patients indicate a need for educational resources. This QI initiative seeks to address these gaps through targeted educational tools, aiming to improve patient knowledge, anxiety, and foster a patient-centered approach to care.

EP157 / #1093

Topic: *AS05. Prevention & Early Detection / AS05a. Epidemiology*

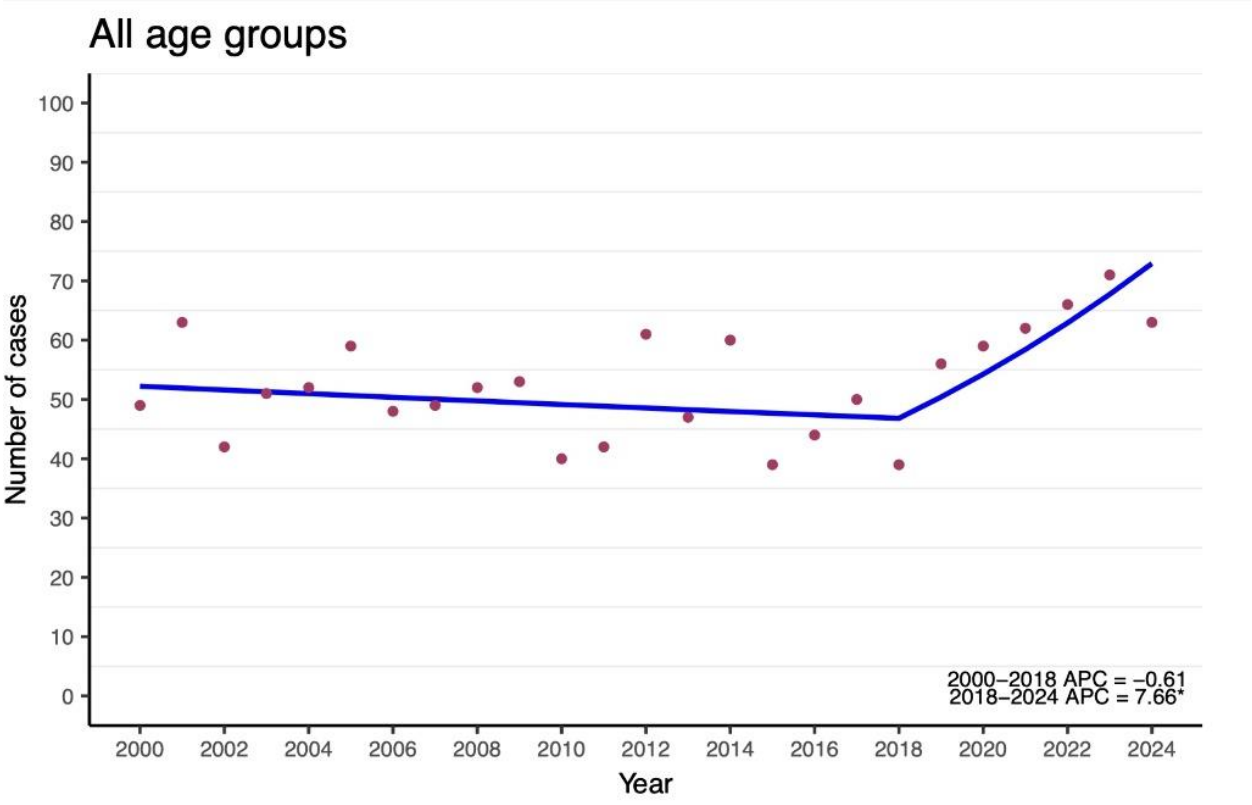
CERVICAL CANCER ELIMINATION IN MANITOBA: WHY STILL A CHALLENGE, EVEN IN HIGH-INCOME JURISDICTIONS?

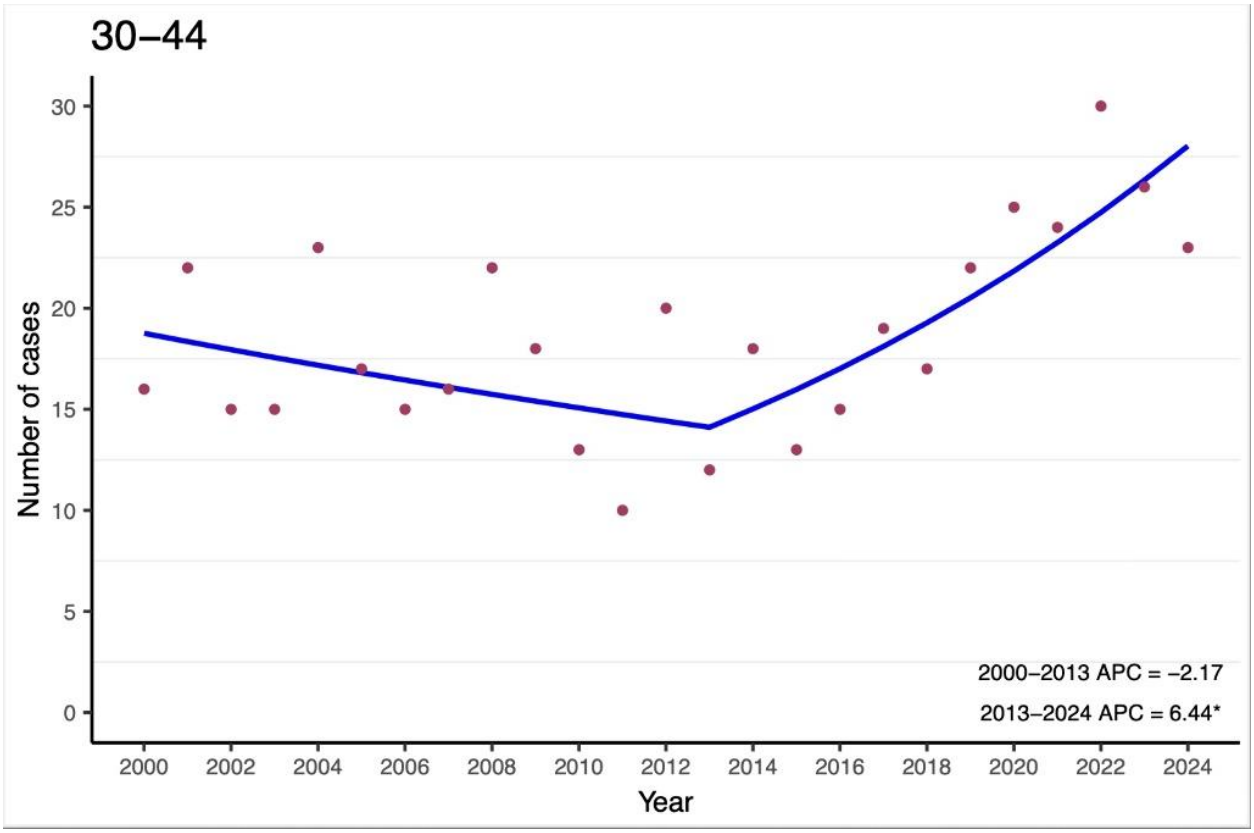
Hailey Benoit[1], Donna Turner[2], Grace Musto[3], Rachel Girimonte[3], Iresha Ratnayake[3], Kelly Brown[3], Sheila Fukumura[3], Carrie O'Conaill[3], Oliver Bucher[3], Kelly Benzulek[3], Pascal Lambert[3], Kathleen Decker[2], Sarah Kean[4]
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Introduction: The World Health Organization aims to eliminate cervical cancer by 2030, yet in Canada, reports show cervical cancer incidence increasing despite Human Papilloma Virus (HPV) vaccination and cervical cancer screening. This study aims to assess whether cervical cancer incidence is rising in Manitoba and help understand why.

Methods: Joinpoint was used to analyze cervical cancer incidence data (2000-2024) from the Manitoba Cancer Registry. Registry data plus chart review were used to explore possible contributing factors. Preliminary analysis focusing on age, immigration and health history in the recent, high-incidence timeframe has been completed.

Results: Cervical cancer incidence in Manitoba has risen since 2018, with a +7.66 annual percent change (APC) ($p<0.05$) in the number of women diagnosed with invasive cervical cancer and a non-significant (NS) +5.5% APC in age-standardized rates. However, rates are decreasing in the oldest and youngest age groups (60+, APC -2.37% ($p<0.05$); ages <30, APC -1.14% (NS)), indicating that the challenge lies in the middle-age groups (ages 30-59). Chart review of a sample of women diagnosed with cervical cancer in 2020-2022 (n=139) show 6.5% were newcomers/required language interpreters, 42.5% had a history of smoking, 7.2% had a history of substance use disorder, and 6.5% had a history of sexually transmitted
infection.


All age groups
Number of cases
Year
2000–2018 APC = –0.61
2018–2024 APC = 7.66*


30–44
Number of cases
Year
2000–2013 APC = –2.17
2013–2024 APC = 6.44*

Conclusion/Implications: Cervical cancer incidence is rising in Manitoba for reasons not fully understood. Cancer registry data contribute significantly to identifying opportunities for new, targeted control strategies. While not fully explaining the increase in incidence, these findings will help focus local prevention and screening interventions.

EP158 / #956

Topic: *AS05. Prevention & Early Detection / AS05a. Epidemiology*

OVARIAN CARCINOMA FOLLOWING OPPORTUNISTIC SALPINGECTOMY IN ONTARIO, CANADA

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Introduction: Opportunistic salpingectomy (OS), the removal of fallopian tubes during hysterectomy or instead of tubal ligation, is recommended to reduce ovarian cancer risk. We examined ovarian cancers arising in people who underwent OS compared to those who had hysterectomy alone or tubal ligation.

Methods: This population-based retrospective cohort included individuals aged 18–80 in Ontario, Canada, who underwent OS or comparison surgeries (hysterectomy with ovarian and tubal conservation or tubal ligation) from 2011 to 2023. Hazard ratios and 95% confidence intervals were estimated using Cox proportional hazards regression. Sensitivity analyses varied the time between surgery and cancer diagnosis to account for pre-existing lesions.

Results: Among 196,839 individuals, 57,941 underwent OS and 138,898 underwent comparator surgeries. During follow-up, 142 epithelial ovarian cancers were diagnosed, with 19 in the OS group and 123 in the comparison group. OS was associated with a reduced risk of ovarian cancer overall, with an adjusted hazard ratio (HR) of 0.59 (95% CI = 0.35 to 0.97) compared with the comparator group. Sensitivity analyses with 12- and 18-months interval between surgery and cancer diagnosis showed adjusted hazard ratios of 0.59 (95% CI, 0.35–0.99) and 0.60 (95% CI, 0.35–1.01) for all ovarian cancers.

Conclusion/Implications: OS was associated with a reduced risk of ovarian cancer in a population where it was performed nearly exclusively for prophylaxis. This study further supports the importance of OS as an ovarian cancer risk reduction strategy, and suggests further expansion of OS could help reduce incidence of ovarian cancer

EP159 / #857

Topic: *AS05. Prevention & Early Detection / AS05a. Epidemiology*

THE INCIDENCE AND TRENDS OF UTERINE CANCER IN TAIWAN AND US GOT WORSE FROM 2001 TO 2022

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Introduction: This study focused on the incidences and trends of uterine cancer in Taiwan and U.S. from 2001 to 2022.

Methods: The U.S. Cancer Statistics 2001–2022 Public Use Research Database and the National Health Insurance Research Database in Taiwan were used to extract the deidentified data of uterine cancer. A total of 1,089,946 cases in the U.S and 42,639 cases in Taiwan were noted. SEER*Prep, SEER*Stat, and Joinpoint regression program were used to calculate the incidences and trends per 100,000. The age-adjusted incidence (AAI) was adjusted by the WHO 2000 standard population. Due to the COVID-19 outbreak, the data for 2020 in the U.S. and the data for 2021 in Taiwan were excluded in the Joinpoint regression analysis.

Results: From 2001 to 2022, the AAI of uterine cancer increased in Taiwan and US, especially in Asian population (Table 1). About three major types, adenosarcoma increased most, followed by mesenchymal cancer, and epithelial carcinoma in Taiwan and US. In epithelial carcinoma, worse cell types (serous carcinoma, clear cell carcinoma, and carcinosarcoma) increased more than endometrioid carcinoma in Taiwan and US. In this study period, the highest average age-specific incidence was 49.54/100,000 women in the 55-59 age group in Taiwan, 106.82/100,000 women in the 65-69 age group in US (Table 2).

Table 1. Age-adjusted Incidences and Trends of Uterine Cancer & Cell Type in Taiwan and US from 2001 to 2022

Uterine cancer	N	AAI 2001 to 2022	2001-2022 AAPC (95% CI)	p
Taiwan	42,639	6.30 to 18.85	5.59 (4.97 to 6.22)	<0.001
US	1,089,946	19.24 to 22.20	0.73 (0.32 to 1.14)	<0.001
US_NHW	819,121	20.27 to 21.67	0.38 (0.07 to 0.69)	0.015
US_NHB	119,176	15.87 to 23.57	2.14 (1.84 to 2.45)	<0.001
US_Hispanic	98,233	14.95 to 22.07	2.29 (2.05 to 2.54)	<0.001
US_NHAPI	39,946	12.23 to 18.51	2.33 (2.10 to 2.57)	<0.001
US_Others	13,470	31.37 to 58.77	3.07 (2.45 to 3.69)	<0.001

	Taiwan			US		
Cell type	AAI 2001 to 2022	2001-2022 AAPC (95% CI)	p	AAI 2001 to 2022	2001-2022 AAPC (95% CI)	p
Uterine cancer	6.30 to 18.85	5.59 (4.97 to 6.22)	<0.001	19.24 to 22.20	0.73 (0.32 to 1.14)	<0.001
Epithelial carcinoma	5.75 to 17.64	5.88 (5.19 to 6.58)	<0.001	18.28 to 21.17	0.75 (0.31 to 1.19)	<0.001
Endometrial carcinoma	4.56 to 14.82	6.04 (5.18 to 6.91)	<0.001	14.83 to 16.65	0.60 (0.12 to 1.07)	<0.001
Serous carcinoma	0.09 to 0.96	9.83 (8.33 to 11.34)	<0.001	0.79 to 1.81	4.30 (3.61 to 4.99)	<0.001
Clear cell carcinoma	0.14 to 0.28	4.58 (3.35 to 5.82)	<0.001	0.25 to 0.33	1.37 (0.74 to 2.01)	<0.001
Carcinosarcoma	0.26 to 0.66	4.45 (2.32 to 6.62)	<0.001	0.75 to 0.99	1.14 (0.25 to 2.04)	<0.001
Mesenchymal cancer	0.47 to 1.14	3.90 (1.41 to 6.44)	0.002	0.84 to 0.89	0.56 (0.34 to 0.78)	<0.001
Leiomyosarcoma	0.29 to 0.66	2.90 (1.92 to 3.90)	<0.001	0.44 to 0.46	0.46 (0.16 to 0.76)	<0.001
ESS	0.14 to 0.29	4.09 (0.66 to 7.65)	0.019	0.28 to 0.23	-0.77 (-1.17 to -0.37)	<0.001
Adenosarcoma	0.02 to 0.07	6.04 (0.92 to 11.43)	0.020	0.09 to 0.13	1.68 (0.79 to 2.59)	<0.001

Table 2. Age-specific Incidences and Percents of Uterine Cancer in Taiwan and US from 2001 to 2022

Uterine cancer	US		NHW		NHB		Hispanic		NHAPI		Taiwan	
Age Group	ASI	%	ASI	%	ASI	%	ASI	%	ASI	%	ASI	%
0-19											0.03	0.0%
20-29											1.37	1.2%
30-34	5.03	1.1%	4.51	0.7%	4.18	1.1%	6.82	3.0%	4.88	2.1%	5.51	2.6%
35-39	9.34	2.0%	8.93	1.5%	7.09	1.9%	11.53	4.9%	9.36	3.9%	9.77	4.8%
40-44	15.44	3.3%	15.41	2.8%	11.53	3.1%	17.26	6.7%	15.63	6.1%	17.51	8.5%
45-49	25.41	5.6%	26.27	5.0%	17.26	4.5%	25.79	8.8%	28.28	10.1%	27.76	13.0%
50-54	46.47	10.1%	49.50	9.8%	30.50	7.6%	42.70	12.4%	46.53	15.0%	42.10	18.6%
55-59	74.93	15.3%	78.51	15.2%	63.29	14.1%	66.43	15.7%	60.63	17.2%	49.54	18.9%
60-64	95.89	17.0%	97.35	17.0%	108.04	19.7%	81.41	14.9%	64.48	15.2%	41.55	13.1%
65-69	106.82	15.7%	107.59	15.9%	130.29	18.5%	90.08	12.5%	63.01	11.8%	34.02	8.4%
70-74	100.53	11.8%	101.61	12.3%	120.49	12.8%	84.14	8.7%	58.75	8.2%	27.38	5.1%
75-79	89.49	8.2%	90.90	8.8%	106.03	8.1%	71.46	5.3%	49.77	4.9%	21.57	3.0%
80-84	77.49	5.3%	79.07	5.9%	87.48	4.6%	62.06	3.1%	39.15	2.6%	18.63	1.7%
85+	56.91	4.2%	57.88	4.7%	63.77	3.3%	45.03	2.1%	30.28	1.9%	13.29	1.0%

Conclusion/Implications: The uterine cancer incidence increased in US and Taiwan, including carcinoma, mesenchymal tumor, and adenosarcoma. The worse carcinoma increased more than endometrioid carcinoma. The highest average age-specific incidence of the major cell types was younger in the Asia population.

EP160 / #646

Topic: *AS05. Prevention & Early Detection / AS05a. Epidemiology*

THE INFLUENCE OF PRE-EXISTING PSYCHIATRIC DIAGNOSES ON PROGNOSIS IN GYNECOLOGIC CANCERS: A RETROSPECTIVE COHORT STUDY

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Introduction: To evaluate whether pre-existing psychiatric diagnoses influence stage at diagnosis, treatment delivery, and survival among women with gynecologic cancers treated in a tertiary center with embedded psychiatric care.

Methods: This retrospective cohort study included women diagnosed with ovarian, uterine, or cervical cancer between 2007 and 2024 at a tertiary medical center with integrated psychiatric services. Patients with documented pre-existing psychiatric disorders, identified using ICD-9 codes, were matched 1:2 to controls without psychiatric diagnoses. Outcomes assessed included stage at diagnosis, time to treatment initiation, treatment completion, recurrence, and overall survival. Multivariable Cox proportional hazards models were used to identify independent prognostic factors, and Kaplan–Meier analyses were performed.

Results: A total of 65 women with pre-existing psychiatric disorders and 130 matched controls were included. Psychiatric diagnoses included depression or anxiety disorders (70.8%), schizophrenia (20.0%), and other psychiatric conditions (9.2%). Stage at diagnosis did not differ between groups across cancer types. Time from diagnosis to treatment initiation, treatment duration, and rates of treatment completion were comparable. Recurrence rates were similar between groups (27.7% vs. 30.0%, $p = 0.943$). In multivariable analysis, advanced disease stage (HR 4.38, 95% CI 1.97–9.77, $p < 0.001$) and older age (HR 1.05, 95% CI 1.02–1.08, $p = 0.003$) were independently associated with mortality. Psychiatric comorbidity was not associated with overall survival (HR 1.16, 95% CI 0.57–2.33, $p = 0.686$). Kaplan–Meier analysis demonstrated no significant survival difference between groups.

Conclusion/Implications: Psychiatric comorbidities were not associated with adverse oncologic outcomes when managed within an integrated psycho-oncology care model.

EP161 / #323

Topic: *AS05. Prevention & Early Detection / AS05a. Epidemiology*

THE ASSOCIATION OF PARTNERSHIP STATUS AND SURVIVAL OUTCOMES IN MELANOMA, SQUAMOUS CELL CARCINOMA, AND BASAL CELL CARCINOMA OF THE VULVA: A RETROSPECTIVE COHORT STUDY

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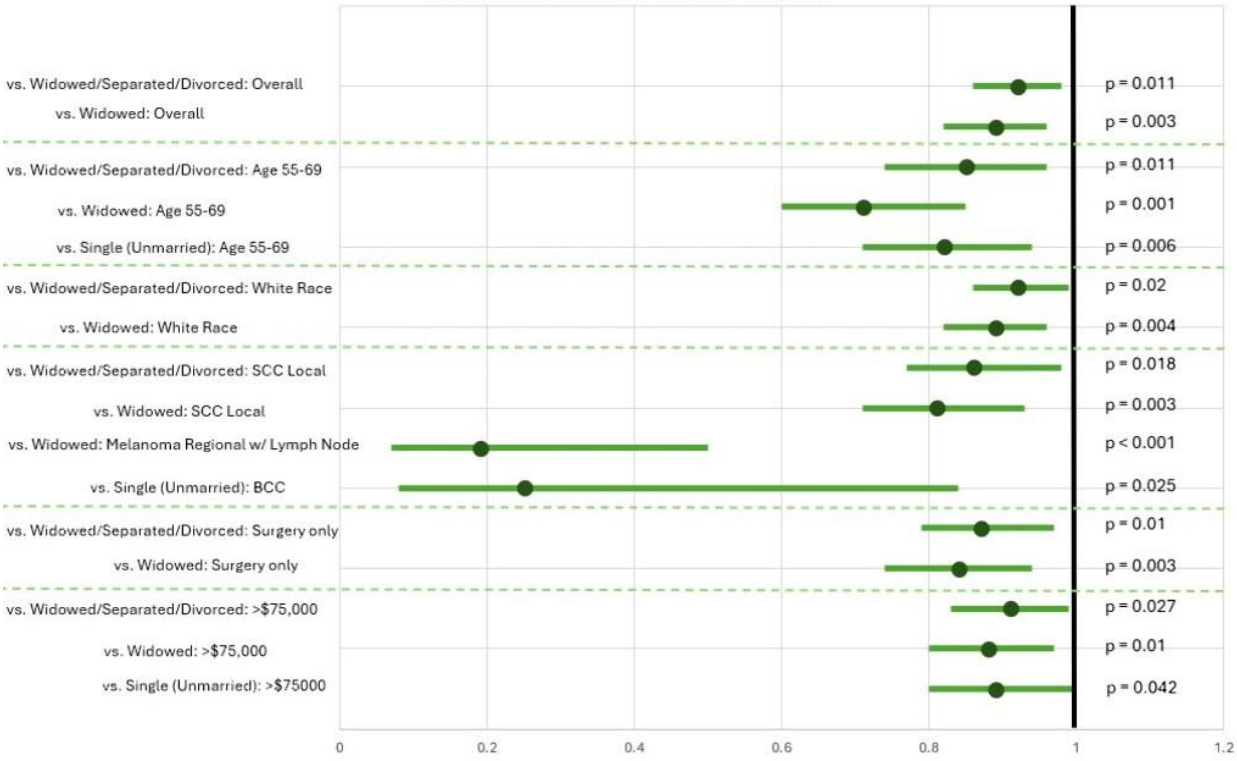
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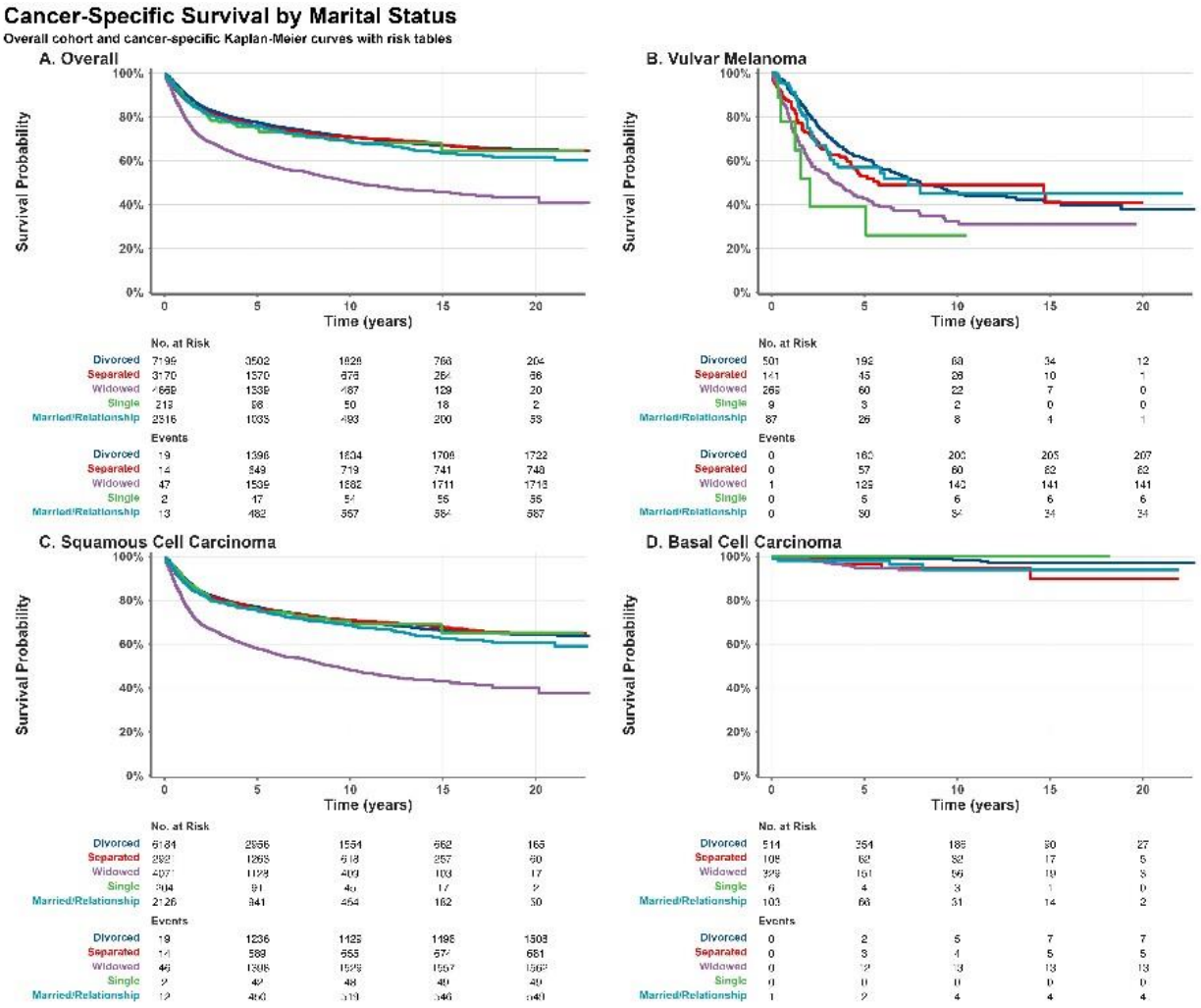
Introduction: The impact of partnership status on survival across histologic subtypes of vulvar cancer remains poorly defined. We evaluated the association between partnership status and cancer-specific survival (CSS) in vulvar melanoma, squamous cell carcinoma (SCC), and basal cell carcinoma (BCC), including variation by sociodemographic and clinical factors.

Methods: We conducted a retrospective cohort study using the Surveillance, Epidemiology, and End Results (SEER) database. Cox proportional hazards models were used to estimate hazard ratios (HRs) for CSS, and Kaplan–Meier analyses compared survival distributions across groups. Subgroup analyses were performed by age, race, income, stage, and treatment modality.

Results: Partnership was independently associated with improved CSS overall (HR 0.92; 95% CI, 0.86–0.98; p=0.011), with the greatest benefit observed in patients aged 55–69 years. Among patients treated with surgery alone, partnership remained protective (HR 0.87; 95% CI, 0.79–0.97; p=0.01). Subgroup analyses demonstrated improved CSS among White patients (HR 0.92; p=0.02) and those with income >$75,000 (HR 0.91; p=0.027). Histology-specific analyses showed a survival benefit in localized SCC (HR 0.81; p=0.003), melanoma with regional nodal involvement (HR 0.19; p<0.001), and BCC (HR 0.25; p=0.025). Widowed patients consistently experienced worse outcomes.

Figure 1. Significant Hazard Ratios for Cancer-Specific Survival in Vulvar Cancer Patients by Partnership Status and Clinical Subgroup





Conclusion/Implications: Partnership is independently associated with improved CSS in vulvar cancer, particularly curable diseases such as localized vulvar SCC or cases treated with surgery alone. Widowed vulvar cancer patients represent a population highly vulnerable to worse cancer specific outcomes compared to partnered patients. The findings highlight the importance of social support as a prognostic factor, supporting the need for targeted interventions for susceptible populations.

EP162 / #1098

Topic: *AS05. Prevention & Early Detection / AS05a. Epidemiology*

CHANGING EPIDEMIOLOGIC TRENDS IN THE INCIDENCE AND MORTALITY OF UTERINE CANCER IN YOUNG WOMEN

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Introduction: Although uterine cancer (UC) incidence is increasing, little is known about the epidemiologic factors surrounding this increase, especially among young women. This study aimed to examine changes in UC incidence and incidence-based mortality (IBM) over time by patient and tumor characteristics.

Methods: We used the Surveillance, Epidemiology and End Results (SEER) database to examine trends in UC incidence and IBM in women aged 18-50 years from 2000-2022 (excluding 2020 due to the COVID19 pandemic). Age-adjusted incidence rates were calculated per 100,000 women standardized to the 2000 US population and adjusted for changing hysterectomy rate. We used JoinPoint regression to examine temporal trends stratified by age, race, and histology and estimated average annual percent change (AAPC).

Results: There was a steady increase in UC incidence from 2000 to 2019 across all races, followed by a decrease from 2021-2022. Endometrioid histology demonstrated the largest overall increase in incidence and IBM over time (AAPC 1.19%, AAPC 2.34%, $p<0.05$). The overall AAPC for UC incidence was 0.82%. The AAPC was statistically significant at 2.24% for Hispanic women ($p<0.05$), 1.07% for non-Hispanic Black women and 0.10% for non-Hispanic White women. UC incidence increased across all age groups, however, the greatest increase was seen in young women (AAPC: 3.16% for ages 18-35 years, $p<0.05$ and 0.28% for 46-50 years, $p<0.05$). IBM increased overall (AAPC: 1.65 %, $p<0.05$) occurring primarily in Hispanic women.

Conclusion/Implications: The incidence and mortality of UC are increasing in young women. These trends disproportionately affect the youngest age groups and Hispanic women.

EP163 / #909

Topic: *AS05. Prevention & Early Detection / AS05a. Epidemiology*

THE CLINICOPATHOLOGICAL CHARACTERISTICS OF CERVICAL CANCER IN THE WETLANDS OF BORNEO, THE CAPITAL ISLAND OF INDONESIA

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Introduction: Cervical cancer (CC) remains a major public health burden worldwide, particularly in LMICs. Borneo Island, designated as the new capital island of Indonesia through the development of Nusantara Capital City, is characterized by extensive wetland ecosystems, limited healthcare accessibility, socioeconomic disparities, and potential environmental exposure to heavy metals that may influence cancer epidemiology and disease characteristics. However, data regarding CC profiles in this unique ecological setting remain limited.

Methods: A retrospective descriptive study was conducted at Ulin General Academic Hospital, Banjarmasin, Indonesia, a tertiary referral center serving the wetland regions of Borneo. Medical records of patients diagnosed with histopathologically confirmed CC between January 2020 - December 2024 were reviewed consecutively. Patients with complete clinicopathological data were included. Variables analyzed included age, body mass index (BMI), menopausal status, histopathological subtype, tumor differentiation, tumor size, disease stage, lymphovascular space invasion (LVSI), and definitive treatment. A total of 2,800 eligible patients were analyzed.

Results: The mean age was 42.33±13.70 years, aged < 55 years (72.57%). Squamous cell carcinoma was the predominant histopathological subtype (70.29%), followed by adenocarcinoma (28%). Poorly differentiated tumors 44.57% of cases, while tumors ≥4 cm were observed in 62.86%. Stage III disease was the most frequent (62.29%). Radiation therapy alone was the primary treatment modality (85.71%).

Conclusion/Implications: CC in the wetlands of Borneo commonly presents at younger ages and advanced stages. Geographic, socioeconomic, and environmental challenges may contribute to delayed diagnosis and increased disease burden, emphasizing the need for strengthened screening programs, HPV vaccination, and community-based healthcare interventions in wetland regions of Indonesia.

EP164 / #1099

Topic: *AS05. Prevention & Early Detection / AS05b. Genetics*

CLINICIAN-LED MAINSTREAMING GERMLINE TESTING: A CASCADE OF CARE APPROACH IN OVARIAN CANCER

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Introduction: The advent of PARP inhibitors (PARPi) has redefined the therapeutic landscape of ovarian cancer (OC). Since germline BRCA1/2 or other pathogenic variants (PVs) represent 25–30% of cases, with an additional 5–10% carry somatic BRCA1/2 mutations, timely genetic testing is indispensable for precision treatment. To address this, Gynecologic-Oncologists at CHUM implemented a prospective mainstreaming strategy to provide germline testing at the time of new cancer diagnosis.

Methods: Between September 2024 and March 2026, 130 high-grade OC patients underwent oncologist-led cascade of care. The workflow plan integrated pre-test counselling, informed consent, blood sample collection, germline testing by NGS (Illumina) using the TruSight Hereditary Cancer Panel, result disclosure, and referral to the genetic division as needed.

Results: Of 130 high-grade OC patients, 116 had serous, 6 clear cell, 1 mucinous, 2 endometrioid, and 5 had serous tubal intraepithelial carcinoma (STIC). Within the combined high-grade serous/STIC cohort (n=121), germline mutations in BRCA1/2 (9.09%), PALB2 (0.82%), RAD51C/D (4.13%), with 0.82% dual mutations in PMS2/RAD51D pairs. An additional 23.14% of BRCA wild-type patients had somatic BRCA1/2 mutations. Mean turnaround time for germline testing was 30 days. Stage III/IV patients with BRCA mutations were eligible for PARPi. Results were disclosed to each patient; those with germline PVs were referred for genetic counselling for familial cascade testing.

Conclusion/Implications: Mainstreaming genetic testing is feasible and accelerates precision OC management. Future interventions should optimize this cascade of care to ensure timely treatment decisions, prompt result disclosure, familial cascade testing, and seamless follow-up, aiming to maximize clinical and familial benefits through preventive strategies.

EP165 / #331

Topic: *AS05. Prevention & Early Detection / AS05b. Genetics*

RATES OF REFERRAL TO GENETIC COUNSELLING AMONG PATIENTS WITH ENDOMETRIAL CANCER ELIGIBLE FOR GENETIC TESTING

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Introduction: The primary objective of this study was to determine the rate of referral to genetic counselling in patients with endometrial cancer eligible for genetic testing.

Methods: This is a retrospective cohort study of consecutive endometrial cancer patients treated at a large tertiary cancer centre in Toronto, Canada between January 1, 2022 and December 31, 2023. Our criteria for genetic testing among patients with endometrial cancer included: patients age >50 years and <80 years with either of the following: MSH2/MSH6 deficiency on immunohistochemistry (IHC) or MLH1/PMS2 deficiency (IHC) with MLH1 promoter methylation negative on polymerase chain reaction(PCR) and patients <50 with endometrial cancer based on personal/family history.

Results: 380 patients with endometrial cancer were included in our study. 73 patients met the criteria for genetic testing. 348 patients (91.6%) were tested for Mismatch repair (MMR) deficiency by IHC, and 92(26.4%) tested patients were categorized as MMR deficient (MMRd). Among the 73 patients eligible for a genetic counselling referral, 29 (40.0%) were referred. 25(34.2%) of the 73 patients underwent genetic testing. 25(86%) of the 29 patients referred to genetic counselling underwent genetic testing. 7(9.6%) of the 73 were confirmed to have Lynch Syndrome.

Conclusion/Implications: Less than half of patients eligible for genetic counselling are being referred. Rates of genetic testing among those referred and rates of Lynch Syndrome among those tested are high, confirming the importance of both genetic counselling and testing. The challenge in biomarker testing performed inconsistently highlights the need for quality improvement initiatives to increase rates of referral to genetic counselling.

EP166 / #928

Topic: *AS05. Prevention & Early Detection / AS05c. Disease Pathogenesis*

COAGULOPATHY AND CARDIAC COMPLICATIONS IN GYNECOLOGIC AND HORMONE-RELATED CANCERS: A SYSTEMATIC REVIEW

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Introduction: Anticancer therapies in women with gynecologic and hormone-related cancers improve survival but are associated with coagulopathy and cardiac complications. These outcomes are often studied independently, and their interplay remains poorly characterized. This systematic review evaluated the incidence, patient characteristics, and potential overlap of therapy-associated coagulopathy and cardiotoxicity in women.

Methods: Following PRISMA guidelines, MEDLINE and Embase were searched for studies of adults receiving anticancer therapy. Eligible studies (≥10 participants) included randomized trials, cohort studies, and registries reporting therapy-related coagulopathy or cardiotoxicity. Twelve of 1067 studies met inclusion criteria and were synthesized qualitatively, with emphasis on gynecologic and hormone-related cancers.

Results: Study populations ranged from 50 to 91,407 participants and were predominantly female. Gynecologic cancer cohorts demonstrated high cardiometabolic comorbidity burden, with hypertension in up to 75% of patients, and frequent advanced disease. Coagulopathy incidence ranged from 2-17%, with higher rates in uterine cancer (17%) and ovarian cancer-associated ischemic stroke (9.4/1000 person-years). Cardiotoxicity ranged from 3-30%. In female-specific cancers, hormone-related and targeted therapies were associated with vascular events, including thrombosis (1.97% with CDK4/6 inhibitors) and cardiovascular events (12.2% with antiangiogenic therapy). Biomarker analyses demonstrated elevations in D-dimer, von Willebrand factor, and circulating endothelial cells, suggesting coagulopathy and cardiotoxicity
interplay.

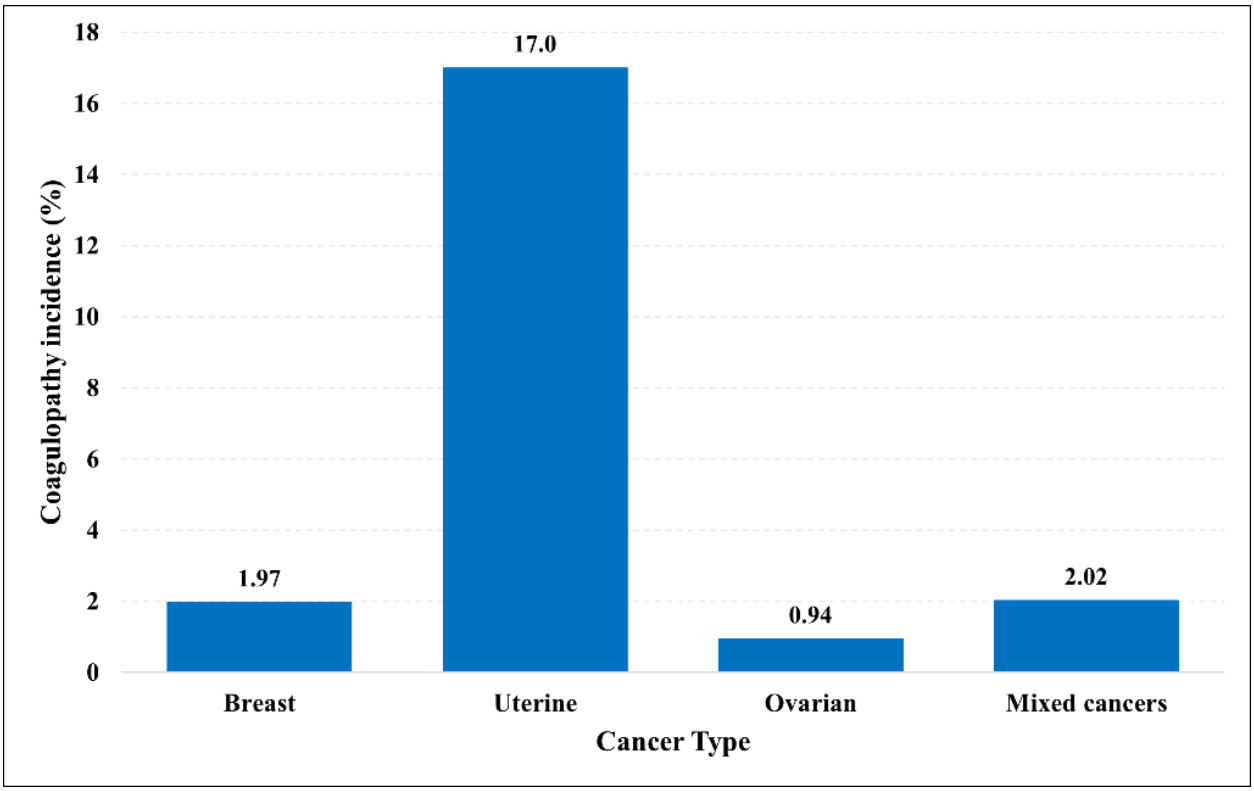


Figure 1

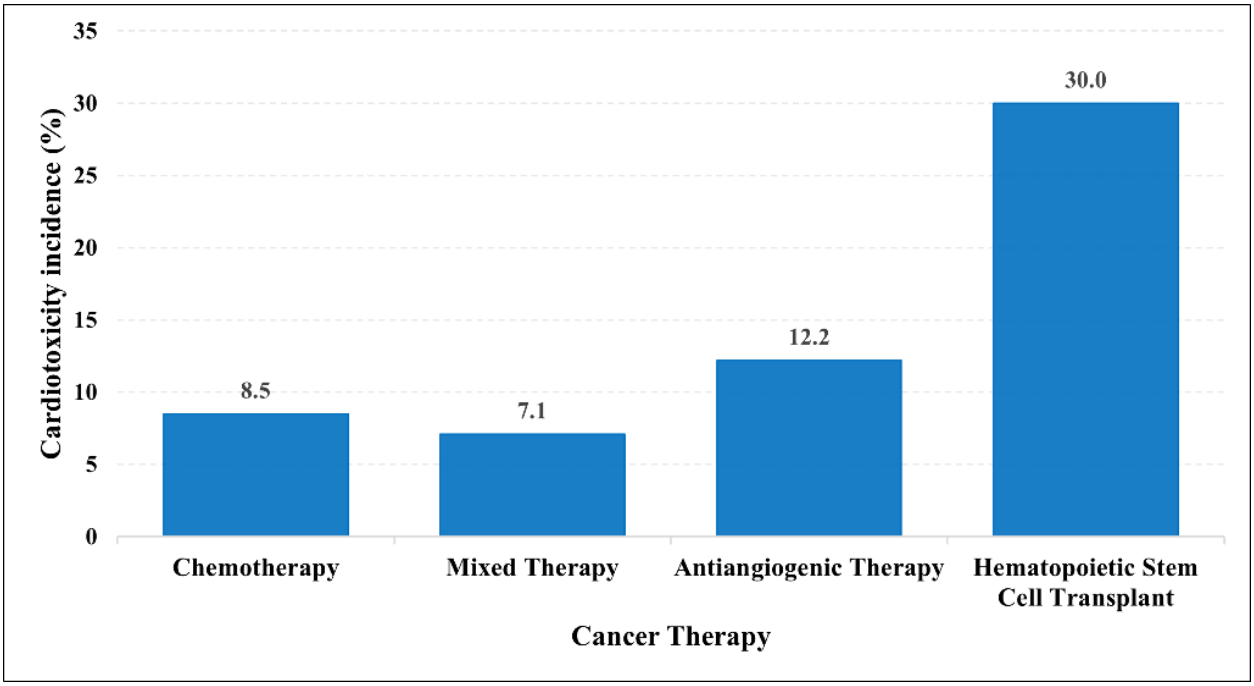


Figure 2

Conclusion/Implications: Coagulopathy and cardiotoxicity are interconnected complications in women with gynecologic and hormone-related cancers, likely reflecting

shared vascular injury pathways. An integrated cardio-oncology risk assessment approach is necessary for early detection, coordinated management and prevention of therapy-related complications. Prospective studies are needed to clarify temporal relationships and refine biomarker-guided risk stratification.

EP167 / #582

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

CHANGES IN HUMAN PAPILLOMAVIRUS STATUS BEFORE AND AFTER CERVICAL CONIZATION: A RETROSPECTIVE STUDY

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Introduction: Human papillomavirus (HPV) infection is a key factor in the development of cervical dysplasia and cervical cancer. However, data on changes in HPV status before and after cervical conization in Japan remain limited. This study aimed to clarify these changes and their clinical significance.

Methods: We conducted a retrospective review of patients who underwent cervical conization for cervical dysplasia at our institution between January 2019 and September 2025. Patients with HPV DNA testing both before and after surgery were included. Postoperative HPV testing was required to be performed within 360 days. We assessed HPV status, postoperative cytological abnormalities, and recurrence of dysplasia.

Results: Among 406 patients who underwent cervical conization, 81 met the inclusion criteria. The median age was 40 years (range, 23–63), and the median follow up period was 752 days (range, 136–1585). HPV was positive in 100% of patients preoperatively and in 9 cases postoperatively, yielding a clearance rate of 88.9%. HPV clearance was lower in patients with positive surgical margins (80.0%, n=12/15) compared with those with negative margins (90.9%, n=60/66).Furthermore, postoperative cytological abnormalities were more frequent in patients with persistent HPV positivity than in those who were HPV-negative (44.4% vs 4.2%). Postoperative dysplasia was observed in 4 cases (2 HPV-positive and 2 HPV-negative), with no recurrence of CIN2 or higher.

Conclusion/Implications: Following cervical conization, HPV became negative in many patients. These findings suggest that postoperative HPV vaccination may reduce the possibility of recurrence of cervical dysplasia due to HPV reinfection. Further large prospective studies are needed.

EP168 / #222

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

A REVIEW OF MANAGEMENT OF ATYPICAL HYPERPLASIA IN A TERTIARY CARE CANCER UNIT

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Introduction: Atypical endometrial hyperplasia (AEH), also termed endometrial intraepithelial neoplasia (EIN), is a premalignant condition associated with the highest risk of developing endometrial carcinoma. Guidance recommends hysterectomy as definitive management in women who have completed childbearing, with conservative progestogen therapy reserved for women wishing to preserve fertility or in selected cases with clear counselling. We evaluated management pathways and histological outcomes in a tertiary UK centre.

Methods: We conducted a retrospective audit of AEH cases at a tertiary London hospital (2022–2024). Data collected included demographics, presentation, risk factors, diagnostic modality, management strategy (hysterectomy versus conservative), and final histology. Outcomes of patients managed non-surgically were reviewed where available.

Results: Fifty-three patients were included after exclusion of duplicate records. The mean age was 54.7 years (range 28–87). Twenty-eight patients (53%) underwent hysterectomy. Surgical approach comprised total laparoscopic hysterectomy (n=14), total robotic hysterectomy (n=9), open hysterectomy (n=3), vaginal hysterectomy (n=1), and one total laparoscopic hysterectomy converted to open. Eleven of 28 patients (39%) undergoing hysterectomy had concurrent endometrial carcinoma on final histology. Twenty-two patients were managed conservatively with progestogen therapy and/or surveillance. Post-menopausal bleeding and metabolic risk factors were common. No consistent clinical or pathological features reliably predicted concurrent carcinoma pre-operatively.

Conclusion/Implications: Two in five patients undergoing hysterectomy for AEH had concurrent carcinoma, consistent with published rates. These findings underscore the significant risk of occult malignancy and support consideration of early definitive surgical management in appropriate patients. For those managed conservatively, robust surveillance pathways remain essential to mitigate risk of progression or missed carcinoma.

EP169 / #658

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

COMPARATIVE OUTCOMES OF LARGE LOOP EXCISION OF THE TRANSFORMATION ZONE IN PATIENTS AGED UNDER AND OVER 50 YEARS

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Introduction: HPV infection demonstrates a bimodal distribution, with an initial peak in younger adults and a second peak in individuals ≥50. Colposcopy assessment in the older population can be challenging, resulting in a lower threshold for large loop excision of the transformaton zone (LLETZ).

Methods: Retrospective review of all LLETZ procedures within a London NHS Trust across two hospital sites between 1st December 2022 and 30th November 2024. Data was collected on LLETZ indication and outcomes and compared amongst <50 and ≥50 age groups.

Results: 419 patients underwent at least one LLETZ: 81% (n=339) were <50, while 19% (n=80) were ≥50. Patients <50 more often had high-grade cytology (77.5%, n=264), whereas patients ≥50 showed a more even distribution of smear grades, with high-grade cytology in 55% (n=44); p<0.0001. This pattern was reflected in final histology; patients <50 predominantly had high-grade disease and this was less common in the ≥50 group (CIN2+ 77%, n=263 v 36%, n=28; p<0.0001). There was no difference in LLETZ depth or margin involvement between the groups (p=0.5782, p=0.2995 respectively). Specimen volume was significantly greater in patients <50 (median 2184mm^3 v 1500mm^3; p=0.0032). The <50 group had a higher proportion of HPV-negative test-of-cure (TOC) (81%, n=255 v 59%, n=40; p<0.0001). However among those with a positive TOC, there was no difference in the grade of abnormality between groups (p=0.2812).

Conclusion/Implications: LLETZ in patients <50 is predominantly performed for high-grade disease and is associated with higher rates of HPV clearance. Older patients exhibit more variable pathology, suggesting age-related differences in disease biology.

EP170 / #368

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

PHASE II RANDOMIZED CLINICAL TRIAL: EFFECTS OF IMIQUIMOD ON IMMUNE RESPONSE AND HISTOLOGICAL REGRESSION IN HIGH-GRADE CERVICAL INTRAEPITHELIAL LESIONS

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Introduction: High-grade cervical intraepithelial lesions (CIN2/3) are precursors of cervical cancer and require appropriate treatment. Although excisional approaches are the standard of care, high-level evidence studies have demonstrated the efficacy of topical imiquimod. This immunomodulator activates both innate and adaptive immune responses and may influence the tumor microenvironment. Characterizing this response may support treatment individualization and optimization of outcomes.

Objectives: To evaluate the immunophenotypic profile of the local immune response and the microbiological profile of the cervicovaginal microenvironment in women with CIN3 treated with imiquimod.

Methods: Prospective clinical trial (NCT06356012) including 66 patients with High-risk Human Papillomavirus (HPV) and CIN3 diagnosis. Participants were randomized into two groups: (G1) topical imiquimod (16 applications, once weekly) and (G2) standard treatment with transformation zone excision. Blood samples were collected at different time points to assess cytokines using Cytometric Bead Array. VISTA and PD-L1 expression were evaluated in biopsy and surgical specimens by immunohistochemistry. Data were associated with clinical and pathological findings.

Current Status & Future Directions: A total of 34 patients were analyzed (19 in G1 and 15 in G2). Groups were comparable regarding age, sociodemographic characteristics, comorbidities, and anthropometric variables, with no statistically significant differences. No differences were observed in HPV type or histopathological findings. PD-L1 expression was predominantly negative (78.9% in G1; 86.7% in G2), while VISTA expression was predominantly positive (73.7% in G1; 64.3% in G2), with no significant differences between groups.

EP171 / #541

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

HPV CLEARANCE AND ACQUISITION RATES AFTER 8 YEARS OF FOLLOW-UP: RESULTS OF UNTREATED DIAVACCS SCREENING TRIAL PARTICIPANTS IN SOUTH AFRICA

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Introduction: Cervical high-risk human papillomavirus (hrHPV) infection is known as mostly transient, allowing conservative management and long screening intervals. However, long-term follow-up data from women in high-prevalence populations and those with immune-depletion is scarce.

Methods: The DiaVACCS screening trial (2026-2020) reported on such a population (hrHPV prevalence 20%-45%; HIV-negative vs. positive women). Here we present initial 5-8 years longitudinal follow-up (LongVACCS) of participants who did not initially need or choose treatment. We compared hrHPV results at baseline and follow-up to describe type-specific persistence, clearance, and new infection. In addition, we describe associated cytology findings.

Results: The current study report on 183 women, mean age 47.4 years [range 32-77]; 26% were HIV-positive. This selected subgroup had an initial overall hrHPV prevalence of 7% at baseline and 10% at follow-up. Worst cytology initially was LSIL and at follow-up it was ASC-H. For HPV-types 16,31,51,56, clearance rates were 100% and one of two HPV58 infections disappeared. New infections occurred in 4 cases each for HPV16,35,51; 3 cases each for HPV56,58 and one each for types 39,45,52. Of the new infections, 8(4.4%) now

qualified for treatment based on having dual positive hrHPV & cytology

Table 1. Type-specific hrHPV/cytology at baseline and follow-up, persistence/clearance/new infection

HPV type [Cytology]	Baseline visit n N=183	Follow-up visit n N=183	Trend in hrHPV infection during follow-up visit		
			Persistence n (%)	Clearance n (%)	New infection n
HPV16 [Cytology]	3 [2 x NILM, 1 x LSIL]	4	0	3 (100) [3 x NILM]	4 [3 x NILM, 1 x ASCUS]
HPV18	0	0	-	-	-
HPV31 [Cytology]	1 [1 x NILM]	0	0	1 (100) [1 x NILM]	-
HPV33	0	0	-	-	-
HPV35 [Cytology]	0	4	0	-	4 [2 x NILM, 1 X LSIL, 1 x ASC-H]
HPV39 [Cytology]	0	1	-	-	1 [1 x NILM]
HPV45 [Cytology]	0	1	-	-	1 [1 x NILM]
HPV51 [Cytology]	1 [1 x NILM]	4	0	1 (100) [1 x NILM]	4 [2 x NILM, 2 x LSIL]
HPV52 [Cytology]	0	1	-	-	1 [1 x NILM]
HPV56 [Cytology]	1 [1 x NILM]	3	0	1 (100) [1 x NILM]	3 [1 x NILM, 1 X LSIL, 1 x ASC-H]
HPV58 [Cytology]	2 [1 x NILM, 1 X ASCUS]	4	1 (50) [1 x NILM]	1 (50) [1 x NILM]	3 [2 x NILM, 1 x ASCUS]
TOTAL HPV types	8	20	1	7	21

Abbreviations: ASC-H = atypical squamous cells, cannot exclude high-grade squamous intraepithelial lesion
ASCUS = atypical squamous cells of undetermined significance
HSIL = high-grade squamous intraepithelial lesion
LSIL = low-grade squamous intraepithelial lesion

tests.

Conclusion/Implications: We observed high clearance rates, but even higher rates of acquisition over the follow-up period of 5-8 years, with the most prevalent types being

HPV16,35,51 followed by HPV56,58. In view of this, and the cytology results associated with new infections, it appears that the screening interval should preferably not exceed 5 years.

EP172 / #387

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

DRY VS. WET: A COMPARATIVE ANALYSIS OF HRHPV DNA DETECTION IN SELF-COLLECTED SWABS EXPERIENCE IN LOW-MIDDLE INCOME COUNTRY

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Introduction: : Cervical cancer is a leading cause of cancer-related deaths among women, especially in low- and middle-income countries with limited screening access. Self-collected vaginal swabs for hrHPV DNA testing offer an alternative to provider-collected exams in preventing cervical cancer. This study compared the performance of self-collected vaginal samples transported dry versus wet for hrHPV DNA detection.

Methods: We analyzed data from 167 women. Each woman provided all three samples (dry,wet and physician collected). The positivity rate for high-risk HPV matched with the healthcare provider's collected swab (used as the reference).

Results: Among the 167 women, the doctor-collected cervical swab (reference standard) detected high-risk HPV in 11 women (6.6%). The dry self-collected swab detected HPV in 10 women (6.0%), while the wet self-collected swab detected HPV in 9 women (5.4%). When compared to the doctor's swab, the dry swab correctly identified 7 out of 11 HPV-positive women (sensitivity 64%), and the wet swab correctly identified 6 out of 11 (sensitivity 55%). Both self-swabs performed excellently at ruling out HPV-negative women, each achieving 98% specificity (153 out of 156 correct). Most importantly, when comparing the two self-collection methods directly against each other, the dry and wet swabs showed agreement in 164 out of 167 women, giving an overall percent agreement of 98.2%. Only 3 women had discordant results between the two self-swabs.

Conclusion/Implications: Self-collected vaginal swabs (both dry and wet) performed very similar. Although they detected slightly fewer positives than the physician's collected swab, both result showed very high agreement (98%).

EP173 / #50

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

TOO YOUNG TO SCREEN? UNMASKING CERVICAL PRECANCER IN WOMEN UNDER 25: A MULTICENTER STUDY FROM THE THAI GYNECOLOGIC CANCER SOCIETY RESEARCH GROUP

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Introduction: Cervical cancer screening is recommended to start at a specified age, yet it is sometimes performed in younger women. The burden of clinically significant lesions and optimal management in this group remain unclear. We assessed abnormal screening results and cervical precancer/cancer in women below the recommended screening age and identified factors associated with CIN2+.

Methods: This multicenter observational study included women aged <25 years with abnormal cervical cancer screening from 8 tertiary cancer centers in Thailand. Cytology and HR-HPV testing (when available), histopathology, follow-up, and immediate and cumulative risks of CIN2+ were evaluated. Logistic regression identified factors associated with CIN2+.

Results: Among 1,016 women (mean age 20.7±2.7 years), 70.5% had never been screened. Cytology showed low-grade abnormalities in 88.0% (ASC-US 48.7%, LSIL 39.3%) and high-grade cytology in 10.6% (ASC-H 4.8%, HSIL 3.5%, AGC 2.3%); 0.2% had squamous cell carcinoma cytology. HR-HPV testing was performed in 59 (5.8%) women; 31 (3.1%) were HR-HPV positive (non-16/18) and 18 (1.8%) were HR-HPV 16/18 positive. Histopathology was available in 431 women; CIN2+ was detected in 74/431, giving an immediate risk of 17.2% (95%CI 13.9–21.0) and a cumulative risk of 19.5% (85/437; 95%CI 16.0–23.4) over a median follow-up of 9.53 months. Immediate CIN2+ risk rose with cytologic severity (ASC-US 12.0%, LSIL 11.4%, ASC-H 52.0%, HSIL 62.1%); cumulative risk was highest with HSIL (72.4%). High-grade cytology independently predicted CIN2+ (adjusted OR 7.20, 95%CI 4.00–12.96; $p<0.001$).

Conclusion/Implications: Although most abnormalities in women <25 are low-grade, CIN2+ is not rare. High-grade cytology identifies a subgroup with substantial risk warranting prompt evaluation.

EP174 / #411

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

IMPROVED DETECTION OF ABNORMAL CERVICAL TISSUE GROWTH USING CASCADE KNOWLEDGE DISTILLATION-BASED DEEP LEARNING

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Introduction: Cervical cancer remains one of the leading causes of mortality among women worldwide, with early detection playing a critical role in improving therapeutic outcomes. Recent advances in deep learning and artificial intelligence have enabled the development of intelligent diagnostic systems, including cervical cancer detection.

Methods: In this study, we propose a novel deep learning framework, CKD-CINet, designed for the joint task of fine-grained classification and precise segmentation of squamous intraepithelial lesions in colposcopic images. The model integrates DeepLabV3+ for spatial feature extraction, Inception-ResNet as the backbone network, long short-term memory units for temporal modeling, Entangle-Cls for feature–spatial interactions, and a multi-scale efficient channel attention module. Publicly available datasets from the IARC Colposcopy Image Bank were partitioned into training, validation, and independent test sets prior to augmentation.

Results: The proposed CKD-CINet achieved a classification accuracy of 96.3%, sensitivity of 92.1%, specificity of 94.6%, and AUC of 96.7% on an independent test set, demonstrating strong discriminative capability and robustness. Training stability was monitored using an internal validation split with early stopping based on validation loss trends to mitigate overfitting.

Conclusion/Implications: The integration of spatio-temporal learning with attention mechanisms significantly improved the model's ability to accurately detect high-grade lesions. This computational strategy enables efficient model optimization and supports near real-time inference for large-scale cervical cancer screening applications.

EP175 / #469

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

CONSERVATIVE MANAGEMENT AND TOPICAL AGENTS FOR DIFFERENTIATED VULVAR INTRAEPITHELIAL NEOPLASIA: A COMPREHENSIVE REVIEW FOR WHEN SURGERY CAN'T CUT IT

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Introduction: Differentiated vulvar intraepithelial neoplasia (dVIN) is an HPV-independent precursor to vulvar squamous cell carcinoma (VSCC), with a high progression rate of 30%. Surgical excision with negative margins is the only recommended management option. However, surgery is not always feasible due to extent of disease, anatomical considerations from repeated excisions, or impact on function and quality of life. Conservative alternatives have largely been unexplored given dVIN's high malignant potential. Nonetheless, when surgery is not possible, alternative management strategies are needed. This review aimed to identify and evaluate conservative treatment approaches for dVIN.

Methods: A comprehensive review of the literature from inception to January 2026 was performed, including studies evaluating conservative management of histologically confirmed dVIN.

Results: A total of 10 of 253 screened studies met inclusion criteria. Four conservative management categories were identified: imiquimod (5 studies), topical corticosteroids (6 studies), laser ablation (2 studies), and expectant management (3 studies). Imiquimod showed variable responses, with some patients achieving complete response while others progressed to VSCC. Topical corticosteroids were associated with lower recurrence rates compared to expectant management (33.3% vs 69.2%). CO2 laser vaporization showed complete response with no recurrence in two patients. Sample sizes were small and outcomes inconsistently reported.

Conclusion/Implications: Evidence for conservative management remains limited but suggests potential benefit from topical therapies, particularly when initiated early prior to the development of VSCC. Prospective studies, along with reporting of novel and unconventional management strategies are needed to expand the therapeutic landscape for this challenging disease.

EP176 / #290

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

CLINICAL VALIDATION OF P16/KI-67 DUAL STAIN AS A TRIAGE TOOL IN A LOW-RESOURCE SETTING: A CROSS-SECTIONAL STUDY FROM BANGLADESH

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Introduction: In low-resource settings such as Bangladesh, cervical cancer screening relies heavily on visual inspection with acetic acid (VIA), which has limited specificity. High-risk human papillomavirus (hrHPV) testing, while sensitive, requires effective triage to avoid over-referral. This study evaluates the performance of p16/Ki-67 dual-stain cytology as a triage tool for screen-positive women.

Methods: A cross-sectional diagnostic study was conducted at the National Institute of Cancer Research & Hospital, Dhaka, from January to December 2022. Women aged 25–65 years with positive VIA, abnormal Pap smear, or hrHPV DNA results underwent colposcopy with biopsy for histopathological verification. p16/Ki-67 dual-stain immunohistochemistry was performed on biopsy specimens. Diagnostic accuracy was calculated against histology as the gold standard.

Results: Of 63 women, 19.0% (12/63) were dual-stain positive. For detecting cervical intraepithelial neoplasia grade 2 or worse (CIN2+), dual-stain showed a sensitivity of 80.0% (95% CI: 44.4–97.5), specificity of 92.5% (95% CI: 81.8–97.9), positive predictive value (PPV) of 66.7% (95% CI: 34.9–90.1), negative predictive value (NPV) of 96.1% (95% CI: 86.5–99.5), and accuracy of 90.5% (95% CI: 80.4–96.4). In comparison, VIA had a sensitivity of 83.3% but a specificity of only 9.8%, while hrHPV DNA testing showed a sensitivity of 75.0% and specificity of 80.4%.

Conclusion/Implications: p16/Ki-67 dual-stain cytology demonstrates high specificity and accuracy for triaging screen-positive women in a low-resource setting. Its use could significantly reduce unnecessary colposcopy referrals and optimize screening pathways in Bangladesh.

EP177 / #927

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

CONIZATION OUTCOMES FOR ADENOCARCINOMA IN SITU OF THE CERVIX

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Introduction: Despite widespread screening and vaccination efforts, the incidence of adenocarcinoma in situ (AIS) and cervical adenocarcinoma continues to rise. This study aims to compare long term outcomes following cold knife conization (CKC) and loop electrosurgical excision procedure (LEEP) for patients with adenocarcinoma in situ.

Methods: The MarketScan commercial database was used to identify patients age 18 to 64 with AIS from 2016 to 2021 who were treated with either CKC or LEEP. Propensity score matching was performed to balance clinical and demographic characteristics between the groups. Patients were followed for up to 36 months and the cumulative rates of repeat diagnostic evaluation (colposcopy, biopsy, endocervical curettage), repeat excision (CKC or LEEP), and hysterectomy for cervical dysplasia or cancer were compared between the groups using Gray's test.

Results: A total of 2,994 patients were identified, including 756 (25.3%) who underwent CKC and 2,238 (74.7%) who underwent LEEP. After propensity score matching, at 36 months, the cumulative incidence of repeat diagnostic evaluation was 21.4% following CKC and 24.7% following LEEP (p=0.08). Repeat excisional procedures occurred in 2.2% of CKC patients and 4.8% of LEEP patients (p=0.03). Rate of subsequent hysterectomy for cervical dysplasia or cancer was 6.9% after CKC and 5.0% after LEEP (p=0.42). The cumulative incidence of cervical cancer was 2.5% following CKC, compared to 1.1% following LEEP (p=0.16).

Conclusion/Implications: Both CKC and LEEP were associated with relatively low rates of repeat intervention and progression to malignancy over 36 months. CKC was associated with lower rates of repeat excisional procedures.

EP178 / #1028

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

WHAT ARE THE HPV TYPES FOUND IN PATIENTS WITH HIGH-GRADE SQUAMOUS INTRAEPITHELIAL LESIONS IN A SAMPLE OF PATIENTS FROM SOUTHERN BRAZIL?

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Introduction: The relevance of HPV infection has been established due to its association with cervical cancer. Characterizing the most prevalent oncogenic subtypes in precancerous lesions of the cervix allows us to outline the circulation profile of HPV genotypes in the female population of southern Brazil.

Methods: A prospective cross-sectional study was conducted among women with biopsy of high-grade squamous intraepithelial lesions (HSIL/CIN2+). HPV DNA were collected prior to the surgical procedure, cold conization or Loop Electrosurgical Excision Procedure (LEEP) in outpatient clinic of the Hospital de Clinicas de Porto Alegre, a University Hospital in southern Brazil, between July 2024 and December 2025. Quantitative variables were described by mean and standard deviation, and categorical variables by absolute and relative frequencies. Associations between variables were assessed using Pearson's chi-square. The level of significance adopted was 5% ($p<0.05$).

Results: A total of 100 participants were included; 9 had HPV PCR test undetectable. Comparing HPV types, 53 (58.2%) patients were detected with other than HR-HPV 16 and 18, and 38 (41.8%) with HR-HPV 16 and/or 18, without statistical difference between them. HPV 18 was detectable in only 2 participants. HPV 16 was present in all patients diagnosed with cervical cancer at the surgical procedure.

Conclusion/Implications: Taken together, the findings demonstrate the predominance of other than 16 and/or 18 HR-HPV types in HSIL, and reinforce the strong association of HPV 16 with more aggressive histological outcomes.

EP179 / #1073

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

PERFORMANCE OF CERVICAL CYTOLOGY AS A TRIAGE TEST FOR PRECANCEROUS LESIONS AND CANCER IN HPV-POSITIVE WOMEN IN SOACHA, COLOMBIA

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Introduction: Cervical cancer is a major public health problem in Colombia, where it is the third most frequent cancer among women, with about 4,570 new cases and 2,435 deaths annually. HPV testing is the primary screening strategy for women aged 30 years and older due to its high sensitivity, but effective triage is required to identify those at greatest risk of CIN3+ or cancer. We aimed to evaluate the performance of reflex cytology for triaging HPV-positive women in ESTAMPA Soacha, Colombia.

Methods: We conducted a cross-sectional study including 1,285 HPV-positive women aged 30–64 years from the municipality of Soacha. We assessed the performance of both conventional cytology and liquid-based cytology (LBC) as triage methods for HPV-positive women to detect CIN3+. Sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) with 95% confidence intervals (CI) were estimated. The McNemar test was used to compare the two methods, and analyses were performed in R and Stata 17.

Results: A total of 1,285 women were analyzed. Abnormal cytology (ASC-US+) was found in 20.7% of conventional cytology and 19.1% of LBC. The sensitivity for CIN3+ was 63.0% (95% CI: 54.3–71.6) for conventional cytology and 46.2% (95% CI: 37.2–55.1) for LBC

(McNemar p-value = 0.0047). Specificity was 83.7% (95% CI: 81.5–85.8) for both tests. The NPV exceeded 90% for both cytology types.

Conclusion/Implications: Conventional cytology showed higher sensitivity than LBC for HPV-positive triage, although overall sensitivity remained suboptimal. Cytology requires quality assurance, and alternative triage strategies for HPV-positive women should be considered in Colombia and similar settings.

EP180 / #535

Topic: *AS05. Prevention & Early Detection / AS05d. Pre-Invasive Disease*

COMPARISON OF THE EFFECTIVENESS OF THERMOCOAGULATION AND CRYOTHERAPY IN THE TREATMENT OF CERVICAL PRECANCEROUS LESIONS

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Introduction: Cervical precancerous lesions represent an early stage before progression to cervical cancer. In low-resource healthcare settings, management of these lesions commonly involves ablative methods. Thermocoagulation, as a newer modality, offers advantages in terms of practicality; however, its effectiveness and comfort compared to cryotherapy still require further evaluation.

Methods: To determine and compare the effectiveness and satisfaction levels of thermocoagulation and cryotherapy in the treatment of cervical precancerous lesions based on VIA results.

Results: Both methods demonstrated good effectiveness in reducing VIA-positive results 3 months after the procedure, with no significant difference between groups. However, thermocoagulation showed advantages in terms of time efficiency and logistical practicality. Thermocoagulation associated with a longer duration of bleeding ($p < 0.001$), while cryotherapy was associated with a longer duration of vaginal discharge ($p < 0.001$). Operator satisfaction was higher with thermocoagulation, particularly in ease of use, time efficiency, and logistics, with good reliability (ICC > 0,75).

Conclusion/Implications: Thermocoagulation and cryotherapy have comparable effectiveness in the treatment of cervical precancerous lesions based on VIA outcomes. Thermocoagulation is superior in operational aspects and operator satisfaction, although it is associated with a longer duration of vaginal discharge and post- procedural bleeding.

EP181 / #829

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

HIGH HUMAN PAPILLOMAVIRUS CLEARANCE AND LOW REINTERVENTION RATES AFTER ADJUVANT VACCINATION FOLLOWING CERVICAL CONIZATION

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Introduction: Persistent human papillomavirus (HPV) infection after treatment of cervical intraepithelial neoplasia is a major driver of recurrence. Adjuvant HPV vaccination has been proposed as a strategy to improve post-treatment outcomes.

Methods: We conducted a retrospective cohort study including patients who underwent cervical conization between January 2023 and October 2024. All patients received adjuvant nonavalent HPV vaccination. Margin status, cytology/HPV cotesting at 6 and 12 months, and need for repeat surgical intervention were analyzed. Viral clearance was evaluated among patients with documented baseline HPV positivity. Missing 6-month cotesting data were supplemented only when 12-month cotesting was negative.

Results: A total of 193 patients were included (mean age 33.5 years) all with CIN2/3. Positive surgical margins were observed in 41% (79/193). Re-conization was required in 5.7% (11/193), and overall reintervention occurred in 7.8% (15/193). Patients with positive margins had a higher risk of re-conization (10.1% vs 2.7%; OR 4.13; p=0.053) and reintervention (12.7% vs 4.4%; OR 3.13; p=0.054). Among patients with baseline HPV positivity, viral clearance was observed in 88.2% at 6 months and 89.7% at 12 months. At 12 months, negative cotesting was observed in 80.5% (132/164) of patients with available follow-up. Among patients with abnormal cotesting at 12 months, 34.4% (11/32) required reintervention, while 65.6% did not develop clinically significant disease.

Conclusion/Implications: Adjuvant HPV vaccination following cervical conization was associated with high viral clearance and low reintervention rates. Further prospective studies are warranted.

EP182 / #659

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

COMPARISON OF LARGE LOOP EXCISION OF THE TRANSFORMATION ZONE OUTCOMES BETWEEN HPV VACCINATED AND UNVACCINATED INDIVIDUALS

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Introduction: Although HPV vaccination has reduced cervical cancer incidence, HPV infection has not been eradicated and high-grade precancerous lesions still occur. Current treatment algorithms do not differentiate between HPV vaccination status.

Methods: Retrospective review of all outpatient large loop excision of the transformation zone (LLETZ) in individuals eligible for the UK HPV vaccination programme within a London NHS Trust between 1 December 2022 and 30 November 2024. LLETZ indication and outcomes were compared between age-matched vaccinated and unvaccinated individuals.

Results: 188 patients ≤35 years underwent an outpatient LLETZ (median age 31, range 25-35): 18% were HPV vaccinated (n=33) and 82% unvaccinated (n=155). There was no difference in index smear between the groups (p=0.3995). However, there were no cases suggestive of invasive disease in the vaccinated group, compared to 2 ?glandular neoplasia of endocervical type and 5 ?invasive squamous cell carcinoma in the unvaccinated group. This was reflected in final histology with no cancers or cervical glandular intra-epithelial neoplasia (CGIN) in the vaccinated group, compared with 2 cancers and 4 CGIN in the unvaccinated. There was no significant difference in histological outcomes (p=0.6204), proportion of HPV-negative test-of-cure (TOC) (p=0.1976) or grade of abnormality among those with positive TOC (p=0.8622).

Conclusion/Implications: In this cohort, HPV vaccination was not associated with any significant differences in index smear, final histology or TOC outcomes. The absence of invasive and glandular pathology in the vaccinated group suggests HPV vaccination may influence disease severity and outcomes.

EP183 / #392

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

CHARACTERISTICS OF PATIENTS WITH CERVICAL CANCER TREATED AT A PUBLIC HOSPITAL IN THE EASTERN AMAZON

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Introduction: Cervical cancer remains a major public health challenge and a leading cause of cancer burden in low-resource settings, despite being largely preventable through vaccination and effective screening.

Methods: This retrospective, cross-sectional, descriptive epidemiological study analyzed records of patients diagnosed with cervical cancer treated at Hospital Universitário João de Barros Barreto, a tertiary referral center in Belém, Pará, Brazil, between January 2018 and January 2024. Demographic, clinical, and pathological data were collected, including HPV vaccination status and prior screening history. Descriptive statistics were used.

Results: A total of 636 patients were included. The majority was aged 30–49 years (53%), and 9.7% were illiterate. Most patients (95.3%) were of mixed ancestry (self-reported as "pardo," according to the Brazilian census classification). Only 0.4% were known to be HPV-vaccinated. Among 296 patients with available screening data, 18.6% had never undergone a prior Pap smear. Among those with cytology results (n=147), 34.4% were normal and 21% showed high-grade lesions. Squamous cell carcinoma (86.7%) and adenocarcinoma (11.2%) were the most frequent histological subtypes. Only 15% of cases were detected through screening, whereas 75% were diagnosed after symptom onset, most commonly abnormal uterine bleeding (55.2%) and pelvic pain (26%).

Conclusion/Implications: These findings underscore critical gaps in the implementation of proven preventive strategies. Extremely low HPV vaccination coverage and limited screening uptake reflect structural barriers in access to care. The substantial proportion of patients with prior normal cytology raises concerns about screening quality, reinforcing the urgent need to strengthen organized screening programs and expand access to HPV-based strategies in underserved regions.

EP184 / #389

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

ONE DOSE OR TWO? COMPARING ANTIBODY RESPONSES TO HPV VACCINATION IN ADOLESCENT GIRLS OF BANGLADESH.

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Introduction: Human Papillomavirus (HPV) Vaccination is a way of preventing cervical cancer. In general, multi-dose vaccination regimens have been utilized in order to guarantee long-term immunity; however, global data recently suggest, single-dose vaccination regimen produces acceptable levels of immunogenicity over the short term. This study aimed to compare antibody responses and safety profiles following single-dose and double-dose HPV vaccination among adolescent girls aged 9–14 years.

Methods: A quasi-experimental study was conducted among 160 adolescent girls in Mymensingh, Bangladesh, between May 2024 and August 2025. Out of 160 participants, 80 girls received a single dose, and 80 of them got two doses of the HPV vaccine. Antibody responses were measured at 1, 6, and 12 months after vaccination.

Results: Antibody responses were comparable between the two groups at both 1-month and 6-month follow-ups, with no statistically significant differences observed. This suggests that a single dose is sufficient to induce an early immune response. However, by 12 months, a marked divergence was observed. The double-dose group demonstrated substantially higher antibody positivity compared to the single-dose group (90.5% vs. 33.3%; RR 2.72, 95% CI 1.82–4.07; P = 0.001), indicating superior persistence of immune response. Additionally, reported adverse events were mild, infrequent, and similar across both groups, supporting the favourable safety profile of both vaccination strategies.

Conclusion/Implications: While a single dose of the HPV vaccine provides a similar short-term immune response, a two-dose regimen offers better long-lasting protection.

EP185 / #330

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

KNOWLEDGE AND UPTAKE OF HPV VACCINATION AMONG FEMALE ONCOLOGY PATIENTS IN A PRIVATE CANCER CENTER IN BRAZIL

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Introduction: Despite the well-established efficacy of HPV vaccination, uptake among adult women remains suboptimal, particularly among female oncology patients. This population is a high-risk group due to treatment-related immunosuppression and an increased risk of second primary malignancies. However, data on vaccination awareness and adherence in oncology patients are limited.

Methods: This cross-sectional study included female oncology patients aged ≥18 years at a private cancer center in São Paulo, Brazil. Data were collected using a structured questionnaire evaluating HPV-related knowledge, vaccination status, medical counseling, and barriers to uptake. Descriptive analyses were performed.

Results: A total of 118 oncology patients were included, with a mean age of 53.2 years. Only 15.3% reported prior HPV vaccination, and among these, 61.1% completed the full vaccination schedule. Awareness of HPV vaccination was relatively high (80.5% were aware of a free vaccination program); however, adequate knowledge was limited, with 62.7% unable to correctly identify the HPV types covered by the vaccine, reflecting a substantial gap in accurate information. Medical recommendation was reported by only 33.3% of vaccinated individuals. Among unvaccinated patients, the main barriers included lack of information and access limitations (44.8%), as well as cost concerns (16.1%). Notably, a considerable proportion expressed willingness to receive vaccination if properly informed.

Conclusion/Implications: HPV vaccination uptake remains critically low despite moderate awareness. A high rate of inadequate knowledge highlights a major gap in patient education. Limited physician engagement further underscores a missed opportunity for cancer prevention in this high-risk population. Integrating structured vaccination counseling into routine oncologic care may significantly improve uptake.

EP186 / #1076

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

MISSED OPPORTUNITIES FOR ENDOMETRIAL CANCER PREVENTION: LEVERAGING PATIENT EXPERIENCES TO INFORM DEVELOPMENT OF SHARED DECISION-MAKING TOOLS FOR THE PRIMARY PREVENTION OF ENDOMETRIAL CANCER

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Introduction: Endometrial cancer (EC) is the most common gynecologic cancer in high-income countries. It is strongly linked to modifiable risk factors such as obesity and anovulation. Although evidence supports risk-reduction strategies such as hormonal intrauterine devices (IUDs) and weight management, little is known about how patients understand these options or engage in decision-making about EC prevention options. This qualitative study explores women's perspectives to inform development of a patient-centered shared decision-making (SDM) tool for women at risk of EC.

Methods: We conducted a pilot qualitative study using semi-structured interviews of women with and without a history of EC. Interviews explored understanding of EC, perceptions of modifiable risk factors, and attitudes toward risk-reduction strategies. Interviews were audio-recorded, transcribed, and analyzed using consensus coding to identify key decisional needs.

Results: Nineteen women participated (n=6 with EC, n=13 without; mean age 44 years). Three primary themes emerged (Table 1). First, participants had limited to no awareness of EC and modifiable risk factors with 17/19 women reporting no prior counseling on EC prevention. Second, participants expressed openness to hormonal IUDs and weight management interventions such as GLP-1 agonists when framed as EC prevention. Third, women with EC experienced grief after requiring hysterectomy for treatment, consistently

describing guilt and regret about missed opportunities for cancer prevention.

Table 1. Representative quotations from interview participants according to theme.

Theme	Representative Quotation
Limited understanding of endometrial cancer and modifiable risk factors	"Nothing. Never even knew it existed." – *Participant 2001*
	"I really don't know much about it … to be honest." – *Participant 1002*
	"I don't think that there is anything that specifically … would cause that." – *Participant 1005*
Openness to risk-reduction strategies when frames as endometrial cancer prevention	"If you're telling me [an IUD] can prevent cancer, then it's just, like, well … OK. I want to hear about it." – *Participant 2005*
	"If I would have known then that even if I wasn't sexually active, I could still have birth control, having, like, an IUD, and that would prevent me from being able to get this, then I would have done it, but I just didn't. You know, it's something that … I wasn't aware of." – *Participant 2003*
	"I would probably just take the [anti-obesity] medicine to prevent this--the cancer, you know … if I'm in that position, I'll--I'll probably just do what I have to do, you know." – *Participant 1004*
Decisional regret following missed opportunities for early counseling	"I know none of the doctors that I've had ever talked to me about what an IUD is, and what it can prevent, and the risk of not having [regular] periods … You know, at the time, you're young, you're like, 'I don't care if I- if I have kids or not,' but once you get to a certain age, you're like, 'I do want to have kids,' you know? So you do need your, you know … your uterus. And all the parts to conceive a baby. But then it's- it's just too late." – *Participant 2006*

Conclusion/Implications: Gaps in patient knowledge regarding EC prevention exist despite accessible and appealing risk-reduction options. Framing strategies as cancer prevention may increase acceptability and uptake. Incorporating these findings into the development of an SDM tool will facilitate actionable patient-provider conversations about EC prevention.

EP187 / #385

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

BARRIERS TO CERVICAL CANCER PREVENTION IN BANGLADESH WITHIN THE WHO CERVICAL CANCER ELIMINATION STRATEGY; A KAP STUDY INSIGHT

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Introduction: Cervical cancer is largely preventable, but causes significant morbidity and mortality in Bangladesh. Assessing KAP will help identify gaps in awareness and barriers to screening and vaccination. The objective was to find out the barriers to cervical cancer prevention among adults in Bangladesh by assessing the knowledge, attitudes, and practices toward cancer

Methods: Cross-sectional study

Results: A total of 1643 participants were included. Mean age was 31.4 years; 80.4% were married. Education: 30.5% graduate+, 26.9% secondary, Occupation: 45.0% housewives, Urban residents: 72.9%, Low income (≤20,000 BDT): 42.0%, multiparity: 51.6%. HPV vaccine awareness was 55.9%, but uptake was only 20.0%. Vaccination was higher among aware participants (29.5% vs 5.5%); the association was significant (χ^2=113.07, p<0.001, V=0.292). Knowledge was poor in 54.8%, moderate in 30.6%, and good in 14.6%, indicating substantial gaps. Attitudes were mostly neutral 52.6%; 34.8% positive, 12.6% negative. Mean score 12.85, reflecting ambivalence. Only 23.8% had ever been screened; 76.2% had never been screened. Moderate/good knowledge increased screening (AOR 3.30; 2.37). Neutral/positive attitudes reduced odds. Education increased screening (AOR secondary 3.70, > graduate 3.15). Higher monthly(BDT) income and multiparity increased screening. Model fit acceptable (AUC 0.731). Table 1: **Association between Screening with Knowledge and Attitude**

Knowledge	**Screened(%)**	**Unscreened(%)**	**significance**
Poor	15.5%	**84.5%**	**p <.001**
Moderate	**39.1%**	60.9%	
Good	23.4%	76.6%	

Attitude			
Negative	43.6%	56.4%	**p <0.001**
Neutral	23.4%	76.6%	
Positive	24.1%	75.9%	

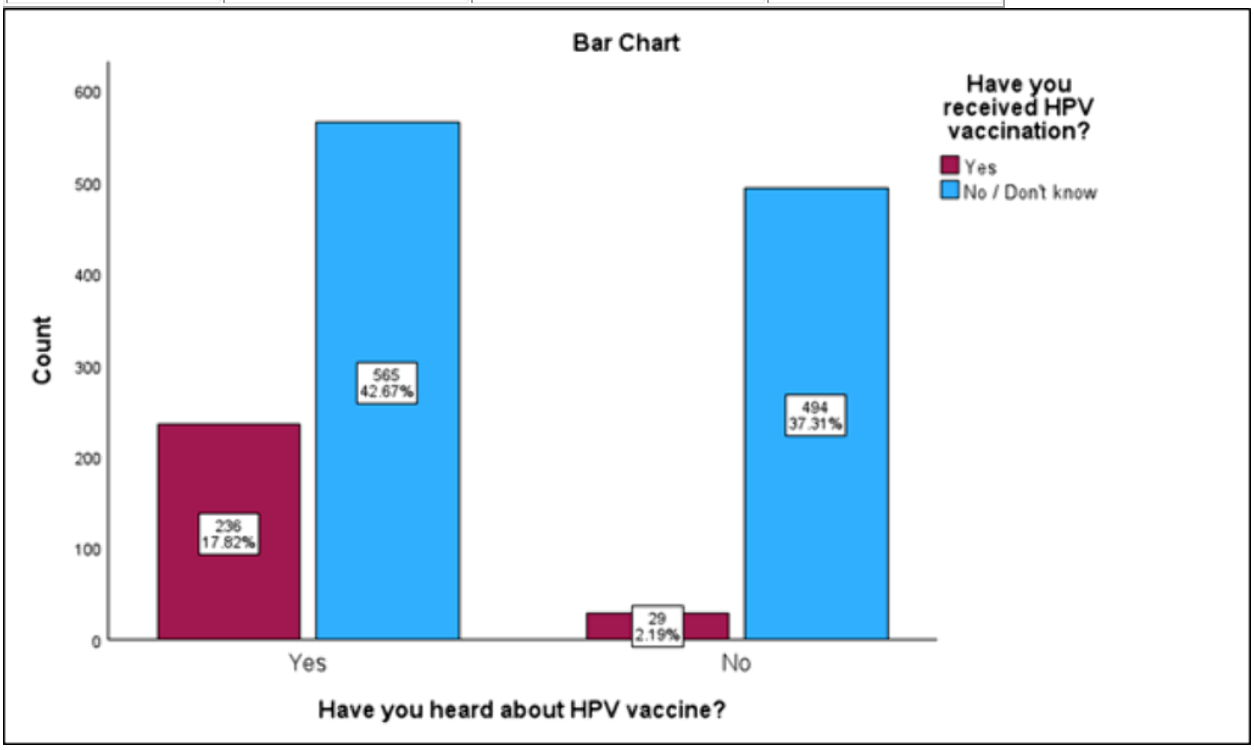


Figure 1 : HPV vaccination uptake by awareness level

Conclusion/Implications: Elimination requires multifaceted strategies, including enhanced knowledge and awareness, improved accessibility, and targeted interventions to address both behavioral and structural barriers.

EP188 / #219

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

SOME YOUNG WOMEN ARE STILL WORRIED ABOUT ADVERSE EFFECTS OF HPV VACCINE IN JAPAN. A QUESTIONNAIR SURVEY FOR VACCINE-WILLING NURSES.

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Introduction: The HPV (human papillomavirus) vaccinated rate is remarkably low in Japanese women born in 2000-2007 mainly because of the intranational widely spread caution about ISRR (immunization stress-related responses) and also because of withdrawal of the national vaccine recommendation from 2013 to 2021. Japanese government resumed proactive vaccine recommendation and provided free catch-up vaccination until 2025 for young women of this age.

Methods: We conducted an IRB-approved questionnaire survey for people who received HPV vaccination during our in-house catch-up administration program.

Results: Seventy-four young women of this age were administered HPV vaccine in our in-house program, and sixty-nine people (93%) answered to the survey; including 55 nurses, 9 students, 2 engineers, a clerk, a resident, and a person who didn't answer about her job status. To a question about fear for adverse effects, fifteen out of 55 (27%) nurses selected YES. As for the resource to decide receiving the vaccine which they had never received before, forty-six people (67%) selected the hospital information about the administration program, followed by the government information and their mother's recommendation.

Conclusion/Implications: Even in nurses who received it, some young women still are worried about the adverse effects of HPV vaccine. We, as for gynecology medical staffs, need to continue informing of the importance of HPV vaccine and cervical cancer screening in Japan.

EP189 / #207

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

EXTENDED POSTOPERATIVE THROMBOPROPHYLAXIS IN GYNECOLOGIC ONCOLOGY PATIENTS UNDERGOING LAPAROTOMY: A QUALITY IMPROVEMENT STUDY

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Introduction: In gynecologic oncology patients undergoing laparotomy, current guidelines recommend 28-day extended postoperative thromboprophylaxis and support the use of direct oral anticoagulants (DOAC). However, adherence to this practice remains heterogenous. The aim of this quality improvement study was to increase prescription rate of extended postoperative thromboprophylaxis to more than 80% in these patients, without increasing postoperative complications.

Methods: This time-series study included all gynecologic oncology patients undergoing laparotomy between September 1st 2024, and December 31st 2025 in a tertiary cancer center. In Phase 1, baseline data was analysed until October 31st 2024. On November 1st 2024(Phase 2), three educational interventions were put in place. On April 15 2025(Phase 3), DOAC were covered under the provincial public drug insurance plan. On September 4 2025(Phase 4), a standardized postoperative order set was implemented.

Results: Among 39 pre-intervention and 232 post-intervention patients, 66%(n=179/271) received extended postoperative thromboprophylaxis. Postoperative thromboprophylaxis rate increased from 36%(n=14/39) in Phase 1 to 74%(n=165/232) (p<0.001) in Phases 2 to 4, reaching 93%(n=49/53) in Phase 4. Use of DOAC increased from 79%(n=11/14) to 96%(n=159/165) (p=0.072). A standardized order set was used in 87%(n=46/53) of patients in Phase 4. One VTE occurred 3 days after discharge in a patient who did not receive extended thromboprophylaxis. Postoperative readmissions were higher in the thromboprophylaxis group(9 vs. 2, p=0.102), but none was associated with significant bleeding.

Conclusion/Implications: Local educative interventions, provincial DOAC reimbursement and a standardized order set significatively improved the rate of extended postoperative thromboprophylaxis prescribed to gynecologic oncology patients undergoing laparotomy, without increasing postoperative complications.

EP190 / #402

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

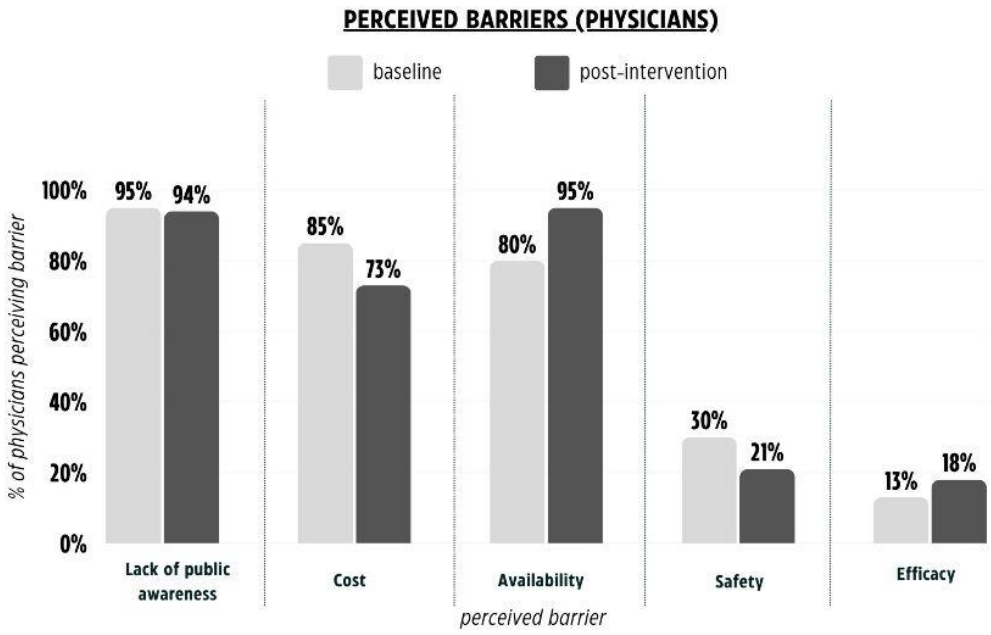
TITLE: IMPROVING HUMAN PAPILLOMAVIRUS VACCINATION IN UKRAINE: IMPACT OF TARGETED PHYSICIAN EDUCATION ON KNOWLEDGE, ATTITUDES, AND CLINICAL PRACTICE

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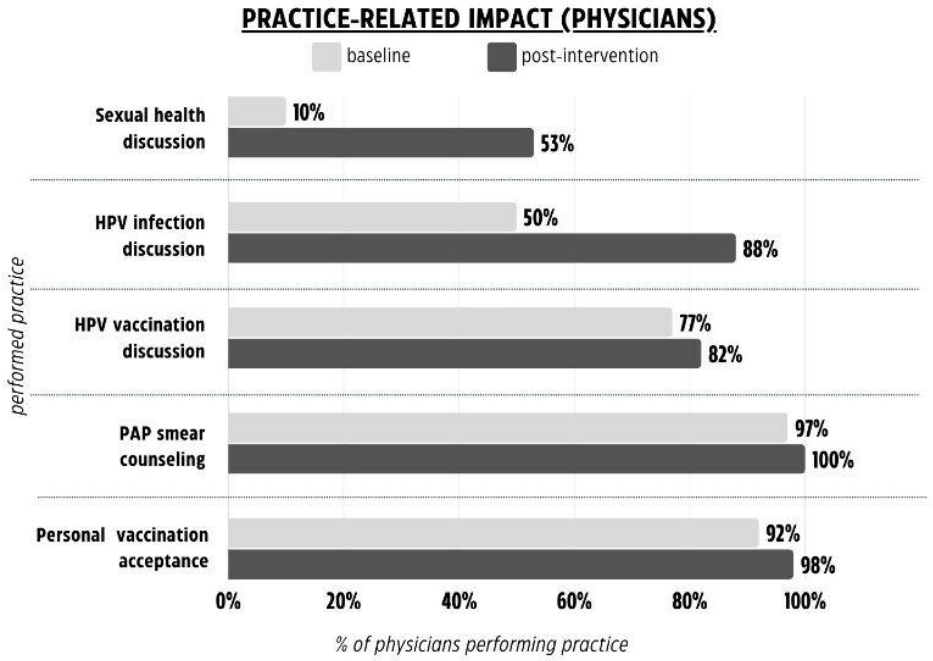
Introduction: Cervical cancer remains a leading cause of cancer-related mortality in low- and middle-income countries and is driven by human papillomavirus (HPV) infection. Despite vaccine availability in Ukraine, uptake remains low. This study aimed to identify barriers to HPV vaccination and evaluate the impact of targeted physician education.

Methods: This prospective study included primary care physicians and patients in Ivano-Frankivsk, Ukraine. Pre-intervention surveys assessing knowledge, attitudes, and barriers were administered. A structured targeted educational program based on European and US guidelines was delivered through continuing medical education events, emails and social media.

Results: 40 physicians were surveyed at baseline. Among physicians, gaps included male vaccination (27.5%), eligibility age (53%), dosing and administration (45%), and follow-up (27.5%). Post-intervention, physician knowledge improved: with reduction of misconceptions about dosing to 0%, age of eligibility to 8%, follow-up to 0%, and male vaccination to 7%. However, misconceptions about HPV risk in individuals with limited sexual exposure increased from 29% to 81%.Perceived cost and safety concerns decreased by 12% and 9% accordingly, while doubts about efficacy increased by 5%. Concerns about vaccine availability increased to 95%, likely related to the ongoing war.



There were several changes in clinical practice: omission of HPV discussions decreased by 38%, routine sexual health discussions increased by 43%, and vaccination recommendation rates reached 95%.



Conclusion/Implications: Targeted physician education improved knowledge and communication; however, persistent misconceptions and barriers highlight the need for continued education and system-level interventions.

EP191 / #1133

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

HUMAN PAPILLOMAVIRUS VACCINATION RECOMMENDATIONN IN COLPOSCOPY: A MISSED OPPORTUNITY

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Introduction: Cervical cancer remains a major global health burden, largely driven by persistent high-risk HPV infection. Although vaccination reduces incidence, uptake and recall remain challenging. This study assessed agreement between self-reported and registry-recorded HPV vaccination status and examined its association with cervical disease severity in colposcopy patients.

Methods: Retrospective study of patients treated in 2024–2025 at the McGill University Health Centre Colposcopy Clinic. Clinical, demographic, and HPV data were extracted from electronic records. Self-reported vaccination was compared with provincial immunization records, with accuracy (sensitivity, specificity, predictive values) as the primary outcome. Associations were assessed using comparative statistics.

Results: Overall, 199 patients were included, 51 (25.6%) were vaccinated per registry-record, whereas 47 (23.6%) self-reported being vaccinated. Agreement between self-reported and official vaccination showed 76.6% accuracy, with sensitivity of 61.7%, specificity of 91.5%, PPV of 87.9%, and NPV of 70.5%. CIN2+ lesions were present in 115 (57.8%) of patients. No significant associations were found between vaccination status and HPV infection, HPV genotypes, or pathology. Vaccinated patients were younger than unvaccinated patients (mean 34.1 vs. 43.8 years, $p<0.05$). Ethnicity was the only variable significantly associated with vaccination status ($p<0.05$), with vaccination uptake of 24 (38.1%) among White participants compared with 7 (15.9%) among Non-White participants.

Conclusion/Implications: Self-reported HPV vaccination moderately matched registry data but underestimated true coverage. Vaccination rates were low in this high-risk population, with notable disparities. These findings highlight the need for better registry integration, equitable vaccine access, and routine vaccination in colposcopy clinics to reduce missed prevention opportunities.

EP192 / #288

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

KNOWLEDGE, ATTITUDES, AND PRACTICES REGARDING CERVICAL CANCER SCREENING AMONG WOMEN LIVING WITH HIV AT A TERTIARY CENTER IN BANGKOK, THAILAND

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Introduction: Women living with HIV (WLWH) face a significantly higher risk of cervical cancer due to persistent high-risk HPV infection and immunosuppression. While screening is available through Thailand's universal healthcare system, awareness and informed participation remain suboptimal. **Objective:** To assess the knowledge, attitudes, and practices (KAP) regarding cervical cancer screening among WLWH at a tertiary hospital in Bangkok and to identify sociodemographic factors associated with screening behavior.

Methods: This cross-sectional study was conducted between May and August 2024 at King Chulalongkorn Memorial Hospital. Seventy-five WLWH aged ≥ 18 years completed a structured questionnaire assessing KAP related to cervical cancer prevention. Knowledge was scored out of 15, with ≥ 5 indicating proficiency.

Results: The mean age of participants was 50.8 years. While 90.7% had undergone screening at least once, only 12.0% demonstrated proficient knowledge (score ≥ 5/15). Although 65.3% identified HPV as a cause of cervical cancer, significant misconceptions existed, such as attributing the disease to poor hygiene (67.3%) or stress (51.0%). Primary barriers to screening included lack of symptoms (16.0%), embarrassment (5.3%), and fear of pain (5.3%). No significant associations were found between knowledge and sociodemographic factors.

Conclusion/Implications: Despite high screening uptake—likely due to provider-initiated care—substantial knowledge gaps persist among WLWH. Integrating tailored educational interventions into HIV clinical services is essential to shift from passive compliance to informed, autonomous health behavior.

EP193 / #246

Topic: *AS05. Prevention & Early Detection / AS05e. Prevention & Vaccination*

HUMAN PAPILLOMAVIRUS VACCINE HESITANCY: UNIQUE PHENOMENON OR GENERAL VACCINE FATIGUE? A POPULATION-BASED LOCALITY STUDY

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Introduction: Human Papillomavirus (HPV) vaccination rates consistently lag behind other routine childhood immunizations globally. It remains unclear whether this discrepancy stems from specific resistance to the HPV vaccine or reflects broader vaccine hesitancy trends within communities. This study aimed to determine whether a locality's adherence to the routine immunization schedule predicts its HPV vaccination coverage, and to identify specific behavioral profiles

Methods: We conducted an ecological study analyzing 2023 vaccination coverage data from 247 Israeli localities. We compared uptake rates of HPV dose-2 vaccination against routine childhood vaccines administered in infancy and adolescence. Spearman's rank correlation coefficients were calculated to assess associations, and gap analyses were performed to identify locality-specific discrepancies.

Results: HPV vaccination rates were consistently lower than other routine vaccines. However, strong positive correlations were found between HPV dose-2 coverage and all other vaccines, such as Rotavirus ($\rho=0.80$, $P<0.001$) and Tdap ($\rho=0.77$, $P<0.001$). Gap analysis revealed four distinct behavioral profiles: 1) High Concordance with minimal vaccination gaps; 2) Specific Refusal in ultra-orthodox Jewish localities showing >90% Tdap coverage but near-zero HPV uptake; 3) High Attrition in Bedouin localities demonstrating >95% Tdap but <15% HPV dose-2; and 4) Generalized Hesitancy, displaying uniformly low uptake across all vaccines.

Conclusion/Implications: HPV vaccination uptake is strongly correlated with other vaccination uptake, spanning from infancy to adolescence. However, the significant gap in specific sub-populations, where routine vaccination is high but HPV vaccination is rejected, suggests that while general hesitancy is a major driver, cultural-specific barriers regarding HPV vaccination remain a distinct hurdle requiring intervention.

EP194 / #694

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

INCIDENCE AND RISK FACTORS OF VENOUS THROMBOEMBOLISM IN EPITHELIAL OVARIAN, FALLOPIAN TUBE, AND PRIMARY PERITONEAL CANCER PATIENTS AT THE DIAGNOSIS AND WHO UNDERWENT NEOADJUVANT CHEMOTHERAPY: A RETROSPECTIVE STUDY

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Introduction: This study aimed to assess the incidence of cancer-associated thrombosis (CAT) during neoadjuvant chemotherapy (NACT) at Siriraj Hospital. Secondary objectives included identifying factors associated with thrombosis and evaluating the accuracy of the Khorana score in predicting thrombotic events.

Methods: This retrospective study included 273 patients who received NACT for ovarian, fallopian tube, or primary peritoneal cancer at Siriraj Hospital between March 2009 and March 2024. Data on baseline characteristics, cancer-related factors, and the incidence of CAT were collected and analyzed. The predictive accuracy of the Khorana score for thrombosis risk was also evaluated.

Results: Among the 273 patients, the incidence of deep vein thrombosis (DVT) was 12.5% and pulmonary embolism (PE) was 8.1% during NACT. A Khorana score cut-off ≥2 demonstrated high sensitivity (79.1%) but poor specificity (14.8%), whereas a cut-off ≥3 improved specificity (69.6%) but severely reduced sensitivity (37.2%). Multivariate logistic regression identified a platelet count ≥350,000/μL as the only factor significantly associated with a decreased risk of thrombosis (aOR=0.35; 95%CI:0.16–0.75; p=0.007).

Conclusion/Implications: Although the incidence of CAT in this Thai cohort is lower than that reported in Western populations, the associated morbidity remains substantial. Interestingly, elevated platelet counts—traditionally considered a prothrombotic risk factor—were inversely associated with thrombosis in this cohort. Consequently, the standard Khorana score alone is insufficient for predicting thrombosis risk in this specific population.

EP195 / #362

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

EXPERIENCE AND FACTORS INFLUENCING UPTAKE OF CERVICAL CANCER SCREENING IN ETHIOPIA

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Introduction: Cervical cancer is a preventable disease when precancerous lesions are detected and treated early. Despite national guidelines, screening uptake remains far below expectations, and cervical cancer continues to be the second most common gynecologic cancer among Ethiopian women. Previous studies have focused mainly on women aged 30–49, leaving limited evidence on screening behaviours among the broader at-risk population aged 21–65.

Methods: An explanatory sequential mixed-methods design was used. Phase I involved a community-based cross-sectional survey of 432 randomly selected women. Phase II consisted of in-depth interviews with nine purposively selected participants. Quantitative data were analysed using SPSS version 30, with variables significant at $p < 0.25$ entered into multivariable logistic regression. Qualitative data were analysed using deductive-led thematic analysis with inductive refinement.

Results: Among the 432 respondents, 80.8% had never been screened, while only 19.2% had undergone screening at least once. Moderate to poor awareness significantly reduced screening uptake (moderate awareness: AOR = 0.06, p = 0.043; poor awareness: AOR = 0.01, p = 0.003). Having multiple sexual partners was negatively associated with screening (AOR = 0.35, p = 0.049). Enhancing factors included family support (AOR = 5.36, p = 0.000), access to HPV self-sampling (AOR = 4.65, p = 0.009), health worker recommendations (AOR = 5.66, p = 0.001), and messages from celebrities (AOR = 2.33, p = 0.039).

Conclusion/Implications: Screening uptake in the Arsi Zone remains critically low. Achieving the WHO target of 70% coverage will require intensified community mobilization, improved education, enforcing laws, and expanded access to acceptable screening methods

EP196 / #735

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

HIGH RISK HUMAN PAPILLOMAVIRUS SELF-SAMPLING FOR CERVICAL CANCER SCREENING IN QUEBEC: A LARGE-SCALE FEASIBILITY STUDY

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Introduction: In Canada in 2025, an estimated 1,650 women were diagnosed with cervical cancer, and 430 died from the disease. Human Papillomavirus (HPV) is responsible for approximately 99,7% of all cervical cancer. In primary screening, HPV testing is now progressively replacing cervical cytology. Although the accuracy and acceptability of self-sampling have been proven, most standardized provincial screening systems still rely on health care professional–collected samples. Large-scale feasibility data on self-sampling remain limited.

Methods: We conducted a prospective cohort study evaluating primary cervical cancer screening using high-risk HPV self-sampling kits for the collection of cervicovaginal cells with a dry swab. Kits were distributed through four mechanisms: by mail or through partner centers. Follow-up was conducted according to current provincial guidelines. Patient satisfaction and preference of self-sampling distribution were assessed through a structured survey.

Results: 1,000 self-sampling kits were distributed through four collection methods with a global return rate of 59,6%. The highest return rate was in the home mailing group (75,3%). Of the returned samples, 0.8% were invalid and the positivity rate for high-risk HPV was 12.1%. Overall, 98.2% of participants reported being satisfied or highly satisfied with the self-sampling process.

Conclusion/Implications: This large cohort demonstrated strong interest in HPV self-sampling as well as the feasibility and effectiveness of a large-scale self-sampling system that requires minimal physician involvement and provides excellent patient follow-up. Integrating HPV self-sampling into cervical cancer screening programs could represent an effective strategy to increase screening participation.

EP197 / #453

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

BARRIERS AND FACILITATORS TO TIMELY FOLLOW-UP AFTER ABNORMAL CERVICAL CANCER SCREENING AND PARTICIPANT-INFORMED COMMUNICATION PREFERENCES TO IMPROVE CARE

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Introduction: The objective of this study was to examine barriers and facilitators to follow-up after abnormal cervical cancer screening (CCS), with particular emphasis on identifying participant-informed preferences to improve follow-up care.

Methods: This qualitative study included individual interviews designed to assess patients' perceived barriers and facilitators to CCS follow-up and communication preferences. Patients with abnormal CCS results were categorized into three groups based on adherence to follow-up and location (urban or rural): adherent (follow-up within 3 months); delayed (follow-up between 3 and 12 months), and nonadherent (follow-up greater than 12 months). Interview transcripts were independently coded by two investigators, and major themes were defined as concepts identified in 50%+ of the interviews.

Results: Thirty women participated in the interviews. Participants were categorized as adherent (n=19), delayed (n=8), or nonadherent (n=4). Most participants were rural residents (n=21) and 10 were categorized as urban residents. The predominant themes identified included health-related fear and stigma(80.0%); fear as a motivator for follow-up (53.3%); structural and practical barriers(53.3%); and interpersonal influence and advocacy related to screening(53.3%). Participants also highlighted substantial education and informational needs(93.3%), as well as preferences regarding communication and access to care(63.6%). Significant knowledge gaps were identified regarding the causes of cervical

cancer(90.0%).

Table 1. Facilitators, barriers, and communication preferences		
Facilitators and barriers (100.0% of women commented on these)		
	Major themes:	Minor themes:
Facilitators:	-Fear as a motivator for action (53.3%) -Advocacy and interpersonal influence (53.3%)	-Normalization of testing as a motivator (30%) -Influence of family experiences (36.6%) -Positive role modeling (16.6%)
Barriers:	-Knowledge gaps and lack of understanding of causes (90.0%) -Health-related fear, anxiety, and stigma (80%) -Structural and practical barriers to care (social challenges, insurance, scheduling difficulties, work conflict) (53.3%)	-Misinformation and misperceptions (30.0%)
Communication preferences (56.6% of women commented on these)		
How to be contacted	Phone 41.2% In person 11.8% Portal 47.0%	
Where they get their information	Internet/social media: 41.2% Physician office: 29.4% No comment: 29.4%	
Comments on preferred education and information needs	Preferred education that was timely and delivered at the time results were communicated, using clear, simple language supplemented by both visual and written materials. Participants also expressed interest in printed resources and app-based educational tools to reinforce understanding and support follow-up care.	

Conclusion/Implications: These findings suggest that patient education along with addressing structural barriers are critical strategies for reducing fear, mitigating both practical and psychosocial barriers, and improving patient experience. Providing clear, accessible, and evidence-based information, including dissemination with social media, may also help address knowledge gaps and misinformation while promoting more informed engagement with care.

EP198 / #98

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

ESTIMATING A PRIORI RISK OF OVARIAN CANCER FROM CLINICAL PRESENTATION: A LIKELIHOOD- BASED FRAMEWORK AND MONTE CARLO SIMULATION

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Introduction: The objective of this study was to develop a clinically interpretable framework for estimating pretest risk of ovarian cancer from symptom profiles and to assess robustness of these estimates under uncertainty.

Methods: We conducted a likelihood-based modeling study with probabilistic sensitivity analysis using eight ovarian cancer findings: abdominal distension, abdominal mass, abdominal pain, abnormal vaginal bleeding, appetite loss, bowel habit change, family history, and weight loss. Positive likelihood ratios served as evidential weights. All 255 non-empty combinations were evaluated across baseline risks of 0.2%, 0.5%, 1.0%, and 5.0%. Unincluded findings were treated as unobserved. Deterministic estimates used Bayesian updating, while probabilistic sensitivity analysis used 50,000 Monte Carlo iterations per profile and scenario. Likelihood-ratio uncertainty was sampled on the log scale, and dependence assessed by attenuating each sampled log-likelihood contribution with a random factor between 0.60 and 1.00.

Results: Across 1,020 profile-baseline combinations, estimated risk increased with baseline risk, number of positive findings, and evidential strength. At a 0.2% baseline risk, median simulated risks for abdominal mass and abdominal distension alone were 2.89% and 1.76%. At the same baseline, abdominal distension with appetite loss produced a median risk of 9.57% (95% simulation interval 3.68–25.97%), and with mass 21.54% (7.86–50.59%). Aggregate summaries showed frequent threshold crossing in multi-finding profiles but reflect model behavior across symptom space rather than expected risk in symptomatic patients.

Conclusion/Implications: Symptom-based risk can be expressed as explicit pretest probability rather than informal judgment. While not a clinical guideline or validated tool, this framework provides a transparent approach to structuring risk before testing.

EP199 / #702

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

PREVALENCE AND GENOTYPE DISTRIBUTION OF HIGH-RISK HUMAN PAPILLOMAVIRUS IN LEBANESE WOMEN: A PILOT STUDY.

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Introduction: To evaluate the prevalence, genotype distribution, and cytological correlates of high-risk human papillomavirus (hrHPV) infection in Lebanese women undergoing cervical cancer screening, and to provide contemporary epidemiological data guiding prevention strategies.

Methods: We conducted a retrospective cohort study including 3,503 women who underwent liquid-based cytology and hrHPV testing using the BD Onclarity assay at a tertiary care center in Lebanon. Cytological findings were classified according to the Bethesda system. HrHPV prevalence, age-specific patterns, and genotype distribution were analyzed and assessed in relation to cytological outcomes.

Results: The mean age of participants was 48.99 years, and 86.3% tested negative for intraepithelial lesion or malignancy (NILM) cytology. The overall hrHPV prevalence was 12%. HrHPV-positive women were significantly younger than hrHPV-negative women (45.3 vs 49.5 years, $p<0.001$), with peak prevalence in the 26–45-year age group (15.5%), followed by a decline with increasing age. HrHPV positivity increased with cytological severity, from 4.7% in NILM to 51.1% in ASC-US and 84.8% in LSIL, reaching 62.5% in ASC-H and 100% in HSIL, although higher-grade categories were limited cases. Notably, 33.7% of hrHPV-positive cases occurred in women with NILM cytology. Genotype distribution was dominated by HPV56/59/66 (30.4%), followed by HPV35/39/68 (20.0%) and HPV16 (18.5%), while HPV18 was less frequent (6.4%).

Conclusion/Implications: This study demonstrates a distinct HPV epidemiological profile in Lebanon, characterized by a predominance of non-HPV16/18 genotypes. These findings support the implementation of HPV-based screening and risk-stratified management, and highlight the potential added value of broader-coverage vaccination strategies in this population.

EP200 / #839

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

BRIDGING THE CERVICAL CANCER SCREENING-TO-TREATMENT GAP IN INDIA: MULTICENTRIC COMMUNITY-BASED IMPLEMENTATION OF HUMAN PAPILLOMAVIRUS SELF-TESTING WITH TRIAGE AND ONSITE THERMOCOAGULATION

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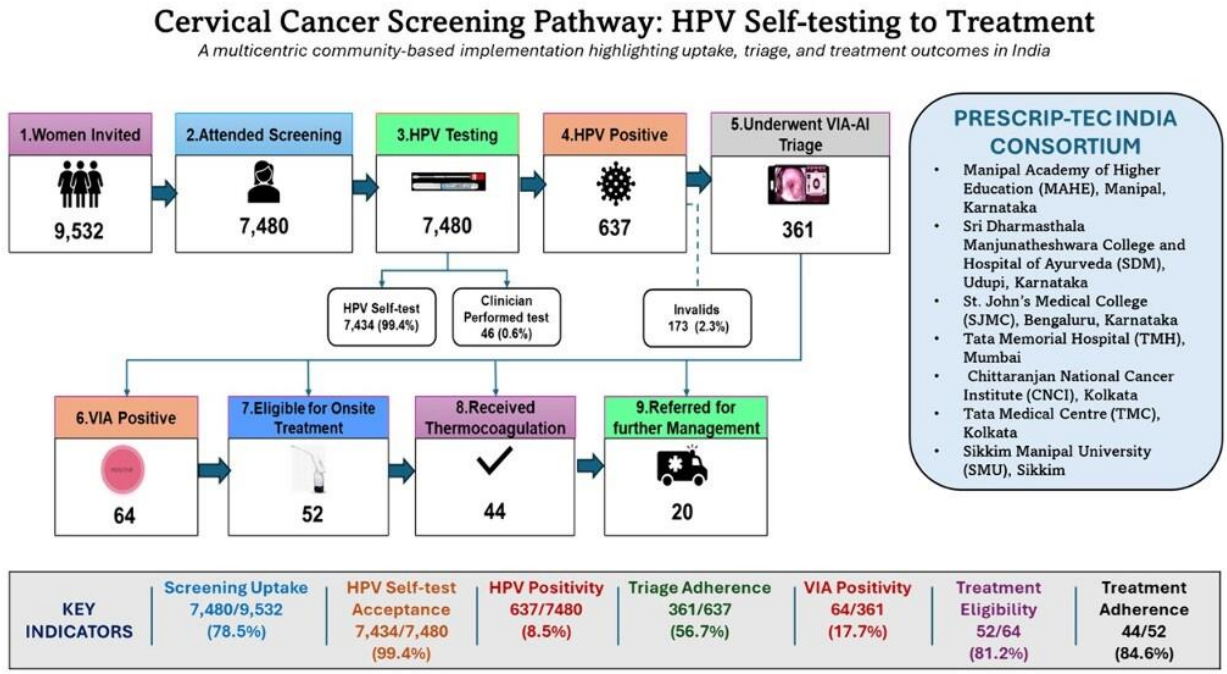
Introduction: Bridging the gap between cervical cancer screening and timely treatment remains a major challenge in low- and middle-income countries. Integrated approaches combining HPV self-testing with point-of-care triage and treatment may ensure enhanced screening and adherence.
To evaluate screening uptake, triage adherence, and treatment completion within a real-world, we planned a multicentric implementation study including primary HPV self-testing followed by AI-assisted VIA along with on-site thermocoagulation/ referral in India.

Methods: This community-based implementation study was conducted across seven centres in India under the multicountry PRESCRIP-TEC initiative. Women were mobilised through community outreach at primary health centres, subcentres, mobile camps, and workplaces. Following informed consent, participants performed HPV self-testing. For women testing HPV positive, we performed VIA-AI triage using the SAKHI-Manipal device (validation phase). Women with ablation-eligible lesions received on-site thermocoagulation; others were referred for higher-level care.

Results: Among 9,532 women invited, 7,480 (78.5%) attended screening. Of these, 7,434 (99.4%) opted for HPV self-testing. Overall, 637 (8.5%) tested HPV positive, while 173 (2.3%) had invalid results. Triage uptake was 56.7% (361/637), representing the largest attrition point. VIA positivity was 17.7% (64/361). Among VIA positive women, 81% (52/64)

were eligible for thermocoagulation, and 84.6% (44/52) underwent on-site treatment. Twenty women required referral.

Conclusion/Implications:



HPV self-testing demonstrated high uptake; on-site treatment was highly acceptable among eligible women. However, a substantial drop-off at the triage stage highlights the need for robust awareness campaigns and counselling. Integrating self-testing with VIA-AI triage and onsite treatment provides a feasible and scalable strategy to reach WHO 90-70-90 goal towards cervical cancer elimination.

EP201 / #318

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

EVALUATING A COMMUNITY VOLUNTEER TRAINING WORKSHOP AS A PATHWAY TO SUPPORTING HPV SELF-SAMPLING IN SINGAPORE

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Introduction: Singapore's cervical screening coverage plateus at 43.5%, highlighting gaps beyond clinic-based models. HPVSimple is a community-driven screening approach where trained volunteers support HPV self-sampling outside clinical settings. This study evaluates the impact of volunteer training on screening outcomes.

Methods: Volunteers recruited through community networks underwent a 2.5-hour workshop comprising didactics on HPV and cervical cancer and role-play components on cervical screening counselling. Pre- and post-workshop surveys assessed volunteers' HPV and cervical cancer knowledge (11 items), confidence, personal screening and vaccination history. Screening event data measured kit return rates, screening preferences, and participant satisfaction with volunteer support.

Results: 81 volunteers (age 16–73, mean 43 years), half from non-healthcare sectors, participated. Notably, 60.5% had never been screened and 61.7% were unvaccinated against HPV. Median knowledge accuracy improved from 63.6% to 81.8% with the largest gain in screening eligibility: knowledge of sexual history as a screening prerequisite rose from 23% to 79%. HPV vaccination literacy improved by 25–36%. Post-workshop, 97.1% reported increased knowledge and 84.1% increased confidence. Fear and cost were key deterrents for both volunteers and screening participants. Post-screening, 71.4% preferred self-sampling and volunteer support was rated 4.7/5.

Conclusion/Implications: This workshop transformed a diverse, largely non-healthcare volunteers into effective advocates, enabling 327 successful screenings. Correcting critical misconceptionsproved achievable across age groups. Shared backgrounds between volunteers and participants position volunteer training as a dual prevention touchpoint, reaching an at-risk population through service. Participant preference for self-sampling signals a behaviour shift, supporting volunteer-driven self-sampling as a cervical cancer elimination strategy.

EP202 / #351

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

EMPOWERING WOMEN THROUGH COMMUNITY-BASED HPV SELF-SAMPLING

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Introduction: Cervical cancer is the 10th most common cancer among women in Singapore. Screening uptake has plateaued at 43.5% despite national subsidies. This study evaluates a community-driven HPV self-sampling model introduced in March 2025.

Methods: HPV Simple is a mixed-methods evaluation of a community-based screening approach combining education with self-sampling HPV tests. The model was co-designed with community stakeholders. Between 2025 and early 2026, screenings were conducted across community centres and religious sites. Women were recruited opportunistically, and samples were self-collected in private tents. Pre- and post-screening feedback was collected via surveys.

Results: 327 screenings were completed. Most participants had heard of cervical screening before the event (80.5%), and only 51.8% have ever gone for their screening in their lifetime. Even among those participants who have screened previously, most did not return for their routine screening because of cost (28.8%), lack of time (20.5%), fear of pain (18.6%) and test-related discomfort (17.9%). Acceptance of self-sampling tests was high, driven by ease of use (80.4%), comfort (53.2%), and privacy (49.0%). Overall, 96.1% would recommend the method, and 74.7% felt confident performing the test themselves. Notably, 71.2% preferred self-sampling for future screening. Satisfaction with volunteer support was strong (mean 4.7/5). All test kits were returned with no invalid results.

Conclusion/Implications: Community-driven HPV self-sampling tests can address screening barriers and expand access to preventive care. By integrating education and volunteer support within familiar community settings, this approach improves awareness, reduces anxiety, and promotes uptake. It shows potential for effective implementation in Singapore.

EP203 / #880

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

ACCURACY OF DIFFUSION KURTOSIS IMAGING IN DETERMINING TUMOR HETEROGENEITY AND MICROSATELLITE INSTABILITY PREDICTION AMONG ENDOMETRIAL LESIONS

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Introduction: Endometrial cancer, the most common gynecologic malignancy, requires reliable non-invasive biomarkers for early diagnosis and molecular characterization. Tumor heterogeneity reflects genetic alterations such as microsatellite instability (MSI), which has key prognostic and therapeutic value. This study evaluates whether diffusion kurtosis imaging (DKI) parameters can differentiate benign, premalignant, and malignant endometrial lesions and assess their ability to predict MSI by capturing intratumoral heterogeneity. Such imaging biomarkers could improve risk stratification, guide personalized treatment, and reduce dependence on invasive tissue sampling.

Methods: In this prospective study, patients with histologically confirmed atypical hyperplasia or carcinoma underwent pelvic Magnetic Resonance Imaging with Diffusion Kurtosis Imaging. Mean kurtosis and mean diffusivity were analyzed. Microsatellite instability status was determined by immunohistochemistry. Group comparisons and ROC analysis were performed.

Results: Carcinomas showed higher mean kurtosis (MK: 1.21±0.18 vs 0.89±0.15, $p<0.001$) and lower mean diffusivity (MD: 0.92±0.12 vs 1.18±0.14 $\times 10^{-3}$ mm^2/s, $p<0.001$) than hyperplasia. MSI-high tumors had higher MK than MSI-low (1.34±0.20 vs 1.05±0.16, $p=0.001$). MK effectively differentiated hyperplasia from carcinoma (AUC=0.89; sensitivity 85%, specificity 82%) and predicted MSI status (AUC=0.86; sensitivity 83%, specificity 78%). Combined MK and MD improved accuracy (AUC=0.92), demonstrating strong diagnostic performance (AUC ≈0.88–0.92), with MK showing the highest sensitivity for malignancy detection.

Conclusion/Implications: Diffusion kurtosis imaging parameters, particularly Mean kurtosis and mean diffusivity, demonstrate potential in differentiating between endometrial lesions. These findings support their role as non-invasive imaging biomarkers of tumor

heterogeneity and a potential “virtual biopsy” approach for molecular risk stratification. Larger studies are required to validate MSI prediction.

EP204 / #292

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

ASSOCIATION BETWEEN CLINICAL SYMPTOMS AND DISEASE STAGE IN ENDOMETRIAL CANCER

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Introduction: Endometrial cancer typically presents with abnormal bleeding; there are cases where patients do not recognize abnormal bleeding even in advanced stages. This study aims to investigate the proportion of patients experiencing symptoms across disease stages and to clarify the association between symptoms and stage.

Methods: The study included patients diagnosed with endometrial cancer at our hospital between September 2023 and April 2026, for whom preoperative symptoms could be confirmed via a questionnaire, with the opportunity to decline to answer the questionnaire. The questionnaire assessed the presence or absence of “vaginal bleeding,” “vaginal discharge,” “odor of vaginal discharge,” and “pain.” We performed a trend analysis of these findings by FIGO 2008 stage. Additionally, a subgroup analysis was performed based on menopausal status.

Results: The study included 70 participants (mean age 60.5), and 24 menstruating (mean age 47.5). As for the stage and number, 43 in Stage I, 6 in II, 12 in III, and 9 in IV. The number of symptomatic patients by stage (Stage I/II/III/IV) was as follows: bleeding: 21/5/8/8; vaginal discharge: 27/6/9/7; odor: 18/3/8/4; pain: 15/3/8/6. Bleeding and pain tended to increase with stage progression, and postmenopausal women showed a similar trend. No clear trend was observed in the number of patients with vaginal discharge or vaginal odor across stages. Regardless of menopausal status, half of the patients in Stage I did not experience bleeding.

Conclusion/Implications: The prevalence of bleeding and pain as symptoms of endometrial cancer is associated with stage. However, half of the early-stage cases did not involve bleeding.

EP205 / #864

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

CLINICAL BACKGROUND OF OVARIAN CANCER DEVELOPMENT IN PATIENTS WITH A HISTORY OF BREAST CANCER

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Introduction: In our country, certain aspects of the HBOC management are covered by health insurance. Consequently, the frequency of BRCA1/2 genetic testing has increased at our institution, and the number of risk-reducing salpingo-oophorectomies performed has also risen. Since 2015, we have been performing RRSO in accordance with various guidelines. However, the optimal timing for these procedures remains a subject of debate. In this study, we examined the clinical background of cases where patients with a history of breast cancer developed primary epithelial ovarian cancer to provide useful information regarding the optimal timing for future RRSO procedures.

Methods: We searched for 273 cases of ovarian cancer diagnosed at our hospital between 2021 and 2025 and conducted a retrospective analysis of the 27 cases (9.9%) with a history of breast cancer.

Results: The histological types of ovarian cancer were as follows: 17 cases of high-grade serous carcinoma, and borderline serous neoplasm; 1 , endometrioid carcinoma; 4, clear cell carcinoma; 3, borderline mucinous neoplasm; 1, mixed malignant neoplasm; 1. The median age at onset was 60 (46–86) years. 19 patients met the NCCN guidelines for HBOC screening prior to the onset of ovarian cancer. Subsequently, the HRD companion diagnostic test was performed in 8 cases, and somatic variants were identified in all of them. Furthermore, BRCA germline pathogenic variants were identified in 3 of the 3 cases tested.

Conclusion/Implications: This study identified cases in which RRSO may have prevented the development of ovarian cancer. We believe this information should be used to recommend RRSO at an appropriate time.

EP206 / #508

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

THE COST OF PREVENTION: SOCIOECONOMIC DEPRIVATION, LOW DOCUMENTED HPV VACCINATION UPTAKE, AND CERVICAL CYTOLOGIC SEVERITY IN A COMMUNITY HEALTH CENTER COHORT

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Introduction: Cervical cancer is preventable through Human Papillomavirus (HPV) screening and follow-up, yet disparities in abnormal cytology persist. Socioeconomic deprivation may influence risk by shaping access to prevention, vaccination, and care.

Methods: We conducted a retrospective chart review of 1,707 women undergoing cervical cytology screening at a community health center in Toledo, Ohio. Deprivation was measured using state-level Area Deprivation Index (ADI) deciles. Cytology was analyzed as an ordinal variable reflecting disease severity (NILM to HSIL). Associations between deprivation and cytologic severity were evaluated using chi-square testing, Spearman correlation, and proportional odds regression. Propensity score matching compared high-ADI patients (deciles 8–10) with lower-ADI patients, balancing age and HPV status.

Results: Among 1,141 patients with available data, only 305 (26.7%) had documented HPV vaccination. Higher deprivation was associated with cytologic severity in unadjusted analyses (Spearman $\rho = 0.074$, $p = 0.002$; χ^2 $p = 0.03$). High-ADI patients had higher HSIL rates (2.82% vs. 1.27%). Each ADI decile increase was associated with higher cytologic grade (OR 1.05, 95% CI 1.02–1.08); this attenuated after adjustment for HPV (OR 1.02, 95% CI 0.99–1.06). HPV remained the strongest predictor of cytologic severity (OR 10.85, $p < 0.001$). In matched analyses, high ADI remained associated with higher cytologic severity (OR 1.32, 95% CI 1.08–1.60) and high-grade lesions (OR 1.72, 95% CI 1.01–2.99).

Conclusion/Implications: Socioeconomic deprivation is associated with increased cervical cytologic severity independent of HPV. Low documented HPV vaccination uptake highlights an opportunity for prevention and screening in high-risk populations.

EP207 / #1035

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

IMPLEMENTATION OF AN HPV-BASED NATIONAL CERVICAL CANCER SCREENING PROGRAM IN NIGERIA: INSIGHTS FROM THE FIELD EXPERIENCE

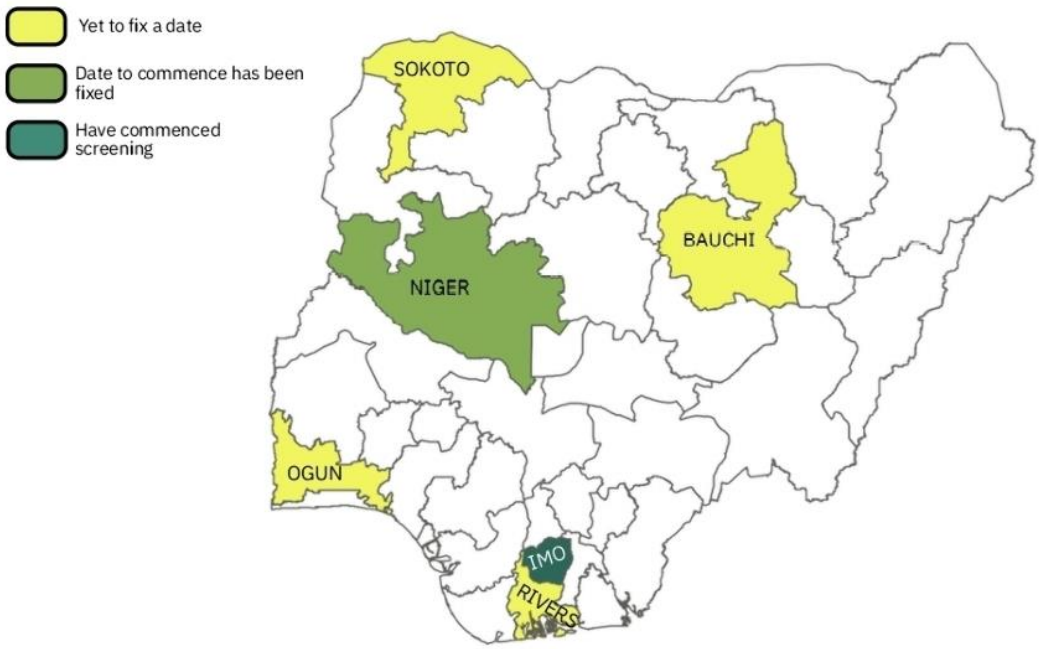
National Project Implementation Committee Ntf-Cce[1], Ishak Lawal[2]
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Introduction: Nigeria officially flagged off an HPV-based organized cervical cancer screening program in 2026.

Methods: Narrative review of the planning and implementation of Nigeria's HPV-based organized cervical cancer screening program. We plan to present the strategic goal, engagement of subnational governments and other stakeholders, production of tools and training approaches to fast-track elimination agenda in the country.

Results: The National Taskforce on Cervical Cancer Elimination (NTF-CCE) was inaugurated in 2024 to lead national efforts toward cervical cancer elimination in Nigeria. The NTF-CCE, with the support of stakeholders within the Partnership to Eradicate Cervical Cancer in Nigeria (PECCiN), developed national tools and a roadmap for cervical cancer elimination in Nigeria. The implementation framework leveraged on the existing healthcare systems, political structures and other resources of the country to ensure sustainability and nationwide coverage. The goal was to screen 8 million women annually to achieve 70% population coverage among eligible women. Donation from the first lady of Nigeria provided the catalytic fund for phase implementation of the developed framework at the subnational level. Integrating the hub and spoke model into the 3-tier health system of the country ensures screen-positive cases are tracked across the continuum of care, while designing the scale-up strategy along the administrative structure of the country to harness

political goodwill for sustainability and community ownership.



Distribution of states for zonal implementation of National HPV-based organised cervical cancer screening program

Conclusion/Implications: HPV-based population screening for cervical cancer is feasible and sustainable in low-resource settings like Nigeria. Coverage of the target population, however, still remains a major concern because of cost.

EP208 / #638

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

CRISPR-CAS12A-DRIVEN AUTOCATALYTIC NUCLEIC ACID CIRCUIT FOR ULTRASENSITIVE MOLECULAR DETECTION

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Introduction: Catalytic nucleic acid circuits are artificial dynamic molecular networks enabling signal amplification, biosensing and logic operations. Highly sensitive circuits for multiple target molecules hold significant value for precise disease diagnosis and prognosis assessment. The CRISPR-Cas12a system enables precise recognition of target sequences and programmable regulation of guide RNA. However, existing CRISPR-Cas autocatalytic circuits can only respond to a single input signal, limiting their application in complex biological samples. Developing an orthogonal circuit capable of responding to multiple target molecules represents a critical breakthrough.

Methods: We designed a CRISPR-Cas-driven autocatalytic nucleic acid circuit for versatile molecular detection. The stringent target recognition capability and efficient trans-cleavage activity of CRISPR-Cas12a were integrated through a switchable spacer guide RNA with self-reporting functionality. The circuit was activated by modulating its on/off state via target molecules, achieving catalytic signal amplification capable of handling multiple input sources without loss, combining sensitivity, timeliness, programmability and orthogonality.

Results: Sensitive detection of human papillomavirus (HPV) infection, cervical cancer-related miRNA-21, UDG, APE-1 and ovarian cancer-associated mutant gene BRCA in clinical samples demonstrated its multifunctionality and practicality, providing a powerful and promising new tool for disease diagnosis.

Conclusion/Implications: This circuit represents a critical breakthrough in molecular detection. By enabling simultaneous response to multiple target molecules while maintaining sensitivity, timeliness, programmability and orthogonality, this system offers a powerful tool for precise disease diagnosis, treatment guidance and prognosis assessment. Its successful application in detecting multiple cancer biomarkers (BRCA, miRNA-21) and other disease-related molecules (HPV, UDG, APE-1) in clinical samples demonstrates significant potential for advancing personalized medicine.

EP209 / #842

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

DETERMINANTS OF DELAYED DIAGNOSIS AND INITIATION OF TREATMENT IN CERVICAL CANCER: A STATISTICAL ANALYSIS FROM UZBEKISTAN

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Introduction: Цель исследования – оценить факторы, связанные с задержкой диагностики и началом специализированного лечения у пациенток с раком шейки матки, с помощью статистического анализа.

Methods: A cross-sectional study included 80 patients with histologically confirmed cervical cancer treated in oncology institutions in Uzbekistan. Data were collected using a standardized REDCap-based questionnaire adapted according to WHO methodology, covering three domains of delay: 1.Patient-related delay 2.Healthcare provider-related delay 2. System (organizational) delay A delay in treatment initiation was defined as an interval exceeding 60 days from diagnosis. Statistical analysis included descriptive statistics, chi-square (χ^2) tests, and multivariate logistic regression to identify significant predictors of delay.

Results: A total of 56% of patients experienced treatment initiation delays exceeding 60 days. Advanced-stage disease (FIGO stage III–IV) was observed in 68% of cases. Key determinants of delay included: 1.Low awareness level (OR = 2.4; $p < 0.01$) 2.Late healthcare-seeking behavior (OR = 3.1; $p < 0.001$) 3.Insufficient oncologic vigilance among primary care providers (OR = 2.0; $p < 0.05$) 4.Healthcare system-related organizational barriers (OR = 2.7; $p < 0.01$) Additionally, patients residing in rural areas demonstrated a significantly higher risk of delayed treatment initiation ($p < 0.05$).

Conclusion/Implications: Delayed initiation of cervical cancer treatment is driven by a complex interplay of patient-, provider-, and system-level determinants. Addressing these delays requires: 1.Strengthening screening programs 2.Improving oncologic awareness among primary care providers 3.Optimizing patient referral pathways 4.Implementing monitoring systems for diagnostic and treatment intervals Targeted interventions at multiple levels are essential to reduce delays and improve clinical outcomes in cervical cancer patients.

EP210 / #388

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

HIGH BURDEN OF UNDETECTED HIGH-RISK HPV AMONG VIA-NEGATIVE WOMEN LIVING WITH HIV: IMPLICATIONS FOR CERVICAL CANCER SCREENING IN LOW-RESOURCE SETTINGS.

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Introduction: Women living with HIV (WLHIV) are at an increased risk of persistent high-risk human papillomavirus (hrHPV) infection and rapid progression to cervical cancer. In Uganda, Visual Inspection with Acetic Acid (VIA) is widely used for screening despite concerns about suboptimal sensitivity in high-risk populations. Therefore the purpose of this study was to determine the prevalence of hrHPV infection and quantify missed detection among VIA-negative WLHIV using HPV DNA testing.

Methods: A cross-sectional study was conducted over 3 months at Rakai Hospital among WLHIV aged 25–49 years. A total of 384 participants were consecutively enrolled. All participants underwent VIA screening followed by HPV DNA testing using GeneXpert. The primary outcomes were hrHPV positivity and concordance between VIA and HPV testing.

Results: The prevalence of hrHPV infection was 50.0% (192/384). All VIA-positive participants were hrHPV-positive, indicating high specificity. However, approximately half of hrHPV-positive women were VIA-negative, suggesting that VIA missed nearly 50% of underlying hrHPV infections. This marked discordance demonstrates a substantial sensitivity gap in VIA-based screening. Clinical patterns further indicated late-stage presentation among referred cases consistent with delayed detection.

Conclusion/Implications: VIA substantially under-detects hrHPV infection among WLHIV missing nearly half of affected individuals. HPV DNA testing offers superior detection and should be prioritized for integration into primary healthcare settings to improve early diagnosis and reduce advanced cervical cancer presentation in resource-limited settings.

EP211 / #576

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

BEYOND ACCESS: PSYCHOLOGICAL, LOGISTICAL, AND SYSTEMIC DETERMINANTS OF CERVICAL CANCER PREVENTION BARRIERS AMONG WOMEN IN ZAMBIA

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Introduction: Cervical cancer is Zambia's leading cause of oncological mortality, exacerbated by high HIV prevalence. In 2022, Zambia recorded the world's second-highest mortality rate (49.4/100,000) and an incidence of 65.5/100,000. This study evaluates persistent prevention gaps 20 years after the Cervical Cancer Prevention Program launch and 13 years post-HPV vaccine introduction

Methods: A digital cross-sectional survey was conducted (November 2025–April 2026) among 587 Zambian women (≥18 years) recruited via social media snowball sampling, exceeding the 384-sample required for 80% statistical power. A structured questionnaire assessed psychosocial, logistical, and systemic barriers to screening and vaccination.

Results: Of 587 respondents, 37.5% (n=220) had never been screened. Barriers included fear of screening procedure (n=145), clinicians not recommending screening during other clinic visits (n=133), difficulty obtaining time away from work (n=94), fear of abnormal results (n=80), prolonged clinic waiting times (n=61), negative staff attitudes (n=56), and lack of privacy (n=51). Regarding HPV vaccination, 74.4% reported they had vaccinated or intended to vaccinate daughters/sisters; however, only 24% reported vaccination of themselves and/or their daughters/siblings. Additional barriers included misinformation that the vaccine "causes cervical cancer and makes girls infertile" or is an "attempt to eliminate Africans." Partner influence varied, with 27.4% reporting lack of partner support.

Conclusion/Implications: Zambia faces a "triple threat" of psychological fear, logistical burdens, and passivity in cervical cancer prevention. Failure to integrate screening into routine care reflects a reactive rather than preventive model. Achieving WHO 90-70-90 targets requires an empathetic, integrated, patient-centered approach proactively incorporating screening into routine care, reducing procedural anxiety, and maximizing prevention opportunities.

EP212 / #699

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

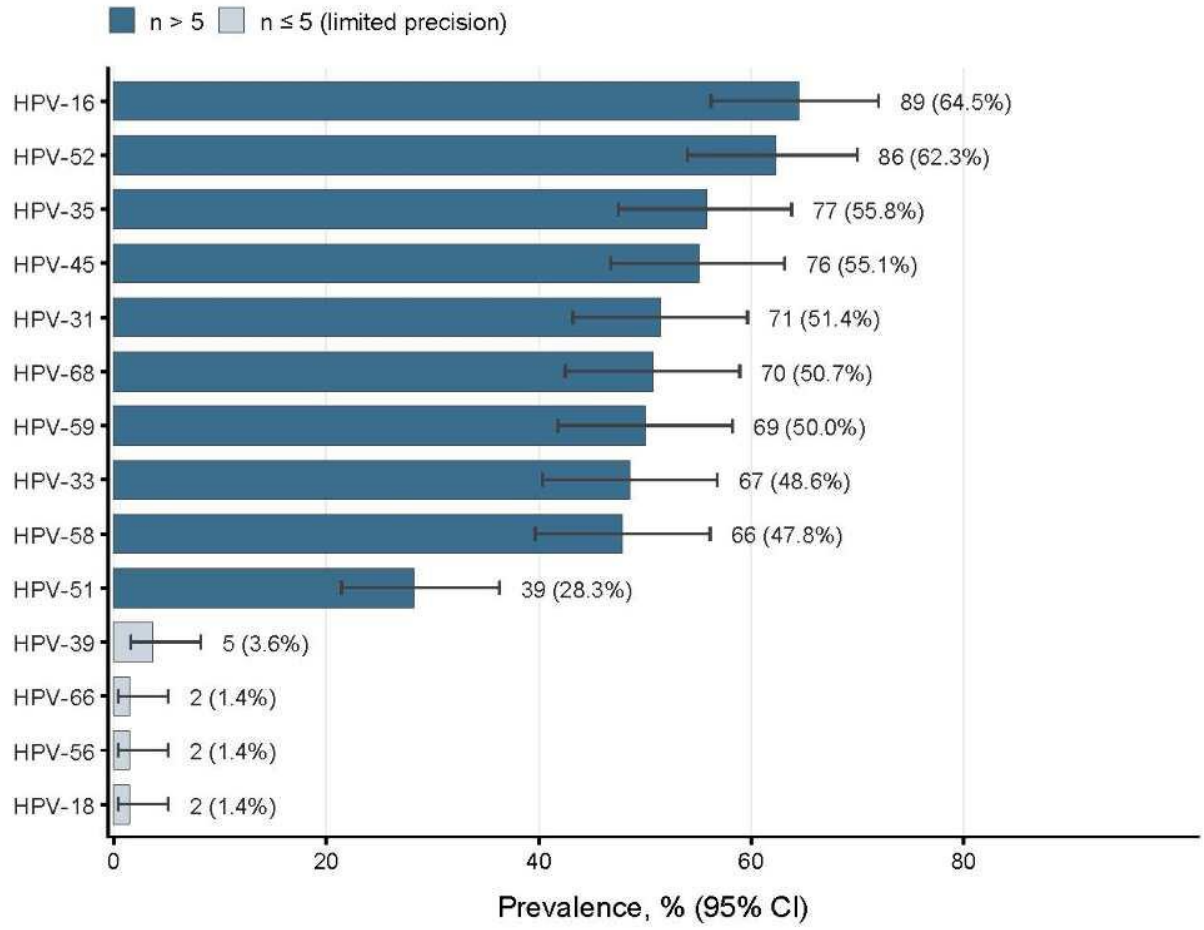
HIGH-RISK HPV BURDEN AND MULTI-GENOTYPE CARRIAGE PATTERNS AMONG WOMEN UNDERGOING CERVICAL CANCER SCREENING IN NIGERIA

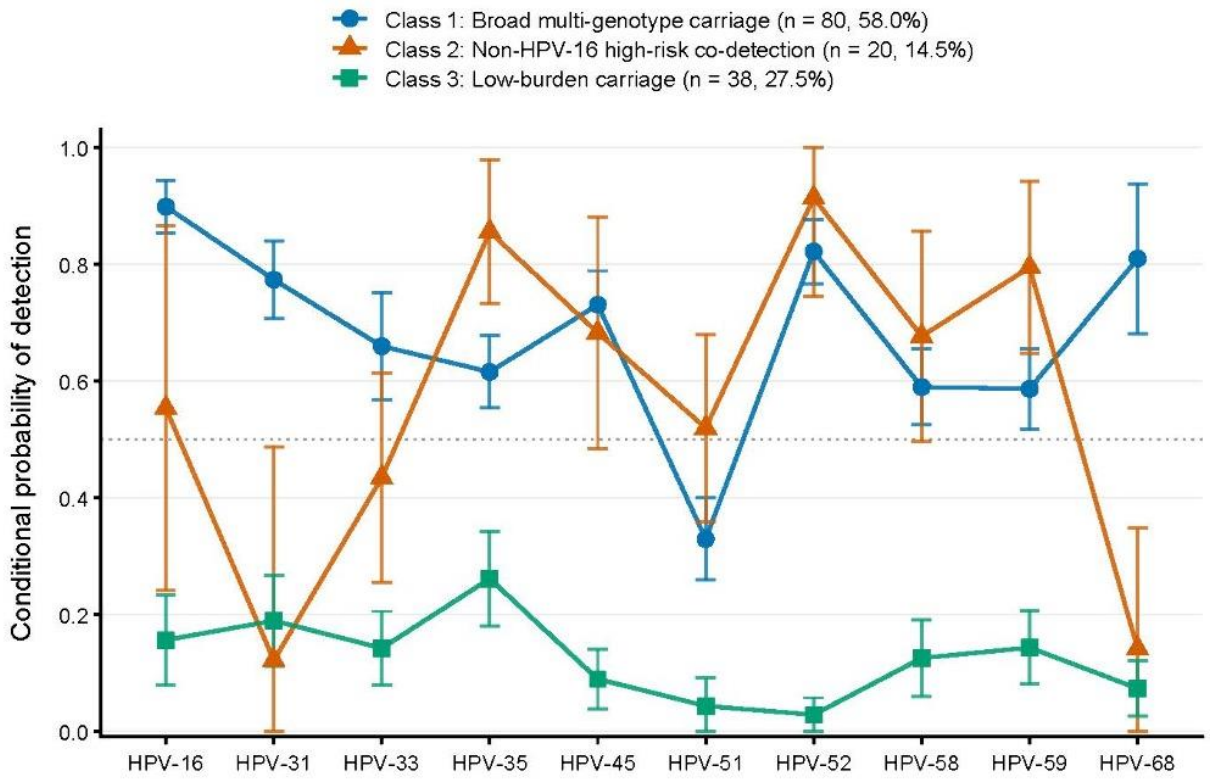
Aisha Mustapha[1], Jovanka Ravix[2], Maurice Cheryl[2], Shehu Abdullahi[3], Anisah Yahya[1], Shehu Umar[4], Yusuf Tukur[5], Nasiru Abdullahi[6], Sandy St Hilaire[2], Adekunle Oguntayo[1], Hamisu Salihu[6], Bala Audu[7], Matthew Schlumbrecht[2], Sophia George[2]
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Introduction: High-risk human papillomavirus (hrHPV) is the necessary cause of cervical cancer, yet genotype-specific data in Nigeria remain limited. We assessed HPV prevalence, co-detection patterns, and prevention service uptake to inform local screening and vaccination strategies.

Methods: A cross-sectional analysis was conducted on 138 women in a Nigerian screening study with complete HPV genotyping data. We collected sociodemographic, clinical, and screening history data. High-risk HPV included 14 types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68). Latent class analysis (LCA) identified genotype carriage patterns.

Results: Participants' mean age was 38.5 years. Awareness and uptake were low: 49.2% had heard of cervical cancer, and 38.3% were aware of screening. Only 11.3% reported prior screening, and 0.9% reported HPV vaccination. Gynecologic symptoms were common, including vaginal discharge in 52 women (42.3%), vaginal bleeding in 14 (11.3%), and postcoital bleeding in 11 (8.9%). Among 93 women with visual inspection with acetic acid (VIA) results, 9.7% were positive. hrHPV was detected in 92.0% of participants, with HPV-16 and/or 18 present in 65.2%. The most frequent genotypes were HPV-16 (64.5%), 52 (62.3%), 35 (55.8%), and 45 (55.1%), HPV-31 (51.4%), HPV-68 (50.7%), and HPV-59 (50.0%). Latent Class Analysis identified three carriage patterns: broad multi-genotype carriage (58.0%), non-HPV-16 high-risk co-detection (14.5%), and low-burden carriage (27.5%).


n > 5
n ≤ 5 (limited precision)
HPV-16
HPV-52
HPV-35
HPV-45
HPV-31
HPV-68
HPV-59
HPV-33
HPV-58
HPV-51
HPV-39
HPV-66
HPV-56
HPV-18
89 (64.5%)
86 (62.3%)
77 (55.8%)
76 (55.1%)
71 (51.4%)
70 (50.7%)
69 (50.0%)
67 (48.6%)
66 (47.8%)
39 (28.3%)
5 (3.6%)
2 (1.4%)
2 (1.4%)
2 (1.4%)
0
20
40
60
80
Prevalence, % (95% CI)



Conclusion/Implications: This population demonstrated extremely high hrHPV prevalence and frequent multi-genotype carriage. The high burden of non-16/18 genotypes like HPV-35 and 52 underscores the urgent need for expanded screening, broader-spectrum vaccination, and robust genotype surveillance in Nigeria.

EP213 / #647

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

EVALUATION OF HPV TESTING ON SELF-COLLECTED URINE SAMPLES AS COMPARED WITH CLINICIAN-COLLECTED CERVICAL SAMPLES FOR CERVICAL CANCER SCREENING

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Introduction: Urine-based HPV testing is a promising noninvasive self-sampling method for cervical cancer screening. However, conflicting data have been reported on the sensitivity of urine samples. This study aimed to evaluate the concordance of HPV results between the PHASiFY™ HPV test (PHASE Scientific International Limited, Hong Kong SAR) on self-collected urine samples and the BD Onclarity™ HPV test (Becton, Dickinson, and Company, USA) on clinician-collected cervical samples, which was used as a reference standard. The PHASiFY™ test uses urine extraction process to utilize larger volumes of urine for detection of HPV and Oxford Nanopore Technologies sequencing equipment to enable detailed HPV genotyping.

Methods: 963 women aged 18 to 78 were recruited from the community and provided self-collected urine samples. All women were offered clinician-collected cervical samples for HPV testing and cytology, of which 351 (36%) accepted. The concordance was assessed using Cohen's kappa.

Results: Of the 963 women, 56.3% (542/963) had never received a cervical screening. High-risk HPV were detected in 10.0% (96/963) of participants, of whom 85.4% (82/96) attended for clinician-collected cervical samples after being informed of their urine results and 29.3% (24/82) had abnormal cytology detected subsequently. The concordance rate between urine HPV and cervical HPV was 87.7% with a kappa of 0.602. The concordance rate for HPV16/18 was 97.7% with a kappa of 0.544.

Conclusion/Implications: This study showed a substantial agreement between PHASiFY HPV test on urine samples and Onclarity HPV test on cervical samples. Urine-based HPV test has the potential to serve as an alternative primary cervical screening approach.

EP214 / #1040

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

SENSITIZATION, MOBILIZATION AND RECRUITMENT (SMR) AS A FOUNDATION FOR EFFECTIVE CERVICAL CANCER SCREENING IN ESWATINI

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Introduction: Cervical cancer remains the leading cancer among women in Eswatini, with a high burden driven by HPV, HIV, and limited screening access. Community engagement strategies such as sensitization, mobilization, and recruitment (SMR) are critical to improving participation in screening programs, particularly in low-resource settings.

Methods: A community-based screening program targeting women aged 20-49 was implemented using a structured SMR approach. Sensitization involved stakeholder engagement and awareness campaigns. Mobilization focused on logistics, training, and community coordination. Recruitment included eligibility screening, informed consent, and appointment scheduling. Screening utilized HPV self-sampling and triage with biopsy and treatment where indicated.

Results: A total of 702 women underwent HPV screening, with 286 testing positive (46.05%). Among those triaged, histopathology revealed varying grades of cervical intraepithelial neoplasia (CIN), including CIN2/3 lesions. Treatment was provided to 132 HPV-positive women (46.15%), primarily via thermal ablation. The program demonstrated strong follow-up through a “screen-and-treat” model, with high rates of sample collection and progression through care pathways. However, delays in triage and logistical challenges led to risk of loss to follow-up.

Conclusion/Implications: SMR is essential for successful cervical screening in resource-limited settings. This approach improves participation, follow-up, and treatment uptake while reducing barriers related to access and trust. Strengthening real-time diagnostics and logistics could further enhance outcomes. These findings support scaling SMR-driven models to improve cervical cancer prevention and control in high-burden regions.

EP215 / #346

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

KNOWLEDGE, ATTITUDES, AND PRACTICES REGARDING CERVICAL CANCER SCREENING AMONG PREGNANT WOMEN: A CROSS-SECTIONAL STUDY

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Introduction: Cervical cancer remains a significant public health concern in Thailand, with suboptimal screening coverage. Antenatal care represents a valuable opportunity to improve screening uptake. This study aimed to assess the knowledge, attitudes, and practices (KAP) of pregnant women regarding cervical cancer screening and to identify factors associated with screening behaviors.

Methods: A cross-sectional study was conducted among 308 pregnant women attending antenatal care at King Chulalongkorn Memorial Hospital. Participants completed a validated questionnaire assessing KAP. Associations between KAP scores and demographic characteristics were analyzed using linear and logistic regression models.

Results: The mean age of participants was 31 years. Prior cervical cancer screening was reported by 56.5% of women, while 48.4% accepted screening during pregnancy. Overall knowledge was moderate; however, misconceptions were common, with 40.3% expressing concern about miscarriage and 39.0% believing that screening could cause infection. Attitudes toward cervical cancer screening were generally positive (mean score: 11.77/15), although attitudes toward screening during pregnancy were less favorable (mean score: 17.04/25). Higher educational level, higher income, and a history of prior screening were significantly associated with higher KAP scores.

Conclusion/Implications: Despite generally favorable knowledge and attitudes, hesitancy toward cervical cancer screening during pregnancy persists, largely driven by misconceptions. Targeted educational interventions during antenatal care and integration of screening into routine prenatal services may enhance uptake and contribute to national cervical cancer elimination efforts.

EP216 / #656

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

BEYOND HPV16/18: FIRST SOUTH INDIAN COMMUNITY SCREENING STUDY USING ABBOTT ALINITY M REVEALS DIVERSE HIGH-RISK HPV LANDSCAPE

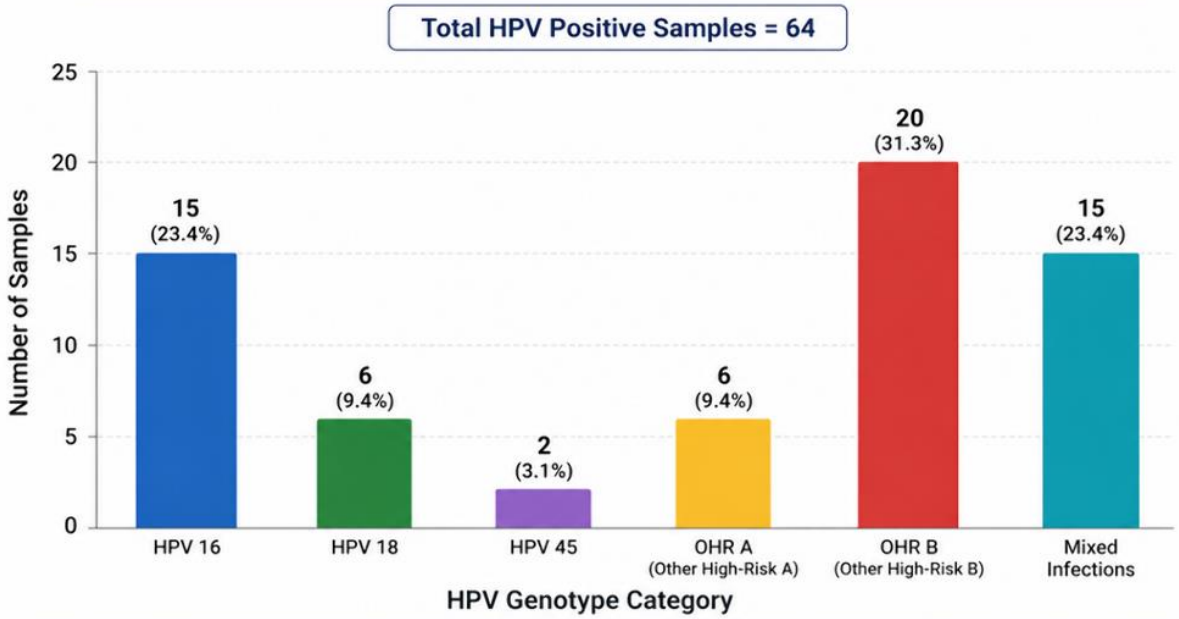
Vijayalakshmi Ramshankar[1], Yasasve Madhavan[1], Sathish Shanmugam[1], Vedhamurthy Giri[1], Vaishnavi Muktineni[1], David Raj Arockia Raj[1], Srinidhi Ramasubramanian[1], Lalitha Subramanian[2], Latha Balasubramani[3]
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Introduction: Cervical cancer screening coverage remains suboptimal in many parts of India. This study evaluated the feasibility of community-based screening in South India using a fully automated high-risk human papillomavirus (HR-HPV) testing platform and characterized genotype distribution, with emphasis on non-HPV16/18 types through extended genotyping.

Methods: A cross-sectional study was conducted among 1,000 asymptomatic women aged 25–70 years across multiple districts in Tamil Nadu (October 2025–March 2026). Participants were recruited through community outreach camps. Cervical exfoliated cells were collected using a Rovers Brush and preserved in ThinPrep(PreservCyt) medium. Primary screening was performed using the Abbott Alinity m HR HPV assay, detecting HPV16, 18, and 45 individually, and other high-risk types in grouped formats. Extended genotyping using the Allplex™ HPV assay(Seegene) was performed on 41 samples comprising other high-risk and mixed infections.

Results: Among 1,000 women screened, 64 (6.4%) were HR-HPV positive, 930 (93.0%) negative, and 6 (0.6%) invalid. Non-HPV16/18 types predominated. Other high-risk group B accounted for 20/64 (31.3%), while mixed infections were observed in 15/64 (23.4%). HPV16 was detected in 15/64 (23.4%), whereas HPV18 and HPV45 were less frequent at 6/64 (9.4%) and 2/64 (3.1%). Among 41 samples with extended genotyping, single infections were seen in 20/41 (48.8%), double in 13/41 (31.7%), and triple in 8/41 (19.5%). HPV59 and HPV66 were most prevalent (17.3% each), followed by HPV33 (15.4%) and HPV58
(13.5%).

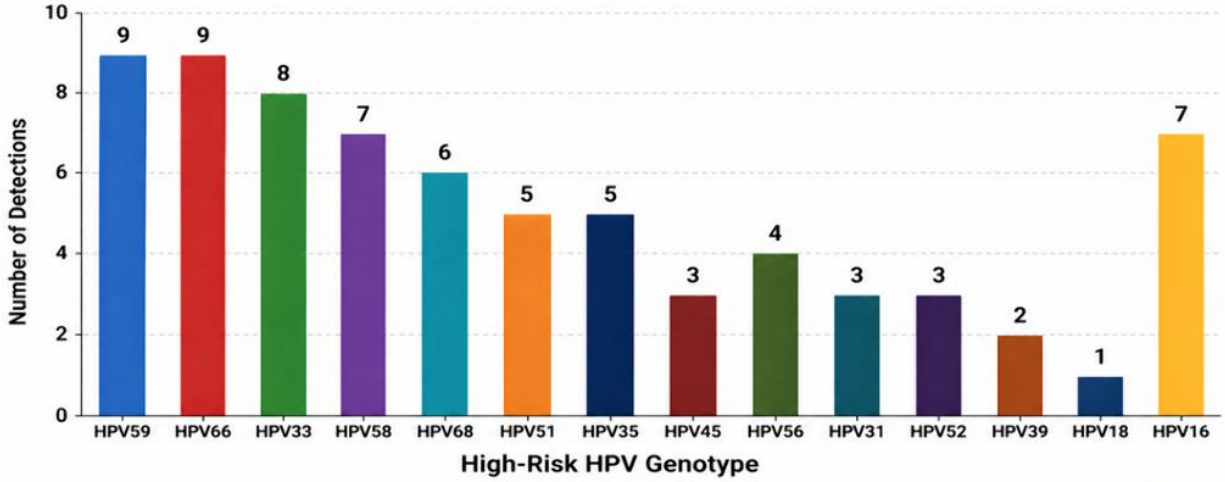
Distribution of HPV Genotypes Among Positive Samples (N = 64)



Among 64 HPV positive samples: HPV16 (23.4%), HPV18 (9.4%), HPV45 (3.1%), Other High-Risk A (9.4%), Other High-Risk B (31.3%), and Mixed Infections (23.4%).

Extended Genotyping (XGT) Results of OHR and Mixed Infections

Distribution of Individual High-Risk HPV Genotypes (N = 52 detections)*



Among the OHR and mixed infection samples (total 52 genotype detections), HPV59 and HPV66 were the most frequent, followed by HPV33 and HPV58..

Other commonly detected genotypes included HPV68, HPV51, HPV45, HPV45, HPV56, HPV31, HPV52, HPV39, HPV18 and HPV16.

**Multiple genotypes in some samples; total detections > number of samples.*

Conclusion/Implications: Community-based HR-HPV screening is feasible and reveals a genotype landscape dominated by non-HPV16/18 types, supporting the integration of extended genotyping for improved risk stratification and targeted cervical cancer control strategies.

EP217 / #1132

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

AGREEMENT BETWEEN VAGINAL AND FIRST-VOID URINE SELF-SAMPLING FOR HPV DETECTION AMONG HISPANIC WOMEN

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Introduction: Human papillomavirus (HPV) testing is central to cervical cancer prevention. Self-sampling strategies perform comparably to clinician-collected specimens when PCR assays are used. Less invasive options, such as first-void urine, may improve screening acceptability; however, real-world data remain limited. This study evaluated agreement between paired vaginal and urine self-collected samples for HPV detection among Hispanic women in a rural U.S.–Mexico border community.

Methods: Self-identified Hispanic women aged 25–65 years were recruited from a federally qualified health center in Southern Arizona. Participants provided paired home-collected vaginal samples using a dry swab (Simpli-COLLECT HPV™), and first-void urine using a dedicated device (Colli-Pee®), capturing a 4 mL initial fraction. HPV testing used the FDA-approved Abbott Alinity m assay targeting 14 high-risk HPV genotypes. Outcomes included agreement, discordance, and Cohen's kappa. This analysis assessed analytical agreement, not diagnostic accuracy.

Results: Among 327 women with paired samples, overall agreement was 95.7%, with 313 concordant pairs (280 negative–negative; 33 positive–positive). Discordant results were observed in 14 pairs (4.3%): 10 vaginal-positive/urine-negative and 4 urine-positive/vaginal-negative results. Positive percent agreement was 82.5%, negative percent agreement was 97.6%, and Cohen's kappa was 0.80, indicating substantial agreement. HPV positivity was 14.3%.

Conclusion/Implications: First-void urine self-sampling demonstrated substantial agreement with vaginal self-sampling for PCR-based high-risk HPV detection. Lower positive percent agreement highlights the need for further clinical validation. Urine-based

testing may support patient-centered cervical cancer screening strategies, although it remains investigational. Further research should assess standardization, clinical performance, longitudinal outcomes, and integration into screening programs.

EP218 / #670

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

PRELIMINARY RESULTS OF SELF-COLLECTED HPV SAMPLES FOR CERVICAL CANCER SCREENING IN LIBERIA USING GENEXPERT HPV PLATFORM.

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Introduction: Cervical cancer is the most common and lethal cancer among women in Liberia. Without a national cervical cancer screening strategy, opportunistic Pap-smears or VIA are commonly used. We report results of the first-time use of GeneXpert HPV in Liberia for cervical cancer screening.

Methods: Three-hundred women responded. After data clearing 18 participants were excluded due to age <25 (2), improper labelling (10) or lost samples (6). Results of 282 participants were summarized using descriptive analysis

Results: Mean age among 282 participants was 42.6 years (25-76 years). HPV results: 47 samples (16.6%) were invalid due to collection errors. HPV positivity rate among valid samples was 15.3% (36/235). Fisher's test was used to ascertain association between age and invalid testing. Participants of unknown age were excluded from this statistical comparison. Results demonstrated no significant difference *(p=0.52)* in the number of self-collection errors based on age (Table
1).

Table 1: Age and self-collect sample validity

AGE	# PARTICIPANTS	# INVALID TESTS	% INVALID TESTS
25-39 years	121	21	17.3%
40-65 years +>65	144	20	13.9%
Age unknown	17	6	35.2%
TOTAL	282	47	16.4%

Eighty-two women (29.1%) had prior knowledge about cervical cancer, but only 15 (5.3%) participants had previous screening (Pap-smear or VIA only). The most common source of information was from health workers. Among women >40 years old, attending an educational forum or having a relative/friend with cervical cancer were the most common sources of

knowledge..

Table 2 - Sources of Information (185 respondents)

Source	Age 25 - 39	Age 40-65+	Age unknown
Health worker	30	18	1
TV/radio	13	8	0
Flyer/magazine	3	0	0
Classroom/ Education forum	17	8	0
Community outreach	7	1	0
Relative or friend with cancer	12	18	0

Conclusion/Implications: Self-collection of vaginal samples has been shown to be feasible and acceptable while increasing access to cervical cancer screening in LMICs. In this cohort, 16% invalid test-rates present an opportunity to increase training and/or clarification of instructions among all age groups for self-collection to be cost effective in Liberia.

EP219 / #471

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

EARLY PREDICTION OF GESTATIONAL TROPHOBLASTIC NEOPLASIA USING THE DAY-14 MOCHIZUKI HCG REGRESSION CURVE AFTER MOLAR EVACUATION

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Introduction: Gestational trophoblastic neoplasia (GTN) is a significant complication following hydatidiform mole evacuation. Early identification is essential; however, diagnosis based on serial β-human chorionic gonadotropin (β-hCG) monitoring using WHO criteria requires multiple time points, which may be limited in resource-constrained settings. In routine clinical practice, follow-up is often performed at two-week intervals, potentially delaying detection. The Mochizuki regression curve may provide earlier indication of abnormal hCG decline.

Methods: A retrospective study was conducted on 30 patients with hydatidiform mole who underwent evacuation and serial β-hCG follow-up. Day-14 β-hCG levels were classified as Mochizuki-positive if they exceeded the expected regression curve and Mochizuki-negative if they remained within the curve. The outcome was GTN during follow-up, determined by clinical diagnosis and WHO/FIGO criteria. Diagnostic performance was analyzed using a 2×2 contingency table.

Results: Four patients developed GTN. Five patients were classified as Mochizuki-positive on day 14. The Mochizuki curve identified all GTN cases, yielding a sensitivity of 100.0% and specificity of 96.2%. The positive predictive value was 80.0%, negative predictive value was 100.0%, and overall accuracy was 96.7%. One false-positive case was observed, while all Mochizuki-negative patients remained free of GTN.

Conclusion/Implications: The day-14 Mochizuki curve demonstrates high sensitivity and excellent rule-out capability for early prediction of GTN. It may serve as a practical early triage tool in settings with limited access to frequent β-hCG monitoring.

EP220 / #1115

Topic: *AS05. Prevention & Early Detection / AS05f. Screening & Early Detection*

ANNUAL RETURN-TO-SCREENING RATES AMONG WOMEN WITH NON-HPV16/18 HIGH-RISK HPV POSITIVE AND NEGATIVE CYTOLOGY: A POPULATION-BASED STUDY

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Introduction: To evaluate return-to-screening rates after repeat HPV testing and detection of high-grade lesions (HSIL) during follow-up of women with non-HPV16/18 high-risk HPV positivity and negative cytology.

Methods: Population-based study within an organized Brazilian screening program using primary HPV DNA testing with partial genotyping (HPV16/18) and pooled detection of 12 other high-risk types (12OT) in women aged 25–64 years. Women with 12OT HPV positivity underwent reflex cytology; those with negative results were advised repeat HPV testing at 12 months. Among 20,551 screened women, 1,352 met inclusion criteria. Outcomes were return to routine screening after negative retest and HSIL detection through follow-up. Data were obtained from a centralized database and analyzed descriptively.

Results: Of 1,352 women, 915 (67.8%) completed follow-up and were analyzed. Return to routine screening after negative HPV retest occurred in 61.0% (558/915) at first follow-up, 50.4% (122/242) at second, and 30.7% (20/63) at third, totaling 76.5%. HSIL detection rates were 2.4%, 3.7%, and 4.8%, respectively. Persistent HPV positivity was common: 94.4% at first follow-up, 92.5% at second, and 95.3% at third. HPV16/18 positivity accounted for 6.6% of cases but 54% of HSIL at first follow-up (7.5% and 11% at second, and 4.7% with no HSIL at third follow-up). No invasive cancers were detected.

Conclusion/Implications: Repeat HPV testing after 12 months in women with non-HPV16/18 positivity and negative cytology shows high return-to-screening rates and low HSIL detection, supporting the safety of this management strategy.

EP221 / #948

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

SURVIVAL AND PREDICTORS OF MORTALITY IN LOCALLY ADVANCED CERVICAL CANCER: A RETROSPECTIVE STUDY FROM A NIGERIAN ONCOLOGY CENTRE

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Introduction: Cervical cancer is a leading cause of cancer-related mortality among women in Sub-Saharan Africa; studies on mortality patterns and determinants are limited. This study assessed the clinical characteristics and treatment patterns among mortality cases of locally advanced cervical cancer (LACC) in a fast-paced Nigerian oncology centre.

Methods: This retrospective study included mortality cases among LACC patients who presented at Medserve-LUTH Cancer Centre between January 2020 and December 2025. Data were extracted from electronic medical records. Descriptive statistics for patient characteristics and Kaplan-Meier survival analysis were deployed. Cox proportional hazards models were used to identify factors associated with mortality.

Results: There were 146 mortality cases among patients with LACC during the study period. The mean age was 57.29±12.97 years; 67.8% were married, 30.1% were premenopausal, and 54.8% were self-employed.
The 1-year overall survival rate was 25.34%, with median survival of 4.7 months. On univariate analysis, premenopausal women had better survival (hazards ratio [HR]=0.854), though not statistically significant (p=0.389). Advanced disease (stage IV HR=3.135, p=0.002) and omission of brachytherapy (HR=2.142, p=0.002) predicted worse survival. Compared with concurrent chemoradiation and brachytherapy, EBRT alone (HR=2.796, p=0.003) or chemotherapy plus EBRT (HR=2.131, p=0.028) predicted worse survival.
On multivariate analysis, stage and treatment modality remained significantly associated with survival. Alcohol use and histology emerged as independent predictors, with non-alcohol users (HR=0.220, p<0.001) and non-squamous histology (HR=0.039, p<0.001) having significantly reduced mortality risk.

Conclusion/Implications: Survival outcomes are poor, driven by late presentation and suboptimal treatment. Early detection and access to comprehensive care, including chemoradiation and brachytherapy, are essential for improving outcomes.

EP222 / #1143

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

IMPACT OF THE INTERLACE TRIAL ON TREATMENT PATTERNS AND COMPLETION RATES IN FIGO IIIC CERVICAL CANCER: A REAL-WORLD ANALYSIS

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Introduction: The INTERLACE trial introduced induction chemotherapy followed by standard chemoradiotherapy (CRT) as a treatment intensification strategy for locally advanced cervical cancer. However, its impact on real-world treatment patterns and feasibility remains unclear. We aimed to evaluate changes in treatment indications and completion rates before and after INTERLACE adoption in FIGO IIIC cervical cancer.

Methods: We conducted a retrospective cohort study including all patients with FIGO IIIC cervical cancer discussed in a tertiary gynecologic oncology tumor board between 2023 and 2025. Radiologic nodal staging was considered valid. Treatment strategies were categorized as chemoradiotherapy with brachytherapy (CRT+BT), induction chemotherapy followed by chemoradiotherapy with brachytherapy (NACT+CRT+BT), or non-standard/palliative approaches. Periods were defined as pre-INTERLACE (2023–2024) and post-INTERLACE (2025). Treatment completion was defined as completion of all planned modalities.

Results: A total of 62 patients were included. In 2023–2024, nearly all patients receiving curative-intent treatment underwent CRT+BT, with no use of induction chemotherapy. In 2025, treatment patterns shifted substantially: 57.1% received NACT+CRT+BT, 23.8% CRT+BT, and 19.0% non-standard treatment, reflecting real-world heterogeneity. Treatment completion was similar between CRT+BT and NACT+CRT+BT (84.1% vs 83.3%; OR 0.95; p=1.00).

Conclusion/Implications: Following the introduction of INTERLACE, induction chemotherapy was rapidly incorporated into clinical practice, with a marked shift in treatment strategies. A substantial proportion of patients did not receive standard treatment, highlighting real-world constraints. Importantly, the addition of induction chemotherapy did not appear to compromise treatment completion, supporting its feasibility with appropriate patient selection.

EP223 / #752

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

BACTERIAL VAGINOSIS: CORRELATION WITH CERVICAL CYTOLOGICAL ABNORMALITIES AND HPV INFECTION

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Introduction: Imbalance in the vaginal microbiota causes bacterial vaginosis (BV). Studies demonstrate significant associations between BV and Human Papillomavirus (HPV). Based on this, it is possible to predict and anticipate more assertive therapeutic approaches based on the analysis of screening tests. Objective: To evaluate the presence of bacterial vaginosis associated with HPV infection, investigating the prevalence of dysbiosis in patients with altered oncotic cytology.

Methods: Individual, cross-sectional, retrospective, with convenience sampling. Medical records of patients seen at the gynecology and obstetrics outpatient service and the lower genital tract pathology outpatient service of the Hospital das Clínicas Samuel Libânio between June 2022 and December 2024 were reviewed. The records of patients who underwent oncotic colpocytology and their results were analyzed. Three characteristics were identified: age, vaginal flora, and oncotic cytology results.

Results: The overall prevalence of bacterial vaginosis was 38.5%. A higher occurrence of the condition was observed among patients with altered oncotic cytology, present in 46.5% of cases, compared to patients with normal oncotic cytology, with a prevalence of 29%. A positive association was demonstrated between bacterial vaginosis and cytological alterations, with a prevalence ratio of 1.7 and an odds ratio of 2.12 (95% CI: 1.45–3.10), indicating a higher chance of altered oncotic cytology in patients with bacterial vaginosis.

Conclusion/Implications: Bacterial vaginosis showed a high prevalence in the study associated with alterations in oncotic cytology, more frequent among patients with altered cytology, reinforcing the importance of identifying and managing bacterial vaginosis in the context of gynecological evaluation and cytological screening.

EP224 / #434

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

PHASE II CLINICAL TRIAL EVALUATING THE POTENTIAL OF CONCURRENT CHEMORADIOTHERAPY WITH GEMCITABINE IN PATIENTS WITH LOCALLY ADVANCED CERVICAL CANCER AND RENAL FAILURE.

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Introduction: In Mexico, cervical cancer is the second leading cause of cancer and death in women of reproductive age. 70% of patients are diagnosed at locally advanced stages, and 14% and 44% may develop obstructive uropathy, requiring the use of urinary catheters. Chemoradiotherapy with cisplatin is not an option, leaving this population without effective treatments. Gemcitabine has been identified as a safe and effective radiosensitizer in this context and could be an alternative.

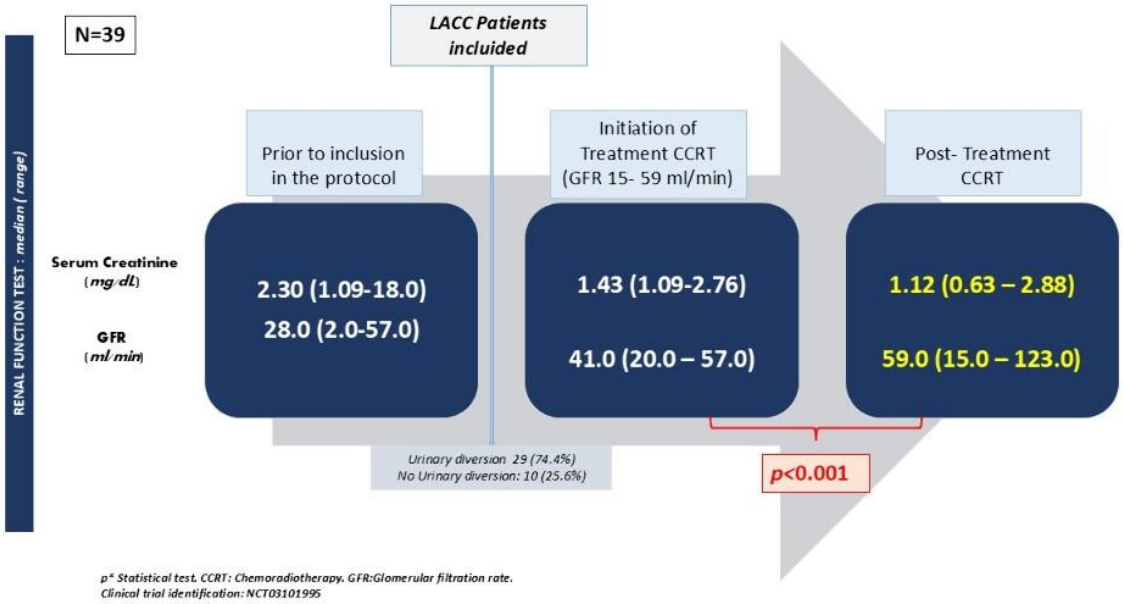
Methods: Objetive: To evaluate the safety and efficacy of chemoradiotherapy with gemcitabine in patients with advanced cervical cancer and renal impairment. This open-label, single-arm, phase II clinical trial included patients with kidney disease (CK) and a glomerular filtration rate (GFR) between 15 and 59 mL/min. Urinary diversion was assessed during the screening phase, with monitoring of renal function. Patients received concomitant chemoradiotherapy with gemcitabine, external beam radiotherapy, and

conventional brachytherapy. Renal function, toxicity, quality of life, and survival were evaluated.

Results: A total of 39 patients were included, with a mean age of 52 years; 87.2% had clinical stages ranging from IIIC1 to IVA. Urinary catheters were required in 74.4% of cases, and an objective response rate of 66.7% was achieved. GFR improved significantly from baseline to one year of treatment, increasing from 28 to 50 mL/min (p = 0.013). The median progression-free and overall survival were 17.5 and 28.2 months, respectively.

Conclusion/Implications:

Renal function characteristics before, during, and after cancer treatment in patients with cervical cancer and renal impairment.



This is the first trial to demonstrate that gemcitabine combined with radiotherapy is safe and effective for these patients and it preserves kidney function, QLQ, and enhances survival.

EP225 / #652

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

SURGICAL PARA-AORTIC STAGING IN LOCALLY ADVANCED CERVICAL CANCER

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Introduction: Locally advanced cervical cancer (LACC) presents a high risk of para-aortic lymph node involvement. Accurate assessment of para-aortic lymph node status is crucial in order to tailor treatment and optimize patient management. Imaging techniques have a high false negative rate, supporting the role of surgical staging. The aim of this study is to determine the results of para-aortic lymph node staging in patients with LACC.

Methods: Retrospective descriptive study of a series of 71 patients with LACC treated at the Department of Oncological Surgery of the Salah Azaiez Institute between January 2018 and December 2024.

Results: Sixty-six patients underwent SPALS. The median age was 51 years. The surgical approach was transperitoneal laparoscopy in most patients (89%). The mean operative time was 161 ± 71 minutes. The mean number of para-aortic lymph nodes removed was eight. Intraoperative and postoperative complication rates were 6% and 5%, respectively. Three patients (5%) had a conversion to laparotomy. Eight patients had positive para-aortic lymph node metastases on histopathology despite negative initial imaging. The false-negative rate was 12%. Surgical staging led to upstaging in 12% of cases to stage IIIC2. The negative predictive value was 87.7% for MRI and 89.5% for CT. Radiological staging by PET-CT led to upstaging in two patients. Overall, the rate of upstaging was 14%.

Conclusion/Implications: Surgical para-aortic staging SPALS in patients with LACC is reliable, and safe, with minimal morbidity, allowing the detection of occult metastases and accurate reclassification of patients according to FIGO 2018 staging.

EP226 / #796

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

EFFICACY OF CONSOLIDATION CONCURRENT CHEMORADIATION FOLLOWING SYSTEMIC CHEMOTHERAPY IN STAGE IV CERVICAL CANCER: A SINGLE-CENTER PILOT STUDY

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Introduction: Stage 4 cervical cancer carries a dismal prognosis, and the optimal treatment strategy has yet to be established. This study aimed to evaluate the clinical outcomes and feasibility of consolidation concurrent chemoradiation (CCRT) following systemic chemotherapy in patients with FIGO stage 4A–4B cervical cancer.

Methods: We retrospectively analyzed patients with FIGO stage IV cervical cancer who received platinum-based systemic chemotherapy, including paclitaxel/carboplatin or cisplatin-based regimens, with or without bevacizumab. Patients who subsequently underwent consolidation CCRT were compared with those who received systemic chemotherapy alone. The primary endpoints were progression-free survival (PFS) and treatment-related toxicity.

Results: A total of 20 patients were included; 10 received consolidation CCRT following systemic chemotherapy. The consolidation CCRT group demonstrated 17.3 months in median PFS compared with 15.1 months in the chemotherapy-alone group($p>0.05$). Treatment-related toxicities were generally manageable, with the majority being grade 1–2. Grade 3 adverse events were observed in 4 patients (thrombocytopenia, anemia, renal dysfunction). No treatment-related mortality occurred.

Conclusion/Implications: Consolidation CCRT following systemic chemotherapy represents a potentially feasible multimodal treatment approach and may confer a survival benefit in selected patients with stage IV cervical cancer, particularly those with a favorable performance status and an adequate response to initial systemic therapy. However, given the limited sample size and retrospective design of this pilot study, these findings should be interpreted with caution and prospective validation in larger cohorts is warranted.

EP227 / #248

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

PD-L1 EXPRESSION PATTERNS IN CERVICAL CANCER: REAL-WORLD DATA FROM A TERTIARY CANCER CENTER IN BOGOTÁ, COLOMBIA

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Introduction: PD-L1 testing has direct therapeutic relevance in cervical cancer. In KEYNOTE-A18, PD-L1 positivity defined by combined positive score (CPS) ≥1 was reported in most patients with high-risk locally advanced disease. Real-world Latin American data remain limited.

Methods: We conducted a retrospective cross-sectional study of 54 consecutive patients with cervical cancer treated at a tertiary cancer center in Bogotá, Colombia, with available PD-L1 immunohistochemistry CPS results. Demographic and clinicopathologic variables were obtained from the institutional database. The primary endpoint was PD-L1 positivity (CPS ≥1). Secondary endpoints included CPS distribution and descriptive clinicopathologic characteristics. Frequencies are reported descriptively.

Results: Median age was 53.5 years (IQR 40.3–67.0; range 26–89). Squamous histology predominated (47/54, 87.0%), followed by adenocarcinoma (7/54, 13.0%). Disease stage was early in 4/54 (7.4%), locally advanced in 42/54 (77.8%), and metastatic in 8/54 (14.8%). Median PD-L1 CPS was 1 (IQR 0–9.75; range 0–80). PD-L1 positivity (CPS ≥1) was observed in 31/54 patients (57.4%; 95% CI, 43.2–70.8). CPS was 0 in 23/54 (42.6%), 1–10 in 23/54 (42.6%), and >10 in 8/54 (14.8%). Among locally advanced cases, only 25/42 (59.5%) were PD-L1

positive.

Table 1. Clinicopathologic characteristics and PD-L1 expression profile of the study cohort

Characteristic	Value
Age, years	53.5 (IQR 40.3–67.0)
ECOG at diagnosis	
0	26 (48.1%)
>0	28 (51.9%)
Histology	
Squamous cell carcinoma	47 (87.0%)
Adenocarcinoma	7 (13.0%)
Stage group	
Early stage	4 (7.4%)
Locally advanced	42 (77.8%)
Metastatic	8 (14.8%)
Sample source for PD-L1†	
Primary tumor specimen	32/42 (76.2%)
Metastatic biopsy	10/42 (23.8%)
PD-L1 CPS	
PD-L1 positivity (CPS ≥1)	31 (57.4%)
PD-L1 category	
CPS 0	23 (42.6%)
CPS 1–10	23 (42.6%)
CPS >10	8 (14.8%)
PD-L1-positive among locally advanced cases	25/42 (59.5%)

† Sample source was assessed only in cases with institutional pathology review.

Conclusion/Implications: In this real-world Latin-American cohort, PD-L1 positivity was frequent but lower than expected from pivotal trial data. These findings support the value of local biomarker epidemiology to guide testing strategies, access planning, and future immunotherapy-focused cervical cancer research in the region.

EP228 / #1087

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

EARLY-STAGE CERVICAL CANCER SURGERY AFTER THE LACC TRIAL: COMPARISON OF LAPAROSCOPIC AND COMBINED LAPAROSCOPIC-ABDOMINAL RADICAL HYSTERECTOMY — SINGLE-CENTER EXPERIENCE FROM ARGENTINA

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Introduction: To compare oncological outcomes of laparoscopic radical hysterectomy (LRH) versus a modified technique combining laparoscopic sentinel lymph node mapping and abdominal radical hysterectomy (LARH) —without uterine manipulator and with/out a vaginal cuff— for early-stage cervical cancer following the LACC trial

Methods: Retrospective study of patients with cervical cancer (FIGO 2009 IA2–IB1 FIGO 2018 IA2-IB2) operated 2013–2025, with at least one year of follow-up. Group 1 (2013–2018): totally laparoscopic RH (LRH). Group 2 (2018–2025): combined laparoscopic-abdominal RH (LARH)

Results: 79 patients were included: 44 in the LRH group and 35 in the LARH group. Median follow-up: 43.0 and 31.0 months, respectively (p=0.049). Recurrence rate: 9.1% (4/44) in Group 1 and 11.4% (4/35) in Group 2 (p=1.0). Mortality: 3 deaths in Group 1 (6.8%) and 2 in Group 2 (5.7%); p=1.0). Recurrence subgroup analysis: median tumor size 27.5 mm; adenocarcinoma in 87.5%; LVI present in 37.5%; tumor >2 cm in 50%; prior conization in 12.5%; positive lymph nodes in 25.0%; In the multivariate analysis, no independent predictor of recurrence was identified. Vaginal cuff protection was used in 5 patients (6.3%), all belonging to Group 2.This subgroup presented a higher-risk profile (median tumor size 30.0 mm and LVI in 80.0%); no recurrences or deaths were observed in this subgroup

Conclusion/Implications: Despite the shift in surgical technique, recurrence rates and mortality remained similar in both groups. The comparable oncological behavior observed across both cohorts is clinically meaningful. These findings raise the question of whether minimally invasive surgery should be abandoned altogether in favor of open RH.

Table 2. Recurrence outcomes by surgical approach

Outcome	LRH – Group 1 (N=4 recurrences)	LARH – Group 2 (N=4 recurrences)
N, % Recurrences	*4 (9.1%)*	*4 (11.4%)*
Local	*2 (50%)*	*2 (50%)*
Distant	*2 (50%)*	*2 (50%)*
Time to recurrence, months (median)	*14.5*	*8.5*
Death from cervical cancer	*3 (75%)*	*2 (50%)*
Tumor size >20mm	*2 (50%)*	*4 (100%)*
Lymph node metastasis	*1 (25%) — micrometastasis*	*1 (25%) — macrometastasis*
Depth of infiltration >10mm	*0 (0%)*	*0 (0%)*
Cone biopsy	*0 (0%)*	*1 (25%)*
Histologic subtype		
Squamous-cell carcinoma	*0 (0%)*	*1 (25%)*
Adenocarcinoma / adeno-squamous	*4 (100%)*	*3 (75%)*
Grading		
G1	*1 (25%)*	*0 (0%)*
G2	*2 (50%)*	*2 (50%)*
G3	*1 (25%)*	*2 (50%)*
Lymphovascular invasion positive	*1 (25%)*	*2 (50%)*
Positive vaginal margin	*1 (25%)*	*0 (0%)*

LRH: laparoscopic radical hysterectomy; LARH: laparoscopic-abdominal radical hysterectomy.

Table 1. Baseline clinicopathological characteristics

Characteristics	LRH – Group 1 (N=44)	LARH – Group 2 (N=35)	p
Follow-up months, Median (IQR)	*43.0 (26.0–94.0)*	*31.0 (18.5–62.0)*	*0.049*
Age at diagnosis, years Median (IQR)	*46 (39.5–56.0)*	*43 (38.0–49.5)*	*0.338*
Histologic subtype			
Squamous-cell carcinoma	*23 (52.3%)*	*22 (62.9%)*	*0.370*
Adenocarcinoma	*19 (43.2%)*	*14 (40.0%)*	*0.821*
Not reported	*2 (4.5%)*	*0*	
Stage of disease (FIGO 2009)			
IA2	*22 (50.0%)*	*2 (5.7%)*	
IB1	*12 (27.3%)*	*22 (62.9%)*	
IB2	*4 (9.1%)*	*10 (28.6%)*	
IIIC1	*6 (13.6%)*	*1 (2.9%)*	
Grading			
G1	*11 (25.0%)*	*16 (45.7%)*	
G2	*20 (45.5%)*	*9 (25.7%)*	
G3	*7 (15.9%)*	*5 (14.3%)*	
Not reported	*6 (13.6%)*	*5 (14.3%)*	
Tumor size (mm), Median (IQR)	*15.0 (13.5–20.0)*	*27.0 (20.0–34.5)*	*0.001**
Tumor size >20mm	*18 (40.9%)*	*10 (28.6%)*	*0.344*
Lymphovascular invasion positive	*11 (25.0%)*	*20 (57.1%)*	*0.005**
Lymph Node Metastasis	*5 (11.4%)*	*2 (5.7%)*	*0.454*
Depth of infiltration (mm), Median (IQR)	*5.5 (3.0–10.0)*	*4.5 (3.0–10.0)*	*0.593*
Depth of infiltration <10mm	*35 (79.5%)*	*11 (31.4%)*	*<0.001**
Cone biopsy	*12 (27.3%)*	*16 (45.7%)*	*0.103*
Uterine manipulator use	*39 (88.6%)*	*1 (2.9%)*	*<0.001**
Adjuvant Treatments	*16 (36.4%)*	*14 (40.0%)*	*0.817*

** Statistically significant (p<0.05). LRH: laparoscopic radical hysterectomy; LARH: laparoscopic-abdominal radical hysterectomy; IQR: interquartile range; FIGO: International Federation of Gynecology and Obstetrics.*

EP229 / #322

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

ASSOCIATION OF BODY MASS INDEX AND METABOLIC HEALTH WITH SURVIVAL IN CERVICAL CANCER PATIENTS TREATED WITH RADIATION THERAPY: A REAL-WORLD ANALYSIS

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Introduction: The prognostic relevance of body mass index (BMI) in cervical cancer treated with radiation remains unclear, particularly in the context of metabolic health. We evaluated the independent and joint associations of BMI and metabolic status with overall survival (OS).

Methods: We conducted a retrospective cohort study using TriNetX multi-center database. Adult cervical cancer patients treated with radiation therapy (RT) (2000–2026) were stratified as non-obese (BMI 20–29.9) or obese (≥30), excluding BMI ≤19.9. Metabolic health, a proxy for metabolic syndrome (MetS) was defined as ≥2 comorbidities (hypertension, diabetes, hyperlipidemia). Propensity score matching (PSM) incorporated demographic, clinical, and treatment variables. OS was estimated by Kaplan–Meier and compared using log-rank and Cox models, with stratification by metabolic health and no formal interaction testing.

Results: A total of 1,042 patients were included after 1:1 PSM with balanced covariates. Median age was 59 (IQR 21) in non-obese and 58 (IQR 20) in obese patients. Median follow-up was 29.5 vs 32.2 months in non-obese and obese patients. Deaths occurred in 24.7% vs 19.2% in non-obese and obese patients. Obesity was associated with significantly improved OS (HR=0.75, 95%CI 0.62–0.89; *p*=0.002). MetS was not associated with OS in obese (n=632; HR=1.12, 95%CI 0.86–1.46; p=0.87) or non-obese patients (n=255; HR=1.44, 95%CI 0.99–2.11; p=0.058). Among patients with MetS, obese patients had improved OS versus non-obese patients (n=632 per group; HR=0.79, 95% CI 0.62–1.00; p=0.049).

Conclusion/Implications: Obesity was associated with improved OS independent of metabolic comorbidities, consistent with an obesity paradox. These findings should be interpreted cautiously due to retrospective design and possible residual confounding.

EP230 / #593

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

THE BILATERAL SENTINEL NODE DETECTION OF FLUORESCENT INDOCYANINE GREEN COMPARED TO TECHNETIUM-99M NANOCOLLOID AND BLUE DYE IN EARLY-STAGE CERVICAL CANCER

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Introduction: This study aimed to determine whether indocyanine green (ICG) is non-inferior to technetium-99m nanocolloid (^{99m}Tc) with single-photon emission computed tomography (SPECT/CT) and blue dye in achieving bilateral sentinel node detection.

Methods: This prospective, intra-patient, non-inferiority study was performed at a tertiary oncology centre. We included patients with stage IA1-IB2 or IIA cervical cancer who underwent primary surgical treatment. All patients underwent sentinel lymph node mapping with ICG and ^{99m}Tc with preoperative SPECT/CT combined with blue dye. The primary outcome was the bilateral detection of sentinel lymph nodes with ICG and near-infrared fluorescence imaging versus ^{99m}Tc with SPECT/CT and blue dye. Non-inferiority margin was set at 5%. Paired proportions were compared using McNemar's test. Clinical trial registration number: 2024-511966-36-00.

Results: Between July 1, 2021, and August 7, 2025, 106 patients were included. Bilateral sentinel node detection with ICG was achieved in 73.6% (95%CI 64.5–81.0%), compared to a bilateral detection of 76.4% (95%CI 67.5–83.5%) with ^{99m}Tc and blue dye. The absolute difference in bilateral detection was 2.8% (95%CI -12.1–7.1%). Paired comparison showed no significant difference between the two modalities (p = 0.549). When all tracers (ICG, ^{99m}Tc and blue dye) were combined, bilateral detection was 87.7% (95%CI 80.1–92.7%). No allergic reactions or serious adverse events occurred following injection of ICG, ^{99m}Tc, or blue dye.

Conclusion/Implications: This study confirms the non-inferiority of ICG compared with ^{99m}Tc and blue dye for the bilateral sentinel node detection in cervical cancer. Combining tracers achieved the highest bilateral detection, highlighting that each tracer method contributes to identifying sentinel lymph nodes.

EP231 / #303

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

MANAGEMENT IN ADVANCED/RECURRENT CERVICAL CANCER: COMPARING PARAAORTIC LYMPH-NODE INVOLVEMENT AND OLIGO-METASTASIS WITH DISSEMINATED DISEASE - RESULTS FROM THE AGO STUDY GROUP QUALITY ASSURANCE PROGRAM.

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Introduction: Understanding different therapeutic modalities and their outcome in oligo-metastatic (OM) cervical cancer patients (including paraaortic lymph node involvement (PALN) is crucial to develop appropriate treatment algorithms.

Methods: Within this analysis cervical cancer patients with either a singular metastasis or PALN diagnosed 2018-2022 were retrospectively identified from medical records of 31

gynecologic cancer centers in Germany. Patient demographic and clinical characteristics, treatment patterns, and clinical outcomes were assessed descriptively and compared to a previously published cohort of patients with disseminated metastatic disease (DMD; n=503). Progression-free- (PFS) and overall survival (OS) were calculated using Kaplan-Meier analysis.

Results: A total of 48 patients with OM (median age 56 years) and 23 patients with PALN (median age 51 years) were analyzed. The localization of OM was as follows: 13 loco-regional, 12 non-regional lymph nodes, 10 peritoneum, 5 bone, and 8 elsewhere. All patients with PALN received radiotherapy, in contrast to OM patients who underwent radiotherapy (n=29), surgery (n=15), both combined (n=1) or best palliation only (n=3). After a median follow-up of 53 months, 36-months OS rates were higher in patients with PALN compared to OM (57% vs 42%), with both being superior to DMD (34%). With regards to localization of OM, patients with non-regional lymph node metastasis had the best OS rate at 36 months (67%) compared to loco-regional (44%), bone (20%), peritoneum (30%) or elsewhere (40%).

Conclusion/Implications: Cervical cancer patients with OM have a better prognosis with loco-regional treatment only conferring less toxicity compared to disseminated metastatic requiring systemic treatment.

EP232 / #575

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

OCCULT PARA-AORTIC LYMPH NODE METASTASIS IN ADVANCED CERVICAL CANCER WITH IMAGING-POSITIVE PELVIC LYMPH NODES: IS PARA-AORTIC LYMPHADENECTOMY STILL INDICATED? DEVELOPMENT OF A NOMOGRAM TO GUIDE CLINICAL DECISION-MAKING.

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Introduction: The role of staging para-aortic lymphadenectomy in patients with locally advanced cervical cancer remains controversial, particularly among those with imaging-positive pelvic lymph nodes, in whom para-aortic involvement may be underestimated by pre-therapeutic imaging. This study aimed to develop a nomogram to estimate the risk of occult para-aortic lymph node metastasis based on pre-therapeutic clinical and imaging assessment.

Methods: This retrospective study included patients with advanced cervical cancer who underwent staging para-aortic lymphadenectomy and were referred between 2010 and 2024 to the Institut de Cancérologie de l'Ouest, a regional referral centre for brachytherapy. Eligibility criteria included a pre-therapeutic assessment with pelvic magnetic resonance imaging (MRI) and positron emission tomography–computed tomography (PET–CT). Histological findings were compared with pre-therapeutic imaging. Univariate and multivariate analyses were used to identify variables associated with occult para-aortic lymph node metastasis and to develop a predictive model, subsequently translated into a nomogram for individual risk estimation.

Results: A total of 250 patients were included, of whom 176 had imaging-positive pelvic lymph nodes. The false-negative rates of combined PET–CT and MRI for the assessment of para-aortic involvement were 12.5% in patients with imaging-positive pelvic lymph nodes and 4% in those without. Among the 176 patients with imaging-positive pelvic lymph nodes, age, local tumour extension, and pelvic lymph node size were significantly associated with occult para-aortic lymph node metastasis.

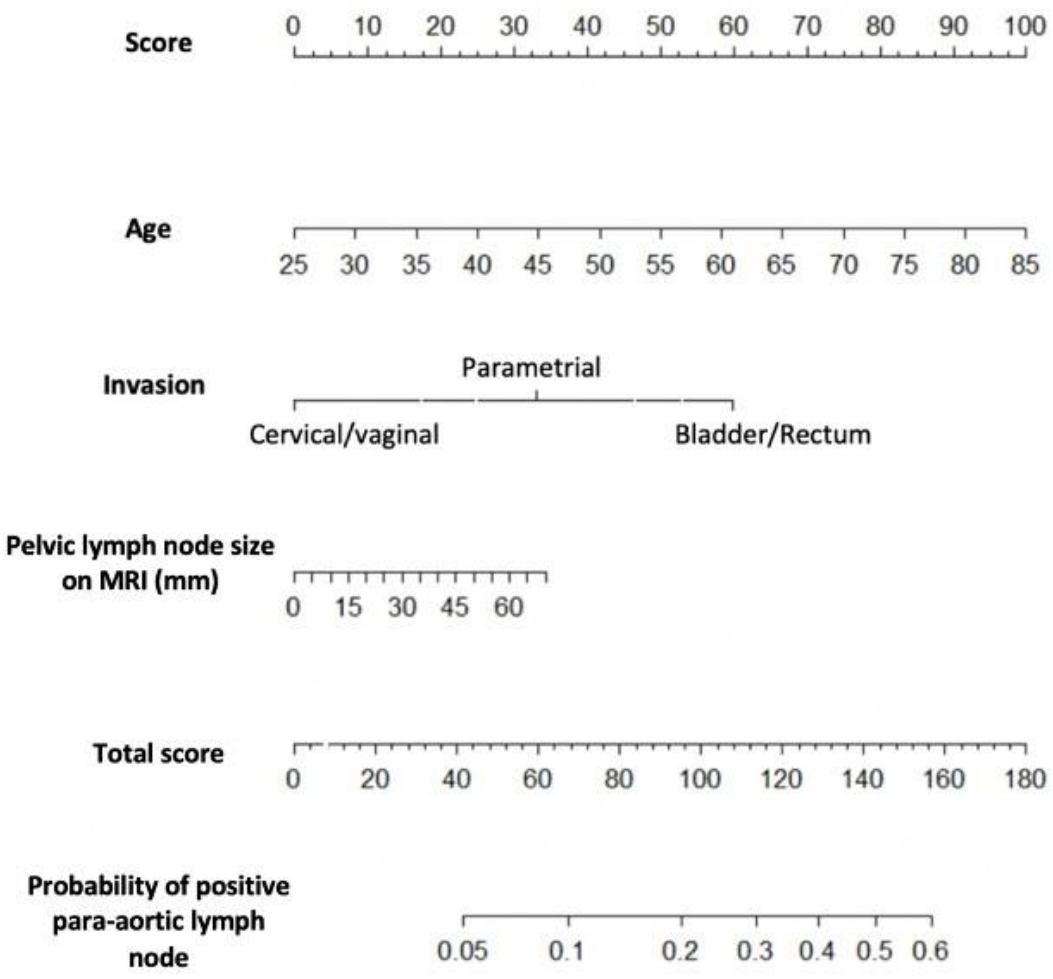


Figure 1. Nomogram predicting the risk of occult para-aortic lymph node metastasis in patients with imaging-positive pelvic lymph nodes.

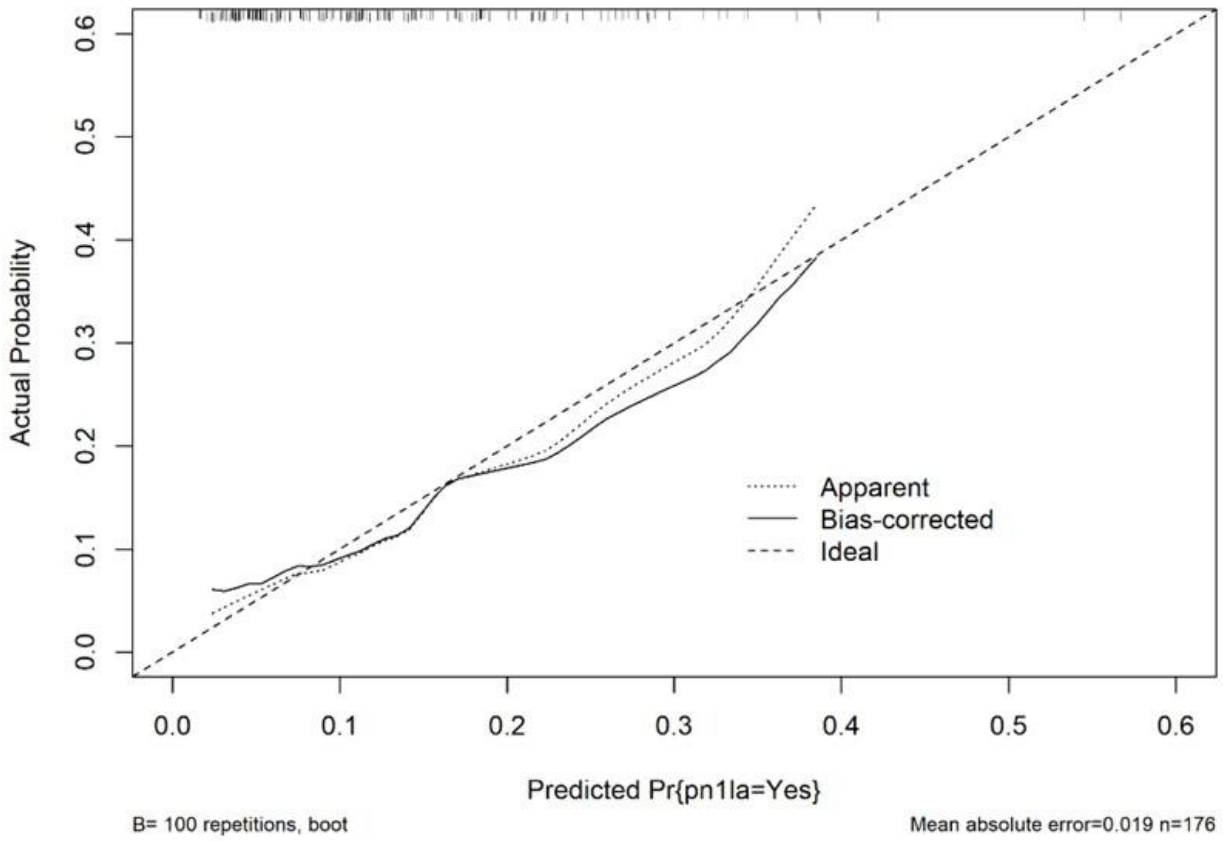


Figure 2. Calibration plot of the predictive model showing agreement between predicted and observed probabilities of occult para-aortic lymph node metastasis.

Conclusion/Implications: This nomogram may assist clinicians in identifying patients at higher risk of occult para-aortic metastasis, who could benefit from staging para-aortic lymphadenectomy and/or personalised treatment strategies.

EP233 / #281

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

ONCOLOGIC OUTCOMES IN STAGE IA1-IB2 ENDOCERVICAL ADENOCARCINOMA WITH AN INVASIVE STRATIFIED MUCIN-PRODUCING CARCINOMA COMPONENT

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Introduction: Invasive stratified mucin-producing carcinoma (iSMC) is a morphologic variant of HPV-associated cervical adenocarcinoma reported to be associated with poor oncologic outcomes, often presenting at high stage with destructive stromal invasion, lymphovascular space invasion, and lymph node metastasis. We examined the clinical characteristics and outcomes of patients specifically with stage I iSMC compared to those with usual-type endocervical adenocarcinoma (UEA).

Methods: We identified patients with pathologic FIGO 2018 stage IA1–IB2 HPV-associated endocervical adenocarcinoma who underwent primary treatment at our institution (7/2018–3/2024), and extracted clinical characteristics. Cases with “stratified mucin” in the diagnosis were re-reviewed by two gynecologic pathologists for confirmation of an invasive stratified mucinous component. Progression-free survival was estimated using the Kaplan–Meier method and then analyzed using Cox regression analysis and permutation log-rank test.

Results: We analyzed 107 patients, with a median age of 40 years (range, 26–69). Twelve patients (11.2%) had adenocarcinoma harboring an iSMC component and 95 (88.8%) had UEA (Table). Stage distribution was as follows: IA1, 49 (46%); IA2, 21 (20%); IB1, 22 (21%); IB2, 15 (14%). Among the entire cohort, 4 patients (3.7%) had disease recurrence. In univariate analysis, there was no difference in progression-free survival among patients with an iSMC component (HR, 2.60; 95% CI, 0.27–25.1) versus patients with UEA (p=0.25; permutation log-rank

test).

Table: Clinical Characteristics.

Characteristic	Overall, N=107	Usual Type, n=95	Stratified Mucinous Type, n=12
Age at Diagnosis (years), median (range)	40 (26–69)	40 (26–69)	45 (30–64)
BMI (kg/m²), median (range)	26 (17–47)	26 (17–47)	26 (19–44)
FIGO Stage			
IA1	49 (46%)	44 (46%)	5 (42%)
IA2	21 (20%)	19 (20%)	2 (17%)
IB1	22 (21%)	19 (20%)	3 (25%)
IB2	15 (14%)	13 (14%)	2 (17%)
Tumor Size (mm), median (range)	8 (0–40)	8 (0–40)	12 (2–35)
Depth of Invasion (mm), median (range)	4.0 (0.2–14.0)	4.0 (0.2–14.0)	3.1 (1.3–6.5)
Lymphovascular Space Invasion			
Negative	88 (85%)	77 (85%)	11 (92%)
Positive	15 (15%)	14 (15%)	1 (8.3%)
Missing	4	4	0
Grade			
Well differentiated	36 (41%)	36 (47%)	0 (0%)
Moderately differentiated	41 (47%)	34 (45%)	7 (64%)
Poorly differentiated	10 (11%)	6 (7.9%)	4 (36%)
Missing	20	19	1
Silva Classification Pattern			
A	27 (33%)	25 (34%)	2 (22%)
B	34 (41%)	29 (40%)	5 (56%)
C	21 (26%)	19 (26%)	2 (22%)
Missing	25	22	3
Surgery Type			
Non-Fertility Sparing	84 (79%)	75 (79%)	9 (75%)
Fertility Sparing	23 (21%)	20 (21%)	3 (25%)
Surgical Lymph Node Assessment	84 (79%)	75 (79%)	9 (75%)
Adjuvant Treatment	5 (4.7%)	5 (5.3%)	0 (0%)
Recurrence	4 (3.7%)	3 (3.2%)	1 (8.3%)

BMI, body mass index

Conclusion/Implications: In this cohort of mostly stage IA HPV-associated endocervical adenocarcinoma, recurrences were uncommon—occurring in 3.7% of patients—and

oncologic outcomes did not appear to be impacted by the presence of iSMC alone, independent of other high-risk features.

EP234 / #527

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

POST-SYSTEMIC THERAPY STATES IDENTIFY TREATMENT OPPORTUNITIES IN STAGE IVB CERVICAL CANCER

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Introduction: Systemic therapy is the standard initial treatment for stage IVB cervical cancer; however, post-treatment clinical courses are heterogeneous, and optimal management after response remains unclear. In the contemporary treatment era, some patients with residual but controlled disease may become candidates for additional local intervention. We investigated whether post-systemic therapy states (PSTS) could stratify outcomes and identify subsequent treatment opportunities.

Methods: We retrospectively reviewed 44 patients with stage IVB cervical cancer treated with systemic therapy at Okayama University Hospital between April 2017 and December 2025. Disease status after initial systemic therapy was classified into four predefined categories: PSTS-A (complete or near-complete response), PSTS-B (oligoresidual disease), PSTS-C (systemically controlled non-oligometastatic residual disease), and PSTS-D (refractory disease). The primary endpoint was overall survival (OS). The secondary endpoint was time to next treatment (TTNT).

Results: PSTS-A, B, C, and D included 8, 7, 10, and 19 patients, respectively. Median OS was 26, 29, 20, and 10 months for PSTS-A, B, C, and D, respectively. Median TTNT was 28, 19, 10, and 8 months, respectively. Both OS and TTNT were significantly stratified by PSTS ($p<0.01$). Subsequent local treatment was more frequently selected in PSTS-A/B. Pembrolizumab-containing regimens were more commonly observed in favorable PSTS groups.

Conclusion/Implications: PSTS significantly stratified prognosis and treatment course in stage IVB cervical cancer. Beyond complete response alone, controlled residual disease may represent a clinically meaningful opportunity for maintenance strategies and selective local intervention in the modern treatment era.

EP235 / #856

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

PREVALENCE AND RISK FACTORS OF RESIDUAL DISEASE AFTER LOOP ELECTROSURGICAL EXCISION PROCEDURE (LEEP) IN PATIENTS WITH CIN GRADES 2 AND 3 AND POSITIVE SURGICAL MARGINS

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Introduction: To determine prevalence and risk factors associated with the residual disease of cervical intraepithelial neoplasia (CIN) grade ≥2 following repeat procedures in patients with CIN ≥2 and positive surgical margins after LEEP

Methods: Women with CIN grades ≥ 2 and positive surgical margins after LEEP, who had undergone additional surgery (repeat LEEP or hysterectomy) between January 2010 and December 2018 at Department of Obstetrics and Gynecology,Siriraj Hospital were retrospectively reviewed. Patients who had undergone second operation within 6 months were included. Patients with incomplete data, pathology reports of AIS, microinvasive cervical cancer or invasive cervical cancer on pre or post LEEP were excluded. Risk factors for residual CIN ≥2 were analyzed including age, parity, menopausal status, initial cytology, time interval between LEEP and second procedures, initial LEEP pathology (CIN 2 VS CIN 3), ECC result (positive VS negative), disease on endocervical margins (positive or negative), glandular involvement, disease surrounding ≥50% of the cervical circumference and multiple sweeps on initial LEEP to excise a lesion. Pathologic slides were reviewed by one of two gynecologic pathologists. Significance was set at $p < 0.05$.

Results: 94 patients underwent repeat procedures. Forty patients (42.6%) had CIN ≥2 residual disease after repeat procedures. No invasive cancer was found in additional surgery. Postmenopausal women and positive endocervical margin were found as predicting factors for residual disease after second operation by multivariate analysis.

Conclusion/Implications: The prevalence of CIN ≥2 residual disease after repeat procedures was 42.6%. Postmenopausal status, and positive endocervical margin were found as predicting factors by multivariate analyses.

EP236 / #921

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

A REVIEW OF TREATMENT RESPONSE BY HISTOLOGY AND HUMAN PAPILLOMA VIRUS STATUS IN CERVICAL CARCINOMA: IMPLICATIONS FOR CLINICAL TRIALS AND LOW-MIDDLE HUMAN DEVELOPMENT INDEX COUNTRIES

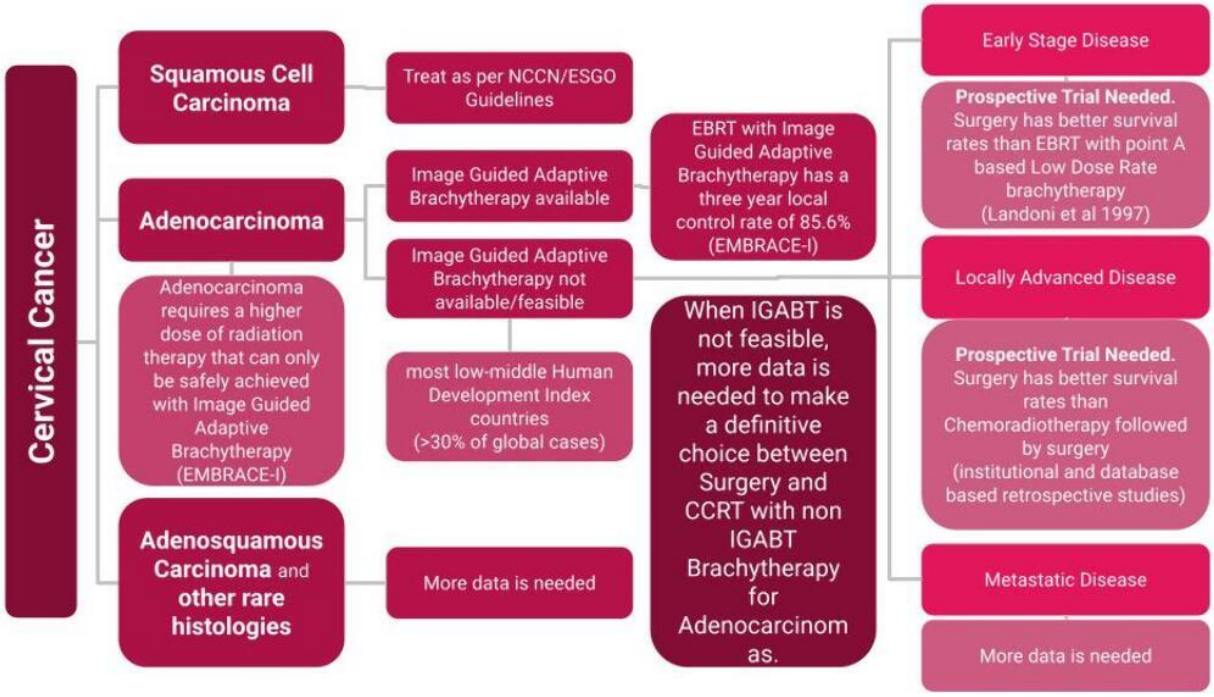
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Introduction: Cervical Epithelial Cancers are primarily of squamous and glandular differentiations, they may be of Human Papilloma Virus(HPV)-associated and HPV-independent histologies.

Methods: In this review we discuss the difference in response to different treatment modalities on the basis of histology and HPV status in literature, its implications and our suggestions for future trials to explore the impact of these factors on treatment choice.

Results: Compared to Squamous histology, Adenocarcinomas have lower survival, higher recurrence and lower complete response rates with conventional point A-based and Computed Tomography-based brachytherapy with External Beam-Radiotherapy. As demonstrated in the EMBRACE-I study, Adenocarcinomas require higher Dose-Volume Histogram characteristics that can only be safely achieved with Image-Guided Adaptive Brachytherapy(IGABT), which may not be feasible in resource limited settings including South Central Asia and Sub Saharan Africa which alone contribute 30% of global cases. In single-institution retrospective studies, primary radical hysterectomy and neoadjuvant chemotherapy with cisplatin and paclitaxel followed by interval radical hysterectomy have shown better survival rates compared to non-IGABT chemoradiotherapy in early-stage and locally-advanced adenocarcinoma patients. In major trials, 20-30% of the patients have non-squamous histologies, which may result in a mixed result for the different histologies, as seen in the KEYNOTE-826 subgroup analysis. Within adenocarcinomas, HPV-independent adenocarcinomas such as the gastric type, have shown a worse response and prognosis compared to HPV-associated

adenocarcinomas.



Conclusion/Implications: Current literature warrants prospective study comparing squamous and adenocarcinoma as well as the choice of treatment for adenocarcinomas, especially in resource limited settings, where IGABT may not be feasible.

EP237 / #835

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

CERVICAL CANCER ELIMINATION ACTIVITIES AT CIVIL SERVICE HOSPITAL OF NEPAL: PROGRESS TOWARD WHO TARGETS

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Introduction: Cervical cancer is the commonest cancer among Nepalese. WHO identified 90-70-90 strategies in vaccination, screening, and treatment for global elimination of cervical cancer. Nepal achieved 94% HPV vaccination coverage in 2025 through national campaign. However, screening coverage of 11.8% and treatment of preinvasive lesions reported <2% highlights major gaps in the second and third pillars in which Civil Service Hospital, Nepal, has been focusing and we report our experiences.

Methods: Descriptive study assessing cervical cancer screening and treatment programs.

Results: Civil Hospital has been providing cervical cancer screening and treatment since its inception (2008). Comprehensive gynecologic oncology services began in 2014, and expanded further after initiation of IGCS fellowship in 2019. Presently, the hospital serves as a designated treatment center for Kathmandu Metropolitan City and referral center in Nepal. Screening has progressed from conventional pap smear to liquid-based cytology (2020) and HPV DNA testing (2022). Annually, approximately 3,223 women undergo LBC screening and 1,904 HPV DNA testing; around 176 colposcopies, 108 ablative and 30 excisional procedures for preinvasive lesions are performed. Regularly hospital and community-based screening and awareness programs are organized in collaboration with the women's groups, government and non-government organizations. Multiple outreach screening camps have been conducted across the country. Training and hands-on workshops, conducted in collaboration with professional societies: ASCO, NESOG, SAFOG, WHO, Cancer Care Nepal and IGCS, have contributed in training over 200 healthcare providers in VIA, colposcopy, and treatment of precancerous lesions.

Conclusion/Implications: Civil Service Hospital demonstrates significant progress toward cervical cancer elimination through screening, treatment, and capacity-building efforts.

EP238 / #992

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

TIPS AND TRICKS OF RADICAL HYSTERECTOMY FOR BEGINNERS IN LOW RESOURCE SETTINGS.

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Introduction: Radical Hysterectomy is a complex surgical procedure for treatment of early-stage cervical cancer. The procedure is traditionally performed by gynaecologic oncologists as opposed to simple hysterectomy that general gynaecologists perform. The need to promote the skills of radical hysterectomy amongst general gynaecologists in low resource settings has been recognized as one of the stopgap interventions toward achieving the 90% treatment target of cervical cancer elimination initiative.

Methods: Narrative review that reflects on a decade experience of the author as a general gynaecologist providing radical hysterectomy services in Nigeria. Landmark cases were highlighted with practical tips and tricks for general gynaecologists in low resource settings seeking to acquire radical hysterectomy skills.

Results: The author performed his first supposed “modified” radical hysterectomy in 2016 with 7hour operation time and 3-liter blood loss. The first true radical hysterectomy performed by the author with clear understanding of relevant surgical anatomy was in 2026. It took a decade of learning curve, 18 supposed radical hysterectomy procedures and 3 major complications for the author to achieve proficiency

Conclusion/Implications: There are significant variations in the surgical steps between simple and radical hysterectomy despite both involving removal of the uterus. The use of the term modified radical hysterectomy further blurs the distinction between simple and radical hysterectomy. It is therefore important to have a defining surgical step such as unroofing of the ureter to distinguish radical hysterectomy procedure.

EP239 / #298

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

OUTCOMES OF PATIENTS WITH GASTRIC-TYPE ENDOCERVICAL ADENOCARCINOMA (GEA) IN A TERTIARY CENTER IN SINGAPORE

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Introduction: Gastric-type endocervical adenocarcinoma (GEA) is a rare type of cervical cancer with an undefined treatment approach. This study aims to present our institutional experience with GEA.

Methods: This retrospective study included patients diagnosed with GEA between 2017 and 2025 at our center.

Results: A total of 37 patients were included. Clinical features are shown in **Table 1**. 14 patients (37.8%) were diagnosed with atypical glandular cells or carcinoma. For the entire cohort, the median overall survival (OS) was 29 months (stage I: not reached; stage II: 26 months; stage III: 29 months; stage IV: 15 months). The median progression-free survival (PFS) was 10 months (stage I: not reached; stage II: 6 months; stage III: 14 months; stage IV: 7 months). Patients with stage IV disease and a primary tumor size≥4cm were independently associated with worse OS and PFS. 22 patients (59.5%) in the cohort received definitive therapy in the form of surgery ± adjuvant treatment (n=16) or radiotherapy (RT; n=6). Patients in the surgical group had a lower disease stage (p=0.016) and smaller tumor size (p=0.034). The 2-year OS rates were 92.9% in the surgery group and 33.3% in the RT group. Correspondingly, the 2-year PFS rates were 72.2% and 16.7%, respectively. The most common pattern of disease progression was distant metastasis in

both groups. A primary tumor size ≥4cm was an independent predictor of worse OS and PFS.

Table 1. Patient characteristics

Characteristics	Strata	Value
Age at diagnosis (years): median, range		60 (37, 80)
Race	Chinese	30 (81.1%)
	Malay	5 (13.5%)
	Indian	0 (0.0%)
	Others	2 (5.4%)
Clinical presentation	Abnormal pap smear	5 (13.5%)
	Vaginal bleeding/discharge	19 (51.4%)
	Abdominal distension/change of bowel habits/abnormal scan findings	13 (35.1%)
Pap smear	Normal	4 (10.8%)
	Atypical squamous cells[1]	3 (8.1%)
	Atypical glandular cells	7 (18.9%)
	Adenocarcinoma in situ	2 (5.4%)
	Carcinoma[7]	5 (13.5%)
	N/A	16 (43.2%)
Stage	IA2	2 (5.4%)
	IB1	3 (8.1%)
	IB2	5 (13.5%)
	IIA2	1 (2.7%)
	IIB	5 (13.5%)
	IIIC1	5 (13.5%)
	IVA	1 (2.7%)
	IVB	15 (40.5%)
Lymphovascular space invasion	Present	13 (35.1%)
	Absent	14 (37.8%)
	Unknown	10 (27.0%)
Tumor morphology	Well differentiated	11 (29.7%)
	Moderately differentiated	7 (18.9%)
	Poorly differentiated	2 (5.4%)
	Not specified	12 (32.4%)
Tumour size	<2cm	6 (16.2%)
	>=2cm, <4cm	17 (45.9%)
	>=4cm	14 (37.8%)
Treatment		
Definitive treatment with surgery (n=16)	Surgery alone	2 (5.4%)
	Surgery with adjuvant CCRT	4 (10.8%)
	Surgery with adjuvant RT	9 (24.3%)
	Neoadjuvant chemoRT then surgery	1 (2.7%)
Definitive treatment with RT (n=6)	RT alone	2 (5.4%)
	CCRT	2 (5.4%)
	Neoadjuvant chemotherapy then CCRT	2 (5.4%)
	CCRT with salvage surgery	1 (2.7%)
Palliative treatment (n=15)	Chemotherapy alone	5 (13.5%)
	Chemotherapy and targeted therapy	1 (2.7%)
	Palliative chemotherapy then surgery	1 (2.7%)
	Surgery then palliative chemotherapy	7 (18.9%)
Median follow-up time (months)		22

Conclusion/Implications: Patients with early-stage GEA and small primary tumors have a favorable outcome. Early detection and optimization of treatment remain unmet needs.

EP240 / #406

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

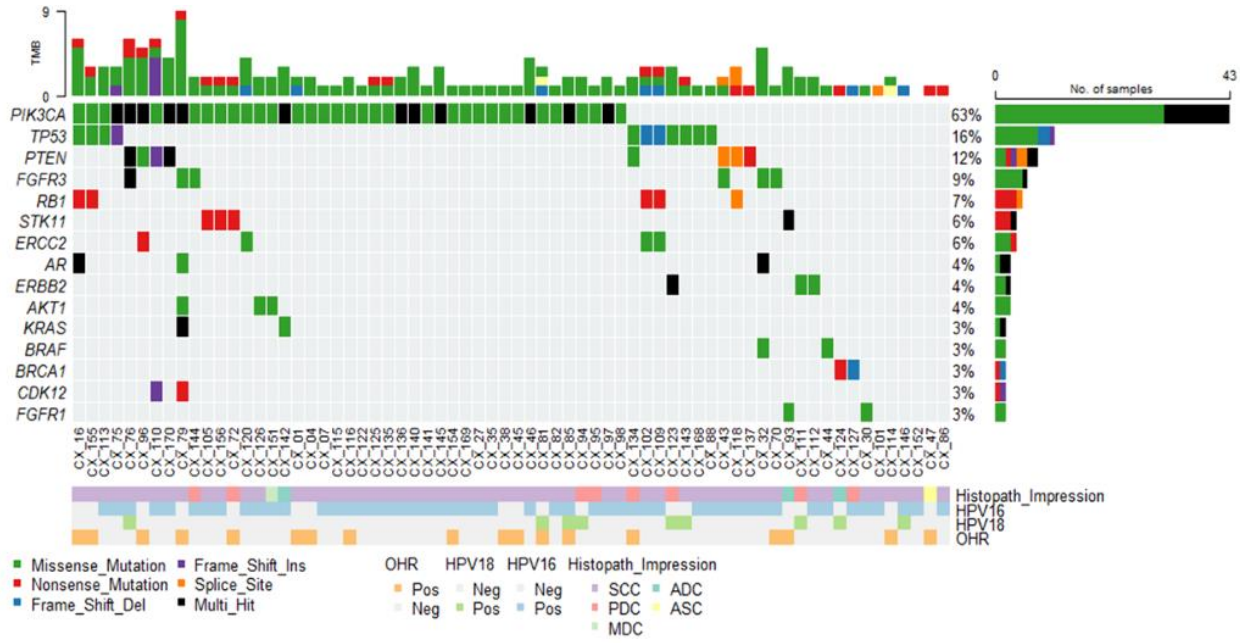
TARGETED NGS PROFILING OF CERVICAL EXFOLIATED CELLS REVEALS PIK3CA AS A DOMINANT DRIVER IN HPV-ASSOCIATED CERVICAL CANCER: A FIRST SOUTH INDIAN COHORT STUDY

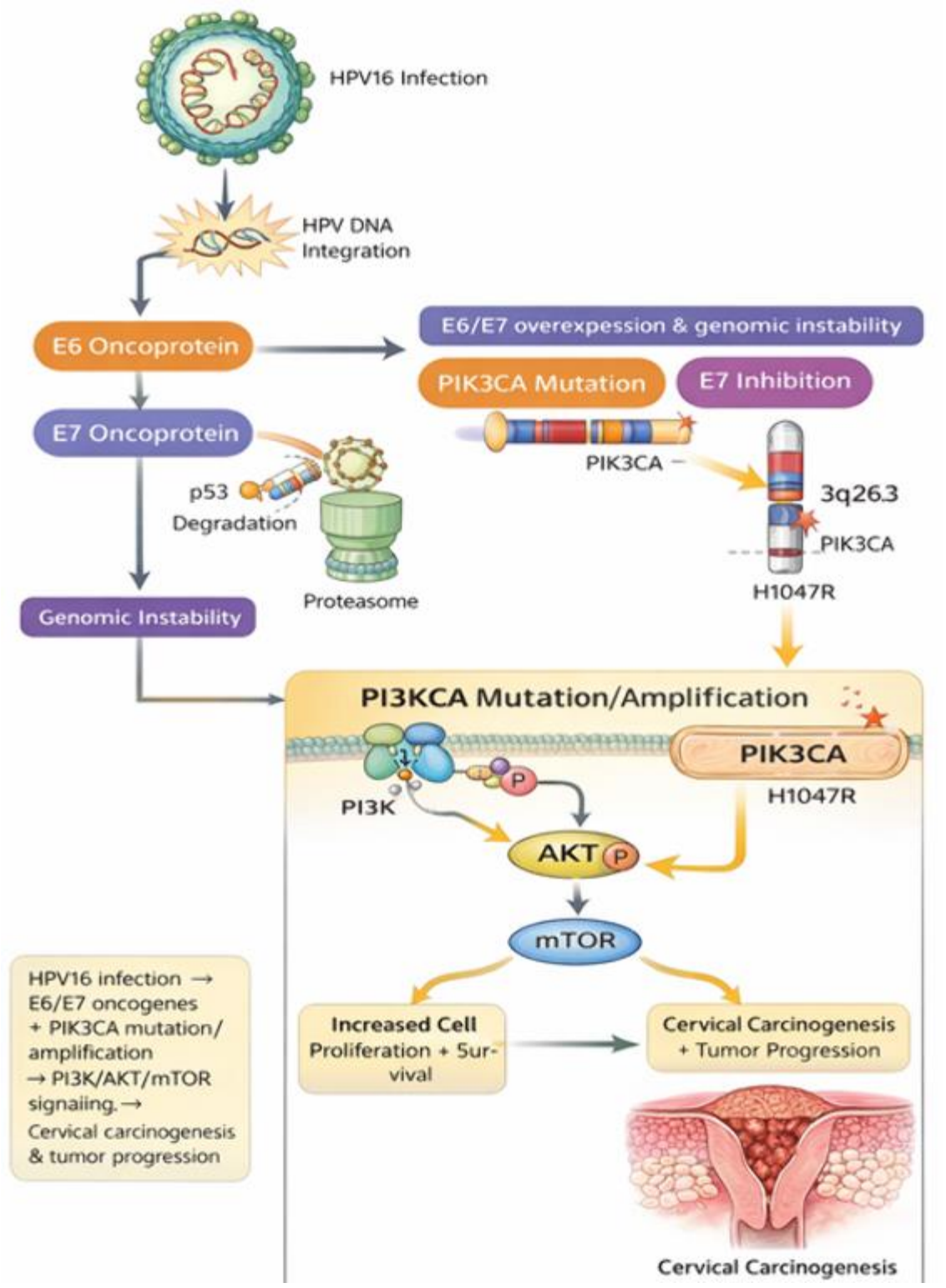
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Introduction: Cervical cancer is driven by persistent high-risk HPV infection, but viral presence alone is insufficient for malignant transformation. Advances in targeted next-generation sequencing (NGS) enable high-resolution detection of these alterations from minimally invasive samples. This study investigates the genomic landscape of HPV-associated cervical cancer using targeted NGS of cervical exfoliated cells in a South Indian cohort.

Methods: Ninety-seven histologically confirmed cervical cancer cases were recruited through convenience sampling from community screening programs. Cervical exfoliated cells were collected in ThinPrep medium. HPV testing was performed using cobas® 4800, with extended genotyping(Allplex™) for non-16/18 types. DNA was extracted, quality-checked, and sequenced using a 126-gene panel on Illumina NextSeq 2000(~1000× depth). Variants were interpreted using iCARE software per ACMG/AMP/ASCO/CAP guidelines.

Results: Genomic alterations were detected in 69/97 cases (71.1%). *PIK3CA* was the most frequently mutated gene (61/97,63%), followed by *TP53*(16%), *PTEN*(12%), and *FGFR3*(9%). Additional alterations included *RB1*(7%), *STK11* and *ERCC2*(6% each), and *ERBB2*, *AKT1*, and *AR*(4% each). Low-frequency mutations(*KRAS*, *BRAF*, *BRCA1*, *CDK12*, *FGFR2*) were observed in 3% each. Mutation patterns varied by HPV subtype: *PIK3CA* mutations were prominent in HPV16(68%) and OHR(66.7%) cases, whereas HPV18 tumors showed higher *TP53* and *ERBB2* alterations(33.3% each). A total of 154 variants were identified, with 59.1% pathogenic and 25.3% likely pathogenic; missense mutations predominated(75%). Co-mutation analysis revealed frequent co-occurrence of *PIK3CA* with *TP53*, *PTEN*, *RB1*, and *STK11*.


TMB
9
0
No. of samples
0
43
PIK3CA 63%
TP53 16%
PTEN 12%
FGFR3 9%
RB1 7%
STK11 6%
ERCC2 6%
AR 4%
ERBB2 4%
AKT1 4%
KRAS 3%
BRAF 3%
BRCA1 3%
CDK12 3%
FGFR1 3%
Histopath_Impression
HPV16
HPV18
OHR
Missense_Mutation
Nonsense_Mutation
Frame_Shift_Del
Frame_Shift_Ins
Splice_Site
Multi_Hit
OHR Pos Neg
HPV18 Neg Pos
HPV16 Neg Pos
Histopath_Impression SCC PDC MDC ADC ASC



Conclusion/Implications: PIK3CA emerges as the central oncogenic driver across HPV subtypes, particularly in HPV16 and OHR infections. High rate of actionable mutations highlights the potential for integrating genomic-profiling into cervical cancer screening

EP241 / #644

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

THE SILVA CLASSIFICATION AS A SCREENING TOOL PRIOR TO PD-L1 EXPRESSION TESTING AND ITS PROGNOSTIC SIGNIFICANCE IN ADVANCED STAGE CERVICAL ADENOCARCINOMA

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Introduction: To evaluate the diagnostic performance of Silva classification for predicting programmed death-ligand 1 (PD-L1) expression in advanced endocervical adenocarcinoma and to assess its prognostic significance.

Methods: 53 patients with advanced (FIGO stage ≥ IIB), persistent, or metastatic usual-type endocervical adenocarcinoma treated between 2018 and 2023 were included. Histological slides were reviewed by two expert gynecologic pathologists and classified according to the Silva pattern-based system. PD-L1 expression was assessed using immunohistochemistry with the PD-L1 22C3 antibody, and reported as the combined positive score (CPS), with CPS ≥1 considered positive. Diagnostic performance of Silva patterns B/C for PD-L1 expression was evaluated. Survival outcomes were analyzed using the Kaplan–Meier method.

Results: Silva classification as pattern A was diagnosed in 10 patients (18.9%), pattern B in 10 (18.9%), and pattern C in 33 (62.3%). PD-L1 positivity was identified in 14 patients (26.4%), with similar distribution across Silva patterns (30.0%, 20.0%, and 27.3%, respectively; $p = 0.92$). When Silva patterns B/C were considered test-positive, sensitivity was 78.6%, specificity 17.9%, positive predictive value 25.6%, negative predictive value 70.0%, and accuracy 33%. Positive and negative likelihood ratios were 0.96 and 1.19, respectively. No significant differences in progression-free and overall survival were observed according to Silva classification or PD-L1 expression.

Conclusion/Implications: Silva classification was not associated with PD-L1 expression and demonstrated limited utility as a screening tool. CPS remains essential for PD-L1 assessment in advanced endocervical adenocarcinoma.

EP242 / #1114

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

CONSERVATIVE MANAGEMENT OF EARLY-STAGE CERVICAL CANCER: A SINGLE CENTRE EXPERIENCE

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Introduction: Objective: The study aimed to evaluate follow-up and recurrence of microinvasive cervical cancer treated conservatively.

Methods: Study methods: A retrospective chart review was performed for stage 1A1- 1B1 cervical cancer patients treated with conservative management (loop electrosurgical excision procedure LEEP or conization) at Sunnybrook Health Sciences Centre in Toronto, Ontario between 2009-2024.

Results: Results: A total of 19 patients were included. Table 1 illustrates their clinical demographics. Most patients had stage 1A1 (79.0%) with negative LVSI (94.7%) and mostly had squamous histology (73.7%). Thirteen (68.4%) underwent a second LEEP/conization at diagnosis due to positive margins for preinvasive disease or close surgical margins. At the end of the conservative treatment, two (10.5%) of patients had positive margins for high-grade squamous intraepithelial lesion (HSIL). After a mean follow-up of 28.3 months, 5 (26.3%) patients had abnormal cytology: two had low-grade squamous intra-epithelial lesion (LSIL), two had atypical squamous cell of unknown significance (ASCUS), and one had atypical squamous cell cannot exclude high-grade (ASC-H). Amongst these, 2 patients (10.5%) recurred and required treatment. One patient recurred after 12 months with carcinoma requiring chemoradiation; she initially had 1B1 with positive lymphovascular invasion and negative margins, and follow-up revealed human papillomavirus (HPV) 16 and LSIL. One had 1A1 adenocarcinoma mucinous type with positive HSIL margin; she recurred at 18 months with adenocarcinoma in situ and was treated with repeat LEEP and was discharged after an additional 28 months of follow-up.

Conclusion/Implications: Conclusions: Conservative management of early-stage cervical cancer is feasible and should be reserved to stage 1 with negative LVSI.

EP243 / #1075

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

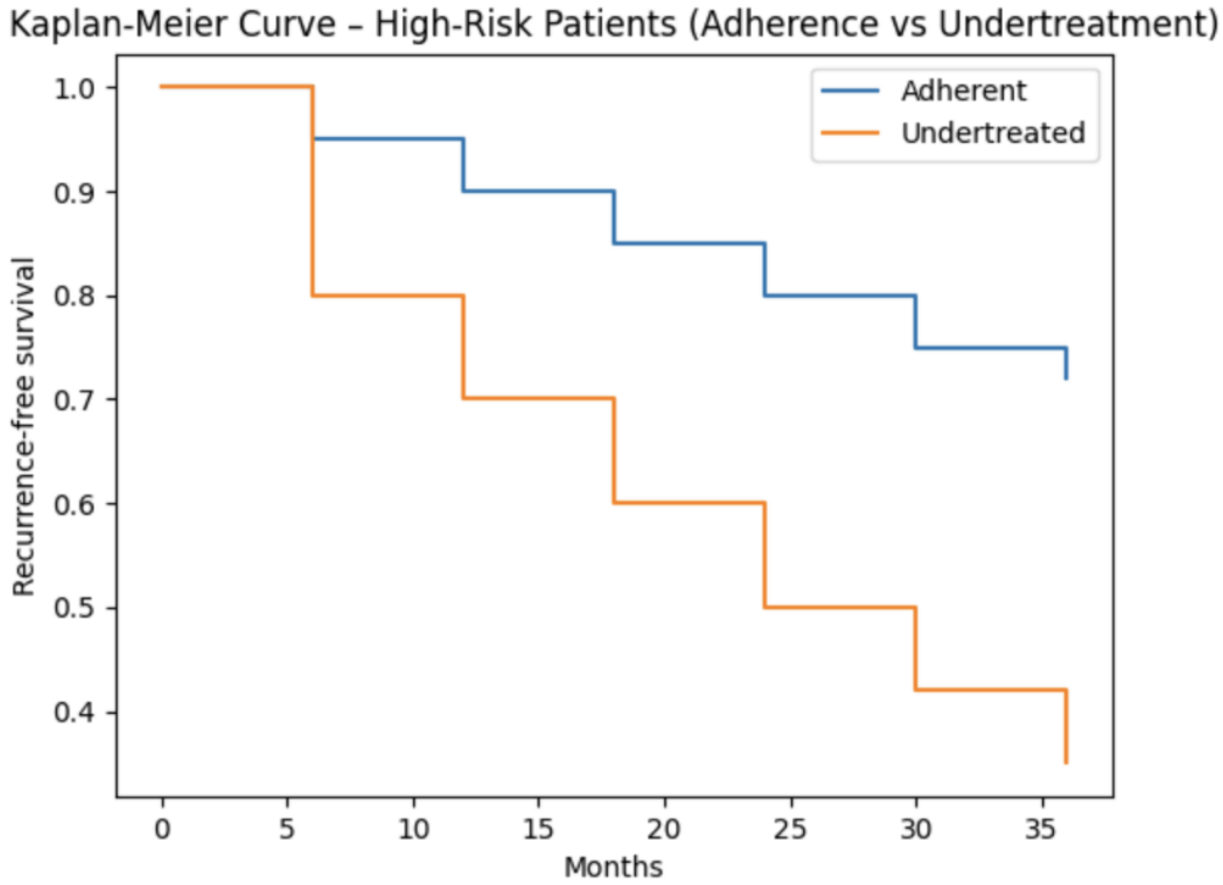
ADHERENCE TO INTERNATIONAL RECOMMENDATIONS FOR ADJUVANT THERAPY AFTER RADICAL HYSTERECTOMY IN EARLY CERVICAL CANCER: CLINICAL AUDIT AT SAN BORJA ARRIARÁN HOSPITAL, CHILE.

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Introduction: Radical hysterectomy with pelvic lymph node assessment is a standard treatment for selected patients with early-stage cervical cancer. Adjuvant therapy is recommended based on pathological risk stratification; however, real-world adherence remains uncertain in Latin American public health systems.

Methods: We conducted a retrospective cohort study including 89 patients who underwent radical hysterectomy at a tertiary public hospital in Chile. Patients were classified as high risk (lymph node involvement, parametrial invasion, or positive margins) or low risk (absence of these factors). Adjuvant treatment was evaluated according to international guidelines (high risk: concurrent chemoradiotherapy; low risk: observation). Adherence was defined as concordant management, undertreatment as omission of indicated therapy, and overtreatment as unnecessary adjuvant therapy. Recurrence-free survival (RFS) was estimated using Kaplan–Meier analysis and compared with the log-rank test.

Results:



Twenty-one patients (24%) were high risk and 68 (76%) low risk. Among high-risk patients, 67% received indicated chemoradiotherapy, while 33% were undertreated. In the low-risk group, 84% were appropriately observed and 16% received unnecessary radiotherapy. The overall recurrence rate was 31%. In high-risk patients, 3-year RFS was 72% in adherent cases versus 35% in undertreated patients (p=0.04). Undertreatment was associated with increased recurrence risk (HR 2.6; 95% CI 1.1–6.4).

Conclusion/Implications: These findings demonstrate clinically significant deviations from guideline-recommended care, particularly undertreatment in high-risk patients, which was associated with worse oncologic outcomes. Strengthening adherence to evidence-based guidelines and multidisciplinary decision-making may improve survival outcomes in public health settings.

EP244 / #1108

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

OVERTREATMENT AND UNDERTREATMENT AFTER RADICAL HYSTERECTOMY FOR EARLY CERVICAL CANCER: EVIDENCE OF A DOUBLE BURDEN IN A CHILEAN PUBLIC HEALTH CENTER

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Introduction: Adjuvant therapy after radical hysterectomy is guided by pathological risk stratification. However, real-world adherence is variable, and both underuse and overuse may coexist. Ongoing de-escalation trials, including CERVANTES study, underscore uncertainty in lower-risk groups

Methods: Retrospective cohort of 89 patients undergoing radical hysterectomy with pelvic lymph node assessment at a tertiary public hospital. High risk: nodal involvement, parametrial invasion, or positive margins (recommended concurrent chemoradiotherapy). Low risk: absence of these factors (observation). Adherence definitions: adherent, undertreatment, overtreatment. Recurrence-free survival (RFS) by Kaplan–Meier; log-rank comparison.

Results: Twenty-one patients (24%) were high risk; 68 (76%) low risk. In high-risk patients, 67% received indicated chemoradiotherapy and 33% were undertreated. In low-risk patients, 84% were observed and 16% received unnecessary radiotherapy. Overall recurrence rate was 31%. Among high-risk patients, 3-year RFS was 72% with adherent treatment versus 35% with undertreatment (p=0.04), with increased recurrence risk (HR 2.6; 95% CI 1.1–6.4).

Conclusion/Implications: A double burden of undertreatment in high-risk patients and overtreatment in low-risk patients was observed, with clinically meaningful impact on outcomes. In the context of de-escalation efforts such as the CERVANTES study, strengthening guideline adherence and risk-adapted decision-making is essential to avoid both harm from omission and unnecessary toxicity.

EP245 / #914

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

CLINICAL FACTORS ASSOCIATED WITH INELIGIBILITY FOR FIRST-LINE BEVACIZUMAB IN ADVANCED CERVICAL CANCER: A REAL-WORLD ANALYSIS

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Introduction: Although bevacizumab plus chemotherapy is a standard first-line treatment for advanced cervical cancer, its use is frequently constrained by safety concerns. In particular, the risk of fistula and bleeding remains a major barrier in clinical practice. However, real-world evidence defining which patients are deemed ineligible for bevacizumab is scarce, limiting the ability to guide treatment selection.

Methods: We performed a retrospective analysis of patients with recurrent or metastatic cervical cancer treated at Humanitas San Pio X, Milan, Italy, between January 2024 and March 2026. The primary objective was to characterize clinical factors associated with ineligibility for first-line bevacizumab. Secondary objectives included documenting reasons for treatment exclusion and patterns of treatment discontinuation.

Results: Thirty-five patients were included; 28 (80.0%) received bevacizumab and 7 (20.0%) were considered ineligible. Impaired performance status (ECOG ≥2) was more frequent among ineligible patients (14.3% vs 7.1%). Ineligibility was primarily driven by clinically relevant contraindications, including fistula or fistula-related conditions (57.1%) and bleeding risk (28.6%), while early clinical deterioration accounted for one case (14.3%). Among treated patients, discontinuation was primarily driven by disease progression, with limited discontinuation related to treatment toxicity.

Conclusion/Implications: Ineligibility for first-line bevacizumab is largely driven by identifiable safety-related factors rather than treatment underuse. These findings highlight a consistent, safety-driven approach to treatment selection and emphasize the need for

clinically applicable strategies to better define high-risk patients. Improved risk stratification may enable more precise use of anti-angiogenic therapy and enhance real-world outcomes in advanced cervical cancer.

EP246 / #663

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

IMPACT OF THE SHAPE TRIAL ON SURGICAL TREATMENT OF EARLY-STAGE CERVICAL CANCER IN A HIGH-VOLUME ACADEMIC CENTER: A RETROSPECTIVE COHORT STUDY

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Introduction: To evaluate outcomes comparing simple hysterectomy(SH) versus radical hysterectomy(RH) in patients with early-stage cervical cancer with low-risk features meeting SHAPE criteria.

Methods: This is a retrospective study of all patients with FIGO stages IA2 and IB1 cervical carcinoma who underwent surgery for FIGO from March 2021- February 2026 at Hôpital Maisonneuve-Rosemont in Canada. All patients had pre-operative imaging (CT, PET-CT and MRI). Decision on SH vs RH was made during multidisciplinary tumor board.

Results: There were 17 patients included; 9 RH and 8 SH. Baseline characteristics were similar in both groups. Most patients were Stage IB1(77.8% RH and 50% SH, p=0.335). Median tumour size on pre-operative MRI was 12mm RH vs 15mm SH(p= 1.0). One patient in each group had stromal invasion over 50%(p=1.0). A 2ndLEEP procedure was performed in 44.4% RH and 12.5% SH(p=0.294) prior to surgical decision-making. More SH patients had minimally invasive surgery(MIS) (50% vs 0% RH,p=0.046). No intraoperative complications were reported in SH vs 22.2% RH(p=0.471). Postoperative complications were reported in 37,5% SH vs 55,6% RH(p=0.637), including urinary retention(44%) and wound infections(11.1%). On final pathology, no residual disease was reported in 33,3%(n=3) RH vs 7.5%(n=3) SH(p=0,858), among which 66,7% also had no residual on preoperative MRI. Two SH patients required postoperative parametrectomy. No patients required adjuvant treatment.

Conclusion/Implications: After adopting SHAPE criteria, there were no significant differences in surgical outcomes between patients undergoing SH and RH. A high proportion of patients underwent 2nd LEEP albeit a high correlation with residual tumour on MRI and final pathology.

EP247 / #798

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

CLINICAL OUTCOMES OF CERVICAL CANCER PATIENTS TREATED WITH CONCURRENT CHEMORADIOTHERAPY AND IMAGE-GUIDED BRACHYTHERAPY

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Introduction: Concurrent chemo radiotherapy (CCRT) followed by image-guided brachytherapy (IGBT) is a standard of care for locally advanced cervical cancer (LACC). Recently, the INTERLACE trial showed improved outcomes with induction chemotherapy. We aimed to evaluate real-world oncological outcomes in LACC patients treated with CCRT and IGBT at our institution, and to benchmark these results against the INTERLACE trial.

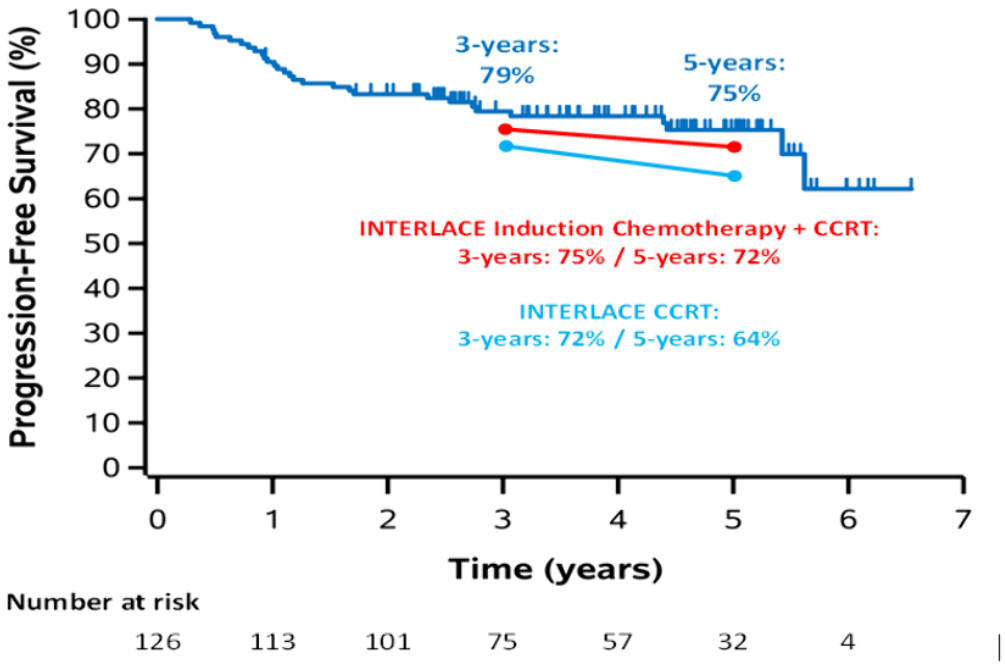
Methods: This retrospective study included patients with LACC treated with curative intent at our institution between 2018 and 2023. Patients with stage IIIC2 disease and incomplete follow-up were excluded. Staging was performed primarily with thorax/abdomen/pelvis CT; 15.8% of patients underwent FDG PET-CT. Treatment consisted of intensity-modulated radiotherapy (per EMBRACE-2 protocol) with weekly cisplatin (40 mg/m^2), followed by IGBT. Survival outcomes were estimated using the Kaplan–Meier method, with the start date of external beam radiotherapy as the time origin.

Results: A total of 126 patients were included (Table 1). Median follow-up was 4.0 years. Concurrent chemotherapy was administered in 96% of patients. Median EQD2 for HR-CTV D90 was 91Gy (IQR 86–95), and median overall treatment time was 44 days (IQR 41–46). 28 patients (22%) experienced disease progression: 4 local, 6 pelvic nodal, 3 para-aortic nodal, and 15 distant. Progression-free survival at 3 and 5 years was 79.4% and 75.3%, respectively (Figure 1). Overall survival at 3 and 5 years was 95.4% and 90.5%, respectively.

Table 1 – Baseline Patient Characteristic	(n=126)
Age (years) –median, (IQR)	49.1 (40.7, 58.9)
Body mass index Kg/m^2) –median, (IQR)	28.4 (24.4, 33.9)
Tumor size (cm) –median, (IQR)	4.50 (4.00, 5.70)
Histology – n (%)	
Squamous cell carcinoma	98 (77.8)
Adenocarcinoma/Adenosquamous	28 (22.2)
FIGO 2008 staging – n (%)	
IB	53 (42.1)
IIA	11 (8.7)
IIB	55 (43.7)
IIIA	1 (0.8)
IIIB	6 (4.8)
FIGO 2018 staging – n (%)	
IB	28 (22.8)
IIA	5 (4.1)
IIB	36 (29.3)
IIIB	9 (7.3)
IIIC	35 (28.5)
IVA	10 (8.1)
Pelvic Nodal disease – n (%)	40 (31.8)

IQR – interquartile range

Figure 1: Kaplan-Meier curve of Progression-Free Survival for patients included in the analysis



Conclusion/Implications: Modern CCRT with IGBT yields excellent survival outcomes that compare favorably with those reported in the INTERLACE trial. A more rigorous comparative analysis with patient-characteristic matching between cohorts is currently underway.

EP248 / #988

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

HIDDEN SEQUELAE OF BRACHYTHERAPY IN CERVICAL CANCER: BODY IMAGE AND SEXUAL DYSFUNCTION IN A TUNISIAN COHORT

Sarra Saidi[1], Asma Ghorbel[1], Hajer Zelaiti[2], Hadhami Ayadi[1], Ghaiet Elfidaa Noubbigh[2], Alia Mousli[1], Nejla Attia[1], Khedija Ben Zid[1], Amani Yousfi[1], Rim Abidi[1], Semia Zarraa[1], Chiraz Nasr[1]
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Introduction: Cervical cancer and its treatments may significantly impair body image and sexual function,thereby affecting quality of life in survivorship.Brachytherapy,a cornerstone of curative treatment,has been insufficiently explored in this context,particularly in low- and middle-income countries.We aimed to evaluate the impact of brachytherapy on body image perception and sexual function among Tunisian cervical cancer survivors.

Methods: We conducted a prospective observational study including women with histologically confirmed, non-metastatic cervical cancer in complete remission, with a follow-up of 24 months. Eligible patients reported active sexual life prior to diagnosis. Exclusion criteria included psychiatric disorders, partner-related sexual dysfunction, and cognitive impairment.All patients received brachytherapy,either low-dose-rate (LDR) or high-dose-rate (HDR). Sociodemographic,clinical and treatment data were collected through structured 40-minute interviews.Body image and sexual function were assessed using the Body Image Scale (BIS) and Female Sexual Function Index (FSFI).

Results: Forty-six patients were included, with a median age of 49 years.Most had intermediate socioeconomic status (74%) and a median marital duration of 22 years.Stage IB1 disease was present in 43.5% of cases.No prior surgery was performed in 56.6%,while 56.5% received chemotherapy and 69.6% underwent external beam radiotherapy,including 21.2% with para-aortic irradiation.LDR brachytherapy was delivered in 65.2% and HDR in 28.3%.Post-treatment body image impairment was frequent, with a median BIS score of 14 [0–30]. Sexual dysfunction was also common,with a mean FSFI score of 34 [23–36],indicating impairment across multiple domains.

Conclusion/Implications: These findings underscore a significant impact of brachytherapy on quality of life in Tunisian cervical cancer survivors. Addressing psychosexual health should be part of standard post-treatment care.

EP249 / #428

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

OVERALL SURVIVAL OUTCOMES OF NEOADJUVANT CHEMOTHERAPY FOLLOWED BY SURGERY COMPARED TO CHEMORADIOTHERAPY IN LOCALLY ADVANCED CERVICAL CANCER

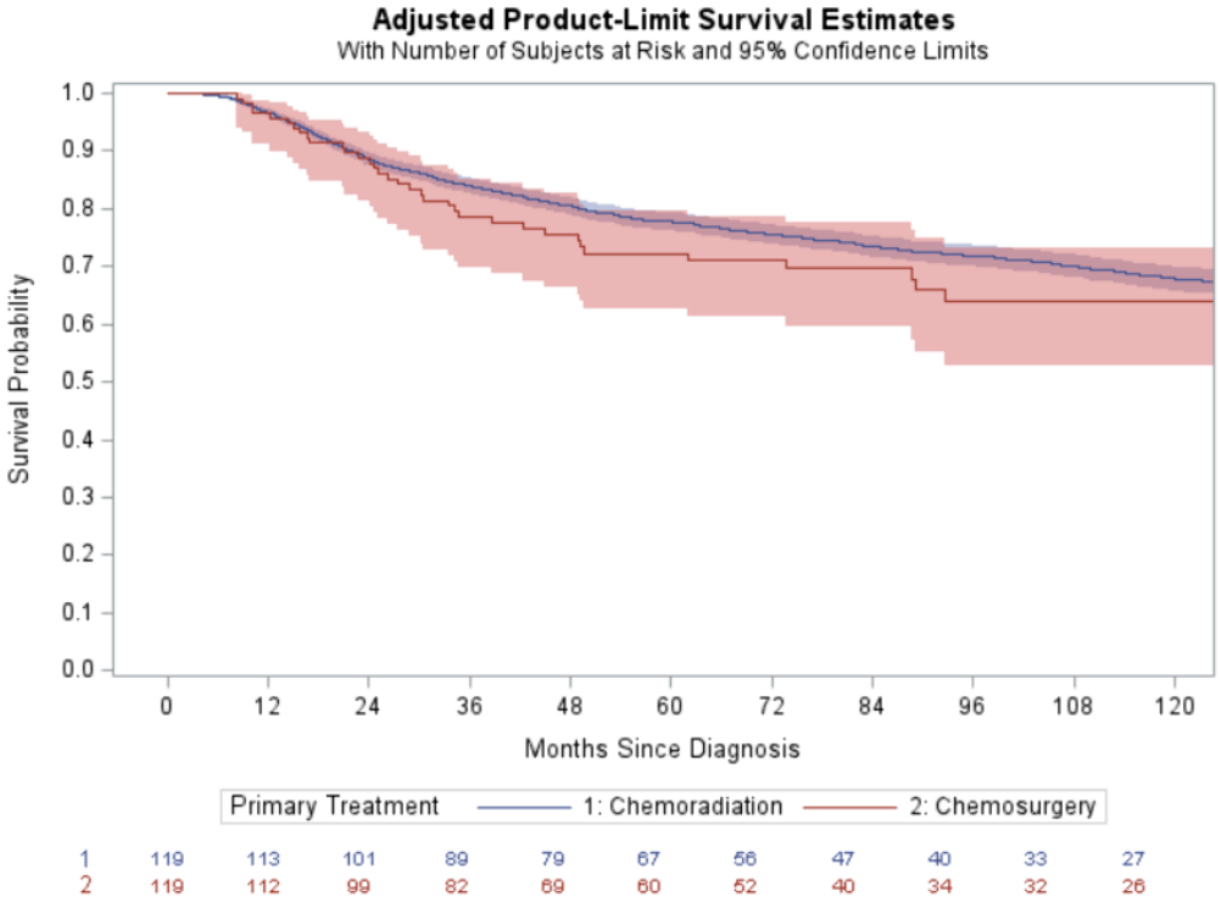
Sha Sha[1], Yongmei Huang[2], Ling Chen[3], Jessica Disilvestro[1], Sarah Paraghamian[1], Rafael Gonzalez[1], Valena Wright[1], Katina Robison[1], Jason Wright[1]
[1]Tufts Medical Center, Department Of Gynecologic Oncology, Boston, United States of America, [2]Columbia University, Department Of Obstetrics & Gynecology, New York City, United States of America, [3]Tufts Medical Center, Obgyn, Boston, United States of America

Introduction: To determine the use and outcomes of neoadjuvant chemotherapy followed by surgery (NACT-S) compared to primary chemoradiation (CRT) for patients with locally advanced cervical cancer (LACC).

Methods: The National Cancer Database was queried for patients with Stage IB2-IIB squamous, adenocarcinoma or adenosquamous cervical cancer treated between 2004-2022. Treatment within 60 days of diagnosis was categorized as: (1) NACT-S (chemotherapy that preceded hysterectomy +/- adjuvant radiotherapy or (2) CRT (external beam radiation and brachytherapy with concurrent chemotherapy without surgery). Patients receiving first-line immunotherapy were excluded. Demographics and clinical variables were collected. Log-linear Poisson regression identified factors associated with NACT-S usage. Overall survival (OS) was compared using propensity score inverse probability weighting.

Results: Among 10,557 patients, 122 (1.2%) received NACT-S and 10,435 (98.8%) received CRT. Most patients were white, commercially insured, with squamous histology. Patients were more likely to undergo NACT-S with Stage IB2 (aRR 5.67; 95% CI, 3.64-8.83) or IB3 (aRR 3.23; 95% CI, 2.07-5.03) tumors, were <40 years old (2.94; 95% CI, 1.63-5.29), had adenocarcinoma (aRR 1.96; 95% CI, 1.28-2.98) or adenosquamous (aRR 2.04; 95% CI, 1.01-4.11) histology. Use of NACT-S has decreased over time. There was no statistically significant difference in OS at 5 years between treatment groups (NACT-S: 72.2%; 95% CI 62.6-79.8%; CRT: 77.8%; 95% CI, 76.2-79.3%) (Figure

1).



Conclusion/Implications: In the US, CRT remains the predominant treatment for LACC. Patients receiving NACT-S were more likely to be younger and be of earlier stage. There appears to be no difference in OS comparing NACT-S and CRT approaches.

EP250 / #450

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

CLEARANCE OF HIGH-RISK HPV SHORT TIME POST LEEP OF CERVICAL CANCER PREDICTS ABSENCE OF RESIDUAL TUMOR

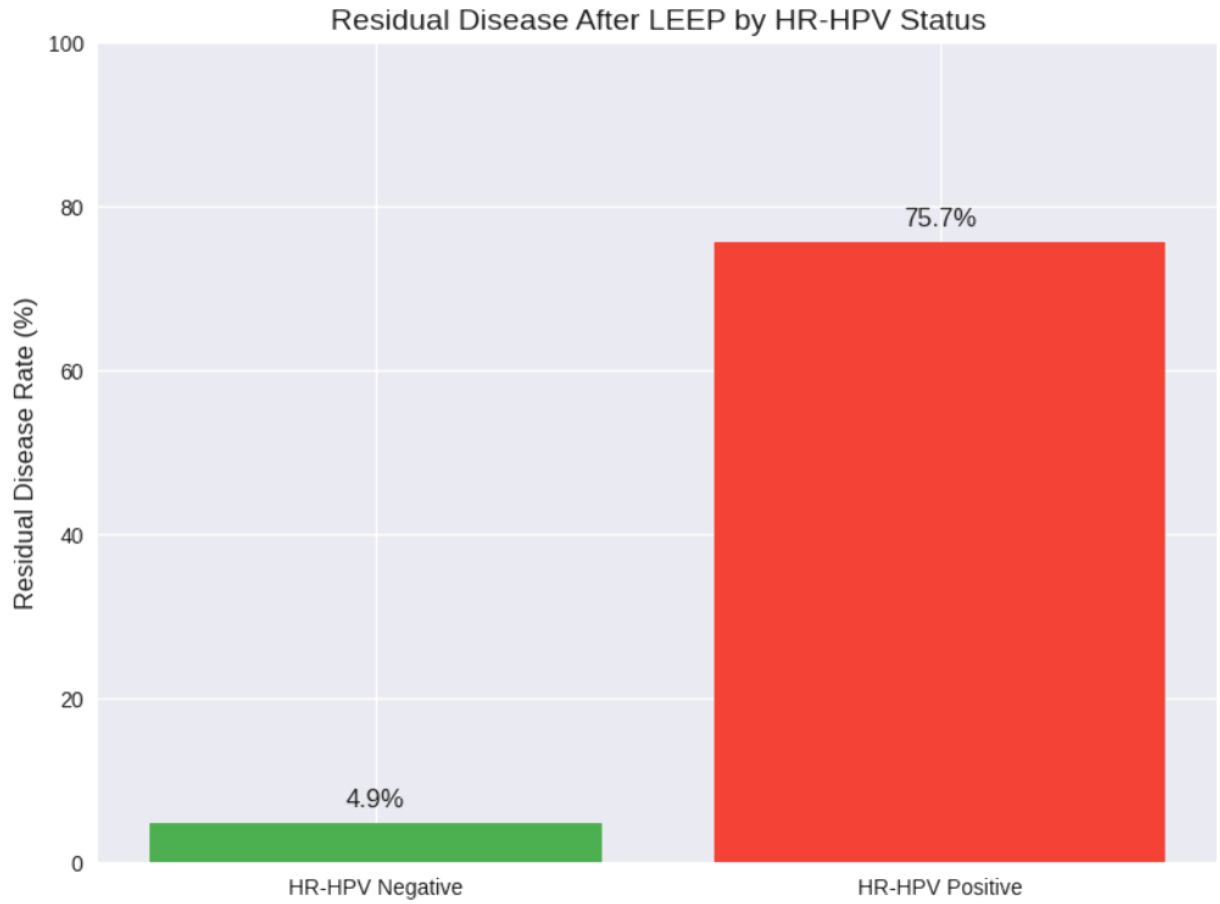
Yoav Siegler[1], Emad Matanes[1], Yakir Segev[2], Pninit Shaked-Mishan[3], Salam Salam Mazarebe[4], Lena Lena Mackuli[2], Nir Kugelman[2], Edmond Sabu[4], Yael Goldberg[2], Ofer Lavie[2], Efraim Siegler[2]
[1]Rambam Health Care Center, Haifa, Israel, [2]Department of Obstetrics & Gynecology, Carmel Medical Center, Haifa, Israel, [3]Carmel Medical Center,, Haifa, Israel, [4]Carmel Medical Center, Department Of Pathology, Haifa, Israel

Introduction: In early-stage cervical cancer (ESICC), reliable indicators of cure or low risk of residual disease are needed. This study evaluated whether early clearance of high-risk human papillomavirus (HR-HPV) following loop electrosurgical excision procedure (LEEP) can predict absence of residual disease on final pathology in women diagnosed with ESICC.

Methods: We present data of 115 women with ESICC, positive for HR-HPV prior to LEEP, who performed repeated HPV test 3-12 weeks post-LEEP and before the final treatment. We compared characteristics of negative and positive HR-HPV women.

Results: Following LEEP, 41 women tested negative and 74 positive for high-risk HPV (HR-HPV). Among HR-HPV–negative patients, 39 (95.1%) had no residual malignancy on final pathology, while 2 (4.9%) had persistent disease. In contrast, among HR-HPV–positive women, 24.3% had no residual cancer and 75.7% had residual disease. In HR-HPV–negative patients, positive surgical margins after LEEP were not associated with residual tumor, as 93.1% (27/29) showed no remaining cancer on final pathology. Additionally, among the 41 HR-HPV–negative women, 15 underwent radical hysterectomy or trachelectomy; of these, 13 (86.6%) showed no residual malignancy on final histologic

evaluation.



Conclusion/Implications: Clearance of HR-HPV following LEEP for cervical cancer predicts absence of residual disease in 95.1% of cases on final pathology. The predictive value of positive margins appears weaker than that of a negative HR-HPV result. Post-LEEP HR-HPV testing may therefore serve as a novel tool for assessing the risk of residual cervical cancer and could support consideration of less radical interventions.

EP251 / #515

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

THE RISK OF CERVICAL CANCER IN WOMEN WITH CIN 2-3 DURING PREGNANCY AND THE SAFETY OF LEEP UP TO 15 WEEKS OF PREGNANCY

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Introduction: Cervical Intraepithelial Neoplasia 2- 3 (CIN 2-3) is a premalignant lesion and Loop Electrosurgical Excision Procedure (LEEP) is the recommended treatment. During pregnancy the consensus guidelines recommend observation only. The risk of a women with CIN 2-3 to be diagnosed with invasive cancer during the pregnancy is controversial.

Objectives: The aim of our study was to collect data of women diagnosed with CIN 2-3 on biopsies during pregnancy and describe the risk of invasive cancer and the outcome of LEEP in the first 15 weeks of pregnancy

Trial Design: Members of the Israeli Society of Colposcopy answered a questionnaire of 210 patients diagnosed with CIN 2-3 in pregnancy between January 2006 and January 2026. 129 women were followed, and 81 women underwent LEEP.

Feasibility and Implementation: Invasive cancer was the final diagnosis in 12(5.7%) of the 210 women diagnosed with CIN 2-3 during pregnancy. Postpartum in the observation group 9 (7%) had cervical cancer, 62% had CIN 2-3, and 26.3% had CIN 1/ Normal histology, 4.6% were lost to follow up.. 81 women underwent LEEP during 15 weeks: The diagnosis was cancer in 3 patients (3.7%), CIN 2-3 or AIS in 73 (90.1%) and CIN 1/ normal results in 6.2%. 71 women continued their pregnancy, 67 (94.6%) had term deliveries 2 late preterm delivery 2 had missed abortion .

Conclusion: The risk of cervical cancer in 5.7% of women with CIN 2-3 in pregnancy, the safety of LEEP in the first 15 weeks suggest that conization should be considered based on individual risk factors and personalized approach

EP252 / #720

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

STRATIFICATION OF CERVICAL SMALL CELL NEUROENDOCRINE CARCINOMA BY NEUROENDOCRINE IMMUNOPHENOTYPE: A COMPARATIVE CLINICOPATHOLOGICAL ANALYSIS.

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Introduction: Cervical small cell neuroendocrine carcinoma (CSCNEC) is a rare and highly aggressive malignancy. Although immunohistochemical detection of traditional neuroendocrine (NE) markers such as CD56, chromogranin A, and synaptophysin is valuable for diagnosing SCNEC, their expression is not required. Small cell lung cancer (SCLC), the prototype for SCNEC in other organs, expresses not only NE markers but also TTF-1 and c-kit, with lower NE marker expression associated with better prognosis. Herein, we investigated clinicopathological differences between NE-high and NE-low CSCNEC.

Methods: We analyzed 29 cases of CSCNEC and stratified them into NE-high and NE-low groups using a NE score defined as the sum of traditional NE markers.

Results: Twenty-nine cases of CSCNEC were stratified into 17 NE-high and 12 NE-low cases. The Kaplan–Meier method was used to analyze disease specific survival (DSS) and progression-free survival (PFS) according to stage, initial treatment, age, specimen type, histological type, individual immunohistochemical markers, and NE score. Tumor stage and NE score were significantly associated with DSS and PFS (stage; DSS, P = 0.002; PFS, P = 0.012, NE-score; DSS P=0.003; PFS, P=0.036). Although TTF-1 expression was more frequently observed in NE-high cases, it was not associated with prognosis, and neither other clinicopathological factors nor the expression of individual immunohistochemical markers showed any prognostic significant.

Conclusion/Implications: NE high cases were more aggressive and more frequently expressed TTF-1 compared with NE-low cases. While NE marker expression is not required for the diagnosis of CSCNEC under current criteria, immunohistochemical examination may help in predicting prognosis.

EP253 / #899

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

PROGNOSIS OF HPV-NEGATIVE CERVICAL CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

Laura Venegas[1], Mariana Noronha[2], Carlos Barbosa[2], Fabrícia Marques[2], David Batista Da Hora[3], Victoria Jatoba[1], Ana Veneziani[1]
[1]Princess Margaret Cancer Centre, Toronto, Canada, [2]Universidade Federal do Ceará, Ceará, Brazil, [3]Federal University of Amazonas, Amazonas, Brazil

Introduction: While human papillomavirus (HPV) infection is the primary cause of cervical cancer (CC), a small subset of tumors is HPV-negative. Emerging evidence suggests this subgroup may exhibit distinct biological behaviors and treatment responses.

Methods: We searched PubMed, Embase, and CENTRAL up to April 2026 for cohort studies involving patients with CC, stratifying by HPV status. Outcomes were overall survival (OS), disease-free survival (DFS), progression-free survival (PFS), and clinicopathological characteristics. Pooled hazard ratios (HR) and odds ratios (OR) with 95% confidence intervals (CI) were calculated in R software.

Results: We screened 995 titles, and 27 studies met the eligibility criteria, comprising 11,214 patients (7.4% HPV-negative). Patients with HPV-negative CC had worse OS (HR 2.05, 95% CI 1.54–2.72, P<0.01, I^2=36.7%) (Figure 1), and DFS/PFS (HR 2.29, 95% CI 1.88–2.79, P<0.01, I^2=2.4%) compared to those with HPV-positive tumors (Figure 2). HPV negativity was strongly associated with a higher likelihood of adenocarcinoma histology (OR 4.11), more advanced disease, including FIGO Stage III-IV (OR 2.40), larger tumor size >4 cm (OR 1.54), increased pelvic/para-aortic lymph node positivity (OR 2.28), higher rates of lymphovascular space invasion (OR 2.46), mutant/abnormal p53 expression (OR 20.32), and poor tumor differentiation (OR 1.62). Figure
1.

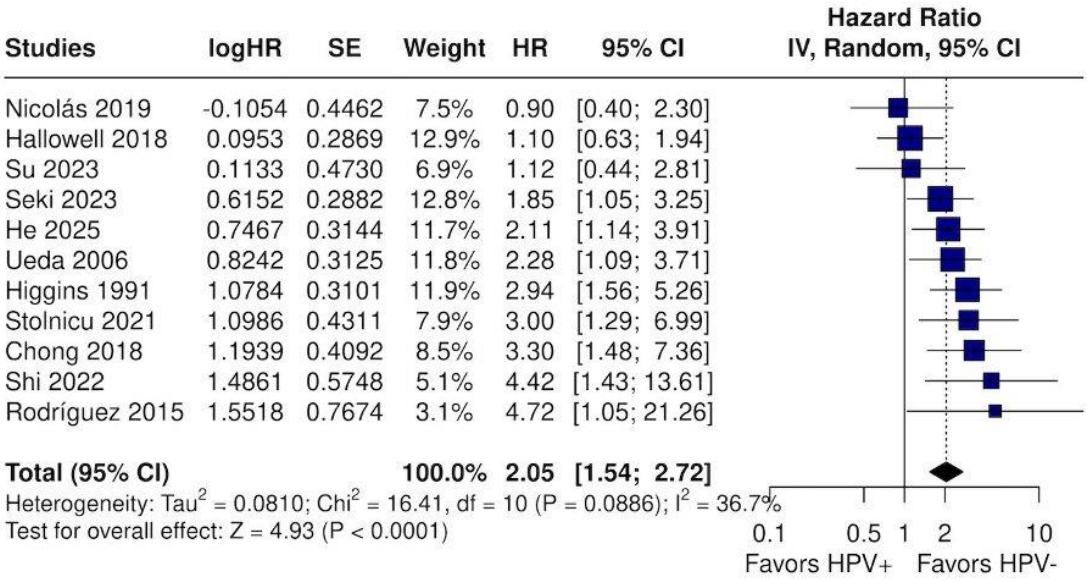
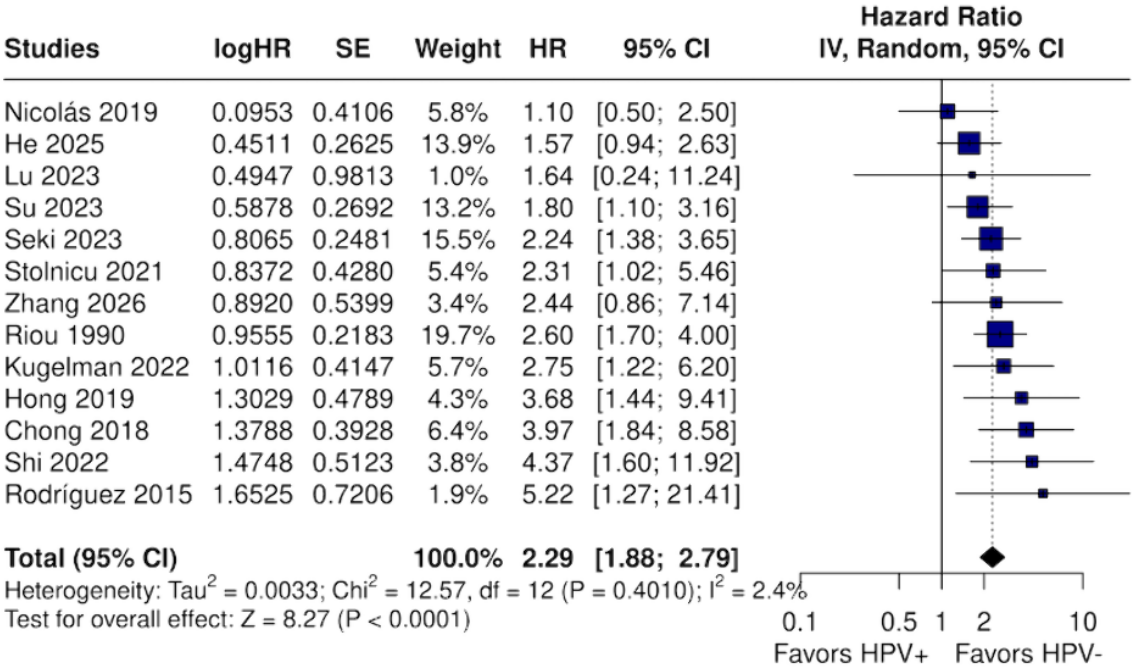


Figure
2.



Conclusion/Implications: HPV-negative CC represents a distinct, highly aggressive clinical entity, characterized by worse survival outcomes, and a higher burden of adverse prognostic factors—particularly advanced stage, nodal involvement, lymphovascular invasion, and aberrant p53 expression—compared to HPV-positive cervical cancer. These

findings underscore the prognostic significance of HPV status in cervical cancer and support its routine assessment.

EP254 / #1139

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

TRENDS AND SURVIVAL OUTCOMES OF CONCURRENT IMMUNOTHERAPY WITH CHEMORADIATION IN LOCALLY ADVANCED CERVICAL CANCER (LACC): A NATIONAL CANCER DATABASE ANALYSIS

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Introduction: The KEYNOTE-A18 trial demonstrated improved 24-month progression-free survival with the addition of immunotherapy to chemoradiation in patients with locally advanced cervical cancer (LACC). We evaluated real-world use and survival outcomes associated with concurrent immunotherapy and chemoradiation in LACC.

Methods: Patients with newly-diagnosed stage IIB–IVA squamous cell carcinoma, adenocarcinoma, or adenosquamous carcinoma (2018–2023) were identified from the National Cancer Database. Chemoradiation was defined as chemotherapy and radiation initiated within 90 days of diagnosis, delivered within 30 days of each other, without surgery. Concurrent immunotherapy was defined as receipt within 90 days of diagnosis. Multivariable logistic regression models identified predictors of immunotherapy use, incorporating year, age, tumor characteristics, facility type, and location variables. Overall survival (OS) at 1 and 3 years and hazard ratios (HRs) were compared across groups.

Results: Among 11,700 patients, 180 (1.5%) received concurrent immunotherapy and 11,520 (98.5%) received chemoradiation alone. Immunotherapy use increased from 0.8% in 2018 to 3.4% in 2023 ($p<0.001$). Median follow-up was 41 months. Patients treated at community institutions were less likely to receive immunotherapy than those at academic centers (aOR 0.40, 95% CI 0.27–0.60), as were patients aged >70 versus 18–39 years (aOR 0.40, 95% CI 0.21–0.78). There was no difference in OS between groups (aHR 0.87, 95% CI 0.55–1.38). Three-year OS was 73.5% (95% CI 64.0–80.8%) with immunotherapy versus 68.4% (95% CI 67.1–69.8%) without ($p=0.42$), with similar results by stage.

Conclusion/Implications: Concurrent immunotherapy use with chemoradiation is increasing among patients with LACC in the United States but was not associated with improved 3-year overall survival.

EP255 / #540

Topic: *AS06. Tumor Types / AS06a. Cervical Cancer*

PROGNOSIS OF STAGE IIIC1P CERVICAL CANCER ACCORDING TO LOCAL TUMOR PROGRESSION AFTER RADICAL HYSTERECTOMY

Kyosuke Yasuda[1], Takuma Wada[2], Minato Tagawa[1], Tomoki Sengiku[1], Reiko Tasaka[1], Makoto Yamauchi[1], Takeshi Fukuda[1], Tomoyo Yasui[1], Toshiyuki Sumi[1]
[1]Osaka Metropolitan University, osaka, Japan, [2]Osaka Metropolitan University, Gynecology, Osaka, Japan

Introduction: The FIGO 2018 staging system introduced stage IIIC for cervical cancer. However, knowledge regarding treatment outcomes based on differences in local tumor progression remains limited. This study evaluates the treatment outcomes of patients with stage IIIC1p (T1/T2) cervical cancer who underwent radical hysterectomy.

Methods: We retrospectively reviewed 173 patients who underwent radical hysterectomy for cervical cancer at our institution between 2015 and 2020. Among them, 52 patients diagnosed with pathological stage IIIC1p were included and divided into two groups based on local progression: the T1 group and the T2 group. We evaluated progression-free survival (PFS) and overall survival (OS).

Results: Of the 52 patients, 24 were classified into the T1 group and 28 into the T2 group. The median PFS was not reached in the T1 group and was 54.3 months in the T2 group. The T1 group demonstrated a significantly better PFS compared to the T2 group (p=0.0453). The median OS was not reached in either group, and no significant difference in OS was observed between the two groups (p=0.784).

Conclusion/Implications: This study suggests that local tumor extent remains a critical prognostic factor even within the node-positive IIIC1p staging category.

EP256 / #369

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

TRENDS IN THE UTILIZATION OF HYSTEROSCOPY FOR THE DIAGNOSIS OF ENDOMETRIAL CARCINOMA: A SINGLE INSTITUTION EXPERIENCE

Ali Al Asadi[1], George Yalamanchili[1], Ahmed Ghanem[1], Rhea Rakheja[1], Nusaibah Mabrouk[1], Chun-Hui Lin[2], Ahmad Awada[3], Mohamed Elshaikh[1]
[1]Henry Ford Health System, Radiation Oncology, Detroit, United States of America, [2]Henry Ford Health System, Public Health Sciences, Detroit, United States of America, [3]Henry Ford Health System, Gynecologic Oncology, Detroit, United States of America

Introduction: Hysteroscopy-guided biopsy plays a pivotal role in the diagnostic evaluation of endometrial carcinoma (EC); however, there is paucity of data regarding trends in its utilization as well as its oncologic safety. We sought to analyze temporal trends in hysteroscopy utilization with a focus on survival endpoints.

Methods: Our prospectively maintained EC database was queried for patients with 2009 FIGO stage I-IIIC2 EC who had a hysterectomy at our institution between 1990 and 2024. Patients with synchronous ovarian carcinoma and those without preoperative biopsy-proven EC were excluded. Descriptive statistics were used to compare patient characteristics between hysteroscopy-directed (HD) endometrial biopsy group and non-hysteroscopy group. Temporal trends in HD biopsy utilization overall were assessed using the Mann–Kendall test in 4-year increments. Concordance between HD endometrial biopsy and final hysterectomy pathology results was evaluated with Cohen's kappa. Univariate and multivariate analyses were performed to identify factors associated with overall survival (OS) and disease-specific survival (DSS).

Results: A total of 2,585 patients were included. HD biopsy utilization increased over time, from <1% in 1990–1994 to 3.4% in 1995–1999, 3.9% in 2000–2004, 6.3% in 2005–2009, 20.0% in 2010–2014, 40.9% in 2015–2019, and 25.4% in 2020–2024. These upward trends in utilization were confirmed by Mann–Kendall analysis ($\tau=0.71$, $p=0.036$) and were consistent across racial groups. Patients with non-endometrioid histology were less likely to undergo hysteroscopy overall (18.0% vs 22.6%, $p=0.011$). Hysteroscopy was not associated with statistically significant increased rates of positive peritoneal cytology. There was a strong concordance between HD biopsy and final hysterectomy pathology results regarding histologic type and grade ($\kappa=0.72$). Independent predictors of worse DSS and OS included older age, African American race, higher comorbidity burden, higher tumor grade, cervical stromal involvement, and advanced FIGO stage.

Conclusion/Implications: Hysteroscopy-directed endometrial biopsy utilization in the diagnosis of endometrial carcinoma has increased over time across all racial groups. Our data suggests that there is a strong concordance in the results between hysteroscopy-directed biopsy and hysterectomy one. Classic prognostic factors in EC rather than the use of hysteroscopy significantly contributed to survival outcome.

EP257 / #67

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

BETELLA ALGORITHM FOR SELECTIVE POLE TESTING IN ENDOMETRIAL CANCER: CLINICAL APPLICABILITY AND COST SAVINGS IN A RESOURCE-LIMITED SETTING

Samanta Antoniazzi, Florencia Alves, Fernando Paesani, Francisco Von Stecher, Mariana Eiben, Gabriel Crimi, Natalia Zeff
Hospital Universitario CEMIC, Buenos Aires, Argentina

Introduction: Molecular classification in endometrial cancer improves risk stratification and optimizes adjuvant treatment. However, its implementation faces economic barriers in resource-limited settings. This study aimed to describe the proportion of patients with P53, MMR immunohistochemistry and POLE sequencing; evaluate the applicability of the Betella algorithm for selective POLE testing; and compare costs between PROMISE algorithm and selective (Betella algorithm) testing strategies.

Methods: Retrospective cohort study conducted in a university hospital in Argentina (2018–2024). Patients with stage I/II endometrial carcinoma with complete P53 and MMR immunohistochemistry were included. Proportions with 95% confidence intervals were reported. Direct costs of molecular studies and chemotherapy were estimated using updated institutional prices (June 2025).

Results: Of 132 patients identified, 42 met inclusion criteria. MMR-proficient tumors (MMRp) were found in 74% (n=31): 14% (n=6) with abnormal P53 and 60% (n=25) wild-type. MMR-deficient tumors (MMRd) represented 26% (n=11). POLE sequencing was performed in 5% (n=2), both non-mutated. Applying the Betella algorithm, 67% of the cohort (n=28) would not have required POLE testing; restricting testing to endometrioid histology raised this to 88% (n=37). PROMISE POLE testing would have cost USD 22,982, versus USD 7,661 with Betella (savings: USD 15,321) and USD 2,736 restricted to endometrioid tumors (savings: USD 20,246). Considering a 10.1% POLE mutation prevalence, selective testing generates a net saving of USD 13,602 per 10 patients tested by avoiding chemotherapy.

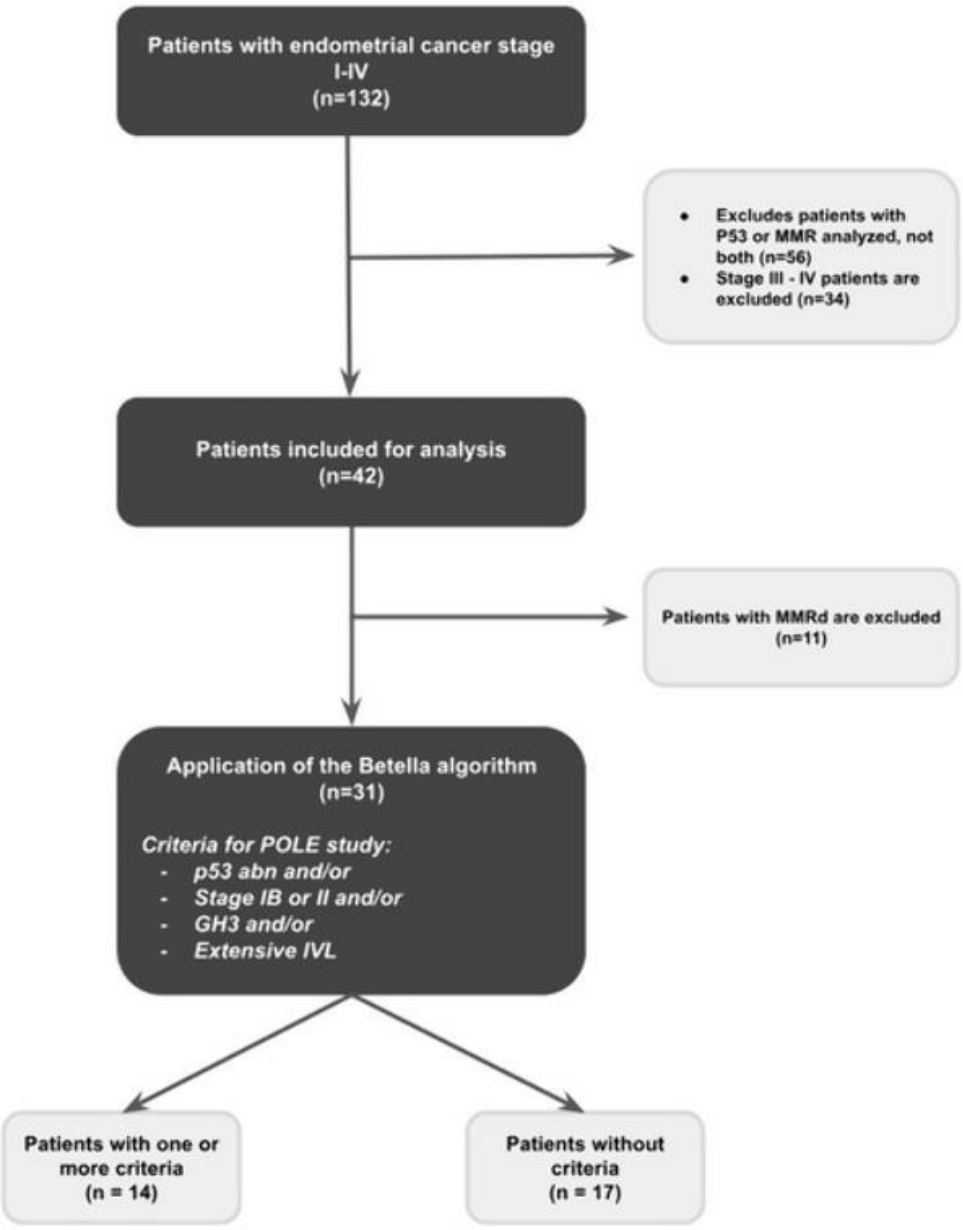

Patients with endometrial cancer stage I-IV
(n=132)
Excludes patients with P53 or MMR analyzed, not both (n=56)
Stage III - IV patients are excluded (n=34)
Patients included for analysis
(n=42)
Patients with MMRd are excluded
(n=11)
Application of the Betella algorithm
(n=31)
Criteria for POLE study:
- p53 abn and/or
- Stage IB or II and/or
- GH3 and/or
- Extensive IVL
Patients with one or more criteria
(n = 14)
Patients without criteria
(n = 17)

Table. Molecular subgroup–stratified clinicopathologic features and POLE testing eligibility (N=42)

Values are n (% within column).

Variable	Category	p53abn/MMRp (n=6)	p53wt/MMRd (n=11)	p53wt/MMRp (n=25)	Total (N=42)
Surgical histology	Endometrioid	1 (16.7)	11 (100.0)	20 (80.0)	32 (76.2)
	Serous	4 (66.7)	0 (0.0)	1 (4.0)	5 (11.9)
	Clear cell	0 (0.0)	0 (0.0)	3 (12.0)	3 (7.1)
	Carcinosarcoma	1 (16.7)	0 (0.0)	0 (0.0)	1 (2.4)
	No residual tumor identified†	0 (0.0)	0 (0.0)	1 (4.0)	1 (2.4)
FIGO stage	IA	3 (50.0)	8 (72.7)	19 (76.0)	30 (71.4)
	IB	2 (33.3)	3 (27.3)	5 (20.0)	10 (23.8)
	II	1 (16.7)	0 (0.0)	1 (4.0)	2 (4.8)
Histologic grade (surgery)	G1–2	1 (16.7)	7 (63.6)	20 (80.0)	28 (66.7)
	G3	4 (66.7)	4 (36.4)	3 (12.0)	11 (26.2)
	Missing	1 (16.7)	0 (0.0)	2 (8.0)	3 (7.1)
POLE sequenced	Yes	0 (0.0)	2 (18.2)	0 (0.0)	2 (4.8)
	No	6 (100.0)	9 (81.8)	25 (100.0)	40 (95.2)
Eligible for POLE testing (Betella)‡	Yes	6 (100.0)	N/A	8 (32.0)	14/31 (45.2) §
	No	0 (0.0)	N/A	17 (68.0)	17/31 (54.8) §

Abbreviations: *p53abn = p53 abnormal pattern; p53wt = p53 wild-type pattern; MMRp, mismatch repair proficient; MMRd, mismatch repair deficient.*
† No residual tumor identified: no tumor in hysterectomy specimen after prior biopsy/curettage diagnosis.
*‡ Betella eligibility is assessed **only in MMRp cases** (n=31).*
*§ Denominators for Betella rows are **within MMRp** (p53abn/MMRp: n=6; p53wt/MMRp: n=25; total MMRp: n=31).*

Conclusion/Implications: Selective POLE testing, particularly in endometrioid carcinomas, is a clinically valid and cost-effective strategy that optimizes resources and facilitates access to precision medicine in resource-limited countries.

EP258 / #210

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

TRENDS IN IMMUNOTHERAPY UTILIZATION AMONG OLDER ADULTS WITH ADVANCED ENDOMETRIAL CANCER: AN NCDB ANALYSIS

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Introduction: Recent clinical trials have established immunotherapy (IO) as a cornerstone in the management of advanced endometrial cancer (EC). However, real-world data regarding the uptake of IO and treatment disparities are limited. This study examines temporal trends in IO adoption and identifies factor-related disparities among older adults with advanced EC.

Methods: We conducted a retrospective cohort study using the National Cancer Database (NCDB), including women aged ≥ 65 years diagnosed with stage III-IV EC between 2019-2023. Temporal trends of IO use were assessed, and multivariable logistic regression identified predictors of IO utilization. Documented reasons for non-receipt were also analyzed.

Results: Among 28,966 patients with advanced EC, 15,607 (53.9%) were aged ≥65 years. IO utilization increased significantly over time across all age groups (P-trend <0.001). By 2023, 1,302 older adults (40.5%) received IO, but utilization remained substantially lower among patients aged ≥85 years (36/159, 22.6%; P<0.001), who were significantly less likely to receive IO (adjusted odds ratio [aOR] 0.47, 95% CI 0.36–0.61, P<0.001). Non-Hispanic Black and Hispanic patients were also less likely to receive IO compared with Non-Hispanic Whites (aOR 0.85, 95% CI 0.75–0.96, P=0.01; aOR 0.82, 95% CI 0.67–1.00, P=0.05, respectively). Among IO non-recipients, patients aged ≥85 years had a significantly higher proportion of clinical contraindications to IO use.

Conclusion/Implications: Despite the proven clinical benefit of IO use for advanced EC, substantial age- and race-based disparities persist. These findings highlight the need for further investigation into clinical, socioeconomic, and structural barriers influencing treatment access in older and minoritized populations.

EP259 / #94

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

QUALITY IMPROVEMENT PROJECT-IMPROVING MMR TESTING AND GENETIC COUNSELLING COMPLIANCE IN ENDOMETRIAL CANCER PATIENTS AT THE JAMES COOK UNIVERSITY HOSPITAL MIDDLESBROUGH.

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Introduction: Endometrial cancer is the most common gynaecological malignancy.These cancers arise due to defects in DNA mismatch repair system.A Quality Improvement Project was undertaken to improve compliance with universal MMR testing. .

Methods: A quality improvement project using the PDSA framework was conducted. Baseline data were obtained through a retrospective audit (Audit #1178) of consecutive endometrial cancer cases discussed at the multidisciplinary team (MDT) meeting between January and July 2022, for 93 patients and included demographic characteristics, tumour stage, MMR immunohistochemistry results, MLH1 promoter methylation testing where indicated, and genetic referral outcomes. Compliance was assessed against standards from NICE DG42 and BGCS guidelines.Several interventions were implemented for the gaps.Introduction of a mandatory MMR status field within the MDT proforma.Addition of an MMR testing prompt in clinic documentation templates.Standardised referral pathway for genetics services.A re-audit using identical methodology was performed between October and December 2024.

Results: In the baseline audit, 90.3% (84/93) of patients had documented MMR testing, below the recommended 100% standard. Among patients with MLH1/PMS2 deficiency, 95.5% underwent MLH1 promoter methylation testing. All patients requiring genetic referral were appropriately referred (100%).Following implementation of targeted interventions, the re-audit included 91 patients diagnosed with endometrial cancer. Compliance improved significantly as 10%. These findings demonstrate complete adherence to national standards after implementation of system-based interventions.

Conclusion/Implications: This Quality Improvement Project successfully achieved 100% compliance with universal MMR testing and genetic referral pathways for patients with endometrial cancer. The introduction of structured MDT documentation, clinical prompts and multidisciplinary engagement proved effective in improving adherence to national guidelines.

EP260 / #893

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

MOLECULAR SUB TYPES OF ENDOMETRIAL CANCER IN OMAN: A SINGLE INSTITUTION EXPERIENCE

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Introduction: Molecular subtypes of endometrial cancer (EC) has not been previously reported from the middle east..

Methods: Retrospective study was conducted on patients consecutively diagnosed to have EC at a tertiary cancer referral center in Oman between September 2021 and December 2025. Demographic data, clinical stage and molecular subtypes were studied

Results: Over the study period, a total of 72 patients were available for evaluation. Median age was 60 (52-78) years. Forty-five (62%) patients were diagnosed with endometrioid EC, 27 (38%) were diagnosed with non-endometrioid (serous, clear cell, carcinosarcoma) histology. Clinical stages using the 2009 FIGO staging were as follows: stage IA (45.9%), stage IB (16.7%), stage II (5.6%), stage IIIA (5.6%), stage IIIC1 (5.6%), stage IIIC2 (2.7%), stage IVA (2.7%), and stage IVB (15.2%). Molecular types were as follows: POLE mutant 3 (4%), MMR deficient 15 (21 %), NSMP 31 (43 %), and p53abn 23 (32%). Based on the molecular profile, 17/72 (23.6%) patients were upstaged to IICmpP53abn. Out of the 31 patients with NSMP, 26 (84%) were ER positive. Four (5.5%) patients showed strong positivity (3+) to HER-2, whereas 19/72 (26.4%) patients had 2+ staining intensity. Importantly, one patient had endometroid histology. Conclusion: Median age was 60 years,

almost 1/3rd of the patients had aggressive histology, 38% had more than stage IA/IB disease, 1/3rd of the patients had p53 overexpressing tumors. Her-2 status should be assessed in all patients.

Conclusion/Implications: Based on these observations, we conclude that women with EC present with aggressive phenotype in Oman.

EP261 / #206

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

PREOPERATIVE ALGORITHM FOR SELECTIVE OMISSION OF SENTINEL LYMPH NODE BIOPSY IN PATIENTS UNDERGOING HYSTERECTOMY FOR ENDOMETRIAL INTRAEPITHELIAL NEOPLASIA: A RETROSPECTIVE COHORT STUDY

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Introduction: Endometrial intraepithelial neoplasia (EIN) carries a 30–50% risk of concurrent adenocarcinoma at hysterectomy. Whether sentinel lymph node biopsy (SLNB) should be performed routinely remains debated, given the low rate of nodal metastases (<2%) reported in this population.

Methods: Retrospective cohort study of patients who underwent hysterectomy for EIN at two affiliated hospitals (October 2021–January 2025). A preoperative algorithm classified patients as low risk if: (1) biopsy without "cannot rule out adenocarcinoma," (2) CA-125 <35 U/mL, and (3) no suspected myometrial infiltration on imaging. Molecular profiling (p53, MMR, hormone receptors) was performed on all concurrent cancers.

Results: Of 56 patients, 19 (33.9%) had adenocarcinoma at final pathology, all grade 1 endometrioid (94.7% stage IA). The "cannot rule out adenocarcinoma" designation was strongly associated with cancer (83.3% vs. 20.5%, p<0.001). Among 46 evaluable patients, 28 met all algorithm criteria; in this subgroup, the rate of clinically significant disease was 3.6% (NPV 96.4%, 95% CI: 82.3–99.4%). No patient meeting criteria had a positive sentinel node. SLNB was associated with higher complication rates (22.2% vs. 0%, p=0.010). All 19 cancers were classified as NSMP (p53 wild-type, pMMR, hormone receptor positive).

Conclusion/Implications: A preoperative algorithm based on biopsy subtype, CA-125, and imaging identifies EIN patients with very low risk of clinically significant disease in whom SLNB can potentially be omitted. The uniform NSMP molecular profile supports the low-risk biology of these cancers. Prospective validation is warranted.

EP262 / #782

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

MOLECULAR PREDICTORS OF FERTILITY-SPARING TREATMENT RESPONSE IN EARLY ENDOMETRIAL CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction: Fertility-sparing treatment is increasingly offered to young women with presumed stage IA, grade 1 endometrioid endometrial cancer, yet clinicopathologic selection fails to predict durable progesterone response. We evaluated molecular predictors of complete response, recurrence and reproductive safety.

Methods: A PRISMA-aligned review searched PubMed, Embase, Web of Science, Cochrane Library and trial registries to December 2025 for fertility-sparing endometrial cancer studies reporting hormone receptors, mismatch repair/microsatellite instability, POLE, p53, NSMP, PTEN/PI3K, CTNNB1 or related biomarkers. Random-effects proportional and diagnostic meta-analyses generated pooled estimates, 95%CIs, heterogeneity, bias and GRADE certainty.

Results: Thirty-four molecular-prognosticator studies comprising 9,165 patients informed qualitative synthesis; meta-analysis was possible for 13 estrogen/progesterone-receptor studies (635 patients) and 10 MSI-H/MMRd fertility-sparing cohorts (66 patients). Benchmark EC-only fertility-sparing evidence showed complete response of 74% (95%CI 69-79, I2=81.2%) and recurrence of 35% (95%CI 28-42%). Negative progesterone-receptor expression significantly predicted poor response (P=0.01, AUC 0.806), whereas estrogen-receptor loss was not independently discriminatory (P=0.16, AUC 0.637). In levonorgestrel-intrauterine treatment, estrogen and progesterone receptors predicted response, but accuracy remained suboptimal (LR+ 6.02 and 2.48, LR- 0.59 and 0.55). MSI-H/MMRd tumours demonstrated inferior pooled remission, 61.8% (95%CI 49.6-72.8), and high relapse, 41.2% (95%CI 30.1-53.3). Emerging ProMisE cohorts suggest favourable POLEmut/NSMP biology, prolonged response kinetics in MMRd disease, and unacceptable uncertainty for p53abn tumours.

Conclusion/Implications: Molecular profiling reframes fertility-sparing endometrial cancer from empiric progestin therapy to biologically selected uterine preservation. Progesterone-receptor positivity, POLEmut and NSMP support candidacy, MMRd/MSI-H

mandates intensified counselling and surveillance, p53abn should remain investigational within multidisciplinary fertility-preservation programmes, preferably until urgent prospective validation.

EP263 / #797

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

PREDICTING RESPONSE OF EARLY-STAGE ENDOMETRIOID ADENOCARCINOMA TO LEVONORGESTREL INTRAUTERINE DEVICE: DEVELOPMENT AND EVALUATION OF A PROGNOSTIC RISK MODEL FROM THE FEMME PHASE II RANDOMIZED TRIAL

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Introduction: The feMMe trial was an open-label, multicentre phase II randomized trial (NCT01686126). 165 females with endometrial atypical hyperplasia or clinical stage I, FIGO grade 1 endometrioid adenocarcinoma were randomized to the levonorgestrel intrauterine device with/without metformin or a weight loss intervention. The objective of this study was to develop a multivariable model incorporating histopathologic features, tissue and blood biomarkers to predict the probability of pathological complete response at six months.

Methods: Four candidate biomarker sets (tissue proteins, tissue DNA, extracellular vesicle-associated proteins and miRNAs) were evaluated. Within each set, least absolute shrinkage and selection operator logistic regression with 5-fold bootstrapped cross-validation identified candidate predictors retained in ≥90% of replicates, with histologic diagnosis included in all models. Candidate predictors were then combined into a final model using the same approach. Model discrimination and calibration were assessed using optimism-corrected C-statistics and standard goodness-of-fit tests.

Results: Among 165 participants, 71 had complete data across all four biomarker sets. Preliminary analyses identified DNA mismatch repair (MMR) status, *CTCF* mutation,

microsatellite instability score, and an extracellular vesicle-associated protein (AKR1C3) as top candidates. Histologic diagnosis, MMR status, *CTCF* mutation, and AKR1C3 were selected for the final model, demonstrating discrimination of 0.818 (95% CI:0.712–0.917) and good calibration. Predicted probabilities of achieving a pathological complete response were 10%, 58%, and 85% in low, moderate, and high probability of response groups, respectively.

Conclusion/Implications: This model demonstrates strong association to predict individualized pathological complete response through integration of molecular biomarkers and histopathological features. External validation is required before clinical implementation.

EP264 / #75

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

THE ROLE OF THE GLUCOCORTICOID RECEPTOR IN ENDOMETRIAL CANCER PATHOLOGY AND ITS MANAGEMENT

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Introduction: Endometrial cancer (EC) is stratified into four molecular subtypes with distinct prognoses. Glucocorticoid receptor (GR) signalling, activated by cortisol, has been implicated in progression and therapy resistance across multiple malignancies. Emerging evidence, including trials of GR modulators (e.g., relacorilant in the ROSELLA trial), supports GR as a potential therapeutic target. This study aimed to characterise GR expression in EC and its association with tumour biology.

Methods: FFPE samples from 26 patients with EC were analysed using immunohistochemistry for GR expression. Slides were digitised and assessed in QuPath. Tumour, stromal, and immune cells were annotated, and GR expression quantified using H-scores and nucleus-to-cytoplasm ratios. Statistical comparisons were performed across cell types and clinicopathological groups.

Results: There was a significant effect of cell type on nuclear GR expression (p=0.0088) with a significant increase in GR H-score on immune cells (59.70±46.55), compared to tumour (31.68±47.32, p=0.0277) and stromal cells (20.31±18.33, p=0.0172). Tumour cells were predominantly GR-negative. There was a significant effect of cell type on nucleus-to-cytoplasm ratio (p=0.0058), with stromal cells being highest (35.24±44.98), suggesting relatively increased GR activation compared to immune and tumour cells. No significant associations were identified between GR expression and EC molecular, histological, or Bokhman subtype. Numbers in each subtype were variable (n=1-14), reducing statistical

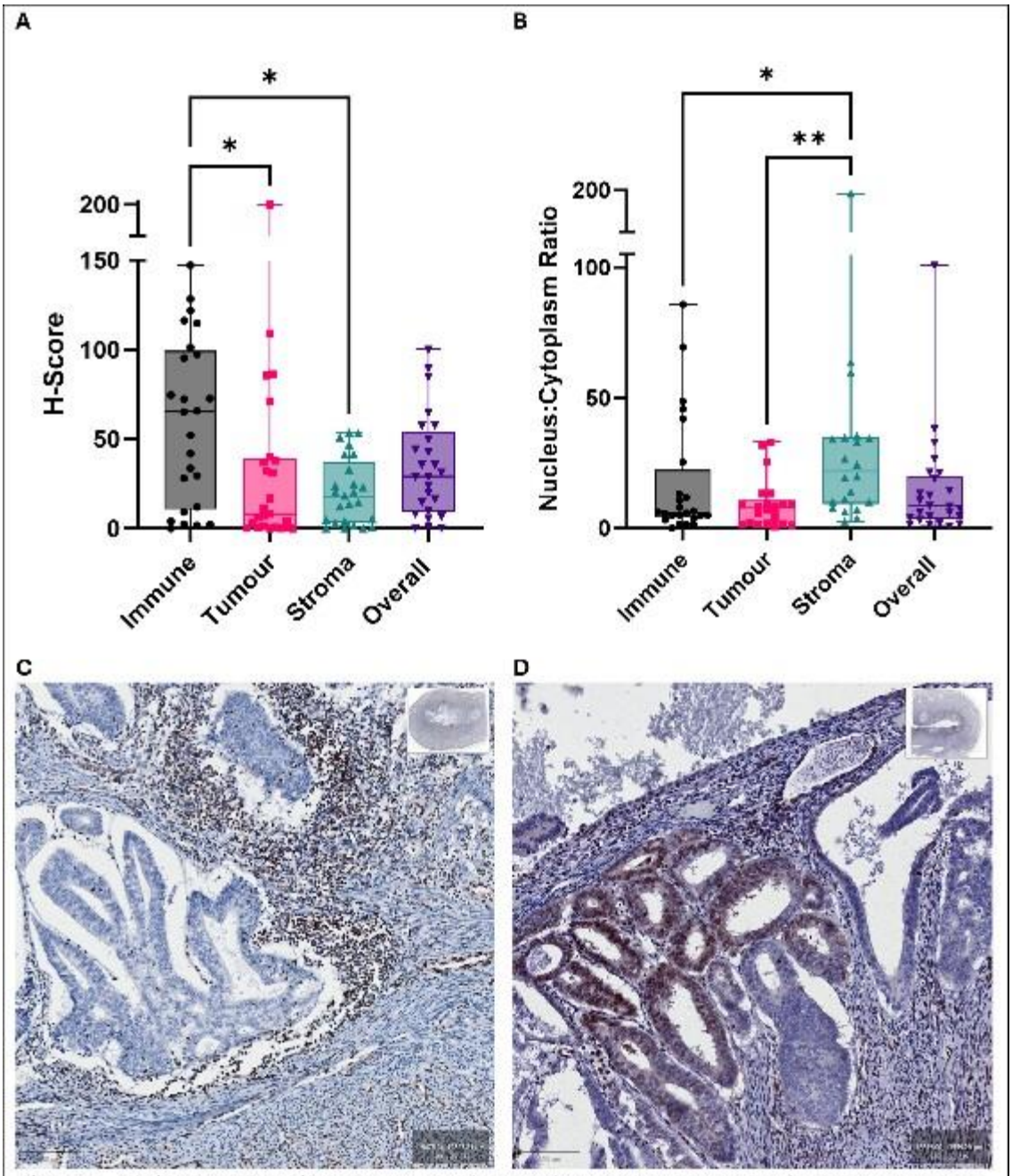


Figure 1. GR is expressed in EC tumour microenvironment rather than in tumour cells. A *Nuclear GR H-Score, n=25;* ***B*** *Nuclear to cytoplasmic ratio of cells positive for GR;* ***C*** *Representative micrograph of EC specimen with low tumour GR positivity, Immune (n=24), Tumour (n=22), Stroma (n=22), Overall (n=25);* ***D*** *Representative micrograph of EC specimen with high tumour GR positivity (rare in this cohort).*

power.

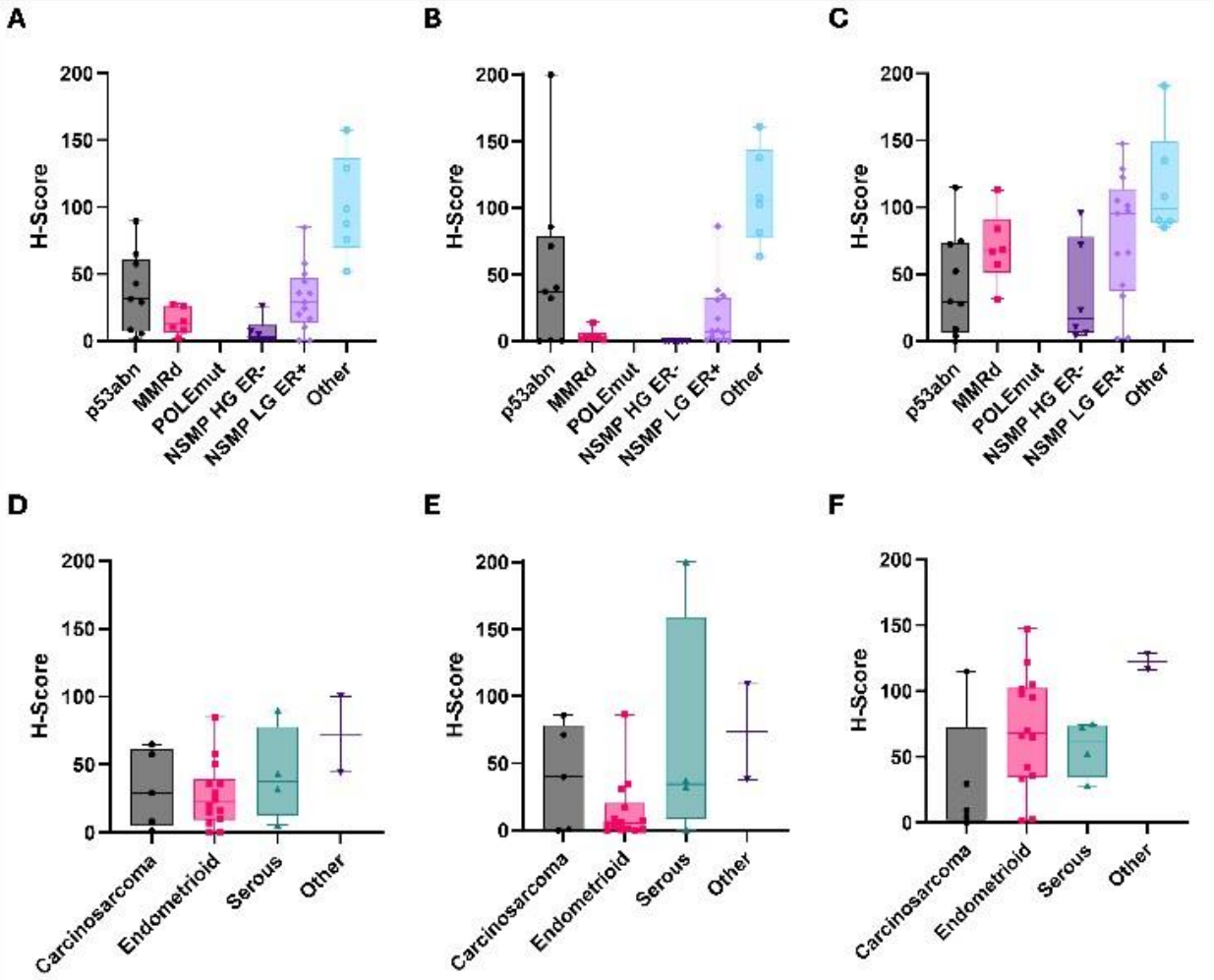


Figure 2. No significant differences in GR expression according to molecular subtype or histological subtype. *Nucleus GR H-Scores **A** Overall, **B** in Tumour, and **C** Immune cells as measured in different molecular subtypes of EC, p53abn (n=9), MMRd (n=1), NSMP HG (n=1), NSMP LG (n=13), Other (n=1). Nucleus GR H-Scores **D** Overall, **E** in Tumour, and **F** Immune cells as measured in different histological subtypes of EC, Carcinosarcoma (n=5), Endometrioid (n=14), Serous (n=4), Other (n=2).*

Conclusion/Implications: GR expression in EC is compartment-specific, predominantly localised to immune cells rather than tumour epithelium. These findings suggest GR signalling may influence the tumour microenvironment rather than directly driving tumour cell behaviour, supporting exploration of GR-targeted therapies in modulating immune–tumour interactions.

EP265 / #595

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

PROGNOSTIC VALUE OF SURGICAL UPSTAGING ACROSS MOLECULAR SUBGROUPS IN EARLY-STAGE HIGH-GRADE OR NON-ENDOMETROID ENDOMETRIAL CANCER

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Introduction: This study assessed incidence of surgical upstaging and associated prognostic outcomes in early-stage high(-intermediate)-risk endometrial cancer by molecular class.

Methods: Patients with clinically staged FIGO 2009 stage I–II endometrial cancer (EC) grade 3 endometrioid or non-endometrioid histology who underwent robot-assisted surgical staging at a tertiary centre were retrospectively included. Staging included total hysterectomy with bilateral salpingo-oophorectomy, systematic pelvic ± para-aortic lymphadenectomy, omentectomy, and peritoneal biopsies. Molecular classification followed WHO diagnostic algorithm. Adjuvant treatment followed contemporary guidelines, generally consisting of vaginal brachytherapy for patients remaining early stage. Survival was analysed using the Kaplan–Meier method and log-rank tests.

Results: In total, 160 patients underwent surgical staging, of which 145 patients had tumour tissue available and successful molecular classification. 20 patients (13.8%) were upstaged; of which 15/83 patients (18.1%) with p53abn EC, 3/8 patients (37.5%) with ER-negative NSMP EC, no patients with ER-positive NSMP EC (0/13, 0.0%), 2/24 patients (8.3%) with MMRd EC, and no patients with POLEmut EC (0/17, 0.0%) were upstaged to FIGO 2009 stage IIIC or IV. Surgical upstaging was associated with worse recurrence-free, overall and disease-specific survival in p53abn and MMRd endometrial cancer ($p < 0.0001$ and $p = 0.015$-0.017, respectively), and with worse overall and disease-specific survival in ER-negative NSMP EC ($p = 0.0067$).

Conclusion/Implications: The value of surgical staging in clinical stage I-II high-grade and non-endometrioid endometrial cancer differs across molecular subgroups. Staging provided prognostic information in MMRd, NSMP ER-negative, and p53abn tumours, while its benefit appeared limited in POLEmut and NSMP ER-positive tumours.

EP266 / #722

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

THE EFFECT OF HORMONAL THERAPY IN RECURRENT ENDOMETRIAL CANCER WITH LUNG METASTASES

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Introduction: To evaluate the effect of hormonal therapy in patients with recurrent endometrial cancer with lung metastases.

Methods: This retrospective study included patients with recurrent endometrial cancer who received hormonal therapy from January 1, 2017 to December 31, 2022 at a single academic center. Demographic data, disease characteristics, treatment regimens, and progression-free survival (PFS) were extracted from the electronic medical record. Statistical analysis was performed using SPSS v.28.

Results: 19 patients met inclusion criteria with a mean age of 62.4 ± 6.5 years, BMI 30.9 ± 6.5 kg/m^2, and Charlson Comorbidity Index 9.0 ± 4.5. Most patients were Stage I (36.8%) at initial diagnosis with endometrioid histology (57.9%). At the time of hormonal therapy, 42.1% had lung metastases. The most common regimen was everolimus/letrozole (63.2%). Median PFS was 7.0 ± 0.7 months, with no significant difference between patients with and without lung metastases (7.0 ± 0.9 vs. 5.0 ± 2.2 months; p=0.76). Of the 8 patients with lung metastases, 37.5% had stable lung disease at progression of other metastases. Only 2 patients (10.5%) had isolated lung involvement at recurrence; this subgroup had a median PFS of 15.0 ± 8 months.

Conclusion/Implications: No difference in median PFS was observed between patients with and without lung metastases. Patients with isolated lung disease had a median PFS twice that of the overall cohort, and over one-third of those with lung metastases demonstrated stable pulmonary disease at progression. These findings suggest hormonal therapy provides meaningful disease control in recurrent endometrial cancer, particularly in patients with lung involvement.

EP267 / #776

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

COMPARISON BETWEEN P53 IMMUNOHISTOCHEMISTRY AND MUTATION STATUS WITH INSIGHTS FOR CLINICAL MANAGEMENT

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Introduction: *TP53* alterations are critical in endometrial cancer progression and therapy selection. Discordance between immunohistochemistry (IHC) and molecular testing creates diagnostic ambiguity. We hypothesized that discordant cases reflect distinct biological subtypes with possible different clinical implications.

Methods: We analyzed 321 endometrial cancer cases with complete paired p53 IHC and *TP53* mutation data. Cases were classified into five categories: Agreement (n=256), Disagreement Subtype 1 (DS1): IHCwt/*p53mut* (n=23), Disagreement Subtype 2: IHCoverexp/*p53wt* (n=24), Disagreement Subtype 3: IHCnull/*p53wt* (n=9), and Disagreement IHC uncertain (n=9). We compared the subset of Agreement cases with abnormal IHC plus *TP53* mutation (n=74) against DS1 cases, characterizing mutation type, mismatch repair (MMR) status, *POLE* mutations, and co-mutation (*KRAS, CTNNB1, PTEN and PIK3CA*) burden.

Results: Agreement cases with abnormal IHC were predominantly p53-driven tumors with 94.6% MMR intact, minimal co-mutations (0.6/case), and 1.4% POLE mutations. DS1 cases represented PI3K-pathway-driven tumors with only 69.6% MMR intact ($p<0.001$), higher co-mutation burden (1.9/case), and 13% *POLE* mutations. DS1 contained hotspot-negative, loss-of-function *TP53* mutations, while Agreement cases harbored stabilizing missense mutations. *PTEN and PIK3CA* mutations occurred in 78.3% and 65.2% of DS1 cases respectively, versus 28.4% and 33.8% in Agreement cases. Cases with uncertain IHC evaluation did not have pathogenic *TP53* mutations.

Conclusion/Implications: *TP53* mutations encompass two distinct endometrial cancer subtypes with fundamentally different biology. DS1 denotes a clinically important PI3K-pathway-driven tumor subtype where *TP53* is a passenger mutation. Co-evaluation of p53 status in endometrial carcinoma tumors by both IHC and mutational analysis thus reveals a subcategory of *TP53*-mutated tumors that may require different clinical management.

EP268 / #1044

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

STATUS OF HER2 AT DIAGNOSIS AND RECURRENCE OF ENDOMETRIAL CANCER TESTED IN A COMMUNITY SETTING

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Introduction: Identifying patients who may benefit from HER2 targeted treatment is an increasingly important area of interest for high-risk endometrial cancer, with overexpression seen in 9-35% of cases in the academic setting. Previous studies have originated from large academic centers and comparability of test results using community-based testing via reference labs has not been well documented.

Methods: An observational case series was analyzed in the Scripps Health community hospital network. All cases with paired tissue samples from initial diagnosis and recurrence were included. Patients initially diagnosed elsewhere or without adequate tissue were excluded. Pathology samples were sent to determine HER2 status by immunohistochemistry with reflex to FISH, completed by Neogenomics Laboratories.

Results: 91 cases of endometrial carcinoma with recurrence were identified. Adequate initial and recurrence samples were identified for 14 patients. HER2 IHC results at diagnosis were equivocal in 35.7%, FISH positive in 14.3%. HER2 IHC results in recurrent disease tissue were equivocal in 50%, FISH positive in 7.1%. Concordance in IHC results was seen in 57% of paired samples.

Conclusion/Implications: This study is the first to evaluate HER2 status in endometrial cancer at time of initial diagnosis versus recurrent disease using commercially available testing in a community setting. The results importantly demonstrate that the rate of HER2 positivity in this community-based testing setting accurately mirrors data reported in studies from large tertiary care academic centers.

EP269 / #76

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

ESTABLISHMENT OF A BRAZILIAN INSTITUTIONAL PROTOCOL FOR THE MOLECULAR EVALUATION OF SURGICALLY TREATED ENDOMETRIAL CARCINOMA IN THE PUBLIC HEALTH SYSTEM: A PROSPECTIVE COHORT STUDY

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Introduction: This study aims to demonstrate the molecular profile associated with each histological type and with oncologic outcomes in a prospective Brazilian cohort of endometrial cancer (EC) patients

Methods: This prospective cohort study included patients diagnosed with EC between 2020 and 2025 at Barretos Cancer Hospital. Sociodemographic, clinicopathological, staging, treatment, and oncologic outcome data were collected. Tumors were classified into four molecular groups: POLE-mutated, microsatellite instability-high (MSI-H), TP53-mutated, and no specific molecular profile (NSMP). From October 2020 to July 2022, molecular classification followed the ProMisE algorithm using immunohistochemistry and PCR for POLE mutation. From July 2022 onward, molecular testing for MMR status and TP53 was performed using molecular techniques.

Results: Among the 402 cases, stages IA (30.3%) and IB (21.3%) were most frequent. Molecular distribution was: NSMP (45.2%), TP53-mutated (21.3%), MSI-H (21.1%), POLE-mutated (8.9%), and multiple classifiers (3.5%). NSMP predominated in endometrioid tumors (50%), whereas TP53 mutations were highly prevalent in serous carcinoma (96%) and carcinosarcoma (73%). Recurrence occurred in 0% of POLE-mutated, 15% of MSI-H, 28% of TP53-mutated, 13% of NSMP, and 10% of multiple-classifier cases. At 24 months, overall survival was highest in POLE-mutated and NSMP tumors (92.9%) and lowest in TP53-mutated tumors (79.1%) (P=0.033). Disease-free survival ranged from 92.7% in POLE-mutated tumors to 55.3% in TP53-mutated tumors (P=0.0009). Older age and lymphovascular invasion were independently associated with worse survival.

Conclusion/Implications: TP53 mutations are strongly associated with high-risk histologies and poorer outcomes. In this prospective Brazilian cohort treated in a public institution, molecular classification proved feasible and clinically relevant for prognostic stratification.

EP270 / #775

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

PREVALENCE OF LYMPH NODE POSITIVITY IN ENDOMETRIAL INTRAEPITHELIAL NEOPLASIA AND EARLY-STAGE ENDOMETRIAL CANCER

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Introduction: INTRODUCTION: Lymph node (LN) assessment is not routinely performed in patients with endometrial intraepithelial neoplasia (EIN) or presumed early-stage endometrial cancer (EC) in many clinical settings, raising concerns about incomplete staging. This study aimed to evaluate the prevalence and risk factors of LN involvement in patients with a preoperative EIN or early-stage low-grade EC diagnosis.

Methods: METHOD: This retrospective study included patients who underwent surgery with sentinel LN mapping for EIN or low-grade stage FIGO 2009 IA–IB EC. The primary outcome was LN positivity. Secondary outcomes included clinical and pathological factors associated with LN involvement.

Results: RESULTS: 426 patients were included (100 EIN, 326 EC). Among EIN, 48% (48/100) were reclassified as EC on final pathology, predominantly stage IA (41/100). One nodal macrometastasis and 3 cases of isolated tumor cells (ITCs) were identified. Among EC, 13% (43/326) were upstaged to stage II or higher: 8 stage II, 11 stage IIIA, 21 stage IIIC1, 2 stage IIIC2, and 1 stage IVB. Nodal metastases were identified in 23 patients (7%), while 20 (6%) had ITCs. In univariate analysis, older age, EC on biopsy, increased endometrial thickness, menopausal status, and elevated CA125 or CA19-9 were associated with LN involvement. In multivariate analysis, only CA125 remained associated (OR=1.02; p=0.020). Molecular classification was assessed in 50% of cases and was not associated with LN positivity (p=0.338-0.714).

Conclusion/Implications: CONCLUSION: A significant proportion of preoperative EIN and early-stage EC cases were upstaged, including 7% nodal metastases among EC. Nodal assessment should be considered in these patients, mostly if elevated CA125.

EP271 / #614

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

DELPHI CONSENSUS ON THE USE OF IMMUNOTHERAPY AND EXTERNAL EXTERNAL-BEAM RADIATION THERAPY IN STAGE III MISMATCH REPAIR-DEFICIENT ENDOMETRIAL CANCER

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Introduction: Multiple trials have demonstrated immunotherapy benefits for mismatch repair-deficient (dMMR) endometrial cancer (EC); due to design limitations, none definitively address use in the adjuvant setting. As approvals allow adjuvant utilization in stage III EC, additional guidance is needed to inform optimal decision-making where current evidence gaps exist.

Methods: An international steering committee of 5 oncologists identified relevant clinical topics, reviewed literature, and drafted statements on stage III dMMR EC management. Statements were rated by an international expert panel (n=18) on a 5-point Likert scale; consensus was achieved if >80% of panelists selected “agree” or “strongly agree.” If needed, statements were revised and re-rated.

Results: Seven key topics were identified: defining “cure,” patient selection, effects of toxicity and quality of life on decision-making, optimal sequencing of treatment modalities, optimal duration of immunotherapy, treatment costs, and the future of clinical decision-making. Of 34 statements, 27 achieved consensus. Most (90%) agreed that dMMR is a validated biomarker to identify patients likely to benefit from anti–PD-(L)1 therapy and that all patients with newly diagnosed/previously untreated recurrent (except adjuvant therapy) stage III dMMR EC, without contraindications, should be offered immunotherapy. Responses to statements on external beam radiotherapy (EBRT) utilization were more heterogeneous. Clinical studies clarifying benefits of adding EBRT to immunotherapy plus chemotherapy (94.4%) and optimal immunotherapy duration (100%) are needed.

Conclusion/Implications: International experts achieved consensus on multiple items related to management of stage III dMMR EC, including consideration of immunotherapy for all patients with stage III dMMR EC, comprising the adjuvant setting.

EP272 / #630

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

THE PROGNOSTIC IMPACT OF SUBSTANTIAL LYMPHOVASCULAR SPACE INVASION ON SURVIVAL OUTCOMES FOR NODE-NEGATIVE EARLY ENDOMETRIAL CANCER PATIENTS MANAGED WITH ADJUVANT VAGINAL BRACHYTHERAPY ALONE

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Introduction: To explore the prognostic impact of substantial lymphovascular space invasion (LVSI) on survival for node-negative 2009-FIGO stage-I uterine endometrioid carcinoma (EC) treated with adjuvant vaginal-cuff brachytherapy (VB) alone.

Methods: We queried our institutional database for patients with stage-I EC who underwent surgical staging between 1990-2025 including lymph node (LN) assessment followed by adjuvant VB alone. We excluded patients who received chemotherapy, VB with pelvic external-beam radiation and those with positive LVSI but not quantified. We compared recurrence patterns, 5-year recurrence-free (RFS), disease-specific (DSS), and overall (OS) survival between women with substantial- versus those with focal- versus no-LVSI.

Results: Out of 308 patients identified, 45 (14.6%) had substantial-LVSI, 58 (18.8%) had focal and 205 (66.6%) had no-LVSI. 184 patients (59.7%) had stage IB. Median LN examined were 11. Median follow-up for the study cohort was 96.3 months. LVSI groups were well-balanced except that patients with substantial-LVSI were relatively younger (*p=0.018*) and had deeper myometrial invasion (*p=0.047*). 27 patients (8.8%) had cancer recurrence that was mainly distant (20/27) as the first site of recurrence. Locoregional recurrences were not statistically different, 8.8% for substantial-LVSI, 6.9% for focal-, and 3.9% for no-LVSI (p=0.10). There was no statistically significant difference in 5-year RFS (85.6%, 89.3% and 89.3%; p=0.68), DSS (100%, 94.3%, 95.8%; p=0.9), and OS (94.4%, 91%, 87.9%; p=0.44), for substantial-LVSI, focal-LVSI and no-LVSI, respectively.

Conclusion/Implications: Our results suggest that for patients with stage-I EC with surgical nodal assessment, quantifying LVSI carries no prognostic significance for patients receiving adjuvant VB alone. A multi-institutional pooled analysis is needed.

EP273 / #528

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

CLINICALLY MEANINGFUL CHANGE IN QUALITY OF LIFE AFTER SENTINEL LYMPH NODE MAPPING ALONE VERSUS SENTINEL LYMPH NODE MAPPING WITH SYSTEMATIC LYMPHADENECTOMY IN ENDOMETRIAL CANCER: SECONDARY ENDPOINT RESULTS OF THE ALICE TRIAL (NCT03366051)

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Introduction: We report a patient-level directional quality of life (QoL) analysis from the ALICE trial, a multicenter, non-inferiority randomised trial comparing sentinel lymph node (SLN) biopsy alone versus SLN biopsy with systematic lymphadenectomy (SLN+L) in high-intermediate and high-risk endometrial cancer.

Methods: One hundred and eighty patients were randomised 1:1 (SLN-only, n=89; SLN+L, n=91); 178 were included in the QoL analysis. QoL was assessed with EORTC QLQ-C30 and QLQ-CX24 preoperatively and at 1, 6, and 12 months. Proportions with ≥10-point worsening or improvement per domain were compared across five intervals (preop→1m, preop→6m, preop→12m, 1→6m, 6→12m) by chi-square.

Results: At 1 month, SLN+L patients had significantly higher worsening rates in fatigue (53.6% vs 29.5%;p=0.001), constipation (37.3% vs 15.9%;p=0.001), pain (42.9% vs 21.6%;p=0.003), nausea/vomiting (19.0% vs 8.0%;p=0.033), insomnia (28.9% vs 15.9%;p=0.041), and appetite loss (21.4% vs 8.0%;p=0.013); SLN-only patients showed higher fatigue improvement (35.2% vs 19.0%;p=0.017) but greater body image deterioration (29.5% vs 14.6%;p=0.020). Between 1 and 6 months, opposing pain trajectories emerged: higher worsening in SLN-only (46.1% vs 20.5%;p=0.001) and higher improvement in SLN+L (43.8% vs 17.1%;p<0.001). By 12 months, fatigue improvement favoured SLN-only (42.9% vs 23.9%;p=0.017); emotional functioning diverged — more improvement in SLN-only

(55.1% vs 38.0%;p=0.043) and more deterioration in SLN+L (22.5% vs 7.2%;p=0.011); lymphedema worsening accumulated in SLN+L (35.7% vs 19.1%;p=0.029).

Conclusion/Implications: Patient-level analysis reveals a broader and more durable morbidity burden with SLN+L than mean-score comparisons suggest. Opposing pain and lymphedema trajectories, sustained fatigue recovery, and emotional functioning divergence support SLN mapping without systematic lymphadenectomy as the preferred patient-centred staging approach.

EP274 / #1137

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

THRESHOLD DEPENDENT DIAGNOSTIC PERFORMANCE OF ENDOMETRIAL THICKNESS FOR DETECTING CLINICALLY SIGNIFICANT PATHOLOGY IN PREMENOPAUSAL AND POSTMENOPAUSAL WOMEN

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Introduction: Corpus uteri cancer occupies 5th place in incidence in Mexico, with 5,347 cases and 10th place in cancer related mortality. (GLOBOCAN, 2022). Endometrial thickness (ET) is widely used to assess endometrial pathology, yet its diagnostic value varies by menopausal status; which is why we evaluated its threshold-dependent performance for detecting clinically significant disease.

Methods: A retrospective cohort of 67 women undergoing transvaginal ultrasound and histopathological evaluation was analyzed. ET was categorized as <5 mm, 5–9.9 mm, 10–19.9 mm, and ≥20 mm. Clinically significant pathology was defined as atypical endometrial hyperplasia or endometrial carcinoma. Diagnostic metrics, including likelihood ratios (LR), were calculated.

Results: Clinically significant pathology was present in 31.3% of postmenopausal and 14.3% of premenopausal women. In postmenopausal patients, ET demonstrated clear threshold-dependent performance. At ≥20 mm, specificity reached 82% (Table 1) with a clinically meaningful LR+ of 3.89 (95% CI 1.08–14.02; p=0.030) (Table 2). Lower thresholds improved sensitivity but lacked diagnostic impact. In premenopausal women, ET showed limited discrimination, with low specificity and modest LR+ (2.27; 95% CI 1.05–4.91; p=0.045)(Table 2), despite apparent high sensitivity. **Table 1.** Endometrial thickness cut-off points' sensitivity and specificity in postmenopausal and premenopausal women

Postmenopausal Women

Cut-off	Sensitivity	Specificity	PPV	NPV	LR+	LR–
≥10 mm	0.90	0.45	0.60	0.83	1.64	0.22
≥20 mm	0.70	0.82	0.78	0.75	3.89	0.37

Premenopausal Women

Cut-off	Sensitivity	Specificity	PPV	NPV	LR+	LR–
≥10 mm	1.00	0.125	0.263	1.00	1.14	0.00
≥20 mm	1.00	0.56	0.417	1.00	2.27	0.00

Table 2. Endometrial thickness cut-off points' LR+ and LR - in postmenopausal and premenopausal
women

Group	Cut-off	LR+	95% CI (LR+)	LR–	95% CI (LR–)	Fisher's Exact p-value
Postmenopausal	≥10 mm	1.64	0.82–3.27	0.22	0.03–1.51	0.149
Postmenopausal	≥20 mm	3.89	1.08–14.02	0.37	0.13–1.08	0.030
Premenopausal	≥10 mm	1.14	0.89–1.47	0.00	Not estimable	1.000
Premenopausal	≥20 mm	2.27	1.05–4.91	0.00	Not estimable	0.045

Conclusion/Implications: Higher ET thresholds improve diagnostic performance in postmenopausal women, supporting their role in risk stratification (Table 3). In contrast, ET has limited standalone value in premenopausal patients and should not guide clinical decisions without additional context. These findings emphasize the need for stratified and multivariable diagnostic approaches.

EP275 / #640

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

EFFICACY AND PROGNOSTIC FACTORS OF LENVATINIB PLUS PEMBROLIZUMAB IN MISMATCH REPAIR-PROFICIENT ADVANCED OR RECURRENT ENDOMETRIAL CANCER: A JAPANESE SINGLE-CENTER REAL-WORLD STUDY

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Introduction: Lenvatinib plus pembrolizumab (LP) demonstrates significant efficacy in advanced or recurrent endometrial cancer (EC). However, real-world data specifically focusing on mismatch repair-proficient (pMMR) EC and clinical prognostic factors remain limited. We aimed to evaluate the real-world efficacy of LP and identify prognostic factors in pMMR advanced or recurrent EC.

Methods: We retrospectively reviewed patients with pMMR advanced or recurrent EC who received LP at a single Japanese institution (Jan 2022-Dec 2025). Progression-free and overall survival (PFS, OS) were estimated using the Kaplan-Meier method. Log-rank tests evaluated prognostic factors: age, histology, stage, prior regimens, treatment-free interval (TFI, from the end of primary treatment to the first recurrence), platinum-free interval (PFI, immediately prior to LP), and 4-week lenvatinib relative dose intensity (4w-RDI). Age and TFI were dichotomized at their medians (68 years and 5.3 months).

Results: Twenty-five patients were analyzed. The objective response rate was 48.0%. Median PFS and OS were 7.0 and 25.5 months, respectively. In log-rank analysis, significant favorable prognostic factors for PFS included TFI ≥5.3 months ($P < 0.001$) and PFI ≥6 months ($P < 0.001$). Maintaining a 4w-RDI ≥80% showed a trend towards improved PFS ($P = 0.051$). Age, stage, histology, and number of prior regimens were not significantly associated with PFS.

Conclusion/Implications: LP therapy showed favorable efficacy in pMMR EC. Our findings suggest that longer TFI and PFI are significant prognostic factors and that maintaining early dose intensity of lenvatinib may also be beneficial for optimizing the management of LP therapy.

EP276 / #457

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

ONCOLOGIC OUTCOMES IN SURGICAL STAGE I ENDOMETRIOID ENDOMETRIAL CARCINOMA: A COMPARISON OF TWO TREATMENT APPROACHES FOR INTRAVAGINAL BRACHYTHERAPY

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Introduction: Recommendations for adjuvant intravaginal brachytherapy (IVRT) in stage I endometrial carcinoma vary across institutions. We compared oncologic outcomes and vaginal recurrences between patients who received IVRT and those who did not.

Methods: This retrospective, multi-institutional study examined surgical FIGO 2009 stage I endometrioid endometrial carcinoma at intermediate or high-intermediate risk per GOG-99 criteria or ESGO/ESTRO/ESP 2021 guidelines. One institution used IVRT per NCCN guidelines, while the other did not. Recurrence and survival analyses were evaluated by Cox proportional hazards model. Five-year progression-free survival (PFS) and overall survival (OS) rates were estimated using Kaplan-Meier method. Landmark analysis was performed on the IVRT cohort. Recurrences were examined using competing risk analyses.

Results: Overall, 662 patients met inclusion criteria. Median follow-up was 85.4 months [95% CI: 79.3-92.7]. Five-year PFS rate was 77.4% [95% CI: 71.7%-82.1%] and 76.1% [95% CI: 70.3%-80.9%] in patients with and without IVRT, respectively (Figure 1). Adjusted hazard ratios (aHRs) for PFS and OS were 0.92 [95% CI: 0.67-1.26] and 1.05 [95% CI: 0.74-1.50], respectively. PFS and OS did not differ between subgroups stratified by GOG-99 or ESGO/ESTRO/ESP 2021 criteria. Five-year cumulative incidence of vaginal and non-vaginal

recurrences were 5.7% [95% CI: 3.3%-8.9%] and 11.7% [95% CI: 8.1%-16.0%], respectively, in patients with IVRT, versus 9.3% [95% CI: 6.2%-13.3%] and 7.5% [95% CI: 4.7%-11.2%], respectively, in those without; aHRs were 1.78 [95% CI: 0.92-3.46] and 0.68 [95% CI: 0.39-1.18], respectively (Figure 2).

Figure 1. Kaplan–Meier curves for progression-free survival (A) and overall survival (B) of patients with surgical FIGO 2009 stage I endometrioid endometrial carcinoma.

Abbreviations: PFS, progression-free survival; aHR, adjusted hazard ratio; IVRT, intravaginal brachytherapy; 5Y, 5 year; OS, overall survival.

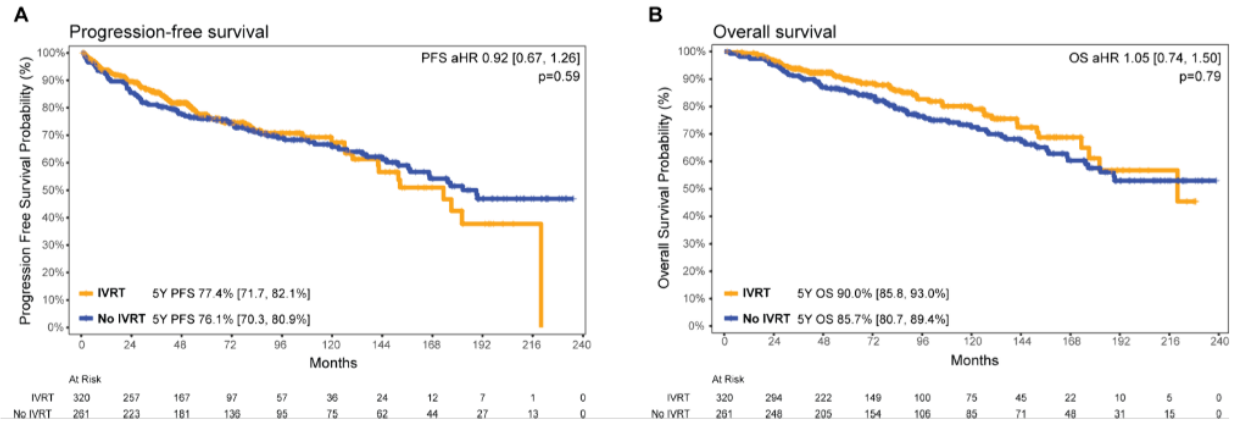
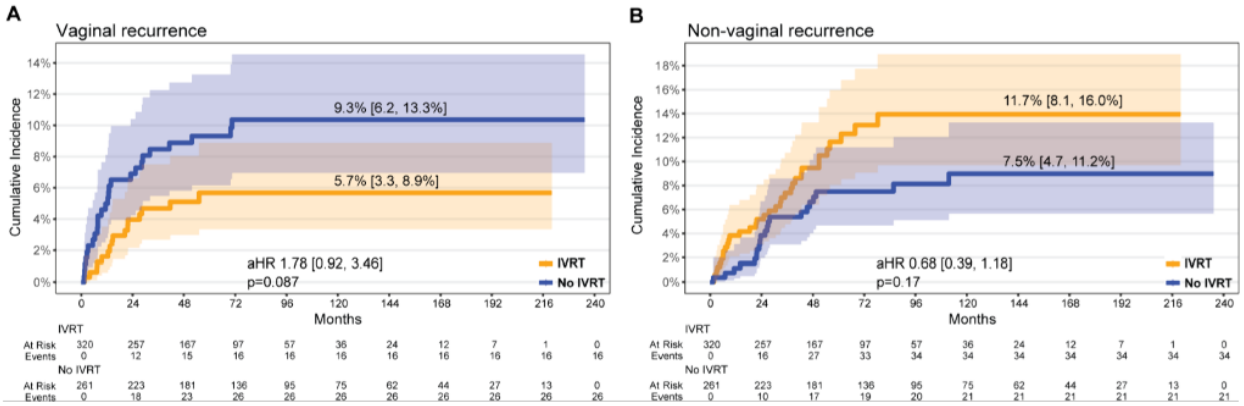


Figure 2. Competing risk curves for vaginal recurrence (A) and non-vaginal recurrence (B) in patients with surgical FIGO 2009 stage I endometrioid endometrial carcinoma.

Abbreviations: aHR, adjusted hazard ratio; IVRT, intravaginal brachytherapy.



Conclusion/Implications: Adjuvant IVRT did not provide recurrence or survival benefit in this cohort of endometrioid endometrial carcinoma, warranting reconsideration of current guidelines.

EP277 / #604

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

IMPORTANCE OF COMPLETE MOLECULAR INFORMATION FOR ENDOMETRIAL CANCER RECURRENCE RISK STRATIFICATION

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Introduction: Since 2013 TCGA described 4 distinct endometrial cancer molecular groups, the most appropriate treatment approach has continued to evolve. This study retrospectively evaluated endometrial cancer patients treated for vaginal recurrence at a single institution to evaluate the prognostic value of molecular status.

Methods: With IRB approval, endometrial cancer patients treated for vaginal recurrence from 2019-2025 were retrospectively evaluated for available molecular information and association with recurrence and grade.

Results: From 2019-2025, 67 patients were treated for vaginal recurrence with 84% having molecular data. Table 1 shows grade and molecular distribution. All 28 patients with stage IA grade 1 received no adjuvant treatment and presented with isolated vaginal recurrence an average of 4.2 years (range 3months-20.6years) after surgery. Molecular testing was done for 64% of the IA grade1. No specific molecular phenotype (NSMP) with beta catenin abnormal was the most common (50%), followed by mismatch repair deficient (MMRd) (39%) and NSMP normal beta catenin (11%).

Table 1. Predominant and secondary molecular group by presenting histologic grade.

	Grade 1(n=34)	Grade 2(n=9)	Grade 3/unfavorable(n=24)
Percentage with molecular data	74%	89%	96%
Predominant	NSMP abn beta catenin(48%)	MMRd(63%)	P53 abn(56%)
Secondary	MMRd(43%)	NSMP nl beta catenin(25%)	MMRd(26%)

Conclusion/Implications: Among recurrent endometrial cancer patients, predominant molecular group varied by grade, with NSMP with abnormal beta catenin being most common when presenting with grade 1. Given the high rate of abnormal beta catenin among the generally low risk IAG1 endometrial cancer suggests the importance of complete molecular data for appropriate risk stratification and potential adjuvant treatment decision making.

EP278 / #350

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

DETECTION RATE OF ROBOTIC SLN DETECTION IN ENDOMETRIAL CANCER USING ICG IN OBESE PATIENTS

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Introduction: Sentinel lymph node (SLN) detection is a recommended part of the surgical treatment of endometrial cancer. For SLN detection to be a viable alternative to systematic pelvic and para-aortic lymphadenectomy, it must achieve a high detection rate (DR) per patient and side specific detection rate (SSDR). One factor that negatively affects both DR and SSDR is high BMI.

Methods: The study included 109 patients with early-stage endometrial cancer and a BMI of 30 or higher. These patients underwent surgery at the Department of Obstetrics and Gynecology between February 2022 and June 2024. SLN detection success rates were prospectively monitored. In all cases, SLN detection was performed exclusively via intracervical application of indocyanine green (ICG). In cases where lymph nodes were not initially visualized, reinjection of ICG was performed.

Results: The overall detection rate (DR) per patient was 100%, while the specific side detection rate (SSDR) was 93% (bilateral SLN detection was achieved in 101 out of 109 patients). The lowest bilateral detection rate was observed in patients with grade 2 obesity—89% (24 out of 27 patients). In patients with grade 1 and grade 3 obesity, SSDR was 94% (48 out of 51 patients and 29 out of 31 patients, respectively). Similar detection rates were observed in non-obese patients (DR 98%, i.e., 52 out of 53; SSDR 92%, i.e., 49 out of 53).

Conclusion/Implications: Robotic SLN detection using ICG in obese patients achieved high detection rates in our study. Additionally, ICG reinjection proved to be an effective method to improve SLN detection.

EP279 / #1136

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

UTILITY OF PRE OPERATIVE IMAGING IN LOW GRADE ENDOMETRIAL CANCER: AN AUSTRALIAN RETROSPECTIVE SINGLE INSTUTION CHART REVIEW

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Introduction: Endometrial Cancer (EC) incidence is increasing world wide. Pre-operative CT imaging for low risk EC is not recommended by guidelines but is routinely performed in Australia's well resourced setting. The objective of this study was to assess the incidence of suspected and confirmed extrauterine disease (EUD), the rate of false positive imaging and incidental findings requiring further investigation.

Methods: Retrospective chart review was performed on all cases low grade endometriod EC referred to the Western Australian Gynaecological Cancer Service (WAGCS) between July 2023 and 2025, managed either medically or with surgical staging. Clinical, radiological, pathological and surgical reports were reviewed and correlated, along with multidisciplinary tumour board assessments and documented management plans including management of incidental radiological findings.

Results: 221 cases were identified, all (100%) receiving CT imaging. 165 (75%) cases received surgical staging and 49 (25%) were managed medically. 29 (13%) had EUD identified on imaging. 6 (3.6%) cases with surgical staging had false positives for EUD on imaging. 9 (4%) of all cases had management modified by results of imaging. All but 2 (0.9%) of these cases had indications for pre-operative CT imaging on clinical history or examination at first visit had local or international guidelines been followed rather than a process of routine imaging.

Conclusion/Implications: The utility of routine pre-operative imaging assessment for extrauterine disease in low risk EC is limited, even in a high resource setting. Rising incidence of EC and health care costs should encourage further review of this practise.

EP280 / #579

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

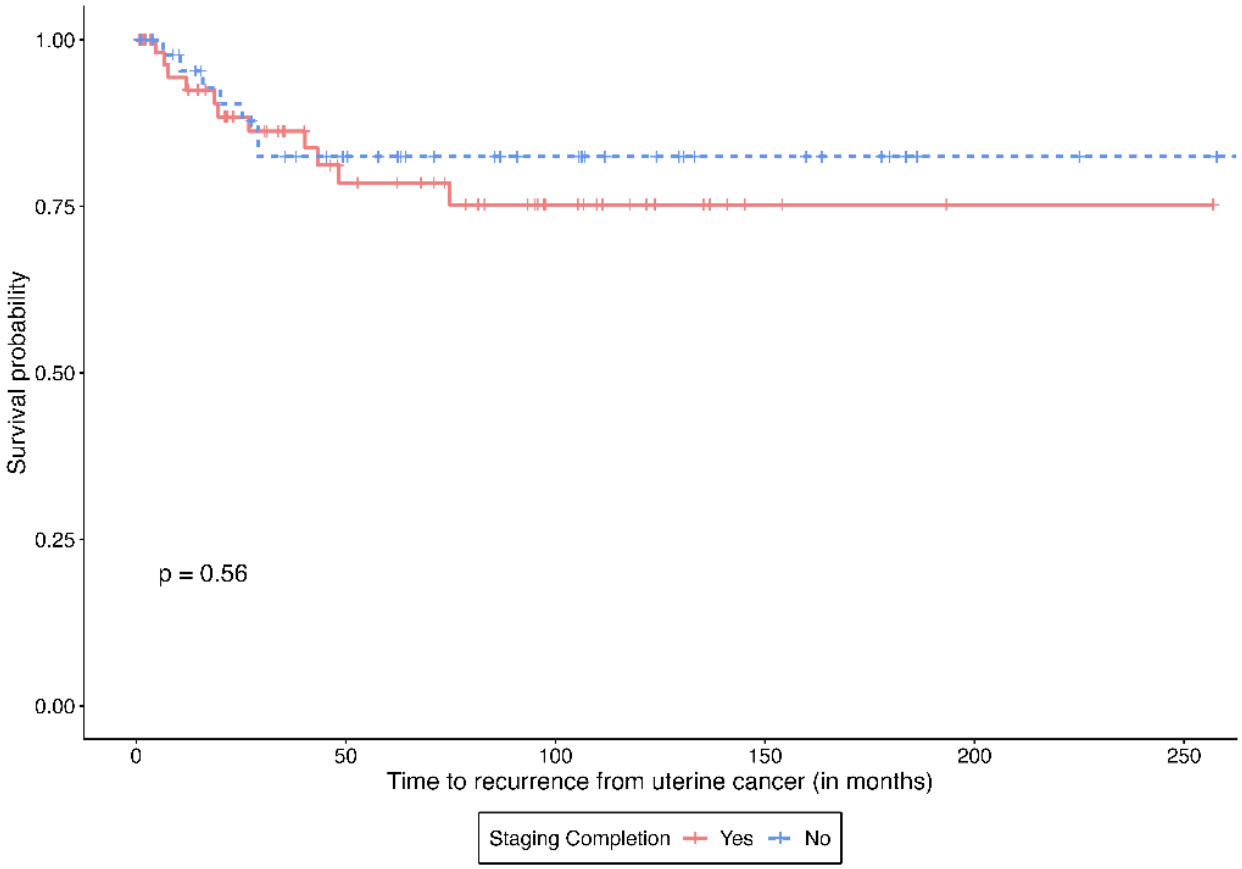
THE INFLEUNCE OF COMPLETE SURGICAL STAGING AND ADJUVANT THERAPIES ON SURVIVAL OUTCOMES IN PATIENTS WITH NON-MYOINVASIVE UTERINE SEROUS CARCINOMA

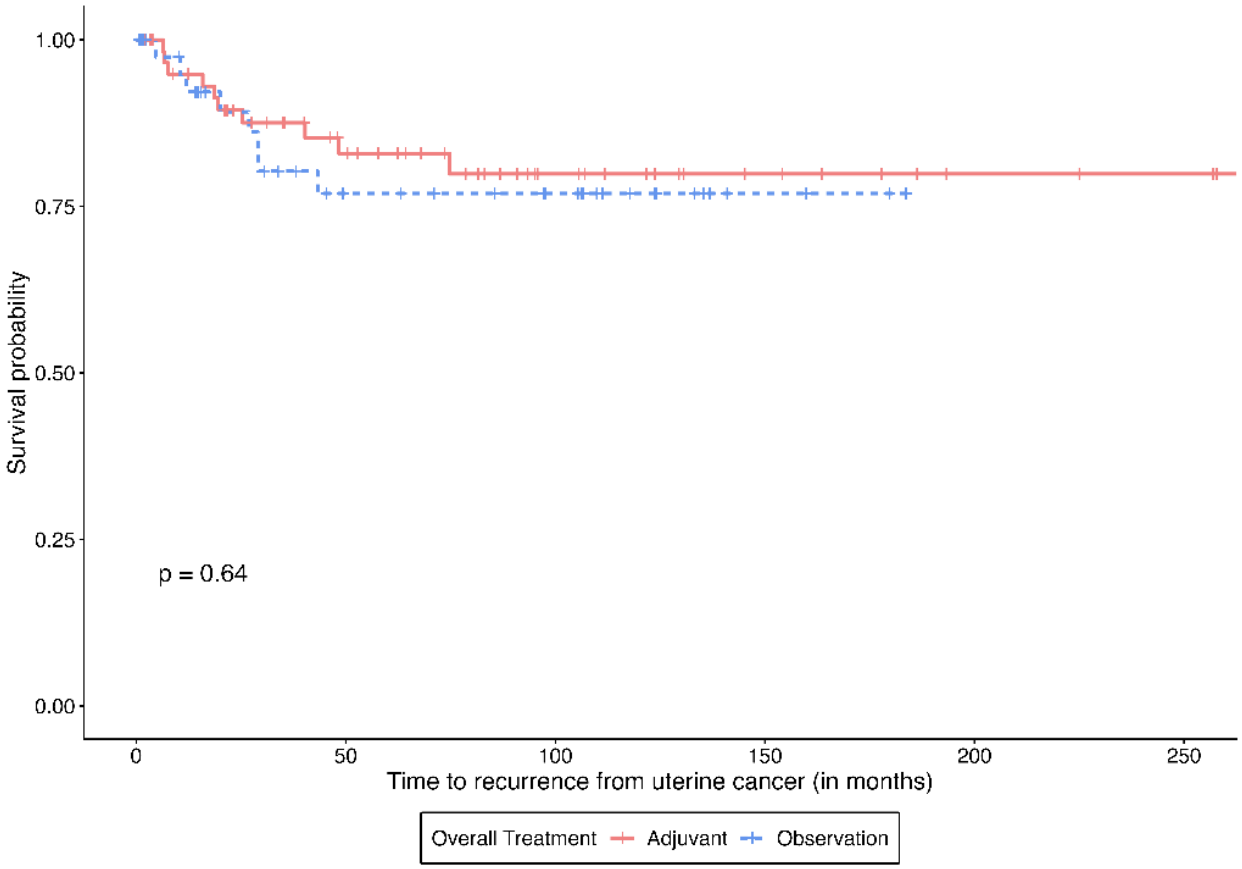
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Introduction: Optimal management of non-myoinvasive uterine serous adenocarcinoma (USC) is controversial. We compared survival outcomes for non-myoinvasive USC based on the extent of surgical staging and adjuvant therapy received.

Methods: We identified all non-myoinvasive USC patients who had hysterectomy between 1990-2025. Patients were considered to have complete surgical staging if they underwent omentectomy, surgical lymph node (LN) assessment and peritoneal cytology. Kaplan-Meier curves, and univariate Cox proportional analyses (UVA) were used to evaluate recurrence-free (RFS), disease-specific (DSS), and overall (OS) survival for surgical staging and adjuvant treatment groups.

Results: 108 patients were identified, median follow-up is 90 months, and median age is 66 years. Fifty-nine patients had complete surgical staging (54.6%); whereas 49 patients had incomplete staging, of which 67%, 77.6%, 69.3% had LN assessment, omentectomy and peritoneal cytology, respectively. After hysterectomy, 47 patients (43.5%) were observed, 8 (7.4%) received radiotherapy alone, 26 (24.1%) received chemotherapy alone, and 27 (25%) received chemoradiation. There were no differences between adjuvant therapies for surgical staging groups. 18 patients had disease recurrence (16.7%). There were no significant differences for 5-year RFS (p=0.56,Figure-1), DSS (p=0.20), or OS (p=0.65) between the two surgical groups. Similarly, there were no statistically significant survival differences according to adjuvant therapy received (Figure-2). On UVA, positive cytology was the only predictor of worse RFS, DSS, and OS (*p<0.001*).


1.00
0.75
0.50
0.25
0.00
Survival probability
p = 0.56
0
50
100
150
200
250
Time to recurrence from uterine cancer (in months)
Staging Completion
Yes
No



Conclusion/Implications: Our study suggests that for non-myoinvasive USC, complete surgical staging followed by observation is a reasonable option. Positive cytology predicts worse survival outcomes. Multi-institutional data is warranted to elucidate the role of adjuvant therapy, if any.

EP281 / #962

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

INCIDENCE AND PREVALENCE OF SECOND-LINE TREATMENT IN ADVANCED ENDOMETRIAL CANCER IN THE UNITED STATES

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Introduction: The US incidence of advanced endometrial cancer (aEC) is increasing, but contemporary estimates are limited. This study estimated the 2026 US incidence and prevalence of women newly initiating and receiving second-line (2L) therapy to inform treatment patterns and healthcare resource needs.

Methods: This retrospective observational analysis used Optum commercial claims (<65 years) and Medicare Fee-for-Service (≥65 years) data (2010-2025). Endometrial cancer was identified using ICD-9/10 codes (≥1 inpatient or ≥2 outpatient claims 30-365 days apart), requiring ≥12 months continuous enrollment before diagnosis. Second-line treatment initiation following platinum-based chemotherapy or immunotherapy was identified using a validated line-of-therapy algorithm. Age-specific, 10-year limited-duration prevalence estimates (SEER) were applied to 2026 US Census population counts to project national EC prevalence. Claims-derived, age-specific progression proportions were used to estimate the number of patients newly initiating 2L therapy and the total number of patients alive in 2026 who received 2L therapy any time (2L-treated population burden).

Results: Overall EC incidence was 28.6 per 100,000 women, with substantially higher rates among women ≥65 years versus 0-64 years (99.5 versus 18.3 per 100,000, respectively). An estimated 5394 women initiated 2L therapy (incident) for aEC in 2026, with most ≥65 years. Approximately 9063 women received 2L therapy (prevalent) in 2026; most were ≥65 years (**Table**), with 50% covered by Medicare (n=4531), 44% by commercial insurance (n=3988), and 6% by Medicaid/uninsured (n=544).

Table. Second-Line Therapy for aEC in 2026

	Initiated 2L Therapy, n (%)	Ever Received 2L Therapy, n (%)
0-64 years	2347 (44)	2977 (33)
≥65 years	3047 (56)	6086 (67)

2L, second-line; aEC, advanced endometrial cancer.

Conclusion/Implications: The estimated annual post-platinum ± immunotherapy inflow and the overall 2L aEC population burden may help guide institutional oncology resource planning, payer assessments, and healthcare system decision-making.

EP282 / #573

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

PREVALENCE AND CLINICAL ASSOCIATIONS OF HER2 EXPRESSION IN ENDOMETRIAL CANCER: A REAL-WORLD ANALYSIS FROM A BRAZILIAN COHORT

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Introduction: Human epidermal growth factor receptor 2 (HER2) has emerged as a relevant therapeutic target in multiple solid tumors, particularly with the advent of antibody–drug conjugates. However, data on HER2 expression in endometrial cancer remain limited, especially in middle-income countries.

Methods: We conducted a retrospective analysis of patients diagnosed with endometrial cancer at a Brazilian cancer center between 2000 and 2022. Clinical, epidemiological, and molecular data were collected. HER2 status was assessed using immunohistochemistry, with in situ hybridization performed when indicated. Descriptive analyses were conducted to evaluate HER2 prevalence and its association with clinicopathological features.

Results: A total of 224 patients were included (median age 61.9 years). HER2 testing was performed in 41 patients. HER2 positivity (3+ or 2+/ISH positive) was identified in 10% of cases, while 10% demonstrated low expression and 80% were negative. HER2-positive tumors were strongly associated with aggressive histological subtypes, including serous carcinoma and carcinosarcoma. Although most patients were diagnosed at early stages, HER2 positivity was enriched in high-risk disease. Additionally, HER2-positive tumors were predominantly associated with proficient mismatch repair status.

Conclusion/Implications: HER2 expression is present in a subset of endometrial cancers, particularly in aggressive histological subtypes. These findings support the potential clinical value of HER2 testing in selected patients, as targeted therapies may represent a relevant therapeutic strategy. Further studies are warranted to define the role of HER2-directed treatments in endometrial cancer.

EP283 / #628

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

HIGH GRADE ADVERSE EVENTS WITH IMMUNE CHECKPOINT INHIBITORS +/- PARP INHIBITORS IN PRIMARY ADVANCED/RECURRENT ENDOMETRIAL CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction: Immune checkpoint inhibitors (ICI) combined with platinum-based chemotherapy are the standard first-line therapy for advanced or recurrent endometrial cancer, particularly for mismatch repair deficient tumors. The addition of PARP inhibitor (PARPi) maintenance may further improve outcomes, although the pooled treatment-related toxicity from these combinations is not established.

Methods: We conducted a PRISMA-directed, PROSPERO registered systematic review and meta-analysis of randomized phase II–III trials evaluating first-line chemotherapy with ICI, with or without PARPi. Databases were searched through October 2025. The primary endpoint was grade ≥3 adverse events (AEs). Risk ratios (RR) with 95% confidence intervals (CI) were pooled using random-effects models. Subgroup analyses compared doublet (ICI + chemotherapy) and triplet (ICI + PARPi + chemotherapy) regimens.

Results: Six randomized trials were included. Addition of ICI increased grade ≥3 AEs (65.6% vs 54.2%; RR 1.20, 95% CI 1.04–1.38) and serious AEs (RR 1.62, 95% CI 1.16–2.27), with higher treatment discontinuation rates (26.6% vs 16.9%; RR 1.83). Immune-related AEs were significantly increased (RR 2.32), including grade ≥3 events (RR 2.77). Hematologic toxicity was largely unchanged, although grade ≥3 anemia increased (RR 1.29). The addition of PARPi did not significantly increase overall grade ≥3 toxicity (RR 1.41, 95% CI 0.99–2.01), but was associated with higher grade ≥3 anemia (RR 1.66).

Conclusion/Implications: Chemo-immunotherapy increases severe and immune-related toxicity but maintains a manageable safety profile. The addition of PARPi does not significantly increase overall high-grade toxicity, though selective hematologic effects are

observed. In the absence of validated predictive biomarkers and clear survival benefit, treatment intensification should be individualized.

EP284 / #375

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

ONCOLOGIC OUTCOMES OF THE SENTINEL LYMPH NODE MAPPING ALGORITHM IN SURGICALLY STAGED AGGRESSIVE ENDOMETRIAL CANCER ACCORDING TO HISTOLOGIC SUBTYPE: A RETROSPECTIVE STUDY

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Introduction: High-grade endometrial cancer (EC) histologies are collectively classified as aggressive in the 2023 FIGO staging system, but their relative prognostic value remains debated. Prior studies included heterogeneous populations, frequently involving systematic lymphadenectomy. We evaluated whether histologic subtype discriminates outcomes in presumed early-stage aggressive EC managed with minimally invasive surgery (MIS) and an sentinel lymph node (SLN) algorithm.

Methods: We retrospectively enrolled patients with presumed FIGO 2009 I-II high-grade EC who underwent MIS staging with SLN mapping according to NCCN algorithm at a single tertiary center (2016-2021). Survival outcomes were analyzed using the Kaplan-Meier method and Cox proportional hazards models.

Results: Among 220 patients, 56 (25.5%) had G3-endometrioid and 164 (74.5%) non-endometrioid histology. FIGO 2009 stage was I/II in 164 (74.5%) and III in 56 (25.5%). During follow-up, 54 recurrences and 58 deaths were observed. Median time to death was 2.5 years (IQR,1.5-3.9). Median follow-up among the remaining 162 patients was 5.7 years (IQR,4.1-7.1). Non-endometrioid histology was not significantly associated with disease-free survival (DFS) on Kaplan–Meier and univariable Cox analysis (p=0.08), and its association with overall survival (OS) was attenuated after age adjustment (HR 1.67,p=0.16). Conversely, tumor stage, LVSI, myometrial invasion, and SLN remained associated with worse DFS and OS after age adjustment.

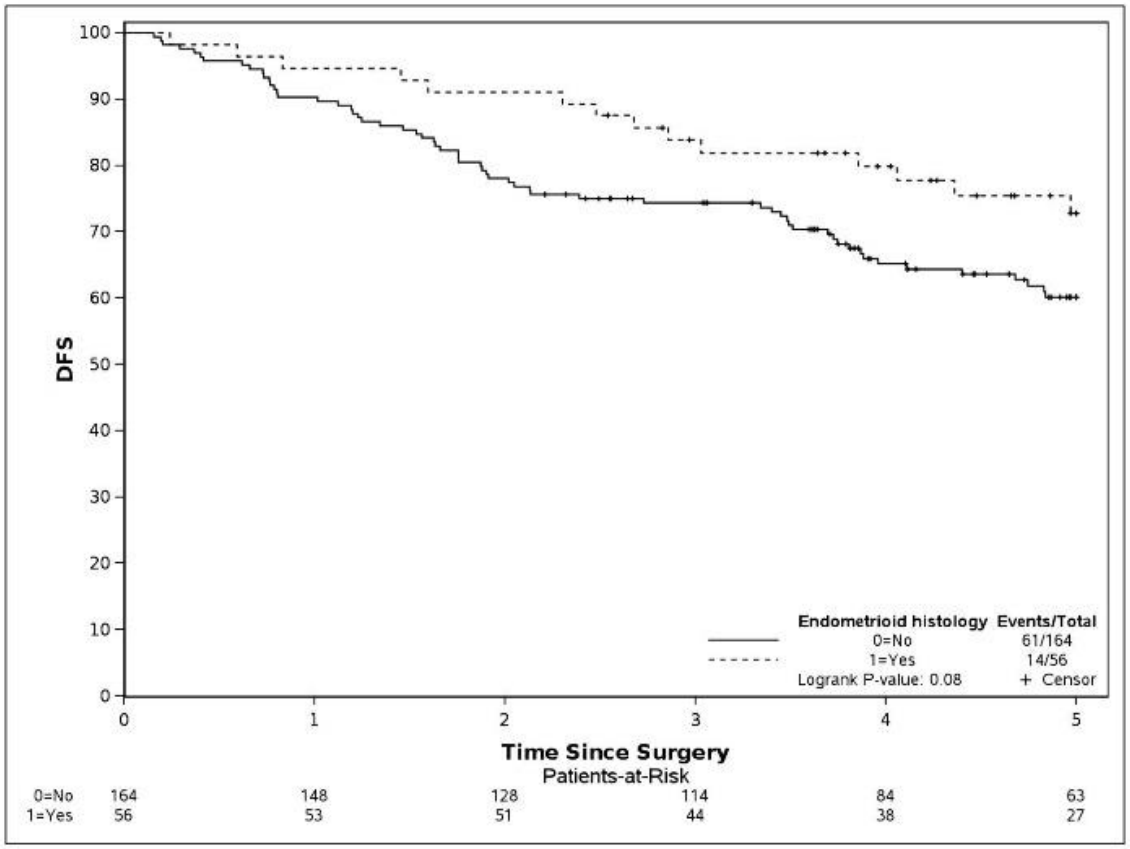


Figure 1. Disease-free survival according to histologic subtype

Kaplan–Meier curves comparing disease-free survival for non-endometrioid (0) versus grade 3 endometrioid (1) histology among patients with aggressive endometrial cancer.

Abbreviations: DFS, disease-free survival.

Variable	DFS age-adjusted HR (95% CI), p	OS age-adjusted HR (95% CI), p
Non-endometrioid vs G3 endometrioid	1.39 (0.77–2.51), p=0.27	1.67 (0.81–3.43), p=0.16
MI ≥ 50%	3.04 (1.44–6.45), p=0.004	2.89 (1.29–6.46), p=0.010
LVSI present vs absent	2.65 (1.68–4.19), p<0.0001	2.38 (1.42–4.01), p=0.001
FIGO 2009 stage III vs I/II	3.78 (2.38–5.99), p<0.0001	3.35 (1.98–5.67), p<0.0001
SLN positive	3.00 (1.84–4.91), p<0.0001	3.09 (1.77–5.38), p<0.0001

Table 1. Age-adjusted Cox models for DFS and OS

Abbreviations: CI, confidence interval; DFS, disease-free survival; FIGO, International Federation of Gynecology and Obstetrics; HR, hazard ratio; LVSI, lymphovascular space invasion; MI, myometrial invasion; OS, overall survival; SLN, sentinel lymph node.

Conclusion/Implications: In a presumed early-stage high-grade contemporary EC cohort staged with the SLN algorithm rather than systematic lymphadenectomy, histologic subtype did not independently affect oncologic outcomes. These findings support the clinical aggregation and internal prognostic coherence of FIGO 2023 aggressive histologies in an SLN-staged population, warranting validation in larger cohorts.

EP285 / #755

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

RISK-ADAPTED LYMPHADENECTOMY IN ENDOMETRIAL CANCER: RECURRENCE AND SURVIVAL IN A LARGE COHORT

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Introduction: The therapeutic role of lymphadenectomy in endometrial cancer remains debated, particularly in early-stage disease. We evaluated whether nodal assessment was associated with recurrence and survival in a large single-center cohort.

Methods: We retrospectively reviewed 480 women with histologically confirmed endometrial carcinoma treated with hysterectomy and bilateral salpingo-oophorectomy at a tertiary referral center between 2010 and 2021. Central pathology review was performed by expert gynecologic pathologists. Associations between lymphadenectomy extent and recurrence-free and overall survival were analyzed using univariable and multivariable methods.

Results: Lymphadenectomy was performed in 329 patients (68.5%). During follow-up, 84 patients (17.5%) recurred, with 96.4% of recurrences occurring within 5 years. In stage I-II disease, lymphadenectomy was associated with lower recurrence and improved 5-year survival (both $p<0.01$). Pelvic lymphadenectomy and node sampling reduced recurrence by 57% and 79%, respectively ($p=0.017$). Sampling was also associated with higher survival (OR 5.51, 95% CI 1.01-30.02; $p=0.048$). Non-endometrioid histology and lymphovascular space invasion increased recurrence risk, whereas age >60 years and lymphovascular space invasion reduced survival in early-stage disease. In stage III-IV disease, age >60 years was the only factor associated with poorer survival ($p=0.008$).

Conclusion/Implications: Pelvic and sampling lymphadenectomy were associated with reduced recurrence and improved survival in early-stage endometrial cancer. Future prospective studies should integrate molecular classification to refine risk-adapted surgical management.

EP286 / #625

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

TREATMENT UTILIZATION AND ASSOCIATED FACTORS IN PATIENTS WITH PRIMARY ADVANCED OR FIRST RECURRENT ENDOMETRIAL CANCER AFTER IMMUNOTHERAPY COMBINATION APPROVAL IN THE UNITED STATES

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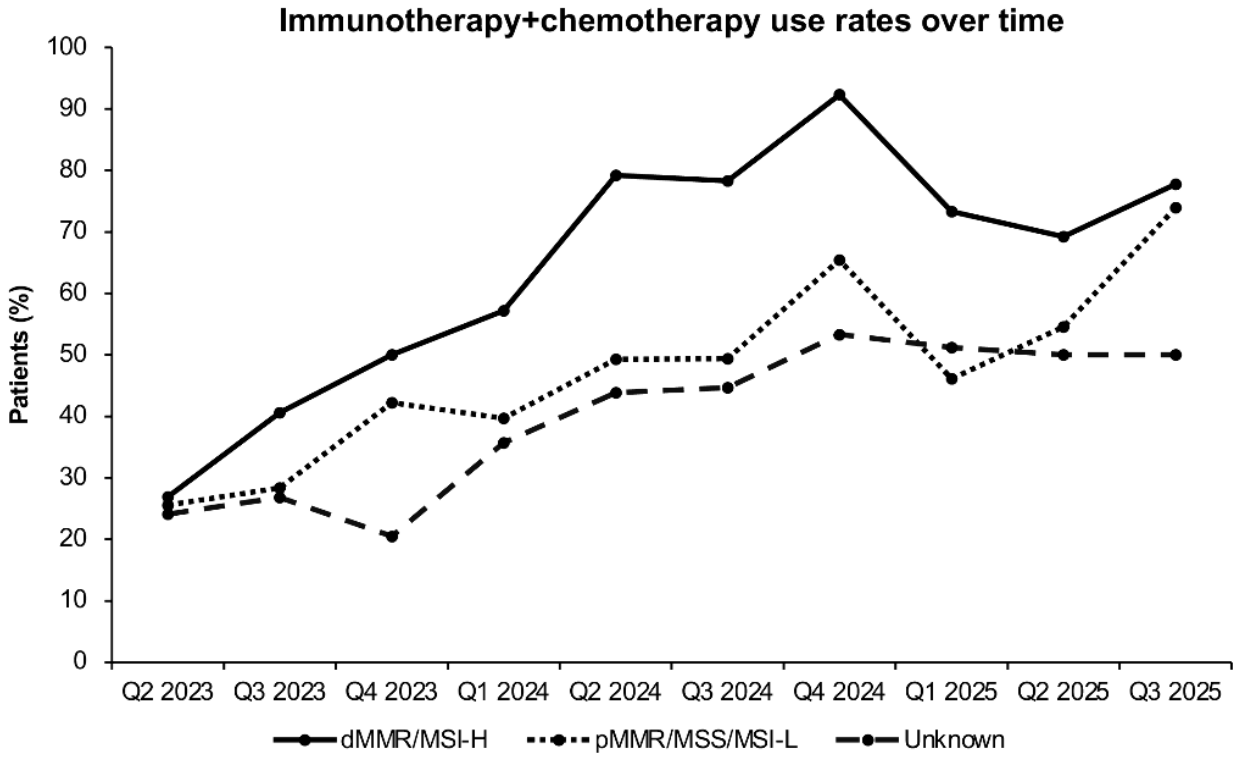
Introduction: Immunotherapy with dostarlimab in combination with carboplatin-paclitaxel significantly increased overall survival for primary advanced/recurrent endometrial cancer (pA/R EC) versus carboplatin-paclitaxel in RUBY (NCT03981796), shifting US standard of care. This study evaluated real-world treatment utilization and associated factors after this shift in standard of care.

Methods: This retrospective study included patients (≥18 years) initiating frontline treatment for pA/R EC between 5/2023 (when guidelines changed) and 8/2025. Baseline characteristics and quarterly treatment utilization trends were described. Logistic regression was applied to examine factors associated with receipt of chemotherapy versus immunotherapy+chemotherapy.

Results: Of 1170 patients, 544 (46.5%) received immunotherapy+chemotherapy, 383 (32.7%) chemotherapy, and 243 (20.8%) other therapy. Overall, receipt of immunotherapy+chemotherapy increased from 25.5% in 2023 to 67.4% in 2025, mostly in dMMR/MSI-H patients (Figure). Factors significantly associated with higher likelihood of chemotherapy versus immunotherapy+chemotherapy use included serous histology (odds ratio [OR], 1.68 [95% CI, 1.18–2.38] vs endometrioid), MMRp/MSS status (OR, 3.09 [95% CI, 1.95–4.89] vs dMMR/MSI-H), and unknown/missing MMR status (OR, 4.06 [95% CI, 2.47–6.66] vs dMMR/MSI-H). Black/African American race was significantly associated with lower likelihood of chemotherapy versus immunotherapy+chemotherapy use (OR, 0.59 [95% CI, 0.39–0.88] vs White).

Conclusion/Implications: Despite increased uptake of frontline combination immunotherapy+chemotherapy after incorporation into guidelines and approval, some patients with pA/R EC, particularly those with serous histology, MMRp/MSS status, or unknown/missing MMR status, still received chemotherapy without immunotherapy. These

results highlight the importance of increasing awareness of guideline-concordant care and education on improved outcomes demonstrated with immunotherapy+chemotherapy in these patient
subgroups.



dMMR, mismatch repair deficient; MSI-H, microsatellite instability-high; MSI-L, microsatellite instability-low; MSS, microsatellite stable.

EP287 / #1063

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

CAN MISMATCH REPAIR PROFICIENCY CHANGE IN ENDOMETRIAL CANCER?

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Introduction: Immune checkpoint inhibitors have significantly advanced the treatment of mismatch repair deficient (MMRd) endometrial cancer (EC). It is unknown what proportion of MMR proficient (p) tumors develop MMR deficiency due to epigenetic events over time or under treatment pressure.

Methods: Retrospective chart review identified patients diagnosed with EC between January 1, 2012, and December 22, 2024, who met the following criteria: MMRp status by immunohistochemistry and availability of paired archived tissue (from recurrent disease or interval debulking surgery) to retest for MMR. Cases showing loss of MLH1/PMS2 expression underwent MLH1 promoter methylation testing. Clinical data were collected from patient records.

Results: Of 2,437 cases reviewed, 116 met inclusion criteria. Paired MMR testing was performed in the following cohorts: (A) at IDS after neoadjuvant carboplatin/paclitaxel chemotherapy (n=63), (B) at recurrence with prior chemotherapy exposure (n=38) and (C) recurrence without prior chemotherapy exposure (n=15). One case from the IDS cohort A was reclassified as MMRd due to the identification of two distinct tumor components on pathology review. Reclassification from MMRp to MMRd due to MLH1 promotor methylation was observed at a rate of 5.3% of patients in cohort B (n=2), and 6.7% of patients in cohort C (n=1).

Conclusion/Implications: These findings suggest that MMR may exhibit temporal heterogeneity, with cancers at recurrence demonstrating evolution of MMR status from MMRp to MMRd. This was an uncommon finding and was not seen under the pressure of neoadjuvant platinum-based chemotherapy. Retesting of MMR at disease recurrence should be considered, as reclassification may impact systemic therapy selection.

EP288 / #1091

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

IS THE NEW PORTEC-4A/ESGO-ESTRO-ESP-ADAPTED ALGORITHM PROGNOSTIC IN A REAL-WORLD POPULATION?

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Introduction: ESGO/ESTRO/ESP guidelines define four prognostic subgroups in early-stage endometrial cancer (EC). PORTEC-4a proposed an integrated algorithm for high-intermediate-risk EC, excluding estrogen receptor (ER) expression. We evaluated a PORTEC-4a/ESGO-ESTRO-ESP-adapted algorithm across molecular subgroups in a real-world cohort.

Methods: We retrospectively analyzed EC treated at a referral cancer center (04/2019-12/2025), with complete molecular profiling (MMR, p53, L1CAM, ER IHC, MSI, and NGS including *POLE, TP53, CTNNB1*. EC were classified into POLEmut, MMRd, p53abn, and NSMP per WHO-endorsed criteria. PORTEC-4a criteria were endometrioid histology and stage IA (with invasion) G3, stage IB G1-2 age ≥60 or substantial LVSI, stage IB G3 without LVSI, stage II G1. PORTEC-4a/ESGO-ESTRO-ESP-adapted algorithm hierarchically stratified into three risk groups: Unfavourable (p53abn, MMRd/NSMP with substantial LVSI and/or L1CAM ≥10%, NSMP ER-negative), Intermediate (NSMP CTNNB1-mutated, all other MMRd) and Favourable (POLEmut and NSMP CTNNB1-wild-type). Comparison used Fisher's exact and Kruskal-Wallis tests.

Results: 141 patients were included: 33 (23.4%) Unfavourable, 52 (36.9%) Intermediate, and 56 (39.7%) Favourable. (Table1) Molecular subgroups were: POLEmut 15.6% (n=22),

MMRd 30.5% (n=43), NSMP 40.4% (n=57), p53abn 13.5% (n=19). Groups differed in grade (p=0.041), and adjuvant treatment. After a median follow-up of 34.5 months, recurrence rate was 15.2%, 13.5%, and 12.5% in Unfavourable, Intermediate, and Favourable groups, respectively
(p=0.926).

Table 1. Clinicopathological characteristics comparison between risk profiles PORTEC-4a/ESGO algorithm adapted endometrioid endometrial cancers

Characteristic	Overall N = 141[1]	Favourable N = 56[1]	Intermediate N = 52[1]	Unfavourable N = 33[1]	P-value[2]
Age, mean (years) ± SD	66.0 ± 10.0	65.2 ± 9.8	66.8 ± 10.6	66.3 ± 9.7	0.681
BMI, mean (kg/m²) ± SD	27.3 ± 6.8	26.7 ± 6.9	28.4 ± 7.5	26.5 ± 5.3	0.351
Molecular group					
POLEmut	22 (15.6%)	22 (39.3%)	0 (0.0%)	0 (0.0%)	
MMRd	43 (30.5%)	0 (0.0%)	35 (67.3%)	8 (24.2%)	
NSMP	57 (40.4%)	34 (60.7%)	17 (32.7%)	6 (18.2%)	
p53abn	19 (13.5%)	0 (0.0%)	0 (0.0%)	19 (57.6%)	
Grade					0.041
Low grade (G1-2)	65 (46.1%)	28 (50.0%)	28 (53.8%)	9 (27.3%)	
High grade (G3)	76 (53.9%)	28 (50.0%)	24 (46.2%)	24 (72.7%)	
FIGO stage (2023)					0.008
IA1	2 (1.7%)	2 (4.4%)	0 (0.0%)	0 (0.0%)	
IA2	1 (0.9%)	0 (0.0%)	0 (0.0%)	1 (4.3%)	
IA3	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	
IB	52 (44.8%)	23 (51.1%)	25 (52.1%)	4 (17.4%)	
IC	9 (7.8%)	4 (8.9%)	4 (8.3%)	1 (4.3%)	
IIA	5 (4.3%)	2 (4.4%)	2 (4.2%)	1 (4.3%)	
IIB	5 (4.3%)	1 (2.2%)	0 (0.0%)	4 (17.4%)	
IIC	41 (35.3%)	12 (26.7%)	17 (35.4%)	12 (52.2%)	
IIIA1	1 (0.9%)	1 (2.2%)	0 (0.0%)	0 (0.0%)	
Myometrial invasion					0.495
<50%	56 (39.7%)	20 (35.7%)	20 (38.5%)	16 (48.5%)	
≥50%	85 (60.3%)	36 (64.3%)	32 (61.5%)	17 (51.5%)	
LVSI					<0.001
None/focal	133 (94.3%)	56 (100.0%)	51 (98.1%)	26 (78.8%)	
Substantial	7 (5.0%)	0 (0.0%)	0 (0.0%)	7 (21.2%)	
Unknown	1 (0.7%)	0 (0.0%)	1 (1.9%)	0 (0.0%)	
Estrogen receptor (ER)					<0.001
Positive	77 (54.6%)	40 (71.4%)	25 (48.1%)	12 (36.4%)	
Negative	10 (7.1%)	2 (3.6%)	0 (0.0%)	8 (24.2%)	
Not done/Not feasible	54 (38.3%)	14 (25.0%)	27 (51.9%)	13 (39.4%)	
L1CAM					0.243
Positive	2 (1.4%)	0 (0.0%)	0 (0.0%)	2 (6.1%)	
Negative	14 (9.9%)	6 (10.7%)	6 (11.5%)	2 (6.1%)	
Not done/Not feasible	125 (88.7%)	50 (89.3%)	46 (88.5%)	29 (87.9%)	
CTNNB1					<0.001
Wild type	115 (81.6%)	53 (94.6%)	31 (59.6%)	31 (93.9%)	
Mutated	26 (18.4%)	3 (5.4%)	21 (40.4%)	2 (6.1%)	
ESGO/ESTRO/ESP 2025 risk class					
Low	24 (18.0%)	21 (40.4%)	3 (6.1%)	0 (0.0%)	
Intermediate	66 (49.6%)	20 (38.5%)	44 (89.8%)	2 (6.3%)	
High-Intermediate	9 (6.8%)	0 (0.0%)	1 (2.0%)	8 (25.0%)	
High	30 (22.6%)	8 (15.4%)	1 (2.0%)	21 (65.6%)	
Advanced/metastatic	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	
Undetermined	4 (3.0%)	3 (5.8%)	0 (0.0%)	1 (3.1%)	
Vaginal brachytherapy (VBT)					<0.001
Yes	27 (19.1%)	8 (14.3%)	9 (17.3%)	10 (30.3%)	
No	25 (17.7%)	8 (14.3%)	3 (5.8%)	14 (42.4%)	
Unknown/Not done	89 (63.1%)	40 (71.4%)	40 (76.9%)	9 (27.3%)	
External beam radiotherapy (EBRT)					<0.001
Yes	22 (15.6%)	6 (10.7%)	5 (9.6%)	11 (33.3%)	
No	33 (23.4%)	11 (19.6%)	9 (17.3%)	13 (39.4%)	
Unknown/Not done	86 (61.0%)	39 (69.6%)	38 (73.1%)	9 (27.3%)	
Adjuvant chemotherapy					<0.001
Yes	25 (17.7%)	7 (12.5%)	2 (3.8%)	16 (48.5%)	
No	30 (21.3%)	10 (17.9%)	12 (23.1%)	8 (24.2%)	
Unknown/Not done	86 (61.0%)	39 (69.6%)	38 (73.1%)	9 (27.3%)	
Recurrence					0.926
Yes	19 (13.5%)	7 (12.5%)	7 (13.5%)	5 (15.2%)	
No	121 (85.8%)	49 (87.5%)	44 (84.6%)	28 (84.8%)	
Unknown	1 (0.7%)	0 (0.0%)	1 (1.9%)	0 (0.0%)	
Follow-up, median (months)	34.5 (18.0-52.5)	36.5 (19.0-52.5)	36.0 (18.0-56.0)	25.0 (15.0-41.0)	0.337

[1]Data reported as n (%) or median (IQR) unless otherwise indicated. [2]One-way analysis of means; NA; Fisher's exact test; Kruskal-Wallis rank sum test

Conclusion/Implications: In this real-world cohort, PORTEC-4a/ESGO-ESTRO-ESP-adapted algorithm did not improve prognostic stratification of high-intermediate-risk EC. This may be attributable to heterogeneous adjuvant treatments, limited follow-up, and a low number of events. These findings raise questions about the clinical utility of incorporating additional molecular features for further risk refinement in routine practice.

EP289 / #728

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

TIME OF DAY OF ADMINISTRATION AS A DETERMINANT OF IMMUNOTHERAPY RESPONSE IN ENDOMETRIAL CANCER

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Introduction: Circadian influences on immune cell trafficking and ICI pharmacokinetics could influence overall survival (OS) and progression-free survival (PFS) as a function of time-of-day of administration (ToDA) of immune checkpoint inhibitors (ICIs).

Methods: Retrospective, real-world cohort study of patients with endometrial cancer who received ≥4 doses of pembrolizumab or dostarlimab (01/01/2019–01/01/2026). The optimal ToDA cutoff was determined by evaluating HRs for OS and PFS across infusion timing thresholds using each patient's median time across their first 4 infusions. Patients were then categorized as early or late, and survival outcomes were compared using the Kaplan-Meier method.

Results: 44 patients were included. A cutoff of 12:30 was selected as optimal (HR [95%CI]: OS 0.28 [0.11–0.70]; PFS 0.26 [0.11–0.66]), with 16 patients in the early group and 28 in the late group. In the early and late groups respectively, median PFS was 34 months (95%CI 19–NR) vs. 4 months (95%CI 4–NR) (HR 0.263 [0.085–0.814]; p=0.017), and median OS was 44 months (21–NR) vs. 11 months (7–NR) (HR 0.279 [0.091–0.857]; p=0.022).

Conclusion/Implications: Earlier ToDA of immunotherapy in endometrial cancer is associated with significantly improved survival outcomes, highlighting infusion timing as an important yet often underappreciated variable.

EP290 / #894

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

LOW-GRADE ENDOMETRIOID ENDOMETRIAL CARCINOMA HARBORING P53 ABNORMALITY: DIAGNOSTIC CHALLENGES AND CLINICAL IMPLICATIONS OF A RARE MOLECULAR SUBTYPE

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Introduction: The FIGO 2023 staging system mandates molecular classification, wherein p53 abnormality confers the highest risk regardless of morphological grade. Coexistence with low-grade endometrioid histology creates molecular–morphological discordance, challenging diagnosis, surgical planning, staging extent, and adjuvant therapy, which are historically guided by morphology alone.

Methods: A retrospective analysis at the All India Institute of Medical Sciences, New Delhi, over 18 months identified low-grade endometrioid endometrial carcinoma with aberrant p53 on preoperative biopsy; clinical, pathological, surgical, and oncological outcomes were reviewed.

Results: Ten cases of Grade 1–2 endometrioid endometrial carcinoma with aberrant p53 on preoperative biopsy were identified. The p53 designation mandated high-risk surgical staging, including systematic lymphadenectomy and omentectomy, in seven cases where morphology alone would have directed conservative surgery. Postoperative upstaging occurred in two cases to serous and dedifferentiated carcinoma with discordant p53 expression, retrospectively validating surgical extensiveness. MMR deficiency identified postoperatively in two cases introduced complexity regarding adjuvant therapy sequencing and immunotherapy eligibility. POLE sequencing was wild-type in two cases; it remained unavailable in eight. Final FIGO 2023 staging ranged from IA to $IIIC_1$; eight cases were HIGH risk by ESGO criteria. Six received sandwich chemoradiation, two received vaginal brachytherapy, and two were observed. Disease-free intervals ranged from 3 to 24 months.

Conclusion/Implications: These cases illustrate the challenges of p53-abnormal low-grade endometrioid carcinoma from sampling error and preoperative risk underestimation to surgical extent decisions and adjuvant escalation in morphologically low-grade disease. Complete preoperative molecular profiling encompassing p53, MMR, and POLE status is imperative to calibrate surgical staging and adjuvant intensity to true biological risk.

EP291 / #976

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

IMPACT OF BRACHYTHERAPY ON BODY IMAGE AND SEXUAL FUNCTION IN ENDOMETRIAL CANCER SURVIVORS: A TUNISIAN PROSPECTIVE STUDY

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Introduction: Endometrial cancer is associated with improving survival outcomes,shifting focus toward long-term survivorship issues.Body image and sexual function are frequently compromised after treatment,particularly in patients receiving multimodal therapy including brachytherapy.This study aimed to evaluate the impact of brachytherapy on body image and sexual function in a Tunisian cohort of endometrial cancer survivors.

Methods: We conducted a prospective observational study including 54 patients with histologically confirmed,non-metastatic endometrial cancer in complete remission,with a follow-up of 24 months.All patients had an active sexual life prior to diagnosis.Exclusion criteria included psychiatric disorders and comorbidities affecting body image.Clinical and treatment data were collected.Body image and sexual function were assessed using the Body Image Scale (BIS) and the Female Sexual Function Index (FSFI) during structured face-to-face interviews.

Results: The median age was 57 years,with 41% having a higher education level and a median marriage duration of 27 years.Most patients had stage IB disease (51%),and surgery was performed in nearly all cases (98.1%).Adjuvant treatments included chemotherapy in 16.7%,external beam radiotherapy in 61.1%,and high-dose-rate brachytherapy in 92.6%.Post-treatment body image disturbances were observed,with a mean BIS score of 12 indicating moderate impairment.Sexual dysfunction was reported in 42% of patients,with a significant decline in FSFI scores from 32.22 to 20.75 after treatment.Desire was the most affected domain.Trends suggested higher impairment in patients receiving combined modalities, although no statistically significant associations were identified.

Conclusion/Implications: Brachytherapy,within multimodal treatment of endometrial cancer,is associated with notable deterioration in body image and sexual function.These findings highlight the importance of integrating psychosexual support into survivorship care to improve quality of life.

EP292 / #622

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

BARRIERS TO GERMLINE GENETIC TESTING IN ENDOMETRIAL CANCER: INSIGHTS FROM A REAL-WORLD COHORT IN INDIA.

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Introduction: Endometrial cancer (EC) is familial in approximately 2%–5% of cases, with germline mutations having important implications for management and cancer risk assessment in women and their families. There is paucity of data from low- and middle-income countries regarding uptake of genetic testing and associated barriers.

Methods: This ambispective observational study included women with EC treated between January 2020 and April 2026 at a tertiary care centre in New Delhi. Women were eligible if they met at least one criterion: mismatch repair deficiency (dMMR) on immunohistochemistry, NCCN (v 4.2024) Lynch syndrome testing criteria, PREMM 5 score ≥ 2.5%, or a relevant personal/family cancer history. The consenting women underwent germline testing using next-generation sequencing with MLPA. The clinical characteristics, testing uptake, and barriers were analysed.

Results: Total 107 women were screened, 93 were enrolled (mean age 54.1 ± 4.8 years). The most common symptom was postmenopausal bleeding (66%), and 67% had BMI >25 kg/m^2. The PREMM5 score ≥2.5% was seen in 47%, and 12% had a prior cancer history. Out of 74 patients with IHC for MMR, 18 (24%) had dMMR; 8 (44%) dMMR patients underwent testing, mutations were identified in 6 (75%), most common mutation was MSH2. Of 56 pMMR patients, 5 (9%) underwent testing, 4(75%) had no pathogenic mutations. The barriers to genetic testing were high cost (70%), perceived lack of benefit (20%), reason not stated (5%) and fear or anxiety (5%).

Conclusion/Implications: Despite high proportion of women eligible for germline genetic testing, uptake of testing was low, highlighting the need for availability of low cost testing.

EP293 / #1002

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

SARCOPENIA AND IMMUNOTHERAPY IN ENDOMETRIAL CANCER: SURVIVAL OUTCOMES AND IMMUNE-RELATED ADVERSE EVENTS

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Introduction: While sarcopenia is associated with inferior immune checkpoint inhibitor (ICI) outcomes in several malignancies, its impact on endometrial cancer (EC) is poorly defined. We evaluated the relationship between sarcopenia, survival outcomes, and immune-related adverse events (irAEs) in patients receiving ICI for EC.

Methods: Single-institution retrospective cohort study of patients receiving ≥3 cycles of ICI from 2015–2022. Sarcopenia was defined as a skeletal muscle index of <38. Kaplan-Meier methods and Cox proportional hazards regression were used to estimate survival.

Results: 80 patients were included; 34 (42.5%) had sarcopenia. Mean age was 67.7 years; pembrolizumab was used in 97.5%. Sarcopenic patients had lower mean BMI (28.3 vs 34.7 kg/m^2, p<0.001) and obesity prevalence (44.1% vs 73.9%, p=0.007); MMR status, histology, and ECOG were similar. Sarcopenia was not associated with OS (median 21.0 vs 21.9 months; HR 0.79, 95% CI 0.47–1.33, p=0.38) nor PFS (median 10.5 vs 6.8 months; HR 0.66, 95% CI 0.39–1.10, p=0.11). Rates of any-grade (50.0% vs 52.2%) and grade 3–5 irAEs (20.6% vs 15.2%) were similar. However, sarcopenic patients had higher rates of immune-related pneumonitis (11.8% vs 0%, p=0.029). Any irAE was associated with better OS (HR 0.59, p=0.041) and PFS (HR 0.60, p=0.039) in this cohort.

Conclusion/Implications: In our cohort, sarcopenia is not associated with worse survival but has a distinct irAE profile, including higher rates of pneumonitis. Given the small number of events and single-institution design, findings should be considered hypothesis-generating and warrant validation before informing clinical practice.

EP294 / #548

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

MANAGEMENT OF SYNCHRONOUS AND METACHRONOUS ENDOMETRIAL AND RENAL CELL CANCER – CASE SERIES FOCUSING ON ONCOLOGIC ROBOTIC SURGICAL APPROACH

Yael Tal Bliman[1], Yuval Adler Glick[1], Amnon Zisman[2], Tal Yehudai Rafaeli[1], Yair Shiber[1], Alla Khashper[3], Zvi Vaknin[1]
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Introduction: The incidence of multiple primary malignancies (MPMs), including synchronous tumors, has increased in recent decades, due to increased life expectancy, improved cancer survival, and advances in imaging. Both endometrial carcinoma (EC) and renal tumors (RT) are rising in prevalence and are strongly linked to obesity. While these malignancies are commonly managed surgically, their synchronous or metachronous occurrence remains rare and presents unique management challenges. There is no established consensus regarding the optimal management of such cases. Our objective is to evaluate the management approach of MPMs involving EC and RT based on cases managed at our institution.

Methods: A retrospective review of patients diagnosed with EC and RT at our institution between 2014 and 2025. Clinical, surgical, and pathological data were collected, including tumor characteristics, treatment modality, surgical technique, perioperative course, and oncologic outcomes. This study was approved by the Institutional Review Board (0263-24ASF).

Results: Eight patients with synchronous or metachronous EC and RT were identified. Seven underwent surgical treatment for both tumors. Three were managed with combined robotic-assisted procedures performed during a single operative session. Patients who underwent combined minimal invasive surgery experienced lower intraoperative blood loss, required no transfusions, and had shorter hospital stays compared to those who underwent staged surgeries.

Conclusion/Implications: Synchronous or metachronous EC and RT are rare, and treatment is not yet standardized. Our experience suggests that combined robotic-assisted surgery may be a feasible and safe strategy, particularly in obese patients. This multidisciplinary approach facilitates more coordinated care delivery and may contribute to improved clinical outcomes.

EP295 / #63

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

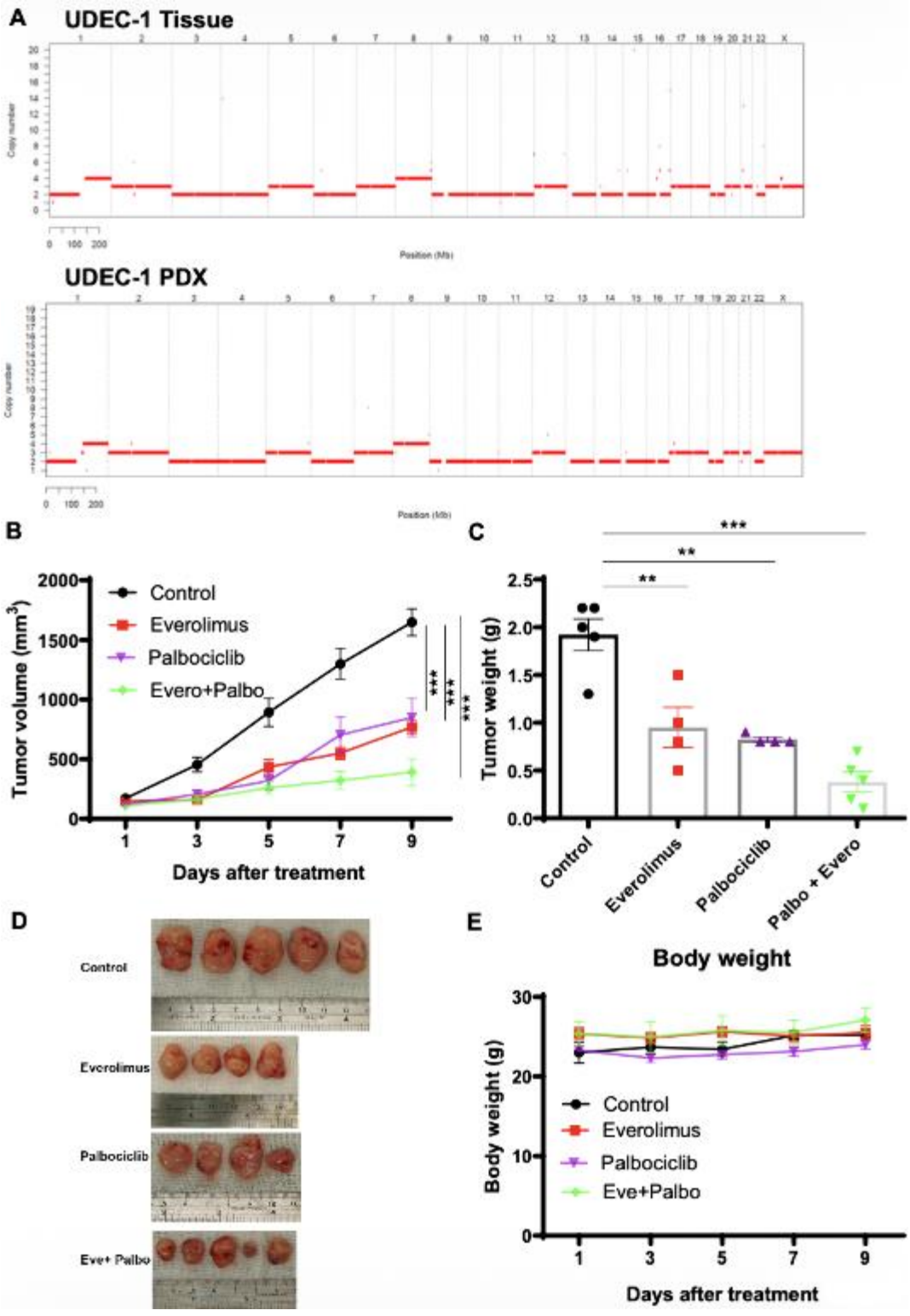
DUAL PI3K/AKT/MTOR AND CDK4/6 INHIBITION SUPPRESSES SURVIVIN TO OVERCOME UTERINE UNDIFFERENTIATED/DEDIFFERENTIATED ENDOMETRIAL CARCINOMA

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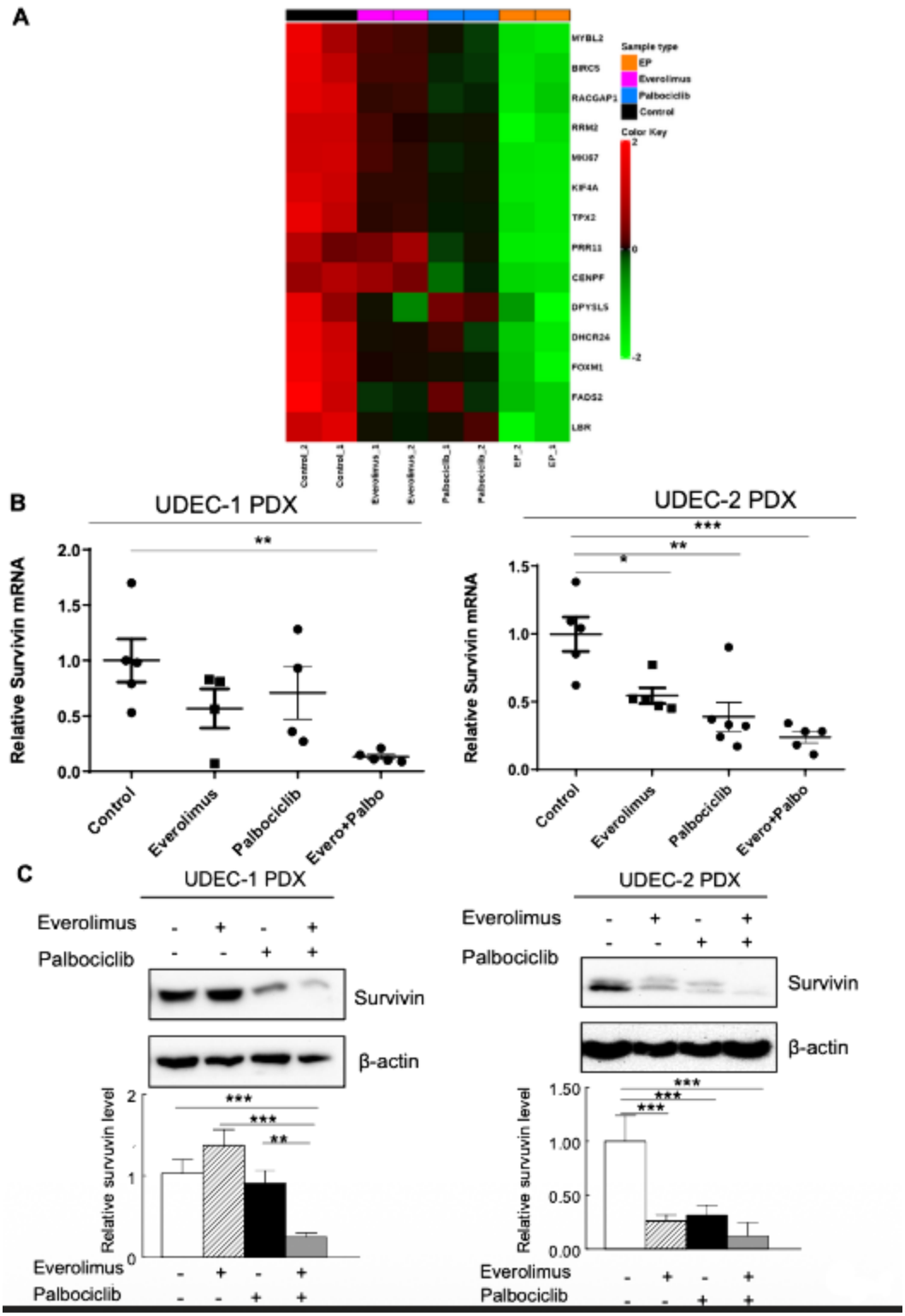
Introduction: Undifferentiated/dedifferentiated endometrial carcinoma (UDEC) is a rare but highly aggressive subtype of endometrial cancer, which characterized by strong metastatic potential, frequent recurrence, and resistance to conventional chemotherapy. Currently, there is no standardized treatment strategy for UDEC. Genomic profiling has revealed a high frequency of *PTEN* mutations, resulting in dysregulation of the PI3K/AKT/mTOR and cell cycle pathways. In recent years, the incidence of UDEC has steadily increased, highlighting the urgent need for effective treatment strategies. In this study, we investigated the efficacy of combining PI3K/AKT/mTOR inhibition (everolimus) with cell cycle pathway inhibition (palbociclib) in UDEC.

Methods: To investigate therapeutic options, we utilized patient-derived xenograft (PDX) and tumoroid models established from PDX tumors derived from UDEC patient samples to evaluate everolimus (an mTOR inhibitor) and palbociclib (a CDK4/6 inhibitor), alone and in combination. Whole-exome sequencing (WES) and RNA sequencing (RNA-Seq) were performed on patient tissues and PDX models to characterize mutational landscapes.

Results: Combination therapy exhibited antitumor effects in UDEC cell lines and tumoroids and significantly suppressed tumor growth in PDX models without inducing weight loss in mice. RNA sequencing of treated PDX tumors identified *survivin* as a consistently downregulated target. Mechanistically, the combination reduced Sp1-mediated transcription of survivin. In a clinical cohort of 29 UDEC patients, higher survivin expression showed a trend toward shorter overall and progression-free survival, supporting its role as a prognostic


A
UDEC-1 Tissue
UDEC-1 PDX
Copy number
Position (Mb)
B
Tumor volume (mm3)
Control
Everolimus
Palbociclib
Evero+Palbo
Days after treatment
C
Tumor weight (g)
Control
Everolimus
Palbociclib
Palbo + Evero
D
Control
Everolimus
Palbociclib
Eve+ Palbo
E
Body weight
Body weight (g)
Control
Everolimus
Palbociclib
Eve+Palbo
Days after treatment

biomarker.



Conclusion/Implications: These findings highlight dual PI3K/AKT/mTOR and CDK4/6 inhibition as a promising strategy for UDEC and demonstrate the translational value of PDX and tumoroid models in aggressive gynecologic cancers.

EP296 / #493

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

IMPACT OF SURGICAL APPROACH IN THE TREATMENT OF SURGICALLY STAGED 2009 FIGO STAGE II ENDOMETRIAL CARCINOMA

Pernille Trent[1,2], Christian Dagher[1,3], Ray Abou Nakad[1], Jennifer Mueller[1,4], Yukio Sonoda[1,4], Vance Broach[1,4], Yun Wang[2], Brynhildur Eyjólfsdóttir[2], Gunn Dahl[2], Ane Gerda Eriksson[2,5], Nadeem Abu-Rustum[1,4], Mario Leitao[1,4]
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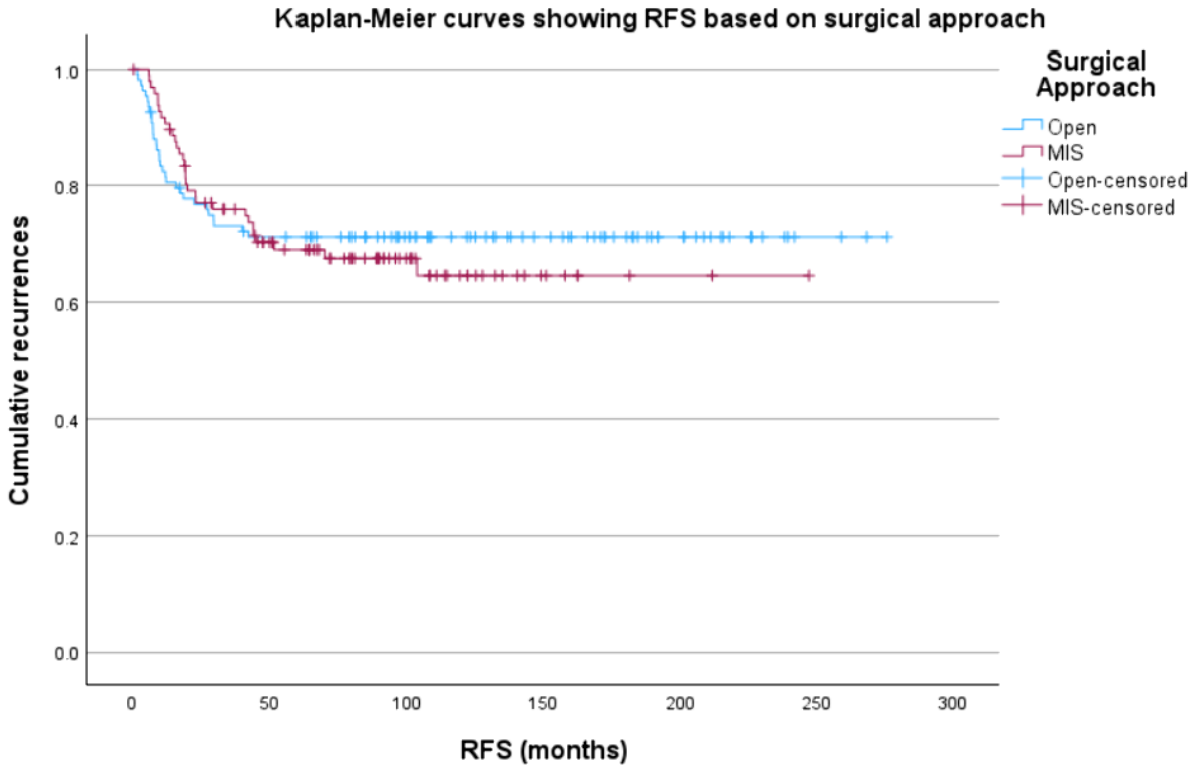
Introduction: The safety of minimally invasive surgery (MIS) in stage II endometrial carcinoma is debated. We compared outcomes between women who had undergone open surgery and MIS.

Methods: For this retrospective, multi-institutional study, we identified all patients with FIGO 2009 stage II endometrial carcinoma of any histology who underwent primary surgical staging at our institutions. Chi-square and Mann-Whitney U testing was used as appropriate. Recurrence-free survival (RFS) and overall survival (OS) were estimated using Kaplan-Meier method and compared with log-rank test. A multivariate Cox proportional hazards model was constructed to estimate adjusted hazard ratios (aHRs) with 95% confidence intervals.

Results: Overall, 207 patients were included in this analysis; 109 (53%) underwent open surgery and 98 (47%) underwent MIS. The cohorts were similar except for depth of myoinvasion (P=0.02) and use of postoperative therapy (P=0.02). Median length of stay was 7 days (range, 2-23) for open surgery and 1 day (range, 0-14) for MIS (P<0.001). Median follow-up time was 96.4 months (IQR, 61.3-146.5) for all cases. Five-year RFS rate for open surgery was 71.2% (95% CI: 61.6%-78.8%) and 69% (95% CI: 58.5%-77.3%) for MIS (P=0.7) (Figure 1). Five-year OS rate was 83.5% (95% CI: 75%-89.3%) for open surgery and 84.1% (95% CI: 74.6%-90.3%) for MIS (P=0.9). The aHR for recurrence for surgical approach was 1.25 (95% CI: 0.74-2.08) adjusting for depth of myoinvasion and use of postoperative

therapy.

Figure 1



Abbreviations: RFS, recurrence-free survival; MIS, minimally invasive surgery

Conclusion/Implications: MIS appears to be associated with similar RFS and OS as open surgery in stage II endometrial carcinoma and is associated with shorter length of stay.

EP297 / #309

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

A PHASE 1 STUDY OF A MUTANT-SELECTIVE INHIBITOR, CGT6297, IN PATIENTS WITH ADVANCED SOLID TUMORS HARBORING PIK3CA MUTATIONS

Dena Westphalen[1], Faisal Fa'Ak[2], Sheena Sahota[3], Wen-Ling Kuo[4], Meredith Little[4], Kevin Moynihan[4], Kathleen Dorris[4], Alexander Spira[5]
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Introduction: Phosphoinositide 3-kinases (PI3Ks) regulate key cellular activities. Aberrant PI3K pathway activation drives tumorigenesis, cancer progression, and treatment resistance. *PIK3CA* gene alterations are common across multiple cancer types. While several PI3K pathway inhibitors have been investigated, use is limited largely due to on-target toxicities (i.e., hyperglycemia, rash, diarrhea). Newer-generation mutant-selective PI3Kα inhibitors may improve tolerability versus pan-PI3K inhibitors.

Objectives: CGT6297 is an investigational PI3Kα inhibitor with selective potency against oncogenic *PIK3CA* mutations. Nonclinical data support evaluation of CGT6297 in a first-in-human study in advanced solid tumors harboring *PIK3CA* mutations (NCT07383506).

Methods: This Phase 1, two-part, open-label study will evaluate safety, pharmacology, and antitumor activity of CGT6297. Phase 1a (Dose Escalation) will enroll adults with advanced *PIK3CA*-mutant solid tumors to determine the maximum tolerated or evaluated dose to be carried forward to Phase 1b. Phase 1b (Signal Seeking) will enroll adults with specific advanced *PIK3CA*-mutant solid tumors across 3 cohorts: (1) endometrial cancer, (2) HR+/HER2- or HER2-low breast cancer, (3) solid tumors ineligible for Cohorts 1/2. Antitumor activity of CGT6297 will be assessed by overall response rate. Patients (N=~50) will be administered oral CGT6297 daily in 28-day cycles.

Current Status & Future Directions: This study is currently enrolling at select sites in the United States.

EP298 / #811

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

REAL-WORLD EFFICACY AND TOLERABILITY OF PEMBROLIZUMAB-LENVATINIB IN MISMATCH REPAIR-PROFICIENT ENDOMETRIAL CANCER: A SINGLE-CENTRE RETROSPECTIVE EXPLORATORY STUDY

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[1]Segal Cancer Centre, Jewish General Hospital, Division Of Gynecologic Oncology, Montreal, Canada, [2]McGill University, Faculty Of Medicine And Health Sciences, Montreal, Canada, [3]Research Institute of the McGill University Health Centre, Montreal, Canada, [4]Lady Davis Institute for Cancer Research, Montreal, Canada

Introduction: Recurrent and metastatic mismatch repair-proficient (MMRp) endometrial carcinoma (EC) has limited treatment options. Pembrolizumab-lenvatinib is the standard second-line therapy but is associated with high toxicity, highlighting the need for real-world data on efficacy, safety, and individualized lenvatinib dosing.

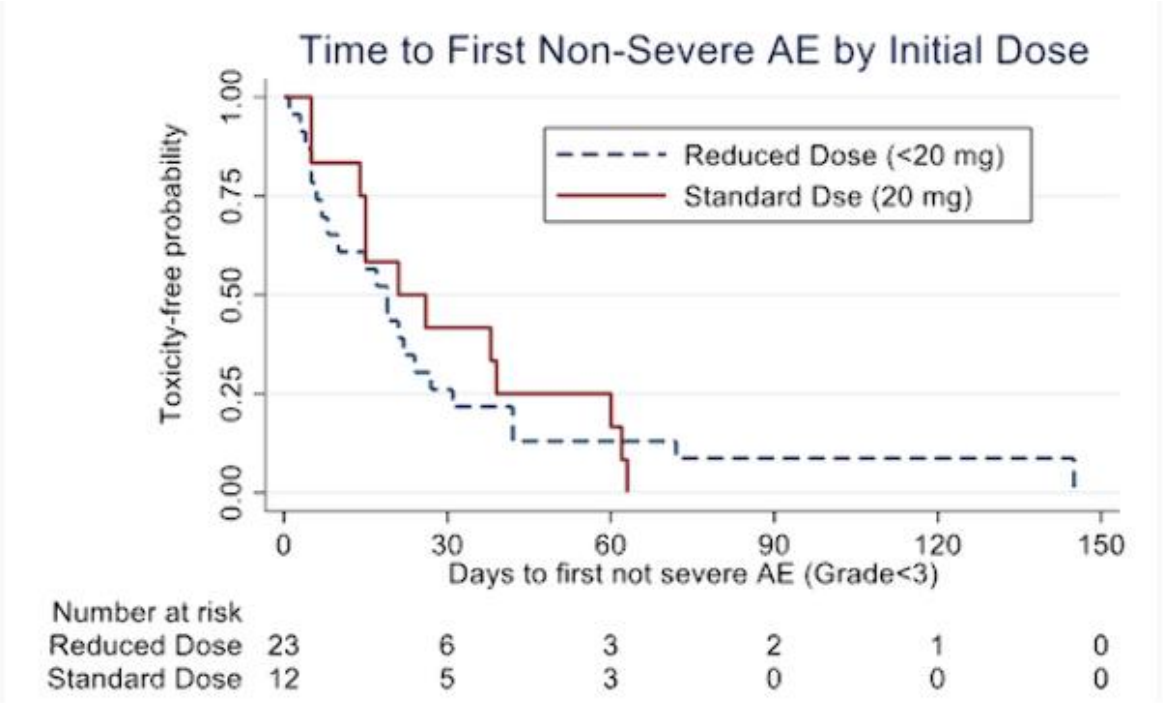
Methods: We conducted a single-institution retrospective cohort study of patients with recurrent MMRp EC treated with pembrolizumab-lenvatinib (2019-2024). Clinical characteristics, treatment patterns, adverse events (AEs), and survival outcomes were analyzed by initial lenvatinib dose (20 mg vs ≤14mg). Kaplan–Meier, log-rank, and Cox regression analyses were performed to evaluate progression-free survival (PFS), overall survival (OS), and AEs.

Results: Thirty-six patients were included (median age 65 years). Twelve initiated lenvatinib at 20 mg and 24 at ≤14 mg. Median PFS (5.1 vs 5.3 months; p=0.62) and OS (9.1 vs 9.1 months; p=0.57) were similar between dosing groups, indicating preserved efficacy with reduced dosing. 61% of patients experienced grade ≥3 AEs, most commonly hypertension (44%) and pain (11%), with earlier onset among patients starting at 20 mg (42 vs 132 days). Compared with KEYNOTE-775, survival outcomes were shorter but toxicity substantially lower (median PFS 6.6 months; median OS 17.4 months; 88.9% grade ≥3 AEs). These findings are consistent with previous real-world data, including the MD Anderson cohort (median PFS 4.6 months; median OS 8.6 months).

Conclusion/Implications: Pembrolizumab-lenvatinib demonstrated meaningful real-world activity and manageable safety. Individualized or lower lenvatinib starting doses improved tolerability without compromising efficacy, supporting a patient-centered approach in clinical practice. Given the limited sample size, we are expanding the cohort to

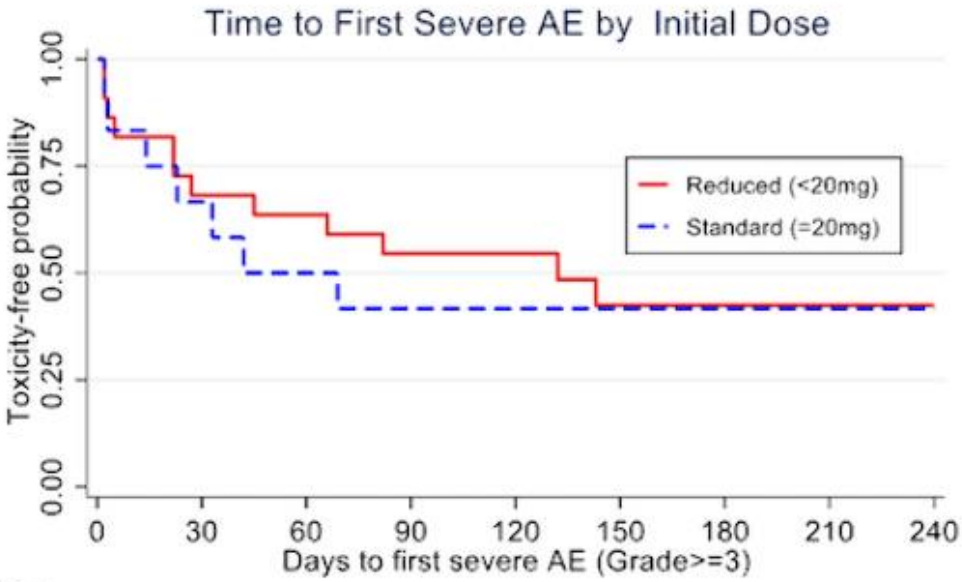
validate these
findings.

A)



Number at risk						
Reduced Dose	23	6	3	2	1	0
Standard Dose	12	5	3	0	0	0

B)



Number at risk								
Reduced Dose	22	15	14	12	9	5	4	4
Standard Dse	12	8	6	4	3	2	2	1

Characteristic	JGH real-world cohort	KEYNOTE-775 Trial	MD Anderson publication
Design	Retrospective, single centre	Phase 3 randomized, multicenter	Retrospective, single centre
Population Size	36	827	70
Median age (years)	65.8	64	65.5
ECOG			
0	12 (33.3%)	246 (59.9%)	31 (44.3%)
1	21 (58.3%)	164 (39.9%)	32 (45.7%)
2	3 (8.3%)	0	4 (5.7%)
3	0	0	2 (2.9%)
Grade			
1	0	59 (14.4%)	4 (6.2%)
2	7 (19.4%)		9 (13.8%)
3 & high-grade histology	28 (77.7%)	227 (55.2%)	52 (80%)
Initial dose	20mg: 12; <20mg: 24	20mg for all patients	14mg most common (n=45/54); 20mg (n=16)
Mean dose	12.5mg	13.8mg (median)	14.4mg
Median treatment duration	269.5 days (8.8 months)	231 days (7.7 months)	Median cycles: 5 (range 1-15)
Median PFS	5.1 months (20 mg), 5.3 months (<20mg)	6.6 months (MMRp), 7.2 months (all)	4.6 months overall, 3.2 months (20mg), 5.5 months (14mg)
Median OS	9.1 months (<20mg); 9.1 months (20mg)	17.4 months (MMRp); 18.3 months (all)	8.6 months overall, 8.6 months (20mg), 9.4 months (14mg)
ORR	38% (39% Vs 37%)	30.3% (MMRp), 31.9% (all)	36.1% all, 28.6% (20mg), 38.3% (<20mg)
High-grade AEs (%)	58% (20mg) 54% (<20mg)	88.9% 20 mg; 63% <20 mg	50% (20mg), 35.2% (<20mg) discontinuation due to AE
Most common severe AE	HTN (58%), fatigue (44%)	HTN (64%), hypothyroid (57%), diarrhea (54%), nausea (49.5%)	Fatigue, anorexia, GI, hematologic (higher at 20mg)
Dose reduction (starting dose 20mg)	30 (83.3%)	270 (66.5%)	10 (62.5%)
Dose reduction (starting dose <20mg)	13 (54.1%)	NA	20 (37%)
Statistical Links	No PFS/AE differences by dose	No randomized dose comparison	No significant OS/PFS difference by dose
Comments	Individualized dosing supported	Protocol: fixed dose	14mg dose: improved tolerability, similar efficacy

EP299 / #494

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

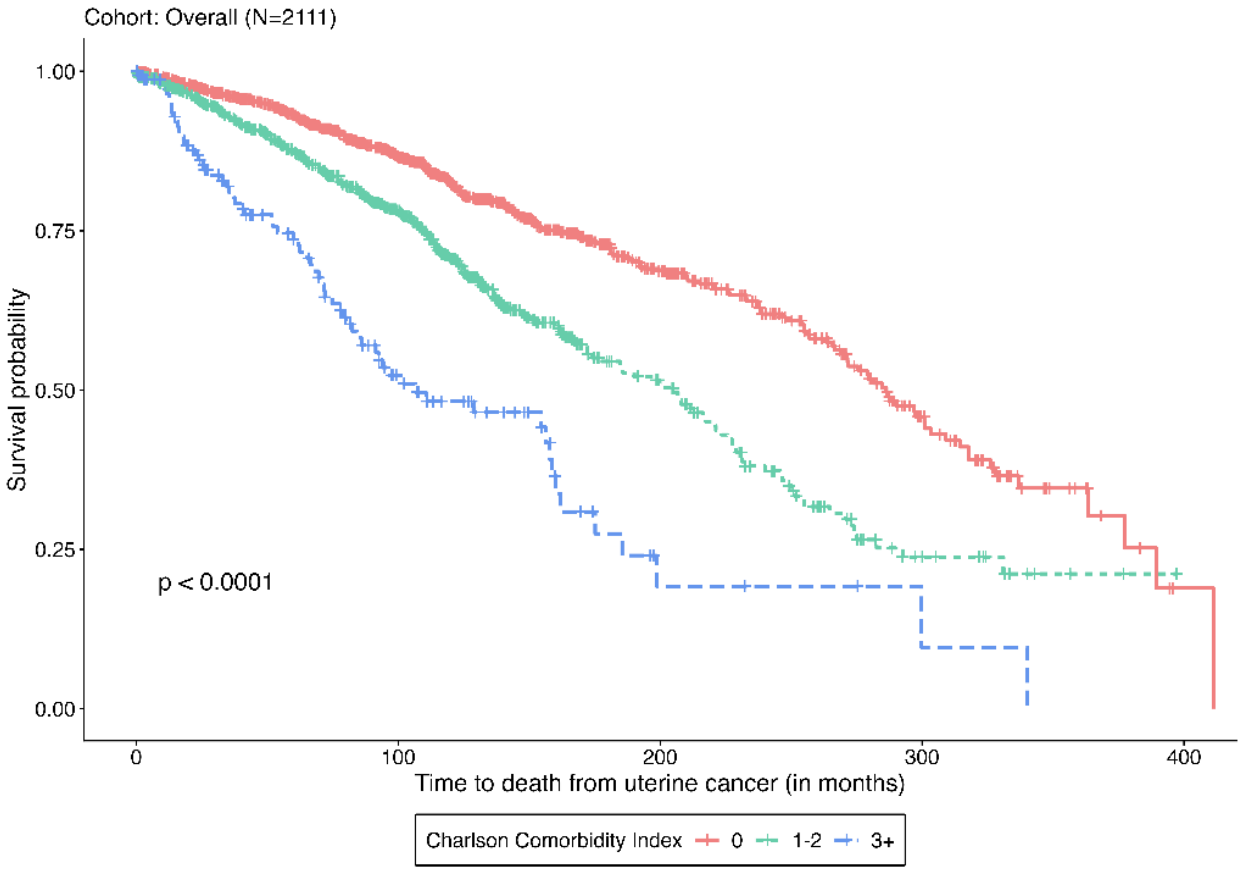
THE PROGNOSTIC IMPACT OF CHARLSON COMORBIDITY INDEX AND BODY MASS INDEX ON OUTCOMES OF WOMEN WITH EARLY ENDOMETRIAL CARCINOMA. A SINGLE INSTITUTION EXPERIENCE

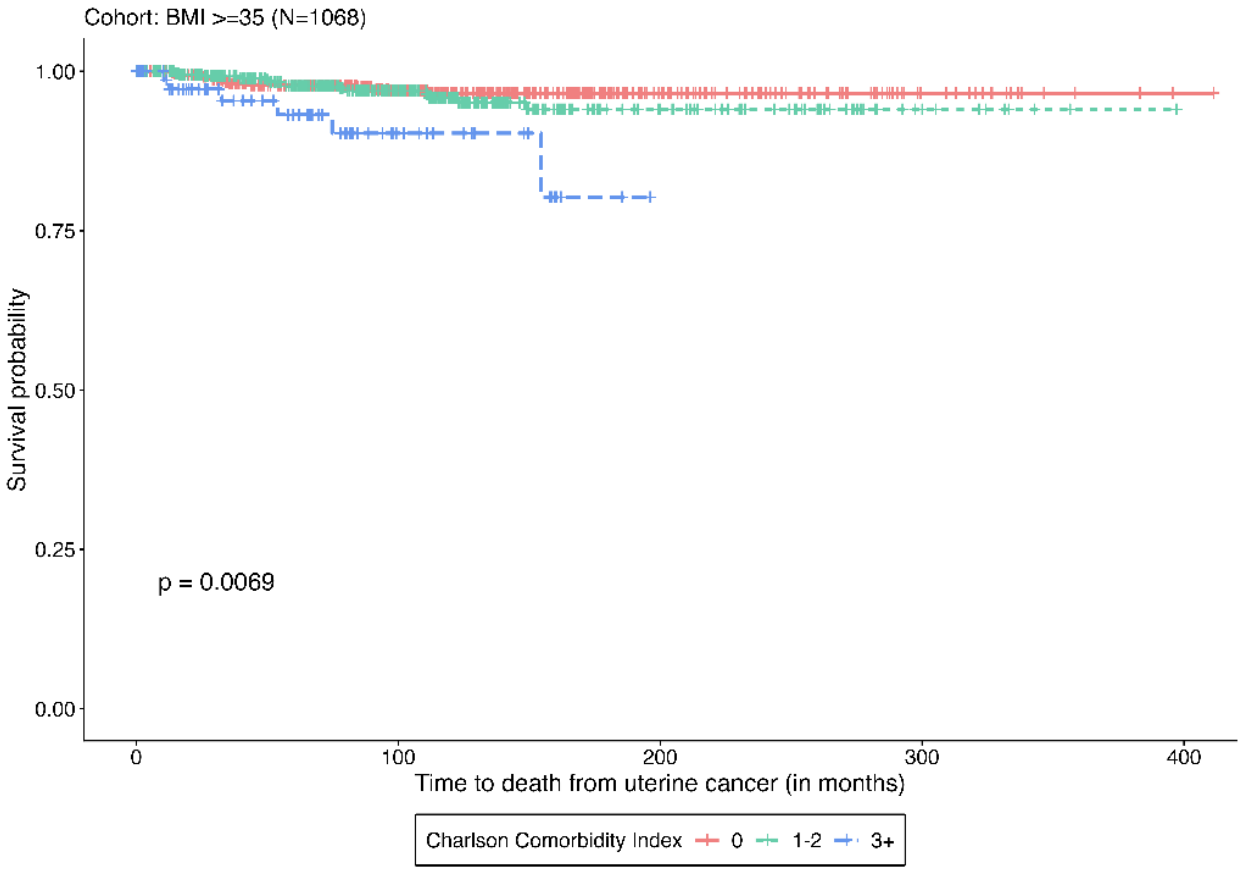
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Introduction: To explore the prognostic impact of the Charlson Comorbidity Index (CCI) and body mass index (BMI) on outcomes for women with 2009-FIGO stage-I uterine endometrioid carcinoma (EC).

Methods: In addition to pathologic variables, CCI scores and BMI at the time of hysterectomy were calculated for stage-1 patients who underwent hysterectomy between 1990-2025. Three groups were created based on CCI score. Recurrence-free (RFS), disease-specific (DSS) and overall (OS) survival was compared between groups, and multivariate Cox regression analyses (MVA) were performed for predictors of outcomes.

Results: 2110 patients were identified with a median age of 62 years, and median follow-up of 118 months. Median BMI was 35.2, high FIGO-grade was 7.8%, stage IB was 21.3%, and 28.5% received radiation. 1165 patients (55.2%) had CCI score-0, 784 (37.1%) had CCI 1-2, and 162 (7.7%) had CCI of 3+. CCI-groups were well-balanced except that higher CCI was associated with advanced age ($p<0.001$) and higher BMI ($p<0.001$). Five- and 10-year OS were significantly worse with CCI-3+ vs 1-2 vs 0 (73.6% and 48.2% vs 87.3% and 70.6% vs 93.2% and 82.5%, respectively; $p<0.001$, Figure-1); whereas RFS and DSS were non-different. On MVA, higher CCI (HR[CI]: 1.32[1.25-1.38]) and higher BMI (HR[CI]: 1.01[1-1.02]) predicted worse OS; and within BMI>35, CCI-3+ predicted worse DSS ($p=0.0069$; Figure-2). Classic prognostic factors such as older age, the presence of lymphovascular space invasion, higher FIGO-grade and -stage were independently detrimental for survival endpoints.


Cohort: Overall (N=2111)
1.00
0.75
0.50
0.25
0.00
Survival probability
p < 0.0001
0
100
200
300
400
Time to death from uterine cancer (in months)
Charlson Comorbidity Index
0
1-2
3+



Conclusion/Implications: Increased CCI and BMI are more important than classic pathological features for predicting overall survival for women with stage-I EC.

EP300 / #937

Topic: *AS06. Tumor Types / AS06b. Endometrial & Uterine Corpus Cancers*

IMPACT OF PATIENT, ONCOLOGIC AND SURGICAL FACTORS ON POSTOPERATIVE SURGICAL SITE INFECTION IN ENDOMETRIAL CANCER

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Introduction: Surgical site infection (SSI) is the most common post-operative complication following endometrial cancer (EC) staging surgery in our quaternary integrated practice unit (IPU), posing a significant burden to the patient and healthcare system. We aimed to identify predictors associated with SSI as targets for future quality improvement initiatives.

Methods: This is a single-centre retrospective review of prospectively collected consecutive EC cases at a quaternary IPU between January 2023-September 2024. The site maintains a quality dashboard of EC patients undergoing primary staging surgery with a gynecologic-oncologist. Electronic medical records were reviewed to collect clinicopathologic and outcome variables. Infections affecting the surgical site within 30 days were considered. Data were analysed using

Results: Sample size was *n*=362, with 38 SSI events (total 10.5%; 31.6% organ/deep space, 68.4% superficial). See Table 1 for characteristics. Patients with SSI had significantly higher BMI (36±11 vs. 30±8kg/m^2, p=0.0009), open surgical approach (31.6% vs. 16.1%, p=0.02), longer surgical duration (2.6±0.9 vs. 2.1±0.7 hours, p<0.001), larger pathologic tumor size (4.9 vs. 4.0cm, p=0.008), greater pathologic tumor stage (p=0.04) and greater FIGO stage (p=0.02). After multiple logistic regression, BMI, FIGO stage, nodal involvement, and surgical duration remained associated with increased odds of SSI (p<0.01 for all). No significant differences were observed for age, diabetes, histology, or molecular

classification.

Table 1. Case characteristics, data presented as mean (±SD) or as n (%)

SSI	Yes	No	Total
Total	**38 (100%)**	**324 (100%)**	**362 (100%)**
Age	67.08 (±9.74)	67.98 (±9.80)	67.88 (±9.78)
BMI	36.23 (±10.97)	30.45 (±8.60)	31.05 (±9.04)
Diabetes	10 (26.32%)	64 (19.75%)	74 (20.44%)
Diagnosis			
Endometrioid grade 1	7 (18.42%)	59 (18.21%)	66 (18.23%)
Endometrioid grade 2	8 (21.05%)	85 (26.23%)	93 (25.69%)
Endometrioid grade 3	7 (18.42%)	49 (15.12%)	56 (15.47%)
Serous	6 (15.79%)	73 (22.53%)	79 (21.82%)
Other*	10 (26.32%)	58 (17.90%)	68 (18.78%)
Molecular classification			
MMRd	18 (47.37%)	124 (38.27%)	142 (39.23%)
NSMP	6 (15.79%)	65 (20.06%)	71 (19.61%)
p53 MUT	12 (31.58%)	124 (38.27%)	136 (37.57%)
POLE MUT	2 (5.26%)	11 (3.40%)	13 (3.59%)
FIGO Stage			
I-II	23 (60.53%)	250 (77.16%)	273 (75.41%)
III-IV	15 (39.47%)	74 (22.84%)	89 (24.59%)
TNM staging (tumor)			
T1a/T1b	24 (63.16%)	252 (77.78%)	276 (76.24%)
T2/T3a/T3b	14 (36.84%)	72 (22.22%)	86 (23.76%)
TNM staging (node)			
N0	25 (65.79%)	229 (70.68%)	254 (70.17%)
Other (N1,N1A, N2A, Unknown)	13 (34.21%)	95 (29.32%)	108 (29.83%)
Type of procedure			
Open	12 (31.58%)	52 (16.05%)	64 (17.68%)
Minimally invasive (laparoscopic and robotic)	26 (68.42%)	272 (83.95%)	298 (82.32%)
Duration of procedure (hours)	2.64 (±0.94)	2.07 (±0.66)	2.13 (±0.71)
Length of stay (days)	4.58 (±9.81)	1.73 (±1.92)	2.02 (±3.73)
Method of lymph node dissection			
No	6 (15.79%)	41 (12.65%)	47 (12.98%)
Yes, full	11 (28.95%)	87 (26.85%)	98 (27.07%)
Yes, sentinel	21 (55.26%)	196 (60.49%)	217 (59.94%)

*Note: Other includes carcinosarcoma, clear cell, mesonephric, mixed and other

Conclusion/Implications: Higher BMI, advanced disease burden, and longer surgical duration were associated with SSI among patients undergoing surgery for EC. These findings support patient risk stratification and may offer targets for SSI reduction strategies.

EP301 / #813

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

KELIM SCORES AND PLATINUM RESPONSE FOLLOWING PARP INHIBITOR EXPOSURE IN ADVANCED RECURRENT OVARIAN CANCER: A REAL-WORLD COHORT STUDY

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Introduction: KELIM score, a CA-125–derived kinetic assessment, reflects tumor platinum chemosensitivity in epithelial ovarian cancer and is associated with oncologic outcomes following primary platinum-based chemotherapy. Its prognostic value in real-world populations after PARP inhibitor (PARPi) exposure remains understudied.

Methods: We conducted a retrospective cohort study of 50 patients with advanced epithelial ovarian cancer treated at The Ottawa Hospital between May 2019 and November 2024. KELIM scores were calculated using a validated online calculator based on early CA-125 kinetics during first-line platinum-based chemotherapy. Patients were divided into favorable and unfavorable groups using a cutoff of 1. Progression-free survival (PFS) and overall survival (OS) were evaluated. A predefined subanalysis compared response to second-line platinum-based chemotherapy at first recurrence in patients previously exposed to PARPi versus PARPi-naïve patients. Descriptive and survival statistics were used.

Results: Fifty patients were included. Median PFS from initiation of first-line chemotherapy was 15.6 months, and median OS was 42.3 months. Patients with favorable KELIM (>1) had longer PFS than those with unfavorable scores (15.6 vs 13.3 months). Among patients receiving subsequent platinum-based chemotherapy at first recurrence, prior PARPi exposure was associated with lower response rates compared to PARPi-naïve patients (11/24 [45.8%] vs 6/7 [85.7%]). Median follow-up was 26.7 months.

Conclusion/Implications: KELIM score is a potential prognostic stratification indicator in advanced epithelial ovarian cancer and may serve as a dynamic, clinically accessible marker of chemosensitivity. Prior PARPi exposure may result in reduced subsequent platinum responsiveness. These findings are hypothesis-generating and warrant further validation. Data collection is ongoing and final results will be presented.

EP302 / #399

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

REAL-WORLD TOLERABILITY AND MANAGEMENT OF OLAPARIB IN HIGH-GRADE EPITHELIAL OVARIAN CANCER: A RETROSPECTIVE ANALYSIS

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Introduction: Olaparib is an effective targeted therapy in selected high-grade epithelial cancers (HGEOC), but treatment-limiting toxicities can necessitate dose modification or interruption. We describe the toxicity profile and treatment-management actions recorded among patients receiving adjuvant olaparib in HGEOC.

Methods: This is a retrospective real-world cohort study of patients with ovarian cancer treated at the Cancer Center, Oman, between March 2022 and December 2025. Toxicities and tolerability of olaparib were analyzed. Anemia, thrombopenia, fatigue, dose reduction, temporary interruption, and median time to toxicity were collected.

Results: Among 22 patients on olaparib, Anemia was reported in 42.9% and thrombocytopenia in 4.8%. Fatigue was reported in 33.3%. Nausea and vomiting occurred in 17% of patients. Dose reduction occurred in 55.6%, and temporary interruption occurred in 44.4%. Time to toxicity median of 2 months (range 0–11 months). No patients stopped treatment due to toxicity. 05 patients already completed 02 years of adjuvant olaparib

Conclusion/Implications: In this real-world cohort, olaparib treatment was commonly associated with anemia and fatigue, and more than half of evaluable patients required dose reduction, with nearly half experiencing temporary interruption. The observed median time to toxicity of approximately 2 months suggests that close monitoring is particularly important in the early post-treatment period. These data provide a pragmatic snapshot of olaparib tolerability and the frequency of treatment modification in routine practice.

EP303 / #401

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

DISTINCTIVE FEATURES AND BIOMARKER PATTERNS OF PLEURAL EFFUSION AT PRESENTATION IN HIGH-GRADE EPITHELIAL OVARIAN CANCER: A RETROSPECTIVE ANALYSIS

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Introduction: Pleural effusion at presentation signals a poor prognosis in high-grade epithelial ovarian cancer (HGEOC). They had a shorter overall survival, as well as increased platinum resistance and lower first-line therapy response rates. We analyzed patients with HGEOC, focusing on those with pleural effusion at diagnosis, and evaluated their key biomarker patterns.

Methods: This is a real-world cohort study of patients with HGEOC treated at the Cancer Center in Oman between March 2022 and December 2025. We retrospectively analyzed patients with, focusing on those with pleural effusion at diagnosis, and evaluated their baseline characteristics and key biomarker patterns.

Results: 50 patients were included in our study. Pleural effusion at presentation was present of in **32%** patients. In the pleural effusion group, there was a strong co-occurrence with Ascites (93.8% of patients). ER positivity was recorded in 72.7% of patients with pleural effusion. P53 abnormality appeared frequently in the pleural-effusion group, with 92.3% versus 66.7% without pleural effusion. WT1 positivity appeared similar between groups. ARID1A alteration or loss was present only in a minority without pleural effusion, at about 12%.

Conclusion/Implications: In this cohort, pleural effusion at presentation affected about one-third of patients. It was strongly associated with concurrent ascites, indicating higher-volume serosal disease at baseline. Biomarker comparisons are exploratory due to missing data and variable denominators, but p53 positivity was notably high among patients with pleural effusion. These findings provide a practical, descriptive snapshot of the pleural effusion subgroup and underscore the need for standardized, complete biomarker reporting to support more robust subgroup comparisons.

EP304 / #908

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

GENETIC TESTING IN EPITHELIAL OVARIAN CANCER IN ARGENTINA: A MULTICENTER RETROSPECTIVE STUDY

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Introduction: Universal genetic testing is recommended for epithelial ovarian cancer, but access remains unequal in resource-limited settings. We evaluated testing uptake, mutation prevalence, associated factors, and survival in an Argentine multicenter cohort.

Methods: Retrospective cohort including adults with FIGO I-IV epithelial ovarian cancer treated during 2013-2023 in 12 Argentine hospitals invited through the Argentine Association of Gynecologic Oncology. Patients without testing information were excluded. Clinical, pathological, testing, barriers, and survival data were collected. Disease-free survival (DFS) and overall survival (OS) were estimated using Kaplan-Meier.

Results: Of 604 patients, 523 were included. Mean age was 59.1 years; 75.9% had advanced-stage disease and 79.0% had serous histology. Testing was performed in 336 patients (64.2%; 95% CI 60-68). Among cases with testing-method data, 64.8% underwent full BRCA1/2 sequencing and 34.3% multigene panel testing. BRCA1 and BRCA2 mutations were identified in 55 (16.5%) and 50 (15.0%) patients, respectively, including five with both mutations. Testing was more frequent in private than public institutions (71.1% vs. 50.8%; $p<0.001$), in serous tumors (88.6% vs. 61.8%; $p<0.001$), and in younger patients (58.1 vs. 61.1 years; $p=0.008$). Main reasons for omission were no physician request (32.1%), patient refusal (26.1%), and payer denial (25.0%). Five-year DFS and OS were 35% and 72% overall;

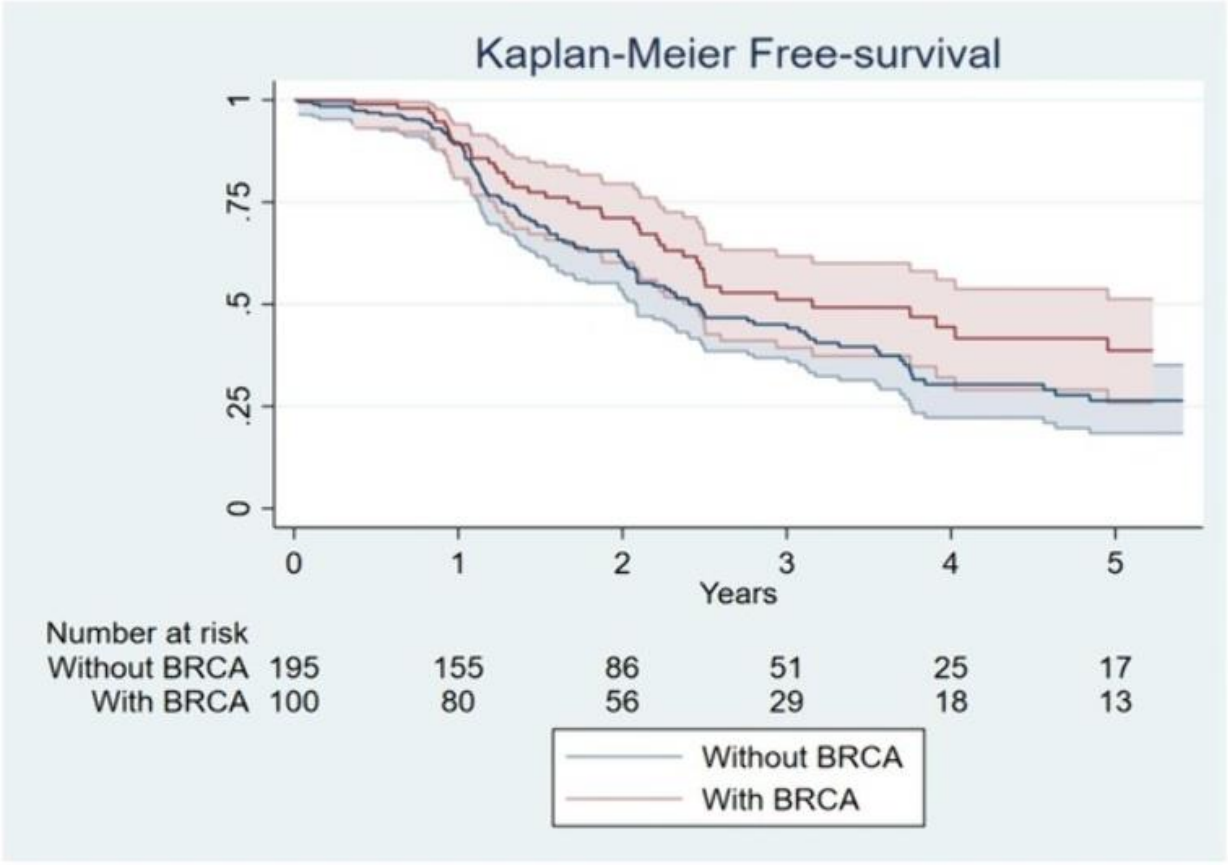
among patients with BRCA status, these rates were 39.8%/88.7% with BRCA mutations and 26.7%/67.8% without
mutations.

Table 1. Baseline clinicopathologic characteristics according to genetic testing status

Variable	All patients (N=523)	No genetic testing (N=187)	Genetic testing (N=336)	p-value
Age at diagnosis, mean (SD)	59.1 (11.8)	61.1 (13.1)	58.1 (10.9)	0.008
Initial histology, n (%)				<0.001
Serous	411 (79.0%)	115 (61.8%)	296 (88.6%)	
Endometrioid	47 (9.04%)	32 (17.2%)	15 (4.49%)	
Clear cell	27 (5.19%)	13 (6.99%)	14 (4.19%)	
Mucinous	27 (5.19%)	20 (10.8%)	7 (2.10%)	
Seromucinous	8 (1.54%)	6 (3.23%)	2 (0.60%)	
Private hospital, n (%)	334 (63.9%)	95 (50.8%)	239 (71.1%)	<0.001
FIGO stage, n (%)				<0.001
Stage I	99 (19.3%)	54 (30.0%)	45 (13.5%)	
Stage II	25 (4.87%)	13 (7.22%)	12 (3.60%)	
Stage III	317 (61.8%)	96 (53.3%)	221 (66.4%)	
Stage IV	72 (14.0%)	17 (9.44%)	55 (16.5%)	

Stage data were missing for 13 patients and histology data for 3 patients; percentages were calculated based on patients with available information.

Figure 1. Disease-free survival in patients with and without BRCA mutations



Conclusion/Implications: In this Argentine multicenter cohort, one-third of patients did not undergo genetic testing, revealing gaps in precision oncology access. Modifiable barriers support institutional protocols, provider education, and equitable funding policies to achieve universal testing.

EP305 / #329

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

INTEGRATION OF HISTOLOGIC PATTERN OF OVARIAN MUCINOUS CARCINOMAS IN CLINICAL DECISION-MAKING: A RETROSPECTIVE COHORT STUDY

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Introduction: Mucinous ovarian carcinoma (MOC) accounts for less than 3% of ovarian malignancies and tends to affect women of reproductive age. In 2014, the World Health Organization revised the histologic classification to define two subtypes—expansile and infiltrative—which exhibit distinct biological behaviors and clinical outcomes. Despite its inclusion in the 2024 NCCN guidelines, the role of the revised classification in guiding fertility-sparing surgery and adjuvant chemotherapy remains uncertain. This study aimed to further characterize oncologic outcomes and the safety of fertility-sparing surgery (FSS) in patients with early-stage MOC based on histologic subtypes.

Methods: We conducted a single-center retrospective cohort study of patients with early-stage MOC treated between 2001 and 2021. Clinical and surgical data were compared by subtype, and progression-free and overall survival were analyzed using Kaplan–Meier curves.

Results: Thirty-six patients were included (31 expansile, 5 infiltrative) with a median follow-up of 57.5 months. Most expansile tumors were stage IA (64%) and showed a trend toward improved PFS (p =0.55) whereas 80% of infiltrative tumors were stage IC or higher. Expansile tumors were more common in premenopausal patients (61% vs. 0%). FSS was performed in 29% (9/31) of the latter, 7 patients were stage IA (78%), the two other patients were stage IC1 and IC2. Recurrence rate was 22% (2/9) and occurred in both stage IA and IC2 patients, both early, distant and fatal.

Conclusion/Implications: These findings highlight the importance of thorough abdominal exploration at surgery and warrant close surveillance after fertility-sparing surgery, regardless of stage and subtype.

EP306 / #209

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

A NOVEL VISUAL-TACTILE SCORING SYSTEM FOR ACCURATE DETECTION OF RESIDUAL DISEASE DURING INTERVAL CYTOREDUCTIVE SURGERY IN ADVANCED OVARIAN CANCER.

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Introduction: Accurate intraoperative identification of residual peritoneal disease following neoadjuvant chemotherapy (NACT) in advanced epithelial ovarian cancer (EOC) remains challenging, as chemotherapy-induced fibrosis often mimics viable tumor. Reliance on subjective visual assessment results in significant misclassification, while frozen section, though accurate, is impractical for extensive peritoneal evaluation. We developed and evaluated a standardized Visual–Tactile Peritoneal Score (VTPS) to improve intraoperative decision-making.

Methods: In this prospective cross-sectional study, 87 patients with FIGO stage IIIB–IVA EOC undergoing interval cytoreductive surgery after NACT were enrolled. The VTPS, incorporating predefined visual (plaque-like thickening, nodularity, discoloration) and tactile (firmness, nodularity, adherence) parameters, was applied across pelvic, paracolic, and diaphragmatic peritoneal regions. Scores were correlated with blinded histopathological examination. Diagnostic performance was assessed using receiver operating characteristic (ROC) analysis.

Results: The majority of patients were aged 41–60 years (73.6%), with stage IIIC disease in 65.5%. Complete cytoreduction (CC-0) was achieved in 58.6%. Residual microscopic disease was identified in 46.0% (pelvic), 29.9% (paracolic), and 35.6% (diaphragmatic) regions. VTPS was significantly higher in regions with confirmed disease ($p < 0.01$). ROC analysis demonstrated excellent discriminatory ability with AUCs of 0.878 (pelvic), 0.932 (paracolic), and 0.918 (diaphragmatic). Optimal cut-offs were >6 (pelvic) and >7 (paracolic/diaphragmatic). The overall VTPS achieved sensitivity of 83.5%, specificity of 90.9%, and accuracy of 88.1%.

Conclusion/Implications: The VTPS is a practical, reproducible intraoperative tool with high diagnostic accuracy for detecting residual peritoneal disease following NACT. Its use may enhance surgical precision, guide peritoneal resection, and reduce unnecessary

morbidity, particularly in resource-limited settings. Further multicentric validation is warranted.

EP307 / #1020

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

FIRST-LINE POLY(ADENOSINE DIPHOSPHATE-RIBOSE) POLYMERASE INHIBITOR MAINTENANCE IN OVARIAN CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction: First-line poly(adenosine diphosphate-ribose) polymerase (PARP) inhibitor maintenance has transformed advanced epithelial ovarian cancer, yet mature survival and toxicity data have complicated universal adoption. We evaluated whether benefit remains clinically compelling across molecular, surgical and response-defined subgroups.

Methods: A PRISMA-aligned systematic review searched MEDLINE, Embase, Web of Science, Cochrane CENTRAL, ClinicalTrials.gov and major congress updates to February 2026. Randomized trials and prospective two-arm studies comparing first-line PARP maintenance with placebo/no maintenance after platinum response were eligible. Random-effects models pooled hazard ratios (HRs) or risk ratios (RRs) with 95%CIs, risk of bias and GRADE certainty were assessed.

Results: Seven randomized trials reported in 13 publications, encompassing 4013 patients, were included: SOLO-1, PRIMA, PAOLA-1, VELIA, ATHENA-MONO, PRIME and FLAMES. PARP maintenance significantly improved progression-free survival overall (HR 0.57, 95%CI 0.46-0.70, I2=61.1%, high certainty), with maximal benefit in BRCA-mutated (HR 0.40, 95%CI 0.35-0.45) and homologous recombination-deficient tumours (HR 0.44, 95%CI 0.39-0.50). BRCA-wildtype disease retained benefit (HR 0.62, 95%CI 0.44-0.86), whereas homologous recombination-proficient tumours did not show a robust advantage. Overall survival was not significantly improved (HR 0.94, 95%CI 0.66-1.34, moderate certainty). Severe adverse events increased substantially (RR 2.40, 95%CI 1.16-4.93), with regimen-dependent haematologic toxicity, whereas high-grade toxicity ranged from veliparib RR 1.15 to niraparib RR 4.73. Grade 3 anemia, thrombocytopenia, neutropenia and treatment interruption dominated toxicity profiles across agents, consistently observed.

Conclusion/Implications: First-line PARP maintenance delivers durable disease-control benefit but not proven survival prolongation, while materially increasing toxicity. Precision use should prioritize BRCA/HRD biology, residual-risk context, patient preference, quality-adjusted survival and access-sensitive toxicity mitigation.

EP308 / #1149

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

THE ROLE OF ROUTINE APPENDECTOMY IN MUCINOUS OVARIAN TUMORS

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Introduction: To evaluate the role of routine appendectomy in patients with mucinous ovarian neoplasms, with emphasis on identifying intraoperative predictors of appendiceal pathology.

Methods: We retrospectively reviewed patients treated at our institution from January 2021 to December 2024. Eligible patients had mucinous, mixed, or related histologies on final pathological analysis and underwent concomitant appendectomy. Clinical, surgical, and pathological data were extracted. Logistic regression was used to identify predictors of appendiceal pathology, and ROC curves assessed diagnostic accuracy.

Results: Of the 77 eligible cases, 56 were included in the final analysis. Appendiceal pathology was identified in 16 patients (28.6%), comprising mucinous neoplasms (n=13, 23.2%) and neuroendocrine tumors (n=3, 5.4%). Grossly abnormal appendices were associated with higher rates of pathology (46% vs 18% in grossly normal, OR 5.14, 95% CI 1.47–18.05, p=0.011). Presence of mucin was similarly predictive (54% vs 12.5%, OR 8.17, 95% CI 1.60–41.62, p=0.011). ROC analysis showed good discriminative ability for gross + mucin combined (AUC 0.82), with minimal improvement when frozen section was added (AUC 0.84).

Conclusion/Implications: Appendiceal pathology was present in nearly one-third of patients with pathologically confirmed mucinous tumors. Gross appearance and presence of mucin are potentially useful intraoperative predictors of appendiceal pathology, whereas frozen section was not informative. These findings favor routine appendectomy for mucinous ovarian tumors.

EP309 / #749

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

COMPREHENSIVE GENOMIC PROFILING IN OVARIAN CANCER TO IDENTIFY ACTIONABLE MUTATIONS IN A REAL-WORLD SETTING

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Introduction: In many settings worldwide, comprehensive genomic profiling (CGP) testing is not routinely performed in ovarian cancer (OC), whether due to lack of access, reimbursement limitations, or resource constraints. This information, however, is important to appropriately select patients for PARP inhibitor (PARPi) maintenance therapy. This study identifies actionable homologous recombination(HR)-related alterations beyond somatic *BRCA1/2* testing using CGP, including HR-deficiency (HRD) scoring.

Methods: This is a retrospective single tertiary centre study (Jewish General Hospital, Montreal). Tissue somatic *BRCA1/2* testing was performed through our Molecular Pathology facility. CGP tissue/plasma testing was performed using the Myriad Genetics MyChoice CDx and/or FoundationOne CDx and/or Illumina's TSO500.

Results: Since 2019, all high-grade OC patients at the JGH have had somatic *BRCA1/2* testing with a mutation rate of 28.8% (n=184). Eighty-eight of the 184 patients had CGP. Of these 88 patients, 24 (27.3%) had pathogenic/likely pathogenic *BRCA1/2* mutations, 12 (13.6%) had non-*BRCA1/2* pathogenic HR-related gene mutations, and 11 (12.5%) had elevated HRD scores without pathogenic/likely pathogenic HR-related gene mutations. This highlights a missed opportunity for PARPi selection in 13.6% (non-*BRCA* HR mutations) and in 12.5% (HRD without HR gene mutations) of patients. Of the patients with CGP, 62.5% received PARPi therapy (55/88) compared to 56.3% of patients without CGP (54/96) (OR: 1.30, p=0.453).

Conclusion/Implications: CGP with HRD scoring beyond *BRCA1/2* testing increases the proportion of patients identified to derive increased benefit from targeted PARPi therapy from 27.3% to around 53.4%.

EP310 / #511

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

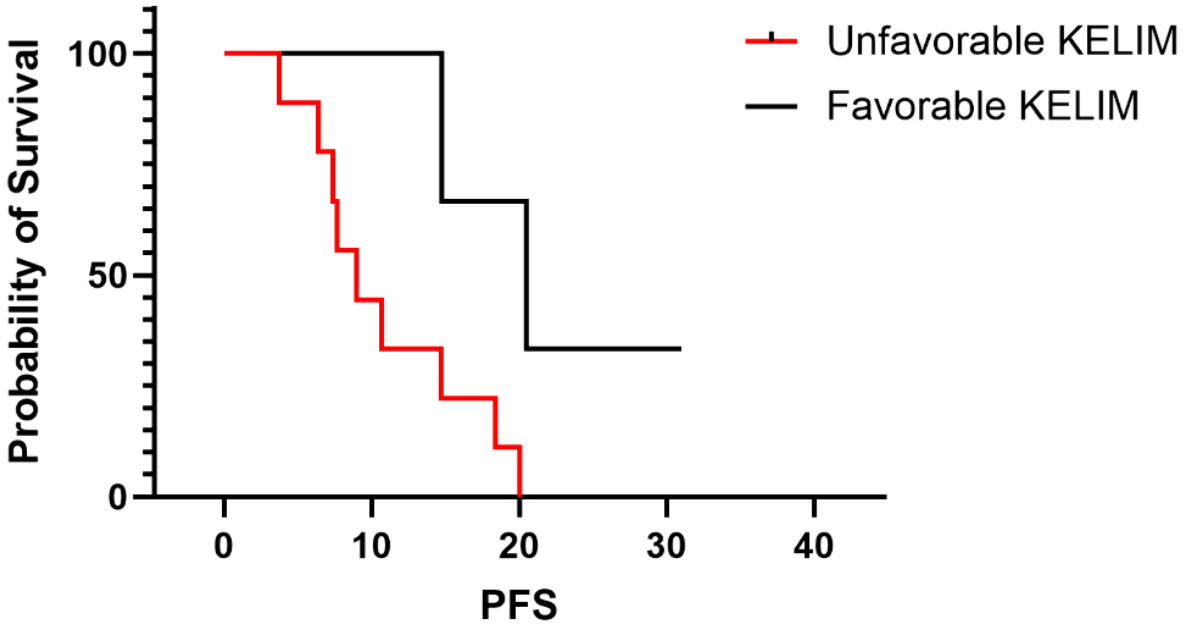
PROGNOSTIC VALUE OF KELIM IN HIGH-GRADE SEROUS OVARIAN CANCER IS RESTRICTED TO HR-PROFICIENT TUMORS

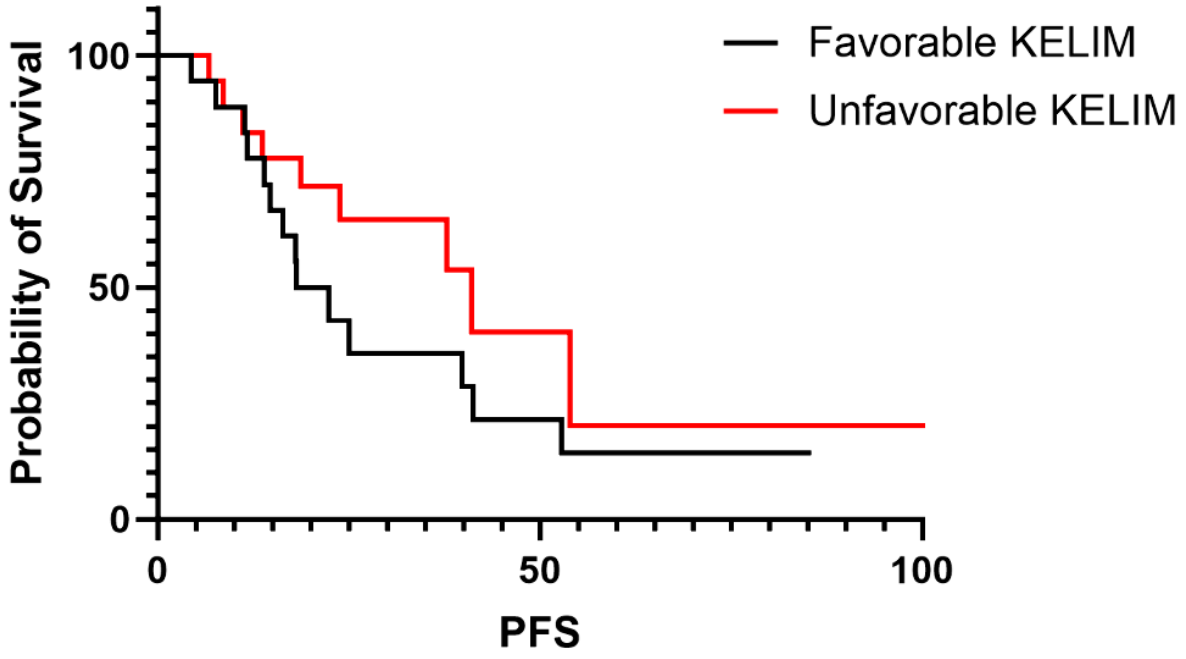
Mayerly Castrillón Sánchez[1,2], Gabriel Levin[3], Lawrie Shahbazian[3], Basile Tessier Cloutier[1,2], Laurence Bernard[3], Xing Zeng[3], Reitan Ribeiro[3], Lucy Gilbert[3], Shuk On Leung[1,2,3]
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Introduction: We aim to evaluate KELIM association with progression-free survival across homologous recombination subgroups in HGSOC.

Methods: This single-center retrospective study included HGSOC patients treated with NACT followed by interval cytoreductive surgery between 2010 and 2025. KELIM scores were categorized as favorable (≥1) or unfavorable (<1). Survival outcomes were analyzed using Kaplan–Meier and Cox proportional hazards models. Subgroup analyses were performed according to HR status (HRD/HRP).

Results: A total of 145 patients were included. Median follow-up time was 59.51 months (95% CI 43.42-97.5). When stratified by KELIM status, patients with favorable score had a median PFS of 16.6 months (95% CI 13.8–23.1) compared to 13.7 months (95% CI 10.4–18.7) in those with unfavorable KELIM (log-rank p = 0.20). In multivariable Cox analysis including KELIM, HR status, and their interaction, HR status remained strongly associated with improved PFS (HR 0.04, 95% CI 0.004–0.38, p < 0.01). In subgroup analysis, among HRD tumors, KELIM was not associated with improved PFS (log-rank p = 0.22), with a median PFS of 20.3 months (95% CI 13.9–41.3) for favorable KELIM and 41.1 months (95% CI 18.7–NR) for unfavorable KELIM. In contrast, among HRP tumors, favorable KELIM was associated with significantly improved PFS, with a median PFS of 20.5 months (95% CI 14.7–30.3) compared to 9.0 months (95% CI 3.8–18.4) for unfavorable KELIM (log-rank p = 0.0318).





Conclusion/Implications: KELIM retains significant prognostic relevance in HR-proficient tumors but has limited utility in HR-deficient disease. Integration of KELIM with HR status may improve risk stratification and support more personalized treatment strategies.

EP311 / #789

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

NEUROENDOCRINE TUMOR METASTATIC TO THE BREAST: AN ANATOMOPATHOLOGICAL DIAGNOSTIC CHALLENGE

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Introduction: Breast secondary lesions of neuroendocrine tumors (NET) are exceptional and represents a significant
diagnostic challenge.
They can clinically and radiologically mimic primary breast cancer, posing a risk of diagnostic and
therapeutic error.
This pattern highlights the complexity of the diagnostic pathway and the risk of initial misinterpretation.

Methods: We report the case of a 47-year-old female patient treated at Salah Azaiez Institute for a NET with a
metastatic isolated breast localisation discovered during follow up.

Results: A 47-year-old female patient operated at our institute for an ovarian mass. She underwent a
hysterectomy and adnexectomy; the definitive histopathological examination revealed a well-
differentiated grade 2 neuroendocrine tumour of the ovary. OctreoScan revealed two suspicious
mesenteric and right colonic foci. the patient underwent a right hemicolectomy and small bowel
resection; the histopathological examination concluded a grade 1 well-differentiated neuroendocrine
tumour.
After one year of complete remission, OctreoScan revealed a breast lesion; breast imaging confirmed
the suspicious nature of the tumour. The biopsy confirmed a metastatic site of her

previously
diagnosed neuroendocrine tumour.

Conclusion/Implications: This case illustrates the complexity of the diagnostic pathway for NETs and the need for an integrated
clinical and pathological approach.
Immunohistochemistry plays a central role in the diagnostic process, enabling the distinction between
a secondary site and a primary breast tumour. Functional imaging also plays an essential role in
assessing disease extent, detecting occult lesions and monitoring disease progression.

EP312 / #623

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

CONSTRUCTION OF A SYNTHETIC EXTERNAL CONTROL ARM IN HRD NEGATIVE OVARIAN CANCER USING REAL WORLD DATA: INITIAL DATA SET DEVELOPMENT AND FEASIBILITY ASSESSMENT

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Introduction: Phase III randomized trials remain the gold standard for drug development and regulatory approval but are resource intensive and can lead to patient dissatisfaction when randomized to SOC. Extensive real-world evidence exists for patients following frontline chemotherapy for advanced ovarian cancer. (OC) We propose leveraging this data to develop a synthetic control arm (SCA) as an alternative to traditional randomization. This approach has generated interest among investigators, sponsors and patient advocacy groups

Methods: This observational study uses deidentified EMR data to assess feasibility of a SCA in advanced OC. We mimicked phase III eligibility criteria from contemporary frontline maintenance trials to develop a real-world cohort benchmarking a control arm used in a randomized trial. Inclusion criteria: newly diagnosed stage III/IV OC, HRD negative, completion of 4-6 cycles of platinum taxane chemotherapy, primary or interval debulking surgery and PARPi ineligible. Extracted data include age, race, histology, stage, surgery, bevacizumab use, ECOG and OS

Results:

Inclusion criteria	Number of patients
Newly diagnosed Stage III or IV epithelial ovarian, fallopian tube, or primary peritoneal cancer during the identification period (1 January 2018 to 31 December 2024).	6,653
Patients tested for HRD/LOH/GIS	2,026
Confirmed homologous recombination deficiency (HRD) negative status	1,438
Age ≥18 years on the index date	1,438
Treated with platinum/taxane combination frontline chemotherapy	799
Receipt of at least 4 cycles but no more than 6 cycles of platinum/taxane combination frontline (1L, adjuvant, neoadjuvant) chemotherapy (with the index date as the date of frontline platinum-based chemotherapy start)	584
History of debulking surgery (PDS or IDS)	489

Exclusion criteria	Number of patients
HRD positive or unknown HRD status	489
Mucinous ovarian cancer, pure sarcomas, or borderline tumors.	483
Recurrent ovarian cancer	483
Receipt of any PARP inhibitor maintenance therapy or immunotherapy (defined in appendix)	209
Clinical trial patients	**184**

Treatment & Outcomes

Maintenance Therapy

Bevacizumab: 73 (39.7%)

No Maintenance: 111 (60.3%)

Overall Survival (%)

Bevacizumab	No Maintenance
12 mo: 97.3	12 mo: 90.1
24 mo: 80.8	24 mo: 74.5
36 mo: 68.3	36 mo: 66.6
60 mo: 41.9	60 mo: 55.0

Key Insight: Similar early survival; no clear long-term advantage

6653 patients with advanced OC were identified (2018-2025) Of 1,438 HRD negative

patients, 184 met criteria. Demographics matched RCT except histology. (58% high grade serous) OS in table 2.

Conclusion/Implications: This is the largest public data set of biomarker selected HRD negative ovarian cancer patients who received bevacizumab or no treatment after frontline chemotherapy. This study highlights both the value and inherent challenges of real-world data including inconsistent biomarker testing, heterogenous treatment patterns and incomplete outcome capture. Despite these limitations, this work demonstrates the feasibility of constructing a meaningful SCA and highlights the path toward reducing reliance on traditional randomization.

EP313 / #964

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

TREATMENT PATTERNS AND SURVIVAL OUTCOMES IN ADVANCED EPITHELIAL OVARIAN CANCER: A MULTICENTER ARGENTINE COHORT STUDY

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Introduction: Cytoreduction is a key prognostic factor in advanced epithelial ovarian cancer. Real-world Latin American data comparing primary cytoreductive surgery (PCS) and neoadjuvant chemotherapy with interval cytoreductive surgery (NACT-ICS) remain limited. We evaluated survival outcomes by treatment strategy and residual disease in an Argentine cohort.

Methods: Retrospective study of advanced ovarian cancer (FIGO III-IV) patients treated between 2010 and 2024 across 13 institutions, categorized into: PCS R0, PCS R>0, NACT-ICS R0, NACT-ICS R>0, and no surgery (NS). PFS and OS were estimated by Kaplan–Meier and log-rank test.

Results: 411 patients were included; 91.2% had serous histology and 82.2% FIGO stage III. Three- and five-year OS were 76.8% (95% CI 71.4–81.3) and 62.2% (95% CI 55.1–68.6). PCS showed superior OS: 85.3% (95% CI 78.1–90.4) and 75.2% (95% CI 65.4–82.6) versus 76.1% (95% CI 67.1–82.9) and 55.5% (95% CI 41.9–67.0) for NACT-ICS (p=0.027). Stratified by residual disease, 3- and 5-year OS were 90.2% (95% CI 82.3–94.6) and 84.6% (95% CI 74.1–91.1) for PCS R0, 67.4% (95% CI 48.4–80.7) and 56.2% (95% CI 34.8–72.9) for NACT-ICS R>0, and 53.9% (95% CI 37.2–67.9) and 35.9% (95% CI 20.1–52.0) for NS (p<0.001). Median PFS was 26.2 months; 3- and 5-year PFS were 37.0% (95% CI 30.9–43.0) and 26.2%

(95% CI 20.1–32.6), favoring PCS: 46.8% (95% CI 38.1–55.0) and 32.9% (95% CI 24.1–41.9) versus 25.0% (95% CI 17.0–33.7) and 18.5% (95% CI 11.0–27.6) for NACT-ICS (p=0.004).

	Total (n= 411)	**PCS (n= 170)**	**NACT-ICS (n= 164)**	**NS (n= 77)**
Age, y, mean (SD)	60.5 (10.8)	58.6 (11.3)	60.1 (10.3)	65.8 (9.1)
CA 125, U/mL, media (IQR)	n=354 647.3 (183-1800)	n= 145 301 (68-984)	n=144 982 (377-2241)	n=63 1132 (411-2517)
Histology, n (%) n = 408				
Serous	372 (91.2)	146 (85.9)	154 (95.1)	72 (94.7)
Endometroid	12 (2.9)	9 (5.3)	1 (0.6)	2 (2.6)
Clear Cell	8 (2)	6 (3.5)	1 (0.6)	1 (1.3)
Mucinous	12 (2.9)	7 (4.1)	4 (2.5)	1 (1.3)
Seromuscinous	4 (1)	2 (1.2)	2 (1.2)	0 (0)
FIGO stage, n (%)				
III	338 (82.2)	150 (88.2)	132 (80.5)	56 (72.7)
IV	73 (17.8)	20 (11.8)	32 (19.5)	21 (27.3)
Duration of surgery, min, mean (SD)	227 (80.9)	233.1 (82.9)	221.2 (78.4)	-
Residual disease, n (%)				
R 0	246 (74.1)	128 (75.7)	118 (72)	-
R >0	86 (25.9)	41 (24.3)	46 (28.1)	-

Table 1. Characteristics of Patients with Stage III—IV Ovarian Cancer

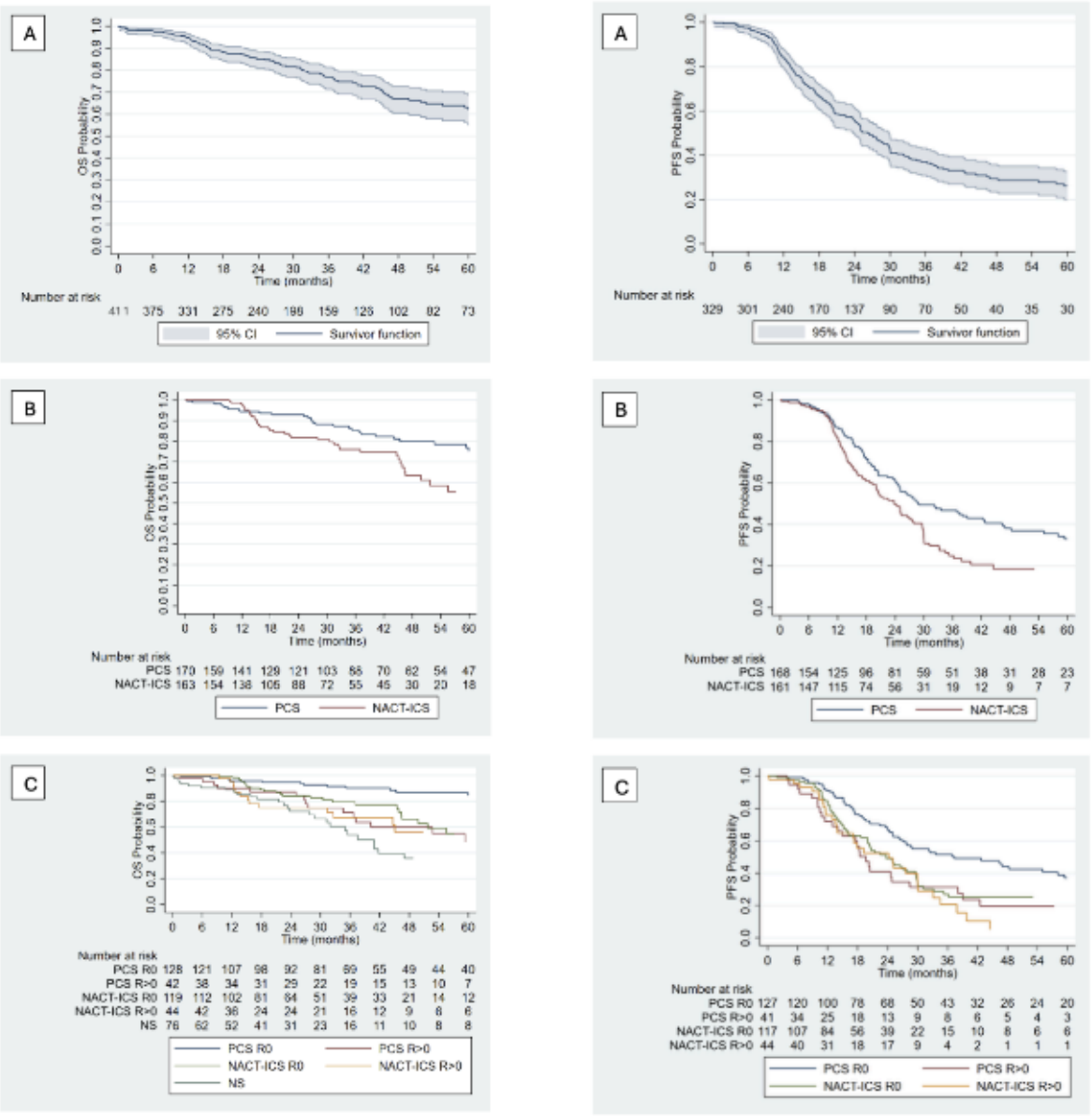


Figure 1. Kaplan-Meier estimates of overall and progression-free survival

A- Data on overall survival (a) and progression-free survival (b) are shown in the total population.
B- Data on overall survival (a) and progression-free survival (b) are shown according to treatment strategy
C-Data on overall survival (a) and progression-free survival (b) are shown according to treatment strategy and residual disease.
OS: overall survival, PFS: progression-free survival, PCS : primary cytoreductive surgery with complete resection, NACT-ICS: neoadjuvant chemotherapy followed by interval cytoreductive surgery, R0: with complete resection, R>0: with residual disease, NS: no surgery

Conclusion/Implications: PCS with R0 resection yielded the best survival outcomes, confirming residual disease as a key prognostic factor in a real-world Latin American setting.

EP314 / #679

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

REAL-WORLD SAFETY AND EFFICACY OF NIRAPARIB MAINTENANCE THERAPY IN JAPANESE PATIENTS WITH PLATINUM-SENSITIVE RECURRENT OVARIAN CANCER: JGOG3031 COHORT 1

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Introduction: Real-world data on niraparib maintenance therapy in Japanese patients remain limited. This analysis evaluated progression-free survival (PFS), overall survival (OS), and long-term safety in JGOG3031 Cohort 1.

Methods: Clinical data were collected from 67 sites. A total of 165 patients receiving niraparib maintenance for platinum-sensitive recurrent ovarian, fallopian tube, or primary peritoneal cancer were enrolled; efficacy and safety were analyzed in the efficacy evaluable population (n=159). The primary endpoint was the incidence of adverse events (AEs); secondary endpoints included PFS and OS. The study was approved by the Tohoku University Ethics Committee (approval number: 34664); informed consent was obtained.

Results: Median observation period was 32.9 months. Median age was 65.0 years, 79.7% had high-grade serous carcinoma. Treatment lines were 2nd-line (54.1%), 3rd-line (31.4%), ≥4th-line (14.5%). 35.8% were previously treated with PARP inhibitors. HRD and germline *BRCA* (g*BRCA*) testing rates were 22.6% and 43.4%, with positivity rate of 33.3% and 21.7%. Prior chemotherapy to niraparib initiation, 32.1% and 65.4% of patients achieved complete response (CR) and partial response (PR). Median PFS and OS were 7.8 months and 41.0 months. The incidence of grade ≥3 hematologic toxicities was 10.7% for thrombocytopenia, 17.0% for anemia, and 11.9% for neutropenia. Safety data will be updated. Myelodysplastic syndrome (MDS) was reported in 4 patients (2.5%).

Conclusion/Implications: With longer follow-up, no new safety signals were identified. In this real-world cohort with diverse clinical characteristics, PFS and OS were generally consistent with those reported in clinical trials, suggesting clinically meaningful benefits as maintenance therapy.

EP315 / #747

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

SURVIVAL OUTCOMES OF PARP INHIBITOR RECHALLENGE IN RECURRENT OVARIAN CANCER: A MULTICENTER RETROSPECTIVE STUDY IN JAPAN

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Introduction: Given the limited evidence supporting PARP inhibitor (PARPi) rechallenge and the potential for acquired PARP resistance, its clinical benefit remains uncertain. This study aimed to evaluate survival outcomes following PARPi rechallenge in patients with recurrent ovarian cancer.

Methods: This multicenter retrospective study included patients with recurrent ovarian cancer who underwent PARPi rechallenge at two government-designated cancer centers in Japan. Rechallenge progression-free survival (rPFS) was defined as the time from initiation of PARPi rechallenge to the start of subsequent anti-cancer therapy following disease progression. Rechallenge overall survival (rOS) was defined as the time from initiation of PARPi rechallenge to death from any cause. Survival outcomes were estimated using the Kaplan–Meier method.

Results: A total of 31 patients were included. *BRCA* mutation was identified in 9.7% of patients, and homologous recombination deficiency positivity in 35.5%. The median rPFS was 11.8 months (95% confidence interval [CI], 8.9–12.9), and the median rOS was 31.8 months (95% CI, 23.8–39.5). Disease control was observed in a subset of patients despite prior PARPi exposure. When stratified by response to the most recent chemotherapy prior to PARPi rechallenge, median rPFS was 12.0 months in patients achieving complete response (CR) and 11.3 months in those without CR.

Conclusion/Implications: PARPi rechallenge may be a feasible treatment option for selected patients with recurrent ovarian cancer, regardless of response to the platinum-based therapy prior to PARPi rechallenge. Further studies are warranted to identify factors associated with clinical benefit.

EP316 / #157

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

OVARIAN CANCER ON TIKTOK: ANALYZING MISINFORATION, AWARENESS, AND PATIENT PERCEPTIONS

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Introduction: In 2025, approximately 3,100 women in Canada were diagnosed with ovarian cancer, with an estimated 2,000 deaths. Because symptoms are often subtle and no screening test exists, many individuals seek health information online. TikTok, a video platform organized by hashtags (e.g., #OvarianCancer), is increasingly used for medical information; however, educational content and misinformation coexist. The objective of this study was to analyze the most-viewed TikTok videos under #OvarianCancer, evaluating creator type, engagement, thematic content, and alignment with guidelines.

Methods: A cross-sectional content analysis was conducted on the 250 most-viewed videos tagged #OvarianCancer between November 15 and December 3, 2025. Eligible videos were categorized by creator type, tone, engagement metrics, and thematic content. Educational content was evaluated using a modified DISCERN tool and compared with SOGC guidelines.

Results: Sixty-eight videos met inclusion criteria. Median engagement per video was 1,228 views, 664 likes, and 89 comments. Most videos were neutral in tone (81.2%), while 10.1% contained misleading information and 7.2% were alarming. Educational content appeared in 66.7% of videos; however, only 13.0% aligned with clinical guidelines. Patient-generated videos comprised the majority (n=48), followed by health influencers (n=9) and healthcare providers (n=8). Although provider-generated content more frequently aligned with guidelines, it represented a small proportion of highly viewed videos and demonstrated lower engagement.

Conclusion/Implications: Popular ovarian cancer content on TikTok reaches a substantial audience but lacks guideline-concordant information. Healthcare providers are underrepresented among highly viewed videos, and accuracy does not appear to drive engagement, highlighting the need for evidence-based strategies that also optimize reach and visibility.

EP317 / #599

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

PATTERNS OF RECURRENCE AND SUBSEQUENT TREATMENT AFTER FIRST-LINE PARP INHIBITOR MAINTENANCE IN OVARIAN CANCER

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Introduction: Recurrence patterns after first-line poly (ADP-ribose) polymerase inhibitor (PARPi) maintenance therapy in advanced ovarian cancer remain unclear. This study evaluated recurrence patterns, subsequent treatments, and clinical outcomes according to lesion number in routine clinical practice.

Methods: We retrospectively reviewed patients with advanced ovarian cancer who received first-line PARPi maintenance therapy at our institution. All patients with recurrence were included. Recurrence was classified as oligometastatic (1-2 or 3-4 lesions) or polymetastatic (≥ 5 lesions). Clinical data including recurrence sites, subsequent treatments, objective response rate (ORR) and overall survival (OS) were analyzed.

Results: A total of 46 patients were included; 9 (19.6%) had oligometastatic and 37 (80.4%) had polymetastatic recurrence. The most common sites were the peritoneum (n=24, 52.1%) and lymph nodes (n=22, 47.8%). Among oligometastatic cases, 5 had 1–2 lesions and 4 had 3–4 lesions. All patients with 1–2 lesions underwent surgery, achieving R0 resection in 4 of 5 cases, whereas systemic chemotherapy was selected for patients with 3–4 lesions. The objective response rate did not differ between patients with 3–4 lesions and those with polymetastatic disease. Patients with 1–2 lesions tended to have longer overall survival compared to those with ≥3 lesions or polymetastatic disease (169 vs. 59 months).

Conclusion/Implications: Recurrence patterns after PARPi maintenance were heterogeneous, with no predominance of oligometastatic disease. Treatment strategies differed by lesion number. Despite similar ORR, patients with 1-2 lesions showed longer OS, suggesting a distinct clinical entity.

EP318 / #675

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

EFFICACY AND SAFETY OF INTRAPERITONEAL PLATINUM WITH INTRAPERITONEAL LIPOSOMAL DOXORUBICIN FOR RECURRENT OVARIAN CANCER

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Introduction: To the best of our knowledge, there are no reports of postoperative repeated intraperitoneal injections of liposomal doxorubicin. This study aimed to evaluate the efficacy and safety of repeated intraperitoneal injections of cisplatin or carboplatin combined with intraperitoneal injections of liposomal doxorubicin for the treatment of recurrent epithelial ovarian cancer.

Methods: From January 2010 to September 2025, we reviewed the medical records of all women with recurrent ovarian cancer who received intraperitoneal cisplatin or carboplatin combined with intraperitoneal liposomal doxorubicin at a tertiary referral center.

Results: Of the 14 women enrolled, 13 were sensitive to platinum-based drugs, and the remaining one was platinum-resistant. Eight women (57%) achieved complete remission, 4 (29%) achieved partial remission, and 2 (14%) experienced disease progression, with an overall objective response rate of 86% (Table 1). The median progression-free survival and overall survival for all 14 women were 12.5 months (95% CI, 7.4 months to infinity, Figure 1) and 60.8 months (95% CI, 23.1 months to infinity, Figure 2), respectively. Toxicity was tolerable (Table 1). The most common grade 3 or 4 toxicities were neutropenia (n=5, 36%) and anemia (n=1,
7%).

Table 1. Baseline characteristics and toxicity profiles (n=14)

Variable	IP (n=14)
Age (years)	56.9±9.6
FIGO Stage	
I	2 (14)
II	1 (7)
III	10 (71)
IV	1 (7)
Histologic subtype	
Serous	10 (71)
Clear cell	2 (14)
Miscellaneous	2 (14)
2nd debulking surgery	11 (79)
Clinical response	
CR	8 (57)
PR	4 (29)
SD	0 (0)
PD	2 (13)
Progression-free survival (months)	12.5 (7.4 to infinity)
Overall survival (months)	60.8 (23.1 to infinity)

	No. of women (%) with WHO toxicity grades			
	1	2	3	4
Hematological				
Neutropenia	4 (29)	3 (21)	5 (36)	0 (0)
Thrombocytopenia	6 (43)	1 (7)	0 (0)	0 (0)
Anemia	4 (29)	9 (64)	1 (7)	0 (0)
Infection	0 (0)	0 (0)	0 (0)	0 (0)
Non-hematological				
Nausea/vomiting	13 (93)	0 (0)	0 (0)	0 (0)
Diarrhea	1 (7)	0 (0)	0 (0)	0 (0)
Stomatitis	8 (57)	0 (0)	0 (0)	0 (0)
Nephrotoxicity	3 (21)	0 (0)	0 (0)	0 (0)
Hepatotoxicity	4 (2)	0 (0)	0 (0)	0 (0)
Neurotoxicity	0 (0)	0 (0)	0 (0)	0 (0)

Figure 1. Progression-free survival

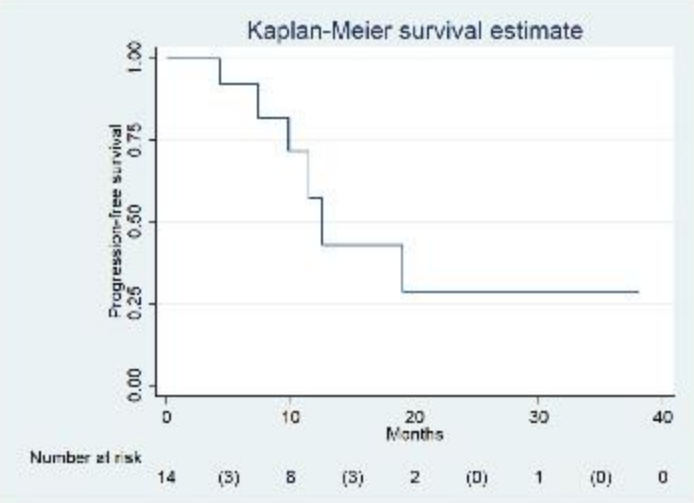
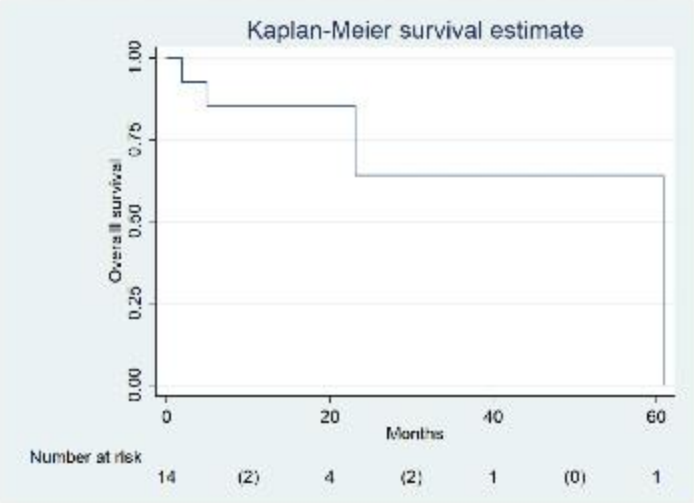


Figure 2. Overall survival



Conclusion/Implications: Intraperitoneal injection of cisplatin or carboplatin combined with intraperitoneal injection of liposomal doxorubicin appears to be a viable option for treating women with recurrent epithelial ovarian cancer.

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SEQUENTIAL CISPLATIN–NAVITOCLAX THERAPY EXPLOITS AN ADAPTIVE VULNERABILITY IN EPITHELIAL OVARIAN CANCER

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Introduction: Epithelial ovarian cancer (EOC) has high recurrence rates after platinum-based chemotherapy, largely due to adaptive tumor evolution under therapeutic pressure. While most studies focus on established resistance, the early post-chemotherapy residual phase remains an underexplored window for intervention. Adaptive responses to chemotherapy may create context-specific vulnerabilities. This study investigated whether cisplatin-induced remodeling can be exploited by sequential navitoclax to enhance therapeutic efficacy in EOC.

Methods: A genome-wide CRISPR–Cas9 sgRNA library screen was performed in EOC cells treated with multiple chemotherapeutic agents to identify adaptive vulnerabilities associated with antagonistic pleiotropy. Residual cell models after cisplatin exposure were used to assess cross-drug sensitivity. Sequential cisplatin–navitoclax treatment was evaluated using cell viability and apoptosis assays. Mitochondrial structure and function were analyzed. Therapeutic efficacy was further evaluated in xenograft and patient-derived xenograft (PDX) models.

Results: CRISPR screening identified genes with antagonistic pleiotropy across chemotherapeutic conditions, with the strongest overlap between cisplatin and navitoclax. Residual EOC cells after cisplatin treatment showed increased sensitivity to navitoclax, whereas navitoclax pretreatment did not affect cisplatin response. This effect was most evident during early adaptation and decreased with resistance. Cisplatin induced mitochondrial remodeling, including reduced oxidative phosphorylation, disrupted structure, and decreased membrane potential. Disrupting mitochondrial dynamics reproduced these effects and increased navitoclax-induced apoptosis. In vivo, sequential cisplatin–navitoclax therapy suppressed tumor growth compared with monotherapy in xenograft and PDX models.

Conclusion/Implications: Cisplatin induces mitochondrial remodeling that creates a vulnerability to navitoclax. This sequential strategy acts as an evolutionary trap to enhance therapeutic efficacy in epithelial ovarian cancer.

EP320 / #218

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

EVALUATION OF HISTOLOGICAL REGRESSION OF PERITONEAL COMPROMISE POST NEOADJUVANT CHEMOTHERAPY IN OVARIAN CANCER USING PERITONEAL REGRESSION GRADING SCORE(PRGS): EXPERIENCE FROM TWO CENTERS IN BOGOTÁ, COLOMBIA

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Introduction: Ovarian cancer(OC) remains one of the leading gynecological malignancies, both in incidence and mortality worldwide. Due to late diagnosis, generally in stages III- IV, neoadjuvant chemotherapy followed by cytoreductive surgery is a common strategy, however a consensus on the evaluation of the histological regression of peritoneal compromise is still lacking. The Peritoneal Regression Grading Score (PRGS) has been proposed as a reproducible tool to quantify tumor regression in peritoneal metastases.

Methods: An observational, retrospective, and cross-sectional study was conducted at two university hospitals in Bogotá (2016–2024). The study included 34 patients with advanced epithelial OC treated with platinum-based chemotherapy followed by cytoreductive surgery. Clinical, imaging, histological, and surgical characteristics were described using measures of central tendency and relative frequencies.

Results: The median age was 57.5 years, and the mean BMI was 23.6 kg/m^2. Most patients (79.4%) presented with FIGO stage IIIC, and 88.2% received carboplatin–paclitaxel. The median baseline CA-125 was 818.5 U/mL, which decreased to 29.7 U/mL post-treatment. The median PRGS was 3 (IQR 2.25–3.0), the Peritoneal Cancer Index (PCI) was 13 (IQR 10–18.5), and the Chemotherapy Response Score (CRS) was 2 (IQR 1–3).

Tumoral response: Surgical and histological indices		
PRGS (Peritoneal Regression Grading Score)	Median 3 (IQR 2,25–3,0)	
PRGS 1–2 (good response)	12	35,3 %
PRGS 3–4 (partial/poor response)	22	64,7 %
PCI (Peritoneal Cancer Index)	Median 13 (IQR 10–18,5)	
≤ 10 (low burden)	10	29,4 %
11–20 (intermediate burden)	20	58,8 %
> 20 (high burden)	4	11,8 %
CRS (Chemotherapy Response Score)	Median 2 (IQR 1–3)	
CRS 1 (minimal response)	9	26,5 %
CRS 2 (partial)	18	52,9 %
CRS 3 (almost complete/complete)	7	20,6 %

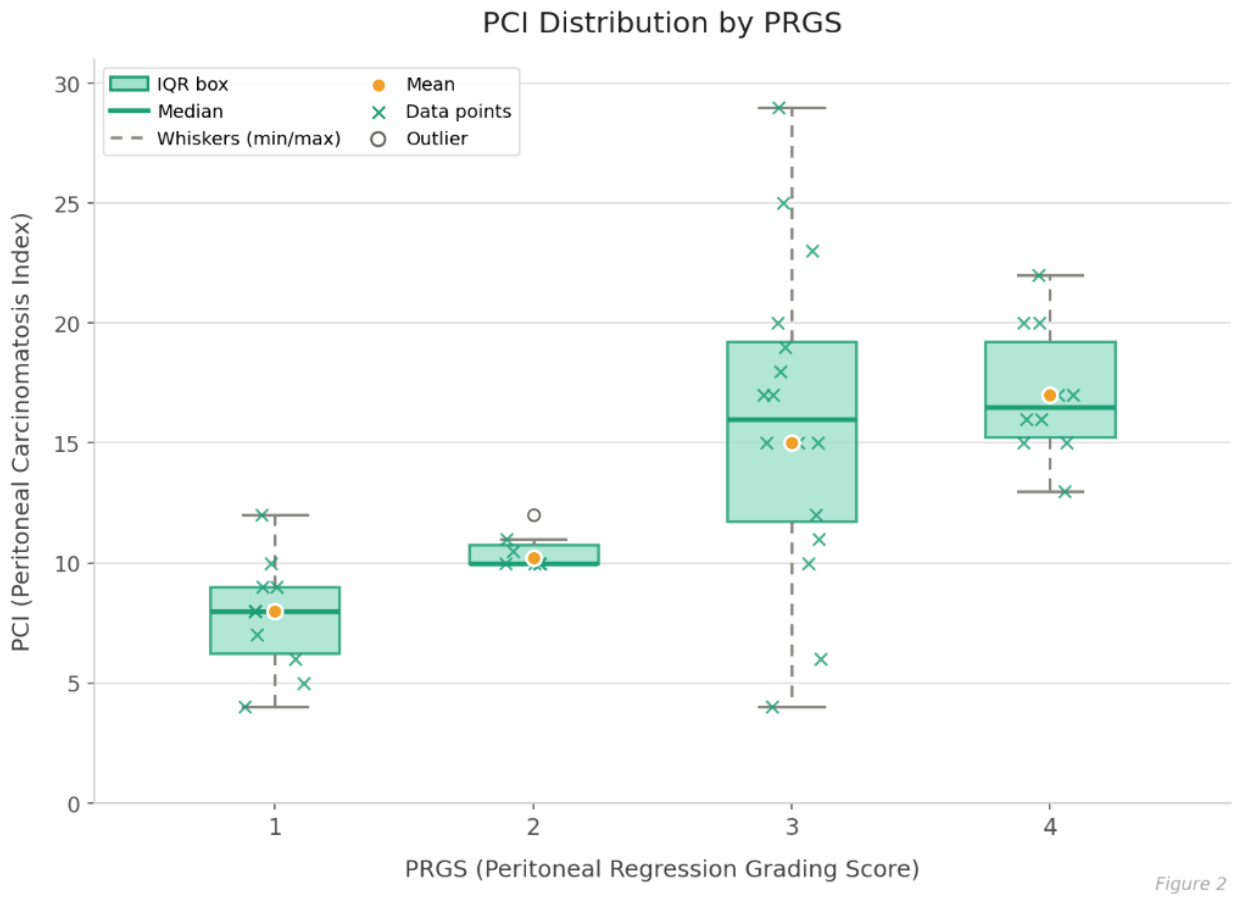


Figure 2

Conclusion/Implications: The PRGS allowed for the objective characterization of the peritoneal histological response following neoadjuvant chemotherapy, showing concordance with clinical and radiological indicators. Its implementation could strengthen the comprehensive assessment of therapeutic response in advanced ovarian cancer.

EP321 / #708

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

ROLE OF THORACOSCOPY IN SURGICAL MANAGEMEN OF ADVANCED OVARIAN CANCERS

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Introduction: The presence of pleural involvement in advanced ovarian cancer has important prognostic and therapeutic implications. Thoracoscopy offers direct visualization and opportunity to biopsy and/or resect macroscopic disease, but its role in surgical decision-making remains under-reported

Methods: Proscpective single institutional observational study.

Results: Between April 2024 and May 2025, 216 underwent CRS. A total of 32 out of 216 patients underwent thoracoscopy. Mean age: 50.8 years and most were ASA class II–III. Preoperative imaging showed pleural effusion in 87.5% and pleural deposits in 19%. Thoracoscopy influenced management in 18.75% of patients. 6 procedures abandoned due to thoracic disease, two abandoned due to abdominal disease and two abandoned due to post induction hemodynamic instability. Of the 22 patients taken forward, complete cytoreduction (CC0/1) was achieved in 100%. High-grade serous carcinoma was the predominant histology (90.6%).Eighteen patients received adjuvant chemotherapy, with a mean initiation time of 40 days. Complications were rare and minor, with no procedure-related mortality.

Conclusion/Implications: Thoracoscopy appears feasible and safe in selected patients, with potential impact on achieving complete cytoreduction with significant change in management in patients planned for curative surgery.

EP322 / #1007

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

PROSPECTIVE EVALUATION OF O-RADS MRI WITH QUANTITATIVE ADC ASSESSMENT IN ADNEXAL MASS CHARACTERIZATION IN A SINGLE TERTIARY CARE CENTRE

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Introduction: Accurate characterization of adnexal masses is essential to optimize management and avoid unnecessary invasive procedures. The O-RADS MRI system standardizes risk stratification but remains limited in indeterminate categories (O-RADS 3–4). This study prospectively evaluates the diagnostic performance of O-RADS MRI and the incremental value of quantitative apparent diffusion coefficient (ADC) analysis.

Methods: In this prospective single-centre study, 60 consecutive women with adnexal masses underwent contrast-enhanced pelvic MRI, including diffusion-weighted and dynamic contrast-enhanced sequences, between December 2023 and April 2025. Lesions were assigned O-RADS MRI scores. ADC values were measured from solid and cystic components using standardized region-of-interest analysis. Histopathology or ≥12-month imaging follow-up served as the reference standard. Diagnostic performance was assessed using sensitivity, specificity, predictive values, and ROC analysis.

Results: Of 60 lesions, 49 were benign and 11 malignant. O-RADS MRI demonstrated high diagnostic performance with sensitivity 92.3%, specificity 87.8%, PPV 75.0%, NPV 96.7%, and accuracy 89.1%. Malignancy rates increased with O-RADS category (0% for scores 1–2, 5.9% for 3, 26.7% for 4, and 66.7% for 5). The optimal ADC threshold for solid components was 0.81×10^{-3} mm^2/s (AUC 0.75), yielding 100% sensitivity. ADC values of cystic components were not significant. Integration of ADC improved characterization of indeterminate lesions and reclassified an O-RADS 3 malignancy (AUC 0.849).

Conclusion/Implications: O-RADS MRI provides robust risk stratification. Quantitative ADC assessment enhances confidence in indeterminate lesions and may reduce missed malignancies and unnecessary interventions. These findings support integration of functional imaging into structured reporting and warrant multicentric validation.

EP323 / #832

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

CLINICOPATHOLOGICAL PROFILE AND MANAGEMENT OF OVARIAN CARCINOMA: A FIVE-YEAR SINGLE-CENTER EXPERIENCE IN NEPAL

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Introduction: Ovarian cancer ranks as the third most common gynecological malignancies worldwide. Majority ovarian cancers, diagnosed at advanced stage, have poor 5-year survival rate. Management of ovarian cancer requires multidisciplinary approach integrating surgery and systemic chemotherapy, targeted therapies and palliative care in selected cases.

Methods: A descriptive study was carried out from Jan 1st 2021 to Jan 1st 2026. All histologically proven cases of ovarian carcinoma that underwent treatment at Civil Service Hospital of Nepal were included. 68 patients were included in the study who fulfilled inclusion criteria. Information on demographic profile, clinical features, FIGO stage, histopathological type, treatment modalities and outcome were obtained and analyzed.

Results: Most ovarian tumors were found in the age group 41-60 years (56%). The commonest presentation was abdominal pain (56%). 58 (85%) were epithelial ovarian cancer and serous cystadenocarcinoma was the commonest. Majority of cases presented in stage III (45.5%). 40 (59%) underwent primary staging laparotomy and 28 (41%) underwent Neoadjuvant Chemotherapy (NACT) followed by Interval Debulking Surgery (IDS), among which 10 (14.7 %) underwent Fertility Sparing Surgery (FSS). In patients operated between 3-5 years , 70.83 % have an OS of >3years and 66.67 % have a DFS of >3 years.

Conclusion/Implications: This study highlights that the majority of ovarian cancer patients presents in advanced stage. This late presentation is the main challenge, contributing to the need for early diagnosis and multimodal treatment which will ultimately impact the overall survival outcome.

EP324 / #681

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

WHEN IS AN EPITHELIAL OVARIAN CANCER PATIENT CURED? A LANCET OVARIAN CANCER COMMISSION ENDORSED PROPOSAL FOR AN INDIVIDUAL PATIENT DATA META-ANALYSIS

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Introduction: Despite improved overall survival for epithelial ovarian cancer (EOC) with innovative treatments, cure remains undefined, and clinicians lack benchmarks to counsel patients accordingly. A Lancet Commission on Ovarian Cancer has been assembled to summarize the state of clinical care and identify critical priorities in the field, including whether advanced EOC patients can be cured. To address this, we propose an individual patient data meta-analysis comprised of randomized trials in EOC published since 2000.

Objectives: Primary Objective: To determine when patients with advanced EOC are cured or at minimal risk of recurrence. This will be defined by the timepoint at which the probability of EOC recurrence within the next 12 months falls below benchmarks of 2.0%, 1.0%, and 0.5%.

Trial Design: We will systematically identify phase 3 randomized trials in EOC published since 2000 that include platinum/taxane treatment arm. Individual patient data from these trials will be obtained from contributing groups and then standardized. Cumulative recurrence risk will be calculated accounting for unrelated death and second malignancies. Key subgroups for analysis will include FIGO stage, histology, residual disease, and BRCA/HRD status when available.

Feasibility and Implementation: We plan to pool trials across international health care systems to yield benchmarks applicable to diverse patient populations. Our goal is to harness the important work tasked to the Lancet Commission to facilitate global IPD acquisition.

Conclusion: This individual patient data meta-analysis will deliver the first empirically derived, treatment-stratified definition of cure in EOC, enabling patient counseling, survivorship planning, and guideline development.

EP325 / #765

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

ONCOLOGIC RISK OF LAPAROSCOPIC CYST ASPIRATION IN LARGE OVARIAN MASSES: A MODEL-BASED ANALYSIS

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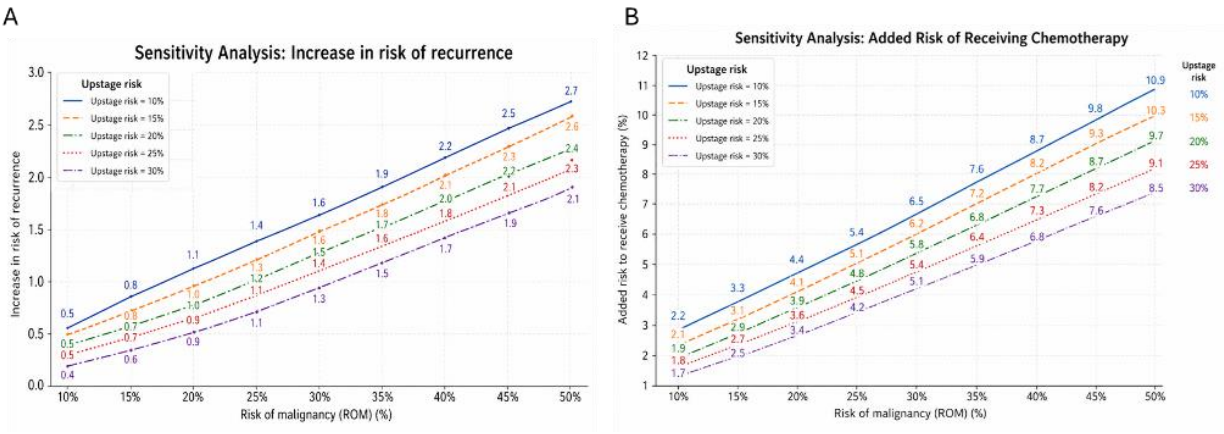
Introduction: Large ovarian masses are commonly managed with midline laparotomy, yet the oncologic impact of planned laparoscopic cyst aspiration is uncertain. Given the perioperative advantages of laparoscopy, quantitative estimates are needed to guide shared decision-making. We aimed to estimate the added risk of recurrence and chemotherapy associated with planned ovarian rupture during laparoscopic management.

Methods: A probability tree model was constructed using published data on ovarian cancer stage I sub-stages, risk of malignancy (ROM), surgical upstaging, and unplanned cyst rupture. Planned ovarian aspiration was modeled as stage migration from IA/B to IC1. Incremental risks of recurrence and chemotherapy were calculated across a range of ROM, and surgical upstaging probabilities (stage I to ≥II) and evaluated using sensitivity analyses. The IOTA model was applied to estimate ROM of ovarian masses >10 cm, without ascites, stratified by presence or absence of solid components. The primary outcome was the number needed to treat (NNT) with laparotomy to prevent one recurrence or one chemotherapy exposure.

Results: At an upstaging rate of 10% and ROM of 10%–50%, the added risk of recurrence ranged from 0.6% to 2.8%, and the added risk of chemotherapy exposure ranged from 2.2% to 10.9% (Figure 1). Simulation of 5,000 masses yielded a mean ROM of 8.7%. The NNT to prevent one recurrence was 104 for masses with solid components and 194 for those

without.

Figure 1: Estimated increased risk of recurrence (A) and risk of chemotherapy exposure (B) associated with planned cyst aspiration and laparoscopic surgery (no solid component).



Conclusion/Implications: Laparotomy for many large ovarian cysts meeting selected criteria may be avoided with minimal incremental oncologic risk; however, real-world data are needed to validate these estimates.

EP326 / #1027

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

TIME TOXICITY IN OVARIAN CANCER: A SCOPING REVIEW

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Introduction: Time toxicity is the cumulative burden of healthcare-related time expenditure during cancer treatment. It is an emerging patient-centred outcome that remains systematically unmeasured in oncology trials. Ovarian cancer carries a uniquely high time burden due to advanced-stage presentation, high recurrence rates, prolonged chemotherapy, maintenance therapy, and intensive surveillance. This scoping review maps the gaps of time toxicity in ovarian cancer treatment.

Methods: MEDLINE and Embase were searched from inception to May 2026. Following deduplication of the 50 retrieved records, 45 unique records were screened; 26 proceeded to full-text review. Eighteen studies met the inclusion criteria. Eligible studies reported healthcare contact burden, treatment time, hospitalisation duration, or patient time expenditure in ovarian cancer. English-language publications were included; case reports, editorials, letters, and conference abstracts were excluded.

Results: Six principal domains of time toxicity were identified: treatment infusion visits, maintenance therapy monitoring, surveillance and imaging, travel and logistics, hospitalisation, and repeated treatment at relapse. Hospitalisation burden was significant, with cytoreductive surgery requiring extended inpatient stays, further prolonged by major complications. Bevacizumab maintenance substantially extends healthcare contact frequency; oral PARP inhibitor maintenance, while eliminating infusion chair time, requires approximately monthly monitoring visits for up to two years. Telephone-based genetic counselling reduced travel and transportation burden without compromising outcomes. Healthcare contact days are poorly reported, and no ovarian-cancer-specific time toxicity instrument has been validated.

Conclusion/Implications: Time toxicity is a substantial, under-reported burden in ovarian cancer. Integrating time toxicity as an outcome measure in clinical trials is essential to enable treatment comparisons that reflect the true patient experience.

EP327 / #22

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

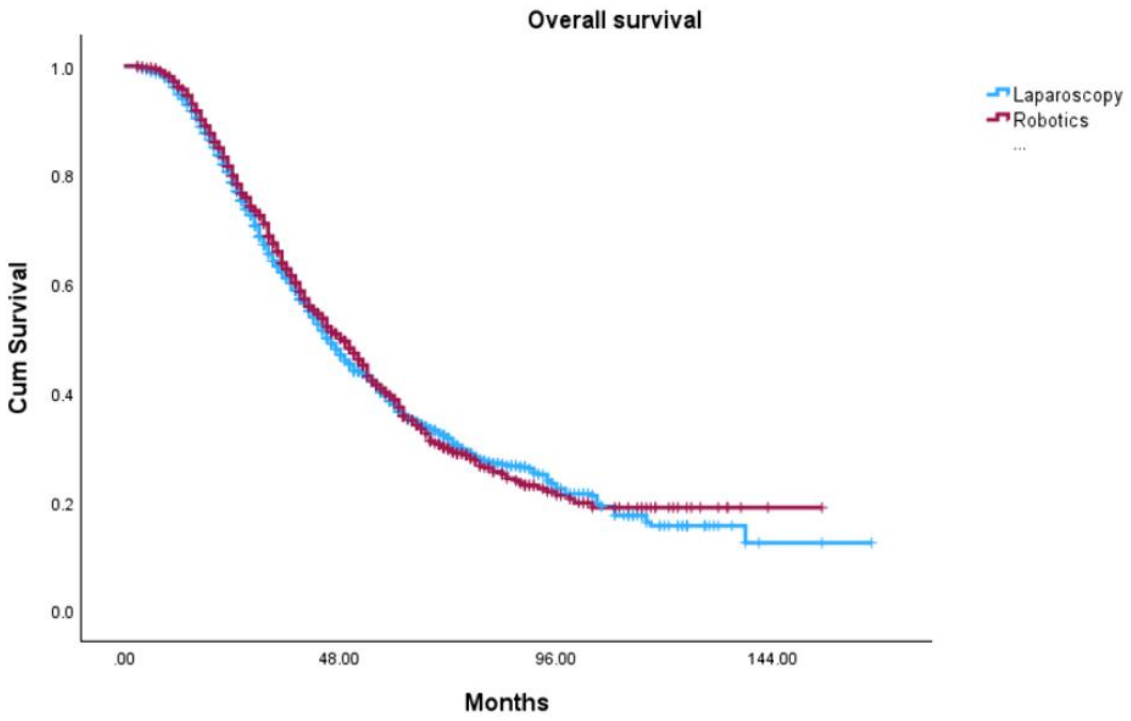
ROBOTIC COMPARED TO LAPAROSCOPIC INTERVAL CYTOREDUCTIVE SURGERY IN STAGE III OVARIAN CANCER: AN ANALYSIS OF THE NATIONAL CANCER DATABASE

Gabriel Levin[1], Nuria Agusti[2], Isabel Beshar[2], Reitan Ribeiro[3], Roni Nitecki Wilke[2], Alexander Melamed[4], Raanan Meyer[5], Jose Alejandro Rauh-Hain[2]
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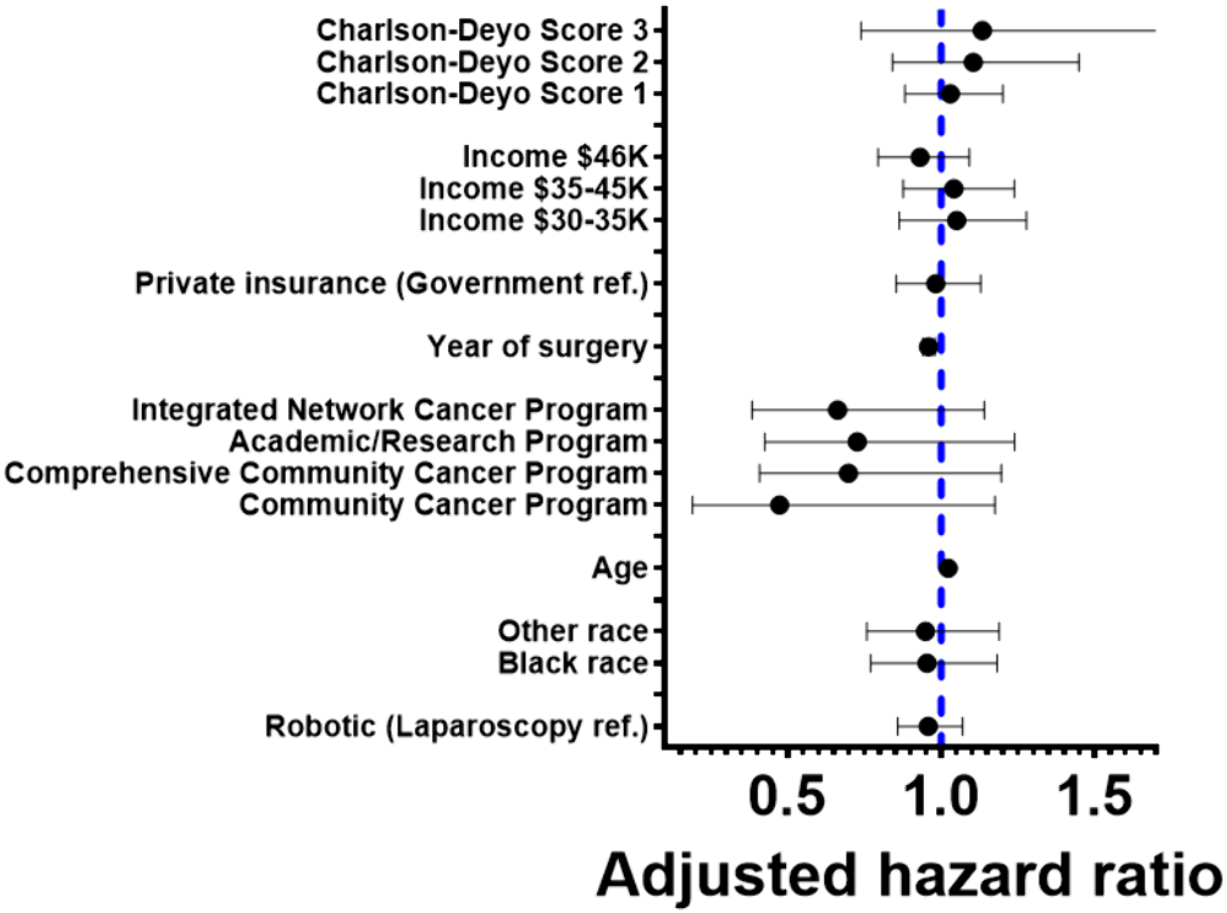
Introduction: The robotic platform may overcome inherent laparoscopy limitation], potentially improving resectability and reducing unplanned laparotomies during interval cytoreduction. However, its survival and perioperative benefits remain unknown. We evaluated overall survival, conversion rates, and short-term outcomes by surgical platform.

Methods: We conducted a retrospective cohort study using the NCDB including patients with stage III high-grade serous ovarian cancer diagnosed from 2010 to 2022. Patients were classified by surgical approach (laparoscopic or robotic), excluding those with unknown stage, surgery timing, or conversions. The primary outcome was overall survival by surgical platform; secondary outcomes included conversion rates and short-term postoperative metrics.

Results: There were 2,993 women with minimally invasive interval cytoreduction during 2010-2022: 1,462 (48.8%) laparoscopic, 1,224 (40.9%) robotic, 256 (8.6%) conversions from laparoscopic to open, and 51 (1.7%) conversions from robotic to open. The median overall survival for robotics was 48.0 months (95% CI 44.6-51.3) vs. 45.0 (95% CI 42.3-47.6) for laparoscopy, p=.57. In Cox regression, surgical platform was not associated with overall survival (adjusted HR 0.95; 95% CI, 0.85–1.07). Conversion rates were significantly lower in the robotic group (4.0% vs 14.9%, $p < .001$). Robotic surgery was associated with shorter hospital stay (2.2 ± 4.5 vs 4.5 ± 6.1 days; $p<.001$). No significant differences were observed in 30-day readmission (3.5% vs 4.1%; p=.41), 30-day mortality (0.2% vs 0.4%; p=.47), or 90-day mortality (0.9% vs 1.2%;
p=.69).



Laproscopy	1346	444	77	2
Robitics	1070	336	34	1



Conclusion/Implications: Minimally invasive interval cytoreduction for stage III HGSOC demonstrated no significant differences in survival outcomes between robotic and laparoscopic approaches, even after adjusting for relevant confounders.

EP328 / #939

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

IMPACT OF BODY COMPOSITION CHANGES ON SURVIVAL OUTCOMES IN PATIENTS WITH HIGH-GRADE SEROUS OVARIAN CARCINOMA WHO RECEIVED FIRST-LINE PARP INHIBITOR MAINTENANCE THERAPY

Hyunji Lim[1], Soo Yeon On[1], Se Lk Kim[1], Maria Lee[1], Hee-Seung Kim[1], Taek Sang Lee[2], Hyun Hoon Chung[1], Jae Weon Kim[1]
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Introduction: To investigate the impact of body composition changes during primary treatment on survival outcomes in patients with high-grade serous ovarian carcinoma (HGSOC) receiving first-line PARP inhibitor (PARPi) maintenance therapy.

Methods: This retrospective cohort study included patients with stage IIIC-IVB HGSOC who underwent primary treatment—comprising cytoreductive surgery, platinum-based chemotherapy, and first-line PARPi maintenance—between 2019 and 2024. Volumetric body composition (skeletal muscle [SM], visceral fat [VF], and subcutaneous fat [SF]) at the waist was assessed using the DeepCatch AI software, comparing CT images obtained at diagnosis with those at the initiation of PARPi maintenance. Factors associated with progression-free survival (PFS) were subsequently analyzed.

Results: A total of 113 patients were included. During a median follow-up of 29.1 months, 54 recurrences and 17 deaths occurred. From diagnosis to the initiation of PARPi maintenance, the mean changes in SM, VF, and SF were -7.02%, -17.44%, and -1.84 %, respectively. Among patients with *BRCA1/2* mutation (n=75), body composition changes showed no significant association with disease relapse. However, in the *BRCA1/2* wild-type group (n=38), SF loss was significantly associated with poor PFS (adjusted HR, 3.359; p=0.010). Furthermore, among patients receiving niraparib, a SM loss of ≥7.0% was associated with significantly worse PFS compared to those with less loss (mean, 19.0 vs. 41.7 months, p=0.030).

Conclusion/Implications: Our findings suggest that body composition changes serve as novel prognostic indicators in patients with advanced *BRCA1/2* wild-type HGSOC undergoing first-line PARPi maintenance. There are potential needs for personalized supportive care, including nutrition and exercise interventions, to mitigate muscle and fat loss during treatment.

EP329 / #400

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

BASELINE ALBUMIN-TO-ALKALINE PHOSPHATASE RATIO (AAPR) AND PROGRESSION-FREE SURVIVAL IN AN OVARIAN CANCER COHORT

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Introduction: Simple, routinely available blood-based indices may help risk-stratify ovarian cancer patients. The albumin-to-alkaline phosphatase ratio (AAPR) has been proposed as a prognostic marker in multiple malignancies, but its value in real-world ovarian cancer datasets requires further evaluation.

Methods: This is a retrospective real-world cohort study of patients with ovarian cancer treated at the Cancer Center, Oman, between March 2022 and December 2025. We used baseline AAPR as the exposure and PFS as the outcome. Analyses used complete-case pairs for AAPR and PFS. AAPR was summarized using median and interquartile range (IQR). Associations between AAPR and PFS were assessed using Spearman correlation.

Results: 42 patients were included in the study. Baseline AAPR had a median of 0.405 (IQR 0.300-0.548), ranging from 0.04 to 1.10. A higher baseline AAPR was associated with longer PFS (Spearman's rho = 0.478, p = 0.00136). In tertile analyses, median PFS increased monotonically with higher AAPR: 12.5 months in the lowest tertile (median AAPR 0.19), 15.0 months in the middle tertile (median AAPR 0.405), and 18.5 months in the highest tertile (median AAPR 0.605); the overall difference across tertiles was significant (p = 0.0200, Kruskal–Wallis).

Conclusion/Implications: In this cohort, higher baseline AAPR was significantly associated with longer PFS, both as a continuous measure and in tertiles. These findings support AAPR as a pragmatic baseline biomarker candidate for prognostic stratification in ovarian cancer, meriting confirmation in larger cohorts and in multivariable analyses adjusting for stage, performance status, and treatment strategy

EP330 / #1086

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY FOR ADVANCED OVARIAN CANCER: COMPARATIVE SHORT- AND LONG-TERM OUTCOMES FROM A RETROSPECTIVE IRISH COHORT

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Introduction: Hyperthermic intraperitoneal chemotherapy (HIPEC) has recently been included as a treatment option in guidelines for select patients undergoing cytoreductive surgery (CRS) for advanced ovarian cancer. However, uncertainty remains with regard to additive morbidity and procedural benefit. We therefore evaluated perioperative and survival outcomes for CRS, with and without HIPEC, at a tertiary referral centre.

Methods: A retrospective review was performed of patients undergoing CRS for advanced ovarian cancer. Patients were grouped according to receipt of HIPEC. Data were collated on clinical characteristics, operative variables, post-operative outcomes and survival. Surgical complexity was assessed using the Aletti Surgical Complexity Score (ASCS). Complications were graded according to the Clavien–Dindo classification system. Survival was assessed using Kaplan Meier method.

Results: A total of 302 patients underwent CRS in the studied timeframe, 30.5% (n=92/302) of which received HIPEC. When CRS was compared to CRS+HIPEC, median age (58 vs 57 years) and estimated blood loss (800 vs 700 mL) were comparable. The addition of HIPEC was associated with longer operative time (median 400 vs 240 minutes, p<.001) and a greater degree of surgical complexity basesd on ASCS score (p=.022). Major complications (Clavien–Dindo ≥ grade 3) occurred in 5.4% (n=5/92) of CRS and 9.5% (n=20/210) of CRS+HIPEC respectively (p=0.28).

Conclusion/Implications: This is the first study to comparatively assess outcomes on morbidity and survival for HIPEC in Ireland. Despite longer operative duration and associated surgical complexity, the addition of HIPEC to CRS was not associated with increased major postoperative morbidity; this supports safe implementation of HIPEC for select cases within specialist centres.

EP331 / #768

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

CANCER ANTIGEN 125 ELIMINATION KINETICS PREDICTS CYTOREDUCTIVE AND SURVIVAL OUTCOMES IN OVARIAN CANCER PATIENTS UNDERGOING HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY AT INTERVAL SURGERY

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Introduction: CA-125 elimination rate constant (KELIM) may predict which patients benefit from hyperthermic intraperitoneal chemotherapy (HIPEC), but its association with cytoreductive outcomes and its prognostic value within HIPEC-treated populations remain unclear.

Methods: Single-center retrospective cohort of FIGO stage III–IV high-grade serous ovarian cancer (HGSOC) patients treated with neoadjuvant chemotherapy (NACT), interval cytoreduction (ICS), and HIPEC (2017–2024). KELIM was calculated from CA-125 kinetics during NACT. Complete cytoreduction (CC0) rates were compared between KELIM groups. Progression-free and overall survival (PFS/OS) were measured from ICS. Cox proportional hazards regression modeled KELIM as binary (≥1.0vs<1.0) and continuous, adjusted for FIGO stage.

Results: Forty-five patients were included; median age 63, 60% stage III. Median follow-up was 37.3months. Twenty-four (53%) had KELIM≥1.0. CC0 was achieved in 93.3%: 100% with KELIM≥1 vs 85.7% with KELIM<1 (p=0.094); all three patients with residual disease (CC1) had KELIM<1. KELIM≥1 showed higher median PFS (32.2 vs 18.8months; p=0.225) and OS (93.6 vs 49.4months; p=0.493). In Cox regression, KELIM ≥1.0 was associated with reduced risk of progression (HR=0.65; p=0.229). As continuous variable (range=0.43–2.00), higher KELIM values were significantly associated with reduced risk of progression (HR=0.34;95%CI=0.12–0.97; p=0.043). The significant association persisted after adjusting for FIGO stage (HR=0.23;0.07–0.83;p=0.025). Similar results were observed for OS (HR=0.36; p=0.173).

Conclusion/Implications: HIPEC achieves high CC0 rates regardless of KELIM, however incomplete cytoreduction occurred exclusively in KELIM<1 patients. Despite the modest

sample size limiting statistical power, this study found clinically significant associations between lower KELIM values and lower PFS and OS in patients with HGSOC treated with NACT+ICS+HIPEC.

EP332 / #626

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

REPEATED PACLITAXEL EXPOSURE IS ASSOCIATED WITH MARKEDLY PROLONGED SURVIVAL IN PLATINUM-RESISTANT OVARIAN CANCER

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Introduction: In platinum-resistant ovarian cancer (PROC), the AURELIA trial suggested activity of weekly paclitaxel, but its role in real-world practice and factors associated with improved outcomes remain unclear. We evaluated paclitaxel utilization patterns and outcomes in a PROC population.

Methods: We analyzed SEER-Medicare (2008–2021), including patients with advanced ovarian cancer receiving ≥4 cycles of first-line chemotherapy. PROC was defined by platinum-free interval of 1–6 months. Patients were categorized by PROC onset after line 1 (L1), line 2 (L2), or line 3+ (L3+). Real-world overall survival (rwOS) and progression-free survival (rwPFS) were described from the time of PROC.

Results: Among 2,854 patients with PROC, 66.4% developed platinum resistance after L1, 21.6% after L2, and 12.0% after L3+. The mean age was 76.4 years. Paclitaxel use declined across lines (L1: 88.5%; L2: 22.3%; L3+: 11.4%), with 17.6% receiving paclitaxel at PROC onset. Median rwOS and rwPFS for the overall cohort were 13.2 months (95% CI: 12.6–13.9) and 7.3 months (95% CI: 6.9–7.8), respectively. A small subset (3.3%) received paclitaxel in L1–L3 and demonstrated prolonged survival, with median rwOS of 24.4 months (95% CI: 18.8–32.2). In contrast, median rwOS was 12 months in patients treated with paclitaxel in L1 only and 9.7 months in those without paclitaxel exposure across lines.

Conclusion/Implications: In this PROC cohort, repeated paclitaxel exposure across multiple lines was uncommon but associated with prolonged survival. These findings highlight the importance of treatment tolerance and warrant further study of sustained therapy and outcomes in

PROC.

Table 1. Observed real-world paclitaxel treatment patterns across LOTs and rwOS associated among PROC patients (N=2854)

Line of therapy	**Paclitaxel utilization[1] n (%)**	**Median rwOS,[2] (95% CI), months**
L1 only	1744 (61.1)	12.0 (11.1, 12.7)
L2 only	50 (1.8)	12.6 (9.0, 20.4)
L1 and L2	490 (17.2)	17.6 (15.7, 19.5)
L3 only	30 (1.1)	16.1 (12.1, 32.0)
L1 and L3	198 (6.9)	18.9 (16.0, 22.4)
L1, L2, and L3	93 (3.3)	24.4 (18.8, 32.2)
Not in L1, L2, or L3	245 (8.6)	9.7 (7.8, 12.0)

Note: The number of patients with use in L2 and L3 was less than 11, thus not reported in accordance with SEER-Medicare data use agreement.

[1] Paclitaxel utilization is defined as having at least two claims of paclitaxel at each line.

[2] Real-world overall survival relative to the index date, which was the date with the first evidence of PROC.

EP333 / #950

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

DURABLE AND TREATMENT-AGNOSTIC MUC16 EXPRESSION IN OVARIAN CANCER SUPPORTS TARGETED ANTIBODY-DRUG CONJUGATE DEVELOPMENT

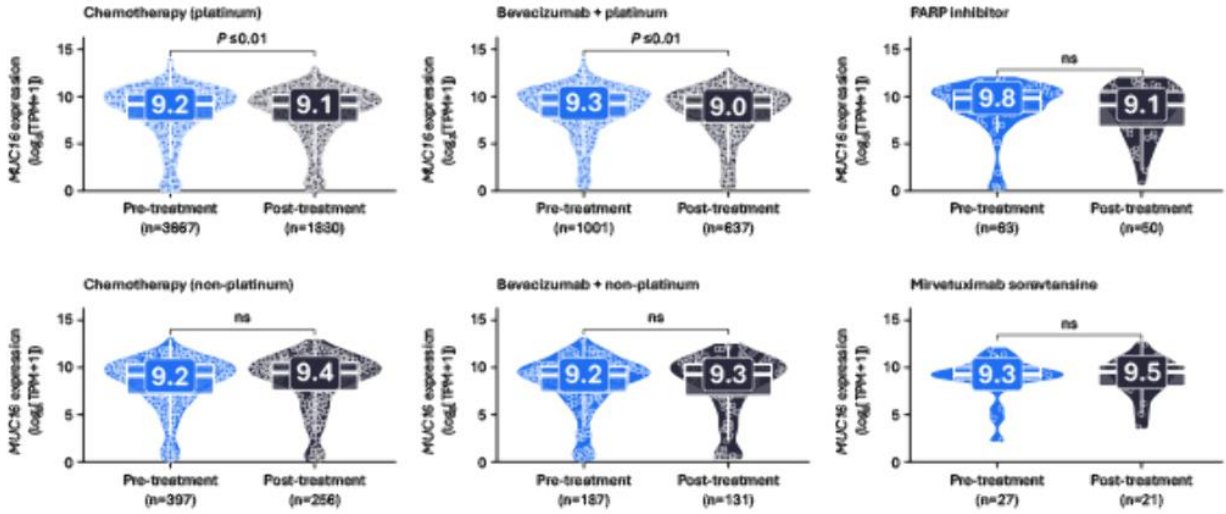
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Introduction: Mucin 16 (MUC16), a cell-surface glycoprotein involved in tumor cell proliferation, metastasis, and immune evasion, is overexpressed in ~80% of epithelial ovarian cancers (OC). Previous analyses showed that *MUC16* expression is higher than other ADC targets in OC, and remains stable irrespective of platinum-sensitivity status. This study aimed to assess *MUC16* expression, and that of other ADC targets, before and after standard-of-care treatments in OC.

Methods: RNA-sequencing data from a de-identified real-world database (Tempus AI, Inc.) were used to examine *MUC16* expression in pre- and post-treatment OC samples (3.0% matched). Median *MUC16* expression was quantified as $\log_2$(TPM+1).

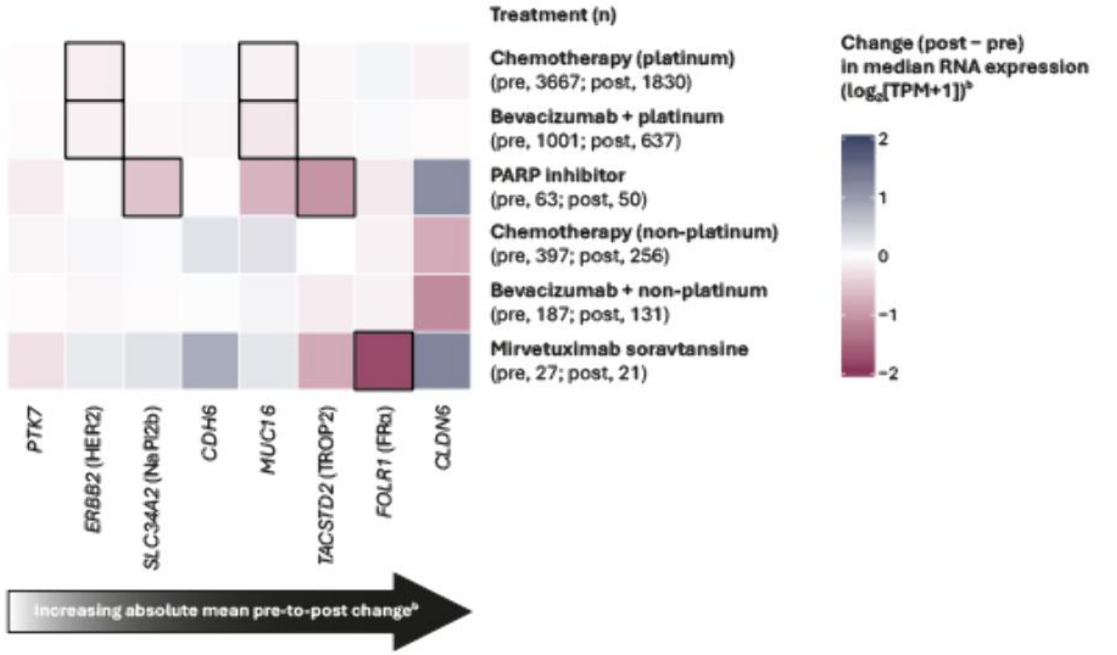
Results: The analysis included 8,267 OC samples. Median *MUC16* expression remained high before and after standard-of-care treatments, including platinum/non-platinum chemotherapy, bevacizumab with/without platinum, and PARP inhibitors, with consistently small effect sizes (**Figure 1**). Other ADC targets (TROP2, FRα, and CLDN6) showed more variable treatment-associated expression than *MUC16* across standard-of-care therapies (**Figure 2**).

Figure 1. Effect of Standard-of-Care Treatments on *MUC16* Expression in Ovarian Cancer Tumor Samples



MUC16, mucin 16; ns, not significant; PARP, poly (ADP-ribose) polymerase; TPM, transcripts per million.

Figure 2. Pre- Versus Post-Treatment Change in Expression of *MUC16* and Other ADC Targets (Ovarian Cancer) Ordered from Most Stable to Most Variable Across Standard Therapies



aBlack frames on the heatmap indicate *P*≤0.05 for the difference in pre- versus post-treatment median expression.
bThe differences were averaged across the six treatment types and biomarkers are listed in order of increasing mean absolute change in expression.
ADC, antibody-drug conjugate; ***CDH6***, cadherin 6; ***CLDN6***, claudin 6; **FRα**, folate receptor alpha; **HER2**, human epidermal growth factor receptor 2; ***MUC16***, mucin 16; **NaPi2b**, sodium-dependent phosphate transport protein 2B; **PARP**, poly (ADP-ribose) polymerase; ***PTK7***, protein tyrosine kinase 7; **TROP2**, trophoblast cell-surface antigen 2.

Conclusion/Implications: *MUC16* expression is highly stable over time across standard-of-care therapies for OC, with lower treatment-associated variability than other ADC targets, indicating low susceptibility to therapy-induced modulation. As *MUC16* is not

downregulated by standard-of-care treatments, MUC16-directed ADCs may be suitable for use both in combination with standard early-line platinum-based treatment and in the relapsed setting. HWK-016, a next-generation ADC targeting the non-shed extracellular domain of MUC16, is currently being evaluated in a phase 1 clinical trial (NCT07470853) in patients with advanced/metastatic solid tumors, including OC. Future analyses aim to identify variables independently associated with *MUC16* expression in matched patient samples.

EP334 / #779

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

THE SILENT GAP: ADVANCED STAGING IN YOUNG PATIENTS WITH LOW-GRADE SEROUS OVARIAN CARCINOMA. A 6-YEAR REGIONAL ANALYSIS.

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Introduction: Low-grade serous ovarian carcinoma (LGSC) is a rare subtype often associated with younger populations and relative chemoresistance. International literature typically reports a mean age of diagnosis between 45 and 55 years, usually with a more indolent progression than high-grade serous carcinoma (HGSC). This study evaluates the clinical presentation and staging of LGSC in a regional reference center in Northern Chile.

Methods: A retrospective review of the oncology committee database (2020-2026) was performed. Out of 79 ovarian cancer cases, histological subtypes, age at diagnosis, and FIGO staging were analyzed to compare LGSC and HGSC cohorts.

Results: LGSC accounted for 5% of all ovarian malignancies and 11.7% of serous cases. A significant age disparity was observed: the mean age for LGSC was 28.8 years (ranging from early 20s to 30s), whereas HGSC averaged 61.2 years. Despite the young age and the expected indolent nature of this tumor type, 75% of LGSC patients were diagnosed in advanced stages (FIGO IIIC to IVA). This contrast with international series-where LGSC is often found at later ages or earlier stages-suggests a critical gap in early clinical suspicion within the regional health network.

Conclusion/Implications: LGSC in Northern Chile presents a unique challenge: it affects patients nearly three decades younger than the global average, yet they reach specialized care in advanced stages. These findings emphasize that young age should not rule out a high suspicion of ovarian malignancy in complex adnexal masses.

EP335 / #294

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

OLAPARIB MAINTENANCE VS PLACEBO OR STANDARD OF CARE IN OVARIAN CANCER: A BIOMARKER-DRIVEN SYSTEMATIC REVIEW AND META-ANALYSIS OF RANDOMIZED TRIALS

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Introduction: Olaparib is widely used as maintenance therapy in ovarian cancer after response to chemotherapy, but the magnitude of benefit across molecular subgroups and its safety profile remain uncertain. This meta-analysis explored outcomes according to biomarker-defined subgroups.

Methods: PubMed, Embase, CENTRAL were searched for randomized controlled trials(RCTs). Primary endpoints were overall survival (OS) and progression-free survival (PFS). Secondary endpoints included time to first subsequent therapy (TFST), time to second subsequent therapy (TSST), and adverse events (AEs). Hazard ratios (HRs) and risk ratios (RR) with 95% confidence intervals (CIs) were pooled using a random-effects model.

Results: Eight randomized trials were included. Olaparib significantly improved PFS compared with control (HR 0.48; 95% CI 0.37–0.62; p < 0.01). The benefit was greater in BRCA-mutated patients (HR 0.33; 95% CI 0.22–0.52) than in BRCA wild-type patients (HR 0.62; 95% CI 0.47–0.82; p for interaction = 0.001). The largest benefit was observed in HRD-positive tumors (HR 0.44; 95% CI 0.35–0.54), whereas HRD-negative patients did not derive a statistically significant benefit. OS showed a favorable trend overall (HR 0.82; 95% CI 0.66–1.02; p = 0.07) and was significantly improved among BRCA-mutated patients (HR 0.66; 95% CI 0.56–0.78). Olaparib also prolonged TFST and TSST but was associated with a higher risk of grade ≥3 AEs, without an increased risk of hematologic events.

Conclusion/Implications: Olaparib maintenance significantly delays disease progression in ovarian cancer, with the greatest benefit observed in BRCA-mutated and HRD-positive tumors. These findings support the use of olaparib as a biomarker-guided maintenance strategy following chemotherapy.

EP336 / #855

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

DIFFERENTIAL PREDICTIVE ROLES OF CHEMOTHERAPY RESPONSE SCORE FOR OLAPARIB AND NIRAPARIB IN TREATMENT OF TUBO-OVARIAN HIGH-GRADE SEROUS CARCINOMA

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Introduction: Poly(ADP-ribose) polymerase inhibitors (PARPi) have transformed management of high-grade serous tubo-ovarian carcinoma (HGSOC). The chemotherapy response score (CRS) is a histopathologic measure of platinum sensitivity, and our objective was to explore the association between CRS and outcomes in molecularly stratified HGSOC.

Methods: We conducted a retrospective cohort study of 94 consecutive HGSOC patients receiving first-line maintenance PARPi in our provincial cancer database between January 2021 and January 2023. CRS was assessed by gynecologic pathologists on omental specimens at interval cytoreductive surgery. Progression rates within each CRS category were characterized, stratified by BRCA status.

Results: Of 94 patients, 45 (48%) were BRCA-mutated, 48 (51%) BRCA-wildtype, and one had unknown status. CRS was available in 57, with distribution not differing between subgroups. Among BRCA-mutated patients on olaparib, higher CRS was associated with improved durability: 67% of CRS 1 and 22% of CRS 2 progressed, versus 0% of CRS 3 (median treatment 832 days). Among BRCA-wildtype patients on niraparib, higher CRS was not associated with improved outcomes: 17% of CRS 1, 64% of CRS 2, and 80% of CRS 3 progressed.

Conclusion/Implications: CRS is associated with olaparib durability in BRCA-mutated HGSOC, however, directionally reversed correlation was demonstrated in BRCA-wildtype patients on niraparib, which warrants further investigation. CRS should not guide PARPi selection in BRCA-wildtype patients without formal Homologous Recombination Deficiency genomic testing

EP337 / #530

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

THE UTILITY OF CANCER GENE PANEL TESTING FOR OVARIAN CANCER

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Introduction: To evaluate the clinical utility and treatment outcomes of cancer gene panel (CGP) testing for ovarian cancer patients at a single institution.

Methods: We conducted a retrospective review of ovarian cancer cases undergoing CGP testing at our hospital between 2019 and 2025. Patient demographics, histological subtypes, clinical stages, and the transition from genomic profiling to targeted therapy were analyzed.

Results: The study included 74 cases (median age: 58 years; range: 31–84). Histology included serous (36), clear cell (24), endometrioid (6), carcinosarcoma (3), mucinous (2), and other carcinomas (3). Most patients were diagnosed with advanced disease (Stage III: 43; Stage IV: 12). The median interval from initial treatment to testing was 34 months, with a median of 3 prior systemic regimens (range: 1–11). Actionable genetic alterations were identified in 73 cases (99%), and druggable targets were found in 52 cases (70%). While treatment based on genetic findings was proposed for 26 patients (35%), only 4 patients (5%) ultimately initiated targeted therapy. Among these, one patient with TMB-high achieved a complete response (CR) with pembrolizumab. Three patients enrolled in clinical trials: results included one CR (ongoing), one disease progression, and one discontinuation due to adverse events.

Conclusion/Implications: Despite a high detection rate of actionable mutations (99%), the actual treatment attainment rate remained low at 5%. This discrepancy suggests that many tests are performed at a stage where clinical application is challenging. To improve the therapeutic impact of CGP testing, it is essential to optimize the timing of the test and carefully evaluate the patient's clinical status.

EP338 / #759

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

IMPACT OF RADIOLOGIST EXPERIENCE AND MRI QUALITY ON INTEROBSERVER VARIABILITY AND DIAGNOSTIC PERFORMANCE OF O-RADS MRI IN ADNEXAL MASS EVALUATION

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Introduction: MRI O-RADS is a structured system for adnexal mass assessment that standardizes reporting and improves risk stratification. Its performance may be influenced by radiologist experience and MRI quality. This study evaluates MRI O-RADS accuracy and the impact of expertise and imaging quality on variability in adnexal mass interpretation.

Methods: In this retrospective study, 189 women with adnexal masses who underwent preoperative MRI and surgical histopathology were included. MRI exams were classified as standard protocol or external studies. Radiologists were grouped by experience (>5 years, <5 years, and low expertise). O-RADS MRI scores were dichotomized as low risk (≤3) and high risk (≥4). Diagnostic performance was assessed using histopathology as the reference, and interobserver variability was analyzed according to reader experience and imaging quality.

Results: Of 189 patients, 44 (23.3%) had malignant pathology. Overall, MRI O-RADS demonstrated 100% sensitivity and 59.7% specificity for malignancy at a cutoff ≥4. Diagnostic performance varied by reader expertise and imaging quality. Experienced radiologists interpreting standard-protocol MRI achieved the highest specificity and agreement with histopathology, while reduced specificity and increased false-positive rates were observed among less experienced and low-expertise readers, particularly when evaluating non-standard studies. Interobserver agreement was moderate overall, with improved concordance in the experienced group and in cases with standard imaging protocols. Variability increased substantially in the setting of suboptimal imaging and lower reader experience.

Conclusion/Implications: MRI O-RADS demonstrates excellent sensitivity for malignant adnexal lesions but lower specificity influenced by radiologist experience and MRI quality.

Standardization and training are needed to improve performance and reduce unnecessary interventions.

EP339 / #762

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

IMPACT OF MRI O-RADS PREOPERATIVE RISK STRATIFICATION ON CONCORDANCE BETWEEN FROZEN SECTION AND FINAL HISTOPATHOLOGY IN ADNEXAL MASSES

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Introduction: Frozen section is widely used for intraoperative assessment of adnexal masses, but its diagnostic accuracy varies. Preoperative MRI O-RADS provides standardized risk stratification, influencing pathological interpretation and surgical decision-making. We evaluated whether knowledge of MRI O-RADS classification is associated with improved concordance between frozen section and final histopathology.

Methods: We conducted a retrospective study of patients with adnexal masses who underwent preoperative MRI and subsequent surgical resection with intraoperative frozen section analysis at a referral center (2010–2024). Final histopathology served as the reference standard. MRI studies were categorized using O-RADS MRI scoring. Frozen section–final pathology concordance was assessed overall and stratified by MRI O-RADS risk category (low vs high risk). Agreement was compared with published benchmark rates of frozen section accuracy in the literature.

Results: A total of 189 patients were included, with final histopathology showing 145 benign (76.7%) and 44 malignant (23.3%) lesions. Overall concordance between frozen section and final pathology was high, with better agreement in O-RADS high-risk cases (≥4) than in low-risk lesions. Most discordances involved borderline tumors and low-grade malignancies. Stratified analysis confirmed higher concordance in high-risk lesions, suggesting that MRI O-RADS classification may aid intraoperative interpretation. Compared with published data, particularly for borderline tumors, concordance appeared favorable, though findings are limited by the retrospective design and potential bias.

Conclusion/Implications: Preoperative MRI O-RADS classification may improve the frozen section interpretation and increase concordance with final histopathology and help surgical decision-making, particularly in high-risk adnexal masses. Prospective studies are needed to determine whether MRI O-RADS directly enhances frozen section performance.

EP340 / #283

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

DIRECT ORAL ANTICOAGULANT FOR VENOUS THROMBOEMBOLISM PROPHYLAXIS DURING NEOADJUVANT CHEMOTHERAPY FOR METASTATIC OVARIAN CANCER: A COST-EFFECTIVENESS ANALYSIS

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Introduction: Most ovarian cancer patients present with advanced stage disease, and many require neoadjuvant chemotherapy prior to proceeding to surgery with curative intent. Both ovarian cancer and chemotherapy increase the risk of venous thromboembolism (VTE) which, in turn, is associated with significant morbidity and mortality. Direct oral-anticoagulants (DOACs) are clinically effective in decreasing rates of VTE, but cost-effectiveness has not yet been established in the context of chemotherapy for ovarian cancer.

Methods: A decision tree model was constructed comparing DOAC VTE prophylaxis to no prophylaxis for advanced stage, intermediate-high risk (Khorana Score $\geq$2) ovarian cancer patients receiving neoadjuvant chemotherapy in the Canadian health care system. Time horizon was 36 months. Primary model outcomes were overall cost and effectiveness in quality-adjusted life years (QALYs).

Results: DOAC VTE prophylaxis was both more effective and more expensive than no prophylaxis, with a cost of $141,476.54 CAD and effectiveness of 2.42 QALYs. The incremental cost-effectiveness ratio (ICER) compared to no prophylaxis was $8633.61/QALY

Conclusion/Implications: DOAC VTE prophylaxis is cost-effective when using the accepted Canadian willingness-to-pay threshold of $50,000 CAD. Given the clinical and economic benefit, DOAC VTE prophylaxis should be recommend for all intermediate-high risk ovarian cancer patients receiving neoadjuvant chemotherapy.

EP341 / #929

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

REAL-WORLD TREATMENT PATTERNS AND OUTCOMES AMONG PATIENTS WITH ADVANCED HIGH-GRADE PLATINUM-SENSITIVE OVARIAN CANCER FOLLOWING PROGRESSION ON FIRST-LINE PARPI MAINTENANCE THERAPY IN THE UNITED STATES

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Introduction: PARP inhibitor (PARPi) maintenance therapy is increasingly used following first-line (1L) platinum-based chemotherapy (PBC) in ovarian cancer (OC). Many patients with platinum-sensitive OC (PSOC; first progression ≥6 months after completion of 1L PBC) experience disease progression during or shortly after PARPi maintenance. Post-hoc clinical trial analyses suggest second-line (2L) chemotherapy has limited efficacy in this population. Given limited real-world (rw) evidence, this study assessed treatment patterns and outcomes in patients with PSOC following progression on/after 1L PARPi maintenance using retrospective data from the U.S.

Methods: Patients with high-grade advanced PSOC, who progressed during or ≤90 days after completing 1L PARPi maintenance and initiated 2L therapy (index date), were identified from ConcertAI's Patient360™ dataset (cutoff: 09/30/2025). 2L treatments were summarized descriptively, and outcomes were analyzed using Kaplan-Meier analysis.

Results: Overall, 191 patients were included. At 2L index, median age was 68 years, 80.6% had ECOG PS 0/1, and 21.5% were *BRCA*-mutated (159/191 were *BRCA*-tested); 30.4% had received bevacizumab in 1L. In 2L, 134 (70.2%) patients received PBC-containing induction regimens, 32 (16.8%) non-PBC regimens, and 25 (13.1%) other non-chemotherapy regimens. 2L PBC-containing regimens received are shown (Table 1); 67.2% received PBC+bevacizumab. Among patients with 2L PBC-containing induction, 38.1% also received maintenance therapy; of these, 70.6% received bevacizumab±other regimen. Median rwOS and rwPFS were 17.7 months and 6.8 months, respectively (Table 2).

Conclusion/Implications: Following progression on 1L PARPi maintenance, patients with PSOC were mainly treated with various PBC-containing regimens and experienced limited clinical benefit, highlighting the need for more effective treatment options.

Table 1. Utilization of 2L PBC-containing regimens, overall and by bevacizumab use, among patients with PSOC who progressed on 1L PARPi maintenance therapy.

2L PBC-containing regimen	Overall 2L PBC cohort (n=134)	2L PBC with bevacizumab (n=90)	2L PBC without bevacizumab (n=44)
Platinum-based doublet CT (±other non-CT),[a] n (%)			
Platinum+doxorubicin	50 (37.3)	30 (33.3)	20 (45.5)
Platinum+taxane[b]	38 (28.4)	28 (31.1)	10 (22.7)
Platinum+gemcitabine	29 (21.6)	23 (25.6)	6 (13.6)
Platinum only (±other non-CT),[a] n (%)	7 (5.2)	4 (4.4)	3 (6.8)
Platinum-based triplet CT (±other non-CT),[a] n (%)			
Platinum+taxane+doxorubicin[b]	3 (2.2)	1 (1.1)	2 (4.5)
Platinum+taxane+gemcitabine[b]	2 (1.5)	1 (1.1)	1 (2.3)
Platinum+doxorubicin+gemcitabine	2 (1.5)	1 (1.1)	1 (2.3)
Platinum+taxanes[c]	3 (2.2)	2 (2.2)	1 (2.3)

[a]Other non-CT includes bevacizumab, PARP inhibitors (olaparib, niraparib, rucaparib), immunotherapy (pembrolizumab), and aromatase inhibitors (letrozole, exemestane). [b]Taxane was paclitaxel or docetaxel. [c]Taxanes (paclitaxel and docetaxel) were administered before any documented progression, likely sequentially due to adverse events, patient preference, or other clinical factors.

Table 2. Real-world clinical outcomes with 2L treatments among patients with PSOC who progressed on 1L PARPi maintenance therapy.

	Real-world overall survival (rwOS)	Real-world progression-free survival (rwPFS)	Real-world time to treatment discontinuation or death (rwTTD)	Real-world time to next treatment or death (rwTTNT)
Events, n (%)	143 (74.9)	165 (86.4)	187 (97.9)	162 (84.8)
Median (95% CI), months	17.7 (15.6–21.6)	6.8 (5.7–8.1)	6.8 (5.5–7.6)	8.0 (7.0–9.2)
Event-free probability, % (95% CI)				
6 months	88.4 (82.9–92.2)	55.2 (47.7–62.0)	54.8 (47.5–61.6)	65.2 (57.9–71.6)
12 months	69.0 (61.8–75.2)	24.1 (17.9–30.9)	24.7 (18.8–31.1)	32.9 (25.9–40.0)
24 months	37.5 (30.1–44.8)	6.2 (3.1–10.9)	6.5 (3.5–10.6)	10.3 (6.0–15.9)

Median follow-up from index via reverse Kaplan-Meier methods: 36.7 months (95% CI, 32.0–47.0).

EP342 / #371

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

DOES SIZE MATTER? A RETROSPECTIVE ANALYSIS OF OMENTAL RESECTION VOLUME AND OVERALL SURVIVAL IN HIGH-GRADE SEROUS OVARIAN CARCINOMA

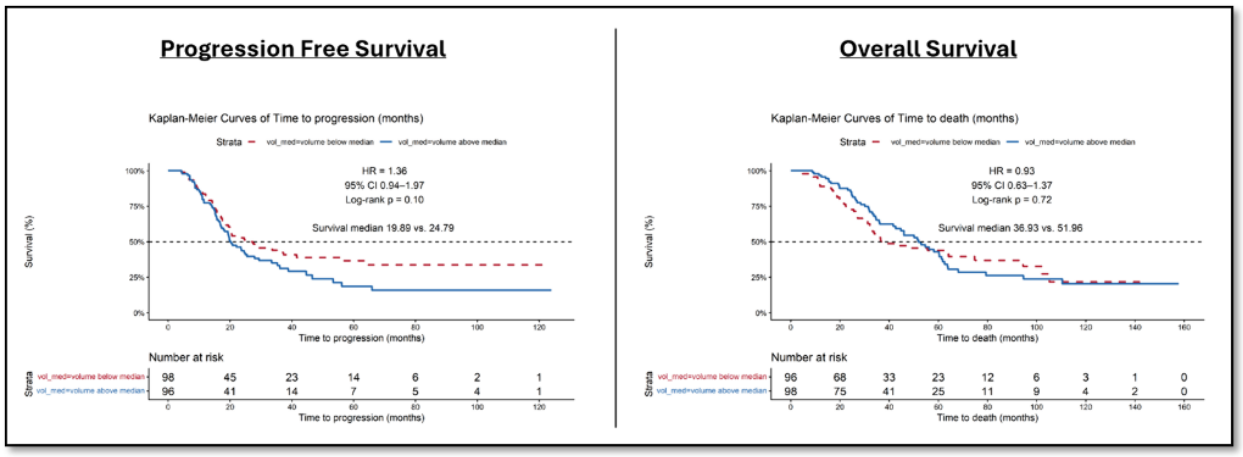
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Introduction: Omentectomy is routinely performed during cytoreductive surgery, a cornerstone of treatment for advanced tubo-ovarian malignancies. However, the impact of resection extent remains unclear. This study evaluates whether omental resection volume is associated with survival outcomes in ovarian cancer patients.

Methods: A retrospective cohort study was performed including patients with ovarian cancer who underwent cytoreductive surgery at Rambam Health Care Campus between 2011 and 2018. Demographic, clinical, pathological, and treatment-related data were obtained from institutional databases. Measurements of the excised omentum—including length, width, thickness, area, and calculated volume—were extracted from pathology reports. Patients were divided into two groups according to omental specimen volume (below versus above the median). Progression-free survival (PFS) and overall survival (OS) were compared between the groups.

Results: The study cohort included 206 patients with a mean age of 60±12 years, the majority presenting with stage IIIC–IV disease (78.9%). The mean omental volume was 1079.9±1067.6 cm^3 (median 827 cm^3). Baseline clinical characteristics were comparable between groups, as were chemotherapy response rates and the use of bevacizumab or PARP inhibitors. Patients in the larger-volume group were more likely to undergo primary cytoreductive surgery (60.2% vs. 33.0%, $p<0.001$). However, no significant differences were observed in PFS or OS between groups (HR 1.36, 95% CI 0.94–1.97, $p=0.10$; HR 0.93, 95% CI 0.63–1.37, $p=0.72$, respectively). Rates of omental metastases and postoperative complications were also

similar.



Conclusion/Implications: The extent of omental resection during cytoreductive surgery was not associated with improved survival outcomes, suggesting that larger omentectomy alone may not provide additional prognostic benefit

EP343 / #25

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

FRAGILITY OF EVIDENCE IN HIPEC RANDOMIZED CONTROLLED TRIALS

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Introduction: Despite randomized-control-trials (RCTs) efficacy in surgical practice, reproducibility of significant findings are rarely quantified. Fragility Index(FI), representing the minimum number of events that must change to render significant-results, non-significant, measures stability of the result. We aim to quantify FI across Hyperthermic intraperitoneal chemotherapy(HIPEC) RCTs.

Methods: Eligibility criteria for studies: (1)patients with primary advanced-stage(FIGO-Stage III/IV) or recurrent-ovarian cancer; (2)studies comparing surgery+HIPEC versus surgery-alone; (3)data from prospective RCTs; (4)report>1 dichotomic outcome. MEDLINE, Embase, and Cochrane Library used to screen articles. FI defined as smallest number of event-status changes(towards the null) yielding p≥0.05.

Results:

Summary of Major HIPEC Trials in Ovarian Cancer

	NAME	Authors	Year	Country	Setting	n	Result	OS Control	OS HIPEC	PFS Control	PFS HIPEC	Binary	FI	LFU
0	CARCINOHIPEC	ascales Campos et	2022	Spain	Primary	71	Significant	45.0	52.0	12.0	18.0	5 y PFS	0.0	1.0
1	OVHIPEC	van Driel et al.	2018	Netherlands	Primary	245	Significant	34.0	46.0	11.0	14.0	3 y PFS	0.0	0.0
2	Lim et al.	Lim et al.	2022	S. Korea	Primary	184	Significant	48.0	62.0	15.0	17.0	2 y PFS	0.0	4.0
3	Poster	Diaz Montes et al.	2018	USA	Primary	19	NS	nan	nan	nan	nan	2 y PFS	0.0	nan
4	C-HOC	Wang et al.	2024	China	Primary	60	No survival analys	nan	nan	nan	nan	-	nan	nan
5	Zivanovic et al.	Zivanovic et al.	2021	USA	Recurrent	98	NS	60.0	52.0	16.0	12.0	2 y PFS	0.0	0.0
6	CHIPOR	Classe et al.	2024	International	Recurrent	415	Significant	46.0	54.0	9.0	10.0	5 y OS	0.0	1.0
7	HORSE	Fagotti et al.	2024	Italy	Recurrent	167	NS	nan	nan	23.0	25.0	2 y PFS	0.0	3.0
8	Spiliotis et al.	Spiliotis et al.	2015	Greece	Recurrent	120	Significant	13.0	27.0	nan	nan	3 y OS	24.0	0.0

Nine HIPEC-RCTs from 2015-2024 were found, five in primary-settings and four in recurrence-settings. Median number of patients was 120(IQR,65-214). Of these, five showed HIPEC superiority(three in primary-setting, two in recurrence-settings), two not(in recurrence-setting), and one not reporting survival analysis. Median survival benefit was 7-14 months, and overall progression-free survival(PFS) benefit was 8-16 months. For FI, binary outcomes were 2-, 3-, and 5-year PFS and 3- and 5-year overall survival. For four RCTs,FI=0, and one FI=24. There were losses to follow-up exceeding the FI in three studies. This means that for binary outcomes reported in the RCTs, only one-of-five studies had

some degree of robustness. Importantly,the FI=24 study is rarely reported, due to questionable results.

Conclusion/Implications: Across HIPEC RCTs in ovarian cancer, survival advantages are statistically-fragile when judged by FI. Among five trials reporting superiority, four had FI=0, and in three, number losses-to-follow-up>FI, further eroding confidence. Findings suggest that claims of HIPEC benefit, particularly from dichotomized survival snapshots, should be interpreted with caution.

EP344 / #879

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

PAOLA-1 STUDY IN CLINICAL PRACTICE: A RETROSPECTIVE ANALYSIS OF OUTCOMES AND SAFETY PROFILE OF FIRST-LINE MAINTENANCE THERAPY WITH OLAPARIB AND BEVACIZUMAB FOR ADVANCED HIGH-GRADE OVARIAN CANCER – EXPERIENCE FROM OUR TREATMENT CENTRE

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Introduction: PAOLA-1 trial has demonstrated a clinical benefit in patients with newly-diagnosed advanced ovarian cancer who tested positive for BRCA mutation and/or homologous-recombination deficiency (HRD), following response to first-line systemic treatment. Our study was aimed at evaluating the efficiency and safety of the regimen in our treatment centre.

Methods: We conducted a retrospective analysis of 34 cases of advanced high-grade ovarian epithelial cancer, treated between 2022 and2026 according to the criteria of PAOLA-1clinical trial.

Results: The age median was 54 years. 61.1% of the cases were FIGO stage III and 38.9% were stage IV. 55.6% of the patients received primary cytoreduction surgery and 33.3% underwent interval surgery. Complete cytoreduction was achieved in 33.3% of the patients,whilst 66.7% of the patients were left with residual disease. 61.1% of the patients tested positive for a BRCA mutation and 38.95 were HRD positive. All the patients received chemotherapy based on carboplatin, paclitaxel and bevacizumab. A complete response was achieved in 55.6% of the cases and a partial response in 44.4%.The most common adverse effects included fatigue(47%), nausea(43,6%), anaemia(38.9%), neutropenia(22.8%), thrombocytopaenia(16.7%)and hypertension(28.2%). Grade3-4 toxicities occurred in 16.7% of the cases, necessitating an olaparib dose reduction in 16.7% of the patients affected, olaparib dose interruption in 22.8%, and treatment discontinuation due to adverse effects 7%. Disease progression during maintenance therapy occurred in 4.25% of the cases.

Conclusion/Implications: Our analysis has demonstrated the PAOLA-1 protocol to have a manageable safety profile, with the outcomes achieved in our centre confirming its efficiency. However, further observation is necessary to determine the PFS and OS rates.

EP345 / #1081

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

TOO LITTLE OR TOO MUCH: EFFECTS OF P53 NULL VS OVEREXPRESSED PATTERNS ON HIGH-GRADE SEROUS OVARIAN CANCER OUTCOMES

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Introduction: High-grade serous ovarian cancer (HGSOC) remains the deadliest form of epithelial ovarian cancer (EOC). These tumours are almost universally associated with TP53 mutation and associated mutant pattern p53 immunoexpression. Overexpressed and null patterns are the most common abnormal immunophenotypes. While TP53 mutation is a hallmark of HGSOC, the clinical significance of the different immunoexpression patterns is not fully understood. The purpose of this study is to determine how p53 immunoexpression influences baseline clinicopathological characteristics and outcomes in HGSOC patients.

Methods: The retrospective cohort study consisted of 350 HGSOC patients with overexpressed or null p53 immunoexpression patterns, seen for initial consultation between Sept 2018-May 2024. Follow up data were collected up to March 2025. Univariable and multivariable regression models were performed on all outcomes.

Results: Tumours showing the overexpressed p53 pattern were associated with lower odds of non-complete cytoreduction at interval debulking surgery (IDS) in univariate logistic regression (OR = 0.397, 95% CI[0.198,0.796], p = <0.01) and multivariate logistic regression (OR = 0.347, 95% CI[0.156,0.773], p = <0.01) (Table 1). No significant differences were noted between p53 groups for all other baseline characteristics and outcomes, including overall survival and time to recurrence (Figure 1).

Conclusion/Implications: Null versus overexpressed p53 patterns were not broadly associated with differences in baseline clinicopathological characteristics or outcomes in HGSOC, with the notable exception of IDS outcomes. Attention to p53 immunoexpression patterns may have potential value in refining surgical risk stratification after neoadjuvant chemotherapy. Further studies should investigate why IDS outcomes differ between p53 immunoexpression patterns.

EP346 / #466

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

FEASIBILITY AND CONCORDANCE OF CIRCULATING TUMOR DNA FOR HOMOLOGOUS RECOMBINATION DEFICIENCY DETECTION IN OVARIAN CANCER

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Introduction: Homologous recombination deficiency (HRD) is a key predictive biomarker in the management of high-grade ovarian cancer (OC), guiding PARP inhibitor treatment selection. Current HRD assessment relies on tumor tissue, which is invasive, may yield inconclusive results and can delay treatment decisions. This study aims to assess the feasibility and performance of plasma-based circulating tumor DNA (ctDNA) HRD testing.

Methods: OC patients treated at the Jewish General Hospital between 2019 and 2025 with tissue-based comprehensive genomic profiling (CGP) were identified and archival matched plasma samples were analyzed (Illumina TSO500). Based on preliminary data, calculated sample size was 50 patients. Tissue and plasma concordance was assessed, and discordant cases were investigated.

Results: Of 218 patients screened, 63 had tissue CGP with matched plasma samples. To date, 35 samples were sequenced, of which 3 failed quality control. Overall, ctDNA and tissue testing provide 75% (24/32) concordance. ctDNA CGP identified 13 HRD+ and 11 HRD- cases. One ctDNA-HRD+ case was not detected on tissue CGP. Among ctDNA HRD-negative cases, tissue CGP identified 7 HRD-positive cases. Discrepancies were attributable to assay limitations, including unavailable HRD score with TSO500 plasma test (3 cases), intronic or polyA mutations (1 case) and copy number assessment limited to a shortlist of genes (1 case).

Conclusion/Implications: These findings support a complementary role for ctDNA in molecular profiling for newly diagnosed OC. Liquid biopsies provide a good alternative to overcome challenges with tissue testing. Timely HRD testing is important, particularly if PARP inhibitors become integrated earlier in treatment.

EP347 / #1043

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

HIPEC AFTER NEOADJUVANT CHEMOTHERAPY FOR ADVANCED EPITHELIAL OVARIAN CANCER IN THE PARP INHIBITOR ERA – A SINGLE INSTITUTION EXPERIENCE

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Introduction: Hyperthermic intraperitoneal chemotherapy (HIPEC) was shown to improve survival outcomes in stage III-IV epithelial ovarian cancer (EOC) after neoadjuvant chemotherapy (NACT) and interval debulking surgery (IDS). However, its value for patients using PARP inhibitors (PARPi) was not clearly elicited.

Methods: Patients with stage III/IV ovarian, fallopian tube, or primary peritoneal cancer in 2018-2023 receiving HIPEC after NACT and IDS were identified. The primary objective was to compare the survival outcomes for patients with and without HIPEC and PARPi.

Results: 347 patients were identified. 145 patients (41.8%) received NACT, of whom 90.6% had high-grade serous carcinoma (HGSC). 13 patients received HIPEC alone, 19 patients received both HIPEC followed by PARPi after completion of chemotherapy, and 30 received PARPi alone without HIPEC. The incidence of homologous recombination deficiency (HRD) was 23.1%, 52.7%, and 36.7%, respectively (p=0.006). The median progression-free survival (PFS) was 18.4 months, 35.6 months, and not reached (p=NS). The median overall survival (OS) was not reached, 47.3 months and not reached (p=NS). Among patients with germline or somatic *BRCA*mutation, no significant difference in PFS was observed across the three groups. Apart from longer operative time in those receiving HIPEC, the incidence of post-operative and other adverse events was comparable to that in patients using PARPi alone.

Conclusion/Implications: HIPEC did not appear to confer a significant survival benefit compared to patients receiving PARPi in this small cohort. Prospective studies are warranted to further evaluate its efficacy and to identify patient subgroups most likely to benefit from it in the era of maintenance therapy.

EP348 / #126

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

OCCULT NODAL METASTASIS IN APPARENT EARLY LOW-GRADE SEROUS OVARIAN CARCINOMA: A META ANALYSIS.

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Introduction: Lymphadenectomy in apparent early-stage low-grade serous ovarian carcinoma remains controversial because this histotype is often grouped with other low-grade epithelial tumors, potentially underestimating nodal risk. We aimed to quantify occult nodal metastasis and stage migration in this setting.

Methods: We performed a systematic review and meta-analysis of observational studies (PROSPERO CRD420251165472). MEDLINE, Embase, and Web of Science were searched through September 2025. We included patients with pathologically confirmed low-grade serous ovarian carcinoma, clinically presumed FIGO 2014 stage I–IIA, undergoing primary surgery with pelvic and/or para-aortic nodal dissection. Single-proportion random-effects models were used.

Results: Eight studies comprising 854 patients met inclusion criteria. The pooled incidence of lymph node metastasis was 9.6% (95% CI 4.4–16.0), and in stage I-only cohorts it was 11.4% (95% CI 5.1–19.8). In three studies reporting isolated nodal stage migration, the pooled upstaging rate attributable solely to nodal disease was 10.0% (95% CI 5.6–15.5). Estimates were similar after excluding registry-based studies and high-risk-of-

bias studies. No included study reported lymphadenectomy-specific perioperative complications. **Figure 1. Forest plot of pooled proportion of lymph node metastasis in clinically early-stage low-grade serous ovarian carcinoma** **Figure 2. Forest plot of upstaging due solely to lymph node metastasis in clinically early-stage low-grade serous ovarian carcinoma**

Conclusion/Implications: Approximately 1 in 10 patients with apparent early-stage low-grade serous ovarian carcinoma harbor occult nodal metastasis, challenging the assumption that nodal spread is rare in low-grade disease. These data support discussing nodal assessment during preoperative counseling and considering it during staging surgery when treatment decisions may hinge on occult extraovarian disease.

EP349 / #386

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

COMPARATIVE PROGNOSIS OF EPITHELIAL OVARIAN CANCER IN FIGO STAGE IVA AND IVB: CLINICAL IMPLICATIONS

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Introduction: In the 2014 FIGO staging system for epithelial ovarian cancer (EOC), Stage IVA (pleural effusion with positive cytology) and Stage IVB (distant metastasis to other organs) offer a distinction in disease spread that influences prognosis and treatment. However, the prognostic value of this dichotomy remains debated. This study aims to assess the impact of Stage IVA vs. IVB on progression-free survival (PFS) and overall survival (OS).

Methods: We analyzed 434 stage IV EOC patients diagnosed between 2010 and 2020 who received at least 3 courses of platinum-based chemotherapy. Clinical, tumor, and treatment characteristics were assessed. PFS and OS were analyzed using Kaplan-Meier log-rank tests and Cox regression models.

Results: Median follow-up was 30.6 months. Characteristics of patients and tumors according to stage are shown in Table 1A. In univariate analysis, Stage IVB showed significantly better PFS (p=0.033) and OS (p=0.002) (Figure 1A and IB). However, after adjusting for clinical factors and treatment, no significant difference in PFS (HR 0.85, p=0.244) or OS (HR 0.84, p=0.19) was found between stages IVA and IVB. Surgical outcome was the strongest predictor, with complete resection significantly improving survival (Table IB and IC). In the subgroup analysis of 208 patients who underwent surgery, no difference in survival was found between stages IVA and IVB (PFS p=0.79, OS

p=0.236).

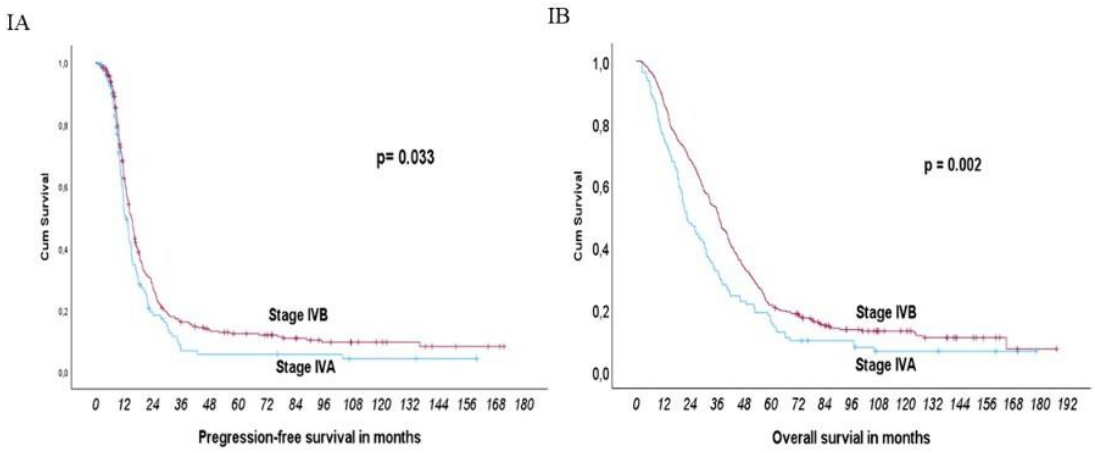


Figure 1 Kaplan–Meier curves of progression-free (1A) /Overall survival (1B) between EOC stage IVA and IVB

Conclusion/Implications: In this cohort, FIGO Stage IVA vs. IVB was not independently associated with survival outcomes. Prognosis was primarily influenced by treatment strategy and surgical outcome, suggesting that the current subclassification of Stage IV disease may not significantly impact prognosis.

EP350 / #881

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

HOXA5 INHIBITS OVARIAN HIGH-GRADE SEROUS CARCINOMA PROGRESSION VIA TRANSCRIPTIONAL ACTIVATION OF INPP4B

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Introduction: HOXA5 has emerged as a novel cancer therapeutic target, yet its role in ovarian high-grade serous carcinoma (HGSC) remains unclear. This study investigated HOXA5 expression, prognostic significance, and functional mechanisms in HGSC.

Methods: HOXA5 expression was assessed in clinical HGSC samples and cell lines by immunohistochemistry. Nomograms integrating HOXA5 scores and clinical features were constructed for risk stratification. Functional roles were evaluated through in vitro and in vivo knockdown and overexpression experiments. Chromatin immunoprecipitation and RNA sequencing identified downstream targets. The therapeutic potential of all-trans retinoic acid (ATRA) as a HOXA5 activator was also examined.

Results: HOXA5 expression was significantly downregulated in HGSC clinical samples and correlated with poor prognosis. Established nomograms demonstrated utility in HGSC risk screening. HOXA5 knockdown promoted HGSC proliferation and neoplasia, while overexpression suppressed tumor development both in vitro and in vivo. Inositol polyphosphate-4-phosphatase type II (INPP4B) was identified as a critical downstream target of HOXA5. INPP4B knockdown partially rescued proliferation suppressed by HOXA5 overexpression. ATRA effectively inhibited HGSC proliferation and neoplasia via HOXA5 promotion.

Conclusion/Implications: This study is the first to demonstrate that the HOXA5/INPP4B axis plays a tumor-suppressive role in HGSC. These findings provide novel insights into HGSC pathogenesis and suggest HOXA5 and ATRA as promising candidates for targeted therapy.

EP351 / #524

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

CLINICAL PRACTICES FOR HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2-EXPRESSING OVARIAN CANCER IN CHINA: A CROSS-SECTIONAL SURVEY

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Introduction: HER2-ADCs have demonstrated substantial efficacy in HER2-expressing solid tumors. Recently, trastuzumab deruxtecan received tumor-agnostic approved for unresectable or metastatic HER2-positive tumors, including ovarian cancer (OC). HER2 has emerged as a biomarker guiding novel HER2-targeted therapies. Therefore, we conducted this study to investigate the current status of HER2 testing and clinicians' knowledge of HER2-ADC therapies in OC in China.

Methods: This cross-sectional study was conducted using online questionnaires among gynecologic oncologists and pathologists from China between December 31, 2025 and January 31, 2026. Clinicians' questionnaire assessed HER2 testing practices and awareness, management of advanced OC, and experience with HER2-ADC therapies, whereas pathologists' questionnaire included HER2 testing awareness and laboratory workflow.

Results:

Figure 1 Patterns of HER2 testing implementation for ovarian cancer in clinical practice

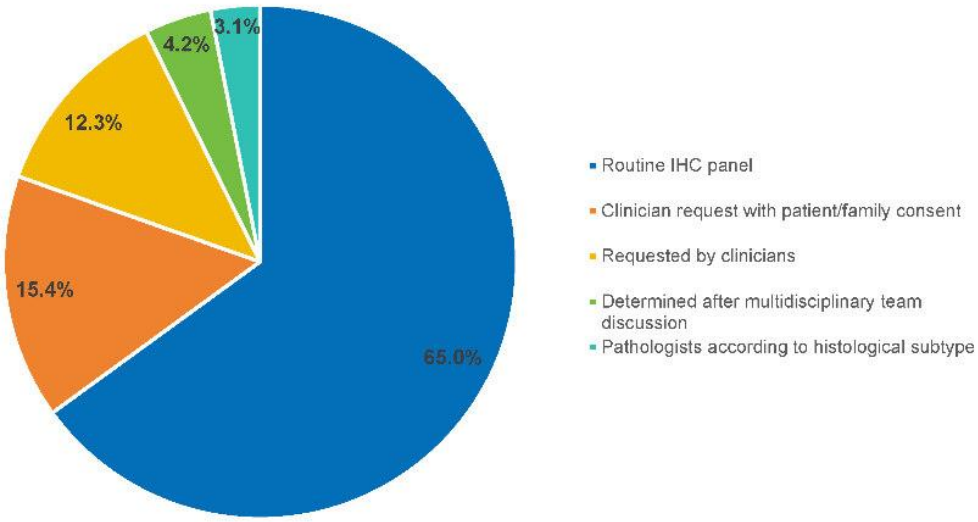
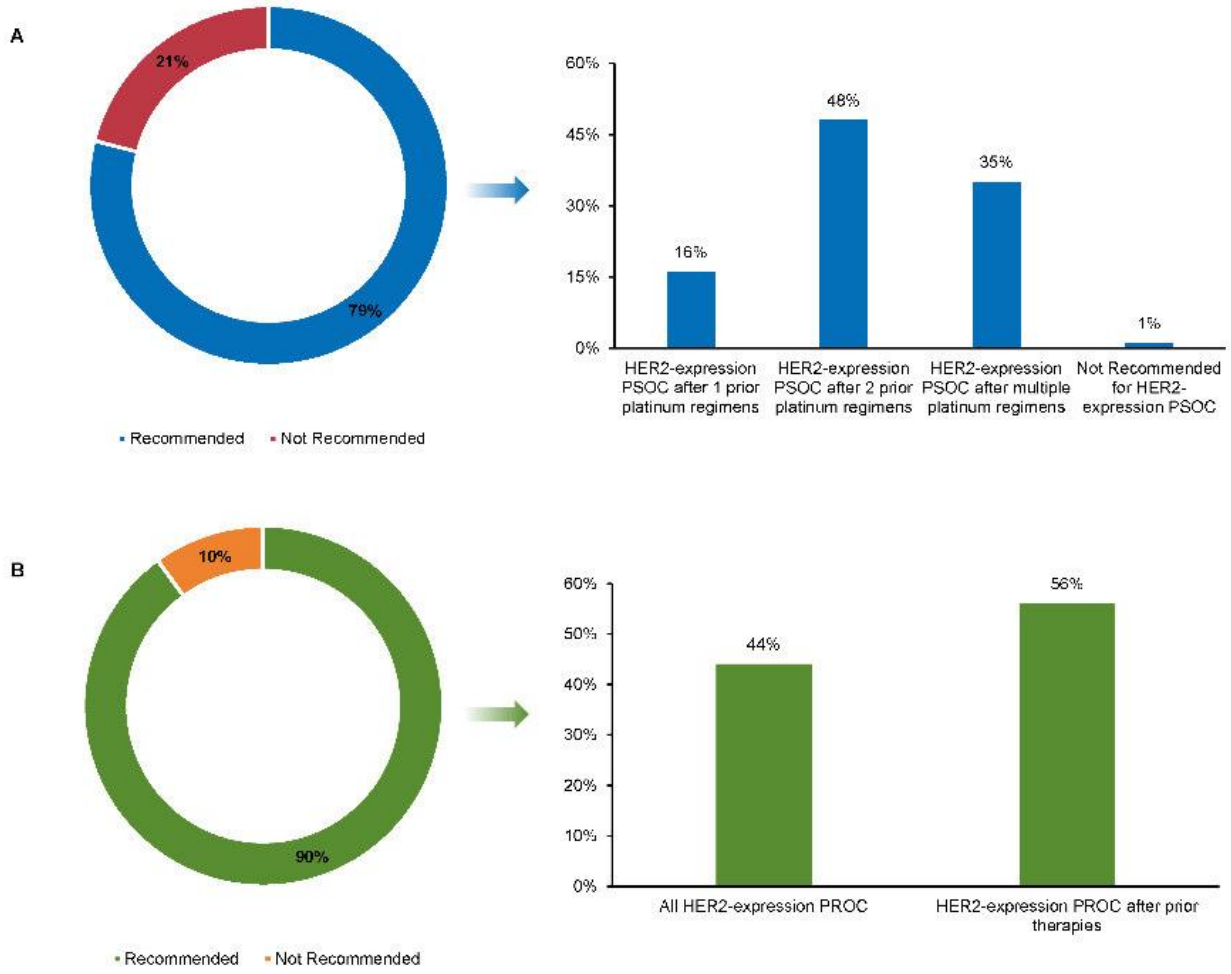


Figure 2 Recommendations for HER2-ADC therapy in ovarian cancer. (A) PSOC (B) PROC



A total of 97 clinicians and 20 pathologists were included. Among them, 53% of clinicians and 45% of pathologists reported awareness of NCCN guideline recommendation for HER2 testing in recurrent OC. Sixty-five percent of clinicians reported HER2 testing was integrated into the routine IHC panel for OC at their hospital (**Figure 1**). For PSOC, 79% of clinicians recommended HER2-ADC therapy, with 48% for patients with HER2-expression tumors after two prior platinum-based therapies. Among PROC, 90% of clinicians favored HER2-ADCs therapy, including 56% for those with HER2-expression tumors and prior treatment failure (**Figure 2**). Eighty-five percent of clinicians had HER2-ADC experience, including 16% extensive (>100 patients) and 36% moderate.

Conclusion/Implications: This study indicated that HER2 testing in OC was progressively implemented in China, although standardization remains suboptimal. Additionally, HER2-ADCs achieved encouraging clinical acceptance in recurrent OC, underscoring their promising therapeutic potential.

EP352 / #935

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

DYNAMIC CHANGES IN FOLR1 EXPRESSION DURING PLATINUM/TAXANE AND MIRVETUXIMAB SORAVTANSINE THERAPY IN OVARIAN CANCER

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Introduction: Folate receptor alpha (FRα), encoded by the *FOLR1* gene, is a validated therapeutic target in ovarian cancer (OC). Understanding how standard chemotherapy/FRα-directed therapy modulate *FOLR1*-expression can inform patient selection/treatment sequencing/mechanisms of resistance.

Methods: We analyzed real-world RNAseq/clinical data from the Tempus Lens database across two OC cohorts. In cohort-1, patients received first-line platinum+taxane (without bevacizumab) and had paired pre-/on-treatment samples(n=20) or paired pre-/post-treatment samples(n=22). On-treatment samples were obtained ≥45 days before real-world progressive disease (rwPD); samples were considered post-treatment if collected <45 days before rwPD/after rwPD. Cohort-2 included patients treated with mirvetuximab soravtansine(MIRV) monotherapy with unpaired flanking pre-treatment samples(n=17) and flanking on- or post-treatment samples(n=11) without intervening therapy. Paired Wilcoxon signed-rank tests were applied for the chemotherapy cohort; analysis of covariance (adjusting for age/specimen site/sampling interval) was used for the MIRV cohort.

Results: MIRV therapy was associated with a significant decrease in *FOLR1*-expression(p=0.006) with a large effect size(Cohen's d=−1.46). Following platinum+taxane chemotherapy, *FOLR1*-expression was decreased in 15/20(75%) on-treatment samples(p=0.036). In contrast, no significant difference was observed between pre-/post-treatment samples(p=0.75), indicating chemotherapy-associated suppression was not sustained after treatment completion or progression.

Conclusion/Implications: Platinum+taxane chemotherapy and MIRV both reduce *FOLR1*-expression. Reduction with chemotherapy appears transient, occurring only during treatment/not persisting post-therapy. This treatment-state–dependent modulation suggests that FRα-expression is dynamically regulated rather than durably lost under cytotoxic pressure, underscoring the importance of contemporaneous FRα-assessment when selecting patients for FRα-targeted therapies. Given the modest sample sizes and

real-world heterogeneity, these findings should be considered preliminary and require validation in larger cohorts.

EP353 / #394

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

EARLY INFLAMMATORY INDICES AS PROGNOSTIC BIOMARKERS IN OVARIAN CANCER: INSIGHTS FROM DYNAMIC MARKER ASSESSMENT

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Introduction: Systemic inflammation is associated with ovarian cancer prognosis, but the optimal timing for measuring inflammatory indices remains unclear. We retrospectively studied high-grade ovarian cancer patients to analyze the link between inflammation and survival

Methods: This is a retrospective real-world study of patients with ovarian cancer treated at the Cancer Center, Oman, between March 2022 and December 2025. We evaluated associations between inflammatory markers and progression-free survival (PFS), adjusting for age, performance status at diagnosis, baseline CA 125, and stage.

Results: 44 patients were included in the study. Early on-treatment markers showed the strongest signal. Platelet count multiplied by neutrophil-to-lymphocyte ratio (P × N/L) at 3 months was inversely associated with PFS (partial correlation coefficient = -0.551; sample size = 36; p-value = 0.001; adjusted q-value = 0.003). Neutrophil-to-lymphocyte ratio (NLR) after 3 months was also inversely associated (partial correlation coefficient = -0.457; sample size = 36; p-value = 0.005; adjusted q-value = 0.017). In contrast, baseline albumin-to-alkaline phosphatase ratio (AAPR) was positively associated with PFS (partial correlation coefficient = +0.410; sample size = 40; p-value = 0.009; adjusted q-value = 0.022). Other screened baseline ratios (e.g., neutrophil-to-lymphocyte ratio, platelet-to-lymphocyte ratio, monocyte-to-lymphocyte ratio) did not remain significant after Benjamini-Hochberg false discovery rate correction.

Conclusion/Implications: In this cohort, three-month inflammatory indices were independently associated with shorter progression-free survival, while a higher baseline albumin-to-alkaline phosphatase ratio was associated with longer progression-free survival. These findings support incorporating dynamic inflammatory measures early in treatment into prognostic assessment and warrant validation in larger cohorts and with time-to-event modeling

EP354 / #395

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

GENE PREVALENCE AND CLINICAL FEATURES OF PIK3CA, ARID1A, AND CTNNB1 IN HIGH-GRADE EPITHELIAL OVARIAN CANCER IDENTIFIED BY NEXT-GENERATION SEQUENCING

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Introduction: Next-generation sequencing (NGS) identifies recurrent genomic alterations that may define biologic subgroups and potentially relate to clinical presentation and outcomes. We described the clinical characteristics of high-grade epithelial ovarian cancer (HGEOC) patients with PIK3CA, ARID1A, and CTNNB1 alterations.

Methods: This is a retrospective real-world study of patients with ovarian cancer treated at the Cancer Center, Oman, between March 2022 and December 2025. For gene-focused characterization, we compared PIK3CA+, ARID1A+, and CTNNB1+ patients by stage group (I–II vs III–IV), BRCA status (TYPE OF BRCA), presence of ascites at presentation, and best RECIST response.

Results: 38 patients were included in the study. the most prevalent gene was TP53 in 23/50 (46%). CTNNB1, BRCA1, and PIK3CA were each present in 10%, while ARID1A and BRCA2 were each present in 8%. In the PIK3CA+, ARID1A+, and CTNNB1+ groups, most patients had advanced-stage (III–IV) disease at presentation (approximately 60% in PIK3CA, 75% in ARID1A, and 80% in CTNNB1). PIK3CA and CTNNB1 cases were entirely BRCA-wild type, whereas ARID1A showed limited overlap with BRCA mutations (~25%). The presence of these alterations was also descriptively associated with the absence of ascites at presentation. Best RECIST responses, skewed toward complete response in these gene-positive subsets, especially CTNNB1.

Conclusion/Implications: Patients with PIK3CA, ARID1A, or CTNNB1 alterations were predominantly stage III–IV and largely BRCA-wild-type, and they tended to present without ascites. The responses appeared favorable in these small subgroups; these findings should be treated as descriptive, and larger cohorts with more complete outcome data are needed.

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Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

ASSOCIATION OF PLEURAL EFFUSION WITH PROGRESSION-FREE SURVIVAL IN AN OVARIAN CANCER COHORT

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Introduction: Pleural effusion at presentation is a marker of advanced disease burden in ovarian cancer, but its prognostic impact within real-world cohorts is variably captured in routine datasets.

Methods: This is a retrospective real-world study of patients with ovarian cancer treated at the Cancer Center, Oman, between March 2022 and December 2025. The exposure of interest was pleural effusion at presentation. The primary outcome was progression-free survival (PFS). Analyses were conducted using complete-case data for pleural effusion and PFS. Group summaries were reported using medians and interquartile ranges (IQR). Between-group differences were assessed using a Mann–Whitney U test, and effect size was estimated using Cliff's delta

Results: 44 patients with high-grade epithelial ovarian cancer were included. Pleural effusion was present in 36.4%. Patients with pleural effusion had substantially shorter PFS than those without pleural effusion: median PFS of 12.5 (IQR 5.75 to 15.25) versus 18.5 (IQR 14.75 to 25.75), respectively, corresponding to a 6-month difference in median PFS. This difference was statistically significant ($p = 0.00176$, Mann–Whitney U). The effect size was large (Cliff's delta 0.574, indicating materially higher PFS values in the no-effusion group).

Conclusion/Implications: In this cohort, pleural effusion at presentation was strongly associated with worse PFS, with an approximately 6-month reduction in median PFS and a large effect size. These findings support pleural effusion as a pragmatic baseline stratification variable in outcome analyses; confirmation in multivariable models adjusting for stage, performance status, and treatment strategy is warranted.

EP356 / #397

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

HIGH-GRADE EPITHELIAL OVARIAN CANCER WITH ER POSITIVITY: DISTINCT BIOMARKER SIGNATURES AND ROBUST EARLY RESPONSE

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Introduction: Estrogen receptor (ER) expression is an important biomarker used to characterize gynecologic malignancies and may correlate with tumor biology and treatment response. We describe the clinicopathologic features of the ER-positive High-Grade Epithelial Ovarian Cancer

Methods: This is a retrospective real-world cohort study of patients with ovarian cancer treated at the Cancer Center, Oman, between March 2022 and December 2025.Descriptive statistics were generated for baseline presentation, immunohistochemistry/molecular markers, tumor size, and early radiologic response, and Tumor size

Results: 50 patients were included in the study. The ER-positive subgroup included 22/50 patients (44%). Tumor size was a median size of 4.75 cm (range 1.5–16 cm). Ascites at presentation was common in ER-positive patients, whereas pleural effusion was absent. Within the ER-positive subgroup, WT1 was frequently positive, and p53 was very commonly positive. Early RECIST response at 3 months showed high rates of objective response, with CR in 47.1%, PR in 47.1%

Conclusion/Implications: In this cohort, ER positivity tumor was characterized by frequent WT1 and p53 positivity. Assessment using RECIST criteria at 3 months demonstrated impressive response rates in ER-positive cases, with 94.2% achieving either a complete or partial response. These findings suggest that ER positivity defines a distinct clinicopathologic subset of high-grade epithelial ovarian cancer with unique biomarker profiles and favorable early treatment responses. Further investigation is warranted to elucidate the prognostic and therapeutic implications of ER expression in this setting, as well as to explore the potential for ER-targeted therapies to improve long-term outcomes in this population

EP357 / #398

Topic: *AS06. Tumor Types / AS06c. Ovarian Cancer*

BEVACIZUMAB USE AND DISEASE BURDEN IN HIGH-GRADE EPITHELIAL OVARIAN CANCER: REAL-WORLD INSIGHTS FROM A RETROSPECTIVE COHORT

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Introduction: High-grade epithelial ovarian cancer (HGEOC) frequently presents with advanced-stage disease and variable response to first-line therapy. Real-world patterns of bevacizumab use may reflect disease burden and clinician selection.

Methods: This is a retrospective real-world cohort study of patients with ovarian cancer treated at the Cancer Center, Oman, between March 2022 and December 2025. Baseline variables, stage, ascites at presentation, pleural effusion, and tumor size were analyzed. Bevacizumab exposure was studied. Progression-free survival (PFS) was calculated.

Results: 44 patients were included in the study. Most tumors were high-grade serous. The majority presented with an advanced stage. Bevacizumab was used in 43% of patients. Ascites and pleural effusion were common. Bevacizumab exposure showed a *trend* toward an association with ascites at presentation: ascites occurred in 75% of bevacizumab-treated versus 44% of untreated patients (odds ratio, 3.82; Fisher p=0.067). No significant association was observed between bevacizumab and pleural effusion, stage IV versus stage III, or tumor size. PFS did not significantly differ between bevacizumab-exposed and unexposed patients. Baseline cancer antigen 125 tended to be higher in the treated group (median 369 vs 92.5, p=0.062).

Conclusion/Implications: In this real-world HGEOC cohort, Bevacizumab exposure showed a borderline association with ascites at presentation and trended toward higher baseline CA125, consistent with treatment selection for higher-burden disease. Larger cohorts and adjusted time-to-event models are needed to better estimate the independent effect of bevacizumab in routine practice.

EP358 / #92

Topic: *AS06. Tumor Types / AS06d. Rare Tumors*

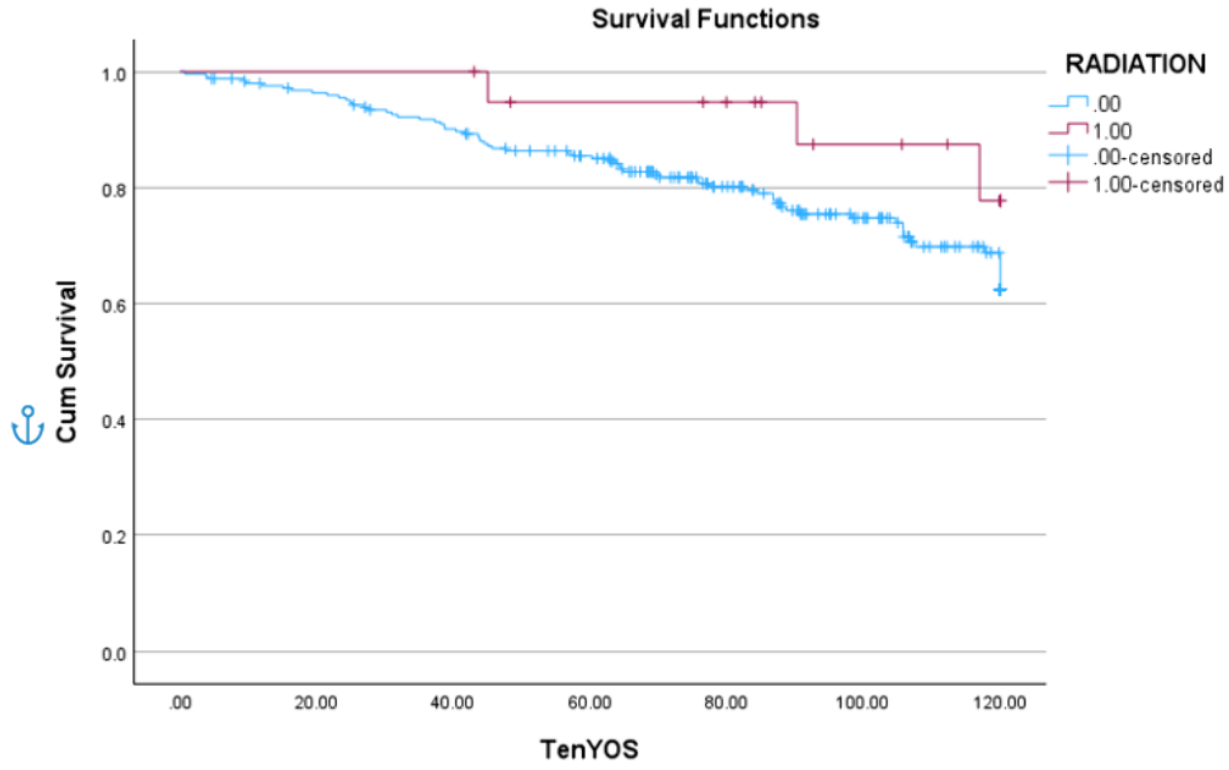
TREATMENT PATTERNS AND OVERALL SURVIVAL FOR SEROUS ENDOMETRIAL INTRAEPITHELIAL CARCINOMA - AN ANALYSIS OF THE NATIONAL CANCER DATABASE

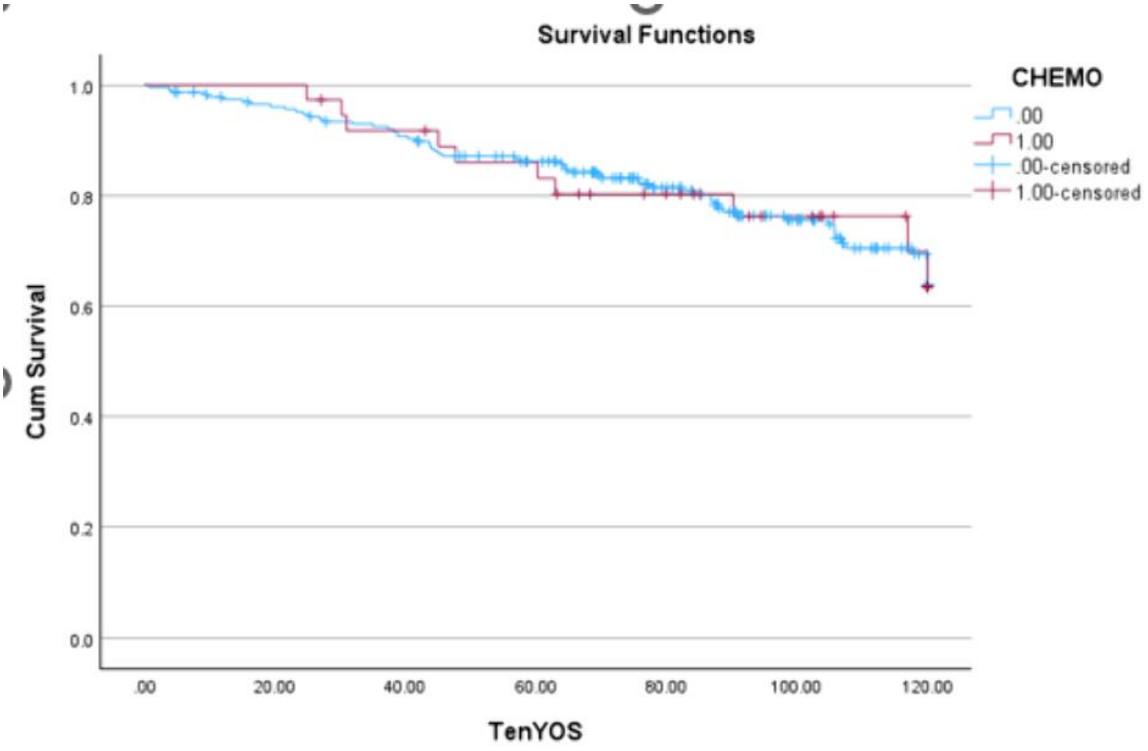
Gabriel Levin[1], Reitan Ribeiro[1], Raanan Meyer[2], Lucy Gilbert[1]
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Introduction: The natural history and long-term prognosis of serous endometrial intraepithelial carcinoma (SEIC) remains poorly characterized. In particular, the potential benefit of adjuvant therapy following diagnosis has not been clearly established.

Methods: A retrospective study of the national cancer database (NCDB) during 2004-2022, including women diagnosed with SEIC. We included women with a diagnosis of serous histology, behavior “in situ”, and a TNM post operative pathology tumor (T) of pIS, pX, and p0. Our primary outcome was 5 years and 10 years overall survival.

Results: Overall, 269 cases were included, with a median age of 65 (IQR 60-70), and a median follow-up of 90.3 months (IQR 63.8-123.2). The median overall survival was 197.3 months (95% CI 146.9-248.0), with 71 (26.4%) events of death. TOf the cohort, 37 (13.8%) women received chemotherapy, 20 (7.4%) received radiotherapy, and 42 (15.6%) received either chemotherapy or radiotherapy. Analysis for 5-years overall survival, there was no difference between women receiving radiotherapy or not, with 85.5%-83.6% alive at 5-years (log rank 0.216). In a 10-years analysis 77.7% were alive in the radiotherapy group vs. 62.4% in the non-radiotherapy group (log rank 0.167). For adjuvant chemotherapy, the 5-year overall survival was 71.7% in the chemotherapy group vs. 71.9%% in the non-chemotherapy group (log rank .985). In a 10-years analysis, the overall survival at 10-years was 63.5% for the chemotherapy group vs. 63.8% in the non-chemotherapy group (log rank .996).





Conclusion/Implications: The use of adjuvant chemotherapy or radiotherapy in SEIC was uncommon and was not associated with improved overall survival.

EP359 / #477

Topic: *AS06. Tumor Types / AS06d. Rare Tumors*

EXPLORING PATTERNS OF DISEASE AND TREATMENT OUTCOMES IN NEUROENDOCRINE CARCINOMA OF THE CERVIX

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Introduction: Introduction: Neuroendocrine carcinoma of the cervix (NECC) is a rare but aggressive cancer with poor prognosis. This study aims to describe treatment, outcomes, and characterize patterns of recurrence in NECC.

Methods: Methods: In this retrospective case series of NECC patients treated at a Canadian tertiary cancer centre (2011 – 2024), review of patient records extracted demographic, clinicopathologic, treatment and outcomes data. As part of initial exploratory analysis, descriptive statistics summarized survival and treatment type by disease extent.

Results: Results: Thirty cases were identified with median age 52 years (22-86), of which 36.7% (n=11) remain alive at median follow-up of 4.8 years (2.1 - 9.6). Initial treatment included systemic therapy, radiotherapy (RT), and surgery (Table 1), with one patient receiving best supportive care
only.

Table 1
Initial treatment for entire cohort

	Local[1] (n=9)		Regional[2] (n=8)		Metastatic (n=13)	
	N	%	N	%	N	%
ChemoEBRT + brachytherapy[3]	7	77.8	7	87.5	1	7.8
Surgery[4] + adjuvant chemotherapy or chemoEBRT[5]	2	22.2	1	12.5		
Palliative chemotherapy[6]					5	38.5
Palliative chemo + EBRT[7]					5	38.5
Palliative EBRT[8]					1	7.8
Supportive care[9]					1	7.8

[1]Local disease is defined as confined to the cervix.
[2]Regional disease includes pelvic or para-aortic node positive disease.
[3]Most patients (n=14) received cisplatin-etoposide (4 cycles, q21d), external-beam radiotherapy (EBRT) (45Gy in 25F) and brachytherapy (for HR-CTV D90: 78.9 - 92.9Gy EQD2). Some node-positive patients received RT boost to affected lymph nodes. One patient with regional disease, who of note had concurrent metastatic breast cancer, received weekly cisplatin (5 cycles).
[4]Local disease: radical hysterectomy with bilateral salpingo-oophorectomy (n=2); one with adjuvant chemotherapy, one following curative intent chemoEBRT + brachytherapy with residual cervical disease post-treatment. Regional disease: radical hysterectomy, partial vaginectomy, bilateral ureterolysis and bilateral pelvic lymphadenectomy with adjuvant chemoEBRT (n=1).
[5]ChemoEBRT refers to concurrent chemotherapy and EBRT, whereas chemo + EBRT refers to chemotherapy and EBRT delivered in sequence
[6]Chemotherapy regimens included cisplatin-etoposide (4-6 cycles, q21d, n=3), carboplatin-etoposide (2 cycles, q21d, n=1) and low dose carboplatin (2 cycles, q21d, n=1).
[7]Most patients (n=3) received pelvic EBRT (40Gy in 15F) after cisplatin-etoposide (4 cycles, q21d). Two received pelvic EBRT (20Gy in 5F), one after cisplatin-etoposide (4 cycles, q21d) and one before carboplatin-etoposide (2 cycles).
[8]EBRT of 20Gy in 5F to the pelvis.
[9]One patient had disease progression prior to planned carboplatin-etoposide (4 cycles, q21d), and was transitioned to best supportive care only.

Of those without distant metastases at diagnosis (n=17), 58.8% (n=10) had not experienced recurrence as of last follow-up. Lung and liver were the most frequent sites of first recurrence (Table 2), notably none at brain. Those presenting with metastatic disease survived 1 to 19 months (median 9). Among patients receiving chemotherapy (n=28), 25% (n=7) of experienced toxicity that required cycle reduction (n=4) or treatment modification (n=3). Non-response to initial 1-2 cycles was rare

(n=3).

Table 2
Survival and recurrence (crude rates)

	Local[1] (n=9)	Regional[2] (n=8)	Metastatic (n=13)
Alive, n (%)	5 (55.6)	6 (75.0)	0
Median follow up time,[3] months (range)			
Alive	90.1 (57.6 - 174.8)	64.8 (26.3 - 114.9)	
Deceased	52.8 (24.9 - 62.4)	40.5 (35.5 - 45.6)	7.4 (2.0 - 19.4)
Number with metastatic recurrence, n (%)	5 (55.6)	2 (25.0)	
Median time of metastatic recurrence,[3] months (range)	13.8 (9.7 - 51.1)	28.5 (18.0 - 39.0)	
First sites of metastasis[4]			
Lung	2		4
Bone			4
Liver	2		1
Peritoneum			2
Retroperitoneum		1	1
Soft tissue neck mass	1		
Rectus Abdominis		1	
Pancreas			1
Supraclavicular lymph node			1
Ovary			1

[1]Local disease is defined as confined to the cervix.
[2]Regional disease includes pelvic or para-aortic node positive disease.
[3]Calculated from date of diagnosis until most recent follow-up for patients who are alive, and until date of death for patients who are deceased.
[4]When multiple metastatic sites were identified concurrently, each site was counted individually. For those with metastatic disease at presentation, the first site was counted as sites involved at diagnosis. Only one local recurrence was seen at vaginal vault.

Conclusion/Implications: Conclusion: Although outcomes for NECC patients are poor, a subset without metastatic disease at presentation may achieve long survival without recurrence. Better understanding of conditions that lead to disease-free status is imperative to inform treatment and subsequent surveillance approaches.

EP360 / #405

Topic: *AS06. Tumor Types / AS06d. Rare Tumors*

OVARIAN CLEAR CELL CARCINOMA - A SINGLE CENTER EXPERIENCE FROM QUEBEC

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Introduction: Ovarian clear cell carcinoma (CCC) is an uncommon histologic subtype of epithelial ovarian carcinoma. Available evidence is largely derived from retrospective series, with limited contemporary data from Western cohorts. We aimed to evaluate clinicopathologic characteristics, treatment patterns, and survival outcomes of patients with ovarian CCC treated at a Canadian tertiary center.

Methods: a retrospective cohort study including patients with ovarian CCC treated between 2017 and 2025. Clinical, surgical, and treatment data were abstracted from a prospectively maintained institutional database. Progression-free survival (PFS) and overall survival (OS) were estimated using the Kaplan–Meier method. Subgroup analyses were performed according to stage and residual disease status.

Results: 31 patients were included. Median age at diagnosis was 55 years (IQR 49–58), and median follow-up was 36 months (IQR 16–70). Stage I disease was present in 55%, while 45% had stage II–IV disease. Complete macroscopic cytoreduction (R0) was achieved in 70%. During follow-up, 29% experienced recurrence and 23% died. Median PFS and OS were not reached. Mean PFS was 74 months (95% CI 56–92), and mean OS was 85 months (95% CI 69–101). The 5-year OS for the entire cohort was 81%. Median PFS for stage III disease was 11 months. In advanced disease, 36-month OS was 100% following R0 resection versus 50% following R1 resection (log-rank p=0.15). In early-stage disease, OS did not differ by substage. A higher number of adjuvant chemotherapy cycles in early-stage patients was numerically associated with improved OS (p=.052).

Conclusion/Implications: ovarian CCC demonstrated encouraging survival outcomes, particularly among patients achieving complete cytoreduction.

EP361 / #677

Topic: *AS06. Tumor Types / AS06d. Rare Tumors*

COMPLETE CYTOREDUCTIVE SURGERY AND ADJUVANT HORMONAL MONOTHERAPY VS. CHEMOTHERAPY IN WOMEN WITH STAGE III LOW-GRADE SEROUS OVARIAN CARCINOMA: A NCDB STUDY

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Introduction: Women with advanced-stage, low-grade serous ovarian carcinoma (LGSOC) have poor chemotherapy response rates. Most LGSOC tumors overexpress hormone receptors, which represent a viable treatment target. There is scarce data to compere adjuvant hormonal monotherapy vs. adjuvant chemotherapy. We aimed to compare patients with complete cytoreduction of stage III LGSOC treated with adjuvant hormonal therapy vs. chemotherapy.

Methods: Patients with ovarian cancer diagnosed between 2004 and 2022 were identified from the National Cancer Database (NCDB). We included only LGSOC, stage III with complete cytoreduction. We included only patients who received either adjuvant chemotherapy or hormonal therapy, defined based on treatment initiation within 90 days of surgery. Propensity score matching was performed using age and race as covariates.

Results: Overall, 189 patients met inclusion criteria, including 22 patients receiving adjuvant hormonal therapy and 167 receiving adjuvant chemotherapy. After propensity score matching based on age and race, the final matched cohort included 41 patients (22 hormonal vs. 19 chemotherapy). The median age was 54 years (IQR 45-66), and the median follow up period was 73 months (IQR 64-88), with 9 (22%) events of death. The median overall survival was not reached in any of the arm. In survival analysis – overall survival was similar between arms ; mean 101 months (95% CI 90-112) in hormonal therapy vs. 106 (95% CI 90-123), log rank =.538 in chemotherapy.

Total ovarian cases in NCDB: 313,216

↓

Included only grade 1; excluded grade 2, 3, 4, 9, missing: 18,044 excluded

↓

Serous histology (8440, 8460, 8461); excluded all other histologies: 4,139 excluded

↓

Clinical stage III (ANALYTICSTAGE3); excluded all other stages: 1,953 excluded

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Complete cytoreduction; excluded unknown or not complete cytoreduction: 259 excluded

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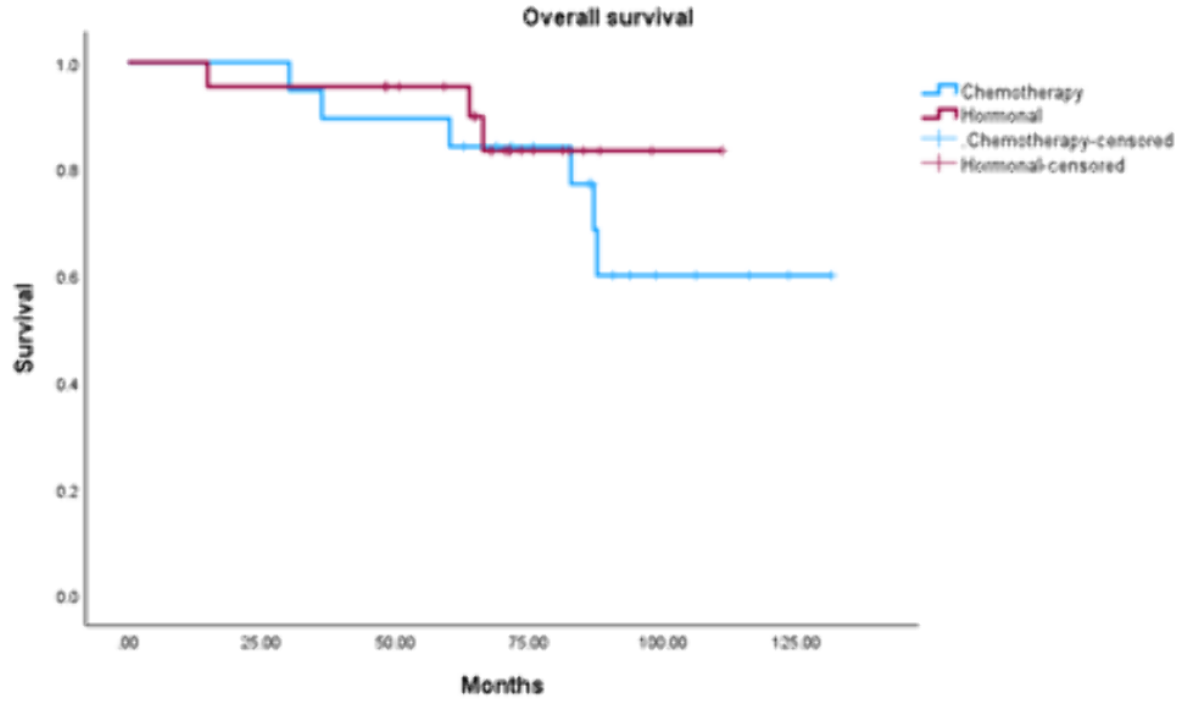
Excluded no adjuvant treatment (no chemotherapy and no hormone): 206 excluded

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Excluded patients receiving both treatments: 189 excluded (22 hormonal, 167 chemotherapy)

↓

Propensity-matched cohort: 41 patients (22 hormonal, 19 chemotherapy)



Conclusion/Implications: Overall survival was similar in hormonal adjuvant monotherapy vs. chemotherapy, indicating that even in large national database, the adjuvant treatment question is challenging to answer.

EP362 / #439

Topic: *AS06. Tumor Types / AS06d. Rare Tumors*

BIOLOGICAL HETEROGENEITY OF CERVICAL NEUROENDOCRINE CARCINOMA REVEALED BY IMMUNOHISTOCHEMICAL ANALYSIS

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Introduction: Cervical neuroendocrine carcinoma (NEC) is a rare and aggressive malignancy in which human papillomavirus (HPV) infection is a major etiological factor. This differs from the pathogenesis of small cell lung cancer (SCLC), although cervical NEC has recently been classified into molecular subtypes analogous to those described in SCLC, suggesting heterogeneity. Their clinical significance remains unclear, so we herein investigated immunohistochemically-defined molecular subtypes of cervical NEC and their association with clinical outcomes.

Methods: We performed immunohistochemical (IHC) staining to evaluate the expression of p16, Rb, and p53 in 20 patients with cervical NEC. In addition, ASCL1, NEUROD1, POU2F3, and YAP1 expression was assessed by IHC in all cases. Histopathological features, including the presence of mixed histological components such as squamous cell carcinoma and adenocarcinoma, were also evaluated. Tumors were classified according to the dominant transcription factor expression pattern using H-score-based evaluation. Associations among histopathological features, immunohistochemical subtypes and clinical outcomes were analyzed.

Results: Most cases demonstrated diffuse p16 positivity, consistent with HPV-associated tumorigenesis. Rb expression was frequently reduced, showing diffusely weak or heterogeneous staining rather than complete loss. Aberrant p53 expression patterns were observed in some cases. A subset of cases demonstrated an immunohistochemical profile resembling that of SCLC, despite HPV-associated features. Additionally, mixed histological components, such as squamous cell carcinoma and adenocarcinoma, were identified in several cases.

Conclusion/Implications: Histological and immunohistochemical findings support the presence of biological heterogeneity in cervical NEC, including variable Rb expression and mixed histological components. These findings may improve understanding of cervical NEC pathogenesis and have potential therapeutic implications.

EP363 / #427

Topic: *AS06. Tumor Types / AS06d. Rare Tumors*

HER2 AND FOLATE RECEPTOR ALPHA EXPRESSION IN OVARIAN CLEAR CELL CARCINOMA: A COMPREHENSIVE MOLECULAR PROFILING ANALYSIS

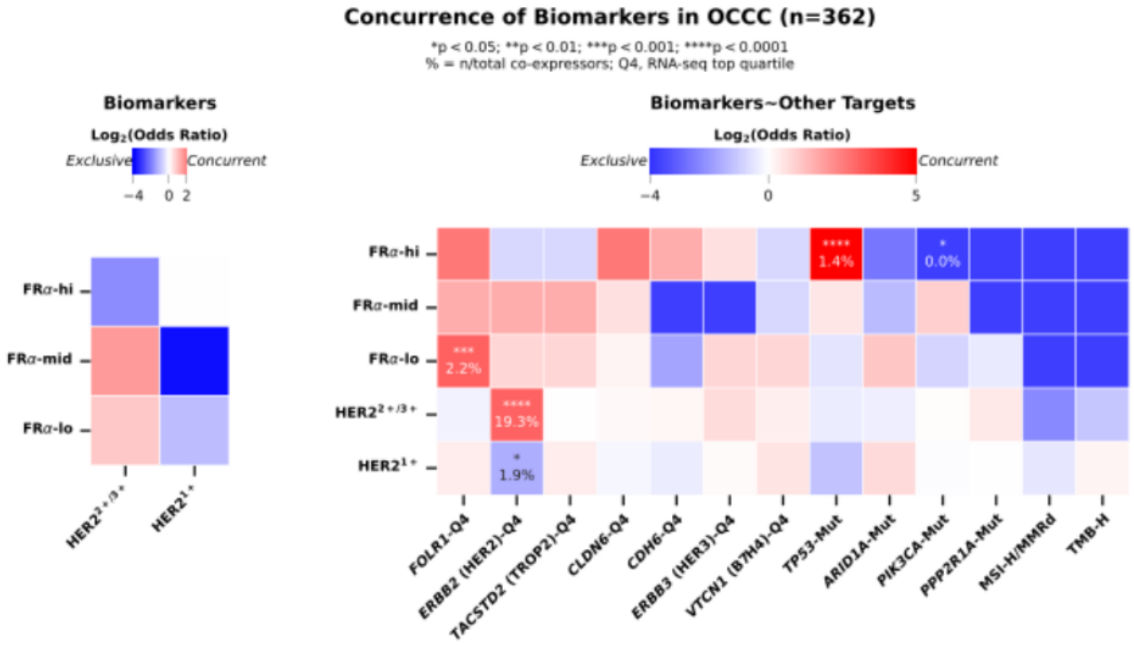
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Introduction: Background: Comprehensive biomarker characterization of ovarian clear cell carcinoma (OCCC) may reveal novel therapeutic options.

Methods: Methods: Molecular data from 362 OCCC cases were analyzed from Caris Life Sciences. Expression of HER2 and folate receptor alpha (FRα) by immunohistochemistry were assessed. FRα expression was defined by 2+/3+ staining intensity present in 25–49% of cells (low), 50–74% (medium), or ≥75% (high). HER2 expression was defined as ≥10% of cells with either 2+/3+ staining intensity or 1+ staining. Other ADC targets were assessed by whole-transcriptome RNA sequencing. *TP53*, *ARID1A*, *PIK3CA*, and *PPP2R1A* mutations and tumor mutational burden (TMB H) rates were evaluated using whole exome DNA sequencing, and combined microsatellite instability high/mismatch repair deficiency (MSIH/MMRd) assessment by DNA sequencing and IHC.

Results: Results: HER2 2+/3+ expression was observed in 40.6% of OCCC cases, with 16.9% classified as HER2 1+. HER2 2+/3+ status was strongly associated with high *ERBB2* RNA seq (19.3% co expressors; OR=8.34, p<0.0001; Figure 1). FRα expression

was uncommon and co expression of FRα and HER2 was rare. Common mutations were *ARID1A* (55.7%), *PIK3CA* (50.4%), *TP53* (12.5%), and *PPP2R1A* (11.6%). MSIH/MMRd (2.2%) and TMB-H (4.4%) were uncommon. Figure
1:



Conclusion/Implications: Conclusions: HER2 2+/3+ expression in over 40% of OCCC cases supports prioritizing HER2 directed therapeutic strategies. FRα is rarely expressed in OCCC, distinguishing it from other ovarian histologies. The OCCC mutational landscape is characterized by common ARID1A and PIK3CA alterations, molecular aberrations which have been difficult to therapeutically target. These data support continued development of biomarker driven, OCCC specific clinical trial design.

EP364 / #665

Topic: *AS06. Tumor Types / AS06d. Rare Tumors*

MUCINOUS OVARIAN CARCINOMA: CLINICAL AND GENOMIC CHARACTERIZATION OF 86 CASES

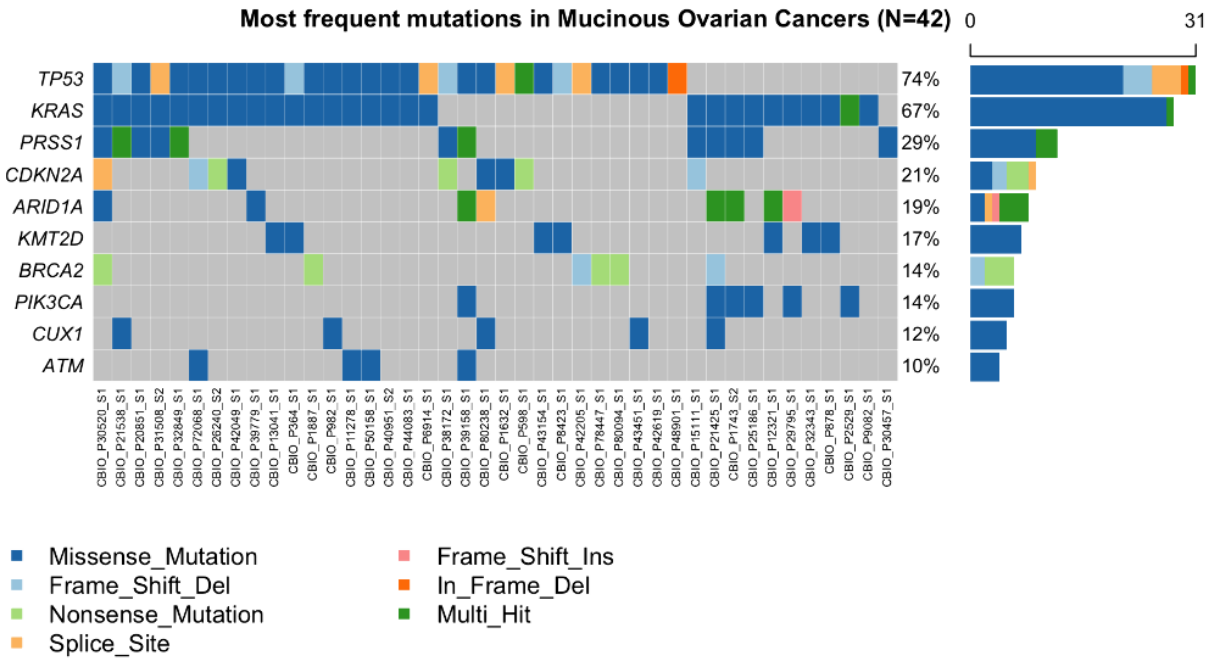
Kelly Modi, Satyakam Mishra, Danniele Lacad, Kyle Kirshen, Madison Zizzo, Alexis Rabbitt, Carlos Parra-Herran, David Kolin, Guruprasad Ananda, Robert Gentleman, Joyce Liu, Nabihah Tayob, Ursula Matulonis, Elizabeth Stover
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Introduction: Mucinous ovarian carcinoma (MOC) is a rare epithelial ovarian cancer with distinct biology, limited treatment data, and poor outcomes, particularly in advanced/recurrent disease. We describe the clinicopathologic features, treatment patterns, and genomic findings in a tertiary referral cohort.

Methods: We performed a retrospective review of 86 patients with histologically confirmed MOC at Dana-Farber Cancer Institute. Clinical variables were collected from medical records. Targeted panel tumor sequencing was analyzed for 42 patients.

Results: Most patients presented with stage I disease (n=55, 64%). Fifteen patients underwent surgery alone. Of stage I patients, 75% received chemotherapy, at diagnosis or recurrence. All stage II-IV patients received chemotherapy. 35% of stage I patients recurred, whereas 77% of stage II-IV patients recurred. For initial platinum regimen, 69% of patients received carboplatin/paclitaxel and 13% received 5-FU/oxaliplatin. 37 patients received second-line or higher systemic therapy. 24 patients demonstrated prolonged treatment duration (>85 days) with at least one regimen, including KRAS-mutant patients treated with RAS/MEK inhibitor regimens, HER2 IHC-positive patients treated with trastuzumab-containing regimens or trastuzumab-deruxtecan, patients receiving single-agent bevacizumab or 5-FU–based regimens, and one BRCA2-mutant patient treated with olaparib. The most common genomic alterations included mutations in *KRAS* (79%) and *TP53* (74%), copy number loss in *CDKN2A* and/or *CDKN2B* (46%) and copy gain in *ERBB2* (40%). Of 33 patients with germline testing information, 6 had pathogenic germline
variants.

Variable	Category	Number (%)
Age	Median	51
	Min	18
	Max	84
Stage	Early (I)	55 (63.9%)
	Late (II, III, IV)	30 (34.8%)
	Unknown	1 (1.1%)
Grade	Grade 1	33 (38.3%)
	Grade 2	23 (26.7%)
	Grade 3	7 (8.1%)
	Not available	23 (26.7%)
Laterality	Bilateral	18 (20.9%)
	Unilateral	68 (79.06%)
Chemotherapy treatment	Chemotherapy	71 (82.5%)
	No chemotherapy	15 (17.4%)
Recurrence	Yes	43 (50%)
	No	40 (46.5%)
	Not available	3 (3.4%)
Total Lines of therapy	0	15 (17.4%)
	1	32 (37.2%)
	2	16 (18.6%)
	3	11 (12.7%)
	4+	12 (14.0%)
Platinum Status after First Line	No Recurrence	46 (53.4%)
	Recurrence - Platinum Refractory	8 (9.3%)
	Recurrence - Platinum Resistant	12 (14.0%)
	Recurrence - Platinum Sensitive	17 (19.8%)
	Not available	3 (3.5%)
Germline testing	No pathogenic mutation	18 (20.9%)
	Pathogenic mutation	6 (7.0%)
	Variant of uncertain significance	9 (10.5%)
	Not available	53 (61%)



Conclusion/Implications: MOC demonstrates substantial heterogeneity in treatment course and outcomes, highlighting the need for integrating clinical and genomic data to guide treatment options. Common genomic alterations represent potential new therapeutic targets for MOC.

EP365 / #1019

Topic: *AS06. Tumor Types / AS06d. Rare Tumors*

HER2 AND FOLATE RECEPTOR ALPHA EXPRESSION IN LOW-GRADE SEROUS OVARIAN CARCINOMA: A COMPREHENSIVE MOLECULAR PROFILING ANALYSIS

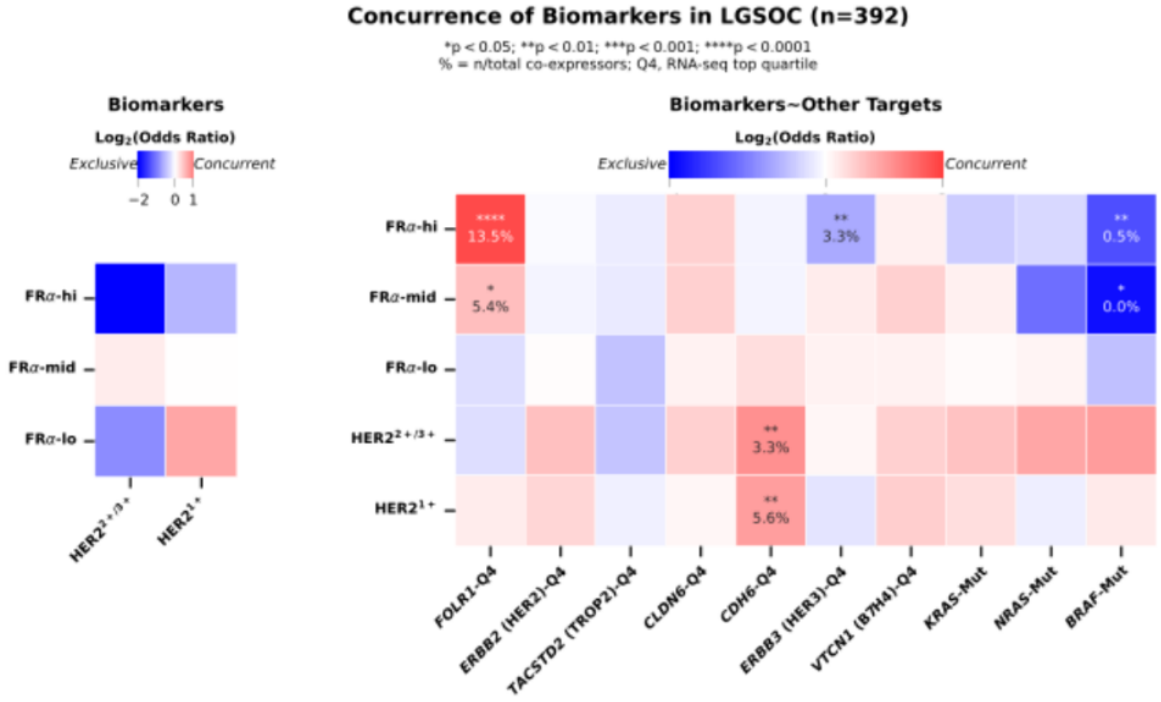
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Introduction: Low grade serous ovarian cancer (LGSOC) is a rare histology with limited response to standard chemotherapy. Endocrine therapy has shown clinical activity, and MEK inhibitors (MEKi) have transformed the treatment of *KRAS* mutated (mut) tumors. Comprehensive biomarker characterization may help identify additional actionable targets.

Methods: Molecular data from 392 LGSOC cases were analyzed from Caris Life Sciences databases. HER2 and folate receptor alpha (FRα) expression were evaluated by immunohistochemistry (IHC). FRα expression low, medium or high was defined as 2+/3+ staining intensity in 25–49%, 50–74% or ≥75% of cells. HER2 expression was defined as ≥10% of cells with either 2+/3+ or 1+ staining intensity. ADC targets were assessed by whole-transcriptome RNA-seq. *KRAS*, *NRAS*, and *BRAF* mutations were evaluated using whole exome DNA seq. Odds ratios (OR) were calculated using chi-square tests.

Results: FRα expression was observed in 51.5% of LGSOC : FRα high, medium, and low in 24.2%, 14.3%, and 13.0%, respectively. HER2 2+/3+ was present in 6.6%. FRα high IHC was

strongly associated with high FOLR1 RNA seq expression (13.5% co-expressors; OR=7.02, p<0.0001; Figure 1). *KRAS*mut was the most common genomic alteration at 22.6%, followed by *BRAF* (10.3%) and *NRAS* (7.2%). Figure 1: Odds Ratios Between Biomarkers in LGSOC



Conclusion/Implications: FRα is expressed in >50% of LGSOC. FRα expression has the potential to serve as an additional predictive biomarker and complement existing MEKi and endocrine therapies. Future analyses are needed to classify LGSOC by the presence and overlap of predictive biomarkers. These data support the incorporation of FRα testing into the molecular workup of LGSOC.

EP366 / #20

Topic: *AS06. Tumor Types / AS06e. Sarcomas*

SURVIVAL OUTCOMES IN PATIENTS WITH STAGE I UTERINE LEIOMYOSARCOMA UNDERGOING ADJUVANT THERAPY

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Introduction: Uterine leiomyosarcoma (uLMS) is an aggressive malignancy with high recurrence rates and poor prognosis. For stage I disease, post-operative observation currently remains the standard of care despite limited survival outcomes. We sought to evaluate oncologic outcomes among patients managed with observation versus adjuvant therapy.

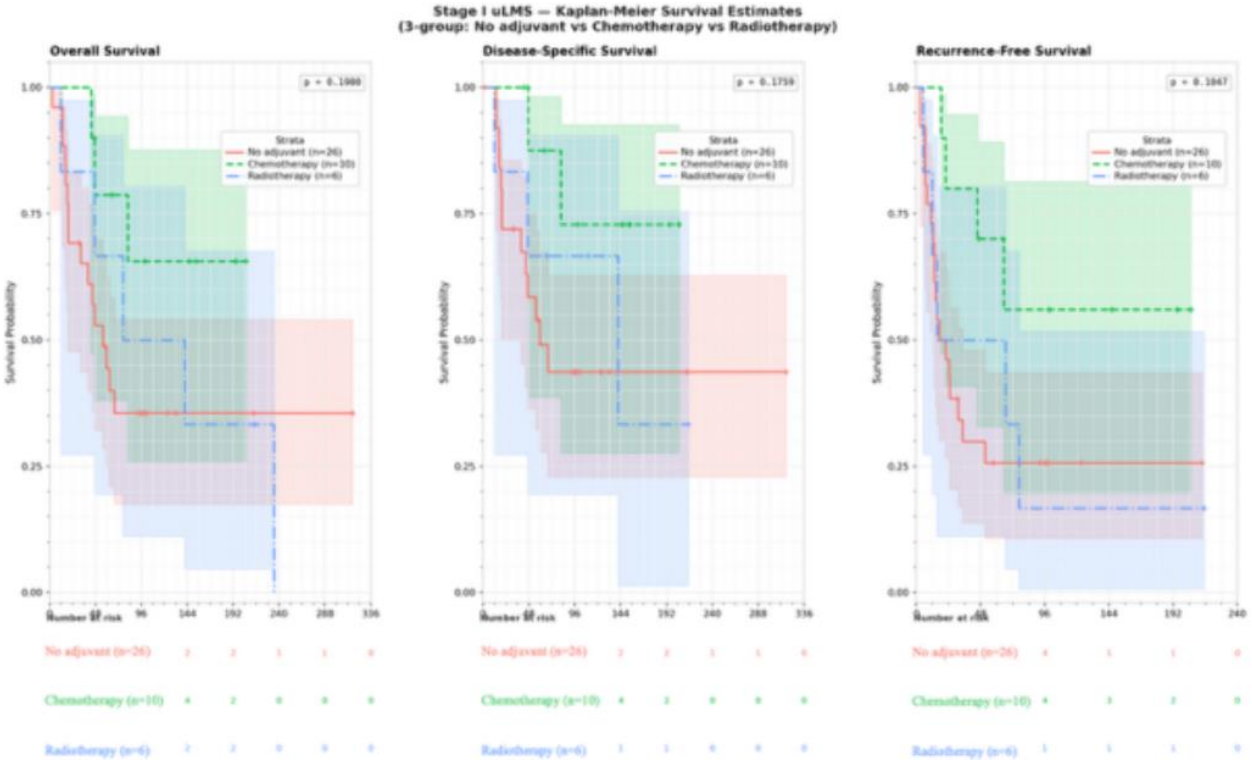
Methods: We conducted a retrospective study of patients with stage I uLMS who underwent surgical management between 1997 and 2023 at a tertiary care centre. Recurrence-free survival (RFS), disease-specific survival (DSS), and overall survival (OS) were estimated using Kaplan-Meier methods. Cox proportional hazards regression adjusted for age at surgery was used to assess associations between adjuvant treatment and survival.

Results: Of 42 patients, 26 (62%) received no adjuvant therapy, 10 (24%) chemotherapy, and 6 (14%) radiotherapy. Median follow-up was 55.4 months. Median OS was 55.4 months, not reached, and 141.6 months for the no adjuvant, chemotherapy, and radiotherapy groups, respectively; corresponding RFS was 17 months, not reached, and 66.5 months. Log-rank tests did not reach significance for any endpoint (OS p=0.19, DSS p=0.18, RFS p=0.11), likely reflecting limited power. On age-adjusted Cox regression, chemotherapy was independently associated with improved OS (HR 0.23, p=0.029), DSS (HR 0.19, p=0.040), and RFS (HR 0.31, p=0.037) versus no adjuvant therapy. Radiotherapy conferred no significant benefit on any
endpoint.

Age-Adjusted Cox Proportional Hazards Regression

Endpoint	Comparison	HR	95% CI	p-value
OS	Observation vs Chemotherapy	**0.23**	0.06 – 0.86	**0.029 ***
	Observation vs Radiotherapy	0.57	0.19 – 1.73	0.322
DSS	Observation vs Chemotherapy	**0.19**	0.04 – 0.93	**0.040 ***
	Observation vs Radiotherapy	0.55	0.15 – 2.04	0.375
RFS	Observation vs Chemotherapy	**0.31**	0.11 – 0.94	**0.037 ***
	Observation vs Radiotherapy	0.84	0.30 – 2.29	0.727

*HR = hazard ratio; CI = confidence interval. Reference group: Observation (no adjuvant therapy). Adjusted for age at time of surgery. * p < 0.05.*



Conclusion/Implications: Adjuvant chemotherapy was associated with improved survival in stage I uLMS after adjustment for age, while radiotherapy showed no measurable benefit. These findings should be interpreted cautiously given the small sample size and chemotherapy regimen heterogeneity.

EP367 / #816

Topic: *AS06. Tumor Types / AS06e. Sarcomas*

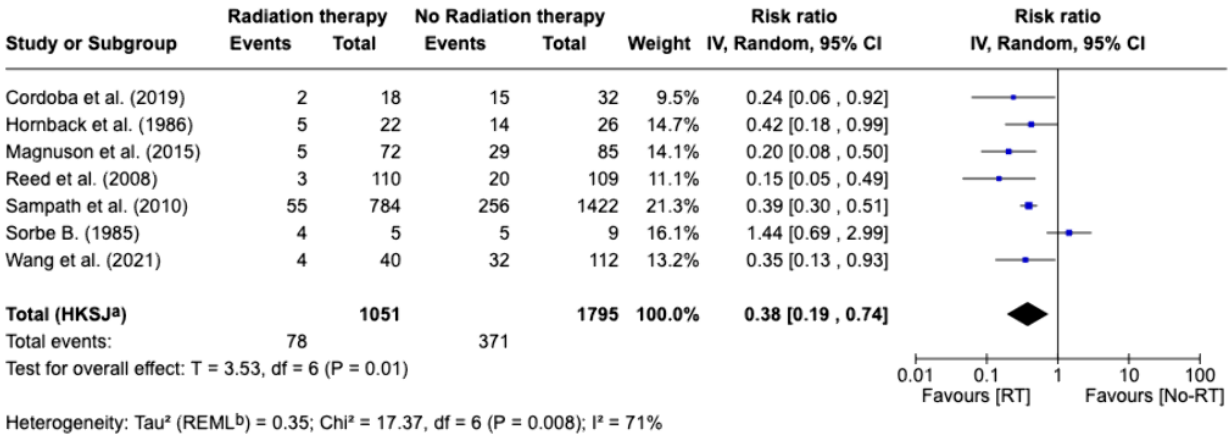
ADJUVANT RADIOTHERAPY IN UTERINE SARCOMAS: A SYSTEMATIC REVIEW AND META-ANALYSIS OF PELVIC RECURRENCE AND DISTANT METASTASIS

Farley Cantidio[1], Gabriel Gil[1], Agnaldo Filho[2], Paulo Diniz[3], Eduardo Candido[2], Marcos Regalin[1], Giselle Ponciano[1], Warne Andrade[3], Maria Gil[4]
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Introduction: The role of adjuvant radiotherapy (RT) in uterine sarcomas remains controversial, particularly regarding locoregional control and distant disease. We conducted a systematic review and meta-analysis to evaluate the impact of RT compared with no RT.

Methods: This systematic review followed PRISMA guidelines, with protocol registration. A comprehensive search of PubMed, Embase, Scopus, Web of Science, and Cochrane Central identified 2869 records; 2378 were screened after duplicate removal. Following exclusions, seven studies were included. Two reviewers independently screened, extracted data, and assessed risk of bias (Cochrane and ROBINS-I). The analysis included 4477 patients with heterogeneous histologies, including leiomyosarcoma, carcinosarcoma, and endometrial stromal sarcoma, predominantly treated with primary surgery (TAH±BSO). Most patients had early-stage disease, although staging and grading data were variably reported. Radiotherapy characteristics varied across studies (30–50.4 Gy, 1.7–2.0 Gy/fraction, with or without brachytherapy). Risk ratios (RR) were pooled using fixed- or random-effects models based on heterogeneity (I^2), with sensitivity analyses by study design.

Results: Adjuvant RT significantly reduced pelvic recurrence (RR 0.38, 95% CI 0.19–0.74; p=0.01; I^2=71%), with consistent direction across studies. The randomized trial showed marked benefit (RR 0.15, 95% CI 0.05–0.49; p=0.002). For distant metastasis (three studies, n=317), RT was not associated with a reduction and was linked to higher observed rates (RR 2.28, 95% CI 1.56–3.34; p<0.0001; I^2=0%). Survival outcomes did not differ meaningfully between
groups.

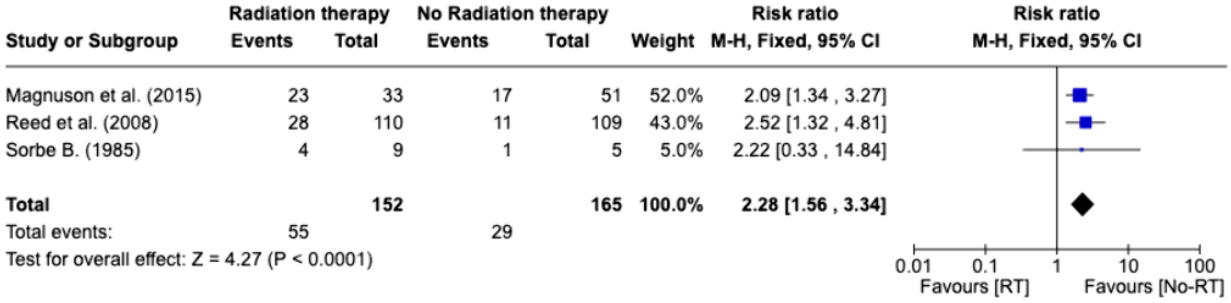


Heterogeneity: Tau² (REML[b]) = 0.35; Chi² = 17.37, df = 6 (P = 0.008); I² = 71%

Footnotes

[a]CI calculated by Hartung-Knapp-Sidik-Jonkman method.

[b]Tau² calculated by Restricted Maximum-Likelihood method.



Heterogeneity: Chi² = 0.24, df = 2 (P = 0.89); I² = 0%

Conclusion/Implications: Adjuvant RT improves locoregional control but does not appear to reduce distant recurrence, likely reflecting tumor biology and selection bias. RT supports local control, while effective systemic strategies remain essential.

EP368 / #482

Topic: *AS06. Tumor Types / AS06e. Sarcomas*

EVALUATION OF THE EFFICACY AND SAFETY OF HORMONE THERAPY FOR ADVANCED OR RECURRENT LOW-GRADE ENDOMETRIAL STROMAL SARCOMA: A MULTICENTER RETROSPECTIVE STUDY (KCOG-G2201S)

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Introduction: To evaluate the efficacy and safety of hormone therapy for advanced or recurrent low-grade endometrial stromal sarcoma (LGESS).

Methods: We analyzed cases treated with hormone therapy (medroxyprogesterone acetate, aromatase inhibitors, etc.) for advanced or recurrent LGESS at participating institutions of the Kansai Clinical Oncology Group (KCOG) between January 2011 and December 2021, focusing on cases diagnosed as LGESS by central pathological review. We evaluated progression-free survival (PFS), overall survival (OS), duration of treatment,

safety, objective response rate (ORR) in cases with unresectable disease, and duration of response (DOR).

Results: Thirty cases were enrolled from 15 institutions, and 26 cases were included in the analysis. A total of 43 treatment courses were administered across the 26 cases. The median follow-up period was 50 months; the median PFS was 69 months; the median OS had not yet been reached, and the 5-year OS rate was 78.5%. Among the 29 treatment courses involving hormone therapy alone, the ORR was 31.0% and the median DOR was 62.5 months. The ORR was 46.6% in the group with no prior hormone therapy, 25% in the group with prior hormone therapy, 25% in the group with prior chemotherapy, and 32% in the group with no prior chemotherapy. Treatment discontinuation due to adverse events occurred in only 2 patients (4.5%).

Conclusion/Implications: Hormone therapy for advanced or recurrent LGESS suggests a high response rate when used as first-line treatment, and no clear impact was observed based on prior chemotherapy history. Most adverse events were manageable, and long-term administration was possible safely.

EP369 / #1024

Topic: *AS06. Tumor Types / AS06e. Sarcomas*

COMPUTED TOMOGRAPHY IMAGING FEATURES AND PATTERNS OF SPREAD IN PATIENTS WITH UTERUS CARCINOSARCOMAS

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Introduction: Uterine carcinosarcoma (UCS) is a rare, highly aggressive mixed epithelial-mesenchymal tumor. Computed tomography (CT) is the gold standard for systemic evaluation; however, specific imaging phenotypes of pelvic carcinosarcomas are often poorly defined. Understanding distinct CT imaging features and predictable patterns of spread is essential for improving diagnostic accuracy, early detection of extrauterine involvement, and personalized treatment.

Methods: Study included 66 patients with histologically confirmed UCS (FIGO 2023 stage I–IV) treated 2013 - 2025 at the Prykarpattia Clinical Oncology Center (Ukraine). Clinical characteristics, CT imaging, tumor differentiation, surgery, survival outcomes, Cox regression were estimated.

Results: The median age was 64.5±1.21 years. Stage distribution: I (22.3%), II (18.2%), III (32.3%), and IV (27.2%). Most cases (84.8%) presented as large, heterogeneously enhancing intrauterine masses. Key CT findings included cystic degeneration/necrosis (72.7%) and deep myometrial invasion (>50%) in 60.8%. Extrauterine disease was detected in 59.5% at initial staging. CT identified pelvic (28.8%) and para-aortic (15.2%) lymphadenopathy (NODE-RADS 3-4), peritoneal carcinomatosis (13.1%), and lung metastases (10.1%). G3-G4 tumors comprised 68.6%. Complete surgical cytoreduction significantly improved median overall survival (OS) compared to incomplete (52 vs. 28 months; p=0.01). Median OS for the cohort was 32 months. FIGO stage (HR 2.45, p<0.01) and CT-detected deep myometrial invasion (HR 1.89, p=0.03) were independent prognostic factors.

Conclusion/Implications: CT effectively characterizes UCS through features like large necrotic masses and deep invasion. Early extrauterine spread is highly prevalent. CT-detected invasion and FIGO stage are critical prognostic markers, while complete cytoreduction remains the primary factor for improving survival.

EP370 / #198

Topic: *AS06. Tumor Types / AS06e. Sarcomas*

ASSOCIATION OF SURGICAL APPROACH WITH SURVIVAL IN CLINICALLY STAGE I UTERINE LEIOMYOSARCOMA: AN NCDB ANALYSIS

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Introduction: We aim to compare oncologic and perioperative outcomes after minimally invasive surgery versus open surgery among women with clinically stage I uterine leiomyosarcoma.

Methods: We performed a retrospective cohort study using the National Cancer Database (2010–2021). Eligible cases were clinical stage I leiomyosarcoma (cT1a/cT1b) treated with hysterectomy and bilateral salpingo-oophorectomy. Patients were grouped by surgical approach (minimally invasive surgery [laparoscopy/robotic] vs open); conversions were analyzed descriptively and excluded from outcome models.

Results: Among 683 patients, 208 (30.5%) underwent minimally invasive surgery, 447 (65.4%) open surgery, and 28 (4.1%) had conversions. Minimally invasive surgery patients more often were White (85.1% vs 70.0%) and privately insured (66.8% vs 54.4%), had higher neighborhood income, more clinical stage IA disease (30.3% vs 15.2%), and smaller tumors (median 7.2 cm vs 9.9 cm; all $p<0.001$). Adjuvant chemotherapy and radiotherapy rates were similar between groups. Minimally invasive surgery was associated with a shorter hospital stay (median 1 vs 3 days; $p<0.001$) and comparable 30-day readmission (both 3.8%). In clinical stage IA, unadjusted overall survival favored minimally invasive surgery (68.0% alive at 94 months vs 51.5% open; log-rank $p=0.028$), whereas stage IB showed no difference (median overall survival 79 vs 79 months; $p=0.72$). In multivariable analysis, surgical approach was not independently associated with overall survival (adjusted HR 1.16, 95% CI 0.91–1.49). Worse overall survival was associated with increasing age, higher stage, and positive margins.

Conclusion/Implications: The surgical approach was not independently associated with survival.

EP371 / #676

Topic: *AS06. Tumor Types / AS06f. Trophoblastic Disease*

ESCALATED ETOPOSIDE AND CISPLATIN IS ACTIVE IN POOR PROGNOSIS GESTATIONAL TROPHOBLASTIC NEOPLASIA.

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Introduction: Novel therapies remain needed for gestational trophoblastic neoplasia (GTN), particularly in high-risk choriocarcinoma and placental site or epithelioid trophoblastic tumors (PSTT/ETT). Here, we evaluated the efficacy of a novel one-day escalated etoposide (500mg/m^2) and cisplatin (60mg/m^2) regimen (Esc-EP) repeated every 14 days.

Methods: A retrospective analysis of GTN patients treated at Charing Cross Hospital with Esc-EP between 1997 and 2022. Data on demographics, prior treatments, and Esc-EP outcomes were collected.

Results: Nineteen patients received Esc-EP, including 13 with choriocarcinoma and 6 with PSTT/ETT. Among choriocarcinoma patients, the median FIGO risk score was 14 (range 8–22), with a median of two (range 0 - 5) prior chemotherapy lines. After a median of 5 cycles of Esc-EP (range 1 – 7) twelve of 13 patients responded, including four complete responses (CR; three durable) and eight partial responses (PR), seven of whom subsequently achieved remission. Median follow-up was 5 years; two patients died of disease. For PSTT/ETT patients, all presented more than four years after the causative pregnancy; two had stage IV disease; there was a median of 2 (range 0 – 6) prior treatments. After a median of 4 (range 3 – 6) cycles, three of six patients responded, including two CRs (one durable) and one PR. Median follow-up was 3.5 years; two non-responders died. Grade 4 toxicity occurred in 4 of 19 patients, primarily febrile neutropenia and thrombocytopenia requiring transfusion, with no treatment-related deaths.

Conclusion/Implications: Esc-EP demonstrates meaningful activity with manageable toxicity in poor-prognosis GTN and warrants further evaluation.

EP372 / #321

Topic: *AS06. Tumor Types / AS06f. Trophoblastic Disease*

POST-EVACUATION BHCG AND UNCLASSIFIED MOLE PREDICT GTN DESPITE THREE DECADES OF IMPROVING DIAGNOSIS: LESSONS FROM 479 PATIENTS AT A BRAZILIAN REFERRAL CENTER

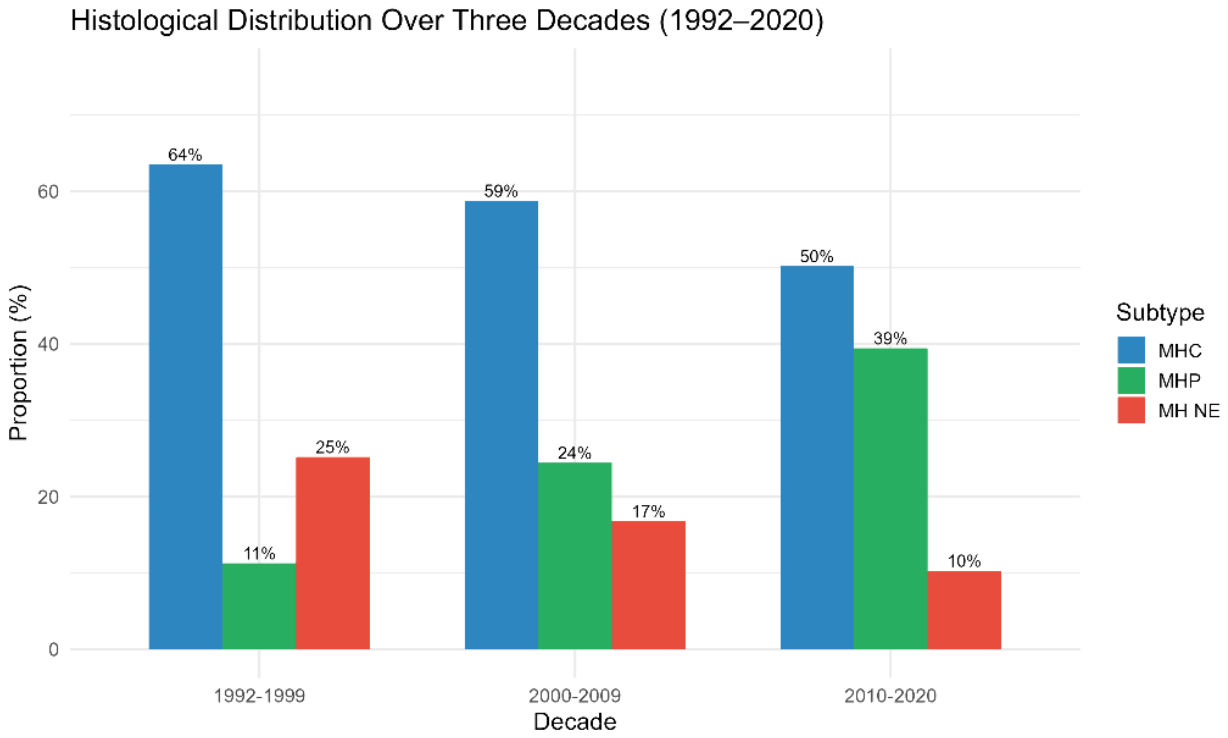
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Introduction: Hydatidiform mole (HM) carries a 15–28% risk of progression to gestational trophoblastic neoplasia (GTN) for complete moles (CHM) and 0.5–5% for partial moles (PHM). The independent predictive value of post-evacuation βhCG and the clinical significance of unclassified HM (HM-NOS) remain underexplored. We analyzed GTN predictors and temporal trends over 28 years at Brazil's second GTD referral center (founded in 1965).

Methods: Retrospective cohort of 629 GTD patients (1992–2020). After excluding primary GTN, indeterminate histology, and early loss to follow-up, 479 HM patients (CHM=266, PHM=122, HM-NOS=91) comprised the analytic sample. Multivariate logistic regression identified independent GTN predictors. Sensitivity analysis excluding HM-NOS and Cochran-Armitage trend tests were performed.

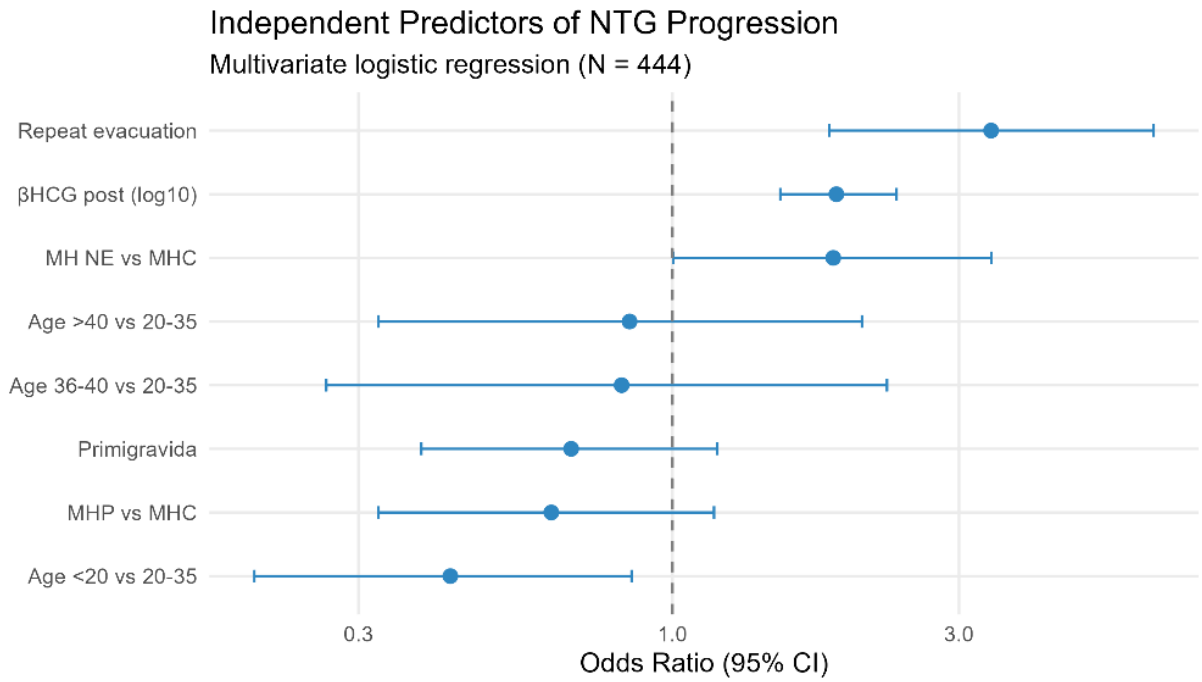
Results: GTN occurred in 113/479 patients (23.6%). Median post-evacuation βhCG was higher in GTN cases (5,000 vs 994 mIU/mL, p<0.001). Independent predictors (N=446): βhCG (log_{10}; OR 1.89, 95% CI 1.53–2.37, p<0.001), HM-NOS vs CHM (OR 2.21, 95% CI 1.22–3.98, p=0.009), and age <20 years (OR 0.40, 95% CI 0.19–0.80, p=0.012). Adding βhCG improved AUC from 0.695 to 0.772. In sensitivity analysis (N=362), βhCG remained the strongest predictor (OR 2.27, p<0.001). Over three decades, PHM increased (11.3% to 39.5%, p<0.001) and HM-NOS decreased (25.2% to 10.3%, p<0.001), yet GTN rate remained stable (~24%,

p=0.815).



Conclusion/Implications: Post-evacuation βhCG is a powerful independent GTN predictor, improving discrimination from AUC 0.695 to 0.772. The high GTN rate among HM-NOS (38.5%) supports routine p57 immunohistochemistry. Despite three decades of diagnostic advances, GTN rates remain unchanged, suggesting earlier diagnosis shifts the disease profile without reducing the biological risk of malignant

transformation.



EP373 / #664

Topic: *AS06. Tumor Types / AS06f. Trophoblastic Disease*

CLINICAL OUTCOMES AND SURVIVAL ANALYSIS OF GESTATIONAL TROPHOBLASTIC NEOPLASIA: A 13-YEAR RETROSPECTIVE COHORT AT A BRAZILIAN REFERRAL CENTER

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Introduction: Introduction Gestational trophoblastic neoplasia (GTN) encompasses rare disorders arising from abnormal fertilization. Despite global data suggesting a predominance of low-risk cases, evidence in developing regions remains limited. This study evaluates the clinical characteristics and treatment outcomes of GTN patients at a tertiary referral center in Pernambuco, Brazil.

Methods: Methods A retrospective cohort study was conducted at the Hospital das Clínicas of the Federal University of Pernambuco (HC-UFPE). We reviewed medical records of patients diagnosed with GTN according to FIGO criteria between 2012 and 2025. Risk stratification followed the FIGO/WHO scoring system.

Results: Results A total of 29 patients were identified, all with histopathological confirmation (100%). The median age was 27 years. Preceding pregnancies included hydatidiform mole (69.0%), abortion (20.7%), and term pregnancy (10.3%). Most patients (72.4%) presented with basal β-hCG levels > 10^5 mUI/mL and tumors ≥ 5 cm (86.2%). Metastatic disease was present in 31.0% of the cohort, primarily in the lungs. Notably, 72.4% of patients were classified as high or very high risk. Resistance to mono-chemotherapy was observed in 37.9% of cases, with an overall chemotherapy resistance rate of 48.3%. The 100% overall survival rate was maintained at a median follow-up of 35 months.

Conclusion/Implications: Conclusion/Implications Our findings confirm a predominance of high-risk patients, consolidating HC-UFPE as a vital tertiary center. The elevated tumor burden at diagnosis indicates failures in early referral. Despite high resistance rates requiring complex rescue regimens, standardized management in a specialized center ensures optimal survival outcomes.

EP374 / #932

Topic: *AS06. Tumor Types / AS06f. Trophoblastic Disease*

CAMRELIZUMAB PLUS APATINIB AND EMA/CO IN ULTRA-HIGH-RISK GESTATIONAL TROPHOBLASTIC NEOPLASIA: A PHASE II STUDY

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Introduction: Ultra-high-risk gestational trophoblastic neoplasia (GTN) has a poor prognosis, necessitating new therapies. This study aimed to evaluate the efficacy and safety of camrelizumab (PD-1 inhibitor) plus apatinib (VEGFR inhibitor) and EMA/CO in ultra-high-risk GTN.

Methods: This single-arm, phase 2 trial enrolled treatment-naïve ultra-high-risk GTN patients (FIGO stage I–III with a score ≥13 or stage IV). Patients received camrelizumab plus apatinib and EMA/CO chemotherapy until β-hCG normalization, followed by 4 cycles of consolidation (camrelizumab+apatinib+chemo) and 6 months of maintenance treatment (camrelizumab+apatinib). The primary endpoint was complete remission (CR) rate. Secondary endpoints included objective response rate (ORR), progression-free survival (PFS), overall survival (OS) and safety. The trial is ongoing (NCT05139095).

Results: A total of 32 patients were enrolled, consisting of 8 with stage Ⅲ and 24 with stage IV disease. Median FIGO score was 13. The CR rate was 93.8% (95% CI: 79.2%–99.2%) and ORR was 100% (95% CI: 89.1%–100.0%). After a median 20-month follow-up, 3-year PFS and OS rates were 76.7% (95% CI: 54.4%–89.1%) and 84.0% (95% CI: 57.9%–94.6%), respectively. Three patients relapsed; of these, two achieved a second CR following salvage therapy. Grade 3-4 toxicities included neutropenia (90.6%), anemia (90.6%), thrombocytopenia (37.5%), hepatic dysfunction (18.8%) and hypertension (3.1%). Despite the frequent occurrence, these abnormalities were reversible with supportive care. One patient developed secondary leukemia and died after chemotherapy. No grade ≥ 3 immune-related adverse events occurred.

Conclusion/Implications: The triple combination of camrelizumab, apatinib and EMA/CO demonstrates remarkable efficacy with manageable safety in ultra-high-risk GTN, representing a promising first-line strategy. Further validation is warranted.

EP375 / #662

Topic: *AS06. Tumor Types / AS06f. Trophoblastic Disease*

PRE-TREATMENT DOPPLER INDICES AS PREDICTORS OF CHEMOTHERAPY RESISTANCE IN LOW-RISK GTN

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Introduction: Gestational trophoblastic neoplasia (GTN) is a highly curable malignancy, with low-risk cases commonly managed with single-agent methotrexate (MTX). A subset of patients develop resistance, resulting in prolonged treatment. Early identification of resistance remains a clinical challenge. This study aimed to evaluate Doppler ultrasound parameters as non-invasive predictors of MTX resistance in low-risk GTN.

Methods: This cross-sectional study was conducted between April 2021 and March 2023 and included 28 women diagnosed with low-risk GTN (FIGO score ≤6) at two referral centers. All participants underwent transvaginal Doppler ultrasound within three days prior to MTX initiation. Uterine artery (UtA) and tumor central vessel (TCV) flow parameters were assessed, including resistance index (RI), systolic/diastolic (S/D) ratio, end-diastolic velocity (EDV), and time-averaged maximum velocity (TAmax). Myometrial invasion was also evaluated. MTX resistance was defined as a plateau or increase in serum human chorionic gonadotropin (hCG) levels after two treatment cycles or the emergence of new metastases.

Results: MTX resistance occurred in 21.4% of patients. Resistant cases showed significantly lower UtA RI and S/D ratios and higher EDV and TAmax values ($p<0.05$). Myometrial invasion was more frequent in resistant patients (100% vs. 44%, $p=0.026$). Among TCV parameters, TAmax was the strongest independent predictor ($p=0.006$). ROC analysis demonstrated good predictive performance for UtA EDV (AUC=0.841) and TAmax (AUC=0.788).

Conclusion/Implications: Doppler ultrasound parameters, particularly UtA EDV and TCV TAmax, may serve as valuable non-invasive predictors of MTX resistance, supporting earlier risk stratification and more individualized management in low-risk GTN.

EP376 / #381

Topic: *AS06. Tumor Types / AS06f. Trophoblastic Disease*

GESTATIONAL TROPHOBLASTIC DISEASE-INDUCED HYPERTHYROIDISM IN A HIGH-RISK COHORT: PREVALENCE, SEVERITY AND OUTCOMES FROM A SOUTH AFRICAN PUBLIC TERTIARY CENTRE

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Introduction: Gestational trophoblastic disease (GTD)-induced hyperthyroidism results from human chorionic gonadotropin (hCG)-mediated stimulation of the thyroid-stimulating hormone (TSH) receptor. Reported prevalence in high-income settings is low, with clinical hyperthyroidism in approximately 2% and biochemical dysfunction in approximately 7% of cases. Data from sub-Saharan Africa are limited. This study describes thyroid dysfunction in a high-risk GTD cohort.

Methods: Retrospective case series of 33 GTD patients managed at the Soweto Comprehensive Cancer Centre from 2022 to 2025. Thyroid dysfunction was biochemically defined. Severity was classified a priori as mild, moderate, or severe based on symptoms, heart rate, and end-organ involvement. The hCG–free thyroxine (fT4) association was assessed using Spearman correlation.

Results: Thyroid dysfunction was identified in 13 of 33 patients (39.4%), exceeding rates reported in UK and US cohorts. The cohort comprised Black African women with mean age 36.3 years; 61.5% had choriocarcinoma, all were high-risk by International Federation of Gynecology and Obstetrics (FIGO) score, and 38.5% were HIV-positive. Median initial hCG was 533,664 mIU/mL. Overt thyrotoxicosis occurred in 10 patients and subclinical disease in 3. Severity was mild in 53.8% and moderate in 46.2%; no thyroid storms occurred. A moderate positive hCG–fT4 correlation was identified. Overall mortality was 46%, with no thyroid-related deaths.

Conclusion/Implications: In this high-risk low- and middle-income country (LMIC) cohort, GTD-associated hyperthyroidism was common but predominantly mild-to-moderate. Outcomes were driven by underlying GTD rather than endocrine complications. These findings support routine thyroid screening while emphasising effective GTD management. Multicentre studies are needed to define African epidemiology.

EP377 / #953

Topic: *AS06. Tumor Types / AS06f. Trophoblastic Disease*

CLIC1 PROTEIN AS A POTENTIAL BIOMARKER FOR EARLY DETECTION OF MALIGNANT TRANSFORMATION IN GESTATIONAL TROPHOBLASTIC DISEASE

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Introduction: The aim of this study was to evaluate the expression of chloride intracellular channel 1 (CLIC1) protein as a potential biomarker of early malignant progression in Gestational trophoblastic disease.

Methods: An observational case-control study included 71 women with GTD aged 16–55 years: 27 with HM, 23 with invasive HM, and 21 with CC. The control group consisted of 25 women with undeveloped pregnancy. Formalin-fixed paraffin-embedded tissue samples underwent immunohistochemical staining using anti-CLIC1 antibody (1:200 dilution). CLIC1 expression was assessed according to staining intensity and percentage of positive cells. β-HCG levels were also monitored dynamically during follow-up. Statistical analysis was performed using SPSS 11.0 with significance set at $p<0.05$.

Results: Weak CLIC1 expression (1+) predominated in HM (72.0%) and controls (72.0%), while strong expression (4+) was observed mainly in invasive HM (47.8%) and was highly prevalent in CC (85.7%). No strong expression was detected in controls. Progressive overexpression of CLIC1 correlated with increasing disease severity from benign HM to malignant choriocarcinoma. Histological analysis also demonstrated increased trophoblastic atypia and proliferative activity corresponding to higher CLIC1 expression. β-HCG levels showed parallel elevation in malignant forms, supporting the association between CLIC1 overexpression and GTD progression.

Conclusion/Implications: CLIC1 overexpression may serve as a promising immunohistochemical biomarker for early detection of malignant transformation in GTD. Its combined assessment with β-HCG may improve risk stratification, early diagnosis, and personalized management of patients with hydatidiform mole at risk of progression to gestational trophoblastic neoplasia.

EP378 / #883

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

FLAP-BASED VULVO-PERINEAL RECONSTRUCTION AND POST-OPERATIVE COMPLICATIONS AFTER VULVAL CANCER RESECTION: A SCOPING REVIEW

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Introduction: Surgical management of vulval cancer can result in significant soft tissue defects with associated functional and psychosexual morbidity. A range of reconstructive techniques have been described. This review aims to summarise current evidence on indications, techniques, and outcomes of vulvo-perineal reconstruction following vulval cancer surgery.

Methods: A scoping review was conducted using PubMed. 45 studies were screened, of which 21 met predefined inclusion criteria. Data were extracted on adult patients undergoing surgery for primary or recurrent vulval cancer. Studies including premalignant disease or exenteration surgery were excluded.

Results: V-Y advancement flaps were the most commonly reported reconstruction (51.3%, n=612), followed by lotus petal flaps (24.7%, n=294). Pedicled perforator-based flaps, including superficial circumflex iliac (SCIP) (2.9%, n=34) and anterolateral thigh (2.0%, n=24) were less frequent. The most commonly reported complication was flap wound dehiscence (6.3%, n=75). Partial flap necrosis was rare (0.2%, n=2), and no cases of complete flap loss were reported. Functional outcomes were inconsistently assessed. Few studies evaluated urinary or sexual function, and only 4 studies (19%) reported improvement in pain or functional status. 6 studies (29%) reported quality of life outcomes, none of which utilised validated scoring systems.

Conclusion/Implications: Vulvo-perineal reconstruction is key component of the surgical management of vulval cancer and can be safely performed with a low complication rate. However, heterogeneity in techniques and paucity of reporting patient reported outcome measures limits comparison between approaches. Prospective studies incorporating validated functional and quality of life outcomes with long term follow up are required to evaluate and therefore optimise reconstructive practice.

EP379 / #784

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

PATTERNS OF CARE FOR VULVAR CANCER PATIENTS TREATED WITH RADIOTHERAPY AT A TERTIARY INSTITUTION IN PRETORIA, SOUTH AFRICA 2018-2023

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Introduction: Vulvar cancer in low/middle-income countries is characterized by young, HIV-positive women presenting with locally advanced disease, yet outcomes data is limited. We evaluated the treatment patterns and outcomes at a tertiary South African hospital in order to identify the actionable system gaps in care.

Methods: This was a retrospective study of 252 patients treated with radiotherapy (RT)+/- surgery from 2018-2023. Overall survival (OS) was estimated using Kaplan–Meier methods and compared with the log-rank test. Multivariable Cox regression identified factors associated with OS.

Results: Median age(n=252) was 42yrs; 87.7%(n=221) HIV-positive. Symptom duration, median 12 months. Among cohort, 29%(n=74) and 71%(n=178) received surgery and RT as primary treatment, respectively. Of patients who received RT alone, over half(n=92) had Stage IV disease and 24%(n=42) received concurrent chemotherapy. OS differed significantly, with median OS of 1.74 years for primary treatment of surgery versus 0.91 years for primary treatment of RT($p<0.0001$). Among patients treated with RT alone, concurrent chemotherapy was independently associated with reduced mortality (aHR 0.28, $p<0.001$). Among patients treated with surgery, HIV-positivity was independently associated with increased mortality (aHR 0.07, $p=0.045$).

Conclusion/Implications: This study represents one of the largest sub-Saharan African vulvar cancer cohorts, revealing a striking convergence of young age, high HIV burden, and advanced-stage presentation. Surgery and concurrent radiotherapy resulted in the best outcomes. The predominance of palliative treatment highlights delays in diagnosis and referral. Survival

EP380 / #1003

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

PRIMARY GROIN LYMPH NODE RADIATION THERAPY VERSUS SURGICAL INGUINOFEMORAL LYMPH NODE RESECTION FOR UNRESECTABLE VULVAR CANCER

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Introduction: Surgical lymph node (LN) assessment is standard for staging of early-stage vulvar cancer. In the setting of locally advanced vulvar cancer with an unresectable vulvar tumor, surgical LN assessment versus primary groin RT alone is controversial. Our objective was to compare overall survival (OS) between surgical LN assessment and primary RT to the inguinofemoral LNs in locally advanced, unresectable vulvar cancer.

Methods: The National Cancer Database was used to perform a retrospective cohort study. We included patients diagnosed with unresectable vulvar squamous cell carcinoma between 2018-2022 who had surgical LN evaluation or primary groin RT. A Cox proportional hazards model compared OS between groups, adjusting for age, stage, facility type, region, and insurance type. Hazard ratios (HR) and 95% confidence intervals (CI) are reported.

Results: 1,293 (89%) patients underwent primary groin RT and 157 (11%) had surgical LN evaluation. The surgery group was more likely to receive chemotherapy (90% vs 72%), have private insurance (34% vs 21%) and receive care at an academic center (54% vs 40%). Those in the RT group were more likely to have stage IV disease (34% vs 17%). OS was similar between groups (adjusted HR: 0.94, 95% CI: 0.75 to 1.19, p=0.63).

Conclusion/Implications: Most patients with unresectable vulvar cancer did not have groin surgery. Despite the surgery group having more favorable demographic and clinical characteristics, there was no significant difference in OS between groups. Our results support that groin RT is a safe alternative to surgery for patients with unresectable, locally advanced vulvar cancer.

EP381 / #1033

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

VAGINAL CANCER AT A TERTIARY CENTRE: A 10-YEAR RETROSPECTIVE ANALYSIS OF PRESENTATION, MANAGEMENT, AND OUTCOMES

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Introduction: Vaginal cancer is rare, representing ~1% of all gynaecological malignancies. Despite its rarity, it poses significant challenges in diagnosis, treatment, and patient quality of life.

Methods: A retrospective analysis of all vaginal cancer patients discussed at a tertiary MDT between 1st January 2014 – 30th April 2024. Demographic, clinical, histological, staging, treatment, and outcome data were collected and analysed.

Results: Forty patients were identified (median age 61.5 years, range 42–99). Vaginal bleeding was the most common presenting symptom (60%, n=24), followed by pain (27.5%, n=11) and discharge (15%, n=6); 5% were asymptomatic (n=2) and 5% had a lesion (n=2). Squamous cell carcinoma predominated (60%, n=24), with adenocarcinoma (15%, n=6) and melanoma (15%, n=6) also observed; four patients (10%) had other subtypes. Most patients had advanced disease (III 35%, n=14; IV 7.5%, n=3; IVA 17.5%, n=7; IVB 12.5%, n=5); early-stage disease included IB (5%, n=2) and II (17.5%, n=7). Staging was unknown in two patients. Initial management was heterogeneous: chemoradiotherapy (n=13, 32.5%) and palliative care (n=11, 27.5%) were most common; other treatments included brachytherapy or radiotherapy alone (n=4, 10%), surgical excision (n=4, 10%), chemotherapy (n=1, 2.5%), vaginectomy (n=1, 2.5%), pelvic exenteration (n=1, 2.5%), and other modalities (n=5, 12.5%). Recurrence occurred in five patients (12.5%). Twenty-six patients died (65%), of which 23 (57.5%) were from vaginal cancer related causes with the majority occurring within 5-years of diagnosis (88.5%, n=23).

Conclusion/Implications: Advanced-stage presentation remains a significant barrier to curative treatment in vaginal cancer, emphasising the importance of early diagnosis and co-ordinated multicentre research to improve outcomes.

EP382 / #451

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

USE OF A MULTICHANNEL VAGINAL APPLICATOR IN GYNAECOLOGICAL BRACHYTHERAPY: THE CLATTERBRIDGE CANCER CENTRE EXPERIENCE

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Introduction: The multichannel vaginal applicator (MCVA) was introduced into clinical practice at our centre in 2024 to enable improved dose conformity in complex gynaecological brachytherapy. This study aimed to evaluate the clinical indications, dosimetric outcomes and procedural safety associated with MCVA use in patients with gynaecological malignancies.

Methods: A retrospective analysis of patients treated with MCVA-based brachytherapy at Clatterbridge Cancer Centre between 1st September 2024 and 2nd April 2026 was performed. Collected data included patient demographics, tumour site and grade, indications for MCVA use, applicator configuration (Table 1), anaesthesia type and dosimetric parameters. Organ-at-risk (OAR) doses were recorded as D2cc for the bladder, rectum, sigmoid and bowel, with target coverage assessed using high-risk clinical target volume D90 (table 2). Procedural complications and early oncological outcomes were also evaluated.

Table 1. Patient demographics, tumour characteristics, and MCVA indications

Patient	Age (years)	Primary site	Histology / Grade	Indication for MCVA	EBRT prior	Anaesthesia	MCVA configuration
1	48	Cervix + Vagina	Squamous cell carcinoma / Grade 3	Combined cervico-vaginal disease (Vaginal intraepithelial neoplasia high grade)	Yes	GA for all fractions	30 mm cylinder; 60 mm IU, 6 catheters
2	84	Endometrium (vaginal vault recurrence)	Adenocarcinoma/ Grade 3	Residual posterior left vaginal vault disease after EBRT	Yes	GA for 1st fraction only	30 mm cylinder; IU 0 mm, 4 catheters
3	49	Vagina and CIN grade 1	Squamous cell carcinoma/ Grade 3	Asymmetric vaginal disease; cervix treated for 1st fraction	Yes	GA for all fractions	30 mm cylinder; IU 60 mm (1st fraction), 0 mm thereafter; 8 catheters
4	69	Vagina	Squamous cell carcinoma / Grade 2	Asymmetric peri-urethral vaginal tumour	Yes	GA for all fractions	30 mm cylinder; IU 0 mm, 8 catheters for 1st fraction and 6 for subsequent fractions
5	77	Vagina	Adenoid cystic carcinoma	Isolated vaginal recurrence	Yes	GA for 2 out of 4 fractions	25 mm cylinder; IU 0 mm, 3 catheters
6	33	Cervix with vaginal involvement	Squamous cell carcinoma /Grade 3	Failure of standard applicator and vaginal involvement	Yes	GA for all fractions	30 mm cylinder; IU 60 mm; 4 catheters
7	80	Cervix	Squamous cell carcinoma / Grade 3	Very narrow vagina – standard applicator unsuitable	Yes	GA for all fractions	25 mm ovoids; IU 40 mm; no catheters
8	74	Ovary (vaginal recurrence)	Endometrioid carcinoma / Grade 2	Distal vaginal/periurethral recurrence	Yes	GA for 1 out of 4 fractions	25 mm cylinder; IU 0 mm; 4, 3, 3 and 2 catheters for 1st to 4th fractions
9	64	Vagina	Squamous cell carcinoma /Grade 2	Asymmetric mid/lower vaginal disease	Yes	GA for 1 out of 4 fractions	25 mm cylinder; IU 0 mm; 3 catheters
10	81	Cervix	Squamous cell carcinoma/ Grade 2	Standard applicator could not be inserted	Yes	GA for all fractions	25 mm cylinder; IU 60 mm; no catheter
11	77	Vagina	Squamous cell carcinoma/ Grade 3	Post-EBRT vaginal residual disease	Yes	GA for 1st fraction and spinal for others	25 mm cylinder; IU 0 mm; 4 catheters

CIN = Cervical Intra-epithelial Neoplasia; IU = Intrauterine; GA = General Anaesthesia; EBRT = External Beam Radiotherapy

Table 2. Dosimetric outcomes: OAR and HR-CTV doses (EQD2)

Patient	Bladder D2cc (Gy)	Rectum D2cc (Gy)	Sigmoid D2cc (Gy)	Bowel D2cc (Gy)	HR-CTV D90 (Gy)	No. of brachytherapy fractions using MCVA
1	69.5	72.3	55.5	45.5	74.4	4
2	64.6	70.0	52.6	43.2	74.6	4
3	55.7	64.8	47.2	43.4	75.8	4
4	67.7	45.5	46.8	71.9	66.3	4
5	48.7	51.6	44.3	44.9	73.0	4
6	65.7	67.9	50.6	46.1	72.9	3
7	52.0	57.2	67.6	49.2	94.8	3
8	44.7	45.3	43.8	44.3	76.5	4
9	48.4	66.4	44.1	45.2	77.1	4
10	82.4	68.9	68.8	48.7	90.0	2
11	46.0	51.8	44.2	43.8	78.0	4

OAR = Organs at Risk; HR-CTV = High-risk Clinical Target Volume; EQD2 = Equivalent in 2 Gy fractions; MCVA = Multichannel Vaginal Applicator

Results: Eleven patients underwent brachytherapy using MCVA, amounting to a total of 41 fractions. Indications were heterogeneous including primary vaginal cancer, vaginal recurrence in endometrial and ovarian cancer, cervical cancer with vaginal extension and

cervical cancer patients with narrow vagina. Treatment was delivered with or without general anaesthesia and all patients had previously received external beam radiotherapy (EBRT). Dosimetric analysis demonstrated that target coverage and OAR doses met mandatory constraints in all cases. No procedural complications were observed. At a median follow-up of 5 months (range 1-21 months), all patients remained recurrence free.

Conclusion/Implications: MCVA is a safe and versatile applicator in gynaecological brachytherapy, allowing individualised dose optimisation across a range of complex clinical scenarios while maintaining acceptable OAR doses.

EP383 / #245

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

ASSOCIATION OF P53 AND P16 EXPRESSION WITH SURGICAL AND ONCOLOGIC OUTCOMES IN VULVAR SQUAMOUS CELL CARCINOMA: A RETROSPECTIVE COHORT STUDY.

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Introduction: To evaluate the association between p53 and p16 expression and clinicopathologic characteristics, as well as surgical and oncologic outcomes, in patients with vulvar squamous cell carcinoma (VSCC).

Methods: This retrospective cohort study included women with VSCC (FIGO stages I–IV) treated at Hôtel-Dieu de France, Beirut, Lebanon, between 2014 and 2024. Demographic, clinical, surgical, and pathological data, as well as recurrence and survival outcomes, were collected. Tumor p53 and p16 expression were assessed by immunohistochemistry, and HPV DNA status by PCR. Statistical analyses included Chi-square, Fisher's exact, and Mann–Whitney tests, with $p < 0.05$ considered statistically significant.

Results: Among 125 patients, 38 (30.4%) were p53-positive, 15 (12.0%) p16-positive, and 14 (11.2%) HPV-positive. p53-positive tumors were associated with midline location, resulting in clitoral resection in all affected cases ($p = 0.008$). They were also associated with higher rates of inguinal lymph node metastasis ($p < 0.001$), greater metastatic nodal burden ($p = 0.001$), and poorer ECOG performance status ($p = 0.04$), consistent with a more aggressive phenotype. A non-significant trend toward deeper invasion was observed. No differences were found in postoperative complications, recurrence, or survival. p16 expression and HPV status were not associated with outcomes.

Conclusion/Implications: In this cohort, p53 expression identifies a subset of VSCC with aggressive features, including increased nodal involvement and greater surgical complexity related to midline disease. However, this does not translate into worse oncologic outcomes. These findings support a potential role for p53 in surgical planning and risk stratification, warranting validation in prospective studies.

EP384 / #552

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

REPEAT SENTINEL LYMPH NODE BIOPSY IN RECURRENT VULVAR CANCER: IS THIS PROCEDURE RELIABLE?

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Introduction: Sentinel lymph node biopsy (SLNB) is the preferred staging approach for early-stage vulvar squamous cell carcinoma (VSCC). In recurrent disease, standard groin management involves inguinofemoral lymphadenectomy (IFL), which carries significant morbidity. Repeat SLNB may be a less morbid alternative; however, data on feasibility and oncologic outcomes remain limited.

Methods: This retrospective cohort study included patients treated at a tertiary academic centre (2008-2025) who underwent planned repeat SLNB for recurrent VSCC. Eligible patients had prior resection of primary VSCC <4 cm with SLNB, histologically confirmed local recurrence amenable to resection, and clinically negative groins. Clinicopathological outcomes were collected. Time-to-event outcomes were analyzed using Kaplan–Meier methods.

Results: Eighteen patients underwent repeat SLNB with a median interval of 22 months between primary and repeat procedures. Detection was achieved in 81% of groins (17/21), and higher in naïve groins (88%, 7/8) than ipsilateral groins with prior SLNB (77%, 10/13). All detected repeat sentinel nodes were negative. Two isolated groin recurrences occurred (12%, 2/17) within 2 years, with groin recurrence-free survival of 89.9%. Median overall survival was 33 months with groin recurrence versus 79.5 months without (p=0.43). In comparison, primary SLNB during this timeframe at this centre had a groin detection rate of 91% (370/408) and groin recurrence rate of 3% (8/256).

Conclusion/Implications: Repeat SLNB in recurrent VSCC is feasible but has lower detection and higher isolated groin recurrence rates than primary SLNB. It may be considered in carefully selected patients where IFL morbidity is a concern, with acknowledgement of increased recurrence risk.

EP385 / #475

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

OUTCOMES OF ENHANCED RECOVERY AFTER SURGERY FOLLOWING RADICAL VULVECTOMY AND INGUINOFEMORAL LYMPHADENECTOMY FOR VULVAR CANCER.

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Introduction: Vulvar cancer is a rare gynecologic malignancy associated with substantial treatment related morbidity. Enhanced Recovery After Surgery (ERAS) protocols have demonstrated benefit in gynecologic oncology but current evidence specific to vulvar cancer surgery is limited. This study aims to assess the impact of ERAS implementation on surgical outcomes in vulvar cancer.

Methods: We conducted a retrospective chart review of all patients undergoing radical vulvectomy and inguinofemoral lymphadenectomy for vulvar cancer from January 1994 to December 2024. The primary outcome measured was length of hospital stay. The secondary outcomes were the rates of hospital readmission and post postoperative complication within 30 days. We investigated the relationships between ERAS components and the outcomes using univariate and multivariate regression methods.

Results: A total of 426 charts were retrieved through the Manitoba Cancer Registry. Only 150 charts met inclusion criteria with exclusion of those without lymph node assessment or vulvar cancer diagnosis. Average length of hospital stay decreased from 8.9 to 3.6 days comparing late (n=66) vs. early (n=84) mobilization ($p<0.05$). Readmission rates remained stable and postoperative complication rates were modestly reduced (76% vs. 67%) following ERAS implementation ($p>0.05$).

Conclusion/Implications: This study demonstrates that ERAS implementation in vulvar oncologic surgery is associated with improved outcomes. Further research is needed to refine surgical care and support more individualized treatment strategies ultimately improving quality of life and reducing health care costs.

EP386 / #944

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

ASSOCIATION OF HUMAN IMMUNODEFICIENCY VIRUS STATUS WITH CLINICAL PRESENTATION OF VULVAR CANCER IN MOZAMBIQUE

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Introduction: Cancer disparities between high-income and low- and middle-income countries (LMICs) are driven in part by key risk factors, including HIV. Co-infection with HIV and HPV may accelerate vulvar carcinogenesis; however, data from high HIV-prevalence regions remains limited. We sought to characterize vulvar cancer presentation in a high HIV-burden population in Mozambique.

Methods: We performed a retrospective cohort study of patients diagnosed with vulvar cancer (2018-2025) at Maputo Central Hospital. Demographical, clinical, and pathological features were described, with exploratory comparisons by HIV status using Wilcoxon rank sum and Fisher Exact tests. Variables included histology, age at diagnosis, and CD4 count among patients living with HIV (PLH). Outcomes included stage and nodal involvement.

Results: In our preliminary analysis of 28 patients, 12 (42.9%) presented with stage III-IV disease and 8 (28.6%) had nodal involvement. Squamous cell carcinoma predominated (n=27, 96.4%). The cohort was overwhelmingly composed of PLH (n=26, 92.9%). Among

PLH, the median CD4 count was 465 (IQR 395-646), and all were receiving antiretroviral therapy. PLH were younger at diagnosis compared to HIV-negative patients (43.2 vs 80.5 years, p=0.02); however, interpretation of between-group differences is limited by the small HIV-negative group (n=2).

Conclusion/Implications: In this high HIV-prevalence cohort, vulvar cancer occurs predominantly among PLH at high median CD4 count. These data highlight the intersection of HIV and HPV-associated malignancy in LMICs and underscore the need for targeted screening and detection strategies in low-resource, high HIV-burden settings. This study is ongoing, with continued data collection aimed at further characterizing disease patterns in this population.

EP387 / #480

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

IMPACT OF V–Y FLAP RECONSTRUCTION ON WOUND HEALING OUTCOMES FOLLOWING RADICAL VULVECTOMY

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Introduction: Radical vulvectomy continues to represent the standard of care in the surgical management of early-stage vulvar carcinoma. However, this procedure is associated with a substantial rate of postoperative wound complications. To reduce these adverse outcomes, reconstructive techniques employing advancement flaps may be utilized during wound closure.

Methods: A retrospective analysis was conducted of 86 patients who underwent surgical treatment for vulvar carcinoma between 2015 and 2025. Collected data included the extent of surgical intervention, length of hospital stay, and postoperative complications (i.e. , delayed wound healing, antibiotic administration, negative pressure wound therapy (NPWT), and reoperations). 74 patients underwent primary wound closure without flap reconstruction, whereas 12 patients received V–Y advancement flap reconstruction. The two cohorts were comparable with respect to body mass index (28.7 vs. 30.2), mean age (71 vs. 68 years), and prevalence of diabetes mellitus (29% vs. 25%).

Results: In the group treated with primary wound closure alone, the incidence of reoperation was 6.8%, and NPWT was required in 5.4% of cases. In contrast, no instances of reoperation or NPWT were observed in the V–Y flap group. Postoperative therapeutic antibiotic administration was recorded in 58% of patients without flap reconstruction and in 83% of those who underwent V–Y flap reconstruction.

Conclusion/Implications: The use of V–Y advancement flap reconstruction was associated with a significant reduction in delayed wound healing, as well as a decreased need for subsequent surgical revision or negative pressure wound therapy. These findings suggest that incorporation of reconstructive flap techniques into wound closure following radical vulvectomy may improve postoperative outcomes.

EP388 / #1079

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

QUALITY-OF-LIFE OUTCOMES IN VULVAR CANCER: A CROSS SECTIONAL STUDY IN AN IRISH POPULATION

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Introduction: Vulvar cancer is rare, however the impact of both disease and treatment on physical, functional and psychosexual health can be significant. The aim of this study is to assess HRQoL outcomes for survivors of vulval cancer in Ireland.

Methods: A cross-sectional survey exploring QoL outcomes was conducted of women with vulvar cancer that were ≥3 months post-treatment. A national referral strategy was employed with single-centre recruitment. Likert-based EORTC QLQ-C30, VU34, and SH22 instruments were administered, and data analysed as per EORTC guidelines using REDCap and SPSS. Scores were reported as mean±SD.

Results: 72 women were screened and 66(91.7%) recruited with a response rate of 92.4% (n=61/66). Mean age was 61.1±12.3 years. 92.4% participants had no prior awareness of vulvar cancer. Mean global QoL score was 65.4±22.3, with generally high scores for functional and symptom scales. There was a notable impact on body image (59.8±37.4). 26.2% (n=16/61) were sexually active, had a mean younger age (48.8 vs 65.5 years, $p<0.001$) and reported a multidomain impairment in sexual function. Of note, sexual activity was not important for 48.9% of those who were not active. For SH22, the degree of missing data correlated with increasing age ($\rho=0.70$, $p<0.001$).

Conclusion/Implications: Disease-related impairment in body image and sexual dysfunction are prevalent in survivors of vulvar cancer. However, absence of sexual activity does not represent an unmet need for every patient and survivorship care, including psychosexual support, should be tailored to the individual. The rate of pre-diagnostic awareness is low with implications for public health policy and preventative strategies.

EP389 / #1082

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

UNDERSTANDING THE LIVED EXPERIENCE OF VULVAR CANCER: AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS

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Introduction: Vulvar cancer is rare, with 60-70 cases diagnosed per annum in the Republic of Ireland. A diagnosis of vulvar cancer can have substantial physical, psychosexual and psychosocial consequences, however, the available evidence is primarily quantitative and dedicated phenomenological studies that explore the individual's lived experience are limited. The aim of this study was, therefore, to address this gap within the Irish context.

Methods: This study used interpretative phenomenological analysis (IPA), as described by Smith (1996), to explore the lived experiences of women treated for vulvar cancer in Ireland. Participants were recruited through a single tertiary referral centre. Semi-structured interviews were conducted and transcribed verbatim. Analysis followed IPA principles of idiographic and iterative interpretation, with each case examined in depth before the development of emergent and superordinate themes across participants. A reflexive approach was adopted throughout, and analytical credibility was supported through independent review.

Results: Six interviews were conducted (four individual and two dyadic with couples) across varying stages in the survivorship journey (6 months – 18 years post-diagnosis) over a period of one month. Within- and cross-case interpretative analysis has identified emergent experiential patterns across participants with independent review in progress.

Conclusion/Implications: This is the first qualitative exploration of vulvar cancer in Ireland and, to our knowledge, is the first to apply the IPA technique as described by Smith (1996) in this setting. By providing greater insight into the patient experience, we hope that the results of this study will support the development of more person-centred models of care.

EP390 / #807

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

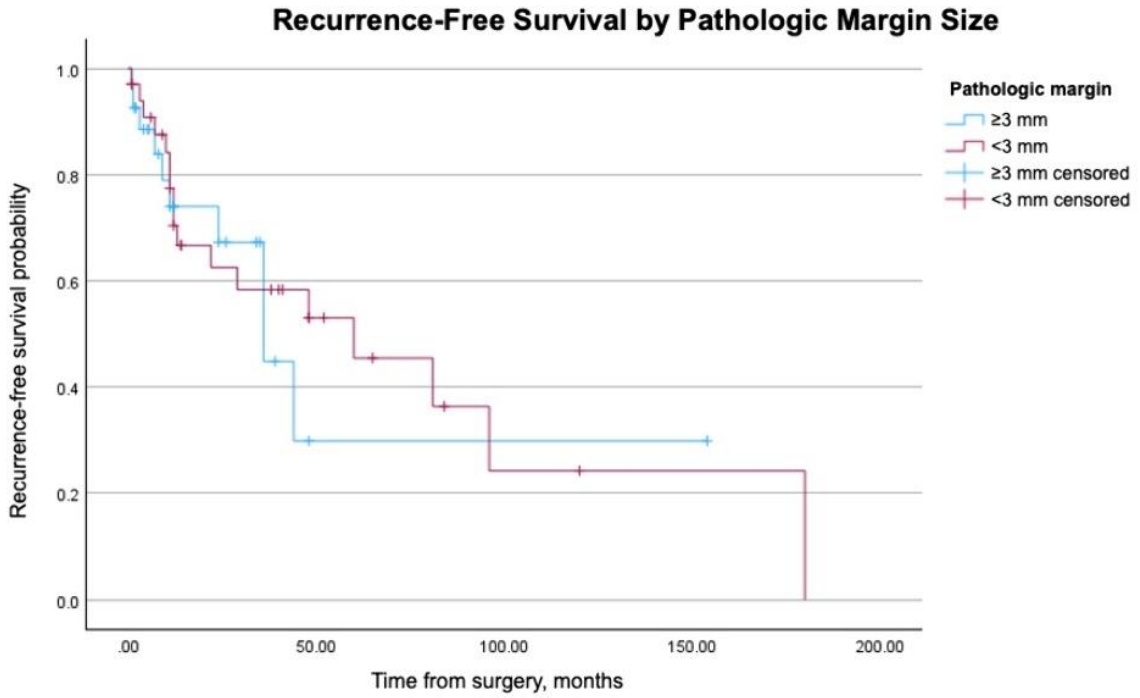
ASSESSING THE DISCRIMINATORY AND PROGNOSTIC ABILITY OF PATHOLOGICAL MARGINS IN VULVAR SQUAMOUS CELL CARCINOMA: INSIGHTS FROM A RETROSPECTIVE SINGLE SITE STUDY

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Introduction: Vulvar squamous cell carcinoma (VSCC) is a rare malignancy with high recurrence risk. Although historical guidelines recommend gross margins >1 cm, corresponding to approximately 8 mm pathologic margins, the prognostic value of pathologic margin size (PMS) remains uncertain. We evaluated PMS, associated histopathologic factors and pre-treatment lymphocyte count in relation to oncologic outcomes.

Methods: We conducted a retrospective cohort study of patients with primary VSCC treated at a tertiary centre in Quebec from 2003-2024. Primary outcomes were recurrence and survival. ROC analysis assessed PMS discrimination for recurrence and death. Kaplan-Meier and Cox regression assessed recurrence by PMS cutoff, adjusted for stage and adjuvant treatment.

Results: Overall, 84 patients were included. Median PMS was 3 mm (IQR 1-6), and recurrence occurred in 65.5%. PMS had limited discriminatory ability for recurrence (optimal cutoff 3.125 mm; AUC=0.624) and was not predictive of death (AUC=0.53). Median recurrence-free survival was similar below versus above a 3 mm PMS cutoff (log-rank p=0.739). In adjusted Cox regression, PMS < 3 mm was not associated with recurrence (HR=1.10, 95% CI 0.33-3.64). Positive margin status was more frequent with recurrence (94.3% vs 75.6%, p=0.032). Greater depth of invasion was associated with recurrence (5.0 vs 2.2 mm, p=0.025) and death (5.2 vs 2.5 mm, p=0.016). Pre-treatment lymphocyte count was not associated with
outcomes.



Multivariable Cox regression for recurrence-free survival

Variable	HR	95% CI	p-value
Pathologic margin < 3mm	1.10	0.33-3.65	0.872
FIGO stage	0.82	0.27-2.50	0.731
Adjuvant treatment	1.17	0.24-5.65	0.845

HR = hazard ratio; CI = confidence interval. Cox regression adjusted for FIGO stage and adjuvant treatment.
HR >1 indicates increased hazard of recurrence.

Conclusion/Implications: PMS was not independently predictive of outcomes. Recurrence risk in VSCC may be driven more by tumor biology than margin distance or lymphocyte count alone, which has important implications for balancing disease control with preservation of function.

EP391 / #661

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

TREATMENT VARIABILITY AND OUTCOMES BY STAGE IN VULVAR CARCINOMA: A 20-YEAR INSTITUTIONAL EXPERIENCE

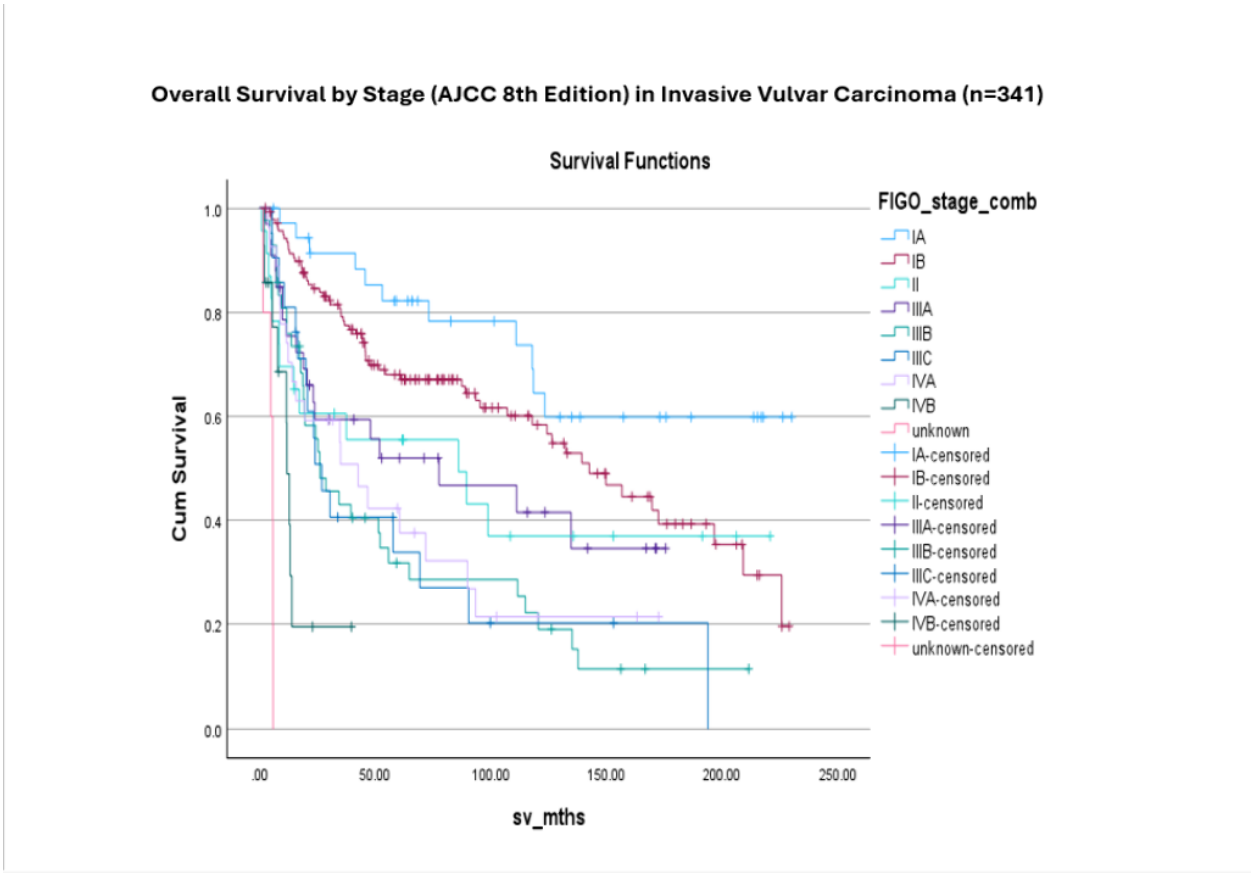
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Introduction: Vulvar carcinoma is rare, and management remains heterogeneous due to limited evidence. We evaluated disease characteristics, treatment patterns, and overall survival (OS) over 2 decades of tertiary cancer care at one Canadian center.

Methods: 359 cases diagnosed between 2005 and 2024 were reviewed. After excluding unusal histologies and incomplete cases, 341 patients with invasive vulvar carcinoma were included. Demographic, tumor, and treatment variables (surgery, radiotherapy, chemotherapy, and brachytherapy), were collected. OS was calculated from biopsy using Kaplan–Meier analysis and compared with log-rank testing.

Results: Median age was 67 years (IQR 56–77), 96.2% (n=328) were squamous cell carcinoma. Stage IB was most common (41.1%), followed by IIIB (12.3%) and IA (10.6%); 4.1% had metastatic disease at presentation. p16 was available for 39% (n=133), of which 50.4% (n=67) were deemed HPV-independent. Surgery was performed in 74.2% (n=253); 56.0% as sole treatment and 18.2% with postoperative radiotherapy +/- chemotherapy. Median OS was 90.4 months overall and differed significantly by stage ($p<0.001$), with the best survival in stage IB (142.6 months). Stage IVA had median OS of 42.6 months, compared to stage IIIB/IIIC of 26.1 and 26.8 months respectively. HPV associated tumors demonstrated better survival

(p=0.028).



Conclusion/Implications: Survival in vulvar carcinoma is influenced by both stage and HPV status. Further analysis is planned. Better understanding of patient- and tumor-related predictors is needed to support biologically informed, risk adapted management strategies.

EP392 / #418

Topic: *AS06. Tumor Types / AS06g. Vulvar & Vaginal Cancer*

USE OF LYMPH NODE RE-STAGING FOR RECURRENT VULVAR CANCER: SENTINEL LYMPH NODE DISSECTION VERSUS FULL LYMPHADENECTOMY

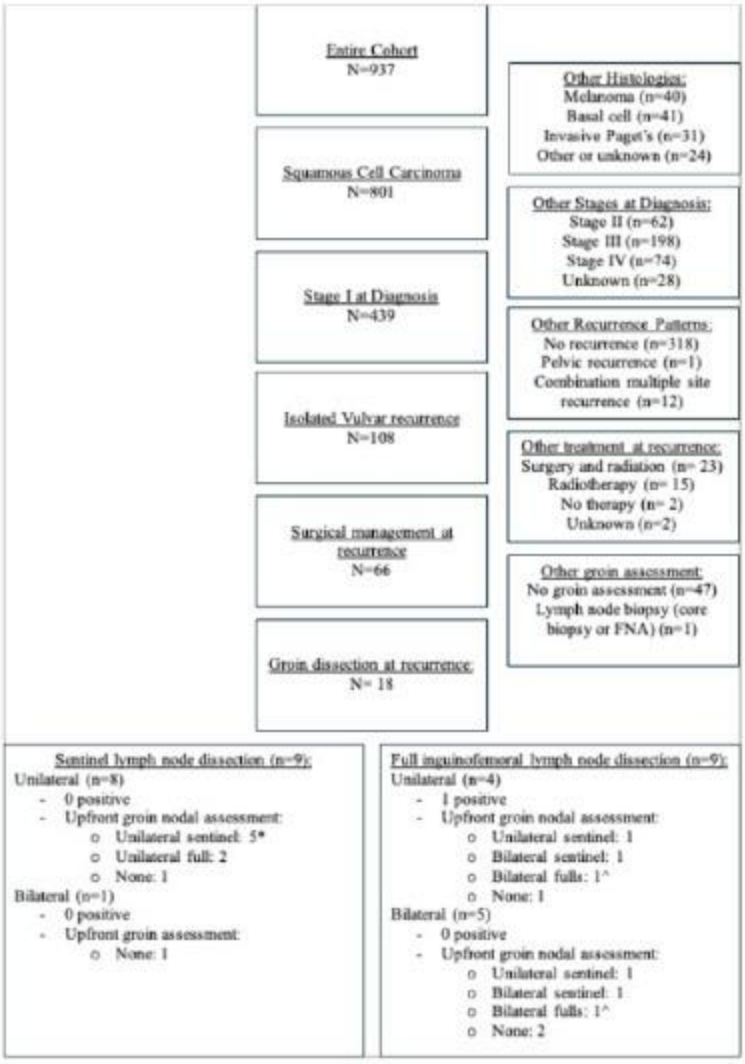
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Introduction: Despite the recognized utility of sentinel lymph node dissection (SNLD) in the management of primary squamous vulvar carcinoma (SCVC), its use in the recurrent setting is poorly described, and oncologic outcomes data are unavailable. We sought to evaluate practice patterns of lymph node assessment at the time of recurrent SCVC and to compare recurrence and survival outcomes by nodal assessment method.

Methods: An institutional retrospective review was conducted of patients with SCVC between 2000-2025. To ensure comparable outcomes, the population was limited to those with surgically managed stage I disease with an isolated vulvar recurrence amenable to surgical treatment. Demographic, clinicopathologic, treatment, and outcomes data were compared by nodal assessment type (SNLD versus full inguinofemoral dissection (IFLD)) at recurrence using descriptive statistics. Subsequent recurrence and survival outcomes were compared using cox regression modeling.

Results: Eighteen patients underwent successful nodal restaging at recurrence with one positive node identified. This included one patient with repeat SNLD on the ipsilateral side of a prior SNLD and two with IFLDs on the ipsilateral side of a prior IFLD. No differences were observed in subsequent groin or overall recurrences by nodal assessment type; similarly, cox regression found no difference in secondary disease-free survival (aHR 2.25, p-value 0.299) or overall survival (aHR 3.39, p-value 0.220), controlling for age, p16, and depth of
invasion.

Figure 1: Practice patterns of groin nodal assessment for isolate vulvar recurrences of squamous cell vulvar carcinoma amongst stage I disease with no prior adjuvant therapy



FNA: fine needle aspiration; * indicates 1 patient in this cohort has a repeat SNLD on the ipsilateral side to their prior SNLD; ^ indicated patients underwent a repeat IFLD on the ipsilateral side to prior IFLD during upfront therapy

Table 1: Demographic, clinicopathologic features, and treatment histology by lymph node dissection for isolated vulvar recurrence of stage I squamous cell vulvar carcinoma without prior adjuvant therapy

	Pathologically Negative Nodes at Recurrence		
	Sentinel nodal dissection# (n=9)	Full lymph node dissection# (n=8)	p-value
Age (mean, 95% CI)	71.4 (59.1, 83.8)	70.5 (60.1, 80.9)	0.8949*
BMI (median, IQR)	27.4 (26.6, 28.9)	31.0 (27.4, 33.7)	0.3704&
Pathologic nodal assessment at initial diagnosis			
No	2	2	1.00^
Yes	7	6	
Bilateral inguinal nodes removed at upfront diagnosis			
No	9	6	0.206^
Yes	0	2	
Depth of invasion at recurrence (mean, 95% CI)	3.87 (1.82, 5.92)	3.50 (1.02, 5.98)	0.7898*
Depth of invasion at recurrence ≤1mm			
Yes	2	0	0.471^
No	7	8	
Pathologic tumor size at recurrence (mean, 95% CI)	1.36 (0.365, 2.360)	1.86 (0.14, 3.58)	0.5049*
Secondary recurrence			
No	4	2	0.620^
Yes	5	6	
Any subsequent groin recurrence			
No	4	5	1.000^
Yes	1	1	

includes both bilateral and unilateral groin dissections; *two sample t-test with equal variance; & Wilcoxon rank-sum test; ^ Fisher's exact test

Conclusion/Implications: This data supports further outcomes-based research utilizing SLND for recurrent SCVC as no differences were observed in subsequent overall

recurrences, groin recurrences, or survival by nodal dissection type in our cohort albeit with small numbers.