ASGO 2022

Annual Scientific Meeting

SOFITEL MELBOURNE ON COLLINS

27TH - 30TH APRIL 2021

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Dr Robert DeBernardo

Robert DeBernardo has been an active member of the NRG (formerly the GOG) since completing his fellowship in 2004. He has served as Co-PI first at University Hospitals and is currently at the Cleveland Clinic in Gynecologic Oncology Division. He was an active member of the GOG ancillary committee.

Since being a member of the GOG/NRG, he has a proven track record of collaborative work with a number of investigators. He has been an author on at least one GOG publication (Alvarez et al, Gynecol Oncol 2014 Jun;133(3):433-8. In addition, DeBernardo has published several manuscripts on Cyberknife radiotherapy (Kunos et al, Front Oncol 2015 Jun5;5: 126.) and the use of hyperthermic chemotherapy for the treatment of gynecologic cancers (Singh et al, Gynecol Oncol Case Rep 2014 May 20;9:24-5). He also has a long-standing collaborative relationship with a lab at Case Medical Center run by Michael Lederman that has resulted in numerous publications over the last 10 years. (Younes et al, J Clin Invest. 2016 Jul 1; 126(7):27 45-56.) More recently, he has had a productive collaboration with Dr. Reizes' laboratory at Cleveland Clinic, which has resulted in a publication in high impact factor journals.

As an active Gynecologic Oncologist with a busy clinical practice, DeBernardo has had the opportunity to discuss and enrol patients in Phase I, II and III trials available through the NRG as well as those open at the Cleveland Clinic and Case Medical Center. He is the Director of the Peritoneal Surface Malignancy Program at Cleveland Clinic and has extensive experience in hyperthermic intraperitoneal chemotherapy {HIPEC). DeBernardo has a large referral base (including from outside Ohio) specifically for the HIPEC procedure for advanced ovarian cancer and other peritoneal malignancies, and will be one of the principal contributors of tumor specimens for Aim 2 of the current proposal.

Prof Christina Fotopoulou

Professor Christina Fotopoulou trained in in obstetrics and gynaecology and subspecialized in gynaecological oncology at the Charité University Hospital of Berlin in the surgical and systemic treatment of gynaecological cancer. She is since 2013 a Consultant Cynecological Oncologist at Imperial College London Hammersmith Hospital in London, and is a principal investigator of the Ovarian Cancer Action Research Centre, UK. She also holds a honorary chair in the Gynaecology Dept at the Charite University of Berlin, where she has been the Vice Director of Gynecology, one of the largest reference and accredited centers for gynecological cancer in Europe, as well the Principal Coordinator of the European Competence Center for Ovarian Cancer.

Her principal area of expertise lies in exenterative procedures for advanced forms of pelvic malignancies, in the cytoreductive procedures for primary or relapsed ovarian cancer and the investigation of predictive and prognostic biomarkers of surgical and clinical outcome. Her further area of focus is bioengineering and implementation of novel bioengineering methods in cytoreductive surgery for advanced ovarian cancer.

She is the lead of the guidelines group of the British Gynaecological Cancer Society (BGCS), elected member of the ESGO- council (European Society of Gynaecologic Oncology) and lead of the ESGO guidelines committee and also member of the German AGO- Ovarian Cancer Steering- and Guidelines Group. She is on the editorial board and reviewer of numerous international gynaecological and oncological journals and is member of various international oncological committees, including BGCS, ASCO, ESGO, IGCS, ESMO, ENGOT, AGO, SGO and NOGGO.

Dr Willemien van Driel

Since 2004 Willemien van Driel is a gynecological-oncologist at the Netherlands Cancer Institute within the Center of Gynecologic Oncology Amsterdam (CGOA) and Associate professor at University of Queensland from 2019-2022.. Following her PhD on Immunological therapeutic aspects for cervical carcinoma, she specialized in gynecology and subspecialized in gynecologic oncology at Leiden University Medical Center, the Netherlands and Barts Hospital/Royal Marsden hospital in London, UK. Since working as a gynecologic oncologist, she has been involved in the national and international gynecological oncology community. Since 2005 she became a member of the Dutch national evidence based guideline committee on ovarian carcinoma and in 2009 she was one of the founding members of the Dutch Gynecologic Oncology Group (DGOG). As of 2010 until 2013, she chaired the national multidisciplinary guideline committee for gynecological oncology in the Netherlands and from 2013-2018 she chaired the Dutch gynecologic-oncological society (WOG) which is the professional organization of Gynecologic-oncology in the Netherlands. As of 2013, she is a member of the scientific committee of the Dutch Gynecological Oncology Audit (DGOA), which she chairs since 2018. She is involved in the project initiated by the IGCS in improving care for patients with ovarian carcinoma globally and collaborates in this project with the Australian national gynaecological oncology cancer registry and Australian expert working group for ovarian cancer. Since 2004, she is local PI for several national and international clinical studies on gynecological oncology in the Netherlands cancer institute and with the OVHIPEC trial group, she conducted the OVHIPEC 1 study. She is currently PI of the OVHIPEC 2 study, which started accrual in 2020.

ASGO 2022 EVENT APP

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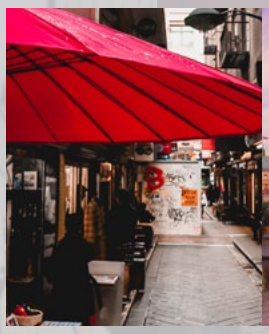

SECRETARIAT

The registration desk will be open throughout the conference to answer any questions you may have. Located Promenade 1st floor.

Mary Sparksman, 0418 877 279
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Wednesday, 27th April: 9.15am – 5.15pm
Thursday, 28th April: 8.00am – 5.00pm
Friday, 29th April: 8.00am – 1.30pm
Saturday, 30th April: 8.15am – 2.00pm

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*Median PFS 56.0 months with LYNPARZA vs 13.8 months with placebo. PFS HR=0.33; 95% CI: 0.25–0.43, p-value not stated. Primary endpoint, *post-hoc* analysis[1]

5 YEAR SOLO-1

ELEVATE YOUR EXPECTATIONS

WITH RESULTS FROM THE **5-YEAR ANALYSIS** OF SOLO-1[1†]

†Women with *BRCA*m high-grade epithelial ovarian, fallopian tube, or primary peritoneal disease in response (CR or PR) to 1st-line platinum-based chemotherapy. Data cut-off 5 March 2020.[1]

PBS Information: LYNPARZA tablets. Authority Required. Refer to PBS Schedule for full information.

BEFORE PRESCRIBING, PLEASE REVIEW FULL PRODUCT INFORMATION AVAILABLE ON REQUEST FROM ASTRAZENECA ON 1800 805 342 OR www.astrazeneca.com.au/PI

LYNPARZA® (olaparib) Tablets Minimum Product Information. INDICATIONS: Ovarian Cancer: Monotherapy for the maintenance treatment of adult patients with advanced BRCA-mutated (germline or somatic) high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete response or partial response) to first-line platinum-based chemotherapy. BRCA mutation status should be determined by an experienced laboratory using a validated test method. Monotherapy for the maintenance treatment of adult patients with platinum-sensitive relapsed high grade epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete response or partial response) after platinum-based chemotherapy. Prior treatment must have included at least 2 courses of platinum-based regimens. Combination with bevacizumab for the maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to first-line platinum-based chemotherapy and whose cancer is associated with homologous recombination deficiency (HRD)-positive status defined by either: a deleterious or suspected deleterious BRCA mutation (germline or somatic), and/or genomic instability. HRD status should be determined by an experienced laboratory using a validated test method. Breast cancer: Monotherapy for the treatment of adult patients with germline BRCA-mutated HER2-negative metastatic breast cancer who have previously been treated with chemotherapy in the neoadjuvant, adjuvant or metastatic setting. Germline BRCA mutation (gBRCAm) status should be determined by an experienced laboratory using a validated test method. Adenocarinoma of the pancreas: Monotherapy for the maintenance treatment of adult patients with deleterious or suspected deleterious gBRCAm metastatic pancreatic adenocarcinoma whose disease has not progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen. Germline BRCA mutation (gBRCAm) status should be determined by a laboratory using a validated test method. *Prostate cancer:* Monotherapy for the treatment of adult patients with BRCA-mutated (germline and/or somatic) metastatic castration-resistant prostate cancer who have progressed following prior therapy that included a new hormonal agent. BRCA mutation status should be determined by an experienced laboratory using a validated test method. **DOSAGE AND ADMINISTRATION: Important Administration Information.** LYNPARZA is also available as a 50 mg capsule. DO NOT substitute LYNPARZA tablets (100 mg and 150 mg) with LYNPARZA capsules (50 mg) on a milligram-to-milligram basis due to differences in the dosing and bioavailability of each formulation. See full PI for LYNPARZA capsules for specific capsule dosing. **Dosage in adults.** LYNPARZA is available as 100 mg and 150 mg tablets. The recommended dose of LYNPARZA is 300 mg (two 150 mg tablets) taken twice daily, equivalent to a total daily dose of 600 mg. The 100 mg tablet is available for dose reductions only. LYNPARZA tablets can be taken with or without food; they should be swallowed whole and not chewed, crushed, dissolved or divided. *Duration of treatment:* Monotherapy maintenance treatment of newly diagnosed advanced ovarian cancer: continue treatment for 2 years or until disease progression. Maintenance treatment of newly diagnosed ovarian cancer in combination with bevacizumab: continue treatment for 2 years or until disease progression. Refer to the Product Information for bevacizumab for recommended dosing information. Platinum-sensitive relapsed ovarian cancer, metastatic HER2-negative breast cancer, metastatic adenocarcinoma of the pancreas, and BRCA-mutated metastatic castration-resistant prostate cancer: treatment be continued until progression of the underlying disease. *See full PI. Dose adjustments:* Treatment may be interrupted to manage adverse reactions such as nausea, vomiting, diarrhoea, and anaemia and dose reduction can be considered, see full PI. *Co-administration with CYP3A inhibitors:* Concomitant use of strong or moderate CYP3A inhibitors is not recommended and alternative agents should be considered. If a strong or moderate CYP3A inhibitor must be co-administered, a dose reduction is recommended, see full PI. *Special patient populations:* For patients with moderate renal impairment (creatinine clearance ≤ 31-50mL/min) the recommended dose of LYNPARZA is 200mg twice daily. LYNPARZA is not recommended in patients with severe renal impairment or end stage renal disease (creatine clearance ≤ 30mL/min), patients with severe hepatic impairment. *Women of childbearing potential:* See SPECIAL WARNINGS AND PRECAUTIONS. For more information, see full PI. **CONTRAINDICATIONS:** Hypersensitivity to the active substance (olaparib) or to any of the excipients. **SPECIAL WARNINGS AND PRECAUTIONS:** *Assessment of mutation status:* Only robust, reliable sensitive tests with demonstrated utility should be used to select patients for treatment with olaparib. *Haematological toxicity* is common in patients treated with olaparib and is generally mild-moderate (CTCAE Grade 1 or 2). Grade 3 or higher events of anaemia (decrease in haemoglobin) occurred in 7.4% of patients in Study 19, and one patient died from a haemorrhagic stroke associated with thrombocytopenia. Patients should not start treatment with LYNPARZA until they have recovered from haematological toxicity caused by previous anti-cancer therapy (haemoglobin, platelet, and neutrophil levels should be ≤CTCAE grade 1). A baseline complete blood count followed by monthly monitoring is recommended for the first 12 months of treatment and periodically after this. If a patient develops severe haematological toxicity or blood transfusion dependence, treatment with LYNPARZA should be interrupted and appropriate haematological testing should be initiated. If blood parameters remain clinically abnormal after 4 weeks of dose interruption, bone marrow and/or blood cytogenic analysis recommended. **Myelodysplastic syndrome/Acute Myeloid Leukaemia* (MDS/AML) *incidence in patients treated in clinical trials, across all indications, with LYNPARZA monotherapy, including long-term survival follow up, was <1.5%. Higher incidence reported in LYNPARZA treated BRCAm platinum-sensitive relapsed ovarian cancer patients who had received at least two prior lines of platinum chemotherapy and were followed up for 5 years, compared to placebo, and to patients receiving LYNPARZA in clinical trials in other indications. For more information, see full PI. Reasonable possibility considered of causal relationship between LYNPARZA and the development of MDS/AML. The majority of events had a fatal outcome. The reports were typical of secondary MDS/cancer therapy-related AML. LYNPARZA treatment duration in patients who developed secondary MDS/AML varied from <6 months to >4 years. All patients had potential contributing factors for the development of MDS/AML, having received previous chemotherapy with platinum agents and many also received other DNA damaging treatments.* If MDS and/or AML are confirmed while on treatment with LYNPARZA, it is recommended that LYNPARZA should be discontinued and the patient be treated appropriately. *Pneumonitis* has been reported in <1% of patients treated with LYNPARZA monotherapy in clinical studies. Reports of pneumonitis had no consistent clinical pattern and were confounded by a number of pre-disposing factors. When LYNPARZA was used in clinical studies in combination with other therapies there have been events with a fatal outcome. If patients present with new or worsening respiratory symptoms, LYNPARZA treatment should be interrupted and prompt investigation initiated. If pneumonitis is confirmed, LYNPARZA treatment should be discontinued and the patient treated appropriately. *Venous thromboembolic events:* including pulmonary embolism have been reported in the PROfound study in patients with metastatic castration resistant prostate cancer. Monitor patients for signs/symptoms of venous thrombosis and pulmonary embolism and treat as medically appropriate, including long-term anti-coagulation as clinically indicated. *Elderly:* limited clinical data in patients aged 75 and over. *Children or adolescents:* Not indicated. *Effects on ability to drive and use machinery:* Asthenia, fatigue, and dizziness have been reported and patients who experience these symptoms should observe caution when driving or using machines. *Use in pregnancy:* Category D. LYNPARZA should not be used during pregnancy due to the teratogenic and genotoxic potential of olaparib. Female partners of male patients taking LYNPARZA should also avoid pregnancy. Women of childbearing potential must use effective contraception during treatment and for 1 month after receiving the last dose. Pregnancy test should be performed prior to treatment, at regular intervals during treatment and one month after receiving last dose. Male patients and their female partners of childbearing potential should be advised that they must use effective contraception during LYNPARZA treatment and for 3 months after receiving the last dose of LYNPARZA. Male patients should not donate sperm during therapy and for 3 months after receiving last dose of LYNPARZA. For more information, see full PI. *Use during lactation:* Breast feeding mothers are advised not to breast-feed during treatment with LYNPARZA and for 1 month after the last dose. **INTERACTIONS:** LYNPARZA co administration with strong and moderate CYP3A inducers or inhibitors is not recommended. If a strong or moderate CYP3A inhibitor must be co-administered, the dose of LYNPARZA should be reduced. Foods that inhibit CYP3A enzymes such as star fruit, grapefruit and Seville oranges should be avoided. CYP3A inducers could substantially diminish the clinical efficacy of LYNPARZA and as such, concomitant use of strong inducers is not recommended. Caution when combined with sensitive CYP3A substrates or substrates with a narrow therapeutic margin. Induction of CYP1A2, 2B6 has been shown *in vitro*. Inhibition of P-gp, OATP1B1, OCT1, OCT2, OAT3, MATE1, MATE2K and BCRP has been shown *in vitro*. Caution should be exercised if LYNPARZA is administered in combination with any statin. Addition of LYNPARZA and other anticancer agents has been shown to potentiate and prolong myelosuppressive side effects. For more information, see full PI. **ADVERSE REACTIONS:** *Very common (≥10%):* anaemia, neutropenia, leukopenia, thrombocytopenia, decreased appetite, dizziness, headache, dysgeusia, cough, dyspnoea, vomiting, diarrhoea, nausea, dyspepsia, fatigue; *Common (≥1% to <10%):* lymphopenia, rash, stomatitis, upper abdominal pain, increase in blood creatinine; *uncommon (≥ 0.1% to <1%): *MDS/AML*, hypersensitivity, **angioedema*, dermatitis, mean cell volume increased; for other listed adverse reactions, see full PI. When LYNPARZA is used in combination therapy with bevacizumab, the safety profile is generally consistent with that of individual therapies, see full PI. Date of first approval: 23 May 2018. Date of Revision: 7 February 2022.

**Please note changes in Product Information.*

BRCA: BReast CAncer; *BRCAm*: *BRCA*-mutated; CR: complete response; CI: confidence interval; HR: hazard ratio; PFS: progression-free survival; PR: partial response. **Reference: 1.** Banerjee S *et al. Lancet Oncol* 2021. DOI: https://doi.org/10.1016/S1470-2045(21)00531-3. Epub 201 Oct 21.

AU-13016. ASTR0563/EMBC. Date of preparation: March 2022.

AstraZeneca

Wednesday 27th April 2022

0915 - 0945	Registration and Morning Tea	
	Fellows Education Day Victoria Suite	**Examiners Workshop**
0945 - 1045	Pathology - **Marsali Newman**	
1045 - 1145	Radiation Onc - **Ming Yin Lin**	
1145 - 1200	GSK and Gynaeoncology - **Niamh Mangan**	
1200 - 1300	Lunch	
1300 - 1400	Med Onc - **Linda Mileshkin**	
1400 - 1500	Radiology - **Andrew Dobrotwir**	
1500 - 1515	Afternoon Tea	
1515 - 1715	Mock OSCE	"So You Want To Be a CGO?"
1800 - 2100	**Welcome Reception**	*Sofitel Melbourne on Collins, Sofi's Lounge*

Thursday 28th April 2022

0800 - 0820	Registration & Trade Exhibition Open	
0820 - 0825	Welcome from Organising Committee & Welcome to Country - **Julie Lamont & Deb Neesham**	
0825 - 0830	Opening of Meeting by ASGO Chair - **Peter Sykes**	
0830 - 1015	**SESSION 1:** KEYNOTE PRESENTATIONS – HIPEC IN OVARIAN CANCER *Session Chairs: Orla McNally & Adam Pendlebury*	*Fitzroy Ballroom*
0830 - 0900	European Experience - **Willemien van Driel**	
0900 - 0930	USA Experience - **Robert DeBernardo**	
0930 - 0945	Medical Oncology Perspective - **Anne Hamilton**	
0945 - 1000	HyNOVA - **Rhonda Farrell**	
1000 - 1012	Panel Questions	
1012 - 1015	Sponsor Presentation - **GSK**	
1015 - 1045	Morning Tea & Trade Exhibition	*Latrobe Ballroom*
1045 - 1200	**SESSION 2:** ADVANCES IN VULVA CANCER *Session Chairs: Julie Lamont & Rob Rome*	*Fitzroy Ballroom*
1045 - 1110	GROINSV2 and Beyond - **Willemien van Driel**	
1110 - 1130	Prognostic Factors in Vulva Cancer - **Lois Eva**	
1130 - 1145	ANZGOG Prospective SLN Audit - **Peter Sykes**	
1145 - 1200	National Gynae-Oncology Registry (NGOR) Update - **Rob Rome**	
1200 - 1203	Sponsor Presentation - **Device Technologies**	
1203 - 1300	Lunch & Trade Exhibition	*Latrobe Ballroom*
1300 - 1430	**SESSION 3:** ACCREDITED FELLOWS PRESENTATIONS & FREE COMMUNICATIONS *Session Chairs: Kris Moloney & Kym Reid*	*Fitzroy Ballroom*
1300 - 1310	The Effect of Surgical Staging Approach on Survival and Recurrence in Women with Apparent Early Stage High Grade and Mismatch Repair Deficient Endometrial Cancer - **Rhett Morton**	

1310 - 1320	Detection of Cervical Cancer in Women Participating in the New Australian Cervical Screening Program – A Large Single Institution Clinical Audit 2018 – 2021- **Melissa McGauran**	
1320 - 1330	Retrospective Analysis of Management and Outcomes of Malignant Bowel Obstruction Associated with Advanced Gynaecological Malignancies - **Rinkita Sinha**	
1330 - 1340	Audit of Borderline Ovarian Tumours at the Royal Women's Hospital 1982 – 2021- **Rosie McBain**	
1340 - 1350	The Use of Intraperitoneal Chemotherapy for Advanced Ovarian Cancer - The Westmead Experience 2006 - 2018 - **Leon Foster**	
1350 - 1400	Mutational Landscape of Ovarian Adult Granulosa Cell Tumors from Whole Exome and Targeted TERT Promoter Sequencing - **Cheryl Yim**	
1400 - 1410	The Correlation Between Macroscopic Surgical Assessment, Histological and Molecular Subtypes of High-Grade Serous Cancer of Female Genital Tract, Ovarian, Tubal and Peritoneal Origin- the FOoTPrint Study - Preliminary Results - **Yael Naaman**	
1410 - 1420	Outcomes in Patients with Metastatic or Recurrent Cervical Cancer Treated with First-line Chemotherapy and Bevacizumab Followed by Maintenance Bevacizumab - **Monica McGauran**	
1420 - 1430	Management of Choriocarcinomas in Victoria: A Retrospective Audit - **Catherine Schepisi**	
1430 - 1433	Sponsor Presentation - **Applied Medical**	Applied Medical – A New Generation Medical Device Company
1433 - 1500	Afternoon Tea & Trade Exhibition	*Latrobe Ballroom*
1500 - 1630	**SESSION 4:** RADICAL PELVIC SURGERY *Session Chairs: Tom Jobling & David Allen*	*Fitzroy Ballroom*
1500 - 1530	"Fit 4 Surgery" - **Hilmy Ismail**	
1530 - 1600	Exenterative Pelvic Surgery for Recurrent Gynae - **Sandy Heriot**	
1600 - 1630	Open Radical Hysterectomy - **Russell Land**	
1630 - 1633	Sponsor Presentation - **BD**	BD
1633 - 1733	**SESSION 5**	*Fitzroy Ballroom*
	Mad, Bad, Sad: Tears, Abuse and Threats - **Robert Glover, Preferred Training Networks**	
1900 - 2200	**Informal Dinner**	*Sofitel Melbourne on Collins, No 35*

Friday 29th April 2022

0800 - 0830	Registration & Trade Exhibition Open	
0830 - 1030	**SESSION 6:** EDUCATION AND TRAINING *Session Chairs: Deb Neesham & Tom Manolitsas*	*Fitzroy Ballroom*
0830 - 0835	Introduction from **Prof Michael Quinn AM**	
0835 - 0905	Training in the Era of Subspecialisation. Who Should be Responsible? - **Sandy Heriot**	
0905 - 0920	"The Other Side of the Table..." – The Transition from Trainee to Trainer - **Archana Rao**	
0920 - 0950	"That was Rubbish" - Productive Candour in Feedback Conversations - **Debra Nestel**	
0950 - 1005	Western Pacific Gynaecological Oncology Liaison Group - **Jim Nicklin & Peter Sykes**	
1005 - 1027	Panel Questions	
1027 - 1030	Sponsor Presentation - **Stryker**	stryker
1030 - 1100	Morning Tea & Trade Exhibition	*Latrobe Ballroom*

1100 - 1230	**SESSION 7:** ACCREDITED FELLOWS PRESENTATIONS & FREE COMMUNICATIONS *Session Chairs: Orla McNally & Deb Neesham*	*Fitzroy Ballroom*
1100 - 1103	Sponsor Presentation - **Sanofi**	
1103 - 1113	A Qualitative Analysis of Inter-disciplinary Collaboration for Exenterative and Advanced Gynae-oncology Procedures: The Spiral of Scramble - **Cecile Bergzoll**	
1113 - 1123	Sentinel Lymph Node Mapping for Uterine Cancer: An Approach to Fulfil the Surgical Competency Assessment Tool and to Improve CGO Fellow Training - **Michael Burling**	
1123 - 1133	The Effectiveness of Sentinel Lymph Node Biopsy in Endometrial Cancer: A Retrospective Cohort Experience at a Major Tertiary Gynaecological Oncology Referral Centre in Sydney, Australia Between the Years 2018-2020 - **Dan Krishnan**	
1133 - 1143	The use of ICG Lymphatic Channels to Identify the Uterine Artery During Sentinel Lymph Node Mapping for Uterine Cancer - **Michael Burling**	
1143 - 1153	The Use of Indocyanine Green in Groin Node Biopsy /Dissection for Vulval Cancer - **Gaithri Mylvaganam**	
1153 - 1203	Groin Sentinel Lymph Node Dissection: 20 Years Experience - **Orgad Rosenblat**	
1203 - 1213	Staged Treatment of Placenta Accreta Spectrum: A Combined Surgical and Interventional Radiology Approach at a Tertiary Centre - **Simon West**	
1213 - 1223	Use of Direct Oral Anticoagulants for Postoperative Venous Thromboembolism Prophylaxis after Surgery for Gynecologic Malignancies- A Review of the Literature - **Marilyn Boo**	
1223 - 1233	Vaginal Vault Smear Cytology in Detection of Recurrence after Hysterectomy for Early Cervical Cancer - **Leah Grace**	
1233 - 1236	Sponsor Presentation - **The O.R. Company**	
1236 - 1330	Lunch & Trade Exhibition	*Latrobe Ballroom*
1330	**ASGO Afternoon Activities**	

Saturday 30th April 2022

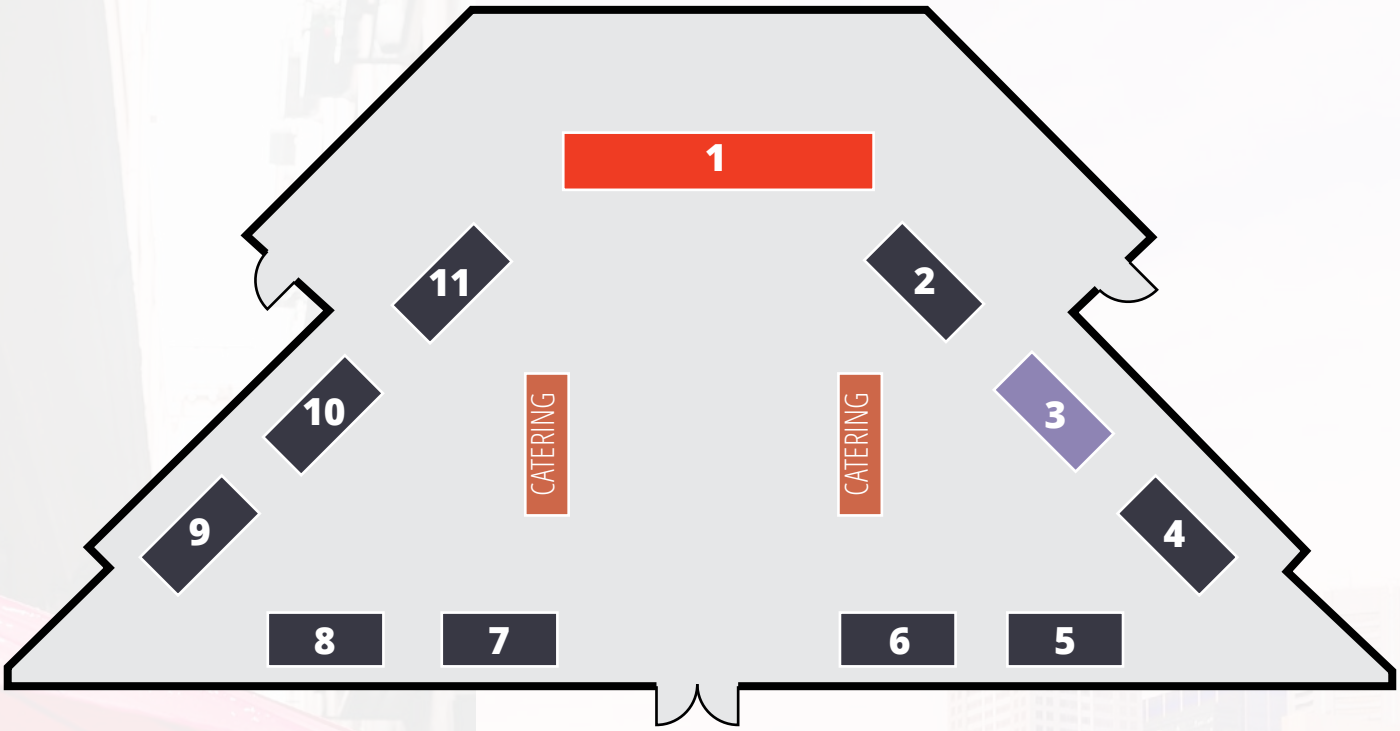
0815 - 0830	Registration & Trade Exhibition Open	
0830 - 1000	**SESSION 8:** CANCER PREVENTION & SURVIVORSHIP *Session Chairs: Simon Hyde & Geraldine Goss*	*Fitzroy Ballroom*
	Session Sponsor by: AstraZeneca	
0830 - 0835	Sponsor Presentation - **AstraZeneca**	
0835 - 0905	Ovarian Cancer and PARP Inhibitors - **Christina Fotopoulou**	
0905 - 0915	Questions	
0915 - 0925	ANZGOG Update - **Clare Scott**	
0925 - 0945	BRCA: Ovarian and Uterine Cancer Risk - **Kelly Phillips**	
0945 - 0957	Panel Questions	
0957 - 1000	Sponsor Presentation - **Karl Storz**	
1000 - 1300	Morning Tea & Trade Exhibition	*Latrobe Ballroom*

1030 - 1100	**SESSION 9:** ACCREDITED FELLOWS PRESENTATIONS & FREE COMMUNICATIONS *Session Chairs: Deb Neesham & Niveditha Rajadevan*	*Fitzroy Ballroom*
1030 - 1040	Participation in Gynaecological Oncology Clinical Trials at Westmead Gynaeoncology Unit: Who, When, Why and Why Not? - **Michael Burling**	
1040 - 1050	Neo-adjuvant Chemotherapy in the Treatment of Advanced Endometrial Cancer: A Propensity Matched Retrospective Cohort Study Examining the Queensland Experience - **Nicole Krzys**	
1050 - 1100	Does p53 Mutation Influence Recommendation for Adjuvant Therapy in Endometrial Carcinoma? - **Tamara Turnbull**	
1100 - 1200	**TUMOUR BOARD** *Moderator: Adam Pendlebury*	*Fitzroy Ballroom*
	Gyn Onc - **Willemien van Driel & Robert DeBernardo**	
	Radiologist - **Clair Shadbolt**	
	Pathologist - **Marsali Newman**	
	Rad Onc - **Adeline Lim**	
	Med Onc - **Anne Hamilton**	
1200 - 1245	**SESSION 10:** ASGO DEBATE *Moderators: Toni Jones & Shih-Ern Yao*	*Fitzroy Ballroom*
	"EAST vs WEST: Pelvic lymphadenectomy SHOULD be part of endometrial cancer treatment"	
	For: WEST / Stuart Salfinger, Raj Mohan, and John Miller	
	Against: EAST / Robert DeBernardo, Geraldine Goss, Rachel O'Sullivan, and Greg Gard	
1245 - 1315	Lunch	*Promenade 1st floor*
1315 - 1330	ASGO Members MBS Discussion	*Fitzroy Ballroom*
1330 - 1600	**ASGO** - Annual General Meeting	*Fitzroy Ballroom*
1900 - 2300	**ASGO Black Tie Dinner**	*Pure South Dining*

Program correct at time of publication and subject to change.

POSTERS

#1	Low-risk Gestational Trophoblastic Neoplasia –20 Years Experience of a State Registry - **Carmel McInerney**
#2	Uterine Perivascular Epithelioid Cell Tumour (PEComa) in a 74-year-old Woman - **Charmian Eng**
#3	Anaplastic Carcinoma Foci Within Borderline Mucinous Ovarian Tumours, A Case Series and Meta-analysis Assessing Adjuvant Treatment and Outcomes - **Lachlan Baxter**
#4	Endometrial Cancer Recurrence on a Foot- An Unusual Tale - **Marilyn Boo**
#5	Chemotherapy Response Score (CRS) After Neoadjuvant Chemotherapy and Interval Debulking Surgery in Tubo-ovarian High-grade Serous Carcinoma: Prognostic Value and Predictors - **Monica McGauran**
#6	Mesonephric Adenocarcinoma of the Uterus, Diagnosis and Management: A Series - **Nicla Lui**
#7	Intraplacental Choriocarcinoma a Rare Malignancy with Obstetrics Complications - **Nina Reza Pour**
#8	Ovarian Cancer Complicating Pregnancy - **Nina Reza Pour**



1 AstraZeneca
2 Device Technologies
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10 BD
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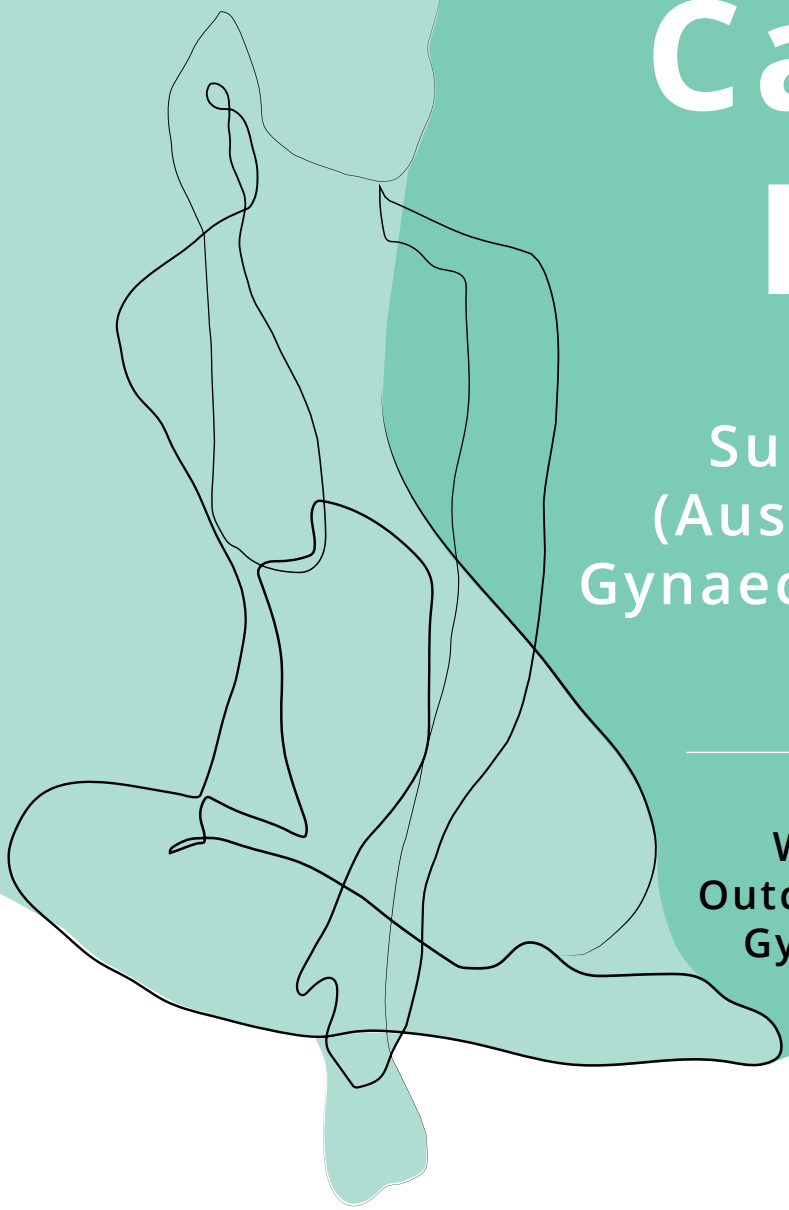
SOCIAL PROGRAM

Wednesday 27th April	6:00pm – 9:00pm	**Welcome Reception** Sofitel Melbourne on Collins, Sofi's Lounge
Thursday 28th April	7:00pm – 10:00pm	**Informal Dinner** Sofitel Melbourne on Collins, No 35
Friday 29th April		**Free Night**
Saturday 30th April	7:00pm – 11:00pm	**ASGO Black Tie Dinner** Pure South Dining Buses depart the Sofitel at 6:30pm



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Working to Improve Outcomes for Women with Gynaecological Cancer

Foundation GOALS:

- Improving the care and outcomes for women suffering from gynaecological cancer
- Establishment of a National Clinical Quality Register and Database to monitor the care of women
- Educating women and the caring professions in the area of gynaecological cancer
- Helping support research in the area of gynaecological cancer

To support the ASGO (Australian Society of Gynaecologic Oncologists) Foundation, please visit the website:

www.asgo.net.au/charity

or refer to the brochure

ASGO Australian Society of Gynaecologic Oncologists Inc.

Caring for women since 1986

WEDNESDAY 27TH APRIL 2022

FELLOWS DAY

Pathology

Marsali Newman[1]

1. Austin Health, Heidelberg, VIC, Australia

NOTES

Radiation Oncology

Ming-Yin Lin[1]

1. Peter MacCallum Cancer Centre, East Melbourne, VIC, Australia

NOTES

Medical Oncology

Linda Mileshkin[1]

1. Peter MacCallum Cancer Centre, East Melbourne, VIC, Australia

NOTES

Radiology

Andrew Dobrotwir[1]

1. Royal Women's Hospital, Parkville, VIC, Australia

NOTES

GSK and Gynaeoncology

Niamh Mangan[1]

1. GSK, Abbotsford, VIC, Australia

NOTES

"So You Want To Be a CGO?"

NOTES

gsk

Zejula
niraparib
capsules 100 mg

IF SHE RESPONDS
TO CHEMOTHERAPY

YOU CAN RESPOND
WITH ZEJULA[1*]

*Approved in first-line advanced ovarian cancer as maintenance therapy for patients who are in response (CR or PR) to platinum-based chemotherapy[1#]

ZEJULA IS THE ONLY PARP INHIBITOR TGA APPROVED FOR WOMEN WITH ADVANCED OVARIAN CANCER IN RESPONSE TO FIRST-LINE PLATINUM-BASED CHEMOTHERAPY, *REGARDLESS OF BIOMARKER STATUS*[1–3#]

[#]ZEJULA is indicated for the maintenance treatment of adult patients with advanced high-grade ovarian, fallopian tube or primary peritoneal cancer who are in response (complete or partial) following completion of first-line platinum-based chemotherapy.[1]

PLEASE REVIEW PRODUCT INFORMATION BEFORE PRESCRIBING.
Product information is available at www.gsk.com.au/zejula

PBS Information: This product is not listed on the PBS

Abbreviations: CR, complete response; PARP, poly (ADP-ribose) polymerase; PR, partial response; TGA, Therapeutic Goods Administration. References: 1. ZEJULA Approved Product Information. 2. Lynparza (olaparib) Product Information. 3. Gonzalez-Martin A, et al. N Engl J Med 2019; 381(25):2391–2402.

THURSDAY 28TH APRIL 2022

SESSION 1: KEYNOTE PRESENTATIONS – HIPEC IN OVARIAN CANCER
Session Chairs: Orla McNally & Adam Pendlebury

European Experience

Willemien van Driel[1]

1. NKI-AVL/CGOA, Amsterdam, Netherlands

NOTES

USA Experience

Robert DeBernardo[1]

1. Cleveland Clinic, Cleveland, OH, United States

NOTES

Medical Oncology Perspective

Anne Hamilton[1]

1. Peter MacCallum Cancer Centre, Melbourne, VIC, Australia

NOTES

HyNOVA

Rhonda Farrell[1]

1. LIFEHOUSE, Sydney, South Coogee, NSW, Australia

NOTES

SESSION 2: ADVANCES IN VULVA CANCER
Session Chairs: Julie Lamont & Rob Rome

GROINSV2 and Beyond

Willemien van Driel[1]

1. NKI-AVL/CGOA, Amsterdam, Netherlands

NOTES

Prognostic Factors in Vulva Cancer

Lois Eva[1]

1. Dept of Gynae Oncology Auckland City Hospital, Auckland, AUCKLAND, New Zealand

NOTES

ANZGOG Prospective SLN Audit

Peter Sykes[1]

1. Obstetrics and Gynaecology, University of Otago, Christchurch, New Zealand

NOTES

National Gynae-Oncology Registry (NGOR) Update

Robert Rome[1], **Aleesha Whitely**[2], **Alice Sporik**[2], **John Zalcberg**[2]

1. Epworth HealthCare, East Melbourne, VIC, Australia

2. Monash University, Melbourne, VIC, Australia

The NGOR commenced in 2017 with the goal of identifying variations in the treatment and outcomes of patients with newly diagnosed gynaecological cancers, with a view to improving patient outcomes and quality of care. Working groups were established to review the literature and develop Quality Indicators (QIs) for the various gynaecological cancers. These were circulated to clinical participants and consumer representatives for feedback before finalisation. The current QIs can be viewed at the following link
- https://ngor.org.au/index.php/asgo2022/

At the end February 2022 the NGOR had registered 1423 patients with epithelial ovarian, tubal or peritoneal (OTP) cancer, 1043 patients with endometrial cancer and 112 patients with rare non-epithelial ovarian malignancies.

Contacts with several overseas quality registries in the Netherlands, Scotland and Italy have been established. Some of the headwinds which have confronted the project include funding, ethics committee approvals, data management and lack of structured surgical datasets.

Primary and interval cytoreductive surgery for advanced OTP cancer and adverse surgical outcomes are topics of current interest. From 2017 to 2020, 573 patients with advanced (stage III and IV) OTP cancer had been registered. At the completion of primary cytoreductive surgery there was no residual disease in 90 of 213 (42.3%) patients compared to 115 of 232 (49.6%) who had interval cytoreductive surgery. Serious adverse events (Clavien-Dindo grade >=3) occurring in the first 30 days after surgery were statistically more common after primary surgery (11.6%) than interval surgery (4.8%), $X2(1) = 6.9$, $p = 0.01$. Eighty-two patients did not undergo surgery, 22 had surgery abandoned and 24 did not have 9the extent of residual disease recorded.

The NGOR continues to expand and will be a significant resource for clinical research into the future. The ongoing support from clinicians, data managers, and of course our patients and their families and friends has been an essential ingredient for the establishment of the Registry. We would especially like to express our gratitude to our sponsors and financial supporters - Ovarian Cancer Australia, The CASS Foundation, the Epworth Medical Foundation, the ASGO Foundation and the Medical Research Future Fund.

NOTES

Arista™ AH

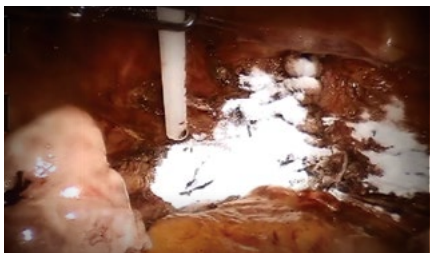
Absorbable Haemostatic Particles

Simple and effective in gynaecologic surgery.[1]

The proprietary Arista™ AH powder achieves broad area coverage[2] on rough surfaces and in hard-to-reach areas,[3] for rapid control of bleeding.[1]

Potential uses for Arista™ AH to control bleeding as an adjunctive hemostat may include:[1,4,5,6]

- Bilateral salpingo-oophorectomy.
- Endometrial and cervical biopsy
- Hysterectomy *(total abdominal or laparoscopically)*
- Uterine fibroid/cyst removal
- Colporrhaphy
- Tubal ligation
- Ovarian lesion/cyst removal



Arista™ AH in an abdominal hysterectomy

BD

DAVINCI

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NZ 0508 DEVICE (338 423) customers@device.co.nz www.device.co.nz

SESSION 3: ACCREDITED FELLOWS PRESENTATIONS & FREE COMMUNICATIONS
Session Chairs: Kris Moloney & Kym Reid

The effect of surgical staging approach on survival and recurrence in women with apparent early stage high grade and mismatch repair deficient endometrial cancer

Rhett Morton[1], Rhonda Farrell[2]

1. Royal Brisbane Women's Hospital, Newstead, QUEENSLAND, Australia

2. Chris O'Brien Lifehouse, Camperdown, NSW, Australia

Publish consent withheld.

NOTES

Detection of cervical cancer in women participating in the new Australian Cervical Screening Program – a large single institution clinical audit 2018 - 2021.

Melissa McGauran[1], Jeffrey Tan[1], David Wrede[1]

1. Royal Women's Hospital, Parkville, VICTORIA, Australia

BACKGROUND AND AIMS

The new Australian HPV Cervical Screening Program was introduced on 1 December 2017. We report on the diagnoses of invasive cervical cancer in women presenting to a large Australian metropolitan colposcopy and oncology clinic after implementation.

MATERIALS AND METHODS

All women seen in the Colposcopy or Gynaecological Oncology Clinic who were diagnosed with cervical cancer with a known HPV status between 1 January 2018 and 31 December 2021 were included. Demographic, cervical screening data and cervical cancer data were collected.

RESULTS

There were 197 women seen, 65 with Stage IA (33.0%), 54 Stage IB (27.4%), 77 Stage II-IV (39.1%) and 1 case undocumented (0.05%). Squamous Cell Carcinoma (59.9%) was more common than Adenocarcinoma (32.5%). The majority of women were HPV16/18 positive (75.8%), with HPV(Not16/18) positive (19.6%) and 9 HPV negative (4.6%). Nine women were found with HPV negative cancers: six adenocarcinoma, two adenosarcoma and one adenosquamous carcinoma. Eight women with high grade (HSIL(CIN2/3)) on cervical biopsies but no suspicion of invasion at colposcopy had unexpected cancer at excisional treatment, all in Stage IA1.

CONCLUSIONS

We have shown the benefit of HPV screening in detecting cancer earlier in women with positive HPV associated with negative cytology. The unexpected cancers found at excisional treatment for high grade abnormality (HSIL) is a caution for using ablative therapy in women over thirty years of age.

NOTES

Retrospective analysis of management and outcomes of malignant bowel obstruction associated with advanced gynaecological malignancies

Rinkita Sinha[1, 2], Jennifer Duggan[3], Anthony Proietto[3, 1], Michael Friedlander[3, 1, 4], King Man Wan[3, 1], Yeh Chen Lee[3, 1, 4]

1. University of New South Wales, Sydney, NSW, Australia

2. Gynaecological Oncology, Monash Womens, Melbourne, VIC, Australia

3. Gynaecological Oncology, The Royal Hospital for Women, Sydney, NSW, Australia

4. Prince of Wales Hospital, Sydney, NSW, Australia

Background:

Malignant bowel obstruction (MBO) is a complex clinical problem associated with high morbidity and mortality. We evaluated outcomes of patients with MBO in a gynaecological oncology unit.

Methods:

Retrospective review of women with advanced gynaecological cancer and MBO from January 2020 to January 2021. Clinical characteristics, management, cumulative length of stay within 90 days of MBO (LOS_{cum90}) and outcomes were reported.

Results:

Twenty-six patients were admitted for MBO and their median LOS_{cum90} was 11 days (IQR 6-25). The majority had ovarian cancer (69%) and median time from primary diagnosis to MBO was 33 months. Treatment received included palliative surgery (60%), chemotherapy (82%), and supportive care only (13%). Nearly all patients (96%) were co-managed by palliative care services. Median survival post MBO was 13 months (IQR 5-20) and 70% survived longer than 6 months.

Conclusion:

Multidisciplinary MBO management can achieve acceptable clinical outcomes, with relatively short hospital admissions and majority surviving beyond 6 months.

NOTES

Audit of Borderline Ovarian Tumours at the Royal Womens' Hospital 1982 - 2021

Rosie McBain[1], Aidan Kashyap[1], Estefania Vicario[1], Mila Volchek[1], Toni Jones[1], Nivetha Rajedevan[2], Deborah Neesham[1], Orla McNally[1, 3]

1. Royal Women's Hospital, Parkville, Victoria, Australia

2. Royal Women's Hospital, Melbourne, Australia

3. University of Melbourne, Melbourne, VIC, Australia

Borderline ovarian tumors represent 10-20% of all epithelial ovarian tumors and one third of patients present younger than 40. We present an updated audit at the Royal Womens' Hospital, reviewing all cases since 1982, with particular focus on outcomes in patients who undergo fertility preserving management; rates, timing and detection of recurrence; duration and frequency of follow-up and rates of progression to cancer. 561 cases were included, 199 (35%) were serous borderline ovarian tumours only, 272 (48%) were mucinous borderline tumours only and 90 (16%) were mixed or other. Mean age at diagnosis was 46. Data for residual disease was available for 431 patients, and of these 417 had no residual disease and 14 had optimal debulk. Further data will be available for presentation.

NOTES

The use of intraperitoneal chemotherapy for advanced ovarian cancer – the Westmead experience 2006 – 2018.

Leon Foster[1], Christine Girgis[2], Alison Brand[3], Adrienne Kirby[4]

1. Gynaecological Oncology, Royal Hospital for Women, Sydney, NSW, Australia

2. Familial Cancer Services, Westmead Hospital, WENTWORTHVILLE, NSW

3. Gynaecological Oncology, Directory, Westmead, New South Wales, Australia

4. University of Sydney, Sydney, NSW, Australia

Introduction:

The platinum-taxane combination has become well established as first-line chemotherapy for women with high grade epithelial ovarian/fallopian tube/ primary peritoneal cancer (ovarian cancer). The dose, route and timing of administration have been the subject of multiple randomised controlled trials and rigorous debate. The Intraperitoneal (IP) route has several characteristics that add to its appeal. As ovarian cancer is a peritoneal based disease, accessing the peritoneal cavity directly permits higher doses of treatment to be applied directly to the tumour. Westmead hospital in Sydney, Australia offers IP chemotherapy as an option for treatment to women with optimally cytoreduced stage III Epithelial ovarian cancer. The aim of this study was to identify the recurrence-free survival (RFS) and overall survival (OS) of women treated with IP chemotherapy at Westmead hospital between 2006 – 2018. A secondary aim was to create a matched cohort of women treated with IV chemotherapy in the same period to compare outcomes.

Methods:

This was a single-institution study undertaken at Westmead Hospital. All women who were planned to have IP chemotherapy between 2006 and 2018 were included. Characteristics examined included competed IP cycles, the distance the patient lived from the hospital, body mass index, date of progression, date of death and of date of the last follow-up. To achieve our secondary objective and create a matched cohort all women with epithelial ovarian cancer treated over the same period were examined. As all women in the IP cohort were 70 years old or younger that was made an inclusion criterion for the IV cohort. Other inclusion criteria were those used in previous randomised controlled trials and included epithelial ovarian cancer (in this instance high grade serous and endometrioid only), Stage II – IVA, underwent primary debulking surgery with less than 1 cm of residual disease. The use of Bevacizumab or Olaparib was not an exclusion criterion. The primary outcome was to identify and compare the recurrence-free survival (RFS) and overall survival (OS) of women who received IP chemotherapy compared to a similar cohort who received standard IV chemotherapy.

Results

746 women with ovarian cancer were available for review. 79 women were in the IP cohort. Overall, 65 women were selected for comparison with the IV cohort. In our IP cohort 72% received 4 or more cycles of IP chemotherapy and 98% of IP and IV patients received 6 or more cycles of chemotherapy overall. The median RFS for the IP group was 26 months. The median OS was 63.9 months. The 5-year OS for women treated with IP chemotherapy was 53% and 10 year OS was 16%. The cohort who received IV chemotherapy had a median RFS of 26 months and a median OS of 57.3 months. The 5 year OS was 45% and the 10 year OS was 3%. There was no difference between the RFS and OS between the IP and IV groups.

Conclusion

In this study, we identified that the PFS and OS for women treated with IP chemotherapy at Westmead hospital between 2006 and 2018 were equivalent to that in the two largest randomised trials that compared its use with IV chemotherapy. We did not find a difference in RFS and OS between the IP and IV cohorts. A 5 year OS of 53% is an excellent outcome for this cohort as is a 10 yr OS of 16%. This indicates that IP chemotherapy provided gold standard outcomes to this patient population.

NOTES

Mutational Landscape of Ovarian Adult Granulosa Cell Tumors from Whole Exome and Targeted TERT Promoter Sequencing

Cheryl Yim[1], Maria Alexiadis[2, 3], Trang Nguyen[2, 3], Peter Fuller[2, 3], Tom Jobling[1], Simon Chu[2, 3]

1. Gynaeoncology Unit, Monash Health, Moorabbin, Victoria, Australia

2. Hormone Cancer Therapeutics Laboratory, Department of Centre for Endocrinology and Metabolism, Hudson Institute of Medical Research, Clayton , VIC , Australia

3. Department of Molecular and Translational Sciences, Monash University, Clayton, VIC, Australia

Background:

Granulosa cell tumours are low grade ovarian malignancies that can be subclassified as juvenile (5%) or adult (95%) types. Adult granulosa cell tumours (aGCTs) are the most common malignant sex cord-stromal tumour of the ovary. Although the majority present with early-stage disease where surgery is curative, those with advanced disease at presentation and those that recur often have a lethal outcome. At present, our understanding of the aetiology of this disease is limited, and there are no standard methods for predicting its behaviour or recurrence.

The somatic missense mutation in the FOXL2 gene (c.402 C>G; p.C134W), which is found in approximately 97% of aGCTs, argues strongly that this mutation has an aetiologic role in these tumours. Studies analysing known oncogenes, tumour suppressor genes and key signalling pathways in order to identify further mutations in aGCTs have largely been unsuccessful. We have performed an unbiased study applying large-scale sequencing to an expanded, well-curated panel of aGCTs to determine the mutational landscape of this disease beyond the ubiquitous FOXL2 p.C134W mutation.

Methods:

We applied whole-exome sequencing (WES) to DNA extracted from 22 aGCTs (14 stage 1 aGCTs and 8 recurrent aGCTs). The data was analysed for potentially oncogenic and/or novel single nucleotide variants (SNV) and insertions or deletions (indels) as well as for copy number variation. We used a targeted approach to examine the promoter region of the TERT gene that encodes the catalytic subunit of telomerase, for two hotspot mutations, -124C>T and -146C>T.

Results:

We report a significant and consistent rate of mutation across the aGCTs including a small number of known oncogenic events. 42% of the aGCTs in our analysis were heterozygous for the -124C>T TERT promoter mutation. Recurrent aGCTs demonstrated a higher frequency (67%) of this mutation, raising the possibility that TERT promoter mutation may be associated with more aggressive clinical behaviour.

Conclusion:

The identification of mutations that predict recurrence and/or aggressive behaviour could inform the management of women with aGCTs, with the potential to identify therapeutic targets in the future.

1. Fuller PJ, Leung D, Chu S. Genetics and genomics of ovarian sex cord-stromal tumors. Clin Genet 2017;91:285–91.
2. Shah SP, K€obel M, Senz J, Morin RD, Clarke BA, Wiegand KC, et al. Mutation of FOXL2 in granulosa-cell tumors of the ovary. N Engl J Med 2009;360;2719–29.
3. Jamieson S, Fuller PJ. Molecular pathogenesis of granulosa cell tumors of the ovary. Endocr Rev 2012;33:109–44.

NOTES

The correlation between macroscopic surgical assessment, histological and molecular subtypes of High-Grade Serous Cancer of Female genital tract, Ovarian, Tubal and Peritoneal origin- *the FOoTPrint Study*- preliminary results

Yael Y Naaman[1], Deborah D Neesham[1], Antonia A Jones[1]

1. Gynaecology- Oncology unit, The Royal Women's Hospital, Melbourne, Victoria, Australia

Background- High Grade Serous Carcinoma (HGSC) of the female genital tract can be divided into Four molecular subtypes (C1, C2, C4 and C5) using microarray gene expression profiling and confirmed in additional studies using RNA sequencing. In addition to distinct expression profiles, the molecular subtypes also display distinct clinical features. To date, there is also no published data that relates to molecular subtype and tumour macroscopic appearance at the time of primary surgery as described by the surgical team.

Aims-

1)To explore the possible correlation between the macroscopic appearance of HGSC at the time of primary surgery and molecular subtype.
2. Evaluate pre-surgical MRI scans to determine if there are subtype-specific characteristics that can be observed.
3. To validate the histopathologic classification criteria of molecular subtyping for HGSC.

Methods- Prospective, exploratory pilot study of patients undergoing primary surgery for HGSC. Tumour samples were collected and sent to molecular subtyping. The cases underwent surgical assessment at the time of operation, MRI assessment and Histopathological assessment.

We will present the preliminary results of the study.

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Outcomes in patients with metastatic or recurrent cervical cancer treated with first-line chemotherapy and bevacizumab followed by maintenance bevacizumab

Monica McGauran[1, 2], Mahendra Naidoo[3], Yael Lefkovits[3], Natasha Pritchard[1], Simon Hyde[2], Linda Mileshkin[2, 3]

1. Department of Obstetrics & Gynaecology, The University of Melbourne, Heidelberg, VIC, Australia

2. Department of Gynaecological Oncology, Mercy Hospital for Women, Heidelberg, VIC, Australia

3. Peter MacCallum Cancer Centre, Parkville, VIC, Australia

BACKGROUND:

The addition of Bevacizumab to platinum-based doublet chemotherapy improves overall survival (OS) in patients with advanced cervical cancer. However, clinical benefit of adding maintenance single agent Bevacizumab to this regimen remains unclear.

METHODS:

This is a retrospective cohort study. We aimed to evaluate progression free survival, overall survival and adverse events in those who had maintenance Bevacizumab after doublet chemotherapy and concurrent Bevacizumab versus those who did not.

RESULTS:

Sixty-five patients were included. Of these, thirty (44%) received maintenance Bevacizumab. Median OS in patients receiving maintenance Bevacizumab at initial diagnosis was 13 versus 15 months in those who did not. Median OS in patients who received maintenance Bevacizumab after progressing or recurring was 33 months versus 22 months. These differences did not reach statistical significance.

CONCLUSION:

The continuation of Bevacizumab beyond combination chemotherapy may be clinically justified to improve outcomes in women with advanced cervical cancer.

Management of choriocarcinomas in Victoria: a retrospective audit

Catherine Schepisi[2, 1], Orla McNally[2]

1. Royal Adelaide Hospital, Adelaide, SA, Australia

2. Royal Women's Hospital, Parkville, Vic

Aim: To determine the management of Choriocarcinoma in Victoria

Background: Management of choriocarcinoma throughout Australia remains relatively unknown, with little to no literature available and no guiding national protocol. Inconsistent state-based reporting requirements contributes to the challenge of reviewing management on a national scale. In Victoria it is recommended that all choriocarcinomas are reported to the Royal Women's Hospital (RWH) Gestational Trophoblastic Disease (GTD) Registry. The Cancer Registry of Victoria (VCR) records all new cases of choriocarcinoma in Victoria. Based on a preliminary inquiry of VCR, not all cases of choriocarcinoma have been referred to the GTD Registry at RWH. This raises the possibility of inconsistent care of women with this cancer which, when mismanaged, can be fatal.

Methods: Data was collated from RWH GTD Registry identifying choriocarcinomas diagnosed between April 1983 and July 2021. Data included demographics, disease history, histopathology, management and outcomes. Complete data sets were unable to be obtained where registered patients were managed privately or through other tertiary centres.

Results: 47 patients were diagnosed with choriocarcinoma over the 38 year period. 4 of these were non gestational choriocarcinomas. Mean age at diagnosis was 34 years-old. Majority of women presented with stage 1 disease and PV bleeding post partum. Of the 29 patients wholly managed through RWH, 26 received first line EMACO therapy, all with complete response. One 36 years-old presenting with stage 4 choriocarcinoma died six months after diagnosis, failing third line chemotherapy.

Discussion Following permission from Cancer Council Victoria, this data will now be compared with the VCR database to identify patients not registered with RWH's registry. It is hoped that this state based audit will form the basis for a national audit of the management of choriocarcinoma, ultimately supporting a centralised registry for this rare but highly treatable cancer.

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SESSION 4: RADICAL PELVIC SURGERY
Session Chairs: Tom Jobling & David Allen

"Fit 4 Surgery"

Hilmy Ismail[1]

1. Peter MacCallum Cancer Centre, Melbourne, VIC, Australia

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Exenterative Pelvic Surgery for Recurrent Gynae

Alexander Heriot[1]
1. Peter MacCallum Cancer Centre, Albert Park, VIC, Australia

NOTES

Open Radical Hysterectomy

Russell Land[1]
1. Greenslopes Specialist Gynaecology, Norman Park, QLD, Australia

NOTES

SESSION 5

Mad, Bad, Sad: Tears, Abuse and Threats

Robert Glover[1]
1. Preferred Training Networks

NOTES

FRIDAY 29TH APRIL 2022

SESSION 6: EDUCATION AND TRAINING
Session Chairs: Deb Neesham & Tom Manolitsas

Training in the Era of Subspecialisation. Who Should be Responsible?

Alexander Heriot[1]

1. Peter MacCallum Cancer Centre, Albert Park, VIC, Australia

NOTES

"The Other Side of the Table…" – The Transition from Trainee to Trainer

Archana Rao[1], **Julian Smith**[2, 3], **Debra Nestel**[4, 5]

1. Department of Gynaecological Oncology, Royal Brisbane and Women's Hospital, Herston, QLD, Australia

2. Department of Surgery, School of Clinical Sciences at Monash Health, Monash University, Clayton, VIC, Australia

3. Department of Cardiothoracic Surgery and Surgery & Interventional Services Program, Monash Health, Clayton, VIC, Australia

4. School of Clinical Sciences, Faculty of Medicine, Nursing & Health Sciences, Monash University, Clayton, VIC, Australia

5. Department of Surgery (Austin), University of Melbourne, Heidelberg, VIC, Australia

The transition from trainee to specialist is a period of significant change and uncertainty, as newly qualified specialists seek to negotiate a range of challenges. Being a trainer is one such challenge. This talk will include preliminary findings from a qualitative, interview-based study of early career Certified Gynaecological Oncologists (CGO's) that seeks to understand their experiences. This study uses the theoretical framework of "threshold concepts" as a way of exploring areas of practice, knowledge and skills that present uncertainty and challenges, and that are negotiated during this period of transition.(1) This lens will be applied to the transition from trainee to trainer, which has also been identified as "troublesome" in other studies related to surgical training and practice.(2,3)

1. Land R, Meyer JHF. The Scalpel and the 'Mask': Threshold Concepts and Surgical Education. In: Fry H, Kneebone R, editors. Surgical Education: Theorising an Emerging Domain [Internet]. Dordrecht: Springer Netherlands; 2011 [cited 2020 Jun 2]. p. 91–106. (Advances in Medical Education). Available from: https://doi.org/10.1007/978-94-007-1682-7_6
2. Blackburn SC, Nestel D. Troublesome Knowledge in Pediatric Surgical Trainees: A Qualitative Study. J Surg Educ. 2014 Sep;71(5):756–61.
3. Smith JA, Blackburn S, Nestel D. Challenges in the Commencement of Consultant Surgical Practice: A Study of Threshold Concepts in Junior Cardiothoracic Surgeons. Int J Pract-Based Learn Health Soc Care. 2018 Jul 31;6(1):78–95.

NOTES

“That was Rubbish” - Productive Candour in Feedback Conversations

Debra Nestel[1]

1. University of Melbourne, Parkville, VIC, Australia

NOTES

Western Pacific Gynaecological Oncology Liaison Group

Jim Nicklin[1], **Peter Sykes**[2]

1. Wesley Hospital, Bardon, QLD, Australia

2. Obstetrics and Gynaecology, University of Otago, Christchurch , New Zealand

NOTES

SESSION 7: ACCREDITED FELLOWS PRESENTATIONS & FREE COMMUNICATIONS
Session Chairs: Orla McNally & Deb Neesham

A qualitative analysis of inter-disciplinary collaboration for exenterative and advanced gynae-oncology procedures: The spiral of scramble

Cecile Bergzoll[1], Debra Nestel[2], Yang Yann Foo[3], Vivian Yu[2]

1. Auckland City Hospital, Auckland, New Zealand

2. The University of Melbourne, Melbourne, Australia

3. Academic Medicine Education Institute, Duke-NUS Medical School, Singapore

Context: When patients with gynaecological malignancies require advanced or exenterative surgical procedures, surgeons from multiple specialties are often involved. Such collaborative preparation directly affects patient care at all stages. This study aims to explore how expert surgeons involved in these procedures currently function in the pre-operative phase, and what safety and quality improvements can be made to these processes.

Methods: Expert surgeons regularly engaging in advanced and exenterative procedures for gynaecological malignancies in Australia and New Zealand participated in semi-structured interviews. Transcribed interviews were analysed using Reflexive Thematic Analysis, sensitized by assemblage theory for a more detailed perspective on the collaboration processes.

Results: Five gynae-oncology, three colorectal and one urology surgeon participated. Three themes were generated from inductive analysis, around the first core concept of inclusiveness: benefits of inclusive care, drawbacks of non-inclusive practice, and barriers to inclusiveness. The second concept of scramble was constructed, defining surgeons' efforts to deliver their goals of care in challenging conditions. Surgeons' individual aspirations for this practice combined notions of patient advocacy with expert quality control, outlining the third core concept of optimal care.

Findings were reviewed through assemblage theory and the notion of territorialisation. All participants reported that a succession of fixed highly technical territorialised episodes conferred a sense of security during patient selection and preparation phases. De-territorialisation, arising from changes and gaps in any of these episodes threatened comfort and safety, via information loss, staff frustration and disengagement.

The analysis also found that surgeons were at risk of developing maladaptive professional behaviours when scrambling to maintain their goals of optimal care. Inter-disciplinary collaboration challenges triggered controlling attitudes, dominant beliefs, tunnel vision and workflow disruption. Accepting the scramble also jeopardized sustainability of services, by limiting the involvement of younger gynae-oncology surgeons into some aspects of these practices.

Discussion: Surgeons renegotiate their professional identity to navigate within inter-disciplinary collaboration. Implementing formal training in leadership and communication skills, as well as mentoring junior gynae-oncologists into these practices, could facilitate this process. Adequate resource allocation to implement structured communication platforms and coordination roles would also allow better patient-centred practices.

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Sentinel lymph node mapping for uterine cancer: an approach to fulfil the surgical competency assessment tool and to improve CGO fellow training.

Michael Burling[1]

1. Westmead, Camperdown, NSW, Australia

Sentinel lymph node dissection is widely used in the staging of endometrial cancer. Moloney et al [1] published the paper on identifying mandatory and prohibited steps of sentinel lymph node (SLN) dissection in endometrial cancer.

This video is an attempt at trying to fulfil the surgical steps of the sentinel LN tool but also an approach that can be useful in training fellows to continue to develop the avascular spaces and identify the anatomy prior to resecting the sentinel lymph nodes. Video footage and still photographs were gleaned from unedited surgical films recorded at our institution and from institutional artists' illustrations. Patients with early-stage uterine cancer, undergoing laparoscopic staging surgery using intracervical dye for SLN mapping, were included.

1. Moloney K, Janda M, Frumovitz M, et al. Development of a surgical competency assessment tool for sentinel lymph node dissection by minimally invasive surgery for endometrial cancer. International Journal of Gynecologic Cancer 2021;31:647-655.

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The effectiveness of Sentinel Lymph Node Biopsy in Endometrial Cancer: a retrospective cohort experience at a major tertiary gynaecological oncology referral centre in Sydney, Australia between the years 2018-2020.

Dan Krishnan[1], **Alison Brand**[1], **Unine Herbst**[1], **Leon Foster**[1], **Ramanand Athavale**[1], **Michael Burling**[1]

1. Gynaecological Oncology, Westmead Hospital, Sydney, NSW, Australia

Background

Endometrial Cancer (EC) remains the most common gynaecological cancer in Australia. Sentinel Lymph Node Biopsy (SLNB) has been proposed as an alternative to traditional staging (complete retroperitoneal lymphadenectomy), the latter being associated with increased morbidity.

Recent evidence has found that SLNB with indocyanine green has a high sensitivity and a low false negative rate for the detection of pathological lymph nodes especially with ultra-staging (micro-sectioning and immunohistochemical staining).

Objective

To Evaluate SLNB practice at Westmead Public and Private Hospitals (major tertiary gynaecological oncology referral centres) and compare it to internationally standardised evidence based practise.

Materials and Methods:

Surgical management of EC referred to Westmead Public and Private Hospitals from 1st of January 2018 to 31st of December 2020 was retrospectively audited and statistically analysed for diagnostic accuracy. Targets used were determined by current evidence in literature (see Table 1).

Results:

SLNB had a Sensitivity of 99.30%, a Negative Predictive Value of 96.30%, an Overall Detection Rate of 86% and a False Negative Rate of 3.70% (See Table 2).

Conclusion:

SLNB practice at Westmead Public and Private Hospitals over the years of 2018 to 2020 is comparable to international practice with targets based on current evidence.

Table 1: Current targets for standard of care with SLNB in EC with all lymph nodes biopsies ultra staged versus Westmead Hospital Data.

	Target	Westmead Hospitals
Sensitivity	>/= 90%	99.3%
Negative predictive value	>95%	96.3%
Overall DR	>80%	86%
FNR	<5%	3.7%

The use of ICG lymphatic channels to identify the uterine artery during sentinel lymph node mapping for uterine cancer.

Michael Burling[1]

1. Westmead, Camperdown, NSW, Australia

Sentinel lymph node dissection is widely used in the staging of endometrial cancer. Moloney et al [1] published the paper on identifying mandatory and prohibited steps of sentinel lymph node (SLN) dissection in endometrial cancer. This video is to demonstrate the use of the ICG lymphatic channels to identify uterine artery at every dissection of the SLN in endometrial cancer.

The surgical steps of the sentinel LN dissection are an useful approach to training fellows to continue to develop the avascular spaces and identify the anatomy prior to resecting the sentinel lymph nodes. It also allows them to always identify the uterine artery and ligate it at its origin hysterectomies for endometrial cancers.

Video footage and still photographs were gleaned from unedited surgical films recorded at our institution and from institutional artists' illustrations. Patients with early-stage uterine cancer, undergoing laparoscopic staging surgery using intracervical dye for SLN mapping, were included.

1. Moloney K, Janda M, Frumovitz M, et al. Development of a surgical competency assessment tool for sentinel lymph node dissection by minimally invasive surgery for endometrial cancer. International Journal of Gynecologic Cancer 2021;31:647-655.

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The Use of Indocyanine Green in Groin Node Biopsy /Dissection for Vulval Cancer

Gaithri Mylvaganam[1], **Michael Burling**[1]

1. Westmead Hospital, Wentworthville, NSW, Australia

These two surgical videos show the utilisation of Indocyanine Green (ICG) for sentinel lymph node biopsy as well as to guide full inguinofemoral lymph node dissection for vulval cancer.

The first video shows sentinel lymph node biopsy following injection of ICG around the site of the primary cancer. An incision is made medial to the femoral vessels just below the inguinal ligament and the sentinel node identified using ICG. The second video illustrates the use of ICG for full groin node dissection where by using the lymphatic channels the chain of lymph nodes can be excised. Its benefit in morbidly obese women, is highlighted here as it is used to ensure adequate lymph node dissection is achieved with minimal blood loss. The use of ICG can also be beneficial over conventional methods such as patent blue as the tissue planes are not obscured by the spill of the dye.

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Groin sentinel lymph node dissection : 20 years experience.

Orgad OR Rosenblat[1], Orla OMN McNally[1, 2], Deborah DN Neesham[1, 2], Antonia AJ Jones[1], Mieka MF Foster[1], Niveditha NR Rajadevan[1]

1. Gynaecological Oncology, Royal Women's hospital, Parkville, VIC, Australia

2. University of Melbourne, Melbourne

Background: A retrospective clinical audit was undertaken to assess patient outcomes following treatment for vulvar cancer which included groin sentinel lymph node dissection undertaken at the Royal Women's Hospital between 2002-2022.

Results:118 patients were identified. Overall, the groin sentinel lymph node detection rate was 86%. ^{99m}Technetium was used in 97.4% of cases, patent blue in 99.1% and indocyanine green in 13%; with detection rates of 83.3%, 81% and 80% respectively. In patients where a sentinel node was identified, 18 (16.2%) were positive. Risk of a positive node was associated with increasing age (p=0.039), tumour grade (p<0.001) and tumour size (diameter p=0.001; surface area p=0.023) and, to a lesser extent, depth of invasion (p=0.095). Mean duration of follow-up was 52 months (range 0-162). Nineteen patients recurred, of which 18 (15.2%) recurred locally and 4 had a nodal with/without distant recurrence.

Conclusion: No patient had an isolated nodal recurrence following a negative sentinel node.

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Staged treatment of placenta accreta spectrum: a combined surgical and interventional radiology approach at a tertiary centre

Simon West[1, 2], Greg Gard[1, 2], Amy Martin[2]

1. University of Sydney, Sydney, NSW, Australia

2. Department of Obstetrics and Gynaecology, Royal North Shore Hospital, Sydney, NSW, Australia

Placenta accreta spectrum (PAS) is a rare but serious complication of pregnancy characterised by abnormal placental invasion into the uterine myometrium. PAS continues to impact maternal health outcomes globally and the incidence is increasing worldwide. Endovascular balloon iliac occlusion, uterine artery embolisation or a combination of the two are used at several centres internationally to reduce uterine blood flow and facilitate rapid haemostasis in the setting of surgical management of PAS.

Data of the staged balloon iliac balloon placement and subsequent embolisation of the uteroplacental bed prior to hysterectomy has been previously analysed at our institution and published, showing significant reduction in blood loss (mean 553 mL vs 4517 mL). Use of stepwise surgical management is supported by research showing combination of Caesarean section uterine artery embolization and hysterectomy resulted less blood loss and should be considered in all cases to minimise maternal morbidity.

Comparison between interventional techniques is challenging due to the low quality of available evidence and the limited numbers for some techniques. There are currently no RCT's investigating the use of interventional radiology in the management of PAS. Ongoing research into the optimal care is required as there is no agreed gold standard approach to management. We present an update on a unique combined surgical and radiological approach at our tertiary institution that has previously shown improvement in outcomes.

Results:

The staged procedure was associated with a significant reduction in estimated total blood loss compared to the non-stage group, with a mean blood loss of 1794mL versus 3731mL (P<0.001). Significantly less women in the staged group had a blood loss over 3 litres (5/30 (16.67%) vs 12/16 (75%), p<0.001), and significantly less required blood transfusion (12/30 (40%) versus 15/16 (94%), p<0.001). The mean transfusion rate in the staged group was 2.5 units packed red cells versus 6 in the non-staged group.

This study shows that planned deliberate expert subspecialist management of PAS in a tertiary setting leads to improved outcomes in keeping with multiple studies worldwide and summarised in a recent comparison of recent guidelines of PAS management

Use of direct oral anticoagulants for postoperative venous thromboembolism prophylaxis after surgery for gynecologic malignancies- a review of the literature

Marilyn Boo[1], Bryony Simcock[1], Peter Sykes[1]

1. Gynaecology Oncology, Christchurch Hospital, Christchurch, New Zealand (South Island), New Zealand

Publish consent withheld

NOTES

Vaginal vault smear cytology in detection of recurrence after hysterectomy for early cervical cancer

Leah Grace[1], Karen Sanday, Andrea Garrett, Russell Land, Jim Nicklin, Andreas Obermair, Archana Rao, Amy Tang, Emma R Allanson

1. Gold Coast University Hospital, QLD

Objective To determine the role of vaginal vault cytology as a surveillance tool for the detection of recurrence in patients with early stage cervical cancer treated with hysterectomy without adjuvant therapy.

Methods A retrospective cohort study was conducted of all women with cervical cancer treated with a hysterectomy from January 2000 to July 2016 at the Royal Brisbane & Women's Hospital, Australia. Women included were diagnosed with the equivalent of International Federation of Gynecology and Obstetrics (FIGO) 2018 stage 1A1 to 1B3 squamous cell carcinoma, adenocarcinoma, or adenosquamous carcinoma, received either simple or radical hysterectomy with or without pelvic lymph node dissection, and did not receive adjuvant therapy. Age, stage, histology, surgical procedure, and details of individual surveillance regimens including examination findings and indications and results for all vault cytology tests performed in the first 5 years following surgical management were collected.

Results A total of 155 women met the inclusion criteria. Most cases were FIGO 2018 stage 1B1 (61.9%) and squamous cell carcinoma (64.5%). Included women underwent a median of 80 months of surveillance (range 25–200, IQR 64–108). In the first 5 years of surveillance, there were a total of 1001 vault cytology smears performed, with a median of 6 smears (IQR 5–9) per woman. A total of 19 smears were abnormal (1.9%). Of the cohort of 155 women, 19 (12.3%) had an abnormality detected; 1 (0.65%) had a high-grade intraepithelial abnormality and 2 (1.3%) had recurrences detected on cytology; however, a lesion was also seen and biopsied in all three women. A total of 16 of 1001 smears (1.6%) had low-grade abnormalities detected, all of which resolved with clinical observation only. All were alive and well at last review. There were in total 6 (3.9%) recurrences, 2 (33%) of which had abnormal cytology as above, and all of which had a lesion to biopsy and/or abnormal medical imaging.

Conclusions The routine use of vaginal vault cytology in surveillance following hysterectomy for early stage cervical cancer did not appear to alter the detection of recurrent malignancy.

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SATURDAY 30TH APRIL 2022

SESSION 8: CANCER PREVENTION & SURVIVORSHIP
Session Chairs: Simon Hyde & Geraldine Goss

Ovarian Cancer and PARP Inhibitors

Christina Fotopoulou[1]

1. Queen Charlotte's and Chelsea Hospital, London, United Kingdom

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ANZGOG Update

Clare Scott[1]

1. Walter and Eliza Hall Institute of Medical Research, Parkville, VIC, Australia

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BRCA: Ovarian and Uterine Cancer Risk

Kelly-Anne Phillips[1]

1. Peter MacCallum Cancer Centre, Melbourne, VIC, Australia

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SESSION 9: ACCREDITED FELLOWS PRESENTATIONS & FREE COMMUNICATIONS
Session Chairs: Deb Neesham & Niveditha Rajadevan

Participation in gynaecological oncology clinical trials at Westmead Gynaeoncology unit: Who, when, why and why not?

Michael Burling[1], **Alison Brand**[1]

1. Westmead, Camperdown, NSW, Australia

Gynaecological cancer accounts for 9.7% of cancers diagnosed in women in Australia, with an estimate of 6652 new cases 2020. The age-standardised incidence rate continues to rise however, the age-standardised mortality rate has decrease since 2003 in Australia. [1] The reasons for this are multifactorial but advances in medical interventions and treatments are a contributing factor. The efficacy and safety of medical interventions relies heavily on clinical trials. [2-3].The recent Australian and New Zealand Clinical Trial Registry (ANZCTR) report showed that a total of 5.2 million people have participated in Australian clinical trials registered over the 10 years (2006–2015), with more than 10,000 clinical trials conducted. The most frequently studied health issue in these trials was cancer at 18% followed by cardiovascular disease at 12% and mental health at 10%. [4] The most recent Reporting for Better Cancer Outcomes (RBCO) report by Cancer Institute NSW (New South Wales) between 2016-17 showed that ratio of cancer trial enrolments to cancer incidence (per 100 new cancer cases) were 8% for all cancer groups and only 3% of gynaecological cancers in the NSW. [5] The Western Sydney Local Health District (WSLHD) had a 18% clinical enrolment rate for all cancer groups which was in line with the National Cancer Institute's Community Cancer Centre's Program overall enrolment rate of 18%. [5-6].

Clinical trial enrolment rate for patients with a gynaecological malignancy in Australian Gynaecological Oncology units is unknown. The aim of this study it to determine the number of patients with newly diagnosed gynaecological malignancy who was enrolled into clinical trials at Westmead Department of Gynaecological Oncology over a two-year period from 2017 to 2018, including reasons for non-enrolment and barriers to enrolment.

Methods: Retrospective audit of both electronic notes/MDT/trial database to cross check these patients were enrolled into eligible trials.

Results: 557 patients were diagnosed with a gynecological malignancy between 1/1/2017 to the 31/12/2018. Median age at diagnosis was 60.3years of age. 50.7% were endometrial cancer, 25.4% were ovarian, tubal or peritoneal cancers and 14.2 % were cervical cancers. 187 patients (33.5% of the total study population) had 258 trials that they could participate in. 99 patients (52.9% of the 187patients) were enrolled into a clinical trial. The 133 patients that did not enter a clinical trial, 39.8% was missed during screening, 31.6% were treated in a rural location, and 28.6% the patient was not suitable for the trial or the patient declined.

Conclusion: Clinical trial participation rate in Westmead Gynaecological unit is well above the targets recommended gynaeoncology registry quality indicator but with areas for improvement.

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5. Cancer Institute NSW. Reporting for Better Cancer Outcomes: Consolidated Performance Report, NSW, 2017. Cancer Institute NSW, Sydney (NSW); April 2018.
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NOTES

Neo-adjuvant chemotherapy in the treatment of advanced endometrial cancer: A propensity matched retrospective cohort study examining the Queensland experience

Nicole Krzys[1]

1. Gynaecology Oncology, Royal Hobart Hospital, Hobart, Tasmania, Australia

Background: Advanced Endometrial Cancer (AEC) is associated with a poor prognosis with five year survival rates ranging from 10-50% (1). Standard treatment involves surgical debulking followed by adjuvant chemotherapy. Endometrial cancer, regardless of histological subtype, has been shown to respond to chemotherapy (2) and given the success of neo-adjuvant chemotherapy (NACT) in the treatment of advanced ovarian cancer, it has been proposed as an alternative treatment approach in endometrial cancer.

To date there are a small number of cohort studies published reporting the use of NACT vs primary cytoreduction (PC) in AEC and no prospective data is available. No published retrospective studies have characterised or controlled for disease burden separate to FIGO stage at diagnosis and as such, are subject to significant treatment bias.

In this propensity matched cohort study we describe the Queensland Center for Gynaecological Cancer's (QCGC) experience with NACT for AEC.

Aim: to assess the safety and efficacy of NACT followed by interval debulking surgery (IDS) in AEC.

Methods: We performed a retrospective cohort study where all cases of AEC treated with NACT over a 15 year period in Queensland were identified and propensity matched for disease burden (as determined by individual chart review separate to FIGO stage), Charlston comorbidity score, age and BMI to cases of AEC treated with PC.

Primary outcomes were progression free (PFS) and overall survival (OS). Secondary outcomes included procedural time, blood loss, complete resection rates, length of stay and peri-operative morbidity.

Results: 51 cases of AEC treated with NACT were identified and propensity matched to 51 cases (from 251) treated with PC with comparable disease burden. Both groups were balanced with respect to histology, and FIGO stage as well as BMI, age and comorbidity score. Secondary outcome data was available for over 50% of cases.

PFS and OS curves will be described and compared. Surgical outcomes including procedural time, blood loss, complete resection rates, and length stay will be compared. Peri-operative morbidity will be reported and described across both groups.

1. Lewin SN, Herzog TJ, Barrena Medel NI, Deutsch I, Burke WM, Sun X, Wright JD. Comparative performance of the 2009 international Federation of gynecology and obstetrics' staging system for uterine corpus cancer. Obstet Gynecol. 2010;116(5):1141
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NOTES

Does p53 mutation influence recommendation for adjuvant therapy in endometrial carcinoma?

Tamara Turnbull[1], Sellvakumaram Paramasivam[1], King Man Wan[2]

1. Gynaecological Oncology, Flinders Medical Centre, Adelaide, South Australia, Australia

2. University of New South Wales, Sydney, New South Wales, Australia

Introduction

Guidelines recommend endometrial cancers should have p53 testing to classify higher risk cancers and guide adjuvant therapy. Endometrial cancer with mutated p53 tumour suppressor gene is associated with poorer survival.

Method

We performed a retrospective review on endometrial cancers to evaluate whether p53 mutation influenced our recommended adjuvant therapy. Patients were presented at a multi-disciplinary team meeting and a management plan was devised with the pathology report available.

Results

34 cases were included in this study, 22 of them tested for p53. Pathology reports regarding p53 staining are shown in the table below.

P53 staining	Patients
Not tested	12
Wildtype	15
Negative	3
Positive	4

8 patients were administered adjuvant chemotherapy and 13 patients adjuvant radiation. The 4 positive p53 cases were within these groups, recommendation being adjuvant chemo-radiation.

Conclusion

Current practice does not include p53 staining for all endometrial cancers. Positive p53 may have influenced the recommendation for adjuvant chemoradiation.

1. Concin, N., Matias-Guiu, X., ... Creutzberg, C.L. (2020). ESGO/ESTRO/ESP guidelines for the management of patients with endometrial carcinoma. International Journal of Gynecological Cancer; 0:12-39. doi:10.1136/ijgc-2020-002230

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Moderator: Adam Pendlebury

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SESSION 10: ASGO DEBATE
Moderators: Toni Jones & Shih-Ern Yao

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