ASCO 2024

ANNUAL SCIENTIFIC MEETING

HOBART, TASMANIA

6-9 MARCH 2024

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HRD+ tumours

~2 in 3
patients alive

65.5% of LYNPARZA + bev patients
vs 48.4% of placebo + bev patients
(HR=0.62; 95% CI: 0.45–0.85, p-value not reported).

HRD+ *BRCA*wt tumours

>1 in 2
patients alive

54.7% of LYNPARZA + bev patients
vs 44.2% of placebo + bev patients
(HR=0.71; 95% CI: 0.45–1.13, p-value not reported).

Pre-specified subgroup analyses from the 5-year final OS analysis (data cut-off 22 March 2022) in patients with newly diagnosed HRD+ advanced high-grade epithelial OC; median follow-up of 61.7 months (LYNPARZA + bev) and 61.9 months (placebo + bev).[2]

The study met its primary endpoint of investigator-assessed PFS in the ITT population, mPFS of 22.1 months with LYNPARZA + bev vs 16.6 months with placebo + bev (HR=0.59; 95% CI: 0.49–0.72, p<0.001); at 5 years, mPFS of 46.8 months with LYNPARZA + bev vs 17.6 months with placebo + bev (HR=0.41; 95% CI: 0.32–0.54, p-value not reported; updated descriptive analysis).[2,3]

*High-grade epithelial ovarian, fallopian tube or primary peritoneal disease with CR/PR after platinum-based chemotherapy.[1]

SAFETY: In the safety analysis set from the PFS2 analysis of PAOLA-1 (data cut-off 22 March 2020), the most-common adverse events (all grades ≥10% in either treatment group) that occurred at a higher incidence among patients receiving LYNPARZA + bev vs placebo + bev were nausea, fatigue or asthenia, anaemia, lymphopenia, vomiting, diarrhoea, neutropenia, leukopenia, urinary tract infection, headache, musculoskeletal pain, neuropathy peripheral.[4] Data on total MDS/AML/AA, new primary malignancies and pneumonitis were collected up to the OS data cut-off (22 March 2022). MDS/AML/AA: 1.7% vs 2.2%; new primary malignancies: 4.1% vs 3.0%; pneumonitis: 1.3% vs 0.7% of patients for LYNPARZA + bev vs placebo + bev, respectively.[2]

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AA: aplastic anaemia; AML: acute myeloid leukaemia; bev: bevacizumab; *BRCA*: BReast CAncer; *BRCA*wt: *BRCA* wild type; CR: complete response; HRD: homologous recombination deficiency; HRD+: HRD positive; ITT: intention to treat; MDS: myelodysplastic syndromes; mPFS: median PFS; OC: ovarian cancer; OS: overall survival; PBS: Pharmaceutical Benefits Scheme; PFS: progression-free survival; PFS2: time from randomisation to second progression or death; PR: partial response. **References: 1.** Pharmaceutical Benefits Scheme. Available at www.pbs.gov.au. **2.** Ray-Coquard I *et al. Ann Oncol.* 2023;34(8):681–692. **3.** Ray-Coquard I *et al. N Engl J Med.* 2019;381:2416–2428. **4.** González-Martín A *et al. Eur J Cancer.* 2022;174:221–231 (including supplementary appendix).

AU-17594. LYN00139/EMBC. Date of preparation: December 2023.

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INTERNATIONAL SPEAKERS

DR RENE PAREJA

Gynecologic Oncologist and minimally invasive surgeon from Medellín Colombia.

20 years of experience in the field of Gynecologic Oncology

Author/coauthor of more than 90 publications in peer reviewed journals

Reviewer for more than 20 specialty related Journals

Author of 10 Book chapters

Member of FIGO Gynaecological Cancer Committee

Associate Editor of International Journal Gynecological Cancer

Current President of Colombian Association of Gynecologic Oncology

Recipient of 2021 AWARD FOR COMMUNITY ADVANCEMENT IN RESOURCE-LIMITED SETTINGS, Rome, IGCS Meeting

DR PEDRO T RAMIREZ

Dr. Pedro T. Ramirez is Chair of the Department of Obstetrics and Gynecologic at Houston Methodist Hospital and Professor at Weill Cornell College of Medicine. He is also the recipient of the Alan L Kaplan, MD Chair in Obstetrics & Gynecology.

He has published a total of 311 manuscripts in peer-reviewed journals, and has published a total of 19 book chapters. In addition, he is the Editor for the textbook titled Principles of Gynecologic Oncology Surgery and is also Editor-in-Chief of the International Journal of Gynecological Cancer.

Dr. Ramirez is the Principal Investigator in the LACC Trial: A Phase III Randomized Clinical Trial of Laparoscopic or Robotic Radical Hysterectomy versus Abdominal Radical Hysterectomy in Patients with Early Stage Cervical Cancer. Most recently, Dr. Ramirez was made member of the IDEAL Council at Oxford University in England.

DR MARIE PLANTE

Dr Plante is Full Professor in the Department of Obstetrics and Gynecology at Laval University and Gynecologic Oncologist at L'Hôtel-Dieu de Québec, CHU de Québec.

She was Vice-President of the International Gynecologic Cancer Society (IGCS) and is currently past Chair of the Cervical Cancer Research Network (CCRN). Dr Plante has major interest in minimally invasive surgery (MIS), sentinel node mapping and fertility-preserving surgery and less-radical surgery in cervical cancer.

She is leading two important international clinical trials in cervical cancer: SHAPE/CX-5 and Contessa.

ORGANISING COMMITTEE

Dr Michael Bunting
Dr Nicole Krzys

SOCIAL PROGRAM

Wednesday 6th March 2024	6.00pm – 8.30pm	**Welcome Reception** Mona Roma II (MR2), Brooke Street Pier Meet at 5.45pm for 6.00pm departure
Thursday 7th March 2024	7.00pm – 10.00pm	**Informal Dinner** Willie Smith Apple Shed Meet in the Hotel Grand Chancellor Foyer by 6.10pm
Friday 8th March 2024		**Free evening**
Saturday 9th March 2024	7.00pm – 11.00pm	Jones & Co Room The Henry Jones

SECRETARIAT

The registration desk will be open throughout the conference to answer any question you may have. Located outside the Federation Ballroom.

REGISTRATION DESK OPENING TIMES

Wednesday 6th March	9.15am – 5.15pm
Thursday 7th March	8.00am – 5.00pm
Friday 8th March	8.00am – 1.30pm
Saturday 9th March	8.15am – 2.00pm

CONTACTS

ASGO Secretariat, YRD Event Management

Mary Sparksman
0418 877 279

Jayme Wagner
0431 825 081

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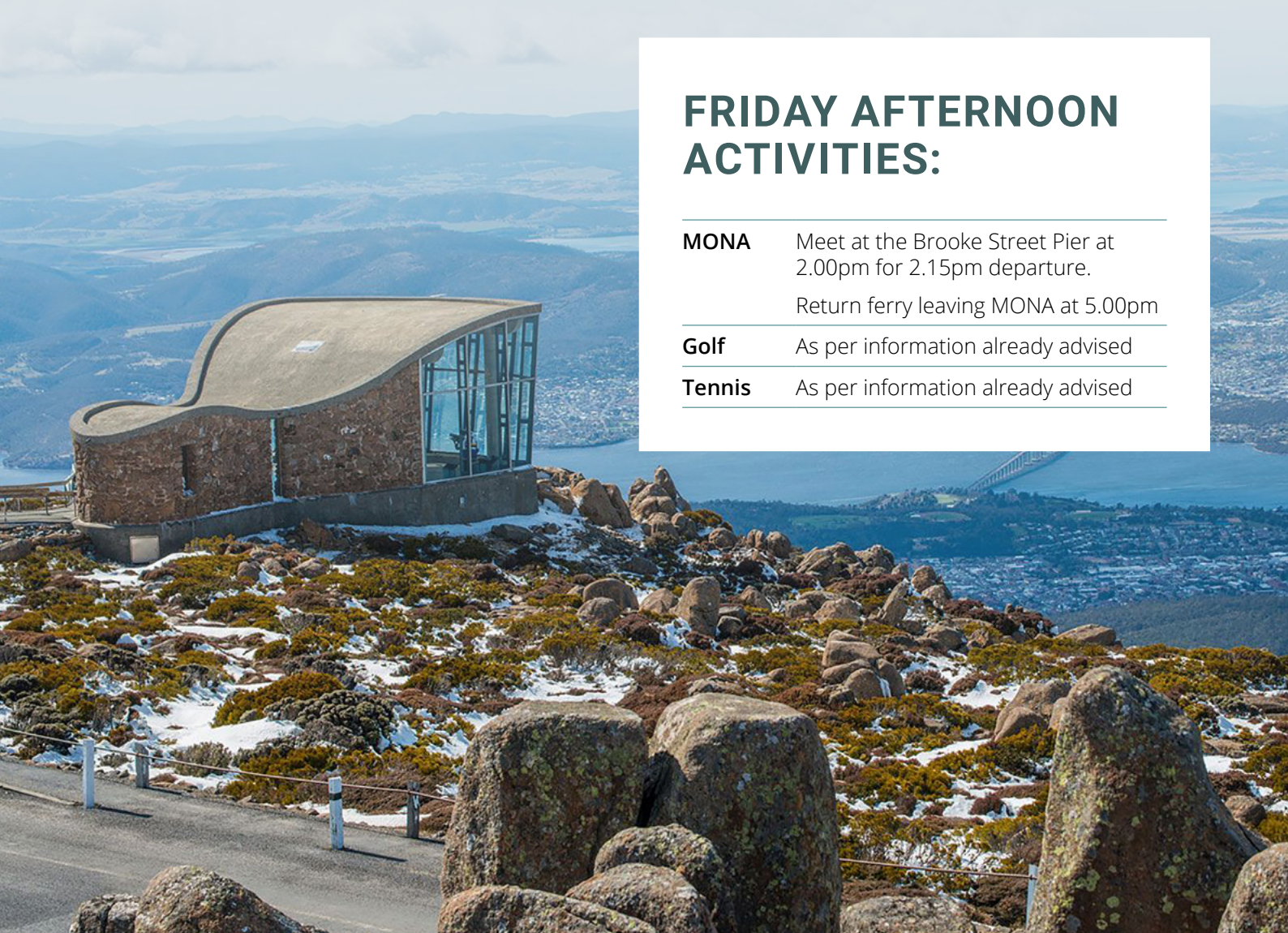

FRIDAY AFTERNOON ACTIVITIES:

MONA	Meet at the Brooke Street Pier at 2.00pm for 2.15pm departure. Return ferry leaving MONA at 5.00pm
Golf	As per information already advised
Tennis	As per information already advised

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Abbreviations: 1L, first line; *BRCAm*, breast cancer susceptibility gene mutation; PBS, Pharmaceutical Benefits Scheme. **References**: **1.** Pharmaceutical Benefits Scheme. Niraparib. www.pbs.gov.au. Accessed October 2023. **2.** ZEJULA Product Information. For information on GSK products or to report an adverse event involving a GSK product, please contact GSK Medical Information on 1800 033 109. GlaxoSmithKline Australia Pty Ltd. Melbourne VIC. PM-AU-NRP-ADVR-230003. Date of Approval October 2023.

GSK

ASGO 2024 ASM PROGRAM

Hotel Grand Chancellor Hobart

6th – 9th March 2024

Wednesday 6th March 2024		
Fellows Education Day		
0930 - 1000	Registration & Morning Tea	
	Fellows and Early Career Consultants **Anatomy, Approach, and Interactive Q&A** *Grand Ballroom*	
1000 - 1045	Upper Abdominal Surgery – ***Rob Bohmer***	
1045 - 1130	Bowel Surgery – ***Jayson Moloney***	
1130 - 1200	Pathways to Training in Robotic Surgery – ***Kris Thompson Fedorov***	
1200 - 1300	Lunch	
	Fellows **Safe Space Interactive Q&A Sessions** *Grand Ballroom*	**Early Career Consultants Information Sessions** *Chancellor Room 4*
1300 - 1330	Pathology – ***Jessica Beechey***	Transition to Consultancy & Setting Up Private Practice – ***Kris Moloney, Shih-Ern Yao, & Nicole Krzys***
1330 - 1400	Medical Oncology – ***Cristina Moldovan***	
1400 - 1430	Radiation Oncology – ***Raef Awad***	Getting Your Finances in Order - ***Signate***
1430 - 1500	CGO Training Program Feedback Session	
1500 - 1530	Afternoon Tea	
1530 - 1730	Mock OSCE	Toward CGO Training and Beyond

Thursday 7th March 2024		
0800 - 0820	Registration & Trade Exhibition	*Federation Foyer*
0820 - 0825	Welcome from Organising Committee & Acknowledgement of Country	
0825 - 0830	Opening of Meeting by ASGO Chair	
0830 - 1000	**Session 1: Controversies in Cervical Cancer** **Session Chair:** Andreas Obermair	*Federation Ballroom*
0830 - 0855	The History of Cervical Cancer – ***Rene Pareja***	
0855 - 0920	Minimally Invasive Surgery in Cervical Cancer Post LACC – ***Pedro Ramirez***	
0920 - 0945	Reducing Radicality: The SHAPE Trial – ***Marie Plante (Online)***	
0945 - 0957	Discussion and Questions	
0957 - 1000	GSK Sponsor Presentation	GSK
1000 -1030	Morning Tea & Trade Exhibition	*Federation Foyer*

*** Please note this program is subject to change without notification***

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1030 -1200	**Session 2: Progress in Ovarian Cancer** **Session Chair:** Nicole Krzys	*Federation Ballroom*
1030 - 1050	Screening in Ovarian Cancer: A History – ***Geraldine Goss***	
1050 - 1110	Australia's Contribution to Screening: OCRF7 and UKCTOCS – ***Carlos Salomon***	
1110 - 1130	Mucinous Ovarian Cancer Research – ***Kylie Gorringe***	
1130 - 1150	ERAS in Ovarian Cancer – ***Pedro Ramirez***	
1150 - 1157	Discussion and Questions	
1157 - 1200	AstraZeneca Sponsor Presentation	AstraZeneca
1200 - 1300	Lunch & Trade Exhibition	*Federation Foyer*
1300 -1423	**Session 3: Fellows Presentations** **Session Chair:** Julie Lamont	*Federation Ballroom*
1300 - 1310	Postoperative Outcomes after Interval Debulking Surgery and Primary Debulking surgery for Advanced Epithelial Ovarian Cancer in Australia: A National Gynae-Oncology Registry Study – ***Monica McGauran***	
1310 - 1320	The Correlation Between Macroscopic Surgical Assessment, Histological and Molecular Subtypes of High-Grade Serous Cancer of the Female Genital Tract, Ovarian, Tubal and Peritoneal Origin - The FOoTPrint Study - Full Results – ***Yael Naaman***	
1320 - 1330	Community, HPV and Equity – ***Sarah Te Whaiti***	
1330 - 1340	Novel Therapies in Management of Ovarian Granulosa Cell Tumours – ***Rinkita Sinha***	
1340 - 1350	Classification of Intraoperative Adverse Surgical Events (CiASE) in Gynaecological Surgery – ***Simon West***	
1350 - 1400	HPV-associated and HPV-independent Vulvar Squamous Cell Carcinoma: Is There an Impact of Resection Margins on Local Recurrence? – ***Marilyn Boo***	
1400 - 1410	Management of Groin Nodes in Early Vulval Cancer: Patterns of Care in a Queensland Population – ***Stacey Davie***	
1410 - 1420	Ureteric Identification with ICG Dye for Complex Minimally Invasive Surgery – ***Georgina Mitchell***	
1420 - 1423	BD Sponsor Presentation	BD
1423 - 1500	Afternoon Tea and Trade Exhibition	*Federation Foyer*
1500 - 1700	**Session 4: Endometrial Cancer** **Session Chair:** Michael Bunting	*Federation Ballroom*
1500 - 1503	Aspen Surgical Sponsor Presentation	aspen surgical
1503 - 1523	Staging From 1987 to 2023 – ***Yee Leung***	
1523 - 1543	2023 Staging of Endometrial Cancer: A Critical Analysis – ***Kailash Narayan***	
1543 - 1603	The Evidence for Follow Up and Focus on Survivorship – ***Emma Allanson***	
1603 - 1623	Immunotherapy in Endometrial Cancer – ***Allison Black***	
1623 - 1643	Update on NGOR – **Rob Rome**	
1643 - 1700	Discussion and Questions	

*** Please note this program is subject to change without notification***

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Friday 8th March 2024	
0700 - 0800	AstraZeneca Breakfast Symposium: HRD Testing: The Australian Real-World Experience **Antonia Jones & Andrew Fellowes**
0800 - 0830	Registration & Trade Exhibition — *Federation Foyer*
0830 - 1000	**Session 5: Levelling the Field** **Session Chair:** Nicole Krzys — *Federation Ballroom*
0830 - 0850	Disparities in Funding for Research – ***Robin Penty***
0850 - 0910	Treatment of Cancer in Resource Limited Settings – ***Rene Pareja***
0910 - 0930	Let's Talk Sustainability…In the Operating Theatre – ***Penny Blomfield***
0930 - 0950	Job Satisfaction and the Modern Workplace – ***Hannah Forsyth***
0950 - 0957	Questions and Discussion
0957 - 1000	Karl Storz Sponsor Presentation
1000 - 1030	Morning Tea & Trade Exhibition — *Federation Foyer*
1030 - 1140	**Session 6: Free Communications** **Session Chair:** Yee Leung — *Federation Ballroom*
1030 - 1040	The Role of p53 and p16 Immunohistochemistry in Vulval Cancer Prognosis – ***Helena Obermair***
1040 - 1050	Node-positive Carcinoma of Vulva Treated with Curative-Intent Radiotherapy: Reported Outcomes from a Large Single Australian Institution – ***Ming-Yin Lin***
1050 - 1100	Patterns of Surgical Care for Patients with Sex Cord-stromal Tumours in the National Gynae-Oncology Registry (NGOR) in Australia – ***Michael Burling***
1100 - 1110	A Practical Illustration of Sentinel Lymph Node (SLN) Mapping for Vulvar Cancer Using Indocyanine Green (ICG) – ***Michael Burling***
1110 - 1120	Effect of a Multidisciplinary Approach to Placenta Accreta Spectrum at a Tertiary Obstetric Hospital – ***Michael Yu***
1120 - 1130	Robotic Assisted Radical Hysterectomy and Sentinel Node Mapping for Early-stage Cervical Cancer Using the McCartney Tube to Prevent Tumour Spillage – ***Felix Chan***
1130 - 1137	Questions and Discussion
1137 - 1140	B.Braun Sponsor Presentation

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1140 - 1240	**Session 7: HPV Related Malignancy** **Session Chair:** Michael Bunting	*Federation Ballroom*
1140 - 1205	Hyperbaric O2 Therapy for Cervical and Vulval Cancers – ***David Cooper***	
1205 - 1230	Anal Cancer in the Spectrum of Gynaecological Oncology – ***Richard Turner***	
1230 - 1237	Questions and Discussion	
1237 - 1240	Arthrex Endoscopy Sponsor Presentation	Arthrex Endoscopy
1240 - 1340	Lunch & Trade Exhibition	*Federation Foyer*
	Afternoon Activities	

Saturday 9th March 2024		
0830 - 0845	Registration & Trade Exhibition	*Federation Foyer*
0845 - 1040	**Session 8: Where Have We Come From and What is the Future?** **Session Chair:** Jim Nicklin	*Federation Ballroom*
0845 - 0848	Device Technologies Sponsor Presentation	DEVICE TECHNOLOGIES
0848 - 0908	The History of Gynaeoncology in Australia and ASGO – ***Rob Rome***	
0908 - 0928	Surgical Experience of Fellows in CGO Training – ***Archana Rao and Cecile Bergzoll***	
0928 - 0943	Update on the Pacific Fellows – ***Nanise Sikiti***	
0943 - 0958	The Rise of the Robot – ***Rene Pareja***	
0958 - 1013	Teaching and Training in the Modern Era – ***Pedro Ramirez***	
1013 - 1033	Australian Space Medicine and the Role of Antarctica as a Space Analogue Environment – ***John Cherry***	
1033 - 1040	Questions and Discussion	
1040 - 1110	Morning Tea & Trade Exhibition	*Federation Foyer*
1110 - 1210	**Tumour Board** **Facilitator:** Greg Robertson	*Federation Ballroom*
	Gynae Oncologists – ***Tom De Greve and Niveditha Rajadevan*** Pathologist – ***Karen Whale*** Medical Oncologist – ***Cristina Moldovan*** Radiation Oncologist – ***Raef Awad*** Radiologist – ***Jess Monkhurst***	
1210 - 1255	**Session 9: ASGO Debate** **Facilitators:** Michael Bunting & Nicole Krzys	*Federation Ballroom*
	Topic: The Future of Gynaecologic Oncology is Robotic **For:** Rene Pareja, Kris Moloney, Jim Nicklin **Against:** Pedro Ramirez, Rosie McBain, Ken Jaaback	
1255 - 1330	Lunch	*Federation Foyer*
1330 - 1700	ASGO AGM	*Federation Ballroom*

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1. Covered by patent EP 1638615 B1 (Polyhydroxyalkanoate medical textiles and fibers).
2. Data on file RDR/DID/MON/MAU/13118
3. Uske K, Rao SK, Venkateshwar P. RANDOMISED CONTROLLED TRIAL ON COMPARISON OF ABSORBABLE EXTRA LONG TERM (POLY HYDROXY BUTYRATE) SUTURE VS NON ABSORBABLE (POLYPROPYLENE) SUTURE FOR ABDOMINAL WALL CLOSURE. International Journal of Current Research. 2017;9(11):60651-9.

POSTERS

1	Management of groin nodes in early vulval cancer: patterns of care in a Queensland population	**Stacey Davie**
2	Endometrial cancer and obesity in the younger population: the uptrend in Queensland that needs attention	**Stacey Davie**
3	In-transit cutaneous metastasis: a rare finding in vulval squamous cell carcinoma. A Case report and review of the literature.	**Stacey Davie**
4	Case series of advanced malignant ovarian germ cell tumour treated with neoadjuvant chemotherapy and fertility preserving surgery	**Minah Ha**
5	Intravenous leiomyomatosis with cardiac involvement: step-by-step multidisciplinary one-stage surgical management of 2 cases of rare and surgically complex tumours	**Sarah Ingamells**
6	Krukenberg tumours from a colorectal origin – the diagnosis, management, timelines and outcomes in a single Australian tertiary centre.	**Gabriel Lirios**
7	MMR status according to ethnicity in new endometrial cancer diagnoses within the Auckland region	**Anna Marshall**
8	Sentinel Node Biopsy in Women with Vulvar Cancer in Pregnancy	**Anna Marshall**
9	Outcome of risk-reducing surgeries in high-risk women - tertiary centre analysis	**Danielle Mor Hadar**
10	A case of adult granulosa cell tumour associated with Ollier disease	**Juliet Whittaker**

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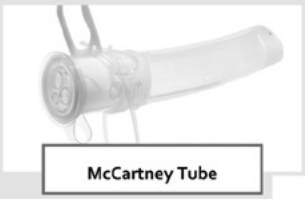
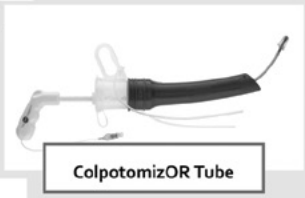


McCartney Tube



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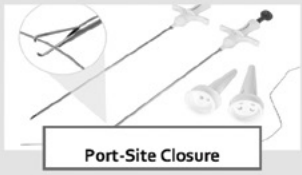

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ASGO 2024 ASM ABSTRACTS AND NOTES

WEDNESDAY 6TH MARCH – FELLOW'S DAY

Fellows and Early Career Consultants Anatomy, Approach, and Interactive Q&A

Upper Abdominal Surgery

Rob Bohmer[1]

1. Royal Hobart Hospital, TAS, Australia

Bowel Surgery

Jayson Moloney[1]

1. QLD Health, QLD, Australia

Pathways to Training in Robotic Surgery

Kris Thompson Fedorov

Fellows Safe Space Interactive Q&A Sessions

Pathology

Jessica Beechey[1]

1. Royal Hobart Hospital, TAS, Australia

Medical Oncology

Cristina Moldovan[1]

1. Royal Hobart Hospital, TAS, Australia

Radiation Oncology

Raef Awad[1]

1. Royal Hobart Hospital, TAS, Australia

CGO Training Program feedback Session

Early Career Consultants Information Sessions

Transition to Consultancy & Setting Up Private Practice

Kristen Moloney[1], Shih-Ern Yao[2], Nicole Krzys[3]

1. Gynaecologic Oncology, Royal Brisbane and Women's Hospital, Brisbane, QLD, Australia
2. Gynaecology Oncology, Monash health, Melbourne, VIC, Australia
3. Gynaecology Oncology, Royal Hobart Hospital, Hobart, Tasmania, Australia

Getting Your Finances in Order

James Sali[1] Craig Abela[1]

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Toward CGO Training and Beyond

THURSDAY 7TH MARCH

Session 1: Controversies in Cervical Cancer

The History of Cervical Cancer

Rene Pareja[1]

1. National Cancer Institute in Bogotá, Bogotá,, Colombia

Minimally Invasive Surgery in Cervical Cancer Post LACC

Pedro Ramirez[1]

1. Houston Methodist Hospital, Houston, United States

Reducing Radicality: The SHAPE Trial

Marie Plante[1]

1. Laval University, Quebec, Canada

Session 2: Progress in Ovarian Cancer

Screening in Ovarian Cancer: A History

Geraldine Goss[1]

1. Box Hill Hospital, Hawthorn, VIC, Australia

Australia's Contribution to Screening: OCRF7 and UKCTOCS

Carlos Salomon[1]

1. University of Queensland Centre for Clinical Research, Herston, QLD, Australia

Mucinous Ovarian Cancer Research

Kylie Gorringe[1]

1. Research, Peter MacCallum Cancer Centre, Melbourne, VIC, AUS

ERAS in Ovarian Cancer

Pedro Ramirez[1]

1. Houston Methodist Hospital, Houston, United States

Session 3: Fellows Presentations

Postoperative outcomes after interval debulking surgery and primary debulking surgery for advanced epithelial ovarian cancer in Australia: A National Gynae-Oncology Registry study

Monica McGauran[1, 2], Simon Hyde[1, 2], Mike Lloyd[3, 4], Sharnel Perera[3, 4], Mahendra Naidoo[3, 4], Robert Rome[3, 4], John Zalcberg[5, 3, 4]

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. National Gynaecologic Oncology Registry (NGOR), Clayton, Victoria
4. Monash University, Clayton
5. Peter MacCallum Cancer Centre, Parkville, VIC, Australia

Background: Treatment of primary advanced epithelial ovarian cancer involves platinum-doublet chemotherapy and surgery, aiming to achieve complete cytoreduction of all macroscopic disease. The extent of tumour cytoreduction is considered an important prognostic factor. Cytoreductive surgery, however, is associated with risk of postoperative morbidity and mortality, particularly when extensive and/or radical resections are required. The administration of neo-adjuvant chemotherapy plays an important role in reducing the size and extent of the tumour to allow for complete macroscopic cytoreduction to be achieved with less extensive surgical resection. No significant difference in survival outcomes between patients who undergo primary debulking surgery and neoadjuvant chemotherapy followed by interval debulking surgery have been found. In addition, the administration of neoadjuvant chemotherapy was associated with reduced postoperative mortality and morbidity. Clinical quality registries play an important role in monitoring and driving improvements in the quality of healthcare provided to patients. Clinical quality registries collect data on quality indicators related to a particular disease and provide benchmarking for participating institutions, feeding back regarding performance in a fair and risk adjusted way against these benchmarks and thereby encouraging consistent, high-quality healthcare across participating institutions. The National Gynae-Oncology Registry (NGOR) is a clinical quality registry based within the cancer research program at Monash University. The Epithelial Ovarian/Tubal/Peritoneal (OTP) cancer module of the NGOR has been collecting data on quality indicators in the care of women with these cancers since 2017. These quality indicators include proportion of women obtaining optimal primary or interval cytoreduction and cytoreduction to no macroscopic disease and proportion of patients experiencing unplanned significant intraoperative and postoperative adverse events. This study will be the first to report data collected by the NGOR on surgical outcomes in patients with advanced epithelial OTP cancer. Understanding performance against quality indicators in addition to understanding up to date (2017 – 2022) practice in Australia and variation of this between institutions, is important in understanding how one might optimise perioperative care for and surgical decision making for women with advanced OTP cancer.

Aims: This study aims to report rates of primary and interval cytoreduction, rates of complete and optimal cytoreduction and intraoperative and postoperative adverse events associated with primary and interval cytoreduction using data collected in the National Gynaecologic Oncology Registry (NGOR).

Methods: The NGOR is a Clinical Quality Registry that collects uniform, observational, data from participating Australian centres offering care to women with gynaecologic cancer. All women with Stage III-IV epithelial OTP peritoneal cancer registered with the NGOR were included in this study (N=1084). The study was designed to report on quality indicators and outcomes including: rates of postoperative complications (Clavien-Dindo Grade III+), rates of primary and interval cytoreductive surgery, rates of complete and optimal cytoreduction, intraoperative complications, institutional

variation in practice and outcomes, and the effects of rurality, ECOG, age, hospital type and socioeconomic status on the rates of postoperative complications, complete cytoreduction and whether primary or interval cytoreduction is undertaken.

Results: Primary cytoreduction was undertaken in 470 (43%) women and interval cytoreduction in 614 (57%) who underwent cytoreductive surgery. Postoperative complications (Clavien-Dindo Grade III+) were significantly more common in those who underwent primary cytoreductive surgery (p=0.025). Intraoperative complications were also more common in those undergoing primary cytoreduction (p=0.009). Optimal cytoreduction (residual disease <1cm) was more commonly achieved in those who underwent interval cytoreduction (p=0.047) though no statistically significant difference was seen between groups for complete cytoreduction. Leading predictors of postoperative complications were receiving treatment at a public hospital, living in a regional area and later cancer stage at diagnosis. Institutional variation and the effect of socioeconomic status, ECOG, age and rurality are reported on in this study.

Conclusion: Interval cytoreduction was associated with less intraoperative and postoperative morbidity, and increased rates of optimal cytoreduction when compared with primary cytoreduction in patients with Stage III-IV epithelial OTP cancer. This is consistent with international literature and this study uses national clinical quality registry data to report on current Australian practice. This NGOR currently has incomplete data on recurrence and survival, but it is anticipated that more complete data on these outcomes will be collected as the registry matures.

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

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Background: High-grade serous Carcinoma (HGSC) of the female genital tract can be divided into Four molecular subtypes (C1, C2, C4, and C5) by 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 tumor 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 the 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. Pre-operative MRI was assessed for PCI scores and lesion characterizations by a dedicated radiologist. Intra-operatively- cases underwent surgical assessment including PCI & Fagotti scores, lesions characterization, and operative findings. Tumour samples were collected and sent to molecular subtyping using the RNA-seq platform and Histopathological assessment to predict the molecular subtype by a dedicated blinded pathologist.
Results: Eighteen cases of HGSC were included in this study, with 48 samples. All molecular subtypes were represented in our patient population. Intraoperative photos show distinct features of the different subtypes. Different subtypes showed distinctive baseline features, surgical results, and clinical outcomes.

Conclusion: This pilot study suggests that different molecular subtypes of HGSC have different lesion appearance and disease spread, and can potentially be predicted by the surgeon to guide clinical management.

Community, HPV and Equity

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Health inequities exist in Aotearoa New Zealand and one example is the higher rate of, and mortality from, cervical cancer experienced by Māori compared to non-Māori (1). The impact of colonisation created biased systems, and these continue to perpetuate inequity and health disparities (1,2). Equity is defined by WHO as "the absence of unfair, avoidable or remediable differences among groups of people... Health equity is achieved when everyone can attain their full potential for health and wellbeing." (3). It has been proven that changing the system is one component of achieving health equity (1-3). The current cervical screening program fails Māori, along with other minority ethnicities, with low screening rates attributed to the high rates of cervical cancer and mortality (4). HPV testing is a better screening tool to prevent cervical cancer and HPV self-testing has been shown to be an acceptable screening tool for under-screened or never screened Māori women (5). Let's test for HPV (and prevent Cervical Cancer) was a pilot HPV cervical screening study which aimed to evaluate the practicalities and process of implementing HPV testing with the option of a self-test. The study involved 3309 people across three regions in Aotearoa NZ. Let's test for HPV study was a collaborative project with representation of Māori, Pacific, general practices and community groups. We wished to assess how this inclusivity, and co-design aspect, improved the equity of the study design. In order to assess the equity, one validated tool *He Pikinga Waiora Implementation Framework* was applied and findings regarding the study design and equity opportunity are discussed here (6).

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Novel therapies in management of Ovarian Granulosa Cell Tumours

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Background: Granulosa cell tumours (GCT) are uncommon ovarian cancers characterised by an indolent clinical course and significant late recurrence rates. Aside from invasive surgery, there are limited therapeutic options, highlighting the need for targeted therapies. The Hudson institute laboratory has previously shown that targeting X-linked Inhibitor of Apoptosis Protein (XlAP) using small molecule inhibitors known as Smac-Mimetics (SM) in combination with other compounds, is a compelling therapeutic strategy in GCT. XlAP inhibition sensitises cancer cells to anti-cancer therapies through the regulation of key pro-survival pathways, namely NF-κB (Nuclear factor kappa-light-chain-enhancer of activated B cells)

Methods: High-throughput screening (HTS) using established drug libraries was performed in a GCT-derived cell line KGN (steroidogenic human granulosa like cell line) and a transformed non-luteinized granulosa cell line (hGrC1), following pre-treatment with SM - Compound A (CmpdA: 500nM). Drug combination hits were defined as >80% reduction in viability compared to CmpdA monotherapy alone. Subsequent validation studies were conducted to measure the effects on cell proliferation, apoptosis and NF-κB transactivation. The impact of the combination therapy was assessed by RNA-seq analysis to identify differentially expressed genes, significant pathways and functional enrichment.

Results: Here we report the use of a histone deacetylase inhibitor (HDACi), panobinostat, in combination with CmpdA, as a potential treatment for GCT. Using cell proliferation and viability assays, we demonstrated that 100nM panobinostat acts synergistically with 500nM CmpdA to significantly decrease cell proliferation and increase apoptosis, as demonstrated by increased caspase 3/7 activity. Apoptotic pathways were further assessed using flow cytometry. A potential mechanism of action for the compounds was tested using real-time PCR and luciferase reporter assays. In KGN cells, panobinostat demonstrated increased NF-kB activity and TNFa expression, which decreased when combined with CmpdA, suggesting that there is enhanced activation of the extrinsic pathway of apoptosis. Transcriptomic analysis showed the top significantly enriched pathways related to mechanisms of cancer pathogenesis. In particular, we observed significant downregulation of SIRT1, a non-classical Class III HDAC that is potentially important in GCT tumorogenesis through its interactions with the FOXL2 transcription factor, affecting cancer pathways such as cell senescence, proliferation, and apoptosis.

Conclusion: We present a promising combination therapeutic strategy for GCT that reduced cell proliferation, increased apoptosis, and reduced inflammatory gene expression. Further studies are now needed to confirm and translate these findings, and to identify the links between SIRT1 gene, and the pathognomonic $FOXL2^{C134W}$ mutation of GCT.

Classification of intraoperative Adverse Surgical Events (CiASE) in gynaecological surgery

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Intraoperative adverse events (IAE) can be classified as any deviation from the ideal intraoperative course between skin incision and skin closure, and includes events related to surgery and anaesthesia.

It is well known that the quality of surgical performance is a major determinant for outcomes. IAEs are associated with an increase in 30-day post-operative mortality, 30-day post-operative morbidity and prolonged post-operative length of stay. Intraoperative complications are often inappropriately combined with postoperative complications or not reported at all.

There is currently an emphasis on improving quality and transparency in healthcare, with that there is a need to develop a simple, systematic, objective, and reproducible grading system for IAEs. It is imperative that the scoring system reflects the surgery undertaken and the impact of the event on the patient and recovery, as not all adverse events are equal. Major events have more significant post-operative morbidity that minor IAE's.

We have created and validated a scoring system for the classification of intra-operative adverse events which can be applied to the field of gynaecology which can be reproduced with good reliability. It is important the grading system is practical and applicable.

HPV-ASSOCIATED AND HPV-INDEPENDENT VULVAR SQUAMOUS CELL CARCINOMA: IS THERE AN IMPACT OF RESECTION MARGINS ON LOCAL RECURRENCE?

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Introduction: Vulval Squamous Cell Carcinoma (VSCC) is classified as Human Papilloma Virus Associated (HPV-A) or HPV Independent (HPV-I), with HPV-I VSCC having greater risk of recurrence and poorer survival. Surgical guidelines do not distinguish between the aetiologies and all previous surgical margins publications report the aetiologies together, traditionally recommending a 8mm margin. This study investigates the impact of resection margins on VSCC first local recurrence stratified by HPV-A and HPV-I subtypes.

Methods: A retrospective single centre clinico-pathological case note review of 314 patients treated with primary surgery for VSCC between January 1990 to December 2018. The impact of surgical margins on first local recurrence was assessed for HPV-A and HPV-I tumours separately in both univariable and multivariable analyses.

Results: Local recurrences occurred in 9/143 HPV-A VSCC (6.3%) compared to 45/171 HPV-I VSCC (26.3%).In HPV-A VSCC, resection margins <8mm compared to >=8mm were not associated with local recurrence in univariable analysis (HR 0.63, 95% CI 0.17-2.39, p=0.50). Low case numbers prevented multivariable analysis. In HPV-I VSCC, resection margins <8mm were associated with increased local recurrence compared to >=8mm in univariable analysis (HR 1.90, 95% CI 1.05-3.44, p=0.03), but this finding was attenuated in the multivariable analysis (HR 1.55, 95% CI 0.79-3.05, p=0.20).

Conclusion/Implication: In HPV-I VSCC, there is some evidence that resection margins may impact local recurrence, but further prospective study is needed. Analysis for HPV-A VSCC was limited by the low recurrence rate. HPV testing may be utilised in VSCC management protocols to individualise treatment.

Management of groin nodes in early vulval cancer: patterns of care in a Queensland population

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Background: Sentinel lymph node biopsy (SLNB) has been proven to be safe in patients with early stage vulval cancer with no clinically or radiologically concerning nodes[1] and is associated with a significant reduction in treatment associated morbidity when compared with total lymphadenectomy[2]. In most centres sentinel node biopsy is the preferred surgical approach, but certain groups of patients are ineligible to undertake sentinel node assessment. There is paucity of information available on the proportion of patients eligible and ineligible for SLNB and associated indications for each chosen approach.

Objectives: The aims of the study were to provide an overview of patterns of care for early stage vulval cancer, focusing on eligibility and method of inguinofemoral lymph node assessment, complications associated with each approach and any patterns of short-term recurrence.

Materials and methods: Retrospective data analysis on patients with early primary vulval squamous cell carcinoma from 2014 to 2017 undergoing primary surgical management (including nodal surgery) at all gynaecology oncology cancer centres in Queensland. Patient data was extracted from the Queensland Centre for Gynaecological Cancer (QCGC) database. SPSS was used for statistical analysis.

Results (Preliminary results only, final results to be presented at conference): 193 patients were included for analysis. Of the 193 patients, 96 were eligible for SLNB (49.8%) and 97 ineligible (50.2%) and therefore underwent regional lymph node dissection. Reasons for ineligibility for SLNB included: failed sentinel lymph node mapping, suspicious lymph nodes on imaging/histopathology, tumour >4cm in size, multifocal disease or other reasons (such as allergies, co-morbidities). Complications occurred in 19/96 patients in the SLNB group (19.8%) and 27/97 in the dissection group (27.8%).

Conclusions: While SLNB has been proven to be a safe and sensitive approach, evidence in this area is still limited due to the rarity of vulval cancer which ultimately limits overall application. This study shows that only approximately 50% of patients with vulval cancer were eligible for SLNB. Consistent with previous evidence SLNB also proved to be a faster and less morbid procedure in comparison to complete inguino-femoral lymph node dissection.

Outcomes such as complications, recurrence rates, cancer-related survival and overall survival to be presented at conference, along with final statistical analysis (including significance of above numbers)

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Ureteric identification with ICG dye for complex minimally invasive surgery

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Background: The risk of ureteric injury during minimally invasive surgery is up to 5-10% (1,2). Indigocyanine green (ICG) dye has gained popularity in colorectal, urological and endometriosis surgery over the last 5-10 years for its ability to improve identification of the ureter (using near-infrared technology) during minimally invasive complex surgery without significantly increasing morbidity for the patients. The current evidence suggests that whilst it increases operating time due to the need for insertion of the ureteric catheters (4-20min) it likely reduces overall operating time as it reduces the need for pelvic side wall dissection for identification of ureters during complex surgery (1-6). A number of techniques are described including insertion of 5 or 6Fr ureteric catheters to 20cm and injecting (2.5-25mg ICG/5-10ml saline) the dye through the lumen or simply inserting the tip of catheter into the ureteric orifice and injecting the dye(1,3-5). The ureters are able to be identified for a median of 489min (268-738min) and the degree of intensity is dependent on dose and depth of ureter from surface of side wall (ie. Adiposity) (1,5). The risks are small (and less than with ureteric stents) but include iatrogenic ureteric injury, acute kidney injury, urinary tract infection and transient haematuria (1,2,7). Given ICG and near-infrared technology is already utilised for identification of sentinel lymph nodes in other gynaecological oncology cancers, we have identified an alternative use for it in gynaecological oncology surgery with the aim to reduce operating time and operator cognitive load.

Aim: To demonstrate a number of techniques for injection of ICG dye to make ureteric identification easier and therefore reduce operating time and operator cognitive load during complex minimally invasive gynaecological oncology operations.

Method: ICG dye can be injected through ureteric catheters either inserted into the ureters or into the ureteric orifice (only) under cystoscopic guidance to allow identification during minimally invasive surgery using near-infrared technology. These techniques will be demonstrated in a number of short videos and we will provide commentary on our clinical experiences with these methods.

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Session 4: Endometrial Cancer

Staging from 1987 to 2023

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2023 staging of endometrial Cancer: a critical analysis.

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Background: A recently published staging of endometrial cancer has described 12 separate clusters. LVSI has been incorporated in stage 1 and 2 LVSI has been considered in G1 and G2 histology and has been ignored in grade 3, clear and serous histology. Stage 3 is divided in 4 categories based on disease extent and nodal metastasis, ignoring both the LVSI and histology.
The aim of this analysis was to distribute endometrial cancer patients according to new stages and based on the patters of failure investigate the inter-group prognostic homogeneity and intra-group heterogeneity. Following which propose a simplified prognostic groupings supported by patterns of failure and survival data.

Methods: Patients with intermediate, intermediate-high- and high-risk endometrial cancer treated with primary surgery and staged as (old) 1 to 3C, presented for adjuvant radiotherapy treatment sequentially between 1996 – 2014 were selected. Observation cut-off date was Dec 2018. Histology included was endometrioid/mucinous, clear cell and serous. OS and DFS as well as patterns of failure were analyzed. Distinct prognostic clusters were identified based on recurrence-free and overall survival (OS) using Cox proportional hazard models and Kaplan–Meier technique
Results: Mean Age of the patient was 64 (24-95 years.) Median survival and relapse free survival of the entire cohort was 5.46 and 5.87 years respectively. Kaplan-Meier survivor function at 5 years by FIGO staging 2023 was 93, 92, 96, 100, 91, 90, 82, 67, 80, 72 and 59% respectively for stage 1A1, 1A2, 1B, 1C, 2A, 2B, 2C, 3A2, 3B, 3C1 and 3C2. As can be seen many of these groups are iso-prognostic. Many stages showed intragroup heterogeneity such as 2C1 (serous histology, LVSI negative) had 5yrs OS 74% whereas, 2C1 (G3, Clear cell, LVSI negative) had 5 yrs OS 89%. Similarly, stage 3A2 had 2 groups with survival of 84% and 56% and 3C1 with survival of 86% and 54%! Based on patterns of failure a 3-tiered staging system could be fashioned that had low-risk n=528, intermediate-risk n=409 and high-risk n=220 with 5 yrs OS of 92%, 83% and 65% respectively. A detailed analysis will be presented.

Discussion: The new staging system is largely based on ESMO/ESGO/ESTRO classification. In this scheme, LVSI has been treated as a binary value, focal and no LVSI as one group and substantial LVSI as another group. The definition of substantial LVSI was 4.8% of patients from a pooled analysis of PORTEC-1 (n=714) & PORTEC 2 (n=427) early-stage endometrial cancer studies. However, prognostic significance of LVSI has a graded effect. A study by Restaino et al. reported that recurrence rates in LVSI-negative, focal-LVSI and diffuse-LVSI cases were 6.6%, 14.7% and 24.9%. Similarly, Pifer et al reported Among patients who underwent surgical LN assessment (n = 347), LNs were involved in 3.3% without LVSI, 7.5% with focal LVSI (OR 2.4), and 15.2% with substantial LVSI (OR 5.3) (p = .005), In our patient population (n=1187) the LVSI rate (present or absent) was 47% and its presence affected the survival in all stages and histology. The present staging system does not include the role of LVSI in advanced stage while more emphasis have been focused on molecular markers. A recently published review by Raffone A et al, has shown that LVSI has a prognostic value for worse oncological outcome independent of the molecular classification. In absence of LVSI and lymph-nodes, histology, grade, myometrial invasion (MI) and tumour size had no prognostic significance, except in serous histology. LVSI was related to histology grade and lymph-node metastasis. The ratio for LVSI to LN was 3:1 except for serous histology where it was 2:1. Based on patterns of failure three prognostic clusters emerged with 5 yrs OS of 92%, 83% and 65% and distant relapse rate of 6.5%, 11.2% and 35.2% respectively.

Conclusions: It is not clear as to the aim of new staging of endometrial cancer. It does not lead to prognostic clustering. Looking at the heterogeneity of disease extent within the same group it also does not facilitate the application of loco-regional adjuvant radiotherapy. Whilst endometrial cancer patients can be stratified in three distinct prognostic group based on histology, LVSI and nodal status irrespective of the extent of the disease. For loco-regional control of disease and providing good quality of life the anatomical extent of the disease should form the basis of adjuvant treatment.

The Evidence for Follow Up and Focus on Survivorship

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Immunotherapy in Endometrial Cancer

Allison Black[1]

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Update on NGOR

Robert Rome[1]

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FRIDAY 8TH MARCH

Session 5: Levelling the Field

Disparities in Funding for Research

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Treatment of Cancer in Resource Limited Settings

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Let's talk sustainability …in the operating theatre.

Penny I Blomfield[1]

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The world is already seeing many adverse health impacts from climate change. In the last few years extreme weather events have caused devastation across every continent. It is estimated heat related deaths around the world increased by 68% between 2000-04 and 2017-21. In the UK in 2020 legislation was introduced to embed net zero emission targets for NHS service providers. Such legislation acts as an enabler of change to more sustainable practices. Harris H et al (2021) reported surgeons in the UK were frequently concerned about climate change and this had led to changes in behaviour in their personal lives. In this study although surgeons agreed they should be aware of environmental impacts in their working lives, fewer had changed behaviours in their work environment. It is hard to say whether this data would be reflective of surgeons' positions in Australia.

In Australia it is suggested that health related activities account for 7% of all air pollution. Discussions around sustainability which address environmental, economic and societal aspects of concern are increasingly commonplace, but seldom relate to hospital and operating theatre environments. Patient care, safety and infection control dominate operating theatre activities and increasing focus on efficiencies and cost savings result in little opportunity for "green discussions".
An example, from a practical standpoint, is a commonly held belief that single use items are safer as regards infection control and cheaper than their reusable counterparts. This viewpoint might have been justifiable 20 years ago but there now many studies using contemporary life cycle analysis, which refute these concerns. I intend to review current evidence and practices from around the world, and Australia, and hope to encourage thoughtful discussion in this space.

Job Satisfaction and the Modern Workplace

Hannah Forsyth[1]

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Session 6: Free Communications

The role of p53 and p16 immunohistochemistry in vulval cancer prognosis

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Background/Introduction: Vulvar cancer is an uncommon gynaecological malignancy in Australia, with approximately 420 new cases each year. The most common histological type is squamous cell carcinoma, of which precursor lesions can be either human papillomavirus (HPV)-dependent, characterised by p16 overexpression or HPV-independent. HPV-independent vulvar cancers can arise from vulvar dermatoses, such as lichen sclerosus, and are often characterised by TP53 mutations. Some previous studies have shown prognostic significance of p16 and p53 expression in patients with squamous vulvar carcinomas.

Objectives: To identify the whether p53 and p16 immunohistochemistry results have prognostic value in vulvar cancer patients, in a retrospective review of patients treated at a single institution.

Methods: A retrospective chart analysis was performed for all patients diagnosed with vulva cancer over a 10 year period (2010-2019) at one institution in Sydney, Australia. Overall, 133 patients were newly diagnosed with vulvar cancer in this time period, of which 111 were squamous cell carcinomas. Pathology for each patient was analysed to determine whether immunohistochemical analysis had been performed, and the results recorded. Kaplan Meier and Log Rank analyses were used to determine the impact of these p16 and p53 immunohistochemistry results on survival outcomes.
Results and Conclusions: Of 133 vulvar cancer cases at this institution over the 10 year time period, 111 were squamous cell carcinomas. Of these, immunohistochemistry results were available for 74 patients (66.67%). 39 patients were p16 positive, 6 patients were p53 positive, 3 patients were positive for both p16 and p53. Follow-up data was available for an average of 4.35 years post diagnosis. Comparing patients that were p16 positive to p53 positive, both p16 and p53 positive and 'others' (which included patients for whom results were not available and those for whom immunohistochemistry analyses were not performed), p16 positive group had the highest overall survival, and p53 had the lowest overall survival, a difference in outcomes that was statistically significant.

Node-positive Carcinoma of Vulva Treated with Curative-Intent Radiotherapy: Reported Outcomes from a Large Single Australian Institution

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Background: Carcinoma of the vulva is an uncommon cancer, accounting for less than 5% of all gynaecological malignancies.[1-2] Surgery is the mainstay of curative treatment for early-stage disease whilst definitive chemoradiotherapy (CRT) can be considered for locally advanced disease to avoid the morbidity of extensive surgery[3-5]. Node-positive disease is often associated with a poor prognosis and poses a management challenge.

Aims: To investigate outcomes of patients with node-positive vulvar carcinoma treated with radiotherapy (RT) +/- chemotherapy with curative intent over a 20-year period, in terms of patterns of failure, failure-free survival (FFS) and overall survival (OS).

Methods: Patients were eligible if they had a histological diagnosis of node-positive vulvar carcinoma and referred to Peter MacCallum Cancer Centre for curative intent radiotherapy +/- chemotherapy either as primary treatment or in the adjuvant setting following definitive surgery between 2000 – 2019. Eligible patients were retrieved from the gynae-oncology unit's research prospective database where clinical, histopathological information, treatment and follow-up data was collected for statistical analysis.

Results: Eighty-eight women met the inclusion criteria. Median age was 65 years (range 33-90). Sixty-two patients received surgery & adjuvant RT [57/62 had concomitant chemotherapy (92%)], 24 patients received definitive CRT and 2 received definitive RT alone. Median dose to gross inguinal nodes (n=43) was 57Gy (range 34-60) and median dose to gross primary disease was 62Gy (n=25) (range 34-64). Median follow-up was 10.8 years (range 1.2-21.4). At 5 years, OS was 54% for the entire cohort; 57% in the patients receiving adjuvant RT and 46% in the definitive group. Forty-four/88 patients (50%) from the entire group (n=88) relapsed, of which 13/44 (30%) failed at the primary site alone. Disease control at the primary site and nodes was achieved in 50/88 patients (57%).

Conclusion: Loco-regional control in patients with node positive vulva carcinoma treated with chemoradiotherapy, with or without surgery is reasonable, with a trend of improved outcomes with a combination of surgery and radiotherapy.

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Patterns of surgical care for patients with sex cord-stromal tumours in the National Gynae-Oncology Registry (NGOR) in Australia

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6. Clinical Trial Centre, Unversity of Sydney, Newtown, NSW, Australia
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8. University of Sydney, Newtown, NSW

Background: Sex cord-stromal (SCS) ovarian tumours, a rare subset of ovarian tumours, require tailored surgical approaches. Whilst surgery is the cornerstone of treatment for these tumours, patterns of management in Australia have not been previously documented. In this study, we aimed to examine surgical patterns of care for SCS tumours using data extracted from the National Gynae-Oncology Registry (NGOR).

Methods: Data from the NGOR's 'Rare Ovarian Tumour Module' were analysed for patients newly diagnosed with malignant ovarian SCS tumours between April 2017 and December 2022. Eligible patients received care at 15 hospitals across Victoria, New South Wales, Tasmania and Western Australia. Demographic and clinical data, including tumour stage, histological diagnosis, surgical procedures, and treatment details, were extracted from medical records. Data were summarised via descriptive statistics.

Results: As of January 2023, a total of 96 patients with SCS ovarian tumours had complete data for analysis. The mean age at diagnosis was 53.2 years (SD=15.0), ranging from 19 to 85 years. Predominantly, patients resided in Victoria (n=53, 55.2%), followed by New South Wales (n=26, 27.1%). Adult granulosa cell tumours (AGCT) emerged as the most prevalent histological type, accounting for 83.3% (n=80) of cases, followed by sex cord-stromal tumour, not otherwise specified (n=10, 10.4%). The majority of patients were diagnosed with early stage disease: FIGO stage IA, 54.2% (n = 52); IB, 1.0% (n = 1); IC, 21.9% (n = 21); II, 9.4% (n = 9); III, 4.2% (n = 4); not documented, 10.4% (n = 10).

The majority of patients (n=63, 65.6%) had their first surgical treatment performed by a gynaecologic oncologist at a hospital with a specialist gynaecological oncology unit (SGOU). Smaller percentages of first surgical resections were conducted by other surgeons at a hospital with an SGOU (n=12, 12.5%), and at a non-SGOU regional (n=11, 11.5%) or metropolitan (n=6, 6.3%) hospital. Of the 29 patients who had their first operation performed by a surgeon without subspecialty training, all were subsequently referred to an SGOU, discussed at a multidisciplinary team meeting, and 13 of 29 (44.9%) underwent a second primary surgery overseen by a gynaecologic oncologist. Most patients only underwent one surgical episode as part of first-line treatment (n=76, 79.2%), though 17.7% (n=17) underwent two and 3.1% (n=3) underwent three first-line surgical procedures.

Fertility-sparing first-line surgery (defined herein as conservation of the uterus and one ovary and fallopian tube) was performed in 20 of 83 cases (24.1%) where these gynaecological structures had not been previously removed. Amongst those aged under 50, 18 of 35 (51.4%) received fertility-sparing first-line surgery. Approximately equal percentages of patients underwent initial laparotomy (n=50, 52.1%) and initial laparoscopy (n=46, 47.9%). Omentectomy or omental biopsy was performed in 57.3% (n=55) of cases during initial surgery, with a smaller proportion (n=9, 9.4%) undergoing

omental resection at their second or third first-line surgical procedure. Rates of intraoperative adverse events (n=8, 8.3%) and 30-day postoperative adverse events (n=11, 11.5%) were low. None of the cases of 30-day postoperative adverse events were classified as severe (≥ Grade IIIA Clavien-Dindo).

Conclusions: Data sourced from the NGOR has provided valuable insight into the patterns of surgical care for patients with sex cord-stromal tumours in Australia. Of note is the predominance of gynaecologic oncologists and gynaecologic oncology centres involved in performing these surgical procedures and the variability in fertility-sparing approaches. There is scope to optimise care by ensuring access to gynaecologic oncologists, promoting standardised surgical approaches, and enhancing the provision of fertility-sparing options. These results may inform clinical practice guidelines and improve the management of patients with SCS tumours in the future.

A practical illustration of sentinel lymph node (SLN) mapping for vulvar cancer using indocyanine green (ICG).

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To date, the use of the SLN procedure has been validated in several large studies and is considered both safe and accurate in a selected group of patients. [1-2] To locate the SLN, a combination of both radioactive tracers and blue dye is currently the gold standard. [3] Near-infrared (NIR) fluorescence imaging using indocyanine green (ICG) has recently been introduced to improve optical identification during the SLN procedure. [4-6] This surgical teaching video has been created to demonstrates the use of ICG in SLN mapping in vulvar cancer. This video demonstrates a practical approach with some tips and tricks to improve SLN detection and dissection.

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Effect of a multidisciplinary approach to placenta accreta spectrum at a tertiary obstetric hospital

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2. Mater Mother's Hospital, Brisbane, QLD, Australia

Introduction: Placenta accreta spectrum (PAS) is increasing in prevalence, with an overall rate of up to 1 in 272 women in the United States in 2016. Maternal morbidity is often high due to both the potential for massive haemorrhage and its associated risks including coagulopathy and thromboembolic disease, and the inherent surgical complexity that can lead to visceral injury and need for re-operation. International guidelines recommend a multi-disciplinary approach to management of placenta accreta spectrum to reduce maternal morbidity. An essential component of the multi-disciplinary team (MDT) is the presence of an experience pelvic surgeon, often a gynaecologic oncologist. An MDT approach to PAS has been shown to improve maternal outcomes with decreased blood loss, decreased intensive care unit (ICU) stay, and decreased post operative stay.

The Mater Mother's Hospital (MMH) is one of the largest obstetrics services in Queensland with over 10 000 births in 2022. It is also the tertiary referral centre for southern Brisbane and southwest Queensland. A PAS MDT was established at the MMH in May 2021 with the aim of providing a multi-disciplinary approach to the assessment, delivery planning and surgical management of these high risk patients. The MDT meets at regular intervals to review newly diagnosed cases, discuss ongoing cases, and give an opportunity for correlation of the pre-operative imaging, intra-operative surgical, and pathological findings for post-operative patients. The MDT members include a radiologist experienced in diagnosing PAS, maternal fetal medicine specialists, gynaecology oncology consultants, obstetricians, neonatologists, anaesthetists and senior nursing team members.
A standardised approach to PAS was developed, that can then be tailored according to the MDT findings and the patients' circumstances. MDT documentation includes location of placenta and area of placenta accreta, type of recommended abdominal incision, use of intraoperative cell salvage, need for optimisation of haemoglobin, and planned gestation of delivery. In cases where it is felt there is a low suspicion of PAS, a recommendation is made as to whether a gynaecology oncologist is required to be present, and whether a conservative approach would be appropriate. A gynaecological oncologist and obstetrician performed all cases of known PAS.

Aims: To evaluate the impact of a PAS MDT on outcomes in PAS in a tertiary obstetric centre

Methods: Review of histologically confirmed PAS patients in the 2 years prior and 2 years post establishment of the PAS MDT was undertaken from April 2019 and April 2023, as well as patients reviewed through the MDT. Patient demographic data, maternal, neonatal and surgical outcomes were examined.

Results: Between April 2019 and April 2023, 72 cases of PAS were reviewed. 40 cases of PAS occurred prior to the establishment of the MDT. 32 cases of PAS were managed through the PAS MDT. Further data to follow.

Discussion: An MDT approach allows for a standardised approach to pre-operative planning and potentially improved maternal outcomes. Other benefits of the MDT include sharing of information and commentary on surgical techniques as well as reflection on past cases, which provides an excellent learning and clinic-radio-pathological correlation opportunity. The PAS MDT allows for an ideal platform for improving future management of PAS, for example; identification of cases where even more individualised approaches such as fertility sparing surgery are possible, further optimising

timing of delivery, or improvement in recognition and diagnosis of PAS. The PAS MDT is a critical component of not only the current, but also the future management of PAS.

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Robotic assisted radical hysterectomy and sentinel node mapping for early-stage Cervical cancer using the Mc Cartney Tube to prevent tumour spillage.

Felix Chan[1], Cherynne Johansson[2], David Lee[1], Gregory Carrutherus[1]

1. Faculty of Medicine, Health and Human Science, Macquarie University Hospital, Macquarie University, NSW
2. Minimally Invasive Surgery Unit, Liverpool Hospital, Liverpool, NSW, Australia

Introduction: Radical hysterectomy plays an important role in the treatment of early-stage cervical cancer however minimally invasive methods of radical hysterectomy have been associated with poorer outcomes compared with laparotomy (1). Such outcomes have been suggested to be related to the use of transcervical uterine manipulators and lack of proper tumour containment, factors which are being addressed in ongoing studies.(2)

Study objective: To demonstrate a technique to prevent tumour spillage using the McCartney tube at the time of robotic-assisted radical hysterectomy for cervical cancer.

Design: A video demonstration of the technique with step-by-step description

Setting: A metropolitan teaching and research hospital

Patient selection: A 46 year old woman with stage 1B1 cervical adenocarcinoma; 1cm tumour confirmed on pelvic magnetic resonance imaging. PET/CT showed no evidence of metastatic disease.

Interventions: Robotic assisted radical hysterectomy, bilateral salpingectomy with sentinel node biopsy and ovarian transposition.

Measurements and Main Results: After inserting a urinary indwelling catheter, 2mL (1.5mg per ml) of ICG was injected at 3 and 9 o'clock positions of the cervix. The appropriate size McCartney tube was inserted.

Using a DaVinci Xi system (ISI Sunnyvale), four ports were placed in an M configuration into the anterior abdominal wall. After gaining entry using Veress needle, pneumo-peritoneum was established. A 10mm assistant port was placed at the left upper quadrant to allow for nodal retrieval, needle exchange and suction irrigation. A 3D high definition 30-degree endoscope was used to enhance the visualisation of the pelvic structures. The lateral pelvic spaces were then developed systematically. Sentinel node mapping utilising the FireflyÒ function of the DaVinci robot was used to enable harvesting of bilateral sentinel nodes. Care was taken not to rupture lymph nodes to avoid potential spillage of disease, and the nodes were retrieved within small bags. The uterovesical fold was opened and the bladder was dissected. The cervico-vesical ligaments were dissected, and the communicating vessels were ligated. The ureters were lateralised, and the uterine vessels were ligated. The 30-degree scope was then rotated upwards to facilitate the development of the rectovaginal space, and the pelvic nerves were lateralised. The paracolpos was then divided using a wristed vessel sealer to minimise bleeding.

A 15cm long 0 barbed suture was used to suture through the vaginal wall into the McCartney tube circumferentially. This allowed the containment of the cervix and the upper vagina within the vaginal tube. Colpotomy was then carried out below this suture line. The specimen attached to the upper end of the tube was then removed trans-vaginally. Finally, the vaginal cuff was closed with 0 barbed suture in a continuous non-locking fashion. The pelvis was irrigated, and haemostasis was achieved. The console time was 100 mins and there was less than 5mL of blood loss.

The patient was discharged in 12 hours with minimal pain. The indwelling catheter was removed at an ambulatory service with standardised trial of void protocol five days after surgery. Her recovery was uneventful, and she remains disease-free after two years.

Conclusion: Suturing of the vaginal cuff to the McCartney tube before colpotomy provides a safe and simple method to prevent tumour spillage at the time of a radical hysterectomy. This may improve outcomes related to minimally invasive surgery in patients with cervical cancer.

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SATURDAY 9TH MARCH

Session 8: Where Have We Come From and What is the Future?

History of Gynaeoncology in Australia and ASGO

Robert Rome[1]

1. Epworth Healthcare, Melbourne, VICTORIA, Australia

Surgical Experience of Fellows in CGO Training

Archana Rao[1], Cecile Bergzoll[2]

1. Department of Gynaecological Oncology, Royal Brisbane and Women's Hospital, Herston, QLD, Australia
2. Gynae-Oncology, Auckland City Hospital, Auckland, New Zealand

Update on the Pacific Fellows

Nanise Sikiti[1]

1. Ministry of Health Fiji Island, Suva, FIJI ISLAND, Fiji

The Rise of the Robot

Rene Pareja[1]

1. National Cancer Institute in Bogotá, Bogotá,, Colombia

Teaching and Training in the Modern Era

Pedro Ramirez[1]

1. Houston Methodist Hospital, Houston, United States

Australian Space Medicine and the Role of Antarctica as a Space Analogue Environment

John Cherry[1]

1. Maitland Hospital, Hamilton, NSW, Australia

Tumour Board

Gynae Oncologists – ***Tom De Greve and Niveditha Rajadevan***
Pathologist – ***Karen Whale***
Medical Oncologist – ***Cristina Moldovan***
Radiation Oncologist – ***Raef Awad***
Radiologist – ***Jess Monkhurst***

Session 9: ASGO Debate

Topic: The Future of Gynaecologic Oncology is Robotic

For: Rene Pareja, Kris Moloney, Jim Nicklin
Against: Pedro Ramirez, Rosie McBain, Ken Jaaback

Poster Abstracts

Management of groin nodes in early vulval cancer: patterns of care in a Queensland population

Stacey Davie[1], Andreas Obermair[1, 2], Karen Sanday[1]

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2. Centre for Clinical Research, University of Queensland, Brisbane, Queensland, Australia

Background: Sentinel lymph node biopsy (SLNB) has been proven to be safe in patients with early stage vulval cancer with no clinically or radiologically concerning nodes[1] and is associated with a significant reduction in treatment associated morbidity when compared with total lymphadenectomy[2]. In most centres sentinel node biopsy is the preferred surgical approach, but certain groups of patients are ineligible to undertake sentinel node assessment. There is paucity of information available on the proportion of patients eligible and ineligible for SLNB and associated indications for each chosen approach.

Objectives: The aims of the study were to provide an overview of patterns of care for early stage vulval cancer, focusing on eligibility and method of inguinofemoral lymph node assessment, complications associated with each approach and any patterns of short-term recurrence.

Materials and methods: Retrospective data analysis on patients with early primary vulval squamous cell carcinoma from 2014 to 2017 undergoing primary surgical management (including nodal surgery) at all gynaecology oncology cancer centres in Queensland. Patient data was extracted from the Queensland Centre for Gynaecological Cancer (QCGC) database. SPSS was used for statistical analysis.

Results (Preliminary results only, final results to be presented at conference): 193 patients were included for analysis. Of the 193 patients, 96 were eligible for SLNB (49.8%) and 97 ineligible (50.2%) and therefore underwent regional lymph node dissection. Reasons for ineligibility for SLNB included: failed sentinel lymph node mapping, suspicious lymph nodes on imaging/histopathology, tumour >4cm in size, multifocal disease or other reasons (such as allergies, co-morbidities). Complications occurred in 19/96 patients in the SLNB group (19.8%) and 27/97 in the dissection group (27.8%).

Conclusions: While SLNB has been proven to be a safe and sensitive approach, evidence in this area is still limited due to the rarity of vulval cancer which ultimately limits overall application. This study shows that only approximately 50% of patients with vulval cancer were eligible for SLNB. Consistent with previous evidence SLNB also proved to be a faster and less morbid procedure in comparison to complete inguino-femoral lymph node dissection.

Outcomes such as complications, recurrence rates, cancer-related survival and overall survival to be presented at conference, along with final statistical analysis (including significance of above numbers)

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Endometrial cancer and obesity in the younger population: the uptrend in Queensland that needs attention

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2. Queensland Cancer Control Analysis Team - Metro South, Cancer Alliance Queensland , Brisbane , Queensland, Australia

Background: Obesity has been established as a modifiable risk factor for endometrial cancer in population-based analyses before and the link between obesity and poorer outcomes in this population has also been well established in the literature. With an observed increase in rates of endometrial cancer across Queensland (40% rise over the last 20 years) attention has turned to mitigation of such risk factors that have risen concomitantly.

Aims: This study analysis will examine overall trends in BMI among Queensland women with endometrial cancer, comparing the age specific rates of obesity at presentation.

Methods: Population data was obtained from the Queensland Oncology Repository, linked to the Queensland Cancer Registry. Treatment data was obtained from both public and private hospitals, and included FIGO staging, biomarkers, treatment data and outcomes, in association with databases from the Queensland Centre for Gynaecological Cancer. BMI data was obtained from oncology information systems and verified with values from admission for treatment. Data was compared to that from 2001 in the Queensland population.

Results: 2,925 patients were included over a 4 year period. The overall incidence of endometrial cancer rose in the interim between 2001 and 2020 by 40% (16.9 per 100,000 to 23.3 per 100,000). The rates of obesity in women aged 18+ has risen from 43% to 56%. The effect of obesity on rates of endometrial cancer is most significantly noted in the younger age group (<40yrs old) where almost 40% of new diagnoses were associated with BMI greater than 40 (in comparison to 30% of new diagnoses aged 60-69). The overall rate of women with Endometrial Cancer that were obese was 68%, which was higher than the general population (52-57%). Obesity is associated with increased medical co-morbidities (22% of class III obese patients having 2+ comorbidities in comparison to 8% of those with BMI <30) which overall impacts suitability for primary surgical treatment. Rates of surgical management in this group (class III obesity) are significantly lower than those in class II and below (73% vs >90%).

Conclusion: Increases in the rates of obesity and endometrial cancer appear potentially linked. Given the modifiable risk factor of increased BMI, more public awareness of this relationship is needed and attention needs to be directed to education and weight loss as a risk reduction tool. As the rates appear highest in the younger age groups <40yr old, attention should be directed to this age group wherein reduction of BMI may not only reduce risk of developing Endometrial Cancer but also potentially reduce the development of comorbidities that are associated with increased risks of treatment complications as well as overall morbidity and mortality.

In-transit cutaneous metastasis: a rare finding in vulval squamous cell carcinoma. A Case report and review of the literature.

Stacey Davie[1], Archana Rao[1]

1. Queensland Centre for Gynaecological Cancer Research, Royal Brisbane and Women's Hospital , Herston, QLD , Australia

Background: Squamous Cell Carcinoma (SCC) of the Vulva are associated with later presentation, more advanced disease, and a propensity to metastasise at the time of diagnosis when compared with similar cutaneous SCC in other sites of the body. Increased tumour staging requires more radical surgical treatment and increases the likelihood of requiring post-operative adjuvant radiotherapy. Advanced tumours generally spread via lymphatics to the lymph nodal basins which is associated with worse prognosis. Dermal in-transit metastases are a rare but aggressive clinical phenomenon which have been reported in other sites of the body from cutaneous SCC and demonstrate dermal lymphatic halting and localised growth in the subcutis. This has rarely been described in the vulval literature, with only 16 cases reported to date[1]. However in all reported cases the prognosis was very poor (with some studies stating a 13% 5 year survival rate[2]) and therefore recommended treatment is a combination of surgery and adjuvant radiotherapy.

Clinical Case: A 78 year old woman was referred to our gynaecology oncology unit with a 4cm vulval SCC and underwent an anterior radical vulvectomy and bilateral inguinofemoral lymph node dissection. Histopathology results diagnosed Stage 1B Grade 2 HPV associated SCC (no LVSI, DOI 10mm, clear of margins) with 0/16 lymph nodes involved. In addition, there was an isolate subcutaneous metastatic deposit (3.1mm), also clear of the margins and not associated with a definite nerve or lymphovascular space (2.7mm from right lateral margin and >5mm from the deep margin). This unusual finding was discussed in the gynaecology oncology multi-disciplinary team meeting and the consensus made for adjuvant radiation therapy based on the scant literature available.

Conclusions: Vulval in-transit metastases are an extremely rare finding but based on literature available (mostly regarding SCC arising in other primary locations) they are associated with high rates of recurrence and poor prognosis. Clinical and pathological recognition of this rare entity is critical as adjuvant radiation is recommended in this setting and close follow up with biopsies of any suspicious lesions on any part of the body.

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INTRAVENOUS LEIOMYOMATOSIS WITH CARDIAC INVOLVEMENT: STEP-BY-STEP MULTIDISCIPLINARY ONE-STAGE SURGICAL MANAGEMENT OF 2 CASES OF RARE AND SURGICALLY COMPLEX TUMOURS

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Introduction: Intravenous leiomyomatosis (IVL) is a rare endovascular disease, which is histologically benign but can exhibit quasi-malignant behaviour. Intracardiac IVL is even rarer, with approximately 200 cases reported worldwide. It can present asymptomatically or with cardiovascular instability and even death. Traditionally, a two-stage surgery has been performed, where the cardiac component of the IVL would be resected first to prevent cardiac complications prior to the pelvic and abdominal component. However, tumour embolisation risk remains and a second operation is required. Hence, a one-stage approach has been proposed. There is little published data on the ideal surgical approach with surgical steps rarely detailed.

Methods: We present the step-by-step surgical management of two cases of intracardiac IVL, which were managed with a one-stage multidisciplinary surgical approach.

Results: Case A is a 54-year-old female whose intracardiac IVL extended from the uterus via the uterine veins and inferior vena cava (IVC) into the right atrium.
Case B is a 51-year-old female whose intracardiac IVL extended from the uterus via the ovarian and uterine veins into the right atrium and right ventricle with adherence to the tricuspid valve.
Both patients were treated with a multi-disciplinary Gynaecological Oncology, Cardiac and Vascular surgical team. A combined sternotomy-laparotomy, cardiopulmonary bypass without cardioplegia, intraoperative cooling, total abdominal hysterectomy, bilateral salpingo-oophorectomy and resection of tumour from the IVC and heart were performed. We detail the surgical decision-making and steps taken in each case.

Conclusions: Intracardiac IVL can be successfully treated in a one-stage procedure with a multidisciplinary team.

Krukenberg tumours from a colorectal origin – the diagnosis, management, timelines and outcomes in a single Australian tertiary centre.

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Introduction: Krukenberg tumours, aggressive metastatic ovarian tumour originating from non-gynaecological sources, remain a challenge for clinicians. The management of those with colorectal origins lacks well-defined guidelines, leading to variations in management and outcomes. We describe the management of Krukenberg tumours from a colorectal origin within a major Australian tertiary centre.

Method: This retrospective study identified Krukenberg tumours of colorectal origin within a single tertiary referral centre (Western Health) in Melbourne, Australia. Data were extracted from a prospective Australian Comprehensive Cancer Outcomes and Research Database (ACCORD) as well as MDT and Hospital Electronic Medical Records.

Results: The clinical trajectories of twenty-one patients (mean age 56.9 years, range 34 – 87) between 2005 and 2023 were identified. The majority of these patients initially consulted general surgeons or gastroenterologists (n=18, 86%), while a smaller fraction sought initial care from gynaecologist oncologists (n=3, 14%). In most cases, Krukenberg tumours presented synchronously with the diagnosis of their primary colorectal tumour (n=18, 86%,). Majority presented with colonic primaries (n=19, 90%), with the remaining cases originating from the rectum (n=2, 10%). The majority of patients (n=16, 76%) underwent primary elective surgical resection (n=11, 69%). The average time between diagnosis and surgery was 39 days (range 0 – 168 days). Amongst those who received surgical management, a notable proportion required a stoma (n=7, 44%), and cytoreductive surgery was attempted in some cases (n=6, 40%). Approximately two-thirds of patients underwent adjuvant chemotherapy (n=14, 66%). The mean length of survival was approximately 19 months (from diagnosis). A noteworthy observation revealed that patients unable to undergo surgical intervention, as well as those afflicted with bilateral ovarian involvement, demonstrated less favourable outcomes and survival durations.

Conclusion: Krukenberg tumours from colorectal origins are aggressive malignancies that predominantly afflict younger individuals, with an average survival less than two years. Given the late presentation of this disease, a high degree of clinical suspicion and timely investigations are imperative for early intervention and improved patient outcomes.

MMR status according to ethnicity in new endometrial cancer diagnoses within the Auckland region

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Introduction: Endometrial cancer (EC) is the most common gynaecological malignancy in New Zealand. Pacific women have the highest incidence, which is rising in those under 50 years of age. The introduction of immunohistochemistry (IHC) for EC has important implications for identification of potential Lynch syndrome (LS). Universal testing of EC tumours for a mutation in one of the DNA mismatch repair genes (MMR) was introduced to New Zealand in 2017. The objective of this study was to investigate the rate of MMR deficient and proficient tumours within our population, and whether these rates vary according to ethnicity.

Methods: This is a retrospective population-based cohort study of all cases of EC diagnosed between 1st January 2017 until 31 December 2018 within the Auckland region. Incidence of MMR deficient and proficient tumours was assessed for each ethnicity and compared.

Results: 409 patients were diagnosed with EC, with 81.6% (n=334/409) undergoing MMR IHC testing. There were 266 pMMR (79.6%) and 68 dMMR (20.4%) EC tumours. 26.1% of EC in European patients were dMMR, compared with 10% in Māori (p=0.06, RR 0.4 (0.1 – 1.2)), and 11.4% in Pacific (p=0.004 RR 0.5 (0.3 – 0.9)), and 28.3% in Asian (ns). 8 patients (2.3%) were diagnosed with Lynch Syndrome: 4/8 (50%) European, 2/8 (25%) Asian, 1/8 (12.5%) Indian, 1/8 (12.5%) Middle Eastern.

Conclusion: Despite having an increased incidence of EC in New Zealand, Māori and Pacific people have significantly lower rates of MMR deficient tumours than the European population. None of the Pacific or Māori patients had Lynch syndrome.

Sentinel Node Biopsy in Women with Vulvar Cancer in Pregnancy

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Background: Vulvar cancer accounts for only 4% of gynaecological malignancies, predominantly affecting the post-menopausal population. However it can affect pre-menopausal women of childbearing age, with case reports in pregnant women. Sentinel node biopsy is the standard of care for early vulval tumours, usually with a combination of radioisotope and blue dye. The use of radioisotopes is not common in pregnancy and women may be reticent due to perceived risks to the fetus. The risk with technetium is small due to the half-life and distance from the fetus, however caution is required with blue dye injection due to the risk of anaphylaxis.

Case: We present a case of 30 year old woman in her first pregnancy diagnosed with FIGO stage IB vulvar squamous cell carcinoma during early pregnancy. She subsequently underwent radical wide local excision and sentinel lymph node biopsy at 18 weeks' gestation under general anaesthetic, with injection of techetium-99m intradermal injections and scintigraphy two hours pre-operatively. Injection of blue dye was omitted due to the risk of anaphylaxis. The sentinel lymph was identified intra-operatively with the gamma probe, and removed. Surgery was uncomplicated, and she delivered her baby by spontaneous vaginal birth at term, with no maternal or fetal adverse effects.
Conclusion: Surgical management including sentinel lymph node biopsy can be utilised safely in pregnant patients with vulvar cancer using technetium, in accordance with recommendations for the general, non-pregnant population. However, due to the risk of anaphylaxis to blue dye, our standard technique was modified.

Outcome of risk-reducing surgeries in high-risk women- tertiary centre analysis

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Introduction: Ovarian cancer is one the most lethal gynaecologic malignancies. The population risk of ovarian cancer is around 1%, with even higher risk, up to 40%, in cases of known family history, gene mutations or various hereditary syndromes.

There is currently no effective method of screening for ovarian cancer in high-risk women. The only effective intervention to reduce the risk of ovarian cancer is removal of both fallopian tubes and ovaries. This study aimed to investigate the surgical outcomes and occult cancer rates of risk-reducing salpingo-oophorectomy in high-risk women.

Methods: This is a retrospective analysis of all women identified as high-risk for ovarian cancer, who were referred to a high-volume tertiary center, and underwent risk reduction surgery. Included in the analysis were patients' demographics, peri and post-operative details, and final histopathological details.

Results: Between 2009 and 2023 more than 1000 women were referred to our center for a risk reduction surgery. This is an interim analysis of 303 women from that cohort.

Of the 303 women who underwent risk-reducing surgery, 88 (29.1%) had a BRCA1 mutation (median age 44, range, 34-69 years), 107 (35.3%) BRCA2 mutation (median age 50 years, range 32-79 years), 30 (9.9%) with HNPCC associated gene mutations (median age 45 years, range 36-57 years), 59 (19.4%) with a family history (median age 52 years, range 33-68 years) and 19 (6.2%) with other rare gene mutations (median age 61, range 43-71 years).

The rate of intra and post operative complications was 7.2% of which 2.6% were major complications (Clavien-Dindo grade of 3 and higher). In nine patients (2.9%) surgeries converted to open.
The overall occult cancer rate was 3.9% (n=12): There were seven (58.3%) high grade serous of the ovary/fallopian tube (HGSOC) and five (41.7%) endometrial cancer found. Of the whole cohort, seven (2.3%) patients were found to have premalignant disease – four serous tubal intraepithelial carcinoma (STIC), two atypical endometrial hyperplasia (AEH) and one low grade dysplasia of the cervix.
11 out of 12 cancers were found in women with known mutations.

Discussion: In our study we found a lower rate of occult cancer when compared to the literature. This may be explained by inclusion women with a strong family history and not just a known mutation. A larger analysis of the whole cohort is to follow.

A case of adult granulosa cell tumour associated with Ollier disease

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Ollier disease is a condition affecting 1 in 100,000, characterized by multiple endochondromas (1). It is caused by sporadic mutations in isocitrate dehydrogenase-1 and 2, although the exact pathogenesis is unknown (1). There have been 11 case reports of juvenile granulosa cell tumour associated with Ollier disease (2,3), however the pathophysiological link between these is unclear. Some postulate that this represents a generalized mesodermal dysplasia in patients with Ollier disease (2). Here we present a case of a 75-year-old woman with Ollier disease, who presented with a large pelvic mass. The histological analysis of this mass was challenging, requiring input from several pathologists over several sites. The diagnosis of sarcomatoid adult granulosa cell tumour was rendered after consensus review. This is the first case, to our knowledge, of an association between adult granulosa cell tumour and Ollier disease. Interestingly, the patient also had an incidental finding of a renal oncocytoma. Ollier disease has also been associated with various other musculoskeletal, CNS, lung, breast and renal tumours (4) but there are no reports of an association with renal oncocytoma.

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