IGCS 2024 Annual Global Meeting DUBLIN
OCTOBER16-18, 2024

IGCS 2024 Abstracts:

Regular Submission Oral Presentations (Plenary Sessions)

Oral abstract presentations are included in the below sessions. The sessions will be recorded for on-demand viewing via the IGCS 360 Educational Portal.

PLENARY 01: ORAL ABSTRACT PRESENTATIONS
Wednesday, October 16, 9:00 – 10:30 AM | Auditorium

PLENARY 02: ORAL ABSTRACT PRESENTATIONS
Thursday, October 17, 9:00 – 9:30 AM | Auditorium

PLENARY 03: ORAL ABSTRACT PRESENTATIONS
Thursday, October 17, 4:00 – 5:00 PM | Auditorium

PLENARY 04: ORAL ABSTRACT PRESENTATIONS
Friday, October 18, 4:00 – 5:30 PM | Auditorium

PO001 / #1130

PLENARY 01: ORAL ABSTRACT PRESENTATIONS

Topic: *AS04. Endometrial/Uterine Corpus Cancers*

IMPACT OF INVESTIGATOR-ASSESSED RESPONSE TO DOSTARLIMAB ON QUALITY OF LIFE IN THE RUBY TRIAL OF PRIMARY ADVANCED OR RECURRENT ENDOMETRIAL CANCER (PA/REC)

Noelle Cloven[1], Henrik Roed[2], Lucy Gilbert[3], Zoltán Novák[4], Mitchell Edelson[5], Antonella Savarese[6], Kari Ring[7], Martina Gropp-Meier[8], Brandon Sawyer[9], Janet Osborne[10], Sara Bouberhan[11], Floor Backes[12], Robert Coleman[13], Paul Nowicki[14], Alberto Mendivil[15], Solomon Lubinga[16], Tilman Payer[17], Kateryna Chepynoga[18], Matthew Powell[19], Mansoor Mirza[20]

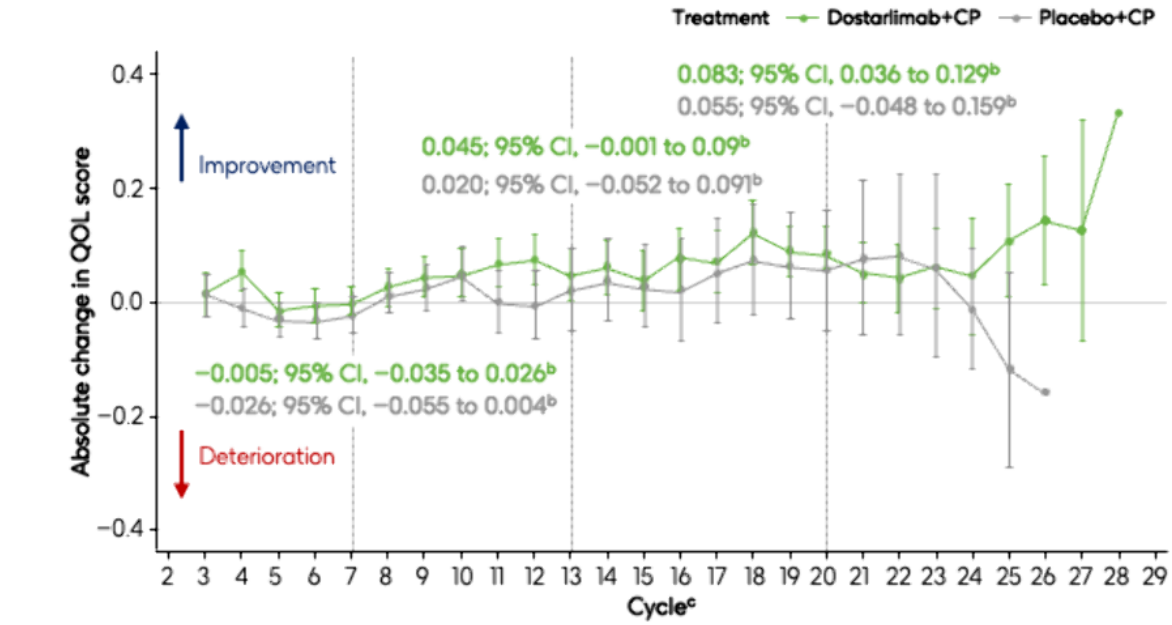
[1]Texas Oncology, Fort Worth, United States of America, [2]Rigshospitalet, Department Of Oncology, Copenhagen, Denmark, [3]Division of Gynecologic Oncology, McGill University Health Centre and the Gerald Bronfman Department of Oncology, McGill University, Montreal, Canada, [4]Department of Gynecology, Hungarian National Institute of Oncology, Budapest, Hungary, [5]Hanjani Institute for Gynecologic Oncology, Jefferson Abington Hospital, Willow Grove, United States of America, [6]IRCCS Regina Elena National Cancer Institute, Medical Oncology, Rome, Italy, [7]University of Virginia Health System, Charlottesville, United States of America, [8]AGO Study Group, Wiesbaden, and Oberschwabenklinik, St. Elisabethen-Klinikum, Ravensburg, Germany, [9]Texas Oncology, Dallas, United States of America, [10]Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Virginia Tech Carilion, Roanoke, United States of America, [11]Massachusetts General Hospital, Boston, United States of America, [12]Division of Gynecologic Oncology, Ohio State University, Columbus, United States of America, [13]Texas Oncology, The Woodlands, United States of America, [14]Baptist MD Anderson Cancer Center,, Jacksonville, United States of America, [15]Gynecologic Oncology Associates, Hoag Cancer Center, Newport Beach, United States of America, [16]GSK, Collegeville, United States of America, [17]Parexel, Madrid, Spain, [18]Parexel, Hørsholm, Denmark, [19]National Cancer Institute–sponsored NRG Oncology, Washington University School of Medicine, St Louis, United States of America, [20]Rigshospitalet, Copenhagen University Hospital, Copenhagen, and Nordic Society of Gynaecologic Oncology-Clinical Trial Unit, Copenhagen, Denmark

Introduction: In RUBY (NCT03981796), dostarlimab plus carboplatin-paclitaxel (dostarlimab+CP) demonstrated statistically significant PFS and OS benefits vs placebo+CP in patients with pA/rEC. This post hoc analysis compared differences in patient-reported quality of life (QOL) among responders and nonresponders to dostarlimab+CP vs placebo+CP in the intent-to-treat population, regardless of mismatch repair status.

Methods: The EORTC QLQ-C30 Global Health Status Scale (global QOL) and EQ-5D-5L (utility index) were assessed at baseline, day 1 of each treatment cycle (C), and end of treatment. Patients with evaluable disease at baseline were stratified as responders or nonresponders (RECIST 1.1) at each time point. Linear mixed-effects models with response, treatment, cycle, and a 3-way interaction evaluated QOL score changes from baseline. Least squares means (LSM) were estimated.

Results: For EORTC global QOL, similar trends were observed among responders in both treatment arms; however, greater improvements were observed with dostarlimab+CP (**Figure 1**). Among nonresponders, global QOL showed a similar trend between arms until C12; after C12, dostarlimab+CP showed improvements while placebo+CP showed a deterioration (**Figure 2**). For EQ-5D-5L, among responders, from C9 onward, dostarlimab+CP showed improved scores while placebo+CP showed a deterioration (C7 LSM [dostarlimab+CP vs placebo+CP], −0.016 vs −0.020; C13, 0.033 vs −0.085); among nonresponders, scores deteriorated before C10 in both arms, and there was no clear trend beyond C10 (C7, −0.093 vs −0.043; C13, −0.067 vs 0.086; C20, 0.

Figure 1: EORTC QLQ-C30 global QOL score change from baseline for responders[a] in the intent-to-treat population

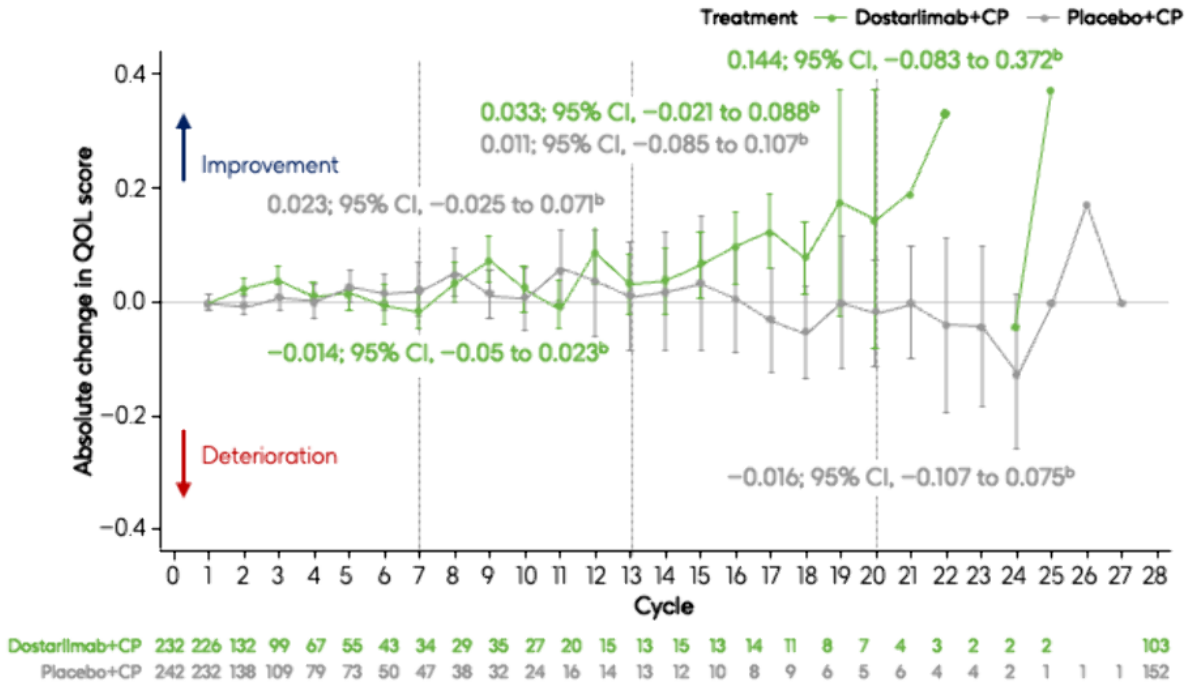


[a] Includes patients with complete or partial response.

[b] Least square means from mixed effect model are estimated with 95% CI.

[c] All patients were considered as nonresponders at baseline and cycle 2. Hence, responders are evaluated from cycle 3 onward, while nonresponders are evaluated from baseline onward.

Figure 2: EORTC QLQ-C30 global QOL score change from baseline for nonresponders[a] in the intent-to-treat population



[a] Includes patients with progressive or stable disease and nonevaluable patients.
[b] Least square means from mixed effect model are estimated with 95% CI.

152 vs −0.0004).

Conclusion/Implications: Trends suggest a higher and sustained QOL improvement with dostarlimab+CP vs placebo+CP in responders and nonresponders, further supporting dostarlimab+CP as an appropriate treatment option.

PO002 / #638

PLENARY 01: ORAL ABSTRACT PRESENTATIONS

Topic: *AS04. Endometrial/Uterine Corpus Cancers*

EFFICACY AND SAFETY OF DOSTARLIMAB PLUS CHEMOTHERAPY IN PATIENTS WITH ENDOMETRIAL CANCER BY AGE CATEGORY IN PART 1 OF THE RUBY TRIAL

Michael Gold[1], Magnus Frödin Bolling[2], Sudarshan Sharma[3], Stefan Kommoss[4], Lucy Gilbert[5], Kari Ring[6], Anna Reyners[7], Ilana Cass[8], Nejat Özgül[9], Brian Slomovitz[10], George Fountzilas[11], Brandon Sawyer[12], Josh Trinidad[13], Floor Backes[14], Helen Eshed[15], Jonathan Berek[16], Sunkyung Kim[17], Shadi Stevens[18], Matthew Powell[19], Mansoor Mirza[20]
[1]Oklahoma Cancer Specialists and Research Institute, Tulsa, United States of America, [2]Karolinska University Hospital, Solna, Sweden, [3]Adventist Medical Center, Hinsdale, United States of America, [4]Diakoneo Diak Klinikum, Schwäbisch Hall, Germany, [5]Division of Gynecologic Oncology, McGill University Health Centre and the Gerald Bronfman Department of Oncology, McGill University, Montreal, Canada, [6]University of Virginia Health System, Charlottesville, United States of America, [7]Department of Medical Oncology, University Medical Center Groningen, University of Groningen, Groningen, Netherlands, [8]Department of Obstetrics and Gynecology, Dartmouth-Hitchcock Medical Center, Lebanon, United States of America, [9]Department of Obstetrics and Gynecology, Faculty of Medicine, Hacettepe University, Ankara, Turkey, [10]Department of Gynecologic Oncology, Mount Sinai Medical Center, and the Department of Obstetrics and Gynecology, Florida International University, Miami Beach, United States of America, [11]Laboratory of Molecular Oncology, Hellenic Foundation for Cancer Research/Aristotle University of Thessaloniki, Thessaloniki, Greece; Aristotle University of Thessaloniki, Thessaloniki, Greece; Department of Medical Oncology, German Oncology Center, Limas, Limassol, Cyprus, [12]Texas Oncology, Dallas, United States of America, [13]Novant Health Cancer Institute, Winston-Salem, United States of America, [14]Division of Gynecologic Oncology, Ohio State University, Columbus, United States of America, [15]Texas Oncology, Austin, United States of America, [16]Stanford Women's Cancer Center, Stanford Cancer Institute, Stanford University School of Medicine, Palo Alto, United States of America, [17]GSK, Collegeville, United States of America, [18]GSK, London, United Kingdom, [19]National Cancer Institute–sponsored NRG Oncology, Washington University School of Medicine, St Louis, United States of America, [20]Rigshospitalet, Copenhagen University Hospital, Copenhagen, and Nordic Society of Gynaecologic Oncology-Clinical Trial Unit, Copenhagen, Denmark

Introduction: In the phase 3 RUBY trial (NCT03981796), dostarlimab+carboplatin-paclitaxel significantly improved progression-free survival (PFS) and overall survival vs placebo+carboplatin-paclitaxel in patients with primary advanced or recurrent

endometrial cancer (pA/rEC). The impact of patient age on the efficacy and safety of immunotherapy in pA/rEC is not well described. Here, we report post hoc exploratory analyses by age subgroups in Part 1 of RUBY.

Methods: Patients with pA/rEC were randomized 1:1 to receive dostarlimab or placebo, plus carboplatin-paclitaxel, followed by dostarlimab or placebo monotherapy for up to 3 years and categorized as <70 or ≥70 years old (yo). Data cutoff dates for PFS (final) and safety were September 28, 2022 and September 22, 2023, respectively. Analyses were performed in the overall population and by mismatch repair/microsatellite-instability (MMR/MSI) status.

Results: Overall, 494 patients were randomized. The previously reported hazard ratio (HR) for PFS in all patients, regardless of age, was 0.64. Consistent benefits were observed for PFS with dostarlimab+carboplatin-paclitaxel compared with placebo+carboplatin-paclitaxel in both the <70 yo and ≥70 yo subgroups, with HRs (95% CI) of 0.71 (0.54–0.94) and 0.50 (0.32–0.77), respectively (Table). Similar trends were observed by MMR/MSI status. Safety was consistent with that reported in the overall population.

	Overall		<70 years old		≥70 years old	
	DOST+CP	PBO+CP	DOST+CP	PBO+CP	DOST+CP	PBO+CP
N (Efficacy)	245	249	171	178	74	71
PFS HR (95% CI)	0.64 (0.51–0.80) *P*<0.0001[a]		0.71 (0.54–0.94)		0.50 (0.32–0.77)	
PFS probability, % (95% CI)						
12 months	48.2 (41.3–54.8)	29.0 (23.0–35.2)	46.7 (38.5–54.4)	32.6 (25.3–40.1)	52.1 (38.7–63.8)	19.9 (10.9–30.8)
24 months	36.1 (29.3–42.9)	18.1 (13.0–23.9)	35.8 (28.0–43.7)	23.4 (17.0–30.5)	36.4 (23.2–49.8)	3.2 (0.3–13.1)
N (Safety)	241	246	170	175	71	71
Any TEAE, n (%)	241 (100)	246 (100)	170 (100)	175 (100)	71 (100)	71 (100)
Any grade ≥3 TEAE, n (%)	174 (72.2)	148 (60.2)	120 (70.6)	101 (57.7)	54 (76.1)	47 (66.2)
Any SAE, n (%)	96 (39.8)	69 (28.0)	64 (37.6)	41 (23.4)	32 (45.1)	28 (39.4)
Any irAE related to DOST/PBO, n (%)	98 (40.7)	40 (16.3)	67 (39.4)	26 (14.9)	31 (43.7)	14 (19.7)
Any TEAE leading to discontinuation of DOST/PBO, n (%)	46 (19.1)	20 (8.1)	29 (17.1)	14 (8.0)	17 (23.9)	6 (8.5)
Death due to AE, n (%)	5 (2.1)	0	4 (2.4)	0	1 (1.4)	0

[a]Trial primary endpoint.
HRs are calculated by stratified Cox regression.
AE, adverse event; CP, carboplatin-paclitaxel; DOST, dostarlimab; irAE, immune-related AE; PBO, placebo; SAE, serious adverse event; TEAE, treatment-emergent adverse event.

Conclusion/Implications: In these exploratory analyses, dostarlimab+carboplatin-paclitaxel prolonged PFS in patients <70 yo and ≥70 yo. Safety remained consistent in both age groups, suggesting no increase in toxicity with increasing age. These results

suggest dostarlimab+carboplatin-paclitaxel can be effective and tolerable for patients with pA/rEC regardless of age, including those ≥70 yo.

PO003 / #1168

PLENARY 01: ORAL ABSTRACT PRESENTATIONS

Topic: *AS04. Endometrial/Uterine Corpus Cancers*

LONGER-TERM SAFETY AND EFFICACY OF SELINEXOR MAINTENANCE THERAPY FOR PATIENTS WITH TP53WT ADVANCED OR RECURRENT ENDOMETRIAL CANCER: FOLLOW UP SUBGROUP ANALYSIS OF THE ENGOT-EN5/GOG-3055/SIENDO STUDY

Jose Alejandro Pérez Fidalgo[1], Ignace Vergote[2], Erika Hamilton[3], Ugo De Giorgi[4], Toon Van Gorp[2], Kristina Lübbe[5], Michael Zikan[6], Limor Helpman[7], David S. Miller[8], Lorena Fariñas-Madrid[9], Carmen Pisano[10], Annelore Barbeaux[11], Jalid Sehouli[12], Hye Sook Chon[13], Nerea Ancizar[14], Jonathan Berek[15], Pratheek Kalyanapu[16], Mansoor Mirza[16], Vicky Makker[17]

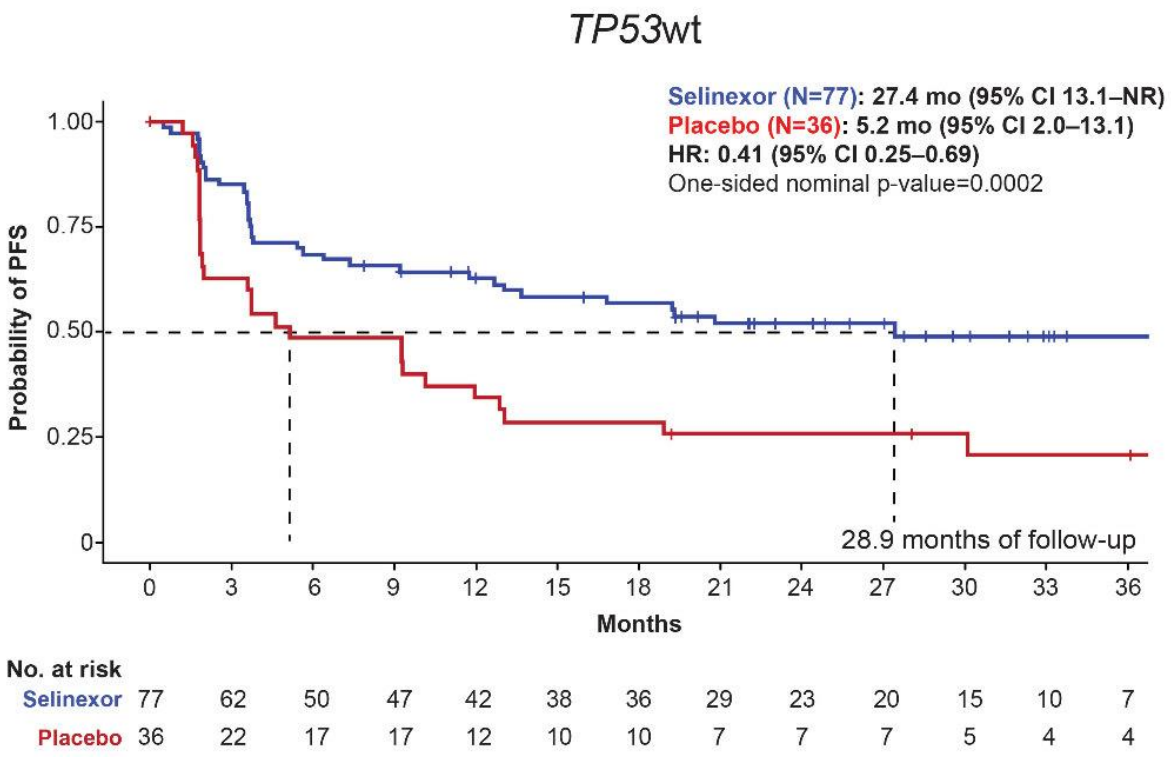
[1]GEICO and Hospital Clinico Universitario de Valencia, Medical Oncology., Valencia, Spain, [2]Belgium and Luxembourg Gynaecological Oncology Group, Leuven Cancer Institute, University Hospitals Leuven, Leuven, Belgium, [3]Sarah Cannon Reseach Institute, Nashville, United States of America, [4]IRCCS Istituto Romagnolo per lo Studio dei Tumori IRST, Meldola, Italy, [5]DIAKOVERE Henriettenstift Gynäkologie, Hannover, Germany, [6]Department of Gynecology and Obstetrics, Charles University - First Faculty of Medicine and University Hospital, Bulovka, Czech Republic, [7]Department of Gynecological Oncology, Sheba Medical Center, Tel-Hashomer, Israel, [8]Department of Obstetrics and Gynecology, Harold C. Simmons Comprehensive Cancer Center, University of Texas Southwestern Medical Center, Dallas, United States of America, [9]Vall d'Hebron University Hospital, Vall d'Hebron Institute of Oncology, Barcelona, Spain, [10]Istituto Nazionale Tumori di Napoli, Naples, Italy, [11]CHR, Verviers, Belgium, [12]NOGGO and Department of Gynecology, European Competence Center for Ovarian Cancer, Charité Comprehensive Cancer Center, Charité–Berlin University of Medicine, Berlin, Germany, [13]H. Lee Moffitt Cancer Center and Research Institute, Tampa, United States of America, [14]GEICO and Hospital Universitario de Donostia, Donostia, Spain, [15]Stanford Women's Cancer Center, Stanford Cancer Institute, Stanford University School of Medicine, Palo Alto, United States of America, [16]Karyopharm Therapeutics, Inc., Newton, United States of America, [17]Memorial Sloan Kettering Cancer Center, New York, United States of America

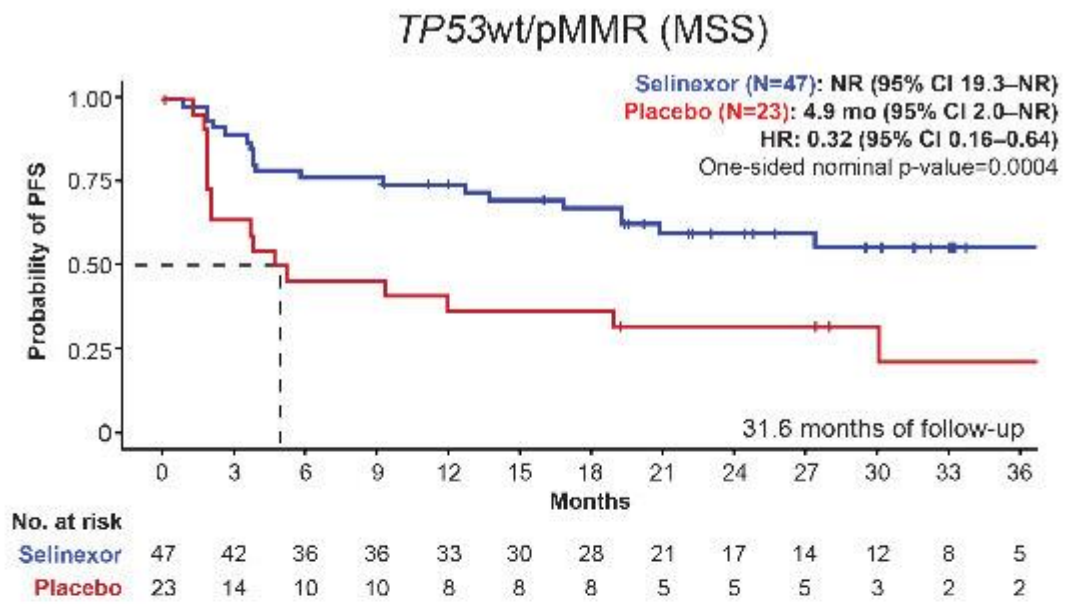
Introduction: Molecular characterization is important to inform treatment decisions for endometrial cancer (EC). Wild type *TP53* (*TP53*wt) is found in >50% of advanced/recurrent EC, of those, 40–55% are microsatellite stable (pMMR[MSS]). Evidence of benefit for these molecular subgroups is limited for patients with *TP53*wt tumors.

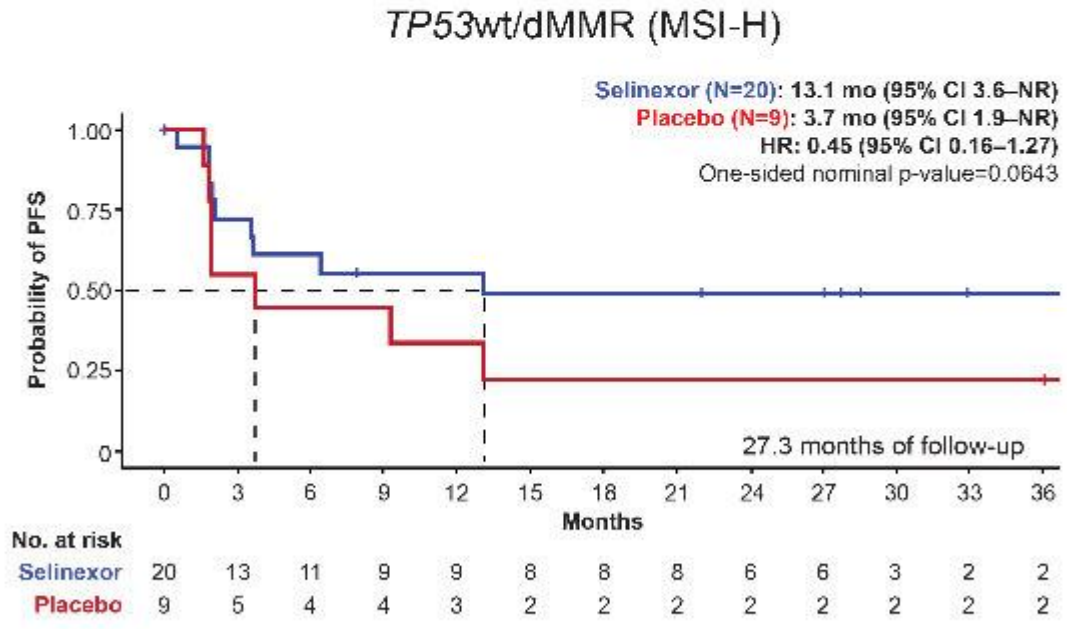
Methods: Long-term follow up analysis of prespecified *TP53*wt exploratory subgroup of ENGOT-EN5/GOG-3055/SIENDO (NCT03555422), a randomized, double-blind, phase 3

trial evaluating selinexor versus placebo as maintenance treatment for advanced/recurrent EC following response to prior systemic therapy.

Results: 113 patients with *TP53*wt EC received selinexor (n=77) or placebo (n=36) as maintenance therapy. Median follow-up was 28.9 months; 23 patients remain on treatment as of September 1, 2023. Median PFS (mPFS) was 27.4 months with selinexor versus 5.2 months with placebo (HR 0.41; 95% CI [0.25–0.69], nominal one-sided p=0.0002) (Figure 1). PFS improvement was observed regardless of microsatellite stability status; respective mPFS was not reached versus 4.9 months in the *TP53*wt/pMMR(MSS) subgroup and 13.1 months versus 3.7 months in the *TP53*wt/dMMR(MSI-H) subgroup. Updated trial data will be available at the time of presentation. Nausea, vomiting, and diarrhea were the most common adverse events (AEs); rates of diarrhea were comparable between treatment arms; 16% of patients discontinued selinexor due to AEs. One death occurred in the placebo group. **Figure 1**: Progression-free survival


TP53wt
Selinexor (N=77): 27.4 mo (95% CI 13.1–NR)
Placebo (N=36): 5.2 mo (95% CI 2.0–13.1)
HR: 0.41 (95% CI 0.25–0.69)
One-sided nominal p-value=0.0002
Probability of PFS
1.00
0.75
0.50
0.25
0
28.9 months of follow-up
0 3 6 9 12 15 18 21 24 27 30 33 36
Months
No. at risk
Selinexor 77 62 50 47 42 38 36 29 23 20 15 10 7
Placebo 36 22 17 17 12 10 10 7 7 7 5 4 4





Abbreviations: HR, hazard ratio; mo, months; NR, not reached; PFS, progression-free survival.

Conclusion/Implications: *TP53*wt status may represent a robust predictive biomarker for selinexor efficacy in EC. A strong PFS signal was observed regardless of microsatellite stability status, particularly in the *TP53*wt/pMMR subgroup, a patient population with high unmet need.

PO004 / #414

PLENARY 01: ORAL ABSTRACT PRESENTATIONS

Topic: *AS04. Endometrial/Uterine Corpus Cancers*

GNRH-A BASED FERTILITY-SPARING TREATMENT OF ATYPICAL ENDOMETRIAL HYPERPLASIA (AEH) AND EARLY ENDOMETRIAL CARCINOMA (EC) PATIENTS：A MULTICENTER, OPEN-LABEL, RANDOMIZED DESIGNED CLINICAL TRIAL

Qian Liu[1], Dongyan Cao[1], Huimei Zhou[1], Mei Yu[1], Jiaxin Yang[2], Tao Wang[1], Yongxue Wang[1], Jinhui Wang[1], Peng Peng[3], Ninghai Cheng[1], Keng Shen[1]
[1]Peking Union Medical College Hospital, beijing, China, [2]Peking Union Medical College Hospital, Beijing, China, [3]Peking union medical college hospital, Beijing, China

Introduction: For young patients diagnosed with AEH or EC, a fertility-preserving approach employing high-dose oral progesterone has been adopted. This study aims to execute a randomized controlled clinical trial to evaluate the efficacy and safety of GnRH-a based treatment.

Methods: The study is a randomized, investigator-initiated clinical trial evaluating the efficacy and safety of GnRH-a combined with letrozole or LNG-IUD(G group) versus progestin(P group). The participants were stratified based on whether BMI is ≥28 kg/m^2 and whether the lesion was recurrent and then they were randomly assigned in a 1:1 ratio.

Results: A total of 94 cases were enrolled.62 cases completed the assessment after 12 weeks of treatment. In the G group, 71.4%(25/35)achieved CR, 20.0%(7/35) achieved PR, 2 cases had SD, and 1 case had PD. In the P group, 37.0%(10/27) achieved CR, 55.6%(15/27) achieved PR, 1 case had PD, and 1 case had SD. The CR rate in the G group after 12 weeks of treatment was significantly higher than that in the progestin group (P=0.007).51 cases completed the evaluation after 24 weeks of treatment,the CR rates of the two groups were 97.0%(32/33) , 77.8%(14/18) respectively (P=0.047). At 24 weeks of treatment, the modified K score was 15.7±10.0 in the non-progestin group and 9.8±6.6 in the progestin group (P=0.008).The main adverse drug reactions were liver function impairment(2.1%) and abnormal vaginal bleeding(30.4%)

Conclusion/Implications: The GnRH-a based treatment has superior efficacy compared to traditional progestin therapy for patients with AEH and EC including those with recurrence and those with a BMI ≥ 28 kg/m^2.

PO005 / #134

PLENARY 02: ORAL ABSTRACT PRESENTATIONS

Topic: *AS10. Ovarian Cancer*

RISK OF MYELODYSPLASTIC SYNDROME (MDS) AND ACUTE MYELOID LEUKEMIA (AML) IN REAL-WORLD OVARIAN CANCER (AOC) PATIENTS TREATED WITH FIRST- OR SECOND-LINE MAINTENANCE PARP INHIBITORS (PARPI)

Alberto Farolfi[1], Nicola Gentili[1], Sara Testoni[1], Francesca Rusconi[2], Salvatore Burgio[1], Ilaria Massa[1], Valentina Danesi[1], Emilio Giunta[1], Nicole Brighi[1], Giorgia Gurioli[1], Daniela Montanari[1], Gema Ibarburu[2], Ugo De Giorgi[1]
[1]IRCCS IRST, Meldola, Italy, [2]TriNetX, Cambridge, United States of America

Introduction: The objective of this study was to estimate the risk of PARPi-related MDS/AML according to the line of treatment.

Methods: Using TriNetX Platform, we defined a cohort (experimental A) of 3,527 AOC patients treated with a first-line maintenance treatment with PARPi and a control cohort of 1,503 AOC patients underwent to at least two lines of a platinum-based chemotherapy and never treated with a PARPi. The third (experimental B) cohort included 356 AOC patients treated with PARPi after platinum-sensitive relapse. Cohorts were propensity score matched 1:1 (experimental A versus control and subsequently experimental B versus control) with respect to age, race, bevacizumab treatment and genetic susceptibility to neoplasms. Hazard ratio (HR) was used to compare the incidence of MDS/AML between the matched cohorts. The time window of observation in both analyses was 10 years.

Results: For the first analyses, propensity scoring generated 1,282 matched pairs, with a mean age of 59.8 (+/-10.2 SD). The overall incidence of MDS/AML showed no significant differences in the experimental A and control groups (1.25% vs 0.86%): HR = 2.06 (95% CI 0.94 - 4.51, p=0.064). For the second analyses, propensity scoring generated 263 matched pairs (mean age 60.2 +/-11.2). The incidence of MDS/AML was the same in experimental B and control cohort (10, 3.8%), HR = 1.76 (95%CI 0.42-7.37, p = 0.432). No differences across PARPi used were seen.

Conclusion/Implications: Our study shows real-world evidence that the use of PARPi as first-line or second-line maintenance treatment in patients with AOC does not increase the risk of MDS/AML.

PO006 / #421

PLENARY 02: ORAL ABSTRACT PRESENTATIONS

Topic: *AS03. Cervical Cancer*

TRENDS OF RADICAL HYSTERECTOMIES FOR CERVICAL CANCER FOLLOWING THE LACC TRIAL AND ASSOCIATED COMPLICATIONS: A NSQIP STUDY

Gabriel Levin[1], Pedro Ramirez[2], Raanan Meyer[3]
[1]Jewish General Hospital, Gynecological Oncology, Montreal, Canada, [2]Houston Methodist Hospital Neal Cancer Center, Obstetrics And Gynecology,, Houston, United States of America, [3]Division of Minimally Invasive Gynecologic Surgery, Department of Obstetrics and Gynecology, Cedar Sinai Medical Center, Los Angeles, CA, USA, Los Angeles, United States of America

Introduction: This study aimed to study the trends of route of radical hysterectomy during 2021-2020, and to evaluate post-operative complications rates before and after the LACC trial (2018).

Methods: A National Surgical Quality Improvement Program study. We included patients that underwent radical hysterectomy in the period 2012-2020. We excluded cases of vaginal radical hysterectomy.

Results: Overall, 2,984 patients were included, 1,531 (51.3%) underwent laparotomy and 1,453 (48.7%) underwent MIS radical hysterectomy. There was a significant decrease in MIS during 2018-2020 (50.4% MIS in 2018 to 13.5% MIS in 2020, p<.001). The proportion of minor complications was lower in the period before the LACC trial [317 (16.9%) vs. 148 (20.4%), p=.040]. Any complications or major complications proportions were comparable between groups (p=.138 and p=.266, respectively). The rate of superficial surgical site infection was lower in the period before the LACC trial [20 (1.1%) vs. 27 (3.7%), p<.001]. In a comparison of MIS radical hysterectomy vs. laparotomy radical hysterectomy during the entire study period (2012-2020). Patients in the MIS group had lower rates of any complications [238 (16.4%) vs. 399 (26.1%), p<.001] and minor complications [178 (12.3%) vs. 344 (22.5%), p<.001]. In a multivariable regression analysis of factors associated with the occurrence of any post-operative complications, route of radical hysterectomy was not independently associated with complications [aOR 95% CI 0.77 (0.46-1.28)].

Conclusion/Implications: While the proportion of MIS radical hysterectomy decreased abruptly and significantly following the LACC trial, there was no change in the rate of major post-operative complications.

PO007 / #167

PLENARY 03: ORAL ABSTRACT PRESENTATIONS

Topic: *AS03. Cervical Cancer*

CHANGES IN CERVICAL CANCER STAGE WITH THE INCORPORATION OF COMPUTED TOMOGRAPHY AND MAGNETIC RESONANCE IMAGING IN BOTSWANA

Magdalena Anchondo[1], Emily Macduffie[2], Jessica George[3], Megan Kassick[2,4], Rebecca Ketlametswe[4], Barati Monare[4], Lisa Bazzett-Matabele[5], Peter Vulysteke[6], Surbhi Grover[2,4]
[1]University of Texas Southwestern Medical Center, Dallas, United States of America, [2]University of Pennsylvania, Radiation Oncology, Philadelphia, United States of America, [3]University of California, Irvine, Information And Computer Sciences, Los Angeles, United States of America, [4]Botswana-UPenn Partnership, Gaborone, Botswana, [5]University of Botswana, Obstetrics & Gynaecology, Gaborone, Botswana, [6]University of Botswana, Medical Oncology, Gaborone, Botswana

Introduction: Cervical cancer is the most common cause of cancer-related mortality in Botswana. Since September 2022, it has become feasible in Botswana to get cross-sectional imaging for all patients with cancer. This study describes stage changes after incorporation of radiographic staging.

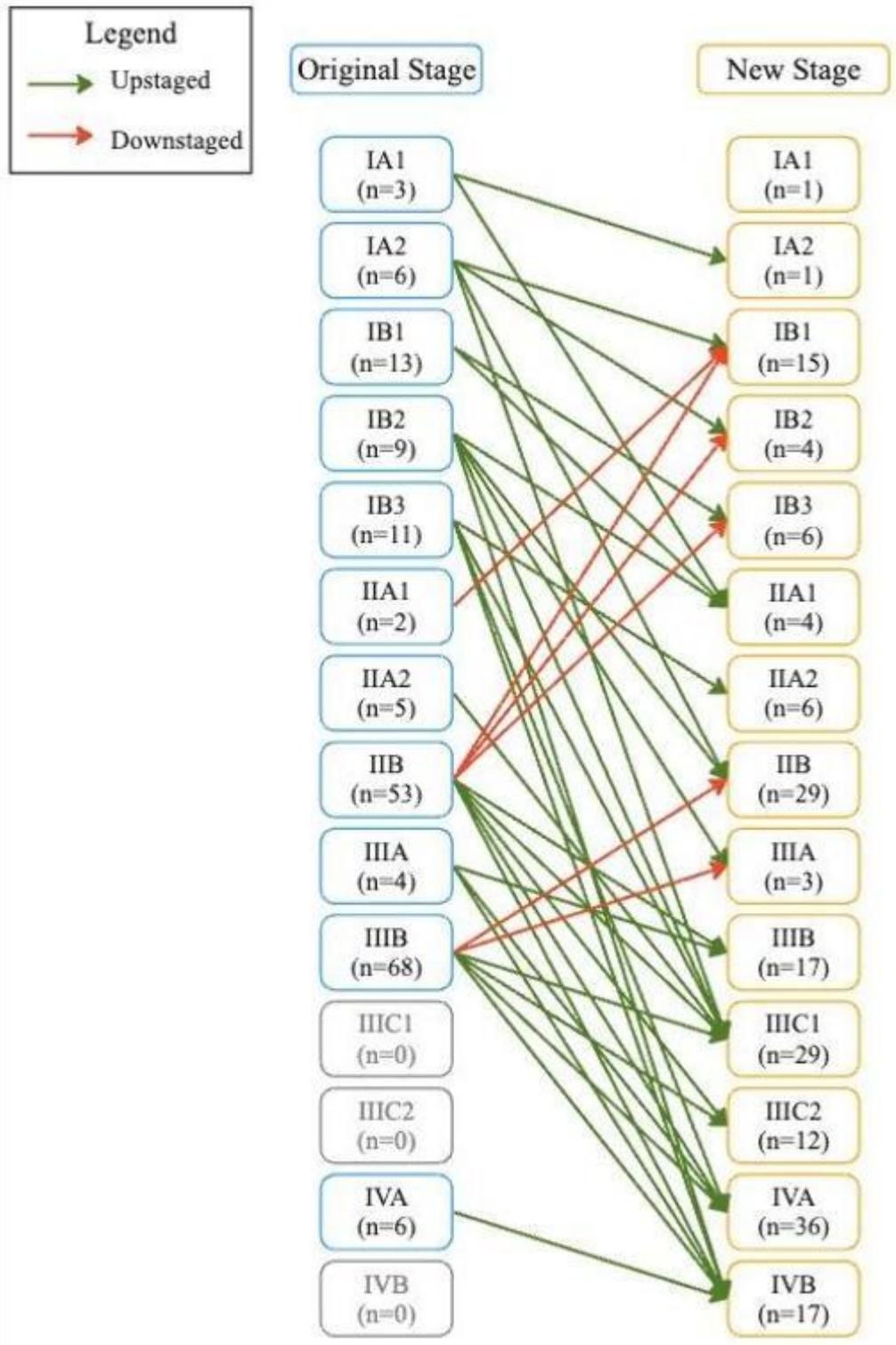
Methods: Patients with pathologically confirmed cervical cancer in Gaborone, Botswana were retrospectively reviewed between September 2022 and December 2023. Initial clinical staging included chest x-ray, abdominal/pelvic ultrasound, and physical exam. Radiographic staging was completed with CT or MR imaging. Only curative patients were referred for imaging. Data was analyzed with descriptive statistics.

Results: Overall, 180 patients were reviewed. Median age was 49 (IQR: 43-59) years and 121 (67.2%) women were living with HIV. By clinical staging, 42 were stage I, 60 stage II, 72 stage III, and 6 stage IV. After radiographic staging, 27 were stage I, 39 were stage II, 61 were stage III, and 53 were stage IV (Table 1). Overall, 108 (60.0%) patients were upstaged, 7 (3.9%) were downstaged, and 65 (36.1%) did not change stage (Figure 1). Among those upstaged, 61 (56.5%) had a change in treatment plan, including 11 (10.2%) patients prescribed chemoradiation rather than surgery and 50 (46.3%) patients upstaged to IVA or IVB warranting induction chemotherapy or palliative radiation rather than upfront concurrent chemoradiation.

Conclusion/Implications: Implementation of cross-sectional imaging resulted in stage changes for over half of patients, resulting in treatment changes for approximately one-third of all patients. Public insurance coverage of imaging for staging could significantly improve treatment outcomes for cervical cancer patients in Botswana.

Stage	Original stage, n (%)	New stage, n (%)
I	42 (23.3)	27 (15.0)
IA1	3 (1.7)	1 (0.6)
IA2	6 (3.3)	1 (0.6)
IB1	13 (7.2)	15 (8.3)
IB2	9 (5.0)	4 (2.2)
IB3	11 (6.1)	6 (3.3)
II	60 (33.3)	39 (21.7)
IIA1	2 (1.1)	4 (2.2)
IIA2	5 (2.8)	6 (3.3)
IIB	53 (29.4)	29 (16.1)
III	72 (40.0)	61 (33.9)
IIIA	4 (2.2)	3 (1.7)
IIIB	68 (37.8)	17 (9.4)
IIIC1	0 (0.0)	29 (16.1)
IIIC2	0 (0.0)	12 (6.7)
IV	6 (3.3)	53 (29.4)
IVA	6 (3.3)	36 (20.0)
IVB	0 (0.0)	17 (9.4)

Values are presented as number (percentage).


Legend
Upstaged
Downstaged
Original Stage
New Stage
IA1 (n=3)
IA2 (n=6)
IB1 (n=13)
IB2 (n=9)
IB3 (n=11)
IIA1 (n=2)
IIA2 (n=5)
IIB (n=53)
IIIA (n=4)
IIIB (n=68)
IIIC1 (n=0)
IIIC2 (n=0)
IVA (n=6)
IVB (n=0)
IA1 (n=1)
IA2 (n=1)
IB1 (n=15)
IB2 (n=4)
IB3 (n=6)
IIA1 (n=4)
IIA2 (n=6)
IIB (n=29)
IIIA (n=3)
IIIB (n=17)
IIIC1 (n=29)
IIIC2 (n=12)
IVA (n=36)
IVB (n=17)

PO008 / #619

PLENARY 04: ORAL ABSTRACT PRESENTATION

Topic: *AS10. Ovarian Cancer*

A MULTICENTRE, PROSPECTIVE COHORT STUDY INVESTIGATING DIAGNOSTIC ACCURACY IN WOMEN WITH SYMPTOMS OF SUSPECTED OVARIAN CANCER (THE ROCKETS STUDY): RESULTS FOR PRE-MENOPAUSAL WOMEN.

Sudha Sundar[1], Ridhi Agarwal[2], Katie Scandrett[2], Clare Davenport[2], Sue Mallett[3], Partha Sengupta[4], Susanne Johnson[5], Radhika Selvi-Vikram[6], Caroline Rick[7], Sean Kehoe[8], Dirk Timmerman[9], Tom Bourne[10], Ben Van Calster[9], Hilary Stobart[11], Richard Neal[12], Usha Menon[3], Alex Gentry-Maharaj[3], Lauren Sturdy[2], Ryan Ottridge[2], Jon Deeks[2]
[1]University of Birmingham, Gynaecological Cancer Surgeon and Clinical Academic, Birmingham, United Kingdom, [2]University of Birmingham, Birmingham, United Kingdom, [3]University College London, London, United Kingdom, [4]County Durham and Darlington NHS trust, Durham, United Kingdom, [5]Southampton University Hospitals, NHS trust, Southampton, United Kingdom, [6]West Hertfordshire Hospitals NHS trust, West Hertfordshire, United Kingdom, [7]University of Nottingham, Nottingham, United Kingdom, [8]St Peter's College - University of Oxford, Oxford, United Kingdom, [9]University Hospitals Leuven, Leuven, Belgium, [10]Imperial College London, London, United Kingdom, [11]Patient advocate, Uk, United Kingdom, [12]University of Exeter, Exeter, United Kingdom

Introduction: ROCkeTS investigated accuracy of risk prediction models; no previous studies investigate all tests as head-to-head comparisons.

Methods: Study design – prospective cohort study.

Recruitment – newly presenting premenopausal women with non-specific symptoms and raised CA125 and/or abnormal imaging underwent Risk of malignancy algorithm (ROMA) testing and International Ovarian tumour analysis (IOTA) ultrasound performed mainly by sonographers.

Index tests – IOTA ADNeX model 3% and 10% thresholds, RMI1 at 200, ROMA at ≥13.1%, ≥12.5%, ≥11.4% (manufacturer recommended threshold), ≥7.4% and CA125 at 87IU/ml. Posthoc ORADS at 10%.

Comparator – Risk of Malignancy index (RMI1) at 250.

Reference standard – Tissue biopsy/cytology within 3 months or 12 months follow-up.

Primary outcome – Sensitivity, specificity, c-index (area under Receiver operating characteristic (ROC) curve), PPV and Negative Predictive value (NPV), calibration plot.

Results: 1123 premenopausal women recruited from 23 hospitals, 88 (7.3%) had primary OC, majority early stage (53/88, 60%). For primary outcome, in comparison to RMI 1 250, sensitivity 40.3% **(**28.1, 53.6), specificity 96.4% (94.9, 97.6); IOTA ADNEX at 10% was more sensitive (difference of 50.0% CI 64.3, 35.7), p<0.001 but less specific (difference of 23.0%, CI 19.7, 26.3), p<0.001, ROMA at manufacturer recommended threshold of 11.4 was more sensitive (difference of 38.3% CI 53.1 - 23.5), p<0.001, but less specific, (difference of 22.1% CI 18.7, 25.5), p<0.001.

Conclusion/Implications: Compared to RMI, IOTA ADNEX at 10% showed highest sensitivity but lower specificity, ROMA at 11.4% achieved good sensitivity but similar specificity to IOTA ADNEX at 10%. IOTA ADNEX at 10% should be standard of care diagnostic test for premenopausal women.

PO009 / #913

PLENARY 04: ORAL ABSTRACT PRESENTATION

Topic: *AS20. Survivorship*

IMPLEMENTATION OF A VIRTUAL PROVINCIAL GYNECOLOGIC CANCER PREVENTION AND SURVIVORSHIP CLINIC (GCPSC) IN CANADA

LESA M DAWSON, MD; SUSAN KEAST, RN; JANICE S KWON, MD. MPH; KATE FANG, R.TCMP; KATE PARK; CHRISTINA LAM; GILLIAN HANLEY, PHD; GAVIN CE STUART, MD
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, UNIVERSITY OF BRITISH COLUMBIA, VANCOUVER COASTAL HEALTH, VANCOUVER, BRITISH COLUMBIA, CANADA

Lesa Dawson[1], Susan Keast[2], Janice Kwon[1], Kate Fang[3], Kate Park[3], Christina Lam[3], Gillian Hanley[1], Gavin Stuart[1]
[1]University of British Columbia, Department Of Obstetrics And Gynecology, Vancouver, Canada, [2]Vancouver Coastal Health, Vancouver, Canada, [3]Gynecologic Cancer Prevention and Survivorship Program, Vancouver, Canada

Introduction: GCPS was established in 2021 to address the challenges of low initiation and compliance with hormone replacement therapy (HRT) among individuals undergoing premature menopause after cancer treatment or risk-reducing salpingo-oophorectomy. The primary objectives were to improve genetics and survivorship care, focusing on enhanced menopause support. This abstract presents the program's model, demographics, and patient experience data collected to date.

Methods: Founded by two physicians, an advanced-practice nurse, and two clinical coordinators, GCPS offers virtual one-hour initial visits and 30-minute follow-ups. All research-enrolled patients were administered baseline questionnaires assessing knowledge, attitudes, and beliefs regarding HRT.

Results: 383 patients from all provincial health regions have been seen in 911 visits. Average age 45y (24-76). Referrals came primarily from oncologists (46%) and clinical geneticists (32%). Pathogenic variants were found in 55% of patients: *BRCA 1/2* (91/88), Lynch Syndrome (37). Gynecologic cancer affected 23%, breast cancer 12%. 62% of women reported good or excellent knowledge of HRT. Only 32% agreed that their family physician was knowledgeable about hereditary cancer risk and HRT. In contrast to a previous population-based study where 50% were ever prescribed HRT after premature surgical menopause, 81.3% of patients in this service were prescribed >1 menopausal management medication, highlighting proactive care.

Conclusion/Implications: The GCPS has proven to be an in-demand and valuable service by addressing the needs of individuals facing premature iatrogenic menopause. By enhancing HRT compliance and knowledge, the program demonstrates its potential

to improve patient outcomes. Significantly, these achievements were attained with modest institutional costs, highlighting the feasibility and efficacy of this model.

PO010 / #730

PLENARY 04: ORAL ABSTRACT PRESENTATION

Topic: *AS21. Symptom Management/Supportive Cancer Care*

THE IMPACT OF FRAILTY ON ONCOLOGIC AND SURVIVAL OUTCOMES IN PATIENTS WITH GYNECOLOGIC CANCERS: A POPULATION-BASED STUDY

Julie Mv Nguyen[1], Tiffany Zigras[2], Anastasia Gayowsky[3], Andrew Costa[4], Maura Marcucci[5], Danielle Vicus[2], Liat Hogen[2], Richard Perez[4]
[1]McMaster University, Division Of Gynecologic Oncology, Department Of Obstetrics And Gynecology, Hamilton, Canada, [2]University of Toronto, Division Of Gynecologic Oncology, Department Of Obstetrics And Gynecology, Toronto, Canada, [3]ICES McMaster University, Hamilton, Canada, [4]McMaster University, Department Of Health Research Methods, Evidence And Impact, Hamilton, Canada, [5]Humanitas University, Clinical Epidemiology And Research Centre (cerc), Department Of Biomedical Sciences, Milan, Italy

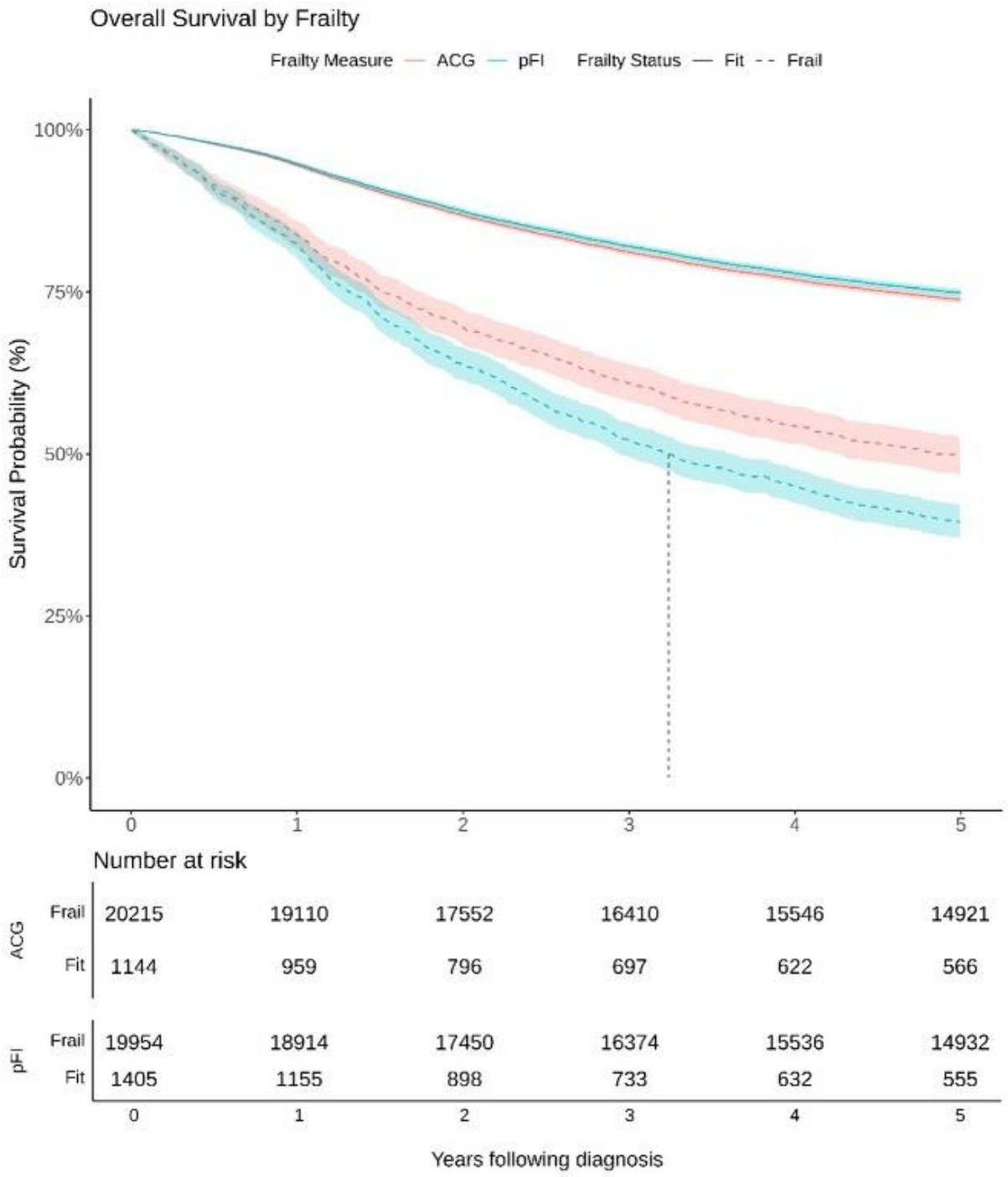
Introduction: There is limited literature on the impact of frailty on oncologic outcomes. We sought to evaluate survival outcomes in a gynecologic oncology population.

Methods: Using province-wide administrative data, patients undergoing a laparotomy for a gynecologic malignancy between 2009-2021 were identified. Frailty was defined using the preoperative frailty index(pFI) and the John Hopkins Adjusted Clinical Groups frailty indicator(ACG). Hazard ratios (HR) were calculated using multivariable cox regression models. Kaplan-Meier curves were used to describe 5-year survival.

Results: Of 21,359 patients, 1,405(6.6%) and 1,144(5.4%) were frail using the pFI and ACG, respectively. On multivariable regression analysis adjusting for age, primary cancer, stage, and Charlson comorbidity score, frailty was associated with lower 5-year survival (pFI: HR 1.3, 95% CI 1.2-1.42, p<0.0001, ACG: HR 1.56, 95% CI 1.43-1.70, p<0.0001). By cancer type, frailty was associated with adverse 5-year survival for endometrial cancer (HR 1.60, 95% CI 1.39-1.88, p<0.0001, ACG: 1.77, 95% 1.55-2.03, p<0.0001), and ovarian/primary peritoneal/tubal cancer (pFI: HR 1.16, 95% CI 1.03-1.30, p=0.01, ACG: 1.38, 95% CI 1.21-1.56, p<0.0001), and but not for cervical cancer (pFI: HR 0.78, 95% CI 0.37-1.66, p=0.52, ACG: 1.74, 95% CI 0.94=3/24, p=0.08). Frailty(pFI) was not associated with a different interval to initiation of adjuvant chemotherapy for ovarian cancer (pFI: mean 6 weeks(standard deviation(SD) 4.3) vs 6.5 weeks(SD 4.8), p=0.08, ACG: mean 6.6 weeks(SD 4.9), vs 6.5 weeks(SD 4.7), p=0.71).

Table 1: Multivariable analysis for overall survival, full cohort

Variable	Value	pEI Frailty Indicator				ACG Frailty Indicator			
		Hazard Ratio	Lower	Upper	p-value	Hazard Ratio	Lower	Upper	p - value
Frailty indicator	Not frail (REF)	1.00	-	-	<.0001	1.00	-	-	<.0001
	Frail	1.30	1.20	1.42		1.56	1.43	1.70	
Age group (years)	<50 (REF)	1.00	-	-		1.00	-	-	
	50-59	1.42	1.29	1.57		1.42	1.28	1.57	
	60-69	1.76	1.60	1.94	<.0001	1.77	1.61	1.95	<.0001
	70-79	2.43	2.19	2.68		2.47	2.24	2.73	
	≥ 80	4.00	3.57	4.49		3.99	3.56	4.47	
Cancer diagnosis	Ovarian/tubal/primary peritoneal	1.61	1.51	1.71		1.61	1.52	1.71	
	Cervical	0.56	0.46	0.67		0.56	0.47	0.68	
	Endometrial/uterine (REF)	1.00	-	-	<.0001	1.00	-	-	<.0001
	Vulvar/Vaginal	1.60	1.37	1.86		1.59	1.36	1.85	
	Other gynecologic malignancy	1.86	1.38	2.51		1.89	1.40	2.55	
Cancer stage	Early (REF)	1.00	-	-		1.00	-	-	
	Advanced	4.46	4.12	4.83	<.0001	4.46	4.12	4.83	<.0001
	Missing	2.60	2.39	2.83		2.59	2.38	2.83	
Charlson comorbidity score	0 (REF)	1.00	-	-		1.00	-	-	
	1-2	1.15	1.06	1.24	<.0001	1.15	1.06	1.24	<.0001
	3+	1.99	1.85	2.15		2.12	1.97	2.27	
	Missing	1.05	0.98	1.13		1.06	0.99	1.14	



Conclusion/Implications: Frailty was significantly associated with adverse long-term oncologic survival, particularly in those with endometrial and ovarian cancer. Future research on the management of frailty is warranted.