Poster (C13)

Cervical Cancer

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Treatment outcomes in early stage cervical cancer: experience of a gynecological oncology unit from India

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Objective: To analyze and critically evaluate the clinico-pathological features and survival outcomes of early stage cancer cervix patients and to reclassify all histopathology reports according to new International Federation of Gynecology and Obstetrics (FIGO) 2018 staging classification and compare their survival outcome.

Methods: A retrospective observational analysis was done from 1st June 2013 to 31st May 2018; over a period of 5 years for patients who underwent radical hysterectomy followed by risk-based adjuvant therapy in our center and later patients were analyzed and evaluated for clinic-pathological features and survival outcome. Patients were reclassified as per histopathology reports according to new FIGO 2018 and their survival outcome were compared with old FIGO staging.

Results: The 100 patients of early-stage cancer cervix were studied. All patients underwent open radical hysterectomy with bilateral pelvic lymph node dissection. The median age of the study population was 52.5 years with median follow up of 62.1 months. The overall survival and relapse free survival were 87.5% and 91.4%, respectively. The study population was then reclassified according to new FIGO 2018 staging. It was seen that the patients with stage IB1 and IB2 cervical cancer had overall survival of 91.1% and 90%, respectively. The overall survival of stage IB3 was 80% and the survival of stage IIC1 was only 60%.

Conclusion: Early stage cancer cervix have good overall survival outcome when treated appropriately with surgery and risk based tailored therapy.

Poster (C14)

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After the laparoscopic approach to cervical cancer (LACC) trial: minimally invasive surgery for early cervical cancer

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Objective: The aim of this study was to compare minimally invasive surgery (MIS) with open abdominal radical hysterectomy (RH) in patients with early-stage cervical cancer after major prospective study called laparoscopic approach to cervical cancer trial in November 2018.

Methods: A retrospective data analysis was performed on patients who underwent surgery at our hospital for early-stage cervical cancer from January 2019 to September 2020. Surgery was compared with classical RH and MIS (laparoscopic, robotic). The patient's stage was IA2–IB2 based on the 2018 International Federation of Gynecology and Obstetrics stage, and the pathology was squamous cell carcinoma, adenocarcinoma, and adenosquamous type.

Results: A total of 149 patients with stage IA2–IB2 cervical cancer were analyzed retrospectively. The 76 patients (48.1%) received MIS (laparoscopic: 56, robotic: 20) and 82 patients (51.9%) underwent open RH surgery. Median follow-up was 23.5 months (range: 13–33). One person who received laparoscopic RH out of a total of 149 people recurred. Complications occurred in 1 case during surgery and 4 case after surgery for open RH, 0 during surgery and 2 after surgery for MIS. There were no other significant differences in the amount of bleeding or length of hospital stay.

Conclusion: Despite of short-term follow up period in our data, there was no difference in the oncological outcome between the 2 groups. Microinvasive surgery can be considered through sufficient discussion with the patient in the case of early stage.

Poster (C15)

Cervical Cancer

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Association of pattern-based classification system to survival outcome in women with cervical adenocarcinoma

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Objective: To assess the survival outcome and recurrence according to pattern-based classification system of cervical adenocarcinoma.

Methods: A retrospective cohort study was conducted in women pathologically diagnosed of endocervical adenocarcinoma (ECA) underwent primary surgery at Rajavithi Hospital during January 2012 and December 2017. Post-operative pathologic slides were reviewed according to the pattern-based classification system. Survival outcome and recurrence were

calculated and analyzed.

Results: A total of 66 patients was eligible for analyses, including 53 patients with usual type and 13 patients with mucinous type of ECA. Patients were classified according to the pattern-based system into pattern A of 21.2%, pattern B of 22.7% and pattern C of 56.1%. Lymph node metastasis were detected 0.0%, 6.7% and 27% in pattern A, B and C, respectively. No recurrence transpired in pattern A and B. However, 5 patients (13.5%) with pattern C recurred during median follow up time of 49.5 months. The 5-year recurrence-free survival rates were not significantly different (pattern A 100%, B 100% and C 86.3%). On the contrary, the 5-year overall survival rates were significantly different among the 3 patterns (pattern A 100%, B 93.3% and C 72.9%) ($p=0.039$). The Silva Pattern-based classification is the significant prognostic factors for overall survival (hazard ratio=5.36; 95% confidence interval=1.26–25.76; $p=0.021$).

Conclusion: ECA patients with pattern A, according to the pattern-based classification system, have excellent prognosis without lymph node metastasis. Contrastingly, pattern C tumor associated with the worse overall survival, higher rate of recurrence and lymph node metastasis.

Poster (C16)

Cervical Cancer

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Diagnosis and treatment cervical cancer in early pregnancy: one case report

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Objective: Recently, the incidence of gynecological malignant tumors during pregnancy has increased, mainly due to increased age of pregnant. The most common gynecological malignancy in pregnancy is cervical cancer, accounting for 71.6%, followed by ovarian malignancy, accounting for 7.0%. Cervical cancer during pregnancy fortunately is diagnosed at an early stage. It is important to highlight that the oncologic outcome of cervical cancer during pregnancy is not different from nonpregnant patients, noting that the impact of pregnancy on tumor biology remains unclear. A delay in treatment to achieve fetal viability or to improve outcome of the fetus may be an option for patients with early-stage cervical cancer.

Methods: A 38-year-old patient G4P3 presented to Maternity and Neonatology Cipto Mangunkusumo National General Hospital Jakarta with a subsequent diagnosis of a squamous cell

moderately differentiated cervical invasive carcinoma confirmed by biopsy. A 2×1.5 cm tumor on the anterior lip of the cervix spread to left fornix with no evidence of parametrial or vaginal involvement was found on physical examination (International Federation of Gynaecology and Obstetrics 2018 stage IIAI). An abdominal and pelvic magnetic resonance imaging (MRI) was ordered. The study revealed heterogeneity in the anterior aspect of the uterine cervix (dimensions not provided by radiologist). No suspicious lymph nodes or parametrial involvement and no evidence of tumor infiltration in the vagina was noted. Given the results of the MRI and the last menstrual period, an ultrasound was requested which confirmed that the patient was intra uterine 7 weeks pregnant. The case was discussed in the Ethics and Law Committee of the Cipto Mangunkusumo National General Hospital and the forensic and medicolegal departments. Tumor Committee and the following options were entertained. If the patient wished to preserve her pregnancy, our recommendation would be to proceed an option of neoadjuvant chemotherapy after 15 weeks and Cesarean section at 32 weeks followed by radical hysterectomy. We also discussed that if the patient decided to end her pregnancy, then proceed with recommendation of pregnancy termination plus type C1 radical hysterectomy with ovarian preservation. The decision was made with the patient who decided to undergo a radical hysterectomy with bilateral lymphadenectomy with ovarian preservation and this was performed at 11 weeks' gestation. Histologically consistent with nonkeratinizing, moderately differentiated squamous cell carcinoma. No lymphovascular invasion was found. The deepest invasion was found to reach 5 mm of the 10 mm thickness of the cervical wall. There was no tumor mass found at the vaginal incision margin. The right and left parametrial preparations did not reveal a tumor mass. Found 21 right pelvic lymph nodes, all found no tumor mass. Found 15 left pelvic lymph nodes, all found no tumor mass. The patient did not require adjuvant therapy.

Results: Analysis of prognosis of cervical cancer during pregnancy shows no negative impact of pregnancy on the outcome of patients; therefore, pregnancy-preserving management should be considered initially. Pregnancy non-preserving management is chosen in advanced disease (stage IIB or higher or lymph node metastases) or in cases when the patient chooses not to preserve her pregnancy (based on local legislation and usually until the 24th week of gestation). Treatment is thus planned without intention to preserve the fetus. In case of an operable disease (IA2–IB2), a radical hysterectomy with fetus in utero (during the 1st or early-2nd trimester) or after hysterotomy (during the late 2nd trimester) can be performed. In IB3 and higher stages, during first trimester chemoradiation can be applied with the fetus