The 43rd Meeting of the New England Association of Gynecologic Oncologists

North Falmouth, Massachusetts

June 7 – 9, 2024

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New England Association of Gynecologic Oncologists

Preamble

In Sturbridge, Massachusetts at the Public House on the Common, a group of physicians from the several states and commonwealths of Connecticut, Massachusetts, Maine, Rhode Island and Vermont were gathered in the afternoon of Saturday, the eighth day of March in the year A.D. nineteen hundred and eighty. These physicians proclaim their existence as gynecologic oncologists in order to advance the practice and science of gynecologic oncology in New England and agree that an organization for such a purpose should be formed and sustained.

It was decreed that this organization henceforth should be known as the New England Association of Gynecologic Oncologists.

It was agreed that invitations to membership should be extended to those who have distinguished themselves by their accomplishments and their extraordinary contributions to the practice and science of gynecologic oncology.

It was agreed that the purpose of the association was to improve patient care by: (1) Enhancing the exchange of medical knowledge among New England physicians treating patients with gynecologic malignancies. (2) Providing a forum for increased communication among gynecologic oncologists in New England which should foster collaborate studies. (3) Encouraging a feeling of camaraderie among gynecologic oncologists and others with common interests.

I hereby agree to the bylaws of this preamble and accordingly affix my signature on Saturday, October 18, 1980.

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The 43rd Meeting of the New England Association of Gynecologic Oncologists

PAST NEAGO MEETINGS AND PRESIDENTS

YEAR	LOCATION	PRESIDENT
1980-1981	Treadway Inn, Newport, RI	Murray Joseph Casey, MD
1981-1982	Black Point Inn, Prouts Neck, ME	Charles R. Boyce, MD
1982-1983	Pleasant Bay, Chatham, MA	Henry C. McDuff, Jr., MD
1983-1984	Woodstock Inn, Woodstock, VT	Thomas Leavitt, MD
1984-1985	Trapp Family Lodge, Stowe, VT	Jerome Belinson, MD
1985-1986	New Seabury, Cape Cod, MA	C. Thomas Griffiths, MD
1986-1987	Inn by the Sea, Cape Elizabeth, ME	Charles L. Easterday, MD
1987-1988	The Hilton Inn, Mystic, CT	Stephen L. Curry, MD
1988-1989	Bar Harbor Inn, Bar Harbor, ME	Ernest I. Kohorn, MD
1989-1990	Sheraton Sturbridge Resort, Sturbridge, MA	Richard E. Hunter, MD
1990-1991	The Equinox, Manchester, VT	Robert C. Knapp, MD
1991-1992	Newport Islander, Newport, RI	John C. Lathrop, MD
1992-1993	Chatham Bars Inn, Chatham, MA	Peter E. Schwartz, MD
1993-1994	Harbor House, Nantucket, MA	Arlan F. Fuller, MD
1994-1995	The Williams Inn, Williamstown, MA	William J. Hewett, MD
1995-1996	The Cliff House, Ogunquit, ME	Harrison G. Ball, MD
1996-1997	Ocean Edge, Brewster, MA	Najmosama T. Nikrui, MD
1997-1998	The White Mountain Hotel, N. Conway, NH	Joseph T. Chambers, MD
1998-1999	The Westin, Providence, RI	C.O. Granai, MD
1999-2000	Cranwell Resort, Lenox, MA	Jonathan M. Niloff, MD
2000-2001	Topnotch Resort and Spa, Stowe, VT	Setsuko K. Chambers, MD
2001-2002	Harbor View Hotel, Martha's Vineyard, MA	James S. Hoffman, MD
2002-2003	Black Point Inn, Prouts Neck, ME	Hector M. Tarraza, MD
2003-2004	Chatham Bars Inn, Chatham, MA	Walter H. Gajewski, MD
2004-2005	Mt. Washington Resort, Bretton Woods, NH	Robert McLellan, MD
2005-2006	The Equinox, Manchester Village, VT	Michel Prefontaine, MD
2006-2007	The Colony Hotel, Kennebunkport, ME	Annekathryn Goodman, MD
2007-2008	The Wequassett Resort, Chatham, MA	Michael Muto, MD
2008-2009	Wentworth-by-the-Sea, New Castle, NH	Leslie DeMars, MD
2009-2010	Spruce Point Inn, Booth Bay Harbor, ME	Beth Nelson, MD
2010-2011	Stowe Mountain Lodge, Stowe, VT	Valena Soto-Wright, MD
2011-2012	Bar Harbor Regency, Bar Harbor, ME	Marcela del Carmen, MD
2012-2013	Water's Edge Resort & Spa, Westbrook, CT	John Schorge, MD
2013-2014	Hyatt Regency, Goat Island, Newport, RI	Richard G. Moore, MD
2014-2015	The Colony Hotel, Kennebunkport, ME	Susan Zweizig, MD
2015-2016	Ocean Edge, Brewster, MA	Colleen Feltmate, MD
2016-2017	The Hilton Mystic, Mystic, CT	Amy Brown, MD, MPH
2017-2018	The Cliff House, Cape Neddick, ME	Emmanuel Soultanakis MD
2018-2019	Omni Mount Washington, Bretton Woods, NH	Dave Boruta, MD
2019-2020	The Equinox, Manchester Village, VT *(Canceled due to pandemic.)*	Cheung Wong, MD
2020-2021	Held virtually *(Due to pandemic.)*	Cheung Wong, MD
2021-2022	Hotel Viking, Newport, RI	Katina Robison, MD
2022-2023	Portland Regency Hotel, Portland, ME	Leslie Bradford, MD

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Past Award Winners

DIANNON PRIZE

(For the best paper presented by a trainee)

1922 Bjorn Bjornsson, MD
1993 Ricardo Saniz de la Cuesta, MD
1994 Iris Wertheim, MD
1995 Thomas Rutherford, MD
1996 Mitchell Edelson, MD
1997 Annette Chen, MD
1998 Donald Wiper, MD
1999 John Schorge, MD

TRAINEE AWARD

1999 Karen Houck, MD
2000 Eugene P. Toy, MD
2001 Richard Moore, MD
2002 Robert DeBernardo, MD
2002 Tanja Pejovic, MD
2003 Laurent Brard, MD
2003 E. Colin Koon, MD, PhD
2004 E. Colin Koon, MD, PhD
2004 Ami Vaidya, MD
2005 Michael J. Callahan, MD
2005 Viven Lee, MD
2006 Katina Robison, MD
2006 Michael Kelley, MD
2007 Eloise Chapman (Clinical)
2007 Emily M. Ko, MD (Clinical)
2007 Katina Robison, MD (Basic Science)
2007 Alexander Olawaiye, MD (Basic Science)
2008 Moune Jabre-Raughley, MD (Clinical)
2008 Leslie Garrett, MD (Basic Science)
2009 Jason Knight, MD (Clinical)
2009 Whitfield Growdon, MD (Basic Science)
2010 Megan Wright, MD (Clinical)
2010 Katrin Kristjansdottir, MD (Basic Science)
2011 Elizabeth Lokich, MD (Clinical)
2011 Leslie Bradford, MD (Basic Science)
2012 Jessica Hsieh, MD (Clinical)
2012 Rachel Clark, MD (Basic Science)
2013 Kevin Elias, MD (Basic Science)
2013 Emily Hill, MD (Basic Science)
2014 Amy Bregar, MD (Clinical)
2014 Elizabeth Lokich, MD (Basic Science)
2014 Carlton Schwab, MD (Basic Science)
2015 Jonathan Black, MD (Basic Science)
2015 Kevin Elias, MD (Basic Science)
2015 Katelyn Dorney, MD (Clinical)
2016 Jenna Emerson, MD (Clinical)
2016 Kevin Elias, MD (Basic Science)
2017 Roni Nitecki, MD (Clinical)
2017 Matthew Oliver, MD (Basic Science)
2018 Searching for Award Winner (Clinical)
2018 Lindsey Beffa, MD (Basic Science)
2019 Deanna Glassman (Clinical)
2019 Jenna Emerson (Basic Science)
2020 No awards given (Meeting canceled)
2021 No awards given (Virtual; no abstracts)
2022 Kaitlin Nicholson, MD (Basic Science)
2022 Kate Kurchena, MD (Clinical)
2022 Julia Dexter, MD NEAGO Collaborative)
2023 Jessica St. Laurent, MD (Basic Science)
2023 Sha Sha, MD (Clinical)

PROGRAM

Friday, June 7, 2024

11:00 am *(Nauset Upper Lobby)*	**Member/Guest Registration**
11:00 am *(Nauset IV & V)*	**Exhibition Hall Opens**
12:00 -1:00 pm *(Nauset III)*	**Industry Session: Speaker Lunch sponsored by GlaxoSmithKine** **Title:** *"A Treatment Option for Patients with Primary Advanced or Recurrent dMMR/MSI-H Endometrial Cancer"* **Speaker:** Dario Roque, MD *Gyn Oncologist at Northwestern Medicine* *Director, Gyn Oncology Fellowship – Northwestern Medicine* *Associate Professor, Dept. of Ob/Gyn – Feinberg School of Medicine*
1:05-1:10 pm *(Nauset I & II)*	**Presidential Welcome:** *Ashley Stuckey, MD*
1:15-2:45 pm *(Nauset I & II)*	**FIRST SCIENTIFIC SESSION** *(Abstract Schedule on Pages 10-11)*
2:45-3:10 pm *(Nauset IV & V)*	**Break with Coffee, Snacks and Exhibits**
3:10-4:45 pm *(Nauset I & II)*	**SECOND SCIENTIFIC SESSION** *(Abstract Schedule on Page 12)*
5:00pm *(Nauset IV & V)*	**Exhibits Close**
5:00-6:30 pm *(Nauset I & II)*	**"Introspective" Tumor Board: Sponsored by Eisai, Inc.** **Title:** *"Continuing the Good Fight"* *with Dario Roque, MD, Aaron Shafer, MD and Sarah Paraghamian, MD*
6:30-7:30 pm *(Volleyball Court)*	**Cocktail Reception … *families welcome and bring your sandals!***

PROGRAM

Saturday, June 8, 2024

7:00 am *(Nauset Upper Lobby)*	**Registration Opens**
7:00-9:00 am *(Nauset III, IV & V)*	**Breakfast Buffet and Exhibition Hall Open**
7:30-8:30 am *(Nauset III)*	**Industry Session: Speaker Breakfast sponsored by AstraZeneca** **Title:** *"LYNPARZA as Maintenance Monotherapy or Combination Therapy in Advanced Ovarian Cancer: Results from Key Clinical Trials"* **Speaker:** Sharyn Lewin, MD, FACS *Director, Division of Gynecologic Oncology - Holy Name of Teaneck, NJ* *President and Executive Director, The Lewin Fund to Fight Women's Cancer*
8:40-10:20 am *(Nauset I & II)*	**THIRD SCIENTIFIC SESSION** *(Abstract Schedule on Page 13-14)*
10:20-10:40 am *(Nauset I & II)*	**GRANT AWARD PRESENTATIONS** *(Grant Award Titles and Presenters on Page 14)*
10:40-11:00 am *(Nauset IV & V)*	**Break with Coffee and Exhibits**
11:00 am-12:00 pm *(Nauset I & II)*	**FOURTH SCIENTIFIC SESSION** *(Abstract Schedule on Page 15)*
12:15-1:15 pm *(Nauset I & II)*	**Keynote Address** "Houston, We Have a Problem: *How Changes in Gynecologic Oncology Represent Broader Concerns for the Future of Obstetrics and Gynecology*" **Speaker:** Warner K. Huh, MD, FACOG, FACS *Chair, Department of Ob/Gyn; Professor, Dept. of Ob/Gyn and Surgery;* *Professor, Dept. of Epidemiology, UAB School of Public Health;* *Senior Scientist, O'Neal Comprehensive Cancer Center*
1:45 pm	**Exhibits Close**
6:00-7:00 pm *(Volleyball Court)*	**Cocktail Hour at Sea Crest Beach Hotel** ***... bring your sandals!***
7:00-9:00 pm *(Courtyard)*	**Dinner at Sea Crest Beach Hotel**

PROGRAM

Sunday, June 9, 2024

7:00-9:00 am *(Nauset III, IV & V)*	**Breakfast Buffet and Exhibition Hall Open**
7:30-8:30 am *(Nauset III)*	**Industry Session: Speaker Breakfast sponsored by Immunogen** **Title:** *"A Targeted Treatment for Ovarian Cancer"* **Speaker:** John K. Chan, MD, Division Director California Pacific Medical Center, Foster City, CA
8:40-10:20 am *(Nauset I & II)*	**FIFTH SCIENTIFIC SESSION** *(Abstract Schedule on Page16-17)*
10:20-10:45 am *(Nauset IV & V)*	***Break with Coffee and Exhibits***
10:45-11:55 am *(Nauset I & II)*	**SIXTH SCIENTIFIC SESSION** *(Abstract Schedule on Page 18)*
11:00 am *(Nauset IV & V)*	***Exhibits Close***
11:55 am–12:10 pm *(Nauset I & II)*	**Closing Remarks:** *Ashley Stuckey, MD, NEAGO President* **Announcement of Trainee Awards** **NEAGO 2025:** *Elizabeth Lokich, MD, NEAGO President-Elect*

ABSTRACT SCHEDULES

(Presenters' names have been listed in bold.)

FIRST SCIENTIFIC SESSION (Friday, June 7, 2024):

TOPIC – "Trials, Tribulations and Treatments" (1:30 – 3:00 pm)

Moderators – Amy Brown, MD and Matthew Oliver, MD

Abstract #1 Adjuvant Treatment and Outcomes for Stage III Serous Endometrial Cancer Patients at a Single Institution. ***Natalie Posever MD***, *Alex E Rosenthal MD ScM, Katharine Esselen, MD, Joanne Jang MD*

Abstract #2 The addition of PD-1 checkpoint inhibitor to the treatment of stage IV high-risk gestational trophoblastic neoplasia with gastrointestinal metastasis. ***Casey Moffitt, MD,*** *Amalia Brawley, MD, Shaina Bruce, MD, Caitlin Farabaugh, MD, Ed Podczaski, MD, Joel Sorosky, MD*

Abstract #3 Implementation of an Electronic Symptom Management (eSyM) System to Monitor Severity of Symptoms in Gynecologic Oncology Patients Initiating Chemotherapy: A Multi-Center Evaluation. *Nguyen LH, Cass I, Wong SL, Hazard Jenkins H, Osarogiagbon R Davis MR Dizon DS, Hassett Md, Schrag D, Wright AA,* ***Bradford L***

Abstract #4 Real-world outcomes with pembrolizumab and lenvatinib for advanced endometrial cancer including in previously ineligible patients: Experience at an academic institution. ***Taliya Lantsman MD***, *Lily Jia PharmD, Andrew Wiechert MD, Meghan Shea MD, Page Widick MD*

Abstract #5 Observational Analysis of Folate Receptor Alpha Positivity and Efficacy of Mirvetuximab Soravtansine in Folate Receptor Alpha-Positive Platinum-Resistant Epithelial Ovarian Cancer: Insights from Clinical Practice. ***Allison Schachter***, *Lauren Dori, Barbara Mahar, Patrick F. Timmins III, Timothy J. McElrath, Jovana Y. Martin, Anne Wilkinson, Lisa Armao, Ciera DeNovellis, Joyce N. Barlin*

Abstract #6 Upfront tumor molecular profiling and treatment response among patients with advanced ovarian cancer receiving neoadjuvant chemotherapy. *Natalie Sands BA, Victoria Gill BA, Cara Mathews MD, Matthew Oliver MD,* ***Julia Salinaro MD***

FIRST SCIENTIFIC SESSION (Friday, June 7, 2024) - Continued:

TOPIC – "Trials, Tribulations and Treatments" (1:30 – 3:00 pm)

Moderators – Amy Brown, MD and Matthew Oliver, MD

Abstract #7 Optimizing post-operative outcomes in patients receiving hyperthermic intraperitoneal chemotherapy. ***Michelle Greenman***, *Blair McNamara, Levent Mutlu, Gary Altwerger, Elena Ratner, Gloria S. Huang, Katyayani Papatla, Mitchell Clark, Peter Dottino, Masoud Azodi, Alessandro Santin, Peter E. Schwartz, Vaagn Andikyan*

Abstract #8 Geospatial Disparities in Access to Fertility Preservation for Women with Early-Stage Gynecologic Cancers and Breast Cancer. ***Alexa Kanbergs, MD, MS***, *Kirsten Jorgensen, MD, MPH, Nuria Agusti, MD, Chi-Fang Wu, PhD, Roni Nitecki, MD, MPH, Ryan Ramphul, PhD, Alexander Melamed, MD, MPH, Jose Alejandro Rauh-Hain, MD, MPH*

Abstract #9 Exploring the Preferences and Experiences of Female Cancer Survivors Regarding Fertility and Fertility Preservation: Insights from the Survivorship Oncofertility Barriers Survey. ***Alexa Kanbergs, MD, MS***, *Alexander Melamed, MD, MPH, Núria Agusti MD, Kirsten Jorgensen, MD, MPH, Roni Nitecki, MD, MPH, J. Alejandro Rauh-Hain, MD, MPH*

SECOND SCIENTIFIC SESSION (Friday, June 7, 2024):

TOPIC – "Gynecologic Oncology: It's more than Surgery and Chemotherapy" (3:15 – 4:50 pm)

Moderators – Cheung Wong, MD and Leslie Bradford, MD

Abstract #10 Evaluation of a novel screening program for financial toxicity in gynecologic oncology patients at initial consultation. *Nadiha Noor Chelsea,* ***Maria Fatima Reyes****, Tina Yi Jin Hsieh, Michele R. Hacke, Katharine M. Esselen*

Abstract #11 Assessing post-operative financial toxicity in a gynecologic oncology surgical cohort. ***Devon A. Harris MD****, Nadiha Noor Chelsea MD, Annika Gompers MPhil, Michele R. Hacker ScD, Katharine M. Esselen MD MBA*

Abstract #12 Gynecologic Oncology providers' perspectives on discussions around sexual health and function of patients. ***Naaman Mehta MD****, Areta Bojko MD, Sarah S Lee MD MBA, Amita Kulkarni MD, Devika Lekshmi MPH, Leslie Boyd MD, Katina Robison MD*

Abstract #13 Contemporary Outcomes among Gynecologic Oncology Patients with Malignant Bowel Obstructions. ***Gabriela Weigel MD****, Marina Hahn BS, Victoria Paterson MPH, Cara Mathews MD, Katherine Miller MD, Julia Salinaro MD*

Abstract #14 Factors associated with missing data among ovarian cancer patients in the National Cancer Database: Is there bias in reporting practices? ***Matthew H. Mossayebi, MD, MPH****; Alexander Melamed, MD, MPH; Michelle Davis, MD; Michael Muto, MD; Stephanie Alimena, MD*

Abstract #15 Implementation of an Electronic Symptom Management (eSyM) System to Monitor Post-Operative Pain in Gynecologic Oncology Surgery Patients: A Multi-Center Evaluation. ***Nguyen LH****, Bradford L, Wong SL, Hazard Jenkins H, Osarogiagbon RU, Davis MR, Dizon DS, Hassett M, Schrag D, Wright AA, Cass I*

Abstract #16 Hereditary Cancer Screening at an Underserved Continuity Clinic. ***Chioma Ogbejesi, MD****, Sheila Flaum, DO, MSc, Heather Einstein, MD, MS*

Abstract #17 Knowledge of and Attitudes towards End-of-life Doulas among Gynecologic Oncologists. ***Chioma Anaemejeh BA****, Gabriela Weigel, MD, Corinne Jansen, MD, Rachel Flink-Bochacki MD MPH, Katherine Miller MD, Benjamin Margolis MD*

THIRD SCIENTIFIC SESSION (Saturday, June 8, 2024):

TOPIC – "Lower Genital Tract" (8:40 – 10:20 am)

Moderators – Heidi Godoy, DO and Ilana Cass, MD

Abstract #18 Provider practices and attitudes for treatment of high-grade cervical lesions with the "see-and-treat" approach. ***Sidika Kajtezovic MD***, *Lindsay Fuzzell, PhD, Naomi C. Brownstein, PhD, Holly B. Fontenot, PhD, RN/NP, Paige Lake, PhD, Alexandra Michel, PhD, RN, CNM, Susan T. Vadaparampil, PhD, Rebecca B. Perkins, MD, Katrin Eurich MD*

Abstract #19 Cervical Cancer Surveillance after Treatment for High-Grade Cervical Dysplasia ***Victoria Wang, MD***; *Jacquelyn M. Lykken, PhD; Jasmin A. Tiro, PhD MPH; Rebecca B. Perkins, MD MSc; Jennifer S. Haas, MD MSc; Claudia Werner, MD; Sarah C. Kobrin, PhD MPH; Sarah Feldman, MD MPH*

Abstract #20 General vs. Local Anesthesia in Loop Electrosurgical Excision Procedures: A Systematic Review and Meta-Analysis. ***Rafaela G Toledo***, *Yasmin Dias, Rafael R H Martin, Michele R Hacker, Andrew Wiechert, Huma Farid*

Abstract #21 Persistent or recurrent cervical dysplasia in women living with HIV after treatment for CIN2 or CIN3 in Botswana. ***Devon A. Harris MD***, *Lapelo Ntshese MD, Rafaela Germano Toledo MD, Michele Hacker ScD, Kelebogile Gaborone, Lorato Mochoba, Katharine M. Esselen MD MBA*, Doreen Ramogola-Masire MD, Roger Shapiro MD, Rebecca Luckett MD MPH*

Abstract #22 Prevalence and characterization of synchronous primary malignancy at time of invasive vulvar cancer diagnosis. ***Jessica Kloppenburg, MD MS***; *Xiao Tong, BS; Sharmilee Korets, MD*

Abstract #23 A retrospective evaluation of sentinel lymph node mapping using indocyanine green in early-stage vulvar cancer. ***Gouri Sadananda MD***, *Shannon Wagner MD, Katina Robison MD, Rafael Gonzalez MD*

Abstract #24 The effect of intrawound vancomycin powder on surgical site infection in inguinal lymph node dissection. ***Jessica Buck DiSilvestro, MD***; *Emily Zitek, MS; Katina Robison, MD; Elizabeth Lokich, MD*

Abstract #25 Surgical Management and Outcomes of Extramammary Paget Disease: A Single Center Experience. ***Sarah G. Danforth***, *Megan R. Murnane, MD, Bradley D. Schroeder, DO, Lindsay M. West, MD, Aparajit Naram, MD*

THIRD SCIENTIFIC SESSION (Saturday, June 8, 2024) - Continued:

TOPIC – "Lower Genital Tract" (8:40 – 10:20 am)

Moderators – Heidi Godoy, DO and Ilana Cass, MD

Abstract #26 The Utility of Vulvar Pap Smears in Vulvar Cancer Surveillance
Ashley Goreshnik MD, *Blair McNamara MD, Minhua Wang MD, PhD, Ore Afon BA, Pei Hui MD, PhD, Gary Altwerger MD*

Abstract #27 Association between frailty and physiologic data from wearable devices in preoperative gynecologic oncology patients. ***Olivia W. Foley MD***, *Allison E. Grubbs MD, Connor C. Wang MD, Brenda Vega BA, Dario Roque MD, Karl Y. Bilimoria MD, Emma L. Barber MD MS*

Abstract #28 The Impact of MMR Status on Carcinosarcoma: A Pathologic and Clinical Outcomes Analysis. ***Mary Kathryn Abel MD***, *Alexandra Bercow MD, Kyle Devins MD, Esther Oliva MD, Alexander Melamed MD MPH*

GRANT AWARD PRESENTATIONS

Moderators – Katina Robison, MD and Katharine Esselen, MD
(10:20-10:40 am)

Grant #1 **Title:** **"The Role of End-of-Life Doulas in Gynecologic Oncology"**
Presented by Benjamin Margolis, MD

Members: Gabriela Weigel, MD, Corinne Jansen, MD, Chioma Anaemejeh, BA, Katherine Miller, MD, and Benjamin Margolis, MD

Grant #2 **Title**: **"Sentinel Lymph Node Mapping and Detection with Indocyanine Green and Spy-Phi Handheld Camera Technology in Early-Stage Vulvar Cancer (PILOT)**
Presented by Rafael Gonzalez, MD

Members: Rafael Gonzalez, MD, Katrin Eurich, MD and Katina Robison, MD

FOURTH SCIENTIFIC SESSION (Saturday, June 8, 2024):

TOPIC – "Back to the Basics" (11:00 am – 12:00 pm)

Moderators – Alessandro Santin, MD and Joyce Barlin, MD

Abstract #29 Datopotomab deruxtecan (Dato-Dxd), a TROP2 targeting antibody-drug conjugate, demonstrates antitumor activity in uterine serous carcinoma. ***Michelle Greenman***, *Cem Demirkiran, Stefania Bellone, Tobias Max Philipp Hartwich, Blair McNamara, Levent Mutlu, Natalia Buza, Pei Hui, Yang Yang-Hartwich, Gary Altwerger, Elena Ratner, Gloria S. Huang, Mitchell Clark, Vaagn Andikyan, Peter Dottino, Katyayani Papatla, Masoud Azodi, Peter E. Schwartz, Alessandro D. Santin*

Abstract #30 Preclinical activity of datopotamab deruxtecan, a novel trophoblast cell-surface antigen 2 (TROP2) directed antibody-drug conjugate targeting TROP2 in high grade serous ovarian carcinoma. *Blair McNamara,* ***Michelle Greenman****, Stefania Bellone, Cem Demirkiran, Levent Mutlu, Tobias Max Philipp Hartwich, Yang Yang-Hartwich, Elena Ratner, Peter E. Schwartz, Alessandro D. Santin*

Abstract #31 Small molecule ubiquitin C-terminal hydrolase L1 inhibition drives cell metabolism changes and exerts variable anti-tumorigenic effects dependent on platinum status in high grade serous ovarian cancer. ***Corinne Jansen****, Julia McAdams, Morgan Woodman, Payton De la Cruz, Cara Mathews, Kathryn J. Grive, and Nicole E James*

Abstract #32 Mechanisms of Resistance to Antibody Drug Conjugate Therapy in Ovarian Cancer. ***William Manning****, Mengyao Xu, Fabian Kraus, Irva Veillard, Raj Kumar, Yusuke Matoba, Maryam Azimi Mohammadabadi, Eugene Kim, Paula DiBenedetto, Amy Bregar, Richard Penson, Sara Bouberhan, Eric Eisenhauer, Tina Colella, Cesar Castro, David Spriggs, Bo Rueda, Oladapo Yeku*

Abstract #33 Neoadjuvant chemotherapy exposure induces phenotypic mast cells changes in high grade serous ovarian cancer. ***Julia McAdams****, Jasmine Ebott, Payton De la Cruz, Daniela Maiz, Joyce Ou, Linda Hanley, Cara Mathews, and Nicole E James*

Abstract #34 Comparing the Effects of Glucagon-like Peptide-1 Receptor Agonists on Endometrial Cancer Incidence in Patients with Type 2 Diabetes Mellitus to Insulin, Metformin, and Sodium-Glucose Transport Protein 2 Inhibitors: A Real-World Multi-Center Cohort Study Across the United States. ***Tina Yi Jin Hsieh****, Jody Dushay, Michele Hacker, Joseph Dottino, James Cheng-Chung Wei, Andrew Wiechert*

FIFTH SCIENTIFIC SESSION (Sunday, June 9, 2024):

TOPIC – "Surgery, Surgery, and more Surgery!" (8:40 – 10:20 am)

Moderators – Kevin Elias, MD and Andrew Wiechert, MD

Abstract #35 Sensitivity of omentectomy for detecting occult omental metastases in high grade uterine cancer. ***Yifan Emily Chang, MD***, *Blair McNamara, MD, Pei Hui, MD, Gary Altwerger, MD*

Abstract #36 Comparison of 2009 to 2023 FIGO staging in uterine-confined endometrial cancer. ***Alex E. Rosenthal, MD***, *ScM, Kaitlin Nicholson, MD, Sara Castro, BA, Annliz Macharia, MPH, Michele R. Hacker, ScD, Marcos Lepe, MD, Devon A. Harris, MD, Fátima Reyes, MD, Andrew Wiechert, MD, Joanne Jang, MD, PhD, Leslie Garrett, MD, Joseph Dottino, MD, MPH, Meghan Shea, MD, Katharine M. Esselen, MD, MBA*

Abstract #37 A pilot randomized controlled trial of laparoscopic surgeon-administered TAP block with liposomal bupivacaine in patients undergoing minimally invasive hysterectomy for endometrial cancer. ***Gouri B Sadananda MD***, *Rafael Gonzalez MD, Sarah Paraghamian MD, Katina Robison MD, Young Bae Kim MD*

Abstract #38 *Updated analysis of rate of postoperative VTE in endometrial cancer patients undergoing minimally invasive surgery.* ***Rose Mahoney, MD***, *Julie Hemphill, MD, Corinne Jansen, MD, Katrin Eurich, MD, Elizabeth Lokich, MD*

Abstract #39 Impact of Minimally Invasive vs. Open Surgery on Discharge Location in Geriatric Patients Undergoing Surgery for Ovarian Cancer. ***Allison Schachter***, *Devneet Singh, Ashar Ata, Benjamin Margolis, Michael Cohen*

Abstract #40 Chemotherapy followed by interval cytoreductive surgery has become the most prevalent approach in the upfront treatment of patients with advanced-stage epithelial ovarian cancer in the United States. ***Alexandra Bercow MD***, *Taylor Stewart MD, Amy J. Bregar MD, Allison Gockley MD, Varvara Mazina MD, J. Alejandro Rauh-Hain MD MPH, Alexander Melamed MD MPH*

Abstract #41 Racial and ethnic disparities in debulking surgery and complete cytoreduction among ovarian cancer patients. ***Stephanie Alimena, MD***, *Victoria Wang, MD, Michelle Davis, MD*

FIFTH SCIENTIFIC SESSION (Sunday, June 9, 2024) - Continued:

TOPIC – "Surgery, Surgery, and more Surgery!" (8:40 – 10:20 am)

Moderators – Kevin Elias, MD and Andrew Wiechert, MD

Abstract #42 Cost Analysis Associated with Enhanced Recovery After Surgery (ERAS) Implementation Among Ovarian Cancer Patients by Race and Ethnicity. ***Taylor P. Stewart, MD***, *Claire H. Packer, MD, MPH, Stephanie J. Alimena, MD, Kevin M. Elias, MD*

Abstract #43 National patterns of hysterectomy counseling for patients with BRCA mutations. ***Shayna Rubenstein MD***, *Jessica B DiSilvestro MD, Emily Zitek MS, Ashley R Stuckey MD, Elizabeth Lokich MD*

Abstract #44 Early pathways to end-of-life (EOL) planning: A multi-center evaluation of the impact of an educational video on documented EOL planning discussions with patients with gynecologic cancers. ***Kali Sullivan, BS***, *Alicia M. Youssef, MD, Gouri Sadananda, MD, Madhuri Nori, Sc.B, Lauren Schlichting, PhD, Grace da Cunha, NP, Katherine Miller, MD, Katina Robison, MD*

Abstract #45 *(Video Presentation)* Laparoscopic pancreatic peritonectomy with splenectomy for recurrent ovarian cancer: a novel approach to achieve R0 while preserving the pancreatic tail. ***Yasmin Abozenah***, *Christina Vlamis, Nicole Pebley, Yifan Emily Chang, Blair McNamara, Gary Altwerger*

SIXTH SCIENTIFIC SESSION (Sunday, June 9, 2024):

TOPIC – "What's New at My Institution: Case Reports and More" (10:45 – 11:55 am)

Moderators – Xun Clare Zhou, MD and Amy Bregar, MD

Abstract #46 Artery of choice: a single institution experience with uterine artery embolization (UAE) comparison of transradial versus transfemoral approach for obstetrical or gynecological surgery. ***Sha Sha, MD***, *David Munger, DO, Ilana Cass, MD*

Abstract #47 Outcomes of Fertility Sparing Treatment in a Case Series of Patients with Lynch Syndrome. ***Hadley Reid, MD, MHS***; *Alexandria Young, MD, PhD; Christina Onyebuchi, MD; Sophia Yin, MD, MBE; Isabela Covelli-Velez, MD; Mary Katherine Abel, MD, MAS; Colleen Feltmate, MD; Jessica St. Laurent, MD*

Abstract #48 Diverticulitis Masquerading as Ovarian Pathology: A Retrospective Case Series. ***Brittany Flores***, *Douglas W Van Pelt, PhD, Terri Febbraro, MD, MPH, Sharon G Siegel, MD*

Abstract #49 Axillary nodal metastasis in ovarian and primary peritoneal carcinoma. ***Carter Johnson, MD***, *Jennifer Jorgensen, MD and Amanda Ramos, MD*

Abstract #50 Growth of Intravascular Leiomyomatosis (IVL) with a Decreasing Pelvic Mass in a Postmenopausal Female: Case Report. ***Chioma Ogbejesi MD***, *Maleek A. Masood BS, Zachary Chadnick MD, Heather Einstein MD, MS, Marguerite Palisoul, MD, Robert Hagberg MD, Parth Shah MD*

Abstract #51 Sharing Challenging News Simulation: A Thematic Analysis. ***Julie Hemphill, MD***, *MBA, Kathryn Kurchena, MD, Kathryn Mills, MD, Kate Baccari, PA-C, Alicia Youssef, MD, Kate Zaluski, MD, Matthew Oliver, MD*

Abstract #52 Biomarkers present in Endometrial and Ovarian Carcinomas and Implications on Treatment. ***Ellie Kolor***, *Heidi Godoy, DO, and Charles Schwartz, DO*

Abstract #53 Proposal of a novel surveillance protocol for rare gestational trophoblastic disease subtypes. ***Isabela Covelli Velez, MD***, *Alexa N. Kanbergs, MD, Mackenzie W. Sullivan, MD, Kevin M. Elias, MD, Ross S. Berkowitz, MD, and Neil S. Horowitz, MD*

1. Adjuvant Treatment and Outcomes for Stage III Serous Endometrial Cancer Patients at a Single Institution

Natalie Posever MD, *Alex E Rosenthal MD ScM, Katharine Esselen, MD, Joanne Jang MD*
Institution: Beth Israel Deaconess Medical Center

Objective: Our study examines clinical outcomes of patients with stage III serous endometrial cancer treated with adjuvant chemotherapy vs combined chemotherapy and radiation. We assessed differences in recurrence free survival (RFS), overall survival (OS), and initial recurrence site.

Methods: Our retrospective cohort study included all stage III serous endometrial cancer patients treated at our institution from 2010-2021. Outcomes were compared between patients who received chemotherapy alone ("chemotherapy" group) vs any combination of chemotherapy and radiation ("combination" group.) The chemotherapy group received up to six cycles of carboplatin/paclitaxel. The combination group received external beam radiation (EBRT) and/or vaginal brachytherapy (VBT) with or without sensitizing cisplatin and with or without up to 6 cycles of carboplatin/paclitaxel, either before or after radiation, or on both sides of radiation in a "sandwich" pattern. Univariate analyses were performed using fisher's exact, Wilcoxon rank-sum, and logrank tests.

Results: A total of 53 patients were included; 11 patients in the chemotherapy and 42 in the combination group. In the combination group, 26 patients received both EBRT and VBT, 11 received EBRT alone, and 5 received VBT alone. RFS was significantly improved for the combination group compared to the chemotherapy group (24.5 months vs 10.3 months, p=0.04). While the difference in OS favored the combination group (46.9 vs 24.5 months, p=0.25,) it was not statistically significant. Local recurrence was significantly increased in the chemotherapy group (45.5% vs 11.9%, p=0.02), with no difference in pelvic or paraaortic nodal or distant recurrence (p>0.05).

Conclusion: Stage III serous endometrial cancer patients treated with both adjuvant radiation and chemotherapy had improved RFS and lower rates of local recurrence when compared to patients treated with adjuvant chemotherapy alone. Adjuvant treatment combining chemotherapy and radiation may increase recurrence free survival in this patient population and should be further evaluated in future clinical trials.

2. The addition of PD-1 checkpoint inhibitor to the treatment of stage IV high-risk gestational trophoblastic neoplasia with gastrointestinal metastasis.

Casey Moffitt, *MD, Amalia Brawley, MD, Shaina Bruce, MD, Caitlin Farabaugh, MD, Ed Podczaski, MD, Joel Sorosky, MD* – Institution: Penn State Health

Objective: To describe the use of pembrolizumab with initial therapy for high-risk gestational trophoblastic neoplasia (GTN) in a woman presenting with massive gastrointestinal (GI) hemorrhage.

Methods: A 23-year-old G1P1001 woman, nine weeks postpartum from a normal spontaneous vaginal delivery, was transferred to our unit after receiving eight units of packed red blood cells (PRBCs) due to GI hemorrhage. Human chorionic gonadotropin (hCG) was 43,000 mIu/mL without findings of intrauterine pregnancy on transvaginal ultrasound. Chest/Abdominal/Pelvic Angiography showed a vascular neoplasm eroding the jejunum along with liver metastases and bilateral pulmonary metastases. Imaging findings were consistent with FIGO stage IV GTN, WHO score 13. One week after low-dose induction etoposide/cisplatin (EP), hCG rose to 175,000 mIu/mL and pembrolizumab was added to the treatment regimen. During her twenty-two day hospitalization, she received two cycles of induction EP, one dose of pembrolizumab, and initiated etoposide, methotrexate, dactinomycin/etoposide, cisplatin (EMA/EP). She received eight additional units of PRBCs during the first three weeks of treatment until the bleeding resolved. hCG normalized after three cycles of EMA/EP and two doses of pembrolizumab.

Results: Pembrolizumab can be administered along with induction EP and continued with EMA/EP with high therapeutic response.

Conclusion: The early utilization of programmed cell death protein 1 (PD-1) checkpoint inhibitors (CPI) in high-risk GTN is not well established, but may play a role in treatment. Expression of PD-L1 has been identified in almost all forms of GTN. Clinical trials and case reports of CPI with pembrolizumab in high-risk chemotherapy-refractory or relapsed disease have demonstrated high rates of remission with good tolerability. Additionally, a synergistic effect of CPIs combined with chemotherapy in this population has been found in cohort and case studies. This case shows strong therapeutic response of pembrolizumab in combination with first-line chemotherapy for stage IV GTN with high risk of GI hemorrhage.

3. Implementation of an Electronic Symptom Management (eSyM) System to Monitor Severity of Symptoms in Gynecologic Oncology Patients Initiating Chemotherapy: A Multi-Center Evaluation

Nguyen LH, Cass I, Wong SL, Hazard Jenkins H, Osarogiagbon R Davis MR Dizon DS, Hassett Md, Schrag D, Wright AA, ***Bradford L***
Institution: Dartmouth Hitchcock

Objectives: To assess implementation of an EHR-embedded electronic symptom management (eSyM) system to track symptoms associated with chemotherapy in gynecologic oncology patients via the patient portal of an EHR across 6 healthcare systems in the Symptom Management Implementation of Patient Reported Outcomes in Oncology (SIMPRO) consortium.
Methods: Gynecologic oncology patients receiving chemotherapy between 10/19 and 9/2023 were invited to complete eSyM surveys weekly during treatment. eSyM administers a multi-symptom questionnaire based on the Patient-Reported Outcomes of the Common Terminology Criteria for Adverse Events (PRO-CTCAE). eSyM ascertains 11 symptoms including: pain, fatigue, constipation, diarrhea difficulty sleeping, anxiety, decreased appetite, numbness, nausea and vomiting and responses are categorized as none, mild, moderate or severe. Self-reported scores were dichotomized as severe or non-severe (none ,mild, moderate). Patient demographics and clinico-pathological data were recorded. Multivariable logistic regression analyzed associations between patient attributes and severe symptoms.

Results: 661 patients initiating chemotherapy submitted eSyM surveys. 316 (48%) reported at least one severe symptom, most commonly pain (61%), fatigue (47%) and constipation (30%). All other domains had < 15% severe symptoms reported. 185 (62%) patients reported > 1 severe symptom. Older patients were less likely to report a severe symptom (OR 0.98 95% CI 0.96,1.0, p= 0.03). Severe symptom reporting did not differ by race, ethnicity, marital status, insurance type, health system, pre-existing medical comorbidities or primary cancer type.

Conclusions: Almost half of gynecologic oncology patients receiving chemotherapy reported at least 1 severe symptom and 60% reported multiple severe symptoms. Efforts to optimize symptom control in this population are indicated.

Univariate Analysis Patient Characteristics and Severe Symptom Score

	No severe symptom	Severe symptom	P value
Age years			
Mean ± std dev.	64.8 ± 11.6	61.6 ± 11.9	0.0007
Cancer Site			0.9
OVARY	135 (39%)	129 (41%)	
UTERUS	124 (36%)	111 (35%)	
CERVIX	40 (12%)	36 (11%)	
Other	39 (12%)	39 (12%)	

4. Real-world outcomes with pembrolizumab and lenvatinib for advanced endometrial cancer including in previously ineligible patients: Experience at an academic institution

Taliya Lantsman MD*, Lily Jia PharmD, Andrew Wiechert MD*, Meghan Shea MD, Page Widick MD*
Institution: BIDMC - Harvard

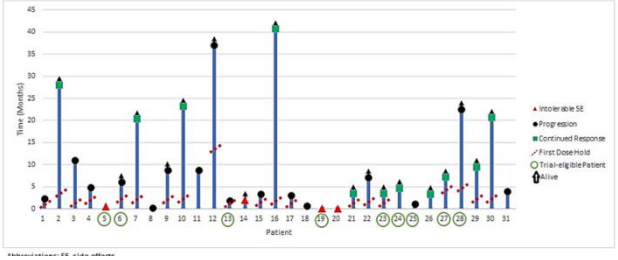
Objective: KEYNOTE-775 evaluated the use of pembrolizumab and lenvatinib in patients with advanced endometrial cancer but excluded several populations, including those with carcinosarcoma and proteinuria. Our objective was to describe the outcomes of pembrolizumab and lenvatinib in all patients, including those who would have been excluded.

Methods: Descriptive statistics were used to characterize the study population. Student's t-tests were performed to compare the differences in continuous variables between patients who were trial-eligible vs trial-ineligible. Fisher's exact tests were used to compare differences in categorical variables between patients who were trial-eligible vs trial-ineligible. All statistics were performed using R version 4.3.

Results: Thirty-two patients with advanced endometrial cancer received pembrolizumab and lenvatinib between 8/2020 and 6/2023. Of these, 25 patients would have been ineligible for treatment per KEYNOTE-775. The most common reasons for trial ineligibility were carcinosarcoma pathology (36%) and proteinuria (28%). The median lenvatinib starting dose was 12 mg (8-14). A majority (77%) required lenvatinib dose holds due to tolerability. Seven patients (21%) required lenvatinib dose reductions due to side effects. Median treatment duration was 3.4 months with the most common cause for discontinuation being disease progression. A third of patients received subsequent treatment after pembrolizumab and lenvatinib. Overall survival was 121 days (47-680) in the trial-eligible group and 170 days (24-509) in the trial-ineligible group.

Conclusion: We report a single academic institution's experience with pembrolizumab and lenvatinib, of which 71% of patients would have been ineligible for inclusion in KEYNOTE-775. No significant differences were observed in clinical outcomes between the trial-eligible and trial-ineligible cohorts. Lenvatinib was well tolerated at lower doses and many patients have continued disease control. This data supports the use of lenvatinib with pembrolizumab in real-world settings at a reduced dose, including in patients who may not meet KEYNOTE-775 inclusion criteria.

Figure 1 - Clinical Outcome Swimmer Plot



5. Observational Analysis of Folate Receptor Alpha Positivity and Efficacy of Mirvetuximab Soravtansine in Folate Receptor Alpha-Positive Platinum-Resistant Epithelial Ovarian Cancer: Insights from Clinical Practice

Allison Schachter*, Lauren Dori, Barbara Mahar, Patrick F. Timmins III, Timothy J. McElrath, Jovana Y. Martin, Anne Wilkinson, Lisa Armao, Ciera DeNovellis, Joyce N. Barlin* – Institution: Albany Medical Center

Objective: While epithelial ovarian cancer (EOC) is typically highly responsive to platinum-based chemotherapy, most tumors ultimately become resistant to platinum-based regimens. Platinum resistant EOC is poorly responsive to further chemotherapy. Mirvetuximab soravtansine (Mirv) is an antibody drug conjugate targeting folate receptor alpha that recently gained FDA approval in platinum-resistant EOC. The objective of our study is to conduct an observational analysis of the rate of FRα-positive EOC in clinical practice and to describe the efficacy of Mirv in FRα-positive patients with platinum-resistant ovarian cancer.

Methods: Eligible patients had a confirmed diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer. FRα testing was performed with positive status defined as ≥ 75%. Demographic information was collected, including platinum-resistant status, prior lines of chemotherapy, response rate, and duration of response. Response to treatment was based on decrease in CA-125 or improved disease on imaging.

Results: A total of 70 EOC patients were identified as having FRα testing, of which 29 patients had tumors that expressed high FRα, consistent with an observed 41% rate of FRα positivity. Nine of these patients started Mirv therapy and one patient is undergoing prior authorization to begin treatment. There was a Cancer Antigen-125 (CA-125) response of 44% amongst patients who received Mirv. Three patients continue treatment and six patients discontinued therapy due to disease progression (5 patients) or drug toxicity (1 patient).

Conclusion: The 41% FRα positivity rate in our community practice was comparable to the 36% of patients that were FRα high in the SORAYA study. In our practice, 44% of patients treated with Mirv demonstrated CA-125 response compared to a 53% response in the FORWARD I study and a 58% response in the MIRASOL trial. Our study demonstrates similar rates of FRα positivity and CA-125 response to Mirv in the community setting compared to clinical trials.

6. Upfront tumor molecular profiling and treatment response among patients with advanced ovarian cancer receiving neoadjuvant chemotherapy

Natalie Sands BA, Victoria Gill BA, Cara Mathews MD, Matthew Oliver MD,* ***Julia Salinaro MD***
Institution: Brown Univ/Women & Infants Hospital

Objective: Upfront tumor molecular profiling [TMP] is an evolving strategy for patients with advanced epithelial ovarian cancer [EOC] receiving neoadjuvant chemotherapy [NACT]. We aim to describe tumor genomics for patients with EOC receiving NACT and to analyze associations with treatment response and outcomes at interval cytoreductive surgery [ICS].

Methods: This was a retrospective, single institution study using a clinical genomics database including all patients who underwent tumor sequencing between 11/2022-1/2024. Eligible patients had EOC and received NACT. Tumor genomic characteristics (mismatch repair [MMR], homologous recombination deficiency [HRD], folate receptor status [FOLR], CPS score, HER2 status, pathogenic mutations in p53, PIK3CA, ARID1A, BRCA1/2, RAD51C/D) were analyzed using descriptive statistics. Fisher's exact test characterized associations between genomics and ICS outcomes.

Results: Twenty-four patients were included. All had at least stage IIIC disease at diagnosis; most were high-grade serous ovarian cancers [HGSOC] (83%) and received 3 cycles of NACT (65%). Of those undergoing ICS (91%), 87.5% had residual disease and 70% were optimally debulked. Two patients had pathogenic germline mutations (1 BRCA1, 1 PALB2). FOLR was positive in 37.5% of tumors, including 42.9% of HGSOC. Two were BRCA1 mutated (8.3%), all had p53 mutations, 4.2% were MMR deficient, 58% had CPS ≥1, 1 was HER2 positive, and 12.5% were HRD positive. Three patients had complete response to NACT: two were FOLR positive, one of which was somatic BRCA1 mutated; the third had no genomic alterations. No other pathogenic mutations were identified. No specific molecular profiles were associated with residual disease or optimal debulking during ICS.

Conclusion: Just over one-third of patients receiving NACT for advanced EOC were FOLR positive, including 2 of the 3 patients with a complete response at the time of ICS. Further investigation is warranted in a larger cohort.

7. Optimizing post-operative outcomes in patients receiving hyperthermic intraperitoneal chemotherapy

Michelle Greenman, *Blair McNamara, Levent Mutlu, Gary Altwerger, Elena Ratner, Gloria S. Huang, Katyayani Papatla, Mitchell Clark, Peter Dottino, Masoud Azodi, Alessandro Santin*, Peter E. Schwartz, Vaagn Andikyan* – Institution: Yale University

Objective: Use of hyperthermic intraperitoneal chemotherapy (HIPEC) can contribute to acidosis, third spacing, coagulation dysfunction, electrolyte abnormalities, hyperglycemia, and need for respiratory support. Therefore, patients are commonly transferred to the ICU post-operatively. At our institution, this is standard practice. However, the average SICU demands frequently outweigh the availability of beds and workers. Further, SICU admissions incur significantly higher hospitalization costs. As HIPEC becomes increasingly more common, we recognize the undue stress this may place on the SICU and the inability for this demand to be met.

Methods: This is a retrospective cohort study of ovarian cancer patients that received HIPEC at our institution. We identified key post-operative factors that would warrant ICU management, including continued intubation following surgery, need for significant respiratory support, hemodynamic instability, elevated lactate, drastic metabolic derangements, hyperglycemia, and acidemia.

Results: We identified 20 patients that received HIPEC. The average patient spent 1.95 nights under SICU care. All were successfully extubated following surgery. Average arterial blood gas following surgery was 7.31 with an average lactate of 1.7. The majority of patients went to the ICU postoperatively as a matter of protocol (80%), while a smaller portion of patients met one of the criteria above necessitating ICU care (20%). Patients infrequently required vasopressor use (2/20, 10%). While patients frequently required supplemental oxygen (55% of patients), the majority were adequately managed on nasal cannula (91%), with only 1 patient (9%) necessitating oxygen via a nonrebreather. Only 1 patient (5%) had hyperglycemia requiring an insulin drip.

Conclusions: Based on our results, routine SICU admission postoperatively is not indicated and care can reasonably and safely be provided in the step down unit. Transitioning away from routine ICU admission can minimize health costs and decrease the burden on the ICU. Careful patient selection is imperative for optimizing outcomes.

8. Geospatial Disparities in Access to Fertility Preservation for Women with Early-Stage Gynecologic Cancers and Breast Cancer

Alexa Kanbergs, MD, MS, Kirsten Jorgensen, MD, MPH, Nuria Agusti, MD; Chi-Fang Wu, PhD, Roni Nitecki, MD, MPH; Ryan Ramphul, PhD, Alexander Melamed, MD, MPH, Jose Alejandro Rauh-Hain, MD, MPH*
Institution: MD Anderson

Objectives: To determine whether geographic disparities influence rates of fertility-sparing surgery (FSS) or the use of assisted reproductive technology (ART) among women with early-stage cervical, endometrial, or ovarian cancer or stage I-III breast cancer.

Methods: We conducted a population-based cohort study of reproductive-aged patients (18-45) with cervical (stage IA, IB), endometrial (grade 1, stage IA, IB), ovarian cancer (stage IA, IC), or stage I-III breast cancer diagnosed between 2000-2015 using data from the California Cancer Registry, the California Office of Statewide Health Planning and Development, and the Society for Assisted Reproductive Technology. Chi-squared or Fisher exact tests were used to assess differences between groups. Generalized linear mixed models with random effects were applied in the study to evaluate geospatial variables.

Results: We identified 7,612 patients with gynecologic cancer and 35,992 patients with breast cancer. Among all patients, 257 (0.6%) underwent ART. Among patients with gynecologic cancer, 1,676 (22.0%) underwent FSS. Stratified by quartiles, women residing at increasing distances from gynecologic oncology or fertility clinics had decreased odds of undergoing FSS (gynecologic oncology clinics Q2, OR=0.76, 95% CI=0.63-0.93, P=0.007; Q4, OR=0.72, 95% CI=0.56-0.94, P=0.016) (fertility clinics Q3, OR=0.79, 95% CI=0.65-0.97, P=0.025; Q4, OR=0.67, 95% CI=0.52-0.88, P=0.004). Those living in communities with higher CHPI scores had greater odds of undergoing FSS (Q3 OR=1.29, 95% CI=1.06-1.57, P=0.01; Q4 OR=1.66, 95% CI=1.35-2.04, P=<0.001) or ART (Q2 OR=1.90, 95% CI=0.99-3.64, P=0.05; Q3 OR=2.86, 95% CI=1.54-5.33, P=<0.001; Q4 OR=3.41, 95% CI=1.83-6.35, P=<0.001) compared with individuals living in disadvantaged communities.

Conclusion: These findings suggest that geographic disparities impact rates of FSS and access to ART for women with early-stage cervical, endometrial, ovarian cancer, and stage I-III breast cancer. By acknowledging the influence of geographic factors, healthcare systems can take meaningful steps toward ensuring equitable access to fertility preservation services to enhance the quality of life and survivorship experiences of cancer patients.

9. Exploring the Preferences and Experiences of Female Cancer Survivors Regarding Fertility and Fertility Preservation: Insights from the Survivorship Oncofertility Barriers Survey

***Alexa Kanbergs, MD, MS**, Alexander Melamed, MD, MPH, Núria Agusti MD, Kirsten Jorgensen, MD, MPH, Roni Nitecki, MD, MPH, J. Alejandro Rauh-Hain, MD, MPH* – Institution: MD Anderson

Objective: The Survivorship Oncofertility Barriers Survey was previously developed and validated to address disparities in fertility care among cancer survivors. In this study, we expanded its scope to a broader patient population with the aim of investigating the preferences and experiences of female cancer survivors regarding fertility preservation and the obstacles they face when attempting pregnancy after a cancer diagnosis.

Methods: Women aged 13 to 45 at cancer diagnosis, currently 18 or older, and 5-10 years post-diagnosis were identified in the MD Anderson or California Cancer Registry and were invited to complete the survey online or by phone.

Results: A total of 157 patients completed the survey. Forty-three percent reported that they were unaware of the option of fertility-sparing surgery or fertility preservation treatments before starting cancer treatment. Furthermore, 78% did not undergo fertility-sparing surgery, with 32% expressing regret about their decision. The most cited challenges when deciding whether to pursue fertility-preserving treatment were the need to start treatment quickly (44.4%), feeling overwhelmed (48.6%), lack of understanding of the options (20.1%), or inability to afford the costs (28.4%). Participants reported the following as helpful interventions: receiving information earlier (40.0%), having access to more information (44.8%), scheduling an appointment to discuss fertility (37.9%), hearing from other women who had similar experiences (37.2%), receiving financial support (50.0%), and getting emotional support (33.1%). Women who attempted pregnancy, in comparison to those who did not, exhibited a higher likelihood of having insurance (25% vs. 7.9%; p=0.004) and reported fewer religious concerns (9.6% vs. 2%; p = 0.03).

Conclusion: Nearly half of women were unaware of fertility preservation options before cancer treatment, and one-third regretted not pursuing them. Common barriers to fertility preservation included emotional, financial, and educational factors. To overcome obstacles to reproductive goals after cancer, interventions should be multidisciplinary, addressing emotional and financial challenges.

Table 1. Barriers to pursuing fertility-sparing treatment for individuals who tried to get pregnant compared with those who did not

Barriers to pursing fertility-sparing treatment	Tried to get pregnant = Yes (52)	Tried to get pregnant = No (101)	P value
Had to start cancer treatment quickly	19 (36.5%)	45 (44.6%)	0.34
Not enough time to consider the decision	24 (46.2%)	34 (33.7%)	0.13
Felt overwhelmed	26 (50%)	44 (43.6%)	0.45
Did not understand the options	13 (25.0%)	16 (15.8%)	0.17
Did not feel like had enough personal or emotional support	7 (13.5%)	8 (7.9%)	0.27
Did not have insurance coverage	13 (25.0%)	8 (7.9%)	0.004
Had difficulty navigating the process/forms	4 (7.7%)	3 (3.0%)	0.19
Pressure from spouse/partner	2 (3.8%)	4 (4.0%)	0.97
Couldn't afford the out-of-pocket cost	17 (32.7%)	24 (23.8%)	0.24
Pressure from family	4 (7.7%)	3 (3.0%)	0.18
Concerns that it did not align with my religious beliefs	5 (9.6%)	2 (2.0%)	0.032
Found conflicting information online	3 (5.8%)	1 (0.1%)	0.077

10. Evaluation of a novel screening program for financial toxicity in gynecologic oncology patients at initial consultation

*Nadiha Noor Chelsea, **Maria Fatima Reyes**, Tina Yi Jin Hsieh, Michele R. Hacker, Katharine M. Esselen*
Institution: Beth Israel Deaconess Medical Center

Objective: Compare feasibility and effectiveness of financial toxicity (FT) and social determinants of health (SDOH) screening in gynecologic oncology patients.

Methods: All new patients were screened for FT and SDOH during 10-month study period. A single FT screening question was used. Responses were categorized as +FT screen (yes/unsure), -FT screen (no), and unanswered. Second, completed a PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) a validated SDOH tool.

Results: Of 765 eligible patients, 649 (85%) were screened by any method. A higher proportion of unscreened patients were non-White (48% v 37%, p<0.01) and non-English speaking (23% v 11%, p<0.001). 69% were successfully screened with the FT question, 17% screened positive, 70% negative and 13% did not answer. Among the 444 (58%) of patients who answered PRAPARE, 8% had a financial need. 1% of patients lacked housing, food, clothing, childcare, or phone; 2% worried about losing housing or utilities; 3% had trouble paying for healthcare and 4% reported difficulty with transportation. There were 42% who were screened with both methods, 66% identified as White, and the majority were English-speaking (90%), completed high school (75%) and had private insurance (59%). Those who screened positive for FT, they had a higher mean PRAPARE score (3.5± 2.0) compared to those who screened negative (2.3±1.4) or with no response (2.9±1.6) (p<0.0001). Of patients screened with both methods, 9 (3%) had a need identified with PRAPARE but screened negative or did not respond the screening question, while 33 (10%) screened positive for FT with no social needs identified with PRAPARE.

Conclusion: Incorporating a FT question and SDOH tool were feasible. The single question was completed more often and was more effective in capturing at risk patients. Further work is needed to understand barriers to screening and optimal screening timing and frequency.

11. Assessing post-operative financial toxicity in a gynecologic oncology surgical cohort

Devon A. Harris MD, *Nadiha Noor Chelsea MD, Annika Gompers MPhil, Michele R. Hacker ScD, Katharine M. Esselen MD MBA*
Institution: Beth Israel Deaconess Medical Center

Objective: To assess baseline and post-operative financial toxicity (FT) in a cohort of gynecologic oncology surgery patients and identify factors associated with worsening FT after surgery.

Methods: New gynecologic oncology surgical patients were invited to a longitudinal study examining FT from June 2022 to April 2023. Surveys containing demographic information, the COmprehensive Score for financial Toxicity (COST) questionnaire, and cost-coping strategies (i.e., need to use savings, borrow money, delay or avoid care) were administered at 0, 3 and 6 months. Clinical data was abstracted from the electronic medical record.

Results: In total, 126 participants completed a baseline survey, 105 (83%) and 95 (75%) completed 3 and 6-month surveys, respectively. At baseline, 10% had severe, 37% had moderate, and 53% had mild/no baseline FT. Sixty percent underwent major surgery and 47% had malignancy on final pathology. One-third of participants at 3 and 6 months (35% and 36%, respectively) had decreasing COST scores, indicating worsening FT, though median COST scores were unchanged. Cost-coping strategies were employed by half of participants. Income, race, education, and advanced stage were all associated with increased baseline FT (all $p<0.05$) but did not contribute to worsening FT at any time point. Being retired or disabled, undergoing major surgery, and mild/no baseline FT were all associated with worsening FT at 6 months (all $p<0.05$), but not at 3 months.

Conclusions: In a gynecologic oncology surgical cohort, one-third had worsening FT post-operatively, while one-half used cost-coping strategies to pay for care. The drivers of worsening FT at these time points appear different and may correlate with timing of surgical bills or other out-of-pocket costs. More work is needed to understand the FT experienced by surgical patients and how and when to best measure FT in a surgical population.

12. Gynecologic Oncology providers' perspectives on discussions around sexual health and function of patients

Naaman Mehta MD, *Areta Bojko MD, Sarah S Lee MD MBA, Amita Kulkarni MD, Devika Lekshmi MPH, Leslie Boyd MD, Katina Robison MD*
Institution: NYU Langone

Objective: Our objective was to determine the proportion of gynecologic oncology providers screening for sexual health concerns among patients with gynecologic malignancies. The secondary objective was to describe gynecologic oncology providers' perspectives on their role in evaluating sexual health concerns and barriers to managing sexual health.

Methods: A quantitative, cross-sectional 23-item survey study was administered across the United States to gynecologic oncology providers, specifically attending oncologists and fellows, using the Society of Gynecologic Oncology database from August to September 2023. Chi-squared tests, multinomial and multivariate regressions were used for analysis.

Results: One-hundred and sixty-six providers completed the survey. Thirty-four (23.1%) were fellow trainees and 113 (77.0%) were attendings. The majority (137/166, 82.0%) were female providers and (29/166, 17.4%) were male. Just over half (99/166, 59.6%) of providers routinely asked about sexual health concerns of their patients. The majority (163/166, 98.2%) believed discussion of sexual health should be done by a gynecologic oncologist, while 89/166 (53.6%) also thought that the patient was responsible for raising sexual health discussions.

Attendings more often discussed sexual health with patients when compared to fellows (OR 2.8, 95% CI 1.6-4.1, $p< 0.01$). Most providers (117/166, 70.5%) felt they needed to improve their knowledge on sexual function and most (129/166, 77.7%) would participate in a training on how to discuss sexual function with their patients. Female providers were more likely to want to participate in the training than male providers (OR 3.3, 95% CI 1.4-8.0, $p <0.01$).

Conclusions: Though over half of gynecologic oncology providers in the US are male, less than one-third of survey respondents were male. While almost all gynecologic oncologists feel sexual health should be discussed with their patients, only 59.6% routinely ask about sex health concerns. Future studies should focus on effective ways to incorporate sexual health screenings into gynecologic oncology clinics.

13. Contemporary Outcomes among Gynecologic Oncology Patients with Malignant Bowel Obstructions

***Gabriela Weigel MD**, Marina Hahn BS, Victoria Paterson MPH, Cara Mathews MD, Katherine Miller MD, Julia Salinaro MD*
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Objective: Malignant bowel obstructions (MBOs) affect many patients with gynecologic malignancies and are associated with significant morbidity and poor prognosis. Optimal management of MBO remains unknown, with limited contemporary data. We aimed to describe updated MBO outcomes for gynecologic oncology patients to inform improved prospective management strategies.

Methods: We conducted a retrospective chart review of admissions to the gynecologic oncology service for MBOs from 1/2022 to 12/2023 at a single academic institution. Patients with complete or partial MBOs were included. Obstructions related to adhesions or non-cancer etiologies were excluded. ICD10 diagnosis codes identified relevant admissions, and accuracy of eligibility and data input were verified by two reviewers. Descriptive statistics were used to analyze clinical characteristics.

Results: Thirty patients (50 admissions) met inclusion criteria. Twenty-four patients were admitted once, while 6 patients constituted the remaining 26 admissions. Most patients had ovarian (80%) or uterine (16%) cancer, with the majority in treatment for recurrence (62%) or diagnosed with a new recurrence during the admission (22%). Nasogastric tubes were placed during 54% of admissions (85% within 0-1 days) and gastric tubes for 16%. Medical management rarely included dexamethasone (7%) or octreotide (0%). Return of bowel function was noted during 78% of admissions within an average of 3.4 days (range 0 to 22 days). 36% of admissions involved a goals of care conversation and few had palliative care consults (14%). Readmission within 30 days was common (32%), most often for recurrent obstruction. Approximately 53% of patients utilized hospice services within 30 days of discharge, 37% died within 30 days of admission and 73% died within 6 months.

Conclusion: Management of MBOs was highly variable, with high readmission rates, hospice utilization and rates of death, consistent with historical data. Implementation of an evidence-based protocol to optimize care for patients with MBO should be considered.

14. Factors associated with missing data among ovarian cancer patients in the National Cancer Database: Is there bias in reporting practices?

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Objective: Optimal treatment of ovarian cancer relies on accurate staging and histopathological grade amongst other variables. Patients with non-gynecologic cancers who have missing datapoints in national databases have worse survival outcomes. We aimed to analyze factors associated with missing stage and grade data among patients with ovarian cancer in the National Cancer Database (NCDB) and to assess differences in survival among those with missing data.

Methods: Patients with ovarian cancer diagnosed between 2006-2021 were identified in the NCDB, and those with missing stage and grade data were assessed. Multivariate logistic regression models were performed to assess factors associated with missing stage and grade. Kaplan Meier analyses were performed to compare survival among those with missing versus complete data.

Results: Of 263,058 patients, 28,369 (10.8%) were missing stage and 103,284 (39.3%) were missing grade data. Significant predictors of unknown stage are shown in Table 1, including extremes of age (< 40 and ≥ age 80), Black non-Hispanic or unknown race/ethnicity, treatment at facilities besides academic/research centers, non-private insurance status; non-serous histology, and those undergoing primary debulking surgery or with unknown surgery/chemotherapy sequencing. Similar predictors for missing grade data were noted, including significant associations with age ≥ 80, Hispanic or Black non-Hispanic race/ethnicity, non-private insurance status, and treatment at facilities besides academic/research centers (Table 1). Furthermore, survival outcomes were significantly worse in patients with missing stage (90.3 months vs 81.5 months, $p<0.001$) and grade (99.8 months vs 72.1 months, $p<0.001$).

Conclusion: About 40% of nationally reported ovarian cancer cases have an unknown grade and 10% have an unknown stage, both correlating with worse survival outcomes. Further research is needed to understand if bias in reporting practices may be occurring, given our findings suggest that non-white and underinsured patients treated in the community may be at particular risk of missing datapoints.

15. Implementation of an Electronic Symptom Management (eSyM) System to Monitor Post-Operative Pain in Gynecologic Oncology Surgery Patients: A Multi-Center Evaluation

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Institution: Dartmouth Hitchcock

Objective: To assess implementation of an EHR-embedded electronic symptom management (eSyM) system to evaluate pain within 30 days of surgery in gynecologic oncology patients via the patient portal of an EHR across 5 healthcare systems in the Symptom Management Implementation of Patient Reported Outcomes in Oncology (SIMPRO) consortium.

Methods: Patients undergoing surgery patients for known/suspected gynecologic malignancies were invited to complete eSyM surveys in a 30-day post-operative period from 10/2019- 9/2023. eSyM administers a multi-symptom questionnaire based on a Patient-Reported Outcomes of the Common Terminology Criteria for Adverse Events (PRO-CTCAE). Self-reported scores were dichotomized as severe or non-severe (none, mild, moderate) eSyM uptake is defined as low (completed 1) versus high (> 1 survey). Baseline patient demographics, surgical data, and opioid use were recorded. Multivariable logistic regression analyzed associations with patient attributes, survey uptake, opioid prescriptions, and pain scores.

Results: 2303 patient submitted eSyM surveys: 1588 (69%) patients > 1 survey (high uptake). 636 (28%) patients reported severe pain score in the 30-day postoperative period. Older patients were less likely to report severe pain (OR 0.97, 95% CI 0.96 –0.98, p < 0.0001). No difference was observed in severe pain reporting by race, ethnicity, insurance type or co-morbidities. MIS patients had less opioids, measured by mean number of tablets prescribed than open surgery 11.8 versus 21.2, (p<0.0001). Patients with severe pain required more opioid refills (OR 2.55, 95% 1.86-3.48, p <0.0001). Patients with high uptake [completed > 1 eSyM survey] reported more severe pain (OR 1.24, 95% CI 1.003,1.54, p< 0.0001) and requested more opioid refills after the first 30 days (OR 2.55, 95% CI 1.86,3.48, p < 0.0001)

Conclusions: eSYM for gynecologic oncology patients after surgery had high patient uptake. eSyM can identify patients at highest risk of reporting severe pain to optimize their post-op course.

16. Hereditary Cancer Screening at an Underserved Continuity Clinic

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Objective: Hereditary cancer syndromes represent approximately 10% of cancers diagnosed in the US. Our primary goal was assessing feasibility of using National Comprehensive Cancer Network (NCCN) guidelines for cancer screening at resident OBGYN clinic at Hartford Hospital. Our secondary goal was to determine if patients who screened positive on the screening tool proceeded to undergo genetic testing and were referred for appropriate follow up.

Methods: A retrospective, single-center chart review was performed. Inclusion criteria included patients with the chief complaint: “annual visit,” “postpartum,” or “breast complaint,” genotypic female, any race/ethnicity, and age ≥18 years old. One thousand charts from April 1, 2021 through April 30, 2022 were reviewed. For eligible patients, we reviewed genetic tests results (positive, negative, high risk negative (patients who tested negative but warranted increased cancer screening from family history)), or variants of undetermined significance (VUS)) and assessed for documentation of a referral for specialist(s).

Results: 67% of patients self-identified as Latinx while 21% self-identified as Black. 232 patients were eligible for genetic testing; 103 of 232 received testing. Eleven out of 103 tested positive (11%), 24 out of 103 resulted as high risk negative (23%), 34 out of 103 resulted as negative (33%), and 33 out of 103 resulted as VUS. For the referral process, 12 out of 24 (50%) high risk negative patients were referred to a specialist and 5 out of 24 (21%) were offered increased surveillance. For the patients who tested positive, 4 of the 11 patients (36%) were referred to a specialist while 5 out of 11 (45%) were referred to genetics.

Conclusion: It is feasible to perform genetic screening among an underserved continuity clinic, which improves access to care for patients of various ethnic backgrounds. Opportunities exist to enhance referral to appropriate specialists for cancer screening and prophylaxis.

17. Knowledge of and Attitudes towards End-of-life Doulas among Gynecologic Oncologists

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Institution: Albany Medical College

Objective: End-of-life doulas (EOLDs) offer non-medical support to patients and families during the final stages of life. Despite their growing role in community-based care, little is known as to how receptive gynecologic oncology providers may be to EOLDs.

Methods: We distributed a Qualtrics survey to members of the New England Association of Gynecologic Oncologists (NEAGO). We assessed demographic data, familiarity with and attitudes towards EOLDs. Descriptive statistics were used to describe respondents. Chi-square testing and Spearman's correlation coefficient were used for comparative analysis.

Results: Thirty-nine of 85 NEAGO members completed the survey (response rate 46%). Most respondents were physician gynecologic oncologists (n=37, 95%) who practiced in academic settings (79.4%) and participated in end-of-life care (92.3%). Fifteen of 39 respondents (38.5%) had ever heard of an EOLD. Only one participant had ever had patients or families request EOLD services, and no one had personally worked with an EOLD. Of those familiar with EOLDs, no one was familiar with their cost. After information outlining the roles of EOLDs, most agreed or strongly agreed that EOLDs could be a valuable component of end-of-life care (87%) and that EOLDs should be accessible and affordable to patients (84.6%). A majority of respondents reported they were very or somewhat likely to recommend an EOLD to patients during the dying period (61.5%). A positive correlation was found between those who perceived EOLDs as valuable and their likelihood to recommend EOLDs to patients (▪ =0.6, p<0.001). There was variation in likelihood of recommending EOLDs by age (p=0.008) and years of practice (p=0.001), with younger and newer clinicians most likely to recommend.

Conclusion: Knowledge of and experience with EOLDs is limited among surveyed gynecologic oncologists. After education on their potential roles, many clinicians see value in their services and would recommend EOLDs to patients.

18. Provider practices and attitudes for treatment of high-grade cervical lesions with the "see-and-treat" approach

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Objective: Expedited treatment, or "see-and-treat", is defined as performing LEEP without colposcopic biopsy confirmation of a high-grade lesion. It is the preferred management strategy for patients with precancer risks of 60% or higher per the 2019 ASCCP Risk-Based Management Consensus. This study assesses the adoption of expedited treatment into practice.

Methods: Physicians and advanced practice providers (APPs) in the United States who perform cervical cancer screening participated in surveys and interviews in 2021. Participants were recruited via the National Association of Nurse Practitioners in Women's Health, email listserv, a healthcare physician panel via Dynata (an online market research firm), and the American Society of Colposcopy and Cervical Pathology (ASCCP) mailing list. Participants were asked about their practice of applying the screen-and-treat approach. Descriptive statistics and multivariable logistic regression were performed. Qualitative interview data underwent content analysis.

Results: A total of 694 colposcopists participated in surveys and 52 participated in interviews. The majority were OB/GYN physicians (46.0%) or APPs (37.2%) and practiced in group or private practices (57.3%). 25.6% currently used expedited treatment, 50.8% performed colposcopy before treatment but were willing to adopt expedited treatment for appropriate patients, and 23.5% were "unlikely" to adopt expedited treatment. Reasons for supporting expedited treatment included reduced loss to follow-up, time savings for patients, and the ability to use shared decision-making. Concerns of respondents included overtreatment of women still considering childbearing, unnecessary procedures if cancer was present, utility of biopsies in planning LEEP procedures, and lack of LEEP capabilities on site.

Conclusions: Approximately 25% of colposcopists currently offer expedited treatment, and an additional 50% are willing to consider this practice for appropriate patients. Wider adoption of this practice must address clinician education and increased access to LEEP procedures. Improving access to expedited treatment for appropriate patients could reduce cervical cancer rates.

19. Cervical Cancer Surveillance after Treatment for High-Grade Cervical Dysplasia

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Objective: To quantify how many patients treated for high-grade cervical dysplasia completed guideline-concordant surveillance follow-up and outcomes for those who did and did not complete surveillance follow-up.

Methods: We completed a longitudinal analysis of patients aged 30-65 treated for an HSIL pathology from 2010-2019 from two healthcare systems in Texas and Massachusetts. The outcome was receipt of three negative co-tests after HSIL treatment . Primary analyses included all patients with an HSIL pathology and treatment while in the cohort. Secondary analyses included patients who had at least four years of observation (4-year cohort) in the healthcare system after HSIL treatment.

Results: Among N=1757 who received treatment for an HSIL pathology, most were 30-39 years old (58.1-63.2%) and had no or few known comorbidities (65.8-91.7%). Few patients received three negative surveillance co-tests after HSIL treatment, regardless of subsequent cohort duration (overall cohort, 20.6% overall; 4-year cohort, 33.6% overall). Approximately 27.1-35.7% of patients went on to have an abnormal co-test after HSIL treatment. The proportion of cervical cancers observed following HSIL treatment was highest among patients who had another abnormal co-test after HSIL treatment (overall cohort, 5.9%; 4-year cohort, 6.1%). Importantly, cervical cancers were rarely observed among those who completed three negative co-tests (overall cohort, 0.8%; 4-year cohort, 0.6%). The proportion of patients with an abnormal co-test completing a subsequent diagnostic evaluation or procedure also dropped between the first and second co-test, regardless of cohort duration (overall cohort, 79.2% vs. 23.3%; 4-year cohort, 82.4% vs. 48.6%).

Conclusion: Most patients did not receive guideline-concordant three negative co-tests after HSIL treatment, and many went on to receive a subsequent abnormal co-test. Patients with high-grade cervical dysplasia are at risk of subsequent abnormalities and should continue to be closely monitored. Additional systems are needed to ensure complete management after dysplasia treatment.

20. General vs. Local Anesthesia in Loop Electrosurgical Excision Procedures: A Systematic Review and Meta-Analysis

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Objective: Loop electrosurgical excision technique (LEEP) is the standard of care for high-grade cervical intraepithelial neoplasia. The anesthesia choice between local (LA) and general anesthesia (GA) varies based on availability across countries, leading to heterogeneity in its use. Our aim was to compare patient-reported outcomes among patients who received LA during LEEP with those who received GA.

Methods: PubMed, Embase and Cochrane databases were searched. Primary outcomes were patient-reported pain (measured on a 10-point scale) and satisfaction (patient reported they would choose the same method again). Secondary outcomes included cone volume and depth and need for repeat procedure. Heterogeneity was assessed with I2, and a random effects model was used.

Results: Six studies with 2169 patients (1536 LA, 633 GA) met inclusion criteria. Though not statistically significant, patient-reported post-procedure pain was lower with GA than LA (Standardized Mean Difference: -0.49, 95% CI -1.88, 0.89), and patients who received GA had higher odds of satisfaction (Odds Ratio: 1.62; 95% CI 0.94, 2.79). Patients under GA had significantly larger cone volumes (mean difference (MD): 0.46cm3; 95% CI 0.29, 0.62); depth of excision also was greater with GA, but the difference was not statistically significant (MD 0.75mm; 95% CI –0.23, 1.74). Other outcomes, such as need for repeat procedure, postoperative bleeding and positive margins also were statistically non-significant different.

Conclusion: Though patients who received GA reported slightly less pain, this difference was not statistically significant, and unlikely to be clinically meaningful. Similarly, patient satisfaction did not differ statistically between groups. Moreover, GA was associated with significantly larger cone volumes, which could contribute to the risk of premature birth; there were no significant differences in other outcomes, including positive margins. Overall, considering the greater risks and cost of GA relative to LA, LA may generally be a better option for patients undergoing LEEP.

21. Persistent or recurrent cervical dysplasia in women living with HIV after treatment for CIN2 or CIN3 in Botswana

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Institution: Beth Israel Deaconess Medical Center

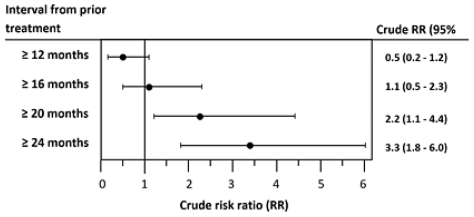
Objective: Limited data guides screening interval recommendations for women living with HIV (WLHIV) after treatment for cervical dysplasia in low- and middle-income countries with high antiretroviral (ART) coverage. The study objective was to determine outcomes 1 year after LEEP treatment for CIN2/CIN3 in WLHIV in Botswana.

Methods: We performed a prospective longitudinal cohort study of WLHIV who had LEEP for CIN2/CIN3 and were followed at 1-year with visual evaluation and biopsy/LEEP, as indicated by national guidelines. Demographics, baseline dysplasia, HIV data and association to risk for CIN2, CIN3, or cancer (CIN2+) at follow-up was evaluated; chi-square and two-sample T-test were used to compare data and risk ratios (RR) were calculated.

Results: Of 124 eligible participants, 83 attended follow-up at a median interval of 15.4 months (IQR 13.6-18.1). Almost all (99%) were on ART with mean CD4 count of 728 (SD±310). Screening methods included colposcopy (61%), visual inspection with acetic acid (28%), and pap smear (11%). Pathology demonstrated 71% of specimens obtained were benign and 29% were CIN2+. Neither demographics nor clinical factors, such as baseline margin status, duration on ART, or CD4 counts were associated with increased risk of CIN2+. However, follow-up interval of ≥20 months was associated with 2 times the risk of persistent/recurrent CIN2+ (crude RR 2.2 (95% CI 1.1-4.4)), rising to over 3 times the risk by 24 months (crude RR 3.3 (1.8-6.0)).

Conclusions: In a cohort of WLHIV on ART, nearly one-third had persistent/recurrent CIN2+ at a median interval of 15 months. Screening interval remained the most important predictor of CIN2+ at the time of re-screening with risk rising significantly at or after 20 months. This data supports the current World Health Organization (WHO) recommendation for a 12-month screening interval in a population of WLHIV who are well-controlled on ART.

Figure 1. Association between increasing interval from prior treatment and risk of persistent/recurrent CIN2+ on pathology



22. Prevalence and characterization of synchronous primary malignancy at time of invasive vulvar cancer diagnosis

***Jessica Kloppenburg, MD MS**; Xiao Tong, BS; Sharmilee Korets, MD* – Institution: UMass Memorial Medical Center

Objective: Synchronous primary malignancy (SPM) for patients with invasive vulvar cancer is not well described. Our study aims to identify the prevalence of SPM and further characterize this population.

Methods: Patients with a tissue diagnosis of invasive vulvar cancer with staging imaging (PET CT or CT chest/abdomen/pelvis) were identified by retrospective chart review (2017-2023). Exclusion criteria were vulvar Paget's disease and microinvasive cancer. Demographics, clinical characteristics, and treatment course were compared between patients with invasive vulvar cancer alone and those with SPM using Mann-Whitney U for continuous variables and Fischer exact test for categorical variables.

Results: Chart review identified 53 patients with invasive vulvar cancer and staging imaging at time of initial workup. Five patients (9%) had SPM: endometrial adenocarcinoma (n=1), lung adenocarcinoma (n=1), colon adenocarcinoma (n=1), rectal adenocarcinoma (n=1), and papillary thyroid carcinoma (n=1). Patients with SPM compared to invasive vulvar cancer alone were similar in age, race, ethnicity, and BMI, but were more likely to have stage III or IV cancer (60% vs 45%, p=0.65). They had similar time from initial visit to procedure (median [interquartile range] 39 days [29-40 days] vs. 27 days [18-44 days]). Patients with SPM were less likely to undergo surgical management (40% vs 54%, p=0.66) but had similar mortality (40% vs 40%, p=1) to patients with invasive vulvar cancer alone.

Conclusion: Synchronous primary malignancy at time of diagnosis for invasive vulvar cancer has a prevalence of 9% at our institution. Patients with SPM were more likely to have advanced disease and were less likely to undergo surgical management. Both groups had similar demographic characteristics and all-cause mortality. While these findings did not reach statistical significance owing at least in part to the rarity of the disease and small sample size, these results are compelling and warrant further investigation with a larger study population.

23. A retrospective evaluation of sentinel lymph node mapping using indocyanine green in early-stage vulvar cancer

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Institution: Tufts Medicine

Objective: Indocyanine green (ICG) is used for sentinel lymph node mapping for endometrial and cervical cancers, but the utility in vulvar cancer is not well defined. The aim of this study is to compare the detection rate of sentinel lymph nodes using ICG to Technetium 99 and blue dye.

Methods: A retrospective review was performed of patients who underwent sentinel lymph node dissection for vulvar cancer. Patients who had sentinel node tracing performed by all three techniques: lymphoscintigraphy with Technetium 99, intra-operative injection of blue dye, and intra-operative injection of ICG were included. The primary outcomes were (1) specification of nodes as "hot" (positive nuclear tracing), "blue" (positive blue dye mapping), or "green" (positive ICG mapping) and (2) pathologic confirmation of lymph tissue. Detection rates were calculated for each technique.

Results: Nine patients met inclusion criteria, resulting in 13 groin dissections. 5 patients had a midline lesion, and 4 patients had a lateral lesion. 5 patients had blue dye and ICG injected directly into the lesion, and 4 patients had the dye injected into the scar of a previous excision. 11 groins (84.6%) were noted to be lymphoscintigraphy positive, 11 (84.6%) were noted to be ICG positive, and 6 (46.2%) were noted to be blue dye positive. There were two groins that were negative for all mapping techniques. All groins that were positive for lymphoscintigraphy and blue dye were also positive for ICG. The average number of lymph nodes per sample was 1.18, and one sample contained no lymphatic tissue.

Conclusions: Sentinel lymph node mapping using ICG for vulvar cancer resulted in similar success in lymph node mapping compared to the current standard of care using lymphoscintigraphy and blue dye. A larger trial evaluating the sensitivity and specificity of ICG alone compared to standard of care is warranted.

24. The effect of intrawound vancomycin powder on surgical site infection in inguinal lymph node dissection

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Institution: Brown Univ/Women & Infants Hospital

Objective: The primary objective of this pilot study was to assess the feasibility of implementing a randomized control trial to assess the impact of intrawound vancomycin powder on postoperative complications after inguinal lymph node dissection in women with vulvar cancer. Secondary objectives included 1) analyzing the composite rate of 30-day postoperative complications, and 2) assessing for adverse effects.

Methods: This is preliminary data from a pilot, unblinded randomized control trial at a single academic institution. Patients with vulvar cancer who are planning to undergo an inguinal lymph node dissection are being randomized 1:1 to receive intrawound vancomycin powder at the time of surgery or not receive intrawound vancomycin powder. Pre- and post-operative questionnaires were administered. Descriptive statistics and Chi-square were utilized.

Results: Thirty-two patients were approached, and 30 enrolled (goal accrual). One patient was ineligible due to a vancomycin allergy. One patient declined enrollment (97% recruitment rate). Three patients did not undergo surgery after randomization (90% retention rate). No patients received the incorrect assigned arm and all patients completed the postoperative survey (100% adherence rate).

Twenty women had bilateral inguinal lymph node dissections while seven had unilateral dissections. Of the 47 dissected groins, 18 underwent sentinel dissection, 7 started with a sentinel dissection but transitioned to a full lymphadenectomy, and 22 underwent planned full lymphadenectomy.

Preliminary analysis was performed on the 26 patients who completed the study (13 each arm). No patients in the vancomycin group had a composite postoperative complication, while three patients in the control arm had complications (all with inguinal wound infections with one patient requiring hospital admission) [0% vs. 23%]. No adverse events occurred in either arm.

Conclusion: This pilot study has thus far demonstrated high recruitment, retention and adherence rates. Although preliminary data suggest clinical benefit with the addition of intrawound vancomycin powder, further research is needed to assess its impact on postoperative complications after inguinal lymph node dissections.

25. Surgical Management and Outcomes of Extramammary Paget Disease: A Single Center Experience

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Objectives: The aim of this study is to retrospectively evaluate the surgical management of Extramammary Paget Disease (EMPD) within our institution with a particular focus on surgical complications, indications for plastic surgery involvement, and recurrence rates associated with various surgical interventions, with the ultimate goal of using this information to optimize surgical management of EMPD for future patients.

Methods: Patients pathologically identified with EMPD within our institution from 2013 to 2023 were retrospectively identified. Clinical approach to management was evaluated, as well as patient characteristics and risk factors, and outcomes and complications of surgical intervention.

Results: Seven patients met criteria for further review. Six patients underwent surgical management. Three of six resections were managed with primary closure. Three of six surgical cases required plastic surgery involvement and were closed via local flap or full thickness skin graft. Four of six surgical patients experienced postoperative complications. Of the four patients experiencing postoperative complications, three had multiple risk factors for poor wound healing. Three of six surgical patients reported changes to voiding function postoperatively. All six surgical patients had positive margins postoperatively. Two of six patients required revision procedures. No patients to-date have clinical recurrence of disease.

Conclusions: There were high incidences of wound complications across our dataset. Complications were seen in patients with lesions requiring plastic surgery involvement and with multiple risk factors for poor healing. Plastic surgery revision and risk factors for poor wound healing appear to correlate with patient-reported functional changes. All patients had positive margins in the immediate postoperative period; however, to-date all patients were clinically disease-free. We propose involvement of plastic surgery for lesions in challenging locations and other indications including anticipated re-excision. We encourage counseling patients on risk reducing behaviors, and setting realistic expectations regarding surgical outcomes, especially in the setting of risk factors for complications.

26. The Utility of Vulvar Pap Smears in Vulvar Cancer Surveillance

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Institution: Yale New Haven Hospital

Objective: Little data exists for surveillance strategies of vulvar cancer following treatment, despite the propensity for local disease recurrence. The purpose of this study was to examine surveillance practices for vulvar cancer and determine the utility of post-treatment cytology via vulvar pap smears as a means of surveillance for vulvar cancer recurrence.

Methods: A retrospective chart review of all patients diagnosed with vulvar squamous cell carcinoma (SCC) from 2003 to 2023 within a single institution was performed.

Results: An initial cohort of 41 patients with vulvar squamous cell carcinoma or dysplasia and presence of vulvar cytology based on pathology records ultimately yielded the charts of 22 patients with primary diagnoses of vulvar SCC which were available for further electronic medical record review. Among these patients, primary vulvar cancers were distributed across Stage I (64%, n=14), II (14%, n=3), III (18%, n=4), and IV (0.05%, n=1). While 41% (n=9) patients developed recurrence of at least vulvar dysplasia, only 18% (n=4) had a recurrence of true vulvar cancer, only one of which was preceded by an abnormal cytology finding collected concurrently with a diagnostic biopsy. 18% of all vulvar pap smears analyzed were unsatisfactory per pathology reports.

Conclusion: Data on utility of vulvar pap smears for surveillance is limited, but preliminary data suggests that there is no additional benefit provided. Collecting vulvar cytology does not appear to minimize invasive diagnostic techniques, as regular physical exams with biopsy as indicated remains the gold standard. By eliminating repetitive vulvar pap smears which have a high rate of unsatisfactory results, we may be able to better save and allocate resources, all while reducing the burden on our cytopathology colleagues. Additional data is needed to inform practices in surveillance and long-term management of post-treatment vulvar cancer patients.

27. Association between frailty and physiologic data from wearable devices in preoperative gynecologic oncology patients.

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Institution: Northwestern Hospital

Objectives: Frail gynecologic oncology patients undergoing surgery have higher odds of 30-day postoperative complications. Existing tools used to assess frailty are imperfect and require significant provider input. We aim to explore the association between frailty and physiologic and activity data from wearable devices to guide future use of this data for preoperative assessment.

Methods: This prospective cohort study enrolled patients undergoing major surgery by a gynecologic oncologist. Participants wore an Oura RingTM for at least three days before surgery. Average heart rate (HR), respiratory rate (RR), heart rate variability (HRV), and steps on the day before surgery were collected. A 54-item electronic medical record-based Pajewski score was calculated for each patient. Based on this score, patients were classified as frail or not frail. Physiologic and activity data were compared between these groups using two-tailed t-tests. Logistic regression analyses adjusting for age were performed.

Results: 75 patients were evaluable. 64 (85.3%) were not frail and 11 (14.7%) were frail based on Pajewski score. Average HR in the frail group was 78.6 beats per minute (bpm) compared to 68.3bpm in the not frail cohort (p=0.007). A logistic regression model adjusting for age demonstrated an association between increased HR and frailty. Average RR was 18.6 breaths/minute (b/m) in frail patients and 16.7b/m in the not frail group (p=0.004). Average HRV was 24 milliseconds (ms) in the frail group and 30.9ms in the not frail group (not statistically significant, p=0.24). The number of steps on the day prior to surgery was lower in the frail group (4,297) compared to the not frail group (7,878) (p=0.017).

Conclusions: Physiologic and activity metrics such as HR, RR, and steps appear to differ between frail and not frail patients independent of age. Wearable devices may be useful in the assessment of preoperative frailty with less provider time required.

28. The Impact of MMR Status on Carcinosarcoma: A Pathologic and Clinical Outcomes Analysis.

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Institution: Brigham and Women's Hospital/MGH

Objective: Uterine carcinosarcoma is an aggressive cancer that accounts for 5% of uterine malignancies. It is unclear whether pathologic or clinical outcomes differ based on mismatch repair (MMR) gene status. We performed an exploratory analysis evaluating the pathologic and clinical outcomes of patients diagnosed with carcinosarcoma by MMR status.

Methods: We performed a retrospective chart review of patients diagnosed with carcinosarcoma at Massachusetts General Hospital from 2013-2022. Exclusion criteria included prior neoadjuvant chemotherapy, secondary cancer diagnosis, or lack of pathologic information. MMR deficiency was defined as loss of expression of MLH1, PMS2, MSH2, and/or MSH6. Clinical, pathologic, and surgical characteristics were collected. Chi square testing was used for statistical analysis.

Results: A total of 60 patients diagnosed with carcinosarcoma were included. Most patients had Stage I disease (46.7%) and mixed endometrioid-serous carcinomatous components (50.0%). Thirty-seven patients (61.7%) had surgical treatment with hysterectomy, bilateral salpingo-oophorectomy, and pelvic lymph node dissection, and 32 patients (60.4%) had recurrence. Six patients (10%) were diagnosed with MMR deficiency. Four patients (66.7%) had loss of the MLH1 gene. There was no difference in age, race, BMI, tumor size, myometrial invasion, or lymphovascular invasion rates by MMR status. All MMR-deficient patients had endometrioid or mixed histology, not pure serous, as their carcinomatous components. One MMR-deficient patient had heterologous elements as their sarcomatous component. Only one patient (16.7%) in the MMR-deficient cohort had a recurrence compared to 20 (41.7%) in the MMR proficient cohort. There was one patient death in the MMR-deficient cohort compared to 19 (38.8%) with MMR proficient disease.

Conclusions: In this introductory analysis of patients with carcinosarcoma, only 10% of patients had MMR-deficient disease. A smaller percentage of patients with MMR-deficient carcinosarcoma had a recurrence of their carcinosarcoma or death compared to those with MMR proficient disease, suggesting that MMR deficiency may be protective.

29. Datopotomab deruxtecan (Dato-Dxd), a TROP2 targeting antibody-drug conjugate, demonstrates antitumor activity in uterine serous carcinoma

Michelle Greenman, *Cem Demirkiran, Stefania Bellone, Tobias Max Philipp Hartwich, Blair McNamara, Levent Mutlu, Natalia Buza, Pei Hui, Yang Yang-Hartwich, Gary Altwerger, Elena Ratner, Gloria S. Huang, Mitchell Clark, Vaagn Andikyan, Peter Dottino, Katyayani Papatla, Masoud Azodi, Peter E. Schwartz, Alessandro D. Santin*
Institution: Yale University

Objective: Datopotamab deruxtecan (Dato-DXd) is a TROP2 directed ADC composed of the humanized anti-TROP2 IgG1 monoclonal antibody, a cleavable tetrapeptide linker, and a topoisomerase I inhibitor payload. The toxic payload component, DXd, has high cell permeability allowing for DNA damage and cell death in adjacent cells regardless of TROP2 expression, creating a significant bystander effect. We looked to evaluate the preclinical activity of Dato-DXd in uterine serous carcinoma (USC).

Methods: Two USC cell lines with 3+ TROP2 expression were treated with Dato-DXd or a non-targeting ADC isotype control (CTL ADC). Flow cytometry was used to evaluate the viability of cells treated with scalar drug concentration. The selected TROP2 expressing USC were co-cultured with a TROP2 non-expressing cell line to evaluate the bystander effect of Dato-DXd. In vivo, mice xenograft models were established from the selected TROP2 3+ ARK2 to a tumor volume of 0.2cm3. Animals were randomized to treatment with vehicle (n=5), Datopotomab (n=5), Dato-Dxd (n=5), or CTL ADC (n=5) with a primary endpoint of overall survival.

Results: In vitro, TROP2 overexpressing cell lines showed remarkable cytotoxicity when exposed to Dato-DXd compared to CTL ADC. When high TROP2 USC cells were admixed with TROP2 negligible/low-expression cells, significant bystander cytotoxicity was observed ($p=0.03$). In vivo, Dato-DXd demonstrated a significant survival advantage in mice xenografted with ARK2 compared to the vehicle control, CTL ADC, and Datopotamab ($p<0.0001$). The median survival for animals randomized to vehicle CTL, CTL ADC, and Datopotamab was 18 days, where the median survival for Dato-DXd was not reached as all mice were still alive at the conclusion of the study on day 50 ($p<0.0001$).

Conclusions: This study demonstrates for the first time the preclinical activity of Dato-DXd against primary USC cell lines and xenografts. Dato-DXd may represent an effective ADC against TROP-2 overexpressing USC.

30. Preclinical activity of datopotamab deruxtecan, a novel trophoblast cell-surface antigen 2 (TROP2) directed antibody-drug conjugate targeting TROP2 in high grade serous ovarian carcinoma

Blair McNamara, ***Michelle Greenman****, Stefania Bellone, Cem Demirkiran, Levent Mutlu, Tobias Max Philipp Hartwich, Yang Yang-Hartwich, Elena Ratner, Peter E. Schwartz, Alessandro D. Santin*
Institution: Yale University

Objective: Datopotamab deruxtecan (Dato-DXd) is a TROP2 directed antibody drug conjugate (ADC) composed of the humanized anti-TROP2 IgG1 monoclonal antibody, a cleavable tetrapeptide linker, and a topoisomerase I inhibitor payload. We looked to evaluate the preclinical activity of Dato-DXd in high grade serous ovarian cancer (HGSOC).

Methods: In vitro cell viability with Dato-DXd was assessed using flow-cytometry based assays against a panel of HGSOC primary cell lines with variable TROP2 expression. The selected TROP2 overexpressing HGSOC (TROP2 3+) were co-cultured with a TROP2 non-expressing cell line (TROP2 0) and similarly treated with Dato-DXd to evaluate potential bystander effect. Mouse xenograft models were established from a TROP2 overexpressing platinum resistant HGSOC cell line. Animals were randomized to treatment groups with control PDS (n=5), Datopotomab (n=5), Dato-Dxd (n=5), or CTL ADC (n=5).

Results: TROP2 3+ HGSOC cell lines demonstrated higher sensitivity to Dato-DXd when compared to TROP2 0 cell lines (IC50: 0.49μM vs. 5.1μM, $p<0.0001$). While negligible activity was detected against TROP2 0 cell lines, Dato-DXd demonstrated significant bystander killing against TROP2 0 tumor cells when admixed with TROP2 3+ tumor cells in vitro ($p=0.009$). Dato-DXd showed tumor growth suppression in in vivo HGSOC PDX models after single retro-orbital injection of Dato-Dxd ($p<0.0001$). Survival of Dato-DXd treated mice was significantly longer than other arms ($p<0.0001$). Toxicity was minimal.

Conclusions: This study shows promising in vitro and in vivo preclinical efficacy of Dato-DXd in HGSOC. This preclinical data supports evaluation of Dato-DXd in patients with advanced or recurrent HGSOC. A Phase 2 trial of Dato-DXd as monotherapy and in combination with other anticancer agents in patients with advanced solid tumors is ongoing (Tropion-Pantumor03).

31. Small molecule ubiquitin C-terminal hydrolase L1 inhibition drives cell metabolism changes and exerts variable anti-tumorigenic effects dependent on platinum status in high grade serous ovarian cancer.

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Institution: Brown Univ/Women & Infants Hospital

Objective: The goal of this study was to test the efficacy of small molecule inhibition of ubiquitin C-terminal hydrolase L1 (UCHL1) in combination with standard of care chemotherapy in high grade serous ovarian cancer (HGSOC) and to characterize tumoral adaptations that occur due to UCHL1 inhibition.

Methods: Comparative-label free proteomic analysis was employed to uncover significant changes in HGSOC cell line OVCAR following treatment with UCHL1 small molecule inhibitor, LDN-5744. Significant pathway changes were determined by KEGG analysis. Matched chemosensitive and resistant HGSOC cells PEA1 and PEA2 were treated in combination with LDN-5744 and carboplatin and a cell viability assay was performed. Western blot analysis was employed to compare common cell growth pathway changes due to UCHL1 inhibition.

Results: Proteomic analysis revealed a significant ($p<0.05$) upregulation in methyl phosphate capping enzyme (MEPCE) (4.9-fold), asparagine synthetase (ASNS) (2.5-fold), Phosphoserine aminotransferase 1 (PSAT1) (1.7-fold), and downregulation in centrosomal protein 55 (CEP55) (-7.2-fold). KEGG pathway analysis using all significantly ($p<0.05$) differentially expressed proteins showcased significant ($p<0.05$) enrichment in amino acid biosynthesis and metabolism, and chemical carcinogenesis-reactive oxygen species. PEA2 cells treated with LDN-5744 and carboplatin demonstrated a 59% reduction in cell viability, significantly ($p<0.001$) lower than the 13% and 22%, that was observed from UCHL1 and carboplatin treatment alone, respectively. Conversely, PEA1, the chemosensitive counterpart to PEA2 demonstrated a significant ($p<0.001$) 37% increase in cell viability upon combinatorial treatment compared with carboplatin alone, indicating that UCHL1 inhibition was rescuing the cells from chemotherapy induced cell death. LDN-5744 treatment in PEA2 led to a reduction in levels of phospho-(p-) AKT, p-STAT3, and p-ERK, while conversely in PEA1 cells levels of these proteins were increased or unchanged.

Conclusion: Our findings demonstrate that targeting UCHL1 results in prominent metabolic changes in HGSOC cells and that the efficacy of UCHL1 inhibition is heavily dependent upon platinum status.

32. Mechanisms of Resistance to Antibody Drug Conjugate Therapy in Ovarian Cancer.

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Institution: Massachusetts General Hospital

Objective: We sought to identify and understand acquired resistance mechanisms to antibody drug conjugate (ADC) therapy in ovarian cancer to inform strategies to overcome resistance, improve response rates, and extend the durability of ADC treatment.

Methods: We developed an in vitro model of resistance to a MUC16 (CA-125)-directed ADC conjugated with monomethyl auristatin E (MMAE) to examine the mechanisms of resistance. After confirming resistance, we assessed differences in MUC16 antigen expression via fluorescence-activated cell sorting, multidrug resistance transporter activity (MDR), and lysosomal pH by fluorescence imaging. To explore the clinical relevance of our findings, we also looked at the differential expression of Folate Receptor Alpha and HER 2 in the ADC resistant and susceptible cell lines by flow cytometry and assessed for cross-resistance with cytotoxicity assays with alternate ADC therapies. Additionally, we established patient derived organoids (PDOs) from patients who had progressed on ADC therapy and performed functional killing assays, immunocytochemistry, and flow cytometry to characterize their resistant tumors.

Results: In a MUC16-MMAE ADC resistant cell line, we demonstrated stable cell surface expression of MUC16, Folate Receptor Alpha, and HER2. Despite retained expression of MUC16, treatment with MUC16 ADCs with other payloads, MUC16-Maytansinoid and MUC16-Caleachamicin also showed an increased IC50 compared with non-resistant cells. Additionally, treatment with Folate Receptor Alpha and HER2 directed therapies showed an increased IC50 compared to the non-resistant cells. We also found increased lysosomal pH in the MMAE-resistant cells compared to susceptible cells, a contributor to resistance. There was no difference in MDR activity in resistant cells. In the PDOs, we observed cross-resistance to alternate ADC therapies.

Conclusion: We demonstrate that MUC16-MMAE resistance confers pan-resistance to ADC therapy. Potential mechanisms of resistance include altered ADC processing via lysosomal pH alterations. Ongoing efforts are focused on further characterizing these mechanisms and evaluating resistance to other ADC payloads.

33. Neoadjuvant chemotherapy exposure induces phenotypic mast cells changes in high grade serous ovarian cancer

Julia McAdams, *Jasmine Ebott, Payton De la Cruz, Daniela Maiz, Joyce Ou, Linda Hanley, Cara Mathews, and Nicole E James*
Institution: Brown Univ/Women & Infants Hospital

Background/Objective: High grade serous ovarian cancer (HGSOC) patients have not responded meaningfully to clinically available immunotherapies. Our past work identified that mast cells, an immune cell subset largely understudied in the context of cancer, are significantly upregulated following NACT exposure. In this current study we sought to characterize phenotypic changes within mast cells following NACT exposure and how these adaptations are associated with HGSOC patient clinical outcomes.

Methods: Human immortalized mast cells, LUVA, were treated with carboplatin and paclitaxel and quantitative PCR analysis was employed to examine changes in mast cell secreted factors. 30 matched pre-and post- NACT HGSOC patient tumors were stained via immunohistochemistry for mast cell specific proteases, Tryptase and CPA3. 10 randomly selected fields per slide were imaged and counted for Tryptase+, CPA3+, and Tryptase+CPA3+ mast cells. Student t-test analysis was employed to determine mast cell protease counts in pre-vs post-NACT tumors. Kaplan Meier curve, Spearman Rank Correlation, and student t-test analyses were employed to examine the relationship between mast cell protease counts and patient survival outcomes.

Results: AREG and CCL2, two mast cell activation factors, exhibited a significant ($p<0.05$) increase in fold change expression, while TGFβ1, an inhibitor of mast cell activation was significantly ($p=0.022$) downregulated following chemotherapy treatment in LUVA cells. Both tryptase+ and Tryptase+CPA3+ mast cells were significantly ($p<0.05$) upregulated in post-NACT treated HGSOC tissue in stromal and intraepithelial compartments. Levels of pre-NACT intraepithelial Tryptase+CPA3+ mast cells significantly negatively correlated with overall survival (OS) ($r=-0.390$, $p=0.033$). Patients with higher median levels of total Tryptase+CPA3+ mast cells had significantly lower OS (HR=2.224 [0.9275-5.348], log-rank-p-value=0.038).

Conclusions: Our findings highlight that mast cell activation and granule content dynamically change following chemotherapy exposure and appears to have differing associations with HGSOC patient clinical outcomes. Future directions include functional studies to determine how mast cells impact HGSOC chemotherapy response.

34. Comparing the Effects of Glucagon-like Peptide-1 Receptor Agonists on Endometrial Cancer Incidence in Patients with Type 2 Diabetes Mellitus to Insulin, Metformin, and Sodium-Glucose Transport Protein 2 Inhibitors: A Real-World Multi-Center Cohort Study Across the United States.

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Institution: Beth Israel Deaconess Medical Center

Objective: To quantify the association of glucagon-like peptide-1 receptor agonists (GLP1RA) with incident endometrial cancer compared to insulin, metformin, and sodium-glucose transport protein 2 inhibitors (SGLT-2i) in type 2 diabetes (T2DM).

Methods: This retrospective cohort study used TriNetX electronic health records from over 50 U.S. healthcare organizations. The cohort consisted of females aged ≥18 who were diagnosed with T2DM and had ≥2 GLP1RA, metformin, or insulin prescriptions from 5/1/2005 (first GLP1RA approval) to 12/31/2021. The cohort for GLP1RA and SGLT2i included those with prescriptions from 5/1/2014 (first SGLT2i approval) to 12/31/2021. The index date was the initiation of medication. Those with hysterectomy or no BMI data were excluded. Endometrial cancer was defined by ICD-10 codes. After 1:1 propensity score matching on demographics, comorbidities, healthcare utilization, other antidiabetic medications before the index date, BMI, and HbA1c, we estimated risk ratios and 95% CI for GLP1RA compared to comparators. Patients were followed from the index date to outcome diagnosis, loss to follow-up, five years, or 4/24/2024, whichever came first. Patients with ≥6 prescriptions were used for as sensitivity analysis.

Results: Compared to insulin, GLP1RA was associated with significantly reduced endometrial cancer risk (RR 0.53; 95% CI 0.41-0.69), with a similar effect at ≥6 doses (RR 0.53; 95% CI 0.36-0.77). GLP1RA also was associated with a lower, though non-significant, risk of endometrial cancer for ≥2 (RR 0.75; 95% CI 0.54-1.03) and ≥6 doses (RR 0.64; 95% CI: 0.40-1.01) compared to metformin. Compared to SGLT2i, GLP1RA was associated with a lower, though non-significant, risk of endometrial cancer for ≥2 prescriptions (RR 0.87; 95% CI 0.66-1.1) and a significantly lower risk for ≥ 6 prescriptions (RR 0.67; 95% CI 0.46-0.98).

Conclusions: GLP1RA may protect against endometrial cancer compared to insulin and, with sustained exposure, SGLT2 inhibitors in women with T2DM. Further studies are needed to understand therapeutic mechanisms.

35. Sensitivity of omentectomy for detecting occult omental metastases in high grade uterine cancer

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Institution: Yale New Haven Hospital

Objective: Omental metastasis is a poor prognostic indicator in uterine cancer. When staging high grade uterine cancer, there is a lack of consensus on whether to perform omentectomy or omental biopsy between NCCN and ESMO guidelines. This study aims to assess the sensitivity of infracolic omentectomy for accurate diagnosis of occult omental metastases in clinical stage I high grade uterine cancer.

Methods: We performed a single-institution secondary pathology review of patients with high grade uterine cancer (serous, clear cell, carcinosarcoma, and grade 3 endometrioid) and occult omental involvement diagnosed from 2005 to 2022. Our institution's protocol for omental review evaluates 5 random 1cm sections of every grossly normal omentum specimen. Omental involvement is classified as present if at least 1 of 5 samples shows invasive disease. Patients were excluded from analysis if pathologists noted gross omental involvement, if fewer than 5 omental sections were available for secondary review by a gynecologic pathologist, or if they had clinically advanced stage disease and/or received neoadjuvant chemotherapy.

Results: 18 patients with clinical stage I high grade uterine cancer were found to have occult omental metastases on infracolic omentectomy/large omental biopsy. Out of 90 total omental sections evaluated, 45 sections (50%) were positive for invasive disease. 55.6% patients (10/18) had only 1-2 out of 5 sections positive for invasive disease. Among patients who had pelvic washing results available, 100% (15/15) of cytology samples were positive for malignant cells. Lastly, 35.7% (5/14) of patients had negative pelvic and para-aortic lymph nodes but positive omental metastasis.

Conclusions: The study evaluates the sensitivity of detecting occult metastasis in an infracolic omentectomy in high grade uterine cancer. Evaluating a single pathological section achieves a sensitivity of 50%. When 5 pathological sections are evaluated, the chance of missing omental metastasis falls to approximately 3%. This change in sensitivity is reliant on the number of pathological sections and therefore raises concerns about the adequacy of current practices regarding the extent of omental sampling (biopsy versus omentectomy) and the number of pathological sections examined. The proper sampling of the omentum is of the utmost importance since there were a group of patients with negative lymph nodes but occult omental metastasis which upstaged the patients to IVB. The difference between stage I and IV is now a matter of treatment eligibility given that adjuvant immunotherapy is recommended for stage IIIC2 and above.

36. Comparison of 2009 to 2023 FIGO staging in uterine-confined endometrial cancer.

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Institution: BIDMC – Harvard

Objectives: The 2023 International Federation of Gynecology and Obstetrics (FIGO) endometrial cancer (EC) staging system incorporates histological subtype and molecular classification to stratify prognostic outcomes and guide treatment algorithms. We aimed to assess the impact of the 2023 FIGO staging system on stage migration in a cohort of uterine-confined ECs and to estimate the prognostic significance of restaging in this cohort.

Methods: We conducted a single-institution, retrospective study of patients diagnosed with FIGO 2009 stage I EC from 2017-2021. All pathological samples were reviewed by gynecologic pathologists. Patients were stratified by 2009 stage and 2023 stage was assigned. Mismatch repair (MMR) and p53 immunohistochemical (IHC) staining results were collected, POLE testing was not available.

Results: We identified 372 patients with 2009 stage I EC, the majority of which were white (71%) and non-Hispanic (83%). Most tumors had endometrioid histologic subtype (83%), followed by serous (15%), and carcinosarcoma (3%). MMR IHC testing was performed in 91% of patients and 41% of patients were MMR deficient. Of patients with high-grade non-endometrioid vs endometrioid histology, p53 staining was performed in 89% vs 19% of tumors respectively and 16% of all tumors were p53 abnormal. Upstaging occurred in 24% of stage IA and 41% of stage IB tumors (Figure 1). Nine percent of all patients recurred. When comparing tumors with and without stage shift, recurrence occurred in 18% vs 6% of patients, respectively ($p<0.01$).

Conclusions : In this cohort, application of the FIGO 2023 EC staging upstaged over 25% of uterine confined tumors. Inclusion of complete molecular testing would both downstage (POLE) and upstage (p53) a subset of tumors. Patients upstaged were significantly more likely to recur. Prospective studies are needed to determine the prognostic significance of stage migration and value of expanded molecular testing in the uterine-confined EC population.

37. A pilot randomized controlled trial of laparoscopic surgeon-administered TAP block with liposomal bupivacaine in patients undergoing minimally invasive hysterectomy for endometrial cancer

Gouri B Sadananda MD, *Rafael Gonzalez MD, Sarah Paraghamian MD, Katina Robison MD, Young Bae Kim MD* – Institution: Tufts Medicine

Objective: There is mixed evidence regarding the efficacy of transversus abdominis plane (TAP) blocks in reducing post-operative pain and opiate use in patients undergoing minimally invasive hysterectomy. This pilot study aims to demonstrate the feasibility and tolerability of using a laparoscopic surgeon-administered TAP block for use in a later randomized controlled trial testing the efficacy of this approach. The secondary aim is to assess pain scores in this population to inform statistical analysis for a larger study.

Methods: A single-blinded, randomized controlled pilot study is being conducted at Tufts Medical Center. Women undergoing minimally invasive hysterectomy for endometrial cancer or endometrial intraepithelial neoplasia were eligible. Patients were randomized to one of three study arms: (1) no TAP block, (2) TAP block with plain bupivacaine, or (3) TAP block with both plain and liposomal bupivacaine. The TAP blocks were administered by the surgeon under direct laparoscopic view, in large volume and at multiple injection sites to maximize distribution of the anesthetic agents. Subjects were blinded to the study arm. Participants were contacted during the first post-operative week to assess the patient-reported pain score and opiate use.

Results: At this time, 13 patients were screened based on scheduled minimally invasive hysterectomy for endometrial cancer or endometrial intraepithelial neoplasia. 7 patients have enrolled. 5 patients declined participation. One patient was not eligible for participation due to a history of chronic opiate use and one patient was excluded due to active peritoneal dialysis. The TAP block was successfully performed in all subjects randomized to the procedure. There have been no serious adverse events.

Conclusion: The preliminary data from this pilot study suggests that this technique is feasible and tolerable. The rate of enrollment of screened patients has been lower than anticipated.

38. Updated analysis of rate of postoperative VTE in endometrial cancer patients undergoing minimally invasive surgery

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Aims: The American Society of Clinical Oncology (ASCO) recommends extended pharmacologic prophylaxis for all gynecologic oncology patients undergoing major surgery, regardless of surgical modality. Data supporting this recommendation is based on open procedures, but, more recently, minimally invasive surgery (MIS) has become the widely accepted standard of care in endometrial cancer surgery. Several large studies suggest a significantly lower rate of postoperative venous thromboembolism (VTE) in patients undergoing MIS as compared to open surgery.

Objective: This study aims to determine the rate of postoperative VTE in patients undergoing MIS for endometrial cancer who do not receive extended outpatient pharmacologic VTE prophylaxis at discharge.

Methods: This is a retrospective chart review of women undergoing MIS surgery for endometrial cancer at a single large academic institution between 2014 and 2020. Patients were excluded for age less than 18, final diagnosis other than endometrial cancer, history of VTE or known thrombophilia already on anticoagulation, surgery done at an outside institution, or conversion to open procedure. The primary outcome was the rate of VTE within 30 days of surgery.

Results: During the study period we identified no patients who experienced a VTE within 30 days of surgery. In our study population of 435 patients, 60.0% of cases were robotic and 39.8% were laparoscopic, and the majority were Stage IA (68.7%). Per hospital policy all patients received mechanical prophylaxis during surgery and postoperatively, and 58.0% of women received pharmacologic prophylaxis while inpatient. Outpatient pharmacologic prophylaxis was given to 1.4% of patients.

Conclusion: The rate of VTE in endometrial cancer patients undergoing MIS surgery who do not receive extended outpatient pharmacologic VTE prophylaxis was extremely low irrespective of surgical modality. We recommend that this patient population does not require extended outpatient pharmacologic VTE prophylaxis and suggest current guidelines differentiate recommendations based on surgical modality.

39. Impact of Minimally Invasive vs. Open Surgery on Discharge Location in Geriatric Patients Undergoing Surgery for Ovarian Cancer

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Institution: Albany Medical Center

INTRODUCTION: Loss of independence is common in older adults after surgery. While the NCCN recommends open surgery for most patients with ovarian cancer, our objective is to compare discharge location outcomes between open surgery and minimally invasive surgery (MIS) in patients aged 65 years and older as a surrogate for functional status.

METHODS: The National Surgical Quality Improvement Program (NSQIP) database was queried to identify surgical procedures for subjects aged 65 years and older with fallopian tube, ovarian, and primary peritoneal cancers from 2016 to 2021. Outcomes between the open surgery group and the MIS group were analyzed using chi square, anova. An adjusted multivariate logistic regression was used to control for variables significant at the $p<0.1$ level or possible confounders.

RESULTS: Of the 6,543 identified patients, 5,943 underwent open surgery and 600 underwent MIS. Groups were matched in terms of age, BMI, and comorbidities, with a mean age of 72 ($p=0.65$). White patients were more likely to undergo MIS ($p<0.001$). In the open surgery cohort, 91% were discharged home, 8% to a facility, and 0.6% to hospice or deceased prior to discharge. Among patients undergoing MIS, 97% were discharged to home, 3% to a facility, and 0.2% to hospice or deceased prior to discharge ($p<0.001$). MIS patients experienced fewer major complications ($p<0.001$) and had a shorter length of stay ($p<0.001$). After risk adjustment, discharge home was more common in the MIS group ($p<0.001$).

CONCLUSION: Patients aged 65 and older who underwent MIS for ovarian cancer were more likely to be discharged home and had significantly shorter length of stay with fewer complications, compared to open surgery. Despite the lack of prospective data to support MIS in ovarian cancer, these data can help guide counseling for individualized decision making for older patients planning ovarian cancer surgery.

40. Chemotherapy followed by interval cytoreductive surgery has become the most prevalent approach in the upfront treatment of patients with advanced-stage epithelial ovarian cancer in the United States

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Institution: Mass General Hospital

Objective: To describe trends in the upfront treatment of patients with advanced epithelial ovarian in the United States.

Methods: This repeated cross-sectional study was set in Commission on Cancer-accredited cancer programs in the United States from 2010 to 2020. We included patients diagnosed with stage IIIC or IV (FIGO 2016) epithelial ovarian cancer. We categorized patients as having received PCS, NACT followed by ICS, or no cytoreductive surgery. We regressed the treatment approach on the year of diagnosis using Poisson regression models with robust standard errors, in which the year was modeled using restricted cubic splines. We then used these models to plot temporal trends and estimate rate ratios (RR).

Results: We identified 68,760 patients, with a mean age of 64.2 (SD 12.2), of whom 59.3% had stage IIIC disease. Overall, 34,031 (49.5%) patients underwent PCS, 22,046 (32.1%) patients underwent ICS, and 12,683 (18.4%) patients received no surgery. The use of PCS and ICS changed dramatically over the study period, with ICS overtaking PCS as the most frequent treatment approach by 2018. From 2010 to 2020, the percentage of patients who underwent PCS fell from 67.4% to 29.0% (RR 0.43, 95% CI 0.41-0.45, $p<0.001$). The percentage of patients who underwent ICS increased 2.6-fold from 17.9% to 47.9% (RR 2.64 2.50-2.79, $p<0.001$). There was a concurrent rise in the proportion of patients who received no surgery from 14.7% to 23.6% (RR 1.60, 95% CI 1.50-1.72, $p<0.001$).

Conclusion: In the decade following the publication of the first randomized trial that found NACT followed by ICS was non-inferior to PCS for advanced-stage epithelial ovarian cancer, there was a dramatic increase in the utilization of NACT and now NACT followed by ICS is the dominant upfront treatment strategy.

41. Racial and ethnic disparities in debulking surgery and complete cytoreduction among ovarian cancer patients

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Institution: Brigham and Women's Hospital

Objective: Racial/ethnic disparities exist for almost all surgical conditions, including for ovarian cancer debulking surgery. However, little is known regarding rates of debulking surgery, sequencing of treatment (neoadjuvant chemotherapy [NACT] versus primary debulking [PDS], and achieving complete cytoreduction by race/ethnicity among ovarian cancer patients.

Methods: Stage III and IV ovarian cancer patients in the National Cancer Database (NCDB) from 2018-2021 were included. Rates of undergoing debulking surgery at the reporting facility, PDS versus NACT, and complete cytoreduction were compared by race/ethnicity using chi-square. Factors associated with complete cytoreduction were assessed using multivariate logistic regression.

Results: Of 46,294 patients, 57.9% underwent surgery at the reporting facility and 25.2% were of non-White race/ethnicity. Of those who underwent surgery (N=26,801), 39.2% had a complete cytoreduction. Rates of undergoing any surgery at the reporting facility were highest for non-Hispanic White patients (59.4%) and lowest for non-Hispanic Black patients (50.3%, $p<0.001$). Among those who underwent surgery, non-Hispanic Black patients had the lowest rates of PDS (36.8%) compared to other groups. Non-Hispanic Black patients and Other/Unknown race patients had the lowest rates of complete cytoreduction (35.0% and 34.4%, respectively, versus 39.8% for non-Hispanic White patients, $p<0.001$). On multivariate analysis, non-Hispanic Black women were less likely to undergo complete resection compared to non-Hispanic white patients (aOR 0.90, 95% CI 0.81-0.99, $p=0.043$, Table 1). Odds of complete cytoreduction were also reduced for patients treated at non-academic programs, in the South or West, without insurance, with grade 3 tumors, or stage IV disease (Table 1).

Conclusions: Non-Hispanic Black women with ovarian cancer in the NCDB are not only less likely to undergo surgery at the reporting facility, but also are less likely to be triaged to PDS and to have a complete cytoreduction. Understanding barriers to surgical outcomes which impact survival may minimize disparities in ovarian cancer care.

42. Cost Analysis Associated with Enhanced Recovery After Surgery (ERAS) Implementation Among Ovarian Cancer Patients by Race and Ethnicity

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Institution: BWH – Harvard

Objective: Prior work at our institution showed that an Enhanced Recovery After Surgery (ERAS) program improved readmissions, length of stay, and blood transfusions among non-white women with advanced stage ovarian cancer, promoting health equity. We sought to expand this work by further understanding the cost effectiveness of ERAS implementation, comparing measures across white and non-white ovarian cancer patients.

Methods: A cost analysis model was constructed using TreeAge Pro 2020 software. Healthcare expenditures associated with preoperative, intraoperative, and postoperative outcomes within 30 days of debulking surgery for advanced stage ovarian cancer were compared by time period (pre-ERAS [January 2010 to July 2015] versus post-ERAS [March 2017 to December 2021]) and by race/ethnicity. Probability data was extrapolated from our prior study, "Improving Health Equity Among Ovarian Cancer Patients Enrolled in an Enhanced Recovery After Surgery (ERAS) Pathway." Further model inputs were derived from the literature.

Results: Before ERAS implementation, average healthcare expenditures totaled $41,542.89 and $50,769.85 for white and non-white patients, respectively. Post-ERAS implementation, costs were $35,690.01 among white patients and $46,707.16 for non-white patients, for a reduction of 14% and 8%, respectively. In order for ERAS to produce cost benefits, white patients would require < 6.15 days in length of stay compared to < 6.25 days in non-white patients. The cost of ERAS could not exceed $10,726.76 for white patients and $8,936.59 for non-white patients to break even (Figure 1).

Conclusions: Implementation of ERAS was associated with reduced healthcare costs within the first 30 days of debulking surgery in advanced stage ovarian cancer patients. This trend is appreciated across white and non-white patients, although average cost reduction associated with ERAS was less in non-white patients in our cohort. This suggests ongoing health inequities. Further research is needed to determine drivers of the reduction in costs related to ERAS and race/ethnicity.

43. National patterns of hysterectomy counseling for patients with BRCA mutations

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Institution: Brown Univ/Women & Infants Hospital

Objective: BRCA mutations (BRCAm) have been associated with the development of endometrial cancer.

Methods: A 21 question survey was distributed to all faculty members of the Society of Gynecologic Oncology (SGO). Results were collected in a RedCap database and analyzed using STATA software.

Results: 210 faculty members completed the survey, for a response rate of 18%. Responses demonstrated a wide distribution of individual response rates from around the country, with 77.1% participants having a residency program at their institution, and 41.2% having a Gynecologic Oncology (GYN ONC) fellowship program. 78.0% of individuals reported GYN ONCs as the primary doctors performing risk reducing surgery (RRS). Surgical counseling noted the majority of GYN ONC faculty (83.3%) recommended a risk-reducing bilateral salpingo-oophorectomy (RRBSO), while less than fifty percent (46.3%) of individuals routinely recommended hysterectomy as part of a RRS. The highest reported reasons to counsel for hysterectomy at the time of RRS were the need for hormone replacement therapy (HRT) (85.7%), to reduce risk of endometrial cancer (84.3%), for benign uterine conditions (78.6%), and need for tamoxifen use (71.4%). Individuals reported reasons against hysterectomy at the time of RRS included surgical complications (65.5%), desire for fertility preservation (51.5%), less so surgical time and cost. 96.7% of respondents indicated that they were familiar with the NCCN guidelines for ovarian and fallopian tube cancers, with 94.8% of respondents documenting knowledge of UPSC. 65.4% of individuals responded that they had altered their management strategies with the most current guidelines from their respective organizations.

Conclusion: This study demonstrated trends of physician recommendations and counseling regarding RRS for BRCA1m and BRCAm across North America.

44. Early pathways to end-of-life (EOL) planning: A multi-center evaluation of the impact of an educational video on documented EOL planning discussions with patients with gynecologic cancers

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Institution: Tufts University School of Medicine

Objective: The primary objective of the study was to evaluate the impact of an EOL planning educational video on patient attitudes regarding EOL care at two academic institutions. The secondary objective was to compare each center's composite means of EOL planning documentation among gynecologic oncology patients with advanced or recurrent disease.

Methods: An observational prospective cohort study was conducted at two academic institutions (Site 1 and Site 2). Patients with advanced (stage III or IV) or recurrent gynecologic malignancy were eligible. Enrolled patients completed a pre-video survey assessing EOL planning attitudes, a validated video created by the Advanced Care Planning Decisions Foundation, and a post-video survey. Through chart review, patients were given a score of documented EOL planning, calculated as the number of EOL items present (advanced directive, medical orders for life sustaining treatment, palliative care referral, or code status discussion) divided by the total number of possible items. Composite means were calculated as the average of these scores and compared using a two-sample t-test in Stata.

Results: Fifty-nine patients enrolled and completed both surveys. In pre-video surveys, 83% of patients thought it was important for their doctor to know their EOL wishes and 69% believed doctors should initiate these discussions, but only 12% reported having them. In post-video surveys, most patients (98%) found the video helpful and would recommend it to others. Fifty-four percent of patients were ready to talk about EOL with their doctor, but only 15% were ready to talk the day they were shown the video. The composite means were 0.76 (SD 0.80) and 0.44 (SD 0.25) at Site 1 and 2, respectively (P = 0.10).

Conclusion: EOL planning is critical in cancer care. Use of educational videos appears to be helpful and could facilitate discussions between patients with gynecologic malignancies and providers and offer more standardized care.

45. Laparoscopic pancreatic peritonectomy with splenectomy for recurrent ovarian cancer: A novel approach to achieve R0 while preserving the pancreatic tail *(Video Presentation)*

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Institution: Yale

Objectives: Demonstrating a laparoscopic splenectomy with anterior pancreatic peritonectomy, a novel approach in gynecologic oncology; and avoiding partial pancreatectomy by combining a retroperitoneal posterior approach with anterior pancreatic peritonectomy.

Introduction: In recurrent oligometastatic ovarian cancer, complete disease removal followed by chemotherapy improves overall survival. For oligometastatic disease involving the spleen, conventional laparoscopic splenectomy is the most cost-effective, minimally invasive method4. We present pancreatic peritonectomy with splenectomy as a novel approach to achieve R0 in recurrent ovarian cancer. Pelvic peritonectomy is a well-described surgical technique in gynecologic oncology applied to cancers spread to the pelvic peritoneum. The anterior pancreatic peritonectomy extends this method to recurrent ovarian cancer closely associated with the pancreas. This enables peritoneum and disease separation from the pancreas's anterior surface, avoiding partial pancreatectomy and ensuring proximal splenic vessel control, especially when accessing the splenic hilum is challenging. Complete disease removal is feasible with pancreatic peritonectomy, as the pancreas is secondarily retroperitonealized.

Methods: A patient in her 60s presented with platinum-sensitive oligometastatic high-grade serous ovarian cancer. PET scan showed a solitary lesion (2.5x3.0 cm, SUV 15) in the splenic hilum extending to the pancreas. Key steps included pancreatic peritonectomy, isolating the proximal splenic vessels, and mobilizing the pancreatic body and tail.

Results: Splenectomy was completed without a partial pancreatectomy. The patient had 50cc blood loss and was discharged without complications on day three, undergoing platinum-based chemotherapy two weeks later.

Conclusion: We demonstrate a novel approach in gynecologic cancer, utilizing laparoscopic pancreatic peritonectomy for tumor removal from the superior border of the pancreas. This facilitates complete cytoreduction with control of the proximal splenic vessels while preserving the pancreatic body and tail. Eliminating the need for a partial pancreatectomy avoids associated complications. This technique leverages established peritonectomy practices in gynecologic malignancies to offer faster recovery and reduced costs compared to open and robotic surgery.

46. Artery of choice: A single institution experience with uterine artery embolization (UAE) comparison of transradial versus transfemoral approach for obstetrical or gynecological surgery

***Sha Sha, MD,** David Munger, DO, Ilana Cass, MD*
Institution: Hitchcock

Objective: Transradial approach (TRA) has become more popular for access in interventional radiology (IR) procedures, including uterine artery embolization (UAE). Compared to transfemoral approach (TFA) for uterine fibroids, TRA is associated with decreased rates of hemorrhage, complications, and shorter catheterization time. TRA for other obstetrical or gynecological indications necessitating UAE has not been well described. We aim to compare the outcomes and complications of both UAE access approaches at our institution.

Methods: A retrospective chart review to identify patients from 1/1/2016 to 4/18//2024 s/p peri-operative UAE. 2.6% (2/29) planned Cesarean-hysterectomies for placenta accreta syndrome (PAS) had pre-operative UAE.

Results: 9 patients underwent UAE in anticipation of a planned obstetrical or gynecological surgical intervention associated with high hemorrhage risk: 1 complete molar pregnancy, 1 cervical ectopic, 1 Cesarean scar ectopic, 1 abnormal uterine bleeding,1 fibroid uterus, 2 PAS, 1 postpartum hemorrhage (PPH), 1 with concern for retained products of conception. 78% (n = 7) were performed via radial approach, 22% (n = 2) femoral approach (Figure 1). There were no cases of failed access or conversion to alternative access site. TRA enabled immediate dorsal lithotomy positioning for surgery. TFE required supine position or a two-hour delay from IR to dorsal lithotomy in the OR. There was no difference in median fluoroscopy time (19.4 vs. 19.2 minutes). One patient in the TRA group experienced a brachial artery spasm requiring nicardipine and general anesthesia for pain. Excluding the hemodynamically unstable PPH patient, there were no major complications or EBL > 1 liter in either group.

Conclusion: Radial approach for pre-operative UAE for an obstetric or gynecologic indication is overall safe and effective compared to femoral access, enabling efficient and optimal patient positioning with dorsal lithotomy. Fluoroscopic time is comparable despite a perceived increased learning curve with TRA.

Figure 1: Uterine Artery Embolization Cases by Type of Arterial Access

ID	Age	BMI	Indication	Planned OBGYN Procedure	UAE Timing	UAE Access Site	Fluoroscopy Time (minutes)	Complications
1	38	29	~9w0A cervical ectopic pregnancy	D&C	Pre-op	Radial	19.2	Local: None Major: None
2	50	29	Abnormal uterine bleeding	Hysteroscopy, D&C	Pre-op	Radial	21.6	Local: None Major: None
3	18	21	~9w0A complete molar pregnancy	D&C	Pre-op	Radial	n/a	Local: Brachial artery spasm Major: None
4	38	32	~24w0A with oligohydramnios, chorioamnionitis, suspected PAS	Cesarean hysterectomy	Intra-op	Radial	10	Local: None Major: None
5	45	24	Fibroid uterus	Total abdominal hysterectomy	Pre-op	Radial	32	Local: None Major: None
6	37	22	Incomplete mAB, Cesarean scar ectopic pregnancy, suspected PAS	D&C, possible hysterectomy	Pre-op	Radial	14.6	Local: None Major: None
7	34	22	Concern for retained products of conception	D&C	Pre-op	Radial	19.5	Local: None Major: None
8	37	28	PPH after Cesarean section	Cesarean hysterectomy	Pre-op	Femoral	25	Local: None Major: None
9	34	45	PAS	Cesarean hysterectomy	Intra-op	Femoral	13.4	Local: None Major: None

Abbreviations: dilation and curettage (D&C), uterine artery embolization (UAE), medical abortion (mAB), placenta accreta spectrum (PAS), postpartum hemorrhage (PPH)

47. Outcomes of Fertility Sparing Treatment in a Case Series of Patients with Lynch Syndrome

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Institution: Brigham and Women's

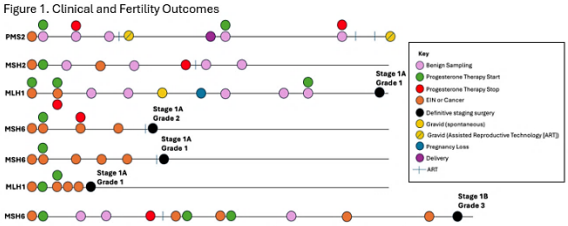
Objectives: The optimal approach to fertility-sparing treatment for patients with Lynch Syndrome (LS) remains unclear. This study examines outcomes from fertility sparing treatment in patients with LS and endometrial intraepithelial neoplasia (EIN) or endometrial carcinoma (EC) to provide evidence for management.

Methods: We conducted a retrospective chart review of patients presenting to an academic cancer center with EC or EIN and a confirmed germline LS mutation. Patients were included if their initial treatment did not include hysterectomy due to desire to preserve fertility. Demographic variables and clinical and reproductive outcomes were collected for each patient and tabulated.

Results: Seven patients were included with a median age of 36 (IQR 31, 38) at diagnosis. The majority were White (86%) and non-Hispanic (86%). All LS mutations were represented: MLH1 (2), PMS2 (1), MSH2 (1) and MSH6 (3). Three patients had an initial diagnosis of EIN, four had EC. Four were treated with both oral progesterone and progesterone containing intrauterine device (IUD) and three with IUD alone. Six out of seven patients were seen by reproductive endocrinology and infertility and five pursued assisted reproductive technology (ART). There were three pregnancies and one successful live birth. Five patients underwent eventual staging surgery. Three had stage 1A grade one EC, one had stage 1A grade 2 EC, and one had a stage 1B grade 3 EC and underwent adjuvant radiation.

Conclusions: More research is needed to understand the typical course and outcomes for patients with LS and EIN or EC who desire fertility sparing management. This limited case series suggests that fertility sparing treatment may be a viable option for patients without serious adverse outcomes, however successful pregnancy outcomes remain rare even with the use of ART. A larger sample is needed to provide more evidence for this patient population.

Figure 1. Clinical and Fertility Outcomes



Timeline of sampling, fertility sparing treatment and assisted reproductive technology and pregnancy outcomes. Each line represents one patient course with events to scale on each individual timeline

48. Diverticulitis Masquerading as Ovarian Pathology: A Retrospective Case Series

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Institution: Tufts University School of Medicine

Objective: To identify characteristics in cases of patients initially diagnosed with primary ovarian pathology but subsequently found to have diverticulitis.

Methods: We identified 7 adult female patients from a cohort of patients collected by the Maine Medical Center radiology department between 2017-2022 for educational purposes with an admitting diagnosis of primary ovarian pathology ultimately found to have diverticulitis with secondary adnexal involvement as a discharge diagnosis. We retrospectively reviewed their clinical course to identify patterns.

Results: Patient ages ranged from 46-83 years old (mean=61). At admission, five subjects presented with leukocytosis and one subject had elevated CA-125. Two patients had a past medical history of diverticulitis. Five of seven CT/MRI reports described a left-sided pelvic mass, with 6 mentioning possible diverticulitis. No imaging reports described evidence of metastatic disease. Five patients had subsequent pelvic ultrasound imaging, resulting in two patients being transferred from general surgery to gynecologic oncology service. Despite imaging suggestions of diverticulitis, 6 patients underwent surgery with gynecology as the lead surgeon. General surgery was consulted intra-operatively in 4 cases. Four cases had post-operative complications requiring subsequent surgeries including sepsis secondary to bowel perforation (2), colorectal anastomosis leak (1), and pelvic abscess (1). Length of stay for the admission and re-admission for complications ranged from 13-42 days. All patients were deemed to have diverticulitis with secondary adnexal involvement as the primary diagnosis after surgical intervention.

Conclusion: Our data suggests diverticulitis with secondary adnexal involvement should be considered as a leading diagnosis in women above the age of 40 with imaging concerning for a pelvic/adnexal mass presenting with leukocytosis, without other indications of metastatic disease. Primary management by general surgery with gynecology consult is recommended. This series encourages further exploration of patterns in clinical presentation and radiologic findings to educate clinicians and facilitate patient triage in this complex setting.

49. Axillary nodal metastasis in ovarian and primary peritoneal carcinoma

Carter Johnson, MD, *Jennifer Jorgensen, MD and Amanda Ramos, MD* – Institution: University of CT

Introduction: Axillary lymph node metastases from ovarian/peritoneal cancers are a rare entity. Prognostic data for these patients is limited; it is unknown if outcomes are worse compared to other patients with stage IVb disease. We present three cases of ovarian and primary peritoneal cancer complicated by axillary lymph node metastases, highlighting the diagnostic and therapeutic challenges faced by pathologists and oncologists.

Methods: Attending physicians identified cases of patients with axillary lymph node. A chart review was performed; demographic and prognostic data were collected and assessed.

Results:

A 55-year-old was referred to the breast center for evaluation of extensive adenopathy. A right breast mass biopsy revealed carcinoma initially believed to be of breast origin. Additional cytopathologic testing determined the lesion was a high-grade serous carcinoma of Mullerian origin. Neoadjuvant chemotherapy was initiated followed by interval cytoreductive surgery with axillary lymph node dissection. She died 20 months after diagnosis.

A 70-year-old with recurrent IVb grade 3 ovarian serous adenocarcinoma presented for scheduled follow-up and was noted to have a left axillary mass. A biopsy resulted as high-grade adenocarcinoma of Mullerian origin. She underwent an axillary nodal dissection followed by adjuvant chemotherapy, but died 44 months after diagnosis.

A 57-year-old underwent routine mammography demonstrating an enlarged right axillary lymph node. A biopsy revealed low-grade papillary serous adenocarcinoma of Mullerian origin. She underwent cytoreductive surgery including axillary exploration followed by adjuvant axillary radiation. She remains without disease progression at 17 months.

Conclusion: This case series describes the diverse presentation and diagnostic challenges for this rare manifestation of primary ovarian/peritoneal carcinomas. Our series suggests that patients with axillary metastases have a challenging and varied clinical course, requiring multimodal management of axillary nodes versus systemic therapy alone. A larger case series is required to understand the prognostic importance of axillary lymph node metastases in this population.

50. Growth of Intravascular Leiomyomatosis (IVL) with a Decreasing Pelvic Mass in a Postmenopausal Female: Case Report

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Institution: UConn

Introduction: Intravascular leiomyomatosis (IVL) is a rare benign smooth muscle mass originating in the pelvis that can extend through the inferior vena cava (IVC) and into cardiac structures. Due to its low prevalence and high mortality, treatment requires multidisciplinary surgical planning. We describe management of IVL in a postmenopausal patient.

Case Presentation: A 58-year-old postmenopausal female with a persistent pelvic mass and DVT was referred to GYN/ONC. CT 5 years earlier showed a filling defect within the external iliac vein with a 12.5cm x 7.3 x 10.1cm pelvic mass. On MRI one month later, the mass was 9.8 x 7.7 x 9.3cm. A degenerating fibroid was suspected. Yearly surveillance ultrasounds showed stability until increased vascularity of pelvic mass, prompting referral to GYN/ONC. CT and MRI showed a persistent filling defect with new extension throughout the IVC. An ECHO showed a 4.2cm x 0.6cm multilobar mass in the right atrium with partial extension into the pulmonary artery. The patient remained asymptomatic and was placed on Eliquis and Letrozole to decrease theoretical response of the tumor to estrogen. A referral to vascular and cardiac surgery was placed for consultation and surgical planning. The surgery was completed in one stage with a sternotomy and midline laparotomy extending to the pubic symphysis. The intracardiac and intravenous portions of the tumor were visualized and removed. On palpation of the tumor, a smooth and rubber-like texture was appreciated without adherence to the venous vasculature. The radical hysterectomy and bilateral salpingoophorectomy was performed with careful ligation of uterine veins.

Conclusion: In a leiomyoma with a persistent DVT, the differential diagnosis should include intravascular leiomyomatosis given the risk of catastrophic consequences if left untreated. IVL can exist in the presence of decreasing pelvic mass. A cardiac evaluation should be performed with management focusing on a multidisciplinary approach.

51. Sharing Challenging News Simulation: A Thematic Analysis

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Institution: Brown Univ/Women & Infants Hospital

Aims: Breaking bad clinical news is difficult: when performed ineffectively, it contributes to physician burnout and decreased patient satisfaction. Although oncology providers are very accurate in predicting 1 year survival, only 33% of patients have had documented end of life planning. Lack of formal training for providers is a barrier to effective communication and guiding goals of care conversations.

Objective: This study evaluates resident physician feedback to simulation-based medical education in sharing challenging news and guiding goals of care discussions.

Methods: A retrospective survey study evaluating resident physician opinions on sharing challenging news was performed. After undergoing simulation-based medication education on sharing challenging news and guiding goals of care conversations, qualitative survey data was collected and thematic analysis was performed.

Results: 20 resident physicians participated in this simulation. 75% (n = 15) responded to the survey. Prior to the simulation training, residents found these conversations to provoke anxiety, dread, and confusion. After simulation training, 100% of respondents reported increased comfort in goals of care conversations. The most helpful factors cited were learning specific language and familiarity with Medical Orders for Life Sustaining Treatment (MOLST) forms.

Conclusion: Sharing challenging news ineffectively contributes negatively to both patient and physician satisfaction. This study demonstrated that formal simulation training improves resident physician confidence in ability to share challenging news and guide goals of care conversations.

52. Biomarkers present in Endometrial and Ovarian Carcinomas and Implications on Treatment

***Ellie Kolor**, Heidi Godoy, DO, and Charles Schwartz, DO*
Institution: Touro College of Osteopathic Medicine

Objectives: This paper will review the biomarkers present in patients with ovarian(OC) or endometrial(EC) carcinomas and investigate the methods of treatment they underwent on the basis of these biomarkers.

Methods: We conducted a retrospective chart and slide review of ten patients diagnosed with ovarian or endometrial carcinomas between January 1st 2017 and October 1st 2023. Evaluation of the role of biomarkers in endometrial and ovarian carcinoma was done at St. Mary's Healthcare Center department of pathology. Slides were reviewed to evaluate the ovarian or endometrial carcinoma type. Subsequent biomarker panels were also reviewed.

Results: Overall, ovarian carcinomas were found to be higher grade than endometrial carcinomas. Increased progesterone and estrogen receptor positivity was seen in endometrial carcinomas when compared to ovarian carcinomas of all types. There was an 85% positivity overall for CA125 levels across both carcinomas. Increased PD-L1, TP-53 and HER-2 positivity was seen in OC than in EC. P53, P16 and Microsatellite instability positivity was increased in EC compared to OC. FRα was only tested for in OC samples and found in 1 out of 2. PTEN, PAX-8 and tumor mutational burden positivity was seen in all samples tested in both EC and OC samples.

Conclusion: There is a significant difference in biomarkers present in endometrial and ovarian carcinomas that may impact treatments available to the patient. Biomarkers need to be taken into consideration in the clinical management of endometrial and ovarian carcinomas as their presence or absence can affect marked differences in therapeutic treatment and subsequent prognosis.

53. Proposal of a novel surveillance protocol for rare gestational trophoblastic disease subtypes

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Institution: BWH – Harvard

Objective: This study describes a novel surveillance protocol for epithelioid trophoblastic tumors (ETT), placental site trophoblastic tumors (PSTT), and atypical placental site nodules (APSN), rare subtypes of gestational trophoblastic neoplasia (GTN). Our study further assesses patient compliance of surveillance.

Methods: Following institutional board review approval, all ETT, PSTT, and APSN cases from 2014 to 2022 were retrospectively collected. Clinical data was abstracted from electronic medical records, and descriptive statistics were applied.

Results: Nine cases met inclusion criteria, 4 PSTT, 3ETT, 2 APSN, with median follow-up of 39 months. Patients had a mean of 14 hCG measurements and 4 CT scans during surveillance and no recurrences occurred. The surveillance regimen, including CT scans and serum hCG measurements, showed a high completion rate, with 93% of prescribed hCG measurements completed.

Conclusion: This study presents a novel and feasible surveillance protocol for ETT, PSTT, and APSN. We recorded a high compliance rate with no patients lost to follow-up, suggesting that this protocol is attainable for patients. Current guidelines lack specific protocols for monitoring rare subtypes of GTN and this work provides a foundational framework for future validation studies, addressing a critical gap in clinical practice.

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