P3.01
Is tumour size a predictor of survival in stage II cervical cancer: a comparison between the old and new FIGO staging criteria
Lim, YK1; Lin, Linda1; Chia, YN1; Yam, KL1; Khoo-Tan2; Yeo, R2; Yap, SP2; Soh, LT2; Chua, EJ2
1 KK Women’s and Children’s Hospital, Singapore; 2 National Cancer Centre, Singapore

Introduction: Recent studies suggest that tumour size is a prognostic factor for Stage IIA cancers. In light of this, the International Federation of Gynecology and Obstetrics (FIGO) revised the cervical cancer staging criteria, subdividing stage IIA into stages IIA1 and IIA2, based on tumour size (≤4 and >4 cm). This study aims to determine if the new sub-staging has any impact on overall survival as well as to elucidate any other prognostic factors and treatment patterns in this category of patients.

Methods: This is a retrospective case series of women diagnosed with Stage IIA cervical cancer in KK Women’s & Children’s Hospital between 2001 and 2005. Statistical analysis was performed with SPSS version 19.

Results: A total of 66 patients were diagnosed with Stage IIA cervical cancer between 2001 and 2005. Of the 50 patients which met the inclusion criteria, 35 (70%) had stage IIA1 and 15 (30%) had stage IIA2 cervical cancer. The overall 5 year survival was not significantly different between stage IIA1 and IIA2. (79.6% vs. 73.3%, P = 0.9) Likewise, the progression free survival was not significantly different between stage IIA1 and IIA2. (76% vs. 80%, P = 0.86) Patients who underwent radical hysterectomy performed better to those treated by primary radiotherapy. (87% vs. 69.6%, P = 0.043) Cox regression analysis showed that age, tumour grade, histology types, tumour size and lymph node status were not independent predictors of survival.

Conclusion: Our preliminary results did not find any difference in overall survival based on the new FIGO sub-staging of IIA1 and IIA2. Larger studies are needed to confirm this finding.

P3.02
Evaluation of human papillomavirus (HPV) infection among women in UMMC – comparison between thin prep and fournier’s self sampling
Hamzah, H; Aziz, A; Lim, BK; Woo, YL; Omar, SZ
Department of Obstetrics and Gynaecology, Universiti Malaya Medical Centre, Kuala Lumpur, Malaysia

Background: Testing for high-risk human papillomavirus (HPV) in primary screening for cervical cancer is considered more sensitive, but less specific, in comparison with Pap smear cytology. Introduction of vaginal self-sampling for human papillomavirus (HPV) DNA testing could increase the rate of screening participation.

Methods: This is a cross sectional study which has been conducted in the period of 12 months from 1st October 2010 till 30th September 2011. A total of 345 patients were recruited. Two samples were taken from all patients by physician directed smear (Thin Prep) and vaginal self-sampling (Fournier’s sampler). Both samples were tested for HPV DNA and cytology. Both results were then compared for its efficacy.

Results: The overall detection of the HPV DNA by Thin Prep among 345 patients was 11.3% (39 of 345 samples), whereas it was 9.9% (34 of 345 samples) by the Fournier’s self-sampling. The absolute agreement between the ThinPrep and Fournier’s self-sampling was 93.3% with a Kappa value of 0.648 indicating good agreement with a P value of 0.405, thus it is not significantly different. Overall the prevalence of HPV infection among Malaysian women was 13.6%. The commonest high risk HPV DNA type detected were HPV 68 and 18, and for low risk type was HPV 42.

Conclusions: Self-sampling device compares favourably with physician directed sampling in terms of HPV detection. It also has high acceptability among Malaysian women. This might be the future screening tools for cervical cancer among Malaysian women.

P3.03
The effectiveness and acceptability of self-sampling against conventional Pap smear in University Malaya Medical Centre (UMMC)
Aziz, A; Hamzah, H; Lim, BK; Woo, YL; Omar, SZ
Department of Obstetrics and Gynaecology, Universiti Malaya Medical Centre, Kuala Lumpur, Malaysia

Introduction: The effectiveness of a device for the self-collection of cervical cells for the purpose of supplying a Pap test and for HPV testing has been previously demonstrated. This study expanded upon earlier studies to determine whether the use of a self-sampling device will be more acceptable to Malaysian women and it has acceptable analytic sensitivity to detect precancerous abnormalities.

Methodology: This is a cross-sectional study which has been conducted in the period of 10 months from October 2010 till July 2011 with 293 subjects enrolled. Two samples were taken from all patients by physician directed smear (Thin Prep) and vaginal self-sampling (Fournier’s sampler). Both samples were tested for cytology. A questionnaire was given to assess their acceptability.

Results: Of 293 women recruited, 289 agreed to participate in the study and performed the self-sampling. We evaluated the sensitivity and specificity of self-sampling by using CytoBrush
(Thin Prep) as the comparing test. The sensitivity of cytology for self-sampling was 41% while the specificity of the test was high 73%. The positive predictive value for the test is 34% and negative predictive value is high of 79%. The acceptability of self-sampling was very good which generally it is more acceptable in patient age 35 years and above. 82% of the women considered self-sampling to be practically easy to perform. 77% of the women preferred self-sampling over gynaecological examination in the clinic. 78.2% of them may recommend the test to their female colleagues.

Conclusions: The usage of self-sampling device as a screening tool in the context of detection cervical premalignant cells is limited albeit well acceptable to the local community.

P3.05
Successful pregnancies following fertility preserving surgery for uterine sarcomas
Melkeet, CS1; Lim, YK2; Chew, SH2; Chia, YN2; Yam, KL2

1 Department of Obstetrics and Gynaecology, Kuala Lumpur Hospital, Malaysia; 2 Department of Gynaecological Oncology, KK Women’s and Children’s Hospital, Singapore city, Singapore

Objective: A significant proportion of patients diagnosed with uterine sarcomas are often young and nulliparous desiring preservation of reproductive functions. Standard therapy for uterine sarcomas includes hysterectomy and bilateral salpingo-oophorectomy. Conservative management followed by term pregnancies has been reported in the literature. We reviewed the outcome in similar patients diagnosed with uterine sarcomas and managed conservatively at Singapore’s KK Women’s and Children’s Hospital (KKWCH).

Methods: 150 patients were diagnosed with uterine sarcoma at KKWCH between 1995 and 2010. These included 65 patients with leiomyosarcoma, 50 patients with endometrial stromal sarcoma (ESS) and 18 patients with adenosarcoma. During a comprehensive review of these patients, we identified a subset of six patients who had fertility sparing conservative surgery. Their progress and reproductive outcome were reviewed.

Results: Fertility sparing surgeries were performed for four patients with ESS and two patients with adenosarcoma. None of the patients diagnosed with leiomyosarcomas were similarly managed. These six patients ranged in age from 21 to 40 years (median 30.5). Five were nulliparous. The only adjuvant therapy prescribed was megace, for a patient diagnosed ESS. A foreigner diagnosed with adenosarcoma was lost to follow up. At a median follow-up of 56.6 months (range 16.7–81.1), the remaining five patients were alive and well without recurrence. Two of these patients subsequently conceived and delivered at term. The first, a 21 years old, was investigated for menorrhagia in 2006. Ultrasound evaluation had revealed a focally thickened and hyper vascular lower endometrium. She was subjected to a hysteroscopy examination at which a pedunculated fibroid was avulsed. The histology revealed endometrial glands within a cellular stroma, enlarged nuclei, increased nuclear-cytoplasmic ratio and periglandular cuffings consistent with a low-grade mullerian adenosarcoma. The second patient, 26 year old, had a myomectomy in 2004, which was reported as ESS with low
mitotic activity. Both these patients were managed conservatively due to their young age and desire to retain fertility. Both delivered at term in 2010.

**Conclusion:** Successful pregnancies are possible after conservative treatment in selected patients desiring pregnancy. Definitive surgery can be postponed until completion of the reproductive functions. Close follow up is mandatory.

**P3.06**

The prevalence of high-grade CIN in women referred with smear suggestive of moderate dyskaryosis treated within a ‘see and treat’ policy

**Fathulla, B; Phadnis, S; Joseph, R; Padwick, ML; Sanusi, FA**

Watford General Hospital, Watford, United Kingdom

**Objective:** To assess a ‘see and treat’ policy for referrals with a moderate dyskaryosis smear.

**Background:** The NHSCSP guidelines states that, ‘treatment at first visit for a referral of borderline or mild dyskaryosis should only be used in exceptional cases, and only when audit has identified that CIN is present in >90% of the excised specimens’. There is no guidance for women presenting with moderate and severe dyskaryosis on referral smear. Whilst literature suggests 95% correlation between cytology and histology for a severe dyskaryosis referral, there is controversy regarding management of smears suggestive of moderate dyskaryosis. In this study we determine the yield of CIN when a ‘see and treat’ policy is employed for such referrals.

**Method:** A thorough search of our INFOFLEX® database between 01/01/2001 and 31/12/2009 was performed. All the cases of moderate dyskaryosis on referral smear treated with a loop biopsy at their first visit were included and histology reports were analysed.

**Results:** There were 9237 patients referred during the study period. There were 1388 (15.0%) patients with moderate dyskaryosis. Histology revealed 935 (68.5%) cases of high-grade CIN, 199 (14.3%) cases of low-grade CIN and in 131 (9.4%) cases, dyskaryosis. Histology revealed 935 (68.5%) cases of high-grade period. There were 1388 (15.0%) patients with moderate dyskaryosis on referral smear. In this study we identified that CIN is present in 90% of the excised specimens. There is no guidance for women presenting with moderate and severe dyskaryosis on referral smear. Whilst literature suggests 95% correlation between cytology and histology for a severe dyskaryosis referral, there is controversy regarding management of smears suggestive of moderate dyskaryosis. In this study we determine the yield of CIN when a ‘see and treat’ policy is employed for such referrals.

**Conclusion:** In our study population, a ‘see and treat’ policy for referrals with a moderate dyskaryosis smear suggests urgent referral within 2 weeks to a gynaec-oncology service if examination findings are positive. This study aims to: (i) Highlight the importance of physical examination findings in determining the urgency of referral to secondary care. (ii) Evaluate the sensitivity and specificity of physical examination findings in detecting malignancy in women with suspected ovarian cancer in primary care. (iii) To compare the use of CA-125 and AUSS in women presenting with symptoms suspicious of ovarian cancer with or without positive physical examination findings.

**Methods:** 96 referral letters (suspected ovarian cancer) were reviewed over a period of 1 year. Outcome of each referral were categorised as ‘malignancy’ or ‘no malignancy’. Data of physical examination findings and initial investigations done in primary care were collected.

**Results:** There were 31/96 detected malignancies; 22 were ovarian. Physical examination findings reported in 66/96 referrals. Physical examination findings not mentioned in 30/96 referrals which yielded 8/31 malignancies; 7 ovarian and 1 peritoneal. Physical examination findings positive (average BMI = 30.66) in 46/66. Outcome = 17/31 malignancies; 12 ovarian, 1 peritoneal, 1 bladder, 1 colorectal, 1 caecal and 1 recurrent breast ca with metastases. All referrals were within the national target (2 weeks). CA125 = 39/46. USS = 29/46. Both = 27/46. None = 5/46. Physical examination findings negative (average BMI = 27.2) in 20/66. Outcome = 6/31 malignancies; 3 ovarian, 1 pancreatic, 1 colorectal and 1 unknown primary. CA125 = 14/20. USS = 11/20. Both = 9/20. None = 3/20. Review of data looking at initial investigations (CA-125 and/or USS) done in primary care for women with suspected ovarian cancer with or without positive physical examination findings is statistically insignificant with a P-value of 0.6454 > 0.01.

**Conclusion:** Detection of malignancy in women with suspected ovarian cancer by means of physical examination findings in primary care has a low specificity (32.6%) but a higher sensitivity (73.9%). Data suggests that physical examination findings do not influence the initial investigations done in primary care with regards to the management of suspected ovarian malignancy which is of great value to secondary care by avoiding further delays in the diagnostic pathway.

**P3.08**

PMB and thin endometrium – is endometrial sampling needed?

**Ragupathy, K; Cawley, N; Ridout, A; Iqbal, P; Alloub, M**

Doncaster Royal Infirmary, United Kingdom

**Background:** Incidence of endometrial cancer in women who present with postmenopausal bleeding ranges between 1% and 10%. Endometrial thickness on transvaginal scan is gold standard for triaging these women into low and high risk groups. Endometrial biopsy is indicated if the thickness is more than 4 mm. However the risk is still existent even if the endometrial thickness is normal, but is reduced to 1/10 the odds or from 10% to 1%. In view of the latter, endometrial sampling (pipelle biopsy/ endometrial washings) is attempted in our outpatient gynaecology clinics even if the scan is normal.
Objective: Assess feasibility of endometrial sampling in women with PMB and thin endometrium; and find the incidence of endometrial cancer in this group.

Methods: Retrospective data collection between September 2007 and December 2010 \((n = 40\) months\). Women who presented with PMB to the rapid access clinic were included in the study. Information collected included USS findings, adequacy of endometrial sampling, and the final histology. Results: In our cohort of women \((n = 671)\), endometrial thickness was measured in 92% \((n = 614)\). 27% \((n = 166/614)\) women had endometrial thickness <4 mm and form the case cohort of our study. Endometrial sampling by means of washings or pipelle biopsy was done in 67% \((112/166)\) of women in this cohort. The sampling was adequate in 64% \((72/112)\) women and all of the adequate samples were reported as benign histology. There were no cases of hyperplasia/malignancy in this group.

Conclusion: In women with PMB and thin endometrium, endometrial sampling is better performed by endometrial washings rather than a pipelle biopsy. However this would be an indication for reassurance rather than to seek pathology because in our cohort of women: no pathology was found. This local study would help us in counselling of women who present to our RAC with the 0% incidence of pathology such as cancer/ hyperplasia being quite reassuring.

P3.09
The role of expectant management of incidental thickened endometrium in asymptomatic postmenopausal women

Murthy, N1; Moncreiffe, L2; Seif, MW2

1 Liverpool Women’s Hospital, Liverpool; 2 University of Manchester, Manchester, United Kingdom

Background: Endometrial cancer presents early as postmenopausal bleeding.1 The calculated statistical probability of developing endometrial cancer is 6.7% for an endometrial thickness (ET) of ≥10 mm in asymptomatic postmenopausal women.2 This risk is similar to the 7.2% risk for an ET of 5 mm among women with postmenopausal bleeding.2

Objective: To evaluate the malignant potential of endometrial thickness cut off level of ≥10 mm and the place for conservative management in asymptomatic postmenopausal women.

Design: Retrospective, single centre study.

Setting: St Mary’s Hospital Manchester, one of the 13 UKCTOCS regional centres, between 2002 and 2010.

Population: The study included 140 healthy postmenopausal volunteers with an ultrasound scan incidental finding of endometrial thickness of ≥10 mm, polyp or cystic changes. Both asymptomatic postmenopausal women with or without HRT or Tamoxifen use were included. Women who reported postmenopausal bleeding were excluded from the study.

Main outcome measure: Histological diagnosis of endometrial cancer or complex atypical hyperplasia.

Results: 106 women underwent invasive tests such as endometrial (Pipelle) sampling, hysteroscopy directed polyp biopsy or polypectomy. 90 women had hysterectomy out of whom 29.54% \((n = 26)\) required inpatient hysteroscopy and 0.78% had to undergo laparoscopy for uterine perforation. Only 2.83% \((n = 3)\) had a diagnosis of focal atypical hyperplasia. There were no cases of endometrial cancer.

Conclusions: Endometrial thickness of ≥10 mm could safely be used as the interventional trigger among asymptomatic postmenopausal women. Endometrial polyps in asymptomatic post-menopausal women are associated with low risk of higher grade pathology.

References:

P3.10
USS diagnosis of gestational trophoblastic pregnancy – a 10 year audit at Whipps Cross University Hospital, London, UK 2001–11

Sivarajasingam, S; Kar, S; Chupi, J; Visvanathan, D; Deo, N

Whipps Cross University Hospital, United Kingdom

Objective: Our aim was to find the sensitivity of transvaginal ultrasonography (TVUS) in the diagnosis of gestational trophoblastic disease (GTD). The outcomes in these women were also evaluated.

Methods: All histologically confirmed molar pregnancies at Whipps Cross University Hospital over a 10 year period, from January 2001 to February 2011, were audited. All women with a confirmed molar pregnancy were referred to the Charing Cross GTD centre from where follow up data was obtained.

Results: 66 women were diagnosed with GTD over this 10 year period; although all notes were retrieved, 6 women had no scan reports available for review. The incidence of GTD was 1/714 deliveries. The age range of women was 19–45 years with an average of 30.9 years. 17 women were primigravidae, 27 were gravidae 2–4 while 5 women were gravidae 5 or more. In 17 women, exact parity was unknown, 28/66 women (42.4%) had a histological diagnosis of a complete hydatiform mole (CHM) and there was a pre-operative TVUS detection rate of 78.5%. The mean gestational age range at diagnosis was 7–24 weeks with an average of 11 weeks. 23 women (82%) presented with vaginal bleeding while five women (18%) were incidentally diagnosed at ultrasound. 36/66 women (54.5%) had a histological diagnosis of partial hydatiform mole (PHM). The TVUS detection rate was 27.8%. The gestational age range for detection was 5–21 weeks with an average of 13 weeks. Ten women (28%) presented with vaginal bleeding while nine women (25%) were incidentally diagnosed at ultrasound. 17 women were excluded due to lack of documentation. 2/66 women (3%) had a histological diagnosis of...
unclassified hydatiform molar pregnancy. Both women who developed persistent trophoblastic disease had CHM. Three women (5%) with a PHM inadvertently undertook medical management however PHM was suspected in one of these women by TVUS. It is noteworthy that no complications were seen in the medically managed PHM.

**Conclusion:** GTD in a mixed ethnic background is still a rare diagnosis with an overall TVUS detection rate of 53.2% which is comparable to RCOG guidelines. The detection rate for both PHM and CHM were comparable to the ones quoted in recent literature which were 80% and 30% respectively. There has not been a significant change in diagnosis at an early gestational age however diagnosis in late pregnancy is rare, as demonstrated by this study with only 4/66 women diagnosed at a gestation >18 weeks.

**P3.11**

**Prevalence of endometrial cancer in symptomatic postmenopausal women with thickened endometrium**

Srinivasan, M; Bakour, S

City Hospital, Birmingham, United Kingdom

**Objective:** (i) To ascertain the pickup rate of endometrial cancer in women attended the post-menopausal bleeding clinic with postmenopausal bleeding and thickened endometrium. (ii) To ascertain the prevalence of other pathology (polyps) in the same cohort of women.

**Methods:** Retrospective review of the case notes of women who attended with symptoms of post menopausal bleeding over 3 year period from Jan 2008 until dec 2010. 262 patients were identified and analysed, 13 were HRT users, 16 were on Tamoxifen.

**Results:** There were 56 clinics and 262 women attended 101 women had thickened endometrium ET >4 mm. Endometrial pipelle samples and further investigations were carried out in these women. Ten women were diagnosed with endometrial cancer (10%) and three women had cervical cancer. Seven women were diagnosed with complex hyperplasia in the initial pipelle sample, of which endometrial cancer was present in four women. 21 patient had sonographic findings suggestive of endometrial polyp of which 12 confirmed by the gold standard (hysteroscopy) (57%).

**Conclusion:** 10% of women with thickened endometrium turned out to have endometrial cancer this correlates to the international observational studies. No cancer cases found in the cohort that had ET < 4 mm.

**P3.12**

**Growing teratoma syndrome: a rare case report and review of the literature**

Kampan, N; Irianta, T; Djuana, A; Arifuddin, Y; Shan, LP; Omar, MH; Dali, A2HM

Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

This report concerned a young patient with growing teratoma syndrome (GTS) who required complete resection. Residual disease is the commonest suspicion following fertility conserving surgery for immature teratoma of ovary in a young woman. Administration of adjuvant chemotherapy is the usual course pathway for management of residual disease. An enlarging intraperitoneal mass despite course of chemotherapy is usually due to treatment failure but rarely may be as a result of GTS. GTs may even occur in a completely excised stage 1a ovarian teratoma. Complete resection is essential to prevent progression of tumour and is often curative, hence, will render better prognosis as mature teratoma are resistant to both chemotherapy and radiotherapy.

**P3.13**

**Fallopian tube carcinoma – revealing than before?**

*Ragupathy, K; Mann, J; Dugar, N; Iqbal, P; Alloub, M*

Doncaster Royal Infirmary, United Kingdom

**Background:** Primary fallopian tube cancer (PFTC) is rare with an incidence of only 1% of gynaecology cancers. However, reports are emerging that it might be more common than the historical figure. Our case series support the latter with six cases of fallopian cancer diagnosed at our district general hospital in the last year.

**Objective:** Evaluate retrospectively all women diagnosed with fallopian cancers, looking at presentation, investigations and final histology.

**Methods:** Retrospective collection of data was done between November 2010 and October 2011. Patient notes were collected to get further data regarding age, clinical presentation, value of CA125, results of radiological investigations, details of surgery and the final histology.

**Case series (n = 6)**

Incidence of fallopian cancers was 3.6% (6/165) of gynaecological malignancies. 50% (n = 3) presented with classical symptoms of pain and discharge while reviews have quoted only 15% PFTC manifesting this way. Preoperative diagnosis is possible only in 0% to 10% cases because of proximity of fallopian tube to ovarian cancer and the latter being more common. We suspected PFTC in three out of the six cases through a combined modality of Ultrasound and MRI of pelvis. Cervical smear positivity occurs in 10–36% of cases and this was shown in our series as well with one woman diagnosed with adenocarcinoma on smear. While majority of women with PFTC (80%) have an elevated CA125 level, our cohort was different with only two among the six with raised CA125 levels. Primary surgery was done in 50% women (n = 3) in our hospital while the rest were referred to tertiary gynaecology centre. PFTC is often diagnosed at an earlier stage (45% are in stage I/II and 55% in stage III/IV). We do not know the final staging in one woman, two (40%) have been diagnosed as having early stage disease and three (60%) as advanced cancer.

**Conclusion:** PFTC poses a challenge and this case review shows the difficulty in correlating clinic-radiological findings, misleading CA125 levels, leading to primary surgery being done by general gynaecologists rather than gyno-oncologists. In view of this, a multi-disciplinary approach is advised with low index of suspicion in a postmenopausal woman presenting with adnexal pain and being aware that PFTC is becoming more common than estimated. We believe our cohort had a higher rate of...
preoperative diagnosis because of the use of MRI and will be presenting the radiological images to elucidate further.

P3.14
Major depressive disorder in gynaecological cancer patients: prevalence and associated factors
Chin, TB1; Saring, ARM2; Noor, MRM3; Aliyas, I4; Midin, M4; Jaafar, NRM4; Sidi, H4
1 Psychiatry and Mental Health Department, Hospital Kulim, Kulim, Kedah; 2 Psychiatry and Mental Health Department, Hospital Sultanah Bahiyah, Alor Star; 3 Gynae-Oncolgy Department, Hospital Sultanah Bahiyah, Alor Star; 4 Psychiatry Department, Faculty of Medicine, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia

Introduction: Major Depressive Disorder (MDD) worsens the illness burden of cancer. Determining the magnitude and associated factors of MDD in cancer patients would enable us to device strategies for prevention and effective treatment of the condition.

Objective: To determine the prevalence of major depressive disorder (MDD) and its associated factors among gynaecological cancer patients.

Methods: This hospital-based cross-sectional descriptive study comprised of 120 gynaecological cancer patients in Hospital Sultanah Bahiyah, Alor Star, Malaysia. Socio-demographic data, clinical variables on gynaecological cancer, history of medical and psychiatric illness were obtained. Mini International Neuropsychiatry Interview (MINI) was used to diagnose MDD. Patients also completed the self-report World Health Organization-Quality of Life-26 (WHOQOL-BREF) for assessment of quality of life.

Results: The prevalence of MDD was 18%. Bivariate analysis showed that MDD was significantly associated with perceived social support ($\chi^2 = 5.31, P = 0.021$), pain perception ($\chi^2 = 15.35, P < 0.001$), past psychiatric history ($\chi^2 = 6.22, P = 0.013$) and all domains of quality of life including physical health, psychological health, social relationship and environment aspects ($all P < 0.001$). The other variables were not significantly associated with MDD.

Conclusion: The prevalence of MDD in gynaecological cancer patients was high. Since the risk factors of MDD in this group of patients are multiple and inter-related, treatment care should be holistic and involve multidisciplinary team work.

P3.15
Management of ovarian cancer in primary care
Lee, F; Somoye, G; Saleh, S
Aberdeen Royal Infirmary, NHS Grampian, United Kingdom

Objectives: Ovarian cancer is the leading cause of gynaecological cancer deaths in the UK with a 5-year survival rate of <35%; often presenting late with vague non-specific symptoms. A high index of suspicion in primary care may lead to the instigation of appropriate investigations and prompt referrals to secondary care. This study aims to provide an overview of the recognition and initial management of suspected ovarian cancer in primary care by: (i) Examining the quality of urgent referrals for suspected ovarian cancer to a specialist gynae-oncology service in Aberdeen, NHS Grampian (Scotland), UK; (ii) Comparing and evaluating any change in practice of CA-125 testing and ultrasound (USS) investigations before (B) and after (A) the introduction of the NICE 122 guideline (April 2011).

Methods: 96 urgent (suspected ovarian malignancy) referral letters from primary care (October 2010–September 2011) were reviewed. Clinical information provided along with relevant investigations were collated: positive/negative physical examination findings (ascites and/or pelvic/abdominal mass; not obviously uterine fibroids), duration of symptoms, specific symptoms (any one/more of abdominal bloating, early satiety, abdominal/pelvic pain, urinary symptoms, or age >50 with symptoms of IBS), general symptoms (any one or more of unexplained weight loss, fatigue, altered bowel habit, in which ovarian cancer is suspected), initial investigations (CA-125, USS).

Results: Documented abdominal examination = 68.8%. (B69% A68.5%) PV examination performed = 27.1% (B19.0% A33.3%). Duration of symptoms in referrals = 56.3% (B57.1% A55.6%). Enquiry of specific symptoms = 74.0% (B71.4% A75.9%). Enquiry of general symptoms = 50.0% (B47.6% A51.9%). No details of any specific and/or general symptoms = 17.7% (B16.7% A18.5%). Serum CA-125 requested = 80.2% (B71.4% A67.0%). USS requested = 72.9% (B78.6% A68.3%). Both CA-125 and USS = 60.4% (B59.5% A61.1%). No CA-125 and/or USS = 7.3% (B9.5% A5.6%). Comparison of initial investigations before and after the introduction of the new NICE guidelines suggest no change in practice ($P$-value 0.3703 > 0.01).

Conclusion: Referral letters from primary to secondary care lack important clinical information. Greater vigilance and instigation of investigations in primary care in accordance to the NICE 122 guideline will ensure prompt, good quality and correct referrals which may lead to early diagnosis and treatment thus improving outcome associated with late presentations.

P3.16
Outcome of large loop excision of transformation zone (LEEP) in women over forty at two London’s hospitals
Aziz, M2; Markus, N2; Lyons, D1
1 King’s College Hospital, London, United Kingdom; 2 St Mary’s Hospital, London, United Kingdom

Large loop excision of transformation zone (LEEP) is widely used procedure to treat cervical intraepithelial neoplasia (CIN), while there are some concerns in treating young age group because of the risk of preterm labour, this less of a concern in women over the age of forty, thus it is likely that we would treat low grade disease in women after the age of forty. Retrospective study to review the outcome of LLETZ treatment in women over the age of forty between two London hospitals St Mary’s hospital (SMH) and King’s College hospital (KCH). A total number of 2036 patient underwent excisional cervical treatment over a 5 years between 2007 and 2011. There was 687 patients from KCH and 1376 patients from SMH. Of those there were 575 (28%) patients over the age of forty. The results of the histological analysis showed variation and concordance in different aspects. Low grade histology was found in 204/350 (58%) from SMH in comparison to 44/225 (20%) at...
KCH group. High grade lesion were 111/350 (33%) of the over forty treated at SMH compared to 105/152 (47%) at KCH group. There were 73 (32.4%) patients were the histology showed no dyskaryosis detected at KCH group compared to 23 (%) patients from St Mary’s group. review of those patients showed some were completion treatment for previous positive margins. There were 11 cancers diagnosed during this period at SMH group. The study suggest that older women are more likely to receive excisional treatment for less severe cervical disease.

P3.17
Enhanced early recovery programme
Abulhassan, N; Maghami, S
Hammersmith Hospitals, United Kingdom

Objective: To assess compliance with a newly introduced programme (enhanced early recovery programme). The enhanced recovery programme was introduced by the department of health on March 31 2010 to improve patients’ outcome and speed up patients’ recovery after surgery. Adopted by the department on the September 6 2010. The underlying principle is to enable patients to recover from surgery and leave hospital sooner. Standard: new protocol which aims to enhance early recovery of gynae-oncology in patients following surgery.

Method: Case records of 49 gynae-oncology referred patients between 02/2009 and 08/2010 were randomly selected before ERP introduction. Data entered onto audit proforma. Data analysed results and outcome were compared with those of patients managed under the ERP Setting: The Gynaecology, department of a Northwest London teaching hospital. Main outcome measure: Reduction of postoperative stay.

Results and conclusions: Pre ERP more than 2/3 of patients: (i) Mobilised and opened their bowels 24–48 h post surgery. (ii) Had their urinary catheter removed after 24 h post surgery. (iii) Length of post-operative stay has been an average of 4–5 days. (iv) None of the randomly selected patients (pre ERP) had vulvectomy for vulval cancer (average length of stay 10 days) post ERP. (i) Length of post op stay has been reduced from an average of 4–5 to 3–4 days. (ii) Data collected post ERP included vulvectomies for vulval cancer which accounts for longer in patient stay and delayed discharge.

P3.18
Beware, don’t get hooked: a case report of a patient with complete hydatiform mole (CHM) presenting with falsely low serum β-hCG who developed ovarian hyperstimulation syndrome (OHSS) shortly after suction and evacuation
Bradford, S¹; Raj, G²; Ali, K²; Raj, M²; Khada-ali²; Tan, YL²
¹ Calvary Hospital ACT; ² General Hospital, Malaysia

Objectives: To bring attention to two rare manifestations that can be seen in complete (CHM).

Methods and results: Case report, review of the literature and discussion. Suspicion of CHM has become much easier with the availability of better ultrasound technology and β-hCG assays. Patients with CHM present with exaggerated symptoms of pregnancy. Clinical examination may identify vaginal bleeding and a fundus that is large for dates. ‘Snow storm’ ultrasound appearance with excessively high serum β-hCG levels is highly predictive for CHM. Serum β-hCG is an excellent marker for suggesting molar pregnancy, has prognostic value and can be monitored to assess treatment response and cure. There have been several cases reported in the literature where patients with gestational trophoblastic disease have been wrongly managed because of falsely low serum β-hCG levels. Additionally, there are cases published demonstrating OHSS related to CHM. Our patient’s β-hCG was extremely low, and although the ultrasound pointed to CHM, treatment/definitive histological diagnosis was delayed whilst her thyrotoxicosis was treated and other gynaecological differential diagnoses were entertained. After evacuation of the uterus OHSS ensued causing further diagnostic and treatment dilemma.

We report on a patient with primary CHM whose clinical course was complicated in the first instance by erroneously low β-hCG levels at presentation and then by OHSS several hours post uterine evacuation.

An erroneously low β-hCG, in this case 487 U/L instead of actual level of 2 656 450 U/L, is called the hook effect and is well described. The quantitative β-hCG is measured with antibodies that are coupled with radio labelled tracer antibody forming complexes that are readily measured. Massive β-hCG levels effectively block the radio labelled antibodies leading to incorrect levels being reported. Dilution techniques are employed in the hook effect is suspected. OHSS is also reported in the literature. The team ordered a bedside ultrasound to check for uterine bleeding behind a uterine Foley’s catheter and/or pelvic collection in case of perforation. The pelvic collection was ascites discovered at laparotomy. This case again displays how a difficult situation can become more complex due to rare diagnoses.

Conclusions: Common things happen commonly. However this case highlights two rare possibilities with CHD. The hook effect must be thought of if the lab results don’t fit with the other evidence, additionally the clinician must aware that OHSS make occur in CHD even immediately post uterine evacuation.

P3.19
Outcomes of women with post-coital bleeding
See, ATA; Havenga, S
Obstetrics and Gynaecology, Peterborough City Hospital, Peterborough, United Kingdom

Background and objective: Cervical cancer may present as post-coital bleeding (PCB). A systematic review by Shapely et al. (2006) suggests that this is not common. However, BSCCP (UK) guidelines recommend that women with persistent PCB should be referred directly to colposcopy clinic. The aim of this audit is to evaluate the outcomes in this group of women.

Method: This is a 1 year retrospective audit of women referred to Peterborough District General Hospital with post-coital bleeding. All women who attended colposcopy clinic from 1 January 2011
Objective: A retrospective audit of the morbidities associated with total abdominal hysterectomy in patients with endometrial cancer diagnosed and treated within Forth Valley Health Board between January 2009 and December 2010.

Methods: 76 patients were diagnosed with endometrial cancer, having been identified by the Gynaecology Oncology team and had a total abdominal hysterectomy as part of their management plan. Of these, 41 patients were included in the study as they were both diagnosed and treated in Forth Valley. A retrospective study was undertaken, reviewing various outcomes to measure morbidity. These included pre and day 2 postoperative haemoglobin, any return to theatre, post op infection, duration and strength of analgesia and patients length of stay. Patient age and past medical history were also noted. FIGO staging was noted and histology codes generated.

Results: The average patient was 66 years of age (range 35–87) and had an average hospital stay of 5 days. No patients had a previous history of endometrial cancer. 61% of patients had history codes 1 or 2 (stage 1a grade 1 or 2). The average haemoglobin prior to total hysterectomy was 130 g/dL and day 2 post op 11.1 g/dL, which equated to an average drop of 23 g/dL. Estimated blood loss ranged from minimal to 3500 mL, average loss being 464 mL. 95% of patients received intra-operative antibiotics. The two patients with no documentation of intra-operative antibiotics did not develop any post-op infections. Ten patients developed post-op infections. All of them received antibiotics and a source was identified in 40%. 98% had LMWH prescribed and 56% had documentation of TED stockings. There were no reported DVTs.

Conclusions: Of those patients who met the inclusion criteria (n = 41), 100% stayed in hospital for >2 days compared to 52% of the patients who underwent a laparoscopic hysterectomy in a large RCT. Post operative complications reported in the study for open hysterectomies were at 21%. Post operative infection rates were 24%, most of which were pyrexia of unknown origin and all were treated with antibiotics. No patients developed thromboembolism and prophylaxis with LMWH was given to 98% of the patients. However, there were two patients who had a prolonged hospital stay. One who developed post operative urinary infection, small bowel obstruction which spontaneously resolved and wound infection and one the other patient with excessive bleeding requiring blood transfusion.

P3.22
Surgical management of endometrial cancer – where does the balance lie?
Balasubramani, L1; Srividhya,2; Mohanraj,1; Balsubramaniam, S1, Nagarajan, VN1
1 VN Cancer centre; 2 Central Trials Unit, GKNM Hospital, Coimbatore, India

The optimal surgical management of stage I endometrial cancer is still under debate. The European guidelines tend to be more conservative with lymphadenectomy not indicated in low risk endometrial tumours,1,2 while NCCN guidelines categorically state that staging has to be performed for all patients with a diagnosis of endometrial cancer.3 This is because the grade of the endometrial tumour on an endometrial sampling can be upgraded on final histopathology in about 20%. Intraoperative frozen

P3.21
Morbidity associated with total abdominal hysterectomy as treatment for endometrial cancer: outcomes from 2 years data collection
Rice, A; Christen, K; Waliullah, F; Milling-Smith, O
Department of Obstetrics and Gynaecology, Forth Valley Royal Hospital, Larbert, United Kingdom

Background: CIN1 has a risk of progression to high grade neoplasia. Follow-up is important until regression occurs or till treatment is undertaken. Several management strategies are adopted such as the cytological surveillance, treatment if the lesion is persistent or progressive and the recent HPV DNA testing for high risk subtypes to decide management.

Aim: The main aim of our study was to evaluate the effectiveness of the strategies adopted for management of CIN1.

Methods: Women diagnosed with CIN1 on colposcopy-directed biopsy during the year 2007 were followed up for a period of 4 years from January 2008 to December 2011.

Results: CIN1 was reported in 122 cases. After initial colposcopy follow-up, cytological surveillance was undertaken. 89 women (73%) were judicious in their followup but 33 women (27%) failed to attend. Of the women who attended, in 40 cases (33%) cervical smears returned to normal without any intervention and were returned to routine recall. 49 women (40%) underwent treatment. The reason for treatment was persistence of the lesion in 28 cases (57%), progression/persistence along with smear abnormality in 15 cases (31%) and abnormal smear in six cases (12%). Cold coagulation was performed in 22 cases, Large Loop Excision of the Transformation Zone (LLETZ) in 27 cases and two women underwent hysterectomy. Re-referrals from the non-intervention group were 15% (6/40). Smear abnormality was the reason in three cases (7.5%) and in the other three cases (7.5%) the reason was suspicious symptoms. Re-referrals from the non-attendance group was 21% (7/33). Interestingly none of the women from the treatment group have been re-referred during this study period.

Conclusion: Our management strategy of treatment only if the lesion is persistent or progressive seems to be effective in managing women with CIN1. However non-attendance rate is quite significant. Hence in our centre, HPV DNA testing for high risk subtypes to decide management in low-grade neoplasia has to be considered in order to improve the performance.

P3.20
How are we managing cervical intraepithelial neoplasia grade 1 (CIN1)? Four year follow-up study
Rajagopal, R; Myint, P; Mclellan, D; Hawthorn, R
Southern General Hospital, Glasgow, United Kingdom

Background: CIN1 has a risk of progression to high grade neoplasia. Follow-up is important until regression occurs or till treatment is undertaken. Several management strategies are adopted such as the cytological surveillance, treatment if the lesion is persistent or progressive and the recent HPV DNA testing for high risk subtypes to decide management.

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section to assess grade and myometrial involvement has not been completely accurate. Our practice has been to perform a staging laparotomy for all patients with endometrial cancer for all patients deemed to be surgically fit. The surgical procedure includes a total abdominal hysterectomy, a bilateral salpingo-oophorectomy, omental and peritoneal biopsies, bilateral pelvic and lower para aortic lymphadenectomy. Our centre is a tertiary referral centre and a large proportion of post operative patients referred for adjuvant treatment. A retrospective case chart review of all patients with a diagnosis of endometrial cancer in our hospital was done. The period of study was from April 2009 to March 2011. Forty-one of these patients were operated outside and seen here for decision regarding adjuvant treatment. All patients who did not have lymphadenectomy as part of their surgical staging have been treated with external beam radiation treatment. We also analysed 44 patients who had standard staging for endometrial cancer – 19 patients had a grade 1 histology post op and 17 patients had no or <50% myometrial involvement. One patient had positive pelvic lymph nodes (3.2%) while the patient with uterine papillary serous carcinoma had para aortic metastasis only. An institutional guideline needs to be put in place for the management of endometroid adenocarcinoma. It may be that we overtreat a subset of low grade endometroid adenocarcinomas but a fool proof method of identifying this sub group still remains elusive.

References:

P3.23
Primary vulval cloacogenic carcinoma
Ganta, S; Hoh, J; Wood, R

County Durham & Darlington NHS Trust, United Kingdom

Cloacogenic carcinoma is a rare embryological tumour with only few cases of vulval or vaginal involvement.

Case report: A 57 year old Caucasian woman presented with a 6 month history of vaginal mass. The mass increased in size occasionally with discharge from the cyst. The patient denied any symptoms of bleeding, pelvic pain, or dysuria. On examination a 1 cm mobile swelling was noted in the region between the urethra and the clitoris, there was no obvious groin lymphadenopathy. It was initially identified as an inclusion cyst in the out patient clinic. A month later she underwent wide local excision under general anaesthesia, a bilobed cystic mass with no obvious capsule was identified. A complete surgical excision of the cyst was not possible due to its location and deep extension of the mass. Histology of the biopsy obtained revealed a poorly differentiated invasive carcinoma with predominantly basaloid appearance with admixed area of squamoid differentiation. The lesion was considered to be Basaloid carcinoma (cloacogenic carcinoma). The exact origin was not apparent on histology, however it appears to have arisen from a mucosa covered surface, erectile tissue was present at the deep margin. It was therefore suspected to have arisen from the distal urethra, with incomplete excision from both margins. In view of this wide local excision of the anterior vestibular scar with bilateral groin node dissection was advised. Pretreatment CXR, CT scan and proctoscopy revealed no evidence of nodal disease or metastatic spread. Final histology revealed no evidence of residual tumour, lymph node biopsy was negative. Radiotherapy was therefore not advised. She is currently being followed up as per protocols for vulval carcinoma. Prognosis: The prognosis appears to be poor when pelvic or inguinal lymph nodes are involved at the time of definitive surgery no matter what treatment is employed. In the absence of nodal involvement the extent of local invasion and the size of the neoplasm appear to affect the prognosis directly. Five-year survival was up to 50%.

Summary: Cloacogenic carcinoma is a rare pelvic malignancy with multi centric origin. Usually limited to the pelvis the cloacogenic carcinoma presents as a mass, and has an indolent course if limited to the pelvis. Aggressive variants with extensive metastatic involvement including cardiac, pulmonary and hepatic involvement have been noted. Surgery and radiotherapy are the main modalities of treatment.

P3.24
The efficacy of bivalent and tetravalent HPV vaccination against cervical intraepithelial neoplasia and persistent HPV 16 and 18 infection
Riaz, H1; Denyer, M2

1 University of Aberdeen, United Kingdom; 2 University of Bradford, United Kingdom

Objective: To perform a pooled analysis of randomised controlled trials on vaccine efficacy in preventing cervical persistent infection and cervical intraepithelial neoplasia (CIN) types 1–3.

Methods: Bibliographic search on electronic databases to identify double blind placebo RCTs. Databases included EMBASE, PubMed, ScienceDirect and Cochrane. Pooled percentage efficacy and meta-analyses were conducted for the following regimens/infections: bivalent AND tetravalent anti-HPV vaccination for CIN 1–3, persistent HPV 16 and HPV 18 infection and tetravalent anti-HPV vaccination for persistent HPV 16 and HPV 18 infection.

Results: Overall 10 studies were selected. The overall bivalent and tetravalent vaccine efficacy against CIN 1–3 was 92.8% (95% CI 96.4–99.9%), 97.5% (95% CI 91.3–99.3%) and 92.4% (95% CI 96.2–99.8%), respectively. The first set of meta-analyses showed a reduction of risk of CIN 1–3 in the vaccination cohort [RR 0.072 (95% CI 0.036–0.153)], [RR 0.025 (95% CI 0.07–0.081)] and [RR 0.076 (95% CI 0.038–0.153)], respectively. The bivalent and tetravalent anti-HPV vaccine efficacy against HPV 16 infection was 89.8% (95% CI 85.5–92.9%) and a significant reduction in risk of infection in the vaccinated cohort [RR 0.102 (95% CI 0.071–0.145)]. The tetravalent anti-HPV vaccine efficacy for HPV 16 infection was 95.9% (95% CI 92.4–97.8%) with a risk of
reduction in infection [RR 0.041 (95% CI 0.022–0.076)]. The bivalent and tetravalent anti-HPV vaccine efficacy against HPV 18 infection was 83.2% (95% CI 72.2–90%) and a significant reduction in risk of infection [RR 0.168 (95% CI 0.102–0.278)]. The tetravalent vaccine efficacy against HPV 18 infection was 96.4% (95% CI 90–98.8%) and a reduction of risk of infection [RR 0.036 (95% CI 0.012–0.0104)].

Conclusion: Anti-HPV vaccinations are safe, highly effective (up to 7.3 years) and cost efficient. The vaccine efficacy is limited to adolescent girls with no prior HPV infection/sexual activity. For women over the age of 30 years, screening remains the gold standard. Barriers to vaccinating include acceptance and awareness. For the success of any national approach tackling cervical cancer, respective Government financial support and regulation is imperative.

P3.25
Molar pregnancy: follow-up beyond one undetectable serum β-hCG, is it necessary?
Nirmala, CK; Lim, PS; Harry, SR; Nor Azlin, MI; Shafiee, MN; Ghani, NAA; Shamsul, AS; Omar, MH; Hatta, MD
Department of Obstetrics and Gynaecology, Faculty of Medicine, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia

Introduction: Gestational trophoblastic disease (GTD) is a common gynaecological problem. The local incidence of hydatidiform mole is 2.8 per 1000 delivery in 1998. Traditionally, patient would be monitored for 2 years following evacuation. Remission is considered when serum β-hCG level is undetectable for 6 months. As a result, high drop-out rate had been observed.

Objective: This study is aimed to determine the need to continue follow-up for uncomplicated molar pregnancy beyond attaining one undetectable serum β-hCG level. The number of defaulters and the number of patient who relapsed after achieving one undetectable serum β-hCG level were determined.

Methods: One hundred and two patients with molar pregnancy between 1st January 2005 and 31st December 2010 who were managed in the local oncology unit were analysed retrospectively. Patients who developed persistent trophoblastic disease before achieving undetectable serum β-hCG level were excluded from analysis.

Results: The local incidence of molar pregnancy was 2.6 per 1000 deliveries. Twenty-eight patients (27.5%) defaulted their follow-up. Four patients (3.9%) with persistent trophoblastic disease before attaining one undetectable serum β-hCG level were excluded. Following one undetectable serum β-hCG level, there was no evidence of relapse demonstrated in those with uncomplicated molar pregnancy.

Conclusion: Continuation of follow up of uncomplicated molar cases beyond obtaining one undetectable serum β-hCG level appeared unnecessary in order to detect relapse of gestational trophoblastic disease. However, a large prospective study is required.
P3.27
Invasive cervical cancer audit
Choy, CC1; Abdoolatiff, I2
1 Konstantinos Polymeros; 2 Calderdale Royal Hospital, Halifax, United Kingdom

Objectives: Every year more than 2800 patients are diagnosed with cervical cancer in the UK and as many as 950 die from the disease, making it the most common cancer in females under 35. The aim of the audit is to assess the effectiveness of the screening programme and to identify areas of good practice and where improvements can be made.

Methods: 50 cases of cervical cancer cases were audited between July 2007 to March 2011 by reviewing the case notes and colposcopy records. Review of the smear cytology over the last decade prior to diagnosis were performed by the pathologist and coordinator as per Department of Health guidelines.

Results: The age range from 26 to 84 years. Five (10%) patients were between 25 and 29 years, 6 (12%) between 30 and 34 years, 11 (22%) between 35 and 39 years, 9 (18%) between 40 and 44 years, 8 (16%) between 45 and 49 years, 2 (4%) between 50 and 54 years, 2 (4%) between 55 and 59 years, 2 (4%) between 60 and 64 years, and 5 (10%) > 65 years. 30 patients (60%) were diagnosed with squamous cell carcinoma, 12 (24%) with adenocarcinoma, 6 (12%) with adenosquamous carcinoma, 1 (2%) with small cell carcinoma and 1 (2%) undifferentiated carcinoma. 17 (34%) were stage 1A1, 1 (2%) stage 1A2, 17 (34%) stage 1B1, 3 (6%) stage 1B2, 8 (16%) stage 2B, 3 (6%) stage 3B, 1 (2%) stage 4B. There were 20 patients with discrepancies when their smears in the last 10 years were reviewed. Nine has 1 discrepancy, five has 2 discrepancies, three has 3 discrepancies, and one each with 4, 5 and 8 discrepancies. The outcome of seven with discrepancies are not affected, but four might be affected and nine definitely would be affected.

Conclusion: 76% (38 patients) were treated surgically. Of these 17 patients (34%) were stage 1A1. This confirmed the effectiveness of screening in picking up earlier disease. 12 cases (24%). The incidence (24%) of adenocarcinoma in this audit is higher than reported (15%). 40% (20 patients) have discrepancies when their smears were reviewed. Although the value and efficacy of the screening programme is well established, there is a constant need for monitoring and audit to maintain the standards and quality of the programme. It is hope that the introduction of HPV testing might further enhanced its accuracy and efficacy.

P3.28
Dermatofibrosarcoma protuberans of the vulva – a case report
Omar, J; Shari, F; Saharan, WSL; Masri, MA; Ganesalingam, M
Hospital Ampang, Selangor, Malaysia

Introduction: Dermatofibrosarcoma protuberans (DFSP) is rare malignant dermal neoplasm characterized by slow infiltrative growth, little metastatic potential but a high tendency to recur locally after surgery excision. The estimated incidence is 0.8–5 cases per 1 million persons per year. And its location on the vulva is uncommon.

Case report: A 49 year old Indian woman presented with slow growing tumour on her vulva for 1 year. Upon examination, there were two masses: one immediately above the clitoris and another mass on the left which is more deep seated, difficult to differentiate from the surrounding tissue and appears continuous in the right upper region towards the superficial inguinal lymph node.

MRI pelvis showed there were two well-defined, solid, avascular, subcutaneous perineal masses with well-defined capsule measuring about 5 × 4 cm on the right and 4 × 4 cm on the left.

She underwent excision of the vulval tumour. Both tumour enucleated out and sent for histopathology examination. The histology study showed intradermal tumours extending and infiltrating the subcutaneous fat. They were cellular and arranged in storiform pattern composed of monomorphic spindle shaped cells with hyperchromatic nuclei. Both tumours expressed CD 34.

The tumour is seen at its excision margin.

For the completion of the treatment of this patient, radiotherapy is required to irradicates the tumour and she will be under our regular and long term follow up.

Discussion: Dermatofibrosarcoma protuberans of the vulva is uncommon. The aim of this case report is to highlight the importance of the surgical intervention in managing this disease. DFSP is rarely metastasizes. The local recurrence rate ranges from 0% to 60%, whereas the rate of development of regional or distant metastatic disease is only 1% and 4–5%, respectively. The initial treatment of DFSP is surgical. If initial surgery yields positive margins, re-resection is recommended whenever possible, with the gold of achieving clear margins. Imatinib mesylate, a protein tyrosine kinase inhibitor, has shown clinical activity against localized and metastatic DFSP tumours containing t(17;22) and has been approved for the treatment of unresectable, recurrent and/or metastatic DFSP. Radiation has occasionally been used as a primary therapeutic modality for DFSP, but it is more commonly used as adjuvant therapy after surgery. Post-operative radiation therapy or imatinib mesylate should be considered for positive surgical margins if further resection is not feasible. If negative margin is achieved, no adjuvant treatment is necessary.

P3.29
Spontaneous rupture of a pyometra in a woman with a mixed mullerian tumour of the uterine corpus — a review of the literature
Aojanepong, T; Sheikh, S; Aung, C; Norris, J; Hill, N
Princess Royal University Hospital, United Kingdom

Objective: Pyometra is a rare condition predominantly affecting elderly women involving the accumulation of purulent material in the uterine cavity. Although often resulting from benign causes, it can also be associated with genital malignancy, most commonly cervical. We present an interesting case of a 61 year old patient with a rare utero carinosarcoma or mixed mullerian tumour who presented acutely with a ruptured pyometra. Furthermore we present a review of the literature on both pyometra and mixed
mullerian tumours of the uterus to highlight the importance of suspecting this diagnosis in elderly female patients presenting with an acute abdomen.

**Methods and results:** A literature search was performed using the keywords spontaneous rupture, pyometra and mixed mullerian tumour, uterine corpus. To our knowledge only 30 cases of spontaneously ruptured pyometra have been reported within the English literature. Of those associated with malignancy, cervical tumours are the most commonly implicated. Only two cases have been associated with endometrial cancer.

**Conclusions:** We present a rare case of a spontaneously ruptured pyometra in combination with an unusual endometrial carcinoma. We believe that this is the first case of its kind and also adds to the existing case series of spontaneously ruptured pyometra to emphasise the importance of this as a differential diagnosis when assessing elderly women presenting acutely with abdominal pain.

**P3.30 Cervical cancer and HPV. what women think?**

*Mimita, M; Magendra, R; Nurdiana, A; Farouk, A*

Maternal and Child Health Clinic Klang, Klang General Hospital, Klang, Malaysia

**Objective:** To assess and evaluate the awareness of cervical cancer and HPV vaccine among mothers attending the antenatal clinic.

**Methods:** Prospective questionnaire based study carried out at the maternal and child health clinic to determine importance and perception of cervical cancer and HPV vaccine. Mothers attending clinic were counselled and questionnaires were distributed.

**Results:** Total of 226 questionnaires were analysed. The majority of mothers had secondary education (64.1%), followed by tertiary education (24.3%). Most were in the reproductive age group (89.6%), 40.7% had at least two children, 16.8% had more than four children. Housewives comprise 45.1% and working mothers who are 50.9%. 81.9% were aware of cervical cancer and 39.4% had read magazines or pamphlets. 11.5% acquired information from doctors, 15.5% were from nurses and 12.4% from family and friends. 51.3% had a Pap smear done at least once whereas 44.7% had never before. 45.1% knew Pap smear should be done yearly whereas 15% were not aware of frequency. Only 4.1% knew the high risk group whereas 58% didn’t. Approximately 2.2% had wrong answer. 80.1% claim cervical cancer can be prevented and surprisingly only 27.9% have heard about human papillomavirus (HPV) vaccine. 62.8% never heard of HPV vaccine, 72.6% would encourage friends or family members to vaccinate. 50.9% encourage teenagers to receive the vaccine whereas 30.5% wouldn’t. 20.8% claim they were too young, 3.1% claim it was dangerous, 3.5% said it was too costly, 0.4% felt it wasn’t useful and 7.1% claim there were no chances of acquiring cervical cancer. 81.4% claim pap smear is advantageous. Among those who were willing to pay for the vaccine, approximately 41 of them were willing to pay between RM 10 to RM 100 and only five of them could afford to pay more than RM200. 82 of them claim we can prevent cervical cancer who acquired information from magazines.

**Conclusion:** This survey concludes that the awareness Pap smear and cervical cancer is still lacking among patients. Hence awareness programme, if well initiated, will improve the knowledge and perception of cervical cancer and HPV vaccine.

**P3.31 Survival outcomes in ovarian cancer**

*See, ATA; Drake, AC*

1 Peterborough City Hospital, Edith Cavell Campus, Bretton Gate, Peterborough, United Kingdom; 2 Lister Hospital, Coreys Mill Lane, Stevenage, Hertfordshire, United Kingdom

**Objective:** To evaluate the effectiveness and safety of the treatment of women with ovarian cancer within the East and North Hertfordshire NHS Trust. We aimed to measure (i) Overall survival (OS), (ii) progression-free survival (PFS) and (iii) surgical morbidity.

**Methods:** A 5 year, multisite, retrospective review of medical records was performed. Women with a histological diagnosis of epithelial ovarian cancer from 1 January 2005 to 31 December 2009 were included. Follow-up was until 31 December 2010. Women with concurrent malignancies were excluded. OS and PFS were calculated using Kaplan Meier estimates.

**Results:** 90 women were studied. 26 (29%) presented with FIGO stage I disease and 64 (71%) with FIGO stage II–IV disease. 67 (75%) had primary surgery with or without adjuvant chemotherapy, 14 (16%) had interval debulking surgery and 9 (9%) had chemotherapy alone. In women with stage II–IV disease, complete cytoreduction was achieved in 39% (n = 22) of cases and a further optimal cytoreduction in 27% (n = 15) of cases. Intra-operative complication occurred in 2 (1.2%) cases and post-operative complication in 17 (21%) cases. 1- and 5-years OS was 74.4% and 55.8%, 1- and 5-year PFS was 77.5% and 40.6% (median = 17 months).

**Conclusions:** East and North Hertfordshire NHS Trust OS is higher than the reported national average. Surgery was not associated with severe morbidity or death. Limitations to data include small sample.

**P3.32 A case of two synchronous tumour of different histology – advanced cervical adenocarcinoma with borderline mucinous ovarian tumour in a 22 year old virgin**

*Kavitha, N; Kanagasabai, S; Who, TS*

1 Department of Obstetrics and Gynaecology, Melaka Manipal Medical College; 2 Department of Obstetrics and Gynaecology, Melaka General Hospital

A 22 year old nulliparous and not sexually active woman presented with heavy bleeding and dysmenorrhoea of 4 months duration. A transabdominal ultrasound demonstrated fluid in the endometrial cavity. This was confirmed by MRI pelvis. The findings of examination under anaesthesia revealed intact hymen, healthy cervix, os stenosed. Pipelle aspiration of the cavity revealed clear fluid followed by blood and pus. She presented after 3 months with acute urinary retention and heavy bleeding. A CT pelvis showed complex bilateral ovarian cyst with minimal ascitis, enlarged paraaortic node at L2 and recurrence of hematometra.
An exploratory laparotomy was performed with bilateral cystectomy, supracolic omentectomy, with uterine and cervical biopsy. The histopathology shows bilateral borderline mucinous tumour of the ovary and primary well differentiated adenocarcinoma of the cervix with metastatic omental nodules. The CT thorax revealed metastatic pulmonary nodules. In view of advanced cervical adenocarcinoma, she was advised palliative chemotherapy with carboplatin and paclitaxel for six cycles. The presence of hematometra is suggestive of mullerian anomalies in young women and invasive cervical cancer in postmenopausal. Hematometra as a clinical feature of cervical adenocarcinoma in young woman like our case is a rare presentation. The mechanism of occurrence of synchronous tumours is probably when embryologically similar tissues (mullerian origin) are simultaneously exposed to carcinogens, they can predispose to synchronous neoplasms.

Immunohistochemistry plays a role in the differentiation of these tumours as primary or metastatic as suggested by Eswari et al. In our case the presence of malignant cells exhibiting positive for CK7, CEA and vimentin negative is suggestive of primary endocervical carcinoma differentiating it from endometrial origin. The cervical biopsy immunostaining was negative for HPV and p53.

The aetiology of cervical adenocarcinoma in our case is related to HPV independent carcinogenesis due to activation of k-ras oncogene or down regulation of cyclic kinase inhibitors. This rapid onset of adenocarcinoma of the cervix in a young patient is identified to be likely in HPV negative cases as studied by Liebrich et al. and Riou et al., that these HPV negative tumours are biologically different subset of tumours with poor prognosis.

In conclusion, synchronous tumours of the ovary and cervix of different histology are rarely reported. We propose the origin of cervical adenocarcinoma in a virgin with atypical presentation and different histology are rarely reported. We propose the origin of biologically different subset of tumours with poor prognosis.

Conclusions: Majority of referrals were in house. 49% of referrals for colposcopy assessment, provided basic investigations have been performed. Colposcopy accuracy for diagnosing abnormal looking Cx is 68%, normal looking cx is 33%. Future recommendations; dedicated PCB colposcopy clinics – managed by all colposcopist. Guidelines needed; local Trust guidelines, including protocol for internal referral & development of flow chart for over 25 years. Re-audit in 12 months.

**P3.34**
**Malignant melanoma, a cause for postmenopausal bleeding**

**Myagerimath, R; Kubwalo, B; Gul, N**  
Wirral University Teaching Hospital, NHS Foundation Trust, Wirral, United Kingdom

**Introduction:** Melanoma is a tumour of the melanocytes of the skin and mucous membranes. Only 2.5% of cutaneous melanomas metastasise to the female genital tract, the most frequently affected organs being the ovaries. The uterus, mainly the myometrium, is only involved in 10% of cases of genital metastases. The endometrium is less frequently involved 1. Uterine metastases of extra genital malignomas are rarely presented in literature. Here we are presenting a case of postmenopausal bleeding secondary to metastatic malignant melanoma.

**Case report:** A 58 years old woman presented with postmenopausal bleeding. She had a history of cutaneous melanoma >4 mm excised 2 year earlier followed by brain metastasis treated by craniotomy, excision of right temporal brain metastasis and radiotherapy for 6 months prior to Hysteroscopy revealed suspicious endometrium and histology reported malignant melanoma. Further imaging ruled out other systemic involvement. After multidisciplinary meeting she was offered palliative laparoscopic hysterectomy BSO, washings and peritoneal biopsy. Histology confirmed metastatic malignant melanoma with positive peritoneal washings. She recovered well without evidence of recurrence and is asymptomatic for more than a year.

**Discussion:** Although genital tract malignancies are a common causes of the postmenopausal bleeding next to atrophic vaginitis, metastatic extra genital malignancies should be considered in a woman with past history of extra genital malignancies. In the index case, palliative surgery was offered for de-bulking and symptom control. Lifetime risk of a woman in the UK developing melanoma is 1 in 117. Melanoma confined to the epidermis is effectively curable and thin lesions carry a >98% 5-year survival rate. However patients with primary tumours of >4 mm thickness have a <50% 5 year survival rate and the median survival for disseminated melanoma is just 7–8 months. The prognosis for patients with advanced visceral metastatic melanoma is particularly poor with a 5-year survival of 5–14% 2. Early diagnosis and appropriate management can improve the survival rate.

**Conclusion:** Abnormal uterine bleeding in patients with a history of malignancy should always alert the physician to consider the diagnosis of metastatic spread to the genital tract.
P3.35
Complex ovarian mass in pregnancy, a case of successful conservative management
Guimicheva, B; Jan, H; Ross, J
Kings College Hospital, NHS Trust, United Kingdom

Objective: We review a case of a complex ovarian mass in pregnancy that with careful accurate ultrasound diagnosis, was managed conservatively until after delivery. We also review some of the evidence that helps guide our management.

Case: A 37-year-old patient presented at 6 weeks to the Early Pregnancy Unit with a history of abdominal pain. She had had previous vaginal delivery and normal menstrual cycles. The only medical history of note was a history of bipolar affective disorder for which she was on sodium valproate and high dose folic acid. She had no personal or family history of cancer. A transvaginal sonographic assessment showed an anteverted uterus, containing a gestational and yolk sac, representing an early intrauterine pregnancy of 4–5 weeks of gestation, with a normal right ovary and an enlarged left ovary. The left ovary contained a thin walled cystic lesion, that was unilocular, avascular, and contained solid papillary projections into the cyst cavity. These findings have a high specificity1 for the diagnosis of a borderline ovarian tumour. Tumour markers were not elevated. The patient was followed up 2 weeks later at which point she was asymptomatic and a viable on going early pregnancy was diagnosed. A plan for conservative treatment with close USS observation was made. The patient was rescanned at 8, 13, 24 and 36 weeks of gestation with no significant change in symptomatology, size or features of the cyst. The patient went on to deliver normally at term, after which she was reassessed and booked for surgery. She under went a routine left oophorectomy, with good recovery. The histology confirmed a borderline ovarian tumour.

Conclusion: Surgery can be undertaken for suspicious ovarian cysts in pregnancy. As our ultrasound skills improve, our certainty of the diagnosis improves. This allows us to delay surgery to after delivery therefore reducing morbidity for both the mother and baby.

Reference:

P3.36
An unusual case of squamous cell cancer in dermoid cyst
Chakrabarti, M; Keating, P; Willett, MJ
Lancashire Women and Newborn Centre, United Kingdom

Objective: To find out suitable management option of uncommon primary malignancy in matured cystic teratoma (MCT) in young women with fertility wishes. Discuss the absence of reliable preoperative prognostic indicator of malignancy.

Methods: A 25 year old nulliparous woman presented with lower abdominal pain. Ultrasound findings showed unilateral ovarian mass suggestive of ‘dermoid cyst’. Biochemical tumour markers (AFP, CEA) were normal except CA125 which was slightly elevated. She was treated with cystectomy and ovarian reconstruction. A relief was sensed that the treatment was complete.

Results: The histopathology result showed a surprising diagnosis of squamous cell carcinoma (SCC) transformation of teratoma. The patient was devastated because of this unexpected diagnosis. Ipsilateral salpingo-oophorectomy, omentectomy and para-aortic lymphadenectomy were performed in a second laparotomy. This showed complete excision of disease. Investigations were undertaken to exclude any other focus of SCC as primary cancer was rare. She will now have follow up like an ovarian cancer.

Conclusion: In common practice ‘Dermoid cysts’ are thought to be generally benign. Few preoperative predictors were discussed in literature, e.g. elderly age, bigger tumour size, ultrasound characteristics, sonar tumour vessel wave form, levels of SCC antigen and CA125 tumour markers, but none of them are conclusive.1,2 This case suggests the usual threshold of 30 years of age1 for more preoperative work up is debatable. Follow up protocol and long term prognosis is also not clear. Further detailed worldwide reporting of such cases is of utmost importance and research is needed to analyse the predictive and prognostic indicators. Histopathology is mandatory as all ovarian masses should be considered malignant until proved otherwise. Patients should be adequately counselled preoperatively. The days of feeling reassured with an ultrasound suggestion of dermoid is over.

(The presentation will be presented in professional and visually attractive power point slides with high definition histopathology pictures, charts and diagrams).

References:
Fourth patient, 30 years old, with history of anticoagulation for pulmonary embolism, presented 3 months following her first caesarean delivery for breech presentation. Ultrasound scanning showed the presence of endometrioma at the site of caesarean section scar. Different options of treatment were discussed. All the patients opted for surgical treatment. All the patients were offered Preoperative back to back oral combined contraceptive pills until the time of surgery. Histopathology examination confirmed the presence of endometrioma, with no evidence of malignancy.

Discussion: Scar endometriosis is not very common there are few case series and large study showing cases of scar endometriosis. Typically occurs after surgery section or hystrectomy. Typically takes about 18 months to manifest. patients complain of pain and swelling which is worse at the time of periods. medical treatment is not very successful. surgical excision is the treatment of choice.

P3.38
Intermediate term report: are we giving the correct carboplatin dose in neoadjuvant/adjuvant setting in gynaecological oncology utilizing two different calculations in a tertiary university centre?

Leong, EWK; Sim, BK; Tan, ACC

Faculty of Medicine, University of Malaya, Hospital Melaka, Malacca

Note: This paper was formally accepted by 63th Annual Congress of JSOG held in Osaka, Japan 2011 but was withdrawn after Great East Japan Earthquake.

Objective: To demonstrate two different calculated carboplatin dosages based on Cockroft formula and 24 h urinary creatinine clearance and actual given dose.

Methods: 93 common-pool patients undergoing chemotherapy for gynaecological malignancy in the institutional first cycle had their actual dose given (ADG), Cockroft (Ckft) and 24 h urine creatinine clearance (24 h CrCl) carboplatin dosages analysed as to dose differentiation between actual dose given versus the other two calculated doses.

Results: 93 patients included of which 2/93 were neoadjuvant setting, 48/93 single agent regime, 11/93 recurrent disease. The ADG-Ckft (mean = 523.17, range = 251.16–1502.41); ADG-24 h CrCl (-13.26, -362 to 278). Age of patients (mean = 55, median = 55, range = 25–79 SD 11.3), 24 h CrCl (1.51, 1.13–2.21). Body surface area (mean = 1.515, median = 1.5, range = 1.13–2.214). Race: Malays 27, Chinese 50, Indians 15, Others 1. Significant difference exists between absolute ADG-Ckft and 24 h CrCl dosages (P < 0.01).

Conclusion: There are significant dose differences in carboplatin dosages calculated but there is no current guide internationally which denotes which dose to choose. This affects effectiveness of dose delivered, toxicity, resistance, combinational toxicity, physician fancy, need for GCSF, cure and recurrence rates. This issue needs to be addressed and answers sought.

P3.39
A cross-sectional study on the knowledge and attitude on HPV and cervical cancer among women attending outpatient clinics in Hospital Raja Permaisuri Bainun

Maizun, I; Uma, DT; Khamini, T

Royal College of Medicine Perak, Universiti Kuala Lumpur, Ipoh, Perak, Malaysia

Objective: To study the knowledge and attitude on human papilloma Virus (HPV) and cervical cancer among women attending outpatient clinics at HRPB. Questionaires were distributed them to evaluate their knowledge and attitude of women on cervical cancer and HPV. Demographic profiles of their age, marital status, races and highest educational level of the respondents were taken. The knowledge was assessed by total score from seven questions and attitude was assessed among them. Their attitudes were evaluated on recommendation of HPV vaccinations to family and friends and the need for Pap smear for women who had sexual exposure.

Results: A total of 280 women participated in this study. Findings showed 75.0% of the 280 respondents have heard about cervical cancer but only 26.4% stated they have heard about HPV. Majority of the respondents (39.6%) have an average knowledge score on HPV and cervical cancer. A total of 31 respondents (11.1%) have poor knowledge and only 33 respondents (11.8%) gave excellent scores. Significant association was shown between the knowledge score, races and the educational levels of the respondents (P = 0.043, P = 0.014). A total of 215 respondents (76.8%) strongly agreed and agreed with HPV vaccination recommendation to their family and friends. Among the respondents, 91.8% were agreed that all women with sexual exposure should do a Pap smear test.

Conclusion: This study confirms some degree of deficient of knowledge on HPV among women. Steps should be taken to increase the knowledge and awareness among women especially those in the lower educational group.

P3.40
Oncological referral patterns of gynaecological cancer patients over 2010–2011. the need for gynaecologic oncology subspeciality services

Usmani, AT; Ayub, S; Basharat, A

Benazir Bhutto Hospital, Rawalpindi, Pakistan

Background: For the most part, gynaecological cancers can be treated for cure. As with the majority of solid tumour cancers, if gynaecologic cancers are discovered at an early stage, surgery can be curative. The number of patients referred from the study hospital over a 1.5-year period is reported. The increase in the utilization of the oncologist by the general gynaecologist over the study period is detailed. The impact of gynaecologic oncology...
subspecialty services on referral patterns of uterine cancer in a tertiary hospital has not been explored in the literature.

**Methods:** The study was carried out at the Department of Obstetrics and Gynaecology at Benazir Bhutto Hospital, Rawalpindi under supervision of Professor Asma Tanveer Usmani. In our study, we reviewed the medical records of patients who were referred to Oncology (NORI) for gynaecological cancers. The study included patients from February 2010 to August 2011. Based on the review of these records, we assessed the clinical presentation of these patients and the reasons for referral.

**Results:** We referred 32 patients with gynecological malignancy to NORI. The age of the patients ranged from 13 to 80 years with a mean age of 47.18 ± 16 years. The most common malignancy was ovarian carcinoma in 10 (31.3%) patients with a mean age of 40.5 ± 13.5 years. The youngest patient was 13 years of age with mixed malignant germ cell tumour. The next most frequent malignancy was cervical carcinoma in 10 (31.3%) patients with squamous cell cancer in nine and adenocarcinoma in one patient; with a mean age of 57 ± 13.7 years. Less common tumours included endometrial carcinoma in four (12.5%) with mean age of 45.2 ± 16.6 years, vulval squamous cell carcinoma in four (12.5%) with mean age of 45 ± 23.3 years and vaginal carcinoma in one (3.1%) with mean age of 52 years. Four (12.5%) patients presented with recurrence after treatment of primary malignancy. All patients had their primary surgery done before referral if it was indicated. The reason for referral was for opinion about chemo-radiotherapy.

**Conclusion:** Gynaecological malignancy referrals contribute to a great burden of out-of-hospital referrals. The availability of gynaecologic oncology subspecialty services can result in a rapid decline in referral to other institutions, an increase in the number of patients treated, and a gradual transfer of responsibility for primary management from general

**P3.41**

**Audit of multidisciplinary oncology meetings (MDM’s) for gynecological cancers at MCH centre PIMS, Islamabad**

Tabassum, A; Mahmud, G; Ambreen, S

Maternal and Child Health Centre, PIMS, Islamabad, Pakistan

**Introduction:** Multidisciplinary meeting are regularly scheduled meeting of core and invited team members for the purpose of prospective treatment and care planning of newly diagnosed cancer patients as well as those requiring review of treatment plans or palliative care. Core team members commonly include radiologists, pathologists, general practitioners, surgeons, physicians, medical oncologists, palliative care practitioners, radiation oncologists, social workers, psychologists, oncology nurses, data managers, research nurses. Multidisciplinary meeting is vital to the extensive care in cancer patients. Patient services can be improved in the hospitals.

**Background:** Multidisciplinary meeting (MDMs) were started in MCH center PIMS in collaboration with Nuclear Oncology and Radiotherapy Institute (NORI) to improve care provided to Cancer Patients. The meetings are conducted fortnightly and are attended by core team members of relevant disciplines.

**Objective:** To assess the load of cancer patients in our institute and identify the key areas of improvement.

**Methods:** An audit of MDMs was conducted from April 2009 to December 2011 at MCH centre, PIMS, Islamabad with the aim of assessing the burden of cancer in our institute. A register was maintained for record keeping, so that outcome of management could be assessed.

**Results:** The audit identified that multidisciplinary meetings helped in achieving many of the ‘Principles of best practice’ of International recommendations. Out of total 196 patients discussed in MDM carcinoma ovary (42.3%) was the leading cancer among the women followed by Ca cervix (20.9%) and Ca Vulva (11.2%). The commonest histological type was serous cyst adenocarcinoma of ovary. Medical Oncologists, Gynaecologist, Radiation Oncologist had 100% attendance in all meetings while Radiologist and Histopathologist had 90% and 50% respectively. There was no delay in examining patients as they were seen the same day they were referred from oncology department.

**Conclusion:** The audit helped us in delivering a new form to record patient’s data and maintain follow up both in the Oncology and Gynaecology Department. Number of cancer surgeries was markedly improved. There were few aspects of record keeping which need improvement.

**P3.42**

**Extraskelatal myxoid chondrosarcoma involving the mons pubis: a case report and review of the literature**

Cawley, N; Solomonsz, FA

Bassetlaw District General Hospital, United Kingdom

**Introduction:** Carcinoma of the vulva is a rare cancer in the UK, when grouped with vaginal cancer it only accounts for 1% of all cancers and 8% of gynaecological cancers. Sarcomas involving the vulva occur infrequently and an extraskelatal myxoid chondrosarcoma of the vulva is an extremely rare tumour, indeed there are only two cases specifically involving the vulva described in the literature. It has a high potential for metastasis and is most commonly found in middle-aged patients. We report a case of extraskelatal myxoid chondrosarcoma involving the Mons Pubis.

**Case description:** A 45 year old woman presented with a swelling over her Mons Pubis, this was initially thought to be a sebaceous cyst. The mass was excised under general anaesthetic, histological examination revealed that this was an extraskelatal myxoid chondrosarcoma with incomplete excision as the capsule was breached. The patient underwent re-excision of the operative site and was further treated with a course of radiotherapy.

**Discussion:** Whenever a patient presents with a soft tissue mass involving the vulva especially in 40–50 years old age group, we should always consider the possibility of the presence of a sarcoma. This is especially if there is a history of increasing size, tenderness or it suspected to be fixed deep to the muscle fascia. Urgent referral to a regional sarcoma team is indicated when the diagnosis is suspected. MRI is the imaging modality of choice, fine needle aspiration for cytological diagnosis has been described. The definitive management for extraskelatal myxoid chondrosarcoma is surgical, normally by wide local excision, it is
relatively resistant to radiotherapy and has a poor response to chemotherapy.

P3.43
Detection of ovarian cancer in primary care
Lee, F; Somoye, G; Saleh, S
Aberdeen Royal Infirmary, NHS Grampian, United Kingdom

Objectives: Ovarian cancer is termed ‘silent killer’ and is the most common form of gynaecological cancer with an incidence rate of 20 per 100 000. It is also widely recognised that most women with ovarian cancer have non-specific symptoms making it particularly difficult to detect, especially in primary care. Most women with ovarian cancer present in the advanced stages, therefore the poor outcome. This study aims to examine the quality of clinical information of urgent referrals for suspected ovarian cancer as provided by primary care physicians to a specialist gynaec-oncology service in the North of Scotland, UK.

Methods: 96 referral letters for suspected ovarian cancer from primary care were reviewed from October 2010 to September 2011. Outcome of each referral were categorised as ‘malignancy’ or ‘no malignancy’. We looked at physical examination findings (ascites and/or pelvic/abdominal mass; not obviously uterine fibroids), duration of symptoms, specific symptoms (any one/more of abdominal bloating, early satiety, abdominal/pelvic pain, urinary symptoms, or age >50 with symptoms of IBS) and general symptoms (any one/more of unexplained weight loss, fatigue, altered bowel habit, in which ovarian cancer is suspected).

Results: Documented physical examination findings = 66/96 (68.75%). 23/31 malignancies; 15 of which were ovarian in origin. No documentation of physical findings = 30/96 (31.25%). 8/31 malignancies; seven of which were ovarian in origin. No details of any specific and/or general symptoms = 17/96 (17.7%) Duration of symptoms in referrals = 54/96 Enquiry of specific symptoms: (i) Persistent abdominal distension = 39/96. (ii) Early satiety and/or loss of appetite = 5/96. (iii) Pelvic or abdominal pain = 41/96. (iv) Urinary frequency/urgency = 22/96. (v) >50 of age with IBS = 8/96. Enquiry of general symptoms: (i) Unexplained weight loss = 23/96. (ii) Fatigue = 2/96. (iii) Changes in bowel habit = 23/96.

Conclusion: Referral letters from primary to secondary care are lacking important clinical information. All referral letters to gynaecological cancer services are evaluated by senior clinicians and prioritised accordingly based on presenting symptoms, physical examination findings and investigation results to determine the urgency of action required (e.g. outpatient clinic appointment or in-patient admission). Obviously, the challenge presented by ovarian cancer is to diagnose the disease as early as possible, therefore primary care physicians play a major role in ensuring that patients with potential ovarian malignancies are directed to the most appropriate clinical pathway as soon as.

P3.44
Case report: complete hydatidiform mole presenting with cardiac failure, acute pulmonary oedema, severe pre-ecclampsia, hyperthyroidism, trophoblastic tissue embolisation and acute myocardial infarction
Lavitha, S; Shilpa, N; Jamil, O; Yong, CM; Muralitharan, G
Department of Obstetrics and Gynaecology, Hospital Ampang, Malaysia

Hydatidiform mole is more common in underdeveloped countries. We present a case of complete hydatidiform mole with all the possible complications, which are rarely seen anymore. A 30 year old Filipina woman presented with a molar pregnancy with a uterus corresponding to 36 weeks. She had anaemia, cardiac failure and acute pulmonary oedema on presentation with a haemoglobin of 6.7 g/dL. She also had severe pre-ecclampsia with hypertension and solid proteinuria. She had biochemical evidence of hyperthyroidism. She was given blood transfusion to bring her haemoglobin up and diuretics to treat the pulmonary oedema. She was started on antihypertensives and also antithyroid medication. Her chest radiograph showed evidence of trophoblastic tissue embolization. She underwent suction and curettage under general anesthesia. 3.5 L of blood and molar tissue was removed. Post operatively she required intensive care and remained intubated and ventilated. Beta blockers were added to control her tachycardia. She developed an acute myocardial infarction 2 days later as evidenced by ECG changes and elevated cardiac enzymes. She was extubated 4 days after the suction and curettage. Her β-hCG taken on admission was 6526 IU/L, which we now believe was a laboratory error as the level was 532 754 IU/L after the procedure. This has been reported as the ‘high dose hook effect’ in other literature. On day 9 post procedure the level was 64 419 IU/L and she was started on chemotherapy with single agent methotrexate. After the first cycle of chemotherapy the level came down to 14 257 IU/L. As she was a foreigner she wanted to go back to the Philippines to continue her treatment. This patient presented to us late in her pregnancy and as such we were able to see the all the rare complications that are associated with molar pregnancy. However, there has been no report in the literature of myocardial infarction associated with molar pregnancy.

P3.45
Risk factor for breast cancer in Iranian women
Abbasi, S
Tehran University Of Medical Sciences, Iran

The objective of the present study was to investigate risk factors for breast cancer among Iranian women. Dermographical Deta and risk factors related information was collected using short structured questionnaire. 150 women with breast cancer and 147 healthy women as control were interviewed. In a multivariate analysis, the body mass index, age at menarch, age at marriage, race, ABO and Rh blood groups, and family history of breast
cancer were associated with increased risk for developing breast cancer significantly ($P = 0.05$). The finding of present study suggests that the family history of breast cancer and marital status may have the most impact on the incidence of breast cancer in Iranian women.

P3.46
A Profile of cases of gestational trophoblastic neoplasia at a large tertiary centre in Dubai
Rangwala, TH; Badawi, F
Department of Obstetrics and Gynaecology, Latifa Hospital, Dubai, United Arab Emirates

Objective: To study (i) the prevalence of different types of gestational trophoblastic neoplasia (GTN) in the local and non-local population of women at Al wasl hospital, a tertiary level referral centre for Northern Emirates, (ii) the safety of cervical preparation before uterine evacuation, (iii) the role of repeat uterine evacuation in curing these cases, and (iv) the percentage of cases ultimately requiring chemotherapy.

Methods: Retrospective analysis of case records of 35 women with diagnosis of gestational trophoblastic neoplasia, managed in the department of obstetrics and gynecology at Al wasl Hospital, over a 2 year period between January 2007 to December 2008.

Results: 35 cases of gestational trophoblastic neoplasia were seen in a 2 year period (January 2007–December 2008) at Al wasl Hospital, with 7000 deliveries per year, prevalence being 1 in 400 live births. 60% cases were local Arabs. Histopathology revealed – complete mole in 13 cases, partial mole – 17 cases, Hydropic degeneration of villi – 4 cases and no identifiable tissue – 1 case. No cases of choriocarcinoma or placental site trophoblastic tumour were seen during the study period. 34% cases received no cases of choriocarcinoma or placental site trophoblastic tumour were seen during the study period. 34% cases received cervical preparation with prostaglandins prior to surgical curettage. Complications were minor. 62% were cured by primary suction curettage, 12% after second (repeat) uterine evacuation, 25% needed single drug chemotherapy. 8% cases defaulted after primary evacuation and were lost to follow up.

Conclusions: Prevalence of GTN is increasing in the local Arab population. Majority of cases are cured by simple suction uterine curettage. Cervical preparation with prostaglandins should be done in selected cases to avoid perforation during evacuation. Second (repeat) uterine evacuation can be curative in some cases with strict selection criteria and avoids the need for chemotherapy. Regional registry of cases is needed to estimate the true incidence of this disease.

P3.47
Epidemiology and pathology of gynaecological cancer at Benazir Bhutto Hospital, Rawalpindi
Basharat, A; Ayub, S; Usmani, AT
Benazir Bhutto Hospital, Rawalpindi, Pakistan

Gynaecological cancers are a group of different malignancies of the female reproductive system, which include cancers of the ovary, cervix, body of the uterus, vulva and vagina. Over the years, irrespective of social class, the number of gynaecological cancers is increasing, with more cases at the younger age. Women health has always remained neglected, because of the traditional reductionistic approach to women health research. The first step towards achieving the needs of women as consumers and providers is to do baseline research so that the nature and magnitude of the problem is assessed.

Methods: The study was carried out at the Department of Obstetrics and Gynaecology at Benazir Bhutto Hospital, Rawalpindi. We reviewed the medical records of patients who were referred to Oncology (NORI) for gynaecological cancers, from June 2008 to August 2011. We assessed the histopathological diagnosis and epidemiology of these patients.

Results: The age of the patients ranged from 13 to 80 years with a mean age of 49.6 ± 17.5 years. On analysis of histopathological diagnosis the most common malignancy was ovarian carcinoma in 22 (36.1%) patients with a mean age of 37.2 ± 13.8 years. Epithelial (serous and mucinous tumours) were the most common in 19 patients. Others included germ cell tumours in three patients (mixed malignant cell tumour, dysgerminoma and yolk sac tumour). The next most frequent malignancy was cervical carcinoma in 17 (27.9%) patients with squamous cell carcinoma in 15 and adenocarcinoma in two patients; with a mean age of 60.8 ± 13.3 years. The next most frequent malignancy was endometrial carcinoma in 16 (26.2%) with mean age of 53.7 ± 14.3 years. The histologic patterns included endometrioid adenocarcinoma in 13, adenosquamous carcinoma in 1, clear cell carcinoma in 1 and leiomyosarcoma in 1. Less common tumours included vulval squamous cell carcinoma in 5 (8.2%) with mean age of 52 ± 25.6 years and vaginal squamous cell carcinoma in 1 (1.6%) with an age of 52 years. Seven (11.4%) patients presented with recurrence after treatment of primary malignancy. All patients had their primary surgery done before referral as indicated. The reason for referral was chemo-radiotherapy.

Conclusion: This study is an initial report of gynaecological cancers in this part of Pakistan, a developing country with alarmingly rising prevalence of carcinomas. Malignancies are now one of the leading causes of morbidity and mortality.

P3.48
Cancer of the cervix in unscreened African women
Yakasai, IA; Gaya, SA; Muhammed, AZ; Galadanci, HS; Garba, DI
Bayero University Kano/Aminu Kano Teaching Hospital, Kano, Nigeria

Background: Cancer of the cervix remains an important health problem amongst women worldwide. Widespread comprehensive cervical cancer control programme have resulted in marked reduction in incidence and mortality in most developed countries. Developing countries bear over 80% of the global burden, with only 5% of global resources for cancer control. Majority of the cases in these countries present late and are incurable at the time of diagnosis.

Objective: To review the presentation and histopathological types of cervical cancer cases seen in Aminu Kano Teaching Hospital Kano, over 16 year period (1995–2010).
P3.49
Leiomyosarcoma of the vulva
Bapir, M; Hoh, J; Al-Inizi, S
South Tyneside Foundation Trust, South Shields, United Kingdom

Background: Leiomyosarcoma of the vulva is rare and accounts for 1% of vulvar cancer. However, it is an aggressive malignancy which can often be mistaken for a benign lesion causing a delay in diagnosis.

Case: 42 years old, para 3 with previous history of grade 2 ductal carcinoma of the left breast and was on tamoxifen. She was referred by her GP with 2 years history of slow growing right labial swelling which was thought to be a possible Bartholin’s cyst causing discomfort during sexual intercourse in the last few months. On examination in clinic, it was felt to be a 6 x 5 cm right Bartholin’s cyst. She was booked for surgery. Under general anaesthetic, it was found to be a 6 x 5 cm hard mass on the right labia majora which looked like fibroid. It was completely excised. Histology confirmed leiomyosarcoma and further imaging was performed to exclude distant metastasis.

Conclusion: Most vulval lesions at the Bartholin’s area are either benign Bartholin’s cyst or abscess. However, the possibility of Bartholin’s gland carcinoma or leiomyosarcoma should always be considered if a rapidly growing large hard vulval mass is found in this area to avoid delay in diagnosis. Fibroids in this area are very rare but any lesions with rapid growth to a certain size are red flag symptoms and leiomyosarcoma should always be part of the differential diagnosis.

P3.50
Preliminary report: proteomics of redivac fluid: comparative analysis of protein clusters in peritoneal lavage fluid and gynaecological cancer
Kong, ELW1; Seriramalu, R2; Rahman, PSA2,3; Adenan, NAM1; Hashim, OH2,3
1 Department of Obstetrics and Gynaecology; 2 Department of Molecular Medicine, Faculty of Medicine; 3 University of Malaya Centre for Proteomics Research

Objective: Gynaecological cancer is a cancer that develops in a woman’s reproductive organs. In Malaysia, gynaecological cancer such as cervix and ovary are common among women. The signs and symptoms for gynaecological cancer remain to be vague and thus hinder early detection. Therefore search for biomarkers using body fluids to provide early detection is urgently needed. The post-operative drain fluid also known as redivac fluid is a fluid that is left over from operative closure washings collected in closed suction bottles. The fluid contains transudation from tissues, exudates from exposed tissues, opened lymphatics post removal of lymph nodes in cancer surgery and left over tumour foci (if any).

Methods: In the present study, we have subjected proteins of redivac fluids from patients with gynaecological cancer and the peritoneal lavage fluid as control to 2-dimensional electrophoresis (2-DE) and mass spectrometry. Currently we are analysing the expression of proteins from both group of samples by using Image Master Platinum version 7.0.

Results: Twenty-four clusters of protein were identified by using mass spectrometry.

Conclusion: The method may be used to analyse the protein compositions of post-operative drain fluids from various cohorts of surgical patients.

P3.51
A migrating IUCD or was it a red herring?
Bashir, A; Sivasuriam, SA; Shah, S
Cwm Taf NHS Trust, Prince Charles Hospital, Merthyr Tydfil, United Kingdom

A 36 year old female presents a month after Mirena IUS insertion with abdominal pain and distension. A CT scan performed clearly demonstrated the Mirena IUS attached to the fundus of the uterus following migration through a uterine perforation. Gross ascitis was noted in conjunction with the above. Ascitic fluid was noted to be a transudate and was negative for malignant cells. The mirena IUS was removed laparoscopically along with a translucent structure lying freely in the pouch of Douglas. The histology of the same was reported as signet ring type adenocarcinoma with further immunophenotype suggesting a primary arising from the stomach or the appendix. An ulcerated growth was noted in the lesser curvature of the stomach at endoscopy. Biopsy of it confirmed invasive diffuse type adenocarcinoma. The patient has since been referred to palliative care. Our initial inference of the Mirena IUS causing ascitis was proven to be wrong. Our second differential was a possible endometrial carcinoma which gave rise to seedlings due to perforation. This was once again wrong. We wish to highlight the importance of attempting to exclude malignancy at all times in those with ascitis due to no obvious medical cause.
Laparoscopy for Pelvic pain 2002 NAD. Depression: seeing the psychiatrist. 13/40: admitted with frequency of micturition and abd pain. 19 + 6: Mild PVB (bright red), P/S cervix not visualised, scan arranged: low lying placenta posterior and covering the internal os. 24 weeks: admitted with APH placenta covering os, urine microscopy suggestive of UTI, on augmentin. 25 + 4 weeks: admitted with PVB, treated for UTI as urine microscopy suggestive of UTI. 26 weeks: admitted with UTI on cephalxin. 28 weeks: treated for UTI, nitrofurantoin USG: kidneys normal. 32 weeks: admitted with lower abdominal pain, tightening, PV bleeding. MSU >200 White cells intravenous Cephalosporin. 32+ weeks: placenta 4.9 cm from os posterior, growth normal, P/S: os closed, no active bleeding. 33 weeks: admitted with abdominal tightening and PVB. P/V cervix nobbly feeling. P/S hard craggy lesion contact bleeding

**Final management:** For colposcopy and biopsy on 20 July 2004. Cancer posterior lip of cervix. Poorly differentiated adenosquamous carcinoma of cervix, immunocytochemistry: neuroendocrine carcinoma. MRI 26 July 2004 Stage 1b at 34 + 4. 35 weeks: uterine contractions, started on Atosiban, settled. Elective classical caesarean section at 35 + 4 with Wertheim’s hysterectomy. Baby weight 2.5 kg.

**Literature:** CEMD 2000–2002: 2 deaths due to cancer of cervix (1 indirect, 1 late indirect). Most common malignancy incidence 1.6–10.6 cases per 10 000 pregnancies. Asymptomatic (approximately 20% cases). Postcoital bleeding. Vaginal bleeding (unrelated to the pregnancy). Abnormal vaginal discharge. Rarely, pelvic pain. No difference in survival between pregnant and non-pregnant women with cervical cancer when matched by age, stage and year of diagnosis. H/O abnormal smears must be passed from the GP to the antenatal care team.

**CEMD recommendation:** When any pregnant women c/o episodes of vaginal bleeding, other than confirmed causes of haemorrhage ca cx must be excluded by direct observation of cervix and a cervical smear taken. This should be undertaken irrespective of her past medical history or reports of normal past cervical smears.

**Diagnosis:** Colposcopy with directed biopsy.

### P3.53

**Endometrial large cell neuroendocrine carcinoma: a case report**

**Sato, R; Kawano, A; Shigeta, H**

Department of Obstetrics and Gynecology, Yokohama Municipal Citizen’s Hospital

**Objective:** Endometrial large cell neuroendocrine carcinoma (LCNEC) is extremely rare. We report a case of combined large cell neuroendocrine and endometrioid adenocarcinoma of the endometrium.

**Methods:** A 61-year-old woman (para 4, gravida 4) visited our hospital for post-menopausal bleeding. Endometrial biopsy revealed to be endometrial adenocarcinoma Grade 1. Magnetic resonance imaging showed a mass (3.0 × 2.5 × 2.1 cm³) in the endometrium and myometrial invasion was suspected in the upper half part of the uterus. Bilateral adnexae were normal. Computed tomography (CT) examination showed no lymphadenopathy. The levels of CEA, CA19-9 and CA125 were within normal limits. Under the preoperative diagnosis of endometrioid adenocarcinoma FIGO stage 1b, modified radical hysterectomy, bilateral salpingo-oophorectomy and pelvic lymphadenectomy were performed.

**Results:** Grossly, a polypoid tumour (3.5 × 2.5 × 2.1 cm³) was found in the uterine corpus. Microscopic examination revealed that the tumour infiltrated more than half of the myometrium. Most of the endometrioid tumour was characterized by endometrial adenocarcinoma Grade 1, however, there was a small portion consisting of solid tumour with necrotic tendency. It was composed of malignant large-sized cells with hyperchromatic nuclei. Immunohistologically, it was positive for synaptophysin and NSE. From these results, the small portion was diagnosed as large cell neuroendocrine carcinoma. Both ovaries and fallopian tubes were unremarkable, and total of 27 lymph nodes dissected by operation were all negative for cancer. She was finally diagnosed as combined large cell neuroendocrine carcinoma and endometrioid adenocarcinoma FIGO stage 1b. Although we recommended her the postoperative chemotherapy, she denied further treatment. No evidence of recurrence was observed for 10 months after surgery.

**Conclusions:** Endometrial LCNEC is extremely rare. However, when we obtained the result of endometrioid adenocarcinoma by endometrial biopsy, we need to keep in mind that it may contain a small part of another histological cancer including LCNEC.

### P3.54

**Audit of reporting of cervical biopsy and cervical smears**

**Rajagopal, R; Sant, M; Ekevall, K**

Stirling and Falkirk Royal Infirmary, Stirling, United Kingdom

**Introduction:** Abnormal cervical smear has negative psychological effects. To allay anxiety the results of investigations are to be communicated within 4 weeks (90%) and 8 weeks (100%) [1].

**Objective:** To analyse the reporting time and communication of cervical biopsy and cervical smear results to the patient and referring practitioner.

**Methods:** Retrospective review of case notes of women who underwent cervical biopsy and cervical smears during September 2007 at Stirling and Falkirk Royal Infirmary was undertaken.

**Results:** Cervical biopsy: 51 women had undergone cervical biopsy and 45 [88%] case notes were available for analysis. Reports were available in 1 week in 89% [40], 2 weeks in 9% [4] and 3 weeks in 2% [1]. Time scale for dictation and typing of letters was 2 weeks in 86% [37] and 4 weeks in 14% [6]. Results were communicated within 4 weeks in 53% [23], 8 weeks in 98% [42] and 11 weeks in 2% [1]. Cervical smear: 76 women underwent cervical smears and 65 [86%] case notes were available for analysis. Reporting time was nearly 2 weeks in 11% [7], 4 weeks in 75% [49], 6 weeks in 3% [2] and unclear in 11% [7]. Results were communicated within 4 weeks in 53% [23], 8 weeks in 98% [42] and 11 weeks in 2% [1]. Cervical smear: 76 women underwent cervical smears and 65 [86%] case notes were available for analysis. Reporting time was nearly 2 weeks in 11% [7], 4 weeks in 75% [49], 6 weeks in 3% [2] and unclear in 11% [7].

**Conclusions:** Test results were communicated to the patient and referring practitioner within 4 weeks in 43% (best practice 90%).
and within 8 weeks in 97% (minimum standard 100%). If the time interval between reporting and dictation of letters is shortened we can easily achieve the target.

P3.55
Symptomatology of gynaecological malignancies: an experience at the gynaecology department, Benazir Bhutto Hospital, Rawalpindi, Pakistan

Ayub, S; Basharat, A; Usmani, AT
Benazir Bhutto Hospital, Rawalpindi, Pakistan

Background: This cross-sectional observational study was undertaken in a gynaecology department to identify the symptoms suggestive of gynaecological malignancies followed by histopathological confirmation of their diagnoses and to determine the proportion of the histopathologically confirmed cases specific to sites.

Methods: In the gynaecology department at Benazir Bhutto Hospital Rawalpindi, records of patients with histopathologically confirmed gynaecological malignancies were reviewed to document their presenting symptoms.

Results: A total of 61 patients were diagnosed as having gynaecological malignancy and were referred to NORI from June 2008 to August 2011. Gynaecological malignancies presented with postmenopausal bleeding in 37 (60.6%); abdominal distension or pain in 19 (31%); excessive, offensive with or without blood postmenopausal bleeding in 37 (60.6%); abdominal distension or discomfort in 29 (47.5%); irregular, heavy or prolonged vaginal bleeding in 19 (31%); excessive, offensive with or without blood stained vaginal discharge in 18 (29.5%); followed by lump in abdomen in 9 (14.7%) and contact bleeding in 5 (8.1%) patients.

Conclusions: This study highlights the need to increase the awareness about the symptoms of gynaecological malignancies among women and the community. Health care personnel have a major role to identify the warning symptoms early for further investigation of the possible cases of gynaecological malignancies.

P3.56
Primary malignant melanoma of the cervix/vagina

Mohd Ali, R; Yong, CM; Ganesalingam, M
Obstetric And Gynaecology Department, Ampang Hospital

Melanoma of the female genital tract is a rare disease which majority are reported in the vulva and vagina. It represents <2% of all malignant melanomas in women.

Case report: A 61 years old nulliparous women, presented with post menopausal bleeding for 1 month duration, no post coital bleeding or abnormal discharge reported. No enlarged lymph node palpable. However on examination the cervix was nodular which involved the entire circumference of the cervix with presence of black pigmentation extending from 9 to 12 o’clock position. It extends to the upper third of the vagina mucosa. Nodularity felt over both parametrium. On per rectal examination, rectal mucosa felt normal. CT scan and PET scan showed no distant metastasis. Cystoscopy, OGDS, colonoscopy and assessment by otorhinolaringology revealed negative findings. The patient underwent radical hysterectomy, bilateral salphingoopherectomy with pelvic lymph node dissection.

Histopathology result showed malignant melanoma of vagina and cervix with involvement of the paravaginal soft tissue. Immunohistochemistry (IHC) studies revealed positive tumour cells for S100 and HMB45, negative studies for LCA, CKA1/EA3. Hence diagnosis of primary melanoma was made. She underwent radiotherapy and subsequent colposcopies were negative. She is under our long term follow up.

Discussion: Primary malignant melanoma of the cervix/vagina has been described in a wide age range, from 19 to 83 years. Patient usually presents with per vaginal bleeding, similar to that seen in carcinoma cervix. It is a rare and usually aggressive tumour associated with poor survival rate. Melanoma in the uterine cervix may be melanotic or amelanotic and diagnosis is confirmed by histological and immunohistochemical study using special staining. Though its staging and treatment are not yet well codified, prognosis is generally poor and unpredictable. Criteria for diagnosis of primary melanoma of cervix was suggested by Morris and Taylor (1966) which includes the absence of melanoma elsewhere in the body, demonstration of junctional change in the cervix and metastasis according to the pattern of cervical carcinoma. The disease is currently not curable and hence needs to be diagnosed early especially if histopathology showed poorly differentiated tumour of the cervix.

P3.57
Association breastfeeding and breast cancer in women

Nouraei, S1; Fard, SA1,2
1 Shahid Beheshti University of Medical Sciences, International-Branch; 2 Faculty of Nursing and Midwifery, Jahrom University of Medical Sciences;

Breast cancer is the second leading cause of cancer-related death in women. Because of the relatively lower percentage of breast cancer cases at younger ages. Although childbearing is known to protect against breast cancer, whether or not breastfeeding contributes to this protective effect is unclear. Breastfeeding protected against both types of breast tumours regardless of when a woman first gave birth. This study aimed to investigate the association between breastfeeding and breast cancer among women. Wise et al. (2009) has done a study about Exposure to breast milk in infancy and risk of breast cancer. The result of this study showed that there is no consistent evidence for an effect of insufficient milk supply on breast cancer risk. Cohen et al. (2009) has done a study about Insufficient Milk Supply and Breast Cancer Risk. The result of this study showed that there is no consistent evidence for an effect of insufficient milk supply on breast cancer risk. Gorman et al. (2009) has done a study about A qualitative investigation of breast cancer survivors’ experiences with breastfeeding. The result of this study showed that interventions to support the efforts of breast cancer survivors who are interested in breastfeeding are warranted. Additional research would aid in the development of such interventions. Lord et al. (2008) has done a study about Breast cancer risk and hormone receptor status in older women by parity, age of first
birth, and breastfeeding – a case–control study. These findings suggest that the effect of parity on a woman’s long-term risk of breast cancer is modified by age at first full-term pregnancy and possibly by breastfeeding.

**Result:** It is recommended breastfeeding in women, that may be an effective measure of breast cancer prevention in women.

**P3.58**

*Uterine sarcomas in RIPAS Hospital, Brunei. A 10 year retrospective study*

**Kurien, A; Ohnmar, S; Yaakub, HRH**

Ripas Hospital, Brunei Darussalam

**Introduction:** Uterine sarcomas are rare but aggressive malignant tumours of the smooth muscle or supporting tissues of the uterus. This study was done to evaluate the demographic profile, risk factors, diagnostic issues and the clinical outcome of patients with uterine sarcomas in Ripas hospital.

**Methods:** All patients with uterine sarcoma registered in the department of obstetrics and gynaecology during a period of 10 years from 2001 to 2010 were studied. Cases were identified through the gynaecology oncology registry. This was a retrospective case file analysis. The data was recorded in a pre-designed proforma and a detailed analysis was done.

**Results:** There were 37 cases of uterine sarcoma during the study period with a mean age of 47.8 years. Thirty patients were Bruneians (81.08%). High risk factors were identified in 29 (78.37%) patients. Abnormal uterine bleeding and mass per abdomen were the commonest clinical presentations in this study. A preoperative diagnosis of malignancy was possible in five cases (13.5%) and in two patients (5.41%) the diagnosis was suspected during surgery and was confirmed by frozen section). At the completion of the 5 year follow up in the first 5 year group (2001–2005) 62.5% patients are alive and disease free. Further research is required to find the reason for the high incidence of uterine sarcoma in the study population.

**Conclusion:** A higher proportion of uterine sarcoma (23.71%) was noted in our patients with uterine cancer. Majority of the patients (78.37%) had one or more risk factors. Unlike endometrial carcinoma a preoperative diagnosis is difficult in uterine sarcoma. At the time of this study 70.27% of patients with uterine sarcoma are disease free and alive. Further research is required to find the reason for the high incidence of uterine sarcoma in the study population.

**P3.59**

*A case of large cell neuroendocrine carcinoma of uterine cervix*

**Kawano, A; Sato, R; Shigeta, H**

Department of Obstetrics and Gynecology, Yokohama Municipal Citizen’s Hospital, Japan

**Objective:** We present a case of large cell neuroendocrine carcinoma (LCNEC) of uterine cervix, which is known to be a rare aggressive neoplasm.

**Methods:** A 40-years-old woman visited our hospital for irregular vaginal bleeding. Adenocarcinoma was suspected by papanicolaou smear, however, squamous cell carcinoma was suspected by cervical biopsy. Although definite pathological diagnosis was not clear, radical hysterectomy was chosen under the diagnosis of cervical carcinoma.

**Results:** Grossly, a yellowish white mass was located in the anterior lip of cervix, measuring approximately 2 cm in diameter. A microscopic examination showed small clusters and trabeculae of malignant cells. Immunohistological examination revealed it was positive for synaptophysin, NSE, NCAM and chromogranin A, negative for CK5/6, 34βE12 and p53. From these findings, it was diagnosed as LCNEC, FIGO stage Ib1 (pT1b1N0M0). The tumour deeply invaded into the stroma of the cervix and involved a blood vessel. Because distant metastases are known to be commonly seen in LCNECs, we chose chemotherapy for adjuvant therapy. Six cycles of PE therapy (Cisplatin 75 mg/m² Day 1, Etoposide 100 mg/m² Day 1–3) was given and clinical evidence of relapse has not seen so far.

**Conclusion:** LCNEC is an aggressive tumour with frequent recurrence and metastasis even if it is diagnosed in early stage. Treatment for small cell neuroendocrine carcinoma is tend to be selected for the treatment for LCNEC, because small cell carcinoma is rather common compare to LCNEC. Further studies are required to establish an effective treatment for LCNEC.
Delayed diagnosis of breast cancer in pregnancy
Umaru, FA; Usmai, Y
Blackpool Victoria Hospital, United Kingdom

This case report describes the diagnosis, initial and long term management of a patient who presented with extensive metastatic breast cancer in pregnancy. The incidence of breast cancer is relatively rare in pregnancy and when a delay diagnosis is involved as in this case, the results can often be catastrophic. This case report looks into the investigations of breast lumps in pregnancy, as well as the management of confirmed breast cancer in pregnancy, particularly metastatic breast cancer. It also looks into the psychosocial needs of patients who are often young and have young children and the support available for families affected by a diagnosis with such great impact.