histology (13.8% vs 2.1%), poorly differentiated tumors (37.9% vs. 19.2%), presence of LVSI (55.2% vs. 44.9%) and positive pelvic lymph nodes (27.6% vs 11.1%) than patients with tumors < 4 cm on final pathology. Upstaged patients were more likely to have preoperative imaging (51.7% vs. 30.3%) with over 85% of imaging being performed with CT or PET/CT.

Factors associated with pathologic upstaging included adenosquamous histology (p=.029), use of preoperative imaging (p=.034), moderately or poorly differentiated tumors (p=.035), positive pelvic lymph nodes (p=.028), and receipt of adjuvant therapy (p<.0001). Recurrence rates were higher in upstaged patients (20.7% vs. 6.1%, p=.017). Median PFS was shorter in upstaged patients than those with pathologically confirmed IB1 disease (84.3 m v 97.7 m, p=.019). There was a trend towards poorer OS in upstaged patients (p=.082)

Conclusions: Accurate evaluation of tumor size on clinical exam is challenging in patients with stage IB1 cervical cancer. Pathological tumor sizes > 4 cm are associated with poor prognostic features and worse outcomes compared to patients with pathologically confirmed IB1 cervical cancer. Further research on how to improve clinical staging should be undertaken.

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Poster #13

Postpartum colposcopy – Is it necessary?

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Objectives: We aimed to determine regression or progression of dysplasia after delivery in regards to necessity of postpartum colposcopy in patients at high risk of non-compliance with follow up.

Methods: This is a retrospective cohort study of pregnant patients with abnormal pap smears from 2009 through 2016. Data collected included demographics, cervical cytology, colposcopy impressions/pathology. Pap smears of HPV+, ASCUS HR HPV-, ASCUS HR HPV+ or LSIL were coded as low grade. ASC-H or HSIL were coded as high grade. Data were analyzed via chi square and logistic regression with significance determined at P<0.05. Power was calculated post-hoc.

Results: Power was calculated post-hoc and was found to be 88%. In this population, the no show rate to postpartum colposcopy appointment was 55.7%. 31.5% of patients did not have follow up cytology any time since delivery to present. Analysis revealed, for patients with follow up cytology available and low-grade antepartum pap smear, postpartum pap smears were negative, low grade and high grade at rates of 57.9%, 33.3% and 8.8% respectively. When dividing this group by shows and no shows to postpartum colposcopy, there was no statistically significant difference between follow up cytology (p = 0.11). For the same population, high grade antepartum pap smears were negative, low grade and high grade at rates of 28.9%, 25.7% and 45.7% respectively.

With respect to antepartum colposcopy compared to postpartum colposcopy, there was no significant difference between antepartum colposcopy impression and postpartum colposcopy pathology (p=0.54) (figure 1).

Conclusions: Low grade pap smears in pregnancy have low risk of progression and it may be reasonable to consider repeat pap in the postpartum period rather than repeat colposcopy. There was no statistically significant difference between next pap smears whether patients did or did not comply with their postpartum colposcopy, implying colposcopy may be an unnecessary intervention in this specific population. Further study is indicated to test this hypothesis.

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Poster #14

Risk of cervical and vaginal neoplasia after surgery for vulvar intraepithelial neoplasia or cancer: A 6-Year follow-up study

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Objectives: Current guidelines to continue cytology screening after hysterectomy are based on history of high-grade intraepithelial neoplasia of the cervix (CIN), but not of the vulva (VIN). Here, we aim to evaluate the utility of cytology among women, with and without prior hysterectomy, who underwent surgical management for VIN3+ disease by estimating the risk of high-grade cervical or vaginal intraepithelial neoplasia or cancer (CIN2+/VAIN2+) diagnosed during vulvar surveillance follow-up.

Methods: Women who underwent surgery for high-grade VIN or vulvar cancer between 2006 and 2014 were identified retrospectively. Patients who underwent prior hysterectomy for any indication were included. Univariate and multivariate logistic regression analyses were used to identify clinical factors of abnormal cytology after surgical treatment for VIN and vulvar cancer.

Results: During our 8-year study period, 302 women were followed with surveillance exams after vulvar surgery over a median follow-up of 72 months. During that time, 100 (33%) women had abnormal cytology: 69 (23%) low-grade, 28 (9%) high-grade, and 2 (0.7%) carcinoma. Overall, 33% of women had a prior hysterectomy, but the risk of intraepithelial neoplasia or cancer was not significantly different from women with an intact cervix [9/99 (9%) VAIN2+ risk vs. 15/203 (7%) CIN2+ risk]. Correlates of high-grade cytology following treatment for VIN/vulvar cancer included non-white race [odds radio (OR) 4.6, 95% confidence interval (CI) 2.4-8.8], immunodeficiency (patients with human immunodeficiency virus or on immunosuppressive medications) (OR 4.0, 95% CI 1.8-8.8), and prior abnormal cytology (OR 4.4, 95% CI 2.1-9.3). The multivariable analysis shows that they remained significant (p<0.01) (Table 1). Prior hysterectomy did not significantly decrease risk of abnormal cytology (OR 0.87, 95% CI 0.5-1.6).

Conclusions: Women treated surgically for VIN/vulvar cancer have a 10% risk of at least high-grade cytology on surveillance screening. Prior hysterectomy does not mitigate the risk, as 9% will develop VAIN2+. Extrapolating from current guidelines, we recommend surveillance cytology screening at least 6-12 months after treatment, especially in women with a history of immunosuppression or prior abnormal cytology.

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Poster #15

The effect of adjuvant therapy for high intermediate-risk endometrial cancer on patients with recurrent disease

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