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**Conclusions**

Our qualitative study showcases the importance of understanding the concerns gynecologic oncology patients face during the COVID-19 pandemic at a large urban NCI designated cancer center.

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**Poster Abstract #19**

**Surgical Management of abnormal uterine bleeding with endometrial sampling during COVID-19**

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**Objectives**

To investigate the delay in surgical management of abnormal uterine bleeding with endometrial sampling during the peak of the COVID-19 pandemic at a single, urban tertiary medical center.

**Methods**

We conducted a retrospective chart review of 868 patients, 466 who received an endometrial biopsy in 2019 and 402 between January 1–March 23, 2020 (during the first peak of COVID-19) at a tertiary academic medical center in Philadelphia. We collected baseline patient characteristics including: age, self-identified race or ethnicity, and BMI. We assessed the time from an abnormal endometrial biopsy to surgical management, use of at least one telemedicine appointment between biopsy and surgical management, and resulting pathology results. Chi-squared test was used to compare proportions of populations and two-tailed student’s T-test was used to compare days between biopsy and surgical management. P-value was set at 0.05.

**Results**

466 and 402 patients underwent an endometrial biopsy in 2019 and between January 1 – March 23, 2020, respectively. In 2019, 4.94% were diagnosed with an endometrial malignancy and 95.1% had resulting benign pathology; while in 2020, 5.22% had a diagnosed endometrial malignancy and 94.8% had benign pathology (p-value = 0.84). Median age was 51.0 years (range, 19.0–89.0) in 2019 and 51.0 years (range 24–89) in 2020. Median BMI was 31.4 (range,
17.6–66.9) in 2019 and 31.1 (range, 16.3–74.2) in 2020. Median time between endometrial biopsy and surgical management was 66.5 days (range, 0–453 days) in 2019 and 94.0 days (range 13.0–335) in 2020 (p-value = 0.57). Median time from biopsy to surgery for patients with a resulting pathology of endometrial malignancy was 53 days (range, 0–441) in 2019 and 87.5 days (range 13.0–323) in 2020 (p-value = 0.50). Median time for patients with resulting benign pathology was 69.0 days (range, 9.00–453) in 2019 and 112 days (range, 33.0–335) in 2020 (p-value = 0.48). 57.4% of patients in 2020 had at least one telemedicine appointment with their physician between the initial encounter for abnormal uterine bleeding and surgical treatment, while no patients had a telemedicine appointment in 2019.

Conclusions

During the COVID-19 pandemic, individual patients with abnormal uterine bleeding may have experienced delays between initial abnormal endometrial biopsy and surgical management. However, comparing the populations as a whole, there was not a statistical difference in time between biopsy and surgical management for abnormal uterine bleeding, reinforcing the quality of care given to our patients. However, further studies are needed to examine the effects of COVID-19 on possible delay in surgical treatment from first symptoms in patients with abnormal uterine bleeding to biopsy and to surgical management.

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- **Poster Abstract #20**
  
  **Secondary prevention is key: Understanding the association between nonprivate insurance and advanced vulvar cancer**
  
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  **Objectives**

  Prior studies in vulvar squamous cell carcinoma (vSCC) show an association of advanced stage disease (Stage III and IV) with older age, nonprivate insurance, and treatment at lower case volume centers. The aim of this study is to investigate demographic and clinical factors that remain associated with advanced vSCC in patients treated at a high-volume, tertiary care center.

  **Methods**

  This was an IRB-approved retrospective cohort study of patients diagnosed with primary vSCC identified from institutional pathology records (2005–2020). Sociodemographic data including age at diagnosis, race/ethnicity, preferred language, marital status and primary insurance type were collected using chart review. Relevant clinical information, including smoking history, immunocompromised state, comorbidities (as defined by the Centers of Medicare & Medicaid Services [CMS] list of 21 chronic conditions), cervical dysplasia or cancer history, prior vulvar pathology and treatment, and disease stage at diagnosis was also obtained. Univariate statistical analysis was performed using Mann-Whitney U and chi-square tests. Bivariate analyses were performed to identify factors associated with advanced stage disease.

  **Results**

  The study cohort included 42 patients with median age of 66 years. The majority were non-Hispanic white (73.8%), preferred English (92.9%) and had a smoking history (57.1%). At least one significant comorbidity was present in 76.2% of patients. The stage distribution was as follows: Stage I 61.9% (n = 26); Stage II 16.7% (n = 7), Stage III16.7% (n = 7); and Stage IV4.8% (n = 2). Stage III and IV vSCC was significantly associated with nonprivate insurance – namely Medicare and Medi-Cal (OR 9.69, 95% CI 1.06–88.66, p = 0.04). No other sociodemographic or clinical factor was identified to be associated with advanced stage disease. Of note, patients with nonprivate health insurance were less likely to have received prior treatment for vulvar pathology when compared to those with private insurance (25.0 vs 42.1%; p = 0.02).

  **Conclusions**

  Even among predominantly non-Hispanic white patients in a high-volume, tertiary care setting, nonprivate health insurance remains associated with advanced stage vSCC at diagnosis. Prior treatment of vulvar pathology was less common amongst patients with nonprivate insurance, suggesting a role for improved secondary prevention in bridging this health disparity.

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- **Poster Abstract #21**
  
  **The impact of BMI on interval cytoreduction and survival for advanced ovarian cancer**
  
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  **Objectives**

  To evaluate the survival impact of high body mass index (BMI) after interval cytoreduction for advanced epithelial ovarian cancer (EOC) and to assess the association among BMI, route of cytoreductive surgery, and rate of complete removal of macroscopic disease (R0 resection) in this cohort of patients.

  **Methods**

  We performed a retrospective cohort analysis of all cases of advanced EOC treated with neoadjuvant chemotherapy (NACT) followed by