with LN assessment. All pathologic specimens were centrally reviewed by an expert gynecologic pathologist.
Results Median age at surgery was 38 years (range; 23–67). Stage at diagnosis was IA2 (33%) and IB1 (67%). Histologic type included squamous cell carcinoma (48%) and adenocarcinoma (52%). Surgery included conization and LN assessment in 44/100 (44%) women and simple hysterectomy with LN assessment in 56/100 (56%) women. Minimally invasive surgery (MIS) was performed in 96/100 (96%) patients: laparoscopic in 83; robotic in 13. Positive LNs were noted in 5/100 women (5%). Residual disease in the hysterectomy specimen was diagnosed in 1/56 patients (1.8%). Median follow-up was 25 months (range 0–71). To date, recurrent disease has been diagnosed in 3 patients (3%).
Conclusions Conservative surgery is oncologically safe in women with early stage, low-risk cervical carcinoma.

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24 UTERUS-11 STUDY: A RANDOMIZED CLINICAL TRIAL ON SURGICAL STAGING VERSUS CT-STAGING PRIOR TO PRIMARY CHEMORADIATION IN PATIENTS WITH FIGO2009 STAGES IIB-IVA CERVICAL CANCER

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Objectives Surgical staging potentially modifies radiation field in locally advanced cervical cancer (LACC), although a survival benefit has never been proved in a randomized clinical trial.

Uterus-11 Study (German GOG and Radiation Oncology Group) is a RCT designed to evaluate the impact of surgical staging compared to standard clinical/radiological staging, followed by chemoradiation (CR). Primary endpoint was disease free survival (DFS), secondary was overall survival (OS).
Methods From 2009 to 2013, a total of 255 LACC patients (FIGO2009 IIB-IVA) were randomized to surgical staging and CR (ArmA), or clinical staging followed by CR (ArmB). CR consisted in pelvic external beam radiotherapy with weekly cisplatin (40mg/m2) and brachytherapy. Extended-field radiation was performed in cases of confirmed paraaortic metastases.
Results Among 240 patients (n=121 ArmA;n=119 ArmB), 236(98.3%) received CR. Arms were balanced. Surgical approach was transperitoneal laparoscopy in 93.4%(mean 19pelvic/17paraaortic lymph nodes (LN). CR started 7–21days after surgery. Surgery upstaged 40/121(33%). Median follow-up: 66.5months. ArmA was superior for PFS (HR=1.38 ArmB vs. ArmA,p=0.115) and OS (HR=1.29,p=0.24). Clinically or surgically LN+ negatively impacted PFS (pelvic:HR=2.38, p=0.007; paraaortic:HR=2.84,p=0.001; anyLN+:HR=2.83, p=0.003) and OS (pelvic:HR=2.90,p=0.003; paraaortic: HR=3.03,p=0.001; anyLN+:HR=3.51,p=0.001). Adeno/adenosquamous were comparable to squamous cell carcinomas (PFS:HR=1.26, p=0.44, OS:HR=1.35, p=0.32). Stages III/IV had worse prognosis than IIb (PFS:HR=1.86, p=0.003; OS: HR=2.07, p=0.001).
Conclusions Although statistical significance could not be reached, surgical staging in LACC lead to superior DFS and OS compared to clinical staging with acceptable morbidity and no significant CR delay. The high risk of distant metastases in both arms underlies the need for further treatment intensification.

Plenary 5

IGCS19-0143

25 CRS WITH HIPEC IN ADVANCED EPITHELIAL OVARIAN CANCER WITH COMPARISON OF ONCOLOGICAL OUTCOME ONLY WITH CRS + INTRAVENOUS CHEMOTHERAPY AND CRS PLUS NORMOTHERMIC INTRA-PERITONEAL CHEMOTHERAPY

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Objectives Current standard of care for patients with stage IIIc epithelial ovarian cancer (EOC) is cytoreduction and intravenous (IV) chemotherapy. Intraperitoneal (IP) chemotherapy is considered superior to standard IV chemotherapy. Recent randomised study has shown benefit of cytoreductive surgery (CRS)+ hyperthermic intra-peritoneal chemotherapy (HIPEC) over IV chemotherapy.
Methods 130 patients diagnosed of stage IIIc EOC between 2013–2018 underwent extensive CRS+HIPEC. CRS+IV or CRS+IP was also done during the same period for other patients diagnosed of stage IIIC EOC. Overall details of HIPEC group is reported with comparison of only the oncological outcome of CRS & IV group & CRS+IP group.
Results Of 130 patients, 65.3% & 34.7% had primary and secondary cytoreduction plus HIPEC respectively. Mean PCI was 14.1, duration of surgery 9.41hours & hospital stay 13 days. Multivisceral resection, diaphragmatic resection & bowel resection was required in 12.7%, 50% & 41.8% respectively. Overall G3- G5 morbidity 40% & 30 day mortality 3.6%. With a median follow up of 46 months DFS