effective method of treatment for IVL is the complete surgical removal of the tumor.

2022-RA-324-ESGO PHASE 2 RESULTS FROM THE LIO-1 STUDY (NCT04042116; ENGOT-GYN3/AGO/LIO): EFFICACY AND SAFETY OF LUCITANIB + NIVOLUMAB IN PATIENTS WITH ADVANCED GYNAECOLOGICAL MALIGNANCIES

[1]Nicole Concin, [2]Manish R Patel, [3]Vicky Makker, [4]Ana Oaknin, [5]Sandro Pignata, [6]Floor J Backes, [7]Antonio González-Martín, [8]Ramez N Eskander, [9]Bhavana Pothuri, [10]Debra L Richardson, [11]Angeles Alvarez Secord, [12]Els van Nieuwenhuysen, [13]Joyce F Liu, [14]Fernanda Musa, [15]Richard T Penson, [16]Kenton Wride, [17]Rachel Dusek, [18]Terri Cameron, [19]Erika Hamilton. *[1]Department of Gynecology and Obstetrics, Medical University of Innsbruck, Innsbruck, Austria and Department of Gynecology and Gynecologic Oncology, Evang. Kliniken Essen-Mitte, Essen, Germany; [2]Drug Development Unit, Florida Cancer Specialists/Sarah Cannon Research Institute, Sarasota, FL; [3]Department of Medicine, Memorial Sloan Kettering Cancer Center, Weill Cornell Medical Center, New York, NY; [4]Gynaecologic Cancer Programme, Vall d'Hebron Institute of Oncology (VHIO), Hospital Universitari Vall d'Hebron, Vall d'Hebron Barcelona Hospital Campus, Barcelona, Spain; [5]Department Uro-Ginecologico, Istituto Nazionale Tumori – Fondazione 'G. Pascale', Naples, Italy; [6]Division of Gynecologic Oncology, Ohio State University Wexner Medical Center and James Cancer Hospital, Columbus, OH; [7]GEICO and Medical Oncology, Clínica Universidad de Navarra, Madrid, Spain; [8]Department of Obstetrics, Gynecology, and Reproductive Sciences, UC San Diego Moores Cancer Center, La Jolla, CA; [9]Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Laura and Isaac Perlmutter Cancer Center at NYU Langone, New York, NY; [10]Division of Gynecologic Oncology, Stephenson Cancer Center/Sarah Cannon Research Institute, The University of Oklahoma, Oklahoma City, OK; [11]Department of Obstetrics and Gynecology, Gynecologic Oncology Division, Duke Cancer Institute, Duke University School of Medicine, Durham, NC; [12]Department of Gynecological Oncology, Campus Gasthuisberg, University Hospitals Leuven, Leuven, Belgium; [13]Department of Medical Oncology, Dana-Farber Cancer Institute, Boston, MA; [14]Department of Gynecologic Oncology, Swedish Cancer Institute, Seattle, WA; [15]Medical Oncology, Massachusetts General Hospital, Boston, MA; [16]Biostatistics, Clovis Oncology, Inc., Boulder, CO; [17]Translational Medicine, Clovis Oncology, Inc., Boulder, CO; [18]Clinical Science, Clovis Oncology UK Ltd., Cambridge, UK; [19]Medical Oncology, Sarah Cannon Research Institute/Tennessee Oncology, Nashville, TN*

10.1136/ijgc-2022-ESGO.397

Introduction/Background LIO-1 (NCT04042116) assesses the combination of lucitanib, an oral anti-angiogenic, multikinase inhibitor administered using safety-based dose titration, and nivolumab, an inhibitor of programmed cell death receptor 1 (PD-1). Here, we present phase 2 study results of this combination in 4 advanced gynaecological malignancies.

Methodology LIO-1 enrolled patients with advanced, recurrent or metastatic endometrial cancer (EC), cervical cancer (CC), high-grade ovarian cancer (OC) or EC/OC with clear-cell histology (EOCC). Patients with EC, CC or EOCC received ≥1 prior platinum-based chemotherapies (CC, ± bevacizumab; EOCC, + taxane); patients with OC received ≥2 prior chemotherapies (including ≥1 platinum doublet). Patients received lucitanib at a starting dose of 6 mg QD plus intravenous nivolumab 480 mg every 28 days. Lucitanib dose could be escalated to 8 mg then 10 mg QD. The data cutoff was 14 April 2022.

Results Total treated was 124 patients; 31 (25.0%) patients are ongoing. At data cutoff, 32 (25.8%) patients escalated to lucitanib 8 mg and 20 (16.1%) to 10 mg. The confirmed best overall response rates at data cutoff were: EC cohort, 5/22 (22.7%); CC cohort, 12/46 (26.1%); OC cohort, 4/33 (12.1%); EOCC cohort, 6/23 (26.1%). Among EC-cohort patients, confirmed responses were reported for 2/5 patients who received prior PD-1 inhibitor (both were non-responders to prior PD-1 inhibitor). Among EC-cohort patients with known microsatellite status, confirmed responses were observed in 3/14 with microsatellite stability and 2/3 with high instability. Grade ≥3 treatment-emergent adverse events (TEAEs) considered study-treatment related were reported in 55 (44.4%) patients, with the most frequent being hypertension (n=30 [24.2%]). TEAEs leading to lucitanib dose reduction or discontinuation occurred in 21 (16.9%) and 20 (16.1%) patients, respectively.

Conclusion Lucitanib + nivolumab displays anti-tumour activity in patients with advanced gynaecological malignancies, including clear-cell cancer. Effective dose titration resulted in manageable safety, similar to previous reports.

2022-VA-445-ESGO ANATOMY OF THE PRESACRAL REGION

[1]Joel Laufer, [1]Santiago Scasso, [2]Alejandra Mansilla, [1]Federico Fleitas, [2]Camila Calleji. *[1]Gynecology, School of Medicine, Montevideo, Uruguay; [2]Anatomy, School of Medicine, Montevideo, Uruguay*

10.1136/ijgc-2022-ESGO.398

Introduction/Background The dissection of the presacral region is an integral component of multiple gynecologic cancer procedures such lymph node staging, advanced staged disease and recurrence surgeries. The lack of knowledge of the anatomy can lead to severe complications such as vascular, ureteral, or nerve injuries that make up the complex region. To show anatomic concerns when surgeons dissect this region and to avoid severe complications we have developed a cadaveric video of the presacral region as well as the analysis and disposition of the more important anatomical landmarks.

Methodology We hereby demonstrate the anatomic data concerning the presacral region. Fifteen female cadaveric dissection models were evaluated. The presacral space was dissected to clearly defined anatomic landmarks. The midline of the region was marked from the promontory to its inferior edge, and measurements were taken from this imaginary line to key anatomical structures proximal to the presacral space. Special emphasis is placed on guiding the surgeon using still photographs and videos of cadaveric and live tissue dissection to optimize the understanding anatomy of the region.

Results The disposition of the following structures was analyzed in relation to the midline of the region; right ureter, right iliac vessels, left iliac vessels, specially left common iliac vein and hypogastric plexus. Additionally, middle sacral vessels were studied. The average distance between the midline of the region and right ureter was 3.1 cm, right common iliac vein 1.9 cm, right common iliac artery 2.6 cm, left common iliac vein 2.7 cm and left common iliac artery 3.4 cm. The location of the middle sacral vessels was quite variable