second-line plus (2L+) have improved outcomes in patients with recurrent/metastatic cervical cancer (r/mCC). Previous reports show potentially enhanced efficacy and tolerable safety with TV + pembrolizumab, carboplatin, or bevacizumab. We report interim safety and efficacy results from the dose-expansion cohorts evaluating 1L TV + pembrolizumab (1L-TP), 2/3L TV + pembrolizumab (2/3L-TP), and 1L TV + carboplatin (1L-TC) in patients with r/mCC.

Methodology In the 1L-TP cohort, patients with r/mCC who had no prior systemic therapy (excluding chemoradiation) received TV 2.0 mg/kg + pembrolizumab 200 mg IV Q3W. In the 2/3L-TP cohort, patients with r/mCC who experienced disease progression on/after 1–2 prior systemic therapies received TV 2.0 mg/kg + pembrolizumab 200 mg IV Q3W. In the 1L-TC cohort, patients with r/mCC who had no prior systemic therapy (excluding chemoradiation) received TV 2.0 mg/kg + carboplatin AUC 5 IV Q3W. The primary end point was confirmed objective response rate (cORR) per RECIST v1.1.

Results In the 1L-TP, 2/3L-TP, and 1L-TC cohorts, respectively, 33, 35, and 33 patients received treatment, and, at data cut-off, median follow-up was 18.8, 15.0, and 14.6 months. cORR was 41%, 38%, and 55%, with a median DOR of not reached, 14.0, and 8.6 months in the 1L-TP, 2/3L-TP, and 1L-TC cohorts, respectively. Adverse events (AEs) of special interest in patients in the 1L-TP, 2/3L-TP, and 1L-TC cohorts (grade 1–2/grade ≥3) included ocular events (58/9; 51/3; 58/9), bleeding (61/6; 61/9; 52/6), and peripheral neuropathy (49/3; 37/3; 48/12), respectively; one patient in 2/3L-TP and one patient in 1L-TP experienced grade 4 and 5 treatment-related bleeding, respectively. Additional data will be presented at the meeting.

Conclusion TV + pembrolizumab or carboplatin in patients with r/mCC demonstrated encouraging and durable anti-tumour activity, with tolerable safety profiles.

2022-RA-1415-ESGO PERSPECTIVE ON THE FUTURE OF THE SENTINEL LYMPH NODE IN CERVICAL CANCER

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Introduction/Background Good oncologic outcomes after surgery have been reported for early-stage cervical cancer with a disease free survival of 90.6% at 3 years and 96.5% at 4.5 years respectively and an overall survival of 96% and 99%, respectively. For this subset of patients, lymph node status is a major prognostic factor since five-year disease free survival falls from 88% to 57% in case of lymph node metastasis.

Methodology We present a systematic review in which we included articles concerning the sentinel lymph node mapping and the future perspective of this procedure.

Results According to the international guidelines for the treatment of early-stage cervical cancer, the gold-standard treatment includes pelvic-lymph-node dissection (PLND) in order to adapt the treatment to a potential lymphatic metastasis. A lymph-node metastasis is present in 27% of early cervical cancers, leading to a high rate of overtreatment with unnecessary pelvic lymphadenectomy in three out of four patients. Moreover, this lymphatic surgery is known to induce significant morbidity and to lead to a decreased quality of life. The sentinel node detection rate is high in women with early stage cervical cancer, 96,3% with 82,0% bilateral detection. Sentinel nodel node mapping has a sensitivity of 96,3% and a negative predictive value of 98,7% in women with tumor size >20 mm.

Conclusion The current trend in cervical cancer management is focused on less aggressive strategy without jeopardizing oncologic outcomes. The sentinel lymph node biopsy is a sturdy alternative to systematic full pelvic lymphadenectomy for lymph node staging in early-stage cervical cancer. In regard with the abundant literature, there is a trend in the acceptance of sentinel lymph node biopsy in current clinical practice and in time maybe will became the gold standard of node stanging in early-stage cervical cancer.

2022-RA-1430-ESGO MINIMALLY INVASIVE SURGERY IN EARLY STAGE CERVICAL CANCER

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Introduction/Background The standard treatment for early stage cervical cancer is represented by radical histerectomy with pelvic lymphadenectomy. Laparotomy has been the main choice of approach for a long period of time and, although effective, it is highly invasive and associated with increased morbidity, longer hospital stay and postoperative complications. Since the early 1990's radical histerectomy with pelvic lymphadenectomy has been succesfully performed laparoscopically. The use of minimally invasive techniques has led to better postoperative outcomes, lower intraoperative bloos loss and shorter hospital stay. Although there is recent debate concerning the significant inferiority of the minimally invasive approach followed by the LACC study in 2018, there are recent studies that question its findings and that sustain that there is still an important place for minimally invasive surgery (MIS) in early cervical cancer.

Methodology We present a systematic review in which we included articles concerning minimally invasive surgery in cervical cancer and the future perspective of this approach.

Results There are several meta-analysis that compared minimally invasive surgery with open surgery for early cervical cancer. Concerning intraoperative blood loss, hospital stay and posoperative complications there are four meta-analysis that conclude that laparoscopic approach is superior to the abdominal one. Careful selection of patients can lead to excelent oncologic outcomes. The results from the studies incriminating minimally invasive surgery showed no significant differences in disease free survival rate and overall survival rate for low risk cervical cancer. So, at least for these patients, MIS is naturally a better solution. Fertility sparing surgery includes mainly patients with low risk cervical cancer,a category for which MIS should be primarily used for.

Conclusion While there are still aspects that undoubtly need to be improved concerning a standardized technique,