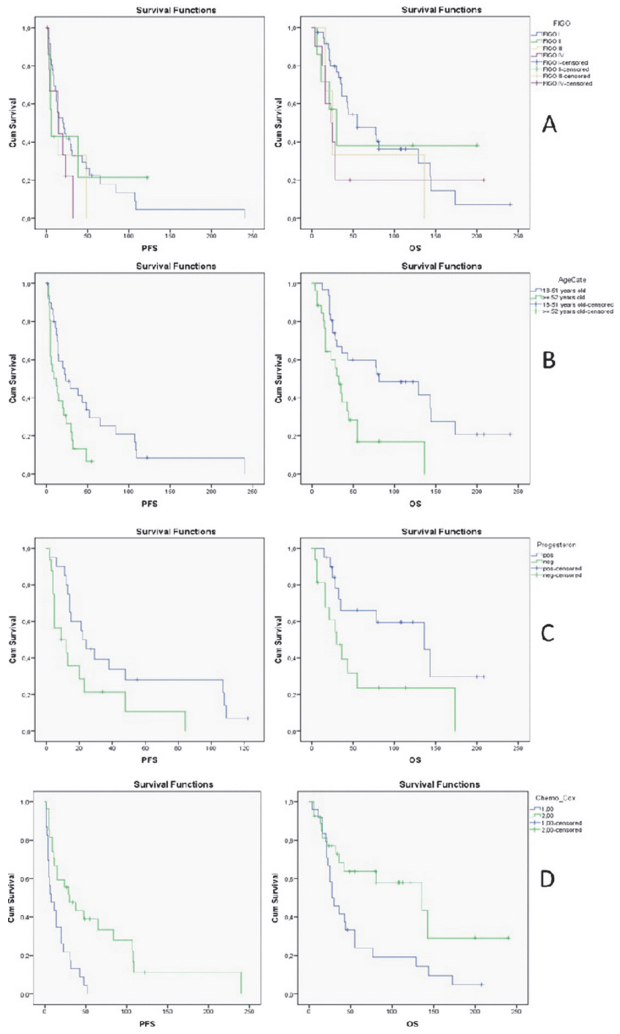

Abstract 663 Figure 1 Kaplan-Meier curves for progression-free survival (PFS) and overall survival (OS) stratified by A: FIGO-stage, B: age category at time of diagnosis over or under 52 years, C: progesterone receptor status and D: application of chemotheraphy (1 = yes, 2 = no)

associated with advanced FIGO stage, suboptimal cytoreduction and application of chemotherapy. In small cohorts, the confirmation in multivariate analysis stays difficult, although trends can be shown. For this aggressive but rare tumour international prospective, multicentric databases are needed to provide more concordant data. Consequent and standardised immunohistopathological workup as a basis for molecular tumour boards is worthwhile. More randomised controlled trials on adjuvant therapy are necessary to give physicians convincing treatment options especially in the recurrent situation.

666 SENTINEL LYMPH NODE BIOPSY AFTER NEOADJUVANT CHEMOTHERAPY IN NODE POSITIVE PATIENTS WITH BREAST CARCINOMA: WE NEED TO IMPROVE

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Introduction/Background* False negative rate (FNR) of SNLB in breast cancer patients who are node positive prior to Neo-adjuvant chemotherapy (NAC) can be improved by removing more than two sentinel nodes. Our objective was to analyse identification rate (IR) and false negatives rates (FNR) in these patients according to the number of sentinel nodes (SN) removed.

Methodology A retrospective cohort study was performed from October 2012 to December 2018. Patients with invasive breast cancer, who were clinical node positive at diagnosis, underwent sentinel node lymph biopsy (SLNB) and axillary lymph node dissection after NAC.

Pathological analysis of SN was stained by haematoxylin and eosin and immunohistochemistry or by one-step nucleic acid amplification. SN was considered positive if any residual disease was detected. IR was defined as the number of patients with successful identification of SN. False negative was considered when there was residual disease in axillary lymph node dissection and SN was negative.

Result(s)* A total of 112 patients with invasive breast cancer and clinical proven node involvement at diagnosis were included. IR of SNLB was 94,6% and FNR was 15.4%. Removing at least three sentinel nodes, FNR decreased to 10%. At least three SN were obtained in 56 patients (50,8%).

Conclusion* : IR is adequate but FNR is high. Removing three or more SN decreases FNR from 16 to fewer than 10% in clinically node-positive breast cancer patients who undergo NAC. This approach would benefit half of patients. Other approaches should be taken for axillary lymph node staging after NAC.

702 PROSPECTIVE, MULTICENTER STUDY OF APATINIB IN TREATING GYNECOLOGICAL CANCER PATIENTS: A REAL-WORLD STUDY FROM CHINA

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Introduction/Background* Apatinib is emerging as an effective treatment for patients(pts) with gynecological cancer. However, the data of gynecological cancer treated by apatinib in the real-world setting is not reported. In this real-world study, we aim to explore the efficacy and safety of apatinib in the treatment of pts with gynecological cancer.

Methodology This was a prospective, multicenter observational study in a real-world setting. Pts aged ≥18 years with well diagnosed gynecological cancer were included. The pts received apatinib treatment. The dose of apatinib was selected by the investigator. The primary endpoint was progression-free survival (PFS). The secondary endpoints were overall survival rate (OS), objective response rate (ORR), disease control rate (DCR) and safety profile. Tumor response was assessed by RECIST1.1.

Result(s)*

From Oct 2020 to May. 2021, 113 well diagnosed gynecological cancer pts were enrolled in this study. Among them, 26 of the enrolled pts were cervical cancer in second-line therapy and above. The treatment regimens were: apatinib combined with chemotherapy (7/26), apatinib monotherapy (7/26),