technique represents other possibility, besides pelvic exenteration for tumors located laterally.

Methodology Video presentation of laterally extened endopelvic resection in patient with cervical cancer recurrence after radiotherapy localized laterally in the left obturator fossa and residual parametria and paracolpium with complete obstruction of ureter and afunctional left kidney.

Result(s)* Recurrent tumor was removed in toto with resection of internal iliac vessel, residual parametria and paracolpium and complet resestion of infiltrated ureter.

Conclusion* Technique of laterally extended endopelvic resection allows – due to precise knowledge of pelvic structures and their topography – for safe removal of even laterally located tumor deep in the pelvis/pevic floor.

848 INDOCYANINE GREEN TO ASSESS VASCULARITY OF BRICKER ILEAL CONDUIT ANASTOMOSIS DURING PELVIC EXENTERATION FOR RECURRENT CERVICAL CANCER

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10.1136/ijgc-2021-ESGO.72

Introduction/Background* Pelvic exenteration performed for recurrent cervical cancer has been associated to urological short- and long-term morbidity, due to altered vascularization of tissues for previous radiotherapy. The aim of the present video is to demonstrate the use of intravenous indocyanine green (ICG) to assess vascularity of Bicker ileal conduit after pelvic exenteration for recurrent cervical cancer and to evaluate the feasibility and safety of this technique.

Methodology The patient was a 64-year-old woman who underwent exclusive chemoradiation for FIGO stage IIB cervical SCC. Seven months after the end of the radiotherapy she was diagnosed with an isolated central pelvic recurrence involving bladder wall. The patient underwent open total pelvic exenteration with Bricker ileal conduit urinary diversion and end sigmoid colostomy. After performing the anastomoses, the perfusion of tissues was analyzed with intravenous injection of 3 ml of ICG and a (1.25 mg/ml) and a near infra-red SPY Portable Handheld Imager (SPY-PHI) (Stryker, Kalamazoo, Michigan, US). After ICG injection, a four-tier (+++ versus ++- versus +– versus —) classification was used to assess the vascularity of each anastomosis: ileum-ileum, right and left ureter with small bowel. The classification of ICG perfusion of anastomoses was independently performed by the urologist and the gynecologic oncologist.

Result(s)* Intravenous injection did not cause any adverse event. After ICG injection, the left ureter-ileal conduit demonstrated sub-optimal vascularization (—), the right ureter-ileal conduit and the ileum-ileum showed optimal vascularization (+++). ICG perfusion is demonstrated with three different modalities: Overlay Fluorescence Mode, Color Segmented Fluorescence Mode, Contrast Fluorescence Mode. Patient developed benign left ureteric stricture which was diagnosed with a CT-scan 45 days after the radical surgery and was treated with anterograde ureteric stenting.

Conclusion* The use of ICG to intra-operatively assess the anastomoses perfusion at time of pelvic exenteration for gynecologic malignancy is a feasible and safe technique. The different vascularization of anastomotic stumps may be related to anatomical sites and to previous radiation treatment and it may be useful to predict post-operative complications. This approach could be of support in selecting patients at higher risk of complications, who may need personalized follow up.

854 SURGICAL LYMPH NODE STAGING IN LOCALLY ADVANCED CERVICAL CARCINOMA

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10.1136/ijgc-2021-ESGO.73

Introduction/Background* Radiation field planning in patients with locally advanced cervical cancer (LACC) undergoing primary definitive chemoradiotherapy is influenced by lymph

Abstract 854 Table 1 Patients demographic and tumor characteristics according to pathological (pelvic and paraaortic) lymph-node status

Characteristics	Negative Lymph-node N= 14 (24.1%)	Positive lymph-node N= 44 (75.9%)	Entire cohort N= 58	p-value
Patient age, years, median (Range)	59.5 (32-72)	51 (26-80)	53 (26-80)	0.228
ECOG* score:	13 (92.9)	41 (93.2)	54 (93.1)	1.000
0	1 (7.1)	3 (6.8)	4 (6.9)	
>0				
Preoperative imaging technique:				
CT	14 (100)	42 (95.5)	56 (96.6)	0.417 (CT)
MRI	11 (78.6)	40 (90.9)	51 (87.9)	0.217 (MRI)
Histological type:	13 (92.9)	39 (88.6)	52 (89.7)	0.719
squamous cell	1 (7.1)	3 (6.8)	4 (6.9)	
sdenocarcinoma small cell	0	2 (4.5)	2(3.4)	
Grading:	6 (42.9)	15 (34.1)	21 (36.2)	0.799
G2	7 (50)	24 (54.5)	31 (53.4)	
G3	1 (7.1)	5 (11.4)	6 (10.3)	
GX				
cT classification:	0	12 (27.3)	12 (20.7)	0.004
1b1	0	2 (4.5)	2 (3.4)	
1b2	0	2 (4.5)	2 (3.4)	
2a1	1 (7.1)	7 (15.9)	8 (13.8)	
2a2	7 (50)	11 (25)	18 (31)	
2b	0	3 (6.8)	3 (5.2)	
3a	1 (7.1)	6 (13.6)	7 (12.1)	
3b	5 (35.7)	1 (2.3)	6 (10.3)	
4a				
Lymph-node site:	————	26 (59.1)	26 (44.8)	
pelvic paraaortal pelvic		6 (13.6)	6 (10.3)	
+paraaortal		12 (27.3)	12 (20.7)	

Data are presented as n (%); Significance was measured using Chi squared * Eastern Cooperative Oncology Group

node (LN) status. LN assessment by imaging methods has several known limitations including a high false negative rate. The present study aimed to compare the accuracy of LN staging by imaging and surgical staging in LACC patients, and to evaluate their impact on radiation field planning.

Methodology A retrospective monocentric study of patients with LACC (International Federation of Gynecology and Obstetrics (FIGO 2018) stage IIA -IVA), undergoing primary definitive platinum-based chemoradiation therapy. Patients were included if LN assessment was available by both methods: surgical (paraaortic/pelvic) and imaging [Thorax/Abdomen Computed Tomography (CT) and/or pelvic Magnetic Resonance Imaging (MRI)].

Result(s)* A total of 58 patients met the inclusion criteria (table 1), 97% (n=56) had a preoperative CT and 88% (n=51) an MRI evaluation. All patients underwent surgical LN staging: 100% paraaortic, and 86% (n=50) additional pelvic lymphadenectomy. Histologically proven LN metastases after surgical LN staging were found in 76% of patients (n=44), 31% (n=18) paraaortic and 76% (n=38) pelvic. As a result of the surgical LN staging, 36% (n=21) of the patients were upstaged (n=11 to FIGO IIIC1 and n=10 to FIGO IIIC2), and 17% (n=10) had treatment modification (extended paraaortic field radiation). LN staging using CT and MRI exhibited a low negative predictive value (29% and 38%, respectively), with a higher positive predictive value (69% and 81%, respectively).

Conclusion* In this cohort of LACC patients, paraaortic LN metastases were present in one third of the cases, while CT/MRI imaging underestimated metastatic LN involvement. We thus stress the value of surgical paraaortic LN staging in cases of negative LN imaging, which may lead to treatment modification in about one fifth of patients.

898 THE IMPACT OF MICROMETASTASES IN CERVICAL CANCER PATIENTS – A RETROSPECTIVE STUDY OF THE SCCAN (SURVEILLANCE IN CERVICAL CANCER) PROJECT

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10.1136/ijgc-2021-ESGO.74

Introduction/Background* The impact of lymph node (LN) micrometastases (MIC) in cervical cancer patients remains a controversial topic given their low incidence and good prognosis of patients managed by primary surgery.

We aim to evaluate the prognostic significance of MIC and isolated tumour cells (ITC) in a large cohort of patients from the SCCAN retrospetive study (Surveillance in Cervical CANcer). SCCAN study analysed data from more than 4300 patients with early stage cervical cancer treated by primary surgery at 20 large tertiary institutions from Europe, North America, South America and Australia.

Methodology In this SCCAN sub-study, we included patients with early stage cervical cancer (T1a1 LVSI+ – T2b) treated between 2007 and 2016 with at least 1-year follow-up data availability, who underwent primary surgery including sentinel lymph node (SLN) biopsy and in whom SLNs were processed by pathological ultrastaging protocol.

Abstract 898 Table 1 Data summary (N = 969)

Characteristics		Description
Tracer type	Radiocolloid	423 (43.7%)
	Dye	662 (68.3%)
	ICG	220 (22.7%)
No. of SLN detected	Mean ± SD	3.2 ± 2.2
Largest type of metastasis in LN including SLN	Negative	795 (82.0%)
	ITC	31 (3.2%)
	MIC	59 (6.1%)
	MAC	84 (8.7%)
Surgical approach	Open	575 (59.3%)
	Robotic	195 (20.1%)
	Laparoscopic	199 (21.5%)
Tumour histotype	Squamous	605 (62.4%)
	Adenocarcinoma	287 (29.6%)
	Adenosquamous	50 (5.2%)
	Neuroendocrine	18 (1.9%)
	Other	9 (0.9%)
Grade	1	149 (15.4%)
	2	406 (41.9%)
	3	246 (25.4%)
	N/A	168 (17.3%)
LVSI	No	316 (32.6%)
	Yes	351 (36.2%)
	N/A	302 (31.2%)
Maximal pathologic tumour diameter [mm]	Mean ± SD	20.6 ± 13.7
	Median (IQR)	19 (10; 30)
	< 0.5 cm	73 (7.5%)
	0.5–1.99 cm	424 (43.8%)
	2–3.99 cm	376 (38.8%)
	≥ 4 cm	96 (9.9%)
Adjuvant therapy		312 (32.2%)
if yes:	radiotherapy	153 (49.0%)
	chemoradiotherapy	136 (43.6%)
	chemotherapy	18 (5.8%)
	chemoradiotherapy + chemotherapy	5 (1.6%)
Recurrence		117 (12.1%)