recurrences appeared at the first year of the follow-up, 48% by year two, and 78% by year five.

Conclusion* ARRM represents a powerful tool for tailoring the surveillance strategy in early-stage cervical cancer patients based on the patient´s risk status and respective annual recurrence risk. It can easily be utilised in routine clinical settings internationally.

966 SENTIX – ACCURACY OF PREOPERATIVE LOCAL STAGING IN THE SENTIX TRIAL (CEEGOG-CX01; ENGOT-CX2; NCT02494063)

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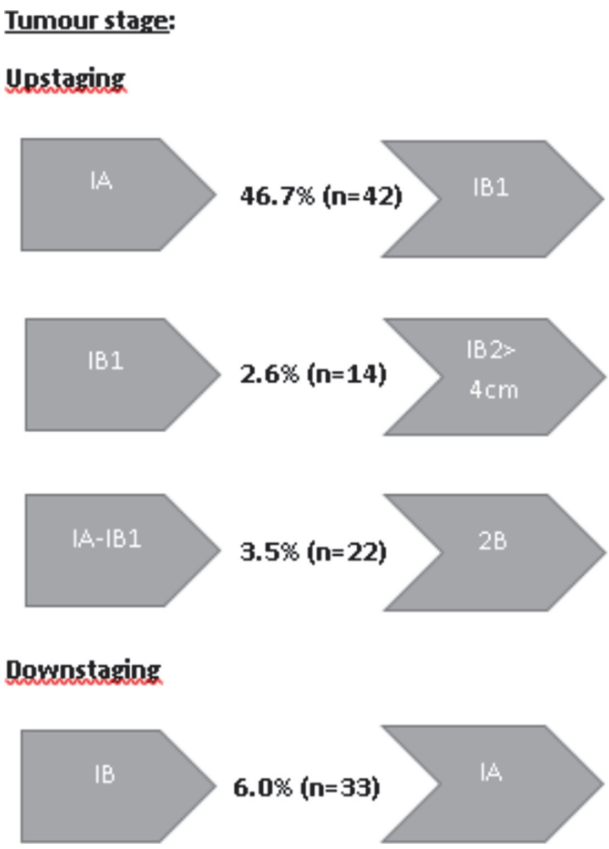
Introduction/Background* The SENTIX is a prospective cohort international study on sentinel lymph node (SLN) biopsy without pelvic lymph node dissection (PLND) in patients with early-stage cervical cancer. The primary end point is a recurrence rate at 24 months´ follow-up after the surgery. Either magnetic resonance imaging (MRI) or expert ultrasound (EUS) was mandatory as a preoperative staging method. The aim of this study is to report the accuracy of preoperative local staging.

Methodology Forty-seven sites from 18 countries participated in the study. Patients with stages T1a1/LVSI+ – T1b1 (FIGO 2009), common histological types and no suspicious lymph nodes on imaging were eligible. Patients were excluded from further study if SLN were not detected on both sides and if SLN was positive on frozen section histological evaluation. Compared were results from preoperative imaging with final pathology reports.

Result(s)* From May 2016 to October 2020, 733 registered patients underwent surgery, 132 were excluded intraoperatively, data from 708 were analysed in this study. Patients' characteristics are in table 1. Out of 90 patients clinically



Abstract 966 Figure 1 Chart 1 the accuracy of local staging

Abstract 966 Table 1 Patient's characteristics

Parameter		N(%)/median (5-95th percentile)
Age		43 (29; 67)
	≤ 40	294 (40.1%)
	41-60	339 (46.2%)
	61+	100 (13.6%)
BMI	≤ 20	73 (10.0%)
	20-25	345 (47.1%)
	25-30	169 (23.1%)
	30+	141 (19.2%)
	NA	5 (0.7%)
ECOG PS	0	701 (95.6%)
	1	28 (3.8%)
	NA	4 (0.6%)
Diagnostic method	Biopsy	331 (45.2%)
	Conization	399 (54.4%)
	NA	3 (0.4%)
Imaging:		
EUS	Yes	392 (53.5%)
MRI	Yes	411 (56.1%)
Maximum preoperative tumour size (mm)	≤ 20	471 (64.2%)
	20.1-40	262 (35.8%)
Preoperative tumour stage	1A1	65 (8.9%)
	1A2	32 (4.4%)
	1B1 ≤ 2 cm	374 (51.0%)
	1B1 > 2 cm	262 (35.7%)
Tumour grade	G1	179 (24.4%)
	G2	373 (50.9%)
	G3	157 (21.4%)
	NA	24 (3.3%)
Tumour type	SCC	508 (69.3%)
	AC	210 (28.6%)
	AS	9 (1.2%)
	NA	6 (0.8%)
Screening failure (SF):		131 (17.7%)
Preoperatively	Surgery cancelled	4 (0.5%)
	ICF withdrawn	4 (0.5%)
Intraoperatively	SLN not detected bilaterally	55 (7.5%)
	Metastatic SLN involvement	48 (6.5%)
	> 1B1	12 (1.6%)
Other		8 (1.1%)

staged as 1A tumours, 42 (46.7%) were upstaged to IB1 (86% ≤ 2 cm, 14% 2-4cm, 0% > 4cm); 76.3% had conisation as diagnostic procedure. Fourteen out of 547 preoperatively IB1 tumours (2.6%) were upstaged to IB2 > 4cm. Analogously 33 patients (6%) with IB tumours were downstaged to IA. Preoperatively unrecognized parametrial involvement was found by pathology only in 22 out of 637 patients (3.5%). EUS and MRI were used equally in the study (53.5% vs 56.1%), both were comparable in the accuracy of tumour size measurement (2 cm size categories shift in stage IB) (p=1.000) and in the failure to detect parametrial involvement (2.9% vs 4.0%) (p=0.535). Chart 1.

Conclusion* Clinical staging with EUS and MRI failed to detect positive parametria only in 3.5% of patients in the Sentix trial. Upstaging from IA tumours was frequent, mostly after previous conization. Only 2.6% of patients were upstaged to IB2 tumours >4 cm (IB3 FIGO 2018). Both EUS and MRI were equally reliable in tumour size and parametrial involvement assessment.

983 SENTINEL LYMPH-NODE BIOPSY IN EARLY-STAGE CERVICAL CANCER: THE 4-YEAR FOLLOW-UP RESULTS OF THE SENTICOL 2 TRIAL

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Introduction/Background* Senticol 2 is a randomized multicenter trial in the treatment of early-stage cervical cancer patients. The aim of the Senticol 2 study was to compare the effect of sentinel-lymph-node biopsy (SLNB) to that of SLNB + pelvic lymphadenectomy (PLND), and to determine the postoperative lymphati

Methodology In the Senticol 2 trial, patients underwent a laparoscopy with a sentinel-node-detection procedure and were randomized into two groups, namely: Group A, in which participants received SLNB, and Group B, in which participants received SLNB + PLND. Patients with an intra-operative macroscopically suspicious lymph node, were given a frozen-section evaluation and were randomized only if the results were negative. All of the patients received follow up with a clinical examination at 1, 3, and 6 months after surgery, and then every 3-4 months after that. The median follow up was 51 months (4 years and 3 months).

Result(s)* Disease-free survival after 4 years for the SLNB group and the SLNB + PLND group were 89.51% and 93.1% (p = 0.53), respectively. The only statistical factor associated with recurrence in the univariate analysis was the adjuvant radiotherapy. No other factors, including the age of the patients, histological type, tumor size, lymph vascular space invasion (LVSI), and positive nodal status, were significant in the univariate or multivariate analyses. The overall survival rates after 4 years in the SLNB and SLNB + PLND groups were 95.2% and 96% (p = 0.97), with five and four deaths, respectively. The univariate and multivariate analyses did not find any prognostic factors.

Conclusion* This randomized study confirmed the results of the Senticol 1 study and supports the sentinel lymph node (SLN) technique as a safe technique for use in patients with early-stage cervical cancer treated with SLNB only. Disease-free survival after 4 years was similar in patients treated with SLN biopsy and patients who underwent a lymphadenectomy.

987 INFLUENCE OF NEW FIGO 2018 STAGING AND TREATMENT OUTCOMES IN EARLY STAGE CERVICAL CANCER: A SINGLE CENTRE STUDY

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Introduction/Background* Cancer of the cervix is one of the most common cancers in women worldwide. According to GLOBOCAN data of 2020, there were 604,127 new cases of cervical cancer and 341,831 deaths due to the same. This shows that the burden of cervical cancer is still high and further research and implementation of screening programs can help us eliminate this cancer from the world. In our study we have evaluated patients with early-stage cervical cancer who had been treated by surgery followed by risk based tailored adjuvant therapy in our Centre. The clinicopathological features and survival outcomes of these patients were evaluated. These patients were restaged as per new FIGO 2018 staging and its impact on survival evaluated.

Methodology A retrospective study conducted from 1st June 2013 to 31st May 2018 in a tertiary care hospital in North India. All patients of early stage (1B1 to IIA1) cervical cancer who underwent primary surgery followed by tailored adjuvant therapy were analyzed. The overall survival and relapse free survival were calculated. On the basis of histopathology reports, reclassification was done into new FIGO 2018 stage. The survival outcome of both groups was then calculated and compared.

Result(s)* 100 patients of early-stage cancer cervix were studied. All patients underwent open radical hysterectomy with bilateral pelvic lymph node dissection. The median age of the study population was 52.5 years. With a median follow up of 62.1 months the overall survival and relapse free survival was 87.5% and 92.3% respectively. The study population was then reclassified according to new FIGO 2018 staging. It was seen that the patients with stage IB1and IB2 cervical cancer had overall survival of 91.1% and 90% respectively. The overall survival of stage IB3 was 80% and the survival of stage IIIC1 was only 60%.

Conclusion* The new FIGO 2018 staging classification has a significant effect on survival outcome when lymph nodes are involved and also in prognostication of patients with cancer cervix. Surgery followed by risk based appropriate adjuvant therapy is able to provide favorable overall and relapse free survival.

1001 THE OUTCOME OF HIGH-DOSE RATE INTRA-CAVITY BRACHYTHERAPY AND INTENSITY-MODULATED RADIATION THERAPY WITH CENTRAL-SHIELDING FOR CERVICAL CANCER

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