Conclusion There was no significant difference in median primary tumour size, but more patients had lymph node involvement and stage IVA disease in 2020 – 2021, suggesting a delay to presentation and/or diagnosis. Inclusion of patients with more advanced disease who were directed to systemic anti-cancer therapy or best supportive care would provide a more comprehensive analysis of the effect of the pandemic on cervical cancer stage at diagnosis.

2022-RA-1244-ESGO SURGICAL PARAAORTIC LYMPH NODE STAGING DOES NOT DELAY CONCOMITANT CHEMORADIATION STARTING AND COMPLETION IN LOCALLY ADVANCED CERVICAL COMPARED WITH FDG-TEP STAGING. A RETROSPECTIVE SINGLE-CENTER COHORT

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Introduction/Background Aortic lymph node involvement represents one of the essential prognosis factors and defines the extent of the radiation therapy. Fluorodeoxyglucose (FDG) positron emission tomography-computed tomography (PET-CT) remains the preferred and most accurate imaging technique to assess the metastatic spread of the tumor. Surgical aortic lymph node staging may be considered in case of negative paraaortic PET-CT uptake to catch up with false negatives of this technique (10–15%). The aim was to assess if surgical staging impacts treatment delays compared with imaging.

Methodology From 01/2009 to 12/2019, we retrospectively reviewed all consecutive patients (pts) addressed for brachytherapy diagnosed with locally advanced cervical cancer FIGO 2009 stages IB2-IVa with negative PET-CT uptake in the paraaortic area. Time to initial cancer treatment (TTI), duration of overall treatment time, and total treatment beyond 50 days were analyzed in two cohorts of pts who underwent either surgical or TEP-CT staging. Student and Chi 2 tests were used to compare groups.

Results 225 pts were analyzed. Median age was 49 years (range 25–82). Paraaortic and imaging lymph node staging was performed in 178 pts (cohort 1) and exclusive imaging staging in 47 pts (cohort 2). Respectively for cohort 1 and 2, median TTI was 47 (34–78) and 46 days (39–61) with p =0.46. Median overall treatment time until brachytherapy completion was 49 (7–81) and 49 days (41–63) with p=0.41. Treatment time beyond 50 days was observed in 48.3% and 41.5% with p-value=0.43.

Conclusion Surgical staging in pts without PET-CT uptake in the aortic area does not impact the time to initiation of definitive chemoradiation and is not associated with prolonged total treatment compared with exclusive PET-CT staging. Other factors than surgery should be studied to implement measures to minimize prolonged total treatment times in locally advanced cervical cancer.

2022-RA-1245-ESGO CORRELATION BETWEEN FALSE NEGATIVES OF FDG-TEP STAGING IN LOCALLY ADVANCED CERVICAL CANCER AND FIGO 2009 CLINICAL STAGING SYSTEM. A RETROSPECTIVE SINGLE-CENTER COHORT

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Introduction/Background Lymph node involvement in locally advanced cervical cancer impacts survival and defines radiation fields. False negatives (FN) of Fluorodeoxyglucose (FDG) positron emission tomography-computed tomography (PET-CT) in the aortic region represent a limitation of this technique. It may lead to undertreatment of metastatic aortic lymph nodes. In selected cases, aortic lymph node staging can be considered to catch up the FN to tailor radiation fields. The aim was to analyze metastatic aortic lymph status according to FIGO 2009 classification and pelvic lymph node status.

Methodology From 01/2009 to 12/2019, we retrospectively reviewed all consecutive patients (pts) addressed for brachytherapy diagnosed with locally advanced cervical cancer FIGO 2009 stages IB2-IVa with negative PET-CT uptake in the aortic area and histologic lymph node involvement after surgical staging.

Results Of 178 pts who underwent surgical staging, metastatic aortic lymph nodes were found in 26 cases (FN rate=14,6%). Among these 26 pts, 12 (46%) did not show pelvic TEP-CT uptake, while 14 (54%) did. FIGO 2009 stages was IB2-II for 5 pts (19%), stage III for 20 pts (77%) and stage IV for 1 pt (4%). When analyzing pts with metastatic pelvic nodes, determined with preoperative PET-CT and FIGO 2009 staging system, aortic involvement was found in 4/5 pts (80%) of stages IB2-II and 10/20 pts (50%) of stages III.

Conclusion Aortic lymph node dissection is helpful to optimize radiation therapy fields in locally advanced cervical cancer. Pts with stages III and IV and those with stage Ib2-II and positive pelvic lymph seems to present the highest risk of occult aortic involvement. Aortic staging may be omitted in pts with stages Ib2-II without pelvic nodes as the risk of aortic involvement remains low.