

related acute pneumonia after surgery. The patient died due to Covid-19 in the 7th postoperative day. Covid-19 represent a real emergency. Treatments of cancer patients would performed only wheater it is not safely delayable. To date there are insufficient data to recommend for/against an open versus laparoscopy approach; however, the surgical team should choose an approach that minimizes OR time and maximizes safety for both patients and healthcare staff.

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USE OF SENTINEL LYMPH NODE MAPPING FOR GYNAECOLOGICAL CANCER: ONE CENTRE EXPERIENCE

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Introduction Preoperative lymphoscintigraphy as a sentinel lymph node mapping has been in use in Estonia since 2004. In 2007 this method was applied for cervical, and vulvar cancer in our hospital. The purpose of this study was to summarise our institution's experience from 2013 to 2018.

Methods Data was collected retrospectively on endometrial, cervical, and vulvar cancer patients who had sentinel lymph node mapping from 2013 until 2018. Electronic health records were analysed following the ethics committee's approval. The aim was to see how many preoperatively mapped lymph nodes were identified during the operation and how many positive nodes were found.

Results During the period 24 vulvar, 94 cervical, and 298 patients with endometrial cancer were operated on, of which 40 patients had lymphoscintigraphy for sentinel lymph node mapping. The median age was 52 years for cervical, 62 years for endometrial and 76 years for vulvar cancer patients with predominantly FIGO stage I. Preoperatively mapped inguinal lymph nodes were identified intraoperatively. Three patients had preoperatively mapped iliac nodes on the left and two on the right, which were not identified intraoperatively. Two patients had positive sentinel nodes on frozen section and two other patients had negative frozen section, but cancer cells were found during the final histology.

Conclusion This is the first analysis of this method in our clinic, where approximately 69 women per year are operated on for vulvar, cervical, or endometrial cancer. Preoperative lymphoscintigraphy for sentinel node mapping has good correlation with intraoperative identification of lymph nodes.

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NERVE SPARING RADICAL HYSTERECTOMY; MUALLEM TECHNIQUE WITH A PRECISE EXPLANATION OF PARAMETRIUM AND PARACOLPIUM

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Even when the radical hysterectomy, as standard therapy for locally invasive cervical cancer, has a long history began since

more than a century by published monograph from Ernst Wertheim, many discrepancies still exist in the literature regarding terminology, anatomy and the technique of surgical dissection. The current anatomical description of radical hysterectomy is more concerned with the uterus and did not recognise the importance of vaginal cuff resection (1/3 to 1/2 of the vagina) and its paracolpium as an essential part of radical hysterectomy.

The dorsal parametrium is only the sacrouterine ligament, and the dorsal paracolpium is the sacrovaginal ligament.

Lateral paracolpium is the vaginal blood supply originated from (artery) and discharged into (vein) the internal iliac artery and vein beneath the ureter. In this way, we identify the ureter as a landmark splitting the now called lateral parametrium (cardinal ligament) to lateral parametrium above the ureter, which contains the uterine artery and vein, and to lateral paracolpium beneath the ureter and contains vaginal artery and vein. These both vessels were wrongly called from the Japanese colleagues as deep uterine vein. The ventral paracolpium is in this way nothing else than the deep layer of vesicouterine ligament and the superficial layer of the vesicouterine ligament is only the ventral parametrium. In the ventral paracolpium, we could identify 2 veins discharging in the vaginal vein and making vein anastomoses with branches from an inferior vesical vein. These are the lateral and the medial vaginovesical vein.

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PALBOCICLIB IN THE DAILY CLINICAL USE: REAL EXPERIENCE IN METASTATIC BREAST CANCER IN OUR INSTITUTION

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Introduction In Argentina 18.000 new cases of breast cancer (BC) are diagnosed each year and it is the commonest cause of cancer death in women reaching 5600 deaths per year.

In postmenopausal women with advanced or metastatic estrogen receptor-(ER) positive, Her2-negative BC, the combination of Palbociclib (P) + Letrozol (L) or Fulvestrant (F) is a good option of treatment.

The objective was to assess clinical benefit, evolution and safety with P + L or F in the context of daily clinical practice.

Methodology We performed an observational study.

Patients (pts) who started CDK4/6 inhibitors P treatment between April 2016 and June 2020 were included.

Results 54 pts with median age 61 years (r:31–85) were analyzed. 11 premenopausal women.

29 pts (53,7%) performed P + L and 25 (46,3%) P + F.

5 pts presented with the novo metastatic disease. The main localization of metastases was bone in 24 pts, lymphatic in 14, liver in 10 and lung in 6.

Clinical benefit:

8 pts (14,8%) stable disease, 18 pts (33,4%) partial response and 3 pts (5,5%) complete response.

Dose reduction to 100 mg P occurred in 7 pts.