

Preoperative ultrasound compared to final pathology report showed a ICC of 0–87 (0.8–0.91) for maximum diameter size and 0.64 (0.4–0.78) for tumour volume measurement.

Conclusion Maximum diameter size showed a good correlation (ICC=0.75–0.9) with the pathology report when measured preoperatively by ultrasound and a moderate correlation (ICC=0.5–0.75) when measured by MRI. For tumour volume measurement both ultrasound and MRI showed a moderate correlation with the final pathology report.

Disclosures All authors contributed to writing the manuscript and read and approved the final manuscript.

The authors declare no conflict of interest.

442 SHOULD WE REALLY ABANDON MINIMALLY INVASIVE SURGERY IN EARLY-STAGE CERVICAL CANCER? ONCOLOGICAL RESULTS OF LAPAROSCOPICALLY ASSISTED RADICAL VAGINAL HYSTERECTOMY

¹Ariel Gustavo Glickman, ¹Jaume Pahisa, ²Blanca Gil Ibanez, ¹Berta Diaz-Feijoo, ¹Pere Fusté, ³Núria Carreras, ³Núria Agustí, ³Lydia Gaba, ⁴Marta Del Pino, ¹Aureli Torne. ¹Hospital Clínic Barcelona; Gynaecological Oncology Unit; ²Gynecological Oncology and Endoscopy Unit. Gynecology and Obstetrics Department. University Hospital 12 de Octubre. Madrid. Spain. Research Institute I+12. University Hospital 12 de Octubre. Madrid; ³Hospital Clínic Barcelona; ⁴Hospital Clínic; Hospital Clínic Barcelona; Gynaecology

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Introduction/Background Recent evidence indicates that some minimally invasive surgery (MIS) approaches, such as laparoscopic- and robotic-assisted radical hysterectomy, offer lower survival rates to patients with early-stage cervical cancer compared with open radical hysterectomy. We evaluated the oncological results of a different MIS approach, that of laparoscopically assisted radical vaginal hysterectomy (LARVH) in the treatment of patients with early-stage cervical cancer.

Methodology From January 2001 to December 2018, patients with early-stage cervical cancer (IA1 with lymphovascular invasion, IA2, IB1, and IIA < 2 cm; FIGO 2009) were treated by LARVH. Colpotomy and initial closure of the vagina were performed following the Schauta procedure, avoiding manipulation of the tumor. Laparoscopic sentinel lymph node (SLN) biopsy was performed in all cases. Women treated between 2001 and 2011 also underwent systematic bilateral pelvic lymphadenectomy after SLN biopsy. Adjuvant radiotherapy or chemo-radiotherapy was administered according to standard guidelines.

Results One hundred fifteen patients were included. Intraoperative complications occurred in nine patients (7.8%). Adjuvant radiotherapy or chemoradiotherapy was administered to 35 (30.4%) and three (2.6%) patients, respectively. After a median follow-up of 87.8 months (range 1–216), seven women (6%) presented recurrence (three pelvic and two paraaortic recurrences, and two had distant metastases). Four women died (mortality rate 3.4%). The three and 4.5-year disease-free survival rates were 96.7% and 93.5%, respectively, and the overall survival was 97.8% and 94.8%, respectively.

Conclusion LARVH offers excellent disease-free and overall survival in women with early stage cervical cancer and can be considered as an adequate MIS alternative to open radical hysterectomy.

Disclosures No disclosures to declare.

445 IMPACT OF AGE ON CANCER SPECIFIC SURVIVAL IN PATIENTS WITH LOCALLY ADVANCED CERVICAL CANCER

¹David Cantu-de Leon, ²Lenny Gallardo-Alvarado, ²Rebeca Ramirez-Morales, ³Salim Barquet-Muñoz, ³Rosa Salcedo-Hernandez, ⁴Gabriel Santiago-Concha, ⁴Sandra Perez-Alvarez, ⁵Delia Perez-Montiel, ²Paulina Trejo-Guerra. ¹Instituto Nacional de Cancerología; Research; ²Instituto Nacional de Cancerología; Clinical Research; ³Instituto Nacional de Cancerología; Gynaecology; ⁴Instituto Nacional de Cancerología; Radiotherapy; ⁵Instituto Nacional de Cancerología; Pathology

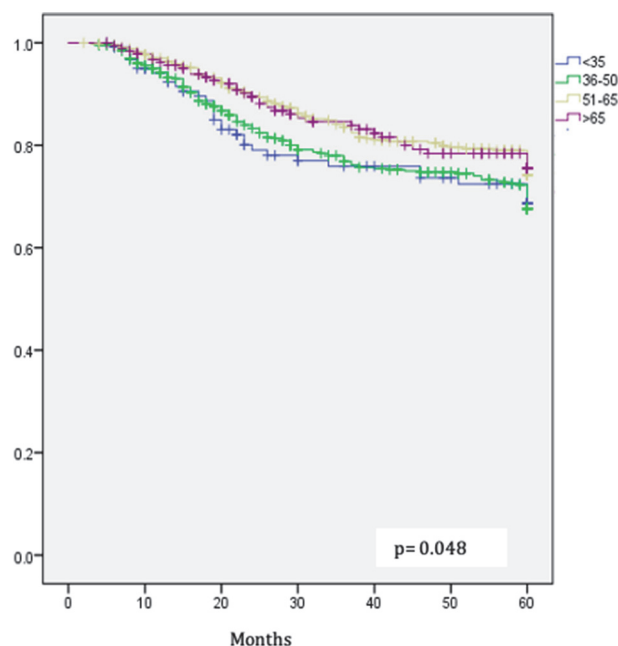
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Introduction/Background Cervical Cancer (CC) is uncommon in very young (<35 years) and in geriatric women (> 65 years), age as a prognostic factor is still controversial. The extremes of life had certain risk factors for being diagnosed with locally advanced cervical cancer (LACC); one of them is that in young women, there is a belief that the disease does not occur; therefore, lack of knowledge of the signs, symptoms and, as an essential factor, a lack of adherence to screening is common. In women older 65 years, the screening has been suspended, explaining how this group of women tend to be diagnosed in advanced stages.

This work aims to compare sociodemographic, clinical, and pathological characteristics, response to treatment, disease-free survival, overall survival, and cancer-specific survival in patients with LACC treated with concurrent chemoradiotherapy, clustered by age.

Methodology It is a retrospective study in patients with LACC treated at the National Cancer Institute of Mexico City from 2005 to 2014. A descriptive, comparative, and survival and cancer specific analysis was conducted.

Results From a total of 2,091 patients with LACC, we found 125 patients (9.7%) younger than 35 years (group 1), 533 (41.35), age between 36–50 years (group 2), 444 (34.4%) between 51–65 years (group 3) and 189 (14.6%) of patients 66 years or older. The general characteristics are found in table 1. More than 50% of women from group 4



Abstract 445 Figure 1 Cancer specific survival

Abstract 445 Table 1 Demographic, clinical and pathological characteristics

	Grupo 1 n=125	Grupo 2 n=533	Grupo 3 n= 444	Grupo 4 n=189	p
Scholarship					0.001
Illiterate	5 (4.0)	48 (9.0)	129 (29.1)	97 (51.3)	
>12 years of education	4 (3.2)	13 (2.4)	5 (1.1)	0	
Clinical Stage					0.001
IB2	24 (19.2)	51 (9.6)	23 (5.2)	9 (4.8)	
IIA	6 (4.8)	22 (4.1)	24 (5.4)	14 (7.4)	
IIB	61 (48.8)	300 (56.3)	271 (61.0)	112 (59.3)	
III	31 (24.8)	148 (27.8)	115 (25.9)	52 (27.5)	
IVA	3 (2.4)	12 (2.3)	11 (2.5)	2 (1.1)	
Histology					0.005
Squamous cell carcinoma	114(91.2)	462 (86.7)	397 (89.4)	191 (95.8)	
Adenocarcinoma	11 (8.8)	71 (13.3)	47 (10.6)	8 (4.2)	
Grade					0.534
1 (well differentiated)	3 (2.4)	23 (4.3)	12 (2.7)	3 (1.6)	
2 (moderately differentiated)	94 (75.2)	390 (73.2)	327 (73.6)	137 (72.5)	
3(poorly/undifferentiated)	28 (22.4)	120 (22.5)	105 (23.6)	49 (25.9)	
Lymphovascular space invasion	13 (10.4)	48 (9.0)	57 (12.8)	16 (8.5)	0.194
Tumour Size> 4cm	99 (79.2)	409 (67.7)	274 (61.4)	110 (58.2)	<0.001
Parametrial involvement					0.18
Negative	30 (24.0)	74 (13.9)	49 (11.0)	24 (12.7)	
Positive but not up to the pelvic wall	66 (52.8)	327 (61.4)	291 (65.5)	127 (67.2)	
Extension to the pelvic wall	29 (23.2)	132 (24.8)	104 (23.4)	38 (20.1)	
Pelvic Lymph nodes	50 (40)	201 (37.7)	148 (24.3)	46 (24.3)	0.014
Pre-treatment Haemoglobin	12.3 (5.3-16.1)	10.6 (3.5-21.1)	13.8 (5.6-20.3)	13.7 (7.1-16.7)	0.002
Final haemoglobin	12.1 (6.7-15.1)	12.2 (5.5-16.1)	12.6 (8.8-15.9)	12.4 (6.3-13.4)	0.288
Blood transfusion	59 (58.4)	175 (39.8)	92 (24.7)	31 (18.9)	<0.001
Treatment outcome	n (%)	n (%)	n (%)	n (%)	< 0.001
Complete response	94 (75.2)	406 (76.2)	380 (85.6)	166 (87.8)	
Partial, progression or stable disease	26 (20.8)	119 (22.3)	27 (12.8)	19 (10.1)	
Unknown	12 (4.5)	8 (1.5)	7 (1.6)	4 (2.1)	
Recurrence	28 (22.4)	125 (23.5)	119 (26.8)	60 (31.7)	0.111
Type of recurrence					0.512
Local	2 (1.6)	17 (3.2)	17 (3.8)	10 (5.3)	
Locoregional	4 (3.2)	11 (2.1)	13 (2.9)	5 (2.6)	
Distance	22 (17.6)	97 (18.2)	88 (19.8)	45 (23.8)	
Disease free survival (months) media (CI95%)	48 (44-52)	48 (46-50)	48 (46-50)	45 (42-48)	0.263
Cancer Specific survival (months) media (CI95%)	49 (45-52)	49 (48-51)	25 (51-54)	52 (50-54)	0.048
Overall survival (months) media (CI95%)	48 (44-51)	49 (50-53)	52 (50-53)	51 (49-54)	0.086

were illiterate. The patients from groups 1 and 2 clinical stage IB2 was more common. Pre-treatment haemoglobin was lower in groups 1 and 2 vs. groups 3 and 4, and 58.4% of the patients in group 1 required at least one blood transfusion. Cancer-specific survival was different between groups 1 and 2 vs. 3 and 4, $p=0.048$ (figure 1). Multivariate analysis showed that clinical-stage, Hazard ratio (HR) 3.62 (CI 95% 1.59–8.20), pre-treatment haemoglobin HR 0.944 (CI 95% 0.89–0.99), and age HR 1.28 (CI 95% 1.02–1.64) are independent prognostic factors in patients

with LACC, with lack of significance in disease free survival and overall survival.

Conclusion There are demographic, clinical, and treatment response differences between very young and young patients (under 50 years) compared to older patients (over 50 years). Cancer-specific survival, which attempts to remove the bias of advanced age in mortality, showed that women younger than 50 years had higher cancer-related mortality than those of older ages.

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