RECURRENCE PATTERNS ACCORDING TO TIME IN LOCALLY ADVANCED CERVICAL CANCER

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Introduction/Background At the time of diagnosis, locally advanced stages in cervical cancer is a common finding and considered the most important prognostic factor, accounting for up to 70% of cases in low-middle-income countries. Recurrence of disease is more frequent in the first two years (8 to 61% depending on the clinical stage). Late recurrence (beyond 5 years) is relatively common (0.4–7.5%). Overall survival after diagnosis of recurrence is 50.5% at two years and 22.3% at five years.

This study aims to analyse the recurrence patterns according to presentation time in patients with locally advanced cervical cancer (LACC).

Methodology This is a retrospective study in patients with LACC who had complete response after treatment with concurrent chemoradiotherapy followed by brachytherapy treated from January 2005 to December of 2014 at the National Cancer Institute in Mexico City.

Results Of 1045 patients with LACC and complete response, 334 (32%) presented recurrence of disease. Two hundred patients (59.9%) relapsed before 2 years (group 1), 88 (26.3%) between 2–5 years (group 2), and 45 (13.5%) after 5 years (group 3). The median age was 50 years of age (range 22–75 years), with no differences between groups. Distant recurrence occurred in 81% of the patients in group 1, 75% in group 2 and 57.8% in group 3, $p = 0.007$. There are no differences in survival after recurrence between the groups. Most patients who presented distant disease presented metastases in more than one site, and the more frequent site was lung. Median survival after the diagnosis of recurrence was 15 months (95% CI: 11–18.9) in group 1, 15 months (95% CI: 7.3–22.68) in group 2 and 25 months in group 3 (95% CI: 0–63), $p = 0.187$.

Conclusion Late recurrence is a common event in LACC, these patients have less risk of having distant disease at time of diagnosis; the prognosis after the recurrence depends on the site,

with statistically significant differences between local recurrence vs. locoregional and distant recurrence but not when the disease recurs. In a high-volume centre, it is important to continue follow-up of patients with LACC because of the risk of having recurrent disease after five years of treatment.

Disclosures The authors reports no conflicts of interest.

RETROSPECTIVE REVIEW OF HEMATOLOGICAL TOXICITY OF CHEMORADIO THERAPY IN LOCALLY ADVANCED CERVICAL CANCERS

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Introduction/Background Concurrent chemoradiotherapy with cisplatin is the standard of care for locally advanced cervical carcinoma. University college London hospital (UCLH) treats patients with cervical cancer with VMAT as a standard practice due to proven advantages. (1,2) However data on haematological toxicity appear limited. We therefore reviewed the haematological toxicity in our patients treated with VMAT.

Methodology Retrospective review of electronic records of all patients with cervical cancer who had VMAT at UCLH up to 31st May 2020 was conducted. Patient with non-carcinoma histology, post-operative treatments, recurrences, no concurrent cisplatin and those started on granulocyte colony stimulating factors (G-CSF) prior to radiotherapy were excluded. Haematological parameters were categorized by CTCAE version 5 haematological toxicity criteria. Findings were compared to published haematological toxicity data for cervical cancer IMRT or VMAT treatments with concurrent cisplatin using predetermined comparator values. (3–13)

Results 38 patients received VMAT treatments and 30 patients fulfilled inclusion criteria. 50% had FIGO (2009) stage IIB disease. 36.7% had regional lymphadenopathy. Neoadjuvant chemotherapy with weekly paclitaxel and carboplatin was received by 70%. 86.7% completed 5 or more cycles of cisplatin. 63.3% were prescribed 50.4Gy in 28 fractions to the pelvis, remainder received higher doses as simultaneous lymph node boosts. 23.3% received para aortic strip extended field

Abstract 479 Table 1 Observed maximum haematological toxicity (CTCAE v5)

Grade	Leucopenia (%)	Neutropenia (%)	Lymphopenia (%)	Thrombocytopenia (%)	Anemia (%)	Maximum HT (%)	Maximum clinical HT* (%)
0	3 (10%)	9(30%)	0	5(16.7%)	5(16.7%)	0	1(3.3%)
1	4 (13.3%)	6(20%)	0	15(50%)	13(43.3%)	0	5(16.7%)
2	8 (26.7%)	9(30%)	1(3.3%)	7(23.3%)	10(33.3%)	0	9(30%)
3	12(40%)	3(10%)	10(33.3%)	2(6.7%)	2(6.7%)	11(36.7%)	12(40%)
4	3(10%)	3(10%)	19(63.3%)	1(3.3%)	0	19(63.3%)	3(10%)
5	0	0	0	0	0	0	0

*Maximum clinical HT includes only WBC, neutrophil and platelet gradings.