the different inclusion and exclusion criteria, we obtained 1156 patients, 733 CC patients and 423 non-CC patients. Subsequently, and after analyzing the first results, we decided to homogenize our database by means of a PMS analysis, by this way, we obtained a new balanced population of 374 patients (187 CC patients and 187 non-CC patients).

**Results** In the general population, patients with CC present a 72% reduction in the risk of relapse compared to non-CC patients (HR: 0.28 95% CI (0.17–0.46) p = 0.000) and a 90% reduction in the risk of death (HR: 0.10 95% CI (0.03–0.33) p = 0.000), these differences may be due to the fact that both populations present differences.

After homogenizing our population using the PMS, we obtained that the reduction in the risk of relapse was 65% for patients who have CC (HR: 0.35 CI 95% (0.16–0.75) p = 0.007) and 75% for the risk of death for the same cohort (HR: 0.25 95% CI (0.07–0.90) p = 0.033).

Regarding the secondary objectives, we observed that the CC seems to have a protective effect in tumors between 2–4 cm (HR: 0.33 95% CI (0.11–0.99) p = 0.049). This same protective effect is observed in patients operated on by laparoscopy (HR: 0.35 95% CI (0.14–0.89) p = 0.028). Finally, the MIS patients who have CC do not present differences compared to those operated by the open approach, whether they are conized or non-conized (Log-Rank p = 0.439 and Log-Rank p = 0.346).

**Conclusion** Patients undergoing CC have a significantly lower risk of relapse and death, this effect is more evident in those patients with 2–4 cm tumors or in those who are operated under MIS.

**Disclosures** I have nothing to disclose.