4. When the superficial inguinal lymph nodes are retracted over the fascia lata from the cranio-lateral part, the fossa ovalis is identified at the central part of the incision, which is covered by the cribriform fascia. Besides, during the excision of the superficial nodes at the caudal part of this area, the great saphenous vein passing through the fossa ovalis is identified.

5. After total excision of the superficial inguinal lymph nodes, the cribriform fascia is dissected. The femoral vein is identified below the fascia lata, covered by the femoral sheath between the sartorius muscle laterally and the adductor longus muscle medially. The great saphenous vein drains into the femoral vein, and the deep inguino-femoral lymph nodes, which are located medial to the femoral vein, are dissected. The femoral artery lies at the lateral part of the femoral vein, and the femoral nerve is the most lateral component in the femoral sheath.

6. The deep inguino-femoral lymph nodes cover the base of the great saphenous vein.

7. During excision of the deep inguino-femoral lymph nodes, the deep external pudendal vein should also be kept in mind, which drains into the great saphenous or femoral vein.

Conclusion* The essential anatomy of the superficial inguinal and deep femoral lymph nodes, with Scarpa's fascia, fascia lata of the thigh, and cribriform fascia should be known to perform an inguino-femoral lymphadenectomy.

Late breaking abstracts

Cervical cancer

58

KEYNOTE-826: PEMBROLIZUMAB PLUS CHEMOTHERAPY VERSUS PLACEBO PLUS CHEMOTHERAPY FOR PERSISTENT, RECURRENT, OR METASTATIC CERVICAL CANCER

¹N Colombo*, ²C Dubot, ³D Lorusso, ⁴V Caceres, ⁵K Hasegawa, ⁶R Shapira-Frommer, ⁷K Tewari, ⁸P Salman, ⁹E Hoyos Usta, ¹⁰E Yañez, ¹¹M Gümüş, ¹²M Olivera Hurtado de Mendoza, ¹³V Samouëlian, ¹⁴V Castonguay, ¹⁵A Arkhipov, ¹⁶S Toker, ¹⁶K Li, ¹⁶S Keefe, ¹⁷B Monk. ¹University of Milan-Bicocca and European Institute of Oncology (IEO) IRCCS, Milan, Italy; ²Institut Curie Saint-Cloud, Group d'Investigateurs Nationaux pour l'Etude des Cancers Ovariens (GINECO), Saint-Cloud, France; ³Fondazione Policlinico Universitario A Gemelli IRCCS and Catholic University of Sacred Heart, Rome, Italy; ⁴Institute of Oncology Angel H. Roffo, Buenos Aires, Argentina; ⁵Saitama Medical University International Medical Center, Hidaka, Japan; ⁶Ella Lemelbaum Institute for Immuno-Oncology, Sheba Medical Center, Ramat Gan, Israel; ⁷University of California Irvine, Irvine, USA; ⁸Oncovida Cancer Center, Providencia, Chile; ⁹Imat Oncomedica S.A., Montería, Colombia; ¹⁰Universidad de La Frontera, Temuco, Chile; ¹¹Istanbul Medeniyet University Hospital, Istanbul, Turkey; ¹²Instituto Nacional de Enfermedades Neoplásicas, Medical Oncology, Lima, Peru; ¹³Centre Hospitalier de l'Université de Montréal (CHUM), Centre de Recherche de l'Université de Montréal (CRCHUM), Université de Montréal, Montreal, Canada; ¹⁴Centre Hospitalier Universitaire de Québec, Université Laval, Québec City, Canada; ¹⁵Medical Rehabilitation Center under the Ministry of Health of Russian Federation, Moscow, Russian Federation; ¹⁶Merck and Co., Inc., Kenilworth, USA; ¹⁷Arizona Oncology (US Oncology Network), University of Arizona College of Medicine, Creighton University School of Medicine, Phoenix, USA

10.1136/ijgc-2021-ESGO.641

Introduction/Background* Pembrolizumab has efficacy in previously treated, PD-L1-positive advanced cervical cancer. KEYNOTE-826 (NCT03635567) was a phase 3, randomised, double-blind trial of pembrolizumab or placebo added to chemotherapy ± bevacizumab for first-line treatment of recurrent, persistent, or metastatic cervical cancer.

Methodology Eligible adults had persistent, recurrent, or metastatic cervical cancer not previously treated with systemic chemotherapy and not amenable to curative treatment. Patients were randomised 1:1 to pembrolizumab 200 mg or placebo Q3W for ≤35 cycles added to chemotherapy (paclitaxel plus cisplatin or carboplatin) ± bevacizumab and stratified by metastatic status at diagnosis, planned bevacizumab use, and PD-L1 combined positive score (CPS). Dual primary endpoints were PFS (RECIST v1.1, investigator review) and OS tested sequentially in the CPS ≥1, all-comer, and CPS ≥10 populations.

Result(s)* 617 patients were randomized: 308 to pembrolizumab plus chemotherapy (63.6% with bevacizumab) and 309 to placebo plus chemotherapy (62.5% with bevacizumab); 548 (88.8%) patients had CPS ≥1, 317 (51.4%) had CPS ≥10. At the protocol-specified first interim analysis, pembrolizumab plus chemotherapy ± bevacizumab significantly improved PFS in the CPS ≥1 (median, 10.4 vs 8.2 months; HR, 0.62 [95% CI, 0.50–0.77]; P<0.001), all-comer (10.4 vs 8.2 months; 0.65 [0.53–0.79]; P<0.001), and CPS ≥10 (10.4 vs 8.1 months; 0.58 [0.44–0.77]; P<0.001) populations. OS was also significantly improved in the CPS ≥1 (median, not reached [NR] vs 16.3 months; HR, 0.64 [95% CI, 0.50–0.81]; P<0.001), all-comer (24.4 vs 16.5 months; 0.67 [0.54–0.84]; P<0.001), and CPS ≥10 (NR vs 16.4 months; 0.61 [0.44–0.84]; P=0.001) populations. Benefits were seen in the with and without bevacizumab subgroups. The incidence of grade ≥3 AEs was 81.8% in the pembrolizumab arm and 75.1% in the placebo arm. Anaemia and neutropenia were the most common grade ≥3 AEs (30.3% vs 26.9% and 12.4% vs 9.7%, respectively).

Conclusion* Pembrolizumab plus chemotherapy ± bevacizumab significantly improves OS and PFS in patients with persistent, recurrent, or metastatic cervical cancer. Along with a manageable safety profile, the clinically meaningful survival benefits suggest pembrolizumab plus chemotherapy ± bevacizumab may be a new standard first-line therapy for this population.

1180

IDENTIFYING PREDICTORS OF LYMPH NODE METASTASES IN EARLY-STAGE CERVICAL CANCER BY TRANSFERRING PREDICTION MODELS ACROSS INTERNATIONAL REGISTRIES

¹T Schnack, ^{2,3}H Wenzel*, ^{4,5}A Norberg Hardie, ^{6,7}R Bekkers, ^{4,5}H Falconer, ¹C Høgdall, ^{8,9,10}P Jensen, ^{2,11}V Lemmens, ²F Martin, ³H Nijman, ²M Van der Aa, ²A Moncada-Torres. ¹Juliane Marie Centre, Rigshospitalet, University of Copenhagen, Department of Gynaecology, Copenhagen, Denmark; ²Netherlands Comprehensive Cancer Organisation (IKNL), Department of Research and Development, Utrecht, Netherlands; ³University Medical Centre Groningen, University of Groningen, Department of Obstetrics and Gynaecology, Groningen, Netherlands; ⁴Karolinska University Hospital, Department of Pelvic Cancer, Stockholm, Sweden; ⁵Karolinska Institutet, Department of Women's and Children's Health, Stockholm, Sweden; ⁶GROW school for oncology and developmental biology, Maastricht University Medical Centre+, Department of Obstetrics and Gynaecology, Maastricht, Netherlands; ⁷Catharina Hospital, Department of Obstetrics and Gynaecology, Eindhoven, Netherlands; ⁸Aarhus University Hospital, Department of Gynaecology, Aarhus, Denmark; ⁹Aarhus University, Institute of Clinical Medicine, Faculty of Health, Aarhus, Denmark; ¹⁰University of Southern Denmark, Clinical Institute, Faculty of Health Sciences, Odense, Denmark; ¹¹Erasmus MC University Medical Centre, Department of Public Health, Rotterdam, Netherlands

10.1136/ijgc-2021-ESGO.642

Introduction/Background* Identifying risk factors for lymph node metastases in early-stage cervical cancer may aid in tailoring treatment. Unfortunately, early-stage cervical cancer research is often hampered by small sample sizes.