

percentage score. Finally the scores for each sub-criteria are added up to the total score of each country.

Result(s)* Belgium, Denmark, Ireland and the UK are the policy champions and lead the Atlas with excellent policies on primary secondary prevention and providing evidence based information to citizens.

Romania, Bulgaria and Slovakia worst performing countries in the EU (no funding for vaccines, vaccine only available to girls, poorly organised screening programmes, absence of reliable online information). In terms of geographical Europe, **Belarus and Azerbaijan** score the worse, as there is literally no information about the HPV prevention to be found and policies on primary or secondary prevention are non-existent.

Conclusion* The situation in Europe is very unequal. There is a clear divide between northern Europe, Southern Europe and Eastern Europe. While vaccine exists and screenings technologies are available – today the access is very dependent on where you live. This leads to high incidence and mortality which could be avoided should proper policies be put in place.

Links ATLAS:

EPF:

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RAISING ADEQUATE VAGINAL MARGINS DURING COLPOTOMY FOR CERVICAL CANCER

T Shylasree*, B Dash, P Poddar. *Tata Memorial Hospital, Gynecological Oncology, Mumbai, India*

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Introduction/Background* Adequate surgical vaginal margins are pre-requisite for improving oncological outcomes in cervical cancer and precancer. Raising the margins through vaginal route helps in visualizing and measuring the vaginal and is more accurate than performing colpotomy from an open abdominal/Minimal access route.

Methodology Following completion of ligation of uterine vessels with or without adequate parametrium depending on the indication for radicality (abdominal/minimal access route/schultas vaginal hysterectomy), surgeon moves to the bottom end of the patient. Cervix is visualised and held with volselum. Circumferential vaginal margin which needs to be removed is marked with cautery. Vaginal mucosa is infiltrated with saline with or without adrenaline. With the help of electrical diathermy vaginal margins are raised all around and separated from underlying cervix. Care should be taken not to be too close to bladder or rectum during dissection. Bladder and pouch of Douglas peritoneum is incised and uterus/cervix delivered depending on the procedure (trachelectomy/radical hysterectomy)

Result(s)* Vaginal is closed with absorbable sutures and specimen sent for final histopathology

Conclusion* Adequate Vaginal margin is a major prognostic factor in cervical cancer. Inadequate or positive margin is associated with recurrence and poor oncological outcomes, hence adjuvant postoperative radiation is indicated in such scenario. Direct visualization and measurement of vaginal to be removed and performing vaginal colpotomy ensures adequate vaginal margin and also prevents the disease being exposed to peritoneal cavity especially in minimal access surgery.

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THE UTERINE RADIATION NECROSIS AFTER DEFINITIVE CHEMOIRRADIATION – IMAGING AND CONTROVERSY, A SINGLE CASE REPORT

M Mikovic*, A Tomasevic, M Radović, D Marjanovic Djoric, J Dedovic Stojakovic, V Plesinac Karapandzic. *Institute of Oncology and Radiology of Serbia, Department of Radiotherapy, Belgrade, Serbia*

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Introduction/Background* distinguishing radiation necrosis of uterus and/or cervix from central rest/recurrence after definitive chemoradiation of locally advanced cervical cancer might be challenging, even for experienced clinicians, despite various diagnostic procedures. This is a rare condition and needs to be treated with intensive local care, while central recurrence requires specific oncological treatment with a good prognosis if operable.

Methodology We present a woman, age 40 with severe acute lower abdominal pain, ten months after completing definitive chemoradiation of FIGO stage IIb cervical cancer, with an initially estimated complete treatment regression effect. Histologically, it was large cell nonkeratinizing HG2, NG2 planocellulare invasive carcinoma with a tumor-cervix diameter of 47 mm. Total transcutaneous (TRT) dose of 46 Gy in 25 fractions was delivered to the whole pelvis (Rapid arc planned), with 5 cycles of weekly Cisplatin-based chemotherapy (40 mg/m²) and 5 intracavitary brachytherapy applications, 1 weekly, with a dose of 7 Gy to reference point A/per application (central tube and two ovoids). After 10 months of complete regression of cancer, clinical exam, ultrasound (US), Positron emission tomography/computed tomography (PET/CT with standardized uptake value, SUV maximum 9.5) and computed tomography (CT) showed an inhomogeneous mass of the cervix, 5 cm in longitudinal dimension, propagating towards rectum, strongly suspected to recurrence. A biopsy was performed with a result of necrotic inflamed tissue.

Result(s)* Due to the large scale of symptoms of inflammation, specific treatment was not conducted at the time. The patient was treated with supportive therapy, antibiotics, and intensive local care. Five months after the first symptoms, MR showed no signs of disease. The patient is scheduled for further MR control and follow-up.

Conclusion* radiation necrosis must be included in consideration if the result of the biopsy is negative even if most of the diagnostic procedures point towards central recurrent disease.

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ESGO QUALITY INDICATORS (QI) IN THE SURGICAL MANAGEMENT OF CERVICAL CANCER. CANARY ISLANDS MATERNAL AND CHILD UNIVERSITY HOSPITAL

O Arencibia Sanchez*, AF Rave Ramirez, D González García-Cano, M Laseca Modrego, A Martín Martínez. *Complejo Hospitalario Universitario Insular Materno Infantil de Gran Canaria, Gynecologic Oncology, las palmas de gran canaria, Spain*

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Introduction/Background* The objective is to know our degree of compliance with the ESGO 2019 quality indicators in surgical management of cervical cancer

Methodology Retrospective study of patients with cervical cancer who underwent laparoscopic radical hysterectomy in the