

technique represents other possibility, besides pelvic exenteration for tumors located laterally.

Methodology Video presentation of laterally extended endopelvic resection in patient with cervical cancer recurrence after radiotherapy localized laterally in the left obturator fossa and residual parametria and paracolpium with complete obstruction of ureter and afunctional left kidney.

Result(s)* Recurrent tumor was removed in toto with resection of internal iliac vessel, residual parametria and paracolpium and complet resection of infiltrated ureter.

Conclusion* Technique of laterally extended endopelvic resection allows – due to precise knowledge of pelvic structures and their topography – for safe removal of even laterally located tumor deep in the pelvis/pevic floor.

848 INDOCYANINE GREEN TO ASSESS VASCULARITY OF BRICKER ILEAL CONDUIT ANASTOMOSIS DURING PELVIC EXENTERATION FOR RECURRENT CERVICAL CANCER

¹N Bizzarri*, ²N Foschi, ¹M Loverro, ¹L Tortorella, ³F Santullo, ¹A Rosati, ¹S Gueli Alletti, ¹B Costantini, ¹V Gallotta, ¹MG Ferrandina, ¹A Fagotti, ¹F Fanfani, ¹G Scambia, ^{1,4}G Vizzielli. ¹Fondazione Policlinico Universitario A. Gemelli, IRCCS, UOC Ginecologia Oncologica, Dipartimento per la salute della Donna e del Bambino e della Salute Pubblica, Rome, Italy; ²Fondazione Policlinico Universitario A. Gemelli, IRCCS, UOC Clinica Urologica, Rome, Italy; ³Fondazione Policlinico Universitario A. Gemelli, IRCCS, UOC Chirurgia Peritoneo e Retroperitoneo, Rome, Italy; ⁴Academic Hospital of Udine, Obstetrics and Gynecology Department, Udine, Italy

10.1136/ijgc-2021-ESGO.72

Introduction/Background* Pelvic exenteration performed for recurrent cervical cancer has been associated to urological short- and long-term morbidity, due to altered vascularization of tissues for previous radiotherapy. The aim of the present video is to demonstrate the use of intravenous indocyanine green (ICG) to assess vascularity of Bicker ileal conduit after pelvic exenteration for recurrent cervical cancer and to evaluate the feasibility and safety of this technique.

Methodology The patient was a 64-year-old woman who underwent exclusive chemoradiation for FIGO stage IIB cervical SCC. Seven months after the end of the radiotherapy she was diagnosed with an isolated central pelvic recurrence involving bladder wall. The patient underwent open total pelvic exenteration with Bricker ileal conduit urinary diversion and end sigmoid colostomy. After performing the anastomoses, the perfusion of tissues was analyzed with intravenous injection of 3 ml of ICG and a (1.25 mg/ml) and a near infra-red SPY Portable Handheld Imager (SPY-PHI) (Stryker, Kalamazoo, Michigan, US). After ICG injection, a four-tier (+++ versus ++- versus +- versus —) classification was used to assess the vascularity of each anastomosis: ileum-ileum, right and left ureter with small bowel. The classification of ICG perfusion of anastomoses was independently performed by the urologist and the gynecologic oncologist.

Result(s)* Intravenous injection did not cause any adverse event. After ICG injection, the left ureter-ileal conduit demonstrated sub-optimal vascularization (—), the right ureter-ileal conduit and the ileum-ileum showed optimal vascularization (+++). ICG perfusion is demonstrated with three different modalities: Overlay Fluorescence Mode, Color Segmented Fluorescence Mode, Contrast Fluorescence Mode. Patient developed benign left ureteric stricture which was diagnosed with a CT-scan 45 days after the radical surgery and was treated with antegrade ureteric stenting.

Conclusion* The use of ICG to intra-operatively assess the anastomoses perfusion at time of pelvic exenteration for gynecologic malignancy is a feasible and safe technique. The different vascularization of anastomotic stumps may be related to anatomical sites and to previous radiation treatment and it may be useful to predict post-operative complications. This approach could be of support in selecting patients at higher risk of complications, who may need personalized follow up.

854 SURGICAL LYMPH NODE STAGING IN LOCALLY ADVANCED CERVICAL CARCINOMA

¹M Interat*, ¹M Moubarak, ²KU Waltering, ³K Berkovic, ³I Stöver, ³A Kozirowski, ^{1,4}B Ataseven, ¹P Harter, ¹A Du Bois, ¹N Concin. ¹Ev. Kliniken Essen-Mitte, Department of Gynecology and Gynecologic Oncology, Essen, Germany; ²Ev. Kliniken Essen-Mitte, Department of Radiology, Essen, Germany; ³Ev. Kliniken Essen-Mitte, Department of Radiotherapy, Essen, Germany; ⁴University Hospital, LMU Munich, Department of Obstetrics and Gynecology, Munich, Germany

10.1136/ijgc-2021-ESGO.73

Introduction/Background* Radiation field planning in patients with locally advanced cervical cancer (LACC) undergoing primary definitive chemoradiotherapy is influenced by lymph

Abstract 854 Table 1 Patients demographic and tumor characteristics according to pathological (pelvic and paraaortic) lymph-node status

Characteristics	Negative Lymph-node N= 14 (24.1%)	Positive lymph-node N= 44 (75.9%)	Entire cohort N= 58	p-value
Patient age, years, median (Range)	59.5 (32-72)	51 (26-80)	53 (26-80)	0.228
ECOG* score:				1.000
0	1 (7.1)	3 (6.8)	4 (6.9)	
>0				
Preoperative imaging technique:				
CT	14 (100)	42 (95.5)	56 (96.6)	0.417 (CT)
MRI	11 (78.6)	40 (90.9)	51 (87.9)	0.217 (MRI)
Histological type:				0.719
squamous cell	1 (7.1)	3 (6.8)	4 (6.9)	
adenocarcinoma small cell	0	2 (4.5)	2(3.4)	
Grading:				0.799
G2	6 (42.9)	15 (34.1)	21 (36.2)	
G3	7 (50)	24 (54.5)	31 (53.4)	
GX	1 (7.1)	5 (11.4)	6 (10.3)	
cT classification:				0.004
1b1	0	12 (27.3)	12 (20.7)	
1b2	0	2 (4.5)	2 (3.4)	
2a1	0	2 (4.5)	2 (3.4)	
2a2	1 (7.1)	7 (15.9)	8 (13.8)	
2a2	7 (50)	11 (25)	18 (31)	
2b	0	3 (6.8)	3 (5.2)	
3a	1 (7.1)	6 (13.6)	7 (12.1)	
3b	5 (35.7)	1 (2.3)	6 (10.3)	
4a				
Lymph-node site:				
pelvic paraaortic pelvic		26 (59.1)	26 (44.8)	
+paraaortic		6 (13.6)	6 (10.3)	
		12 (27.3)	12 (20.7)	

Data are presented as n (%); Significance was measured using Chi squared * Eastern Cooperative Oncology Group

node (LN) status. LN assessment by imaging methods has several known limitations including a high false negative rate. The present study aimed to compare the accuracy of LN staging by imaging and surgical staging in LACC patients, and to evaluate their impact on radiation field planning.

Methodology A retrospective monocentric study of patients with LACC (International Federation of Gynecology and Obstetrics (FIGO 2018) stage IIA -IVA), undergoing primary definitive platinum-based chemoradiation therapy. Patients were included if LN assessment was available by both methods: surgical (paraaortic/pelvic) and imaging [Thorax/Abdomen Computed Tomography (CT) and/or pelvic Magnetic Resonance Imaging (MRI)].

Result(s)* A total of 58 patients met the inclusion criteria (table 1), 97% (n=56) had a preoperative CT and 88% (n=51) an MRI evaluation. All patients underwent surgical LN staging: 100% paraaortic, and 86% (n=50) additional pelvic lymphadenectomy. Histologically proven LN metastases after surgical LN staging were found in 76% of patients (n=44), 31% (n=18) paraaortic and 76% (n=38) pelvic. As a result of the surgical LN staging, 36% (n=21) of the patients were upstaged (n=11 to FIGO IIIC1 and n=10 to FIGO IIIC2), and 17% (n=10) had treatment modification (extended paraaortic field radiation). LN staging using CT and MRI exhibited a low negative predictive value (29% and 38%, respectively), with a higher positive predictive value (69% and 81%, respectively).

Conclusion* In this cohort of LACC patients, paraaortic LN metastases were present in one third of the cases, while CT/MRI imaging underestimated metastatic LN involvement. We thus stress the value of surgical paraaortic LN staging in cases of negative LN imaging, which may lead to treatment modification in about one fifth of patients.

898

THE IMPACT OF MICROMETASTASES IN CERVICAL CANCER PATIENTS – A RETROSPECTIVE STUDY OF THE SCCAN (SURVEILLANCE IN CERVICAL CANCER) PROJECT

¹L Dostalek*, ¹M Borcinova, ²K Benesova, ³J Klat, ⁴H Falconer, ⁵SH Kim, ⁶LR Van Lonkhuijzen, ⁷A Lopez, ⁸D Isla Ortiz, ⁹F Landoni, ¹⁰J Kostun, ¹¹R Dos Reis, ¹²D Odetto, ¹³J Zapardiel, ²J Jarkovsky, ³V Javukova, ⁴S Salehi, ⁵NR Abu-Rustum, ³P Graf, ¹D Cibula.

¹Gynecologic Oncology Center, Department of Obstetrics and Gynecology, First Faculty of Medicine, Charles University and General University Hospital, Central and Eastern European Gynecologic Oncology Group, (CEEGOG), Prague, Czech Republic; ²Institute of Biostatistics and Analyses, Faculty of Medicine, Masaryk University, Brno, Czech Republic; ³Department of Obstetrics and Gynecology, Faculty of Medicine, University Hospital and University of Ostrava, Ostrava, Czech Republic; ⁴Department of Pelvic Cancer, Karolinska University Hospital and Department of Women's and Children's Health, Karolinska Institutet, Stockholm, Sweden; ⁵Department of Surgery, Memorial Sloan Kettering Cancer Center, New York, NY 10065, USA; ⁶Department of Gynecological Oncology, Amsterdam University Medical Center—Center for Gynecological Oncology Amsterdam, Amsterdam, the Netherlands; ⁷Department of Gynecological Surgery, National Institute of Neoplastic Diseases, Lima, Peru; ⁸Gynecology Oncology Center, National Institute of Cancerology Mexico, Mexico; ⁹University of Milano-Bicocca, Department of Obstetrics and Gynecology, Gynaecologic Oncology Surgical Unit, ASST-Monza, San Gerardo Hospital, Monza, Italy; ¹⁰Department of Gynaecology and Obstetrics, University Hospital Pilsen, Charles University, Prague, Czech Republic; ¹¹Departamento de Ginecología Oncológica, Hospital de Amor – Barretos, Brazil; ¹²Department of Gynecologic Oncology, Hospital Italiano de Buenos Aires, Instituto Universitario Hospital Italiano, Buenos Aires, Argentina; ¹³Gynecologic Oncology Unit, La Paz University Hospital – IdiPAZ, Madrid, Spain

10.1136/ijgc-2021-ESGO.74

Introduction/Background* The impact of lymph node (LN) micrometastases (MIC) in cervical cancer patients remains a controversial topic given their low incidence and good prognosis of patients managed by primary surgery.

We aim to evaluate the prognostic significance of MIC and isolated tumour cells (ITC) in a large cohort of patients from the SCCAN retrospective study (Surveillance in Cervical Cancer). SCCAN study analysed data from more than 4300 patients with early stage cervical cancer treated by primary surgery at 20 large tertiary institutions from Europe, North America, South America and Australia.

Methodology In this SCCAN sub-study, we included patients with early stage cervical cancer (T1a1 LVSI+ – T2b) treated between 2007 and 2016 with at least 1-year follow-up data availability, who underwent primary surgery including sentinel lymph node (SLN) biopsy and in whom SLNs were processed by pathological ultrastaging protocol.

Abstract 898 Table 1 Data summary (N = 969)

Characteristics	Description	
Tracer type	Radiocolloid	423 (43.7%)
	Dye	662 (68.3%)
	ICG	220 (22.7%)
No. of SLN detected	Mean ± SD	3.2 ± 2.2
Largest type of metastasis in LN including SLN	Negative	795 (82.0%)
	ITC	31 (3.2%)
	MIC	59 (6.1%)
Surgical approach	MAC	84 (8.7%)
	Open	575 (59.3%)
	Robotic	195 (20.1%)
Tumour histotype	Laparoscopic	199 (21.5%)
	Squamous	605 (62.4%)
	Adenocarcinoma	287 (29.6%)
	Adenosquamous	50 (5.2%)
	Neuroendocrine	18 (1.9%)
Grade	Other	9 (0.9%)
	1	149 (15.4%)
	2	406 (41.9%)
	3	246 (25.4%)
	N/A	168 (17.3%)
LVSI	No	316 (32.6%)
	Yes	351 (36.2%)
	N/A	302 (31.2%)
Maximal pathologic tumour diameter [mm]	Mean ± SD	20.6 ± 13.7
	Median (IQR)	19 (10; 30)
	< 0.5 cm	73 (7.5%)
	0.5–1.99 cm	424 (43.8%)
	2–3.99 cm	376 (38.8%)
Adjuvant therapy if yes:	≥ 4 cm	96 (9.9%)
	radiotherapy	312 (32.2%)
	chemoradiotherapy	153 (49.0%)
	chemotherapy	136 (43.6%)
	chemoradiotherapy + chemotherapy	18 (5.8%)
Recurrence		5 (1.6%)
		117 (12.1%)