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

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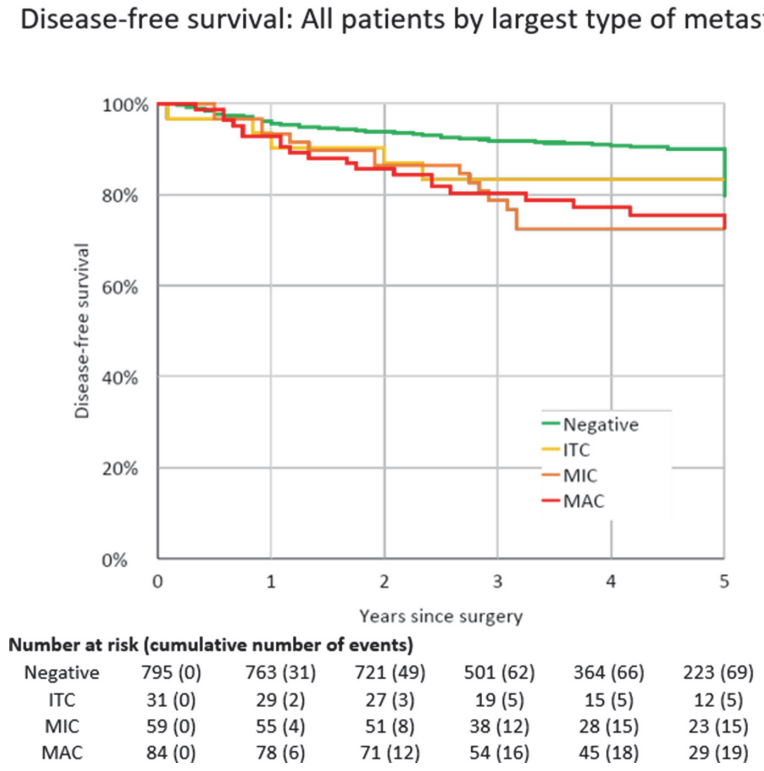
Introduction/Background* The impact of lymph node (LN) micrometastases (MIC) in cervical cancer patients remains a controversial topic given their low incidence and good prognosis of patients managed by primary surgery.

We aim to evaluate the prognostic significance of MIC and isolated tumour cells (ITC) in a large cohort of patients from the SCCAN retrospetive 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%)
	MAC	84 (8.7%)
Surgical approach	Open	575 (59.3%)
	Robotic	195 (20.1%)
	Laparoscopic	199 (21.5%)
Tumour histotype	Squamous	605 (62.4%)
	Adenocarcinoma	287 (29.6%)
	Adenosquamous	50 (5.2%)
	Neuroendocrine	18 (1.9%)
	Other	9 (0.9%)
Grade	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%)
	≥ 4 cm	96 (9.9%)
Adjuvant therapy		312 (32.2%)
if yes:	radiotherapy	153 (49.0%)
	chemoradiotherapy	136 (43.6%)
	chemotherapy	18 (5.8%)
	chemoradiotherapy + chemotherapy	5 (1.6%)
Recurrence		117 (12.1%)



Abstract 898 Figure 1

Abstract 898 Table 2 Univariate analysis of factors associated with disease-free survival (N = 969)

Predictor	Category	n	HR (95% CI)	p-value
Surgical approach	Open	575	Ref.	
	Robotic	195	1.21 (0.74; 1.97)	0.439
	Laparoscopic	141	1.51 (0.93; 2.45)	0.097
	Combined	58	1.06 (0.48; 2.31)	0.888
Tumour diameter	< 0.5 cm	73	Ref.	
	0.5–1.99 cm	424	1.67 (0.51; 5.47)	0.399
	2–3.99 cm	**376**	**3.98 (1.25; 12.69)**	**0.019**
	≥ 4 cm	**96**	**6.35 (1.91; 21.13)**	**0.003**
LVSI	No	316	Ref.	
	Yes	351	**2.31 (1.47; 3.63)**	**< 0.001**
Tumour histotype	Squamous	605	Ref.	
	Adenocarc.	287	1.13 (0.75; 1.71)	0.554
	Adenosquamous	50	1.38 (0.66; 2.89)	0.385
	Other	27	**3.03 (1.45; 6.31)**	**0.003**
Grade	1	149	Ref.	
	2	**406**	**2.08 (1.02; 4.22)**	**0.044**
	3	**246**	**3.35 (1.64; 6.85)**	**< 0.001**
Largest type of metastasis in LN	Negative	795	Ref.	
	ITC	31	1.67 (0.68; 4.14)	0.264
	MIC	**59**	**2.55 (1.47; 4.43)**	**< 0.001**
	MAC	**84**	**2.36 (1.44; 3.87)**	**< 0.001**
Largest type of metastasis in LN	Negative	795	Ref.	
	ITC	31	1.67 (0.68; 4.14)	0.264
	MIC+MAC	**143**	**2.44 (1.63; 3.64)**	**< 0.001**

Result(s)* Out of 969 included patients with at least 1 SLN detected, 174 (18%) had positive LN (table 1). Maximal tumour diameter >2cm, positive LVSI, grade ≥ 2, uncommon histological type (neuroendocrine, sarcoma, etc.) and macrometastasis (MAC) or MIC in LN were factors associated with significantly decreased five-years disease free survival (DFS) (table 2). MAC, MIC or ITC was the largest LN metastasis in 84 (9%), 59 (6%) and 31 (3%) cases respectively. Adjuvant (chemo)radiation was administred in 89%, 85% and 58% of patients with MAC, MIC and ITC. DFS reached 75%, 73% and 83% in patients with MAC, MIC and ITC compared with 90% in the N0 patients. Patients with MAC and MIC had significantly decreased DFS than those with N0 disease (HR=2.36 and 2.55).

Conclusion* Early-stage cervical cancer patients with MIC in pelvic LN have significantly decreased DFS. Their management should follow the same principles as in patients with MAC.

917 PHASE 1B TRIAL OF FIRST-LINE BINTRAFUSP ALFA, A BIFUNCTIONAL FUSION PROTEIN TARGETING TGF-β AND PD-L1, PLUS CHEMOTHERAPY WITH OR WITHOUT BEVACIZUMAB IN CERVICAL CANCER

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