Conclusion* We have developed the first robust model of disease-specific survival after recurrence stratifying relapsing cervical cancer patients according to their risk profile using six traditional prognostic markers. The strongest factor related to the length of post-recurrence survival was the largest size of the primary tumour, followed by the presence of symptoms at the time of diagnosis, which remained significant even after correction for lead-time bias.

950 SENSITIVITY AND FALSE NEGATIVITY OF SLN FROZEN SECTIONHISTOLOGICAL EVALUATION IN THE SENTIX TRIAL (CEEGOG-CX01; ENGOT-CX2; NCT02494063)

[1]R Kocian*, [2]C Kohler, [1]S Bajsová, [1]S Sebestova, [3]I Zapardiel, [4]GDI Martino, [5]L Van Lonkhuijzen, [1]B Sehnal, [3]O Arencibia Sanchez, [3]B Gil-Ibanez, [4]F Martinelli, [1]J Presl, [1]L Minar, [1]R Marek, [6]P Kascak, [1]P Havelka, [1]M Michal, [7]T Van Gorp, [1]K Nemejcova, [1]D Cibula. [1]*Czech Republic*; [2]*Germany*; [3]*Spain*; [4]*Italy*; [5]*Netherlands*; [6]*Slovakia*; [7]*Belgium*

10.1136/ijgc-2021-ESGO.79

Introduction/Background* SENTIX is a prospective cohort multicentric international study on sentinel lymph node (SLN) biopsy without pelvic lymph node dissection (PLND) in patients with early-stage cervical cancer. SLN frozen section (FS) and pathological ultrastaging were mandatory by the protocol. Samples from SLN were reviewed centrally for pathological assessment quality control. Only sites experienced in SLN biopsy technique could join the trial.

Methodology In total, 47 sites from 18 countries participated in the trial. Patients with FIGO 2009 stages T1A1/LVSI+ – T1B1 (<4 cm or ≤ 2 cm for fertility sparing), with common tumour types and no suspicious lymph nodes on imaging were registered in the trial. Patients remained in the trial after the surgery if SLN were detected on both sides of the pelvis and if SLN were negative on FS histological evaluation. Blue dye, radioactive tracer, indocyanine green or their combinations were all eligible tracers for SLN detection. Intraoperative SLN pathological processing consisted of SLN examination in one randomly selected slice. SLN ultrastaging protocol included a complete processing of all SLN tissue in slices of 2 mm thickness, 2 sections in 150 µm from each block until no tissue left, one stained with H&E and second examined immunohistochemically.

Abstract 950 Table 1 Patient's characteristics (N=733)

Parameter		N (%)/median (5-95th percentile)
Age		43 (29; 67)
	≤ 40	294 (40.1%)
	41-60	339 (46.2%)
	61+	100 (13.6%)
BMI	≤ 25	418 (57.0%)
	25-30	169 (23.1%)
	30+	141 (19.2%)
	NA	5 (0.7%)
ECOG PS	0	704 (96.0%)
	1	29 (4.0%)
Diagnostic method	Biopsy	331 (45.2%)
	Conization	399 (54.4%)
	NA	3 (0.4%)
Enrolled patients by site`s size:		
	≤10	126 (17.2%)
	21-20	81 (11.1%)
	21+	526 (71.8%)
Maximum preoperative tumour size (mm)	≤ 20	471 (64.2%)
	20.1-40	262 (35.8%)
Preoperative tumour stage (FIGO 2009)	1A1	32 (4.4%)
	1A2	54 (7.4%)
	1B1	647 (88.2%)
Tumour grade	G1	179 (24.4%)
	G2	373 (50.9%)
	G3	157 (21.4%)
	NA	24 (3.3%)
LVSI	yes	448 (61.1%)
Tumour type	SCC	508 (69.3%)
	AC	210 (28.6%)
	AS	9 (1.2%)
	NA	6 (0.8%)
Excluded:		83 (11.2%)
Preoperatively	Surgery cancelled	4 (0.5%)
	ICF withdrawn	4 (0.5%)
Intraoperatively	SLN not detected bilaterally	55 (7.5%)
	> 1B1	12 (1.6%)
Other		8 (1.1%)

Abstract 950 Table 2 SLN status assessed by frozen section and final ultastaging (N=650)

Type of SLN involvement	SLN status (No. of patients)			SLN frozen section outcome (%)		
	Frozen section	Ultrastaging	Final SLN status*	Sensitivity	False negativity	NPV
MAC	44	9	53	83.0%	17.0%	98.5%
MIC	4	26	30	13.3%	86,7%	95.7%
ITC	0	19	19	0.0%	100,0%	96.8%
MAC + MIC	48	35	83	57.8%	42,2%	94.2%
MAC + MIC + ITC	48	54	102	47.1%	52.9%	91.0%

Result(s)* Altogether 733 patients were registered until Sentix enrolment closure in October 2020, 83 patients were excluded (table 1) and 650 patients was analysed. Patients` characteristics are shown in table 1. Bilateral SLN detection rate reached 95%. FS detected macrometastases (MAC) in 44 cases and micrometastasis (MIC) in 4 cases. SLN ultrastaging found additional 9 cases with MAC, 26 with micrometastases (MIC) and all 19 cases with isolated tumor cells (ITC). Sensitivity of FS was 83.0% for the detection of MAC, 57.8% for pN1 status (MAC or MIC) and 47.1% for any type of SLN involvement (MAC, MIC, ITC). Table 2.

Conclusion* High bilateral detection rate of 95% was achieved in Sentix sites experienced in the SLN biopsy technique. Intraoperative pathological assessment of SLN failed to detect majority of MIC (86.7%), all cases with ITC and 42.2% with pN1 (MIC or MAC).

955 WATER-JET DISSECTION IN NERVE-SPARING RADICAL HYSTERECTOMY: POSTOPERATIVE OUTCOMES

S Mukhtarulina*, M Meshkova, O Trushina, H Maltsagova, E Novikova. *P.A. Hertsen Moscow Oncology Research Center – branch of FSBI NMRRC, the department of gynecologic oncology, Moscow, Russian Federation*

10.1136/ijgc-2021-ESGO.80

Introduction/Background* The development of a nerve-sparing technique of radical hysterectomy leads to a significant functional improvement after surgical treatment of cervical cancer. However, the risk of nerve fibers damage remains high because of difficulties in recognition of elements of the autonomic nervous system. One of approaches for precise nerve dissection is tissue-selective dissection with a water-jet. The main advantage of this method is selective dissection and preservation of nerve fibers and vessels with minimal deformation of the surrounding tissue. This study was aimed to evaluate

Int J Gynecol Cancer: first published as 10.1136/ijgc-2021-ESGO.80 on 12 October 2021. Downloaded from http://ijgc.bmj.com/ on April 19, 2024 by guest. Protected by copyright.

functional results after nerve sparing radical hysterectomy (RH type C1) in patients with stage IB1-IIA cervical cancer according to the International Federation of Gynecology and Obstetrics (FIGO 2018) staging system.

Methodology Inclusion criteria consisted of the following: histopathologically proven primary cervical cancer of squamous carcinoma, adenocarcinoma or adenosquamous carcinoma, stage IB1-IIA cervical cancer, the lack of preoperative radiation therapy or chemotherapy, ECOG PS 0-1 and normal bladder filling. The main group consisted of 26 patients with stage IB1-IIA cancer after RH type C1 using the water-jet technique. The hypogastric nerve, pelvic splanchnic nerves S2-S4 and vesicular branches of these plexus were selectively isolated under water pressure of 35 Bar. The comparison group A included 79 patients who underwent RH type C1 with the traditional technique. The comparison group B included 52 patients who accepted radical hysterectomy RH type C2.

Result(s)* The average duration of urinary bladder catheterization after surgery in the main group and comparison groups A and B was 2.9±1.8; 6.9±3.8 and 16.1±10.9 days, respectively ($p<0.05$). The average time for recording of residual urine volume less than 100 ml in the main group amounted to 3.8±1.2 days, in the comparison group A – 10.2±7.5 days, and in the comparison group B – 21.2±20.8 days ($p<0.05$). In the main group patients had no sign of bladder dysfunction whereas in comparison groups A and B patients encountered these symptoms in 7.6% and 26.2% of cases, respectively ($p<0.05$).

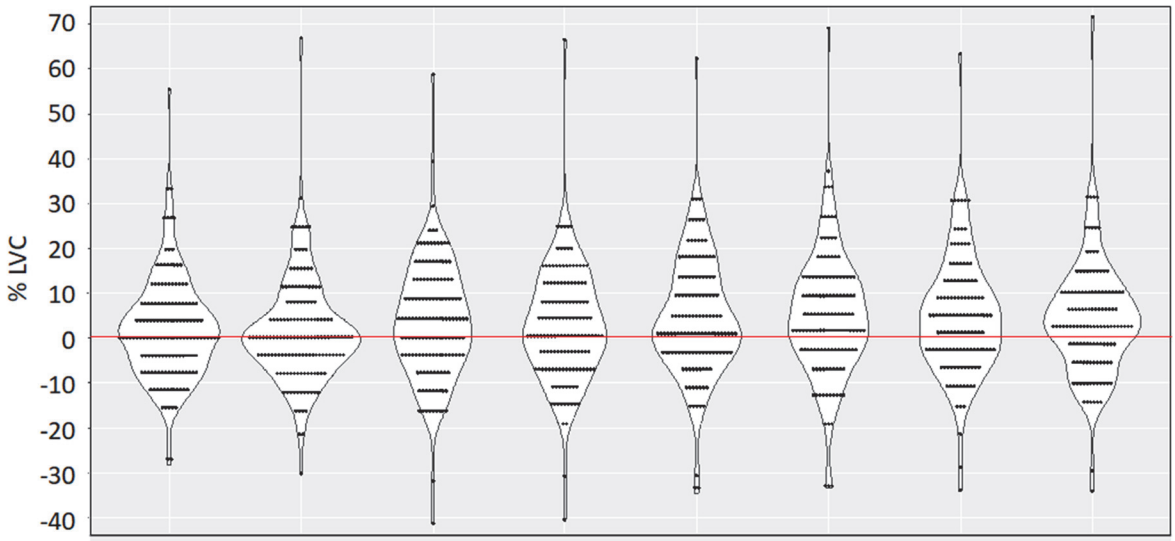
Conclusion* The first results suggest that using the water-jet technique in tissue incision contributes to the most atraumatic dissection of the autonomic nervous system. Thus, RH type C1 with water-jet dissection result in restoration of lower urinary tract functions in a shorter time.

959 CHALLENGES IN LOWER LIMB LYMPHOEDEMA ASSESSMENT BASED ON LIMB VOLUME CHANGE: LESSONS LEARNT FROM THE SENTIX PROSPECTIVE MULTICENTRE STUDY

[1;2]M Borčinová*, [1;2]R Kocián, [3]V Ragosch, [4]J Jarkovsky, [2;5]S Bajsová, [2;6]R Pilka, [7]B Gil Ibanez, [8]S Garrido-Mallach, [2;9]J Presl, [10]A Palop Moscardó, [11]S Tingulstad, [12;13]IB Vergote, [2;14]M Redecha, [15]F Raspagliesi, [16]W Szatkowski, [17]M Pakiz, [18]LC Snyman, [3]K Siegler, [1;2]D Cibula. [1]*First Faculty of Medicine, Charles University and General University Hospital, Prague, Czech Republic, Gynecologic Oncology Center, Department of Obstetrics and Gynecology, Prague, Czech Republic*; [2]*Central and Eastern European Gynecologic Oncology Group, CEEGOG, Czech Republic*; [3]*Asklepios-Clinic Hamburg, Department of Special Operative and Oncologic Gynaecology, Germany*; [4]*Faculty of Medicine, Masaryk University, Institute of Biostatistics and Analyses, Brno, Czech Republic*; [5]*University Hospital Ostrava, Department of Obstetrics and Gynecology, Ostrava, Czech Republic*; [6]*Palacky University, University Hospital Olomouc, Department of Obstetrics and Gynecology, Faculty of Medicine and Dentistry, Olomouc, Czech Republic*; [7]*Hospital Clinic-Institut d'Investigacions Biomediques August Pi i Sunyer (IDIBAPS), University of Barcelona, Unit of Gynecological Oncology, Institute Clinic of Gynaecology, Obstetrics, and Neonatology, Barcelona, Spain*; [8]*La Paz University Hospital, Gynecologic Oncology Unit, Madrid, Spain*; [9]*University Hospital in Pilsen, Department of Obstetrics and Gynecology, Pilsen, Czech Republic*; [10]*Instituto Valenciano de Oncologia (IVO), Gynecology Department, Valencia, Spain*; [11]*Trondheim University Hospital, Trondheim, Norway*; [12]*University Hospital Leuven, Leuven Cancer Institute, Department of Gynecology and Obstetrics, Leuven, Belgium*; [13]*Belgium and Luxembourg Gynaecological Oncology Group, BGOG*; [14]*University Hospital, Comenius University, Department of Gynaecology and Obstetrics, Bratislava, Slovakia*; [15]*Fondazione IRCCS Instituto Nazionale Tumori, Milan, Italy*; [16]*M. Sklodowska-Curie Memorial Institute, Krakow, Poland*; [17]*University medical Centre Maribor, Maribor, Slovenia*; [18]*Kalafong Provincial Tertiary Hospital, Pretoria, South Africa*

10.1136/ijgc-2021-ESGO.81

Introduction/Background* Lower limb lymphoedema (LLL) is the most disabling adverse effect of surgical staging of pelvic lymph nodes. In studies, LLL is often assessed by calculation of limb volumes based on five circumference measurements. However, the lack of standardisation of this method hinders direct comparison between the studies and makes LLL



	FU6 vs. preoperative		FU12 vs. preoperative		FU18 vs. preoperative		FU24 vs. preoperative	
	Right Leg	Left leg	Right Leg	Left leg	Right Leg	Left leg	Right Leg	Left leg
change by ≥ 20 %	6.0%	7.4%	8.3%	5.5%	11.2%	11.2%	11.6%	8.6%
change by 10 to 19%	13.4%	13.4%	20.7%	20.7%	18.7%	23.9%	17.8%	18.0%
change by 0 to 9%	38.9%	30.9%	30.3%	32.4%	33.6%	31.3%	29.5%	40.6%
change by -9 to 0%	31.5%	36.2%	27.6%	29.0%	27.6%	21.6%	30.2%	21.1%
change by -19 to -10%	8.7%	10.1%	11.7%	10.3%	6.7%	9.0%	8.5%	10.2%
change by > -20%	1.3%	2.0%	1.4%	2.1%	2.2%	3.0%	2.3%	1.6%

Abstract 959 Figure 1 Distribution of the limb volume change (from preoperative assesment; LVC) of right and left lower limb during the folloe-up-period. Each dot on the violin plot represents the LVC of one patient's limb. 6M: six months post-surgery; 12M months post-surgery; 18M months post-surgery; 24M: 24 months post-surgery.

Int J Gynecol Cancer: first published as 10.1136/ijgc-2021-ESGO.80 on 12 October 2021. Downloaded from http://ijgc.bmj.com/ on April 19, 2024 by guest. Protected by copyright.