23.5%) Risk of recurrence prediction was quite similar between calculated and observed. (26.7% calculated and 25.6% observed) In low risk group, FIGO stage (p=0.004) and old age (p=0.04) was related of the risk of recurrence using univariate analysis.
Conclusion* The KGOG-1024 risk assessment model accurately predicted a distant recurrence after chemoradiation in patients with locally advanced cervical cancer, especially in intermediate-risk group. The model may be helpful in identifying patients who may benefit from adjuvant systemic treatment after chemoradiation.

1169 ROBOTIC-ASSISTED LYMPHADENECTOMY IN PREGNANCY AS CERVICAL CANCER STAGING – A CASE REPORT

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Introduction/Background* Cervical cancer represents one of the most commonly diagnosed tumours in pregnancy. Robotic-assisted surgery is considered the standard method for surgical staging of cervical cancer. There is a very limited data in the available literature on the use of this method to perform lymphadenectomy in patients with cervical cancer during pregnancy. In the case report we describe the procedure of robotic pelvic lymphadenectomy in a patient with cervical cancer T1b in pregnancy.
Methodology A 43 years old nulliparous woman pregnant for the third time was referred to our department with a confirmed cervical adenocarcinoma in the 15th week of pregnancy. According to the preoperative imaging examination (pelvic MRI scan, expert sonography), she suffered from stage T1b cervical cancer. The patient preferred the continuation of the pregnancy. Informed about the associated risks, she signed an informed refusal rejecting proposed radical surgical treatment. Based on the recommendation of the multidisciplinary team of gynaecological oncology, a surgical staging procedure was indicated before possible neoadjuvant systemic therapy. The robotic-assisted laparoscopic lymphadenectomy was performed on 21.5.2020 as a surgical modality of a minimally invasive approach. The procedure was performed without any complications, blood loss was up to 20 ml. Histopathological examination excluded the cancer dissemination into the lymph nodes. Subsequently, systemic treatment (cisDDP + Paclitaxel) was administered for 9 cycles to ensure adequate foetal maturity. Planned caesarean sections combined with a radical surgical treatment – radical hysterectomy and bilateral adnexectomy – were performed in gestational age 30 weeks and 5 days.
Result(s)* According to definitive histology and after the neoadjuvant treatment the stage of the disease was classified as FIGO IA1 ypT1a1 ypN0 ypMX Mandard TRG3. A close follow-up is ongoing in the patient.
Conclusion* In pregnant patients with cervical cancer, robot-assisted laparoscopic lymphadenectomy is a very gentle and effective method of staging.

Diagnostics

133 ACCURACY OF TRANSVAGINAL/TRANSRECTAL ULTRASOUND IN PREOPERATIVE PELVIC LYMPH NODE ASSESSMENT IN CERVICAL CANCER PATIENTS

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Introduction/Background* The aim of the study was to evaluate diagnostic accuracy of ultrasound in preoperative assessment of pelvic lymph nodes (LNs) in cervical cancer patients.
Methodology Patients were retrospectively included if they met following inclusion criteria: 1) histologically verified cervical cancer; 2) preoperative ultrasound examination performed by one of three experienced sonographers (transvaginal or transrectal and transabdominal approach); 3) surgical lymph node staging (sentinel lymph node biopsy, SLNB and/or systematic pelvic lymphadenectomy, PLND or pelvic lymph node debulking). The final pathological examination served as the

Abstract 133 Table 1 Characterisation of study population

Characteristic	Value (N = 394)[a]
Age, median (range), years	43 (20 – 82)
BMI, median (range)	24.5 (14.1 – 44.9)
Histological type	
Squamous cell carcinoma	298 (75.6)
Adenocarcinoma	79 (20.0)
Neuroendocrine carcinoma	13 (3.4)
Other	4 (1.0)
Stage (FIGO 2009)	
IA1	18 (4.5)
IA2	15 (3.8)
IB1	236 (60.0)
IB2	44 (11.1)
IIA1	5 (1.2)
IIA2	2 (0.5)
IIB	47 (12.0)
IIIA	1 (0.3)
IIIB	3 (0.8)
IVA	2 (0.5)
IVB	21 (5.3)
Type of pelvic LN staging	
SLNB only	87 (22.1)
SLNB + PLND	241 (61.1)
PLND only	35 (8.9)
Debulking of pelvic LNs only	31 (7.9)
Pelvic LN status	
Normal	308 (78.2)
Macrometastases (± MIC ± ITC)	53 (13.5)
Micrometastases (± ITC)	23 (5.8)
Isolated tumour cells only	10 (2.5)

[a]Data are presented as number (percentage) of patients unless otherwise indicated.

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