(LND). However, several low- and middle-income countries lack gynecological oncology expertise. We present our outcomes from treating patients with stage IA2-IB1 cervical cancer with neoadjuvant chemotherapy (NACT) followed by a simple hysterectomy and LND in absence of a gynecological oncologist.

Methods Between 2017 and 2019, 8 women with early stage cervical cancer (IA2-IB1) with tumor size less than 2cm and absence of lymphovascular invasion in Botswana were treated with 3 cycles of NACT (carboplatin and paclitaxel) followed by a simple hysterectomy and pelvic LND performed by a general gynecologist.

Results The median age at surgery was 50 years (42–63). Six women (75%) had stage IB1 disease. Six women (75%) were HIV-positive. Three patients (38%) had a pathological complete response with no detectable tumor on final pathology, and the other 5 patients (62%) had a partial response to chemotherapy and were able to undergo surgery. All patients completed chemotherapy as prescribed. None of the women had any high risk features consistent with Peters or Sedlis criteria. Median follow-up time was 3.5 years. One patient died 6 months after treatment due to a non-cancer related cause (accident). Overall survival for all patients was 87.5% and cause-specific survival was 100%.

Conclusions These pilot data suggest favorable outcomes with NACT followed by a simple hysterectomy and LND for women with early stage cervical cancer in Botswana.

EPV066/#382

PRELIMINARY RESULTS OF NIRAPARIB AND BRIVANIB DUAL THERAPY EVALUATION IN RECURRENT, METASTATIC AND PERSISTENT CERVICAL CANCER (CQGOG0101: AN OPEN-LABEL, SINGLE ARM, PHASE II CLINICAL TRIAL

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Objectives The aim of this study (CQGOG 0101) is to evaluate the safety and activity of Niraparib (an oral PARP1/2 inhibitor) combined with brivanib in patients with recurrent, metastatic, or persistent cervical cancer.

Methods The CQGOG0101 study is an open-label, single-arm, single-center, phase 2 trial.

Results Between May 8th, 2020 and Jan 22nd, 2021, 9 patients (median age, 50 years old [28–73]) were enrolled. Patients had received a median of two (1–3) previous lines of platinum-based therapy. All of nine patients had distant metastatic lesions and had underwent at least one post-baseline tumor assessment (To deadline for submission), including 1 confirmed partial response, 4 with stable disease, 4 with progressive disease. Median duration of treatment was 3.8 months (3–8.2), three patients were still on treatment. No drug-related

Abstract EPV066/#382 Figure 1 Study design

Abstract EPV066/#382 Table 1 Brief inclusion and exclusion criteria

Inclusion Criteria:	Exclusion Criteria:
1. Subjects join the study voluntarily and sign the informed consent;	1. Patients who are known to be allergic to niraparib or the active or inactive ingredients of drugs with similar chemical structure to niraparib
2. The damage caused by other treatments has recovered (NCI CTCAE 5.0 version grade $\leq$ 1), ECOG physical status score is 0-2;	2. Patients who are known to be allergic to toripalimab or the active or inactive ingredients of drugs with similar chemical structure to toripalimab
3. Life expectancy $\geq$ 3 months;	3. Factors that significantly affect the absorption of oral drugs, such as inability to swallow, chronic diarrhea, and intestinal obstruction with clinical significance;
4. Female subjects are 18 to 70 years old;	4. Patients with symptomatic, uncontrol-able brain metastases or pial metastases;
5. Histologically confirmed squamous cell carcinoma, adenosquamous carcinoma, or adenocarcinoma of the cervix;	5. Major surgery was performed within 3 weeks before enrollment;
6. Subjects with recurrent, persistent or metastatic cervical cancer not amenable to curative treatment with surgery and/or radiation therapy;	6. Palliative radiotherapy was performed on $>$ 20% bone marrow within 1 week before enrollment;
7. Measurable lesions must be required: a tumor lesion has a long diameter $\geq$ 5mm and a lymph node must be 10 mm in short axis when assessed by CT scan, CT scan slice thickness recommended to be no greater than 5 mm (defined by RECIST 1.1)	7. Aggressive cancer other than cervical cancer has been diagnosed within 2 years before enrollment (except for fully treated basal or squamous cell skin cancer);
8. Subjects agree to take a blood sample;	8. Patients who have previously or currently diagnosed myelodysplastic syndrome (MDS) or acute myeloid leukemia (AML);
9. Subjects have enough organ function;	9. Serious or uncontrolled diseases, including but not limited to:
10. Women of child-bearing age should have negative results of serum or urine pregnancy test within 14 days before recruited and must not be in lactation. Women are willing to adopt the appropriate methods of contraception during the trial and 3 months after last administration.	i. Uncontrollable nausea and vomiting, inability to swallow the study drug, any gastrointestinal disease that may interfere with the absorption and metabolism of the drug;
	ii. Active viral infections such as human immunodeficiency virus, hepatitis B, hepatitis C, etc;
	iii. Uncontrolled grand mal seizures, unstable spinal cord compression,

grade 3 or worse treatment-emergent adverse events were detected, the most common grade 1–2 adverse events (AEs) included: neutropenia (4 of 9 patients), anemia (2 of 9 patients), thrombocytopenia (1 of 9 patients), hypertension (2 of 9 patients), proteinuria (1 of 9 patients), fatigue (1 of 9 patients), and increased ALT/AST (1 of 9 patients).

Conclusions This combo seems to show a similar efficacy compared to other recurrent cervical cancer late-line therapies. We are also seeking to amend the protocol and explore niraparib combined with immunotherapy in recurrent CC in our trial later. Clinical trial information: NCT04395612.

EPV067/#391

QUALITY CONTROL IN EARLY STAGE CERVICAL CANCER MANAGEMENT: A SINGLE-INSTITUTION'S EXPERIENCE

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Objectives Institutional quality control measures, such as monthly quality assessment meetings and stricter patient selection criteria for operation method, have been implemented since 2014 to better monitor cancer patient management. In this study, we evaluated effects of such monitoring on the clinical outcomes of cervical cancer patients.

Abstracts

Methods Medical records of cervical cancer patients who received operation in our institution from January 2007 to December 2018 were retrospectively reviewed. Cases were divided into 2 period groups (group 1, 2007–2013, and group 2, 2014–2018), based on the date of operation. Between the two groups, clinical outcomes, including clinicopathologic variables, surgical methods, operative details, adjuvant treatments, 3-year recurrence rates and disease-free survivals (DFS) were compared.

Results A total of 331 cervical cancer patients were included in the study analysis, 224 patients in group 1 and 107 in group 2. Overall, minimally invasive surgery (MIS) was more frequently performed in group 2 (56.3% vs. 69.2%, $p=0.025$), especially in earlier stages (stage IA, 69.0% vs. 100.0%; stage IB1, 52.9% vs. 67.3%). However, the mean tumor size of stage IB cervical cancer cases treated by MIS was significantly smaller in group 2 (23.6 vs. 17.7 mm, $p=0.019$). In addition, adjuvant treatment was less frequently performed in group 2, especially in stage IB1 (52.9% vs. 32.7%, $p=0.015$). There was a trend of decreased 3-year recurrence rates (8.5% in group 1 vs. 4.7% in group 2, $p=0.211$).

Conclusions Institutional quality control monitoring positively affected clinical outcomes of cervical cancer patients.

EPV068/#398

RANDOMIZED CONTROLLED TRIAL OF THE EFFICACY OF ADJUVANT CHEMOTHERAPY IN PATIENTS WITH RESIDUAL LESIONS AFTER CONCURRENT CHEMORADIATION THERAPY FOR LOCALLY ADVANCED CERVICAL CANCER (CQGOG0102)

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Objectives The aim of this trial is to compare response rate and survivals of locally advanced stage cervical cancer patients with residual lesions who had Concurrent Chemoradiation therapy (CCRT) alone to those who had adjuvant chemotherapy after CCRT.

Methods The CQGOG0102 study is a single-center, randomized controlled trial. The patients who have residual lesions after CCRT are randomized to arm A by observation or arm B by adjuvant chemotherapy with paclitaxel plus cisplatin every 3 weeks for 3 cycles.

Results In our center, a retrospective study found that residual lesion after CCRT was one of the most important prognostic factors in patients with LACC. PFS and OS was decreased when the size of the residual lesion was over 10 mm. A

PS: All the patients with residual lesions of cervix will undergo the cervical biopsy by ultrasound localization.

Abstract EPV068/#398 Figure 1 Study design

Abstract EPV068/#398 Table 1 Brief inclusion and exclusion criteria

Inclusion Criteria:	Exclusion Criteria:
1. Cervical cancer stage IIB to IVA with a histopathology of squamous cell carcinoma, adenosquamous cell carcinoma, adenocarcinoma	1. Activity or uncontrol severe infection
2. Complete CCRT(Radiation Dose: A point 85Gy(±10%), B point 50Gy(±10%), concurrent platinum-containing chemotherapy)	2. Liver cirrhosis, Decompensated liver disease
3. MRI is performed within 4 weeks after CCRT and shows residual lesions (non-lymph node ≥10mm, lymph node shortest diameter ≥15mm).	3. History of immune deficiency, including HIV positive or suffering from congenital immunodeficiency disease
4. ECOG ≤2	4. Patients who cannot tolerate chemotherapy because of chronic renal insufficiency or renal failure
5. Expected survival is longer than six months	5. Have suffered or combined with other malignant tumor
6. Hb ≥70g/L, WBC ≥3.5 × 10 ⁹ /L, ANC ≥1.5 × 10 ⁹ /L, PLT ≥80 × 10 ⁹ /L	6. Myocardial infarction, severe arrhythmia and NYHA (New York heart association) ≥2 for congestive heart failure
7. ALT and AST ≤2 × ULN, Serum creatinine ≤1.5 × ULN	7. A history targeted therapy or pelvic artery embolization
8. The serum or urine pregnancy test must be negative within 7 days before enrollment for the women of childbearing age who should agree that contraception must be used during the trial	8. Artery-venous thrombosis within 6 months
	9. Patients with autoimmune diseases
	10. Complications, need to be treatment with drugs which may lead to liver or kidney injury
	11. Patients with disease progression after chemoradiation

further study showed that patients with residual lesion after CCRT treated with ACT had a significantly longer PFS compared to patients without ACT (22.4m vs. 12m, $p < 0.05$). So, we designed the randomized controlled trial, CQGOG0102, to evaluate the efficacy of ACT in LACC with residual lesions after CCRT. At present, 30 patients have been enrolled. Pathological evidence of cervical residual lesion was identified in 23.3% (7/30). This trial is currently open and enrolling patients.

Conclusions ACT may improve the prognosis of LACC who has the residual lesion after CCRT. We will report the primary, midterm and final results about this study in the future. Clinical trial information: NCT04409860

EPV069/#40

SYSTEMATIC COMPARISON OF INTERNATIONAL TREATMENT GUIDELINES FOR LOCALLY ADVANCED CERVICAL CANCER

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Objectives Globally, cervical cancer is a leading cause of death. Lack of international consensus on standard-of-care (SoC) treatment for locally advanced cervical cancer (LACC) (Stages IB2-IVA) may contribute to inconsistent treatment. We compared LACC treatment recommendations from international guidelines.

Methods Literature databases (1999–2020), national authority websites, and bibliographies were searched for English-language cervical cancer guidelines, with no restriction on