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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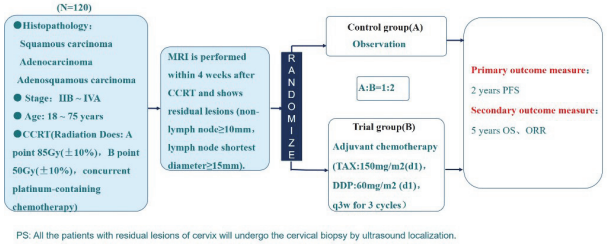
10.1136/ijgc-2021-IGCS.136

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 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



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 2. Complete CCRT(Radiation Does: A point 85Gy(+/-10%), B point50Gy(+/-10%), concurrent platinum-containing chemotherapy) 3. MRI is performed within 4 weeks after CCRT and shows residual lesions (non-lymph node≥10mm, lymph node shortest diameter≥ 15mm). 4. ECOG<2 5. Expected survival is longer than six months 6. Hb≥70g/L、WBC≥3.5×10⁹/ L 、ANC≥1.5×10⁹/L、PLT≥80×10⁹/L 7. ALT and AST≤2×ULN, Serum creatinine≤1.5×ULN 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	1. Activity or uncontrol severe infection 2. Liver cirrhosis, Decompensated liver disease 3. History of immune deficiency, including HIV positive or suffering from congenital immunodeficiency disease 4. Patients who cannot tolerate chemotherapy because of chronic renal insufficiency or renal failure 5. Have suffered or combined with other malignant tumor 6. Myocardial infarction, severe arrhythmia and NYHA (New York heart association)≥2 for congestive heart failure 7. A history targeted therapy or pelvic artery embolization 8. Artery-enous 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

EPV069/#40 SYSTEMATIC COMPARISON OF INTERNATIONAL TREATMENT GUIDELINES FOR LOCALLY ADVANCED CERVICAL CANCER

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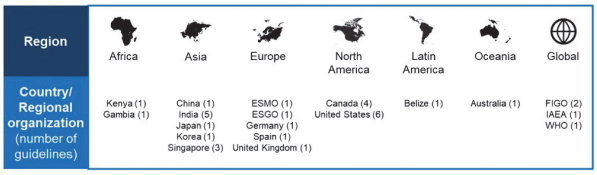
10.1136/ijgc-2021-IGCS.137

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



Abstract EPV069/#40 Figure 1

geography. Included guidelines were treatment-focused and represented the latest update.

Results Thirty-four guidelines were identified (figure 1), with the majority updated 2016–2021. Seven provided only high-level overviews of treatment modalities, and were excluded. Treatment recommendations were based on FIGO 2009 (n=20 guidelines), FIGO 2018 (n=6), and TNM (n=1) staging. For Stage IB2-IIA2, treatment options were diverse within/between guidelines and included radical hysterectomy (RH), cCRT, radiotherapy. The most common recommendation was a choice of RH/cCRT (IB2 n=12; IIA n=18), with variable treatment selection criteria between guidelines. Adjuvant cCRT/radiotherapy after RH was advisable with high/intermediate recurrence risk (n=23). For Stage IIB-IVA, cCRT was SoC, with ≥67% guideline consensus. However, for Stage IIB, surgery was SoC in Japan/Germany. Ten guidelines offered Stage IVA treatment alternatives. Kenya/Gambia recommendations were distinct, offering chemotherapy alone and/or excluding cCRT. Consensus cCRT regimen was weekly cisplatin (40mg/m^2) concurrent with external beam radiotherapy followed by brachytherapy; for 6 guidelines it was unclear if cCRT included brachytherapy.

Conclusions With few exceptions, there is international consensus for cCRT as SoC for Stage IIB-IVA LACC, whereas recommendations for Stage IB2-IIA disease varied. Funding: AstraZeneca

EPV070/#401 RANDOMIZED CONTROLLED TRIAL OF THE EFFICACY OF LYMPH NODE DISSECTION ON STAGE IIICR OF CERVICAL CANCER (CQGOG0103)

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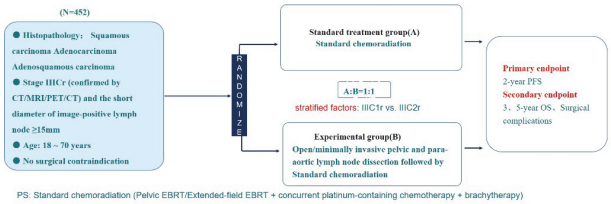
10.1136/ijgc-2021-IGCS.138

Objectives Our goal is to assess the impact of lymph node dissection on stage IIICr of cervical cancer and to examine the specific complications of this therapy

Methods This is an national, prospective, multicenter and randomized clinical study designed to determine if patients with stage IIICr of cervical cancer have longer PFS and/or OS with lymph node dissection before Concurrent Chemoradiation therapy (CCRT) when compared to CCRT.

Results In our center, a study showed that surgical staging of women with locally advanced cervical cancer can provide more accurate information than CT/MRI scans and resulted in a longer PFS when the short diameter of image-positive lymph node ≥15mm (33m vs. 24m, p <0.05). Therefore, we designed the randomized controlled trial, CQGOG0103, to determine if patients with stage IIICr of cervical cancer have longer PFS and/or OS with lymph node dissection before CCRT when compared to CCRT. Up to today, 9 patients have been enrolled. This trial is currently open and enrolling patients.

Conclusions Lymph node dissection may improve the prognosis of stage IIICr of cervical cancer. We will report the primary, midterm and final results about this study in the future.



Abstract EPV070/#401 Figure 1 Study design

Abstract EPV070/#401 Table 1 Brief Inclusion and Exclusion Criteria

Inclusion Criteria:	Exclusion Criteria:
1. Histopathology: squamous cell carcinoma, adenocarcinoma, adeno-squamous cell carcinoma 2. Cervical cancer stage IIICr (confirmed by CT/MRI/PET/CT) and the short diameter of image-positive lymph node ≥15mm 3. ECOG score 0~1 4. Expected survival over 6 months 5. 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 6. No surgical contraindication	1. Activity or uncontrol severe infection 2. Liver cirrhosis, Decompensated liver disease 3. History of immune deficiency, including HIV positive or suffering from congenital immunodeficiency disease 4. Chronic renal insufficiency or renal failure 5. Has combined with other malignant tumor which diagnosed within 5 years and/or needed to be treated 6. Myocardial infarction, severe arrhythmia and NYHA (New York heart association) ≥2 for congestive heart failure 7. A history of pelvic artery embolization 8. A history of pelvic radiotherapy 9. A history of partial hysterectomy or radical hysterectomy 10. A history of severe allergic reaction to platinum drugs 11. During the treatment for complications, the drugs which lead to serious liver and/or kidney function impairment need to be used, such as tuberculosis

EPV071/#412 DOSIMETRIC STUDY ON OCCULT UTERINE PERFORATION DURING IMAGE-GUIDANCE BRACHYTHERAPY OF CERVICAL CANCER

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10.1136/ijgc-2021-IGCS.139

Objectives Based on occult perforation CT images during brachytherapy in cervical cancer, to evaluate the dosimetric parameters between 3D plan and 2D plan for providing clinical reference.

Methods The patients with cervical cancer who received intracavitary (intrauterine tandem + vaginal colpostats) were retrospectively reviewed between January 2019 to December 2020 at Chongqing University Cancer Hospital. Based on Oncentra Brachytherapy planing system, same prescription 6Gy, design 3D and 2D plan on perforated CT images respectively. Target volume, conformity index (CI), conformal index (COIN) and organs-at-risk (OARs) D2cc were assessed in two plans.

Results A total of 817 patients were included in this study. Perforations were observed in 16 patients (1.96%). The volume of prescription dose curve in the 3D plan was significantly reduced 50.72±4.73 cm3 than 2D plan (P<0.05), but there was a similar volume of HR-CTV; the CI and COIN of 3D plan were promoted 0.41±0.01 and 0.35±0.78 than 2D plan (P<0.05), respectively; the dose received by OARs (bladder, rectum, sigmoid, small intestine) D2cc in 3D plan were significantly decerased [(241.97±86.64) cGy, (158.89±46.14)