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FERTILITY-SPARING TREATMENT IN PATIENTS WITH IB1 CERVICAL CANCER – RESULTS OF THE INTERNATIONAL MULTICENTRE RETROSPECTIVE FERTISS STUDY (ENGOT CX14; CEEGOG CX-03)

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Introduction/Background One of the key conditions for selecting candidates for fertility sparing treatment (FST) is a tumour size not exceeding 2 cm in the largest dimension. While there is a consensus on the choice of surgical treatment in stage IA, both radical (radical trachelectomy) and non-radical (simple trachelectomy or conisation) procedures are advocated in stage IB1, often depending on tumor size (>1 cm vs. 1–2 cm) and the presence of LVSI.

Methodology Patients with IB1 cervical cancer were recruited from the international multicenter retrospective FERTISS study. Inclusion criteria were lymph node negativity, age 18–40 years, and any type of FST, regardless of neoadjuvant chemotherapy, histotype, or tumour grade. Parameters representing disease and treatment characteristics were analyzed for risk of recurrence.

Results A total of 356 stage IB1 patients from 44 institutions in 13 countries were enrolled in the study. The mean age of the patients was 31.7 years, 70.2% of them were nulliparous. One-third of the tumours were adenocarcinomas and one-third of cases were LVSI positive. Oncological treatment characteristics are summarized in table 1. During median follow-up of 72 months there were 27 recurrences (7.6%) and 8 deaths (2.3%) from the disease. Recurrence rates did not differ between patients after non-radical cervical procedures (conization or simple trachelectomy) and radical trachelectomy (7.5% vs. 7.7%; $p=0.957$), even after subgroup analysis according to tumour size (<1 cm: 5.2% vs. 7.4%; $p=0.507$; 1–2 cm: 10.9% vs. 8%; $p=0.553$) or presence of LVSI (11.5% vs. 9.4%; $p=0.725$) (table 2).

Abstract 2022-RA-689-ESGO Table 1 Overview of oncological treatment

Stage		IB1 (N=356)
NACT		
No		330 (92.7%)
Yes		26 (7.3%)
Type of LN staging		
Sentinel lymph node biopsy		171 (48.0%)
Pelvic lymphadenectomy		310 (87.1%)
Paraortic lymphadenectomy		15 (4.2%)
Type of cervical procedure		
Non-radical Procedures	Conization	133 (37.4%)
	Simple vaginal trachelectomy	27 (7.6%)
Radical procedures	Laparoscopic radical trachelectomy	30 (8.4%)
	Radical abdominal trachelectomy	93 (26.1%)
	Radical vaginal trachelectomy	67 (18.8%)
	Robotic radical trachelectomy	6 (1.7%)
Repeated cervical procedure		N=65
Hysterectomy		3 (4.6%)
Laparoscopic radical trachelectomy		1 (1.5%)
Radical abdominal trachelectomy		3 (4.6%)
Radical vaginal trachelectomy		4 (6.2%)
Re-conization		37 (56.9%)
Robotic radical trachelectomy		4 (6.2%)
Simple vaginal trachelectomy		13 (20.0%)
Adjuvant chemotherapy		
No		343 (96.3%)
Yes		13 (3.7%)

Abstract 2022-RA-689-ESGO Table 2 Recurrences risk according to different radicality of FST

Category (N; %)	Recurrence				p-value
	Yes		No		
	Less radical	Radical	Less radical	Radical	
IB1	12 (7.5%)	15 (7.7%)	148 (92.5%)	181 (92.3%)	0.957
IB1 L1	6 (11.5%)	5 (9.4%)	46 (88.5%)	48 (90.6%)	0.725
IB L0	4 (4.4%)	8 (6.5%)	86 (95.6%)	115 (93.5%)	0.520
IB1 (<1 cm)	5 (5.2%)	9 (7.4%)	91 (94.8%)	112 (92.6%)	0.507
IB1 (1-2 cm)	7 (10.9%)	6 (8.0%)	57 (89.1%)	69 (92.0%)	0.553

L1 = Lymphovascular space invasion positivity; L0 = Lymphovascular space invasion negativity

Conclusion We have demonstrated that in patients with HPV-associated tumour types, negative regional lymph nodes, and tumour size ≤ 2 cm, oncological outcome after FST is excellent, and it is not inferior after non-radical cervical procedures.

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HIGH GRADE SQUAMOUS INTRAEPITHELIAL LESIONS IN PREGNANCY: CASE SERIES OF 35 PATIENTS

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Introduction/Background Reports on outcomes and the impact of mode of delivery on the clinical course of cervical high-grade squamous intraepithelial lesions (HSIL) during pregnancy and the postpartum period are limited and inconsistent.

Methodology Data of 35 pregnant women with morphologically verified cervical HSIL who were referred to Outpatient Department at NN Alexandrov National Cancer Centre between 2006 and 2021 were retrieved. Median age was 31 (range, 23–43) years. Median weeks of gestation at first examination during pregnancy was 17 (range, 8–34). The progress and outcomes of cervical HSIL and the association with delivery mode were retrospectively analyzed.

Results Median of follow-up was 49 (range, 5.8–162) months. Among 35 women, 24 (68.5%) delivered vaginally and 11 (31.5%) underwent caesarean section. Data of postpartum biopsy or morphology of resected cervical specimen were evaluated from all patients. Postpartum regression of HSIL was noted in 9 cases (25.7%), persistence – in 26 (74.3%). There was not progression of HSIL into invasive cancer during pregnancy. Postpartum regression of HSIL was reported in 7 women who gave birth vaginally (7/24, 29.2%) and in 2 (2/11, 18.2%) women who had a caesarean section ($p = 0.685$). Among women who delivered vaginally and by caesarean section, 17 (17/24, 68.0%) and 9 (9/11, 81.8%) women, respectively, had persisted lesions after delivery ($p=0.685$).

Conclusion According to our data, postpartum regression of HSIL was noted in every fourth case (25.7%). The higher rate of regression of HSIL (29.2% vs 18.2%, $p=0.685$) and the lower rate of persistent lesions (68.0% vs 81.8%, $p=0.685$) in association with vaginal delivery compared with caesarean section were established. None of the women had progression of the invasive disease. Despite the small number of patients, postpartum results suggest that the presence of HSIL in pregnant women is not an indication for caesarean section.

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LAPAROSCOPIC RADICAL TRACHELECTOMY FOR EARLY CERVICAL CANCER – SAFE, EFFECTIVE AND FEASIBLE

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Introduction/Background Radical trachelectomy (RT) is a viable alternative in selected women who wish to preserve fertility with comparable oncological outcomes to radical hysterectomy. Laparoscopic/robotic routes are associated with better outcomes for recovery, aesthetics and blood loss. RT is undertaken for tumours <2 cm. Uterine artery conservation during LRT is associated with best fertility outcomes.

Methodology We report a case of LRT with uterine artery preservation and bilateral pelvic lymphadenectomy performed at Guy's & St Thomas' Cancer Centre in United Kingdom. This video illustrates this technique in a nulligravida woman who was 33 years old and keen to preserve fertility. She had an abnormal cervical smear followed by a large loop excision of transformation zone (LLETZ) for CIN 3. Histology of LLETZ diagnosed G3 endocervical adenocarcinoma FIGO stage IA2 completely excised (tumor

size 3.3 mm width and 3.5 mm depth with an extra focus of 1 mm). There was no lympho-vascular space invasion (LVSI). There was associated CIN-2 and high grade CGIN. Pre-operative MRI pelvis and CT chest & abdomen did not identify any metastases.

Results The histology specimen included a cervix with vaginal cuff and attached parametrial tissue and measured 55x50x25 mm. There was no residual cancer in the specimen or lymph nodes. The pelvic lymph node count was 18. The catheter was removed in 48 hrs and bladder assessed by measuring post-void residual volume. The patient was discharged on second day after surgery without complications. She continues to be under surveillance with a disease free interval of 21 months and has not yet tried to conceive.

Conclusion LRT and LND with uterine artery preservation is feasible in young women who desire future fertility. It is a safe option for early cervical cancer with <2 mm size. Advantages with minimally invasive procedures, include enhanced visualization, precise dissection, less blood loss, fewer complications, and shorter hospital stay.

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ALL-CAUSE AND CANCER-SPECIFIC MORTALITY AFTER FERTILITY-SPARING SURGERY FOR STAGE I EPITHELIAL OVARIAN CANCER

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Introduction/Background To compare all-cause and cancer-specific mortality between women who underwent fertility-sparing (FS) surgery with those who underwent standard surgery for stage I epithelial ovarian cancer.

Methodology A cohort study using data from the California Cancer Registry, identified women ages 18–45 diagnosed with stage IA and IC epithelial ovarian cancer between 2000–2015. Fertility-sparing (FS) surgery was defined as retention of at least one ovary and the uterus. Standard surgery included removal of one or both ovaries, the uterus, and possible additional structures. The primary outcome was survival based on time from diagnosis to death or study completion. Inverse probability of treatment propensity score matching was used to create cohorts balanced on covariates of interest. Survival analysis was conducted with Kaplan-Meier method and Cox proportional hazards modeling.

Results We identified 799 women ages 18–45 diagnosed with stage IA or IC epithelial ovarian cancer between 2000–2015. 265 (33.1%) received FS surgery. There was an increasing trend in FS surgery over the study period (21% in 2000 to 46% in 2015). Before matching, there were significant ($P<0.05$) differences in age at diagnosis, race/ethnicity, marital status, rurality, tumor size, grade, histology, receipt of chemotherapy and lymph node dissection. Propensity-score matching yielded a matched cohort of 176 women who did and 176 women who did not receive FS surgery, balanced on observed covariates. There were 16 overall deaths in the fertility-sparing cohort (median follow-up, 7.3 years), and 21 deaths in the control cohort (median follow-up, 8.2 years). Fertility-sparing