Methodology Eligible patients had FIGO 2009 stage IB2-IIIB cervical cancer with no or only limited (≤5 mm) vaginal involvement. Comprehensive assessment of vaginal changes was done before treatment, at 4–6 weeks and 3, 6, 12 and 24 months thereafter using CTCAE v3.0 and additional assessments. PRO were assessed at the same timepoints using validated Quality of Life (EORTC QLQ-C30 and CX24) and sexual questionnaires. Statistical methods included generalized linear mixed model analysis and Spearman's rho correlation coefficients.

Abstract 2022-RA-934-ESGO Figure 1 Vaginal changes clinical measuremnts over time (some of the CTCAE and additional assessments). The proportion of woman is shown in percentages. BM = baseline measurement; CTCAE = common terminology criteria for adverse events; DM = diameter; M = months; N = number of woman astrisk at the specific timepoint; O = observed number of women at the specific timepoint; W = weeks

Results 113 eligible patients were included. Over time, mild (grade 1) vaginal changes were reported in 10.8–36.8% of the participants. Of the 113 participants, 46.7% reported not being sexually active at 24 months, mostly because of losing interest in sex or lacking a partner. Among the sexually active women (41–54/113), 43.2–51.3% reported vaginal functioning problems starting at 4–6 weeks and more severe sexual problems and distress were reported by 5–15% of them. Significant differences ($p \leq .05$) in physician-assessed vaginal morbidity were found between baseline and follow-up, without further clear changes. No or only small associations between vaginal changes and vaginal functioning problems and sexual distress were found.

Conclusion Relatively mild vaginal changes were reported after image-guided radio(chemo)therapy and brachytherapy according to EMBRACE-protocol. Vaginal functioning problems were reported by almost half of the sexually active women, while more severe problems and distress were reported by up to 15% of them. These results are favourable compared to previous data, potentially due to the combination of tumours with limited vaginal involvement and EMBRACE-specific treatment optimization and rehabilitation recommendations.

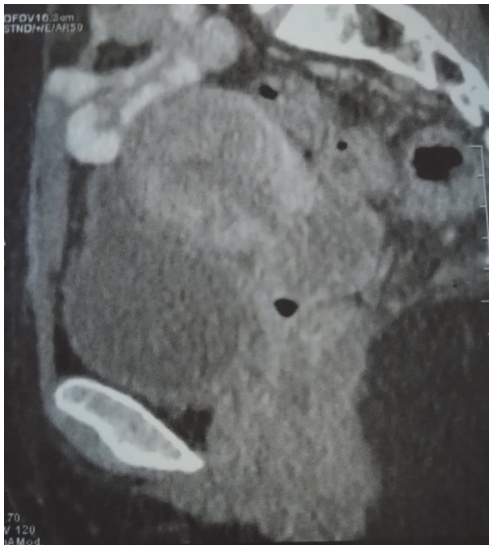
2022-RA-958-ESGO INVASIVE STRATIFIED MUCIN-PRODUCING INTRAEPITHELIAL LESION (ISMILE) A RARE ENTITY OF CERVICAL CANCER

Zeineb Zemni, Mohamed Rebei, Sarah Amari, Manel Abbes, Outeyba Belkhayatia, Anis Fadhlaoui, Moez Kdous, Monia Ferchiou. *Aziza othmana hospital, tunis, Tunisia*

10.1136/ijgc-2022-ESGO.75

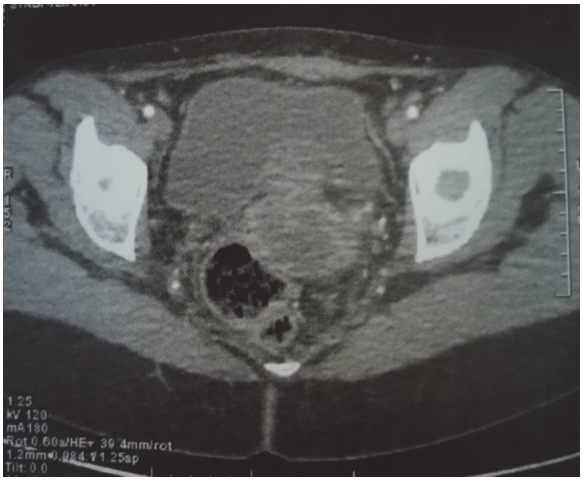
Introduction/Background ISMILE adenocarcinoma is a rare entity, recently described as a distinct entity of invasive lesion associated with Human Papilloma Virus infection. Described in the few cases in the literature as a form with a poor prognosis. Clinical and prognostic data of this entity are very limited in the literature. In this case, we describe the clinical presentation, management and two-year follow-up of an invasive SMILE adenocarcinoma.

Methodology A 47-year-old female patient, with no pathological history, mother of 3 children, not yet menopausal, who had no previous cervical cancer screening; the reason for consultation was vaginal bleeding and pelvic pain. Examination found a suspicious 4 cm budding and exophytic cervical mass.



Abstract 2022-RA-958-ESGO Figure 1

Results The appearance was in favour of a SMILE adenocarcinoma in situ with early cervical invasion. The tumour was classified as FIGO stage IIB. Treatment consisted of chemotherapy, external pelvic radiotherapy and neoadjuvant uterovaginal brachytherapy. Operated within one month she had a total hysterectomy associated with an inguinal lymphadenectomy. Final pathological examination concluded to a localized invasive cervical tumor type SMILE measuring 4 cm. Follow-up was without recurrence after 2 years.



Abstract 2022-RA-958-ESGO Figure 2

Conclusion SMILE adenocarcinoma is a rare entity of cervical tumour, recently described in the literature. Its treatment should not differ from other forms of invasive cervical carcinoma. However, knowledge of this entity and its capacity for invasion and distant metastasis is important to ensure proper management of patients.

2022-RA-959-ESGO PELVIC SENTINEL LYMPH NODEDISTRIBUTION; THE FINAL OUTCOME OF THE SENTIX TRIAL (CEEGOG-CX01; ENGOT-CX2; NCT02494063)

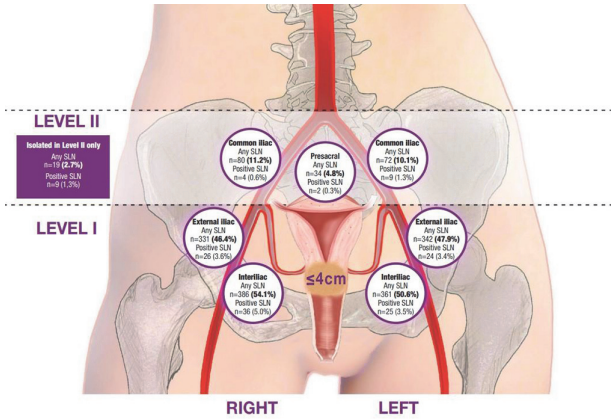
[1]Roman Kocian, [2]Christhardt Koehler, [3]Sylva Bajsova, [4]Klara Benesova, [5]Ignacio Zapardiel, [6]Giampaolo Di Martino, [7]Luc van Lonkhuijzen, [8]Borek Sehnal, [9]Octavio Arencibia Sanchez, [10]Blanca Gil Ibanez, [11]Fabio Martinelli, [12]Jiri Presl, [13]Lubos Minar, [14]Radim Marek, [15]Peter Kascak, [16]Pavel Havelka, [17]Martin Michal, [18]Toon van Gorp, [19]Kristyna Nemejcova, [1]David Cibula. *[1]Gynecologic Oncology Center, Department of Obstetrics and Gynecology, First Faculty of Medicine, Charles University and General University Hospital in Prague, CEEGOG, Prague, Czech Republic; [2]Department of Special Operative and Oncologic Gynaecology, Asklepios-Clinic Hamburg, Hamburg, Germany; [3]Department of Obstetrics and Gynecology, University Hospital Ostrava, CEEGOG, Ostrava, Czech Republic; [4]Institute of Biostatistics and Analyses, Faculty of Medicine, Masaryk University, Brno, Czech Republic; [5]Department of Obstetrics and Gynecology, La Paz University Hospital, Madrid, Spain; [6]Department of Obstetrics and Gynecology, Unit of Gynecologic Oncology Surgery, San Gerardo Hospital, Monza, Italy; [7]Centre for Gynecologic Oncology, Academic Medical Centre, Amsterdam, Netherlands; [8]Department of Obstetrics and Gynecology, University Hospital Bulovka, First Faculty of Medicine, Charles University, CEEGOG, Prague, Czech Republic; [9]Department of Gynecologic Oncology, University Hospital of the Canary Islands, Las Palmas de Gran Canaria, Spain; [10]Unit of Gynecological Oncology, Institute Clinic of Gynecology, Obstetrics and Neonatology (ICGON), Hospital Clinic of Barcelona, Barcelona, Spain; [11]IRCCS Foundation National Cancer Institute in Milan, Milan, Italy; [12]Department of Gynaecology and Obstetrics, University Hospital Pilsen, Charles University, CEEGOG, Pilsen, Czech Republic; [13]Department of Gynecology and Obstetrics, Faculty of Medicine, Masaryk University, CEEGOG, Brno, Czech Republic; [14]Department of Obstetrics and Gynecology, Faculty of Medicine and Dentistry, Palacky University, University Hospital Olomouc, CEEGOG, Olomouc, Czech Republic; [15]Department of Obstetrics and Gynecology, Faculty Hospital Trencin, CEEGOG, Trencin, Slovakia; [16]Department of Obstetrics and Gynecology, KNTB a.s, CEEGOG, Zlin, Czech Republic; [17]Department of Obstetrics and Gynaecology, Hospital Ceske Budejovice, JSC, CEEGOG, Ceske Budejovice, Czech Republic; [18]Department of Gynecology and Obstetrics, University Hospital Leuven, Leuven Cancer Institute, BGOG, Leuven, Belgium; [19]Institute of Pathology, First Faculty of Medicine, Charles University and General University Hospital, Prague, Czech Republic*

10.1136/ijgc-2022-ESGO.76

Introduction/Background Over the last twenty years, data from more than 2000 patients from thirty studies on sentinel lymph node (SLN) mapping in early-stage cervical cancer were published. Many of these reports come from small single-centre studies or retrospective data from the time when detection rates were much lower. We present final results on SLN mapping from the Sentix study, the largest prospective cohort study of more than 700 patients.

Methodology Eligible were patients with cervical cancer stages T1a1 L1 – T1b2 (<4 or ≤2 cm for fertility sparing), common tumour types and no suspicious lymph nodes on preoperative imaging. All detection techniques (blue dye, radiocolloid, indocyanine green) and combinations were allowed. Preoperative lymphoscintigraphy was not required and not used. All approaches, laparotomy, laparoscopy, or robotic surgery were acceptable. Intraoperatively pelvic (external iliac, interiliac, common iliac, presacral) and low paraaortic regions were examined for the presence of SLN. All patients with successful bilateral SLN detection and a completed postoperative data continued in the study.

Results Final cohort of 714 patients were analysed, enrolled between 2016–2020 in 47 centres and 18 participating countries. Bilateral SLN detection rate reached 92.3% with the median of 3 SLNs per patient. All SLNs were detected in the pelvis, no SLN in the low paraaortic region. The majority (97.3%) were localized in the pelvic level I, below the interiliac bifurcation. There was an extremely low rate (1.3%) of isolated positive SLNs in pelvic level II. No laterally distinct distribution of SLNs was found.



Abstract 2022-RA-959-ESGO Figure 1

Conclusion During SLN biopsy, surgical pelvic dissection should focus on the bilateral anatomical area below the interiliacal bifurcation, the external iliac vessels region, and the obturator fossa, where SLNs are most frequently located. Occurrences outside this region are rare with an extremely low risk of isolated metastatic SLN in the pelvic level II.

2022-RA-971-ESGO LAPAROTOMY SPARED RATE IN TWO STEPS SURGERY FOR EARLY STAGE CERVICAL CANCER

[1]Blanca Segarra Vidal, [2]Pedro M Beira. Salvador, [2]Victor Lago Leal, [2]Pablo Padilla Iserte, [3]Santiago Domingo del Pozo. *[1]UNIDAD DE GINECOLOGIA ONCOLOGICA, HOSPITAL UNIVERSITARIO Y POLITECNICO LA FE, Valencia, Spain; [2]Unit of Gynecology Oncology, Hospital Universitario y Politecnico La fe, Valencia, Spain; [3]Unit of gynecology Oncology, Hospital Universitari y Politecnico La Fe, Valencia, Spain*

10.1136/ijgc-2022-ESGO.77

Introduction/Background One of the unanswered clinical questions in the treatment of the early stage cervical cancer is the surgical approach of sentinel lymph node (SLN). Our proposal is performing a laparoscopic SLN biopsy with a frozen section of the SLN as the first step in the procedure. If lymph nodes are negative for malignancy intraoperative, an open radical hysterectomy can be continue. If lymph nodes are positive for malignancy, the radical hysterectomy is avoided and a paraaortic staging should be performed. In this last scenario, the open surgery is not performed after the laparoscopy, sparing the patient a futile laparotomy.

Methodology Patients were eligible if they had any histological type of invasive carcinoma of the cervix on final pathology with a clinical-stage IA1 to IB2 according to the staging system of the FIGO 2018, no extrauterine disease detected by an imaging test, and a laparoscopic SLN performed. Patients with pelvic or abdominal previous radiotherapy, extrauterine disease, or laparotomic SLN approach were excluded.Patients