

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.

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PELVIC SENTINEL LYMPH NODE DISTRIBUTION; THE FINAL OUTCOME OF THE SENTIX TRIAL (CEEGOG-CX01; ENGOT-CX2; NCT02494063)

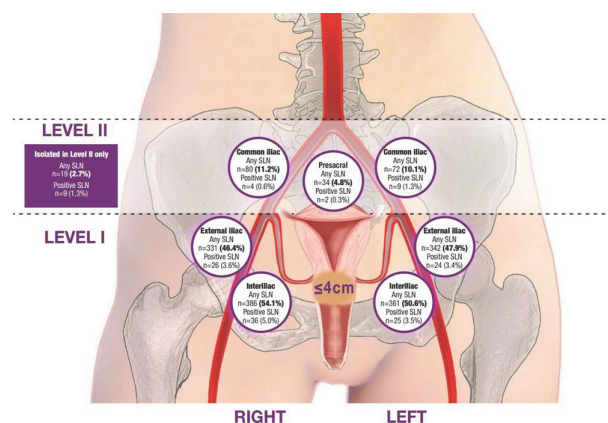
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Introduction/Background Over the last twenty years, data from more than 2000 patients from thirty studies on sentinel lymph node (SLN) mapping in early-stage cervical cancer were published. Many of these reports come from small single-centre studies 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 interiliac 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.

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LAPAROTOMY SPARED RATE IN TWO STEPS SURGERY FOR EARLY STAGE CERVICAL CANCER

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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 para-aortic 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