

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)

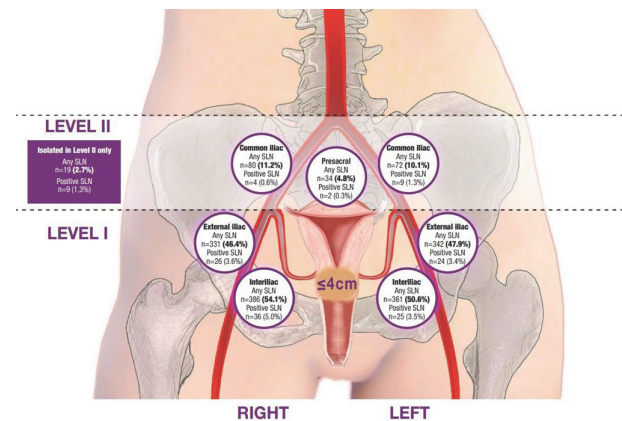
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Introduction/Background Over the last twenty years, data from more than 2000 patients from thirty studies on sentinel lymph node (SLN) mapping in early-stage cervical cancer were published. Many of these reports come from small single-centre studies 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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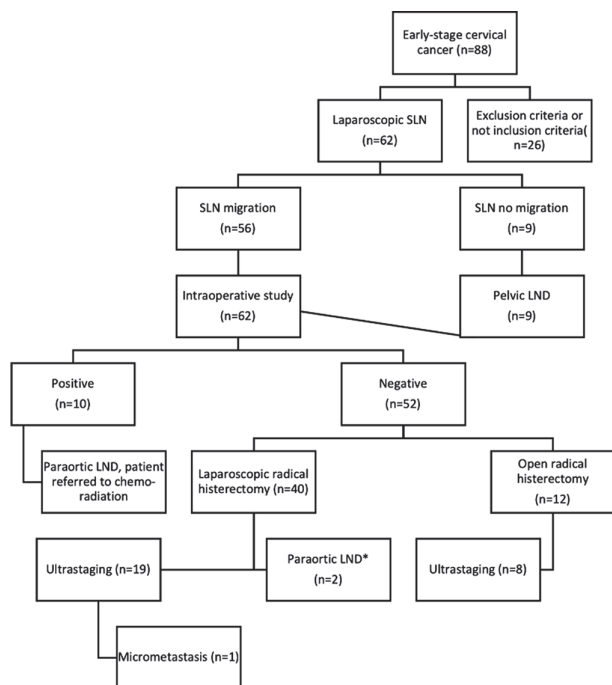
10.1136/ijgc-2022-ESGO.77

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 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

were categorized a priori into two groups based on the surgical approach of the radical hysterectomy (laparoscopy vs laparotomy).

Results A total of 88 patients with early-stage cervical cancer between January 2010 and July 2021 were evaluated. Sixty-two patients met the inclusion criteria. Fifty-two patients (84%) had a negative intraoperative SLN performed by laparoscopy: 40 patients who underwent laparoscopic radical hysterectomy vs. 12 with open radical hysterectomy. Ten patients (16%) had a positive intraoperative SLN and the radical hysterectomy was discarded, paraortic lymphadenectomy was performed and the patients were referred to definitive treatment with chemoradiation.



Abstract 2022-RA-971-ESGO Figure 1

Conclusion Laparoscopic SLN biopsy with an intraoperative analysis before open radical hysterectomy spare a 16% of futile laparotomies.

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HIGH-RISK HUMAN PAPILLOMAVIRUS (HR-HPV) VIRAL LOAD: A NEW APPROACH FOR HIGH-GRADE CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN) TREATMENT?

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Introduction/Background Standard treatment of high-grade cervical intraepithelial neoplasia (CIN) is conization. Merely one conization out of four is an overtreatment due to regression of lesion from biopsy to cone. Beside increasing unnecessarily the costs, CIN overtreatment might hamper the feasibility of follow-up and negatively affect reproductive outcomes. The

aim of this study is to develop a new approach for high-grade CIN treatment.

Methodology Consecutive women with a diagnosis of high-grade CIN undergoing laser CO₂ conization were recruited at the Outpatient Service of Central Tuscany (Florence, Italy) from September 2015 to October 2018. Before conization, cervical samples were collected for each patient and viral load of HR-HPV was assessed with Hybrid Capture 2 (HC2), which considered as positive only samples with viral load above a defined threshold. Histology reports of both biopsy and cone, as well as clinical data, were collected for each patient. Statistical analysis was performed with IBM SPSS statistics 23.0 software, using contingency tables, Pearson's chi-square test and nonparametric tests.

Results 295 patients were enrolled. Cone histology showed a lesion regression (negative for high-grade CIN) in 40,5% of CIN II at biopsy (62/153) and in 26,9% of CIN III (25/93). Viral load in cervical samples at conization was statistically associated with CIN grade at cone histology ($p < 0,001$): 75,7% of negative samples resulted in CIN I at cone histology, whereas 72,8% of positive ones resulted in high-grade CIN or worse at cone histology. Furthermore, all the lesions that progressed from biopsy to cone were positive at HC2 and presented higher viral load compared to those that regressed ($p < 0.001$).

Conclusion HR-HPV testing with viral load assessment at the time of scheduled conization might be used to stratify patients referred to the procedure, identifying those who are eligible to repeat biopsy versus those who have indication to proceed with conization.

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ASSESSMENT OF HIGH-RISK HUMAN PAPILLOMAVIRUS INFECTIONS AND CERVICAL DYSPLASIA IN HUMAN IMMUNODEFICIENCY VIRUS-POSITIVE PREGNANT WOMEN IN GERMANY: A PROSPECTIVE CROSS-SECTIONAL TWO-CENTER STUDY

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Introduction/Background Cervical dysplasia up to cervical carcinoma are in almost 100% associated with a high-risk HPV (HR-HPV) infection. The immunosuppressive influence of Human Immunodeficiency Virus (HIV) and the immunocompromised period of pregnancy are risk factors for acquisition and persistence of HR-HPV infections and their progression to precancerous lesions and HPV-associated carcinoma. There is still a lack of guideline-defined approaches, due to the lack of sufficient research, especially in Europe, for the screening and follow up of pregnant women living with HIV (WLWH) to prevent HPV-related cervical dysplasia.

Methodology HIV-positive pregnant women were included (n=81). HPV test and genotyping HPV test (multiplexed genotyping with BSGP5+/6+ PCR and Luminex read-out),