Conclusions LVS1, tumours size and depth of invasion were the most important risk factors of pN+. Based on that, we identified a group at very low risk of pN+, in whom sentinel lymph node mapping should be considered to replace radical pelvic lymphadenectomy.

INTRODUCTION MIS has been abandoned in many centers for cervical cancer treatment after publication of the LACC trial in 2018. Several critics and theories emerged afterward. Our study looked at data of a single large volume institution. Disease free survival (DFS) and mortality rates were compared for both surgical approaches.

METHODS We retrospectively reviewed all surgical cervical cancer cases from 2006 to 2017 of the Centre Hospitalier de l’Université de Montréal. Only patients treated by Minimal Invasive Surgery (MIS) or laparotomy were included. We compared cohorts’ characteristics and survival outcomes for MIS and laparotomy. Descriptive data is presented in means, standard deviations, and percentages. Kaplan-Meier was used to generate disease free survival (DFS) and overall survival (OS) curves; log-rank was used to compare curves. Survival outcomes of the use of intrauterine manipulator were also investigated. Statistical significance was 0.05.

RESULTS 257 patients were included (94 robotic, 38 laparoscopy, 125 laparotomy). Patients’ characteristics did not significantly differ among groups. Histology was 50.6% squamous cell carcinoma, 35.4% adenocarcinoma, 3.9% adenosquamous and 10.1% other subtypes. Patients were FIGO stages IA (51.0%), IB (43.1%) and IIA or more (5.9%). Median follow-up was 161 months. Intrauterine devices were used in 70.2% of the MIS group. 48.8% had no residual disease at surgery. No differences in intra-operative, post-operative complications and readmission rates between MIS and laparotomy was observed. Total cohort intra-operative and post-operative complications rates were respectively 4.5% and 25.2%. Recurrence rates and death rates were significantly lower for MIS than for laparotomy approach (respectively 1.5% vs 8.1%, p=0.013, 1.5% vs 4.8%, p=0.043). Disease-specific mortality rate did not statistically differ (MIS=1.5%, laparotomy =4.8%, p=0.121).

Conclusions Selected cervix cancer patients may benefit from MIS. Further studies are needed.

IMPLEMENTATION OF A COMPREHENSIVE CANCER GENOME PROFILING PROGRAMME INTO CLINICAL PRACTICE: AN ITALIAN EXPERIENCE IN A REFERRAL CENTRE FOR GYNECOLOGICAL CANCERS

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Introduction The implementation of cancer molecular characterization in clinical practice has improved prognostic definition extending the eligibility to a continuous increasing number of targeted treatments. A molecular based primary tumor agnostic approach, could satisfy this purpose. Although in 2020 the European Society of Medical Oncology recommended comprehensive genomic profiling (CGP) implementation at least in academic centers many challenges have to be acknowledged.

Methods In the present monocentric interventional prospective study, ten cancer types including ovarian and endometrial cancer treated at our Institution from January 2022, were identified and profiled using a FPG500 molecular platform. An analysis was designed to evaluate the feasibility of CGP from Formalin- Fixed Paraffin- Embedded specimens, turnaround times, presence of targetable alteration as well as a description associated with identified biomarkers and applied results.

Abstract 2022-LBA-1282-ESGO Table 1 Risk of lymph node metastases, stratified by the most important risk factors

<table>
<thead>
<tr>
<th>LVSI lymphovascular space invasion</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depth of invasion</td>
<td>p&lt;0.05</td>
<td>95% CI</td>
</tr>
<tr>
<td>≤20 mm</td>
<td>2%</td>
<td>3-2</td>
</tr>
<tr>
<td>21-40 mm</td>
<td>5%</td>
<td>6-3</td>
</tr>
<tr>
<td>≥40 mm</td>
<td>12%</td>
<td>13-11</td>
</tr>
<tr>
<td>≥50 mm</td>
<td>23%</td>
<td>25-20</td>
</tr>
<tr>
<td>≥60 mm</td>
<td>35%</td>
<td>30-40</td>
</tr>
</tbody>
</table>

Abstract 2022-LBA-1282-ESGO Figure 1 Approaches to analysing data from different sources; a) Centralisation. This is the traditional approach, but has several disadvantages such as loss of data control logistics data governance and (most importantly) putting at risk sensitive patient data. b) Federated warring in this decentralised approach, privacy-sensitive patient data are not shared, but kept undisclosed and safe at their original location. Communication within the infrastructure is end-to-end encrypted.

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