invasive cervical cancer. The surgical margins were positive in 78 (31.7%) of the patients. The average age of the patients was 41.13 and 35 (14.23%) of the patients were menopausal. The multivariate logistic regression identified preoperative forcepts biopsy of micro-invasive SCC, HSIL or higher cone specimen histology and shorter cone depth as independent predictors of surgical margin involvement in patients undergoing cold knife conization.

Conclusion In the current study, we have found no association between the inherent characteristics of the patient and the surgeon and the surgical margin state after a CKC. The most important predictors for positive margins were the severity of the lesion and the cone depth.

Conclusion In the current study, we have found no association between the inherent characteristics of the patient and the surgeon and the surgical margin state after a CKC. The most important predictors for positive margins were the severity of the lesion and the cone depth.

Disclosures I have nothing to disclose.

#85 CLINICOPATHOLOGICAL CHARACTERISTICS AND ONCOLOGICAL OUTCOMES OF THREE SUBTYPES OF NEUROENDOCRINE CARCINOMA OF THE CERVIX: A MULTICENTER RETROSPECTIVE STUDY OF 288 PATIENTS

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Introduction/Background Neuroendocrine carcinoma of the cervix (NECC) is a rare type of cervical cancer, and is divided into small cell neuroendocrine carcinoma (SCNEC), large cell neuroendocrine carcinoma (LCNEC) and mixed neuroendocrine-non-neuroendocrine neoplasm (MiNEN). Present literature on NECC mainly focus on SCNEC, and the clinical features of LCNEC, especially MiNEN, are not well understood.

Methodology The multicenter, retrospective study enrolled 288 patients. The primary outcomes were progression-free survival (PFS) and overall survival (OS). The Kaplan-Meier method and Cox proportional hazard analysis were performed.

Results With a median follow up of 25 months, the 5-year PFS of NECC, SCNEC, LCNEC and MiNEN was 40.2%, 40.4%, 30.3%, and 41.6%; and the 5-year OS was 45.4%, 40.4%, 32.3%, and 50.3%. In the whole cohort, it showed the Kaplan-Meier survival analysis for the study of the recurrence were used to identify the risk factors of recurrence and the multivariate logistic analysis (c) the multivariate regression analysis on the recurrence of the lesions was conducted as well.

Conclusion This multicenter retrospective study first focused on three pathological subtypes of NECC. SCNEC has a worse biological behavior than the other two types. Patients with MiNEN did not show better prognosis than the other two. LVSI and >2/3 stromal invasion and adjuvant chemoradiotherapy are prognostic factors for PFS; age, LVSI, and >2/3 stromal invasion and adjuvant chemoradiotherapy are prognostic factors for OS in patients with NECC.

Disclosures There was no conflicts of interests, and I have nothing to disclose.

#97 INCIDENCE OF CERVICAL CANCER AFTER PRIMARY TREATMENT OF CERVICAL INTRAEPITHELIAL NEOPLASIA

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Introduction/Background The aim of this study was the evaluation of the incidence of cervical cancer after primary treatment for high-grade squamous intraepithelial lesions of the cervix (HSIL) and the identification of risk factors of cervical pathology recurrence after surgical treatment.

Methodology This was a retrospective study of patients with cervical pathology (CIN 2+) during the period 2014—2020. The Chi-square test (x2) and the multivariate regression analysis were used to identify the risk factors of recurrence and the Kaplan-Meier survival analysis for the study of the recurrence of the lesions was conducted as well.
# Abstracts

## SURVIVAL OF WOMEN WITH ADVANCED STAGE CERVICAL CANCER: NEOADJUVANT CHEMOTHERAPY FOLLOWED BY RADIOTHERAPY AND HYPERTERMIA VERSUS CHEMORADIOThERAPY WITH OR WITHOUT NODE DEBULKING

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**Introduction/Background** According to ESGO guidelines, chemoradiation without nodal debulking is standard care for patients with (locally) advanced cervical cancer (LACC). In some centers, for selected cases induction chemotherapy followed by radiotherapy and hyperthermia is offered. In other centers lymph node debulking is performed prior to chemoradiation. These different approaches have not been compared directly in prospective clinical trials.

**Methodology** This is a retrospective observational study to investigate the overall survival (OS) and progression-free survival (PFS) using the Cox-proportional hazards model in women who underwent either upfront chemotherapy followed by radiotherapy and hyperthermia (triple therapy, TT) or chemoradiotherapy (either with, i.e. CRTN, or without prior, i.e. CRTO, lymph node debulking) for advanced stage cervical cancer in the Netherlands.

**Results** A total of 373 patients were included: 213 (57%) in the CRTO group, 66 (17.6%) in the CRTN group and 94 (25.2%) in the TT group. Mean age was 50.14 (SD 13.95) years. The mean tumour size was 61.98 (SD 16.72) mm.

Squamous cell carcinoma (91.4%) was the most frequent histological type. According to FIGO 2009 stage, following groups were observed: 15.5% IB2, 18.3% IIA, 31.6% IIB, 7.2% IIIA, 21.4% IIIB, 5.6% IV. According to treatment group, the five-year overall survival rate was 46% for the CRTN group and 54% for the TT and CRTO group (p=0.479). The five-year PFS was 64% for the TT group, 53% for the CRTO group and 38% for the CRTN group (p=0.054). Cox proportional hazards analysis could identify FIGO stage as significant covariate.

**Conclusion** Overall survival results were similar between groups (p=0.479). Our data suggests an improvement in PFS for TT in comparison to CRTN (p=0.014). This could, however, be explained by the heterogenous study population and retrospective nature of the data.

**Disclosures** No conflict of interest.

## LAPAROSCOPIC ANATOMIC IDENTIFICATION OF THE INFERIOR HYPOGASTRIC PLEXUS AND NERVE

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**Introduction/Background** To clarify the laparoscopic anatomy necessary for the nerve sparing radical hysterectomy. We meticulously separated the blood vessels and connective tissues to preserve, the pelvic splanchnic nerve, the hypogastric nerve and the bladder branch of the inferior hypogastric plexus.

**Methodology** Operative procedure

- Isolation of the deep uterine vein could preserve one of the branches of the pelvic splanchnic nerve.
- The hypogastric nerve in the lateral rectal wall was isolated to the inferior hypogastric plexus.
- During the division of the posterior leaf of the vesicouterine ligament, isolation of the inferior vesical vein could reveal the bladder branch from the inferior hypogastric plexus.
- Only the uterine branch from the inferior hypogastric plexus was isolated and divided.
- The T-shaped nerve plane consisting of the hypogastric nerve, the pelvic splanchnic nerve and the bladder branch from the inferior hypogastric plexus is preserved.

**Results** All patients recovered their urinary function completely by POD 3–5.

**Conclusion** In order to accomplish the nerve sparing procedure, it is necessary to meticulously divide the posterior leaf of the vesicouterine ligament.

By the separation of the inferior vesical vein in the posterior leaf of the vesicouterine ligament, the bladder branch from the inferior hypogastric plexus can be identified and preserved.

## EFFECT OF DIABETES MELLITUS ON TREATMENT RESPONSE IN PATIENTS OF CERVICAL CARCINOMA

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**Introduction/Background** To study the effect of Type 2 diabetes mellitus on treatment response in locally advanced