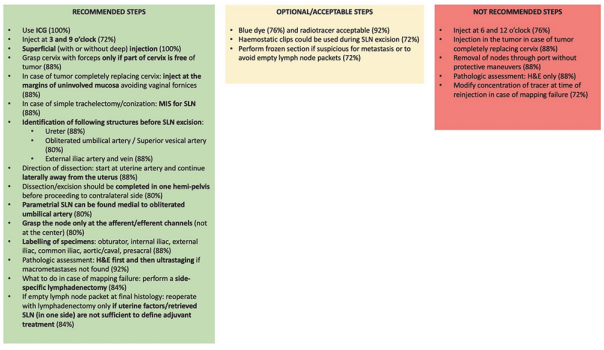
Introduction/Background Brachytherapy is a key step in the treatment of locally advanced cervical cancer (LACC). We aim to report our experience with the use of transrectal ultrasound (TRUS)-guided implantation of brachytherapy applicators.
Methodology A monocentric retrospective study was conducted at the University Hospital of Liège between January 2018 and August 2022, including 141 patients who underwent intracavitary ± interstitial applicator implantation with TRUS guidance for high-dose-rate image-guided adaptive brachytherapy (HDR-IGABT) for a total of 274 procedures. The procedure and the treatment planning with magnetic resonance imaging (MRI) were analyzed. Accuracy of implantation, D95 for high-risk clinical target volume (HR-CTV), organs-at-risk (OAR), dose constraints D2cc (minimal dose of the 2cc with the highest dose), complications and local control were described.
Results The procedure was successfully performed in 273 (99.6%) cases, with only one requiring immediate readjustment due to inappropriate implantation. 266 procedures (97%) were conducted with routine material (ring and tandem applicator +- interstitial needles), and 8 (3%) required adapted material due to intraoperative anatomical difficulties. Based on MRI, we have reported 7 (2.5%) cases of complete uterine perforation through endoluminal applicator and 2 (0.7%) cases of intestinal perforation by interstitial needles. These 9 cases of perforation had no subsequent clinical consequences. The mean D95 HR-CTV was 83.3 Gy, while mean rectum, sigmoid, and bladder D2cc were 60.4, 56.6, and 75.4 Gy, respectively. With a median follow-up of 19.1 months, local control was achieved in 125 patients (88.7%).
Conclusion In this study, all patients with LACC benefited from IGABT, and no procedure withdrawal were necessitated. The use of TRUS intraoperative guidance allows the applicators implantation optimization. This appears to be a reliable and effective method resulting in high local control rates for LACC patients with a low rate of clinically meaningful complications.
Disclosures /

#756 CONSENSUS ON SURGICAL STEPS FOR SENTINEL LYMPH NODE DISSECTION IN CERVICAL CANCER

[1]Nicolò Bizzarri*, [2]Andreas Obermair, [3]Arthur Hsu, [4]Enrique Chacon, [5]Anna Collins, [6]Irina Tsibulak, [7]Alex Mutombo, [8]Jaime R Garcia, [9]Pedro T Ramirez. *[1]UOC Ginecologia Oncologica, Dipartimento per la salute della Donna e del Bambino e della Salute Pubblica, Fondazione Policlinico Universitario A. Gemelli, IRCCS, Rome, Italy; [2]Queensland Centre for Gynaecological Cancer, Herston/Brisbane, Queensland, Australia; [3]National Taiwan University Cancer Center, Taipei City, Taiwan; [4]Gynecologic Oncology Unit, Universidad de Navarra, Pamplona, Spain; [5]University Hospitals of Leicester NHS Trust, Leicester, UK; [6]Department of Obstetrics and Gynaecology, Medical University of Innsbruck, Innsbruck, Austria; [7]University of Kinshasa, Kinshasa, Congo; [8]The University of Texas MD Anderson Cancer Center, Houston, USA; [9]Department of Obstetrics and Gynecology, Houston Methodist Hospital, Houston, USA*

10.1136/ijgc-2023-ESGO.184

Introduction/Background Sentinel lymph node (SLN) biopsy is routinely performed in early cervical cancer. Variation in surgical techniques impacts diagnostic accuracy and poses barriers to the comparison of outcomes across institutions. Standardization of technique and quality assessment tools are critical. The purpose of this study was to establish a consensus on the surgical steps of SLN dissection in cervical cancer.
Methodology A survey containing 26 questions was emailed to international expert gynecological oncology surgeons. A two step modified Delphi method was used to establish consensus. After a first round of online survey, the questions were amended and a second round, along with semi-structured interviews was performed. Consensus was defined if a step was considered recommended, optional or not recommended using a 70% cut-off for agreement.
Results Twenty-five of 38 (65.8%) experts responded to the online survey. Agreement >70% was reached in 13 (52.0%) questions at first round and 15 (60.0%) at final round. Figure 1 shows the consensus agreement which identified 15 recommended, 3 optional and 5 not recommended steps. Agreement of 70% was not reached for ICG concentration, total volume of tracer injected, timing of injection, approach to SLN in case of radical hysterectomy or radical trachelectomy, exposure of retroperitoneal spaces before dissecting SLN, how to approach multiple SLNs, avoid empty packets, or how to retrieve SLN. In 32% of cases, experts suggested the use of frozen section to confirm nodal tissue and exclude metastasis.
Conclusion Recommended, optional and not recommended steps of SLN dissection in cervical cancer have been identified based on consensus among international experts. An operation guide may be used by surgeons in clinical trials and for quality assurance in routine clinical care.



Abstract #756 Figure 1 Recommended algorithm (experts agreement % in parenthesis)

Disclosures None

#757 IN STAGING OF LYMPH NODE POSITIVE CERVICAL CANCER, THE WIND IN THE AJCC WAS CALMED AND MATCHED WITH FIGO STAGING. FIGO STAGING IS ESSENTIAL, BUT AJCC'S SOUND IS GOOD

Kamuran Ibis*, Deniz Yanik, Ali Osman Uysal, Selnur Ozkurt, Seden Kucucuk. *Istanbul University, Institute of Oncology, Department of Radiation Oncology, Istanbul, Türkiye*

10.1136/ijgc-2023-ESGO.185

Introduction/Background American Joint Committee on Cancer (AJCC) released its 9th-version in 2021 similar as FIGO-2018. Previously, there was a mismatch between the FIGO and AJCC stages. While lymph node (LN) involvement did not change the stage in FIGO-2009, in AJCC-7th, the presence of pelvic LN was staged as IIIB, the presence of PA-LN as IVB. In AJCC-8th, the presence of LN did not affect AJCC prognostic stage groups. In this study, stage distributions according to the changing FIGO and AJCC (TNM) staging system in patients with LN-positive cervical cancer were examined.