yet been fully explored. The aim of this retrospective, multicenter study (MITO RT-02) was to define efficacy and safety of SBRT in a very large, real life dataset of metastatic/persistent/recurrent cervical cancer (MPR-CC) patients.

Abstract 933 Table 1 Patients and treatments characteristics

	N. (%)
Patients	84
Lesions	126
Age, yrs	58 (30-92)
Median (range)	
ECOG Performance Status	79 (94.1)
0-1	5 (5.9)
2-3	
Histotype	77 (61.1)
Squamous	36 (28.6)
Adenocarcinoma	5 (4.0)
Adenosquamous	3 (2.4)
Clear cell	5 (4.0)
Other	
N. lesions per patients	61 (72.6)
1	13 (15.4)
2	10 (12.0)
≥3	
Type of lesion (%)	70 (55.5)
Lymph node	46 (36.5)
Parenchyma	10 (8.0)
Bone	
Anatomic Site	7 (5.5)
Neck	34 (27.0)
Thorax	32 (25.4)
Abdomen	46 (36.6)
Pelvis	7 (5.5)
Bone	
Metachronous lesions	99 (78.6)
No	27 (21.4)
Yes	
N. patients undergoing previous radiotherapy in site	53 (63.1)
No	31 (36.9)
Yes	
Equipments	108 (85.7)
INAC	10 (7.9)
Cyberknife	1 (0.8)
Tomotherapy	7 (5.6)
MRI LINAC	
Type of treatment	26 (20.6)
SRS, stereotactic radiosurgery (single fraction)	100 (79.4)
SBRT, stereotactic radiotherapy (more fractions)	
PTV	16.8 (1.8-223.3)
Median, range (cc)	
Total dose, Gy	35 (5-60)
Median (range)	
Dose/fraction, Gy	7 (2.5-26)
Median (range)	
Dose prescription	48 (38.1)
Specific isodose	32 (25.4)
Isocenter	46 (36.5)
Target mean	

Methodology Clinical and SBRT parameters have been collected in order to fulfill primary endpoints, i.e. the rate of complete response (CR) to SBRT, and the 24-month actuarial local control (LC) rate on 'per lesion' basis. The secondary end-points were acute and late toxicities. Objective response rate (ORR) included CR and partial response (PR). Clinical benefit (CB) included ORR and stable disease (SD). Toxicity was evaluated by RTOG/EORTC and CTC-AE scales, according to center policy.

Result(s)* Fifteen centers participated to the study; after evaluation of inclusion/exclusion criteria, 84 CC patients, carrying a total of 126 lesions treated by SBRT between March 2006 and February 2021, were selected for the analysis. Patient characteristics and treatment data are summarized in **table 1.** Complete and partial response, as well as stable disease were observed in 73 (57.9%), 30 (23.8%), and 16 (12.7%) lesions, respectively, reaching about 94% CB rate. With a median follow-up of 14 months (range: 3-130), the 24-month actuarial LC, DFS and OS rate were 61.8%, 22.3%, 52.9%, respectively. Mild acute toxicity was experienced in 14 (16.6%) patients; late toxicity was documented in 4 patients (4.7%).

Conclusion* This study confirms the efficacy and safety of SBRT in MPR-CC patients. The low toxicity profile suggests a wider use of this treatment in this setting, however combinations with new drugs are needed to improve outcomes.

937 ABSTRACT WITHDRAWN

942 SURVIVAL AFTER RECURRENCE IN EARLY-STAGE CERVICAL CANCER PATIENTS

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Introduction/Background* Up to 26% of early-stage cervical cancer patients relapse after primary surgical treatment. However, little is known about the factors affecting prognosis

following disease recurrence. Hence, the aim of this study was to evaluate post-recurrence disease-specific survival (PR-DSS) and to identify respective prognostic factors.

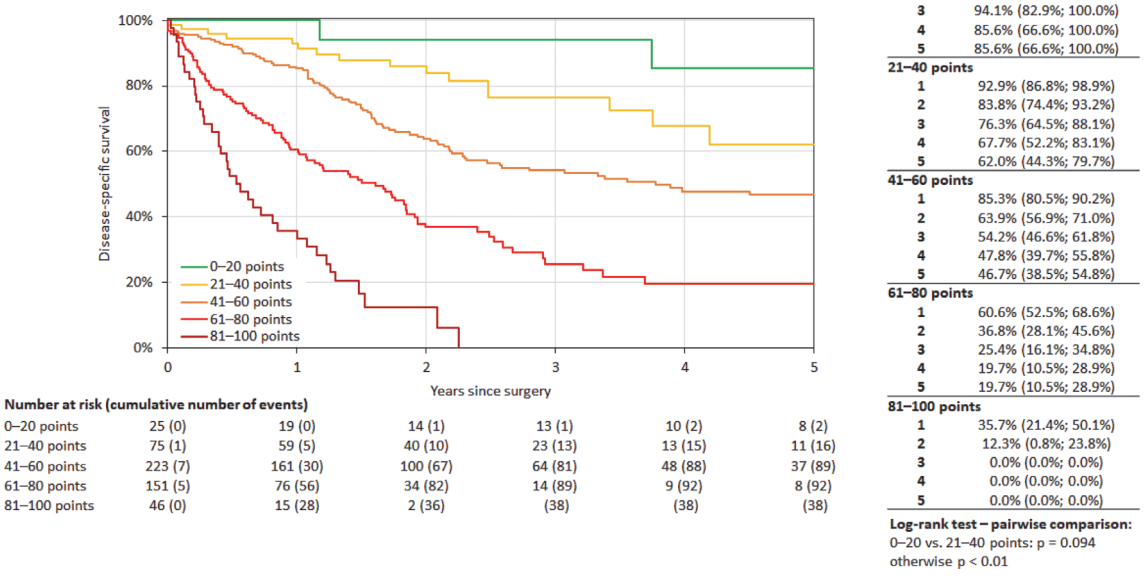
Methodology Data from 528 early-stage cervical cancer patients who relapsed after primary surgical treatment performed between 2007 and 2016 were obtained from the SCCAN study (Surveillance in Cervical CANcer). Parameters related both to primary disease and recurrence diagnosis were combined to develop a multivariable Cox proportional hazards model predicting PR-DSS.

Result(s)* Five-year PR-DSS reached 39.1% (95% confidence interval: 22.7% – 44.5%) with median disease-free survival between primary surgery and recurrence diagnosis (DFI1) of 1.5 years and median survival after recurrence of 2.5 years. Six variables significant in multivariable analysis were included in the PR-DSS prognostic model; two related to the primary disease characteristics: maximal diameter of the tumour and lymphovascular space invasion; and four related to the recurrence diagnosis: DFI1, age, presence of symptoms, and recurrence localization (table 1). C-statistics of the final model after 10-fold internal validation equalled 0.701 (95% CI: 0.675 – 0.727). Five risk groups significantly differing in prognosis were identified, with 5-year DSS after recurrence of 85.6%, 62.0%, 46.7, 19.7%, and 0% in the highest risk group (figure 1).

Abstract 942 Table 1 Multivariable Cox regression model for prediction of disease-specific death after recurrence

Predictor		B	SE(β)	HR	95% CI	P-value	Points (max. 100)
Years from surgery to recurrence	> 1 year			Reference			0
	< 1 year	0.516	0.132	1.676	1.294–2.169	**< 0.001**	11
Age at recurrence	< 65 years			Reference			0
	65+ years	0.543	0.187	1.720	1.192–2.482	**0.004**	12
Maximal pathologic tumour diameter*	< 0.5 cm			Reference			0
	0.5–1.9 cm	0.947	0.602	2.577	0.792–8.380	0.116	20
	2.0–3.9 cm	1.269	0.593	3.557	1.113–11.374	**0.032**	27
	≥ 4.0 cm	1.481	0.598	4.397	1.363–14.184	**0.013**	31
LVSI*	No/unknown			Reference			0
	Yes	0.672	0.148	1.957	1.463–2.619	**< 0.001**	14
Recurrence symptoms	No			Reference			0
	Yes/unknown	0.788	0.151	2.199	1.634–2.958	**< 0.001**	17
Recurrence localization	Isolated			Reference			0
	Multiple	0.687	0.135	1.987	1.526–2.587	**< 0.001**	15

*Characteristics at the time of primary surgery



No. of years	Disease-specific survival (95% confidence interval)
0–20 points	
1	100.0% (100.0%; 100.0%)
2	94.1% (82.9%; 100.0%)
3	94.1% (82.9%; 100.0%)
4	85.6% (66.6%; 100.0%)
5	85.6% (66.6%; 100.0%)
21–40 points	
1	92.9% (86.8%; 98.9%)
2	83.8% (74.4%; 93.2%)
3	76.3% (64.5%; 88.1%)
4	67.7% (52.2%; 83.1%)
5	62.0% (44.3%; 79.7%)
41–60 points	
1	85.3% (80.5%; 90.2%)
2	63.9% (56.9%; 71.0%)
3	54.2% (46.6%; 61.8%)
4	47.8% (39.7%; 55.8%)
5	46.7% (38.5%; 54.8%)
61–80 points	
1	60.6% (52.5%; 68.6%)
2	36.8% (28.1%; 45.6%)
3	25.4% (16.1%; 34.8%)
4	19.7% (10.5%; 28.9%)
5	19.7% (10.5%; 28.9%)
81–100 points	
1	35.7% (21.4%; 50.1%)
2	12.3% (0.8%; 23.8%)
3	0.0% (0.0%; 0.0%)
4	0.0% (0.0%; 0.0%)
5	0.0% (0.0%; 0.0%)

Log-rank test – pairwise comparison:
0–20 vs. 21–40 points: p = 0.094
otherwise p < 0.01

Abstract 942 Figure 1 Disease specific survival of all patients stratified by risk score (N=528). Time zero was set at date of recurrence diagnosis

Conclusion* We have developed the first robust model of disease-specific survival after recurrence stratifying relapsing cervical cancer patients according to their risk profile using six traditional prognostic markers. The strongest factor related to the length of post-recurrence survival was the largest size of the primary tumour, followed by the presence of symptoms at the time of diagnosis, which remained significant even after correction for lead-time bias.

950 SENSITIVITY AND FALSE NEGATIVITY OF SLN FROZEN SECTIONHISTOLOGICAL EVALUATION IN THE SENTIX TRIAL (CEEGOG-CX01; ENGOT-CX2; NCT02494063)

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Introduction/Background* SENTIX is a prospective cohort multicentric international study on sentinel lymph node (SLN) biopsy without pelvic lymph node dissection (PLND) in patients with early-stage cervical cancer. SLN frozen section (FS) and pathological ultrastaging were mandatory by the protocol. Samples from SLN were reviewed centrally for pathological assessment quality control. Only sites experienced in SLN biopsy technique could join the trial.

Methodology In total, 47 sites from 18 countries participated in the trial. Patients with FIGO 2009 stages T1A1/LVSI+ – T1B1 (<4 cm or ≤ 2 cm for fertility sparing), with common tumour types and no suspicious lymph nodes on imaging were registered in the trial. Patients remained in the trial after the surgery if SLN were detected on both sides of the pelvis and if SLN were negative on FS histological evaluation. Blue dye, radioactive tracer, indocyanine green or their combinations were all eligible tracers for SLN detection. Intraoperative SLN pathological processing consisted of SLN examination in one randomly selected slice. SLN ultrastaging protocol included a complete processing of all SLN tissue in slices of 2 mm thickness, 2 sections in 150 µm from each block until no tissue left, one stained with H&E and second examined immunohistochemically.

Abstract 950 Table 1 Patient's characteristics (N=733)

Parameter		N (%)/median (5-95th percentile)
Age		43 (29; 67)
	≤ 40	294 (40.1%)
	41-60	339 (46.2%)
	61+	100 (13.6%)
BMI	≤ 25	418 (57.0%)
	25-30	169 (23.1%)
	30+	141 (19.2%)
	NA	5 (0.7%)
ECOG PS	0	704 (96.0%)
	1	29 (4.0%)
Diagnostic method	Biopsy	331 (45.2%)
	Conization	399 (54.4%)
	NA	3 (0.4%)
Enrolled patients by site`s size:		
	≤10	126 (17.2%)
	21-20	81 (11.1%)
	21+	526 (71.8%)
Maximum preoperative tumour size (mm)	≤ 20	471 (64.2%)
	20.1-40	262 (35.8%)
Preoperative tumour stage (FIGO 2009)	1A1	32 (4.4%)
	1A2	54 (7.4%)
	1B1	647 (88.2%)
Tumour grade	G1	179 (24.4%)
	G2	373 (50.9%)
	G3	157 (21.4%)
	NA	24 (3.3%)
LVSI	yes	448 (61.1%)
Tumour type	SCC	508 (69.3%)
	AC	210 (28.6%)
	AS	9 (1.2%)
	NA	6 (0.8%)
Excluded:		83 (11.2%)
Preoperatively	Surgery cancelled	4 (0.5%)
	ICF withdrawn	4 (0.5%)
Intraoperatively	SLN not detected bilaterally	55 (7.5%)
	> 1B1	12 (1.6%)
Other		8 (1.1%)

Abstract 950 Table 2 SLN status assessed by frozen section and final ultastaging (N=650)

Type of SLN involvement	SLN status (No. of patients)			SLN frozen section outcome (%)		
	Frozen section	Ultrastaging	Final SLN status*	Sensitivity	False negativity	NPV
MAC	44	9	53	83.0%	17.0%	98.5%
MIC	4	26	30	13.3%	86,7%	95.7%
ITC	0	19	19	0.0%	100,0%	96.8%
MAC + MIC	48	35	83	57.8%	42,2%	94.2%
MAC + MIC + ITC	48	54	102	47.1%	52.9%	91.0%

Result(s)* Altogether 733 patients were registered until Sentix enrolment closure in October 2020, 83 patients were excluded (table 1) and 650 patients was analysed. Patients` characteristics are shown in table 1. Bilateral SLN detection rate reached 95%. FS detected macrometastases (MAC) in 44 cases and micrometastasis (MIC) in 4 cases. SLN ultrastaging found additional 9 cases with MAC, 26 with micrometastases (MIC) and all 19 cases with isolated tumor cells (ITC). Sensitivity of FS was 83.0% for the detection of MAC, 57.8% for pN1 status (MAC or MIC) and 47.1% for any type of SLN involvement (MAC, MIC, ITC). Table 2.

Conclusion* High bilateral detection rate of 95% was achieved in Sentix sites experienced in the SLN biopsy technique. Intraoperative pathological assessment of SLN failed to detect majority of MIC (86.7%), all cases with ITC and 42.2% with pN1 (MIC or MAC).

955 WATER-JET DISSECTION IN NERVE-SPARING RADICAL HYSTERECTOMY: POSTOPERATIVE OUTCOMES

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Introduction/Background* The development of a nerve-sparing technique of radical hysterectomy leads to a significant functional improvement after surgical treatment of cervical cancer. However, the risk of nerve fibers damage remains high because of difficulties in recognition of elements of the autonomic nervous system. One of approaches for precise nerve dissection is tissue-selective dissection with a water-jet. The main advantage of this method is selective dissection and preservation of nerve fibers and vessels with minimal deformation of the surrounding tissue. This study was aimed to evaluate