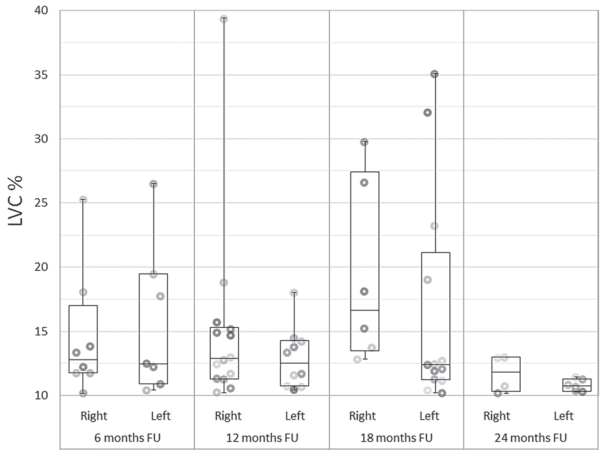
reporting unreliable. The aim of our study is to report outcomes from a prospective SENTIX trial that have implications for the standardisation of LLL assessment.

Methodology In the prospective international multicentre trial SENTIX (ENGOT-cx2/CEEGOG CX-01), a group of 150 patients with stage IA1–IB2 cervical cancer treated by uterine surgery with bilateral SLN biopsy was prospectively evaluated by objective LLL assessment, based on limb volume change (LVC) using circumferrential limb measurements and subjective patient-reported swelling. The assessments were conducted in six-month periods over 24 months post-surgery.

Result(s)* Patient LVC substantially fluctuated in both positive and negative directions (figure 1), which were comparable in frequency up to 14% +/- LVC increments. Thirty-eight patients experienced persistent LVC increase and >10% classified as LLL, for whom median time to onset was nine months (95% CI: 7.0-11.0). Some 34.2% of cases experienced onset later than one year after the surgery. Thirty-three patients (22%) experienced transient oedema characterised as LVC >10%, which resolved without intervention between two consequent follow-up visits (figure 2). No significant correlation between LVC >10% and a patient-reported swelling was observed.



Abstract 959 Figure 2 Incidence of transient oedema. Each dot marks the transient oedema (>10% LVC increase from preoperative measurement) of one patient. Boxplots depict the median value of respective transient oedema LVI (%); the percentile range was set at 25% and 50%; the whisker is between minimal and maximal calculated value. FU; follow-up; LVC: limb volume change.

Conclusion* Our study showed that lower-limb volumes after surgical treatment of cervical cancer significantly fluctuate in positive and negative directions. A diagnostic threshold for LLL should be increased to >15% LVC. Transient oedema occurs frequently, and its distinction from persistent LLL requires repeated measurements. One-third of new LLL cases were diagnosed in the second year of follow-up, highlighting the importance of a sufficient follow-up period duration. Finally, patient-reported limb swelling correlated poorly with LVC and should only be used as an adjunct to objective LLL assessment.

960 THE ANNUAL RECURRENCE RISK MODEL FOR TAILORED SURVEILLANCE STRATEGY IN CERVICAL CANCER PATIENTS

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Introduction/Background* Current guidelines for surveillance strategy in cervical cancer are rigid, recommending the same strategy for all survivors. The aim of this study was to develop a robust and comprehensive model allowing for individualised surveillance strategy based on risk profile of early-stage cervical cancer patients that were referred for surgical treatment with curative intent.

Methodology The data of 4,343 cervical cancer patients with pathologically confirmed early-stage cervical cancer treated between 2007 and 2016 were obtained from SCANN consortium centres of excellence (Surveillance in Cervical CANcer). Only patients with complete key predictor variables and a minimum of one-year follow-up data availability were included. Based on the prognostic markers, a multivariable Cox proportional hazards model predicting disease-free survival (DFS) was developed and internally validated. A risk score, derived from regression coefficients of the model, stratified the cohort into significantly distinctive risk groups. On its basis, the annual recurrence risk model (ARRM) was calculated by conditional survival analysis.

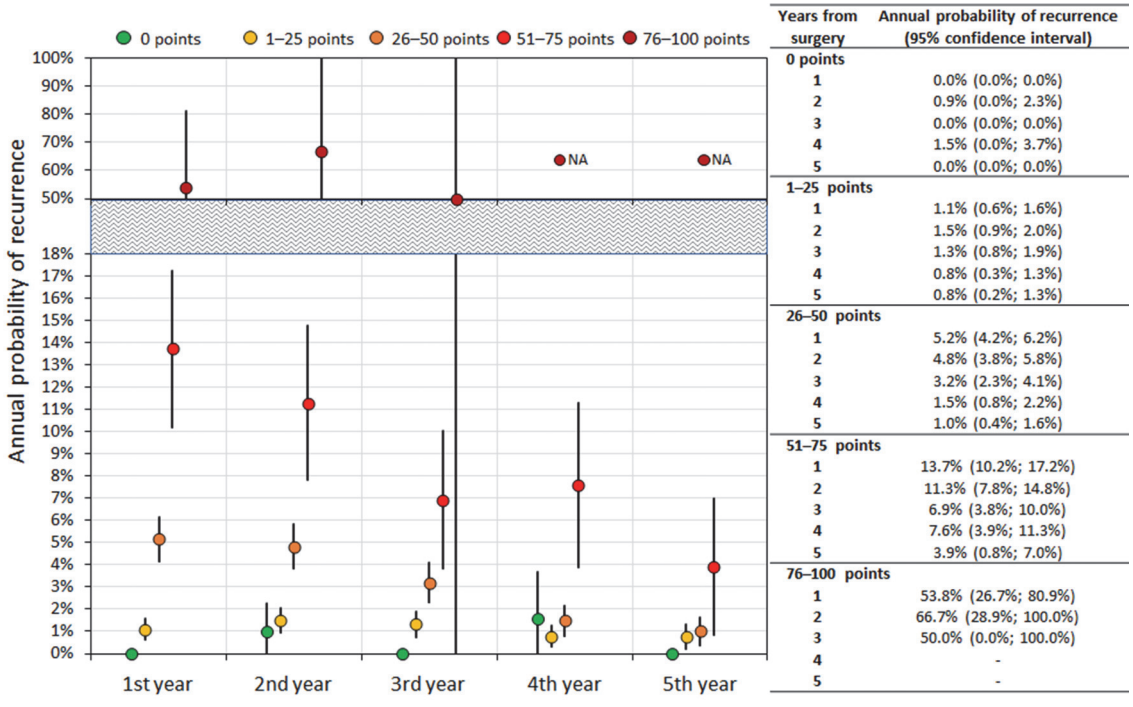
Result(s)* Five variables significant in multivariable analysis of recurrence risk were included in the prognostic model: maximal pathologic tumour diameter, tumour histotype, tumour grade, the number of positive pelvic lymph nodes, and lymphovascular space invasion (table 1). The model was ten-fold

internally cross-validated with the average AUC of 0.732. Five risk groups significantly differing in prognosis were identified: with five-year DFS of 97.5%, 94.7%, 85.2%, and 63.3% in consecutive increasing risk groups, while two-year DFS in the highest risk group equalled 15.4%. Based on ARRM, the annual recurrence risk in the lowest risk group was below 1% in the first year of follow-up and declined below 1% at years three, four, and >5 in the three medium-risk groups (figure 1). The proportion of pelvic recurrences declined in groups with the growing risk. In the whole cohort, 26% of

Abstract 960 Table 1 Multivariate model for risk of recurrence prediction

Predictor		β	SE(β)	HR (95% CI)	*P*-value	Risk points (max. 100)
Histotype	Squamous cell			Reference		0
	Adenocancer	0.342	0.116	1.408 (1.120; 1.771)	0.003	7
	Adenosquamous	0.598	0.164	1.819 (1.317; 2.513)	< 0.001	11
	Neuroendocrine	1.741	0.246	5.704 (3.514; 9.260)	< 0.001	33
	Other	1.145	0.270	3.144 (1.848; 5.349)	< 0.001	22
Tumour diameter	< 0.5 cm			Reference		0
	0.5–1.99 cm	0.501	0.237	1.651 (1.035; 2.634)	0.035	10
	2–3.99 cm	1.115	0.236	3.051 (1.915; 4.858)	< 0.001	21
	≥ 4 cm	1.556	0.245	4.738 (2.925; 7.674)	< 0.001	30
Grade	1			Reference		0
	2	0.260	0.214	1.297 (0.852; 1.976)	0.235	5
	3	0.457	0.247	1.579 (0.970; 2.570)	0.085	9
Positive pelvic LN	0 / not assessed			Reference		0
	1	0.255	0.154	1.291 (0.953; 1.748)	0.098	5
	2	0.482	0.170	1.619 (1.158; 2.264)	0.005	9
	≥ 3	0.939	0.144	2.557 (1.927; 3.394)	< 0.001	18
LVSI	No / not assessed			Reference		0
	Yes	0.538	0.106	1.713 (1.390; 2.111)	< 0.001	10

β: beta coefficient; CI: confidence interval; LN: lymph node; LVSI: lymphovascular space invasion



Years from surgery	Annual probability of recurrence (95% confidence interval)
0 points	
1	0.0% (0.0%; 0.0%)
2	0.9% (0.0%; 2.3%)
3	0.0% (0.0%; 0.0%)
4	1.5% (0.0%; 3.7%)
5	0.0% (0.0%; 0.0%)
1–25 points	
1	1.1% (0.6%; 1.6%)
2	1.5% (0.9%; 2.0%)
3	1.3% (0.8%; 1.9%)
4	0.8% (0.3%; 1.3%)
5	0.8% (0.2%; 1.3%)
26–50 points	
1	5.2% (4.2%; 6.2%)
2	4.8% (3.8%; 5.8%)
3	3.2% (2.3%; 4.1%)
4	1.5% (0.8%; 2.2%)
5	1.0% (0.4%; 1.6%)
51–75 points	
1	13.7% (10.2%; 17.2%)
2	11.3% (7.8%; 14.8%)
3	6.9% (3.8%; 10.0%)
4	7.6% (3.9%; 11.3%)
5	3.9% (0.8%; 7.0%)
76–100 points	
1	53.8% (26.7%; 80.9%)
2	66.7% (28.9%; 100.0%)
3	50.0% (0.0%; 100.0%)
4	-
5	-

Abstract 960 Figure 1 ARRM: Landmark analysis of the annual probability of recurrence after surgery. N/A not analysed.

recurrences appeared at the first year of the follow-up, 48% by year two, and 78% by year five.

Conclusion* ARRM represents a powerful tool for tailoring the surveillance strategy in early-stage cervical cancer patients based on the patient´s risk status and respective annual recurrence risk. It can easily be utilised in routine clinical settings internationally.

966 SENTIX – ACCURACY OF PREOPERATIVE LOCAL STAGING IN THE SENTIX TRIAL (CEEGOG-CX01; ENGOT-CX2; NCT02494063)

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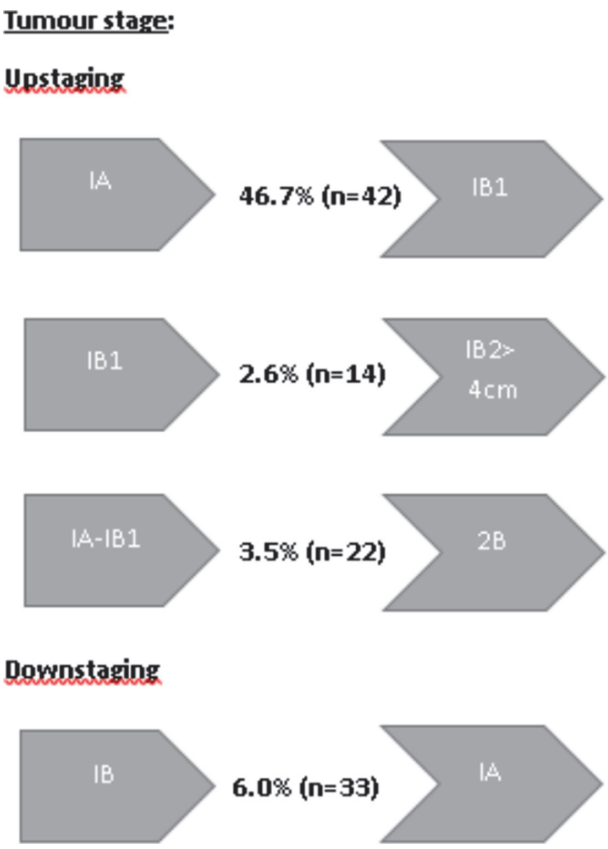
Introduction/Background* The SENTIX is a prospective cohort international study on sentinel lymph node (SLN) biopsy without pelvic lymph node dissection (PLND) in patients with early-stage cervical cancer. The primary end point is a recurrence rate at 24 months´ follow-up after the surgery. Either magnetic resonance imaging (MRI) or expert ultrasound (EUS) was mandatory as a preoperative staging method. The aim of this study is to report the accuracy of preoperative local staging.

Methodology Forty-seven sites from 18 countries participated in the study. Patients with stages T1a1/LVSI+ – T1b1 (FIGO 2009), common histological types and no suspicious lymph nodes on imaging were eligible. Patients were excluded from further study if SLN were not detected on both sides and if SLN was positive on frozen section histological evaluation. Compared were results from preoperative imaging with final pathology reports.

Result(s)* From May 2016 to October 2020, 733 registered patients underwent surgery, 132 were excluded intraoperatively, data from 708 were analysed in this study. Patients' characteristics are in table 1. Out of 90 patients clinically



Abstract 966 Figure 1 Chart 1 the accuracy of local staging

Abstract 966 Table 1 Patient's characteristics

Parameter		N(%)/median (5-95th percentile)
Age		43 (29; 67)
	≤ 40	294 (40.1%)
	41-60	339 (46.2%)
	61+	100 (13.6%)
BMI	≤ 20	73 (10.0%)
	20-25	345 (47.1%)
	25-30	169 (23.1%)
	30+	141 (19.2%)
	NA	5 (0.7%)
ECOG PS	0	701 (95.6%)
	1	28 (3.8%)
	NA	4 (0.6%)
Diagnostic method	Biopsy	331 (45.2%)
	Conization	399 (54.4%)
	NA	3 (0.4%)
Imaging:		
EUS	Yes	392 (53.5%)
MRI	Yes	411 (56.1%)
Maximum preoperative tumour size (mm)	≤ 20	471 (64.2%)
	20.1-40	262 (35.8%)
Preoperative tumour stage	1A1	65 (8.9%)
	1A2	32 (4.4%)
	1B1 ≤ 2 cm	374 (51.0%)
	1B1 > 2 cm	262 (35.7%)
Tumour grade	G1	179 (24.4%)
	G2	373 (50.9%)
	G3	157 (21.4%)
	NA	24 (3.3%)
Tumour type	SCC	508 (69.3%)
	AC	210 (28.6%)
	AS	9 (1.2%)
	NA	6 (0.8%)
Screening failure (SF):		131 (17.7%)
Preoperatively	Surgery cancelled	4 (0.5%)
	ICF withdrawn	4 (0.5%)
Intraoperatively	SLN not detected bilaterally	55 (7.5%)
	Metastatic SLN involvement	48 (6.5%)
	> 1B1	12 (1.6%)
Other		8 (1.1%)