

UD was completed. A near infra-red camera was used to evaluate ICG perfusion of anastomoses (ileum-ileum, right and left ureter with small bowel and colostomy or colo-rectal sides of anastomosis) few second after ICG injection.

Result(s)* Fifteen patients were included in the study. No patient reported adverse reactions to ICG injection. Only 3/15 patients (20.0%) had an optimal ICG perfusion (+++) in all anastomoses. The remaining 12 (80.0%) patients had at least one ICG deficit; the most common ICG deficit was on the left ureter: 3 (20.0%) versus 1 (6.7%) patient had no ICG perfusion (—) on the left versus right ureter, respectively ($p=0.598$). 8/15 (53.3%) and 6/15 (40.0%) patients experienced \geq grade 3 30-day early and late postoperative complications, respectively. Of these, two patients had early and one had late postoperative complications directly related to poor perfusion of anastomosis (UD leak, ileum-ileum leak and benign ureteric stricture): all these cases had a sub-optimal intraoperative ICG perfusion.

Conclusion* The use of ICG to intra-operatively assess the anastomoses perfusion at time of pelvic exenteration for gynecologic malignancy is a feasible and safe technique. The different vascularization of anastomotic stumps may be related to anatomical sites and to previous radiation treatment. This approach could be of support in selecting patients at higher risk of complications, who may need personalized follow up.

353

DOSE-DENSE NACT FOLLOWED BY CCRT IN LOCALLY ADVANCED CERVICAL CANCER: FEASIBILITY AND SAFETY

¹G Parpinel*, ²M Buffa, ³JDI Muzio, ⁴A Peruzzo Cornetto, ⁵C Palladino, ²ME Laudani, ²M Barboni, ²E Peirano, ²M Girimonte, ⁴E Madon, ²P Zola. ¹University of Turin, Surgical Sciences, Turin, Italy; ²University of Turin, Surgical Sciences, Italy; ³Città della Salute e della Scienza di Torino, Oncology and Radiation Oncology, Italy; ⁴Città della Salute e della Scienza di Torino, Medical Physics, Italy; ⁵University of Turin, Oncology and Radiation Oncology, Italy

10.1136/ijgc-2021-ESGO.25

Introduction/Background* First-line treatment for locally advanced cervical cancer (LACC) is concurrent platinum chemoradiation therapy (CCRT) followed by cervico-vaginal brachytherapy (BT). Neoadjuvant chemotherapy (NACT) followed by CCRT+BT has been proposed as an alternative scheme, but its feasibility is still investigational. The aim of this study was to evaluate safety and efficacy of this treatment.

Methodology In our Institution 30 patients with LACC have been treated between 2016-19. They received 6 cycles of weekly NACT with Carboplatin AUC 2 and Paclitaxel 80mg/mq, followed by CCRT (pelvic EBRT (45Gy) weekly Cisplatin 40mg/mq followed by cervico-vaginal BT-HDR (10Gy).

Primary endpoints were 3-year overall survival (OS) and progression-free survival (PFS) while secondary endpoints were safety and toxicity.

Result(s)* The most frequent histological type was squamous cell carcinoma (80%) and G3-grading (66,7%).

9/30 patients had FIGO III stage. Radiological complete response (CR) after NACT was 3,3% while partial response (PR) was 86,6%; only 1 patient had progressive disease (PD).

21 patients (70%) received more than 4 cycles of concurrent Cisplatin during EBRT, while 8 received less than 4 cycles.

After a median follow-up of 36.7 months 3-year OS and PFS values were 71.8% and 65.2%, respectively. Patients with higher values of haemoglobin pre-CCRT (i.e.>10 g/dl) reported a superior 3-year OS value (i.e. 70%, n=25) vs 50% for patients with < 10 g/dl (n=5).

Local and lymph-node recurrence occurred in 30% and 23% of patients while distant-metastasis in 10% of patients.

Only 1 patient experienced G3 anaemia after NACT while 3 cases of G3 haematological toxicity after CCRT+BT-HDR were observed. One patient had G3 neurotoxicity after NACT and 3 patients experienced G3 nausea and diarrhoea after CCRT+BT-HDR.

Conclusion* In our study NACT followed by CCRT+BT resulted to be a feasible treatment. Our data are consistent with the published literature in term of feasibility and safety and the NACT could be synergic with CCRT in the treatment of LACC.

358

THE CASE OF CERVICAL CANCER IB3 WITH MIELOTOXICITY AFTER 2 CYCLE OF CHEMOTADIOTHERAPY TREATED WITH RADICAL HYSTERECTOMY AS THE LAST METHOD OF CHOICE

E Milnerowicz-Nabzdzyk*, J Tomiczek-Szwiec, K Nowak, M Kalus. PZOZ Opolskie Centrum Onkologii im. prof. Tadeusza Koszarowskiego, Opole, Poland

10.1136/ijgc-2021-ESGO.26

Introduction/Background* Patients with stage IB3 cervical cancer are usually qualified for radiochemotherapy. However, sometimes there is a high toxicity of this treatment, which lead us to look for non-standard solutions. Nevertheless, we know that a combination of radical surgery, radiotherapy and chemotherapy is also burdened with a high toxicity.

Methodology Radical hysterectomy type C Querleu-Morrow and pelvic and para-aortic lymphadenectomy was performed with laparoscopy – as a minimally invasive procedure.

Result(s)* The case of a 27 year old lady with cervical cancer FIGO IB3 is qualified for chemoradiotherapy (Histopathology: Cervical adenocarcinoma G2). She had received 28 f Grey and one cycle of cisplatin (70 mg). The treatment was postponed because of huge myelotoxicity. As no other choice, she was qualified for radical hysterectomy type C Querleu-Morrow and pelvic – para-aortic lymphadenectomy. Radical hysterectomy was performed with laparoscopy – as a minimally invasive procedure that is less traumatizing for depressing immune system. Postoperative histopathology: cervix -chronic inflammation. There were observed no neoplastic changes in the uterus, fallopian tubes, ovaries, pelvic and para-aortic lymph nodes. One month after surgery there was observed massive vaginal fistula, massive inflammatory changes were visible in cystoscopy. Two months after surgery -bilateral hydronephrosis, both in double J ureteral stent were inserted. 5 months after surgery no hydronephrosis was detected, both double J stents from the ureters were removed. Next there were observed episodes of high urosepsis with bilateral hydronephrosis, finally 7 months after surgery – double J stents to both ureters were necessary.

Conclusion* We are conscious that finally, retransplantation of the ureters is necessary otherwise the patient will be obliged to continuous exchange of the double J stands in both ureters and the episodes of the urosepsis would reply – but if the urologic surgery is needed it could be done not earlier than