would need to be analyzed by TP53 IHC, only 46 (7.7%) by MMR IHC and 286 (48.1%) *POLE* sequencing reactions.
Conclusion* Application of the 2021 molecular risk groups is feasible and shows significant differences in survival. IHC for TP53 and MMR and applying POLE sequencing is only needed in selected cases and leads to shifting risk groups both upward and downward for a sizeable number of patients. It is possible to significantly reduce the number of analyses required to implement the classification if resources are limited.

860 COMBINED USE OF ICG AND TECHNETIUM DOES NOT IMPROVE SENTINEL LYMPH NODE DETECTION IN ENDOMETRIAL CANCER

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Introduction/Background* There is scarce evidence available about the benefit of combining technetium (99mTc) and indocyanine green (ICG) for sentinel lymph node (SLN) biopsy in endometrial cancer. The aim of this study was to compare the overall and bilateral pelvic detection rates of sentinel lymph nodes in two retrospective cohorts: ICG exclusive vs. combined ICG+99mTc.
Methodology Multicentre retrospective study (November 2015-June 2020) including patients diagnosed with endometrial atypical hyperplasia or early-stage endometrial carcinoma who underwent sentinel lymph node biopsy by cervical injection of ICG with or without 99mTc in four different referral centers in Spain.
Result(s)* A total of 180 patients were included, 51% (n=92) in ICG group and 49% (n=88) in ICG+99mTc group. Eighty-six percent of the patients presented endometrioid histology, and over ninety-nine percent of the procedures were performed by a minimally invasive approach. Both groups were comparable regarding their basal characteristics, except for a higher body mass index in ICG+99mTc group and a bigger proportion of robotic-assisted procedures in ICG group.

Overall detection rate was 92.8% and similar between groups (ICG: 94.6% vs ICG+99mTc: 90.9%, p=.34). No significant differences were observed neither in bilateral pelvic nor aortic mapping rate. When 99mTc was used, surgical procedures were significantly longer. In 6.7% of patients, at least one positive SLN was found (ICG:9.8% vs ICG+99mTc:3.4%, p = .164). Empty node packet rates and number of SLNs retrieved per patient were also similar between cohorts.
Conclusion* Combining preoperative 99mTc to intraoperative ICG did not improve SLN detection in endometrial cancer, but resulted in longer procedures.

862 SENTINEL LYMPH NODE BIOPSY IN OPEN SURGERY FOR GYNAECOLOGICAL MALIGNANCIES

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Introduction/Background* Sentinel node biopsy has been introduced as alternative to lymph node dissection for lymph node staging for endometrial cancer patients. This surgical video has the objective to show the feasibility of Indocyanine Green (ICG) sentinel node sampling using SPY Portable Handheld Imaging System during open endometrial cancer surgery.
Methodology 72 years old patient with diagnosis of endometrioid G2 endometrial cancer underwent open surgery due to anesthesiological and surgical contraindications.
Result(s)* Laparotomy with total extrafascial hysterectomy, bilateral salpingoophorectomy and bilateral lymph node biopsy was performed. Operative time was 110 minutes and blood loss was 200cc. Patient was discharged after 4 days without any complication.
Conclusion* The use of SPY Portable Handheld Imaging System in open surgery seems to be a feasible and useful tool for the detection of SLN in endometrial cancer patients underwent open surgery.

863 METASTATIC ENDOMETRIAL CARCINOMA ARISING FROM ADENOMYOSIS, PRESENTING WITH DEEP VEIN THROMBOSIS AND VISUAL IMPAIRMENT; CASE REPORT

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Introduction/Background* Endometrioid carcinoma arising in adenomyosis (EC-AIA) is a rare entity. We present a case of an advanced stage presenting with deep vein thrombosis (DVT) and visual impairment.
Methodology 42-year old patient presented to our institution, due to DVT of left femoral vein. During hospitalisation, an abdominal ultrasound showed a uterine tumour, resembling a myoma. Increased Ca 125 and Ca 15-3 were observed. No subsequent diagnostic procedures were performed, a follow up visit with personal gynaecologist was recommended. In the following weeks, she noticed visual impairment and trouble with understanding. Cranial MRI showed metastatic lesions and possible meningeal carcinosis. Patient was readmitted. Abdominal computer tomography (CT) showed a pelvic necrotic formation between right ovary and uterus, with pathologic iliac and paraaortic lymph nodes. Multidisciplinary team indicated primary debulking surgery. Before the procedure, she underwent coloscopy and gastroscopy without pathologic findings.

Median laparotomy with hysterectomy, omentectomy, appendectomy and debulking of pelvic and paraaortic lymph nodes were performed. Pathohistological report showed a necrotic tumour, originating in the myometrium on the right lateral side of the uterus and infiltrating the right salpinx and ovary. Microscopic evaluation revealed endometrioid adenocarcinoma, grade 1, originating in myometrium, without involvement of endometrium. Positive right obturator and paraaortic lymph nodes did not involve the capsule. Immunohistochemistry showed positive oestrogen and progesterone receptors and p53-wt expression. Additional genetic analysis was done, due to loss of MSH6 protein. Due to probable cranial involvement, stage was set as FIGO IVB. Subsequent treatment consisted of palliative radiotherapy of the cranium, followed by