Molecular classification yielded 6 (9.1%) *POLEmut*, 17 (25.8%) *MMR-D*, 29 (43.9%) *NSMP* and 14 (21.2%) *p53abn*. Between *POLEmut*, 3 (50%) were low-grade endometrioid, while the rest were high-grade. 2 (14.3%) of *p53abn* were low-grade endometrioid, 2 (14.3%) high-grade endometrioid and 10 (71.4%) non-endometrioid hystotype. Regarding *MMR-D* cases, loss of MLH1 and PMS2 expression was observed in 11/17 (64.7%), of those MLH1 promotor hypermethylation was identified in 7/11 (63.1%). Rest of cases were referred to germline testing, although no germline mutations have been identified yet.

According to final prognostic group, 25/66 (37.9%) were low risk, 9/66 (13.6%) intermediate risk, 7/66 (10.6%) high-intermediate risk, 17/66 (25.8%) high risk. Between low-risk patients, 3 would have classified as high risk if molecular classification had not been taken account, and 2 between high-risk would have classified as low-risk. Consequently, 7.6% of cases were reclassified and adjuvant therapy adjusted.

Conclusion Implementation of molecular classification is feasible in routine clinical practice. *POLEmut* and *p53abn* are identified not only in high-grade cases but also in low-grade. Molecular classification leads to a change in adjuvant therapy in a non-negligible proportion of cases.

IMPLEMENTING SENTINEL LYMPH NODE BIOPSY IN ALL RISK GROUPS IN ENDOMETRIAL CANCER: OUR EXPERIENCE AT DR. JOSEP TRUETA UNIVERSITY HOSPITAL

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Introduction/Background The aim of this study is to assess outcomes of sentinel lymph node biopsy at our institution since its implementation in all risk groups and to evaluate factors associated with migration.

Methodology Retrospective cohort study including all newly clinical early-stage endometrial cancer cases operated between January 2021 and April 2022. Minimum preoperative work-up included endometrial biopsy with histomolecular information, transvaginal ultrasound and pelvic MRI. Toraco-abdominal TC was added in high-risk.

Results 56 cases were included. Sentinel node biopsy was done in 39/56 (69.6%). 11/56 with no nodal staging because of anaesthetic risk: 8 low/intermediate risk, 3 high-intermediate/high risk. In 5/56 (8.9%) lymphadenectomy was done: 2 were re-staging procedures, 1 for preoperative diagnosis of primary cervical cancer and 2 were excluded of sentinel node protocol due to antecedent of pelvic radiotherapy. Median BMI was 28.5 (IQR 25–35), age 65.5 y (IQR 57.0–73.0), operating time 145 min (IQR 126–170), and hospitalization time 2 days (IQR 2–3). Way of approach was robotic surgery in 94.6%. Between sentinel node patients, cervical injection and indocianine green were used in all cases. No intraoperative complications and 3/39 postoperative complications (Clavien-Dindo II) were reported. Overall detection rate was 92.3% and bilateral detection rate 74.3%. Side-specific lymphadenectomy was needed because of no detection and high-intermediate/high risk in 2/39. Reinjection of tracer was 20.5%. 63 nodes were detected, most frequent localization was external iliac 35/63 (55.5%). Overall positive nodes were 5.1%: macro-metastasis in 1 case (preoperative low-risk) and microme-tastasis in 1 case (preoperative intermediate-risk). No differences in bilateral detection were observed regarding age, BMI, comorbilities or molecular group.

Conclusion Sentinel lymph node biopsy is feasible in routine clinical practice with bilateral detection rates similar to that reported. Positive nodes were observed in low/intermediate risk and not only in high-risk patients so it cannot be omitted in these groups.

LAPAROSCOPIC EXTRAPERITONEAL SYSTEMATIC PARA-AORTIC LYMPHADENECTOMY, A STEP-BY-STEP EDUCATIONAL VIDEO

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Introduction/Background Para-aortic lymphadenectomy is part of the standard staging procedure of endometrial cancer. Laparoscopic extraperitoneal para-aortic lymphadenectomy is a feasible alternative technique avoiding the difficulties of the intraperitoneal techniques (extreme trendelenburg, limited surgical space associated problems). Extraperitoneal technique excels due to minimal risks of bowel injury and adhesions formation, avoids trendelenburg position and can be performed in spite of previous abdominal operations. On the other hand, limitations of this technique are the limited surgical space and the lack of anatomical landmarks which can lead to disorientation. The aim of this video is educational, to provide step-by-step the technique of the extraperitoneal para-aortic lymph node dissection.

Methodology We present a case of a 65-year-old woman with serous endometrial cancer stage II grade 3 (FIGO) who operated in our department and underwent laparoscopic extraperitoneal para-aortic lymphadenectomy followed by total laparoscopic hysterectomy (TLH), bilateral saplingo-oophorectomy (BSO) and bilateral pelvic lymphadenectomy. The steps of the extraperitoneal para-aortic lymphadenectomy are listed below:- Intraperitoneal laparoscopy to exclude advanced disease.- Developing the retroperitoneal space- Identification of the anatomical landmarks- Para-aortic lymphadenectomy- Conversion to intraperitoneal laparoscopy for TLH-BSO and pelvic lymphadenectomy

Results Intraoperative and postoperative periods were uneventful. The patient discharged on the next day.

Conclusion Extraperitoneal laparoscopic para-aortic lymphadenectomy is a feasible surgical technique to overcome the conundrums of the intraperitoneal technique even when the patients have history of multiple previous abdominal surgical operations. This technique requires advanced laparoscopic skills and good knowledge of the anatomy of the retroperitoneal space.