

overall MMR status when age 50 was used as a hypothetical testing threshold. After correcting for tumour grade as a confounding variable it was shown that MLH1 and PMS2 expression were negatively correlated with increasing age while MSH6 expression was positively correlated with increasing age at diagnosis (figures 1 and 2).

Conclusion There is no statistically significant difference in overall immunohistochemical MMR status when using the age of 50 as a threshold for tumour analysis. Such a threshold would have missed 82.3% of cases with tumoral MMR deficiency and should not be included in lab protocols for EEC IHC analysis. Reflex testing of all EEC cases is highly advised as IHC testing is no longer solely about diagnosis of Lynch syndrome. Prospective evidence is required to clarify the role IHC scoring and semi-quantitative analysis should play in MMR status interpretation and patient management especially in the ever-evolving field of targeted therapeutics.

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RECURRENCE AND SURVIVAL AFTER LAPAROSCOPY VERSUS LAPAROTOMY IN EARLY STAGE ENDOMETRIAL CANCER: FOLLOW-UP FIVE YEARS AFTER A RANDOMISED TRIAL

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Introduction/Background Laparoscopic hysterectomy has been proven to be a safe surgical procedure and is globally accepted as the standard treatment for early-stage endometrial cancer, despite insufficient data on long-term survival. Aim was to provide the five-years outcomes of a randomised Dutch trial on total laparoscopic hysterectomy (TLH) versus total abdominal hysterectomy (TAH) in early-stage low-risk endometrial cancer.

Methodology Follow-up of a multi-centre, randomised controlled trial on TLH versus TAH without routine lymphadenectomy. A total of 279 women with stage I endometrial cancer were enrolled between 2007–2009 in a 2:1 randomisation to undergo either TLH (n=185) or TAH (n=94). Primary outcome was disease-free survival. Secondary outcomes were primary site of recurrence, overall and disease-specific survival. The Kaplan-Meier survival curves and Cox proportional hazard ratios were applied.

Results Follow-up data of 253/279 patients are available. At a median follow-up time of 5.0 years, disease-free survival was 90.4% after TLH and 83.3% after TAH, HR 0.68 (95% CI 0.31–1.49). There were no port-site metastases and local recurrence rates were comparable. After adjustment for the covariates, overall survival outcomes were comparable between groups HR 0.64 (95% CI 0.33–1.26). Disease-specific survival was comparable between both groups.

Conclusion This is the first study reporting on survival among women with early-stage endometrial cancer randomised to TLH or TAH, without routine lymphadenectomy. No significant differences were found in disease-free, overall and disease-specific survival five-years postoperatively. This supports the widespread use of laparoscopic hysterectomy as primary treatment procedure for early-stage, low-grade endometrial cancer.

Disclosures None.

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PREDICTING LYMPHEDEMA ASSOCIATED WITH LYMPH NODE DISSECTION IN PATIENTS WHO UNDERGO SURGERY FOR ENDOMETRIAL CANCER: ROLE OF DEMOGRAPHIC AND CLINICAL CHARACTERISTICS

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Introduction/Background Multimodal treatments have significantly improved oncological outcomes in patients with endometrial cancer. Therefore most of the patients are long-term survivors and may experience adverse effects related to treatment. Lymph node dissection in patients who undergo total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH+BSO) may be associated with adverse effects such as lymphedema. Several factors including number of removed lymph nodes and extent of lymph node dissection have been postulated to be associated with adverse events. However, in most studies the definition of the complications is poorly described and contradicting findings exist. In this prospective study we aim to assess the complications related to lymph node dissection in patients who undergo TAH+BSO and potential factors that predict adverse events.

Methodology We conducted this prospective study to assess the complications related to lymph node dissection in patients who underwent TAH+BSO for endometrial cancer. Patients with prior history of lower limb surgery, pelvic radiation and prior history of cancer treatment were excluded from study. Additional exclusion criteria were heart failure, uncontrolled thyroid abnormalities and other disorders associated with impaired lymphatic drainage and/or lower limb edema. Demographic and clinical characteristics including age, body mass index, pathologic stage, and extent of lymph node dissection were recorded. We also assessed complications related to lymph node dissection i.e. lymphedema, lymphatic leakage and lymphocele. Lymphedema was defined based on American Physical Therapy Association criteria. We applied Gynecologic Cancer Lymphedema Questionnaire to evaluate severity of symptoms related to lymphedema. Written informed consent was obtained from all patients and institutional review board approved the study.

Results A total of 135 patients with a mean age of 57.6 ± 11.5 underwent TAH+BSO during the study period. Lymph node dissection was performed in 83 (61.4%) patients. The extent of lymph node dissection was limited to pelvis in 18 (33.3%)