289 COMPARISON OF PET/CT AND MRI IN LYMPH NODE INVOLVEMENT AND PELVIC EXTRAUTERINE DISEASE DETECTION OF ENDOMETRIAL CANCER: PRESURGICAL STAGING

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Introduction/Background* Pre-surgical staging in endometrial cancer is crucial for planning surgical treatment and adjuvant therapy of the disease. The aim of the present study is to determine the diagnostic accuracy of PET/CT and MRI in the detection of pelvic extrauterine disease and lymph node involvement.

Methodology An ambispective descriptive study was conducted including patients diagnosed with early stage high-risk endometrial cancer or advanced stage endometrial cancer between January 2011 and July 2021 in our Institution. In all cases included, a pre-surgical study with PET/CT and MRI was performed and lymph node debulking or lymph node staging with pelvic and para-aortic lymphadenectomy was carried out.

Finally, we compared the sensitivity, specificity, positive predictive value, and negative predictive value for the detection of adenopathies and/or extrauterine pelvic disease detected by PET/CT and MRI. All statistical analysis were performed using the software SPSS Statistics v.24.0 (IBM Corp., Armonk, NY, USA).

Result(s)* The results after final statistical analysis will be available when the prospective data collection has been finalised.

Conclusion* The hypothesis we plan to confirm is that MRI is not superior to PET/CT in the detection of lymph node involvement and can be omitted in the pre-surgical study of early stages of high-risk endometrial cancer. However, in advanced stages, MRI may be useful given its greater ability to delineate the pelvic extension of the primary tumor.

660 EARLY STAGE, LOW GRADE ENDOMETRIAL ADENOCARCINOMA IN REPRODUCTIVE AGED WOMEN: PILOT TESTING OF A PATIENT DECISION AID

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Introduction/Background* Endometrial adenocarcinoma (EAC) is rare in reproductive aged women. Patient perspectives of treatment in this cohort have highlighted unmet needs in information provision and decisional conflict around standard surgical treatment or treatment with progestins, and implications for fertility and oncological outcomes. Decision aids have been used to support information provision and clinical decision-making. Patients exposed to decision aids are more knowledgeable, better informed and clearer about their values. We developed and pilot tested a decision aid for reproductive aged women with low grade, early stage EAC.

Methodology A decision aid was developed in accordance with International standards. A literature review and observational data on the treatment perspective of this cohort were used to create the first draft. It was reviewed by key experts including Gynaecology Oncology, Fertility, and Decision Aid Development experts, along with 2 consumers. A finalised draft decision aid was tested amongst healthcare practitioners and consumers. It was distributed with an online survey assessing format, content, length, acceptability, and utility. Seventy-five women aged 18–40 years with early EAC, treated at the Royal Women's Hospital (RWH), Melbourne, Australia, were identified from patient databases and invited to participate. Online survey links were distributed via mobile text message. Ninety-four multi-disciplinary healthcare providers involved in the care of women with EAC at RWH were identified through the MDT meeting group and invited to participate via email of the survey link.

Result(s)* Nineteen participants completed the survey, 10 consumers, 9 healthcare practitioners. Overall, all respondents liked the decision aid, thought it was relevant, useful and helpful for both consumers and health care practitioners. Improvements to formatting and layout of the decision aid were suggested by both groups. Almost all consumers indicated the amount of information was about right or not enough, compared to half of practitioners expressing concern about too much information, suggesting a mismatch in informational desires between consumers and healthcare practitioners.

Conclusion* The decision aid for young women diagnosed with early EAC was acceptable and useful to patients and healthcare professionals. Information from this study will be used to produce a final draft the decision aid. Prospective evaluation of the decision aid would further assist in optimising the decision aid and understanding its utility in clinical practise.

768 DISCLOSURE OF OUR LATEST DATA USING SENTINEL LYMPH NODE (SLN) FOR STAGING ALL ENDOMETRIAL CANCERS

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Introduction/Background* SLN biopsy can be considered for staging in patients with low-risk/intermediate-risk disease and it is an acceptable alternative to lymphadenectomy for LN staging in stage I/II. LN staging should be performed in patients with high-intermediate-risk/high-risk disease. Four prospective cohort trials have shown high sensitivity to detect pelvic LN metastases and a high negative predictive value applying a SLN algorithm in high-risk/high-grade endometrial carcinomas. Our aim is present our prospective results in endometrial cancer applying new ESGO/ESMO/ESTRO recommendations for staging all endometrial cancers comparing them with our previous 333 patients data.

Methodology A prospective observational study is being conducted since 1 January 2021 with patients that undergo laparoscopic surgery for endometrial cancer at our institution. We perform only SLN biopsy with dual cervical and fundal indocyanine green injection in all endometrial cancers. All

SLNs were processed with an ultrastaging technique. Between 26 June 2014 and 31 December 2019 with 333 patients we applied the previous treatment algorithms. Between January and 30 August 2021 we did only SNL in 45 patients.

Result(s)* Comparation of the results between the ancient and the new serie (ancient/**new**): Detection rate 94%/**97.7%** overall for SLNs; 91.3%/**97.7%** overall for pelvic SLNs; 70.5%/**88.8%** for bilateral SLNs; 68.1%/**88.8%** for paraaortic SLNs, and 2.9%/**0%** for isolated paraaortic SLNs. Macrometastasis 18%/**6%** patients and microdisease 17.6%/**8.8%** patients, overall rate of LN involvement 16.2%/**11%.** Isolated Aortic metastases 4.2%/**2.2%** (14/333–1/45). Assuming the results of the ancient serie there was one false/negative (negative SLN with positive lymphadenectomy). Our sensitivity of detection was 98.3% (95% CI 91–99.7), specificity 100% (95% CI 98.5–100), negative predictive value 99.6% (95% CI 97.8–99.9), and positive predictive value 100% (95% CI 93.8–100).

Conclusion* SLN biopsy is an acceptable alternative to systematic lymphadenectomy for LN staging in stage I/II. We avoid 22/45 (48.8%) lymphadenectomies with new algorithm, reducing the morbidity in our patients. Our surgical times were shorter improving our theaters efficiency with all that implies for. Additionally, this technique allows a high rate of aortic detection, identifying a non-negligible percentage of isolated aortic metastases. Isolated Aortic metastases in endometrial cancer are possible and we should not give up actively looking for them.

773 THE IMPACT OF SENTINEL LYMPH NODE BIOPSY ALONE ON SURVIVAL OF PATIENTS WITH ENDOMETRIAL CANCER (TRSGO-SLN-007)

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Introduction/Background* Diagnostic efficacy of sentinel lymph node (SLN) biopsy is proven in many studies in terms of the detection of lymphatic spread in endometrial cancer. However, there are limited data about the effect of SLN biopsy only on survival. The aim of this study was to investigate whether SLN biopsy only compromises oncologic outcomes compared to systematic lymphadenectomy in a large cohort.

Methodology In this multicentric study, records of 564 endometrial cancer patients who underwent surgical staging with either sentinel lymph node biopsy alone or sentinel lymph node biopsy followed by systematic lymphadenectomy with at least 6 months of follow-up time were retrospectively reviewed. The impact of type of lymphadenectomy and histopathologic factors on recurrence, disease-free survival (DFS) and overall survival (OS) were assessed. DFS and OS rates were calculated using Kaplan-Meier method and log-rank test was used to calculate statistical significance between the groups. Cox univariate and multivariate analyses were used to identify prognostic factors for DFS and OS.

Result(s)* Median follow up time was 28 months (range: 6-130) and 14 (2.5%) of the 21 (3.7%) deaths were due to the disease. 2- and 3-year OS were 98.2% and 97%, respectively. Median time to recurrence was 12.5 months (range: 3-30). Sites of the 42 (7.4%) recurrences were as follows: 12 (28.6%) locoregional, 19 (45.2%) distant, 3 (7.1%) nodal and 8 (19%) more than one site. 2- and 3-year DFS were 93.1% and 92.6%, respectively. While non-endometrioid subtypes ($p=0.048$), grade 3 histology ($p<0.001$) and presence of lymphovascular space invasion (LVSI) ($p<0.001$) were found as independent prognostic factors for decreased DFS, age ($p=0.017$) and tumor size ($p=0.041$) were independent factors for shorter OS. Type of lymphadenectomy was not a prognostic factor lymphatic recurrence, DFS and OS.

Conclusion* Our study showed that removal of only SLNs was not associated with worse survival compared to systematic lymphadenectomy in endometrial cancer patients. Nodal recurrence rate was also similar between the groups.

813 FERTILITY PRESERVATION IN ENDOMETRIAL CANCER: PERINATAL AND ONCOLOGIC OUTCOMES

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Introduction/Background* The aim of our study is to evaluate the oncological and perinatal outcomes in young women diagnosed with atypical endometrial hyperplasia (AH) or endometrial cancer (EC) treated with hormone therapy.

Methodology A single institutional ambispective study was performed including all patients diagnosed with AH or EC grade 1 without myometrial invasion who received hormone therapy between January 2011 and July 2021. We analyzed the complete response rate and recurrence rate of disease and pregnancy rate in these patients as well as perinatal results (live births rate, type of delivery and perinatal morbidity). In addition, we evaluated complete response rate according to type of hormone therapy, dosage received and treatment length.

A review of literature was performed to identify studies involving patients with AH or EC who received fertility sparing management.

All statistical analysis were performed using the software SPSS Statistics v.24.0 (IBM Corp., Armonk, NY, USA).

Result(s)* There were 6 patients with AH/EC (4 and 2 patients respectively) who received hormone therapy with a mean treatment time of 8.6 ± 1.96 months. Hormone therapy with megestrol acetate was carried out in 4 patients (66.6%). Complete remission was achieved in 5 patients (83.3%) and 2 of them (33.3%) attempted pregnancy. Finally, no complications during pregnancy were reported in this 2 patients and both had normal delivery. The rate of live birth was 33.3%. During the follow-up no recurrences were detected and overall survival was 100%

Conclusion* Conservative management with progestins of young patients with AH or EC grade 1 limited to the endometrium is an acceptable possibility given the high remission