

woman had FIGO-IIb PEComa with recurrence within 2 months following surgery in vagina and lung. She underwent vaginal and thoracic surgery resecting tumors. She did not receive chemotherapy for ovarian cancer due to medical fitness. PEComa relapsed aggressively in the pelvis, lungs and diaphragm within 6 months and she was treated with Siroli-mus and Nab-siroli-mus. With this aggressive tumour, her over-all survival was 14 months.

**Conclusion** This illustrates the natural history of a rare uterine tumour (PEComa) and the management in rare presentations with aggressive tumours. The management can be challenging requiring multidisciplinary approach. There is lack of evidence how to manage recurrence of PEComa not salvaged by surgery.

## 2022-RA-768-ESGO

### FREE CANCER CELLS IN FALLOPIAN TUBES (FLOATERS) AS ARTIFACTS OF UTERINE MANIPULATOR USE IN MINIMALLY INVASIVE SURGERY (MIS) FOR ENDOMETRIAL CANCER: DOES IT MATTER? A RETROSPECTIVE COHORT STUDY

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**Introduction/Background** It is unclear if free cancer cells in fallopian tubes (FT) floaters increase with the use of uterine manipulators (UM) and whether it may increase cancer recurrence. Our objective is to assess the rate of FT floaters associated with UM use in endometrial cancer treated by MIS and its impact on oncologic outcome.

**Methodology** This is a single center retrospective cohort study including patients who underwent surgery for apparent early-stage endometrial cancer by either laparoscopy, robotics or laparoscopic assisted vaginal hysterectomy (LAVH) from 11/2012 to 12/2020. Data on manipulator type, isolated tumor cells (ITC), cytology, LVSI, FT floaters, stage, histology and grade were collected. Primary outcome was the rate of FT floaters. Secondary outcome was cancer recurrence and disease-specific death. Kaplan-Meier curves, univariate and multivariate logistic regression were used for statistical analysis.

**Results** 1,020 women with endometrial cancer were included; 876 (86%) had hysterectomy with UM and 144 (14%) without, with a mean follow-up of 44,6 months. 84,7% had endometrioid histology, 84,5 % were grade 1 or 2 and 97,2% had stage I disease. Intra-uterine balloon manipulator (V-Care) was associated with the presence of FT floaters on univariate analysis (OR 2,47; 95% CI, 1,17–5,23; p=0,018) with a rate of 14,2%. Endocervical manipulator (Hohl) was not associated with floaters (OR 0,93; 95% CI, 0,43–1,98; p=0,854) with a rate of 5,9%. No manipulator MIS had a floater rate of 6,3%. Prior tubal ligation statistically reduces the risk of floaters (OR 0,33; 95% CI, 0,17–0,65; p=0,001). On multivariate analysis, FT floaters were not associated with recurrence (OR 1,14; 95% CI, 0,486–2,68; p=0,760) and disease-specific death (OR 0,650; 95% CI, 0,116–3,65; p=0,623).

**Conclusion** Intra-uterine balloon manipulators used in endometrial cancer MIS is associated with higher rates of FT floaters, but were not associated with recurrence and disease-specific death. Prior tubal ligation is protective.

## 2022-RA-772-ESGO

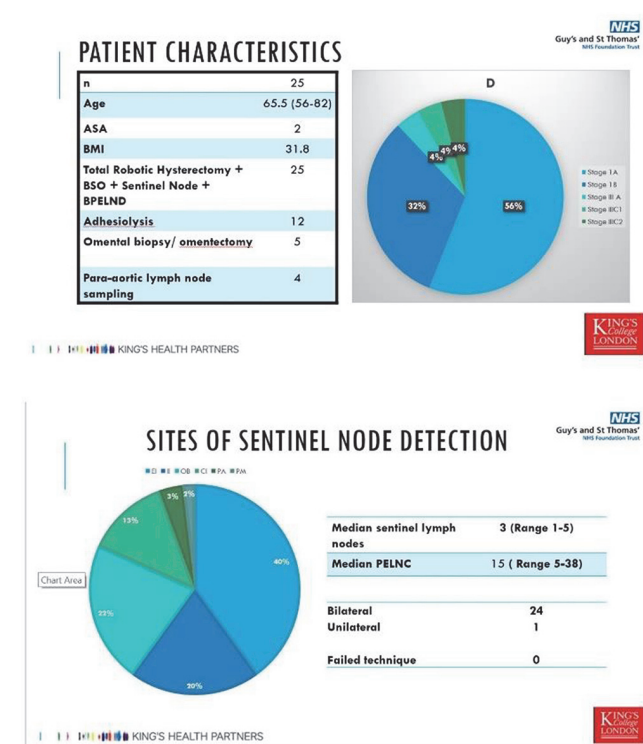
### ROBOTIC SENTINEL LYMPH NODE DETECTION IN ENDOMETRIAL CANCER – A PILOT SERIES AT GUY'S AND ST THOMAS' HOSPITAL

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**Introduction/Background** Sentinel lymph node (SLN) technique identifies the first node(s) draining any organ and uses ultra-staging to detect micro-metastases. SLND reduces surgical-related morbidity, lymphedema, lymphocyst formation and operative time. It detects nodal metastases at aberrant sites and upstages 18–20% in high-risk patients.

**Methodology** Women requiring lymphadenectomy in intermediate & high-risk endometrial cancer at Guy's and St Thomas' Cancer Centre were included. Data was collected prospectively and results analysed. Intra-cervical IndoCyanine Green (ICG) was injected at two sites and surgery performed using Xi Davinci robot. SLN were mapped using firefly fluorescent camera and sampled. Bilateral pelvic lymphadenectomy (BPLND) was performed following SLN sampling.



Abstract 2022-RA-772-ESGO Figure 1

**Results** 25 patients underwent SLND during robotic staging for intermediate and high-risk endometrial cancer. Mean age

was 65.5 years (56–82), ASA score=2 and mean BMI=31.8. Women underwent total hysterectomy and bilateral salpingo-oophorectomy in all, adhesiolysis (48%), omental sampling (20%) and para-aortic sampling (16%). The FIGO stages included stage-I (88%) and Stage-III (12%). Median lymph node count in SLN was 3 (1–5) and BPLND was 15 (5–38). Nodal metastasis was 8%. Para-aortic lymph node positivity was 4%. SLND sensitivity was 100%, specificity 96.15%, false-negative rate 0%, negative predictive value 100%. Median time for SLND was 15 min (10–22) while BPLND was 35 min (25–40). Bilateral SLND was achieved in 96%. Obturator node was the most common SLN site (40%). 8% SLN were detected in paraaortic and parametrial sites. Complication rate was 1.8%.

**Conclusion** Our pilot study shows that SLND with ICG in intermediate and high-risk endometrial cancer is accurate with high negative predictive values. The quality of nodal assessment was improved by identifying aberrant location in 8% women with SLND. Our series is comparable to international standards and mandates a change in institutional practice. SLND-only is accurate technique for nodal assessment in surgical staging for intermediate and high-risk endometrial cancers.

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#### MLH1 PROMOTER HYPERMETHYLATION IN MISMATCH REPAIR DEFICIENT ENDOMETRIAL CANCER. DEFINING A NEW SUBGROUP?

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**Introduction/Background** Nearly 30% of unselected endometrial cancer (EC) are mismatch repair deficient (MMRd). The majority resulting from epigenetic changes due to MLH1 promoter hypermethylation (MLH1-PM) and only a fraction from mutations in the Lynch genes (*MLH1/MSH2/MSH6/PMS2*). Identifying patients with MMRd has two clinical implications: first, detecting patients with high probability for Lynch syndrome and secondly classification into molecular subtypes for prognosis and/or prediction of therapy. Since less is known about the clinical characteristics of MMRd tumors especially based on MLH1-PM we aimed at clarifying the clinical features of EC with MLH1-PM.

**Methodology** EC patients treated between 2015–2022 who underwent MMR(IHC) +/- MLH1-PM (PCR)-testing were included. Three groups were defined. A) MMR proficient(p) B) MMRd/MLH1-PM 3) ‘probable’ Lynch (defined as MMRd not due to MLH1-PM).

**Results** MMR-testing was performed in 337/365 cases (279 MMRp and 58 MMRd). 36 of 45 tumors with MLH1 +/- PMS2 deficiency had MLH1-PM analysis, identifying MLH1-PM in 28 (77.8%). MMRd tumors were detected at higher stages, more often showed angioinvasion and endometrioid

subtype and less abnormal p53 expression compared to MMRp. Patients with MMRd-PM were significantly older (65 y vs 56 y), more often had endometrioid histology (89% vs 76%), showed no abnormal p53 expression (0% vs 19%) compared to ‘probable’ Lynch. 5-year PFS was 73, 81 and 100 months ( $p=0.343$ ) for MMRp, MMRd/MLH1-PM, and ‘probable’ Lynch patients, respectively.

**Conclusion** Significant differences in clinical characteristics were detected between MMRd and MMRp tumors, as well as between MMRd tumors depending on MLH1-PM status. Thus, this analysis supports evidence of heterogeneity in MMRd tumors concerning prognosis.

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#### ROLE OF FOLLOW UP OF STAGE ONE ENDOMETRIAL CARCINOMA FOR DETECTION OF RECURRENCE

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**Introduction/Background** To investigate the rate of asymptomatic recurrence of stage 1 endometrioid endometrial cancer and assess the role of routine hospital follow-up after treatment.

**Methodology** We performed a retrospective case-note review study of women who were diagnosed with stage 1 endometrioid endometrial adenocarcinoma at Queen’s Hospital, Romford, between January 2008 and December 2016.

**Results** We included 299 patients with a median follow-up period of 44.4 months. All the patients underwent total hysterectomy and bilateral salpingo-oophorectomy. Adjuvant radiotherapy was offered to the patients subsequent to discussions in the multidisciplinary team meeting in accordance with the risk stratification criteria. There was no significant correlation between the risk factors and disease recurrence. In total, 11 patients presented with recurrent disease with original staging: 1a,  $n=6/199$ ; and 1b,  $n=5/100$ . Four patients presented with vaginal bleeding due to vault recurrence and one patient with abdominal pain due to pelvic mass. Locoregional recurrence was an incidental finding in two other patients. Four patients presented with symptomatic distant metastases to the lung ( $n=2$ ), liver ( $n=1$ ), and bone ( $n=1$ ). No asymptomatic recurrences were identified on routine follow-ups, despite several hospital appointments and clinical examinations. The recurrence rate for patients with stage 1a and 1b, grade 1, and grade 2 disease was 3.53%, and that for patients with stage 1a, grade 1, and grade 2 disease was 2.7%.

**Conclusion** Routine clinical examinations have a low yield in finding recurrence in asymptomatic women and should be questioned for their value, considering the limited resources of the National Health Service (NHS). Recent evidence has supported the shift to telephone clinics and patient-initiated follow up.