Objective To evaluate the demographic factors associated with the increase in incidence of uterine cancer after correcting for hysterectomy.

Methods From 2001–2016, incidence rates of uterine cancers (epithelial carcinoma and sarcomas) were estimated from United States Cancer Statistics after correcting for hysterectomy prevalence based on Behavioral Risk Factor Surveillance System data. SEER*Stat and Joinpoint regression were used to calculate incidence rate (per 100,000) and average annual percent change (AAPC).

Results Of 720,984 patients, 78% White, 10% Black, 8% Hispanic, and 3% Asian/Pacific-Islander. After correcting for hysterectomy, the estimated incidence increased from 27.1 to 42/100,000 women. Over 15 years, the incidence increased from

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40.8 to 42.9 with an annual percent increase (AAPC) of 0.5% per year (p<0.05). The 65–69 year old group had the highest incidence (185.4). With respect to race, the highest baseline incidence was in Blacks at 49.5 that increased 2.3% per year (AAPC). Whites had an incidence of 43.6 with an annual percent increase of only 0.4%. The Hispanics had an incidence of 35.0 (AAPC=1.1%), then Asians incidence 24.0 (AAPC=1.3%). The intersectionality of age and race showed that the group with the highest risk was 65–69 year old and Black with an incidence of 281.1 (AAPC=2.3%).

Conclusion The intersectionality of age and race found age 65–69 Black women with the highest incidence of uterine cancer with a six-fold increase compared to the general population, using hysterectomy-corrected data. Further studies are warranted to determine potential genetic, social-determinant, or environment exposures to explain these findings.

IGCS20_1179

SURVIVAL OUTCOMES IN ENDOMETRIAL CANCER PATIENTS HAVING LYMHPHADENECTOMY, SENTINEL NODE MAPPING FOLLOWED BY LYMHPHADENECTOMY AND SENTINEL NODE MAPPING ALONE: LONG-TERM RESULTS OF A PROPENSITY-MATCHED ANALYSIS

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10.1136/ijgc-2020-IGCS.31

Objective Sentinel node mapping (SLNM) has replaced lymphadenectomy for staging surgery in apparent early-stage endometrial cancer (EC). Here, we evaluate long-term survival of three different approaches of nodal assessment in EC.

Methods This is a multi-institutional retrospective study evaluating long-term outcomes (at least 3 years) of patients having lymphadenectomy, SLNM followed by lymphadenectomy and SLNM alone. We applied a propensity-matched algorithm. Survival outcomes were assessed using Kaplan-Meier and Cox proportional hazard models.

Results Applying a propensity score matching algorithm we selected 180 patients having SLNM (90 SLNM vs. 90 SLNM followed by lymphadenectomy). Additionally, a control group of 180 patients having lymphadenectomy was selected. Overall, 10% of patients were diagnosed with positive nodes. Low volume disease was observed in 16 cases (5 micrometastasis and 11 isolated tumor cells). Patients having SLNM followed by lymphadenectomy had a higher possibility to be diagnosed with a stage IIIC disease in comparison to lymphadenectomy alone (p=0.02); while we did not observe a difference in the diagnostic value of SLNM followed by lymphadenectomy and SLNM (p=0.389). Median follow-up time was 69 (7–206) months. There were no statistical differences in terms of disease-free (p=0.570, log-rank test) and overall survival (p=0.911, log-rank test); Similarly, they did not impact on survival outcomes after stratification by low, intermediate and high-risk patients.

Conclusions Our study highlighted that SLNM provides similar long-term oncologic outcomes than lymphadenectomy, even in high-risk patients. Further evidence is warranted to assess the prognostic value of low volume disease detected by ultrastaging in patients following SLNM.

IGCS20_1067

MOLECULAR SUBTYPE DIAGNOSIS OF ENDOMETRIAL CARCINOMA: COMPARISON OF NGS PANEL AND PROMISE CLASSIFIER

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10.1136/ijgc-2020-IGCS.33

Objectives The molecular classification of endometrial carcinoma (EC) is taking the diagnosis on EC to a more comprehensive level and will aid to better identify those patients whose disease is likely to behave differently than predicted when using traditional risk stratification. We are transitioning