

patients, whereas, 3 (2.2%) patients underwent pelvic and para-aortic lymph node dissection. Median number of dissected lymph nodes was 11 (interquartile range: 5.7–21.2). Among patients who underwent lymph node dissection, 14 (16.3%) patients showed lymph node involvement. Stage I, II and III were recorded in 97(71.9%), 13 (9.6%), and 25 (18.5%) patients respectively. We did not observe lymphedema in our study participants. Other complications related to lymph node dissection were low grade and were not associated with age, BMI, extent of lymph node dissection, total number of dissected lymph nodes, lymph node involvement and disease stage.

Conclusion Complications related to lymph node dissection including lymphedema are rare after TAH+BSO for endometrial cancer and the extent of lymph node dissection or disease stage is not associated with higher risk of such complications.

615 CLINIC-PATHOLOGICAL FEATURES OF MIXED ENDOMETRIAL CARCINOMA; EVALUATION OF 29 PATIENTS IN A SINGLE TERTIARY CENTER

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Introduction/Background Mixed endometrial carcinoma (MEC) refers to a tumor that is comprised of two or more distinct histotypes. Each component histotype by definition has to represent more than 5% of the tumor. Although it is relatively rare, both diagnosis and management can be troublesome. Molecular and histopathologic features have become important in the identification and more importantly the precise management of the MEC's.

In our study, we aimed to evaluate the clinical and pathological characteristics of the MEC

Methodology The clinical and pathological records of the 29 MEC patients who were operated on and regularly followed up in the clinic between January 2000-December 2019 were reviewed. Clinical features, operation characteristics, pathological findings, myometrial invasion degree (MI), lymph node involvement (LNI), lymphovascular space invasion (LVSI), adjuvant therapies, and follow-up data of the patients and their effects on survival were investigated.

Results During the study period, 29 out of 1110 patients with endometrial cancer had MEC (2.6%). Eighteen of the cases had endometrioid + serous, 7 had endometrioid + clear, 3 had endometrioid + serous, and 1 had clear + serous histopathology. The mean age of the patients was 63.2±12.1. Laparoscopic surgery was performed in 8 of the cases (27.6%). Sixteen of the cases were in stage 1 (55.1%), 4 were in stage 2 (13.8%), and 9 were in stage 3 (31%). LVSI was positive in 17 cases (58.6%). LNI was detected in 7 cases (24.1%). Approximately 80 percent of cases received adjuvant therapy. While 80% of the cases received chemotherapy, this rate was 55% for radiotherapy.

Conclusion MECs are tumors that can be difficult to diagnose and manage. In addition to histopathological features, revealing and evaluating their molecular properties will help us to better understand this group of tumors.

Disclosures None

Miscellaneous

594 IMPACT OF THE COVID PANDEMIC ON GYNAECOLOGICAL CANCER SURGERY – RESULTS FROM THE COVIDSURG GYNAECOLOGICAL CANCER INTERNATIONAL STUDY

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Introduction/Background Covid-19 has resulted in significant number of elective surgeries being delayed or cancelled worldwide with an estimated 28 million patients being affected.¹

Studies show that perioperative Covid-19 infection has a high perioperative mortality of 23-8%. (2) Complications increase with any additional treatment burden such as cytotoxic chemotherapy, radiotherapy or immunotherapy.³ In an effort to reduce treatment related morbidity and mortality during the Covid-19 pandemic, many elective anticancer treatments have been postponed or modified.⁴

Methodology We investigated the impact of the Covid-19 pandemic on gynaecological cancer surgery in an international prospective multi-centre study. Participating centres entered consecutive patient's data into a customized electronic database for 12 weeks from the first COVID positive patient managed in their hospital between March and June 2020. Patients were eligible for enrollment if they were planned to undergo surgery during the study duration, regardless of COVID-19 status and whether they underwent surgery as recommended or not. Patients who did not undergo their planned surgery were followed up for 12 weeks to observe outcomes. Descriptive analysis of outcomes is presented.

4490/4472 (95%) patients received surgery; of these 17% (n=758) experienced change or adaptation of surgery. The main impact was on surgical timing; 11% (n=483) experienced delay in surgery, 3% (n=119) a change in choice of operation, 10% (n=452) received surgery in alternative hospital.

Patients in this study had confirmed resolved COVID-19 prior to surgery in 0.95% (n=45) patients with an additional 0.34% (n=16) with probable resolved COVID-19 infection. A post-operative COVID-19 rate of 2.27% (n=25) and pulmonary complication rate of 1.8% (n=20) was found in the initial analysis of the Covidsurg cancer data, analysing outcomes for 1102 gynaecological cancer patients. The overall 30-day mortality rate in this cohort was 1.18% (n=13).⁵

Conclusion The largest multi-centre analysis of gynaecological cancer surgery during the Covid-19 pandemic has

demonstrated significant adjustments of timing, indications and radicality of surgery in an effort to reduce COVID-19 related complications and has exposed constraints, even in high

Abstract 594 Table 1 Table Showing participating countries and number of patients entered into the study

Country	Freq.	Percent
United Kingdom	1398	29.61
Italy	581	12.3
India	322	6.82
United States	267	5.65
Spain	261	5.53
Japan	232	4.91
Turkey	201	4.26
Colombia	143	3.03
Singapore	115	2.44
Mexico	108	2.29
Brazil	103	2.18
Puerto Rico	90	1.91
Argentina	76	1.61
Greece	72	1.52
Egypt	63	1.33
Saudi Arabia	62	1.31
Austria	49	1.04
Serbia	46	0.97
Germany	42	0.89
France	41	0.87
Malaysia	37	0.78
Poland	32	0.68
Portugal	32	0.68
Slovenia	32	0.68
Ireland	31	0.66
Korea, Rep.	30	0.64
Libya	27	0.57
Denmark	25	0.53
Armenia	24	0.51
Czech Republic	22	0.47
Uruguay	22	0.47
Jordan	18	0.38
Pakistan	15	0.32
Switzerland	15	0.32
Morocco	14	0.3
Botswana	12	0.25
Nigeria	10	0.21
Romania	10	0.21
Chile	5	0.11
Guatemala	5	0.11
Peru	5	0.11

income countries. Nevertheless, perioperative pulmonary complications and death rates of COVID-19 affected operated women were overall low compared to data reported for other cancers. Failsafe systems are urgently needed to ensure continuity of high standard oncologic care to preserve cancer survival.

Disclosures

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RETROPERITONEAL METASTATIC PELVIC ADAMANTINOMA: A NOVEL LOCATION MIMICKING OVARIAN MALIGNANCY AND REVIEW OF THE CURRENT LITERATURE

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Introduction/Background Adamantinoma is a rare primary low-grade malignant tumour of the appendicular skeleton. It primarily affects the long bones and is most commonly found in the tibia. The disease process has an indolent course and histogenic origin has not been clearly defined, however there have been several suggestions pertaining to a vascular origin in the literature. Local recurrences and lung metastases occur over a protracted duration. Less frequently, they have also been reported elsewhere; including four documented cases of soft tissue and five of pelvic bony adamantinoma. There is only one documented case of adamantinoma of the ovary and one of concurrent unrelated primary tumour. There are also no reports available regarding surgical management of a retroperitoneal adamantinoma of the pelvis within a gynaecological oncology surgical setting. Clinical guidelines have not yet been established.

Results We present the case of a 65-year-old female with known recurrent and metastatic right tibial disease. On further investigation, a Positron Emission Tomography scan identified a primary breast lesion and an 11 cm mass in the right iliac fossa of suspected ovarian malignancy amenable to surgical resection (figure A). The patient underwent total abdominal hysterectomy, bilateral salpingo-oophorectomy and resection of a retroperitoneal mass arising from the pelvic sidewall encompassing the iliac vasculature. The tumour was cleaved from the external iliac artery successfully, however the external iliac vein perforated during dissection. A Satinsky clamp was placed and a small cuff of vein wall was removed alongside adherent tumour. The vein defect was closed with 5–0 prolene, ensuring a patent lumen (figure B).