those with and without Sentinel Node Biopsy (SNB) in the first procedure.

Methodology Retrospective cohort study involving 27 patients diagnosed with low-risk EC (ESMO-ESGO-ESTRO criteria) with surgical restaging due to upstage in the final histological result at the Hospital Universitario Donostia from April 2013 to September 2018. Surgical and oncological results were compared between patients who underwent hysterectomy and double adnexectomy without any additional procedure (SNB-) n=17 and those who also had a pelvic and aortic SNB (SNB +) n=10. The main outcome evaluated in the study was intraoperative complications. Secondary outcomes were mean operative time, length of hospital stay, number of nodes obtained, Progression-Free Survival (PFS) and Overall Survival (OS).

Results The median duration of restaging surgery was 240 minutes (Q25 - Q75: 180 – 300) in the SNB(-) group, and 300 (Q25 - Q75: 247.5 – 330) minutes in the SNB(+) group, this difference being statistically significant (one-side t-student test, p=0.0295). With regard to intraoperative complications, there were 17.65% vs 40% respectively, all of them vascular, this difference being not significant. There were no statistical differences in length of hospital stay and number of pelvic nodes obtained. PFS and OS in both groups were the same.

Conclusion Women with EC who require lymph node restaging due to upstage and have previously undergone sentinel lymph node biopsy have greater surgical difficulty with longer duration of the procedure. The risk of complications is increased. We advise against performing a second re-staging surgery in patients sentinel node biopsy.

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491 HAVE WE IMPROVED UTERINE SEROUS CARCINOMAS MANAGEMENT THE LAST TWO DECADES? A SINGLE CENTER EXPERIENCE

Michail Liontos, 1Anna Svarna, 2Roubini Zakopoulou, 3Flora Zagouri, 3Charalampos Theofanakis, 4Nikolaos Thomakos, 5Dimitrios Haidopoulos, 4Alexandros Rodolakis, 3Maria Sotiropoulou, 4Meletios-Athanasiou Dimopoulou, 5Ef Stavridi, 6Maria Kapaneli, 6Konstantinos Koutsoukas, 1General Hospital of Athens 'Alexandras'; 2National and Kapodistrian University of Athens; Department of Clinical Therapeutics; 3University of Athens; Alexander Hospital; 1Department of Obstetrics and Gynecology; 4National and Kapodistrian University of Athens; 1Department of Obstetrics and Gynecology; 5Department of Pathology, Alexander Hospital; 6Department of Clinical Therapeutics, National and Kapodistrian University of Athens, Alexander Hospital

Results 121 patients with USC and complete clinical data were identified. Median age was 66.9 years. Pure serous carcinomas were diagnosed in 66 patients, while the remaining had mixed histologies. At diagnosis, 33 patients (28.0%) had stage Ia disease, but also 28 patients had stage IV disease (23.7%). 115 patients were treated with surgery including lymphadenectomy in 63 cases (55.8%) and omentectomy in 83 cases (73.5%). 64 patients (52.9%) were treated from 1999 to 2009. There was no statistical difference in the stage distribution, omission of lymphadenectomy or omentectomy and type of adjuvant treatment among patients treated prior or after 2010. Also, for patients with stage I-III disease, eligible for adjuvant treatment, both disease free survival and overall survival (OS) per stage did not differ significantly between the two decades. Finally, in patients with de novo stage IV disease there was no improvement in either first line Progression Free Survival or OS between the two decades (mPFS 1st vs 2nd decade: 8.6 vs 5.9 months 95% CI [1.5–15.7], [3.4–8.5] and mOS 18.4 vs 11.6 months 95% CI [1.7–34.9], [10.0–25.1]).

Conclusion Despite recent clinical trials, surgical and medical management of USC had not changed significantly the last two decades in everyday clinical practice. This is reflected in the survival of the patients.

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