Result(s)* BAX protein was significantly higher in Type 1 ($p=0.004$) and Type 2 ($p=0.024$) EC compared to atrophic samples; both types showing higher levels in the glandular tissue; only Type 1 EC demonstrated significantly higher stromal staining. By contrast, Bcl-2 expression was significantly ($p=0.017$) lower only in Type 2 EC. Increased proliferation (Ki-67 staining) of both Type 1 ($p=0.003$) and Type 2 ($p<0.0001$) EC was observed. The BAX:Bcl-2 ratio was only significantly ($p<0.001$) higher in the Type 2 EC because of glandular expression. BAX expression ($r=0.615$; $p=0.0001$), and the BAX:Bcl-2 ratio ($r=0.507$; $p=0.003$) were directly related to proliferation whilst Bcl-2 expression was inversely related ($r=-0.544$; $p=0.0009$).

Conclusion* Since BAX (pro-apoptotic signal) was increased in both types of EC, whilst Bcl-2 (anti-apoptotic signal) was decreased, then increased apoptosis is present in EC tissue. The direct correlation between the BAX:Bcl-2 ratio (indicator of increased or decreased apoptosis) and cellular proliferation indicates that as the tumours grow, they also undergo significant apoptosis. Since these tissues have increased production of anandamide₄, then it is probable that anandamide is not stimulating cellular proliferation but is attempting to control tissue hyperplasia through increased apoptosis.

511 OBTURATIVE NERVE COMPLICATION IN LAPAROSCOPIC TREATMENT OF ENDOMETRIAL CANCER

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10.1136/ijgc-2021-ESGO.161

Introduction/Background* Intraoperative, iatrogenic damage of peripheral nerves are rare but serious operative complication. Miss it or incorrect repair can get serious consequences for patient. During laparoscopic pelvic lymphadenectomy, specially when we remove metastases from obturator fossa, the risk of damage obturator nerve is considerable. Very important is correct intraoperative diagnosis of those complication and the knowledge of repair techics.

Methodology The aim of reconstruction of damaging obturator nerve is to restore the appropriate function. That's the motoric nerve responsible for adduction and walking. Subtile disfunction of a sensation are possible as well.

Result(s)* 54 years old women with clarocellular endometrial cancer with Massive infiltration of cervix, was admitted to Oncological Center for surgical treatment. She was previously hospitalized in Oncosurgery department due to isolating change in paraaortic lymphnodes. The enlarged nodous were removed. In H-P the suspicious of the endometrial cancer as primary focus were given. In CT and MRI examinations the selective pathology of lymphnodes of the left pelvic side were detected. The radical hysterectomy type B with selective lymphadenectomy of the left side were done. During dissection of obturative space the iatrogenic damage of the obturative nerve were detected. The preparation of whole obturative nerve were performed end to end anastomosis with 6.0 monofilament suture was made. The surgery were continued due to qualification. In postoperative observation the patient didn't claimed any mobile disfunction of

the left leg. In neurological examination discreet symptoms of disfunction could be observed, which subside in a few weeks.

Conclusion* Described case proves that laparoscopic technique has the benefits not only in minimally invasive treatment of endometrial cancer but in neural complications as well what could be much more difficult in traditional laparotomical route.

514 ENDOMETRIAL CANCER IN PRE-MENOPAUSAL WOMEN: CLINICAL AND PROGNOSTIC FACTORS ANALYSIS IN A TERTIARY CENTRE

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10.1136/ijgc-2021-ESGO.162

Introduction/Background* Management of endometrial cancer (EC) in pre-menopausal women represents nowadays a clinical challenge. The median age of diagnosis of EC is 65 years. Prevalence has increased in the last years in younger people related to increased risk factors. Around 20% of cases are diagnosed before menopause. EC typically presents with abnormal uterine bleeding. The diagnostic evaluation of premenopausal patients with this main clinical feature supposes an additional difficulty. The aim of our study is to evaluate the clinical and pathologic factors associated with EC in this group.

Methodology Retrospective unicentric study of 244 patients with EC diagnosed, treated and followed-up at *Hospital Universitario 12 de Octubre* (Madrid, Spain) between 2013 and 2020. Exclusion criteria were neoadjuvant chemotherapy or primary radiation as treatment. Menopausal status at diagnosis was used to classify patients into two groups.

Result(s)* A total of 244 patients were included, of which 45 (18.4%) were pre-menopausal and 199 (81.6%) were postmenopausal. **Demographic and pathologic characteristics of the two cohorts are described in table 1.**

Conclusion* In our institution, premenopausal status was associated with a lower parity record (1.1 ± 0.8 vs 2.15 ± 1.3 , $p=0.04$), lower prevalence of hypertension (13.0% vs 59.4%, $p=0.001$), higher rate of smokers (28.9% vs 14.9%, $p=0.039$) and endometrioid histology (97.8% vs 83.5%, $p=0.01$). Hysterectomy was performed in all cases, and only one premenopausal patient underwent ovarian preservation. A total of 39.1% and 38.0% of the patients had pelvic lymph node assessment in the premenopausal and postmenopausal groups, respectively ($p=0.4$) and paraaortic in 37.0% and 30.0% ($p=0.19$). There was no significant difference in stage distribution, grade differentiation, myometrial invasion or lymphovascular space invasion, between the two groups. The rate of administration of adjuvant chemotherapy was 15.6% in premenopausal and 13.8% in postmenopausal patients ($p=0.75$) and 28.9% and 37.9% ($p=0.26$) of adjuvant radiotherapy, respectively. According to these results, in our population, there was no significant difference in the favourable clinical prognostic factors in premenopausal women. The retrospective nature of the study and the small size of the cohort could justify these findings.

Abstract 514 Table 1 Demographic and pathologic characteristics of women with endometrial cancer by menopausal status

Factor	Total (n=244)	Premenopausal (n=45)	Postmenopausal (n=199)	P value
Age (mean, SD)	64.3 (11.9)	43.1 (19.9)	68.2 (14.4)	0.032
BMI Kg/m ² (mean, SD)	29.7 (7.7)	28.7 (11.2)	30.6 (10.3)	0.6
Parity (mean, SD)	2.0 (1.37)	1.1 (0.8)	2.15 (1.3)	0.04
Tobacco use (n, %)	36 (17.4)	11 (28.9)	25 (14.9)	0.039
Diabetes mellitus (n, %)	39 (16.3)	4 (8.9)	35 (18.0)	0.5
Hypertension (n, %)	123 (50.6)	6 (13.0)	117 (59.4)	0.001
Lynch syndrome (n, %)	0 (0.0)	-	-	-
Surgical treatment (n, %)	244 (100)	-	-	-
Hysterectomy	244 (100)	-	-	-
Bilateral salpingo-oophorectomy	239 (98.0)	44 (97.8)	195 (98.0)	0.9
Pelvic lymphadenectomy	94 (38.2)	18 (39.1)	76 (38.0)	0.4
Para-aortic lymphadenectomy	67 (28.3)	17 (37.0)	60 (30.0)	0.19
Histology (n, %)				
Endometrioid	212 (86.2)	45 (97.8)	167 (83.5)	0.01
Non endometrioid	34 (13.8)	1 (2.2)	33 (16.5)	
Grade (n, %)				
1-2	176 (71.8)	36 (79.5)	140 (70.6)	0.06
3	58 (23.7)	6 (13.0)	52 (26.1)	
Myometrial invasion (n, %)				
< 50%	168 (69.1)	36 (80.0)	132 (66.7)	0.08
≥ 50%	75 (30.9)	9 (20.0)	66 (33.3)	
Lymphovascular space invasion (n, %)	45 (18.5)	8 (17.4)	37 (18.8)	0.39
Stage (n, %)				
I-II	214 (87.4)	36 (80.4)	177 (88.9)	0.118
III-IV	31 (12.6)	9 (19.6)	22 (11.1)	
Adjuvant treatment (n, %)				
Chemotherapy	34 (14.2)	7 (15.6)	27 (13.8)	0.757
Radiotherapy	88 (36.2)	13 (28.9)	75 (37.9)	0.257

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RETROSPECTIVE ANALYSIS OF OVERALL SURVIVAL AND PATTERN OF RELAPSE UTILISING SEQUENTIAL CHEMORADIO THERAPY IN HIGH-RISK ENDOMETRIAL CANCER

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10.1136/ijgc-2021-ESGO.163

Introduction/Background* Management of endometrial cancer (EC) consists of surgery, followed by tailored adjuvant therapy in intermediate to high-risk disease. PORTEC3 reported 5-year overall survival (OS) of 81% and 25% relapse rate (pelvic failure 6% and distant failure 24%) in women who received concurrent chemoradiotherapy followed by 4 cycles of chemotherapy, with most marked benefit demonstrated in stage III and/or high grade serous (HGS) EC. In the West of Scotland Cancer Network (WoSCAN), standard post-operative protocol for high-risk disease is 4–6 cycles of carboplatin/paclitaxel prior to external beam radiotherapy (EBRT), 4500cGy/25 fractions. We compared our practice to PORTEC3 to investigate if alternative sequencing affects OS and/or pattern of relapse.

Methodology Data were collected retrospectively from electronic clinical records in WoSCAN patients who commenced adjuvant chemotherapy between January 2012 and December 2016. Statistical analysis was performed using R[®]. OS was estimated using Kaplan-Meier method.

Result(s)* 108 patients were identified, 57 had chemotherapy +/- vaginal brachytherapy and 51 had chemotherapy + EBRT. In the EBRT cohort, median age was 62 years (range 47–78), and FIGO stage was as follows: IB (13%); II (18%); III (59%); IVB (10%). LVSI was positive in 69% and nodal staging performed in 39%. Pathology consisted of: EEC (61%), HGS (22%), carcinosarcoma (10%), or other (7%). Residual disease and/or positive margins were present in over 10%. Median number of chemotherapy cycles was 4 (range 3–6), and 37% had 5 or 6 cycles. 95% completed EBRT. OS at 3-years was 72% (95% Confidence Interval 61–86). Relapse rate was 39% (pelvic failure 17% and distant failure 33%).

Conclusion* Pelvic and distant failure rates were higher and OS was less favourable in our series, but over 30% of patients would have been excluded from the PORTEC3 trial based on pathology, stage, and residual disease. Chemotherapy prior to EBRT does not appear to result in better outcomes, but this cohort consisted of women with very high-risk EC.