526 STELLA-2 TRIAL: SURGICAL COMPLICATIONS COMPARING EXTRAPERITONEAL VS TRANSPERITONEAL MIS AORTIC STAGING IN EARLY STAGE OVARIAN AND ENDOMETRIAL CANCER

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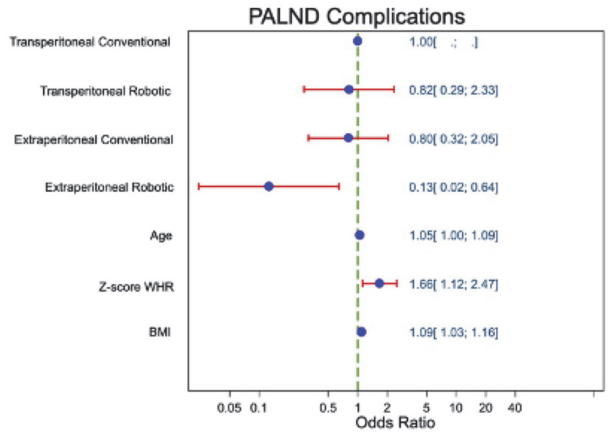
Introduction/Background* The surgical approach of minimally invasive surgery (MIS) for paraaortic staging lymphadenectomy (PALND) in gynecologic malignancies is controversial. The STELLA-2 trial was designed to determine whether the extraperitoneal approach for PALND results in a lower rate of surgical complications compared to the transperitoneal approach.

Methodology Prospective randomized multicenter study of patients with early-stage endometrial or ovarian cancer who underwent PALND as part of the staging process between June 2012 and January 2019. Patients were randomized to PALND by MIS (laparoscopy or robotic-assisted) using an extraperitoneal or a transperitoneal approach. The primary end point measure was a composite outcome that included developing one or more of the following surgical complications: bleeding during paraaortic lymphadenectomy ≥ 500 mL, any intraoperative complication related to paraaortic lymphadenectomy, severe postoperative complication (Dindo ≥ IIIA), impossibility to complete the procedure, or conversion to laparotomy. Secondary end points included the number of lymph nodes retrieved, the operative time, the length of hospital stay, and oncologic outcome (overall survival and disease-free survival). A post-hoc analysis to compare all possible approaches (transperitoneal or extraperitoneal, robotic-assisted or laparoscopic) was performed.

ClinicalTrials gov id:NCT02676726).

Result(s)* Of 209 women randomized, 103 in the extraperitoneal group and 100 in the transperitoneal group underwent PALND. Differences in the composite outcome between both groups (transperitoneal 26.0% vs extraperitoneal 18.4%: *P*=.195) were not found. A higher number of lymph nodes were retrieved through the extraperitoneal approached (median, interquartile range [IQR] 12 [7-17] vs 14 [10-19]: *P*=.026). Differences in the operative time, conversion to laparotomy, intraoperative bleeding, or survival were not observed.



Abstract 526 Figure 1

The post-hoc multivariable analysis revealed that age (OR: 1.05, 95% CI: 1.00-1.09), body mass index (OR: 1.09, 95% CI: 1.03-1.16), and waist-hip ratio (OR: 1.66, 95% CI: 1.12-2.47) were found to independently increase the risk of PALND complications, while extraperitoneal robotic approach (OR: 0.13, 95% CI 0.02-0.64) was an independent protective factor for complication occurrence.

Conclusion* Extraperitoneal approach is a safe procedure for PALND in the minimally invasive surgical staging of women diagnosed with early-stage endometrial or ovarian malignancy. Moreover, in the post-hoc analysis, robotic-assisted extraperitoneal PALND was associated with fewer surgical complications.

546 LAPAROSCOPICAL SENTINEL NODE FOR LOW AND INTERMEDIATE RISK ENDOMETRIAL CANCER: PILOT RESULTS OF A PROSPECTIVE COHORT

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Abstract 526 Table 1 Intraoperative, early, and late complications associated with paraaortic lymph node dissection (PALND)

Complication	Laparoscopic approach		*P* Value
	Extraperitoneal (N = 103)	Transperitoneal (N = 100)	
Intraoperative, N (%)	2 (1.9)	7 (7.0)	.642
Vascular injury	2 (1.9)	3 (3.0)	
Inferior mesenteric artery		1	
Vena cava	2	1	
Left renal vein		1	
Intestinal serosal lesion		2 (2.0)	
Ureteral lesion		2 (2.0)	
Incomplete PALND, N (%)	9 (8.7)	13 (13.0)	.330
Conversion to transperitoneal approach, N (%)	8 (7.8)	NA	
Conversion to laparotomy, N (%)	9 (8.7)	6 (6.0)	.456
Early postoperative (≤ 30 days), N (%)	1 (1.0)	1 (1.0)	1.00
Chylous ascites (Dindo ≥ IIIA)	1 (1.0)	1 (1.0)	
Late postoperative (> 30 days until 6 months), N (%)	2 (1.9)	0	.506
Lymphedema left lower limb	2 (1.9)		

Introduction/Background* Sentinel node presents almost the standard of care regarding low and intermediate-risk endometrial cancer patients. However, every oncological team should continuously evaluate outcomes of this relatively newly implied technique. Main objective of the present study is to present the surgical outcomes of laparoscopic sentinel node technique in low and intermediate-risk endometrial cancer patients.
Methodology A prospective cohort study was initiated on 03/2020 enrolling patients with low and intermediate-risk endometrial cancer being eligible for total laparoscopic hysterectomy and laparoscopic pelvic sentinel node. Primary outcomes of the study was the rate of successfully detected sentinel nodes, number of resected nodes as well as nodal status of resected notes. Pilot results of this cohort are presented in the current study.
Result(s)* There were overall 11 cases performed during 03/2020-05/2021, of which 8 were low and 3 were intermediate-risk endometrial cancer patients. Successful bilateral detection of SLN was achieved in 8 cases (72.7%), unilateral detection in 2 cases (18,2%) while no detection in 1 case. Median number of resected nodes was 2.5 nodes from the left side and 3 nodes from the right side. No lymph node was observed to be invaded in this sample of enrolled patients. Postoperative period was uneventful in all patients.
Conclusion* SLN is the standard of treatment in low and intermediate-risk endometrial cancer patients. Continuous training improves surgical technique thereafter optimizing surgical and oncological outcome.

555 ENDOMETRIAL CLEAR CELL CARCINOMA (ECCC): A A DECADE OF EXPERIENCE FROM A LARGE CANCER CENTRE

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Introduction/Background* ECCCs are non-endometrioid (type II) cancers. Representing 3% of uterine malignancies, ECCCs are not hormonally-driven, but aggressive – with high rates of LVSI, metastases and extra-pelvic relapse. Five-year survival is 60%. Latest European guidance (2020) recommends primary surgery – incorporating sentinel or pelvic lymph node dissection (PLND); but omitting omentectomy in stage I disease. Excluding those with tumour confined to endometrium, adjuvant chemo-radiation is recommended.
Methodology All patients treated for ECCC in a large cancer centre between 2009-2019 were identified and data collected retrospectively.
Result(s)* 17 patients were identified, representing <2% uterine malignancies treated. Mean age was 68.6years and BMI 26.8kg/m2. 82.4% (n=14) presented with post-menopausal bleeding and 11.7% (n=2) were diabetic.

All patients underwent primary surgery (total hysterectomy and bilateral salpingo-oophrectomy). 94.1% (n=16) had PLND and omental biopsy. All were grade 3; 70.6% (n=12) LVSI positive; and endometrial hyperplasia co-existed in 1 case. 76.5% were stage 1; 5.9% stage II; and 17.6% stage III. 94.1% (n=16) received adjuvant treatment: vault brachytherapy in 58.8%; reserving chemotherapy for stage III.

17.6% (n=3) recurred: on average 22.3months from surgery and most often (66.7%) upper abdominally. All patients with relapse were high grade with LVSI; and 2/3 stage III. 5-year survival was 75% overall; 66.7% in advanced disease.
Conclusion* In keeping with literature, our experience suggests ECCC is rare and not associated with obesity, diabetes, endometrial hyperplasia or omental disease. High grade, LVSI and advanced stage appear to be risk factors for upper abdominal recurrence. Whilst our stage III survival data is as expected, relatively favourable overall figures likely reflect the high proportion of early stage disease captured. Latest guidance may encourage more sentinel nodes, less omental surgery, and a switch from vault brachytherapy to wider administration of chemo-radiotherapy for ECCC.

569 OUTCOMES OF FEMALE GENITAL TRACT CARCINOSARCOMAS – FIFTEEN-YEAR EXPERIENCE FROM A CANCER CENTRE IN INDIA

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Introduction/Background* Owing to scarce and small-sampled studies from India about uterine carcinosarcomas, we embarked on this retrospective study, to assess clinicopathologic factors, treatment and recurrence patterns and to ascertain survival outcomes of these cancers.
Methodology Retrospective analysis of all patients who presented to our tertiary care cancer centre with a diagnosis of carcinosarcoma of female genital tract between January 2004 and December 2018. Clinicopathological features, treatment details, follow-up, recurrence and survival were collected from medical records. Chi-square test and Fisher Exact test were used to compare categorical data. Overall and disease-free survival (OS and DFS) were calculated using the Kaplan-Meier method and significance calculated by log rank test.
Result(s)* 101 patients presented with diagnosis of female genital tract carcinosarcoma during the study period. Of these 83 (81.8%) were uterine, 12 ovarian, 2 cervical, 3 vaginal and one of unknown origin. Median OS for uterine tumours was 44 months whereas for ovarian, cervical and vaginal were 22, 17and 23 months, respectively(p=.080). Due to small numbers of extrauterine carcinosarcomas, only uterine lesions were further analysed. Of 62 analysable uterine carcinosarcomas, 61.3% had early stage disease (stage I) and 38.7% had advanced disease. 18% had nodal involvement. On follow up, there were 12 patients with locoregional recurrences and 18 with distant metastases. Histology of carcinosarcoma with homologous elements had more survival, although non-significant than those with heterologous or rhabdomyosarcoma (45 vs 30 or 18 months).

With a median follow up of 63 months, median OS was 44 months and DFS of 23 months. Lymph node involvement and lack of primary surgery had a dismal survival of only 4 months each. Stagewise OS – Stage IA- 101 months, IB-44, II-30, IIIA/B- 34, IIIC- 4, IV-12 months. In stage IIIC disease,