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 \( \geq 500 \) 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.

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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%; \( P=0.195 \)) 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]; \( P=0.026 \)). Differences in the operative time, conversion to laparotomy, intraoperative bleeding, or survival were not observed.

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

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.

Results 17 patients were identified, representing <2% uterine malignancies treated. Mean age was 68.6 years and BMI 26.8 kg/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 I; 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 22.3 months 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.