simultaneous determination of 37 different proteins with the Luminex xMAP™ multiplexing technology.

Result(s)* The case group comprised 38 patients with endometrioid EC, with mean age 65.9 ± 8.2 years and mean body mass index (BMI) of 31.8 ± 6.1 kg/m². Lymphovascular invasion (LVI) was present in five patients while deep myometrial invasion (DMI) was present in 12 patients. The control group included 38 patients with mean age 66.8 ± 8.3 years and mean BMI of 27.6 ± 3.9 kg/m². There was a significant difference in the BMI distribution between the case and control group (p<0.01). The plasma levels of **sTie-2** and **G-CSF** were significantly decreased in EC patients compared to those of control patients, while the plasma levels of **leptin** were significantly higher in EC patients. Within the EC group, Tie-2 levels were lower in patients with LVI and DMI; however, these differences did not reach statistical significance. Additionally, **follistatin**, **IL-8** and **neuropilin-1** were also showing promising results.

Conclusion* The results of our study indicate that the plasma levels of different AFs might be involved in the growth of endometrioid EC. The plasma levels of G-CSF, Tie-2, and leptin significantly differ between EC and control patients. The plasma concentrations of these AFs could represent an important additional diagnostic tool for the early detection and characterization of EC and could guide the decision-making regarding the extent of surgery. Further validation studies with larger patient numbers are currently ongoing.

| 632 | PERIOPERATIVE COMPLICATIONS AFTER ENDOMETRIAL CANCER SURGERY: IS IT A REASON FOR UNDERTREATING OLDER PATIENTS? |

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Introduction/Background* Older patients (OP) usually present with more aggressive endometrial cancer (EC) at diagnosis. However, they often receive suboptimal surgical treatment compared with non-older patients (NOP). Undertreatment, along with the presence of more aggressive tumours can explain the worse prognosis of EC in OP.

There is limited evidence comparing perioperative outcomes between OP and NOP. The benefit of applying complex procedures to OP is still controverse. The goal of this study was to compare complications after surgical treatment of EC between NOP and OP.

Methodology This is a retrospective single-center observational study including women undergoing surgery for EC between 2010 and 2019. Patients were classified according to age as NOP (younger than 75 years) or OP (75 years or older). Basal characterisitcs of groups were compared using Chi-square, Fisher's exact tests, student T-tests or Mann-Whithney tests. Kaplan Meier analysis was used to evaluate survival.

Abstract 632 Table 1

	<75	≥75	Total	p-value
Surgical approach				0.04
Laparoscopy (N, %)	145 (78, 4%)	85 (88, 5%)	230 (81, 9%)	
Laparotomy (N, %)	31 (16, 8%)	6 (6.3%)	37 (13.2%)	
Vaginal (N, %)	1 (0.5%)	2 (2, 1%)	3 (1, 1%)	
Conversion to laparotomy (N, %)	8 (4, 3%)	3 (3, 1%)	11 (3, 9%)	
Type of surgery (N, %)				<0,01
HT + DA only	75 (40, 5%)	60 (61, 2%)	135 (47, 5%)	
+ LFD-p	22 (11, 9%)	13 (13, 3%)	35 (12, 4%)	
+ LFD-p + LFD-PA	43 (23, 1%)	9 (9, 2%)	52 (18, 4%)	
+ LFD-p + LFD-PA + Omentectomy	42 (22, 7%)	13 (13, 3%)	55 (19, 4%)	
+ Omentectomy only	3 (1, 6%)	3 (3, 1%)	6 (2, 1%)	
Nodal dissection				
Pelvic lymphadenectomy (N, %)	107 (57, 8%)	35 (36, 5%)	142 (50, 5%)	<0,01
Pelvic nodes dissected (mean, SD)	13,4 (7,7)	11,8 (7,6)	12,9 (7,7)	0,24
Aortic lymphadenectomy (N, %)	85 (45, 9%)	22 (22.9%)	107 (38, 1%)	<0,01
Aortic nodes dissected (mean, SD)	10,6 (7,9)	6,7 (6,3)	9,5 (7,7)	0,01
Duration of surgery (mean, SD)	175,4 (89,2)	152,2 (76,1)	167,4 (85,4)	0,03
Estimated blood loss (median, min-max)	150 (10-2500)	100 (10-2500)	100 (10-2500)	0,30
Complications (N, %)				
Intraoperative	12 (6, 5%)	12 (12, 4%)	24 (8, 5%)	0,12
Post-operative	25 (13, 5%)	20 (20, 6%)	45 (16, 0%)	0,13
Early post-operative	22 (11, 9%)	20 (20, 6%)	42 (14, 9%)	0,06
Late post-operative	7 (3, 8%)	1 (1, 1%)	8 (2, 9%)	0,27
Clavien-Dindo classification (N, %)				0,51
I	2 (1, 1%)	1 (1, 1%)	3 (1, 1%)	
II	14 (7, 7%)	9 (9, 5%)	23 (8, 3%)	
III	8 (4, 4%)	7 (7, 4%)	15 (5, 5%)	
IV	1 (0, 5%)	0	1 (0, 4%)	
V	0	1 (1, 1%)	1 (0, 4%)	
Blood transfusion (N, %)	9 (4, 9%)	8 (8, 2%)	17 (6, 0%)	0,30
Number of CH (median, min-max)	2 (1-6)	2 (1-4)	2 (1-6)	0,67
Abdominal drainage (N, %)	121 (68, 4%)	53 (55, 2%)	174 (63, 7%)	0,03
Time drainage removal (median, min-max)	3 (1-14)	3 (1-28)	3 (1-28)	0,14
Need for reintervention (N, %)	8 (4, 5%)	4 (4, 3%)	12 (4, 4%)	1,00
Length of hospital stay (median, min-max)	4 (1-137)	4 (2-32)	4 (1-137)	0,87
Disease-specific survival				
5-year DSS	86,0% (0, 4)	66,9% (0, 7)		0.02
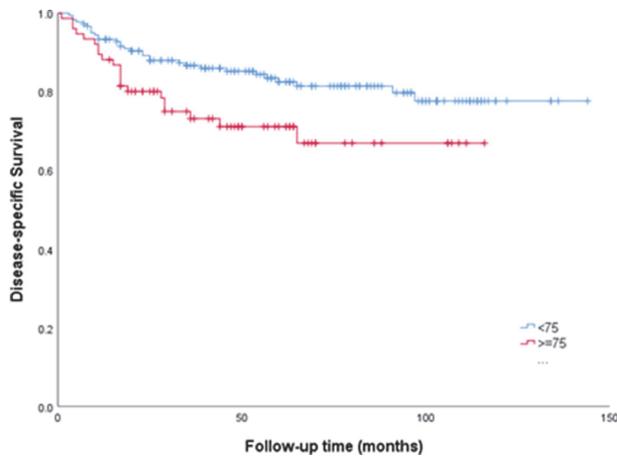
Abstract 632 Figure 1

Result(s)* In total 283 patients were included, 185 were classified as NOP while 98 as OP. No differences were found in disease characteristics. Laparoscopy was performed in 82% of patients. Both pelvic and para-aortic lymphadenectomy were performed more frequently in NOP than in OP (56,8% vs. 36,7%; p<0,01 and 45,9 vs. 22,9%; p<0,01). Rates of intra-operative (6,5% vs 12,4%, p=0,12) and post-operative (13,5% vs 20,6% p=0,13) complications were similar between NOP and OP respectively, as well as the severity of complications according to Clavien-Dindo classification (4,4% vs 7,4% grade III, 0,5% vs 0% grade IV, p=0,51). No differences were found in other surgical and post-operative variables. The 5-year disease-specific survival (DSS) rate was lower in OP (66,9% vs 86,0%, p=0,02). When analyzing only patients who underwent complete staging surgery (107 of the NOP and 35 of the OP), no differences were found in perioperative complications rate. In this subgroup, there were no differences in DSS between NOP and OP (78,1% vs 71,0%, p=0,64).

Conclusion* OP do not present a higher rate of perioperative complications compared to NOP. However, they underwent less lymphadenectomies and presented poorer DSS. Considering only patients in whom complete surgery was performed, OP presented similar DSS to NOP, without presenting a higher rate of perioperative complications.

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Introduction/Background* Endocrine therapy (ET) is a well-tolerated treatment strategy among women with low grade, hormone receptor positive advanced endometrioid endometrial cancer (EC).

Methodology In this retrospective cohort study, we identified patients with advanced endometrioid EC who were treated with ET between 2016-2018 by a medical oncologist at the Sunnybrook Odette Cancer Centre (Toronto, Canada). Descriptive analyses were performed. Median PFS from the time of starting ET and OS from diagnosis of advanced disease were assessed using Kaplan Meier methods. Predictors of PFS were evaluated using Cox regression models.

Result(s)* Twenty nine patients were included. Median age at diagnosis of advanced disease was 65.7 years. The majority of patients had grade 1 (55%) or grade 2 (29%) EC. Twenty three patients (79%) had ER and/or PR positive tumors (≥1% using immunohistochemistry); ER/PR status was negative in 1 case and unknown for 5 patients. Only 17% of patients received chemotherapy for advanced disease prior to starting ET. Letrozole (52%) and progestins (48%) were the most frequently used. Interestingly, the majority of patients (79%) received radiotherapy for oligoprogression while receiving ET.

Median PFS was 12.8 months. Median OS has not been reached, however, 73% of patients survived at least 4 years [95% Confidence Interval (CI) 56.4% to 95.5%]. Use of a progestin as first-line ET was associated with a longer PFS [Hazard Ratio (HR) 0.42; 95%CI 0.18-0.97, p=0.04], with a trend toward longer OS [HR 0.20; 95%CI 0.04-1.06, p=0.06]. Lack of oligoprogression requiring radiotherapy was associated with a longer PFS [HR 0.23; 95%CI 0.07-0.83, p=0.02], but not OS. Patient age, tumor grade, time to diagnosis of metastatic disease, stage at initial diagnosis, and use of chemotherapy prior to ET were not significantly associated with PFS or OS.

Conclusion* The clinical benefit of ET was greater in our cohort compared to prior published reports, possibly due to selection of patients with low grade and ER/PR positive tumors. The use of first-line progestins and lack of oligoprogression requiring radiotherapy were significantly associated with longer PFS in this small cohort.

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Introduction/Background* The goal of this study is to review the sentinel lymph node (SLN) in endometrial cancer in the University Hospital 12 de Octubre in Madrid from June 2016 to October 2020. The aim is to know the demographic and clinical features of the patients and to assess the outcomes of SLN in our population with technetium99 (Tc99), indocyanine green (ICG) or blue dye.

Methodology

Result(s)* From June 2016 to October 2020, 166 patients diagnosed with endometrial cancer underwent surgery in our hospital. In 34.4% (n= 57) of them SLN was performed and included in this review.

Demographic and clinical features are shown in table 1. 80.7% (n=46) were classified as low risk endometrial cancer and 19,3% (n=11) as intermediate risk.

Laparoscopy was the most frequent approach (96.4%). Median operative time was 203 minutes (IQR, 173 to 249).

A combined tracer technique was used in 75.4% cases. Most of them combining Tc99 and ICG (64.9%). Tc99 and blue dye were used in 10.5%. Only one tracer was used in