statistics were used to present patients' and disease characteristics, as well as Kaplan- Maier curves for disease free survival and overall survival curves were estimated.
Result(s)* Records from 45 patients with stage IIIC and IV endometrial cancer between 2012 and 2018 were retracted. In our records, 35 (78%) patients were treated with primary debulking and 10 (22%) with neoadjuvant chemotherapy and interval debulking, because of primary inoperable tumor. Patients were staged as IIIC1 (13/45) IIIC2 (13/45) and IVa (1/45) and IVb (18/45). Complete or optimal debulking (primary or interval) was achieved in 31/45 patients (69%), while residual or unresectable disease was recorded in 14/45 (31%). Median overall survival was 38 months. Specifically, median overall survival in patients with complete cytoreduction (RD 0) was > 96 months and 41 months in patients with optimal cytoreduction (RD <1). However, patients with residual disease >1cm had a median overall survival of 7 months. RD < 1 showed a 4,67 increased risk for death (p: 0.012) and R>1 showed a 12,2-fold (p<0,01) increased risk for death compared to complete cytoreduction. Age and ca- 125 at diagnosis and Charlson comorbidity index did not seem to have an impact on survival.
Conclusion* Complete cytoreduction is the most important factor which influences survival in advanced endometrial cancer patients.

689 IS THE SARCOMATOUS COMPONENT THE PROGNOSTIC 'DRIVING FORCE' IN EARLY-STAGE UTERINE CARCINOSARCOMAS?

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Introduction/Background* Uterine carcinosarcomas (UCSs) are aggressive biphasic malignancies, with a high grade carcinomatous/epithelial component and a high grade sarcomatous/mesenchymal counterpart. Several studies identified the carcinomatous part as the main factor affecting the aggressive behaviour of UCSs. However, other studies reported that the sarcomatous component, especially the presence of heterologous elements, was associated with a worse prognosis. The prognostic 'driving force' is not completely clear for these kind of tumours. For this reason, the aim of our study was to evaluate the impact of the sarcomatous component (Homologous vs Heterologous) on the overall survival (OS) and progression-free survival (PFS).
Methodology This is a multicenter observational retrospective study conducted in patients with stage I and II UCSs.
Result(s)* Ninety-five women with histological diagnosis of early stage UCSs were retrieved: 60 (63.2%) had tumors with homologous sarcomatous components, and 35 (36.8%) with heterologous. Tumors with a sarcomatous heterologous component were significantly larger than the homologous (T ≥ 50 mm: 82.9% *vs* 51.7%, p-value=0.002) and presented more often lymph-vascular space invasion (62.9% vs 25.9% respectively in patients with heterologous and homologous component, p-value=0.001). At univariate analysis, a stromal invasion ≥ 50%, the presence of clear cell, serous or undifferentiated carcinomatous component, the heterologous sarcomatous component and the FIGO stage IB and II were shown to be variables with a statistically significant negative impact on PFS. Similarly, a depth of invasion ≥ 50%, the heterologous sarcomatous component and the FIGO stage IB and II were statistically negative prognostic factors also concerning OS. At multivariate analysis, only the heterologous sarcomatous component was confirmed to be a statistically significant negative prognostic factor both on PFS (HR 2.362, 95% CI 1.207-4.623, p-value=0.012) and on OS (HR 1.950, 95% CI 1.032-3.684, p=0.040).
Conclusion* In conclusion, in our large series of UCSs, both carcinomatous and sarcomatous components played a role in tumor progression and patients' survival. However, only the sarcomatous component retained a statistical significance at the multivariable model suggesting its preeminent prognostic role in early stage UCSs.

692 PROGNOSTIC INDICATORS OF MALIGNANT INTRALUMINAL CELLS FOR PATIENTS WITH ENDOMETRIAL CANCER

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Introduction/Background* Hysterectomy with bilateral salpingo-oophorectomy with nodal analysis is the preferred primary management for the vast majority of patients with endometrial cancer.[1] Microscopic evaluation of the fallopian tubes occasionally identifies free floating intraluminal cancer cells (FFICC) without an in situ or invasive tubal component.[2] FFICCs have been recently reported in the literature to be associated with lower survival in high risk endometrial cancer histologies.[3] The mechanism of action proposed involves exfoliation through the fallopian tubes and spillage into the peritoneal cavity leading to widespread metastatic potential.[4] Although the significance of peritoneal cytology has historically been questioned and since removed from surgical staging, a positive correlation for FFICCs has been noted among patients with positive washings.[5] Our study aims to determine the incidence of FFICC's, risk factors as well as their prognostic significance.
Methodology A retrospective analysis was performed including all patients at our institution with a diagnosis of endometrial cancer who underwent surgical management between the years 2015 and 2018. Demographic and histopathologic variables were collected including stage, grade, lesion size, histologic subtype, and cytologic analyses. All recurrences, treatment plans, date of follow up and date of death were documented
Result(s)* A total of 481 patients were included. Median age was 63 (28-92) with median follow up of 32 months. FFICCs were identified in 14% of the total sample (endometrioid, n= 55 versus non-endometrioid histologies, n= 13). Patients who had a robotic vs abdominal hysterectomy had an increased risk of FFICCs with an odds ratio of 2.9 (p=0.016). Presence of FFICCs was not clearly associated with grade or stage. Positive cytology was associated with an odds ratio of 6.6

(p<0.001) for presence of FFICCs. A statistically significant (SS) decrease in overall survival (OS) was noted among patients with FFICCs (p=0.045), however progression free survival (PFS) was not found to be SS.
Conclusion* The presence of FFICCs may provide important prognostic information specifically with regard to determining adjuvant treatment in those with positive cytology and/or high risk histologies. In addition, the higher incidence among robotic hysterectomies may warrant a closer look at mode of uterine manipulation. Lack of difference in PFS with statistical significance in OS suggests either a difference in the pattern of recurrence or possibly in postoperative therapy.

693 UTERINE CARCINOSARCOMA: A MULTICENTRE REVIEW OF TREATMENT AND OUTCOMES OVER 26 YEARS

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Introduction/Background* Uterine carcinosarcoma (UCS) is a rare and aggressive subtype of endometrial cancer with carcinomatous and sarcomatous elements. It comprises less than 5% of all uterine malignancies but carries the worst prognosis. The rarity of this disease and its inclusion in heterogenous groups with other rare uterine neoplasms has resulted in limited and unclear evidence to guide best practice. Our aim was to review the characteristics, treatment and outcomes of UCS cases across two public gynaeoncology units and five private gynaeoncology practices in Melbourne over 26 years.
Methodology A retrospective observational study was conducted where UCS cases were identified from hysterectomy pathology records between 1994 and 2020 inclusive. Patient demographics, treatment details, recurrence and survival data were extracted from patient records. Ethics exemptions were obtained from each of the involved institutions.
Result(s)* 208 cases of UCS were identified. The overall recurrence rate was 26.0% and the overall death rate was 60.1%. Increasing age at diagnosis was associated with an increased risk of death (adjusted OR 1.04, 95% CI 1.01-1.08, p=0.019). Risk of death was highest in Stage III disease (adjusted OR 4.37, 95% CI 1.67-11.40). Recurrence was a strong determinant of death, with an adjusted OR of 7.58 (p<0.001). These predictors of survival were independent of modality of adjuvant therapy.
Conclusion* This is the largest Australian series of homogenous UCS cases to date, and one of the largest cohorts worldwide. This adds important information to the existing body of evidence regarding UCS.

709 TVS VS MRI FOR ASSESSING MYOMETRIAL INFILTRATION IN ENDOMETRIOID LOW GRADE ENDOMETRIAL CANCER: A PROSPECTIVE STUDY

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Introduction/Background* Determining the degree of myometrial infiltration in endometrial cancer allows establishing the best therapeutic approach for each patient as it is an important factor in predicting nodal metastases.

Few prospective studies comparing the diagnostic performance of transvaginal ultrasound (TVS) and magnetic resonance imaging (MRI) in the preoperative local staging of endometrial carcinoma have been reported. In fact, a recent meta-analysis has shown that both techniques have similar diagnostic accuracy. However, to the best of our knowledge, there has been no prospective comparison of the diagnostic performance of TVS and MRI in the same group of patients with low-grade endometrial cancer.

The aim of this study was to assess and compare the diagnostic performance of transvaginal ultrasound, magnetic resonance imaging (MRI) and intraoperative pathological study for detecting deep myometrial infiltration in patients with a preoperative endometrial biopsy result of low-grade (G1/G2) endometrioid endometrial cancer.
Methodology Observational prospective study performed at a single tertiary care centre from 2016 to 2020, comprising 156 consecutive patients diagnosed by endometrial sampling as having an endometrioid grade 1/grade2 endometrial cancer. TVS and MRI were performed prior to surgical staging for assessing MI, which was estimated using subjective examiner's impression and Karlsson's method for both TVS and MRI. During surgery, intraoperative assessment of MI was also performed. Definitive pathological study considered as reference standard. Diagnostic accuracy for ultrasound, MRI and intraoperative biopsy was estimated and compared.
Result(s)* Sensitivity and specificity of TVS for detecting deep MI were 75% and 73.5% for subjective impression and 65% and 70% for Karlsson method, respectively (p=0.54). Sensitivity and specificity of MRI for detecting deep MI were 80% and 87% for subjective impression and 70% and 71.3% for Karlsson method. MRI subjective impression showed a significant better specificity than MRI Karlsson method (p=0.03). MRI showed better specificity than TVS when subjective impression was considered (p< 0.05), but not for Karlsson method. Sensitivity and specificity of intraoperative were 75% and 97%, respectively. Intraoperative biopsy showed better specificity than ultrasound and MRI either using examiner's impression or Karlsson method (p< 0.05)
Conclusion* MRI revealed a significant higher specificity than TVS when assessing deep myometrial infiltration. However, the intraoperative biopsy offers a significant better diagnostic accuracy than preoperative imaging techniques