carcinoma-with bowel strangulation at 5mm-trocar site in the 4th postoperative day.

Methodology

CASE PRESENTATION A 69-years old patient had referred to our hospital with the diagnosis of endometrial carcinoma. *Minimal invasive staging approach with laparoscopic hysterectomy, bilateral salpingo-oophorectomy and pelvic¶-aortic-lymph-node-dissection was performed. A 10-mm-trocar at the umbilical site was inserted with direct technique, and bilateral accessory trocars of 5-mm (two left, one right) were placed under direct visualization. Second 10-mm-trocar positioned as suprapubically was also entered to abdomen for performing para-aortic lymph node dissection. After the operation abdominal drain was introduced from left inferior 5mm trocar site. Fascial defect in umbilical and suprapubic trocar sites were sutured via vicryl suturing and skin incisions were closed. Patient had no abnormal symptoms throughout early postoperative period. Spontaneous flatus passage was occurred in the 2nd postoperative day. On the 4th postoperative day she had non-severe discomforting symptoms as a subtle abdominal pain and nausea. A palpable, 8 cm, subdermal mass was diagnosed on abdominal examination and abdominal computerized-tomography was performed for a suspected early postoperative incisional hematoma or hernia. Bowel-herniation was diagnosed on CT-imaging (figure 1) and exploratory laparotomy was performed for GIS pathology. During operation midline abdominal incision was made and 30 cm herniated small bowel herniation without strangulation was diagnosed at the left superior 5mm-trocar-site. No segmental-bowel-resection was performed*

Abstract 828 Figure 1

Abstract 828 Figure 2

upon surgery because bowel-segment vascularity and peristalsism were evaluated as well preserved during exploration.

Result(s)* Patient was followed up clinically by physical examination, abdominal drainage and leucocyte and C-reactive-protein levels. On the 7th day after secondary surgery patient was discharge without any further complication.

Conclusion* Early detection of trocar-site-hernia is important because of leading severe morbidity, such as intestinal strangulation and necrosis. After laparoscopic surgery, in the case of unexplained intestinal obstruction and abdominal pain, abdominal-CT imaging is very helpful in diagnosis.

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IMPLEMENTATION OF THE 2021 MOLECULAR ESGO/ESTRO/ESP RISK GROUPS IN ENDOMETRIAL CANCER

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Introduction/Background* In 2021, a joint ESGO/ESTRO/ESP committee updated their evidence-based guidelines for endometrial cancer, recommending a new risk grouping incorporating both clinicopathologic and molecular parameters. We applied the new risk grouping and compared the results to those of the prior 2016 clinicopathologic system.

Methodology We classified molecularly a cohort of 604 women diagnosed with endometrial cancer using immunohistochemistry for TP53 and MMR proteins on a tissue microarray, as well as Sanger sequencing for *POLE* mutations. These results, combined with clinicopathologic data, allowed the patients to be risk grouped using both the new 2021 molecular/clinicopathologic parameters and the prior 2016 clinicopathologic system.

Result(s)* The application of the 2021 molecular markers shows Kaplan-Meier curves with a significant difference between the groups for all survival. Molecular classification under the 2021 guidelines revealed a total of 39 patients (39/594, 7%) with a change in risk group in relation to the 2016 classification system: the shift was alone due to either P53abn or *POLEmut* molecular marker. In order to ensure correct 2021 molecular risk classification, not all patients with endometrial cancer need a molecular diagnostic: 433 (72.9%) cases

would need to be analyzed by TP53 IHC, only 46 (7.7%) by MMR IHC and 286 (48.1%) POLE sequencing reactions.

Conclusion* Application of the 2021 molecular risk groups is feasible and shows significant differences in survival. IHC for TP53 and MMR and applying POLE sequencing is only needed in selected cases and leads to shifting risk groups both upward and downward for a sizeable number of patients. It is possible to significantly reduce the number of analyses required to implement the classification if resources are limited.

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COMBINED USE OF ICG AND TECHNETIUM DOES NOT IMPROVE SENTINEL LYMPH NODE DETECTION IN ENDOMETRIAL CANCER

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Introduction/Background* There is scarce evidence available about the benefit of combining technetium (99mTc) and indocyanine green (ICG) for sentinel lymph node (SLN) biopsy in endometrial cancer. The aim of this study was to compare the overall and bilateral pelvic detection rates of sentinel lymph nodes in two retrospective cohorts: ICG exclusive vs. combined ICG+99mTc.

Methodology Multicentre retrospective study (November 2015-June 2020) including patients diagnosed with endometrial atypical hyperplasia or early-stage endometrial carcinoma who underwent sentinel lymph node biopsy by cervical injection of ICG with or without 99mTc in four different referral centers in Spain.

Result(s)* A total of 180 patients were included, 51% (n=92) in ICG group and 49% (n=88) in ICG+99mTc group. Eighty-six percent of the patients presented endometrioid histology, and over ninety-nine percent of the procedures were performed by a minimally invasive approach. Both groups were comparable regarding their basal characteristics, except for a higher body mass index in ICG+99mTc group and a bigger proportion of robotic-assisted procedures in ICG group.

Overall detection rate was 92.8% and similar between groups (ICG: 94.6% vs ICG+99mTc: 90.9%, p=.34). No significant differences were observed neither in bilateral pelvic nor aortic mapping rate. When 99mTc was used, surgical procedures were significantly longer. In 6.7% of patients, at least one positive SLN was found (ICG:9.8% vs ICG+99mTc:3.4%, p = .164). Empty node packet rates and number of SLNs retrieved per patient were also similar between cohorts.

Conclusion* Combining preoperative 99mTc to intraoperative ICG did not improve SLN detection in endometrial cancer, but resulted in longer procedures.

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SENTINEL LYMPH NODE BIOPSY IN OPEN SURGERY FOR GYNAECOLOGICAL MALIGNANCIES

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Introduction/Background* Sentinel node biopsy has been introduced as alternative to lymph node dissection for lymph node staging for endometrial cancer patients. This surgical video has the objective to show the feasibility of Indocyanine Green (ICG) sentinel node sampling using SPY Portable Handheld Imaging System during open endometrial cancer surgery.

Methodology 72 years old patient with diagnosis of endometrioid G2 endometrial cancer underwent open surgery due to anesthesiological and surgical contraindications.

Result(s)* Laparotomy with total extrafascial hysterectomy, bilateral salpingo-oophorectomy and bilateral lymph node biopsy was performed. Operative time was 110 minutes and blood loss was 200cc. Patient was discharged after 4 days without any complication.

Conclusion* The use of SPY Portable Handheld Imaging System in open surgery seems to be a feasible and useful tool for the detection of SLN in endometrial cancer patients underwent open surgery.

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METASTATIC ENDOMETRIAL CARCINOMA ARISING FROM ADENOMYOSIS, PRESENTING WITH DEEP VEIN THROMBOSIS AND VISUAL IMPAIRMENT; CASE REPORT

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10.1136/ijgc-2021-ESGO.205

Introduction/Background* Endometrioid carcinoma arising in adenomyosis (EC-AIA) is a rare entity. We present a case of an advanced stage presenting with deep vein thrombosis (DVT) and visual impairment.

Methodology 42-year old patient presented to our institution, due to DVT of left femoral vein. During hospitalisation, an abdominal ultrasound showed a uterine tumour, resembling a myoma. Increased Ca 125 and Ca 15-3 were observed. No subsequent diagnostic procedures were performed, a follow up visit with personal gynaecologist was recommended. In the following weeks, she noticed visual impairment and trouble with understanding. Cranial MRI showed metastatic lesions and possible meningeal carcinosis. Patient was readmitted. Abdominal computer tomography (CT) showed a pelvic necrotic formation between right ovary and uterus, with pathologic iliac and paraaortic lymph nodes. Multidisciplinary team indicated primary debulking surgery. Before the procedure, she underwent colonoscopy and gastroscopy without pathologic findings.

Median laparotomy with hysterectomy, omentectomy, appendectomy and debulking of pelvic and paraaortic lymph nodes were performed. Pathohistological report showed a necrotic tumour, originating in the myometrium on the right lateral side of the uterus and infiltrating the right salpinx and ovary. Microscopic evaluation revealed endometrioid adenocarcinoma, grade 1, originating in myometrium, without involvement of endometrium. Positive right obturator and paraaortic lymph nodes did not involve the capsule. Immunohistochemistry showed positive oestrogen and progesterone receptors and p53-wt expression. Additional genetic analysis was done, due to loss of MSH6 protein. Due to probable cranial involvement, stage was set as FIGO IVB. Subsequent treatment consisted of palliative radiotherapy of the cranium, followed by