introduction of letrozole as maintenance therapy. Follow up imaging studies showed no signs of disease progression. At the last check up, the patient was in good condition, without specific complaints.

**Result(s)**

**Conclusion** Mechanism of EC-AIA is not well understood. As in our case, the tumour can mimic benign uterine lesions and postpone a proper diagnosis. This can lead to advanced stage disease with uncommon clinical presentation. Few studies have described the molecular mechanism of adenomyosis formation. It has been suggested that loss of heterozygosity in the DNA mismatch repair family is associated with adenomyosis and its pathogenesis. Better understanding of the molecular and immunologic drivers of response and resistance will be critical in management of EC-AIA.

**Abstract 864**

MINIMALLY INVASIVE VERSUS OPEN HYSTERECTOMY IN HIGH-RISK ENDOMETRIAL CANCER: A PROPENSITY SCORE MATCHING ANALYSIS

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**Introduction/Background** Randomized trials have shown comparable oncologic outcomes between open versus minimally invasive surgery for endometrial cancer. Limited data is available specifically in patients with high-risk disease. The aim of this study was to compare disease-free survival, overall survival, and recurrence rates between minimally invasive surgery versus open surgery in patients with high-risk endometrial cancer.

**Methodology** This was a multicentric, propensity score matched study of patients with high-risk endometrial cancer who underwent total abdominal hysterectomy, bilateral salpingo-oophorectomy and staging between January 1999 and June 2016 at two referral cancer centers. High-risk endometrial cancer included uterine grade 3 endometrioid, serous carcinoma, clear cell carcinoma, and undifferentiated carcinoma or carcinosarcoma with any degree of myometrial invasion. Patients were categorized a priori into two groups based on the surgical approach, propensity scores were calculated based on potential confounders and then both groups were matched in a 1:1 fashion using the nearest neighbor technique. Cox hazard regression analysis was used to evaluate effect of surgical technique on survival.

**Result(s)** A total of 626 patients were eligible, of which 263 patients underwent minimally invasive surgery and 363 open surgery. The median age was 67 years (IQR 60-74), and the median body mass index was 30.5 kg/m² (IQR 25.5-35.8). After matching, both groups had 185 matched pairs with comparable demographics and clinical characteristics. In the matched cohort, there were no differences in disease-free survival rates at 5-years between open surgery (53.4% [95%CI 45.6-60.5%]) and minimally invasive surgery (54.6% [95% CI 46.6-61.8%]; P=0.82). Minimally invasive surgery was not associated with worse disease-free survival (HR 0.85, 95% CI 0.63 to 1.16; P=0.30), overall survival (HR 1.04, 95% CI 0.73 to 1.48, P=0.81), or recurrence rate (HR 0.99; CI 95% 0.69-1.44; P=0.99) compared to open surgery. Use of uterine manipulator was not associated with worse disease-free survival (HR 1.01, 95% CI 0.63 to 1.61; P=0.96), overall survival (HR 1.04, 95% CI 0.73 to 1.48, P=0.81), or recurrence rate (HR 0.99; CI 95% 0.69-1.44; P=0.99) compared to open surgery.

Abstract 864 Figure 1
Conclusion* There was no difference in oncologic outcomes when comparing minimally invasive and open surgery among high-risk endometrial cancer patients

Methodology In this case, we summarize the management of a 58-year-old lady who underwent laparotomy, pelvic exenteration, Bricker colicureterostomy, end colostomy formation for recurrent endometrial carcinoma, despite previous total abdominal hysterectomy and bilateral salpingo-oophorectomy followed by brachytherapy, chemotherapy and external beam radiotherapy for high grade serous carcinoma.

Result(s)* Preoperatively, an advance decision to refuse blood products was discussed, to ascertain all the options that were suitable. Since her preoperative haemoglobin was acceptable (127 g/L), no further intervention was required. Intraoperatively, blood loss was effectively minimised with meticulous haemostasis, intraoperative haemodilution and cell salvage. Despite these interventions, total blood loss was 1030 mL and postoperative haemoglobin was 113 g/L. Postoperative measures therefore included intravenous iron infusion, minimisation of phlebotomy and optimisation of cardiopulmonary status. Erythropoieitin was also considered, but was not necessary as patient responded to the previous measures well and was successfully discharged after an uncomplicated recovery.

Conclusion* Only a few cases of total pelvic exenteration have been described in the literature for Jehovah’s witness patients. However, our case shows that laparotomy and pelvic exenteration is feasible in patients refusing blood products, if performed under a multidisciplinary team and with careful preoperative, intraoperative and postoperative planning, also in the setting of previous radical hysterectomy and co-adjvant therapy.

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