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

865 EFFECTIVENESS AND SAFETY OF SENTINEL NODE IN ENDOMETRIAL CANCER : REVIEW OF THE LITERATURE

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Introduction/Background* Main objective of the present study is to discuss the effectiveness and safety of sentinel lymph node in endometrial cancer cases.
Methodology A comprehensive review of published literature in Pubmed, with special focus on meta-analyses and prospective studies, was performed.
Result(s)* Sentinel lymph node (SLN) is indicated for treatment of low and intermediate risk endometrial cancer. Since lymphadenectomy is an important source of morbidity (17.5%) with 2.5% mortality and no proven therapeutic value has been indicated for systematic lymphadenectomy, minimization of approach aims to reduce postoperative morbidity such as lymphedemas. Blood loss, operation time and postoperative complications of SLN are comparable with no lymphadenectomy and significantly decrease compared with systematic lymphadenectomy. SLN detection rates are reported to reach 97% per patient, 87% per hemipelvis and 78% bilaterally. SLNs detected bilaterally are associated with 95.8% sensitivity and over than 98% negative predictive value. Use of SLN strategy is proven to mitigate concern for missed paraaortic micormetastasis, thereafter eliminating risk for postoperative overtreatment. Finally, regarding used regimen, ICG is potentially superior to blue dye as its use was associated with 26.5% increase od SLN dtections rates. Furthermore, a larger dose of ICG is associated with a higher number of retrieved SLNs but not with an increased bilateral DR
Conclusion* SLN is a safe and effective strategy to identify nodal micrometastasis, thereafter optimizing complentary therapy in low and intermediate risk endometrial cancer patients.

872 BLOODLESS MANAGEMENT OF PATIENT UNDERGOING PELVIC EXENTERATION

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Introduction/Background* Blood transfusions are common in the surgical management of gynaecology oncology patients, up to 93% of patients undergoing pelvic exenteration may require blood products. However, increasingly more patients are cautious in receiving blood products, either for fear of potential risks or for religious believes. It is therefore vital to optimize the management of these patients in order to avoid blood transfusions.

We describe the case of a 58-year old female Jehovah's witness patient undergoing pelvic exenteration, focusing on the preoperative, intraoperative and postoperative measures that allowed an uncomplicated surgery without blood transfusion.

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 1030mL and postoperative haemoglobin was 113 g/L. Postoperative measures therefore included intravenous iron infusion, minimisation of phlebotomy and optimisation of cardiopulmonary status. Erythropoietin 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-adjuvant therapy.

875 ECTOPIC LEFT RENAL ARTERY ORIGINATING FROM LEFT COMMON ILIAC: A RARE ANATOMIC VARIATION

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Introduction/Background* Main objective is to present the case of a rare anatomic variation observed during laparotomy procedure along with performing a relative review of the literature.
Methodology Medical eleents of patient were reviewed with special focus on epidemiological, surgical and histopathological characteristics. A comprehensive review of published literature in Pubmed, with special focus on meta-analyses and prospective studies, was also performed.
Result(s)* A 56-year old woman was operated with laparotomy to peform full surgical staging with total hysterectomy with bilateral salpingoophorectomy, pelvic lymphadenectomy, paraaortic lymphadenectomy and infracolic omentectomy because of initial diagnosis of serous endometrial cancer. During laparotomy procedure, the diagnosis of an ectopic left renal artery (LRA) originating directly from the left common iliac artery (LCIA) was made. Woman was already known to have an ectopic pelvic kidney (EPK). EPK was found in retroperitoneal space, approximately in the level of sigmoidal bend. The LRA indeed originated just 2 cm below the level of bifurcation, while the left renal vein (LRV) was originated relatively from the left iliac vein (LIV) also 2-3 cm below the level of venal bifurcation, having a parallel route just below the LRA.

To our knowledge, this is the first published case of such an anatomical intraoperative finding, which indicates the high complexity degree that may characterize the performance of a para-aortic lymphadenectomy.

Conclusion* Appropriate preoperative imaging evaluation of potential anatomic variations based on imaging findings may contribute in avoiding significant intraoperative challenges.

890 AUDIT ON COMPLIANCE IN ADHERING TO NEW IMAGING PROTOCOL IN ENDOMETRIAL CANCER

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Introduction/Background* Regional guidelines were changed from MRI scan to CT scan as the choice of investigation to optimize treatment decision making in women with endometrial cancer. We audited our practice to assess the compliance in adhering to this guideline, to assess to need for further investigations like MRI and to correlate our CT staging to final histological staging.

Methodology All Endometrial cancer cases diagnosed on pippelle biopsy from Aug 2017 to Mar 2020 were retrospectively analyzed. We reviewed case notes, radiology and pathology results to assess the compliance in following the guideline and the reasons for performing additional MRI scans.

Result(s)* There were 198 cases during this period. Grade 1 Endometrioid Endometrial Cancer (EEC): 92; Grade 2 EEC:37; Grade 3 EEC :35, Serous, clear cell adenocarcinoma, or carcinosarcoma: 21; Atypical/Complex Atypical hyperplasia :11. Biopsy was inconclusive in 2.

Our compliance in adhering to requesting CT scan was 99% (196 out of 198 cases). In addition to CT scan MRI scan was only required in 19% of cases (8%, 29%, 33% of patients in Gr 1 EEC, Gr 2 or 3 EEC and other types of endometrial cancer respectively). In 11 patients (5%) CT scan was performed for additional reasons.

The reasons for imaging (CT and MRI) out with the policy were MDT request (14), pre op evaluation (9), local extension (10), Adnexal masses (5), Radiologist request (2).

In cases where CT staging and final histological staging was available (N=38), the Positive Predictive Value of CT scan in staging the disease in stage 1, stage 2 and stage 3 are 100%, 33% and 70% respectively.

Conclusion* Our compliance in adhering to the guideline was good and we managed to reduce the MRI work load by 80%. This change in trust guidelines makes optimal use of premium resources like MRI scan.

930 COMPARISON OF CLINICOPATHOLOGICAL CHARACTERISTICS AND SURVIVAL OUTCOMES OF PATIENTS WITH GRADE III ENDOMETRIOID ADENOCARCINOMA AND CARCINOSARCOMA

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Introduction/Background* The clinicopathologic characteristics, recurrence patterns, and survival of patients with grade III endometrial cancer (G3EC) and uterine carcinosarcoma (UCS) were compared.

Methodology The medical records of patients treated for G3EC and UCS between January 1996 and December 2016 at X gynecologic oncology centers in Turkey and Germany were analyzed.

Result(s)* UCS was diagnosed in 353 (48.2%) of the enrolled patients and G3EC in 380 (51.8%). The patients in each group were divided into three subgroups depending on the disease stage: early (stage IA), locally advanced (IB-II) and advanced (III-IV). For all stages, the recurrence rate was higher in patients with UCS than in those with G3EC. Adjuvant treatment type had no significant effect on disease-free survival (DFS) or overall survival (OS) in patients with early stage tumors. In patients with locally advanced disease, radiotherapy (RT) + chemotherapy (CT) was the most effective type of adjuvant therapy with respect to DFS and OS. In those with advanced disease, RT + CT was the most effective type of adjuvant therapy but only with respect to DFS.

Conclusion* The recurrence rate was higher in UCS patients than in G3EC patients, regardless of disease stage. DFS was of shorter duration in UCS than in G3EC patients. OS did not significantly differ between UCS and G3EC patients with early or locally advanced disease. In patients with early stage UCS or G3EC, adjuvant therapy modalities had no effect on survival. However, in both groups of patients with locally advanced disease, adjuvant CT and RT resulted in a significant improvement in DFS and OS.

931 PROGNOSTIC FACTORS AND SURVIVAL OUTCOMES OF WOMEN WITH UTERINE LEIOMYOSARCOMA: A TURKISH UTERINE SARCOMA GROUP STUDY-003

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Introduction/Background* To assess the clinicopathological features, prognostic factors, and survival rates associated with uterine leiomyosarcoma (uLMS).

Methodology Databases from 15 participating gynecological oncology centers in Turkey were searched retrospectively for women who had been treated for stage I-IV uLMS between 1996 and 2018.

Result(s)* Of 302 consecutive women with uLMS, there were 234 patients with Federation of Gynecology and Obstetrics (FIGO) stage I disease and 68 with FIGO stage II-IV disease. All patients underwent total hysterectomy. Lymphadenectomy was performed in 161 (54.5%) cases. A total of 195 patients received adjuvant treatment. The 5-year disease-free survival (DFS) and overall survival (OS) rates were 42% and 54%, respectively. Presence of lymphovascular space invasion (LVSI), higher degree of nuclear atypia, and absence of