

Abstract 1019 Table 1 Treatment modalities of patients with UCS

Post-op FIGO stage	N (%)
Early-stage disease (FIGO I-II)	46 (56)
Late-stage disease (FIGO III-IV)	36 (44)
Early-stage treatment	
Surgery alone	16 (34.8)
Surgery and chemotherapy	4 (8.7)
Surgery and radiotherapy	17 (37)
Surgery and combined chemoradiotherapy	9 (19.5)
Late-stage treatment	
Surgery alone	7 (19.5)
Surgery and chemotherapy	16 (44.4)
Surgery and radiotherapy	4 (11.1)
Surgery and combined chemoradiotherapy	9 (25)

Abstract 1019 Table 2 Recurrence and survival outcomes of patients with UCS

Recurrence and survival outcomes of patients with UCS	N (%)
Recurrence	50 (61)
Early-stage disease (FIGO I-II)	22 (47.8)
Late-stage disease (FIGO III-IV)	28 (77.8)
Disease free five year survival	11/52 (21.2)
Early-stage disease (FIGO I-II)	9/29 (31)
Late-stage disease (FIGO III-IV)	2/23 (8.7)
Overall five year survival	13/52 (25)
Early-stage disease (FIGO I-II)	10/29 (34.5)
Late-stage disease (FIGO III-IV)	3/23 (13)

Conclusion* UCS is highly aggressive and has a poor prognosis. Significant rates of lymph node metastases have implications for adjuvant treatment in addition to high rates of relapse and distant metastases. Without an optimal treatment strategy established, discussions continue regarding adjuvant management as to potential improvements in prognosis. Whilst surgery remains the mainstay, multimodal treatment plans including combination of systemic chemotherapy followed by vaginal brachytherapy may be reasonable to address risks of both local relapse and distant metastases. In view of limited data and few prospective trials, we report on the results of our cancer network in contribution to evaluation of results of care in building a consensus for case management. We stress the importance of an individualised multidisciplinary team approach for management of UCS.

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ULTRASONOGRAPHIC ENDOMETRIAL THICKNESS AS A PREDICTOR OF THE RISK OF ENDOMETRIAL CANCER IN PATIENTS WITH POSTMENOPAUSAL BLEEDING

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Introduction/Background* Transvaginal ultrasound scanning (TVUS) to measure the endometrial thickness (ET) has historically been recommended as a first-line investigation of patients with postmenopausal bleeding. The aim of the study was to determine the diagnostic performance of endometrial thickness measured by transvaginal sonography in diagnosing endometrial cancer in patients presenting with post-menopausal bleeding.

Methodology The databases of the Department of Gynecological Oncology at the University Clinic of Gynecology and Obstetrics in Skopje, in the period January – December 2015 were searched in order to identify patients that underwent

endometrial sampling due to newly-diagnosed postmenopausal bleeding. The following data were extracted from the patient records: age at sampling, age at menopause, parity, body mass index (BMI), American Society of Anesthesiologists physical status rating (ASA), history of hypertension and diabetes, endometrial thickness and the histology from the endometrial sampling. The endometrial thickness measurement was acquired in the mid sagittal plane at the thickest part. All patients underwent D&C, with optional previous hysteroscopic evaluation (at the discretion of the attending) under general anesthesia.

Result(s)* A total of 158 patient records that met the criteria were identified. The prevalence of endometrial cancer was 15.2%. Endometrial thickness was a statistically significant independent predictor of the presence of endometrial cancer and atypical endometrial hyperplasia (OR 1.19 95% CI 1.09-1.29 for each 1mm increase in thickness, $p < 0.001$). The ROC curve analysis in our study had an AUC of 0.83 ($p < 0.001$) and identified a cut-off level for endometrial thickness of 8mm which was associated to a sensitivity of 88.9%, specificity of 65.6%, PPV of 34.8% and NPV of 96.6% for the detection of endometrial cancer. Using a cut-off for endometrial thickness of ≤ 3 mm achieved 100% sensitivity.

Conclusion* None of the analyzed cut-off points for endometrial thickness achieved optimal diagnostic accuracy, as all cut-off values associated to sensitivity rates above 95% had false positive rates of over 60%. Nevertheless, an endometrial thickness cut-off of 3mm, due to the associated high sensitivity, can safely be used to identify women with postmenopausal bleeding who are highly unlikely to harbor endometrial cancer and that can forego initial endometrial sampling.

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SENTINEL LYMPH NODE BIOPSY IN ENDOMETRIAL CANCER: DUAL INJECTION, DUAL TRACER. PELVIC AND PARA-AORTIC SLN DETECTION

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Introduction/Background* The aim of this study is to report the pelvic and Para-aortic SLN detection with a dual technique of indocyanine green (ICG) injection and Technetium 99 (Tc99) into the cervix and uterine fundus, in patients with Endometrial Cancer (EC)

Methodology Unicentric Prospective Study. 47 patients underwent laparoscopic surgery for EC in our center (with previous confirmative biopsy) between January 2019 and December 2020. A **Dual Tracer** was used (radiocolloid Technetium 99 (Tc99) and Indocyanine green (ICG) in 47 patients and a **Dual Injection** was performed (cervical and fundal) in 28 patients.

Result(s)* The detection rates were: 95.7%/45/47) for pelvic SLNs (90.9% bilateral) in Tc99 injection and 100% (44/44) for pelvic SLNs (88.6%) for ICG tracer. A 6.38% (3) showed direct atypical drainage outside the standard field of pelvic lymphadenectomy (two presacral SLNs and one with direct drainage to