The para-aortic SLNs rate was 44.11% (15/34) for Tc99 tracer and 57.1% for ICG (16/28). Overall rate of lymph node involvement was 10.6% (5/47). Macroscopic lymph node pelvic metastases were found in 4 patients (8.5%) and in only 1 case (2.1%) microdisease in SLN was found. A 30.7% (4/13) who para-aortic SLN was not detected, had infiltration of para-aortic lymphadenectomy. Two of them had also pelvic SLNs infiltration. There was a 4.2% positive para-aortic lymphadenecotomies with negative pelvic lymph nodes.

**Conclusion** The SLNs biopsy with dual tracer and dual injection (cervix and fundus) offers good overall detection and could increase para-aortic detection compared with cervical injection alone. When SLNs is not detected in para-aortic area we should complete the lymphadenectomy because in our study the rate of positive lymphadenectomy is not negligible (30%). A dual tracer could help in the ICG learning curve and ensure that the right SLN is removed.

**Diagnostic Accuracy of Intraoperative Histopathological Assessment in Endometrial Cancer**

1M Plancha, 1A Miguel, 1D Djokovic, 1PA Duarte, 1C Barros, 1P Pinto*. 1Alfredo da Costa Maternity Hospital, Gynecology, Lisboa, Portugal; 2Nova Medical School, Obst/Gyn, Lisboa, Portugal; 2Alfredo da Costa Maternity Hospital, Lisboa, Portugal; 2First Faculty of Medicine Charles University, Prague, Czech Republic

**Introduction/Background** Endometrial cancer (EC) is the most common gynecologic malignancy in developed countries and the main treatment consists of surgery. Myometrial invasion is commonly used in guiding surgical extent and can be evaluated by intraoperative assessment (IOA). There are studies that show different reports regarding its adequacy and reliability. The aim of this study was to assess the diagnostic accuracy of IOA comparing with definitive histopathologic report surgically resected EC.

**Methodology** We analysed retrospectively all patients submitted to surgical staging for presumed EC with a definitive diagnosis of endometrioid carcinoma grade 1 and 2 at a tertiary hospital in 2017-2020. Results of IOA were compared to the final pathology report. The accuracy, sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) of the IOA were calculated.

**Result(s)** A total of 97 patients underwent surgical staging for EC. We had 41 women with histologically confirmed endometrioid carcinoma in which 39 were performed the IOA. The IOA had an accuracy of 82.1%, sensitivity of 64.3%, specificity of 92%, PPV of 81.8% and NPV of 82.1% in predicting myometrial invasion. In the definitive histopathological report 26 patients were classified with stage IA and 13 with stage IB. In the 27 cases identified as stage IA in IOA, the pathology reported stage IB in 4/39 (10.2%). 11/39 (28.2%) cases were identified as stage IB in IOA, and only 2/39 (5.1%) were in fact stage IA in the final pathology report. Surgery, based on the result of the IOA, caused undertreatment in 4/39 (10.2%) and overtreatment in 2/39 (5.1%) patients.

**Conclusion** Our IOA results have reasonable accuracy rates in predicting malignancy. However, the concordance of tumor myometrial invasion between IOA and pathology report was suboptimal, leading to the need of a secondary surgery in some patients.
Abstract 1089 Figure 2

cardiac surgeons, pathologists, oncologists and cardiovascular anesthesiologists were involved. A complete trans-thoracic echocardiogram was performed, showing an isoechic, mobile, adherent to the tricuspid ring, 22 x 50 mm mass with non-smooth margins, resulting in obstruction of the right ventricular filling (gradient 7 mmHg). Cardiac magnetic resonance imaging (MRI) demonstrated a 41x35 mm, polylobed mass, adhered to the tricuspid ring on the inferior-posterior side, which incorporated the posterior and septal flaps of the tricuspid valve, extensively emerging in the ventricular cavity in the diastolic phase. The mass obstructed the right ventricular filling and its most caudal portion partially occupied, in the systolic phase, the outlet of the inferior vena cava in the atrium. Because of the life-threatening obstruction, the mass was removed by cardiac surgeons with sternotomy in extracorporeal circulation. During surgery, the mass was analyzed by pathologist, confirming the endometrial origin. Postoperatively, radiotherapy (RT) on the heart was performed, followed by second line CHT with Liposomal Doxorubicin till February 2021.

Result(s)* In February 2021 cardiac MRI was performed, showing no evidence of disease. Complete response of the oropharyngeal and abdominal recurrences was also detected. But the woman presented with neurological symptoms, as partial paralysis of the legs. Encephalic MRI was performed showing brain metastases. The woman underwent pan-encephalic RT with subsequent reduction of those lesions.

In June 2021, the woman is still alive without neurological nor other symptoms.

Conclusion* A multidisciplinary approach is essential to treat rare EC metastases. Reference centers for the treatment of EC must have specialists from other disciplines available, to ensure the best clinical practice.