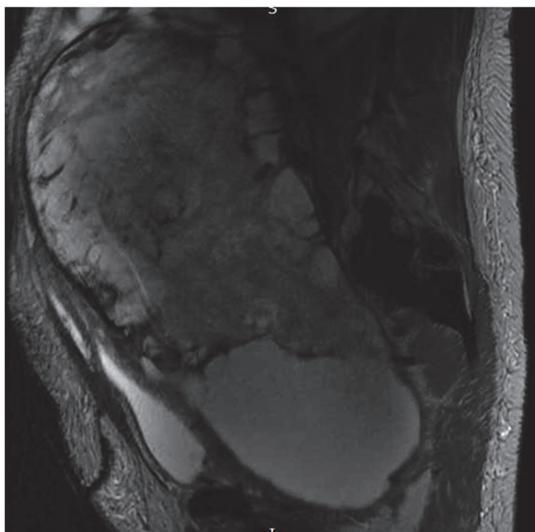


case selection. In general, this includes preservation of patient choice and informed consent regarding realistic outcomes balanced with surgical risk and morbidity. Further patient individualised factors include age and performance status, comorbidities, tumour grade and extent and symptom severity. **Methodology** We present a 44-year-old otherwise fit and well female whom previously underwent complete resection of leiomyosarcoma. Subsequent imaging identified lung metastases, pelvic nodal disease and further avid pelvic mass managed with chemotherapy. Despite complete distant disease resolution, pelvic progression led to bilateral ureteric stenting and nephrostomy insertion, with enactment of Do Not Attempt Cardiopulmonary Resuscitation directive (DNACPR), palliative care and hospice input.



Abstract 1022 Figure 1



Abstract 1022 Figure 2

Result(s)* Multidisciplinary team recommendation was for palliative debulking surgery due to significant symptom profile and pain in view of potential resectability despite visceral involvement. The patient underwent midline laparotomy, modified posterior en-bloc exenteration, right ureteric resection and reimplantation with psoas hitch and stent replacement, bladder repair, primary ileo-ascending colon anastomosis, Hartmann's procedure and end sigmoid colostomy. The patient made an uneventful recovery with a normal postoperative retrograde cystogram and whilst histopathology reported involvement of bowel mucosa and serosa, clear margins were achieved.

Conclusion* Palliation aims to relieve suffering and support quality of life for seriously ill patients and their families, alongside life-prolonging and curative surgical treatments. We report on this case to highlight the value of radical and multiple resections of sarcoma in younger patients as well as the value of the surgical multidisciplinary team in achieving clear resection margins. We recognise a shift from cancer elimination to symptom elimination. Palliative care need not be synchronous with end of life care; an illustration of which is that the DNACPR was withdrawn in our patient's case. Whilst impact on survival may be limited, we emphasise the value in continuing to explore all treatment options and further delineate the balance between provision of false hope versus not giving up hope.

Pathology

163 PATHOLOGICAL ASSESSMENT OF LYMPH NODE STATUS IN CERVICAL CANCER: COMPLETE EMBEDDING DOES NOT DOES NOT YIELD MORE NODE METASTASES

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Introduction/Background* Assessment of lymph node status is essential in patients with cervical cancer, particularly to determine prognosis and further therapy. The current pathological protocol states that only tissue with visible or palpable lymph nodes is investigated, the residual fatty tissue is stored.

We determined in a retrospective cohort study the value of embedding and examining all removed tissue, compared to the current pathological protocol.

Methodology Patients surgically treated (radical hysterectomy and pelvic lymph node dissection) for early stage cervical cancer at the Erasmus MC between 2017 and 2019 were included. In a multivariate analysis the extra lymph node count is compared to BMI and initial lymph node count.

Result(s)* Ninety-eight patients were included, the residual fatty tissue was assessed in 50 (51%). The median number of lymph nodes found by conventional pathological assessment was 26 (range 9-58) and 9 (range 0-28) in the residual fatty tissue. Ten patients (10.2%) had positive lymph nodes, all were found during conventional pathological assessment. In patients with a BMI above 30 kg/m², more lymph nodes are detected in the residual fatty tissue, compared to patients with a BMI under 30 kg/m² (R²=0.265). The calculated extra costs of assessment of the rest fatty tissue is € 240.

Conclusion* Assessment of the residual fatty tissue results in the finding of 30% more lymph nodes. This did not result in the detection of more lymph node metastases. We do think it is worthwhile to investigate the residual fatty tissue in women with a high BMI (>30 kg/m²).

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GENOMIC ALTERATION OF A METASTATIC GASTRIC-TYPE CERVICAL ADENOCARCINOMA: HINTS AND PERSONALIZED TREATMENT OPTIONS

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Introduction/Background* Cervical adenocarcinoma accounts for 20-25% of all uterine cervical cancers with 90% of cases being associated with HPV. Of the remaining, non-HPV associated adenocarcinomas, the most common subtype is the gastric-type (GAS). GAS portends a poorer prognosis irrespective of tumor stage. We report the genomic study of a stage FIGO IVB GAS.

Methodology A 52 years old patient was admitted for atypical glandular cells (AGC) on the cervical smear. Pelvic MRI described a mass infiltrating the proximal third of the vagina, the cervix and the isthmus of the uterus and suggested para-aortic lymphadenopathies. The PET-CT confirmed the nodal involvement and a right iliac bone lesion. Both cervical and bone biopsies were positive for a p53 positive, p16, HER2 and PD-L1 (SP263 clone) negative, GAS. In the absence of standard of care treatment we performed a 52-gene next generation sequencing (NGS) of the cervical biopsies, containing 30% tumor cells

Result(s)* NGS detected the following pathogenic mutations: *TP53* exon 8 (p.Arg280Thr, variant allele frequency (VAF) 18%), *ERBB2* exon 20 (p.Val777Leu, VAF 14%), *KRAS* exons 2 (p.Gly12Ser, VAF 4%) and 4 (p.Ala146Val, VAF 5%).

Conclusion* The most frequently mutations reported in GAS are *TP53*, *STK11*, and *CDKN2A*. The presence of a generally, mutually exclusive, *ERBB2* and *KRAS* in our patient is a rare constellation potentially suggestive of multiple subclones. In the absence of a specific treatment guideline for GAS we initiated a cisplatin, paclitaxel and bevacizumab treatment combination. Based on the NGS results, in case of treatment failure, a MAPK targeted treatment by a MEK inhibitor could be considered.

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CLINICOPATHOLOGICAL FEATURES OF PATIENTS WITH ENDOMETRIAL STROMAL NODULE AND ENDOMETRIAL STROMAL SARCOMA, SINGLE CENTER EXPERIENCE

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Introduction/Background* To present the clinicopathological features of cases with Endometrial Stromal Nodule (ESN) and Endometrial Stromal Sarcoma (ESS) in our center.

Methodology The cases diagnosed between 2008-2020 were re-examined microscopically. The information for clinical follow-up were retrieved from the hospital archives, retrospectively.

Result(s)* ESN cases consisted of 11 patients between the ages of 41-68 (mean 51,8), Low Grade Endometrial Stromal Sarcoma (LGESS) cases consisted of 13 patients between the ages of 24-53 (mean 44), High Grade Endometrial Stromal Sarcoma (HGESS) cases consisted of 9 patients between the ages of 60-84 (mean 71,2).

Mean tumor size was 3,3 cm (1,7-8 cm) in ESN cases; 6,4 cm (1-13 cm) in LGESS cases; 6,5 cm (4,5-9 cm) in HGESS cases.

In LGESS cases, the number of mitosis in 10 high power fields was 0-7 (average 2,8); In HGESS cases it was counted as 10-45 (average 22). Ki-67 proliferation index was evaluated as 2-5% (mean 3.8%) in LGESS cases; as 30-100% (mean 68%) in HGESS cases.

At the median follow-up of 56,5 months (range, 21-147 months), all of 11 ESN cases are alive. At the median follow-up of 60 months (range, 47-144 months), 1 of 13 case of LGESS have died (8%). At the median follow-up of 8 months (range, 1-53 months), 5 of 9 cases of HGESS have died (56%). Distant metastasis was seen only in 1 case of 9 HGESS, the location of metastasis is lung.

85% of cases with LGESS were presented in stage I and, 9% 15 were in stage II. 37.5% of cases with HGESS were presented in stage I, 50% were in stage III and 12.5% were in stage IV.

Conclusion* Endometrial stromal neoplasms are rare lesions of the uterus, usually presenting in the postmenopausal period. The histological type and stage of these lesions are directly related to the clinical course. Average mitotic activity and Ki-67 levels can also provide information in the direction of the clinical course.

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RELIABLE IDENTIFICATION OF ENDOMETRIAL PRECANCERS THROUGH PAX2, β -CATENIN, AND PTEN IMMUNOHISTOCHEMISTRY

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Introduction/Background* The diagnosis of endometrial atypical hyperplasia/endometrioid intraepithelial neoplasia (AH/EIN) remains challenging and subjective in some cases, with variable histologic criteria and differences of opinion among gynecologic pathologists, potentially leading to under/over-treatment. There has been growing interest in the use of specific immunohistochemical markers as adjuncts in AH/EIN diagnosis. For example, the WHO 2020 Classification lists loss of Pten, Pax2, or mismatch repair proteins as desirable diagnostic criteria. Other markers, most notably β -catenin and Arid1a, are also aberrantly expressed in some AH/EIN. However, the performance of these markers individually—and more importantly as a group—has not been rigorously explored, raising critical questions as to which marker(s) or combination(s) thereof is the most efficient and reliable in practice.

Methodology Inclusion criteria was a diagnosis of AH/EIN on an endometrial tissue sample based on histologic features. Formalin-fixed/paraffin-embedded tissue sections from n=111