Abstracts

Cancer Quality of Life Questionnaire-Core 30 [EORTC QLQ-C30] and Endometrial Cancer Module [EORTC QLQ-EN24]). Enrolment began December 2020 and is ongoing at 221 sites in 28 countries.

Result(s)* N/A

Conclusion* N/A

189 LAPAROSCOPIC REPAIR OF OBTURATOR NERVE INJURY AT THE TIME OF PELVIC LYMPHADENECTOMY

R Linder*, J Gomez, T Feigenberg. *trillium health partners, Gynecological Oncology, Canada*

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Introduction/Background* The obturator nerve is formed by the lumbar plexus, receiving its fibers from the anterior division of L2-4. Clinically, obturator nerve injury manifests with sensorial loss at the medial aspect of thigh, pain at medial portion of the groin and ipsilateral adductor weakness. The risk of obturator nerve injury is increased during pelvic lymphadenectomy and surgeries for gynecologic malignancies. Here, we present a video film of full-thickness transection of obturator nerve at the time of pelvic lymphadenectomy in a patient who underwent laparoscopic surgery for endometrial cancer. The transected nerve was primarily repaired through a laparoscopic approach at the time of surgery. The patient experienced a full recovery with no motor function deficiencies

Methodology

Result(s)* In this surgical film we present an 83-year-old woman, G2P2, who was diagnosed with a grade 3 endometrioid endometrial adenocarcinoma. She underwent a laparoscopic hysterectomy and sentinel lymph-node biopsies as well as resection of enlarged external iliac node. During the

procedure, we identified a complete transection of the obturator nerve. To enable an end to end repair, the external iliac artery and vein were mobilized. The proximal end of the nerve was identified lateral to these vessels. An end-to-end anastomosis of the nerve was performed using Prolene sutures. The patient experienced an uneventful post-operative recovery and was discharge home on post-operative day 2, able to ambulate independently with no assistance required.

Conclusion* Obturator nerve injuries are a well-recognized complication of pelvic lymphadenectomy. Immediate laparoscopic nerve repair, can facilitate earlier motor recovery and prevent the need for laparotomy.

198 UTILITY OF PELVIC MRI AND TUMOR MARKERS HE4 AND CA125 TO PREDICT DEPTH OF MYOMETRIAL INVASION AND CERVICAL INVOLVEMENT IN ENDOMETRIAL CANCER

¹N Zamani*, ¹M Modares, ²F Zamani. ¹Tehran University of Medical Sciences, gynecologic oncology, Tehran, Iran; ²Tehran University of Medical Sciences, radiology, Tehran, Iran

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Introduction/Background* The purpose of this pilot study was to determine whether the MRI and biomarkers human epididymis protein 4 (HE4) and CA125 correlate with depth of myometrial invasion, histologic grade, cervical involvement and nodal metastases in patients with endometrioid adenocarcinoma of the uterus.

Methodology This was a prospective, observational study in women with biopsy-proven endometrial adenocarcinoma of the uterus. Preoperative pelvic MRI was performed and concentration of HE4 and CA125 were assessed before surgery. All surgical specimens were reviewed by a single expert

Abstract 198 Table 1 Relation between serum CA125 level, serum (HE4) level and histopathological prognostic factors

	HE4 < 140PM [n (%)]	HE4 ≥ 140PM [n (%)]	p	CA125 < 35ku/l [n (%)]	CA125 ≥ 35ku/l [n (%)]	p
FIGO			0.003			0.002
I	47 (90.4%)	5 (9.6%)		38 (73.1%)	14 (26.9%)	
II	6 (66.7%)	3 (33.3%)		3 (33.3%)	6 (66.7%)	
III	3 (42.9%)	4 (57.1%)		1 (14.3%)	6 (85.7%)	
Myometrial invasion			0.001			0.0001
No	1 (100%)	0 (0)		1 (100%)	0 (0)	
< 50%	37 (97.4%)	1 (2.6%)		32 (84.3%)	6 (15.7%)	
≥ 50%	18 (62.1%)	11 (37.9%)		9 (14.3%)	6 (68.9%)	
Grade			0.035			0.001
I	27 (96.5%)	1 (3.5%)		23 (82.2%)	5 (17.8%)	
II	25 (71.5%)	10 (28.5%)		19 (31.1%)	16 (45.7%)	
III	4 (80%)	1 (20%)		0 (0)	5 (100%)	
Node involvement			0.007			0.002
No	54 (85.2%)	8 (14.8%)		42 (66.7%)	20 (33.3%)	
Yes	2 (33.4%)	4 (66.6%)		0 (0)	6 (100%)	
Cervical stromal Involvement						0.006
No	48 (88.9%)	6 (11.1%)		38 (70.4%)	16 (29.6%)	
Yes	8 (57.2%)	6 (42.8%)		4 (28.6%)	10 (71.4%)	

Abstract 198 Table 2 Diagnostic performance regarding detection of myometrial and cervical invasion

	TP	FP	FN	TN	Sensitivity %	Specificity %	Accuracy %	PPV*	NPV**
FICO									
I	34	2	18	14	65.4%	78.5%	70.5%	94.4%	
II	5	3	4	56	55.5%	94.9%	89.7%	62.5%	
III	3	3	4	58	42.8%	95.1%	89.7%	50%	93.5%
Myometrial Invasion									
No	1	18	0	50	100%	73.5%	75%	5.2%	100%
< 50%	19	8	19	22	50%	73.3%	60%	70.3%	53.6%
≥ 50%	20	2	9	37	68.9%	94.8%	83.8%	90.9%	80.4%
Node involvement									
No	59	3	3	3	95.1%	50%	91.1%	95.1%	50%
Yes	3	3	3	59	50%	95.1%	91.1%	50%	95.1%
Cervical stromal involvement									
No	53	5	1	9	98.1%	64.3%	91.1%	91.4%	90%
Yes	9	1	5	53	64.3%	98.1%	91.1%	90%	91.4%

*Positive predictive value; **Negative predictive value

pathologist. The results were compared with the final histopathology report of surgical staging.

Result(s)*

Results Included were a total of 68 women with endometrioid adenocarcinoma of the uterus, most (76%) with stage I disease. Levels of serum HE4 greater than 140PM and CA125 greater than 35 ku/L were observed in 12 (17%) and 26 (38.2%) of patients respectively whose greater proportion were cases with deep myometrial invasion and high grade tumor. In the evaluation of deep tumoral invasion (> 50%) of the myometrium sensitivity, specificity, and diagnostic accuracy of MRI were 68.9%, 94.8% and 83.8% respectively. For lymph node involvement these values were 50%, 95.1% and 91.1% respectively and for cervical stromal involvement were 64.3%, 98.1% and 91.1% respectively.

Conclusion* Higher stage, deep myometrial invasion, and lymph node or cervical stromal involvement increase diagnostic accuracy of MRI. Higher levels of HE4 and CA125 were observed in patients with deep myometrial invasion and higher grade of tumor.

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ENDOMETRIAL CARCINOMA MOLECULAR SUBTYPE CORRELATES WITH THE PRESENCE OF LYMPH NODE METASTASES

¹EF Thompson*, ²A Jamieson, ³J Huvila, ⁴S Leung, ¹A Lum, ⁵C Morin, ⁵K Ennour-Idrissi, ⁶A Sebastianelli, ⁶MC Renaud, ⁶J Gregoire, ⁶M Plante, ¹D Huntsman, ⁷CB Gilks, ⁵K Grondin, ²J Mcalpine. ¹The University of British Columbia, Molecular Oncology, Vancouver, Canada; ²The University of British Columbia, Gynaecologic Oncology, Vancouver, Canada; ³University of Turku, Institute of Biomedicine, Turku, Finland; ⁴The University of British Columbia, Genetic Pathology Evaluation Centre, Vancouver, Canada; ⁵Chu De Québec-Université Laval, Pathology, Québec, Canada; ⁶Chu De Québec-Université Laval, Gynecology Oncology Service, Québec, Canada; ⁷The University of British Columbia, Vancouver General Hospital, Pathology and Laboratory Medicine, Vancouver, Canada

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Introduction/Background* The role of lymph node (LN) assessment in endometrial cancer (EC) has been a subject of debate for decades, with significant variation in use between centres. Molecular classification of EC provides objective, prognostic information and be performed on diagnostic endometrial biopsy specimens. The Proactive Molecular Risk Classifier for Endometrial Cancer (ProMisE) uses targeted next-generation sequencing to detect pathogenic *POLE* exonuclease domain mutations (*POLEmut*) and immunohistochemistry to evaluate for the presence of mismatch repair deficiency (MMRd), *TP53* mutations (p53abn) or tumours with no specific molecular profile (NSMP/p53wt). Herein, we assessed the association between EC molecular subtype and LN metastases in a single institutional cohort with a uniform approach to LN assessment.

Methodology All ECs treated with primary surgery from a single institution in 2015 underwent ProMisE molecular subtyping and collection of clinicopathologic and outcomes data.

Result(s)* Complete pelvic and para-aortic lymphadenectomies were performed in 171 of 172 consecutive cases of EC. The distribution of ProMisE subtypes and clinicopathologic features associated with molecular subtype are outlined in table 1. The p53abn subtype was observed across a range of EC histotypes, including low grade endometrioid endometrial carcinoma. LN metastases were found in 31/171 (18.1%) patients: pelvic only in 83.9% and pelvic plus para-aortic in 16.1%. LN metastases included macrometastases (19/31), micrometastases (5/31), and isolated tumour cells (ITCs) (7/31).

Molecular subtype was significantly associated with LN metastases ($p=0.004$); there was a strong association between LN metastases and p53abn EC (nodal involvement in 44.8% of cases). LN metastases were observed in 14.2% of *POLEmut*, 14.9% of MMRd, and 10.8% of NSMP EC.