no mapping hemipelvis is recommended. Nevertheless, most hemipelvis lymphadenectomies showed no nodal involvement. Previously, we published a preoperative predictive score of nodal involvement. In case of a negative score (value 3–4), the risk of nodal metastases was extremely low. The present multicentre study aims to validate the predictive score of nodal involvement in patients undergoing nodal assessment.

Methods EC patients undergoing surgical treatment with nodal staging were included in the analysis. A preoperative predictive score of nodal involvement was calculated for all patients before surgery was performed. The score included myometrial infiltration, tumor grading (G), tumor diameter, and Ca125 assessment. STARD (standards for Reporting Diagnostic accuracy studies) guidelines were followed for the score accuracy.

Results 1038 patients were included in the analysis and 155 (14.9%) nodal metastases were detected. The score was negative (3 and 4) in 475 patients and positive (5–7) in 563 cases. The score showed 83.2% sensitivity, 50.8% specificity, 94.5% negative predictive value, and 55.7% diagnostic accuracy. The area under the curve (AUC) was 0.75. The logistic regression between negative score and absent nodal metastases showed OR 5.133, 95% CI (3.30–7.98), p < 0.001.

Conclusions The nodal preoperative predictive score is a fair diagnostic test. The risk of nodal metastasis is extremely low in case of negative score. In SLN failure, the application of the present score associated with SLN algorithm could avoid unnecessary lymphadenectomies.

EPV147/#253

LIVE BIRTH, REMISSION AND RELAPSE RATES FOR FERTILITY-PRESERVING TREATMENTS OF ENDOMETRIAL ADENOCARCINOMA: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Objectives Endometrial adenocarcinoma affects over 380,000 women annually, with increasing incidence primarily driven by obesity. 5–7% of women are below 45 years at diagnosis, and many of these desire fertility-preservation rather than standard surgical treatment. This updated review aims to inform decision making in clinical practice, by evaluating the efficacies of different fertility-preserving treatments on the live birth, regression and relapse rates for women with endometrial carcinoma desiring fertility.

Methods A systematic search was performed of Medline, Embase, Central, & Cochrane, to identify studies describing fertility-preserving treatment for endometrial cancer. Patients were divided into 3 treatment groups: systemic progestogens, intra-uterine progestogens, or hysteroscopic resection with adjuvant progestogen. A random-effects meta-analysis model was used.

Results 41 observational studies met inclusion criteria, with 1057 patients in total. The proportion of women receiving systemic progestogens who achieved a live birth was 18.1% (95% CI 12.6–23.7%), remission 71.5% (95% CI 66.5–76.4%) and relapse 20.3% (95% CI 13.1–27.4%). For intra-uterine progestogens, the proportion achieving a live birth was 13.3% (95% CI 11.1–15.5%), remission 65.9% (95% CI 53.0–78.8%) and relapse 2.86% (95% CI 0.0–9.16%). For hysteroscopic resection, the proportion achieving a live birth was 19.1% (95% CI 8.79–29.5%), remission 82.7% (95% CI 73.1–92.3%) and relapse 6.80% (95% CI 1.72–11.9%).

Conclusions Although the quality of evidence is limited, these results demonstrate that hysteroscopic resection with adjuvant progestogen is associated with the highest rates of live birth and remission. This enables women considering such treatments to be fully counselled on the realistic possibilities of their desired reproductive and oncological outcomes.

EPV148/#91

OUTCOMES OF VARIOUS FERTILITY-SPARING OPTIONS FOR EARLY CERVICAL CANCER PATIENTS VERSUS ABDOMINAL RADICAL HYSERECTOMY: ONE CANCER CENTER TEN-YEAR EXPERIENCE

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Objectives Cervical cancer (CC) is one of the most common malignant neoplasms and is diagnosed at the youngest middle