was 65.5 years (56–82), ASA score=2 and mean BMI=31.8. Women underwent total hysterectomy and bilateral salpingo-oophorectomy in all, adhesiolysis (48%), omental sampling (20%) and para-aortic sampling (16%). The FIGO stages included stage-I (88%) and Stage-III (12%). Median lymph node count in SLN was 3 (1–5) and BPLND was 15 (5–38). Nodal metastasis was 8%. Para-aortic lymph node positivity was 4%. SLND sensitivity was 100%, specificity 96.15%, false-negative rate 0%, negative predictive value 100%. Median time for SLND was 15 min (10–22) while BPLND was 35 min (25–40). Bilateral SLND was achieved in 96%. Obturator node was the most common SLN site (40%). 8% SLN were detected in paraaortic and parametrial sites. Complication rate was 1.8%.

Conclusion Our pilot study shows that SLND with ICG in intermediate and high-risk endometrial cancer is accurate with high negative predictive values. The quality of nodal assessment was improved by identifying aberrant location in 8% women with SLND. Our series is comparable to international standards and mandates a change in institutional practice. SLND-only is accurate technique for nodal assessment in surgical staging for intermediate and high-risk endometrial cancers.

2022-RA-781-ESGO MLH1 PROMOTER HYPERMETHYLATION IN MISMATCH REPAIR DEFICIENT ENDOMETRIAL CANCER. DEFINING A NEW SUBGROUP?
1Nina Pauly, 1Philipp Harter, 1Florian Heitz, 1Malak Moubarak, 1Alexander Traut, 1Sabrina Kaiser, 1Beyhan Ataseven, 2Department of Gynecology and Gynecological Oncology, Klinikum Essen Mitte, Essen, Germany, 3Department for Gynecology with the Center for Oncologic Surgery Chanté Campus Vrinchow-Klinikum, Chanté – Universitätsmedizin Berlin, corporate member of Freie Universität Berlin, Humboldt-Universität zu Berlin, and Berlin Institute of Health, Berlin, Germany, 4Department of Obstetrics and Gynecology, University Hospital LMU Munich, Munich, Germany
10.1136/ijgc-2022-ESGO.238

Introduction/Background Nearly 30% of unselected endometrial cancer (EC) are mismatch repair deficient (MMRd). The majority resulting from epigenetic changes due to MLH1 promoter hypermethylation (MLH1-PM) and only a fraction from mutations in the Lynch genes (MLH1/MSH2/MSH6/PMS2). Identifying patients with MMRd has two clinical implications: first, detecting patients with high probability for Lynch syndrome and secondly classification into molecular subtypes for prognosis and/or prediction of therapy. Since less is known about the clinical characteristics of MMRd tumors especially based on MLH1-PM we aimed at clarifying the clinical features of EC with MLH1-PM.

Methodology EC patients treated between 2015–2022 who underwent MMR(IHC) +/- MLH1-PM (PCR)-testing were included. Three groups where defined. A) MMR proficient(p) B) MMRd/MLH1-PM 3) ‘probable’ Lynch (defined as MMRd not due to MLH1-PM).

Results MMR-testing was performed in 337/365 cases (279 MMRp and 58 MMRd). 36 of 45 tumors with MLH1 +/- PMS2 deficiency had MLH1-PM analysis, identifying MLH1-PM in 28 (77.8%). MMRd tumors were detected at higher stages, more often showed angioinvasion and endometrioid subtype and less abnormal p53 expression compared to MMRp. Patients with MMRd-PM were significantly older (65 vs 56 y), more often had endometrioid histology (89% vs 76%), showed no abnormal p53 expression (0% vs 19%) compared to ‘probable’ Lynch. 5-year PFS was 73, 81 and 100 months (p=0.343) for MMRp, MMRd/MLH1-PM, and ‘probable’ Lynch patients, respectively.

Conclusion Significant differences in clinical characteristics were detected between MMRd and MMRp tumors, as well as between MMRd tumors depending on MLH1-PM status. Thus, this analysis supports evidence of heterogeneity in MMRd tumors concerning prognosis.

2022-RA-782-ESGO ROLE OF FOLLOW UP OF STAGE ONE ENDOMETRIAL CARCINOMA FOR DETECTION OF RECURRENT
1George Kouklidis, 2Michelle Godfrey, 3Vasileios Mitsopoulos, 4Manolis Nikolopoulos.
1Obstetrics and Gynaecology, NHS, Poole, UK; 2Department of Gynaecological Oncology, Queen Alexandra Hospital, Portsmouth, UK, NHS, Portsmouth, UK; 3Gynaecological Oncology Department, Poole Hospital NHS Trust, Poole, U.K., NHS, Poole General Hospital, UK; 4Department of Gynaecological Oncology, Epsom and St Helier University Hospitals and NHS Trust, St Hel, NHS, London, UK
10.1136/ijgc-2022-ESGO.239

Introduction/Background To investigate the rate of asymptomatic recurrence of stage 1 endometrioid endometrial cancer and assess the role of routine hospital follow-up after treatment.

Methodology We performed a retrospective case-note review study of women who were diagnosed with stage 1 endometrioid endometrial adenocarcinoma at Queen’s Hospital, Romford, between January 2008 and December 2016.

Results We included 299 patients with a median follow-up period of 44.4 months. All the patients underwent total hysterectomy and bilateral salpingo-oophorectomy. Adjuvant radiotherapy was offered to the patients subsequent to discussions in the multidisciplinary team meeting in accordance with the risk stratification criteria. There was no significant correlation between the risk factors and disease recurrence. In total, 11 patients presented with recurrent disease with original staging: 1a, n=6/199; and 1b, n=5/100. Four patients presented with vaginal bleeding due to vault recurrence and one patient with abdominal pain due to pelvic mass. Locoregional recurrence was an incidental finding in two other patients. Four patients presented with symptomatic distant metastases to the lung (n=2), liver (n=1), and bone (n=1). No asymptomatic recurrences were identified on routine follow-ups, despite several hospital appointments and clinical examinations. The recurrence rate for patients with stage 1a and 1b, grade 1, and grade 2 disease was 3.53%, and that for patients with stage 1a, grade 1, and grade 2 disease was 2.7%.

Conclusion Routine clinical examinations have a low yield in finding recurrence in asymptomatic women and should be questioned for their value, considering the limited resources of the National Health Service (NHS). Recent evidence has supported the shift to telephone clinics and patient-initiated follow up.