

**Results** Of the 177 patients who meet the inclusion criteria, 83 underwent SLN biopsy and 94 cases were staged with systematic LMP. The median follow-up was 36 months (12–46). No significant differences in median age ( $p=0.439$ ), median BMI (0.268), FIGO stage ( $p=0.164$ ), and adjuvant therapy ( $p=0.775$ ) were found in the two groups. Thirty-two recurrences were registered (14 in the SLN and 18 in the LMP group) and 15 cancer-related deaths were reported (8 in the SLN and 7 in the LMP group). One-year OS was 100 vs. 100%, 2-year OS was 94 vs. 95%, and 3-years OS was 92 vs. 93% in groups 1 and 2, respectively (hazard ratio 0.73, Confidence Intervall 95% 0.26–2.00,  $p=0.54$ ). One-year DFS was 96.4 vs. 97.9%, 2-years DFS was 85.2 vs. 86.7%, and 3-year DFS was 83.4 vs. 83.2 in groups 1 and 2, respectively (hazard ratio 1.01, Confidence Intervall 95% 0.48–2.13,  $p=0.97$ ). **Conclusion** SLN biopsy shows long-term survival outcomes superimposable to systematic LMP in HREC patients.

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**INTRODUCTION OF A SENTINEL LYMPH NODE PROTOCOL FOR ENDOMETRIAL CANCER AT A REGIONAL CANCER CENTER IN UK**

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**Introduction/Background** Lymphadenectomy in endometrial cancer (EC) is one of the controversial topic in gynecologic oncology. Sentinel lymph node (SLN) has become a popular option in the last few years .Belfast City Hospital – Regional Cancer Center in United Kingdom started using SLN since 2021. The aim of this study is to develop a protocol for SLN to standardize the practice in the center.

**Methodology** Retrospective cohort of EC patients with apparently early stage EC undergoing surgical staging with SLN were analyzed from January 2021 onward . All patients with high grade, early stage EC were included .The primary outcome was to assess the overall, bilateral successful and unsuccessful SLN mapping. Secondary outcome was identifying the predictors for mapping failure and adverse events.

**Results** Total of 286 patients with EC diagnosed since January 2021 were analyzed. Seventeen patients were diagnosed as high grade, early stage of EC. However, two were morbidly obese and unfit for SLN. Mean age 69.4 range (53–81 years) including 7 patients with high grade endometrioid adenocarcinoma, 4 with carcinosarcoma, 3 with serous carcinoma and 1 with clear cell carcinoma. Mean body mass index (BMI) was 27.5 (calculated as weight in Kilogram divided by height in meters squared) range (22–36). Regarding detection rate; the successful bilateral mapping, at least successful unilateral mapping and the mapping failure of SLN (60%, 80%, 20%) respectively. No major adverse events were recorded. The advanced age affects the anatomical distribution of SLN. Non endometrioid histotype and lymph vascular space invasion (LVSI) represent independent predictor of unsuccessful mapping.

**Conclusion** SLN is an available option for surgical staging of EC with markedly less complications compared to full lymphadenectomy . We consider all the major factors which might cause failure of SLN during preparation of a protocol in our center.

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**PROSPECTIVE MULTICENTER TRIAL ASSESSING THE IMPACT OF POSITIVE PERITONEAL CYTOLOGY CONVERSION ON ONCOLOGICAL OUTCOME IN ENDOMETRIAL CANCER PATIENTS UNDERGOING MINIMALLY INVASIVE SURGERY WITH THE USE OF AN INTRAUTERINE MANIPULATOR**

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**Introduction/Background** Minimally invasive surgery is the standard approach in early-stage endometrial cancer according to evidence showing no compromise in oncological outcomes but lower morbidity compared to open surgery. However, there is limited data available on the oncological safety of the use of intrauterine manipulators in endometrial cancer.

**Methodology** This prospective multicenter study included endometrial cancer patients undergoing laparoscopic staging surgery with the use of an intrauterine manipulator. We obtained three different sets of peritoneal washings: at the beginning of the surgical procedure, after the insertion of the intrauterine manipulator and after the closure of the vaginal vault. The rate of positive peritoneal cytology conversion and its association with oncological outcomes was assessed (figure 1).

**Abstract 2022-RA-886-ESGO Table 1** Clinicopathological characteristics among the different study groups

	Total N= 124	Group 1 N= 98	Group 2a N= 16	Group 2b N= 10	P- Value
Mean age at surgery, years ± SD	66.1 ±10.0	66.3±10.1	63.6±9.4	68.0±9.4	.495
Mean BMI, kg/m <sup>2</sup> ± SD	29.5±8.1	30.1 ±8.3	28.2 ±7.5	28.2 ±7.5	.266
History of tubal sterilization, N (%)	16 (12.9)	13 (13.3)	2 (12.5)	1 (10.0)	.957
Preoperative hysteroscopy, N (%)	79 (63.7)	64 (65.3)	9 (56.3)	6 (60.0)	.759
Surgical lymph node staging performed, N (%)	95 (76.6)	76 (77.6)	14 (87.5)	5 (50.0)	.080
High-grade histology, N (%)	31 (25.0)	23 (23.5)	7 (43.8)	1 (10.0)	.014
Advanced FIGO stage (III/IV), N (%)	20 (16.1)	11 (11.2)	7 (43.8)	2 (20.0)	.020
Positive lymph node status, N (%)	15 (12.1)	8 (8.2)	7 (43.8)	0 (0.0)	<.001
Endometrioid histology, N (%)	109 (87.9)	86 (87.8)	13 (81.3)	10 (100)	.317
LVSI positivity, N (%)	26 (21.0)	15 (15.3)	8 (50.0)	3 (30.0)	.021
Adjuvant treatment performed, N (%)	66 (53.2)	49 (50.0)	13 (81.2)	4 (40)	.145

**Results** 124 patients were included. Clinicopathological data are provided in Table 1, mean follow-up was 120.7 (95% CI 116.2–125.2) months. Peritoneal cytology was negative in 98 (group 1) and positive in 26 patients (group 2). In group 2