molecular subgroups: 75%, 11% and 11% of respectively TP53-mutated, MMRd and NSMP tumors and for the single POLE-mutated tumor.

**Conclusion**
More half of UTOLA tumors are associated with poor prognosis molecular profiles. A high concordance of NGS MSI/P53 and IHC was observed. High platine sensitivity and genomic instability observed in TP53 mutated tumors reinforces the rational to evaluate olaparib in this population.
Conclusion The world's largest collection of molecularly classified EC with long-term follow-up data was pooled for the development of a prognostic and therapeutic framework. In the next months, we will develop and validate models for other clinical outcomes in order to create a framework that can improve evidence-based risk stratification and support decisions on adjuvant therapy.

## FEASIBILITY OF LAPAROSCOPIC EXTRAPERITONEAL PELVIC LYMPHADENECTOMY IN OBESE ENDOMETRIAL CANCER PATIENTS

Mohamed Hamdy, Adel Fathi, Khaled Gaballa. Surgical oncology, Oncology center Mansoura university, Mansoura, Egypt

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### Introduction/Background

**Objective:** To describe the feasibility of extraperitoneal approach to perform complete para-aortic and pelvic lymphadenectomy in patients with endometrial cancer. Theoretically, extraperitoneal approach is technically easier in the obese patient as it naturally creates a bowel-free operative field.

### Methodology

A prospective descriptive study evaluating laparoscopic extraperitoneal lymphadenectomy in patients with endometrial cancer, 20 endometrial cancer patients were enrolled in the trial.

## RESULTS

- **Result:** 2 cases were shifted to open and excluded from the trial. The median BMI of the patients was (37.5), in 3 (16.6%) cases, right nodal dissection was performed through the transperitoneal approach. The average number of pelvic nodal yield was (20). The mean total operative time was 298 (±53.2) minutes. The mean lymphadenectomy time 194.4 (±34.3) minutes. The mean blood loss was 120 (±25.2) ml. the mean hospital stays1.67 (±0.76) days. No patient experienced tumor recurrence with mean follow-up of 12 (±5.6) months.

**Conclusion** Laparoscopic extraperitoneal pelvic lymphadenectomy is feasible, effective, and safe approach and has an added value when offered to obese females such as cases with endometrial cancer.

## LAPAROSCOPIC EXTRAPERITONEAL PARAORTIC AND PELVIC LYMPHADENECTOMY IN OBESE ENDOMETRIAL CANCER PATIENTS; OVERVIEW OF STEPS

Mohamed Hamdy, Adel Fathi, Khaled Gaballa, Cherif Akladios. Surgical oncology, Oncology center Mansoura university, Mansoura, Egypt; Hautepierre hospital Department of gynecology, Strasbourg, France

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### Introduction/Background

**Objective:** Describe the extraperitoneal approach to perform complete para-aortic and pelvic lymphadenectomy in patients with endometrial cancers. Theoretically, extraperitoneal approach is technically easier in the obese patient as it naturally creates a bowel-free operative field.

### Methodology

Descriptive study evaluating laparoscopic extraperitoneal lymphadenectomy in patients with endometrial cancer, 20 patients were enrolled.

**steps:**

1. **port placement:** standard exploration was done. Then, a 1–2 cm incision is made 2–3 cm above and medial to the left anterior superior iliac spine to develop the extraperitoneal space. Another 10–12 mm trocar is placed in mid axillary line and a 5 mm trocar at the subcostal area in the external clavicular line.

2. **landmarks:** LT psoas major muscle, ureter and gonadal vessels, IMA and left renal vein.

3. **Nodal dissection:** from level of the bifurcation of Aorta up to left renal vein.

4. **LT pelvic dissection:** of LT external iliac artery. The internal iliac artery and its branches. The external iliac vessels should be freed from its pelvic wall. left obturator nerve identification and obturator lymph nodes removal.

5. **Right iliac dissection:** mesorectum retracted caudally, development of retro-rectal space is important.