

Conclusion The worlds' 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.

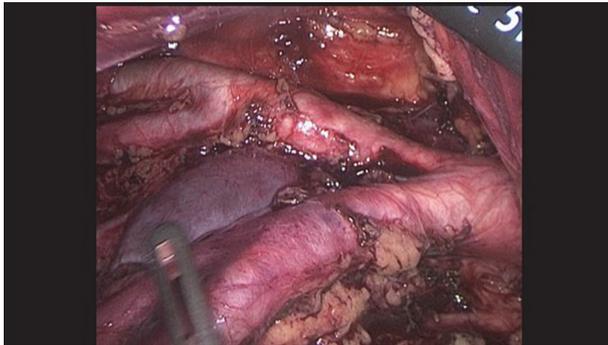
2022-RA-936-ESGO **FEASIBILITY OF LAPAROSCOPIC EXTRAPERITONEAL PELVIC LYMPHADENECTOMY IN OBESE ENDOMETRIAL CANCER PATIENTS**

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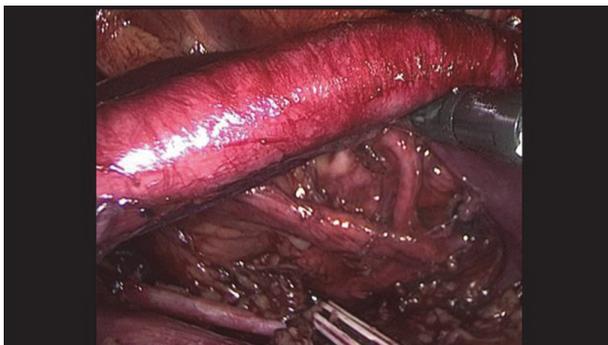
10.1136/ijgc-2022-ESGO.259

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 pelvic lymphadenectomy in patients with endometrial cancer, 20 endometrial cancer patients were enrolled in the trial.



Abstract 2022-RA-936-ESGO Figure 1



Abstract 2022-RA-936-ESGO Figure 2

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 stays 1.67 (± 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.

2022-VA-942-ESGO **LAPAROSCOPIC EXTRAPERITONEAL PARAORTIC AND PELVIC LYMPHADENECTOMY IN OBESE ENDOMETRIAL CANCER PATIENTS; OVERVIEW OF STEPS**

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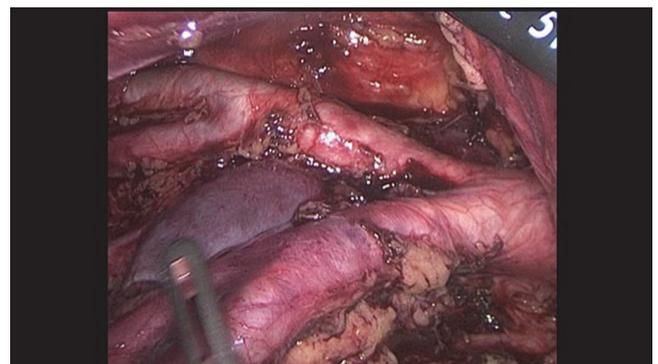
steps: 1.port placement: standard exploration was done. Then, a 1–2 cm incision is made 2–3 cm above and medial to the left anterior superior iliac spine to develop the extraperitoneal space. Another 10–12 mm trocar is placed in mid axillary line and a 5 mm trocar at the subcostal area in the external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



Abstract 2022-VA-942-ESGO Figure 1