Introduction/Background We assessed the impact of low-volume metastasis (LVM) on disease-free survival (DFS) of women with apparent early-stage endometrial cancer (EC) that underwent sentinel lymph node (SLN) mapping.

Methodology Patients with preoperative diagnosis of EC were retrospectively collected from eight referring institutions.

Results 1428 patients were included in this analysis. One hundred and eighty-six patients (13%) had lymph node involvement. Forty-eight percent of positive sentinel lymph nodes had macrometastasis (MAC), 31.3% micrometastasis (MM), and 20.5% isolated tumor cells (ITC). Fifty-seven percent of patients with positive lymph nodes didn’t receive adjuvant therapy. At a median follow-up of 23.7 months, 114 women recurred (8%). Recurrence rate was 28%, 12% and 19% in women with MAC, MM, and ITC, respectively. Patients with MAC in the SLN’s had a worse prognosis in terms of disease-free survival (DFS) compared to patients with negative nodes or with LVM (P<.0001). The type of nodal metastasis did not impact on DFS of patients (HR1.58; p = 0.094). The multivariate analysis showed a difference in DFS when the negative subgroup of women was added to the model (HR 1.26; p = 0.014).

Conclusion In our retrospective study we found that women with MAC have a worse disease DFS compared to women with negative nodes, while the patients with LVM might be considered at intermediate risk. The type of nodal metastasis in the SLN nodes seems to not significantly impact on the risk of recurrence. In the era of molecular profiling, ongoing studies will better clarify the value of SLN biopsy and the of performing a pelvic and/or aortic lymphadenectomy in early-stage EC.

ENDOMETRIAL CANCER: AGREEMENT BETWEEN MICROSATellite INSTABILITY IN IMMUNOHistoCHEMISTRY AND MOLECULAR BIOLOGY?

Introduction/Background Endometrial carcinoma (EC) is the most common cancer of the female genital tract in developed countries. Microsatellite instability (MSI), that represents 30% of EC, is an important prognostic and predictive biomarker. This status is assessed by detection of loss of MMR genes’ proteins by immunohistochemistry (IHC) or by molecular biology. We aimed to compare the agreement between MSI status in IHC and molecular biology.

Methodology Between January 2019 and December 2021, we conducted a monocentric retrospective study of 166 patients treated for EC (all stages) at the CHU of Liège. Sixty-seven patients were excluded. The remaining 99 patients had a complete IHC and molecular analysis for MSI. McNemar’s test and a Kappa of Cohen coefficient were used to evaluate the agreement between both techniques.

Results The McNemar’s test demonstrated 41.4% and 39.4% of MSI in IHC and molecular biology, respectively (p=0.81). There were ten tumors with false-positive staining in IHC and MSS in molecular biology (specificity of 75.6%). Moreover, there were eight tumors with false-negative IHC but MSI-H in molecular analysis (sensitivity of 85.2%). The agreement between MSI in IHC and molecular analysis was 81/99 (81.8%) patients. The Kappa of Cohen coefficient was 0.62 (IC95%: 0.47–0.78), confirming the agreement between both techniques.

Conclusion The methods of testing MSI by IHC and molecular biology are clearly concordant. Presence of MSI in IHC can be considered as a reliable surrogate test for MSI molecular status. Moreover, IHC testing is quicker, easier to perform.

References

1Christine Gennigens, 2Adriane Dheur, 3Vincent Bours, Katty Delbecque, Elodie Gonne, Clemence Pleyers, Laurence Seidel, Sylvie Street, Marie-Jeanne de Copere, Frederic Goffin, Pierre Lortie, Athanasios Kakios, Frederic Kreidel, Alice Salmon. 1Oncology, CHU Liège, CHU Liège, Belgium; 2Gynaecology and Obstetrics, CHU Liège, CHU Liège, Belgium; 3Human Genetics, CHU Liège, CHU Liège, Belgium; 4Pathology, CHU Liège, CHU Liège, Belgium; 5Radiation Oncology, CHU Liège, CHU Liège, Belgium; 6Biostatistics, CHU Liège, CHU Liège, Belgium

10.1136/ijgc-2022-ESGO.266

Abstracts
and less expensive. Nevertheless, based on a 25% and 15% rate of false positivity and negativity respectively, consideration should be given to confirm MSI IHC status for all patients by molecular analyses.

**Introduction/Background** Endometrial cancer is one of the common malignant tumors of the female reproductive system. The recurrence and 5-year overall survival rates of patients with FIGO I-II are 2–15 and 74–91%, respectively. Secondary cytoreductive surgery is associated with improved overall survival in patients with recurrent disease. This video aims to present metastasectomy along with the infrarenal vena cava in a patient with recurrent ovarian cancer.

**Methodology** A 68-year-old woman was admitted with a gross abdominal mass. She has been diagnosed with stage 1, grade 1 endometrial cancer, and underwent a primary staging surgery 2 years ago. The magnetic resonance imaging revealed a 43x39x49 mm abdominal mass involving vena cava inferior. Also, positron emission tomography scan showed a 45x47x50 mm metastatic lymph node extending to the aortocaval pre-vertebral area. Metastasectomy along with the infrarenal vena cava, resection of bulky paraortic lymph nodes, partial resection of the duodenum, and duodenojejunostomy were performed as part of maximal secondary cytoreduction.

**Results** She stayed at the intensive care unit for one day and discharged without any grade 3 or 4 adverse event in post-operative period.

**Conclusion** Secondary cytoreduction for endometrial cancer with no residual disease is a major impact on survival, and maximal cytoreduction is necessary in selected cases. The management of this condition should be performed with expert multidisciplinary teams in gynecological oncology.