SBRT and 11 with surgery. Complete response was achieved in 80% and 90.9%, respectively. 9(56%) vs 11(11.1%) patients were alive and without disease at the end of follow-up (median follow-up: 5.9 years) in local and systemic treatment groups, respectively (p=0.05). Median-time-to-progression was higher in local treatment group (3.5 vs 0.7 years, p=0.029), as well as 5-year OS (80.8% vs 44.4%, p=0.88). No statistically significant differences were found between multiple-site metastatic patients and isolated lung recurrent patients regarding molecular profiling: 21.9% were MSI, 34.4% NSMP, 21.9% p53-abn and 0% POLEmut.

Conclusion Isolated lung recurrent patients locally-treated had the best DFS, OS, and a higher median time-to-progression. Among tumors recurring in the lung, NSMP was the most frequent group. DFS was similar after lung recurrence treatment regarding molecular profile in the oligometastatic cohort.

2022-RA-998-ESGO

INTERMEDIATE-RISK ENDOMETRIAL CANCER: ISOLATED TUMOR CELLS (ITC) VERSUS NODE-NEGATIVE IN SENTINEL LYMPH NODE MAPPING. AN INTERNATIONAL MULTI-INSTITUTIONAL COMPARATIVE STUDY

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Introduction/Background The clinical impact of isolated tumor cells (ITC) (≤0.2 mm) in sentinel lymph nodes (SLN) of endometrial cancer (EC) is unclear. This study compared the recurrence-free survival (RFS) of intermediate-risk EC patients who underwent SLN biopsy and were node-negative vs. those who had ITC.

Methodology Patients with SLN-ITC, between 2012 and 2019, were identified from 21 centers worldwide, while SLN-node-negative patients were identified from Mayo Clinic, Rochester, between 2013 and 2018 and served as comparing group. Only patients with uterine-confined EC and intermediate-risk factors [grade 1 or 2 endometrioid and myometrial invasion (MI) ≥50%; grade 3 endometrioid and MI <50%; non-endometrioid without MI] were included. Adjuvant therapy (ATx) included vaginal brachytherapy (VB), external beam radiation and/or chemotherapy (EBRT ± CHT). The primary outcome was non-vaginal recurrence (hematogenous, peritoneal or lymphatic).

Results Of 200 patients included, 74 had ITC and 126 were node-negative. Sixteen patients had a non-vaginal recurrence and the median follow-up for patients without recurrence was 2.9 (IQR, 1.8–3.8) and 2.8 (0.8–4.4) years for the two groups, respectively. Among the 162 patients with ATx (VB
only=112; EBRT±CHT=50), there was no significant difference in non-vaginal RFS between ITC vs. node-negative patients \( p=0.34; 4\text{-year RFS 84.1\% (95\% CI, 72.1–98.1\%)} \) vs. 91.5\% (95\% CI, 84.1–99.4\%) for 61 ITC vs. 101 node-negative). However, we observed worse non-vaginal RFS in the subgroup of 32 patients with concurrent ITC and LVSI \( p=0.006, \) figure 1). In particular, the 4-year RFS was 64.6\% (95\% CI, 43.2–96.8\%) in this subgroup compared to 93.3\% (95\% CI, 81.5–100\%) and 91.7\% (95\% CI, 83.9–100\%) for the node-negative patients with and without LVSI, respectively. There were no recurrences among 29 patients with ITC and no LVSI.

**Conclusion**

Our results on intermediate-risk EC, who received ATx, suggest that the simultaneous presence of ITC and LVSI is associated with a poorer prognosis. Further studies are warranted.

**2022-RA-999-ESGO**

**Clinical Relevance of Clinicopathological and Molecular Factors in Women with Surgically Treated Stage IV Endometrial Cancer**

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10.1136/ijgc-2022-ESGO.275

**Introduction/Background**

Risk stratification, treatment and prognosis of stage I-III endometrial cancer (EC) are dependent on its molecular subclassification. The role of this classification has not been investigated for stage IV EC. Studies on optimal treatment for stage IV EC are scarce and management is authority based and individualized. Cytoreductive surgery (CRS) combined with chemotherapy has been associated with superior overall survival (OS). This study aims to investigate whether the molecular EC subclassification can be used as a predictive marker for successful CRS.

**Methodology**

A retrospective cohort study was performed from 01–01–2000 until 31–12–2018 including 157 surgically-treated stage IV EC patients from five hospitals in The Netherlands. Tumour samples were molecularly classified according to the WHO 2020 classification and estrogen receptor (ER) expression status was evaluated. Molecular risk factors for intra-abdominal residual disease were identified by multivariable logistic regression analysis. OS after CRS was estimated using Kaplan-Meier’s method, groups were compared using the log-rank test. Prognostic factors for OS were determined by multivariable Cox regression analyses.

**Results**

Molecular classification shows a dissimilar distribution compared to stage I-III EC; i.e. POLE mutation (POLEmut) 3.2\%, mismatch-repair deficient (MMRd) 13.4\%, no specific molecular profile (NSMP) 24.8\%, p53 abnormal (p53abn) 58.6\% (table 1). A trend for incomplete CRS was observed for p53-abn and NSMP EC (OR 3.25, \( p=0.094 \) and OR 4.12, \( p=0.057 \) respectively), compared to MMRd EC. Complete CRS, histotype, grade and ER status had a significant impact on OS (figure 1A-C). Molecular classification not (figure 1D). Optimal (HR 2.99, \( p<0.0001 \)) and incomplete CRS (HR 2.73, \( p<0.0001 \)), grade 3 endometrioid (HR 3.00, \( p=0.001 \)) and non-endometrioid histotypes (HR 2.50, \( p=0.006 \)) were independent risk factors for shorter OS.