Conclusion: Restaging with lymphadenectomy does not alter prognosis of early-stage, LVSi positive patients.

**2022-VA-1045-ESGO**

**SURGICAL RESTAGING OF EARLY-STAGE ENDOMETRIAL CANCER PATIENTS WITH LYMPHOVASCULAR INVASION DOES NOT SIGNIFICANTLY IMPACT THEIR SURVIVAL OUTCOMES**

Stamatos Petousis, Beatriz Navarro, Chrysoula Margioula-Sirakou, Guillaume Babin, Frederic Guyon. Institut Bergonie, Bordeaux, France

10.1136/ijgc-2022-ESGO.283

Introduction/Background: Lymphovascular space invasion (LVSi) is considered to be a poor prognostic factor in endometrial cancer. However, management of patients with early-stage endometrial cancer with positive LVSi remains controversial. Main objective of the present study is to investigate whether surgical restaging of such patients has a significant effect on survival outcomes or may be otherwise omitted.

Methodology: A retrospective cohort study was conducted in Gynaecologic Oncology Unit, Institut Bergonie, Bordeaux, France regarding the period 2003–2019. We included patients with definitive histopathological diagnosis of early-stage, grade 1–2 endometrial cancer with positive LVSi. Patients were divided into two groups, those being restaged with pelvic and para-aortic lymphadenectomy (group 1) and those not restaged and receiving complementary therapy (group 2). Primary outcomes of the study were overall survival and progression-free survival. Epidemiological data, clinical and histopathological characteristics as well as complementary treatment received were also studied. Kaplan-Meier and cox regression analysis were performed for the scope of this study.

Results: There were overall 30 patients retrieved, of which restaging with lymphadenectomy was performed in 21 patients (group 1), while another 9 patients (group 2) were not restaged and received complementary therapy. Positive lymph node was observed in 23.8% of patients of group 1 (n=5). No significant difference was observed between groups 1 and 2 in terms of survival outcomes. Median OS in group 1 was 91.31 and 90.61 in group 2 (HR:0.71, 95% CI: 0.03–16.58, p=0.829). Median DFS was 87.95 and 81.52 respectively for two groups (HR:0.85, 95% CI:0.12–5.91, p=0.869).

Conclusion: The current evidence for SLN mapping versus LND was reviewed. (4, 5, 6, 7). Regardless of the surgical approach, SLN reduces blood loss during surgery. Further studies on operative time and complications are needed for further analysis. SLN mapping is more targeted for fewer lymph node dissections and more positive lymph node detection, even in high-risk patients. The utility of SLN does not imply adverse survival in EC patients.