endocervix and endometrium in patients with endometrial cancer. Due to the ease of obtaining the material from the cervix during cytological screening, the expression of selected proteins might be used as a predictive factor in endometrial cancer.

**Methodology** The study was performed on group of 101 patients with type I and II endometrial carcinoma using immunohistochemical methods.

**Results** Our results showed that both cadherins were expressed in the endocervix. In endometrial cancer type I, no significant differences were found in the expression of cadherins between the tumor and the cervix. It is possible to suspect an evenly ongoing neoplastic process both in the primary site and in the cervix. Statistically significant differences in the results turned out to be in the case of type II endometrial cancer, where a higher cadherin expression was noted in the tumor mass compared to the cervix, which suggests a greater dynamics of the EMT process in the tumor itself than in the cervix.

**Conclusion** Our results may have significant clinical outcomes in the diagnosis of endometrial cancer.

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**LAPAROSCOPIC VERSUS OPEN ABDOMINAL HISTERECTOMY IN ENDOMETRIAL CANCER PATIENTS: ANALYSIS OF OUTCOME ACCORDING TO RISK GROUP**

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**Introduction/Background** For treatment of low-risk endometrial cancer, laparoscopic hysterectomy is the standard surgical approach. On the other hand, oncologic safety of minimally invasive technique in high risk disease has not yet been proven.

**Methodology** Between 1996 and 2010, 359 endometrial cancer patients underwent laparoscopic or abdominal hysterectomy at Jena University Hospital. Recurrence rate and survival were analysed depending on surgical approach and risk categorization by classical histopathology (low-risk: stage IA without nodes metastasis, G2 or G2 with endometroid carcinoma; high-risk: stage IB or G3 or with nodes metastasis or serous papillary or clear cell type). Median follow-up was 72 months (minimum=2, maximum=214).

**Results** In low risk patients, disease-free survival (DFS) rate was 95.6% and overall survival (OS) rate was 96.6% after laparoscopic hysterectomy (n=158) compared to DFS rate of 92.9% and OS rate of 100% after abdominal hysterectomy (n=43). In high risk patients, we found a DFS rate of 75.3% and OS rate of 85.1% in the laparoscopy group (n=97), while DFS rate was 73.3% and OS rate was 84.2% in the open surgery group (n=61). Proportional hazards assumption of Kaplan-Meier curves was not satisfied.

**Conclusion** Long-term oncologic outcome of the laparoscopic procedure was not inferior compared to open abdominal hysterectomy in both low risk and high risk endometrial carcinoma patients according to data from our cohort. Results from patients treated in our center between 2011 and 2021 are under progress.
guideline have been implemented for more than four years. Very recently, the introduction of the molecular classification of endometrial carcinoma (EC) as a prognostic and predictive factor is going to change the morphological classification used so far. Based on cancer registry data we analysed how clinical practice has changed according to guideline recommendations.

**Methodology** A data set of patients with endometrial cancer diagnosed prior (2016–2017) and after (2019–2020) publication of the S3 guideline was extracted from the Hamburg Cancer Registry (HCR). Reports on diagnosis, treatment, and course of disease were evaluated and compared between both groups.

**Results** After publication of the S3 guideline changes in the treatment management of patients with endometrial cancer over time were observed in the Hamburg Cancer Registry data. Regarding surgical therapy, a decrease in lymphadenectomies performed in patients with low-risk type I endometrial cancer and changes in surgical techniques (such as open versus laparoscopic surgery) occurred.

**Conclusion** Our study demonstrates that cancer registry data can be used to monitor the reality of care for patients with endometrial cancer across institutions and sectors of treatment. In order to further improve this valuable source of data, more complete and comprehensive collection of cancer registry data should be intensively pursued.

**Introduction/Background** Minimal invasive surgery (MIS) has emerged as the gold standard for surgical staging of women with assumed early-stage endometrial cancer (EC). In cervical cancer the use of MIS has decreased after publication of the LACC-trail in 2018. We sought to compare women treated by laparotomy versus MIS for EC in respect to survival outcomes and recurrence.

**Methodology** Women with assumed uterine-confined endometrioid grade 3 and non-endometrioid EC from 2006 to 2021 were identified in our institutional database. Risks of recurrences, p=0.25. When adjusted for age, histology, stage and LVIS, risk of recurrence and cancer-specific death was not significantly different between groups, p=0.04 and p=0.02, respectively. More women in the laparotomy group underwent comprehensive lymphadenectomy and more women in the MIS group underwent sentinel lymph node biopsy. Acknowledging the small number of isolated nodal recurrences, there was no significant difference in rate of these recurrences (p=0.25). When adjusted for age, histology, stage and LVIS, risk of recurrence and cancer-specific death was not significantly different between groups, HR=1.28 (95%-CI 0.94–1.74) and HR=1.19 (95%-CI 0.82–1.74), respectively.

**Results** In total, 152 EC patients (mean age: 71.0 +/-7.4 years) with a median follow-up time of 31.0 [8.0 – 68.5] months entered the study. EC patients receiving RBC were faced with a significantly decreased 5-year PFS (79.8% vs. 26.0%; p<0.001) and 5-year OS (82.6% vs. 25.7%; p<0.001). In the univariable Cox regression analysis, FIGO-Stage, histological grade of differentiation, the RBC solely retained significance as a relevant prognostic parameter for PFS (HR: 1.76; 95%-CI [1.01–3.07]) and OS (HR: 2.38; 95%-CI [1.50–3.78]).

**Conclusion** These results underline the impact of RBC and selected clinical-pathological cancer characteristics on the prognosis of patients with EC. To which extent a multidimensional diagnostic and treatment algorithm covering standardized transfusion management, the clarification of AOC, as well as the determination of global health status by validated frailty assessment tools support the maximal surgical efforts in the elderly patients with EC needs further evaluation.