

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 challenge 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.

2022-RA-1129-ESGO ANEMIA OF CANCER, TRANSFUSION RATES AND FRAILTY STATUS PREDICT SURVIVAL IN WOMEN WITH ENDOMETRIAL CANCER

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Introduction/Background Perioperative red blood cell transfusions (RBC) have been associated with increased morbidity and worse oncologic outcomes in various solid neoplasms. In order to elucidate whether RBC themselves, the preoperative anemia of cancer (AOC) or the impaired global health status might explain this impact on patients with endometrial cancer (EC), we performed a retrospective, single-institution cohort study.

Methodology Women older than 60 years with EC were included. The impact of RBC, AOC and frailty status determined by the G8 geriatric Screening tool (G8 Score) as well as clinical-pathological cancer characteristics on progression-free survival (PFS) and overall survival (OS) were determined by using the Kaplan Meier method and the Cox regression analyses.

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, postoperative residual tumor burden and RBC, as well as preoperative frailty status for both, 5-year PFS and 5-year OS were associated with decreased survival rates (all p -values < 0.05). In the multivariable analyses, besides selected clinical-pathological cancer characteristics (FIGO-Stage and

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.

2022-RA-1181-ESGO SURVIVAL OUTCOMES AND RECURRENCE PATTERNS OF LAPAROTOMY VERSUS MINIMAL INVASIVE SURGERY IN WOMEN WITH INTERMEDIATE- AND HIGH-RISK UTERINE CANCER AT A TERTIARY REFERRAL CENTER

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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-trial 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 recurrence and cancer-specific death were estimated, stratified by surgical approach. Appropriate statistical tests were applied.

Results 786 women were identified, 463(58.9%) laparotomy and 323(41.1%) MIS (82/323 laparoscopy, 241/323 robotic), see figure 1 for distribution over time. Patient and tumor characteristics are described in table1. There was no difference between groups regarding age, BMI, smoking, ASA, histology, presence of LVIS, or adjuvant therapy. Significantly more women in the laparotomy group were stage III (29% vs 21%) and IV (7% vs 2%), respectively ($p < 0.0001$). Nodal assessment and anatomic distribution of recurrences varied between groups, see table1. There were more women in the laparotomy group with isolated vaginal recurrences and multiple site recurrences, $p = 0.04$ 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 LVSI, 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.