2022-RA-1627-ESGO · VAGINAL MICROBIOME IN PATIENTS WITH ENDOMETRIAL CANCER

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Introduction/Background Mechanisms by which microbiota exert their influences on human health are not well-defined, but under certain circumstances certain bacterial communities can become altered, thereby disrupting normal homeostasis and resulting in human disease. While disruption of the vaginal microbiome may potentially promote gynecologic carcinogenesis (i.e. cervical cancer), the exact role of the microbiome in endometrial cancer still remains unclear. The aim of the present study was to identify selected species of microorganisms in women with endometrial cancer, and endometrial precancerous lesions.

Methodology 48 women with endometrial cancer, endometrial atypical hyperplasia and benign gynaecological conditions were included in this study. In each case, two swabs were taken: vaginal and endocervical. Each patient signed an informed consent form. Real-Time PCR was used to identify bacterial species. differences between vaginal and endocervical microbiota were examined.

Results Samples from the vagina in terms of isolated microbial species were more diverse than samples from endocervical canal. Mobiluncus curtisii and Fusobacterium nucleatum were the most frequent species detected in vaginal sample, whereas Gardnerella vaginalis i Atopobium vaginae were the most frequently detected in endocervical canal samples. Patients with endometrial cancer have more abundant vaginal microbiota in comparison to endocervical canal, while women from control group have a comparable number of isolated microorganisms in vaginal and endocervical canal swabs. It was observed that the number of Lactobacillus spp. and Bifidobacterium spp. was statistically decreased in cancer patients compared to controls. It was also shown that significantly more microorganisms were isolated from endocervical canal swabs in women from control group compared to endometrial cancer.

Conclusion Microbiome of patients with endometrial cancer shows clear quantitative and qualitative differences when compared to control groups. The results of our stud raise the possibility of a microbiome role in the manifestation and/or etiology of endometrial cancer that should be further investigated.

2022-RA-1630-ESGO · ROBOTIC SURGERY AND PERIOPERATIVE MORBIDITY IN VERY ELDERLY WOMEN (≥80 YEARS OLD) WITH INTERMEDIATE AND HIGH RISK ENDOMETRIAL CANCER

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Introduction/Background To investigate the feasibility, safety, and short-term outcomes for elderly patients, (age ≥80 years old) undergoing robotic surgery for intermediate and high risk endometrial cancer.

Methodology Prospective data collection, cohort study of all patients ≥80 years old that underwent robotic surgery for the treatment of endometrial cancer (intermediate and high risk) in our centre between 1/1/2015 and 15/03/2022

Results We reviewed 752 cases and identified 82 patients ≥80 years old with a mean age of 83 (80–91) years old. They have significant incidence of comorbidities: 80% cardiovascular disease, 29.1% diabetes, 19% chronic obstructive pulmonary disease. Mean BMI was 30 (range 18–45). 76% of them had previous abdominal surgery and 38.2% of them had a performance status (ECOG) ≥2. 24% of them had been treated for another cancer in the past. All comorbidity characteristics were statistically higher other than BMI, compared to the younger group of our patients in the same period. 60% underwent pelvic Lymphadenectomies and 22% sentinel lymph node biopsy; and 16.4% had positive lymph node identified and upstaged. 33% of them were discharged day 1 post op. Mean and median length of hospital stay was 3 and 2 days respectively. There was no difference in the minor post operative complication rate (9.8% vs 10%, p<0.05), but we observed 4.8% grade III-IV vs 2.8% (p>0.05). There were no 30-day post-operative deaths in none of the groups.

Conclusion Robotic surgery is feasible with acceptable postoperative complication rate in comparison to younger women, ensuring appropriate oncological staging and treatment We observed a longer length of hospital stay and a slightly higher grade III-IV complications of 4.8%. Very elderly women (≥80 y.o) should be considered suitable for robotic surgical staging, and consented appropriately of risks.

2022-RA-1635-ESGO · ACCURACY OF MRI IMAGING IN PREOPERATIVE STAGE ASSESSMENT OF ENDOMETRIAL CANCER IN DETERMINING EXTENSION OF SURGICAL PROCEDURE

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Introduction/Background The preoperative stage assessment of endometrial cancer, determined by the FIGO staging system, is based on imaging and determines the extent of the surgical procedure. Uncertain situations or technical difficulties require MRI as a reference technique. In published papers the accuracy of this technique is done upon a high quality examination (expert radiologist in a reference center), whereas everyday practice shows otherwise. The aim of this retrospective cohort study is to evaluate the concordance between preoperative MRI data and final histopathological examination.

Methodology A retrospective observational study of 106 patients operated for endometrial cancer was performed between July 2021 and February 2022. All patients included were women who had the primary radical surgery for all histological types. The exclusion criteria were lack of preoperative pelvic and abdominal MRI assessment. The final histopathological data from surgical operations were compared with preoperative imaging data.

Results For deep myometrial infiltration the accuracy of MRI was 66,7%, sensitivity was 75%, specificity was 45,5%. For the cervical stroma infiltration the accuracy was 84,1%, sensitivity was 47,6%, specificity was 81,4%. For the parametrium

infiltration the accuracy was 84,1%, sensitivity was 28,6%, specificity was 91,8%. Nodal metastases were detected in 15,9% patients (11,6% in PLN and 4,3% PLN&PALN). The accuracy of the MRI for the detection of nodal metastasis was 75,4%, sensitivity 30,8%, specificity 84,2%. Further analysis evaluated the impact of the following features on the MRI efficiency: histological type, patient age, presence of myomas and the reference status of the radiology center.

Conclusion Unsatisfactory results of MRI imaging, particularly that overestimate the local infiltration, lead to performing too extensive lymphadenectomy, especially that the ability of detecting LN metastasis by MRI has low rate. All quality bias should be taken into consideration when analyzing the results of the MRI to tailor the surgical treatment.

PARA-AORTIC LYMPHADENECTOMY INCREASES VASCULAR LESIONS COMPARED TO PELVIC LYMPHADENECTOMY IN ENDOMETRIAL CANCER, A STUDY IN A MEXICAN POPULATION

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Introduction/Background Endometrial cancer in Mexico represents the second place, followed by cervical cancer. High-risk staging and treatment involves total hysterectomy, bilateral salpingo-oophorectomy with pelvic and/or para-aortic lymphadenectomy. Surgical staging is necessary in high and intermediate risk cases to assess the extent of the disease and the need for adjuvant therapy, which is why it is important to know the lymph node status to assess the prognosis. Our objective is to evaluate whether para-aortic lymphadenectomy increases vascular lesions compared to pelvic lymphadenectomy in endometrial cancer in a cancer reference center in Mexico.

Methodology A retrospective analysis of 44 cases of endometrial cancer that had complete surgical staging was performed. Comparisons were analyzed using Student's t-test and Mann-Whitney tests. For the statistical analysis, SPSS version 23 was used.

Results The surgeries were performed by experienced gynecologists or surgical oncologists. The median age was 53 years, in the analysis we could not identify statistical differences between the rest of the complications, the main complication was lymphocele with p: 0.03, between the pelvic lymph node dissection (PLND) group, compared with the group of PLND and para-aortic lymph node dissection (PALND), vascular injuries were not significant, as well as ureteral injury, reintervention, infection.

Conclusion PLND and PALND do not increase vascular lesions, however if the number of lymphoceles increases, our pelvic and para-aortic lymph node dissections are performed by experienced gynecologists or surgical oncologists with more than three years of surgical training in a national reference center, which could be an important factor, however, in this study we can conclude that vascular injuries do not increase when we perform para-ortic dissection.

SAME DAY DISCHARGE PROTOCOL FOR GYNAECOLOGICAL ONCOLOGY ROBOTIC SURGERY: SINGLE INSTITUTE EXPERIENCE OF INITIAL IMPLEMENTATION

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Introduction/Background Same-day discharge (SDD) is safe following minimally invasive hysterectomy. The Christie is a high-volume tertiary Cancer centre offering robotic surgery on high-risk patients with a successful Enhanced Recovery programme. Our aim was to create a pathway for SDD acknowledging that only a small cohort of our patients would be eligible. We present the feasibility and safety of service development.

Methodology Prospective cohort study of all patients who underwent robotic surgery for the treatment of gynaecological cancer, in our centre since March 2022, following clinical approval of Enhanced recovery and SSD pathway.

Results Initial, seven patients that were eligible for SSD were prospectively monitored. Mean age was 59(range 50–67)years old. 85.7% had previous abdominal surgery and 28.6% had undergone treatment for a different cancer, in the past. Mean BMI was 37(range 27–47) and they all had performance status of 0 and ASA=2. None was diabetic as this was an exclusion criterion. 42.9% had well controlled hypertension and another 42.9% were ex-smokers. Pre-operative haemoglobin was 139 (range 126–150) g/l.All had operations in the morning session and discharged successfully by 6pm same day.All patients underwent robotic total hysterectomy with bilateral salpingo-oophorectomy, 57% had sentinel lymph nodes and 42.8% omentum biopsied. There were no intraoperative complications and estimated blood loss was 50 mls. There were no concerns reported on follow up phone call day 1 and 2 post op. There were no readmissions and none 30-day post-operative complication on follow up clinic review. Patients satisfaction assessed by clinical nurse specialists as part of holistic needs assessment was very positive.

Conclusion Initial implementation is successful; following a robust preoperative and perioperative care pathway, including appropriate patients' selection and preparation. Post operative support and follow up is paramount. This is supported by a well established gynaecological oncology robotic service.

IMPACT OF TUMOR VOLUME ON SURVIVAL OF PATIENTS WITH LYMPH NODE METASTASIS IN ENDOMETRIAL CANCER

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Introduction/Background Endometrial carcinoma is the most frequent malignant tumor of the female genital tract. The worse prognosis of patients with lymph node disease is well known, but little is known about the relevance of the tumor volume. Our objective is to analyze the impact of the tumor volume of these metastases on the survival.