1000 mg Q6W until disease progression, discontinuation, or withdrawal.

**Results** At this third interim analysis of GARNET, the safety population included 605 patients. irAEs were experienced by 32.2%, with 10.1% of patients experiencing grade ≥3 irAEs (table 1). Few, 5.5%, discontinued treatment because of an irAE. No irAEs led to death. Of patients experiencing irAEs, 64.6% were treated with immune modulatory medications (IMMs; referring to steroids, immune suppressant, and/or thyroid therapy); 58.7% of these patients experienced resolution. Average time to resolution was 69 days. For the 35.4% of patients not treated with IMMs, 56.5% experienced a resolution. Average time to resolution was 67 days. The most common irAEs were hypothyroidism (7.6%; 45 of 46 [97.8%] patients treated with thyroid therapy) and arthralgia (5.6%; 8 of 34 [23.5%] patients treated with steroids).

**Conclusion** Across all tumour types evaluated in GARNET, 32.2% of patients experienced irAEs, 68.7% of whom experienced grade 2 events. 58.7% of patients experienced discontinuation due to irAEs. Overall discontinuation due to irAEs upon treatment with an IMM. Across all tumour types evaluated in GARNET, 32.2% of patients treated with steroids). 58.7% of patients experienced resolution. 64.6% were treated with immune modulatory medications (IMMs; referring to steroids, immune suppressant, and/or thyroid therapy); 58.7% of these patients experienced resolution. Average time to resolution was 67 days. The most common irAEs were hypothyroidism (7.6%; 45 of 46 [97.8%] patients treated with thyroid therapy) and arthralgia (5.6%; 8 of 34 [23.5%] patients treated with steroids).

**Conclusion** Intensive perioperative thromboprophylaxis with tinzaparin 8,000 Anti-Xa IU, OD for up to 1 month post gynecologic cancer surgery found to be effective and safe. Additional data is needed to confirm these findings.

**Introduction/Background** Paratubal cysts may mimic ovarian cysts, and most of them are diagnosed postoperatively. They originate from the mesosalpinx between the ovary and the fallopian tube. Only a few are large, and most paratubal cysts are less than 10 cm. We report a paratubal cyst in a 15-year-old woman, whose only preoperative complaint was abdominal pain and vomiting. Conservative surgery was performed with cyst removal while preserving the ovaries and tubes and detorsion. A paratubal cyst should be included in the differential diagnosis of a large pelvic masses, especially in the reproductive age group.

**Methodology** The patient was 15 years old single lady presented with sudden severe left lower abdominal pain which radiated to the groin and associated with vomiting and mild fever she was single medically and surgically free menarche at 11 years old with regular cycle LMP was one week ago. On Examination she was in severe lower left-abdominal tenderness and rebounding ultrasound showed left adnexal cystic structure with multiple septation suggesting hemorrhagic cyst
Signs of ovarian torsion, CT pelvis showed the cyst and confirmed ovarian torsion.

Results Urgen laparoscopic surgery was done and we found the left ovarian pedicle torted 5 times with a pedicle of para-tubal cyst which was making 5 loops around the ovarian pedicle and torted together. Detorsion done and the para-tubal cyst was removed with its pedicle and signs of revascularization was observed in the left ovary histopathology result showed cyst excision benign cystic structure with ciliated epithelium and fibromuscular wall-consist with dilated fallopian tube segment.

Conclusion This case suggests that a para-tubal cyst should be included in the differential diagnosis of pelvic masses, especially in the reproductive age. A para-tubal cyst may mimic an ovarian cyst preoperative.

THE UTERINE SARCOMA REPRESENTS 1 TO 5% OF MALIGNANT TUMORS OF THE UTERUS

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Introduction/Background The uterine sarcoma represents 1 to 5% of malignant tumors of the uterus.

Distribution 1. T Mixed epithelial and mesenchymal elements (T Mixed müllerian) (50–60%): represented by the carcinosarcoma, adenosarcoma; 2. leiomyosarcoma (35%); 3. endometrial stromal sarcoma (ESS) (chorion cytogene low grade Bad prognosis except SBS 10%): low grade, and undifferentiated. Improved Surgery of the primary tumor and metastasis is essential. Place of the adjuvant chemotherapy remains as only the local control. Sensitivity differently according under histological type. Place determined of targeted therapeutic to define: the trabectedine.

Methodology The retrospective study of 17 cases of uterine sarcoma support in the medical oncology and surgical department at CPMC during the period between 2011–2018.

Results average age of diagnosis: 51 years. The diagnosis been done on the histological examination revealed to the operating room and post-operative. Three varieties: 10 cases of leiomyosarcoma, 3 cases of carcinosarcoma, 4 cases of endometrial stromal sarcoma (ESS) (chorion cytogene of the endometrial).The stage IV of the tumor was found in 50% of tumors and 25% for the stage IA. The prognosis is closely related to the stage of the tumor. The treatment was essentially a radical surgery in 5 cases, 12 cases have beneficed of chemotherapy, in cases of recurrence or metastasis. The protocols used concurrent chemoradiotherapy (CCRT) has been performed in patient presenting a carcinosarcoma. The answer: Total response (7 cases); Partiel response (2 cases); Stable disease (4 cases); failed (4 cases). Follow up: nine patients alive in remission, 4 patients died, 4 living patients in recurrence.

Conclusion the uterine sarcoma is a tumor of bad prognosis significance, the surgical of the primary tumor and metastases is essential; the chemotherapy is reserved in the event of a recurrence or metastatic. We report in this study, the Algerian experience in support of uterine sarcomas.