cancer with a lower risk of lymphatic complications. Our results support the use of SLN mapping improving the quality of life of patients with endometrial cancer.

**Abstracts**

**2022-LBA-1382-ESGO**

**GENOMIC SIGNATURES FOR THE PREDICTION OF RECURRENCE AND METASTASIS IN ENDOMETRIAL CANCER**

1Alba Farres, 1Natalia Teixeira, 2Pia Espanol, 1Eva Magret, 1Rocio Luna, 1Cristina Soler, 3Pau Martin-Malpartida, 3Mara Jesus Macia, 3Maria Virtudes Cespedes, 1Ramon Rovira, 3Gynecology and Obstetrics; Grup d’Oncologia Ginecologica, Institut d’Investigacions Biomèdiques, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain; 2Gynecology and Obstetrics, Hospital Universitari Son Espases, Palma de Mallorca, Spain; 3Institute for Research in Biomedicine, The Barcelona Institute of Science and Technology, Barcelona, Spain; 4Institut Catalana de Recerca i Estudis Avançats (ICREA), Barcelona, Spain; 5Oncologia Ginecològica i Peritoneal, Institut d’Investigacions Biomèdiques, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain

10.1136/ijgc-2022-ESGO.1016

**Introduction** Lymphadenectomy is normally indicated in Endometrial Cancer (EC) staging. Only 20–25% of patients are diagnosed with nodal involvement, therefore 70% of patients will have lymphadenectomy-related risk without therapeutic benefit. Moreover, one fourth of node-negative EC recur, suggesting that some high-risk tumors are not detected using lymphadenectomy. We hypothesize that genetic/transcriptomic and clinical differences among patients might help predict tumor recurrence risk. This study aims to develop a diagnostic tool to determine the probability of relapse/metastasis using genetic indicators.

**Methods** Tumor samples from a cohort of patients surgically staged for EC were collected. Total RNA was obtained, then, gene and microRNA expression arrays were performed. Clinical and pathological data were extracted from patient files. Artificial intelligence using the machine learning protocol was first trained with clinical and genetic data downloaded from public databases. Re-training of the system will be performed with the newly acquired data from the current study.

**Results** Genetic material has been extracted from 120 of the 150 samples considered optimal. Transcriptomic profiles have been quantified and obtained from 90 of these samples. The patient samples studied were classified into low-risk (groups A and B) and high-risk tumors (remaining), and each of the groups has been subdivided according to surgical treatment (with or without lymphadenectomy). Each subgroup has been classified into recurrence (yes/no), resulting in groups of patients between A-H. With the available transcriptomic data, we can identify potential patients that although classified as low risk, would suffer recurrence. So far, these are preliminary data obtained from a pilot study. Additional samples are currently being analysed to increase the statistical value of the observations.

**Conclusions** With the transcriptomic data obtained to date, we can identify patients with a higher risk of recurrence despite being classified as low risk.

**2022-LBA-607-ESGO**

**HOW LONG DO OUR PATIENTS STAY FASTING? A MULTICENTRIC PROSPECTIVE SURVEY ON THE PERIOPERATIVE FASTING IN 924 PATIENTS CONDUCTED BY THE JAGO STUDY GROUP**

1Maximilian Heinz Beck, 2Derya Balci-Hakimeh, 3Florian Scheuerecker, 2Charlotte Wallach, 3Hannah Willbrock, 2Jens-Uwe Blöher, 3Jalid Sehouli, 3Klaus Pietzner. 1Department of gynecology and breast center CCM, Charité Universitätsmedizin Berlin, Berlin, Germany; 2Department of gynecology, St. Joseph Krankenhaus Berlin, Berlin, Germany; 2Department of gynecology, UKF Hamburg, Hamburg, Germany; 3Department of gynecology, Kath. Marienkrankenhaus Hamburg, Hamburg, Germany; 3Department of gynecology CVK, Charité Universitätsmedizin Berlin, Berlin, Germany

10.1136/ijgc-2022-ESGO.1017

**Introduction** The optimization of perioperative fasting is a key step in increasingly established ERAS (extended recovery after surgery) concepts in (gynecologic) surgery. But only little data exists about actually observed fasting intervals before and after surgery in clinical routine. This prospective study of the JAGO (Young Academy of Gynecologic Oncology) and NOGGO e.V investigates the length of perioperative fasting in a multicentric survey.

**Methods** In 13 German gynecologic departments the length of pre- and postoperative fasting intervals were recorded by questionnaire. Furthermore, the patients’ subjective condition, clinical history and experience and ideas about fasting were documented. Subgroup analyses were performed for benign and malignant indications, as well as for the extent of surgery.

**Results** A total of 924 patients participated in the study. On average, patients did not eat for 17:02 h and did not drink for 9:21 h before surgery. The first postoperative meal was 9:42 h after surgery. Patients with malignant indications had significantly longer pre- (Δ=67 min) and postoperative (Δ=166 min) fasting intervals. Prolonged fasting intervals were also observed for patients with extensive surgery. In general patients felt well informed and the majority did not feel impaired by the adherence to fasting restrictions.

**Conclusions** Patients fast significantly longer than recommended. Even more prolonged fasting intervals are observed in patients with malignant indications and extensive surgeries, where optimized fasting could play the greatest role. Therefore, better protocols on optimized perioperative fasting need to be implemented in routine clinical practice.