of risk of malignancy at ultrasound (US) examination by an experienced sonographer in the field and a pelvic MRI were performed. MRI included morphological, functional sequences and O-RADS MRI score (from 1 to 5: 1, nonadnexal lesion; 2, almost certainly benign; 3, low risk; 4, intermediate risk and 5, high risk). Patients were enrolled to surgery and the US and MRI results were compared to the reference standard (histopathological report).

Abstract 2022-RA-1712-ESGO Table 1

	Histological findings		
Expert US subjective impression N=34	Benign	Borderline	Malignant
Inconclusive	15 (44.1%)	3 (8.8%)	4 (11.8%)
Benign	5 (14.7%)	1 (2.9%)	0
Borderline	0	2 (5.9%)	1 (2.9%)
Malignant	1 (2.9%)	1 (2.9%)	1 (2.9%)
O-RADS MRI final score N=34			
1	0	0	0
2	6 (17.6%)	0	0
3	14 (41.2%)	2 (5.9%)	2 (5.9%)
4	1 (2.9%cl)	4 (11.8%)	0
5	0	2 (5.9%)	4 (11.8%)
O-RADS MRI final score in inconclusive expert US Subjective impression N=22			
1	0	0	0
2	3 (13.6%)	0	0
3	12 (54.5%)	0	0
4	0	2 (9.1%)	0
5	0	1 (4.5%)	4 (18.2%)

Results In 34 patients enrolled, 21 (61.8%) had a benign ovarian mass, 6 (17.6%) borderline ovarian tumour and 7 (20.6%) ovarian cancer. At the US examination by an experienced sonographer 22 (64.7%) ovarian masses remained inconclusive at the US examination, 5 (41.7%) were classified correctly as benignant and 5 (41.7%) as malignant.The false positive and negative rates were both 16.7% for the experienced US examination. O-RADS MRI correctly classified as benign (score 2–3) 20 (58.8%) and as malignant (score 4–5) 10 (29.41%) ovarian masses. O RADS MRI showed a false positive rate of 5% and a false negative rate of 23% for the diagnosis of ovarian tumour risk of malignancy. O-RADS MRI showed an accuracy of 88%. Interestingly, in the subgroup of ovarian lesions inconclusive at the US expert examination (n=22), O-RADS MRI showed an overall accuracy of 100%.
Conclusion In this study, the O-RADS MRI score was accurate when stratifying the risk of malignancy in adnexal masses. O-RADS MRI score can be used to further characterise ovarian lesions indetermined by Simple Rules that remained inconclusive at US expert examination.

Endometrial cancer

2022-RA-129-ESGO ULTRASOUND STAGING OF ENDOMETRIAL CANCER

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Introduction/Background Endometrial cancer is common in old age and can be divided in to type 1 related to estrogen exposure and type 2 not related to estrogen exposure . Staging can be done by MRI along with staging . Ultrasound can be used recently due to advanced technologies in ultrasound.
Methodology Staging of endometrial cancer in a simplified manner is as follows, stage 1 affection of the endometrium with stage 1a as superficial myometrial affection (less than 50% myometrial affection) and 1b as deep myometrial affection (more than 50% affection) , stage 2 with cervical affection, stage 3 with pelvic Peritoneum, adenxal, pelvic and paraaortic nodal affection, ascites, positive wash and stage 4 with bladder and rectal affection, inguinal nodes, abdominal metastasis including peritoneal ones.
Results Firstly, We assess the tumor location, size (three diameters), sonomorphology .Secondly, assessment of the Extent of tumor infiltration into the myometrium along with tumor serosa distance especially at the fundus . Thirdly, Cervical stromal involvement is assessed . the extent of tumor stromal invasion whether (≤ 2/3 or > 2/3) or measurement of tumor-free stroma . The last is done by measuring the distance between the tumor and the pericervical fascia which is the paracervix at he level of the cervix and the paracolpos at the level of the vagina .Fourthly, the assessment of the uterine serosa, adenxa and nodal affection . Finally, The spread into the urinary bladder and/or rectum, inguinal nodes and liver, spleen and kidney along with Omentum or abdominal peritoneal lesions (stage 4) can be determined .
Conclusion We present our checklist for ultrasound scanning in cancer cervix.

2022-RA-135-ESGO CYTOREDUCTIVE SURGERY IN RECURRENT ENDOMETRIAL CANCER: A NEW PARADIGM FOR SURGICAL MANAGEMENT?

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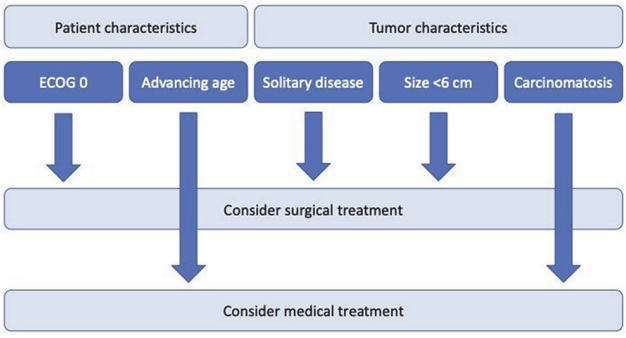
Introduction/Background To review the literature on the effect of surgical cytoreduction in recurrent endometrial cancer on survival and identify factors associated with improved survival. In addition, we sought to assess the effect of previous radiotherapy on surgical achievement.
Methodology This review was performed according to the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines. We performed a search of PubMed and Cochrane Library to identify studies comparing cytoreductive surgery to medical management and studies reporting on patients receiving cytoreductive surgery as part of multi-modal

treatment. Primary outcomes included overall survival and progression free survival, secondary outcomes included factors associated with improved survival.

Results A total of 11 studies fulfilled the inclusion criteria, comprising 1146 patients. All studies were retrospective studies. Cytoreduction as part of treatment for recurrent endometrial cancer was associated with prolonged overall survival and progression free survival. Complete cytoreduction was an independent factor associated with improved survival. Other factors associated with prolonged survival were tumor grade 1, endometrioid histology, ECOG performance status 0, and isolated pelvic recurrences. Factors associated with obtaining complete cytoreduction included solitary disease, tumor size <6 cm and ECOG performance status 0. Previous radiotherapy was not associated with achieving complete cytoreduction.



Abstract 2022-RA-135-ESGO Figure 1

Conclusion Cytoreductive surgery may benefit patients meeting specific selection criteria based on a limited number of retrospective studies, with complete cytoreduction showing the largest survival gain. However, further prospective studies are needed to validate the survival benefit and aid in patient selection.

2022-RA-166-ESGO PROGNOSTIC SIGNIFIENCE OF MOLECULAR GENETIC FACTORS IN ENDOMETRIAL CANCER. A MODERN APPROACH TO THE PROBLEM

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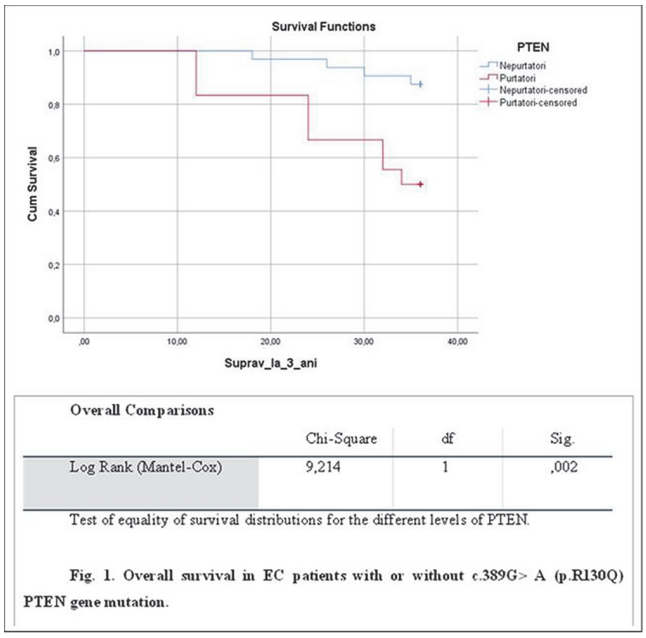
Introduction/Background Modern methods of studying DNA structure, including cluster analysis, make it possible to determine the genetic profile of tumors.

Methodology The prospective study was performed on 50 patients with EC in stages I and II. The study design includes the description of the first stage of the study, marked by the evaluation of clinical-morphological features and the second stage marked by research of genetic features: determination of c.389G> A (p.R130Q) PTEN gene mutation.

Results The rate of the presence of the c.389G> A (p.R130Q) PTEN gene mutation is shown in all 4 subgroups of recurrence risk of patients with EC. The median survival time of patients with c.389G> A (p.R130Q) PTEN mutation was 15.7 ± 1.89 (95% CI [11.3–20.5]) months (95% CI 7–7 months), which did not differs (F = 0.005; p = 0.943) from mean time to progression in patients without mutations – 16.0 ± 3.97 (95% CI [12.0–28.0]) (figure 1). **$$MISSING OR BAD GRAPHIC SPECIFICATION (2C128DE7-E0AB-4E14-ADC4–2A80097FE4FA) $$**

Thus, the median survival time of patients in the low-risk group was 13.5 ± 3.37 (95% CI [9.0–18.0]) months, differing significantly from that in patients high risk – 15.8 ± 3.34 (95% CI [10.5–23.0]) months (F = 16.2; p = 0.891). Our research showed that group risk did not have an impact on the survival time of patients with PTEN mutation, this suggested that c.389G> A (p.R130Q) PTEN gene mutation may be regarded as a powerful prognostic factor for decreased survival time in patients with EC.



Abstract 2022-RA-166-ESGO Figure 1 Overall survival in EC patients with or without c.389G> A (p.R130Q) PREN gene mutation

Conclusion This study showed that c.389G> A (p.R130Q) PTEN genetic mutation is strongly correlated with poor prognosis in EC patients. This may indicate that c.389G> A (p.R130Q) PTEN genetic mutation could be regarded as an important factor in the pathogenesis of EC. However, this finding is derived from small data in observational study, hence well conducted high-quality randomized trials are warranted.

2022-RA-168-ESGO DOES ORDER OF ADJUVANT TREATMENT FOR HIGH RISK ENDOMETRIAL CANCER MATTER? A RETROSPECTIVE REVIEW

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