33% from 2004 to 2018 (p<0.05). Predictors of receiving adjuvant RT varied by histology but included stage II or III, high grade, and >=7 lymph nodes removed.

Conclusions For uterine sarcomas, TH+BSO without LNS was the main surgical modality. We identified high-risk features predictive of receiving RT, including stage II/III, high grade, and more extensive LNS. Overall, adjuvant RT utilization is decreasing over time for uterine sarcomas, particularly in leiomyosarcomas.

**Conclusions**

For uterine sarcomas, TH+BSO without LNS was the main surgical modality. We identified high-risk features predictive of receiving RT, including stage II/III, high grade, and more extensive LNS. Overall, adjuvant RT utilization is decreasing over time for uterine sarcomas, particularly in leiomyosarcomas.

**EP131/#268 ONCOLOGIC SAFETY OF MINIMALLY INVASIVE SURGERY IN NON-ENDOMETRIOID ENDOMETRIAL CANCER**

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Objectives This study was aimed to compare the oncologic outcomes of patients with non-endometrioid endometrial cancer who underwent minimally invasive surgery with the outcomes of patients who underwent open surgery.

Methods This is a retrospective, multi-institutional study of patients with non-endometrioid endometrial cancer who were surgically staged by either minimally invasive surgery or open surgery. Oncologic outcomes of the patients were compared according to surgical approach.

Results 113 patients met the inclusion and exclusion criteria. 57 underwent minimally invasive surgery and 56 underwent open surgery. Patients who underwent minimally invasive surgery had smaller tumors (median size, 3.3 vs. 5.2%, p=0.0001) and a lower lymphovascular space invasion rate (29.8% vs. 48.2%, p=0.045). In the overall population, the numbers and rate of recurrence were significantly higher in the open surgery group (p = 0.016). In multivariate analysis, disease stage and tumor size were associated with DFS in contrast to surgical procedure.

Conclusions Minimally invasive surgery showed similar survival outcomes when compared to open surgery in non-endometrioid endometrial cancer patients, irrespective of disease stage. When minimally invasive surgery is managed by expert surgeons, non-endometrioid histological subtypes should not be considered a contraindication for minimally invasive surgery.

**EP132/#323 CLINICAL RELEVANCE OF RED BLOOD CELL DISTRIBUTION AS PROGNOSTIC MARKER IN ENDOMETRIAL CARCINOMA**

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Objectives Increasing evidence is focused on the relationship between hematologic biomarkers and gynecologic malignancies. Red blood cell distribution width (RDW) is a standard parameter of the complete blood count and indicates variability in red blood cell size. The purpose of this study was to detect whether the preoperative RDW can be used to predict the prognosis of endometrial carcinoma.

Methods Medical records of patients diagnosed with endometrial carcinoma were registered from May 2006 to June 2018. In addition to RDW, the clinicopathological factors, survival curves and prognosis of the patients with endometrial carcinoma were compared between the high and low groups according to the median RDW value (12.8%).

Results The patients with high RDW had significantly higher body mass index (BMI) (25.0 ± 6.34 vs. 24.6 ± 3.82; p=0.00), pelvic lymph node metastasis (36.0 ± 16.9 vs. 19.0 ± 8.7; p=0.01) and recurrence (37.0 ± 17.4 vs. 20.0 ± 9.2; p=0.01) compared to the low group. There was an upward trend in RDW value according to advanced surgical stage. In the univariate analysis with DFS as the endpoint, surgical stage, type II histology, grade, RDW and lymph