Conclusions LSR is associated with tumor growth, invasion, metastasis, and poor prognosis in EC. Anti-LSR mAb is a potential therapeutic agent which induces apoptosis and shows a significant antitumor effect in EC.

**EP138/#375** INCIDENCE AND CHARACTERISTICS OF OVARIAN CANCER FOLLOWING ENDOMETRIAL CANCER – IMPLICATIONS FOR COUNSELING IN THE ERA OF CONSERVATIVE MANAGEMENT – A SEER ANALYSIS

Chen Nahshon, 1Yakir Segev, 1Meirav Schmidt, 1Ludmila Ostrovsky, 2Eden Gerszman, 1Ofer Lavie. 1Carmel Medical Center, Gynecological Oncology, haifa, Israel; 2Carmel Medical Center, Department of Surgery B, haifa, Israel

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**Objectives** Ovarian preservation in young endometrial cancer (EC) patients is controversial and requires further consideration. We aimed to assess the risk for ovarian cancer (OC) following EC in patients who underwent ovarian preservation as part of the initial EC staging and to characterize this group of patients.

**Methods** With permission of the Surveillance, Epidemiology and End Results (SEER) program of the United States National Cancer Institute, clinicopathological and prognosis information of women diagnosed with EC and following OC were analyzed. Patients were divided into groups: Group A – EC patients that had BSO performed; Group B– EC patients that had ovarian preservation performed. Incidence of OC and survival rates were compared.

**Results** 383 patients diagnosed with OC following EC were documented. Of them 260 patients had a known BSO performance status. Incidence of OC did not differ between groups (IRR 1.07, CI 0.83–1.39, p=0.59). Survival rates were significantly shorter in ovarian preservation patients compared to patients with BSO performed as part of their EC staging and treatment. However, when analyzing by age, in women diagnosed with EC up to age of 49 years old, no differences in survival rates were found comparing the two groups.

**Conclusions** Ovarian preservation in EC patients under the age of 49 years may be considered safe, with no impact on OC incidence or survival, benefiting a longer natural hormone status. In EC patients who went through ovarian preservation a close follow-up for at least 7 years from the EC diagnosis is recommended.

**EP140/#780** VAGINAL HYSTERECTOMY FOR THE TREATMENT OF LOW-RISK ENDOMETRIAL CANCER: INTERIM SURGICAL AND ONCOLOGICAL ANALYSIS

Fernando Nobrega*, Luisa Martins, Vanessa Bezzera, Vinicius Campos, Bruna Bottura, Sergio Podgace, Renato Moretti-Marques, Hospital Municipal Vila Santa Catarina; Hospital Isaura Albert Einstein, Ginecologia Oncológica, São Paulo, SP, Brazil

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**Objectives** The purpose of this study was to evaluate the role of vaginal hysterectomy for the treatment of patients with low-risk endometrial cancer.

**Methods** We retrospectively reviewed the medical records of patients who underwent vaginal hysterectomy for treatment of endometrial cancer or its precursor lesions at a single center in São Paulo, Brazil. Medical data obtained included comorbidities, pre and postoperative histological diagnosis, perioperative outcomes, adjuvant treatments and oncological and surgical follow-up.

**Results** Medical records from 34 consecutive patients who underwent vaginal hysterectomy for endometrial cancer or its precursor lesions between April 2019 and November 2021 were analyzed. Mean age was 61.9 years and body mass index (BMI) was 34; 76.5% of patients were obese (BMI ≥ 30). Medical comorbidities including hypertension (67.7%) and diabetes (35.3%) were commonly noted. Sixty-one percent of patients had two or more comorbidities. Mean operative time and hospital stay were 109 minutes and 1.2 days, respectively. Four (11.8%) patients had conversion of surgical route to laparotomy due to vascular trauma (2 cases) or anatomical difficulties (2 cases). No other major complications were found. Patients undergoing surgical conversion had greater uterine volume (226.8 vs 110.4 ml, p=0.036), longer operative time (116 vs 98 min, p=0.0075) and hospital stay (56.8 vs 23.2 hours, p<0.0001). Twenty-eight patients had low-grade endometrioid carcinoma; three (10.7%) of them received adjuvant parametrial involvement (T3B) were identified in the National Cancer Database. Patients who underwent SLNBx (with or without LND) or systematic LND alone (defined as at least 20 LNs removed) were identified. Overall survival (OS) was compared with the log-rank test. A Cox model was constructed to control for confounders.

**Results** A total of 2108 patients were identified; 1090 (51.7%) with cervical, 745 (35.2%) with serosal/adnexal, 246 (11.7%) with parametrial/vaginal involvement and 27 (1.3%) with T3 not specified. A total of 1786 (87.4%) patients had sLND (78.1% with para-aortic LND), while 322 (15.3%) underwent SLNBx. Rate of LN metastases was 35.8% in the sLND and 32.6% in the SLNBx group, p=0.27. Rates of chemotherapy (p=0.36) and radiotherapy (p=0.34) were comparable. There was no OS difference between patients who had SLNBx or sLND (p=0.60; 4-yr OS rates 71.5% and 73.9%) even after controlling for confounders (HR 1.10, 95% CI: 0.84, 1.45). OS was comparable for patients with T2 (p=0.60), T3A (p=0.34), T3B (p=0.38). Patients who had SLNBx alone (n=103), had lower incidence of LN metastases (22.3%, p=0.005), but did not have worse OS compared to those who had sLND (p=0.87; 4-yr OS rate 72.2% and 73.9%).

**Conclusions** Patients with extra-uterine involvement have a high incidence of LN metastases. SLNBx is associated with similar OS compared to LND.
radiotherapy. Mean follow up was 14.6 months. No patient relapsed or died during the study period.

Conclusions Vaginal hysterectomy could be an appropriate and cost-beneficial treatment for well-selected patients with low-risk endometrial cancer.

EP141/#791 DOES POSITIVE PERITONEAL CYTOLOGY ALTER ONCOLOGIC OUTCOMES OF PATIENTS WITH CLINICAL EARLY STAGE LOW-GRADE ENDOMETRIOID ENDOMETRIAL CARCINOMA?

1Dimitrios Nasioudis, 2Gabrielle Gossner, 3William Burke, 4Theofano Orfanelli, 5University of Pennsylvania, Division of Gynecologic Oncology, Philadelphia, USA; 6Stony Brook University, Division of Gynecologic Oncology, Department of Obstetrics, Gynecology and Reproductive Medicine, Stony Brook, USA

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Objectives Investigate the prevalence and outcomes of positive peritoneal cytology among patients with clinical early stage low-grade endometrioid endometrial carcinoma (EEC).

Methods Patients with no history of another tumor diagnosed between 2010–2015 with clinical early-stage grade 1 or 2 EEC after hysterectomy with lymphadenectomy and known peritoneal cytology, as well as data on depth of myometrial invasion, lymph node and lymph-vascular invasion (LVSI) status were included. Overall survival (OS) was compared with log-rank test following generation of Kaplan-Meier curves. Cox model was constructed to control for confounders.

Results 33161 patients met inclusion criteria; 1553 (4.7%) had positive peritoneal cytology. Patients with positive peritoneal cytology were younger (median 61 vs 62 years, p<0.001), more likely to have grade 2 tumors (52.2% vs 42.1%, p<0.001), outer half myometrial invasion (38.4% vs 23.3%, p<0.001), positive lymph nodes (14.6% vs 3.9%) and LVSI (28.7% vs 11.9%, p<0.001). They were more likely to receive radiation therapy (36.4% vs 19.4%, p<0.001), and chemotherapy (22.6% vs 4%, p<0.001). There was no difference in OS between patients with negative and positive peritoneal cytology (p=0.10; 4-year OS rates were 94.5% vs 93.2% respectively). Positive peritoneal cytology was not associated with worse OS when controlling for confounders (HR: 1.06, 95% CI: 0.86, 1.30) neither when excluding lymph node metastases (HR 1.23, 95% CI: 0.99, 1.53). Negative lymph nodes and positive peritoneal cytology (n=1322), radiation therapy (p=0.59) and chemotherapy (p=0.83) were not associated with better OS.

Conclusions For patients with clinical early-stage low-grade EEC, positive peritoneal cytology was rare and not associated with worse overall survival.

EP143/#1065 HIGH-GRADE ENDOMETRIAL CANCER BEHAVIOR AND OUTCOMES AT HOSPITAL SOTERO DEL RIO, SANTIAGO, CHILE

1Emiliano Pertosa*, 2Miguel Urtiza, 3Oscar Puga, 4Victoria Perez, 5Javier Retamales, 1Pontificia Universidad Católica de Chile/Hospital Sotero del RIO, Oncología Ginecológica, Santiago, Chile; 2Clínica las Condes/Hospital Sotero del RIO, Oncología Ginecológica, Santiago, Chile; 3Hospital Dr Sotero del RIO, Radiotherapy, Santiago, Chile

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Objectives Describe behavior, management and outcomes of high-grade endometrial cancer at our center.

Methods Surgical staging (with no SLN mapping) privileging minimally invasive approach of candidates (those with no evidence of disease of CT or MRI) with HG histologies and adjuvant treatment for those who required. Inverted PORTEC III consisted in 4 cycles of chemotherapy (carboplatin plus paclitaxel) followed by radiotherapy with weekly cisplatin during treatment.

Results 197 patients with endometrial cancer were surgically treated at our center between 2018 and 2021. Hence, 65% of patients had nodal staging. After surgery 9,7% had positive LN (FIGO IIIc), 24,3% were FIGO IBV. 26,8% received an inverted PORTEC III, 41,4% chemotherapy alone, 12,1%EBRT + VBT, 4,8% chemotherapy follow by EBRT, 1 died after surgery (mesenteric ischemia). FIGO IIIc patients who completed adjuvancy had 32,6 months of OS and those FIGO IBV 15,1 months. No severe adverse effects were recorded. Hormonal therapy was initiated on patients with progression.

Conclusions More than 30% of patients with HG histologies were on advanced stages at diagnosis. There is a considerable difference on OS between patients with nodal compromise against peritoneal implants. Inverted PORTEC III did not show more adverse effects than those described in the original publication. It should be considered as an alternative scheme for those centers which can not afford out standard regimen.

EP142/#1021 SENTINEL LYMPH NODE MAPPING IN ENDOMETRIAL CANCER- A COMPARISON OF FIVE NATIONAL GUIDELINES

1Aharon Dick, 2Gabriel Levin, 3Tamir Perri*, 4Uron Kogan, 5Benny Brandt, 6Raanan Meyer. 1Hadassah Medical Center, Gynecologic Oncology, Jerusalem, Israel; 2Chaim Sheba Medical, Tel-aviv, Israel

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Objectives To compare national guidelines regarding sentinel lymph node (SLN) mapping in endometrial cancer (EC).

Methods A descriptive comparative study of: The National Comprehensive Cancer Network (NCCN) (United States), The Society of Gynecologic Oncology (SGO)(United States), The European Society of Gynecological Oncology (ESGO), The British Gynecological Cancer Society (BGCS) and the Japan Society of Gynecologic Oncology (JSGO).

Results There is a broad consensus that SLN is an appropriate alternative to pelvic lymphadenectomy for uterine-confined endometroid EC. It is broadly accepted that a full lymphadenectomy should be performed in case of failed SLN mapping and that fluorescent dye indocyanine green mapping is superior to other methods. It is agreed that the cervix is the preferable site for dye injection, and pathology ultrastaging is advocated by most guidelines. Regarding high-risk patients (i.e. high grade histology and non-endometroid carcinomas) some accept yet other guidelines do not currently advocate SLN as a sole method for lymph node evaluation. There is no consensus regarding para-aortic LN evaluation in pelvic SLN positive patients.

Conclusions National guidelines for SLN are comparable with regard to most principles in SLN mapping in low-risk EC, with some variations regarding high-grade histology and positive pelvic LN.