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-GRADENDOMETRIOID ENDOMETRIAL CARCINOMA?

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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

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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 IVB. 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 IVB 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 uphold to standard regimen.

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

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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 endometrioid 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.