CTNNB1 mutations were associated with improved response with 87.5% CBR (95%CI: 67.6–97.3%) vs 60.0% (95%CI: 43.3–75.1%) in CTNNB1wt. PIK3CA mutations were associated with worse survival (median OS 11 months vs 28 months in PIK3CAwt (P<0.045)).

Conclusions Molecular findings may help predict treatment response to ET. Further exploration of the correlation between mutations and treatment response in a larger prospective population are needed.

Focused plenary: Surgery

0036/#221 INTRATHORACIC SURGERY AS PART OF PRIMARY CYTOREDUCTION FOR ADVANCED OVARIAN CANCER – GOING TO THE NEXT LEVEL: A MEMORIAL SLOAN KETTERING TEAM OP STUDY

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Objectives We report on a cohort of patients undergoing intrathoracic cytoreduction as part of primary debulking surgery (PDS), assessing safety and survival outcomes.

Methods We conducted a single center, database review of patients with stage IIIB-IV ovarian carcinoma who underwent intrathoracic cytoreduction as part of PDS at our institution between 01/2001–12/2019. Patients were excluded if they received neoadjuvant chemotherapy.

Results During the study, 179 patients had intrathoracic surgery as part of PDS. This represents 11% (179/1579) of patients who had a PDS at our institution during this time. Supradiaphragmatic cardiophrenic lymph nodes were excised in 64% of patients (114/179); mediastinal (not cardiophrenic) nodes 13% (23/179); pleural nodules 7% (12/179); lung parenchyma 1% (2/179), and multiple intrathoracic areas 16% (28/179). Complete gross resection (CGR) was achieved in 73% of patients (127/179), 26% (44/179) had optimal cytoreduction (1–10 mm of residual disease (RD)), and 1% (2/179) underwent suboptimal cytoreduction (>10 mm of RD). Median length of follow-up among survivors was 55 months. Patients with an intrathoracic cytoreduction of carcinoma where CGR was achieved had a median OS of 97 months versus 54 months following an optimal cytoreduction with RD (p = 0.0036). Patients with an intrathoracic cytoreduction where CGR was achieved had a median PFS of 22.1 months versus 14.4 months following an optimal cytoreduction with RD (p = 0.04).

Conclusions Intrathoracic cytoreduction during PDS for advanced ovarian cancer is safe and feasible. CGR can be obtained in patients with intrathoracic disease if properly selected. Resection of all gross RD including intrathoracic disease significantly improves both PFS and OS.

0037/#239 ARE UTERINE MANIPULATORS HARMFUL IN MINIMALLY INVASIVE SURGERY (MIS) FOR ENDOMETRIAL CANCER? A RETROSPECTIVE COHORT STUDY

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Objectives To assess the oncological safety of uterine manipulators in apparent early-stage (FIGO I-II) endometrial cancer treated by MIS.

Methods This is a single center retrospective study including patients who underwent endometrial cancer surgery for apparent early stage disease by either laparoscopy, robotics or laparoscopic assisted vaginal hysterectomy from 11–2012 to 12–2020. Data on manipulator type, isolated tumor cells (ITC), cytology, LVSI, free cancer cells in fallopian tubes (floaters), stage, histology and grade were collected. Primary outcome was cancer recurrence. Secondary outcome was disease specific death. Kaplan-Meier curves and multivariate logistic regression were used for statistical analysis.

Results 935 women with early-stage endometrial cancer were included; 794 (85%) had hysterectomy with uterine...
Laparoscopic single-site versus conventional laparoscopic surgery for early-stage endometrial cancer: prospective randomized controlled trial (LESS-E)

Objective To evaluate the feasibility of laparo-endoscopic single-site staging surgery (LESS group) compared to conventional laparoscopic staging surgery (four-port group) for early-stage endometrial cancer.

Methods Patients with clinical stage IA, IB, grade 1–3 endometrial cancer were randomly assigned to LESS group or four-port group. The primary endpoint was to confirm the non-inferiority of LESS in operation time and number of resected lymph nodes. Non-inferiority has considered if the LESS group showed difference in operating time (< 24 min) and the number of resected lymph nodes (< 5.2) within the lower limit of 20% compared to the four-port group.

Results Each of 54 patients were assigned to LESS group (n=54) and four-port group (n=54). There were no differences between LESS and four-port groups in clinical factors including age, body mass index, menopause, previous abdominal surgery, and in pathologic factors including histologic type, histologic grade, lympho-vascular space invasion, and stage of the disease. There was no clinically significant difference in total operation time (LESS group vs. four-port group, 154.96±40.81 min vs 158.19±48.77 min, P = 0.712), and in the number of resected lymph nodes (LESS group vs. four-port group, 17.81±8.73 vs 22.41±10.56, P = 0.016). After median follow-up time of 34 months (range, 2–242 months), each one patient in each group had a recurrence, and one patient in LESS group died of the disease.

Conclusions LESS surgical staging was feasible for surgical management of patients with early-stage endometrial cancer. It was comparable to conventional laparoscopic surgical staging in perioperative and oncologic outcomes.