Lymphadenectomy in Clinically Early Epithelial Ovarian Cancer and Survival Analysis - A Multicenter Retrospective Study (LILAC) - Golila 3002

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Objective: This study was to evaluate the role of lymphadenectomy by comparing survival outcomes for patients with clinically early epithelial ovarian cancer (eEOC) who underwent lymphadenectomy versus those who did not.

Methods: We conducted a multicenter retrospective study of patients diagnosed with eEOC by imaging study from 2007 to 2021. Clinicopathological characteristics and oncologic outcomes were compared between the lymphadenectomy group and the no lymphadenectomy group.

Results: In this study, out of 586 clinical eEOC patients, 453 (77.3%) had lymphadenectomy and 133 (22.7%) did not. The upstaging was 4/133 (3.0%) in the no lymphadenectomy group; the upstaging by lymph node metastasis was 143/453 (31.8%). Compared to the no lymphadenectomy group, the lymphadenectomy group had a longer operating time (P = 0.000), a higher EBL (P = 0.000), and a higher rate of postoperative adverse events (P = 0.004). Among histological subtypes of eEOC, serous carcinoma showed more improved PFS in the lymphadenectomy group compared to no lymphadenectomy group (P = 0.048). There was no difference in PFS in mucinous (P = 0.67), endometrioid (P = 0.41), and clear cell (P = 0.89) carcinomas between the two groups.

Conclusions: This study showed that in patients with clinical eEOC, histological subtype is associated with a survival benefit for lymphadenectomy. In serous carcinoma, lymphadenectomy showed improvement in PFS, but other histological subtypes did not differ significantly. Considering the higher risk of perioperative adverse events in lymphadenectomy, lymphadenectomy in patients with clinically eEOC can be selectively performed according to histological subtype.

Laparo-Endoscopic Single-Site Versus Conventional Laparoscopic Surgery for Early-Stage Endometrial Cancer; Prospective Randomized Controlled Trial (LESS-E)

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Objectives: To evaluate the feasibility of laparo-endoscopic single-site staging surgery (LESS) 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, gravida, 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.

Evaluating the Impact of Microsatellite Instability on Lymph Node Metastases in an Endometrial Cancer Cohort

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Objectives: Endometrial cancer (EC) is a molecularly driven disease, and prognostic and treatment paradigms are transitioning to focus on molecular subtyping. Surgical staging and the role of lymphadenectomy has similarly evolved over time,