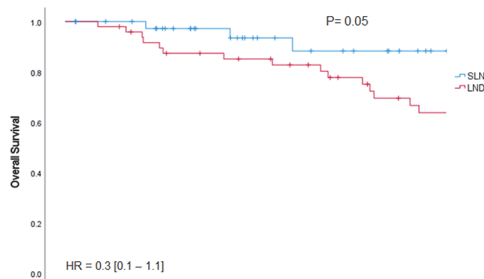


**Introduction/Background** Sentinel lymph node mapping (SLN) is becoming universally adopted as the method of choice to assess nodal spread in early-stage endometrial cancer, however the oncologic outcomes of this have not been specifically evaluated in patients with UCC. Our objective was to assess oncologic outcomes among patients with uterine confined UCC undergoing SLN versus lymph node dissection (LND).

**Methodology** Patients who underwent surgical management for newly diagnosed UCC between 10/1996 and 6/2021 were retrospectively identified and allocated to SLN or LND groups. Patients with successful bilateral SLN and backup LND were treated as LND (n=4). Patients with unilateral mapping requiring hemipelvis LND and those with empty nodal packets were excluded from analysis (n=3). Appropriate statistical tests were used.

**Results** Eighty-nine patients met inclusion criteria:

40 (45%) underwent SLN and 49 (55%) LND. Forty-two (86%) patients in LND underwent paraaortic LND vs 3 (7%) in SLN (p<0.001). Sixty-eight (76%) patients had FIGO-stage I/II, 17 (19%) FIGO-stage III, and 4 (5%) FIGO-stage IV. Age, BMI, FIGO-stage, depth of myoinvasion, lymph-vascular invasion, and washing status did not differ between groups. Thirty-five (88%) patients in SLN received adjuvant therapy and 42(86%) in LND (P=0.8). The adjuvant therapies used were: chemotherapy alone (0% SLN vs 17% LND), radiation alone (34% SLN vs 45% LND), and chemoradiation (66% SLN vs 38% LND) (P=0.01), Median follow-up time was 38 months (range, 2–117) for SLN and 61 months (range, 7–235) for LND. Three-year progression-free survival (PFS) was 79% (SE ± 7%) for SLN and 64% (SE ± 8%) for LND (P=0.1). Three-year overall survival (OS) was 89% (SE ± 6%) for SLN and 83% (SE ± 6%) for LND (P=0.05). On multivariate analysis, only FIGO-stage was found to be associated with decrease in both PFS and OS.



	Follow-up time (Months)	0	12	24	36	48	60	72
SLN	Number at risk	40	40	37	30	21	17	14
	Cumulative OS	100%	100%	97%	93%	89%	89%	89%
LND	Number at risk	49	48	47	40	37	34	28
	Cumulative OS	100%	98%	87%	85%	83%	75%	64%

**Abstract #274 Figure 1** Kaplan-Meier Curve comparing overall survival for SLN vs LND

**Conclusion** SLN and LND yielded similar oncologic outcomes when used in staging uterine-confined UCC.

**Disclosures** Dr. Abu-Rustum reports grant funding from GRAIL paid to the institution. Dr. Leitao is an ad-hoc speaker for Intuitive Surgical, Inc., has consulted for Medtronic, and has served on the advisory boards of Ethicon/Johnson & Johnson and Immunogen.

#275

**ONCOLOGIC OUTCOMES OF MINIMALLY INVASIVE SURGERY VERSUS LAPAROTOMY FOR THE TREATMENT OF APPARENT UTERINE-CONFINED CLEAR CELL CARCINOMA**

<sup>1</sup>Christian Dagher\*, <sup>2</sup>Dib Sassine, <sup>1,3</sup>Nadeem R Abu-Rustum, <sup>1</sup>Jennifer J Mueller, <sup>1,3</sup>Vance Borach, <sup>1,3</sup>Oliver Zivanovic, <sup>1,3</sup>Yukio Sonoda, <sup>1,3</sup>Mario M Leitao. <sup>1</sup>Gynecology Service, Memorial Sloan Kettering Cancer Center, New York, USA; <sup>2</sup>Gynecologic Oncology, Columbia University Department of Obstetrics and Gynecology, New York, USA; <sup>3</sup>Department of Medicine, Weill Cornell Medical College, New York, USA

10.1136/ijgc-2023-ESGO.300

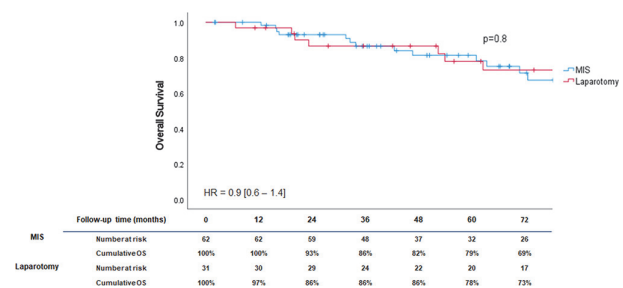
**Introduction/Background** Minimally invasive surgery (MIS) has become the approach of choice for staging endometrial cancers. Recent reports have demonstrated its non-inferiority to laparotomy especially in early-stage disease across many endometrial histologies, but have not specifically evaluated MIS for UCC. Our objective was to compare oncologic outcomes for patients undergoing MIS versus laparotomy for uterine-confined UCC.

**Methodology** Patients who underwent surgical management of newly diagnosed UCC between 6/1997 and 10/2021 were retrospectively identified and allocated to MIS or laparotomy groups. Patients with conversion to laparotomy were analyzed as MIS in an intention to treat manner. Appropriate statistical tests were used.

**Results** Ninety-three patients met inclusion criteria:

62 (67%) underwent MIS (34% non-robotic and 66% robotic-assisted laparoscopy) and 31 (33%) laparotomy. Four (6%) patients had conversion to laparotomy. Seventy-one (77%) patients had FIGO-stage-I/II, 17 (18%) FIGO-stage-III, and 5 (5%) FIGO-stage-IV. Age, BMI, FIGO-stage, depth of myoinvasion, and washing status did not differ between groups. Patients undergoing MIS were less likely to have lymph-vascular invasion (20 vs 43%), (P=0.03). The rate of perioperative complications was 13% in the MIS and 65% in laparotomy (P<0.001). The median number of nodes was 8 (range, 1–40) in MIS and 21 (range, 1–59) in laparotomy (P<0.01). Para-aortic nodes were removed in 36% of MIS compared to 72% in laparotomy (P<0.001). Rates of adjuvant treatment did not differ between groups.

Median follow-up time was 53 months (range, 2–235) and did not differ between groups. Three-year PFS was 68% (SE ± 7%) for MIS and 67% (SE ± 10%) for laparotomy (P=0.9). Three-year OS was 81% (SE ± 6%) for MIS and 87% (SE ± 6%) for laparotomy (P=0.8). On multivariate analysis, only FIGO-stage was associated with decrease in both PFS and OS.



**Abstract #275 Figure 1** Kaplan-Meier Curve comparing overall survival for MIS vs laparotomy

	Follow-up time (months)	0	12	24	36	48	60	72
MIS	Number at risk	62	62	59	48	37	32	26
	Cumulative OS	100%	100%	93%	86%	82%	79%	69%
Laparotomy	Number at risk	31	30	29	24	22	20	17
	Cumulative OS	100%	97%	86%	86%	86%	78%	73%

**Conclusion** MIS does not compromise oncologic outcomes in patients with uterine-confined UCC. MIS should be considered to minimize surgical morbidity.

**Disclosures** Dr. Abu-Rustum reports grant funding from GRAIL paid to the institution. Dr. Leitao is an ad hoc speaker for Intuitive Surgical, Inc., has consulted for Medtronic, and has served on the advisory boards of Ethicon/Johnson & Johnson and Immunogen.

### #277 SYSTEMIC THERAPY AND OUTCOMES IN METASTATIC/RECURRENT ENDOMETRIAL CANCER – REAL WORLD POPULATION STUDY

<sup>1</sup>Agnes Ho\*, <sup>2</sup>Anu Chinnadurai, <sup>1</sup>Alexandra Lemanowicz, <sup>3</sup>Longlong Huang, <sup>3</sup>Shaun Zheng Sun, <sup>4</sup>Jenny Ko. <sup>1</sup>University of British Columbia, Vancouver, Canada; <sup>2</sup>University of Western Ontario, London, Canada; <sup>3</sup>University of the Fraser Valley, Abbotsford, Canada; <sup>4</sup>BC Cancer, Abbotsford, Canada

10.1136/ijgc-2023-ESGO.301

**Introduction/Background** Endometrial cancer comprises heterogeneous subgroups with varying outcomes. This study assessed disease characteristics and survival outcomes in patients with recurrent/de novo metastatic endometrial cancer.

**Methodology** Patients diagnosed with recurrent or de novo metastatic endometrial cancer between 2012–2015 in BC, Canada, were included. Disease characteristics and treatments were summarized with descriptive statistics. Median overall survival (mOS) was assessed using univariable and multivariable analyses. Survival analysis was estimated with the Kaplan-Meier method.

**Results** Of 188 patients, 97 had recurrent disease and 91 had de novo metastatic disease. Median age was 65 (range 36–93). 73 patients (39%) received one line of palliative systemic therapy, 26 (14%) received 2 lines, 26 (14%) received 3 lines, and 12 (6%) received  $\geq 4$  lines. 51 patients (27%) received no systemic therapy, but had definitive salvage treatment for locally recurrent disease. mOS from time of metastasis was similar between patients with de novo or recurrent metastatic disease (16.2 vs 15.6m,  $p=0.43$ ). Patients with isolated relapses in the vagina (67.3m) and pelvis (83.6m) had longer OS than those with other recurrences ( $p=0.00013$ ). mOS was similar between those who received first-line palliative systemic therapy vs those who did not (17.1 vs. 15.6m,  $p=0.11$ ); however, 35% of patients with no palliative systemic therapy continued to survival beyond 5 years, mostly due to salvage therapy for locally recurrent disease. mOS was longer in those treated with 1st line aromatase inhibitors or tamoxifen than with platinum doublet therapy (30.1 vs. 13.9m,  $p=0.041$ ). Patients who underwent  $\geq 4$  lines of therapy had longer mOS outcomes compared to  $\leq 3$  lines of therapy (HR 0.349, 95%CI 0.127–0.962,  $p=0.042$ ).

**Conclusion** Those with recurrent/metastatic disease amenable to local salvage therapy or palliative hormone agents have prolonged OS. A select number of patients underwent multiple lines of treatment, with extended survival. Future studies should examine outcomes with immunotherapy.

**Disclosures** None.

### #302 INFLUENCE OF UTERINE MANIPULATOR ON ONCOLOGICAL OUTCOME IN MINIMALLY INVASIVE SURGERY OF ENDOMETRIAL CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

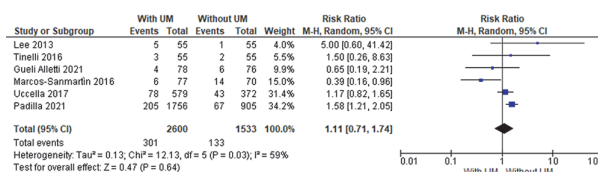
<sup>1</sup>Gennaro Scutiero, <sup>2</sup>Giuseppe Vizzielli, <sup>1</sup>Cristina Taliento\*, <sup>1</sup>Giulia Bernardi, <sup>1</sup>Ruby Martiniello, <sup>3</sup>Stefano Cianci, <sup>4</sup>Gaetano Riemma, <sup>5</sup>Giovanni Scambia, <sup>6</sup>Pantaleo Greco. <sup>1</sup>University of Ferrara, Ferrara, Italy; <sup>2</sup>University of Udine, Udine, Italy; <sup>3</sup>University of Messina, Messina, Italy; <sup>4</sup>University of Campania, Caserta, Italy; <sup>5</sup>Gynecologic Oncology Unit, Rome, Italy; <sup>6</sup>Fondazione Policlinico Universitario A. Gemelli IRCCS, Ferrara, Italy

10.1136/ijgc-2023-ESGO.302

**Introduction/Background** The endoscopic approach for early-stage endometrial cancer (EC) treatment is considered gold standard. Some authors expressed their concern regarding uterine manipulator (UM) as a risk factor for tumor spillage and dissemination allowing peritoneal or lympho-vascular spaces invasion (LVSI). This meta-analysis aimed to evaluate the effect of UM on the presence of LVSI, recurrence rate and presence of atypical or malignant peritoneal cytology in patients with endometrial cancer.

**Methodology** We searched electronic databases including PubMed, MEDLINE, Embase, Scopus, EBSCO, Google Scholar, and ClinicalTrials.gov. The pooled results were used to evaluate the association between the use of UM and oncological outcomes. This systematic review was reported according to PRISMA statement 2020. Statistical meta-analysis was performed using Review Manager software.

**Results** This systematic review included 18 studies (3 prospective studies, 13 retrospective studies, and 2 RCT). The pooled results showed no significant difference (RR: 0.86, 95% CI, 0.69 to 1.08) in the incidence of LVSI between manipulated hysterectomy and total abdominal hysterectomy (TAH) and between UM group and non-UM group in minimally invasive surgery (RR: 1.18, 95% CI, 0.76 to 1.85), no significant difference in the rate of recurrence (RR: 1.11, 95% CI, 0.71 to 1.74), in the incidence of positive peritoneal cytology between manipulated and non-manipulated hysterectomies in minimally invasive surgery (RR: 1.89, 95% CI, 0.74 to 4.83) and before and after the use of uterine manipulator (RR: 1.21, 95% CI, 0.68 to 2.16). We found a positive association between malignant cytology and hysterectomies in which a uterine manipulator had been used in a sub-group analysis where LH/LAVH were compared to TAH. (RR  $\frac{1}{4}$  2.26, 95% CI, 1.08e4.71. P  $\frac{1}{4}$  0.03).



**Abstract #302 Figure 1** Forest plot of comparison: Risk ratio (RR) and Forest Plot for the incidence of recurrence with or without uterine manipulator, outcome: recurrence. In the graph, Left graph label: with UM (LH). Right graph label: without UM (LH).

**Conclusion** This meta-analysis supports that the use of uterine manipulator for minimally invasive treatment of endometrial cancer does not increase the rate of recurrence and LVSI.

**Disclosures** No conflict of interest