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, 7–233) 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.

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.
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.

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 ≥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 survive 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 ≥4 lines of therapy had longer mOS outcomes compared to ≤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

Gennaro Scoziero, Giuseppe Vizzielli, Cristina Taliento*, Giulia Bernardi, Ruby Martinello, Stefano Cianci, Gaetano Riemma, Giovanni Sambria, Pantaleo Greco, University of Ferrara, Ferrara, Italy; University of Udine, Udine, Italy; University of Messina, Messina, Italy; University of Campania, Caserta, Italy; Gynecologic Oncology Unit, Rome, Italy; Fondazione Policlinico Universitario A. Gemelli IRCCS, Ferrara, Italy

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