control and limited toxicity in 5 patients treated with this approach. Further studies are needed to optimize this treatment modality.

Disclosures The authors have no conflicts of interest to declare. All co-authors have seen and agree with the contents of the manuscript and there is no financial interest to report. We certify that the submission is original work and is not under review at any other publication.

#325 IMPACT OF EPIDURAL ANAESTHESIA ON THE OUTCOME OF ELDERLY WOMEN WITH ENDOMETRIAL CANCER – RESULTS OF A RETROSPECTIVE COHORT STUDY

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Introduction/Background Epidural anaesthesia is a standard procedure to mitigate pain during endometrial cancer (EC) surgery. Little data exist about the influence of epidural anaesthesia on the oncological outcome in elderly patients with EC. This retrospective study aims to investigate potential correlations between epidural anaesthesia and cancer recurrence in patients with EC.

Methodology We screened the archives of patients treated surgically for EC at the University Medical Centre Mainz between January 2008 and December 2019. All women underwent general anaesthesia (GA) alone or combined with epidural anaesthesia (EGA). Cox regression as well as the Kaplan-Meier method were used to analyse the prognostic influence of this aesthetical technique on survival.

Results A total of 152 women with EC were included. 29 patients (19.1%) formed the EGA cohort. The median time of follow-up was 31 months (interquartile range (IQR): 8–67.5). 26 patients (17.1%) developed recurrence in the follow-up (FU) at a median of 13 months (IQR: 7.75–29.5). 32 patients died during FU (21.1%). The EGA cohort showed higher FIGO-stages and a higher histological grading than the GA cohort. Regarding anaesthesiologic scores, such as the Charlson Comorbidity Index and the ASA Physical Status Classification System, no differences were recorded between the two cohorts ($p>0.05$). EGA showed a significantly reduced 5-year recurrence-free survival (RFS) (36.5% vs. 72.6%, $p<0.001$) and overall survival (OS) (58.6% vs. 79.9%, $p=0.008$). However, in multivariate cox regression analysis including FIGO stages und the histological grading, EGA was not associated with improved or decreased RFS (HR: 1.89, 95%- CI [0.90–3.98], $p=0.093$), nor with OS (HR: 1.22, 95%-CI [0.51–2.92], $p=0.649$).

Conclusion Though in our heterogeneous cohort EGA showed a decreased 5-year RFS and OS in elderly patients with standardized EC surgery, this effect could not be reproduced in multivariate analysis considering tumour characteristics. Prospective randomized trials are warranted.

Disclosures The authors have no conflicts of interest to declare that are relevant to the content of this article.

#328 FREQUENCY AND PATTERN OF RELAPSE FOLLOWING ADJUVANT PELVIC RADIOTHERAPY OR VAGINAL BRACHYTHERAPY FOR HIGH-INTERMEDIATE RISK ENDOMETRIOID ENDOMETRIAL CANCER

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Introduction/Background Management of endometrial cancer consists of surgery followed by tailored adjuvant therapy but there is a risk of pelvic and/or systemic recurrence. Here, we evaluated clinical/pathological features in addition to frequency and site of first relapse in patients with ESGO/ESTRO/ESP High-Intermediate Risk (HIR) endometrioid endometrial cancer who received adjuvant external beam radiotherapy (EBRT) to the pelvis or vaginal brachytherapy (VBT) (± chemotherapy).

Methodology The central radiotherapy prescribing system at our institution was interrogated to identify patients who commenced adjuvant pelvic EBRT (4500cGy/25#) or VBT (2100cGy/3#) for Stage I/II endometrial cancer, 1st January 2017 to 31st December 2019. Risk stratification was performed retrospectively; only those with HIR endometrioid endometrial cancer were included. Clinical follow up was conducted 3–6 monthly until 5 years had elapsed or death occurred (data lock 31st December 2022). Imaging was requested if recurrence was suspected.

Abstract #328 Table 1

	EBRT, n=73		VBT, n=100	
Characteristic	n	%	n	%
Age				
• Median	66 years (range 31-80)		67 years (range 37-90)	
Stage (FIGO 2018)				
• IA	0	0	32	32%
• IB	51	69.9%	40	40%
• II	22	30.1%	28	28%
Grade				
• 1	15	20.5%	36	36%
• 2	28	38.3%	47	47%
• 3	30	41.1%	17	17%
Lymphovascular invasion				
• Yes	60	82.2%	85	85%
• No	13	17.8%	15	15%
Pelvic lymph node dissection				
• Yes	2	2.7%	14	14%
• No	71	97.3%	86	86%
Adjuvant chemotherapy				
• Yes	12	16.4%	9	9%
• No	61	83.6%	91	91%
Relapse				
• Yes	9	12.3%	17	17%
• No	64	87.7%	83	83%
Alive				
• Yes	63	83.6%	87	87%
• No	10	13.7%	13	13%

Results In total, 173 patients were identified (EBRT, n= 73 and VBT, n=100). Patient demographics and clinical/pathological features are illustrated in table 1. Median follow up was 33 months (range 0–68). By study end, 9/73 (12.3%) patients had relapsed in the EBRT group and 17/100 (17%) in the VBT group. Pattern of relapse consisted of pelvis only (2/9), distant (4/9), and both (3/9) in the EBRT cohort compared with pelvis only (11/17), distant (1/17), and both (5/17) in the

VBT cohort. Isolated pelvic relapse, total pelvic relapse, and distant failure rates were 2.7%, 6.8%, and 9.6% following EBRT, and 11%, 16%, and 6% following VBT, respectively.
Conclusion Distant failure rates were lower in the VBT group but isolated and total pelvic failure rates were higher, suggesting that EBRT may be optimal for achieving locoregional control. EBRT is now considered at our institution for HIR endometrioid endometrial cancer in accordance with ESGO/ESTRO/ESP 2020 guidelines, especially in the absence of lymph node staging.
Disclosures None

#333 FREQUENCY AND PATTERN OF RELAPSE FOLLOWING ADJUVANT VAGINAL BRACHYTHERAPY FOR ENDOMETRIAL CANCER BASED ON ESGO/ESTRO/ESP RISK CLASSIFICATION

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Introduction/Background The management of endometrial cancer consists of surgery followed by tailored adjuvant therapy but there is a risk of pelvic and/or systemic recurrence. Here, we evaluated the frequency and site of first relapse in patients who received vaginal brachytherapy (± chemotherapy) for FIGO Stage I-II endometrial cancer and stratified retrospectively according to ESGO/ESTRO/ESP 2020 risk classification.
Methodology The central radiotherapy prescribing system at our institution was interrogated to identify patients who commenced vaginal brachytherapy, 2100cGy/3#, for endometrial cancer between 1st January 2017 and 31st December 2019. Only those with Stage I-II disease were included. Clinical follow up was undertaken until death or 5 years had elapsed (data lock 31st December 2022). Imaging was performed if recurrence was suspected.
Results In total, 258 patients were identified. The median age was 69 years (range 40–90) and median follow up was 33 months (range 0–68). FIGO 2018 Stage distribution: IA (35%); IB (48%); II (17%). Pathology subtype: endometrioid (73%); serous (15%); carcinosarcoma (5%); other (7%). ESGO/ESTRO/ESP risk group distribution: Intermediate (43%); High-intermediate (HIR) (39%); High (18%). Adjuvant chemotherapy was delivered to 8.5% of the cohort. By study end, 50 (19%) patients had relapsed and 43 (16%) had died. Frequency of recurrence per risk group: Intermediate 13/112 (11.6%); HIR 17/100 (17%); High 20/57 (35%). Pattern of relapse was as follows: vagina only - 3 (1.1%); pelvis only - 22 (8.5%); distant only - 6 (2.3%); both pelvis and distant – 22 (8.5%). Frequency of pelvic relapse per risk group was Intermediate 11/112 (9.8%), HIR 16/100 (16%), and High 17/57 (29.8%), respectively. Overall pelvic failure rate was 17%.
Conclusion Isolated vaginal relapse rates were very low but pelvic recurrences occurred in up to 15–30% of HIR/High risk patients suggesting that external beam radiotherapy should be considered to optimise loco-regional control in these risk groups.
Disclosures None

#346 AMBIGUOUS HIGH-GRADE ENDOMETRIAL CARCINOMAS – AN ANALYSIS OF CLINICOPATHOLOGIC FACTORS AND PROGNOSTIC OUTCOMES

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Introduction/Background High-grade endometrial carcinomas, such as FIGO grade 3 endometrioid carcinoma (EC3) and serous carcinoma (SEC), pose diagnostic challenges due to overlapping and ambiguous features. The significance of clinicopathologic characteristics and prognosis of ambiguous cases remain unclear, adversely affecting the provision of individualised patient counselling and management.
Methodology This analysis of 129 consecutive cases of EC3 and SEC at Soroka University Medical Center (2006–2022) compares clinicopathologic characteristics and prognosis in definite and ambiguous EC3 and SEC. All pathological slides were revised and reclassified as definite or ambiguous for EC3 and SEC and prognostic data was extracted retrospectively from medical records. Survival, progression-free survival, and associations between tumour histologic type and clinicopathologic factors were analysed.
Results Definite SEC displayed higher mortality compared to definite EC3 (68.2% vs. 41.4%, p=0.023) and a non-significant trend towards diminished 5-year survival (48.3% vs 60.1%, p=0.096). Ambiguous SEC also showed higher mortality compared to ambiguous EC3 (68.8% vs. 37.5%, p=0.020) and a non-significant trend towards reduced 5-year survival (30.5% vs 55.1%, p=0.098). Overall, ambiguous cases displayed behavior that fell between the two definite groups, with a mortality rate exceeding that of definite EC3 but favourable to that of definite SEC (p=0.024). Other variables showed a similar trend, including lymph node metastases (p=0.013) and omental involvement (p=0.002). No significant differences were observed in 5-year progression-free survival between all the subpopulations in the study (p=0.288).

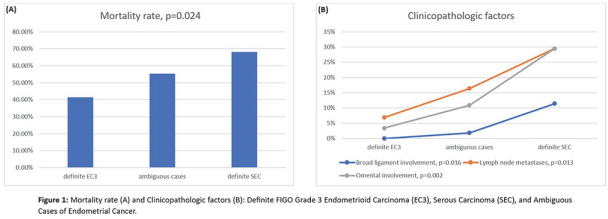

Figure 1: Mortality rate (A) and Clinicopathologic factors (B): Definite FIGO Grade 3 Endometrioid Carcinoma (EC3), Serous Carcinoma (SEC), and Ambiguous Cases of Endometrial Cancer.

Abstract #346 Figure 1 Mortality rate (A) and Clinicopathologic factors (B): Definite FIGO Grade 3 Endometrioid Carcinoma (EC3), Serous Carcinoma (SEC), and Ambiguous Cases of Endometrial Cancer.

Conclusion This study highlights the importance of accurate histological classification in high-grade endometrial carcinoma subtypes. Ambiguous cases constitute a distinct intermediate group with clinicopathologic features more aggressive than definite EC3 but less than definite SEC, potentially influencing counselling and management of these patients. Further