

laparoendoscopy surgery in a single site (LESS) to combine the advantages of robotic surgery with the aesthetic result of a single incision and to overcome LESS limitations in terms of loss of door triangulation, and instrumental collisions. This study aims to review the existing studies on RSS hysterectomy in patients with endometrial cancer and verify its safety and feasibility.

**Results** Seven studies met the inclusion criteria, and 258 patients were included with a median age of 53 to 64 years and a BMI of 24.6 to 27 kg/m<sup>2</sup>. The median pre-surgical time ranged from 8 to 12.5 min, the median operative time ranged from 90 to 175 min, the median console time from 46 to 136 min, and the median blood loss from 50 to 145 ml. No intraoperative complications were observed; only a study reported a conversion rate of 1.25%. The median hospital stay ranged from 2 to 3 days. The postoperative complication rate was estimated at 5.42%.

**Abstract #460 Table 1** Studied outcomes (intraoperative and postoperative)

Author, Year	Median pre-surgical time, min (range)	Median console time, min (range)	Median operative time, min (range)	Median estimated blood loss, ml (range)	Intra-operative complications	Post-operative complications (%)	Conversion to LPS/LPT	Median pelvic lymph nodes, no (range)	Median hospital stay, (range)	Reoperation (%)
J. Fagotti 2013	8 (4-14)	NN	90 (60-147)	75 (50-250)	0	1 (5%)	0	-	-	-
G. Corrado 2017	7.5 (4-14)	46 (20-100)	90 (45-150)	50 (10-250)	0	1 (2.2)	0	13 (10-32)	3 (2-6)	0
G. Corrado 2016	12.5 (5-43)	80 (20-260)	122 (75-282)	50 (10-250)	0	10 (12.4)	1 (0.8%)	13 (5-32)	2 (1-16)	1 (0.8%)
E. Yliza 2013	9.5 (6-17)	48 (25-73)	90 (70-147)	75 (50-150)	0	0	0	-	2 (0-3)	-
G. Corrado 2016	-	-	110 (60-160)	50 (10-150)	0	1 (4.3)	0	14 (13-15)	2 (2-5)	1 (4.3%)
LA Mookatel 2017	-	136 (100-155)	175 (150-230)	50 (10-100)	0	0	0	25 (1-10)	1	0
H. Chung 2019	10 (4-20)	75 (55-115)	155 (120-190)	145 (100-200)	0	1 (6.7)	0	9 (6-15)	3 (2-9)	0

\*Median Pre-surgical time includes port placement and docking time  
LPS: Laparoscopy; LPT: Laparotomy

**Conclusion** Our findings support the safety and feasibility of robotic single-site technique in endometrial cancer treatment, which was associated with short operative times and acceptable complication rates. In addition, RSS allows you to combine the advantages of robotic surgery with the aesthetic result of a single incision. Further studies are warranted to confirm results and determine the optimal approach for minimally invasive surgery (MIS) in endometrial cancer.

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#### COMPARISON BETWEEN SINGLE AND DUAL DOCKING ROBOTIC SURGERY IN ENDOMETRIAL CANCER

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**Introduction/Background** Endometrial cancer is one of the most common gynecological neoplastic diseases in Poland. According to ESGO recommendations, simple hysterectomy with bilateral salpingo-oophorectomy and bilateral sentinel lymph node detection should be performed. However, completed pelvic and paraaortic lymphadenectomy is indicated in cases of high-risk endometrial cancer. Minimally invasive surgery is the method of choice. Nowadays, procedures assisted with robotic surgery are increasingly common.

The aim of the study was to compare completed pelvic and paraaortic lymphadenectomy performed by dual or single docking during robotic surgery assisted with the da Vinci X system.

**Methodology** The analysis was based only on 25 patients with high-risk endometrial cancer after completed pelvic and paraaortic lymphadenectomy with mean age 60.07±10.67 (range 34.69–83.23) years. Mean BMI was 28.4±5.62 (range 18–41.5) kg/m<sup>2</sup>. Mean duration of surgery was 196±0.02 (range 110–295) minutes. The analyzed population was divided into two groups: in one, a one-site docking operation was performed; the second underwent dual docking surgery.

**Results** Average numbers of removed pelvic and paraaortic lymph nodes were respectively 24.5±8.7 and 15.87±6.83 in the first group and 24.88±11.75 and 18.05±7.92 in the second. There were no significant differences between one-site and dual docking. The number of removed lymph nodes did not differ significantly according to type of docking, experience of surgeon, or use of Vessel Sealer. Number of lymph nodes retrieved correlated with BMI of patients (p<0.005). Duration of operation was not associated with type of docking, but it was significantly associated with previous surgery (p<0.005).

**Conclusion** Robotic surgery is a novel method of minimally invasive surgery. No difference was found between the two types of docking in quality of lymphadenectomy.

**Disclosures** The authors declare no conflict of interest.

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#### PRETREATMENT CARCINOEMBRYONIC ANTIGEN CAN ASSIST CANCER ANTIGEN 125 IN PREDICTING LYMPH NODE METASTASIS IN ENDOMETRIAL CARCINOMA

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**Introduction/Background** We aimed to investigate whether the cost-effective, pretreatment tumor markers carcinoembryonic antigen (CEA) and carbohydrate antigen-125 (CA-125) can be used to predict lymph node metastasis (LNM) in endometrioid-type endometrial cancer (EC) and to develop a predictive model.

**Methodology** This was a single-center retrospective study of patients with endometrioid-type EC who underwent complete staging surgery between January 2015 and June 2022.

**Results** The optimal cut-off values of CEA and CA-125 were 1.4 ng/mL (area under the ROC curve (AUC) 0.62) and 40 U/mL (AUC 0.75), respectively. Multivariate analysis showed that CEA (odds ratio (OR): 1.94; 95% confidence interval (CI): 1.01–3.74) and CA-125 (OR: 8.75; 95% CI: 4.42–17.31) were independent predictors of LNM. Our nomogram showed adequate discrimination with a concordance index of 0.78. Calibration curves for the probability of LNM showed optimal agreement between the predicted and actual probabilities. The risk of LNM for markers below the cut-offs was 3.6%. The negative predictive value and negative likelihood ratio were 96.6% and 0.26, respectively, with moderate ability to rule out the possibility of LNM.

**Table 1.** Clinicopathological characteristics of the study population

a) 1 case was excluded in I25L. Grade items due to missing data

Variable	N=total	%
Age (years)	342	61.9
Median, range	56.2 (41-80)	
< 60	275	80.4
≥ 60	139	40.4
Parity	299	73.8
≥ 1	299	73.8
Body mass index (kg/m <sup>2</sup> )	285	86.6
Median, range	28.5 (19.2-44.1)	
< 30	285	86.6
≥ 30	285	86.6
FIGO stage	286	86.7
Ia	246	85.7
Ib	40	14.0
II	24	8.4
III	42	14.7
IV	11	3.7
Pathologic tumor sites	130	39.6
Endometrium	286	86.6
Serous	247	86.1
Yes	137	39.9
Metastatic location	103	30.1
Endometrium	117	36.0
Other	285	86.6
Yes	285	86.6
CA-125 (U/ml)	285	86.6
Median, range	24.7 (0.0-100)	
< 6 U/ml	285	86.6
CA-158 (ng/ml)	285	86.6
Median, range	1.6 (0.0-16.6)	

**Table 2.** Comparison of the clinical characteristics between negative and positive lymph node metastasis

	LN meta (-) N=337	LN meta (+) N=48	p-value
	N(N%)	N(N%)	
Age(≥ 60years)	114(31.9%)	14(29.2%)	0.699
Parity ≥ 1	263(75.7%)	36(75%)	0.844
BMI(≥ 25(kg/m <sup>2</sup> ))	176(69.3%)	28(58.3%)	0.24
Grade 2/3	168(47.2%)	35(72.9%)	<0.001
CA-125(U/ml)	21.90 [14.36-38.45]	63.60 [33.65-108.25]	<0.001
CEA (ng/ml)	0.95 [0.49-1.61]	1.46 [0.76-6.25]	0.001

a) Data of CA-125 and CEA are described as median and interquartile range, IQR (25<sup>th</sup> to 75<sup>th</sup> percentile)

**Table 3.** Univariate and multivariate logistic regression analyses of clinical risk factors in endometrioid type endometrial cancer with lymph node metastasis

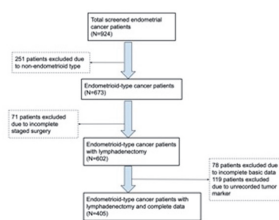
Variable	No.	Univariate Analysis		Multivariate Analysis	
		OR (95% CI)	p-value	OR (95% CI)	p-value
Age(years) ≥ 60	128	0.88(0.45-1.70)	0.699		
Parity ≥ 1	299	1.07(0.54-2.15)	0.844		
BMI(kg/m <sup>2</sup> ) ≥ 25	204	1.44(0.78-2.65)	0.242		
CA-125(U/ml) ≥ 40	119	8.75(4.42-17.31)	<0.001	8.75(4.42-17.31)	<0.001
CEA(ng/ml) ≥ 1.4	141	2.74(1.49-5.06)	0.001	1.94(1.01-3.74)	0.001

a) OR, odds ratio; CI, confidence interval; BMI, body mass index; CA125, cancer antigen-125; CEA, carcinoembryonic Antigen.

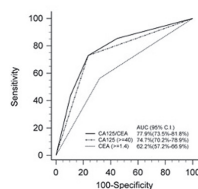
**Table 4.** Predictive performance of different combinations

	Sensitivity(%)	Specificity(%)	PPV(%)	NPV(%)	LR(+)	LR(-)
If all negative(CA-125<40, CEA<1.4)	85.4	55.2	-	96.6	-	0.26
If all positive(CA-125≥40, CEA≥1.4)	43.8	89.4	35.6	-	4.11	-

**Figure1.** CONSORT flow diagram of study population.



**Figure2.** Comparison of area under ROC curve in different variable



**Abstract #483 Figure 1**

**Conclusion** We report a cost-effective method of using pre-treatment CEA and CA-125 levels to identify patients with endometrioid-type EC who are at a low risk for LNM, which may guide decision-making regarding aborting lymphadenectomy.

**Disclosures** There are no conflicts of interest to declare.

**#495 VAGINAL HYSTERECTOMY FOR LOW-RISK ENDOMETRIAL CANCER: COSTS, PERIOPERATIVE OUTCOMES, AND ONCOLOGICAL RESULTS IN A SINGLE CENTER IN SÃO PAULO, BRAZIL**

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**Introduction/Background** This study aims to evaluate the costs, perioperative outcomes, and oncological results of vaginal hysterectomy as a treatment for low-risk endometrial cancer. Vaginal hysterectomy shows potential as a cost-effective option, but comprehensive assessments are lacking. This retrospective analysis aims to fill this gap by examining patient records from a single center in São Paulo, Brazil.

**Methodology** Medical records of patients who underwent vaginal hysterectomy for precursor and invasive endometrial lesions were retrospectively analyzed. Data collected included patient comorbidities, pre- and postoperative histological diagnosis, perioperative outcomes, total procedure cost, adjuvant treatments, and oncological follow-up. The study focused on patients treated between April 2019 and November 2021.

**Results** The analysis comprised 34 patients with a mean age of 61.9 years and a mean BMI of 34. Obesity (BMI ≥ 30) was prevalent in 77% of the sample. Common comorbidities included hypertension (68%) and diabetes (35%). The mean operative time was 109 minutes, and the average hospital stay was 1.2 days. Four patients (12%) required conversion to laparotomy, primarily due to bleeding or technical difficulties. No major intraoperative complications were reported. The total cost of vaginal hysterectomy was US\$ 2058.77 (R\$ 10925.91), representing 47% of the cost related to non-vaginal procedures. Final pathology showed that 28 patients had low-grade endometrioid carcinoma, while six had intermediate-risk endometrial cancer. Three of these patients received adjuvant radiotherapy. The mean follow-up period was 20.0 months for the entire group and 23.4 months for cancer-diagnosed patients. Disease recurrence occurred in one case after 16.6 months, and no deaths were recorded during the study period.

**Conclusion** Vaginal hysterectomy demonstrates potential as a cost-effective treatment option for well-selected patients with low-risk endometrial cancer. The procedure exhibited favorable perioperative outcomes, minimal complications, and promising oncological results. Further research and prospective studies are needed to validate these findings and establish guidelines for patient selection.

**Disclosures** The authors have no conflicts of interest to declare.