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.

Disclosures The authors made no disclosures. No specific funding was disclosed.

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/m2. Mean duration of surgery was 196±1.78 (range 110–208) 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.

**Abstract #460**

**Table 1: Studied outcomes (interoperative and postoperative)**

<table>
<thead>
<tr>
<th>Study</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
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<tr>
<td>Door triangulation</td>
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<tr>
<td>Instrumental collisions</td>
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<td>1</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Time</td>
<td>Duration</td>
<td>90</td>
<td>175</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>110</td>
<td>208</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>80–170</td>
<td>160–230</td>
<td></td>
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</tr>
</tbody>
</table>

Abbreviations: SD = standard deviation, RSS = robotic single-site, LESS = laparoendoscopy surgery in a single site (LESS)

**Abstract #468**

**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.
Conclusion We report a cost-effective method of using pretreatment 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

Fernando De Souza Nobrega*, Vanessa Alvarenga Bezerra, Luisa Marcella Martins, Guilherme Bicudo Barbosa, Pedro Ernesto Di Cillo, Priscila Moura Queiroz, Rafael Salim, Renato Moreti Marques, Hospital Municipal Vila Santa Catarina; Hospital Israelita Albert Einstein, 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.