#591 ADVANCED ENDOMETRIAL CANCER – OUTCOME OF PATIENTS UNDERGOING CYTOREDUCTIVE SURGERY: A RETROSPECTIVE STUDY

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Introduction/Background Women with advanced endometrial cancer include a heterogeneous group with high local and systemic disease recurrence. The prognosis for these patients remains poor and optimal treatment strategies are yet to be established.

The objectives were to assess the overall and disease free survival in patients with advanced (Stage III and IV) endometrial cancer who undergo cytoreductive surgery, and to assess the factors affecting recurrence.

Methodology 80 patients with advanced endometrial cancer who had undergone surgery in Regional Cancer Centre Thiruvananthapuram between 2008 and 2018 were included.

Results Mean age was 59.9 yrs. 81.2% of the patients had stage III and 18.8% had stage IV endometrial cancer. 66.3% had endometrioid histology while 15% had serous carcinoma, 7.5% had clear cell carcinoma and 11.2% had carcinosarcoma. 69 (86.3%) patients had primary surgery, while 11 (13.7%) had upfront chemotherapy or radiotherapy before surgery. 90% of the patients had a complete cytoreduction. Post operative adjuvant treatment was chemotherapy and radiation in 51.2% patients, chemotherapy alone in 18.8% and radiotherapy alone in 21.3%. Median follow up was 92 months. 62.5% of the patients had a relapse. 5 year DFS was 39% and OS was 46.9%. Factors significantly correlating to recurrence on univariate analysis included age> 60 years, non endometrioid histology, high grade, LVSI and nodal involvement. On multivariate analysis, only non endometrioid histology significantly correlated with recurrence. Factors significantly correlating to OS were age > 60 yrs, Albumin < 4 g%, non endometrioid histology, high grade, presence of LVSI and site of recurrence in lung and para aortic lymph nodes. On multivariate analysis, only non endometrioid histology significantly correlated with survival.

Conclusion In carefully selected patients with advanced endometrial cancer, a combination of surgical cytoreduction with appropriate adjuvant treatment and neoadjuvant treatment when indicated gives good results with an acceptable morbidity and mortality and reasonable overall survival.

Disclosures None.

#603 CHEMOKINES EXPRESSION IN ENDOMETRIAL CANCER – MOLECULAR AND PATHOLOGICAL ASSESSMENT

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Introduction/Background Introduction of molecular classification of endometrial cancer (EC) in clinical practice led to search of further markers. Chemokines are a family of cytokines which play important role in inflammation in tumour microenvironment. Their role in EC development remains unclear.

Methodology The research included 97 patients of whom 49 were diagnosed with stage I-II EC and formed a study group. Control group consisted of patients who underwent a hysterectomy due to non-oncological indications. Following axes of chemokines and their receptors were selected to analysis through a literature research: CXCL12-CXCR4/CXCR7, CCL2-CCR2, CCL20-CCR6, CXCL10-CXCR3. Expression of genes encoding the molecules was assessed in endometrial tissue with real-time polymerase chain reaction (PCR). Chemokines which presented a significant differences in expression were additionally evaluated with immunohistochemistry, both in endometrial and stromal tissue using immunoreactive score (IRS). Received data was analysed with parametrical and non-parametrical tests followed by correlation analysis.

Results Molecular analysis in 36 patients revealed significantly increased expression of CXCL10 (p=0,01) and CCL20 (p=0,001) in the study group. The expression of CXCL12 was higher in the control group (p=0,01). Overexpression of CXCL10 in EC tissue was confirmed in immunohistochemistry (group of 77 patients, p=0,006) with positive correlation with molecular findings. Stromal expression of CXCL12 was higher in the control group (p=0,008), as well as both endometrial and stromal expression of CCL 20 (p=0,002, negative correlation with PCR results).

Conclusion The overexpression of CXCL10 in non-advanced EC was detected in molecular and pathological assessment. This might be considered favourable prognostic factor, as CXCL10 plays a role in limitation of neoplastic process in preceding studies on other malignancies. Inconsistent results of CCL20 expression in PCR and immunohistochemistry indicate a need of further research, preferably with inclusion of advanced EC cases. This considers also CXCL12 and other chemokines evaluated in the study.

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#614 SURGICAL AND HISTOPATHOLOGICAL OUTCOMES OF EARLY-STAGE ENDOMETRIAL CANCER TREATED BY LAPAROSCOPIC HYSTERECTOMY AND SENTINEL NODE: A PROSPECTIVE COHORT STUDY

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Introduction/Background Sentinel node is indicated for staging of low and intermediate risk patients of apparent early-stage endometrial cancer. Main objective of the present cohort was to evaluate the surgical and histopathological outcomes of the first 30 cases in which sentinel node was performed in our ESGO-accredited Department.

Methodology A prospective cohort study was conducted during 2020–2022 including the first 30 patients with early-stage endometrial cancer in which sentinel node technique was performed. All cases included in the present study were

supervised by certified Gynaecologic Oncologist of Endoscopic Surgeon (S.P, F.G or K.D respectively). Epidemiological, surgical and histopathological outcomes of patients were recorded in a computerized database. Primary outcome of the study was to assess rates of any sentinel detection, bilateral or unilateral detection as well as to record main intraoperative and postoperative complications. Secondary outcome was to report final FIGO staging along with main histopathologic parameters.

Results Mean patients' age was 64.5 years. Technique was performed laparoscopically in 28 cases and with laparotomy in 2 cases. At least one sentinel node was detected in all cases of the cohort. Macroscopic bilateral detection was achieved in 28 cases (93.3%), while histologically confirmed detection in 24 cases (80.0%). Non-detection concerned left side in 4 cases and right side in 2 cases. No major intraoperative or postoperative complication was observed in these cases. There was 1 case in which sentinel node was positive for nodal involvement (3.3%) and was upstaged to IIIC. Final FIGO staging was IA in 33.3% of patients (10/30), IB in 60.0% of patients (18/30), II in 6.7% of patients (2/30) and IIIC in 3.3% (1/30).

Conclusion Sentinel node is safe and effective technique with high rates of nodal status detection. Current ESGO guidelines necessitating the performance of technique in apparent early-stage endometrial cancer cases should be widely implemented by ESGO-accredited Departments.

Disclosures Authors have nothing to disclose

#618 MULTICENTER ANALYSIS OF THE RELAPSE PATTERN AND TREATMENT IN RELAPSED ENDOMETRIAL CANCER

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Introduction/Background Endometrial cancer is the most prevalent gynecologic malignancy. Despite its generally favorable prognosis at primary diagnosis, recurrence of endometrial cancer remains an important clinical challenge.

The purpose of this study is to analyze the patterns of recurrence and the treatment options in the 'real world' setting.

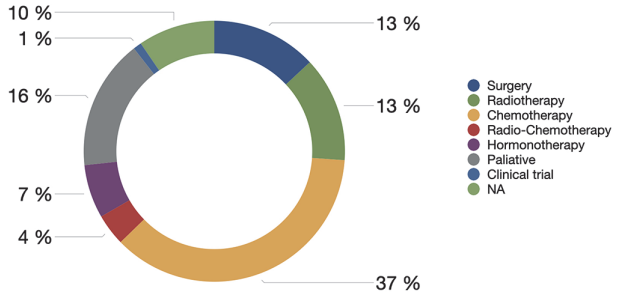
Methodology A multicenter retrospective study endorsed by the Spanish Investigational Network Gynecologic Oncology Group (Spain-GOG) was performed. Patients with disease apparently confined in the uterus at the time of surgery, with histological confirmation of endometrial cancer after hysterectomy and bilateral salpingo-oophorectomy were assessed for eligibility. Finally, those patients who presented a recurrence during the follow-up period were included (468)

Results 468 out of 3618 patients from 15 centers presented a relapse (12.9%), with a mean follow-up period of 8.3 ± 3.6 years (range 3–13). Most of the recurrences presented an endometrioid histology (60.6%), followed by serous (17.5%) and carcinosarcoma (7,2%).

Distant recurrences (37.2%) were more frequently detected than local (25.4%), followed by carcinomatosis (19.6%) and lymphatic (17.3%). Regarding the local pattern recurrence 13.2% were in vaginal cuff and 12.2% were limited to pelvis.

Regarding the treatment 177 received chemotherapy (37.8%), 63 radioterapy (13.4%) and 19 both treatments; only 78 patients had surgery options (16.6%), and another 78 patients received palliative care (16.6%).

Figura 2. Treatment of endometrial cancer recurrence (n 468)



Abstract #618 Figure 1 Pattern recurrence in endometrial cancer

Conclusion Between patients with a relapse, most of them presented disease not suitable for surgical treatment. Further studies are needed to elucidate treatments option for relapsed endometrial cancer not candidates for radical treatment

Disclosures No disclosure

#629 MICROSATELLITH INSTABILITY IN ENDOMETRIAL CANCER: DETECTION WITH IMMUNOHISTOCHEMICAL MARKERS AND ITS RELATIONSHIP WITH CLINICAL OUTCOME

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Introduction/Background Endometrial cancer (EC) is the most commonly diagnosed gynecologic malignancy among women worldwide and may be classified on the basis of different molecular, pathologic and genetic alterations, including microsatellite instability (MSI). Although MSI is associated with a more favorable outcome in colorectal cancer, its relationship with prognosis in EC cancer is not yet clear.

Methodology 100 primary endometrioid type endometrial carcinoma cases, surgically staged in Ege University Gynecological Oncology Department, were included in the study. The files of the patients who applied between 2002–2016 were searched. A tumor sample was defined as MMR deficiency (dMMR) with a loss of at least one of the MMR proteins. The cases were divided into two groups as MMR-deficiency and MMR-proficient. The cases were compared in terms of prognostic factors with loss of nuclear expression in MMR proteins by IHC method. The effects of these parameters on survival were examined.

Results According to the FIGO 2009 staging system, the patients included in the study were distributed as stage I patient group 77 (77%), stage II 14 (14%), stage III 8 (8%), stage IV 1 (1%). Twenty-eight (28%) of the cases were found to be grade 1, 57% grade 2, and 15% grade 3. There was no statistically significant difference between the dMMR and MMR-proficient groups in terms of age, menopausal status, family history, need for adjuvant treatment, recurrence, mortality, FIGO stage, grade, adnexal involvement, lymph node involvement and tumor size ($p>0.05$). LVSI was more common in the dMMR group than in the MMR-proficient group