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.

Abstracts

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

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Introduction/Background Endometrial cancer (EC) 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 ± 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 radioretherapy (13.4%) and 19 both treatments; only 78 patients had surgery options (16.6%), and another 78 patients received palliative care (16.6%).

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). LVI was more common in the dMMR group than in the MMR-proficient group.