

( $p=0.020$ , respectively). In addition, deep myometrial involvement was less common in the dMMR group compared to the MMR-proficient group ( $p=0.002$ , respectively).

**Abstract #629 Table 1** Association between MMR deficiency and clinical parameters

Parameter	MMR deficiency (n, %)	MMR normal (n, %)	P Value
Age (years, median)	57.7	58.3	0.775
Menopausal status			1.000
Premenopause	5 (17.2)	12 (16.9)	
Postmenopause	24 (82.8)	59 (83.1)	
Family history			1.000
Yes	4 (13.8)	10 (14.1)	
No	25 (86.2)	61 (85.9)	
Grade			0.244
I	8 (27.6)	20 (28.2)	
II	14 (48.3)	43 (60.6)	
III	7 (24.1)	8 (11.3)	
FIGO Stage			0.616
I	25 (86.2)	52 (73.2)	
II	3 (10.3)	11 (15.5)	
III	1 (3.4)	7 (9.9)	
IV	0 (0)	1 (1.4)	
Tumor size (mm)	35 (range, 22.5-50)	30 (range, 25-43)	0.653
Deep myometrial infiltration			0.002
Yes	4 (13.8)	35 (49.3)	
No	25 (86.2)	36 (50.7)	
LVSI			0.020
Yes	16 (55.2)	20 (28.2)	
No	13 (44.8)	51 (71.8)	
Adnexal involvement			1.000
Yes	0 (0)	2 (2.8)	
No	29 (100)	69 (97.2)	
Lymph node status			0.093
Positive	1 (3.4)	4 (5.6)	
Negative	26 (89.7)	50 (70.4)	
Not described	2 (6.9)	17 (23.6)	
Adjuvant therapy			1.000
Yes	28 (96.6)	69 (97.2)	
No	1 (3.4)	2 (2.8)	
Recurrence			0.502
Yes	2 (6.9)	9 (12.7)	
No	27 (93.1)	62 (87.3)	
Mortality			0.502
Yes	2 (6.9)	9 (12.7)	
No	27 (93.1)	62 (87.3)	
OS months (median)	33.2 (range, 30.8-35.6)	39.2 (range, 36.4-42.1)	0.649
PFS months (median)	32.2 (range, 29.6-34.9)	38.9 (range, 35.9-41.8)	0.046

OS, overall survival; PFS, progression-free survival; LVSI, lymphovascular space invasion.

**Conclusion** As a result, in endometrioid type endometrial cancers, a significant relationship was found between MMR and lymphovascular space involvement and deep myometrial invasion. However, there was no effect on survival.

**Disclosures** The aim of our study is to reveal the molecular features of endometrial cancer by immunohistochemical (IHC) method and to determine their relationship with prognostic variables.

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### TRIPLE SYNCHRONOUS MALIGNANT TUMORS OF BREAST, ENDOMETRIUM AND STOMACH: A CASE REPORT

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**Introduction/Background** We present a Triple neoplasm case to diagnose and raise awareness about other primary cancers that may develop after primary cancer.

**Methodology** A retrospective case was demonstrated.

**Results** 56 years patient has comorbidities of asthma, hypothyroidism, hypertension. During the breast cancer screening, the patient underwent USG and the right breast was reported

as BI-RADS 3 and the left breast as BI-RADS 1. Tru-cut biopsy of the right breast resulted as IDC. Endometrial biopsy was performed because of concomitant abnormal uterine bleeding, and it was concluded as Endometrial Carcinoma. In the meantime, because of the thickening and heterogeneity of the gastric mucosa on MRI, malignancy was suspected and endoscopy was performed. Endoscopy results were reported as 'differentiated adenocarcinoma' in the lower end of the esophagus and 'gastric adenocarcinoma' in the cardia. First, segmental mastectomy was performed on the right breast, and biopsy was confirmed as IDC. Then Laparoscopic Hysterectomy- BSO -SLN was performed, the result was confirmed as Endometrial Endometrioid Carcinoma. At this time, it was thought that gastric cancer might be an advanced stage peritoneal tumor, surgery was planned immediately after 4 cycles of neoadjuvant chemotherapy were given. After chemotherapy treatment, total gastrectomy - D2 dissection was performed and the biopsy result was confirmed as 'gastric adenocarcinoma'. Letrozole added to treatment. The patient was discharged in good health and our follow-up continues.

**Conclusion** Until future studies incorporate the increased risk for certain types of neoplasm into appropriate guidelines, physicians should ensure that endometrial cancer survivors are counseled on this risk, while being screened not only for recurrence of the primary tumor but also for other types of cancer. It should be noted that; there may be patients who are successfully treated and followed up for endometrial carcinoma but are not adequately screened for subsequent neoplasms and remain undiagnosed until they reach an advanced stage.

**Disclosures** There is no conflict of interest in this statement.

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### RADIATION-INDUCED GYNECOLOGIC CANCERS: ABOUT 9 CASES

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**Introduction/Background** Although rare, gynecological cancers following therapeutic radiation are a reality that cannot be ignored nowadays. Ionizing radiation is an established risk factor for the development of primary second cancers. While post-radiotherapy gynecological sarcomas are well-documented, it's harder to prove the existence of post-radiotherapy gynecological carcinomas.

**Methodology** A retrospective study was conducted at our institution between January 1st, 2018 and December 1st, 2022, to analyze the data of 367 patients hospitalized for the management of a gynecologic cancer. Among these 367 patients, only 9 had a history of gynecologic cancer treated with radiotherapy that met Cahan's extended criteria for potential radiation induction. These criteria include the location of the second tumor, it's histology, and the time interval between the initial irradiation and its appearance.

**Results** The average age at the onset of the first gynecological cancer treated by radiotherapy was 58.6 years and the second post-irradiation cancer was 63.7 years. All nine patients had squamous cell carcinoma of the cervix, all treated with radiochemotherapy. The average dose received was 53.6Gy with fractionation adapted to the stage of each patient, particularly

to the different regions to be irradiated. The total duration of radiotherapy varied from 2 to 4 months. 8 of our patients also underwent endovaginal brachytherapy, except for one patient, with an average dose of 26.5 Gy, a fractionation between 6.5 and 7 Gy/F weekly, and a total duration ranging from 2 to 3 months. 8 of our patients developed endometrial cancer after radiotherapy, while the last one presented with ovarian cancer.

**Conclusion** This topic presents a major challenge: proving that gynecological tumors resulting from previous radiation therapy are radio-induced as there is no histological way to differentiate them from tumors that occur spontaneously. The answer to this question is gradually becoming demystified thanks to the latest developments in molecular biology.

**Disclosures** All the authors have no financial disclosure or conflicts of interest with the presented material in this presentation.

#656

#### RETROSPECTIVE STUDY OF 17 CASES OF ENDOMETRIAL CARCINOSARCOMA: EXPERIENCE OF THE HASSAN II UNIVERSITY HOSPITAL OF FEZ

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**Introduction/Background** Carcinosarcoma is a rare and aggressive cancer that combines a sarcomatous and carcinomatous component. Regarding the gynecological area, carcinosarcoma accounts for 2–5% of endometrial cancers and 1% of ovarian cancers.

**Methodology** A retrospective study was conducted at our institution between January 1st, 2018 and December 1st, 2022, to analyze the data of 113 patients who were hospitalized for endometrial cancer management. Out of these patients, 17 patients were diagnosed with uterine carcinosarcoma and included in the study.

**Results** The average age at diagnosis was 54.7 years. 9 patients were overweight or obese. All patients consulted for metrorrhagia, with 7 patients being peri-menopausal and 10 being post-menopausal. Some patients also reported pelvic pain, hydrorrhea, altered general condition, and urinary signs. Pelvic ultrasound showed an intracavitary image in 11 patients and suspicious endometrial thickening in 6 patients. However, preoperative histology had a significant number of false negatives and diagnosed carcinosarcoma in only 10 cases. Pelvic MRI classified 2 tumors as FIGO (International Federation of Gynaecology and Obstetrics) 2009 stage Ia, 4 as Ib, 3 as Ic, 1 as II, 5 as IIIa, and 2 as IIIc. Distant metastases were found on CT scans in 2 patients. Surgical treatment was the first-line approach for all our patients, exception made for 2 of them who went through neoadjuvant chemotherapy first. Adjuvant chemotherapy and radiotherapy were also administered to 8 and 3 of patients, respectively. However, 4 patients refused any additional treatment. The median survival of the 8 patients who died was 13 months, 5 patients are still undergoing neoadjuvant chemotherapy/radiotherapy, 4 are lost to follow-up.

**Conclusion** Uterine carcinosarcomas are rare and aggressive tumors that require prompt attention. Surgical intervention is

the recommended first-line treatment, and adjuvant chemotherapy has shown promising results. The role of radiotherapy in the management of carcinosarcoma remains to be further explored.

**Disclosures** All the authors have no financial disclosure or conflicts of interest with the presented material in this presentation.

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#### RADIO-HISTOLOGICAL CORRELATION OF THE FIGO CLASSIFICATION FOR NON-ENDOMETRIOID ENDOMETRIAL CARCINOMAS (PROSPECTIVE STUDY ON 25 CASES): EXPERIENCE OF THE HASSAN II UNIVERSITY HOSPITAL OF FEZ

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**Introduction/Background** Non-endometrioid endometrial tumors represent 10–20% of endometrial cancers and are considered high-grade forms with unique aggressiveness. The International Federation of Gynaecology and Obstetrics FIGO 2009 classification provides precise terms to unify terminology among different healthcare providers. It's used to adapt initial surgical treatment based on the radiological FIGO classification using abdominopelvic MRI, as well as adjuvant treatment based on the histological FIGO classification obtained postoperatively.

**Methodology** A prospective study was conducted between January 1st, 2018 and December 1st, 2022, to analyze the data of 25 cases of non-endometrioid endometrial carcinoma in our institution. The aim of the study is to evaluate the concordance between the radiological FIGO classification and the anatomopathological classification. The focus was on the MRI performance for determining local extension due to the resulting surgical implications.

**Results** Preoperatively, MRI found 74% of stage I, 8% of stage II, and 28% of III. In the study, MRI presented a specificity of 57% and a sensitivity of 77% for myometrial invasion, a specificity of 50% and a sensitivity of 53% for cervical invasion, a specificity of 88% and a sensitivity of 28% for serosal/adnexal invasion, a specificity of 100% and a sensitivity of 62% for lymph node involvement. The final FIGO stage was determined for each operative specimen, with 48% at stage I and 36% at stage II. 44% of the 25 patients showed a discordance between preoperative and postoperative FIGO classification. Underestimation of the risk was noted in 54% of patients, while overestimation was observed in 45%.

**Conclusion** The standardization of the MRI protocol, already underway for several years in our center, will undoubtedly improve the performance of MRI in evaluating the local extension of endometrial cancer in our daily practice, particularly through the systematic use of high-resolution T2 double oblique sequences on the uterine body and high-resolution oblique diffusion.

**Disclosures** All the authors have no financial disclosure or conflicts of interest with the presented material in this presentation.