impact of delay in the initiation of adjuvant therapy on disease free survival.

Results Completion staging was done at a mean interval of 6.6 weeks after the initial surgery. Postmenopausal bleeding (79.8%) was the primary indication for the inadequate initial surgery. Notably, only 34.5% of patients underwent preoperative endometrial biopsies, with 16 (19%) being diagnosed with endometrial cancer. The most common reason for offering restaging was non endometroid carcinoma (25%) followed by extra-uterine disease (19%). Postoperative complications occurred in 21 patients, with urinary tract infections being the most common.

After proper restaging, 29.76% of patients required no adjuvant treatment, while 20.24% received vaginal brachytherapy, and 27.38% received combined chemoradiation. The mean interval between primary surgery and initiation of adjuvant treatment was 10.37 weeks. During follow-up, 15 patients experienced disease recurrence, with a median disease-free survival of 91.13 months (80.56–101.69, 95% CI).

Conclusion This study provides valuable insights into the outcomes of completion staging in endometrial cancer patients, emphasising the significance of accurate staging and personalized treatment decisions. Increased utilization of preoperative endometrial biopsies, improvements in surgical staging practices, and tailoring of adjuvant treatment, avoiding risks of overtreatment and under treatment are warranted to ensure the best possible care for women with endometrial cancer.

Disclosures No conflict of interest.

#678 FERTILITY SPARING TREATMENT IN WOMEN WITH COMPLEX ATYPICAL ENDOMETRIAL HYPERPLASIA-OUR CLINICAL EXPERIENCE

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Introduction/Background Complex atypical endometrial hyperplasia suggests a pre-malignant state of endometrial cancer which tends to occur in women of reproductive age. Oral progestins have been used as conservative treatment in young women with atypical endometrial hyperplasia who want to preserve their fertility. This treatment can be used alone or combined with Levonorgestrel-releasing intrauterine system (Mirena). LNG-IUD could be also used alone. The aim of our study was to evaluate the response of treatment in women who received oral progestins as monotherapy and others who were treated with LNG-IUD.

Methodology We conducted a randomized prospective study, at the gynecological department of the Naval Hospital of Athens since 2019. We included women, 32–38 years old, with complex atypical endometrial hyperplasia, treated with oral progestins alone, compared to Levonorgestrel-releasing intrauterine device. The histology of the patients was reevaluated every 6 months by hysteroscopy and curettage.

Results So far, 12 women wishing to preserve fertility, have been included in the study. Five patients received oral progestins alone and 4 out of 5 achieved disease regression. Five patients were treated only with LNG-IUD and are free of disease. Two quite obese patients were treated with a combination of LNG-IUD and oral progestins and are also free of disease.

Conclusion Although a larger sample is needed, the preliminary results are encouraging. Both oral progestins and LNG-IUD are effective in women who undergo fertility sparing treatment. Megestrol acetate had higher and quicker remission rates than medroxyprogesterone acetate. Regarding disease regression, the LNG-IUD proved to be more effective. Furthermore, there were no side effects associated with the use of LNG-IUD, whereas one woman who received megestrol acetate experienced secondary adrenal insufficiency. After complete response, conception should be recommended. Maintenance therapy with strict follow-up can also be proposed to decrease recurrence, along with proper counseling over the safety of this approach.

Disclosures No conflict of interest

#680 PELVIC RECURRENCE FOLLOWING ADJUVANT VAGINAL BRACHYTHERAPY FOR STAGE I/II NON ENDOMETRIOID ENDOMETRIAL CANCER

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Introduction/Background Stage III endometrial cancer is managed with surgery and adjuvant chemoradiotherapy. The optimal treatment for Stage I/II high risk disease remains controversial. Here, we evaluated frequency and site of first relapse following adjuvant vaginal brachytherapy for FIGO Stage I-II endometrial cancer with non-endometrioid histology.

Methodology The central radiotherapy prescribing system at our institution was interrogated to identify patients who commenced vaginal brachytherapy, 2100cGy/3#, for endometrial cancer, 1st January 2017 to 31st December 2019. Only those with Stage I-II disease and non-endometrioid pathology were included. Clinical follow up was undertaken until death or 5 years had elapsed (data lock 31st December 2022).

Results In total, 68 patients were identified. Median age was 69 years (range 47–92) and median follow up was 33 months . FIGO 2018 Stage: IA (54.4%); IB (20.6%); II (25%). Pathology: serous (60%); carcinosarcoma (22%); clear cell (12%); undifferentiated/mixed (6%). Pelvic lymph node dissection (PLND) was performed in 50/68 (74%) and lymphovascular invasion (LVSI) was present in 25/68 (37%). Adjuvant chemotherapy (Carboplatin AUC5/Paclitaxel 175mg/m2) was delivered to 11/68 (16%) patients; median number of cycles - 4 (range 2–6). By study end, 23/68 (34%) patients had relapsed and 17/68 (25%) had died. Relapse frequency based on clinical/pathological characteristics: pathology (serous - 16/23, other - 9/23), stage (IA/B - 11/23, II - 12/23), LVSI (yes - 13/23, no – 10/23), PLND (yes – 17/23, no – 6/23), chemotherapy (yes – 5, no – 18).Pattern of relapse: pelvis only - 6/23 (26%), distant only - 4/23 (17%), both pelvis and distant – 13/23 (57%). Overall pelvic failure rate was 19/68 (28%).

Conclusion Pelvic recurrence rate was almost 30% despite adequate nodal staging and negative LVSI in >60% of cases. External beam radiotherapy should be strongly considered in early stage non-endometrioid pathology to improve loco-regional control.

Disclosures None