manuscript, or in the decision to publish the results; but provided support for data collection.

ROC curve showing the OSNA assay vs. pathological ultrastaging for the detection of SLN metastasis in endometrial cancer.

#698 DIAGNOSIS OF ENDOMETRIAL CARCINOMA THROUGH CORNIER CANNULA AT RAMON Y CAJAL HOSPITAL IN 2021–2022

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Introduction/Background ENDOMETRIAL CARCINOMA THROUGH CORNIER CANNULA AT RAMON Y CAJAL HOSPITAL IN 2021–2022

Endometrial carcinoma is the most common gynecological tumor and its prevalence has increased in recent years. The definitive diagnosis is made through histopathological study, usually obtained through endometrial biopsy, and sometimes through hysteroscopy, which is the gold standard for diagnosing endometrial carcinoma.

Methodology A retrospective analysis was conducted on patients who underwent endometrial cancer surgery at our center between 2021 and 2022. The diagnostic methods used in these patients, the results of endometrial biopsy, and the need for hysteroscopy were evaluated.

Results A total of 60 patients underwent surgery at our center between 2021 and 2022. Among them, 42 patients were diagnosed with endometrial carcinoma through Cornier cannula. In 11 cases, hysteroscopy was performed directly due to the inability to obtain endometrial biopsy samples through aspiration due to lack of access, cervical stenosis, or patient discomfort. In 4 cases, the Cornier sample was insufficient, so hysteroscopy was performed, which diagnosed endometrial adenocarcinoma. In 3 cases, the biopsy results were normal, and the definitive diagnosis was made through hysteroscopy. In all cases, hysteroscopy revealed a suspicious formation of endometrial neoplasia.

Conclusion Endometrial biopsy is a simple test that can be performed in the clinic when there is a diagnostic suspicion of endometrial carcinoma. In some cases, it may not be feasible, and in others, if the biopsy is unsatisfactory or negative, hysteroscopy should be performed, which is the gold standard for diagnosing endometrial cancer. The false-negative rate of endometrial biopsy in our center was 6.66%, and in all cases, hysteroscopy was performed due to clinical suspicion.

Disclosures No conflicts of interest.

#704 THREE-DIMENSIONAL ANATOMICAL MODEL SUPPORTING LAPAROSCOPIC PELVIC LYMPHADENECTOMY IN OBESE ENDOMETRIAL CANCER PATIENTS: A CASE-CONTROL STUDY

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Introduction/Background In early stages endometrial cancer (EC) patients, the standard surgical approach is hysterectomy and bilateral salpingoophorectomy, with pelvic lymphadenectomy or with sentinel lymph node staging, based on clinical and molecular risk factors.

The role of 3D imaging reconstruction is currently under debate.

The aim of this research is to assess the clinical value of a 3D imaging reconstruction model of pelvic lymphnodes to be used simultaneously in the operating room to identify lymphatic tissue in obese patients.

Abstract #704 Figure 1
Methodology A study was performed on obese patients with EC treated between March and October 2022 in Santa Maria Annunziata Hospital (Florence) using REAL 3D-MIC device (group 1). Prior to surgery, we performed a 3D imaging reconstruction of pelvic lymph nodes used to guide the intraoperatively lymphadenectomy. This group was compared with a historical series of EC patients treated without the 3D model (group 2).

Results The two groups (group 1=13 patients and group 2=11 patients) showed homogeneous clinical characteristics. The correspondence between virtual 3D model and real anatomy was analyzed comparing lymph nodes location in virtual 3D model and operative data. We recorded a consistency of 85% (85% for group 1 vs 45% for group 2, p=0.06). In REAL 3D MIC group we found one nodal EC metastasis and one case of B cells Lymphoma synchronous to EC.

Conclusion REAL-3D MIC could improve the identification of lymph nodes simultaneously with surgery, especially in obese women. Further studies are needed to demonstrate the effectiveness of REAL-3D MIC in lymph nodal mapping.

Disclosures The Authors have no conflicts of interests to declare.

Abstract #736 PREDICTION MODEL FOR AORTIC INVOLVEMENT IN ENDOMETRIAL CANCER

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Introduction/Background Clinical guidelines for pelvic SLNB in endometrial cancer (EC) do not address the need for evaluation of the aortic region. Isolated aortic involvement in EC is rare. However, in selected groups, the incidence increases, nearly 25%. Moreover, >50% of the cases with pelvic involvement also exhibit aortic involvement. The objective of this study is to develop a prediction model for aortic involvement to guide SLNB, based on preoperative risk factors.

Methodology We evaluated the area under the ROC curve of a prediction model for aortic lymph node involvement using logistic regression, constructed with 376 women who underwent surgery for EC at the University Hospital Donostia (August 2014 - July 2022).

Results The prediction model demonstrated good discrimination, with a c-index of 0.82, and explained 29.33% of the variability in aortic lymph node involvement.

To assess the clinical utility of the model, a decision curve analysis was conducted. Firstly, the net benefit graph was created, not performing aortic lymph node assessment in any patient. It can be observed that the strategy of performing aortic BSGC based on the risk predicted by the prediction model is superior to performing it only in patients with preoperative risks. The use of the model is also superior for the majority of the probability ranges, until the match at 3%. This is because 3% is the minimum predicted probability by the model, so its results are the same as performing BSGC in all cases. Moreover, the net true negatives graph was created, using the strategy of performing aortic BSGC in all patients, as is done at the University Hospital Donostia.

Conclusion The graph demonstrates that using the prediction model to restrict aortic lymph node assessment to patients with a predicted risk above a certain threshold would result in a significant reduction of unnecessary evaluations.

Abstract #740 EVOLUTION OF AORTIC AND PELVIC DETECTION RATES AFTER VALIDATION OF THE SENTINEL LYMPH NODE BIOPSY IN ENDOMETRIAL CANCER

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Introduction/Background The systematization of sentinel lymph node technique by a dedicated team implies an improvement in detection rates and a decrease in the acquisition of 'empty' nodes. The number of procedures necessary to acquire this experience has been studied in several publications, demonstrating the importance of the surgeon's experience to achieve good sensitivity of the technique. Cutoff points have been established between 10 and 40 procedures to reach a plateau.

The improvement in detection rates by abandoning research and validation protocols with sentinel lymph node and lymphadenectomy, and exclusively using sentinel lymph node technique by a dedicated team after a number of procedures exceeding 100–300, including aortic territory, has not been studied.

The objective of this study is to compare changes in detection rates after validation of the sentinel lymph node technique in a high number of procedures at our hospital.