#890 A CASE OF CAUTION: DO NOT ALWAYS BELIEVE PET-CT!!

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Introduction/Background Pre-operative radiologic staging with PET-CT is generally used in patients diagnosed with endometrial cancer. The false positive rate of PET-CT is not so low and positive findings on PET-CT changes the treatment plan in these patients and sometimes assigns these patients into higher stages

Methodology 69 year old patient referred to our clinic with post menopausal bleeding

Results Endometrial biopsy revealed endometrioid type endometrioid grade 1 adenocarcinoma. In pelvic MRI, 4 cm tumor invading <1/2 myometrial thickness without any concomitant finding. In PET CT scan, 19 mm measuring hypermetabolic (SUV max:11.86) lymphnode in right paraesophageal area was revealed. In the first impression, a clinically stage IV disease was decided in multidisciplanry tumor board and systemic chemotherapy was decided. However, the Ca 125 levels were within normal limits and there was no sign of extrauterine disease in abdominal area. With this discordant findings in hand, thorax surgery consulation was carried out and removal of this lymph node was decided. Lymph node was excised with mini toracotomy just under the seventh intercostal area corresponding to paraesophageal area. The final pathology revealed granulomatous lymphadenitis without any malignant process. By excluding distant metastasis, the patient underwent total laparoscopic hysterectomy and bilateral pelvic sentinal lymph node mapping with ICG. The final pathology revealed a grade I endometrioid type adeno cancer with myometrial invasion > ½ along with negative bilateral sentinel lymph nodes on both sides. The patient was referred to external pelvic radiotherapy.

Conclusion Discordant findings in radiologic imaging should always be evaluated cautiously and any suspicous finding should be histologically confirmed before assigning the patient into a higher stage and proceeding to final treatment.

Disclosures None

#891 THE IMPACT OF COMPLETE SURGICAL RESECTION ON THE LONG-TERM SURVIVAL OF PATIENTS WITH RECURRENT ENDOMETRIOID ENDOMETRIAL CANCER

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Introduction/Background This study was aimed to evaluate the impact of complete surgical resection of recurrent tumor on the long-term survival of patients with endometrioid type endometrial cancer.

Methodology Medical records of patients diagnosed with endometrioid endometrial cancer between 2009 and 2019 at six different hospitals were reviewed. Eligible criteria included patients who underwent appropriate primary treatment including hysterectomy and surgical staging according to practice guidelines, had no radiologic evidence of residual disease after completion of primary treatment, and experienced recurrence. Patients with insufficient data for survival analyses were excluded. Time to second objective disease progression (PFS2) and second-line overall survival (OS2) were analyzed using the Kaplan-Meier method and compared using the log-rank test. The prognostic significance was assessed using the Cox regression hazards model. Patients were followed up for a median of 43.0 months (95% CI 40.7–58.3) after their first recurrence.

Results A total of 75 patients meeting the eligible criteria were included in the survival analysis. The median PFS2 was significantly longer in patients who underwent complete surgical resection compared to those who did not (34.0 vs. 10.0 months, log-rank P < 0.001). Multivariable analysis showed that complete surgical resection was associated with favorable PFS2 (adjusted HR, 0.46; 95% CI, 0.22–0.94; adjusted P = 0.033). However, the median OS2 was not significantly different between the two groups (not reached vs. 40.0 months, log-rank P = 0.062). Multivariable analysis revealed that presence of peritoneal recurrence was the only factor associated with OS2 (HR, 2.31; 95% CI, 1.12–4.74; adjusted P = 0.023).

Conclusion Our study suggests that complete surgical resection for recurrent endometrioid endometrial cancer may delay the time from the first to second recurrence; however, it does not appear to improve OS2. The presence of peritoneal recurrence was associated with worse OS2.

Abstract #891 Table 1 Factors associated with second objective progression-free survival and second-line overall survival

Variables	Second objective progression-free survival (PFS2)						Second-line overall survival (OS2)					
	Univariate analysis			Multivariate analysis			Univariate analysis			Multivariate analysis		
	HR	95% CI	*P*	HR	95% CI	*P*	HR	95% CI	*P*	HR	95% CI	*P*
Age (≥60 vs. <60)	1.14	(0.65-2.00)	0.656				1.11	(0.57-2.14)	0.770			
BMI (≥24 vs. <24)	1.04	(0.61-1.79)	0.889				0.63	(0.33-1.19)	0.153			
Medical comorbidities												
Hypertension (yes vs. no)	0.86	(0.45-1.63)	0.640				0.64	(0.28-1.45)	0.285			
Diabetes (yes vs. no)	0.69	(0.27-1.74)	0.429				0.84	(0.30-2.37)	0.740			
Tumor size (≥4cm vs. <4cm)	1.49	(0.84-2.65)	0.170				1.02	(0.52-2.00)	0.964			
Invasion depth (≥50% vs. <50%)	1.33	(0.76-2.33)	0.315				1.14	(0.58-2.21)	0.707			
LVSI (yes vs. no)	0.96	(0.55-1.70)	0.899				1.13	(0.59-2.19)	0.709			
FIGO stage (III-IV vs. I-II)	1.39	(0.80-2.41)	0.244				2.18	(1.15-4.12)	**0.017**	2.01	(0.99-4.09)	0.054
Grade												
2 vs. 1	1.37	(0.69-2.70)	0.367				1.38	(0.61-3.16)	0.443			
3 vs. 1	1.78	(0.82-3.86)	0.145				1.67	(0.67-4.15)	0.272			
Open surgery vs. MIS	1.34	(0.78-2.32)	0.292				1.72	(0.91-3.24)	**0.097**	1.21	(0.60-2.43)	0.589
Treatment modalities for recurrent disease												
Complete surgical resection (yes vs. no)	0.36	(0.19-0.66)	**0.001**	0.46	(0.22-0.94)	**0.033**	0.52	(0.26-1.05)	**0.068**	0.64	(0.30-1.35)	0.241
Chemotherapy (yes vs. no)	1.83	(0.96-3.50)	**0.068**	0.76	(0.26-2.22)	0.621	1.42	(0.69-2.93)	0.342			
Radiotherapy (yes vs. no)	0.55	(0.30-1.02)	**0.058**	0.58	(0.21-1.61)	0.296	0.60	(0.29-1.24)	0.168			
Sites of recurrence												
Multiple sites vs. isolated recurrence	3.31	(1.65-6.64)	**0.001**	1.75	(0.71-4.33)	0.225	2.45	(1.12-5.36)	**0.024**	1.54	(0.61-3.84)	0.359
Distant vs. localized recurrence	1.16	(0.67-1.99)	0.601				1.03	(0.54-1.94)	0.937			
Vaginal recurrence (yes vs. no)	0.91	(0.43-1.94)	0.807				0.70	(0.27-1.78)	0.449			
Peritoneal recurrence (yes vs. no)	2.17	(1.25-3.77)	**0.006**	1.50	(0.84-2.69)	0.176	2.82	(1.49-5.35)	**0.002**	2.31	(1.12-4.74)	**0.023**
PLN/PaLN recurrence (yes vs. no)	1.12	(0.62-2.01)	0.707				1.81	(0.93-3.49)	0.080			
Pulmonary recurrence (yes vs. no)	1.11	(0.64-1.92)	0.719				0.74	(0.37-1.46)	0.382			

Covariates with $P < 0.1$ on univariate analysis were included in multivariate model using backward elimination method.
Abbreviations: BMI, body mass index; LVSI, lympho-vascular space invasion; FIGO, International Federation of Gynecology and Obstetrics; MIS, minimally invasive surgery; PLN, pelvic lymph node; PaLN, para-aortic lymph node.

Disclosures None

#892 POSITIVE PERITONEAL CYTOLOGY IN ENDOMETRIAL CANCER: IS IT SIGNIFICANT IN LOW-RISK DISEASE?

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Introduction/Background Positive peritoneal cytology (PPC) in endometrial cancer (EC) has been reported as a risk factor for worse oncologic outcomes, but its prognostic role is unclear for patients with low-risk EC. We investigated the prognostic role of PPC in patient with low-risk EC.

Methodology Patients who underwent primary surgical treatment for EC at Mayo Clinic, Rochester, from 1999 to 2021 were included. The prognostic role of PPC was investigated in the entire cohort and in two subsets: low-risk ECs according to NCCN guidelines [endometrioid, grade 1–2, stage IA] and