

Abstract #949 Table 2 Pathological findings of patients

Characteristics	Total Population (n=139)	Adenomyosis (n= 40)	Nonadenomyosis (n= 99)	P
Hystological type				
Serous	54 (38.8)	16 (40)	38 (38.4)	0.147
Mucinous	14 (10.1)	5 (12.5)	9 (9.1)	
Clear cell	17 (12.2)	5 (12.5)	12 (12.1)	
Carcinocarcoma	31 (22.3)	4 (10)	27 (27.3)	
Undifferentiated	16 (11.5)	8 (20)	8 (8.1)	
Mixt type	7 (5)	2 (5)	5 (5.1)	
Myometrial invasion				0.259
<1/2	80 (57.6)	26 (65)	54 (54.5)	
≥1/2	59 (42.4)	14 (35)	45 (45.5)	
Cervical stromal invasion				0.926
Yes	32 (23)	9 (22.5)	23 (23.2)	
No	107 (77)	31 (77.5)	76 (76.8)	
Lymphovascular space invasion				0.307
Yes	81 (58.3)	26 (65)	55 (55.6)	
No	58 (41.7)	14 (35)	44 (44.4)	
Tumor size, cm	4 (0.4-15.3)	3.75 (0.5-10.5)	4 (0.4-15.3)	0.360
Peritoneal fluid cytology				0.511
Negative	128 (92.1)	38 (95)	90 (90.9)	
Positive	11 (7.9)	2 (5)	9 (9.1)	
Omental metastasis				0.238
Yes	16 (11.5)	7 (17.5)	9 (9.1)	
No	123 (88.5)	33 (82.5)	90 (90.9)	
Lymph node metastasis				0.717
No	104 (74.8)	33 (82.5)	71 (71.7)	
Pelvic	6 (4.3)	1 (2.5)	5 (5.1)	
Paraortic	5 (3.6)	1 (2.5)	4 (4)	
Pelvic+paraortic	24 (17.3)	5 (12.5)	19 (19.2)	

Data are given as median or n (%). P<0.05 accepted as statistically significant

**Methodology** We identified all patients with consecutive diagnosis of non-endometrioid EC who underwent surgical staging at a single center between May 1998 and March 2023. Patients with insufficient clinical or surgical data were excluded from the study. The patients were divided into two groups as adenomyosis and non-adenomyosis group. Demographic characteristics and clinical findings such as age, BMI, menopausal status and pathologic variables like presence of adenomyosis, tumor grade, depth of myometrial invasion, lymphovascular space involvement, lymph node status, and distant spread were obtained hospital records

**Results** A total of 139 patients were enrolled, 40 (28.7%) in the adenomyosis group and 99 (71.3%) in the non-adenomyosis group. There was no significant difference among non-endometrioid type EC patients with and without adenomyosis as regards to patient demographic characteristics and final pathologic variables ( $p>0.05$ ). There was no difference between the two groups in terms of recurrence time ( $p>0.05$ ). In addition, over all survival was found to be statistically significantly higher in the non-endometrioid type EC group with adenomyosis than in the without ( $p=0.02$ )

Abstract #949 Table 3 Recurrence and survival time of patients

Characteristics	Total Population	Adenomyosis	Nonadenomyosis	P
Recurrence time, month	137.3 ± 13.8	175.2 ± 24.4	95.1 ± 11.2	0.166
Survival time, month	125.1 ± 13.1	172.7 ± 24.1	102.2 ± 13.9	<b>0.021</b>
Death related to EC	79	17	62	0.537
Yes	58 (73.4)	14 (82.4)	44 (71)	
No	21 (26.6)	3 (17.6)	18 (29)	

Data in boldfont indicates statistically significant values.

Data are given as mean ± SD or n (%). P < 0.05 accepted as statistically significant.

**Conclusion** The presence of adenomyosis in non-endometrioid type endometrial cancer was not associated with pathological variables such as myometrial invasion, tumor diameter and lymphovascular space involvement. Although the rates of disease-free survival and cancer-related death were similar, the overall survival rate was significantly higher in the presence of adenomyosis

**Disclosures** The authors disclosed no conflict of interest

#951

### MISMATCH REPAIR ABNORMALITY IN ENDOMETRIAL CANCER AND ITS CORRELATION WITH CLINICOPATHOLOGICAL PARAMETERS

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**Introduction/Background** Endometrial cancer (EC) is one of the common female cancers. In India the incidence of EC is low. National cancer registry project (NCRP) estimated 27922 cases of EC in 2022 in India. Mismatch repair (MMR) abnormality and Lynch syndrome (LS) constitute about 3–5 % of all EC. MMR proteins behave as tumour suppressors. Mutations in MMR result in a Micro satellite unstable phenotype known as MMR deficient (MMRd/MSI-H) EC.

**Methodology** 53 EC cases were studied using MMR expression of MLH-1, MSH-2, MSH-6, and PMS with immunohistochemistry (IHC) and their expression was correlated with the stage & grade of the disease.

**Results** Of 53 cases, on histology, endometrioid type was found in 42 (79%) patients. 10 (18%) had serous and 1 (1.8%) had clear cell carcinoma. Of the endometrioid (42 cases), 39 (92.8%) presented in stage 1 and 3 (7.14%) in higher stage. Total 22 cases were MMRd and 31 were MMR proficient (MMRp). MMRd status was not associated with a high grade (grade 3). In contrast MMRp was associated with highest tumour grade (clear cell/serous) in 11 cases. Combined loss of MLH1/PMS2 (82%) was most common MMRd pattern. Combined loss of MSH2/MSH6 and isolated loss of MSH1 were seen in 9% each. Age, grade or FIGO stage was not statistically significantly correlated with MMR expression. **Conclusion** No significant difference was observed between MMRd rates in Grade 1 & 2 Tumours (MMRd: Grade 1 vs Grade 2: 40.0% vs 60%; p-value = 0.233).

However, MMRd (MSI-H) status was observed to be higher in patients with Grade 2 Tumours (73%) as compared to those who had Grade 1 (27%) Tumour. Within the limitation of our small sample size, we can conclude that MMRd tumours are low/intermediate grade and present in early stages. However further studies may confirm this correlation.

**Disclosures** Conflict of Interest Disclosure Statement

The European Society of Gynaecological Oncology requires clear disclosures from all presenters at its annual congress regarding any financial holdings, funding sources, or affiliations that might raise questions of bias or be perceived to have potentially influenced presentation content. Please disclose any financial relationship from the past three years (dating from the month of submission) of any size.

Abstract #951 Table 1 Association between MMR deficiency rates with Tumour Grade

Tumour Grade	MMR deficient (n = 22)	MMR proficient (n = 31)	Total (n = 53)
Grade 1	6 (40.0%)	9 (60 %)	15
Grade 2	16 (60%)	11 (40 %)	27
Grade 3	0 (0.0%)	11 (100 %)	11

Z value – 1.200; p-value = 0.233

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We have no potential conflict of interest to report

**#955 THE VALUE OF INTRAOPERATIVE SENTINEL LYMPH NODE ANALYSIS USING OSNA TECHNIQUE IN EC**

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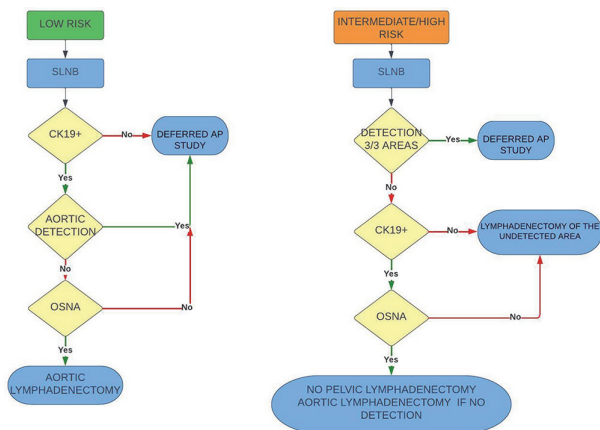
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**Introduction/Background** Sentinel Lymph Node Biopsy (SLNB) is effective for assessing lymph node status in endometrial cancer (EC). When sentinel lymph node (SLN) is not detected, lymphadenectomy is required to determine lymph node involvement. Intraoperative frozen section examination has low sensitivity, but the One Step Nucleic Acid Amplification (OSNA) technique offers a definitive diagnosis. Knowledge of the lymph node status of removed SLNs helps determine the need for lymphadenectomy in undetected areas, avoiding unnecessary surgery. Our objective is to present an algorithm minimizing lymphadenectomy in EC patients with undetected SLN.

**Methodology** We analysed 116 patients who underwent SLNB for EC between January 2021 and January 2023. We studied cases requiring OSNA based on detection rates, CK19 positivity and feasibility. Patients were stratified by preoperative risk profile, including molecular profile.

OSNA is performed in CK19(+) patients, influencing the decision to perform or omit lymphadenectomy. Omitting lymphadenectomy is justified when OSNA is positive, as it does not affect prognosis or treatment decision in undetected areas.

OSNA also aided in assessing aortic lymph node involvement in adjusting radiation fields for stage IIIC1 in the low-risk group.



Abstract #955 Figure 1

**Results** Out of 116 patients, 55 were low-risk and 59 high/intermediate risk preoperatively.

Among patients with high/intermediate risk, which represents the most relevant group, 9 lacked bilateral pelvic

lymphatic detection, so OSNA was performed. Additionally, 15 had aortic detection without pelvic detection.

Between low-risk patients, two had no pelvic detection, with one lacking aortic level detection and the other skipping aortic SLN search. Among the remaining 8 low-risk patients without bilateral pelvic detection, 6 had aortic detection, enabling selective OSNA.

Approximately 12.9% of the series could benefit from the lymph node status knowledge, with 56% eligible for intraoperative OSNA.

**Conclusion** Intraoperative OSNA reduces the need for lymphadenectomy in EC patients with undetected sentinel lymph nodes.

**Disclosures** No disclosures.

**#957 SENTINEL LYMPH NODE BIOPSY WITH CARBON DYE FOR ENDOMETRIAL CANCER STAGING: A SINGLE CENTER, PROSPECTIVE, COHORT STUDY**

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**Introduction/Background** Endometrial cancer is the 4th most common cancer in women. Systematic lymphadenectomy determines the disease stage and prognosis. Sentinel lymph node biopsy (SLNB) may be defined as a minimally invasive procedure compared to systematic lymphadenectomy. Many agents have been used for the detection of SLNB in endometrial cancer. Carbon dye, which has a powerful colored ability and high contrast due to its dark black color, makes the lymph nodes efficiently identified. This is the first study on the use of carbon dye during the SLNB procedure in endometrium cancer. Our aim was to evaluate the safety and efficacy of carbon dye in the detection of sentinel lymph nodes in endometrial cancer patients.

**Methodology** The present trial was designed as a single-center, prospective, cohort study. The data from 89 patients were collected for the present study between December 2021 – August 2022.

Abstract #957 Table 1 Sensitivity and specificity data of SLN8 with carbon dye

	True Positive Nodes	True negative Node
Positive Sentinel Lymph Nodes	5	0
Negative Sentinel Lymph Nodes	0*	83

\*one patient had para-aortic lymph node metastasis

**Results** Of the 89 patients, bilateral pelvic lymphadenectomy and para-aortic lymphadenectomy were performed in 89 (100%) and 36 (40.5%), respectively. Two hundred nine sentinel lymph nodes were harvested (104 from the right side, 105 from the left side), and five of the 89 patients had positive nodes. Of the five patients with positive sentinel lymph nodes, three had micrometastasis, and one had isolated tumor cells. The sensitivity of the SLNB with carbon dye in detecting nodal metastatic disease was 97.8%. However, one patient with negative SLNB had a positive para-aortic lymph node