Conclusion Low Grade Endometrial Sarcomas must be considered in young patients with abnormal uterine bleeding and including suspected fibroids. Although hysterectomy and salpingo-oophorectomy is the standard treatment, in young patients, fertility sparing approaches and preserving ovaries can be priority for their choice. We well inform them about these choices and observe in short intervals.

Disclosures endometrial stromal sarcoma, ovarian sparing, fertility sparing

Abstracts

#1059 RETROSPECTIVE ANALYSIS OF TREATMENT OUTCOMES FOLLOWING PRIMARY SURGICAL TREATMENT OF HIGH-RISK ENDOMETRIAL CANCER AT A SINGLE TERTIARY LEVEL CENTRE FROM 2013 TO 2016

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Introduction/Background Endometrial carcinoma is the most frequent gynaecological malignancy in the Western world, with around 100,000 cases in Europe each year. In recent years, a new molecular classification has divided endometrial carcinomas into four distinct subgroups with specific molecular characteristics. A fourth subgroup is a group of carcinomas with an aggressive growth pattern and poor outcomes. The most typical representative is serous endometrial carcinoma; others include clear cell carcinoma, uterine carcinosarcoma and high-grade endometrioid carcinoma.

Methodology A retrospective, observational study of a single tertiary-level centre between January 2013 and December 2015. Clinical data were gathered from the Division of Gynaecology and Obstetrics archive, University Medical Centre Ljubljana.

Results A total of 366 patients were surgically treated with histologically verified endometrial carcinoma. Out of those, 66 were treated for high-risk endometrial cancer; 27 with serous carcinoma, 22 with high-grade endometrioid carcinoma, 12 had carcinosarcomas, 3 had clear cell carcinomas, and two had dedifferentiated carcinomas. The surgical approach was divided between minimally invasive and open surgery; 35 cases were completed laparoscopically, 31 with open surgery, which included two conversions. There were ten cancer-related deaths in the laparoscopic arm and 17 in the open arm. There were no statistically significant differences between both arms. However, more advanced-stage disease (II-IVb) cases were in the open arm, 18 vs 15.

Conclusion ESGO/ESTRO/ESP guidelines for the management of patients with endometrial carcinoma recommend minimally invasive procedures in FIGO stages I and II. However, with a more extensive lymphadenectomy required in the high-risk group, an open technique still has its place. The surgical approach in stage III and IV disease must be decided with a goal of complete cytoreduction.

Disclosures No

#1065 PREDICTION NORMOGRAM OF AORTIC INVOLVEMENT IN ENDOMETRIAL CANCER

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Introduction/Background The current sentinel node algorithms in endometrial cancer (EC) do not include the need to perform a surgical study of the aortic area.

Although it is known that isolated aortic involvement is low, it is influenced by the risk of global lymph node metastasis in this cancer. However, in selected groups it represents approximately a 25%. Furthermore, more than half of the cases where pelvis is involved, aortic region is also affected.

The objective of this study is to create a prediction model for aortic involvement, based on preoperative risk factors.

Methodology 376 women who underwent surgery because of EC at the Donostia University Hospital (August 2014 - July 2022) were retrospectively identified.

The prediction model for aortic lymph node involvement was performed using logistic regression. Due to low the frequency of aortic lymph node involvement in EC, a reduced number of variables were specified to reduce the risk of overfitting and the prediction error, as well as their clinical applicability.

Results From 376 patients, metastatic involvement of the aortic SLN was detected in 25 of them (6.65%). The table shows the distribution of risk factors for dissemination between affected women and those who were not. In the univariate analysis, all potential predictors were more prevalent among women with aortic lymph node involvement, and were statistically significantly associated with it, except for non-endometrioid histology, with tumor extension beyond the uterine body being the factor with a greater association with the presence of positive aortic SLN. In the multivariate logistic regression model, this positive association was maintained, but with greater uncertainty, and the extension beyond the uterine body was the only one maintaining its statistical significance.

Conclusion This normogram is useful to calculate the risk of aortic lymph node involvement in EC and may be useful in making decisions about its approach.

Abstract #1065 Figure 1
Disclosures Nomogram for the prediction of aortic sentinel node involvement in women with endometrial cancer. Instructions: Locate the tumor grade determined by preoperative biopsy ‘Grade’ axis. Draw a straight line up to the ‘Points’ axis to determine how many points toward the probability of positive sentinel aortic nodes the patient receives for her tumor grade. Repeat the process for each variable. Sum the points obtained for each of the predictors. Locate the final sum on the ‘Total Score’ axis. Draw a straight line down to find the patient’s probability of having positive aortic nodes.

#1074

Lombo-Aortic Lymphadenectomy in Endometrial Cancer: Histological and Therapeutic Evaluation

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Introduction/Background Accurate staging is crucial in endometrial cancer management, particularly for lombo-aortic lymph node involvement. The therapeutic role of lombo-aortic lymphadenectomy remains controversial. This study evaluates its outcomes and current position in endometrial cancer treatment.

Methodology A retrospective study included 50 endometrial cancer patients who underwent surgery with complete pelvic and lombo-aortic lymphadenectomy at a Tunisian medical center.

Results Patients had a mean age of 54 years. All cases underwent complete pelvic and lombo-aortic lymphadenectomy, with average lymph node retrieval of 20.6 in the pelvic region and 21.93 in the lombo-aortic region. Lombo-aortic lymph node involvement was observed in 13 patients (26%), with an average of 8.12 involved nodes. Skip metastasis occurred in 4 patients with negative pelvic lymphadenectomy (8%). Various lymph node regions were affected, primarily inter-aortico-caval, peri-aortic, and peri-caval regions.

Histological type 2 showed higher lombo-aortic lymph node involvement (33.33%) compared to type 1 (22.22%). Lymph node involvement was more common in higher histological grades (2–3), with rates of 47.36% for grade 2–3 tumors and 18.18% for grade 1 tumors. Among patients with myometrial infiltration exceeding 50%, 4.4% had positive lombo-aortic lymphadenectomy, compared to 30% in tumors with infiltration below 50%. Lombo-aortic lymphadenectomy resulted in upstaging of three tumors from initial stages IB, II, and IIIA to stage IIIC, while three tumors initially classified as stage IIIC were downgraded.

Conclusion The role of lombo-aortic lymphadenectomy in endometrial cancer management is better understood. Clear indications exist for its use in most cases. Performing lombo-aortic lymphadenectomy requires technical mastery and quality control.

Disclosures The information presented in this study is based on retrospective data and should be interpreted with caution. The findings and conclusions are specific to the study population and may not be generalizable to all cases of endometrial cancer.

#1079

VALUE OF THE INTRAOPERATIVE STUDY OF THE SENTINEL NODE USING THE OSNA TECHNIQUE IN ENDOMETRIAL CANCER

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Introduction/Background The Sentinel Node technique allows knowing the lymph node status in the endometrial cancer (EC) and higher detection rates. However, in cases of non-detection, a lymphadenectomy is required to determine its lymph node status.

The intraoperative study by freezing has a low sensitivity (60%). However, the OSNA technique can be performed intraoperatively, constitutes a definitive diagnosis of lymph node status and has already been validated in Gynecology.

Our objective is to present an algorithm that makes it possible to minimize the need for lymphadenectomy in patients with nodal areas not detected on EC.

Methodology 116 patients with SLNB in EC have been retrospectively analyzed (from January 1, 2021 to January 31, 2023).

Patients are stratified according to preoperative risk, including the molecular profile of the tumor.

All patients undergoing surgery for EC require a prior biopsy that specifies the type and histological grade of the tumor, and molecular profile, including CK19.

Intraoperative study is performed only in those patients with CK19(+), 56% of the sample.

If the aortic or pelvic OSNA study were negative and there was no detection in an area, lymphadenectomy would be required in that area. Otherwise, if it were positive, its execution would be omitted.

Results In 9 high or intermediate risk patients there was no bilateral pelvic detection, and they underwent the OSNA IO technique.

8 low-risk patients without bilateral pelvic detection had aortic detection in 6 of them. OSNA technique could also be performed on them selectively.

12.9% of the series could benefit from knowing the lymph node status, of which the OSNA IO technique could be performed in 56%.

Conclusion Carrying out an intraoperative study of the sentinel node is interesting to minimize the number of lymphadenectomies to be performed in the EC.

Abstract #1079 Figure 1 Classic preoperative risk groups in endometrial cancer. If known molecular profile POLE(+) confined to the uterus, corresponds to low risk, p53abn would be intermediate risk if it does not infiltrate myometrial, and high risk if it infiltrates myometrium.

Disclosures OSNA technique can be performed intraoperatively in endometrial cancer.