around 3%. In our small series, the overall incidence of aberrant anatomy was 20%.

Conclusion The PLC’s treatment approach is not well established however surgical resection remains the standard-of-care. More studies are required for further understanding of its clinical behavior and optimal treatment guidelines.

Disclosures the authors have nothing to disclose.

#600 LAPAROSCOPIC RETROPERITONEAL PARA-AORTIC LYMPHADENECTOMY: POSTOPERATIVE AND SURVIVAL OUTCOMES OF THE FIRST GREEK CASE-SERIES STUDY

Introduction/Background Laparoscopic para-aortic lymphadenectomy is a procedure performed for staging purposes. Retroperitoneal approach is an alternative approach, potentially superior to intraperitoneal regarding bowel dysfunction and hemorrhage. Main purpose of the present study was to present the main intraoperative, postoperative and short-term survival outcomes of first relative cases treated with this approach in an ESGO-certified Gynecologic Oncology Center.

Methodology A prospective observational cohort was performed during 2020–2022. Epidemiological, histopathological characteristics and indications of the procedure were reviewed. Primary outcomes were intraoperative and postoperative complications, namely hemorrhage, vessel injury, need for transfusion, bowel injury, postoperative bowel dysfunction, perinephral hematoma, total hemoglobin drop, hospitalization duration. Short-term survival outcomes were also reviewed.

Results There were overall 8 cases in which laparoscopic retroperitoneal para-aortic lymphadenectomy was attempted. Median age was 52 years, median BMI 26.4. Indications were restaging for apparent early-stage ovarian cancer (n=3), surgical staging of high-risk apparent early-stage endometrial cancer (n=2), restaging for concomitant early-stage endometrial and ovarian cancer (n=1), staging for apparent advanced-stage cervical (n=1) and staging for potential lymph-node recurrence of previously treated vulvar cancer (n=1). All operations were performed by ESGO-certified gynecologic oncology physicians (S.P, N=6 and F.G, N=2). Method was abandoned in one case in which diagnostic laparoscopy for apparent early-stage serous endometrial cancer revealed diffuse omental metastasis and conversion was decided. Median surgical time was 135 minutes. Median number of resected nodes was 15. No major intraoperative and postoperative complication was observed. There was only 1 case of subcutaneous hematoma observed on 1st postoperative day, treated conservatively with compression. Median haemoglobin reduction was 2.3 gr/dl. Median hospitalization duration was 2 days. The total of patients remains free of recurrence and alive during follow-up period (5–29 months).

Abstract #590 Figure 1 Operative photographs and reconstructed CT images of aberrant anatomy

Disclosures NONE
Conclusion Laparoscopic retroperitoneal para-aortic lymphadenectomy is a safe and effective method, which is associated with low rates of intraoperative and postoperative complications along with favorable oncological outcomes.

Disclosures All Authors have nothing to disclose.

#615 TWO-STEP FRAILTY ASSESSMENT ALGORITHM LEADING TO A HIGH RATE OF STATE OF THE ART SURGERY IN WOMEN WITH GYNECOLOGICAL MALIGNANCIES – RESULTS OF AN INTERIM-ANALYSIS OF A PROSPECTIVE COHORT STUDY

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Introduction/Background The omission of state of the art (SOTA) surgery results in lower survival rates in the elderly. Here, we report an interim-analysis of a prospective observational cohort study on the impact of a preoperative, multidisciplinary, two-step frailty assessment in gynecological malignancies.

Methodology Women were included meeting one of the following criteria 1) age 60 years and older, 2) BMI>30kg/m² or 3) subjective frail impression. The screening step uses the G8-Score accompanied by the Lee-Index and various laboratory values. If the G8-Score was impaired, a complete geriatric assessment (CGA) was performed accompanied by the history of falls, MiniCoq, Barthel-Index and Geriatic Depression Scale. Here, we report an interim-analysis after a recruiting period of 33 months.

Results 133 women (median age 69.9 years) were included. 45 (33.6%) patients were affected by ovarian cancer, 40 (29.9%) by endometrial cancer, 28 (20.9%) by vulva cancer, 7 (5.2%) by cervical cancer and 13 (9.7%) by other malignancies. The first screening step identified 36 (27.1%) patients out of them 20 (15.0%) were regarded as frail by the CGA. 16 (12.0%) patients received an individualized operative strategy. Therefore, 117 patients (88.0%) underwent SOTA surgery. Impaired G8 score was associated with a higher rate of individualized operative surgery (24.2% vs. 8.5%), revision procedures (20.0% vs. 6.4%) and re-admission (20.0% vs. 4.0%) (all p-values <0.05). 21 (15.8%) recurrences and 11 (8.3%) deaths were recorded during the median follow-up time of 13.2 months.

Conclusion Our two-step frailty-assessment algorithm is feasible and identifies a substantial portion of patients who safely underwent SOTA surgery. Contrastingly, patients with an impaired G8 score were faced with an unfavorable perioperative outcome. Whether our two-step frailty-assessment algorithm stratifies patients in terms of prognosis will be addressed by this ongoing trial and should be answered with a larger number of events and an adequate follow-up time.

Disclosures The authors declare, that there do not exist any financial conflicts with the submitted abstract.

#657 GLOBAL SURVEY ON TRAINING IN SENTINEL LYMPH NODE MAPPING FOR ENDOMETRIAL AND CERVICAL CANCER

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Introduction/Background Sentinel lymph node mapping (SLN) for endometrial (EC) and cervical cancer (CC) is routinely performed worldwide. However, it has not yet been integrated into practice universally. Early career gynaecologic oncologists training practices in SLN mapping were assessed in a global survey.

Methodology An anonymous questionnaire containing 53 questions was distributed via email to the ESGO-ENYGO and IGCS member database. Respondents who were younger than 40 years of age (early career gynaecologic oncologists) were included in this descriptive analysis.

Results 238 respondents from 58 countries took part in the survey: 103 (43%) certified gynaecologic oncologists, 69 (29%) subspeciality trainees/fellows, 18 (8%) residents, while 48 (20%) did not mention their level of training. Responses was distributed via email to the ESGO-ENYGO and IGCS member database. Respondents who were younger than 40 years of age (early career gynaecologic oncologists) were included in this descriptive analysis.

Conclusion A total of 8–15% of respondents stated not to perform SLN procedure at their institution and 12% were not trained in any lymph node surgery. SLN mapping in EC was reported to be used more routinely than for CC.

Disclosures COI submitted where applicable.