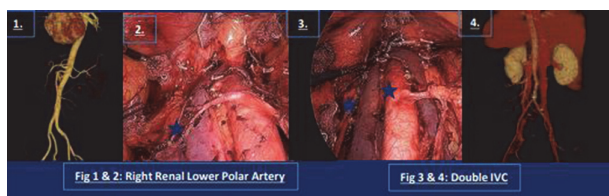


around 3%. In our small series, the overall incidence of aberrant anatomy was 20%.



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

**Disclosures** NONE

**#593 PLEOMORPHIC LOBULAR CARCINOMA OF THE BREAST : CLINICAL PRESENTATION AND THERAPEUTIC CHALLENGES**

<sup>1</sup>Ines Houissa\*, <sup>1</sup>Olfa Jaidane, <sup>2</sup>Yoldez Houcine, <sup>1</sup>Ameni Jellali, <sup>1</sup>Lamia Najja, <sup>2</sup>Nedia Ben Othman, <sup>2</sup>Salma Kamoun, <sup>2</sup>Yamina Chaabani, <sup>1</sup>Tarak Ben Dhieb, <sup>2</sup>Maha Driss. <sup>1</sup>Surgical oncology department salah azaiez institute, Tunis, Tunisia; <sup>2</sup>Pathology department Salah Azaiez Institute, Tunis, Tunisia

10.1136/ijgc-2023-ESGO.467

**Introduction/Background** Invasive pleomorphic lobular carcinoma (PLC) represents 15% of invasive lobular carcinoma (ILC) and is thought to be more aggressive with a worse prognosis.

**Methodology** We retrospectively reviewed the clinical records of 18 patients diagnosed with PLC in Salah Azaiez Institute (2006–2021)

**Results** All reported cases were females, with a median age of 59.5.

Median tumor size was 30mm. Four patients had multifocal lesions while only two presented with bilateral tumors.

Only 5 cases were classified as stage T3/4 tumors and two patients were metastatic at the time of diagnosis

65% of the patients had preoperative core needle biopsy yielding a diagnosis of PLC in only 6 cases (46.15%). Two patients did not undergo surgery owing to the advanced stage at presentation and chemotherapy was conducted instead.

Among patients for whom surgery was stated, 11 patients underwent total mastectomy (64.7%). Sentinel lymph node dissection was performed on exactly 4 patients. Lymph nodes were free of tumor in the majority of cases.

On pathological examination, LPC was associated with invasive ductal carcinoma in 9 cases.

Almost 90% of the cases were high-grade carcinomas with a lympho-vascular invasion present in 8 cases. The tumor cells were positive for hormone receptors in 90% of cases while HER2neu was negative in 94.44% of cases.

Data on adjuvant treatment was available on merely 12 patients. Concomitant radio-chemotherapy with endocrine therapy was indicated for 10 patients, while others received either exclusive radiotherapy or chemotherapy.

The median follow-up was 27 months. At that time, most of the patients were free of disease, while one patient developed ipsilateral relapse for which she underwent total mastectomy. Two patients died 04 months after the onset of the treatment.

**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**

<sup>1</sup>Stamatios Petousis\*, <sup>1</sup>Chrysoula Margioulou-Siarkou, <sup>1</sup>Georgia Margioulou-Siarkou, <sup>2</sup>Frederic Guyon, <sup>3</sup>Konstantina Mponiou, <sup>4</sup>Pavlos Papakotoulas, <sup>5</sup>Alexios Papanikolaou, <sup>5</sup>Konstantinos Dinas. <sup>1</sup>2nd Department of Obstetrics and Gynaecology, Aristotle University of Thessaloniki, Thessaloniki, Greece; <sup>2</sup>Institut Bergonie, Bordeaux, France; <sup>3</sup>Radiation Oncology Unit, Theagenio Anticancer Hospital, Thessaloniki, Greece; <sup>4</sup>Medical Oncology Unit, Theagenio Anticancer Hospital, Thessaloniki, Greece; <sup>5</sup>2nd Department of Obstetrics and Gynaecology, Aristotle University of Thessaloniki, Thessaloniki, Greece

10.1136/ijgc-2023-ESGO.468

**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 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).

**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

Katharina Anic, Valerie Catherine Linz, Mona Wanda Schmidt, Ina Shehaj, Maria Schröder, Philip Klecker, Dennis Jung, Slavomir Krajnak, Marcus Schmidt, Roxana Schwab, Annette Hasenburg, Marco Johannes Battista\*. *University Hospital Mainz, Mainz, Germany*

10.1136/ijgc-2023-ESGO.469

**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 praoperative, 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/m<sup>2</sup> 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 Geriatric 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

<sup>1</sup>Irina Tsubulak\*, <sup>2</sup>Anna Collins, <sup>3</sup>Heng-Cheng Hsu, <sup>4</sup>Enrique Chacon, <sup>5</sup>Nicolò Bizzarri, <sup>6</sup>Alex Mutombo Baleka, <sup>7</sup>Zoia Razumova, <sup>8</sup>Charalampos Theofanakis, <sup>9</sup>Joanna Kacperczyk-Bartnik, <sup>10</sup>Alexandra Natalia Strojna, <sup>11</sup>Andrei Pletnev, <sup>12</sup>Natalia R Gómez-Hidalgo, <sup>13</sup>Alexander Shushkevich, <sup>14</sup>Jaime Garcia, <sup>15</sup>Michael Frumovitz, <sup>16</sup>Pedro T Ramirez. <sup>1</sup>Department of Obstetrics and Gynaecology, Medical University of Innsbruck, Innsbruck, Austria; <sup>2</sup>University Hospitals of Leicester NHS Trust, Leicester, UK; <sup>3</sup>National Taiwan University Cancer Center, Taipei City, Taiwan; <sup>4</sup>Department of Obstetrics and Gynecology, Universidad de Navarra, Pamplona, Spain; <sup>5</sup>UOC Ginecologia Oncologica, Fondazione Policlinico Universitario A. Gemelli, IRCCS, Rome, Italy; <sup>6</sup>Kinshasa University Hospital, Kinshasa, Congo (DRC); <sup>7</sup>Department of Women's and Children's Health, Karolinska Institute, Stockholm, Sweden; <sup>8</sup>Department of Gynecological Oncology, General Hospital of Athens Alexandra, Athens, Greece; <sup>9</sup>II Department of Obstetrics and Gynaecology, Medical University of Warsaw, Warsaw, Poland; <sup>10</sup>Department of Gynecologic and Gynecologic Oncology, Evangelische Kliniken Essen Mitte, Essen, Germany; <sup>11</sup>Department of Obstetrics and Gynecology, University of Zielona Gora, Zielona Gora, Poland; <sup>12</sup>Department of Gynaecologic Oncology, Vall d'Hebron Hospital, Barcelona, Spain; <sup>13</sup>Department of Surgery, Institute of Biology and Medicine, Taras Shevchenko National University of Kyiv, Kyiv, Ukraine; <sup>14</sup>Department of Institutional Research, The University of Texas – MD Anderson Cancer Center, Houston, USA; <sup>15</sup>Department of Gynecologic Oncology and Reproductive Medicine, The University of Texas – MD Anderson Cancer Center, Houston, USA; <sup>16</sup>Department of Obstetrics and Gynecology, Houston Methodist Hospital, Houston, USA

10.1136/ijgc-2023-ESGO.470

**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%) subspecialty trainees/fellows, 18 (8%) residents, while 48 (20%) did not mention their level of training. Responses differed for EC and CC (p<0.001): 8% stated that no SLN for EC is performed at their institution, while for CC it was 15%. Only 32% (n=77) perform SLN mapping for all eligible cases in EC and 16% in CC (n=38). A SLN surgical algorithm was reported by 59% of respondents for EC and by 47% for CC. Fifty-five percent of respondents were initially trained in systematic lymph node dissection (LND), 33% in SLN mapping and 12% were not trained in either SLN mapping or systematic LND. When assessing which steps of SLN mapping are usually performed (136 responses): 89% (n=121) reported injecting the tracer, 90% (n=122) inspect the pelvic area, 85% (n=115) dissect anatomic landmarks and identify the SLN, and 83% (n=113) perform the dissection of the SLN. Poor access to training was the main challenge reported by 96% (n=229) and 84% (n=199) reported to be predominantly self-taught.

**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.