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 praeoperative, 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^2 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

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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 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.