

(Grade 1: n=33) and class 2 (Grade 2 and Grade 3: n=37) using texture analyses. The least absolute shrinkage and selection operator was used to select four TFs for each model and construct a discriminative model. A binary logistic regression analysis and receiver-operating characteristic analysis of the axial T2WI TFs, axial ADC TFs, sagittal T2WI TFs, and combined TFs models were performed to compare the two histological class.

Results Four models were constructed from each of the four selected features. The area under the curve (AUC) values of the discriminative model using these features were 0.71, 0.70, 0.77, and 0.82 for the sagittal T2WI TFs, axial T2WI TFs, axial ADC TFs, and combined TFs models, respectively. The AUC value of the combined TFs model was the highest.

Conclusion/Implications A combined TFs model may help distinguish UEC histological grades.

EP137/#905

COMBINED PELVIC AND PARA-AORTIC LYMPHADENECTOMY IS NOT ASSOCIATED WITH SURVIVAL BENEFIT IN EARLY-STAGE HIGH-GRADE ENDOMETRIAL ADENOCARCINOMA

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Introduction The therapeutic effect of para-aortic lymphadenectomy in early-stage high-grade endometrial cancer remains controversial. In this study, we investigated whether combined pelvic and para-aortic lymphadenectomy has a survival benefit compared to pelvic lymphadenectomy alone in patients with pathologically diagnosed FIGO stage I-II grade 3 endometrioid and non-endometrioid endometrial cancers.

Methods Weretrospectively reviewed the medical records of 281 patients with histologically confirmed FIGO stage I-II grade 3 endometrioid and non-endometrioid endometrial cancers who underwent pelvic lymphadenectomy alone or combined pelvic and para-aortic lymphadenectomy in staging surgery at two tertiary centers in Korea and Taiwan. Prognostic factors to predict outcomes in these cases were also analyzed.

Results Among 281 patients, 144 underwent pelvic lymphadenectomy alone and 137 underwent combined pelvic and para-aortic lymphadenectomy. Within a median follow-up of 45 months, there was no significant difference in recurrence-free survival (RFS) and overall survival (OS) between the two groups. In multivariable analysis, age at diagnosis ≥ 60 years (HR = 2.20, 95% CI 1.25–3.87, $p = 0.006$) and positive lymph-vascular space invasion (LVSI) (HR = 2.79, 95% CI 1.60–4.85, $p < 0.001$) were associated with worse RFS, and only non-endometrioid histology was associated with worse OS (HR=3.18, 95% CI 1.42–7.12, $p=0.005$). In further subgroup analysis, beneficial effects of combined pelvic and para-aortic lymphadenectomy on RFS and OS were not observed.

Conclusion/Implications In this study, combined pelvic and para-aortic lymphadenectomy could not improve survival compared to pelvic lymphadenectomy alone in patients with FIGO stage I-II grade 3 endometrioid and nonendometrioid endometrial cancers. Therefore, para-aortic lymphadenectomy may be omitted for these cases.

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PREDICTION OF FINAL PATHOLOGY DEPENDING ON PREOPERATIVE MYOMETRIAL INVASION AND GRADE ASSESSMENT IN LOW RISK ENDOMETRIAL CANCER PATIENTS: A KOREAN GYNECOLOGIC ONCOLOGY GROUP ANCILLARY STUDY

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Introduction Fertility-sparing treatment might be considered an option for reproductive women with low risk endometrial cancer (EC). However, in low risk EC patients, concordance rates between preoperative assessment and postoperative pathology are not high enough. We aimed to predict postoperative pathology depending on preoperative myometrial invasion (MI) and grade in low risk EC patients to help extend current criteria for fertility-sparing treatment.

Methods In Korean Gynecologic Oncology Group (KGOG) 2015, a prospective, multicenter study, 529 EC patients underwent preoperative assessment using MRI and endometrial biopsy followed by surgical staging. This ancillary study included patients who had no MI or MI $< 1/2$ on preoperative MRI and endometrioid adenocarcinoma and grade 1 or 2 on endometrial biopsy. Among eligible patients, Groups 1 - 4 were defined with no MI and grade 1, no MI and grade 2, MI $< 1/2$ and grade 1, and MI $< 1/2$ and grade 2, respectively. New prediction model using machine learning was developed.

Results Among 251 eligible patients, Groups 1 - 4 included 106 (42.2%) patients, 41 (16.3%), 74 (29.5%), and 30 (12.0%), respectively. Compared with conventional analysis, new prediction model showed somewhat better prediction values. In new prediction model, NPV, sensitivity, and AUC of preoperative each group to predict postoperative each group were 88.9%, 77.6%, and 0.714 for Group 1, 97.1%, 64.3%, and 0.676 for Group 2, 77.5%, 76.5%, and 0.641 for Group 3, and 92.4%, 64.9%, and 0.691% for Group 4.

Conclusion/Implications In low risk EC patients, prediction of postoperative pathology was ineffective enough. New prediction model might provide better prediction.