

could impact treatment choices. The aim of this study is to determine the accuracy of each method in diagnosing UCS.

Methods Pathology reports were acquired from the Dutch Nationwide Pathology Databank of patients diagnosed with UCS in pre- and/or postoperative histology between 2001 to 2021. Patients without available pre- or postoperative pathology reports were excluded. The postoperative histology was set as reference. A 2×2 table 1 was plotted to compute the sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) for each sampling method.

Results 1273 patients were included. Overall sensitivity and specificity of preoperative diagnostic sampling was 35.5% and 73.9% respectively. None of the methods were superior. The sensitivity for aspiration biopsy (n=714) was 30%, with a specificity of 82%, a PPV of 85%, and a NPV of 26%. Hysteroscopic biopsy (n=56) had a sensitivity of 30% and a specificity of 79%, while the sensitivity of dilatation and curettage (n=111) was 38% and specificity 67%. The PPV of hysteroscopic biopsy and dilatation and curettage were 73% and 78%, and the NPV of these sampling methods were 37% and 26% respectively.

Conclusion/Implications Preoperative sampling methods have a low accuracy in diagnosing UCS, irrespective of the sampling technique. This highlights the need for novel preoperative diagnostic or pathologic assessment, i.e. via p53 immunohistochemistry or hypermethylation profiles.

PR042/#442

SURVIVAL BENEFIT OF CYTOREDUCTIVE SURGERY IN PATIENTS WITH PRIMARY STAGE IV ENDOMETRIAL CANCER: A SYSTEMATIC REVIEW & META-ANALYSIS

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Introduction The role of cytoreductive surgery (CRS) in primary stage IV endometrial cancer (EC) remains debatable due

to lack of evidence from large studies and heterogeneity of stage IV EC. To address this, we conducted a systematic review and meta-analysis to investigate the survival benefit of CRS in patients with primary stage IV EC.

Methods Five medical literature databases were systematically searched for original studies reporting survival data on primary stage IV EC by outcome of CRS (complete, optimal, or incomplete resection). Pooled hazard ratio's (HR) were calculated using a random-effects model.

Results Twelve studies, including 733 patients, were analysed. Of them, 187 (26%) had complete CRS and 146 patients (20%) optimal CRS. In five studies, including 79 patients (11%), complete and optimal CRS were combined. Ten studies reported a significant overall survival (OS) benefit after complete (18–48 months), and optimal CRS (13–34 months) compared to incomplete CRS (7–19 months). In patients with serous EC or extra-abdominal metastasis, a benefit of complete/optimal CRS was also observed. The pooled data showed improved OS from complete/optimal vs. incomplete CRS (HR=0.38, 95% CI 0.21–0.69, p=0.0016) (figure 1). Heterogeneity between studies was substantial.

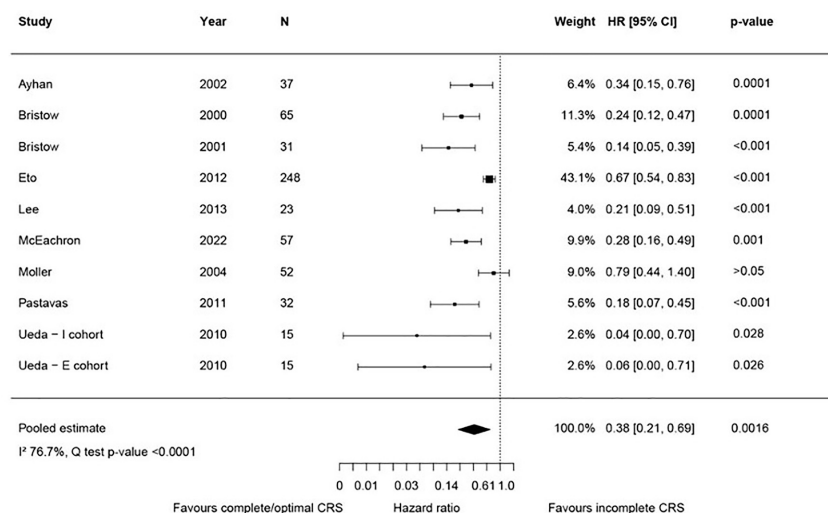
Conclusion/Implications This study indicates an OS benefit of complete/optimal CRS for patients with primary stage IV EC, including patients with serous EC or extra-abdominal metastasis. A superior survival benefit was seen after complete CRS compared to optimal CRS. Despite the considerable heterogeneity between studies, our findings suggest that CRS should be considered in the treatment of patients with primary stage IV EC.

PR043/#416

RESTAGING UTERINE CANCER PATIENTS WITH THE 2023 FIGO GUIDELINES: CLINICAL CHARACTERISTICS AND SURVIVAL DIFFERENCES

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Abstract PR042/#442 Figure 1 Forest plot of the meta-analysis comparing complete and optimal CRS vs incomplete CRS The p-value are the values mentioned by the authors