

Conclusion Our cost-effective prediction model may help gynecological oncologists to guide clinical personalized treatment plan regarding the need of lymphadenectomy. Further confirmatory studies are still required to validate our findings.
Disclosures We report for the first time that a new scoring method for ER/PR status in preoperative curettage in addition to CA125 level may improve the identification of low- and high-risk EC patients for LNM.

#158

CLINICAL PITFALLS IN SETTING UP A 'ENDOMETRIAL CANCER SENTINEL LYMPH NODE MAPPING' SURGICAL PROTOCOL

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Introduction/Background Sentinel lymph node (SLN) mapping with indocyanine green (ICG) with Mini-Invasive surgery (MIS) is becoming the standard technique in the treatment of early-stage endometrial cancer (ESEC). The setting up of a standardized surgical and pathology protocol to acquire proficiency is crucial to optimize the SLN detection rate. We sought to describe the first 18 months' results of such implementation in a large metropolitan hospital in Milan.

Methodology All patients diagnosed with ESEC, treated with MIS as primary surgery, and undergoing ICG injection to detect SLN, between 09/2021–03/2022, were included. Ultra staging technique for nodal analysis has been adopted. We assessed variables affecting successful and unsuccessful mapping.

Results Of 46 included patients 80.4% had successful SLN mapping, with 54.3% bilateral and 26.1% monolateral detection. The overall rate of positive SLN was 6.5%, with 2 macro metastasis and 1 isolated tumor cells. Sites of SLN mapping were external iliac (64.4%), obturator fossa (20.3%), common iliac (10.2%). Considering three semesters time-frame, successful mapping progressively increased with (9/12)75.0%, (13/17)76.5%, (15/17)88.2% in the 1st, 2nd and 3rd semester, respectively. SLN empty nodes rates were 16%, 6%, 5% respectively. To gain such proficiency, we progressively adopted a composite standardized protocol including: injection-to-mapping time extension (8.3%, 20.0%, 29.4% respectively), cervical reinjection (0, 1, 1 case respectively), SLN frozen section in not obvious nodal tissue (0, 1, 4 cases respectively). Comparing successful and unsuccessful mapping cases, patients' and tumor features did not significantly differ between the groups in the three time-frames.

Conclusion Patients and tumor features did not affect the successful migration rate in ESEC SLN mapping in this initial period. On the other hand, a satisfactory rate of successful migration was reached after acquiring an adequate technical skill armamentarium, with a learning curve of about 30 cases.

Disclosures no disclosures reported

#169

COMPLICATIONS AFTER LAPAROSCOPIC SYSTEMATIC LYMPHADENECTOMY VERSUS SENTINEL LYMPH NODE BIOPSY IN EARLY ENDOMETRIAL AND CERVICAL CANCER

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Introduction/Background Lymph node status is one of the main prognostic factor that play an important role in the postoperative treatment strategy.

The goal of the study was to compare the rate of complications after laparoscopic systematic lymphadenectomy versus sentinel node biopsy in early endometrial and cervical cancer.

Methodology The retrospective study during 2018–2022 years included 96 patients with early endometrial cancer (FIGO stage IB-IIA, G2–3 endometrioid adenocarcinoma) and early cervical cancer (FIGO stage IB-IIA, without parametrial invasion). In 89 from 96 patients (92,7%) detected comorbid diseases (hypertension, obesity, diabetes mellitus etc). All patients underwent total laparoscopic hysterectomy (TLH) with pelvic lymph node dissection as a part of surgical staging and divided into two homogenous groups. The first group consisted of 40 patients who underwent systematic pelvic lymphadenectomy (PLE), the second group included 56 patients who underwent indocyanine green (ICG) marked sentinel lymph node (SLN) sampling.

Results Ultrasound scalpel was used for lymphadenectomy in both groups. The lymph nodes involvement were detected in 3 (7,5%) cases in the first group and no metastases were detected in the second group. Operation time in the first group was significantly longer on 35,4 min than in second group (115,8+11,5 min and 80,4+9,2 min, respectively). In the first group there were postoperative complications: obturator nerve damage in 1 patient (2,5%), that was diagnosed and reconstructed intraoperatively, lymphocele - in 2 cases (5%), prolonged lymphedema - in 3 patients (7,5%), urogenital fistula- in 1 patient who received preoperative radiotherapy. No complications there were in the second group. In both group there were no bleeding and intraoperative pelvic organ damages.

Conclusion The use of laparoscopic ICG marked SLN sampling for early endometrial and cervical cancer is less traumatic, reduces the rate of intra- and postoperative complications, shortens the time of surgery and can also be proposed for high risk patients.

Disclosures no

#171

LONG-TERM OUTCOMES OF DIFFERENT STRATEGIES TO KNOW THE LYMPH NODE STATUS IN PATIENTS WITH INTERMEDIATE, INTERMEDIATE-HIGH AND HIGH-RISK ENDOMETRIAL CANCER IN EARLY STAGES

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