| M1.3 | **Multidisciplinary Management of Aortic Nodal Metastasis in Endometrial Cancer** | 10:45 Room 221 |

Role of Pathologist in Lymph Node Assessment for Patients with Endometrial Cancer

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In Hong Kong, endometrial cancer is currently the most commonly diagnosed gynaecological cancer and its incidence is rising. Presence or absence of lymph node metastasis is one of the most important prognostic factors in endometrial cancer. Surgical staging with lymphadenectomy facilitates the decision on adjuvant therapy but morbidity exists. Sentinel lymph node (SLN) biopsy refers to the selective removal of the first lymph node or group of nodes draining a cancer. SLN can be identified by injection of tracer dye into or close to the primary tumour. Intraoperative evaluation (frozen section) of SLN or non-SLN is practised although limitation exists. Identification of the metastasis at SLN indicates the need for full lymphadenectomy. This targeted sampling approach allows more thorough pathologic examination (ultrastaging) that can reduce the morbidity due to complete lymphadenectomy. SLN biopsy is widely applied in patients with breast cancer and melanoma, and SLN mapping has been proposed to be applied for staging patients with endometrial cancer particularly the low risk group with minimal myometrial invasion or low-grade histotype. There is a variation in the methodology of how SLN or non-SLN should be examined by pathologists, i.e. the number and intervals of haematoxylin and eosin stained deeper sections and the use of cytokeratin immunohistochemistry to detect low volume metastasis. An optimal approach should be established to provide efficient utilisation of resources in pathology service while ensuring a high standard of sensitivity and specificity for patient management. The significance of low volume metastases (micrometastasis, and isolated tumour cells) versus macrometastases in SLN and non-SLN is also an area of attention.