physiologically achievable concentration (maximum plasma concentration (Cmax) value).

Results Sequencing revealed amplifications of ERBB2 (17q12), RAF1, c-myc, and ERBB3 (12q13.2) low-level gain. Inhibition of viability was moderate by single agents: Afatinib, binimetanib, JQ1, as shown by inhibitory effect values of 14.4%,47.8%, 8.8%, respectively at physiologically achievable concentrations (Cmax) of afatinib. Combinations demonstrated increasing inhibitory effect values: 99.7% for Afatinib+ binimetanib, and 99.5% for Afatinib+JQ1. Synergy was evidenced for both combinations by a combination index <1 (figure 1).

Conclusions Combined inhibition of pan-ERBB with inhibition of MEK or BET proteins synergistically suppress viability in patient-derived serous EC harboring ERBB amplifications.

EPV106/#249 ENDOMETRIAL CANCER IMMUNOHISTOCHEMICAL RISK STRATIFICATION IN A LARGE UTERINE-CONFINED CANCER SERIES

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Objectives The aim of this study is to assess the clinical reproducibility and the oncological validity of the Endometrial cancer (EC) risk stratification based on the molecular information given by the immunohistochemistry (IHC).

Methods Retrospective IHC analyses were conducted in a large series of 778 pre-operative uterine-confined ECs, studying the presence/absence of MLH1, MSH2, MSH6, to define the mismatch repair (MMR) stable or instable phenotype; the presence of p53 mutations and other molecular features. The molecular profile was correlated with histological, clinical and prognostic EC patients' data.

Results Based on the IHC, we defined 3 EC populations: MMR stable (MMRs), instable (MMRi) and p53 mutated (p53+) patients. Our result demonstrated that the IHC stratification statistically correlated with the most relevant anatomo-clinical features: FIGO stage (p<0.001), grading (12,5% G3 in MMRs vs 22.9% in MMRi vs 95.3% in p53+, p<0.001), histotype (Type II 6.2% in MMRs vs 5.3% in MMRi vs 87.5% in p53+, p<0.001), presence of LVSI (positive in 16.3% in MMRs vs 23.8% in MMRi vs 38.7% in p53+, p<0.001), myometrial invasion and tumor dimension (p=0.003 and p<0.001 respectively). Again, the 3 IHC populations statistically reflected the EC risk class ESGO-ESMO-ESP classification 2020 (p<0.001). These results were confirmed also in Kaplan-Meier curves in terms of over-all survival (OS) and disease-free survival (DFS) (p<0.001) (figure 1).

Conclusions In this large series, we demonstrated that the pragmatic and systematic use of IHC may have an important role to properly stratify, in terms of histological features and clinical outcome, the uterine-confined EC patients.

EPV107/#258 ENGOT-EN11/GOG-3053/KEYNOTE-B21: PHASE 3 STUDY OF PEMBROLIZUMAB OR PLACEBO IN COMBINATION WITH ADJUVANT CHEMOTHERAPY WITH/WITHOUT RADIOTHERAPY IN PATIENTS WITH NEWLY DIAGNOSED HIGH-RISK ENDOMETRIAL CANCER

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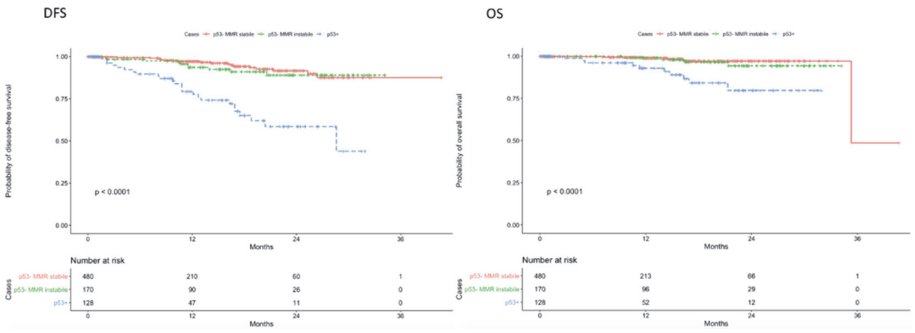
Objectives Pembrolizumab, an anti–PD-1 antibody, has demonstrated activity as monotherapy and in combination with lenvatinib in patients with previously treated mismatch repair (MMR) deficient and MMR proficient endometrial cancer (EC). ENGOT-en11/GOG-3053/KEYNOTE-B21 (NCT04634877) is a phase 3, randomized, double-blind study of pembrolizumab or



Abstract EPV106/#249 Figure 1

placebo in combination with adjuvant chemotherapy with/without radiotherapy in patients with EC.

Methods Eligible patients are ≥18 years with newly diagnosed high-risk (stage I/II non-endometrioid or with p53 abnormality and any histology, stage III/IVa), previously untreated EC following surgery with curative intent with no evidence of disease post-operatively. 990 patients will be randomized to receive pembrolizumab 200 mg or placebo Q3W for 6 cycles plus chemotherapy (carboplatin area under the curve [AUC] 5/6 plus paclitaxel 175 mg/m^2 Q3W or carboplatin AUC 2/2.7 plus paclitaxel 60 mg/m^2 QW) in stage 1. Patients receive pembrolizumab 400 mg or placebo Q6W for 6 cycles in stage 2. Radiotherapy (external beam radiotherapy [EBRT] and/or brachytherapy) ± radiosensitizing cisplatin 50 mg/m^2 (days 1 and 29) may be administered after completion of chemotherapy. Randomization is stratified by MMR status (pMMR vs dMMR) and, within pMMR, by planned radiation therapy (cisplatin-EBRT vs EBRT vs no EBRT), histology (endometrioid vs non-endometrioid), and FIGO surgical stage (I/II vs III/IVA). Dual primary endpoints are disease-free survival (DFS; per investigator assessment) and OS. Secondary endpoints include DFS (per BICR), DFS (per investigator assessment) and OS by biomarker status (PD-L1 and tumor mutational burden), safety, and QoL. Enrollment began December 2020 and is ongoing in 28 countries.

Results Not applicable

Conclusions Not applicable

EPV108/#267 PITFALLS IN PRE-OPERATIVE PREDICTION OF LYMPH NODE METASTASIS IN EARLY ENDOMETRIAL CANCER

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Objectives The role of lymphadenectomy in early-stage endometrial cancer is controversial as it is associated with intraoperative complications, and its therapeutic benefit is not established. Prediction of lymph nodal metastasis to perform selective lymph node dissection is desirable. This study was conducted to study the grade of the tumor obtained by endometrial biopsy specimen and depth of myometrial invasion assessed by imaging pre-operatively as predictors of lymph nodal metastasis in early endometrial cancers.

Methods This was a cross-sectional study where we studied 100 patients from August 2016 to May 2018. After Ethical Committee clearance, all patients diagnosed with early endometrial cancer in our hospital were included in the study after getting informed consent. Pre-operative tumor grade and depth of myometrial invasion were studied as predictors of lymph nodal metastasis.

Results The incidence of positive lymph node metastasis in our study was 18.6%. Both pre-operative tumor grade and depth of myometrial invasion were not significantly associated with lymph node metastasis. There was significant variation between pre-operative and post-operative tumor grade and depth of myometrial invasion. Among postoperative histopathological factors, only lymphovascular space invasion was significantly associated with lymph node metastasis.

Conclusions In our study, neither pre-operative nor postoperative grade of the tumor and depth of myometrial invasion were significantly associated with lymph node metastasis. There was considerable variation between pre-op and post-op grades of the tumor, making pre-op grade an unreliable factor in predicting lymph node metastasis in endometrial cancer. Among postoperative histopathological factors, only lymphovascular space invasion was significantly associated with lymph node metastasis.

Abstract EPV109/#274 Table 1

	All patients n= (%)	Recurrence n= (%)	*P* value
Sum ?=	968	68	0,000014
Average age patients	57,98	59,6	0,219965
Type of surgery:			
-type A			
-type B	391 (40,39)	25(36,76)	
-type C	87(8,99)	23(33,82)	
	8(0,83)	20(29,41)	
Substage:			0,000022
-1A			
-1B	266(27,48)	22(32,35)	
-1C	510(52,69)	34(50)	
	93(9,61)	12(17,65)	
Degree of differentiation:			0,027500
-G1	232(23,97)	26(38,24)	
-G2	595(61,47)	29(42,64)	
-G3	141(14,57)	13(19,12)	
Type of treatment:			0,00013
Surgical treatment	630(65,08)	21(30,89)	
Surgical + Radiation therapy	127(13,12)	4(5,88)	
Surgical + Chemotherapy	166(17,15)	30(44,12)	
Surgical + Radiation Therapy + Chemotherapy	45(4,65)	13(19,12)	

Notes: At p <0.05 to compare the correlation between treatment, age of patients, stage Ia, Ib, Ic, tumor differentiation.

EPV109/#274 ANALYSIS OF THE FREQUENCY OF ENDOMETRIAL CANCER STAGE I

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Objectives In 2020, according to the National Cancer Registry, endometrial cancer in the structure of cancer took second place (10.9%) after breast cancer. Although the detection and treatment of the disease in the early stages has good prospects, but there are relapses from 2% to 26%, according to various literature.

Methods The analysis of recurrence rate among 968 patients with endometrial cancer and stages of endometrioid type. Recurrences amounted to 68 cases (7.02%). The staging took place according to the 1988 FIGO classification. The following statistical methods were used: standard descriptive, parametric and nonparametric. Differences at p <0.05 were considered significant.

Results The analysis was performed depending on the characteristics of the tumor process and the type of treatment, the recurrence rate was estimated - see table 1. The average age of patients ranged from 25 to 85 years. The recurrence time was detected, on average, after 36 months ± 15.97 months. In combination treatment, receiving adjuvant radiation therapy, recurrences were most often detected - after 6–18 months ± 13.53 months. Long-term recurrences were detected after a combination of surgical treatment with chemotherapy at 32–