between 01/01/2011 and 30/06/2019, and 1 documented platinum-based treatment. Start of a subsequent line of treatment (LOT) after platinum was defined as the add-on of a substance or the switch to a new substance ≥3 months after regimen start. Any treatment after a gap of >3 months was also considered a new LOT. Postplatinum therapy initiation (index) was defined as the date of the first claim for an EC drug after the end of prior platinum-based therapy.

Result(s)* We identified 6832 patients with EC diagnosis. Of these, 716 received a platinum-based treatment, with 201 receiving ≥1 postplatinum treatment. Median age was 71 years (35–86 years). Median (postindex) survival was 335.00 days (95% CI, 276.29–393.71 days; figure 1). Overall, 39.3% of patients received >1 LOT, 10.4% received >2 LOTs, and 2.0% received >3 LOTs after their first platinum-based treatment. The most frequent postplatinum regimen was chemotherapy with 2 agents (10.0%; table 1). Other frequently used regimens were medroxyprogesterone (8.0%), doxorubicin (7.0%), carboplatin with paclitaxel (5.5%), and paclitaxel monotherapy (4.0%).

Conclusion* This claims database analysis demonstrates that treatment options are highly varied, indicating no standard of care. In this treatment landscape, survival of patients with recurrent EC remains poor.

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80 CONCORDANCE BETWEEN PREOPERATIVE ESMO-ESGO-ESTRO RISK CLASSIFICATION AND FINAL HISTOLOGY IN EARLY-STAGE ENDOMETRIAL CANCER

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Introduction/Background* The aim was to evaluate the concordance between preoperative ESMO-ESGO-ESTRO risk classification in early-stage endometrial cancer (EC) assessed by endometrial biopsy and magnetic resonance imaging (MRI) with this classification based on histology of surgical specimen.

Methodology This bicentric retrospective study included women diagnosed with early-stage EC (≤ stage II) who had a complete preoperative assessment and underwent a surgical management from January 2011 to December 2018. Patients were preoperatively classified into three degrees of risk of lymph node (LN) involvement based on endometrial biopsy and MRI. Based on final histological report, patients were re-classified using the preoperative classification. Concordance between the preoperative assessment and definitive histology was calculated with Cohen's weighed kappa coefficient.

Result(s)* A total of 333 women were included and kappa coefficient of preoperative risk classification was 0.49. The risk was underestimated and overestimated in 37% and 10% of cases, respectively. Twenty-nine percent of patients had an incomplete LN staging according to the degree of risk of the re-classification. The observed discordance in the risk classification was attributed to MRI in 75% of cases, to the biopsy in 18% and in 7% to both (p <0.001). Kappa coefficient for concordance was 0.25 for MRI and 0.73 for endometrial biopsy.

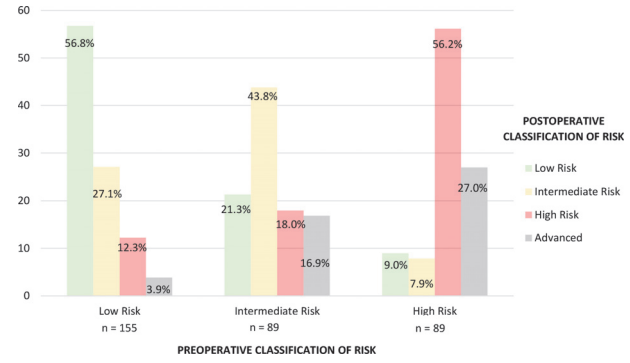
Conclusion* Concordance between preoperative ESMO-ESGO-ESTRO risk classification and final histology is weak. Given that the risk was underestimated in the majority of patients

Abstract 80 Table 1 Accuracy analyses of preoperative classification, endometrial biopsy and magnetic resonance imaging

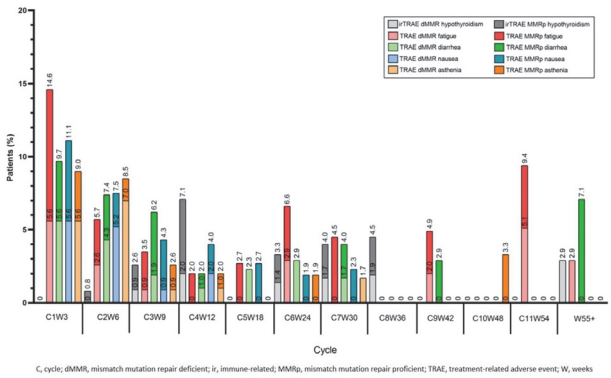
Sensivity% [95% CI]	Specificity% [95% CI]	PPV% [95% CI]	NPV% [95% CI]	Efficiency% [95% CI]	n
PREOPERATIVE CLASSIFCATION					
≥ High Risk	56.9 [48.3-65.1]	92.6 [88.2-95.5]	83.1 [74.0-89.5]	77.0 [71.4-81.9]	78.7 [74.0-82.7]	333
≥ Intermediate Risk	69.3 [62.9-75.0]	76.5 [68.0-83.3]	84.8 [78.8-89.4]	56.8 [48.9-64.3]	71.8 [66.7-76.3]	333
BIOPSY						
G3*	67.6 [51.5-80.4]	98.5 [95.8-99.5]	89.3 [72.8-96.3]	94.4 [90.5-96.8]	93.8 [90.1-96.2]	243
Type 2	72.5 [61.9-81.1]	96.0 [92.9-97.8]	85.3 [75.0-91.8]	91.7 [87.8-94.5]	90.4 [86.7-93.1]	333
G3 and Type 2	76.9 [68.6-83.5]	95.8 [92.1-97.8]	91.2 [84.1-95.3]	87.9 [83.0-91.5]	88.9 [85.1-91.8]	333
Internal biopsy						
G3*	72.0 [52.4-85.7]	98.2 [93.7-99.5]	90.0 [69.9-97.2]	94.0 [88.2-97.1]	93.4 [88.0-96.5]	137
Type 2	76.0 [62.6-85.7]	94.5 [89.5-97.2]	82.6 [69.3-90.3]	91.9 [86.5-95.3]	89.7 [84.7-93.3]	195
G3 and Type 2	77.2 [66.8-85.1]	94.8 [89.2-97.6]	91.0 [81.8-95.8]	85.9 [78.9-90.9]	87.7 [82.3-91.6]	195
External biopsy						
G3*	58.3 [32.0-80.7]	98.9 [94.2-99.8]	87.5 [52.9-97.8]	94.9 [88.6-97.8]	94.3 [88.2-97.4]	106
Type 2	66.7 [48.8-80.8]	98.1 [93.5-99.5]	90.9 [72.2-97.5]	91.4 [84.9-95.3]	91.3 [85.4-95.0]	138
G3 and Type 2	76.2 [61.5-86.5]	96.9 [91.2-98.9]	91.4 [77.6-97.0]	90.3 [83.0-97.0]	90.6 [84.5-94.4]	138
MRI						
≥IB Stage FIGO	53.2 [45.7-60.5]	84.0 [77.5-88.8]	77.8 [69.4-84.4]	63.0 [56.3-69.1]	68.2 [63.0-72.9]	333

95% CI: 95% confidence interval; PPV: positive predictive value; NPV: negative predictive value; G3: endometrioid grade 3 adenocarcinoma; MRI: magnetic resonance imaging; and FIGO: international federation of gynecology and obstetrics

*Accuracy of grade 3 endometrioid subtype was evaluated in patients with an endometrioid subtype in preoperative biopsy and in final histological evaluation



Abstract 80 Figure 1 Concordance between preoperative risk classification assessed by endometrial biopsy and magnetic resonance imaging with the final histological analysis of the surgical specimen



Abstract 83 Figure 1 Incidence of the most common irTRAEs and TRAEs in patients with dMMR and MMRp EC by cycle

wrongly classified, sentinel LN procedure instead of no LN dissection could be an option offered to preoperative low risk patients to decrease the indication of second surgery for re-staging and/or to avoid toxicity of adjuvant radiotherapy.

83 TIME COURSE OF ADVERSE EVENTS DURING DOSTARLIMAB TREATMENT IN PATIENTS WITH RECURRENT OR ADVANCED ENDOMETRIAL CANCER IN THE GARNET TRIAL

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Introduction/Background* Dostarlimab is a humanized programmed death-1 (PD-1) receptor monoclonal antibody that blocks interaction with the PD-1 ligands. GARNET (NCT02715284) is a phase 1 study assessing antitumor activity and safety of dostarlimab monotherapy in patients with solid tumors. Dostarlimab has shown antitumor activity in patients with mismatch repair deficient (dMMR) and mismatch repair proficient (MMRp) advanced and recurrent endometrial cancer (EC). Here we report on the time of onset of treatment-related adverse events (TRAEs) and immune-related (ir) TRAEs over the course of dostarlimab treatment in patients with dMMR (cohort A1) and MMRp (cohort A2) EC in the GARNET trial.

Methodology Patients with advanced or recurrent dMMR or MMRp EC that progressed on or after a platinum regimen received 500 mg of dostarlimab every 3 weeks for 4 cycles, then 1000 mg every 6 weeks (Q6W) until disease progression or discontinuation.

Result(s)* A total of 126 patients with dMMR EC and 145 patients with MMRp EC were included in the safety population. Few TRAEs were seen in ≥10% of patients: fatigue (17.3%), diarrhea (14.4%), nausea (13.7%), and asthenia (11.1%). The majority of cases occurred during cycles 1–3, with a peak occurrence at cycle 1 for all 4 TRAEs. Hypothyroidism was the only irTRAE seen in ≥5% of patients, and 94% of cases occurred between cycles 2 and 8, with a peak occurrence seen at cycle 4. irTRAEs that were seen in ≥1% of patients included diarrhea (4.1%), amylase increased (2.2%), aspartate aminotransferase increased (2.2%), alanine aminotransferase increased (1.8%), colitis (1.5%), hyperglycemia (1.5%), lipase increased (1.5%), adrenal insufficiency (1.1%), and hyperthyroidism (1.1%).

Conclusion* When analyzed over the dMMR and MMRp EC safety population of the GARNET trial, dostarlimab has an acceptable safety profile with manageable adverse events. irTRAEs and TRAEs were seen in a low percentage of patients and were seen more frequently earlier in the time course of dostarlimab treatment. No increase in the rate of TRAEs or irTRAEs was seen when changing to the 1000-mg Q6W dose.

C, cycle; dMMR, mismatch mutation repair deficient; ir, immune-related; MMRp, mismatch mutation repair proficient; TRAE, treatment-related adverse event; W, weeks

86 ENDOMETRIAL CANCER IMMUNOHISTOCHEMICAL RISK STRATIFICATION IN A LARGE UTERINE-CONFINED CANCER SERIES

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Introduction/Background* Nowadays, after the recent insights about the molecular Endometrial cancer (EC) classification, the usual key histological parameters (i.e histotype and grade) have been shown to have poor reproducibility and adequacy in EC stratification risk. The need to define a more precise guidance of surgical and adjuvant approaches has suggested the possibility to refine the prognostic assessing, considering other EC characteristics. Inspired by these concepts, the aim of this study is to assess the clinical reproducibility and the oncological validity of the EC risk stratification based on the molecular information given by the immunohistochemistry (IHC).

Methodology 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