Results A total of 155 patients were evaluable; 41.9% carcinosarcoma, 36.8% serous, 17.4% G3 and 3.9% CC; 67.1% received chemoradiation, 25.8% received chemotherapy-alone and 7.1% received RT-alone. Adjuvant therapy regimens were well-balanced between different histologies (p=0.351). There was no difference in the frequency of treatment delays between regimens (p=0.571). G3 tumors occurred less frequently (66.7%) versus serous (80.7%), CC (83.3%) and carcinosarcoma (84.6%) (p=0.269). Abdominal recurrence occurred most often in CC and serous. Carcinosarcoma was most likely to recur in the lung. There was a trend towards greater retroperitoneal recurrence with chemoradiation-alone (25.9%) versus chemotherapy (8.4%) and RT-alone (7.7%) (p=0.252). G3 tumors demonstrated improved PFS and OS (26 and 42-months, respectively) versus serous (17 and 30-months, respectively), carcinosarcoma (14 and 24-months, respectively) and CC (24 and 30-months respectively) (p=0.002, p<0.001). Chemoradiation was superior to chemotherapy-alone and RT-alone in PFS (p<0.001) and OS (p<0.001).

Conclusion The majority of stage IIIC HGEC recurs. Chemoradiation was associated with improved survival and less retroperitoneal recurrence versus chemotherapy-alone. G3 tumors demonstrated improved survival compared other histologies regardless of adjuvant treatment modality.

Study Methods This was a retrospective cohort study, which included patients diagnosed with non-endometrioid high-risk endometrial cancer (serous, carcinosarcoma, clear cell, and undifferentiated) between 2003 and 2017. A cut point of January 2014 was chosen to allow 6 months for knowledge translation and define 2 regionalization periods.

Results We identified 3518 patients with high risk endometrial cancer. Patients who had surgery with a GO had a median surgical wait time from diagnosis to hysterectomy of 55 days compared to 59 days pre-regionalization (p=0.0002), and from first GO consultation to hysterectomy of 29 days compared to 32 days pre-regionalization (p=0.0006). Survival was worst for patients who had surgery within 14 days of diagnosis (HR death 1.94, 95%CI 1.48–2.54), indicating disease severity. Decreased survival occurred with surgical wait times of more than 45 days from the patient’s first GO appointment (HR death 1.19, 95%CI 1.04–1.36).

Conclusion Regionalization of surgery for high risk endometrial cancer has not had a negative impact on surgical wait times. Impact on survival is seen with patients who have surgery more than 45 days after surgical consultation.

Abstract 263 Table 1 Concordance of mismatch repair (MMR) immunohistochemistry (IHC) and microsatellite instability (MSI) results between ovary and endometrium for five cases with Lynch syndrome

<table>
<thead>
<tr>
<th>Case</th>
<th>Germline Mutation</th>
<th>MMR IHC in Ovary</th>
<th>MMR IHC in Endometrium</th>
<th>MSI in Ovary</th>
<th>MSI in Endometrium</th>
<th>MMR IHC Concordance between Ovary and Endometrium</th>
<th>MSI Concordance between Ovary and Endometrium</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MSH6</td>
<td>MSH6 deficient</td>
<td>MSH6 deficient</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>2</td>
<td>MSH6</td>
<td>MSH6 deficient</td>
<td>MSH6 deficient</td>
<td>MSH-H</td>
<td>MSH</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>3</td>
<td>MLH1</td>
<td>MLH1/PM2S2 deficient</td>
<td>MLH1/PM2S2 deficient</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>4</td>
<td>PMS2</td>
<td>Intact</td>
<td>MSH6 subtotal</td>
<td>MSH-H</td>
<td>MSH</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>5</td>
<td>MSH6</td>
<td>MSH6 deficient</td>
<td>MSH6 deficient</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

Abbreviations: MSI-H, microsatellite instable; MSS, microsatellite stable.