with MTIT (24.1% vs. 60.7%, $P = 0.005$). Wound breakdown was the most common complication in our cohort, which occurred less frequently in the M-MTIT group than in the MTIT group (10.3% vs. 35.7%, $P = 0.022$). Multivariate logistic regression analysis identified M-MTIT as an independent predictor of reduced risk of wound breakdown. The incidence of other complications, including lymphedema, wound infection and cellulitis was lower in M-MTIT group than in MTIT group; however, the differences did not reach statistical significance. Median follow-up time of this study was 33 months. The Kaplan-Meier survival graphs did not show significant differences in recurrence-free survival and overall survival between the two groups.

Conclusions M-MTIT correlates with lower morbidity rates and does not compromise oncological safety compared with MTIT. It could be considered as a safe and feasible option for vulvar cancer patients with locally advanced disease.

IGCS20_1344

322 PREVALENCE OF HRHPV DNA AND P16/KI67 EXPRESSION AMONG WOMEN WITH CERVICAL DYSPLASIA

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Objectives Markers such as HPV DNA, p16 and ki67 are helpful to decide who among the screen positives require further management and treatment. So, this study was planned to estimate the prevalence of HPV DNA, p16 and Ki67 expression among the women with cervical dysplasia and to correlate high risk HPV DNA positivity and P16/Ki67 expression among them.

Methods In this hospital-based cross-sectional study, 146 women with abnormal Pap smear reports were included in the study and were subjected to HPV DNA testing and colposcopy and directed biopsy for histopathology and immuno-histochemistry for p16 and ki67. Women who have already received treatment for dysplasia and women who were pregnant were excluded from the study.

Results Totally 146 women with abnormal Pap report with a mean age of 47.8 years were studied. The prevalence of high-risk HPV was 44.5% and HPV 16, 56 and 18 were the common genotypes. The prevalence of P16 and Ki67 expression more than 5% was 20.5% and 34.3% respectively. Positive correlation was noted between high risk HPV and P16/Ki67 expression (p value of 0.0189 for P16 expression and HPV positivity, p value of 0.0027 for Ki67 expression and HPV positivity).

Conclusions The prevalence of high-risk HPV in our study population comprising of women with abnormal Pap smears was 44.5%. Positive correlation was noted between HPV, histopathology and P16 and Ki67 suggesting that these markers can be used as adjuncts in inconclusive cases during histopathological examination.

IGCS20_1346

323 ENGOT-EN9/LEAP-001: A PHASE 3 STUDY OF FIRST-LINE PEMBROLIZUMAB PLUS LENVATINIB COMPARED WITH CHEMOTHERAPY IN ADVANCED OR RECURRENT ENDOMETRIAL CANCER

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Background Prognosis and OS are poor in patients with advanced or recurrent endometrial cancer (EC). First-line standard of care for these patients is paclitaxel-carboplatin chemotherapy; however, more effective and tolerable therapies are needed. In the phase 1b/2 trial KEYNOTE-146, which assessed the PD-1 inhibitor pembrolizumab combined with the multikinase inhibitor lenvatinib, an ORR of 38% was observed in patients with previously treated advanced EC. ENGOT-en9/LEAP-001 (NCT03884101) is a randomized, open-label, active-controlled, phase 3 study investigating pembrolizumab + lenvatinib vs chemotherapy in patients with EC.

Trial design Patients with newly diagnosed advanced (stage III-IV) or recurrent EC not previously treated with antiangiogenic agents; systemic chemotherapy (unless within a chemoradiation regimen); PD-1, PD-L1, or PD-L2 inhibitors; or other T-cell receptor-targeted therapies will be eligible. Patients will be randomized 1:1 to receive pembrolizumab 200 mg Q3W + lenvatinib 20 mg daily or paclitaxel 175 mg/m² Q3W + carboplatin AUC 6 Q3W. Randomization will be stratified by proficient vs deficient mismatch repair (pMMR vs dMMR) status. The pMMR population will be further stratified by prior chemoradiation (yes/no), measurable disease (yes/no), and ECOG performance status (0/1). Patients will receive treatment for ≤35 cycles of pembrolizumab vs 7 cycles of chemotherapy or until initiation of a new anticancer treatment, unacceptable AEs, or withdrawal of consent. Primary endpoints are PFS (per RECIST v1.1 by blinded independent central review) and OS. Secondary endpoints are ORR, health-related QOL, safety/tolerability, and lenvatinib pharmacokinetics. Exploratory endpoints are disease control rate, clinical benefit rate, and duration of response. Enrollment is ongoing.

IGCS20_1347

324 THE COMPLEXITY OF DECISION-MAKING FOR RISK-REDUCING SURGERY IN WOMEN WITH LYNCH SYNDROME

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Introduction Risk-reducing surgery (RRS) in Lynch Syndrome effectively prevents endometrial and ovarian cancers.

Abstract 324 Table 1 Lynch syndrome and risk-reducing surgery

	Analysis at age 45 for MLH1/MSH2 mutations				Analysis at age 50 for MLH1/MSH2 mutations			
	Women who did not undergo risk-reducing surgery by age 45 (n, %)	Women who did undergo surgery by age 45 (n, %)	Compliance rate (%)	p-value	Women who did not undergo risk-reducing surgery by age 50 (n, %)	Women who did undergo surgery by age 50 (n, %)	Compliance rate (%)	p-value
All patients	43	39	47.6%		24	52	68.4%	p=0.001
Mutation				p=0.33				p=0.08
MLH1	20 (46.5%)	14 (35.6%)	41.2%		14 (58.3%)	19 (36.5%)	57.6%	
MSH2	23 (53.5%)	25 (64.1%)	52.1%		10 (41.7%)	33 (63.5%)	76.7%	
Surgical and Radiation History				p=0.11				p=0.001
Prior bowel surgery or pelvic radiation	17 (39.5%)	9 (23.1%)	34.6%		14 (58.3%)	10 (19.2%)	41.7%	
No prior bowel surgery or pelvic radiation	26 (60.5%)	30 (66.7%)	53.6%		10 (41.7%)	42 (80.8%)	80.8%	
Type of Surgery								p=0.88
Hysterectomy with BSO		33 (91.7%)				46 (88.5%)		
Hysterectomy only (at least 1 ovary remains)		5 (12.8%)				5 (9.6%)		
BSO only (uterus remains)		1 (2.6%)				1 (1.9%)		

Guidelines recommend discussing prophylactic hysterectomy and bilateral salpingo-oophorectomy (BSO) by age 40–45 for women with MLH1 or MSH2 mutations but lack consensus for timing of surgery. This study aims to define factors that impact decision-making for RRS.

Methods This IRB-approved retrospective study assessed 282 women with Lynch Syndrome with records from 2002–2020. Those preoperatively diagnosed with endometrial hyperplasia or cancer were excluded (n=75). The cohort was divided by mutation and age. Medical history was collected. Comparisons were made with Chi-Squared, McNemar, and Fisher exact tests. Compliance was calculated as the proportion of patients who underwent RRS by the specified age compared to all who met that age.

Results For MLH1 and MSH2 mutation carriers, compliance increased from 47.6% by age 45 to 68.4% by age 50 (p=0.001). Ten patients with prior bowel surgery or pelvic radiation underwent RRS by age 50 compared to 42 patients without this history (p=0.001). Compliance was 41.7% and 80.8% respectively. Surgery by age 50 included: 46 (88.5%) hysterectomy with BSO, 5 (9.6%) hysterectomy alone, and 1 (1.9%) BSO alone. The patient who underwent BSO alone had prior bowel surgery and radiation.

Conclusion The decision to undergo RRS in women with Lynch Syndrome is complex and often individualized. Factors that impact the compliance and timing of surgery include age, mutation status, and prior bowel surgery or pelvic radiation.

Dermatomyositis occurring as a paraneoplastic syndrome in a high grade serous ovarian carcinoma is rare and treating the disease condition is a challenge.

A 46-year-old, nulligravid presented with an eight-month history of rash, joint pain, and progressive muscular weakness. Dermatomyositis was diagnosed in the background of cutaneous manifestations, progressive muscle weakness, elevated muscle enzymes and electromyographic findings. She was treated with prednisone, however during the course of

Abstract 325 Figure 1

IGCS20_1348

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DERMATOMYOSITIS AS A PARANEOPLASTIC SYNDROME IN HIGH GRADE SEROUS OVARIAN CARCINOMA: A CASE REPORT AND REVIEW OF LITERATURE

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