lymphadenectomy), radiotherapy (external beam radiotherapy and brachytherapy) and systemic therapies (chemotherapies, immunotherapies and hormonal therapies) were identified and described by LOT. The first treatment received post diagnosis was classified as LOT1. Treatments initiated within ±90 days of surgical procedures, 30 days of the end of a radiotherapy, and 28 days of the start of a systemic therapy were considered to be a part of the same LOT. Study outcomes included time to treatment initiation, most frequently received treatments in LOT1 and LOT2, and per patient per month (PPPM) costs attributable to LOT1 and LOT2.

Results Among 5,006 newly diagnosed endometrial cancer patients, 3,574 (71%) received at least LOT1 and 771 (15.4%) received LOT2. The median time from diagnosis to LOT1 initiation was 1.0 (1.0 – 2.0) month. Hysterectomy (98.9%) was the most common treatment in LOT1. Majority of patients received radiation therapy (65%) in LOT2. Treatments received in LOT1 and LOT2 are summarized in table 1. The mean total healthcare cost from diagnosis to end of follow-up was $6,088 PPPM. The PPPM costs attributable to each LOT are presented in figure 1. The total healthcare costs during LOT2 exceeded those incurred during LOT1 with outpatient costs being the biggest driver.

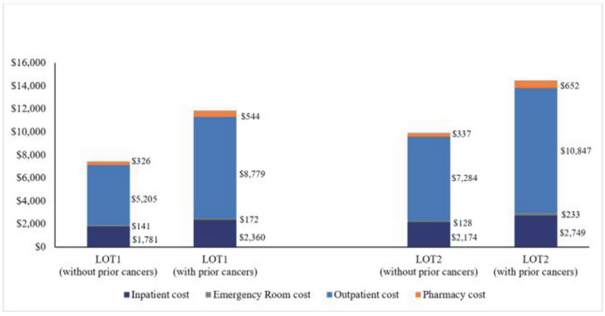
Conclusion Newly diagnosed endometrial cancer patients received treatments consistent with guidelines with hysterectomy being the most common LOT1 treatment. Outpatient costs accounted for 70%-80% of total healthcare costs attributable to LOT1 and LOT2. Moving from LOT1 to subsequent LOTs was associated with an increase in healthcare costs which may be indicative of disease progression/recurrence.

Disclosures This study was funded by Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., Kenilworth, NJ, USA. Chizoba Nwankwo is an employee of Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc. Anuj Shah, Ruchit Shah, Shelby Corman, and Nehemiah Kebede are employees of Pharmerit, which received consulting fees related to this study.

Abstract 292 Table 1 Treatment patterns among endometrial cancer patients initiating systemic therapy by line of therapy

Treatments	First Line of Therapy	Second Line of Therapy
No prior presence of non-endometrial cancer		
Systemic therapy only [a]	N=278	N=80
Carboplatin	66 (23.74%)	11 (13.75%)
Megestrol acetate	62 (22.3%)	14 (17.5%)
Paclitaxel	58 (20.86%)	10 (12.5%)
Other	176 (63.31%)	64 (80%)
Systemic therapy + radiation [a]	N=19	N=9
Carboplatin	8 (42.11%)	4 (44.44%)
Megestrol acetate	4 (21.05%)	2 (22.22%)
Paclitaxel	7 (36.84%)	3 (33.33%)
Other	10 (52.63%)	6 (66.67%)
Prior presence of non-endometrial cancer		
Systemic therapy only [a]	N= 1,933	N=721
Carboplatin	791 (40.92%)	171 (23.72%)
Paclitaxel	702 (36.32%)	147 (20.39%)
Megestrol acetate	167 (8.64%)	66 (9.15%)
Other	1251 (64.72%)	597 (82.8%)
Systemic therapy + radiation [a]	N= 429	N=67
Cisplatin	133 (31%)	9 (13.43%)
Carboplatin	113 (26.34%)	13 (19.4%)
Paclitaxel	95 (22.14%)	11 (16.42%)
Other	251 (58.51%)	58 (86.57%)

[a] These categories are mutually exclusive however patients may have received a combination of treatments listed under each category. Radiation therapy includes EBRT and brachytherapy.



Abstract 292 Figure 1 Mean per patient per month healthcare costs by line of therapy among endometrial cancer patients newly initiating systemic therapy

292 REAL-WORLD TREATMENT PATTERNS, HEALTHCARE RESOURCE USE, AND COSTS BY LINE OF THERAPY AMONG ENDOMETRIAL CANCER PATIENTS NEWLY INITIATING SYSTEMIC THERAPIES

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Introduction/Background NCCN guidelines recommend the use of systemic therapy for women with advanced endometrial cancer. However, there are no data examining real-world treatment patterns and economic burden in this population. Therefore, this analysis described treatment patterns, and costs in a real-world cohort of endometrial cancer patients initiating systemic treatment.

Methodology Endometrial cancer patients with ≥2 claims for a systemic therapy (i.e., chemo-, immuno- or hormonal therapies) within a 4-week period or a claim for an intrauterine device between June 2014 – September 2018 and having continuous medical enrollment for 6 months prior and 3 months post therapy initiation were identified in the Optum Clinformatics DataMart database. Patients with endometrial cancer-related surgery performed within ±90 days of systemic therapy initiation were not included to exclude adjuvant use. All claims for the same systemic therapy without a >90-day gap or a new systemic treatment initiated within 28 days were a part of the same line of therapy (LOT). We reported the most frequently used treatments and per patient per month (PPPM) healthcare costs for LOT1 and LOT2. All analyses were stratified by the presence of non-endometrial cancers prior to systemic therapy initiation.

Results 2,659 women with endometrial cancer newly initiated systemic therapy (i.e., LOT1), 877 (32.98%) received a LOT2, and 350 (13.16%) had a LOT3. Most patients had a non-endometrial cancer (88.9%) prior to initiating systemic therapy. The treatments received and associated costs in LOT1 and LOT2 are described in table 1 and figure 1, respectively. The median durations of LOT1 and LOT2 were 3.5 and 3.1 months, respectively. The proportions of patients receiving monotherapy in LOT1 and LOT2 were 55.3% and 54.4%, respectively. The mean PPPM total healthcare expenditure over the entire follow-up was $11,109 and outpatient costs ($8,073) accounted for ~75% of this burden. Healthcare expenditure increased as patients moved from LOT1 to LOT2.

Conclusion Both taxanes and platinum-based therapies were used as the primary systemic treatments in this population.

The use of targeted and immunotherapies was not common perhaps because the approval of these treatments was recent and not adequately captured in the data. Delaying progression to subsequent LOTs may help reduce the economic burden in this population.

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298 PROGNOSTIC FACTORS FOR LOCALIZED UTERINE CARCINOSARCOMA – 18 YEARS OF REAL-WORLD PRACTICE OF A PORTUGUESE CANCER CENTRE

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Introduction/Background Uterine carcinosarcoma (UCS) is a rare but aggressive malignancy. It represents 5% all of uterine tumors and is responsible for 30% of uterine cancer deaths. Known risk factors for UCS are age, pelvic irradiation, and tamoxifen use. Prognostic factors are not clearly defined. This study aims to determine prognostic factors for survival in UCS.

Methodology Observational retrospective study of pts with UCS treated in a Cancer Centre between 2000–2018. Clinical data was retrieved from records. Prognostic variables were tested by multivariate analysis using Cox's proportional hazards regression model, and Kaplan-Meier survival curves were generated.

Results A total of 73 women with early or locally advanced UCS were identified, with median age 68.0 yrs (46–89). Most pts had Performance Status (PS) 0–1 (n=59, 80.8%). Regarding predisposing factors, 8 had used tamoxifen and 5 had underwent pelvic radiotherapy. FIGO stage distribution as follows: 26 (35.5%) stage I; 13 (17.7%) stage II; 30 (41.0%) stage III; and 4 (5.8%) stage IVA.

Initial treatment was surgery for 70 pts. All pts underwent total hysterectomy and bilateral anexectomy, 22 (31.4%) pts pelvic and lomboaortic lymph node dissection (LND), and 19 (27.1%) pts isolated pelvic LND. Residual disease was present in 15 pts (20.5%). Adjuvant treatment was prescribed as follows: isolated radiotherapy (RT) for 22 pts (30.1%) (of which 13 received additional brachytherapy), chemotherapy followed by RT for 17 pts (23.3%) and isolated chemotherapy for 11 pts (15.1%). Isolated adjuvant RT was prescribed mostly before 2010, and afterwards the use of adjuvant chemotherapy became more common.

After a median follow up of 29.7 months (95% CI [22.1–37.4]), 51 pts (69.9%) died. Relapse occurred in 40 pts (54.8%), mostly with a pattern of distant failure (33 pts). Local recurrence occurred in 18 pts. Median overall survival (OS) and disease free survival (DFS) were 18.3 (95% CI 13.3–23.3) and 11.3 (95% CI 7.5–15) months, respectively.

In multivariate analysis, PS (HR 3.93, 95% CI [1.16–13.27], p=0.028), residual disease (HR 12.21, 95% CI [2.13–70.02], p=0.005), adjuvant RT (HR 0.27, 95% CI [0.09–0.83], p=0.022) and adjuvant brachytherapy (HR 0.31, 95% CI [0.09–0.99], p=0.048) were independent prognostic factors for OS. No prognostic factors for DFS were found.

Conclusion In concordance with previous studies, UCS presented a high rate of recurrence and mortality. This study identified PS, residual disease, and adjuvant radiotherapy and brachytherapy as prognostic factors for OS. Despite relapse occurring mostly at distance, adjuvant chemotherapy did not impact survival.

Disclosures The authors have no disclosures.

299 SENTINEL LYMPH-NODE MAPPING WITH INDOCYANINE GREEN IN ENDOMETRIAL CANCER: DETECTION RATE AND ANATOMICAL SITES

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Introduction/Background Lymph-node status is one of the prognostic factors related to the survival of patients with endometrial cancer (EC). However, systemic pelvic lymphonodectomy (PLN) is related to increased perioperative morbidity. A number of studies using different techniques have demonstrated the sentinel lymph-node biopsy (SLB) could be a better alternative to PLN in different patient groups. With evidence still lacking, SLB is considered an experimental method by major professional organisations like European Society of Gynaecologic Oncology. The aim of this study was to evaluate the adherence of the SLB procedure in a center with no previous experience of SLB in EC.

Methodology Prospective interventional study was performed in Lithuanian University of Health Sciences Hospital, Centre of Oncogynaecology in the period of 2018 March and 2020 July. 96 patients with histologically confirmed endometrioid endometrial carcinoma were included into the study. Indocyanine green (ICG) dye was used to map sentinel lymph-nodes using previously described technique. PLN was performed after SLB procedure for intermediate and high-risk patients.

Results Detection rate, timing and anatomical sites

The overall SL detection rate was 87.5% (bilateral in 63.5% (61/96), unilateral in additional 24.0% (23/96) of patients). The median time for the detection of the 1st SL was 35 minutes after injection of ICG (range 13–140 min), and 45 minutes (range 25–115 min) for the 2nd (contralateral) one. The median number of SL removed was 2 (range 1–8). The most frequent sites for SLs were right external iliac area (31.0%), left external iliac area (24.2%), right internal iliac area (11.9%) and left obturator fossa (11.3%). 4.8% of SL mapped in paraaortic region.

SL metastasis rate Lymph node metastasis were found in 6 (6.3%) patients and 4 (4.4%) of them were detected by SLB. The sensitivity of SLB was 66.7% and negative predictive value 97.4%. SLB has moderate – strong agreement with PLN (kappa coefficient 0.787, $p < 0.001$).

SL mapping failures SL mapping failed in 12.5% (12/96) of the patients. The factors that might be associated with mapping failure was age (73 vs. 64.5 vs. 62.8, p=0.005) and present extragenital pathology (100% vs. 60.9% vs. 57.4%, p=0.019).