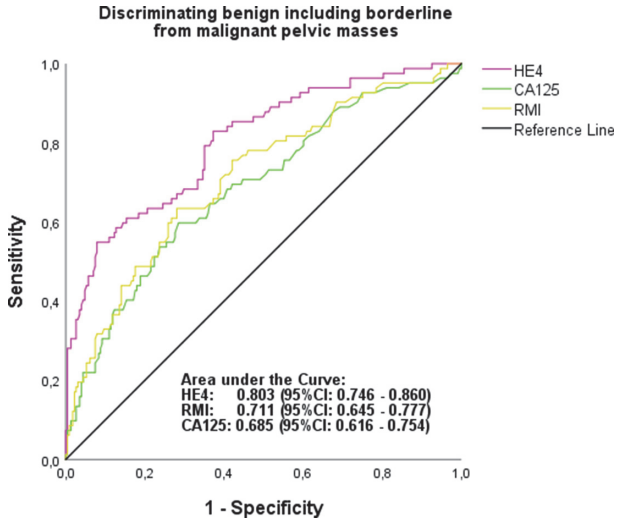
Abstract 1069 Table 1 Specificity, PPV and NPV at 85% sensitivity in discriminating benign and borderline from malignant pelvic masses. Table 1

	Specificity	PPV	NPV
HE4	58%	42%	92%
RMI	33%	31%	85%
CA125	34%	32%	87%
HE4 in elevated RMI group	63%	45%	92%



Abstract 1069 Figure 1 Discriminating benign including boardline from malignant pevic masses

Methodology In this prospective, observational cohort study, we included patients with a pelvic mass between 2017 and 2021 from nine general hospitals. HE4 and CA125 were measured using electrochemiluminescence in preoperative samples. All patients underwent surgery. Accuracies of HE4, RMI, CA125, and combinations hereof, were determined using Area under the Curve (AUC), sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV).

Result(s)* We included 311 patients, of whom 82 patients had a malignant pelvic mass. Sixty-six patients had epithelial OC, 6 non-epithelial OC and 10 had ovarian metastases or a pelvic mass of non-ovarian origin. The remaining patients had a benign (n=190) or a borderline pelvic mass (n=39). HE4 had the highest AUC (figure 1). The addition of HE4 in patients with an elevated RMI score at a pre-specified 85% sensitivity had the highest specificity, PPV and NPV (table 1) in differentiating malignant from benign and borderline pelvic masses.

Conclusion* HE4 is superior to CA125 and RMI in predicting malignancy in a population with a low prevalence of OC. The addition of HE4 in patients with an elevated RMI score improved the performance of HE4 alone in discriminating malignant from benign including borderline pelvic masses. Although there is still room for improvement, this confirms that HE4 can be used to support referral decisions in a population from general hospitals.

Endometrial cancer

10 THE ADOPTION OF SENTINEL NODE MAPPING WITH OR WITHOUT BACKUP LYMPHADENECTOMY IN ENDOMETRIAL CANCER

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Introduction/Background* Sentinel node mapping (SNM) has replaced lymphadenectomy for staging surgery in apparent early-stage endometrial cancer (EC). Here, we evaluate the long-term survival of three different approaches of nodal assessment in low, intermediate, and high-risk EC.

Methodology This is a multi-institutional retrospective study evaluating long-term outcomes (at least 3 years of follow-up) of EC patients having nodal assessment between 2006 and 2016. In order to reduce possible confounding factors, we applied a propensity-matched algorithm.

Result(s)* Charts of 940 patients were evaluated: 174 (18.5%), 187 (19.9%), and 579 (61.6%) having SNM, SNM followed by backup lymphadenectomy and lymphadenectomy, respectively. Applying a propensity score matching algorithm (1:1:2) we selected 500 patients: 125 SNM vs. 125 SNM plus backup lymphadenectomy vs. 250 lymphadenectomy. Baseline characteristics of the study population were similar between groups. The prevalence of nodal disease was 14%, 16%, and 12% in patients having SNM, SNM followed by backup lymphadenectomy and lymphadenectomy, respectively. Overall, 19 (7.6%) patients were diagnosed with low volume nodal disease (7 and 12 patients with micrometastasis and isolated tumor cells). The mean (SD) follow-up time was 62 (±11) months. The survival analysis comparing the three techniques did not show statistical differences in terms of disease-free (p=0.750) and overall survival (p=0.899). Similarly, the type of nodal assessment did not impact survival outcomes after stratification on the basis of uterine risk factors.

Conclusion* Our study highlighted that SNM provides similar long-term oncologic outcomes than lymphadenectomy. Further evidence is warranted to assess the prognostic value of low-volume disease detected by ultrastaging and the role of molecular/genomic profiling.

15 ABSTRACT WITHDRAWN

37 INTRACAVITARY BRACHYTHERAPY AS THE METHOD OF CHOICE IN FRAGILE PATIENTS WITH EARLY-STAGE ENDOMETRIAL CANCER

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Introduction/Background* In patients presenting with fragility syndrome or morbid obesity an individualised treatment is required. Intracavitary brachytherapy is a technique which allows to deliver high dose radiation to the uterine corpus sparing adjacent organs. This technique can be the method of choice in the group of fragile patients with early-stage endometrial cancer. We present a series of patients diagnosed of FIGO stage I and II endometrial carcinoma treated exclusively with intrauterine brachytherapy.

Methodology 57 patients with early-stage endometrial cancer treated by brachytherapy from 2011 to 2017 in National Research Institute of Oncology were included. All but two patients presented endometrioid histology. 54 patients were classified as FIGO stage I and 5 patients were FIGO stage II. The vast majority of patients (70.1%) presented with obesity superior to body max index 30. The contraindication from surgical or external beam radiotherapy were related to a combination of comorbidities, advanced age and morbid obesity. High dose rate intracavitary brachytherapy with Rotte applicator, uterine probe or Fretcher applicator with uterine probe were used and 3-dimmensional planning according to computed tomography were performed. 52.5Gy per 7 fractions in 43 patients, 45Gy per 6 fractions in 1 patient and 45Gy per 5 fractions in 13 patients were delivered.

Result(s)* After a follow up of 5 years, 11 (19.3%) patients recurred. There were 6 (10.5%) local recurrences (54.5% of recurrences), and 5 distant recurrences (45.5%). A total of 25 (44,5%) patients died and, of these, 7 patients (12.7%) died of disease. Cancer non-related deaths were more common in this cohort of patients and represented 31,8%. Early and late side effects were not observed in this series. Early complications in the form of bleeding after insertion of applicators were not observed.

Conclusion* Exclusive brachytherapy is feasible and safe management in fragile patients with endometrial cancer FIGO stage I or II. Their survival outcome is more conditioned by the associated comorbidities than by the evolution of oncological disease.

73 POST-PLATINUM TREATMENT LANDSCAPE IN PATIENTS WITH RECURRENT ENDOMETRIAL CANCER: ANALYSIS OF GERMAN CLAIMS DATA

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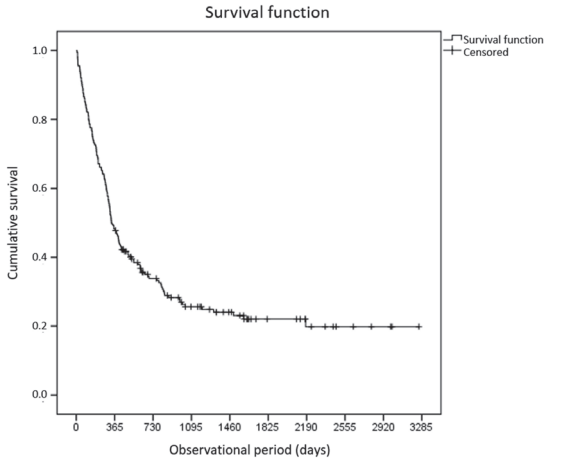
Introduction/Background* Recurrent or advanced endometrial cancer (EC) affects 2527 to 3245 women in Germany each year, with median survival of <1 year for patients with progression on or after first-line platinum therapy. Patients in this population have limited treatment options.

Methodology This study was a retrospective, noninterventional, cohort analysis that used claims data from the AOK PLUS, a statutory health insurance provider, from 01/01/2010 to 30/06/2020 for about 3.4 million individuals in Germany. Eligible patients were >18 years old, had ≥2 outpatient specialist-confirmed EC diagnoses or 1 respective inpatient diagnosis

Deaths during follow-up[a]	Patients, N	Deaths, n (%)
All patients[b]	201	149 (74.1)
Patients <71 years at index	100	69 (69)
Patients ≥71 years at index	101	80 (79.2)

[a]Mean follow-up was 613.8 days; [b]Median age of all patients is 71 years.



Observational period (days)	0	365	730	1095	1460	1825	2190	2555	2920
Patients at risk	201	97	56	36	26	14	9	5	3

Abstract 73 Figure 1 survival of patients from first administration of postplatinum treatment

Abstract 73 Table 1 Most frequent postplatinum regimens and agents observed (line after platinum treatment only)

Most frequent regimens, n (%)	Patients N=201
Noncomplex chemotherapy with 2 agents (inpatient)[a]	20 (10.0)
Medroxyprogesterone (monotherapy)	16 (8.0)
Doxorubicin (monotherapy)	14 (7.0)
Carboplatin and paclitaxel	11 (5.5)
Paclitaxel (monotherapy)	8 (4.0)
Tamoxifen (monotherapy)	7 (3.5)
Carboplatin and doxorubicin	7 (3.5)
Moderate complex chemotherapy with 2 agents (inpatient)[a]	6 (3.0)
Carboplatin and gemcitabine	6 (3.0)
Gemcitabine (monotherapy)	6 (3.0)
Anastrozole (monotherapy)	5 (2.5)
Fulvestrant (monotherapy)	4 (2.0)
Megestrol (monotherapy)	4 (2.0)
Bevacizumab and carboplatin and paclitaxel	4 (2.0)
Noncomplex chemotherapy with 1 agent (inpatient)	4 (2.0)
59 other combinations (<4 patients)	78 (38.8)
Most frequent agents, n (%)	
Carboplatin	42 (20.9)
Paclitaxel	33 (16.4)
Doxorubicin	30 (14.9)
Noncomplex chemotherapy with 2 agents (inpatient)[a]	26 (12.9)
Medroxyprogesterone	20 (10.0)
Gemcitabine	17 (8.5)
Bevacizumab	16 (8.0)
Moderately complex chemotherapy with 2 agents (inpatient)[a]	10 (5.0)
Tamoxifen	8 (4.0)
Noncomplex chemotherapy with 1 agent (inpatient)	8 (4.0)
Megestrol	7 (3.5)
Anastrozole	6 (3.0)
Cisplatin	5 (2.5)
Docetaxel	5 (2.5)
Fulvestrant	5 (2.5)
Immunotherapy (inpatient)	5 (2.5)
Trabectedin	5 (2.5)
23 other agents/procedures (<5 patients)	48 (23.9)